Quality-Based Procedures Clinical Handbook for Cataract Surgery

Ministry of Health and Long-Term Care

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Ontario

Table of Contents

Quality-Based Procedures Clinical Handbook: Cataract Surgery

1.0 Purpose

This clinical handbook has been created to serve as a compendium of the evidence-based rationale and clinical consensus driving the development of the policy framework and implementation approach for Cataract Surgery in 2012/13.

This handbook is intended for a clinical audience. It is not, however, intended to be used as a clinical reference guide by clinicians and will not be replacing existing guidelines and funding applied to clinicians. Evidence-informed pathways and resources have been included in this handbook for your convenience.

2.0 Introduction

Quality-Based Procedures (QBP) are an integral part of Ontario's Health System Funding Reform (HSFR) and a key component of the Patient-Based Funding (PBF). This reform plays a key role in advancing the government's quality agenda and its ***Action Plan for Health Care***. HSFR has been identified as an important mechanism to strengthen the link between the delivery of high quality care and fiscal sustainability.

Ontario's health care system has been living under a global economic uncertainty for a considerable period of time. At the same time, the pace of growth in health care spending has been on a collision course with the provincial government's deficit recovery plan.

In response to these fiscal challenges and to strengthen the commitment towards the delivery of high quality care, the ***Excellent Care for All Act*** (ECFAA) received royal assent in June 2010. ECFAA is a key component of a broad strategy that improves the quality and value of the patient experience by providing them with the right care at the right time, and in the right place through the application of evidence-informed health care. ECFAA positions Ontario to implement reforms and develop the levers needed to mobilize the delivery of high quality, patient-centred care.

Ontario's ***Action Plan for Health Care*** advances the principles of ECFAA reflecting quality as the primary driver to system solutions, value and sustainability.

2.1 What are we moving towards?

Prior to the introduction of HSFR, a significant proportion of hospital funding was allocated through a global funding approach, with specific funding for some select provincial programs and wait times services. A global funding approach reduces incentives for Health Service Providers (HSPs) to adopt best practices that result in better patient outcomes in a cost-effective manner.

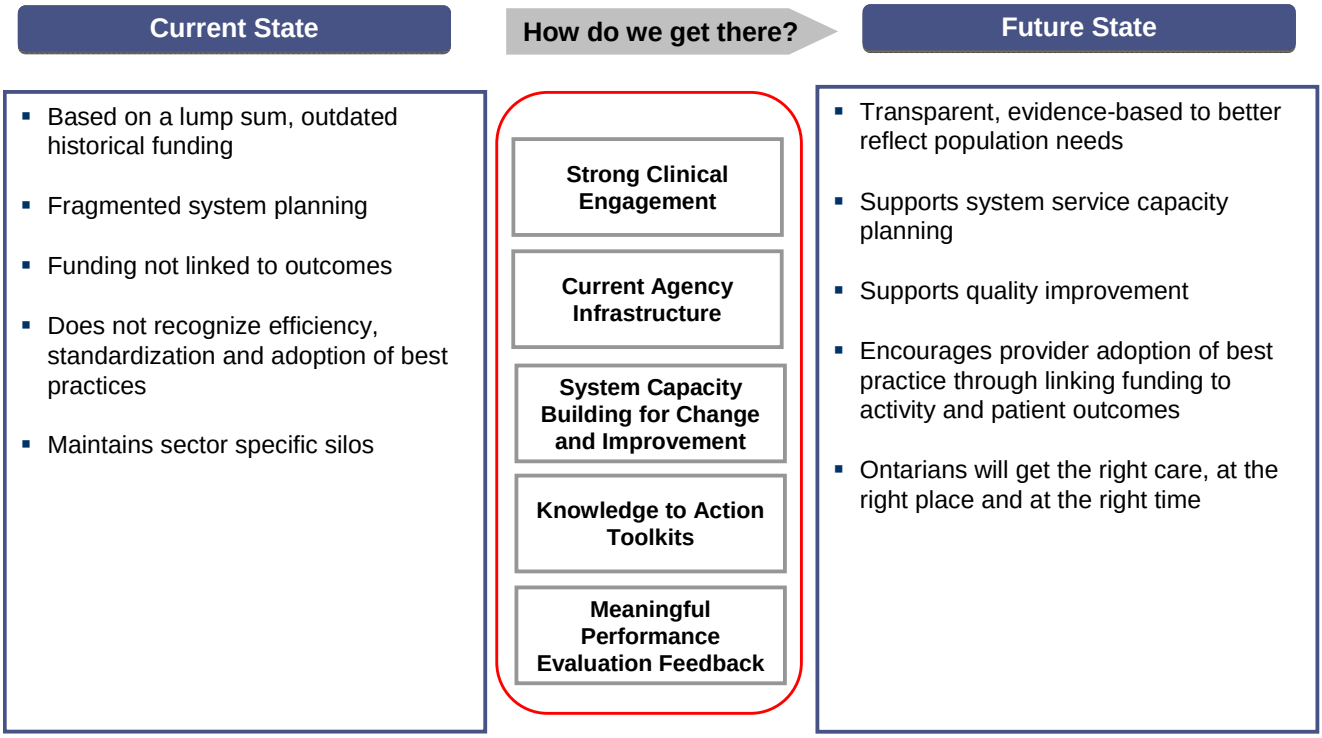
To support the paradigm shift from a culture of 'cost containment' to 'quality improvement,' the Ontario government is committed to moving towards a patient-centred funding model that reflects local population needs and contributes to optimal patient outcomes (Figure 1).

Internationally, PBF models have been implemented since 1983. Ontario is one of the last leading jurisdictions to move down this path. This puts the province in a unique position to learn from international best practices and lessons learned by others to create funding models that are best suited for Ontario.

PBF supports system capacity planning and quality improvement through directly linking funding to patient outcomes. PBF provides an incentive to health care providers to become more efficient and effective in their patient management by accepting and

adopting best practices that ensure Ontarians get the right care, at the right time and in the right place.

Figure 1: The Ontario government is committed to moving towards patient-centred, evidence-informed funding that reflects local population needs and incents delivery of high quality care



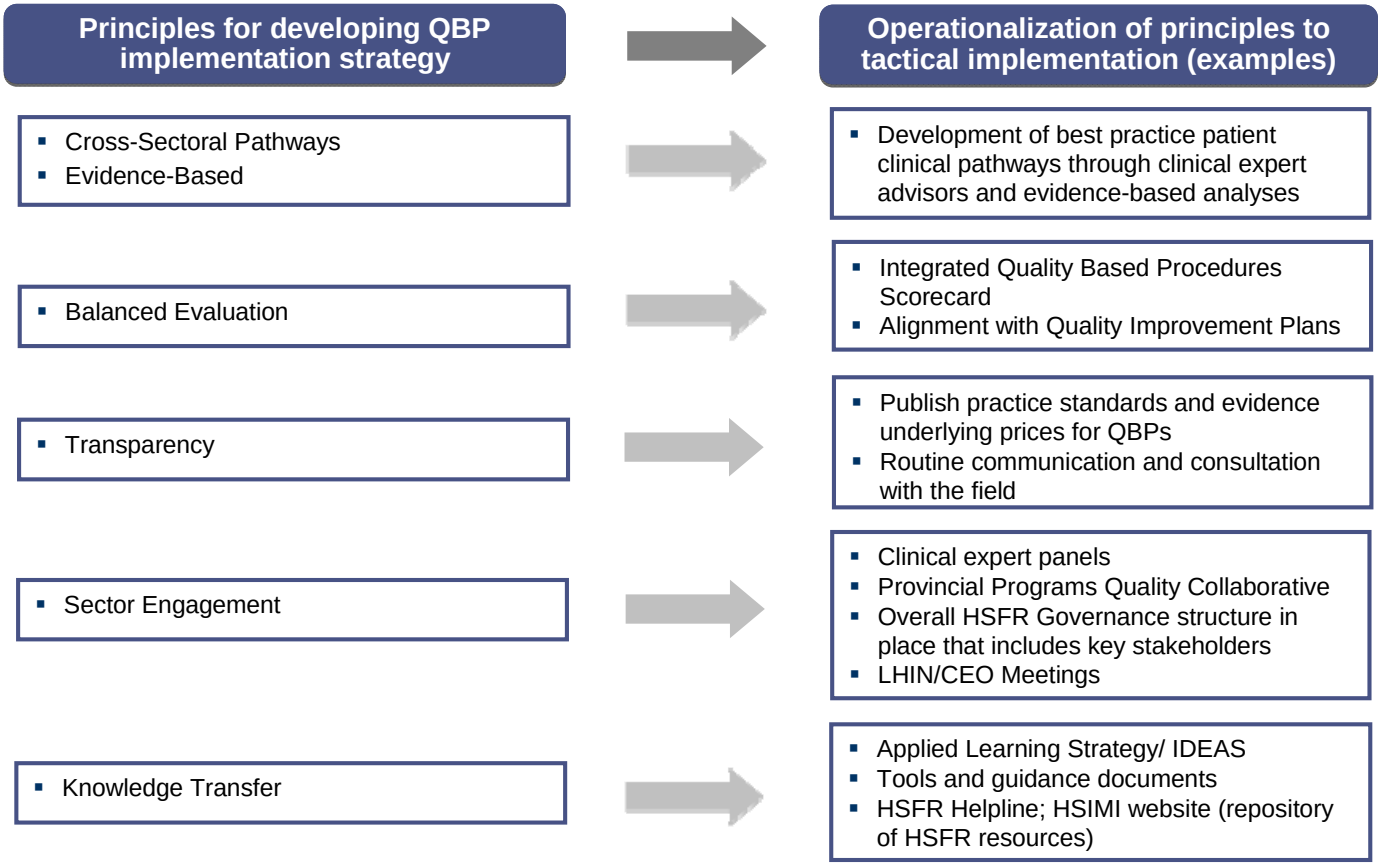
2.2 How will we get there?

The Ministry has adopted a three-year implementation strategy to phase in a PBF model and will make modest funding shifts starting in fiscal year 2012/13. A three-year outlook has been provided to the field to support planning for upcoming funding policy changes.

The Ministry has released a set of tools and guiding documents to further support the field in adopting the funding model changes. For example, a Quality-Based Procedure (QBP) Interim list has been published for stakeholder consultation and to promote transparency and sector readiness. The list is intended to encourage providers across the continuum to analyze their service provision and infrastructure in order to improve clinical processes and where necessary, build local capacity.

The successful transition from the current, 'provider-centred' funding model towards a 'patient-centred model' will be catalyzed by a number of key enablers and field supports. These enablers translate to actual principles that guide the development of the funding reform implementation strategy related to QBPs. These principles further translate into operational goals and tactical implementation, as presented in Figure 2.

Figure 2: Principles guiding the implementation of funding reform related to Quality-Based Procedures



2.3 What are Quality-Based Procedures?

QBPs involve clusters of patients with clinically related diagnoses or treatments. Cataract Surgery was chosen as a QBP using an evidence- and quality-based selection framework that identifies opportunities for process improvements, clinical re-design, improved patient outcomes, and enhanced patient experience as well as potential cost savings.

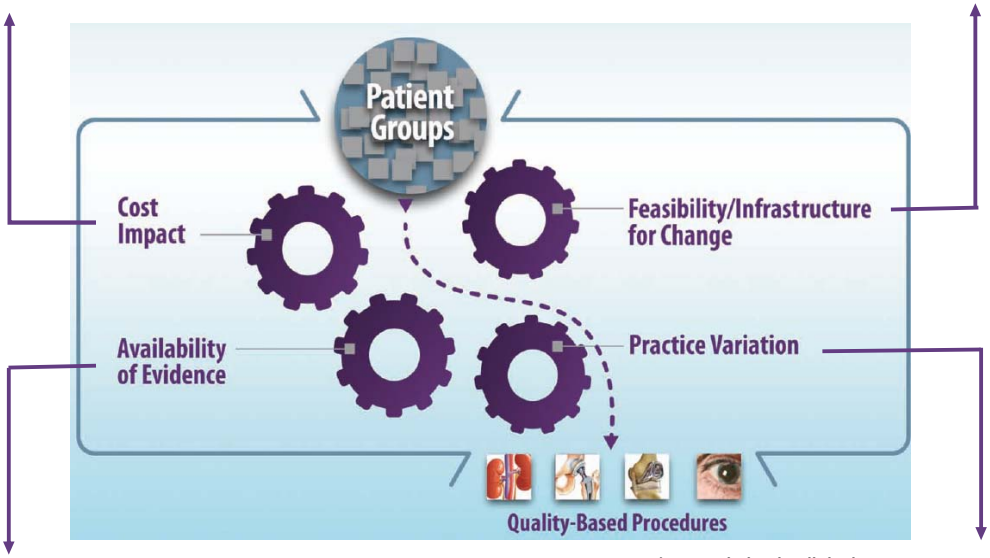
The evidence-based framework used data from the Discharge Abstract Database (DAD) adapted by the Ministry of Health and Long-Term Care for its Health Based Allocation Methodology (HBAM) repository. The HBAM Inpatient Grouper (HIG) groups inpatients based on the diagnosis or treatment responsible for the majority of their patient stay. Day Surgery cases are grouped within the National Ambulatory Care Referral System (NACRS) by the principal procedure they received. Additional data was used from the Ontario Case Costing Initiative (OCCI). Evidence such as publications from Canada and other jurisdictions and World Health Organization reports were also used to assist with the patient clusters and the assessment of potential opportunities.

The evidence-based framework assessed patients using four perspectives, as presented in Figure 3. This evidence-based framework has identified QBPs that have the potential to both improve quality outcomes and reduce costs.

Figure 3: Evidence-Based Framework

- Does the clinical group contribute to a significant proportion of total costs?
- Is there significant variation across providers in unit costs/ volumes/ efficiency?
- Is there potential for cost savings or efficiency improvement through more consistent practice?
- How do we pursue quality and improve efficiency?
- Is there potential areas for integration across the care continuum?

- Are there clinical leaders able to champion change in this area?
- Is there data and reporting infrastructure in place?
- Can we leverage other initiatives or reforms related to practice change (e.g. Wait Time, Provincial Programs)?



- Is there a clinical evidence base for an established standard of care and/or care pathway? How strong is the evidence?
- Is costing and utilization information available to inform development of reference costs and pricing?
- What activities have the potential for bundled payments and integrated care?

- Is there variation in clinical outcomes across providers, regions and populations?
- Is there a high degree of observed practice variation across providers or regions in clinical areas where a best practice or standard exists, suggesting such variation is inappropriate?

1. Practice Variation

The DAD has every Canadian patient discharge, coded and abstracted for the past 50 years. This information is used to identify patient transition through the acute care sector, including discharge locations, expected lengths of stay and readmissions for each and every patient, based on their diagnosis and treatment, age, gender, co-morbidities and complexities and other condition specific data. A demonstrated large practice or outcome variance may represent a significant opportunity to improve patient outcomes by reducing this practice variation and focusing on evidence-informed practice. A large number of 'Beyond Expected Days' for length of stay and a large standard deviation for length of stay and costs, were flags to such variation. Ontario has detailed case costing data for all patients discharged from a case costing hospital from as far back as 1991, as well as daily utilization and cost data by department, by day and by admission.

2. Availability of Evidence

A significant amount of research has been completed both in Canada and across the world to develop and guide clinical practice. Working with the clinical experts, best practice guidelines and clinical pathways can be developed for these QBPs and appropriate evidence-informed indicators can be established to measure performance.

3. Feasibility/ Infrastructure for Change

Clinical leaders play an integral role in this process. Their knowledge of the patients and the care provided or required represents an invaluable component of assessing where improvements can and should be made. Many groups of clinicians have already formed and provided evidence and the rationale for care pathways and evidence-informed practice.

4. Cost Impact

The selected QBP should have no less than 1,000 cases per year in Ontario and represent at least 1 per cent of the provincial direct cost budget. While cases that fall below these thresholds may in fact represent improvement opportunity, the resource requirements to implement a QBP may inhibit the effectiveness for such a small patient cluster, even if there are some cost efficiencies to be found. Clinicians may still work on implementing best practices for these patient sub-groups, especially if it aligns with the change in similar groups. However, at this time, there will be no funding implications. The introduction of evidence into agreed-upon practice for a set of patient clusters that demonstrate opportunity as identified by the framework can directly link quality with funding.

2.4 How will QBPs encourage innovation in health care delivery?

Implementing evidence-informed pricing for the targeted QBPs will encourage health care providers to adopt best practices in their care delivery models, and maximize their efficiency and effectiveness. Moreover, best practices that are defined by clinical consensus will be used to understand required resource utilization for the QBPs and further assist in the development of evidence-informed prices. Implementation of a 'price X volume' strategy for targeted clinical areas will incent providers to:

- Adopt best practice standards;
- Re-engineer their clinical processes to improve patient outcomes; and
- Develop innovative care delivery models to enhance the experience of patients.

Clinical process improvement may include the elimination of duplicate or unnecessary investigations, better discharge planning, and greater attention to the prevention of adverse events, i.e. post-operative complications. These practice changes, together with adoption of evidence-informed practices, will improve the overall patient experience and clinical outcomes, and help create a sustainable model for health care delivery.

3.0 Description of Cataract Surgery as a Quality-Based Procedure

Cataract surgery, as a QBP, refers to all procedures which begin with the code 1CL89*. Beginning April 1, 2012, these cases will no longer be a part of the Wait Time Strategy and thus, there will no longer be base volumes and incremental volumes for cataract surgery. All cases that fall within this inclusion criteria will be a part of the QBP and the Health Service Providers (HSP) will be funded as such.

As implementation progresses, greater emphasis will be required on ensuring the quality, completeness and timeliness of clinical documentation pertaining to cataract surgery into the relevant health database. The activity for the QBP will be determined by those patient cases that fall under the inclusion criteria. Therefore, for a hospital to receive recognition for having performed cataract surgery, the coded and abstracted data must include the assignment of the appropriate codes to identify the surgery as the principal procedure with a most responsible diagnosis that reflects the need for the surgery. The abstracted data must be submitted to the Ministry within the dates provided to the HSPs.

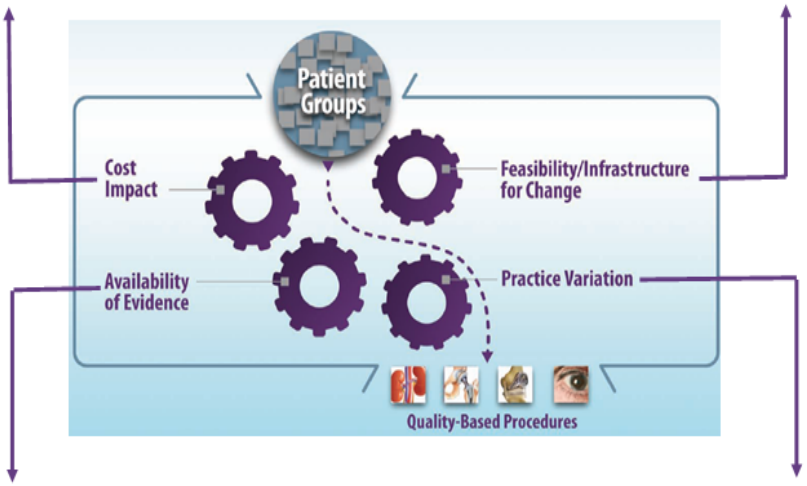
HSPs are expected to continue to meet the performance expectations specified within their accountability agreements.

Cataract Surgery has been identified as a QBP using the evidence-based selection framework, as presented in Figure 4.

Figure 4: Evidence-based framework for Cataract Surgery

- Ontario spends $84.5 annually (direct costs) on cataract surgery.
- There is significant cost variation between hospitals (44% variation in price between 25th and 75th percentile cost per case).

- Increased focus on the role community-based clinics can play in the delivery of cataract surgery (for example the Kensington Eye Institute in Toronto).



- Widespread anecdotal evidence regarding volumes and appropriateness.
- The ministry is working with ICES to explore some initial appropriateness research that has been carried out.

- Adoption of best practices allows for opportunities to standardize care and reduce practice variation.

1) Practice Variation

Currently, there are significant variations in the rates of cataract surgery across LHINs in Ontario. While the majority of LHIN-level wait times for cataract surgery remain under the Ontario Wait Time Strategy target, there remains a significant spread in median wait times. Moving forward, evidence-informed models for cataract surgery will be developed to standardize patient care and reduce practice variation.

2) Feasibility and Infrastructure for Change

There are many settings in which cataract surgery is performed in Ontario, ranging from rotations in multi use operating rooms to a high volume dedicated facility independent of a hospital. In some communities, LHINS may have the capacity to develop facilities that function with a high level of efficiency, safety and low cost using best practices from Ontario and elsewhere.

Data reporting on cataract surgery has been in place for hospitals using the Wait Time Information System, providing a tool that is able to support change management and analysis. The wait time target for access to cataract surgery from surgeon consultation is 182 days.

3) Availability of Evidence

The Ministry consults with clinical leaders in the field of cataract surgery for advice and best practices for cataract surgery. There is some evidence regarding the volumes and appropriateness of cataract surgery in Ontario.

Cataract surgeries have become more efficient with the use of new technology thereby improving patient outcomes and recovery times, and reducing the risks associated with the procedure. As a result, there is demand for cataract surgeries to be done at lower levels of disability.

Based on population demographics, evidence shows that Ontario's rate of cataract surgery is currently high, suggesting that the threshold for the surgery can be increased to maintain function at a reasonable level.

4) Cost Impacts

Prior to 2012, Ontario spent over $84.5 million annually on cataract surgeries. Upon reviewing the case costing data, the Ministry found a significant cost variation between hospitals in performing the surgery. Through the reduction of cost variation, there was potential for setting standards and increasing efficiency.

4.0 Evidence-informed practice[1] guiding the implementation of Cataract Surgery

Although there is already a high level of care provided to patients having cataract surgery, there remain areas where improvements could be achieved in the delivery of cataract surgeries. Within the hospital walls, there are opportunities for standardizing practice variation and using evidence-informed practices to better manage the costs of care.

Opportunities for the future include the development of evidence-informed patient clinical pathways that align the provision of service with agreed upon benchmarks and levels of disability. The evidence-informed practices and clinical pathway will be developed by Ontario's *Vision Care Team* with representation from leading experts in the field, clinicians and surgeons.

The clinical pathway will lay out other components of the care delivery journey where improvement in patient outcomes can be achieved. These include:

- Hospital processes designed to support patient flow:
    - Patients should not be admitted for cataract surgery
    - Surgeries are not cancelled
    - Patients are fully informed of all aspects of their care especially what to expect at each stage form referral, through surgery, post-surgery and follow up care.
    - Staffing is organized to allow for available resources

- To allow for benchmarking with peers, ready access to data that demonstrates quality and consistency for patients having cataract surgery is needed

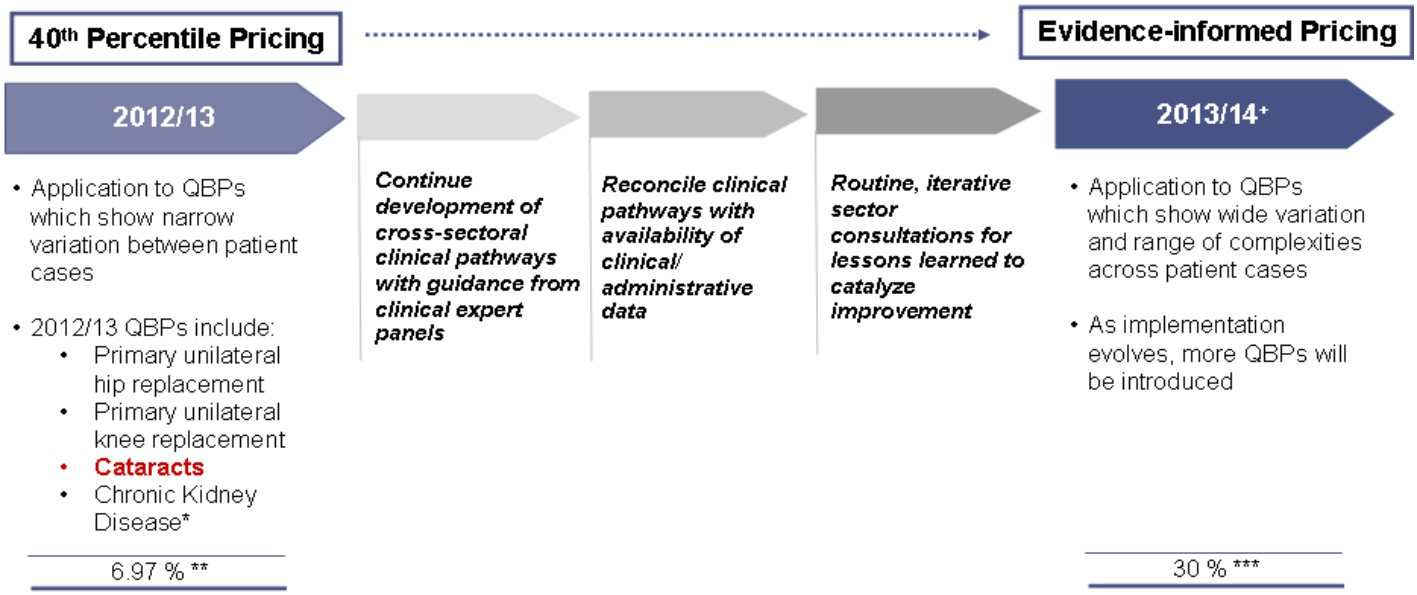
- The provision of consistently high quality patient educational information, including information in languages other than English must be improved

The patient clinical pathway is not a treatment practice guideline; it is intended to be used by multidisciplinary teams and is focused on the quality, coordination and efficiency of care. It does not replace specific clinical decision making.

While fiscal year 2012/13 has marked the initial implementation of Cataract Surgery as a QBP, this is to be considered a starting point to the move towards evidence-informed pricing (Figure 5).

[1] Evidence-informed practice refers to a combination of best available evidence and clinical consensus

Figure 5: As implementation evolves, an evidence-informed price will be set for Cataract Surgery



** Interim price is based on actual direct cost retrieved from OCCI data*
*** In 2012/13, QBPs will comprise approximately 6.97% of the total hospital global budget*
**** At the end of 2014/15, QBPs will comprise approximately 30% of the total hospital global budget*

5.0 How does Cataract Surgery improve patient outcomes?

Cataract surgery focuses on ensuring that patients and their families receive the best care possible, regardless of where they are in the province. From a patient's perspective, as well as excellent surgical care, this means a streamlined and an integrated systems approach. This includes improved and better access to care, shorter wait times and improved patient and family education on both the procedure and the post operative care.

6.0 What does it mean for clinicians?

6.1 How does Cataract Surgery as a QBP align with clinician practice?

Clinicians continue to work hard to improve the quality of care they provide to their patients. Innovative approaches and the development and adoption of evidence-informed practices have resulted in better outcomes and improved patient experiences, with shorter lengths of stay. QBPs will encourage the adoption of these best practices to optimize the patient experience and will maximize system capacity through improvements in length of stay and better use of operating room resources.

6.2 Will this have any implications for clinicians?

The changes associated with QBPs focus on identifying and implementing evidence-informed practice driven by clinical consensus. Clinicians will be tasked with identifying within their own practice standard treatment protocols and pinpointing where there are variances from such practice. Collaboration with their hospital administration will assist the clinicians in identifying the challenges within the service, as well as opportunities and the feasibility for changes to the treatment protocols.

Clinicians will continue to play an essential role in guiding hospitals to meet the needs of their patient population and ensuring that the highest quality care is provided for all their patients.

6.3 Will this change current practice?

For many clinicians the change to QBPs will have little impact on their current clinical practice unless there is a need to better align with agreed-upon practice.

At this time, physician payment models and OHIP fee schedules, as they relate to QBPs, will remain unchanged. Physicians' currently working under fee-for-service will continue to submit claims to OHIP for consultations, performing the procedure and follow-up.

7.0 Service capacity planning

The service capacity planning for cataract surgery will build on already existing capacity planning processes that are in place for the wait-time priorities. The types and number of QBPs a HSP provides will be determined by the institution, in close collaboration with their LHINs, their physicians, and other partners to ensure there are no access issues for the patients.

7.1 How will clinician volume management be affected by or affect hospital Cataract Surgery volumes?

Clinicians and administration within their organization will need to continue (or initiate) volume plans for all their cataract surgeries. Where the HSP considers a large change in their desired volumes, discussions and collaboration with the physicians and their LHINs will be essential to maximize the potential to achieve the new volume targets.

7.2 How will the new model of budget planning include clinicians?

Clinicians will continue to work with hospital administration to ensure that operating room allocations are sufficient to meet the needs of their local patient population. At the LHIN level, decisions will also be made on community services to meet the needs for patients.

8.0 Performance, evaluation and monitoring

Currently, cataract surgery performance is being measured through adherence to Ontario's wait time target of 182 days.

In the future, QBPs will be adjusted for both patient complexity and the quality of health care delivered. Together with academic experts, hospital administrators and clinicians, indicators for each QBP will be developed. These indicators will provide a comprehensive and integrated view of the quality of care provided to patients in terms of outcomes, patient-centeredness and efficiency with regard to the respective QBP.

Recognizing the different users of the indicator information, the Ministry envisions a cascade of measures. There will be a number of system or provincial level indicators that will be impacted by other measures or driving factors that are relevant for LHIN's, hospitals or physicians. The indicators will enable the province and its partners to monitor and evaluate the quality of care and allow for benchmarking across organizations and physicians. This will in turn support quality improvement and enable target setting for each QBP to ensure that the focus is on providing high quality care, not reducing costs.

An evaluation framework for assessing the impact of Health System Funding Reform on the health care system will be developed through literature reviews and expert consultation. An integrated QBP scorecard will be developed to assess the impact of QBPs against indicators of quality. This scorecard will be aligned with currently existing quality indicators used in other reporting processes.

9.0 Support for Change

Ontario has many system leaders that can act as champions of change. Ontario's *Vision Care Team* (to be established shortly) will provide input on the overarching HSFR strategy for system change and specifically, lead the change management related to the QBP for cataract surgery.

The Ministry, in collaboration with its partners, will deploy a number of field supports to support adoption of the funding policy. These supports include:

- Strong clinical engagement with representation from cross-sectoral health sector leadership and clinicians to develop standards of care and guide the development of evidence-informed patient clinical pathways for the QBPs

- Strengthened relationships with Ministry partners and supporting agencies to seek input on the development and implementation of QBP policy, disseminate quality improvement tools, and support service capacity planning

- Alignment with quality levers such as the Quality Improvement Plans (QIPs). QIPs strengthen the linkage between quality and funding and facilitate communication between the hospital board, administration, and public on the hospital's plans for quality improvement and enhancement of patient-centered care

- Deployment of a Provincial Scale Applied Learning Strategy known as IDEAS (Improving the Delivery of Excellence Across Sectors). IDEAS is Ontario's investment in field-driven capacity building for improvement. Its mission is to help build a high-performing health system by training a cadre of health system change agents that can support a approach to improvement of quality and value in Ontario

We hope that these supports, including this Clinical Handbook, will help facilitate a dialogue between hospital administration, clinicians, and staff on the underlying evidence guiding QBP implementation. The field supports are intended to complement the quality improvement processes currently underway in your organization.

10.0 Frequently Asked Questions

Question 1:

I only operate on complex patients with complex needs. Have these cases been considered?

The funding methodology has been used to set a funding rate based on the practice patterns that have been tracked through the administration and financial databases and represent quality practice for cataract surgery in Ontario. However, there may be cases that are high risk or complex that will need to be funded through the global budget with funding allocated as per usual hospital practice.

Question 2:

What is stopping me from just accepting straightforward patients?

Patient case mix , patient complexity and patient needs for treatment and care will not change due to the creation of QBPs and HSPs will continue to be guided by their agreements with their LHINs, their Wait Times obligations and their HSP clinical focus. . Funding will be reflective of patient acuity and resource requirements as we move forward. Thus, accepting only straightforward cases will result in a reduction of funding for the organization in addition to reducing access to care for patients with a high acuity and urgent need for care.

Question 3:

How can I obtain more information about this?

- Helpline
  - Email: HSF@ontario.ca
  - Phone: 416-327-8379
- The Ministry's public website: www.health.gov.on.ca
- Access the "Health Care Professionals" page
  - Excellent Care For All (www.health.gov.on.ca/en/ms/ecfa/pro/)
  - HSFR (http://www.health.gov.on.ca/en/ms/ecfa/pro/initiatives/funding.aspx)
- Password protected website for provider: www.hsimi.on.ca
  - Repository of HSFR resources, including HBAM results and education materials

For further information, please visit:

Cancer Care Ontario
https://www.cancercare.on.ca/

Excellent Care for All Act
http://www.health.gov.on.ca/en/ms/ecfa/pro/about/

Health System Funding Reform
http://www.health.gov.on.ca/en/ms/ecfa/pro/initiatives/funding.aspx

Ontario Medical Association
https://www.oma.org/Pages/default.aspx

Health Quality Ontario
www.hqontario.ca

Canadian Institute for Health Information
http://www.cihi.ca/CIHI-ext-portal/internet/EN/Home/home/cihi000001

Institute for Clinical Evaluative Sciences
http://www.ices.on.ca/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