Assessing Value in Ontario Health Links

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Overview

- Context
- Three-part project
- First Study:

  Assessing Value in Ontario Health Links: Lessons from US Accountable Care Organizations.
- Second Study:

  A perspective from early adopter Health Links.

Health Links

- Launched in January 2013 to deliver integrated care to high needs population (5%).
- Lead organization and core partners, based on strong pre-existing relationships:
  - 65% of primary care providers, hospital, CCAC, and others.
- A number of other health and social care organizations (e.g., public health units, police, local city government).
- Flexibility to create their own strategies based on local conditions.
- Little is known about their current and future value.

Three-Part Project

1. Identify how has ‘value’ been recognized and measured in U.S. Accountable Care Organizations and how these lessons may inform Health Links’ strategies.
2. To identify promising Health Links’ strategies and why these strategies are creating value for patients and the health care system.
3. To conduct empirical analysis testing the impact of promising Health Links’ strategies on critical ‘value’ measures using ICES data.

Study Team

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- Luke Mondor
- Dr. Walter Wodchis

Assessing Value in Ontario Health Links
Lessons from US Accountable Care Organizations

Objectives

- Identify how value has been recognized and measured in US Accountable Care Organizations (ACOs).
- How these lessons may inform Health Links' Strategies.

Methods

- Narrative review of the health services and policy literature.

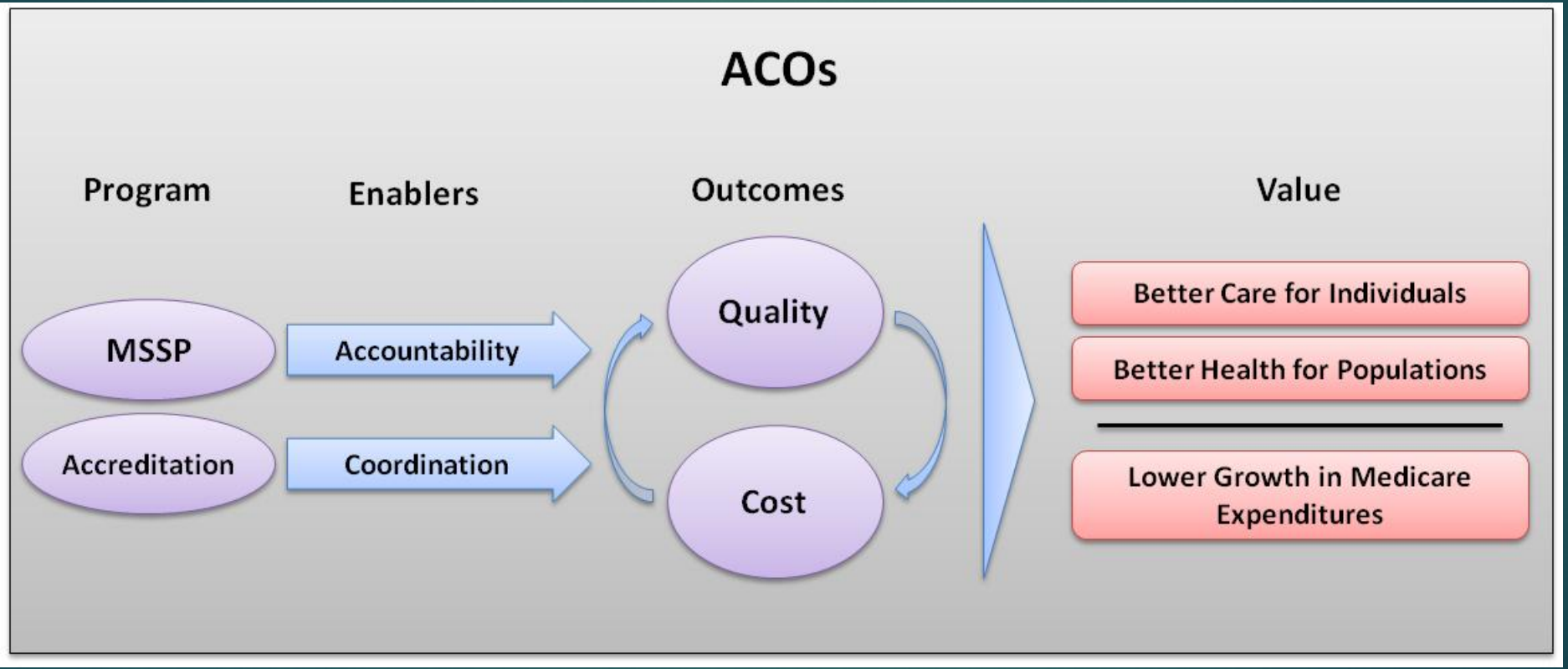
ACOs have several common characteristics with Health Links

- Collaborative models of regional partnership among health care and social care organizations:
  - To deliver integrated health care services.
  - Focus on the high needs population.
- Voluntary
- Flexibility to create their own strategy depending on local resources, population needs, strengths, and barriers:
  - Strong foundation of patient-centred primary care.

...yet important differences

- ACOs can be held accountable for the cost and quality of care delivered to a defined population (*US Patient Protection and Affordable Care Act*)
- Medicare Shared Savings Program (MSSP):
  - Payment system that allows ACOs to share Medicare savings.
  - Conditional on delivering high quality care (33 quality indicators).

Conceptual Value Creation Chain of ACOs



MOHLTC Health Links Performance Indicators

- Quality of care → 7 (3 op.)
- Adequate use of resources → 4 (3 op.)
  - Total of 11 indicators (6 operational)

Framework for Assessing Value in Health Links

Aims	Domains	Health Links Performance Indicators
Better Care for Individuals	Patient/Caregiver Experience	• Increase the number of complex patients with regular and timely access to a primary care provider. • Enhance the health system experience for complex patients.
	Patient Outcomes/Safety	• Reduce the number of 30 day readmissions to hospital (Op).
	Care Coordination/Integration	• Ensure the development of coordinated care plans for all complex patients. • Reduce time from referral to home care visits (Op). • Reduce the time from primary care referral to specialist consultation. • Ensure primary care follow-up within 7 days of discharge from an acute care setting (Op).
Better Health for Populations	Preventive Care	
	Healthy Lifestyle	
	Target Population Health Outcomes	
Lower Growth in Health Care Cost	Cost Containment	• Reduce the average cost of delivering health services to patients.
	Adequate Use of Resources	• Reduce the number of ED visits for patients with conditions best managed elsewhere (Op). • Reduce unnecessary admissions to hospitals (Op). • Achieve an ALC rate of 9 per cent or less (Op).

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Assessing Value in Ontario Health Links

A PERSPECTIVE FROM EARLY ADOPTER HEALTH LINKS

Define value from the perspective of Health Links

- Who is the target population?
- What value do Health Links expect to create?
- How are Health Links creating value?
- What have Health Links accomplished so far?
- How do we move forward, and in what direction?

Methods

- 11 interviews with 21 individuals in key positions within 10 Health Links.
- Sample based on their advancement in:
  - Program implementation.
  - Partner collaboration.
  - Innovation and promising practices.
  - Variety in terms of location, LHIN, and type of lead organization.

Who is the target population?

IDENTIFICATION

Retrospective → **Real time**

- Hospital data
- High users
  - Seniors.
  - Admissions and ED visits.
  - Multimorbidity (COPD, CHF, mental health).
  - Polypharmacy.

- Identification by physicians and other providers and organizations.
- Pre-high users
  - Younger population with multimorbidity.
  - Mental health and addictions.
  - Inadequate housing and social support.

Definition of value was concurrent with the HSPRN Framework for Assessing Value in Health Links

Aims	Domains	Concepts of Value Identified
Better Care for Individuals	Patient/Caregiver Experience	Timely access, satisfaction, trust, shared decision making.
	Patient Outcomes/Safety	Quality of care and patient safety.
	Care Coordination/Integration	Integrated seamless care, coordination among provider organizations.
Better Health for Populations	Preventive Care	
	Healthy Lifestyle	Focus on the social determinants of health.
	Target Population Health Outcomes	
Lower Growth in Health Care Cost	Cost Containment	Cost reduction, efficiency, sustainability.
	Adequate Use of Resources	Reductions in ED visits and hospital admissions.

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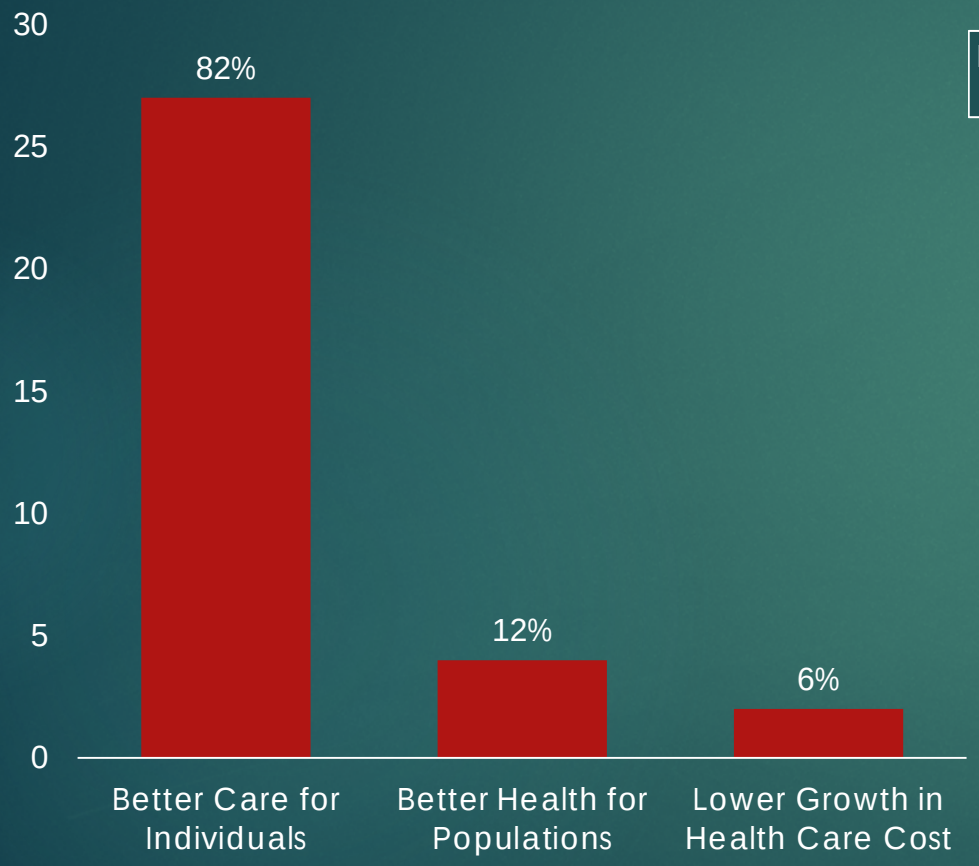
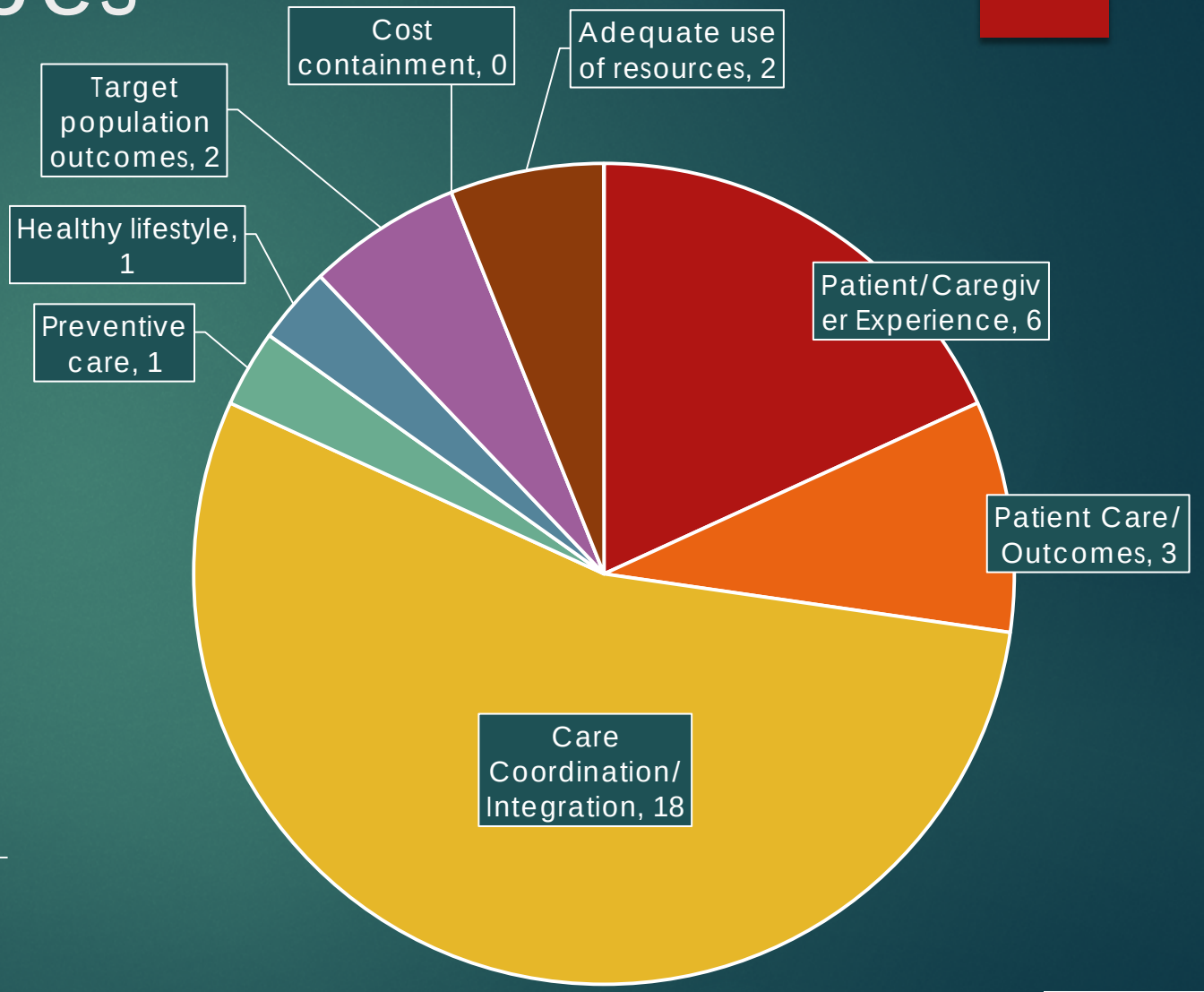
Innovative Practices





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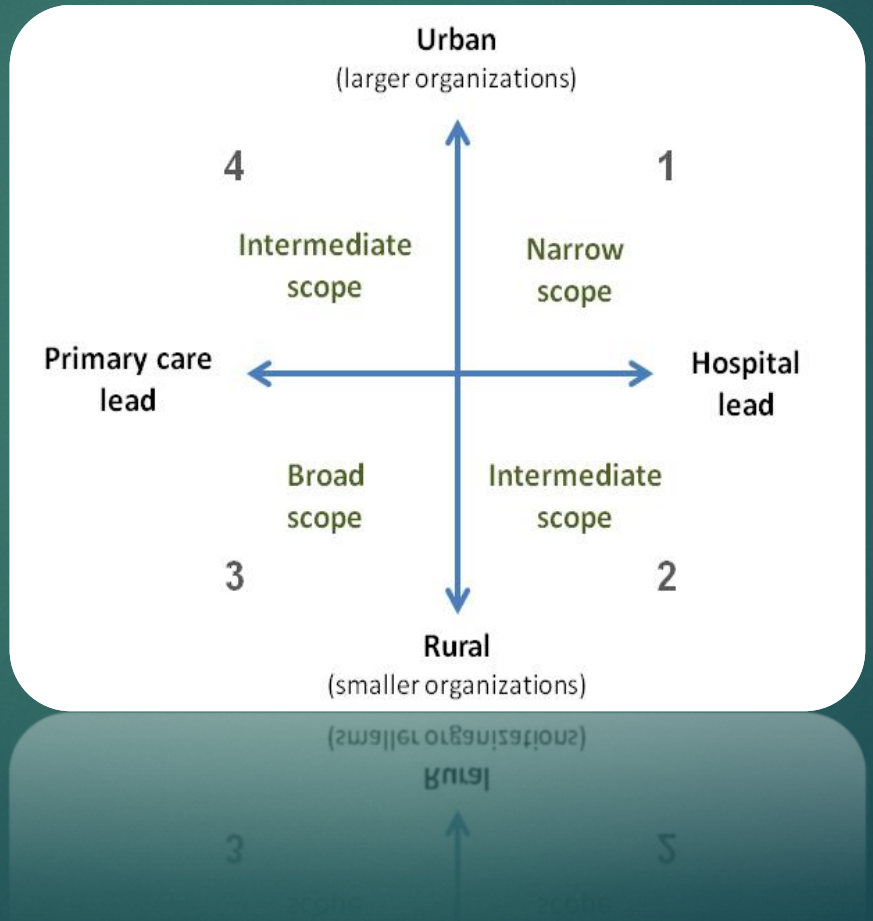
How are Health Links Creating Value?

- Scope of Integration

  Extent to which processes and organizational structure are transformed in order to achieve integration.



- Narrow

  Focused on processes directly affecting care to HL target patients.

- Broad

  Focused on general organizational and inter-organizational processes of care.

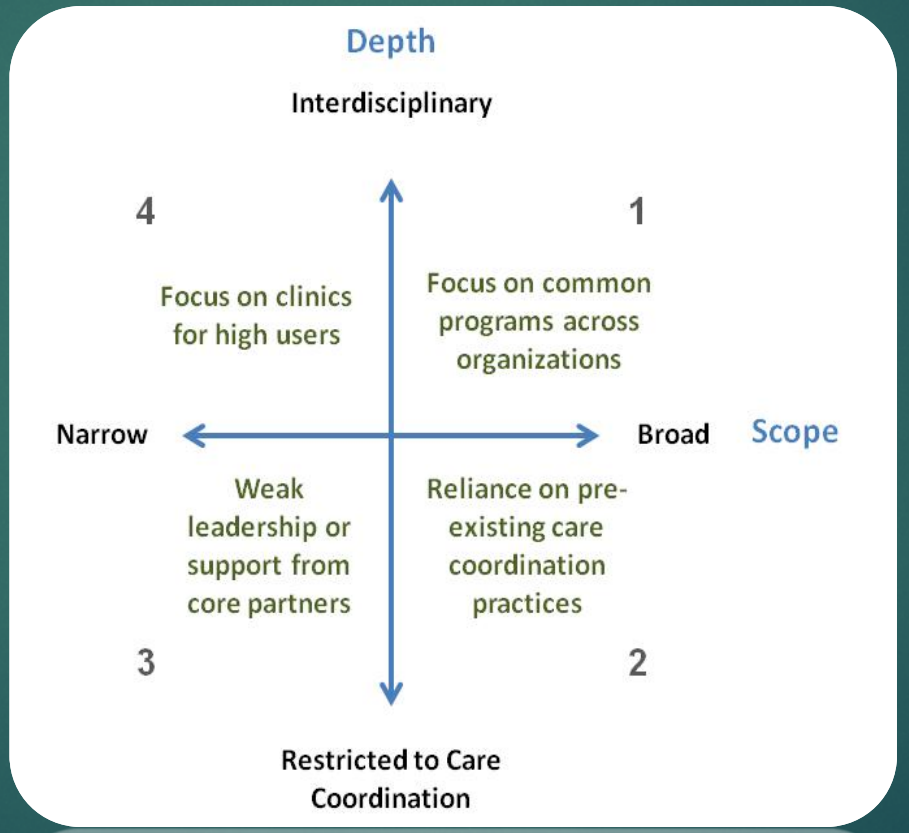
Integration scope & depth

- Narrow & interdisciplinary

  Focused on interdisciplinary clinics for high users.

- Narrow & restricted

  Weak leadership or support from core partners.



- Broad & Interdisciplinary

  Focused on common programs across organizations.

- Broad & restricted

  Targeting high users with pre-existing care coordination practices.

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Long-Term Vision

- A vehicle to transform health and social services into an integrated seamless system of care,
- that persists over time,
- and extends beyond the high user population:
  - patient/client-centred and patient/client-driven care,
  - includes social supports in the community as another active partner,
  - giving importance to prevention,
  - individually tailored services,
  - interdisciplinary teams aware of the care delivered across the system,
  - aligned across Health Links in the same region.

Enablers

- The opportunity to find local solutions to local problems.
- A philosophy of collaboration and common purpose.
- Physician engagement through communication and motivation from peers.

Challenges & Barriers

- Billing or allocating cost to multiple organizations.
- Care coordination by CCAC staff within the HL involves not only CCAC services
  - Demand new processes and expertise (e.g. mental health patients).
- Integration at the Ministry level - put down silos.

Key Resources Needed

- IT support.
- Eliminate barrier to sharing of information, provincially.

Highlights

- Value from Health Links goes beyond patient outcomes and cost, and involves building system integration, improving user/caregiver experience, and enhancing population health.
- Work is needed on accountability for quality of care and cost (performance measures and incentives).
- Current value creation in:
  - care coordination/integration,
  - patient/caregiver experience,
  - patient outcomes, and
  - adequate use of resources.

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Highlights

- Key IT support and data sharing.
- Long-term vision of a vehicle to effective system transformation.
- Integration needs to scale up beyond Health Links.