Queensland Government

Queensland Health

Enquiries to: Liz Lea
Director Funding and Costing
Healthcare Purchasing and Funding
Telephone: (07) 3708 5914
File Ref: C-ECTF-21/4034

Mr James Downie
Chief Independent Officer
Independent Hospital Pricing Authority
PO Box 483
DARLINGHURST NSW 1300

Email: james.downie@ihpa.gov.au

Dear Mr Downie

Thank you for your letter dated 26 March 2021, regarding the Round 24 National Hospital Cost Data Collection (NHCDC) Data Quality Statement.

I am pleased to provide (enclosed) the Data Quality Statement for the Queensland submission to the Round 24 of the NHCDC.

I acknowledge the delay with the provision of this statement, however, officers in my Department have been actively working with your team to resolve queries in relation to the submission and I considered it important to provide you an accurate and realistic assessment of the Queensland NHCDC submission which meant, further discussions were required with local costing practitioners, and it has taken longer to be sure of the content of this document than initially anticipated.

Should you have any questions with regarding to this statement, please contact Ms Liz Lea, Director, Funding and Costing, on telephone (07) 3708 5914 or email liz.lea@health.qld.gov.au.

Yours sincerely

Nick Steele
Deputy Director-General
Healthcare Purchasing and System Performance
25 / 10 / 2021

NHCDC Round 24 Data Quality

Healthcare Purchasing and System Performance

National Hospital Cost Data Collection Round 24

Data Quality Statement - Queensland

1. Overview of Costing Environment

Queensland comprises sixteen Hospital and Health Services (HHS) plus the Mater Public Hospitals (Brisbane), each providing health services to the community in admitted and non-admitted settings (acute, sub-acute, non-acute, emergency, facility-based outpatient ambulatory clinics and community-based heath intervention and support services).

Each HHS and the Mater undertake costing of their services and provide cost data to the Department which is then submitted to the National Hospital Data Collection (NHCDC). The NHCDC is the primary data collection used to develop the National Efficient Price (NEP). To ensure accurate information is submitted to the NHCDC and subsequently available for the NEP determination, there are validation and quality assurance processes conducted.

The following describes the costing processes and data quality issues that have been identified in the NHCDC Round 24 (2019-2020) data for Queensland.

1.1 Processing the cost data

Of the sixteen HHSs plus the Mater Public Hospitals (Brisbane), four of the HHSs are in rural and remote areas and the costing process is undertaken on behalf of these HHSs by the costing team within the Department of Health (the Department). The remaining HHSs plus the Mater Public Hospitals (Brisbane) have their own costing teams that undertake the costing.

1.2 Costing frequency

The frequency HHSs do the costing ranges from daily to annually, with the majority costing on a monthly basis. Once the costing process is finalised for the reference year, the data is extracted from each site costing database and submitted to the Department. The Department then undertakes the final data transformation processes, data quality, validation and reconciliation to the general ledger required prior to submission of the NHCDC.

1.3 Costing systems

For the period covered in this report (2019-2020), there were two costing systems in use across the Queensland: Power Performance Manager and CostPro. During 2019-2020, all sites that had used the legacy costing system Transition II in the 2018-2019 fiscal year, implemented their site costing databases as part of the state-wide solution using CostPro (the costing engine) and IntelPlus. Work in progress data

for those patients with costs in prior fiscal years was transferred to site databases to ensure continuity of end to end cost reporting.

1.4 Jurisdiction training and support

Each HHS is a statutory body governed by a Hospital and Health Board. Each has experienced costing practitioners with the necessary expertise to undertake the costing and to manage and train users in costing methodology and the technical skills required to operate the costing system. There is a costing team with the Department that works closely with each HHS providing technical advice and expertise regarding clinical costing issues as required. The Department costing team makes clinical costing resource material available including costing guidelines and standards.

1.5 Costing improvements

Queensland HHSs continually monitor the implementation of new clinical data collection systems to assess whether they can be utilised for clinical costing, and they also work collaboratively with data managers to improve existing systems to attain minimum requirements for costing.

The most significant change in feeder systems during 2019-2020 was the redesign of the mental health data. This better reflects the model of care used for provision of mental health services where mental health teams provide specialised services to patients not only in their local HHS but across the State.

Community mental health is run in a multidisciplinary, multiteam multi-Local Hospital Network environment; the source system is a state-wide system and clinicians can access and provide support to consumers in any location. Some specialist services such as Court Liaison are centralised. A new data view allows the provider costs from one HHS to be reflected against a patient of another HHS.

As part of the implementation of the new state-wide costing solution, a detailed review of all feeder systems was undertaken. This extensive review included the data elements, their relationships across tables, applicability of the data elements to be used for costing purposes and an in-depth review of relative value units and cost outputs produced for each system.

2. Submitted Cost Data

The jurisdiction received data from 408 facilities which have been costed at patient or service level in the 2019-2020 fiscal year. There was 11,644,442 episodes submitted at a total cost of $14 billion including several facilities that are out of scope for the NHCDC for which cost data are held by the Department. The excluded facilities accounted for 5.06 per cent of costs ($733 million) and 3.27 per cent of episodes (381,108) and are all out of scope for the National Efficient Price (NEP) and National Efficient Cost (NEC) determinations. 239 facilities were submitted as part of the NHCDC in Round 24.

2.1 Submitted Facilities

There were 239 facilities reported in Round 24, a net increase of 41 facilities over Round 23. Table 1 (below) shows the changes between Rounds by funding type.

Table 1: Count of facilities by funding type and facility type submitted

Funding Type	Round 23	Round 24	Variance	Percent Change
BLOCK	70	70	0	0.00%
NONABF	90	121	31	34.44%
ABF	38	38	0	0.00%
ABF PRIVATE		10	10	100.00%
State Total	***198***	***239***	***41***	***20.71%***

Table 2 (below) shows the change in episodes and costs submitted to the NHCDC between Rounds. It shows an increase of approximately 10.81 per cent in episodes and 8.55 per cent in costs across the submitted hospitals. There was a significant decrease in submitted costs for block funded Public Psychiatric Facilities in Round 24. This is outlined in more detail in section 2.4.

Table 2: Episodes and costs submitted to NHCDC

NHCDC Round	Episodes	Total Cost ($M)
23	8,825,791	$11,663
24	9,780,266	$12,660
Variance	***954,475***	***$997***
Percentage Change	***10.81%***	***8.55%***

2.2 Costing movements between Rounds

COVID-19

The major impact on costing outcomes is associated with the management of the Novel Coronavirus (COVID-19) across parts of the 2019-2020 costing year. This has impacted activity volumes, with lower volumes leading to a higher average cost per unit, changes in service delivery profiles with a greater use of telehealth and planned stoppages in elective surgery during the initial phases of the COVID-19 response. The profile of health service delivery has changed in an atypical year of healthcare activity.

Queensland HHSs were impacted by COVID-19 from January 2020.

The *COVID-19 Response Costing and pricing guidelines Version 0.4* states IHPA anticipates that there will be two distinct costing periods in the 2019–20 financial year; business as usual and COVID-19 response. The attached document 'Townsville HHS COVID costing approach for DOH' describes the costing approach adopted by the majority of Queensland HHSs to apply the *COVID-19 Response Costing and pricing guidelines Version 0.4*.

This document describes how Queensland sites identified COVID-19 patient related costs and attributed those to episodes classified as COVID-19 through data collection systems, and that underutilised capacity in the COVID-19 period has been spread across all episodes within the financial year. Table 3 (below) summarises whether sites created two distinct costing periods and how the site managed additional expenditure as a result of COVID-19, which was reported via the National Partnership on COVID-19 Response (NPCR) State Public Health Payment (SPHP).

Table 3: COVID-19 costing approach

HHS	Number of Costing Periods	Management of NPCR SPHP
Cairns & Hinterland	Single costing period	NPCR SPHP attributed to COVID-19 episodes
Central QLD	Single costing period	NPCR SPHP attributed to virtual patients
Central West	Single costing period	NPCR SPHP attributed to virtual patients
Children's Health	Two costing periods	NPCR SPHP attributed to virtual patients
Darling Downs	Single costing period	NPCR SPHP attributed to virtual patients
Gold Coast	Two costing periods	NPCR SPHP attributed to virtual patients
Mackay	Single costing period	NPCR SPHP attributed to virtual patients
Mater	Two costing periods	NPCR SPHP excluded
Metro North	Single costing period	NPCR SPHP attributed to virtual patients
Metro South	Single costing period	NPCR SPHP attributed to all episodes
North West	Single costing period	NPCR SPHP attributed to virtual patients
South West	Single costing period	NPCR SPHP attributed to virtual patients
Sunshine Coast	Single costing period	NPCR SPHP non-labour costs attributed to virtual patients
Torres Cape	Single costing period	NPCR SPHP attributed to virtual patients
Townsville	Single costing period	NPCR SPHP attributed to virtual patients
West Moreton	Single costing period	NPCR SPHP attributed to virtual patients
Wide Bay	Single costing period	NPCR SPHP attributed to virtual patients

A number of Queensland HHSs noted in their COVID-19 post-workshop jurisdictional questionnaire that NPCR SPHP costs were submitted to the NHCDC and it is important to note that these were attributed to virtual patients and therefore excluded from the final NHCDC submission.

Three Queensland HHS have informed the Department of issues with the management of NPCR SPHP costs. These include Cairns and Hinterland HHS where NPCR SPHP costs were attributed via COVID-19 specific products to COVID-19 patients, Metro South HHS where NPCR SPHP costs were attributed to all costed episodes via an overhead allocation, and Sunshine Coast HHS where labour related NPCR SPHP costs were attributed to all costed episodes. The Department recommends that IHPA consider removing these HHSs from NEP determinations. It is noted that three HHSs complied with the *COVID-19 Response Costing and pricing guidelines Version 0.4.*

Cost buckets

The legacy system utilised a single overhead/indirect cost type. Sites using the new state-wide costing solution are now able to map through to the appropriate cost categories. This has led to a better direct alignment of overhead costs to all cost buckets and caused apparent significant differences in most cost buckets on a percentage basis when compared to previous rounds. The implementation of the new state-wide costing solution means all Queensland HHSs now have access to this contemporary functionality.

2.3 Factors influencing submission

Unlinked Activity

Pathology, imaging, and pharmacy records that are not able to be matched or linked to an Episode through the data matching process are currently out-of-scope for the NHCDC. These records occur for several reasons including: external referrals, legacy clinical systems with no date of order fields (but date of test is collected), planned pre-admission and pre- return presentation tests that occur prior to the episode matching window and multiple Patient Master Index (PMI) accounts.

Table 4: Unlinked Activity

HHS	Unlinked Records	Percent Unlinked Records
Cairns & Hinterland	179,518	2.02%
Central QLD	153,393	2.83%
Central West	8,298	3.33%
Children's Health	12,577	9.15%
Darling Downs	34,180	11.72%
Gold Coast	30,989	5.41%
Mackay	42,154	0.89%
Metro North	201,333	0.84%
Metro South	132,131	0.60%
North West	44,061	3.25%
South West	52,180	7.20%
Sunshine Coast	153,912	1.50%
Torres Cape	121,316	11.53%
Townsville	163,642	2.01%
West Moreton	50,465	0.84%
Wide Bay	22,675	7.95%
State Total	***1,402,824***	***4.44%***

Virtual Patients

There are many situations where expenditure is attributed to a virtual patient record, these include:

- There are several defined business services and defined accounts that are considered out of scope for the NHCDC, these are, mapped to defined direct departments and are costed at service level using a virtual patient.
- Defined cost centres for Clinical Education and Research are mapped to defined direct departments and are costed at service level using virtual patients.
- COVID-19 response costs in defined cost centres, internal order numbers, accounts or material groups attributable to the NPCR SPHP, that are out of scope for NHCDC and for which there is no patient level feeder data, were mapped to defined direct departments and are costed at service level using virtual patients.

All virtual patient data is excluded from the NHCDC as no activity has been reported for these cost records.

Patient Travel

Patient travel costs in Queensland are significant but are not fully reflected in the NHCDC submission. This is due to the absence of patient level feeder data available for costing. Where patient level feeder data is not available, these services are costed against a virtual patient. The costs are reported against system-generated virtual patients and are excluded from the NHCDC.

During the 2019-2020 costing year a state-wide feeder system for patient retrieval services was implemented for those sites using the state-wide clinical costing system. This feeder system is associated with high cost retrieval services and long distance interfacility transfers. Total patient travel costs over the 2019-2020 fiscal year were less than the prior year due to the impact of COVID-19.

2.4 Challenges costing specific products

Mental Health

A two-step process is used to match the cost data to the activity data. Firstly, the cost data are matched to a package of care i.e. to records in the Mental Health Care Episode dataset, then to a phase of care i.e. to records in the Mental Health Care Phase level dataset, using the datetime stamp of the service record. Episodes without a phase record can arise due to several reasons including no clinical outcomes data recorded or not complete, or a combination of data quality and matching rules in the source data. These records are submitted to the Independent Hospital Pricing Authority (IHPA) at an episode level.

There are four dedicated Public Psychiatric Hospitals that are Block funded as 'Standalone hospitals providing specialist mental health services'. There was a significant difference in the submitted costs associated with these facilities between Rounds 23 and Round 24. In 2019-2020 two of these facilities had a significant component of their costs $47 million attached to virtual patients which are excluded from the NHCDC submission, a further $15 million was excluded as the cost record could not match to an activity record as they are yet to be discharged from the facility.

An issue has been identified with unlinked/ungroupable mental health episodes; 39 facilities reported 4,432 episodes equating to $123 million in expenditure that could not be linked.

Of these records, 37 per cent relate to community care units, step up step down facilities and balance in other community mental health services. The results show that a missing data element for location/setting and/or age for episodes recorded for these specific facility types. Further work will be undertaken with the data custodian to resolve these anomalies prior to the 2020-2021 NHCDC submission.

The remaining unlinked/ungroupable episodes (63 per cent) have been reported against acute hospitals. Of this cohort, 98 per cent of the records can be attributed to:

- Gold Coast University Hospital (43 per cent),
- Logan Hospital (9 per cent),
- Princess Alexandra Hospital (7 per cent),
- Nambour Hospital (16 per cent), and
- Royal Brisbane and Women's Hospital (22 per cent).

Further work will be undertaken with these sites to resolve the mapping anomalies prior to the 2020-2021 submission.

Palliative care phases

Palliative care patients are costed at the encounter level within the costing system. IHPA has requested phase level data be provided for palliative care where possible. The phase level information i.e. phase categories and phase date changes are in the activity data submitted to IHPA as part of the Admitted Patient Care National Minimum Data Set (APC NMDS). The episode level cost records are firstly linked to the APC and then costs are allocated to the phases based on date-of-service and the phase dates

Non-Admitted activity reporting and encounter costing

The counting rules for activity based funding (ABF) purposes involving multiple health care providers stipulates that irrespective of whether the patient was seen jointly or separately by multiple providers, only one non-admitted patient service event may be counted for a patient at a clinic on a given calendar day (noting that for counting purposes multidisciplinary group sessions with three or more practitioners are identified as such).

Sites using the new state-wide costing system have incorporated business rules as part of the episode matching process to align outputs with the counting rules. These sites do not require any rollup of outpatient

data. For the remaining sites the data is specific to the service and reports for each separate service event. To be consistent with the ABF counting rules the costs of patients with multiple clinic records on the same day are rolled up into a single clinic visit.

Organ Procurement

Queensland public hospitals that utilise the Hospital Based Corporate Information System (HBCIS) do not register patients as organ procurements. Organ procurement data is collected by DonateLife Queensland which is then submitted electronically and retrospectively added to the APC. This process had previously restricted Queensland from supplying organ procurement episodes in Rounds of the NHCDC, but has been resolved in 2019-20, however data was not extracted due to a mismatch between the costing record and the APC. This will be resolved for Round 25 submission.

2.5 Quality Assurance

Initial quality control is carried out at the HHS level, each HHS has its own quality assurance processes in place to assess the suitability of the data for inclusion in NHCDC. Once the HHS has finalised the costing for the period and data quality issues addressed, they agree to use, in the case of the state-wide system, or formally submit the data to the Department for collation into the NHCDC.

Further checks are then carried out regarding the internal consistency of the data and mapping of the data to the NHCDC costing framework which include:

- Orphaned cost and encounter records
- Unmapped departments
- Unmapped items
- Invalid/missing product codes
- Low cost encounters
- Negative costs
- Linking to activity data sets
- Date/time validations
- Validations on demographic information
- Validations on morbidity information

A financial reconciliation is undertaken, and the data transformed into the NHCDC data specification format. This information is provided to each HHS for confirmation of results prior to submission to the IHPA.

A five-year cost summary report is compiled which allows HHSs to compare their data with the consolidated Queensland results and with other HHSs, at various levels of aggregation, e.g. HSS, facility, product, cost bucket.

It has been identified that one HHS had not responded to the validation/confirmation process and data was subsequently submitted that should not have been included for Round 24.

Cost C Exclusions

The majority of exclusions prior to the final jurisdiction submission are associated with matching cost records to the activity records submitted to IHPA. This can be at phase level or episode level.

3. Adherence to National Costing Standards

Guidance for preparing cost data are published in the Queensland Clinical Costing Guidelines (QCCG). It is a supplementary document to the Australian Hospital Patient Costing Standards (AHPCS) and is a guide to the HHS costing teams in the application of the AHPCS within the technical environment of the feeder data and costing systems used within Queensland Health. These guidelines are applied by each HHS in the preparation of their costing data and therefore are compliant with AHPCS Version 4.0.

The IHPA and the Administrator of National Health Funding Pool are required to carry out a number of functions to implement the financial arrangements as specified in the NPA and in response, IHPA released the *COVID-19 Response Costing and pricing guidelines Version 0.4* which specifies IHPA's process for costing and pricing of activity for the duration of the NPA.

Survey documents received from HHSs indicate that due to significant changes to hospital activity, models of care, procurement of services and products, Queensland costing practitioners found accurately costing 2019-2020 extremely challenging however all sites ensured adherence with AHPCS Version 4.0 and the majority worked commendably towards compliance with the *COVID-19 Response Costing and pricing guidelines Version 0.4.* Specific information regarding the application and compliance with the *COVID-19 Response Costing and pricing guidelines Version 0.4* is included in section 2.2.

Queensland notes that the only area of non-compliance with the AHPCS Version 4.0 relates to the provision of organ procurement episodes however historically this issue was caused by system limitations which have been resolved with the implementation of the new state-wide clinical costing system, and the state will provide cost data for these episodes from NHCDC Round 25 (2020-2021).

4. Governance and use of cost data

4.1 Use of Cost Data

Within the Department, the consolidated patient costed data are used for a variety of purposes including:

- Health service planning
- Queensland funding models and localisations
- Research
- Benchmarking
- Informing the determination of appropriate funding levels for specified services, for example in business cases for change.

4.2 Contributions to jurisdictional and other national collections

As well as extensive use with the Department and HHSs, the data is provided to other national collections including subscription based external benchmarking organisations including Health Roundtable and Women's and Children's Healthcare Australasia.

4.3 Costing practice consistency

A governance process has been adopted to ensure decisions associated with costing are undertaken in a collaborative manner between the HHS and corporate units. This allows for ongoing benchmarking and variance analysis to occur, whilst maintaining a robust costing system with outputs that meet HHS, State and National reporting requirements. Central to this is the HHS Costing and Funding Network which meets once a month to discuss costing issues as they arise.

4.4 Review and approval

Queensland Health is required under the National Health Reform Agreement to provide an attestation as to the completeness and quality of the costing and activity data provided to the Commonwealth for the NHCDC. Specifically, a Statement of Assurance from jurisdictions (under Clause I40) and the Commonwealth (under Clause I41) will include commentary on:

- steps taken to promote completeness and accuracy of activity data (for example, audit tools or programs, third-party reviews, stakeholder engagement strategies).
- efforts applied to ensure the classification of activity was in accordance with the current year's standards, data plans and determinations.
- variations in activity volumes and movements between activity-based funding and block funding; and
- other information that may be relevant to users of the data, as determined by the signing officer.

To meet the requirement, a Statement of Assurance for NHCDC Round 24 (2019-2020), a Costing Survey spreadsheet which describes current clinical costing processes, feeder systems used by the HHS for

costing and any changes to costing methodologies since the previous collection is sent to HHSs. The Statement of Assurance has three components:

- HHS Reconciliation Summary
- Costing Methodology Questions
- Standards Compliance Questions

The survey is completed by the HHS Clinical Costing Manager, endorsed by the Chief Finance Officer. Then a financial reconciliation is undertaken. All data is validated by the Department and the HHS prior to submission to the IHPA.

Declaration

In a year when twelve Hospital and Health Services (HHSs) implemented a new costing system as well as significantly updating patient intermediate products and relative value units, the results of the 2019-2020 National Hospital Cost Data Collection (NHCDC) submission has proven to be on a best-efforts basis for those sites. Whilst not ideal, given the challenges arising with the costing for COVID-19, this investment will enable Queensland to refine costing processes and improve the accuracy of costing results.

Data provided by Queensland Health to Round 24 (2019-2020) of the NHCDC submitted to the Independent Hospital Pricing Authority has been prepared in adherence with the Australian Hospital Patient Costing Standards (AHPCS) Version 4.0 and the state has worked on a best efforts compliance with the *COVID-19 Response Costing and pricing guidelines Version 0.4,* as described in Section 3 of this statement, noting the issues identified.

Section 3 provides details of any qualifications to our adherence to the AHPCS Version 4.0 and the *COVID-19 Response Costing and pricing guidelines Version 0.4*.

Assurance is given that to the best of my knowledge the data provided meets the requirements of the NHCDC as best as possible considering the constraints and challenges outlined in this statement.

Signed:

Nick Steele
Deputy Director-General
Healthcare Purchasing and System Performance

Patient costing for COVID

The following is a high level summary of the approach proposed by Townsville HHS to apply the COVID-19 (COVID) response costing and pricing guidelines in 2019-20.

IHPA's guidelines anticipate having two distinct costing periods – BAU and COVID-19 response. While it was possible to define these periods operationally, it was not possible from a general ledger and costing activities perspective to "split" the costing years. Therefore all patient costing has been performed on a full year to date basis.

The impact of this is twofold: patients who had COVID-19 (or were tested for it) and were treated during the COVID-19 period are at the base level, not costed any differently from non-COVID patients. The exception being a COVID surcharge applied to their records. Secondly, standby or unutilised capacity is not factored into the costing. This means that BAU patients (for example elective surgery patients) who were treated during the COVID-19 period when most surgeries were suspended, will not appear any more expensive than those treated in the BAU period. In effect, the cost of unutilised capacity has been distributed across all patients during the year.

Cost centre and general ledger adjustments

Townsville HHS did not capture COVID expenditure in separate cost centres but used an Internal Order Number (ION) to track spend.

As a result, several journals were required to adjust the cost ledger to draw additional COVID spend from home cost centres to COVID cost centres.
For the rest of this document COVID expenditure refers to the *additional incremental expenditure* as acquitted through the service agreement process. COVID expenditure does not include estimates for latent capacity or costs not funded through the NPA.

The HHS submitted a final claim of $4.29m for COVID funding in 2019-20. A breakdown of the expenditure types is below.

Sytem response	Category	Category
Public Health - Comm, Media, Advert	Communication, media and advertising	State Public Health Payment
Disaster Management	The operation of the Health Emergency Operating Centre (HEOC)	State Public Health Payment
Community Screening	Community screening support utilising 13Health, contact tracing and airport screening	State Public Health Payment
Community Quarantine	The cost of transport and compensation for quarantined patients incl. bio-security zones	State Public Health Payment
Public Hospital Care - ED, ICU, Wards	Care of COVID-19 patients in ED, ICU, medical wards or outpatient clinics	Hospital services payment
Public Hospital Care - Fever Clinic	Establishment and operation of fever clinics	Hospital services payment
Public Hospital Care - Alternatives	Hospital alternatives (i.e. HITH, Medi-hotels, virtual clinical consults)	Hospital services payment
Clinical Support costs - Essential Equipment	Essential equipment (e.g. PPE)	State Public Health Payment
System Support - Data & IT systems	Data & IT systems	State Public Health Payment
System Support - HHS governance support	HHS governance support	State Public Health Payment
Workforce Mgt - Staff redeployment	Staff redeployment where backfilled	Hospital services payment
Total expenditure		reconcile to service agreement & ION
Pathology	Additional testing, diagnostics	Hospital services payment
Capital reimbursed		
Capital reimbursed - capitalised B/Sheet	Capital reimbursed outside HSP - capitalised B/Sheet	no action, not embedded in 2019-20 expenditure
Capital reimbursed - expensed in cc 350004	Capital reimbursed outside HSP - expensed in cc 350004	State Public Health Payment
Capital reimbursed - expensed in cc 350004 bu	Capital reimbursed outside HSP - expensed in cc 350004 but excluded cost type	Out of scope
RASS funding		remain in home cost centres
RASS clawback		remain in home cost centres

Some items of note:

- Hospital services payments were identified in the EOFY template submitted to Finance Branch, however in the Service Agreement the expenditure funding is all assigned as State Public Health Payment.
- Pathology expenditure actuals and accrual were in the 2019-20 general ledger but not captured against the Internal Order Number and not submitted for funding 2019-20. These were all claimed in 2020-21. Because the actual spend is in the general ledger for 2019-20, pathology has been included in the COVID costing process even though the funding under NPA was not received until 2020-21.
- RASS funding was provided and clawed back to a net impact of $116k. These costs remain in their home cost centre.

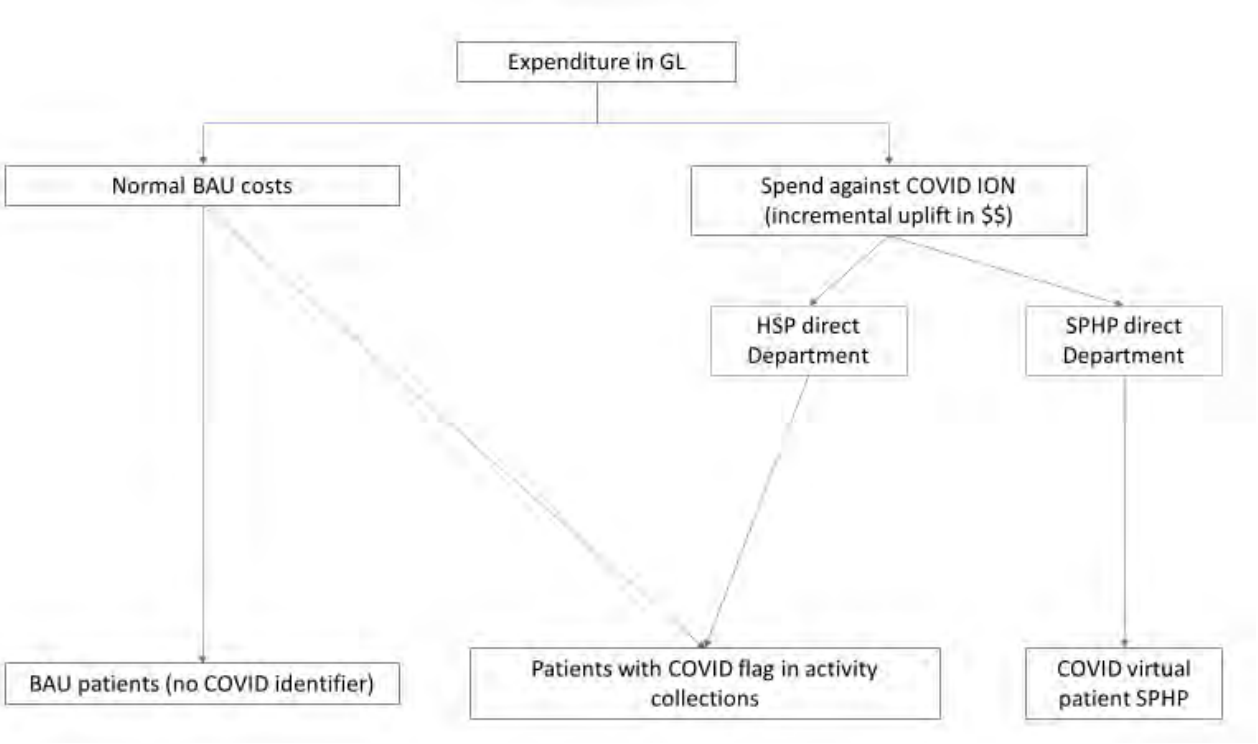
As per the categories above, costs have been journaled out of home cost centres and against one of two new cost centres established in the cost ledger, according to their allocation in the table above:

Cost Centre	Description	Department
35COVID-SPHP	HHS-COVID SPHP EXPENDITURE	90364_GMD.COV_HHS.COVIDSPHP - COVID 19 STATE PUBLIC HEALTH PAYMENT COSTS (THHS)
35COVID-HSP	HHS-COVID HSP EXPENDITURE	90364_GMD.COV_HHS.COVIDHSP - COVID 19 HOSPITAL SERVICES PAYMENT COSTS (THHS)

The reason for doing this is to differentiate the treatment of State Public Health Payments (SPHP) vs Hospital Services Payment (HSP) expenditure through the costing system.

Products and feeder keys

The intent is that all patients (COVID or otherwise) will be costed as per normal processes, with a COVID surcharge applied to specifically identified patients drawing on costs from the HSP Department. Costs in the SPHP Department will be mapped to a Virtual Patient.



BAU patients with no COVID identifier are costed normally using existing feeder keys and products.

COVID patients attract two elements of expenditure:

1) Normal BAU patient costing from relevant Departments
2) A differentiated COVID surcharge (derived only from Hospital Services Payment expenditure) spread over all admitted, non admitted and emergency patients.

All SPHP expenditure is directed to a virtual patient.

The primary reason for this approach is that there is a blend of COVID-identifiable feeder data.

Feeder	Feeder keys / products	Comment
HQI / inpatients	Ward, doctor unit, bedday TTCW (temp capacity) HOMECO (COVID HITH) & other wards	Not all patients were confined to the TTCW and HOMECO wards. Furthermore the TTCW ward was used for other purposes before the COVID period. Not possible to differentiate the products.
EDIS/Firstnet	Presentations URG/UDG & triage count	No way to differentiate patients with or suspected of having COVID in these products
Auslab	Lab test code	COVID test can be identified
ESM / QNAP	CCC	COVID fever clinic appointments can be identified

As a result, a blended approach has been used to map products to the COVID HSP Department:

Source	Approach
IP	Manually created COVID feeder using all IP admissions identified with COVID flag in GEN-WAU
ED	Manually created COVID feeder using all ED presentations identified with COVID flag in GEN-WAU
QNAP	Specific CCC (376) products mapped to COVID HSP department using QNAP feeder
ESM	Products sent to xProd
Auslab	Specific pathology tests (NCVPCR) remapped from home Pathology Departments to the COVID HSP department against account Pathology and cost type Path
All other	All other feeders linked to patients as part of normal costing processes (eg QRIS, ipharmacy etc)

As a result, inpatient and ED presentations will receive an element of BAU cost and then a COVID surcharge applied, with any linked pathology also. Outpatient attendances to COVID clinic attract only the COVID surcharge reflective of no other BAU cost being used for that service.

The COVID surcharge derived from the HSP department has been differentially applied based on local information, to differentiate between the estimated costs of COVID services run by the HHS, namely:

- COVID testing in ED
- COVID clinic screening and testing in non-admitted outpatients
- Inpatients treated with suspected or actual COVID, and inpatients simply tested for COVID during their stay

Facilities expenditure will be differentiated through the patient identifier; the HHS has not separated COVID expenditure by facility but taken a whole of HHS approach.

Townsville HHS treated 23 patients with COVID during 2019-20. A remaining 9,801 episodes were COVID-related (be it an ED presentation, OP service event, IP admission with a test, or an unlinked Auslab test).