INTEGRATED FUNDING -
A FUND HOLDER'S GUIDE & FAQ

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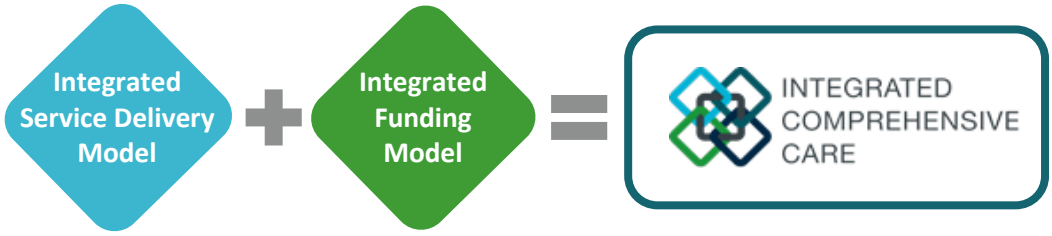
Since 2012, St. Joseph's Health System has pioneered Integrated Care in Ontario in partnership with patients, front line staff, health care delivery partners, as well as the Ministry of Health and local funding bodies. Through on-going quality improvement and our commitment to co-design we have continually evolved our Integrated Comprehensive Care model to better support patients, their families and our staff. We have worked with thought leaders and academics both within Canada and internationally to refine our approach, evaluate its impact and document its advantage. Our practical hands-on experience is beneficial to any organization seeking to implement an evidenced based integrated service delivery and integrated funding model or, embarking on an Ontario Health Team (OHT) initiative.

Integrated Funding - A *new* Lever to Enable Priority Outcomes

St. Joseph's Health System's (SJHS) **Integrated Comprehensive Care** (ICC) is an evidence-based model of Integrated Care that supports patients with ***One Team, One Record, One Number to Call, 24/7***. ICC is enabled by a co-designed integrated service delivery model and an integrated funding model, which we refer to as ***One Fund***. Our focus is to make the patient experience as seamless as possible, while utilizing existing resources across the health care continuum.



The Integrated Care co-design and the dollars / capacity made available through this process, allows healthcare leaders to redefine care paths and reallocate resources. We focus first, on what is best with the patient ***and then*** consider how we can fund that solution through the reallocation of existing resources and reinvestments of savings generated by program re-design.

As such, an integrated funding model introduces *new* levers that can break down traditional healthcare silos and enable the redesign care delivery across the complete patient journey. The

care path is our True North; our rapid cycle change management approach afforded by the flexibility within the model ensures our approach is ***'patients first and funding follows'***.

One Fund **Holder**

This evidenced-based approach to the development of an Integrated Funding model (***One Fund***) supports a shared understanding of costs, outcomes, and the role of each partner organization within the care team has in achieving agreed upon outcomes. Central to its success is the commitment of a single point of accountability to facilitate this change in patient experience and outcomes.

In order to establish an effective ICC program, there must be ***One Fund*** holder, this role is sometimes referred to as the 'bundle' holder. Any organization (LHIN, Hospital, Primary Care or other organization) could be the ***One Fund*** holder. This single organization will be accountable for the tracking, reporting and allocating a pool of funds in a manner that is transparent and accountable to all partner organizations.

Today, the ***One Fund*** holder is typically a hospital, as they generally have expertise & resources to oversee the process, in addition to the largest financial stake in care delivery. In the future, the ***One Fund*** holder could be an OHT or an OHT member organization accountable for a specific patient population.

The key accountabilities for the ***One Fund*** holder include:

- Provide strong leadership to support the establishment of an integrated care model and drawing in partners / stakeholders to achieve common purpose
- Work with partners to foster ***One Team***, with ***One Record*** and ***One Number*** enablers
- Facilitate the development of the complete care path across the entire continuum of care; as defined by the care team including patient advisors
- Provide regular updates on patient care utilization and operating costs
- Ensure all clinical, patient priority, and financial outcomes are realised
- Oversee the delivery of all services via direct management and partnership agreement(s)
- Address day to day issues that arise between partners or with patients / care plan
- Establish and maintain process to support flexibility of rapid cycle change within the integrated care model and ensure ongoing evolution of the care path aligns with evolving priority outcomes

The ***One Fund*** holder must closely collaborate with all partner organizations to facilitate integration and deliver on these accountabilities.

Care Path Co-Design:

Our approach to the co-design of a care path begins with the care team including patient advisors (with change management support). They drive the process, with early and frequent engagement with the finance and decision support teams.

Our first priority is to establish a common understanding of shared goals and priority outcomes. We map out *current state*; document historical resource utilization (or consumption), capability and costs. Then using the Guiding Principles of the ICC model, re-design *future state* based on the groups shared perspective and informed by evidence / leading practices. This provides the integrated care team with a common understanding of the redesigned future state, full patient journey, associated costs and opportunities for improved outcomes. Our next priority is to arrive at a common understanding of all potential funding sources and obtain agreement on the level of contribution by all the stakeholders to achieve a balanced bundle, thereby establishing ***One Fund***.

Building a Bundle

Existing Ministry of Health (MoH) Bundle Care programs, such as Hip and Knee, have a prescribed bundle rate established. When no prescribed rate is available, the ***One Fund*** holder works in collaboration with stakeholders to identify the required resources to support a particular care path and to identify all potential funding sources. The chart (***Figure 1*** on the following page) describes the development journey of ICC vs. bundle care.

The ***One Fund*** holder and ***One Team*** members work to allocate the total contributions based on:

- The newly developed patient care path, actual utilization, and hospitals and other provider's capacity for different modes of care
- Anticipated costs
- A pre-determined MOH bundle allocation (if applicable)
- Quality Based Procedure care guidelines, when prescribed
- If not prescribed it would be the identified standard cost or negotiated rate
- Predictions of local patient needs which, typically involves a discussion of volumes*

Surgical volumes or elective activity is impacted as funded volumes change. The larger issue to consider is that non-elective activity may be impacted by growth, aging population, or other factors. Providers may wish to consider how they responded to increases in non-elective activity prior to establishing the bundle to create a principle-based approach.

Figure 1:

	Prescribed Rates Provided e.g. MOH Bundled program	**No Prescribed Rate** e.g. OHT building One Fund
Approach	MOHLTC identifies a patient population that requires hospital and post –acute care uses this funding model to drive partnerships across sectors.	Hospital and community partners identify an opportunity to use the ICC model of integrated care for a specific patient population. This improvement will assist in providing an integrated standard of care between the hospital and post-acute providers. Stakeholders make a collective decision to pilot a change in care.
Care Plan Design	In this case the Ministry will guide *Bundle Holders in the* development of a post-acute care paths by providing utilization data, outcomes measures and access to tools and other dedicated resources to assist in the planning and operationalization of the program.	Hospital & partners work collaboratively to design a care path that meets desired patient care needs. Co design with stakeholders and patients is an essential step in building a care plan
Funding Sources	MOHLTC provided, hospital and community partners may support the model by providing additional funds where needed.	Stakeholders develop a *Standard Cost*, based on micro costing each activity in the care plan developed (e.g. cost of resource + time spent). Once the standard cost is established, potential funding sources are identified by all those involved in providing care through existing resources. Based on the care plan design, stakeholders will work to balance the integrated fund by pooling together existing budgets and potential savings in length of stay, avoidance in ED visits or readmission.
Data Sources	Stakeholders can choose to use data to assist in the care plan development process. MOHLTC provides data and benchmarking to support model.	Stakeholders use available data sources to determine selected populations to better support post-acute transitions. Metrics to consider include volume, LOS, ED revisit, readmission within 30 days patient experience, etc.

A Foundation of Trust

Building a shared vision, co-designing care paths and transparent open dialogue between financial, clinical and patient partners establishes trust. Trust is required to operate an Integrated Comprehensive Care program and realise the many benefits it can deliver.

As a pioneer and leader in models of Integrated Care, St Joseph's Health System has established the **Centre for Integrated Care** to help guide your organization through this journey. For more information, please visit www.SJHS.ca/IntegratredCare.

The Centre for Integrated Care would like to thank Laura V. L. and Nancy S., our generous and insightful patient advisors, who helped in the development of this paper.

Frequently Asked Questions on Integrated Funding

1. **What is the benefit of implementing an Integrated Care program?**
   You are better able to make every dollar count; Integrated Care creates value for patients and the system as it promotes high quality patient-centred care across the care continuum. Through purposeful co-design, more patients will receive best practice care, improved transitions, outcomes and experiences. It also improves system sustainability through cost management and continued focus on efficient care. The ***One Fund*** design and dollars made available through this process allow for patients to receive appropriate care in the right place, at right time, by the right resource.

2. **How do Providers / OHTs develop an Integrated Comprehensive Care funding model?**
   Following a patient co-design approach, the design of an integrated funding model (***One Fund***) is driven by clinical teams with early and frequent engagement with finance. Patients first, funding follows. This is an important shift in thinking.

   The care team (***One Team***) with change management support, documents the *current state* process and current state resource utilization summary, develops a detailed *future state* care path that supports and enhances the patient journey according to predetermined priority outcomes such as:

Patient Outcomes	Provider / System Outcomes
• Return home sooner	• Reduced Hospital Length of Stay (LOS)
• Empowering patient education and self-care; and	• Reduced Emergency Department (ED) visits
• Increased patient access via home and virtual care / one number to call – always there	• Reduced Hospital readmissions
• Enhanced patient experience	• Enhanced provider experience
• Reduced anxiety for both the patient and family post-discharge	• Enhanced integration between hospital, home & community

3. **How do you co-develop an integrated care path from hospital to home?**
   An optimal and complete patient care path is built by representatives from across the full care team (***One Team***) with change management support, based on identified population needs and pre-determined priority outcomes. Where available the care team will utilize post-acute historical data as a guide to develop care paths. Historical data can come from multiple sources, such as the hospital projected volumes or the LHIN for current post-acute utilization. Historical data helps to guide how resources are allocated and care plans can be refined further to better meet patient needs and priority outcomes in the ICC program**.** The initial service delivery model is not static, we continuously learn and adjust care paths through rapid cycle change to better meet patient needs.

4. **How do you fund the Integrated Comprehensive Care model when there is no prescribed rate?**
   Building off confirmed agreement amongst the stakeholders on what they will contribute to fund the redesigned care path, both historical utilization and impact of anticipated changes in service delivery model and care paths inform funding. Once the *future state* care path is finalized, the finance team develops a standard cost methodology to cost the anticipated pre-admission, acute and post-acute phases of care. Defining the full care path will require specific details related to post-acute workload, including who sees the patient (RN, RPN, PT, etc.), duration of time spent with patient, number of visits per care plan duration. The finance team can use various tools for costing the care path including case costing (acute care), cost per visit modeling (post-acute), allocating indirect costs, as examples.

5. **When there is no prescribed rate, how do you balance *One Fund* and where does the money come from?**
   One Fund can be balanced by looking at historical resource utilization of each provider and the impact of the anticipated new integrated service delivery model which may, result in efficiencies at various stages in a care path, service delivery or other areas such as LOS savings, ED readmit or revisit efficiencies. Balancing strategies requires agreement amongst all stakeholders of what they will contribute both from the hospital and current post-acute providers to then be able to pool potential bundle funding.

6. **How do you manage the risk of being the *One Fund* holder?**
   Establishing a risk/gain sharing agreement in advance that considers the most likely scenarios that could be encountered, along with a pre-defined mitigation plan for resolving these concerns, will support transparency and helps to build trust across all members of ***One Team***.

Risks can be managed effectively by carefully monitoring and reporting progress against your goals to stay within predetermined utilization and cost. Monitoring and reporting should be shared transparently between the ***One Fund*** holder and all delivery partner organizations. It helps to have a good historical understanding of utilization patterns for post-acute care and defined patient populations requiring post-acute support. Information of this kind helps in understanding potential program volumes and care coordinator workload.

7. **Who should be the *One Fund* holder?**
   The ***One Fund*** holder should be the organization that has the greatest risks and gains related to a Bundled Care program**.** In our experience, this is typically the hospital. Historically, preadmit and acute care costs account for approximately 85 to 90% of the Bundled Care program cost and therefore the hospital holds the greatest risk. Also, hospitals are the entry point for patients into the ICC program and hospitals have some control over volumes for elective cases. Regardless of who holds the funds, the risk and gains should be shared across the all partner organizations (***One Team***).

8. **Who is responsible for overseeing service delivery and achieving priority outcomes?**
   The ***One Fund*** holder is ultimately responsible and works closely with all delivery partner organizations to optimize delivery, aligned with guiding principles and priority outcomes. In some cases, they may partner with an organization with specific expertise to oversee and manage service delivery and outcomes.

9. **What data is available to help you understand utilization?**
   Hospital, Primary Care, Home Care and Community partners need to work together to track and reconcile volumes through Canadian Institute for Health Information (CIHI) Discharge Abstract Database (DAD) and National Ambulatory Care Reporting System (NACRS) and within Digital Health Record systems on a frequent basis. Home Care service provider organizations (Home Care-SPO) need to be able to support the ***One Fund*** holder with utilization data of post-acute care so that the ***One Team*** members can take any corrective action as necessary. All partners document in ***One Record*** (a shared Digital Health Record) with transparent access to clinical records, patient phone calls and home care visit details. Note: If you don't have a care coordinator on your team, you would need to decide how you will monitor post-acute utilization.

   Many Canadian home care providers use an information system such as AlayaCare™, GoldCare™ or Procura™ to track scheduling by discipline and other factors, to help finance and clinical teams in decision making. With these systems ability to track every single patient visit by date, type and discipline as well as other factors, it helps finance and clinical teams

understand the utilization and care path better to make informative decisions. The utilization data is used to support rapid cycle change improvements and help build more up-to-date care path for future care streams.

10. **How does Integrated Comprehensive Care differ from current Bundled Care programs?**

    Bundled care is an enabler for integrated care. ICC is both an integrated service delivery model and an integrated funding model, whereas the MOH Bundled Care program only stipulates the integrated funding component, and could be implemented via existing service delivery models. This could however be a missed opportunity. Solely focusing on cost harmonization and cost containment would negate the additional patient, provider and system benefits delivered by the evidenced-based Integrate Comprehensive Care model. In following this wider approach, additional infrastructure and indirect costs such as care coordination can be incorporated in the integrated service delivery design and supported by the ***One Fund***.