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ACADEMIC ARTICLES

- **08** Creating a High-Performing Health Care System for Ontario
- **18** Developing a Health
 Care Capacity Plan for
 Ontario
- **26** Bundling Care and Payment: Evidence from Early Adopters



On the cover

The word cloud incorporates themes that you will find in our Academic Articles, Features, and Snapshot content.

FEATURES

- **14** A Focus on Long-Stay ALC Patients in CCC and Mental Health Inpatient Beds
- 22 The Journey to Health Hubs: Investigating the Benefits of the Health Hub Model in Ontario
- **32** Q&A with Dr. Bob Bell
- **36** Regionalization with Hospital Boards
- **40** Bridging the Gap: Assessing Hospitals' Health Analytics Needs

SNAPSHOTS

- **31** Integrating Care around the Patient
- **35** Local Health Hubs: A One-Stop Shop for Health Care Services
- **42** Supporting the Transition from CAMH to the Community





Questions? Comments?

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Ontario Hospital Association 200 Front Street W., Suite 2800, Toronto, ON M5V 3L1 Canada +1 416 205 1300, oha.com

Contributors

Renata Axler, Institute of Health Policy Management and Evaluation, University of Toronto

G. Ross Baker, Institute of Health Policy Management and Evaluation, University of Toronto; Li Ka Shing Knowledge Institute, St. Michael's Hospital

Dr. Bob Bell, Deputy Minister of Health and Long-Term Care

Adalsteinn Brown, Institute of Health Policy Management and Evaluation, University of Toronto

Imtiaz Daniel, Institute of Health Policy Management and Evaluation, University of Toronto; Ontario Hospital Association

Brian Ferguson, University of Guelph; Canadian Centre for Health Economics

Samantha Grant, Ontario Hospital Association

Tamarah Harel, Ontario Hospital Association

Christopher Helyar, Hay Group Health Care Consulting

John P. Hirdes, University of Waterloo

J. Jacobs, Ivey Business School, Western University; Institute of Health Policy Management and Evaluation, University of Toronto

Audrey Laporte, Canadian Centre for Health Economics; Institute of Health Policy Management and Evaluation, University of Toronto;

Jerrica Little, University of Waterloo

Michelle MacLeod, Ontario Hospital Association

Gregory Marchildon, Institute of Health Policy, Management and Evaluation, University of Toronto

Linda Mohri, Centre for Addiction and Mental Health

Lou Reidel, Ontario Hospital Association

Luke Turcotte, University of Waterloo

Jim Whaley, Independent Hospital & Health Care Consultant

Walter Wodchis, Institute of Health Policy Management and Evaluation, University of Toronto; Toronto Rehabilitation Network; Institute for Clinical Evaluative Sciences

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ISBN # 978-0-88621-361-9

Achieving a High-Performing Health System in Ontario

Ontario's health care system is undergoing major transformation. Amidst this change, the Ontario Hospital Association (OHA) is focused on ensuring that we are using the best available evidence and experience in making decisions. That's why I am pleased to announce that we've launched the OHA's health policy journal, *Redefining Health Care*.

This journal is intended to support hospitals and their partners by initiating a dialogue on emerging and evolving health policy issues in Ontario; commissioning research and conducting interviews from leaders from within Ontario and abroad; and communicating and disseminating fact-based research and advice to government and stakeholders across the province. It's through this critical research and analysis that the OHA hopes to generate thoughtful discussion on health system reconfiguration, particularly at this critical juncture as hospitals and their partners begin initiating or scaling transformation initiatives within their communities.

Our vision at the OHA is to achieve a high-performing health system. But it's only through our members and our partners across the system, that this vision can be met. As a result, our mission is to support them by delivering high-quality products and services, championing innovation and performance improvement, and advancing health system policy in Ontario.



Upcoming issues of the journal will focus on a variety of topics, including hospital-physician alignment and patient- and family-centred care, which may evolve as the long-term priorities of the OHA progress. We hope you find this journal valuable as a resource and tool for evaluating current practices and identifying opportunities for change.

Hospitals and their partners are on a continuous journey of improvement toward high-quality health care; and, at the OHA, we're working with hospitals, government and their provider partners to ensure that health system change is grounded in evidence and facts and focused firmly on patients and clients.

Anthony Dale
President and CEO
adale@oha.com
@AnthonyDaleOHA

Policies, People, and the Pace of Change



This issue reflects the work of Ontario Hospital Association (OHA)-sponsored researchers in 2015. The OHA began last year with a purposeful approach to identifying important issues in health system transformation and commissioned thought leadership papers on these issues from respected and well-known researchers and experts. In some ways, the OHA's choice seems prescient. In December of 2015, the Ontario Ministry of Health and Long-term Care released its own discussion paper entitled *Patients First: A Proposal to Strengthen Patient-Centred Care in Ontario*.

The Ministry's discussion paper builds on previous policy initiatives such as the *Excellent Care for All Act* (2010) and health system funding reform efforts to propose the most fundamental changes to our health system since the *Local Health System Integration Act* (2005). These changes are motivated by – and will depend upon – many of the same issues covered by papers in this issue. But both the Ministry's discussion paper and the papers in this issue share the underlying goal of creating a sustainable health system in Ontario that engages with and meets the needs of patients across the province.

It would be unfair to provide a précis to the articles that follow this editorial. However, it is worth touching on some of the common themes. Integration of care around the patient and their caregivers: Virtually all of the articles included in this journal deal with the integration of care. When we talk about integration, we tend to think about reorganizing the system so that patients flow between sectors at the right time. Improved patient flow, particularly between higher and lower cost sectors, is key to the sustainability of the system, but the papers in this issue point to an equally important aspect of integration. When we bring together sectors, we can plan for capacity and make investments across those sectors in a way that maximizes the efficiency of our system. However, to realize these potential gains, we will have to make sure our system is set up to make these sorts of decisions wisely, and for this reason, governance and analytic capacity will need to improve alongside any integration efforts.

Opportunities for improved performance: We live in a somewhat paradoxical health system. The twin pressures of expenditure-control and demand-increases mean that the people in our system are likely working harder than ever before; but at the same time, virtually every article points to the opportunity for improved performance whether it be greater efficiency, higher technical quality, or improved patient-centredness. So how do we create the space for improvement when everyone is already working so hard? The articles provide advice on this question as well, but they tend to focus on ensuring that the capacity to make smart decisions for improvement sits at the same level as the improvement. This means asking critical questions like, who holds the moneys that result from improvement? How do providers work together across sectors in a common enterprise? And how do these providers working together figure out where to make investments across their sectors for successful system transformation?

One size does not fit all: The integrated models of care that work for urban southern communities may not be the right models for northern rural communities. Bundled payment models work well for some types of care but not for all patient trajectories. The right way to build or redirect capacity will not be the same in each community.

This means that policy implementation as we restructure the system should not be the same in every community or type of care. There will be a constant requirement for local analysis and local planning in line with the role of the Local Health Integration Networks and for local leadership that can understand and work with the nuances of local health systems.

The importance of people. Taken together, commonalities across the articles point to the importance of people. The article by Baker and Axler on high-performing health systems starts with a series of premises that reflect the critical importance of human capacity at all levels and in all roles in our health system. Simply pushing forward new tools, new structures or new policies will not yield the health system we want. The danger – as is often the case – is to treat these structural changes as solutions in themselves. We could call this the Field of Dreams fallacy. We should not assume that the people working in our health system will immediately start performing differently (and better) with the introduction of new structures, that is, there is no field of dreams that overwhelms the decades of training,

experience and habits that typify most of the people working in our health system. We will have to invest in people – as well as policies – if we are to build and maintain a credible pace of change in our health system.

The vision of a patient-centred health system underlying *Patients First* is a critical corrective for our health system. It reminds us that care is for people and it should reflect their needs, not the rules or policies that serve particular institutions or interests in our system. As we build this new system, we would do well to remember that we do this with the people who work within our system and we will have to ensure that they are set up to succeed in the future.

Adalsteinn Brown

Director, Institute of Health Policy, Management and Evaluation Dalla Lana Chair in Public Health Policy University of Toronto



Creating a High-Performing Health Care System for Ontario



Background

In 2015, the Ontario Hospital Association (OHA) commissioned research from the University of Toronto on the elements that make up a high-performing health care system. The paper, Creating a High Performing Health Care System for Ontario: Evidence Supporting Strategic Changes in Ontario, prepared by Dr. Ross Baker and Dr. Renata Axler, reviews local evidence on what patients and caregivers want to experience when they receive care, the international evidence on the attributes of "high-performing" health care systems, and the results of deliberations from expert panel discussions. What follows is an abbreviated version of this research. The full paper is available online at oha.com/hsreconfiguration.

There is general consensus across health system experts that maintaining the status quo will not yield high performance.

There has been significant attention to studying, measuring, and analyzing high-performing health systems at the organizational or systems level.

High performance is a product of health care systems that "have created effective frameworks and systems for improving care that are applicable in different settings and sustained over time" (Baker et al., 2008).

There is general consensus across health system experts that maintaining the status quo will not yield high performance, and changes should be made based on the best national and international evidence; yet, there is disagreement about the most effective and affordable means to improve performance (Baker, et al., 2008).

High-performing health care systems are thus dynamic and become high-performing through ongoing and emergent processes (Bate, Mendel, & Robert, 2008).

From a review of evidence garnered from international health care organizations and systems, 12 key attributes of high-performing health care systems were identified. Each of the 12 attributes is important on its own, and also interrelates with a number of other attributes to promote and sustain high performance in health care systems.

12 Key Attributes of High-Performing Health Care Systems

- 1. Focusing on Quality and System Improvement as the Core Strategy
- 2. Developing Leadership Skills
- 3. Enhancing System Governance
- 4. Investing in Capacity to Support Improvement
- 5. Improving Accountability and Performance Measurement
- 6. Enabling Comprehensive Information Infrastructures
- 7. Strengthening Primary Care
- 8. Improving Integration and Care Transitions
- 9. Enhancing Professional Cultures and Engaging Clinicians
- 10. Engaging Patients, Caregivers and the Public
- 11. Attending to Access and Equity Issues
- 12. Considering Population Health and Chronic Disease Management in Care Management Strategies

Focusing on Quality and System Improvement as the Core Strategy

The development of an explicit quality agenda by senior leadership is a key factor in promoting a high-performing health care system (Baker & Denis, 2011; VanDeusen, Lukas, et al., 2007). Leadership must develop unambiguous quality goals and support efforts to improve performance. This leadership and investment help to prioritize quality goals across organizations and support a culture of performance improvement within health care systems.

While it is common for health care organizations to identify quality goals, high-performing health care organizations ensure that these goals are aligned with other priorities, linked to "big dot" measures, and communicated and monitored throughout the organization.

2. Developing Leadership Skills

Leaders play an important role in high-performing health care systems, in shaping improvement strategies and implementing change within organizations and systems at large (Baker, 2011; VanDeusen, Lukas, et al., 2007).

Senior leadership is crucial, but leadership needs to be distributed across the system, with agreement on the methods and strategies to drive this change, and local leaders, champions, and change agents who have the potential to accomplish this.

Effective leadership must be consistent and supportive of quality improvement activities. While leaders can identify models for improvement

from other jurisdictions, they must adapt these to their own settings.

Many individuals must assume leadership roles within their individual units, and physician leadership plays a particularly important role.

Enhancing System Governance

Organizational governance plays an important role in improving quality and safety, and boards need to create an environment where clinical staff and leadership are committed to quality and patient safety efforts (Baker, Denis, et al., 2010).

The success of Jönköping County Council, Sweden, in their efforts to improve performance was greatly aided by the close connection between leadership and governance, where a stable majority of politicians were elected to the Council's assembly and led by the same Chair through the near two-decade tenure of the CEO who led the initial efforts (Baker et al., 2008).

Attention to the structure and governance of a health care system can also reduce fragmentation. The Veterans Health New England Health Care System is one of 21 Veterans Integrated Service Networks (VISNs) in the United States established in the mid-1990s that transformed the Veterans Health Administration (VHA) from a hospital care system to a health care system. Its focus is on integrated regional care that emphasizes primary care in the community.

VISN 1 (the New England region of the VHA) has focused on

Organizational governance plays an important role in improving quality and safety, and boards need to create an environment where clinical staff and leadership are committed to quality and patient safety efforts.

standardization and systemization, developing a system's view of the network to improve patient access and flow.

Through the establishment of a networked model of governance, supports were streamlined through all levels of care, promoting safety. Budgets were centralized and planning was integrated to coordinate care pathways and save resources (Baker, et al., 2008).

Additional improvements in care at the VISN 1 rested on this structural foundation, highlighting the importance of enhancing or rethinking governance structures as a way to focus on system-level issues and improve patient care.

Investing in Capacity to Support Improvement

Effective leadership and governance strategies must be linked to organizational and system capability for improving performance. This capability requires investments to give individuals and teams the knowledge, skills and confidence needed to plan and implement improvements (Bevan, 2010).

Implementing a focus on learning requires investment, both in facilitating these efforts, and dedicated staff time and resources within the delivery sectors to integrate new practices and policies.

Improving Accountability and Performance Measurement

Performance measurement systems allow health care organizations to collect and report a range of meaningful indicators to assess current performance and monitor the impact of efforts to improve care.

Attention to accountability and performance measurement should be coupled with action, impacts should be measurable, and action should be taken if performance goals are not achieved.

However, performance measurement and accountability tools may create a double-edged sword. Developing elaborate performance accountability structures may limit local flexibility and performance and contribute to a fragmented system where there is less capability to respond to areas of poor performance across organizations (Baker, et al., 2008).

Health care systems must avoid an over-reliance on performance measures that generate compliance, not commitment, or fail to address meaningful goals for practitioners and patients.

6. Enabling Comprehensive Information Infrastructures

Performance measurement, improvement and accountability within high-performing health care systems require information infrastructures that can track and monitor progress and provide timely feedback. Information infrastructures are the technical backbone that support performance improvement.

Growing numbers of health care organizations are developing electronic health records and decision support systems to support clinical decision-making. Ideally, these systems should be interoperable to facilitate information sharing and comparisons within and between providers in broader health care systems.

7. Strengthening Primary Care

Enhancing primary care and strengthening its linkages to acute and community-based care can improve health services, promoting high performance (Baker & Denis, 2011).

Researchers have shown that improved access to primary health care delivered by inter-professional teams can improve patient health and patient experiences (Denis, et al., 2011).

This attention to primary care may involve practice networks, multi-specialty physician group practices, or integrated services with a focus on primary care, and may require commitments from organized medical associations.

8. Improving Integration and Care Transitions

Closely connected to the need for improvements in primary care, high-performing health care systems focus efforts on ensuring integration of care and effective care transitions across the continuum.

Effective teamwork and communications may be facilitated by education, common patient records

or through other linkages between providers as a standard component of care delivery.

One approach used to facilitate improved patient coordination and care transitions at Jönköping County Council was to focus on the needs of the patient using the persona of "Esther". Esther is a fictitious 88-year-old woman living in the community with multiple chronic conditions. Based on their understanding of her needs, Esther's movements through care settings were mapped by providers who were then able to identify improvements in care and patient flow.

To improve care for patients like Esther, the Jönköping staff redesigned the intake and transfer process across the continuum of care, instituted open access scheduling, team-based telephone consultation, integrated documentation and communication and strategies to educate patients in self-management, yielding a reduction in hospital admissions, a redeployment of resources to the community, a reduction in hospital use for heart failure, and a reduction in wait times (Baker, et al., 2008).

Similar integration initiatives may be challenging in Ontario's health care delivery environment, where autonomy in the governance and management of delivery organizations can lead to fragmentation that complicates care transitions.



Enhancing Professional Cultures and Engaging Clinicians

The engagement of physicians and other clinicians in quality initiatives is essential to achieve high performance in health care systems.

An example of effective physician engagement can be drawn from the experience of the Calgary Health Region (2003-2008), where leadership developed a Physician Partnership Steering Committee to help redesign care. This initiative provided pilot funding for physician-led projects aimed at improving service delivery, and led to initiatives around the standardization of orders, medication safety and performance data, among others (Baker, et al., 2008).

Engaging Patients, Caregivers and the Public

An emerging set of initiatives in Canada and elsewhere focuses on patients, caregivers and the public and their role in designing high-quality health care (Baker, 2011). Patient engagement includes not only individual participation in choices about care, but also patient

involvement in the improvement of care processes.

While many organizations have attempted to engage patients and include patient voices into the design of their care, there is limited evidence on how best to do this, and how to ensure that patients and the public are seen as equal partners in health care system design.

Effective patient engagement will therefore need to be accompanied by significant efforts to empower and educate patients, their caregivers and the public, and meaningful efforts are needed to ensure their inclusion into health care decision-making.

Leading practices from successful organizations, such as Kingston General Hospital and Thunder Bay Regional Health Sciences Centre should be shared so that patient engagement can become a standard practice.

Attending to Access and Equity Issues

Access issues have been highlighted as a key concern in a number of health care systems.

Chris Ham, the CEO of the King's Fund in the U.K., has argued

that the most important characteristic of a high-performing health care system is ensuring universal coverage for all individuals in that system (Ham, 2010).

Though the Ontario Health
Insurance Plan insures residents of
Ontario for most health care costs,
there continue to be concerns about
meeting the needs of those in rural or
underserviced locations, and access to
prescription pharmaceuticals among
other issues. Attention to these access
and equity issues will create a health
care system where different groups of
patients have similar access to care.

Broader priorities such as this one face significant implementation challenges in a complex health care system. Addressing access and equity issues is especially difficult in the demographically and socioeconomically diverse population, and the expansive geography of Ontario.

These initiatives will require significant investments at the provincial level, and coordination across many sectors within and beyond the health care domain. Nonetheless, this remains an important priority area to consider as Ontario moves toward a high-performing health care system.

12. Considering Population Health and Chronic Disease Management in Care Management Strategies

Policy makers in many jurisdictions increasingly recognize that health care alone does not equal a healthy population. Other services, including social services, education and public

Closely connected to the need for improvements in primary care, high-performing health care systems focus efforts on ensuring integration of care and effective care transitions across the continuum.

health, contribute in important ways to outcomes and patient experiences.

Although there are considerable resources focused on major health promotion issues, such as tobacco control, food labeling, and nutrition, these efforts tend to be separate from care delivery and thus not always

targeted at individuals. Increased efforts to motivate and inform citizens need to be integrated into primary and community-based care.

Individuals should be provided with the resources to self-manage their conditions outside of the formal health care system (Ham, 2010), and

this should be incorporated into system-level priorities.

Like equity and access issues, these public health and disease prevention efforts will be broad in scope, and likely extend beyond the traditional boundaries of the health care system.

Conclusion

Advancing the attributes of a high-performing health care system requires deliberate strategy and investment. Each attribute presents challenges, and the development of a system that supports such performance requires not just a few of these attributes, but sustained efforts to achieve all (Baker, et al., 2008; VanDeusen Lukas, 2007).

Creating the environment that supports such transformation requires broad support from all levels: from the development of supportive policies to the daily work of front line teams.

High-performing health care systems provide a different experience for patients and providers. Patients accessing care within this system can communicate effectively with their care teams, access care when necessary, and experience seamless care transitions. As health delivery organizations and systems continue to learn and measure their performance, working towards a culture of quality and improvement, patients will experience increasingly safe, effective, efficient and high-quality care.

At the same time, providers in high-performing health care systems should have an easier time in delivering the care their patients need and coordinating that care with others.

Ontario has demonstrated significant progress in many current, albeit mostly small-scale efforts to improve quality, safety, and achieve high performance.

Efforts are needed to scale these initiatives in a focused and efficient way.

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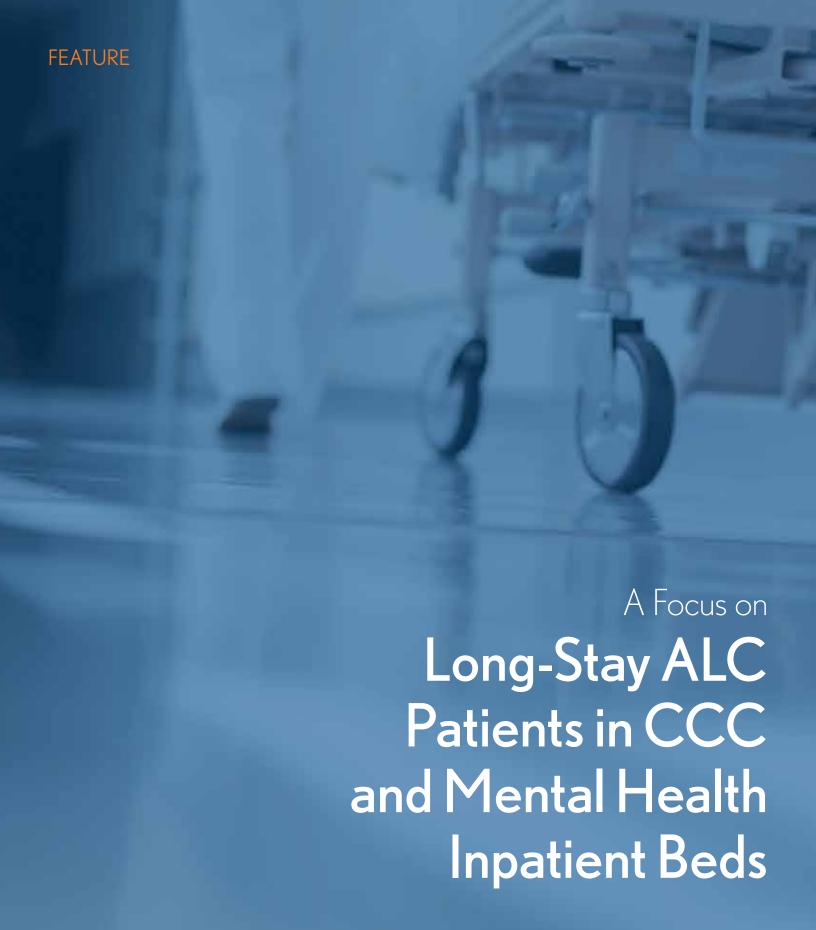
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There are a number of barriers to system performance. One that has received considerable public attention in recent years is Alternate Level of Care (ALC) patient days. Patients are given an ALC designation when they occupy a hospital bed, but no longer require that level intensity of resources and services; in other words, they are waiting to receive more appropriate care elsewhere in the system.

One of the most important markers of a high-performing health system is timely access to care for those who need it.

ALC patient days are an inefficient use of system resources and may prevent access to care for others who require medical care. Similarly, for ALC patients, having to wait for extended periods of time may negatively affect their health outcomes, quality of life, and patient satisfaction.

Currently in Ontario, about 14.5 per cent of inpatient beds are being occupied by ALC patients who are waiting for more appropriate care in the community. This is according to March 2016 data from Cancer Care Ontario's (CCO) Access to Care (CCO-ATC) Wait Time Information System (WTIS). Of these 4,139 ALC patients, 33 per cent reside in complex continuing care (CCC) and mental health beds and contribute 67 per cent of ALC days in hospitals.

Finding effective solutions to the ALC challenge is not an easy undertaking. Health care is highly complex and very much interconnected, so that difficulties in one part of the system are often symptomatic of broader issues at play. In the case of ALC patient days, a more integrated system that spans the entire continuum of care is needed, and as such, the government's push to strengthen the home and community

care sector is an encouraging development with the potential to increase access to the right care, at the right time, and in the right place.

Two Studies Investigating ALC Patient Days

In order to gain a deeper understanding of ALC patient needs, the Ontario Hospital Association (OHA) commissioned two research papers from Jerrica Little, Luke Turcotte, and Dr. John P. Hirdes from the School of Public Health and Health Systems, University of Waterloo.

Both studies focused on long-stay ALC patients defined as patients who have accumulated more than 30 ALC patient days within an episode of care. Focusing on this group acknowledges the fact that unavoidable ALC days may be incurred at the end of an episode of care as patients transition to a less intensive care setting, despite best efforts to discharge them in a timely manner.

Long-stay ALC patients are therefore, more likely to be those individuals who are having a harder time transitioning to a more appropriate, lower-intensity setting.

FEATURE

According to the CCO-ATC WTIS data, of the ALC patients waiting more than 30 days, 33 per cent are waiting in a Complex Continuing Care (CCC) bed and 16 per cent are waiting in a mental health bed.

The goal of these research studies was three-fold:

- To identify common characteristics of long-stay ALC patients in both mental health and CCC settings,
- To determine services required to help these patients transition to a more appropriate care setting, and finally,
- To assist the OHA in pinpointing service gaps that could inform potential solutions targeted at reducing ALC patient days.

Both studies adopted the Andersen-Newman (1973) theoretical framework, which theorizes that health service use is dependent on both societal and individual determinants. The model was chosen as it serves as a valuable guide to analyzing complex problems.

Societal determinants may include factors such as volume of resources available relative to population served and accessibility of services. Individual determinants consist of predisposing factors such as demographics, social structure and beliefs; enabling factors which facilitate access to health services, such as income and geographic location; and illness level as perceived by the patient and evaluated by a health professional both of which determine the use of health resources.

Currently in Ontario, about 14.5 per cent of inpatient beds are being occupied by ALC patients.

ALC Patients in CCC Beds

CCC facilities provide hospital-based nursing and rehabilitation services to people recovering from acute illness or who have complex clinical needs requiring specialized medical care over an extended period of time. For most patients, these facilities are a transition point between acute care hospitals and home care or residential long-term care settings.

The CCC study by Luke Turcotte and Dr. John P. Hirdes, relied on CCO's WTIS data; the WTIS is considered a valuable tool for measuring wait time efficiency at various points in the health system.

Data was also drawn from the Resident Assessment Information – Minimum Data Set 2.0 (MDS 2.0) which provides important insights into the individual-level determinants of long-stay ALC patient status, particularly with respect to predisposing factors and illness level.

Analyses were conducted to identify clinical characteristics and clinical predictors of long-stay ALC patients.

It was found that risk factors include a history of hospitalization, functional and cognitive impairment, aggressive behaviours, pain, and neurological disease conditions (e.g., Alzheimer's disease and related dementias, stroke).

Protective factors, which reduce the likelihood of a person becoming a long-stay ALC patient, include the presence of a spousal caregiver and the provision of community skills training. As well, the need for advanced medical treatments and endstage health status made it less likely for a long-stay ALC outcome as these factors may determine the need for care in a CCC facility.

The findings highlight potential avenues for better meeting the needs of ALC long-stay patients who often present with behavioral issues and cognitive impairments, such as developing community supports that focus on these needs or specialized behavioural units in long-term care settings. These patients also seem to benefit from community-based informal caregivers and community skills training which can be opportunities for further investment.

The research also provided predictors that may help identify potential long-stay ALC patients early in their episode of care, which can enable providers to collaborate with their community partners, so they can work together towards more timely intervention.

ALC Patients in Mental Health Beds

Inpatient mental health settings are hospital-based facilities for the observation, care and treatment of persons experiencing mental illness. Once admitted to a mental health unit, patients are assessed for their presenting symptoms, challenges and needs.

Those overseeing their care formulate a discharge plan. When acute mental health symptoms have stabilized, many mental health patients will transition back home or to outpatient or community care settings according to their discharge plan; however, some may be designated ALC.

As of June 2015, 10 per cent of designated mental health beds in Ontario were occupied by ALC patients.

The primary data source for the paper that examined ALC patients in mental health beds, by Jericca Little and Dr. John P. Hirdes, was interRAI's Resident Assessment Instrument – Mental Health (RAI-MH) which was mandated for use in inpatient psychiatry across Ontario in 2005, which included 68 participating hospitals.

The RAI-MH is a tool for evaluating patient clinical characteristics and needs, including cognitive, social and physical functioning, as well as mental illness and health service utilization. The study also relied on CCO's WTIS, which collects valuable data regarding specialized needs and barriers to discharge.

The analyses examined the proportion of ALC episodes and distribution of ALC days, demographic and clinical characteristics of both long-stay and less than 30 days ALC groups, and clinical predictors of long-stay ALC patients.

The findings showed that although a relatively small percentage of mental health patients end up becoming long-stay ALC patients, the number of days accumulated over time by this small group tends to be significant.

It was also revealed that the prevalence of various characteristics and mental disorders differed between the ALC population and other mental health inpatients. There were also several risk and protective factors associated with ALC designations. The strongest predictor was a diagnosis of a cognitive disorder, followed by disorders of childhood/adolescence and intellectual disabilities.

As well, a patient was more likely to be designated ALC if they

were older, male, or if their primary language was not English or French. Other predictors included limited or no insight into their own mental health, if they had four or more lifetime admissions to a psychiatric hospital, and if they had not been visited by a social relation in the last 30 days.

The results of this study can guide the development of clinical interventions that target mental health patients during the first three days after admission based on identified risk and protective factors. The findings also point to the needs of long-stay mental health patients, providing policy-makers and providers with opportunities to create better supports.

Find out how the

Centre for Addiction and

Mental Health (CAMH)
is helping their clients transition
from CAMH to the community
on page 42

Looking Ahead

Both these studies focusing on long-stay ALC patients offer an important starting point for better understanding the complex challenges that characterize patients that fall within this important patient group. Future work will focus on developing an algorithm that can be used to assess the risk of ALC status at admission for both CCC and mental health inpatients.

The studies shed light on critical gaps in Ontario's health care system that will require the attention and collaboration of different providers and policymakers to ensure that patients receive the care they need rather than waiting for the right services to be delivered in the right setting.

Solutions will not only improve the quality of care for long-stay ALC patients, but will free up much needed resources needed to optimize efficiency and access for others who are also waiting to receive health care services.

Developing a Health Care Capacity Plan for Ontario



Background

In the 2015 Ontario Budget, the government announced it would be creating a comprehensive capacity planning framework to better align key initiatives, maximize investments and ensure that Ontarians have a health care system that is both high-quality and sustainable.

The Ontario Hospital Association (OHA) had been calling for such an initiative and welcomed this commitment. To support the development and implementation of the capacity planning framework, the OHA engaged Hay Group Health Care Consulting to review capacity planning experiences in other jurisdictions, analyze patterns of health service utilization across the Local Health Integration Networks (LHINs), and use this information to develop a basic capacity planning model as a 'proof of concept' demonstration of the feasibility of applying a provincial capacity planning framework at the LHIN level.

Select elements of the advice of the project team are presented in this article. The full paper is available online at oha.com/hsreconfiguration.

The value of capacity planning is not necessarily that it will generate a definitive timetable for health service investment, but that it will promote more effective planning and understanding of the health system to inform policy decisions and force more explicit consideration and clarity around the risks and benefits of alternative actions.

Benefits of Capacity Planning

Capacity planning projections are used to simulate the impact of alternate planning assumptions on future requirements for health services. Even when focused exclusively on the potential impacts of demographic change, the projections can provide early warning of pressure points (i.e. what sector, geography, or individual service, is most likely to face growth in demand that may exceed the system's current capacity). Because of the lead time needed to increase capacity for services that require significant capital investments (e.g., facility-based inpatient care) or extended training (e.g., specialist medical care), such advance warning is necessary either to ensure that the capacity is in place when the demand occurs or to take action to mitigate the projected demand.

The value of capacity planning is not necessarily that it will generate a definitive timetable for health service investment, but that it will promote more effective planning and understanding of the health system to inform policy decisions and force more explicit consideration and clarity around the risks and benefits of alternative actions. A comprehensive health service capacity planning

process itself will promote a system view and more proactive consideration of integration opportunities, as well as the impact of changes in one sector on others.

Implementation of the Health Based Allocation Model (HBAM) for Ontario hospitals has been highly effective in promoting the search for further efficiencies in providing care, but has been less effective in supporting identification and reduction of inappropriate (or low-value) care. A population-based approach to capacity planning, incorporating strategies to mitigate the impacts of increases in demand for care, requires a balance of attention to both efficiency and effectiveness.

Roles in Capacity Planning

In Ontario, the *Local Health System Integration Act* defines the role of LHINs, which is to "improve the health of Ontarians through better access to high-quality health services, coordinated health care in local health systems and across the province and effective and efficient management of the health system at the local level."

In most jurisdictions that engage in capacity planning, the responsibility for doing the planning is aligned with the accountability for ensuring health services are available. As such, in Ontario, the LHINs would be responsible for capacity planning.

While the LHINs should be responsible for implementation of the capacity planning for their population, the framework and the tools (i.e. the actual models) to support their capacity planning should be generated centrally, by the

Ministry of Health and Long-Term Care (Ministry). The modelling and analytical resources, along with the expert input to create a comprehensive capacity planning model should not have to be replicated 14 times (as is currently the case, where each LHIN takes its own approach and uses its own assumptions when projecting future requirements, and considering potential demand mitigation strategies). The oversight of capacity planning model development should rest with the Ministy, with additional participation by representatives from the sectors to be included in the model.

The Institute for Clinical Evaluative Sciences (ICES) should be engaged to support the model's development, given their experience with creation of research atlases showing geographic breakdowns of regional patterns in health care delivery, both at the overall system level, and for disease-specific topics. The access of ICES researchers to linked Ontario health care administrative databases, including primary care service data, will facilitate the identification of interrelationships between sectors that could be incorporated into the model.

Another key participant in the capacity planning model development should be Health Quality Ontario (HQO). HQO's legislated mandate is to "evaluate the effectiveness of new health care technologies and services, report to the public on the quality of the health care system, support quality improvement activities and make evidence-based recommendations on health care funding." HQO's expertise

in using evidence to support quality improvement has been demonstrated through their work on selected Quality Based Procedure (QBP) clinical handbooks and the link between capacity planning and health care funding.

Capacity Model Structure and Use

The base model developed by the Ministry should incorporate any given policy assumptions, and default settings for 'levers' to be included in the model. This model can be both an internal Ministry tool to support risk management and simulation of potential policy changes or investment impacts, as well as the model provided to the LHINs to support their capacity planning.

The provincial model should be population-based, driven by projected changes in the size and the age composition of the population for which a LHIN is responsible, but with the additional adjustment factors that can be modified by a LHIN, as required, to reflect local circumstances.

There should be an onus on the LHIN to justify deviating from the default settings for each factor by presenting the evidence supporting such a change. The LHIN feedback will create the feedback loop necessary to support continuous refinement and improvement of the model. Differences in assumptions across LHINs will also promote explicit articulation of what variation may be warranted, and what variation may be unwarranted.

ACADEMIC ARTICLE

While there may be a desire to build in practical constraints as part of the base capacity model (e.g., available resources, time lag for capacity expansion, barriers to achieving efficiencies, etc.) it would be preferable if these were explicitly identified and built on top of the base model, so that informed decisions can be made about relative priorities and trade-offs. The goal should be to identify the required capacity to provide appropriate, quality health care to the residents of Ontario. Showing the gap between the service capacity that can be supported with available funding and the capacity requirement projected by the model, should be used as an incentive to develop mitigation strategies (rather than an opportunity to attack the Ministry for under-funding).

Need to Better Understand Variation and Inter-Relationships across Sectors

There are a few examples of evidence of potential inter-relationships across sectors with face validity, such as:

- Very low use of inpatient rehabilitation by residents of the South East LHIN, and very high use of CCAC home rehabilitation services.
- Very high rates of low acuity emergency department visits in the northern LHINs, and low rates of OHIP payments per population among family physicians.

But in most cases, there are just as many examples where the expected relationships do not exist. Finding these evidence-based relationships between health sectors is arguably the greatest challenge in creating a comprehensive capacity projection model, given the often unexplained variation in patterns of health service use across populations.

Incorporating Expert Qualitative Input

Development of capacity plans should involve clinicians and researchers who can help with understanding the factors that should be incorporated into projection models. Availability of

individuals with the ability to construct sophisticated models will not be a barrier, but defining the assumptions and relationships that should be included in the models may be.

Considering Factors to Include in a Capacity Planning Model

While the base capacity planning model should be driven by projected population size and age/gender composition, additional factors that may influence future health service requirement should be built into the model. The types of factors to consider (which may vary by sector) should include:

Population Characteristics:

These are characteristics of the population that are generally independent of health system performance, and have been identified (through analysis, literature review, and stakeholder feedback) as influences on health service needs.

Population Health Status and **Needs:** The population need for health care services is influenced by the population characteristics outlined above and the health status of the population, but also by additional characteristics that are amenable to modification by the health system.

Health Service Requirements: Not all need for health services generate a requirement for services from the public health care system. Some of the need for health services will be met by self-care and by informal care providers, and others by alternative medicine providers.

Capacity planning projections are used to simulate the impact of alternate planning assumptions on future requirements for health services.



While a population may have a need for health care, there is rarely only one way that the health system can respond to that need. The service delivery models employed (e.g., relative use of institutional care versus community care, emphasis on illness prevention versus treatment, reliance on one occupation versus another for care) will influence both the mix and volume of health services required to appropriately respond to the population's health status and needs.

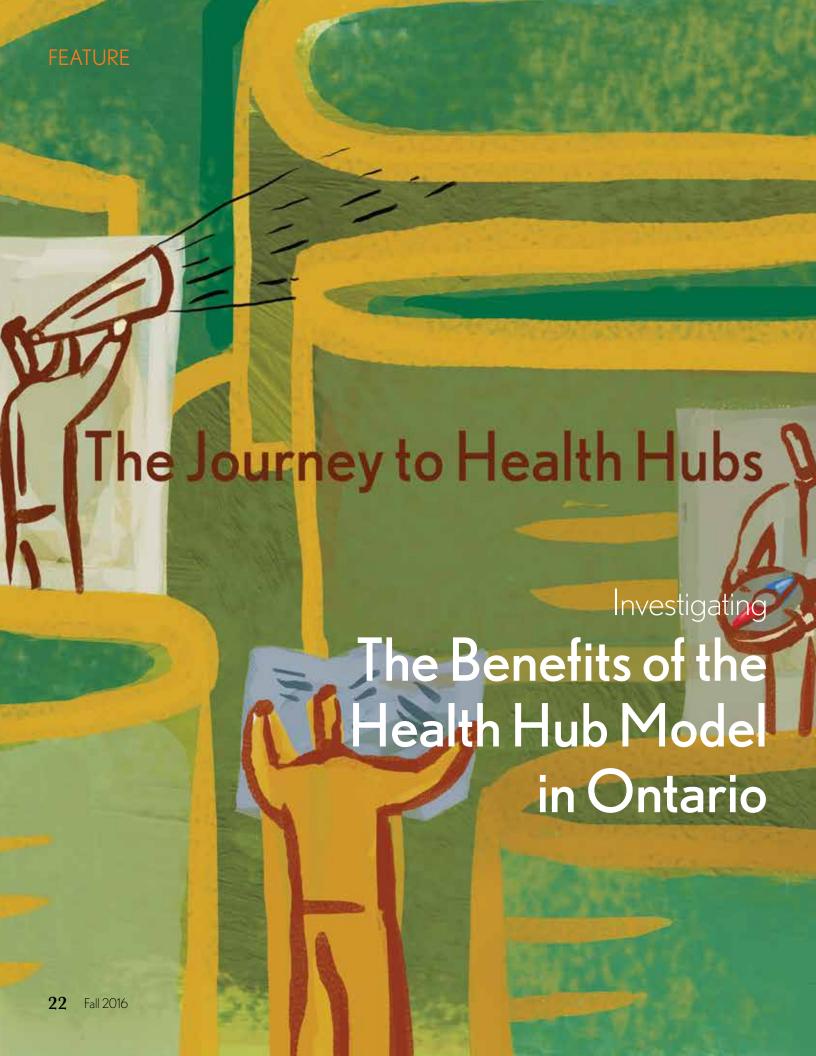
overall health system design is unlikely to change significantly, new service delivery models are constantly being introduced as part of the ongoing search for improved health system quality and efficiency. Service delivery models are ways of organizing health care services (e.g., by sector, by discipline, by location, etc.) into 'packages' to facilitate cost-effective provision of care. Changes in delivery models may allow shifting of services across

sectors or improve efficiency and effectiveness. These factors influence the determination of the capacity requirements to satisfy the projected demand for health services.

Existing and potential innovative service delivery models should be considered in order to determine the most appropriate treatment modality (or sector) to respond to identified health service needs. While some health care services may be provided in a range of sectors, there will be some health care needs that are likely to be met only in one sector (e.g., needs of multi-trauma patients for critical care are likely to be met only in an acute care hospital, and not by community or home care services).

• New Technology Impacts: The model should accommodate simulation of the impact of new technologies that may change service modalities (e.g. move from institutional care to community care, or move from ambulatory care to inpatient care). Potential Criteria for Selecting Capacity Planning Model Factors

Finally, not all potential factors will be included in the provincial capacity planning model. Criteria in the full project report have been provided to help identify the subset of factors that should be included. In our experience, availability of data to support current and future measurement of the factor can become an overriding consideration. As new data systems are developed and implemented, some factors that were excluded because of absence of robust data should be tested for inclusion in future refinements of the model.





s Ontario moves to transform its health care system and the way care is delivered to patients and clients, hospitals have been doing their part to lead and support changes aimed at improving quality-of-care.

In particular, some small, rural and northern hospitals have been developing health hubs, a new model of care that maximizes available resources while optimizing patient care.

Under the health hub model, small, rural or northern hospitals manage a wide range of acute and non-acute services, including long-term care, primary care, community support services and mental health and addiction services.

In many cases, health hub hospitals are functioning as multi-site, multi-sector health care "We are committed to exploring innovative solutions such as the rural health hub model, and plan to support small and rural hospitals who are working towards this model."

- Ministry of Health and Long-Term Care

corporations where there is no meaningful distinction between hospital and community services.

While some communities are just beginning to explore collaborative partnership opportunities, there are a number of small, rural hospitals that have already achieved a high degree of success in local health system integration and are ready to establish fully-integrated rural health hubs.

While success has been noteworthy to date, deeper integration is required to achieve all of the benefits this model has to offer.

As such, with the support from its members, the Ontario Hospital Association (OHA) has been advocating for government-supported, fully-integrated, rural health hub pilot projects.

And in May 2015, during the OHA's Rural and Northern Conference, the Minister of Health and Long-Term Care, the Honourable Eric Hoskins, commended rural health leaders for driving health system transformation in their communities.

"I applaud the leadership of the OHA and you, its rural members, as this model is very much aligned with our government's priorities...We are committed to exploring innovative solutions such as the rural health hub model, and plan to support small and rural hospitals who are working towards this model...This is why I have instructed my Ministry to work with the OHA on identifying pilot sites."

On Sunday August 7, Premier Kathleen Wynne announced that the provincial government will be launching a pilot project for rural health hubs, investing \$2.5 million over three years to five pilot sites.

The five sites chosen include: Espanola Regional Hospital and Health Centre, Dryden Regional Health Centre, Manitouwadge General Hospital, North Shore Health Centre (formerly Blind River District Health Centre), and Haliburton Highlands Health Services.

To examine, identify and communicate the value of health hubs, the OHA commissioned two research papers.

The first paper shares important insights from eight health hub hospitals that are already well-advanced in their journey to becoming fully-integrated health hubs, and offers recommendations for next steps. The second proposes a new evaluation framework for evaluating the efficiency gains that can be achieved through integration.

Implementing Fully-Integrated Health Hubs

Prepared by Dr. Jim Whaley, *The*Case for Implementing Fully Integrated
Rural Health Hubs on a Pilot Project
Basis, illustrates the feasibility, patient
benefit and administrative efficiency
of implementing fully integrated rural
health hubs.

The author explores health hubs' various attributes based on the experiences of eight reference hospitals that served as the project working group. The paper clearly builds the case for fully-integrated health hub pilot projects and provides guidance for implementation.

The benefits to this model for patients, clients, and residents are numerous, and include greater responsiveness, improved access, more efficient transitions, reduced travel costs based on care closer to home, more robust patient and family engagement, shared (common) client intake processes, comprehensive supports for seniors, better system navigation and shared electronic patient records.

However, implementation also comes with its challenges, including those resulting from potential labour adjustment costs and the integration of long-term care (LTC) homes into fully-integrated delivery models.

The paper provided several recommendations for rural health hub pilots in Ontario, including:

- Having all local health integration network (LHIN) funding managed by the hub hospital (as defined by existing service accountability agreements).
- A single funding envelope that includes funding for primary care allied health professionals, an allocation for homecare services to be delivered by the

- hub hospital, and a per diem adjustment for hub hospitals managing long-term care homes.
- Including additional local health services in the health hub funding envelope.
- A single, consolidated service accountability agreement (SAA) with performance metrics to be developed collaboratively by the Ministry of Health and Long-Term Care (Ministry), the participating LHINs and the pilot hub hospitals.
- A single governance structure (either the existing hospital board or a collaborative governance structure agreed to by all health hub partners).
- A single, consolidated quality improvement plan developed collaboratively by the Ministry, Health Quality Ontario and the pilot hub hospitals.

Beds and Facility Locations for Health Hub Reference Hospitals

Hospital Corporation	Health Care Sites	Catchment Population	Acute Beds	CCC/ELDCAP / LTC Beds	Other
Sioux Lookout Meno Ya Win Health Centre	Sioux Lookout	30,000	44	5/20	5
Dryden Regional Health Centre	Dryden	15,000	31	10	
Riverside Health Care	Fort Frances, Emo, Rainy River	20,000	41	20/33/164	
Arnprior Regional Health	Arnprior	20,000	30	14/60	20
Blind River District Health Centre	Blind River, Thessalon, Richards Landing	13,000	20	10/10/22	16
Espanola Regional Hospital and Health Centre	Espanola	14,000	15	32/32	49
Haliburton Highlands Health Services	Haliburton, Minden	17,000	14	92	
Manitouwadge General Hospital	Manitouwadge	2,100	9	9	

To complement this work, the OHA commissioned a separate paper in 2015 to identify a new economic model for evaluating and understanding the success of health hub projects.

Evaluating Health Hubs

In their paper, Evaluation of Fully-Integrated Rural Health Hubs, authors Dr. Audrey Laporte and Dr. Brian Ferguson, explore the question of how to evaluate efficiency and value in a health hub model.

The starting point for their work is the proposition that there is very little technical efficiency left in the health care system and that managers are doing the best they can with the resources available to them.

Based on their definition of technical efficiency, an organization is "technically efficient" when it is not possible for the hospital to produce more services without increasing the quantity of resources it uses.

Given that there is already a high degree of technical efficiency within the health care system, other aspects of efficiency must be considered.

"Scale efficiency" refers to the economic notion of economies of scale. It suggests that a larger-scale operation would have lower costs due to volume discounts.

For example, an LTC home or assisted living facility may share a kitchen and dietary services with a hospital to take advantage of volume discounts. Even if a care provider is technically efficient (using its staff to its full potential), it may still be scale inefficient if it is not operating at the

The benefits to this model for patients, clients, and residents are numerous, and include greater responsiveness, improved access, more efficient transitions.

right size to take advantage of these volume effects.

"Allocative efficiency" is about increasing a health system's total input (or productivity) without a change in resources (including more funds or staff). More simply, allocative efficiency is about doing more with less. Rather than consider the allocative efficiency of a single health service provider, the authors argue that policy makers must consider the entire system.

An example of system-allocative efficiency has been demonstrated at Espanola Regional Hospital and Health Centre, in which the LTC home does not have to retain separate 24-hour, on-site Registered Nurse (RN) services. Instead, they draw from the RN resources working in the hospital.

There was no change in overall nurse labour input, but the treatment

Find out how

Manitouwadge

Community Health Centre
has integrated care across the
continuum to meet
local challenges
on page 35

of some patients was shifted to the LTC facility rather than the patients being moved to the hospital for treatment.

The authors conclude that system-allocative efficiency must be used as the starting point for a formal assessment of rural health hubs.

A full analysis would also need to consider the possible limitations on the scope of system-allocative efficiency gains to avoid looking for gains where they would be unlikely to accrue.

For the full research paper, please visit oha.com/hsreconfiguration.

Next Steps on Health Hubs

Currently, there is considerable interest, and a wide range of readiness among health service providers to move forward with the planning and implementation of locally-driven, community-based rural health hub models. The research summarized in this journal will help inform the development and evolution of this model across Ontario.

Bundling Care and Payment: Evidence from Early-Adopters



Background

Many leading jurisdictions around the world have been experimenting with bundled care and bundled payments for quite some time. The Ontario Hospital Association (OHA) has observed that this approach is providing better integration and more patient-centred care. As such, there is much that the OHA can learn from an examination of bundled care and payment in other jurisdictions.

In 2015, the OHA commissioned a research paper to determine the most effective strategy for moving forward with bundled payment, based on the experiences of early adopters. What follows is a summary of the research paper, *Bundling Care and Payment: Evidence From Early Adopters*. The full paper is available online at oha.com/hsreconfiguration.

Bundling care that rightly belongs as part of a single-care pathway is a common-sense approach to optimizing care, cost and outcomes that is becoming increasingly popular.

Bundling care that rightly belongs as part of a single-care pathway is a common-sense approach to optimizing care, cost and outcomes that is becoming increasingly popular. Bundling care and payment offers health care payers an opportunity to align incentives and focus clinicians' efforts on improving quality, while maintaining control over costs.

This is clearly an appealing outcome. However, these programs are in the early stages of development, with evidence still emerging.

There are relatively few examples with rigorous evidence of success compared to the number of efforts that have been made to implement care bundles – particularly for programs that include providers from multiple sectors of the health care system.

The most successful models are implemented in sophisticated environments with robust information technology (IT) systems, clear quality goals and strong physician engagement, and are inclusive of all related providers. Whether all of these conditions are necessary or sufficient cannot be assured, but they are certainly important enabling factors.

Ontario is one province that is implementing a variety of

payment reforms, particularly with institutional providers. Bundled care is an important component of these reforms, primarily through the introduction of quality-based procedures (QBPs). The extent and focus of the implementation of bundled care and payment can vary widely – and there is much that Ontario can learn from the path taken by early adopters.

What is Bundled Care?

Bundling of services can occur across the continuum-of-care and can range from including services for a particular procedure to all services related to all health care for a given time period.

The most common types of care bundles focus on diagnostic-related groups or specific procedures. A number of programs and pilots aim to integrate care from acute care services through to home and community as well as nursing home care, or to coordinate community-based care for specific chronic conditions.

Bundled payment involves payers transferring a pre-determined payment to providers to deliver all care included in the care bundle, thereby transferring risk to the providers who control the decisions about which services are provided to patients.

Key Challenges to Bundling Care and Payment

• Deciding what to include in a bundle. It can be challenging to determine which services should go in a bundle. For longer-term

Effective bundles are inclusive of all payments to all providers within the period (i.e., acute and post-acute, primary care, home care, drugs, etc.) which enables accountability.

bundles for specific chronic conditions, it is especially difficult to ensure all related care and ongoing patient costs are included in one bundled payment. If all care is not included, the resulting incomplete bundles can reinforce fragmented care for patients with co-occurring conditions and create incentives to shift care and costs to providers outside of the care bundle.

- Ensuring quality of care. Bundled payments can create incentives to skimp on care and do not address quality concerns about service provision that extend beyond the time horizon of a given bundle. Quality monitoring is used in all the bundled care programs evaluated in this report and is an important safeguard against reductions in quality.
- Pricing, risk shifting, and provider participation. Determining an appropriate price for a bundle of services requires a significant amount of data and involvement from multiple stakeholders.
 Setting a price too low may result in limited provider buy-in because providers face losses as financial risks are shifted to them.

• Data requirements and IT.

Setting up, pricing, performance monitoring and evaluating a bundle requires detailed historical and current administrative data from multiple sources. IT investments are required to ensure this information is shared with providers in a timely manner.

• Deciding on a fund holder.

A bundled payment involves a payer providing lump-sum compensation for a bundle of services that often crosses multiple care sectors and many providers. This may lead to uncertainty regarding which entity is best suited to hold and distribute funds, especially for bundles that involve services in multiple care.

Find out how

St. Mary's

General Hospital

is using bundled care to deliver
better services for patients
on page 31

ACADEMIC ARTICLE

Recommendations for Bundling Care and Payment

Based on a review of the literature and evidence available to date, there are a number of factors that policy-makers should consider before implementing bundled care and payment.

- 1. Choose conditions carefully. Most other recommendations flow from this initial decision. The availability (or development of) specifications on best practice care and agreement of physicians and other care providers on these specifications is essential to: engage physicians with a focus on improving patient care; enable risk-management; set the duration of care; determine and monitor quality indicators; and set appropriate payment levels. Effective bundled care and payments have ranged from short-term procedural episodes to ongoing funding models. Shortterm bundles related to specific procedures tend to have more clearly defined care pathways, providers and timeframes, which
- imply more easily measurable outcomes and leads to a better ability to set appropriate prices and hold the appropriate practitioners accountable for care. Long-term bundles can also be successful, noting that severityadjusted, capitation payments that encompass all related care for an individual have been most successful to date. Regardless of the length of the bundle, it is important that a bundle capture all necessary patient care related to the condition, procedure or population.
- 2. The definition of episodes covered by payment should match the duration of the condition. The duration of the episode should cover the entire duration of treatment for a specific condition. Time-limited conditions are suitable for short episodes with little follow-up care, while chronic conditions are best managed with a capitated model where all care for related conditions is included. In planned procedures, pre-operative care can also be included in the bundle.

Regardless of the length of the bundle, it is important that a bundle capture *all* necessary patient care related to the condition, procedure or population.

- Include all providers in a bundled care price. Effective bundles are inclusive of all payments to all providers within the period (i.e., acute and post-acute, primary care, home care, drugs, etc.) which enables accountability. In many health systems, physicians are remunerated outside of the usual course of care and have a high degree of autonomy and a relatively low degree of affiliation. All of the successful models reviewed included physician payment within the single payment for the bundle of care. Physicians make most of the decisions about the care that is provided to patients, and including their payment within the bundle increases their partnership with other providers also paid through the bundle. It also ensures both clinical and financial accountability.
- 4. Early physician leadership is integral. The most successful bundles have developed care pathways with physician leadership. Physicians are integral to implementing changes to care delivery, so their involvement in defining care pathways is necessary. For the reviewed case studies in the report, physician involvement in translating evidence-based medicine into clinically meaningful processes was important to ensuring provider buy-in.
- 5. Ensure continuing physician engagement through a number of mechanisms. Physician engagement is an important component of bundling care.

Increasing physician engagement was most successful when physicians had leadership roles in the selection and implementation of best practice care. All of the successful examples of bundled care and payment in the review had adopted this approach. Ongoing physician engagement can be achieved through appropriate compensation which includes risk-sharing and aligning the incentives of providers and payers with quality assurance stipulations. Compensation, however, is not the only factor in ensuring physician engagement. Clinical governance structures that include payer and provider representatives as well as IT systems that deliver information to providers in a timely manner are also important ways to engage physicians.

6. Ensure timely and integrated data.

The receipt of data from multiple sources in a timely manner is required to facilitate the construction, pricing, operation, and evaluation of bundled care programs. Though Ontario has substantial administrative data, integrating this information and delivering it to providers in a timely manner will be necessary to ensure fair pricing, to allow providers to adjust care as necessary, and to monitor quality of care.

7. Invest in IT. Electronic health records that can be easily shared across providers have been a component of all the successful bundled care and payment initiatives that were reviewed.

The use of these systems has been integral in facilitating care coordination between stakeholders and the exchange of information, as well as enabling the automation of processes. These systems also play a central role in performance monitoring. For organizations where these systems are not already in place, funding for integrated IT systems is important.

- 8. Monitor quality of care. Bundled payment programs should include clear quality metrics focused on desired clinical outcomes. In the most successfully bundled care programs, providers must achieve certain quality levels to maximize their payment. It should be noted that a *limited* set of outcomes beyond process measures should consistently be monitored to ensure that quality outcomes are being met and that programs are able to meet reporting requirements.
- 9. Choose bundles based on provider and cost variation. The most suitable opportunities to improve care by bundling services occurs when within-provider variation for similar patients is low reflecting the capability of providers to ensure consistent care for patients with similar conditions, but between-provider variation for similar patients is high, suggesting opportunities for better alignment with best practice care and improved efficiencies across providers.



ACADEMIC ARTICLE

Bundled payments work best when there are no opportunities for shifting some (e.g., more complex) patients or services and costs outside given bundles to other parts of the health care system.

Bundling payment holds the most opportunity to impact total costs when variation in outcomes is low, while variation in cost is high.

- 10. Ensure transparency of cost and quality data. Transparency between all the parties involved in the creation, pricing, delivery and evaluation of a care bundle is important. Transparency can help to support partnership between payers and providers. In particular, transparency and accuracy in cost estimates are central to setting an appropriate price for a service bundle that will help to ensure provider engagement. Transparency of quality data was also important in facilitating discussions between physicians and administrators in the early stages of some bundled care programs, and physician report cards were cited as a possible mechanism to facilitate this. Less successful programs cited a lack of transparency with respect to cost arrangements as a major challenge.
- 11. Include risk adjustment in prices. Risk adjustment and the identification of outlier patients is an important tool to incorporate into price setting. There needs to be transparency and agreement when it comes to risk

adjustment methodology, as some hospitals and provider groups will have disproportionately sicker and more costly patients. This transparency is important in assuring physicians that the risk adjustment methodology adequately differentiates sicker, more complex patients from healthier patients.

12. Move towards as much bundling as possible. Comprehensive patient-centred care should be the goal for bundled care and payment. Bundled payments work best when there are no opportunities for shifting some (e.g., more complex) patients or services and costs outside given bundles to other parts of the health care system. If a bundled payment system operates alongside other payment to providers for the same patients and in the same time period, it can be difficult to ensure that costs are not simply shifted outside of a bundle. In evaluating care bundles, it is important to track total system costs to determine whether costs are being shifted outside of a bundle.

Conclusion

International evidence exists for the success of bundled care and payment for time-limited procedural care and for all-inclusive and comprehensive patient-centered care, but not for episodic management of chronic conditions.

Nonetheless, the authors believe that the opportunities, challenges and recommendations summarized in their report apply to all conditions considered for bundled care and payment.

They report that there is ample evidence for recommending bundled care and payment as a component of a sophisticated health care system.

The authors also found strong support for the engagement of all providers, including physicians, in the development and implementation of bundled care and the incorporation of all costs, including physician remuneration, within care bundles.

SNAPSHOT

There is

ample evidence

for including bundled

payments as a component

of a sophisticated health

care system.

Integrating Care around the Patient

In Ontario, there are a number of successful examples of integrating hospital and community care services

at a local level. One such program that was originally developed at St. Joseph's Health System in Hamilton called the Integrated Comprehensive Care Project (ICC), was designed for complex care patients to help ensure better patient outcomes, shorter hospital stays and fewer emergency room visits.

In 2013, the ICC was expanded to St. Mary's General Hospital in Kitchener to care for patients with heart and lung disease.

How the Process Works

The ICC uses dedicated care coordinators that follow complex care patients from the time they are admitted to the hospital, to the time they are discharged back home. The same care team follows the patient along his/her entire journey, and offers the patient and family 24/7 access to their dedicated care team.

St. Mary's has taken the ICC one step further by implementing a virtual care component to the ICC program. This entails a two-way coordination plan whereby dedicated integrated care coordinators work with patients to seamlessly plan and support their journey of care from hospital to home.

When patients are discharged, they follow a standard ICC care path, which includes virtual homecare for those patients not requiring a standard number of homecare visits. Virtual care includes check-in phone calls and a

telephone number that patients can call 24/7 to have questions answered by a care professional who is familiar with their care plan and has access to their hospital records. Patients have said that they feel reassured and supported knowing they have access to qualified staff that not only understand their care journey, but also have access to their history and can answer their specific questions.

What are the Benefits?

St. Mary's ICC pilot was recently evaluated by The Programs for Assessment of Technology in Health (PATH) Research Institute at McMaster University in Hamilton. The assessment team reviewed data for about 520 patients, half of whom were part of the ICC pilot and half whom were not part of ICC. Preliminary findings indicate the ICC group had reduced lengths-of-stay and reduced total cost (hospital and homecare) per patient of:

- Cardiac surgery 13 per cent reduction in length-ofstay and 13 per cent reduction (\$3,200) in total cost per patient.
- Thoracic surgery 17 per cent reduction in length-ofstay and 20 per cent (\$4,400) reduction in total cost per patient.
- Chronic obstructive pulmonary disease 58 per cent reduction in readmission rates.
- Congestive heart failure 30 per cent reduction in return visits to the Emergency Department.



with Dr. Bob Bell, Deputy Minister of Health and Long-Term Care

Strong patient-centred care is how we need to look at every part of our health care system, whether we focus on engagement, funding, procurement, governance or clinical care. What was the impetus for Patients First: A Proposal to Strengthen Patient-Centred Care in Ontario?

BB | Over the past decade, Ontario's health care system has improved in a number of important ways. But we can still do more to improve the patient experience.

Ninety-four per cent of Ontarians have a family health care provider. Only half report being able to see that person when they are sick. That puts Ontario 10th out of 11 countries in the 2014 Commonwealth Fund report. If people can't see their family health care provider when they are sick, they go to emergency, walk-in clinics or don't seek medical help until their condition is more severe.

Ninety-two per cent of home and community care clients say their care experience has been good, very good or excellent. However, some Ontarians also find that home care and community services are difficult to navigate, that they seem inconsistent across the province, and that care isn't as integrated as they need it to be. That said, integration of home and community care is what we expect from a high-performing health system.

Ontario has some of the best health care professionals in the world who work hard every day to care for patients and clients. The problems we see are the result of structural challenges in our system that hinder our collective ability to put patients first.

What major gaps currently exist in the structure of Ontario's health care system?

BB | Primary care is the cornerstone of any health system. In the Baker-Price report on Primary Care in Ontario, the expert panel noted the World Health Organization values of:

- Building on the principles of equity, universal access, community participation, and inter-sectoral approaches.
- Taking account of broader population health issues, reflecting and reinforcing public health functions.
- Creating the conditions for effective provision of services to poor and excluded groups.
- Organizing integrated and seamless care, linking prevention, acute care and chronic care across all components of the health system.
- Continuously evaluating and striving to improve performance.

We can do better in all of these areas and there are elements of the proposed changes (coupled with improvements to home and community care) that address all of these principles. We think that engaging our public health system more closely is going to help make sure that population health needs and equity are clear priorities.

What key opportunities exist for improving patient-centred care?

BB | Strong patient-centred care is how we need to look at every part of our health care system, whether we focus on engagement, funding, procurement, governance or clinical care. In many places, hospitals have been leaders in designing care around patients and families so we hope to spread that expertise around the health care system, particularly so we can improve transitions across care settings throughout the health care system. *Patients First* is our mission statement.

In your view, what are the most critical attributes of a high-performing health care system?

A strong, vibrant and responsive primary care sector is essential to a high-performing health system. Research has shown this. So too is a committed health care workforce. Ontario has some of the best health professionals in the world. We have excellent nurses, doctors, allied health professionals and sophisticated researchers and administrators. What we need today to make this a high-performing system is to bring all of those people together and to better connect them so there is both coordination and collaboration for each and every patient.

We also need to be accountable and transparent about the performance of our health care system, which means we need to measure and report on the outcomes we have set out to achieve – improved access, high-quality care, and better patient experiences. When we achieve

Ontario has some of the best health care professionals in the world who work hard every day to care for patients and clients.

FEATURE

these, we'll know we have an effective and efficient health system, where care is designed around the patient.

How will today's health
care system be different
from the one patients
experience five years
from now?

BB | If adopted, *Patients First* would improve
Ontario's health care system in many noticeable ways:

 There will be more effective integration of services, and the system will be more

- focused on equitable access to health care for all.
- More patients will be telling us that they have timely access to primary care when they are sick or need care.
- Patients will also have easier access to home care, and home care will be more consistent across the province, so that people know what to expect from the system as well as how to get the home and community care they need.
- There will be stronger connections between public health and the rest of the health care system, because we know

- that prevention is critical to population health.
- There will be more effective and better integrated health services for Indigenous people, based on a foundation of meaningful engagement with our Indigenous partners.
- Through our many discussions with nurses, physicians, researchers, health system planners and others, we have found that health care providers and organizations have a common goal of continuing to improve our health system—and that's what we've found so inspiring about this opportunity to put Patients First.



Local Health Hubs: A One-Stop Shop for Health Care Services

Opened in 1996, the Manitouwadge Community Health Centre (MCHC) was designed as a health centre for the entire community. When the MCHC built its facility in the mid-1990s, it was not a new idea, but one that suited the operational context; the community lacked infrastructure and many service providers tended to be small, often with just one full-time employee.

Today, the MCHC is regarded as what is commonly known in the Northwest Local Health Integration Network (LHIN) as an Integrated Health Care Organization (IHCO).

By co-locating all services onto one site, patients can have their needs met in a single location.

Beyond housing and providing governance for acute care, emergency, diagnostic imaging, laboratory services, long-term care, cancer treatment outreach, the family health team (FHT), home nursing services, medical transportation, seniors programs, diabetes education and Meals on Wheels, the Manitouwadge General Hospital (MGH) has helped co-locate many services (from mental health and addictions to a mobile CNIB clinic).

Furthermore, a primary care clinic for all local physicians, a dental clinic and an emergency medical services station are also located on the same property in hospital-owned buildings. A recently introduced contract management service for the primary care physicians' practice has further aligned the patient care experience to make access to all services as seamless as possible.

The launch of my Care home nursing services, a joint initiative between the Community Care Access Centre and hospital, has further enhanced the hospital's ability to offer more continuity of care. This means that sometimes, the same nurse will work with a patient during each phase of care.

Also, since the MGH provides information technology services for the medical centre, FHT and hospital, all patient records can be accessed from any location.

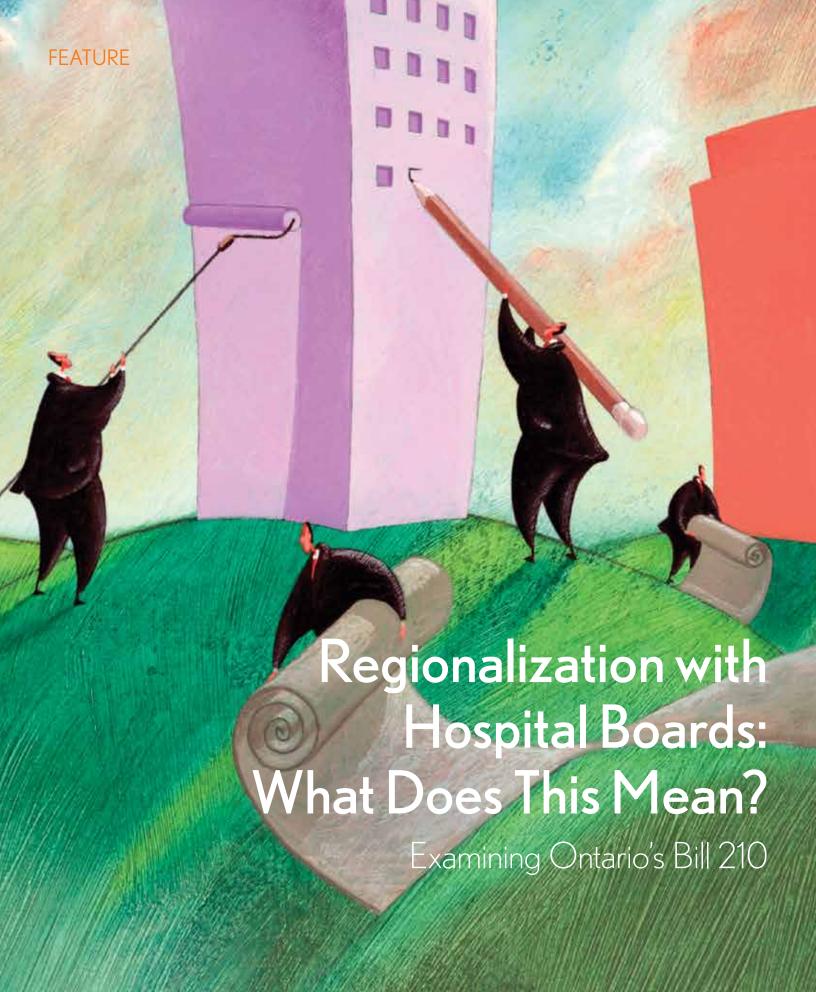
Medical Advisory Committee directives are standardized for all staff regardless of the setting they work in be it acute care, long-term care, clinic, FHT or home nursing.

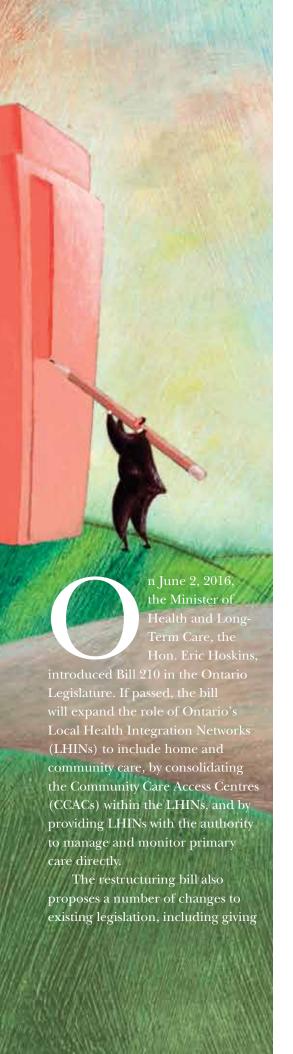
One of the keys to successful service integration has been the connection between the FHT and primary, acute, long-term care and emergency care. As it matures into a local health hub, the MCHC has been careful to address concerns the community has over losing staff or resources.

MEASURING SUCCESS

Strong leadership from the board, the CEO and the FHT director, along with a solid community focus, helped to make this integration a success – and the results are measurable.

- FHT and hospital collaboration on wound care has led to a 50 per cent decrease in visits to the emergency department (ED) since the introduction of the program in 2010/2011.
- The same wound care collaboration has been expanded to include advance diabetes foot care, and has reduced diabetic foot ulcer ED visits by 90 per cent.
- Patient satisfaction surveys confirm the community's support for this approach.





"Health policy is a contentious arena and few things draw more heat than the way in which health care is financed and administered."

- Dr. Gregory Marchildon

additional authority to LHINs over hospitals, primary care, home and community care and public health. More specifically, the CCACs would be wound down, with staff and functions being transferred to the LHINs, and management of primary care will become a responsibility of the LHINs. Each LHIN would be divided into "LHIN sub-regions" based on the current geographic boundaries of the Health Links (which, in turn, are based on referral patterns in local care). In total, there would be approximately 80 sub-regions across the province. Public Health Units will have a formal relationship with LHINs, but funding and oversight will remain with the Ministry and municipalities.

This model has not yet been seen in Canada – and it could put Ontario at the forefront of innovation when it comes to health system design. To better understand the implications of Bill 210 – and how this proposal compares to other jurisdictions in Canada, the Ontario Hospital Association interviewed Dr. Gregory Marchildon, Ontario Research Chair in Health Policy and System Design, Institute of Health Policy, Management and Evaluation at the University of Toronto.

Why do you think the Ontario government is moving towards a model of regionalization?
Why now?

GM | To improve quality and reduce the cost of inappropriate and ineffective care, the Ontario government (like other provincial governments) wants more integration and coordination of health services, providers and organizations – in other words, a more coherent health system. This is the main point in the interview with Dr. Bob Bell, the current Deputy Minister of Health and Long-Term Care. However, as Adalsteinn Brown points out in his introduction, the problem is that regionalization does not automatically produce better integration and coordination. In fact, in some cases, regionalization has simply replicated some of the very divisions and silos that prevent integration and coordination in the past. However, I would argue that in the context of the Canadian system, regionalization still provides a more solid foundation than the alternatives to achieving better coordination and deeper integration.

Ontario began the process of regionalization over a decade ago. However, recent changes, particularly the *Patients First* bill, is nudging the

FEATURE

Ontario model of regionalization more in the direction that regionalization has taken in the rest of Canada.

How does this model differ from other jurisdictions in Canada?

GM Unlike regionalization in the rest of Canada, the original LHIN model government kept financing and administration separate from delivery – what public administration experts call a purchaser-provider split. The original mandate was limited to funding, contracting and performance monitoring. The Patients First bill changes two key things. The first is that LHINs will now be responsible for managing community care and will have the option of directly managing CCACs. The second is that LHINs will be directly accountable for primary health care even though the Ministry of Health and Long-Term Care will continue to pay doctors centrally out of provincial funds rather than transfer these funds to the LHINs – an arrangement that is identical to what occurs in other provinces. This is still a far cry from LHINs directly owning and managing hospitals and long-term care facilities, a common feature of regionalization outside Ontario.

Is there any evidence that supports improved patient outcomes with this model of regionalization?

Unfortunately, there is almost no evidence on the connection between health system performance and regionalization much less on the specifics of a particular model of regionalization and patient outcomes.

I think there are at least three reasons for this. The first is that. for whatever reason, hardly any independent researchers have tackled the subject despite its importance to decision-makers. The second is the difficulty of isolating regionalization as a causal factor of patient outcomes. They are so many other potential factors causing change. Moreover, you are dealing with fairly recent organizational changes in the case of Ontario and there is often quite a large gap between a policy change and a desired (or undesired) outcome. The third reason is the reluctance of provincial governments to initiate this research either internally or through contract for the understandable reason that it may open them up to considerable criticism from opposition parties and the media. Health policy is a contentious arena and few things draw more heat than the way in which health care is financed and administered.

What are the fundamental lessons that Ontario can learn from other jurisdictions?

GM I think much can be learned from the experience of regionalization. The first and most fundamental lesson is to not underestimate the sophisticated human resource capacities required to lead and manage a regionalized system.

The second fundamental lesson is that regionalization requires real delegation and roles that are defined from the beginning. There is considerable evidence based on the experience of regionalization in the rest of Canada of how difficult it is

to divide roles and responsibilities. We are now in the second phase of the LHIN model that will require a redefinition of roles and responsibilities between the ministry and LHINS, between LHINs and the organizations with which they contract; and now between LHINs and primary and community care providers as well as LHINs and sub-LHINs.

How has the role of hospitals changed in other jurisdictions that have moved towards regionalization?

Few things have been changed as much by regionalization as the ownership and management of hospitals. In Western Canada, for example, all hospitals – with the important exception of Catholic hospitals – are owned and managed by regional health authorities (RHAs). Of course, the major exception is Ontario where almost all hospitals have independent ownership, governance and management. What has this change meant in places with the more typical model of regionalization?

On the positive side, it means that acute care is potentially easier to integrate and coordinate with other health services and institutions by the RHA – although not all RHAs have taken advantage of this potential.

There is no competition among hospitals and no incentives in terms of hospital payment that create obstacles to more patient-centred care. The potential disadvantage is that the governance and management of an individual hospital is separated from the facility itself creating a sense

of distance. However, this too is an under-researched area that should be looked at more closely.

What will be the biggest barriers during the transition and implementation phase?

GM For sure, there will be two major challenges. The first is a leadership and human resource issue. The current LHIN executive teams, and their employees, are now expected to manage health care much

more directly than in the past. The mix of knowledge and skills required to fulfill the more ambitious mandate set out in the Patients First bill is different. The learning curve will be steep and there will be little tolerance by the public (and therefore any provincial government) for failure. There will be a premium on effective leadership, particularly at the CEO level. Even the creation of sub-LHINs – the administrative layer that may end up doing the heavy lifting in terms of organizing and managing primary and

community-based care – will present major leadership and managerial challenges.

The second challenge is for the Ministry to achieve the right balance between central direction and vision and the high degree of delegation that is involved in any model of regionalization. Here again, Ontario can learn much from the RHA experience in other provinces.



GM Given the impossibility of going back to old passive payment system and the difficulty inherent in any single ministry of health managing everything, I expect Ontario to delegate even more to the LHINs and to give the LHINs greater authority in terms of direct ownership and management. However, this is far from inevitable.

We have seen in other provinces such as Alberta and Nova Scotia the very opposite movement. This has been due to what I have called the recent "crisis" of regionalization where the expectations of the political tier of government outstrip the ability of the civil service and delegated bodies (like RHAs and LHINs) to deliver the goods. In these cases, cabinet is very capable of reversing itself and putting all authority in a single, centralized (but still delegated) delivery agent at the provincial level. Time will tell whether this more centralized approach will work. However, in the case of Alberta, the evidence concerning health system performance has ranged from mixed to poor since Alberta Health Services was created in 2008.



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Bridging the Gap

Assessing Hospitals' Health Analytics Needs



health system funding reform (HSFR) in Ontario has created a new decision-making environment whereby hospitals must lever the appropriate clinical, operational and financial data for the purposes of planning, benchmarking and continuous quality improvement.

he introduction of

While it has been noted that progress is being made on many of the challenges associated with HSFR in Ontario, primarily through a new joint governance structure between the Ministry of Health and Long-Term Care (Ministry), the Ontario Hospital Association (OHA) and Local Health

The challenges commonly cited by Ontario hospitals include: limited access to timely and integrated clinical and financial data; continued need for greater clinical engagement; and a lack of resourcing, including skill sets to support analytics. Integration Networks (LHINs), the chief concern among hospitals of all sizes is the inherent issues within the Health Based Allocation Model (HBAM) formula, particularly as it relates to replicating, predicting and forecasting. In many cases, data availability was described as being poor.

However, the health analytics needs and capacity of hospitals differ across the province. Many are at different stages of development in understanding and implementing solutions to adapt to the new environment. There are also a range of capabilities across hospitals and significant potential for creating shared analytical capacity across groups of hospitals.

As such, the OHA is working to ensure that hospitals have the needed analytical capacity to adapt to this new environment.

To that end, the OHA has embarked on an effort to investigate and understand the health analytics needs of hospitals. The work is being sponsored by the OHA Health Analytics Advisory Panel, an advisory committee that is being chaired by Dr. Mike Apkon, President and CEO of the Hospital for Sick Children, and is comprised of hospital leaders with expertise in this field. Tectonic Advisory Services provided support to the OHA with the initial phase of this effort and has developed several recommendations for the panel, following extensive research and consultation with hospitals of varying sizes across the province.

Examining the Results

Multiple issues have been identified through the research as needing further examination and consideration by the OHA. Overall, the research has shown unanimous support for the OHA's initiation of this research, a high level of interest in the findings by the hospitals and the Ministry, and unanimous macrolevel support for HSFR itself. In addition, there is great support for all stakeholders to play a greater role in influencing the direction of HSFR and in supporting health analytics. Finally, hospitals agree that the OHA should play a greater role in establishing the direction of HSFR and in supporting health analytics in Ontario.

The challenges commonly cited by Ontario hospitals include: limited access to timely and integrated clinical and financial data; continued need for greater clinical engagement; and a lack of resourcing, including skill sets to support analytics. The shortage of health analytics personnel and the need for formal training programs was also a high priority for most respondents. An interesting finding in the research was the current work by many large hospitals to create data warehouses at the institutional level, which has been driven by the need for easily accessible and timely data. There is also strong support for data to be consolidated and housed in a portal at the provincial level. This would ensure that all hospitals have access to the appropriate information at the appropriate time to make decisions that provide the best

quality and cost effectiveness. There appeared to be general consensus that LHINs should be considered along with hospitals as data users, versus data generators or data holders, with shared access through portals to the provincial repository.

Potential Areas of Support

The research and needs-gap analysis gathered to date by Tectonic for the OHA provides an important validation of the need for better health analytics in support of HSFR. In terms of the potential areas of support for OHA members, hospitals agreed that they need: 1) timely access to data and benchmarking reports; 2) partnering, advocating and convening; 3) education and training at the post-secondary level; and 4) educational programs for the hospital work force.

The OHA will be reviewing these findings and will work to develop plans to assist hospitals in the near term. Over the longer-term, the findings will be aligned with the vision and direction of the OHA over the next five years. Moving forward, it will be critical for the OHA to continue working closely with hospitals the Ministry, LHINs, and other stakeholders across the system to determine the most effective method for meeting these needs, particularly as the system moves towards a more integrated and collaborative structure in the months to come.

Supporting the Transition from CAMH to the Community

At the Centre for Addiction and Mental Health (CAMH), mental health and addictions (MHA) alternate-level-of-care (ALC) rates were once as high as 20 per cent per month with almost 100 ALC clients. Most were waiting for high-support housing and specialized clinical supports, which is in contrast to ALC patients in acute and chronic care settings who are typically waiting for long-term care.

Recognizing that a prolonged hospital stay does not constitute optimal care, in 2013, CAMH worked closely with partners from the community to help their clients live independently outside of the hospital setting and receive care that promotes recovery and successful integration into the community.

The solution involved a collaborative effort: CAMH along with high-support housing providers and community mental health providers developed a proposal to support the transition of Mental Health ALC clients at CAMH to the community, and to promote flow from high-support housing to lower levels of support.

On April 1, 2013, the pilot project was launched. It involved both high-support and medium-support housing providers and an Interdisciplinary Transition Team (ITT). The ITT consisted of a Registered Nurse, Social Worker, Behaviour Therapist, and Psychiatrist, who together worked with the client and their family or substitute decision-maker prior to discharge. The ITT also provided intensive support post-discharge.

In parallel, the Toronto Central Local Health Integration Network (TC LHIN) high-support housing providers agreed to identify clients in existing units who were interested and able to move to medium-support housing in order to create capacity.

Between April 2013 and November 2014, a total of 26 CAMH ALC clients were discharged. The first

two clients discharged returned to CAMH within weeks, prompting a critical review of the process.

The review led to the development of Matching Meetings to better ensure success. The meetings were attended by the inpatient team, including the psychiatrist, high-support housing providers, the ITT, project coordinator and Community Care Access Centre. At these highly collaborative discussions, team members discuss the patient's unique situation, and determine their strengths, challenges, special needs, and level of support required.

Efforts are underway to develop cost comparisons, and it is anticipated that the savings to the system will be considerable: the annual cost of the initiative is likely 75 to 80 per cent less expensive than inpatient care. And as important, clients and family members have universally positive reviews of this initiative. In a qualitative study conducted after the first year of operation, many clients reported that they felt greatly supported in their new environment and enjoyed the social aspect of being in the new housing units.

Today, the program has graduated from the pilot stage and receives dedicated base funding from the TC LHIN. Regeneration Community Services, LOFT Community Services and Pilot Place Society are providing high-support housing for close to 60 ALC patients, and many more housing providers are supporting the initiative as patients continue to move to housing with lower levels of support.

Contributed by Linda Mohri, Executive Director, Access & Transitions, CAMH.

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