Innovations for Health System Improvement: Balancing Costs, Quality and Equity

Pay for Performance as a "Disruptive Innovation" in BC

…. Now we need to "Frack" the Financial and Operational Processes

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Chief Financial Officer and Vice President Systems Development and Performance

May 2012

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Pay for Performance Funding History

- 2007 – ED pay for performance launched at 4 hospitals at Vancouver Coastal
- 2009
  - Lower Mainland Innovation and Integration fund launched $50 over 2 years
    - EDP4P extended to 4 Fraser Health Hospitals
- 2010 – Health Services Purchase organization launched - $80m
- 2011 - Budget $130m
- 2012 – Budget $100m
  - Accelerated Integrated Primary Care Fund - $50m
  - HSPO - $50m

Why is Pay for Performance a "Disruptive Innovation"?

- Fundamentally changes the rules of the game for Ministry and Health Authorities
- Desire of many to return to the old block funding days
  - " Those were the days my friends"
- Changes decision processes. Lose funding if cut service to balance budgets
- Transparency and accountability is hard
  - Challenges reluctance to commit to deliverables
- Decisions can be made at the point of care, knowing that funding will support decisions.
- 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 – P4P works well at the margins

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Background VCH

- Overall funding $3bn pa
- Overall continuing operations cost growth 2.5%
- Structural deficit in 2007/8 $50m, now generates $50m surplus reinvested in previously starved infrastucture
- Three communities of Care covering primary, acute. Residential, and home support
  - Vancouver
  - Richmond
  - Coastal
- In 2010/11 26% of Acute care funding Activity Based

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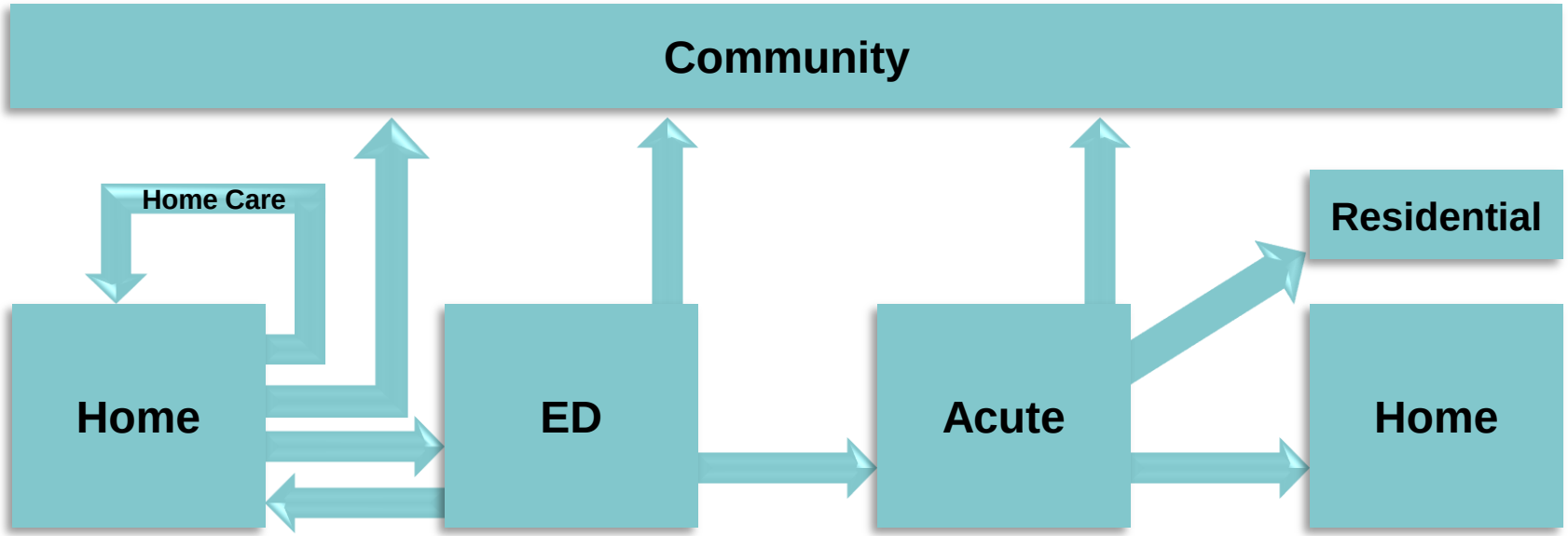
Pay for Performance Needs A Systems View



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

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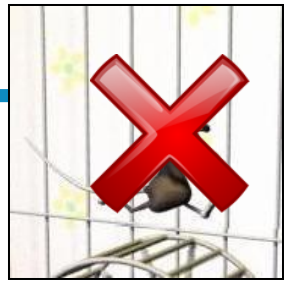
Pay for Performance Basics

- **VCH is organized into Communities of Care**
  - Cluster of primary and community care, hospitals, primary care, residential care, home support
- **All Money earned goes to the Community of Care**
  - Believe that best decisions are ones made locally
  - Sense of “provider ownership” created by control of money
  - But nobody keeps any money
- **Pay for Performance is not an improvement strategy in itself**
  - Money must be invested in improvement (QI) processes
  - Relatively easy improvements can generate confidence & cash to fund more difficult changes
- **Hospitals are free to invest as they see fit**, but must report how money has been used

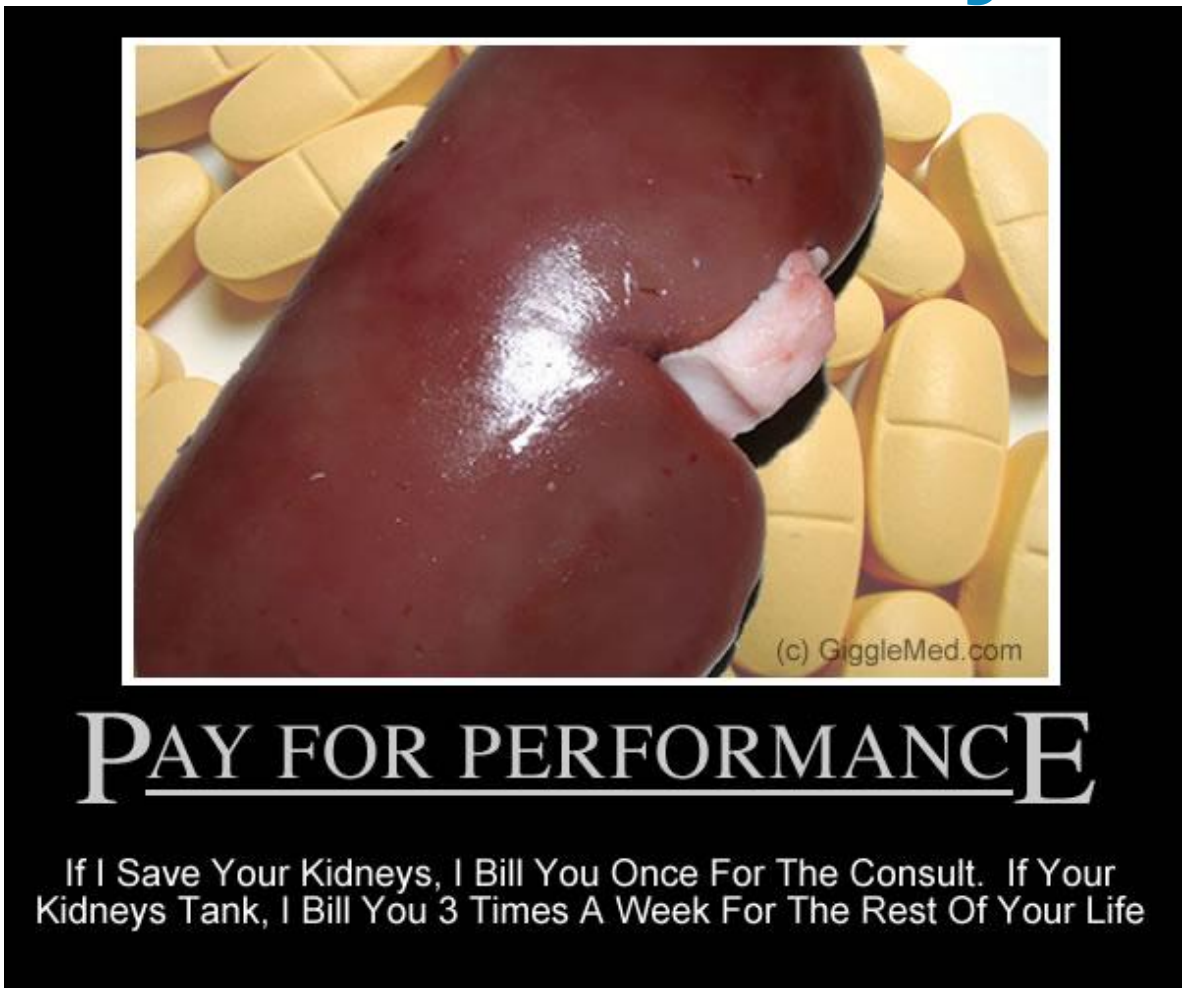
What P4P is NOT



- It is <u>NOT</u> a way to make People work Faster
  - It is a Way of making them Pay Attention and re-think their approach to the Patient Experience
- Money is <u>NOT</u> the Incentive
  - *Improvement* is the real incentive

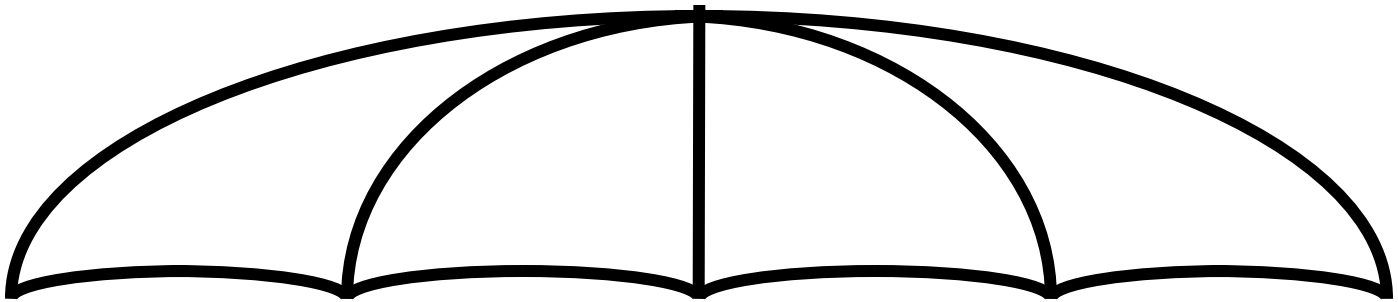
- If Money is “not a reward”, then why is it tied to Performance?
  - Because it is a **Shared RISK** strategy

What P4P is Definitely NOT



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

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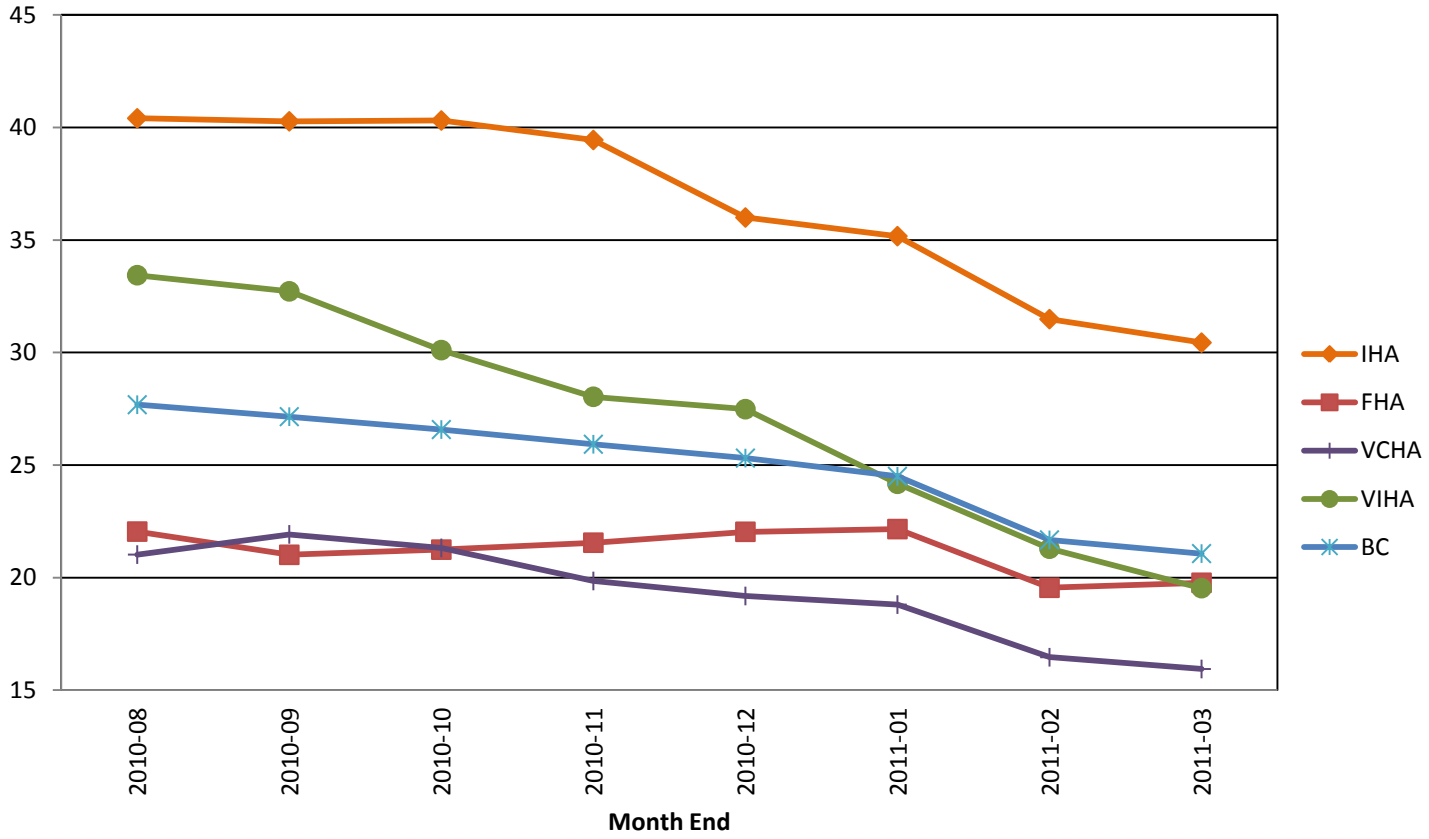
Top 10 Day Surgery - Average Wait Time (Weeks) for Cases Waiting

Contracted Cases at Contracted Facilities



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TENNIS B.C.'s Vasek Pospisil looks to improve on breakthrough year with upset win at Davis Cup in Vancouver. SPORTS, PAGE 9

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THE GLOBE AND MAIL
TUESDAY, FEBRUARY 7, 2012

Globe British Columbia

BC EDITOR: PATRICK BRETHOUR

HEALTH CARE

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

ROD MICKLEBURGH VANCOUVER

B.C. health authorities were hit with nearly $7-million in penalties by the provincial government last year for failing to meet waiting-time targets for hip, knee and cataract surgery.

Figures released to The Globe and Mail show that the specific fiscal punishments, believed to be a first for Canada's health-care system, were assessed against three of the province's five regional health authorities.

The money, in the form of withheld payments, went to general revenue to help the government's fight against the deficit, according to a Health Ministry spokesman.

All indications are that the government's no-nonsense approach is working.

"It's a significant amount of money, and it's been quite successful at getting people to pay attention to wait lists," said Les Vertesi, head of B.C.'s Health Services Purchasing Organization, the patient-focused funding arm of the government, which has taken over responsibility for meting out non-performance sanctions.

Before the penalties, said Dr. Vertesi, hospitals that allowed waiting lists to build faced no cost consequence.

"They were just letting people accumulate, so were doctors. ... Now, people have got down to work and lowered their wait lists. A lot more surgeries are being performed," he said.

The Interior Health Authority took the biggest financial whack, losing out on $3.4-million for coming up short on prescribed time limits for patients to receive hip or knee replacements or cataract operations.

Donna Lommer, chief financial officer for Interior Health, said the authority does not begrudge the cash.

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HOMELESSNESS

Downtown Vancouver Business Improvement Association wins human-rights case

JUSTICE

What will Clark do about B.C.'s growing court backlog?

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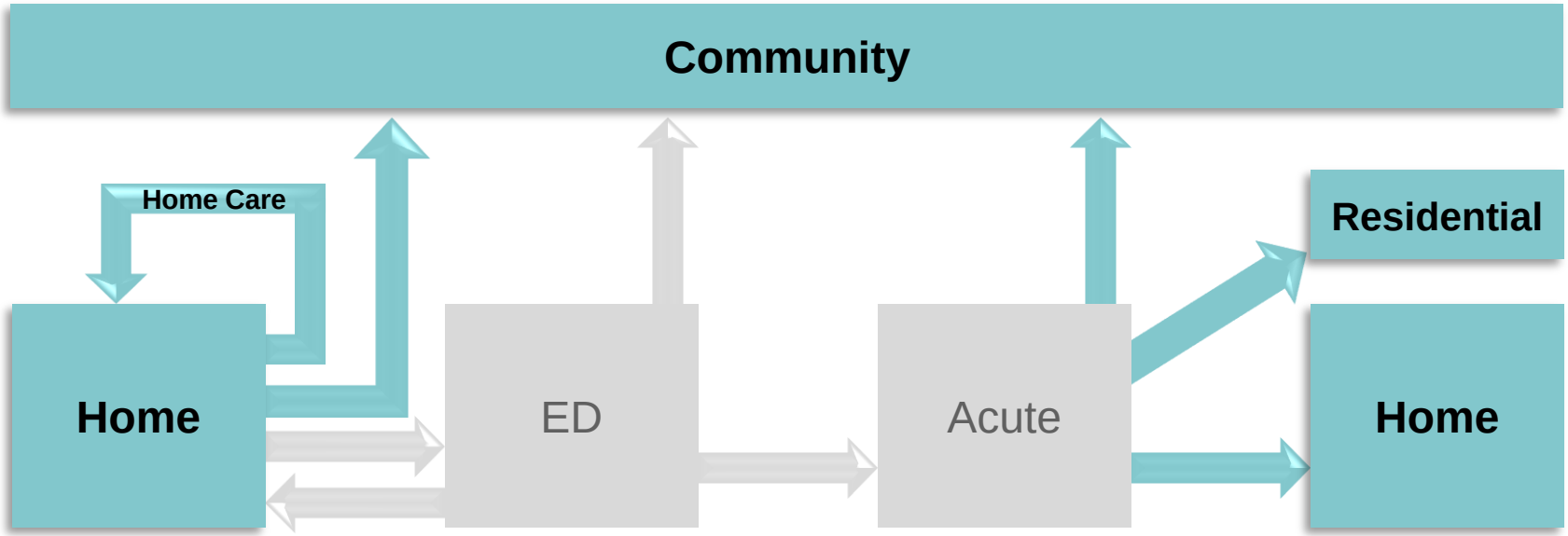
Invest in Community, Home Support and Primary Care



Invest in Community and Home Support

- Reduce ED visits
- Reduce length of stay
- Reduce ALC
- Reduce Acute and Residential Care Admissions
- Reduce Readmissions

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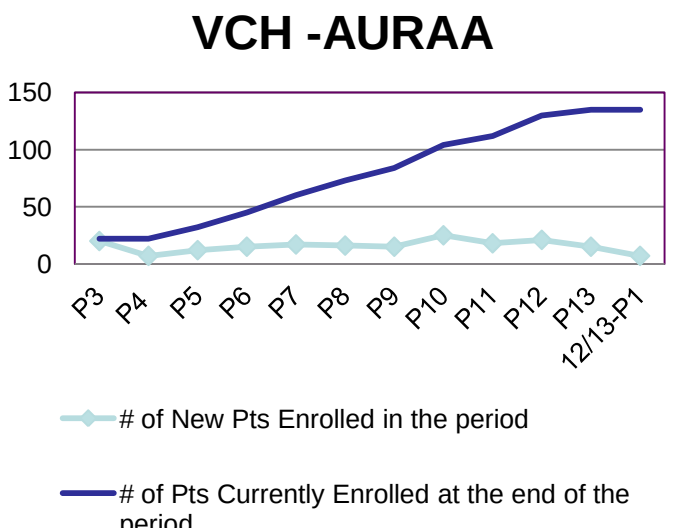
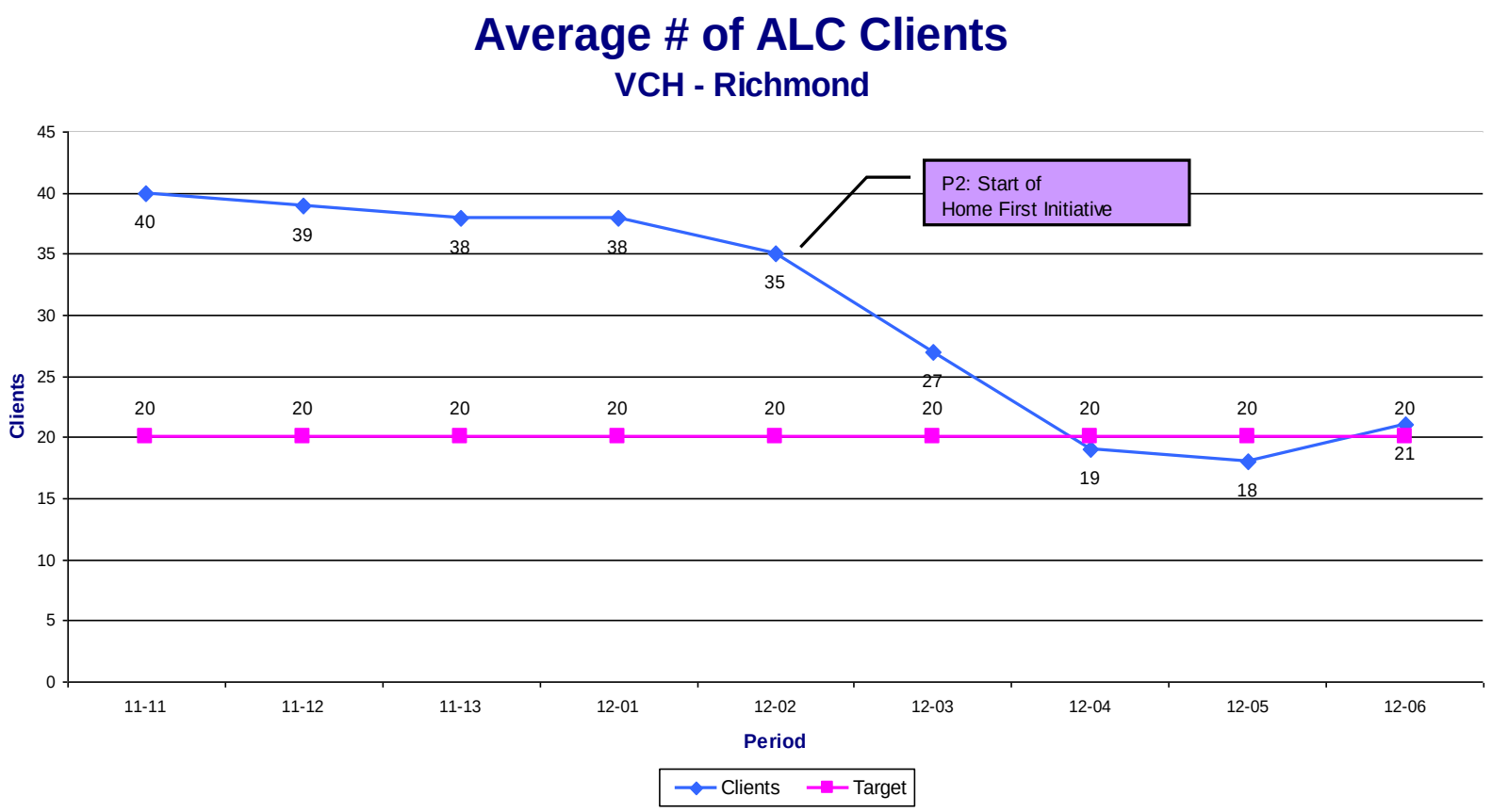
Home First Community Initiative

- Eligible for Residential Care
- Community-based proactive care to reduce avoidable ED, Acute and Residential Care admissions
- 138 patients enrolled across 6 communities in VCH
- 92% of these patients are still in the community and have not had to be admitted to residential care



P for P can Lead to Better, Earlier Discharges: Home First



Source: VCH Decision Support

Prepared by: Ana Himani

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Fracking the Finance and Operations Processes

- Fracking is defined as using pressure to free precious resources from the earth
  - Pay for performance is the force to extract precious resources from operations and the tendency to “own and defend” their budget
  - Pay for Performance blow up current financial management models
  - Pay for performance requires that the money follows the patient across the continuum
- Financial systems need to get agile to support changes in operational decision making

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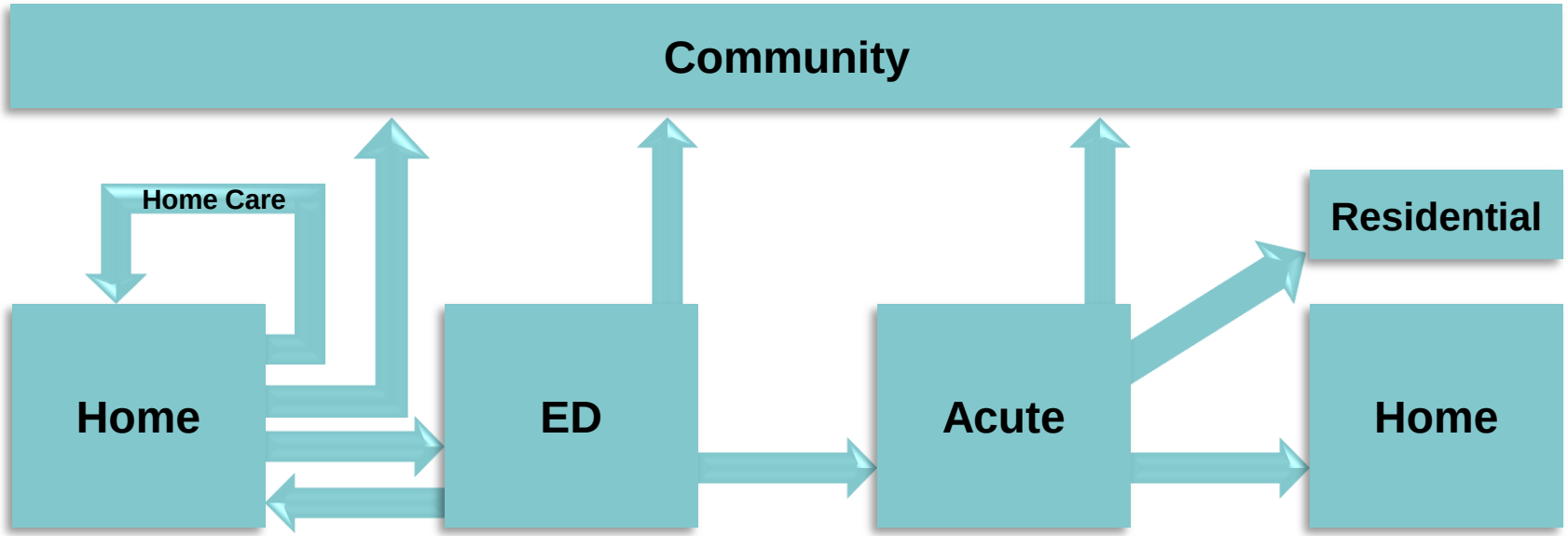
This is what Agile Financial Processes Look Like

1. Real time information updated every 15 minutes – ED visits and Pay for Performance metrics, census and bed maps, staff scheduling and availability, discharges and targets.
2. Forecasting and scheduling software that predicts census, volume mix, physician and clinical staffing, operating room and acuity
3. Using analytics to make decisions in real time e.g. whether to flex beds up or down, use overtime understanding PFF revenue and costs.
4. Very little time spent wondering what happened as part of decsions when they did happen
5. Have sufficient notice based on forecasts to staff plan at straight time

This is what Agile Financial and Operation Processes Look Like

1. Manage wait times through complex scenario analysis
   - Real time based on forecast models and simulation the optimum balance of scheduled and unscheduled surgeries against wait time targets, bed capacity, physician and clinical staffing, and diagnostics
2. Forecasting revenue based on RIW, Volumes, and capacity constraints
3. Budgeting is simple – driven by forecasts, revenue, staffing and efficiency assumptions
4. Pay for Performance agency pays for all growth (could be subject to a cap)
   - Block funding becomes a smaller and smaller part of funding

Supporting Systems



Real time decision support tools for agile decisions

- **Forecasting – staffing, census, Operating Rooms**
- **Kronos Scheduling and timekeeping**
- **Acuity**
- **ED Performance monitoring**
- **Bed management**
- **Portals and decision support metrics**
- **Management practices and bed meetings**

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The Old and New Budget Paradigm

The "Good Old Days"

- Game of chicken
- Fixed budget set in stone
- Deep silo's – difficult to move
- No incentive to improve, just justify budget ask
- Patients treated as costs
- Wait times less important than balancing budget
- Cost pressure driven
- Cut service if unable balance

The New World

- Revenue focus (need to understand capacity)
- Flexible budgets
- Pay for performance support access,flow, and wait times
- Forecasting and scheduling the key driver to financial performance
- PFF to support shift in care setting
- Money follows the patient, monthly
- Any cut in service results in less funding

Armour vs. Fly by Wire

Key Messages

1. Pay for performance works and is a key accountability tool
2. Blow up the old finance processes – Frack the finance processes
3. Pay for Performance is an important driver to create an agile organization
4. Need flexible real time information and analytics to create agile processes
5. Revenue and cash flow received must flow to operations monthly – cash must follow the patient/ client
6. Must incent patient flow across the continuum of care – cannot concentrate on a single area in a bigger system.
7. Coders are the new rock stars in the system – need CIHI measures outside the hospital walls
8. Need an outside funding agency to drive accountability
9. Don’t chase money – funding needs to enable behaviour change to support the right clinical actions
10. Not one time money- at VCH approach here to stay and grow

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

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Where to Next

1. Enhance and grow Pay For Performance
    1. Bundled payments
    2. Increase proportion to 50% plus
    3. Support high quality and consolidation of clinical services
2. Roll out “Don’t pay for what you don’t want” disincentives

3. Invest with CIHI or others RIW like metrics outside to acute setting
    1. Mental Health would be a good start

4. Proactive and visible wait time management
5. Enhance decision support tools and enhanced forecasting and intelligence analytics

Thank you

- David Thompson and Dr Les Vertesi for guiding us
- Les Vertesi for some of his slides
- Jason Sutherland for inviting me and the work on evaluating our PFF programs.

Questions?
http://www.vch.ca

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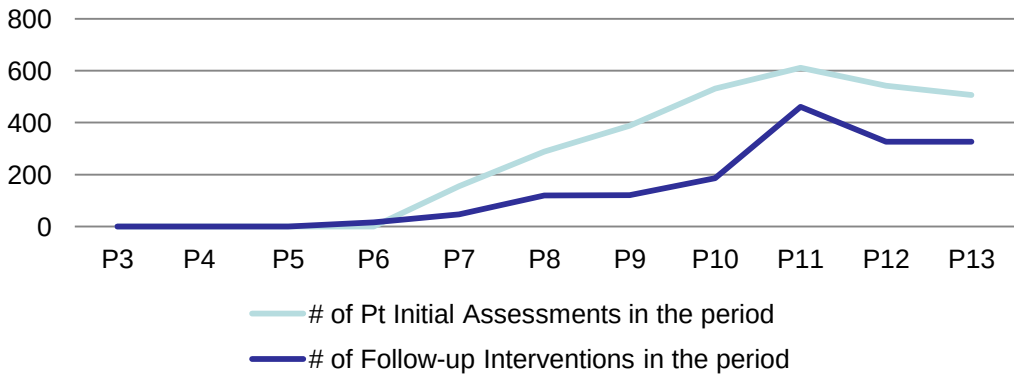
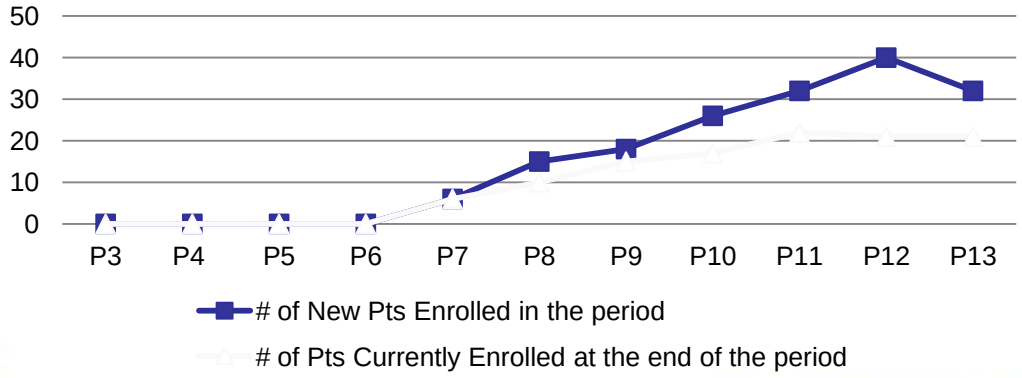
VCH - Frail Ederly, Dementia within ED



Home is Best - Mental Health & Addictions



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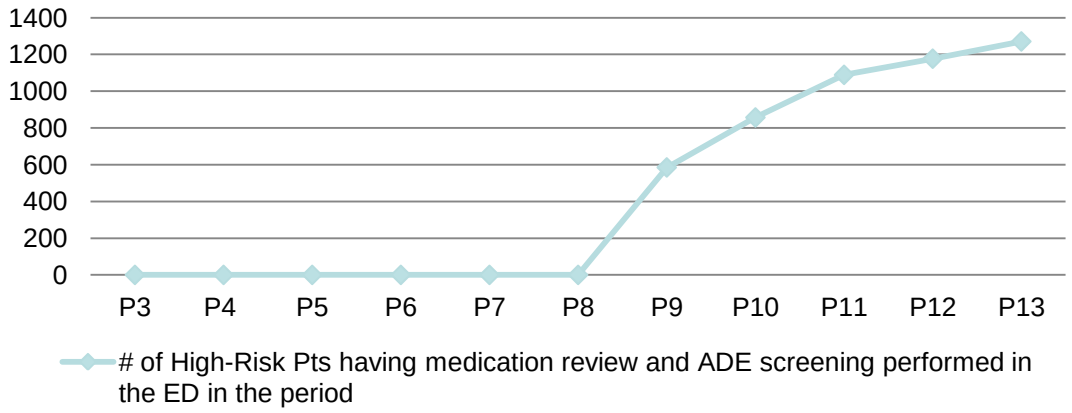
VCH - Adverse Drug-related Events in ED



VCH Early Supported Discharge - Stroke