Surgical Backlog Implementation Q&As

1. **Why is the Ministry of Health (ministry) supporting surgical ramp-up by flowing a premium on existing funded volumes?**

    - When the ministry provided hospital funding allocations in May of this year, a full year's worth of QBP, cardiac, and other priority services volumes were flowed to hospitals. Existing backlog data indicates that many of these funded surgical volumes (which the ministry recognizes many hospitals were not able to be complete in the spring/summer) make up a significant portion of the existing surgical backlog.
        - For example, Access to Care data illustrates that orthopedics and ophthalmology represent the two highest clinical areas of backlog and 87% of ophthalmology backlog is volume-funded cataract surgery, while 79% of orthopedic backlog is volume funded QBPs (e.g., hip knee replacements, etc.).
    - Therefore, by flowing this premium, the ministry is encouraging hospitals to try to complete their existing funded volume allocation for key backlogged surgeries and priority services, while also encouraging hospitals to apply any excess premium funds to backlogged surgical procedures in other clinical areas (e.g., surgeries that are funded through global budgets).

2. **Can you give a step-by-step example of how this premium will be applied?**

    If Hospital A was initially allocated 100 cases in a volume-based program at a funding rate of $1,000 per case for the entire fiscal year 2020-21, then:
    - Each case after the 50th case up to the funded target of 100 cases (i.e., up to 50% of the annual funded volumes of 100) will be eligible to generate a COVID-19 premium;
    - The COVID-19 premium applicable to each eligible case noted above will be 20% of the funding rate – in this example, 20% of $1,000 = $200.

    So, if Hospital A anticipates completing a total of 90 of the allocated 100 cases by year end, then a funding letter would flow in Q3 to allocate $8,000 (40 cases x $200 per case) in additional dollars to the hospital for this particular volume-based program.

3. **What is the expectation of the surgical plan being submitted to the OH Regions?**

    - Hospitals are expected to submit their plan to add extra hours to address the surgical backlog.
    - These plans should include considerations on availability and efficient use of pre-operative testing, including lab work and diagnostic imaging, post-operative, and post-discharge care.
    - Hospitals are encouraged to look at partnerships between hospitals within their LHIN or region to make full use of diagnostic and surgical resources in order to be able to extend hours and continue providing non-emergent services.
    - The OH Regions will take a regional approach to assessing the hospital plans to ensure that the regional-level backlogs are being addressed in an efficient and equitable way.

4. **If I receive $10,000 in COVID-19 premiums for various volume-funded procedures, but calculate that my hospital has only incurred $8,000 in extra costs to actually complete those specific surgeries, will my hospital be able to keep the remaining $2,000 and use for other priorities?**

- COVID-19 premiums will not be recovered by the ministry, LHINs, or OH (CCO) on volumes that are completed, and the ministry encourages hospitals to invest any excess funds and apply to backlogged surgical procedures in other clinical areas (e.g., surgeries that are funded through global budgets).
- Hospitals are encouraged to use the revenue from the COVID-19 premium to take an equitable approach to achieving this.
    - For example, given hospital efforts to continue with urgent surgeries during the spring, cancer surgery is significantly less backlogged than other clinical areas. While QBP-funded cancer surgeries are eligible for the COVID-19 premium, and if the additional funding provided by OH(CCO) is not needed to complete cancer volumes during evenings or weekends, it can be used to keep the ORs open on evenings and weekends for other surgeries or procedures that aren't volume-funded.

5. Will surgical volumes be reconciled, and recoveries made after year end if the target volume-funded surgical procedures are not achieved?

- The ministry, LHINs, and OH (CCO) will closely monitor how the pandemic is impacting completion of surgical volume across the system in Q3 and Q4 (through SRI, Wait Times Information System, and other data streams), and will communicate with the hospital sector later in the year if there are any updates to either the standard in-year one-time reallocation processes (which shift existing volumes to hospitals with capacity to complete additional cases, thereby allowing more patients to be served), or the year-end reconciliation processes (i.e., if unspent volume funding can be applied towards COVID-19 expenses as was the case for the end of the fiscal 2019/20 year).
- Currently, consistent with accountabilities, volumes not completed for the intended and approved purposes are subject to recovery in accordance with the ministry's year-end reconciliation policy. Ministry, LHIN, and OH(CCO) volume management, in-year reallocation, and reconciliation policies remain the same until an official policy document is released amending them.

6. What happens if my hospital over-estimates in Q2 the number of funded volumes that will be achieved by Q4? What if we forecast completing 90 volumes by the end of Q4, the ministry then flows additional price premium funding on that basis, and then only 80 volumes are achieved at my hospital?

- The ministry recognizes that it is a very difficult task for hospitals to accurately forecast surgical volumes that will be achieved by year-end using Q2 data, especially given the unpredictable impact of potential local or system-wide outbreaks on hospital operations.
- The ministry encourages hospitals to make as accurate a forecast as is possible given these circumstances.
- Currently, ministry, LHIN, and OH(CCO) volume management, in-year reallocation, and reconciliation policies remain the same until an official policy document is released amending them. That means there is still a reallocation process that takes place late in Q4 that is based upon Q3 data reporting.
- The ministry, LHINs, and OH (CCO) will closely monitor how the pandemic is impacting completion of surgical volume across the system in Q3 and Q4 (through SRI, Wait Times Information System, and other data streams) and will communicate any updates to financial processes and policies later in the year.

7. **If I am on track to complete less than my funded volume allocation is there the possibility that the LHIN, ministry, or OH (CCO) will recover funds in Q4 and reallocate to another hospital?**

    - Standard ministry, LHIN, and OH(CCO) in-year reallocation processes ensure funding follows the patient, and that if a given hospital cannot complete surgical cases, funding can be moved to a hospital that has capacity to complete cases and serve patients, thereby reducing system wait times, and ensuring as many patients as possible get the access to care they require.
    - Currently, ministry, LHIN, and OH(CCO) volume management, in-year reallocation, and reconciliation policies remain the same until an official policy document is released amending them.
    - The ministry, LHINs, and OH (CCO) will closely monitor how the pandemic is impacting completion of surgical volume across the system in Q3 and Q4 (through SRI, Wait Times Information System, and other data streams) and will communicate any updates to financial processes and policies later in the year.

8. **What happens if my hospital under-estimates what volumes will be achieved by Q4? What if we forecast completing 90 volumes by the end of Q4, the ministry flows additional funding on that basis, and then in fact 100 volumes are achieved?**

    - After the in-year reallocation process, the ministry, LHINs, and OH (CCO) will assess options to address overperformance of volume targets.
    - Hospitals are encouraged to notify their Region and the ministry as soon as possible if they exceed their allocated volumes.

9. **What happens if my hospital achieves above our initial funded allocation in one of the volume-based programs? If I am funded for 200 of a particular QBP and I am able to achieve 205, will I be eligible for the usual rate plus the premium for all volumes achieved above target?**

    - If you believe that your program will exceed its volume allocation, please contact your LHIN and the ministry.
    - The goal of this funding is to address the backlog across all surgeries that resulted from the ramp down. Hospitals are encouraged to take an equitable approach to achieving our shared goal of reducing the overall provincial backlog.

10. **Why were some volume-funded procedures not included in the premium?**

    - This COVID-19 premium is intended to address in-hospital surgeries and procedures that are backlogged, so certain funding lines were not included, such as the non-elective QBPs as non-elective and emergent procedures continued throughout the ramp down.
    - For some specific QBPs (e.g., Knee Arthroscopy, Non-Cancer Hysterectomy surgical) the ministry expects the declining volumes of both procedures in Ontario to continue, with a corresponding shift toward effective evidence-based medical and conservative surgical treatments, as well as minimally invasive approaches as first line options for these conditions.
    - For Wait Times surgical procedures, the inclusions are:
        - Adult surgeries include:

        - hip and knee revisions, general surgery – anorectal, cholecystectomy, ventral hernia repair, groin hernia repair, intestinal surgery.

    - Paediatric surgeries include:

        - dental extractions, strabismus repair, cleft lip and palate repair, craniosynostosis, scoliosis repair, arthroscopy, ACL repair, hypospadias repair, ophthalmology (excluding strabismus repair), pyeloplasty, treatment of hemangiomas/vascular anomalies, maxiofacial surgery, ureter implant, orchiopexy.