Central East LHIN

2010/11 Hospital High Growth Funding Presentation to CE LHIN Board

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Hospital High Growth Funding Announcements

Announcement	*"LHIN Hospital Growth Demands Funding"*	"$120 million over three years to assist hospitals in areas experiencing high-population and service usage growth to meet anticipated demand"					
Year	2007-08	2008-09	2009-10	2010-11	Total	Grand Total	
Provincial Allocation	$5M (allocated to five LHINS)	$30M	$40M	$50M	$120M	$55M	
Net Base Increase	$5M	$30M	$10M	$10M	$50M		
CE LHIN Allocation	$1,063,372	$4,756,500	$1,410,000	$1,201,100	$7,367,600	$8,430,972	15.33%

In 2008/09 and 2009/10:

- Funding per Local Health Integration Network (LHIN) was determined/allocated according to the Health-Based Allocation Model (HBAM).
- While the ministry identified LHINs and recommended allocations for highest growth hospitals, LHINs determined the appropriate distribution and the timing of the funding based on their local circumstances.
- The funding was to be for base allocations only to the hospital sector.
- The funding was not to be used for the creation of new programs or related expansions or for any one-time initiatives.

2008/09 CE LHIN Allocation Model for High Growth Funding

Central East Local Health Integration Network (CE LHIN) developed and utilized a local methodology:

Step One: Identify Material and Significant Growth.

Step Two: Identify High Direct Costs.

Step Three: Determine Pot Sizes - Cost Basis.
Determine Pot Size - Performance Basis.

Step Four: Determine Hospital Level Allocations.

NOTE: All CE LHIN Acute Public Hospitals received a share of the funding and a portion was used to implement a stroke centre at Lakeridge Health Corporation (LHC).

2009/10 CE LHIN Allocation Model for High Growth Funding

CE LHIN gave option of three allocation models to the hospitals:

- CE LHIN developed local methodology used in 2008/09.
- To develop a new methodology in collaboration with the hospitals.
- To use Ministry of Health and Long-Term Care (MOHLTC) allocation informed by HBAM.

The hospitals preferred MOHLTC's HBAM informed allocation.

2010/11 Hospital High Growth Funding - LHIN Allocations

LHIN	Growth Funding 2010/11
Central	2,261,000
Central East	1,201,100
Central West	923,300
Champlain	116,100
Erie St. Clair	0
Hamilton Niagara Haldimand Brant	347,600
Mississauga Halton	2,465,100
North East	289,600
North Simcoe Muskoka	924,000
North West	111,900
South East	105,700
South West	57,800
Toronto Central	72,900
Waterloo Wellington	1,123,900
TOTAL	10,000,000

2010/11 Hospital High Growth Funding - Allocation Approach

Approach consistent with the allocation of the $10 million in growth funding for 2009/10:

- Used HBAM to inform allocation;
- Targeted funding to the top 25% fastest growing hospitals (i.e., 75th percentile);
- Used the full range of hospital programs: acute inpatient and day surgery, acute mental health, emergency, chronic care, inpatient rehabilitation, long-term mental health, non-modeled programs (e.g. ambulatory clinics);
- Did not disadvantage hospitals for funding received from other similar funding sources (e.g. PCOP, IPBA, base priority service funding); and
- Provides for a funding floor of $50,000 for qualifying hospitals.

PCOP: Post-Construction Operating Plan
IPBA: Integrated Population Based Allocation

2010/11 MOHLTC HBAM Allocation Methodology

1. The 2009/10 hospital growth funding is allocated consistent with the principles of the Health Based Allocation Model (HBAM).
2. HBAM's utilization model estimates the expected annual use of health services, taking into account each Ontario resident's clinical, social, demographic conditions. The model also takes into account patient flows. HBAM utilization model results are based on 2008/09 clinical data and 2008 Census Data and are forecast to 2010/11 using Ontario Ministry of Finance Population Projections and Statistics Canada Census 2008 Population Estimates.
3. HBAM utilization estimates and forecasts are combined with its cost model results to determine HBAM estimated and forecast expenses.
4. The growth funding methodology takes into account historical and future growth. This is measured by the variance between 2008/09 hospital expenses and the forecast HBAM share of expenses for 2010/11:

$$\text{\% Variance} = \frac{\text{Share of Hospital Expenses in 2008/09}}{\text{Share of Hospital HBAM Forecast Expenses in 2010/11*}} - 1$$

Value of Variance= *% Variance X Hospital's HBAM Forecast Expenses in 2010/11**

*Calculated at 2008/09 unit costs.

2010/11 MOHLTC HBAM Allocation Methodology (Cont'd)

5. Hospitals were ranked by the percent variance. The greater the negative variance (i.e. actual hospital share of expenses is less than HBAM forecast share of expenses) the higher a hospital was ranked. This is as an indication of relatively fast growth and associated funding requirements.

6. Funding is restricted to the top 25% of hospitals with the highest ranked variance. This focuses funding on hospitals serving the fastest growing regions.

7. The relative share of growth funding was set proportional to each eligible hospital's share of the total value of variance above the 75th percentile (i.e. the higher the relative value of variance, the greater the funding).

8. All hospitals that qualified under the 75th percentile would receive a minimum of $50,000 (floor).

9. Hospital funding allocations were aggregated by LHIN to determine LHIN allocations (bottom-up approach).

MOHLTC 2010/11 Hospital High Growth Fund - Criteria

Each LHIN has full decision making authority regarding the allocation of funds; however the following criteria must be considered by LHINs when making their decisions:

- **These funds are only to be allocated as base dollars to those hospitals facing the fastest/highest growth and increased service pressures associated with these demands;**
- Funding is not to be used for the creation of new programs or related expansions or for any one-time initiatives;
- These funds are to help stabilize services in these hospitals and in the LHIN; and
- Where a hospital is in a high growth community but does not have the operational capacity, these funds may also be used to stabilize peer hospital services in the LHIN to promote an integrated approach to supporting the identified high growth community.

MOHLTC 2010/11 Hospital High Growth Fund - Engagement Strategy

Required consistent process for LHINs to follow:

- LHINs meet with the Ontario Hospital Association (OHA) to share the 2010/11 hospital high growth approach – **DONE.**
- Each LHIN shares 2010/11 hospital-specific MOHLTC HBAM results with their hospitals as part of their 2010/11engagement – **DONE.**
- Each LHIN engages its local hospitals with regards to allocation process – **DONE.**
- Each LHIN shares proposed allocation and rationale with the MOHLTC (by September 3rd) – **DONE.**
- Each LHIN then moves forward to approve/implement hospital allocation at the local level – **TODAY.**
- LHINs share LHIN allocation decision information with OHA following LHIN communication with recipient hospitals and local hospital system – **NEXT STEP.**

Options/Methodologies Considered (Cont'd)

Two methodologies were discussed with CE LHIN hospital Chief Financial Officers / Vice Presidents of Finance. No additional methodologies were tabled:

1.) MOHLTC HBAM.

2.) To develop CE LHIN methodology.

MOHLTC HBAM Methodology

Pros:

- Assesses growth from a population need perspective as well as hospital utilization perspective;
- Assesses growth over a 4 year period; and
- Eliminate “double counting” of growth (considers such things as PCOP, etc.).

Cons:

- Only the 75 %ile threshold can be applied for highest growth;
- The data is not available for review by hospitals; and
- Cannot equitably include Mental Health activity.

CE LHIN 2008/09 Clinical Utilization Methodology

Pros:

- Any threshold can be applied for highest growth (e.g. 50th %ile, 75th %ile, etc.); and
- The data is available for review by all hospitals.

Cons:

- Requires consensus on high growth threshold;
- Current model is assessing one year and would require considerable work to apply as multi-year growth;
- Does not easily eliminate "double counting" of growth (does not consider such things as PCOP, etc.);
- Many hospitals are reducing clinical activity to balance but operating in areas of significantly high growth and as such should be entitled to funding but will not qualify;
- Does not measure population need (only hospital utilization); and
- Cannot equitably include Mental Health activity.

CE LHIN Hospital/CCAC Advice – 10/11 High Growth Funding

The following HSPs supported use of the MOHLTC HBAM allocation model:

- Community Care Access Centre (CCAC) - (do not receive funding).
- Ontario Shores Centre for Mental Health Sciences (OSCMHS) - (do not receive funding) NOTE: Want to pursue different methodology to use for future allocation.
- Campbellford Memorial Hospital (CMH) - (do not receive funding).
- Northumberland Hills Hospital (NHH) - (do not receive funding).
- Rouge Valley Health System (RVHS) - (would receive $273,410).
- Lakeridge Health Corporation (LHC) - (would receive $696,500).
- Haliburton Highlands Health Services (HHHS) - (would receive $54,800).
- The Scarborough Hospital (TSH) - (do not receive funding).
- Peterborough Regional Health Centre (PRHC) - (do not receive funding).

The following HSPs did not support the MOHLTC HBAM allocation model:

- Ross Memorial Hospital (RMH) - (would receive $176,410) – would have preferred to use CE LHIN developed methodology.

Motion

Whereas the Ministry of Health and Long-Term Care has, in 2010/11, provided Central East LHIN (CE LHIN) with a total of $1,201,100 in base funding that can only be provided to highest growth hospitals in CE LHIN; and

Whereas the Ministry has developed an allocation model that quantifies highest growth among hospitals and allocates the funding accordingly;

Be it resolved that the CE LHIN Board approve that the Ministry hospital allocation methodology be used and the funding be distributed as follows:

- $176,400 for Ross Memorial Hospital;
- $54,800 for Haliburton Highlands Health Services Corporation;
- $273,410 for Rouge Valley Health System; and
- $696,500 for Lakeridge Health Corporation.