

Review of the Victorian
Ambulatory Classification System
Report on Consultancy Findings

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Executive Summary

Following the Audit-Generals report into “access to specialist medical outpatient care” and in conjunction with the department’s own consultations with health service on delivery of outpatient services, DHS established the Outpatient Improvement and Innovation Strategy (OIIS) to address key challenges identified with the delivery of outpatient services in Victorian hospitals.

Under the auspices of the OIIS, a funding reform sub-committee was established to oversee a consultancy to review the current Victorian Ambulatory Classification and Funding System (VACS). Aspex Consulting was appointed to analyse costing, activity, and financial data, and to undertake extensive consultation with health services to identify key reforms to the funding system that would improve its responsiveness to changing models of care, more accurately reflect care delivery costs, and to maximise health service flexibility in determining where and how services should operate.

A review of international literature indicated that, in the absence of good quality clinical patient level data, there was no better approach to classifying outpatient services in Victoria than under the existing VACS system. They did, however, identify a range of enhancements that would better redress funding concerns, emerging models of care, and flexibility in service delivery.

In general, the funding of activity to target was assessed as being adequate, yet there remained significant unfunded and unmet demand. Within the constraints of outpatient budgets, the following enhancements to the current funding system were proposed:

- Improving health service flexibility and autonomy through single weighted activity targets
- Recognising emerging models of care through new clinic types and enhanced scope of practice
- Potential development of expanded VACS categories to reflect cost and clinical differences
- Discontinuing the current Base Grant in favour of increased variable payment rate
- Establishment of Reform and Innovation funds to promote and continue reforms
- Allocation of Teaching grant on total (VACS + MBS) activity
- Discontinuance of ambulance grants with retention of funds within the system
- Re-assessment of the need for some specified grants and conversion to variable payments
- Extension of VACS to Maroondah and possibly Goulburn Valley Hospitals

DHS accepts in principle many of these proposals and will expedite the implementation of health service targets, provision of project funds to promote early adoption of new models of care, and progressive re-allocation of the Teaching Grant on an activity basis. Further consideration will be given to the establishment of a Reform and Innovation fund, and to explore the potential impact of combining Base and Variable grants along with establishing a single weighting scale across Medical/Surgical and Allied Health categories.

Introduction

Outpatient services are an important part of the continuum of care for many patients. They provide pre-admission and post-discharge care for patients with planned interventions, ongoing management of patients with chronic disease or complex health problems, and a referral and diagnostic service for GPs and specialists for complex patients.

The Victorian Ambulatory Classification and Funding System (VACS) was introduced in 1997. The introduction of an output-based funding system for outpatients paralleled the use of casemix for inpatients.

VACS is a classification system based on 35 weighted medical and surgical clinical specialties and 11 unweighted allied health specialties. It is used for funding outpatient care at 17 health services. As a funding model, VACS includes variable grants, base grants, teaching grants, and specified grants. Health services are funded up to targets, with targets being set separately for medical and surgical services, and for allied health services.

VACS has remained largely unchanged for the last 10 years.

In June 2006, the Victorian Auditor-General released a performance audit report on access to specialist medical outpatient care in Victorian public hospitals. The three broad areas of performance examined in the report were whether:

- The funding and target setting process was responsive to service needs;
- State-wide planning for outpatient service delivery was effective; and
- Sound data was available for planning and performance monitoring.

The development in 2006 of the Outpatient Improvement and Innovation Strategy further catalysed the focus on reviewing outpatient services. Outpatient funding reform was identified as one of six major work areas being advanced under the Strategy. In late 2006, DHS undertook extensive consultation with health service to develop key themes related to the funding and delivery of outpatient services. These initiatives culminated in the establishment of the "Review of the Victorian Ambulatory Classification and Funding System".

The Approach

The Victorian Department of Human Services (DHS) engaged Aspex Consulting to review the Victorian Ambulatory Classification and Funding Systems (VACS).

The objectives of the project were to:

- Evaluate the existing VACS funding system and the current funding arrangements for the larger non-VACS funded health services
- Make recommendations on the development of a more refined VACS/output based funding system for outpatient services; and
- Provide advice on the suitability of larger non-VACS hospitals to transition to the VACS funding system.

The funding reform project was overseen by the Funding Reform Sub-committee of the Outpatient Improvement and Innovation Strategy. The consultants, with assistance from a DHS convened technical reference group comprising representation from DHS and health services, developed an analytical framework under which the investigation, analysis, and interpretation of data was to be undertaken.

Health service data routinely provided during annual cost data collection was supplemented with detailed costing elements and combined with activity data reported through the department's Agency Information Management System (AIMS). Additional data relating to clinic structures and MBS activity was collected via survey. Together, these data sources provide the consultants with a vast array of information upon which to draw.

Following extensive data analysis and development of interim reports discussed at routine sub-committee meeting throughout the project, the consultants outlined a range of proposals which then formed the basis of exhaustive consultation with each health service involved.

Combining advice from the department and health services, the consultants finalised their report and recommendations for formal review.

The Findings

A review of international literature was unable to identify a better approach to the classification of outpatient services in the absence of good quality clinical patient level data. Consequently, the consultants proposed extension/enhancement to the current model to improve its clinical and financial relevance.

The current VACS system comprises the following funding components which were explored in detail:

- Base Grant – largely originating from an historical transition fund;
- Variable Grant – providing a differential activity based payment for each encounter;
- Teaching Grant – to recognize and support the important role of teaching within larger health services

Through analysis of costing, activity, and financial data, the consultants concluded that funding of target activity was generally sufficient but that activity exceeded target and unmet demand remained.

Further analysis of costing data revealed significant variation both within VACS categories and across health services. While much of the variation within categories was due to differences in the utilisation of diagnostic services, the variation between health services could range from a number of factors including:

- Structural differences
- Complexity differences
- Costing methodology differences
- Accuracy in cost identification and allocation

Other areas of concern identified when examining costing data included:

- Incomplete identification of subsidised (S100/PBS) pharmaceuticals
- Cost allocation rules and unmatched costs
- Differences in reported activity within costing and DHS administrative systems

Despite these shortcomings, there was sufficient data to allow a number of key issues to be explored and recommendations formulated.

Key Recommendations

The following key recommendations were made:

- Combining Base and Variable grants into a single activity based payment
- Establishing a single weighted activity target at health service level
- Weighting Medical/Surgical and Allied Health services across a common scale
- Establishment of new clinic types/categories to reflect best practice models of care
- Recognising enhanced scope of practice
- Splitting some VACS categories on cost and clinical grounds
- Rolling some specified grants into variable payments
- Establishing a Reform and Innovation grant
- Inclusion of Maroondah outpatient services within an adjusted Eastern Health target, and possible inclusion of Goulburn Valley hospital under VACS funding

- Allocation of Teaching Grant on total VACS and MBS activity

Combining Base and Variable Grants

While there was some concern that abolition of the Base Grant may lead to the (perceived) non-payment of indirect administrative activity such as telephone calls, interpreter services etc. it was generally agreed that the purpose of the Base Grant was not well understood and should be converted to variable funds due to the relatively low fixed overhead costs encountered within outpatient departments (as capital costs are reported separately and therefore excluded from the output payment model).

Unfortunately, due to the historical origin of the grant and its CPI adjustment over time, the ratio of these funds to variable activity payments differs considerably across health services. Simply rolling these funds into variable payments would result in significant budget variations between health services resulting in some big winners and losers. The impact of this proposal will likely need to be ameliorated by consideration of further transition or compensation arrangements.

Single Target

Currently, the setting of separate Medical/Surgical and Allied Health targets was seen as an impediment to role substitution, requiring re-negotiation or trading between these two funding categories with DHS consent. This was an area clearly identified by health services as a potential barrier to flexibility in service delivery.

The establishment of single targets combining both Medical/Surgical and Allied Health activity is seen as a positive step towards recognising the increased opportunity for role substitution, and enhancing the autonomy and flexibility for hospitals in determining the most appropriate service delivery model(s). Health service autonomy would be further enhanced by extending the targets to span the whole health service with reduced emphasis on the location of service delivery, rather than localising them to individual campuses.

Common Weighting Scale

Although Allied Health activity is under-represented in the costing data, it is apparent that significant cost differences occur between categories. In combination with establishing single weighted activity targets, the weighting of allied health categories across the same scale as Medical/Surgical specialties would ensure that funding more accurately reflects costs. Further, it would enable longer term comparison of role substitution to be properly evaluated.

In the short-term, the impact of weighting Allied Health categories may result in significant realignment of cost weights and an associated shift in funding between all categories. It may be desirable to ensure that more robust data is available through future cost weight studies before enacting this proposal.

New Clinic Categories

A range of new models of care were observed and discussed with health services. Increasingly, multidisciplinary care (MDC) is emerging as a best practice model especially in complex and multi-faceted treatment. Together, with care plan conferencing (CPC), these new approaches to best practice were seen to be inadequately represented in the classification system resulting in underpayment for these services.

The consultants also identified opportunities to enhance the prospects for role substitution, diversion, and discharge planning through the introduction of Early Assessment and Linkage (EAL) clinics. These clinics would enable health services to ensure that all pre-clinic diagnostic services were completed, allow timelier triage of patients, and create the opportunity to quickly identify those patients that may be diverted back to the community or directed to more accessible and potential conservative treatment options.

Further work will be required to establish the guidelines for operation of these new clinic types, to assess the likely take-up, and estimate the potential cost prior to their implementation.

Scope of Practice

DHS generally supports the consultants' proposal that Nurse Practitioners be granted eligibility to claim Medical/Surgical VACS in a similar manner in which Midwives are eligible for Obstetric VACS payments. Further extension to other practitioners under enhanced scope of practice may be considered subject to the development of assessment/certification requirements.

VACS Splits

Although the consultants have identified several VACS categories (oncology, cardiothoracic, neurosurgery) that may be split based largely on high-cost diagnostic services, the clinical basis for splitting has not been established. Further, the increasing use of private diagnostic services may ameliorate the need for these splits.

An enhanced role for the VACS clinical panel to review future VACS splitting proposals was discussed and is supported by DHS.

Specified Grants

Currently ambulance specified grants are available to metropolitan health services, with the size of each grant bearing little relationship to expenditure on ambulance services. The consultants propose, and DHS is supportive, that these grants be discontinued and the funds be retained for re-allocation within the VACS system.

There are another 23 (non-ambulance) specified grants within VACS. The consultants propose that these be re-examined to determine their continuation as either grants or variable payments according to the following criteria:

- Do they represent a specialised state-wide function
- Are some services funded at some health services but not others, and why
- Can reliable cost weights be developed
- Should they be funded under alternative funding streams
- Can they be measured on an output basis
- Do they support a closely related inpatient activity

DHS will further evaluate these grants and the basis upon which they are funded following delivery of additional information from the consultants and in consultation with the impacted health services.

Reform & Innovation

In recognition of the significant changes that are likely to be required to support the implementation of new models of care, improve data collection and reporting, and to promote ongoing improvement and innovation, all health services were strongly supportive of the proposal to provide additional non-bid based funding.

DHS is supportive of this approach in the short-term and will endeavour to provide funding subject to budget limitations.

Non-VACS Hospitals

The consultants were asked to review the outpatient services offered at the following non-VACS hospitals to determine whether they may be suitable for inclusion within the VACS funding framework:

Casey Hospital
Maroondah Hospital
Latrobe Regional Hospital
Goulburn Valley Hospital

Maroondah hospital was considered a strong candidate for VACS funding, Goulburn Valley's suitability was marginal, and VACS funding for Casey and Latrobe Valley was not considered appropriate.

DHS will discuss these recommendations further with the impacted sites, and in particular, will further consider including Casey within a global Southern Health target.

Teaching Grant

There was general support for reallocating the existing Teaching grant on a total activity (VACS and MBS) basis, and ensuring that the proportion of funding for teaching purposes remained constant into the future.

DHS supports the reallocation of these funds on a total activity basis but its impact is difficult to assess due to the current lack of MBS reporting.

Implementation

While the department is generally supportive of these reforms, many will take time to implement as they are dependent upon the collection and evaluation of underlying activity and costs. In particular, assessing the impact of the introduction of new models of care (EAL, MDC, CPC) is difficult without knowing the level of adoption nor associated costs. Nonetheless, DHS is keen to progress the implementation of these aspects.

Summary

The following tables provide a comparison of current and proposed VACS models and outline how the model objectives are addressed.

| Current Model | Proposed Model |
|--|---|
| Clinic-based classification system with 35 medical and 11 allied health categories | Clinic-based classification system with additional categories comprising: <ul style="list-style-type: none"> ➤ 1 EAL clinic (new type of clinic); ➤ 2 MDC clinics (new type of clinic); ➤ 1 CPC clinic (new type of clinic). Patient not required to be in attendance; and ➤ At least three split clinical categories |
| Weighted medical and unweighted allied health clinical categories | Weighted medical and allied health clinical categories (including weighted EAL, MDC and CPC clinics) |
| Two separate VACS targets for medical and allied health clinical categories | One VACS target over all clinical categories |
| Fixed payments: <ul style="list-style-type: none"> ➤ Base grant. ➤ Teaching Grant on an historical basis ➤ Specified Grants | Fixed payments <ul style="list-style-type: none"> ➤ Discontinue Base Grant. ➤ Retain Teaching Grant and fund on % of patient activity ➤ Retain a reduced number of Specified Grants. ➤ Introduce Reform and Innovation Grant |
| Medical clinical categories requiring attendance/ supervision of medical specialist | Medical clinical categories requiring attendance/ supervision of a medical specialist or a nurse practitioner, with the option of expanding role substitution through enhanced scope of practice of nurses and allied health practitioners. |
| VACS sites confined to hospital campus | Locational flexibility as to where VACS services are provided |

| Model Objectives | Proposed Model |
|---|---|
| Patient-focused | <ul style="list-style-type: none"> ➤ Retention of output based funding approach. ➤ Retention of encounter based approach to funding. ➤ Supporting individual patient care planning through MDC & CPC clinics. ➤ Elimination of Base grant. |
| Clinically Meaningful Classification System | <ul style="list-style-type: none"> ➤ Retention of clinical categories as the backbone of the classification system. ➤ No overlap or duplication of patient categories unlike other systems |
| Sustainability – reliability, efficiency & accountability | <ul style="list-style-type: none"> ➤ Retention of payments based on weighted encounters. ➤ The development of weights based on costs. ➤ VACS funding of services where there is a reliable, high volume of services. ➤ Retention of monitoring and reporting systems that ensures integrity of activity data. ➤ Elimination of Base grant. |
| Improved Access | <ul style="list-style-type: none"> ➤ More prompt assessment and booking of referred patients through EALs. ➤ Potential for provision of VACS at locations flexibly determined by health services. |
| Support best-practice evidenced-based model of care | <ul style="list-style-type: none"> ➤ Introduction of MDC clinic categories. ➤ Introduction of Care Plan Conferencing clinic categories. ➤ Introduction of Early assessment & Linkage clinic categories. |
| Support workforce substitution | <ul style="list-style-type: none"> ➤ Inclusion of EAL, MDC and CPC clinics that assist in workforce substitution. ➤ Introduction of Nurse Practitioners for medical clinic categories. ➤ Scope for introduction of broader role substitution through expanded scope of practice. |
| Simple and transparent funding model | <ul style="list-style-type: none"> ➤ Retention of clear funding components. ➤ Simple basis and explanation of how model components might operate. |
| Support care in the community | <ul style="list-style-type: none"> ➤ Timely 'discharge' of patients through review mechanism (EAL). ➤ Introduction of effective substitution and diversion of referrals through EALs. ➤ Inclusion of health care professionals from outside the entity in CPC and MDC clinics. |
| Recognise patient choice & private specialist services | <ul style="list-style-type: none"> ➤ Enhanced reporting of private clinic activity. ➤ Enabling VACS to operate in conjunction with private ambulatory clinics |

Priorities

The Funding Reform Sub-committee identified, and DHS agrees in principle with, the following implementation priorities.

Single Targets

The establishment of single targets combining medical/surgical, allied health, and new service categories would facilitate substitution and further devolve clinical management decisions to health service executives.

Setting targets at the health service, rather than campus, level would promote greater flexibility in location of services to maximise use of facilities and exploit economies of scale, and further enhance health service autonomy.

DHS plans to implement Health Service targets commencing in the 08/09 funding year, with further consideration of combining Medical/Surgical and Allied Health targets given during 08/09 with possible implementation in 09/10 subject to development and shadowing of relevant and reliable cost weights.

Weighted Allied Health

Costing data, albeit incomplete, clearly depicts differences in the cost of different allied health disciplines that may reflect staffing, equipment, and diagnostics utilisation.

While agreeing in principle with this proposal, DHS has concerns over the robustness of current costing data and the potential impact on funding across VACS categories. The department therefore plans to continue to evaluate the impact of this proposal through the development, publication, and shadowing of the likely impact using provisional weights calculated from existing 05/06 and 06/07 cost data. The adoption of these new weights, including assessment of 08/09 activity, will be considered for 09/10.

In the interim, Health services should endeavour to improve their costing and data collection systems to ensure that allied health data is as accurate and meaningful as possible.

Converting Base to Variable

DHS agrees in principle with the proposal to convert current Base Grant funds into Variable price but due to the existing disparity in the distribution of Base Grants across health services, simply rolling these into variable payments would result in significant and undesirable budget shifts across all health services. Furthermore, it is unclear to what extent the quantum of funds reflects structural, complexity, availability, and staffing issues that are difficult to identify in the absence of a true patient level clinical classification system.

DHS is examining ways in which this impact can be minimised and this will likely involve partial conversion with residual funds being aggregated into other funding components. Due to the complexity

of this matter further analysis will be undertaken during 08/09 prior to consideration of transitional arrangements in the following year(s).

It is anticipated that current special purpose components of the Base Grant (TPN, HEN, CPAP) will be isolated and continued to be paid on a grant basis.

Further details of this approach will be disseminated at the earliest opportunity.

Nurse Practitioners

DHS agrees with the proposal to allow Nurse Practitioners to claim Medical/Surgical VACS payments subject to Health Services registering relevant clinic schedules with the VACS Clinical Panel commencing in 08/09. Extending these provisions to other allied health professionals under enhanced scope of practice need to be further evaluated with the development of associated guidelines, establishment of agreed certification arrangements, and assessment of likely take-up.

Reform & Innovation

The department acknowledges the need for funding to assist in up-take of key reforms and offset the potential increased cost of emerging models of care that offer timelier treatment and improved outcomes. Ideally these funds should be recurrent, but in the first instance are likely to be provided on a project basis.

In 08/09, Health services would be required to submit business plans that clearly identify how these funds would be used to provide new/enhanced services, indicating how these would be configured and delivered, and outlining an evaluation strategy against which their performance would be measured in terms of throughput, costs, and outcomes.

Strengthening right of choice provisions may also be addressed through allocation of funds to assist expansion of MBS initiatives.

Teaching Grant

Although total (VACS + MBS) activity has not been fully quantified, DHS proposes to implement this proposal with the first year's funding (08/09) being set at current levels and progressively being re-allocated on an activity basis over the ensuing 2 years. This will ameliorate the impact of moving from an historical/staff basis to an activity basis.

Further Activities

During 08/09 much work will be required to develop the guidelines and promote the take-up of new models of care (EAL, MDC, CPC). A program of work will be developed to address the following outstanding issues:

- Collect and validate MBS activity
- Evaluate specified grants for retention or conversion to variable
- Establish KPIs for Reform and Innovation Grants
- Establish guidelines for EAL, MDC, CPC – VACS Advisory Committee to be established
- Develop/refine Allied Health weightings
- Consider further proposals for development or splitting of new VACS categories on clinical and cost grounds
- Promote benchmarking and transparency through publication of comparative costing data