Pay for Performance as a Disruptive Innovation in BC

Pay for What You Want
Don't Pay for What You Don't Want

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President and CEO Vancouver Coastal Health
Professor of Medicine University of British Columbia


SUPER, NATURAL
BRITISH COLUMBIA®
CANADA
YUKON TERRITORY
N. W. T.
ALASKA (USA)
ALBERTA
PACIFIC
OCEAN
PRINCE GEORGE
KAMLOOPS
WILLIAMS LAKE
KITIMAT
DAWSON CREEK
FORT ST. JOHN
FORT NELSON
EDMONTON
CALGARY
KELOWNA
VERNON
PENTICTON
NELSON
CRANBROOK
REVELSTOKE
BANFF
VANCOUVER
NANAIMO
VICTORIA
BELLINGHAM
EVERETT
SEATTLE
U S A
British Columbia
Multi - Lane Highway
Other Highway
Ferry Route
Major Airport


Kimsquit
Klemtu
Anahim Lake
Ocean Falls
Hagensborg
Nimpo Lake
Bella Coola
Waglisla
Bella Bella
Namu
Dawsons Landing
D'Arcy
Pemberton
Mount Currie
Whistler
Lund
Powell River
Blubber Bay
Vananda
Egmont
Brackendale
Squamish
Gilles Bay
Garden Bay
Britannia Beach
Madeira Park
Port Mellon
Halfmoon Bay
Lions Bay
Sechelt
West Vancouver
Roberts Creek
North Vancouver
Gibsons
Bowen Island
Vancouver
Richmond

Budget Breakdown Update with $ at risk

	Base $million)	At risk $million)	Total $million)	% at Risk
Base Funding using Resource intensity weighting	**$ 887.0**	**$ 224.0**	**$ 1,111.0**	20%
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%
PFF Program Earnings				
Emergency dept pay for performamce	$ -	$ 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/ Pharamcare	**$ 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%**

Disruptive Innovations in Health

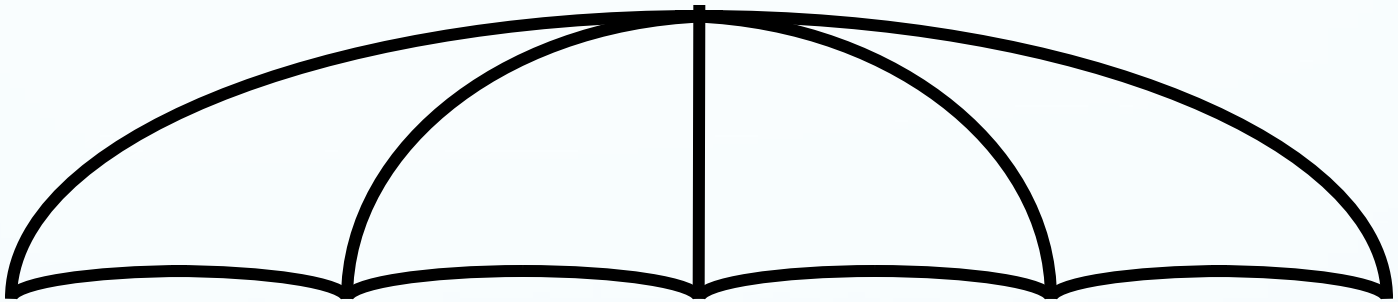
- Minimally invasive surgery
- Robotic surgery
- Advanced Imaging
- Interventional radiology
- “Personalized” medicine
- Electronic health records
- Integrated health care
- Pay for performance

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

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Effects of Pay for Performance on the Quality of Primary Care in England

Stephen M. Campbell, Ph.D., David Reeves, Ph.D., Evangelos Kontopantelis, Ph.D., Bonnie Sibbald, Ph.D., and Martin Roland, D.M.

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.

N Engl J Med 2009;361:368-78.

Table 1. Mean Clinical-Quality Scores for 42 Family Practices in 1998, 2003, 2005, and 2007.*

Variable	Mean Clinical-Quality Score			
	1998	2003	2005	2007
Clinical care				
Coronary heart disease†	58.6±1.4	76.2±1.6	85.0±1.0	84.8±1.3
Asthma	60.2±2.5	70.3±2.5	84.3±1.8	85.0±1.4
Diabetes	61.6±1.8	70.4±1.5	81.4±0.8	83.7±0.7
Patients' perceptions				
Communication with physicians	69.4±1.0	70.5±1.4	69.1±1.6	71.3±1.2
Access to care (appointment within 48 hr)				
To see a particular physician	39.0±4.3	33.3±4.0	34.4±3.9	32.1±3.2
To see any physician	67.2±3.3	61.0±3.7	63.9±3.2	64.2±3.2
Continuity of care	70.7±1.7	70.3±1.7	66.2±1.8	66.0±1.6

NEJM 361;4 July 23, 2009

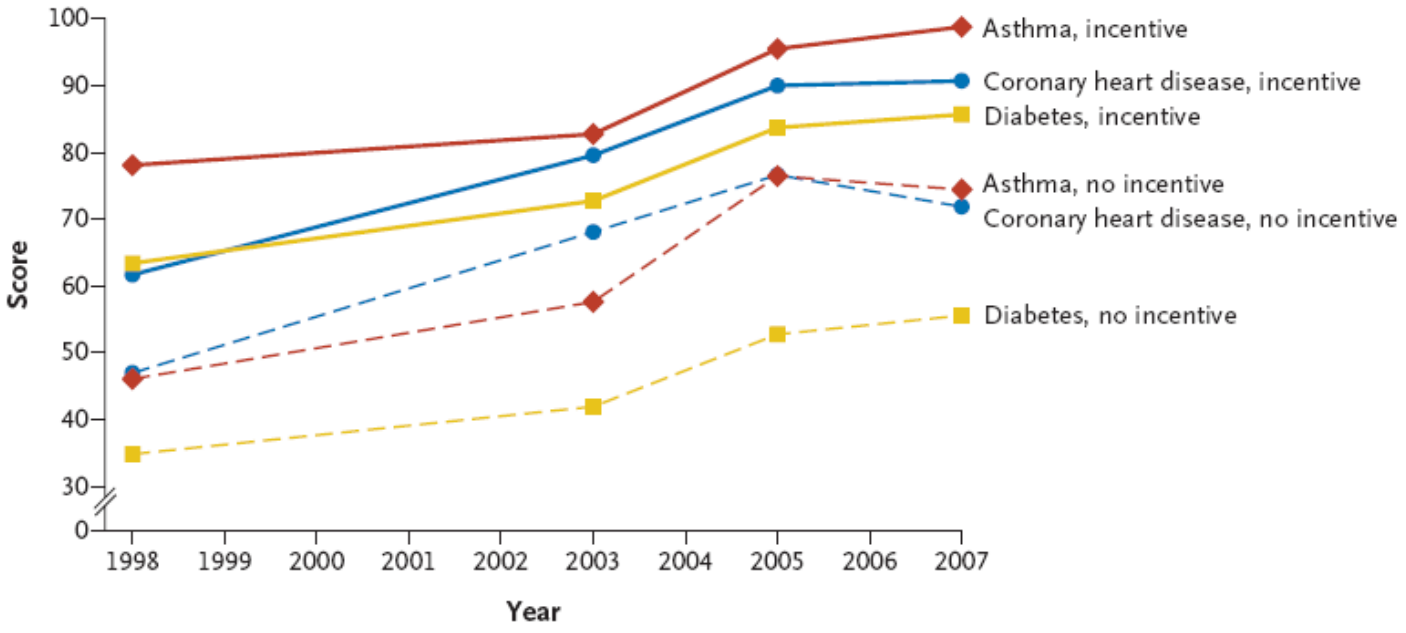


Figure 2. Mean Scores for Clinical Quality at the Practice Level for Aspects of Care for Coronary Heart Disease, Asthma, and Type 2 Diabetes That Were Linked with Incentives and Aspects of Care That Were Not Linked with Incentives, 1998–2007.

Quality scores range from 0% (no quality indicator was met for any patient) to 100% (all quality indicators were met for all patients).

NEJM 361;4 July 23, 2009

Mail Online

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

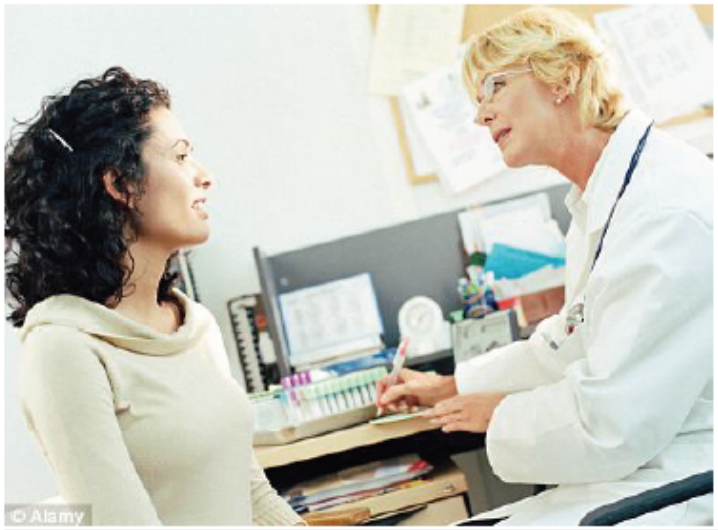
By Jenny Hope

Last updated at 1:15 PM on 26th 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.



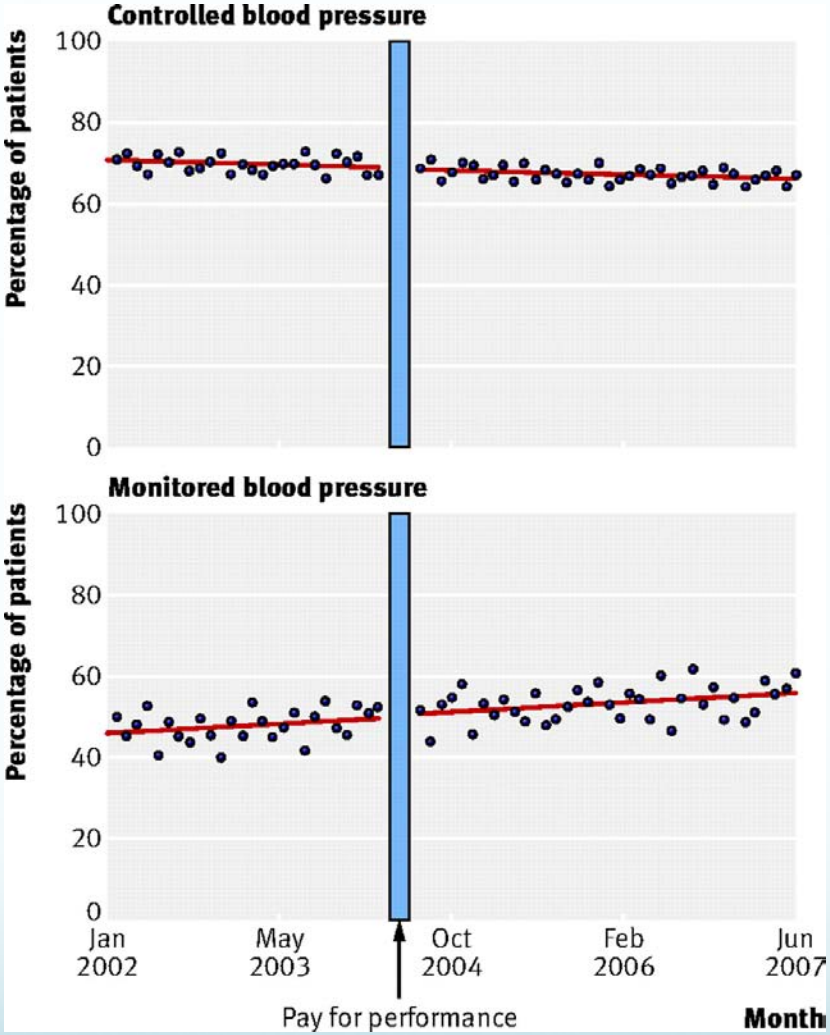
Target culture: A new report claims performance-related GP's pay offered little benefit to patients

Pay-for-performance targets were introduced by Labour in 2004 at a cost of £1.8billion 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

P4P Unintended consequences-US

- Resentment with patients who refused to adhere to advice (not UK)
- MD's by-passed informed consent to do tests
- MD felt autonomy was lost (not UK)
- Increased workload (UK= hire more nurses, US = anger)
- Targets in UK incremental, in US fixed
- Data entered by MD in UK –US had few EHRs

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!
- Is this all the Hawthorn Effect?

Serumag,Ross-Degnan, Avery et al

Effect of pay for performance on the management and outcomes of hypertension in the UK: interrupted time series study, BMJ 2011:342:d108

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

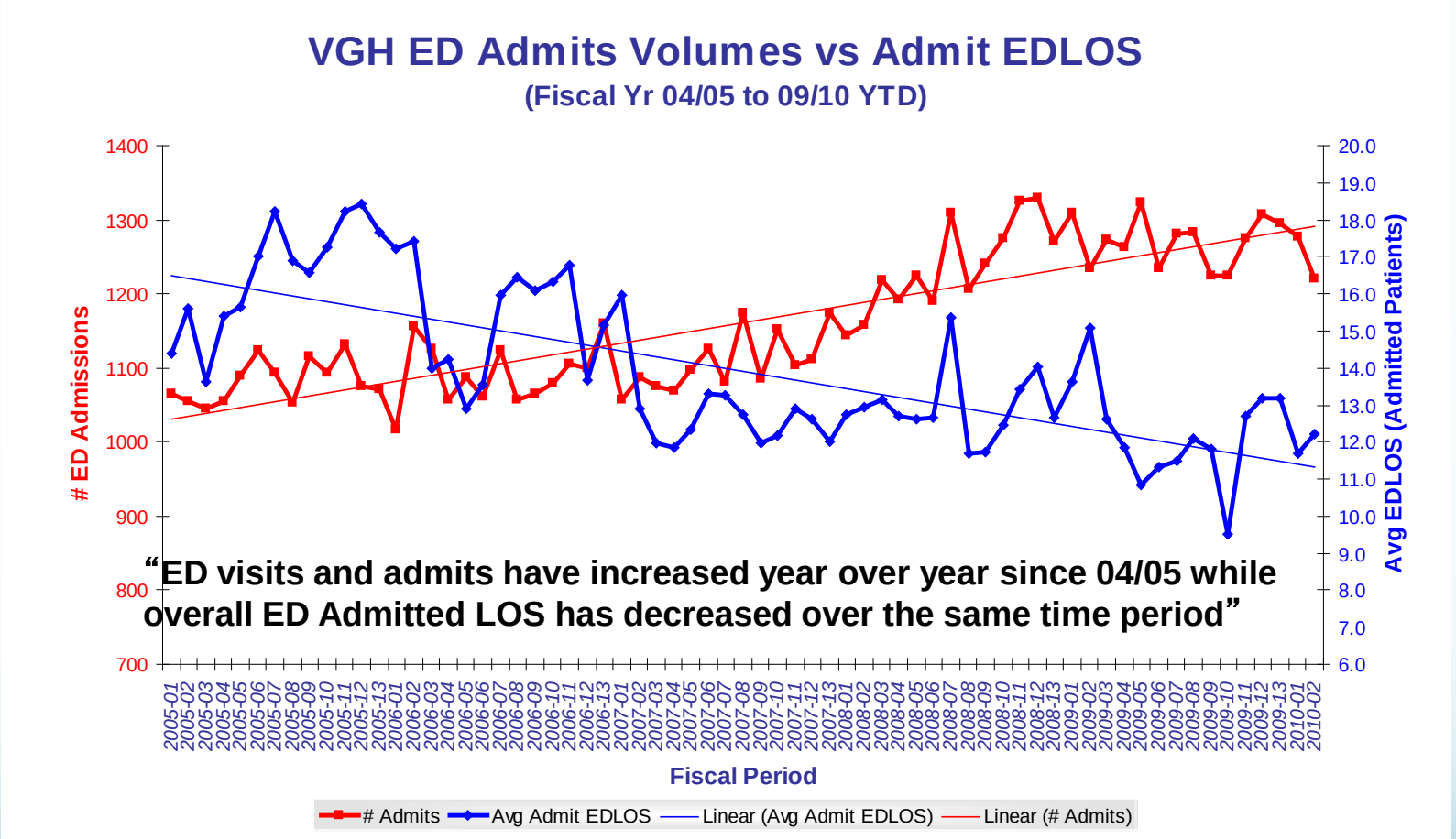
1. VCH - Success with ED P4P

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

Vancouver General Hospital
Admitted Patient ED Length of Stay
(04/05 to 09/10 YTD)



"ED visits and admits have increased year over year since 04/05 while overall ED Admitted LOS has decreased over the same time period"

Prepared by: Sheazin Premji, Director Special Projects (VA)

June 15, 2009

Source: QUIST Emergency CUBES

Flags: VGH, Admitted to Hospital, Measures: Case Count, LOS – average hours (from arrival to disposition)

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

What is a CMG?

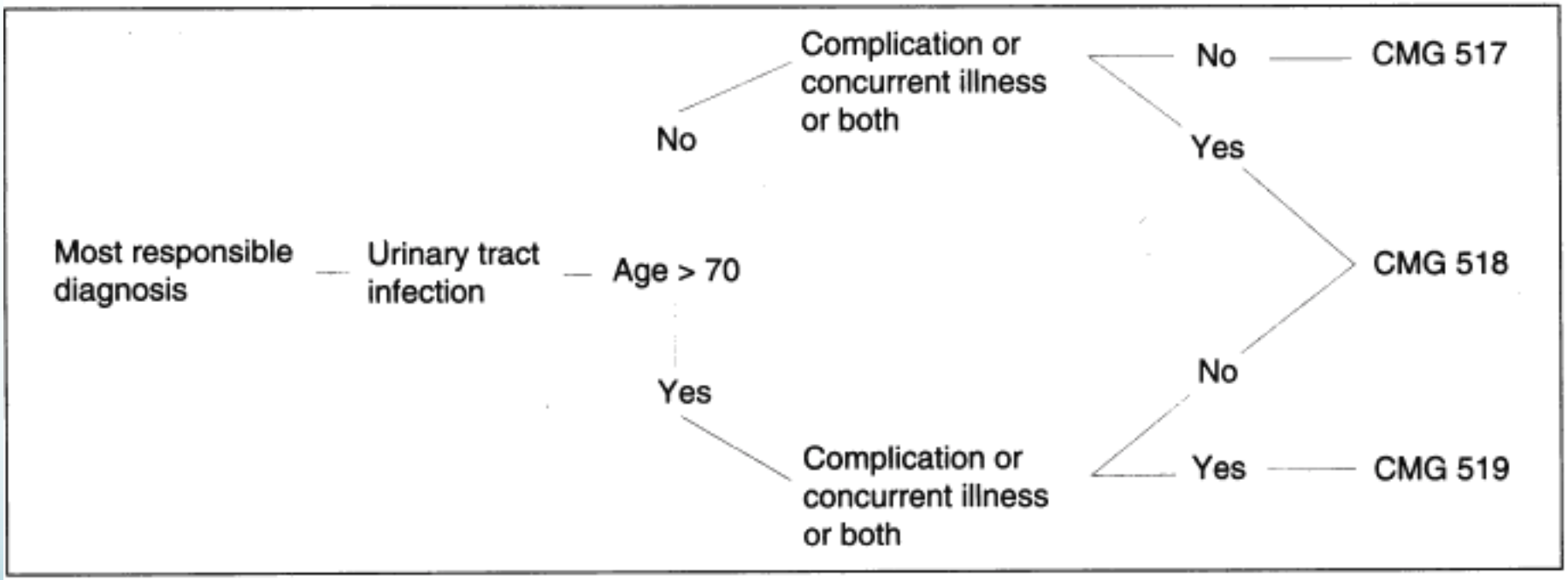


Fig. 1: Algorithm used to assign patients to a Case Mix Group (CMG) in major clinical category 11 (diseases and disorders of the kidney and urinary tract).

RIW Funding

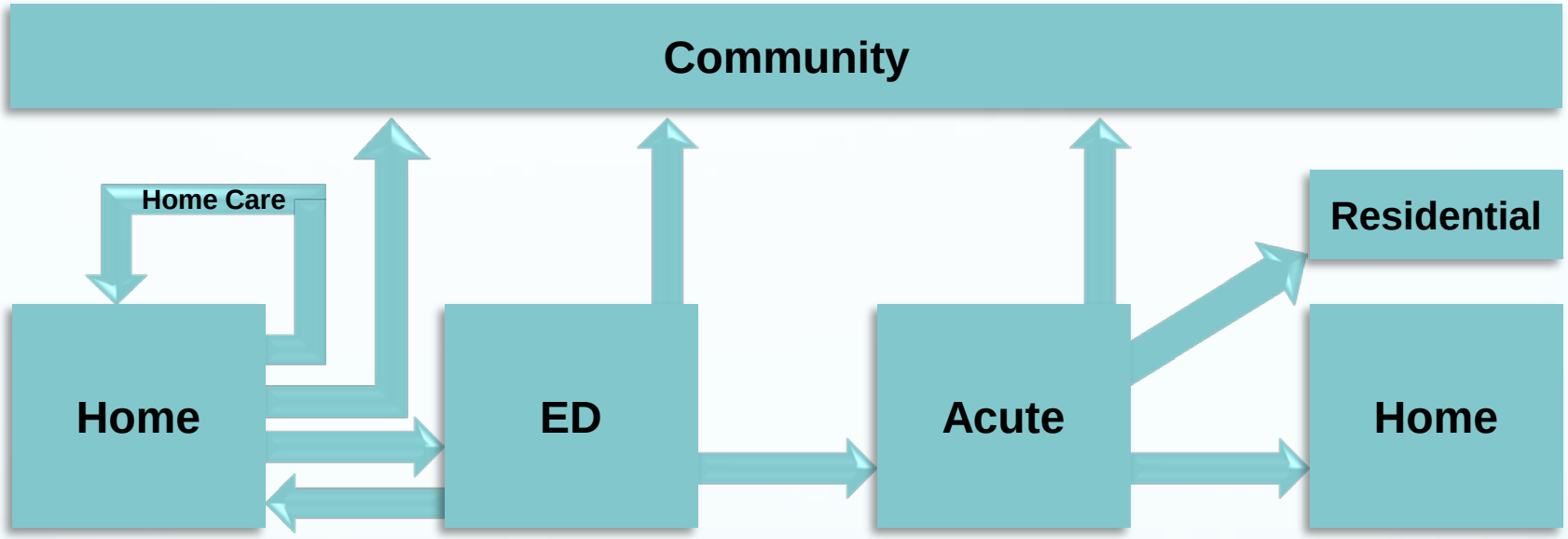
- Relates to the Case Mix Group and complexity of specific case
- Former method: “Global Funding” with new funding based upon old budget and ± %
- In an attempt to encourage:
  - More out patient surgery
  - Faster turnover of patients
- RIW for *inpatients* funded at 0.4 and *outpatients* at 1.0+
-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

VCH – Period 7 YTD
ABF $ Change from 2011/12 Baseline
ABF Facilities (Included Procedures)

($ million)	Same Day ABF $		Inpatient ABF $		Total ABF $			
	2011/12	Change from 11/12 baseline	2011/12	Change from 11/12 baseline	2011/12	Change from 11/12 baseline	2011/12 Annual Notional ABF Allocation	ABF Payable
VGH/UBC	**$ 10.33**	**$ (0.13)**	**$ 45.31**	**$ 2.26**	**$ 55.64**	**$ 2.13**	**$ -**	**$ 2.13**
PHC	**$ 8.40**	**$ 0.36**	**$ 26.59**	**$ (1.03)**	**$ 34.99**	**$ (0.67)**	**$ -**	**$ (0.67)**
LGH	**$ 4.36**	**$ 0.07**	**$ 13.67**	**$ 0.92**	**$ 18.04**	**$ 0.98**	**$ -**	**$ 0.98**
Squamish	**$ 0.56**	**$ 0.03**	**n/a**	**n/a**	**$ 0.56**	**$ 0.03**	**$ -**	**$ 0.03**
RH	**$ 2.58**	**$ 0.29**	**$ 10.10**	**$ 1.35**	**$ 12.68**	**$ 1.63**	**$ -**	**$ 1.63**
Less: MOH expected growth (unallocated)		**$ (0.18)**		**$ (0.65)**	**$ -**	**$ (0.82)**		**$ (0.82)**
Grand Total	**$ 26.23**	**$ 0.44**	**$ 95.67**	**$ 2.85**	**$121.91**	**$ 3.29**	**$ 10.10**	**$ 3.29**

Notes:
- Procedural Care Program RIWs excluded
- Unused funds in one HA can be earned by another HA subject to HSPO approval and up to the total maximum earnings available for all HAs.

3. Community Based A Systems View

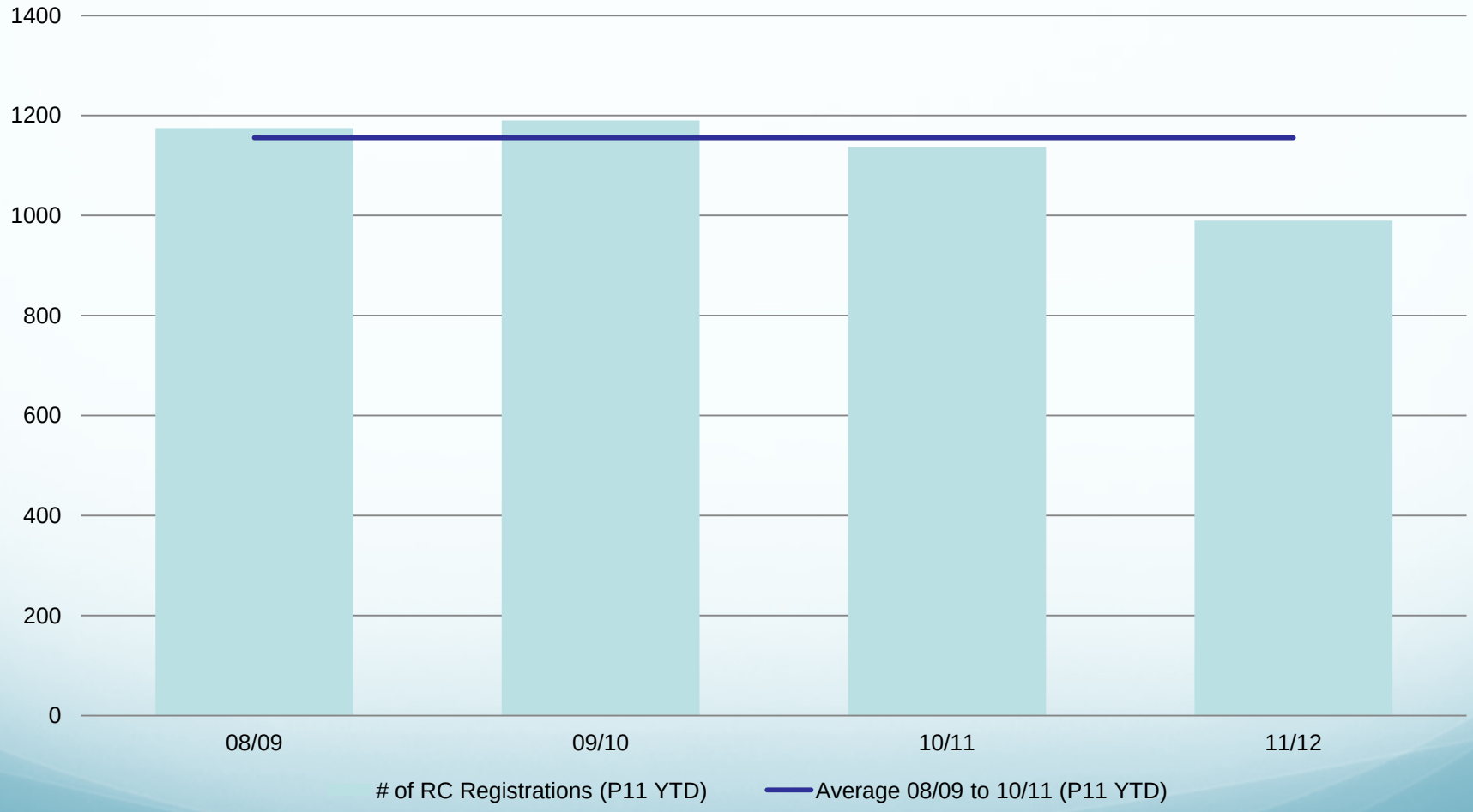


- Treat people in the most appropriate care location
- Deliver the highest quality of care
- Ensure effective use of resources
- Emphasize scalability of services

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 (eg 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

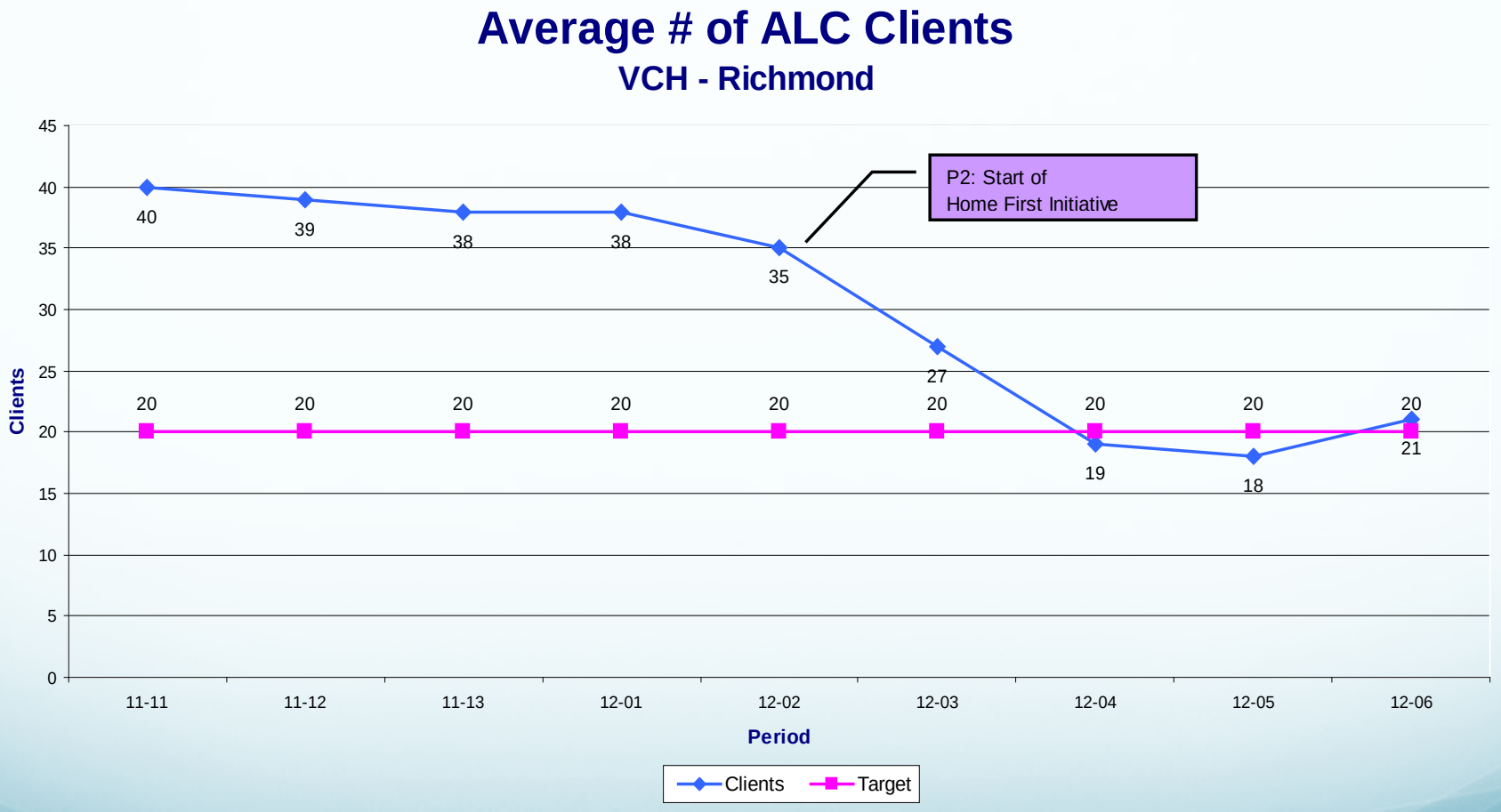
of RC Registrations (Total) by Fiscal Year (P11 YTD) Vancouver



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



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)

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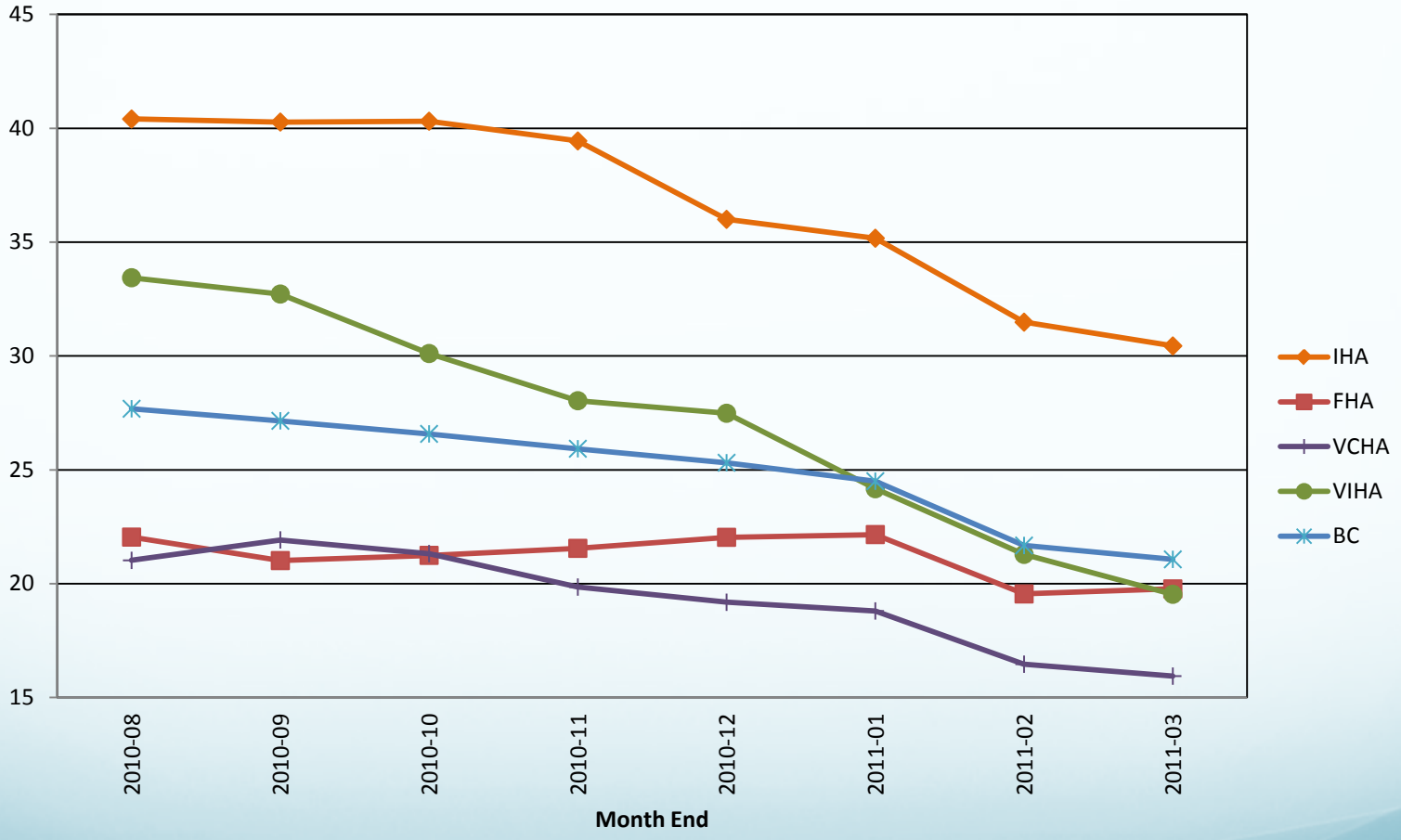
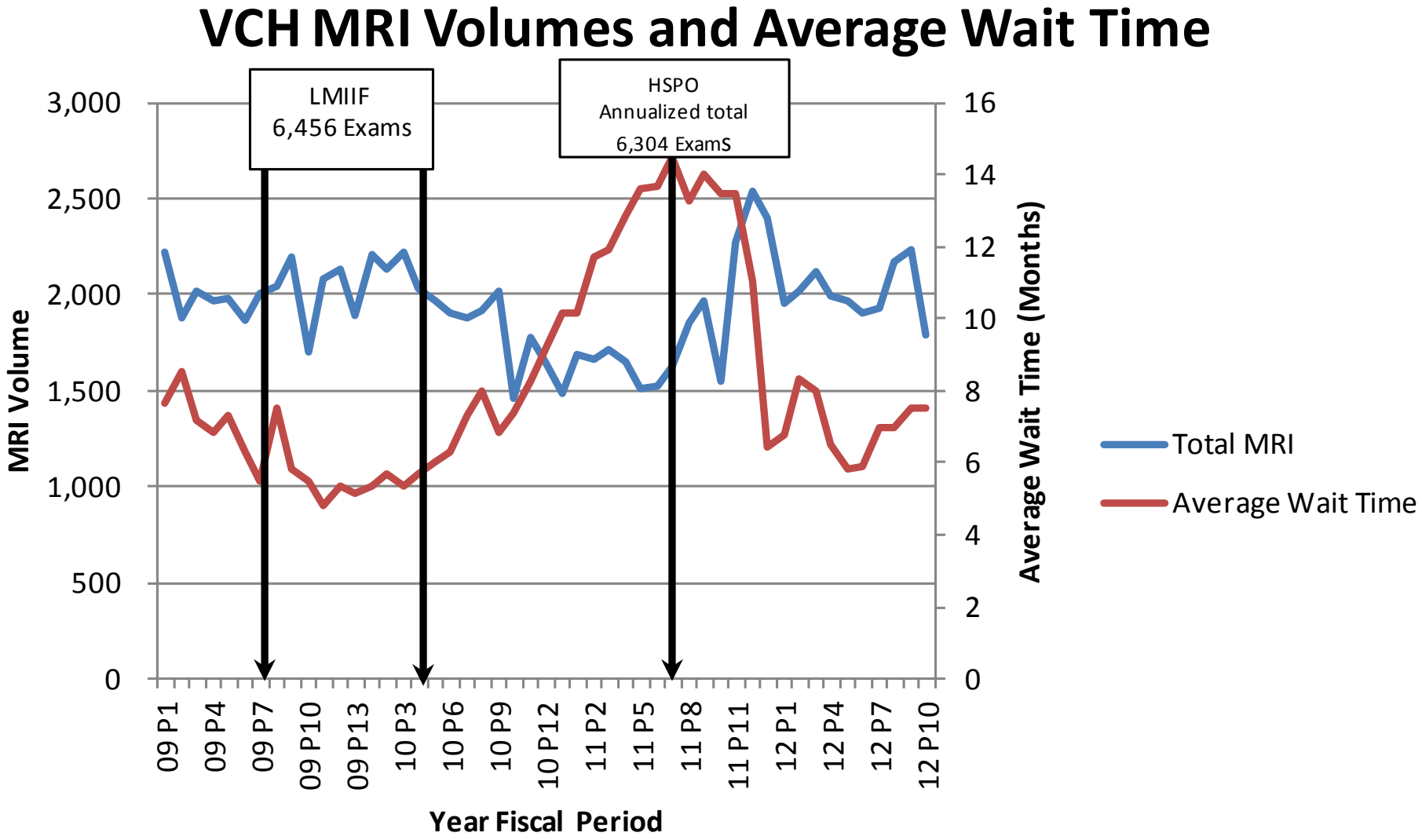
- Surgery funded at usual costs
- Other procedures funded at marginal costs (MRI)

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

Contracted Cases at Contracted Facilities



MRI Wait Times



P4P to reduce wait times: Learning

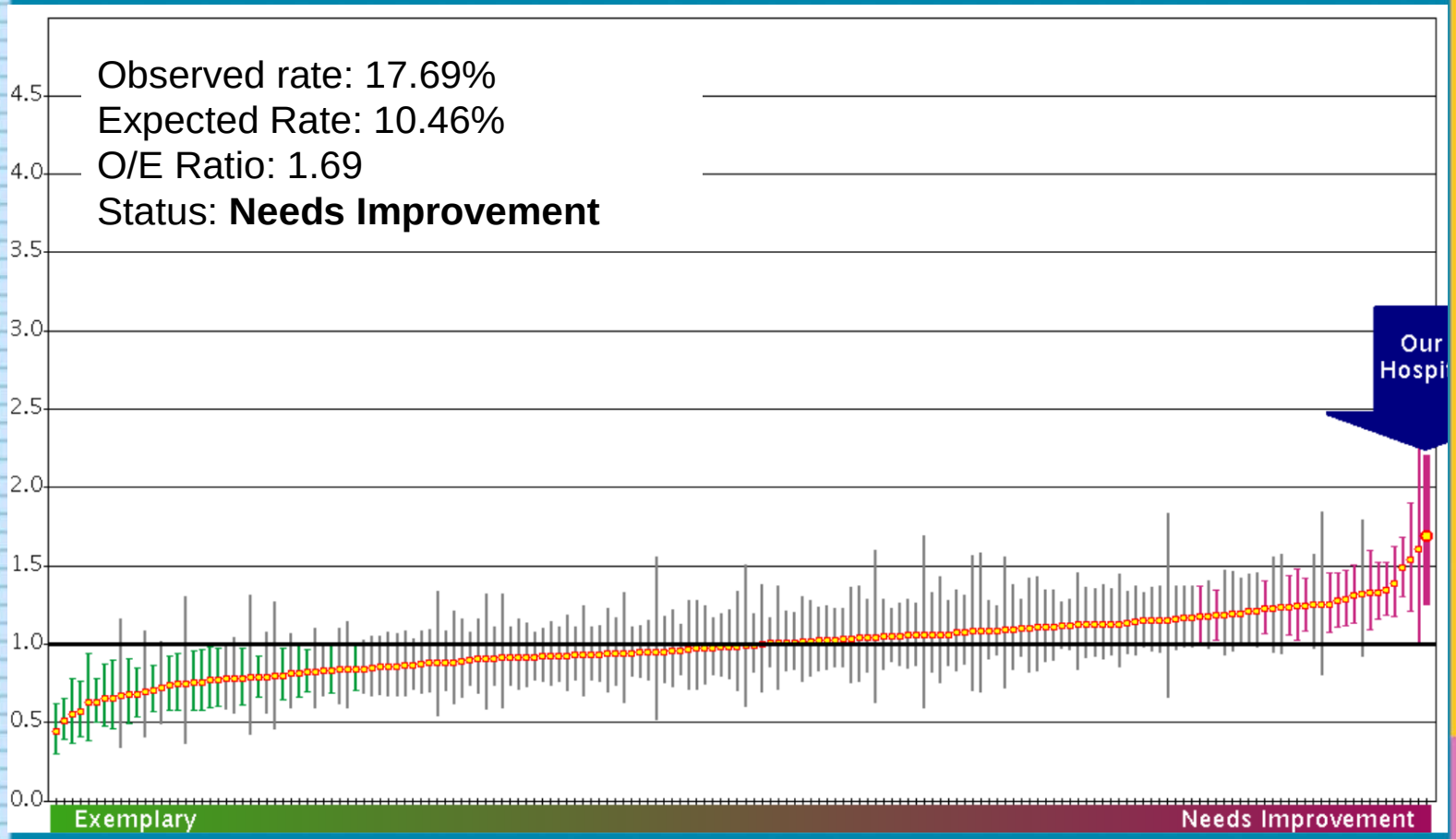
- Try to choose area where the new costs are marginal:
  - CT/MRI/Interventional Radiology (shift changes/ other efficiencies)
  - New organizational efficiencies (OR scheduling and pre/post op planning)
- **Must include the MD costs!**

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

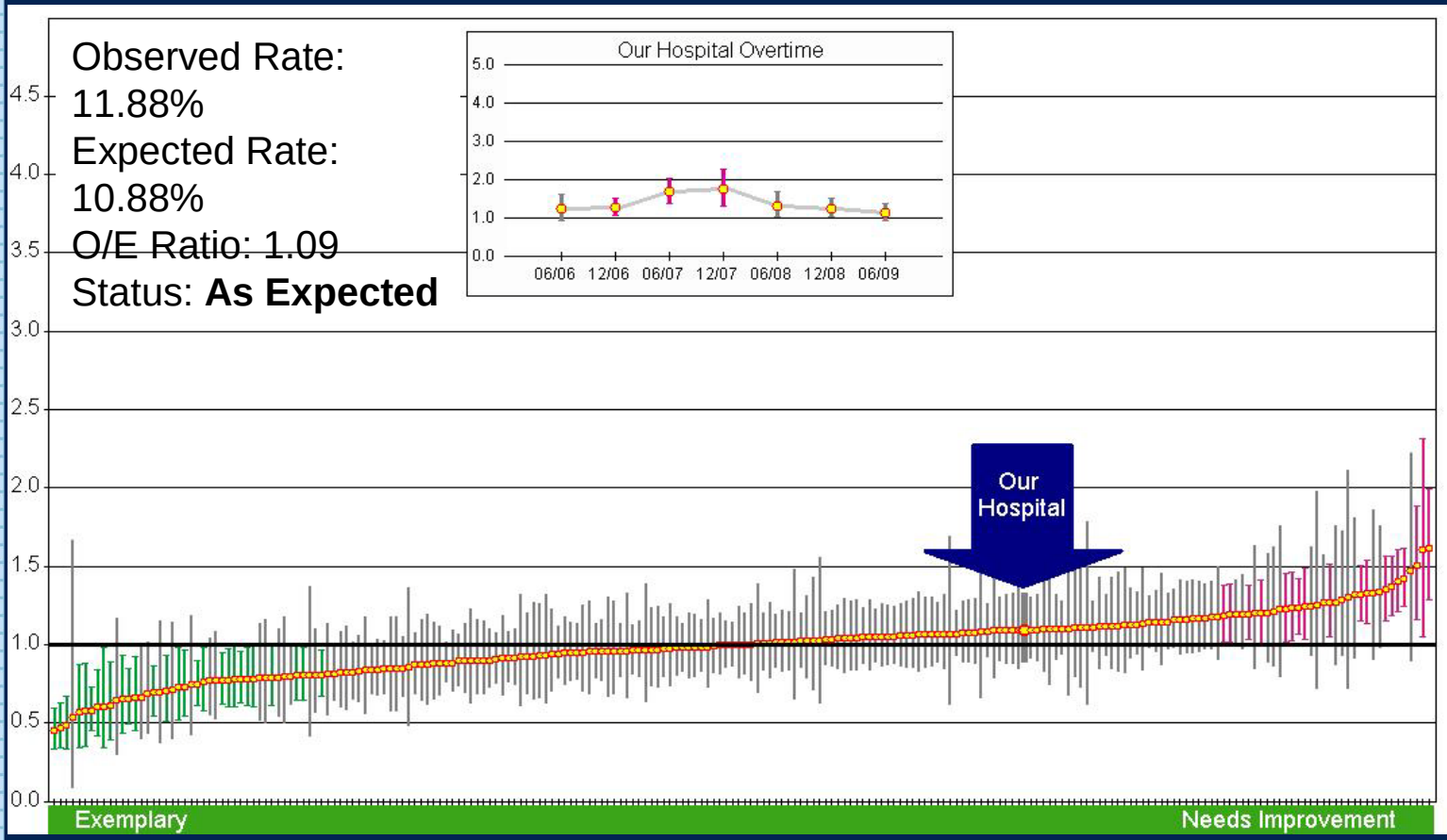


* Includes General and Vascular Surgery Cases

After

Overall* 30-Day Morbidity

ACS NSQIP



* Includes General and Vascular Surgery Cases

II. Don’t Pay for What you Don’t Want

Using negative incentives

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

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

THE GLOBE AND MAIL
TUESDAY, FEBRUARY 7, 2012

SECTION S

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.

Health, Page 2

HOMELESSNESS

Downtown Vancouver Business Improvement Association wins human-rights case

JUSTICE

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

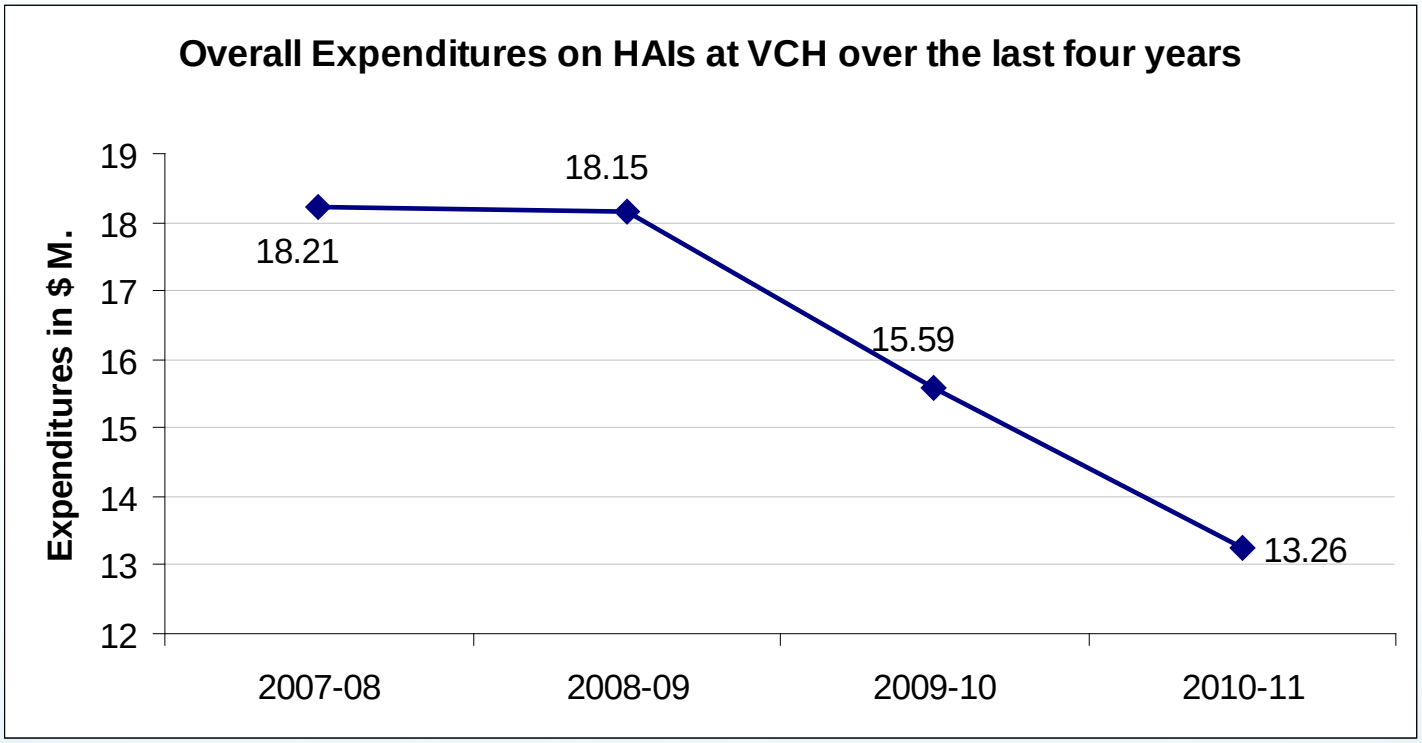
Don’t pay for what you don’t want

- Readmissions:
  - Mental Health Patients
  - Surgical patients
  - Medical Patients
- MRSA Infections/Hand washing
- C. difficile infections
- Urinary tract infections

Mental Health and Addictions Readmissions

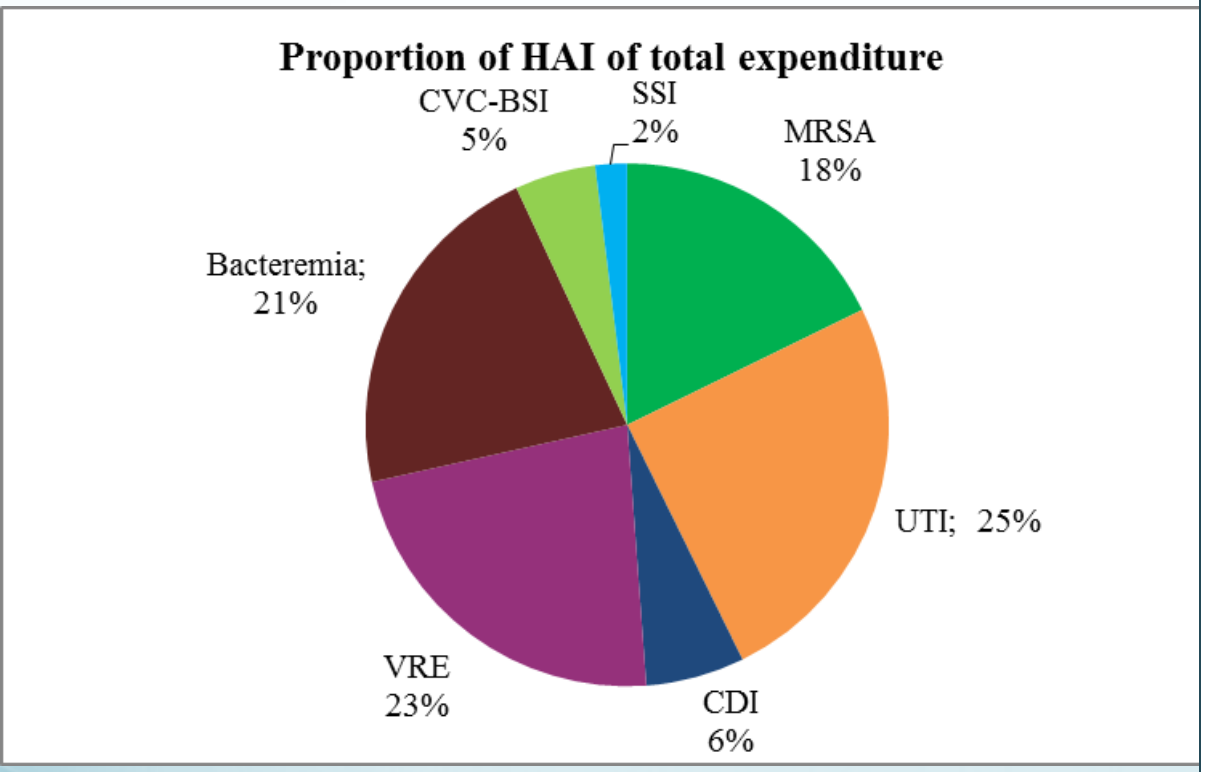
- Indicators:30 day mental health readmission
- Benchmark: CIHI: 11.4/100,000
- VCH 15.7/100,000
- VCH excess=4.3/100,000 x 10 = 43 cases
- Cost/readmission= LOS x $/day = 13 x 736 = $9,568
- Total cost = $ 411,424
- Etc. for surgery and medical readmissions

Cost Evaluation



VCH spent more than $ 65.2 M for the treatment of the **selected** HAIs over the last 4 years

Proportion



- UTI, Bacteremias and VRE are the main cost drivers and responsible for almost 70% of costs concerning HAIs

UTI Cost-Analysis

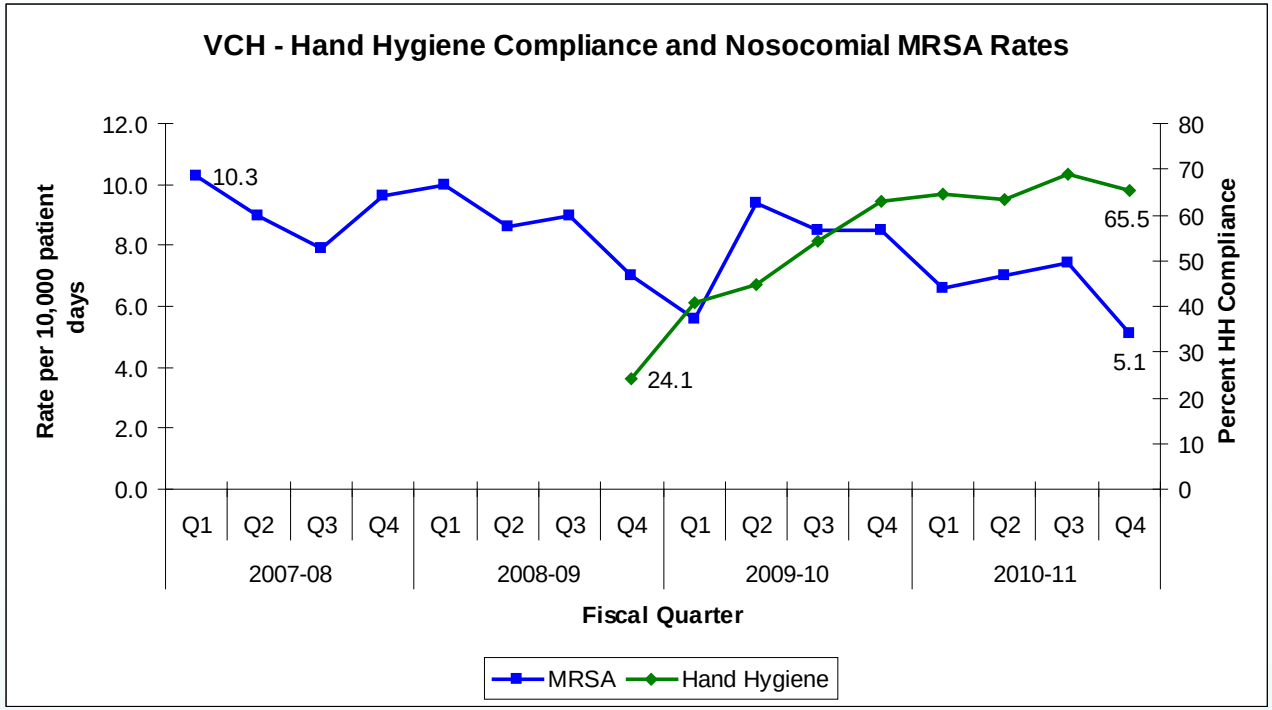
Year	Number of Infections	Cost spent for UTI at VCH (VGH, RH, LGH)*	
		Low Cost	High Cost
2006/07	9,600	$ 8,275,200	$ 9,667,200
2007/08	6,600	$ 5,689,200	$ 6,646,200
2008/09	6,000	$ 5,172,000	$ 6,042,000
2009/10	4,000	$ 3,448,000	$ 4,028,000
2010/11	2,300	$ 1,982,600	$ 2,316,100
Total Costs/Savings VCH (VGH, LGH, RH)	**28,500**	**$24,567,000**	**$28,699,500**

* Costs are based on Zoutman study

UTI at VCH

- Average LOS = 16.74 days
- Expected LOS = 11.82 days
- **Extended LOS = 4.93 days**

MRSA and Hand Hygiene



Further research is necessary to prove and evaluate the impact of HH on a reduction of infection rates

Decision Making in a Democracy

- Take “impossible” decisions out of hands of politicians

- Four Year Cycle leads to emasculation of politicians and the decision making process

“Economist Don Drummond has accomplished what government could never do**: <u>Lay out all the province’s economic options</u>”**

Globe and Mail Feb 16 2012

You can take a horse to water but can you make it drink?

Patient Focused Funding
Period 7 YTD Earnings Summary for VCH

($ million)	Procedural Care Program	Community Programs[2]	ED P4P funded by HSPO (New Floor)	Total HSPO Funding
Vancouver	0.717	0.354	2.560	3.631
PHC	1.305		1.625	2.930
Coastal	1.352	0.114	0.912	2.378
Richmond	0.750	0.084	0.728	1.562
MRI (P6 YTD)	1.221			1.221
Regional		0.005		0.005
NSQIP[1]	0.996			0.996
Total VCH	$ 6.342	$ 0.557	$ 5.825	$ 12.723
Annual contract	$ 14.63	$ 11.56		

[1] **NSQIP** - National Surgical Quality Improvement Program

[2] **Community Programs** (incl. start up funds)