Budget Impact Analysis for Implementation Projects

Selected slides from the presentation of the same name presented by Dr. Rebecca Raciborski, PhD at the QUERI Adjunct to the 2023 AcademyHealth Annual Research Meeting in Seattle, WA on 6/27/2023.

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* Views are hers and do not represent official policy of the Department of Veterans Affairs or QUERI
* Dr. Jacob Painter provided an early version of these slides
* Drs. Bo Kim and Sara Landes noted insightful ways to make the presentation more useful to implementation scientists
* All errors are the presenter’s

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|  | This presentation is designed to introduce implementation scientists to fundamentals of BIA  It assumes you will either be (1) working with an economist from the beginning of your project or (2) getting set up on your own but eventually having an economist or other analyst complete the BIA  In short, it is not designed to teach you how to do a BIA! |
|  | “Budget impact” may be confusing because it is not clear what is being affected and what is causing the effect  It is the budget that is being affected by changes in care |
|  | Imagine a new diuretic to treat hypertension during comes on the market; unlike some existing drugs, this can be used during pregnancy  How does this change how much VA pays for hypertension care?   * Brand & not generic * Lower pregnancy complications could offset cost   A BIA could tell us how much the cost of the new drug was offset by the savings from fewer healthcare encounters for complications. |
|  | We don’t use BIAs for questions about how much care we could provide if we increased the budget.  For example, we couldn’t use BIA to ask a question about how many more people we could treat with the new drug if we increased VA’s budget by $10 million. |
|  | We also don’t use BIAs for questions about how our spending affects health.  For example, we couldn’t use BIA to answer a question about how many more people have their blood pressure under control given the $500,000 we spent on the new medication in the last year.  Cost-effectiveness analysis is used to answer questions about *value*. |
|  | Typically think of BIA as happening before a payer (VHA) decides to pay for the treatment – that is, it informs the coverage decision  May also be used in adoption decisions:   * How to implement * Whether offering an effective treatment appears to be sustainable * How many patients can feasibly be covered per budget cycle given current constraints |
|  | Mandates can be Congressional or from national VA to local VAMCs |
|  | Focus is on cost incurred by whoever pays for the new intervention (“payer” or “budget holder”)  In VA, the payer could be VACO, a specific program office, or even a VISN or VAMC if an intervention is implemented with local funds  Time horizon for projections is generally short to align with budget cycles and planning periods  Notice how implementation costs are missing? |
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|  | Not either/or; it is “and” – or changing how the same services are provided |
|  | We use microcosting when we need detail about how much different strategies cost  We use macrocosting when we need only to know how much implementation costs |
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|  | Hypothetical example intervention |
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|  | In this case VACO is the payer because they will be funding future implementations  The BIA will be done from VACO’s perspective |
|  | Several of the items on this list are of interest to researchers, but not necessary for a BIA from VACO’s perspective for this scenario:   * Development costs could be interesting if we want to know pre-implementation start-up costs, but because these are paid for by the grant and won’t be “paid” again, we do not need them in this example * Diffusion is interesting as a measure of reach and “successful” treatment (finishing all sessions) as a measure of effectiveness may be important RE-AIM metrics, but not used in BIA * Specific health outcomes are not in a BIA, only short-term changes in use leading to changes in health costs   For the site-specific items we do collect, we want to make sure to get data at all sites across the implementation timeline |
|  | Alternate scenario for our exercises – new decision maker & strategies |
|  | Each VAMC is the payer because the adoption and sustainment decision will be made locally |
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|  | Why aren’t the national (central) salaries needed? Because newly-adopting local VAMCs won’t be paying these in the future  We may or may not need salaries for local staff – we may choose to use national estimates for job titles because different sites may staff these roles differently  We also may not need to account for time engaging with the community of practice if that is done within a provider’s usual continuing education protected time  This time we add diffusion because we need to know what the uptake will be  Why not successful treatment, cost of a visit, or number of visits? Hopefully you got your clinics set up with a way to track that easily using CDW data 😊 |

# Selected resources and references

* <https://www.herc.research.va.gov/include/page.asp?id=budget-impact-analysis>
* <https://www.herc.research.va.gov/include/page.asp?id=implementation-tools-resources>
* Cost-Analyses of FUNCTION QUERI Programs: STEP-KOA and STRIDE <https://www.hsrd.research.va.gov/for_researchers/cyber_seminars/archives/video_archive.cfm?SessionID=6281>
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