INTEGRATED FUNDING MODELS CENTRAL EVALUATION

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CONTEXT

In 2015, the Ministry of Health and Long-Term Care (MOHLTC) issued a call for proposals to participate in an Integrated Funding Model (IFM) initiative. Six projects were selected to test innovative approaches to integrate care and funding over a patient's episode of care. The episode of care began in acute care and included a transition to community-based post-acute care. The goal of the IFM was to improve efficiency and value for money as well as patient, caregiver and provider experience.

OBJECTIVES

The objectives of the evaluation were to: identify success factors and potential barriers to implementation; measure patients' health outcomes; measure and report on healthcare resource utilization and costs as well as patient, caregiver and provider experience; and to inform policy and potential provincial spread.

METHODS

The central evaluation of 6 selected IFM programs used a mixed method design and consisted of four components: 1) implementation (qualitative interviews); 2) patient and caregiver experience (quantitative surveys and qualitative interviews); 3) ongoing monitoring and reporting of common indicators; and 4) comparative effectiveness analysis.

FINDINGS

Although of IFM programs focused on different types of patient populations and involved different groups of providers, there were common early success factors including partnerships and trust, leadership and clinical engagement, operational and implementation cohesiveness. Sharing clinical information, financial pressures and competing organizational priorities were common challenges. Patients generally reported positive experiences in hospital and home care with the biggest challenges during the transition from acute to home. Caregivers on the other hand were often neither informed about patient needs, nor asked about their willingness to help. Overall, across all patients enrolled in the IFM program compared to similar patients in non-IFM hospitals, the IFM pilot was associated with significant decreases in initial hospital length of stay, total hospital days, 30-day ED visits, 30-day readmissions, and average 30-day total costs. However only the two largest programs were independently significant and the programs with a focus on patients with COPD/CHF were unable to enrol even half of the target population. Interviews with program staff in the latter programs identified a range of changes that could improve implementation, effectiveness and the sustainability of the IFM model for chronic conditions such as COPD/CHF. They suggested a number of changes such as including a wider range of health and social resources, addressing physician compensation and other conflicting incentives. Patients with COPD/CHF who participated in the IFM programs appreciated improvements in their self-management skill and knowledge as well as the 24-hour telehealth number but also indicated that the program could be more patient-centred and responsive to individual needs.

CONCLUSIONS

Overall the IFM program was associated with positive patient outcomes and reduced health care cost. Much of the overall success of the IFM initiative is attributable to the two largest projects (MH-PPATH and HNHB ICC 2.0). If both initiatives were rolled out provincially with the same uptake and success, an estimated annual savings of $42.7M could be realized. The bundled approach to care was a valuable strategy to pursue. It appeared to be easier to implement the bundled care for short-term and generally more predictable surgical care pathways. We recommend expanding bundled care quickly to all surgical care and to further explore the improvements that are needed in order for the model to be successful for all patients who require ongoing care for chronic medical conditions.

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