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COPD/ CHF Integrated Funding Models Qualitative Results

Slide deck prepared for the MOHLTC as part of the IFM Central Evaluation

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Leveraging the culture of performance excellence in health systems

Overview

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    2. Primary care engagement
    3. Building trust across organizations, professions, & sectors
4. Strategies used to address concerns
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The Sample

- 3 programs (Central, South West, & HNHB)
  - Of different scales, from a LHIN-wide program with 9 hospitals to another with 1 hospital
  - Variations in clinical focus, clinical pathways, & funding models
- 18 interviews completed
  - 6 semi-structured interviews conducted with each program
  - Conducted between January-March 2018
  - Results based on participants' observations of their own programs
- Interviews conducted with:
  - Hospital & community partners
  - Leaders & front-line staff
  - Integrated care coordinators/ navigators
  - Clinical champions

Program-Specific Issues

What's on stakeholders' minds within programs?

Central: Changing Partners

Central was concerned about program sustainability as it would have to partner with Home and Community Care rather than St. Elizabeth as sole provider, going forward:

> “We want to have a sole provider because we know our patients like to have confidence in the people that are coming into their homes, and they want regular people coming into their homes, […] So we don’t get feedback on that. So when we transfer them back to CCAC then it goes back to the prior system where we don’t get the sort of feedback on those patients.” (Participant P, Central)

HNHB: Owning the Bundle

Some HNHB stakeholders suggested restructuring bundle so that equal bundle contributions across partners would not dilute rewards:

"… if [Hospital X] was not performing as well in terms of the length of stay, or if our coordinators were putting in substantially more homecare resources […], the challenge with the way the bundle is structured now is that it averages out across everyone. So there's, in theory, a little less incentive for [Hospital X] in that scenario, or [partner] even, to be really pushing the envelope and to be innovating because they don't get as direct an impact from that. […] my strong bias is that […] those that are influencing their own care pathways actually have ownership of the bundle because then they can benefit from the changes that they're making and not have them be a bit diluted across the system."

(Participant J, HNHB)

SW: Rethinking Funding Model

South West set up a gains/ risk-sharing model that circumvented the challenge of projecting patient volume in advance:

"…we don't see a stability in us being able to project what [patient] volumes are going to be. […] while we know everyone's trying […] to push the money out in advance, we're thinking more retrospectively that it might be better to come up with some model where we might say gosh, we think we're going to have between 50 and 100 patients. Don't send out the money for 100, send out for 50 and then we'll do some sort of reconciliation process as we go through that." (South West, Participant B)

This would help:

a) Build small-site confidence
b) Alleviate pressure to trim pathways in response to funding constraints
c) Facilitate balanced financial partnership mirroring clinical counterpart

Program concerns and strategies

What’s on stakeholders’ minds across programs?

Patient Enrollment

- Patient enrollment lagged behind expectations, as patients were reluctant or unable to enroll. Their reluctance was due to:
  - Unwillingness to give up rapport established with Personal Support Workers (PSWs) provided through Home and Community Care. (Of particular concern for 2 programs that contracted directly with homecare organizations, bypassing Home and Community Care).
  - Concern about waitlist to regain original PSW services at program end & uncertainty of being re-allocated previous PSW
  - Eligibility criteria requiring patients to have a COPD diagnosis and family physician to participate, while preventing inclusion of those hospitalized after having been on the program

Strategies: Expanding Boundaries

"So we expanded the borders a little bit […] we sort of crept into some of the other LHINs. So when the patients are then discharged after the IFM, they do go back to the other LHINs. […] Initially we only were taking the patients that came to cardiology that were CHF patients. So then we expanded to the whole hospital. So we said, okay, we'll take anybody in the hospital who comes in with CHF."

(Participant M, Central)

Strategies: Program Flexibility

"… your ICC coordinators are really key to being able to get people to buy into the model. They stretch it a little bit, right. … [They] figured out a way to get people into the program, and what would benefit them. And that they didn't need maybe all the bundled services. Maybe they only needed a piece of the ICC bundle. […] Because initially we set it up, you'd get a PSW, you'd get all these things. Well, some people don't need everything, right. […] And they started making some, I'm going to say, like work-arounds, I guess, sometimes."

(Participant H, HNHB)

Strategies: Rethinking Eligibility

"… one of the eligibility criteria is that they need to have [a primary care physician] in the community to be on program. So we're reassessing that right now, seeing if […] some of the specialists may be willing to follow these patients for a month while they're on program. […] Another eligibility criteria is a diagnosis of COPD. Many of these patients when they're in hospital don't go for pulmonary function tests when they're in hospital. They usually go a week or two after discharge. […] Well, what we say is if they walk like a duck then we're going to assume that they have COPD."

(Participant D, South West)

Primary Care Engagement

- Family physicians played an important role
  - Their consent could be needed for patient enrollment
  - They followed up with patients post-discharge

- Early strategies to facilitate engagement included:
  - Active partnering with family health teams
  - Working with the LHIN's primary care lead for outreach

- Primary care reluctance was due to:
  - Lack of familiarity with program
  - Fear of being burdened with more responsibility & less reimbursement, without being consulted in process
  - Lack of comfort with titration
  - Concern about occupying the most responsible physician role once patients were discharged in context of patient unfamiliarity and liability
  - Concern about being contacted by video conference at home

Strategies: Engaging primary care

To encourage engagement, programs:

- Distributed newsletters about the program
- Involved respected family physicians as champions
- Presented at sub-region tables, addressed primary care concerns, and incorporated feedback in pathway design
- Conducted rounds for Department of Family Medicine
- Relayed information through coordinators to community physicians with small patient loads, rather than requiring attendance at lengthy rounds
- Booked patients' post-discharge appointments with family physicians
- Used tele-homecare to foster comfort with the model
- Contacted family physicians before discharge to provide information about the program, and reassurance that hospitalist would remain MRP for 5 to 7 days after discharge, and participation at required video-conference a week later would not be onerous

Strategies: Engaging primary care

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> “We have our director, our medical director for family care on the steering committee. We’ve also done rounds for the Department of Family Medicine. And we also do a newsletter to the Department of Family Medicine. So we keep them connected because they’re their patients, and they need to know about the project. We also have our clinical care coordinator send them a discharge note with the project on discharge, and with her contact information in case they want to connect back with the care coordinator. And we try to get that appointment booked for them within the first x number of days that they’re home. So we ensure that follow-up.”
>
> (Participant P, Central)

Negotiating Difference

Integrated care delivery required the negotiation of differences within and across organizations, systems, and sectors:

“I think the biggest issue […] would be the hospital’s [lack of] desire to understand Home and Community Care services. […Because] if your team is more understanding of someone else’s work, it decreases barriers. […] And I wish there was a desire on their behalf to learn that because we see ourselves as equal partners in healthcare.” (Participant D, South West)

“[…] every hospital has a different set of rules, a different set of union rules, a different set of ideas about how they could function […]. There's a lot of opinion in everything you do and every decision you make now needs to go through nine hospitals. If you want to change a weekend rotation for the coordinators, you have to have nine hospitals agree. And guess what? They don’t.” (Participant K, HNHB)

Strategies: Negotiating Difference

Programs worked towards transcending differences by:

- Using information technology that allowed clinicians to access, monitor, and respond to patients in real time
- Fostering trust by involving stakeholders across sectors and professions in model design
- Fostering physician confidence by sharing evidence of program success
- Encouraging hospital and community clinicians to learn together, develop an understanding of each other's practice, and interact closely
- Participating in shared visioning and community of practice meetings where participants continuously asked:

> "How can we improve;" "Is there value in each interaction, in each piece of that pathway? What is the meaning? What is the value that we can measure? What is [valuable] from a patient experience point of view too?" (Participants O, P, Q, R, Central)

Strategies: Negotiating Difference

Transcending egos, and professional and corporate identities helped bridge difference:

"…how this became successful is when I went and had a conversation with the CCAC. My first couple of conversations were not really good because it really did come out about, you know, my patients or whatever. And that wasn't good and helpful or anything else. So I said at the time, I'm not talking about the who, I'm talking about the what. And why don't we do this? If these are your patients, great. I'm here to help you. […] So as we start to plan, why don't we put all our corporate identities away. […] Only talk about the patient and what we need to do to optimize that patient. And in fact, let's not even talk about money. We'll figure that out later. And by everybody agreeing to that principle, it actually happened." (Participant A, South West)

Sustainability

How can IFMs be sustained?

Sustainability Measures

Measures suggested to encourage IFM sustainability:

1. Resolve contradictions in IFM objectives aimed at reducing hospital visits and volume-based QBP funding
2. Compensate physicians; reward specialists for telephone work

> "…there has to be some incentive for the physicians involved to maintain quality input rather than just being an altruistic thing. […] I just know from a physician perspective, this is a bit of an added burden without getting rewards from our Ministry. I think the money is being put into healthcare providers who I think are excellent at what they do. We still need the specialists and the family doc input.
>
> (Participant F, South West)

Sustainability Measures

3. Develop standardized templates for data collection and finance
4. Consider moving model upstream, starting with self-management education in primary care, which may also serve as point of intake
5. Pursue more meaningful evaluation

> “We had one patient who came in twice to the emergency department because they couldn't poop. But it still counts against us. [...] And so they fixed him up and then he couldn't poop again. And they fixed him up and he didn’t come back. But that’s part of what you’re measuring, is how often do they come to the emergency department. At all cost.” (Participant N, Central)

Sustainability Measures

6. Wrap care around patient more effectively by:
   a) Addressing patient complexity (eg. comorbidities and social complexity)

> "…in an ideal world […] it wouldn't have been COPD, it would have been comorbid conditions, regardless of what they were. And then the whole model would be wraparound care around that patient, trying to stay healthy or optimize their health in living with their disease. […But] in order to get a care pathway that is truly comorbid, [you need] a system that you go in and say this person has got COPD, CHF and depression, and you check off. And the care plans and the care pathway comes up, and it gets rid of any duplication, and then it creates one comorbid care pathway that everybody can follow […]"
>
> (Participant A, South West)

Sustainability Measures

b) Linking to wider health resources

> “…people come back to hospital […] because maybe they’re not health literate, or they may not have food, and maybe they don’t have transportation. […] I find it sort of a bit funny that it’s not more aligned to Health Links. […] So the Ministry, the LHIN, we need to tie these things together and not be doing them separately.”
>
> (Participant G, HNHB)

> “I think the navigator role is sometimes under-valued […]. Those patients who come into the hospital who aren’t appropriate for this program or they’re not interested […] instead of these people just kind of falling to the wayside, we can [be] referring them to different programs or providing different supports to them.”
>
> (Participant E, South West)

Sustainability Measures

c) Linking to wider social resources

"…using existing community services like the YMCA is an example, would be important to do. If we looked at not just through the lens of the Ministry of Health but the Ministry of Recreation, the Ministry of Housing. […] Like breaking down all the silos across the system." (Participant P, Central)

d) Focusing on system-wide sustainability rather than cost-savings

"… [it's] a financially driven initiative as opposed to a sustainability patient care driven initiative. That's how I've experienced it. I think that we've got to shift that. This is a sustainability model. And in the long run, it's going to save us oodles of money because it's cost avoidance." (Participant A, South West)

Sustainability Measures

e) Increasing bundle length

“… I’d give their acute portion up to 60 days. But I would keep them on with a navigator forever […] every patient with COPD, whether they had low, moderate or high needs. […] it’s the right thing to do. That would change the healthcare system. […] if I was the Ministry, I’d be all over this one. […] just think, 290 patients, and they were only the moderate, what if we did a navigator and a nurse and a team on all COPD patients that walked into this hospital, and they were followed? I bet you the results would be off the roof positive. Because even patients that are low […] if I had a navigator that I could talk to, who would phone me up and say, “Oh by the way, you know, it’s fall. […] the standards of practice are X, Y and Z. And we haven’t done X so I want you to go to your family doctor,” or whatever. Think of the difference that’s going to make in the long term for the healthcare system.” (Participant A, South West)

Sustainability Measures

7. Accounting for differences across clinical conditions & local program contexts when spreading/ scaling models

> “You know, we’ve designed a factory line to build a car. We just happened to put the right car together that works well on this line. And I really don't know if it's translatable or not. And so that’s my biggest fear. That being said, I totally think it’s worth doing.”
>
> (Participant B, South West)

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