JPPC News
JOINT POLICY AND PLANNING COMMITTEE

REPORT OF THE EXECUTIVE DIRECTOR

Earlier this year the Joint Policy and Planning Committee (JPPC) held a retreat for the members of the JPPC Senior Committee. The purpose of the retreat was to discuss the short and medium term role of the JPPC with a view to identifying the major new projects that will be undertaken in the near future. Three options were proposed. One option was to maintain the role of the JPPC as it presently was at that time such that its core strength in funding analysis and equitable formulae development be continued. There was considerable discussion about the need to bring other partners to the table and the desirability of expanding the role of the JPPC. This led to the second option, to change the role of the JPPC to become akin to an Ontario Health Council. However, there was concern that expanding the JPPC's role to this large degree would bring the JPPC too far from its historical core competencies. Thus, the JPPC Senior Committee decided to endorse option three; the JPPC should moderately expand its role and process. In order to assure the continuation and expansion of the body of JPPC's work, the Ministry of Health and Long Term Care and the Ontario Hospital Association have committed to three years funding for the JPPC.

The expansion of the role of the JPPC has already begun. We are in the process of renewing our successful work on utilization with the introduction of a new Performance Committee that will begin to examine the relationship between utilization and clinical outcomes. As well, we have recently undertaken other new initiatives including rehabilitation, radiation oncology in cooperation with Cancer Care Ontario, and waiting lists.

With respect to our continued focus on funding, the JPPC has undertaken a number of initiatives with an end goal of unifying and updating the funding formulae. The model currently being discussed and researched holds facilities accountable to specific volumes and rates within each type of patient activity.

This model is based upon eight funding principles:

- Promotes accountability
- Sensitive to population changes and characteristics
- Integrates funding and both the hospital level and the health system level
- Advocates fairness/equity
- Integrates and maintains province-wide priority programs
- Maintains strong academic capacity
- Supports restructuring
- Promotes local flexibility/responsiveness

There are a number of potential applications and uses of the model that may be considered depending upon the confidence that the Ministry of Health has with the funding model and upon the degree of change that can be tolerated in the field. Three options have been discussed. Option one is the replacement of global budgeting with proposed funding model. The second option is to retain global budgeting and use the proposed model for marginal change or release of new funds. Retain global budgeting and use the new funding formula as a diagnostic tool is the third option.

The formula has three stages of implementation depending upon the availability of data. In the year 2000, acute inpatient, day surgery, priority programs, complex continuing care and small hospital data will be available. Emergency and mental health data will be added to the formula in the year 2001. In the year 2002, clinic, rehabilitation and quality indicator data will be ready for implementation. Careful consideration will have to be taken into the merits of including clinic data.

One way that the JPPC is meeting this challenge is by reviewing the committee membership of all of the committees. We have individuals from over one hundred

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REPORT RELEASES FROM THE COMPLEX CONTINUING CARE FUNDING WORKING GROUP

In September of this year, the Complex Continuing Care Funding Working Group (CCCFWG) released their first reports, an interim summary report (JPPC Reference Document #8-11) and a technical paper (JPPC Reference Document #8-12), both outlining the work of this committee. These reports contain comparative information on the provincial and facility-specific 1997/98 cost per RUG-III-weighted patient day for Ontario hospitals with Ministry of Health designated chronic beds. The purpose behind releasing this information at that time is two-fold. First, it is hoped that facilities will use this information to identify data quality and reporting issues and to use the insights gained from this information to make any necessary final changes to their data from 1998/99 and beyond, for both cost and patient activity. Second, the CCCFWG would appreciate feedback from the field regarding the work completed thus far. This feedback will be used during Phase Two of its work; to use 1998/99 data to develop a funding model for implementation for April 2000. It is for these reasons that we strongly urge facilities to use this information for internal purposes only. This data is not meant to indicate relative efficiencies or suggest proposed future funding allocations.

The CCFWG also recently held two technical briefing sessions to assist facilities in interpreting these comparative reports as well as understanding the methodology used in their construction. Both of these sessions were well attended; just fewer than 200 participants from hospitals all over the province gained a thorough understanding of the methodology used to calculate the information provided in the reports. Special thanks to the speakers, Lou Reidel, Dr. Chuck Botz, and Dr. Gary Teare, members of the CCCFWG who shared their insights and knowledge of the work of this committee to the field.

All inquiries and/or feedback pertaining to the work of this committee should be sent to **Howard Baker** by e-mail hbaker@jppc.org or by facsimile at (416) 934-0711.

Executive Director's Report

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institutions serving on JPPC committees at present. We would like to thank those people for their dedication to the JPPC, and ask those and others if they would like to sit on JPPC committees in the future. ❑

Frank Markel

FAREWELL & WELCOME: Staff Changes And Responsibilities

Two members of the JPPC Secretariat recently left the JPPC to pursue new endeavours. **Nizar Ladak** has taken a management position at the Canadian Institute for Health Information; **Rob Forbes** has joined the Cardiac Care Network of Ontario as Special Projects & Operations Co-ordinator. The JPPC Secretariat dearly misses them. We would like to wish both Nizar and Rob all the best in their new positions and look forward to our new working relationships with them.

Caroline Rafferty, who has been working on various projects for the JPPC including the stewardship of the medical trainee data since 1996, has recently become a full-time member of the JPPC. Besides continuing her current JPPC involvement, which includes supporting the Ambulatory Care Implementation Team, Caroline will also be supporting other JPPC initiatives such as the Waiting Lists Project.

Three new faces are now present at the JPPC. **Nan Brooks** has joined the JPPC and is providing support for several JPPC committees including the Hospital Funding Committee, the Rate Sub-Committee, and the Blood Utilization Working Group. Nan brings a wealth of knowledge and experience in both health care administration and law from her previous work in these fields, including her recent involvement with the OHA Hospital Report Card Project.

Colin Preyra, a recent graduate from the University of Toronto's Health Administration Ph. D. programme, has also joined the JPPC. Colin's area of expertise is in Health Economics and he will be providing analytical support to the JPPC, particularly in the development of hospital funding formulae.

Carolyn Plourde, who recently graduated from the University of Waterloo with a Ph. D. in Cognitive Psychology, has joined the RAI-MH Project Team as the RAI-MH Post Doctorate Fellow. Carolyn's main responsibilities will be to provide support for two committees, the RAI-MH Case-Mix and Clinical Advisory Groups.

Nan, Colin and Carolyn, welcome to our team!

JPPC SENIOR COMMITTEE RETREAT SUMMARY

The purpose of the JPPC Senior Committee retreat was to discuss the short and medium term role of the JPPC with a view to identifying the major new projects that will be undertaken in the near future. As a first step, both OHA and MoH committed to three year funding for the JPPC.

The need to bring other partners to the table and the desirability of expanding the role of the JPPC was discussed at length. It was generally agreed that there should be a moderate expansion of the JPPC role and process. It was agreed that on an ad hoc basis, JPPC would involve other key stakeholders in projects where their viewpoints are required or helpful. However, the JPPC agenda and process would still be decided upon by the two existing partners, with other participation solicited as needed. There was concern that expanding the JPPC's role too far would bring it too far from the following things that it has historically been best at:

- Objectifying the hospital / MoH relationship
- Gaining credibility as an organization that presents information of utility to both partners and the system as a whole.
- Providing excellent analysis of agreed upon data
- Providing transparent, evidence-based methodologies
- Producing work that is useful – i.e. used
- Being credible.

There was strong agreement that the JPPC should continue its core strength in funding analysis and development of equitable funding formulae. In this regard, JPPC should continue to develop the population-based Rate and Volume Equity Funding. As well, JPPC should continue to provide short and medium term support and expertise to the province in financial issues of immediate importance, as agreed upon by its partners. JPPC should be the forum for objectifying the advocacy / funding relationship.

There was also general agreement that JPPC would revitalize the work on utilization in which it has been so successful in the past. There is a need to examine the hospital system after three years of restructuring, in order to assess the impact of the myriad changes in the last few years, and to provide evidence and guidance to the hospital sector and the MoH over the next few years. This will involve establishing new benchmarks for efficient hospital utilization. However, there was firm agreement that any work in utilization must look at outcomes to ensure that Ontario hospitals are providing the best care to their patients, and to ensure that benchmarks reflect appropriate clinical care, and take into account the impact of changes in utilization patterns on patient outcomes.

Considerable discussion ensued about tying outcomes and utilization to funding. First, JPPC should begin to assess the impact of funding methodologies on patients and on hospital operations. Second, JPPC should use the work on outcome-based utilization to analyse how to develop funding that provides appropriate incentives to hospitals to provide efficient care with proven effective outcomes for patients.

A list of potential projects was compiled from the discussions. Each project was then discussed in turn, and the Senior Committee members agreed that JPPC Secretariat should have high priority new projects. For each of these, the secretariat subsequently provided a project plan and budget at the next Senior Committee meeting. The following are the new projects that were eventually agreed upon:

- Waiting Lists: Both the MoH and the OHA members expressed a keen desire to have the JPPC conduct a rigorous examination into the phenomenon of waiting list for hospital services in Ontario. Little information currently exists about the function, role, and forces that govern waiting lists.
- Utilization & Outcomes: As had been mentioned in the discussion, tying utilization to outcomes is critical. This project would have to include an assessment of the impact of restructuring on hospital utilization, and the establishment of new efficiency benchmarks in the restructured environment. These benchmarks would be developed in light of clinical evidence of efficacy and quality. For this reason, it was suggested that representation from physician groups (OMA) and nursing groups (RNO) be sought.

JPPC Committee Membership Review

The JPPC is honoured to have representatives from 119 organizations in Ontario on its Committees and Working Groups. As with all organizations with long standing committees, it is time to do a comprehensive review of the membership of JPPC committees. The JPPC has recently been given a three-year mandate, and it was felt that a comprehensive membership review would be wise as we enter the new millennium.

Please have individuals from your organization who are interested in serving on JPPC Committees send their name, title, organization, communication information and committee(s) you are interested in sitting on to Nan Brooks at either fax: (416) 934-0710 or mail to: nbrooks@jppc.org.

IT'S ALL THE RAVE

A common concern often expressed about existing hospital funding methodologies is that they need to be integrated into one comprehensive formula. Another concern is that they need to be sensitive to the changing demographic profile of communities across Ontario (i.e., be population based). Early in 1998, the Hospital Funding Committee decided it would develop a hospital funding methodology aimed at achieving equity in funding rates and patient volumes. The method would achieve 'rate equity' by adjusting for variations in hospital characteristics (e.g., teaching versus community, rural location, prices) resulting in a similar payment for similar services delivered. 'Volume equity' would be achieved by adjusting for variations in population characteristics (e.g., age, gender, health status) resulting in a predicted patient volume for a population based on its size and demographic characteristics. The title of this method is Rate and Volume Equity (RAVE) funding.

Two sub-committees reporting to the Hospital Funding Committee were formed to develop this methodology called Rate and Volume sub-Committees. The JPPC's Volume Sub-Committee released its phase 1 report in the summer of 1999. The report is called: Predicting Hospital Volumes for Communities (JPPC Discussion Paper #3-5). The Volume Sub-Committee's mandate is to develop a method of estimating the expected volume of hospital activity, given the size and characteristics of the population served by the hospital on the hospital activity rate. The Volume Sub-Committee has divided its work plan into two phases: Phase 1: to identify the population factors that affect hospital utilization, and Phase 2: to allocate the impact of these factors to service providers (i.e., hospitals). This report is a summary of the first phase of the Volume Sub-Committee's work.

The report contains detailed descriptions of the research techniques and data sources used in its first phase of work. The report contains community-specific appendices detailing the factors affecting patient volumes.

The JPPC's Rate Sub-Committee has been meeting intensely over the summer. It has divided its work plan into two streams. The first stream is cost adjustment factors. The Cost Adjustment Factors Working Group is analyzing the current adjustment factors, and enhancing the model by reviewing and analyzing other factors beyond the hospital management's control that might affect the cost per weighted case. The factors considered include factors such as socio-economic status and size of the hospital. The Revenue Adjustment Factors Working group is analyzing funding equity by reviewing the current Ministry of Health funding and reviewing and analyzing other funding sources. It is expected that a discussion paper will be released by the Rate Sub-Committee in the late fall.

For further information regarding these projects, contact **Nan Brooks** at (416) 934-0710 extension 234.

BLOOD UTILIZATION

In his final report on the Canadian blood system, Justice Krever recommended that the new national blood service – The Canadian Blood Service — be funded through hospital payments for the blood products and components supplied to hospitals. As a result, the Joint Policy and Planning Committee of Ontario (JPPC) struck the Working Group on Blood Utilization. This Working Group is responsible for investigating the provincial utilization of blood products and alternatives, and examining potential funding issues related to the purchase of blood products by hospitals.

The first task in investigating provincial utilization is to conduct a feasibility survey assessing the availability of information at Ontario hospitals: What blood utilization information is available at Ontario hospitals? Is the data available electronically or manually? What kind of systems do individual hospitals have in place to monitor and track blood use at their institutions?

Preliminary drafts of the surveys were released to seven "pilot" hospitals in mid-July to provide the Working Group with feedback on questionnaire design and reliability. The final surveys were released to all hospitals on September 27th. Results from this feasibility survey will help the Working Group to develop a full-scale Blood Utilization study for the province. Please ensure that your hospital is completing their surveys and has them back to us by October 29th, 1999.

In addition to the above study the working group also conducted an expert panel survey, which was recently completed in June of this year. The panel was convened to assist The Working Group in identifying trends that will affect future utilization of blood products and alternatives.

A total of 12 transfusion medicine experts from a variety of medical disciplines participated in a process that consisted of the following:

1. Completing a questionnaire designed to obtain opinions on major trends

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OCCP UPDATE: OCCP Cost Data Used in RIW Development

The primary objective of the Ontario Case Cost Project has been to produce a made-in-Ontario case cost database from which to develop case weights for use in hospital funding. When the OCCP was established in 1992, Resource Intensity Weights (RIWs), and therefore Ontario Case Weights, were based on New York charge (not cost) data, and in 1995, were calibrated with Maryland charge data. Case weights that were based on actual costs and reflective of Canadian medical practices were believed to provide a better estimate of the relative costs of treating patients in Ontario hospitals than U.S.-based weights.

The OCCP and CIHI have been working together to improve case weights. For the past two years, Ontario case cost data collected from the First Generation hospitals has been used by CIHI in the calibration of RIWs. However, this year marks the first year that Ontario case cost data has been used as the principal calibration database. The calibration database for RIW 99 has incorporated over 272,000 OCCP acute inpatient cases from fiscal years 94/95 and 95/96. Where OCCP volumes were insufficient to calibrate some RIWs, Maryland charge data was also used. For these RIW calculations, Maryland charge data was scaled to reflect the OCCP cost profile, and a blended RIW using both OCCP and Maryland data was calculated.

As data from the Second Generation of OCCP hospitals is added to the calibration database, it is hoped that the increase in case volumes will result in the exclusive use of Canadian cost data and therefore the achievement of the OCCP's main objective.

Ambulatory Care Costing

Several Project hospitals are in the process of implementing ambulatory care costing, which began July 1, 1999. Hospitals are collecting statistical and clinical data related to a patient's ambulatory care encounter using CIHI's Ambulatory Care Minimum Data Set. Currently these hospitals are costing only the Emergency Room, but there are plans to expand into the outpatient clinics in the future.

The OCCP is currently conducting site visits with the participating hospitals to ensure that data collection, data interfacing and data quality issues are identified and resolved prior to the collection and submission of case cost data. We expect to complete these audits in September, and to receive six to nine months of case cost data in the submission for fiscal year 1999/2000.

The implementation of case costing in the Emergency Room coincides with the JPPC Ambulatory Care Implementation Team's pilot study of the Ambulatory Care Minimum Data Set. Most of the hospitals currently collecting Emergency case cost data are also participating in this pilot, and the OCCP has been collaborating closely with the JPPC on this project.

Staff Update

Olive Collaco accepted a secondment with the Ontario Ministry of Health in November 1998. The OCCP wishes Olive all the best in her new position.

Kamini Milnes joined the OCCP as a Project Consultant in January 1999. Prior to joining the OCCP, Kamini worked at the Joint Policy & Planning Committee.

OCCP Website

The OCCP website is now up and running at www.occp.com. Information posted on our site includes a summary of the case costing methodology, history of the Project and sample data analyses. We will post the newly revised Ontario Guide to Case Costing in the near future, so that it will be readily accessible to all hospitals. We encourage you to visit the site and invite your feedback and suggestions for additional information or links.

Ontario Guide to Case Costing, Version 2.0

We are pleased to announce that the Ontario Guide to Case Costing, version 2.0 is now available. Since the last revision in 1995, the OCCP has enhanced the case costing standards as part of the evolution of case costing, and developed standards for costing ambulatory and chronic care activity. The Guide is available from the OCCP for a cost of $40.

For further information regarding OCCP initiatives, please contact **Doreen Rafeiro** (ext. 224) or **Kamini Milnes** (ext. 231) at (416) 934-0710.

JPPC News

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Blood Utilization

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related to blood product and alternative utilization over the next 3-5 years.

2. Participating in a conference call with other expert panelists to discuss questionnaire results and arrive at a consensus regarding the impact of future trends and technological developments in blood infusion and transfusion medicine on blood utilization.

The questionnaire was developed based on a thorough review of the literature and consultation with experts working with Geyer Szadkowski Consulting Inc.

From both of these initiatives The Working Group hopes to obtain:

- a greater understanding of the quality of the information on the utilization of blood products and alternatives
- a greater understanding of the methodological options for data collection; and
- the ability to forecast future requirements for blood products and alternatives.

For further information please contact **Nan Brooks**, (416) 934-0710 extension 234.