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The Clinical Coders' Society of Australia (CCSA) appreciates the opportunity to be involved in the public consultation process for the draft Australian National Subacute and Non-Acute Patient Classification Version 5.0 (AN-SNAP V5).

Our feedback for the consultation questions is below.

Consultation question

Do you support IHPA's proposed approach to use the Frailty Risk Score calculated from ICD-10-AM codes as proxy markers of frailty? If not, why not?

If the Frailty Risk Score is adopted for AN-SNAP V5, do you support IHPA's proposed approach to exclude less defined and redundant codes from the score's calculation? If not, why not?

For future work (i.e. beyond AN-SNAP V5), do you prefer any particular prospective frailty instrument being prioritised by IHPA for further investigation (including potentially being proposed for the admitted subacute and non-acute hospital care national best endeavours data set)? If so, why? Examples of the type of instruments include but are not limited to:

- the Rockwood Clinical Frailty Scale[1]
- the Australian National Aged Care Classification (AN-ACC) assessment tool[2].

While CCSA can see the benefit of the inclusion of a frailty assessment for Subacute and Non-Acute episodes of care, we are concerned as to the changes over time to Australian Coding Standard (ACS) 0002 *Additional diagnoses* and the impact this has, and will continue to have, on ICD-10-AM code assignment that will be used to calculate a score. Can further information be provided to show how changes to ACS 0002 has been factored into, and impacts, the modelling?

We also have concerns about some of the ICD-10-AM codes that have been proposed to be excluded in the frailty assessment methodology. Some of the codes that are proposed to be excluded are quintessentially related to a person being in a frail state (for example R26.8 *Other and unspecified abnormalities of gait and mobility*).

Deficiencies in clinical documentation is also of concern. Due to lack of clear or comprehensive documentation, it can often be difficult to assign more specific ICD-10-AM codes. At times, frailty can only be described by number of unspecific conditions.

We would like to know if the investigation done thus far has included review and utilisation of the supplementary codes for chronic conditions. While a condition may not be actively treated, its presence as a

[1] See Rockwood K, Song X, MacKnight C, Bergman H, Hogan D B, McDowell I, & Mitnitski A. (2005). A global clinical measure of fitness and frailty in elderly people. *CMAJ: Canadian Medical Association journal = journal de l'Association medicale canadienne*, *173*(5), 489–495.

[2] See Westera A, Snoek M, Duncan C, Quinsey K, Samsa P, McNamee J, & Eager, K. (2019) *The AN-ACC assessment model. The Resource Utilisation and Classification Study: Report 2*. Australian Health Services Research Institute, University of Wollongong.

chronic condition can impact a person's frailty. The data captured in these codes could be a value resource in further understanding this patient cohort.

This methodology should be based on clear, consistent and transparent clinical assessment.

As the Frailty Risk Assessment will be calculated after completion of the episode of care (from coded data), does the model include capacity that will allow for identification of frailty that has occurred during the episode of care. I.e. Does the model use the Condition onset flag indicator in the calculation of the assessment score?

Consultation question

Do you support IHPA's proposal to establish a new impairment type group *Orthopaedic conditions, replacement* for knee, hip and shoulder replacement activity

CCSA does support the establishment of a new impairment type group *Orthopaedic conditions, replacement* for knee, hip and shoulder replacement activity, but we suggest that the name of the proposed group more clearly indicate that this group does not include all orthopaedic replacements, i.e. it only incorporates selected joint replacement activity (elbow, wrist, interphalangeal appear to be excluded). Is it intended that 'Orthopaedic condition, replacement' is only intended to capture the activity immediately after specified joint replacement (including revision) or will is also include Subacute and Non-Acute care for mechanical and other specified joint replacement complications?

Is there a cost impact for unilateral versus bilateral joint replacement episodes of care?

Consultation question

Do you support a measure of frailty being introduced into the classification for adult admitted rehabilitation care, in principle? If so, do you have an approach you recommend?

Do you support IHPA continuing to explore the Functional Independence Measure for children (WeeFIM™) as a potential variable within the paediatric rehabilitation classes? If not, why not?

Do you have any other suggestions for future work to refine the classification of adult or paediatric admitted rehabilitation care such as:

- care cost drivers which could be further investigated; and/or
- data items to consider for national collection?

CCSA supports the further development and exploration of a measure of frailty being introduced for adult admitted care but suggest that the tool/ methodology be made available for organisations and jurisdictions to model the impact on more current and local data.

CCSA supports IHPA continuing to explore the Functional Independence Measure for children (WeeFIM™) as a potential variable within the paediatric rehabilitation classes.

We would be interested to see further information about how patients that are identified as frail and undergo interventions such as dialysis and endoscopy procedures during their rehabilitation episode of care are impacted by the frailty measure. By the nature of these interventions a patient's resilience can be impacted. With chronic renal failure, we recognise that the proposed ICD-10-AM code range includes N18.4 to N18.5, but this does not definitively mean a patient received dialysis interventions during the Subacute and Non-Acute episode of care.

Due to the recency of COVID-19, we would suggest that there should be active consideration and monitoring of the impact of post COVID-19 condition related episodes of care in the rehabilitation setting. It may be that the ICD-10-AM code for post COVID-19 should be considered for inclusion in the frailty methodology.

Consultation question

Do you have any suggestions for future work to refine the classification of adult or paediatric admitted palliative care such as:

- care cost drivers which could be further investigated; and/or
- data items to consider for national collection?

CCSA would like to suggest that the impact of isolation requirements, as seeing in COVID-19 affected episodes of care be investigated for palliative care.

Consultation question

Do you support IHPA's proposal to introduce the Frailty Risk Score as a variable for the GEM care type? If not, why not?

As already noted, while CCSA does support the introduction of a Frailty Risk Score, we have some concerns and questions about the proposed methodology. We suggest further modelling with release of this information and supporting case studies be released for consideration.

In the modelling did Age have any impact on the Frailty Risk Score for this cohort of patients?

Consultation question

Do you have any suggestions for future work to refine the classification of GEM care such as:

- care cost drivers which could be further investigated; and/or
- data items to consider for national collection?

CCSA does not have any suggestions for further work to refine the classification of GEM care.

Consultation question

Do you support IHPA's proposal to adopt the HoNOS 65+ total score to split short stay overnight episodes in the Psychogeriatric care type?

CCSA supports IHPA's proposal to adopt the HoNOS 65+ total score to split short stay overnight episodes in the Psychogeriatric care type.

Consultation question

Do you support IHPA's proposal to introduce the Frailty Risk Score as a variable for the non-acute care type? If not, why not?

In principle, CCSA does support IHPA's proposal to introduce the Frailty Risk Score as a variable for the non-acute care type – for all age groups. But as per above comments, we have concerns and questions about the proposed methodology.

Consultation question

Do you have any suggestions for future work to refine the classification of non-acute care such as:

- care cost drivers which could be further investigated; and/or
- data items to consider for national collection?

CCSA has concerns about the proposal in that the frailty score is only being suggested for those aged 65 years and over. Frailty can be defined as 'the quality or state of being frail'[3]. Frailty is not age specific.

As mentioned above, while we realise that due to the recency of COVID-19, we would suggest that there should be active consideration and monitoring of the impact of post COVID-19 condition related episodes of care in the Subacute and Non-Acute setting. It may be that the ICD-10-AM code for post COVID-19 should be considered for inclusion in the frailty methodology.

Please do not hesitate to contact me if you have any questions about our feedback or require further information.

Regards,

Chris Moser
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[3] Frailty | Definition of Frailty by Merriam-Webster, accessed 10 May 2021, <https://www.merriam-webster.com/dictionary/frailty>