HIV Outpatient: Providers

Name
Date

Current Position (1)

- HIV services have a budget and are performance managed against it
- Some also have Service Line Reporting and measure HIV profitability on a regular basis
- Department of Health collect average attendance costs (split first and follow up) on an annual basis in a process called Reference Costs

Current Position (2)

- Various forms of contracts – e.g. Number of attendances and price per attendance through to Number of patients and price per patient per year
- ARV drug costs are typically a “pass through cost” although some areas have a ARV price per patient
- Service Improvement Plans / Quality Measures quite often built into contracts
- CQUIN sometimes has specific HIV items in it

Implementation

- End to End test
- Results
- Conclusion

Reference Costs (1)

- Reference Costs might move to a cost per category per patient (rather than cost per first/follow up per attendance)
- 1: Providers already know the full cost of their HIV department and will still know it going forwards.
- 2: The HARS data will show the level of attendances etc. occurring in each category.
- 3: The HARS data will show the amount of time and number of patients in each category

Reference Costs (2)

- Using 2 (i.e. Attendances): can locally weight each of the 3 categories e.g. Cat 1 = X times Cat 2, Cat 3 = Y time Cat 2
- Using 3 (i.e. Patients by category over time): can weight the activity using these local weights
- Using 1 (i.e. Full cost): can then calculate the average cost of one weighted unit of activity
- Average cost of one weighted unit of activity times weighting = average cost

Reference Costs (3)

- Alternatively using HARS dataset then know the inputs going into each patient so can:
- Multiply all of the inputs by the input cost
- Sum up this total cost by category
- Divide this total cost per category by the number of patients and arrive at average cost per patient
- So reference costs might change but it should be manageable – the important thing is to implement the HARS dataset as soon as possible.

Budget Setting

- Does not need to have any impact...
- Although as the HARS dataset is more refined will indicate better the level of resources being used, including support services such as testing.
- Could help improve the accuracy of budget setting.

Service Line Reporting (1)

- Arguably this doesn't need to have any impact whatsoever.
- However, as know commissioners will be performance monitoring using the new categories etc. then ideally adapt SLR to reflect them.
- As shown with reference costs could also show the costs of each category – will help with getting clinical validation of the costs.

Service Line Reporting (2)

- With much more refined data being collected and on an attendance basis should help improve the accuracy of costing.

- Also puts you in a good situation when pricing (locally or nationally) is per category.

Contracts (1)

- As the DH is looking to mandate the currency then it makes sense to include the HARS dataset in local information flows, with an expected date from when it can start to be provided.

- Big uncertainty is how contracts will change (if at all) with the move from PCTs to the new arrangements in 2013/14.

- Should try to start reporting activity by category on a regular basis so that both providers and commissioners can get used to the new terminology.

Contracts (2)

- With a move to a new currency that will support improving quality and innovation CQUIN might be a suitable approach to assist with its adoption as core business.

Subcontracts

- Other Payment by Results pathways involve the lead provider receiving the tariff and they then subcontract with any others they require to help them deliver the pathway leading to better understanding and integration.

- If they don’t already then important that providers understand which other providers are currently involved in the pathway and what they deliver.

- No need to change contractual arrangements at this stage

Improving Efficiency

- With more information about the patient pathway collected consistently across all providers in a timely fashion then this could give an invaluable resource to measuring provider efficiency and suggesting possible ways to improve it.

Improving Quality

- Need to start working with commissioners now to identify how the new dataset can be used to measure quality and more importantly improvements in quality.

Department of Health

Any Questions?