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Hip and Knee Replacement Bundles: Qualitative Results

HSPRN briefing to Integrated Care Branch and Program Development Unit, MOH
July 23, 2019

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Overview

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   - Key changes resulting from bundle implementation
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   - What program stakeholders thought of the Hip/ Knee Replacement bundle
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The Sample

- 7 programs across 4 LHINs:

LHIN	Bundle Holders Included / Outpatient Rehab Arrangements	
Toronto Central	**Sunnybrook** Draws on roster of community physiotherapy clinics (CPCs)	**Michael Garron** MOU with single rehab provider
South East	**Quinte** Own outpatient clinic & informal working relationship with rehab provider	**Kingston** Own outpatient clinic & MOU with rehab provider
Hamilton Niagara Haldimand Brant	**HHS** Multiple CPCs; Request for Proposals (RFP) to formalize partnership with one in process	**Joseph Brant** Own out-patient clinic
North West	**Thunder Bay Health Sciences Centre** (hub/ bundle holder); **Lake of the Woods District Hospital** (1 of 3 spokes) Hub and Spoke model: Hospital-based outpatient clinics & rehab provider	

The Sample

- 47 interviews conducted
  - 11-12 with program stakeholders at each LHIN
  - Conducted between Feb – May 2019
- Interviews conducted with:
  - Stakeholders across hospital – rehab spectrum & LHINs including:
    - Leaders (E.g. Program Director, V.P Finance, LHIN Director)
    - Managers (E.g. Clinical/ Project manager)
    - Clinicians (E.g. Physiotherapists, surgeons)

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Program Structure:

Why programs were structured the way they were

The Programs: Diverse Structures

- Programs within LHINs shared little in common
  - Featured different rehab arrangements (E.g. hospital owned outpatient clinic; MOU with single rehab provider; informal partnerships with multiple CPCs)
  - Exception: NW LHIN's hub and spoke model
    - Program based on existing Regional Orthopedic Program
- LHINs' role largely administrative; involved as needed by programs:
  - Exception: TC LHIN
    - Program facilitated by LHIN's leadership role as bundle-holder for first year; role transitioned to hospitals

Toronto Central LHIN

- TC LHIN: Pre-qualified & rostered CPCs

… our [LHIN's] hospitals are literally like, "So do we need to have contracts with each other, and then with all these other providers? And how do you allow for patient choice if you're just choosing one provider and directing patients to one clinic?" So that was kind of the genesis of that EOI (Expression of Interest) concept. […] But we [told private clinics] at a minimum, these are the fees that our hospitals are willing to pay for this kind of service. […] we have all these ways that we work with our partner hospitals all together because there is recognition that **somebody has to call the table because the hospitals are too close to each other**. And if they started working independently, we would be doomed as a city. G7

TC LHIN: Sunnybrook

- **Sunnybrook**: Using LHIN's rostered clinic list; future planning for rehab partnerships in progress

… in Toronto Central LHIN, where we're surrounded by 5 other LHINs, and we've got patients coming from all over the place, […] 50% or more of our patients live 50 plus km away. […] Some of the partners are hospitals that have outpatient departments that have been reluctant in the past to accept patients that have not had their surgery at their institution. […] And so it's a challenge to have partnerships. […] It's just **basically a business relationship** with someone. You provide the service, here's how you bill us, is the bottom line. G6

TC LHIN: Michael Garron

- **Michael Garron**: Selected key rehab partner

… we have an existing relationship with [name] because they're another acute hospital, standalone. So we usually refer a lot of patients to them for rehab services, especially because our location is so **close to each other**. So it makes sense for us to refer to them as well, assuming most patients probably live in the same area. So I know [hospital leader] and the clinical team at [name] already have an **existing relationship**. So when this project came up, I think we created a working group for the two hospitals as well just to make sure the patient flow makes sense. H3

HNHB LHIN: HHS

- **HHS:** Going through RFP process to contract single rehab provider

…the clinics were still billing OHIP episodes of care versus billing the bundle holder […] they were not really anywhere near aware of what was happening compared to say the hospitals that were Involved. And it's because they're so diverse, right. There's so many clinics. And it's just not something that they're familiar with, right. […] We feel very hopeful that **once we have this RFP partner established**, once it's finalized, **we're going to be much more integrated** in all of our planning because we'll be able to work with one organization, right, compared to 25. And then the clinic [will be] very fluent with hip and knee bundled care. B1

HNHB LHIN: Joseph Brant

- **Joseph Brant**: Set up own outpatient clinic

Why didn't we just pick an outpatient clinic? The problem was that each of our surgeons had their own clinic, and they tended to refer to their own clinic. And there was an OHIP funded clinic but they would not have considered that route. So in order to have the surgeons join onboard, we had to **pick a route that was neutral**. Nobody is benefitting or profiting from our clinic other than our patients, really. Because $249 isn't a profitable amount. And so **the surgeons were all onboard** because of that. […] they all had private clinics, and they all wanted their patients to go back to their own clinics. But the amount that's allocated is not profitable. A5

SE LHIN: Quinte

- **Quinte**: Set up own outpatient clinic; informal working relationship with community rehab partner

… historically [outpatient clinic site] had been a service offering rehab. We brought all of our totals back for physiotherapy here. But that ended 7, 8 years ago. We had the facility available which made this an easier decision for the organization. Because we already run a rehab day hospital for other conditions. So the **physical space and equipment was there**. Easy access to the lobby. Not a lot of travelling through the hospital for patients. So ideal location. Really all we needed to do was hire additional staff to support the activity. D1

SE LHIN: Kingston

- **Kingston**: Has own outpatient clinic; selected key rehab partner

[Name] is our only rehab hospital in our area. […] They've always had an established outpatient program. So **they were a natural fit.** […] we were in a different place than a lot of others in the province. So others really relied heavily on homecare to deliver its rehab. But I would say 5 or 6 years ago, in our area we changed so that […] referring to homecare was the exception rather than the norm. [And] **we'd always had an outpatient rehab program**. And we really just referred to homecare based on the clinical need. C1

NW LHIN: Hub and Spoke

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- **Hub and Spoke Model**: Modelled on Regional Orthopedic program

So many, many years ago […] everyone wanted their own homegrown surgeon rather than a hub and spoke centralized program coming out to them. But we have wild recruitment and retention issues up here. […] it took us several years to say let us recruit to a central team in Thunder Bay and we will come out to you. Not only that […] you're decreasing your complication rates [because] it's the same team of surgeons that do hundreds of these procedures per year […] And then we developed a regional orthopedic program advisory committee. […] So it is very much those **same key players** that I invited to form the bundled care working group committee. […] **there's so much partnership here** that I'll tell you, we even all agreed to have the same legal firm review our service level agreements through the lens of both the bundle holder and the participant site. E1

What has changed?

Key changes resulting from bundle implementation

Moving away from homecare

Move from 1:1 in-home to group outpatient rehab due to:

a. Fiscal pressures of bundled funding & Rehab Care Alliance Guidelines:

…let's say you get $11,000 for a hip. They base the money on that 10% of your patients go to rehab, and like 70% of your patients go to outpatient rehab. […] So based on that we never would have aligned **with one-on-one visits** […], **we would never financially make it […].** [And] the **Rehab Care Alliance** had updated their best care models around the same time [which] were **supportive also of a group-based physio model**. So we had 2 factors that were kind of driving us to create this clinic which we did. A3

… with these RCA guidelines […] homecare doesn't necessarily follow that. And I think they know there's a gap there. C5

Moving away from Homecare

b. Lack of trust/ transparency with Home Care

I tried for 10 years to find out how much they pay homecare to do homecare therapy on a total knee or a total hip. For 10 years I tried to get that information. I could not get it. So that's obfuscation. And the reason was because **they didn't want to share it** because they knew that it cost too much. […] the LHIN does try but it's just ineffective. Whereas the homecare branch is just downright sneaky buggers. F3

❖ Home Care still used in remote geographies/ exceptional cases:

We had one gentleman who cared for an adult disabled daughter […] and he couldn't leave her. […] So there are exceptions. […] the staff came to me and said, "What do you recommend?" And I said, well, basically you want him to receive the education and the treatment but **if he's not able to attend, then we're blessed to have the homecare option** A4

Administrative Coordination

Increased administrative burden; coordination needed for:

a. Case costing & volume prediction

> … I can't even generate a list of how many unique clients we see here. It's a very convoluted, complex way to figure that out […by] looking at volumes, historical volumes in our programs, and being able to identify different populations. We don't track clients by diagnosis. […] And you've got to look at […] for example, **where have all the referrals in the city or region been going to for hip and knee** prior to this new initiative? And then how is this new initiative maybe going to create some **unintended consequences** that might affect my program directly? F6

Administrative Coordination

b. Tracking invoices

I got a call [from community clinic] saying, "Oh, I have a patient that's referred from you. He did this and that. We're going to bill you for this service." And then I would be like, hold on, first of all, **I need to validate that this patient is actually from us**, and that we actually referred him to this service provider, this clinic. And then also I need to make sure that this clinic is eligible to the bundle program because they would have to sign a MOU or some kind of an agreement with the LHIN. And then we have to validate the rate because I believe the LHIN has set up the rate schedule for different procedures, and whether it's inpatient, outpatient, homecare, and the different rates related to that. H3

Stakeholder Reception

What program stakeholders thought of the Hip/ Knee Replacement bundle

Bundle Reception

Mixed perceptions of benefits to patients & program participants:

- Patients
  - Despite reservations, many leaders, managers, and physiotherapists saw benefit to patients as model adhered to RCA guidelines
  - Physicians amongst most vociferous critics, feared fiscal motivation; some physiotherapists feared patient complexity was not acknowledged

… the patients bond over the fact that they've all received a similar surgical procedure, and they are inspired by one another because they see the progress that their counterparts have had. And so they feel optimistic that… the function will return. […] And so they certainly feel a **sense of community** with all these other folks who have also received total joint replacement. And then they share stories and they encourage each other, and they talk about, "Oh, who was your physician?" "Oh, my physician was this person." "Oh, who was your anesthesiologist?" "My anesthesiologist…" A1

Bundle Reception

- Administrators & Clinicians:
  - Widespread concern over administrative burden

… goodness, like my life, I had no idea that it's going to be the way it is. Like I just live and breathe medicine. Even today I've had existential thoughts about who am I, what am I doing, what's this all about, like this is crazy. […] Wake up at 5 in the morning – medicine, medicine, medicine […] a life misspent. You know, leaving your grandkids playing. "Baba, can't you stay, can't you stay?" Saturday afternoon, beautiful day, I've got to go home and latch myself to the computer. I've got stuff to do. Is it actually patient care? No, **it's not patient care. It's bureaucracy.** […] We tend not to [communicate with team about patients] …secure messaging is not a new concept. […] And we are nowhere close to having that kind of system. And the question is why not? […] You know, because we're too busy trying to figure out how we can decrease length of stay. A4

Bundle Reception

- Reception varied by organization/ program
  - Eg. CPCs least engaged, hub and spoke program (physician-led) most engaged

I think for the first time the Ministry has empowered us to get people to sit up and pay attention. And I've been able to bring about more change in my pathway in this short time than I have in the 10 years that I've been working with this group. Because **we're finally incenting in the right ways**. Saying the processes are yours to bear. Or look, if we drive patients through this way, we can reinvest this money back into our program. […] Like I mentioned, our pricing is higher. But in being able to justify our pricing in terms of frequency and intensity of care, you know, it was laid out there for us. So that was beautiful. E1 (Hub and Spoke)

Key Concerns

Logistical & conceptual concerns about the bundle

Lack of Preparation

- Hospital participants wanted more lead time, CPCs amongst least prepared

My office manager [of community clinic…] actually watched one of the webinars […]. And then she was like, "I have no idea what any of this stuff is." […] they were using a lot of jargon that we had never heard of before. Like Quorum and NACRS Lite. […] we were like **what the heck is going on?** So CIHI and all these acronyms that we had never been exposed to before […] I think the biggest area where we struggle, and I think most clinics would agree, is dealing with the stats, the NACRS Lite system. […] Like they were talking to us like we were hospital workers. And we aren't, and we didn't have that exposure to the system. B5

Administrative Burden

Administrative burden caused by….

a. Unreliable patient tracking information

… because we don't have partnerships, we don’t really have sharing agreements with information at these clinics. So the database is strictly kept within the hospital and not shared externally. So patients are given a form to keep track of their physiotherapy appointments. And then on the form, a phone number to call us back and to let us know this is where I went for therapy, and these are the dates. So it's a self-reported tracking tool. And there's **tons of gaps in the data.** Because as you can imagine, patients, they go home, they might forget. […] So essentially when an invoice is coming in from one of these physio clinics, we’re looking to say is the patient within our bundled care model? B3

Administrative Burden

b. … difficulty identifying qualifying patients due to privacy concerns

… they [bundle holder hospital] don't give us [rehab provider] a list of everyone that they referred to us […], they feel it's a **breach of confidentiality** for them to send a full list to us. So we have to tell them who we've seen. Which is not how we do it with [another bundle holder…] But [with this hospital], we're required to tell them who we saw, who we think we saw. So we try to include everybody because we don't want to not include someone that we would get paid for. […] That's the piece that's hard for us, is that communication piece. C2

Administrative Burden

c. … unanticipated cost of administrative coordination with no additional resources

You've got PROMs and PREMs, the financial cost of sending invoices, paying institutions, keeping that financial cost. Understand that **cost is big.** […] there are costs built into delivering care in the bundled funding model that I don't think were appreciated or were under-estimated in the discussions, and now are a living issue for the institutions and the patients. And I think are having a somewhat negative impact on patient care simply because the money's got to come from somewhere. G6

Bundle Clarity

Lack of clarity on…

a. Type and frequency of services included

… we actually had one particular patient that we questioned because they had 200 PSW (Personal Support Worker) visits in that 90 day period. And I'm pretty sure that wasn't really what the Ministry meant. […] So we asked the question – **is this included, not included?** And we got yes from somebody, no from somebody […] I mean that person had physio, OT (occupational therapy), social work, and PSW. How did they end up with all of those? […] in a 90 day span, that's more than one a day. […] So I think that was maybe a gap in understanding… B2

Bundle Clarity

b. … the meaning of "functional"

… Home and Community, the LHIN, basically they provide 5 or 6 treatments. And again, their mandate is that they be functional. And **what does functional mean?** A5

… we understand from the HNHB LHIN that they will never discharge a patient from service until they've attained their functional goals. So when a patient is discharged from homecare, sometimes then they will seek treatment in the community after the fact. But from our perspective, you wouldn't be released from homecare unless you had achieved your functional goals. So it kind of creates this sort of dilemma in that we **don't really know what our obligation to the community clinics is.** A2

Tailoring Bundle

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Bundle needs to be tailored; doesn't account for local contexts & patient types

a. Geography and patient complexity challenges ability to work with pre-set pricing

… in the north, **we're not like the GTA**. […] Our BMI issues up here are significant – body mass index. Our patients are sicker. So the number of comorbidities that they have. In the north, people are less healthy. So we do operate on more complex patients. And I think our opportunities for pushing people through the pathway safely and quickly is overall less than what it is in southern Ontario. And then we don't have the opportunities for grouping. I know in [city], they're bringing 10 people in at a time for a knee class. Like we can't do that. And then we have our care providers having to drive those long distances to access people that live more than 75 km from a main hub. And so all of that had to be built into our pricing. So we asked for leniency. E1

Tailoring Bundle

b. Large, already efficient hospitals have little means of increasing efficiency

… you're almost one of the most efficient places, and you're asked now to be even more efficient, **I don't have any low hanging fruit.** […] our hospital actually didn't want to participate. [But] we have to be able to look at the challenges associated with large academic institutions, and how the bundle may be adversely affecting them. And whether it's even just surgeon morale. I mean you can't have a place where the surgeons, you know, we're doing our best trying to get as many cases done in a day. We've got surgeons doing 5 joint replacements in an OR day where we used to only do 4. We've closed beds. […] And then you turn around to the surgeons and you say you're still costing too much money. Like eventually the surgeons go like, "#%@$ you! Like I'm tired of this. Like get off my back!" G6

Sharing Rehabilitation Resources

- Mechanism needed to share rehab funding as required by patient

… there's times when a client might not be able to attend outpatients for the first few weeks for whatever reason. Maybe it's the geography of where the surgery was done, maybe it's where the client lives and then they're relocating, who knows. Or maybe they had complications upfront. But by 3 or 4 weeks, […] they could go out for it. […] and [hospitals] don't know how to do that. Everybody agrees that […] it's appropriate. And even in the RCA guidelines, it says transition to outpatients as soon as it's clinically appropriate. […] But the **bundled funding doesn't [know how to] share the resources across two sectors** for the same patient. D5

Rehabilitation Pricing

Rehab pricing…

a. … is inadequate/ unlucrative for some CPCs

… before when we [CPC] were getting an episode of care, we would get paid about $300 for each patient we would see. But they've already had 6 weeks of physio at that point. Now we're seeing them like acutely post-op […] but we're expected to see them for the whole period of time for exactly the same amount of funding as we had before when we would only see them from 6 weeks onward. […] I feel like the bundled care holders for the most part have taken that extra rehab **money** and reallocated it somewhere within the hospital. It certainly **hasn't come to rehab**. […] We would not be taking bundled care if it weren't for the fact that we are strong leaders in our community and really feel that we want to support people here. […] B5

Rehabilitation Pricing

b. … pricing structure needs to be reconceptualized

… when I was first approached about the actual dollar amount, I think it was like $249 for the knee and $299 for a hip […], I was kind of shocked by the actual dollar amounts. In order to provide best practice, the frequency required, $249 isn't enough to pay for a physio in a clinic and whatnot. […] And a knee I think needs more physio frequency than a hip. And so they should have been **reversed in terms of the dollar amounts**. The one that needed more, the knee was less than what the hip was. […] But that was my biggest concern, was whoever was setting that up wasn't resourcing it right. D5

Fiscally Motivated

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a. Fear that model is driven by cost-savings….

I see bundled care as being more of a financial model than a medical model. Its genesis is from the concept of how do we contain care costs? So we create a bundle, and we attach hooks and barbs to that bundle. And I think unfortunately it has unintended consequences. My perception is that we risk, if you will, **widgetizing patient care**. A4

b. … and therefore may lead to cherry-picking

There are a lot of surgeons who would never do a knee replacement on an obese person or a 90 year old. […] the problem with the obese patients is that they have a much higher chance of the wound opening. […] So those people are all high risk and labour intensive. To get someone up who has a body mass index of 48, you know, when they're struggling […]. And now when you look at the bundle, **who's going to take those people?** A5

Masked Costs

- Transferred/ masked costs not included in evaluation, giving programs appearance of success

Three weeks ago they were saying suture removal was going to be done either by nurses at homecare or by nurses in ambulatory day or possibly by the physios in the physio clinic. And there was a certain fund attached to the suture removal visit. Yesterday they rolled out a new thing and said, okay, suture removal is going to happen by the physician. People have to go to their physician to get their sutures out, and that way we'll save money on the bundle because the physician will bill the Ministry and it won't come out of the bundled care. And that will save the bundled care money. So **someone's still paying,** and is actually now paying a physician $120 to take those sutures out that physio would do for free. F3

Accountability

- Inability to reference quality-based outcomes (E.g. PROMs) when awarding contracts

There isn't sufficient focused capacity on really cracking the nut around quality outcomes. And then putting, for the contract piece, putting the right mechanisms in place to penalize for poor quality outcomes. […] We're not doing a lot of like, oh, poor outcomes, we're not going to fund you anymore. […] I know from talking to the surgeons, they're like, yeah, you know, if I send my patient to this place, and then they don't recover as well as I expect them to, then I just don't send anyone there afterwards. But there isn't like the closing the loop of that. […] there is **no means to manage quality that way**. G7

Minimal Integration

- Little clinical & sectoral integration; focus is on administrative coordination

… **we communicate** I'd say more **through our patient** than directly as a team between myself [physiotherapist] and the surgeons. A6

… hospitals have to be very fiscally astute as to how to manage [lean bundled payments]. So some hospitals […] have decided that not only are they going to do this outpatient clinic […], they've become their own homecare service. So from the bundle, they're saying, okay, well, **we're going to just give it to us.** A5

Stakeholder Recommendations

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- Address administrative burden of bundle
- Provide more preparation time for programs; engage CPCs sooner
- Provide guidance on bundle scope & service provisions
- Revisit rehab pricing
- Account for different patient types, needs & geographies
- Acknowledge transferred/ masked costs & hidden patient outcomes in evaluation
- Encourage incorporation of quality-based assessments (E.g. PROMs) when allocating volume/ awarding contracts

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