Case Mix and Clinics – From case-mix to clinical applications

Organizers and Presenters: Michael Wilke, Carlos Elvira, Maria Angeles Gogorcena, Henrique MG Martins, Marc Berlinguet

Goal: To find out, which added value for clinical work and for the measurement of quality in healthcare systems can be drawn out of CaseMix – routine data.

Aims of the workshop

1. Presentations on the use of CaseMix data in clinical contexts
2. Background information on existing methods of quality evaluation in healthcare
3. Collaborative discussion
4. Creating inspiration for the participants
5. Possibilities for international collaboration

Workshop presentation: We would like to conduct a workshop open to participants from all countries and learn from examples as well as discussing the ifs and odds of the issue.
The following topics should be reflected:

- Extending the benefits of CaseMix data
    - Quality indicators (AHRQ, OECD, others)
    - Prevalence or incidence statistics drawn out of the data
    - Morbidity and mortality reporting
    - Quality indicators as quality of coding
    - Linking inpatient and outpatient data to create “pathways” or “episodes of care”
- Chances and limitations
    - Are the allegations among clinical researchers real limitations or is it a question of communication culture?
    - What could be done to promote the multidisciplinary use of the data?
- International implications
    - Where do we have data that could be used even for international comparisons?
    - The experience of a Ministry of Health: health indicators of CaseMix data

Workshop presentation:

14:00 Opening, introduction – Michael Wilke

14:10 Introduction & expectations

14:30 Theme 1: Quality Indicators – Marc Berlinguet

14:55 Theme 2: The use of indicators for a National Health Service – Maria Gogorcena

15:20 Theme 3: Ucoding infections – Michael Wilke

15:45 Coffee break

16:00 Theme 4: Linking Patient Classification (PC) and Clinical Practice (CP) – Henrique Martins

16:25 Theme 5: Practical experience applied to a hospital - Carlos Elvira

16:50 Discussion & wrap-up

17:00 The End

Background to each theme:

Theme 1: Quality Indicators

"The limitation of administrative data sets are the classifications used that do not incorporate all the meaning of say the lab and imaging results, and the sheer fact of secondary coding from medical charts and abstracts. However, many clinical quality indicators can still be documented, Hence outcome quality indicators like the risk of mortality, potentially preventable complications (*) and potentially preventable readmissions can be derived, These and other quality indicators proposed the Agency For Health Research and Quality (AHRQ) in USA and the OECD can be generated and be useful for clinical applications and future research. "
(*)Especially when the notion of Present on Admission (POA-now mandated for documentation by CMS in USA) is available.

Theme 2: The use of indicators for a National Health Service

From Minimun Basic Data Set and CaseMix, the Ministry of Health of Spain has designed a system of analysis based on indicators to know the operation of hospitals in different regions of the country. Knowing how the casemix and the availability of standards for hospitals compared allows advance the indicivual own analysis of each hospital

Theme 3: Uncoding infections

In many countries vast data collections are existing, which all – more or less – are containing coded patient informations. These data collections are mainly used for administrative purposes especially in the CaseMix settings they are used for funding, reimbursement, planning, etc. On the other hand the data contain – at least if the respective country is 'mature' in CaseMix – multitudes of clinical and medical information. In some countries even medication information (using ATC-codes) such as France or the U.S. are collected and stored.
Surprisingly enough there are comparatively few publications that are using these data collections to reflect on clinical research questions on a broader basis than e.g. in the own hospital settings. About the reasons can only be speculated, a common allegation – at least among clinical researchers – is that the data quality is not eligible for clinical research as it was collected for 'administrative' purposes.
On the other hand vast data collections are waiting to be exploited and years of workpower for extra double or triple data acquisition for various purposes could be saved.

Theme 4: Linking Patient Classification (PC) and Clinical Practice (CP)

Patient classification (PC) is often looked down by clinicians. It is frequently perceived as an unnecessary activity of health organizations or worst as something to do with management or finance services only. This lack of interest is sometimes accompanied by a lack of collaboration in implementation and development of better systems. Likewise, clinical practice (CP) is often misinterpreted by the people involved in classification systems that should represent it. This means CP may be perhaps oversimplified, or worst misrepresented with implications for adequate funding and sometimes acting as a disincentive mechanism for certain specialities or procedures. Thus, there is in fact a PC-CP gap. This would likely need to be closed if both areas are to benefit from further improvements in the future. Both management areas of complexity and system thinking as well as information system use and knowledge management are likely to be helpful when trying to address this issue.

This theme with try to explore the dynamics between patient classification systems (existent or new) and clinical practice (current and desirable), while introducing concepts from complexity theory and human resource management potentially useful in the approximation of PC and CP.

Theme 5: Practical experience applied to a hospital…

It is customary to use the casemix as an element of support for funding and as a tool for comparison and analysis of clinical practice in terms of efficiency (compared to average stays for example). But analysis of casemix allows other perspectives oriented quality of clinical practice or to obtain information to provide value to assistance. Here are some examples from the experience of a hospital in his introduction.

Audience: Intended preferably to: clinicians dealing with CaseMix; b) IT – experts; c) CaseMix economists; d) Clinical coding staff. Ideally participants should be knowledgeable of their respective local CaseMix System; have some clinical background. Have some knowledge of data structures and content that is today mainly used for CaseMix

Duration: 2 hours 30 minutes

Presenters' Biographies

- **Dr. med. Michael Wilke, Dr. Wilke GmbH – inspiring.health, Munich, Germany**
    - CEO of Dr. Wilke GmbH – inspiring.health since 04/2007
    - Business Manager at Ramboll Management 2005 – 03/2007
    - Head of DRG Competence Center, Munich Schwabing hospital, 2001-2004
    - Clinical work as surgeon, intensive care and emergency physician 1994 – 2001
    - Member of PCS/I since 2001
    - Member of CaseMix advisory committee in the German ministry of health, 2002-2004
    - Member of the German Association of Medical Controllers

- **Dr. Carlos Elvira, MD**
    - Chief of the Admissions and Health Information Service, Hospital Universitario San Carlos de Madrid, Spain

- **Henrique MG Martins, MD, PhD (Management Studies)**
    - Assistant Professor, Faculty of Health Sciences, UBI, Portugal
    - Internal Medicine resident, Serviço de Medicina I, HFF, Portugal

- **Marc Berlinguet, MD., MPH**
    - International Medical Manager, I.B.U., 3M Health Information Systems, 100 Barnes Road, Wallingford, CT, USA 06492

- **Maria Angeles Gogorcena, MD**
    - Technical consultant, Institute for Health Information, Spanish Ministry of Health