Activity Based Management
“Are we there yet?”

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Department of Health, Western Australia
43,000 staff
Metro
5 teaching & 7 secondary
2 private/public
Community Health
Child & Adolescent Health

Country
13 health campuses
15 secondary, 51 small hosp
numerous nursing posts, health centres
Fiona Stanley Hospital

- 783 bed tertiary/quaternary facility incl. State Rehab
- 150,000m² of floor space = 250 average residential blocks
- More than 5 hectares of natural bush land, parks, gardens, courtyards and plazas = 83 average residential blocks
- 83% private rooms in main hospital building
- Practical completion by end 2013
- Commence phased opening in October 2014
Perth Children’s Hospital

- Cost = $1,168.7 billion
- Beds = 274 (from 220)
- Construction began in January 2012
- Due for completion in 2015
- Approximately 100,000m² of built space
- Includes:
  - Increased operating theatre capacity – increase from 6 to 11
  - The Telethon Institute of Child Health Research
  - The State’s only paediatric trauma centre
  - Parent beds in each standard inpatient room
  - A family resource centre
WA Health Budget Distribution 2014-15

Total Health Budget ($8.0 billion, 100%)

Hospital Services ($5.4 billion, 68%)

Activity Based Funding ($4.6 billion, 86%)

Block Funding ($0.8 billion, 14%)

Non-Hospital Services Block Funding including prevention, promotion and protection, dental services, and support services ($2.6 billion, 32%)
The ABF/ABM journey

In April 2010 an ABF/ABM Program was established in the Department of Health (DoH). Over the past four years, significant work has taken place to build the foundation for ABF/ABM across WA Health.

- Consistent activity based approach to purchasing health services;
- Annual Service Agreements with Health Services;
- Performance Management Framework;
- Premium Payments Program to reward best evidence-based care;
- Procurement and implementation of a statewide clinical costing system;
KEY achievements

- Clinical documentation improvement program;
- New classification systems in Emergency Department, Subacute and Non-admitted Services, which align with national ABF requirements;
- Statewide DoH-led program of training and education on the building blocks of ABF/ABM;
- Publications: Managing in an ABF Environment, Clinical Casemix Handbook and Education and Training Manuals;
- Policies: Purchasing, Funding, Admitted and Non-admitted care recording and reporting
Change Management

• The **new** environment of ABF/ABM impacts on all aspects of health service delivery
• Purpose of existing data collections expands
• Every admission is an invoice requesting payment for product/service delivered
• Wilful resistance
• WHADILT
• Opposing/Conflicting policy e.g. NEAT
• Policy required to ensure appropriate and legitimate funding of activity
• Rules required to guide health services
Step 1: counting activity correctly

Funding is based on activity. If activity is not accurately captured in a data system, it won’t be funded correctly.
Basic Criteria for admission:

• The patient’s condition/treatment requires inpatient care, and they are admitted to an inpatient ward/unit, and the care provided meets the applicable admission criteria:
  • Documentation requirements
  • Same day specific criteria for emergency admissions (LOS and level of care)
  • Procedure exclusions set by the Commonwealth
  • Clinical Assessment and Care planning

Some KEY rules

• One admission per day
• One care type change per day
• Must leave ED no virtual ward admissions in ED
• Medical admission = 4hrs
• Subacute care must meet SAC definitions
• No care type change day of admission or discharge
• HITH must be in patient care provided in the home
• Admitted care = inpatient care
• Procedures not automatically classified as admitted care.

• WA health services have an obligation to count and label activity in an accurate and consistent fashion

• The ARDT policy provides a framework, containing detailed rules and criteria to enable the correct counting and classification of admitted care
Risky activity

- ED incorrect data EDIS
- Virtual ward is not real inpatient admitted care
- Discharge ward/transit lounge is going not coming
- Subacute care in non designated units is usually not meeting definitions/criteria
- Palliation not automatically Palliative care type
- Admitted care reported in OPD virtual ward
- Newborn qualified V unqualified
Ongoing key challenges

- Policy and Quality management
- Classification of care
  - ED is URG
  - Inpatient is DRG
  - Other is Tier 2
- Activity Creep (inflating activity)
  - Transfers splitting the care across hospitals
  - Contract care
  - Care type changes
  - Readmissions
  - False reporting
Perverse Incentives

• Chasing the revenue
  – New services
  – Incorrect counting and classifying care.

• Opposing forces
  – 4 hour rule
  – Nursing hours per pat day
  – Managing LOS => care type change
  – KPI coding completion
Hospital in the Home review 2014
Case for Action

- Previous audits of the ARDT policy, have identified a number of issues relating to incorrect and/or invalid reporting of Hospital in the Home (HITH) activity.

- Large volume of non admitted care

- HITH admitted care not provided in the home but in hospital outpatient clinics
Focus review of HITH

- Provide a profile of HITH activity in WA
- Assist Health Services in review of HITH care
- Audit of Policy compliance
- Consult with key stakeholders to identify issues and concerns with HITH services.
- Establish recommendations to improve HITH service delivery, and the counting and classification of activity
What is HITH

- Hospital in the Home (HITH) provides an alternative to hospital based care by providing care within an admitted patient’s residence as a substitute for traditional hospital accommodation.

- Without HITH the patient would require a hospital admission.

- When a patient is transferred to HITH from in-hospital based care, this is considered continuous care.

- Days that the patient is not receiving care must be reported as leave days.

- Day of discharge is recorded as the last day the patient received care.

- Care provided entirely in settings other than the home should be reported as non-admitted care.
HITH profile

- Analysis of HITH activity April – June 2013

- 1894 admitted care episodes reporting HITH activity.

- Older adults aged 65 and over accounted for 42.1% of patients who received HITH care

Core Business:
- IV antibiotics
- Wound care
- anticoagulation therapy
- joint replacements.
HITH profile: Length of Stay

- Majority have a LoS 8-21 days
- 96% of DRGs with a HITH component exceeded the national average length of stay.
- 21% of episodes were above the High Boundary
- 68% of cases the actual HITH beddays component is extending the LoS above HB
- Over High Boundary WAU = 2,445
- 93% of same day admissions (LoS 1 day) did not meet the HITH admission criteria
TOP 20 HITH DRGs– ALOS COMPARISON
HITH outpatient activity

- 13,208 service events in HITH clinics (2013)
- 35% were current HITH inpatients
- 65% ambulatory non admitted care. Historically excluded from reporting. (not counted)
- 43 clinics across five hospitals. 19 were providing care to HITH patients from other Health Services. Clinical Governance
  - Inpatient at admitting hospital and outpatient at HITH provider hospital.
- Clinics incorrectly classified (Tier 2) For example, dressings and anticoagulation clinics classified as Rehabilitation.
Medical Record Audit

A sample of 270 HITH episodes was selected from the top 5 hospitals. A total of 218 episodes were reviewed to identify compliance:

- **31%** of episodes not meeting the admission criteria for HITH
- **38%** of admissions to HITH were direct admissions, not continuous care within the same hospital
- Data quality was an issue with **19% (53%)** of reported admission and discharge dates reported incorrectly
- Documentation for each day of care counted as HITH was lacking in **22%** of episodes
- Discharging and readmitting to HITH the next day
Medical Record Audit

- 86% of all episodes reviewed did not comply with the leave reporting requirements
- 67% of leave days (identified as days where no care was provided) were incorrectly recorded as days of care
- 14% of the total reported HITH beddays were falsely reported as days of care
- 13% of episodes are receiving all their care as non-admitted care in the hospital (not HITH)
- 38% of cases are being treated by a combination of home and hospital outpatient care
Consultation

• Visited all sites and presented findings and discussed recommendations

• 7 Questions
  • Review HITH services, improvements
  • Areas of concern
  • Outsource, any issues
  • Non-admitted activity
  • Benchmarking
  • Recommendations/comments
  • Further comments
What we found

• Commonalities
  • LoS
  • Leave days
  • ARDT policy compliance issues
  • Casemix

• Issues and concerns
  • Outsourcing
  • Cross boundary HITH
  • Understanding ABF
  • Adequate funding in Tier 2
Stakeholder Engagement

SCGH SUBs group

• Established from Length of Stay work focus on HITH during ABF Reconfiguration project

South Metropolitan Health Service Reconfiguration Workshop scenarios with SMHS

• How to report activity for common pathways
Did the earth move?

- HITH stakeholders have collaborated to establish standardised clinic labelling (HLK) and classification for non-admitted activity.
- Only 8 clinics now
- Workshop with key stakeholders metropolitan HITH to:
  - Identify opportunities to improve the HITH service delivery model
  - Ensure a sustainable service under ABF that delivers the right care, in the right place and time
Workshop outcomes

• Hospital in the Home Service Delivery Guidelines being developed:
  – Business rules for data reporting aligned with ABF policy
  – Principles of Clinical Governance
  – Processes and Eligibility for HITH
  – Models of care and care pathways
Policy & ABM = success

- ARDT Policy compliance audit and LOS management projects have assisted HITH to analyse its business and is a key driver in the development of criteria led discharge in select patient groups.

- SCGH HITH had assessed its historical practice and in collaboration with the treating teams is reviewing care provided and rationalising the use of its resources.

- Development of care pathways in liaison with the treating teams has assisted the hospitals understanding of the patient journey inclusive of HITH which has facilitated conversations for cost effective discharge options and to direct care requirements based on evidence based patient care across the patient journey.
Review of the evidence, the patient journey and a standardisation/change of clinical practice.

Simple Mastectomy – On day 10 drain removed by HITH then discharged.

Drain removed day 4 HITH day 5 then discharged

Further improved to discharge day 4 (no HITH required)

- Elective Joint Replacement LOS up to 12 days (staples removed)
- HITH & RITH both attending
- Pain and Bowel Mgt issues delay in Rehab
- Discharged day 4. Non-admitted care follow up.
Feedback from HITH manager

• The Elective Joint QI project attached has generated a lot of interest from the stakeholders and assisted in bringing care providers together. We have certainly triggered a coordinated approach to improvement.

• This ‘Peeling of the onion’ starting with the policy audit is unravelling practice and increasing the understanding across the various departments at each point of the patient journey.

• We have started something here ….. this is an opportunity to influence a change in practice across the board, from the decision point for surgery to set patient expectations, coordinated patient care, improvements in clinical handover and most importantly maximising use of the Health resource and linkage to primary care.
Lessons Learnt - Governance

Policy → Implement → Monitor → Evaluate → Audit → Improve → Policy

- Improve
- Implement
- Monitor
- Evaluate
- Audit
- Measure
WA Health Reform

ABF/ABM implementation
2008 National P/ship agreement to move to ABF

2010 National Health and Hospitals Network Agreement – WA did not sign

2011 National Health Reform Agreement – confirmed move to national ABF

Year 1 WA ABF/ABM 2010-2011 WA ABF Budget

Year 3 WA ABF/ABM 2012-2013 Start National ABF

Year 5 WA ABF/ABM 2014-2015 and through forward estimates. Full National ABF

Year 8 WA ABF/ABM 2017-2018 Alignment between state and national price

This requires a reduction in cost growth in WA hospital services from 2.7% to 0.9%
• The relative average cost of public hospital services is 13% higher in WA than the national average.
• Community Service Subsidy of $320.2m in 2014-15 decreasing to $146.7m in 2016-17 and zero by 2017-18
• In 2014-2015 funding allocated to WA Health accounts for over 28% of the WA public sector expenditure, up from 24% in 2010-2011
WA health reform - WA Health has established a wide ranging and ambitious program of reform that will improve their ability to deliver better care and better value.

Linked elements involving:

- Governance reform, supported by legislative change
- ABF/M implementation
- Workforce planning & industrial relations
- Revenue reform
- Budget reform – program structure and internal processes
- Performance management
- Procurement reform
- Shared services reform
- Safety & Quality
- Clinical engagement
- Leadership
## External reviews of progress on ABF/ABM implementation in 2014 found:

<table>
<thead>
<tr>
<th>Done</th>
<th>To be done</th>
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<tbody>
<tr>
<td>• ABF operating model</td>
<td>• Refinement of operating model</td>
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<tr>
<td>• Statewide clinical costing system implemented</td>
<td>• Increased clinical engagement</td>
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<tr>
<td>• New policies clarifying rules for counting and classifications</td>
<td>• Improved quality and timeliness of data</td>
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<td>• Statewide Performance Management Framework</td>
<td>• Improvements to budget allocation processes</td>
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<td>• Information and education campaign by DoH</td>
<td>• Improvements to governance arrangements</td>
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Training, education and capability

Leadership and strategy

Clinical coding and classification
Clinical costing
Business intelligence
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<tr>
<th>ABM reform work streams</th>
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<td><strong>Strategy and leadership</strong></td>
<td>To define a clear vision and strategy for the future application of ABF/ABM within WA Health which is understood and consistently supported by all levels of the system’s leadership</td>
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<td><strong>Training, education and capability</strong></td>
<td>To develop a training and education ABF/ABM program tailored to specific needs in a language that engages and sets clear expectations of the individual’s role</td>
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<td><strong>Clinical costing</strong></td>
<td>To establish effective and efficient clinical costing processes which will ensure sustainable delivery of timely and consistent clinical costing information and will support ABM at all levels of the health system</td>
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<td><strong>Coding and classification</strong></td>
<td>To ensure quality counting, classification and coding of activity to inform ABF/ABM</td>
<td></td>
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<tr>
<td><strong>Business intelligence, data and information</strong></td>
<td>To establish a standard ABF/ABM data set that is accessible and provides consistent, comparable and customisable information which supports the needs of the full range of end users</td>
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ABM reform outcomes

• To improve how ABF/ABM is understood, applied and managed across WA Health.

• To ensure that ABF/ABM is effectively applied by clinicians, so that it appropriately influences front-line decision making. This will require providing tools and system supports to enable clinicians and managers to operate effectively in an ABF/ABM environment.

• To establish an environment of effective and timely information that enables effective decision making at all levels.

• To enable, through the routine use of ABM, a reduction in the State average cost, moving towards the national average over a three-year period.
Roles and Responsibilities in Managing Change

Achieving the ambitious outcomes of the ABM Reform Program will require many people at all levels in the system to play an active role in managing change.

Frontline and middle managers are responsible for introducing new ways of working to their teams and stakeholders, and engaging people in that work.

Senior leaders and executives play a lead role in creating the environment and culture within which these changes can be implemented, and by setting clear performance expectations of their teams.

I am not telling you it is going to be easy, I’m telling you it’s going to be worth it.