Introduction

The introduction of casemix funding to Victorian hospitals in 1993 was the beginning of many changes for health information managers. This segment provides a policy overview of casemix funding and describes its impact in each of the various health sectors from a health information manager’s perspective. The introduction is by Professor Stephen Duckett, who has played a major role in casemix policy development and implementation at both national and state levels. The transformation of the health information manager role has provided many exciting opportunities for professional development and skills diversification. Despite the different sizes, specialties and locations of hospitals, it seems obvious that the effect of casemix-based funding has been consistent: increased profile, greater responsibility, improved coding quality and a greater involvement in financial decision making and planning have been experienced by health information managers across the state.

By way of background, the following definitions have been sourced from the Victorian Department of Human Services (DHS) casemix website <www.casemix.health.vic.gov.au/>. Victoria defines the admitted patient workload of a hospital in terms of WIES (weighted inlier equivalent separations):

- A patient’s WIES value depends upon the amount of time they stay in hospital compared with other patients with similar conditions (inlier equivalence) and the relative cost of treating their condition compared to the cost of other illnesses (cost weight or relativity).

- Cost weights are developed each year and are based upon the costs of treating individual patients in Victorian public hospitals. Hospitals report the costs of over half a million patients annually. In addition to new cost weights, DHS often makes changes to the WIES in response to health industry concerns. Consequently, casemix funding in Victoria has evolved considerably from the relatively simple model introduced in 1993-1994.

Overview of a decade of casemix in Victoria

In retrospect, it seems obvious that hospitals ought to be paid on the basis of what they do rather than what they say, what they did, how vociferous they are in the media, how good they are at lobbying, or indeed the population they claim to serve. However, simple ideas are often the most profound. The introduction of casemix funding in Victoria represented a quantum leap forward in the way public hospitals were funded in this state and had flow-on effects in other states. Of course, casemix funding in Victoria had a number of antecedents. Victoria had 10 years’ experience of requiring all separations from public hospitals to be coded. The Diagnosis Related Group (DRG) classification system had been developed in the United States 20 years before, and the Australian adaptation had been on the agenda for at least the previous 5 years. Casemix funding for Medicare patients had been implemented in the United States a decade earlier and had been talked about in publicly oriented systems over a similar period.

Casemix funding had been foreshadowed by the Labor government in 1992, but this commitment did not attract the attention of public hospitals, neither did the considerable developmental work that had taken place in the Health Commission of Victoria and its successors over the years. Computer printouts of information on a hospital’s casemix had been provided to hospitals for a number of years; the ‘Rainbow Books’ had provided performance data in terms of comparative efficiency over a similar period. Although casemix funding may have been seen to be subject to rapid implementation, the policy directions had been set for many years. Health Information Managers were obviously aware of DRGs, their design and their implications, but clinicians and managers ignored the portents.

Casemix funding was tainted by the opprobrium associated with the contemporaneous budget cuts, but casemix funding has been retained as the principal basis for funding public hospitals under the Labor government elected in 1999. The idea thus seems to transcend political parties.

Casemix funding in Victoria 10 years after implementation is quite different from the system that was implemented in 1993. Initially, casemix funding only applied to inpatient services. A wider range of hospital activity is now funded on a casemix basis: outpatients (using Victorian Ambulatory Classification Scheme, VACS) and rehabilitation (using Casemix for Rehabilitation and Funding Tree, CRAFT) are the most notable extensions of scope. In terms of discourse, hospital boards are crucially aware of the importance of ‘revenue’, particularly casemix payments relating to activity levels.

Casemix funding has shown that it can develop as systems of how to describe hospital activity evolve. Casemix funding can also change as new priorities, policies and personalities emerge on to the policy stage. Interestingly, even a decade on, hospital managements are still learning about how to use casemix information in management and how to involve clinicians in the quest for improved efficiency and outcomes.

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Casemix in the private sector
The introduction of casemix, or, as we refer to it in the private sector, episodic funding or episodic based payments, has had an enormous impact on our profession as well as on the environment in which we work.

The primary emphasis is on coding, and coding quality, due to the ever-present demand to shorten the revenue cycle. This is critical to the financial stability of private hospitals that rely on incoming revenue. Unfortunately, this emphasis on coding has led to the under-utilisation of other skills. In my experience, private hospitals are generally well resourced, and health information managers certainly are encouraged and supported to attend continuing education sessions, conferences and coding updates. The main problem has been, and remains, the recruitment and retention of qualified coders, due to a high demand for coders across the state.

From an information technology (IT) perspective, most health information managers have access to the internet and e-mail, yet the private sector is yet to embrace the use of automated coding software products. Health information managers in the private sector work closely with their organisation’s Credit/Finance Department due to the focus on revenue and coding turnaround times.

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Casemix in the aged care sector
The introduction of casemix funding for Victorian hospitals had no immediate impact on funding of aged care services. It was recognised that DRGs would not measure some inpatient groups appropriately and these groups remained funded by special grants or per diem payments. These groups included rehabilitation, geriatric evaluation and management (GEM), palliative care, and aged persons’ mental health, and included nursing home care and respite care. Although it was recognised that maximising independence and quality of life and better management of long-term care for older people could result in cost savings in acute and residential areas, data collected by the DHS did not provide an accurate picture of specialised resources required to care for older people.

The first impact of casemix in aged care occurred with the development of casemix funding for rehabilitation. The Victorian Rehabilitation Project commenced in 1994 with a pilot study, resulting in additional reporting requirements to DHS for rehabilitation and other subacute inpatients from 1995. Over the next few years, the Casemix Rehabilitation and Funding Tree (CRAFT) model was developed to fund inpatient rehabilitation episodes of care. CRAFT (also called VicRehab) was introduced in Victoria in July 2001 after 2 years of CRAFT shadow funding. During this period, subacute inpatient facilities, and health information managers in particular, invested a great deal of time analysing current practices and service activity to measure the impact of CRAFT on future funding. DHS also started looking at the options for episode based funding of GEM patients during this time, and a report was commissioned by DHS to provide an overview of strategic directions for subacute services in Victoria. The implementation of CRAFT funding and ongoing development of service and funding mechanisms within aged care created many challenges for managers of Health Information Services (HIS). In aged care services, HIS is seen as the ‘engine room’ of the organisation, the link between clinical, administrative, IT, and financial services and the provider of key information for financial and service planning.

Each of the services comprising aged care has specific state and federal reporting requirements and funding mechanisms. Because IT systems that can manage all requirements are still in the early stages of development, it has been very time consuming to provide comprehensive organisational activity reports. With increasing focus on development of coordinated services to provide clinically effective and financially viable care for older people, ad hoc and ongoing requests for information have increased dramatically over the last couple of years as new projects commence. These have included the Acute to Subacute Breakthrough Collaborative, Hospital Admissions Risk Program (HARP) and Community Health Online Record Project (CHORD), just to name a few.

Casemix funding models for aged care will continue to evolve over the next few years, in both inpatient and non-inpatient areas. Because of the limited number of health information managers with experience in aged care services, we will continue to be challenged to ensure that funding models are developed with a real understanding of what is actually happening at the patient level and will be sensitive to the evolving nature of health services within subacute care.

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Casemix in small, non-metropolitan health services
The introduction of casemix-based funding in Victoria has been the single biggest development in health information management in my time in the profession. It is unfortunate that casemix funding in Victoria was introduced at the same time as massive budget cuts in the health sector, as this has led to the continuing impression that casemix funding is synonymous with making productivity savings. In fact, casemix should have been perceived as a wonderful step in the right direction; for the first time hospitals were being paid for the work they did.

Health Information Services, through the provision of timely and accurate coding, were now responsible for nearly all acute, inpatient funding. As a health information manager I assumed a presence that had not been evident previously; the priority of management shifted dramatically and I became very involved in budget negotiations with DHS and formed a close internal liaison with the Finance Department. I saw this as a golden opportunity to prove the range of talents of health information managers. As the only person
who truly understood how WIES were allocated, I was now the expert in casemix funding; this meant some very quick lessons to learn about debtors, creditors and general ledgers so that I could contribute in a meaningful way in budget meetings.

Ten years down the casemix path, as a profession we remain in the best place to see the big financial picture in terms of casemix funding. It remains a lasting concern that our undergraduate course still contains very little in the way of financial training. There is no reason why a health information manager should learn not only about variable casemix-based payments, but also the other components, which comprise the total revenue budget.

Before casemix funding I remained a coding purist; there was no way I was going to go down the path of automated coding; the books were the only real way to code! Having the option of an allocated DRG at the time of coding and the ability to ensure the optimum WIES for each patient soon meant a radical change of heart. One year after casemix was introduced we purchased an automated coding system; this pays for itself repeatedly, simply by ensuring that we claim the appropriate WIES. Extra resources, in the form of an additional health information manager, were provided to ensure that our coding was completed in a timely and accurate manner but also because of a realisation that health information managers were capable of so much more than our hospital management may have been aware previously.

As other patient programs, and in particular, residential aged care, moved towards a modified casemix-based funding system, it seemed a natural progression for Health Information Services to assume responsibility for the claiming of all government-based revenue, both State and Commonwealth. Therefore, 10 years down the track the Health Information Service is an integral component of the executive structure, and sits very comfortably alongside the Finance Department. The role of the health information manager has grown in stature with the realisation that members of our profession have a range of talents and that we are limited only by our individual perceptions of our professional capabilities.

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Casemix in large, non-metropolitan health services

In July 1993, when the casemix payment system was introduced in Victoria, I was happily working in the aged care sector and oblivious to the frenzy occurring in acute healthcare. My experience of casemix at the time was limited to the six regional hospitals where I provided a medical record service. The impact in these hospitals was not significant, but it did provide a catalyst to reviewing clinical documentation standards and ensuring that ‘diagnoses’ such as ‘delivery’ and ‘death’ were no longer used. The other obvious impact was the urgent interest by senior management in coded data and the need to reduce the coding turn-around time as the effect of the new funding model became apparent. It was surprising to note that 5 years later when I commenced work at a large rural hospital things were not much different from the small regional hospitals, except in scale.

There continues to be a strong focus on the coding standards, which has assisted in improving the accuracy and consistency of coding. The standards have also facilitated regular internal and external audits, the latter evoking significant interest from executive staff. The work of the National Centre for Classification in Health (NCCH) has ensured that coding standards continue to evolve in line with clinical practice, thereby making the codes more meaningful to clinicians.

The increased complexity of coding has created a reliance on the Encoder and led to the demise of the old ‘cheat sheets’. Coding without reference to the codes or standards is no longer possible. The increasing number of standards has also placed a greater importance on understanding anatomy, physiology and the pathological relationships between diseases. While this provides great scope for ongoing education for health information managers, it can be difficult to maintain the levels of knowledge required to ensure coding accuracy. Regular contact with clinical staff provides opportunities for addressing clinical questions and gaining more information about medical conditions and surgical procedures.

Health information managers are considered experts in casemix and they continue to provide education and advice to clinical and administrative staff. ‘WIES’, ‘DRGs’ and ‘inliers’ are now part of the vocabulary of most staff members; in addition, clinicians now understand the impact that documentation has on the funding of the hospital, and subsequently the quality of documentation has improved. Weekly coding audits with clinicians have created an effective forum for communicating about documentation, clinical practice and other casemix-related issues.

Casemix has had a significant impact on the profile of health information managers, which has provided a springboard for promoting our diverse range of skills. Health information managers in large rural health services have an opportunity to contribute to the development and refinement of casemix systems in acute, subacute and ambulatory services by participating in cost studies, data analysis and clinical reviews. It is important that, simultaneously, they ensure that coding is recognised as a highly skilled and important task while continuing to value and demonstrate the many other health information manager roles.

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Casemix in acute care, metropolitan hospitals

I started my professional career just prior to the introduction of casemix funding and remember how at the time we ‘played’ with these funny things known as Diagnosis Related Groups for a year or two before it all became real. At the time, we were medical record ad-
administrators, no one knew our names, the only time we left the Medical Record Department was to go to lunch, we referred to the doctors as ‘Doctor’ and we even wore white coats. We spent our days sitting in offices without computers, or, if we were really important, had access to a green-screen dumb terminal. WIES was something unmentionable, we had memorised the ICD-9-CM codes, and we chased up our outstanding uncoded episodes once annually, at the end of the financial year!

How things have changed! Today we are health information managers and hold highly respected, well-paid and quite senior positions within our health services. Doctors now come to us for advice or are concerned that we will tell them what they should be doing. We are consulted on major policy decisions regarding funding of services and throughput options, and we spend more time out of our offices in meetings than in them. We have ditched the white coats and have access to some of the most powerful PCs in the health service. The codes are now in ICD-10-AM and the DRGs look very different. We know the revenue for every item from an outpatient encounter to a complex ICU patient, and WIES is part of our standard vocabulary. Indeed, we are the only ones who actually know what it stands for, let alone means, and our outstanding uncoded episodes are measured in days, with hours being the next unit of measure.

Our profiles have improved dramatically, as a modern day Edna Huffman once said, “Information is power!” (Jackie McLeod, Manager of Health Information Services, The Northern Hospital). We are the information experts and as a result hold a substantial power base in today’s healthcare environment.

I have been a member of the Victorian Advisory Committee on Casemix Data Integrity (VACCDI) for over 5 years, and when my involvement with this committee commenced the members were mainly medical directors and senior hospital administrators, with a handful of health information managers involved. Today, health information managers account for approximately 90% of the membership and represent most metropolitan health services. The alteration in membership of this committee also demonstrates the effect of casemix funding on our profession. We are the recognised professionals in relation to data capture and information reporting and, as such, are being sought more and more for the provision of expert advice on this component of the health system.

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Casemix in specialist teaching hospitals

The first of July 1993 saw the introduction of casemix payment to Victorian public hospitals. The American experience of the previous 9 years had already given some insight into the impact of casemix funding on medical record administrators, department processes and the financial implications for individual institutions. Data for the previous several years had been analysed at the Royal Children’s Hospital (RCH) to ensure that the development of the casemix funding formula would consider the tertiary, training and specialised nature of the hospital and its clientele.

The initial stages of casemix introduction saw responses to processes that focused on timeliness and quantity of documentation. ‘Discharge summary’ forms were redesigned for brevity in the hope that this would encourage their completion at the time of discharge. In hindsight, not all these decisions were favourable towards meeting the long-term requirements of casemix, as they adversely affected the quality of documentation, which in turn affects the completeness of coding and, inevitably, the funding. The number of coders employed did not alter in the initial stages of casemix funding, but over time, as coding audits and documentation reviews proved to be financially productive, the number of hours dedicated to these processes has increased, requiring additional qualified staff. Additional clerical support has also become necessary as weekly and monthly deadlines for coding completion have become incorporated into the objectives of Health Information Services and hospitals. In light of the need to increase the efficiency of the coding function, discharge completion processes were altered to meet the need for coding to be completed as soon as possible after discharge. At RCH, this decision was made to the detriment of timeliness of discharge summaries to referring and local doctors. Casemix was altering the priorities of the department.

Data analysis is now a key skill of the health information manager, and a strong understanding of underlying coding principles, DRG construction, and casemix classification is essential. The coded data are often combined with financial information. The traditional uses of coded data for utilisation, review and research, for example, have now been overshadowed by the financial language of the data.

The impact on the health information manager has been significant in many ways. The introduction of casemix brought with it the National Centre for Classification in Health (NCCH), the introduction of more Australian coding standards and the need for more consistent coding to ensure the appropriate DRG output. This resulted in ICD-10-AM (Australian Modification) and the update of coding classification books every 2 years. All these processes have resulted in additional pressure on health information managers and clinical coders. The recognition of the important contribution of clinical coders has also been a significant outcome.

The impact of casemix on the profession within the hospital context has been positive, although this has been a slow outcome. There has been an increase in the understanding of the role of health information managers, their skills in data analysis, and their knowledge of the intricacies of casemix. The potential of the profession in the casemix area will be fully realised only when health information managers take up the opportunities, available in all teaching hospitals, to lead and staff the casemix departments.

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Note: All authors, with the exception of Professor Duckett, are qualified health information managers.