Tools for Change: Funding Incentives and Levers for Integrating Patient Care in Ontario

November 2010

HEALTH CARE DESERVES OUR FINEST THOUGHT

THE CHANGE FOUNDATION

About The Change Foundation

The Change Foundation is an independent policy think tank, intent on changing the health-care debate, health-care practice and the health-care experience in Ontario.

A charitable foundation established in 1996 and funded though an endowment, The Change Foundation leads and leverages research, policy analysis, quality improvement and strategic engagement to enable a more integrated health-care system in Ontario designed with individuals and caregivers top of mind.

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Introduction

How can we re-think and redesign our funding models and payment systems to incent providers to work together in the best interests of individuals and their caregivers as they move through the health-care system? At the invitation of Ontario's Ministry of Health and Long-Term Care (MOHLTC), The Change Foundation hosted a symposium in April 2010 to investigate the impact that funding levers and financial incentives can have on the quality of people's experience as they navigate their way through the continuum of care.

> "The most serious barrier to the delivery of these services is the separate funding of the various sectors."
>
> — Gina Browne, McMaster University Health & Social Service Utilization Research Unit, A Better Pill to Swallow: *A global view of what works in Healthcare* (KPMG International, April 2010).

Organizational and provider payment methods are an indirect mechanism for integrating care. The misalignment of these structures — and their associated incentives — can create barriers to system integration, manifesting in visibly poor coordination and continuity of care for patients. Increasingly, provider payment methods are acting as a catalyst for clinical integration. In principle, the more global the unit of payment (on a continuum from fee-for-service, to capitation, to salary), the stronger the incentive for closer relationships among providers at different stages in the care continuum. The question remains: which funding methods facilitate system-wide integration?

The Change Foundation reviewed key documents to better understand these issues; *Appendix 1* presents a summary of key findings from the literature and provides links to four background papers. The Foundation also commissioned two international case studies to see what we could learn from other jurisdictions; *Appendix 2* provides a summary of key findings from the U.S. and U.K. case studies. Finally, we hosted the symposium, *Tools for Change: Levers and Incentives for Integrating Patient Care in Ontario*, to discuss the issues. It was attended by an engaged audience of almost 100 health-care leaders from provincial associations, purchaser and provider organizations, MOHLTC and academic/research organizations. *Appendix 3* summarizes the symposium presentations and dialogue.

Canadian examples

Within Canada, a number of jurisdictions are experimenting with and implementing different funding models and incentive schemes. A few examples:

- In Ontario, the provincial government passed its *Excellent Care for All* legislation, which includes plans to implement **patient-based payment** in large hospitals starting in April 2011 (replacing the current, largely global, budget system). Reimbursement will be based on types, volumes and quality of care; and **pay-for-performance** will be introduced for hospital executives, with a portion of their salaries linked to the achievement of improvement targets which will have been set out in annual quality improvement plans. Hospitals are the initial focus of the legislation, but the changes are expected to spread to other sectors over time through regulations, e.g., long-term care facilities and Community Care Access Centres (CCACs). And following a two-year review, MOHLTC is revising the funding model for long-term care facilities, i.e., starting to use interRAI data to determine the cost of care.
- In Alberta, the provincial government recently announced **five-year funding commitments** (with a 6% increase for each of the first three years and a 4.5% increase for each of the next two) and the introduction of **activity-based funding** starting with long-term care facilities in 2010/11 and moving into acute in-patient services, acute ambulatory services and designated assisted living in 2011/12 and beyond.
- In British Columbia, the provincial government announced its intention to adopt **patient-focused funding** in hospitals by 2012/13, with the goal of attaching up to 20% of "eligible" acute-care spending to patient volume and services provided; hospitals will compete for patients and be financially rewarded if they attract them by delivering high-quality services.

What we learned: 8 Points to consider

The Change Foundation reviewed the "what we know" and "what we think we know" from the literature, from the field (including experience articulated by symposium panelists), and from other provincial and international jurisdictions. We now offer the following observations on how to design funding models and payment systems that encourage providers to work together in delivering coordinated, integrated, comprehensive and high-quality care to patients as they move through Ontario's health system.

1. System-wide impact is critical.
   It is critical that strategic priorities and policy objectives for the health system be established and promoted. Funding arrangements and provider payment models must be designed to support strategic priorities and policy objectives — the "big dots" that executives, managers, policy-makers and providers are tracking to. A clear policy framework is needed to provide direction for funding arrangements and provider-payment models across sectors along the continuum of care — a framework that will make sense as we try to address patients' needs as they transition between different parts of the system (e.g., from hospitals to home or to long-term care facilities), or try to manage complex chronic conditions.

   Policy makers need to look out for the impact a new priority initiative may have on the entire system, not just on the area of focus. In the absence of a system-wide view, unintended consequences such as a decline in quality or access in areas that have not been identified as priorities may result. Strategies should lead to improvements in quality, not contribute to a culture of simply working-to-payment incentives. We know it is possible to be both technically efficient (to produce activity at a low cost) and wasteful (being efficient at things that don't need to be done).

   At the Local Health Integration Network (LHIN) level, a system-wide approach to planning and purchasing is also critical. The funding that Ontario LHINs currently receive is the sum of all of the current funding models of their providers — regardless of the drawbacks or benefits of each of these funding envelopes.

   The limitations of this approach are increasingly evident: (i) LHINs are limited to flowing money to health service providers rather than acting as true purchasers/ commissioners of health services;[1] (ii) the current structure and funding framework restricts population-based financial accountability and integration; and (iii) there is little incentive for LHINs to invest in health promotion and disease prevention given the current funding model.

   Further, LHINs currently have responsibility for only a small component of the primary care sector — i.e., Community Health Centres; they have no jurisdiction over fee-for-service (FFS) physicians or Family Health Teams (FHTs). In contrast, the Primary Care Trusts (PCTs) in England receive fixed capitation funding based on their population, have the built-in incentive to reduce demand for expensive hospital services by commissioning primary care services and investing in upstream services, and are true commissioners choosing between provider A and provider B.[2]

   Future refinements to the authority and accountabilities of regional bodies need to reflect the benefits of system-wide planning and commissioning.

2. Organizational span matters.
   Our health-care system does not behave as a single organizational unit with subdivisions — one of the key reasons it is so difficult to achieve cost minimization by delivering effective service in the most efficient manner and location. The concept of integrated health care was not in the forefront when the Canada Health Act was passed, mandating public funding for medically necessary hospital and physician services. Neither was it top of mind when the OHIP Schedule of Benefits was created or the legislative silos between hospitals, CCACs and long-term care constructed. Our provider-focused funding models are the result of historical developments and not part of a grand system design. How it functions today is a reflection of the behaviour that funders have incented over the years.

   Fully integrated health systems — such as Kaiser Permanente and the Geisinger Health System in the U.S. — have organizational alignment across the

1. The exception in Ontario is in the area of home care where CCACs are actually choosing between providers.

2. The new Secretary of State for Health in England has presented a White Paper to Parliament which outlines the new Government's intent to significantly change the structure and culture of NHS England, including transitioning the roles of the PCTs and devolving commissioning responsibility to GPs and practice teams.

continuum of care, and compatible incentives for patient-centred care that cross subdivision or business-unit boundaries. These are major strengths. Compare what happens in these integrated systems to how things currently stand in Ontario, where hospitals have incentives (and pressures) to discharge patients, and patients with higher-care needs may be "unaffordable" for CCACs. It would make more sense to consider the total cost of delivering care to a patient/client from a cross-organizational — or system — perspective.

Take, for example, a patient who receives services in primary care, spends time in hospital, then transitions back home with community support or into long-term residential care. In a "money follows the patient" approach, the budgets for serving the patient each step of the way would be combined — thus creating a huge shared incentive to find the lowest-cost option. If the care could be delivered more cost-effectively by one provider or setting than another, the difference in cost between the two could be recognized with some sort of "transfer price" concept. This would allow both of the providers or settings — as well as the patient — to benefit from the most cost-effective, highest-quality, patient-centred care pathway.

The Ontario Ministry of Health and Long-Term Care is starting to do some costing analysis with a cross-continuum focus (e.g., long-term care funding reform, Integrated Client Care project, etc.), but an overall framework is urgently required.

3. Include primary care in system planning.
Investments to expand and enhance primary care in Ontario are paying off for some patients and communities. However, without a strategy for integrating primary care with the rest of the health system, there is a risk of losing momentum for change and failing to maximize the return on investment. In many communities across the province, primary care practitioners and other health-care providers have attempted to collaborate to meet patient needs. But their attempts to cross traditional boundaries have been hindered by competing structural incentives and, for all involved, the lack of clear organizational mandates to make integration succeed.

Some LHINs have engaged primary care providers informally, but they lack a clear mechanism for supporting and funding new care models based in the community (e.g., primary-care driven strategies for aging at home, or for diabetes management). As well, new primary care models may be expected to pick up services that are downloaded from other organizations' budgets, particularly as hospital budget growth is restricted to address the provincial deficit.

Boundaries between primary care and other care providers can perpetuate inefficiencies and limit opportunities for care continuity, appropriateness and quality. Ontario can learn from other jurisdictions where primary care providers play a lead role in managing patients across the continuum of care. However, there is significant variation in the stages of development in the primary care sector in Ontario, and policy-makers will need to take this into account.

4. Blunt the effect of fee-for-service (FFS) payment models.
A review of high-performing health systems indicates the importance of moving away from a sole reliance on FFS and towards population-based funding and blended payment models.[3] In the U.S., one major strength of integrated delivery systems such as Kaiser Permanente and the Geisinger Health System lies in their physician governance and compensation arrangements. In these delivery systems, physicians are salaried employees (who have the potential to earn bonus payments). This strengthens their accountability for delivering evidence-based care, their uptake of new technologies, and integration with other health professionals.

In Ontario, two-thirds of physicians are funded through a form of FFS payment. However, physician surveys indicate that most of them favour alternative payment plans or blended payment approaches with components of capitation, FFS and bonus payments.[4] A recent TD Economics report[5] advocated for a change in the way Ontario's doctors are compensated — a move away from FFS billing towards a blended per capita, salary

3. G.Ross Baker, Ann MacIntosh-Murray et al., *High Performing Healthcare Systems: Delivering Quality by Design* (Toronto: Longwoods Publishing Corporation, 2008).

4. College of Family Physicians of Canada (CFPC), Canadian Medical Association (CMA), and Royal College of Physicians and Surgeons of Canada (RCPSC). 2007 National Physician Survey: Analysis in Brief (Ottawa: CIHI, March 2010).

5. TD Economics. *Charting a Path to Sustainable Health Care in Ontario: 10 proposals to restrain cost growth without compromising quality of care* (TD Bank Financial Group, May 2010).

and volume structure. The current agreement between MOHLTC and the Ontario Medical Association (OMA) ends in March 2012, and MOHLTC should seriously consider these conclusions and recommendations as it enters into negotiations for the next agreement.

5. Financial incentives alone cannot change culture.
   We know gaming is most likely to happen when the organizations and/or individuals for whom financial incentives are intended simply look for ways to maximize their income. There are various approaches to reducing or avoiding this. Some practice cultures — Kaiser Permanente, for one — appear to thrive without the micro-level incentives that are inherent in pay-for-performance (P4P) systems. Kaiser provides an example of other kinds of incentives that can influence behaviour — i.e., extensive use of peer review and feedback; a direct financial interest, for physician groups, in the overall financial success of the organization; outcome-based bonuses; the use of a 'polyclinic' model, in which referrals are made to different specialties without concern about FFS revenue; and a salary approach which allows for more flexibility to adapt to new technologies and care processes.

   Organizations and individuals have other values in addition to financial well-being. Different carrots, so to speak, are required for different values. We need to think about how to design non-financial incentives — incentives, for example, that appeal to a desire for excellence. Ideally, funding models and payment systems — augmented by *non-financial* incentives — would support a culture of quality and continuous improvement within organizations and professions.

6. Demonstrate a commitment to quality.
   A fundamental question is to what extent can we expect funding models and incentive schemes to influence quality and efficiency. A review of high-performing health systems suggests that incentive schemes don't play a prominent role in their achievements.[6] In other words, it could be more important to get rid of obviously perverse incentives than to imagine achieving granular control and impact by fine-tuning incentives. If the system obliges people to think only about money, they will think only about money. Great health systems seem to resolve perverse incentives most of the time, and create a culture where people focus on quality.

6. Baker, G.R. et al (2008)

7. Accountability and performance reporting must play a bigger role.
   Data, metrics and public reporting are recognized as key contributors to motivating providers and ensuring system accountability. As funder, the government needs to articulate its goals and policy objectives so that provider organizations can potentially align their resources, track to a key set of metrics, and, in a word — deliver. Accountability and reporting requirements need to be established and further developed to facilitate reporting on the impact of, and return on, investment; and on comparative provider performance.

   Currently, some sectors of Ontario's health-care system have more sophisticated data capacity and reporting systems than others (hospitals and CCACs, for example, compared to the primary care sector and community support services). Quality monitoring processes and performance reporting systems need to be developed, especially in primary care.

   The development of accountability and reporting requirements could facilitate:
   - the ability of government to make longer-term funding commitments (e.g., five-year commitments);
   - the ability of LHINs to manage discretionary funding to nurture integration opportunities;
   - the ability of provider organizations to pursue bundled funding opportunities;
   - the ability of primary care organizations to use targeted funding to advance LHIN and provincial priorities; and
   - the opportunity to expand existing experiments in integrated delivery systems (e.g., St. Joseph's Health System in Hamilton and Group Health Centre in Sault Ste. Marie).

8. Continuous Improvement applies to funding models.
   The cost-containment elements of global budgets are a key advantage of the Canadian hospital funding system over the U.S. model. Accordingly, some jurisdictions are experimenting with funding models that retain the cost-containment element of a global budget, and incorporate activity-based funding with incentives for efficiency. We need sophisticated funding and payment models that incent integrated, coordinated, comprehensive and high-quality care. The challenge is to

continuously improve our funding models by retaining the benefits we already have, and removing perverse incentives before considering the addition of new ones. Also, we need to consider whether new incentives will work on top of the existing ones; whether old incentives are still doing their job; and whether some providers may become "over-incentivized."

The way we fund organizations and pay providers matters. It directs activity and behaviour. A narrow focus on funding or payment models — be it for specific providers or sectors, or organizations within sectors, for specific interactions or conditions or without consideration of other influential factors such as culture and leadership — often results in unintended consequences. The design of our funding and payment models must be approached within the context of our whole health system, and cannot be compartmentalized. The right questions are starting to be asked, but we await the answers — and the follow-up actions.

APPENDIX 1:
Key findings from the literature

Unique incentives and disincentives exist for all funding and payment methods. In a paper published in 2008 in *Canadian Public Administration*,[7] Raisa Deber and her co-authors present a conceptual framework for categorizing the basis of provider payment as follows: (i) costs incurred, (ii) time spent, (iii) services delivered, (iv) population served, and (v) outcome achieved. The paper describes the inherent incentives and disincentives associated with each. For example, a payment method based on services delivered such as the FFS model — the prominent reimbursement model for most medical care — emphasizes volume over quality, and encourages episodic care instead of coordinated care across providers and over a period of time. Table 1 (page 9) presents a description of incentives associated with the various reimbursement models along the patient journey in the Ontario context.

The terminology for different payment methods is complicated. For example, "service-based funding" (SBF) is a method that reimburses hospitals based on the episodes of care for which patients are admitted and on the type of services or procedures performed. Funding is administered according to an agreed-upon volume of services at a set price/rate per service (usually with rate adjustments for factors such as rurality and academic mandate). SBF relies heavily on an understanding of what constitutes a case (how cases may be grouped clinically), and on relative resource use, which is often based on case-mix groups (CMGs), day procedure groups (DPGs), or diagnosis-related groups (DRGs).[8,9] Accordingly, related terms and variations of an SBF model include case-mix funding, activity-based funding, volume-based funding, payment-by-results, and patient-focused funding or — the term used most recently in Ontario — patient-based funding. SBF models have been criticized as leading to "procedure-driven" health care rather than comprehensive and integrated care.

There are links and overlaps among different types of payment methods. For example, pay for performance (P4P) programs are typically structured as bonus schemes, supplying additional funding to organizations and physicians who meet criteria or targets related to service volumes or timeliness. For example, the U.K.'s payment by results program (PbR) was an "extensively documented application of patient focused funding."[10] The distinction between SBF and P4P, at least theoretically, is that P4P involves a direct link between providers' or institutions' performance and their compensation — how *well* they perform — and SBF involves a direct link between an institution's volume of activity and its financing — how *many* services are performed.[11] P4P schemes have generally been associated with increased performance reporting and greater accountability in the area specifically targeted for results.

Incentives inherent in one provider payment method can be incongruent with incentives for other providers. As Deber and her co-authors describe:

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7. Raisa Deber, Marcus J. Hollander, and Philip Jacobs. "Models of funding and reimbursement in health care: A conceptual framework," *Canadian Public Administration* 51:3 (2008): 381-405.

8. Association of Canadian Academic Healthcare Associations (ACAHO), Canadian Health Services Research Foundation (CHSRF), Canadian Medical Association (CMA). Service-based Funding and Paying for Performance — A Briefing, 3rd Annual EXTRA CEO Forum, February 16, 2009.

9. CMA Ad Hoc Working Group on Patient-Focused Funding. Patient-Focused Funding and Pay-for-Performance: A Discussion of the Concepts and Experience (Canadian Medical Association, July 2007).

10. CMA Ad Hoc Working Group 2007, p. 3.

11. ACAHO, CHSRF, CMA, 2009.

- → Hospitals funded on global budgets have incentives to limit the volume of cases, whereas physicians funded on the basis of services have incentives to increase volumes.
- → Hospitals with case-mix funding have incentives to discharge people quickly to increase the turnover rate; long-term care facilities funded on a standard cost-per-bed basis have an incentive to admit clients with lower level-of-care needs; and home-care providers paid on a flat fee per visit have an incentive to maintain existing cases, particularly those who can be cared for in less time than the standard visit.

There are advocates for and against various funding models. For example, service- based/patient-based funding was endorsed in the 2002 Kirby report. The Canadian Medical Association (CMA) emerged as a strong proponent; and the Ontario Hospital Association (OHA), in partnership with a number of provincial community-based organizations, also endorsed the model.[12] However, the Canadian Healthcare Association, the Association of Canadian Academic Healthcare Organizations, Canadian Doctors for Medicare and the Council of Canadians have criticized it.[13] In response to the Ontario government's commitment to patient-based payment, the Ontario Hospital Association has recently declared its continued support of this model (or SBF) and has articulated elements of an effective patient-based payment plan.[14]

Blended payment models appear to be an ideal approach. As Deber and her co-authors conclude, the selection of funding models will vary, depending on policy goals and service and organizational models. "Funders need to decide whether they are concerned with over-use, under-use or mis-use, and the extent to which they are willing to leave decision-making authority with providers."[15]

"The most common remuneration recommendation is a mixture of capitation, fee-for-service and program funding to encourage professionals to provide co-ordinated, comprehensive care with a focus on prevention."

— (Health Policy Monitor/Canadian Policy Research Network; 2004).

There are close links between quality, efficiency, demand management and the structure of the health-care payment system.[16] Pressure to control health spending has been the impetus behind payment reform in most jurisdictions. More sophisticated payment models will be required as governments face the difficult challenges of balancing quality, efficiency and demand.[17]

12. Ontario Hospital Association (OHA). 2009 (February). Protecting Access and Quality in our Health Care System: Advice to Government on Funding and Capacity Planning Policy in Ontario. OHA, Ontario Association of Community Care Access Centres (OACCAC), Ontario Long-Term Care Association (OLTCA), Ontario Federation of Community Mental Health and Addiction Program (OFCMHAP), Ontario Association of Non-Profit Homes and Services for Seniors (OANHS).

13. See ACAHO, CHSRF,CMA, February 16, 2009 for a summary of the criticism and reference documents.

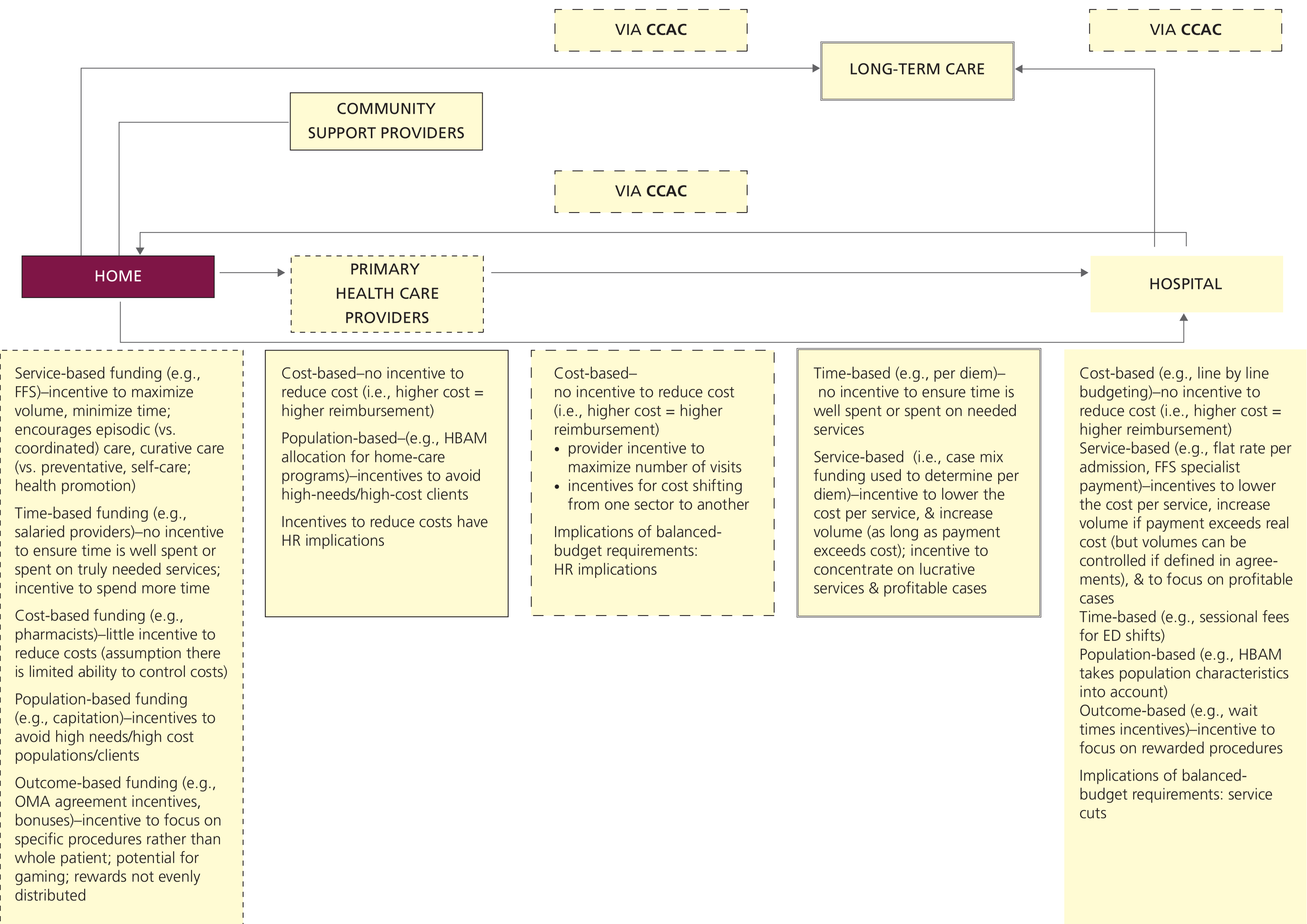
14. See: Tom Talks — Patient-Based Funding and Competition; March 4, 2010.

15. Deber, Hollander, and Jacobs 2008, p. 401.

16. PricewaterhouseCoopers' Health Research Institute. You get what you pay for: A global look at balancing demand, quality, and efficiency in healthcare payment reform. (PricewaterhouseCoopers International Ltd., 2008)

17. PricewaterhouseCoopers 2008.

Table 1: Inherent Incentives Associated with Resource Allocation/Reimbursement Models along the Patient Journey



APPENDIX 2:
Summary of key learning from international case studies

U.K. CASE STUDY

The Change Foundation was interested in England's experience with commissioning for primary care on the basis of a set of quality outcomes via the Quality and Outcomes Framework (QOF).[18] The following is a summary of key findings from the case study prepared by Dr. David Woodhead, Incentives to improve primary care: critiquing the Quality and Outcome Framework in England.

Note: Since this case study was commissioned, the new Secretary of State for Health has presented a White Paper to Parliament which outlines the government's intent to significantly change the structure and culture of NHS England. Proposed changes include the development of quality standards by the National Institute for Clinical Excellence to inform the commissioning of all NHS care and payment systems, paying providers according to their performance, devolving commissioning responsibility to GPs and practice teams, and transitioning the roles of strategic health authorities and primary care trusts. At this point, it is not clear how the QOF will be impacted by components of the White Paper and impending legislation.

One significant difference between Ontario's Local Health Integration Networks (LHINs) and England's Primary Care Trusts (PCTs) is that the PCTs establish contracts with general practitioners. According to the author, the PCTs view this contract relationship as one of the most challenging and potentially most beneficial to the health of the local population. The GPs are remunerated through a blended payment system, including pay-for-performance payments through the QOF, with objectives to improve the general quality of primary care and eliminate practice variation across providers.

Evaluation of the QOF is still in early stages, but emerging research is pointing to its impact and some red flags:

- There has been an extraordinary increase in GP income as a result of the QOF.
- The framework has been successful in focusing GPs on areas of practice that had previously been neglected.
- For conditions that are not linked to incentives, early research is indicating that the quality of care has declined.
- Areas of focus are in disease management, not prevention – there have been calls to provide GPs with incentives to take a much more proactive role in disease prevention and health promotion.
- Some research has suggested that continuity of care has been reduced since the introduction of the QOF scheme.
- There do not appear to be any requirements or incentives for primary care providers to work with other partners in the community, i.e., QOF does not appear to provide a mechanism for PCT commissioners to better align community goals with other parts of the system.
- The framework has been a significant driver in improving IT systems.

Whether the QOF has resulted in improvements in quality remains a hotly debated topic. Evaluation efforts are complicated — given the challenge of defining quality, the focus on process measures, and variables outside the framework itself that contribute to quality improvements. The case study concludes that the QOF must be understood in the context of a raft of other health reform initiatives, and that the framework's effects on tackling inequality, promoting health, reducing the burden on secondary care, and linking to other areas of social policy remain underdeveloped.

U.S. CASE STUDY

The Change Foundation was interested in learning about Federally Qualified Health Centers (FQHCs), which constitute the single largest national network of primary care in the U.S. and offer an ever-expanding menu of primary, ancillary and specialty services. The following is a summary of key findings from the case study prepared by Joni Steinman, A U.S. case study: Federally Qualified Health Centers (FQHCs).

18. PricewaterhouseCoopers, in its report, *You get what you pay for*, which surveyed 200 executives in 20 countries, referred to QOF as "the most promising" of the pay-for-performance systems to embed quality and efficiency incentives.

FQHCs were of interest for a case study for a number of reasons:

- They received $2 billion in stimulus funding under the American Recovery and Reinvestment Act of 2009, and the health reform legislation (The Patient Protection and Affordable Care Act, 2010) will further enshrine a leadership position for FQHCs (i.e., $11 billion over five years for expansion of capacity and services.).
- They are governed by community boards, typically serve high-need communities, and must meet performance and accountability requirements.
- They have unique financing structures, leveraging federal, state, county, city and other funding sources.

This case study highlighted a number of observations:

- Ease of access and referral to specialty care continue to pose challenges for the FQHCs — some FQHCs have worked together, locally and regionally, and have also established alliances with other providers to improve continuity of care.
- Improved referral practices can sometimes mitigate funding disparities between primary care and specialty providers.
- Visit-based reimbursement (with 15-minute limits) does not permit FQHCs to address disease management generally, and it restricts the ability of FQHC practitioners to get medically necessary care for their patients, i.e., diagnostic, specialty or hospital care.
- FQHC providers have used ingenuity to promote and achieve integration and continuity of care, in the face of funding policies that appear to have been devised without adequately considering the implications for patients.

Accountable Care Organizations (ACOs) would be another interesting focus for a U.S. case study. ACOs are mandated to manage the full continuum of care and be accountable for the overall costs and quality of care for a defined population. Different forms of ACOs include physician/hospital organizations, multi-specialty practice groups, independent practice associations, and virtual interdependent networks of physician practices. ACOs emphasize alignment of provider incentives and accountability for providers across the continuum of patient care. ACO payment models include combinations of FFS, capitation and performance payments. As reported in a recent *New England Journal of Medicine* paper (supported by the Commonwealth Fund), ACOs need a strong foundation of high-performing primary care to succeed.

(See: Diane R. Rittenhouse, Stephen M. Shortell, and Elliot S. Fisher (December 10, 2009) “Primary Care and Accountable Care – Two Essential Elements of Delivery-System Reform,” *New England Journal of Medicine*, 361;24.)

APPENDIX 3:
Summary of symposium, *Tools for Change: Levers and Incentives for Integrating Patient Care in Ontario*

The April 26, 2010 symposium, *Tools for Change: Levers and Incentives for Integrating Patient Care in Ontario*, was designed to facilitate discussion among planners, provider organizations, health policy-makers, and decision-makers on how funding and payment systems can positively or adversely affect the provision of integrated care to patients. The central question of the symposium: how do we create funding and incentives that encourage providers to deliver seamless, coordinated care for patients across all settings?

We know from research that there are other important complementary factors beyond financial incentives that contribute to integrated care systems (e.g., leadership and culture). However, this symposium focused on funding and payment systems, and their associated intentional or unintentional incentives and disincentives that influence interactions with patients.

The symposium was attended by an engaged audience of almost 100 health-care leaders from provincial associations, purchaser and provider organizations, MOHLTC, and academic/research organizations. The agenda included presenters from other jurisdictions, notably Howard Dean, former Governor of Vermont, and Mike Conroy, Executive Vice President of Corporate Services for Alberta Health Services. Other presenters included panelists from Ontario's primary care, hospital and community care sectors, commentators from the Local Health Integration Networks (LHINs), the Community Care Access Centres (CCACs), and the Ontario Hospital Association (OHA) as well as speakers profiling new initiatives in the province. (See: www.changefoundation.com for links to the presentations.)

The following is a summary of what we heard during symposium presentations and panel discussions.

Howard Dean's opening comments about recent health reform **developments in the U.S.** and his experience as a family physician stimulated an animated discussion about initiatives to achieve improvements in the areas of quality, access and affordability. He identified two key points of relevance to the focus of the symposium: FFS (fee-for-service) reimbursement models, and vertically integrated delivery systems.

Dean reiterated the well-known caution that fee-for-service models drive up volumes, contribute to inflationary health system costs, and do little to advance quality and prevention. In response to a question about whether the recently announced patient-based payment initiatives planned for Ontario hospitals could result in similar problems to those associated with FFS models, Dean responded that it would be "exceptionally foolish" to pursue fee-for-service reimbursement methods, given the associated perverse incentives for over-servicing and increasing volumes. This debate about whether SBF (service-based) approaches based on CMGs and DRGs (case-mix groups and diagnosis-related groups) suffer the same perverse incentives as FFS models is common in the literature as well.

Dean advocated vertically integrated delivery systems with stronger connections and accountability among primary care, acute care and specialty care, as well as diagnostics, laboratory, pharmacy services and community care. He referred to Kaiser Permanente — known for its "one-stop shopping" model. Kaiser Permanente's strategies for integrated care include a team approach; active management of patients at all stages; use of care pathways; use of hospitalists and discharge planners; promotion and support for self-care; and a state-of-the-art information system that facilitates these strategies.

Fully integrated delivery systems like Kaiser Permanente and Geisinger Health System have key advantages in terms of organizational alignment and incentives for patient-centred care. A major strength of these systems from the policy-design perspective is their physician governance and compensation arrangements: physicians are salaried employees of the health system (with potential bonus payments based on performance and administrative duties), rather than independent contractors as in most of the Ontario system. This has major advantages in terms of both reducing the reliance on fee-for-service reimbursement, and strengthening accountability for delivering evidence-based care, uptake of new technologies like electronic health records, and integration with other health professionals.

Mike Conroy of **Alberta Health Services** (AHS) spoke to his province's experience with activity-based funding (ABF) and primary-care funding. He noted that Alberta's adjusted per capita provincial expenditure on health is the highest in the country. He also noted that the cost-containment elements of global budgets are a key advantage of the Canadian hospital funding system over the U.S. model.

The Australian approach to activity-based funding, which is currently being considered in Alberta, retains this global cost-containment structure while strengthening incentives for efficiency within the overall envelope.

AHS will establish funding modifiers (to account for rural/remote considerations, teaching mandates and capital equipment requirements), and is developing quality-monitoring processes. The question remains as to if, and how, ABF can be combined with population-based funding. Conroy described some of the unintended consequences of implementing ABF: gaming with the coding, inappropriate services and admissions, a degree of risk selection, concerns about managing to activity, and – on the positive side – reduced funding for services in inappropriate settings.

Currently, 33 Primary Care Networks (PCNs) cover 66% of the Albertan population, and nine more are under development. The networks were introduced in 2003 through a trilateral agreement among the Alberta Medical Association, Alberta Health and Wellness, and the regional health authorities. The PCNs establish a formal relationship between physicians and the health region (now Alberta Health Services) to collaboratively plan and deliver health services based on population needs. PCNs were developed to better integrate health-care delivery across the continuum of care, including specialty, acute and long-term. Conroy described the funding supports to PCNs, including enrollment incentives, electronic medical record (EMR) supports and tele-health investments, alternative funding arrangements, and a transition fund. He offered two cautions: (i) plan for and require accountability through performance reporting; and (ii) design primary care so that it is more integrated with other health services.

Primary Care Panel

The symposium's Primary Care Panel included speakers from three Family Health Teams (FHTs). This focus on FHTs was deliberate. They are a key component of the provincial government's primary health-care reform agenda. We wanted to hear about their challenges and barriers, about disincentives associated with funding and payment methods, and innovations to address these barriers.

The introduction of blended payment models and the creation of FHTs in Ontario has significantly reduced the number of people without access to a primary care provider, and laid the foundation for improving quality through interprofessional collaboration and information management. However, there is still a strong divide between primary care and the rest of the health system. While some LHINs have engaged primary care providers informally, they lack a mandate to formally include primary care in planning initiatives and a mechanism for supporting and funding new care models based in the community. Almost all FHT funding is requested and approved by the Ministry on a line-by-line basis, reducing FHTs' ability to respond to local needs using unique local resources.

In many communities, primary care and other health-care providers have attempted to collaborate to meet patient needs. But initiatives that try to cross traditional provider boundaries have been hindered by competing structural incentives and the lack of a clear mandate for either organization to make integration successful.

Bill Casey described Peterborough Networked Family Health Teams' efforts to work with its community partners to develop an integrated primary, specialty and hospital care program to identify and manage at-risk vascular patients. Elements of the program include outreach to high-risk patients, screening, diagnosis, triage to appropriate care, treatment to guidelines-based targets, education, self-management and follow-up.

Funding from partners in the private and not-for-profit sectors was secured in December 2008, along with a funding commitment from the LHIN. However, since there was no direct accounting relationship between the LHIN and the Networked FHTs, the funds could not flow directly to the FHTs — a new arrangement had to be found. The project was set to go in April 2009, but it wasn't until five months later, in September, that the LHIN arranged to flow funding to the local hospital. The private and not-for-profit funding was transferred to the hospital and from the hospital to the project that month. But the LHIN contribution — the bulk of the funding — was further delayed. It flowed to the hospital in September, but didn't move from the hospital to the project until January 2010. As a result, what was originally a two-year project became a 14-month project — but with the same deliverables. The funding is in place until March 2011 but an additional 10 months will be required to follow patients as planned, and to fully demonstrate the potential impact of the program.

As primary care continues to develop in Ontario, the Ministry, LHINs and hospitals seeking to partner with primary care providers will be challenged by the diversity of the sector. Approximately 75% of the province's 9,000 practising family physicians are in blended-capitation payment models. However, this includes a significant number — those in solo practice or in Family Health Groups,

for example — who are predominantly reimbursed via FFS with nominal capitation incentives. This is not indicative of multidisciplinary and collaborative models of care, which are more characteristic of the FHT model, and also of Family Health Network (FHN) and Family Health Organization (FHO) models.[19]

To give a sense of scale, about 750 physicians are working in FHTs. Even within the FHTs and capitation groups there is tremendous variation — in particular, smaller FHTs and capitation groups have struggled to become effective clinical teams and adopt the latest technology. For MOHLTC, new policies for primary care face the significant challenge of being applied to a sector that is at different stages of development across the province. For LHINs and hospitals, it can be hard to identify which primary care providers are currently practising in a community, let alone their models of care or levels of technology adoption.

Ross Kirkconnell described the **Guelph Family Health Team**'s experience with its International Normalized Ratio (INR) clinic, reflecting that his comments reiterated concerns expressed by Howard Dean about the FFS funding model and the lack of vertically integrated delivery systems.

The traditional approach to INR management is for patients to be sent to a lab to have their blood drawn, the lab calls the doctor with the results, and the doctor calls patients with instructions for any medication changes. In this scenario, the doctor bills OHIP for monitoring (G-code), and the lab bills OHIP for INR testing (L-code). With a pool of 70,000 patients, the Guelph FHT thought there were opportunities to improve system efficiency, and patient and physician satisfaction. Their innovation was an INR clinic staffed by nurses, where patients' fingers were pricked, the blood put on test strips, and the patients informed, through the use of medical directives, of whether changes to their medication were required. The FHT doctor billed OHIP for monitoring and also for the L-code, using this to reimburse the clinic for the cost of the lancets and test strips. They have demonstrated that 80% of patients have INR levels within range (compared to 55% in traditional INR management).

19. A brief description of the reimbursement models: Family Health Group (FHG) — FFS with bonus payments for specified preventative services, with few governance requirements; Family Health Network (FHN) and Family Health Organization (FHO) — blended capitation with FFS payment system; Family Health Team (FHT) — blended salary model; and Community Health Centre (CHC) — salary model.

However, the Guelph FHT was informed by MOHLTC that claims submitted by physicians for services performed by someone not employed by the physician are not payable. The Ministry's policy review process to enable this point-of-care testing through the use of medical directives was initiated two years ago. A policy change has not yet been announced.

Joy Galloway described the **Timmins Family Health Team**'s experience of establishing a common IT system for staff across four sites and EMRs (electronic medical records) for 22,000 rostered patients. The OntarioMD program provides incentives to physicians: a one-time payment of $2,000 to buy a computer with attendant software; a monthly stipend of $600 for three years for operating and updating the system; and a one-time performance bonus of $2,500 for establishment of an EMR for two-thirds of rostered patients. In total, physicians can get approximately $25,000 to assist with technology enhancements.

> "We have the system we've incented… if we want something different we will have to incent it differently."
>
> — Kevin Smith

Key issues highlighted were the lack of connectivity standards and accountability requirements. The Timmins FHT has struggled with connectivity problems, i.e., since 2006 when incentives were first provided through OntarioMD, the FHT's 24 physicians have purchased computers and software from nine different vendors. In some cases, doctors had technology that was incompatible with computers in other organizations or used by other physicians. The four sites are now connected and quality management standards are being established.

Hospital and Community Care Panel

The Hospital and Community Care Panel included Kevin Smith (President and CEO, St. Joseph's Health System, Hamilton), Bonnie Adamson (President and CEO, North York General Hospital) and Cathy Szabo (CEO, Central CCAC).

St. Joseph's Health System (SJHS) in Hamilton is one of the largest health-care corporations in Canada, with member organizations that include home care, long-term care, complex continuing care, rehabilitation services and acute, specialty and tertiary care. SJHS is probably the

closest model Ontario has to a Kaiser Permanente type of integrated delivery system, save for the significant absence/minimal participation of primary care. As noted by Smith, it is an experiment in progress that has provided the organization's leadership with a broader appreciation of the unique cultures, and sometimes the parochialism, of member organizations.

Smith argued that there is no perfect way to compensate providers but that SJHS — and the government — will be challenged to look at how providers across the continuum of care are compensated. He advocated for more robust remuneration models: salaried models with guarantees, competitive compensation for clinical leadership roles, bundled funding where the dollars follow the patient, performance funding where providers share bonus payments, etc. Given the current fiscal pressures in the provincial health system, he suggested that the options are to pay fewer people or pay people less (i.e., pay less-expensive providers to do the same work). He suggested that the days of government absorbing unlimited costs are coming to an end; and that there is an opportunity for government to exert some economic control, but this will take political courage. He said we should look at both incentives and penalties in efforts to finance integrated delivery systems.

Smith also reflected on the importance of data, metrics and public reporting to motivate providers and ensure system accountability — "reputation incentives."[20] It was noted that reporting and accountability requirements have not been part of recent investments in primary care and in FHTs, making it difficult to determine the impact and return on investment (ROI) of recent policy decisions and investments. The goals and policy objectives of the government — as funder — need to be articulated so that provider organizations can potentially align resources, track a key set of metrics, and deliver on the government's objectives.

Bonnie Adamson and Cathy Szabo described the joint efforts of North York General Hospital (NYGH) and Central CCAC to consider their service delivery to Alternative Level of Care (ALC) patients from a systems perspective — and improve it. Using lean methodologies, the partnership documented that only 12% of the total steps in the NYGH/CCAC patient placement process were value-added; 74% of the total process was wait time; 138 "handoffs" were required to discharge one patient; and 45 distinct functions were involved in transitioning one patient to the community. A number of QI initiatives has resulted in a 46% reduction in the number of days waiting for a long-term care placement and a 150% improvement in the availability of equipment for patients being transferred into the community. In addition, this joint project with the CCAC has had a significant impact on the culture of North York General. Previously the hospital's culture was to automatically work to send patients to long-term care facilities, whereas now the orientation is to try to send them home with supports.

Szabo described the CCAC's *Home First* initiative, which accepts up to 15 clients from NYGH and four clients from Sunnybrook Health Sciences Centre. The program provides an enhanced level of CCAC services to allow ALC hospital patients to return home safely, and it provides them and their families with more time to make decisions regarding long-term care options. Szabo reviewed the Home First metrics from the NYGH clients and said they seem to indicate that the program is successful but costly.

She articulated that funding is project based, with project-specific reporting requirements. She advocated for longer-term funding commitments with accountability requirements, and with flexibility in opportunities to bundle funding.

From the hospital perspective, Adamson highlighted a number of funding recommendations that would have a positive impact on the continuity of care for patients: (i) funding should follow the patients as they move across the currently separately funded sectors along the care continuum; (ii) extra funding should be available when providers initiate integration projects; (iii) funding should be realigned to support CCAC resources in the community; and (iv) a framework of both financial rewards and penalties should be developed.

This partnership effort suggests that it would be sensible to combine budgets for serving patients who spend time in hospital and are on their way to the community or long-term residential care. As things now stand, hospitals have incentives (and pressures) to discharge patients, whereas patients with higher-care needs may be "unaffordable" for the CCAC. A combined or bundled budget would create an incentive to find the lowest-cost option.

20. As noted in the EXTRA CEO Forum briefing paper (see footnote 8), available evidence supports the effectiveness of financial and reputation incentives in improving quality (p.14).

New Directions in Ontario Panel

Brian Golden, a professor of strategic management at the University of Toronto's Rotman School of Management and a health-care strategy consultant, described both the current state and the fully realized model planned for the Integrated Client Care (ICC) Project. Currently, the CCACs manage separate contracts with multiple providers delivering various services to the same clients. Payment is per unit of service or visit, and providers generally do not coordinate with each other. The ICC Project is moving in the direction of a single contract to a lead provider agency to coordinate services based on client needs. Payment will be based on client complexity and needs, and the CCAC's role will be to evaluate outcomes and coordinate care with providers in other sectors.

The project has grappled with a number of concepts related to the funding model. For example, a core principle is that "money should follow the patient/client," rather than funding sector-specific units of service. For community services such as home care and social care, a client-based envelope approach seems like the most effective — i.e., allocate a pot of money to clients based on their needs and have the flexibility to use this money across the continuum of both health and social interventions. The challenge will be to operationalize this concept.

A related concept is that of "transfer pricing." With transfer pricing, the health system would be treated as one large organization with many different arms or business units. These units would need to consider the total cost of delivering care to a client/patient from the total organizational perspective. If care could be delivered more cost-effectively by one provider or setting than another, the difference in costs between the two would be recognized with a transfer price. This would allow both of the providers/settings to benefit in the end from the most cost-effective care pathway.

Tai Huynh, Director of MOHLTC's Excellent Care for All Strategy, spoke about future funding directions for Ontario from the Ministry of Health and Long-Term Care's perspective. The Ontario budget outlined a multi-year plan to decrease growth in health spending from the average 6% annual rate of growth to 3.1% by 2012/2013. Huynh noted that the policy challenge for the Ministry and government is how to ensure appropriate access to high-quality health services while containing growth in expenditures.

Canadian Institute for Healthcare Information (CIHI) data was presented to illustrate that the supply-side cost-containment efforts during the recession in the 1990s were followed by a steeper rate of growth from 2001 to 2009. Public Accounts data was reviewed to demonstrate the steady trend towards more population-based funding models. Huynh said a Ministry task force, established to identify and quantify waste in the health-care system, highlighted how the largest areas of waste from a cost and outcome perspective (i.e., unplanned re-admissions, ambulatory care sensitive conditions) occur in the transitions in care between sectors.

As indicated in the Speech from the Throne and the budget, the government and the Ministry are committed to pursuing reforms to ensure health system sustainability. Huynh acknowledged that looking at how we pay our health system providers is a critical step in such reform.

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Read our Strategic Plan 2010,
Hearing the stories,
changing the story

THE CHANGE FOUNDATION

The Change Foundation is an independent policy think tank, intent on changing the health-care debate, health-care practice and the health-care experience in Ontario. It leads and leverages research, policy analysis, quality improvement and strategic engagement to enable a more integrated health-care system in Ontario designed with individuals and caregivers top of mind.

VISION

To be Ontario's trusted advisor advancing innovative health policy and practice.

GOAL

- To improve the experience of caregivers and individuals as they move in, out of, and across the health-care system over time.
- The Foundation will adopt a participatory approach to the following four methods: research, policy analysis, quality improvement, and engagement.

MISSION

- To make caregivers and individuals in need of health care part of the health-care discussion about how to find solutions to improve their experiences.
- To stimulate new ways of thinking, behaving, and interacting to foster improved health care for people, especially when they are in transitions.
- To generate robust and independent research and policy analysis of health-care issues related to improving the experience of individuals and caregivers as they navigate the health-care system.
- To lead informed discussion and strategic engagement with the stewards, stakeholders and users of the health-care system.

MANDATE

To promote, support and improve health and the delivery of health care in Ontario.

VALUES

Excellence. We strive for excellence in all we do. Innovation. We take innovative approaches in developing new ideas. Collaboration. We work in partnership with others to achieve success. Inclusivity. We strive to include all voices and views.