Data, Monitoring and Recording Eating Disorder Activity for Funding

Dr Sarah Maguire: Director and state-wide coordinator, CEDD
Dr Susan Hart: Peter Beumont Day Program, RPA, SLHD
Hani Hijazi: Mental Health Information Services Manager, SLHD

Why We Record

- We record the patients that present to us and what we do with and to them while in our care because it is our clinical duty
- We also have a medico-legal responsibility to do so
- AND the recording of patients who present and what we do funds, our district and pays our salaries

Planning for Good Data Recording

- This will take TIME so get the support of your managers to spend time on a data and recording strategy for your service
- This should be part of the regular planning activities of your service
- Seek the advice of your local data or information officer, make sure that the way you are entering and recording data means you are completing the right fields and keeping sufficient notes to ensure you capture the payments for the activities you are completing
- If you can, work with your data or information officer to get monthly or quarterly feedback on the data flowing through from your service, NOTHING MOTIVATES clinicians better than seeing that the hard work they are doing IS NOT SHOWING UP
- If you can, work with your local data or information team to conduct an audit of DRGs for inpatient activity and Principal Service Categories for ambulatory activity to make sure your data recording is accurate and aligned with ABF principals

Tips for recording

- Always record a diagnosis (even if the field is not compulsory) and even if it is a general eating disorder diagnosis, select the F code, write it in the notes, at reviews, as part of treatment plans and in discharge summaries.
- Ensure you are collecting your clinical outcome measures especially HoNOS or HoNOSCA

For Inpatient Activity

- Eating Disorders compared to other mental illnesses, and a number of physical illnesses, have a highly weighted NWAU (payment) so make sure when you are treating a person with an eating disorder, ensure that they get this diagnosis if it is the principal diagnosis (the principal reason why they are in treatment)
- Assume nothing in notes: you are talking to your colleagues BUT you are also recording for a non-clinician who needs to know what the patient has and what you administer for the whole Length of Stay (LOS).
- The Principal Diagnosis influences the payment. Coders determine this by starting with the Principal Diagnosis recorded in the Discharge Summary and then check that the notes mention this same diagnosis throughout
- Each ward round having an issues list for the patient and matching actions you took will ensure procedures are recorded
- Record all complications and their treatment, this drives higher payments
- For eating disorder patients where LOS can be long and made up of various phases of care – medical stabilisation, nutritional rehabilitation, then maintenance – all separate activities attract separate payments, so explore with your local authorities the processes for changing 'care type' during an admission, and establish procedures for this

For Ambulatory Activity

- Don't fill in a record without a diagnosis, even if field not compulsory
- Find F50 in the list, try to be specific if you know the diagnosis BUT better to put something than nothing (e.g. 50.9 Eating Disorder Unspecified – still get paid)
- Accurately reflect your hard work in the electronic records, everything you do clinically should have a matching record
- For every activity you must record a Principal Service Category and then this must reflect the clinical activity as recorded elsewhere
- If you have distinct service events (e.g. the patient receives 3 different types of service, e.g. medical consult, then dietetic consult, then counselling) you need the data to reflect this in the choice of three different Principal Service Categories you select