Activity Based Funding

The need for clinical engagement

Experience in Trauma and Orthopaedics

28th May 2015

David Moore

RCSI

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive
Clinical Strategy and Programmes Division

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TRAUMA & ORTHOPAEDIC SURGERY CLINICAL PROGRAMME

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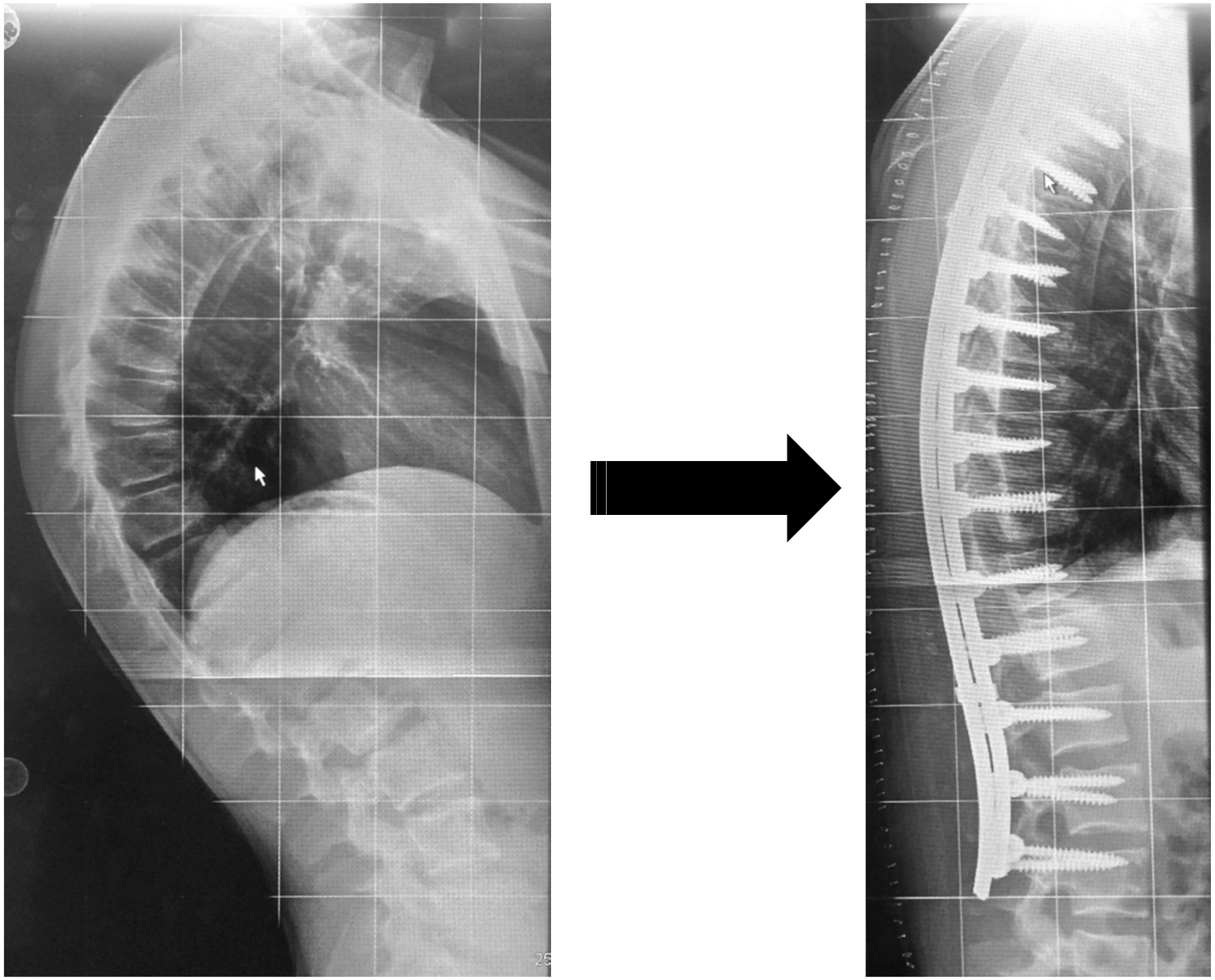
- Funding system designed to improve care, manage resources and deliver quality outcomes

What is ABF?

What is ABF?

- Hospitals paid fixed amount per patient episode of care
- Activity bundles account for
  - Patient diagnosis
  - Complexity of care
- Funding should be transparently linked to services and outcomes

How does ABF work?



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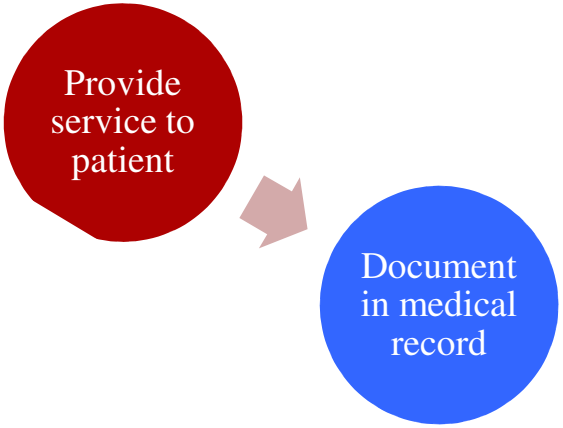

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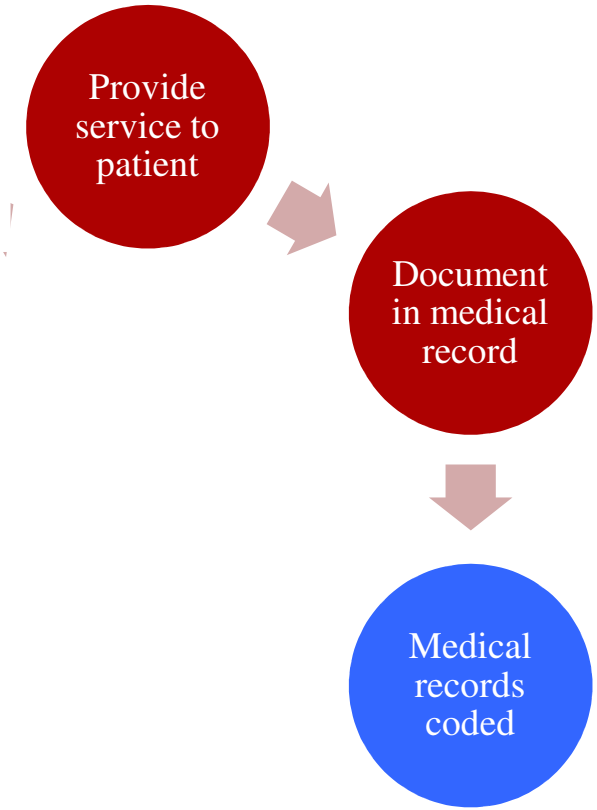

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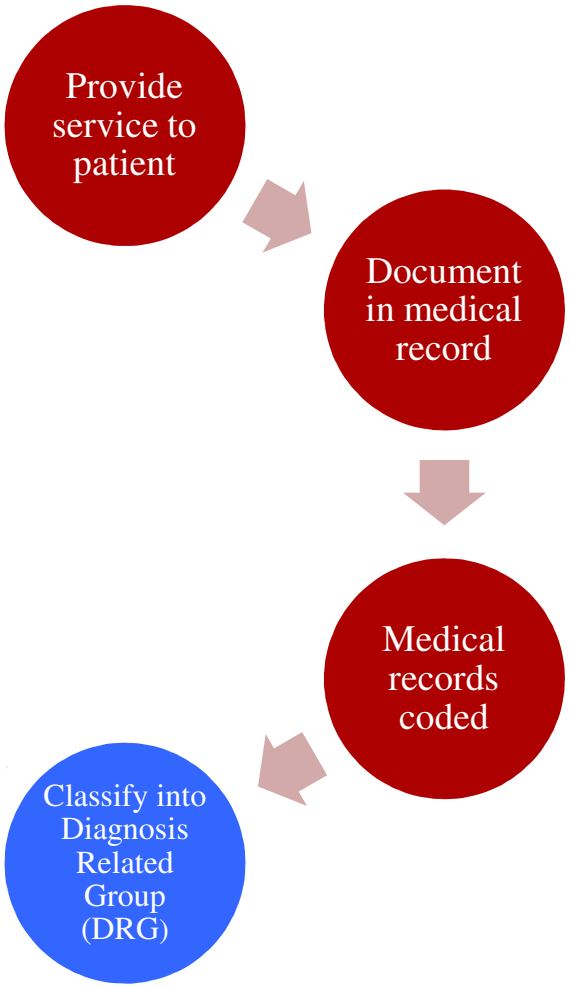

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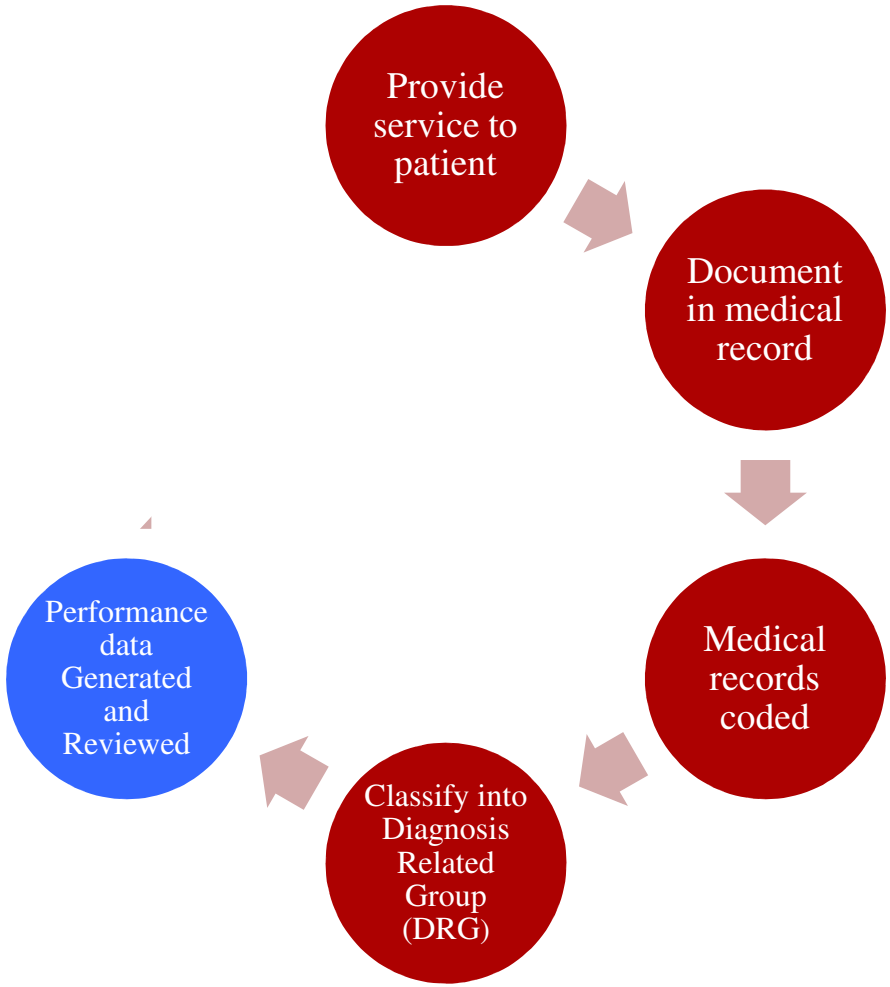

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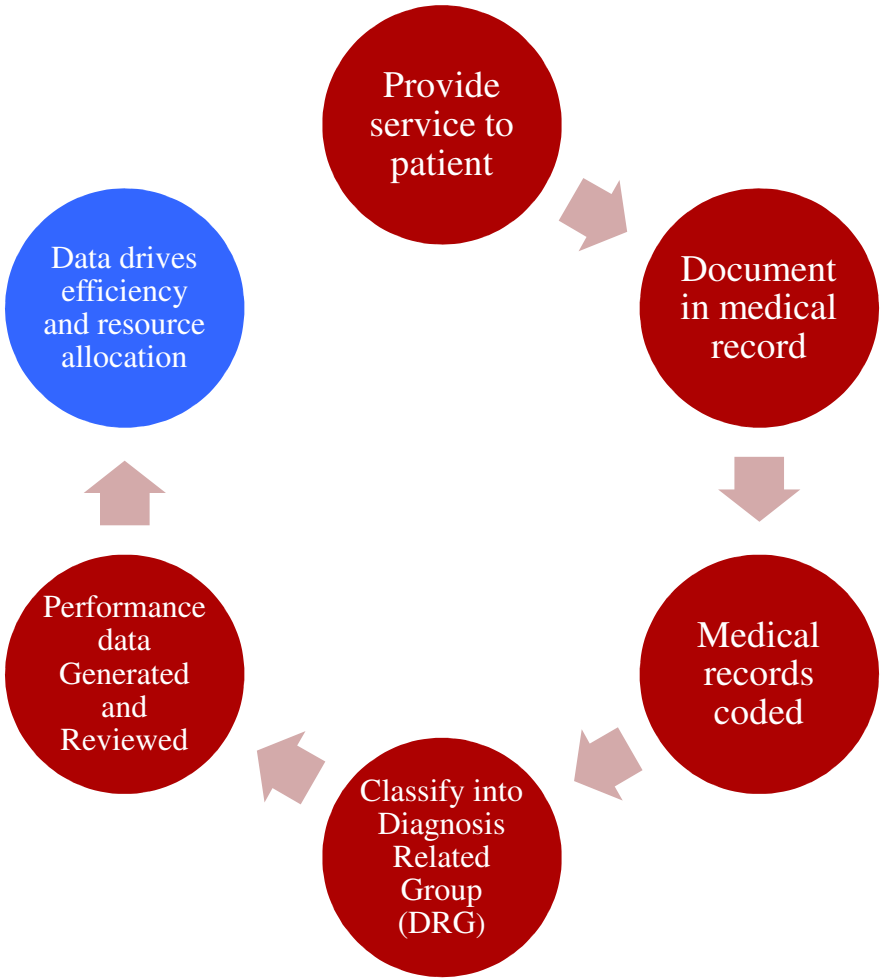

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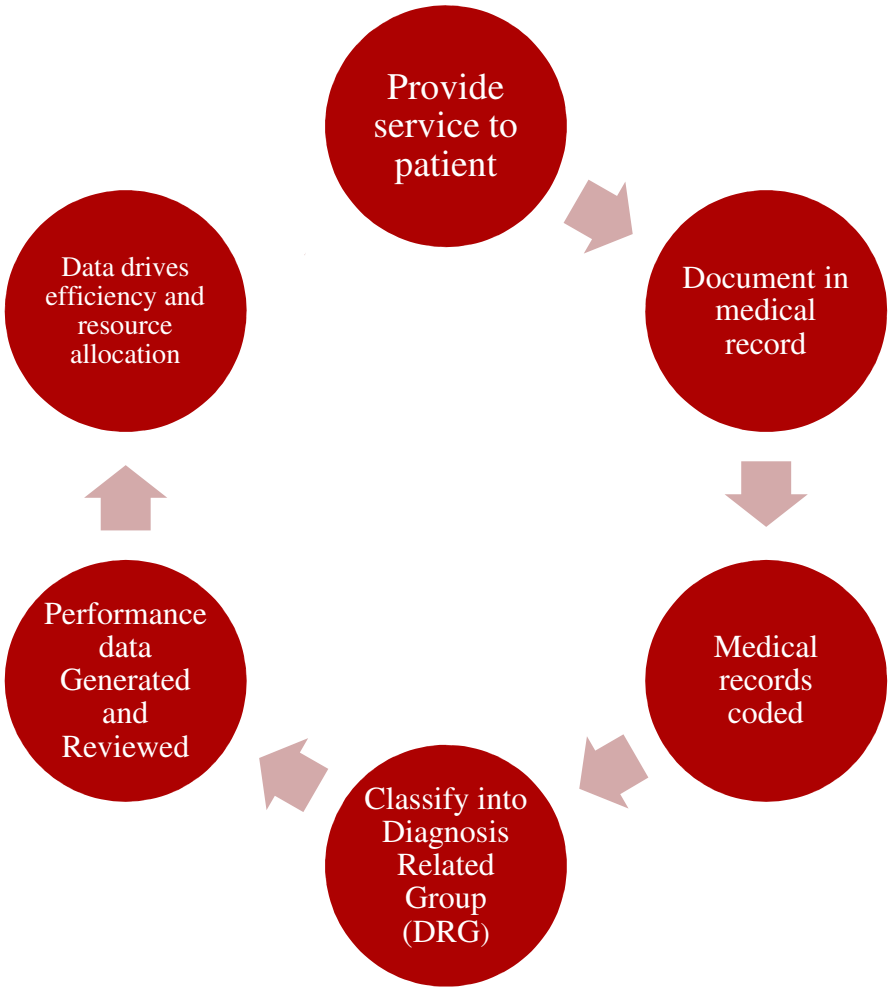
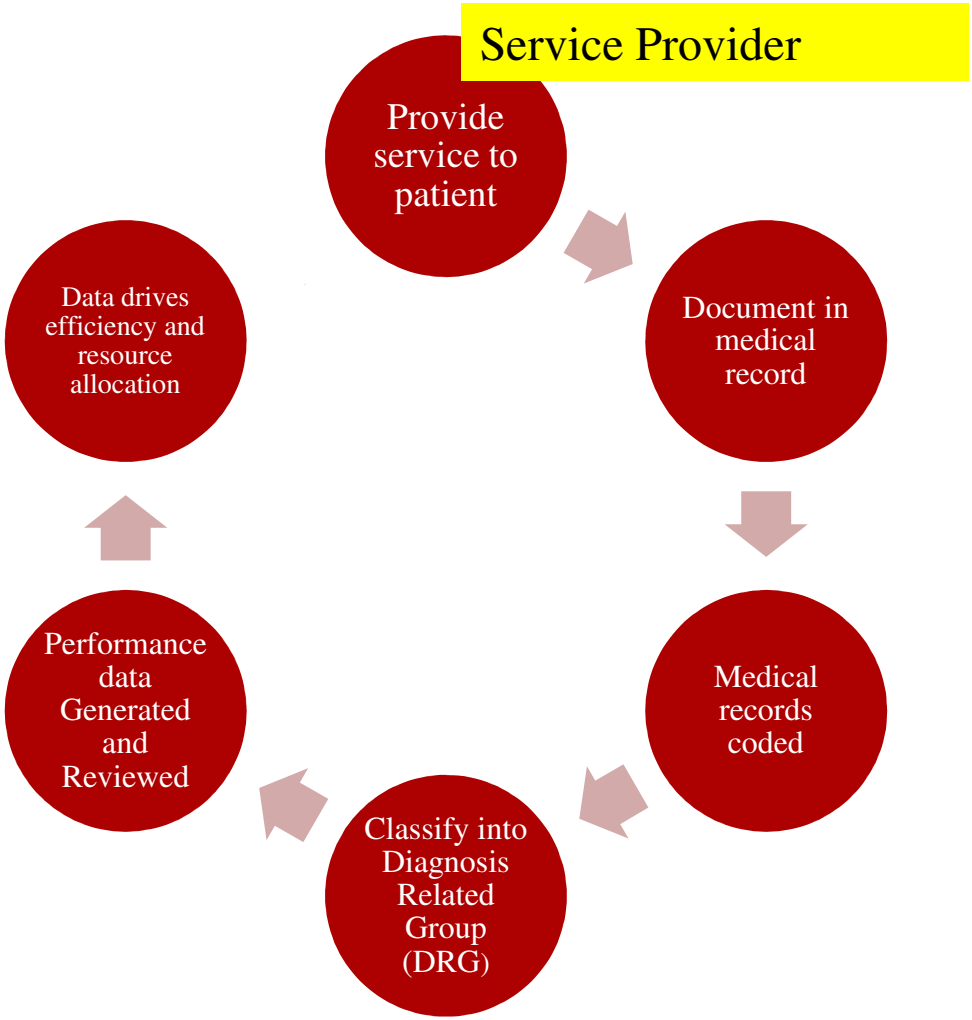


Roles of the clinician

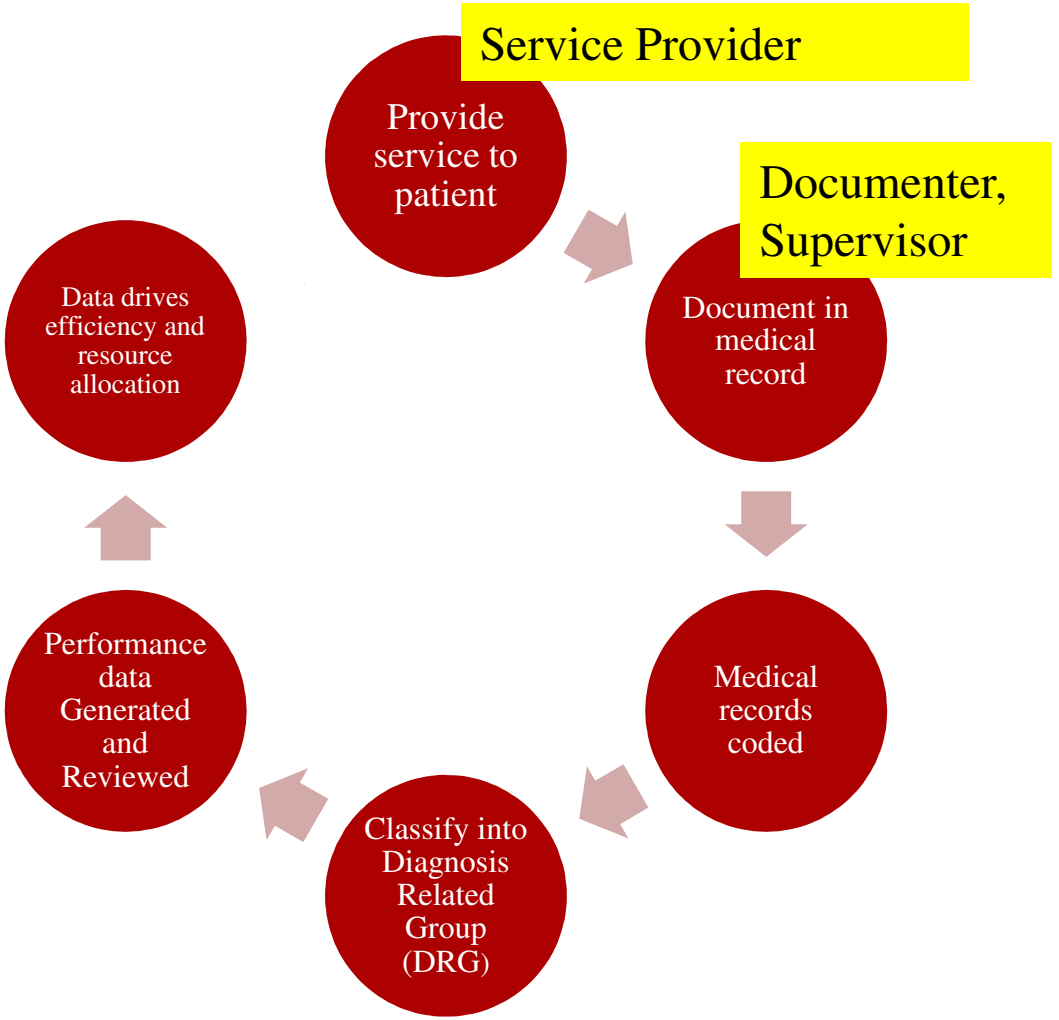


Roles of the clinician

Complexity varies

	No. of codes		Volume
Lower limb	103		20,466
Upper limb	84		12,397
Spine	19		1,048
T&O other	26		5,056
Non surgical	17		13,184
	249		52,151

Procedure codes done >20 times per year = 249



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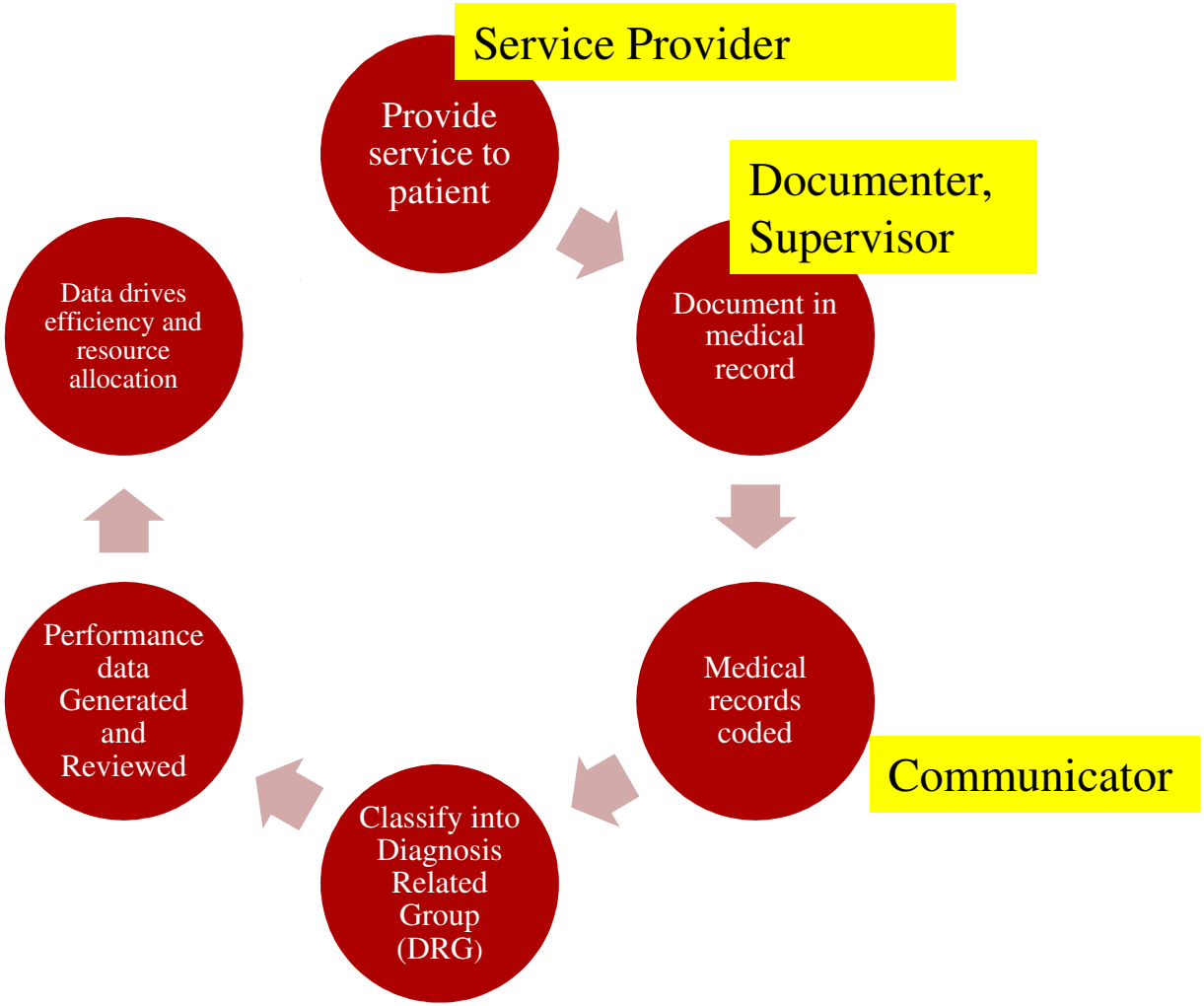
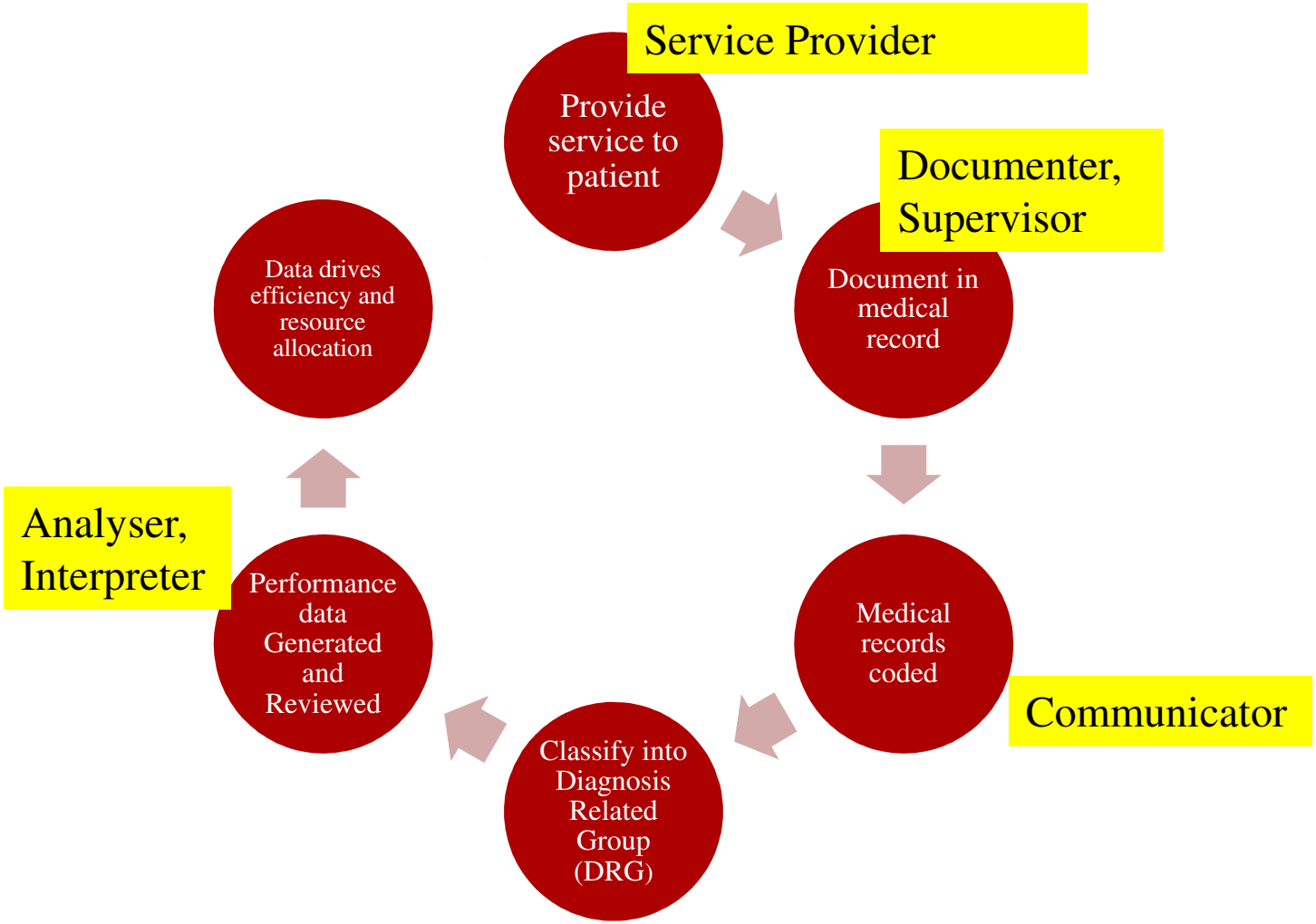
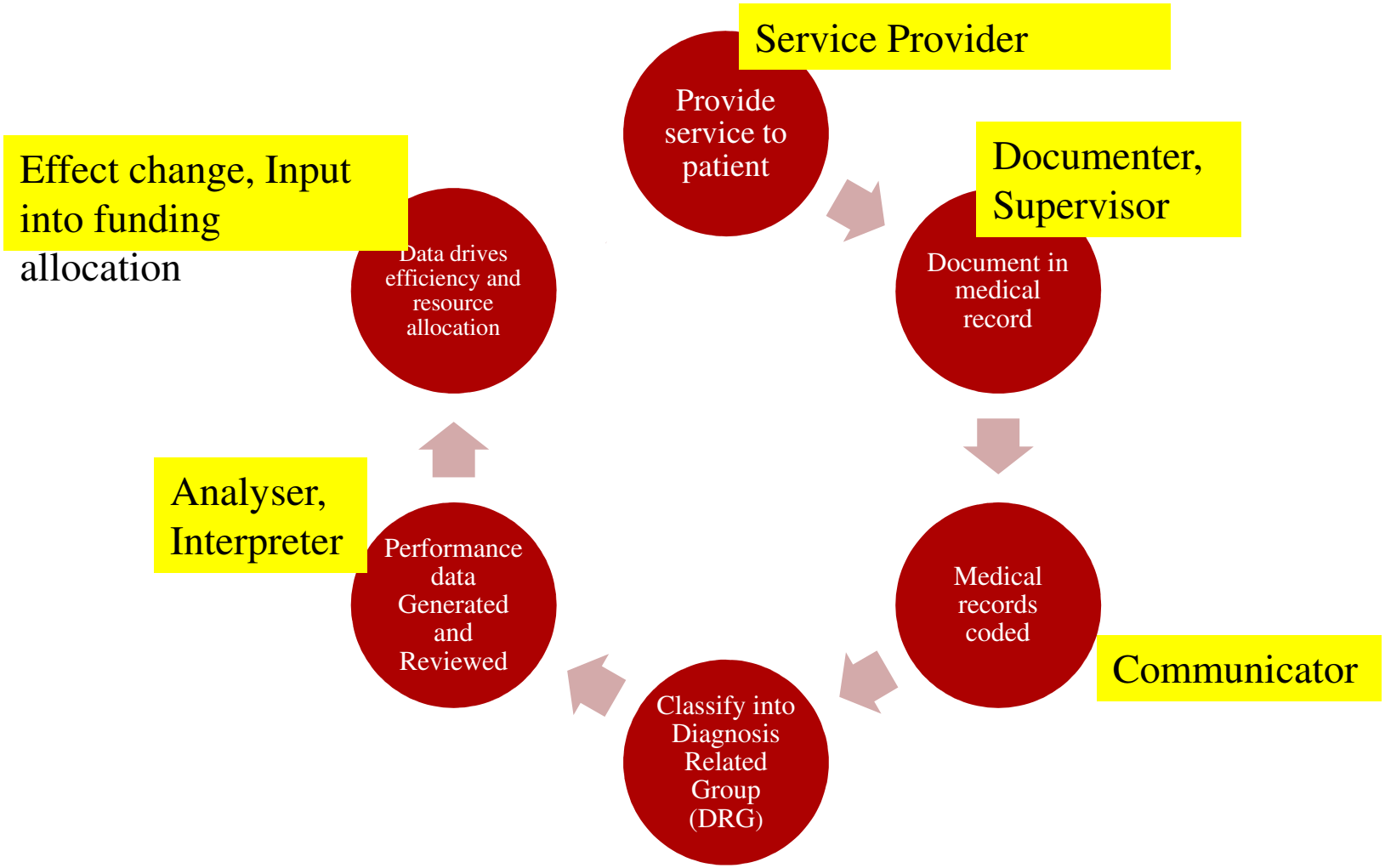


Roles of the clinician



Roles of the clinician



Roles of the clinician

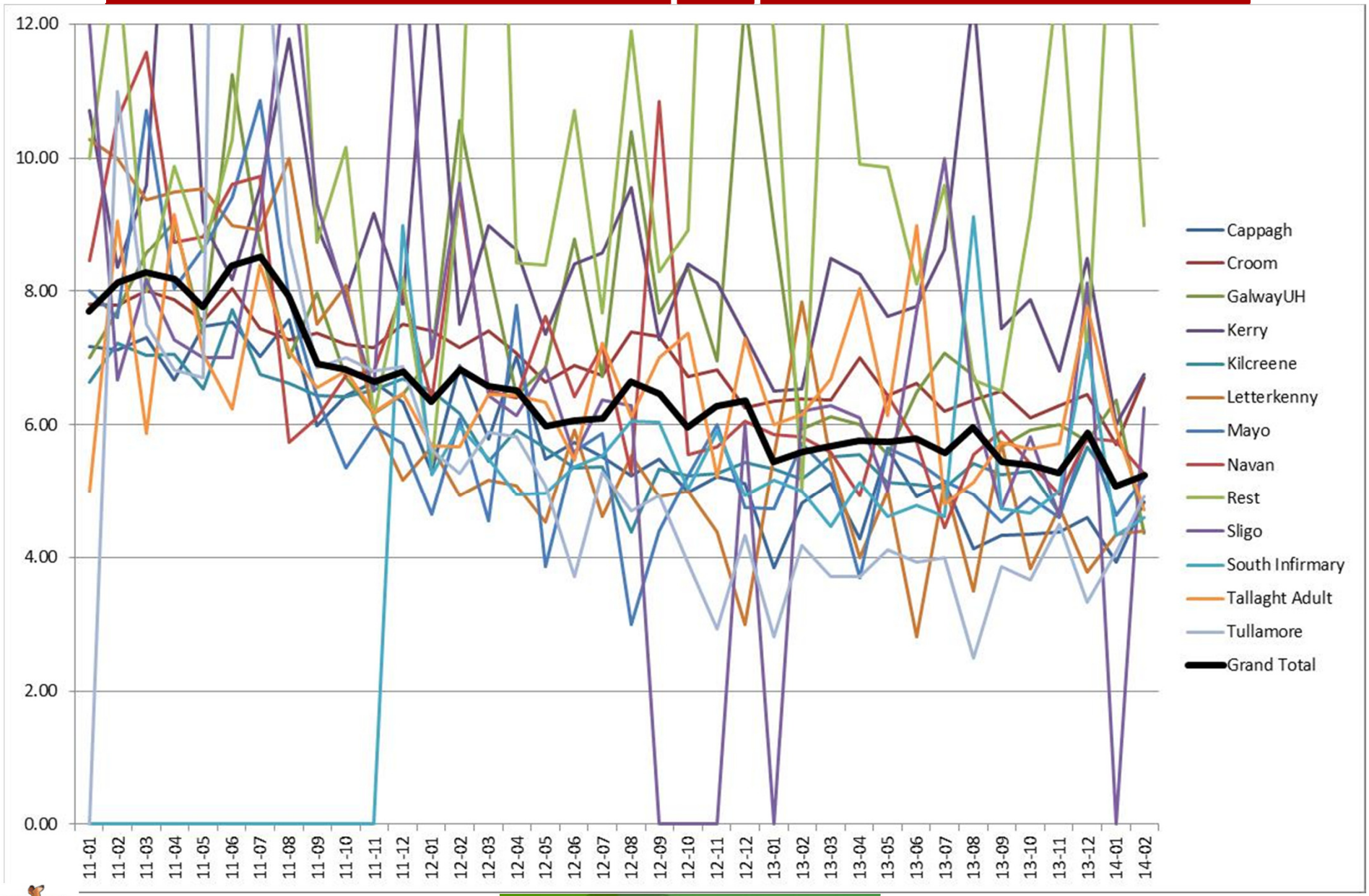
- Prospective funding – hip & knee replacements
- National Procurement
- Irish Hip Fracture Database
- Musculoskeletal Physiotherapy Programme
- Virtual Fracture Clinics
- Point of care coding

Experience in TOP

Prospective funding pilot July 2011

- Primary hip and knee replacements
- Four DRGs
- Average length of stay
- Day of surgery admission rates

AvLOS for Hip Replacement



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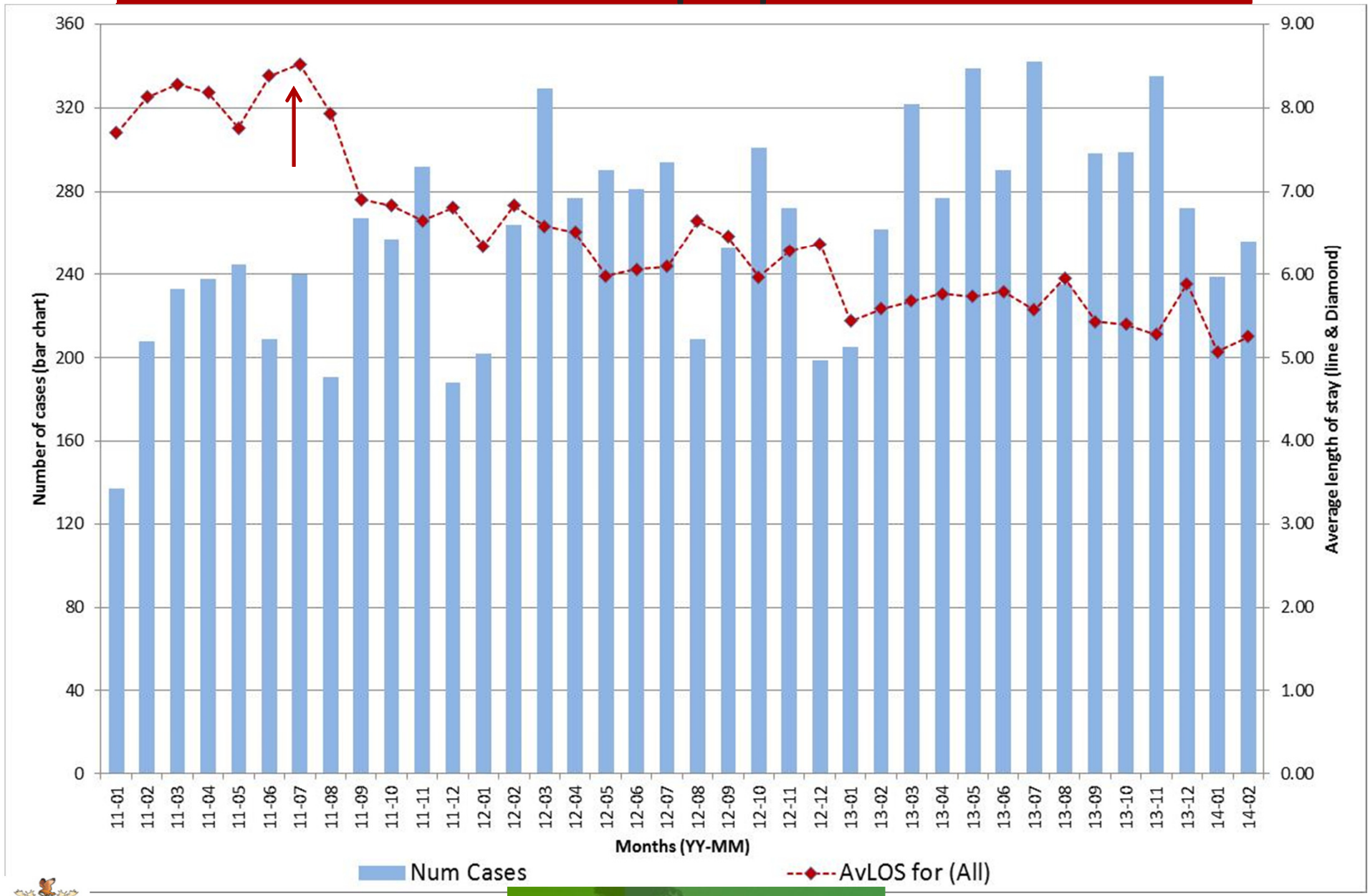
AvLOS for Hip Replacement



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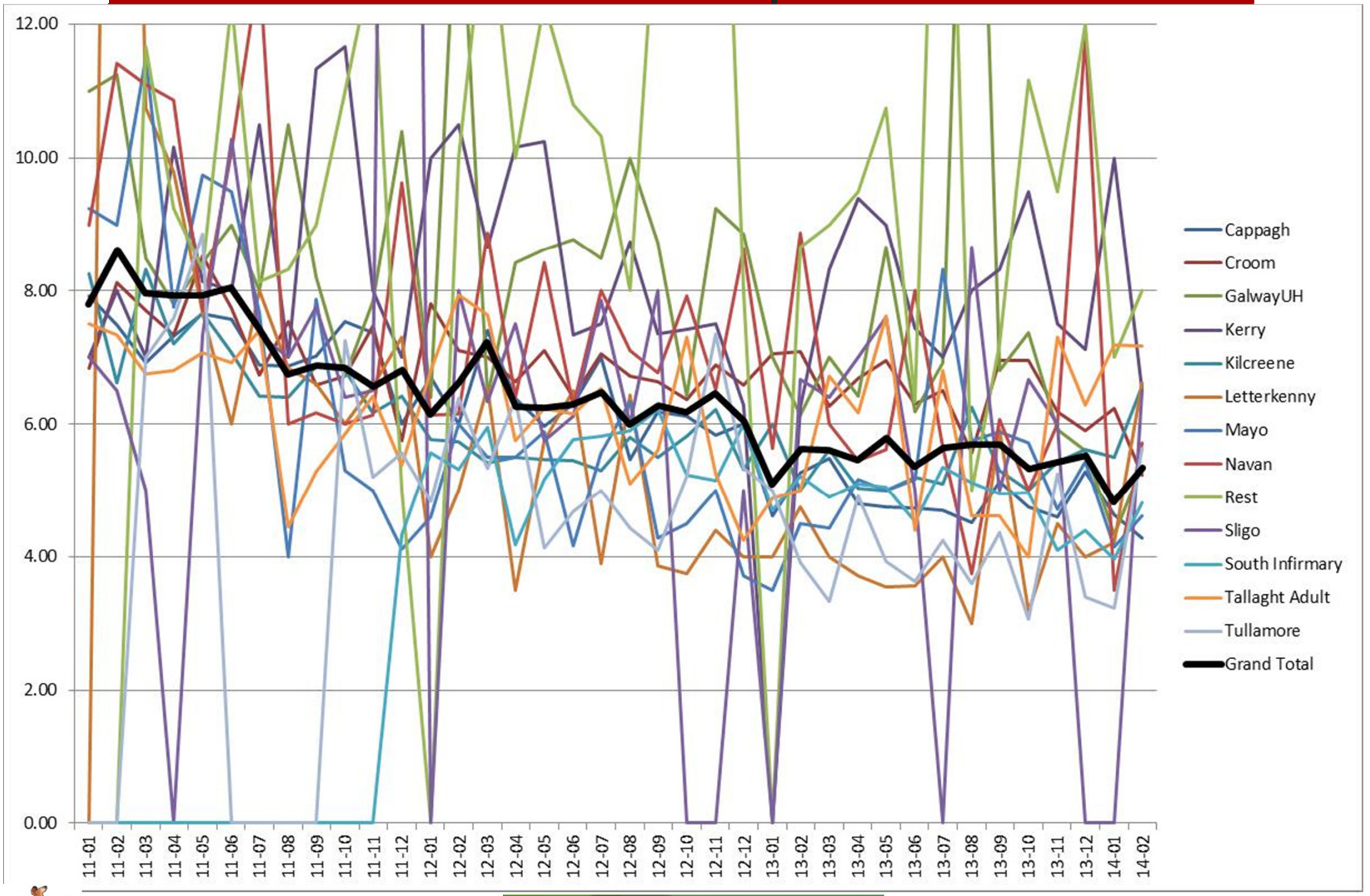
AvLOS for Knee Replacement



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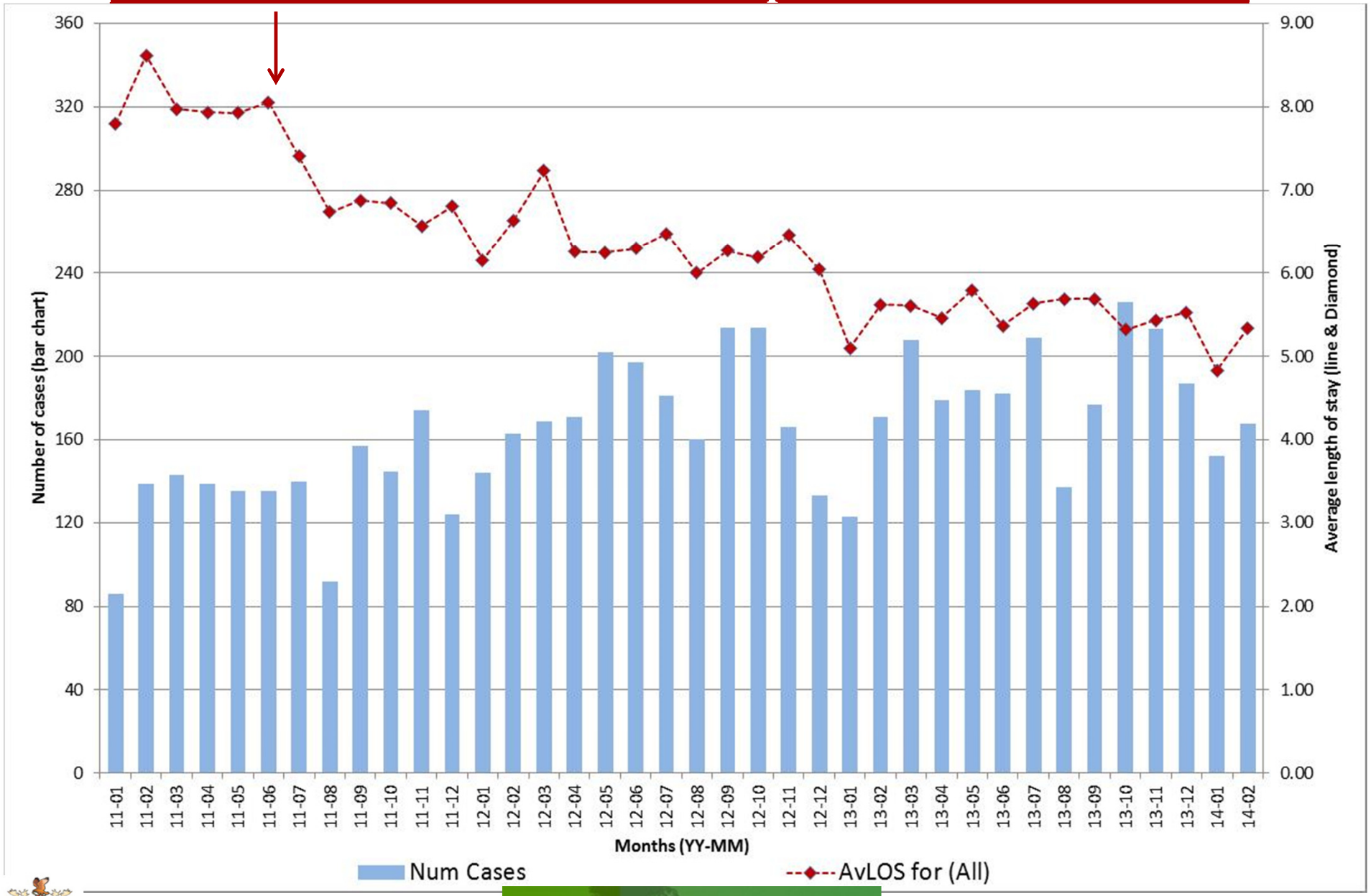
AvLOS for Knee Replacement



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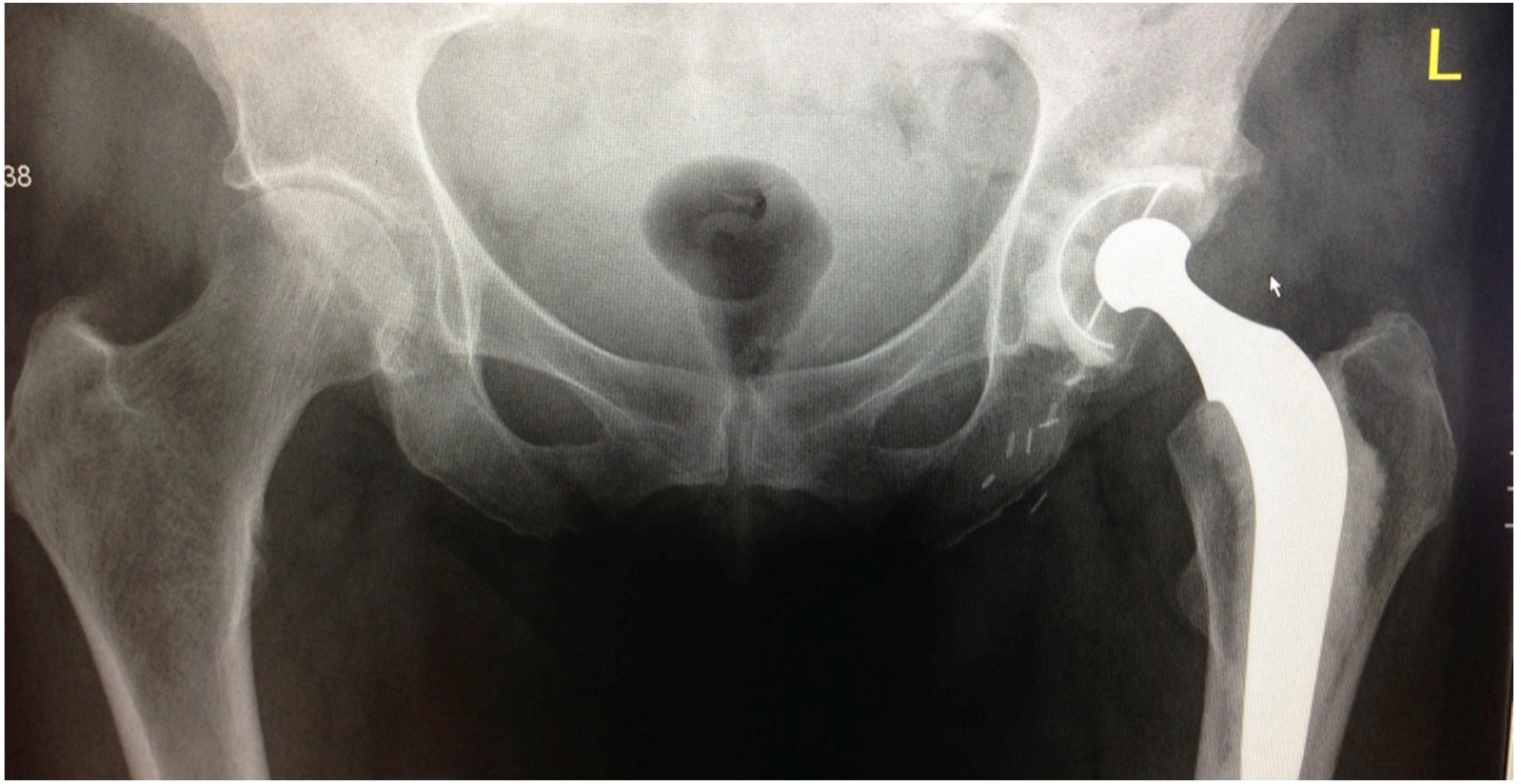
Bed days saved

- AvLos decreased
  - THR 8.5 – 5.3
  - TKR 8.0 – 5.2
- DoSA rate improved dramatically (22 – 90%)
- 18,860 more bed days would have been required to deliver the T&O service without the AVLoS reduction and DoSA increase started by the Prospective Funding Pilot
- Reduced AvLos and increased DoSA maintained
- Clinical engagement critical



National Procurement

- HSE spends c.€40m p.a. on Trauma and Orthopaedics

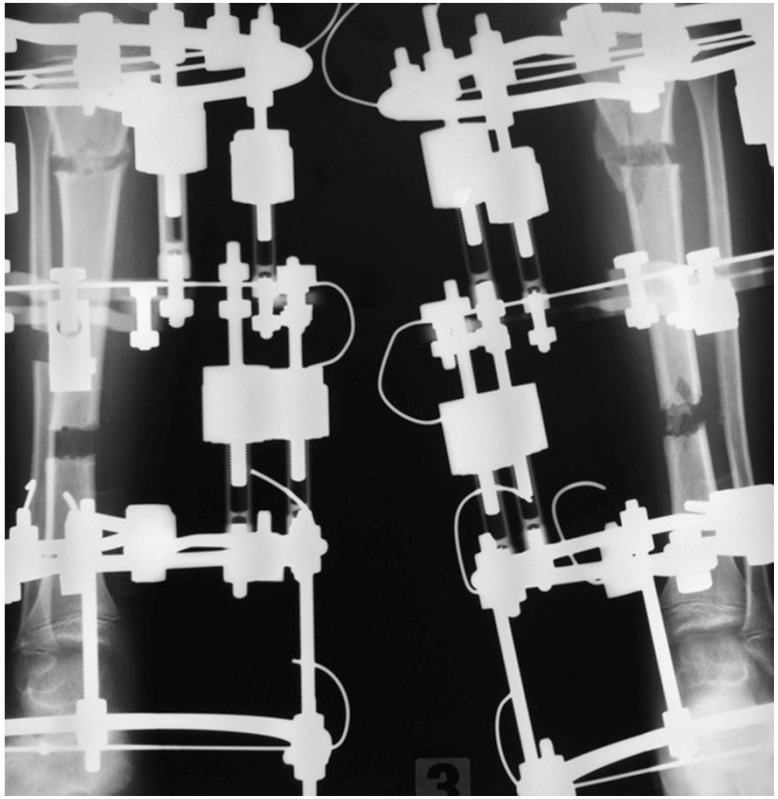
- Hips €14.6m
- Knees €9.1m

- Most contracts / supply agreements rolled over beyond original expiry

National Procurement

National Procurement

- Current approach leads to
  - Duplication of effort
  - Lack of standardisation of quality and service support for hospitals
- Differential in commercial arrangements between hospitals
- Issues re compliance with procurement regulations for hospitals
- May 2015– Framework for Primary Hips and Knees published



National Procurement

- Geriatric Medicine
- ESRI
- HIPE
- Measures quality – improved patient care
- All 16 hospitals contributing
- Clinician driven

- Best practice tariff

Irish Hip Fracture Database

Best Practice Tariff Criteria

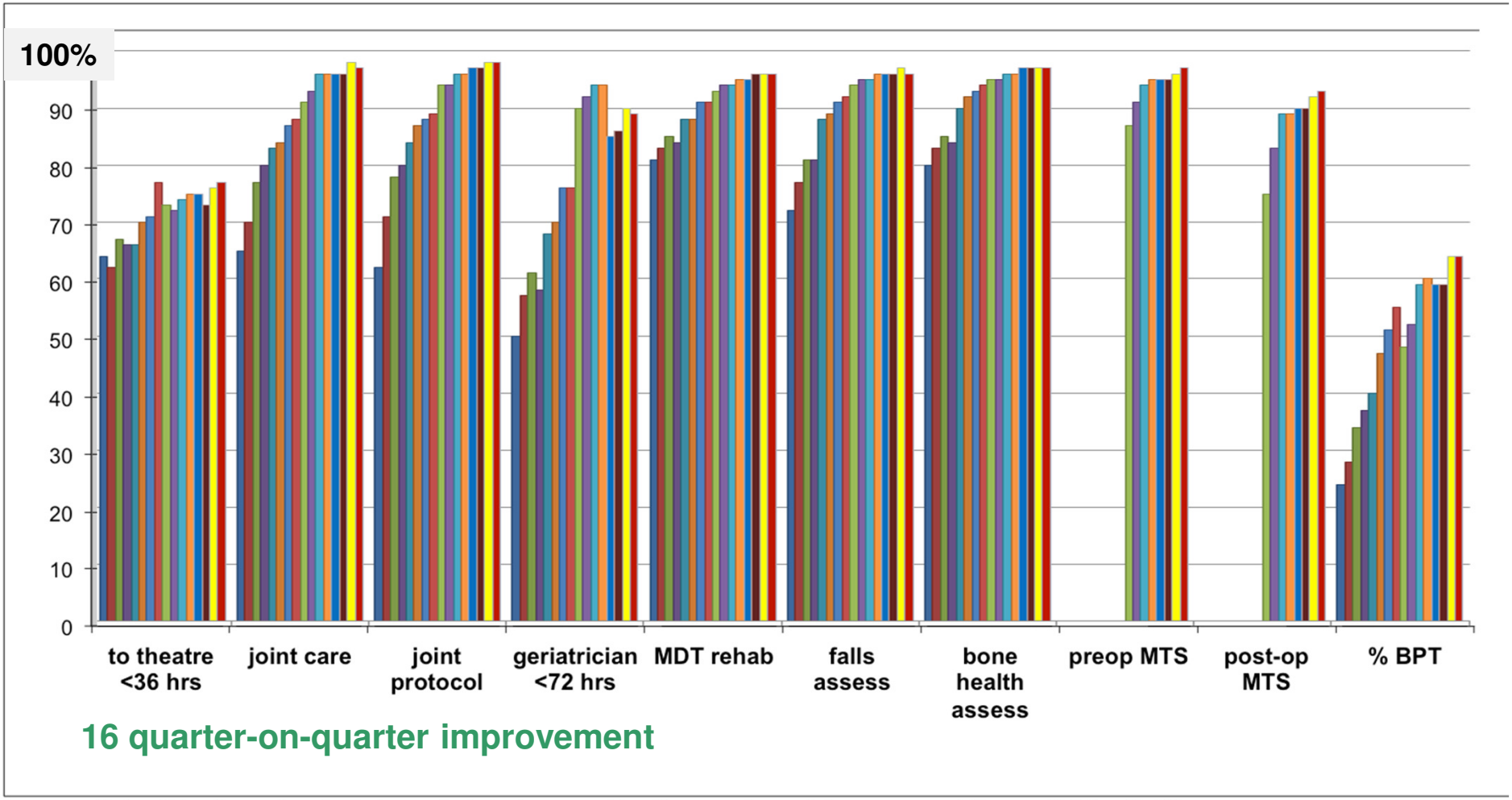
- Time to surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an inpatient, to the start of anaesthesia
- Involvement of an (ortho) geriatrician:
- Admitted under the joint care of a consultant geriatrician and a consultant orthopaedic surgeon
- Falls assessment protocol

Best Practice Tariff Criteria

- Assessed by a geriatrician in the perioperative period (defined as within 72 hours of admission)
- Postoperative geriatrician-directed
- Multi-professional rehabilitation team
- Fracture prevention assessments (falls and bone health).

Improvement in Hip Fracture Care 2010 - 2014

Best Practice Tariff: percentage attained for each criteria; all criteria 24 to 64%



Admitted under joint geriatric/anaesthetic protocol increased from 64 to 97%;
Surgery within 48 hours rising from 65 to 77% in 36 hours, to 87% in 48hrs;
Seen acutely by a Geriatrician up from 48 to 90%; bone health assessment up 72 to 97%

Best Practice Tariff neck of Femur Fracture

To qualify for the best practice tariff, all the criteria must be achieved.

Incentivise quality

Better care is cheaper

Pilot scheme being planned

Out-patient clinics Fracture clinic New & review

Adult & paediatric Spinal clinic Urgent & routine

Non admitted patients

- 405,000 patients waiting for out patients
- 58,000 orthopaedic appointments

Non admitted patients

Musculoskeletal Physiotherapy Programme

- T&O and Rheumatology
- Consultant led
- 24 physiotherapists
- 46,000 pts removed from waiting list
  - 80% orthopaedic
- Effective and efficient - 85% discharge rate
  - ……but

- Increased surgical waiting lists

MSK Programme Opportunities

- Embed and expand the model
- Pathway development
- Advances in Physiotherapist practice
  -Image prescribing
  - Injection Therapy
- Move towards interface clinics - GP engagement
- Hospital Groups – governance

Virtual Fracture Clinics

- Patient seen in Emergency department
- Treatment protocols in place
- Referred to VFC
- Consultant review of notes and xrays
- Nurse contact with patient
- Reduces unnecessary hospital attendances
- Liberates resources

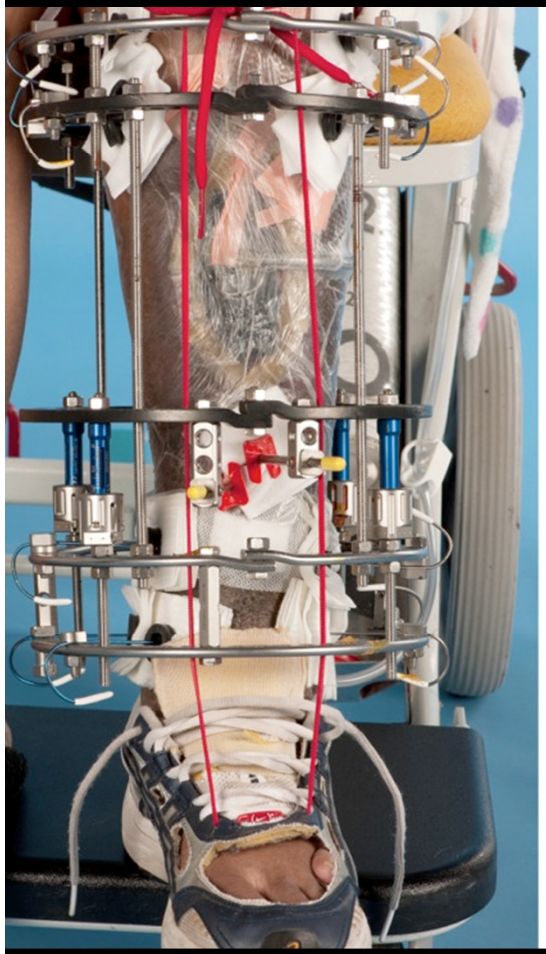
Virtual Fracture Clinics

- 4270 patients
- 2517 patients required face-to-face review
- Overall rate of ED and VFC discharge was 3802/6385 (60%)
- Only 34 (0.8%) patients were identified at the VFC as requiring semi-urgent admission for surgery

Virtual Fracture Clinic Glasgow Royal Infirmary

Virtual Fracture Clinics

- Safer clinics
  - New v review appointments
- Reimbursement / funding metrics
- Opportunities created
  - Additional operating lists
  - Reduce outpatient waiting lists



anging

- Day case v Out patient treatment
- Injection therapy
- Removal of percutaneous metal
- Clinician involvement essential to select appropriate procedures in various specialties

Activity Based Funding

Historically in Ireland, some planned procedures that can be done in outpatient settings have been carried out as a day case and captured on HIPE for statistical, reimbursement and other purposes.

As ABF progresses, it should be possible to carry out these procedures in outpatients without incurring any financial penalties or loss of data – regardless of where these procedures are done they will be reimbursed at the same rate.

This process will be facilitated by the new Irish Outpatient Classification System (IOCS) developed by the Healthcare Pricing Office (HPO) in 2014. The classification is based on the Tier 2 clinic used in Australia for classifying and reimbursing outpatient work.

IOCS Clinic Description	**IOCS Code**
Interventional Imaging	10020
Minor Surgical	10030
Endoscopy – Gastrointestinal	10060
Endoscopy- Orthopaedic	10080
Pain Management Interventions	10140

Point of care coding

	No. of codes		Volume
Lower limb	103		20,466
Upper limb	84		12,397
Spine	19		1,048
T&O other	26		5,056
Non surgical	17		13,184
	249		52,151

Procedure codes done >20 times per year = 249

- ICD-10
  - 19,000 diagnoses, complications & co-morbidities
  - 6,300 procedures
- 1350 orthopaedic and related (plastics / miscellaneous)
- Master T&O manual
  - Region specific
  - Common procedures with associated ICD-10 code
- Circulation to all surgeons and units

Point of care coding

Concerns

Incentives to treat high-volume, low-risk patients over higher-needs, less predictable patients

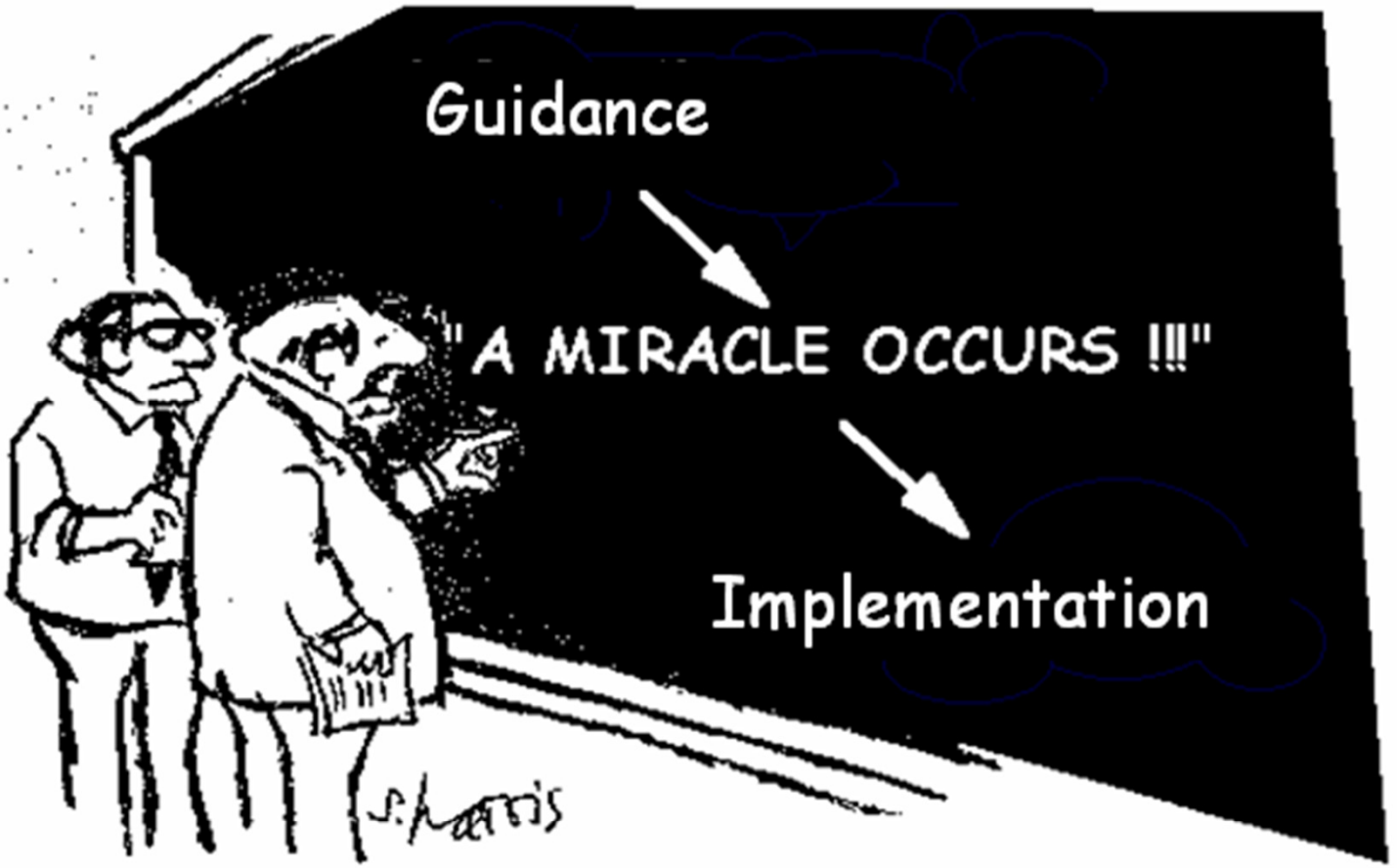
Inappropriate care

Quality of care implications

Concerns

- Lowest ratio of Orthopaedic consultants to population in the Western world
- Over Activity Based Funding
- Historically stagnant waiting lists persist
- Recognize urgent requirement to invest in more consultants, nurses and HSCPs

The future



I think you should be more explicit here in step two."

Raise awareness

The future

Clinician engagement essential

Education initiatives

Budgetary involvement

Balance service delivery with teaching and research

Audit the process

Best Clinical Practice		ABF
• Patient centred	→	• Individual patient data
• Evidence based	→	• Improved coding and data
• Equitable	→	• Transparent funding allocation
• Easily accessible	→	• Reduces waiting lists
• Efficient, Benchmark	→	• Investigation of cost variation
• Evolving	→	• Learn and improve from inefficiencies

Best clinical practice and ABF in harmony

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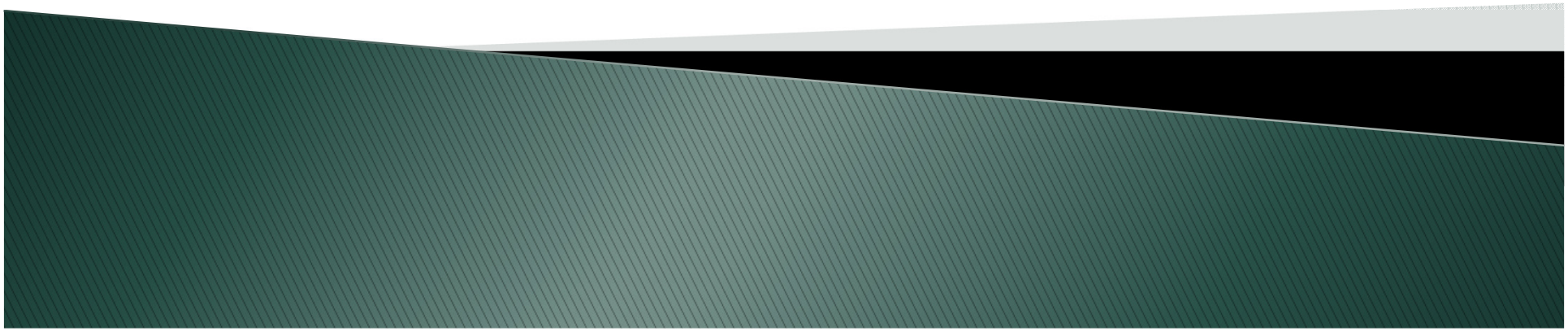
Chart Documentation & HIPE Coding

Jacqui Curley & Mark O'Connor
Healthcare Pricing Office



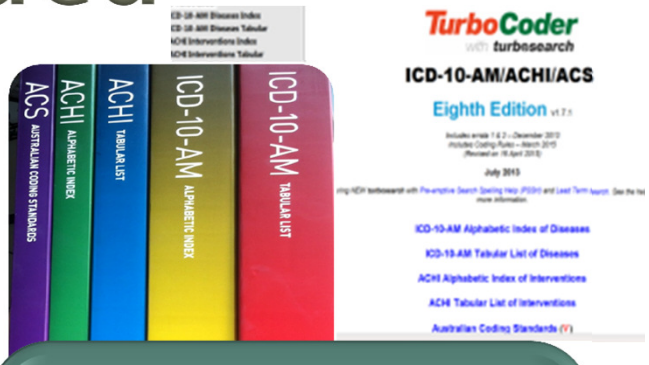
How a Chart gets Coded

Chart

- Accuracy
- Complete
- Summary
- Chart Flow
- PAS data

Analysis of Entire Chart by Trained Clinical Coder

- Clinical Notes
- Discharge Summary
- OP Sheets
- Histology
- X ray report



ICD-10-AM/

ACHI/ACS 8th Edition

- 16,708 Dx Codes
- 6,362 Intervention Codes
- Guidelines

- HIPE Collects per Case up to
  - P Dx & 29 additional
  - P Proc & 19 additional

- PAS data

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Partnership

Trained clinical coder and clinical staff

- HIPE data is the recording of patient care
- Recognition of clinical practice/complexity
- Accurate and timely information required.

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Best Practice

- Review of entire chart – resource intensive ☑
- Assign codes in line with National Guidelines ☑

- Real examples of best practice:
  - Work with clinicians and teams
  - Encourage completion of information
  - Correct use of classification & guidelines
  - Review entire chart
  - Appropriate use of feeds from systems – e.g. theatre/lab
  - Access to information and systems- e.g. histology
  - Flow of information back to clinicians

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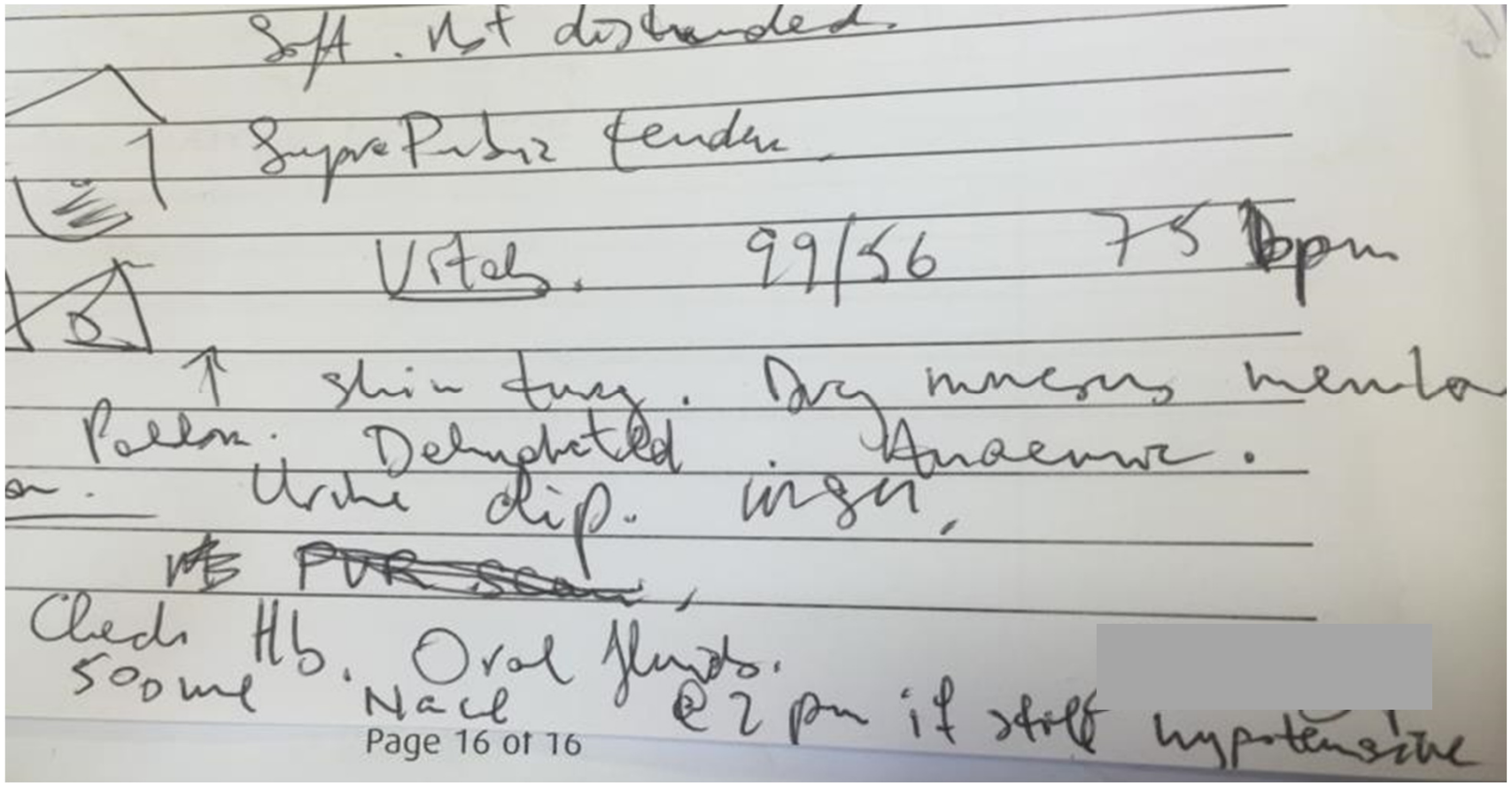
Importance of clear charts



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Why Focus on HIPE?

- Inputs
  - Fully staffed HIPE
  - Fully trained HIPE
  - DIT certification
  - Clinician Involvement
  - Utilise rich data
  - Complete documentation
  - Local support
  - Data quality review
  - Timely Accurate Data

Outputs

- Quality data
- Accurate complexity
- Up-to-Date
- Expertise
- Understanding of role of HIPE/ABF

Patient care & Planning and provision of healthcare

Healthcare Pricing Office

What is a DRG

- Diagnosis Related Group (DRG)
  - Clinically-similar diagnoses and procedures are grouped together
  - They consume similar amounts of resources
- 1.6 million patients – 698 DRGs for inpatients (and 350 for day-cases)
  - Makes analysis and comparison feasible and meaningful
- Use for clinical purposes – identify clinical variations
  - Average length of stay
  - Diagnoses and procedures
- Use for funding – identify cost variations
  - Medical, nursing, theatre, diagnostic costs

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1.6 million episodes

698 DRGs

Dialysis
170,000
patients

Normal delivery
50,000
patients

Knee
replacement
2,000
patients

Heart
transplant
10
patients

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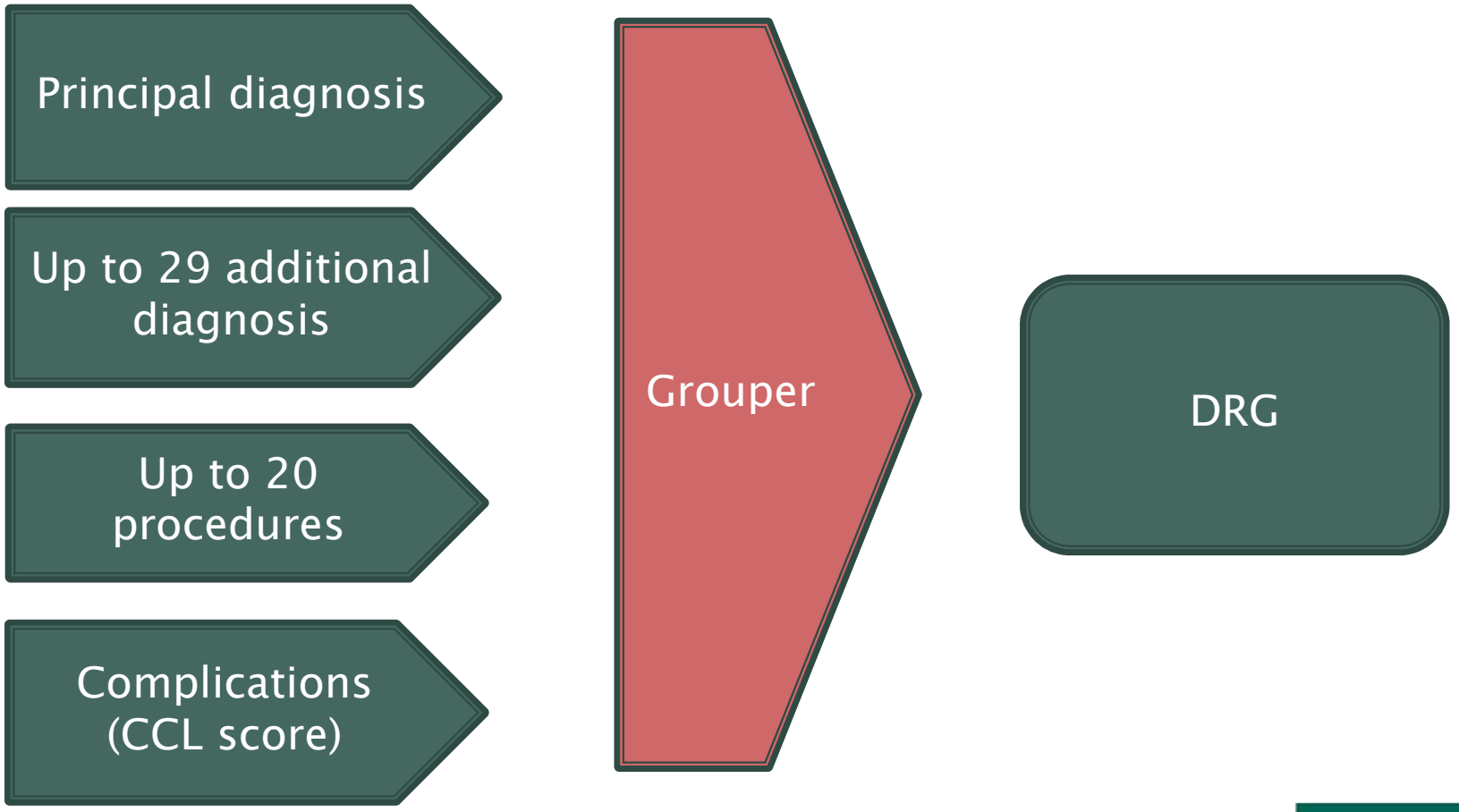
Taking HIPE coding to a DRG



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Complexity counts

Age 82 years – length of stay 51 days	
Principal diagnosis	I639 Cerebral infarction unspecified (stroke)
Additional diagnosis	I48 Atrial fibrillation and flutter
	I10 Essential (primary) hypertension
DRG	**B70C Stroke without catastrophic/severe complications/comorbidities**
ABF Price	**€5,159**
Principal diagnosis	I639 Cerebral infarction unspecified (stroke)
Additional diagnosis	I48 Atrial fibrillation and flutter
	I10 Essential (primary) hypertension
	G819 Hemiplegia unspecified
DRG	**B70B Stroke with severe complications/comorbidities**
ABF Price	**€9,410**
Principal diagnosis	I639 Cerebral infarction unspecified (stroke)
Additional diagnosis	I48 Atrial fibrillation and flutter
	I10 Essential (primary) hypertension
	G819 Hemiplegia unspecified
	L891 Decubitus ulcer and pressure area
DRG	**B70A Stroke with catastrophic complications/comorbidities**
ABF Price	**€23,261**

Complexity increasing with additional diagnoses

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Be Specific – Avoid 'Other'

If Principal Diagnosis = J22 **Unspecified acute lower respiratory infection**			
	DRG E75 applies – "Other respiratory system diagnosis"	**Price**	**2014 discharges**
A	With catastrophic complications	€6,375	1,865
B	With serious or major complications	€3,605	5,646
C	Without complications	€2,170	7,687

If Principal Diagnosis = J13 **Pneumonia due to Streptococcus pneumoniae**			
	DRG E62 applies – "Respiratory infection/inflammation"	**Price**	**2014 discharges**
A	With catastrophic complications	€8,683	3,253
B	With serious or major complications	€4,932	4,434
C	Without complications	€2,658	3,812

Difference per case with pneumonia v acute lower respiratory infection		
A	With catastrophic complications	€2,308
B	With serious or major complications	€1,327
C	Without complications	€488

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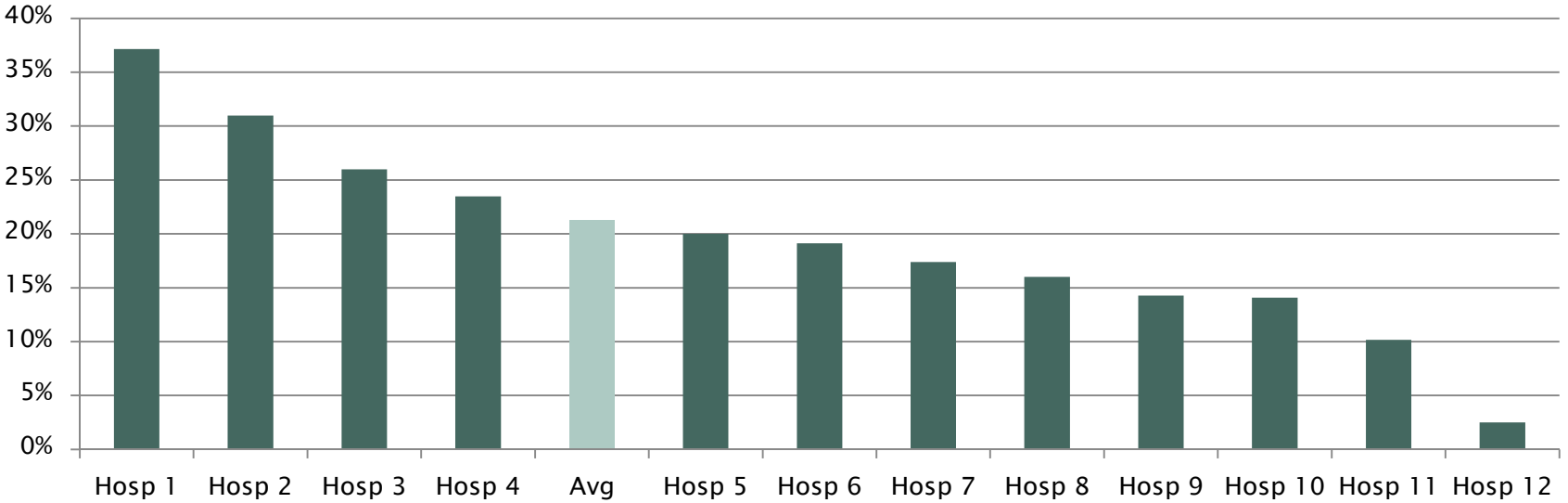
A06 – Artificial ventilation

where A06 cases > 50 in 2014



DRG	Description	Price
A06A	Tracheostomy with ventilation > 95 hours with catostrophic complications/comorbidities	€124,082
A06B	Tracheostomy with ventilation > 95 hours without catostrophic complications/comorbidities OR tracheostomy or ventilation > 95 hours with catastrophic complications/comorbidities	€54,440
A06C	Ventilation > 95 hours without catastrophic complications	€29,797
A06D	Tracheostomy without catastrophic complications/comorbidities	€38,166

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Case Study

- Looked at a hospital where low complexity was identified at DRG level
- Hub hospital so complexity should be average
- 3 coders lost to long-term sick leave

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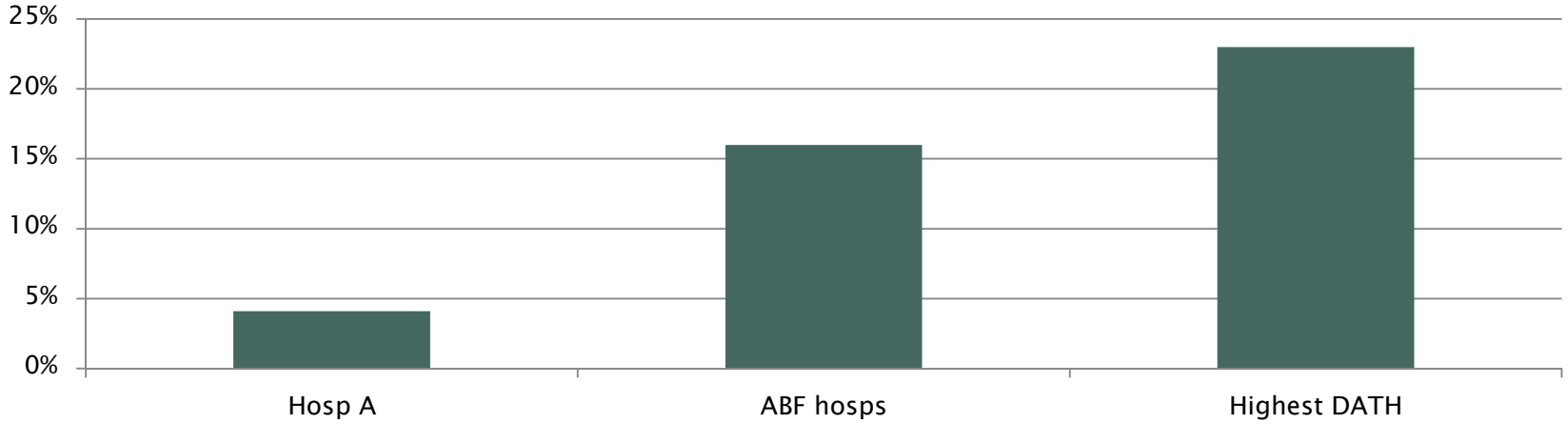
Case Study: B70 Strokes

B70A – Stroke with catastrophic complication



DRG	Description	Price	2014 cases	2014 %	ABF hosps
B70A	Stroke and other cerebral disorder with catastrophic complications/co-morbidities	€23,261	15	4%	16%
B70B	Stroke and other cerebral disorder with serious complications/co-morbidities	€9,410	79	22%	27%
B70C	Stroke and other cerebral disorder without catastrophic or severe complications/co-morbidities	€5,159	226	62%	47%
B70D	Stroke and other cerebral disorder died/transferred within 5 days	€1,707	46	13%	10%
			366	100%	

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Case Study

- Hospital Response & Action
  - Appointed new HIPE staff – [lead time for training]
  - Change in Chart flow
  - Relocation of HIPE office
  - Education of clinicians, Grand Rounds
  - Increased awareness around importance of quality documentation, HIPE coding and ABF implications

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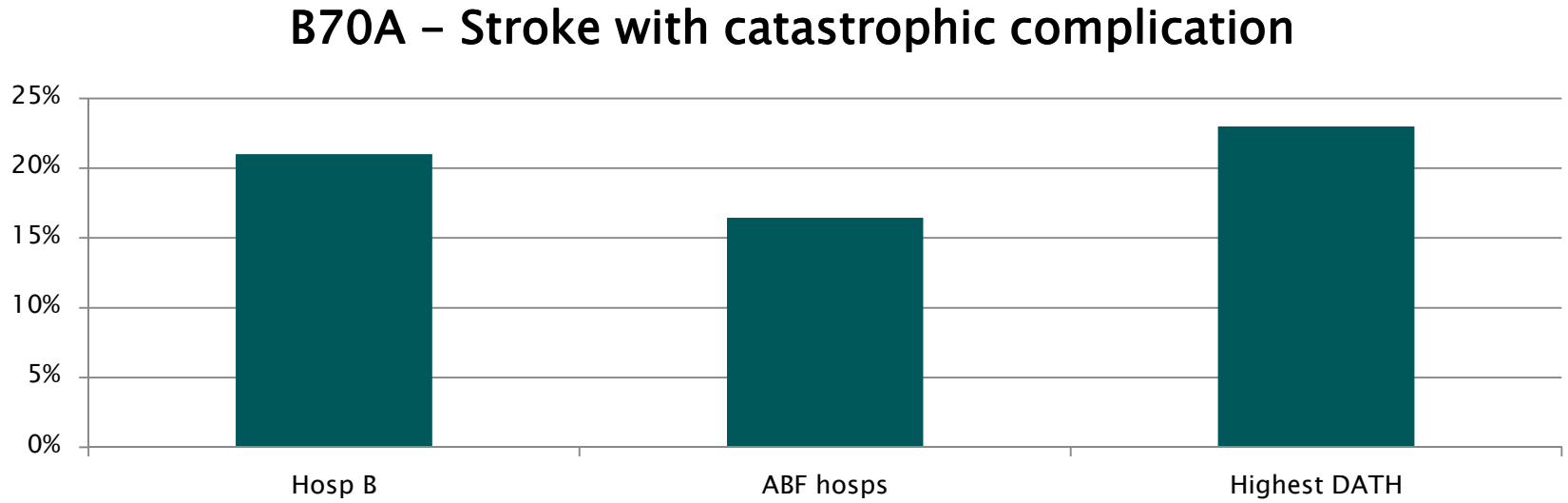
Contrasting hospital



- Coding staff experience ranging from 15 years to 22 years
- Strong relationships established with clinical colleagues
- Capacity to question and search for in-depth analysis of patient's care

Quality of care is evident in quality of coding

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Working together

- HIPE Department/Manager
  - Break out of the office
  - Communication with clinicians
- Clinical staff
  - Understand the importance of clear and complete documentation
  - Partnership with clinical coders in continuous improvement of coded data

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Thank You

- Questions
- Additional information

- Contact:

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Activity-Based Funding Conference 2015

What has happened so far – next steps

28th May 2015

Royal College of Surgeons of Ireland

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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Fair Deal

- Went live with client-level billing in 2012
- Explicit price and volume links
- Public Fair Deal beds more accessible

Feidhmeannacht na Seirbhíse Sláinte
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HEALTHCARE PRICING OFFICE

Fair Deal platform

- Platform for commitment of €74m by Government

- Making visible what the health system is delivering for the state's investment

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ABF pilot in orthopaedics

Healthcare Pricing Office

- Carried out a pilot in elective orthopaedics during 2011 and 2012
- Small coverage but very significant results
- Length-of-stay reduced
- Day-of-surgery admission increased
- Clinical engagement critical

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Orthopaedic Pilot

	From	To	Change	%
Hip Replacement				
ALOS (days)	7.8	6.1	-1.7	-22%
DOSA Rate (%)	22%	58%		+164%
Knee Replacement				
ALOS (days)	7.2	5.8	-1.4	-19%
DOSA Rate (%)	23%	62%		+170%

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Moving into acute hospitals

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- Vastly more complex than Fair Deal or Orthopaedic pilot
- Removing block grants and creating price/volume budgets
- Major requirement for clinical leadership and direction
- Creating incentives for best-practice and improved outcomes

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Mobilisation during 2014

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- Clinical engagement sessions held in Dublin, Cork and Galway

- Meetings with clinical leads, hospital groups, individual hospitals, Department of Health, Department of Public Expenditure & Reform

- Presentation at conferences such as NUI Galway, IMSTA, Millin Meeting, Orthopaedic Surgeons, Orthopaedic nurses

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HIPE coding transformed

- HIPE coding was typically 90+ days in arrears [requirement to use BIU data for publication]
- Viewed as a ‘back-room’ activity
- Many complaints about the quality of the data
- Absence of partnership between clinical coders and clinicians
- Currently over 98% of cases are now coded within 30 days of the period end
- Plan to migrate from BIU data to HIPE data for published reporting

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Next Steps

- Benchmarking each hospital against national average prices for their range of work
- Understanding why hospitals may be spending more than the average for a DRG
- Quality of HIPE coding
- Quality of costing for ABF work
- Impact of Agency Staff
- Structural issues

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Collaborative Approach

- Working with hospital CFOs on the benchmarking
- Working with the Clinical Programmes to develop early examples of how we can incentivise best-care
- Implementing Patient-Level Costing Software in hospitals
- Retention of ‘Pavillion Health’ to run a national HIPE Audit

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Driving clinical practice

- How do we use ABF to incentivise best-practice ?
- +30% of patients with hip fracture die within 12 months
- Many are over 90 years of age
- HIPE/Orthopaedics have developed a ‘portal’ with a detailed data-set on fractures
- Key criteria such as pre-op assessment by a geriatrician

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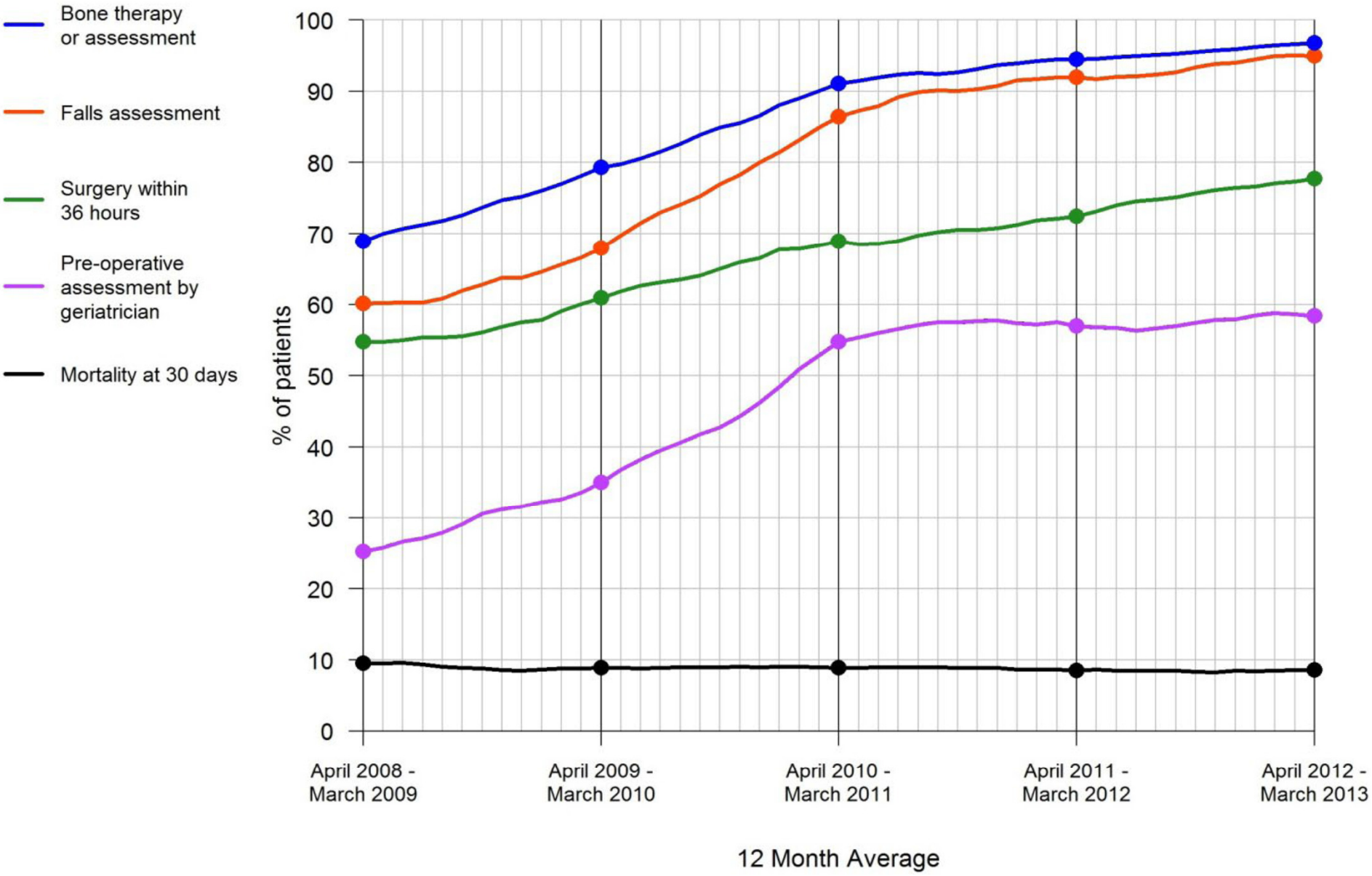
Driving Clinical Practice

- Time-to-theatre critical
- There are almost the full 3,000 fractures now up and running in the dataset
- We can assess how many are meeting the criteria (or 75% for example of the criteria)
- We can pay a Quality Incentive Payment or a ‘Tariff Uplift’ for those cases



Data taken from 46794 patients from 27 hospitals with good data completion and case ascertainment over the period 1st April 2008 - 31st March 2013

ew Window Help
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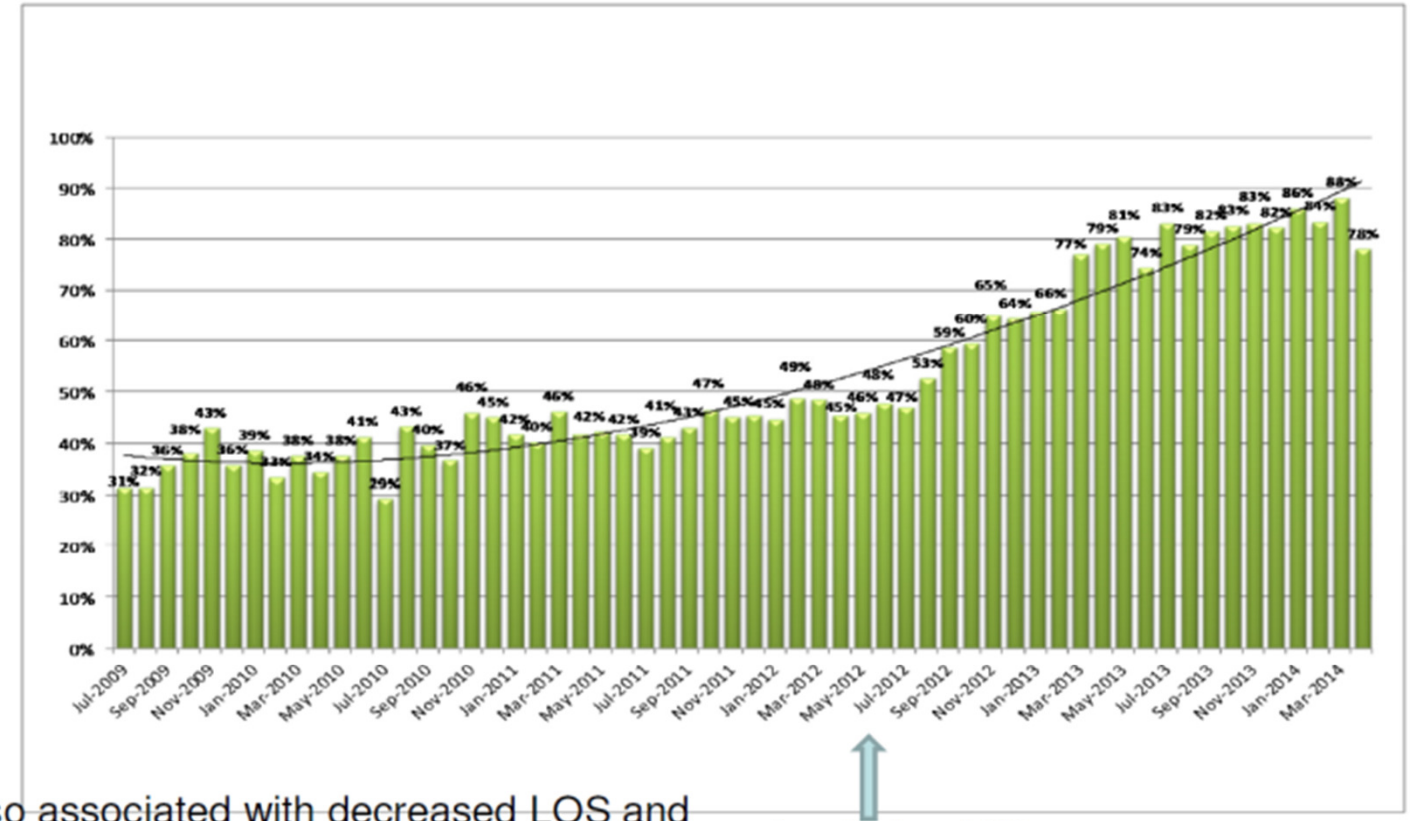
119%
Tools Sign Comment
Click on Sign to add text and place signature on a PDF File.

Impact of incentives: example QIP Stroke Unit Care

Proportion of stroke patients in Stroke Unit bed by month



Also associated with decreased LOS and cost equating to around $1m saving p.a.

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Hospital Avoidance

- Many initiatives in hospitals prevent admission to inpatient care
- Emergency physicians make a significant contribution to keeping hospital beds clear
- Medical Assessment Units with senior decision-makers send people home
- None of this activity is recorded on HIPE
- Hospital avoidance has to be addressed

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2016 Service Plan using ABF

- Need assessment gives the health system a sense of the volume of work which can be anticipated
- Demographic trends, chronic conditions, acceptable wait times
- Negotiate with funders for resource
- Model how much work can fit within the ‘envelope’ of funding
- Weighted units linked with money

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Paying the average price

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- Not a ‘race to the bottom’
- Zero harm to patients
- Prices must reflect the appropriate staffing level to deliver safe care
- Surgical wound infections per 1,000
- 3rd and 4th degree tears

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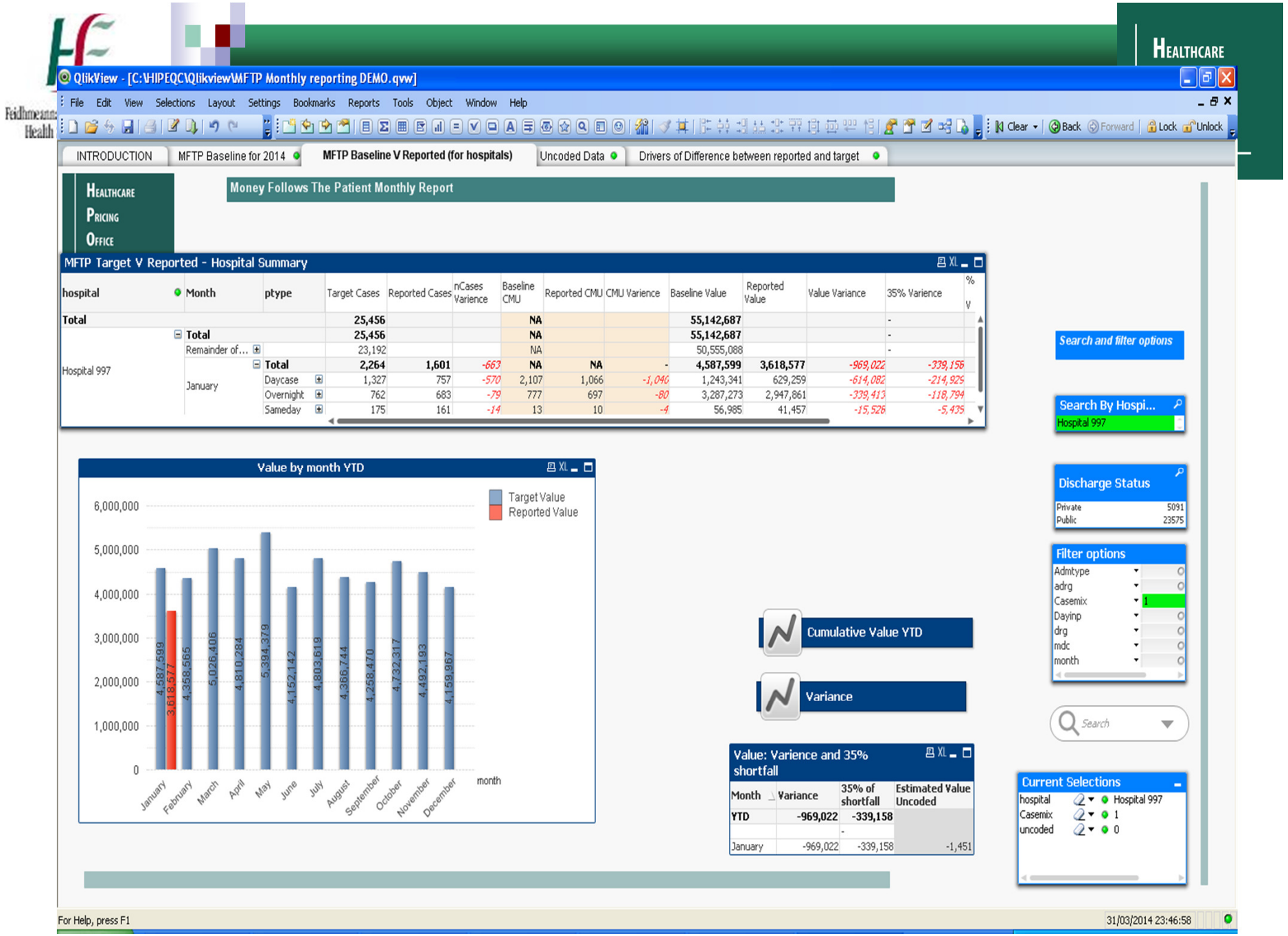
Group/Hospital Actions

- Hospital management and clinicians need to examine their own data and compare it to peers
- Improve the quality of your own data and use it
- Length-of-stay is a good place to start
- Qlikview allows easy access to HIPE-coded data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INTRODUCTION
MFTP Baseline for 2014
MFTP Baseline V Reported (for hospitals)
Uncoded Data
Drivers of Difference between reported and target
Healthcare Pricing Office
Money Follows The Patient Monthly Report
MFTP Target V Reported - Hospital Summary
hospital Month ptype Target Cases Reported Cases nCases Varience Baseline CMU Reported CMU CMU Varience Baseline Value Reported Value Value Variance 35% Varience %
Total 25,456 NA 55,142,687 -
Total 25,456 NA 55,142,687 -
Remainder of... 23,192 NA 50,555,088 -
Hospital 997 January Total 2,264 1,601 -663 NA NA - 4,587,599 3,618,577 -969,022 -339,158
Daycase 1,327 757 -570 2,107 1,066 -1,041 1,243,341 629,259 -614,082 -214,929
Overnight 762 683 -79 777 697 -80 3,287,273 2,947,861 -339,413 -118,794
Sameday 175 161 -14 13 10 -4 56,985 41,457 -15,526 -5,435
Value by month YTD
Target Value
Reported Value
6,000,000
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4,587,599
3,618,577
4,358,565
5,026,406
4,810,284
5,394,379
4,152,142
4,803,619
4,366,744
4,258,470
4,732,317
4,492,193
4,159,967
January February March April May June July August September October November December
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Hospital 997
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Private 5091
Public 23575
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Month Variance 35% of shortfall Estimated Value Uncoded
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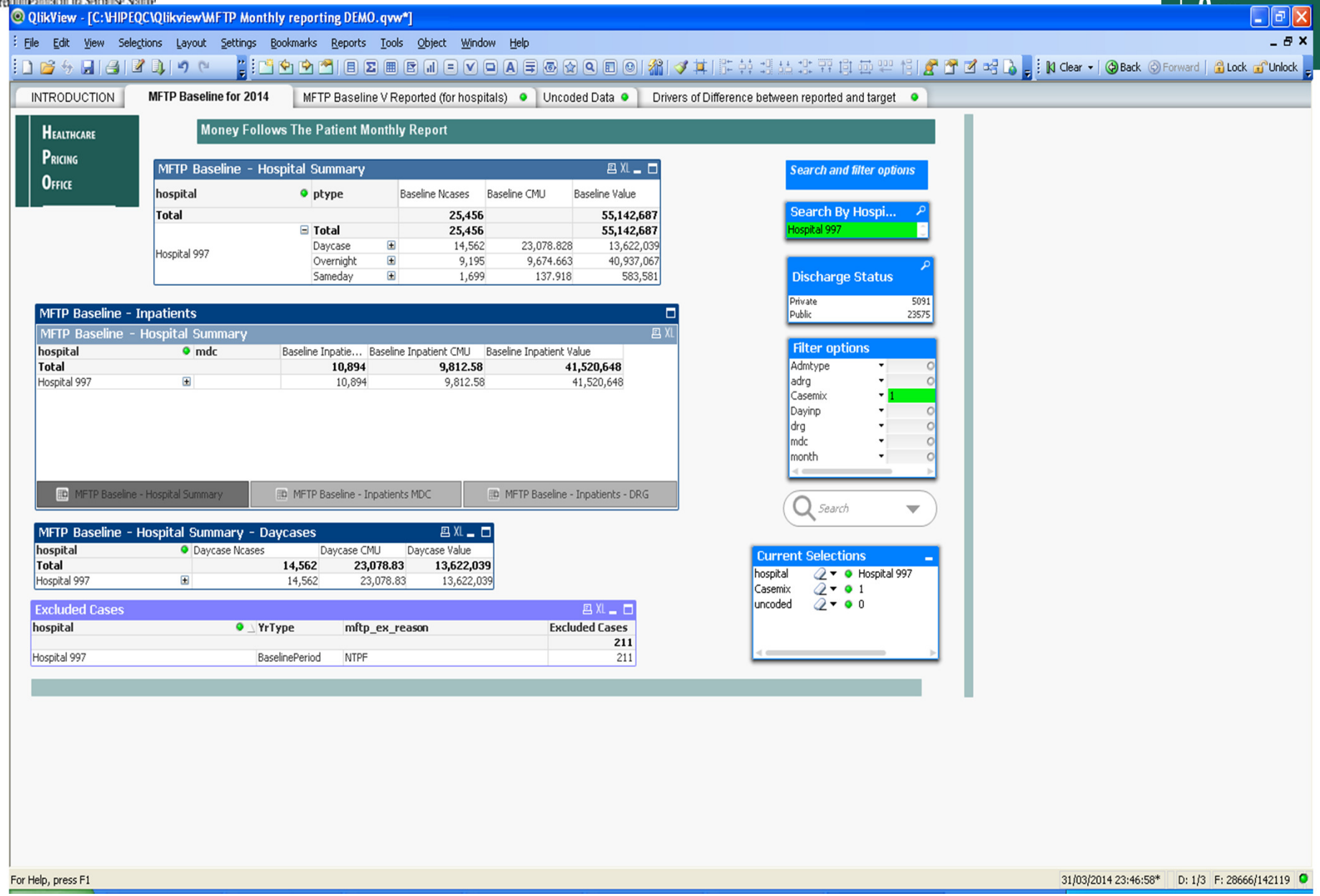
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hospital ptype Baseline Ncases Baseline CMU Baseline Value
Total 25,456 55,142,687
Total 25,456 55,142,687
Hospital 997 Daycase 14,562 23,078.828 13,622,039
Overnight 9,195 9,674.663 40,937,067
Sameday 1,699 137.918 583,581
MFTP Baseline - Inpatients
MFTP Baseline - Hospital Summary
hospital mdc Baseline Inpatie... Baseline Inpatient CMU Baseline Inpatient Value
Total 10,894 9,812.58 41,520,648
Hospital 997 10,894 9,812.58 41,520,648
MFTP Baseline - Hospital Summary
MFTP Baseline - Inpatients MDC
MFTP Baseline - Inpatients - DRG
MFTP Baseline - Hospital Summary - Daycases
hospital Daycase Ncases Daycase CMU Daycase Value
Total 14,562 23,078.83 13,622,039
Hospital 997 14,562 23,078.83 13,622,039
Excluded Cases
hospital YrType mftp_ex_reason Excluded Cases
211
Hospital 997 BaselinePeriod NTPF 211
Search and filter options
Search By Hospi...
Hospital 997
Discharge Status
Private 5091
Public 23575
Filter options
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Thank You