Integrated Client Care Project (ICCP)

Leveraging Innovation for Added System Value

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Integrated Client Care Project

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Ontario Local Health Integration Network / Réseau local d'intégration des services de santé

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Collaborative for Health Sector Strategy

With *Health Quality Ontario* providing quality improvement coaching and capability-building

ICCP vision

❖People, including those with complex medical, clinical and psycho-social needs, receive the care and support they need to live successfully in the community.

❖To achieve optimal client outcomes for home and community care clients to drive value in health care (i.e. maximum value achieved for money spent)

Goals:

❖To achieve better health care more cost effectively

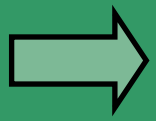
❖To improve population outcomes

❖To improve the quality of home and community care delivery

The case for integrated care

ICCP is the proof of concept for the value proposition that a person's condition is the unit of value creation in health care delivery:

VALUE =
Patient/client health outcomes
Total cost of care for the patient/client's condition



END GOAL:
Healthier Ontarians
Sustainable health care expenditures

❖Remembering **client impact** is key

❖ICCP's unique value proposition champions **integrated care, payment for outcomes (alternative reimbursement)** and **system navigation**

❖**Integrated care** addresses system fragmentation by using, in a coordinated manner, all of the people across multiple sectors for the contribution each is best positioned to make. Integration builds transformative relationships.

❖**Outcome-based payment** will move us from a system which pays for activity (e.g. nursing visits) to a system which pays for results.

❖**System navigation** recognizes that optimal health involves support from many sources beyond the traditional "health care" sector, i.e. the determinants of health; it provides that support at key transition points in the trajectory of care.

Client populations

ICCP focuses on 4 client populations:

- Wound care (first phase)
- Palliative care (current phase)
- Frail seniors (future)
- Medically complex children (future)

ICCP model in practice

ICCP is driving on-the-ground practice and care delivery changes:

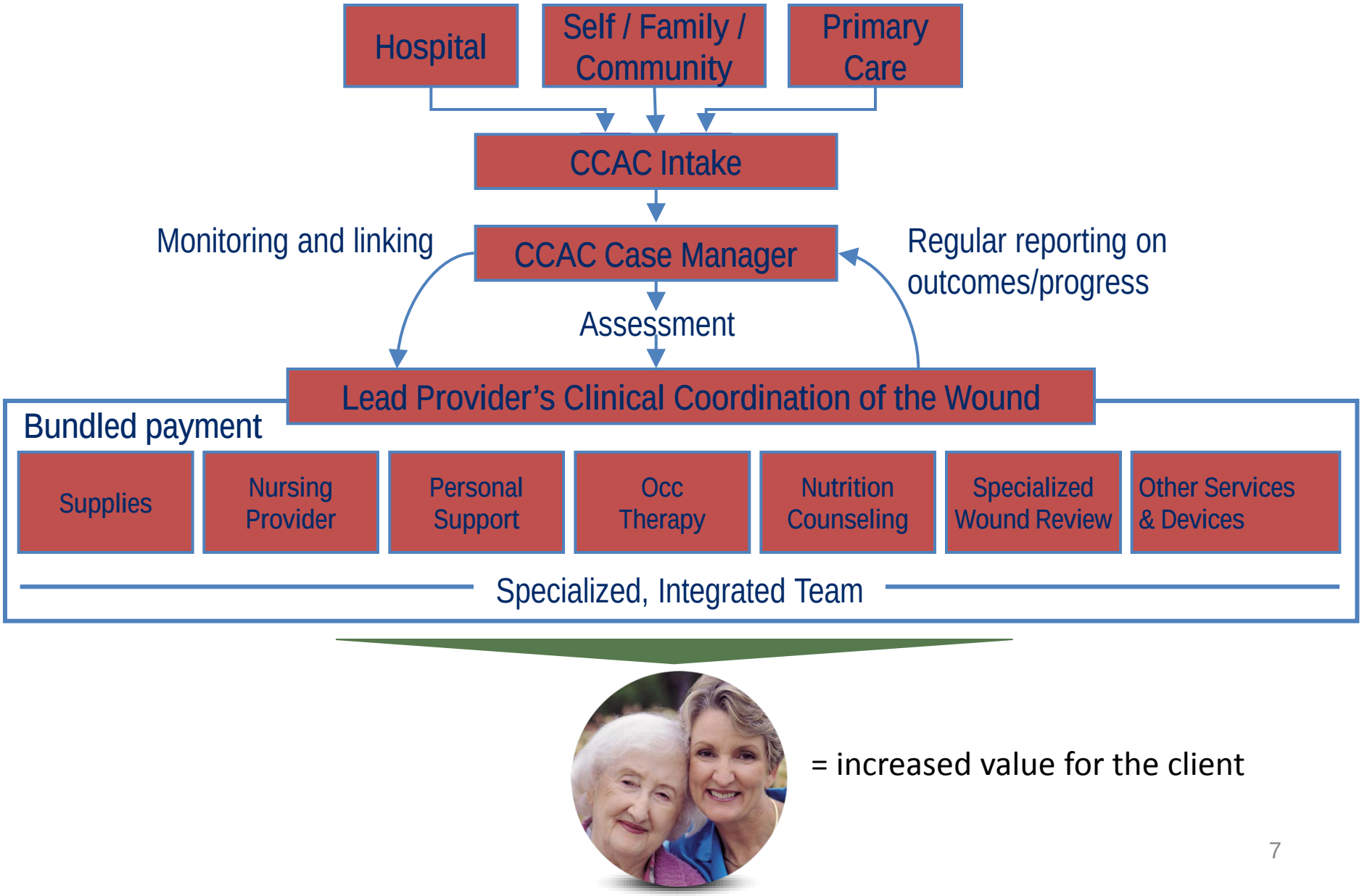
- ✓ Standardized best practice care pathways promote integrated care delivery
- ✓ Payment for outcomes drives behaviour change and accountability

Processes and structures supporting integrated team delivery:

- ✓ Client-centered care planning and coordination
- ✓ Population-based specialized case management and system navigation (aligns with CCAC Client Care Model)
- ✓ Virtual “circle of care” teams, including providers across sectors and across systems (formal, informal and volunteers) based on client need and goals
- ✓ Standardized, shared assessment, common client record, and overall care plan with common goals shared across all providers

Current ICCP focus: wound care model spread

Integrated care delivery by population: wound client example



= increased value for the client

Key accomplishments – wound care

- Number of clients served to date: 1107

- Wound reduction successes:
  - At 4 weeks, all sites exceeded target wound reduction of 30%
  - Actual reduction for Venous Leg Ulcers (VLU) ranged from 38% to 80%

- Dramatic improvement to self-management

- 72% of clients reported better ability to self-manage using program provided to them during the integrated client care assessment

ICCP and the shift towards outcome-based payment

❖With a system that focuses on paying for visits, not outcomes, value of care is compromised

❖Aligning provider payment mechanisms with value delivery drives system transformation efforts around the world – it's time to get on board

❖Wound client grouping is an excellent start to testing/implementing payment models based on **defined** outcomes

❖ICCP's alternative reimbursement approach supports Ontario's Health System Funding Strategy's direction towards evidence-based, person-centred funding methods based on the needs of patients, clients and residents

❖ICCP shifts home care reimbursement towards paying for the full 'bundle' of services related to an episode of care, promoting quality, efficiency and care coordination while freeing providers to innovate

❖The ICCP reimbursement approach for home care providers is well-aligned with the pending introduction of case mix funding for CCACs

“Bundled” reimbursement trajectory for ICCP wound care clients

The way we currently pay for care does not incent best practices.

The unique **alternative reimbursement** model being tested by ICCP incents providers to aim for better outcomes and innovations when caring for the client. It has the potential for province-wide adoption and is tailored to four specific client populations, with potential to expand to others.

How did we get to the “wound bundle?”

- Developed outcome-based payment principles focused on client needs
- Developed reference price through collection of CCAC length of stay and cost data; removed medical supply and equipment costs (contractual obligations)
- Developed standardized coding and definitions for outcomes – began with measurement/payment, and baseline bundled test price for 2 wound types: diabetic foot ulcers/venous leg ulcers
- Created a wound client trajectory, benchmarking key milestones on a shared care pathway
- Established consistent expectations regarding what is included in the alternative reimbursement “bundle”
- Developed process for shadow billing

Model spread – broadening wound care and applying learnings to other populations

- Share key best practice tools with CCACs and service providers
- Transfer ICCP reimbursement methodology to all wound types through development of standardized care paths across the province
- Test prices & process for shadow-billing for 2 initial wound types (eventually for all 10 wound types)
- Explore and secure electronic solutions to support service provider data collection; implement shadow-billing support
- Continue to refine pricing by evaluating all variables involved in provider-level funding/payments (e.g. cost mix; case intensity; risk adjustment)
- **All of the above will reduce system inefficiencies and build capacity to spread model to other populations**

ICCP palliative care

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Palliative care - the challenges

- Research provides evidence of what good palliative care looks like
- Care delivery is not as integrated as it could be
- We need to create the culture and structure to deliver better care consistently; this includes dismantling the barriers
- The importance of a fresh, “new eyes” approach to long-standing challenges should not be underestimated

The palliative care opportunity

❖**System transformation** – using existing resources and building relationships across organizations and disciplines for increased communication/collaboration. This will lead to better care and system-wide improvements. ICCP partners will identify priorities for action, truly sharing responsibility for implementing change.

❖**Advancing evidence-based, family and person-centred** care that aims to relieve suffering, close gaps for palliative patients and help them live and die as comfortably as possible in the location of their choice

❖**Support fiscal sustainability**: use evidence adoption to drive quality and outcome-based payment strategies to incent innovation and improve care

❖Provide evidence to help inform **provincial palliative care policy**, helping to align existing efforts and explore priorities for action

Encouraging innovation

- Channelling our human resources towards work they are best positioned to deliver – creating space for creativity and innovation
- Capitalizing on new resources efficiently
- Developing and measuring key clinical and system-level outcomes to address current gaps and needs (Palliative Outcomes Working Group)

Indicators: Key domains for assessing ICCP palliative care intervention performance

Key Domains	Sample Indicators
Outcomes	• Quality of life preceding death/quality of death
Quality	• Client, caregiver and provider experience • Pain and symptom management • Depth of team integration/quality of care coordination (within home care and cross sector teams)
Health System Impact/ Cost effectiveness ❖Improved cost/service efficiency in home care ❖Cost avoidance in health care system	• Change in home care costs over a cycle of care (services, supply costs, CCAC administrative costs) • Change in client utilization of health system resources in particular use of acute services in last month of life (ED visits and/or avoidable hospitalization; days spent in hospital; drug costs; hospital/home death)

Moving forward with ICCP

- Immediate priority: begin implementing and evaluating the ICCP alternative reimbursement concept more broadly
- Provide necessary tools (standard care path, best practice tools) to encourage uptake of new wound care model in implementation sites
- Set up crucial supporting infrastructure (people and IT)
- Standardize provincial capacity to track 10 wound types
- Tap into current provincial funding projects to leverage expertise and case costing work to date
- Define palliative outcomes
  - Outcomes should drive best practice
  - Outcomes should provide framework for reimbursement

The provincial perspective

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Health system transformation

The Excellent Care for All Strategy represents a significant culture shift. The health care system is steadily moving towards fairer, more evidence-based approaches to respond to emerging health care needs and built-in incentives to deliver high quality care

Continuity of Care
People want to experience the health system as a true system, not the fractured and fragmented patchwork of health care providers it is today. To make this a reality, there is a need to move towards greater integration among providers by introducing a new service delivery model

Excellent Care for All

Quality based on the adoption of best practices and evidence is vital to health care system sustainability and better outcomes

Funding Reform

A broad health system culture shift, moving away from global funding and introducing activity based funding with payment for outcomes.
With this type of funding, providers will be compensated based on what they do, how many people they look after, and the specific needs of the population they serve

The provincial policy perspective

- ICCP is considered a breakthrough strategy to transform health care delivery in Ontario
  - Care is being organized around the person
  - Quality is a critical goal
  - Quality of care is supported by best evidence and standards of care
  - Payment, policy and planning support quality and efficient use of resources
  - Realigning funding and performance incentives will drive quality and system value
- Strengthening the capacity of home care and community sectors has long been identified as a key strategy to improve health system sustainability (e.g. divert growing demands on LTC homes, reduce unnecessary ER, hospital and ALC utilization)
- Increasing health expenditures as a share of GDP, demographic trends and advances in health technologies represent both the catalyst and the imperative to introduce health sector reforms to emphasize community-based long-term (continuing) care
- ICCP provides a testing ground for us to discover what changes to home and community funding and delivery models are important and effective in achieving better outcomes for key populations and improved system performance, while also enhancing people's experience of the care they receive

What we learn through ICCP will help us set new directions to accelerate health system transformation

ICCP is unique compared to many other health system policy initiatives:

- It focuses first on extracting optimal value from existing investments, rather than relying on new resources and new capacity to advance system redesign

- It represents a population approach that flexibly addresses the needs of both complex and chronic populations in terms of on-going, long-term support and continuing care delivery requirements

- ICCP is developing a new delivery model including bundled reimbursement, client/provider level outcome tracking and shared accountability across providers for population and system outcomes

- It positions all providers to work within a single care plan based on common client goals

- Exploration of flexible, virtual delivery structures across sectors to accelerate integration and reduce costs
  - Structural integrative solutions, while concrete, may take years to implement, and do not resolve underlying collaboration and integration challenges

What we learn through ICCP will help us set new directions…(cont'd)

- ICCP is unique in terms of its approach to impact assessment and value measurement
  - First scientific assessment of effectiveness of system level programming (pragmatic randomized control trial design) : gold standard in terms of reliability and applicability
  - Detailed impact assessment of system level implementation to provide key knowledge for spread and sustainability planning
  - Based on a collaborative, participatory research approach with impact assessment teams involved from the beginning to enhance intervention development and ensure data measurement and quality
  - Formative and summative evaluations, with an expectation of regular audit and feedback on delivery implementation. Learning will be used to course correct throughout the implementation phase
  - Neutral, arm's length evaluation managed by ICES with independent teams selected through an open competitive process to conduct the impact assessment for each population group
  - Will provide a template for future impact assessments in any sector

Wound care and palliative impact assessment frameworks posted at www.ices.on.ca

Contact information

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Appendix 1: What is ICCP?

- ❖Multi-year population-based initiative with potential to improve provincial population health outcomes
- ❖Develops, implements, evaluates new and existing home care model delivery
- ❖ICCP aligns with the CCAC-wide commitment to integration, quality improvement, and better client outcomes
- ❖Partnership among MOHLTC, the Ontario Association of Community Care Access Centres (OACCAC), the Collaborative for Health Sector Strategy, University of Toronto, Rotman School of Management and the Local Health Integration Networks (LHINs)

Appendix 2: ICCP framework

Integrated Service Delivery

- Team is as broad as needed for client's needs
- Clinical leadership/accountability provided by a lead service provider; depending on care setting, leadership/accountability assigned to individual best positioned/qualified
- Includes single chart/shared care plan **facilitated by a coordinated assessment**

Alternative Reimbursement (Payment for Outcomes)

- Rewards service providers based on results/use of **best practices**
- Encourages innovation & service delivery improvement

System Navigation

- **CCAC specialized Case Manager (CM)** becomes the point of contact to coordinate care across health and other support systems, ensuring seamless transition for clients at key transition points
- **CM** coordinates care with social determinants of health in mind

Clinical Best Practices

Appendix 3: Introducing our palliative sites

There are 5 participating sites and one evaluation site, divided into 3 streams:

Participating site stream	Site purpose
Spotlight Sites - Hamilton Niagara Haldimand Brant CCAC/LHIN with Bayshore; Mississauga Halton CCAC/LHIN with Spectrum; Waterloo Wellington CCAC/LHIN with Bayshore	System-wide approach to implementing the ICCP model (i.e., integration of the entire system)
Home Care Quality Improvement Sites - Toronto Central CCAC with Spectrum and St. Elizabeth; Central West CCAC with Bayshore	Mechanisms to improve the quality and impact of CCAC related palliative care delivery
Leading Practice Site - South East CCAC	Seen as leaders

Questions?