Wrapping care around the COPD/ CHF patient: Lessons in sustainability from three Integrated Funding Models in Ontario

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Introduction

We conducted 18 interviews with a range of stakeholders at three COPD/ CHF programs from January to March 2018 to understand what implementation challenges were encountered and how they were resolved as programs evolved. Participants (six at each program) included organizational leaders who helped conceptualize programs, clinical and financial administrators, and clinicians such as integrated care coordinators, navigators, and physicians tasked with implementing programs across the hospital-community spectrum. We asked participants how their programs had evolved over time, what was working well, and what needed to be addressed to foster program sustainability. Data were coded and analyzed thematically.

All three programs contended with three key issues: a) how to increase patient enrollment, b) engage primary care physicians, and c) negotiate differences, while building trust across organizations, professions, and sectors. However, their unique local program contexts also resulted in different model development journeys. Their unique and shared concerns are explored below. We conclude with stakeholders' thoughts on how they would like to see these models evolving as they mature.

Evolution of the models

The three programs continuously revisited their bundles over time, incorporating feedback from patients and front-line providers, and responding to on-the-ground implementational challenges. For example, at Central, physiotherapist visits were spread out more in response to patient feedback that home visits were too frequent and closely paced (Central 1, 3, 6). OTN was involved in a variety of ways, with it first being accessible only for providers, and later for families too. Health team members were able to signal the need for social work involvement if necessary (Central 3). The CHF pathway itself changed to allow for active patient monitoring of their health and medication, in conversation with patients and cardiologists (Central 3). A nurse visit within 24 hours of discharge to ensure medication reconciliation was added to the pathway, as gaps in medication filling in the community became apparent in the CHF population (Central 5). Information about palliative care was included in IFM education modules, to encourage patients to start planning ahead in the context of their chronic conditions (Central 5). Ongoing conversations related to how differences between COPD and CHF populations might affect the bundle going forward, as the CHF population tended to be older and frailer, have multiple comorbidities, and were less able to come in for outpatient rehabilitation, therefore requiring more in-home services. While all three programs experienced more commonplace transformations such as these, each also contended with unique local circumstances.

Central: Changing partners

Having partnered with St. Elizabeth as its sole provider, Central found that it would have to partner with Home and Community Care instead once its CSS status expired, as it did not have the resources to fund the care coordinator role (Central 3). There was concern about the sustainability of the program in this context as the IFM team had built a strong trusting relationship with St. Elizabeth, its case managers had direct access to hospital physicians, and patients too were secure in their understanding of what services they would receive in the community (Central 3, 6). This sense of security was absent in their relationship with Home and Community Care as the patient was handed off to the community with little understanding of how many hours of service would be provided. This uncertainty led a participant to suggest the need for a QBP-like standardized pathway for community services too:

> … just like the QBP standardized pathways to ensure best practices, I think the community also needs to have some standardized pathways, especially for these elderly chronic disease management folks that have a lot of anxiety, not always able to manage the full scope of their illness. So from dietary, to pharmacy, to transportation, to social issues, and all of those things. And people need to have a touchpoint with these frail elderly more regularly and in a planned way. (Central 3)

At the same time, Central stakeholders were aware of the benefits of partnering with Home and Community Care as it related to facilitating patient enrollment (Central 5), leading stakeholders to suggest that a hybrid model that drew on St. Elizabeth's expertise for nursing alone, while nesting the PSW with Home and Community Care might be a way forward (Central 5, 6).

HNHB: Owning the bundle

As bundle-holder, St Joseph's Healthcare facilitated the analysis of bundle utilization, evaluation, and report-back to evaluators across the nine hospitals that participated in its program. It contributed the same financially to the bundle as its partners, which encouraged sharing and helped mitigate risk. However, as time went on, it also diluted rewards and stymied innovation, resulting in a desire voiced by St. Joe stakeholders for individual hospitals to have ownership of their own bundles:

> … if St. Joe's was not performing as well in terms of the length of stay, or if our coordinators were putting in substantially more homecare resources […], If our cost per patient was much higher and we weren't performing as well as [partner], 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 St. Joe's 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 it should be, you know, each hospital is a bundle holder, or whichever group we define. But 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. (HNHB 2)

In a LHIN-wide implementation context where the program was "given to each hospital site" rather than developed by them, such autonomy may be welcomed by some (HNHB5). However, while autonomous bundle ownership may enhance accountability at the organizational level, it also had potentially detrimental implications for small organizations within larger bundles that were often supported by their larger counterparts. This was the case of a small community hospital with low volumes and a 0.2 coordinator role that needed to be buttressed by a larger partner hospital providing additional support and shared roles (HNHB 4). The dilemma then, may be how to be inclusive while simultaneously retaining bundling incentives.

South West: Developing the funding model

South West program stakeholders had a clear message to policy makers: "stop talking about the funding bundle only being the way they envisioned it at the beginning" (South West 1). The program adopted a different approach to the funding bundle; instead of each partner preemptively putting funds correlating with anticipated services used into a bundle, the two partners involved 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. So we think that from a model perspective, while we know everyone's trying to push this bundled model perspective, 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. I think when you get down to putting out the money as well, I think if you want to sort of direct it to each organization, I think there's good practice in that. I think it makes sense to do that. I think we can come up with a price for that. But I think that one of the challenges will be that if the bundle comes out and you start putting together two or three different diseases into this, then it becomes… You know, because we start netting things out. I think that it actually will start to create some unintended consequences by doing so. And I only say that based on the fact that our CHF population performs very differently than our COPD population. (South West 3)

As this stakeholder also noted, this way of conceptualizing the funding process would help build confidence in spreading the model as small sites might not be as worried about how many patients would end up qualifying for the model, given low volumes. It also mitigated organizational pressures of having to meet pre-set targets despite variability across clinical populations and in per patient cost. This could alleviate pressure to trim the pathway in response to financial constraints that in turn might result in a bounce back on readmission rates. In addition, keeping funding for different clinical conditions distinct would help programs better understand the individual pressures each faced. Finally, not designating a specific organization as bundle-holder would also allow for a well-balanced financial partnership that closely mirrored its clinical counterpart (South West 3). Reconciling budgets at year end and collaboratively agreeing on a price for the bundle was therefore seen as an antidote to the many perceived pitfalls of the originally envisaged prescriptive funding model.

Despite their unique local program contexts, Central, South West, and HNHB faced similar, albeit differently manifested challenges, and developed a range of strategies to address them. These related to how to increase patient enrollment, engage primary care physicians, and bridge differences across professions, organizations, systems, and sectors.

1. Increasing enrollment

All three programs contended with recruitment challenges, as patient enrollment lagged behind expectations. Stakeholders developed unique strategies to encourage enrollment that would work within their local program contexts. For the two programs that had contracted directly with homecare organizations, therefore bypassing Home and Community Care, this was largely due to patients' reluctance to enroll in the program. This was a particular concern for the Central program, which included not only moderate-needs but also high-needs patients (Central 5). For many, it would mean giving up the Personal Support Workers (PSWs) provided through Home and Community Care, with whom they had already established rapport. They were put off by the possibility of a waitlist to regain these services at the end of the program, as well as the uncertainty of being re-allocated their previous PSW.

Programs addressed these and other enrollment challenges in creative ways. These included expanding the geographic boundaries of enrollment (Central 1,3), and expanding patient inclusion criteria. Doing so allowed for the enrollment of ICU patients (Central 3), and enabled recruitment from not only from the cardiology floor, but also from other medicine units, with MRPs not always being cardiologists as originally envisaged (Central 5). Efforts were in fact made to include "anybody in the hospital who comes in with CHF" (Central 4), including those who were not QBP patients because their primary diagnosis was not COPD or CHF (HNHB 3). An HNHB stakeholder described how the program turned to IT solutions to print out a census across each participating organization with anybody with a CHF/ COPD diagnosis to facilitate case finding. The program's integrated care coordinators played a key role in persuading patients to join by flexibly working with both patient needs and program structure:

> … I think what we found really important was that 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. And so we were able to do that. 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. So let's use our resources wisely […] They did it on the ground. And they started making some, I'm going to say, like work-arounds, I guess, sometimes. And I should say as well, it's about how they presented the bundle too. Because they were sort of like sales people, right. (HNHB 3)

Other strategies used included increasing the amount of PSW services offered during the program, and better aligning the languages spoken by nurses working in the community with languages spoken in specific geographic areas (Central 1). Nevertheless, the number of PSW hours that would have to be included as part of the bundle to lure patients over begged questions about the potential limits of integrated bundles as programs thought about spread and scale: "Are we looking at all patients or just the ones that are medium stream?" (Central 5)

The South West program did work with Home and Community Care to deliver the program, but faced different enrollment challenges. For instance, patients were required to have a family physician to participate. While some did not have a family physician, those that did may have a reluctant one. A COPD diagnosis was another eligibility criterion. Both were being reassessed in an effort to increase enrollment.

> … 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. And even at the end of the day, if they don't, we still help the patient go towards self-management with whatever disease process they have. (South West 6)

Early eligibility criteria that prevented the inclusion of those who were hospitalized after having been on the program were also changed (South West 1), while increasingly complex COPD patients were accepted as clinicians became more comfortable with the program (South West 5). The possibility of accepting patients without a primary care physician was also discussed, despite not being implemented (South West 1).

HNHB participants, with their previous experience with a longer tenured program, also noticed that the shorter 60 day bundle length was a key factor in low enrollment. In their second year, it became evident that many were return patients, suggesting that a longer program may be more valuable (HNHB 3) going forward. A hybrid model was also under consideration, where the ICC team would work with patients' existing PSWs. While one participant welcomed this as a way of driving up volume (HNHB 3), another worried that not including the PSWs within the ICC fold would erode a vital link connecting the patient with other healthcare staff (HNHB2). Extending the length of the bundle was also favoured as a way of more effectively wrapping care around the patient, as noted below.

2. Engaging physicians

Developing comfort with the integrated care initiative, programs found, was key in winning the support of hospital-based doctors. A successful strategy through which this was accomplished was ensuring the coordinator role was occupied by someone with established rapport with these physicians. As such, one program hired respiratory therapists as COPD coordinators, while CHF navigators were nurses specializing in cardiology who had spent time on the cardiology floor and had well-established relationships with cardiologists (Central 5). This strategy, as well as physicians' increasing experience with the program (South West 5), the successful resolution of compensation-related concerns (South West 2), and an information-sharing program that allowed physicians to respond to patient needs in real-time (South West 2) helped win over most hospitalists, some of whom worked as formally appointed and informal champions for the program. Over-servicing moderate COPD patients was another early strategy used to build physician confidence:

> Starting off at moderate was purposeful, by the way, … And we over-resourced those moderate patients to begin with. […] And I think there was a fear factor with docs. That, oh my God, these patients, they're going to send them out and they're going to die. […] Now that they're seeing the success of the program, I think we're starting to see more and more acute patients. (South West 2)

Building physician confidence in the program was therefore key. This confidence was challenged in HNHB's early roll out when its community partner was unable to always provide the quantum of services needed due to human resource deficits, leading to concerns about a loss of trust in the system: "The reason why we've been able to shave off length of stay is that we've built up trust in partnerships with our physician group as well. To say, "Listen, we've got it. I'll get a nurse and all this out" (HNHB 3).

The engagement of coordinators and other clinicians was itself secured by educating them about the program, providing a space where they could meet with each other, draw from pooled information resources, learn together and teach each other (Central 1, 2), sharing early data showing that their work was making a difference (HNHB 3), and actively seeking their input for problems such as low enrollment (HNHB 3). These clinicians were often amongst the programs' most stalwart champions; they located themselves at the heart of the program, often doing the "heavy-lifting" of securing both physician engagement and patient consent (HNHB 3).

While physicians working most closely with the program with frequent contact with program coordinators (those from the Department of Family Medicine, or family health teams) tended to be more invested in it, those more removed from the program, working in primary care, were more reluctant. Primary care physician engagement was therefore an uphill battle for all three programs. Family physicians played an important role as they had to follow up with the patient post-discharge, after having received a letter notifying them that their patient was on the program (Central 5). Their consent could be a pre-condition for patient enrollment in the program too, as noted above. As such, two programs had partnered with family health teams to facilitate primary care involvement, while the third worked with their LHIN's primary care lead to reach out to family physicians. Despite these efforts, primary care engagement lagged.

> … what we've really struggled with is getting the GPs interested. […] we sent them a letter. You know, Mrs. Jones is on the program, blah, blah, blah. And somebody said, "Don't make it too long. I won't read it anyways." [Regardless], we just send them the damn letter. What are you going to do? Because you know, we've gone to the guy who's in charge of the

> family health team on our steering committee, and he doesn't come to the meetings. Okay, fine. Oh, he says, "No, sorry." And you know, he says the meeting's not on his clinical time. And he says, "No thank you." (Central 6)

Primary care physicians were reluctant for reasons that ranged from a lack of familiarity with the program, a lack of comfort with titration (Central 5), worries that what was perceived as "hospital work" would be downloaded to them (South West 3), and concerns about occupying the most responsible physician role once patients were discharged in the context of patient familiarity and liability. They were also concerned about being contacted by video conference at their homes. These concerns were largely alleviated once early participants were reassured that program resources would mitigate burden: "That was always a perception on their part that they would be burdened with more responsibility and perhaps less reimbursement without really being consulted in the process" (South West 4).

In this context, programs developed a variety of strategies to encourage engagement that ranged from sending out newsletters about the program (Central 6), involving respected family physicians as champions (South West 4), involving clinical coordinators who could relay information to community clinicians with small patient caseloads rather than requiring their participation during lengthy virtual rounds (Central 4), and conducting rounds for the Department of Family Medicine, and even booking follow up appointments with family physicians on behalf of patients upon their discharge (Central 3, South West 4). One program found success in having the respirologist-coordinator personally contact the family doctor before discharge to inform them about the program, as well as to reassure them that a hospitalist would remain the MRP for the first 5 to 7 days after discharge, and that the video-conference that would take place a week later would not be too onerous (South West 4, 6). Tele-homecare was yet another tool used to foster primary care comfort with the model:

> …one of the things that we've done, and again we did this purposefully, is build tele-homecare into the care pathway more as a transitional tool. So once our patients are discharged from the IFM care pathway, some of them, the patient goes onto the tele-homecare program. And with the tele-homecare monitoring portion of the program, the primary care physicians are notified whenever there's a change in the patient's status. When the patients are in the IFM program however, we tend to bring them back to our heart function clinic for diuretic titration and longitudinal monitoring. Predominantly because in terms of the primary care physician, some are more comfortable at titration than others. (Central 5)

Stakeholders also drew on their experience with COPD programs when later implementing CHF initiatives to ensure family physicians were engaged early on, tapping hospital-based physicians to reach out to their community-based counterparts (South West 3). Family physician engagement also increased as awareness of the program spread by word of mouth, and physicians' comfort levels rose with experience of the program (South West 4) and better understanding one of its goals – "that the patient won't require as many primary care physician hours as they did prior to going on the program" (South West 6). The larger scale HNHB program worked with the LHIN's primary care lead on an engagement strategy that involved a process of presenting the program at each of the sub-region tables across the LHIN, addressing their concerns and redesigning the pathway as needed (HNHB 1).

Physician engagement – both in hospitals and the community – was also contingent on physicians being secure that the program would continue to be well-resourced, and that expansion would be thoughtfully implemented. Physicians also needed to feel that their work was valued, and that not just integrated care coordinators but physicians too were compensated for their contribution:

> [While this program is] an excellent use of resources […], I do think that at some point if they want this to continue, that the money will have to be provided and the experts will have to be rewarded. I mean there has to be some incentive for the physicians involved to maintain quality input rather than just being an altruistic thing, helping the healthcare system. […] I'm not sure our Ministry is all that sensitive to physicians' concerns in that regard. […] 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. (South West 4)

The assurance of sustainability was therefore a helpful pre-requisite for physician engagement, even as physician engagement itself help foster it by providing evidence of the effectiveness of these programs. Addressing this conundrum and winning primary care over would help fulfil the long-term vision of those who wanted to see community sites rather than hospital wards serve as the recruitment ground for programs, allowing the focus to move towards prevention and patient education (Central 2, HNHB 2 South West 2, 5).

3. Negotiating difference

The delivery of integrated care required the negotiation of differences across professions, organizations, systems, and sectors. Transcending cross-sectoral differences could be a challenge even in programs that boasted high levels of trust between team-members. As a Home and Community Care participant noted:

> I think the biggest issue […] would be the hospital's 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. And sometimes that doesn't always feel like it's reciprocated. (South West 6)

It also required providers to have the ability to nimbly learn different ways of practicing and collaborating, both across and within professions:

> …nursing was very used to being case managed in the community. So the work they did with any given patient was case managed through them, the CCAC. And as part of this pathway […] they then needed to be the regulated health professional, whom they are. And I don't think it was a big hurdle but it was to wrap my head around, if I'm the nurse visiting, that I am responsible, I don't defer to a care coordinator around the decisions on this. I've got a pathway, I've got work to do, it's my responsibility to use this team and accomplish the outcomes, right. […] And I think it was just a change in how a nurse functions in the community compared to […] what they do in other areas of their nursing delivery. (Central 2)

Many organizations also used different documentation systems, with information technology systems used in hospitals and the community often being incompatible. This required providers to learn new technologies to share patient care in some contexts, and make peace with using different systems, in others (Central 1, 2, 3). Even when clinical systems were compatible, organization-level ordering, delivery, invoicing, and finance services might not be, leading in one case, to the incorrect categorization of a single patient that resulted in a surprise rise in CHF pricing when a coordinator didn't "push the right button to show that Mrs. Jones was discharged" (Central 6).

These differences were perhaps amplified for the HNHB program, due to its scale. Stakeholders found that "each hospital has a distinct personality" (HNHB1), with some of its nine hospitals getting along better with each other, and others "hav(ing) to be pushed a bit more" due to organizational structure and perceptions about leadership commitment (HNHB 3, HNHB 1). With small hospitals in close-knit communities and their urban counterparts replete with specialist clinics feeling like "two different worlds" (HNHB 4), differences in hospital size and resources led to a small hospital opting out of the bundle (HNHB 3). Even human resources were implicated, as different perspectives on unions regulations came into play, resulting in different opinions about who could occupy which roles (HNHB 3). The hospital-based integrated care coordinator positions for instance were disputed by CCAC coordinators who were concerned that the new positions were taking work away from them (HNHB 2).

> … every single hospital site has a different set of rules and a different [set of forms]. [So you have to teach the coordinators] how to interpret 12 different discharge summaries and 12 different med reconciliations, and why does one hospital not even provide one, and why can't they get one. […] There's a lot of politics when you involve various different hospitals, and you're providing a program to them that they didn't develop. It's not necessarily well received. So a lot of challenges and roadblocks working with multiple hospital sites, […] 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. (HNHB 5)

The complexities of scale were particularly felt at the coordinator level where 15 coordinators spread across 9 hospitals, some being the only one at their sites, raised concerns about practice standardization and isolation (HNHB 1, HNHB 5). This was further compounded by the lack of formal coordinator orientation and oversight (HNHB 5). Sharing information across multiple hospitals unsurprisingly brought its own challenges. Not only did stakeholders have to contend with voluminous patient referrals to the community every day across the LHIN (HNHB 2), but they had to do so while negotiating different privacy regulations governing data sharing (HNHB 4), and ensuring that communication across providers occurred "without bombarding everybody with emails or communication they don't need to know about" (HNHB 5).

While one program found success with a program that allowed all relevant clinicians to access, monitor, and respond to patients in real time (South West 2), differences were largely bridged by fostering trust across professions, organizations, and sectors. This was done successfully when hospitals and community organizations were both involved in model development and decision-making (South West 1), each profession was allowed to voice what was important from their perspective (Central 2), champions at each partner organization helped resolve issues (Central 5), and when hospital and community-based clinicians learnt together (Central 3), developed an understanding of each other's practice (Central 5), and interacted closely through fora such as weekly interorganizational, multidisciplinary clinical rounds (Central 5). As noted above, trust was also fostered as coordinators and physicians built rapport with each other:

> I've had one of the respirologists kind of say at a meeting when he was talking about the program that he knows that if a navigator comes and talks to him about a patient, he knows that the simple things have kind of already been done. Kind of the easy checks and the little things, the simple solutions have already been kind of worked over, and there's a reason why that they're coming to you. (South West 5)

Recognizing that expanding the program across the LHIN had had an adverse impact on provider perceptions about the model, HNHB too purposefully brought people together for in-person meetings to regain a sense of lost intimacy and purpose (HNHB 2). Effective program managers and community of practice sessions, where program participants could work with directors they had never met before were also helpful (HNHB 3).

Stakeholders recognized that these programs represented innovative ways of working, given that they required people who did not know each other at first to work together to share accountability for the patient across sectors. Their success, stakeholders suggested, was due to the transcendence of egos, as well as professional and corporate identities (HNHB 1).

> The only common denominator that we have in healthcare right now is patients. […] This is a pie sharing exercise. There isn't more money. […] 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. (South West 2)

Looking ahead, stakeholders warned that spreading this model and working with Home and Community Care might raise further complications given that while hospitals may be able to identify patients using specific criteria, Home and Community care in different jurisdictions might have differing patient categorization systems (South West 3)

Despite these challenges, what set this model apart as stakeholders suggested, was visioning tables shared with partners, and the continued return to decision-making tables, armed with feedback from patients and front-line providers, asking "how can we improve" (Central 1, 3, 5); "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?" (Central 2)

Looking ahead

Stakeholders appreciated the low rules environment established by the MOHLTC that allowed them to develop programs sensitive to local contexts, allow for direct partnerships that bypassed Home and Community Care, and decide collaboratively on what measures were important to evaluate (Central 1). However, participants suggested that IFMs would be sustained long-term only when they were supported by systemic changes at the policy level. For instance, hospitals that were better funded for patients coming through emergency disincentivized the work of IFMs, suggested one participant (Central 2), while another spoke of the need for legislation around long-term care placement, given that it was a barrier to discharging patients on their intended pathways (Central 3). Changes also needed to be made to allow specialists to be paid for work done over the telephone (South West2). Furthermore, standardized templates for data collection and finance could be developed across programs to ensure that they were in fact "comparing apples to apples," and that more meaningful evaluation was pursued overall (Central 6):

> 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 fix 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. (Central 6)

Participants also wondered if case-management should be dislodged from its traditional place in the community and moved to acute care settings as needed on the one hand (Central 3), and if the community could take a lead in identifying patients for the program, on the other (South West 3).

> … if you've got CCACs which are providing these services, they might be able to provide a length to which patients are suitable for their programs without us getting too worried about specific disease sites. So I think that as this program matures, you know, you might not need to have those special nurse managers in place but you do have a CCAC resource which is able to come to the hospital and say, you know, "We looked at all your patients and gosh, you know, these five patients would qualify for the types of services we offer. […] They don't need to stay here any longer. […] Because really they're the ones providing the service, and most likely are going to know which patients are going to meet their criteria. I think we're a little bit backwards in sort about making sure [hospitals] are comfortable with doing it. (South West 3)

Addressing patient complexity

> Overall, while the integrated funding model was appreciated as a step in the right direction by countering transactional treatment-based healthcare with a focus on holistic patient care (Central 1), stakeholders across programs thought that more needed to be done for the model to meaningfully reimagine healthcare delivery to account for comorbidities and social complexity. "We need to package our patients as patients, not as diseases," they said (Central 3).
>
> …in an ideal world, we would not have focused on one specific disease entity. So 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 and is clear and consistent that the patient knows, the physicians know, and the staff know, and that sort of thing. [Without it, teams have to] do that manually. [Furthermore], we don't focus heavily on teaching patients way upstream about self-management. We don't have all the system supports. We don't have a prepared proactive team. On this model, we're getting there. But it's been a struggle. So we're not doing the chronic care model in the pure sense of the form. (South West 2)
>
> There's no real focus on the determinants. And so people come back to hospital because they weren't able to follow up on appointments because maybe they're not health literate, or they may not have food, and maybe they don't have transportation. And that's not being met with the current model. […] I find it sort of a bit funny that it's not more aligned to Health Links. […] So we will actually get Health Links, our Health Links team members involved because somebody needs to address it [but] not everybody is doing that Health Links philosophy of care? […] So the Ministry, the LHIN, we need to tie these things together and not be doing them separately. (HNHB 4)

Another stakeholder spoke of the benefits of community of practice sessions for patients. The classes in cardiac education and COPD acted as a support group for those who were lonely and isolated, she said, as she wondered if there was scope to offer this support in other fora:

> I think by 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. You know what I mean? Like breaking down all the silos across the system. (Central 3)

Sustainability strategy

There was an effort to reclaim the model from a perceived over-emphasis on its financial aspects. Decision-makers emphasized that “it’s not a cost savings strategy; it’s a sustainability strategy” (South West 2), and suggested that “hospitals should be doing this with their patients, and should be working with CCACs regardless of funding” (South West 3). They complained of a disjunct in how the model was conceptualized and where value was placed by the MOHLTC and themselves:

> …from what I’m hearing [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. […] Because right now there's too many people […] Why are we not going out and shifting resources into the community, providing care in a different way, and stopping the tsunami? Like let’s maintain what we’ve got right now in acute care, but really invest in the community. And this is an acute care person saying it so I’ll probably be hung. But I believe it. (South West 2)

> …what if there’s more volume than what you’re funded […]. We’re still going to give service to those patients. We’re not going to say sorry, you’re the 101st patient through, we only have funding for 100. That is not how we should work. And that’s what we want to avoid. But there is a little bit of that sort of view from Ministry, etc., that, “Oh, we funded you for 100. You’re probably only going to 100, unless you choose to do otherwise.” Really? (South West 3)

A majority also saw increasing the length of the bundle as a way of better wrapping care around the patient, leading to better long-term patient outcomes, with implications for systemic sustainability:

> … if we had tons of money and everybody invested, I would keep these patients on forever. 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, like say I’m a healthy individual but I have a bit of COPD, but every once in a while I’m going to get a cold and I’m going to panic because I can't breathe, or I’m going to do something else, or I don't know that I need to get my flu shot. 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. I just want to make sure you get your flu shot. Oh by the way, 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. (South West 2).

As this decision-maker noted, extending the model in this way would shift the conversation from the high users of the healthcare system to "the rising risk;" those who would metamorphose into these users if their healthcare was not managed differently (South West 2). A clinical navigator shared similar sentiments, suggesting that the role was underutilized:

> I think the navigator role is sometimes under-valued […]. We're not just kind of a sales person who's walking around trying to sell a program to patients. We're very involved with the patient care. And we should be seen as resources for that particular disease. […] those patients who come into the hospital who aren't appropriate for this program or they're not interested in this program, these are still patients that have to be accounted for. […] So 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. (South West 5)

As noted above, stakeholders across the three programs also wanted to embed this model "way upstream into primary care" (South West 2), so that primary care became a point of education, intake, and prevention.

Spreading IFMs

The MOHLTC's plans to spread the model to hip and knee by setting a rate for the entire episode of care was seen as a facilitator for these new programs, as they would not have to contend with intra-program funding negotiations with partners who might be unwilling or unable to contribute to the shared funding pot (HNHB2). At the same time, there was concern that these new programs were being thrown into the deep-end, beset by demanding deliverables and limited autonomy:

> … these poor folk… Right now I'm lending a hand for the hip and knee director until she gets her own project manager. Oh my God, it is being thrown at them. They are just swimming and trying to understand deliverables and cost and options and… You know, I think from a sustainability point of view, saying […] here are a couple of choices for CHF and COPD, here's your money, go ahead. I think that will help. (Central 6)

Participants spoke about the need for careful consideration of unique clinical conditions and local contexts when spreading these models across sites, or even to other clinical condition within the same program. Strategies to facilitate success might include intensive initial meetings to understand what it takes to roll out a program that was successful elsewhere, along with someone from the original program being on site to help navigate logistics (South West 3).

> 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. (South West 3)

Despite their concerns, participants' sense that these models were "worth doing" – albeit with a view towards holistic care and system-wide sustainability - was felt unanimously across the board.