Queensland Government
Queensland Health

Elective Surgery Business Rules 2003/04

Surgical Access Service

Waiting List Reduction Strategy

Endorsement by Zonal Managers

This document has been developed in consultation with the Zonal Management Units, and endorsed for approval by the General Manager (Health Services).

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..... Date 29 / 10 / 2003

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TABLE of CONTENTS

PURPOSE OF BUSINESS RULES

The Elective Surgery Business Rules (ESBR) have been developed to specify the conventions associated with gaining access to additional elective surgery funding, the allocation of surgical targets and the reporting requirements of Queensland Health. The ESBR additionally specify the timetable of events for payments for surgical activity and the roles and responsibilities of the parties involved.

INTENT OF THE SURGICAL ACCESS PROGRAM

Surgical Access funding is to be used to increase elective surgery throughput.

The intent of the Government's *Waiting List Reduction Strategy* (WLRS), under which Surgical Access funding is allocated, is to provide incentives to establish and extend access to elective surgical services across the state. In practical terms, funding is used to assist Districts to:

- maintain or increase existing levels of surgical services
- establish new programs to treat patients who are unable to access surgical treatment within a reasonable timeframe
- effectively manage urgency classification and theatre booking of patients requiring surgery

The Surgical Access Service is the business area responsible for ensuring the intent of the WLRS is achieved, in consultation with the Zonal Management Units.

FUNDING POOLS AND PAYMENT RATES

The 2003/04 funding model for Elective Surgery was created to purchase activity additional to that funded from operating budget. Base elective surgery targets have been established for facilities using 1996/97 as the benchmark financial year. This ES Base has been increased through investment of recurrent growth funding to some Districts. The Surgical Access Service allocates **non-recurrent** funding to provide targeted surgical throughput in excess of the volumes performed from hospital recurrent budgets, and Commonwealth and State new initiatives.

ES funding pools are managed by the Surgical Access Service under the following initiatives:

Elective Surgery Fund (ESF)	Funding rate based on Phase 5 marginal rate and historical rates from Hospital Access Bonus Pool payments
Surgical Incentive Fund (SIF)	Phase 5 marginal rate funding adjusted for casemix variations from 2000/01
Elective Surgery Enhancement Initiative (ESEI)	Conditional Phase 7 full rate funding
Surgical Access Roll-overs	Rates negotiated on a case by case basis

QUALIFYING CRITERIA

Classification criteria for cases funded and reported as surgical activity are as follows;

Elective Surgery

The Queensland Health Admitted Patient Data Collection (QHAPDC) defines an elective admission as;

> *"Admission of a patient for care or treatment which, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least 24 hours."*
>
> *(QHAPDC 2002/03, Section 7.29, Page 731)*

For the purpose of monitoring, funding, and reporting elective surgery throughput, records will be selected from the Data Services Unit dataset using the criteria

- Elective Status: 2 (Elective)
- DRG Type: S (Surgical)
- Urgency Category: 1, 2 or 3
- NMDS Speciality: Between 1 and 11
- Care Type: 01 (Acute) or 05 (New born)

Blocks of records adjusted retrospectively will not be accepted for funding purposes. Hospitals are expected to have processes in place to ensure that the elective status of patients proceeding to theatre is confirmed and data entered within a reasonable timeframe, preferably prior to the patient's discharge from hospital..

Note that **all** presentations recorded as elective surgery will be subject to audit. It is not the intent of the Surgical Access Program to purchase emergency patient treatment. This is funded through recurrent operating budgets.

Emergency Surgery

QHAPDC defines an emergency admission as

> *"An admission of a patient for care or treatment which, in the opinion of the treating clinician, is necessary and admission for which should occur within 24 hours."*
>
> *(QHAPDC 2002/03, Section 7.29, Page 731)*

Records selected from the Data Services Unit dataset will be classified as emergency surgery using the criteria .

- Elective Status: 1 (Emergency)
- DRG Type: S (Surgical)
- Care Type: 01 (Acute) or 05 (New born)

Other Surgery

All surgical cases not meeting the criteria for classification as either elective surgery or emergency surgery are classified as other surgery. Selection criteria used will be:

- Elective Status: 2 (Elective) or 3 (Not Assigned)
- DRG Type: S (Surgical)
- Care Type: 01 (Acute) or 05 (New born)
- Not qualifying as "elective surgery" or "emergency surgery"

Total Surgery

All surgical cases are reported as total surgery with a Surgical DRG and a Care Type of 01 (Acute) or 05 (New born)

SETTING SURGICAL TARGETS AND FUNDING

Surgical activity targets are established at the commencement of the financial year, in consultation with the Zonal Management Units. The following information is used to establish draft allocations of funding and associated targets.

- A review of the hospitals historical performance in terms of activity achieved against allocated targets.
- A review of statewide and site specific issues that have impacted upon the ability to achieve targets.
- A review of past and current waiting list performance and demand issues.
- A review of the facilities end of year budget position.
- A review of previous growth or new initiative funds provided and their associated impact upon surgical activity.
- An assessment of the impact on surgical activity of current Growth and New Initiative funds.

Following these reviews, draft targets and funding are distributed to the Zonal Management Units for consultation and negotiation with District Executives. This process is finalised by a joint submission to the General Manager (Health Services) for approval and resolution of any outstanding issues.

COST WEIGHTS USED

For 2003/04, elective surgery activity will be managed using Queensland Health *"Hospital Benchmarking and Pricing Model"* cost weights, commonly known as "Phase 8". Negotiated targets will be converted from Phase 7 to Phase 8 using a factor calculated from actual total elective surgery weighted separations achieved during 2002/03.

PROGRESSIVE TARGETS

The elective surgery target for each facility is a composite of activity from any of the four funding pools. The amount of activity and funding assigned is determined by volumes and prices provided in prior years, achieved throughput over the previous two years, and changes to theatre capacity and clinical services planned during the coming year.

Targets and funding are assessed progressively, from the oldest to the most recent initiatives:

- Base elective surgery and elective surgery funded from recurrent growth funds is assigned and assessed first. Recurrent funding for this activity is managed by Zonal budget allocations, independently of the Surgical Access Service.
- ESF activity is assigned and assessed next. If the total elective surgery achieved for the year is less than the ESF target, funding is reduced on a pro-rata basis for each weighted separation below target.
- SIF is assigned and assessed after ESF. Again funding is adjusted on a pro-rata basis if total ES activity achieved is less than the sum of ESF and SIF targets.
- ESEI is assigned and assessed after SIF, with the same progressive adjustments.
- Roll-over activity, where not targeted at specific patient groups, is assigned and assessed after ESEI.
- Targeted roll-over activity is assessed independently, with qualifying weighted separations quarantined from the balance of general elective surgery achieved.

PAYMENT SCHEDULE

Following approval of elective surgery allocations for 2003/04 funding is transferred between the Surgical Access Service and Districts via post-budget adjustments.

- An initial allocation of 100% of ESF, and 50% of SIF and ESEI funds is released after approval of negotiated targets by the General Manager (Health Services), usually by the end of October.
- An allocation of between 0-50% of SIF and ESEI is released after analysis of surgical throughput from July-December, usually by the end of February.
- Allocations for targeted services or equipment funded through elective surgery roll-overs will be negotiated and managed on a case by case basis
- An adjustment of funding for the balance of activity projected to be achieved by 30 June is made based on facility surgical snapshot returns, coded morbidity data, and clinical benchmarking information. This will occur in June, prior to close of the financial year.
- An adjustment of funding for activity achieved is made following finalisation of morbidity coding in the **following** financial year and after consultation with the Zonal Management Units. This is dependent upon DSU processing, usually by the end of November.

GUIDELINES FOR THE DISTRIBUTION OF ELECTIVE SURGERY FUNDING

Elective Surgery Fund (Budget line item 5.1-287)

Prospective funding for the full year followed by adjustments based on activity projected to be achieved by 30 June. Payment is made following approval of funding and targets for the financial year.

- Review after receipt of projected surgical activity from the 1 June surgical snapshots by facility. This will occur during June.
- Post budget adjustment prepared to provide payment for all elective surgery projected to be achieved by 30 June.
- Funding allocated for activity not projected to be achieved by 30 June will be rolled over to the following financial year. Finalisation of payments will be made upon receipt of 12 months of coded morbidity data from the Data Services Unit. It is anticipated that this will occur during November of the following financial year.

Surgical Incentive Fund (Budget line item 5.2-021)

Prospective funding for 6 months, followed by adjustments for activity projected to be achieved by 30 June.

- It is a condition of participation in this initiative that other Elective Surgery targets excluding those associated with the Elective Surgery Enhancement Initiative targets are met.
- Initial budget adjustment for half of the proposed annual activity made with the approval of funding and targets.
- Review after finalisation of six (6) months of coded hospital morbidity data by the Data Services Unit. It is anticipated this would occur during February of any given year.
- Post budget adjustment prepared for second half of the financial year taking into consideration outcomes of the mid-year review and projected activity levels. A payment for up to half of the projected annual activity may be made at this time.
- Review after receipt of projected surgical activity from the 1 June surgical snapshots by facility. This will occur during June.
- Post budget adjustment prepared to provide payment for all elective surgery projected to be achieved by 30 June.
- Funding allocated for activity not projected to be achieved by 30 June will be rolled over to the following financial year. Finalisation of payments will be made upon receipt of 12 months of coded morbidity data from the Data Services Unit. It is anticipated that this will occur during November of the following financial year.

Elective Surgery Enhancement Initiative (Budget line item 4.2-041)

Prospective funding for 6 months, followed by adjustments for activity projected to be achieved by 30 June.

- It is a condition of participation in this initiative that all other Elective Surgery targets are met.
- Budget adjustments will be made on the same schedule as Surgical Incentive Funds.

- Payment for activity will be at the same 'marginal rate' calculated for Surgical Incentive Funds where the 5% benchmark for Urgency Category 1 or Category 2 patients waiting for longer than 30 days and 90 days respectively ('long waits') has not been met and maintained for two (2) successive quarterly reports. The General Manager (Health Services) has final discretion in the application of this clause in the payment model.
- Payment for activity will increase to Phase 7 rates under the QH Hospital Funding Model where facilities have met and maintained Category 1 and Category 2 patients below the 5% benchmark for 'long wait' patients, subject to the approval of the General Manager (Health Services).

Roll-over initiatives (Budget line item 5.2-021)

Prospective funding negotiated for the provision of additional services or equipment to address specific patients unable to access surgical services within a reasonable timeframe.

- Where funding is provided for general increases in throughput from existing theatre capacity, it is a condition of participation in this initiative that all other Elective Surgery targets are met.
- Where funding is provided targeting specific patient groups, an appropriate monitoring regime will be negotiated prior to release of payments to Districts.
- Funding allocated for activity not projected to be achieved by 30 June will be held by the Surgical Access Service until the following financial year. Finalisation of payments will then be made upon receipt of 12 months of coded morbidity data from the Data Services Unit. It is anticipated that this will occur during November of the following financial year.

GMHS DISCRETION

All elective surgery funding is subject to the absolute discretion of the General Manager (Health Services).

MONITORING OF ACHIEVED SURGICAL THROUGHPUT

Each facility receiving funding under the Surgical Access Program reports surgical activity and performance through the following collections:

- **Monthly Surgical Activity Snapshot**
  - Comparison of activity achieved and projected against approved targets
  - Submitted by the 5th working day of each month to the SAS and Queensland Health Finance
  - Activity to be reported in Phase 8 weighted separations

- **Monthly Elective Surgery Waiting List Census Report**
  - 'Long wait' performance and throughput by urgency category
  - Submitted by the 3rd working day of each month to the SAS

- **Daily Elective Surgery Waiting List data**
  - Booked, treated, and patients entered on surgical waiting lists using the Elective Admissions Management module
  - This data is downloaded automatically each night

Districts managing elective surgery programs across more than one facility submit data for each funded facility, as well as a consolidated District-wide return.

In assessing the level of elective surgery activity likely to be achieved by 30 June, the Surgical Access Service will base full year projections upon the 1 June **Monthly Surgical Activity Snapshot** where confirmed monthly activity is consistent with data from Data Services Unit, clinical benchmarking, and other relevant sources. It is the responsibility of each District to ensure that mandatory reporting, including the Surgical Activity Snapshot are accurate and realistic.

In assessing actual surgical activity achieved for 2003/04 the finalised morbidity data provided by Data Services Unit is the corporate reference source. Changes to morbidity coding and EAM records following the closure of data submission for the financial year to DSU are not included within activity funding adjustments, or published reporting from the Surgical Access Service.

DISTRICT WIDE MANAGEMENT

Districts with more than one facility currently included and funded under the Surgical Access Program may elect to manage activity targets and funding on a District-wide basis. Zonal Management Units will advise the Surgical Access Service of these Districts during the target and funding consultation process.

Districts sharing clinical services across more than one facility will report achieved activity for each facility to the Surgical Access Service, and will receive target memoranda showing each facility. Districts should advise internal target changes between facilities to the Surgical Access Service as they occur.

When assessing variance to target and funding adjustments, the Surgical Access Service will combine activity from all funded facilities within these Districts.

MONITORING LONG WAIT PERCENTAGES

Achievement of 5% long wait benchmarks for urgency category 1 and 2 patients is required to access Phase 7 funding rates for ESEI activity. Assessment of the number of patients waiting and treated during each month will be made from the **Monthly Elective Surgery Waiting List Census Report.**

MAINTAINING TOTAL SURGICAL THROUGHPUT

The General Manager (Health Services) has advised all District Managers of the need to meet total surgery targets as well as these for funded elective surgery. In line with this requirement, performance against the total surgery target will be reviewed during the financial year to ensure that access to emergency and non-qualifying elective procedures is maintained. Significant variances to total surgery throughput indicate a need to review theatre management practices and case classification, particularly where a reduction in total surgery is not reflected in the elective surgery throughput reported.

Where a variation between actual and targeted levels of activity occurs, a performance review will be undertaken in association with Zonal and District Executives at the discretion of the General Manager (Health Services).

AUDIT REGIME

The Surgical Access Service will conduct audits to ensure that activity classified and funded as additional elective surgery meets the intent of the *Waiting List Reduction Strategy.* This regime will ensure;

- Emergency presentations are not reclassified as elective surgery, where the patient was not already present on an elective surgical waiting list. Patients transferred from another hospital (as indicated by the admit source) will be considered exceptions if assessment has occurred elsewhere, and a decision made to refer to another treating facility.
- Long wait percentages are not manipulated through inappropriate use of "Not Ready For Surgery" periods.
- Patients are not added to elective surgery waiting lists on or after admission, with the exception of patients admitted for elective medical or non-qualifying elective surgery procedures who subsequently proceed to surgery within the same admission. It is expected that all such patients would be present on an elective medical waiting list prior to admission.
- Elective Surgery throughput recorded is in accordance with the National Data Definitions established by the Australian Institute of Health and Welfare.
- Procedure Indicators recorded on the Elective Admissions Management module are consistent with ICD10 morbidity coding, and qualify for inclusion within National Minimum Data Set (NMDS) clinical specialties 1 to 11.

ROLES AND RESPONSIBILITIES

The **Surgical Access Service** is responsible for:

- Establishing base line elective surgery activity targets
- Accountability for dedicated elective surgery funds
- Negotiating activity and funding levels with Zonal Management Units
- Monitoring performance against agreed targets and benchmarks
- Recommending to the General Manager (Health Services) adjustments to elective surgery activity and funding.
- Processing surgical budget adjustments.
- Facilitating the process of transferring elective surgery funds between Districts.

Zonal Management Units are responsible for:

- Consulting with District Executives to establish achievable surgical activity targets for the available funding.
- Consulting with the Surgical Access Team regarding requested alterations to surgical activity targets or funding.

- Negotiating and monitoring the impact of additional funding provided through Growth and New Initiatives, and advising the Surgical Access Service of additional elective surgery funded from these sources.

District Executives are responsible for:

- Ensuring appropriate and sufficient resources are allocated to achieve negotiated activity targets and meet or maintain surgical benchmarks.
- Submission of mandatory surgical reporting as specified within this document.
- Ensuring surgical patients are classified and recorded appropriately according to the definitions within this document
- Ensuring all patients booked for elective surgery are placed on the Elective Admissions Management module prior to admission for treatment with the possible exception of those noted in (1) on page 4 (Elective Surgery)
- Ensuring that all hospital staff involved in planning and management of elective surgical services are conversant with the principles and procedures governing booking, treating and recording elective surgical patient activity
- Ensuring regular procedural and data quality audits are developed and implemented for elective surgical access

The **General Manager (Health Services)** is responsible for:

- Approving the Elective Surgery Business Rules
- Approving the initial allocation of elective surgery targets and fund distributions
- Approving post budget adjustments for elective surgery funds
- Approving alterations to surgical activity targets
- Approving variations to the Elective Surgery Business Rules on a case by case basis as appropriate to organisational needs and priorities

FURTHER INFORMATION

For further information contact the Surgical Access Service on (07) 3234 0500.