Health System Funding Reform – New Directions

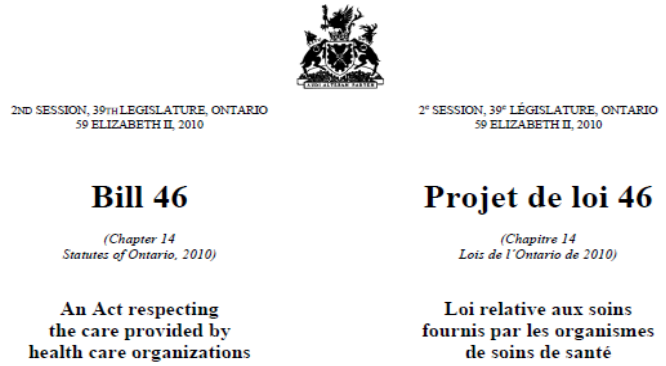
Melissa Farrell, Assistant Deputy Minister, Health System Quality and Funding Division, MOHLTC
Fredrika Scarth, Director, HQO Liaison and Program Development Branch, MOHLTC

Health Achieve
November 7, 2017

Ontario
Ministry of
HEALTH AND
LONG-TERM CARE

Laying the foundation for quality

1. ***The Excellent Care for All Act (ECFAA),*** 2010 sets out principles and levers to embed a culture of quality and accountability in the delivery of patient-centred health care services.



2ND SESSION, 39TH LEGISLATURE, ONTARIO
59 ELIZABETH II, 2010

Bill 46

(Chapter 14
Statutes of Ontario, 2010)

An Act respecting the care provided by health care organizations

2e SESSION, 39e LÉGISLATURE, ONTARIO
59 ELIZABETH II, 2010

Projet de loi 46

(Chapitre 14
Lois de l'Ontario de 2010)

Loi relative aux soins fournis par les organismes de soins de santé

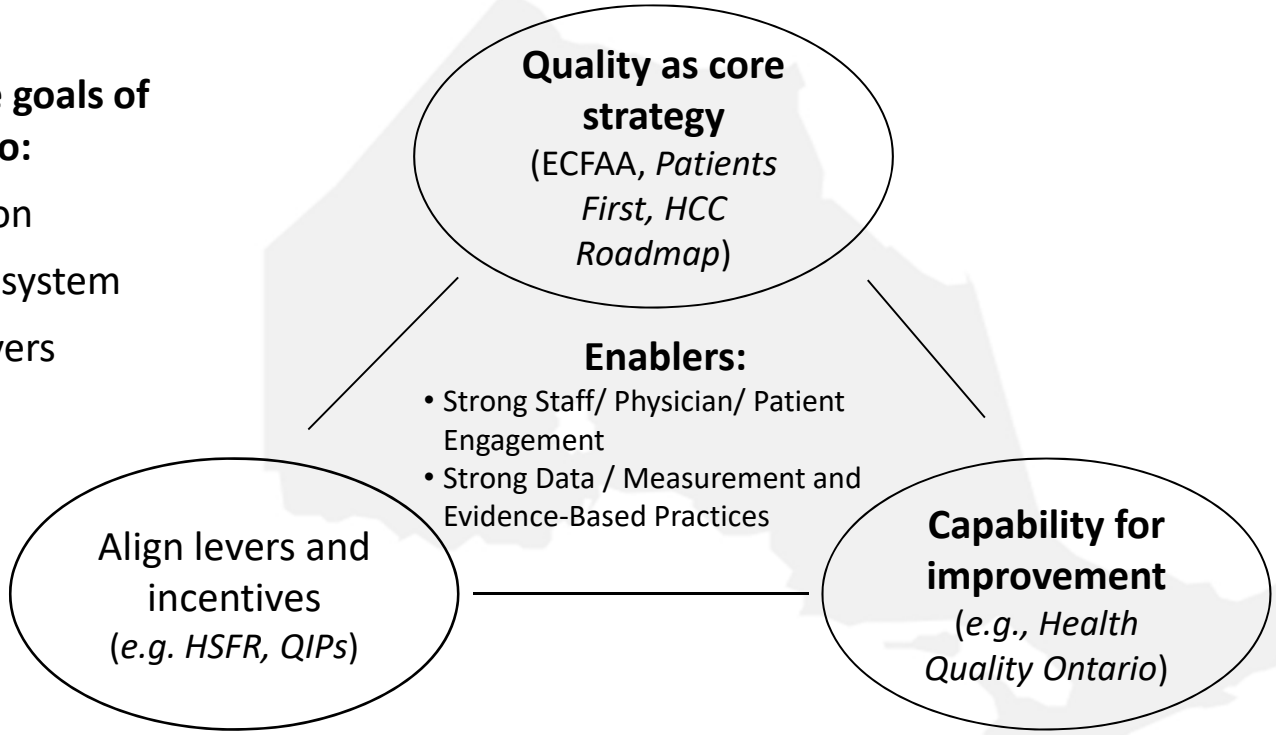
2. ***Patients First: Action Plan for Health Care*** exemplifies the commitment to put people and patients at the centre of the system by putting patients' needs first.

Access	Connect	Inform	Protect
Improve access - providing faster access to the right care	Connect services – delivering better coordinated and integrated care in the community, closer to home	Support people and patients – providing the education, information and transparency they need to make the right decisions about their health	Protect our universal public health care system – making decisions based on value and quality, to sustain the system for generations to come

Patients First is supported through a strong quality foundation

To meet and achieve the goals of *Patients First*, we need to:

1. Provide clear direction
2. Build capacity in the system
3. Strategically align levers



Health System Funding Reform: Goals and objectives

HSFR goals and objectives

- Reflects the needs of the community
- Equitable allocation of healthcare dollars
- Better quality care and improved outcomes
- Moderate spending growth to sustainable levels
- Adopt/learn from approaches used in other jurisdictions
- Phased in over time at a managed pace

HSFR's goals and objectives are translated into HBAM and QBP components

Health Based Allocation Model (HBAM)

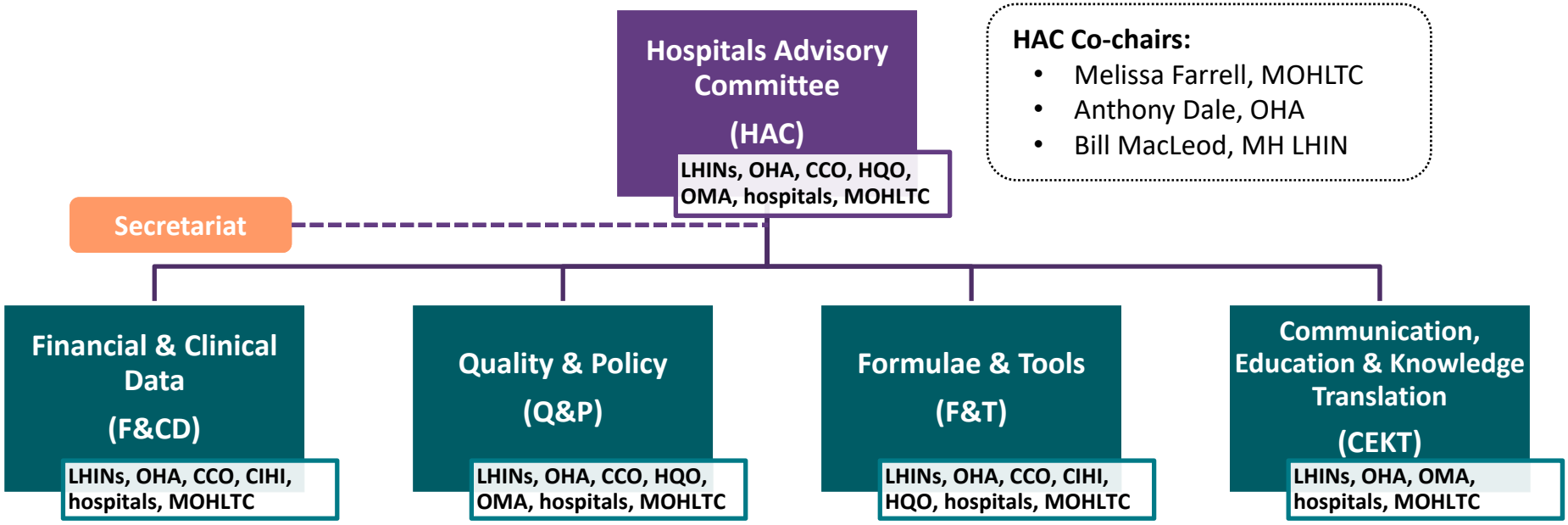
- Evidence and health-based funding formula
- Enables government to equitably allocate available funding for local health services
- Estimates future expense based on past service levels and efficiency, as well as population and health information e.g., age, gender, population growth rates, diagnosis and procedures

Quality-Based Procedures (QBPs)

- Clusters of patients with clinically related diagnoses / treatments and functional needs identified by an evidence-based framework as providing opportunity for:
  - Aligning incentives to facilitate adoption of best clinical evidence-informed practices
  - Appropriately reducing variation in costs and practice across the province while improving outcomes

HSFR governance

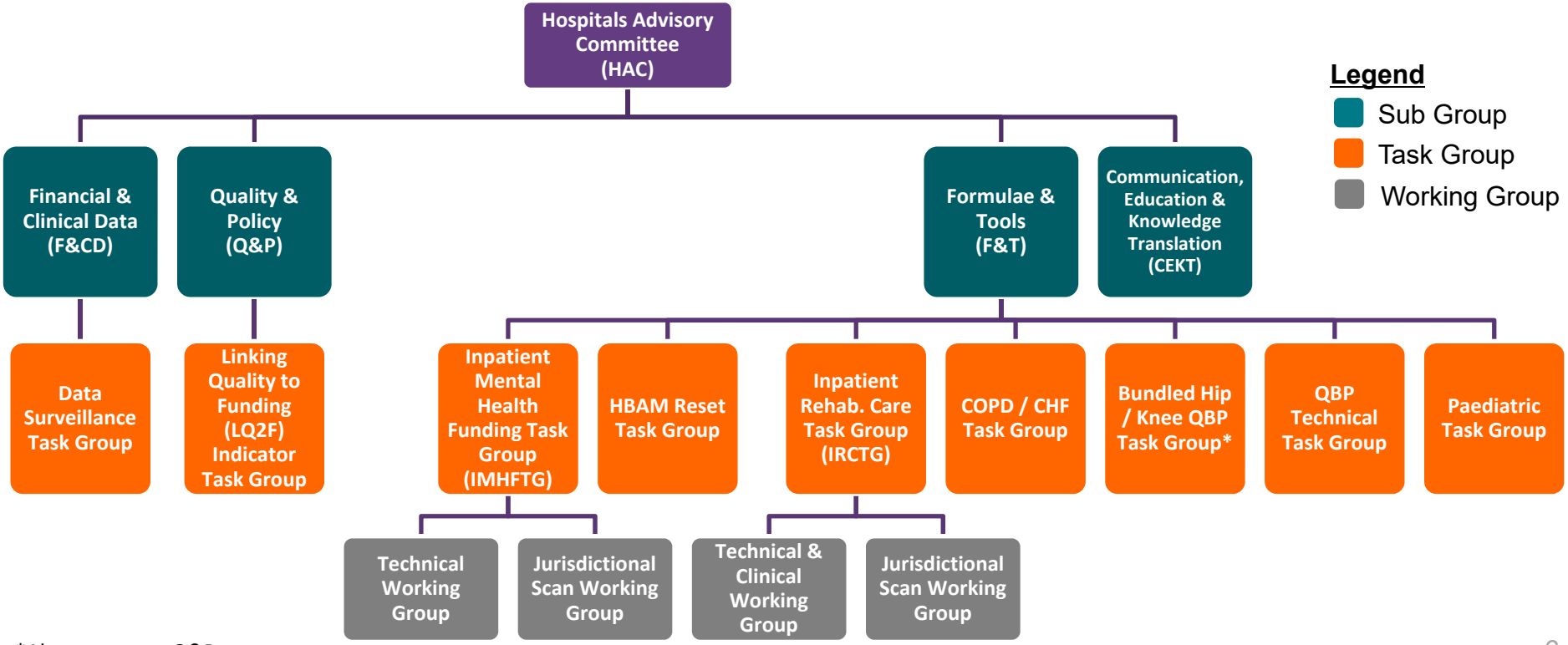
- In 2015/16, the HSFR governance structure was revised, in collaboration with the Local Health Integration Networks (LHINs) and the Ontario Hospital Association (OHA), to improve the effectiveness and transparency of the decision-making process.
- The Hospitals Advisory Committee (HAC) adopts a tri-partite governance approach, and is co-chaired by the Assistant Deputy Minister, Health System Quality and Funding, MOHLTC, the CEO of the Mississauga Halton LHIN, and the CEO of the OHA.
- In 2017/18, a Financial & Clinical Data Sub Group was added to focus on the quality and availability of clinical and financial data, and to support new and existing funding models.



HAC success: collaboration and consultation

There are over 100 members of HAC, its Sub Groups, and task and working groups representing:

- MOHLTC
- OHA
- LHINs
- Cancer Care Ontario (CCO)
- Health Quality Ontario (HQO)
- Hospitals
- Physicians
- CorHealth
- Institute for Clinical and Evaluative Sciences (ICES)
- Rehabilitative Care Alliance
- Western University
- University of Toronto
- Ontario Telemedicine Network
- Canadian Institute for Health Information (CIHI)



*Also reports to Q&P

Letter to HAC from the Minister of Health and Long-Term Care

April 28, 2017

Ministry of Health and Long-Term Care
Office of the Minister
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto ON M7A 2C4
Tel 416-327-4300
Fax 416-326-1571
www.ontario.ca/health

Ministère de la Santé et des Soins de longue durée
Bureau du ministre
Édifice Hepburn, 10e étage
80, rue Grosvenor
Toronto ON M7A 2C4
Tél 416-327-4300
Téléc 416-326-1571
www.ontario.ca/sante

Ontario

2017-00397

APR 2 8 2017

To the HSFR Hospitals Advisory Committee:

I would like to take this opportunity to acknowledge the excellent work of the Health System Funding Reform (HSFR) governance structure and the effectiveness of the collaboration between the ministry team and our partners.

Over the past year, the hard work of the many sector leaders involved in HSFR governance resulted in a number of achievements, including: significantly moving up the timing of allocations and Health Based Allocation Model (HBAM) results, more open and transparent communications with the Local Health Integration Network (LHIN) and hospital sectors, a better understanding of the volatility in the annual funding allocations, and the development of approaches to ensure greater predictability and stability in hospital funding for the coming year.

Insights from the Hospitals Advisory Committee (HAC) and its Sub-Groups were integral to the successful investment of an additional $140 million in new funding in 2016-17 to address access and operational capacity challenges facing hospitals across our province.

As my ministry focuses on improving the quality of health care to the residents of Ontario, some hospitals continue to experience operational challenges as we transform our health care system and put patients first.

Significant progress has been made in ensuring funding follows the patient while improving cost effectiveness and reducing patient risks. However, we have heard from our hospital and LHIN partners that there are areas that continue to require attention to ensure that hospital funding is appropriate and sustainable.

HSFR Hospital Advisory Committee

In preparation for the 2018-19 hospital funding allocations, I request that attention be given to the following priority sites:

- hospitals that provide specialized health care services to patients (e.g., complex continuing care and rehabilitation, speciality paediatric, mental health services, and specialty psychiatric hospitals);
- medium-sized hospitals, with recommendations to address concerns flagged in fiscal 2016/17 by August 2017; and
- hospitals in communities experiencing high-growth demand for health care services.

I also encourage you to continue improving existing formulas that support innovation while exploring new funding models, especially those that drive care integration (including the continued expansion and testing of bundled care models and Rural Health Hubs) and more directly link quality to funding. Finally, I ask that you focus attention on the evolving role of HSFR to support the *Patients First* agenda.

Your continued collaboration to identify and support solutions to ensure funding is equitably allocated while driving greater integration of care will improve patient experiences across the province. I look forward to hearing about your plans and progress.

Yours sincerely,

Dr. Eric Hoskins
Minister

c: Dr. Robert Bell, Deputy Minister, Ministry of Health and Long-Term Care
Ms. Melissa Farrell, Assistant Deputy Minister, Health System Quality and Funding Division

HAC Recommendations to the Minister in 2017/18

HAC recommendations so far this year

- ☑ Health-Based Allocation Model (HBAM) methodology and allocations for:
  - Medium and small chronic / rehabilitation hospitals
  - Inpatient rehabilitation
  - Growth
  - Inpatient mental health
  - HBAM Reset
  - Specialty paediatric hospitals
  - CMI adjustment to Quality-Based Procedures (QBPs)
- ☑ New Quality-Based Procedures for 2018/19 and 2019/20
- ☑ Bundled Care models for:
  - Hip / Knee QBP
  - Chronic Kidney Disease QBP
  - Complex, Chronic QBPs (COPD / CHF) - pilot

Upcoming HAC recommendations

- ❑ HSFR Evolution
- ❑ Linking Quality to Funding pilot
- ❑ Data Surveillance Plan
- ❑ Guiding Principles for 2018/19 Hospital Investments
- ❑ Small and rural hospitals funding approach

New QBPs

CCO's cancer surgery QBPs and 7 new QBPs will be phased into the QBP funding stream over the next two years.

FY 2018/19 – Year 1	FY 2019/20 – Year 2
Non-emergent Integrated Spine Care	**Non-Cancer Hysterectomy**
Degenerative Disorders of the Shoulder	Cancer Surgery: • Ophthalmic • Head and Neck • Endocrine • Abdominal (Stomach, Abdominal Other) • Gynaecology Excluding Hysterectomy • Sarcoma (Bone, Soft Tissue) • Skin – Soft Tissue • Non-Site Specific
Integrated Corneal Transplant	
Cancer Surgery: • Neurosurgical (Brain, Spinal) • Thorax (Lung, Esophagus, Thorax-other) • Abdominal (HPB-Liver, HPB-Pancreas) • Genitourinary (GU) • **Hysterectomy**	
	Low Risk Delivery*
	Coronary Artery Disease (CAD)*
	Aortic Valve Disease (AVD)*

*Inclusion for 19/20 dependent on resolution of data issues for carve-out purposes. Additional work required to determine most appropriate usage for data and resolve linkages between registry and administrative data sets.

Handbooks **bolded** are those that were recommended for potential funding following the 16/17 QBP review (one handbook in place for cancer and non-cancer hysterectomy)

Moving forward: HSFR Evolution

Health System Funding Reform Goals

1. Reflect the needs of the community
2. Equitable allocation of healthcare dollars
3. Better quality care and improved outcomes
4. Moderate spending growth to sustainable levels
5. Adopt / learn from approaches used in other jurisdictions
6. Phased in over time at a managed pace

Current State Review + **Jurisdictional Scan**

Five years into the journey…

- How far have we have progressed against established HSFR goals?

Since the introduction of HSFR…

- What funding efforts have been introduced in other jurisdictions?

Gap Analysis → **Themes**

Based on…

1. HSFR goals
2. Current state assessment
3. An appreciation of funding efforts in other jurisdictions

Identify opportunities to refine current funding approaches and identify new funding mechanisms

Findings to be validated during Regional Sessions

HSFR Evolution – topics for regional sessions

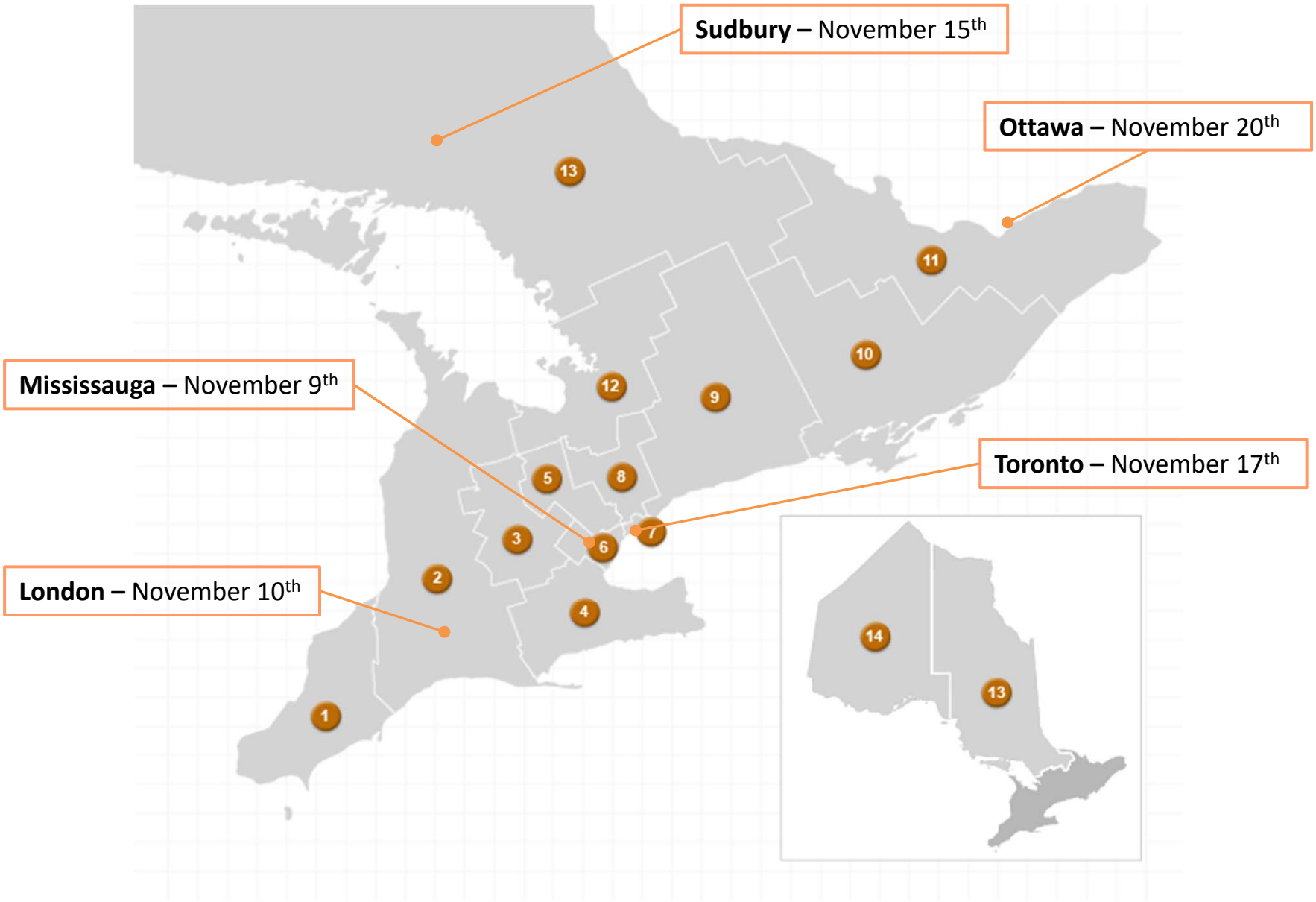
Areas of focus over the next 2-3 years to advance a longer-term vision

Current State: Efforts have focused heavily on formulaic adjustments aimed at ensuring equitable allocation of health care dollars for providers and improving stability.

Future State: Increased emphasis on improving quality and outcomes, integration of care and enabling care that reflects the needs of local communities.

1. **Ensure clinical and program infrastructure supports for QBPs**
   - Identify clear accountability for clinical oversight
   - Tap into existing or develop new clinical networks and regional clinical leads (e.g., LHIN VP Clinical)
   - Provide timely and meaningful performance information to organizations and clinicians
2. **Scale and spread bundled care**
   - Finalize a five-year plan to take IFM pilots and move to provincial level
3. **Develop / align incentives supporting appropriate care in right settings**
   - Disseminate clinical recommendations regarding decision to treat
   - Implement deliberate funding conditions that address appropriateness
   - Enhance access to benchmarking data regarding utilization rates (e.g., hysterectomy)
4. **HSFR model enhancements – HBAM & QBPs**
   - Mitigate HBAM allocation issues (BFE) while developing a permanent solution
   - Enhance QBP pricing and volume strategies
5. **Targeted interventions to improve equity**
   - Partner with HQO and others to leverage existing equity work
   - Recognizing formulaic methods are not well suited to impact equity, establish special purpose funding targeting limited populations with known inequities

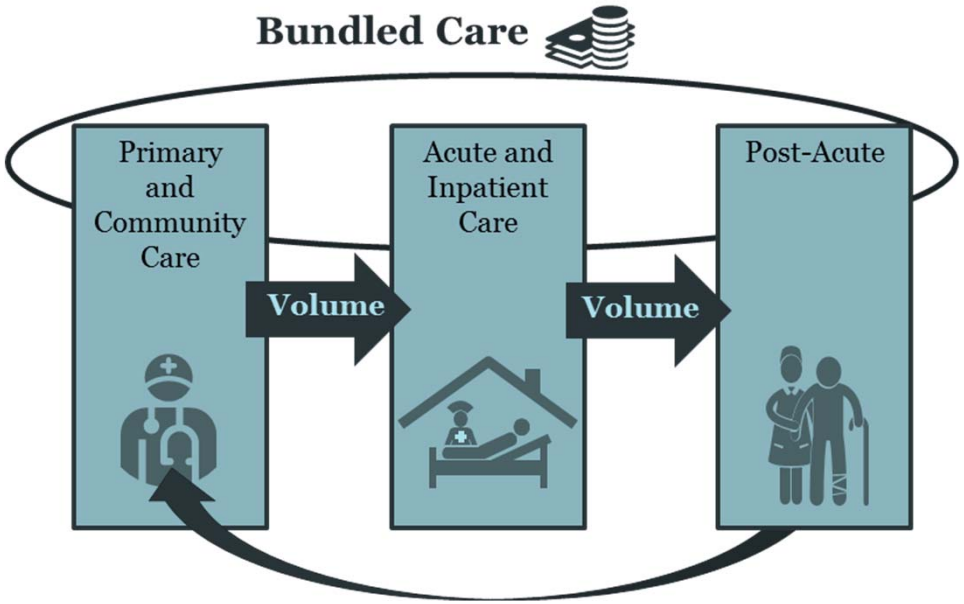
HSFR Evolution – regional sessions



Bundled models build the foundation for collaboration and improved quality

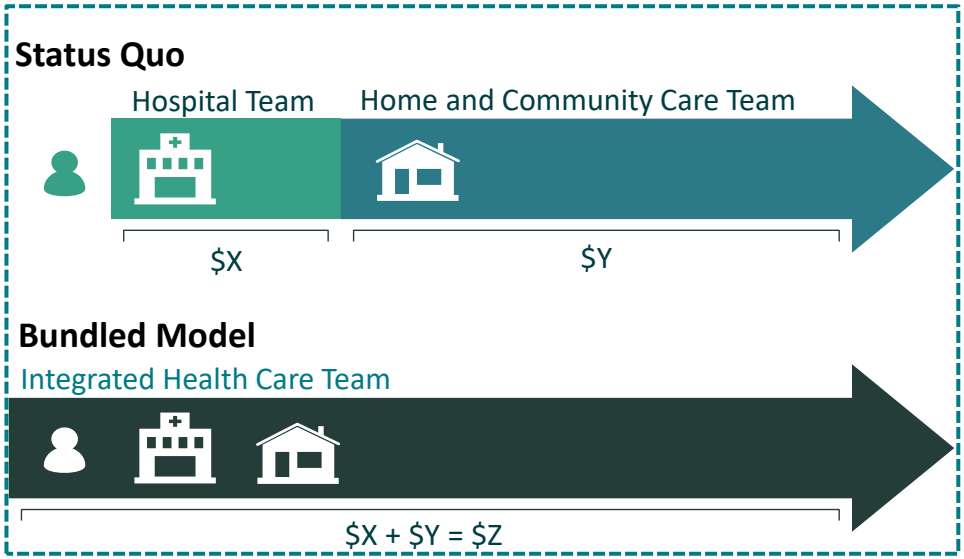
- Bundled models provide a single payment for an episode of care across multiple settings and providers.[1]

- With bundled care:
  - Care is integrated to create seamless transitions and ease a patient's move from hospital to home
  - Providers share risks and gains, incenting collaboration and integration
  - Providers are accountable for quality outcomes (value-based care)



1. Sutherland, J & Repin, N. (2014). Episode of care payments policy brief (Policy brief 2014:1).

Six partnerships are implementing bundled care models to inform policy and broader spread



The Bundled Care pilots have shown early signs of improved outcomes*:

- As of Spring 2017, All sites report reduced readmission rates; 2 sites report reductions of more than 30%

Integrated funding models are underway in six sites:

South West LHIN (London Health Sciences Centre, SW CCAC) – "Connecting Care at Home" - *COPD and CHF Patients*

HNHB LHIN (LHIN-wide, led by St. Joseph's Health System) – "Integrated Comprehensive Care 2.0" - *COPD and CHF patients*

Central West LHIN (William Osler, CW CCAC) – "Hospital 2 Home" - *Nursing-sensitive conditions (Cellulitis and Urinary Tract Infections (UTI)*

Mississauga Halton LHIN (Trillium Health Partners) – "Putting Patients at the Heart" - *Cardiac Surgery*

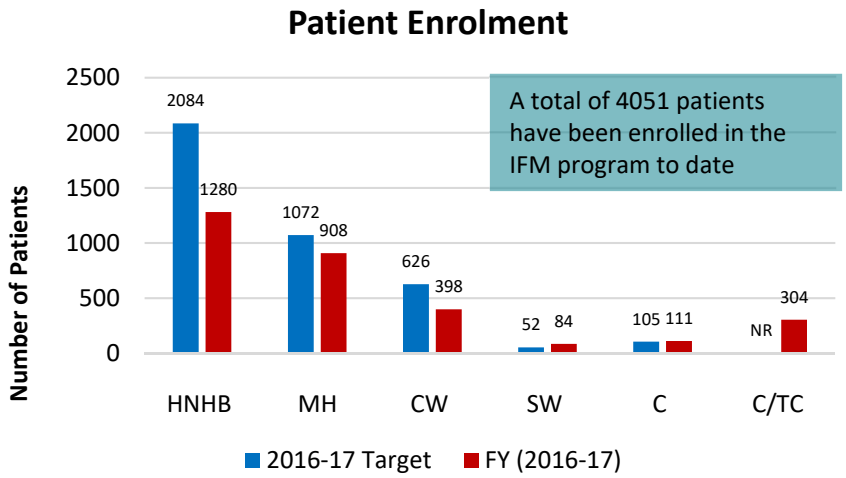
Toronto Central and Central LHINs (Sunnybrook and CCAC) – " One Client, One Team" - *Stroke patients*

Central LHIN (North York General Hospital) – "Integrating Specialized and Primary Care - *COPD and CHF Patients*

**Preliminary, self-reported data, not to be used in publication*

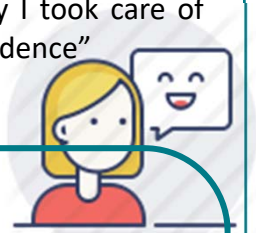
Patients and providers feel a real difference

An increasing number of patients are experiencing bundled care…



On a patient's overall experience…

- "All I can say is from the time I entered the medical system, all the care and attention I received was awesome. Thanking all of you."
- "Everything was good. [I] was very happy with the services received. The health care team was amazing and very helpful."
- "[I] really liked it, have no complaints. [I] have numbers to be able to reach them at any time because they're always on call. The program is great for [me] personally. It should be extended to everyone."
- "Thought it was excellent and changed the way I took care of myself. Gave myself and my wife a lot more confidence"



"I never though that we would find a program that would actually increase patient satisfaction and at the same time save significantly on resources and actually decrease the cost of a patient stay. Physicians have to be fully engaged in order to reap the benefits of an integrated funding model"
- **Cardiac Surgeon**

"The program helps ease them into their home. The patient population is known for high anxiety so anything that helps ease their anxiety will make their breathing easier. Even if there is a benefit for 20% of this population, I would say it's worth it"
- **Respirology RN**

Feedback from the field

Once back in the Community;

- **93%** of patients felt the IFM program helped them feel more confident about their health.
- **88%** of patients reported having a positive care experience at home.

On the experience with transition from hospitalization;

- **93%** of patients felt their preferences (and those of their family caregivers) were taken into account when deciding what their health care needs would be when they left.

Short-term plan to spread bundled care

Reflecting on the learnings from the bundled care pilot sites and advice received from key thought leaders, the ministry committed to a voluntary expansion of bundled care in 2017/18 and 2018/19, along two streams:

Scale Standardized Bundles

- Bundled Hip & Knee Replacement QBP
- Assisted Peritoneal Dialysis (Chronic Kidney Disease QBP)

- Each LHIN will be offered the option to identify cross-provider teams to participate in a voluntary expansion of the bundled care program for the hip and knee replacement QBP and the bundled QBP price for these teams will be introduced in FY18/19.
- The Ontario Renal Network (ORN) has led the selection and launch of six teams trial an integrated payment model for assisted peritoneal dialysis as part of the chronic kidney disease QBP.

Pilot Complex, Chronic Bundles

- Bundled Chronic Obstructive Pulmonary Disease (COPD) QBP
- Bundled Congestive Heart Failure (CHF) QBP

- The ministry is working to develop a bundled model that supports care across the entire patient journey and prevents unnecessary hospital admissions. The next iteration of complex, chronic bundles will be considered an 'innovation' phase to test a new bundle design.

Plan for spread and scale: Starting with the implementation of the bundled hip and knee replacement QBP

Why hip and knee replacement?

- The ministry is initiating the scale and spread of bundled care with hip and knee replacement surgery because it is a clearly defined episode of care, with accepted best practices and a jurisdictional precedent for bundling.

What is being offered?

- The bundled hip and knee replacement QBP is an extension of the existing surgical QBP into a bundled model. This bundle will bridge a patient's episode of care from the acute phase to post-acute phase.

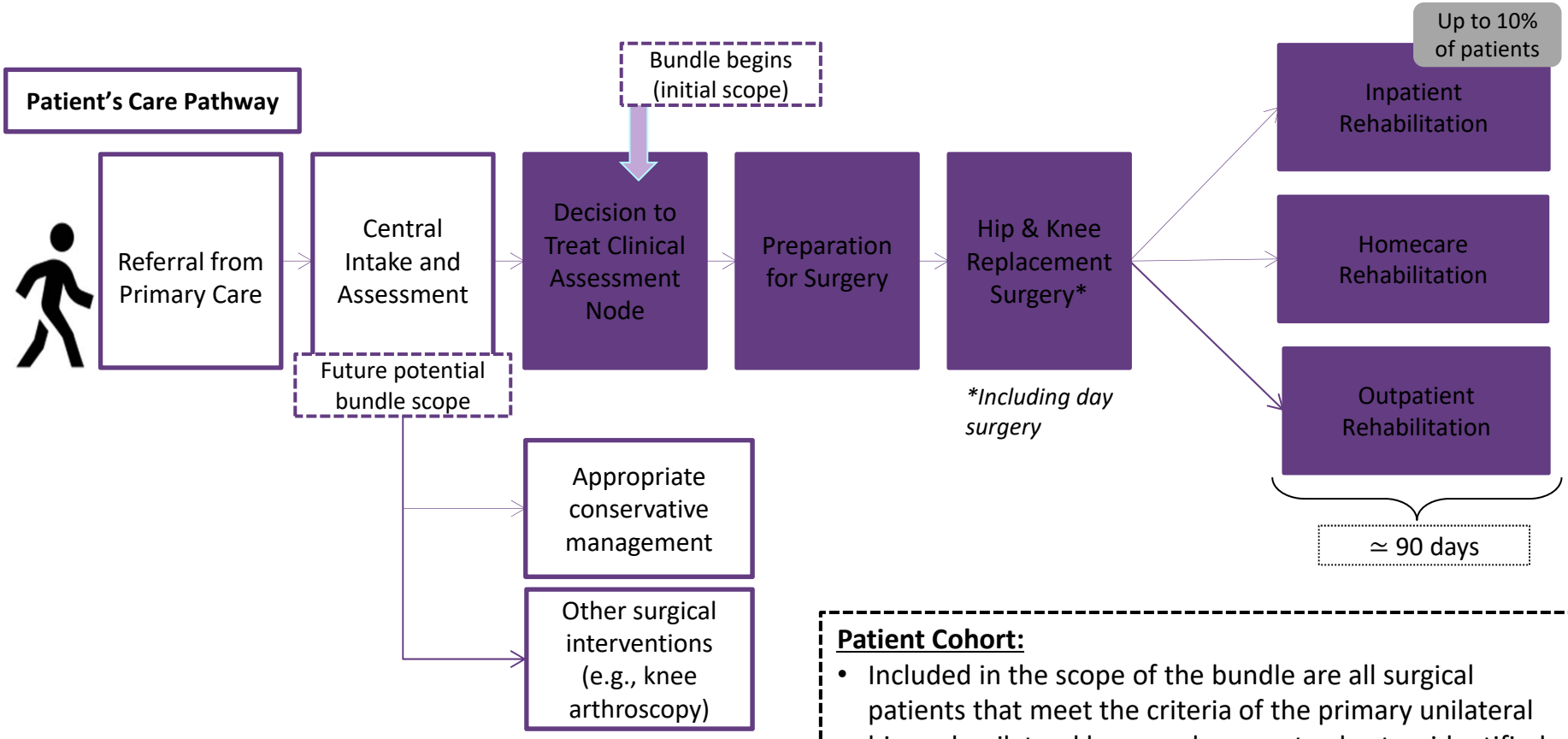
- Each LHIN is being offered the opportunity to identify cross-provider teams to participate in a voluntary year of bundled care for hip and knee replacement surgery**.**

- Teams will begin working together in November 2017 and the bundled price will be introduced on April 1, 2018, for the full FY18/19 fiscal year.

- The hip and knee replacement QBP bundle has a standardized patient cohort, price and outcome measures. Standardizing these elements only allows for local flexibility in service delivery and provider mix. All teams will collect standardized PROMs.

Hip & knee replacement bundle pathway

- Teams will work with a *standard cohort, price and outcome measures*
- Service delivery models are flexible to allow for *local innovation*



Patient Cohort:

- Included in the scope of the bundle are all surgical patients that meet the criteria of the primary unilateral hip and unilateral knee replacement cohort as identified in the QBP clinical handbook.
- Over time the bundle may evolve to include non-surgical options (informed by HQO's osteoarthritis quality standard, implementation of MSK intake, assessment and management models, etc.)

Bundled payment applies | **Outside bundled payment** | **Best practice recommendation**

Pricing approach for the bundled hip and knee replacement QBP

An **introductory bundled QBP price** has been set, using the QBP pricing methodology.

The following considerations were used in the development of the price:

- The bundle price is built so that **every surgical patient** can receive post-acute rehabilitative care, **according to best practice*;**
- The price will exclude readmissions and revisions; outcomes will be monitored and tracked to inform future bundle scope;
- The bundled price for hips is $9,630.84[1] and the bundled price for knees is $8,626.69[1];
- **FY 18/19 is an introductory year. The price will evolve over time as data gaps are filled.**

*Best practices outlined in:

- Clinical handbook for primary hip and knee replacement. Toronto: Health Quality Ontario; 2014 February. 95 p. http://www.hqontario.ca/evidence/publications-and-ohtac-recommendations/clinical-handbooks; and
- Rehabilitative Care Best Practice Framework for Patients with Primary Hip and Knee Replacements; 2017 March. http://www.rehabcarealliance.ca/uploads/File/Initiatives_and_Toolkits/QBP/RCA_TJR_Rehab_Best_Practice_Framework__March_2017_.pdf

Notes:

1. *Prices are calculated using a 2015/16 provincial average CMI x cost per weighted case*
2. *Information comparing 2018-2019 facility level QBP price to the bundle price will be made available to LHINs and nominated teams*

Reporting, outcome measurement and evaluation

- Standard performance and outcome measurements have been set.
- Teams' continued participation in the program will be contingent on reporting on these outcomes.
- Teams are expected to report on clinical and financial data to support outcome reporting, evaluation and protection of financial stability.
    - All activity must be reported in appropriate health admin databases (i.e., DAD, NACRS, CHRIS)
- Teams will participate in the provincial Patient Reported Outcome Measures (PROMs) pilot initiative.[1]
    - Patient Reported Experience Measures (PREMs) will be included as part of the PROMs data collection
- Teams will also have to participate in a central evaluation of the bundled hip and knee QBP. This work will require data collection and quarterly reporting.
    - Guidance and templates will be provided to support the central evaluation.

What indicators will be evaluated?

- ✓ Rate of revisions within 365 days
- ✓ Risk-adjusted 30-Day All-Cause Mortality Rate
- ✓ Total health system costs
- ✓ Utilization outside the bundle 6 months prior and following the episode
- ✓ Patient Reported Outcome and Experience Measures
- ✓ Volumes*
- ✓ Wait time 1 & 2*
- ✓ Length of Stay & % ALC *
- ✓ Discharge destination (% home)*
- ✓ Adverse Events *
- ✓ Surgeon 12 week follow-up *
- ✓ Readmissions + ED visits *

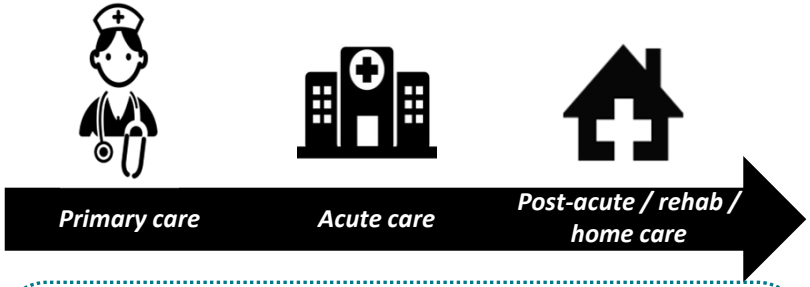
**Denotes indicators that will also be monitored*

Through bundled care pilot projects, we are moving towards a vision where funding supports the full patient journey

The vision for the health care system in Ontario is a **higher-performing, better-connected, more integrated and patient-centred system** for patients and care providers. Funding care through bundled payments serves as a way to support improved patient continuity through the care continuum and incent high quality outcomes, while monitoring costs. For episodic bundles, early data shows that this approach has been effective to achieve these goals.

Episodic Bundles: Defined episodes of care where symptoms emerge, are treated and abate. Patients follow a predictable care pathway.
Development of episodic bundles is the anticipated next step in expanding bundled care.

Chronic Complex Bundles: Conditions that require ongoing care across the continuum. Pending results of pilot projects and preliminary analysis, bundles for these conditions will need to reflect the predominance of care provided in community settings.



Focus of Existing Pilots & QBPs

- Hip & Knee Replacement
- Chronic Kidney Disease
- Cardiac Surgery
- Chronic Obstructive Pulmonary Disease*
- Congestive Heart Failure*

- Stroke
- Hip Fracture
- Spine surgery
- Osteoarthritis

**Existing bundled payments and QBPs are focused on acute exacerbations*

Questions?