Activity Based Funding

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James talks to Dr Bethan Richards about Activity Based Funding and its implementation.

Dr Bethan Richards is a Staff Specialist Rheumatologist based at Royal Prince Alfred Hospital and the Network Director of Physician Training for the Royal Prince Alfred Hospital Basic Physician Training (BPT) Network. Bethan has been extensively involved in the implementation of Activity Based Funding in NSW and currently Chairs the Sydney Local Health District (SLHD) Targeted Activity Report Systems (STARS) Committee which reviews our districts performance and oversees the implementation of strategies to improve our efficiency and quality of patient care.

Activity Based Funding

with Dr Bethan Richards, Network Director of Physician Training and Rheumatology Staff Specialist at Royal Prince Alfred Hospital, New South Wales, Australia

Case – Jane and Mary are two patients being admitted to hospital with chest pain on a background of poorly managed diabetes. Both receive angioplasty and stenting for NSTEMI and both are complicated by urinary tract infection and hyperkalaemia requiring treatment. How can the junior doctor affect healthcare dollar allocation under Activity Based Funding for Jane and Mary?

1. What is Activity Based Funding?

- ABF is how hospitals and departments are funded based on activities performed for patient care
- Prior to 2012, NSW had ‘block funding’, a system where services were allocated blocks of money to each department based on historical need
    - No transparency
    - No patient level data
    - Unable to analyse efficiency of use
- Now Australian healthcare is facing an ageing and increasingly obese population with greater patient numbers and greater patient complexity – projected healthcare spending is unsustainable
- How to make each healthcare dollar go further?

- Obtain patient level data on how we practice → drive resource allocation
- More transparent
- More fair and equitable

2. How does Activity Based Funding work?

- An occasion of service is provided to patients
- Junior doctors are primarily in charge of documenting in the medical record
- Coders look at the medical record and form diagnosis related groups (DRGs)
- Government reviews the DRGs and use this information to allocate funding
- Consultants at hospitals receive performance reports – this provides a comparison between peers in other hospitals and leads to improvements in patient care

3. Where do junior doctors fit into Activity Based Funding?

- Junior doctors are the primary documenters of patient care and are thus critical in the ABF process!
- The documentation that you complete is reflected in your department's performance and is fed back to your consultants – the quality of your documentation forms part of your mid-term and end-of-term assessments.
- High quality documentation helps everybody
    - Better clinical handover within the hospital
    - Better communications to patients and GPs
    - Better allocation of healthcare funding
- Improvement in healthcare resource allocation ultimately leads to better services, access to treatment, more positions for doctors – good outcome for doctors and patients alike

4. Case study - how does this work in practice?

- Jane and Mary are two patients with identical presentations, complications, and length of stay – and both received the same investigations and treatments
- Jane's doctor writes about her hyperkalaemia and treatment with resonium while Mary's doctor does not – how does this affect funding allocation?
    - Mary's documentation is inadequate and her medical record is incomplete: this is bad for clinical handover, bad for Mary and her

family, and bad for her GP – none of these people will known that she had hyperkalaemia requiring treatment!
    - Based on this one difference in documentation alone, Jane's DRG is allocated $18,573.97 while Mary's DRG is allocated $10,755.04
- Despite receiving the same level of care and requiring the same hospital resources, Jane's admission was allocated nearly $8,000 more funding – this funding pays for length of admission, the hospital bed, nursing and medical staff, investigations, and treatment
    - This is a significant impact on funding and quality of patient care!

5. Six basic tips to help junior doctors

1. **Issues lists** – Try to document an issue list for each patient (both clinical issues and others, such as social) on admission and every few days in hospital. This optimises your documentation and will improve your clinical problem solving.
2. **Investigations** – Record investigations that are performed for the patient, as well as any treatments you initiate and an examination of the underlying cause. Remember that the coders are unable to interpret results to establish DRGs. (For example, document 'hypokalaemia' instead of 'K = 3.2' and include if you treated with resonium or if you think it's secondary to frusemide use.)
    - This includes imaging – write 'pneumonia' instead of just 'consolidation' when commenting on your chest X-ray in the medical record if that is the diagnosis you are managing
3. **Diagnoses** – It's acceptable to write 'probable' or 'possible' diagnoses in the medical record. If a patient has a fever and WCC in their urine, you can write 'probable UTI' even in the absence of a positive culture. After all, this patient will still be prescribed antibiotics and receive the same investigations: probable and possible diagnoses are included and costed into admissions.
4. **Discharges** – Don't leave a symptom or sign as the primary diagnosis on your discharge summaries. Write 'pneumonia' instead of 'shortness of breath' and 'disc prolapse' instead of 'back pain'.
5. **Medications** – Starting, stopping, or changing medications should be in the medical record, as well as the reasoning behind each change. Don't just change the medication chart; write in the notes too!
6. **Senior staff** – If you are unsure of a clinical diagnosis or management plan, you can always ask your team's registrar or other senior staff. This is not only critical for your education but will improve documentation.

6. Are there any tools to assist in documentation?

- **CaseMix guidelines:** available via the SLHD intranet or as a belt card; similar resources should be available in other districts – if not, you can take the initiative

to implement this at your hospital!

- **ABF phone app:** convenient provision of documentation information without requiring a terminal; currently in phase 2 of development and will be rolled out later in 2015
- HETI learning module: Activity Based Funding
- NSW Health: The Next Step – Funding Reform

Take home messages

- High quality documentation is key and leads to....
    - Better learning and clinical handover
    - Better feedback from clinical supervisors and improves your future employability
    - Better funding allocation and thus new services, new medications, new positions
    - Better patient-centred care and patient outcomes
- Junior doctors are the primary documenters and are critical in this new funding environment!

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