Managing the ‘knowns, unknowns and uncertainties’ in preparing for national activity-based funding reforms within a public hospital and health service in Tasmania

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There are known knowns; there are things we know we know. We also know there are known unknowns; that is to say we know there are some things we do not know. But there are also unknown unknowns – there are things we do not know we don’t know. (Donald Rumsfeld, United States Secretary of Defence, 2002)

Conditional certainty and activity-based funding
Since early 2010, we have used the idea of ‘conditional certainty’ to guide the implementation of national ABF reforms within our service. Depending on common-sense, environmental awareness and applying a range of technical, policy and administrative skills, our team has set about understanding and communicating the givens or knowns of ABF to staff, while working hard to understand the unknowns and uncertainties or unknown unknowns (and to make them known). While we do not know all the detail of how our health service will be administered in one to two years’ time due to national health reform changes to service funding and governance, we do know, in varying degrees, some detail regarding the implementation of local hospital networks and their governing boards, the emergence of Medicare locals and the application of ABF to fund services.

National ABF reforms and classification systems: known, unknown and uncertain
In anticipation of national health reforms, a significant amount of developmental work regarding ABF funding models and classification systems has been underway, at the federal and state levels across Australia. In July 2011, the National Health Reform Agreement (NHRA) committed states and territories to the establishment of a national approach to ABF and that public hospitals will be funded, wherever possible, on the basis of a national efficient price (NEP), for each public hospital service provided to public patients. The NHRA also committed the Australian Government to increase its contribution to ‘efficient growth’ funding for hospitals to 45% from July 2014, increasing to 50% from July 2017. In December 2011, the Independent Hospital Pricing Authority (IHPA) was implemented under the auspices of a National Health Reform Amendment (Independent Hospital Pricing Authority) Act 2011. It is the role of the IHPA to determine efficient growth funding, through applying the NEP to a range of ABF classification systems that will be introduced from July 2012.

Known - specific classification systems and current, identified timeframes
Specific classification systems and current, identified timeframes are outlined in Table 1.

Partially known, uncertain and pending resolution – ABF pricing, scope and ongoing national consultation
Exactly how much NEP funding our service might receive under ABF is, at the time of writing (March 2012), unknown. While our state, like many jurisdictions, has been administering an indicative or ‘shadow ABF’, national ABF issues of classification pricing and scope; as well as ongoing consultation are still being resolved; hence these factors are uncertain or partially known.

With regard to costing, the IHPA is using 2009/10 NHCDC Round 14 cost data to calculate how much NEP funding each classification will deliver, and significant variations in NHCDC reporting processes and reported costs across Australia have had an impact on IHPA timeframes. Issues of ABF classification scope continue to be identified, discussed and resolved. For example, a recent national stock-take and Review of Non-Admitted Community Based Health Services has, in late February 2012, led to a proposed expansion of the Non-admitted Tier 2 List classification.

The IHPA recently released the draft ABF Pricing Framework consultation document, and by the close of submissions on 21 February 2012, significant feedback from a broad range of stakeholders had been received. The final ABF Pricing Framework is pending but the draft document indicates that some portion of the initial Australian Government ABF contribution is likely to be ‘block funded’ due to ‘technical requirements’ not being met. (It is well worth a read and can be accessed at http://www.ihpa.gov.au/)

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1 The authors of this paper are both employed by Area Health Services within Tasmania, and are both actively involved in implementing activity-based funding (ABF).
Notwithstanding the abovementioned capability '7Cs', 'building blocks' and technical about ABF: process, 'envelopes', to communicate what we know Engaging staff and stakeholders state and Federal governments. other representative groups, and the media, as well as via this engagement is occurring through professional bodies, stakeholders are becoming increasingly engaged. Some of away , and as this date draws closer, clinicians and other to 'go live' from 1 July 2012. This is only a few months hospital and associated local hospital network activity is knowns

<table>
<thead>
<tr>
<th>SERVICE TYPE</th>
<th>CLASSIFICATION SYSTEM</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>FROM 1 JULY 2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admitted Acute</td>
<td>AR-DRG Version 6.0X</td>
<td>The Australian Refined – Diagnostic Related Group (AR-DRG) classification has longstanding use and associated coding conventions. It has been recently amended and known grouper issues/concerns with 6.0 resolved.</td>
</tr>
<tr>
<td>Emergency Department (ED)</td>
<td>URGs for larger EDs, with UDGs proposed for smaller EDs (not 24/7 medically staffed)</td>
<td>Urgency Disposition Groups (UDGs) and Urgency Related Groups (URGs) were developed in Western Australia (Jelinek, 1992). UDGs apply four disposition categories (admitted/transferred; died; discharged and did not wait), with the admitted/transferred and discharged categories branching into five triage categories (seconds, minutes, an hour, hours, days). URGs involve a further branching of most of the UDGs by whether or not a major or minor injury had occurred, and, if not, by body system. Work is still being undertaken to refine URG’s.</td>
</tr>
<tr>
<td>Non-Admitted</td>
<td>NHCDC Tier 2 Clinics</td>
<td>The existing National Hospital Cost Data Collection (NHCDC) outpatient clinic list is being expanded to detail 116 services. Clinic types include: Procedures, Medical Consultation, Stand-Alone Diagnostic; as well as Allied Health and/or Clinical Nurse Specialist Interventions</td>
</tr>
<tr>
<td>FROM 1 JULY 2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub Acute (Admitted)</td>
<td>AN-SNAP</td>
<td>The Australian National Sub-Acute and Non-Acute Patients (AN-SNAP) was developed by the University of Wollongong (Eager, 1997). AN-SNAP involves the application of outcomes measures to patients who have been care-typed and receiving treatment from designated rehabilitation, geriatric evaluation and management (GEM), psychogeriatric, palliative or maintenance services. Patients care-typed as sub-acute, but not treated by a designated service are likely to be classified and funded differently.</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Unknown possibly MHCASC, adapted AR-DRG, Tier 2 Clinic List or other</td>
<td>In the late 1990’s, the Australian Government auspiced the development of Mental Health Classification and Service Costs (MH-CASC), which involve the application of outcomes measures across inpatient, residential and community settings. AR-DRG may also be used, as an inpatient classification; whilst expanded Tier 2 clinics may be used for non-admitted services.</td>
</tr>
<tr>
<td>UNKNOWN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community (hospital auspiced)</td>
<td>Unknown, possibly an expanded Tier 2 Clinic List</td>
<td>A national ABF workstream for hospital-auspiced community services was identified in late 2010. Most of this work appears to have been taken up through an expanded non-admitted Tier 2 classification. The other identified classification and national funding mechanism is the Medicare Benefits Schedule (MBS).</td>
</tr>
<tr>
<td>Teaching, Training &amp; Research</td>
<td>Unknown</td>
<td>A national workstream for Teaching, Training &amp; Research (TTR) was identified in late 2010. Only ‘Teaching’ and ‘Research’ are currently described with the current Australian Hospital Patient Costing Standards. The NHRA (Clause A49) stipulates ‘Consideration of teaching, training and research by no later than 30 June 2018’.</td>
</tr>
</tbody>
</table>

Engaging staff and stakeholders to communicate what we know about ABF: process, ‘envelopes’, ‘7Cs’, ‘building blocks’ and technical capability

Notwithstanding the abovementioned unknowns, partially knowns and uncertainties, ABF for the majority of public hospital and associated local hospital network activity is to ‘go live’ from 1 July 2012. This is only a few months away, and as this date draws closer, clinicians and other stakeholders are becoming increasingly engaged. Some of this engagement is occurring through professional bodies, other representative groups, and the media, as well as via state and Federal governments.

The process of engaging with and communicating ABF reforms at the service level

In planning and responding to the conditional certainties of ABF, our staff has been engaged at various levels. This has included attendance at national conferences and strategic engagement with the Health Roundtable and state stakeholders, as well as providing active input into national ABF consultations and recently keeping track of IHPA updates via their website. In this way we have been able to keep informed, anticipate reforms, and target action at the service executive and management levels. At the operational level, our service has undertaken simple messaging of ABF knowns using staff forums, newsletters and fact sheets with intranet links, all of which has been augmented by providing in-depth staff education sessions and the development of an ABF Handbook for clinicians. The Handbook details concepts and provides information that health information management services
staff have long known, such as AR-DRGs, cost-weights, clinical coding, length-of-stay, care typing, principal and additional diagnoses, complications and comorbidities, procedure coding, multiple diagnostic categories and clinical documentation including discharge summaries, as well as clarifying acute and chronic conditions and accurately specifying diagnoses.

Explaining ABF in simple terms – an ‘envelope of funding’ in return for an ‘envelope of clinical activity’
ABF is part of the NHRA national reforms and it functions to enable the Australian Government to influence service reform through funding. This is our simple response to the inevitable question that our clinicians ask: Why ABF and why now? The operation of ABF is described to our staff in simple transactional terms - an ‘envelope of funding’ that is given in return for an ‘envelope of information regarding clinical activity’, which includes:
- patient identifier (e.g. UR number);
- date and time (of service event beginning and ending)
- clinical information regarding episode (diagnostic category or group)
- type of service provided (e.g. emergency or planned assessment or intervention, type of procedure)
- who provided the service (e.g. staff designation)
- the location of the service (e.g. emergency department, hospital ward, outpatient or community).

So that the ‘activity envelope’ can be processed, staff members are asked to consider or nominate:
- a distinct service identifier (e.g. service name and descriptor), so this activity that can be attributed to a specific cost-centre
- a means for documenting and capturing the activity (e.g. information management systems, as well as administrative and clinical staff recording activity).

While somewhat simplistic, the concept of the discreet ‘envelope’ for NEP prospective payments associated with ABF classifications appears to be readily understood by clinicians and administrative staff. It usefully illustrates the need for comprehensive activity data capture and reporting, in that if all clinical activity (including teaching, training and research) is not discreetly reported, then it can not be discreetly paid for. In this way, the implications of moving from historical funding to ABF, including the potential negative impact upon health service sustainability of non-reported clinical activity is outlined.

Using the 7Cs to explain how to identify and address ABF issues at the operational or service level
The alliterative ‘7Cs’ are useful in engaging staff, in detailing processes, in making known and addressing issues so that clinical activity may be reported for ABF purposes within our service:

1. Activity must be captured; the clinical service delivery of every clinician must be understood and detailed. Clinical documentation is one way of capture, another being data extracts from electronic clinical information management systems, such as the patient administration system.
2. Clinical activity must be classified; it must be grouped in a way that details the nature, location and resource utilisation of the service.
3. Activity must be coded; the process of abstracting, reviewing and grouping classified data needs to occur.
4. The coded activity data set must be counted, with the exact number of specific types of service or clinical encounters reported to the state health department.
5. The count of coded activity data must be costed, through a cost-study that compares input costs of delivering the activity with the prospective ABF pricing or payment. In this way clinical service sustainability can be analysed.

The last two Cs relate need to oversee the first 5Cs, including:
6. the need to co-ordinate ABF activities across the service
7. the requirement for communication across all services (clinical, administrative and technical) regarding ABF and associated activities.

Explaining the ABF building blocks – documentation, information and business management systems
As with the abovementioned ‘envelopes’ and ‘7Cs’, the concepts behind and general operation of ABF are reasonably straightforward. The knowns diminish and unknowns and uncertainties emerge within the development of integrated technical systems and capability to operationalise ABF within our service. A number of these technical issues, including classification, pricing, and scope have been previously described.

In an environment of conditional certainty, simple, straightforward approaches assist in understanding and implementing what is known. The fundamental elements or ‘building blocks’ underpinning effective ABF implementation are threefold: first, clinical documentation that is legible, clinically meaningful and succinctly describes diagnoses and interventions (for coding) is a useful place to start; second, electronic information management systems that use a shared unit record (UR) and are integrated, so that activity information can be readily extracted; and third, finance and business management systems, including a chart-of-accounts that allow accurate costing and management at the ‘granular’ unit or patient, level. Although we have a reasonable idea of what is required, the precise specifications or parameters required of these systems is currently unknown or uncertain. That noted, we strongly anticipate an increased requirement for the technical capability. To this end, our service is enhancing its business intelligence capability. This includes the ability to undertake cost-studies of

3 www.healthroundtable.org/.
Using a project management framework to draw it all together
We know that ABF implementation involves every clinical output within our health service, and that it involves a broad range of reforms at the national, state and local level that are rapidly evolving within relatively compressed timeframes. Within this context of unknowns and uncertainties, the approach within our service has been one of managing ‘conditional certainty’, of focusing effort on the knowns, while endeavouring to know the unknowns and uncertainties and make contingencies to manage them. A project management approach has been the logical way to manage ABF implementation at the service level. In doing so, we have developed an 'ABF work plan' for our service that ‘chunks’ effort by (previously listed) ABF classification streams as well as national funding and pricing, while the enablement and transition management at service level has been ‘chunked’ according to matters of governance, marketing and communication, information systems, and coding and classification. The service ABF work plan, risk register and issues register are regularly updated, and the service executive is kept informed through monthly progress reports.

Conclusion
We know that ABF will not make ‘the sky fall on our heads’. Indeed, fiscal restraint, at the state level within Tasmania and other Australian jurisdictions, is currently a more immediate matter of pressing necessity. However, the consequences of ABF are likely to be significant as the form of services will be influenced by funding as the Australian Government contribution increases over time, then ABF pricing and funding will determine long term service sustainability.

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HAVE YOUR SAY: Revision of HIM entry-level competencies

Over the past two years the Health Information Management Association of Australia (HIMAA) Education Committee has undertaken a comprehensive review of the health information management entry-level competencies. The review has now reached the point where the draft competencies are ready for release to the HIMAA membership for feedback. All Full Members of HIMAA, plus other interested stakeholders will shortly receive a copy of the draft competencies and an online survey for feedback to the Education Committee.

HIMAA is responsible for the development of professional competency standards for Health Information Managers (HIMs) and for periodic reviews of the competencies to ensure they remain contemporary and tertiary programs continue to represent the professional skills and attributes required of new graduates. They are an integral part of the accreditation process for education programs in health information management. In summary, the purpose of the health information management entry-level competency standards is to:

- Define the core skill set of a HIM
- Act as a guide for employers as to the ‘skill set’ an employer can expect as a minimum of a new graduate
- Use as a guide for developing position descriptions
- Guide universities in curriculum development
- Underpin health information management course accreditation
- Guide professional development

Refinement of the health information management competency standards has included a review of the American health information management standards and other international health information management competency standards.

The development and endorsement of the competencies is a significant and considerable undertaking. Members are encouraged to devote the time necessary to read the draft competencies and provide feedback via the online survey tool.

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