# Development of the Australian National Subacute and Non-Acute Patient Classification Version 5.0

Consultation paper

Victorian Department of Health response

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OFFICIAL

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**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?**

Victoria supports this approach.

**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?**

Victoria has concerns regarding the exclusion from the frailty risk score of external cause codes that further describe falls, and the exclusion of the R29.6 Tendency to fall, not elsewhere classified code.

Victoria notes IHPA's comment throughout the AN-SNAP V5 development phase that a fall that results in a minor injury will not attract a frailty risk score. Further, superficial injury and concussion have been excluded with the rationale being that these codes capture injuries that are likely to be insignificant and susceptible to gaming.

IHPA DTG analysis of codes that decreased in 2019-20 indicates that codes for some superficial injuries decreased likely due to the revised ACS 0002 Additional diagnosis standard, therefore suggesting that these codes are less likely to be assigned if not significant.

Victoria does not support the exclusion of the score on external cause codes in addition to exclusion of some injury codes. This is because a patient who falls and only sustains a superficial injury will not attract a score on either the injury (because it is considered minor) or the external cause.

Victoria also does not support the exclusion of R29.6 Tendency to fall, not elsewhere classified from the frailty risk score because in addition to this code being assigned when the patient tends to fall/has had repeated falls with no injury (or no codable injury), it is also assigned when the cause of the repeated falls is investigated and the cause is not found. In cases where a cause is found e.g. hypotension, R29.6 would not be assigned and the hypotension, which is coded, attracts a score.

**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? Examples of the type of instruments include but are not limited to:**

- **the Rockwood Clinical Frailty Scale the Australian National Aged Care Classification (AN-ACC) assessment tool.**

Safer care Victoria's (SCV) Older Person Clinical Network identified the Rockwood as the preferred tool to screen for frailty – only validated for use in hospital; Note this is a screening not an assessment tool.

Future work should consider including 'frailty' in the acute classification given this is where a frail older person usually enters hospital, and this should impact resource utilisation in the acute setting. The Rockwood Clinical Frailty Scale can predict adverse outcomes in older people in hospital, including hospital-based harm, ED and inpatient length of stay, the need for aged care facility placement, and even death.

Another tool for IHPA to consider in future versions of AN-SNAP is the Edmonton Frail Scale (EFS) which has been found to be a quick and reliable tool that "was validated in the hands of non-specialists who had no formal training in geriatric care. Thus, the EFS has the potential as a practical and clinically meaningful measure of frailty in a variety of settings".

## Rehabilitation

**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?**

Victoria supports further work to incorporate frailty into the Rehabilitation arm of the classification in principle; However, the IHPA would need to determine whether this is relevant for all rehabilitation classes. Victoria suggests looking at 'reconditioning' or 'orthopaedics other' AN-SNAP classes where older patients with functional issues may sit.

Victoria supports a **consistent approach** to measuring frailty across rehabilitation & GEM (and all care types).

**Consultation Question**

**Do you support IHPA continuing to explore the Functional Independence Measure for children (WeeFIM™) as a potential variable within the paediatric rehabilitation**

Victoria supports IHPA continuing to explore the Functional Independence Measure for children (WeeFIM™) as a potential variable 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?**

At this stage, Victoria does not have any other suggestions.

**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?**

Victoria supports the IHPA's proposal to establish a new impairment type group Orthopaedic conditions, replacement for knee, hip and shoulder replacement activity

## Maintenance 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?**

Victoria supports the proposal to introduce the Frailty Risk Score as a variable for the non-acute care type.

**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?**

There is currently a lack of understanding of the patient cohorts that sit in maintenance care – further work would be useful to identify this, for example, the Report on Government Services (ROGS) use maintenance care as a proxy measure for older people awaiting residential aged care.

In Victoria maintenance care is used for people requiring additional time to regain function and for long term care planning. There is no age specific age identified and includes people with disability – frailty may not adequately capture the needs of this or other groups in maintenance care.

There is an opportunity to further explore the classification for this care type so that the costs of care are adequately captured to ensure maintenance care is differentiated from more complex care types such as GEM and rehabilitation.

## *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?**

Victoria supports the proposal to introduce the Frailty Risk Score as a variable for the GEM care type.

**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?**

Victoria supports the IHPA undertaking further work on the GEM arm of the classification for future versions of AN-SNAP.

In Victoria that there are a number of particular cohorts within GEM, for example, patients with behaviours and psychological systems of dementia (BPSD) – we know that these are associated with a different model of care which has significant resource implications. These patients may not be well differentiated from others with less complex dementia by frailty risk score alone.

Victoria's program areas have identified a significant overlap between rehabilitation for older patients and GEM in Victoria, for example, patients with fractures or strokes.

## *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?**

Victoria notes that there are no changes to the palliative care arm of the classification. Given an appropriate replacement model has not yet been provided we support continuation of the current classifications of adult and paediatric admitted palliative care.

Victoria supports future AN-SNAP developments considering the suitability of alternatives, or complementary tools to the RUG-ADL tool for the palliative care type. RUG-ADL is a very blunt instrument with a heavy focus on the nursing support required.

In relation to data items for inclusion in future national data collection we support exploration of the Symptom Assessment Scale and Australian Modified Karnofsky Performance Scale (or other suitable alternatives).

Another item for future consideration as part of national data collection is triage score on admission to an inpatient palliative care unit (the RUN-PC Triage Tool) to understand if those with the most urgent need are receiving care. Extensive international and local research completed by Dr Beth Russell and Palliative Nexus on a triage score on admission which considers the clinical status and the person and family/carer situation. A new optional data item will be introduced into Victoria's admitted palliative care dataset from 1 July 2021. This is expected to be mandatory from 1 July 2023. Victoria understands that this data items may be rolled out in other Jurisdictions across Australia.

Future AN-SNAP developments should consider data capture to support a funding model which incentivises holistic care at the end of life.

## *Overall comments/feedback*

Consistent with the Addendum to the NHRA, Victoria supports the need for the IHPA to balance the national benefits of access to requested data against the impact on jurisdictions providing that data. We acknowledge that the work to date on AN-SNAP Version 5 does not propose the reporting of any additional data items. In future AN-SNAP classification development work, Victoria's preference is that full consideration is given regarding the cost and impact of the collection and reporting of any additional data items against the improvement to the model for Reduction in Deviation (RID).

Victoria notes that the improvement in RID as a result of draft AN-SNAP version 5 is relatively modest. It would be useful to have further discussion about the expected improvement in RID at the care type level.

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