

10 Welcome – Afternoon Session

Mark Gill, Manager, HDSS, DHS, welcomed participants to the afternoon session of the Forum, introduced HDSS representatives Irene Kearsey, Greg O’Connell, Anna Cooper, Katherine Hunt, Leanne Daking, Sara Harrison, Shahn Campbell and Joanne McLachlan, and advised that Jenelle Hurley and Nicolette Theirn had left DHS to venture into other employment streams.

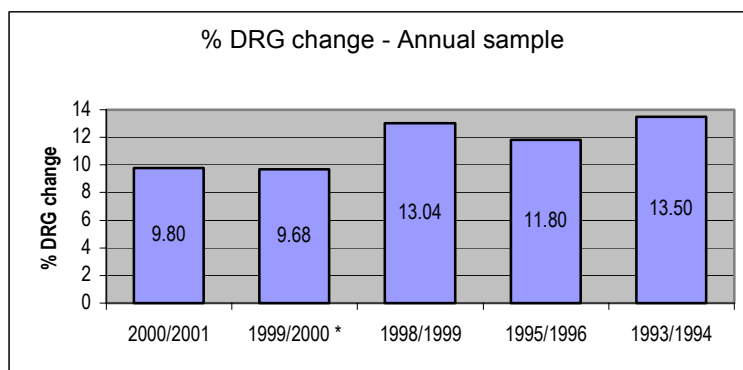
11 VAED Audit Update

Joanne McLachlan, HDSS, DHS, presented the final results of the audit of 2000-2001 VAED data, the final report of which was being prepared by Healthcare Management Advisors (HMA), who had undertaken the 3 year audit project for DHS. The report was expected to be available at the HDSS website [early in 2002]. Hospitals would again be informed of password access details by DHS letter.

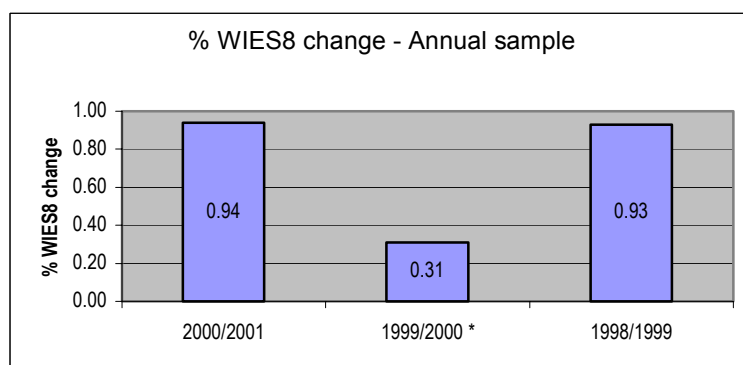
The total audit sample for 2000—2001 had been divided into 4 groups:

- Annual sites: randomly selected, within a broad framework requiring all hospitals to be audited at least once every 3 years, with some randomly selected sites each year
- Follow-up sites: selected due to results exceeding pre-determined unacceptable rates of change for either DRG and/or WIES in the previous year’s Annual sample
- Supplementary sites: selected due to results exceeding pre-determined unacceptable rates of change for either DRG and/or WIES in the previous year’s ‘Follow-up sites’ sample
- 4th Quarter sites: selected from the Annual group for audit of preceding financial year’s final quarter data.

The data audited in 2000—2001 provided another state-wide result, as did data from 1998—1999. The result for the Annual sample in 1999—2000 was not a true ‘statewide’ result as the sample was not structured to represent all hospital groups. Figures for 1999—2000 were included for reference only.

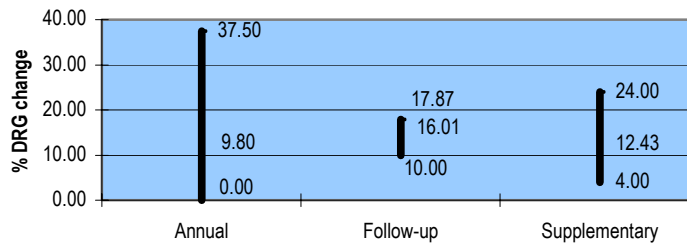


The 2000 – 2001 statewide percentage DRG change was substantially lower than that achieved for 1998 – 1999, when ICD-10-AM was introduced.



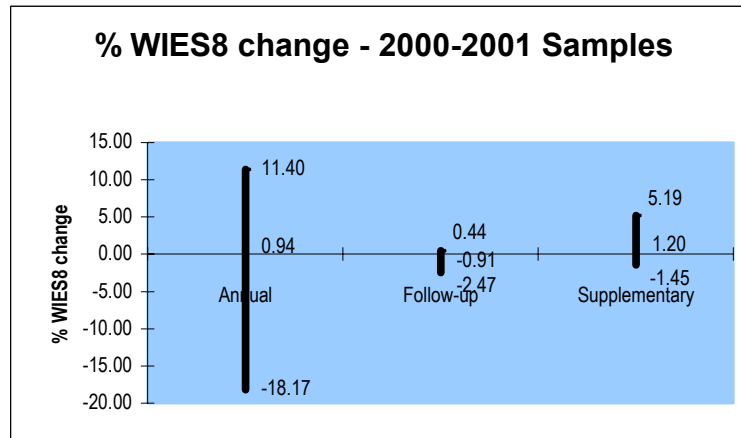
The percentage WIES change in 2001—2002 was remarkably similar to the 1998—1999 statewide result. The percentage WIES change, and the average WIES per case, for the Annual sample for 1999—2000 were lower than either state-wide result. A larger proportion of smaller and/or rural hospitals had been audited that year.

% DRG change - 2000-2001 Samples



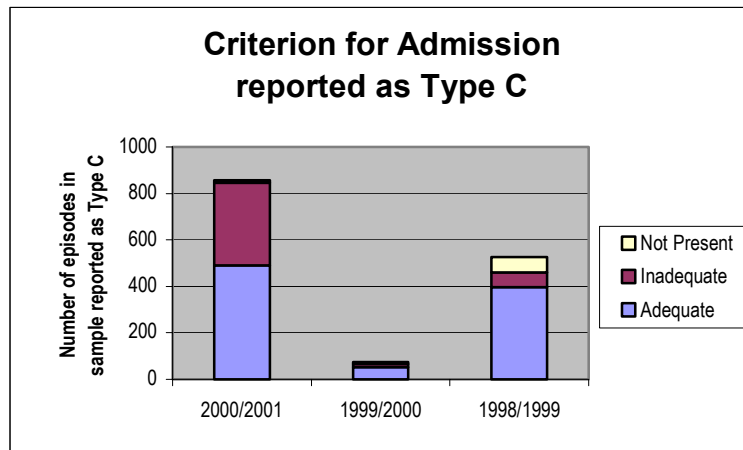
The percentage DRG change for the 3 samples assessed during 2000—2001 was compared, with the lowest, highest and average results for each sample identified. Five sites in the 2000 – 2001 Annual sample recorded no percentage DRG change and were commended. Two of the four ‘Follow-up sites’ remained above the pre-determined acceptable level of DRG and/or WIES change, as did two of the seven ‘Supplementary sites’.

% WIES8 change - 2000-2001 Samples

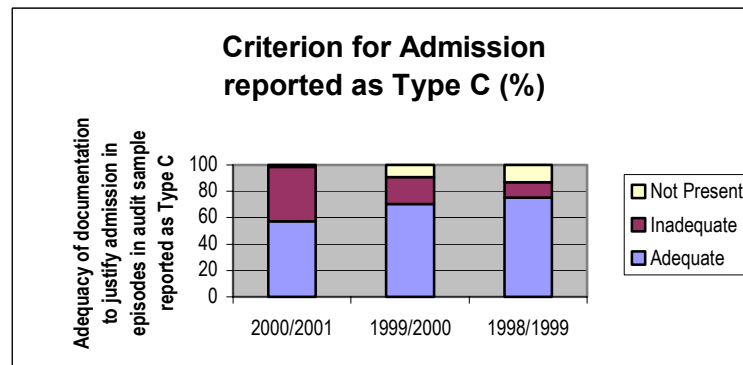


The percentage WIES8 change for the three sample groups in 2000—2001 was displayed, with negative values indicating the auditor’s WIES8 result was lower than the hospital’s result; conversely, a positive result indicated the auditor’s result was higher than the hospital’s result.

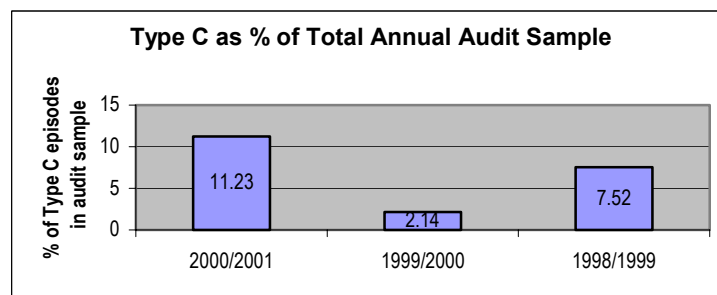
One of the project’s objectives was to assess the adequacy of documentation in the medical record to justify the admission of cases reported to the VAED with Criterion for Admission Type C (Type C Professional Attention Procedure). Type C admissions, by definition, require a procedure defined by the Commonwealth as not usually requiring admission to hospital. In cases where no procedure was performed, the treating doctor had more discretion, but it would appear the ‘4 hour rule’ is used in some quarters to ‘admit by computer’.



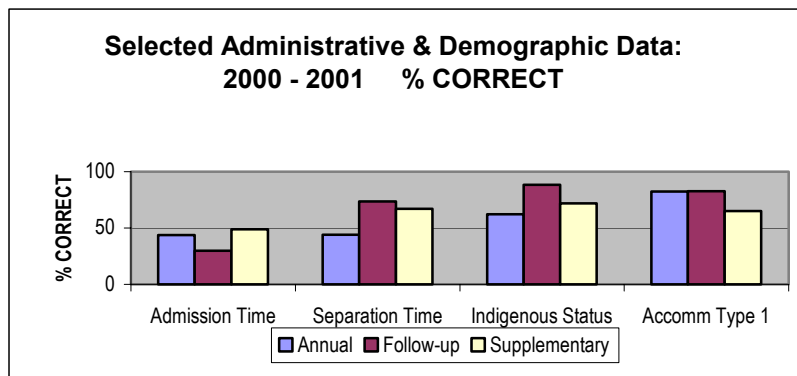
The number of Type C admissions during the 3 years varied considerably. The proportion of cases with adequate documentation declined, while the proportion with inadequate documentation increased. The inclusion in the 1998—1999 and 2000—2001 samples of more of the large, metropolitan hospitals would have increased the number of Type C episodes, and more accurate reporting of Type C cases might also have contributed. Previously, many cases were reported as Type B, when they should have been Type C, if admission was justified at all. This problem remains in some hospitals. Over the 3 years of the project, the proportion of Type C cases with inadequate documentation to justify admission increased, with a decline in the proportion with no documentation.



The proportion of Type C cases in the total audit sample had increased from the previous state-wide result. Further investigation was needed to determine if this was a reporting issue, that is hospitals were reporting more accurately, or an admission practice issue, that is hospitals were admitting more ambulatory patients.



The third key objective of the audit was to assess the accuracy of a range of administrative and demographic data items reported by hospitals to the VAED. Auditors were supplied with the values for these items held in the VAED, and compared those with the documentation for the audited episode, as held in the patient record.

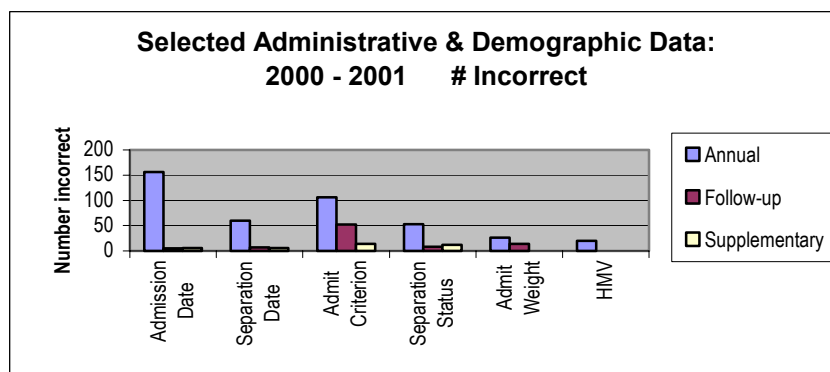


The results for 2000—2001 identified a few items where the data showed scope for much improved accuracy: Admission Time was correct in fewer than half the episodes audited; Separation Time was slightly better.

Indigenous Status was shown to be correct in some 60% of cases, better than the 40% for 1998 - 1999.

The incorrect reporting of Accommodation Type was mainly due to same day patients being reported as code 3, when that hospital did not have designated same day beds.

Incorrect values in some key administrative and demographic fields were highlighted, showing 156 Admission Dates (just over 2% of the Annual sample) were incorrect, most commonly in cases admitted via the Emergency Department, where the Admission Time was wrongly reported, and when corrected, this also affected the Admission Date.



The Admission Criterion was mainly incorrect for same day admissions and the Separation Status was typically reported incorrectly as 'home' for destinations that were not classified as such.

Admission Weight and Hours of Mechanical Ventilation (MHV) were not relevant to every case, but were incorrect in a number of cases where they were required to be reported. Over 20% of episodes where HMV was reported contained incorrect details. This is a logical item for in-house data quality activities, as it has an impact on funding.

Joanne commented that, during the 3 years of the VAED data audit project, Victorian hospitals had overwhelmingly embraced the audit process as a positive learning experience. Overall results were good, showing improved percentage DRG change and consistency in percentage WIES change. It had also reassured DHS, as the funding body, that expenditure based on the VAED data is broadly verified. The audits had identified some targets for hospitals', and DHS', data quality activities, and future audit topics.

Mark Gill congratulated hospitals for achieving a DRG change rate under 10% and for continuing to lead the country in coding accuracy.

12 Proposals for Revisions to the VAED

12.1 Transport Accident Commission (TAC)

Candice Charles, TAC, presented the TAC proposal for electronic billing for admitted TAC patients. TAC is proposing that Victorian public hospitals collect two additional VAED data items from 1 July 2002: *Date of Accident* and *TAC Claim Number*, which would allow electronic billing/remittances for WIES-funded accounts for TAC clients admitted to a public hospital.

The new process would be based on the billing procedure used for Department of Veteran Affairs (DVA) patients, and would enable quick and efficient processing of TAC accounts. Candice outlined the proposed process:

- TAC would forward a pre-payment to DHS quarterly
- Hospitals providing services to admitted patients would report *Date of Accident* and *TAC Claim Number*, if available, with their PRS/2 data transmissions
- DHS would construct one file with data from all hospitals and forward to the TAC monthly
- TAC would process data, reconcile against pre-payment and forward electronic remittance to DHS
- DHS would process remittance and allocate funds to hospitals according to VAED data.

If the *TAC Claim Number* was unknown, the TAC could process accounts if correct *First Name*, *Surname* and *Date Of Accident* details were provided. If the patient had not submitted a claim for compensation with the TAC at the time of billing, the TAC would hold the account for 10 weeks attempting to find a matching claim.

The benefits for hospitals would be:

- TAC admitted patients would follow the same process as DVA patients - no need to bill differently for different funding bodies
- No need to raise and submit paper invoices to the TAC - data would be provided to DHS via the VAED
- DHS would conduct reconciliation - all account enquiries would be via DHS who would then liaise with TAC Accounts Department.
- Less administrative effort overall, and therefore fewer resources required.

Candice encouraged all hospitals to establish electronic billing/remittances for non-casemix TAC episodes. Queries regarding electronic billing for TAC patients were directed to Evan Kastrinakis, Operational Efficiency Division on 9664 6047 or via email to evan_kastrinakis@tac.vic.gov.au

12.2 Duration of Continuous Positive Airways Pressure (CPAP)

Steve Gillett, DHS, presented a proposal to collect information on the duration of Continuous Positive Airways Pressure (CPAP). Steve said that CPAP was similar to, but less invasive than, mechanical ventilation. A study conducted by Lillian Lazarevic of HMA was the first to advocate CPAP as a severity measure and neonatal specialists had been seeking its introduction to the funding formula for many years. Neonate hospitals were already collecting CPAP hours.

Mechanical ventilation was introduced last year as a rough measure of severity for neonates. The review of Women's and Children's Hospitals then being conducted had also identified that the addition of CPAP would provide a better indicator.

Steve said the neonatal problem list was not revised for AR-DRG Version 4.1. The Commonwealth had been asked to develop CPAP as a pre-MDC DRG for Version 5, similar to the current Mechanical Ventilation DRG. Steve had argued strongly against this but he believed there would be a DRG in the Respiratory MDC for CPAP exceeding 24 hours.

Steve said it had been decided that next financial year's VAED would collect CPAP hours in Special Care Nurseries and Neonatal Intensive Care Units. The issue was whether to broaden the collection to all patients. Collection could be quite involved because CPAP was less invasive and patients were on and off CPAP more often than mechanical ventilation. The Department was keen to receive the information for non-neonates in order to support funding policy considerations but wanted to avoid data collection which was too onerous.

12.3 Interim Care Program Care Types

Basia Sudbury, DHS, presented a proposal to introduce two new Care Types. Basia noted the Interim Care Program was a two-year pilot program implemented in five Metropolitan Health Services to improve the patient flow from acute and sub-acute through the hospital system.

The patient group being targeted was mainly elderly, who had completed their acute or sub-acute episode of care, and were medically stable, but needed considerable support with functional activities and were waiting to return to the community, most via a residential aged care bed. It was widely held that the shortage of residential aged care beds in the community contributed to the slow exit of this patient group, and Interim Care was one of the programs in the Hospital Demand Management Strategy looking to resolve this.

The Interim Care Program is being evaluated during its two-year trial period, and was likely to continue in some form due to the increasing aged population and the differing availability of residential aged care beds in some areas. Patients in the Interim Care program were required to receive active social work intervention to assist them and their families secure suitable accommodation and they required allied health assistance to maintain their functional abilities. This was especially important in placing patients in residential care.

Interim Care and Nursing Home Type patients shared similar medical/care needs, however Interim Care patients must have an ACAS assessment and a recommendation for residential care, while Nursing Home Type patients may or may not have this. Interim Care patients must receive the additional active assistance described earlier. While Interim Care and Nursing Home Type shared features in common, in future the Interim Care program was likely to be used selectively by DHS where patient need and Health Service need is greatest. There was no intention for Interim Care to supplant Nursing Home Type. Few patients waiting for placement were reported as Nursing Home Type but rural hospitals had Nursing Home Type patients virtually residing at the hospital.

The current arrangements for Health Services to report Interim Care to PRS/2 were complicated and difficult for DHS to extract. It was not possible to report Interim Care patients as Care Type 1, NHT/ Non-Acute, as a Barthel Score must be reported for these patients and is not required for Care Type 1.

The proposal was to introduce two new *Care Types*:

- D – Interim Care – NHT
- Patients can access Interim Care after being assessed as Nursing Home Type

- E – Interim Care

Assessment and eligibility can occur before 35 days, as some leave before 35 days

It was proposed that the Barthel Score be collected for the duration of the pilot to assist with evaluation. Therefore, the Sub-Acute Record S2 would need to be changed to allow for the *Barthel Score* to be collected for these proposed *Care Types* on Admission and on Separation.

12.4 Prisoner Account Classes

Milena Canil, DHS, discussed the proposed revision to the *Account Classification* field to enable reporting of two new codes for prisoners.

Milena commented that a review of VAED data conducted in October revealed a number of discrepancies in relation to the reporting of admitted patients who were also correctional services prisoners. The types of discrepancies in reporting were varied, and a number of hospitals were involved. For the most part, hospitals had reported prisoners correctly, using P-N as the *Medicare Suffix* and a blank *Medicare Number*.

However, some hospitals had not reported prisoners with a P-N suffix. This had arisen, in part where a person had attended the hospital prior to being a prisoner and the Medicare details were retained on the hospital's patient administration system. Also, in spite of the P-N suffix, prisoners were in the main identified in the VAED as public patients and there was no guarantee that all prisoners had been identified and separated out of the dataset upon which case payments were made. In addition to the problems caused for financing, the inability to accurately identify prisoners had made it unsuitable for any meaningful analysis.

To resolve this problem in the short term, a HDSS Bulletin had been circulated to all hospitals asking that arrangements be made to ensure P-N was used in the *Medicare Suffix*, and the *Medicare Number* remained blank. Hospitals were also asked, where patient details were already held in the hospital's patient administration system, to update those details when the patient attended the hospital whilst a prisoner.

As a longer-term solution to the identification problem, the review recommended that prisoners be identified as a distinct *Account Classification* in the same way as DVA and TAC patient. Consequently, the introduction of new prisoner *Account Classifications* was proposed to make the reporting system more accurate and assist with identification of this group of patients.

Identification of prisoners in this way also reflected the National Health Data Dictionary data item that nominated correctional facilities as the funding source for prisoners.

Mention had been made in the Proposal that DHS would review the system for billing of prisoners. Instead, to assist hospitals, the Fees Manual would be updated with a list of contacts for all Victoria's correctional facilities. Should hospitals feel this is inadequate, they should contact the HDSS Help Desk.

13 Other Business – Afternoon Session

Mark Gill invited those present to raise items of other business, or to discuss further proposals raised earlier in the afternoon.

TAC payments were discussed further. It was clarified that it was necessary to report relevant information for all TAC patients, including sub-acute. Currently only casemix payments could be made electronically. The next step will be per diem payments for non-casemix-funded episodes.

Note was made of typographical errors on the *Proposals for Revisions to PRS/2 and the Victorian Admitted Episodes Dataset (VAED)*, which lists the proposed *Care Type* codes for Interim Care as C and M, but which should be D and E. The new *Care Type* codes for Interim Care had not been introduced on 1 July 2001 as the program had been developed too late for them to be included at that time.

The introduction of *Duration of CPAP* was discussed with particular regard to the counting of hours, the use of the rules used to calculate mechanical ventilation hours, and whether the information was to be collected for both adults and babies. Other issues such as the increase in coding time and changes to software were discussed. It was suggested that a definition and were required before a decision could be made on the scope of implementation. The purpose of collecting information on adults was to get baseline data.

The use of the DVA/TAC field as a dual field was discussed as some hospitals felt that implementing this may cause complications.

13.1 ICD-10-AM

Mark Gill presented information on the introduction of ICD-10-AM, 3rd Edition, from 1 July 2002. Use of AN-DRG v4.2 would continue, with mapping from 3rd to 2nd edition codes. A new library file will be made available. The mapping tables were available from the NCCCH website and would be finalised in January 2002. Coding workshops and possibly web-based training in the 3rd Edition would be provided prior to July.

14 TAC and Work Cover Update

Tony La Sala, DHS, provided an update on TAC and Work Cover fees and billing.

TAC fees for the first 6 months of 2001—2002 remained the same as for 2000—2001. DHS advised via HDSS Bulletin 29 and Hospital Circular that first quarter TAC invoicing for admitted patients could proceed according to the previous year's price. DHS would advise via HDSS Bulletin in the following few weeks that the second quarter invoicing could also proceed at those rates. Processing of admitted patient statements would be batched for the second quarter as per the first quarter to save hospitals having to re-transmit TAC patient records.

Fees for the remaining 6 months were still being negotiated between DHS and TAC. DHS would advise the outcome as soon as it was reached. Non-admitted patient fees for 2001—2002 had been agreed: fees for the first 3 months of 2001—2002 remained the same as 2000—2001; fees for the remainder of 2001—2002 would increase, with effect from 1 October. The fee schedule had been updated on the Fees Manual website (www.health.gov.au/feesman/).

Tony reported negotiations continued between DHS and VWA for admitted and non-admitted patient fees for 2001—2002. Hospitals were asked not to send any VWA invoices relating to 2001—2002 until further notice. It was expected fee changes would be effective from 1 July, 2001. Hospitals would be advised immediately fees were agreed, and DHS would again arrange with Allegiance Systems to 'batch' admitted patient statements to save re-transmission of these records.

15 PICQ and Data Quality Update

Greg O'Connell, HDSS, DHS, discussed the availability of two software programs which analyse the quality of coded data: the Australian Coding Benchmark Audit (ACBA) and the Performance Indicators for Coding Quality (PICQ). The Department had purchased statewide licences for both products and the software was available to download from the HDSS website (<http://hdss.health.vic.gov.au/picq/index.htm>).

Greg noted the ACBA was a tool to assist the audit of individual patient records, while the PICQ was to assess datasets against indicators based on Australian Coding Standards (ACSs). Greg reported 20 sites had at that time contacted DHS to obtain PICQ and ACBA software via the HDSS website, however if modem access was slow, the software could be mailed out.

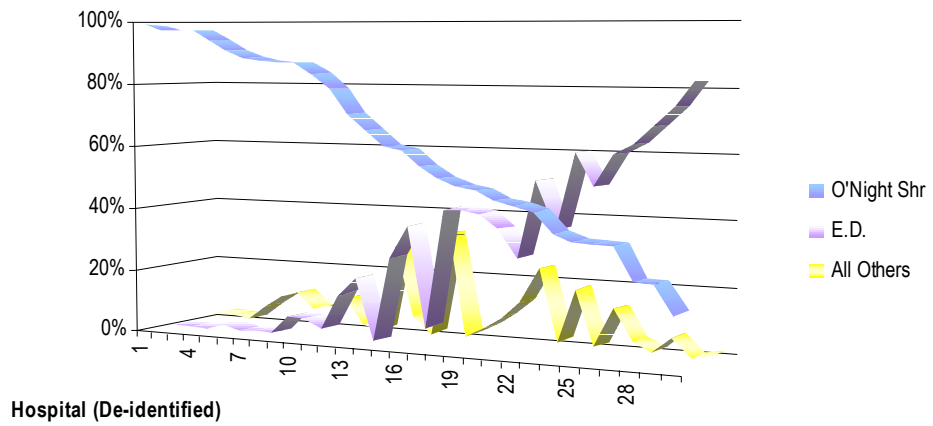
Feedback or suggestions were welcomed by DHS, and could be directed to the PICQ/ACBA email address (picq.acba@dhs.vic.gov.au). Relevant issues would be forwarded to the National Centre for Classification in Health (NCCCH) for addition to their Frequently Asked Questions (FAQ) web page.

Greg noted two common questions to date:

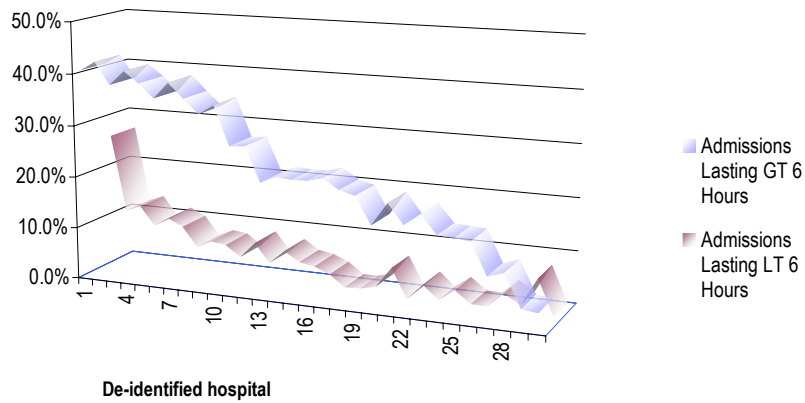
- “What do I do when PICQ detects a genuine issue in data I have already submitted to DHS?”
The answer was to correct the errors and resubmit the data.
- “How do I get the data into PICQ?”
Greg commented this could be a stumbling block for new users, as PICQ needed access to episode level coded data, and some data elements needed recoding. Delimited text format was probably easiest to use. Skilled database advice would be an advantage. Greg noted he had sent emails to some hospitals to draw attention to questionable data, and thanked those who had resubmitted data as a result. He stressed that data quality was not just about input edits: data could pass input edits but still not make any sense.

Greg outlined a recent data quality exercise which matched admitted patient episodes, from the July and August 2001 editions of the VAED, with corresponding emergency episodes from the VEMD for the same periods. This had identified large variations in emergency admission practice across sites.

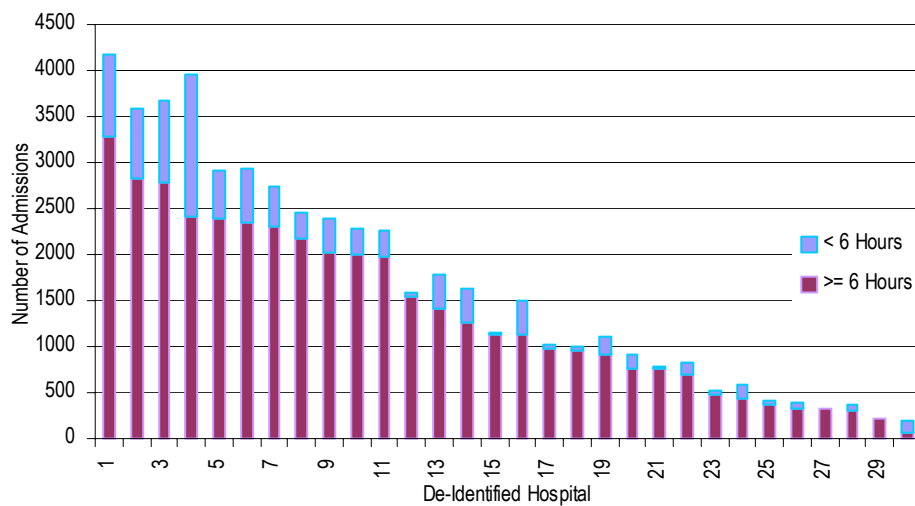
**FIRST ACCOMMODATION TYPE OF PATIENTS WITH ADMISSIONS
CORRESPONDING TO E.D. EPISODES**



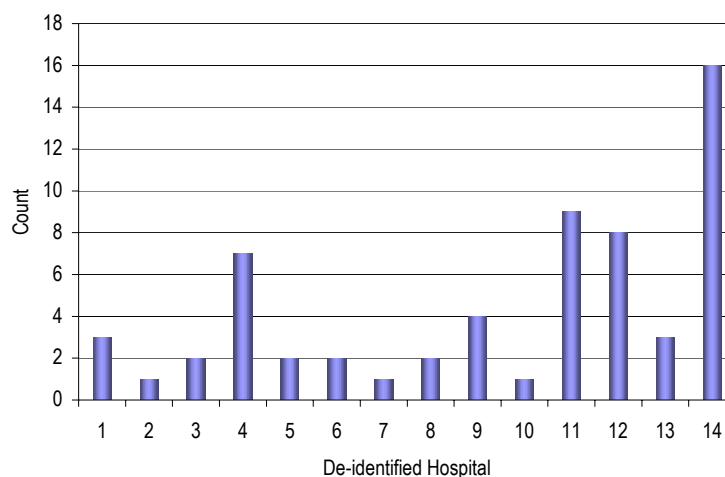
PERCENTAGE OF ED EPISODES WITH CORRESPONDING INPATIENT EPISODES



E.D. ADMISSIONS BY HOSPITAL BY LENGTH OF ADMISSION



E.D. EPISODES WITH CORRESPONDING INPATIENT ADMISSIONS WHERE E.D. DATA INDICATES PATIENT LEFT E.D. WITHOUT BEING SEEN BY A CLINICIAN



16 PRS/2 Training

Mark Gill reported that PRS/2 training sessions had been held twice in 2001, with good feedback. It was expected that two training sessions would again be provided in 2002, in April and October.

17 Close – Afternoon Session

Mark Gill thanked all in attendance, presenters and the HDSS Unit for preparing and facilitating the Forum. He encouraged feedback on the issues discussed, requesting this be directed to the HDSS Help Desk:
Email: PRS2.Help-Desk@dhs.vic.gov.au, Ph 9616-8141, Fax: 9616-7629

Please Note:

These notes of this HDSS Forum were prepared and distributed by the Department of Human Services, using the Department's PRS/2 Manual mailing list, unless otherwise notified.

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