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Integrated Funding Models Qualitative Results – Preliminary Findings

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April 2016

Preliminary Qualitative Results

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- 6 programs - 5 included; 1 interviews scheduled
- 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 <u>preliminary</u> observations
  - interviews ongoing
  - based on participants' observations of their own programs

Drivers of Success

1. Building on existing partnerships & priorities
2. Strong leadership; belief in model
3. LHIN leadership and involvement
4. Good relationships/trust among partners
5. Program cohesiveness at operational and implementation levels
6. Physician engagement
7. Navigator/ Coordinator role

Drivers of Success

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1. Building on existing partnerships & priorities

   … we were having conversations with [partners] before the IFM call came out… we were very well connected even before the project started. [30]

2. Strong leadership; belief in model

   “…the partners’ belief and involvement in the program has really made it happen more smoothly because everyone’s on the same page, everyone has the same goals, and everyone believes in the project in the same way.” (27)

3. LHIN leadership and involvement

   “We have a very good relationship with the LHIN across the hospitals…it has been for many years.” (1)

Drivers of Success

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4. Good relationships/trust among partners

"… ongoing trust is certainly there, [partners are] volunteering for certain things and saying, you know what, we need to do that anyway." (2)

5. Program cohesiveness (operational and implementation levels)

"…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)

6. 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)

Drivers of Success

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7. Navigator/ coordinator role

“we’ve got fantastic coordinators here at [site]. They’re brilliant at what they do, and they cover for each other, and they support each other. (5)

Challenges to Success

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1. Culture differences across partners
2. Financial pressures
3. Competing organizational priorities
4. Savings taken up by increased volume
5. Complexity of patient populations
6. Covering large geographies (capacity)
7. Physician Buy-in
8. Information-sharing
9. Unions

Challenges to Success

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1. Culture differences across partners
   - Different LHIN/ CCAC risk-taking cultures, best practices, 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)

2. Financial pressures
   - Lack of resources (human/ financial) particularly affects smaller-scale partners); impacts buy-in desire/ ability

   "It surprises me that the expectation was to do these kinds of large scale projects with so little resources.." (17)

Challenges to Success

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3. Competing organizational priorities

   "I find the time is the biggest issue. Because nothing has been taken off my plate. there are… the challenges of everything else being priority." (17)

4. Savings taken up by increased volume

   "… 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)

Challenges to Success

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5. Complexity of patient population

“... some of these medical diagnoses are very complex people. So nobody comes in with just COPD or just CHF. And so some patients may be ineligible because of their complexity. And it becomes very difficult when you look at inclusion, exclusion criteria to have these purist populations.” (26)

6. Covering large geographies while not at full capacity

“… 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)

Challenges to Success

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7. Physician buy-in

“…that has been our biggest barrier, is physician buy-in… Most of them want to know what they’re getting out of it.” (12)

8. Information-sharing

“…there's 2 health records basically from the hospital’s perspective. So it would be nice if we could somehow align the 2 systems. (30)

“… the data sharing agreement was a bit of a challenge to get sorted out.” (26)

9. 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)

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
- Expand resource allocation
  - Resource allocation per site (versus per program) may be preferred by smaller sites
  - Make funding model more responsive to patient complexity

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)

Suggestions From Early Adopters

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- Initiate discussion around IFM sustainability

  “There’s going to be some disincentive through the QBP funding model. And by that I mean, right now, [hospital] gets funded for the volumes of patients that come in with COPD because of the QBP. If the goal is to keep people out of the hospital and provide them with better care at a lower cost, that’s out in the community, we’re going to lose money. Because it’s better for us to bring them in and treat them because it means more money coming into the organization. So it’s a disincentive that’s going to come back and bite.” (25)

Making a Difference

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- There is great enthusiasm for the IFM initiative across programs despite the 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)