Pay for Performance as a “Disruptive Innovation” in BC

Pay for What You Want
Don’t Pay for What You Don’t Want

Duncan Campbell
Chief Financial Officer and Vice President
Systems Development and Performance
Will Paying the Piper Change the Tune?

There were times that people wanted to pay me to stop playing!!!
Realistic Options for Canada

• Bundle services across the continuum
• Use Pay for Performance to shift from activity to outcomes across the continuum of care
  – Mental Health and Substance use
  – Residential Care (follow Alberta)
  – Home is Best
• Extend RIW/ DPG outside acute across the continuum of care
  – Don’t wait for perfect data use surrogates
• Have external neutral provisioning body – HSPO for BC
  – Reduce exceptions from RIW
• Increase the proportion of funding at risk from 20- 30% to 50% plus
• Use Pay for Performance together with other tools to drive system improvement (Lean, Forecasting and scheduling tools)
Key Learning's

• Context is important
• Bundling services and payments
• Move outside the hospitals
• Resource Intensity information needed outside the acute sector
• Learn from other jurisdictions
• Yes….. and No
**In Conclusion – Key Factors for Success**

1. Don’t chase money – funding needs to enable behaviour change to support the right clinical actions
2. Not one time money - at VCH approach here to stay and grow
3. Accountability document is key
4. Pay acute operations based on RIW funding – earnings drives understanding
5. Need to resource real-time information and analytics
6. Revenue and cash flow received must flow to operations monthly
7. Coding accuracy and timing is key – need to compute RIW internally
8. Must incentivize patient flow across the continuum of care – cannot concentrate on a single area in a bigger system.
9. Part of the strategic direction
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Detailed Presentation
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About Vancouver Coastal Health

VCH delivers acute, residential and community healthcare services directly to more than one million residents in the cities of Vancouver, Richmond, North Vancouver and West Vancouver, 17 other municipalities and regional districts and 16 First Nation communities.

- $2.8 billion annual funding
- 22,000 staff
- 2,500 physicians
- 5,000 volunteers
- 556 locations including:
  - 13 hospitals
  - 3 diagnostic and treatment centres
  - 15 community health centres
- 3 million+ patient days of care
- 308,000+ annual emergency department visits
- 640,000+ annual clinic visits
- 116,000+ annual surgeries
- 79,000+ inpatient discharges
- 2.3 million+ residential care days
- 1.9 million+ home support hours
- 199,000+ home nursing visits
Background

- Overall funding $3bn
- Three communities of Care covering primary, acute, Residential, and home support
  - Vancouver
  - Richmond
  - Coastal
- 26% of Acute care funding Activity Based
- $29m received by VCH for “Pay for performance programs”
- Focus is to shift activity and funding outside acute
# Vancouver Coastal Health Strategic Framework

## Lens
- People First

## Vision
- We will be leaders in promoting wellness and ensuring care by focusing on quality and innovation.

## Mission
- We are committed to supporting healthy lives in healthy communities with our partners through care, education and research.

## Values
- Service
- Integrity
- Sustainability

## Drivers
- Patient/Community Focus
- Engaged Team
- Operational Excellence
- Financial Sustainability

## Goals
- Provide the best quality of care.
- Promote better health for our communities.
- Optimize our workforce and prepare for the future.
- Use our resources efficiently to sustain a viable health care system.

## Objectives

| 1.1 | Use a standardized, rigorous process to accelerate the creation and broad use of evidenced-based protocols in all clinical areas and programs. |
| 2.1 | Reduce health inequities in the populations we serve through focused improvements in core public health programs. |
| 3.1 | Enhance workforce utilization and match staffing to clinical volumes and patient acuity. |
| 4.1 | Embed LEAN thinking at all levels to fulfill objectives and to deliver quality outcomes. |
| 4.4 | Respond to provincial patient-centered funding model. |

| 1.2 | Develop a regional program for Mental Health and Addiction and Cardiac Sciences to improve quality of care. |
| 2.2 | Build on VCH integration strategies to support implementation of the MoHS directive to deliver integrated primary care, home and community care and community mental health services. |
| 3.2 | Recruit and retain the best people by fostering a culture of excellence, recognition and respect. |
| 4.2 | Develop and implement best practices in care management to reduce unnecessary days of stay. |
| 4.5 | Develop service agreements with funders and service providers. |

| 1.3 | Build a regional medication reconciliation system across the continuum. |
| 3.3 | Build organizational capacity by strengthening leadership and management competencies. |
| 4.3 | Deliver administrative and support efficiencies through the shared services organization and consolidation. |
| 4.6 | Develop and implement a strategy to secure increased capital funding. |
| 4.7 | Continue our commitment to “Green Care” alternatives by reducing waste and our carbon footprint. |
A Systems View

- Treat people in the most appropriate care location
- Deliver the highest quality of care
- Ensure effective use of resources
- Emphasize scalability of services
Disruptive Innovations in Health

- Minimally invasive surgery
- Robotic surgery
- Advanced Imaging
- Interventional radiology
- “Personalized” medicine
- Electronic health records
- Integrated health care
- Pay for performance
Why is the Funding Change Disruptive Innovation?

• It fundamentally changes the rules of the game for Ministry and Health Authorities – Lose funding if cut service to balance budgets
• Transparency and accountability is hard
  – Reluctance to commit to deliverables
• Decisions can be made at the point of care, knowing that funding will support decisions.
• Desire of many to return to the old block funding days
  – “Those were the days my friends”
• Budgets and financial reporting needs to be more flexible
  – Funds need to flow to operations across continuum
  – P4P is a transparent way of moving funds
• Collecting baseline and performance data is tough for an industry that has used data as an excuse for inactivity
• With so little money you can make a big difference – P$P works well at the margins
Disruptive Innovations: Pay for Performance

• Pay for what you want
• Don’t pay for what you don’t want
I. Pay for Performance

- Learning from the UK and US
- P4P at Vancouver Coastal Health:

- Emergency Department
- P4P
- Activity Based Funding
- Community Initiatives
- Procedural Care Program
- NSQIP
Effects of Pay for Performance on the Quality of Primary Care in England

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From the National Primary Care Research and Development Centre, University of Manchester, Manchester (S.M.C., D.R., E.K., B.S., M.R.); and the University of Cambridge General Practice and Primary Care Research Unit, Institute of Public Health, Cambridge (M.R.) — both in the United Kingdom. Address reprint requests to Dr. Campbell at the National Primary Care Research and Development Centre, University of Manchester, Oxford Rd., Manchester M13 9PL, United Kingdom, or at stephen.campbell@manchester.ac.uk.


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NHS 'wasting billions with no benefits for patients' on cash incentives for GPs

By Jenny Hope

Last updated at 1.15 PM on 20th January 2011

Paying GPs cash incentives to improve healthcare often fails to produce the desired results, a damning report says today.

It accuses the NHS of wasting billions on 'pay-for-performance targets', which allow family doctors to supplement their incomes.

The study's conclusions are based on a multi-billion pound plan to lower patients' blood pressure, which had 'no impact' on cutting heart attacks and strokes.

Pay-for-performance targets were introduced by Labour in 2004 at a cost of £1.8 billion a year as part of a new contract for GPs. Around one-third of their average income — currently £105,000 a year — is linked to achieving these targets.

But the study found they did not help patients with high blood pressure and provides the strongest evidence yet that pay-for-performance offers little benefit.

The Government has pledged to reform the way GPs are paid for this type of work in the face of increasing criticism. They are to receive sweeping new spending powers under Health Secretary Andrew Lansley's controversial reforms and will form consortia to replace the soon to be abolished Primary Care Trusts.
Fig 2 Effect of pay for performance on blood pressure control and monitoring in United Kingdom.

Serumaga B et al. BMJ 2011;342:bmj.d108
Learning from UK/US

• Why pay extra for what you already have?
• “Good quality of care for hypertension was stable or improving before pay for performance was introduced.”
• Trends were already improving
• What are you looking for: evidenced based care? Patient experience: they may not be the same thing!

Serumag, Ross-Degnan, Avery et al
Examples of P4P at VCH

• 1. P4P in the Emergency Department
• 2. Activity Based Funding in Acute Care
• 3. Community Initiatives
• 4. Procedural Care
• 5. Seed funding for quality
1. VCH - Success with ED P4P

Three separate streams of patients with independent targets to reduce wait times and improve access:

1. Admitted Patients (to an inpatient bed within 10 hours)
2. Not admitted patients, High Priority (discharged within 4 hours)
3. Not admitted patients, Low Priority (discharged within 2 hours)

Additional 36,000 patients treated within target wait time in 2010/12
“ED visits and admits have increased year over year since 04/05 while overall ED Admitted LOS has decreased over the same time period”
2. Activity vs Block Funding for Acute Care

• Goal:
  – A. to move acute care to outpatient services
  – B. to decrease length of stay

• Use RIW as index of acuity and fund on the margin

• Give more value to the ambulatory activity than the inpatient
RIW Funding

- Relates to the Case Mix Group and complexity of specific case
- Former method: “Global Funding” with new funding based upon old budget and ± %
- In an attempt to encourage:
  - More out patient surgery
  - Faster turnover of patients
- RIW for *inpatients* funded at 0.4 and *outpatients* at 1.0+
- RIW = CDN $ 3,400
Invest in Community, Home Support and Primary Care

Invest in Community and Home Support

- Reduce ED visits
- Reduce length of stay
- Reduce ALC
- Reduce Acute and Residential Care Admissions
- Reduce Readmissions
Avoidance of Unnecessary Residential Care and Acute Admissions (AURAA)

• A comprehensive set of community-based services designed to provide proactive care to prevent exacerbation of known complex disease

• Will prevent avoidable ED, Acute and Residential Care admissions and reduce LOS amongst the population at highest risk, while improving overall health status at home

• 118 patients enrolled across 6 communities in VCH
  • All 118 patients were waitlisted or eligible for residential care
  • 92% of these patients are still in the community and have not had to be admitted to residential care
  • Early success is being seen with health outcomes (e.g., lowered MAPLE and CHESS scores for select clients)
  • Due to intensive care management, patients have been stabilized and require less resources enabling support at home
# of RC Registrations (Total) by Fiscal Year (P11 YTD) Vancouver

- 08/09
- 09/10
- 10/11
- 11/12

- Vancouver

Legend:
- # of RC Registrations (P11 YTD)
- Average 08/09 to 10/11 (P11 YTD)
Impact of the AURAA Program on Reducing ALC in Richmond

- The number of ALC clients in acute care has dropped from 40 to 24 on average on any given day.
- The number of ALC days have dropped from 937 days/period to 691 days/period.
- 800 ALC days saved at Richmond Hospital YTD.
- Many AURAA clients have foregone Residential Care facilities when offered all together, as they have improved and function well with family and Home Health services combined.
P for P can Lead to Better, Earlier Discharges: Home First

**Average # of ALC Clients**

VCH - Richmond

- **Clients**: 40, 39, 38, 38, 35, 30, 25, 20, 20, 20, 20
- **Targets**: 20, 20, 20, 20, 20, 20, 20, 20, 20, 20

**Period**

- **11-11**: 40
- **11-12**: 39
- **11-13**: 38
- **12-01**: 38
- **12-02**: 35
- **12-03**: 27
- **12-04**: 20
- **12-05**: 19
- **12-06**: 18, 21

**Source**: VCH Decision Support

**Prepared by**: Ana Himani
Home First: Successes

• Established regular meetings with acute and community care staff
• Starting to see a shift in culture
• Decreased the trajectory demand from acute to residential care placement
• Reduced the number of ALC days in acute care
• ALC clients that moved home – stay home
4. Procedural based care

- Surgery funded at usual costs
- Other procedures funded at marginal costs (MRI)
Top 10 Day Surgery - Average Wait Time (Weeks) for Cases Waiting

Contracted Cases at Contracted Facilities

Month End

2010-08  2010-09  2010-10  2010-11  2010-12  2011-01  2011-02  2011-03

Vancouver Coastal Health
Promoting wellness. Passing care.
MRI Wait Times

VCH MRI Volumes and Average Wait Time

LMIIF 6,456 Exams

HSPO Annualized total 6,304 Exams

MRI Volume

Year Fiscal Period

Average Wait Time (Months)

0 2 4 6 8 10 12 14 16
0 500 1,000 1,500 2,000 2,500 3,000

Total MRI
Average Wait Time
P4P to reduce wait times: Learning

• Try to choose area where the new costs are marginal:
  – CT/MRI/Interventional Radiology (shift changes/ other efficiencies)
  – New organizational efficiencies (OR scheduling and pre/post op planning)

• **Must include the MD costs!**
5. Seeding Quality

• Thesis: improve overall surgical outcomes by joining the American College of Surgeons’ National Surgical Quality Improvement Project
**Before**

**Overall* 30-Day Morbidity**

- **Observed rate:** 17.69%
- **Expected Rate:** 10.46%
- **O/E Ratio:** 1.69
- **Status:** Needs Improvement

*Includes General and Vascular Surgery Cases*
After

Overall* 30-Day Morbidity

Observed Rate:
11.88%

Expected Rate:
10.88%

O/E Ratio: 1.09

Status: As Expected

* Includes General and Vascular Surgery Cases
II. Don’t Pay for What you Don’t Want

Using negative incentives
If you don't want to pay for cheque services, don't pay for your cheque services.
Negative Incentives

• BC government had instituted a negative funding option based upon agreed upon wait times for federal-provincial targets on surgery: If negotiated targets are not met by December 31, funding is withheld for a percentage of the cases
  – Primary Hip and Knee replacement surgery
  – Cataract surgery
  – Non emergent cardiac surgery
Penalties for surgery waits: $7-million

Three of five regional health authorities in B.C. lost out on funds for missing targets on hip, knee and cataract surgery

BOB MCDONALD/ VANCOUVER

B.C. health authorities were hit with nearly $7-million penalties by the provincial government last year for failing to meet waiting times targets for hip, knee and cataract surgery. The penalties, in the form of withheld payments, were in general response to help the government’s fight against the deficit, according to a health ministry official. All indications are that the provinces’ new government approach is working. The penalties were a significant improvement over previous situations at some health authorities. The new government has taken steps to hold hospitals and health authorities accountable for meeting targets and have taken steps to hold hospitals and health authorities accountable for meeting targets.

JOHN SETSILL

Downtown Vancouver Business Improvement Association wins human-rights case

PHILIP JORDAN

What will Clark do about B.C.’s growing court backlog?
Don’t Pay for What You Don’t Want in Acute Care

• No accountability on quality:
  – Post operative infections
  – Re-admissions
  – Prolonged length of stay

• No accountability on access

• No accountability on integrated outcomes

• No accountability on total cost of care
Don’t pay for what you don’t want

• Readmissions:
  • Mental Health Patients
  • Surgical patients
  • Medical Patients

• MRSA Infections/Hand washing
• C. difficile infections
• Urinary tract infections
Mental Health and Addictions
Readmissions

- Indicators: 30 day mental health readmission
- Benchmark: CIHI: 11.4/100,000
- VCH 15.7/100,000
- VCH excess = 4.3/100,000 x 10 = 43 cases
- Cost/readmission = LOS x $/day = 13 x 736 = $9,568
- Total cost = $411,424
- Etc. for surgery and medical readmissions
Overall Expenditures on HAIs at VCH over the last four years

VCH spent more than $65.2 M for the treatment of the selected Hospital Acquired Infections over the last 4 years.
Further research is necessary to prove and evaluate the impact of Hand Hygiene on a reduction of infection rates.
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Questions?

http://www.vch.ca
### Budget Breakdown Update with $ at risk

<table>
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<tr>
<th>Base Funding using Resource intensity weighting</th>
<th>At risk</th>
<th>Total</th>
<th>% at Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base</td>
<td>887.0</td>
<td>224.0</td>
<td>1,111.0</td>
</tr>
</tbody>
</table>

| Activity Based Funding form PHSA/ MOH          |         |        |           |           |
| Transplant                                    | 4.0     | 6.0    | 10.0      | 60%       |
| Cardiac                                       | 86.0    | 80.0   | 166.0     | 48%       |
| Renal                                         | 8.0     | 26.0   | 34.0      | 76%       |
| Hips and Knees                                | -       | 46.0   | 46.0      | 100%      |
| Cataracts                                     | -       | 6.0    | 6.0       | 100%      |
| Total Funding PHSA                            | 98.0    | 164.0  | 262.0     | 63%       |

| Pay for Performance Program Earnings          |         |        |           |           |
| Emergency dept pay for performance            | -       | 10.0   | 10.0      | 100%      |
| Procedure based funding                       | -       | 14.0   | 14.0      | 100%      |
| Activity Based funding                        | -       | 5.0    | 5.0       | 100%      |
| Total PFF earnings                            | -       | 29.0   | 29.0      | 100%      |

| Total Acute                                   | 985.0   | 417.0  | 1,402.0   | 30%       |
| Medical Services plan/ Pharmacare             | 325.0   | -      | 325.0     | 0%        |
| Patient/ Resident                             | -       | 82.0   | 82.0      | 100%      |
| other costs (depreciation)                    | 76.0    | -      | 76.0      | 0%        |
| Total Acute                                   | 1,386.0 | 499.0  | 1,885.0   | 26%       |
| Other sectors and overhead                    | 1,277.0 | -      | 1,277.0   | 0%        |
| Total Vancouver Coastal Health                | 2,663.0 | 499.0  | 3,162.0   | 16%       |