TALKING CASEMIX

September 2001 • volume 5 issue 3

THE NEWSLETTER OF THE NATIONAL ALLIED HEALTH CASEMIX COMMITTEE

Funded by the Commonwealth Department of Health and Aged Care

Adjusting the IFI for Adjustment

ADJUSTMENT: disorders where the focus is on the individual's inability to manage life events or changed circumstances.

In this article, David Nilsson, Social Worker and Research Fellow at Melbourne Royal Children's Hospital shares his thoughts on the NAHCC IFI – 140 "Adjustment".

In spite of the wide consultation process in developing the IFI model by NAHCC in 1998/9, there has remained a challenge for the individual allied health professions to test its efficacy for practice in the 'real world'. Ultimately it remains our responsibility to test its adequacy in describing the reasons why we become involved with our clients and to offer any constructive suggestions for improvement of this model.

The IFI code set has critical importance for social work practitioners in that clear 'problem' conceptualisation is crucial as a pre-curser to the selection of appropriate intervention strategies thus ensuring appropriately focused professional practice.

As a social worker in a paediatric hospital I was intrigued by the particular significance of IFI 140 *Adjustment* which accounts for approximately 53% of all IFI allocation in our generic social work program. Indeed, the sub-categories of 142 *Adjustment to Health Condition* and 143 *Adjustment to Hospitalisation* each respectively account for approximately 37% and 10% of all our IFI coding.

Given the apparent significance of these few codes to our social work role, I wanted to explore how well social workers understand these concepts in order to ensure their validity and that they are used reliably. To this end I undertook to interview eighteen experienced social workers at two different hospitals (The Royal Childrens Hospital and The Alfred Hospital) about what they believe these concepts mean and what theory or theories underpin their understanding of *Adjustment*. The data from these interviews has been analysed thematically.

The key themes that emerged from the data were that *Adjustment* must be viewed as an ongoing process, that it relates to the ability of client(s) to manage or cope with changes brought about by the health condition/situation, and that this concept particularly relates to emotional response/functioning. While there were multiple related social work theories identified in the interviews, respondents did not identify any key unifying theory as central to the concept of *Adjustment*. The author postulates however that the Folkman and Lazarus (1984) model of coping as a mediator of emotion has much to offer in providing a unified theory to explain the concept of *Adjustment*. The author will be attempting in the near future to provide a modified version of the Folkman and Lazarus model through his DSW thesis to assist social workers in articulating this important concept.

One implication of these findings is that they bring into question the relevance of having the D level IFIs under IFI 142 *Adjustment to Health Condition* given that all these codes may essentially be describing the same concept (ie. the emotional ability to manage or cope

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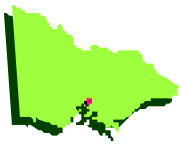
State and Territory Allied Health Casemix Groups



In each state and territory NAHCC has a member association representing the Allied Health professions. The Victorian Allied Health Casemix Committee (VAHCC) is chaired by Dr Helen Cleak (Latrobe University) and is represented on NAHCC by Catherine Itsiopoulos (RMIT University). Following are details of VAHCC's membership and terms of reference.

Membership is open to Victorian members of Associations who are members of NAHCC. Membership currently includes Victorian Branch representatives of:

- Audiological Society of Australia
- Australian Podiatry Association
- Australian Association of Social Workers
- Australian Psychology Association
- Australian Music Therapy Association
- Dietitians Association of Australia
- Australian Orthoptics Association
- Occupational Therapy Australia
- Australian Orthotic Prosthetic Association
- Society of Hospital Pharmacists of Australia
- Australian Physiotherapy Association
- Speech Pathology Australia

VAHCC Terms of Reference

1. To monitor and review the development of casemix related matters at state and national levels.
2. To provide a forum for discussion of casemix issues relevant to allied health service providers and professional associations.
3. To actively contribute to casemix development projects, to provide advice and to represent allied health matters through state and national forums. This will involve planning, development, implementation and evaluation processes.
4. To facilitate the dissemination of information and support the development and implementation of education programs on casemix matters.
5. To maintain direct representation on the Victorian Clinical Casemix Committee (VCCC), the National Allied Health Casemix Committee (NAHCC) and other appropriate state and national bodies.
6. To function as a resource/liaison unit for the various allied health professions in Victoria.
7. To support NAHCC in the achievement of its strategic plans and activities.

VAHCC Office Bearers and Meeting Schedule

- One member from each of the member bodies listed above.
- The Chairperson and Secretary who shall be elected annually on the vote of Committee members.
- The Committee will provide an elected representative to NAHCC.
- Office bearers shall be elected at the meeting prior to the NAHCC annual general meeting.
- Meetings shall be convened at least bi-monthly. A quorum shall be four members of the Committee.
- Members may invite observers to a meeting but should give prior notice to the Chairperson.

Adjusting the IFI for Adjustment *continued*

with a change in health condition). Indeed, another study by myself and my colleague, Karen Fitzgerald, concluded that some of the other 140 series C level IFIs may also require modification in light of this increased understanding of *Adjustment* processes.

This is the kind of debate that needs to continue within our professional groups in order to ensure that the IFI model is valid and reliable in describing our work. It is essential after all that we get these crucial building blocks right before we move on to the development of PIs (Performance Indicators) which will describe our all-important outcomes. Reflective analysis such as this also benefits our profession in ensuring that we are better able to articulate our practice. The ability to firstly accurately describe the indicators for our involvement is imperative given that these IFIs supposedly represent the *raison d'etre* for the very existence of our service.

Reference:
Folkman, S. & Lazarus, R. cited in Monat, A. & Lazarus, R. (1991) *Stress and Coping*, Columbia University Press, New York.

FURTHER INFORMATION

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Note: Readers can access the full NAHCC Indicators for Intervention report at: www.bf.rmit.edu.au/nahcc/pubs/

ICD-10-AM Review

Readers may be aware that the current International Classification of Diseases Tenth Edition Australian Modification Second Edition is currently under review.

The intent is to create Edition Three codes for national implementation in July 2002. The National Centre manages this process for Classification in Health (NCCH).

David Stokes, NAHCC Psychology representative has coordinated the response from the Allied Health professions, although a number have also dealt directly with the NCCH.

David has provided the following update for *Talking Casemix*:

The review process has been a very variable exercise from the NAHCC point of view. For a number of the Allied Health professions it has been a quite perfunctory exercise requesting a few minor changes or additions to the codes.

For other professions it has been more challenging to try to fold their professional perspectives into a rigid classification system. Overall there has been limited change – which is good and bad news all in one.

The big picture conclusion is that we are still part of an important classification system, we have had the chance to grapple with it and some of us have had made significant progress. Above all we have the basis of a procedural/intervention classification. We acknowledge that there will need to be some discipline specific extensions for it to be useful as a local management tool, but it has nationally accepted basis.

It may help to have some examples of what was achieved for various allied health groups, so here are some specific extracts:

1. **Redefining:** The Speech Pathologists have redefined language assessment (**1820**:96014-00) from 96014-00 Language assessment
   Assessment of language:
   - spoken/non spoken
   - written/non written

   TO
   96014-00 Language assessment
   Note: Assessment of communication skills (comprehension, expression, recognition) for spoken/on spoken and written/non written language
2. **Additions**: **Occupational Therapy** and others will be glad to know their concerns over self-care assessment were heard. To 1**822**: 96021-00 Self-care/self maintenance assessment you can now add: eating, feeding, oral hygiene

   Physiotherapists will be glad that "suctioning" (that wonderfully soporific experience) is now included at 96157-00 [1889].
3. **Movements**: **Those concerned with the aged care section will note that Ageing Assessment (previously 1822: 96023-00) has been moved to block 1824 (Other assessment, consultation...)**
   96023-00 Ageing assessment
   Includes: physiological, psychosocial and mental status assessment

   Note: An evaluation of a client's ability to cope with the characteristics of the ageing process performed particularly to distinguish the effects of ageing from the effects of pathology in order to determine the most suitable care or treatment for the client.
4. **Major Revisions:** Of interest to **Social Work** and **Psychology**, and, to some extent other professions such as **OT**, has been the major rework of "mental health" codes. The extent of change is too large to reflect here but **1874** Psychosocial Therapies has been merged with **1873** Psychological Therapies and becomes "**1873**: Psychological/psychosocial therapies". There are also changes made to codes within. This was done with extensive and sometimes difficult consultation among the affected professions.
5. **Reluctance to Change**: Orthoptics had a problem with 1940: 55055-00: Unidimensional ultrasound of orbital contents. This is now being done by laser technology so this will require separate coding to ultrasound. The NCCH response was to request a definition for the laser therapy. Orthoptics responded with "Axial length measurement of the eye(s) using Partial Coherence Interferometry (PCI)". NCCH replied with: "Will consider introducing a new code when this procedure becomes accepted practice under the MBS schedule."

Release Dates: NCCH intends to publish ICD-10-AM, Third Edition, in February 2002 with national implementation in July 2002.

As soon as the codeset review is completed by NCCH, NAHCC intends to produce a "cut-down" set of Allied Health sensitive codes for national distribution. *This will most likely occur in late November 2001.*

FOR MORE INFORMATION on ICD-10-AM codes and the NCCH visit the NCCH website:
http://www.cchs.usyd.edu.au/ncch/

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Profile: Stephen Tucker

Australian Podiatry Council Rep to NAHCC

Podiatry is the health profession devoted to the treatment and prevention of foot problems. Podiatrists are registered in all states, and are required to complete a four year Bachelor of Podiatry at one of six Australian universities. Podiatrists treat a large range of foot conditions, using a large range of treatment modalities (just look at the version 1 IPA intervention set).

There are about 2000 podiatrists working in Australia, with 70-80% working in private practice. Of the 20% that work in the public sector they are spread between community health centres, acute hospitals and rehabilitation settings. There would be only about 50 podiatrists working full time in acute hospitals across Australia, but most acute hospitals do employ podiatrists, but usually only one, so you soon become an expert in not just podiatry but also the politics of hospitals.

The Australasian Podiatry Council's representative to NAHCC, is Stephen Tucker, who completed his initial podiatry qualification in 1984. Stephen has been working at St. Vincent's Hospital, Melbourne as the sole podiatrist since 1988, providing comprehensive podiatry services to in and out patients of the hospital, with a focus on treating and preventing diabetes related foot problems, such as foot ulcers.

Stephen was initially the A.Pod.C. rep to NAHCC back in 1995 for a period of 12 months, but has been active on the Victorian Allied Health Casemix Group continually since 1993, and last year again became the A.Pod.C. rep and was also elected to the NAHCC executive. The A.Pod.C. representative to NAHCC is selected from the small number of hospital based podiatrists who have an interest and understanding of casemix, or who just want to make sure that the smaller professions don't get left behind. There are currently two podiatrists on the full NAHCC committee, the other being Fred Howard the Tasmanian rep to NAHCC, so for a small group of people we are quite involved.

Stephen is currently completing a Master of Public Health, through La Trobe University, looking at the influence of podiatry interventions on the length of an out patient occasion of service and juggling the care of his three children, James 5, William 3, and Natasha 1, with his wife Elizabeth.

Cancellation of 13th Casemix Conference – Hobart

Readers who had planned to attend the casemix conference in Hobart will be aware that the program was cancelled because of the suspension of services by Ansett Australia. NAHCC cancelled the associated Allied Health workshop. Regrettably, with so many delegates and speakers booked on Ansett flights to Hobart the organisers had to make the difficult decision to cancel the conference. A smaller program went ahead for those delegates already in Hobart.

The quality of papers submitted for the Allied Health workshop was very high and NAHCC Committee is considering the option of rescheduling this workshop and expanding it to a one-day program in a capital city – most likely Melbourne – in the coming months.

Further details will appear in the next *Talking Casemix.*

An Annual Reflection

Ian Woodruff, NAHCC Executive Officer

This month we farewelled the old NAHCC Committee and welcomed in the new (see the back page for the new NAHCC Committee).

It is important to stop and reflect occasionally on what we are "all about" and the annual change over of NAHCC representatives is a good time to do this.

NAHCC began in 1993 as a collective of enthusiastic individuals who recognised the importance of a collective response to the challenges that casemix funding was presenting to Australia's Allied Health clinicians.

The challenge was expressed primarily in financial terms – could Allied Health "survive" in a casemix-funded environment?

We have seen over the intervening years, however, that the challenge from casemix was a much deeper one – was Allied Health performing optimally (and in the clients' interests)?

Casemix provided the tools for a *whole of service* examination of who we treat, how we treat them and what outcome(s) they may have experienced. It stimulated research into a wide range of quality and efficiency measures in Australian hospitals that is continuing even today.

NAHCC has assisted in this evolution with developmental work in areas as diverse as:

- Activity recording: data definitions and activity hierarchy
- Activity data collection and processing: software specifications
- Activity descriptors: ICD-9 / ICD-10-AM Ed 1 and 2 codes for Allied Health related interventions
- Indicators for Intervention
- Performance Indicator models
- Allied Health Service Weights

The very dynamic nature of health care means that this work is always in need of review and NAHCC is fortunate to have a solid core of dedicated professionals keen to progress these issues.

Australia has had almost a decade of Casemix based hospital funding. With casemix concepts and practices now so well entrenched in Australian healthcare practice, NAHCC has been loosening its focus on casemix as a technical system in acute care to more broadly consider health services management. (The NAHCC Strategic Plan details the breadth of our current interest – it can be viewed at the NAHCC website: www.bf.rmit.edu.au/nahcc)

In the acute sector, what organisational structures work best for Allied Health? What is the evidence base for Allied Health interventions?

At the broader population health level, are the myriad skills of allied health professionals currently put to best use in improving the community's health status? Indeed, how do we even measure the impact of Allied Health on the community's health:

- If some physiotherapy is good, is more better?
- If the population is growing more obese, should we train more dietitians?
- Would more social workers result in fewer social problems?
- Would Australia be a land of orators if we doubled the number of Speech Pathologists?

A big challenge in even thinking about these questions is… how much of the solution can be attributed to Allied Health compared with how much is a function of the level of community resources / genetic and attitudinal factors or other health professionals.

Casemix in the hospital setting has provided a universally understood language for communicating across professions on a particular health issue and has done much to advance evidence-based practice.

Once we have similar classification systems for community health, mental health and population health, we will be much closer to being able to begin answering these questions.

The work continues.

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