Austin HEALTH
Austin Hospital

6th December 2023

Dear IHACPA,

I apologise for this late submission and hope it will nonetheless be included for your consideration.

Austin Health has some additional feedback on the proposed changes by IHACPA (Independent Health and Aged Care Pricing Authority) to the ICD-10-AM/ACHI/ACS Thirteenth Edition.

Austin Health support modifications to the AR-DRG and ICD-10-AM/ACHI/ACS Classification System to better identify and describe the cohort of Australian's receiving specialist palliative care. This has been identified as a gap in the classification system for palliative care.

This aligns with the Information Priority – Identify who is providing care to Australian at their end of life as per the National Palliative Care and End of Life Care Information Priorities Document, January 2022, https://www.aihw.gov.au/getmedia/17b82c56-83ff-45dc-be93-392bc5669fab/national-palliative-care-and-end-of-life-care-information-priorities.pdf.aspx.

The current classification system only includes the additional diagnosis code of Z51.5. This can be anyone who is receiving palliation or end of life care.

Austin Health asks that IHACPA considers either the creation of fifth characters at Z51.5 to separately identify:

- End of life care delivered by a treating clinician who does not have specialist training or expertise in palliative care
- Specialist palliative care delivered under the management of a clinician with specialised expertise in palliative care
- Palliative care informed by a clinician with specialist expertise in palliative care (i.e. result of secondary consultation with a specialist palliative care clinician)

Alternatively, IHACPA may consider the creation of ACHI codes to identify the type of palliative care provided in the admitted episode.

The National Information Priorities Document distinguishes specialist palliative care, palliative care, and end of life care (last 12 months of life).

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In Victoria, specialist palliative care consultants provide support and assistance (including direct care) to people with life limiting illness across the range of admitted care types. Supporting people in the admitted setting is a significant component of our work, as well as supporting people in emergency departments, non-admitted specialist/outpatient clinics, and care in the community such as rapid discharge or until such time as the community palliative care provider can take over.

Accurate identification and reporting of this activity is currently very challenging. The classification changes suggested above would be a logical and greatly appreciated solution.

Many thanks for your consideration,

Dr Sarah Charlton
Acting Director, Palliative Care, Austin Health