

A QUALITATIVE INSIGHT INTO RURAL CASEMIX
EDUCATION

by

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EXECUTIVE SUMMARY

NSW, while often regarded as the non-Casemix state, has been using Casemix information to assist planning and funding of hospitals. However, the use of this tool and the necessary education and knowledge about Casemix has not been evenly spread throughout the state, with health service staff in metropolitan areas relatively more familiar with its use than their colleagues in rural NSW.

In 1998, both NSW Health and the NSW Casemix Clinical Committee (NCCC) proposed that an effort be made to increase the knowledge and participation of rural clinical and health service staff in Casemix activities. This research was proposed as a means of establishing the current situation regarding Casemix, knowledge in rural areas, providing advice regarding the best methods of implementing Casemix education for rural staff and, if possible, evaluating the success of the education.

Casemix is a broad term referring to the tools and information system used to assist in such activities as planning, benchmarking, managing and funding health care services. Casemix is underpinned by classification systems that allow meaningful comparisons of workload or throughput between facilities.

In this study, qualitative research methods were used to examine the issues faced by rural health service staff in gaining knowledge of and using Casemix. This information was supplemented by a survey, which assessed the level of knowledge and understanding of Casemix in two rural areas.

Seven people participated in an unstructured interview focusing on the level of casemix understanding and education within their AHS. These participants were “key” to the issues being discussed because they were either in managerial positions, had detailed knowledge of casemix and/or had been involved in casemix education in the AHSs in question. Purposeful sampling identified participants. That is, an initial informant was identified who then recommended one or more informants who were perceived to have information relevant to the research. Subsequent participants also identified one or more potential informants. The information from the interviews was subjected to a thematic analysis.

Survey respondents were opportunistically recruited. In both AHSs, surveys were placed in staff pigeonholes or handed out at staff or other appropriate meetings by an employee of the AHS. One AHS attached a letter from the CEO of the AHS encouraging staff to participate in the survey. Frequencies and percentages were calculated and the results tabulated.

The results from both the interviews and surveys revealed a generally low level of knowledge about Casemix in the two rural areas. One or two people in each area had a detailed knowledge of the tool, but most staff did not understand it well enough to comprehend its potential impact on their work. Rural staff were keen to acquire more knowledge, but in the context of understanding what NSW Health’s policy regarding Casemix was. In other words, they needed to have clarified why and how the Department would implement its Casemix policy as well as the potential impact Casemix would have on them, their work and the hospital as a whole.

Specific issues about how to implement Casemix education were addressed in the interviews. As well as the education being at a suitable time and place, research participants felt that it would be important for the education to be pitched at the right level, to be undertaken by people who would be perceived as peers and who also had some rural experience. Finally, respondents identified the need for follow-up education. It was also considered important that each hospital have the services of a committed “expert” on Casemix whose role would be to motivate staff, supply up-to-date information about Casemix and generally maintain the interest and enthusiasm of staff in using Casemix information. The important role computers play in the system and the relative lack of them in rural area was a recurring theme in the interviews.

This research has demonstrated the usefulness of a qualitative approach to understanding knowledge about Casemix and need for Casemix education. It has revealed important contextual issues related to rural health services which will have an impact on the design and implementation of any education. Subsequent to this research, a pilot education strategy has been undertaken successfully, however, the evaluation of this stage is yet to be completed.

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1 INTRODUCTION

1.1 Why do this research?

NSW, whilst being touted as the non-Casemix state, has been using Casemix information in various components of both its planning and funding of NSW hospitals. Whilst staff from most hospitals in metropolitan Sydney have become quite literate and vocal within Casemix circles, rural areas have seen less of Casemix, and subsequently are less vocal.

In 1998 it was realised by the NSW Health and the NSW Casemix Clinical Committee (NCCC), the peak clinical voice in Casemix, that there was a need to increase participation of rural clinicians and other hospital staff in Casemix activities. To these ends it was proposed that special efforts be made to increase the level of knowledge of Casemix in rural NSW.

In reply to a request made by Macquarie Area Health Service, NSW Health and the NCCC decided to implement a pilot of rural based Casemix education, it was decided to undertake a qualitative analysis of the current situation regarding casemix knowledge and education. The objective of this research was to inform both the pilot education and further education of staff in rural areas focusing on Casemix. It was suggested that the standard training programs had to be modified to be suitable in a rural setting, and that qualitative research and evaluation methods would be suitable vehicles with which to achieve this aim.

Thus the agenda of this research was set: to use qualitative research methods to understand how best to implement the rural education and; if possible, evaluate the success of the education. The research was supported by the Casemix Policy Unit, NSW Health, and the Centre for Health Economics Research and Evaluation (CHERE).

1.2 What is Casemix?

Casemix is a broad term referring to the tools and information systems used to assist in activities such as planning, benchmarking, managing and funding health care services. Casemix is underpinned by classification systems that allow meaningful comparisons of

workload or throughput between facilities. The defining features of these systems are:

- *Clinical meaning.* Patients in each class of the classification system should be clinically similar.
- *Resource homogeneity.* Patients in each class of the classification system should utilise similar levels of resources.
- *Manageable number of classes.* The number of classes in the classification system should be large enough to ensure that the classes are clinically meaningful and resource homogenous, yet small enough to contain an adequate number of observations in each class for comparison purposes and statistical robustness.

The Diagnosis Related Group (DRG) is the most common of the Casemix classification systems and various versions are used to describe acute hospital workload in a number of countries including the US, Australia, Canada and France.

1.2.1 A Brief History of Casemix

The earliest formal developments in Casemix occurred in the 1960s at Oxford University. Professor Martin Feldstein found that the types of patients treated by a hospital (that is, the mix of services offered by the facility, for example, medicine, surgery, obstetrics and paediatrics) had a large influence on its costs.

This work was continued at Yale University from about 1967 by Professor Robert Fetter, Professor John Thompson and colleagues. The Yale group was responsible for the development of the first DRGs, and for creating a better understanding of the issues and concepts associated with Casemix.

The first DRGs were developed to enable utilisation review. There was a demand in the 1960s for a system that enabled hospitals to identify cases that appeared to deviate considerably from the norm in respect of resource utilisation and costs. DRGs were developed with this in mind.

In the early 1980s, the Health Care Financing Administration (HCFA) funded the Yale group to develop an improved version of DRGs that would then form the basis of payments to hospitals by the Federal Government for Medicare inpatients. HCFA has

continued to fund the development of new versions of DRGs.

1.2.2 Casemix in Australia

The Casemix Development Program was initiated by the Commonwealth Department of Human Services and in 1989. Many activities have taken place as part of this program, including the development of an Australian version of DRGs (Australian National or AN-DRGs). In addition to the tools developed at a national level, the Program has funded various organisations to undertake research to further develop Casemix in Australia, for example, in the areas of funding, classification and costing.

1.2.3 Casemix Education

A National Casemix Education Series was launched as part of the Casemix Development Program in Australia in 1994. The Series included a set of resources to assist Casemix education activities throughout Australia. In addition to these formal materials, funding was also made available for other Casemix education initiatives. In NSW, funds for casemix education were distributed by the NSW Health Department to Areas/Regions demonstrating the need for, and capacity, to develop and implement Casemix education programs. Rural Regions were not targeted specifically; however, they received funds along with metropolitan Areas. Funds were often used to employ staff to oversee Casemix developments in the Areas/Region, or for one-off workshops.

Since the initial wave of funding provided by the Commonwealth and the State, Casemix education has not been specifically targeted in funding. Rural and metropolitan Areas with the means to provide ongoing education (that is, those with dedicated Casemix staff) have provided education, mostly on an informal basis. Others have not provided any form of education to staff. The funding approach adopted by NSW (that is, there is no explicit Casemix funding formula) has not encouraged an investment in Casemix education.

1.3 Qualitative research methods

Qualitative methods permit the researcher to study issues in depth. They allow topics to be approached without the constraints of pre-determined categories, thus facilitating a

more in-depth inquiry into the subject matter at hand. Thus, the results consist of a wealth of detailed information about a relatively small number of people and/or situations. Qualitative research allows the researcher and the respondents to fully explore the rich tapestry of causation and interaction that can explain personal and social behaviour (Patton 1990, p13-14).

1.3.1 Different paradigms that qualitative analysis can build upon.

Patton (1990) states that rather than aligning with either of the paradigms, a good researcher should reject methodological orthodoxy in favour of methodological appropriateness. That is, does the methods chosen make meaningful and worthwhile inroads into the problem at hand.

Qualitative research emphasises and builds upon several interconnected themes.

Patton (1990) lists and describes ten themes of qualitative research.

- i *Naturalistic inquiry*: Studying real-world situations as they unfold naturally; non-manipulative, unobtrusive, and non-controlling; openness to whatever emerges – lack of predetermined constraints on outcomes.
- ii *Inductive analysis*: Immersion in the details and specifics of the data to discover important categories, dimensions, and interrelationships; begin by exploring genuinely open questions rather than testing theoretically derived (deductive) hypotheses.
- iii *Holistic perspective*: The whole phenomenon under study is understood as a complex system that is more than the sum of its parts; focus on complex interdependencies not meaningfully reduced to a discrete variables and linear, cause effect relationships.
- iv *Qualitative data*: Detailed, thick description; inquiry in depth; direct quotation capturing people's personal perspectives and experiences.
- v *Personal contact and insight*: The researcher has direct contact with and gets close to the people, situation, and phenomenon under study; researcher's personal

experiences and insights are an important part of the inquiry and critical to understanding the phenomenon.

- vi *Dynamic systems*: Attention to process; assumes change is constant and ongoing whether the focus is on an individual or an entire culture.
- vii *Unique case orientation*: Assumes each case is special and unique; the first level of inquiry is being true to, representing, and capturing the details of the individual cases being studied; cross-case analysis follows from and depends on the quality of individual case studies.
- viii *Context sensitivity*: Places findings in a social, historical, and temporal context; dubious of the possibility or meaningfulness of generalisations across time and space.
- ix *Empathic neutrality*: Complete objectivity is impossible; pure subjectivity undermines credibility; the researcher's passion is understanding the world in all its complexity - not proving something, not advocating, not advancing personal agendas, but understanding; the researcher includes personal experience and empathic insight as part of the relevant data, while taking a neutral non-judgemental stance toward whatever content may emerge.
- x *Design flexibility*: Open to adapting inquiry as understanding deepens and / or situations change; avoids getting locked into rigid designs that eliminate responsiveness; pursues new paths of discovery as they emerge.

These themes are all-important parts of the tapestry of qualitative analysis as a research discipline. It is important to realise that qualitative analysis is not a single research technique. One of the important sources of qualitative analysis is the various disciplines from which it is formed. Even though these different techniques use inductive and qualitative methods they vary differently in their conceptualisation of research techniques and their view of the underlying 'nature' of the empirical world.

The following is a simple review of the different theoretical traditions that make up the qualitative analysis. (Patton, 1990)

Perspective	Disciplinary roots	Central questions
1. Ethnography	Anthropology	What is the culture of this group of people?
2. Phenomenology	Philosophy	What is the structure and essence of experience of this phenomenon for these people?
3. Heuristics	Humanistic psychology	What is my experience of this phenomenon and the essential experience of others who also experience the phenomenon intensely?
4. Ethnomethodology	Sociology	How do people make sense of their everyday activities so as to behave in a socially acceptable way?
5. Symbolic interactionism	Social psychology	What common set of symbols and understandings have emerged to give meaning to people's interactions?
6. Ecological psychology	Ecology, psychology	How do individuals attempt to accomplish their goals through specific behaviours in specific environments?
7. System theory	Interdisciplinary	How and why does this system function as a whole?
8. Chaos theory, non-linear dynamics	Theoretical physics, natural sciences	What is the underlying order, if any, of disorderly phenomenon?
9. Hermeneutics	Theology, philosophy, literary criticism	What are the conditions under which a human act took place or a product was produced that makes it possible to interpret its meaning?
10. Orientational, qualitative	Ideologies, political economy	How is a particular ideological perspective manifest in this phenomenon?

1.3.2 Reasons for qualitative research

Qualitative research methods are derived from a number of disciplines across the social sciences. Qualitative methods can be used in health services research in at least five ways (NHMRC, 1995).

- i** *To study and explain the economic, political, social and cultural factors which influence health and disease.* Qualitative methods enable health researchers to apply theoretical understandings to otherwise vague concepts such as participation and empowerment. Such studies are important for obtaining an in-depth understanding of the complex way in which factors affect health outcomes and health care.
- ii** *To gain an understanding of how communities and individuals within them interpret health and disease.* They have considerable strength in allowing researchers to document and interpret the different ways in which people make sense of their experience of health and disease and how these experiences influence health service delivery and health outcomes.
- iii** *To study interactions between the various participants who are relevant to any given public health issue.* For example, the causal link between tobacco and lung cancer may be explained by experimental and quasi-experimental methods, but these approaches are not equally powerful in helping us to understand why people smoke despite strong evidence (and published warnings) about the health risks entailed. Issues such as the power of tobacco companies, their advertising strategies and an understanding of the social significance of smoking for example in adolescent females, require qualitative research.
- iv** *To elicit contextual data in order to improve the validity of quantitative survey instruments, and use in conjunction with quantitative research.* Thus qualitative studies have played an important role in improving the cultural specificity and validity of epidemiological and other survey instruments.
- v** *To elaborate causal hypotheses emerging from epidemiological and other medical studies.* In this case qualitative research can be used to explore reasons for correlations between variables. Thus, while income levels and morbidity and

mortality correlate strongly, quantitative data, generally, do not explain the nature of the relationship. Qualitative methods (for example in-depth interviews or case studies) can explore the detailed connection between income and the effect on health status.

1.3.3 What are the different qualitative research methods?

Qualitative analysis involves the development of a research design and information collection process that is appropriate for the specific situation and which is informative to a decision making process. There is no single best method of qualitative research, even for a given question for a given population at a given point in time.

The design of a qualitative study will depend upon a number of factors:

- Who and what is the information for?
- How will this information be used?
- What kind of information is needed?
- When is the information needed?
- What resources can be devoted to the study?
- What previous studies have been done in the area of question?

Patton (1990) defines three types of qualitative methods:

- i *In depth, open-ended interviews* with individuals or groups;
- ii *Direct observation* consisting of detailed description of people's activities, behaviours, actions and interactions which may include analysis of audiotaped and video taped medical and other health encounters. Observational research methods can be extended by including aspects of 'material culture', for example, graffiti, garbage and other forms of street culture.
- iii *Written data*, usually from documents yielding excerpts, quotations or entire passages form organisational, clinical or program records, personal diaries, official records or publications, and open-ended written responses to questionnaires.

Qualitative results may be presented alone or in conjunction with quantitative results. Such mixed methods use the strengths of each of the methods help overcome the weaknesses of the other. For example, adding quantitative results to a qualitative study can increase its validity through demonstrating that adverse sampling has not occurred. Qualitative analysis can help guide the formation of quantitative studies and can help explain any unusual or unexplained results.

1.3.4 The Validity of Qualitative Analysis

The validity and reliability of qualitative studies depends greatly on the researcher. In this type of study the researcher is the tool of investigation. The methodological skill, sensitivity and integrity of the researcher will have a great effect on the results of the study.

Qualitative methods are often used in evaluation. Evaluation is defined broadly as any effort to increase human effectiveness through systematic data-based inquiry. Evaluation is a form of applied research and hence differs from the traditional form of academic research. The aim of evaluation, and applied research in general, is to inform action, enhance decision making, and apply knowledge to solve human and societal problems.

Whereas quantitative measures are succinct, parsimonious, and easily aggregated for analysis, qualitative findings are longer, more detailed, diverse in content, and can introduce new and more involved questions. The task for the qualitative researcher is to establish an appropriate framework upon which the respondent can build a meaningful and truthful response.

Whereas epidemiological methods are used to remove bias from the data, qualitative findings are rich with biases. These biases predominantly come from the respondents, as they are the focus of the analysis, but also include societal, linguistic and researcher biases. Unlike traditional methods that seek to adjust such results for biases that were detected, qualitative analysis is often satisfied with highlighting their existence.

In qualitative analysis there are a number of ways in which rigour and credibility can be assessed. For example, Patton (1990) discussed how validity is maintained through the preparation, training and neutrality of the researcher. Qualitative research is structured

through systematic and self conscious research design, data collection, interpretation, and communication. Mays (1995) suggests that qualitative researches collect and maintain meticulous records of the interviews or observations, and document the processes of analysis and interpretation.

Often triangulation is used to increase the rigour of qualitative studies. Triangulation methods includes:

- *Method triangulation:* The use of multiple methods for gathering data
- *Data triangulation:* The use of multiple data sources
- *Analyst triangulation:* The use of multiple analysts to independently review the same data.
- *Theory triangulation:* Using multiple theoretical perspective to look at the same data.

2 PROJECT DESIGN

In this study, two methods of research were utilised. A number of people employed in one of two Area Health Services (AHS) were interviewed (see Appendix 1, Aide memoir for the details of the interview questions). In addition, surveys were administered opportunistically in both Area Health Services.

2.1 Open ended interviews

Seven people participated in an unstructured interview focusing on the level of casemix understanding and education within their AHS. These participants were “key” to the issues being discussed because they were either in managerial positions, had detailed knowledge of casemix and/or had been involved in casemix education in the AHSs in question. Participants were identified by purposive sampling. That is, an initial informant was identified who then recommended one or more informants who were perceived to have information relevant to the research. Subsequent participants also identified one or more potential informants.

The interviews took place at a time and place nominated by the participants. All interviews were taped with the consent of the informants. The interviewer set the scene for the interview by explaining the purpose of the research and his position as a member of the NSW Department of Health’s health economics training scheme. After any questions regarding these aspects had been answered, the interview proceeded.

All interviews were transcribed by a professional secretarial company with considerable experience in transcribing research interviews. Confidentiality was ensured by requesting the transcribing service not to identify the interviewer, participants, other people mentioned in the interviews or the Area Health Services by name. Tapes and transcriptions were kept in locked filing cabinets.

2.2 Survey

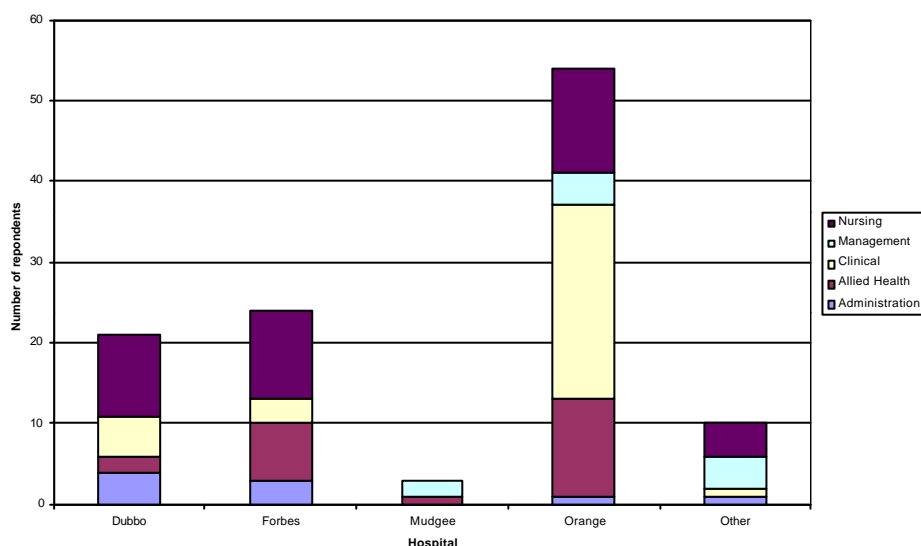
Survey respondents (see Appendices 2 – 5) were opportunistically recruited. In both AHSs, surveys were placed in staff pigeon holes or handed out at staff or other appropriate meetings by an employee of the AHS. One AHS attached a letter from the CEO of the AHS encouraging staff to participate in the survey.

3 RESULTS

3.1 Results from surveys

In the original study design it was intended to evaluate the educational intervention at Dubbo and Mudgee, using Orange and Forbes as control groups. However, due to the poor response rate at Mudgee the project had to be modified. The best response came from Orange, with a large number of clinicians, nursing and allied health respondents. Diagram 3.1.1 illustrates the response rates. The ‘other’ group is made up of staff from MWAHS, Wellington (some staff attended the Dubbo training) and Parkes (the original control group).

DIAGRAM 3.1.1 RESPONDENTS



The following Tables (Tables 3.1.1 – 3.1.9) illustrate the proportion of respondents providing the indicated response. While most respondents knew (more or less) what the letters “DRG” stand for, (Diagnosis or Diagnostic Related Groups), nearly 30% did not know or left the answer blank (Table 3.1.1). However, most respondents either did not know or left blank the answer to a similar question about MDC (Major Diagnostic Category) (Table 3.1.2).

TABLE 3.1.1 WHAT DO THE LETTERS "DRG" STAND FOR?

Written response	%
Diagnosis related	1%
Diagnosis Related Groups	31%
Diagnostic ... groups	1
Diagnostic Related Groups	37
Disease register grouper	1
Disease related groups	1
Don't know	9
Blank	20
Total	100

TABLE 3.1.2 WHAT DO THE LETTERS “MDC” STAND FOR?

Written response	%
Major Diagnostic Category	6
Medical diagnosis category	1
Medical Diagnostic Category	3
Medical diseases classification	1
Medical related index	1
Medically diagnosed condition	1
Midwives data collection	1
Multi diagnostic codes	1
Multiple diagnostic categories	1
Don't know	18
Blank	67
Total	100

The classification systems operating within casemix were understood to varying degrees by respondents from different parts of the health care system. While seven per cent and four per cent of respondents indicated a strong understanding of the DRG and SNAP classification systems (Tables 3.1.3 and 3.1.4 respectively), none perceived that they had a strong understanding of the MH-CASC or UDAG classification systems. More managers than other health worker classifications indicated either basic or strong understanding of the DRG or SNAP systems. While managers were most likely to perceive some understanding of the other two systems, only 10% stated they had a basic level of understanding and none had a strong understanding (Tables 3.1.5 and 3.1.6).

TABLE 3.1.3 HOW WELL DO YOU UNDERSTAND THE DRG CLASSIFICATION SYSTEM?

	DRG Administration	Allied Health	Clinical Management	Nursing	Total
Never heard of it	33%	23%	24%	20%	18%
Vague understanding	44%	36%	24%	10%	35%
Basic understanding	22%	32%	45%	50%	40%
Strong understanding	0%	9%	6%	20%	7%

TABLE 3.1.4: HOW WELL DO YOU UNDERSTAND THE SNAP CLASSIFICATION SYSTEM?

	SNAP Administration	Allied Health	Clinical Management	Nursing	Total
Never heard of it	89%	64%	91%	40%	78%
Vague understanding	11%	32%	3%	10%	13%
Basic understanding	0%	5%	0%	40%	5%
Strong understanding	0%	0%	6%	10%	4%

TABLE 3.1.5 HOW WELL DO YOU UNDERSTAND THE MH-CASC CLASSIFICATION SYSTEM?

	MH-CASC Administration	Allied Health	Clinical Management	Nursing	Total
Never heard of it	89%	91%	97%	90%	96%
Vague understanding	11%	9%	3%	0%	4%
Basic understanding	0%	0%	0%	10%	1%
Strong understanding	0%	0%	0%	0%	0%

TABLE 3.1.6 HOW WELL DO YOU UNDERSTAND THE UDAG CLASSIFICATION SYSTEM?

	UDAG Administration	Allied Health	Clinical Management	Nursing	Total
Never heard of it	89%	91%	100%	80%	96%
Vague understanding	11%	5%	0%	10%	3%
Basic understanding	0%	5%	0%	10%	2%
Strong understanding	0%	0%	0%	0%	0%

Most respondents had a clear understanding of the basis for DRG classification (Table 3.1.7).

TABLE 3.1.7 THE BEST DESCRIPTION OF THE BASIS FOR DRG CLASSIFICATION?

Response	Total
Clinical pathway	3%
Diagnosis associated with inpatient stay	79%
Don't know	8%
Resource use	7%
Severity of illness	2%
Blank	1%
Total	100%

The majority of respondents answered correctly for the first three questions in Table 3.1.8 (correct answers were yes, yes and no respectively). A moderate number answered correctly for the next three questions (yes, no, no were correct) and a low number answered the last two correctly (no, yes were the correct answers). The question about the significance of neonatal transfer produced the highest combined “don’t know” or blank response.

TABLE 3.1.8: WHICH FACTORS ARE SIGNIFICANT FOR A PATIENT'S ASSIGNMENT TO A DRG?

Factors	Yes	No	Don't know	Blank	Total
ICD-9-CM or ICD-10-AM	68%	2%	28%	3%	100%
Surgical procedure	69%	5%	23%	3%	100%
Ethnicity	2%	63%	27%	9%	100%
Body system affected	47%	21%	25%	7%	100%
Haemoglobin level	17%	48%	25%	10%	100%
Blood pressure	16%	48%	26%	10%	100%
Neonate transfer	29%	26%	37%	9%	100%
Age of patient	29%	33%	33%	4%	100%

This question answered in Table 3.1.9 had a very low attempt rate. Seventy-seven per cent of respondents either did not know the answer or did not respond. Seven per cent of respondents knew the correct answer (i.e. 500-700 DRGs), with nine per cent over-estimating and seven per cent under-estimating the number of DRGs currently in use.

TABLE 3.1.9 HOW MANY DRGS ARE THERE?

Response	%
20-30	3
450-500	4
500-700	7
800-950	9
Don't know	73
Blank	4
Total	100

3.2 Key themes emerging from the interviews

In this section, the major themes which emerged from the interviews are highlighted and discussed briefly. Each theme is illustrated by a number of direct quotes from the interviews. In order that the reader can make sense of them, missing words or clarifying information has been added to the quotes by the use of square brackets []. A total of twelve themes emerged, some of which can be seen to be generally related to casemix knowledge and education and some of which were specifically related to rural issues. The first four themes (including four sub-themes) listed below deal with general issues.

Level of knowledge

The consensus among interview participants was that the level of Casemix knowledge in their AHSs varied, was generally poor and related to outside education – such as through the Colleges or through study for degrees and diplomas. All respondents agreed that their Area's knowledge was similar to other rural Area's, with Dubbo slightly behind the average.

My opinion is that Casemix awareness is not very high in country areas. You might have a sprinkling of people, a manager who knows all about it, but overall health services managers have very little knowledge of it. Interview One.

Some have a very good understanding and other don't have much of an understanding at all. Interview Three.

Some of the staff have a vague understanding of what it is, but the majority of the staff I don't think do and I don't think they realise how it could apply to their own jobs. Interview Four.

Their knowledge of the concept of case mix is still a bit patchy and is related to where the college is up to, more than where we are up to. Interview Seven.

Ideal sessions and training needs

There was a great deal of discussion about the ideal sessions and training needs of the staff. The themes which emerged have been separated into the 'Why', the 'When and Where', the 'How', and the 'Who'.

Why casemix now?

One of the major themes of the interviews was that NSW Health had to reveal its position or policy on Casemix and how it was related to funding, otherwise staff would not be interested in making an effort to learn about it and implement the strategies. Participants expressed mixed emotions about the Victorian experience, but the interviews revealed an attitude that the staff needed to be told why they needed to know about Casemix. It was stated that members of staff need to be informed of the benefits not only to them, but also to the Hospital and its reputation.

[Casemix] seems to keep changing all the time, is that right. Interview Two.

Why isn't it being driven at departmental level? Who is driving it there? Is it really being driven? Interview Seven.

Give the clinicians a reason to get involved. Interview Seven.

You have to tell them why. Maybe if you give case examples of what can happen in Victoria for instance, scare the hell out of them. Interview Six.

I find Victoria being on case mix funding fairly frightening. The horrendous stories you hear that come out of hospitals. Interview Three.

Because NSW Health hadn't gone down the track like Victoria, it was viewed as "when it comes we'll get our minds around it". Interview Three.

It's not got anything to do with funding, but more to do with status of the hospital. Interview Seven.

They have to be convinced that this is a good practice and there are benefits out of it. Interview Four.

What is in it for the clinicians? Why should they bother to change their mode of thinking? Interview Seven.

Being a traditional conservative bureaucracy we will just puddle along doing the things we do now until we have got a reason to change. We haven't seen great incentive for changing. Interview Seven.

If we don't have a straight answer for why we are doing [the education] they won't really listen. Interview Seven.

a) When and where.

The key theme relating to time and location of the education was that education would be most successful if it were held in a normal meeting time. To facilitate this, separate sessions should be run for different staff groups. The provision of good food would also act as an incentive to attract staff.

Run different sessions for different audiences, a session for nurses, a session for management and a session for clinicians, the Doctors. Interview One.

Put some food on. If you have food you will get anyone there. And during the working hours for staff. Interview Five.

My view would be a travelling road show I think would be more effective. You could mark out a week in all these peoples' diaries. Interview Five

b) How

Respondents maintained that to be successful education has to be aimed at the right level. Whilst it was stressed that education should not be too academic it also had to be practical and backed up by evidence. A key theme was the need to stress the basic elements of the importance of clinicians' input into the process, that is the front sheet of the medical record – this sheet that is translated into ICD code and used to assign a DRG.

My focus would be on getting [the clinicians'] documentation right. [Demonstrate] how their documentation affects allocation of DRGs and funding in the future. Interview One.

We don't want it too academic, otherwise you lose the coalface workers. Interview Five.

Give us some examples of how it's being used to improve patient care. That is where they will come from. Unless you do that, they won't be much interested. Interview Seven.

It's got to be clinically based and they have to understand from the point of view of the front sheets. Interview Seven.

Maybe if there is a [handout] that makes people think about the sort of questions. Sometimes if you look at something beforehand, it raises issues and that gives you an idea of what it's going to be about, and also the sort of questions you can ask. Interview Two.

I'm very practical and find when you are involved in something and there is room for feedback and to talk about things, you get a greater understanding of things. Interview Two.

c) Who

It was a key theme that other clinicians (peers) be involved in the education and if at all possible that this person/s have either rural experience or be currently practicing in a rural area. Participants stressed that any person using data need to really understand it and be able to relate it to the clinicians.

For the doctors it would have to be another doctor, a peer. [Having a peer] is probably not as important for nursing or management. Interview One.

It's alright to have a key person who is non-nursing, but if they don't communicate to other people about it as well, or other people on this same sort of level in the different disciplines, then it doesn't go anywhere. Interview Two.

I don't know where you might find a good rural person. Interview Two.

Obviously someone who has a very good knowledge of case mix and can sell it.
Interview Four.

I think also a number cruncher, a person who knows their numbers with these people. That is where it's all going to come back to. That person needs a good grip on the RDF. Interview Five.

Bringing in a clinician who is already doing it in a rural area and doing it well.
Interview Six.

Follow Up

Most of the interviews discussed the necessity for follow up to education and training. There had been previous education in Dubbo, but there had been little in the way of follow up. Follow up and other forms of reinforcement – such as up to date benchmarks – would be an important component of a successful education strategy.

We didn't follow up on [previous Casemix education]. They were very interested, there was a lot of debate on the night, but didn't follow up on it. Interview One.

We don't have anything locally to reinforce it. Interview Seven.

I want to make sure that we build on that, we keep going, we keep presenting to groups who they've missed out that sort of thing. But keep the ball rolling. Interview One.

Case mix seems to have gone like this, there was a whole lot of talk about it and then it seems to raise its head again, and then there's nothing, that is how I've seen it out here.
Interview Two.

Show me the money

The old adage that clinical staff will not be involved in Casemix until it hits the hip pocket nerve was reinforced throughout the interviews. Whilst financial interests were important, they did not have to be faced personally by the staff for the staff to be concerned about the hospital's financial and benchmark position.

If [clinicians] can't see that it's affecting the services they are providing and affecting their hip pocket, they won't be interested in it. Interview Two.

Everything goes back to money and the cost of things. Interview Two.

At the end of the day it all comes back to resources. Interview Five.

At the end of the day, they will say “what is in it for me?” and that is the target we should be driving towards. Interview Five.

What is in it for me? What does this mean to me as an individual and as a clinician? What does it mean to our hospital? Does it mean more money, less money? As an area health service what does it mean? Interview Five.

3.3 Key themes in the interviews relating to Casemix in general in the rural setting.

In this section, six themes which can be seen to be specifically pointing to problems of casemix and casemix education and training in a rural setting are listed, discussed and illustrated. They are discussed under the titles of “a fair system”, “Allied Health”, “one person to drive the agenda”, “further education”, “lack of computers and “RDF and flows”.

A fair system

Interview Seven focused a lot upon the fairness of the system as a whole, especially with funding of Hospitals. This was also touched upon in other interviews.

The clinicians would like to see that there is a fairer payment for what is done. Interview Seven.

They see a lot of unfairness in the system at the moment. Interview Seven.

If it’s unfair, it won’t be accepted at all. Interview Seven.

Allied Health

One of the interviews focused upon issues relating to allied health – especially that Casemix to date has focused upon the inpatient episode of care and that coding of allied health procedures and outcomes would be beneficial in terms of reviewing practice.

I have a concern that there are so many different projects going on, that I don’t have to learn diagnostic codes for my acute inpatients, my non-acute outpatients, my rehabilitation patients, my emergency department patients. I see all those types of patients, and I’ve been trying to say this for a few years, I hope they don’t have 6 or 7 classification systems of diagnoses, we are going to then have to turn around and work out which ones we use in rural areas. Interview Six.

Our outcomes have not been coded at all. Interview Six.

So what if I know I've got 50% of my patients have got neck pain, but I need to go further and say is the costing effective. I have got two different treatments, which is the most effective. I think if I am going to code, I'm going to code the whole damn lot. Interview Six.

One person to drive the agenda

It was generally agreed that Casemix would not take hold in rural hospitals unless there was someone in particular to drive it. This 'one person' would be responsible for the motivation of staff and supply of up to date information.

I think why there isn't more focus on it is there is no one person responsible for it. There isn't someone driving it. Interview One.

There was no one driving it and the [clinicians] lost interest in it. Interview One.

I actually got put on the committee because I knew what DRG stood for. Interview Six.

There are some areas that are good and have a few key people involved. Interview Seven.

We need the people to make it happen. Interview Seven.

There are individuals throughout the area who have taken on tertiary education that has explored the Casemix concept. There has been a lot of informal discussion and debate about the pros and cons of case mix, mainly coming from the interstate perspective. Interview Five.

Further education

Almost all interviewees commented that they had been involved personally in tertiary education. This theme is closely related to the above theme of the 'one person', as it is most likely that the this person has or will have tertiary qualifications relating to Casemix.

We were taught at college and in all our literature from our association and we do the coding and realise how DRG is derived etc. Interview One.

There are research opportunities, but we haven't identified them yet. Interview Seven.

I wasn't computer literate until about 6 months ago and as soon as I worked it out, I am doing a uni course and I learnt Excel, came home from Adelaide and in 3 hours, coded 3 years of statistics at home. Interview Six.

Lack of computers

A recurring theme in the interviews was that rural Areas have very little in the way of computers. Thus the education had to be sensitive to this. It was surprising to note that most interviewees talked about having high quality computers at home - normally linked to tertiary education they were or had been undertaking.

We have asked for an Encoder. It's a fairly expensive program, like \$20,000 a year each year that has to be paid to have the Encoder. I think that was an unsuccessful request. Interview One.

Most have it at home, but work not so much. I have it and I think most people have computers [at home]. Interview Two.

I actually have a 286 without a mouse at work, I have a decent one at home now I've just bought. [One hospital] has got a 486, [another] has got a 386 which is full to its brim. They are the lucky ones. We get hand-me-downs. Interview Six.

I can trace the owners and they said "you can take it" when I was in charge, "Don't tell anyone, we know you desperately need a computer." Interview Six.

We have hospitals that are manual in this area. It's disgusting in this day and age. Interview Seven.

RDF and Flows

One surprising theme was how often the RDF and Cross Area Flows were discussed by the interviewee's. It was implied that how the RDF operated was well known in the Rural Areas and that is was a possible way to get people involved into Casemix.

"There are big holes" they seem to think "in the way the RDF is put together", in some ways I think it's good to go through these things and look at them, as there are so many different ways you can "cook a chook". Interview Two.

There has been this notion that we'd better start and understand what the RDF means. Interview Five.

Recent Data and peer groups

Another related theme raised by the interview participants was that of the availability of recent data of other peer hospitals for the use of benchmarking their own hospitals' performance.

I think the more recent the data the more interested they are. Interview One.

We need information and we need it to be like last month's data. Interview One.

So you can't compare anything until we get peer hospital figures from the Department. Interview Four.

And each VMO is going to say their hospital is different than the state average, unless you can say that the benchmarking is done on a comparative basis. Interview Four.

Rural issues – lack of staff and small hospitals etc

A number of rural issues were also indirectly raised throughout the interviews. These included the lack of appropriate staff and lack of computers, but also issues related to the types of services that rural hospitals have to provide such as social admissions and the high availability of beds that lead to high lengths of stay.

With any profession in the country – we are trying to attract good health information managers is like pulling teeth-no one wants to live in the country. Interview One.

You have to open the doors each day and it costs to do that and there are cleaners and cooks, even if you just have one patient. Interview One.

People we admit to our hospitals wouldn't even get a look in the metropolitan area. Interview Three.

You wouldn't get social admissions in the metropolitan area, there just aren't the beds. Interview Three.

They can keep putting people into hospital because there isn't pressure on the bed. Interview Three.

Money is so short and we just don't seem to be able to get anywhere. Interview Three.

3.4 Key themes in the open-ended questions in the survey

In addition to the information gained by way of the unstructured interviews, a wider range of views about casemix education needs was gathered from the answers to three open ended questions in the survey administered in the rural hospitals. The questions were:

What would you like to gain from education in Casemix?

What area would you like to see covered in Casemix Training?, and

Do you have any other questions or suggestions?

For a full set of responses to these questions, see Appendices 3 to 5. In general, the responses to these questions reinforce the themes presented above. One additional theme raised was that any Casemix education had to be brief.

4 CONCLUSIONS

The main aim of this research was to inform planning for casemix education in rural Area Health Services. A secondary aim was to demonstrate the usefulness of qualitative research methods in the Casemix environment. Both aims have been met. Using predominantly qualitative methods, the research has demonstrated that rural AHSs are likely to have both similar and different casemix education needs to urban AHS. For example, rural AHS want to understand why the Department of Health might be introducing more casemix into the health system and that any education and training would be accepted more easily if it was designed and delivered with a specific group in mind. It is probable that participants from an urban setting would also express such opinions. However, the results have also demonstrated how a rural context (for example, the general lack of resources such as people with casemix expertise and computer hardware) provides a different starting point for any casemix education. They also provided an insight into the perceived overlap that exists between issues such as casemix, the Resource Distribution Formula (RDF), the problems of recruiting and retaining staff and those of running small rural hospitals.

As a follow-up to this research, a pilot education package has been conducted successfully. However, the evaluation stage of this project has yet to be completed. A number of issues requiring further research emerged from this study. They include an evaluation of the education, a comparison of rural and metropolitan- based training and a qualitative study of clinicians' involvement in the annual NSW hospital costing consultation process.

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APPENDIX 1: AIDE MEMOIR

Qualitative analysis in MAHS and MWAHS on casemix education needs

Key lead in questions (*aide memoire*)

1. What is the level of Casemix understanding among staff?
2. What are the training needs of staff?
3. What are the benefits of Casemix education?

Supplementary areas of interest

1. What has hindered the level of Casemix education? Does understanding vary across staff? What level of Casemix understanding is needed? Is Casemix more valuable for clinical or financial decisions? Does the level of understanding differ in relation to other AHSs (Rural/Metro)?
2. Do training needs vary across staff? Which staff need the highest level of understand? Why/what do your staff need to know about Casemix? Does the needs differ with respect to other AHS (Rural/Metro)?
3. What is the best types of Casemix education? Who are the best people to provide this? Which aspects of Casemix need to be explained? What have been your experiences of Casemix education in the past? Does the level of benefit differ with respect to other AHS (Rural/Metro)?

Theoretical slant

Phenomenology – What is the structure and essence of experience of Casemix and Casemix education programs for these people?

Systems Theory – How and why should Casemix education take place?

Research themes

Qualitative data – Capturing peoples personal perspective and experiences.

Personal contact and insight – Researcher to get personal contact with the phenomena.

Empathic neutrality – The researcher to take an empathetic insight as part of the relevant data, while taking a neutral non-judgemental stance towards the issues as they emerge.

APPENDIX 2 : SURVEY FORM

Casemix questionnaire – March 1999

This questionnaire has been designed by NSW Health to better understand the level of Casemix knowledge and design Casemix education for rural NSW.

Please return to

By 31st March 1999

What hospital do you work for? Indicate with a single X.	Dubbo Base	
	Mudgee	
	Parkes	
	Orange Base	

What type of position are you currently in? Indicate with a single X.	Clinical (VMO and RMO)	
	Nursing or nursing management	
	Allied health	
	Administration	
	Management	

1. What do the letters "DRG" stand for?	
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2. What do the letters "MDC" stand for?	
---	--

How well do you understand the following Casemix classification systems? Indicate with a single X.	Never heard of it	Vague understanding	Basic understanding	Strong understanding
3. DRG				
4. SNAP				
5. MH-CASC				
6. UDAG				

7. Which one of the following best describes the basis of DRG classification? Indicate with a single X.	Severity of illness	
	Diagnosis associated with inpatient stay	
	Clinical pathway	
	Resource usage	
	Don't know	

Which of the following factors may be significant in the assignment of a patient to a particular DRG? Indicate with a single X for each question.	Yes	No	Don't know
8. International Classification of Diseases (ICD-9-CM or ICD-10-AM)			
9. Surgical procedure			
10. Ethnicity			
11. Body system affected by illness			
12. Haemoglobin level			
13. Blood pressure			
14. Neonate transfer			
15. Age of patient			

16. Approximately how many AN-DRG-3 are there? Indicate with a single X.	20-30	
	450-500	
	500-700	
	800-950	
	9500-10000	
	Don't know	

Indicate using a X whether you believe the following statements to be true or false. If you are unsure or have to guess then answer using Don't Know.	True	False	Don't know
17. A patient's health insurance status affects the DRG to which the patient is assigned			
18. Resource usage was one of the criteria used in the development of DRGs			
19. Clinical coherence was one of the criteria used in the development of DRGs			
20. The presence or absence of complications and comorbidities are not considered when assigning DRGs			
21. The term "outlier" when used in respect of DRGs refers to an inpatient whose stay is much longer than the average for a DRG			
22. A DRG grouper is a computer program which assigns diseases and operational/procedure codes			
23. DRGs may be used to compare the efficiency of acute care hospitals			
24. DRGs may be used for charging private patients			

Please indicate whether you agree or disagree with the following statements	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
25. DRGs cannot keep up with rapidly occurring changes in medical technology					
26. DRG classification will increase hospital efficiency					
27. DRG classification will pressure clinical staff to be more aware of the costs of treating patients					
28. DRG classification will increase the paperwork of clinical staff to the detriment of patient care					
29. DRG classification fails to take into account nursing care intensity					
30. DRG classification has little or no relevance in a rural hospital					
31. Rural hospitals do not have the technical support to adequately use Casemix					

The following questions relate to a Casemix education program that is currently being designed for implementation in rural NSW. Your responses will assist in better understanding the Casemix education needs of staff in rural hospitals.

32. What would you like to gain from education in Casemix?

33. What area would you like to see covered in Casemix training?

34. Do you have any other questions or suggestions?

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APPENDIX 3 – QUESTION 32

What would you like to gain from education in Casemix?

A thorough understanding of Casemix; its objectives benefits. To become conversant in the subject.

Administrator: Dubbo.

An increased knowledge of the concept. Administrator: Dubbo.

Basic understanding of the concepts and its applications. Administrator: Dubbo.

To know what it is all about. Allied health: Dubbo.

A better understanding of the system, its role in health care and its application in NSW. Clinical: Dubbo.

Better understanding of the process. Clinical: Dubbo.

Don't know. Not interested. Clinical: Dubbo.

Understanding, When can it start, will funding increase to match efficiency. Clinical: Dubbo.

A better understanding. Nursing: Dubbo.

A better understanding of DRG and Casemix and how this will affect me and my work. Nursing: Dubbo.

A thorough understanding of the process. Nursing: Dubbo.

How it would be used, why and nurses responsibilities. Nursing: Dubbo.

Overall knowledge regarding Casemix, if we must. Nursing: Dubbo.

To be able to understand what it is and how it works. Nursing: Dubbo.

What is involved from nursing perspective. Nursing: Dubbo.

Full understanding of Casemix. Administrator: Forbes.

A better understanding of Casemix and its relevance to overall health care and the health system. Allied Health: Forbes.

A better understanding of what it is and how it applies to allied health staff. Allied Health: Forbes.

As I have never had any education or training in Casemix I don't even know what I could gain from education in Casemix. Allied Health: Forbes.

Knowledge of system and how it applies to patient/clients. Allied Health: Forbes.

A basic understanding with minimal time. Clinical: Forbes.

An understanding of Casemix. Clinical: Forbes.

A basic understanding of terminology. Nursing: Forbes.

An overview. What it is, how it works. Its implications for work practices. Nursing: Forbes.

Don't know anything about Casemix, so don't know what. Nursing: Forbes.

How is it applied to rural health services and it's significance. Nursing: Forbes.

How it affects daily assessment and management, to understand it, use it as a tool to be more effective. Nursing: Forbes.

Increased knowledge. Nursing: Forbes.

Understanding and purpose. Nursing: Forbes.

Yes, it is a must to understanding formula's and criteria used to guide resources utilised in patient care. Nursing: Forbes.

Clearer direction from Dept. of Health. There is a Casemix 3 monthly meeting in Mudgee which addresses data and implementation and Committee members have some knowledge. Management: Mudgee.

Further information on clinical indicators used to assign DRG. How average LOS are Calculated. Management: Mudgee.

Knowledge and understanding. Management: MWAHS.

A greater knowledge of how Casemix works. Administrator: Orange.

A better understanding of the whole concept. Allied Health: Orange.

A good understanding of how Casemix will be applied in NSW. Allied Health: Orange.

General introduction. Allied Health: Orange.

It is likely Casemix will be used as a funding basis for public hospitals. Education in Casemix will allow allocation of health funding fairly to those hospitals/ institutions who have greatest needs. Allied Health: Orange.

Knowledge of what it is and its relevance to me in my job. Allied Health: Orange.

Methodologies to assist in training of other personnel. Allied Health: Orange.

My understanding is very basic. Need an overall workshop defining the process of DRGs and how it fits into the broader economic system / health planning and how any of it may relate to community workers.

Allied Health: Orange.

Practical understanding of Casemix funding models. Allied Health: Orange.

Understand its relationship (if any) to outpatients. Allied Health: Orange.

What it is about and how it affects me and my work. Allied Health: Orange.

An understanding of the need to use it, the process and the benefits of its use. Clinician: Orange.

Basic understanding. Clinician: Orange.

Brevity. Clinician: Orange.

I could complete discharge summaries more effectively if I knew the value (monetary value) ie/ do I list the patients background diagnoses as well. Clinician: Orange.

I will not waste my time learning about Casemix unless it is implemented a basis for hospital funding.

Clinician: Orange.

I'd like to know what Casemix is about. Clinician: Orange.

Increased efficiency in public hospitals with usage of funds. Clinician: Orange.

Information as to its application. Clinician: Orange.

Interesting to know how hospitals are run and funded. Clinician: Orange.

Relevance to my clinical practice. Clinician: Orange.

The ability to achieve a high level of understanding of Casemix as it is clear that it is here to stay and will become an essential part of all practice. Also need to be convinced of it's appropriateness for this setting.

Clinician: Orange.

Understand how it works and both advantages and disadvantages. Clinician: Orange.

Understanding in how it works, what it is, etc. Clinician: Orange.

What is it? Clinician: Orange.

What is necessary to write in a discharge summary to get the most amount of money for the hospital.

Clinician: Orange.

Why fascination with DRG. Clinician: Orange.

As my knowledge is extremely rudimentary, I want to be well informed so that the concept is understood.
Management: Orange.

Practical info on Casemix data usage to improve efficiency. Management: Orange.

Unsure. Management: Orange.

A better understanding of Casemix etc., because we have no choice, They will be implemented. Nursing:
Orange.

A better understanding of same. Nursing: Orange.

All about the importance of DRGs and how this will or will not effect nursing. Nursing: Orange.

Better understanding and knowledge of processes. Nursing: Orange.

Better understanding of concepts and principles. Nursing: Orange.

Better understanding of how it is influenced by lack of accurate clinical information and how to improve
the accuracy of information. Nursing: Orange.

Better understanding of the systems. Nursing: Orange.

Better understanding of whole process. Nursing: Orange.

Clarify what Casemix is and how this would benefit the hospital. Nursing: Orange.

Professional development. Understanding of terminology of accounting and clinical financial
information systems used by hospital. How information is used in strategic planning. Nursing: Orange.

Understanding, practical applications. Nursing: Orange.

How is it to be used. Clinical: Parkes.

I don't understand it. Administrator: Wellington.

All about Casemix. Nursing: Wellington.

Understand it enough to be able to apply. Nursing: Wellington.

Full understanding of how it actually works. How is data collected and distributed. What about small
<50 bed sites. Management: Small rural hospital.

To gain a sound basic understanding of the subject. Management: Small rural hospital.

Expectations for small rural facilities. Nursing: Small rural hospital.

APPENDIX 4 - QUESTION 33

What area would you like to see covered in Casemix Training?

As my knowledge is minimal, I would like to see all areas covered. Administrator: Dubbo.

Not sure. Administrator: Dubbo.

Overall description of the concepts, its benefits etc. Administrator: Dubbo.

All areas. Allied Health: Dubbo.

Demonstration of ultimate benefits of such a system. Clinical: Dubbo.

Everything. Clinical: Dubbo.

Training in correctly classifying hospital stays so that Casemix is correctly reflected. Clinical: Dubbo.

All areas. Nursing: Dubbo.

All necessary areas to provide a thorough understanding. Nursing: Dubbo.

Basic outlines of how it is used, why and how it can benefit daily nursing care. Why it is relevant to nurses. Nursing: Dubbo.

Nursing. Nursing: Dubbo.

What are the advantages and if there are any disadvantages. Nursing: Dubbo.

A complete overview of Casemix, not just bits and pieces. Administrator: Forbes.

Basic training in system and how it is to be applied. Allied Health: Forbes.

Don't know. Allied Health: Forbes.

Education for VMOs as to relationship between accurate/complete documentation and accurate coding. Education for management as to the importance of the level of staffing and ongoing training of clinical coders. The importance of the role of the clinician. Allied Health: Forbes.

General overview. Allied Health: Forbes.

All areas. Nursing: Forbes.

All areas but nuts and bolts presentation as mentioned above with opportunities for further learning by reading. Nursing: Forbes.

As above. Nursing: Forbes.

How it affects our rural hospital. Nursing: Forbes.

There is to gain from education Need basic education and then determine ongoing education needs.
Nursing: Forbes.

Rural doctors taking the challenge and being prepared to put their skills (clinical) to the test. Peer review.
Allied Health: Mudgee.

Expectations on Rural Health. Accountability to medical officers for documentation. Management:
Mudgee.

All areas. Management: MWAHS.

All aspects of Casemix as I know only the very basic facts. Administrator: Orange.

1. Essential all hospital staff have a general knowledge of Casemix. 2. Critical that all administration staff have a full knowledge of Casemix and DRGs. 3. DRG/Casemix understanding with information pertaining to allied health (pathology especially). Allied health: Orange.

A good clear overview of all aspects. Allied health: Orange.

Everything that is relevant. Allied health: Orange.

Everything. Allied health: Orange.

How do DRGs impact on everyday clinical issues? Allied health: Orange.

How is casemix data going to be used in NSW. How will it impact on funding allocation? Allied health:
Orange.

Practical usage of the data presented at all levels, eg. Ward, at admission, clinical staff. Allied health:
Orange.

Brief talk or booklet in medical records re usefulness of filling out classification. Clinician: Orange.

Clinical usefulness. Clinician: Orange.

Difficult to say given current level. Clinician: Orange.

Education to medical staff. Clinician: Orange.

How this could advantage referral centres such as OBH. How it could attract more services. Clinician:
Orange.

If it is not implemented, no point learning. Clinician: Orange.

Relevance to me / work practices. Clinician: Orange.

SNAP/ education and discussion. Clinician: Orange.

VMO input. Clinician: Orange.

Why it is necessary. Clinician: Orange.

Everything that is relevant. Management: Orange.

Examples of how Casemix data can be presented to physicians to increase their involvement in efficient allocation of resources. Management: Orange.

All staff have little to no knowledge on this topic. Nursing: Orange.

Because I know so little about Casemix a basic coverage initially. Nursing: Orange.

Examine clinical and financial information systems used in this hospital. And how to use this information in the management of my clinical area. Nursing: Orange.

How it can reduce bureaucratic structure and improve clinical bedside care. Nursing: Orange.

In all areas. Nursing: Orange.

The importance of accurate clinical information in medical record and that it be legible. Nursing: Orange.

Use and implementation, practical things, not history and theories. Nursing: Orange.

What it is, benefits and costs. Nursing: Orange.

Information to achieve the above. Management: Wellington.

APPENDIX 5 – QUESTION 34

Do you have any other questions or suggestions?

Why not use words instead of first letters. One may have a better chance of learning what you want us to know. Clinician: Dubbo.

Probably lots, once I gain some more knowledge. Nurse: Dubbo.

That all levels of employees have a chance to learn about Casemix. Administrator: Forbes.

What is Casemix? Administrator: Forbes.

All health related staff be educated. Allied health: Forbes.

Poorly designed questionnaire. Allied health: Forbes.

I feel this education is a little late in view of surveys that have been carried out in Mid West Area Health. Some education is better than none, timely or not. Nurse: Forbes.

I will let you know after I have gained some knowledge and insight into the DRG haze. Nurse: Forbes.

If answers to questions 1 and 2 are don't know - you could have said go to Q31 or no further questions. Nurse: Forbes.

No - not well enough aware. Nurse: Forbes.

Please bring the training further west than Bathurst. Nurse: Forbes.

Why do this - reason? Nurse: Forbes.

It would be helpful if some printed material on Casemix/ DRGs could be circulated to hospital departments. There is a dearth of good reference information at present. Allied health: Orange.

Rural areas have less staff, clinical and clerical and limited access to information technology (compared to Metropolitan areas). Will the infrastructure be put in place to enable Casemix to be used comprehensively and equivalent to Metropolitan hospitals. Allied health: Orange.

Victorian colleagues have told me of terrible things regarding patient care directly due to DRG funding. Will such stupidity be replicated here? Allied health: Orange.

Does it affect a general practitioner registrar such as myself. Clinician: Orange.

I would appreciate more info on Casemix be it literature etc. Clinician: Orange.

Is it relevant to General Practice. Clinician: Orange.

Its practical use in getting any extra funding for rural hospitals has not been demonstrated as already rural NSW health has a lower proportion of health per person than city. Clinician: Orange.

