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Queensland Government
Queensland Health

SUBMISSION TO:

☐ **General Manager (Health Services)**

☐ **Deputy Director-General, Policy and Outcomes**

(Please tick one box only)

DATE:	30 July 2003		
PREPARED BY:	Col Roberts, Principal Project Officer, Surgical Access Team	**Contact No:**	41125
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SUBMITTED THROUGH:	Glenn Cuffe, Manager Procurement Strategy Unit	**Contact No:**	52361
DEADLINE:	8 August 2003	**File Ref:**	1224-0023-016

SUBJECT: **Reclassification of Emergency Presentations as Elective Surgery**

APPROVED/ NOT APPROVED

COMMENTS

(Dr) Steve Buckland
General Manager (Health Services)
/ / 2003

PURPOSE:

To gain approval to establish an ongoing audit process to identify the extent of reclassification of emergency presentations to elective surgery to maximise surgical access funding. This, in turn, will potentially lead to adjustments in funding arrangements and changes in elective surgery business rules.

BACKGROUND:

In April 2003 a memo was forwarded from the General Manager (Health Services) to all District Managers stressing the need to achieve total surgery targets as well as those for elective surgery. This was in response to discrepancies between the volume of elective procedures being reported in monthly surgical snapshots, and the volume of total surgery achieved. Analysis by the Surgical Access Service shows that the principal source of these anomalies has been reclassification of cases from emergency to elective surgery after presentation.

During 2002/03 there was a significant increase in patient reclassification from emergency to elective presentations, where the patient was admitted and undergoes surgery. The effect of this reclassification is to maximise activity that can be claimed against specific surgical access funding. In many cases the overall effect is a reduction or maintenance of the total volume of surgical work performed. The practice is of concern to the Surgical Access Service and contravenes the principle of additional elective surgery funding providing additional elective surgery activity.

In order to identify those hospitals actively reclassifying, and to estimate its impact on funding and activity reporting, an audit process has been initiated based on information available electronically within the Queensland Health data repositories.

Of particular concern are those hospitals showing a sharp escalation of this practice within the last financial year, where there is a substantial investment for the purchase of additional elective surgical activity.

ISSUES:

1. Criteria and Definitions

Key Point – Existing criteria and definitions are subject to interpretation

The Elective Surgery Business Rules (ESBR) state criteria under which activity is classified as "elective surgery" for the purposes of setting targets, monitoring activity, and provision of funding. For 2002/03 these criteria were expressed in terms of the select criteria used in statewide database queries, based on extracts from the HBCIS ATD system and the Elective Admissions Management module (EAM).

In order to qualify, an admission needed to meet the following criteria;

- Elective Status of patient: 2 Elective
- DRG Type: S Surgical
- Urgency Category: 1, 2 or 3
- NMDS Speciality: Between 1 and 11
- Admission type: 01 Acute, 05 New born

To be effective, these criteria require the "Elective Status" of the patient to be consistent with the admission type in accordance with the Queensland Hospital Admitted Patient Data Collection (QHAPDC) manual of instructions and procedures. QHAPDC defines elective and emergency admissions as follows:

"An emergency admission is 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.

An elective admission is an 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)

Note that there is **no mention** within this definition of whether **surgery** can be delayed for at least 24 hours.

Staff at some hospitals are interpreting the QHAPDC instructions as allowing a patient to be admitted as elective if they do not go to theatre until at least 24 hours after admission. Other hospitals have the treating clinician routinely sign a statement that the admission **could** have been delayed for at least 24 hours, when the patient was admitted from an emergency presentation, and the surgery performed would not have been planned if the emergency presentation had not occurred.

Curbing emergency reclassification is considered critical to maintaining the volume of total surgery performed. Currently, only elective surgery attracts additional activity funding. If Districts are able to meet or exceed elective surgery activity targets by reclassifying emergency surgery presentations, there is no incentive to increase or maintain elective surgical services. In fact it could be argued that there is a financial incentive to reduce these services as far as possible.

Proposed Solutions – Amend ESBR and QHAPDC Criteria

Key Point – New ESBR criteria will be effective only if accompanied by QHAPDC changes

1. Amend the Elective Surgery Business Rule elective surgery criteria to include
    - Presentation was not through Emergency Department
    - Patient was not added to the waiting list on, or after admission
2. Amend QHAPDC instructions for elective admission to

    "An elective admission is an admission of a patient for care or treatment **which has been planned prior to presentation to hospital**, and which in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least 24 hours."

3. Include a clear statement of intent within the Elective Surgery Business Rules that funding is intended to purchase additional elective surgical services, while maintaining the existing volumes of emergency and other surgical services.

2. Incidence of Reclassification of Emergency Admissions

Key Point – Reclassification is spreading but is only being abused by a minority of hospitals

The majority of elective surgical patients are admitted from outpatient department, private medical practitioners, and hospital transfers, with small numbers from routine readmissions or episode changes. However a number of hospitals have commenced actively reclassifying patients presenting and triaged through the emergency department as "Elective".

The table below shows the volume of weighted separations from emergency department presentations admitted as "Elective Surgery" by facility over the previous 3 financial years.

Table 1 – Elective Surgery w/seps (Ph7) with Admission Source 02 - Emergency Department

Hospital	2000/01	2001/02	2002/03
Bundaberg	28	607	563
Caboolture	1	21	3
Cairns	7	0	0
Caloundra	-	0	2
Gladstone	0	0	0
Gold Coast	4	643	172
Hervey Bay	0	11	912
Ipswich	0	3	3
Logan	0	0	10
Mackay	141	8	87
Maryborough	0	0	117
Mater Adult	0	6	22
Mater Children's	9	92	134
Mater Mothers	-	0	0
Nambour	30	112	2,780
PAH	1,088	1,134	1,919
Prince Charles	77	25	0
QE2	172	259	617
Redcliffe	391	325	14
Redland	1	5	14
Rockhampton	0	9	0
Royal Brisbane	19	80	678
Royal Children's	0	0	69
Royal Women's	18	0	0
Toowoomba	317	1,228	1,419
Townsville	57	248	18
Total	**2,360**	**4,816**	**9,553** (1)

(1) Interim total does not include discharges not yet coded at 13 July 2003.

Source: Transition II COR Encounter Table 18/7/2003

From the table above, it is clear that 3 years ago only PAH, Redcliffe, Toowoomba and Mackay were actively reclassifying emergency presentations as elective surgery. During 2002/03 the practice has spread to 10 hospitals claiming 100 weighted separations or more as funded elective procedures.

3. Funding Implications

Key Point – Dedicated funds are being eroded by buying activity already funded in Base

Statewide, more than 9,553 w/seps will be claimed as elective surgical activity from emergency presentations. Of these 9,311 have been claimed by 10 hospitals, with Nambour the most extreme example, with 2,780.

Emergency and **Other Surgical** activity is funded by Queensland Health through the normal budgetary process. Base operating budgets already include payment for these patient categories, with District activity targets negotiated with Zonal Units through service level agreements (SLAs).

Claiming elective surgery funding for emergency surgery effectively funds the same activity twice, while volumes of total surgery performed drop. The Surgical Access Service considers that claiming funding for reclassified emergency presentations is contrary to the principle of dedicated elective surgery funding purchasing **additional** elective surgery activity. Using reclassified emergency activity to meet elective surgery targets is "double dipping".

In terms of elective surgery activity payments already released to Districts, a total **overpayment of $4,515,617** has been provided for emergency admissions (assuming none of these cases are genuine planned elective admissions).

The table below summarises activity payments already made to each hospital for reclassified emergency presentations during 2002/03, as per the Elective Surgery Business Rules.

Table 2 – Elective Surgery payments generated from reclassified emergency presentations

Hospital	Funding Adjustment
Nambour	-1,480,036
PAH	-736,000
Toowoomba	-1,075,827
Hervey Bay	-393,020
Royal Brisbane	0
Bundaberg	-372,407
QEII	-407,049
Gold Coast	-110,413
Mater Children's	+59,135
Maryborough	0
Total	**-4,515,617**

Proposed Solution - Financial Penalties

Key Point – Restricting growth of emergency reclassification requires financial disincentives for those hospitals excessively gaming

Left unchecked, the practice of emergency reclassification will continue to increase in volume and spread. Financial adjustments to those hospitals showing apparently deliberate policy changes in 2002/03 will send a clear message to all Districts that funding is tied to maintaining and increasing real surgical volumes. Currently, only ten hospitals are of concern, with Nambour, PAH, QEII, Toowoomba, and Hervey Bay claiming more than 91% of the statewide total funding from reclassified cases ($4,091,932 of $4,515,617). Applying funding adjustments to these hospitals equivalent to the w/seps generated from reclassified activity would ensure that Districts focus on providing additional surgical services, rather than clerically adjusting activity.

4. Proof of Intent

Detailed Audits

Key Point – More detailed audits are needed to prove deliberate intent

The Surgical Access program has been in operation now for a number of years. As one of the only sources for additional funding within the Queensland Health acute hospital system, Districts have focussed on maximising revenue through documentation audit practices and service planning. It is unlikely that the ten hospitals showing continued or suddenly increased numbers of reclassified emergency presentations have achieved these as a result of administrative errors.

However, for these hospitals, and in particular those where funding adjustments are considered, more detailed chart audits are appropriate. These would focus on whether the surgical procedure performed was directly linked to the reason for emergency presentation. Audits should be undertaken by the Surgical Access Service, with the assistance of local health information managers.

Opportunity For Response

Key Point – District Managers to assume direct responsibility for accuracy of data

Following the identification of significant volumes of reclassified admissions among ten hospitals, it is appropriate to advise District Managers that more detailed audits are forthcoming, and to seek a commitment from them that all elective surgical cases have been appropriately classified and coded. The need to provide such a commitment ensures that District Managers assume responsibility for current practices, prior to undertaking any financial adjustments.

5. Impacts on Data Collection and Reporting

Impact on Waiting Lists and Throughput

Key Point – The predominance of Cat 1 in reclassified records increases EAM throughput

Reclassified cases have been added to, and treated from EAM waiting list to qualify for funding. In 2002/03 a total of 1,585 reclassified patients were added to lists, or 1.3% of total EAM throughput. However 86% of these were assigned to urgency category 1. This represents over 3.4% of all category 1s booked and treated.

For individual hospitals the proportional effect is even greater. At Nambour 475 of the 2,098 category 1 patients treated were reclassified (23%).

Statewide trends show an increase in the volume of category 1 patients treated, while category 3 continues to grow. At least part of this effect is explained by emergency reclassification.

Reduction in Long Wait Percentages

Key Point – Reclassification can be strategically used to lower 'long wait' percentages.

The percentage of urgency category 1 and 2 patients waiting longer than 30 and 90 days respectively is reduced by adding emergency cases. The majority (98%) of re-classified cases are assigned urgency category 1 or 2, as patients have already proceeded to treatment. This increases the denominator in long wait percentage calculations.

A policy of selective reclassification on the last day of the month could be used to deliberately reduce long wait percentages below 5% benchmarks in order to maximise funding.

Not surprisingly, Nambour has met urgency category 1 long wait benchmarks. RBH and PAH have also both achieved long wait benchmarks corresponding with classification of elective surgery cases claimed from emergency presentations.

Attachment A shows the number of cases and weighted separations (Phase 7) by Urgency Category for hospitals interfaced to Transition II.

Skew in Statewide Data Collection

Key Point – Emergency systems data does not align with admitted inpatient data

Hospitals reclassifying emergency presentations show corresponding decreases in the volume of patients reported as emergency admissions. This contradicts empirical evidence that emergency presentations, and the share of theatre time assigned to emergency work, is increasing. For example, Nambour Hospital shows a decline in emergency surgery admissions of 2,977 weighted separations, or 38% in 2002/03, while raw emergency presentations have actually increased by 432 (1.4%).

6. Political Considerations

Key Point – Avoid exposing Minister for Health & jeopardising $10M funding

The real volume of elective surgery performed each year appears to be declining. In terms of weighted separations, full year projections for 2002/03 are 6,423 weighted separations above the total achieved in 2001/02. This is consistent with changes in clinical practice towards minimally invasive surgery, increased cardiology and endoscopic procedures, and treatment under CMBS in an ambulatory setting.

Without the contribution of reclassified emergency surgery in 2002/03, there would have been a decline in elective surgery achieved by 3,130 w/seps. To ensure the non-recurrent pool of funding for additional activity and long wait incentives is maintained ($10M ESEI), the Surgical Access Service needs to demonstrate a continued demand for ES services and that funding is expended appropriately. During both 2001/02 and 2002/03 allocated activity funded from this ESEI allocation was not fully achieved, despite the increase in elective surgery generated from emergency reclassification.

Proposed Solution – Provide financial incentives to hospitals to meet elective surgery targets

Key Point – No bonus for making target

Incentives need to be made available to encourage all hospitals to maximise elective surgery throughput. More than 92% of elective surgery activity purchased each year is funded from pools with no incentives to meet targets or maximise throughput. While most hospitals are allocated ESEI funding at fair payment rates, a significant proportion of these funds were returned in 2002/03 due to reduced throughput from issues such as medical indemnity and nursing workforce.

Within the Elective Surgery Business Rules for 2003/04 consideration should be given to provide incentives for hospitals to meet progressive activity targets.

BENEFITS AND COSTS:

Financial adjustments to the ten hospitals reclassifying more than 100 w/seps during 2002/03 would recover $4.5M to purchase genuine additional surgical services. Adjusting only the top 5 hospitals (Nambour, PAH, QE2, Toowoomba, and Hervey Bay) would return $4.1M.

If no action is taken, and reclassification is adopted by all hospitals within the Surgical Access Program, up to 15,000 weighted separations may be shifted from emergency surgery to funded elective surgery during 2003/04. Total surgery achieved would be reduced by the same amount.

CONSULTATION:

Consultation with the following staff has occurred in preparing this submission;

Gary Walker, Manager, Surgical Access Service
Michael Zanco, Surgical Access Service
Simon Wenck, Surgical Access Service

ATTACHMENTS:

Attachment A: Emergency Presentations Reclassified as Elective Surgery

RECOMMENDATIONS:

It is recommended that the General Manager (Health Services):

1. Reaffirms the requirement to achieve total surgery as well as elective surgery targets as communicated to District Managers – GMHS Memorandum April 2003
2. Approves amendment of the Elective Surgery Business Rules and QHAPDC admission procedures to specifically exclude presentations from Emergency Departments from claimable elective surgery activity.
3. Approves performance of detailed clinical and chart audits for those hospitals showing significant reclassification of emergency presentations to elective surgery.
4. Approves financial adjustments for those hospitals shown to be actively reclassifying emergency presentations to elective surgery.

Attachment A

Emergency presentations reclassified as Elective Surgery

	Cases by Category				W/Seps by Category			
Hospital	Cat 1	Cat 2	Cat 2	Total	Cat 1	Cat 2	Cat 2	Total
Nambour	475	5	-	**480**	2,724	56	-	**2,780**
PAH	122	37	7	**166**	1,527	305	87	**1,919**
Toowoomba	297	2	2	**301**	1,393	15	11	**1,419**
Hervey Bay	233	-	-	**233**	912	-	-	**912**
Royal Brisbane	2	87	1	**90**	22	653	3	**678**
QE2	93	9	3	**105**	556	40	21	**617**
Bundaberg	100	1	-	**101**	561	2	-	**563**
Gold Coast	21	4	-	**25**	159	13	-	**172**
Mater Children's	8	-	-	**8**	134	-	-	**134**
Maryborough	23	-	2	**25**	106	-	11	**117**
Sub-Total	1,374	145	15	**1,534**	8,094	1,084	133	**9,311**
Mackay	3	17	-	**20**	7	80	-	**87**
Royal Children's	9	-	-	**9**	69	-	-	**69**
Mater Adult	2	-	1	**3**	17	-	5	**22**
Townsville	3	1	-	**4**	14	4	-	**18**
Redcliffe	2	3	3	**8**	14	-	-	**14**
Redland	2	-	-	**2**	14	-	-	**14**
Logan	2	-	-	**2**	10	-	-	**10**
Caboolture	1	-	-	**1**	3	-	-	**3**
Ipswich	1	-		**1**	3	-		**3**
Caloundra	1	-	-	**1**	2	-	-	**2**
Cairns	-	-	-	-	-	-	-	-
Gladstone	-	-	-	-	-	-	-	-
Mater Mothers	-	-	-	-	-	-	-	-
Prince Charles	-	-	-	-	-	-	-	-
Rockhampton	-	-	-	-	-	-	-	-
Royal Women's	-	-	-	-	-	-	-	-
Total	**1,400**	**166**	**19**	**1,585**	8,247	1,168	138	9,553
Percent of Total	**88%**	**10%**	**1%**		86%	12%	1%	

Source: Transition II COR database 30/7/2003

Selection: Admission Source 02-Emergency, Care Type 01 or 05, Elective Status 2-Elective, NMDS Specialty 1 to 11, Urgency Category 1 to 3, DRG Type S-Surgical, Discharge Fiscal Year 2003, Discharged and Coded cases only.

Notes:

Totals will increase until 30 Sep 2003 as morbidity coding is finalised for 2002/03.
Mount Isa is not included, as not interfaced to Transition II

Prepared by Col Roberts, Surgical Access Service, 31 July 2003