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James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
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Attention: Julia Hume

Dear Mr Downie

Subject: Independent Financial Review of the National Hospital Cost Data Collection

On 30 June 2021, I wrote to you providing Tasmania's data quality statement to accompany Tasmania's National Hospital Cost Data Collection (NHCDC) for the Round 24.

It has since been identified that there were duplicates records in Tasmanian mental health phase of care cost data and the cost data has been revised back to the Episode level.

Please find an updated data quality statement to reflect this change.

Yours sincerely

Ross Smith
Deputy Secretary, Policy, Purchasing, Performance and Reform

20 August 2021

Data Quality Statement for TASMANIA

NHCDC Round 24

1. Overview of costing environment

The Department of Health (DOH), Clinical Costing Unit provides an annual cost study on behalf of the Tasmanian Health Service (THS). The output of the costing study is provided to the THS to support their internal cost management strategies.

The costing process in Tasmania is an annual process and requires the clinical costing team to conduct consultations with hospital business managers and unit managers to discuss the costing methodology and utilisation requirement for the cost study.

The Department utilises the clinical costing software Usercost. The current contract will expire on 30 June 2022. The Department is currently prioritising resources to support the procurement process for the costing software and to support business improvement processes to support this.

2. Submitted cost data

The 2019-20, Round 24 National Hospital Cost Data Collection (NHCDC) submitted data covered 24 public hospitals, consisting of 4 major hospitals, 18 rural hospitals and a state-wide mental health service. Each hospital provides health services to the community in admitted and non-admitted setting (Acute, Sub-acute, Emergency and Non acute, Mental Health facility based on outpatient clinics and community-based health, Residential Aged care and Home and Community support services).

To ensure consistency with the national approach, July 1, 2019 saw Tasmania adopt an admission policy where a patient treated solely within the Emergency Department are not considered an admitted patient and the admission could not commence until the patient had left the Emergency Department.

2019-20 saw the inclusion of the Forensic Mental Unit of Wilfred Lopez Centre as part of the state-wide mental health service.

Due to Covid-19 outbreak in Burnie, the North West Regional Hospital (NWRH) which included the contracted maternity service provider the North West Private Hospital and the NWRH facilities were closed for a deep clean. All staff were required to go into quarantine for two weeks. Admitted patients from the NWRH were sent to the Mersey Community Hospital (MCH), but a "limited" few patients were sent to other hospitals in the state. The Australian Defence Force (ADF) and an Australian Medical Assistance Team (AUSMAT) were enlisted to ensure that the Emergency Department at the NWRH remained open, providing essential health services. This included ADF medical doctors, emergency nurses, a pharmacist, a radiographer, an environmental health officer and a small group of general support personnel.

The MCH was also affected and required a period of service disruption as the Emergency Department was closed for a deep clean. To assist in the recovery of service on the North West coast the Mersey Community Hospital Reset Plan included reopening the Emergency Department with the restricted opening hours of 08:00 to 22:00 on May 31, 2020.

To account for the impact of COVID-19 costs and utilisation, the Round 24 study was segregated in to two sections, the first being July 1 2019 to 28th February 2020 (pre COVID-19) and the second being March 1 2020 to June 30, 2020 (COVID-19). The costing team utilized the IHPA COVID-19 Response Costing and pricing guidelines when costing the COVID-19 period.

Pathology diagnostic data was used to identify and weight the utilization and patient. If a pathology diagnostic was a positive result, the costing transformation activity process identified the patient as a COVID-19 patient.

This year's study with the hospitals identified the following in relation to COVID-19:

- Emergency Department location information could identify "hot" or COVID-19 unit and these areas were weighted to account for the high staffing and high PPE usages that were required to treat patients suspected or diagnosed as having COVID-19. For example, ED confirmed COVID-19 cases receive a weighting of 4 and suspected cases a weighting of 3 on the time based RVU.
- Designated COVID-19 wards did not require uplifting of the RVU as cost and utilization within these areas were appropriate.
- Imaging staff had to have a higher than normal level of PPE usage if a patient came through the "hot" unit of the ED or were suspected of being COVID-19 positive. They received an extra weighting.
- Due to the number of staff and increased use of PPE for protocols dedicated for COVID-19, wards were not weighted or altered.

The National Partnership on COVID-19 Response (NPCR) payments were excluded from the COVID-19 costing study. A non-patient product was created to align with the "State Public Health Payment" (SPHP) codes. Expenditure was then adjusted into these "dummy" cost centres to exclude it from the NHCDC data submission.

It is important to note that the internal financial reporting structure is not the same as is required for the NHCDC so allocation method is designed to allocate to the nationally reporting structure.

Current contractual arrangements with health service providers have not identified all expenditure to patients, this is difficult to quantify. The effect of the purchase of service for Compensable and Private patient as services or products are at times directly claimed by the vendor from the insurer or patient. This effects radiology, pathology and some Medical and costs in general at the contracted rural facilities (including Medical expenditure).

Activity and Utilization products are in the Health Central database prior to transformation and integration into the clinic costing system.

Consistent with prior years, Teacher Training and Research was not included as part of the 2019-20 NHCDC Round 24 submission.

Tasmania has concentrated on the following areas in the round 24 NHCDC submission, these are:

- Intermediate Products – Imaging, Pathology and Pharmacy data are linked according to the Tasmanian data matching rules, utilisation that is not able to be matched to an episode is assigned to an unlinked episode and excluded from the data submission. These rules are

- One day before and 14 days after for Pathology, Imaging, and Blood
- One day before and 7 days after for Pharmacy
- Mental Health – Admitted Mental Health was submitted for the Round 24 NHCDC at the episode of care level for both Admitted hospital and Community.
- Blood Products – Tasmania reported the blood costs that could be matched in an episode of care. Blood supplied to private hospitals, blood wastage or unmated utilisation was excluded from the data submission.
- Work in Progress – Episodes in WIP has been adjusted accordingly for Round 24 NHCDC.

3. Adherence to the Australian Hospital Patient Costing Standards

Tasmania continues to make best efforts to adhere to the AHPCS Version 4.0. Areas where Tasmania is transitioning to the AHPCS compliance are as follows:

- Third Party Expenses (AHPCS 1.2.1.1.) due to contractual arrangements with external suppliers of pathology and radiology services as well as public hospital facilities, expenditure incurred is providing public hospital services to private and compensable patient is not always charged to the public hospital as it claimed directly from the Compensable Insurer or Patient, Medical Benefits Schedule and private health insurers. An estimate provided by the pathology vendor was used to allocate cost to the private patient at the Mersey and North West Regional Hospital. However, it needs to be noted that there are occurrences were cost for public hospital patients are being allocated to all patients regardless of funding sources which will dampening down cost item within these sites. In Round 24 rural facilities were cost data is not available for private or compensable patient the activity associated has not been submitted to reduce the distortion that it would create.
- Data Quality Framework (AHPCS 6.1.1.3.3 and 6.1.3.5). The Tasmanian Data Quality Framework has minimal independent testing and minimal external. Costing data is not formally audited by an independent body.
- Teaching and Training costs (CG4.1, CG4.2, CG4.3). Tasmania's approach to teaching and training costs includes identifiable expenditure and a percentage-based allocation.
- Allocation of Medical costs for private and public patients (Business rule 1.1A) The Tasmanian Costs study includes the known expenditure reported in the Private Practice scheme and all Hospital Medical expenditure. The Tasmanian costing process treat the allocation of cost the same regardless of Patient election

4. Governance and use of cost data

The NHCDC submission has generally been used to meet national reporting requirements and has been little used to inform or help better understand clinical and service costs in the THS. In addition, the knowledge that is gained during the data capture, transformation and validations phases is not widely disseminated or used to inform the development of budget initiatives or the agencies budgeting process.

The annual clinical costing process draws on a number of information systems across the Department and collates data according to the NHCDC data standards onto a Departmental SQL database. From here, Usercost has been used to bring together activity and finance information, the critical component of the current software being the distribution of overhead costs.

New clinical costing software should deliver more than the NHCDC report but also build capability and capacity in the Department and the THS.

Data was reviewed over the submission period by the Department's Clinical Costing Unit and relevant THS staff. The Clinical Costing Unit conducts data quality checks of all data to identify any missing, incomplete or inaccurate data and take appropriate action to have data reviewed and corrected as required checking process reviews:

- Cost variation at the episodes level
- Cost variation at the product end class level (DRG, Tier 2 and URG) between study years
- Cost bucket variation between local bucket cost and national buckets. Compares current year to the prior year's cost bucket.
- Volume analysis to ensure RVU values are as expected.
- Palliative Care costing, in particular phases of care level costing rather than costing episodes of care.

Declaration

All data provided by *Tasmania* to Round 24 (2019-20) of the National Hospital Cost Data Collection (NHCDC) submitted to the Independent Hospital Pricing Authority has been prepared to the best of our ability to adherence with the Australian Hospital Patient Costing Standards (AHPCS) Version 4.0 as described in Section 3 of this statement.

Data provided to this submission has been reviewed and is complete and free of known material errors.

Section 3 provides details of any qualifications to our adherence to the AHPCS Version 4.0.

Assurance is given that to the best of my knowledge the data provided are suitable to be used for the primary purpose of the NHCDC, which includes development of the National Efficient Price.

Signed:

Ross Smith

Deputy Secretary, PPPR