Hospital in the Home 2009

HITH Manager's Forum

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HITH MANAGER'S FORUM – Audit of Patient Admitted Data

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Funding Health & Information Policy

Why do we audit

- Accountable for funding
  - Equitable distribution of funds under casemix model
- Data quality
  - Informs funding
  - Used to monitor patient safety
  - Used for health service planning

Audit methodology (principles)

- 1% of annual separations
- Each hospital audited x1 every three years
- Public hospitals only
- Acute care only
  - Casemix funded

Audit methodology (principles)

- Capacity for
  - Follow up audit
  - Supplementary audit
  - Targeted audits
- Dispute process

Audit reports

- % DRG change
- % WIES change
- Questionable admissions
  - Don't qualify for admission
- Incorrect criteria for admission
  - Qualify for admission but reported incorrectly

Questionable admissions

- HITH admissions deemed questionable when:
  - Entire admission does not meet any criteria for admission
    - Sameday subcutaneous injections
  - No documentation to support patient need for HITH

Change of dates

- Change to admit and separation dates when
  - HITH component does not meet criteria for admission **AND**
    - No documentation to support patient need for HITH
    - Patient not seen on HITH and leave days not recorded

Audit data

- Audit reports what data would look like if it was changed
  - Not real data
  - Money is not taken back
  - May be clinically appropriate but no evidence
- Future audits may have a different way to judge HITH activity

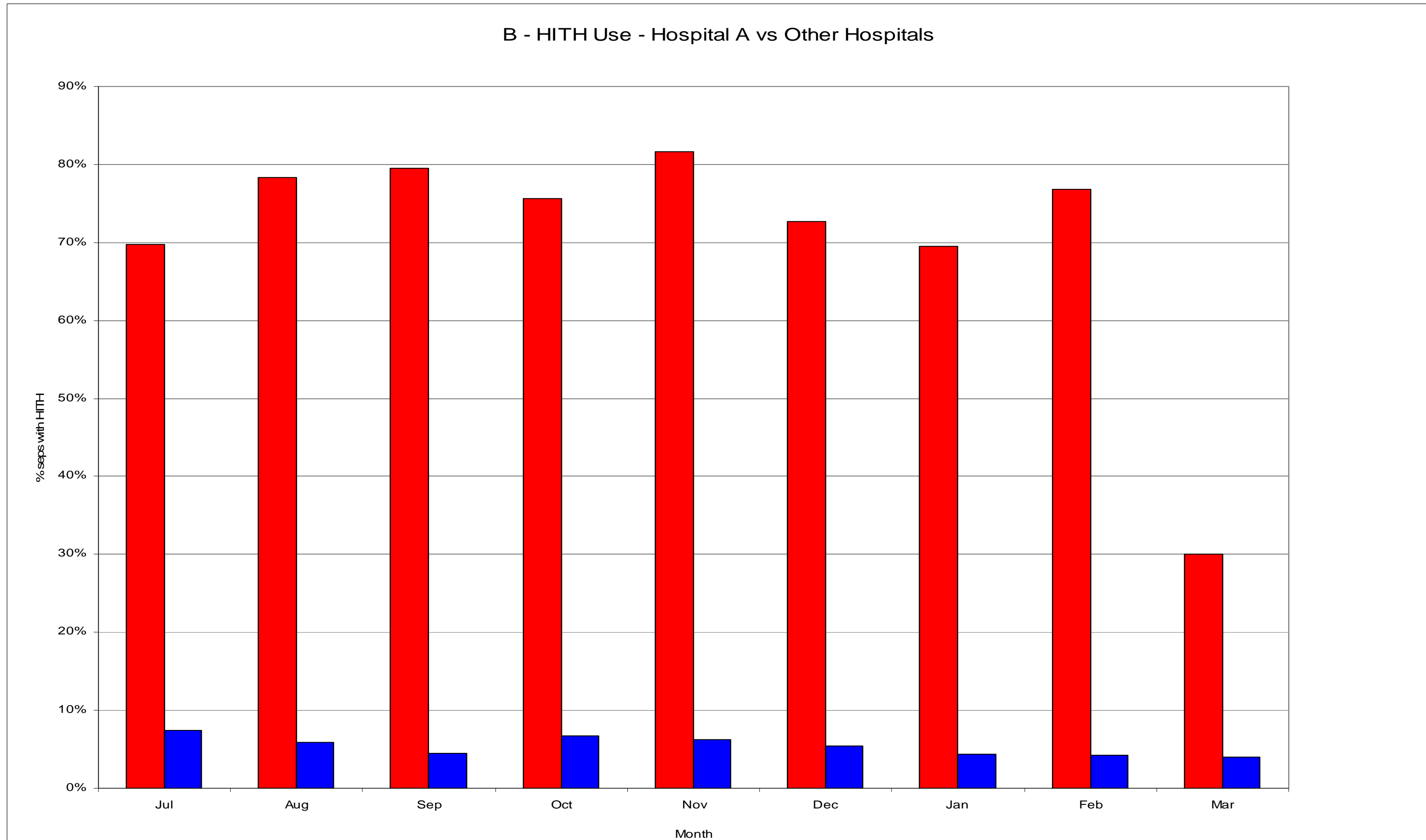
HITH program and audit

- Many discussions
- Many episodes appropriate for HITH
  - Auditor has no evidence
- Development of guidelines
  - Ongoing
- Development of business rules to accommodate current clinical practice

Data analysis

- Follow up of audit issues
- Look at bigger sample
- Learn more about HITH use.

Outlier Analysis – example



Data Reform

- Major project at DHS
  - Reporting mechanisms to change
  - Funding easier to direct appropriately
  - Easier to monitor usage of different programs
  - Can see patient journey through system

HITH guidelines - update 2009

- Developing HITH in Victoria
- Coordinated approach (DoH)
- Key themes
- Data analysis
- Guidelines update 2009
- The HITH Review
- Future directions

Data enables development...

- Admission criteria
- Substitution remains the principle
- Alternative pathways
- Right care, right time right place

Data findings – key themes in HITH

- Top DRG's in HITH stable over 5 years
- Separations declined
- Reduced LOS for in hospital component
- Single day HITH admissions
- Expanding services and patient groups
- Specialist Roles

VAED Activity
Endoscopy Analysis HITH

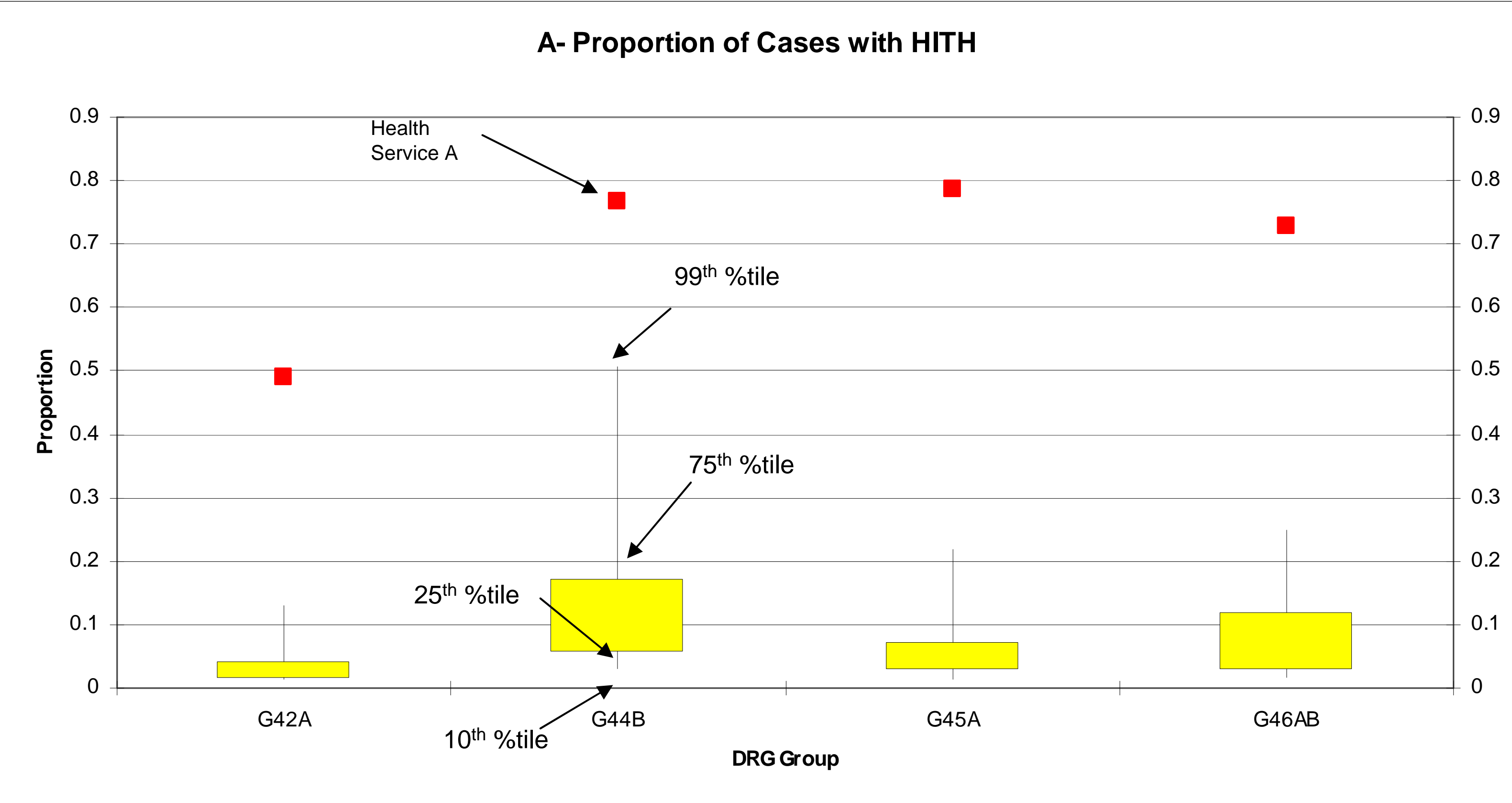
1 July 2008 to 30 April 2009

Information supplied by Health Information Provision, DHS.

C – Multiday DRG analysis	G42A	G44B	G45A	G46AB	Total
Seps in DRG analysed	102	417	249	248	1016
Expected proportion with HITH [2]	0.018	0.099	0.028	0.076	0.068
Expected number with HITH	1.85	41.15	6.92	18.97	68.89
Procedures under analysis 1 day HITH [3]	44	290	181	166	681
Number in excess of expected	42.15	248.85	174.08	147.03	612.11
Claimed WIES	1.1416	0.6071	0.6993	0.8579	0.7306
WIES expected as sameday without HITH	0.3307	0.3165	0.2739	0.3788	0.3200
WIES difference x number in excess	34.18	72.32	74.06	70.44	250.99
WIES amount	$3,468	$3,468	$3,468	$3,468	$3,468
Excess $ claimed	$118,542	$250,790	$256,823	$244,292	$870,448

1. Endoscopy DRGs are multiday G42A, G44B, G45A, G46A, G46B, and same day 42B, G44C, G45B, and G46C
2. Based on data for all other sites
3. Episodes of with LOS=1 and 1 day HITH (hospital visit followed by HITH day)

Endoscopic one day HITH



Guideline development

- Builds on 2008 feedback & audit cycles
- Allows greater flexibility and clinical factors to influence pathways
- Reporting requirements remain the same
- Promotes greater autonomy and empowers HITH staff
- Maintains acute substitution role of HITH

Key amendments

- Patients at work
- Maternity services
- Meeting admission criteria
- HITH “pre” and “post” ward care
- Final interventions – the “whole episode”
- Auditors will incorporate these guidelines into evaluation process
- Will encourage innovation and growth

The HITH Review

- Workshops – metro and regional
- Site visits
- Interviews
- Call for submissions
- Patient satisfaction evaluation
- Literature review
- Data analysis

Next steps

- Advisory Group - summary of findings
- Data analysis presented to DH
- Patient interviews completed
- Draft Report to Advisory Group
- Final report and recommendations
- Department response to final report

Future Directions

- Recommendations in final report
- Response to report
- Key themes arising
- Models of care
- Implementation
- Development & service improvement

Proposed changes to Hospital Admissions Policy

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The Place To Be

What is admissions policy?

- The rules regarding which patients are regarded as ‘admitted’ to the hospital (usually to the ward)
- Criteria to determine some types of funding (access to WIES)
- Affects payments, should not affect care

Criteria for admission

- **Type B:** Day Only Bands 1A, 1B, 2, 3 and 4
- **Type C:** Professional Attention Procedures
- **Type N:** Qualified Newborn
- **Type U:** Unqualified Newborn
- **Type E:** Extended Medical Treatment
- **Type O:** Patient expected to require hospitalisation for minimum of one night
- **Type S:** Secondary Family Member

Type O

- Expected to be admitted at least overnight.
- Used for multi-day stays.
- Likely to be appropriate for HITH – if they would otherwise be admitted to a ward overnight, they are a Type O.

Type B

- Receive a procedure listed as a Type B procedure in the Commonwealth Day Only Procedure Manual; OR
- Receive a general, regional or intravenous anaesthetic.
- Some Type B procedures may be suitable for HITH – such as chemotherapy.

Type C

- Patient receives a procedure which would not normally be admitted.
- The patient's condition is unusual, (perhaps through co-morbidities), and requires admission.
- Needs supporting evidence from a clinician as to why this patient requires admission.

Admissions policy review

- Admissions policy was reviewed in 2008.
- A number of issues, short and long-term were identified.
- Several short term changes were identified as priorities.
- During 2009-10, admissions policy will be further reviewed and addressed.

Improving admissions policy

- VAED audit: Criteria for Admission error rate of 19 per cent
  - mainly Type B, Type C and Type E admissions
- Proposed changes to Type B and Type E for 2010-11
  - aims to enhance objectivity, consistency, accountability and transparency
  - provides a level playing field between health services
  - reduces the administrative burden on hospitals and DHS

What will change:

- New Type B list
  - currently in MBS codes
  - will be provided in ACHI codes

- Type E will be more clearly defined as:
  - extended treatment where it is intended that there is four hours or more of:
  - half hourly observations;
  - OR continuous monitoring such as ECG, EEG;
  - OR continuous IV therapy of any sort.

Type C monitoring

- Seemingly high number of Type C admissions
- During 2009-10 Type C admissions will be monitored for compliance
  - *"would normally be undertaken on a non-admitted basis and therefore not normally accepted as admissions"*

Implementation of potential changes

- DoH will work with health services during 2009-10 to ensure that changes are simple, logical, and fair
  - proposed changes will be monitored by DoH for several months
  - hospitals to receive regular feedback on where current practice is different with proposed changes

Implementation continued

- DoH will monitor and seek advice on the potential financial and clinical impacts on health services
- To assist in improving the admissions policy, we are:
  - consulting with CEOs and coding committees
  - preparing a circular for distribution to all health services
- Any agreed final changes would be implemented in 2010-11

Thank you

www.health.vic.gov.au/hith

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Clinical Guidelines - Cellulitis

- Comparison of Victoria and NSW
- Strengths, omissions of each
- Commonality, variations
- Keeping guidelines updated to reflect evidence based best practice
- Centralised treatment pathways?

Home visit risk assessment

- All programs undertaking process?
- Brokered/external agency responsibility
- Tools local or state wide?
- Comparison of documentation
- Responsibility & accountability
- Pre discharge or once home?
- Common tool, centralised systems?