

Hip & Knee Bundled QBP

Overview and Information Required to Submit a Nomination Form

October 16, 2017

Health System Quality and Funding Division
Ministry of Health and Long-Term Care

Webinar Objectives

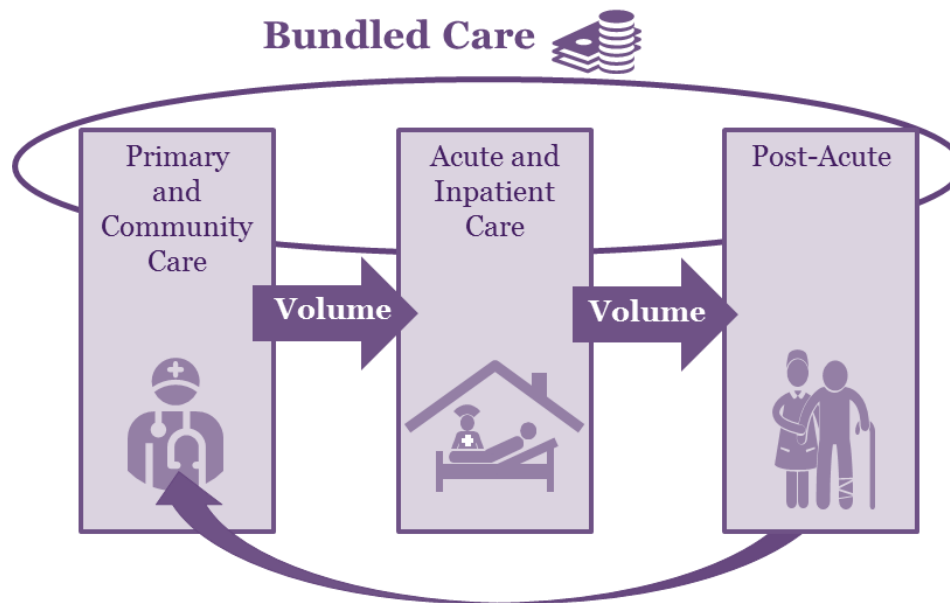
Today, we will discuss:

- Provincially defined standards for the hip & knee replacement bundled QBP, specifically:
 - Clinical pathway and scope of the bundle
 - Price and pricing approach
 - Outcome measurement and reporting requirements
- Parameters for site selection & participation, and;
- Next steps/timelines

Detailed policy and implementation guidance will be provided through further documents and webinars to teams who express interest in participation by submitting a nomination form.

Bundled care

- Bundled models provide a single payment for an episode of care across multiple settings and providers.¹
- With bundled care:
 - Care is integrated to create seamless transitions and ease a patients' move from hospital to home
 - Providers share risks and gains, incenting collaboration and integration.
 - Providers are accountable for quality outcomes (value-based care)



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

Integrated Funding Models: A single payment for an episode of care spanning multiple settings and providers

Status Quo



IFM Bundle

Integrated Health Care Team



Integrated funding models are underway in six sites:

South West LHIN (London Health Sciences Centre, SW CCAC) –

“Connecting Care at Home” - COPD and CHF Patients

HNHB LHIN (LHIN-wide, led by St. Joseph’s Health System) – “Integrated

Comprehensive Care 2.0” - COPD and CHF patients

Central West LHIN (William Osler, CW CCAC) – “Hospital 2 Home” -

Nursing-sensitive conditions (Cellulitis and Urinary Tract Infections (UTI))

Mississauga Halton LHIN (Trillium Health Partners) – “Putting Patients at

the Heart” - Cardiac Surgery

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

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

Pilot goals:

1. **Promote patient-centred care across the care continuum:** Through establishing one plan of care that is entirely seamless to the patient
2. **Improve quality and reduce unwanted or unwarranted variation of patient care pathways:** Through adopting best practices and through introducing outcome-based measures
3. **Inform policy:** Through testing innovative delivery of bundled hospital and community-based care and integrated payment models focused on value

The IFM pilots have shown early signs of improved outcomes*:

- Two sites cut their readmission rates by over 25%
- One site has reduced length of stay by 50%
- One site has cut their ED visit rates in half

*Notes:

1. Preliminary, self-reported data, not to be used in publication
2. Based on Q1 data for the period of June 2017 – August 2017

Plan for spread and scale; starting with the implementation of the bundled hip and knee replacement QBP

Why hip and knee replacement?

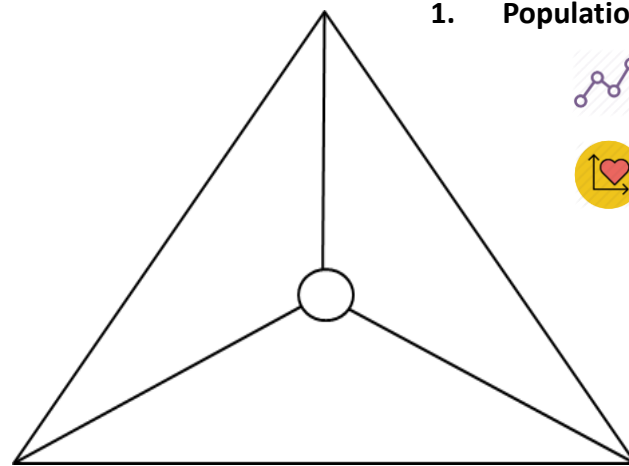
- The ministry is initiating the scale and spread of bundled care with hip & knee replacement surgery because it is a clearly defined episode of care, with accepted best-practices and a jurisdictional precedent for bundling.

What is being offered?

- The bundled hip and knee replacement QBP is an extension of the existing surgical QBP into a bundled model. This bundle will **bridge a patient's episode of care from the acute phase to post-acute phase.**
- Each LHIN is being offered the opportunity to identify cross-provider teams to participate in a **voluntary year of bundled care for hip & knee replacement surgery.**
- Teams will begin working together in November 2017 and **the bundled price will be introduced on April 1st 2018**, for the full FY18/19 fiscal year.
- The hip and knee replacement QBP bundle has a **standardized patient cohort, price and outcome measures.** Standardizing these elements only allows for **local flexibility** in service delivery and provider mix.

Objectives of the bundled hip and knee replacement QBP

The objectives of the hip and knee bundled QBP are aligned with the triple aim approach...



1. Population Health



Reduce variation in access to an appropriate form of post-acute services



Improve outcomes for patients (e.g. reduced revision rates)

3. Per Capita Cost



Reduce utilization (e.g. appropriate surgeries, reducing emergency department visits, hospital readmissions)



Improve efficiency through more integrated use of resources, and improved value for money (e.g. shift towards day surgery when/where appropriate while maintaining quality; shift away from inpatient rehab appropriately)



Develop a payment model that supports quality dimensions

2. Experience of Care



Ensure better integration across services for patients, their families and caregivers

And...



Inform policy direction to move toward other episodic surgical services



Support innovation in service delivery

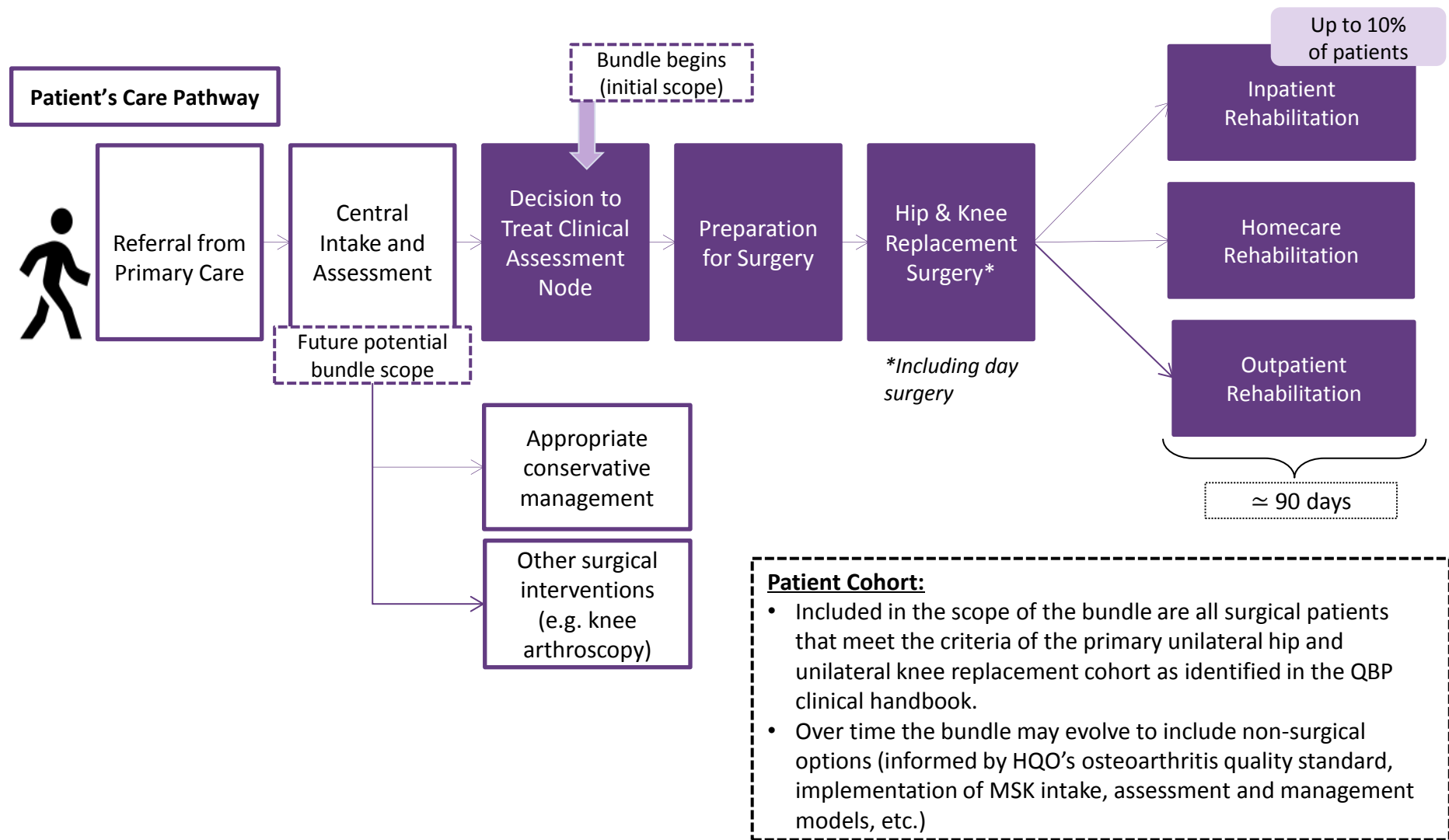
HIP/KNEE BUNDLED QBP DESIGN

The following section outlines the provincially defined standards:

- ✓ Clinical pathway and scope of the bundle
- ✓ Price and pricing approach
- ✓ Outcome measurement and reporting requirements

All standard elements of bundle design have been endorsed by the Hospitals Advisory Committee and the Hip and Knee Bundled QBP Task Group¹

Hip & knee replacement bundle pathway



Pricing approach for the bundled hip and knee replacement QBP

An **introductory bundled QBP price** has been set, using the QBP pricing methodology for elements of the pathway that have already been priced. **No new carve-out** will result from participation in the bundled model in FY18/19.

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

- The bundle price is built so that **every surgical patient** can receive post-acute rehabilitative care, **according to best practice***;
- Elements of the pathway have been weighted according to best practice and current utilization;
- The outpatient rehab component has been priced based on the Rehab Care Alliance best practice framework and;
- The price will exclude readmissions and revisions; outcomes will be monitored and tracked to inform future bundle scope

FY 18/19 is an introductory year; the price will evolve over time as data gaps are filled

| Hip and Knee Bundled QBP Pricing Model | | | | | | | | |
|--|----------------------|------------|------------------------------|--------|------------------|--------|------------------|--------------------|
| | Acute / Surgical | Post-acute | | | | | | Total ² |
| | | weight | IP rehab | weight | Homecare | Weight | OP rehab | |
| Hips | \$8,605 ¹ | + | (10% x \$6,184) ¹ | + | (36% x \$682.51) | + | (54% x \$299.52) | = \$9,630.84 |
| Knees | \$7,666 ¹ | + | (10% x \$5,590) ¹ | + | (48% x \$618.45) | + | (42% x \$249.60) | = \$8,626.69 |

The Ministry will flow funds to the LHIN and will not prescribe the bundle-holder. The bundle holder is responsible for transferring funds to partners and is accountable to work with those partners to deliver the in-scope services.

*Best practices outlined in:

- Clinical handbook for primary hip and knee replacement. Toronto: Health Quality Ontario; 2014 February. 95 p. <http://www.hqontario.ca/evidence/publications-and-ohrac-recommendations/clinical-handbooks>; and
- Rehabilitative Care Best Practice Framework for Patients with Primary Hip and Knee Replacements; 2017 March. http://www.rehabcarealliance.ca/uploads/File/Initiatives_and_Toolkits/QBP/RCA_TJR_Rehab_Best_Practice_Framework_March_2017_.pdf

Additional notes:

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

Reporting, outcome measurement and evaluation

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

What indicators will be evaluated?

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

**Denotes indicators that will also be monitored*



SITE SELECTION AND PARTICIPATION

The following section outlines:

- ✓ Information on how sites can be nominated;
- ✓ Key success factors for participation in the bundled care initiative, and;
- ✓ Timelines and next steps.

Note: Detailed policy guidance will be provided to all teams who express interest in participation, as well as dedicated webinar sessions as needed

Site selection and participation

Each LHIN will have the opportunity to nominate teams based on their own assessment of readiness using the guidance provided in the nomination template.

1. LHINs are able to nominate multiple teams per LHIN
 - To volunteer for participation in the bundled model, interested teams must complete a nomination form and submit to their local LHIN representative who will then submit to the Ministry.
2. Ministry will not approve sites and site selection should be the discretion of the LHIN; teams that meet the eligibility criteria are able to participate.
3. Deadline for each LHIN representative to submit nomination forms to the Ministry is November 6 2017. Teams participating in the voluntary hip and knee bundled QBP will be confirmed on December 1 2017.
4. Teams will begin to work within the bundled price as of April 1st 2018
 - Teams will use the time between December 2017 and April 1st 2018 to come together, develop the service delivery/care pathway, establish risk and gains sharing agreements and collect baseline data.

Requirements for participation

Teams should meet the following requirements before they consider putting forward a nomination.

- **“All in” approach:** for teams that choose to participate in the bundle, all of the surgical QBP volumes and associated rehab QBP volumes will be bundled. Participating hospital providers are not able to have a bundle stream and traditional QBP stream simultaneously.
- **The team must identify who the bundle-holder is:** this allows for appropriate accounting processes from the Ministry's perspective (i.e. service contracts, data reporting requirements etc.).
- **Participating teams must commit to developing a formal risk and gain sharing agreement:** This ensures that teams are aware of existing ground rules and have thought about mitigation strategies in advance.
- **MSK Intake, Assessment and Management Models:** LHINs that are currently working to implement the hip & knee replacement surgery pathway as part of their MSK intake, assessment and management model should indicate plans to align and support bundle development.
- **Reporting, Outcome Measurement and Evaluation:**
 - Teams will be required to facilitate collection of Patient Reported Outcome and Experience Measures through participation in the provincial PROMs pilot initiative
 - Teams will also have to participate in a central evaluation of the bundled hip and knee QBP. This work will require data collection and quarterly reporting
 - Providers will be expected to report on clinical and financial data to support outcome reporting, evaluation and protection of financial stability
- **Community of Practice:** The community of practice (CoP) is a monthly forum hosted by Health Quality Ontario to enhance learning and share their experiences with one another. As with the six Integrated Funding Model Pilot Sites, all bundled care teams will be required to participate in the CoP.
- **Policy and Implementation Considerations:** Teams will be required to adhere to the Broader Public Sector (BPS) Procurement Directive and ‘approved agency’ requirements under the home care legislation.

Guidance for participation (cont`d)

The following considerations are critical success factors for teams interested in participating in the bundled care model. **Teams should consider the below critical success factors before submitting their nomination.**

Critical Success Factors

- **Strong system partnerships and clinical leadership:** participation in the bundle will require cross-sector and cross-provider partnerships and the development of gain and risk sharing agreements across hospital, home care, rehab and other settings. This requires strong potential for collaboration and trust among providers.
 - Building capacity for strong leadership and change management will be required.
- **Appropriate bundle holder:** The ministry will not prescribe the bundle holder; teams have the opportunity to decide who will hold the funds.
 - Evidence from other jurisdictions indicates that the stakeholder with the largest financial and operational risk will typically hold the bundle; however teams share equal bearing in how services should be implemented and delivered. This should be expressed in a contractual agreement between collaborators.
- **Capacity for data collection and financial reporting:**
 - Capacity for data collection and reporting is essential to further our understanding of the process and pricing during this testing year.
 - Strong experience and expertise with financial reporting and accounting is critical for the bundle holder.
- **Flexibility:** Teams will be comfortable taking a “learn as we go” approach to identify and co-create policy and funding changes.

Supports

The following supports will be provided to bundled care participants:

1. Detailed policy guidance and supporting documents:

- Guidance documents and additional webinars be provided to teams including detailed information around operationalization of the model, specifically:
 - Reporting requirements and data standards, both for the evaluation and appropriate capture of service delivered
 - Developing risk and gains sharing agreements
 - Policy on home care procurement and contracting
- These documents will be sent to all teams who submit a nomination form

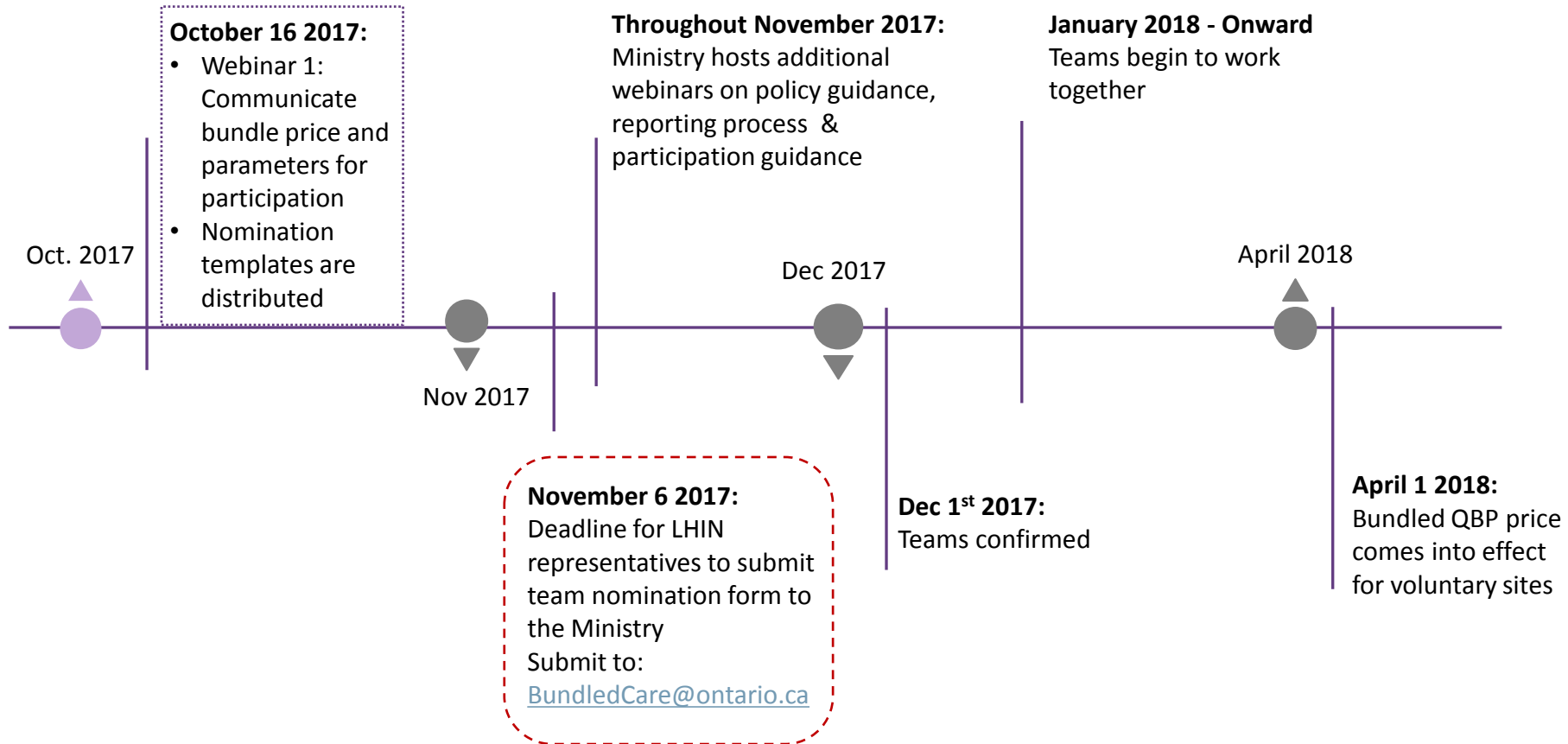
2. Project management supports

3. Communities of practice (CoP):

- Monthly discussions led by Health quality Ontario for bundled care teams to share experiences with one another and provide an update on their work

4. Additional supports & knowledge transfer will be made available to teams as needed

Next steps for the hip & knee replacement bundle



Communication with LHINs and site teams
Additional supports as required (e.g., Community of Practice)

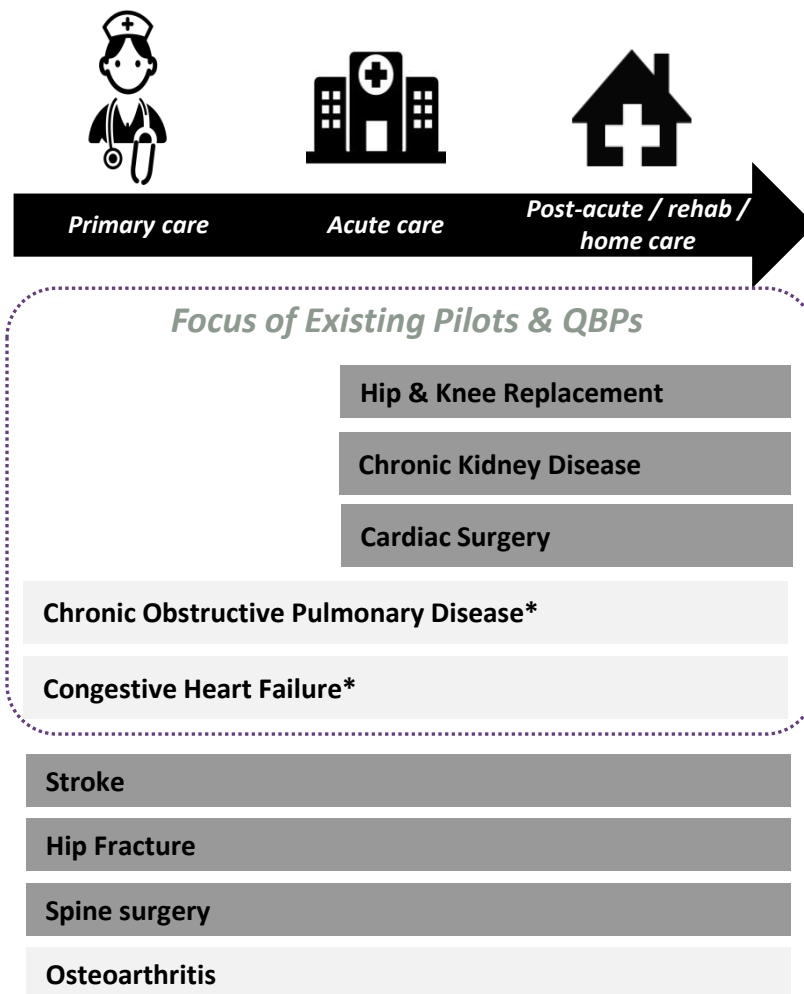
FUTURE DIRECTION

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

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

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

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



Questions?

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APPENDICES

Task group members

| Name of Member | Affiliation |
|---------------------------|--|
| Co-Chair: Patti Cochrane | Senior Vice President of Clinical Strategy & Chief Innovation Officer, Trillium Health Partners |
| Co-Chair: Fredrika Scarth | Director, HQO Liaison and Program Development Branch, MOHLTC |
| Daniel Ball | Director, Community Integration, Access & Flow, Rehab, and Complex Continuing Care - William Osler Health System |
| Dr. Nigel Clements | Orthopaedic surgeon, Trillium Health Partners; Patient representative |
| Pete Crvenkovski | Director, Performance Quality and Knowledge Management – Erie St. Clair LHIN |
| Imtiaz Daniel | Senior Consultant, Financial Analytics and System Performance – Ontario Hospital Association |
| Dr. Jeffrey Gollish | Medical Director - Holland Orthopedic & Arthritic Centre Associate Professor - Division of Orthopedic Surgery |
| Erik Hellsten | Manager, Quality Standards Strategy - Health Quality Ontario |
| Sherry McGeough | Director, Quality and Performance - Central CCAC |
| Scott McLeod | Chief Executive Officer – Central West LHIN |
| Malcolm Moffat | Executive Vice President - Sunnybrook Health Sciences Centre |
| Tomi Nieminen | Deputy Chief Financial Officer - St. Michael's Hospital |
| Dr. Peter Nord | Vice President, Chief Medical Officer - Providence Healthcare Foundation Co-Chair – Rehab Care Alliance |
| Tom Peirce | Vice President Quality, Performance & Chief Innovation Officer – HNHB CCAC |
| Stephen Peterson | Senior Analyst, Evidence Development and Standards - Health Quality Ontario |
| Chris Sulway | Director, Performance Management - Toronto Central LHIN |
| Dr. Jim Waddell | Orthopaedic surgeon, St. Michael's Hospital |

PROMs: Background & Context

- Patient Reported Outcome Measures (PROMs) capture patient perspectives on aspects of their health status that are not typically captured by standard diagnostic tools
 - PROMs complement traditional, clinical-based outcomes, enabling a more comprehensive understanding of outcomes and effectiveness.
 - PROMs can also inform decisions regarding resource allocation to ensure investments support improvements in population health.
- Although evidence shows that the systematic use of PROMs data can lead to better communication and decision-making between doctors and patients and improve patient satisfaction with care, the use of PROMs data in clinical practice is intermittent.
- Health systems the world over are increasingly recognizing the value of collecting PROMs data and developing systems to collect PROMs data across all health sectors.

PROMs in Action

Canada

British Columbia, Alberta, Saskatchewan, and Quebec collect PROMs related to hip and knee replacement, prostate care, lower-leg ischemia, and palliative care.

In Ontario, Cancer Care Ontario (CCO) has developed innovative systems for collecting PROMs data associated with cancer treatment.

England

The National Health Service (NHS) has been a leader in PROMs instrument development, research and utilization for several decades.

The NHS made it mandatory to collect PROMs for hip and knee replacement surgeries, hernia repairs and varicose vein surgeries in 2009.

United States

Several national PROMs initiatives are currently under way in the US.

For example, a network of practices in 30 states are using PROMs to improve care for children with inflammatory bowel disease. Since forming the network in 2007, remission rates have improved from 55% to 77% for 17,000 patients.

Sweden

A Swedish rheumatology quality registry was established in 1995 and contains PROMs data on 66,000 patients (about 85% of people in Sweden with rheumatoid arthritis).

Sweden has also been collecting PROMs related to hip replacement surgery since 2002.

Case for Action:

Aligning Initiatives to Improve Patient Care

- To support the delivery of patient-centred, evidence-based care, the ministry will test the implementation of PROMs in hospital settings and MSK intake, assessment and management models across Ontario.
- The implementation of a hip and knee PROMs pilot is timely, considering:
 - ✓ The ministry will begin a bundled hip and knee replacement QBP pilot in 2017/18.
 - Linking this program to a PROMs pilot would facilitate the collection of real-time, patient-provided data and support the delivery of more patient-centred care.
 - ✓ The ministry is also implementing a hip/knee replacement surgery intake and assessment model, which would be a key touch point for hip/knee PROMs measurement.

Why Hips & Knees?

Hip and knee replacement surgery was selected as the area of focus for the proposed PROMs pilot for three reasons:

1. Ontario **performs nearly 42% of the hip and knee replacement surgeries** conducted in Canada
2. Ontario's health system spends **more than \$650 million annually** to provide these surgeries
3. Other provinces and jurisdictions are increasingly measuring hip/knee PROMs; implementing similar data collection/analysis methods in Ontario would allow for **pan-Canadian and international comparisons of PROMs data.**