

Community Hospital Health Centre – A model for Health System Integration in Ontario

Discussion Document



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The Ontario Health System is complex and fragmented

Mental Health Services

- 3 Psychiatric Hospitals
- 4 Specialty Psychiatric Hospitals
- 355 Community Programs
- 159 Homes for Special Care
- 3,600 Homeless Supportive Units
- 6,900 dedicated Supportive Housing Units
- 160 Agencies for Drug and Alcohol Treatment Services
- 47 Problem Gambling Treatment Agencies

Health Care Providers

- More than 23,000 Physicians
- Over 135,000 Nurses
- 23 Regulated Professions and 21 Regulatory Colleges

Drugs

- Over 2,700 Pharmacies
- 3,600 Drugs on Formulary

Groups & Assocs.

- 400 Health Interest Groups and Professional Associations

Community Services

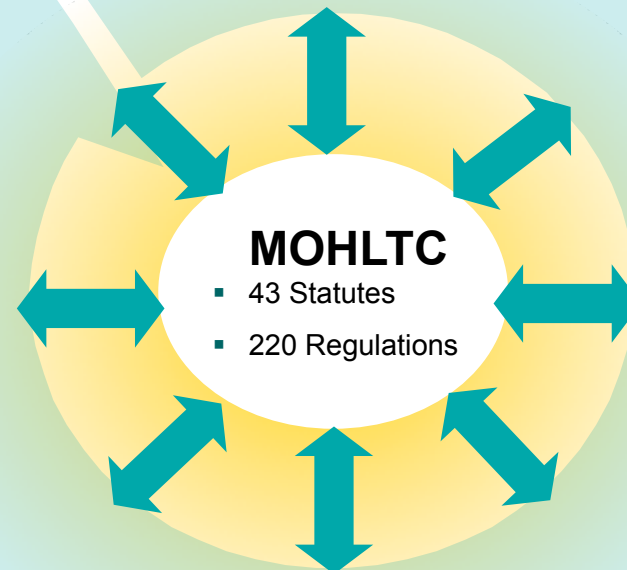
- 850 Community Service Agencies
- 67,441 beds in 560 Long-Term Care Facilities
- 37 local Boards of Public Health
- 55 Community Health Centers operating in over 70 cities
- 18 Children Treatment Centers
- 275 Hospital, Community (private) and Public Health Laboratories
- 1,100 Assistive Device and/or Home Oxygen vendors
- 42 Community Care Access Centers
- 969 Independent Health Facilities
- 70 HIV/AIDS Education Support Programs
- 67 Land Ambulance Operators
- 134 Diabetes Education Centers

Laboratories

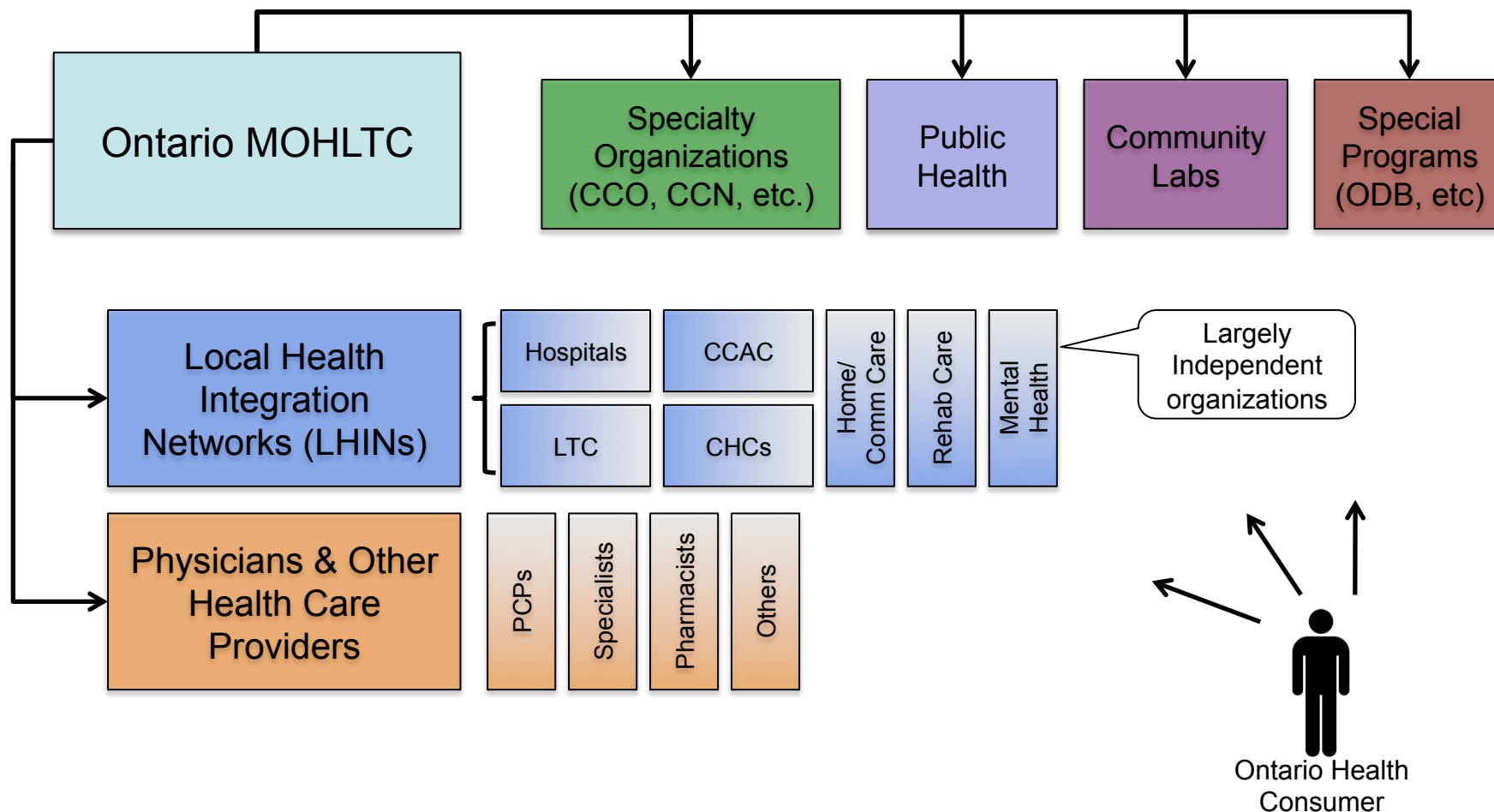
- 204 Hospital Labs
- 96 Community Labs
- 377 active Licensed Specimen Collection Centers
- 200 Million Tests annually

Hospitals

- 154 Corporations in 228 cities



The current landscape in Ontario is not truly integrated with multiple providers delivering care / services



Latent structural issues exist that impede integration

- The current cost-plus funding structure distributes funds across several relatively separate entities (physicians, hospitals, community care, priority programs, drugs, etc.) without focus on overall health outcomes.
- In the current fee-for-service model, providers (physicians) do not consider the cost effectiveness of treatments. In fact, there is an incentive to over utilize resources.
- Current Incentive systems (especially for physicians) are not organized in a way that is aligned with the desired system and patient outcomes.
- LHINs Distributes funds to various care providers and are accountable for health of entire population but do not “own” care providers.
- At the hospital level, existing hospital funding formulae (e.g. JPPC) provide little incentive to efficiently allocate resources across different providers of care.
- Funds flow down to hospitals without regard to market share, consumer demand, quality, or efficiency.
- The current system lacks an architecture for true integrated health care delivery.

Integration case studies from other jurisdictions provide lessons for Ontario

Case Study Example

Lessons for Ontario

Primary Care Trusts, United Kingdom

- Evolved from primary care groups and serve a population of 100,000+
- Each have an annual budget of ~£60M+, representing nearly 80% of NHS funds
- Strong physician and local community leadership (most PCTs are led by a physician)
- Most are integrated, single organizations which contract for a full complement of services in their regions from multiple sources including National Trust hospitals or tertiary/quaternary care centres, independent physicians, dentists, etc.
- PCTs develop local strategy and ensure quality of care
- A large number of PCTs (142) are focused on and committed to local integration

- FHT, FGHS, and FHNs may be leveraged to develop PCTs
- Development of PCTs will require OMA agreement
- At present, FHN, FHGs, and FHTs do not have the administrative sophistication to drive a PCT agenda

Kaiser Permanente, United States

- Based on the Kaiser Permanente model of vertically integrated health organization/systems
- A vertically integrated health care system requires an aggregation of health care units, including acute care centres
- Community hospitals serve as natural points of aggregation of health care resources
- Association between hospitals and physicians may be formalized similar to the Primary Care Partnership model used in Australia
- Will maintain current community involvement

- In Ontario, the most sophisticated health care organization in a community is the community hospital
- Does not require OMA input to enter into agreements with physician groups
- Will require legislative changes to permit expanded mandate of community hospitals

Geisinger Health System, United States

- A physician-led integrated delivery system serving approximately 2.6M people
- Employs more than 12,000 people, including over 740 multispecialty physicians at 50 sites
- Staff and management have worked to reduce variability and implement standardized care through use of check-lists, clinical pathways, and guidelines
- Integrated model is based on multi-disciplinary teams and advanced use of information technology (Geisinger has invested over \$100M in IT to develop its EHR)
- Developed *ProvenCare*, a pay-for-performance model leading to improved outcomes and decreased costs (decreased length-of-stay, lower readmission rates, less costs)

- Integration requires involvement of health professionals at all levels to coordinate care from initial diagnosis, treatment, discharge, and follow-up
- Use of standardized treatment protocols facilitates integration between organizations while improving care

Utilizing existing structures, there are opportunities to aggregate, then integrate care/services in the Ontario System

Primary Care Groups

- Ontario is ripe for primary care integration as an increasing number of family physicians are in either Family Health Teams (FHTs), Family Health Groups (FHGs), or Family Health Networks (FHNs)
- These groupings may be used as a foundation for an integrated health care system

Hospital Medical Staff

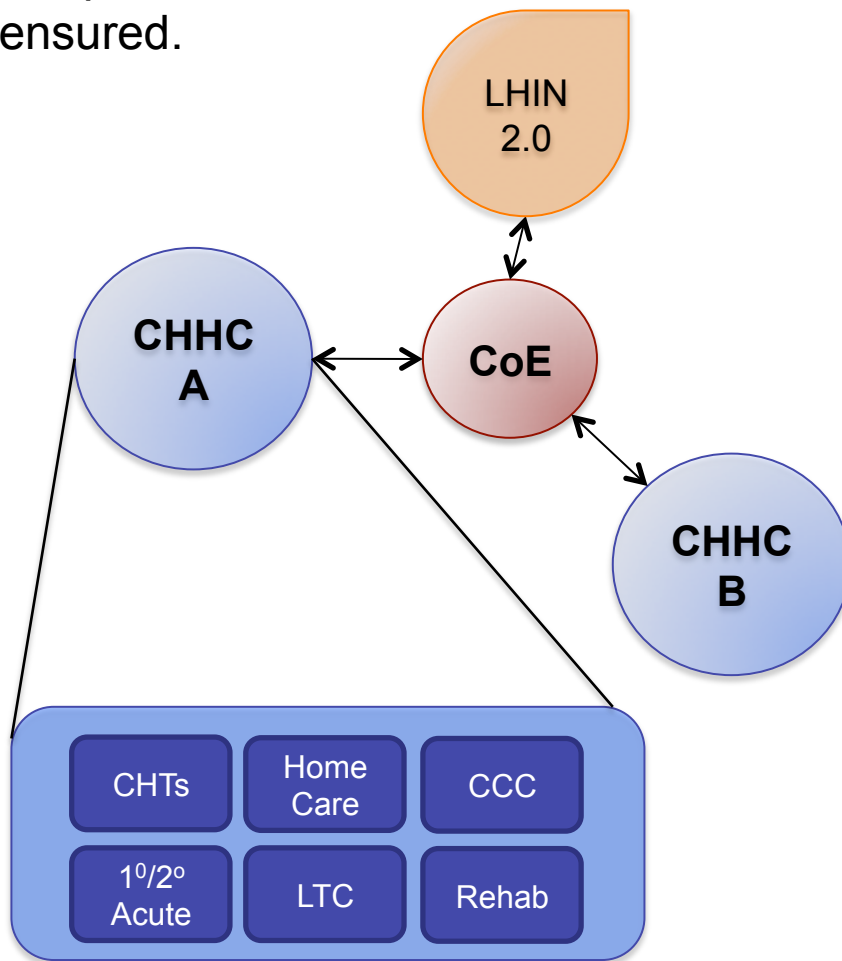
- Hospitals are a community of managers, employees, and medical staff
- Hospital medical staff members are often the only constant within the organization because physicians are unlikely to move after establishing a practice
- Strong primary care and community specialist relationships exist within hospital medical staff
- Natural and long-standing relationships between community specialists and primary care physicians set the tone for physician group integration
- Physician-led integration has been successfully employed in England (i.e., Primary Care Trust Model) and by Kaiser Permanente (i.e., a fully integrated hospital/health centre)

Community Hospitals

- Highly valued in the community for the delivery of care
- They remain the most sophisticated and best supported healthcare organizations in the community

A potential integration model - Community Hospital Health Centre

Model requires aggregation of delivery services at local levels with integration of system services occurring at the provincial level. Leveraging the Community Hospital offer a more immediate solution, provided physician leadership is ensured.



- Community Hospital Health Centre (CHHC)
 - Aggregation of Community Health Teams (CHT) composed of primary care and community specialists with acute care hospitals, long-term care/home care facilities
 - Micro-meso integrators of local health care from primary and specialist care (CHTs) through the health care continuum of secondary and limited tertiary care, rehabilitation, home care or LTC
- Centres of Excellence (COE)
 - Deliver tertiary and quaternary acute care and act as meso-macro integrators of regional complex health care
 - Academic Health Science Centres,
- “LHINs 2.0”/ Ontario-Wide Integrators
 - Will not deliver care, but act as a macro integrator for health care across the province
 - Ensures consistent delivery mechanisms and standards through a robust clinical governance body
 - May be an existing organization like Cancer Care Ontario (CCO) or a new all-encompassing organization

For more information or to find out how we can help, please contact:

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