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Planning for ABF as part of reforming the Australian healthcare system

Dr Lisa Fodero, PhD

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Health Reform in Australia

- **29th November 2008**: the Council of Australian Governments (COAG) *"agreed to provide a basis for a more efficient use of taxpayer funding of hospitals, and for increased transparency in the use of those funds through the introduction of ABF".*
- **March 2010:** "*National Health and Hospital Network for Australia's Future*" –sets out the architecture and foundations of the Government's national health reform plan
- **April 2010:** *National Health and Hospitals Network Agreement* (NHHNA) – accelerated plan for ABF implementation
- **13th February 2011** - *COAG's Heads of Agreement - National Health Reform* –commitment to implement ABF for public hospitals from 1st July 2012.
- **2nd August 2011:** *National Health Reform Agreement (NHRA)* :
  - Supersedes the NHHNA and the *Heads of Agreement - National Health Reform*
  - Outlines roles of two new national bodies: Independent Hospital Pricing Authority (IHPA) and the National Health Performance Authority (NHPA)

Health Reform Implementation Group (HRIG)

- COAG established the Health Reform Implementation Group (HRIG) to oversee the execution of the health reforms
- HRIG created the ABF sub group
- The ABF sub-group established five sub groups aligned to the five workstreams in the *Activity Based Funding National Framework and Implementation Plan:*
  - Subacute Care Advisory Working Group (SCAWG);
  - Emergency Care Advisory Working Group (ECAWG);
  - Non Admitted Care Advisory Working Group (NAWG);
  - Mental Health Care Advisory Working Group (MHAWG); and
  - National Hospital Cost Data Collection Technical Working Group (NHCDC TWG).
- **Terms of reference:** "the development of a work plan for the implementation of ABF", which will contribute to an "overall national work plan to implement ABF".

Proxy Classification Systems

The HRIG ABF Sub Group had decided on the proxy classification systems to be used in the initial ABF implementation:

- **Acute admitted:** Australian Refined Diagnosis Related Groups (AR-DRGs)
- **Sub-acute:** National Sub-Acute and Non-acute Patient Classification (AN-SNAP)
- **Non-admitted:** National Hospital Costs Data Collection (NHCDC) Tier 2 Clinics
- **Emergency services:** Urgency Related Groups classification (URGs)

METHOD

The planning methodology for the development of the work plans involved five steps:

1. **Survey:** A scoping survey for each workstream sent to key ABF staff in each state/territory. Information was collected on the current position in relation to:
   - Data collections, classification systems, funding arrangements, computer systems, data quality and assurance processes and governance processes
2. **Scoping/gap analysis paper:** Identified the desired minimum position in terms of ABF infrastructure, and the gaps in current infrastructure
3. **Preparing draft work plans:** Draft work plan developed for each workstream to identify the agreed minimum position to support ABF implementation
4. **Reviewing the draft work plans:** The draft work plans were presented and reviewed at the third meetings of the AWGs, which focussed on reaching agreement to the project priorities
5. **Developing an overarching work plan:** Integration of the projects within the five AWG work plans into higher level projects. Identification of projects that were considered critical/essential to enable ABF to be implemented nationally by 1st July 2012 including risk management strategies.

RESULTS
THE FIVE AWG AND OVERARCHING WORK PLANS

- 99 projects identified which were grouped into 35 overarching projects.
- Projects in each workstream were grouped under the infrastructure areas of:
  - ABF scope and data set coverage; classification system development; counting rules and unit of count development; activity based costing, funding model development; support infrastructure (which included workforce development); data quality assurance; and governance.
- Each consolidated project was assigned a priority
- 13 projects were identified as critical/essential to support ABF implementation from 1st July 2012
- A similar number of projects were identified in each infrastructure area for sub acute, non-admitted, mental health and emergency care.
- The NHCDC TWG workstream work plan focus was slightly different, given the Group's role in developing infrastructure to support national costing

Table 1: High level projects and priorities as identified in overarching work plan

Project Number	Project Title	Priority Status
ABF scope and data set coverage		
1	Identify ABF in-scope services	**Critical/essential**
2	Develop ABF data set specification and data collection process	**Critical/essential**
3	Assess current data set coverage of ABF in-scope services	High
4	Enhance the relevant NMDS to capture data items required for casemix classification	Medium
Classification system development		
5	Develop overarching classification framework for capturing all relevant activity	**Critical/essential**
6	Develop peer group classification for funding purposes	**Critical/essential**
7	Identify enhancements to proxy classifications required for implementation	**Critical/essential**
8	Ongoing development of classification and funding approaches	High
Counting rules and unit of count		
9	Develop counting rules for non-admitted services and define units of count	**Critical/essential**
10	Identify sub-acute component in non-admitted services	High
11	Identify mental health component in non-admitted services	High
12	Definition of hospital-auspiced community based health services	High
13	Alignment between general hospital and mental health program specific data collections	**Critical/essential**
Costing		
14	Complete NHCDC Round 14 data collection	**Critical/essential**
15	Develop an all product costing methodology for use in any supplementary costing studies	**Critical/essential**
16	Develop service weights and/or relative value units to support costing	High
17	Undertake costing studies to develop costs weights for proxy classifications	**Critical/essential**
18	Analyse admitted patient costs with and without specialist mental health input	High
19	Enhance the scope and coverage of the NHCDC	High
20	Further develop the Australian Hospital Patient Costing Standards	High
21	Undertake NHCDC Round 15 data collection	Medium
Funding models		
22	Develop baseline and ongoing establishment level expenditure estimates	High
23	Design funding model and set efficient prices	**Critical/essential**
24	Negotiate proposed activity levels with LHNs	**Critical/essential**
25	Approve initial budget allocations and issue initial budget advice	**Critical/essential**
Support infrastructure		
26	Enhance capability of hospital computer systems	High
27	National data access and reporting	Medium
28	Develop and implement a training program to support ABF implementation	High
29	Develop and implement an ABF workforce development strategy	High
Data quality assurance		
30	Finalise development of the NHCDC Quality Framework	High
31	Develop national and state/territory level data quality assurance program	High
Governance		
32	Update national and state/territory level ABF work plans	High
33	Establish governance committees at national and state/territory levels	High
34	Establish mechanisms to engage clinicians at national and state/territory levels	High
35	Undertake process and impact evaluation of ABF implementation	High (long term)

Results

Development of a phased implementation Approach

- A three-phased approach was formulated given the short time available between the development of the plans and the target date for the start of ABF
- The phasing was designed to recognise that it is likely that not all states/territories will be able to achieve the same starting point for ABF by 1st July 2012.
- The readiness for ABF implementation varied across workstreams, and focussed on acute admitted, non-admitted and emergency services workstreams.
- The aim of 'Phase 0' (ending 1 July 2012) of the strategy is to leverage off already available data and systems to reach a position where a form of ABF can be implemented across the three focus workstreams.
- The aim is that at the end of phase 2 of the strategy, Australian approaches in each workstream will be consistent with international best practice.

Results

Implementation timeframe and available resources

- A significant amount of work needs to be done at national and state/territory levels.
- All AWGs expressed concerns about the restricted timeframe available to complete the work necessary to prepare for ABF implementation on 1st July 2012.
- Issues included: lack of collective capacity and capability in the resources available across Australia to implement the work plans in the required time frame.
- 10 of the 13 initial projects are considered resource intensive at national level (they are of an infrastructure building nature)
- 6 of the 13 projects are considered resource intensive at state/territory level (they involve significant data collection and provision).

Table 2: Work required at the national level in the 13 "critical/essential" projects identified in the Overarching Work Plan

Project No	Project Title	Work required at national level	Significant work required
1	Define ABF in-scope services	• Establish project team to advise on ABF scope (focus on non-admitted subacute, mental health and hospital auspiced community based health services)	✓
2	Develop ABF DSS	• Establish project team to define ABF DSS covering all ABF workstreams	✓
5	Develop overarching classification framework	• Establish project team to develop overarching classification framework (focus on subacute, non-admitted and emergency services)	✓
6	Develop peer group classification for funding	• Establish project team to develop peer groups to be used for funding purposes	✓
7	Enhance proxy classifications	• Establish project team to complete refinement work on NHCDC Tier 2 Clinics • Establish project team to determine best strategy for refining and/or extending AN-SNAP • Establish project team to update and refine URGs	✓
9	Develop counting rules	• Establish project team to develop counting rules (focus on non-admitted subacute, mental health and hospital auspiced community based health	✓
13	Align general hospital and mental health program data	• Establish project team to examine the degree of alignment between general hospitals and mental health program specific data collection systems, and advise on the potential for using data from mental health program specific data collections to support the operation of ABF	✓
14	Complete NHCDC Round 14 data collection	• Existing DoHA project team (and the NHCDC TWG) to coordinate and manage the completion of NHCDC Round 14 data collection	
15	Develop an all-product costing methodology	• Establish project team to develop the all product costing methodology under the auspices of the NHCDC TWG	✓
17	Undertake costing studies	• Establish project team to work under the auspices of the NHCDC TWG to manage and coordinate the costing activities across all work streams (including regeneration of NHCDC Round 14 data and supplementary studies, as necessary)	✓
23	Design funding model and set efficient prices	• Establish project team (in, or under the auspices of, Transition Office/IHPA) to develop funding model for all ABF workstreams	✓
24	Negotiate activity levels with LHNs		
25	Approve and issue initial budget allocations	• Establish project team (in, or under the auspices of, Transition Office/IHPA) to determine and approve initial budget allocations to states/territories	

Table 2: Work required at the state/territory level in the 13 "critical/essential" projects identified in Overarching Work Plan

Project No	Work at state/territory level	Significant work required
1	• Work with project team to contribute to definition of ABF scope and identify relevant state/territory level issues arising from the various definition options	
2	• Work with project team to review/refine ABF DSS specification • Determine best strategy, and make arrangements for providing data in accordance with ABF DSS across all workstream (first submission due in February 2013)	✓
5	• Work with project team to identify relevant state/territory level issues arising from overarching classification system (i.e. characteristics of services that can report AN-SNAP, NHCDC Tier 2 Clinic and URG data respectively)	
6	• Work with project team to contribute to the definition of the peer groups and identify relevant state/territory level issues arising from adoption of the peer groups in the ABF model	
7	• Participate in work to refine NHCDC Tier 2 Clinics • Participate in work to determine best strategy for refining and/or extending AN-SNAP • Participate in work to update and refine URGs	✓
9	• Work with project team to contribute to development of the counting rules and identify relevant state/territory level issues arising from the various counting rules options	
13	• Work with project team to identify the state/territory level issues associated with using data from metal health program specific data collection systems to support the operation of ABF	
14	• Provide NHCDC Round 14 data in accordance with contract	✓
15	• Work with project team to refine/review the all product costing methodology	
17	• Work with project team to regenerate NHCDC Round 14 data, as necessary • Work with project team to establish and conduct supplementary costing studies (in subacute, non-admitted, emergency and mental services as may be required) across an appropriate range of services in the state/territory	✓
23	• Work with project team to contribute to development of the funding models and identify relevant state/territory level issues arising from the various funding model options	
24	• Establish project team (state/territory health authority staff) to negotiate activity levels with LHNs, having regard to the developed ABF model	✓
25	• Establish project team to determine LHN budgets, based on agreed activity levels and process set by IHPA; then advise LHNs of budget allocations for 2012/13	✓

Results
Risk analysis and mitigation

- As part of addressing the timing and resources concerns, each Work Plan includes a risk analysis and associated risk mitigation strategies.
- All listed risks are considered to be jointly owned by the Commonwealth and States/Territories
- The best risk management strategy is to proceed with the three-phase approach to implementation, with the initial focus on the activities in the 13 critical/essential projects.
- This approach optimises the use of the available time and resources and makes it possible to reach the minimum position specified for 'Phase 0' and to build the base for attaining the 'Phase 1' and 'Phase 2' minimum positions.

Table 3: Summary of risk analysis in the five work AWG work plans

Risk ID	Risk description	Mitigation strategies
1	That the time frames established for the implementation of ABF are inadequate to enable: • completion of the costing studies required for the development of cost weights and efficient unit prices for all ABF • development of infrastructure (definitions, classification, counting rules, etc.) to support collection of the necessary data • states/territories to implement the required data collection systems and processes	• adopt the three-phase strategy for ABF implementation; • keep goals and targets realistic and manage expectations across all stakeholders; • allocate highest possible priority to critical/essential projects; • allocate the best available resources to the critical/essential projects; • start costing methodology development studies now; • maximise the use of existing data in 'Phase 0' while simultaneously establishing infrastructure for desired data collection; • accelerate work on the defining the DSSs for each ABF workstream; • ensure that the funding model is able to deal with situations where not all required data are available (proxy data); and • provide targeted support to smaller hospitals, through the development of IT infrastructure at national level that can be rolled out across the country.
2	That there is insufficient workforce availability and capability at national and state/territory levels within government, and also external to government, to implement the Work Plans	• allocate adequate resources to ABF implementation; • use external resources (i.e. contractors, consultants) as required (note, there may be insufficient skilled external resources available); • make skills transfer a feature of any project in which external (to hospitals, LHNs, states/territories and DoHA) resources are used; • undertake development projects to build long term workforce capacity and capability.
3	That interim arrangements established to achieve initial ABF implementation and operation may create perverse incentives including: • the interim arrangements may continue in the longer term, as they will be difficult to change due to the initial expectations set • the funding model will not encourage adoption of emerging models of care, leading to maintenance of out-dated practices that may not benefit patients or the health system • longer term requirements (e.g. development of appropriate classification system, data definitions, etc.) will be overlooked in trying to achieve short term goals	• establish mechanisms for submissions to be made in the case of a perceived lack of fairness of funding or other issues/errors arising from the initial implementation of ABF; • early correction of errors in the classification/funding system so as to ensure that any 'unfair' funding is rectified as soon as possible; • smooth out known differences in the funding model design for the initial implementation of ABF for each workstreams, while progressively refining the model as consistency improves; • establish culture of ongoing refinement to the classification/funding models, and therefore, expectation of changes over time; • engage clinicians early to ensure that new/emerging models of care are considered in the design of the funding model; • undertake further research on known issues in the classification and funding models of care (e.g. consultation liaison service, in reach services, improved classification for mental health, etc.); • initiate and progress work on the non-critical/essential projects, wherever possible, while attaining 'Phase 0' milestones; • further develop the Work Plans to flesh out long term requirements; • actively measure and monitor the progress on the implementation of the Work Plans.

Results

Ongoing governance of the implementation process

- A high degree of ownership of the work plans was developed amongst the AWG members
- These groups should continue to meet (using a mixture of face-to-face, telephone and email meetings) to monitor implementation and further develop projects and priorities.
  - This allows retention of the common knowledge that has been built up within the AWGs; and
  - Ensures projects are implemented as intended.
- The terms of reference for the AWGs were amended to focus on supporting implementation and continuing refinement of the work plans
- The original terms of reference focused largely on developing the work plans

Discussion
Subacute care workstream

- The proxy classification (AN-SNAP) will be activity occurring in designated services, which is achievable for several of the states and territories.
- Some states and territories will face major challenges as they are starting from a very low data collection base.
- Implementation will be easier to achieve for Rehabilitation (Australasian Rehabilitation Outcomes Collaboration (AROC)) and Palliative Care (Palliative Care Outcomes Collaboration (PCOC))
- **What needs to be done:**
  - A national definition of sub-acute services needs to be developed and states/territories need to identify designated sub-acute services that meet this definition.
  - Significant work is required to address issues for GEM and psychogeriatric care, as well as to make AN-SNAP (or alternative) more appropriate to subacute mental health care.
  - Implementation needs to allow for reported episodes where the required data are not available or where proxy data are available.
  - The collection of data on sub acute care delivered in non-designated services needs to be a longer term goal.

Discussion
Non-admitted care workstream

- The proxy classification proposed for non-admitted care is being refined
- The existing version is not implemented in any routine data collection systems
- All the data available for the proxy system (which is only in the NHCDC) are produced as a result of either primary or secondary mapping collected using a different classification system.
- **Implementation challenge:** limited historical data aligned with the refined classification.
- **What needs to be done:**
  - Approaches to counting non-admitted patient activity vary considerably across states/territories – work is required to improve consistency.
  - Definition of ABF in-scope services
  - Improvements to the classification system so it better covers non-admitted sub-acute, mental health and hospital auspiced community based health services.
  - Mapping existing non-admitted data from existing state/territory data collection systems to the refined NHCDC

Discussion
Emergency department workstream

- Most states and territories have data collection systems in Emergency Departments (EDs) that include the 'ED diagnosis'; the data item that is required for the proxy classification (URGs)
  - This approach will suffice in the first stage of implementation
- Short term: URGs can be used only in ABF hospitals that have an ED that meets the national definition.
  - Urgency and Disposition Groups (UDGs, diagnosis not required) can be used for emergency services that do not meet the definition of an ED.
- **What needs to be done:**
  - The URG classification needs to be refined and updated in the short term
  - Several states and territories will need to extend their data collection to all EDs within scope.
  - A medium term challenge will be to achieve a minimum and consistent standard for recording ED diagnosis across states/territories.

Discussion
Mental Health Care Workstream

- The best data on mental health services is in program specific information systems, not in mainstream hospital systems.
- There is duplication in both systems
- There is no alignment in the data collected or in the counting rules used.

- **What needs to be done**
  - The initial approach to ABF for mental health services is to deal with it in the context of the proposed proxy classifications, therefore the issues associated with mental health are similar to those outlined in other workstreams
  - Significant limitations in the proxy classification systems i.e. other than psychogeriatric care, 'sub and non-acute mental health' is not handled within the AN-SNAP system nor well defined; and work is required to develop a classification (either added to or separate from AN-SNAP) and ABF approaches to this component of care in the immediate future.

Discussion
National hospital Costs Data Collection Workstream

- The immediate challenge for the NHCDC TWG is to generate the costs data as input to developing national cost weights for the proxy classification and setting the efficient prices for all ABF workstreams
- Australian Hospital Patient Costing Standards have only been recently developed, they are not widely adhered to, nor is there much consistency in the underlying costing methodology used by states/territories to generate the current costs data
- Any supplementary studies commissioned to address these issues, need to be finished by November/December 2011
- Issues in conducting supplementary studies due to the lack of underlying activity data and/or inflexibilities in current costing infrastructure.
- In the mid-term, the NHCDC should be enhanced to ensure that costs data are generated according to a nationally consistent costing methodology and that there is representative coverage of patient level costing data for services in all workstreams

Conclusion

- Development of the five AWG and the overarching work plans demonstrated that it will be difficult to achieve a common starting point for ABF across states/territories by 1st July 2012.
- To reach the specified minimum position, there is considerable work required that it needed to start urgently.
- There were concerns about the available resources but work plans fairly represented what was required to implement ABF across all workstreams
- A three-phased approach to implementation based on the priorities assigned to the 35 high level projects was the best risk management approach.
- Success is dependent on resources being allocated to progress the 13 critical/essential projects
- The implementation strategies will challenge states/territories to reach the specified minimum position