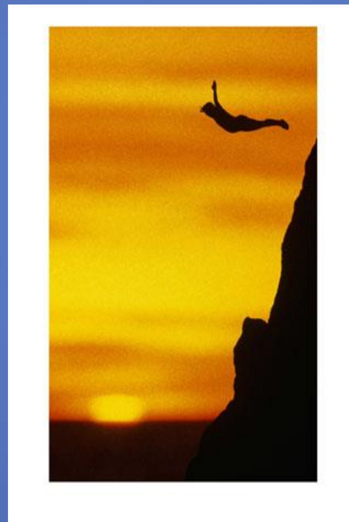
Patient Focused Funding

Taking the Plunge in BC



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Edmonton AB

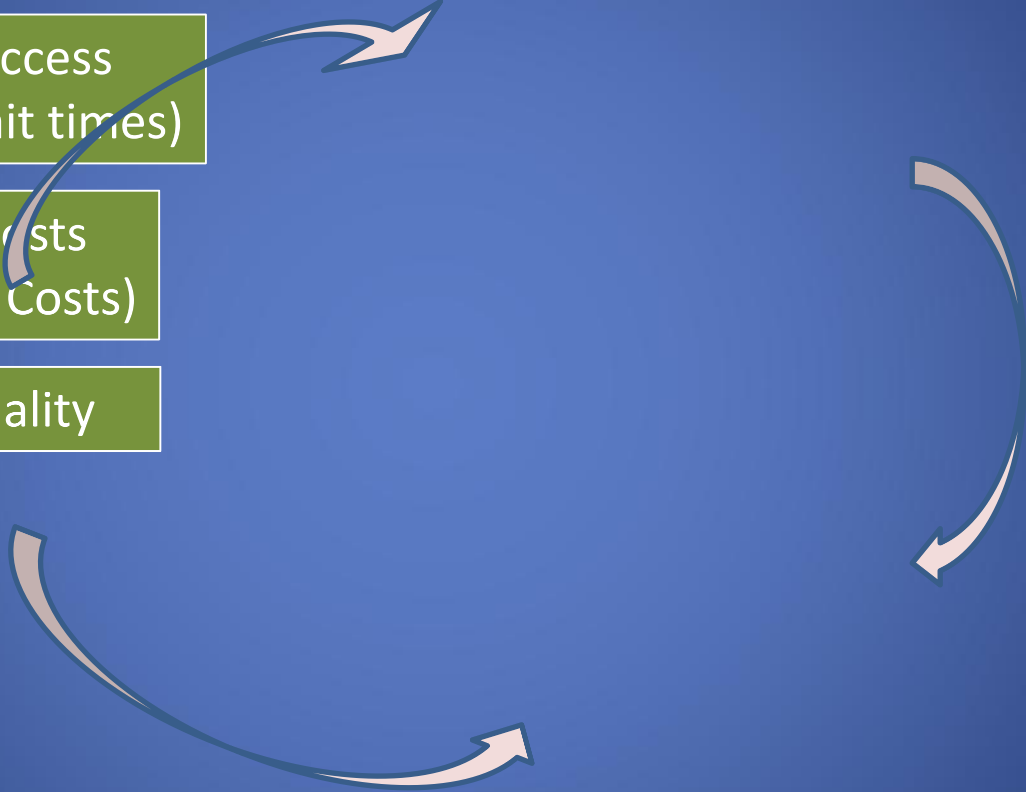
Nov 26, 2010

Our Objectives

Improve Access (decrease wait times)

Control Costs (Growth in Costs)

Improve Quality



How is Funding Methodology Relevant?

Q: Why Change Anything?

- Senate Report (Kirby 2002) suggested change to “service based funding “ for hospitals
- International Evidence that Waitlists are linked to Global funding (OECD 2003 & others)
- Canada is one of the few developed countries to use a funding methodology without a component for activity

- Even within Canada, *hospitals are the exception*; other health services are funded by activity

Q: Why Has Canada Taken So Long?

- Original Reasons for Global Funding:
  - Simplicity
  - Financial Stability & Certainty for all
  - Cost Control
  - Seemed to be Working (?)
- Possible Reasons for Resisting Change?
  - Fear of runaway costs
  - Possibility of stimulating unnecessary services
  - Maybe we don’t know how to do it differently?
  - Debate paralysis

The Long Term Legacy of Global Budgets

- Inability to compare /understand costs across institutions
- Hospital Services have no Value -> No reward for productivity
- Cutting services is the easiest way to improve the bottom line
- Never ending Struggle between Cost Control and Patient Access

- Patients become “burdens” at the bottom of the chain of influence

The Vicious Cycle of Cost Escalation

A Cumulative Cost Burden

1. The Vicious Cycle of Delay
2. Inter-Institutional Friction
   - Classic sub-optimization
3. Growth of ALC
   - Global budgets encourage the growth of ALC
4. A Barrier to Quality
   - *Access* (aka 'Timeliness') is an important component of Quality
   - "*Patients as burdens*" is not consistent with quality
   - The NSQIP example

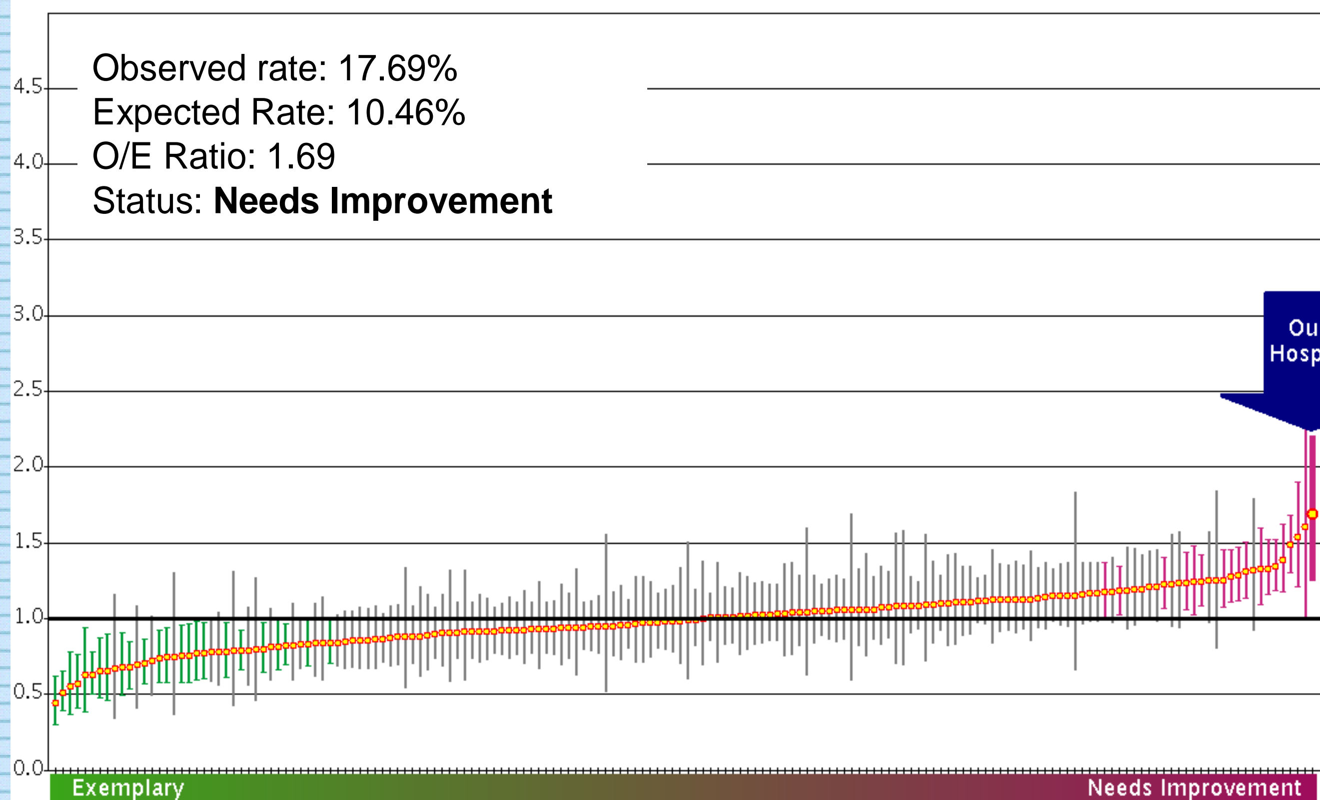
Working with NSQIP

Risk-Adjusted Outcomes in one BC Hospital

- National Surgical Quality Improvement Program
  - American College of Surgeons
- Data Collection & Validation
- Risk Adjustment relative to other NSQIP hospitals
  - *E.g. Observed* vs. *Expected* complication rates

- Assumes that:
  - Reduction of Complications is good for patients
  - … and it saves money too.

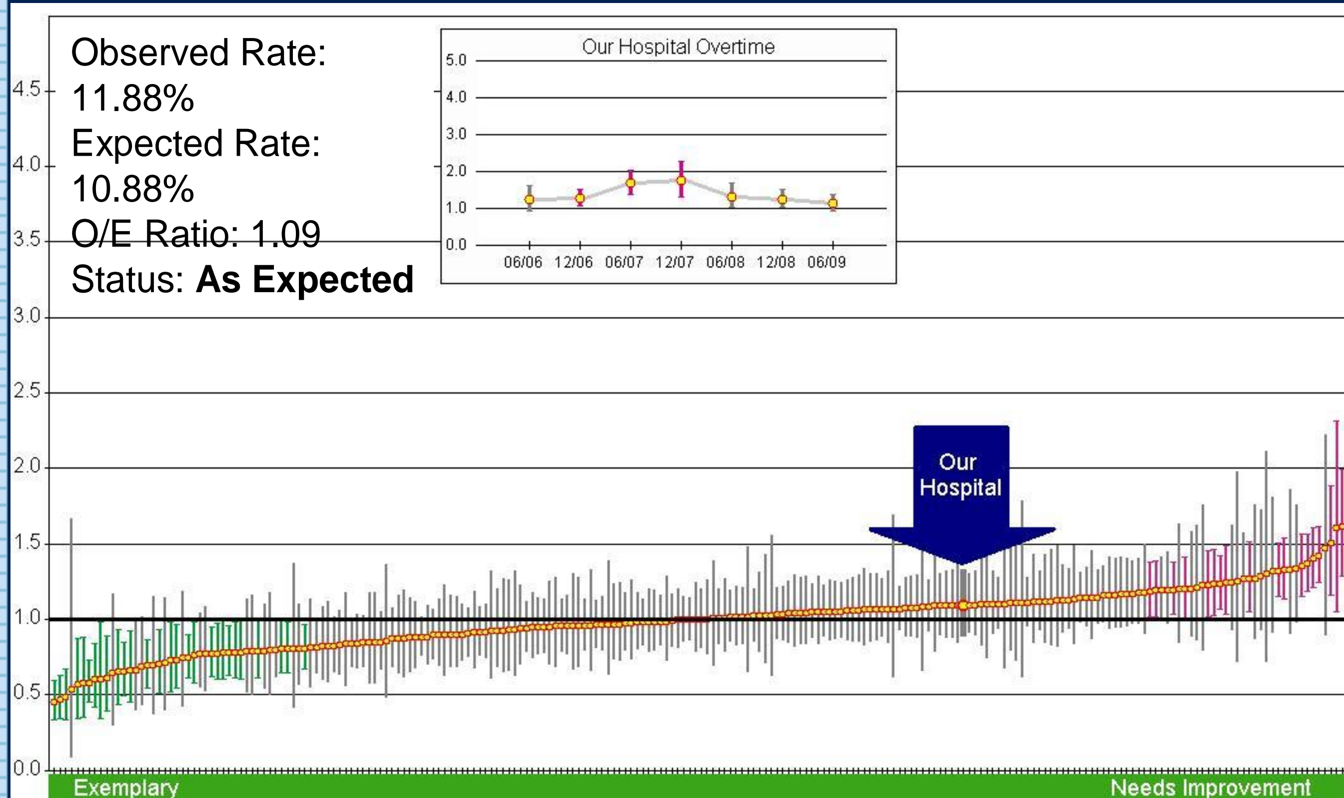
Before



After

Overall* 30-Day Morbidity

ACS NSQIP



* Includes General and Vascular Surgery Cases

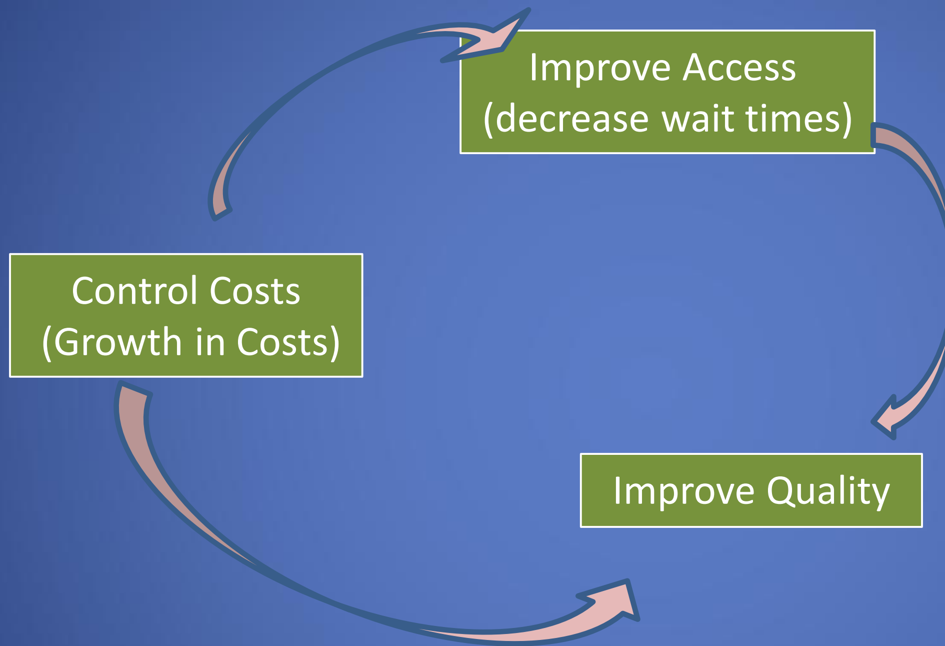
Net Effect

- Success in Achieving Lower Complication Rates
  - better flow, better patient experience
  - Demonstrated savings in return to OR, antibiotics, shorter LOS
  - Net value of savings at hospital = **$1.5M per year**

- *Actual* effect under a Fixed Budget:
  - Inability to actually close beds to recoup the money
  - **More patients** served but …
  - All staff now working even harder within same resources & budget
  - Average cost per patient decreased but total cost increased

Fixed Funding carried a PENALTY for achieving Quality

Question is not … *“<u>Why</u> Change?”*



… But <u>HOW</u> to change while avoiding the pitfalls?

Some of the “Pitfalls” to Avoid

- An “army of accountants”?
  - (Avoid by Use of CIHI’s RIW system based on CMG+)
- Runaway increase in costs
  - (Avoid by Un-incenting inappropriate admissions)
- Creating Financial Instability for Hospitals
  - (Avoid by Transparent Formula & Promise of Revenue Neutrality)

- Other Potential Adverse Consequences:
  - Loss of “quality” at the expense of volume
  - Cherry-picking of services just to create revenue
  - A perceived “Catch-22” for smaller hospitals?

Guiding the Change in BC

- Creation of a new “BC Health Services Purchasing Organization”
  - Small group selected for particular expertise
  - Clarifies roles through “purchaser-provider split”
  - Reports directly to the Minister
    - Members of Board include DM and senior ADM’s
  - Supplementary budget of $250M

- Purpose: to guide transition from Fixed Budgets to “Patient Focused Funding” while avoiding the pitfalls

Keeping it Simple

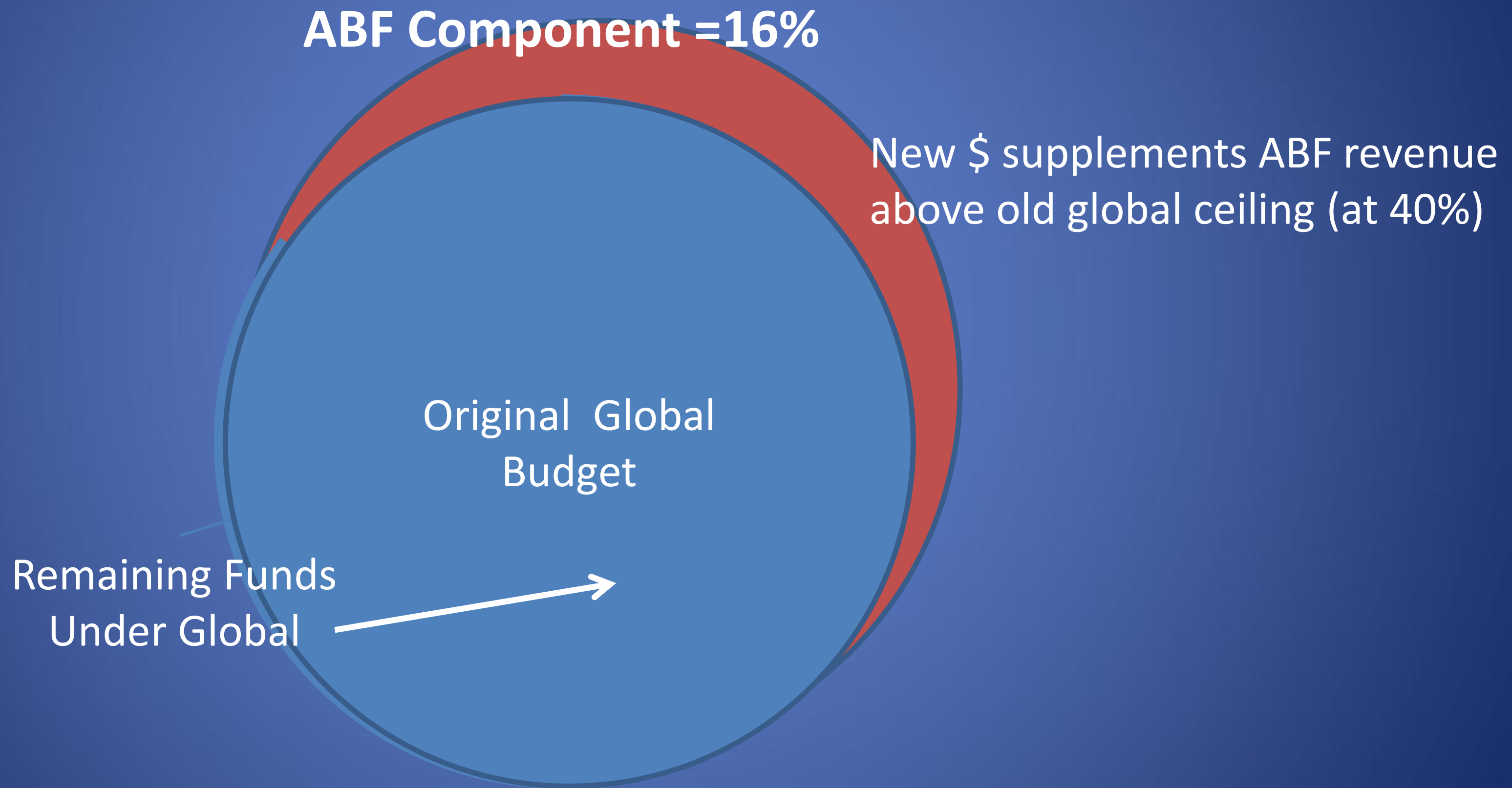
- Over 80% of Health Authority Funding remains Global. Activity based component confined to Margins:

- Use of “sliding scale” RIW scores created by CIHI’s CMG+ avoids arbitrary decisions about pricing etc
  - No new infrastructure needed
  - Instant past history and detailed forward projections available
  - Includes <u>all</u> of Acute Care (inpatient & SDC)
    - Some exceptions explained
- Fairness within a pan-Canadian standard

A Balanced Formula

- Definitely NOT a reimbursement strategy
- Starts with Fixed value of $3800 pwc as “Variable Cost (VC)”
  - Day Cases paid **@80%** of VC
  - Inpatient cases paid **@40%** of VC
  - Deliberate exclusion of ED admits that stay in the ED (DDFE)
- Objective: stimulate growth in Same Day Care but not Inpatients
  - But still support legitimate growth in volume or complexity
- Not a ‘Reward’ but Better Matching of Funds to Services
  - Money following patients instead of institutions

How Much Money?



Four Components of Patient-Focused Funding

1. Activity Based Funding of all inpatient and Same-Day care using CIHI's RIW formula
2. Focused Support for Areas with prolonged waitlists through selected contracts
3. Expansion of ED Pay-for Performance and province-wide tracking of DDFE
4. The *Quality* Agenda:
   - Expansion of NSQIP to all BC hospitals
   - Attaching quality parameters to case funding

Short Term Objectives

- No more cutting services to meet financial targets

- Dramatic reduction in waitlists in several key areas
- Decrease Number of Admitted Patients held in ED
- Better understanding of costs & comparison of best practices through common pricing
- Better matching of funds to services should improve flow

- **Message**: Get serious about Quality

Longer Term Objectives

- Improved Public Satisfaction through better Access
- Lower the Growth of Costs through:
  - Decrease in Cost per Case
  - Reduction of ALC and increase in Community support
  - Improved inter-facility flow
  - Reduction of complication rates
  - Better ability to “steer” the system
- Better Engagement with Physicians will mean better Management

So How is it Working?

- Still Early Days
- Wide spread support from all Health Authorities, our Ministry, Managers, Nursing staff and Physicians
- Attitude requires a Cultural change & will take more time
- Continuing Support of doctors, managers is key
- A Special Thank You to CIHI

Prediction is very difficult … especially about the Future
(Niels Bohr)