JPPC News
JOINT POLICY AND PLANNING COMMITTEE

The JPPC PARTNERSHIP: Refocusing Hospital Reform

Our Background

Ontario has a history and tradition of collaboration and consultation among key stakeholders in the health care industry. Increasing financial constraints facing the hospital sector have, however, at various times, threatened to undermine this historical approach. It was within this context that the Joint Policy and Planning Committee (JPPC) was conceived in 1992.

The JPPC was formed as a partnership between the Ontario Ministry of Health (MoH) and Ontario's hospitals, through the Ontario Hospital Association (OHA) with the specific mandate to recommend and facilitate the implementation of hospital reform in Ontario. This alliance has fostered a participatory and consensus-building environment, leading to improved decision-making between the stakeholders. This has proven to be a key strength of the JPPC and the organization has emerged as a dynamic force within the hospital reform process.

Our Approach

The JPPC partnership is especially valuable in recommending and implementing policy direction because it provides a forum for hospitals, through the OHA, and the MoH to share perspectives on health care. Beyond its specific objectives, the JPPC partnership has been forged to:

- foster a cooperative environment between hospitals and the MoH to assist the MoH in making decisions for the hospital system which ensure high quality health care for the people of Ontario;
- support and assist in defining the evolving role of hospitals within a reformed and restructured health care system;
- contribute to an orderly and systematic shift in direction and development of policy to influence reform in the hospital sector within a broader health care system; and
- establish processes whereby stakeholders can be brought together to contribute to a sound policy framework for the institutional health care system.

Our Objectives

The JPPC strives to meet the following objectives through its work:

- to define the role of hospitals in a reformed health care system;
- to recommend hospital funding that promotes effectiveness, efficiency, and equity among hospitals;
- to provide input with respect to policies and methods to implement health care reform;
- to assist in the development and implementation of provincial standards for hospital information; and
- to assist hospitals to effectively use information for internal management purposes.

Recent Accomplishments

Several initiatives were completed during the past year to fulfill our mandate and meet our objectives, as noted in the following list of JPPC reports distributed to hospitals and other stakeholders:

- Replacing Peer Groups with Adjustment Factors
- Methodology Used to Calculate 1996/97 Transfer Payments to Ontario Hospitals
- Day Surgery Incentive Model
- Revised 1994/95 Day Surgery Incentive Model
- Improving Patient Classification Systems in Psychiatry

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- Evaluation of CIHI's Psychiatric CMG'sTM
- Moving Toward Classification of Chronic Care Patients in Ontario
- The Selection of an Emergency Patient Classification System
- Proposal for the Implementation of Non-Financial Data Audits in Ontario Hospitals
- MIS Guidelines Implementation: Information for all Hospitals
- Ontario Hospital Reporting System User's Guide: Version 2
- Methodological Improvements in the Calculation of Hospital Referral Population and Utilization Rates
- Advice to Government on the Transformation of the Ontario Health Care System
- How-do-you Compare: A Resource Manual for all Ontario Hospitals
  - i Moving to Outpatient Surgery
  - ii Reducing Length of Stay
  - iii Moving to Ambulatory Care
- Navigating Through Unchartered Waters: A Guidebook for Human Resource Planning for Restructuring Hospitals
- A Collaborative Clinical Improvement Project: Tonsillectomy and/or Adnoidectomy Surgery
- Evaluation of the Effectiveness of the JPPC

The Value of the Partnership

The value of the JPPC process has been reaffirmed by the findings and results of the *"Evaluation of the Effectiveness of the JPPC"*. The Evaluation, completed in March, 1995, confirmed the appropriateness of the role and mandate of the JPPC and recommended that the partnership continue. At the same time, it was noted that in order for the JPPC to realize its fullest mandate, it will be necessary to broaden and balance its agenda to include an emphasis on the future role of hospitals in a reformed and integrated health care delivery and funding system.

The Commitment to the Partnership

Commitment to the JPPC partnership has been demonstrated by both partners and endorsed by the JPPC Senior Committee through an extension of the existing JPPC mandate beyond the original three-year sunset clause. There is also a shared financial commitment and contribution by both partners to support the operation of the JPPC.

Hospitals are also committed to the JPPC process, as evidenced by their positive feedback in the JPPC Evaluation, their active and extensive involvement on JPPC committees, and their participation at JPPC Regional Sessions. Currently, approximately 300 individuals, including stakeholders from throughout the health care industry, are involved in a voluntary basis on its committee and other activities.

Current Strategic Directions

To continue to fulfill its mandate, the JPPC has refocused on two interrelated strategic priorities to further hospital reform: **hospital funding and hospital restructuring.**

Hospital funding initiatives will focus on the following:

- funding for hospitals in high growth areas *(the article on page 5 provides more details on the work being done in this area);*
- funding that is sensitive to small hospitals;
- refining the Adjustment Factors Model with potential incorporation of additional factors;
- refining the current funding methodology
- extending funding to all hospital activity and integrating current funding initiatives. *(refer to page 5 for information on Responsive Global Funding);*
- improving data quality;
- assessing the financial implications of hospital restructuring; and
- developing a fiscal funding approach to meet hospital funding targets for 1997/98 and 1998/99

Hospital restructuring initiatives will focus on improving the management of hospitals within an evolving health care system, including:

- identification and prioritization of key issues in the implementation of hospital restructuring;
- development of tools to assist hospitals in improving their utilization management;
- provision of information, tools, and advice to hospitals regarding restructuring within the hospital system; and
- a longer term objective of facilitating the integration of hospitals into a reformed health care system.

Joint hospital funding and hospital restructuring initiatives will include the identification of strategies to meet fiscal targets defined by hospital funding and the assessment of the magnitude of savings resulting from hospital restructuring.

The JPPC will also continue to support the implementation of the **Management Information Systems (MIS) Project**, to coordinate the consistent collection of high quality, comparable data integral to evidenced-based decision-making in hospital funding, restructuring and management. Liaison with the Ontario Case Costing Project (OCCP) and the use of case cost data will be integral to this undertaking. *Refer to page 3 for the article on Ontario Case Cost Data.* ❑

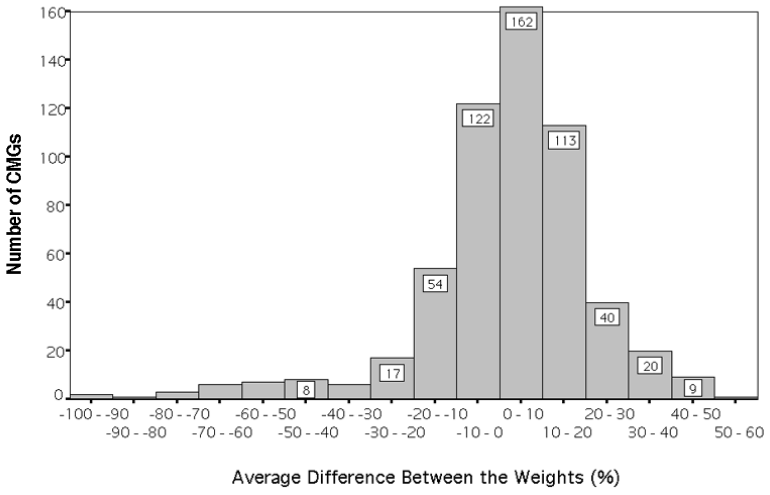
HOW DOES THE RIW COMPARE TO THE ONTARIO CASE COST DATA?

A critical component of Equity Funding, Reallocation and Responsive Global Funding (formerly called Rate Based Funding) is the Ontario Case Weight or OCW. The OCW for typical cases is based on the Resource Intensity Weight or RIW, which is developed and maintained by the Canadian Institute for Health Information (CIHI). The RIW is currently based on a hospital charge database from the state of Maryland and is recalculated annually using new data - the most recent funding reallocation for 1996/97 used the 1994 RIW. CIHI's RIW National Advisory Group is currently working towards incorporating Canadian cost data (including OCCP data) in the RIW calculation.

Using the full year of patient cost data collected from eleven Ontario hospitals, the OCCP developed a set of case weights based on the RIW case weighting methodology. A comparison of the Maryland-based RIWs and the Ontario hospital-based OCCP weights was performed. This comparison yielded interesting results, some of which are provided in this article.

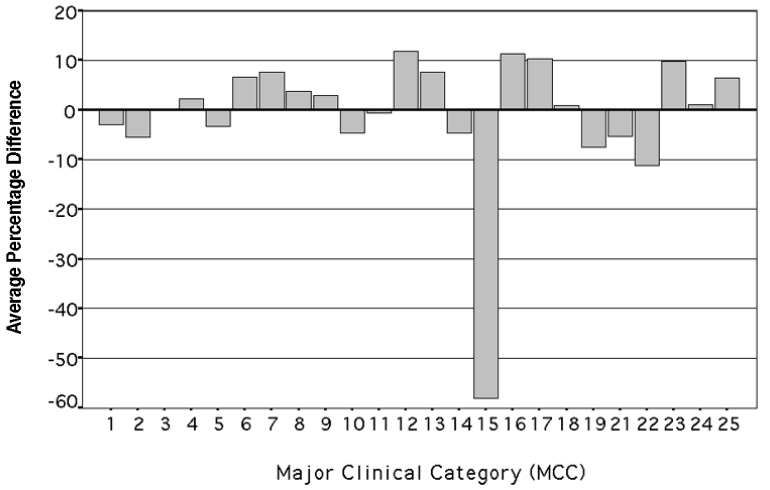
For the majority of CMGs, the percentage difference between the RIW and the OCCP Weight is within 20%. There are, however, a significant number of CMGs where the discrepancy is much more pronounced - up to 100%. Figure 1 shows the distribution (or scope) of the difference between the two sets of weights. Note that a negative percentage difference indicates the RIW is lower than the OCCP Weight (or the CMG is undervalued by the RIW) while a positive percentage difference indicates the RIW is higher than the OCCP weight (or the CMG is overvalued by the RIW). For example, there are 122 CMGs for which the RIW is *lower* than the OCCP Weight by 0 to 10%.

Fig. 1: Case Weight Difference by CMG (RIW vs. OCCP Weights)



Examining the differences by Major Clinical Category (MCC) reveals certain patterns in the discrepancies. Figure 2 shows the average percentage difference for all the CMGs within each MCC. MCCs group CMGs according to body system or function. There are 13 MCCs where the RIW is overvalued relative to the OCCP Weight (represented by a positive difference) and 10 MCCs where the RIW is undervalued (represented by a negative difference). Most differences are within plus or minus 10%. MCC 15 (New-borns) stands out with an average difference of -58% indicating that the RIWs are considerably undervalued for neonatal cases. The neonatal adjustment developed by the JPPC's Adjustment Factors Sub-Committee and applied in the 1996/97 funding reallocation is aimed at compensating for this problem.

Fig. 2: Case Weight Difference by MCC (RIW vs. OCCP Weights)



Further investigations reveal patterns in the differences between Medical and Surgical CMGs. The CMGs in each MCC were categorized as Medical or Surgical. Figure 3 shows the results of the

Comparison *...continued on page 4*

Comparison ...continued from page 3

comparison for the first 13 MCCs (the rest show the same patterns). In 12 of the 13 MCCs, the Surgical CMGs are undervalued relative to the Medical CMGs. In fact, in nine of the MCCs, the Surgical CMGs have a negative weight difference (the RIW is lower than the OCCP weight) while the Medical CMGs have a positive variance (the RIW is higher than the OCCP weight). The results clearly indicate discrepancies in the relative weighting of medical and surgical cases in the RIW vs. the OCCP weights.

An aggregated analysis shows that Medical C M G s are actually overvalued. In this analysis, CMGs are grouped into four categories: Medical, Surgical, Neonatal and Maternal. The overall average difference between the RIW and OCCP Weights is calculated for each category. The box plots in Figure 4 show the results of this analysis. Box plots are useful because they show the median, the dispersion and the distribution shape of the data. The box represents the middle 50% of the observations, the top and bottom whiskers indicate the range and the horizontal line in the box is the median. Interestingly, for both Maternal and Surgical cases, there are an equal number of overvalued and undervalued CMGs (median is near 0). For Medical cases, however, a majority of CMGs *are overvalued* by the RIW relative to the OCCP weight. Neonates are vastly undervalued as was observed in Figure 2

Patterns in the weight discrepancies have been found between Tertiary, Secondary and Primary CMGs. CMGs, for this analysis, are aggregated by the level of care as per the methodology used by the JPPC's Adjustment Factors Sub-committee. CMGs are assigned as Primary, Secondary or Tertiary depending on their RIW, the number of hospitals treating the CMG, and the percentage inflow of cases for that CMG into Metro Toronto. Figure 5 provides the results of the comparison. The majority of Primary and Secondary CMGs are overvalued by the RIW relative to the OCCP Weight while the majority of Tertiary CMGs (around 70%) are undervalued by the RIW. The tertiary adjustment developed by the JPPC group is aimed at compensating for this.

The use of Ontario Case Cost data in developing future funding weights would alleviate many of the problems identified here. This is because the OCCP data provides a better estimate of Ontario hospital costs than other available databases. The robustness of the OCCP database is being enhanced further as more data is collected from the 35 Ontario hospitals participating in the Project. ❑

Fig. 3: Case Weight Difference by MCC (RIW vs. OCCP Weights)

By Medical and Surgical CMGs

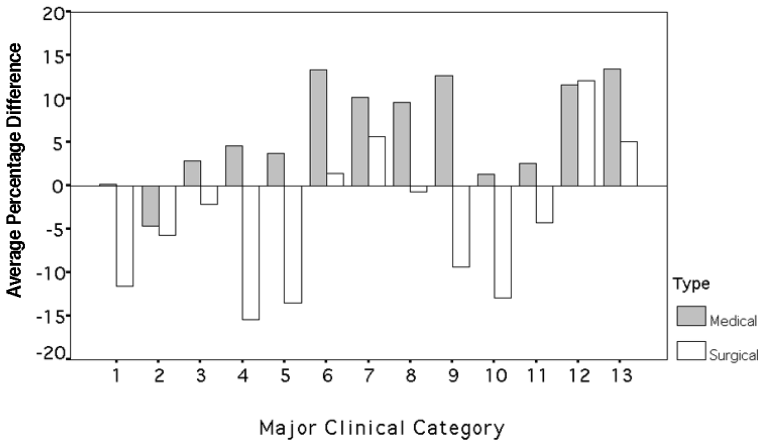


Fig.4: Case Weight Difference by Case Type

(RIW vs. OCCP Weights)

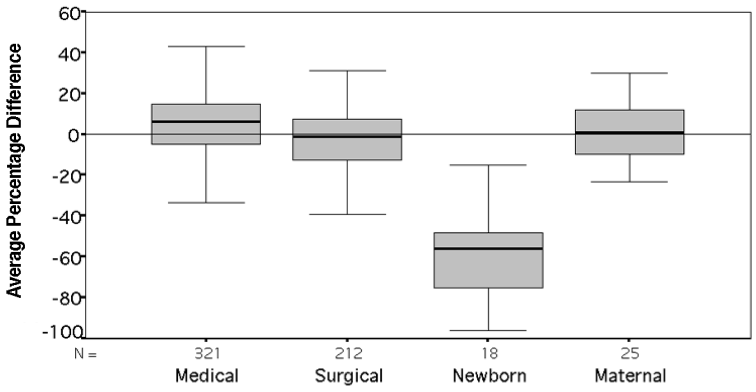
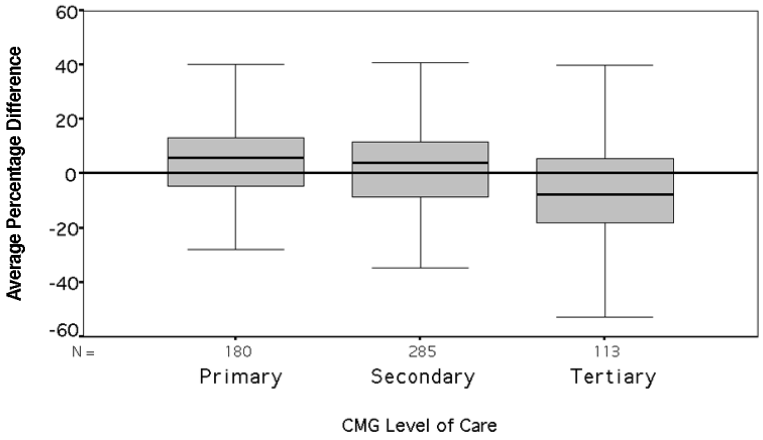


Fig. 5: Case Weight Difference by Level of Care

(RIW vs. OCCP Weights)



ALLOCATION OF $ 25 MILLION
Service Protection Fund for Hospitals in Areas of High Population Growth

In February, 1996, the Ministry of Health (MoH) asked the JPPC to provide recommendations for equitably allocating $ 25 million to hospitals located in areas of high population growth. The $ 25 million was available on a one-time basis for 1996/97. The JPPC established the Growth Funding Working Group (GFWG) under the direction of the Hospital Funding Committee (HFC) to carry out this mandate within a one-month period.

The GFWG considered several approaches to accomplish this task, including; a submission approach, whereby hospitals would submit proposals for the use of funds within their facilities, pro-rata methodologies, such as the one selected, and the model presented by the Greater Toronto Area (GTA) Hospitals.

Given the time limitations and the fact that this was a one time funding exercise, the group agreed that the methodology would have to be simple. The approach taken involved three steps; (i) identification of data to determine 'high growth hospitals', (ii) analysis to identify high growth hospitals, (iii) allocation of the $ 25 million among the high growth hospitals.

In step (i), the Expected Stay Index (ESI) Referral Population was selected as a means to identify 'high growth'. In step (ii), when growth in ESI Referral Population from 1994 to 1999 for all Ontario hospitals was plotted on a graph, two distinct groupings of hospitals stood out. The 18 hospitals in these two groupings were recognized as "high growth" and therefore selected for funding assistance. Most of these were 905 hospitals, however, one was from the 613 and another from the 519 area codes.

The total dollar amounts allocated to each hospital was based on the relative size of the ESI Referral Population served as well as the relative rate of growth of that population. Screens were also applied to ensure that (i) hospitals did not receive more money than their initial 1996/97 funding reduction and (ii) high cost/inefficient hospitals did not receive acute inpatient and day surgery relief greater than 5.46% (under the 1996/97 funding methodology, hospitals received a 5.46% reduction if their expected cost per weighted case (CPWC) was equal to their actual CPWC.

The one time methodology to allocate $ 25 million in one-time funding is the first phase of the GFWG's work plan. The group has agreed that a more comprehensive approach is needed to incorporate a population growth component into emerging funding methodologies.

A more detailed description of this methodology was sent to all hospitals and DHCs in early May. If you have any specific questions about the methodology, please contact ***Natalie Rashkovan**, Technical Planning Consultant, JPPC, at ext. 4058*. ❑

WHAT'S IN A NAME? RESPONSIVE GLOBAL FUNDING
Ontario's Methodology to Fund Hospitals

In the Fall 1995 issue of JPPC News, an article was written about Rate-Based Funding and common misconceptions. From the suggestions we received concerning potential name changes, it was decided that the name, *Responsive Global Funding*, provided a truer description of this funding tool.

The Responsive Global Funding tool would consider hospitals' case mix volumes and prospectively developed funding rates to determine hospital global budgets that are responsive to the service needs of the hospitals' referral populations. Funding would also be more responsive to changes in technology, medical practice, and to the size of the hospital vote.

The rest of the article will discuss commonly asked questions pertaining to Responsive Global Funding (RGF).

Will hospitals align their programs to maximize their funding under RGF?

RGF will not answer questions pertaining to program planning or funding policy guidelines. For example, the tool will not be used to determine which hospitals should perform which services. This decision needs to be made by the purchaser (i.e. MoH) through consultation with providers (i.e. hospitals). RGF will also not answer funding policy questions, such as whether a hospital's ability to generate non-MoH revenues should be considered in determining a hospital's MoH allocation. Decisions on revenue policy also need to be made by the

What's in a name *...cont'd on page 6*

What's in a name *...continued from page 5*

purchaser. RGF will, however, allow the MoH to implement and operationalize program planning and funding policy once decisions have been made.

Will RGF impede or encourage hospital restructuring initiatives?

RGF can be used to facilitate current restructuring initiatives. Once the decision has been made regarding program shifts between hospitals, a mechanism will be needed to determine the appropriate adjustments to hospital budgets. RGF provides a basis to make these adjustments in a rational and equitable manner since it considers both the volume and mix of services a hospital provides.

Will RGF allow for the integration of health care services or would it serve as a barrier?

An integrated health services delivery system is a customer focused network of health care organizations that are fiscally accountable for the health outcomes of a defined population. Within this integrated health system a rational funding mechanism is still required to distribute funding to hospitals that provide acute medical services. RGF provides a basis to make these allocations in an equitable manner.

Will RGF be responsive to small and rural hospitals that have a high percentage of fixed costs?

Rural hospitals are often obligated to provide a minimum level of services to maintain accessibility to care. As a result, these hospitals have less opportunities to rationalize services. If this lack of flexibility is deemed to have a material impact on a hospital's operating costs, adjustments to account for this could easily be incorporated into the funding rates. RGF could also be designed to be sensitive to minimum threshold levels of funding which would be set at a hospital's level of fixed costs.

There are many more questions which could potentially be discussed, particularly in relation to the setting of funding rates and service volume corridors. It is important, however, that the ability of the current funding system to address these issues be assessed and compared to that of RGF. RGF represents an improvement to the current funding system. At the very least, by making hospital service levels and funding rates more explicit, both the purchaser and providers will understand the rational behind the current distribution of hospital funding. This in turn would increase the accountability of both parties to ensure that the funding and provision of hospital services is consistent with the health needs of all Ontarians. ❑

A Vision FOR THE FUTURE

While the JPPC focuses on hospital reform, the context for this focus is the broader health care reform process. It is anticipated that this process will increasingly stress and promote the integration of health services, ultimately resulting in an evolutionary redesign of the health care system. Within this context, the JPPC can play a key role by:

Acting as a catalyst for change by facilitating the articulation of a strategic direction and vision for an integrated health services delivery system.

Providing a forum to discuss, test, evaluate, and operationalize the changing role of hospitals.

Identifying the opportunities for and barriers to hospitals in participating as part of an integrated health services delivery system.

Educating hospital leaders on the changing role and management of hospitals within the context of an integrated health services delivery system.

Assisting hospitals in improving internal and systemic operating efficiencies by contributing to the planning, management, and monitoring of the hospital system.

Providing recommendations to the Ministry of Health on legislation and policy development through research and analysis, testing, and evaluation.

JPPC News

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