HEALTHCARE PRICING OFFICE

ABF in Ireland

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Healthcare Pricing Office
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DRG Forum
Nidelven Hotel, Trondheim

Tour of Ireland's experience with ABF

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Who am I?

- Management accountant
- National Casemix Programme/Healthcare Pricing Office since 2007
  - Price setting
  - Guardians of all Casemix activity and cost data
- Worked in Casemix in
  - 2002-7 Mater Hospital
  - 2001 – 2 Beaumont Hospital
- 'Poacher turned game-keeper' (krypskytter slått skogvokter)

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History lesson

- 1991 National Casemix Project established
  - 15 Hospitals
  - Inpatient activity only (overnight and planned same-day)
  - Low 'Blend Rates' (Low exposure to Casemix)
- Over time
  - More hospitals included
  - Activity expanded to include Day Cases, Outpatients and ED attendances
  - Blend Rates increased to 90%
- Final Casemix budget adjustments in 2012
  - Based on costs and activity comparisons on 2010 data

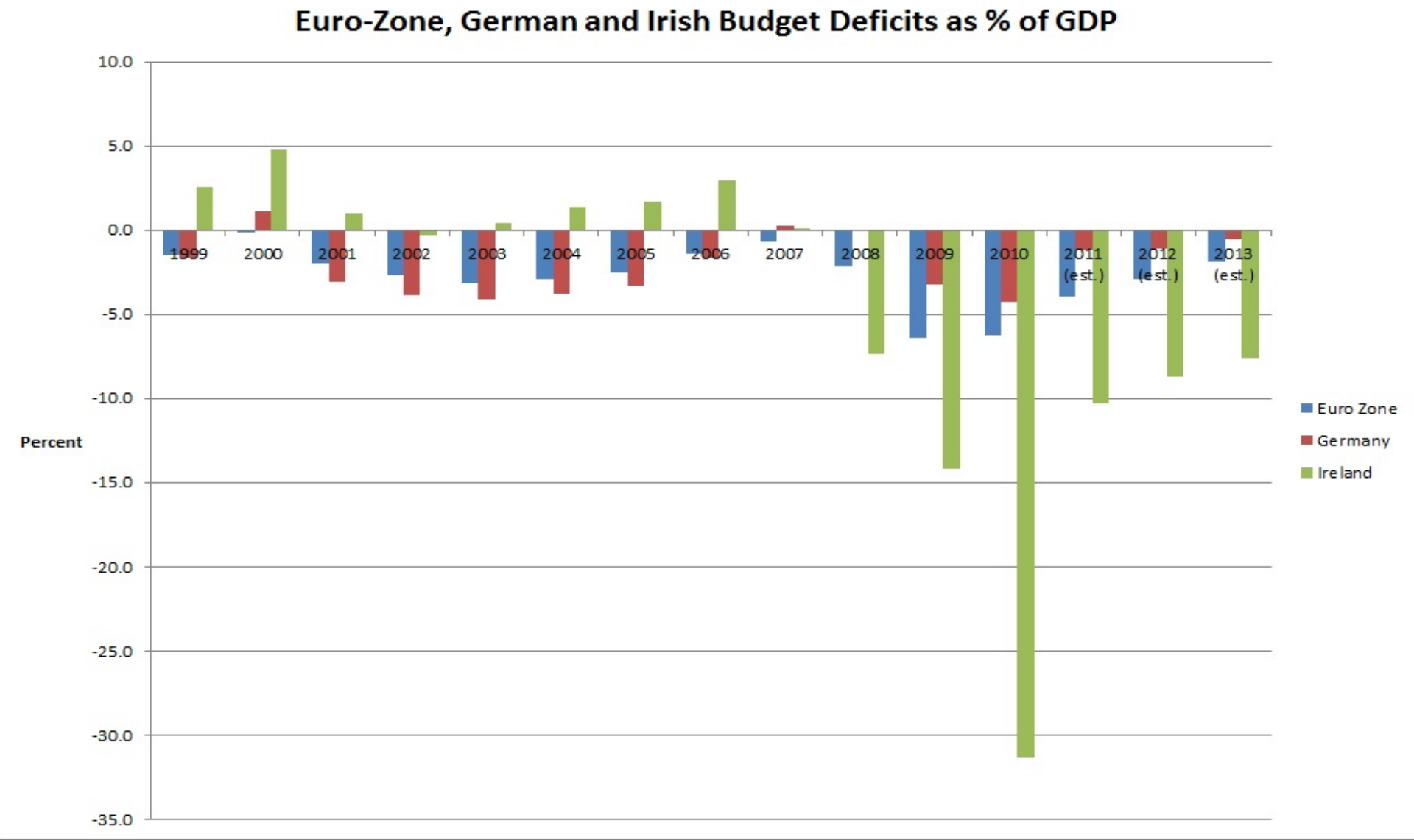
Goodbye Casemix
Hello Money Follows The Patient

- Casemix paused to prepare for MFTP
- Professor Ric Marshall conducted 'State of Readiness Review'
- "higher than the level of readiness that has been found necessary to implement MFTP in other countries"
- "Perfection is the enemy of progress"
- "Perfeksjon er fiende av fremgang"

Money Follows The Patient!!

- More patients = More money
- MFTP became ABF
- Unfortunately there was no extra money because……

Ireland's financial meltdown

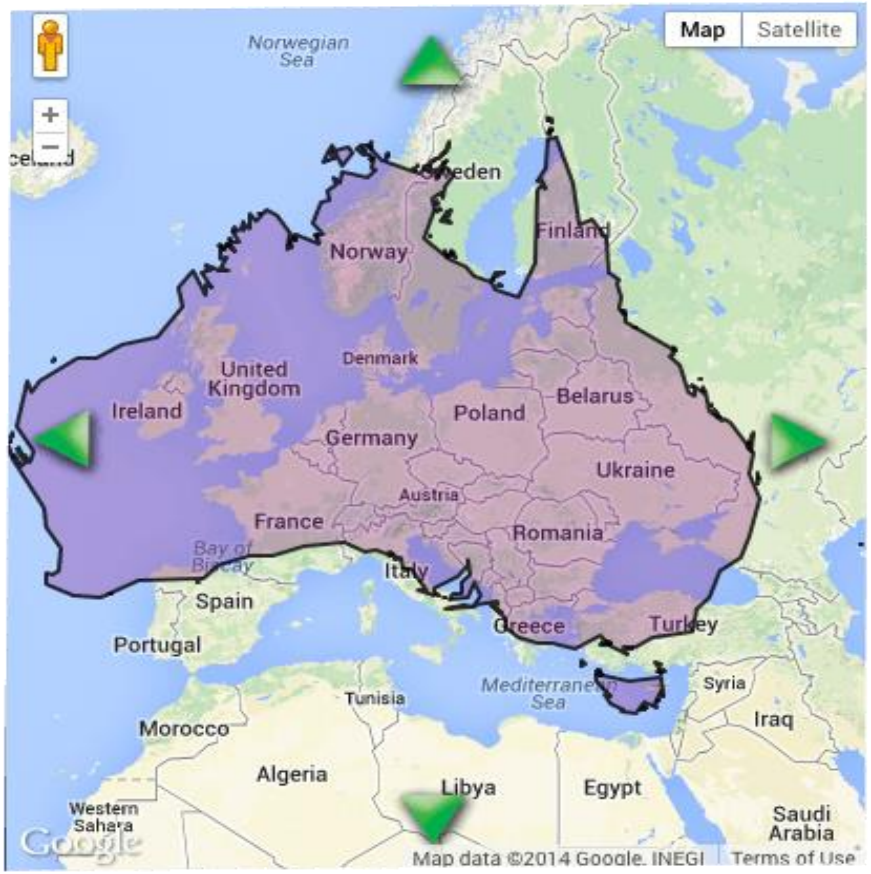


Ireland's Australian connections

- 2004 decision to use AR-DRGs
- 2015
  - ICD-10-AM/ACHI/ACS 8th edition
  - Grouper version AR-DRG 6.0
- 2016
  - ICD-10-AM/ACHI/ACS 8th edition
  - Group activity using both V6.0 and V8.0

So much in common!

- Australia
  - 7,692,024 km² (6th)
  - 24 million
  - 3 persons per km² Surrounded by Indian & Pacific Oceans
  - Very, very sunny
- Ireland
  - 70,273 km² (120th)
  - 4.6 million
  - 65 persons per km²
  - Atlantic Island on edge of Europe
  - Lots and lots of rain



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Different cost profiles

- We used cost weights from Victoria State
  - Similar population
  - More urban
  - Better match of patient profile
- Significant differences in cost profile
  - Different salary levels
  - Blood free to hospitals : use New Zealand blood cost data for blood cost weights
  - Pharmaceuticals considerably cheaper in Victoria

Different patient profiles

- Acute medical assessment units
  - National initiative to take pressure off Emergency Departments
  - Largely non elective same day admissions
- Differences in admission policies
  - Maternity hospitals
  - Outpatient procedures taking place in theatres
  - Ultraviolet light therapy
- **Different patient profiles can lead to inappropriate payments based on foreign weights**

Firkantet pinne inn i et rundt hull!

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Irish Patient Level Costing Project

- PowerHealth Solutions – Australian company
- Pilot project involving 15 hospitals
  - All national centres – heart, neurosurgery, liver, burns, transplants
  - Specialist orthopaedic, maternity, paediatric hospitals
- Significant resource commitment
  - Costing resources
  - Information technology
- Irish DRG cost weights for Irish patients

Typical Hospital Financial Ledger

Cost centre --->	Specialty	ED	Ward	ICU	Labs	Radiology	Theatre	Physio	Procedure room	Overheads	Total
Cost element	€000	€000	€000	€000	€000	€000	€000	€000	€000	€000	€000
Medical pay	300	500		300	450	400					1,950
Nursing pay		2,000	2,500	4,000			2,250		300		11,050
Paramedical pay					1,000	900		750	150		2,800
Admin pay		150	35	75	100	100	75	50		1,000	1,585
TOTAL PAY	**300**	**2,650**	**2,535**	**4,375**	**1,550**	**1,400**	**2,325**	**800**	**450**	**1,000**	**17,385**
Drugs		100	250	600					50		1,000
M&SS		50	75	150	25	75		150	50		575
Lab supplies					1,500						1,500
Radiology supplies						1,500					1,500
Heat power light										2,000	2,000
Office expenses		25	15	20	100	150		25		1,500	1,835
TOTAL NON PAY	**0**	**175**	**340**	**770**	**1,625**	**1,725**	**0**	**175**	**100**	**3,500**	**8,410**
TOTAL GROSS COST	**300**	**2,825**	**2,875**	**5,145**	**3,175**	**3,125**	**2,325**	**975**	**550**	**4,500**	**25,795**

- Cost centres matching physical locations
- Budget holders in these physical locations responsible for managing their expenditure versus budget

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Patients are different

	ED	Ward	ICU	Labs	Radiology	Theatre	Physio	Procedure Room	Overheads
Leg fracture									
Car crash multiple trauma									
Stroke without complications									
Heart transplant									
Hip replacement									
Colonoscopy									
GP referral									

- Use patient identifiers across hospital systems to link costs in each area to the patients actually using them
- These patients summarise upwards into DRG
- Cost profile for each DRG = Cost weight

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PLC evolution

- Move from PowerHealth carrying out studies to local hospital implementation
  - Software and servers installed locally
- Hospitals responsible for own data compiling and processing and running their own reports
  - Use results to ensure efficient (financial) running of hospital
  - Move from ABF to ABM
  - Positive feedback so far
- HPO (me and my friends) to be 'Centre of Excellence'
  - Develop and maintain standards
  - Interrogate and audit results
  - Use results to set accurate prices

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Specialty Costing process

- PLC implemented in 15 hospitals (19 now)
  - Useful data for them
  - Essential for setting relativities for price setting
- To set national prices we need national costs
- 38 hospitals engaged in ABF
  - Send back standard Excel files
  - Subject to rigorous audit with queries returned to hospitals
  - Exchange files until I'm happy!
- Gives us the ABF versus Block split

ABF in Ireland 2016 – splitting budgets

Each hospital's funding is split between

- ABF funding
  - Inpatients (including non elective same day)
  - Elective day cases

  These patients are coded and grouped into DRGs

- Block funding
  - Non coded inpatients : long stay geriatric care/psychiatry
  - Emergency department
  - Out patients
  - Services provided by hospitals for external bodies

- Specialty Costing gives us the ABF/Block % split
- ABF funding moves from being guaranteed funding to 'Once-off' funding that must be earned every year

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What data do we need for ABF

- Coded data – HIPE system
  - What type of admitted patients are treated in Ireland
    - 50,000 O60Z Simple Delivery
    - 5,000 I03B Hip Replacement – CCC
    - 1,000 B70A Stroke + CCC
    - 10 A05Z Heart transplant
- PLC
  - The cost of each patient in the PLC hospitals (15)
  - Summarises up to a relative cost for each DRG
  - Cost of Complex stroke = 4 * Cost of Simple Stroke
  - Uncomplicated knee replacement = 2 * Average cost across all DRGs
- Specialty Costs
  - Gives us the broader Irish costs to which the PLC relativities apply to
- These datasets build into a price

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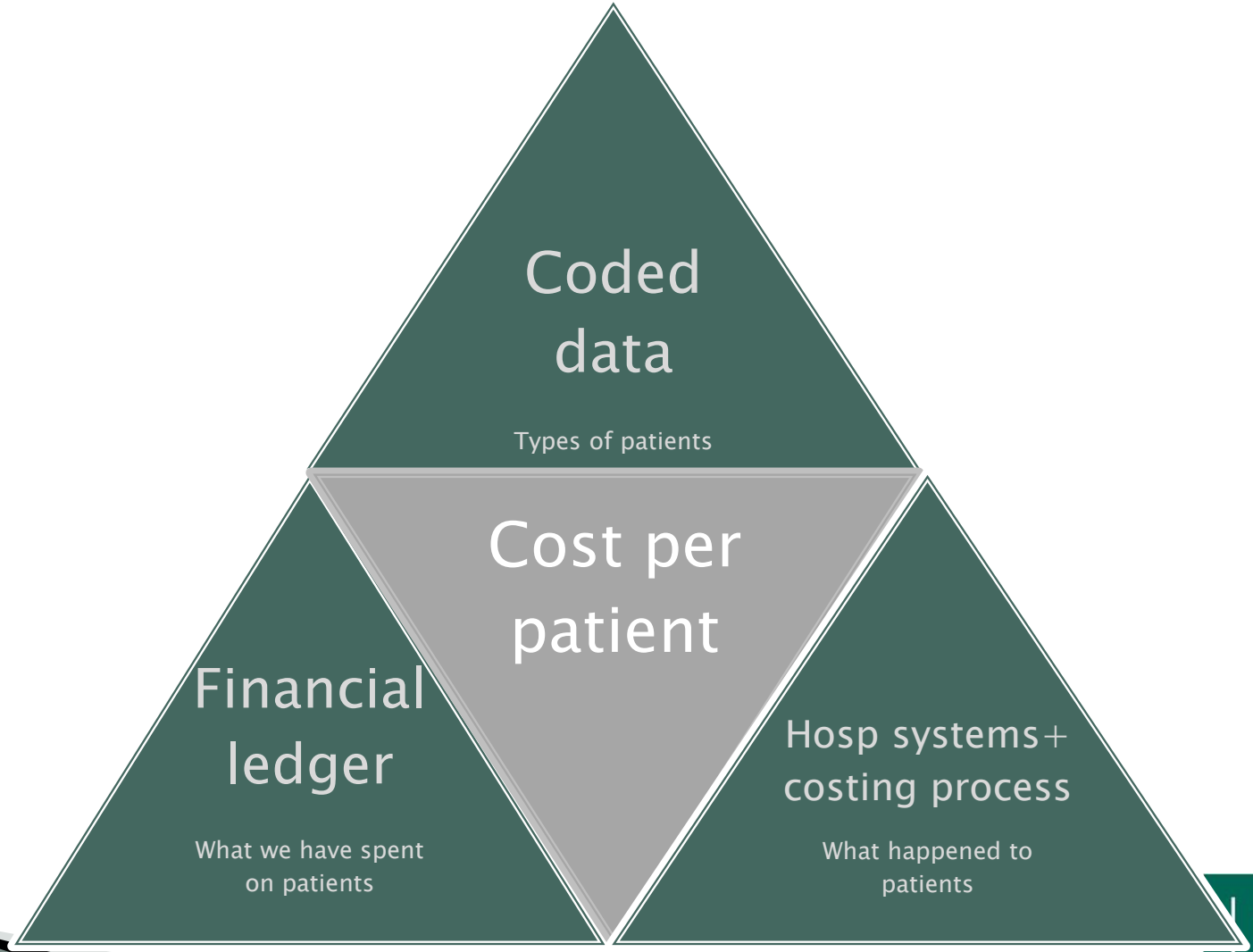
PLC requires connecting



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ABF Benchmarking in 2015

- Conversion year
  - Differences between the cost and value of ABF activity calculated and communicated
- Hospitals had 2015 to
  - Communicate and engage with stakeholders
  - Identify reasons for differences between cost and value
  - Deal with new reporting structures
  - **NO ACTUAL ADJUSTMENTS**

‘Mind the Gap’ – PCSI The Hague

- First benchmarking results produced
  - Showed the difference between cost and value of activity
- Focus on one hospital with large negative performance
  - Visited the hospital to engage with management/clinicians Audited to identify reasons for that variance
  - Compare coding against other hospitals
  - Look for specific cost issues affecting that hospital
- Reported back to hospital on findings

ABF – THEIR PROBLEM??!!

- J Paul Getty

"If you owe the bank $100 it's **YOUR** problem"

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OR OUR PROBLEM??!!

- J Paul Getty

"if you owe the bank $100,000,000, it's **THEIR** problem"

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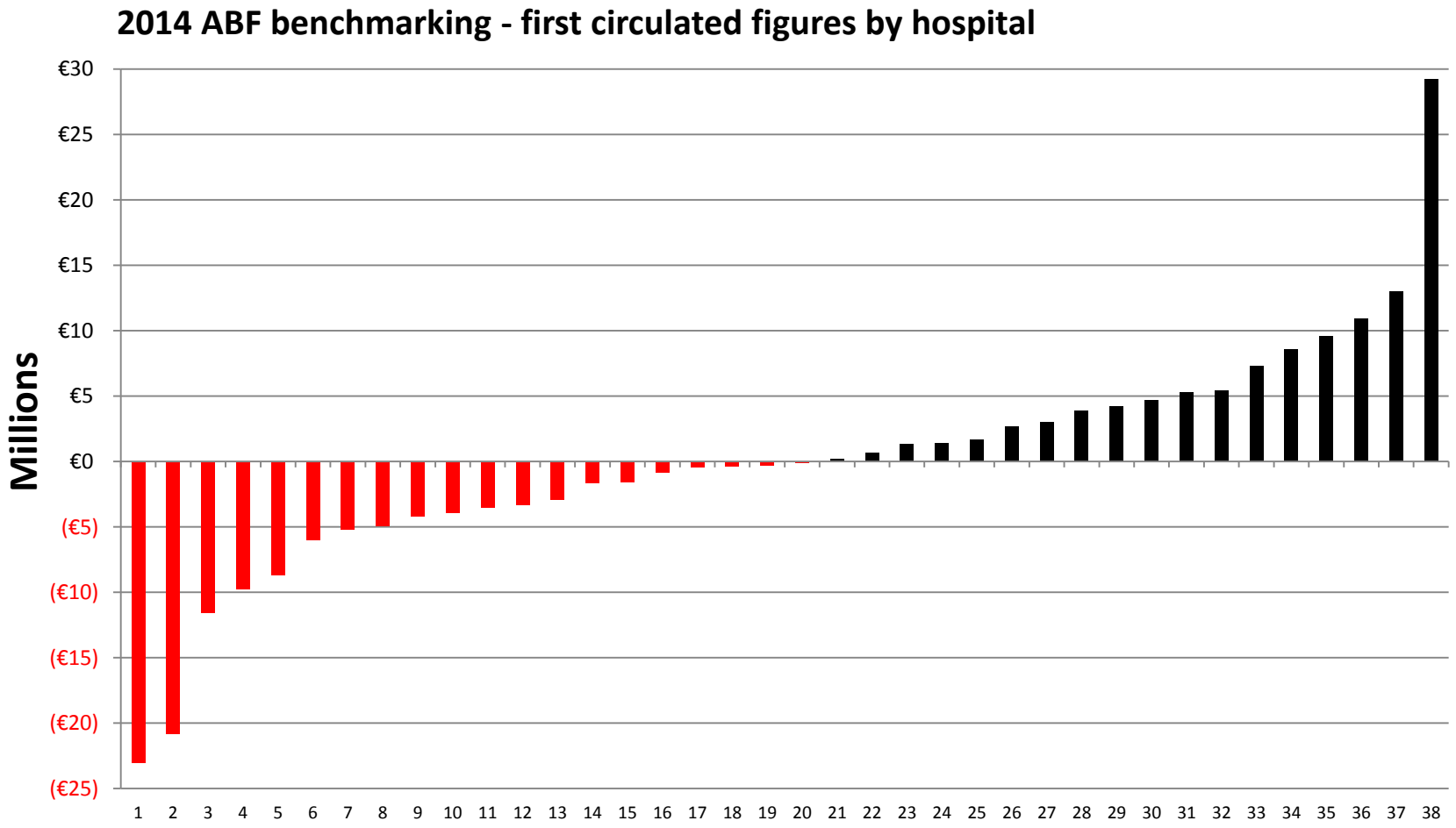
Scale of ABF funding gaps



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Reaction to ABF

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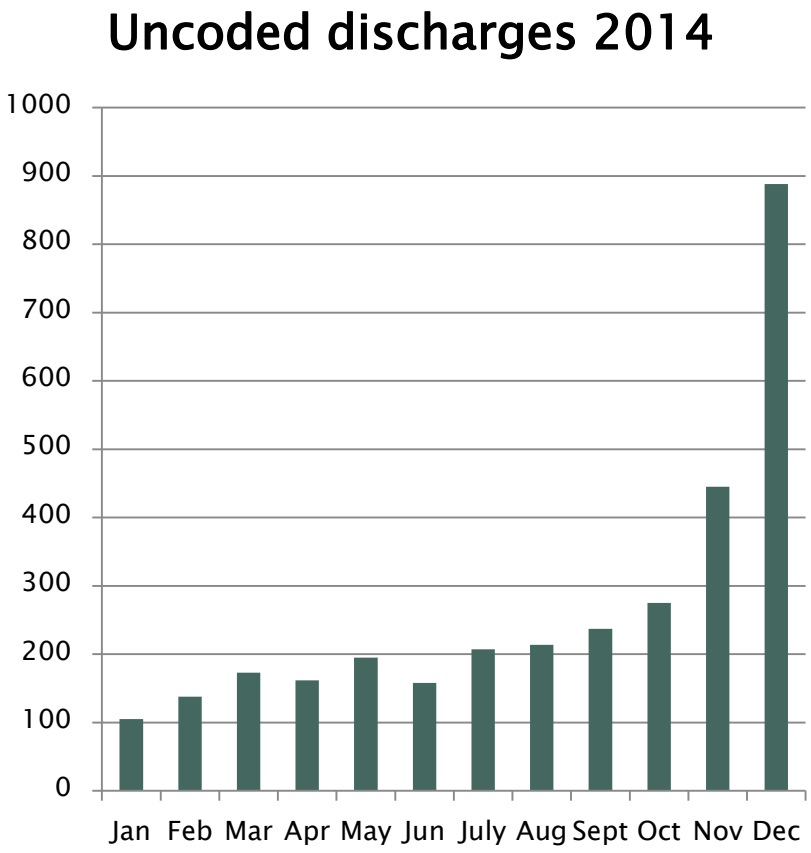
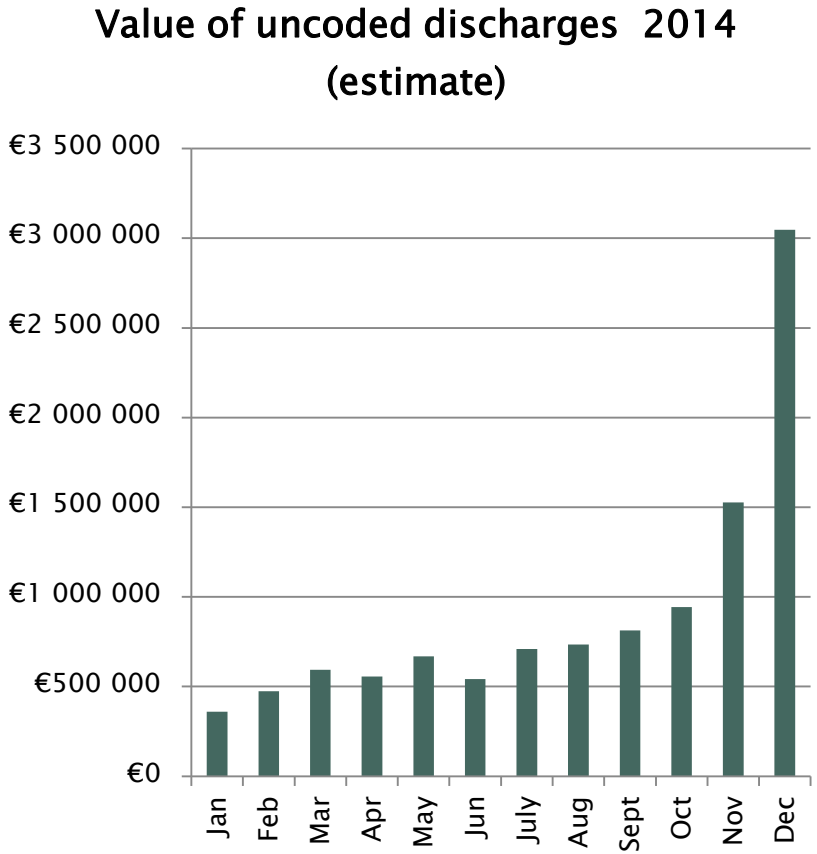
Uncoded activity 2014 end January 2015





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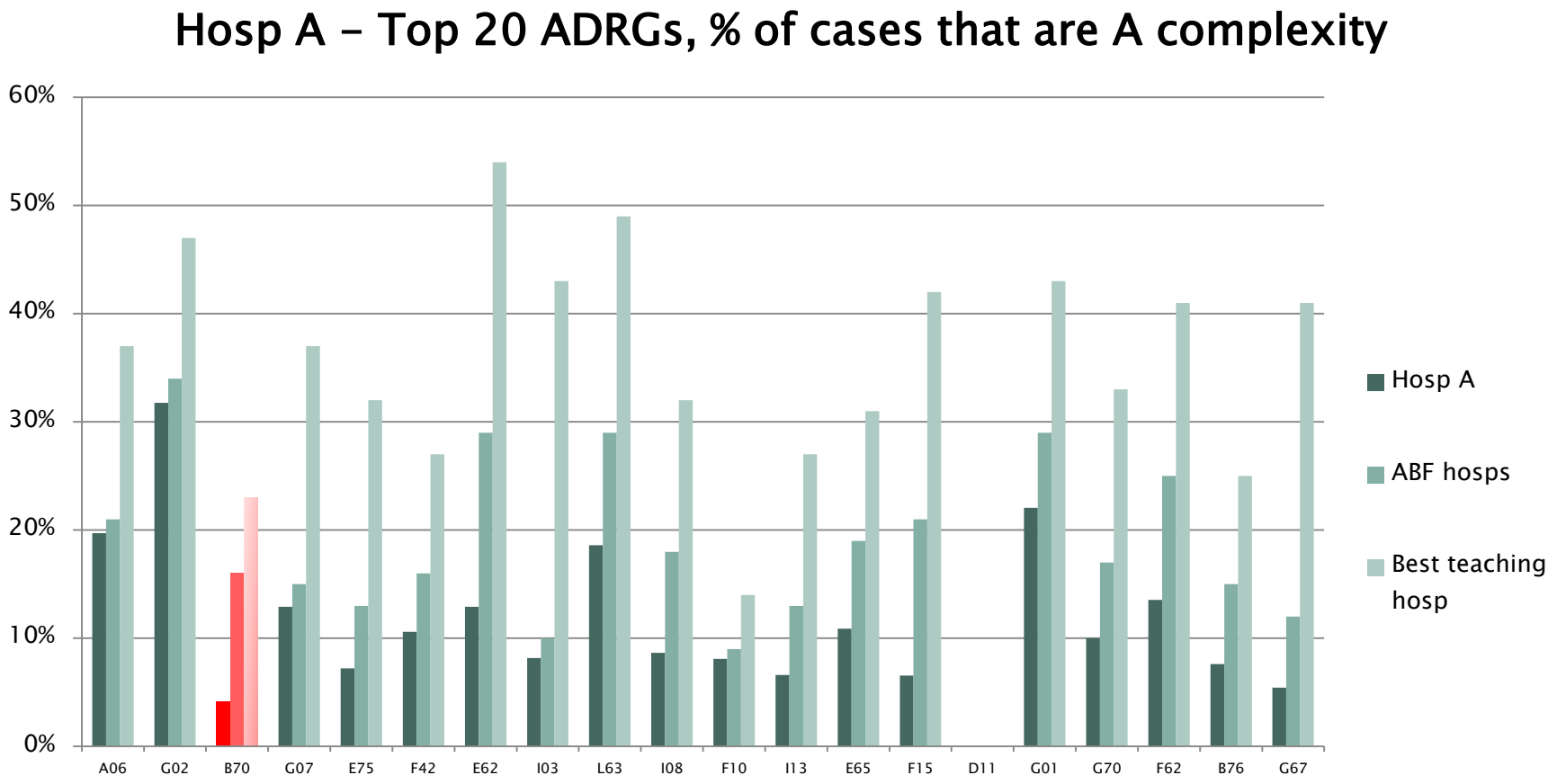
Coding – comparison



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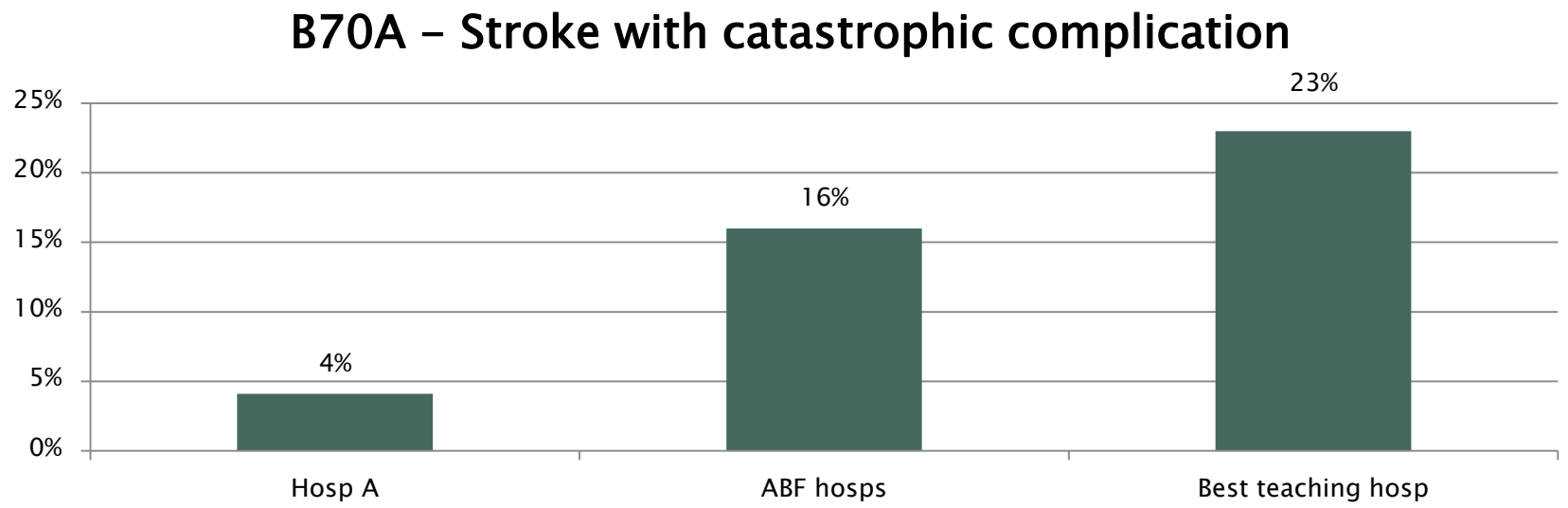
B70 Strokes

B70	Stroke and other cerebral disorder	Value
B70A	With catastrophic complications/co-morbidities	€23,261
B70B	With serious complications/co-morbidities	€9,410
B70C	Without catastrophic or severe complications/co-morbidities	€5,159
B70D	Died or transferred within 5 days	€1,707



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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

Coding – 4 Golden Rules

- Coverage
  - Code every chart : No coding = no funding
- Complexity
  - Ensure that all complexity is captured :
    Incomplete coding = incomplete funding
- Deadlines
  - Coded late – funded late = gap between costs and funding
  - Deadline is one month in arrears
- Guidelines
  - HPO Irish coding standards
  - Activity is subject to audit

- **CODED PATIENT = INVOICE**

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Coders:

'the only administration staff that can earn their salary in a morning's work!'

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Fixing the coding deficit

- Presented on this to senior hospital management
  - Problems in achieving deadlines
  - Resource deficits in coding: unfilled posts, sick leave
- Immediate audit on Stroke cases – findings supported conclusions drawn from graph of significant under-coding
- National Audit Project – Pavilion Health

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Group structures

- Hospital is lead hospital within a group
  - Shared medical consultant appointments
  - Shared management structure
  - Use of diagnostic facilities by other hospitals
- Carrying costs attributable to other sites
- Cost increases in the hospitals group being borne entirely by the ABF hospital

Agency pay

Agency Staff	2011 €m	2014 €m
Management/admin		0.6
Medical	1.5	9.6
Nursing	0.6	1.2
Paramedical		1.0
Support services		3.9
Total agency pay	2.1	16.3

- Some hospitals struggling to fill permanent posts – not as attractive as teaching hospitals
- Structural disadvantage – a question yet to be answered

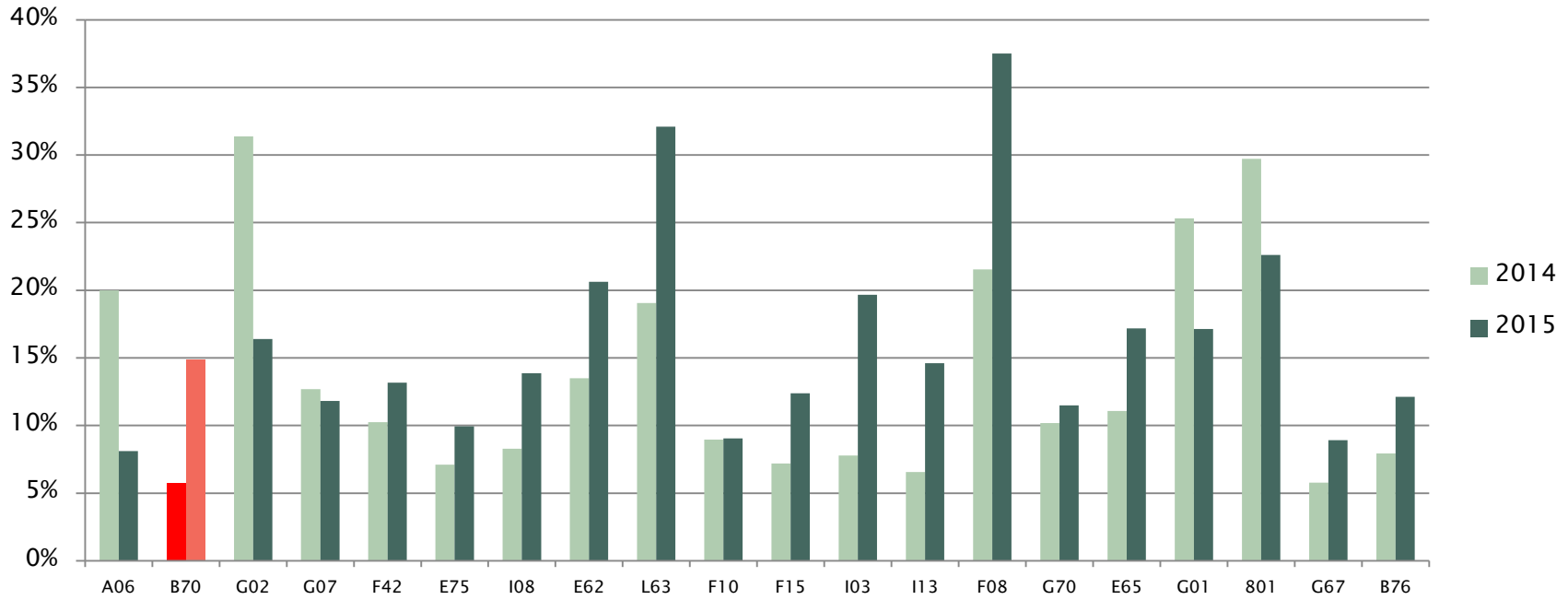
Costing systems

- Senior financial managers not involved
- Manual process – handwritten theatre logs
  - All resources given to data preparation not analysis
  - Met with ICT to detail requirements
- Hospital has been unable to participate in Patient Level Costing studies
- High cost areas/patients
  - Allowances are where DRG tariff doesn't cover these costs
  - Hospital not making any submission for these patients

Hospital A – Conclusions of ABF audit

- ABF is a learning curve and requires senior administrative and clinical management support
- Coding
  - Additional resources
  - New office within main hospital building
  - Began to communicate the importance of coding within hospital
- Costing
  - Senior managers involved
  - Bring other group hospitals into ABF
  - Scheduled to be involved in Patient Level Costing

Top 20 Inpatient ADRGs by value – % of cases in A (highest complexity) 2014 v 2015



- 15 out of top 20 ADRGs (by € value) the coded complexity has increased within Hospital A

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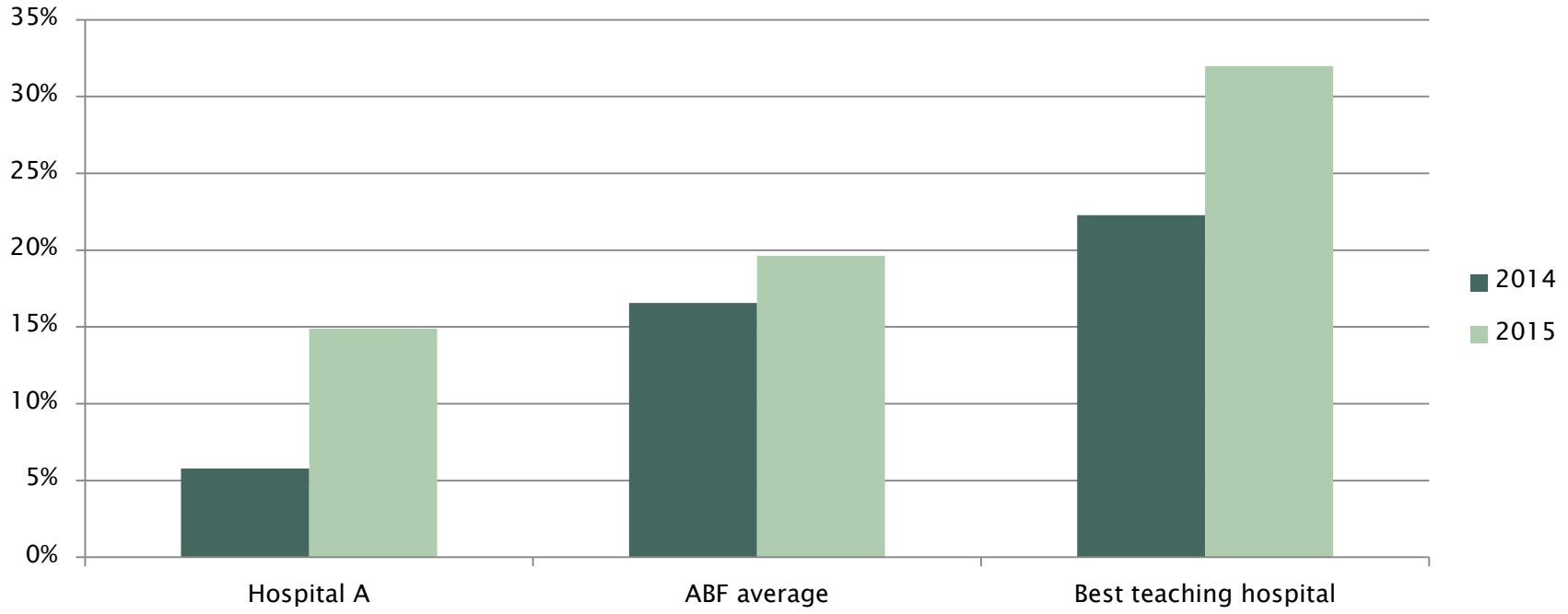
B70 Strokes – % of cases in A (highest complexity)



- All hospitals can be expected to improve coding
- Need to run to stand still

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National Audit of Coded Patient Data

- Pavilion Health – Australia
- Assess the validity of data underpinning the health service ABF funding model
- Validate a range of data reported to the HPO by acute hospitals
- Support data quality improvement in admitted patient data
- Identify best practice clinical coding service management and coder skills and knowledge

National Audit elements

- ADRG benchmarking audit
  - Select peer hospitals and benchmark activity
  - Conclude +/- weighted units for each hospital
- PICQ™ (Performance Indicators for Coding Quality)
  - Analyse full year 2014 data
  - Relative specificity of codes
  - Look for 'Fatal' and 'Probable'
  - Comparison against national and international benchmarks
- Chart based audit
  - 10 sites, 150 charts weighted towards complex patients
- Coding service assessment
  - Assess coding function in 12 hospitals – local interviews
- Individual report for all 38 ABF hospitals
- National report

Pavilion Health – draft conclusions Hosp A

- ADRG benchmarking
  - Hospital is considerably understating complexity versus peers
  - Particular issues in Nervous, Respiratory, Circulatory Major Diagnostic Categories
- PICQ
  - One of lowest quality ratios
  - Above average use of non specific codes
- Chart based audit
  - ICU charts not filed with medical record
  - Nursing notes not used
  - Charts not filed consistently
  - Lack of clinical liaison
  - Discharge summaries incomplete, received after coding
- Coding service assessment
  - Medical records lacking in key data and sometime inaccessible
  - Management of coding services is not strategic
  - Poor charts flow – some charts missing

Pavilion Health – National Conclusions

- Final report in draft stage
- To be launched at Irish National Seminar end of May
- To be presented at PCSI Conference in Dublin in October
- Store salgstricks morgendagens!

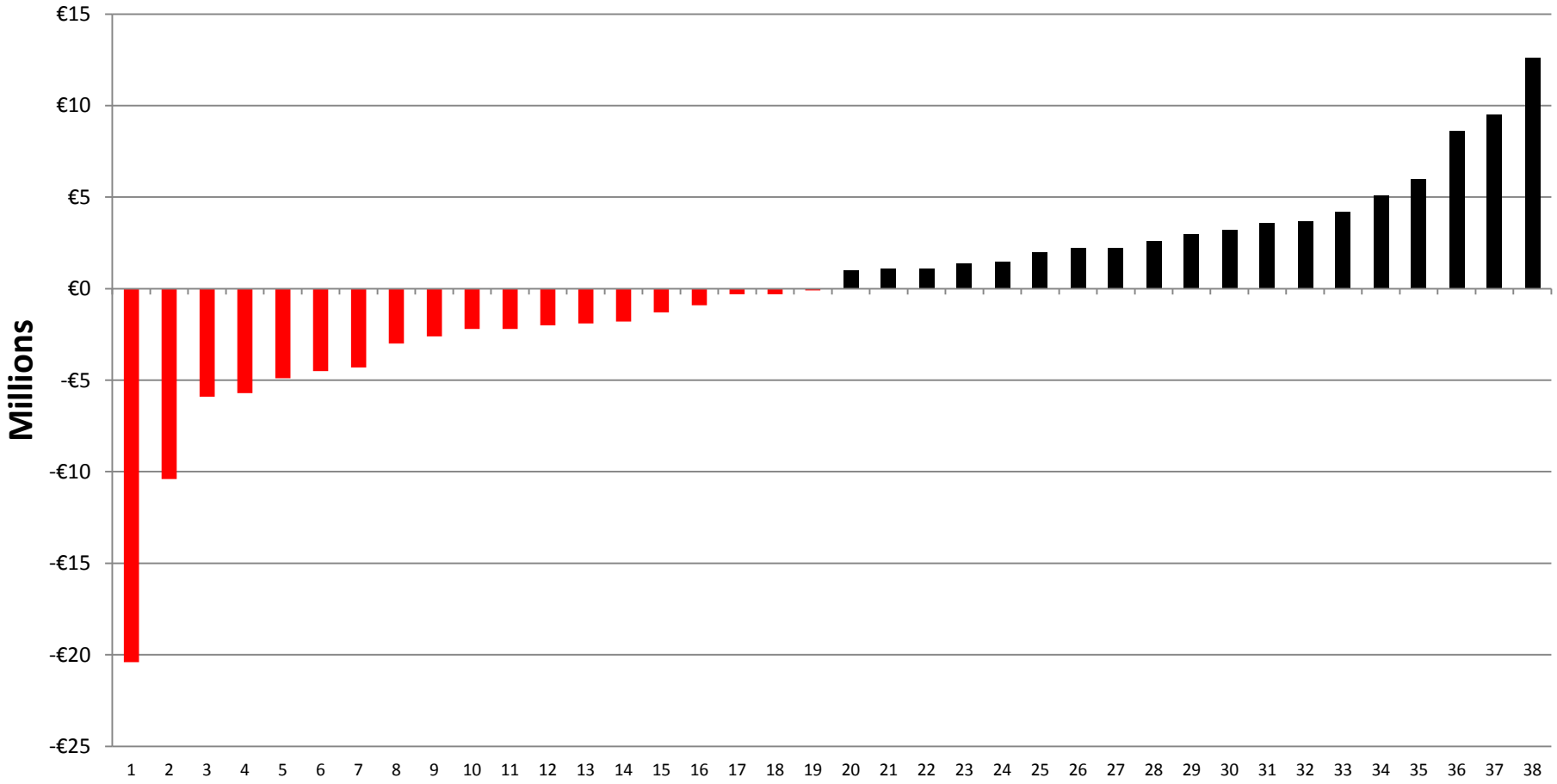
ABF – 2015

- Repeat of 2014 exercise but with these adjustments

Order	Adjustment	Type	Affects	Total Amount
1	High Cost Oncology Drug	Cost and activity adjustment	Base prices and individual RVs	€86m
2	Tertiary Referral and Paediatric Hospital	Cost adjustment	Base prices	€95m and €43m respectively
3	Agency disadvantage	Cost adjustment	Base prices	€44m

- Average tariff of Chemotherapy DRG doesn't accurately cover cost of high cost drugs – affects small patients numbers within large numbers coded to this DRG
- Average cost in teaching and paediatric hospitals higher than other hospitals
- Some hospitals have difficulty recruiting staff – geographic disadvantage
- All of these adjustments (except Paediatric) has a positive impact of Hospital A – we are learning as we go

2015 ABF benchmarking



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Conclusions

- 2015 benchmarking gaps (both +/−) generally less than 2014
- 2016 budget being made 'Once-off' makes ABF real for Group/Hospital Management
- PLC being implemented locally to enable moving from ABF to ABM
- National Audit of Admitted Patient data gives clear roadmap for data improvement
- Increased attention and resources for coding, costing
- Benchmarking positions are volatile as hospitals get 'up to speed'

The Future

- Drop the ‘F’ word
- AB F to AB M 
- And start using our valuable coding and costing data not just to measure hospitals but to manage them too
- PCSI Dublin 2016

Information = Illumination

"The future's so bright I gotta wear shades"

Timbuk 3 1986

Mållinjen!!

- Takk for din oppmerksomhet
- Har du noen spørsmål

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