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BAC-CO-34823

Professor Michael Pervan
Chief Executive Officer
Independent Health and Aged Care Pricing Authority
PO Box 483
DARLINGHURST NSW 1300

Dear Professor Pervan

Thank you for your letter dated 20 March 2023 addressed to the Secretary, Professor Euan M Wallace AM, regarding the data quality statement for the Round 26 National Hospital Cost Data Collection. As the matter you raise falls within my portfolio your letter has been referred to me for my consideration and response.

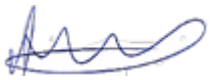
Victoria's submission to the 2021-22 Round 26 National Hospital Cost Data Collection (NHCDC) has been finalised in accordance with your three-year data plan. Please find Victoria's completed Data Quality Statement (DQS) attached.

Victoria recognises the opportunities to work collaboratively with IHACPA to improve the quality of the cost data and identify areas requiring development. Victoria has been committed to improving the costed results in accordance with the Australian Hospital Patient Costing Standards (AHPCS) where possible. We note the decision to not undertake an independent financial review, and to use the data and reports submitted to understand the quality of the NHCDC. Victoria is committed to ensuring the quality of the data and nominates Joanne Siviloglou, Manager, Modelling and Costing as our representative.

VICTORIA State Government

If you have queries regarding this advice, please contact Joanne Siviloglou on (03) 9668 7377 or email Joanne.Siviloglou@health.vic.gov.au.

Yours sincerely



Andrew Haywood
Executive Director,
Funding Policy, Accountability and Data Insights
Commissioning and System Improvement Division

01 / 05 / 2023

VICTORIAN DATA QUALITY STATEMENT

ROUND 26 (2021-22) NATIONAL HOSPITAL COST DATA COLLECTION

OFFICIAL

All data provided by Victoria to the 2021-22 National Hospital Cost Data Collection (NHCDC) has been prepared in accordance with the Independent Health and Aged Care Pricing Authority's Three-Year Data Plan 2021–22 to 2023–24, Data Compliance Policy June 2021, and the Australian Hospital Patient Costing Standards (AHPCS) Version 4.1.

Best endeavours were undertaken to ensure complete and factual reporting and compliance. Data provided in this submission has been reviewed for adherence to the AHPCS Version 4.1 and is complete and free of known material errors.

Section 3 provides details of any qualifications to Victoria's adherence to the AHPCS Version 4.1.

1 Governance processes and results

1.1 Governance arrangement

The individual public Local Health Networks (LHN) undertake patient costing and subsequently submit to the Victorian Department of Health (the department) via the Victorian Cost Data Collection (VCDC).

Victorian public hospitals are required to report costs for all activity, regardless of funding source, and are expected to maintain patient level costing systems that monitor service provision to patients and determine accurate patient-level costs.

Generally costing is undertaken once a year however some (few) LHNs do cost either quarterly or six monthly. The VCDC submission to the department is yearly.

1.1.1 Changes to costing or activity recording practices

The VCDC submission process is reviewed yearly to ensure that the data submitted meets the local and national requirements. Health service costing practitioners also undertake reviews, in conjunction with relevant stakeholders, to ensure the underlying details are reflective of the services and the costs of those services are reasonable.

Some main improvements include review of the costing General Ledger (GL) structures, continuous improvements with activity extraction methodologies, ongoing data quality and refinement, internal validation reports before submissions, implementing new feeder systems not easily accessible, improving linking, implementation of Electronic Medical Record systems, refinement on allocated costs at staff level and continued work to reduce the amount of unlinked activity.

1.1.2 Process for review and approval before submission to NHCDC

The VCDC submission involves a five-phase process to ensure the data submitted meets the reporting requirements and adherence to any guidance provided. The five phases include:

Phase 1 - receipt of submission. Acknowledgment of receipt of files and a summary report of the details submitted for verification.

Phase 2 - file validations. The submissions must follow the Data Request Specifications and where validations of each field have identified critical errors, these must be rectified by the health service and resubmitted.

Phase 3 - linking/matching VCDC to activity. The VCDC follows a single submission multiple use format where the collections include a few fields that will enable the cost data to be linked and matched to activity records already submitted. Reports on the level of linking/matching are provided to LHN for confirmation.

Phase 4 - data quality assurance checks. A suite of reports is provided to LHN where records have been flagged as not meeting specific criteria around various cohorts. The checks provide a level of understanding of the usefulness of the patient level data for development of funding models and interpretation for analysis, benchmarking and reporting. They compare the data submitted for the current year to prior years and to a state/national average where specified. It takes into consideration the total costs as well as specific cost bucket costs.

Phase 5 - reconciliation report and Data Quality Statement:

> Reconciliation report - designed to assist the department (and users) to understand the completeness of a final submission including the source data by which the VCDC is created and its reconciliation.
>
> Data Quality Statement (DQS) - LHN complete a DQS where a signed declaration confirming adherence to the national and local requirements including the standards and acknowledging the validity and completeness of the data submitted.

Once the final VCDC has been consolidated, the submission to the NHCDC is developed by the department ensuring that the reporting requirements are met in terms of the final cost centres, line items and activity reported. The NHCDC submission is reconciled to the VCDC, and a brief prepared for sign off by the Secretary or their delegate for the NHCDC data quality statement.

The NHCDC submission through the portal is also reconciled and any file validations are rectified. The quality assurance reports are reviewed and checked for inconsistencies not already known.

1.1.3 Consistency and standardisation of costing practices

Victorian public LHN costing practices are consistent in their methodologies. Victoria's LHN follow guidance provided by the department which takes into consideration feedback after consultation with relevant stakeholders and costing practitioners.

1.1.3.1 Guidelines

To ensure there is consistent, reliable, and quality costed data, LHN are to adhere to VCDC documentation, and any other documentation or guidance provided by the department as well as comply with the national Australian Hospital Patient Costing Standards (AHPCS) Version 4.1 or the most recent version available.

The VCDC documentation assists LHN in the reporting and costing of patient level cost data providing details in relation to:

- Data Request Specifications – details of the requirements of the files to be submitted including the structure, values, and validation rules.
- Business Rules – guidance of specific criteria and conditions of the reporting and costing requirements to the Victorian Cost Data Collection.
- Specific Costing Guidance – guidance on specific conditions of areas for the reporting and costing requirements to Victorian Cost Data Collection.

- Review and reconcile – details of the data quality assurance checks and reconciliation reporting requirements
- Communication – notifications at each stage of the submission process.

1.2 Summary of 2021-22 results

1.2.1 Number of hospitals

In Victoria there are two different costing vendors used – PowerHealth Solutions and cbs – Business Intelligence Specialist covering 40 LHNs and 89 campuses submitted to the NHCDC. This is an increase of nine LHNs (mainly regional) from the Round 25 NHCDC submission. They are:

- Western District Health Service - Penshurst
- Barwon Health North
- Southwest Healthcare - Camperdown
- Djerriwarrh Health Service - Bacchus Marsh
- Maryborough District Health Service (Dunolly)
- Echuca Regional Health
- Caritas Christi Hospice
- Djerriwarrh Health Services - Melton Health
- Thomas Embling Hospital

Increases in data submitted to the NHCDC include:

- six regional LHN for non-admitted service events,
- nine LHN (mix of regional and major) for mental health phase of care and episodic data
- one regional health service for palliative care phase of care
- one service for acute admitted.

1.2.2 General ledger costs included/excluded

All expenses within the general ledgers of LHN have been used in the allocation to patient treatments. Expenses excluded mainly consist of specific purpose accounts not relating to the provision of treatment, capital and depreciation expenses as well as other expenses not used in providing treatment to patients. Included expenses are for the National Blood Allocation, Health Purchasing Victoria costs not in the GL.

Costs excluded to the NHCDC are those that have been allocated to patients not yet discharged, specific COVID activities where costs are sought via the State Public Health payment, out of scope programs not related to Activity Based Funding and any unlinked costs reported to VCDC.

There is a minor reconciliation variance identified to the extent of 0.18% between the GL expenses and the NHCDC submission. This is contained within a handful of LHNs, and we are currently investigating the cause of these variations, however as this is a minor variance, we do not expect it to impact the overall costs for Victoria.

1.2.3 Activity count compared to previous year

Overall, activity for Victoria has increased 7.1%, however the majority of the increase is due to more community mental health activities being reported at a phase of care level.

1.2.4 Explanations of significant cost movements from previous year

There has been an increase in the number of LHNs submitting more costed records associated with community mental phase of care. This cost increase (98%) is in line with the increase in activities (87%) as in the table below.

		Total (In scope for NHCDC) 2021-22			Total (In scope for NHCDC) 2020-21			% Change	
Stream		**Records**	**Cost**	**Average**	**Records**	**Cost**	**Average**	**Activity**	**Cost**
Acute		1,682,454	9,377,982,680	5,574	1,659,309	8,651,638,307	5,214	1.4%	8.4%
Subacute	*Episodes*	30,347	798,255,327	26,304	30,788	718,971,199	23,352	-1.4%	11.0%
	Phases	15,741	120,004,220	7,624	14,969	109,487,343	7,314	5.2%	9.6%
Emergency Department		1,817,818	1,671,395,531	919	1,704,061	1,441,071,115	846	6.7%	16.0%
Non-Admitted		5,423,425	2,052,194,931	378	5,038,904	1,845,232,431	366	7.6%	11.2%
Admitted Mental Health	*Episodes*	476	64,799,859	136,134	449	63,888,948	142,292	6.0%	1.4%
	Phases	25,512	600,145,269	23,524	26,473	576,215,162	21,766	-3.6%	4.2%
Community Mental Health	*Episodes*	205,348	48,962,901	238	205,750	44,542,587	216	-0.2%	9.9%
	Phases	223,996	532,995,090	2,379	119,841	269,560,444	2,249	86.9%	97.7%
Unlinked Mental Health	*Episodes*	-	-	-	-	-	-		
	Phases	-	-	-	-	-	-		
Other	*Episodes*	111	1,873,966	16,883	120	1,864,995	15,542	-7.5%	0.5%
	Phases	-	-	-	-	-	-		
Total		**9,425,228**	**15,268,609,774**	**1,620**	**8,800,664**	**13,722,472,532**	**1,559**	**7.1%**	**11.3%**

In addition to this, improvements in allocation of costs and costs associated with COVID activities deemed out of scope in the prior year, as identified in Victoria's COVID guidelines, have been included and allocated to patients. Most of these increases relate to the emergency (16.0%) and non-admitted (11.2%) settings.

1.3 Compliance to the Australian Hospital Patient Costing Standards (AHPCS)

The Victorian submission to the Round 26 (2021-22) National Hospital Cost Data Collection (NHCDC) is based on the 2021-22 VCDC submissions.

The business rules for the VCDC collection are released to costing practitioners and provides guidance to LHNs in the costing and reporting of patient level cost data to the VCDC.

Victorian LHN are required to adhere, where possible, to the Australian Hospital Patient Costing Standards (AHPCS) – version 4.1 (or the most recent version in the instance that a successor becomes available), the VCDC business rules and specifications and any other guidance provided by the department in the submission year.

All relevant expenses are identified and included in the NHCDC submission (AHPCS; Stage 1: identify relevant expenses, Stage 2: create cost ledger, Stage 3: create final cost centres).

All hospital activity been identified and included in the costing process (AHPCS Stage 4: identify products).

Costs have been allocated to patients in accordance with allocation methodologies outlined in the AHPCS (Stage 5: assign expenses to products) and VCDC documentation.

The process for reconciling cost and activity data (AHPCS Stage 6: review and reconcile) is outlined in section 1.1.3.

1.3.1 Exceptions

1.3.1.1 Exceptions to the AHPCS standards include the following:

Capital and Depreciation - Victoria does not include non-cash expenditures such as depreciation as it does not impact upon operational costs and comparisons should not be driven by an asset's estimated life.

Teaching and Training costs - where the sole purpose of the activity is teaching, and training Victoria includes these costs as an overhead. Where teaching and training cannot be separated from routine work undertaken, it has been included as a salary and wages expense.

Research costs - these activities and costs are excluded from Victoria's submission pending further developments in the Activity Based Funding work stream.

Posthumous organ donation – the application of this standard is being considered by Victorian however extensive updates to the development of the specific guidance in V4.1 of the AHPCS is required to ensure full costing of posthumous organ donations.

1.3.1.2 Transitioning to AHPCS standards for:

Allocation of medical costs for private and public patients - Victorian LHN will allocate medical expenses only relating to private patients where these can be distinguished between medical expenses relating to public. Otherwise, all medical expenses are allocated to patients regardless of funding source.

- The department is currently working with LHN to determine their capability to comply with this standard as outlined in V4.1. However, Victoria will be reliant on further development of the V4 to the AHPCS to provide clarification and specific guidance on this standards application.

1.3.1.3 Specific areas

All prior year costs relating to patients discharged within the submission year but admitted in prior years have been included and no escalation of costs have been applied.

Blood product costs have been included as a line item in the submission as has the separation of Pharmaceutical Benefits Scheme (PBS) and Non-Pharmaceutical Benefits Scheme (PBS) drugs.

Medical costs associated with private patients have been included in the submission however Eastern Health is the only health service to exclude private patient medical costs for their non-admitted services only.

1.3.1.4 Ancillary costs for private patients

Most of the Victorian LHN include ancillary costs for private patients in their NHCDC submission except for:

- Northern Health (Private patient pathology and radiology costs are excluded from the VCDC)
- Barwon Health (Private patient pathology costs are excluded from the VCDC)
- Ballarat Health (Private patient pathology and radiology costs are excluded from the VCDC)
- Peninsula Health (Private patient pathology costs are excluded from the VCDC)
- Western Health (Private patient pathology costs are excluded from the VCDC)
- Alfred Health Caulfield Campus (Private patient radiology costs are excluded from the VCDC)

2 Other relevant information

2.1 Impact of COVID-19 on the 2021-22 submission

The impact of COVID-19 since 2020 has provided some challenges with data collection, accounting for expenses and costing. To the best of our knowledge, our LHN have adhered to the guidance and advice

provided by the department and the Commonwealth in respect to the treatment of activities and costs related to the impact of COVID-19.

Data collection for COVID-19 on activity and expenses has continued to be a challenge to costing teams. Costing practitioners have undertaken best endeavours to reconcile the GL to the departmental COVID expense template.

Major LHN continue to update and utilise a COVID-19 Pandemic Plan by site to meet patient demand and the requirements set out by the Victorian Government.

As in the prior year submission:

- Staff who are rostered for direct COVID services are paid from respective COVID-19 cost centres.
- Cost of consumables and services which are purchased higher than normal stock levels or higher consumption to prepare for the COVID-19 responses are also included in these cost centres.
- COVID-19 medical units and wards are established to admit and provide care to confirmed or suspected COVID-19 patients. Patients who are admitted to these wards/ICU and/or seen by the COVID-19 Medical teams are allocated with costs from the respective COVID-19 cost centres.
- Costs relating to implementation of COVID-19 safe practices throughout the health service are reported in aggregated dummy episode.
- Wards were re-commission to and decommission from COVID-19 designated wards according to the bed demand. Some wards were also converted to hybrid wards where the wards were divided into two separate zones -the acute care zone will usually provide acute care for General Medicine patients with standard precautions, whereas the isolation zone will admit suspected and confirmed COVID-19 patients and will operate in full personal protective equipment.
- Elective Surgery was interrupted and/or cancelled during the year, which impact the cost of remaining operations in the theatres and procedure rooms.
- A coordinated Pandemic Code Brown was implemented across all Victorian public metropolitan and major regional hospitals in January 2022.
- COVID-19 Positive Pathway team was expanded during the year to meet increasing demand during outbreak of Delta and Omicron variants.
    - Primary care response testing facilities and vaccination clinics for staff and community
    - Greater utilisation of teleLHN

Due to the rapid changes in demand requiring scaling up and down of service capacity inclusive of inpatient, community and testing services, there may have been delays and/or impacts on capturing the activity data.

To ensure that all admitted activities associated to COVID-19 outbreak are accurately coded and identifiable, audits are conducted with HIS team on Coding, Pathology, Admission and Ward Transfer data. Patients who had COVID-19 Screening Pathology tests linked, or seen by COVID-19

Medical team and/or admitted to COVID-19 wards are checked for COVID-19 Emergency codes. Episodes which were coded with COVID-19 Emergency codes but do not meet IHACPA coding rules on COVID-19 classification are also reviewed.

Continued challenges with COVID-19 demanding agile operations such as creation and cessation of services, relocation and redeployment of existing work forces, recruitment of or outsource to additional work forces, and adoption of new data recording practices etc. To certain extent, these have caused variances and inconsistencies in data quality.

2.1.1.1 Non-admitted services

Victoria allocates a cost to all non-admitted activity whether at a patient level or aggregate level. We have submitted all cost records that have been able to link to a non-admitted activity record as well as provided cost records for those not linkable to activities due to under reporting and aggregate activities.

The records submitted to the VCDC at a patient level (or contact) may have been aggregated to a service event for submission to the NHCDC. Our reconciliations will be at a patient level.

Our LHNs review allocations and methodologies yearly to ensure that the resources are costed reasonably and accurately as possible. These reviews will vary results from year to year indicating improvement in the costed data.

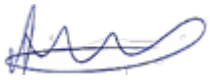
2.2 Other significant factors and challenges that impacted the 2021-22 NHCDC submission

- Higher demand of emergency services, especially towards the last Quarter of FY20/21.
- Impact of staff turnover across the organisation also impacts the quality of costing with smaller regional LHN.
- Higher employee costs due to several Enterprise Agreements registered through the year and the cost of staffing to manage COVID-19 (including furloughing of staff and coverage for staff shortages due to illness).
- Amalgamation of smaller rural LHN where:
    - several feeder systems do not record UR numbers or record UR numbers as a free text
    - clinics registration details can also be outdated
    - matching ancillary services to the correct patient episodes.
- Mental Health admitted activity has identified data entry issues at the source which are being investigated and addressed for next year.
- Considerable work has been undertaken to ensure non-admitted activities are captured and aligned with expenses. Some data entry issues have been identified at the source which are being investigated and address for next year.
- Some issues with the underlying patient activities for specific programs or state-wide services meant that the costs were allocated to virtual patients rather than at patient level.

3 NHCDC declaration

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

Signed:



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