Ontario's LHINs

HOSPITAL SERVICE ACCOUNTABILITY AGREEMENT (HSAA)

FREQUENTLY ASKED QUESTIONS (FAQ)

2019-2020

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Ontario
Local Health Integration Network

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INTRODUCTION

This document contains answers to frequently asked questions (FAQs) related to the 2019-20 Hospital Accountability Planning Submission (HAPS).

GLOSSARY OF TERMS

HAPS: Hospital Accountability Planning Submission. The HAPS is the planning tool used by hospitals to inform the negotiation of the Hospital Service Accountability Agreement (HSAA).

HSAA: Hospital Service Accountability Agreement. The HSAA is the service accountability agreement that the LHINs are required to enter into with the hospitals pursuant to the terms of the Local Health System Integration Act (LHSIA).

HSFR: Health System Funding Reform. HSFR is comprised of Health Based Allocation Methodology (HBAM) Funding and Quality Based Procedures (QBP) Funding.

MLAA: Ministry-LHIN Accountability Agreement. The purpose of the accountability agreement is to set out the mutual understandings between the MOHLTC and the LHIN of their respective performance obligations for the stated period. It is an accountability agreement for the purposes of section 18 of the LHSIA.

SRI: Self Reporting Initiative. SRI is the self-reporting solution for submission and review of information between Health Service Providers (HSPs) and the Local Health Integration Networks (LHINs) and the Ministry of Health and Long-Term Care (the Ministry). It includes any hardware or software that may be provided to the User for the purpose of using SRI.

HISAA: Hospital Integrated Service Accountability Agreement. The HISAA is the service accountability agreement that is being developed for hospitals that also provide community and/ or long-term care services so that they will only need to complete a single agreement with the LHINs pursuant to the terms of the Local Health System Integration Act (LHSIA).

FREQUENTLY ASKED QUESTIONS AND ANSWERS

1. HSAA Template Agreement

1.1 How long is the current HSAA in effect?

A: The current HSAA is in effect until March 31, 2020. The HSAA Steering Committee convenes in the fall. At that time it will determine the direction for the HSAA and a communique will be distributed following the meeting. Negotiations are currently underway regarding the integrated HSAA. We are hopeful that work will be completed in the near team such that implementation of the integrated HSAA can occur.

1.2 When will the integrated HSAA be implemented?

A: Negotiations are currently underway regarding development of the HISAA. We are hopeful that work will be completed in the near team such that implementation of the HISAA can occur.

1.3 Does the requirement to prohibit the restriction of services based on patient residence apply to out of country patients as well?

A: The requirement to have a policy prohibiting the restriction of services based on patient residence is intended to apply primarily to Ontario patients. As set out in section 20.1 of LHSIA. LHINs are not permitted to enter into agreements with health service providers that limit services based on a patient's residence (for example, refusing to provide services to patients referred from a different LHIN). This obligation is made an explicit commitment of hospitals in the 2018-20 HSAA template.

Hospitals should continue to provide services to out-of-country and out-of-province patients as required or permitted by law, including providing care in emergencies, and follow existing policies and practices for elective procedures with respect to out-of-country and out-of-province patients. Hospitals are encouraged to seek out legal advice in specific circumstances.

1.4 The language in Clause 4.6 can be interpreted as requiring LHINs to attach all historic PCOP letters as part of Scehdule C4. Is this the intent? Is the intent only to include current PCOP letters (ones just coming into based funding in the current year or ones that are still in effect within the PCOP reconciliation period?)

A: This clause recognizes that sometimes PCOP funds may be provided to hospitals under a funding letter that amends the HSAA in place at the time. An old HSAA is no longer in effect once a new HSAA is implemented, along with amendments to it. The point of this section is to capture the terms and conditions of any funding letter for PCOP funding that was provided under the previous HSAA, where the PCOP funding continues to be provided under the new HSAA. Only funding letters that set out the terms and conditions of funding currently being received by a hospital should be attached to the HSAA. It is not necessary to attach all historical letters.

2. Planning / Funding Assumptions

2.1 How should planning assumptions be made?

A: The expectation is that hospitals will individually and locally determine reasonable planning assumptions for use in the completion of the 2019-20 HAPS and the HSAA schedules using information currently available including assumptions for HBAM and Quality Based Procedures. The LHIN will assess these assumptions for reasonableness. Hospitals are encouraged to engage with their peers in the development of assumptions. In some LHINs, the LHIN and hospitals may collectively agree on a common set of assumptions.

2.2 When will we receive our 2019-20 funding information?

A: This has not yet been determined. Hospitals and LHINs should engage in setting planning assumptions necessary to develop and populate the HAPS and Schedules.

2.3 Without funding information, are Hospitals expected to submit a balanced budget?

A: Yes, hospitals are expected to submit a balanced budget within their HAPS.

2.4 What is the Materiality Trigger"?

A: Materiality is assessed on performance indicators and volume targets. Where the HSFR assumptions used in planning are different than actual funding allocations, and these result in the hospital being unable to deliver on a performance commitment, this may trigger a resubmission/renegotiation of the affected HSAA schedules.

The materiality triggers are generally the same for each hospital in that the triggers are from the HSAA performance indicators, which are universal. The actual targets and applicable indicators will vary between hospitals, but the general principle – not being able to meet a target due to an incorrect assumption – is the same for all hospitals.

2.5 When will the new funding formula result be available?

A: There are two stages to this process. The first stage is the release of the actual and expected weighted cases caress and the second stage is the HBAM shares construct. There are currently ongoing discussions between the MoHLTC and related Advisory Committees and Work Groups to finalize this process.

2.6 When will the QBP information for 2019-20 be released?

A: This has not yet been determined. For HAPS purposes, hospitals should use conservative assumptions reflecting local situations and known information.

2.7 Should ED weighted cases be budgeted in HIG weights versus RIW for the next fiscal year?

A: ED weighted cases are attributed to the ambulatory classification of weighted cases (i.e. CACS) and are not coded under HIG weights. HIG weights are defined exclusively for inpatient activity. It is recommended that ED weighted cases continue to be defined under the CACS methodology.

3. HAPS

3.1 Where are the HAPS forms posted and when will they be available to Hospitals?

A: The 2019-20 HAPS forms are available on SRI at the following website https://www.sri.moh.gov.on.ca/SRI/faces/login.xhtml and will be available in early October, 2018. An Additional Input Form will be used (as in the past) to capture information that is required for the Schedules but not available directly from the HAPS forms. The template will be distributed to the LHINs and is also embedded directly into the HAPS Guidelines. Both the HAPS submission and the HAPS Supplemental Form can be submitted to the LHIN through SRI.

3.2 When will the 2019-20 HAPS Guidelines be available?

A: The HAPS Guidelines will be made available to hospitals by early October 2018.

3.3 When is the HAPS submission date?

A: The HAPS submission is due to the LHINs on November 23, 2018. Please contact your LHIN to discuss any locally determined requests or direction regarding HAPS submission.

3.4 Is there a section in the HAPS that requires partner involvement and joint risk mitigation strategies?

A: Please refer to Section 2.3.3 (Framework for Making Choices) in the HAPS Guidelines. This information should be captured in the HAPS Narrative (Health Partner Engagement and Risk sections).

3.5 Are there any available resources that can facilitate performance diaglogue between hospitals and LHINs?

A: The Health Improvement Plan (HIP) Toolkit outlines various concepts and frameworks to assist hospitals with improvement planning, and can provide guidance for performance discussions. A copy of the current HIP Toolkit is included here for reference.

(DRAFT) HIP Toolkit.docx

3.6 If we are considering service changes as part of the HAPS process, where do I capture these?

A: Information regarding proposed service changes is to be included in the Service Delivery Change Form. The template and process guide are both embedded in the HAPS Narrative template. This information is necessary to be detailed separately as it informs conversations that will need to occur between hospitals and their LHINs in order to assess the impact of the service change on the local and regional health system as well as to determine whether the service change is an “integration” as per LHSIA and whether the proposed service change requires additional due diligence as part of that LHSIA process.

3.7 Will hospitals be required to submit a 2019-20 HAPS narrative similar to previous years?

A: Yes, there will continue to be a narrative component. Please refer to the HAPS Guidelines for further detail on the HAPS Narrative template. The template is embedded directly into the HAPS Guidelines.

3.8 Some of the sections in the HAPS narrative may be challenging for a hospital to complete dependent on its circumstances. Is the completion of each of these sections necessary?

A: The information provided by the hospitals in the HAPS narrative informs conversations that will occur between hospitals and their LHINs in the analysis of the HAPS and the completion of the HSAA. The information requested provides important insight into the impact of a hospital on the local and provincial health systems. Should hospitals require additional clarification or have questions regarding the completion of the HAPS narrative, they are advised to contact their LHINs.

3.9 What is the purpose of the Adjusted Working Funds tab in the HAPS and quarterly reporting?

A: The Adjusted Working Funds tab in the HAPS and quarterly reports is intended for hospitals that were involved in the MOHLTC's Hospitals Working Funds Initiative that took place between 2011-12 and 2016-17 to report to LHINs as per their accountability agreements.

4. HSAA Indicators and Target Setting

4.1 What is the difference btween performance indicators and explanatory indicators?

A: Performance indicators are included in Service Accountability Agreements (SAAs) and may trigger consequences under the agreement. They are associated with a target and corridor, or at minimum, have a benchmark.

Explanatory indicators are complementary to the performance indicators and support planning, negotiation or problem solving at the provincial or LHIN levels. As these indicators have data that may be provided through existing reporting systems, health service providers will not be required to report on them through SAA reporting requirements.

4.2 Are the HSAA Indicators aligned with the MLAA Indicators?

A: The current HSAA Indicators are aligned with the 20187-189 MLAA Indicators. The 20189-1920 MLAA Indicators have not yet been finalized.

4.3 When will the 2019-20 Schedules and Indicators be distributed?

A: An education session will be provided to hospitals in October 2018 on the 2019-20 Schedules and indicators. Hospitals are asked to contact their local LHIN for further information.

4.4 Is the Readmission to Own Facility performance indicator risk adjusted?

A: No, the Readmission to Own Facility performance indicator will no longer be risk adjusted. The technical specifications have been updated to reflect this. The revised calculations will be in effect for the accountability periods reported for 2019-20. A more robust discussion of this indicator will take place among the Indicators Work Group for potential additional changes in 2020-21.

4.5 How will hospital targets be set?

A: Hospitals and LHINs are encouraged to set targets through discussions about local, relevant factors, as well as through review of historical performance. A Target Setting Guideline, which is updated and distributed to the hospitals every year, can also be reviewed for guidance prior to and during these local discussion.

4.6 Why aren't technical specifications for Cancer QBPs included in the HSAA supporting documents?

A: Cancer Care Ontario (CCO) has separate agreements and information dissemination processes with hospitals for these documents (i.e. CCO is not part of HSAA). All pertinent information is shared with the hospitals through Regional Vice Presidents and Regional Cancer Care Directors, and hospitals know where to send their requests for these and other documents, if they ever need.