Clinical Participation and Activity Based Funding

Taking the opportunity

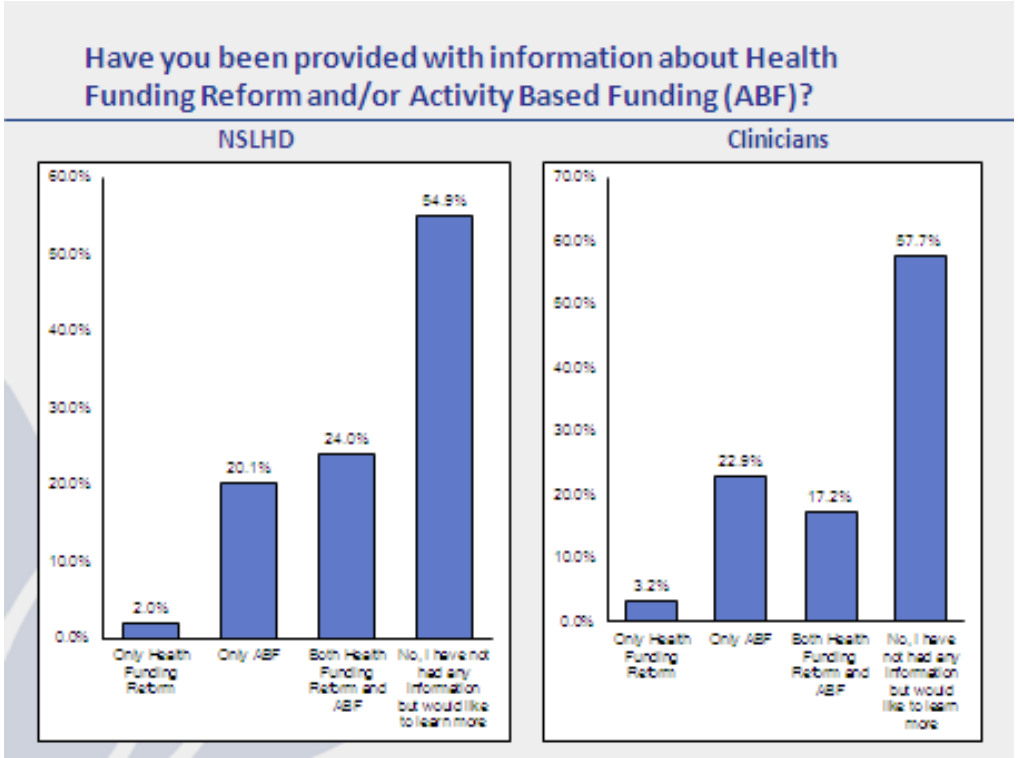
Dr Philip Hoyle

ABF is more than budgeting

- The “Activity” in ABF is **care of people**
  - DRGs, NWAUs etc are labels, not reality
  - Engage with the reality to get the benefits
- Clinician participation is key
- Non-participation skews values and systems
  - Monovalent funding, budgeting…

The current situation

- NSW Health Survey (2013)
  - Little knowledge
  - Would like to know more



= Contrast with Casemix Mark 1

Why is it hard to ignite and sustain clinical interest in ABF?

- Perceived irrelevance.
  - discursive silence on relevance to care, care delivery and improvement.
- Change fatigue.
  - Background with a host of mandates: NEAT, NEST, NSQHCS, reorganisations
- Cultural barriers.
  - The costing/ pricing focus signalling economic purpose
  - A way to control clinical work from the “outside”.
- Lack of incentives.
  - Prospect of meetings rarely attractive
  - Opportunities to increase autonomy and grow are not visible.
- Structural separation from normal business activities.
  - ABF working in parallel to normal business activities e.g. access, financial and quality targets.
  - Little management interest in casemix view of care processes and efficiency

  → ABF thinking remains alien.

Balnave and Reid (2007)

Australian Health Review **31** , 59–67

- Must overcome
  - clinical reluctance to have their practice laid open to scrutiny, and
  - deep seated organisation cultural barriers to devolution and genuine power sharing

Summary so far

- ABF is rich in opportunity at an operational level
- It needs clinical input
- Clinicians are interested but withholding commitment

Approach to securing participation

Three dimensions

Approach to participation

A. Make ABF relevant to the clinical world
B. Open minds to the opportunities
C. Support clinical involvement

A. Relevance

ABF is rich in clinically relevant concepts:

- Quality of care
- Appropriateness
  - *Should we do this?*
- Clinical process reliability:
  - *How often do we get it right/wrong?*
- Absolute resource use:
  - *can we afford to do this?*
- Relative resource use:
  - *are we under-using allied health?*
- Accurate targeting of improvement:
  - *Unexplained variation*

Links into management and governance

- Clinical Departments
  - Can we do better?
  - Free up resources for change e.g. new tech
- Health Services
  - Start conversations with clinicians
    - What are the opportunities?
    - What should we collectively do?
  - Link clinical and budget strategies at care level
- Clinical Networks
  - Who does what, where?
  - Advice on service commissioning : what *should* they do?
- LHD
  - Links to planning and governance

Horatio Nelson

…in case signals can neither be seen or perfectly understood,

no captain can do very wrong if he places his ship alongside that of the enemy.

A simple example

Start conversations with clinicians

Where are we nominally “losing” under ABF?

- Work backwards from the economic data to the clinical care
- Nominal facility profit or loss by DRG
- Thresholds for materiality
  - Volume e.g. >30
  - Cost >3 Standard Deviations

“excessive” cost DRGs

25 DRGs account for 50% of excess

Class	Avg Cost Per NWAU(13)	Excess cost per NWAU	total excess cost over funded level	proprn total excess cost	cum propn total excess cost
G64B-Inflatory Bow el DIS	$14,163	$10,180	$365,637.26	8%	8%
I03B-Hip Replace-CCC	$4,802	$819	$124,877.28	3%	11%
O60B-VaginalDel-CSCC	$4,520	$537	$124,037.65	3%	14%
I08A-Oth Hip & FEMO PR	$4,592	$609	$111,894.23	3%	17%
J64B-Cellulitis-CSCC	$5,256	$1,273	$107,770.91	2%	19%
Z64A-Oth Hlth Stat	$4,813	$830	$103,291.40	2%	21%
E41Z-RESP SYS DX-Inv VNT	$5,961	$1,978	$93,849.99	2%	24%
I13A-HTF Ankl PR+CC	$5,201	$1,218	$92,542.00	2%	26%
I04B-Knee Replace-CSCC	$6,158	$2,175	$84,191.60	2%	28%
F08A-Mjr Rec VAS PR-PMP	$7,086	$3,103	$83,661.78	2%	29%
K01A-OR PR Diabetic +CCC	$13,465	$9,482	$80,208.11	2%	31%
I07Z-Amputation	$8,174	$4,191	$77,175.45	2%	33%
G02A-Mjr Bow el PR+CCC	$4,780	$797	$71,005.16	2%	35%
E62A-RESP Inf/Infl+CCC	$4,408	$425	$70,807.84	2%	36%
G46C-Comp GAST SD	$4,880	$897	$66,994.57	2%	38%
I20Z-Oth Foot PR	$5,025	$1,042	$65,054.07	1%	39%
H08A-LapChole+CDE/+CSCC	$4,949	$966	$60,371.17	1%	41%
E70B-WC &Acte Brnchio-CC	$5,105	$1,122	$58,435.59	1%	42%
J12A-L Lmb PR+ULCR/CELS	$5,592	$1,609	$54,073.97	1%	43%
G03B-SO&Duo PR-Mal	$10,077	$6,094	$50,334.24	1%	44%
G10A-Hernia PR+CC	$5,008	$1,025	$49,616.84	1%	46%
F11A-AMP CIRC SYS-Up L&T	$5,215	$1,232	$49,006.36	1%	47%
D63Z-Otitis Media & Uri	$4,555	$572	$47,946.82	1%	48%
I04A-Knee Replace+CSCC	$5,111	$1,128	$44,063.43	1%	49%
E65A-CHR Obs Air DIS+CCC	$4,488	$505	$40,067.68	1%	50%

Identify broad care types with systematically high costs

- Roll-up DRGs by MDC or similar
  - a proxy for high level clinical process (e.g. orthopaedics or cardiology).
  - reduces clinical department attribution error
- Important link to clinical governance systems

By Specialty

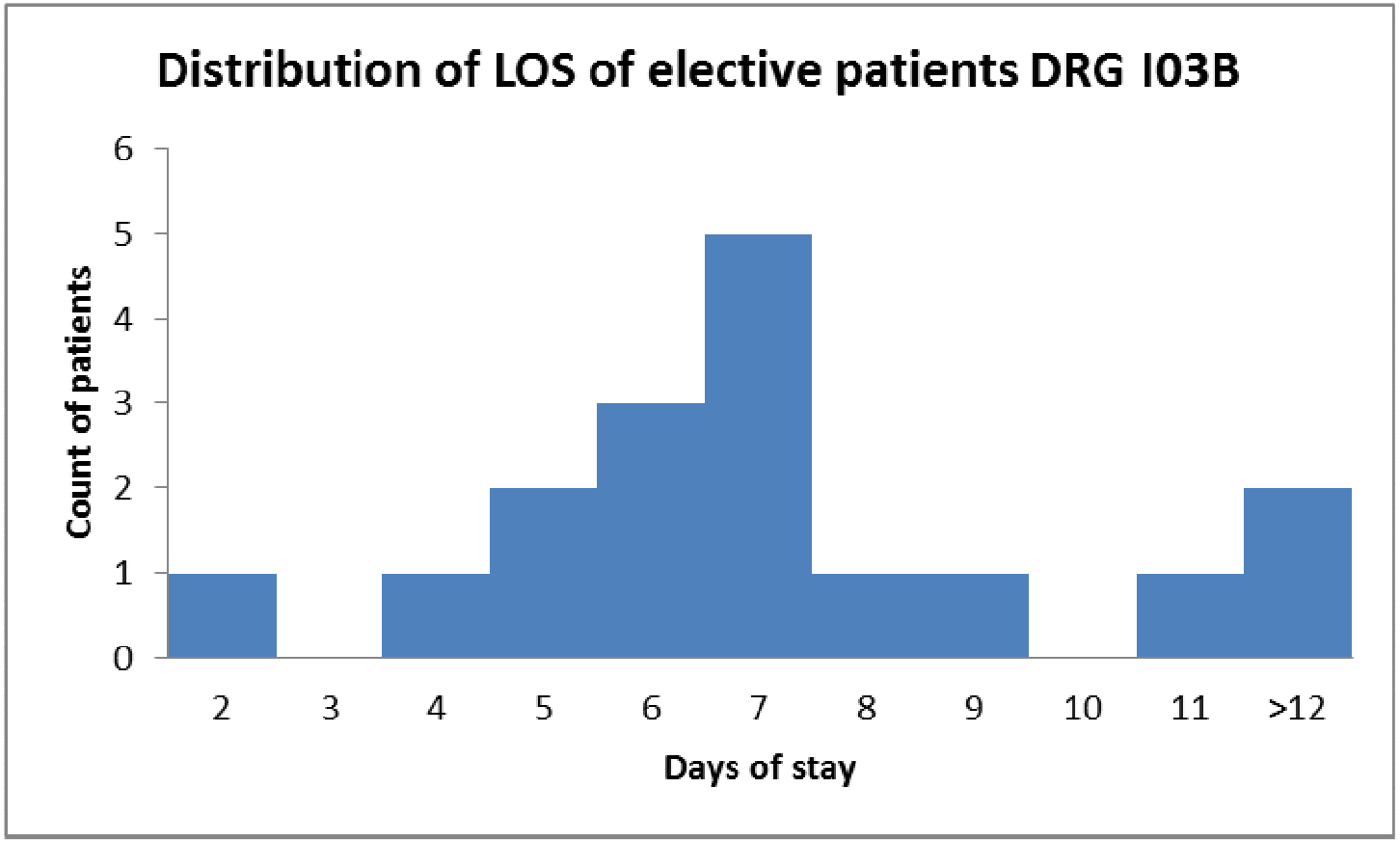
Spec	Total Excess
GenSurg	$231,327.42
Med	$743,739.75
O&G	$124,037.65
Orth	$522,622.61
Placement	$103,291.40
Vasc	$451,896.58
Grand Total	$2,176,915.41

Understand the clinical drivers

Understand the care in detail

- ICD/ Procedure composition
- Emergency versus booked
- Age distribution
- LOS distribution

LOS


Distribution of LOS of elective patients DRG I03B
Count of patients
0
1
2
3
4
5
6
2
3
4
5
6
7
8
9
10
11
>12
Days of stay

Understand the cost drivers

- Inputs can give insights into process
- Cost bucket analysis

Facility	OR	Pros	Avg Cost / Enct
M+MVH	$3,450	$4,140	$18,294
Mona Vale	$2,977	$5,264	**$18,606**
Manly	**$3,788**	$3,337	**$18,072**

Mona Vale- Manly cost (red = excess at Mona Vale)	**-811**	**1,927**	534

Talk to the surgeons

- Understood the issues but not the need for a system
  - LOS 8 days, best practice 2.9
  - Inefficient lists
  - Expectations not managed
  - Rehab phase built in
  - No preconditioning
  - Anaesthesia not consistent
- Want to move into anterior THR

Agreed Actions

Agreement to

- Develop best practice elective orthopaedic service in coming year
- Redeploy some savings to clinical innovation
- Develop extended clinical management systems along the continuum

B. Open minds to the opportunities

- **Awareness program**
  - Linked to concrete actions e.g. governance changes, rollout of reporting
- **Formal training and education (not just the clinicians!!)**
  - Teams
  - Individual skills
    - e.g. statistical thinking for managers, basic casemix concepts
  - Clinical documentation

C. Support for involvement

- Clinicians will **choose** whether to get involved
- Support as a signal of organisational commitment
- Supports include:
  - Training and education
  - Good information
    - readily available, technically accessible
  - Capacity to ask and answer questions
  - Expert analytical support
  - Recognition that it is real work e.g. in job planning
  - Management structures that empower clinicians over care

The clinical management role is key

- Evolve from a “position” to a “role” responsible for care systems
  - “Accountable autonomy”
- Systems thinking applied to clinical work
- Technical knowledge
  - health economics, casemix, statistics
- Skills: language, social, managing differences

Source: Degeling et al op cit

Summary

- ABF creates opportunities to improve real care for real people
- It can precipitate broader cultural benefits
- This requires clinical participation
- Clinical participation requires
  - Demonstrated relevance
  - Awareness of the opportunities
  - Support for involvement
- It is out there, waiting for us!

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