



**Rehabilitative
Care Alliance**

Financial and Clinical Implications of Re- Classification

January 2015

Objectives

To present the context for and findings of the Rehabilitative Care Alliance's PCRC Initiative including:

1. Provide an Overview of Current Characteristics of CCC/Rehab Beds
2. Describe Influencing Initiatives & Potential Drivers of Re-Classification
3. Describe Clinical & Financial Considerations for Re-classification of CCC/Rehab Beds
4. Appendix - Describe the Evolution and Summary of the Funding of CCC/Rehab Beds

Objective #1 - Overview of the Current Characteristics of CCC and Rehab Beds

Situational Overview

- Definition of Complex Continuing Care dates back to the early 90's, when Slow Stream Rehab (aka LTLD rehab) in CCC beds was much less common than today.
- Establishment of the Rehabilitative Care Alliance in Spring 2013 has resulted in the development of new definitions of bedded levels of rehabilitative care to be delivered in “rehab” beds.
- As a result of the Definitions Framework, and other system drivers, LHINs and hospitals may assess the need to realign the number of CCC vs Rehab beds.

What Does the “Current State” Bedded Rehabilitative Care System Look Like?

- The intensity of therapy available to patients is generally dependant on the type of bed they are admitted to (i.e. CCC/In-patient rehab)
- This supports patient flow as patients are triaged to the most appropriate program based on their diagnosis and tolerance for rehab
- However, as patient’s functional tolerance fluctuates, they must be moved, actually or virtually, between bed types (i.e. CCC/In-patient rehab) to access more/less intensive therapy services.
- When patients are transferred between rehabilitative care bed types (i.e. CCC/In-patient rehab), they must be discharged and new orders written/received. Each transfer results in potential duplication, errors and treatment delays.

Complex Continuing Care

There are currently 2 cohorts of patients in CCC

#1 Patients with Complex Medical Needs

Medically
Complex

Behavioural
Health

End of Life
Care

- Are medically stable and who may be at risk for becoming medically unstable
- Are medically complex, with long-term illnesses or disabilities typically requiring:
 - Ongoing medical / nursing support;
 - Skilled, technology-based care not available at home or in long-term care homes.
 - Assessment and active care management by specialized inter-professional teams

#2 Patients with Primarily Rehab Needs

- Are medically stable
- Have restorative potential
- Have significant physical/functional impairments
- Require and are able to participate in a comprehensive inter-professional rehabilitation program, at a low to medium intensity to enhance functional / cognitive ability.
- Are placed within Special Rehabilitation RUG categories
- May fit within existing RPGs but have a longer than expected LOS and/or lower admission FIM

Differences in Rehab & CCC Data Coding & Models of Care

In-patient Rehab

- Uses NRS/FIM
- Admission and discharge assessment
- Full interdisciplinary team is the standard of care
- Higher therapy intensity
- Financial incentive to discharge patients within target LOS

Slow Stream Rehab within CCC

- Uses CCRS/MDS
- Admission assessment guides the amount of therapy to be provided
- No mandated discharge assessment
- Limited access to Allied interdisciplinary team (often by consultation)
- Lower therapy intensity
- Incentive for high occupancy of CCC beds
- Less financial incentive to maximize flow

Objective #2

Influencing Initiatives and Potential Drivers of Re-Classification

Influencing Initiatives and Drivers

Assess and Restore Policy

- The policy promotes the functional independence of community-dwelling frail seniors for as long as possible by facilitating the adoption of evidence-informed clinical processes and interventions with demonstrated efficacy.
- The policy will establish:
 - the criteria to be used for identifying seniors who are eligible for facility-based A&R interventions
 - the three levels of care provided through facility-based A&R interventions that are to be made available to residents of each LHIN;
 - the essential elements of a cross-sectoral A&R approach to care (screening, assessment, placement, interventions, and transitions home);
 - within each element, the shared and individual roles and responsibilities of LHINs, CCACs, hospitals, LTCHs and other providers; and
 - accountability and performance measurement expectations for LHINs and HSPs.

Influencing Initiatives and Drivers

Rehabilitative Care Best Practices

QBP's clearly define best practices for some specific populations (stroke, hip fracture). In some cases (e.g. stroke) these best practices can only be provided in inpatient rehab.

- In health care, it is generally accepted that critical mass is required to achieve delivery of best practice.
- The evidence is clear for stroke that early intensive therapy results in more complete functional recovery. Evidence for other patient populations requires further investigation.

Influencing Initiatives and Drivers

Fundamentals of Patient Centered Care - What Does the “Clinically Ideal” Bedded Rehabilitative Care System Look Like According to RCA Stakeholders?

- Patients are able to receive therapeutic interventions that match their functional goals, expected functional trajectory and/or current functional tolerance with minimal redundant re-assessment, transitions and handovers.
- Services are resourced to support the capability to safely manage patient complexities
- Streamlined data collection/reporting across rehabilitative care and broader health care systems.

Influencing Initiatives and Drivers

RCA Definitions Initiative/Framework

- The RCA Definitions Working Group has developed a provincial Definitions Framework to establish provincial standards for rehabilitative care levels of care across the continuum of care.
- The objectives in developing a provincial Definitions Framework are to:
 - Establish provincial standards for rehabilitative care levels of care across the continuum of care
 - Provide clarity for patients, families and referring professionals on the focus and clinical components of rehabilitative care programs
 - Provide a foundation to support system and local capacity planning through a common understanding of rehabilitative care services

DEFINITIONS FRAMEWORK FOR BEDDED LEVELS OF REHABILITATIVE CARE (FINAL DRAFT)

The definitions for the bedded levels of rehabilitative care reflect the understanding that the focus of rehabilitative care across the 4 levels may vary from where it is a primary focus in some levels (e.g. Rehabilitation and Activation/Restoration) to a more secondary focus in others where the medical complexity of the patient is higher than in other levels (e.g. Short and Long Term Complex Medical Management).

Bedded Levels of Rehabilitative Care

(i.e. Hospital-based designated inpatient rehab beds and complex continuing care beds as well as convalescent care/restorative care beds within LTCH)

		<i>Rehabilitation (Low to high intensity)</i>	<i>Activation / Restoration</i>	<i>Short Term Complex Medical Management</i>	<i>Long Term Complex Medical Management</i>
Functional Trajectory		Progression	Progression	Stabilization & Progression	Maintenance
Level of Care - Goal					
Patient Characteristics	Target Population				
	Functional Characteristics				
	Estimated Average LOS	<div style="border: 1px solid black; padding: 10px; background-color: #e0e0e0;"> <p style="margin: 0;"><i>Content for Each Area of the Bedded Levels of Rehabilitative Care Have Been Defined, Validated and are ready for final endorsement by LHIN CEOs</i></p> </div>			
	Discharge Indicator				
Medical/Allied Health Resources	Medical Care				
	Nursing Care				
	Therapy Care				
	Intensity of Therapy				
Reporting Tools					

Response to RCA Definition Framework

- After the new RCA framework for rehabilitative care is presented, LHINs/HSPs across the province should consider the appropriate balance of rehab and CCC beds at both the institutional and LHIN levels through completion of a rehabilitative care system capacity plan and in the context of other system influencing initiatives/drivers .
- The potential need for a re- classification of CCC beds to rehab beds (and possibly to a lesser extent from Rehab to CCC) may be the result.
- The RCA has developed a flow diagram outlining a potential re-classification process and the tools that are being developed to support this process

1. Process to Assess Need for Re-Classification of CCC/Rehab Beds

Potential Drivers of
Re-Classification



TOOLS

RCA Capacity Planning Framework

- Education Modules
 - A. Financial and Clinical Considerations for Re-classification of Rehab/CCC Beds
 - B. Implications of the RCA Definitions Framework & Proposed Directions
- Stakeholder Risk / Benefit Considerations - Patient/Caregiver & HSP Considerations

- PCRC Case Studies/Scenarios
- RPG Cost Weights 2014/15
- RPG Provincial Average LOS 2013/14
- HBAM Calculator
- Fundamental Considerations for Data Analysis

- LHIN Business Case Template
- Guidelines for Hospital Beds Re-Classification, LHIN Liaison Branch, Relations and Coordination Unit, MOHLTC (Appendix A)

Business Case
Preparation

Does 'Feasibility Analysis' support need to re-classify beds? If yes, determine process and documentation required by LHIN (e.g. "Guidelines for Hospital Beds Re-Classification") including:

- Proposed bed patient/program configuration – CCC/Rehab bed mix, patient/case mix
- Demonstration of alignment with LHIN and provincial directions/planning
- Description of anticipated financial impact including funding/QBP impact, interim funding solution to mitigate time lag before HSFR calculations reflect reclassification (i.e. how will higher rehab costs be funded in the intervening years?), co-payment/semi-private revenue, hospital margin 3-year proforma, capital costs, staffing/HR impact
- Reporting implications (CIHI)
- Evaluation Outcomes/Metrics
- Where relevant, appropriate community engagement
- Description of anticipated impact on system (flow, ALC etc.)

Business Case Review by LHIN

Business Case Approval, Revised HSAA and HAPS

Monitor/Evaluate

- Stakeholder Risk / Benefit Considerations - Patient/Caregiver & LHIN Considerations
- Re-Classification Evaluation Criteria

Objective #3

Clinical and Financial Considerations for Re-classification of CCC/Rehab Beds

Clinical Considerations for the Re-Classification of CCC / Rehab Beds

What types of patients are appropriate to consider for re-classification?

- General Guideline - Where providing more intensive therapy is expected to result in improved patient outcomes & shorter LOS (i.e. within QBP and/or NRS ELOS)
- Patients who are currently in CCC beds who are receiving therapeutic intervention to achieve functional goals and who are expected to be discharged to the community once those goals are accomplished (i.e. those placed within Special Rehabilitation RUG categories upon admission to CCC)
- Populations likely not appropriate for consideration for re-classification include complex medical, palliative, & neurobehavioural.

Financial Implications of Current CCC Funding Formula & Copayment Revenues

Daily weight is driven by periodic (every 90 day) assessments, has an effective upper limit on the amount of daily rehab, and copayment is not billable if discharge destination is home. Therefore:

- Weights may not reflect changes in patient condition within each 90 day interval or encourage more frequent treatment plan review
- Does not promote ongoing discharge/patient flow focus, but encourages high bed occupancy
- Does not reward high levels of daily rehabilitation beyond 120 minutes
- Does not encourage discharge home if result will be a significant loss of copayment revenue

Financial Implications of Rehab

Funding Formula and Patient Revenues

- Discharge planning based on expected length of stay encouraged. Notional HSFR funding “win” if shorter ALOS than the *expected length of stay*.
- Encourages increases in patient flow and shorter ALOS to increase notional HSFR funding.
- Upon reclassification, Rehab semi private revenue gain is generally far less than lost CCC copayment revenue
- HSFR funding can lead facilities to develop strict admission criteria to manage LOS. This can result in situations where patients with viable rehab potential will be viewed as not meeting admission criteria where LOS is a key factor

Financial Implications of Rehab Funding Formula and Patient Revenues (con't)

- Under HSFR, there is a financial incentive to discharge patients more quickly from rehab beds as funding is based on “weighted cases” for inpatient rehab and funding is generally not adjusted for a longer or shorter actual length of stay.
- HSFR funding for CCC inpatients is based on “per diem” calculations (“weighted days”).

Financial Considerations

LHINs require a business case for any proposed re-classification of beds. Financial aspect must include impact of:

- HSFR, including the impact of the time lag from the time the reclassification becomes effective until HSFR calculations reflect reclassification (i.e. 2012/13 data largely drives 2014/15 HSFR calculations) Issue – how will higher hospital rehabilitation costs be funded in the intervening year(s)?
- Potential funding changes as QBP replaces HBAM for selected patient diagnoses in the future
- Change in patient revenues on hospital budget (loss of copayment may be a significant issue). How will this be addressed?
- Overall HSP operating margin, multi-year projection
- Capital costs – reconfiguration of CCC units

Appendix

Objective #4 - Evolution and Summary of the Funding of CCC/Rehab Beds

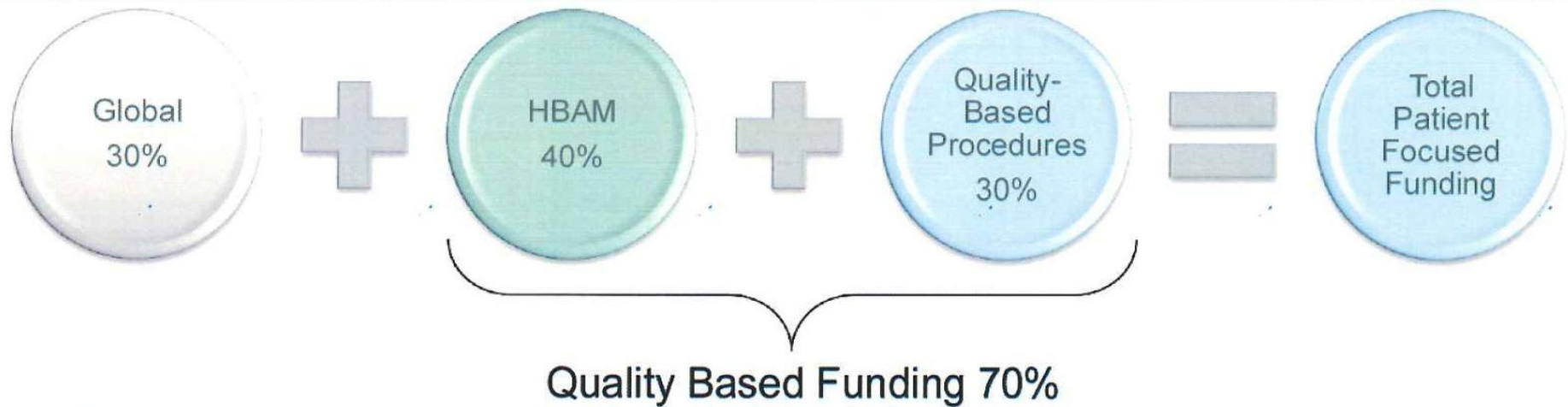
Health System Funding Reform Roll-out

- Health System Funding Reform (HSFR) being phased in over 4-5 fiscal years beginning in fiscal 2012/13
- Represents a transition from a **provider**-centred funding model (hospital global budget) towards a **patient**-centred funding model (funding must be “earned” based on patient activity and hospital productivity)
- HSFR represents the most significant development in the funding of the health system over the last 30 years

History of Health System Funding Reform

		Global Allocation	Quality/ volume Based
1982	BOND	100%	
1980s	Growth formula Acute Inpatient cost effectiveness formula	95% or more	5% or less
1990s	Day Surgery, Emergency room cost formula CCC classification system & funding formula	95% or more	5% or less
2000s	Rehab classification and cost formula	95% or more	5% or less
2010s	Patient-Focused Funding Refinement of existing hospital formula, expansion to CCAC, community services and beyond	30%	70% (HBAM + Quality Based Procedures)

Patient-focused funding will be phased-in to comprise 70% of a hospital's funding over a 4-5 year period



What is HBAM?

- The Health Based Allocation Model identifies an organization's share of overall provincial hospital funding based on demographic, clinical and financial information that is used to estimate expected weighted volumes and costs at the hospital level.
- Core element of the calculation of “funding share” is “weighted case/day x expected cost for your peers”
- CCC patients are funded by the weighted day, generally with the same weight applying for every day until the next 90 day stay assessment

What is HBAM? (cont'd)

- Rehab patients in Rehab beds will earn funding for the episode of care (weighted case) which encourages timely discharges and supports patient flow through rehab beds
- HBAM calculation for 2014/15 is largely based on hospital and provincial activity in 2012/13.



Evolution of Complex Continuing Care Funding

- Much definitional work in the late 80's, today's definition and system configuration largely flowed from work of HSRC in mid 1990's
- Definition is essentially: “complex continuing care patients who required medical care for life beyond the capabilities of LTC”
- JPPC selected MDS (RUG-44) patient classification system for CCC patients in 1997/8

CCRS RUG Categories

RUG III 44-Group		
Category	Name	CMI 2013
1: Special Rehabilitation – Ultra High	RUC	1.6791
	RUB	1.3851
	RUA	1.2278
1: Special Rehabilitation – Very High	RVC	1.3141
	RVB	1.2384
	RVA	1.0480
1: Special Rehabilitation - High	RHC	1.2938
	RHB	1.1295
	RHA	0.9721
1: Special Rehabilitation - Medium	RMC	1.3244
	RMB	1.1183
	RMA	1.0079
1: Special Rehabilitation - Low	RLB	1.0641
	RLA	0.7886

CCRS RUG Categories

RUG III 44-Group

Category	Name	CMI 2013
2: Extensive Care	SE3	1.3891
	SE2	1.1372
	SE1	0.9886
3: Special Care	SSC	0.9518
	SSB	0.8882
	SSA	0.8474
4: Clinically Complex	CC2	0.9612
	CC1	0.8366
	CB2	0.7753
	CB1	0.7202
	CA2	0.7004
	CA1	0.6250
	IA1	0.4513
5: Impaired Cognition	IB2	0.5970
	IB1	0.5756
	IA2	0.4865
	IA1	0.4513

RUG III 44-Group

Category	Name	CMI 2013
6: Behavior Problems	BB2	0.5883
	BB1	0.5593
	BA2	0.4720
	BA1	0.4006
7: Reduced Physical Function	PE2	0.6940
	PE1	0.6790
	PD2	0.6345
	PD1	0.6188
	PC2	0.5731
	PC1	0.5570
	PB2	0.4239
	PB1	0.4260
	PA2	0.4058
PA1	0.3862	

Evolution of Complex Continuing Care Funding

- Subsequently MOHLTC mandated MDS reporting to CIHI for all CCC patients in CCC designated beds every 90 days
- JPPC identified “weighted patient day” times “expected cost per weighted day” as the best estimate of the expected cost to treat these patients based on profile of CCC patients in late 1990’s. Current HBAM formula builds on this. Current costs (2014) per weighted day in the range of \$450-500.

Evolution of CCC Funding (cont'd)

- Based on argument that CCC patients are relatively stable in their complex condition and resource needs
- Amount of rehab per week is a significant driver of weight assigned for each group. Max rehab category is “over 120 minutes per day”
- Concern expressed that classification system does not work well for palliative or behavioural patient populations

Evolution of CCC Funding (cont'd)

- Over the last 10 years, the CCC population has become increasingly multi-modal, with a significant portion representing a shorter stay (less than 100 days) population that benefit from rehab and ultimately are discharged home or to the community.
- However, the funding system and patient classification system for CCC beds remains essentially the same.
- HSFR has created the “burning platform” for reviewing how this shorter term population is classified and funded

Patient Revenues for CCC Patients

- Copayment revenue of approx. \$57/day can only be charged if “patient is more or less a permanent resident in the hospital or awaiting discharge to a long-term care facility”
- No copayment can be charged where discharge destination is “home”
- Daily semi-private rates approx. \$50/day

Rehab Classification & Funding Evolution

- JPPC selects NRS/FIM classification system 2002 – NRS reporting to CIHI for rehab beds mandated
- JPPC identifies “weighted case * expected cost” methodology as best estimate of expected cost in 2003. Basis of current HBAM calculations for rehab.
- Weights are generally proportional to expected (OCCI average) length of stay (ELOS). When compared to CCC funding, cost per day is equivalent to \$650-750 based on ELOS.
- Concern expressed that classification system not working well for behavioural or geriatric patient populations

National Rehab System (NRS) Grouper

2014-15 Provincial RPG Cost Weights



Note: Cost Weights are expected to change from year to year

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REHAB GROUP COST WEIGHTS

Rehab Group	RPG	Cost Weight
11 - Stroke	1100	2.4043
	1110	2.1061
	1120	1.4695
	1130	1.2389
	1140	1.9289
	1150	0.7309
	1160	0.5668
12 – Traumatic Brain Injury	1200	7.0583
	1210	4.594
	1220	2.7101
	1230	2.673
	1240	1.6146
	1250	1.2502
13 – Non - Traumatic Brain Injury	1300	2.9967
	1310	1.5495
	1320	1.2429
	1330	0.8141
14 - Neurological	1400	2.2371
	1410	1.5058
	1420	0.9074
	1430	0.5427

Source: Canadian Institute for Health Information (CIHI)

National Rehab System (NRS) Grouper

2014-15 Provincial RPG Cost Weights



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Note: Cost Weights are expected to change from year to year

REHAB GROUP COST WEIGHTS

Rehab Group	RPG	Cost Weight
15 - Traumatic Spinal Cord Injuries	1500	6.067
	1510	4.2717
	1520	4.01
	1530	1.7664
16 - Non-Traumatic Spinal Cord Injuries	1600	3.0728
	1610	1.7545
	1620	1.9202
	1630	1.1476
	1640	0.9905
17 – Amputation, Not Lower Extremity	1700	1.384
	1710	0.7384
18 – Amputation, Lower Extremity	1800	1.9614
	1810	1.4126
	1820	1.6823
	1830	1.124
19 - Osteoarthritis	1900	0.8123
	1910	0.3271
20 - Rheumatoid Arthritis & Other Arthritis	2000	0.8271
	2010	0.632
21 - Pain	2100	0.8487
	2110	0.4161

Source: Canadian Institute for Health Information (CIHI)

National Rehab System (NRS) Grouper

2014-15 Provincial RPG Cost Weights



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Note: Cost Weights are expected to change from year to year

REHAB GROUP COST WEIGHTS

Rehab Group	RPG	Cost Weight
22 - Fracture of Lower Extremity	2200	1.1494
	2210	1.167
	2220	0.9357
	2230	0.8368
	2240	0.7014
	2250	0.6157
23 – Replacement of Lower For hips and knees, this is a QBP and subject to funding restrictions	2300	0.813
	2310	0.4726
	2320	0.5661
	2330	0.3811
	2340	0.3339
	2350	0.2829
24 - Other Orthopedic	2400	1.0996
	2410	0.7115
	2420	0.8287
	2430	0.4399
	2440	0.4072
25 - Cardiac	2500	1.0211
	2510	1.8564
	2520	0.4593
	2530	0.444
	2540	0.5275

Source: Canadian Institute for Health Information (CIHI)

National Rehab System (NRS) Grouper

2014-15 Provincial RPG Cost Weights



Note: Cost Weights are expected to change from year to year

REHAB GROUP COST WEIGHTS

Rehab Group	RPG	Cost Weight
26 – Pulmonary	2600	0.8389
	2610	0.7265
	2620	0.7986
	2630	0.6298
27 - Burns	2700	1.4128
28 - Major Multiple Trauma, Other Multiple Trauma & Major Multiple Fracture	2800	1.8512
	2810	0.9765
	2820	1.4069
	2830	1.1636
	2840	0.9192
29 - Major Multiple Trauma with Brain or Spinal Cord Injury	2900	2.7268
	2910	1.1306
	2920	0.9173
30 - Vent Dependant Respiratory Disorders	3000	0.4499
31 - Other Disabilities	3100	1.2253
	3110	0.8555
	3120	1.0389
	3130	0.8121
	3140	0.6688

RPG Provincial Average Length Of Stay 2013/14



Note 1: ALOSs are expected to change from year to year

Note 2: ALOSs may have no relation to the published RPG cost weight

RPG Provincial Average Length Of Stay 2013/14		
Rehab Group	RPG	Provincial Average LOS (2013-14 Provincial target LOS based on 2011-12 data)
11 - Stroke	1100	48.9
	1110	41.8
	1120	35.8
	1130	25.2
	1140	14.7
	1150	7.7
	1160	0.0
12 – Traumatic Brain Dysfunction	1200	109.8
	1210	73.4
	1220	61.6
	1230	55.0
	1240	31.8
	1250	24.9
13 – Non - Traumatic Brain Injury	1300	76.2
	1310	37.9
	1320	31.1
	1330	23.7
14 - Neurological Conditions	1400	50.7
	1410	35.4
	1420	23.2
	1430	38.0

RPG Provincial Average Length Of Stay 2013/14



Note 1: ALOSs are expected to change from year to year

Note 2: ALOSs may have no relation to the published RPG cost weight

RPG Provincial Average Length Of Stay 2013/14

Rehab Group	RPG	Provincial Average LOS (2013-14 Provincial target LOS based on 2011-12 data)
15 - Traumatic Spinal Cord Injuries	1500	65.0
	1510	91.0
	1520	60.3
	1530	28.3
16 - Non-Traumatic Spinal Cord Injuries	1600	56.4
	1610	36.6
	1620	43.8
	1630	28.9
	1640	13.2
17 – Amputation, Not Lower Extremity	1700	41.7
	1710	16.5
18 – Amputation, Lower Extremity	1800	42.1
	1810	38.5
	1820	38.9
	1830	29.6
19 - Osteoarthritis	1900	26.5
	1910	13.5
20 - Rheumatoid Arthritis & Other Arthritis	2000	27.9
	2010	13.0
21 - Pain	2100	19.2
	2110	5.9

RPG Provincial Average Length Of Stay 2013/14



Note 1: ALOSs are expected to change from year to year

Note 2: ALOSs may have no relation to the published RPG cost weight

RPG Provincial Average Length Of Stay 2013/14		
Rehab Group	RPG	Provincial Average LOS (2013-14 Provincial target LOS based on 2011-12 data)
22 – Fracture of Lower Extremity	2200	29.4
	2210	29.8
	2220	24.1
	2230	23.1
	2240	19.2
	2250	17.2
23 – Replacement of Lower Extremity	2300	20.8
	2310	16.1
	2320	16.2
	2330	14.2
	2340	12.1
	2350	11.7
24 - Other Orthopedic	2400	29.3
	2410	30.4
	2420	21.4
	2430	20.2
	2440	13.3
25 - Cardiac	2500	26.5
	2510	23.5
	2520	17.9
	2530	14.7
	2540	18.0

RPG Provincial Average Length Of Stay 2013/14



Note 1: ALOSs are expected to change from year to year

Note 2: ALOSs may have no relation to the published RPG cost weight

RPG Provincial Average Length Of Stay 2013/14		
Rehab Group	RPG	Provincial Average LOS (2013-14 Provincial target LOS based on 2011-12 data)
26 - Pulmonary	2600	22.1
	2610	20.7
	2620	17.0
	2630	18.2
27 - Burns	2700	21.0
28 - Major Multiple Trauma, Other Multiple Trauma & Major Multiple Fracture	2800	54.8
	2810	33.0
	2820	33.4
	2830	44.3
	2840	21.4
29 - Major Multiple Trauma with Brain or Spinal Cord Injury	2900	51.5
	2910	34.8
	2920	32.8
30 - Vent Dependant Respiratory Disorders	3000	16.3
31 - Other Disabilities Includes Medically Complex	3100	32.9
	3110	24.2
	3120	20.2
	3130	19.9
	3140	17.0

Patient Revenues for Rehab Patients

- Copayment revenue is not applicable in the vast majority of cases
- Semi private differential approx. \$200/per day

What are Quality Based Procedures?

- Targeted activities that will be funded on a “price * volume” basis.
- Based on focused best practice evidence such that the specific activity funding can be expected to encourage improved outcomes, reduce variation between providers and improve “value for money”.
- To date, no QBP funding for patients in CCC beds because CCRS does not classify these patients by diagnosis/specific condition

What are Quality Based Procedures?

- QBP's for TJR (hip/knee), hip fractures and stroke will affect Rehab patients (and replace HBAM calculation) as price and volumes are determined/assigned
- Assigned volumes are not readily adjustable and may reflect historic volume levels in designated rehab beds for individual hospitals

Implications of QBPs

- Support achieving underlying best practices (ALOS, intensity of care, etc.)
- Only apply to patients in designated rehab beds so a consideration when re-classifying beds from a funding perspective
- Classifications of QBP patients may not be consistent with Rehab RPGs, so the potential impact on calculated funding should be considered