

# **Hospital Demand Management (HDM) Strategy**

## **Business Rules 2003-2004**

### ***Version 1.2 - October 2003 Update***

This document is an update of the HDM Strategy Business Rules 2003-2004 released on 1 July 2003.

This document includes the following:

- Confirmation that Barwon Health is not measured against Emergency KPI 1: Percentage of Operating Time on Hospital Bypass,
  - Confirmation that Elective Surgery Information System (ESIS) procedures in the new code range from 500-513 will not be included in measuring performance against Elective KPIs,
  - Updates of relevant website addresses, and
  - Correction of other anomalies in text.
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# Key Performance Indicators and Bonus Framework

A consolidated Hospital Demand Management (HDM) Strategy bonus funding pool totalling \$20 million has been allocated for 2003-2004. The total bonus funding pool is subject to performance against targets for the suite of key performance indicators (KPIs) for metropolitan health services detailed below.

## **Key changes in the HDM Business Rules for 2003-04 include:**

- Fewer indicators subject to bonuses
- Reduction of the number of health services eligible to receive bonus allocations
- All health services will continue to have KPIs and KRAs monitored and reported regardless of bonus eligibility

The following pages include three figures that describe responsibility for providing indicator data to the Department.

*Figure 1* outlines which health services are to report against emergency services indicators, and of those health services reporting, which health services are eligible for HDM bonus funding.

*Figure 2* outlines which health services are to report against elective surgery indicators, and of those health services reporting, which health services are eligible for HDM bonus funding.

*Figure 3* outlines which health services are to report against critical care services indicators. No bonus funding is attached to these indicators.

Neonatal and Hospital in the Home indicators, which were previously monitored under the 2002-03 business rules, are not included in the indicator suite this year. However neonatal indicators will continue to be monitored outside the HDM framework, for quality purposes.

**Figure 1: Reporting Matrix for Emergency Indicators**

<b>Metropolitan Health Service / Hospital</b>	<b>KPI 1</b>	<b>KPI 2</b>	<b>KRA 1</b>	<b>KRA 2</b>	<b>KRA 3</b>	<b>KRA 4</b>	<b>KRA 5</b>
Angliss Hospital	☑	☑	✓	✓	✓	✓	✓
Austin Health	☑	☑	✓	✓	✓	✓	✓
Barwon Health	N/A	☑	✓	✓	✓	✓	✓
Box Hill Hospital	☑	☑	✓	✓	✓	✓	✓
Dandenong Hospital	☑	☑	✓	✓	✓	✓	✓
Frankston Hospital	☑	☑	✓	✓	✓	✓	✓
Maroondah Hospital	☑	☑	✓	✓	✓	✓	✓
Monash Medical Centre	☑	☑	✓	✓	✓	✓	✓
Royal Melbourne Hospital	☑	☑	✓	✓	✓	✓	✓
Sandringham & District Hospital <sup>1</sup>	N/A	N/A	N/A	N/A	N/A	N/A	N/A
St Vincent's Hospital	☑	☑	✓	✓	✓	✓	✓
Sunshine Hospital	☑	☑	✓	✓	✓	✓	✓
The Alfred	☑	☑	✓	✓	✓	✓	✓
The Northern Hospital	☑	☑	✓	✓	✓	✓	✓
Western Hospital	☑	☑	✓	✓	✓	✓	✓
Williamstown Hospital	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mercy Hospital - East Melbourne	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mercy Hospital – Werribee	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Peter MacCallum Cancer Institute	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Royal Children's Hospital	N/A	✓	✓	✓	✓	✓	✓
Royal Victorian Eye and Ear Hospital	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Royal Women's Hospital	N/A	N/A	N/A	N/A	N/A	N/A	N/A
<b>Rural Health Service / Hospital</b>	<b>KPI 1</b>	<b>KPI 2</b>	<b>KRA 1</b>	<b>KRA 2</b>	<b>KRA 3</b>	<b>KRA 4</b>	<b>KRA 4</b>
Ballarat Health Services	N/A	✓	✓	✓	✓	✓	✓
Bendigo Health Care Group	N/A	✓	✓	✓	✓	✓	✓
Goulburn Valley Health	N/A	✓	✓	✓	✓	✓	✓
Latrobe Regional Hospital	N/A	✓	✓	✓	✓	✓	✓
Wangaratta District Base Hospital	N/A	N/A	N/A	N/A	N/A	N/A	N/A
West Gippsland Health Care	N/A	N/A	N/A	N/A	N/A	N/A	N/A

N/A

KPI/KRA not applicable for this site (No ED/Does not submit data/Not Assessed)

☑

Health service is assessed against KPI/KRA indicator and is subject to HDM bonus funding

✓

Health service performance for KPI/KRA is monitored but not subject to HDM bonus funding

**Figure 2: Reporting Matrix for Elective Indicators**

<b>Metropolitan Health Service / Hospital</b>	<b>KPI 1</b>	<b>KPI 2</b>	<b>KPI 3</b>	<b>KPI 4</b>	<b>KRA 1</b>	<b>KRA 2</b>	<b>KRA 3</b>
Angliss Hospital	☑	☑	☑	☑	✓	✓	✓
Austin Health	☑	☑	☑	☑	✓	✓	✓
Barwon Health	☑	☑	☑	☑	✓	✓	✓
Box Hill Hospital	☑	☑	☑	☑	✓	✓	✓
Dandenong Hospital	☑	☑	☑	☑	✓	✓	✓
Frankston Hospital	☑	☑	☑	☑	✓	✓	✓
Maroondah Hospital	☑	☑	☑	☑	✓	✓	✓
Monash Medical Centre	☑	☑	☑	☑	✓	✓	✓
Royal Melbourne Hospital	☑	☑	☑	☑	✓	✓	✓
Sandringham & District Hospital	☑	☑	☑	☑	✓	✓	✓
St Vincent's Hospital	☑	☑	☑	☑	✓	✓	✓
Sunshine Hospital	☑	☑	☑	☑	✓	✓	✓
The Alfred	☑	☑	☑	☑	✓	✓	✓
The Northern Hospital	☑	☑	☑	☑	✓	✓	✓
Western Hospital	☑	☑	☑	☑	✓	✓	✓
Williamstown Hospital	☑	☑	☑	☑	✓	✓	✓
Mercy Hospital - East Melbourne	✓	✓	✓	✓	✓	✓	✓
Mercy Hospital - Werribee	✓	✓	✓	✓	✓	✓	✓
Peter MacCallum Cancer Institute	N/A	N/A	N/A	N/A	N/A	✓	✓
Royal Children's Hospital	✓	✓	✓	✓	✓	✓	✓
Royal Victorian Eye and Ear Hospital	✓	✓	✓	✓	✓	✓	✓
Royal Women's Hospital	✓	✓	✓	✓	✓	✓	✓
<b>Rural Health Service / Hospital</b>	<b>KPI 1</b>	<b>KPI 2</b>	<b>KPI 3</b>	<b>KPI 4</b>	<b>KRA 1</b>	<b>KRA 2</b>	<b>KRA 3</b>
Ballarat Health Services	✓	✓	✓	✓	✓	✓	✓
Bendigo Health Care Group	✓	✓	✓	✓	✓	✓	✓
Goulburn Valley Health	✓	✓	✓	✓	✓	✓	✓
Latrobe Regional Hospital	✓	✓	✓	✓	✓	✓	✓
Wangaratta District Base Hospital	✓	✓	✓	✓	✓	✓	✓
West Gippsland Health Care	✓	✓	✓	✓	✓	✓	✓

N/A

KPI/KRA not applicable for this site (Does not submit data)

☑

Health service is assessed against KPI/KRA indicator and is subject to HDM bonus funding

✓

Health service performance for KPI/KRA is monitored but not subject to HDM bonus funding

**Figure 3: Reporting Matrix for Critical Care Services Indicators**

<b>Metropolitan Health Service / Hospital</b>	<b>KRA 1</b>	<b>KRA 2</b>	<b>KRA 3</b>	<b>KRA 4</b>
Angliss Hospital	N/A	✓	N/A	✓
Austin Health	✓	✓	✓	✓
Barwon Health	✓	✓	✓	✓
Box Hill Hospital	✓	✓	✓	✓
Dandenong Hospital	✓	✓	✓	✓
Frankston Hospital	✓	✓	✓	✓
Maroondah Hospital	✓	✓	✓	✓
Monash Medical Centre	✓	✓	✓	✓
Royal Melbourne Hospital	✓	✓	✓	✓
Sandringham & District Hospital	N/A	N/A	N/A	N/A
St Vincent's Hospital	✓	✓	✓	✓
Sunshine Hospital	N/A	N/A	N/A	N/A
The Alfred	✓	✓	✓	✓
The Northern Hospital	✓	✓	✓	✓
Western Hospital	✓	✓	✓	✓
Williamstown Hospital	N/A	N/A	N/A	N/A
Mercy Hospital - East Melbourne	N/A	N/A	N/A	N/A
Mercy Hospital - Werribee	N/A	N/A	N/A	N/A
Peter MacCallum Cancer Institute	N/A	N/A	N/A	N/A
Royal Children's Hospital	N/A	N/A	N/A	N/A
Royal Victorian Eye and Ear Hospital	N/A	N/A	N/A	N/A
Royal Women's Hospital	N/A	N/A	N/A	N/A
<b>Rural Health Service / Hospital</b>	<b>KRA 1</b>	<b>KRA 2</b>	<b>KRA 3</b>	<b>KRA 4</b>
Ballarat Health Services	N/A	N/A	N/A	N/A
Bendigo Health Care Group	N/A	N/A	N/A	N/A
Goulburn Valley Health	N/A	N/A	N/A	N/A
Latrobe Regional Hospital	N/A	N/A	N/A	N/A
Wangaratta District Base Hospital	N/A	N/A	N/A	N/A
West Gippsland Health Care	N/A	N/A	N/A	N/A

N/A

KPI/KRA not applicable for this site (Does not submit data/Not Assessed)

✓

Health service is assessed against KPI/KRA indicator but is not subject to HDM bonus funding

The bonus funding pool will be paid retrospectively on the basis of performance against targets for the suite of KPIs listed below.

### **Monthly KPIs**

- Percentage of operating time on hospital bypass
- Percentage of emergency patients requiring admission who are admitted to an inpatient bed within 12 hours
- Percentage of category 1 elective patients admitted within 30 days

### **Quarterly KPIs**

- Average waiting time of category 2 elective patients on the waiting list
- Number of hospital-initiated postponements (HiPs) *per* 100 waiting list admissions
- The number of patients on the elective surgery waiting list

### **Allocation of Bonus Funding**

Bonus funding will be paid to nine metropolitan health services and Barwon Health each quarter. Each health service is allocated \$1.35 million for each hospital for which both elective and emergency bonuses are payable, and \$0.55 million for hospitals that are eligible for elective bonuses only.

A summary of the allocations by campus and health service can be found in Figure 4 on the following page.

**Figure 4: Summary of KPIs and Allocation of Bonus Funds by Metropolitan Hospital<sup>1</sup>**

<b>Health Service</b>	<b>Hospital</b>	<b>Emergency</b>	<b>Elective</b>	<b>Total HDM Strategy Bonus Allocation</b>	<b>Total Payable to Health Service</b>
Austin Health	Austin Health	✓	✓	\$1,350,000	\$1,350,000
Barwon Health	Barwon Health	✓	✓	\$1,350,000	\$1,350,000
Bayside Health	Sandringham & District Hospital		✓	\$550,000	\$1,900,000
	The Alfred	✓	✓	\$1,350,000	
Eastern Health	Angliss Hospital	✓	✓	\$1,350,000	\$4,050,000
	Box Hill Hospital	✓	✓	\$1,350,000	
	Maroondah Hospital	✓	✓	\$1,350,000	
Melbourne Health	Royal Melbourne Hospital	✓	✓	\$1,350,000	\$1,350,000
Northern Health	The Northern Hospital	✓	✓	\$1,350,000	\$1,350,000
Peninsula Health	Frankston Hospital	✓	✓	\$1,350,000	\$1,350,000
Southern Health	Dandenong Hospital	✓	✓	\$1,350,000	\$2,700,000
	Monash Medical Centre	✓	✓	\$1,350,000	
St Vincent's Health	St Vincent's Hospital	✓	✓	\$1,350,000	\$1,350,000
Western Health	Sunshine Hospital	✓	✓	\$1,350,000	\$3,250,000
	Western Hospital	✓	✓	\$1,350,000	
	Williamstown Hospital		✓	\$550,000	

1. Including Barwon Health.

## Explanation of Weighted Indicators

As discussed above, in the 2003-04 HDM Business Rules, six key performance indicators attract bonus funding, as described above. The key performance indicator *Percentage of emergency patients requiring admission who are admitted to an inpatient bed within 12 hours* is weighted as 30 per cent of the total funding allocated to each health service. *Percent of operating time on hospital bypass* is weighted at 16.2 per cent. Elective indicators are each weighted at 14.6 per cent except *Total number of patients on the waiting list* which has a weight of 10 per cent.

The applicable weighted percentage is divided by the number of periods per year to make up the maximum allowable HDM bonus payment per indicator per period. Based on performance against the indicators, a proportionate amount is paid in respect of each quarterly or monthly KPI for which the target is met.

**Figure 5: Key Performance Indicator Weightings and Periods for 2003-04**

<b>Total Funding: \$1.35 million</b>	<b>Weighted %</b>	<b>Value of Weighted Indicator Per Year</b>	<b>Periods Per Year</b>	<b>Eligible Bonus Per Period</b>
Percentage of operating time on hospital bypass	16.2	\$218,700	12	\$18,225
Percentage of emergency patients who are admitted to an inpatient bed within 12 hours	30	\$405,000	12	\$33,750
Percentage of category 1 elective patients admitted within 30 days	14.6	\$197,100	12	\$16,425
Average waiting time of category 2 elective patients on the waiting list	14.6	\$197,100	4	\$49,275
Number of hospital-initiated postponements (HiPs) per 100 waiting list admissions	14.6	\$197,100	4	\$49,275
Total number of patients on the elective surgery waiting list	10.0	\$135,000	4	\$33,750

<sup>1</sup>based on emergency and elective funded hospital eligible for \$1.35 million in 03-04

For health services that are only assessed against elective indicators, each indicator will have a weight of 27.14 per cent, except for *Total number of patients on the elective surgery waiting list*, which will be weighted at 18.58 per cent. The same periods for the elective indicators apply.

Barwon Health Service is only assessed against 5 indicators. As Barwon Health Services, because of its geographic location, is not able to go on hospital bypass bonus funding has been allocated against one emergency and four elective Key Performance Indicators. The total funding pool remains unchanged. The allocation per indicator has been separately communicated to Barwon Health Service.

From 2003-04, data quality and timeliness will no longer be subject to bonus through the HDM framework. The Health Data Standards and Systems Unit (HDSSU), has responsibility for managing ESIS and VEMD data collections. From 2003-04 audits of ESIS and VEMD compliance will commence, with a particular focus on the performance indicator data.

## Rural Health Services

Rural hospitals are not eligible to receive funding in the 2003-04 bonus framework as rural bonus funding (\$2.7M in 2002-03) and rural non-ESIS grants totalling \$1.17M are to be targeted back to rural hospitals as specified grants so that no funding is lost.

Rural performance will still be monitored and reported through Hospital Demand Management reporting, conducted quarterly, and will be taken into account in assessment of health service performance.

## Allocation of Unspent Bonuses

In each quarter, for each hospital and each indicator, the change in performance from the previous quarter will be measured. For each indicator, hospitals are then ranked as high, medium or poor performers. They are then allocated points as follows: two points for each indicator for which they are high performers, one for medium performers and no points for poor performers. The available unspent funds are then allocated proportionately to the points scored by each hospital.

**In the example below there is \$1 million of unspent funds available. Hospital D is only eligible for two of the three indicators. The ranking has allocated a total of ten points therefore each point is worth one tenth of the unspent funds pool.**

Hospital	Indicator 1	Indicator 2	Indicator 3	Total Points	Dollars
A	High 2pts	Medium 1pts	Low 0pt	3	\$300,000
B	Medium 1pt	Low 0pt	Medium 1pt	2	\$200,000
C	High 2pts	Low 0pt	High 2pts	4	\$400,000
D	Low 0pt		Medium 1pt	1	\$100,000
<b>Total</b>				<b>10</b>	<b>\$1,000,000</b>

The example above is indicative only. The funding available is dependent on the amount of funds which are unallocated at the end of the quarter.

## **Force Majeure**

From time to time, events may occur that impact on hospital performance. Examples of such events are an internal disaster leading to hospital bypass, or third party related failures leading to interruption of service delivery (eg power failure). In such circumstances, where this has resulted in targets not being achieved, a hospital may request a force majeure.

At the discretion of the Department, force majeure may be applied system wide in extraordinary circumstances.

The intent of the force majeure process is to address extraordinary events that affect service delivery or reporting requirements and that are genuinely beyond the control of the organisation. The process is not intended to be applied to ad hoc operational difficulties, or planned interruptions of services such as capital works.

Further, when a hospital is reliant on services provided by a third party, the hospital is responsible for ensuring that, as far as practicable, the service is of an acceptable quality and delivered in a timely way. For this reason, failure of a third party to deliver a product or service in itself is not regarded as acceptable grounds for the granting of a force majeure.

In this respect, difficulties related to software conversion are not acceptable reasons for requesting force majeure unless it can be demonstrated that reasonable steps were taken to ensure continuity of data collection and recovery.

It is the policy of the Department to only consider issues of force majeure retrospectively - health services should not apply for force majeure in anticipation of poor results. It is recommended that health services review their results against indicators at the end of the applicable period to see the effect of the event on performance.

Only after it is determined that an event occurred that prevented achievement of goals and targets during the period should a health service contact the Department about leniency in the matter. Appropriate documentation of the force majeure should be forwarded for a decision to be made.

To support a claim of force majeure, it is suggested that appropriate supporting data be collected during the event. Documentation should provide necessary details in support of a case for reduced health service capacity while under demand pressure. Examples of supporting data might include:

- Number of cubicles closed for what period of time
- Contingency plans and what failed to work
- Workload over the period showing duress
- Effect of unforeseen event on operations

# Key Result Areas

There are a range of performance indicators derived from Departmental datasets which are not included in the HDM Bonus funding pool 2003-2004. These include some performance indicators which were previously Key Performance Indicators in the 2002-2003 HDM Bonus Framework. These indicators will continue to be monitored by the Department in 2003-2004, as Key Result Areas (KRAs) to ensure maintenance or improvement of performance. Some KRAs from 2002-2003 have been removed from the Framework and are no longer monitored.

There are no performance bonuses attached to KRAs.

The Department will monitor metropolitan health service performance on a monthly, quarterly and six-monthly basis against the suite of KRAs listed below.

## Monthly KRAs

- percentage of triage category 1 emergency patients treated immediately
- percentage of triage category 2 emergency patients treated within 10 minutes
- percentage of triage category 3 emergency patients treated within 30 minutes
- percentage of triage category 4 emergency patients treated within 60 minutes
- percentage of triage category 5 emergency patients treated within 120 minutes

## Quarterly KRAs

- number of category 2 patients waiting more than 90 days
- average number of open intensive care beds
- average number of open coronary care beds

## Six-monthly KRAs

- day of surgery admission (DOSA) rate
- sameday surgery rate
- percentage of intensive care patients transferred due to an intensive care bed not being available
- percentage of coronary care patients transferred due to an coronary care bed not being available

Targets for all emergency and elective surgery KRAs for health services have been set for the full financial year. The basis and methodology for individual targets are summarised in Figure 6 on Pages 11 through 13. Further information regarding targets for emergency and elective surgery KRAs is provided in Parts B1 and B2 of this document. No targets have been set for the quarterly critical care KRAs for 2003-2004.

**Figure 6: Summary of KPIs and KRAs – Definitions, Targets and Reporting Requirements**

<b>Section</b>	<b>KPI or KRA</b>	<b>Indicator</b>	<b>2003-2004 Targets<sup>1</sup></b>	<b>Numerator</b>	<b>Denominator</b>	<b>Assessment Period</b>	<b>Bonus Funding Applicable<sup>2</sup></b>
Emergency	KPI1	The proportion of time a hospital's emergency department goes on bypass.	3% system wide – Targets to be set with individual health services	Number of occasions of hospital bypass multiplied by 2 (hours of bypass)	Number of hours in the period	Monthly	Yes
Emergency	KPI2	The percentage of emergency patients who spent less than 12 hours in the emergency department prior to being admitted to an inpatient ward.	90% system wide - Targets to be set with individual health services	The number of emergency patients who were admitted to a ward within 12 hours.	The total number of emergency patients who were admitted to a ward during the month.	Monthly	Yes
Emergency	KRA1	The percentage of Triage Category 2 emergency patients treated within 10 minutes.	80% of these patients to receive treatment within 10 minutes.	The number of Triage Category 2 patients treated in 10 minutes or less during the month.	The number of Triage Category 2 patients treated during the month.	Monthly	No
Emergency	KRA2	The percentage of Triage Category 3 emergency patients treated within 30 minutes.	75% of these patients to receive treatment within 30 minutes.	The number of Triage Category 3 patients treated in 30 minutes or less during the month	The number of Triage Category 3 patients treated during the month.	Monthly	No
Emergency	KRA3	The percentage of Triage Category 4 emergency patients treated within 60 minutes.	60% of these patients to receive treatment within 60 minutes.	The number of Triage Category 4 patients treated in 60 minutes or less during the month.	The number of Triage Category 4 patients treated during the month.	Monthly	No
Emergency	KRA4	The percentage of Triage Category 5 emergency patients treated within 120 minutes.	60% of these patients to receive treatment within 120 minutes.	The number of Triage Category 5 patients treated in 120 minutes or less during the month.	The number of Triage Category 5 patients treated during the month.	Monthly	No

<b>Section</b>	<b>KPI or KRA</b>	<b>Indicator</b>	<b>2003-2004 Targets<sup>1</sup></b>	<b>Numerator</b>	<b>Denominator</b>	<b>Assessment Period</b>	<b>Bonus Funding Applicable<sup>2</sup></b>
<b>Emergency</b>	<b>KRA 5</b>	<b>The percentage of Triage Category 1 emergency patients treated immediately.</b>	<b>100% of these patients to receive immediate treatment.</b>	<b>The number of Triage Category 1 patients treated within &lt; 1 min during the month.</b>	<b>The number of Triage Category 1 patients treated during the month.</b>	<b>Monthly</b>	<b>No</b>
<b>Elective</b>	<b>KPI1</b>	<b>The percentage of Category 1 patients admitted within 30 days.</b>	<b>100% of Category 1 patients to be admitted from the waiting list within 30 days.</b>	<b>The number of Category 1 patients admitted from the waiting list during the month/quarter whose total waiting time prior to admission was 30 days or less.</b>	<b>The number of Category 1 patients admitted from the waiting list during the month/quarter.</b>	<b>Monthly</b>	<b>Yes</b>
<b>Elective</b>	<b>KPI2</b>	<b>The average waiting time of Category 2 patients on the waiting list.</b>	<b>5% reduction in waiting time systemwide - Targets to be set with individual health services.</b>	<b>The number of days accumulated by Category 2 patients on the waiting list at the end of the quarter.</b>	<b>The number of Category 2 patients on the waiting list at the end of the quarter.</b>	<b>Quarterly</b>	<b>Yes</b>
<b>Elective</b>	<b>KPI3</b>	<b>The number of hospital-initiated postponements (HiPs) per 100 waiting list admissions.</b>	<b>Targeted reductions, or maintenance, in the number of HiPs per 100 waiting list admissions in 2002-2003.</b>	<b>The number of HiPs experienced by patients who were admitted from the elective surgery waiting list during the quarter.</b>	<b>The number of patients admitted from the elective surgery waiting list during the quarter.</b>	<b>Quarterly</b>	<b>Yes</b>
<b>Elective</b>	<b>KPI4</b>	<b>The number of patients on the elective surgery waiting list.</b>	<b>A reduction in the number of patients on the waiting lists systemwide- Targets have been set with individual health services.</b>	<b>N/A</b>	<b>N/A</b>	<b>Quarterly</b>	<b>No</b>

<b>Section</b>	<b>KPI or KRA</b>	<b>Indicator</b>	<b>2003-2004 Targets<sup>1</sup></b>	<b>Numerator</b>	<b>Denominator</b>	<b>Assessment Period</b>	<b>Bonus Funding Applicable<sup>2</sup></b>
<b>Elective</b>	<b>KRA1</b>	<b>The percentage of Category 2 patients waiting more than 90 days.</b>	<b>Targeted reduction or maintenance of the percentage of Category 2 patients waiting more than 90 days, as at 30 April 2003.</b>	<b>The number of Category 2 patients on the waiting list at the end of the quarter whose waiting time was greater than 90 days.</b>	<b>The number of Category 2 patients on the waiting list at the end of the quarter.</b>	<b>Quarterly</b>	<b>No</b>
<b>Elective</b>	<b>KRA2</b>	<b>The percentage of planned overnight elective surgery admissions on the day of surgery (DOSA).</b>	<b>95% for ENT, Ophthalmology, Orthopaedics, Plastics and Urology.85% for Cardiothoracic, General, Gynaecology, Neurosurgery and Vascular.</b>	<b>The number of elective surgery patients admitted during the six-month period that were planned overnight whose admission date was equal to the date of procedure.</b>	<b>The number of elective surgery patients admitted during the six-month period that were intended overnight.</b>	<b>Six-monthly</b>	<b>No</b>
<b>Elective</b>	<b>KRA3</b>	<b>The percentage of elective surgery admissions for the basket of specified procedures and associated DRGs treated as sameday.</b>	<b>80% for a basket of procedures and associated DRGs for non-specialist hospitals. Tailored for Specialist hospitals</b>	<b>The number of elective surgery patients admitted during the six-month period for the basket of specified procedures and associated DRGs where [separation date - admission date] - HITH days = 0</b>	<b>The number of elective surgery patients admitted during the six-month period for the basket of specified procedures and associated DRGs.</b>	<b>Six-monthly</b>	<b>No</b>

<b>Section</b>	<b>KPI or KRA</b>	<b>Indicator</b>	<b>2003-2004 Targets<sup>1</sup></b>	<b>Numerator</b>	<b>Denominator</b>	<b>Assessment Period</b>	<b>Bonus Funding Applicable<sup>2</sup></b>
<b>Critical Care</b>	<b>KRA1</b>	<b>The percentage of intensive care patients transferred due to an intensive care bed not being available.</b>	<b>Set at hospital level</b>	<b>The total number of intensive care patients transferred in the six months due to an intensive care bed not being available.</b>	<b>The total number of intensive care separations for the six months.</b>	<b>Six-monthly</b>	<b>No</b>
<b>Critical Care</b>	<b>KRA2</b>	<b>The percentage of coronary care patients transferred due to a coronary care bed not being available.</b>	<b>Set at hospital level</b>	<b>The number of coronary care patients transferred in the six months due to a coronary care bed not being available.</b>	<b>The number of coronary care separations in the six months coded as principal diagnosis "I" &amp; admission source emergency department.</b>	<b>Six-monthly</b>	<b>Yes</b>
<b>Critical Care</b>	<b>KRA3</b>	<b>The average number of open intensive care beds.</b>	<b>No target</b>	<b>The number of intensive care beds open during the month.</b>	<b>The number of days in the month.</b>	<b>Quarterly</b>	<b>No</b>

<b>Section</b>	<b>KPI or KRA</b>	<b>Indicator</b>	<b>2003-2004 Targets<sup>1</sup></b>	<b>Numerator</b>	<b>Denominator</b>	<b>Assessment Period</b>	<b>Bonus Funding Applicable<sup>2</sup></b>
<b>Critical Care</b>	<b>KRA4</b>	<b>The average number of open coronary care beds.</b>	<b>No target</b>	<b>The number of coronary beds open during the month.</b>	<b>The number of days in the month.</b>	<b>Quarterly</b>	<b>No</b>

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<b>Part B</b>	<b>Business Rules</b>
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<b>B1</b>	<b>Emergency Services</b>
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## **Introduction**

The 2003-2004 budget includes additional funding under the Hospital Demand Management Strategy (HDM) for targeted strategies aimed at tackling problems of access to emergency departments and emergency services in both major metropolitan hospitals and The Geelong Hospital. This is in addition to recurrent funding of strategies previously funded as part of the HDM Strategy.

In 2003-2004, the HDM Strategy will continue to support a strategic approach to managing demand for public hospital services. The Strategy will build on the very successful work undertaken during the previous two years and will address these key policy directions:

- Funding growth
- Diverting patients from acute to other more appropriate forms of care
- Preventing the need for emergency department presentation and hospital admission under the Hospital Admission Risk Program (HARP)
- Improving patient care processes in emergency departments.

Health Service performance against key emergency service performance indicators will be regularly monitored in 2003-2004. Emergency Service performance indicators were introduced in 1995 to encourage improved access to emergency services in terms of improved waiting times for treatment and, if necessary, admission. In 2003-2004, the key emergency services performance indicators are:

- Percent of operating time on hospital bypass (previously ambulance bypass)
- Proportion of emergency patients requiring admission who are admitted within 12 hours

Monthly targets will be set for each of these indicators and performance in respect of these targets will be monitored on a regular basis. As in 2002-2003, bonus payments will be made in respect of health services performance against these targets. These indicators will be monitored in the context of the HDM monitoring and reporting framework described in this document.

## **Failure to Submit Electronic Data**

Where a hospital is unable to submit complete electronic VEMD data (e.g. due to software replacement), the Department (HDSS) must be notified of the problem in writing before the 10<sup>th</sup> of the month following data collection. Until normal submissions of data resume a minimum dataset must be submitted to the Hospital Demand Management (HDM) group. For further information, please contact the HDM group.

<b>KPI 1</b>	<b>Percent of Operating Time on Hospital Bypass.</b>
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The number of occasions of hospital bypass has been collated as a measure of access to emergency services. In this edition of the business rules, occasions of hospital bypass will be monitored as percent of operating time on hospital bypass. The change from reporting number of bypass events to reporting the percentage of time on bypass will present the same data in a different format. This change will enable comparison between health services with different numbers of hospitals (for example, the private system or interstate).

Percent of operating time on bypass is calculated by:

**Numerator:**

- Number of occasions of hospital bypass multiplied by 2 (hours of bypass)

**Denominator:**

- Number of hours in the period

This indicator is expressed as a percentage.

An occasion of hospital bypass is a period of up to two hours during which a hospital requests that ambulances take patients with non life threatening conditions to the next closest hospital. In calculating the percentage of time on bypass, it is assumed that each episode of bypass lasts two hours, which is the maximum time allowable under the current business rules. This criterion remains unchanged from the prior year.

Hospital bypass should be minimised where possible by proactive management of emergency demand. Appropriate admission policies and bed management practices should streamline the transfer of patients requiring admission from the emergency department. Processes and patient flows should be such that patients not requiring admission are assessed, treated and safely discharged in a timely manner.

From 2003-04, the term hospital bypass, rather than ambulance bypass, will be used to better reflect that the capacity limitation relates to a hospital rather than ambulance resources.

### **2003-2004 Targets**

In 2003-2004, monthly targets for per cent of operating time on hospital bypass will be set at the individual hospital level taking into account hospital performance, local demand issues and the expected impact of demand management strategies that have been funded.

### **Calculating Performance**

Calculations of bonus payments are based on 'Hospital Bypass Notification' data provided to the Department by the Metropolitan Ambulance Service (MAS). MAS record and submit data on occasions of hospital bypass to the Department daily and this

data is used for all calculations and reporting of percent of operating time on hospital bypass.

For the purpose of Hospital Bypass notification, monitoring and reporting, MAS and the Department have agreed on the following for counted occasions of bypass:

- An occasion of hospital bypass is two hours or part thereof
- The period of one day is from 00:01 to 23:59 hours
- Occasions of bypass that cross midnight are only counted in the total of the day in which they commenced
- Requests for bypass from the same hospital but by different staff within 20 minutes of each other may be counted as the same episode. However, greater intervals between requests are counted as separate occasions
- All occasions of hospital bypass are recorded and monitored, however for the purpose of bonus payments, only bypass where the reason is 'A & E Full' is used

All queries related to the recording of bypass or requests to change the details of bypass events as recorded in the Hospital Bypass notification reports should be directed to the Hospital Demand Management (HDM) group in the first instance.

## **Primary Reason for Bypass**

During 2002-03, work was done with health services on developing a standardised list of descriptors for recording the "Primary Reason for Bypass". From 2003-04, these descriptors will replace the existing set of Bypass reasons such as "A& E Full". The use of consistent definitions for the primary cause or reason for Bypass and/or HEWS will allow more valid comparisons of the drivers for these events both for individual sites as well as system wide.

In the new financial year Metropolitan Ambulance Service will be updating the Computer Aided Dispatch (CAD) system to reflect these descriptions and health services will be advised when this is to occur. At that time Emsystem will also be altered to reflect these changes in options. In the meantime hospitals should incorporate the descriptions into their current Bypass recording and documentation process where this has not already been adopted.

For the purpose of bonus payments, Primary Reason 1,2,3 and 4 will be used (previously these were collectively recorded in CAD as 'A & E Full').

It is acknowledged that there may be other factors contributing "upstream" to access block or multiple contributing factors within the ED however, the aim is to capture the **primary reason** for the event as experienced by the ED. Sites may wish to record secondary reasons in addition to the primary reason.

## Primary reason for Bypass

No.	Primary Reason	Definition
1	<b>Inpatient Access Block</b>	The primary reason for the Bypass or HEWS is that the majority of available ED treatment spaces are occupied by patients who have been assessed as needing admission, have been notified to the bed manager, allocated a bed and are waiting for internal transfer to an inpatient bed.
2	<b>Acuity/Resource Intensive Patients</b>	The primary reason for the Bypass or HEWS is that the acuity mix of patients in the ED exceeds the available resources (including staff). There are a greater than usual number of high acuity patients being managed in the ED including patients requiring respiratory support/ventilation, cardiac monitoring, intensive assessment, intervention and management requiring a 1:1 staff-patient ratio. <b>Note:</b> This assumes the usual rostered number/skill mix of staff for that time and day are available otherwise, consider using Acute Staff Shortage as reason.
3	<b>ED Volume Overload</b>	The primary reason for the Bypass or HEWS is an large and/or unpredicted increase in presentations of all levels of acuity to the ED which temporarily exceeds available resources. This may result in an unacceptable number of patients waiting to be seen longer than appropriate. Note: This assumes the usual rostered number of staff for that time and day are available and that the presentation pattern is beyond that which normally occurs at that time/day. <b>Note:</b> If it is high acuity patients rather than the volume, use Resource Intensive Patients/Acuity as reason.
4	<b>Acute ED Staff Shortage</b>	The primary reason for the Bypass or HEWS is related to ED staffing levels of key clinical staff (medical and/or nursing) below the usual rostered numbers or skill mix for that time of day/day of week resulting in reduced ED capacity to manage the usual pattern of presentations.
5	<b>Emergency Responses / Disasters - Internal or external</b>	The primary reason for the Bypass or HEWS is that the Hospital and/or ED is involved in a internal or external emergency response such as Fire, Bomb threat, Internal disaster, security incident etc and access to the emergency department has been temporarily suspended or activity contained to existing patient population in the ED.

## Considerations For Future Review

Almost all bypasses extend for the full two hours; this may reflect the lack of incentive for a hospital to end bypass before the two-hour period as much as the clinical need for bypass for the full two hours. Where there are periods of bypass lasting less than two hours this will have an effect of reporting a slightly higher percentage than the actual time on bypass.

There may be an opportunity in future to amend the calculation to reflect bypasses that end in less than two hours and thus the actual percentage of operating time on bypass.

<b>KPI 2</b>	<b>Percentage of emergency patients who are admitted to an inpatient bed within 12 hours.</b>
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This indicator monitors the percentage of patients requiring admission who are admitted from the emergency department to an inpatient bed within 12 hours.

This indicator is a measure of access from the emergency department to inpatient areas of the hospital. Appropriate admission policies and bed management practices should streamline the transfer of patients from the emergency department to inpatient beds, avoiding long waits in the emergency department.

Prolonged waits in emergency departments, which are not configured for providing inpatient care for long periods, can lead to delays in the provision of optimal care.

It is acknowledged that this indicator has a number of limitations. During 2003-2004, the Department will work with hospitals to analyse a range of issues around length of stay (LOS) in emergency departments.

There will be a focus in 2003-04 on those patients who experience very long waits in Emergency Departments (ED) for care and/or admission. The majority of patients leave the ED in under 24 hours (98.8 per cent) while a small number wait for longer periods. Further there is a marked variation in the distribution of long stay patients across the metropolitan sites with 72 per cent of all patients with an ED length of stay greater than a day occurring at just four hospitals.

A program of work is to be undertaken this year with health services to develop a system to identify, escalate and rectify cases of excessive waits in real time. This program will include mandatory reporting of all individual ultra long waits to the Department. In addition, work will also be undertaken to understand how new models of ED care such as short stay units and enhanced triage practise including "fast track" impact on the emergency department length of stay. The optimal ED length of stay for the different ED streams of patient s will also be investigated.

This and other work will assist in the development of an appropriate emergency department LOS indicator.

### **2003-2004 Targets**

In 2003-2004, monthly targets will be set at the individual hospital level taking into account hospital performance since 1999, local demand issues and the expected impact of demand management strategies funded in 2003-2004. Targets for this indicator are contained in individual Health Service HDM agreements.

### **Calculating Performance**

Performance data for this indicator is derived from the Victorian Emergency Minimum Dataset (VEMD). For complete details and descriptions of the VEMD data items, refer to *Victorian Emergency Minimum Dataset (VEMD) User Manual, Version 8, July 2003*.

In summary, performance data is derived using the following data items:

- **Arrival Date** and **Arrival Time**
- **Departure Date** and **Departure Time**
- **Departure Status** - **Code 2** - Admission to ward (including HITH)/return to inpatient ward and **Code 3** - Admission to Registered SOU and **Code 13** - Admission to Registered EMU

If the interval between **Departure Date/Departure Time** and **Arrival Date/Arrival Time** for **Departure Status** Code 2 and 3 patients is less than 12 hours (or 720 minutes), the patient is to be included in the calculation of percentage of emergency patients admitted within 12 hours.

### **Special Notes**

- Many hospital emergency departments now have discrete Short Stay Observation Units (SOU) or Emergency Medical Units (EMU). These are designated areas within or attached to emergency departments that are used to accommodate patients expected to require a short episode of care i.e. 4-48 hours. These units are designed to provide intensive short-term assessment and/or therapy for selected conditions and streamline the episode of care.
- From 2001-2002 a departure status code for SOU for use by those hospitals with units that are registered with the Department has been included in the VEMD. In 2003-04, a departure status code for EMU will be instituted. For the purposes of calculating the percentage of emergency patients admitted to an inpatient bed within 12 hours, patients in SOU and EMU are **included** in the calculations. Thus, if an emergency patient waits greater than 12 hours to be admitted to the registered SOU or EMU, they are considered to be a 'blocked admission'.
- Transit lounges/holding areas are not generally considered to be Inpatient wards. Thus, emergency patients located in these areas, prior to being admitted to a ward should be considered to be in the care of the emergency department. The time spent in these areas is **included** in all calculations of percentage of emergency patients admitted within 12 hours until the patient is actually physically admitted to an Inpatient bed/ward.

<b>KRA</b>	<b>Percentage of triage category 1-5 patients treated within recommended time.</b>
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Triage refers to the system of classifying patients according to their clinical need and priority. Patients are triaged according to the National Triage Scale developed by the Australasian College for Emergency Medicine (ACEM) in 1993. The scale has five categories of severity from category one, the most severe, to category five, the least severe. Each category has a recommended time for treatment to commence. In 2003-2004, targets for the following indicators will be set across hospitals as in previous years:

- Percentage of triage category 1 patients treated immediately
- Percentage of triage category 2 patients treated within 10 minutes
- Percentage of triage category 3 patients treated within 30 minutes
- Percentage of triage category 4 patients treated within 60 minutes
- Percentage of triage category 5 patients treated within 120 minutes.

In 2003-04, an edit will be introduced in the record submission process to ensure all category 1 patient records which are submitted below the target time to treatment will generate a submission warning to health services. It is recognised that when dealing with time periods of less than a minute accuracy can be difficult and so the edit is to act as a prompt to ensure the recording of these critical events accurately reflects the clinical outcome.

### **2003-2004 Targets**

The following targets are applicable for the time to treatment for triage indicators:

<b>Indicator</b>	<b>Description</b>	<b>Target</b>
KRA	Percentage of triage category 1 patients treated immediately	100%
KRA	Percentage of triage category 2 patients treated within 10 minutes	80%
KRA	Percentage of triage category 3 patients treated within 30 minutes	75%
KRA	Percentage of triage category 4 patients treated within 60 minutes	60%
KRA	Percentage of triage category 5 patients treated within 120 minutes	60%

### **Calculating Performance**

Performance data for all Triage KRAs is derived from Victorian Emergency Minimum Dataset (VEMD). For complete details and descriptions of the VEMD data items, refer to *Victorian Emergency Minimum Dataset (VEMD) User Manual, Version 8.0, July 2003*.

The following VEMD fields are used to derive the "Time to treatment" data for triage KRAs:

- **Arrival Date** and **Arrival Time**

- **First Seen By Doctor Date and First Seen By Doctor Time or First Seen By Nurse Date and First Seen By Nurse Time**
- **Triage Category**

Patients are calculated as treated within the recommended time if:

- Triage Category 1**      The time interval between either:
- ***First Seen By Doctor Date/First Seen By Doctor Time or***
  - ***First Seen By Nurse Date/First Seen By Nurse Time and***
  - ***Arrival Date/Arrival Time***
- is less than or equal to one minute.
- Triage Category 2**      The time interval between either:
- ***First Seen By Doctor Date/First Seen By Doctor Time or***
  - ***First Seen By Nurse Date/First Seen By Nurse Time and***
  - ***Arrival Date/Arrival Time***
- is less than or equal to 10 minutes.
- Triage Category 3**      The time interval between either:
- ***First Seen By Doctor Date/First Seen By Doctor Time or***
  - ***First Seen By Nurse Date/First Seen By Nurse Time and***
  - ***Arrival Date/Arrival Time***
- is less than or equal to 30 minutes.
- Triage Category 4**      The time interval between either:
- ***First Seen By Doctor Date/First Seen By Doctor Time or***
  - ***First Seen By Nurse Date/First Seen By Nurse Time and***
  - ***Arrival Date/Arrival Time***
- is less than or equal to 60 minutes.
- Triage Category 5**      The time interval between either:
- ***First Seen By Doctor Date/First Seen By Doctor Time or***
  - ***First Seen By Nurse Date/First Seen By Nurse Time and***
  - ***Arrival Date/Arrival Time***
- is less than or equal to 120 minutes.

## **Special Notes**

- From 2002-2003, the calculation of treated within recommended time has been from either *First Seen by Doctor Date/Time* **OR** *First Seen by Treating Nurse Date/Time*, **whichever is earlier**. This reflects changes in clinical practice such as use of clinical pathways/protocols and changes in role delineation of staff within the emergency department. It recognises that treatment may be provided by clinicians of different disciplines - medical, nursing or allied health (although the VEMD does not capture the latter).

- The concept of treatment needs further clarification. At the simplest level treatment may be described as a clinical intervention directed at the management of a patient's presenting problem or complaint. "Baseline observations after triage" are included in the *Victorian Emergency Minimum Dataset (VEMD) User Manual, Version 8.0, July 2003* definition of *First seen by Treating Nurse Date/Time* however when observations are routinely performed this is not considered "treatment" for the purpose of this calculation.
- The following are excluded from the calculation of triage performance data:
  - *Departure Status Code 6* 'Left before being seen by doctor or definitive service provider' and
  - *Departure Status Code 10* 'Left after clinical advice regarding treatment options'
- If the triage category of a patient changes during their emergency attendance, the original triage category is to be transmitted to the VEMD (regardless of whether the re-categorisation is higher or lower).

## **B2 Elective Surgery Services**

### **Introduction**

Categorisation of patients on elective surgery waiting lists according to the degree of urgency was introduced in Victoria in 1991 and is designed to identify the relative priority of patients so that they are treated on the basis of their clinical need. Three clinical urgency categories are defined, which are now national standards.

Elective surgery performance indicators, targets and incentives were introduced in 1994-1995 to encourage improved performance in the management of health care provision to elective surgery patients.

For 2003-2004, elective surgery performance indicators and targets focus on:

#### *Subject to Bonus Funding*

- Ensuring that all Category 1 (urgent) patients continue to be treated within the clinically desirable time of 30 days
- Reducing average waiting times for Category 2 patients
- Reducing the total number of patients on the elective surgery waiting list
- Reducing hospital-initiated postponements (HiPs) of patients' elective surgery

#### *Not Subject to Bonus Funding*

- Improving access of Category 2 (semi-urgent) patients to treatment by focusing on patients overdue (waiting more than 90 days) on hospital waiting lists
- Improving day of surgery admission (DOSA) and sameday elective surgery rates.

Individual hospital/health service targets have been set in order to achieve system-wide targets of:

- At or below 37,000 patients on the elective surgery waiting list
- A maintenance of Category 2 patients waiting more than 90 days as at 30 April 2003
- A 5% reduction in the AWT of Category 2 patients on the waiting list as at 30 April 2003
- Continued downward trend in hospital-initiated postponements *per* 100 waiting list admissions.

Individual health service/hospital waiting list and Category 2 targets are based on estimates of 30 June 2003 performance.

Waiting list and Category 2 targets take into account any growth funds received for elective surgery in 2003-2004, including:

- Growth for hospitals to treat additional patients (particularly long-waiting Category 2 patients) from their own waiting lists
- The potential of hospitals to refer their long waiting Category 2 patients to Designated Elective Surgery Centres, in the specialty areas of ENT, ophthalmology, urology, orthopaedics and general surgery.

Data items relating to performance against all elective surgery indicators, except sameday surgery rates, are derived from the Elective Surgery Information System (ESIS). Detailed information on this system can be found in the *ESIS User Manual Version 6.0, July 2003*.

Sameday surgery rates are derived from the Victorian Admitted Episodes Dataset (VAED). Hospitals report this data to the Department on a monthly basis.

A number of non-ESIS-reporting hospitals also provide data on DOSA to the Department. Further details of the reporting requirements for these hospitals are included at [www.dhs.vic.gov.au/ahs/quality/inpat.htm](http://www.dhs.vic.gov.au/ahs/quality/inpat.htm)

For 2003-2004 a number of previously unreported procedures have been added to the ESIS data collection. These procedures have been assigned PPP codes from 500-513. Procedures in this code range remain 'non-included' or 'excluded' procedures and will not be used when calculating performance against the elective surgery KPIs and KRAs.

The procedures for the code range 500-513 will also not be included in waiting list and waiting times figures reported by the Victorian Government, Australian Institute of Health and Welfare and the Commonwealth Department of Health and Aged Care.

<b>KPI 1</b>	<b>Percentage of Category 1 patients admitted within 30 days.</b>
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Category 1 (urgent) elective surgery patients are those patients for whom admission within 30 days is desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency.

This indicator measures hospitals' performance in admitting these urgent elective surgery patients within the clinically desirable time.

### **2003-2004 Targets**

In 2003-2004, the target for all hospitals is 100% of Category 1 patients to be admitted from the waiting list within 30 days.

### **Calculating Performance**

If a hospital's monthly data file shows that a Category 1 patient was overdue this must be confirmed or, if incorrect, amended by the hospital within two weeks of notification by the Department. If this is not done, the patient will be regarded as overdue for the purpose of performance measurement.

Bonus reduction against this indicator is determined based on the actual number of patients that were not admitted within the clinically desirable time.

<b>KPI 2</b>	<b>Average waiting time of Category 2 patients on the waiting list.</b>
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Category 2 (semi-urgent) elective surgery patients are those patients for whom admission within 90 days is desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency.

This indicator measures the average (mean) waiting time of Category 2 patients on the elective surgery waiting list, and is designed to assess hospitals' performance in managing Category 2 patient access to elective surgery.

### **2003-2004 Targets**

Targets for health services have been advised to health services.

### **Calculating Performance**

Hospitals' performance against this indicator is expressed in days. For the purposes of assessment, performance is rounded to a whole number. For example, (i) 125.2 days is rounded down to 125 days and (ii) 125.6 days is rounded up to 126 days.

**KPI 3****Number of hospital-initiated postponements (HiPs) per 100 waiting list admissions.**

Postponements of elective surgery by hospitals can result in significant distress and inconvenience to patients (for example those who travel long distances to hospital or take time off from work). It is therefore important to ensure that they are minimised.

The indicator measures the number of HiPs experienced by elective surgery patients admitted during the quarter *per 100* waiting list admissions.

**2003-2004 Targets**

To assist in setting 2003-2004 HiP targets, a regression analysis was performed to determine what characteristics are most strongly related to the HiP rate, consistent with the analysis of 2001-02, the data for 2002-03 continues to show that:

- Parameters associated with emergency admissions had more influence over HiP rates than those associated with elective admissions or ESIS patient profiles
- Total volumes were more strongly related to HiP rates than proportional volumes, ratios or averages

Hospitals have been divided into groups based on their average monthly emergency WIES and the HiPs average of each group determined, based on 2002-2003 year-to date data (generally July 2002 – March 2003). The group averages are as follows:

- Group 1 – 24 HiPs *per 100* waiting list admissions
- Group 2 – 13 HiPs *per 100* waiting list admissions
- Group 3 – 6 HiPs *per 100* waiting list admissions

Hospitals above their group average are expected to achieve the average or better for the year. Hospitals at or below their group average are expected to maintain performance for the year. Targets for hospitals and health services have been communicated to health services.

**Calculating Performance**

A postponement is hospital-initiated if the patient has been informed of the scheduled admission date and the *Reason for Rebooking* in ESIS is coded as:

- H – Hospital – the patient has been informed of their scheduled admission date for surgery which has been postponed because the operating room, hospital bed, staff or other hospital resource is unavailable, for example, because of the need to treat other patients in the hospital. Hospital resource includes prostheses for implantation, etc, but not blood.
- D – Surgeon – the patient has been informed of their scheduled admission date for surgery which has been postponed because the surgeon booked to perform this procedure has cancelled their scheduled theatre time.

Hospitals' performance against this indicator is expressed as the number of HiPs *per* 100 waiting list admissions. For the purposes of assessment, performance is rounded to a whole number. For example, (i) 25.12 HiPs is rounded down to 25 and (ii) 25.5 HiPs is rounded up to 26.

<b>KPI 4</b>	<b>Number of patients on the elective surgery waiting list.</b>
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This indicator measures the number of patients waiting for elective surgery and hospitals' performance in managing the size of their waiting lists.

### **2003-2004 Targets**

Targets for health services have been communicated to health services.

<b>KRA 1</b>	<b>Percentage of Category 2 patients waiting more than 90 days.</b>
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Category 2 (semi-urgent) elective surgery patients are those patients for whom admission within 90 days is desirable for a condition causing some pain, dysfunction or disability, but which is not likely to deteriorate quickly or become an emergency.

This indicator measures the percentage of Category 2 patients who have been waiting longer than 90 days on hospitals' elective surgery waiting lists. It is designed to assess hospitals' performance in treating their Category 2 patients within the clinically desirable time by focussing on the percentage of overdue patients on the waiting list.

### **2003-2004 Targets**

Targets for health services have been communicated to health services.

### **Calculating Performance**

Hospitals' performance against this indicator is expressed as a percentage. For the purposes of assessment, performance is rounded to a whole number. For example, (i) 25.2% is rounded down to 25% and (ii) 25.6% is rounded up to 26%.

**KRA 2****Percentage of planned overnight elective surgery admissions on the day of surgery (DOSA).**

Admission on the day of surgery improves bed utilisation and, therefore, access to inpatient treatment, with evidence showing that it does not delay discharge or increase morbidity or mortality for selected groups of patients.

This indicator measures the percentage of planned overnight elective surgery patients admitted to hospital on the day of their surgery.

**2003-04 Targets**

In 2003-2004, DOSA targets apply at specialty level as follows:

- 95% for ENT, Ophthalmology, Orthopaedics, Plastic Surgery and Urology.
- 85% for Cardiothoracic, General, Gynaecology, Neurosurgery and Vascular.

**Calculating Performance**

DOSA rates are calculated for patients registered on ESIS. The ESIS field (*Planned Length of Stay*) enables identification of the patient group to whom DOSA rates are relevant (that is, coded as 'Intended Overnight'). In 2002-2003, DOSA rates were reported to the Department via email in MS-Excel format. In 2003-2004, DOSA rates will be calculated from ESIS (a new field – *Date of Procedure* – has been included in ESIS Version 6.0 to enable this to occur).

DOSA rates for patients admitted for ESIS reportable procedures at some non-ESIS-reporting hospitals are also measured by the Department. A list of ESIS-reportable procedures can be found in the *ESIS User Manual Version 6.0, July 2003*. In 2003-2004 non-ESIS-reporting hospitals should continue to report DOSA data to the Department via email in MS-Excel format. Further details of the submission protocols are in the DOSA Business Rules which can be found at [electivesurgery.health.vic.gov.au/dosa.03.pdf](http://electivesurgery.health.vic.gov.au/dosa.03.pdf)

Targets are only applicable to specialties with a higher volume of planned overnight admissions (80 per annum).

<b>KRA 3</b>	<b>Percentage of elective surgery admissions treated as sameday.</b>
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The increased use of sameday or day surgery has been facilitated by improvements in anaesthesia, analgesia, surgical technology and earlier post-operative mobilisation of patients. In addition to reducing costs, increasing throughput and relieving demand pressure for hospital beds, sameday surgery is often more convenient and less traumatic for patients and their families.

The aim of the sameday surgery indicator is to encourage health services to treat more multi-day patients as sameday, where opportunities exist to do so without compromising quality of care. Sameday surgery targets are set to encourage long-term practice change in the way that procedures are performed and patients are managed.

This indicator measures the percentage of elective surgery patients who had their procedure performed on a sameday basis.

### **2003-2004 Targets**

In 2003-2004, a sameday surgery target applies to an overall 'basket' of 18 procedures and 38 associated DRGs. This is the same basket used in 2002-2003. Generally, these procedures have wide variation in sameday rates across the sector and significant sameday throughput at the majority of hospitals. Only DRGs without complicating conditions are included in the sameday basket, thereby focusing the indicator on a group of patients more suited to sameday treatment. A detailed description of the sameday basket is provided at Appendix 1.

This methodology is similar to the UK National Audit Committee's approach to measuring and comparing sameday surgery performance for a basket of procedures between NHS Trusts. Approximately 13 of the 18 procedures included in the sameday basket for non-specialist hospitals for 2003-2004 are also included in the basket of 25 procedures identified by the UK National Audit Committee.

The target for non-specialist hospitals for the basket of procedures and associated DRGs is 80%. Performance against this target is assessed six-monthly.

The basket of procedures and associated DRGs has been tailored for each of the specialist hospitals to reflect their distinct case-mix of patients. A detailed description of the 'specialist' baskets is provided at Appendix 2.

The target for the specialist hospitals is:

- 90% for the Royal Women's Hospital and Mercy Hospital – East Melbourne
- 85% for the Royal Children's Hospital
- 80% for the Royal Victorian Eye and Ear Hospital (95% for cataract procedures)
- 80% for the Peter MacCallum Cancer Institute.

Performance against this target is assessed six-monthly.

## Calculating Performance

The sameday surgery performance indicator is expressed as follows:

<b>Numerator</b>	Total number of elective surgery patients admitted during the six-month period for the basket of specified procedures (ICD-10 AM codes) and associated DRGs (AR-DRG V4.1 codes) where [separation date - admission date] - HITH days = 0.
<b>Denominator</b>	Total number of elective surgery patients admitted during the six-month period for the basket of specified procedures (ICD-10 AM codes) and associated DRGs (AR-DRG V4.1 codes).

Hospitals' sameday surgery rates are derived from the VAED which is reported to the Department on a monthly basis.

Sameday surgery rates are measured for the overall basket of procedures and associated DRGs, as defined by International Classification of Disease – 10<sup>th</sup> Revision, Australian Modification (ICD-10 AM) and Australian Revised Diagnosis Related Group Version 4.1 (AR-DRG V4.1) codes. Only those patient episodes where any one of the 'basket' procedures is listed as the principal procedure (ie. the first ICD-10 AM code listed for the patient episode) and which are grouped into any one of the associated DRGs are included in the numerator and denominator.

For example, one item in the non-specialist hospitals' basket is the procedure:

- Local excision of lesion of breast (ICD-10 AM 3034200)

To be included in the sameday calculation, it must be listed as the principal procedure and be grouped into one of the three associated DRGs:

- Minor Procedures for Non-Malignant Breast Conditions (AR-DRG V4.1 J07B)
- Major Procedures for Non-Malignant Breast Conditions (AR-DRG V4.1 J06B)
- Minor Procedures for Malignant Breast Conditions (AR-DRG V4.1 J07A)

### Excluding Patients with Complicating Conditions

Some patients intended for sameday treatment develop complications as a result of the procedure performed and some patients undergo more than one significant procedure during their hospital stay. Defining each basket item as one procedure associated with one or more DRGs without complicating conditions ensures that patients least suited to sameday treatment are excluded from the numerator and denominator.

### Identifying Elective Surgery Patients

Elective surgery patients are identified in the VAED where Admission Type = X 'other planned admission'.

### Hospital In The Home

Hospital in the Home (HITH) can be used for pre-operative and post-operative care to ensure that the time a patient spends in the acute hospital setting is minimised. HITH days are excluded from the length of stay for the purposes of assessing performance

against the indicator to encourage the use of HITH as a means of minimising in-hospital bed days.

### **Excluded Separation Types**

Patients identified in the VAED with a Separation Type = D 'death' or Z 'left against medical advice' are excluded from the numerator and denominator.

Hospitals' performance against this indicator is expressed as a percentage. For the purposes of assessment, performance is rounded to a whole number. For example, (i) 79.2% is rounded down to 79% and (ii) 79.6% is rounded up to 80%.

**B3****Critical Care Services****Introduction**

Critical care inter-hospital transfer performance targets were introduced in 1998-99 to encourage better bed management and quality of care for patients requiring intensive or coronary care. Specifically, the CCIHT indicator aims to:

- Enhance patient access to critical care through maximising bed availability
- Reduce inappropriate inter-hospital transfers between public hospitals.

An inappropriate transfer of a critically ill patient from a public hospital occurs when a patient is transferred because a service normally available at that hospital is not currently available. In the case of critical care transfers, this is because an intensive or coronary care bed is unavailable.

The adult critical care system in Victoria provides comprehensive support and care of patients within the full range of medical and surgical services/specialties. Most hospitals with critical care units have the capability of providing care for patients requiring the majority of service/specialities. There are, nonetheless, a number of major hospitals, which do not provide all services/specialties, and certain hospitals that provide critical care for state-wide services not normally available in most public hospitals. In addition, patients often present at the closest rather than the most suitable facility. Under these circumstances, hospital transfers are appropriate and suitable.

<b>KRA</b>	<b>Percentage of intensive care patients transferred due to an intensive care bed not being available.</b>
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<b>KRA</b>	<b>Percentage of coronary care patients transferred due to a coronary care bed not being available.</b>
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## 2003-2004 Targets

CCIHT targets for Intensive Care Services (ICU) and Coronary Care Services (CCU) are detailed below.

<b>HOSPITAL</b>	<b>ICU TARGET</b>	<b>CCU TARGET</b>
Alfred Hospital	1.7%	4.0%
Angliss Health Service	n/a	15.8%
Austin Campus	1.7%	5.0%
Box Hill Hospital	8.0%	7.0%
Dandenong Hospital	7.0%	7.0%
Frankston Hospital	7.0%	7.8%
Geelong Hospital	5.0%	4.0%
Maroondah Hospital	8.0%	18.9%
Monash Medical Centre	3.5%	12.4%
Northern Hospital	7.0%	11.9%
Royal Melbourne Hospital	1.7%	4.0%
St Vincent's Hospital	3.0%	7.0%
Western Hospital	3.5%	4.0%

## Reporting Performance

### Data Source

All data required is provided by hospitals via the Victorian Admitted Episodes Dataset (VAED) and the Victorian Emergency Minimum Dataset (VEMD). Transfers are to be counted according to the date of separation from the receiving hospital. For example, the period July-December includes transfers separated on or after 1 July up to and including 31 December. Patients with both CCU and ICU hours will be included in the denominator of each area but will be counted in the numerator according to the transfer code.

### Data Confirmation

Data is to be confirmed and verified by both receiving and sending hospitals. This process will take approximately eight weeks from the time data is first sent to hospitals

for confirmation. It is expected that hospitals will achieve a 15 working day turnaround time for the return of data.

1. The original CCIHT code is recorded on the VAED by both the receiving hospital and the sending hospital in the 'Reason for Critical Care Transfer' field, which is part of the diagnosis record.
2. The original CCIHT code is recorded on the VEMD by the sending hospital in the 'Reason for Transfer to Another Hospital or Health Service' field, which is part of the diagnosis record.
3. Data extraction dates for the VAED and VEMD are as follows:

Data Collection	When Data Extracted	Example
VAED	On or near the 21 <sup>st</sup> in second month after separation from the receiving hospital. <sup>1</sup>	January data is downloaded on 21 <sup>st</sup> March.
VEMD	On or near the 21 <sup>st</sup> in second month after separation from the receiving hospital	January data is downloaded on 21 <sup>st</sup> March.

1. Delay occurs because completed diagnosis records do not appear in the VAED consolidation until two months after the month in which the separation occurred.

4. Unmatched or mismatched records will then be forwarded to sending and receiving hospitals as appropriate. The CCIHT code should be checked and amended where necessary for mismatched records, and added for unmatched records. Explanations for corrections or other actions should be noted in the 'comments' column. Any transfers coded 'W' (other reason for transfer from acute hospital) should include an explanation as to why this code was used.
5. Inaccuracies identified by sending and receiving hospitals will be reconciled and notified for correction on the VAED and the VEMD by the sending and receiving hospitals as appropriate.

### **Resolving Coding Differences**

The transfer code recorded by the receiving hospital may differ to that of the sending hospital's reason for transfer. The resolution of these transfers will occur through the provision of additional information and data clarification by the sending hospital. However, the sending hospital's original intent for the transfer shall determine the finalisation of the confirmed CCIHT code.

Contact between receiving hospitals and sending hospitals and exchange of information is encouraged and is essential in ensuring that the correct information is captured for the VAED and the VEMD. Often the factor underlying the decision on whether a transfer is categorised as 'Specialty Not Available' or 'Bed Not Available' is the receiving hospital's knowledge of the availability of the service/specialty at the sending hospital. These Business Rules should therefore be used in conjunction with industry knowledge of the services available at certain hospitals, to verify the reason for transfer.

## Coding Information in VAED

Transfers are coded according to the following protocols.

Both receiving and sending hospitals report the reason for transfer of critical care patients in the data field 'Reason for Critical Care Transfer' on the VAED using the appropriate code as detailed below.

### Receiving Hospitals

Hospitals which **receive** a patient following their transfer from another hospital for the provision of critical care, report **the first appropriate value** from:

- 'X' Transfer from acute hospital - Specialty not available at **sending** hospital
- 'E' Transfer from acute hospital - ICU bed not available at **sending** hospital
- 'J' Transfer from acute hospital - CCU bed not available at **sending** hospital
- 'W' Other reason for transfer from acute hospital for critical care

### Sending Hospitals

Hospitals which **send** an admitted patient to another hospital for the provision of critical care, report the **first appropriate value** from:

- 'Y' Transfer from acute hospital - Specialty not available at **this** hospital
- 'F' Transfer from acute hospital - ICU bed not available at **this** hospital
- 'K' Transfer from acute hospital - CCU bed not available at **this** hospital
- 'Z' Other reason for transfer from acute hospital for critical care

### Sent and Received

Where, in a single episode, a patient was **received** by the hospital for the provision of critical care and later **sent** by the hospital to another hospital for the provision of critical care, the hospital should report **the sending code only** for this episode, ie the sending code will overwrite the receiving code.

## **VAED Coding Rules**

### **Receiving = 'X' and Sending = 'Y' - Specialty Not Available at Sending Hospital**

The 'X' code is used by receiving hospitals and the 'Y' code is used by sending hospitals when a patient is transferred for:

#### *Intensive Care Services*

- From a hospital without an ICU to a hospital with an ICU, for treatment in the ICU.
- From a hospital to the Alfred for major burns, heart lung transplant, pre-transplant mechanical cardiac supports or hyperbaric treatment.
- From a hospital to the Alfred or Royal Melbourne Hospital for the treatment of major trauma.
- From a hospital to the Austin and Repatriation Medical Centre for a spinal injury or liver transplant.
- From a hospital to the Austin and Repatriation Medical Centre for treatment at the Victorian Respiratory Support Service.
- From a hospital to the Alfred or Royal Melbourne Hospital for a bone marrow transplant or complication of a bone marrow transplant.
- From a hospital with a Level 1, 2 or rural ICU to a hospital with a Level 3 ICU for neurology/neurosurgery, cardiac surgery or thoracic surgery.
- From Box Hill Hospital or Frankston Hospital to a hospital with a Level 3 ICU for neurology/neurosurgery, or cardiac surgery.
- From the Western Hospital to a hospital with a Level 3 ICU for cardiac surgery.

#### *Coronary Care Services*

- From a hospital without a CCU to a receiving hospital with a CCU, for treatment in the CCU.
- From a hospital with a Level 2 cardiac care service to a hospital with a Level 3 or Level 4 cardiac care service for consideration or provision of angiography, angioplasty, cardiac surgery, assist device or electrophysiology.
- From St Vincent's Hospital to a hospital with a Level 4 cardiac care service for electrophysiology.

#### *Intensive and Coronary Care Services*

For the purpose of the CCIHT 'X' or 'Y' code, a 'Specialty Not Available' includes a service or expertise not offered at the sending hospital. This reason may be used in the following circumstances:

- From a hospital without the clinician responsible for the patient's original and on-going treatment to a hospital for on-going care by the original treating clinician.
- From a hospital without a requested or clinically needed specialist to one with a requested or clinically needed specialist.

Note: The determination as to whether transfers fall into either of the latter two categories is the decision of the sending hospital clinician.

### **Receiving = 'E' and Sending = 'F' - ICU Bed Not Available at Sending Hospital**

The 'E' code is used by receiving hospitals and the 'F' code is used by sending hospitals when a patient is transferred to a hospital with an ICU for treatment in the ICU, *outside the circumstances listed under X/Y*. Such circumstances include:

- When a patient is transferred from a hospital where the service/specialty/procedure is normally provided, but an ICU bed, facilities, equipment, or staff (medical/nursing/ ancillary) are not available for the care of the patient. This transfer should be categorised as 'Bed Not Available'.
- Return transfer of an admitted patient to the original sending hospital's ICU for continued care (ie. a 'Down-transfer').
- Where a patient is sent for critical care, but critical care is not provided at the receiving hospital.

### **Receiving = 'J' and Sending = 'K' - CCU Bed Not Available at Sending Hospital**

The 'J' code is used by receiving hospitals and the 'K' code is used by sending hospitals when a patient is transferred to a hospital with a CCU for treatment in the CCU, *outside the circumstances listed under X/Y*. Such circumstances include:

- When a patient is transferred from a hospital where the service/specialty/procedure is normally provided, but a CCU bed, facilities, equipment or staff – (medical/nursing/ ancillary) are not available for the care of this patient. This transfer should be categorised as 'Bed Not Available'.
- Return transfer of an admitted patient to the original sending hospital's CCU for continued care (ie. a 'Down-transfer').
- Where a patient is sent for critical care, but critical care is not provided at the receiving hospital.

### **Receiving = 'W' - Other Reason for Transfer from Acute Hospital**

The 'W' code is used by receiving hospitals when a patient is transferred:

- To the receiving hospital but not for admission to the ICU or CCU. However, the patient *later* spends time in the receiving hospital's ICU or CCU (the *sending* hospital does not report a 'Reason for Critical Care Transfer' in this instance).
- From extended care/rehabilitation/geriatric centre and *later* spends time in the receiving hospital's ICU or CCU.
- For the provision of critical care in an ICU/CCU when the *sending* hospital *is able* to provide the care required, but the following circumstances apply:
  - Transfer is required to a hospital closer to home
  - Transfer is required to another hospital due to family convenience

## **Sending = 'Z' - Other Reason for Transfer from Acute Hospital**

The 'Z' code is used by *sending* hospitals when a patient is transferred for the provision of critical care in an ICU/CCU when the *sending* hospital *is able* to provide the care required, but the following circumstances apply:

- Transfer is required to a hospital closer to home.
- Transfer is required to another hospital due to family convenience.
- Privately insured patient who has elected to use this insurance at another hospital.

## **Coding Information in the VEMD**

*Sending hospitals* report the reason for transfer of critical care patients in the data field 'Reason for Transfer to Another Hospital or Health Service' on the VEMD using the appropriate code as detailed below.

### **Sending Hospitals**

Hospitals that *send* a patient to another hospital for the provision of critical care, report the **first appropriate value** from:

- '1' Transfer from acute hospital - ICU bed not available at **this** hospital
- '2' Transfer from acute hospital - CCU bed not available at **this** hospital
- '4' Transfer from acute hospital - Specialty not available at **this** hospital
- '5' Transfer from acute hospital - Previous patient of **receiving** hospital
- '7' Patient preference

**Note:** Codes '3 General bed not available' and '6 Insured/compensable' are not applicable for CCIHT. Code '9' is also not applicable as all circumstances are covered by other codes.

## **VEMD Coding Rules**

### **Sending = '1' - ICU Bed Not Available at Sending Hospital**

- When a patient is transferred from a hospital where the service/specialty/procedure is normally provided, but an ICU bed, facilities, equipment, or staff (medical/nursing/ ancillary) are not available for the care of the patient. This transfer should be categorised as 'Bed Not Available'.

### **Sending = '2' - CCU Bed Not Available at Sending Hospital**

- When a patient is transferred from a hospital where the service/specialty/procedure is normally provided but a CCU bed, facilities, equipment, or staff (medical/nursing/ ancillary) are not available for the care of this patient. This transfer should be categorised as 'Bed Not Available'.

### **Sending = '4' - Specialty Not Available at Sending Hospital**

#### *Intensive Care Services*

- From a hospital without an ICU to a hospital with an ICU, for treatment in the ICU.
- From a hospital to the Alfred or Royal Melbourne Hospital for the treatment of major trauma.

- From a hospital to the Alfred for major burns, heart lung transplant, pre-transplant mechanical cardiac supports or hyperbaric treatment.
- From a hospital to the Austin and Repatriation Medical Centre for a spinal injury or liver transplant.
- From a hospital to the Alfred or Royal Melbourne Hospital for a bone marrow transplant or complication of a bone marrow transplant.
- From a hospital with a Level 1, 2 or rural ICU to a hospital with a Level 3 ICU for neurology/neurosurgery, cardiac surgery or thoracic surgery.
- From Box Hill Hospital or Frankston Hospital to a hospital with a Level 3 ICU for neurology/neurosurgery or cardiac surgery.
- From the Western Hospital to a hospital with a Level 3 ICU for cardiac surgery.

#### *Coronary Care Services*

- From a hospital without a CCU to a receiving hospital with a CCU, for treatment in the CCU.
- From a hospital with a Level 2 cardiac care service to a hospital with a Level 3 or Level 4 cardiac care service for consideration or provision of angiography, angioplasty, cardiac surgery, assist device or electrophysiology.
- From St Vincent's Hospital to a hospital with a Level 4 cardiac care service for electrophysiology.

#### *Intensive and Coronary Care Services*

- 'Specialty Not Available' may be used when needed expertise is not offered at the sending hospital, for example, from a hospital without a requested or clinically needed specialist to one with a requested or clinically needed specialist.

### **Sending = '5' - Previous Patient of Receiving (or Destination) Hospital**

'Previous Patient of Destination Hospital' may be used when the patient is transferred from a hospital without the clinician responsible for the patient's original and on-going treatment to a hospital for on-going care by the original treating clinician.

### **Sending = '7' - Patient Need**

This should be used by *sending* hospitals when a patient is transferred for the provision of critical care in an ICU/CCU when the *sending* hospital *is able* to provide the care required but the following circumstances apply:

- Transfer is required to a hospital closer to home.
- Transfer is required to another hospital due to family convenience.

## **Calculating Performance**

Performance against targets is assessed six-monthly, enabling hospitals to flexibly respond to changes in demand influenced by seasonal factors.

Inappropriate transfers of public patients to private hospitals are included in the calculation of hospital performance except where the transfer is to a colocated private hospital.

<b>KRA</b>	<b>Average number of open intensive care beds.</b>
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<b>KRA</b>	<b>Average number of open coronary care beds.</b>
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These performance indicators measure the average number of intensive care and coronary care beds open per month by unit, and are reported quarterly. Hospitals are encouraged to maintain availability of these services to ensure the most appropriate management of patients requiring critical care, to reduce the number of inappropriate inter hospital transfers of critically ill patients and to minimise the number of refusals to intensive and coronary care services.

### **2003-2004 Targets**

No targets have been set for this indicator for 2003-2004.

### **Reporting Performance**

Data is provided via the Victorian Critical Care Bedstate website. Each unit provides the following information:

#### **Intensive Care Services**

- The number of intensive care beds open.
- The number of beds available.

#### **Coronary Care Services**

- The number of coronary care beds open.
- The number of coronary care beds available.

Reports on performance will be extracted from the website data.

**Part C**

**Metropolitan Health Services'  
HDM Monitoring Framework**

# **HDM Monitoring Framework**

In 2003-04, the framework for monitoring HDM initiatives is intergrated with mechanisms developed to more broadly monitor the performance of metropolitan hospitals. These mechanisms include:

- an integrated monthly performance report comprising individual health service and comparative data
- meetings with health services to discuss key performance issues

## **Health Service HDM Agreements**

For health services funded under the Hospital Demand Management (HDM) Strategy, including the Hospital Admission Risk Program (HARP), service agreements will be completed. These agreements form one part of the Health Service Agreement between the Department and the health service. These:

- Describe the basis upon which HDM (including HARP) funds are allocated to the health service
- Outline key access issues to be addressed by HDM and HARP strategies
- Summarise the key strategies to be employed by the health service to improve access
- Identify the agreed targets for the key performance indicators.

## **Provision of Data**

In addition to the provision of data and financial reports identified as conditions of funding in the *Victoria - Public Hospitals and Mental Health Services Policy and Funding Guidelines 2003-2004*, health services are required to provide data for monitoring and review purposes. Some of these are regular planned monitoring activities such as the quarterly bed census, others are adhoc activities generated to monitor or measure specific processes or events.

# List of Appendices

## Part B: Business Rules

### Elective Surgery Services

1. Sameday Basket of Procedures and associated DRGs for Non-Specialist Hospitals
2. Sameday Baskets of Procedures and associated DRGs for Specialist Hospitals:
  - Royal Women's Hospital and Mercy Hospital – East Melbourne
  - Royal Children's Hospital
  - Royal Victorian Eye and Ear Hospital
  - Peter MacCallum Cancer Institute

## Part C: Metropolitan Health Services' HDM Monitoring Framework

3. Definitions of Key Activity Indicators

## **Appendix 1**

## Basket of Procedures and associated DRG's for Non-Specialist Hospitals: 2002-2003

### 19 Hospitals

18 Procedures & 38 DRG's

	Code	Procedure Name		DRG Code	DRG Name
1	3034700	Excision of lesion of breast	1	J07B	Min Procs for Non-Malignant Breast Cond
			2	J06B	Maj Procs for Non-Malignant Breast Cond
			3	J07A	Minor Procs- Malignant Breast Conditions
2	3039000	Laparoscopy	4	N08Z	Endoscopic Procs for Female Repro System
			5	N07Z	Oth Uterine & Adnexa Procs for Non-Malig
			6	G12B	Oth Dig Sys ORP No C/S CC No Malignancy
3	3039300	Laparoscopic division of abdominal adhesions	7	N11B	Oth Fem Repro Sys ORP <65 No Malig No CC
			8	N10Z	Diagnostic Curettage or Hysteroscopy
			9	N11A	Oth Fem Repro Sys ORP >64 or Malig or CC
			10	N09Z	Conistation,Vagina,Cervix & Vulva Procs
			11	G04C	Peritoneal Adhesiolysis Age<50 W/O CC
4	3044500	Laparoscopic cholecystectomy	12	H04B	Cholecyst'my No Closed CDE No Cat/Sev CC
5	3061402	Repair of inguinal hernia, unilateral	13	M04B	Testes Procedures W/O CC
			14	G10Z	Hernia Procedures Age<1
			15	G09Z	Inguinal & Femoral Hernia Procedures >0
			16	G08Z	Abdominal,Umbilical & Oth Hernia Procs>0
6	3061700	Repair of umbilical hernia	17	G08Z	Abdominal,Umbilical & Oth Hernia Procs>0
7	3067601	Excision of pilonidal sinus or cyst	18	J09Z	Perianal and Pilonidal Procedures
8	3123500	Excision of lesion of skin and subcutaneous tissue of other site of head	19	J11Z	Other Skin, Subcut Tissue & Breast Procs
			20	J10Z	Skin,Subcut Tissue & Breast Plastic ORPs
			21	J08B	Oth Skin Graft +/- Debride Proc No C/S CC
9	3213800	Haemorrhoidectomy	22	G11B	Anal & Stomal Procs W/O Catast/Severe CC
10	3250800	Interruption of sapheno-femoral junction varicose veins	23	F20Z	Vein Ligation and Stripping
11	3683904	Endoscopic resection of bladder lesion or tissue	24	Z01B	ORPs W Diags Oth Contacts W/O Cat/Sev CC
			25	L07B	Transur Proc Exc Prostatectomy No C/S CC
12	3933101	Open release of carpal tunnel	26	B05Z	Carpal Tunnel Release
13	4178900	Tonsillectomy without adenoidectomy	27	E02C	Oth Resp System OR Procs W/O Cat/Sev CC
			28	D11Z	Tonsillectomy or Adenoidectomy
14	4189200	Bronchoscopy with biopsy	29	Z01B	ORPs W Diags Oth Contacts W/O Cat/Sev CC
			30	E02C	Oth Resp System OR Procs W/O Cat/Sev CC
			31	Q02B	Oth ORP- Blood+Forming Organs W/O C/S CC
15	4270204	Extracapsular extraction of crystalline lens by phacoemulsification and aspiration of cataract with insertion of foldable artificial lens	32	C08Z	Major Lens Procedures
			33	C03Z	Retinal Procedures
			34	C07Z	Other Glaucoma Procedures
16	4792700	Removal of pin, screw or wire, not elsewhere classified	35	I23Z	Loc Exc+Removl Int Fix Dev Exc Hip,Femur
			36	I12C	Infect/Inflam Bone,Jnt+Misc Pr No C/S CC
17	4793000	Removal of plate, rod or nail, not elsewhere classified	37	I23Z	Loc Exc+Removl Int Fix Dev Exc Hip,Femur
18	4955700	Arthroscopy of knee	38	I24Z	Arthroscopy

## **Appendix 2**

## Baskets of Procedures and associated DRG's for Specialist Hospitals: 2002-2003

### Mercy East Melbourne & Royal Women's Hospital

10 Procedures & 16 DRG's

	Code	Procedure Name		DRG Code	DRG Name
1	3561800	<b>Cone biopsy of cervix</b>	1	N09Z	Conistation,Vagina,Cervix & Vulva Procs
2	3564000	<b>Dilation &amp; curettage of uterus [D&amp;C]</b>	2	N09Z	Conistation,Vagina,Cervix & Vulva Procs
			3	N08Z	Endoscopic Procs for Female Repro System
			4	N07Z	Oth Uterine & Adnexa Procs for Non-Malig
3	3562200	<b>Endoscopic endometrial ablation</b>	5	N07Z	Oth Uterine & Adnexa Procs for Non-Malig
4	3563702	<b>Laparoscopic diathermy of lesion of pelvic cavity</b>	6	N07Z	Oth Uterine & Adnexa Procs for Non-Malig
5	3563710	<b>Laparoscopic excision of lesion of pelvic cavity</b>	7	N11B	Oth Fem Repro Sys ORP <65 No Malig No CC
			8	N10Z	Diagnostic Curettage or Hysteroscopy
			9	N07Z	Oth Uterine & Adnexa Procs for Non-Malig
6	3039300	<b>Laparoscopic division of abdominal adhesions</b>	10	N11B	Oth Fem Repro Sys ORP <65 No Malig No CC
			11	G04C	Peritoneal Adhesiolysis Age<50 W/O CC
7	3039000	<b>Laparoscopy</b>	12	N08Z	Endoscopic Procs for Female Repro System
			13	G12B	Oth Dig Sys ORP No C/S CC No Malignancy
8	3552000	<b>Treatment Bartholin's gland abscess</b>	14	N09Z	Conistation,Vagina,Cervix & Vulva Procs
9	3562300	<b>Uterine myomectomy via hysteroscopy</b>	15	N07Z	Oth Uterine & Adnexa Procs for Non-Malig
10	3563301	<b>Uterine polypectomy via hysteroscopy</b>	16	N07Z	Oth Uterine & Adnexa Procs for Non-Malig

## Baskets of Procedures and associated DRG's for Specialist Hospitals: 2002-2003

### Royal Children's Hospital

10 Procedures & 10 DRG's

	Code	Procedure Name		DRG Code	DRG Name
1	4180100	Adenoidectomy without tonsillectomy	1	D11Z	Tonsillectomy or Adenoidectomy
2	3782100	Distal hypospadias, single stage repair	2	M03B	Penis Procedures W/O CC
3	3120500	Excision of benign lesion of SSCT of other site	3	J11Z	Other Skin, Subcut Tissue & Breast Procs
4	4164400	Excision of rim of perforated tympanic membrane	4	D09Z	Misc Ear, Nose, Mouth & Throat Procs
5	3780300	Orchidopexy for undescended testis, unilateral	5	M04B	Testes Procedures W/O CC
6	4792700	Removal of pin, screw or wire, not elsewhere classified	6	I23Z	Loc Exc+Removl Int Fix Dev Exc Hip,Femur
7	4793000	Removal of plate, rod or nail, not elsewhere classified	7	I23Z	Loc Exc+Removl Int Fix Dev Exc Hip,Femur
8	3061403	Repair of inguinal hernia, bilateral	8	G10Z	Hernia Procedures Age<1
9	3061402	Repair of inguinal hernia, unilateral	9	M04B	Testes Procedures W/O CC
10	4283301	Strabismus procedure involving 1 or 2 muscles, 2 eyes	10	C10Z	Strabismus Procedures

## Baskets of Procedures and associated DRG's for Specialist Hospitals: 2002-2003

### Royal Victorian Eye & Ear Hospital

10 Procedures & 13 DRG's

	Code	Procedure Name		DRG Code	DRG Name
1	4180100	Adenoidectomy without tonsillectomy	1	D11Z	Tonsillectomy or Adenoidectomy
2	4562601	Correction of ectropion/entropion with wedge resection	2	C11Z	Eyelid Procedures
3	4270203	Extracapsular extraction of crystalline lens by simple aspiration (and irrigation)	3	C09Z	Other Lens Procedures
		technique with insertion of other artificial lens	4	C03Z	Retinal Procedures
4	4155100	Mastoidectomy, intact canal wall with myringoplasty	5	D06Z	Sinus, Mastoid & Complex Middle Ear Procs
5	4270210	Other extraction of crystalline lens with insertion of foldable artificial lens	6	C09Z	Other Lens Procedures
6	4270204	Extracapsular extraction of crystalline lens by phacoemulsification and aspiration	7	C08Z	Major Lens Procedures
		of cataract with insertion of foldable artificial lens	8	C03Z	Retinal Procedures
			9	C07Z	Other Glaucoma Procedures
7	4283302	Reoperation of strabismus procedure involving 1 or 2 muscles, 1 eye, 2nd procedure	10	C10Z	Strabismus Procedures
8	4283301	Strabismus procedure involving 1 or 2 muscles, 2 eyes	11	C10Z	Strabismus Procedures
9	4283300	Strabismus procedure involving 1 or 2 muscles, 1 eye	12	C10Z	Strabismus Procedures
10	4274604	Trabeculectomy	13	C07Z	Other Glaucoma Procedures

## Baskets of Procedures and associated DRG's for Specialist Hospitals: 2002-2003

### Peter MacCallum Cancer Institute

7 Procedures & 8 DRG's

	Code	Procedure Name		DRG Code	DRG Name
1	4189200	<b>Bronchoscopy with biopsy</b>	1	E02C	Oth Resp System OR Procs W/O Cat/Sev CC
2	3123500	<b>Excision of lesion of skin and subcutaneous tissue of other site of head</b>	2	J11Z	Other Skin, Subcut Tissue & Breast Procs
3	3120500	<b>Excision of lesion of skin and subcutaneous tissue of other site</b>	3	J11Z	Other Skin, Subcut Tissue & Breast Procs
4	3123002	<b>Excision of lesion of skin and subcutaneous tissue of ear</b>	4	J08B	Oth Skin Graft +/- Debride Proc No C/S CC
5	3123001	<b>Excision of lesion of skin and subcutaneous tissue of nose</b>	5	J10Z	Skin,Subcut Tissue & Breast Plastic ORPs
			6	J08B	Oth Skin Graft +/- Debride Proc No C/S CC
6	4189801	<b>Fibreoptic bronchoscopy with biopsy</b>	7	E02C	Oth Resp System OR Procs W/O Cat/Sev CC
7	3034700	<b>Excision of lesion of breast</b>	8	J07B	Min Procs for Non-Malignant Breast Cond

## **Appendix 3**

## HDM Monitoring & Review Information & Definitions

During 2002-03, Health service performance against selected Key Performance Indicators (KPIs), Key Result Areas (KRAs) and Key Activity Indicators (KAIs) will be monitored through monthly and quarterly meetings between the Department and health service. The purpose of these meetings is to provide a forum for joint discussion of:

- Progress towards achievement of targets for KPIs and KRAs
- Monitoring of KAIs
- Implementation of HDM strategies, including initiatives funded under HARP
- Financial and WIES throughput issues

### Process for reporting HDM Data

Due to reporting cycles for VAED, VEMD and ESIS, the data reviewed in the monthly monitoring meetings will need to be jointly provided by DHS & MHS. A 3 part proforma will be emailed out to each Health Service by the 4th day of the month. Health services need to complete the Provisional data report and email back to catherine.nguyen@dhs.vic.gov.au by the 7th day of the month. DHS will then collate all data, and provide printed copies of the proforma at the HDM Monthly meeting.

### HDM Monitoring & Review Data Proforma

**Part A (.xls) KPIs, KRAs & KAIs** Note: Part A is split into 2 sections:

- (i) **Provisional Data** - all provisional data and data not extracted from formal datasets (VEMD, VAED or ESIS) to be entered here **by Health Service**
- (ii) **ALL monthly, quarterly & bi-annual Data** compared to targets and/or last financial year (**DHS ONLY**). This will automatically include data provided by Health service that does not come from formal datasets.

### Part B - Graphs (.xls)

A graphical overview of current monthly performance compared to set targets and/or last financial year for selected data items

### Part C - HDM Initiatives/Projects Implementation Monitoring (As per Gantt Chart)

Each initiative/project funded under HDM for 2002-03 has been included in a Health Service Project Plan (MS Project). Key milestones for each project have been identified to assist DHS to monitor project implementation. Generally these milestones are Staff Recruitment Completed, Capital Works Completed, Patients Recruited

Health services are asked to provide updates on progress against the plans for each project at the monthly HDM meetings and identify any implementation delays, together with revised timelines.

### Data Definitions

	DATA ITEM	SOURCE	DEFINITION
<b>KEY PERFORMANCE INDICATORS</b>	<b>Monthly</b>		
	Occurrences of Ambulance Bypass	MAS/DHS	Occurrences of Ambulance Bypass as reported by MAS
	% Admissions w/i 12 Hours	VEMD	Admissions w/i 12 hours/Total admissions. Admissions is where departure status = 2 (admitted to ward) or 3 (admitted to SOU)
	% Triage Cat 1 Seen Immediately	VEMD	Triage Cat 1 Patients Seen Immediately/Total Triage Cat 1 Patients
	% Elective Cat 1 Admitted w/i 30 Days	ESIS	Elective Cat 1 Patients admitted within 30 days during month/Total Elective Cat 1 Patients admitted during month
	<b>Quarterly</b>		
	Total on Waiting list	ESIS	Total patients on the elective surgery waiting list at end of quarter
	% Cat 2 Waiting > 90 Days	ESIS	Elective cat 2 patients waiting > 90 days on the waiting list at end of quarter/Total elective cat 2 patients on the waiting list at end of quarter
	Avg Cat 2 Waiting Time	ESIS	Average waiting time in days for elective cat 2 patients on the waiting list at end of quarter
	Hospital-Initiated Postponements per 100 Admissions	ESIS	Total number of hospital-initiated postponements per 100 waiting list admissions during quarter
	<b>Six-Monthly</b>		
	% Intensive Care Patients Transferred (ICU Bed N/A)	VAED	Total number of intensive care patients transferred in the six months due to ICU bed not available/Total number of intensive care separations in the six months
	% Coronary Care Patients Transferred (CCU Bed N/A)	VAED	Total number of coronary care patients transferred in the six months due to CCU bed not available/Number of coronary care separations in the six months coded as principal diagnosis "I" and admission source emergency dept.
<b>MONTHLY MONITORING</b>	<b>ED Processes</b>		
	Emergency Separations (YTD)	VAED	Emergency Separations are based on 'Admission Type' and 'Care Type' as defined in the PRS/2 Manual. Please provide monthly cumulative figures
	% Triage Cat 2 Seen w/i 10 Minutes	VEMD	Triage Cat 2 Patients Seen within 10 minutes/Total Triage Cat 2 Patients
	% Triage Cat 3 Seen w/i 30 Minutes	VEMD	Triage Cat 3 Patients Seen within 30 minutes/Total Triage Cat 3 Patients
	% Triage Cat 4 Seen w/i 60 Minutes	VEMD	Triage Cat 4 Patients Seen within 60 minutes/Total Triage Cat 4 Patients
	% Triage Cat 5 Seen w/i 120 Minutes	VEMD	Triage Cat 5 Patients Seen within 120 minutes/Total Triage Cat 5 Patients
	Number of RoTES Major Trauma Admissions	MHS	Only relevant to Bayside Health and Melbourne Health
	<b>Elective Surgery Services</b>		
	Number of Admissions from the Waiting List	ESIS	Patients removed from the waiting list with ESIS reason for removal codes W (admitted to this hospital for awaited procedure as a planned admission) and X (this hospital/health service arranged admission at a hospital under contract)
	Total Elective Surgery Separations (YTD)	VAED	Total elective surgery separations. Elective separations are based on 'Admission Type' as defined in the PRS/2 Manual. Please provide monthly cumulative figures
	<b>Patient Flows</b>		
	Emergency : Elective Bed Day Ratio	VAED	Emergency & Elective Beddays (SD & MD) as a % of Total Beddays
	Multi Day Occupied Beds	VAED	Total MD Beddays/Days in Period (Emergency & Elective)
	Acute Patients with LOS > 14 Days at EOM	MHS	Number of acute patients with length of stay greater than 14 days at the end of the month (EOM)
	<b>Exit Block</b>		
	Acute Patients Waiting For Resi Care at EOM	MHS	Number of acute patients waiting at End Of Month for Residential Care Bed
	Sub-Acute Patients Waiting For Resi Care at EOM	MHS	Number of sub-acute patients waiting at End Of Month for Residential Care Bed
Interim Care Patients at EOM	VAED	Only relevant to Northern Health, Eastern Health, Southern Health, Melbourne Health or St Vincent's Health, or if a patient is being treated under contract to a hospital involved in the interim care pilot program. Interim Care patients are reported via PRS/2 as Care Type 1 or 9, and with an Admission Type of "Z" (Admission to Interim Care)	
Avg LOS in Interim Care	VAED	Average length of stay in days for interim care patients (see definition above)	
Avg LOS in subacute care (days) - REHAB 2	VAED	Average length of stay for Care Type 6 patients (Rehab 2)	
Avg LOS in subacute care (days) - GEM	VAED	Average length of stay for Care Type 9 patients (GEM), except where Admission Type = "Z"	

For more information, please refer to the Hospital Demand Management Business Rules 2002-2003 or:

- Tim Williamson (9616 9878) for data items derived from ESIS
- Leone Carberry (9616 8328) for ICU and CCU data items
- the EDCG Contact for your Health Service for all other data items.

Return all HDM Monitoring Data by the 7th of each month to catherine.nguyen@dhs.vic.gov.au





# [NAME OF HEALTH SERVICE]: Part A - ALL HDM Monitoring & Review Data

DATA ITEM		REPORTING PERIOD														
<b>KEY PERFORMANCE INDICATORS</b>	<b>Monthly</b>	Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL/YTD RATE	
	Occasions of Ambulance Bypass	01/02														
		02/03														
		Target														
	% Admissions w/i 12 Hours	01/02														
		02/03														
		Target														
	% Triage Cat 1 Seen Immediately	01/02														
		02/03														
		Target														
	% Elective Cat 1 Admitted w/i 30 Days	01/02														
		02/03														
		Target														
	<b>Quarterly</b>	Year	Quarter 1			Quarter 2			Quarter 3			Quarter 4			TOTAL/YTD RATE	
	Total on Waiting list	01/02														
02/03																
% Cat 2 Waiting > 90 Days	01/02															
	02/03															
Avg Cat 2 Waiting Time	01/02															
	02/03															
Hospital-Initiated Postponements per 100 Admissions	01/02															
	02/03															
<b>Six-Monthly</b>	Year	July - December						January - June						TOTAL		
% Intensive Care Patients Transferred (ICU Bed N/A)	01/02															
	02/03															
% Coronary Care Patients Transferred (CCU Bed N/A)	01/02															
	02/03															
<b>MONTHLY KRA &amp; KAIS</b>	<b>ED Processes</b>	Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL/YTD RATE	
	Emergency Separations (YTD)	01/02														
		02/03														
		Target														
	% Triage Cat 2 Seen w/i 10 Minutes	01/02														
		02/03														
	% Triage Cat 3 Seen w/i 30 Minutes	01/02														
		02/03														
	% Triage Cat 4 Seen w/i 60 Minutes	01/02														
		02/03														
	% Triage Cat 5 Seen w/i 120 Minutes	01/02														
		02/03														
	Number of RoTES Major Trauma Admissions	01/02														
		02/03														
		Target														
	<b>Elective Surgery Services</b>	Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL/YTD RATE	
	Number of Admissions from the Waiting List	01/02														
		02/03														
		Target														
	Total Elective Surgery Separations (YTD)	01/02														
		02/03														
		Target														
	<b>Patient Flows</b>	Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL/YTD RATE	
	Emergency : Elective Bed Day Ratio	01/02														
		02/03														
	Multi Day Occupied Beds	01/02														
		02/03														
	Acute Patients with LOS > 14 Days at EOM	01/02														
		02/03														
	<b>Exit Block</b>	Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL/YTD RATE	
Acute Patients Waiting For Resi Care at EOM	01/02															
	02/03															
Sub-Acute Patients Waiting For Resi Care at EOM	01/02															
	02/03															
Interim Care Patients at EOM	01/02															
	02/03															
Avg LOS in Interim Care	State Av															
	01/02															
Avg LOS in subacute care (days) - REHAB 2	02/03															
	State Av															
Avg LOS in subacute care (days) - GEM	01/02															
	02/03															

**Legend:**  During 2002-03 where ESIS, VAED and VEMD data have not passed all edits, provisional data provided by hospitals has been used.