Patient Focused Funding

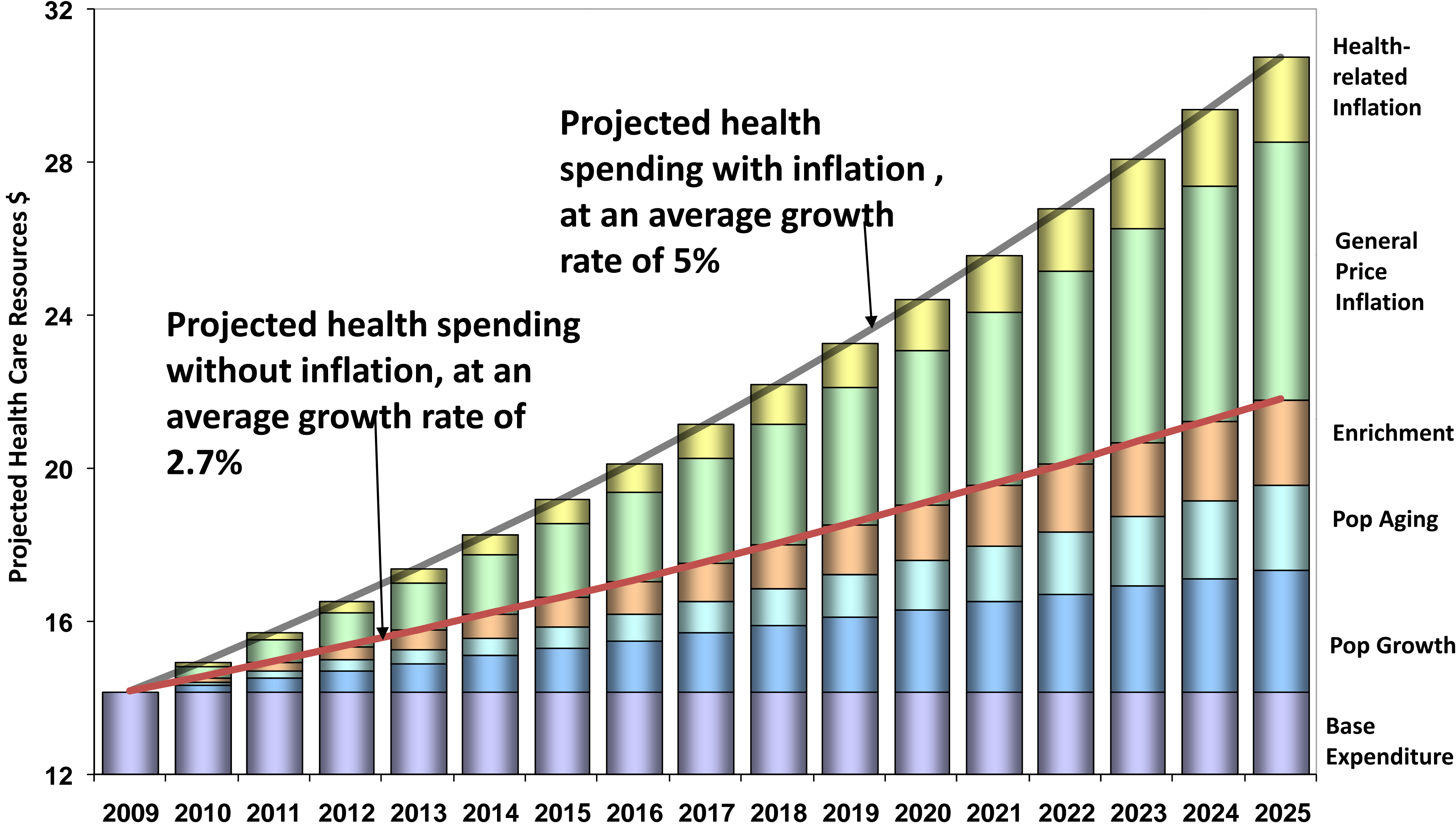
Better Enabling Health Providers to Do What is Best for Patients

BC Health Services Purchasing Organization

November 10, 2010

HQN Session

Projected Health Care Spending, 2009/10 – 2025/26



Source: HSPA2010_289 Health Systems Planning and Analysis Branch, Ministry of Health Services

What is Patient Focused Funding?

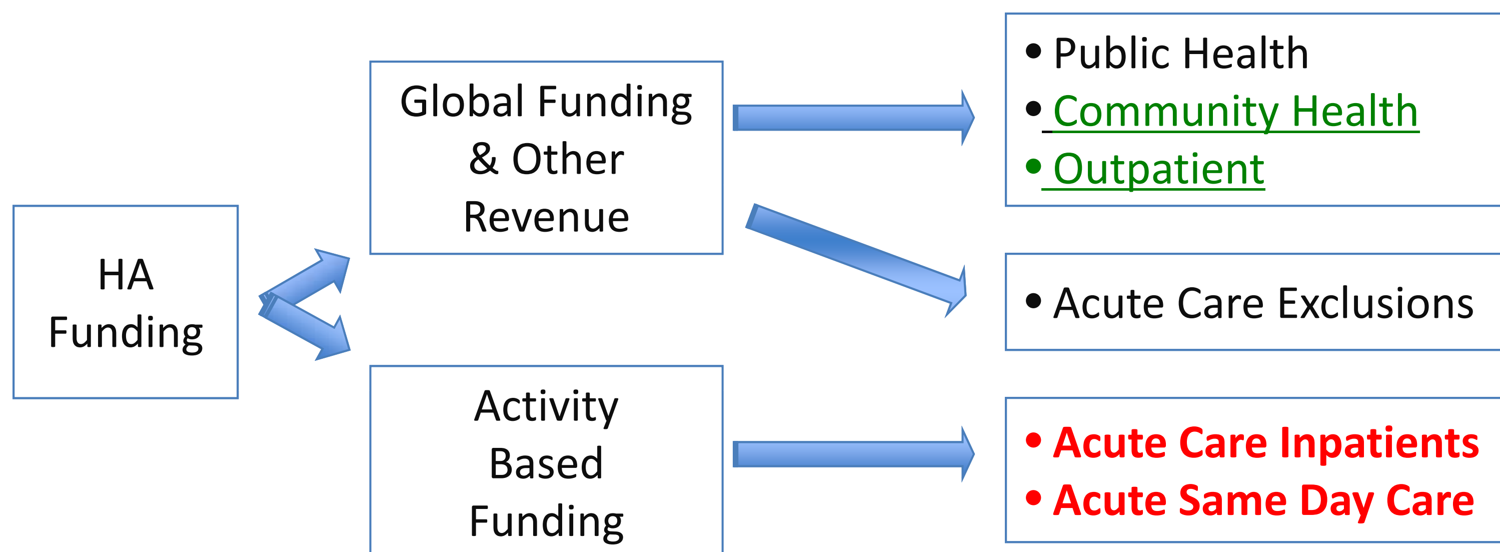
- It is payment for quality patient care.
  - That is Acceptable, Appropriate, Accessible, Safe, Effective and Efficient care
- It is ‘activity based funding’ and ‘pay for performance’ combined
  - <u>Activity Based Funding</u>: payment primarily for access. i.e. payment for a discrete unit of work such as a discharge, visit or procedure
  - <u>Pay for Performance</u>: payment for other dimensions of quality

BC Health Services Purchasing Organization
Purchasing Quality Health Services

- BC HSPO has $80M in 10/11 and $170M in 11/12 to work with…
- Current investment streams to change the "current reality":
  - Activity Based Funding
    (not exactly same as ABF described on slide 5; one step closer to 'Quality Based Funding')
    - Rewarding efficiency within existing resources
    - Reducing barriers to implementing best practice
    - Payment for workload generated due to move towards best practice
  - EDP4P
    - Rewarding timely patient access to care
    - Reducing barriers to implementing best practice
  - Procedural Care Program (scheduled procedures & MRIs)
    - Adding resources/capacity where most needed
  - Care Model Redesign & Quality Improvement
    - Breast Health
    - Foot & Ankle Clinic
    - Patient Reported Outcome Measures (PROMs)
    - National Surgical Quality Improvement Program (NSQIP)

Activity Based Funding

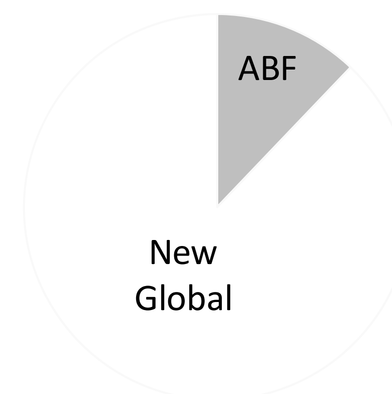
INITIAL FOCUS AND POTENTIAL FUTURE FOCUS



FY 10/11: HA global budget converted

- Split into new "global" and "ABF" portions
- Total amount is identical to existing global budget

Old Global Budget

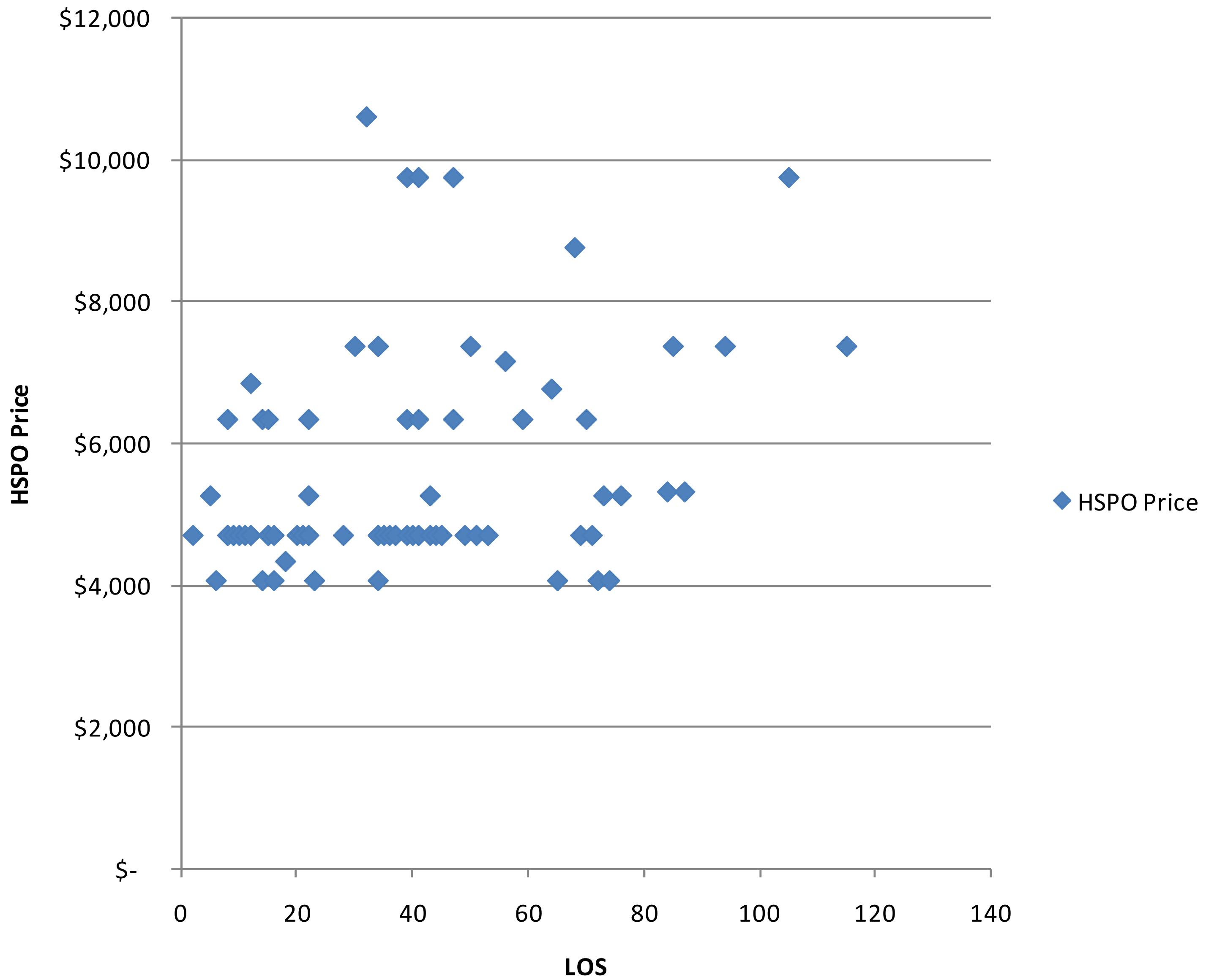


Activity Based Funding: how it works in FY 10/11

- HSPO pays $1,520 per inpatient Resource Intensity Weight (RIWs) and $3,040 per same day care RIW – no contract required
- Every patient discharged has a RIW value and, thus, you can start thinking about earning revenue
  - Growth in demand, reduce DDFEs, increased flow, currently funded capacity but underutilized, fund backfill for innovation, reduce ALC
- The payment rates per inpatient and daycare RIW:
  - Do not cover full cost to open new capacity. They are intended to aide management, staff and physicians to make improvements within existing capacity.
  - Remove the hard financial cap on expenditures
- ABF will flow bi-weekly to HAs as per usual assuming last year's activity levels
  - ABF revenue will be adjusted quarterly based upon increases / decreases from planned levels YTD
  - FY 10/11 RIW growth currently capped at 3%

Points of Interest / Possibilities

- VCH exploring changes to internal flow of revenue (could empower front line managers to make changes that generated efficiencies)
- Very early discussions with VIHA on exploring post-acute opportunities for dementia patients (e.g. modified assisted living?)
- DDFE revenue
- No correlation between LOS and RIW-based price for 'typical' patients


Correlation between Price and LOS
(RJH 'typical' cases - Dementia CMG 670)
$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$-
HSPO Price
0
20
40
60
80
100
120
140
LOS
HSPO Price

EDP4P

Target: Total Time in ED

Why Total Transit Time?

Why Three Separate Targets?

1. $600 for Admitted Patients
   - to Ward Within 10 hrs ($600)
2. $100 for Non-Admitted Hi Acuity
   - (CTAS 1-2-3) (within 4 hrs)
3. $100 for Non-Admitted Low Acuity
   - (CTAS 4-5) within 2 hrs

Payment is for EACH patient that meets targets

It Doesn’t Have to be Perfect …
Definition of “Complete Success`` = 80% meeting targets

What is a “Floor”?

Each hospital has their own “funding floor” based on their historical performance

- Each new patient (above that floor) that meets the P4P guidelines for TT in department has the same $ value
- Implies some recognition for previous investments in access
  - But the go-forward rules and $ amounts are the same for all hospitals
- Makes <u>both</u> Volume and Quality (access) count

Successful Strategies

- Within the ED:
  - A Shift in attitude at Triage
  - Better streaming through RAZ
  - De-Sequencing
  - Identifying Barriers to Decision Points
- Within the Hospital:
  - Short-Stay Units (e.g. MAU)
  - i-Care at Lion's Gate
  - Buying additional LTC capacity
  - "Pull" Strategies

Points of Interest / Possibilities

- Admitted patient revenue stream ($600 per patient) owned by inpatient areas in IH and VIH
- Exploring possible pilot of ERP reassessment fee

Procedural Care Program

Procedural Care Program: how it works in FY 10/11

- OR and Non-OR
  - Payment for volumes above established baseline
  - Contract required
- MRI
  - FY 10/11 – HSPO cost sharing with HAs for 14,000 exams above planned levels
  - Payment for volumes above established baseline
    - If new capacity needed then HA must also co-fund
    - If within existing capacity with only marginal investment required then HSPO payment may cover costs (e.g. batching; balancing techs and rads)

Main OR - Incremental Volumes Contracted by HSPO 22-Sep-10

Procedure	FH	IH	NH	VCH	VIH	BC
Subtotal - Top 10	***3,623***	***763***		***986***	***906***	***6,278***
Subtotal - Other HA Priorities	***1,196***	***639***	***360***	***611***	***55***	***2,861***
Grand Total	**4,819**	**1,402**	**360**	**1,597**	**961**	**9,139**

Non-OR - Incremental Volumes Contracted by HSPO

Procedure	FH	IH	NH*	VCH	VIH	BC
Grand Total	**2,000**	**1,313**	**1,250**	**3,254**	**2,578**	**10,395**

* TBD

	FHA	IHA	NHA	PHSA	VCHA	VIHA	BC
MRI	4,448	2,074	807	1,400	3,152	2,119	14,000

Increase in volumes over planned annual baseline volumes†

Main OR – Top 10: 32% increase; HA Priorities: 25% increase

Non-OR – 14% increase

MRI – 15% increase

† Baselines only reported for participating hospitals; network wide increases are lower

Points of Interest / Possibilities

- Targeted investments at managing the tail
- Expected wait time improvements
- Highlighted variations in appropriateness in select populations (e.g. varicose veins)
- Visiting surgeon models (e.g. LGH, DH)
- VIH exploring contracting out cases for very fast surgeon(s) and, thus, financially breaking even
- Possible MRI access in Lower Mainland across HA boundaries – who to co-pay if needed?

Care Model Redesign & Quality Improvement

Points of Interest / Possibilities

- Breast Health
  - looking for opportunity to take MSJ model to the next step
  - Potential for MSP revisions (e.g. multiple billings for same patient on same day)
- Regional Anesthetic Block for Distal Surgery
- Patient Reported Outcome Measures (PROMs)
- National Surgical Quality Improvement Program (NSQIP)
  - Investments in improvements in safety and outcomes can increase efficiency and reduce cost per patient treated
  - Can there be a MQIP?

Discussion/Questions

Appendix

FY 10/11 - ABF Exclusions

- Cases not abstracted into Health Records System (primarily ambulatory clinics, non-admitted ED)
- Any facility other than the 23 named
- PHSA Funded Cases
  - Most cardiology and cardiac surgery
  - Transplants
  - Cochlear Implants
- Newborns & Maternity
- Non-BC Residents
- ECTs, Cardioversions, Cystoscopies
- Discharges Direct from Emergency (DDFEs)
- Hips, knees and cataracts
- HPSO Contracted Cases (incremental volume contracts)

DDFE Details

ABF does not pay for DDFEs

1. DDFE cases are identified in the DAD (Health Records System)
2. Apply all case type exclusions listed earlier
3. Inpatient cases discharged directly from emergency room (or left ED and stayed in inpatient bed for less than 4 hours)
   - difference between Discharge Date/Time and LeftER Date/Time is 4hrs or less
4. Based on entry code E (from emergency department)
5. Discharge disposition does not equal ‘07 – deceased’ (i.e. discharged alive)

Resource Intensity Weights (RIW)

- Assigned to every case abstracted in Health Records after patient is discharged from hospital
- Nationally created by CIHI with goal of explaining cost variation in acute care setting
- RIW values provide a measure of a patient's relative hospital resource use compared to an average typical patient cost
- RIWs are scaled so that a typical average acute care case is value 1.0 RIW
- A higher RIW suggests a larger use of resources. Conversely, a lower RIW suggest lower use
- RIW values are currently updated annually

Included Hospitals

For Inpatient Care:

Fraser Health
RCH incl QPH
Langley Memorial
Surrey Memorial
Burnaby Hospital
Eagle Ridge
Ridge Meadows
Abbotsford Regional
Chilliwack General
Peace Arch

Vancouver Coastal
Vancouver Acute (incl UBCH)
St. Paul's + MSJ
Lion's Gate
Richmond General

Vancouver Island
Vic General
Royal Jubilee
Nanaimo General

Interior Health
Kelowna General
Penticton Regional
Royal Inland
Vernon Jubilee

Northern Health
Prince George

For Same Day Care:

1. All of the above
2. Others as determined by the relevant Health Authority