Health Quality Transformation 2014

Partnering to accelerate best care, best health, best value

Session 7: HSFR

Moderator: Susan Fitzpatrick

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Presenter Disclosures

Presenters: Cathy Szabo, Donna Cripps, Kevin Smith, Adalsteinn Brown

Relationships with commercial interests: None

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Disclosure of Commercial Support

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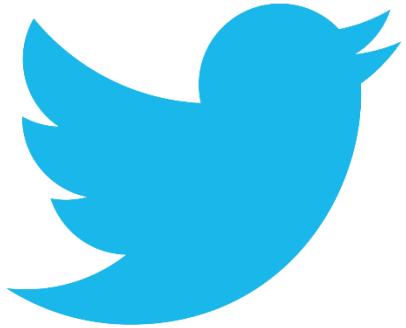

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Rehab, Complex Care and Community perspective on HSFR

Cathy Szabo, President & CEO
Providence Care, Kingston

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The evolution of Complex Care

- Over the past decade Ontario's Complex Care and Rehabilitation sectors have undergone significant change.

- These changes have occurred in response to improved research, changing population needs, and the increasing burden of chronic disease.

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Complex Care Patients…

- Have increased complexity of care requiring active rehab as part of their care plan;
- Require periodic changes to their care plans and redefinition of their therapeutic goals;
- Have shorter length of stays compared to the historic ‘chronic care’ model;
- Require greater intensity of services, including medical nursing and allied staff;
- Need access to slower paced rehabilitation program to improve functionality.

Providence Care

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Complex Care at Providence Care – A Paradigm Shift - TODAY:

- Increased focus on providing rehabilitative services within complex care services;
- Admission to a Complex Care program is not intended as a “final destination” for the patient;
- The care and service is focused on achieving patient goals (patient-directed), and plans for transition to the community;
- Improved Case Mix Index – **average CMI now at 1.12 (2014) from 1.06 (2013)**

How we adapted:

- Educated frontline staff and physicians on appropriate and consistent documentation related to patient care needs
- Identified a need for a specific client population within our community: patients who would benefit from restorative rehabilitative (slow-pace rehab) services

Restorative Rehabilitative Care program (Slow-Pace Rehab in CCC funded beds)

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Operational Beds	**12 beds** - October 2013 – June 2014; **14 beds** - 2 beds added July 2014
Admissions	42
Discharges	65%
D/C Destination	Home with CCAC 54% LTC 5% Active Rehab 10% Acute Care 16% (due to acute episodes.) Other 15% (e.g. retirement home)
Referral Sources	SMOL Active Rehab, KGH, L&A and community
Occupancy	100 %
Length of stay	53.8 days
CMI	Low 1.1 High 1.6

Providence Care

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As a result of our efforts – Complex Care has seen:

- A 67% decrease in length of stay
- A 50% increase in discharges (not deaths, or repatriations to acute)
- An 16% increase in the Case Mix Index range for special rehabilitation provided to patients in CCC

Lessons learned:

- Early, timely assessments are critical to reflect the true complexity of the patient, and ensure the patient is receiving maximum benefit of our specialized services;
- Don’t under-estimate the need for staff and physician engagement throughout the process, and our changing role in the community to meet complex patient needs;
- Goal is for the patient to be receiving the **right level of care, in the right place at the right time.**

Approach to Integrated Bundle Payments

Dr. Kevin Smith

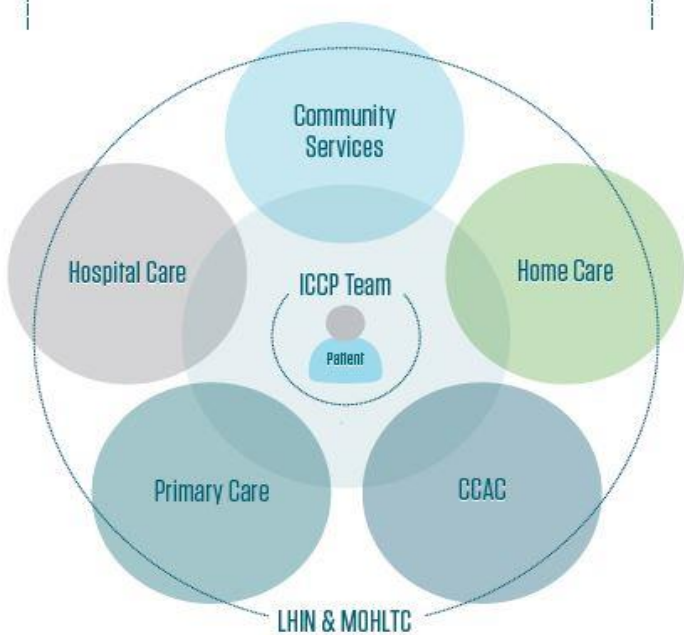
President and CEO, St. Joseph's Health System
CEO, Niagara Health System
Associate Professor
Michael G. DeGroote School of Medicine,
McMaster University

St. Joseph's HEALTH SYSTEM

WHAT WE DEVELOPED

WORKING TOGETHER TO DEVELOP THE
INTEGRATED COMPEHENSIVE CARE PROGRAM

SUPPORTED BY OUR BOARDS, CLINICAL LEADERS AND EXECUTIVES.



St. Joseph's HEALTH SYSTEM

SEVEN ELEMENTS

OF THE INTEGRATED COMPREHENSIVE CARE PROGRAM

1. **Client centred care**
   Empowering clients with knowledge, participation and self-care
2. **Integrated care coordinators**
   Following clients across the continuation of care
3. **Integrated team committed to standardization**
   Interdisciplinary care pathways spanning hospital and community
4. **A shared electronic health record**
   Also serves as a hub for communication
5. **Simple, available technology**
   Flexibility in communication
6. **Ready access to medical care**
   Community-based 24/7 contact number for patients
7. **Flexibility in the delivery of care**
   Continual process improvement

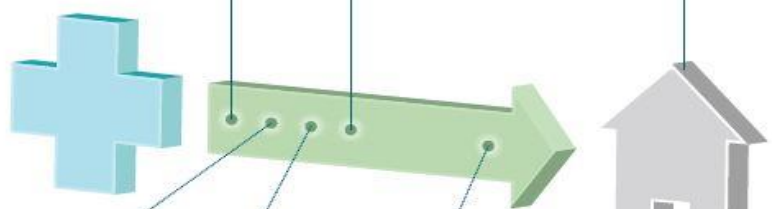
St. Joseph's HEALTH SYSTEM

INTEGRATED CARE WITH BUNDLED FUNDING

PATHWAY FOR THORACIC SURGERY – DEVELOPED BY ONE TEAM
WITH HOME CARE AND HOSPITAL MEMBERS

+ Day 1:
Patient has interaction with the ICCP coordinator

+ At Home:
ICC supports patient with home visits, Skype calls with clinicians and 24/7 hotline



+ Day 3:
Patient is discharged home with chest tube, supported by ICCP Team

+ Day 4:
Respiratory Therapist comes to patient's home

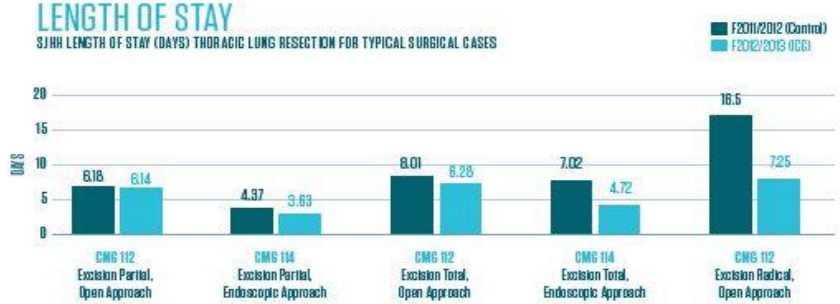
+ Day 10:
Patient's activity returns to pre-surgery level with rest periods as needed

St. Joseph's HEALTH SYSTEM

IMPACT

LENGTH OF STAY

SJHH LENGTH OF STAY (DAYS) THORACIC LUNG RESECTION FOR TYPICAL SURGICAL CASES



ICC PROGRAM: WHERE CLIENTS LIVE

HOME LOCATIONS OF THORACIC CLIENTS FOR ICC PROGRAM 2013/14

PATIENTS AND FAMILIES ARE SAYING:

"I was very happy with my health care at St. Joe's. I really enjoyed using Face Time (iPad). I thought it worked very well."

Patient

"The project gave my mom piece of mind. Having access to her care coordinator made her feel like she wouldn't have to go to the ER when she had a healthcare concern."

Family Member

"I thought the ICC program was great! I've had three (surgeries) at St. Joe's and by far, this program enabled me to have the fastest and best recovery."

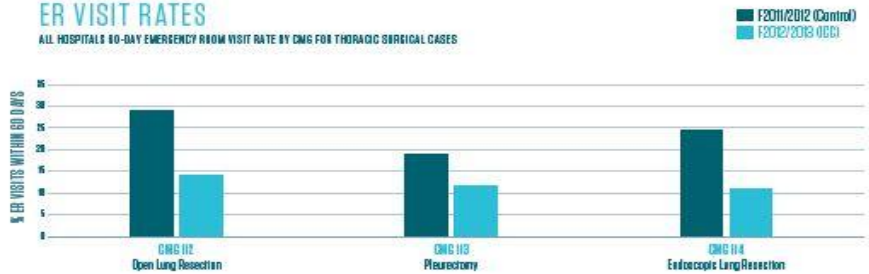
Patient

St. Joseph's HEALTH SYSTEM

CREATING BETTER, CHEAPER & FASTER CARE

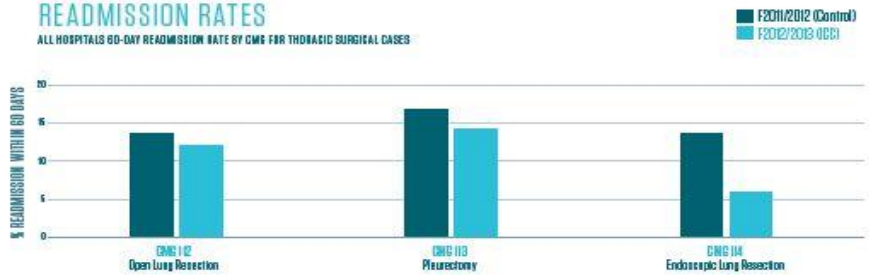
ER VISIT RATES

ALL HOSPITALS 60-DAY EMERGENCY ROOM VISIT RATE BY CMG FOR THORACIC SURGICAL CASES



READMISSION RATES

ALL HOSPITALS 60-DAY READMISSION RATE BY CMG FOR THORACIC SURGICAL CASES



St. Joseph's HEALTH SYSTEM

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Health System Funding Reform

……From a LHIN perspective

Donna Cripps, CEO
Hamilton Niagara Haldimand Brant LHIN

Overall

- Creating a less imperfect funding system that is transparent and can be explained
- Providers more focused on ensuring good data
- Conversation has changed – focusing more on the person served
- Understanding of the formula will drive behaviour so need to be aware of unintended consequences

Quality Based Procedures

- Leverage the concept to build our integrated clinical programs
  - Bring the physicians and other clinicians to the table
  - Understand the funding and modifying behaviours to meet the needs of the patient
- Influencing ALC – changing the face of people being designated ALC
- Willingness of hospital to manage situation out of global budget
- Some hospitals considering ‘getting out of the business’.

HBAM

- First two years focused on understanding the formula
- Changed the conversation
  - CCAC – which patients need to be taken home
  - How can we work with CSS agencies
  - How can we improve efficiencies
  - What are others doing that we are not doing
- Now that formula ‘has landed’ seeing HSP’s working on how they can improve
- Mitigation has mitigated impact but now true impact is being felt
- Must keep up efficiencies relative to the province

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Funding Reform: Linking Cost and Quality

What do we know from the evidence?

What do we know from practice?

Adalsteinn Brown, Director Institute of Health Policy, Management, and Evaluation
and Dalla Lana Chair in Public Health Policy

What do we know about quality improvements, cost savings, and funding models?

What does the literature on the quality, cost and funding look like?

- Strong policy interest in linking cost and quality through funding
  - New structures such as Accountable Care Organizations, Patients' Medical Homes in the US
  - Initiatives such as Dark Green Dollars and Triple Aim from the Institute for Health Care Improvement in the US
  - Excellent Care for All (Ontario)
- However, it is a relatively under-developed area of study
  - Excellent grey literature, good case studies of leaders from IHI, other groups
  - Largely US and and UK literature
- Methodological challenges with studies
  - Costing details unclear, may not include cost of improvement
  - Measurement of quality and costs incomplete or over a short period of time
  - Scalability and generalizability of projects unclear
  - Highly selected test-sites with favourable conditions for success
- Difficult to separate out funding reform, structural change, and market characteristics

1 Ovretviet, 2009; 2 Marshal and Ovretveit (2011

Cost and quality are linked in hospital care, largely through compliance to guidelines

ProvenCare[1]	forty verifiable behaviours for evidence-based cardiac surgery "hardwired" within the electronic health record	5% decrease in hospital charges
US Surgical Safety Checklist[2]	A two-minute tool that is designed to help operating room staff improve teamwork and ensure the consistent use of safety processes	$103,829 annual savings for hospitals with 4,000 non-cardiac operations
Simulation intervention in central venous catheter insertion [3]	mandatory simulation-based program on catheter insertion	Annual savings projected of approximately $700,000
Quality Improvement in Paediatric ICU[4]	1) Strict compliance on hand hygiene; 2) IHI VAP bundle; 3) compliance with guidelines on central-line catheters	Average adjusted costs were lower in ICU ($8,826) and in hospital ($12,136)
Michigan Keystone ICU Safety[5]	1) interventions to improve safety culture, teamwork, and communication and 2) interventions to improve compliance with evidence on central line-associated bloodstream infections	Savings for the average hospital was $1.1 million per year
Regional Surgical QI Program (Michigan)[6]	QI development program paid for by a private insurer	Net savings of $15 million (program cost $5 million)`

1 Casale et al. 2007; 2 Semel et al. 2010; 3 Cohen et al. 2010; 4 Harris et al. 2011; 5 Waters et al. 2011; 6 Share et al 2011

Cost and quality become more tightly linked as scope increases for policy action and patient care

Diabetes management program in Germany[1]	Primary care physicians enrol patients, educate and advise patients with regards to the management of their disease and use of the health care system	Net cost reduction o f$209.10 per enrollee
Quality and Outcomes Framework in UK[2]	Pay-for-performance incentive schemes; payment was determined by achievement of quality indicators related to 10 chronic conditions	Reduced hospital costs by approximately £130 million
Kaiser Permanente disease management program for diabetes and heart disease[3]	clinical guidelines, self management education, disease registries, risk stratification, proactive outreach, reminders, multidisciplinary care teams, and performance feedback to providers	Costs rose for each of the four conditions including 19 % for CAD patients
Kaiser Permanente Performance Improvement System[4]	Measurement, QI capacity development, support for improvement projects in 22 centres	Average savings of $2.36 for every $1 invested for a net return of $434,600 per centre
Intermountain QI efforts[5]	Measurement, capacity development, and central oversight and guidance for QI projects	Several examples of savings including $50 million through obstetric protocol redesign

1 Stock et al. 2010; 2 Dusheiko et al. 2011; 3 Fireman et al. 2004; 4 Schilling et al, 2010;

However, linking cost and quality results from many factors including funding

- Integration is a critical element of cost reduction
  - Evidence of success in disease pathways,care coordination
  - Integrated systems appear to be leaders in cost-quality trade-off
- Trust and physician leadership appears to be critical issue
  - Physician connected strategies include post-hospital nurse monitoring, disease management programs, and error reduction initiatives that allow substitution of lower cost for higher cost care[1]
  - Clinician/patient driven quality improvement strategies more effective than manager/policy-maker driven strategies[2]
  - Trust is critical issue in construction of new Accountable Care Organizations in US[3] Pilot Program
- But many changes not effective without substantial change in funding and organization of systems[4,5]
  - No regular identification of savings with QI in long-term care settings
  - Mixed evidence on care coordination[6]
  - Role revision does not change costs on its own[7,8]
  - Cost avoidance more likely with changes in technology use than cost elimination because of rigid funding structures[9]

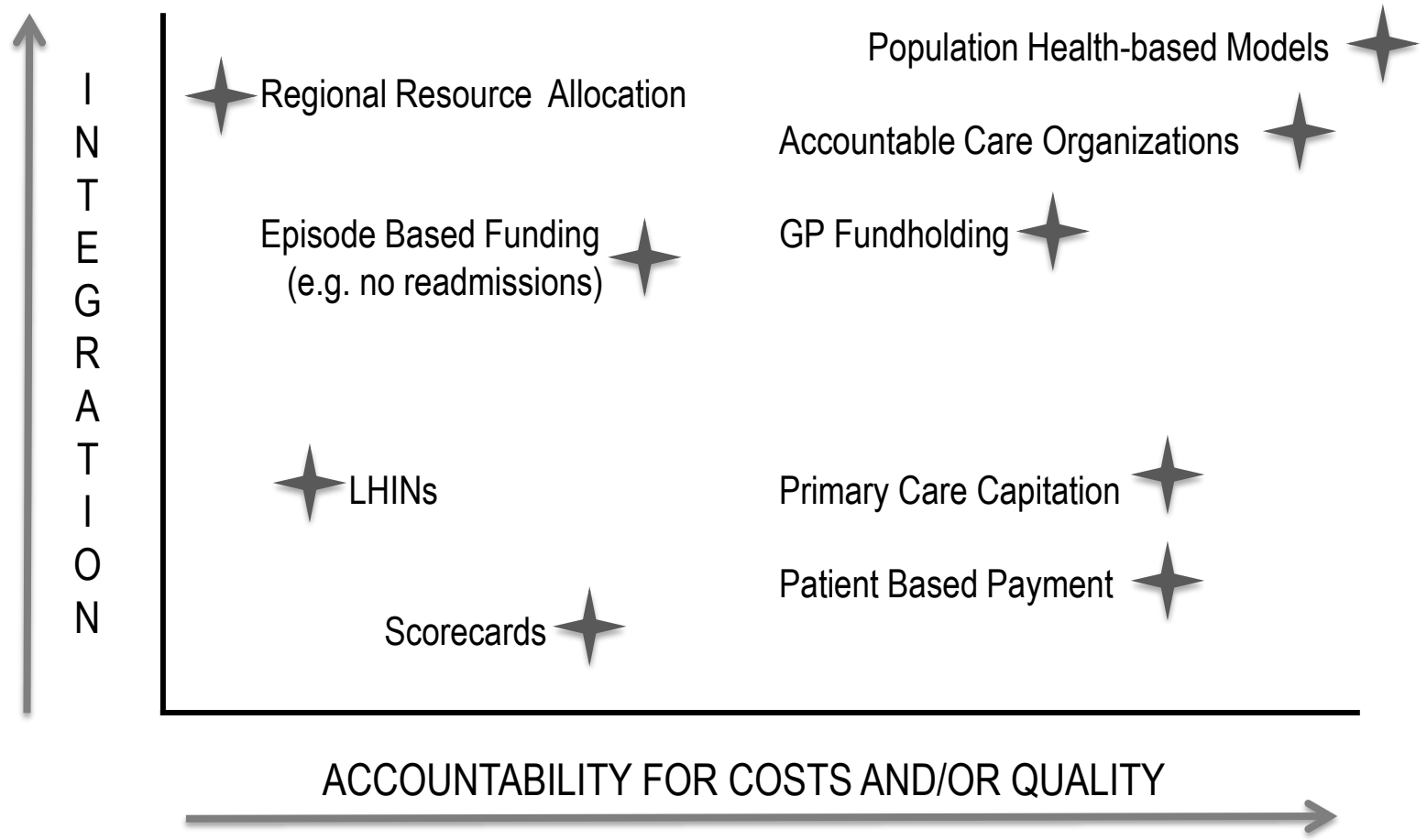
1 Bodenheimer & Fernandez, 2005; 2 Scott et al. 2009; 3 Van Citters et al. 2012; 4Hillestad et al. 2005; 5 Øveretveit, 2009; 6 Nelson, 2011; 7 Bosch et al, 2009; 8 Laurant et al 2010; 9 Levin, 2012

Limited evidence suggests gain-sharing may work… but with many caveats

- US study of gain sharing around inpatient care at a tertiary centre found:
  - Savings higher in gain-sharing ($16 million) compared to non-participants (9 million) although substantial savings in both arms
  - Savings due to range of factors as in IHI model including reduced length of stay, reductions supply costs, and improvements in documentation and completion of medical records[1]
- US Study of gain sharing in interventional cardiology shows reduction in costs by 7.4%
  - Vast majority of savings come from lower cost inputs[2]
- Gain-sharing behind new ACO models
- Gain-sharing also raises several important ethical issues
  - Principal-agent difficulties
  - Potential for underservice as opposed to overservice
  - Anti-competitive behaviour
  - Kickbacks

1 Leitman et al. 2010; 2 Ketcham & Furukawa, 2008

Policy makers have started to take a broader approach to transformation linking funding across wider groups of services with greater links to quality



But linking funding for larger sets of services (and for broader outcomes) requires health system funding reform across multiple silos in any system of care

Adverse Events		Hospitals & Hospital Physicians
Readmissions		+ Community Physicians
Chronic Disease Mgmnt		+ Drugs
Alternate Level of Care		+ Community Care
Health Outcomes		+ All providers, caregivers, and self-care

So what do we know and funding, quality, and costs?

- No one system of funding works consistently well
  - Some implementations work well, others do not (activity-based funding)
  - Gains with any system are modest (activity-based funding, fund-holding)
  - Integration seems to be key to larger gains (population-based funding, accountable care organizations)
  - Capacity for improvement and good governance is critical (accountable care organizations)
  - Success requires funding, policy, and (likely) structural reform
- Value is a vector; some changes may be translated easily into cost reductions (readmits), some may not (satisfaction).
- Inequalities in health exceed inequalities in access to, costs of, or quality of care. No funding model will not reduce inequalities on its own.
  - Can funding models adjust for inequalities in a way that rewards reduction of inequalities
  - Can funding and governance models extend to broader determinants of health

1Reinhardt, 2011; 2 Bierman, 2012

The system level changes necessary to improve quality and cost do require rethinking of how we organize and support better care

Poor quality and adverse events are common and costly

Some interventions are effective, but carry costs that exceed savings

The costs and benefits of quality are spread over time and between stakeholders

Contextual factors influence whether a provider saves money from QI

Providers would be helped by information relevant to their situation

Saving avoidable suffering may be speeded up by the business case

Ensure that providers bear more of the costs of poor quality, especially for their deficiencies in patient transfer and prevention

Measure quality and quality costs in routine settings as part of management and payment systems

Finance local improve expertise – shared between providers – and link to savings

Spread the investment costs for developing improvement capacity over time and between partners; possibly through intermediate finance organizations.

1Ovretveit, 2009.

So what can we do?

- Redefine relationships across out system
  - What is the definition of community that can be accountable for care to a defined population
  - How will payors and providers work together

  Successful US cases are emerging as partnerships between payors and providers to handle capacity issues[1]
- Refocus measures of performance on quality that is sensitive to integration
  - Shift away from current sector-specific measures
  - Focus on outcomes and experience measures
- Promote governance, improvement, and managerial capacity for providers so that care can be coordinated and improved and benefits shared
  - Focus on change management at all levels and improvement capacity in the field
- Review regulations for barriers to collaborations and improvements that create value (e.g. privacy, self-referral, delegation, credentialing)
- Set funding models that encourage integration and quality management through redistribution of savings and aggregation of care bundles

1Fisher et al, 2011

The essential system level changes necessary to promote better performance do not depend on additional spending but they will make any additional spending much more impactful

There are only three common elements to healthcare systems that have improved on cost and quality over time

1. A public, specific statement of goals for improvement with a plan for reaching these goals
2. Public reporting of results with a clear link to improvement plans that become part of the strategy
3. Strong physician & clinical leadership of improvement efforts aligned to improvement goals

Strategies that fail to include these elements will fail an appeal to intrinsic incentives

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Questions & Discussion