Non-admitted Care Costing Study
Public consultation paper 1 – data collection

Questions for stakeholders
(please email feedback to abf.national@health.wa.gov.au)

PCH Burns CNC feedback (Clinic J) – Tania McWilliams
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1. ***What changes to the scope of the study, as described above, should be considered?***

   Nil changes to scope.

2. ***In what ways can the selection/ feasibility criteria for sites to participate in the study be clarified or improved?***

   N/A (***Note:*** *WA has already sent nominations as requested by IHPA).*

3. ***What other aspects of coordination of the study at the site-level should be considered?***

   - Who to contact re issues/questions on weekends (we run clinics 0700-1530 Monday to Saturday).
   - Who to contact re IT issues with the website.
   - Internet speed.

4. ***What are the issues in collecting primary data (Part B: Primary data) for the proposed two-month period? Are there strategies that could be employed to keep clinicians motivated to collect data accurately?***

Clinician time to complete the required data entry, their ability to remember all patients seen and how long they spent with them by the end of the day (it is not feasible to enter data online after each patient from a time management perspective) and compliance of all team members will be an issue.
For example:
CNC led Nurse reviews (40.31)
Patients in our clinics will be seen by either a Clinical Nurse and a Clinical Nurse Consultant or an Occupational Therapist . Patients are booked throughout the day will minimal/nil time between each patient.
Telehealth reviews are seen by the CNC and the nurse at the rural/remote facility. This is complex – for the study do I only enter my time, or should I also enter the time and resources used at the rural end? If I only enter my end it will underestimate the true cost of such care. How would I enter this?
Consultant led MDT reviews (20.48)
Patients will be seen by a Burns Consultant and/or Burns Registrar and/or Burns Fellow plus:

- a Clinical Nurse or Clinical Nurse Consultant plus
- an Occupational Therapist plus
- a Physiotherapist.

For all outpatients appointments these patients also see the clinic clerk who organises appointments, parking forms and organises PATS (travel to rural areas) which is also time consuming. This is not included in clinician time but represents a vital part of coordination and continuity of outpatient care. How is clerical time needed to run these clinics captured?

How is researcher or clinic assistant time captured?
How is clinical photographer time captured?
Compliance of every single staff member entering every single patient they see during the day when these clinicians also have responsibilities for inpatients, ED, new referrals being called in etc is very unlikely and will decrease the accuracy and completeness of the data collected in this study if the clinicians themselves need to enter data on a computer or phone etc.

My suggestion is that at the front of each patient's chart there is a form (Appendix 1: I've made for our own clinic to use) which I propose each clinician will complete as they complete their review time/intervention/high cost consumables for the patient. This form is handed to the clerk as the patient is leaving the clinic and the clerk could organise the patients follow up appointment plus enter the data on behalf of all clinicians to the website at the same time. This will give far more complete and accurate data collection and compliance for your study.

5. What issues should be addressed to ensure collection of data on a mobile app will be acceptable for health services and clinicians?

Time and compliance with data collection will be an issue if each person has to enter their own data. A MDT data entry form (Appendix 1) completed by the team and entered by the clerk would be the best solution for our clinic.
If we are absolutely not allowed to have clerical data entry these will be the potential issues:

- Will you be providing ipads/mobile phones for this study?
- If staff need to bring their own mobile – what if they do not have one or do not wish to use their personal mobile phone for this study – will one be provided?
- If their personal mobile phone is used for this study and it is stolen who do we need to notify?
- If we have issues with the website do we contact you or our internal IT staff. If your staff - will they be open WA times or for EST?

I believe clerical staff entering on behalf of clinicians from a dedicated form will be far more accurate and will result in much more complete data than relying on a large number of individuals to each enter their own data every day. On any given day up to 15 different clinicians provide care in our clinic and will all need to remember to enter data for all patients they saw that day which will result in incomplete data and underestimate the time/input.

6. What are other ethical issues that should be considered for the study?

Nil.

7. Are there any unnecessary data elements on the list in Table 1? Why are they unnecessary?

No.

8. Are there any data elements that are not on the list in Table 1 that should be included (i.e. features of patients/ service events that are likely to impact the cost of the care delivered to a patient)? For what reasons should these be collected in the study?

No.

9. What clarifications or enhancements can be made to the definitions and/ or values of the proposed data elements in Table 1?

The category "Major reason for attendance" needs to allow us to use multiple reasons.

For example, a recent burn injury post grafting review – will need to be able to use both no. 2 and no. 6, or a long term burn patient with scars having review pre laser surgery will need to be categorised as both no. 3 and no. 5 as we are reviewing from both perspectives. Both are equally as important and need to be captured.

10. The short list of primary presenting conditions is provided at Appendix A. Does the list capture the range of conditions encountered by each non-admitted clinic type that might be relevant for a patient-level classification of non-admitted care?

- No. It is not specific enough to reflect the various complexities of acute, rehabilitative and reconstructive paediatric burn patients we see.
- All categories are too broad with respect both size and depth of burn to accurately reflect complexity, time and cost.

Multidisciplinary Burns Clinic 20.48 and Burns 40.31					
22-0050	Burn, superficial, partial thickness (erythema, sunburn, first degree, second degree) < 10% of body surface	Thermal burn, chemical, radiation burn, combined erythema and partial thickness burns; burns up to 9% BSA	Burns of multiple anatomical regions of the body	T30.3	Burn of full thickness, body region unspecified
22-0051	Burn, full thickness (third degree, fourth degree, complex) < 10% of body surface	Thermal burn, chemical, radiation burn, combined partial and full thickness burns; burns up to 9% TBSA	Burns of multiple anatomical regions of the body	T30.3	Burn of full thickness, body region unspecified
22-0052	Burn, superficial (erythema, sunburn, first degree) >= 10% of body surface	Thermal burn, chemical, radiation burn, erythema; burns greater than 10% BSA	Burn of a single anatomical site of the skin	T30.0	Burn of unspecified body region, unspecified thickness
22-0053	Burn, partial or deep partial thickness (sunburn with blisters, second degree) >= 10% of body surface	Thermal burn, chemical, radiation burn, combined areas of superficial and partial thickness burns; burns greater than 10% TBSA	Burn of a single anatomical site of the skin	30.2	
22-0054	Burn, full thickness (third degree, fourth degree, complex) >= 10% of body surface	Thermal burn, chemical, radiation burn; combined partial and full thickness burns; burns greater than 10% TBSA	Burn of a single anatomical site of the skin	T30.3	Burn of full thickness, body region unspecified
22-0055	Burn of internal organ	Thermal burn, chemical, radiation burn; burns of internal organ (including oesophagus, stomach and respiratory tract)	Burn of skin (single or multiple body area of skin)	T28.4	Burn of other and unspecified internal organs
22-0056	Post traumatic wound infection	Infection of wound from burn, superficial injury, and open wound with or without foreign body	Post procedural infection	T79.3	Post traumatic wound infection, not elsewhere classified

<u>Suggested improvements to 20.48 and 40.31:</u>

- Needs to include ALL mechanisms of burn (i.e. electrical, and friction).
- Needs to specify if it is a review for wound management (bath and dressing), a review for scar management or a mix of both wound and scar management, as this changes what is used, the time required and the cost.
- All subcategories are too broad to reflect the complexity of the patient.
- **22-0050** – needs revision as it is too broad. Superficial burn is erythema only – no dressing required. Partial thickness is skin loss/blistering and ranges from superficial partial which should heal within 7 days with dressings, all the way to deep partial which may require surgery to heal (often recell). This category needs to be separated

out into 1) superficial (no blister/skin loss) 2) superficial partial thickness and 3) deep partial thickness burns. TBSA needs to be separated out more also. For example: there is a huge difference between a 10% deep partial thickness burn and a 0.5% superficial partial thickness burn in terms of treatment, both wound management and scar management required, as well as analgesia, immune response, fluid resuscitation and nutrition.

- **22-0051** – needs revision as it is too broad. For example: there is a huge difference between a 10% full thickness burn and a 0.5% full thickness burn in terms of both wound management and long term scar management required, as well as analgesia, immune response, fluid resuscitation and nutrition.

- **22-0053**- needs revision as it is too broad. For example: there is a huge difference between a 10% superficial partial thickness burn in a teenager and a 90% deep partial thickness circumferential scald in a toddler in terms of both wound and long term scar management.

- **22-0054**- this definitely needs revision as it is far too broad. For example: there is a huge difference between a teenager with a 10% full thickness burn to their back and toddler with 95% full thickness flame burns in terms of wound management and ongoing wound breakdown, issues with growth, contracture, scar management, prevention of contracture, reconstruction and the psychological impact of the injury itself and scarring long term as the scar matures and raises/tightens and then as the child grows with age.

- **22-0055**- this would be the remit of ENT usually if no external burns, so probably belongs in 20.18 somewhere more than 20.48.

- **22-0056** – this excludes post procedural infection, so where would we classify burn wound infection post grafting?

11. The list at Appendix A is also being proposed for secondary presenting conditions. Is the list appropriate to use towards determining the complexity of patients for the classification?

No – please see answer to question 10.

Also, there needs to be capture of psychosocial needs, as some patients will cope well following burn injury, yet others have ongoing anxiety, trauma and psychological issues due to the injury itself and their altered body image/school reintegration/teasing etc. Some patients require no social worker support, but others require extensive social worker input re transport, schooling, attendance for follow up etc. which needs to be captures also.

Need to add hypertrophic scar, keloid scar, scar contracture, normal scarring, alopecia and itch please.

12. Appendix B provides a list of interventions that will be specified for the study. Is the list sufficient to capture differences in costs between patients treated in non-admitted settings? Are there any changes that should be made to the list?

No, it is not sufficient in its current form.
Yes, changes should be made please.

- **22-0001** (dressing of burn <10%) and 22-0002 (dressing of burn >10%) and 22-0003 (graft to burn) are under Paediatric surgery 20.12 – these belong under both 20.48 and 40.31 only.

- **22-0001**: Does this classification reflect the current open TBSA or the original TBSA of the burn? If so, needs revision as it is too broad. In paediatrics there is a huge difference in the time required, the staff needed and the type and amount of dressings used in a 0.5%TBSA superficial partial thickness scald in an infant and a 10%TBSA full thickness scald to the chest of a teenager.

- **22-0002** – Does this classification reflect the current open TBSA or the original TBSA of the burn? Needs revision as it is too broad. Even if it refers to the TBSA of original injury there is a huge difference for example between the bath and dressing of a 11% superficial partial thickness scald in a toddler who is almost healed and requires a few tiny foam dressings and some sorbolene to their scars with minimal chance of long term scarring, compared to teenager with a recently discharged from inpatient care 80% TBSA full thickness burn with multiple scattered wounds, each requiring individual dressings according to their wound status, extensive massage of all scar areas, application of silicone gel and sheets, application of pressure garments and application of splints, in addition to review by allied health. Differences in the ongoing outpatient care for these two patients are huge in terms of time required, the staff required and the size, type and cost of dressings, moisturiser and scar management (pressure garments, silicone, splints etc).

- **23-0010** – needs to also include scars from other causes such as surgery, trauma, meningococcal purpura fulminans etc. also needs to reflect how many garments are provided and how large/extensive the garments are/cost. For example a tiny glove for an infant versus a full body suit for a tall teenage will vary in terms of cost, time to measure and time to apply.

- Need to add CO2 laser for scars please.

- Need to add expansion of tissue expander for scar reconstruction please.

13. Appendix C provides a list of high-cost consumables that will be specified for the study. Are there any changes that should be made to this list?

No appendix c, so these are my suggestions

- VAC dressing
- PICO dressings
- Silicone foam dressings
- Acticoat dressings
- Duoderm dressings
- Pressure garments(include number ordered)
- Silicone gel
- Silicone sheets
- Splints
- Dermaveen bath and shower oil

14. Can the data elements listed for primary collection be collected accurately and reliably by clinicians? If not, can additional guidance be provided to support accurate and reliable collection?

Yes, but the category “Major reason for attendance” needs to allow us to use multiple reasons. For example, a recent burn injury post grafting review – will need to be able to use both no. 2 and no. 6, or a long term burn patient with scars having review pre laser surgery will need to be categorised as both no. 3 and no. 5 as we are reviewing from both perspectives.

15. Are there any additional sources of secondary data that should be specified?

- WEBPAS
- Isoft/ICM
- BIMS

16. Will the data submissions specified for the study support the analyses outlined for developing the ANACC?

No, I don’t think the categories in Appendix A and Appendix B are specific enough in the current form to give you the level of patient complexity and resultant costing you require (in 20.48 and 40.31). We would be happy to work with you to further develop such categories.

17. Will the data elements outlined in the previous Chapter support investigating bundling of service events (e.g. into courses of treatment, episodes of non-admitted care, pre- and post-hospital admission etc.)?

Possibly, if the categories within 20.48 and 40.31 are further developed to be more specific to more accurately reflect patient complexity and costs.

18. Are there other markers of complexity for non-admitted patients that should be built into the data collection?

Yes. For burns patients this would include:

- Age
- Burn depth
- Burn size
- Burn sites (eg hands/joints)
- Abnormal scarring
- Comorbidities
- Surgery

19. What are other uses of the ANACC in addition to ABF that need to be considered in its design? Does the proposed data collection suit these uses?

- Long term outcome measures.
- Benchmarking.
- NHPPD / staffing for outpatient care.

Not yet.

20. Are there any other issues that should be considered in the conduct of this study?
Permission for participating sites to access their own data and publish a paper on the study.

APPENDIX 1 **ANACC FORM – PCH CLINIC J (BURNS)**

ACUTE BURN		or	SCAR>3/12 OLD	
PRE-OP	or	POST OP	or	POST ADM (NO SURGERY)

OPC	TH PHONE/PHOTO	TH VC
40.31 CNC LED NR	20.48 CONSULTANT LED MDT RV	

DEPTH & TBSA:	<10%	>10%	
SUPERFICIAL (ERYTHEMA ONLY)		PARTIAL	FULL

INFECTED TODAY? Y N

DRESSING CHANGE Y N DEBRIDED TODAY? Y N

MEASURED/FITTED/GIVEN GARMENTS TODAY? Y N

TIME SPENT WITH PT INCLUDING PHONE/REFERRAL/LIAISON ETC

	MINS		MINS		MINS
CONSULTANT		CNC		PHOTOGRAPHER	
FELLOW		CN/RN/EN		RESEARCHER	
REG		OT		CLERK	
RMO		PHYSIO		OTHER	

HIGH COST CONSUMABLES USED TODAY:

SPLINT DERMAVEEN SILICONE GEL SILICONE SHEET

PRESSURE GARMENT:_____

ACTICOAT: 20X10 10X10 5X5

MEPILEX/BORDER: SACRUM 10X10 7.5.7.5 4X5

DUODERM ET: 15X15 10X10 5X10

OTHER:_____