Data, Monitoring and Recording Eating Disorder Activity for Funding

Dr Sarah Maguire, CEDD
Hani Hijazi, SLHD Mental Health Information Manager
Sharon Smith, NSW ABF Taskforce
Natalie Bryant, NSW ABF taskforce
Dr Susan Hart, Manager Day Program SLHD

Why record?

- Vulnerable patients
- Accurately documenting the care that you give is a clinical imperative
- Medico-legal responsibilities
- Build business cases
- Your LHD and all its services are funded based on the activity you record
- Benchmark with other services

Frequently used Acronyms

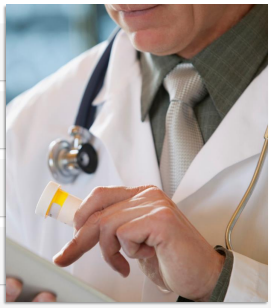
- ABF - Activity Based Funding
- DRG – Diagnosis Related Group (DRG) the diagnosis group (U66)
- NWAU – Nationally Weighted Activity Unit: the single measure of cost for an activity (DRG) across all 3 services (hospital, A&E, outpatient)
- SP –State Price (SP) per NWAU
- IHPA – Independent Hospital Pricing Authority
- AMHCC – Australian Mental Health Care Classification (2016/2017 onwards)

What is ABF

- Activity-based funding (ABF) is a method of funding healthcare where providers are allocated funds based on the type and volume of services they provide, and the complexity of the patient population they serve
- International norm for funding healthcare
- Each DRG represents clinically comparable hospitalisations with similar expected costs, and ABF pays hospitals based on the value associated with the assigned DRG
- If it is not recorded it is not funded

ACTIVITY BASED FUNDING IS...

- A method to fund health facilities for **services they provide** (output funding instead of input)
- A means of **transparently** identifying funding allocation
- A tool to assist in **evaluating** models of care and current allocation of resources
- **Not an uncapped funding source** for additional work



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Who Uses ABF?

- Hospital funding in NSW already paid on an ABF basis – that is if you don't record it it is not funded at your LHD (health 2012/13, mental health 2013/14)
  - All admitted care including hospital in the home and forensic
  - All emergency department services
  - Other non-admitted services that meet criteria: directly related to inpatient or to substitute inpatient, to manage patients with frequent admissions or is reported as a public hospital service
- Outpatient and Community in NSW is also activity funded

SCHEDULE C

XXX LHD - Budget 2015/16

		2015/16 BUDGET					Comparative Data			
		A	B	C	D	E	F	G	H	I
		Target Volume (NWAU15)	Volume (Admissions & Attendances) Indicative only	State Price per NWAU15	LHD/SHN Projected Average Cost per NWAU15	Initial Budget 2015/16 ($ '000)	2014/15 Annualised Budget ($ '000)	Variance Initial and Annualised ($ '000)	Variance (%)	Volume Forecast 2014/15 (NWAU15)
A	Acute Admitted	150,511	140,060	$4,569	$4,662	$687,684	$663,801	$23,883		146,627
	Acute - Highly Specialised Services*	-								-
	Emergency Department	22,165	182,132			$101,274	$96,340	$4,934		21,573
	Non Admitted Patients^	49,590	815,921			$181,508	$174,048	$7,460		48,830
	Total	222,266	1,118,113			$970,466	$934,189	$36,277	3.9%	217,030
B	Sub-Acute Services - Admitted	10,132	6,633			$46,294	$42,330	$3,963		9,487
	Sub-Acute Services - Non Admitted*	2,009				$7,323	$7,162	$161		2,009
	Total	12,141	6,633			$53,617	$49,492	$4,124	8.3%	11,496
C	Mental Health - Admitted (Acute and Sub-Acute)	15,914	7,211	$4,569	$4,662	$72,710	$70,071	$2,639		15,686
	Mental Health - Block Funded Hospitals					$7,516	$7,351	$165		
	Mental Health - Non Admitted*	13,057	225,670			$34,036	$32,276	$1,760		12,836
	Mental Health - Transition Grant									
	Total	28,971	232,881			$114,262	$109,698	$4,564	4.2%	28,522
D	Block Funding Allocation									
	Block Funded Hospitals (Small Hospitals)					$76,890	$75,200	$1,690		
	Block Funded Services In-Scope									
	- Teaching, Training and Research					$31,382	$30,692	$690		
	- Other Non Admitted Patient Services									
	Total					$108,272	$105,892	$2,380	2.2%	
E	State Only Block Funded Services Total					$135,051	$132,882	$2,969	2.2%	

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How are prices calculated?

- NSW Produces a State Price (SP) for:
  - Acute inpatient services
  - Emergency department services
  - Outpatient services
  - Sub-acute services
- The federal body produces a weighting for a particular (IHPA) DRG, called the NWAU
- The annual Service Agreement between LHD and Ministry determines the volume and distribution of services within streams
  - Acute level activity
  - Emergency activity
  - Sub-acute activity
  - Non-admitted activity (all in NSW)
- LHD and clinicians determine what services are delivered within those streams

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PRICING

Funding

Pricing ❯ Funding

State Price ✖ Price Weight (NWAU) ✖ Volume

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Calculating the NWAU for eating disorder activity

- The average hospital service is worth one NWAU – the most intensive and expensive activities are worth multiple NWAUs, the simplest and least expensive are worth fractions of an NWAU
- The NWAU is updated annually, and named to reflect the year of its operation., In 2013-14, the NWAU was called NWAU(13), in 2016/17 it will be called NWAU(16)
- Price of the NWAU is determined by the recorded occasions of care across the country
- NWAU (15) for eating disorders is $26,500 for 13-30 days **without loadings**, in excess gets per diem approx 1000 per day

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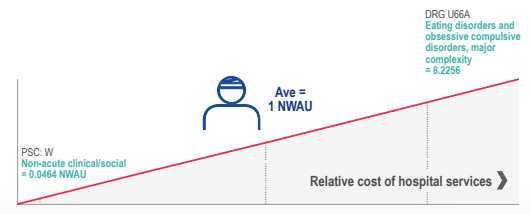
WHAT IS AN NWAU

(National Weighted Activity Unit)?

The NWAU is the 'currency' used to express the price weights for all services funded on an activity basis



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ADJUSTMENTS TO PRICE WEIGHTS

Adjustment	Healthcare Setting/Context	NWAU15		NWAU16
Indigenous	Acute admitted Admitted subacute ED Non-admitted	4%	↑	5%
Remoteness				
Outer Regional	Acute admitted Admitted subacute	8%	=	8%
Remote	Acute admitted Admitted subacute	16%	↑	18%
Very remote	Acute admitted Admitted subacute.	22%	↑	23%

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ADJUSTMENTS TO PRICE WEIGHTS

Adjustment	Healthcare Setting/Context	NWAU15		NWAU16
Private Patient Service (Sub-acute)	Maintenance Care Type	3.8%	↓	1.6%
	Psychogeriatric Care Type	3.5%	↓	3.4%
	Palliative Care Type	3.4%	↓	3.1%
Specialist Psychiatric Age >17 age NOT in MDC 19/20	Acute	34%	↓	32%
≤17 age in MDC 19/20	Acute	15%	↑	21%
	Specialised Children's Hosp.	9%	↑	10%
≤17 age NOT in MDC 19/20	Acute	22%	↑	24%
	Specialised Children's Hosp.	41%	↑	45%

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Activity Price is calculated

- Inpatient: At the conclusion of the encounter (once its closed ie. discharged)
- Ambulatory Care: At the processing of the entered activity. Can have an open encounter with multiple occasions of service (i.e. contacts or activities) which you record in the EMR and that determines the activity price
- In the ambulatory context each time you see that patient, make a phone call about the patient, write a letter about the patient, have a ward round of meeting, each activity attracts a payment
- A patient who is admitted through ED, to an acute medical ward, then transitioned to sub-acute service/bed/facility will attract three separate payments - the emergency activity, the acute activities and the sub-acute admission activities
- Or you can complete a change of care form/procedure while they in the same ward/facility and the activity will attract another payment
- If they were then transferred to a day program or specialist inpatient unit this would be another activity for which they received payment

NWAU CALCULATOR

The NWAU calculator is an education tool developed to assist clinicians and managers understand the factors that influence the calculation of NWAU for an episode of care or for a patient journey.

http://nwaucalc.moh.health.nsw.gov.au/#/

Royal Price Alfred Hospital
16 year old
Not indigenous

Sydney Children's Hospital
16 year old
Not indigenous

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Activities within Hospitals Not Under ABF

- Teaching Training and Research
- Small rural hospital under about 32-34 beds
- Some specialist hospitals like Tresillian

F codes and ABF

- All F Codes fit into the same DRG
- 50 Eating Disorders
- 50.0 Anorexia Nervosa
  - 50.00 unspecified
  - 50.01 restricting type
  - 50.02 binge eating/purging type
- 50.1 Atypical Anorexia Nervosa
- 50.2 Bulimia Nervosa
- 50.3 Atypical Bulimia Nervosa
- 50.8 Other Eating Disorders
- 50.9 Eating Disorder Unspecified
- For monitoring the success of the service plan recording right F code matters

Eating Disorder F Codes and DRG

- All eating disorder F codes fall under AR-U66Z DRG, i.e. Eating & Obsessive Compulsive Disorders
- AR denotes mental health, Z denotes 'no split'
- Currently paid as a level 6 NWAU
- Same NWAU for all of U66Z (all F codes) , i.e. for all eating disorders
- As of July 1 2016 this DRG will be split - U66
  - Eating & Obsessive with MINOR complications (paid 4)
  - Eating & Obsessive with MAJOR complications (paid 8)
- July 2016 roll-out of the AMHCC will begin and it will eventually replace DRGs in mental health (medical vs mental)
- Under AMHCC you must do a HONOS to receive payment

ABM PORTAL

The ABM Portal is a tool to assist in evaluating the efficiency and efficacy of health service delivery in order to review and improve care, leading to better patient outcomes

https://abmportal.moh.health.nsw.gov.au/qlikview/FormLogin.htm

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Recording Inpatient Care

- Keep good clinical notes
- Document the diagnosis (for allocation to DRG) and what you do with and to the patient (procedures)
- Coders in medical records extract and enter the relevant data to determine the payments for activities
- They review the documentation
- They are trained in how to code
- 2 year training
- Strict rules about how you code and what you can and can't code
- Coders are not DOCTORS or clinicians (even if they are they are not allowed to make assumptions about the typical care expected for a condition)
- Specialist facilities have to be careful to assume nothing in notes, document everything e.g. if a test result reveals a diagnosis and necessitates a treatment put BOTH in the notes – the CODER is not allowed to interpret test results
- E.g. must write Hypo or Hyper not the K level or it won't be coded, and document the treatment provided

Recording Inpatient Activity

- Eating disorders (U66Z) has a heavily weighted NWAU so recording the diagnosis in the notes at multiple points will help this get accurately assigned
- Principal diagnosis in discharge summary influences the DRG (activity payment)
- But coders do also look at the notes to determine diagnosis – they need the discharge diagnosis to correspond with the notes
- Coders are coding the principal activity (or diagnosis), but complexities can drive the payment up
- They need know that not only did the patient have that diagnosis BUT that it was the reason for care i.e. the patient received treatment for it, e.g. if a patient came in with anorexia nervosa but there are no notes regarding the treatment for it, it won't be recorded as principal, at best it will be an ancilliary (U Code)
- In ward round or similar meetings have an issues list married to an action list: things that you are currently providing treatment for (procedures) e.g. renal, electrolyte, malnutrition
- Ideally all presenting problems that received some form of treatment are listed on the discharge summary (and then reflected in notes, issues lists and action lists)

Recording Inpatient Activity

- Diagnoses must be stated as anorexia nervosa or bulimia nervosa, not just anorexia
- The more specific the better, anorexia nervosa better than eating disorder
- Record the severity of malnutrition and treatment provided, this is perhaps necessary for new DRG
- With a split DRG (major vs minor complexities) very important to document every complication especially if they are being treated, but also if the patient had a history of severe illness or malnutrition that history would be important to document as it might determine which code, this will drive the higher level of payment

Recording Inpatient Activity

- You can change a patients care type during their stay (on the same ward).
- Care type can be Acute (e.g. medical stabilisation), Rehabilitation (e.g. refeeding), Palliative, or Maintenance
- E.g. SLHD SWSLHD has a care type change order on CERNER, this also has to be clearly documented in the notes e.g. ACUTE Care type no longer required and changing to rehabilitation, or palliative etc.
- AND this would usually accompanied by a new treatment plan in the notes (except if you change to a Maintenance care type)

Recording Ambulatory Data

- Ambulatory or non-admitted activities don't use DRG to calculate payment
- They use the Principal Service Category to determine price
- In the system non-specific categories have a lower price (e.g. mental health unspecified), the more specific category have a higher price (e.g. emergency clinical, extended clinical)

Recording Ambulatory Activity

- Make sure you complete a record in the EMR
- Every activity you perform should have a corresponding electronic record
- Don't fill in a record without a diagnosis, even if field not compulsory
- Find the F code 50 in the list and try to be specific BUT an unspecific diagnosis better than none (e.g. 50.9)
- Always select a Principal Service Category and the nature of this clinical activity must be reflected elsewhere in the notes
- If you have distinct service events involving different clinicians doing different things with the patient, need different Principal Service Categories

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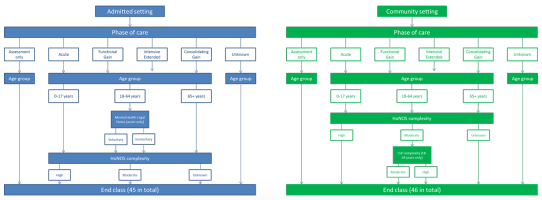
A NEW APPROACH – AMHCC

IHPA have developed a new mental health care classification that will be implemented for pricing admitted mental health services from 1 July 2017



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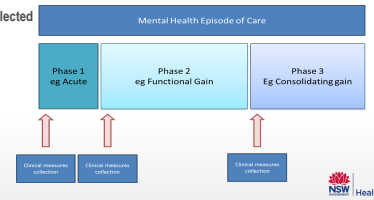
IMPLEMENTATION OF THE AMHCC IN NSW

Mental Health Phase of Care

- Requires a clinical decision
- Reflects the prospective goal of care
- Defines the collection points for clinical outcome measures
- Current status: not collected



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HONOS COMPLEXITY

HoNOS complexity

- Final variable within the admitted branch of the AMHCC
- HoNOSCA, HoNOS or HoNOS65+ used as clinically appropriate
- Weighted individual scores based on age group and MHPoC
- Required at admission and then change of MHPoC
- This is no change from the existing MH-OAT protocol for HoNOS
- It is expected that end-classes with unknown HoNOS will have the lowest price weights

28 | NSW Implementation of the AMHCC

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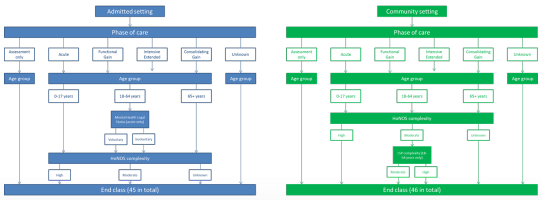

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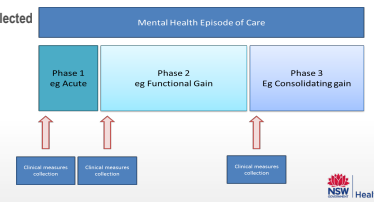

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COUNTING

Just remember…

Electronic patient data is the invoice to the Ministry of Health

If activity data isn't recorded in an organisational system, it can not be used in the funding formula

It will be as if the data didn't exist at all!

IF IT ISN'T IN THE SYSTEM, IT DOESN'T COUNT!

AD HOC CHARTING

.....A misnomer

Dr Susan Hart
Accredited Practising Dietitian
Program Manager
The Peter Beumont Day Program, RPA

A DATA ENTRY PLAN

1. Data entry is not "ad hoc"
2. It is necessary to have a planned and systematic data entry plan/strategy
   - How to ensure that "data entry" works for your clinicians and your service?
   - To ensure it is not a meaningless exercise
   - To maximise the benefit of ABF funding structure for your service
3. Accurate data = the future of your service
   - Ensure that your clinicians understand this

4. Data entry captures and describes the hard work of your service
   - It demonstrate how busy you are
   - How do you accurately describe /represent /communicate /capture your teams clinical activity?
   - How does it reflect the clinical interventions that you are providing?
   - You feel that you are very busy, but data entry will demonstrate to you and others just how busy you are
     - "where did I spend my time today"

THINGS THAT HELP?

- Getting feedback on your monthly activity is helpful as a manager
- It is a process
- Taken a while to work out how to best "describe" my teams clinical activity.
- Taken a while to get the team on board, and to make it part of their daily routine
- Making time initially to develop your plan
  - Prioritising time for it each day
  - Get quicker at it with practice i.e. practice makes perfect!
  - When you have a plan it is much easier

THINGS THAT HELP?

- Communicate with your local data expert to get advice and check that what you are doing is correct.
- Lots of reminders to my team "have you entered your clinical activity"
- Doing it in "real time".
  - The closer it is to real time the more accurate the data is going to be
- Clear instructions on how to enter data for your team.
- Easier when using CHOC or electronic medical records as the file is already open. More difficult when using paper notes.
- A culture in your team where everyone does it

OBSTACLES

- Not being familiar with the software
- Not being clear on how to enter it
  - Having ambiguous instructions
- Not being aware of the value or purpose of this information
- Not having enough support and instructions initially
- Being a busy clinician
  - Easy to get bogged down in clinical business that data entry is forgotten
- It does take time (more in the beginning)

ABOUT THE PETER BEUMONT DAY PROGRAM

- 4 days per week, 6 hours per day
- Intensive treatment, closer to inpatient intervention where people don't sleep than an outpatient intervention where patients might present for 1 session per fortnight.
- Mainly group work, a minimum of 4 hours of face to face for each day for the patient
- Some individual work on top of this
- Highlights the challenge of describing "group" interventions

COMPARE "DAY PROGRAM" TO "OUTPATIENTS"

Outpatients	DAY PROGRAM
✓ Counted as "ambulatory" or non admitted	✓ Counted as "ambulatory" or non admitted
✓ Non admitted patients = the same process	✓ Non admitted patients = the same process
✓ A multi-disciplinary intervention ▪ Multiple clinicians may see patients at each visit i.e. dietitian & doctor	✓ A multi-disciplinary intervention ▪ Multiple clinicians may see patients at each visit i.e. dietitian & doctor
× Often individual treatment	× Usually group intervention
× Lower intensity of treatment per patient but greater numbers of patients are seen	× High intensity of treatment per patient, but for fewer patients seen i.e. 6 -8 at a time

BRIEFLY....SIMILARITIES

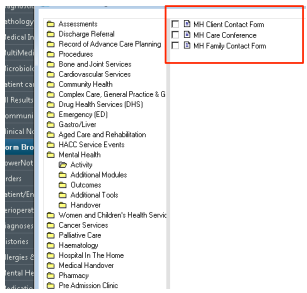
- If your outpatient service =
  - 1 patients sees 1 clinician then leaves (straightforward)
- BUT multi-disciplinary care is best practice in eating disorders. In ambulatory setting patients may be seeing multiple clinicians at each visit
  - i.e. Seeing the doctor and dietitian in same day.
  - In outreach, likely to see multiple clinicians
  - have to think realistically how this activity gets captured

THE CHALLENGE OF CAPTURING GROUP ACTIVITY

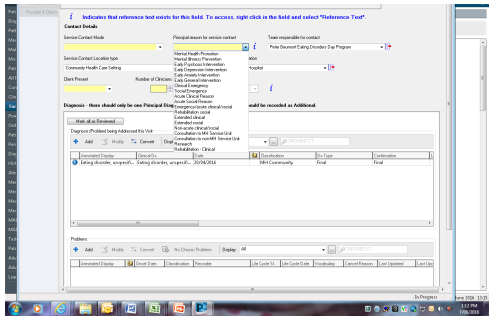
There are several ways to capture the information:

1. Enter group activity in way that is similar to individual activity
2. OR enter it via scheduling books
3. OR send your occasions of service to your LHD data person to collate (*felt this under-represented day program activity*)

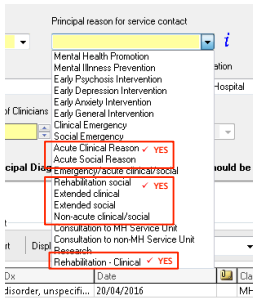
CLIENT CONTACT FORMS …what is important?



PRINCIPLE REASON FOR SERVICE CONTACT



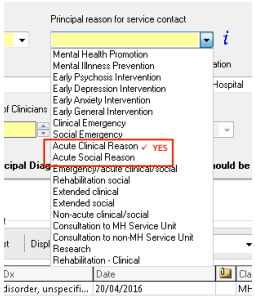
PRINCIPLE SERVICE CATEGORIES



- Learn and know the definitions of each PSC.
- If you are unsure consult your local data expert.

PRINCIPLE SERVICE CATEGORY IS REALLY IMPORTANT

- It is important to reflect on which PSC (Principle Service Category) your service is delivering
  - How does the PSC apply to the intervention/activity that you are providing
- Weightings for each PSC are different
  - Gives the value of once service contact
  - Some activities are more "expensive than others"
- Must accurately reflect the type of care being provided



"Acute Clinical Reason"

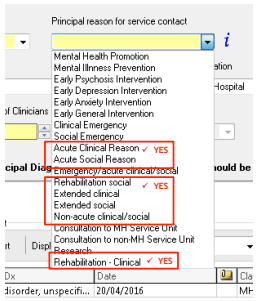
- *"Treatment is focused on clinical symptom reduction with a reasonable expectation of substantial improvement in the short term"*
- *"No previous history or ….acute exacerbation of clinical symptoms"*
- This is the core reason why patients admit i.e. Newly diagnosis with an eating disorder or exacerbation of previous symptoms such as binge eating, vomiting and/or restricting present to our service.

THE DAILY TIMETABLE

	Monday
9.45	WEIGH IN
10.15	AM SNACK
10.30	WEEKEND DEBRIEF & CBT GROUP
12.00	*Free time*
12.30	LUNCH
1.00	NUTRITION or OT GOAL SETTING
2.30	*Free time*
3.00	PM SNACK
3.15	WARD ROUND 3.15 to 5.00 pm

- A typical Monday
- Our busiest day of the week
- All staff are working i.e. ward rounds, team meetings
- 6 patients attending
- In a 6 hour day only 2 X 30 mins breaks

PRINCIPLE SERVICE CATEGORIES



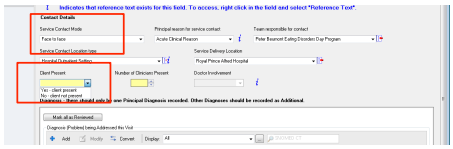
	Monday
9.45	WEIGH IN **Extended Clinical**
10.15	AM SNACK **Rehabilitation Social**
10.30	WEEKEND DEBRIEF & CBT GROUP **Acute Clinical Reason**
12.00	*Free time*
12.30	LUNCH **Rehabilitation Clinical**
1.00	NUTRITION or OT GOAL SETTING **Acute Social Reason**
2.30	*Free time*
3.00	PM SNACK **Rehabilitation Social**
3.15	WARD ROUND **Non Acute Clinical**

- Matching intervention to PSC
- Clearly greater than one clinical activity to be counted.
- 6 patients attending this day
- 2-4 clinicians delivering face to face (6 clinicians in total in our team)
- Planned group therapy
- Planned ward round and weigh-in (both individual contacts)
- Other unplanned occasions of service

ANOTHER IMPORTANT NOTE

- If the PSC is the same on multiple client contact forms in one day, only one service event will be counted
- Enter 5 separate activity forms
  - I.e. 5 separate groups each with 5 patients

CLIENT PRESENT? YES OR NO



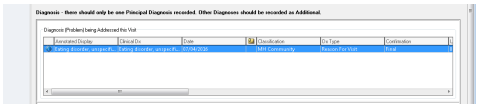
CLIENT PRESENT?

- The amount of face to face activities (or "client present") is important
- "Client present" activities are the only ones that are funded by ABF
- Learn what face to face activities are?
  - This might surprise you
- For one FTE
  - 65% of time should be of clinically related work
  - Face to face should be a large amount (but not all).

CLIENT PRESENT?

- When there is 2 way dialogue between clinician and patients
  - Including phone calls, emails
  - Assessments, intake, group therapy and other individual sessions
  - Ward round
  - Meal supervision
  - Time spent by clinician on self monitoring diaries (when it is providing feedback to the patient)
- Research intervention at Day Program
  - Previously had not any clinical activity relating to our research assistant
  - Realised a significant amount of work was 2 way intervention

DIAGNOSIS



- Always make sure that an eating disorder diagnosis is entered.

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Health
NSW GOVERNMENT
Sydney Local Health District

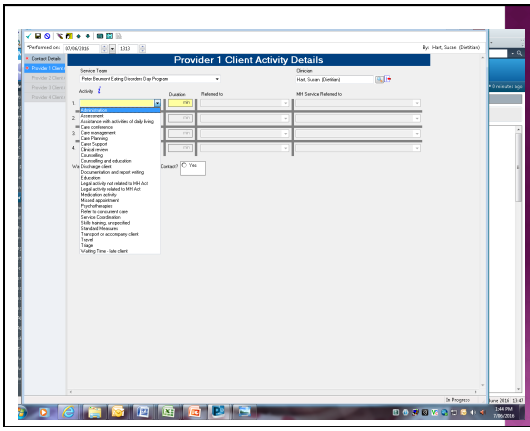
Eating disorder F50 codes

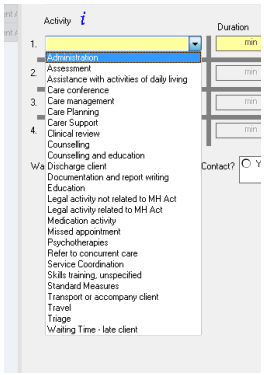
- F50 Eating disorders
  - F50.0 Anorexia nervosa
  - F50.1 Atypical anorexia nervosa
  - F50.2 Bulimia nervosa
  - F50.3 Atypical bulimia nervosa
  - F50.4 Overeating associated with other psychological disturbances
  - F50.5 Vomiting associated with other psychological disturbances
  - F50.8 Other eating disorders
  - F50.9 Eating disorder, unspecified

- Consider "eating disorder unspecified" F50.9 as your default diagnosis, when unsure of the exact diagnosis
- EDNOS/OSFED - is the most common eating disorder in the community (gives no indication of behaviours present i.e. vomiting)

	Monday
9.45	WEIGH IN **Individual Client Contact form**
10.15	AM SNACK **Group Therapy**
10.30	WEEKEND DEBRIEF & CBT GROUP **Group Therapy**
12.00	*Free time*
12.30	LUNCH **Group Therapy**
1.00	NUTRITION or OT GOAL SETTING **Group Therapy**
2.30	*Free time*
3.00	PM SNACK **Group Therapy**
3.15	WARD ROUND **Care Conference - Individual** 3.15 to 5.00 pm

- In eating disorder services meal support is GROUP THERAPY



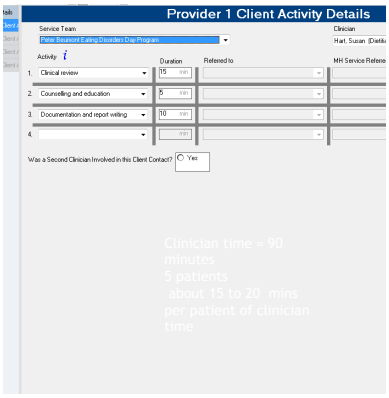


- How do these activities apply to the service/ intervention that you are providing
- Some are "client present" and some are not.
- Learn the definitions of what each activity is
- Consult with your data expert when unsure

	Monday
9.45	WEIGH IN
10.15	AM SNACK **Activities of daily living, Education**
10.30	WEEKEND DEBRIEF & CBT GROUP **Clinical Review** **Psychotherapies**
12.00	*Free time*
12.30	LUNCH **Activities of daily living, Education**
1.00	NUTRITION or OT GOAL SETTING **Skills training OR Counselling and Education**
2.30	*Free time*
3.00	PM SNACK **Activities of daily living, Education**
3.15	WARD ROUND 3.15 to 5.00 pm

WHICH ACTIVITIES?

- Activities of daily living = the provider is involved in doing the activity with the client
- Each activity incurs some "administration" or "documentation and report writing"
- Education (psycho-education is core aspect of eating disorder treatment)



Clinician time = 90 minutes
5 patients
about 15 to 20 mins per patient of clinician time

A NOTE ABOUT ENTERING TIME?

- The time recorded for an activity reflects the clinician time
- This is a challenge for reflecting the clinician time involved in group therapy

	Monday
9.45	WEIGH IN **About 5 mins per patient**
10.15	AM SNACK **15 mins of clinician time**
10.30	WEEKEND DEBRIEF & CBT GROUP **90 mins of clinician time**
12.00	*Free time*
12.30	LUNCH **30 mins of clinician time**
1.00	NUTRITION or OT GOAL SETTING **90 mins of clinician time**
2.30	*Free time*
3.00	PM SNACK **15 mins of clinician time**
3.15	**WARD ROUND** 3.15 to 5.00 pm **About 20 mins per patient**

TIME

1. Clinician time for group = 90 minutes
   - 5 patients
   - Equates to about 15 to 20 mins per patient of clinician time
   - Time allocated to each patient cannot exceed 90 minutes
2. Clinician time for meals = 30 minutes
   - 5 patients
   - about 5-10 mins per patient of clinician time
3. Clinician to use judgement about the time spent with each patient at a meal and in a group.
   - Time allocated to each patient cannot exceed 30 minutes

IN SUMMARY

1. Data entry is not “ad hoc”
2. It is necessary to have a planned and systematic data entry plan/strategy
3. Accurate data = future of your service
4. Data entry captures and describes the hard work of your service
5. Communicate regularly with your local data expert
6. Capturing group interventions accurately posses some challenges.
7. Understanding your “principle reason for service contact” and “principle service category” is essential
8. Appropriately capturing “client present” or “face to face” activities is important
9. Entering data correctly and accurately affects the future of your service.