

Reallocating Cancer Surgery Payments for Alternate Level of Care in Ontario: What Are the Options?

Réaffectation des paiements pour les chirurgies oncologiques à un autre niveau de soins en Ontario : quels sont les choix?



JUDITH WONG, MA

Methodologist

Ontario Health (Cancer Care Ontario)

Toronto, ON

SHANNON MILROY, MA, MSc

Health Economist

Ontario Health (Cancer Care Ontario)

Toronto, ON

KATHERINE SUN, MPH

Senior Analyst

Ontario Health (Cancer Care Ontario)

Toronto, ON

PIERRE IORIO, MSc

Methodologist

Ontario Health (Cancer Care Ontario)

Toronto, ON

MAY SETO, MLT

Group Manager

Funding Unit

Ontario Health (Cancer Care Ontario)

Toronto, ON

JULIA MONAKOVA, PhD, MPP

Group Manager

Funding Unit

Ontario Health (Cancer Care Ontario)

Toronto, ON

JASON M. SUTHERLAND, PhD

*Faculty, UBC Centre for Health Services
and Policy Research*

*Professor, UBC School of Population and Public Health
University of British Columbia
Vancouver, BC*

Abstract

This article examines how alternate-level-of-care (ALC) days are funded through the cancer surgery funding model in Ontario and evaluates policy options to better address ALC days. The contribution of ALC days to hospital funding and the impact of removing or reallocating this funding from cancer surgery is measured. Though costs associated with ALC days in cancer surgery are low, this article highlights the need for policy options that would realign funding across the healthcare system in Ontario to better meet the needs of patients waiting for ALC, reduce pressure on inpatient bed capacity and improve value for money.

Résumé

Cet article examine comment les journées d'hospitalisation d'autres niveaux de soins (ANS) sont financées grâce au modèle de financement pour les chirurgies oncologiques en Ontario et évalue les choix stratégiques pour mieux traiter la question des journées ANS. On y mesure la contribution des journées ANS au financement des hôpitaux ainsi que l'impact de la suppression du financement pour les chirurgies oncologiques ou de sa réaffectation. Bien que les coûts associés aux journées ANS en chirurgie oncologique soient faibles, cet article met en évidence le besoin de stratégies politiques pour réaligner le financement dans l'ensemble du système de santé de l'Ontario afin de mieux répondre aux besoins des patients en attente d'ANS, de réduire la pression sur la capacité des lits d'hôpital et d'améliorer l'optimisation des ressources.

Introduction

In Canadian provinces, when a patient no longer requires the intensity of resources or services provided in acute care, but is waiting to be discharged to a more appropriate care setting, the patient is designated as needing alternate level of care or ALC (CIHI 2009, 2012; Sutherland and Crump 2011, 2013). ALC is a long-standing challenge across hospitals in Ontario, with negative impacts including patients not receiving care most suited to their needs, decreased hospital capacity to admit new patients and higher costs to the health system. ALC is not exclusive to Canada; the Netherlands, England, Spain and Italy have all reported issues with delayed discharge (Landeiro et al. 2017; National Audit Office 2016).

There are significant health and financial impacts of not discharging patients who no longer need the intensity of care provided in an acute-care hospital bed (Costa and Hirdes 2010). In the fiscal year 2015–2016 (April 1, 2015, to March 31, 2016), 13.9% of inpatient bed days in Ontario, Canada, were occupied by patients waiting for an alternate setting of care (Health Quality Ontario 2017). This percentage equates to an average of 3,961 hospital beds per day in Ontario (Health Quality Ontario 2017) at a cost of over \$4 million per day or over \$1.5 billion per year (based on an estimated cost of C\$1,090 [as of 2016] per ALC bed day; Sutherland et al. 2019).

Excessively long hospitalizations are an ineffective use of scarce hospital resources, leading to denial of beds to waiting patients; recent statistics from a number of Canadian provinces have shown hospital occupancy rates at over 100% (CBC News 2016; Grant 2017; Ontario Health Coalition 2017). In Canadian hospitals with the highest occupancy rates, up to one-third of the beds are filled with patients designated ALC (Lavergne 2015; McCloskey et al. 2014), and some small community hospitals have reported even higher rates. For patients, longer hospitalization while waiting for ALC is associated with increased risk of functional decline (Manville et al. 2014; McCloskey et al. 2014) and adverse events (Baker

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et al. 2004). Moreover, patients designated ALC have reported feelings of guilt, being undeserving of staff attention (McCloskey et al. 2015), stress due to the uncertainty of the discharge process (Cressman et al. 2013; Kuluski et al. 2017), social isolation and physical and mental stagnation due to prolonged hospital stays (Wilson et al. 2013).

The causes of ALC days are complex, including potential patient, hospital and community factors. A lack of adequate community care is often cited as the most common cause because hospitalized patients may not have a discharge location in the community where their care needs can be safely met, or their preferred discharge location may not have beds available (Afilalo et al. 2014; Costa and Hirdes 2010; Jutan et al. 2013; McCloskey et al. 2014). Processes within hospitals may play a role as well, including the underestimation of patients' potential for independence, the deconditioning of patients while in hospital and hospital staff's lack of understanding of home care (Bender and Holyoke 2018).

Hospital funding in Ontario

In Ontario, the Ontario Ministry of Health (MOH) provides funding for hospitals through regional health authorities called Local Health Integration Networks (LHINs). Cancer Care Ontario (CCO), now a division of Ontario Health – an agency funded by the MOH – finances hospitals for cancer and renal care.

Approximately 55% of hospitals' public revenues are based on global budgets set by the MOH (Palmer et al. 2018). Approximately 30% of revenues are based on Ontario's Health-Based Allocation Model, a proportional allocation of funding based on hospitals' case mix, relative cost-efficiency, market share and volume (Ontario Ministry of Health and Long-Term Care 2011). The final 15% of revenues are funded by the MOH or CCO on a per-case basis for 20 service groups, called Quality-Based Procedures (QBPs) (Palmer et al. 2018).

The cancer surgery QBP is one of the volume-based QBPs funded by CCO. The scope of QBP-funded cancer surgery activity spanned four cancer disease sites in the fiscal year 2016–2017: colorectal, prostate, breast and thyroid surgeries. The transition of all cancer surgery disease sites to volume-based QBP funding was completed in fiscal year 2019–2020 (Ontario Ministry of Health and Long-Term Care 2019).

For the Cancer Surgery QBP, hospitals receive per-case funding from CCO based on the provincial price per weighted unit and the hospital's average weight per case for each disease site. CCO sets the provincial price per weighted unit following MOH guidelines (Ontario Ministry of Health and Long-Term Care 2013). For inpatient surgeries, the funding amount remunerates the hospital for the episode of care, including the procedure and inpatient stay. The funding amount does not include community-based health services such as post-discharge home care or long-term care, which are funded separately by the MOH.

Funding and incentives

Given that Ontario hospitals operate within a system of multiple decision makers, including

patients, clinicians and senior administrators, and varying incentives created through different revenue sources, Ontario's hospital funding policies may contribute to the problem of ALC days.

The per-case funding calculation includes incremental hospital funding for ALC days, as each patient's case weight increases with additional ALC days. This policy has two undesirable consequences. First, the funding models do not address the issue of ALC directly as funding is spread across multiple envelopes, making the financial incentives to the hospitals unclear and giving no direct incentive to home care or long-term care to take on ALC patients. Second, by including ALC days in QBP funding for cancer surgery, the distribution of funding to hospitals is distorted, increasing funding to hospitals with more ALC days rather than for more complex cancer patient or surgery characteristics.

ALC days do not provide good value for money, as patients are not being served in the most appropriate setting for their care needs and acute care is costlier than community care. In many countries, value-for-money concepts have been embedded in funding formulas and nonpayment based on quality measures is becoming more common. In the US, a medicare policy reduces payments to hospitals for excessive readmissions (Desai et al. 2016; Zuckerman et al. 2016), and the National Health Service in England uses a similar hospital-based policy (Kristensen et al. 2014). In Germany, hospital readmissions for the same reasons or for complications of treatment are not remunerated (Kristensen et al. 2014), and in Australia, incremental hospital costs attributable to avoidable events are not remunerated (Independent Hospital Pricing Authority 2018).

Given the provincial policy goals of reducing ALC days and increasing acute inpatient bed capacity, there is a need for policy options that would realign funding to better meet the needs of patients waiting for other settings of care, reduce pressure on inpatient bed capacity and improve value for money. The purpose of this study is twofold: first, to untangle the financial impact of funding ALC days within cancer surgery episodes and, second, to assess funding policy options. Aligning funding policies with improving patient and health system outcomes aims to generate renewed interest in policy and decision makers to tackle an endemic problem in Canada.

Data and Methods

For QBP-funded cancer surgeries, inpatient hospital discharge summaries from the Discharge Abstract Database (DAD) are used for the fiscal year 2015–2016. Breast and thyroid surgeries may also be performed in an outpatient setting, but as these cases are not relevant to ALC, they have been excluded from the analysis.

Eligible QBP-funded cases are identified from the DAD dataset using diagnosis and intervention codes (Ontario Ministry of Health and Long-Term Care 2019). Each discharge summary includes a variable for whether the hospitalization was scheduled or emergent. Cases ineligible for QBP funding are excluded (pediatric cases, non-residents of Ontario,

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those ineligible for provincial insurance and those whose surgeries were cancelled or abandoned; Ontario Ministry of Health and Long-Term Care 2019).

Each inpatient discharge summary includes variables for length of stay and the number of ALC days. ALC designation is defined the same way for cancer-related hospitalizations as for non-cancer-related hospitalizations. Each hospitalization includes a case weight assigned by the Canadian Institute for Health Information's (CIHI) case mix algorithm. The financial impact of removing ALC days from cancer surgery QBP funding cannot be calculated by simply multiplying the average cost of an ALC bed day by the number of ALC days – it requires recalculating each component of the QBP funding methodology, excluding costs associated with ALC.

Cancer surgery QBP pricing

Funding per case for each cancer 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 average weight per case or case mix index (CMI). The base price is set for each disease site based on average costs reported in Ontario Case Costing Initiative (OCCI) data, which is Ontario's repository of retrospective patient-level cost data generated by a sample of hospitals (Wodchis et al. 2013). This case costing data includes patients' costs for each applicable cost centre (department). CCO adjusts the cost data to remove hospital-specific factors expected to impact cost, including teaching hospital status, proportion of tertiary cases and rurality. Eligible patients' hospitalization costs are then divided over the sum of their weighted cases to obtain the cost per weighted unit (base price) and scaled to fit the available funding envelope.

Hospital CMIs

The CMI is a continuously valued variable that reflects a hospital's case mix, or the average weight of its cases in the same QBP and disease site. For each disease site, each hospital's CMI is calculated as the average weight per case among eligible cancer surgery cases. Hospitals' CMIs are updated each fiscal year for each disease site.

Removing ALC costs

First, the case weights are recalculated excluding ALC days from patients' hospitalization weight calculation. This calculation is achieved by using CIHI's case weight calculation algorithm and subtracting the ALC portion of the stay from the total length of stay.

There are three ways by which the removal of ALC days impacts inpatient case weights: the category into which each case is assigned determined by length of stay (long stay outlier status), the number of days beyond the length of stay trim point and additional case weight adjustments for flagged interventions that are based on the length of stay percentile. Revised case weights are applied to hospitals' activity to calculate hospitals' average CMIs while excluding ALC days.

The second step is to remove ALC costs from the base price calculations. The base price is recalculated by removing ALC costs from the total cost calculations in OCCI and by dividing these costs with the revised total weighted cases. Finally, the available funding envelope is recalculated based on the revised total weighted cases, and the base price is then scaled to fit the revised total available funding for cancer surgery.

To remove patients' costs associated with their ALC days, ALC days are assumed to occur at the end of each stay. This assumption is necessary because the DAD does not distinguish acute days of stay from ALC days. It is possible that ALC days may not occur at the end of the patient's stay if, for example, they are designated ALC but subsequently experience a deterioration in health that designates them acute for a second time during the same hospitalization. The cost of ALC could then increase if some of the acute days' costs are assumed to be costs of ALC days. Also, in the OCCI data, a number of inpatient departments' costs, such as laboratory and pharmacy expenses, could not be separated from the ALC days' costs. These costs were retained in the patients' hospitalization costs, which may understate the impact of removing ALC.

In a third step, the funding amounts received from QBP for hospitals' cancer surgeries are recalculated based on the hospitals' revised CMI values and revised base price multiplied by their case volumes, and the difference between the original and revised funding amounts are noted as the impact of removing ALC days. The total number of QBP-funded cancer surgeries and the sum of ALC days are calculated to illustrate the magnitude of the impact on cancer surgery funding. The policy's effect on QBP prices and hospitals' funding is examined by region (i.e., the LHIN) to measure impact.

A simplified version of this methodology is then applied to all cancer and non-cancer QBPs in the fiscal year 2016–2017, for which technical specifications were available (as of fiscal year 2017–2018) to estimate total provincial spending on ALC days through QBP payment models. The simplified methodology recalculates CMIs for each QBP when excluding ALC days and multiplies the change in CMI by the base price and total cases for each QBP. The QBP base prices are not recalculated, given the negligible change in base price observed after recalculating the base price for colorectal cancer surgery.

Results

As shown in Table 1, the number of ALC days included in cancer surgery cases ranged from zero to 2,369 in the fiscal year 2015–2016, with QBP-funded colorectal cancer surgeries having the highest number of ALC days among cancer surgery disease sites. For colorectal cancer surgery, 4.3% of the total days of stay were designated ALC in 2015–2016, less than half the overall Ontario proportion of 13.9% of acute inpatient bed days. Subsequent analyses focused on the impact of ALC days associated with QBP-funded colorectal cancer surgery, as the number of ALC days associated with the other QBP-funded cancer surgeries was negligible.

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TABLE 1. Number of ALC days by disease site for fiscal year 2015–2016

QBP-funded cancer surgery disease site	Number of eligible QBP cases	Total days of stay	ALC days	Ontario Average CMI
Colorectal	6,501	54,937	2,369	2.58
Prostate	2,405	5,726	0	1.44
Breast (with immediate reconstruction)	616	1,458	0	1.71
Breast (without immediate reconstruction)	2,299	3,405	70	0.98
Breast (delayed reconstruction)	378	1,093	5	1.78
Thyroid	3,451	5,436	42	0.83

As shown in Table 2, patients undergoing emergency, rather than elective colorectal surgery, were most likely to be designated ALC ($p < 0.01$). This finding is consistent with that of some other studies, which report that emergent cases have longer lengths of stay and are more likely to have complications such as surgical site infection, evisceration and anastomotic leakage (Bayar et al. 2016).

TABLE 2. Admission category for colorectal cancer surgery cases with and without ALC days, fiscal year 2015–2016

Admission category	Cases without ALC days	Cases with ALC days	Total	P-value
Scheduled/Elective	5,254 (83.8%)	108 (46.8%)	5,362	<0.01
Urgent/Emergent	1,016 (16.2%)	123 (53.2%)	1,139	

Changes in the CMI associated with the removal of hospitals' ALC days from QBP-funded colorectal cancer surgery resulted in a decline in the average CMI of 0.05 (1.94%), from 2.58 to 2.53. As shown in Table 3, there was variation in average CMI between regions.

Removing ALC days from the payment amount resulted in an increase in the base price of \$0.76 (from \$5,203 to \$5,204 or 0.01%). The small increase is attributable to removing ALC from the numerator and denominator in recalculating the cost per weighted unit.

As shown in Table 4, Ontario spent over \$87 million on hospitals' colorectal surgeries in fiscal year 2015–2016. Removing QBP funding for ALC days would reduce spending on QBP-funded colorectal cancer surgery by almost \$2 million for fiscal year 2015–2016 activity, or 2.25% of CCO's total payments to hospitals for their QBP-funded colorectal cancer activity. Divided across the 2,369 ALC days associated with these surgeries, the funding amount was \$829 per ALC day.

TABLE 3. Effect of removing ALC days on hospitals' and LHINs' CMI, fiscal year 2015–2016

Local Health Integration Network (LHIN)	Average CMI – including ALC days	Average CMI – excluding ALC days	Average Hospital change	Range of hospital change (min., max.)
Overall	2.58	2.53	-0.06	(0, -0.67)
Erie St. Clair	2.54	2.46	-0.04	(0, -0.14)
South West	2.52	2.48	-0.05	(0, -0.24)
Waterloo Wellington	2.56	2.54	-0.01	(0, -0.04)
Hamilton Niagara Haldimand Brant	2.90	2.81	-0.08	(-0.01, -0.25)
Central West	2.42	2.33	-0.05	(0, -0.10)
Mississauga Halton	2.48	2.42	-0.09	(-0.02, -0.17)
Toronto Central	2.68	2.65	-0.04	(-0.00, -0.18)
Central	2.51	2.40	-0.10	(-0.04, -0.16)
Central East	2.56	2.54	-0.02	(-0.00, -0.03)
South East	2.56	2.51	-0.11	(0, -0.37)
Champlain	2.57	2.48	-0.07	(0, -0.41)
North Simcoe Muskoka	2.45	2.43	-0.02	(0, -0.10)
North East	2.47	2.43	-0.12	(0, -0.67)
North West	2.27	2.26	-0.00	(0, -0.01)

The largest absolute change in cancer surgery funding was in the Central LHIN, the region with the highest amount of ALC days, corresponding to a total decrease of over \$400,000 and approximately 4.5% of CCO's funding for colorectal cancer surgery in this region. At the same time, a number of regions, such as the North West LHIN, had few ALC days and the absolute and relative impact would be small, less than \$5,000 and less than 0.30% of funding.

Total provincial spending on ALC days across all cancer and non-cancer QBP's was estimated at over \$100 million per year in Ontario, with wide variation between QBP's in the proportion of inpatient days that were designated ALC and the proportion of QBP funding attributable to ALC days.

Discussion

CCO spends \$829 per ALC day or about \$2 million per year on QBP-funded colorectal cancer surgery. This funding amount is based on 4.3% of days being designated ALC among QBP patients, a proportion substantially lower than the provincial average of 13.9% of total inpatient days. The proportion of ALC days was even lower for the other cancer surgery disease sites examined in 2015–2016. It should be noted that this study did not examine factors such as age or comorbidities of patients, and it is possible that ALC rates among cancer surgery patients may be higher than the provincial average after accounting for these factors.

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TABLE 4. Financial impact of removing payment for ALC days from colorectal surgery funding, fiscal year 2015–2016

Local Health Integration Network (LHIN)	Funding for colorectal surgery, including ALC days	ALC days	Impact of removing ALC Days	Percentage impact of removing ALC days
Overall	\$87,414,461	2,369	-\$1,963,757	-2.25%
Erie St. Clair	\$4,049,585	137	-\$137,210	-3.39%
South West	\$7,798,469	67	-\$93,776	-1.20%
Waterloo Wellington	\$4,369,091	50	-\$34,783	-0.80%
Hamilton Niagara Haldimand Brant	\$12,256,171	453	-\$372,746	-3.04%
Central West	\$2,797,318	86	-\$104,520	-3.74%
Mississauga Halton	\$5,614,399	152	-\$116,380	-2.07%
Toronto Central	\$11,447,313	145	-\$120,905	-1.06%
Central	\$8,983,965	469	-\$402,853	-4.48%
Central East	\$9,365,382	152	-\$74,224	-0.79%
South East	\$3,339,292	63	-\$63,907	-1.91%
Champlain	\$8,836,149	416	-\$334,309	-3.78%
North Simcoe Muskoka	\$3,072,856	47	-\$30,366	-0.99%
North East	\$4,093,162	115	-\$73,551	-1.80%
North West	\$1,391,303	17	-\$4,220	-0.30%

Although QBP funding increases with increased ALC days, the myriad funding and cost incentives faced by hospitals and care providers make it difficult to assess the impact of any single funding policy. The variation in ALC rates between both disease sites and regions suggests that the QBP funding model is not a primary driver of ALC days among QBP patients.

Though this study did not find evidence that the QBP funding model is driving worse outcomes than the provincial average with respect to ALC days, it is also clear that the funding model does not fully align with its stated goals. Because the CCO Cancer Surgery QBP funding model aligns with the methodology for all MOH-managed QBPs, the implications of this model apply to all CMI-based QBP funding models. The QBP Clinical Handbook states that “QBPs incent healthcare providers to become more efficient and effective in their patient management by adopting clinical best practices that ensure Ontarians get the right care, at the right time, and in the right place” (Ontario Ministry of Health and Long-Term Care 2019). For hospitals, incremental funding for ALC days does not incent either efficiency or ensuring that their patients get care in the right place. For CCO and the MOH, a policy of removing ALC from QBP funding would disentangle funding on QBPs from funding for ALC days, which are a health system challenge much broader in scope than individual procedures. Embedded funding for ALC days means that, should the broader issues of unmet ALC needs persist or worsen, CCO and the MOH risk rising per-case

QBP costs, which would in turn reduce the number of cases that can be funded within a finite funding envelope.

An advantage of working to realign funding policies to better address ALC needs among QBP patients is that the funding policy is already designed to provide incremental per-case funding, and the amount currently spent on ALC days can be estimated using the methodology developed in this study. Policy options framed in terms of better allocation of current spending may be politically more feasible than options where additional investment is required and potential cost savings are unknown. This study estimated that funding for ALC days across all cancer and non-cancer QBPs is over \$100 million per year. Realigning QBP funding models to better address ALC could improve funding efficiency and care outcomes for QBP patients, and potentially yield lessons for how to better support the non-QBP patient population waiting for ALC.

There are several policy options for realigning QBP funding to better address ALC needs. Given the relatively small proportion of ALC days funded through any individual QBP, and the complexity of the funding and other incentives at work, coordinated provincial action to reduce ALC is needed, including applying multiple funding and non-funding policy changes in concert. Policy options include removing incremental funding for ALC days from QBP funding formulas, redirecting current QBP spending to the home and community care sectors and creating bundled payments for acute and post-acute care.

Removing incremental funding for ALC days from QBP case weight calculations would disentangle patients' ALC needs from their QBP episode needs, separating and making transparent the funding drivers. Making this policy change alone shifts the financial risk associated with the ALC portion of hospital care from QBP funding envelopes to hospital budgets. Hospitals may in turn work to transfer this risk to the MOH through requests for increased non-QBP funding, or to patients through increased discharge pressure. Among QBPs with a higher risk of ALC days, it is also possible that hospitals may choose to avoid the financial risk by not accepting QBP patients or funding.

A complementary funding policy change redirecting current QBP funding for ALC days to the home and community care sectors has the advantage of boosting capacity in the areas where patients with ALC needs would be more appropriately served. Long-term care is the most common discharge location for patients designated ALC, but home care and supportive housing play an important role too (Health Quality Ontario 2017). As costs of delivering care are generally lower outside the acute hospital setting, cost savings per patient day could potentially be achieved. However, increased funding to home and community care providers alone does not remove the financial risk that hospitals would incur if ALC funding is removed from hospital funding formulas. As previously noted, QBP funding accounts for a minority of ALC days, so redirecting QBP funding alone is unlikely to fully meet the broader capacity challenges in home and community care. Hospitals may still incur financial risks when treating QBP patients with a high probability of waiting for ALC.

One potential resolution to the competing financial risks and incentives between CCO,

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the MOH, hospitals and community providers may lie with the recent initiatives to pilot bundled payments covering acute and community care. The current health system funding is predominantly siloed, with separate funding streams for hospital services and other aspects of the patients' continuum of care. Making hospitals the primary fund-holders for bundled payments may allow them to more effectively manage the financial risks associated with long waits for ALC by purchasing post-acute care for patients in a variety of settings, such as long-term care and home care. Care providers would also have the flexibility to invest bundled payments in other ways that could potentially reduce hospital length of stay, such as enhanced discharge planning or rehabilitation services.

The finding that patients undergoing emergency rather than elective colorectal cancer surgery were more likely to have ALC days suggests that there may also be areas for improvement in patients' pre-surgery care. Improvements in the screening and diagnosis stages of the cancer care path may reduce the frequency of emergency surgeries, leading to improved patient outcomes in many areas, including ALC. This finding may also indicate a correlation of multiple access issues for subgroups of patients (i.e., weaknesses in access and referral to cancer services, as well as home and community supports). Although further research should be undertaken to explore the needs of these patients, it should also be noted that the majority of ALC days for colorectal cancer surgery patients were among patients who had elective surgery, as these comprise the majority of QBP patients.

This discussion has focused on realignment of funding policies to better serve QBP patients. These policy changes would help to remove funding as a potential barrier to providing more efficient and appropriate care. However, they will be ineffective if non-funding barriers such as patient capacity assessments or hospital staff knowledge of home care are driving ALC days (Bender and Holyoke 2018). A comprehensive policy solution will need to explore and address any non-financial barriers to providing patients with care in the most appropriate setting.

Limitation

This study is limited by its focus on cancer surgery cases across four disease sites, primarily colorectal cancer surgery. Relatively few ALC days were observed for these patients; however, an extension of the study's methodology found a larger magnitude of ALC days and QBP funding across all provincial inpatient QBP funding, which rely on the same patient weight calculations. Further research could examine patterns of ALC days across multiple QBPs and explore patient, hospital and regional characteristics that may be driving ALC days.

Conclusion

This study sought to approach the long-standing challenge of ALC days in Ontario hospitals from the perspective of QBP funding policy. The analysis demonstrates that funding for ALC days through QBP-funded cancer surgeries is relatively low. However, there are opportunities to realign QBP-funding policies by removing incremental funding ALC days from

the QBP funding formula and reallocating this funding to the home and community care sectors or by combining these two changes by implementing bundled payments that would cover both acute and post-acute care. Funding policy changes implemented across multiple QBPs could create larger financial incentives, and lessons learned from these changes could potentially be applied to ALC days among non-QBP patients. Reducing the number of patients designated ALC and the wait times for ALC would serve both the health system, through more efficient care, and ALC patients, through improved care outcomes.

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Correspondence may be directed to: Jason M. Sutherland, UBC Centre for Health Services and Policy Research, 201–2206 East Mall, Vancouver, BC. He can be reached by phone at 604-822-6812 or by e-mail: Jason.sutherland@ubc.ca.

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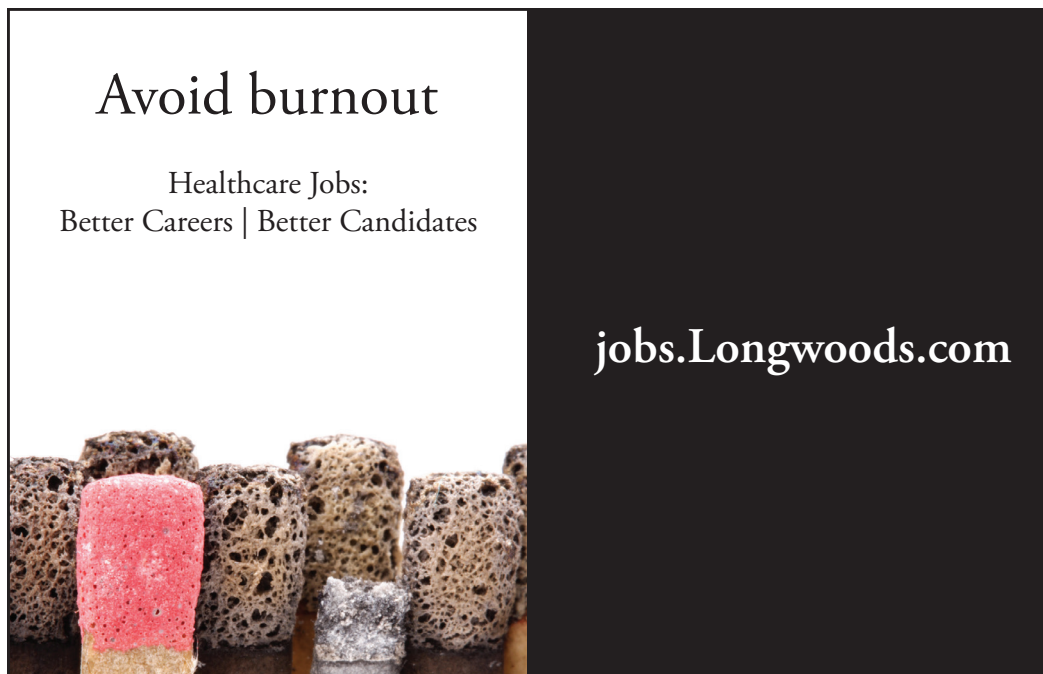
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