

Which way from here?

The Tasmanian ABF coding experience

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Basic problem

- ❑ Tasmania will continue to develop and roll out ABF as the primary funding model
- ❑ National and Local ABF models are used
- ❑ Tasmania is an outlier in reported cost/ weighted separation
 - Significant effort made on refining costing processes but coding contributes by impacting on weighed separations
- ❑ Evidence of some poor coding in Tasmania
 - Comparison of proportions within adjacent DRG
 - Targeted coding audits / episode review
 - Data analysis
 - Queries on coding standards

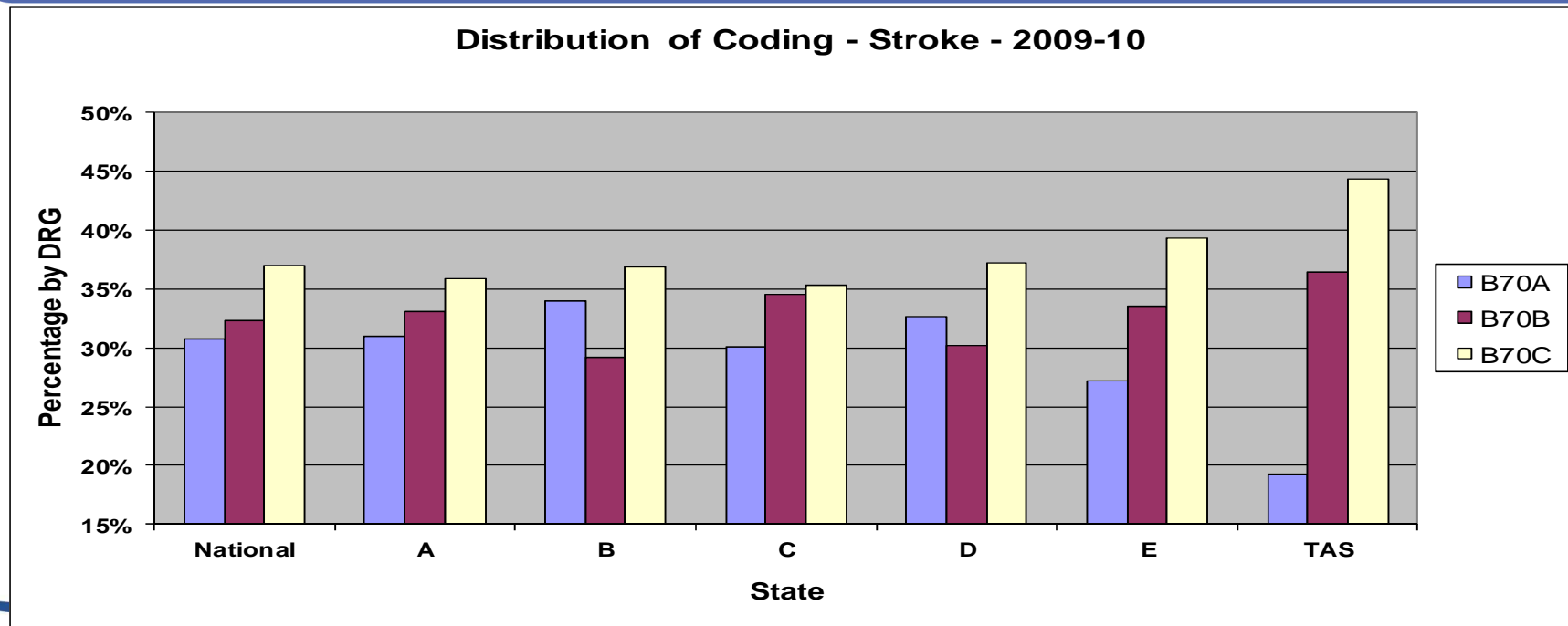
Response to potential coding issues

- A DHHS Casemix Risk Team formed
- Comparative analysis undertaken of complexity reflected by Tasmanian coded data with that from other states
- Some key coding standards reinforced to Clinical Coders
- Engaged Clinicians regarding documentation that supports clinical coding
- Opportunities for improvement in coding quality processes explored
- The appropriateness and application of national definitions and directives for Tasmania investigated
- How well have we done and where to we want to get to?

Initial look

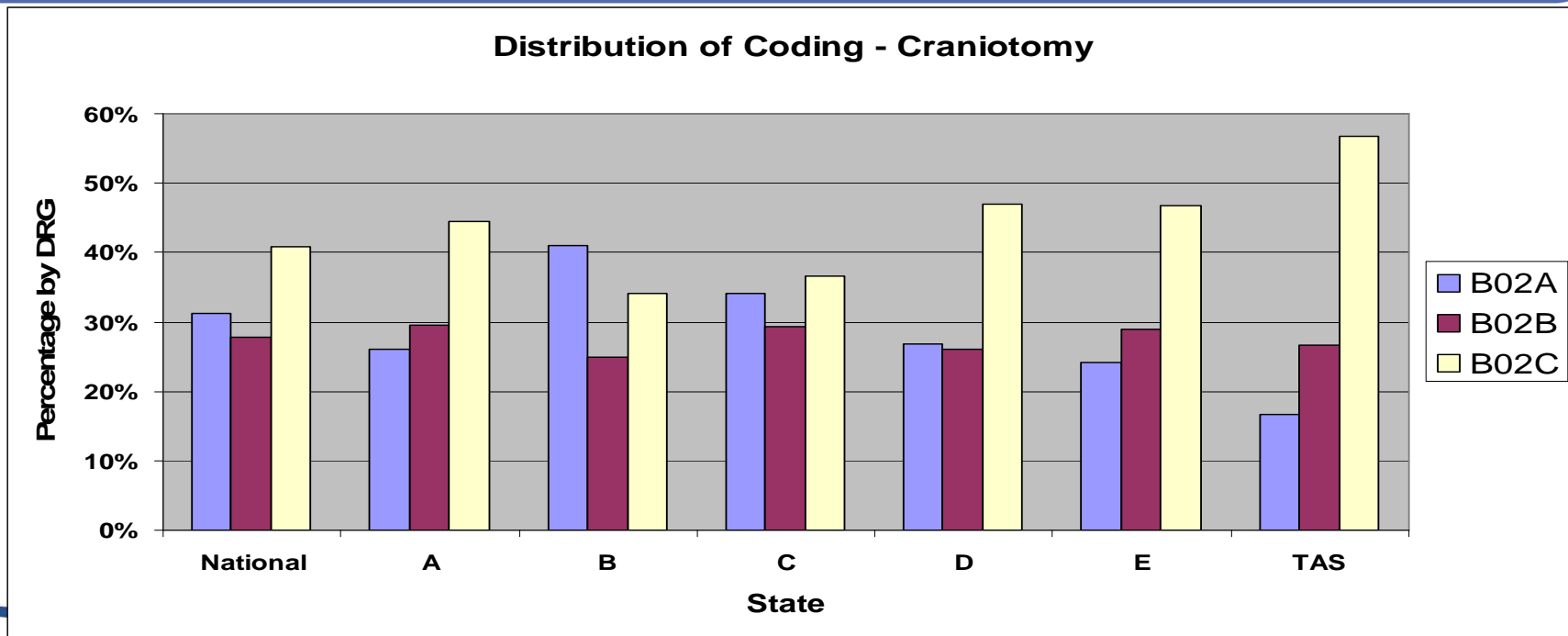
- ❑ How well does the Tasmanian clinical coded data, (that was currently produced), support the ABF process?
 - Initial indications were not good
- ❑ Comparison Tas vs other states
 - Every Adjacent DRG with a Severity Split was examined
 - Round 14 data 2009-10 used
- ❑ Costly Care: Making Public Hospitals more efficient
 - Grattan Institute 2014.
- ❑ Basic assumption is that Tasmanian morbidity should **not** be less than the national average

Effect of Coding Issues



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A Surgical example



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National Coding Impact

	Main Analysis (514 DRGs)	Major Medical Conditions (3 DRGs)
TAS	-4.1%	-8.6%
WA	-2.1%	-4.3%
ACT	-1.9%	-3.4%
QLD	-1.0%	-2.7%
NSW	-0.1%	-2.8%
SA	2.5%	1.4%
VIC	2.9%	9.4%

3 Medical DRGs result shows impact of coding of secondary diagnoses and coexisting conditions (E61, F62, T60)

Source – Technical Supplement - Costly Care Report – Grattan Institute - 2014
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Some issues we found

- Poor capture of secondary diagnoses
- Deficient documentation in terms of providing support for secondary conditions (ACS 0002)
- Poor capture of hours of mechanical ventilation
- Significant coding from discharge summaries rather than whole of notes – e.g. Mental health where notes in some cases were not available to coders
- Some autocoding that may be inappropriate
 - particularly in Mental Health and day cases
- Not all records have discharge summaries, or summaries written by a doctor who actually saw the patient
- Some notes difficult for coders to read
 - e.g. ICU clinical charts
- Abnormal counts – e.g. qualified neonates

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Rectification of Undercoding

- ❑ Coding Audit and Validations
 - Scattergun approach
 - Sample data
 - Select random sample of data from all records
 - Focussed Audit
 - Examination of data with following attributes;
 - Inliers - LOS >1.5 times AR-DRG average but less than 3 times average (high inliers)
 - Outliers LOS >3 times National ALOS
 - LOS >6 days (material LOS therefore worth looking at)
 - <3 Diagnosis codes (the level of coding is not likely to explain the additional LOS)
or
 - PCCL = 0
 - NO highly complex procedure undertaken
 - Standard tools are available
 - PICQ – or In-house

Steps taken

- ABF has itself assisted in achieving some focus of attention
Education sessions with clinicians on documentation
- Production of coding bulletins with local issues
 - Mechanical ventilation
- Admission policy
- Coding plan
- Meetings with coding groups

So How has it gone?

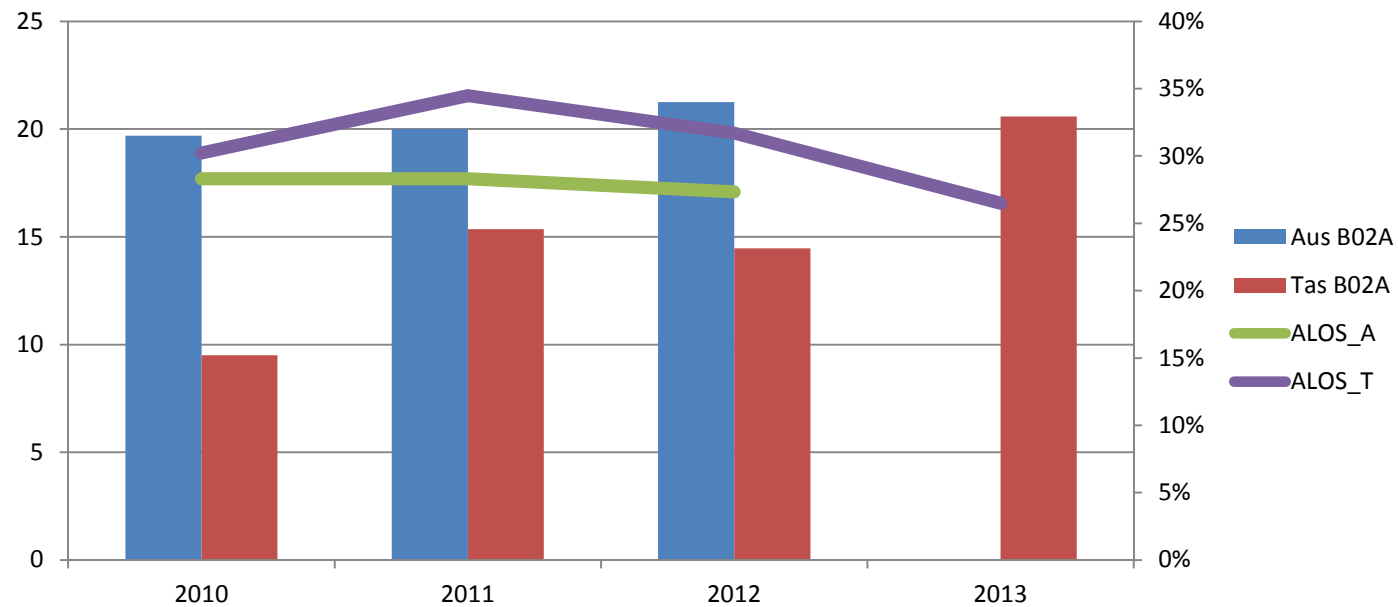
- ❑ Without undertaking a major coding Audit
 - Examine the coded output as per identification of initial problem
 - Look at most recent coded dataset against most recent National Public Estimated results

Examination over time

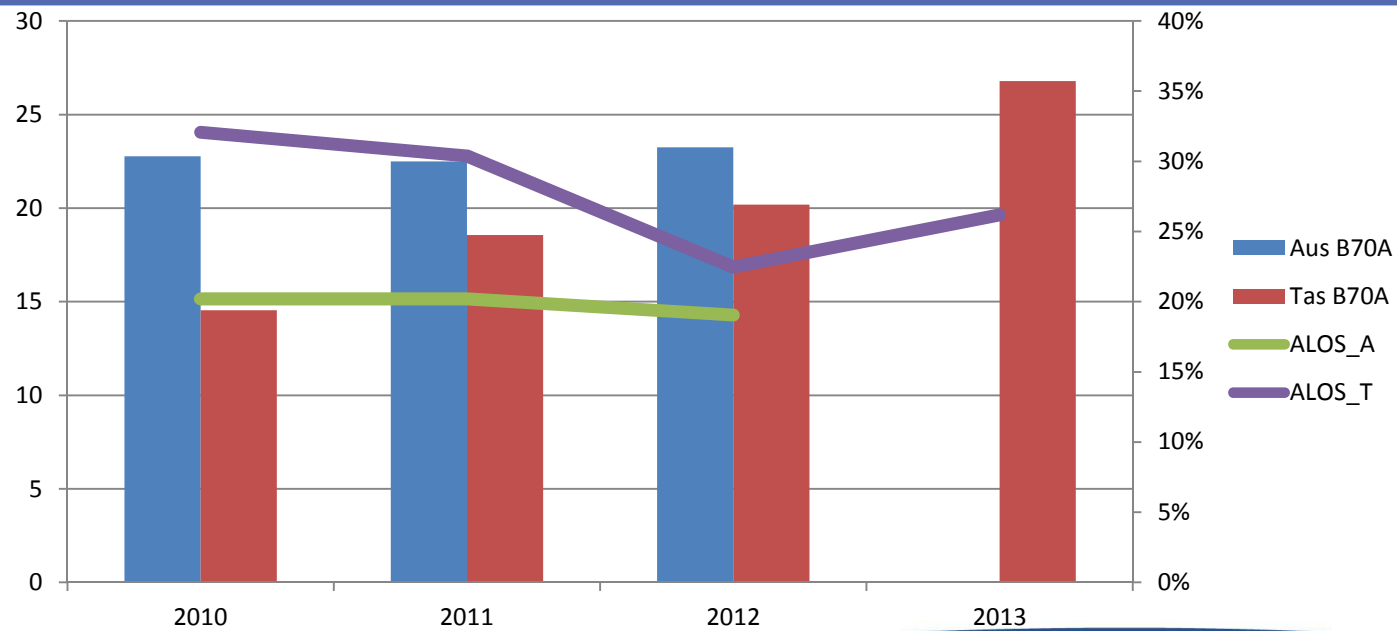
- ❑ 4 years of Recent Tasmanian coded data was examined
- ❑ Compared against Nat R14 and R16 (latest available)
- ❑ Significant improvement in 2013 c/w 2010
- ❑ But National data also shows improvement
 - Both need to be considered together
 - Examination is required at the DRG level to clarify

 - Note – 2010-12 are same for National Data
 - R17 (2012-13) National data are not yet available

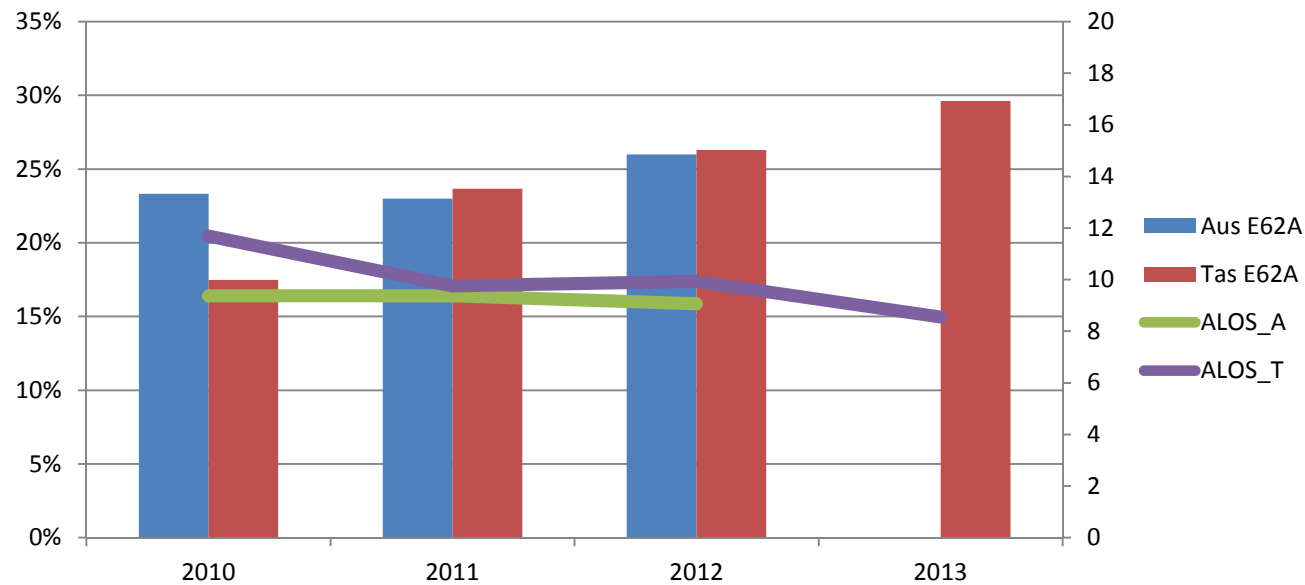
B02A - Craniotomy



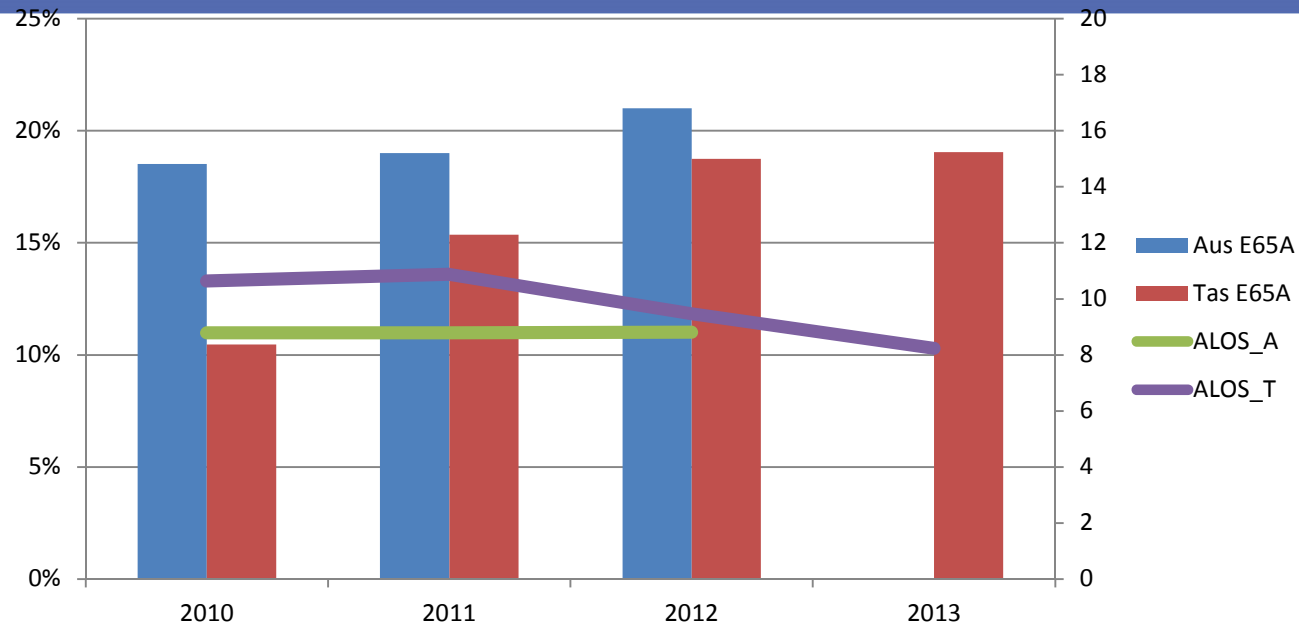
B70A - Stroke



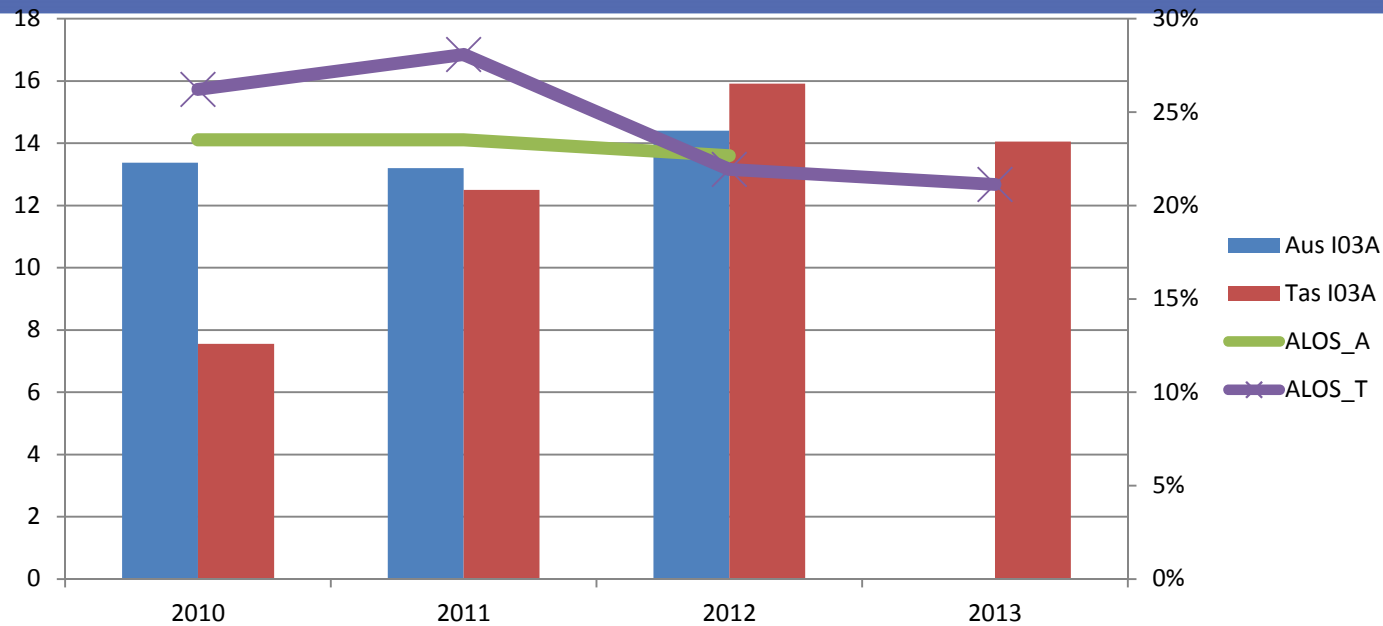
E62A – resp Infection



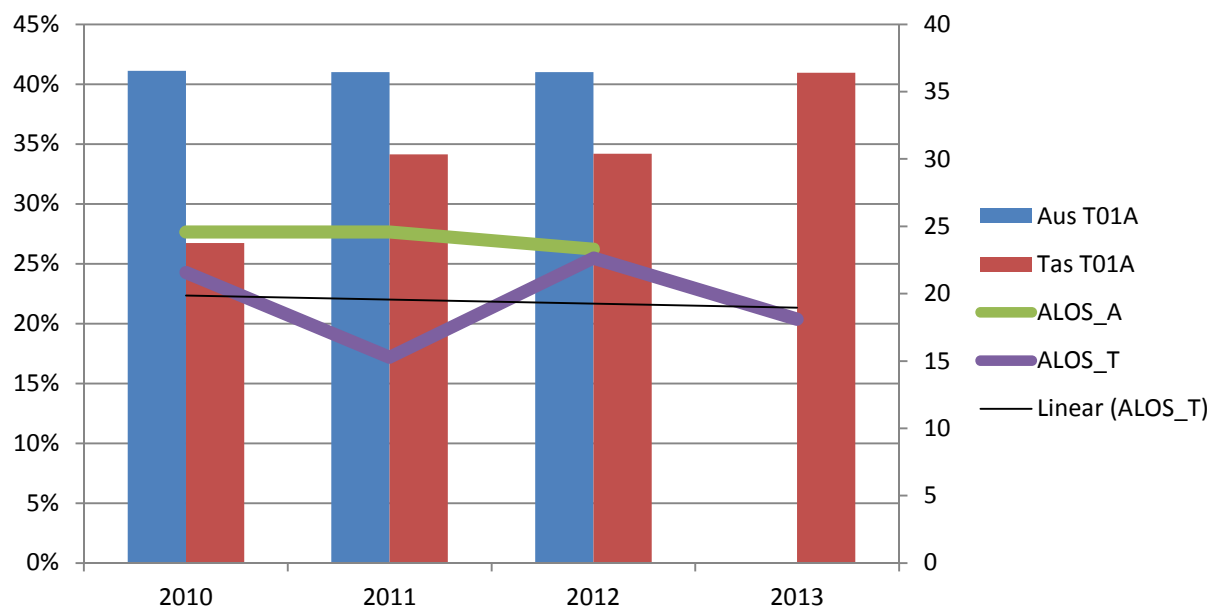
E65A - COPD



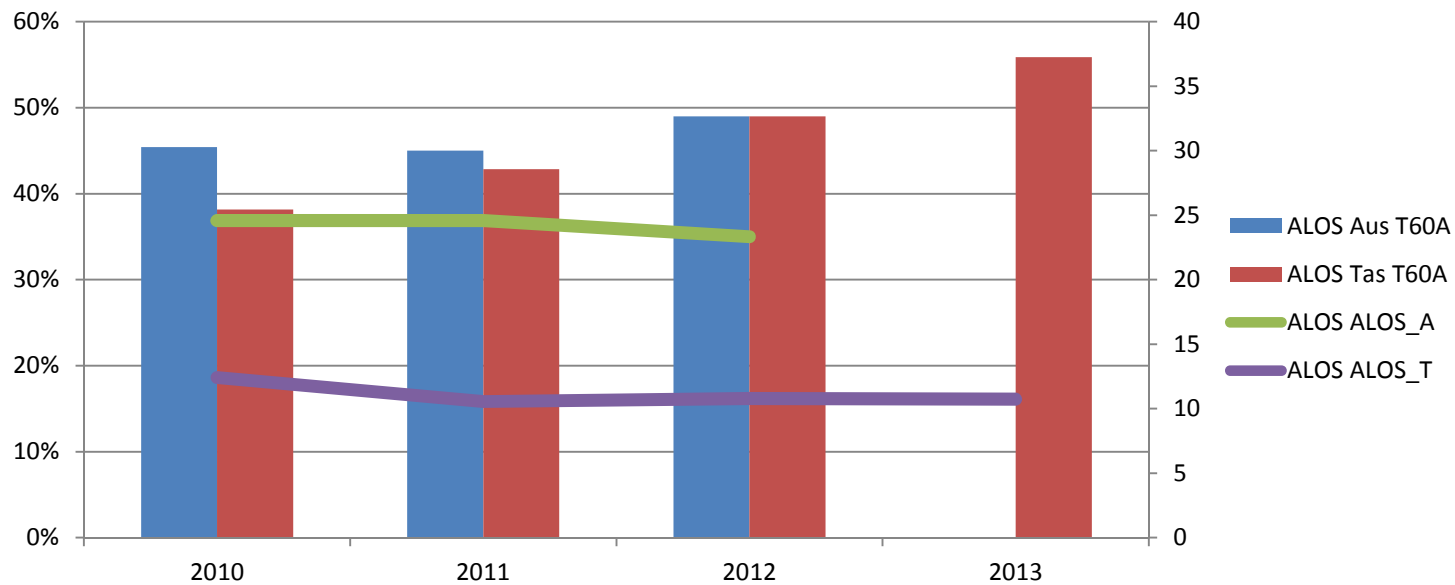
I03A – Hip Replacement



T01A – OR proc. for Infection



T60A - Septicaemia



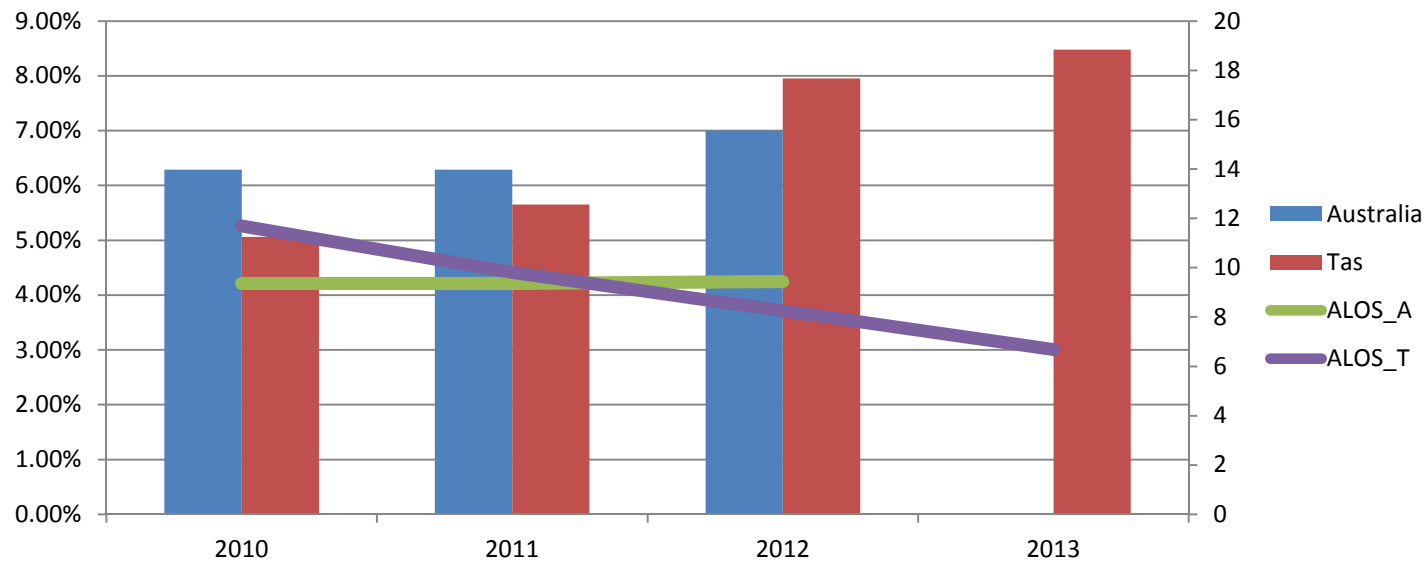
Overall Effect

- ❑ There has been an increase in proportion of “A” DRGs generally in Australia between Round 14 and Round 16
- ❑ Using Round 16 as the baseline
 - Considering every Severity split within the Adjacent DRGs the increase in weighed separations is approximately 1.7%
 - Tasmania has improved over the past 3 rounds by about 6.5%
- ❑ Considering the previous position of being undercoded, Tasmania is now much more consistent with national result than in 2010-11

Some interesting effects

- ❑ As coding improves so does ALOS comparisons
 - Undercoding will tend to send lower LOS cases back to the lower DRG class
 - E.g. from B70A to B70B or even B70C
 - This increases the ALOS of both the Higher and Lower ranked DRGs
- ❑ We can also see some cases where an analysis for reasons Tasmania would be coding at a higher level is required
 - The question of possible overcoding should and can also be asked

001A – Caesarean delivery



Summary

- ❑ Tasmania has improved its performance in coding
 - No longer the outlier
- ❑ This method of analysis provides a good guide and is a powerful tool
 - A measure is also possible in weighted separations
 - But does not remove the need to audit
- ❑ Targeted audit is likely to provide good improvement
 - Far lower cost than undertaking a wide sample random audit
- ❑ Sample audits are still required but should be stratified
- ❑ National data also shows increase in coding for the “A” DRG
- ❑ Improvement in Discharge Summaries is an area where we will be focussing more effort

Where do we want to be

- ❑ Coding should reflect;
 - What was wrong with the patient
 - What happened to the patient
 - What was done to the patient

- Now for the rest of the Casemix Agenda.....



Questions?

Identification of an “at risk” cohort

- ❑ Diabetes is an example of high risk group.
 - Similar effect with COPD, Dementia, CCF, etc
- ❑ Diabetes is recognised as a major healthcare issue in Australia
 - advice from clinical specialists is that it is always important in the care of a patient
 - These patients often cost more to provide care
 - Increased nursing, investigation, etc.
- ❑ We had some undercoding of diabetes in Australia - coding standard changed in 2013
- ❑ A simple dataset was created
 - any patient with any coded mention of diabetes in any episode identified.
 - All episodes related to these patients during 2008-09 were identified and compared against all episodes in the major hospitals.
 - 305,000 individual patients over 10 years

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5% incidence of diabetes ever coded in the patient group

- ❑ From the next slide, a level of diabetes undercoding can be seen.

Prevalence of Diabetes Coding

Hospital	total Individuals Admitted	Individuals with known Diabetes admitted	% of individuals admitted	Total Episodes	Diabetes Episodes	% Diabetic Episodes	Coded Diabetic Episodes	% Diabetics Coded
Hosp1	19,990	2,743	14%	45,904	14,638	32%	1,975	13%
Hosp2	6,762	1,245	18%	10,057	2,197	22%	910	41%
Hosp3	6,822	1,162	17%	10,045	2,091	21%	766	37%
Hosp4	30,007	3,694	12%	64,073	13,526	21%	3,380	25%
<i>Total</i>	63,581	8,844	14%	130,079	32,452	25%	7,031	22%

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