

Australian Allied Health Classification System – A Refresher

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National SARRAH Conference
September 2006



Queensland Government

Queensland Health

Acknowledgements

- Health Activity Hierarchy Version 1.1
National Allied Health Casemix Committee
(2001)
- Indicators for Intervention (IFI) Project
IFI Coding Manual
National Allied Health Classification
Committee (2006)

Key Health Management Functions in Today's Health Care Environment

- Defining and measuring service activity and service outcomes
- Costing and pricing activities
- Analysing best practice (efficiency and effectiveness)
- Workforce planning
- Workload management
- Benchmarking exercises

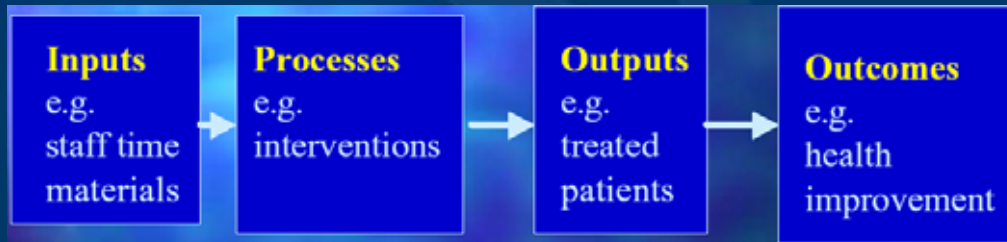
Introduction / overview of presentation.

Why am I doing this presentation

Key Health Management Functions in Today's Health Care Environment

- Effectively competing with alternative providers in the health sector
- Workload management / staff accountability and comparisons
- Conducting research
- Providing quality and equity

Health Service Delivery Elements



To gather the information needed to do these management functions We need to look at the elements involved in health service delivery. Define what is involved and how it is grouped, classified and measured. There are a number of systems, guidelines and rules we can use.

Classification Systems

- International Classification of Diseases and Related Health Problems ICD-10 (WHO).
- International Classification of Functioning, Disability and Health (ICF)
- Australian Allied Health Classification System (AAHCS)
- Australian Classification and Terminology for Community Health (CATCH) -

ICF

- International Classification of Functioning, Disability and Health.
- WHO's framework for health and disability.
- A bio-psycho-social model ie combines the medical and social paradigms.

Australian Allied Health Classification System (AAHCS)

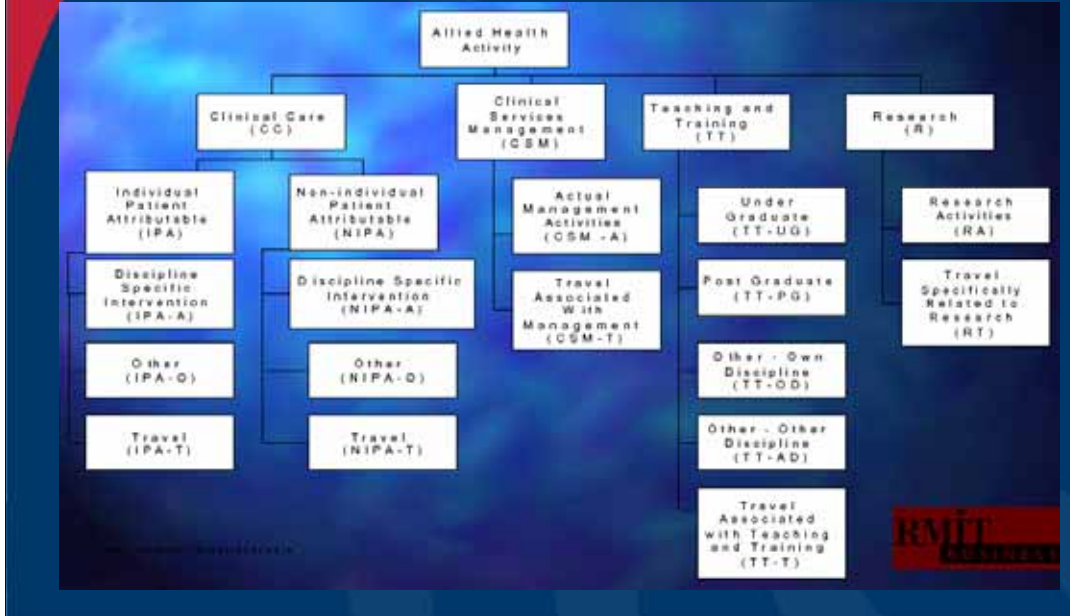
- Describes reason for intervention/activity.
- Describes the range of activities done by AHP's and classifies them into different components/hierarchies.
- Defines a Minimum Data Set.
- Provides the framework to measure AH services and compare clinical practice.

AAHCS Activity Hierarchy

The Allied Health minimum data set defines all the data elements that allied health service providers record on patient/client services.

- Minimum Data Set
 - client demographics
 - client special needs
 - critical dates
 - service features (provider, source, setting)

The AAHCS Activity Classification Hierarchy



Clinical Care

Clinical Services Management

Teaching and Training

Research

AAHCS Activity Hierarchy First Tier

Clinical Care:

- Activities which provide a service to an individual, group or community to influence health status.

AAHCS Activity Hierarchy First Tier

Clinical Services Management

- Professional and management activities which support and are essential to clinical care.

AAHCS Activity Hierarchy First Tier

Teaching and Training:

- **Formal** teaching or training activities which relate to the **imparting** of knowledge, skills and clinical competency to undergraduate and post graduate students, practitioners in own discipline, and other practitioners as part of a structured program

AAHCS Activity Hierarchy First Tier

Research:

Activities undertaken to advance the knowledge of the delivery of care to an individual, group or community. Research is limited to activities that lead to and follow formal approval of the project by a research committee or equivalent body.

Health Service Delivery Elements



To gather the information needed to do these management functions We need to look at the elements involved in health service delivery. Define what is involved and how it is grouped, classified and measured. There are a number of systems, guidelines and rules we can use.

Indicator for Intervention

Definition

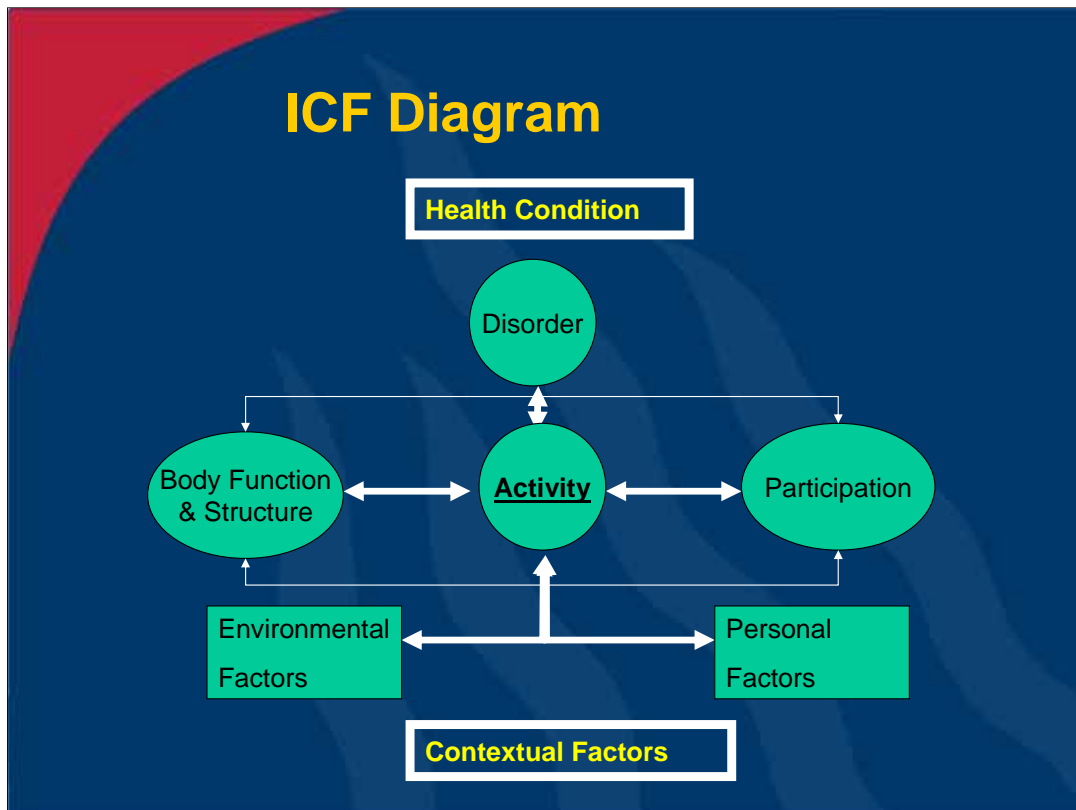
- The Indicator for Intervention is a *service provider* description of the characteristics of the individual or population which indicate need for intervention (NAHCC, 2000).

The Allied health classification committee have been working with the Professions to further develop IFI that were clinically meaningful

Kept coming back to the ICF and the connection between ICF Classifications and Allied Health IFI's

The AusToms is based on the ICF framework

Initial work in developing the IFIs



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The AusToms is based on the ICF framework

ICF Codes

ICF provides codes in four domains:

- body functions (b)
- body structures (s)
- activity and participation (d)
- and environment (e).

That means the first letter of the ICF code for a client or patient will be b, s, d or e.

ICF Codes for Dummies

Introduction to ICF Codes

This system ascribes a code for each client/patient dependent on their problems. It is very much along the lines of the IFI in that it is focused on patient characteristics of real or potential disability and the interplay of person factors and environment issues.

1 Firstly, ICF provides codes in four domains: body functions (b), body structures (s), activity and participation (d) and environment (e). That means the first letter of your code for a client or patient will be b, s, d or e.

*Comment: These divisions are similar to our person/environment but avoid our present confusion of the **function** with **structure** and **environment** with **participation**. What it means though is that you can code any person with at least four codes and, in some cases, more than one code in each domain. Now this means we would have to decide on a policy or practice on whether we code a person by priorities (just the most important at the time and change it as the therapy progresses) or whether we are trying to use the codes to characterise everything about the person.*

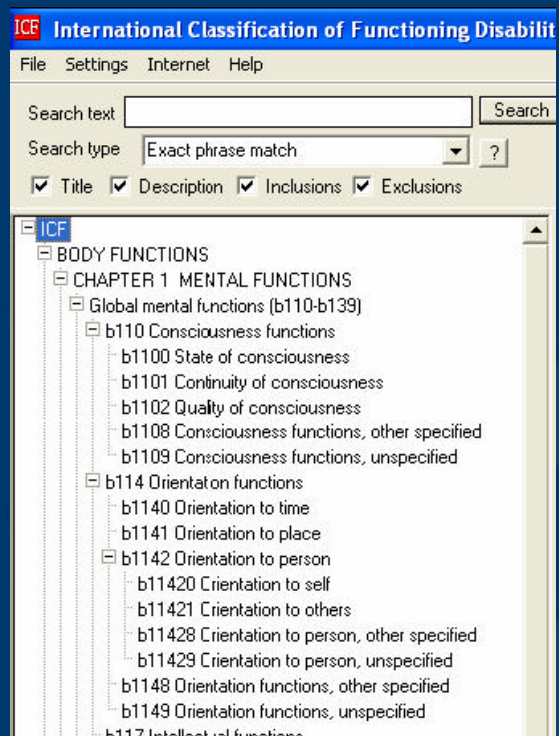
2 Secondly, you identify a sub area (they call them chapters and categories) within that domain and this is indicated by a number. For example, b3 is Voice and Speech and b310 is Voice; s3 are the structures involved in voice and speech and s310 is Structure of Nose; d3 is Communication and d310 is communicating re spoken messages; e3 is Support and Relationships and e310 is Immediate Family. And so on.

Comment: This is where the hard work has been done for us in creating code lists in a categorical and hierarchical manner. You can go down to d3101(nasal septum) if you wish a more specific category. Once we have got our heads around these and think they might work, our task is to canvas our members and see if it works for them. Then finding a workable system of using them simply and reliably will be our final objective.

3 Third and last task is the *qualifiers*. These are about assessing the severity or extent of the issue or need so are really measures of the factor. They are represented by numbers that follow a decimal point. For example, d310 above would be followed by .11 (ie d310.11) meaning "mild difficulty" with performance (the first "1") and "mild difficulty" with capacity (the second "1").

Comment: This could be quite a debatable feature and may well be optional. It does have significant relevance in measuring change or applying for resources but may be achieved by other means. Or some may feel it is an essential core of the system. (We can argue that one F2F.)

ICF Browser



ICF Allocation

Steps to aid in providing a standardised approach to coding using the ICF as an IFI.

1. State the IFI in plain language first by asking, “*Why* am I intervening? *Why* has the client/patient come to see me? What does the patient expect as a result of my interventions?”
2. Follow the procedures guide to use the ICF search capacity and use the profession specific codes or online browser (<http://www3.who.int/icf/onlinebrowser/icf.cfm>) to ensure clinicians are all accessing the same options and reading the same definitions.
3. Use direct questions to check the reason for intervention with the client. Ask them, “So the reason you are seeking intervention is for...” This is important as the clinicians and client/patient may have different expectations regarding the reason for intervention.

What is an IFI?

An IFI is what the clinician believes is the most relevant issue of the client/patient that has led the client/patient to seek or be referred to an allied health professional for service. Unlike the diagnosis, it is not one of the medical disorders or complex illnesses that are described by the "diagnosis" (e.g., ICD-10, DSM-IV) but is more likely to be one of the symptoms, behavioural characteristics or circumstances associated with a person for which allied health services are being sought.

Diagnoses, such as are found in ICD-10 or DSM-IV, are a mixture of causation (e.g., acute brain injury) and disease processes (e.g., diabetes) that conveniently classify medical disorders. For example, “stroke” identifies a disease process, not how the patient presents. Likewise, “osteoporosis” describes little about what effects it may have on the sufferer but more about which parts of the body are involved and which disease process is occurring. In contrast, IFIs focus on the characteristics of the person’s behaviour or situation, not the disease process. So a stroke patient would have an IFI of mobility problems, swallowing difficulties, accommodation problems or possibly all three. *These* issues are the indicators for allied health intervention(s), rather than the stroke itself.

IFI allocation decision making process

Identify

- Reason AHP has been asked to intervene
- Intervention
- List possible Profile Codes in ICF
- IFI allocation
- Rationale

Appendix 3 – Multidisciplinary Case Study

For the following case study, each allied health profession has outlined why they may have been asked to intervene in the care of the patient, what their intervention may be, all the possible IFI codes which may be assigned, the IFI code which was assigned and the rationale for selecting this IFI. This case study has been included to outline the different roles and interventions allied health professionals may have in the care of the client.

Multidisciplinary Case Study

Mr. Z is a 67-year-old man who lives alone in his second level flat. His wife of 40 years recently died of cancer and his two grown children both live interstate. Mr. Z has diabetes, smokes, is overweight and does not exercise regularly. Recently while out shopping he experienced sudden onset of left hemiparesis. An ambulance was called and he was taken to the hospital. At the hospital he was diagnosed with righthemisphere stroke with left hemiparesis affecting upper and lower extremities. While in hospital he was observed to have difficulties swallowing when eating. He also had difficulties responding to verbal cues and appeared to be down and withdrawn.

Reason that Audiology has been asked to intervene: Medical Staff requested a hearing assessment to establish whether a hearing loss was causing the patients difficulties with responding to verbal cues and, if so, to arrange management of the hearing loss as the communication problems were having a negative impact on patient care.

Reason that Psychology has been asked to intervene: Staff requested the Psychologist to come and assess Mr. Z for possible unresolved grief and depression.

Reason that Dietetics has been asked to intervene: Review adequacy of current nutritional intake, Presence of stroke risk factors – diabetes, obesity

Reason that Occupational Therapy has been asked to intervene:

1. To assess the impact of stroke on Mr Z's ability to perform his daily tasks prior to his admission.
2. To identify barriers towards his safe discharge into a suitable environment.
3. Work with client to address the identified barriers and issues as a result of the stroke and return to safe and independent performance of his chosen tasks to pre-admission level where possible (including self care, meal preparation, shopping, finance, transport and social interaction with others).

Reason that Social Work has been asked to intervene: Likely need for alternative post discharge accommodation and supports and emotional support

Reason that Speech Pathology has been asked to intervene: Mr Z's swallowing difficulties during eating and his difficulty responding to verbal cues.

Reason that Physiotherapy has been asked to intervene:

- To assist in recovery of muscle strength and endurance associated with the hemiparesis
- To maintain joint range and muscle length during the period of hemiparesis
- To reduce increased muscle tone associated with the hemiparesis
- To improve transfer skills resulting from the hemiparesis
- To improve mobility resulting from the hemiparesis of the lower extremity

Performance indicators

Performance Indicator

= IFI + Dimension factor
combined with a
threshold

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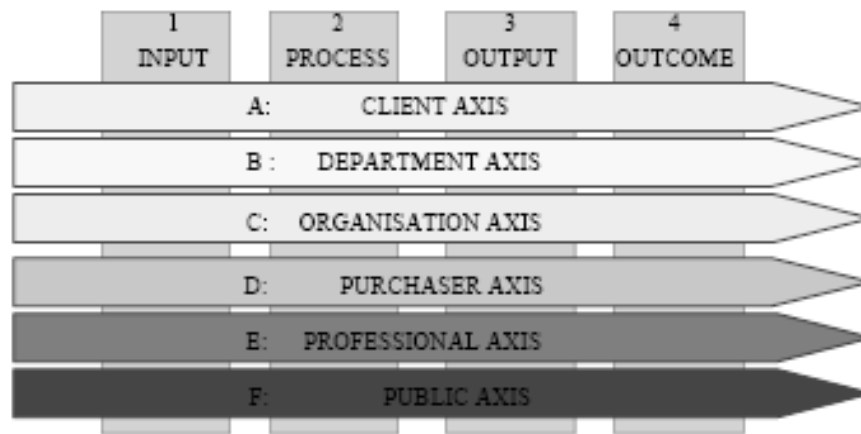
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Quality Dimensions

CDHAC QUALITY PERFORMANCE FACTORS		DIMENSION
Access		Efficiency
Safety		Effectiveness
Continuity		Technical proficiency
Appropriateness		Acceptability

Performance Reporting Model



4. Create a performance model

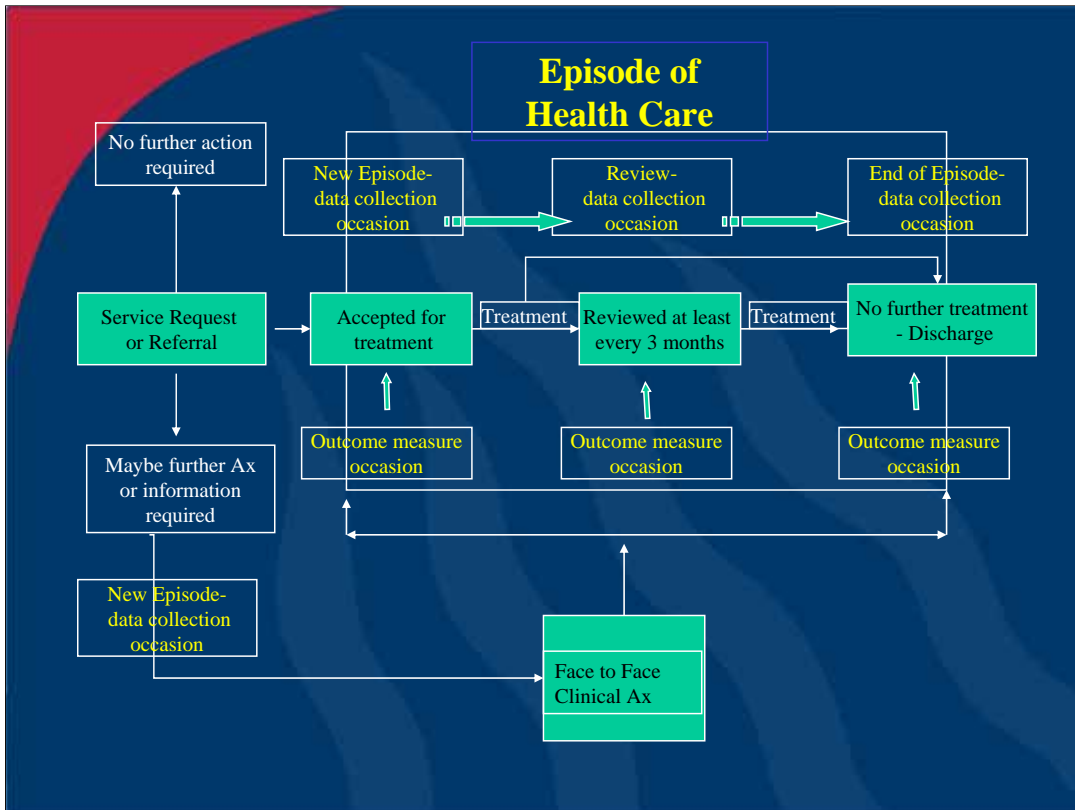
	Dimensions of performance							
C level IFI examples with roll-up B level IFI	Access	Efficiency	Safety	Effectiveness	Continuity	Technical Proficiency	Appropriateness	Acceptability
Cognition → Memory	•	•	•	•	•	PO3•	•	•
Head & Trunk Control → Joint / Bone issue	Prioritisation	Number of Treatments	•	Clinical Outcome	•	•	•	•
Food Tolerance → Enzyme deficiency	•	•	•	•	Follow up	•		•
Nutrient Adequacy → vitamin adequacy	•	•	Screen within 3 days	•	•	•	•	•
Speech → Acquired resonance	Referral Criteria	•	•	•	•	•	•	•
Environment → Housing	•	•	•	•	•	•	Cultural Approp	Client Satisfaction

Outcome Measures

- Many different reasons for measurement and the reason determines the tool.
- Not all things can be measured directly, so we use indicators as a substitute.
 - ☞ Clinical effectiveness
 - ☞ Cost efficiency
 - ☞ Allocating scarce resources
 - ☞ Clients need met – satisfied
 - ☞ Evidence
 - ☞ Improvement
 - ☞ Planning
 - ☞ Informed Choice
 - ☞ Provider satisfaction

Performance Measures

- Time spent - clinical care, clinical services management, teaching, research.
- Costs of – wages, supplies, equipment.
- Types of activities.
- Clinical Outcome Tools
- Survey of Satisfaction
- Quality - Waiting time, safety
- Competency – skill, knowledge.



Useful websites

World Health Organisation ICF Website

www3.who.int/icf/icftemplate.cfm

www3.who.int/icf/onlinebrowser/icf.cfm

Australian Institute of Health and Welfare ICF

www.aihw.gov.au/disability/publications.cfm

National Allied Health Classification Committee

www.nahcc.org.au

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