JPPC News
JOINT POLICY AND PLANNING COMMITTEE

THE NON ACUTE HOSPITALIZATION PROJECT

The Non-Acute Hospitalization Project is, perhaps, the most ambitious project of the JPPC Utilization Management Sub-Committee. The project is co-sponsored by the Institute for Clinical Evaluative Sciences (ICES) and the Toronto East General Hospital, with project management support provided by Agnew Peckham Consultants.

The objectives of the Project are twofold:

- to determine the level of non-acute use of acute care beds in Ontario hospitals (both non-acute admissions and non-acute days), and identify the alternate type of care required; and
- to provide hospitals with comparative information on their percentage of non-acute utilization, and an easy-to-use, validated tool for assessing non-acute utilization

Assessment Tool

The tool selected for the project is called the ISD (1996 version) developed by *InterQual.*

The ISD tool is an instrument for reviewing hospital charts on the basis of criteria for determining the acuity of both *admissions* and *days of stay.* It measures acuity on the basis of *intensity of service* (IS) and *severity of illness* (SI). There are different versions of the ISD for each main category of hospital service (e.g., medicine and surgery, paediatrics). Within each version, there are specific lists of criteria for each main body system (e.g., respiratory / chest).

The tool is designed to help answer questions such as:

- Was the patient sufficiently ill at admission to require the inpatient services of an acute care hospital, and, if not, what alternate care would have been appropriate; and
- On each subsequent day of stay, did the patient require (receive) services that necessitated continued inpatient stay in an acute care hospital, and if not, what alternate care would have been appropriate, and why was the patient still in acute care.

A one-day consensus conference was held in February, 1996 to validate the use of the 1996 tool for Ontario. Input was sought from utilization 'experts' from throughout Ontario.

The project is divided into two phases: Phase I involves using the ISD-A tool in a retrospective chart review; Phase II involves applying the tool concurrently on selected patient charts.

Retrospective Phase

Hospital representation from across the Province was solicited. Approximately one hundred hospitals in the Province agreed to participate in the Retrospective Phase. 150 charts for each hospital were selected, drawn from discharges with the following seven diagnoses:

Medical:

- Acute Myocardial Infarction (AMI),
- Chronic Obstructive Pulmonary Disease (COPD),
- Congestive Health Failure (CHF),
- Cerebral Vascular Accident (CVA),

Surgical:

- Hip/Knee replacement
- Hysterectomy,
- Trans-urethral resection of the prostate (TURP)

Thirteen nurse reviewers were recruited and trained in the use of the tool. The retrospective review began in April, 1996 and is scheduled to finish by September, 1996. Preliminary hospital-specific

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results from the retrospective phase will be available in the fall, with the final report to be released in February, 1997.

Concurrent Phase

A decision was made in August to delay the start of the concurrent phase, due to the possibility of job action by members of the Ontario Medical Association, and its potential impact on physician involvement, crucial to the success of the project. The Sub-Committee will assess and monitor this situation. Presently, mid to late October is being a targeted for commencing the concurrent phase, unless there is prolonged and disruptive job action.

To start the concurrent phase, a three-day training session will be held at the Toronto East General Hospital. Each participating hospital will send one to two Registered Nurses to be trained. Training will be done by InterQual, ICES and the Toronto East General Hospital. The concurrent phase will run for three to four months, with each hospital reviewing between 100 and 200 patient charts. Hospitals will have the capability over that period to test the tool and to produce reports directly from the software. The concurrent phase will not be part of the final report.

Next Steps

It is hoped that the extensive testing and refinement of the ISD tool will produce an effective utilization management application that can be used to help meet the challenge of providing appropriate, cost-effective hospital care. Results of the retrospective phase of the project will be provided to all hospitals in early 1997.

In addition to the 100 hospitals currently involved in this project, several hospitals with large paediatric populations will be taking part in a study to review paediatric acute utilization. ❑

*For further information, please contact **Rob Stewart** at 416-360-1510 ext. 234 or 416-360-1570 (fax).*

FUNDING REFORM INITIATIVES UNDERWAY

A rose by any other name is NOT just a rose

The conversion of the hospital funding formula to utilize Management Information Systems (MIS) Trial Balance information has been completed. The funding formula used by the Ministry of Health to determine cost per weighted case will now be based on hospital specific information obtained through implementation of the MIS Guidelines. In recognition of the changes to the formula, the formula will now be referred to as the Cost Distribution Methodology.

A user guide has been prepared for distribution to all Ontario Hospitals enabling them to calculate their cost per weighted case. Expected release of this user guide is late September 1996. Hospital specific MIS based data for 1994/95 will accompany this guide. After reviewing the data, hospitals can re-submit their 1995/96 hospital specific data. For further information, please refer to the MIS article in this volume of JPPC News.

Targeting for an early release!

The JPPC Hospital Funding Committee has developed an aggressive work plan that is intended to provide hospitals with an early preliminary indication of their funding for fiscal 1997/98. By late September 1996, the range of funding reductions to be expected using 1994/95 MIS and CIHI data will be released to all hospitals. By October, a stage 3 edit of the 1995/96 MIS and CIHI data is expected to have been completed. The range of funding reductions for next year will then be calculated using this more current information.

Given that further reductions have been announced for the coming fiscal year, a similar methodology used in 1995/96 is likely to be used for 1996/97 with minor modifications. Consequently, JPPC committees are continuing their efforts to enhance the funding formula and the processes used to determine funding reductions. As well, a consultant has been hired to evaluate the development, decision making process and impact of using the hospital funding formula for the next fiscal year. The results of this evaluation are expected by mid-October, 1996.

Further Funding Formula Refinements

During fiscal 1994/95, lacking valid and reliable measures of cost information for ambulatory, chronic and rehabilitation care, across the board reductions were applied. The Funding Integration Sub-

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INFORMATION INTEGRATION:

Working Together Towards an Ambulatory Care Management Information System

Information on ambulatory care services is integral to comprehensive models for health care reform

Development efforts in hospital management and funding have primarily focused on acute inpatients as evidenced by the use of such tools as Case Mix Groups (CMG's™), Ontario Case Weights (OCW's), Resource Intensity Weights (RIW's™), departmental workload measurement, and patient abstracting. As technology and medical practice shift an ever increasing amount of hospital care from inpatient to outpatient, inpatient services account for a decreasing proportion of hospital expenditures. In recognition of this shift in the utilization and cost of hospital care, the first classification and funding tool for ambulatory care - Day Procedure Groups (DPG's™) was implemented in Ontario. While this development has allowed for the measurement and funding of day surgery, there are still extensive areas of ambulatory care for which there is no method to classify and fund activities. This shortcoming will, however, soon be remedied.

CIHI is developing a national reporting system

In the past year, both the Canadian Institute for Health Information (CIHI) and the Ontario Case Cost Project (OCCP) have launched major initiatives in Ambulatory Care. CIHI's Steering Committee on the development of a National Ambulatory Care Reporting

System began its work in the Spring of 1995. The Committee's objective is "to develop a national, comprehensive ambulatory care database for hospital and community-based ambulatory care services". As part of achieving this mandate, a minimum data set for national reporting purposes as well as a grouping methodology applicable across ambulatory care services will be developed. The minimum data set is currently being piloted by a group of hospitals across Canada. CIHI will most likely adopt a modified version of the Ambulatory Care Classification System (ACCS) developed in Alberta, to group ambulatory care visits based on the information collected in the minimum data set. The plan is to begin implementing the minimum data set and ACCS in April, 1997.

A methodology for costing ambulatory care services will be developed and implemented by the OCCP

Coinciding with CIHI's efforts is the work of the Ambulatory Care Costing Group of the OCCP. The objective of this group is "to develop systems and procedures for the costing of hospital ambulatory care patients within the context of the definitions and standards developed by CIHI and adopted by the Ontario policy environment." The costing methodology will be based on the acute care costing standards, which are, themselves, based on CIHI's MIS Guidelines. Twenty-five OCCP hospitals are participating in the ambulatory care case costing project and will begin collecting costs on ambulatory care visits (for Emergency, Day/Night Centres and clinics) in April, 1997.

The OCCP and CIHI initiatives are co-ordinated toward an April, 1997 implementation date

The work plans and associated time frames for both initiatives coincide. The two major pieces of developing an ambulatory care management information system, the patient descriptive pieces being developed by CIHI, and the patient costing piece being developed by the OCCP, will come together at the beginning of the 1997/98 fiscal year. To get there, the OCCP and CIHI are working closely together, co-ordinating their efforts, and exchanging feedback. Two representatives from CIHI participate on the OCCP Ambulatory Care Group and a number of OCCP hospitals are involved in CIHI's ambulatory care hospital pilot project.

Integrating the various information tools provides a comprehensive management information system for ambulatory care

This co-operation is critical since many of the deliverables of the CIHI project are pre-requisites for ambulatory care costing. Defining the nature and scope of the ambulatory care visit allows for the assignment of costs to that visit by accounting for the costs of services provided by the various functional centres involved. Visit costs by themselves are not very useful without a grouping methodology that allows for the calculation of average costs for types of visits that share common clinical and resource use profiles. Finally, the cost

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information, in conjunction with the grouping methodology, can be used to develop funding weights for ambulatory care visits (analogous to the RIW's for acute care cases). The information will also be important in supporting hospital/regional management decisions for organizing ambulatory care services.

Moving closer to costing episodes of care

With patient descriptive and costing information becoming available for ambulatory care services, along with acute inpatient, chronic care and rehabilitation, the major pieces of the institutional health care delivery system puzzle would be in place. This wiil enable the linking of patient information at the episode level, spanning the various system encounters related to a specific condition. Again, if such an ambitious task is to be successfully undertaken, a fully co-ordinated approach involving hospitals, CIHI, the OCCP and other relevant parties would be necessary. This effort would constitute a major step towards the development of an integrated health care services information system. ❑

*For further information on these initiatives, please contact **Rami Rahal** (OCCP) at 416-360-1510 ext. 224 or Lindsay Campbell (CIHI) at 416-429-0477 ext. 3501.*

JPPC FUNDING REFORM INITIATIVES
Regional Sessions

The context within which hospital funding is applied is rapidly changing due to funding reductions, differential funding and restructuring. The impact of these and other forces on the evolving hospital funding formulae will be discussed, as will the relation between hospital funding and restructuring in meeting the fiscal targets for hospitals during the next two years.

Proposed refinements to the hospital funding formulae for the 1997/1998 fiscal year will be presented, including the Ontario cost distribution methodology (case cost formula) based on the new MIS trial balance, revised adjustment factors, small hospitals and growth funding. The results of an external review of the methodology, process and implementation of hospital funding for 1996/97 will be presented, along with proposed changes for fiscal 1997/98. An update on work-in-progress will be provided, including the status of chronic care, rehabilitation, psychiatry, ambulatory care, responsive global funding and additional adjustment factors.

These sessions will be of considerable interest and importance to:

- Hospital CEO's/Administrators
- Hospital CEO's and Finance personnel
- Hospital CIO's and MIS staff
- Hospital Health Records Directors
- DHC Executive Directors and staff

For further information and registration contact OHA Education and Convention Services (416) 205-1300.

DATE	LOCATION
November 18	Thunder Bay
November 19	Sudbury
November 22	Kingston
November 26	Toronto
November 28	London
November 29	Hamilton

Initiatives *...continued from page 2*

Committee is examining the potential of developing proxies for costs incurred when providing ambulatory, chronic and rehabilitation services. Information about these proxies is expected by November 1996.

During fiscal 1994/95, small hospitals (i.e., with less than 50 beds) also experienced across the board reductions. The Small Hospitals Working Group is attempting to develop a funding formula applicable to small hospitals. The formula is expected to promote equity based on hospital efficiency.

A recent study commissioned by the JPPC concluded that teaching hospitals experience higher costs to provide service because of their teaching component. Consequently, a provincial registry is being developed by the JPPC Adjustment Factors Sub-Committee to collect information on the number of medical student trainees in Ontario hospitals. In September, two research analysts from the JPPC will be working closely with Teaching hospitals and Ontario universities with medical education programs to gather this information. Tertiary and Neonate adjustment factors will also be revisited.

Recognizing the pressures of hospitals located in high growth areas, a $25 million growth fund was established to offset part of the funding reductions for 1995/96. The JPPC Growth Sub-Committee was formed specifically to recommend methods to distribute these funds. The $25 million growth fund was expected to be a one time occurrence. Consequently, the Sub-Committee is endeavoring to develop a model which will equitably fund hospitals experiencing changes in population and demographic growth. Recommendations are expected by November 1996. ❑

A series of regional sessions focusing on JPPC Hospital Funding Reform Initiatives is planned for the last two weeks of November, 1996 (See page 4 for details). For further information regarding JPPC funding initiatives, please contact ***Alexandra Flatt*** *(ext. 232) or* ***Nizar Ladak*** *(ext. 238) at (416) 360-1510 or by E-mail at JPPC@interlog.com.*

USING THE MIS TRIAL BALANCE IN HOSPITAL FUNDING
The 'Cost Distribution Methodology'

With the change of reporting from the Part A & B submissions to the MIS Guidelines there was an opportunity to more accurately identify hospital actual cost per weighted case using the primary and secondary account structure. Acute inpatient care and day surgery costs, used in the calculation of cost per weighted case, can be more precisely identified under the framework of the MIS Guidelines. The methodology to determine hospital cost per weighted case has been termed the *Cost Distribution Methodology* and will reflect a more accurate, but not significantly different, measure of hospital activity. The methodology was developed by the MoH and the Funding Integration Sub-Committee. A number of sites were also chosen to test the data and their input assisted in the refinement of the methodology.

Release of Hospital-Specific Data

A user guide has been developed to assist hospitals in calculating their cost per weighted case. It is expected that the user guide along with hospital-specific cost per weighted case, calculated using 1994/95 fiscal data, will be released in late September to the hospital field. Once hospitals have had an opportunity to review the 1994/95 submission and re-submit 1995/96 data, hospital-specific cost per weighted case using 1995/96 data will be distributed to the field. Please note that the methodology refers to the reporting framework developed under Version 1 of the MIS Guidelines.

Key Reporting Requirements

When reviewing your hospital data for the 1994/95 fiscal year, please keep the following reporting requirements in mind:

- All hospitals are required to distribute expenses in the functional centre incurring the costs.
- OHIP recoveries are treated as a recovery for absorbing functional centres.
- Under the MIS Guidelines, Version 1 hospitals are required to report workload and number of procedures for designated Diagnostic and Therapeutic functional centers by patient type in order to identify non-acute costs.
- Hospitals must not use interdepartmental revenue and expense accounts to transfer costs between hospital service functional centres and marketed services or other functional centres.

Methodology *...cont'd on page 6*

Methodology *...continued from page 5*

- All hospitals are required to report revenue, recovery and other funds as specified in the MIS Guidelines, Version 1. Recoveries are used to offset costs.
- Hospitals must report patient activity statistics regardless of payment source. Facilities must report statistics for patients they have assumed responsibility for. This implies the generation of a health record. Private clinic patient statistics are not required.
- Education and Research costs must be expensed to the appropriate functional centers. If hospitals generate substantial revenues or expenses for education-related activity, this revenue should be reported in the marketed services functional centre.
- Outpatient drug expense must be distributed to outpatient functional centers. Hospitals have the option of distributing inpatient drug expenses to each consuming functional center or charging the inpatient component to the Pharmacy functional center.
- Hospitals should expense direct incremental costs of activity to marketed services and research. These expenses will not be allocated through the Ontario Cost Distribution Methodology. ❑

*For further information regarding the Cost Distribution Methodology, please contact **Alexandra Flatt** (ext. 232) or **Donna Thomson** (ext. 233) at (416) 360-1510 or by E-mail at JPPC@interlog.com.*

Orientation to the JPPC

An Orientation to the JPPC was recently distributed to the MoH, OHA, all hospitals and other stakeholders. The orientation provides an overview of the JPPC, including the background, mandate, approach, objectives, value of and commitment to the partnership, participation of other stakeholders and communication vehicles. In addition to this overview, the orientation outlines the current strategic directions

- committee structure
- vision of the future
- (role of) JPPC Secretariat
- list of publications
- how to contact the JPPC

*For a copy of the **Orientation to the JPPC**, please contact **Susan Juodele** at (416) 360-1510 or (416) 360-1570 (fax)*

Advantages to Using the MIS Guidelines

- Costs for activities which are not funded by the Institutions Branch of the MoH (Fund Type 1) are identified through the second digit of the primary code. These costs are excluded unless costs exceed revenue and global funds are required to support the activity.
- Information is grouped into a specific framework section which identifies specific types of activities. Calculations are unique to each section (e.g. inpatient costs are treated differently than research costs).
- Primary accounts (functional centres) identify specific types of service (e.g. the inpatient nursing functional centre accounts identify Chronic Care, ELDCAP, Palliative Care and Rehabilitation costs which are excluded from the formula).
- Standard "roll up" of accounts in information reporting allows comparisons of hospital costs regardless of facility size.
- Consistent distribution of secondary financial accounts to primary accounts enhance comparability.
- Standard definitions for revenues, recoveries and expenses as well as the process for aggregation, ensures costs are uniformly applied to primary accounts to facilitate comparisons of costs for specific activities.
- The secondary statistical accounts are used to isolate the expenses in functional centres that provide services to more than one patient type.
- Standard definitions for statistical accounts and a standard workload reporting framework ensures that the distribution of costs provides a more accurate reflection of resource consumption.
- Hospitals have the ability to determine their actual cost per weighted case internally using MIS reporting framework.

JPPC News

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