TALKING CASEMIX

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THE NEWSLETTER OF THE NATIONAL ALLIED HEALTH CASEMIX COMMITTEE

Funded by the Commonwealth Department of health and Family Services by a Grant through the Casemix Development Program

Development of Allied Health Indicators for Intervention and Performance Indicators

NAHCC AWARDED GRANT TO DEVELOP IFI AND PI SETS

NAHCC is pleased to announce that the Commonwealth Department of Health and Family Services (Health Outcomes and Casemix Branches) have agreed to fund a twelve month project to develop Indicators for Intervention (IFI) and Performance Indicators in Allied Health.

Many readers will be aware that IFIs are needed in the Australian Allied Health Classification System to give it greater patient focus. NAHCC plans to have the IFI set included in Version Two of the Classification.

The Performance Indicators will be a useful tool to highlight the importance of Allied Health involvement in the health care process and will ultimately facilitate benchmarking across services.

The following is a brief summary of the proposed approach to the project.

BACKGROUND

Allied Health Professionals in all areas are feeling the impact of change and restructuring in healthcare institutions and services. Implementation of casemix funding, EQUIP and the focus on outcomes by ACHS, major cost containment, introduction of Clinical Service Units, community-based programs, and constant management rearrangements are examples of these changes. What is important is the need to acknowledge that all of this is a response to current social issues and changes that are anticipated to continue into the next decades.

Australia is one of many developed countries facing enormous pressures on health services: escalating costs of services, increasing demands for such services, consumer demands for higher quality service and for improved outcomes. These are all by-products of the increasing age of the population, greater health awareness and knowledge, perpetual developments in medical procedures and technology, and political pressures against increasing the taxation base that funds public health care. This has produced greater rationalisation of funding and precipitated the application of business management strategies to healthcare. The result is a feeling of tension between greater efficiency in the use of the health dollar and still increasing demand for improved quality and effectiveness.

While feeling this tension, most allied health professionals are keen to embrace the issues of accountability, efficiency and quality because of their commitment to patient care. For this reason there is a generally felt need to better measure what we do and to relate this to effective management and care for patients.

THE NAHCC RESPONSE

In this context NAHCC has sought, and is seeking, to develop tools that allow the quantification and efficacy of Allied Health interventions.
Before it could focus on outcomes and develop performance standards, there was some important groundwork for NAHCC to achieve:

1 It had to ensure that all Allied Health Professionals were collecting data and measuring what they were doing;
2 To do this effectively, it had to gain agreement on definitions of activities to

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ensure all professionals were comparing the same things;

3 It needed to establish general categories of patients to ensure all were talking about the same conditions;

4 It needed, then, to adopt common performance measures to ensure all outcomes were comparable.

A program of education and dissemination of information carried out by NAHCC from 1993 has successfully raised awareness (Point 1). The Australian Allied Health Classification System (AAHCS), soon to be renamed an Activity Classification System, has been completed and published and, with minor modifications, will meet the expectations of Point 2.

Although Point 3 is met by DRGs or ICD grouping for medical and nursing groups, for many Allied Health Professionals these are often less than meaningful categories. Development of Allied Health *Indicators for Intervention* (IFIs) is seen as a way of achieving meaningful profession- specific patient groupings.

Once adopted and utilised, these could provide a valid and nationally acceptable set of data about processes, treatments, interventions and outcomes that can be compared. This will allow the setting of benchmarks and indicators of best practice.

PROJECT AIMS

This current research project has two aims:

1. The development of a nationally-accepted set of Allied Health Indicators for Intervention.

2. The creation of a series of Performance Indicators relevant to Allied Health and focussed around the two key performance areas of access and cost-effectiveness.

NEED FOR SUPPORT

The project is funded by the Commonwealth Department of Health and Family Services (Outcomes and Classification and Payments Branches) and NAHCC maintains a high level of contact with these Branches. For this work to succeed, however, it is essential that we gain the cooperation and support of the various Allied Health professional associations, state and territory health Allied Health Casemix Groups and, of course, the state and territory health authorities. NAHCC will produce a project information kit to clearly describe the desired end-points, the timeframe and what we are asking of each of the above-mentioned stakeholders as the first stage of the project.

RESEARCH COMPONENTS

The research will be conducted in several phases.

- A project information kit distributed to all stakeholders
- A literature review of existing IFIs and PIs
- A national "stocktake" of research already completed / underway in Australia
- Consultations with Allied Health professional associations with a view to achieving an agreed national format for IFI / PI models.
- Consultation with other key stakeholders (eg ACHS, state health authorities, AIHW, NCCH)
- A series of workshops around Australia to test the models developed and to ensure inclusivity for a wide range of people.
- A discussion paper outlining the proposed models and how they might be integrated in the broader health agendas and reporting systems.
- Revision of the Australian Allied Health Classification system to incorporate the newly developed IFIs

If you would like a copy of this information kit please complete the fax response sheet in this Talking Casemix.

TIMEFRAME

The project will be completed by May 1999.

STEERING COMMITTEE

- Ms. Janet Lapworth, Assistant Director Service Development Section Health Service Outcomes Branch, Commonwealth Department of Health and Family Services
- Ms. Jo Murray, Acting Assistant Secretary, Classification and Payments Branch, Commonwealth Department of Health and Family Services
- Prof. Stephen Duckett, Dean, Health Sciences Faculty, Latrobe University
- Ms. Gayle Smith, NAHCC Classification portfolio and Occupational Therapy representative to NAHCC
- Mr. Ian Woodruff, NAHCC Executive Officer
- Mr. Paul Murray , NAHCC Treasurer and Speech Pathology representative to NAHCC
- Mr. David Stokes, NAHCC Classification Portfolio support and Psychology representative

Are you involved with either IFI or PI development?

As part of this project NAHCC is undertaking a 'stocktake' of existing work in the area of IFI & PI development. If you are/have been involved we'd be delighted to hear from you. Please call Ian or Kate at the NAHCC office or complete the fax response sheet and we'll call you.

to NAHCC
- Mr. Scott Lisle, Casemix Unit, Structural and Funding Policy Branch, NSW Health (Scott has a background in Physiotherapy)

NAHCC will also be seeking to establish two "advisory groups" - one for the IFI work and another for the PI work.

It is anticipated that these advisory groups will comprise senior Allied Health professionals from each of the ten Allied Health professions represented in the AAHCS plus representatives from relevant national bodies such as the National Centre for Coding in Health. These groups will be convened in consultation with the various national associations.

If you are interested in being involved with one of the advisory groups please complete the fax response sheet in this Talking Casemix.

How the workshops will run

Aim:

To test the IFI / PI framework proposed from the literature review / national stocktake / Professional Association consultation on a representative sample of AH professionals

Structure:

Separate IFI and PI workshops in each capital city and selected regional / rural locations. Several "speciality" workshops with "non-mainstream" groups.

Participants:

Three representatives from each of the ten professions represented in the AAHCS (ie 30 invitees per workshop).

Select according to:
- known involvement in related matters
- sufficiently senior in profession / organisation to be able to action any outcomes of the workshops
- recommendation from professional associations

Ideally a key state health bureaucrat should open each workshop and give respective state overview.

Facilitators:

Depending on location and logistics, two to three of the following:
- NAHCC project coordinator
- NAHCC member in that city
- NAHCC Executive Officer
- NAHCC project worker

The NAHCC Annual Seminar

The program for NAHCC's September 6 seminar has been finalised. This year the focus is on Allied Health outcomes and the impact of the newer classifications that are under development or being implemented in various parts of the country.

A CEO from a major hospital will give his perspective on what is expected of Allied Health in terms of activities and outcomes. An Allied Health manager in a hospital network will then present her views on the same issue

The seminar has been designed to be interactive, providing the participants with the opportunity to explore issues of relevance to their own workplace. There will be updates on various activities around Australia including AH coding changes, ICD-10 introduction, SNAP implementation and a variety of presentations from groups working on IFIs and Performance measures.

The seminar will be held at the Melbourne Convention centre and runs from 10 am to 5 pm. The cost is $110. Full details can be found in the registration brochure posted out with this Talking Casemix.

NAHCC 98 AGM

The annual general meeting of NAHCC will be held at 5.00 pm at the Melbourne Convention Centre on Sunday September 6, 1998 (immediately after the NAHCC Seminar).

Each year, at this time, each of the twenty-four member bodies confirms (or replaces) its representative on the NAHCC committee. The NAHCC Executive comprises an elected group of eight from the twenty-four on the full committee. Nomination forms for the 1998 - 99 Executive will be sent out to member bodies in the next few weeks. If an election is necessary (ie more nominations than positions) the result will be announced at the AGM. NAHCC's financial statements, chairman's report and Executive Officer's report are all tabled at the AGM. Items of general business can be added to the AGM agenda. Please contact Ian at the National Office if there is anything you would like to have considered at the meeting.

If you do not have a registration brochure and would like to attend, please complete the fax

response form on the back and we'll send one out to you.

WHO's WHO AT NAHCC

We will bring you a brief description of NAHCC committee members over the next few issues of Talking Casemix. We start in this edition with our NAHCC Chairperson - Annette Byron

Annette trained as a dietitian at Flinders University, graduating in 1983. Her first job was at the Riverland Community Health Service in South Australia, which started out as a four-week locum but somehow ended up being a 4-year stint! (was it the wine, the dried fruit, or the sunshine??) The position was a mix of community and hospital work, rather like a travelling circus.

Her next major appointment was at the Adelaide Children's Hospital for 5 years, which, in contrast to the Riverland was within walking distance of good cappuccino and gelati. During this time she had a mix of clinical and management duties.

Annette began an MBA while at the Children's Hospital and by the time she had completed it in 1996 she had already moved over to her current position as Head of Nutrition at the Royal Adelaide Hospital.

The casemix connection occurred in 1993 when she became the Dietitians' Association Casemix Committee chairperson, which led to her becoming the Dietitians' Association NAHCC representative. In September last year Annette took up the reigns as NAHCC's Chairperson.

She has always had a "management bent" having a long history of involvement in committees of one sort or another, such as the Australian Diabetes Educators Association and numerous positions within the Dietitians' Association SA Branch.

On the rare occasion that Annette has some spare time you're likely to find her quilting, walking, reading, or in true dietetic spirit - wining and dining.

NAHCC Survey - Casemix in Allied Health Curricula

Part of NAHCC's education strategy is to ensure that Allied Health professionals maintain high level awareness of casemix and related issues to effectively participate in the ever-changing healthcare sector. We were interested to establish the level of casemix exposure of new graduates.

A survey was developed and sent to 63 Allied Health training courses coordinators in Australian Universities. The purpose was to determine the extent to which casemix-related issues were included in the training program curriculum. Where casemix was not included, reasons for this were sought.

Summary results:

- casemix is included in the curriculum in only approximately 60% of AH training courses
- mostly casemix is taught by "in-house" staff - many of whom feel they lack current casemix "expertise"
- few allied-health specific casemix teaching resources are available to teaching staff
- time pressures in the course sometimes prevented casemix issues being included
- there is a demand for current, AH-specific casemix teaching resources
- One quarter of courses including casemix, specifically assess this in exams - this rises to three quarters when "indirect" casemix assessment is included

The NAHCC committee will be considering the survey results in the review of its Education Strategy.

The survey was designed by Helen Cleak and Ian Woodruff and conducted by the NAHCC secretariat.

PHARMACY COSTS FOR AN-DRGs - THE NATIONAL PHARMACY CASEMIX BRIDGING

Copies of the full curriculum report are available from Kate at the NAHCC office or can be requested via the fax response sheet.

The National Pharmacy Casemix Bridging Project was conducted as a joint initiative of the Society of Hospital Pharmacists of Australia (SHPA) and the Classification and Payments Branch of the Commonwealth Department of Health and Family Services and is the first study of this kind to be conducted. The primary aim was to develop and implement a methodology for determination of Australian pharmacy service cost weights for AN-DRG Version 3. The final report, which includes the detailed costing methodology and disk copies of the data produced, has recently been published and is now available from the offices of the SHPA.

The costing methodology developed for the Bridging Project focused on a clinical costing approach and addressed the complexities and variations in the provision of pharmacy services. A standard approach to definitions was adopted for all project sites based on the Standard Definitions for Hospital Pharmacy Services (1) and a detailed method for calculation of the Pharmacy inpatient fraction (IFRAC) was developed. At all stages in the development of the methodology, pharmacy practitioners, hospital casemix and information personnel provided significant input. This contributed to the overall success of the project and confidence in the validity of the final results.

Eleven public hospitals, representing five states, participated in the costing study. Of the eleven, nine were major teaching hospitals including a major paediatric hospital. All acute inpatient admissions during the data collection phase were included and hospitals collected data prospectively for a period of 5-6 months between October 1995 and March 1996.

Approximately 170,000 acute inpatient episodes were captured during the data collection phase and all 667 AN-DRGs were represented in the final sample.

Analysis and review of the results of the Bridging Project has provided validation of the methodology and of the pharmacy service cost weights derived. Comparison with the existing Maryland-based drug cost weights revealed significant variation. The sources of variation included sample size, site selection, standard definitions and costing methodology, differences in clinical practice between Australia and the United States and clinician involvement in the costing process.

The major outcomes of the Bridging Project are the development of a standardised, reproducible costing methodology and implementation of this methodology in a range of hospitals across the country to determine the first Australian pharmacy service cost weights for AN-DRGs. Underlying this is an improvement in understanding of pharmacy and hospital cost structures, providing information for quality improvement; for planning and purchasing services; and negotiation of budgets. The data also have broader applications in informing the ongoing development of classification and payment systems and for review of drug and pharmacy service utilisation on an individual hospital, State and national basis. In addition, it has facilitated an understanding of the requirements for pharmacy feeder systems and for the application of data generated through hospital clinical costing systems.

The final report includes a series of recommendations, a number of which have already been addressed. Importantly, the Commonwealth has adopted the pharmacy service cost weights for AN-DRG version 3 and episode level data produced from the project will be utilised to derive weights for version 4 later this year. The standard approach to costing for pharmacy services has been adopted by a number of States Health Departments and consistent statistical data collection has been promoted within the pharmacy profession to facilitate longitudinal studies on clinical service provision. In addition, work has commenced on the further development and refinement of a management tool for pharmacy services utilising the costing and clinical data derived from the project.

I. SHPA, Practice Standards and Definitions, 1996.

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E-mail : nburgess@gp.rah.sa.gov.au Naomi is the national pharmacy representative on NAHCC

The CHIME Enterprise

The Community Health Information Management Enterprise (CHIME), the joint venture between NSW Health, Queensland Health, South Australian Health Commission and ACT Health & Community Care, is developing an electronic client record. While this software has been primarily developed for community based health services, there are senior executives within the Australian health system who recognise the potential for broader application, that is, other ambulatory services as well as the smaller district hospital.

The CHIME Project is developing an integrated suite of three modules and the following table contains a broad outline of the functionality within each module:

CHIME Project Modules

MODULE	CONTENTS	
Client Identification	Service Request Service Provider Details Preliminary Audit PMI Interface	Client Registration Security Reporting System Administration
Client Management	Service Delivery Client Management Plan Increased Audit Interfaces to other clinical systems	Resource Maintenance Program Management Reporting
Resource Scheduling/Information Management	Data Collections Interfaces Increased Security and Audit Resource Scheduling (including Appointment Scheduling)	Communications Reporting

The first module is due for General Release on 29 September 1998 with the second module planned for early 1999. Resource Scheduling/Information Management will be delivered in the middle of 1999.

The CHIME application will provide client level information to inform the development of a number of ambulatory management tools. Of particular relevance are:

- resource utilisation formulas which identify service mix
- case co-ordination methodologies applicable to the Australian health system
- performance measurement at a number of levels within the health system, particularly service delivery benchmarks
- health information management strategies
- health service management structures relevant to current health service delivery.

If you require further information on CHIME please contact:
Julie Bargenquast, CHIME National Project Manager,
Moblie 0418 672 652
Email: jbarg@doh.health.nsw.gov.au

Things you've always wanted to know about

Who makes up the NAHCC?

NAHCC currently has a membership of 22 organisations:

- Each state and territory has a committee or group which deals with allied health casemix issues. Each of these groups has a representative on NAHCC.
- Fourteen Allied Health Professional Associations each have a national representative.

How is it run?

The full committee generally meets once or twice a year to consider overall strategies and to ensure good communication back to the respective associations and groups.

Most of the day to day work is managed by an executive of eight members (elected each year at the NAHCC AGM). The Executive works together as a team on issues and meets by teleconference once a month. To clarify roles within the executive a system of portfolios has been established. Most aspects of NAHCC's activities are coordinated by the relevant portfolio holder.

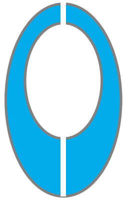
The NAHCC Executive Officer supports the work within each of the portfolios and manages the routine affairs of the national office

Portfolio	**Responsibilities**
Chairperson *Annette Byron*	• representing NAHCC externally , chairing meetings, supporting other portfolios
Treasurer *Paul Murray*	• management of NAHCC funds, supporting other portfolios
Classification *Gayle Smith* Classification support *David Stokes*	• coordination of NAHCC responses to new classification systems (eg ICD-10, AN-SNAP), health service funding arrangements and development of Allied Health classification systems.
Education *Joanne Meldrum*	• developing appropriate casemix related education resources for Allied Health professionals
Information Technology *Marie Oxlade*	• dealing with issues relating to Allied Health access to adequate IT systems
Special projects and Communication *MaryLee Sinclair Vogt*	• Strategies for enhancing communication between NAHCC and its constituents. Management of "non-portfolio" issues
ACCC Liaison *Helen McCathie*	• Liaison between NAHCC and the Australian Casemix Clinical Committee

How is NAHCC funded?

The majority of NAHCC funding is from a Commonwealth Department of Health and Family Services Grant. A small amount is also raised from professional association membership fees.

NAHCC has been fortunate in attracting funding for each of the major projects undertaken. The most recent example being the IFI /PI project.



National Allied Health Casemix Committee

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Fax Response Sheet

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Please:

- ☐ Add me to the *Talking Casemix* mailing list
- ☐ Consider me for membership of the
  - ☐ IFI advisory group
  - ☐ PI advisory group
- ☐ Send me the following NAHCC publication(s)
  - ☐ Australian Allied Health Classification System
  - ☐ Software Recommendations for Allied Health Management Information Systems
  - ☐ NAHCC Indicators for Intervention/Performance Indicators Project Information Kit
  - ☐ NAHCC Casemix in Allied Health Curricula report
- ☐ Send me a NAHCC Seminar registration brochure
- ☐ Call me to discuss the IFI/PI work I am aware of/have been involved in.

name:Dr/Mr/Mrs/Ms____

position title:____

organisation:____

address:

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____postcode:______________

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