Improving transparency and comparability and the development of clinical coding in private healthcare

Matt James, *Chief Executive,* PHIN

www.chks.co.uk

CHKS Data Quality and Clinical Coding Conference 2015

Improving transparency and comparability and the development of clinical coding in private healthcare

Matt James, Chief Executive
Private Healthcare Information Network

In 2014, the Competition & Markets Authority ordered private hospitals and consultants to produce better information for patients

- *"A lack of independent, publicly available performance and fee information"*
- *"Adverse effects on competition"*

- Legally enforceable remedies covering:
  - Publication of performance measures
  - Publication of fees [Not yet in force]
  - Establishment of the "Information Organisation"

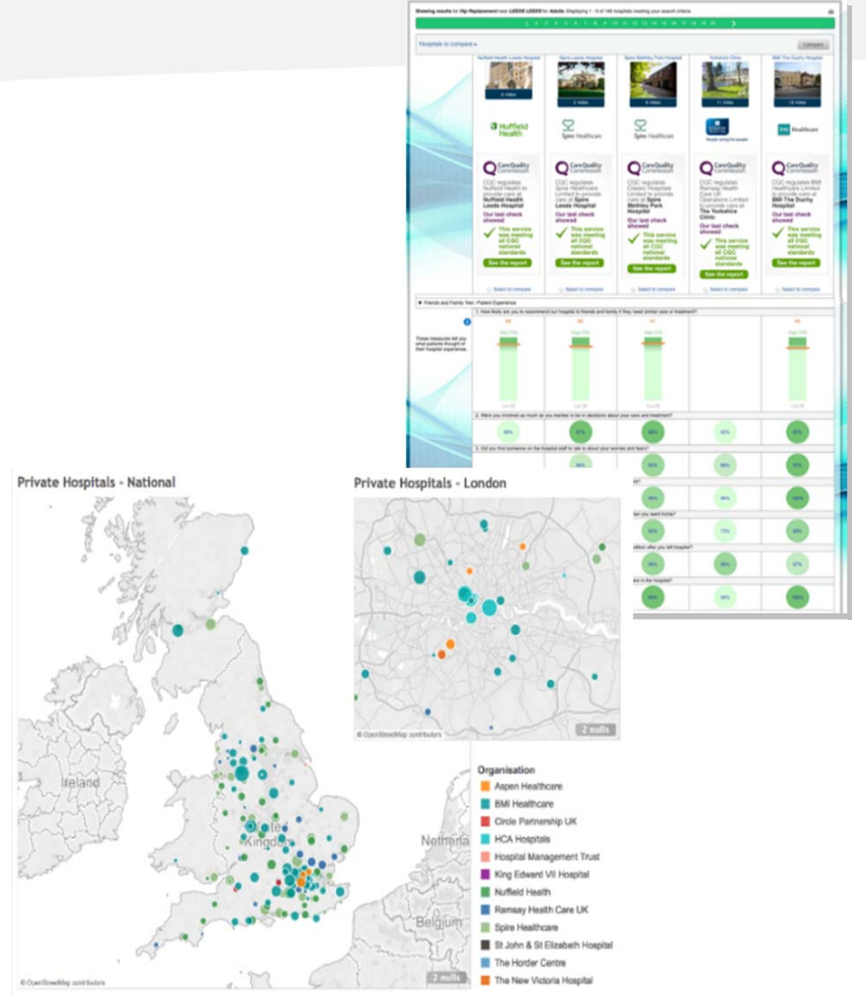
- Applies to all private hospitals, including NHS
- Better information to be published by 30 April 2017

In simple terms

Private healthcare must
produce and publish
information
to the same standards as the
NHS

PHIN is the approved independent information organisation for private healthcare

- Not for profit, established 2012
- Founded and funded by hospitals
- Collects and manages data like the HSCIC, publishes like NHS Choices
  - Process >1 million episodes each year
  - Website lets patients compare hospitals based on performance measures
  - Next step: consultants and prices
- Working in partnership with the HSCIC, CQC, CMA, GMC, RCSEng and others.

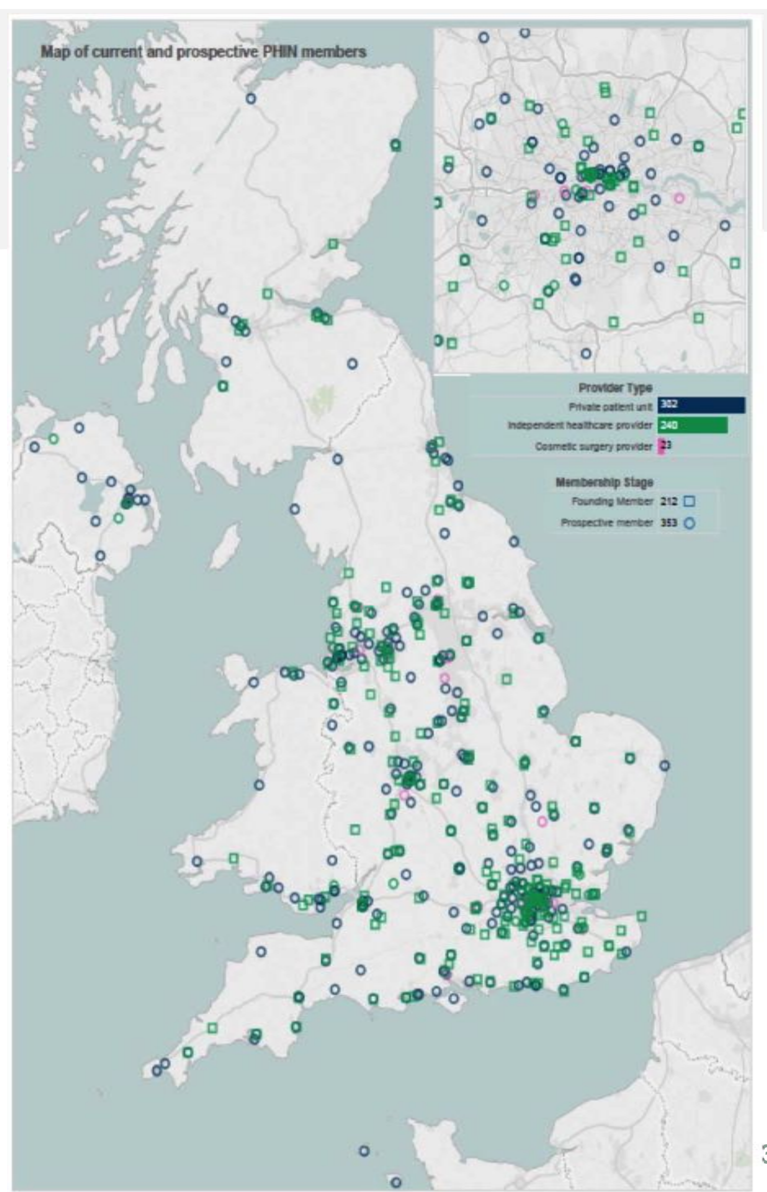


PHIN

Private healthcare means care *not paid for by the NHS*

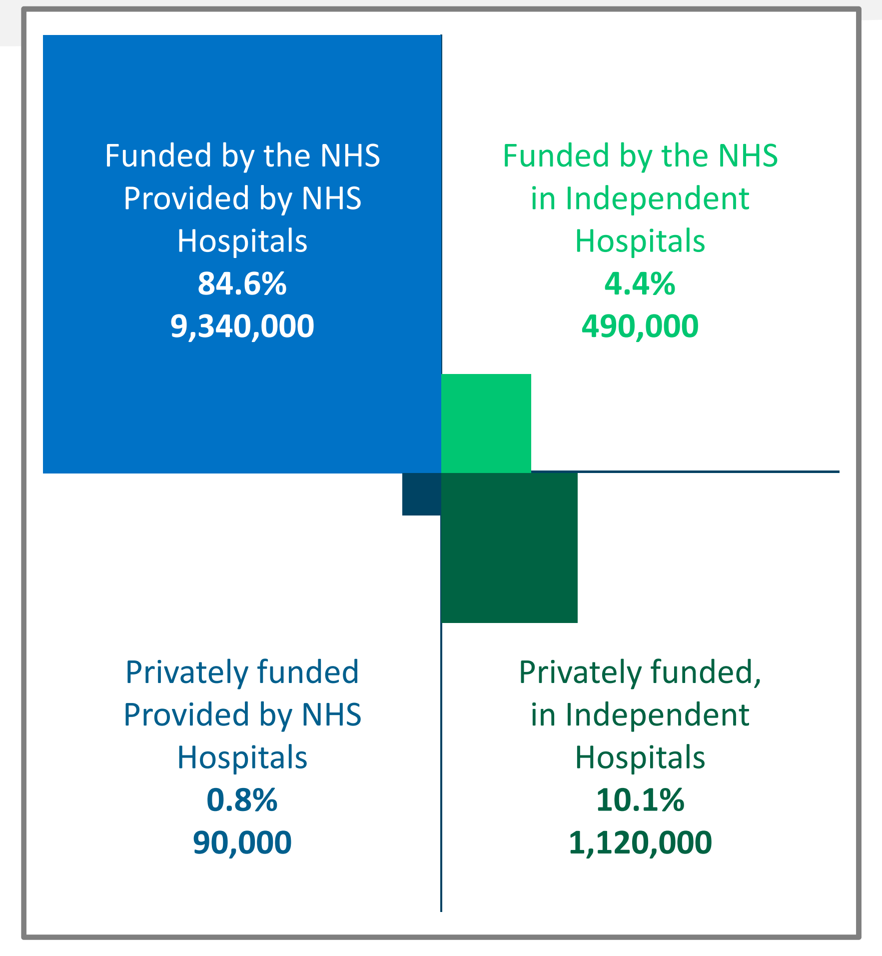
- In the CMA's terms, a *private hospital* is any hospital that offers privately funded care
  - Most independent hospitals
  - Many NHS Hospitals
  - About 500 in total

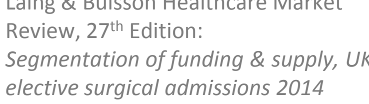
- NHS-funded care offered in independent hospitals is not in the CMA's scope
  - Already captured in NHS data and reporting



Private Healthcare represents about 11% of elective care nationally

Privately funded healthcare
10.9%
1,210,000 admissions





The information remedies require actions from both hospitals and consultants

Hospitals	Consultants
Produce and submit data (Articles 20.1, 21.2)	
Support publication of performance measures (Article 21.1)	Support publication of performance measures (Article 21.1)
Check compliance from consultants on fees info (Articles 22.2, 22.7) Awaiting appeal outcome	Publish fees information via PHIN (Article 22.1) Send fee letters to patients (Articles 22.3, 22.4) Direct patients to PHIN's website (22.3e 22.4e)
Fund PHIN (Articles 21.4, 24.3)	

Hospitals must produce data to NHS standards for private episodes

For every patient record

- GMC Number for consultants
- NHS Number for all patients
- Diagnosis and co-morbidity coding (ICD10)
- NHS Procedure Coding (OPCS4.7)

Additional data items

- PROMs Data
- Adverse Events Data

Patient consent to data use

- New consent forms needed to enable data sharing and linkage

PHIN's Minimum Data Set specification echoes the SUS CDS

FIELD NAME IN FILE	FULL FIELD DESCRIPTION / HYPERLINK	FURTHER INFORMAT
PROVSPNO	HOSPITAL PROVIDER SPELL NUMBER	Alternatively **Admi**
SITETRET	SITE CODE (OF TREATMENT)	
ADMIAGE	AGE ON ADMISSION	
ETHNOS	ETHNIC CATEGORY	
SEX	PERSON GENDER CODE CURRENT	
ADMIDATE	ADMISSION DATE	
ADMIMETH	ADMISSION METHOD CODE	
ADMINCAT	ADMINISTRATIVE CATEGORY CODE	
ADMISORC	SOURCE OF ADMISSION CODE	
CONSULT	CONSULTANT CODE	Must be valic
SURGEON_CODE	MAIN OPERATING CARE PROFESSIONAL	*Required if tl*
ANAESTHETIST_CODE	RESPONSIBLE ANAESTHETIST	*Required if*
COUNTRY	COUNTRY ISO CODE	ISO_3166 A
POSTCODE	POSTCODE OF USUAL ADDRESS	**LEAVE BLA**
POSTCODE_SECTOR	POSTCODE_SECTOR	e.g. **W1G**
DIAG_01	PRIMARY DIAGNOSIS (ICD)	
DIAG_02	SECONDARY DIAGNOSIS (ICD)	
DIAG_03	SECONDARY DIAGNOSIS (ICD)	
DIAG_04	SECONDARY DIAGNOSIS (ICD)	
DIAG_05	SECONDARY DIAGNOSIS (ICD)	
DIAG_06	SECONDARY DIAGNOSIS (ICD)	

The data collected will inform most of the 11 specified performance measures

Driven from Minimum Data Set	From MDS and also Needs linkage	From other data sources
Activity Volume (number of admissions)	Readmission rates (28 days)	Infection rates, (SSIs and HCAIs)
Length of stay	Unplanned transfers	Patient feedback and/or satisfaction
	Mortality rates	Clinical registries and audits
	Improvement in health (PROMs)	Revision rates
		Adverse events

Why does private healthcare need data produced to NHS standards?

- ✓ Make private healthcare visible and comparable
- ✓ Enable direct comparison
  - Count the same things in the same way using OPCS
- ✓ Enable case-mix or risk adjustment
  - Most methodologies rely on ICD10 coding: Charlson Comorbidity Index, etc
- ✓ A longer-term view: interoperable patient records

Your analysis is only as good as your data

What’s the issue with asking for NHS data standards?

Private healthcare typically:

- Uses local identifiers for consultants
- Has never recorded NHS numbers and can’t obtain them easily
- Has never used diagnostic coding
- Mainly uses a procedure coding scheme specified by the insurers (CCSD)

Please note: independently provided, NHS-funded activity has used NHS information standards since around 2008: this is about private episodes.

Problem 1: cosmetic surgery has no national codes

- No NHS cosmetic surgery = no OPCS codes
- No insured cosmetic surgery = no CCSD codes
- Largest providers are specialists: no contact with NHS or insurers
- All use local codes

Problem 2: a lack of clinical coders

- Apparent national shortage of clinical coders
- A lack of available technology offering an alternative to professional clinical coding

= **Right now private healthcare needs more clinical coders than it can find or train**

- The solution may be shared services

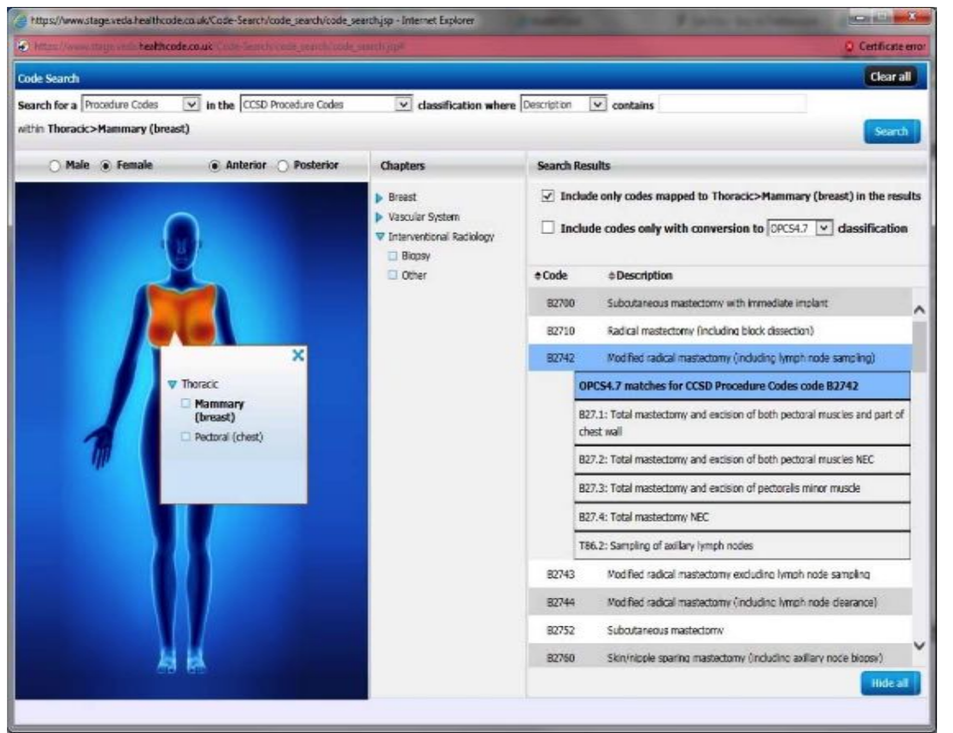
Problem 3: no alignment of coding to payment may affect quality

- Insurers will continue to reimburse based on CCSD
- Insurers don't consi

- Providers will dual-
- OPCS and ICD10 w t

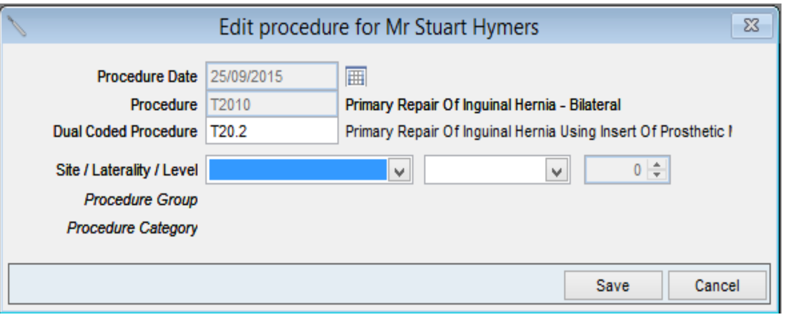
How seriously wo n't determine payments?

Systems suppliers including Healthcode and Streets Heaver (Compucare) are offering some solutions for private coding challenges



Healthcode

Compucare



Problem 4: time is very tight

2014	2015	2016	2017	2018	2019
Order laid 1 October	In force 6 April	Data required 1 September*	Publication 30 April 2017		Remedy Review April

Planning

Implementation

Data gathering

Publication

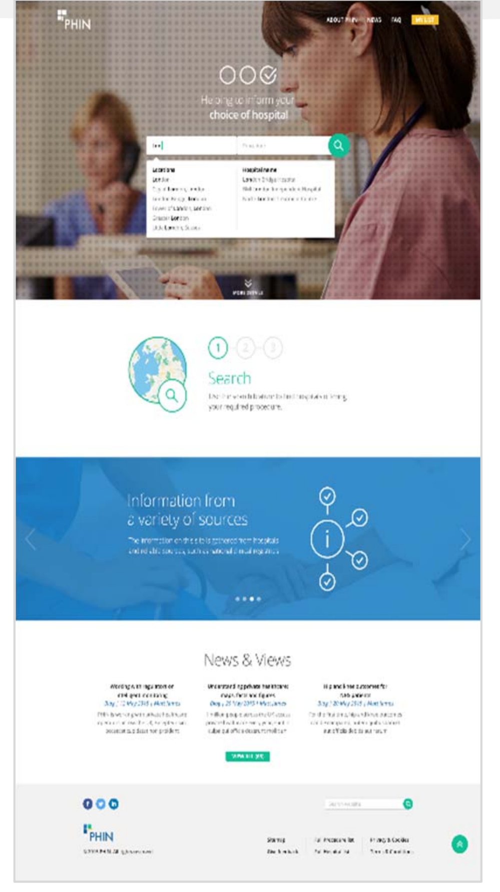
Fees

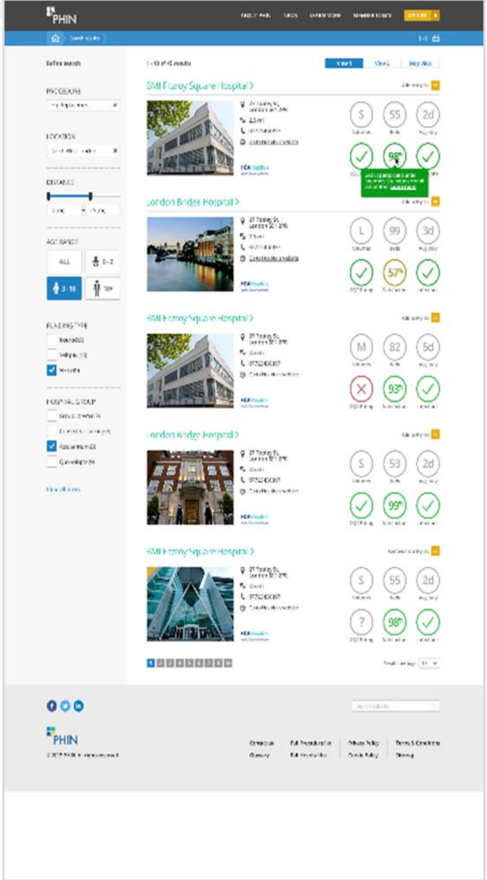
*Most measures will need a full year of CMA compliant data

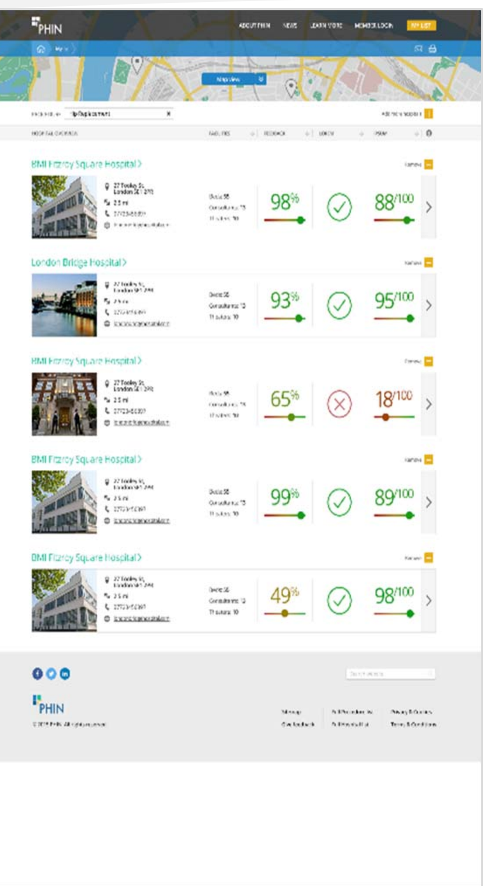
Participating hospitals and consultants will have access to PHIN's secure Member Information Portal for data quality assurance

- Check your data
- Understand performance against benchmarks to enable improvement

The data will be analysed and used to produce our website







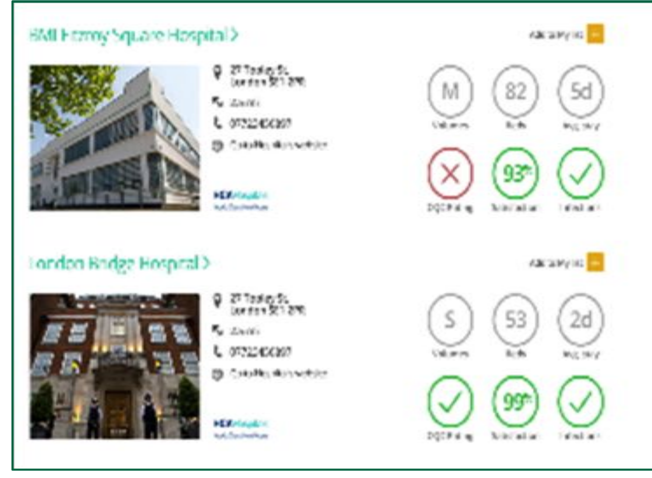
The challenge is to emerge with simplicity from complexity

Professionals want to know that the analysis is complete, robust and fair

- Complete, whole-practice data
- Adjusted for complexity
- With sample sizes and confidence levels understood

Patients want information to be simple

- Simple, clear visualisation
- Summarised data
- Benchmarks



Dummy data

The 11 specified performance measures will give patients and others an improved view of safety and effectiveness

Measure	Safe	Effective	Caring	Responsive	Well-Led
Activity Volume (number of admissions)					
Length of stay		✓			
Patient feedback and/or satisfaction	✓	✓	✓	✓	✓
Improvement in health (PROMs)		✓			
Infection rates, (SSIs and HCAIs)	✓				
Readmission rates (28 days)	✓				
Mortality rates	✓				
Unplanned transfers	✓				
Revision rates		✓			
Clinical registries and audits	✓	✓			
Adverse events	✓				

www.phin.org.uk