



Alternative Level of Care Days: Non-payment for poor quality in Ontario hospitals

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Background

In Canadian provinces, hospital beds that are occupied with patients that no longer require the intensity of resources or services provided in an acute care setting are designated alternate level of care, or ALC¹⁻⁵.

ALC patients continuing to receive care in an acute setting instead of in the home/community is an inefficient use of health system resources⁴. For patients, ALC is associated with increased risk of functional decline⁶⁻⁷.

Statistics from fiscal year 2015/16 estimate that 13.9 percent of acute inpatient beds in Ontario were occupied by patients that were discharged from acute care but not to their place of residence⁸. This translates to 250 beds in Ontario each day. The cost of ineffective ALC bed use is estimated to exceed \$250 thousand per day.

CCO's funding policy for cancer surgery pays hospitals on a volume basis (number of cases times price times average cost weight). Four disease sites are funded through the cancer surgery QBP: colorectal, prostate, thyroid and breast.

In its role as funder, CCO's opportunity is to change its policies to create financial incentives for hospitals to reduce poor quality outcomes in the form of ALC days.

Cancer Surgery QBP

Funding per case for each disease site in the cancer surgery QBP is based on the product of the provincial price per weighted case ('base' price) and each hospital's specific average weight per case or case mix index (CMI). The CMI reflects the hospital's case mix, or the average complexity of its cases.

Table 1 shows the base price, hospitals' average case mix and average QBP prices by disease site. There is a 2 year data lag for setting prices, thus 2015/16 data was used to measure the impact on 2017/18 prices.

Table 1. Funding per case for Cancer Surgery QBP, fiscal year 2017/18

Cancer Surgery Disease Site	Base Price	Provincial Average CMI	Average Funding per Case
Colorectal	\$5,105	2.58	\$13,171
Prostate	\$4,943	1.44	\$7,116
Thyroid	\$5,174	0.77	\$3,984
Breast (w/ immed. Recon)	\$5,869	1.41	\$8,099
Breast (w/o immed. Recon)	\$5,066	0.56	\$2,837
Breast (Delayed recon.)	\$5,542	0.89	\$4,766

References

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Objective

This study evaluates a policy option for CCO to eliminate funding for ALC within the Cancer Surgery QBP.

The aims would be to disentangle cancer surgery funding from ALC and create a financial incentive for acute care hospitals to reduce or eliminate ALC.

Data Sources

Eligible QBP-funded cases for fiscal year 2015/16 are identified using diagnosis and intervention codes from the Cancer Surgery QBP Funding Guide⁹. Cases are excluded if they are pediatric cases, non-residents of Ontario, not eligible for provincial insurance, or if surgeries were cancelled or abandoned.

The population of inpatient hospital discharge summaries is used for April 1, 2015 to March 31, 2016. For breast and thyroid cancer surgery, outpatient hospital activity is accessed through the National Ambulatory Care Reporting System (NACRS) dataset.

Each hospitalization or visit includes patients' cost weight assigned by the CIHI's case mix algorithms.

Methods

Hospital CMIs

There are 3 ways that removing ALC days impacts cost weights: the category into which each case is assigned determined by length of stay, the number of days beyond the length of stay trim point, and additional cost weight adjustments for flagged interventions that are based on the length of stay percentile. Costs weights are reassigned and averaged to calculate hospitals' average CMIs excluding ALC.

QBP Base Price

The number of ALC days for each patient was identified from the DAD data. Non-acute costs were excluded for these ALC days. Weighted units associated with ALC were also removed from the denominator of the base price calculation, and from the funding envelope.

Results

In fiscal year 2015/16, colorectal surgery cases had the highest number of ALC days (Table 2) within the cancer surgery QBP.

Table 2. Number of ALC days by disease site for fiscal year 2015/16.

For colorectal cancer surgeries, removing ALC days resulted in a reduction in the provincial average CMI (Table 3). Few ALC days were observed for thyroid and some breast surgeries.

Table 3. Effect on Hospital level CMI of removing ALC days, fiscal year 2015/16.

The QBP base price was recalculated for colorectal cancer surgery.

The total funding impact would have been \$1.9 million for fiscal year 2017/18 (Table 4).

Table 4. Funding Impact of removing ALC days on colorectal surgery, FY2017/18.

Figure 1. Colorectal surgery funding with and without ALC days, FY2017/18.

Discussion

Non-payment for ALC days for CCO's QBP-funded cancer surgeries creates a financial incentive for hospitals to reduce ALC by eliminating funding associated with their ALC activity.

There is much work to be done to develop options for aligning funding policies with effective health system resource use. This policy option shifts financial risk for some portion of hospital care from CCO to other providers in the health system.

While the policy supports CCO's objectives of reducing ineffective care, the impact on the broader health system is unclear.

As ALC days can occur for hospitalizations across conditions and payers (the MOHLTC and CCO), a coordinated policy approach should investigate the policy's impact on demand for community care.