

More than just activity: pricing and funding for quality and safety

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Introduction

There is strong evidence that the provision of timely and relevant data to clinicians is a key driver for the delivery of safe and high quality healthcare. The rich clinical data provided by admitted patient data collections has played an important role in measuring and monitoring safety and quality indicators to date in Australia, but has arguably not been used to its fullest potential. The April 2016 Heads of Agreement signed by all Australian governments to incorporate a safety and quality component to the national activity-based funding (ABF) model looks set to unlock some of this potential. It means an even greater spotlight on the clinical coded data and the health information management workforce involved in its collection. The health information workforce, which has already had to adapt as a profession to accommodate the changing health-care landscape due to ABF, are well placed to deal with these developments.

Approaches to pricing and funding for safety and quality

There are many indicators and measures that can be used to evaluate the safety and quality of healthcare being delivered. Measures of health service accessibility, population health, continuity of care, patient outcomes, rates of hospital complications, healthcare incidents and patient satisfaction are just some of the domains through which the performance of the health system can be assessed. Multiple domains means a multi-pronged approach needs to be developed to improve safety and quality in the healthcare system.

Funding is one of the levers that can be used to drive safety and quality but it cannot be the only mechanism if we want to see practice changes. The Australian Commission on Safety and Quality in Health Care's (the Commission) *Australian Safety and Quality Framework for Health Care* sets out 21 action areas that can be taken by all people involved in the health system to improve the safety and quality of care provided. The action areas are grouped into three overarching principles, which describe safe, high quality healthcare as being:

- consumer centred
- organised for safety
- driven by information (Australian Commission on Safety and Quality in Health Care, 2010).

The framework notes that the system should ensure funding models are designed to support safety and quality. However, there is good evidence that other mechanisms such as the availability of benchmarking systems to compare the performance of providers and to identify best practice have a



significant impact on driving improvements in quality and patient outcomes (Eagar et al., 2013).

A variety of funding mechanisms have been implemented in Australia and health systems around the world in an effort to improve patient outcomes, ensure quality care and reduce hospital acquired complications. Some examples of these funding and pricing models include best practice pricing, paying for performance and normative pricing.

Best practice pricing involves determining what constitutes the best clinical practice and then putting a price on the best practice "package" (Independent Hospital Pricing Authority [IHPA], 2012). The largest implementation of best practice pricing has been in the United Kingdom. The National Health Service in England introduced best practice pricing in 2010 for cholecystectomy, hip fracture, cataract and stroke cases. For example, hip fracture cases were paid an additional component if the patient received surgery within 36 hours of diagnosis, was assessed by a geriatrician within 72 hours of the surgery and received fracture prevention, cognitive, nutrition and physiotherapy assessments during the episode. The United Kingdom continues to expand the areas where a best practice price is applied. In 2017, new best practice prices were introduced for chronic obstructive pulmonary disease and non ST-segment elevation myocardial infarction cases, bringing the number of best practice pricing models to 19 (National Health Service England, 2017). Best practice pricing relies on extensive clinical registry data in addition to the ICD-10-AM and Australian Classification of Health Interventions data currently available.

Paying for performance links the funding provided to a hospital to the outcomes it achieves on selected safety and quality measures. This can be through incentives when a hospital meets key performance indicators or disincentives when they do not. An example of paying for performance can be seen in the United States, where the Centre for Medicare and Medicaid introduced a model whereby hospitals receive reduced payment for episodes where a selected hospital

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acquired complication occurred. There are currently 14 hospital acquired complications where this reduced payment is applied to episodes, including catheter associated urinary tract infections, deep venous thrombosis and pulmonary embolism after orthopaedic surgery and falls and trauma resulting in injuries such as fractures, dislocations and burns (Centers for Medicare and Medicaid Services, 2015).

Normative pricing uses price to influence the way healthcare is delivered. For example, it may use pricing to encourage certain procedures to be carried out on a day only basis rather than admitting a patient for overnight care. This is the case in the United Kingdom's Payment by Results model, whereby certain procedures have a higher price weight for a day-only case than for the same procedure carried out in an overnight admission (National Health Service England, 2017).

The road to pricing and funding for safety and quality in Australia

A number of states and territories in Australia have investigated how a pricing and funding approach may lead to improved patient safety and quality of care. Queensland has in place a number of healthcare purchasing initiatives designed to improve safety and quality. These include zero payment for selected sentinel events (serious events that result in severe harm or death of the patient), a discounted payment for fractured neck of femur cases where surgery was not undertaken within two days, no payment for emergency department presentations where the patient did not wait for treatment and a loading for stroke cases if the patient received care in a stroke unit (Queensland Health, 2016).

Western Australia has previously trialed a Premium Payments Program, which provided incentives to improve the safety and quality of care in a number of areas including hip fracture, stroke and myocardial infarction (Department of Health Western Australia, 2016).

National health reform has also been a major impetus behind the agenda on pricing and funding for safety and quality. The National Health Reform Agreement had among its aims the improvement of public hospital efficiency, transparency and sustainability through the use of ABF based on a national efficient price (National Health Reform Agreement, 2011). Hospital acquired complications are just one of the areas with a significant impact on patients and costs in the Australian healthcare system. A study carried out on behalf of the Commission in 2013 estimated a hospital acquired diagnosis increased the average cost of a hospital admission by about \$9,200, while the incremental impact on length of stay was 5.3 days (Health Policy Analysis, 2013). Through the implementa-

tion of a national ABF model, it could be said that national ABF already contributes to quality care through financial disincentives for the higher cost long stay outliers, such as those episodes of care with a hospital acquired diagnosis.

However, the National Health Reform Agreement states that IHPA, in setting the national efficient price, must have regard to ensuring clinical safety and quality in the public hospital system (National Health Reform Agreement, 2011). Therefore, IHPA has considered the incorporation of a safety and quality pricing component into the national efficient price since its inception. In 2012 IHPA consulted on a number of the approaches used internationally, including best practice pricing and pay for performance measures, to understand the views of the health system on incorporating a pricing and funding component into the national efficient price. Following this consultation, IHPA formed the view that time was needed for the pricing system to become established before implementing any of these approaches (IHPA, 2012).

IHPA and the Commission established a Joint Working Party in 2012 to oversee a safety and quality pricing work program. One of the working party's earliest projects was the development of a list of 16 national high priority complications (Australian Commission on Safety and Quality in Health Care, 2016). The list of hospital acquired complications was developed via a clinically driven process, which involved review of the literature, the establishment of a clinical group to guide the identification of the hospital acquired complications of interest, and two proof-of-concept studies to test the list. In most cases, the identification of the hospital acquired complications relies on the accurate reporting of the condition onset flag, an indicator that describes whether a diagnosis was present on admission to the hospital or arose during the hospital episode. Assessment undertaken during the hospital acquired complications proof of concept study suggested the coding of the condition onset flag was sufficiently accurate to support the implementation of the hospital acquired complications list. Analysis by IHPA confirmed that in 2014-15, 92% of admitted acute episodes nationally had a valid condition onset flag value (IHPA, 2016).

2016 Heads of Agreement

In April 2016, all Australian governments signed a Heads of Agreement, which indicated a commitment to develop and begin to implement reforms to improve the health outcomes of Australians through funding and pricing for safety and quality (Council of Australian Governments, 2016). IHPA subsequently received a Direction to advise the Council of Australian Governments Health Council on options for a

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comprehensive risk adjusted model to determine how pricing and funding could be used to improve patient outcomes in relation to sentinel events, hospital acquired complications and avoidable readmissions (IHPA, 2017). IHPA provided this advice in November 2016. IHPA recommended that there should be no funding for episodes of care where a sentinel event occurred, that funding should be reduced for episodes of care where a hospital acquired complication occurred, and that further work was required to appropriately define an avoidable readmission prior to the implementation of any pricing and funding adjustment.

IHPA received a further Direction from the Commonwealth Minister for Health in February 2017 to undertake implementation of the three recommendations related to sentinel events, hospital acquired complications and avoidable readmissions (IHPA, 2017). Work is being led by the Commission to refine the list and definitions of sentinel events. The Commission has also convened a clinical curation committee to govern the maintenance of the hospital acquired complications list and consider possible refinements as well as developing a methodology for defining and identifying avoidable hospital readmissions.

IHPA is currently working on refining a risk adjustment methodology for the pricing and funding for safety and quality measures recommended. The aim is to balance the likelihood that some patients will be at higher risk of experiencing a hospital acquired complication while recognising that all hospitals have scope to improve safety and quality (IHPA, 2017). IHPA and the Commission have consulted with clinical and other stakeholder groups to identify patient factors that may increase the likelihood of a hospital acquired complication occurring, such as certain diagnoses, comorbidities or whether the patient required mechanical ventilation.

Implications for the health information workforce

Clinical coded data have been used to monitor safety and quality in healthcare since diagnosis and procedure coding was introduced. A number of safety and quality tools, such as the Classification for Hospital Acquired Diagnoses (CHADx) (Australian Consortium for Classification Development 2017), use the clinical coded data to enable hospitals to have a comprehensive overview of all complications in order to monitor their safety and improvement efforts (Jackson et al., 2009). Provision of information to clinicians on rates of hospital acquired complications and other adverse events in their hospital is critical for system changes to occur. To this end, IHPA has recently added hospital acquired complication

data to its National Benchmarking Portal, providing health information professionals and clinicians with easy access to information regarding hospital acquired complication rates. The portal is available to all public hospital staff, and access is controlled by jurisdictions (see <https://www.ihsa.gov.au/what-we-do/data-collection/national-benchmarking-portal> for details of how to access the portal).

The clinical coded data have also been fundamental to ABF. Health Information Managers and Clinical Coders (CCs) are well aware of the scrutiny applied to the clinical coded data in the ABF environment. The introduction of ABF has been associated with increased engagement in the clinical coding process from clinicians and hospital managers and a greater emphasis on clinical coding audits to ensure the integrity of the data.

Shepherd (2017) has previously outlined some of the ways ABF models impact on the clinical coding workforce, including the ethical dilemmas associated with balancing the financial needs of their hospital with the need for accurate and reliable data for purposes other than ABF. In the consultations IHPA has conducted with clinicians and other stakeholders regarding pricing and funding for safety and quality and the use of the clinical coded data to identify hospital acquired complications, there has been consistent feedback on the professionalism of CCs in applying the coding standards based on the clinical documentation. It is critical that the profession continues to maintain these high standards into the future.

In conclusion

A funding and pricing approach on its own will not be a “quick-fix” solution to drive further improvement in the safety and quality of public hospital care. It needs to be part of a broader framework. The Commission’s *Australian Safety and Quality Framework for Health Care* states safe and quality healthcare is driven by information. It relies on the collection and analysis of accurate information and the expertise and professionalism of the health information workforce. The health information workforce has shown themselves to be professional, resilient and adaptable in meeting the challenges thrown up by the ABF environment and the work carried out to date indicates the clinical coded data is of sufficient quality to implement a pricing and funding approach to improve safety and quality in Australian public hospitals.

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