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Integrated Funding Models - Identifying Early Challenges and Drivers of Success

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

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Background

- 6 programs - 4 included; 2 at REB stage
- 6 semi-structured interviews conducted with each program
- Interviews conducted with:
  - hospital & community partners
  - leaders & front-line staff
  - integrated care coordinators/ navigators
  - clinical champions
- Diversity in program scale, disease area, bundle features
  - ranges from a LHIN-wide chronic-disease program to a 3 key partner short-term nursing program
- These are preliminary observations
  - interviews still ongoing
  - based on participants' observations of their own programs

One Client, One Team

- **Disease area:** Stroke
- **Partners:**
  - Sunnybrook Health Sciences Centre and St John's Rehab
  - North York General Hospital
  - Mackenzie Health
  - Providence Healthcare
  - Toronto Central CCAC and Central CCAC
- **Care Bundle:**
  - Length of bundle: 104-days post-discharge
  - Key elements: Secondary prevention visits, outpatient rehab (inpatient rehab in future phases)

One Client, One Team - Facilitators

- Leadership belief in model
  - "…we believe that it can make an absolute difference to the way patient care is provided." (4)
- Trust between partners facilitates collaboration
  - "… ongoing trust is certainly there, [partners are] volunteering for certain things and saying, you know what, we need to do that anyway. So no, we're not going to use this as an opportunity to get this initiative to pay for that cost. We're going to pay for it ourselves." (2)
- Merged financial and clinical groups
  - "It's created a more common language …we don't end up getting recommendations coming from the clinical group saying, for example, we think we should hire a navigator. What we end up getting is we have an idea for investment, and it's been vetted financially, and here's the business case for actually dong the investment." (4)

One Client, One Team - Challenges

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- Partner differences in scale, practices, resources (e.g. referral processes, clinical tools) requires organizational culture change
  - "…to try and change an organization … and now tell them that we're now going to do things differently… It's not that it can't be done, it's just trying to do it with existing resources, that's very challenging." (17)
- Different LHIN/ CCAC risk-taking cultures
- Unions
  - "… even though the navigation function, wouldn't be taking over anybody's job … there's a lot of concern that it would be an impingement on the CCAC care coordinator's role." (3)
- Patient enrollment

Hospital 2 Home

- **Disease area:** UTI and Cellulitis
- **Partners:**
  - William Osler
  - Headwaters Health Care Centre
  - Central West CCAC
  - Ontario Telemedicine Network
- **Care Bundle:**
  - Length of bundle: 60-days post-discharge
  - Key elements: Short-term nursing interventions with approx. 14 nurses hired specifically for this intervention, full access to electronic health record both in and outside of the hospital, one contact number

Hospital 2 Home- Facilitators

- Well-established partnership; back end integration (HR, IT, Finance, etc.)
  - "…we have a joint CFO… (who) can look at the finances of each of our organizations and say… we can take a risk here… It takes the money out of the equation when you're trying to do the right thing." (11)
- Care team cohesion
  - "… we have eliminated the providers because we have become the providers. So we've just directly hired our own staff…. so you know, I think we were all ready for this model to go." (14)
- Strong physician engagement & LHIN involvement
  - "… our chief of staff is also the primary care lead for the LHIN. So he took on the coordination of crafting… the information to go out to all the primary care physicians … We also have primary care at the planning table within the Central West LHIN." (11)

Hospital 2 Home - Challenges

- Capacity and geographical coverage
  - "… part of the challenge we're having right now is just because we're not at that full capacity. There's more travel time than we had anticipated because the nurse is having to travel… We have a very large geographic area." (11)
- Increased volume challenges cost-savings
  - "… you'll save patient days but the way our business is right now, there's always another patient waiting to come into that bed… We're seeing the outcomes that we want to see. But I wouldn't say that this is saving us money by any means." (19)

Connecting Care to Home

- **Disease area:** COPD and CHF
- **Partners:**
  - London Health Sciences Centre
  - South West Community Care Access Centre
  - St. Joseph's Health Care London
  - Thames Valley Family Health Team
  - South West Local Integration Network
- **Care Bundle:**
  - Length of bundle: 60-days post-discharge
  - Key elements: eHomecare model (eShift/eClinic) for remote monitoring immediately post-discharge, 24/7 telehealth, navigator, clinical care coordinator

Connecting Care to Home - Facilitators

- Previous collaboration; good relationship with CCAC
  - "…at LHSC, there is a commitment to work with the CCAC as a partner. … Once we demonstrated to them the vision that we could bring to that 60 day care plan and the E-home care supports, and some of the other important pieces like a dedicated provider, they recognized (the benefits) pretty quickly… that realization came… because we've had a pretty good track record… where we have worked together as a joint team." (8)
- Care team cohesiveness
  - "In the Connecting Care to Home team, they work very tightly. I've never seen a team that's as well connected." (12)
  - "We don't say who the employer is, we don't use organization names. We just call ourselves the homecare team." (8)

Connecting Care to Home - Challenges

- Physician buy-in
  - "…that has been our biggest barrier, is physician buy-in and what… Most of them want to know what they're getting out of it." (12)
- Risk stratification
  - "… the blend of both clinical and social factors can be so broad, the risk stratification continues to contain a substantial portion of subjective analysis." (8)
- Information-sharing
  - "… there's such a time delay between when a patient is discharged from hospital and we can actually get more concrete information from the hospital data set." (8)

Integrated Comprehensive Care 2.0

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- **Disease area:** COPD and CHF
- **Partners:**
  - St. Joseph's Healthcare Hamilton, Brant Community Health System, Centre de Santé Communautaire, Grand River Community Health Centre, Haldimand War Memorial Hospital, Hamilton Health Sciences, HNHB Community Care Access Centre, HNHB Local Health Integration Network, HNHB Primary Care lead, Joseph Brant Hospital, Niagara Falls Community Health Centre, Niagara Health System, Norfolk General Hospital, North Hamilton Community Health Centre, St. Joseph's Home Care, West Haldimand General Hospital
- **Care Bundle:**
  - Length of bundle: 60-days post-discharge
  - Key elements: Integrated care coordinator, 24/7 telephone line; virtual team rounds, lead home care agency

Integrated Comprehensive Care 2.0 - Facilitators

- Strong LHIN involvement
  - "We have a very good relationship with the LHIN across the hospitals…it has been for many years." (1)
- Collaboratively working through risk scenarios
  - "So across the organizations… we've had risk scenarios which we've examined … thought about how we should weight things." (1)
- Mentorship by St. Joe's
  - "…the project lead at St. Joe's, one of our ICCs for the COPD, CHF stream from St. Joe's, they're actually sitting on all the working groups. So it's really helpful." (5)
- Physician engagement
  - "…we're able to bring our LHIN physician leads to meet with the hospital leads. They're able to talk, offer support, if they want presentations to their teams, etc…It's helped with the recruitment of physician leads." (5)

Integrated Comprehensive Care 2.0 - Challenges

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- Scale complexities; diverse organizational cultures (different approaches to privacy, QBP best practices, MOU, discharge, etc.)
  - "You'll find each hospital has a bit of a different take on the QBP best practice … And sometimes they hold those values quite strongly. You know, we're right and others need to change." (1)
- Contentious relationship with CCAC
  - "…there really was a [CCAC] reluctance. And even now, like here at [the hospital], working with the management team with CCAC, there's still that, you know, sort of negativity." (6)
- Lack of clear ground-up process to facilitate implementation
  - "…when we built ICC, we really built it from the ground up. Looking at us little low lying fruit, they really took us and helped make it build up… With the IFM, it started a bit high level. And so we're missing a bit of that implementation and engagement." (9)

Shared Drivers of Success

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1. Building on existing partnerships
2. Strong leadership; belief in model
3. LHIN leadership and involvement
4. Good relationship with CCAC
5. Program cohesiveness at operational and implementation levels (e.g., merged operational committees; shared back end processes, care team cohesiveness)
6. Physician engagement
7. Navigator/ Coordinator role (1 program in ongoing discussion about need)
8. Alignment with existing priorities

Shared Challenges

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1. Privacy culture differences across partners
   - challenges information sharing & management
2. Financial pressures
   - Lack of resources (human/ financial) particularly affects smaller-scale partners; impacts buy-in desire/ ability
3. Competing organizational priorities
4. Savings taken up by increased volume
5. Covering large geographies while not at full capacity
6. Coordination

Making a Difference

- There is great enthusiasm for the IFM initiative across programs despite the implementation challenges identified:
  - "Definitely I've seen a huge difference in patients going home with no care compared to this. It's astronomical the difference it can make." (12)
  - "…what I find very inspiring, is that the patients that are part of these various… the steering committee (…etc.), they keep coming back. They keep saying that this is good." (13)
  - "I totally am convinced. As a family doc, as a primary care lead, and as the physician lead, like I really believe it's the way to go." (7)
  - "…if I can speak as the chief of staff, I think this is… the way of the future. And I keep repeating it – way of the future, way of the future." (16)

Suggestions From Early Adopters

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- Facilitate information sharing across programs
  - Eg. guidelines, common learnings, tools; provide more material that can be shared across programs on website.
- Provide guidance on data sharing challenges
  - Patient data collected differently across partners, different privacy cultures, lack of common technological platform
- Promote consistency in LHIN engagement
  - Variation in LHIN buy-in impacts partnerships with CCACs
- Provide more resources
  - Resource allocation per site (versus per program) may be preferred by smaller sites

Suggestions From Early Adopters

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- Streamline integrated care initiatives to mitigate competing priorities
  - "I find generally there's a very siloed approach from many aspects of the Ministry. …It's a puzzle to me, we're trying to create integrated care but there's not a lot of integration within the Ministry around the number of things going on at the same time." (1)
- Balance ongoing support and spread of IFM
  - "…be very, very, very cautious about any more (IFM) projects being implemented for a CCAC like us that's already involved in one." (8)
- Acknowledge bundled care as a driver of success
  - "I would say if there's a little bit of a disconnect… the Ministry talks about integrated funding models. We talk about integrated care models… For the Ministry, it may be an exercise in how to distribute resources. For us, it's an exercise in how to deliver care." (18)

Next Steps

- Ongoing interviews with additional programs
  - Identification of themes from qualitative analysis of interviews
  - Development of publication

- Future interviews with programs later in evolution
- Quantitative evaluation through Institute for Clinical Evaluative Sciences
- Patient surveys to summarize patient experience
- Ongoing reporting