

HIV Outpatient and Payment by Results Currency – A Simple Guide

An HIV Adult Outpatients currency will be mandatory from April 2013.

The HIV outpatient currency is a clinically designed clinical pathway for three groupings of adult patients that supports an annual year of care approach.

The groupings are:

Category 1: New (newly diagnosed or newly on ARV drugs)

Category 2: Stable

Category 3: Complex

The currency only applies to HIV Adult outpatients and **NOT** inpatient or paediatric care. It does not include the cost of any anti retroviral drugs (ARVs) or other PbR excluded high cost drugs.

Commissioners and providers are encouraged to apply the new currency from 2013/14 with local prices. Providers will need to start collecting data against these currencies. It has been recognised in some areas that there is a need to allow time to update information systems to capture against the new HARS dataset.

In practical terms, this means that Providers and Commissioners will need to discuss and agree an implementation plan for collecting the underlying data to support the delivery of the currency through either the HARS dataset or local systems so that patients can be categorised. Providers need to establish robust reporting systems in sufficient time in 2013-14 to support accurate forecasting and planning for 2014-15.

This guide updates previous versions of guides contained on the PbR website. It aims to be a plain English guide of the HIV Adult Outpatient Currency.

HIV Outpatients Payment by Results

The Tariff has been developed with the following in mind:

- Adherence to best practice (British HIV Association (BHIVA), British Association for Sexual Health and HIV (BASHH)) guidelines
- Compatibility with the open access nature of sexual health services
- Compatibility with commissioning principles of good quality, safe, cost effective and affordable care.

As with all PbR tariffs the introduction of a new methodology for counting and paying for activity should not result in a cost pressure to either providers or commissioners. Additionally it will be important that the tariff is able to contribute to the QIPP programme in terms of improved quality and outcomes given that this is an area where demand is planned to increase.

History of Payment by Results

Payment by Results (PbR) was first introduced in 2003. It is a method of payment per patient, based on improving outcomes and replacing other funding methods like block contracts. Block contracts do not provide incentives for organisations to improve the care they provide.

The HIV Currency

A PbR currency is defined as the unit of healthcare for which a payment is made as opposed to a tariff which are the set prices for a given currency unit. Therefore, in 2013/14 we are introducing a national currency while retaining local pricing mechanisms.

HIV Adult Outpatients

The HIV outpatient currency is a clinically designed clinical pathway based on a year of care approach.

The HIV Outpatient Currency is divided into three separate elements: New patients, stable patients and complex patients.

Category 1: New patients

Category 1 patients are those that have been newly diagnosed in the UK **or** have newly started ART.

This category allows for the recognition that patients in the first year of diagnosis require more intensive clinical input than stable patients. This will include a greater number of initial and more complex diagnostic tests and more frequent clinic visits with a greater input from the Multi Disciplinary Team.

A newly diagnosed patient will be a category 1 patient for 1 year after which they will automatically become a category 2 patient.

Similarly, a patient newly starting ART for the first time will be a category 1 patient for 1 year when they will automatically become a category 2 patient.

These events can immediately follow each other. For example, a patient may be newly diagnosed and then after 7 months start ART. As a result, the patient would be in category 1 for 19 months and then automatically become a category 2 patient.

If a patient is category 1 but has one of the listed category 3 complexities then they would be uplifted to being a category 3 patient for the duration of the complexity.

Patients can only be in one category at any one time.

If a patient's care transfers from one provider to another they must have been on the pathway somewhere for at least 12 months for them to no longer be a Category 1 patient.

Category 2: Stable Patients

Category 2 covers stable patients not on ARV or stable and started ARV more than 1 year ago. This category will cover the majority of patients and therefore **should be** used as the default category unless category 1 or 3 criteria can be demonstrated and validated.

If a patient transfers in to an HIV service and had started ARV for the first time more than a year ago then they would automatically be classified as category 2 unless they had one of the complexities resulting in them being a category 3 patient.

No patient should be classed as a category 1 patient for more than two years.

The categorisation of a patient changing ARV therapy for toxicity/simplification/adherence issues is not affected and these patients should remain as category 2 patients. If this change occurs outside of their first twelve months of first starting ARV, and they have no complexities, then they will be a category 2 patient.

Some patients may require further discussion at virtual clinics or need additional tests to be performed, but this does not automatically make them a category 3 patient.

Patients on ARV with transient viraemia (viral blips) remain within Category 2.

Category 3: Complex Patients

Patients who fall into category 3 have a complexity that identifies them as a special patient group, needing high levels of maintenance, or being highly dependent patients.

A full table of complexities and their definitions can be found in the Clinical Pathway/Dataset.

In summary complexities include:

- Current TB co-infection on anti-tuberculosis treatment
- On treatment for chronic viral liver disease
- Receiving oncological treatment
- Active AIDS diagnosis requiring active management in addition to ARV (not inpatient care)
- HIV-related advanced end-organ disease
- Persistent viraemia on treatment (> 6 months on ARV)
- Mental illness under active consultant psychiatric care
- HIV during current pregnancy

Care Transition

Although the categories of complexity are numbered, it is not necessary for patients to always progress from Category 1 through Category 2 and then Category 3.

All newly diagnosed HIV patients entering care will start either as a category 1 or category 3 if they are deemed complex from the start. This is in recognition of the additional resources required to stabilise patients quickly to improve clinical outcomes and get them to the stable category 2 state as soon as possible.

Patients may enter the pathway at any point. For example, a patient may be diagnosed as HIV positive and have a current TB co-infection on anti-tuberculosis treatment. Due to the medical complexity of treatment required this patient would be a Category 3 patient.

The aim is to ensure patients are stabilised quickly and the expectation is that the majority of patients will be category 2 patients. Where patients are defined as category 3 these will be reviewed and validated to ensure that services are securing the best clinical outcomes.

If a patient's care transfers from one provider to another they must have been on the pathway somewhere for at least 12 months for them to no longer be a Category 1 patient.

Patients with complex psycho/social needs

The nature of HIV disease means that patients may have an additional range of complex psycho social needs, which go beyond the remit of the hospital, based HIV team to meet. Local pathways of care will need to be designed to meet these needs with appropriate referral to social care, community services, mental health services and voluntary sector services such as advice and advocacy. The cost of meeting such needs is not included in the tariff development to date.

However, in developing the HIV Currency it is acknowledged that there are a number of patients with complex psycho-social needs who may inappropriately rely on the HIV clinic to meet those needs. It is important that these patients are receiving the appropriate level of support at the right time in the right place from those services with the skills and knowledge required to meet those needs. These patients should be referred to the appropriate mental health service and their care shared where appropriate.

One of the fields in the data set, currently going through the Information Standards Board approval process, allows both providers and commissioners to monitor the impact of patients being under the care of social workers.

Where service users with a high level of social needs are identified this can provide an opportunity for commissioners and providers to work together to ensure the appropriate access to support services and thus alleviate the burden on HIV service resources.

How will this activity be measured?

The Health Protection Agency and the Department of Health (DH) has worked with the Information Standards Board (ISB) to establish both the HIV outpatient services categories and activity to develop the HIV and AIDS Reporting System (HARS),.

The HARS dataset has been mandated and HPA have been working with software suppliers to introduce the new HARS system.

A new quarterly reconciliation process, undertaken by the HPA, will begin during 2013/14 to collate the actual patient case mix and volumes. This will be used to compare actual service usage against planned or predicted activity and provide a baseline for future contracting activity.

Public Health Agenda

As HIV detection and expected life span of those living with HIV lengthens, more innovative care, treatment solutions and technologies will be found. This will have an impact on the HIV tariff and the tariff will need to be reviewed routinely to ensure that it remains reflective of current patterns of care.

Further information

Further detailed information on HIV Outpatient Currency can be found at: http://www.dh.gov.uk/en/Managingyourorganisation/NHSFinancialReforms/DH_124341

National guidance for the provision of treatment and an appropriate service specification should be consulted and provides considerably detail (see www.bhiva.org and www.bashh.org).

More information on PbR can be found on the DH website at: <http://www.dh.gov.uk/pbr>

If you have any specific queries about PbR that are not answered here or on the website, please email the Department of Health PbR Team, with "HIV PbR" in the title, to: pbrcomms@dh.gsi.gov.uk

Any comments on the Adult HIV Outpatient Currency should be sent to : pbrcomms@dh.gsi.gov.uk with HIV PBR in the title