Welcome to Fireside Chat # 428

December 16, 2014 2:00 – 3:30 PM Eastern Time

Health Canada – in-camera webinar
for federal/provincial/territorial government representatives, including members of the committee on Health Workforce

Bridging the Silos:
Moving To Integrated Health Care Provider Funding Models in Canada

Presenter:

Erik Hellsten

Senior Specialist, Quality-Based Funding
Health Quality Ontario

Commentary by:

Jillian Paul

Acting Director, Health Quality Branch

Ontario Ministry of Health and Long-Term Care

Teleconference: ***(All audio via teleconference)***
(Teleconference open for participants at 1:50 PM ET)

1 866 261 6767 or in Toronto: 416 850-2050 ***PARTICIPANTS PASSCODE: 5528549#***

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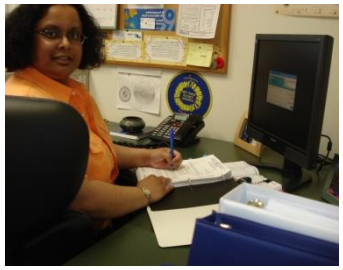
How to post comments/questions during the Fireside Chat



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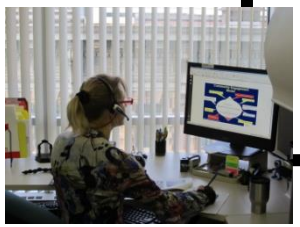

Please introduce yourself!

- ***Name***
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- ***Location***

- ***Group in Attendance?***

Joining by
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Introductions

- Recording will begin now.

- Introductions:
  - Julie Thorpe, Senior Policy Analyst

  Health Care Programs and Policy Directorate,

  Strategic Policy Branch

  Health Canada

Presenter

Erik Hellsten

Health Quality Ontario

Institute for Health Policy, Management and Evaluation, University of Toronto

Centre for Health Services and Policy Research, University of British Columbia

Commentary by:

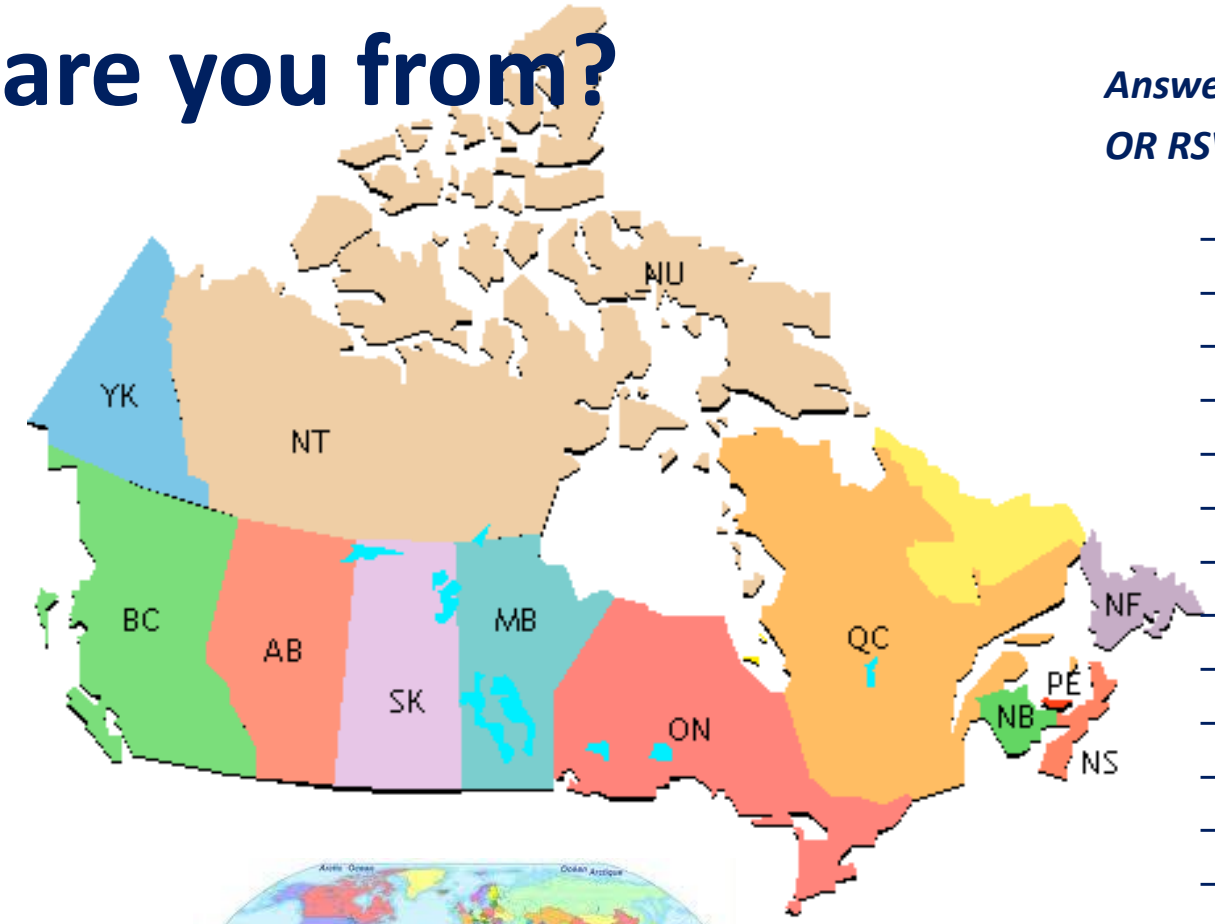
Jillian Paul

Acting Director

Health Quality Branch

Ontario Ministry of Health and Long-Term Care

What province/territory are you from?



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- **BC**
- **AB**
- **SK**
- **MB**
- **ON**
- **QC**
- **NB**
- **NS**
- **PEI**
- **NL**
- **YK**
- **NWT**
- **NU**
- **Other**

Themes for this afternoon

- Integrated funding models – why all the interest?
- Reviewing international developments, with a focus on Obamacare reforms in the US
- Applying these analytical models in Canada: taking a look at Health Quality Ontario's Episode of Care analyses

Health Quality Ontario: What we do

- Public and confidential provider reporting on health system quality and outcomes
- Support quality improvement activities
- Health technology assessment function to inform government public funding coverage and policy recommendations
- Providing evidence, analysis and clinical expert input to government funding models

2ND SESSION, 39th LEGISLATURE, ONTARIO
59 ELIZABETH II, 2010

2e SESSION, 39e LÉGISLATURE, ONTARIO
59 ELIZABETH II, 2010

Bill 46

(Chapter 14
Statutes of Ontario, 2010)

An Act respecting the care provided by health care organizations

Projet de loi 46

(Chapitre 14
Lois de l'Ontario de 2010)

Loi relative aux soins fournis par les organismes de soins de santé

The people of Ontario and their Government:

...

Believe that the patient experience and the support of patients and their caregivers to realize their best health is a critical element of ensuring the future of our health care system

...

Share a vision for a Province where excellent health care services are available to all Ontarians, where professions work together, and where patients are confident that their health care system is providing them with excellent health care

...

Recognize that a high quality health care system is one that is accessible, appropriate, effective, efficient, equitable, integrated, patient centred, population health focussed, and safe

The problem:

The problem:


Acute care
Physicians
Drugs
Community care
Rehab
Long-term care
Social care
Primary care

Do payment models play a role?

"Organizational and provider payment methods are an indirect mechanism for integrating care. The misalignment of these structures—and their associated incentives—can create barriers to system integration, manifesting in visibly poor coordination and continuity of care for patients. In principle, the more global the unit of payment the stronger the incentive for closer relationships among providers at different stages in the care continuum."

Tools for Change: Funding Incentives and Levers for Integrating Patient Care in Ontario
Change Foundation 2010

Buying a product in most industries…

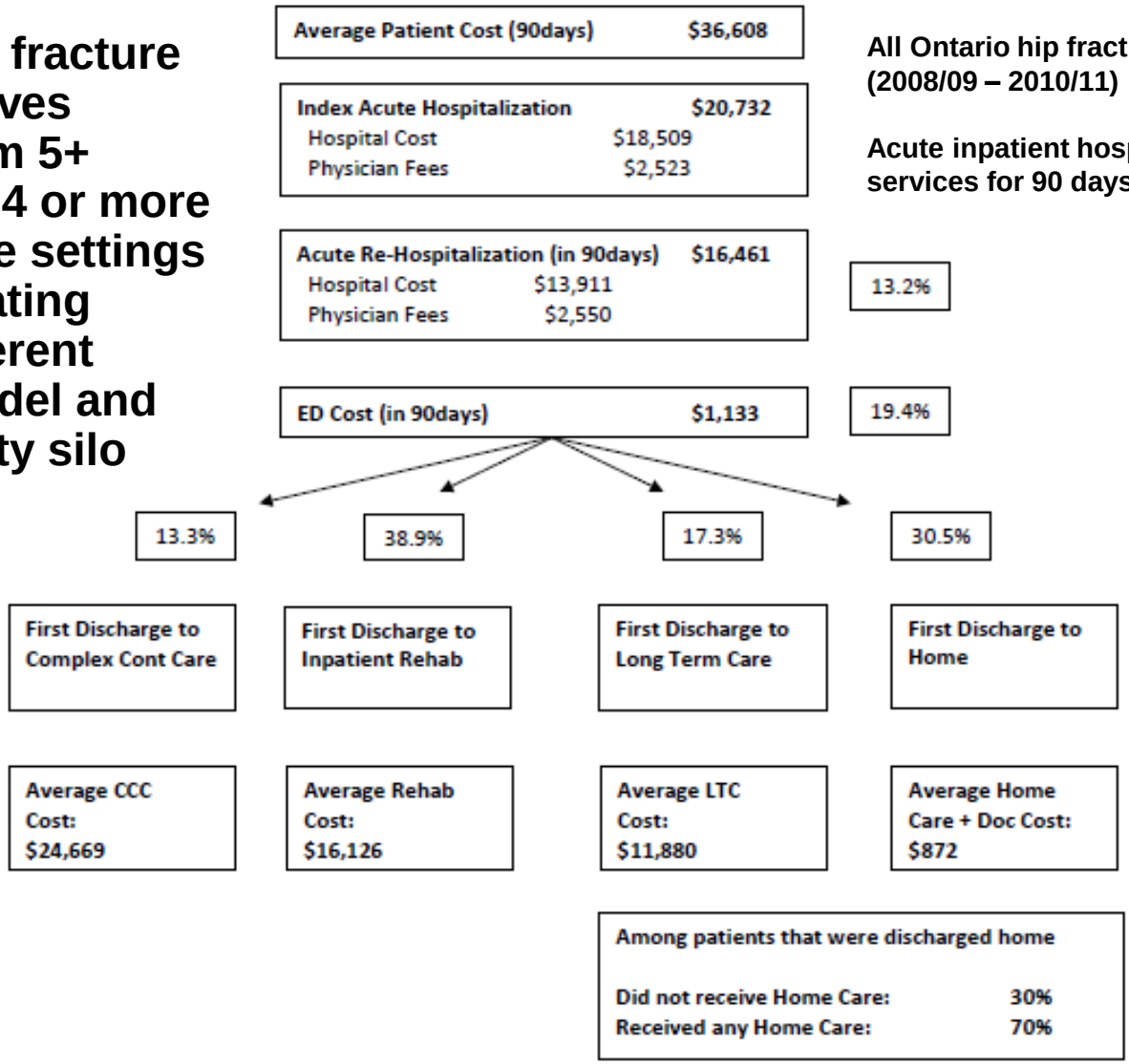
+

Buying a product in health care…

Buying a product in health care…

The Ontario hip fracture patient journey
What does the 'full product' look like?

A typical hip fracture patient receives services from 5+ providers in 4 or more different care settings – each operating within a different payment model and accountability silo



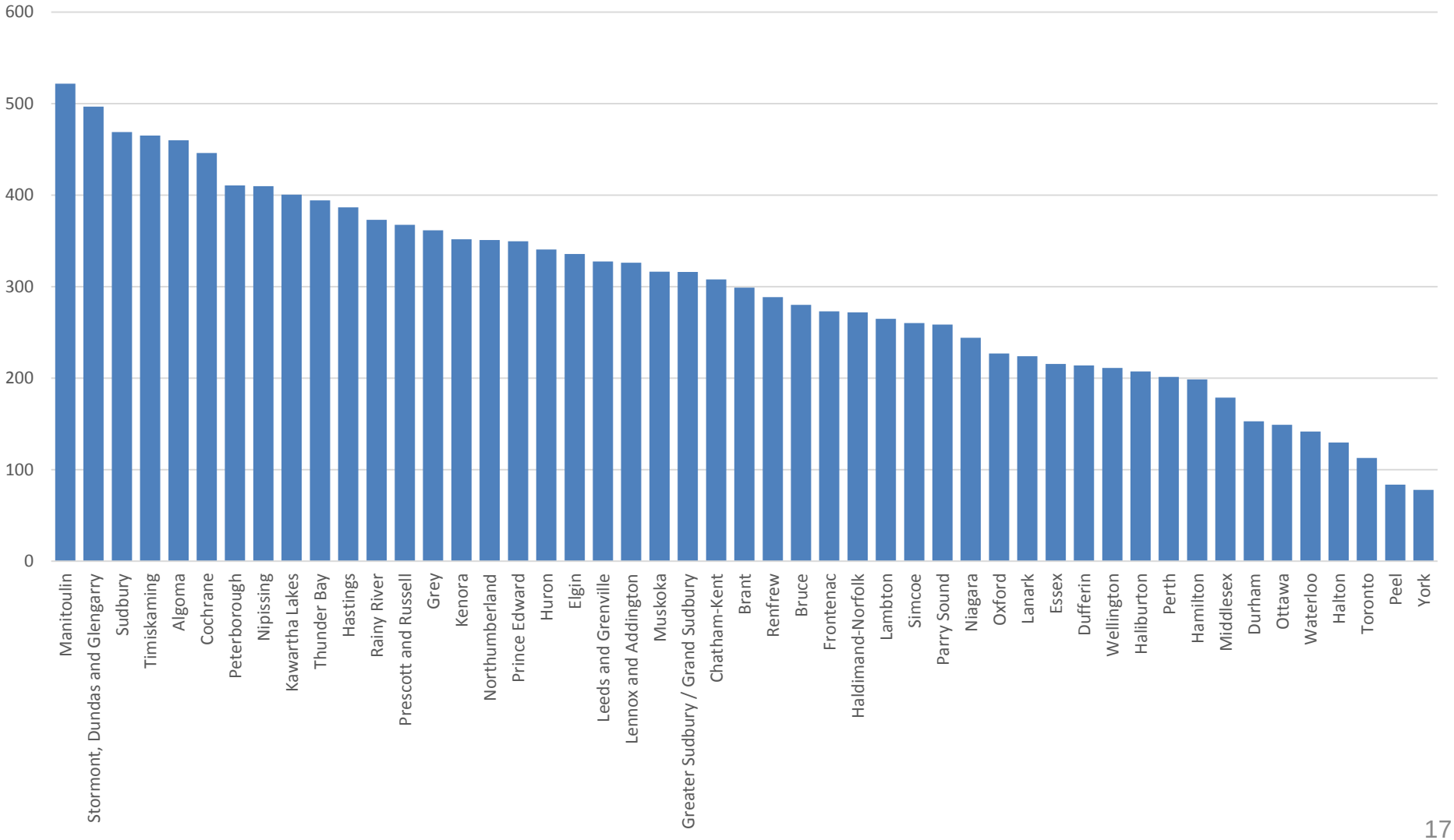
All Ontario hip fracture discharges (2008/09 – 2010/11)

Acute inpatient hospitalization + health services for 90 days post-discharge

Regional variation in COPD hospitalizations

Could better integration of primary and secondary care improve things?

Age/sex standardized COPD discharge rates by Ontario census area (2012/13)



Provinces' current provider payment systems

Service or provider type	Primary payment mechanisms employed
Acute care	Mostly global budget; increasing use of activity/case mix-based payment in several provinces
Rehabilitation & chronic care	Mostly global budget
Long-term care	Global budgets and per diems; shift towards case mix adjusted per diems in several provinces
Home care & community services	Mix of public fee-for-service and global budget payments and private / out-of-pocket payments; some use of case mix methods for home care in Ontario, BC, Alberta
Physician services	Mostly fee-for-service; some provinces (e.g. Ontario) making increasing use of capitation for primary care, alternate funding plans for hospital-based services
Prescription drugs	Mix of public and private payments, depending on provincial drug coverage policies

Does regionalization improve integration?

Service or provider type
Acute care
Rehabilitation & chronic care
Long-term care
Home care & community services
Physician services
Prescription drugs

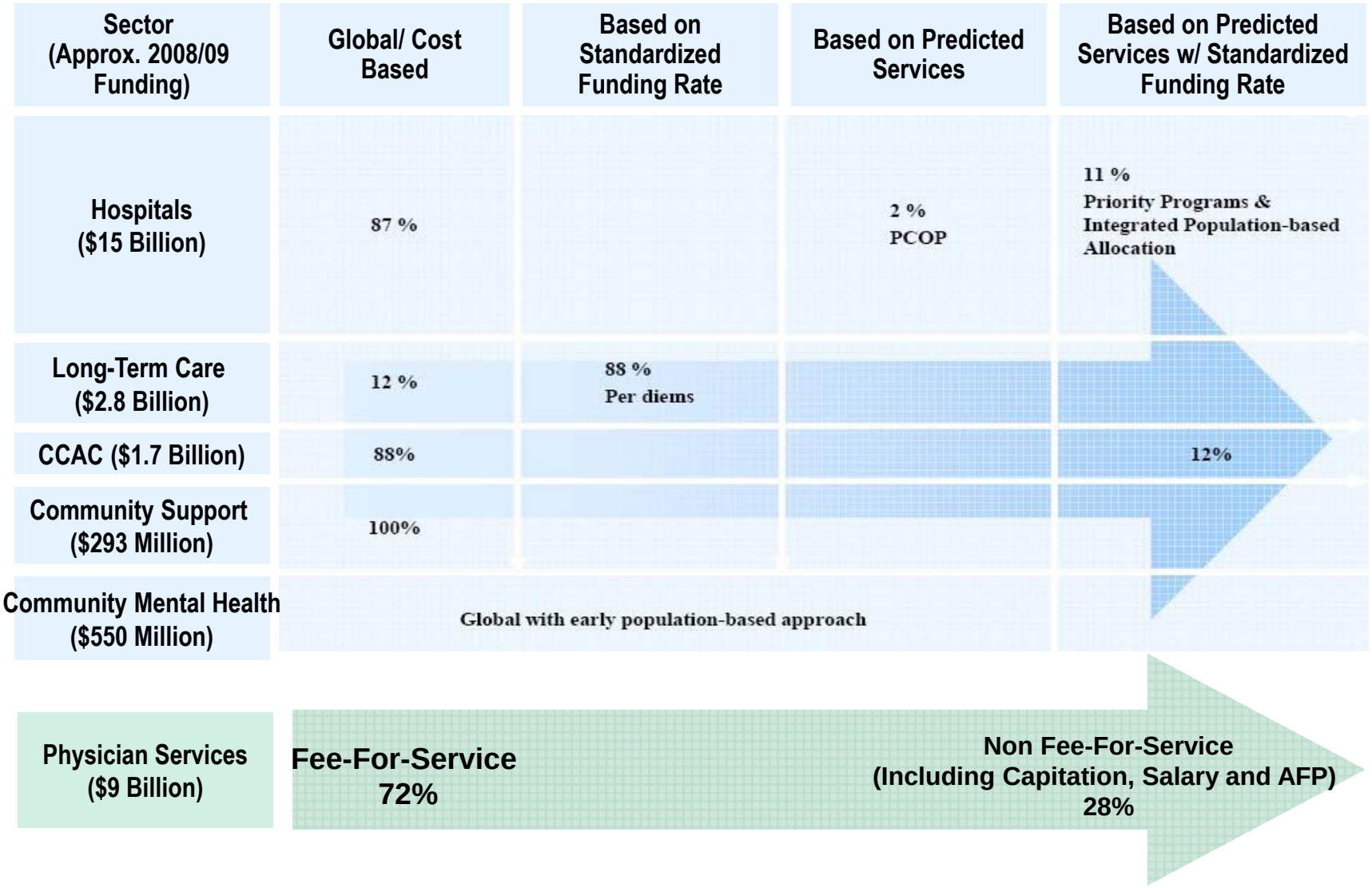
Scope of services included under most provincial regional health authorities

Generally funded separately through Ministries of Health

In some provinces: a shift towards more 'patient-based' payment mechanisms across sectors

But still funded and operated in silos

Ontario, circa 2009



Good news: Canada is not alone!

"Medicare's payment systems create separate payment "silos" (e.g., inpatient hospitals, physicians, post-acute care providers) and do not encourage coordination among providers within a silo or across the silos."

- Glenn Hackbarth, Chairman, Medicare Payment Advisory Committee
Statement to Senate Finance Committee Roundtable on Reforming America's Health Care Delivery System

"In its current form, the payment system does not support joint working between organisations within the health service, let alone more widely. Both providers and commissioners of health care are fragmented, with separate budgets and payment systems for different services, which act as a barrier to joint working and integration of treatment pathways"

- *The NHS Payment System: Evolving Policy and Emerging Evidence*
Nuffield Trust

An international policy response: new directions towards integrated (or 'bundled') payment models

ACO Manifesto: 50 Things to Know About Accountable Care Organizations

Written by Molly Gamble and Heather Punke | September 03, 2013

Thousands of providers join Medicare's bundled pay program

Interest surges in M payment initiative

GLOBAL HEALTH

By Dinny H. de Bakker, Jeroen N. Struijs, Caroline B. Baan, Joop Raams, Jan-Erik de Wildt, Hubertus J.M. Vrijhoef, and Frederik T. Schut

Early Results From Adoption Of Bundled Payment For Diabetes Care In The Netherlands Show Improvement In Care Coordination

Spending Differences Associated With the Medicare Physician Group Practice Demonstration

By David C. Miller, Cathryn Gust, Justin B. Dimick, Nancy Birkmeyer, Jonathan Skinner, and John D. Birkmeyer

Large Variations In Medicare Payments For Surgery Highlight Savings Potential From Bundled

Medicare's Bundled Payment Pilot For Acute And Postacute Care: Analysis And Recommendations

CAPITATION & SHARED SAVINGS

By Paul Markovich

INNOVATION PROFILE

A Global Budget Pilot Project Among Provider Partners And Blue Shield Of California Led To Savings In First Two Years

Making Good on ACOs' Promise — The Final Rule for the Medicare Shared Savings Program

Donald M. Berwick, M.D.

ACCOUNTABLE CARE ORGANIZATIONS

By Lawton R. Burns and Mark V. Pauly

ANALYSIS & COMMENTARY

Accountable Care Organizations May Have Difficulty Avoiding lures Of Integrated y Networks Of The 199(

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DOI: 10.1377/hlthaff.2012.1144

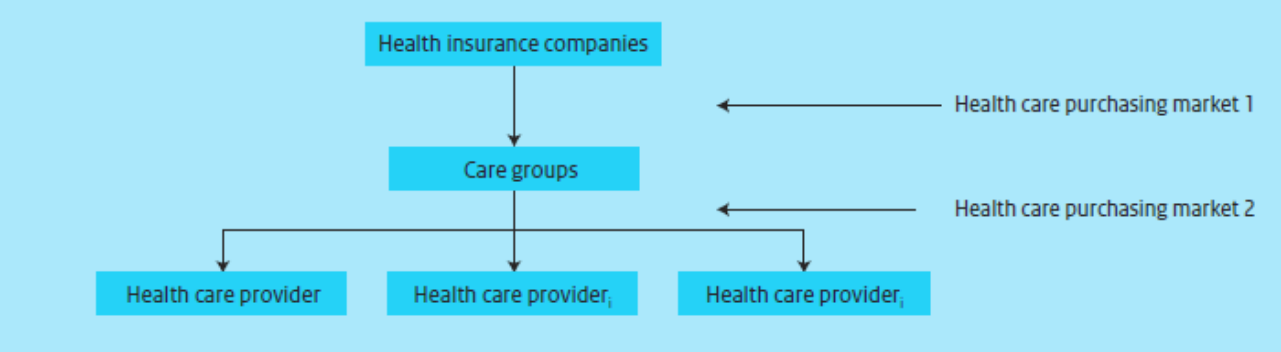
Many Accountable Care Organizations Are Now

Why Physicians Should Like Bundled Payment

Some integrated funding models now in play around the world

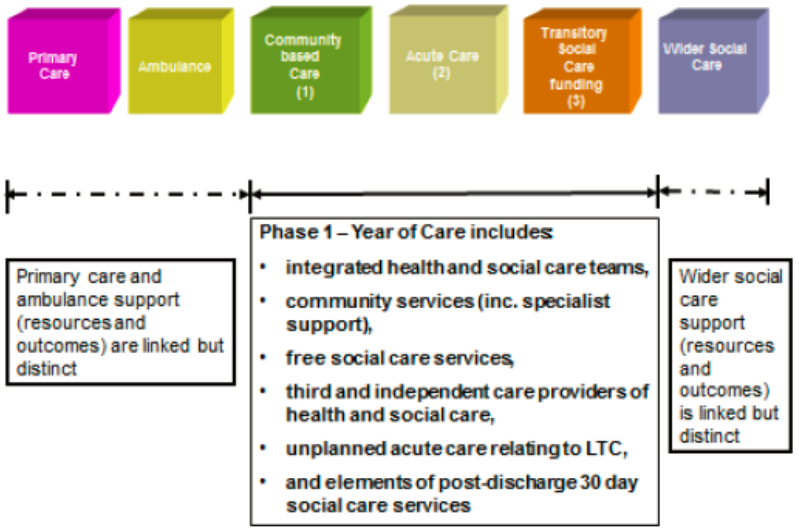
- **Most European hospital payment systems:** include physician services within case rate
- **Integrated health systems (e.g. Kaiser Permanente, VHA integrated service networks):** integrated capitation budgets
- **Netherlands:** bundled payments for chronic disease management (diabetes, COPD)
- **Sweden:** integrated payment for hip and knee replacement episodes of care
- **England:** ‘Year of Care’ tariffs for long-term conditions
- **United States:** bundled payments; gainsharing; Accountable Care Organizations

Netherlands: chronic disease bundled payments



- First pilot implemented in 2010 for diabetes, followed by COPD and vascular risk management
- Health insurers pay a single (negotiable) annual fee per patient to “care groups”, who then subcontract for services with other providers
- Includes all primary care and outpatient specialist care services related to the disease, as specified in evidence-based standards
- Does not include services related to other conditions (e.g. comorbidities), hospitalizations or drugs (hence estimated ~90% of total costs of patients not included)
- Results to date: improved coordination of care, better guideline adherence, lower proportion of patients treated in hospital
- Initially higher costs due to upfront investments in primary care

England: Year of Care tariff for patients with long-term conditions



- Pilot sites implemented in 2012 with shadow budgets
- Risk-adjusted annual capitation budget for elderly with long-term conditions based on standard needs assessment system
- Patients identified through risk profiling of GP practices
- Integrated teams providing both health and social care services, with primary care at the core
- Single designated lead clinician for each patient

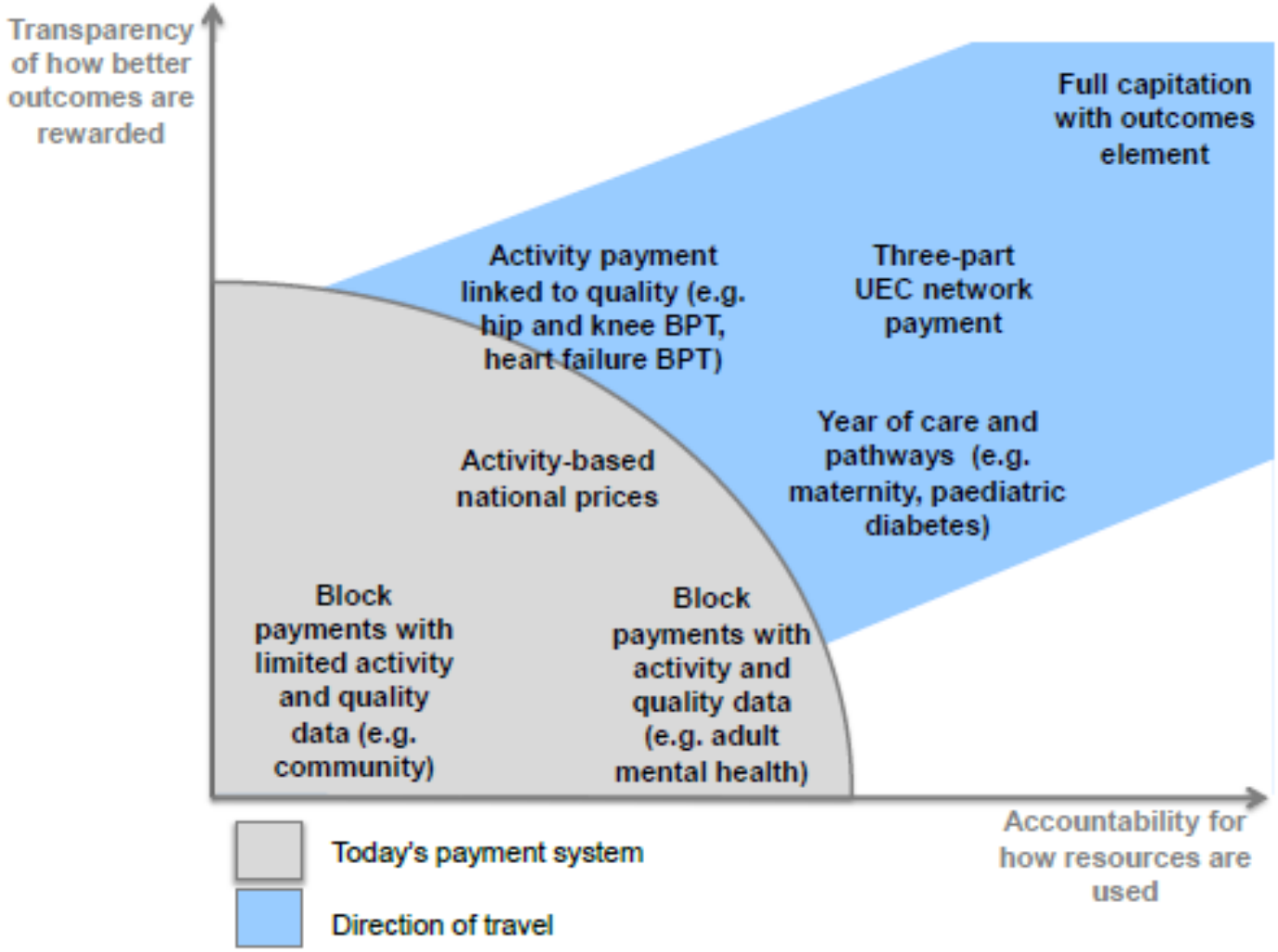
Payment reform in England: 5 year plan

"Broadly speaking, the payment system is likely to comprise menus for locally determined payments, from which commissioners and providers could choose the most appropriate approaches for their local models of care and service contracts; a number of national prices for episodes of care delivered by centres of excellence and specialised services networks; and national guide prices for other currencies."

- *Reforming the payment system for NHS services: Supporting the Five Year Forward View* (2014)

Payment reform in England: policy direction

Figure 1.1: Transparency and accountability of different payment approaches



Reforming the payment system for NHS services: Supporting the Five Year Forward View (2014)

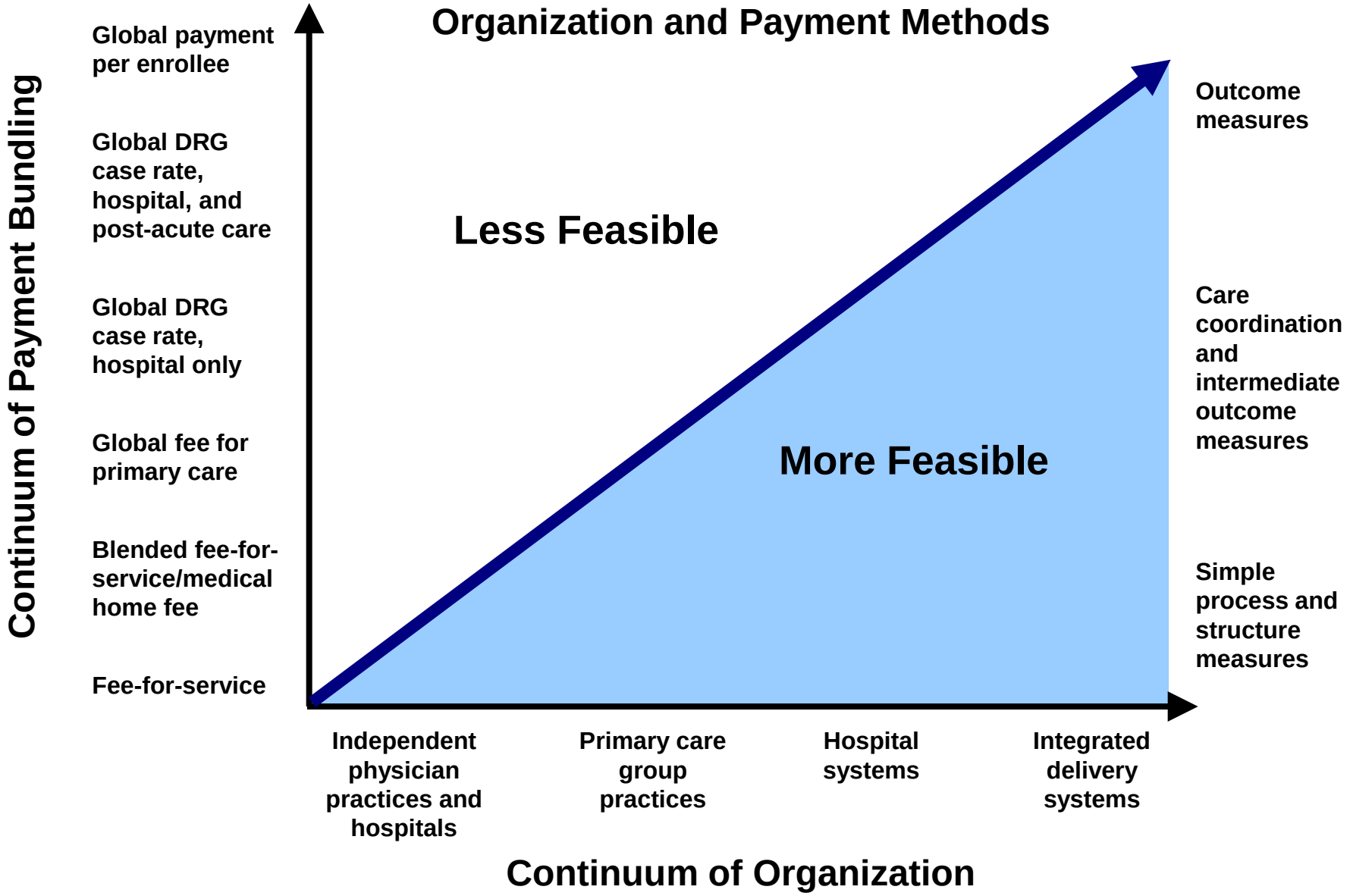
Looking south…

- **Donald Berwick**
  Administrator,
  US Centres for
  Medicare and Medicaid
  Services (2011)

"Delivering the highest possible quality of care to all Americans, while reducing overall health care costs, will require major innovations in care delivery and payment to create the conditions for the best, most effective, most affordable health care. This is what the Affordable Care Act does. Thanks to the health reform law, the Obama Administration is moving forward to implement a menu of new options to transform health care delivery and lower costs with higher quality, more coordinated and patient-centered care.

Not all of these options will be right for everyone. Our goal is to give doctors and hospitals the freedom and flexibility to implement innovative new practices that work for them."

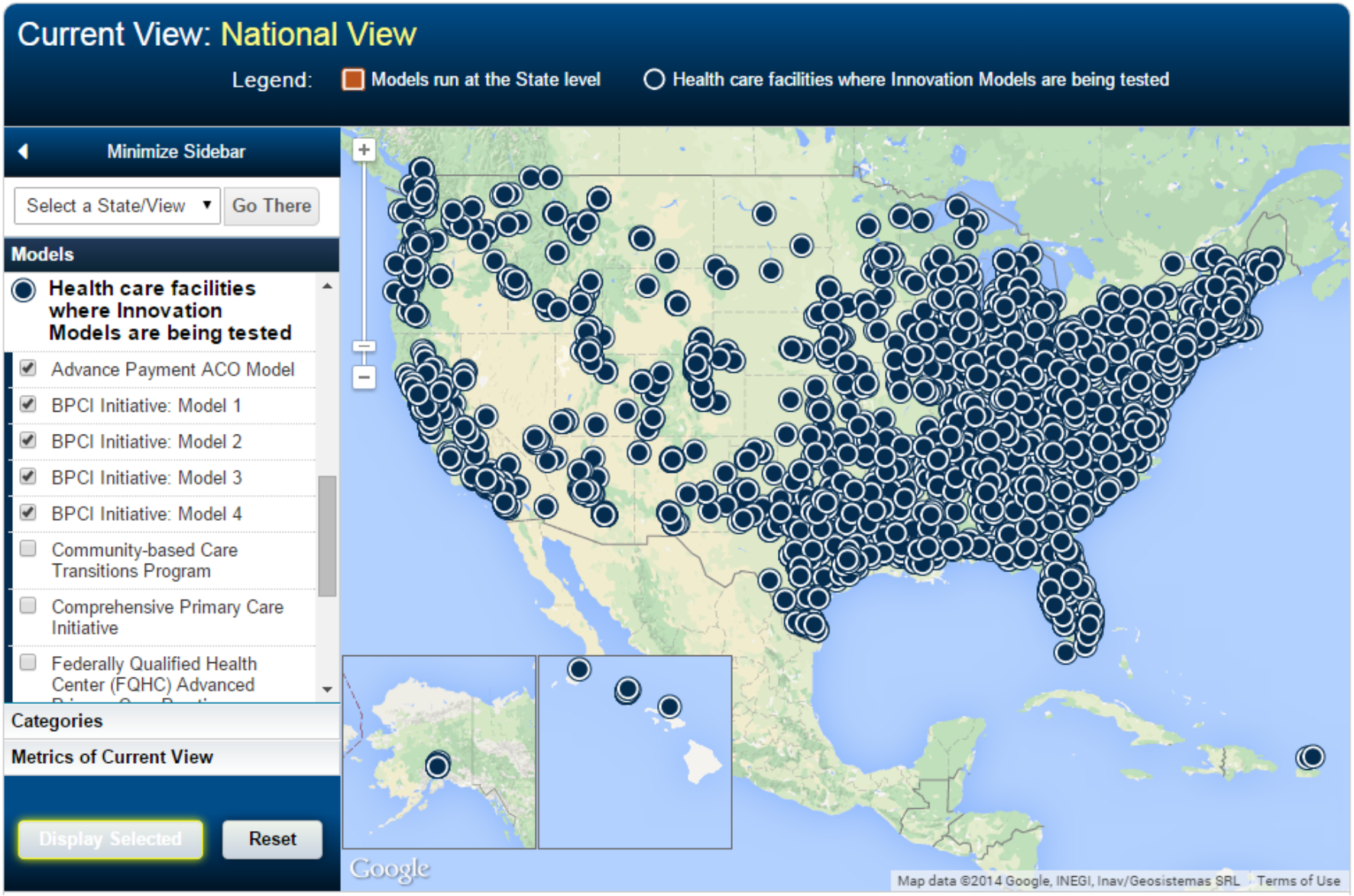
The ‘menu’: U.S. payment and delivery system reform



Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

No longer unicorns of health policy

Approximately 3000 bundled payment and ACO demonstration project sites now in progress



Bundled payments vs. ACOs: comparison

	Bundled Payment	Accountable Care Organization
Population	Specific patient conditions or procedures	Entire enrolled population
Performance time window	Episode of care; typically acute hospitalization plus optional post-acute window (CMS: 30, 60, 90 days)	Based on annual performance
Quality measures	Participants required to report; not factored into payment	Participants must first meet quality thresholds to share in cost savings
Pricing approach	Either prospectively set or reconciled against target "price" based on 3 year historical costs of services in episode, with savings targets	Based on comparison with projected future spending growth (derived from historical + national spending trends)
Impacts on existing payment models	Either replaces existing payment models with prospective price or overlays existing payments and reconciles against target 'price' at year end	Overlay on existing payment models; reconciled against target 'price' at year end for bonus/penalty/gainsharing
'Lead' service	Generally acute-led; focus on specialty care and (CMS pilots) post-acute care	Generally primary care-led; focus on PHC / community based care
System change implications	Narrowly focused but substantial; changes in provider contracting relationships, patient and information flow	Broad and transformative; changes in entire delivery model orientation
Scope of risk	Both upside and downside risk in current CMS models	Varies by model; can be upside-only or upside/downside
Current state (US)	Currently 2700+ awardees (each representing multiple providers) in various stages of 4 CMS BPCI models	37 – 43 M insured lives (Feb. 2013); 278 organizations contracting as CMS ACOs (Nov. 2013)

Medicare Bundled Payments for Care Improvement demonstration

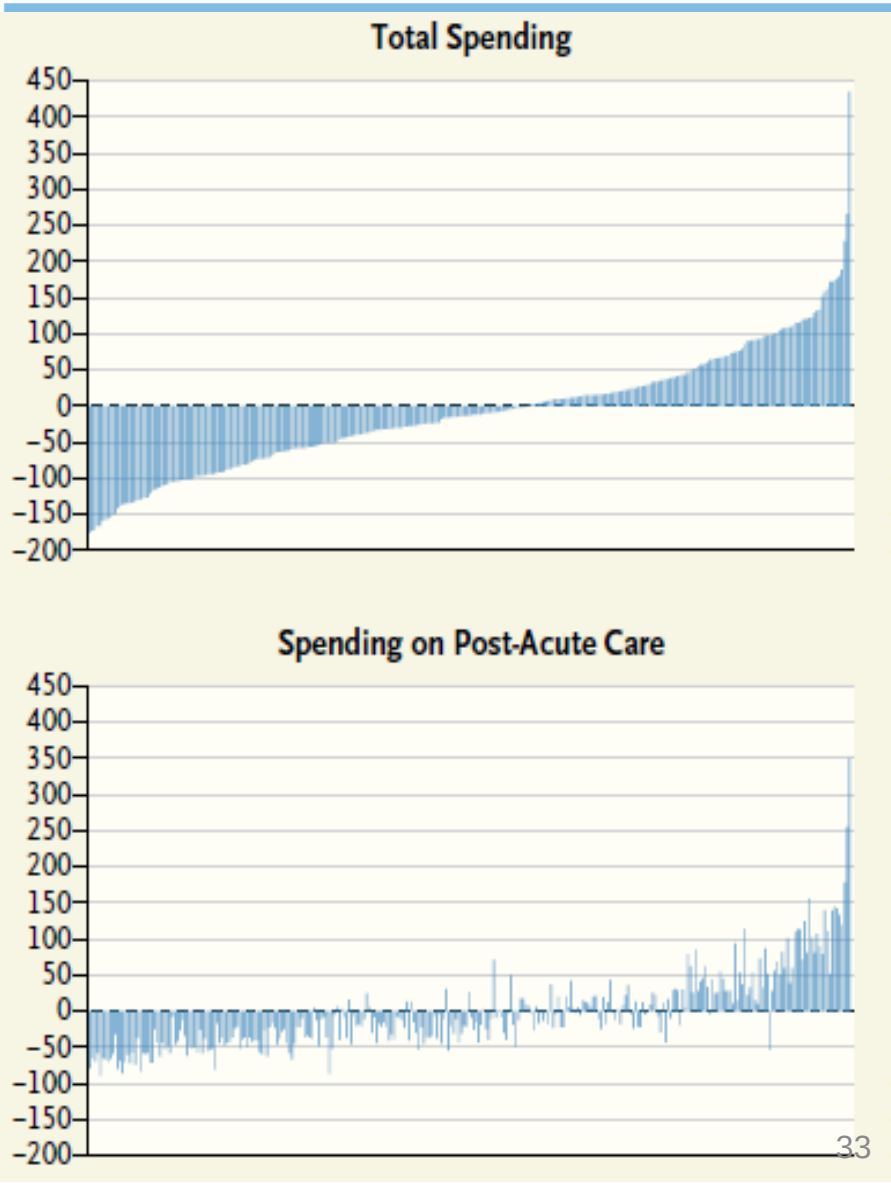
- 4 BCPI models with different parameters:
  1. **Acute inpatient stay** – discounted separate payments to hospital and physician as before but allows hospital – physician gainsharing
  2. **Acute inpatient stay** (hospital + physician) plus post-acute care - *retrospective*
  3. **Post-acute care only** – *retrospective*
  4. **Acute inpatient stay** (hospital + physician) only – *prospective*
- 48 eligible conditions (based on acute inpatient DRGs)
- Providers choose between 30, 60, 90 day post-acute care window
- Retrospective models based on reconciling future annual episode costs against a target 'price' set based on 3 years of historical episode data + national price trends, with 2 – 3.25% discount applied
- Options for thresholds for gain / risk sharing between providers and CMS – upside only (less potential gain) and both upside / downside risk
- All pilots using new post-acute care assessment tool (B-CARE) standardized across post-acute care settings
- Measurement through specified set of quality metrics

Key focus area for bundled payments: Targeting variation in post-acute care

"…if there were no variation in post-acute care spending, the variation in total Medicare spending across hospital referral regions would drop by 73%"

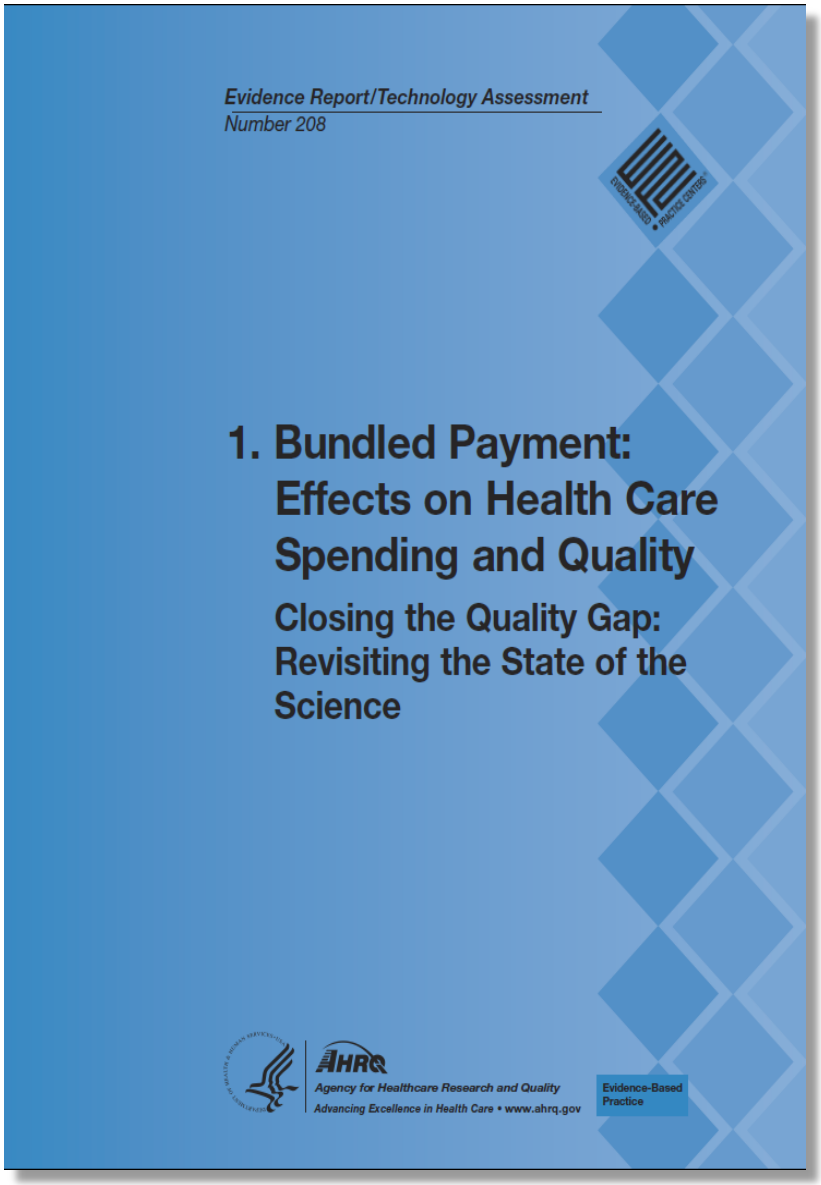
Variation in Health Care Spending: Target Decision-Making, Not Geography
Institute of Medicine 2013

IOM Finds Differences In Regional Health Spending Are Linked To Post-Hospital Care And Provider Prices



Bundled payments: what's the evidence?

- Limited number of studies to date
- Best quality studies have focused on CABG and limited to acute inpatient hospitalization setting (hospital + physician integrated payment)
- Consistent evidence of reduction in episode costs and/or utilization (typically in ~5-10% range)
- Savings in reduced LOS, reduced ICU admissions, reduced device costs
- Consistent evidence of savings to payers (often due to negotiating discounted prices upfront)
- Mixed findings on quality; no significant negative effects
- Most studies examine relatively short term endpoints (e.g. 1-3 years)

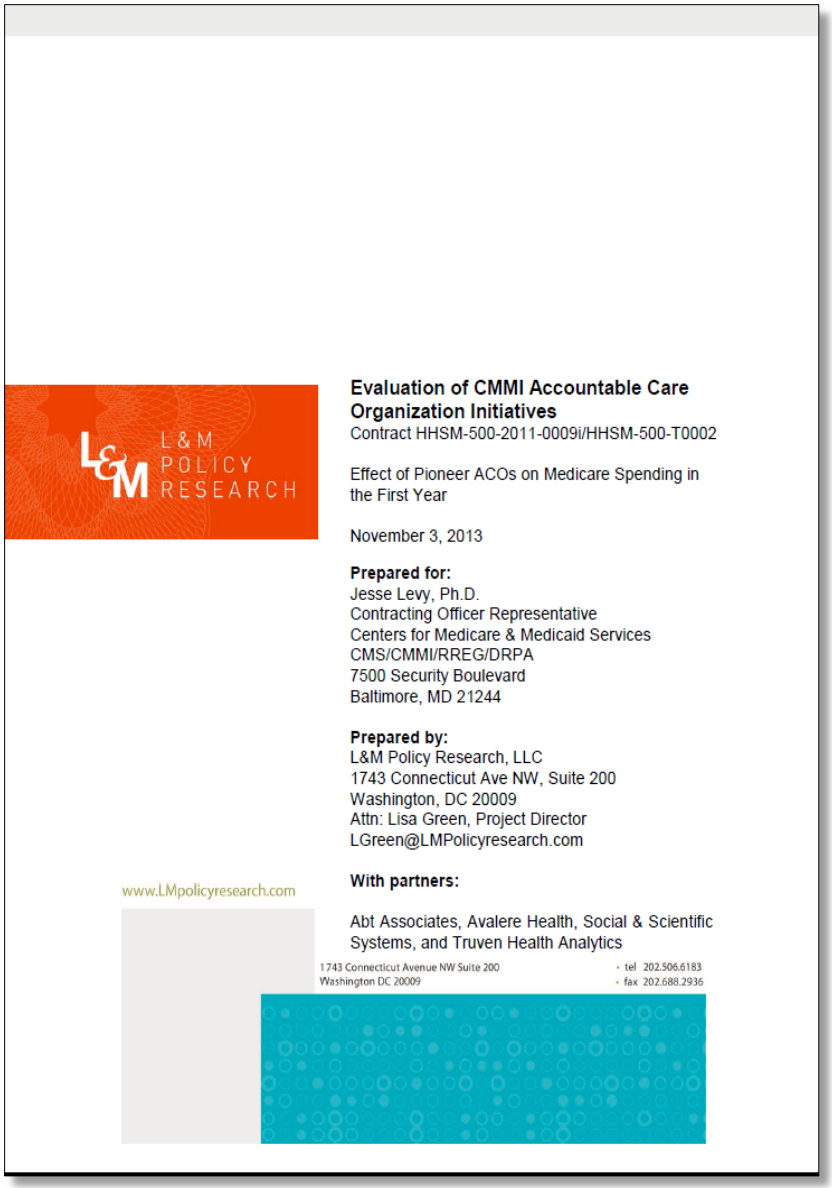


Accountable Care Organizations

- **2 major Medicare ACO models:**
  - **Medicare Shared Savings Program:** Functions as an overlay over existing fee-for-service payment schemes; more limited risk sharing
  - **Pioneer ACO Model:** Greater downside risk sharing than MSSP, enables multi-year pathway to full population-based payment
- ACO beneficiary populations assigned through primary care services (patients do not need to be formally enrolled)
- Cost benchmarks set using 3-year historical per capita costs for assigned beneficiaries, adjusted for national expenditure trends
- ACOs must meet specified thresholds on 33 quality measures in order to claim share in any savings
- Medicare provides upfront financial support to rural or under-resourced ACOs to make investments in care coordination infrastructure; to be recovered through future savings

ACOs: what's the evidence?

- ACOs had lower growth in total Medicare spending per capita vs FFS providers
- Individually, 23 of 32 ACOs did not differ significantly in total spending differences; 8 had significantly lower growth with estimated savings of $155.4 million
- 13 ACOs eligible for gainsharing
- Only 1 ACO had higher spending
- All ACOs improved in overall quality
- High performing ACOs varied in terms of geography, market size, organizational structure – suggests different models can achieve success
- Reduced service-specific spending in outpatient and physician services seen across many models
- Qualitative findings of organizations in transition; still working to optimize new relationships and models



L&M POLICY RESEARCH

Evaluation of CMMI Accountable Care Organization Initiatives
Contract HHSM-500-2011-0009i/HHSM-500-T0002

Effect of Pioneer ACOs on Medicare Spending in the First Year

November 3, 2013

Prepared for:
Jesse Levy, Ph.D.
Contracting Officer Representative
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Key success factor in both bundles and ACOs: **Physician participation and leadership**

"Why should physicians support bundled payment now, given past experience [with capitation]? The simple answer is that the alternatives now look worse than before and bundled payment has gotten better."

- Michael Chernew, 'Why Physicians Should Like Bundled Payment' *Health Services Research,* 2011

- New models implemented over backdrop of fee-for-service price decreases
- Bundled payments and ACOs allow physicians to take on active leadership role in care redesign – and share in efficiency savings achieved
- Primary care physicians are "CEOs of $10 million dollar companies" whether they know it or not, influencing majority of downstream expenditures; ACOs allow PCPs to actively manage this spending
- 2014 survey: 51% of ACOs are physician-led, another 33% jointly led by physicians and hospitals, and in 78% physicians make up a majority of the governing board
- Bundled payments allow specialists (particularly surgeons) to lead care redesign around acute + post-acute care, share in efficiencies

Looking back home: Is there a case for integrated provider payment models in Canada?

What Canada can learn from U.S. health reform

ANDREW S. BOOZARY AND PIERRE-GERLIER FOREST
Special to The Globe and Mail
Published Wednesday, Sep. 03 2014, 1:27 PM EDT
Last updated Wednesday, Sep. 03 2014, 1:41 PM EDT

Focusing on payment reform: holding providers accountable

A centrepiece of the ACA is the formation of accountable care organizations (ACOs). These are essentially networks of providers responsible for the whole spectrum of care through lump-sum payments. As an example, if a patient is managed in a cost-effective fashion, any savings are shared among providers. In contrast to LHINS (Local Health Integration Networks) in Ontario, the concept here is to do away with the bureaucratic layers and get right to what is really known to drive costs: the physician's pen. To make sure this doesn't lead to systematic rationing, providers can't keep the savings unless they reach measurable quality improvements. Surely, not all ACOs will be equal either; and only time will tell how successful they are in bringing costs down. But if they can eliminate unnecessary tests or procedures, there lies an upside both for patients and the public purse.

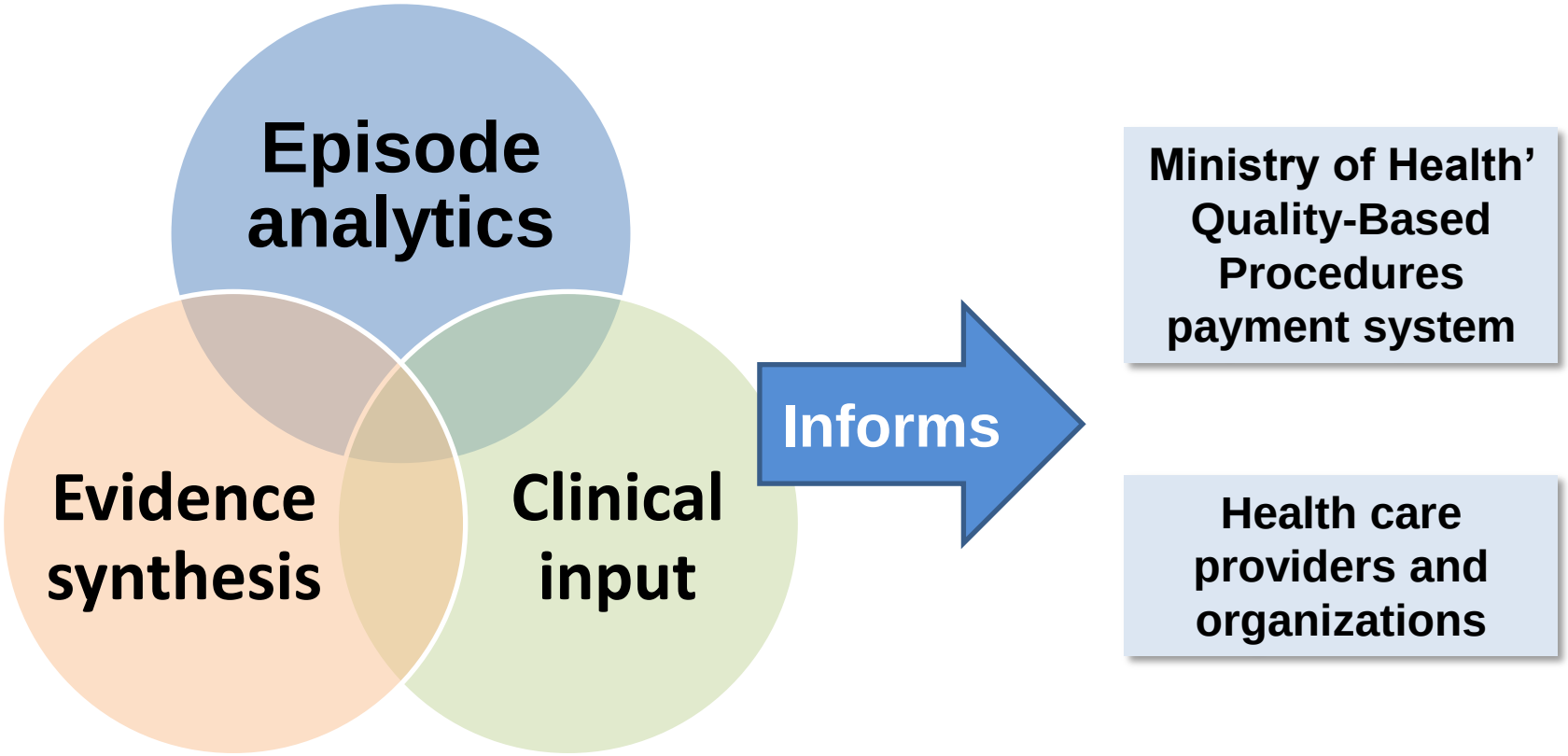
While a fee-for-service model alarmed Bernard Shaw more than a century ago, much of Canada still runs on one. Experimenting with how to better align incentives with the needs of the patient should continue at home, while also finding the right mix of bundled payments to improve the co-ordination of care. There are certainly trade-offs with different payment schemes – and questions over which quality measures work best – but the United States is moving the way of rewarding value over volume. We should, too.

What's different about the Canadian context?

- **Single payer systems:**
  - Enable more comprehensive data capture and less concern about patient 'leakage' vs. the US, but…
  - Provide fewer 'test sites'; provinces rarely pilot test major policy shifts. Hospital payment reforms underway in several provinces may provide opportunities to experiment
- **Regional health authorities:** What role do they play in these models? Do they distribute the bundle or just get in the way?
- **Prospective budgets (Canada) versus claims basis (US):** Challenging for provinces to extract 'dark green dollars' in cash savings from hospitals and other budget-based providers; money is already committed
  - ➢ Need all-service costing methodologies that act as proxies for claims pricing – we are using these in Ontario

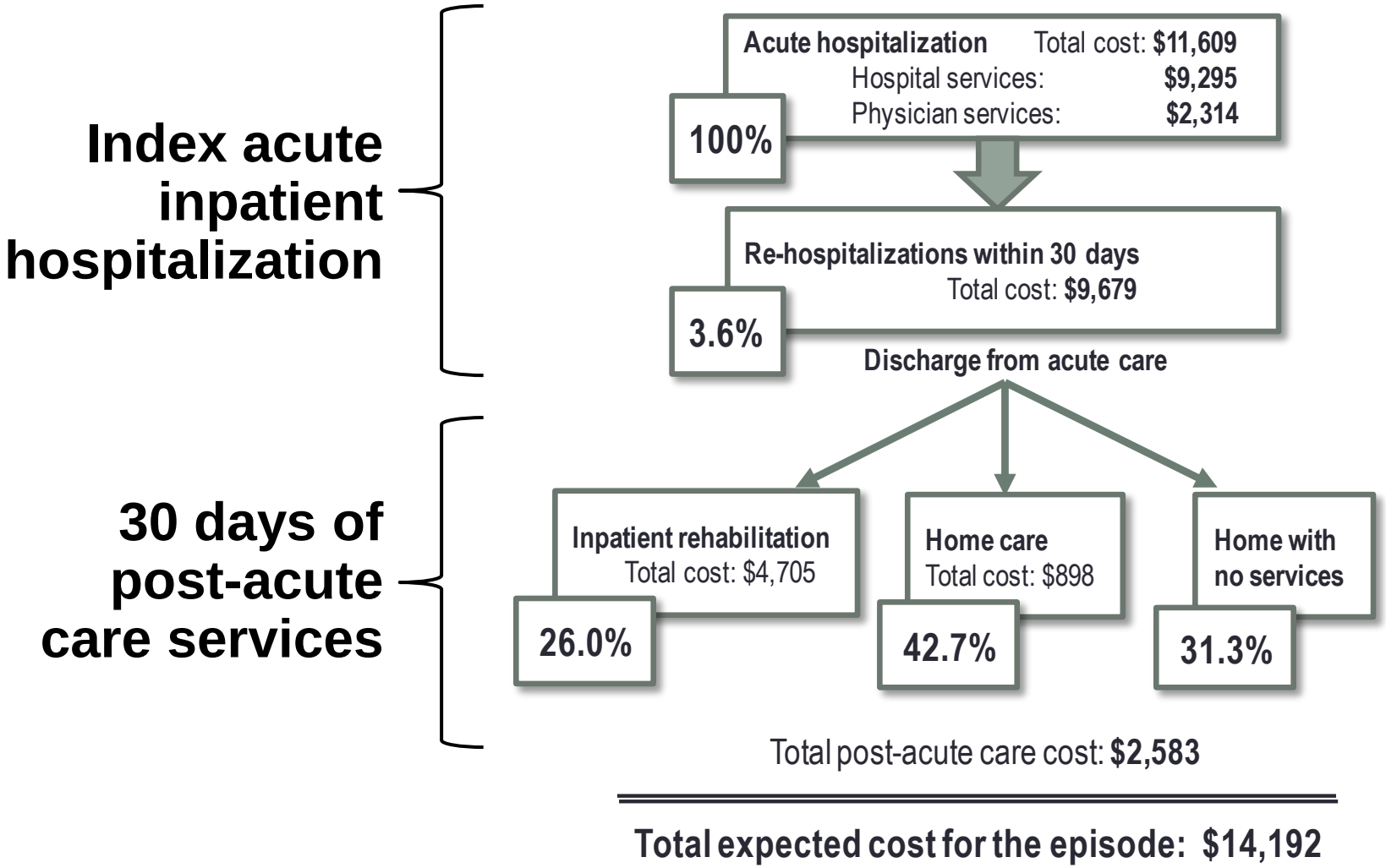
Applying integrated analytic models in Ontario: HQO's Episode of Care analyses

Combine linked data analytics, evidence synthesis and clinician input to develop integrated best practice care pathways, analysis and recommendations in high burden patient populations

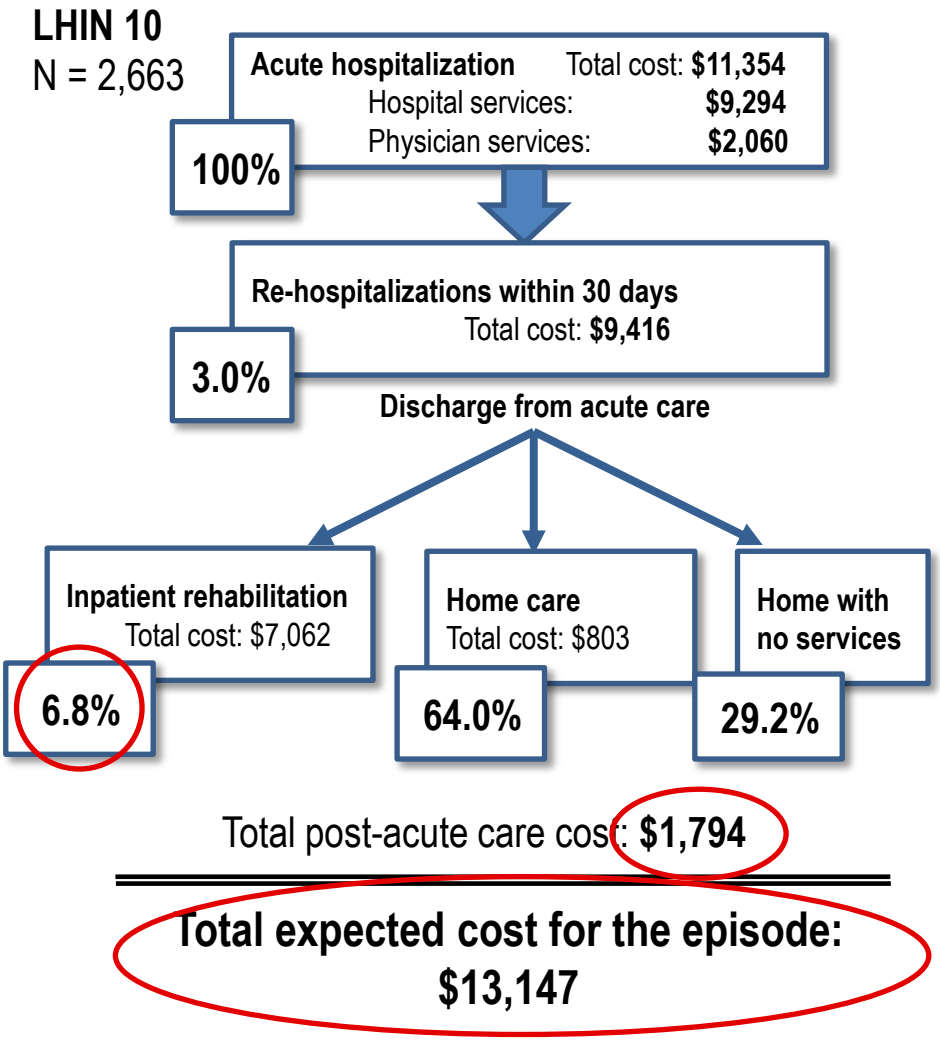


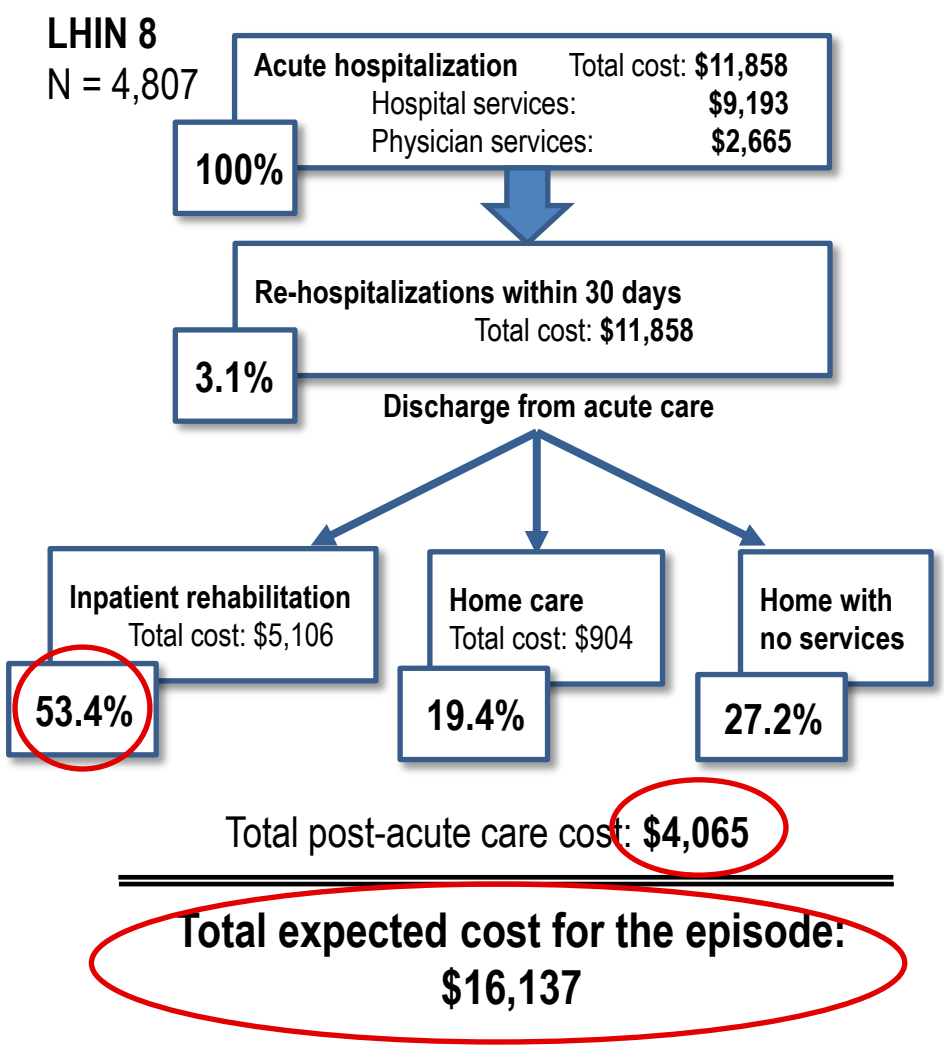
Using an episode lens to examine total knee replacement patient pathways in Ontario

Costs derived from CIHI hospital case mix methodologies, physician fee schedules and home care service costs



Using the episode lens to compare regional variations in utilization and costs





Is there any evidence to suggest which pattern of utilization is ‘better practice’?

OHTAC Recommendation

Physiotherapy Rehabilitation after Total Knee or Hip Replacement

Based on one large randomized controlled trial of high quality there is no advantage to receiving inpatient physiotherapy compared with a home-based physiotherapy program for primary total hip or knee replacement patients.

Often no, but in this case: yes

Setting an evidence-based best practice target through a clinician expert panel and linking this back to the episode

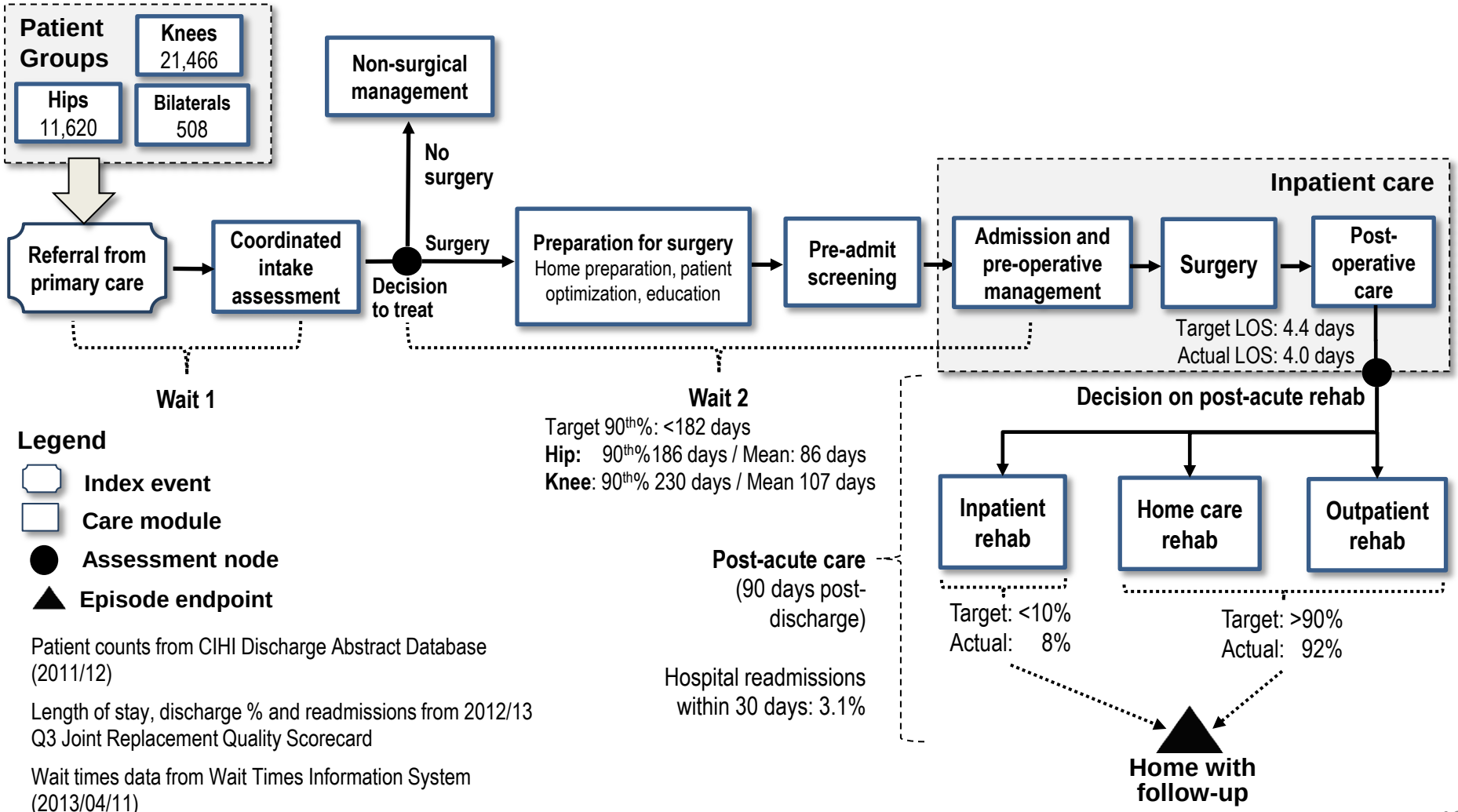
Indicators and recommended targets

Discharge disposition: 90% LHIN target for discharge home with a 10% corridor (or +/- 9 percentage points from absolute target).

LHIN	Number of Cases	Acute Hospitalization				Post-Acute Care			All Services
		Average Acute Inpatient Cost	Average Physician Claims	Average Inpatient & Physician Cost	% Readmitted within 30 days (Cost)	% Discharged to Inpatient Rehabilitation (Cost)	% Discharged to Home with Home Care (Cost)	Post-Acute Care Cost	Total Episode Cost
Ontario	**50,331**	**$9,295**	**$2,314**	**$11,609**	**3.6% ($9,679)**	**26.0% ($4,705)**	**42.7% ($898)**	**$2,583**	**$14,192**
1	3,304	$9,151	$2,183	$11,334	4.1% ($10,598)	10.0% ($4,951)	59.4% ($1,089)	$2,086	$13,420
2	4,807	$8,999	$1,992	$10,991	4.9% ($10,991)	3.5% ($7,342)	68.8% ($803)	$1,666	$12,657
3	2,560	$9,228	$2,090	$11,318	3.1% ($11,318)	8.2% ($5,087)	72.9% ($1,020)	$1,928	$13,246
4	6,579	$10,043	$2,401	$12,444	3.5% ($8,274)	9.0% ($7,021)	61.9% ($948)	$2,068	$14,511
5	2,444	$9,174	$2,554	$11,728	3.3% ($8,749)	51.1% ($5,044)	13.5% ($988)	$3,899	$15,627
6	3,147	$9,347	$2,538	$11,885	3.1% ($10,211)	32.7% ($5,420)	25.7% ($909)	$3,033	$14,918
7	3,031	$9,510	$2,628	$12,138	3.6% ($10,799)	48.5% ($5,273)	28.0% ($912)	$3,998	$16,137
8	4,536	$9,193	$2,665	$11,858	3.1% ($11,858)	53.4% ($5,106)	19.4% ($904)	$4,065	$15,923
9	6,219	$9,040	$2,352	$11,392	2.6% ($10,829)	38.1% ($4,102)	36.4% ($857)	$2,872	$14,264
10	2,663	$9,294	$2,060	$11,354	3.0% ($9,416)	6.8% ($7,062)	64.0% ($803)	$1,794	$13,147
11	5,089	$9,131	$2,291	$11,422	3.1% ($10,542)	40.5% ($2,743)	16.6% ($707)	$2,198	$13,620
12	1,771	$9,165	$2,101	$11,266	3.3% ($9,015)	13.7% ($4,439)	45.1% ($787)	$1,777	$13,043
13	2,875	$9,325	$2,215	$11,540	5.9% ($9,308)	9.6% ($4,823)	38.8% ($851)	$1,870	$13,410
14	1,122	$9,033	$1,687	$10,720	6.4% ($10,720)	33.2% ($4,651)	49.3% ($652)	$2,879	$13,599

Developing evidence-based provincial best practice pathways for episodes of care

HQO Primary Hip and Knee Replacement episode of care model



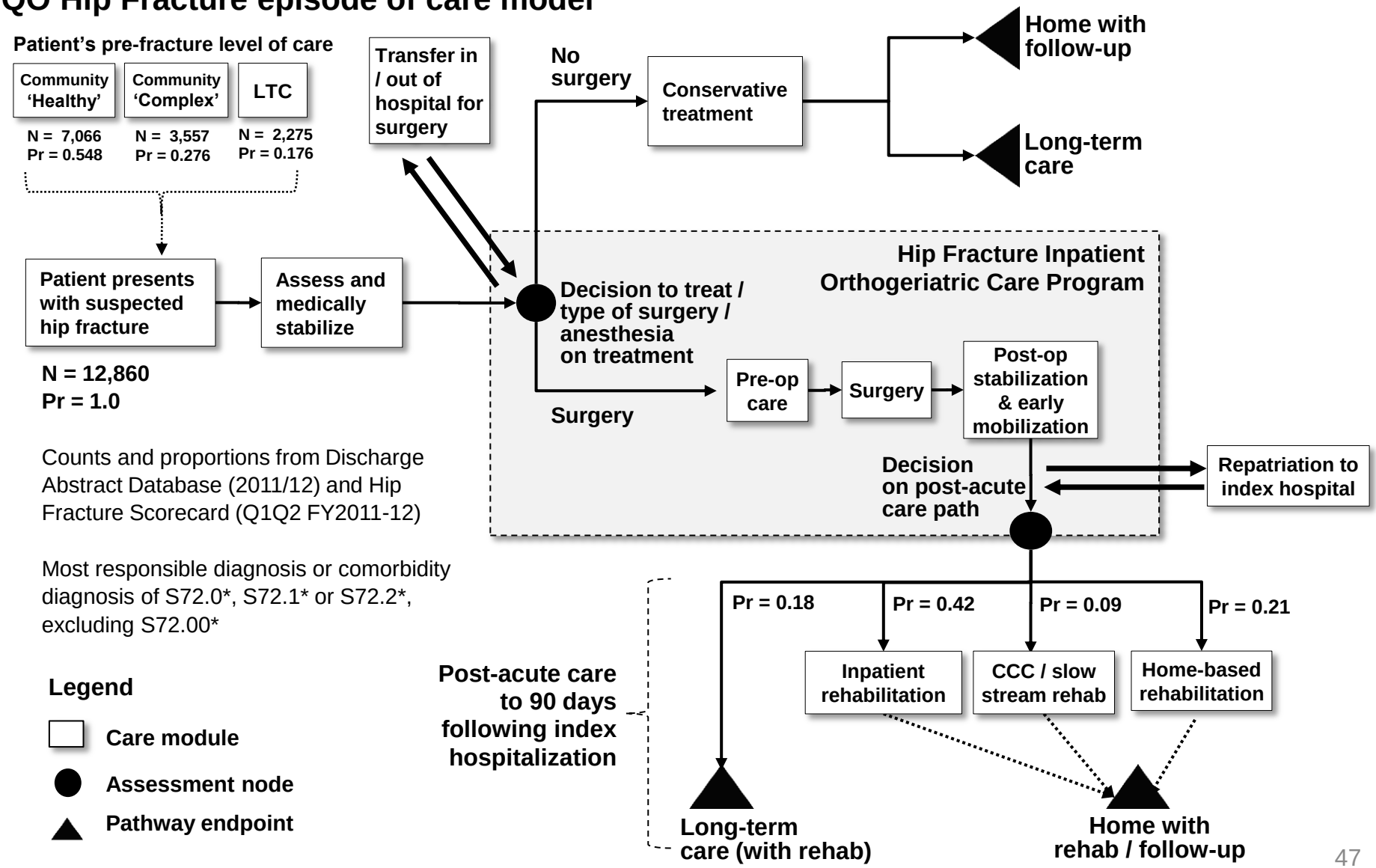
Patient counts from CIHI Discharge Abstract Database (2011/12)

Length of stay, discharge % and readmissions from 2012/13 Q3 Joint Replacement Quality Scorecard

Wait times data from Wait Times Information System (2013/04/11)

Developing evidence-based provincial best practice pathways for episodes of care

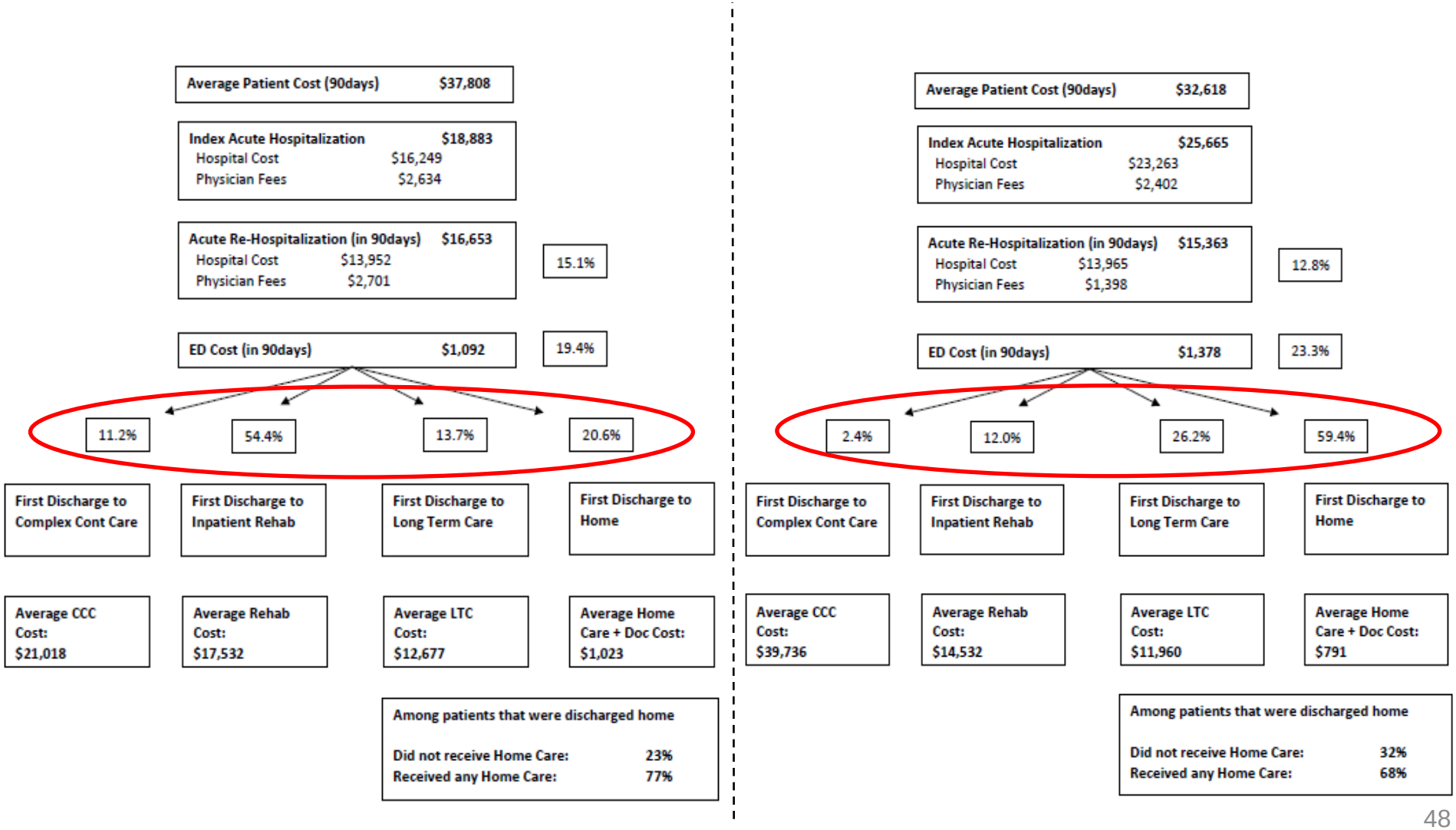
HQO Hip Fracture episode of care model



Comparing episodes of care for hip fracture

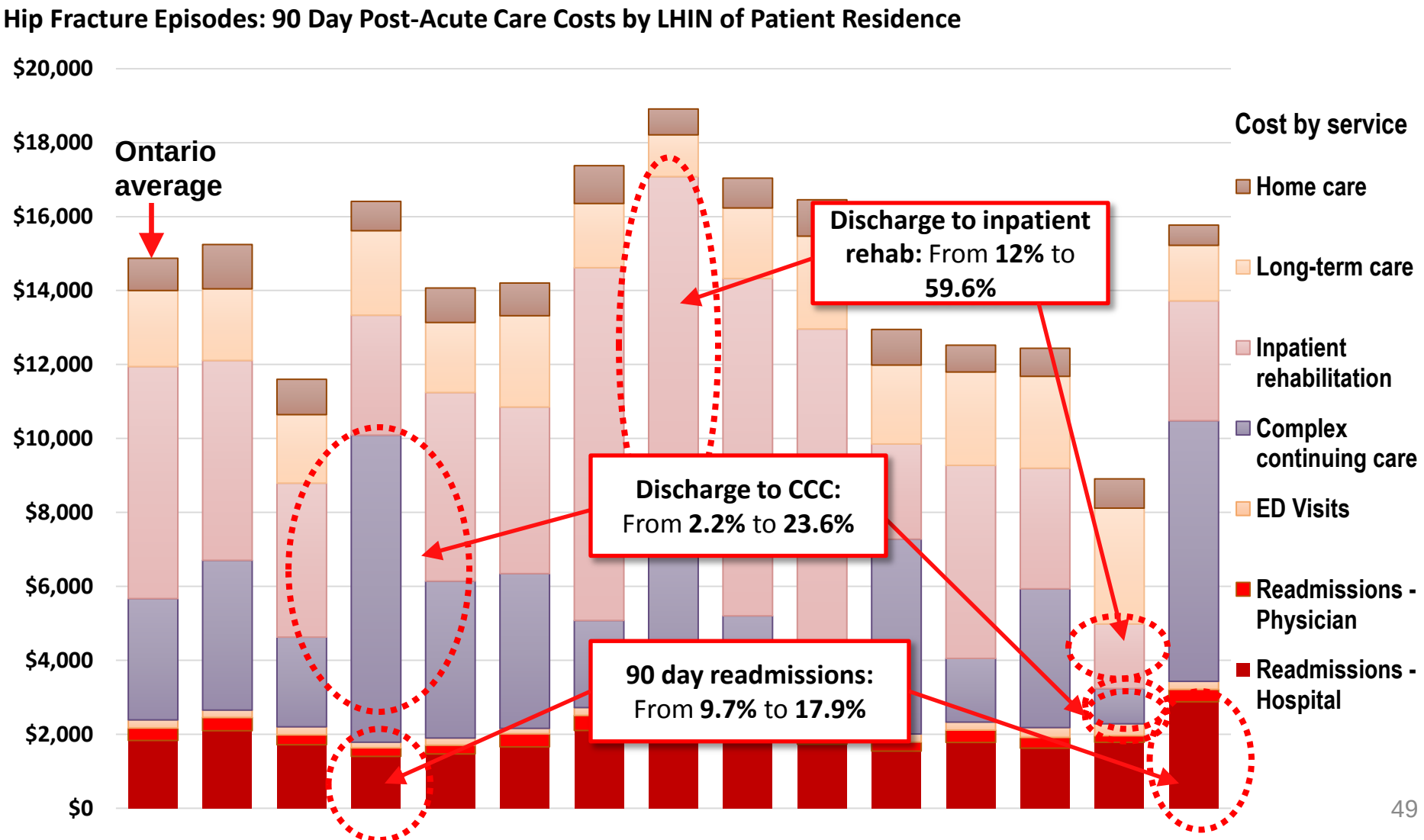
Similar regional variation observed in post-acute care

Index hospitalization + 90 days post-acute discharge by LHIN of patient residence



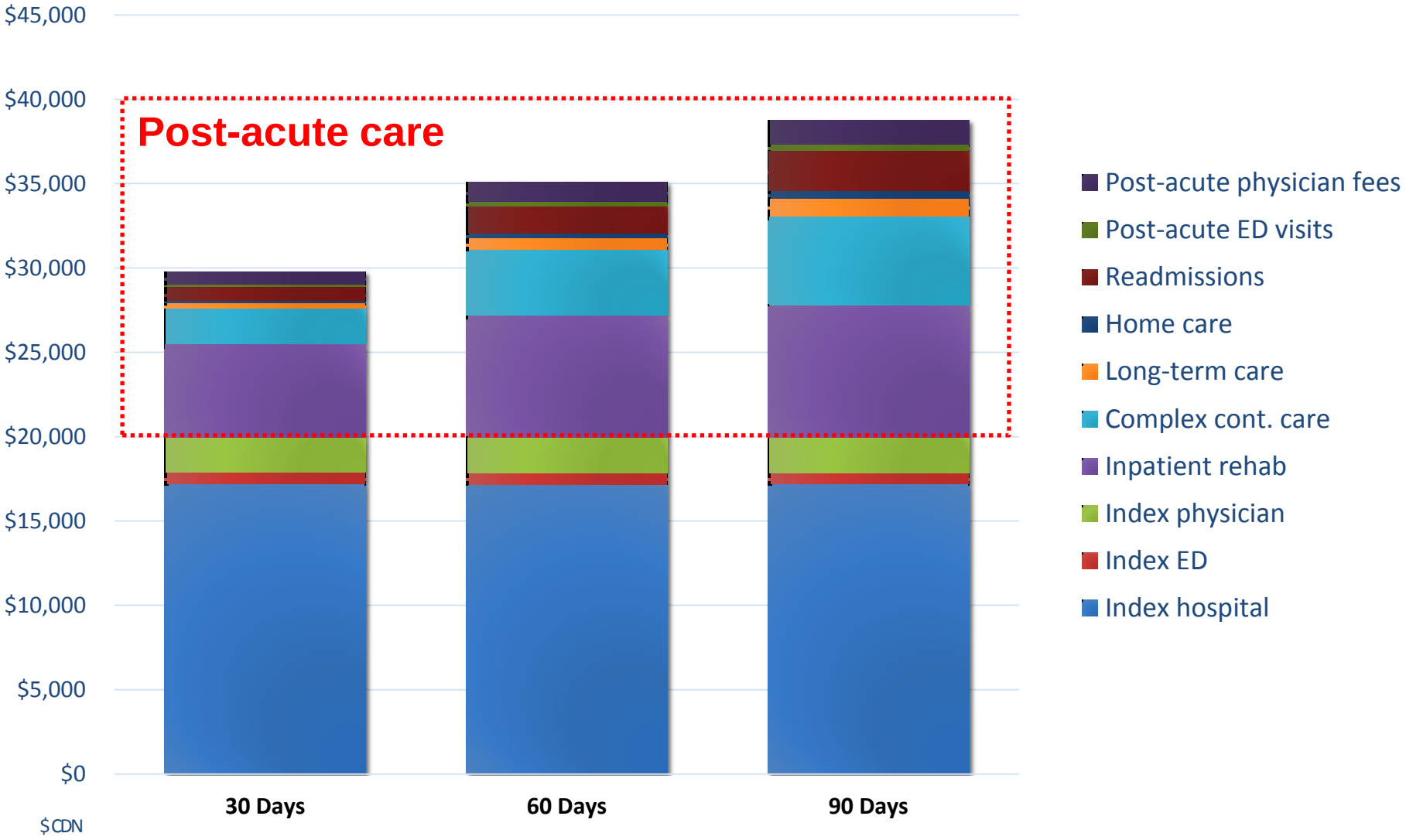
Variations in hip fracture post-acute care drive variations in total episode costs

Consistent with the US bundled payment experience



Key questions for defining the 'bundle': duration of the episode and scope of services included

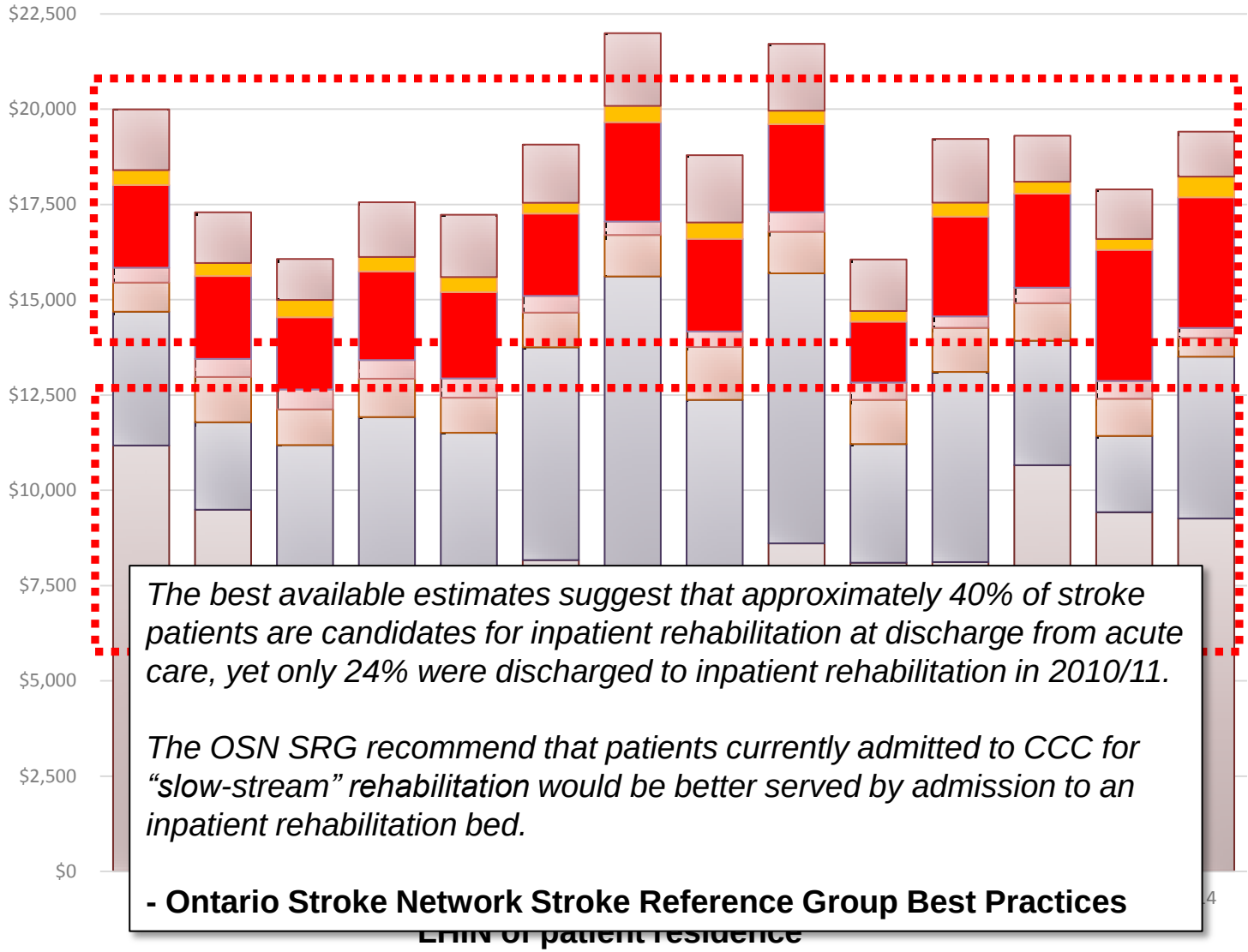
Ischemic stroke episodes



Ischemic stroke 90-day post-acute episodes

As with joint replacement, clinical leaders have set evidence-informed best practice targets for post-acute stroke pathways

…but in this case, best practice may not be cheaper



Variation in 90-day readmission rates: from 15.4% to 26.5% across LHINs

Variation in use of IP Rehab (from 26.2% to 43%) and CCC (from 5.9% to 19.9%) across LHINs

The best available estimates suggest that approximately 40% of stroke patients are candidates for inpatient rehabilitation at discharge from acute care, yet only 24% were discharged to inpatient rehabilitation in 2010/11.

The OSN SRG recommend that patients currently admitted to CCC for "slow-stream" rehabilitation would be better served by admission to an inpatient rehabilitation bed.

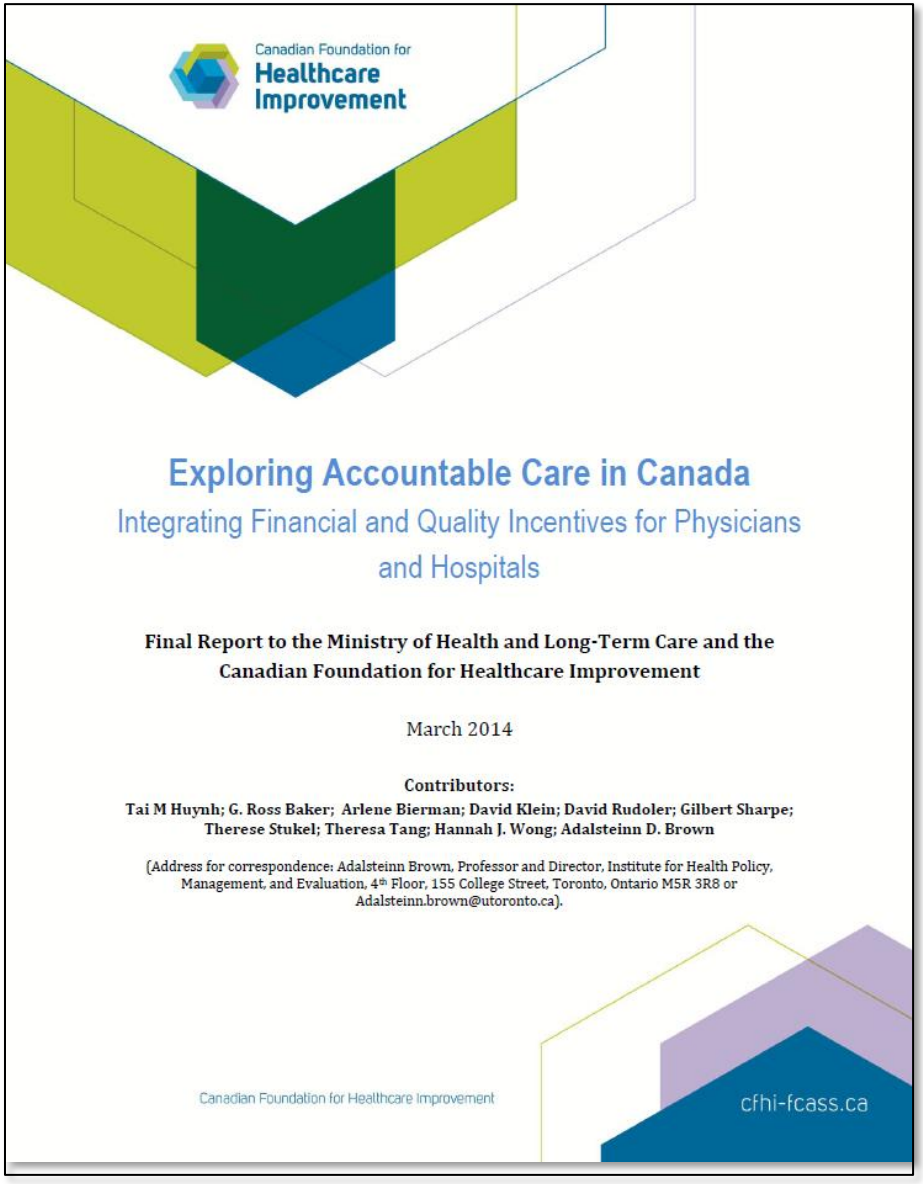
- Ontario Stroke Network Stroke Reference Group Best Practices

LHIN of patient residence

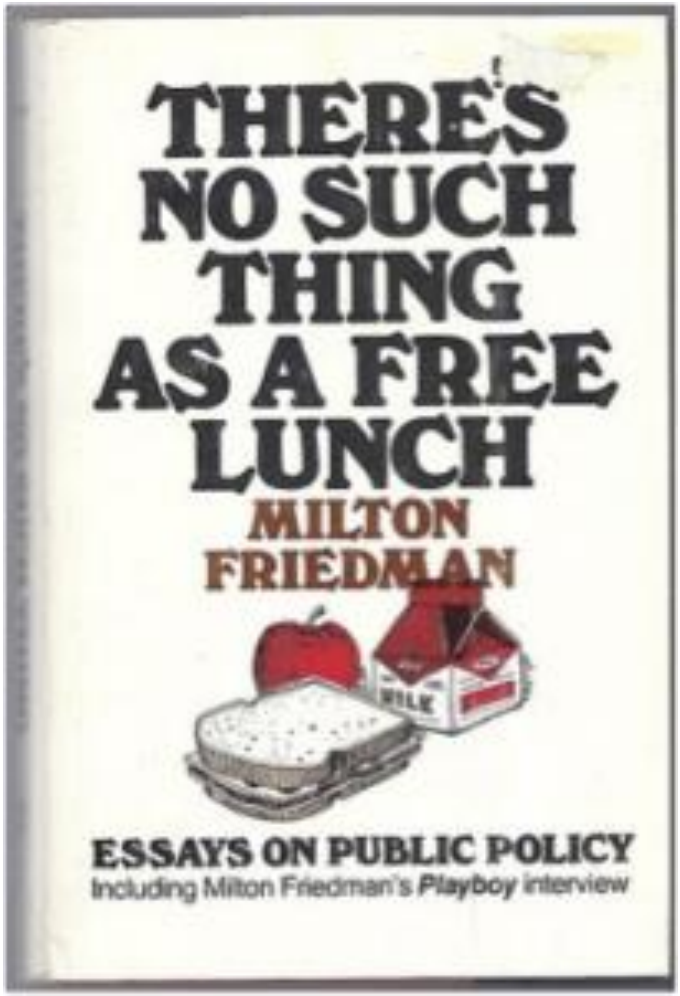
Accountable Care Organizations in Ontario

Canadian Foundation for Healthcare Improvement report

- Demonstrates technical feasibility of constructing ACOs using linked admin datasets capturing vast majority of publicly funded services and costs
- Organizes ACOs using ICES multi-specialty network model, based on historical referral patterns
- Simulates ACO gainsharing options by comparing historical ‘baseline’ years against most recent ‘performance’ year
- Differences observed in per capita costs and outcomes between ACOs
- Qualitative interviews with wide range of health system leaders demonstrate broad conceptual support for ACO-type model (..but will they be as enthusiastic when they see their numbers?)
- Many contracting and accountability issues still to be resolved



Closing thought…



"What is the best way to pay providers to deliver health services? The research evidence strongly suggests that there is no single answer; rather, one must consider the incentives and disincentives inherent in alternative health care funding models."

Deber R, Hollander MJ and Jacobs P. 2008. Models of Funding and Reimbursement in Health Care: A Conceptual Framework. *Canadian Public Administration* 51:3 381-405

Thank you.

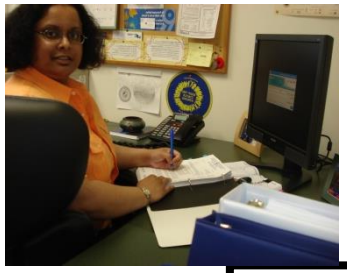
For more on HQO's work discussed here:
http://www.hqontario.ca/evidence/evidence-process/episodes-of-care

Questions and feedback:
erik.hellsten@hqontario.ca

Recording will stop now.

- Jillian Paul, Acting Director for the Health Quality Branch at the Ontario Ministry of Health and Long Term Care, joins us now to offer her commentary.

Your comments/questions please!



Joining in by:
Telephone
+
Adobe Connect Internet Conference

Use the Text Box…

Joining by:
Telephone
+ backup PowerPoint?

By email: Respond to *:*
Julie.Thorpe@HC-SC.gc.ca
Julie is cc'd on the invitation emai

Thanks for joining in!

Your feedback please…RSVP by

Friday, December 19th, 2014 4:00 PM ET

http://fluidsurveys.com/surveys/chnet/12-16-14-hc-bridging-silos-evaluation-form/