



Ambulatory emergency care

Reimbursement under the national tariff

Introduction

Ambulatory emergency care is defined as a service that allows a patient to be seen, diagnosed and treated and discharged in the same day, doing away with the need for a bed.

The British Association of Ambulatory Emergency Care (BAEC) sets out a comprehensive list of over 50 clinical scenarios where an ambulatory care approach could work. Ambulatory care can be described as a mindset – a working assumption is made that the patient will not need a bed.

Background

A best practice tariff (BPT) was introduced in 2012/13 to encourage take up of ambulatory emergency care for several clinical scenarios who are currently admitted and stay overnight – for example, asthma and deep vein thrombosis (DVT). Under the tariff, an additional payment of around £240 is given for those patients who are discharged within 1 day. The clinical scenarios are identified at sub-HRG level, using a set of ICD:10 codes.

The expected outcome is therefore a shift in the proportion of admitted patients from stays of one or two nights to same-day discharges. In the future, once datasets in the non-admitted setting become rich enough to capture the activity of ambulatory emergency care, there is the potential for prices to be developed to encourage further shifts from the admitted setting.

The BPT continues to expand by covering additional scenarios, but its aim is still to reduce variation in length of stay for emergency admissions by incentivising a 0 length of stay i.e. same-day care and reduction of overnight stays.

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The best practice tariff

Although a best practice tariff is in place, Group members see that its application runs into problems linked to:

- the existence of an actual ambulatory care unit
- incomplete capture of all patients treated in an ambulatory manner
- the requirement for a non-elective admission to attain the best practice tariff.

The issues are detailed below:

1. **An organisation doesn't need an ambulatory care unit to get the best practice payment**

As the additional payment is dependent on diagnosis codes and length of stay, there are hospitals who do not have ambulatory emergency care units or pathways set up, but still acquire the best practice payments by seeing patients for an ambulatory sensitive condition in the same-day.

2. **The BPT doesn't capture patients who were treated in an ambulatory manner, but were diagnosed with something else**

A patient may attend with suspected DVT, but the eventual diagnosis proves to be something else. The patient's length of stay might be less than one day and was treated in an ambulatory way, but this will not attract the BPT as the BPT only covers specific conditions (although these are expanding). This can be discouraging for those clinicians setting up ambulatory care units/ involved in ambulatory care.

3. **Only 19 clinical scenarios are recognised, but many more are used in practice**

As already noted above over 50 pathways have been developed by the BAEC, but only 19 attract a bonus payment. For 2017/19, seven new clinical scenarios were introduced into the scope of the BPT. Also, due to increased pressure in A&E, new pathways not covered by the BAEC have been developed by individual providers to ease pressure on A&E. This can either mean that providers aren't receiving financial recognition for these new pathways or that they are sometimes overpaid if the relevant HRG doesn't have a short stay tariff.

4. **An emergency admission is needed to obtain the BPT**

The ambulatory emergency care rhetoric often talks about this initiative leading to reduced admissions. However, to obtain the BPT, a non-elective emergency admission is required to enable the capturing of the appropriate ICD:10 and OPCS codes – vital for income and accurate data capture.

In addition, if a patient has first presented at A&E, the referral to treatment (RTT) clock can only stop with admission or discharge, and so even if they are being treated in an ambulatory way, an emergency admission is still required.

5. **Treatment of subsequent attendances are not reflected**

It is a fairly standard element of most ambulatory emergency care pathways that the patient comes back the next day for either additional scans or test results. Guidance on how to

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record these subsequent attendances is not provided.

6. Commissioner challenge

Commissioners may challenge payment for ambulatory emergency care patients as their stay can be short – around 2-3 hrs. If the HRG is not eligible for a short stay reduction, then it can seem as if payment does not match the resource employed.

Survey results

To create a better understanding of the current approaches taken to the recording and reimbursement of ambulatory care, the HFMA's National Payment Systems Group is looking at the situation as part of its work programme. Consequently, the HFMA surveyed its members to establish some basic benchmarking information to see how the guidance is currently applied.

16 organisations completed the survey.

Not all organisations answered every question and the percentages referred to are percentages of respondents answering the specific question. (Some tables may not add up to 100% due to rounding or the completion of multiple options by respondents.)

The survey revealed the following key points:

- Although only a small number of organisations responded, all parts of England were represented
- Half of respondents operate ambulatory emergency care with an agreed local price and half used the national price
- The way that first attendances are recorded is split evenly across:
 - Non-elective emergency admission
 - Mixture of A&E attendance and emergency admission
 - Outpatient first appointment
 - Outpatient follow-up appointment
- 69% of respondents record a second visit as an outpatient follow-up appointment
- Respondents agreed that that the current arrangements need to change.

Regional split

Respondents are spread across the United Kingdom as follows:

Region	Number
London	2
Midlands and East	6
North of England	7
South of England	1
Wales	
Total	16

Ambulatory care units

All 16 respondents have a dedicated ambulatory care unit.

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Recording of ambulatory care patients

The survey asked respondents how ambulatory care patients are recorded in their organisation. The results for first visits were as follows:

Type of visit	Number
A&E attendance	
Non-elective emergency admission	3
Mixture of A&E attendance and emergency admission	4
Outpatient first appointment	5
Outpatient follow-up appointment	4
Other	
Total	16

Comments included:

'We record it technically as admitted patient care (APC) as we and the commissioners wish to capture a fully coded data set which we are not set up to do for outpatients and as such it gets submitted to SUS as APC, however in our local contracting algorithm (and also understood by CSU and agreed with CCG) this is adjusted to be reported as a non-mandatory outpatient appointment charged at an agreed average unit price.'

'Recorded either as inpatient or outpatient, based on pathway/condition. If BPT is applied, remains an emergency admission; if not, then charged as an outpatient procedure/ward attender local tariff.'

'This follows discussions with AEC who would not guide, but suggested that this is the most frequently used methodology. I would suggest that there should be a separate recording stream for these going forwards.'

'Classed as ward attender from 1st April 2017. Previously classed as non-elective, emergency admission.'

The results for follow-up visits were as follows:

Type of visit	Number
A&E attendance	
Non-elective emergency admission	1
Mixture of A&E attendance and emergency admission	
Outpatient follow-up appointment	11
Other	4
Total	16

Comments included:

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'Clarity sought and reference cost/ (tariff) guidance and costings to be aligned to this methodology.'

'Will depend if further appointments are pre-booked (e.g. as outpatient) or unplanned.'

Non-elective emergency admission: *'Driving both artificial price (? and cost) and high re-admission rates.'*

Reimbursement of ambulatory care patients

The survey asked respondents how they charged for ambulatory care patients. The results were as follows:

Reimbursement	%
National price	50
Locally agreed price	50

Comments noted the use of a block contract by one trust and also included:

'Looking to work towards a locally agreed price. Also, developing an ambulatory CDU.'

'For the last 3 years, the Trust has been unable to agree a local price for ambulatory care due to lack of data transparency in recording the activity as outpatient attendances. The CCG's offer is to pay this at the top A&E tariff this would include the patient's stay in A&E and also ambulatory care. The Trust rejected this as we feel we should receive the A&E tariff for triage and the ambulatory care payment for treatment given in the ambulatory care unit. This has resulted in the Trust accepting a block with the CCG until this can be resolved. We get paid the national price for the patients admitted into a bed on the short stay ward as per the national guidance.'

'Actually, a mixture of both. Where inpatient BPT available, then national tariff is charged. Otherwise, a local ward attender tariff. If recorded as an outpatient, then receives the national outpatient tariff.'

'The local (trust) tariff for acute medical clinic (AMC) is £468.44. It is important to note that this is not a standard (outpatient) appointment and includes full diagnostic work up and the patient may be in 'clinic' for anything up to 23 hours.'

The solution

Finally, the survey asked respondents what they would like to see by way of changes to the current situation. The main points identified were:

- a change to SUS with the introduction of a third category (other than outpatient or admitted patient care)
- clarity over recording and collecting data
- a national price to reflect the cost of treatments provided
- a mandatory currency and price.

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It should be noted that the introduction of the emergency care data set (ECDS - that is based on SNOMED) initially just covers A&E activity but the Royal College of Emergency Medicine would like to explore the options of using ECDS for ambulatory emergency care.

Comments included:

'Before the tariff can change the currency needs to change. SUS needs to be adapted so there is a 3rd category i.e. not just (admitted patient care) or (outpatients).'

'There should be a separate recording methodology attributed to this, so the full cost of these services and impact of them can be understood and recompensed correctly.'

'Agreement over recording mechanism - do we include (emergency department) attendance into any AEC tariff? Should there be a new way of recording - new dataset/collection. - Need to be clear what we should be collecting. National AEC templates HRG driven - should there be something different for AEC related? - Recording as IP allows granularity and to capture LoS etc - if move to OP lost. - Not necessarily pathway driven as will slow down innovation.'

'Recognition that it is a replacement to admission rather than a default if not dealt with in A&E - costs should be captured relating to ambulatory care units and prices > A&E < admission. BPT should go now as given current pressures should be no further need to incentivise ambulatory care.'