# AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

TRIM: D16-37013

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James

Dear Mr Downie

I am writing to provide a response to the Independent Hospital Pricing Authority's (IHPA) *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2017-18* (the Pricing Framework). The Australian Commission on Safety and Quality in Health Care's (the Commission) response to the Pricing Framework is provided at **Attachment 1** and relates to two key areas where our work intersects:

- Chapter 9 (Bundled pricing for maternity care)
- Chapter 11 (Pricing and funding for safety and quality).

As the Pricing Framework highlights, the commitment by governments to integrate safety and quality in hospital pricing and funding follows a four year program of collaboration between the Commission and IHPA. This is a significant step and I look forward to continuing to provide advice on this matter in the future.

The Commission agrees that to be effective IHPA's proposals to incorporate safety and quality into pricing and funding must be complemented by other approaches, such as:

- the provision of information to clinicians and hospital managers to allow benchmarking and quality improvement
- the design of safe systems
- supporting consumers to take an active role in making decisions about their health care.

The Commission is committed to its ongoing work in these areas, as part of its role in leading national improvements in safety and quality in health care. The Commission is also committed to providing ongoing input on bundled pricing for maternity care, through its membership on the Bundled Pricing Advisory Group.

Thank you for this opportunity to provide a response to the Pricing Framework.

Yours sincerely

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**Attachment 1. Commission response to the Pricing Framework.**

## Bundled pricing for maternity care

*Do you support IHPA's intention to introduce a bundled price for maternity care in future years? What other issues should IHPA consider in developing the bundled price?*

There is much overseas literature that supports bundled pricing and IHPA's work is thorough in considering applicability to the Australian context. Care must continue to be taken to minimise any potential undesirable and inadvertent consequences. The Commission is committed to providing IHPA with ongoing input on bundled pricing for maternity care, through its membership on the Bundled Pricing Advisory Group.

## Overview of scope and approaches to pricing and funding

*Is there support for pricing and funding models for safety and quality to be applied broadly across all types of public hospitals, all services, all patients and all care settings?*

Measurement is foundational to advancing safety and quality improvement. To understand what the major safety issues are across the care continuum, meaningful metrics are required to identify, measure and proactively mitigate patient safety risks. The Commission has therefore worked towards providing clinical information to the healthcare sector – including through clinical registries and existing data that is routinely generated from the patient medical record (patient clinical data). Metrics of safety and quality should be appropriate to the setting and care type. The Commission therefore suggests that this should be an additional criterion when assessing different options.

*What factors should be considered in risk adjustment for safety and quality in pricing and funding models for hospital care?*

The selection of risk factors should be granular enough to reflect real differences in patient variables and service provision. The Commission will continue to work with IHPA, providing advice on clinical issues related to risk adjustment throughout 2016-17.

*Do you agree with the use of these assessment criteria to evaluate the relative merit of different approaches to pricing and funding for safety and quality? Are there other criteria that should be considered?*

Other criteria that could be considered are:

- Minimising undesirable and inadvertent consequences
- Reach of the approach – to assess the scope of healthcare settings and care types where implementation of the proposed approach is appropriate.
- Alignment to intent – to assess how well options align to the intention of sending a signal at the healthcare system level, while supporting improvements in data quality and information available to inform clinicians' practice.

## Sentinel events

*Do you support the proposal to not fund episodes that include a sentinel event? If not, what are the alternatives and how could they be applied consistently?*

The Commission supports the proposal to not fund episodes that include a sentinel event. However, the technical aspects surrounding implementation will need to be carefully considered and a guide for use, which contains definitions and rules, should be provided. It is appropriate that the proposal should be across all hospitals and settings as these events are associated with extremely serious patient outcomes.

*Do you support the proposal to include a sentinel events flag to improve the timeliness and consistency of data that is used for funding purposes?*

Support for the use of a flag would be contingent upon how the flag is applied. A sentinel events flag may not solve the timeliness issue, given that timeframes are largely due to the requirement to investigate Severity Assessment Code 1 (SAC1) events.

The Commission considers that a flag may improve the accuracy (but not necessarily the consistency) of reported sentinel event data, depending on how the flag is used. For example, jurisdictions may report sentinel event data to IHPA that is captured from their incident management systems, and IHPA may then undertake an audit of those results by assessing them against the administrative data. Consideration should be given to those sentinel events that cannot be captured through administrative data sets.

*Do you agree with IHPA's assessment of this option (not funding episodes with a sentinel event)?*

Consideration should be given to the Commission's current review of the national sentinel events list and how this may affect implementation. The review is being undertaken on behalf of the states and territories with the goal of achieving a more contemporary list and more consistent national reporting. The final report for this piece of work will be submitted to Health Ministers in mid-2017. IHPA should consider the process to implement the revised list.

## Hospital acquired complications

*What are the advantages and disadvantages of Option 1 which reduces funding for some acute admitted episodes with a HAC?*

*Do you agree with IHPA's assessment of this option?*

This option targets a proportion of admitted episodes with a HAC ie those that change DRG assignment. Careful messaging around the remaining episodes that do not change DRG assignment, should be considered in conjunction with this option – as they may still contain instances of preventable poor quality patient care.

*What are the advantages and disadvantages of Option 2 that adjusts funding to hospitals on the basis of differences in their HAC rates?*

*Do you agree with IHPA's assessment of this option?*

*What are the advantages and disadvantages of the approaches to risk adjustment?*

The funding approach for this option is currently the same whether a patient has one or more HACs. An exploratory analysis undertaken by the Commissions suggests that 28% of episodes containing a HAC had more than one HAC. Communication around the prevention of multiple HACs should be considered in conjunction with this option.

Risk adjustment is required to ensure that fair pricing signals are implemented. As the Pricing Framework highlights, further analysis around the statistical validity of the different risk adjustment approaches for this option is required. The Commission will continue to work with IHPA, providing advice on clinical issues related to risk adjustment throughout 2016-17.

*What are the advantages and disadvantages of Option 3 that combines funding incentives and penalties?*

*Do you agree with IHPA's assessment of this option?*

The pricing component of Option 3 would apply across all public hospital services in scope for activity based funding, including settings that are less likely to influence HACs rates. The importance of educational materials, which make the link between local HACs rates and the pricing signal clear and understandable to clinicians, should be considered in conjunction with this option.

The funding component of this option incorporates incentives, aligning with evidence from the literature around pay-for-performance schemes.

## Avoidable hospital readmissions

*What approach is supported for setting timeframes within which avoidable hospital readmissions are measured?*

*Is there Australian evidence (including guidelines or recommendations) that could be used to implement condition specific readmission timeframes?*

The Commission agrees that the most suitable timeframes may vary depending on the definition of avoidable hospital readmission that is accepted, and supports condition specific readmission windows. Once the definition of an avoidable hospital readmission has been chosen, an iterative process combining clinical consultation and statistical modelling and testing

of actual readmission windows is required. A decision will also need to be made on the level at which these discussions occur – for example, condition, diagnosis, ICD code.

As noted in the Pricing Framework, the Commission has developed a set of Core, Hospital Based Outcome Indicators (CHBOI) which provide specifications for unplanned/unexpected hospital readmission of patients discharged following management of: a) acute myocardial infarction b) knee replacements c) hip replacements d) paediatric tonsillectomy and adenoidectomy. The CHBOI originally included hysterectomy, prostatectomy, cataract surgery and appendicectomy, as described in Option 2. However, these were retracted during development because clinical input and literature suggested that they were not suitable for safety and quality monitoring. The CHBOI specification includes a list of conditions that may be attributable to the original condition and readmission windows for each of these – for example, the readmission window for patients discharged following management of acute myocardial infarction is 30 days for a principal diagnosis of cardiac arrest and 7 days for Staphylococcal infection.

The role of community and household-level factors beyond hospitals' control will also need to be assessed, and policy implications considered, when setting timeframes. For example, a recent paper has suggested that 'shorter intervals of seven or fewer days might improve the accuracy and equity of readmissions as a measure of hospital quality for public accountability'[1].

The Commission has led and consulted on a number of projects to develop clinically meaningful safety and quality indicators for readmission. The Commission will continue to work with IHPA providing advice on this matter.

*Other comments on readmissions*

The approach described in Option 3 limits the clinical scenarios in which a readmission for a HAC could be counted. An alternative, clinically relevant scenario is readmissions for HACs diagnoses that were not identified before discharge – for example, post-surgical wound infections that take a number of days to manifest. This would capture, and improve focus on, HACs that manifest both before and after discharge.

Consideration should also be given to variation in jurisdictional models of care – for example, Emergency Department admission policies and procedures, transfers, and statistical type changes – and how this impacts on the accepted definition of avoidable hospital readmissions.

## Implementing a pricing and funding approach

*What do you think are the most important considerations for implementation of pricing and funding approaches for safety and quality?*

In 2010 Health Ministers endorsed the Australian Safety and Quality Framework that was developed by the Commission. This framework specifies that safe, high-quality care is always consumer centred, driven by information and organised for safety. It also provides 21 areas for action by people in the healthcare system. One area for action is to 'Ensure funding models are designed to support safety and quality'. Within this action area the Commission identified that policy makers should consider issues such as the implication of specific funding models and programs on the delivery of care, and how they support compliance with clinical guidelines and healthcare standards. This remains an important consideration for implementation.

The National Safety and Quality Health Service (NSQHS) Standards were developed by the Commission to drive the implementation of safety and quality systems and improve the quality of health care in Australia. The NSQHS Standards help to embed the Australian Safety and Quality Framework in the Australian healthcare system and have contributed significantly to improvements in patient safety. Since the implementation of the NSQHS Standards, there has been:

- better integration of governance and quality systems and clarification of the roles and responsibilities of Boards

[1] Chin DL *et al*. Rethinking Thirty-Day Hospital Readmissions: Shorter Intervals Might Be Better Indicators Of Quality Of Care. *Health Affairs* 2016;35(10):1867-1875

- a 13.5% reduction in *Staphylococcus aureus* bacteraemia (SAB) rates, 40% reduction in methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia rates and 50% reduction in Central Line Associated Blood Stream Infection (CLABSI) rates
- a 30% reduction in prescription errors, and a reduction in the total number of prescriptions from 13.3 to 5.6 per resident and medication errors from 5.2 to 1.7 per 1,000
- a $70 million reduction in expenditure on blood products
- a 20-30% reduction in hospital cardiac arrest rates

The Pricing Framework notes that to be effective, pricing and funding approaches must be complemented by other approaches. This is another important consideration and the options chosen should be the ones that:

- lend themselves the most to a holistic approach, aligning with the Australian Safety and Quality Framework
- send the most appropriate signal to the health care system.