NSW GOVERNMENT | Health

Mr Shane Solomon
Chair
Independent Hospital Pricing Authority
Email: secretariatihpa@ihpa.gov.au

Our ref H21/89821

Dear Mr Solomon

Please find enclosed NSW Health's submission to the Independent Hospital Pricing Authority's (IHPA) draft *Australian Subacute and Non-Acute Patient (AN-SNAP) Classification Version 5.0*.

NSW supports in-principle a proxy marker of frailty but does not support the IHPA's proposed frailty risk score at this stage. NSW recommends that any chosen frailty assessment should be clinically meaningful, supportive of prospective patient care and be a validated assessment tool.

NSW is also concerned about the reasoning behind the choice of variables retained or removed from the methodology and encourages the IHPA to consider feedback from all stakeholders when considering inclusion or exclusion of data variables.

NSW Health looks forward to further consultation on the development of the AN-SNAP Classification Version 5.0 through IHPA's Sub-and-Non-Acute Working Group and relevant advisory committees.

If you would like more information, please contact Susan Dunn, Acting Director, Activity Based Management, NSW Health at Susan.Dunn1@health.nsw.gov.au or on 02 9391 9405.

Yours sincerely

Neville Onley
Executive Director
Activity Based Management

Encl. NSW Submission to IHPA draft Australian Subacute and Non-Acute Patient Classification Version 5.0.

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Independent Hospital Pricing Authority's Development of the Australian National Subacute and Non-Acute Patient Classification Version 5.0

NSW Health Submission

Chapter 1 – Introduction

Nil comment.

Chapter 2 – Overview of AN-SNAP V4

2.1 AN-SNAP V4 structure

Nil comment.

Chapter 3 – Developing AN-SNAP V5

3.1 Project objectives and overview

NSW Health have actively participated in development of the Australian National Subacute and Non-Acute Patient (SNAP) Classification Version 5.0, both as participants of IHPA SNAP working groups, by actively engaging relevant NSW clinicians in the discussion and feeding this consultation back to IHPA.

3.2 Project governance

Nil comment.

3.3 Decision principles

Nil comment.

3.4 Data sources

Nil comment.

3.5 Optimising the existing AN-SNAP variables

Nil comment.

3.6 Exploring potential new AN-SNAP variables

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?

NSW supports in principle a proxy marker of frailty. NSW does not endorse however use of the proposed frailty risk score with exclusions and changes to score thresholds for any sub or non-acute care type. Feedback received from NSW stakeholders, including clinicians and the NSW Agency for Clinical Innovation Frailty Taskforce, states a need for the chosen frailty assessment to be clinically meaningful, supportive of prospective patient care and be a validated assessment tool (proposed changes to the existing tool require a revalidation exercise).

The frailty score does not consider the younger cohort of patients (< 75 years) who may also be considered frail. Nor does it take into consideration individual function, which may not be captured in ICD codes. NSW clinicians are concerned about applying a risk score developed and validated for the 75 years + age cohort across a broader range of ages in any of the proposed care types.

NSW stakeholders note that coding based on ACS 0002 may result in inconsistencies, especially where a condition/s are not well documented. NSW stakeholders also note that defining frailty based on a 'subjective' coding construct may not be ideal, especially with inclusion and exclusion of codes based on ACS 0002.

Consultation question: 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?

NSW does not endorse the exclusion of codes where they do not represent a validated measure or application of frailty in the Australian context. There is concern around exclusion of codes for common conditions leading to frailty. Frailty scored in this manner (by clinical diagnoses, as opposed to physical measurements in a phenotypic frailty model) characterises an accumulation of clinical deficits, which includes sub-acute and latent conditions impacting long-term function and clinical outcomes, as opposed to only those that directly require inpatient care.

Accurate assessment of frailty in a coded cumulative deficit model requires consideration of all prior diagnoses, rather than just those coded as arising during an inpatient episode of care. This divergence of clinical and coding concepts is likely to impact impressions of clinical validity and acceptance of coded frailty measure amongst clinicians.

Consultation question: 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?

NSW recommends that an appropriate frailty assessment should be based on what is most appropriate for managing clinical care and supporting a patient's journey in the first instance, with system data capture, reporting and funding subsequently developed. The NSW Agency for Clinical Innovation Frailty Taskforce recommends use of the FRAIL Scale or the Clinical FRAIL Scale. This reiterates the need to utilise a frailty assessment most appropriate for the individual patient and would also accept further exploration of the Rockwood Scale as a measure with greater general awareness amongst clinicians.

Recommendations:

- NSW recommends use of the FRAIL Scale or the Clinical FRAIL Scale, reiterating the need to utilise a frailty assessment most appropriate for the individual patient.

Chapter 4 – The draft AN-SNAP V5 classification

4.1 Overview

Recommendations:

- NSW suggests IHPA undertake further investigation on the use of a delirium and dementia assessment tool/s for use in the GEM care type.
- NSW recommends continued use of the current delirium and dementia flags until a validated assessment tool can be agreed on.

4.2 The AN-SNAP V5 admitted classes

4.2.1 Rehabilitation

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?

NSW endorses IHPA's recommendation to establish a new impairment type group for orthopaedic replacement for knee, hip and shoulder activity. There is however a need to differentiate upper versus lower limb.

While a shoulder replacement fits this category as an orthopaedic replacement, the post-operative protocol for shoulder replacement is very different from knee and hip replacements. The post-operative protocol for a shoulder replacement more closely resembles that of upper limb fracture in that patients are in a sling, immobilised and non-weight bearing through that limb for six weeks.

Recommendations:
• NSW recommends moving shoulder replacements with upper limb fractures, rather than with knee and hip replacements.

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?

NSW supports a measure of frailty being introduced for adult admitted rehabilitation care in principle, if it is a prospective measure used for case planning at time of the rehabilitation admission. The FRAIL scale can screen for frailty and allows for a management plan to be implemented immediately.

NSW notes Asia-Pacific Clinical Practice Guidelines for the Management of Frailty have three strong recommendations and three conditional recommendations. The strong recommendations include assessment of frailty utilising a validated tool such as the FRAIL Scale. Along with the Rockwood Clinical Frailty Scale, Cardiovascular Health Study Scale (also known as the Fried Phenotype or Frailty Phenotype) and Frailty Index, the FRAIL scale has been validated in primary care, hospitals and residential aged care.

Consultation question: 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?

NSW endorses and supports IHPA to further explore the WeeFIM™ as a potential variable for use within the paediatric rehabilitation classes.

Consultation question: 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?*

NSW has no suggestions regarding cost drivers or additional data items at this time.

4.2.2 Palliative care

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?*

NSW have no suggestions regarding cost drivers or additional data items at this time.

4.2.3 Geriatric Evaluation and Management (GEM)

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?

NSW does not support use of the Frailty Risk Score as a variable for the GEM care type. NSW is concerned that any chosen frailty assessment should be a validated and prospective tool used to inform clinical care. NSW notes changes IHPA have made to the thresholds and suggest this may not be clinically representative of the NSW/Australian cohort without a validation exercise.

NSW note use of the code R29.6 tendency to fall. This is frequently assigned as a principal diagnosis at a facility reflecting the highest percentage of GEM activity in NSW. This code is not assigned for frailty and is used where the patient has a history of repeated and current falls impacting admission.

The frailty score does not consider younger patients (< 75 years) who may also be considered frail. Nor does it take into consideration individual function, which may not be captured in ICD codes. NSW is concerned about applying a risk score developed and validated for the 75 years + age cohort across a broader range of ages in any of the proposed care types.

Recommendations:
• NSW recommends use of the FRAIL Scale or the Clinical FRAIL Scale, reiterating the need to utilise a frailty assessment most appropriate for the individual patient. • NSW encourages IHPA to consider feedback from all stakeholders when considering inclusion or exclusion of data variables.

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?*

NSW recommends IHPA undertake further investigation on use of a delirium and dementia assessment tool/s for use in the GEM care type.

4.2.4 Psychogeriatric 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?

NSW does not endorse the proposed split of HoNOS 65+ for psychogeriatric care type. NSW clinicians and other key stakeholders note that the proposed split is not appropriate for clinical management of a patient. Clinicians note that HoNOS 65+ variables do influence patient care and staffing levels. The current prioritisation of behaviour and ADL items of HoNOS 65+ is more clinically relevant, rather than shifting to using a total HoNOS score across a larger range, particularly where behaviour severity impacts resources required for care. NSW note however that short stay overnight episodes likely reflect a very different patient cohort than complex cases requiring more extended periods of care.

NSW emphasises the difficulty of changing end classes on such low volumes.

4.2.5 Non-acute care

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?

NSW does not endorse IHPA's proposal to introduce the Frailty Risk Score as a variable for maintenance care type (non-acute). NSW clinician stakeholders are firm in their stance that any clinical assessment tool inform the prospective management of patients to support best practice. NSW notes concern (as above) about Frailty Risk Score validated in the over 75 years cohort only with no validation in the under 75 years or in the Australian context.

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?*

NSW have no suggestions regarding cost drivers or additional data items at this time.

4.3 Performance of the overall proposed AN-SNAP V5 model

NSW is concerned about the reasoning behind the choice of variables retained or removed from the methodology as it appears to be based on considerations other than the performance of the model. An example of this is the non-acute care length of stay splits that are being retained as they were a new feature in SNAP Version 4 despite the model performance improving without them.

Chapter 5 – Next steps

NSW looks forward to further consultation on AN-SNAP V5 through the Subacute and Non-acute Working Group and the IHPA's advisory committees prior to its finalisation.