

Building trust to integrate funding and care for chronic diseases in Ontario, Canada

Summary

- The Integrated Comprehensive Care (ICC) 2.0 programme in Ontario, Canada, uses bundled episode-based payments for patients with chronic obstructive pulmonary disease (COPD) or congestive heart failure (CHF).
- First implemented in a single hospital, the programme was expanded in 2015 to include nine acute care hospitals, representing about 10% of hospital volume in Ontario. Between October 2015 and March 2018, 3010 patients voluntarily enrolled in ICC 2.0, representing 44% of all eligible patients admitted to these hospitals for COPD and CHF.
- The goal of ICC 2.0 is for patients to have one team deliver integrated patient-centred care to reduce unwarranted variation in quality, while improving the experiences of patients and caregivers, and value for money.
- A single, integrated payment is shared between the hospital and the home care provider for patients admitted for CHF or COPD for one episode of care beginning with acute hospital care and extending to home-based care after discharge for up to 60 days.
- An external independent evaluation reported positive effects but the evaluation could not fully control for differences in clinical severity between the intervention and comparator populations, nor could it capture other key factors that may have biased the findings.

Key elements of the programme

- The most important design elements included having a single organization to coordinate and provide all postacute care, including clinical

services, and having telehealth systems available 24 hours/day 7 days/week for the entire episode of care.

- A designated care coordinator facilitated the provision of care across multiple health care settings, while standardized integrated care pathways ensured patients received optimal, evidence-based care, thus reducing variation across providers.
- Using information technology (i.e. to share electronic records across providers) ensured that complete information was available to providers regardless of whether patients were in the hospital or receiving home care services. However, in some cases, this required providers to learn how to use different information systems across different organizations.

Results

- Stays in ICC 2.0 hospitals were associated with reductions in the mean length of stay, rates of readmission, visits to emergency departments and deaths after 60 days relative to comparators.
- For the 60-day bundle period, the total cost savings was US\$ 2705 (2019) greater per episode for patients enrolled in ICC 2.0 relative to comparators between October 2015 and March 2018.
- The analyses could not control for several factors that may bias the findings, including differences in clinical severity between the intervention and comparator populations, nor could it capture key outcomes, such as hospital-acquired infections, gaps in follow up or functional decline, and patients' experiences of care. Moreover, patients who returned after the 60-day episode window were considered new cases thus artificially reducing readmission rates.

Facilitating factors

- Many participating hospitals had pre-existing working relationships that facilitated programme implementation and sharing of resources and data in real time.
- Differences across professions, organizations, systems and sectors were bridged by fostering trust and allowing each profession to voice what was important from their perspective.
- Working through risk scenarios, encouraging input from clinicians and administrators, and accounting for different perspectives in the acute care and community care sectors allowed a model to be developed that was applicable across the programme.
- Building confidence among clinicians was done by involving them in developing the model, utilizing integrated care coordinators who had pre-existing relationships with physicians and identifying clinical champions.

Inhibiting factors

- Factors inhibiting information-sharing included the lack of a single electronic medical record system and differing organizational interpretations of privacy regulations.
- Coordination of programme roll out was hindered when organizations differed in size and levels of resource availability.
- Patients satisfied with their existing home care organization hesitated to enrol, given that ICC 2.0 employed care coordinators and service providers specific to the bundled care programme, requiring patients to switch caregivers. This limited the number of patients enrolling in ICC 2.0, which interfered with programme scale and spread.

- Different perspectives on union regulations came into play. Positions for hospital-based integrated care coordinators were disputed by pre-existing home care coordinators over concerns that the new positions were taking work away from them. There was a lack of oversight of and orientation for coordinators in the expanded programme that led to nonstandard practices.

Lessons learned for other settings

- Successful implementation relies on aligning the programme with the context in which it is being implemented. Involving stakeholders in the various stages of designing and implementing ICC 2.0 ensured there was sustained engagement from local providers. This involvement allowed health care providers to voice their concerns, building a sense of trust and encouraging their active participation.
- Information-sharing across providers is a crucial component of providing integrated care. This requires a strong infrastructure for information technology that can be used across participating organizations.
- Financial stability is vital for successful implementation. Having a stable source of funding increases support for the programme from local clinicians, allowing providers to focus on improving patient outcomes. In addition, cost savings resulting from the provision of integrated care essentially become additional revenue for participating organizations when a bundled-care approach is used.
- Nonmedical determinants of health and outcomes must also be considered. These may include transportation, food security and even housing. Providers are often reluctant to assess these determinants if there are not relevant linked programmes or funding.

This policy brief is based on Wodchis WP, Rashidian L. *Integrated Comprehensive Care programme in Ontario, Canada*. Geneva: World Health Organization, Organisation for Economic Co-operation and Development; 2023.