Activity Based Funding
Local Implementation & issues for services
A Clinician-Manager's View

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Topics

1. ABF to services?
2. Data Collection
3. Synaptix
4. Health Information Exchange (HIE)
5. Tier 2 (Non Admitted) Services
6. NAPOoS, WEBNAP & EDWARD
7. Educational Portal

ABF to Services

- Commonwealth (DoH) uses ABF to provide "some" funding to NSW
- NSWMoH uses it own ABF formula to fund LHDs based on recorded activity that is held in the HIE

ABF to Services

Formula will take into account smaller or rural or remote hospitals

These hospitals will be block funded to take into account the infrastructure required

ABF to Services

ABF will be used to spread the funding between the LHDs

LHDs that have more activity recorded should get a slice of the funding pie according to that Activity

ABF to Services

There is NO extra funding available

If ALL LHDs RECORDED MORE ACTIVITY, THEN THE PRICE OF EACH ACTIVITY CASE WEIGHT GOES DOWN

THE FUNDING PIE REMAINS THE SAME

ABF to Services

LHDs are **NOT** likely to fund hospitals or services using ABF

But clinicians will NEED TO submit data for their LHDs

Recording Data for Inpatients

- Many are paper based collection systems
- Collect data when Phase Changes or Daily or Twice Daily
- Needs to be PALLIATIVE MEDICINE CONSULTANT led
- SNAP/PCOC/Phase Vocabulary to be used everyday as part of rounds, handovers and clinical meetings

Recording Data for Inpatients

- The more clinically accurate phase changes that are submitted, the more accurate that clinical care is funded

Recording Data for Inpatients

- SYNAPTIX to submit SNAP/PCOC data
- Patient Admitted Systems (PAS)
- Both data sets end up in the HIE
- NSWMoH marries the data (especially admission and discharge dates)

Undesignated Activity

- Episodes of Care or Admitted or Inpatient
  - with incorrect or mis-matched dates or
  - without SNAP data
- Currently funded at 60% of the lowest case weight
- Funded at 0% from July 2015

Other Non Specialist Palliative Care Activity

- Some hospitals (easily identifiable, down to which ward) type change patients to Palliative Care without the need to consult Palliative Care Services.
- Palliative Care Case Type does not mean specialist services, only the intent of care

Other Non Specialist Palliative Care Activity

- These undesignated activity (mostly by aged care inpatient services) piggy-back their acute DRG with further subacute activity/funding
- These do not normally have SNAP data submitted, and therefore will not be funded from July 2015
- Collection of SNAP data will (may) differentiate specialist from non-specialist services

Other Non Specialist Palliative Care Activity

How easy is it for Aged Care Clinicians to collect

- ❖Age
- ❖Phase
- ❖RUG-ADL

Brisbane based Geriatrician, 2013

Tier 2 (Non Admitted) Services

Tier 2 (Non Admitted) Services

Each LHD, Hospital are currently identifying Non Admitted Services and identifying

- Name of services
- Disciplines involved
- Assigning HERO service codes

Tier 2 (Non Admitted) Services

- Disciplines involved
  - Multidisciplinary (Medical plus other staff)
  - Medical Only
  - Non Medical Only (Nursing & Allied Health to be differentiated if possible)
- Possible Differentiated Funding

Tier 2 (Non Admitted) Services

- Modality of Contact Type
  - Direct Contact with Patient +/- others
  - Direct Contact with Carer/Family only
  - Case Planning
- Possible Differentiated Funding

WebNAP

- Currently used to submit number of Non-Admitted Patient Occasions of Service (NAPOoS)
- Planned transition to EDWARD

EDWARD

- Complex data submission per NAPOoS
- Remember using COAG counting methodology
  - 8.41 NAPOoS equivalent to 1 occupied bed-day

EDWARD

Data Submission

- Electronic ONLY
- 44 data items for each NAPOoS !!!

EDWARD
Data Items per NAPOoS

Service Unit Code	
Service Unit HERO Id	Service Unit Name
Facility Code	Facility Name
Service Type Code	Service Type Name
Provider Type Code	Provider Type Name
Setting Type Code	Setting Type Name
Modality Of Care Code	Modality Of Care Name
Funding Source Code	Funding Source Name
Service Date/Time	
Referral Date	

EDWARD
Data Items per NAPOoS

Source Of Referral Code	Source Of Referral Name
Referral Receipt Date**	
First Name	
Last Name	
Gender	
Date of Birth	
Country Of Birth Code	Country Of Birth Name
Aboriginality Code	Aboriginality Name
Street	
Suburb	
Post Code	

EDWARD
Data Items per NAPOoS

AUID/MRN Flag	AUID/MRN
AUID	Facility MRN
Financial Group Code	Financial Group Name
DVA Card Type	DVA Card Number
Source System	
Service Event ID	
Initial / Subsequent Indicator	
Service End Date/Time	
MBS Item Number	

EDWARD

- Planned to Start July 2014
- Systems Implementation (lack of) may delay start
- Need to start conversation about electronic data feeds

EDWARD
vs
Ambulatory / Community
SNAP/PCOC

Educational Tools

Educational Tools

Sacred Heart jointly with University of Wollongong (PCOC) & NSW MoH

To Streamline / Standardise SNAP & PCOC Assessments

Interdisciplinary Education

Educational Tools

Creating an online portal to

1. Bring educational material together
2. Spaced Education Methodology
3. Multiple Choice Questions
4. Core and Advanced Areas of Inquiry
5. Re-Credentialing every ?? 2 years

Educational Tools

Possible MCQ

- Case Based Scenario presented
- Multiple Choice Question surrounding the understanding of Phase, Phase Changes, Scoring
- Take home clinical message with each answer
- Financial implications behind the answer

Scenario

Peter is a 68 year old male admitted with unrelieved back pain related to his metastatic prostate cancer and bone metastasis. On admission, he scores his pain as 9/10; his phase is ‘unstable’; and PCPSS pain score ‘3’. The team commences q4h s/c morphine and he is referred to radiation oncology. On day 3 of his admission, John’s pain has been controlled with regular and breakthrough analgesia, and he is now scoring his pain as 3/10. He remains on q4h s/c morphine and is due to commence palliative radiotherapy tomorrow. Your PCPSS of his pain is now 1.

Question

How would you describe Peter’s SNAP/PCOC phase today?

Answers

- Choice A: Unstable – the patient remains on 4/24 s/c morphine and continues to have breakthrough analgesia
- Choice B: Stable – a plan is in place and there is a decrease in the PCPSS pain score
- Choice C: Unstable – the patient has not commenced palliative radiotherapy yet.
- Choice D: Deteriorating – the patient is on 4/24 s/c morphine.

Take home message

An improvement of the PCPSS for pain, other symptoms, psychosocial and carer issues, indicates that the current management plan is working. It can help guide clinicians to move patients between phases.

Consequences and/or Further Information

- PCPSS is a screening tool used to measure the severity of physical and psychological problems. The PCPSS has four domains - the first three are patient specific, the fourth domain measures family/carer problems associated with the patient's condition or palliative care needs:
- Not making a change may lead to ……incorrect clinical assessment or ↓ funding

References Provided

Trialling at Sacred Heart in the next few months

? before a statewide rollout ?

Question Time

Thank you