Approach to Implementing Costing

- Previously we used Australian Cost Weights
- 13 Hospitals out of 39
- Important that all specialties were covered by these hospitals
- Decided at the outset that we would use one supplier
- Did Costing Studies first carried out by Powerhealth
- Bottom up approach to costing
- All areas of the hospital costed – Admitted / Outpatients and ED
- Tendered for a National PLC System
- Powerhealth successful in the tender
- 1 National License with 7 installation (1 for each hospital Group)
- Data stored on separate server for each Group.

How to engage Hospitals

- Accentuate the Benefits – Their costs contribute to price setting
- Early adopter benefits
- Provide sufficient Training & Education
- T&E a key component of the Tender process – Not just buying the PLC system
- Offer assistance to the Hospitals – HPO provided Costing, IT and Data Analytical Support.
- Provided funding for PLC Accountants and IT (Data Extract) positions at Group Level.
- Made the decision that resources be held at Group level
- Provision of HIPE Admitted data with ward transfer data
- HPO provided Nursing Cost Weights at the DRG Level and updated these as required.
- Understand their performance in ABF

What does good look like in relation to Data Quality

- All expenditure accounted for and Costed
- All activity costed
- Consistency in Cost per DRG
- Consistency across Cost Buckets
- Highest % of costs Directly allocated v Allocation methods
- Reclassification of the GL to ensure more direct allocations
- Use of automated feeder systems
- Creation of local weights from hospitals with good data.
- Quality score for each hospital based on the direct v non direct allocations and quality of feeder systems
- Audits carried out on Costing and activity data
- If the Coding is wrong the DRG cost is incorrect

Key Factors that helped and hindered the cost collection process

- Helped
- Doing a Costing Study first
- Costing Standards and Instruction Manual
- Training and Education
- IT / DA Support provided by HPO teams
- Resources provided at Hospital Group level

- Hindered
- Availability of staff to complete the PLC
- Lack of systems providing patient level data
- Lack of data extract / manipulation skills
- It is a lot of work if there are no designated positions
- Not Mandatory

Data Quality and how long it took to improve

- An ongoing issue – always trying to improve
- Ensuring all Admitted cases are coded and assigned to DRG's
- Never reach 100% DQ as there are always areas to get better patient level data
- Reclassification of GL a key piece of work
- Costing of Outliers / Non ABF areas within hospitals
- Costing of Medical Pay between patient types – critical to get this correct.
- Matching of feeder data with admitted data.
- Reporting on the data and comparison at the cost bucket level.
- Reviewing the level of direct v non direct allocation
- Updating of Nursing Cost weights.

How benefits of the data were realised -especially for providers

- Price Setting for ABF Benchmarking Process
- Understanding who and where in the hospital is consuming resources
- PLC can also assist in improving coding quality. Cost of a patient in a DRG may be too high because the case is in the wrong DRG.
- Costing of new Services
- Challenging DRG Prices
- Comparison against peer hospitals

Lesson Learnt

- Get Started – Don't let perfection be the enemy of the good
- Supported at a Senior Management Level
- Use one PLC Software as makes comparability between hospitals a lot easier.
- Start with a Costing Pilot in a number of hospitals in order to do a GAP analysis of areas that require improvement.
- Organise at the National level but ensure that hospitals have skin in the game.
- Provide financial support as it is new work at the Hospital Group level so you don't end up relying on one person in each site.
- Make PLC mandatory
- Automate data processing – Input
- Focus on reporting – Output

Questions?

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