Ontario Health
CorHealth Ontario

Business Case Template

Version Date: February 8, 2022.

Background & Introduction

Heart failure (HF) is a complex, chronic, and progressive condition and one of the top 5 reasons for hospital admission in Ontario.[1] In 2018, there were approximately 28,200 hospital admissions for HF funded through the Ministry of Health's (the "ministry") Congestive Heart Failure Quality-Based Procedure (CHF-QBP) funding envelope; this translates to approximately $233 million in annual hospital costs.[2]

The provision of better integrated, more coordinated care for Ontarians living with HF requires efforts across all health care sectors. Ontario Health Teams (OHTs) were introduced in 2019 as a new model of integrated, population health-focused care, where groups of providers and organizations will be clinically and fiscally accountable for delivering a full and coordinated continuum of care to a defined population.

The ministry and Ontario Health (OH) recognize the opportunity to advance HF care through OHTs. To this end, we are planning to *test and assess* opportunities to integrate the service delivery model for HF patients through OHTs, including primary care, community-based and hospital care, starting with five (5) demonstration sites across the province. Information from this demonstration project may be used to inform future decisions regarding the service delivery model for HF patients as well as provide insights into the broader development of integrated funding models for OHTs.

Hospitals interested in becoming a demonstration site for HF patients by offering non-acute services must complete and submit the following business case template and receive endorsement from their OH region.

Participating demonstration sites will have:

1. A 'no-loss provision' applied to their CHF QBP funding allocation for two consecutive fiscal years (2022/23 – 2023/24), as they engage in quality improvement initiatives to reduce acute care utilization for people with HF by offering appropriate non-acute services (see Table 1 for examples) for this patient population, including with other OHT service providers. The no-loss provision will help to ensure that sites which are successful in reducing hospital admissions will not be subject to recoveries for CHF QBP volumes not performed.
2. An opportunity to receive additional financial supports (seed funding flowed through the identified OHT Implementation Supports Funding transfer payment recipient) to accelerate integrated, and digitally enabled, HF services in collaboration with their OHT.
    a. OH (CorHealth and Population Health teams) and the Digital and Virtual Care Secretariat will oversee the allocation of funding to approved proposals according to a criteria-driven process.

[1] Wodchis WP, Austin PC, Henry DA. A 3-year study of high-cost users of health care. CMAJ 2016 Jan. 11

[2] Data source: Discharge Abstract Database (DAD), Heart Failure Cohort (Schultz et al. 2013); National Ambulatory Care Reporting System (NACRS), Ontario Drug Benefit Claims (ODB), Ontario Health Insurance Plan (OHIP) Claims Database, Registered Persons Database (RPDB) FY 2017/18

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Demonstration sites will be evaluated based on several factors including their ability to:

- Deliver appropriate non-acute services using an integrated approach

And if part of an approved or in-development OHT, their ability to:

- Demonstrate strong alignment with the OHT model in the areas of leadership and integration with primary care and community partners
- Demonstrate how the OHT model will be leveraged
- Implement non-acute services using a model of care that includes digital health, virtual care, and/or remote care management to avoid hospitalizations

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A. Participation Criteria

Eligibility criteria for demonstration project *

Hospitals applying to be a demonstration site must:

- Currently perform CHF-QBP volumes and receive associated funding
- Report data, including key performance indicators (KPIs)
- Implement a plan to improve and integrate the service delivery model for HF patients, and reduce acute care utilization in partnership with primary care and community providers
- Continue being responsible for providing appropriate care for HF patients that require hospitalization
- Commit to promote equitable access for high-risk patient populations
- Participate in continuous engagements and future evaluations with OH and keep ministry and OH informed of any major project changes
- Complete and submit this **business case template**

** Participation in an approved or in-development OHT is viewed as a benefit to the overall application. Sites that are members of an in-development OHT are encouraged to include those partners as part of their submission.*

Additional eligibility criteria for OHT seed funding:

- ☐ QBP site should be part of an approved or in-development OHT
- ☐ The business case must be an integrated HF care proposal involving active cross-sector collaboration between OHT members, be endorsed through the OHT's Collaborative Decision-Making Arrangement (CDMA) (in the case of approved OHTs) and have the mandatory participation of a CHF-QBP hospital as well as primary care and/or home and community care partners.

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- ☐ The proposal must be designed with input from patients/family caregivers, with mechanisms to measure and improve the patient experience
- ☐ The proposal includes distribution of resources based upon involvement in the pathway, including the non-acute components
- ☐ QBP site and involved partners must have a plan for identifying those patients most at risk and best suited for the appropriate non-acute services, ideally by population segmentation
- ☐ QBP site must have reviewed the clinical standards as outlined in the Heart Failure Care in the Community for Adults Quality Standard, and in CorHealth's document, "*Minimal requirements and key clinical services for heart failure programs within a spoke-hub-node model of care*", and plan to implement or leverage at least two appropriate non-acute services (either from those identified by CorHealth/OH, or other evidence-informed strategies), and
    - Must have a plan in place to deliver appropriate non-acute services using a model of care that includes digital health, virtual care, and/or remote care management
    - Remote care management must meet minimum standards, and adhere to the remote care management technology and clinical requirements (see Appendix A)
- ☐ QBP site must be willing to systematically collect patient reported outcome measures (PROMs) (i.e., using OH's license for the Kansas City Cardiomyopathy Questionnaire- KCCQ-12) for the purpose of improving symptom management at the point of care. Sites will be expected to implement OH's electronic platform to collect PROMs (the Integrated Symptom Assessment and Collection (ISAAC) tool). OH will provide support for the implementation. Sites which have already implemented an alternative electronic platform to collect PROMs must be able to send data to OH's provincial PROMs database, with adherence to all applicable standards (e.g., data standards, privacy).

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B. Demonstration Site General Information

1. Hospital Lead Name and Title: Click or tap here to enter text.
   Hospital Lead Email Address: Click or tap here to enter text.
   Hospital Lead Telephone: Click or tap here to enter text.

2. OHT Lead Name and Title: Click or tap here to enter text.
   OHT Lead Email Address: Click or tap here to enter text.
   OHT Lead Telephone: Click or tap here to enter text.

3. *For sites applying for seed funding:*
   Proposal must have a health service provider organization sponsor (i.e., the TPA holder) that the region deems suitable to manage the initiative, and to which the funding can be flowed from OH according to existing financial processes. The funding recipient should be the OHT fundholder or designate. The health service provider organization identified below is agreeing to enter into an agreement with OH to manage and flow the funds to any other organizations and vendors involved in this initiative. Any vendor agreements will be between the health service provider organization and the vendor.

   Legal Name of Transfer Payment Recipient: Click or tap here to enter text.

   Executive Contact at Sponsoring Organization to be named in the Notice of the Funding Agreement:
   Name, Position: Click or tap here to enter text.
   Email Address: Click or tap here to enter text.
   Telephone: Click or tap here to enter text.

   Senior Financial Contact (CFO, CAO) at Sponsoring Organization to respond to required requests related to the funding agreement:
   Name, Position: Click or tap here to enter text.
   Email Address: Click or tap here to enter text.
   Telephone: Click or tap here to enter text.

4. Partnerships:

   Please list the name of each organization (including primary care providers/organizations) that will be participating in the initiatives.:
   Click or tap here to enter text.

Submitted By: Click or tap here to enter text.

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C. Initiative Description

1. Objective and description of overall initiative

- Please describe the **key objectives of the initiative.**

  Click or tap here to enter text.

- Please describe the evidence-based appropriate non-acute services (e.g., rapid access clinic, HF clinic, remote care management, nurse navigator) you intend to implement and specify how they will **integrate and improve the care trajectory** of your HF patients. Please identify the Quality statements from the Heart Failure Care in the Community for Adults Quality Standard that are addressed by the non-acute services you intend to implement. Note: at least some of the care must be provided outside of the hospital in-patient setting.

  Please describe:

- the HF population(s) this initiative will target. Which point of the **patient's care journey** will the service target? (e.g., early identification, HF symptoms monitoring, care navigation, chronic disease management, end-stage care).
- how patients will be identified/enrolled. Please provide details about how patients will be identified, including if a population segmentation approach will be used.
- the **care settings** where you anticipate providing the new or expanded service(s). (e.g., hospital setting, primary care, outpatient specialty health care setting, home and community care). Please include an overview of the team roles and responsibilities.
- the process for including the **input of patients and caregivers** in your initiative. Please remember that engaging patients/family caregivers during proposal development is one of the funding criteria.
- your communications plan and plan for change management to ensure buy-in

  <u>If you are applying for seed funding, be sure to</u>

- explain what problem the proposed innovation is intended to solve and *how* it will provide the desired results (i.e., what is the theory of change)
- include details about how your model of care will include digital health, virtual care, and/or remote care management
- provide an explanation of how your proposed new or enhanced program or service involves an innovative use of technology, data, and/or clinical process re-design to transform health care delivery

- consider any existing remote care management programs and how they would align with new initiatives. Describe any modifications that may be required to existing programs to align with the clinical standards and to ensure that the right offerings are provided to the right patients.
- describe any considerations, including consideration of patient experience, for potential scalability of the selected solutions, and possible application to other chronic disease conditions

Click or tap here to enter text.

2. Integrated care model

a. Please describe the plan and process for building and sustaining **integration** across OHT and regional **partner programs** and services, including details about plans to involve primary and/or community care. Please reference how your integrated model aligns with the CorHealth spoke-hub-node model of integrated HF care.

Click or tap here to enter text.

b. *For sites applying for seed funding*: please describe precisely how and when (date) this proposal received endorsement through your OHT's collaborative decision-making arrangement (CDMA). (Members of in-development OHTs which do not have an established CDMA should describe in detail how and when this proposal received endorsement from partner organizations).

Click or tap here to enter text.

3. Data

If and when needed, Ontario Health-CorHealth Ontario could provide quantitative information on the prevalence, service use, and outcomes of the Heart Failure patient population in the site's catchment. Please contact OHTSupport@ontariohealth.ca for more information.

Monitoring and reporting on the success of the initiatives will be the site's responsibility.

a) Based upon your proposed initiatives, please list the key indicators that will be used to measure and monitor success.

- Key performance indicators (KPIs)
  - E.g., CHF QBP admissions, Diverted CHF admissions, re-admission rates, CHF ED visits
- Patient-reported outcomes and experiences (PREMs/PROMs)
  - E.g., Quality of life measures, caregiver burden measures
- Process indicators (site-specific based on selected appropriate non-acute services)

- E.g., volume of new referrals of HF patients seen in clinic, remote care management reporting metrics (i.e., patient enrolments, health data, encounters, and escalations)

Click or tap here to enter text.

☐ **By checking this box, you agree to work with OH to measure, monitor, and report on these data throughout the course of the initiative and acknowledge that there will be a requirement in the TPA to additionally report standardized KPIs.**

b) Describe how many patients you anticipate serving (in Year 1, and then in subsequent years), and how the initiative plans to **reduce acute care utilization by HF patients.** Please provide quantification of targeted improvements.

Click or tap here to enter text.

c) If applicable, explain how you will use data and analytics to better support the episode of care for your patient population, **in alignment with population health management principles**.

Click or tap here to enter text.

4. Initiative budget

a) In the template below **(Schedule A),** please provide an estimate of the one-time investments that will be incurred in Year 1 (i.e., by the end of March 2023) that are required to support the initiative.

For sites applying for seed funding, please note that proposed budgets must

i. Demonstrate alignment to funding criteria, and adhere to expense eligibility (see Appendix B)
ii. Include a budget for up to $500k in one-time project/capital expenses (including up to $50k to support provincial project reporting, including implementation of the Interactive Symptom Assessment and Collection (ISAAC) tool). Note that higher one-time funding can be approved, with sufficient justification.
iii. Include significant co-investment. Any requests for clinical staffing expenses should be matched with in-kind clinical staffing resources. This will help to build capacity within the OHT to ensure sustainability of the model without relying on one-time funding for staffing in the longer term.

b) If applicable, explain how the proposal leverages previous digital investments (e.g., ministry or organization-funded projects) at your organization/OHT

Click or tap here to enter text.

c) Given the one-time nature of this funding opportunity, please outline what measures you will put in place to sustain the plan in Year 2 and beyond, and under what assumptions. Note that at the end of Year 1, sites will be invited to re-validate their plan for Year 2 (2023-34) which, together with the progress and results from Year 1, will be evaluated by OH and the ministry. Pending confirmation of funding, ministry may approve one-time funding for 2023-24 to support sustainment plans.

Click or tap here to enter text.

Schedule A

Service/ Initiative	Description	A. Dollar Investment Estimate: funds from existing budgets	B. Dollar Investment Estimate: net new funding *(if applying for seed funding)*	Total Dollar Investment Estimate (A+B)

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D. Key Milestones and Timing

Please outline key milestones and timelines associated with the implementation of the initiative. (e.g., hiring and training a nurse navigator, identifying/stratifying HF patient population, set up multidisciplinary team, purchase/install remote monitoring technology)	
Key Initiative Milestones	**Target Dates**

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E. Submission Confirmation

We hereby declare and consent that our hospital meets the criteria and requirements outlined in Section A to be eligible to participate in the CHF-QBP demonstration initiative.

We agree to provide additional evidence of meeting the above requirements if requested by OH or the ministry.

Note: Names are required for each position/role listed below. In addition, sites that are applying for OHT seed funding must include the names of the OHT Lead, as well as their OH Region Chief Regional Officer, and, if not already included, the OHT TPA holder. Additional rows may be added if required.

Position	Name	Title	Date
CEO/CFO			
Project Lead			
Clinical Lead(s)/ Champion(s)			
Administrative Lead(s)/ Champion(s)			
Data Lead			
(if applicable) OHT Lead			
(if applicable) OHT TPA Holder			
(if applicable) OH Chief Regional Officer			

Please complete and e-mail your signed Business Case Template to OHTSupport@ontariohealth.ca

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Table 1 – Examples of appropriate non-acute services for HF Care

Patient Care Needs	Alignment with HF Quality Statement	Examples	Examples of applicable digital/virtual tools
Earlier diagnosis of HF and management of the underlying cause	1	Rapid access to specialist consultation to help identify- heart failure/etiology	Care provided through virtual care platform (e.g., existing eReferral and/or eConsult platforms are available across the province) Using segmentation data to proactively initiate early care
Receive evidence-based therapies	3,4,5,8	Specialized outpatient multidisciplinary care Clinical decision-making support for primary care providers (PCPs)	Outpatient care enabled by virtual modalities, remote care management and self-management education provided through virtual platform Communication tools to support integration between PCP and specialist engagement on care plan
Recognition & management of early decompensation	3,6,8	Access to providers who have the resources to coach patients and provide timely management of fluctuations in patient status	Alerts management – remote care management, coaching, and self-management support and intervention as needed
Care coordination/ integration	2,7,9	Patient level and system level care coordination	Care navigation tools (circle of care communication, data and analytic tools)
Management of palliative care needs and EOL planning	10	Access to providers to support pain and symptoms management, psychosocial need	Symptom management, caregiver support – remote care management Virtual modalities to support patient/ caregiver and provider interactions or provider/provider interactions

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Appendix A

Remote Care Management technology and clinical requirements:

Remote care management must ensure clinical integration across care settings, and must align with the clinical standards as outlined in the Heart Failure Care in the Community for Adults Quality Standard and in CorHealth's "*Minimal requirements and key clinical services for heart failure programs within a spoke-hub-node model of care*"

Proposals must:

- Define **target patient group(s)** with heart failure for remote care management (RCM)
- Establish clear **referral sources and pathways** to enroll eligible patients with heart failure e.g., discharge planning from inpatient units, Home and Community Care assessments, Primary Care Providers, Telehealth Ontario, specialist office, heart function clinic etc.
- Demonstrate how care will be provided **outside of an acute care setting**
- Provide patients with access to an RCM **technology solution and/or device**, support onboarding/training, and offer technical support to its users
    - If technology solution has not yet been acquired, include expected timeline for procurement
- Define **evidence-based** clinical care pathways that are **standardized** across the region including:
    - Thresholds for the biometric and survey data collected for timely escalation for both urgent and non-urgent issues
    - Established escalation pathway e.g., secondary assessment, on-call support, PC visit, home visit, referral to home and community care, specialist provider or team, etc.
    - Established mechanism for follow up interventions and for patients to connect with their monitoring clinician or team if issues arise. Communication may be initiated through the technology solution (i.e., secure messaging or video) or through other communication channels (i.e., phone or email).
    - Ensure that patient generated data (trended daily) reports are available to share with clinical team to determine the need for further intervention, care plan updates, and support the decision to discharge the patient from the program.
- Remote care management must meet minimum standards and adhere to the remote care management technology requirements:
    - Leverage a technology solution with demonstrated remote patient monitoring capabilities or an equivalent "low touch" alternative.

- Proposals can leverage the existing remote care management solutions in operation within their region, or propose an alternative solution if pricing is competitive and solution meets minimum requirements.
- Solutions should offer evidence-based clinical features.
- Solutions should have options for full remote monitoring kit and have a BYOD (Bring Your Own Device) component
- Deliver regular reporting to the most responsible provider and sponsoring organization
- Where video or secure messaging are anticipated, successful proposals will be required to use an OH-verified solution (https://www.ontariohealth.ca/our-work/digital-standards/virtual-visits-verification-standard/vendor-list) or use a solution provider that is actively participating in the verification process
- Proposed remote care management solutions must:
    - Provide basic remote care monitoring functionality, including protocol management and clinical alerting, trending data and reporting functions.
    - Store all biometric and questionnaire/survey data in a patient-identifiable form so that it may be used for research or clinical purposes in the future.

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Appendix B

Guidelines for proposed budgets: eligible expenses

One-time funding is for new or enhanced care pathway development. Employee hardware is only eligible if it is clearly tied to the care pathway development.

- Project lead/management resources dedicated to as the lead the project design and implementation
- Decision support resource to support project reporting and evaluation
- Innovative use, or use in an innovative context, of data, digital and/or virtual tools to support care pathways, communication, and data analytics
- Technical/licensing costs for technology with remote monitoring functionality
- Clinical resources for new/expanded roles to support the new care pathways and integration of care across sectors, matched in-kind
- Physicians can be funded to support program development/operations, not for on-call/clinical care
- Resources to support project communications and/or resources for patients, referral sources, OHT members
- Hardware or software (e.g., HL7 bridge for EMR integration for the implementation of PROMs collection using an electronic platform)
- Technical and/or administrative support
- Eligible virtual care technology:
  - Any funding requested for technology, including infrastructure, solution licenses, set-up or configuration costs, devices, voice or data plans, must support the delivery of health care resources and services to patients.
  - Eligible virtual care tools include patient navigation and screening, online appointment booking, videoconferencing, phone, asynchronous messaging, and remote care management solutions that support care pathways and the collection and exchange of patient biometric or self-reported data.
  - Digital self-care tools that support health promotion, disease prevention and chronic disease management and provider-to-provider messaging tools may also be eligible if they are part of a broader program that supports the delivery of virtual care services to patients.
  - Proposals for device lending programs, with or without data plans, must be cost-effective, targeted at individuals who face barriers to accessing care, and include a sustainability plan

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Guidelines for proposed budgets: ineligible expenses

The Project shall not include developing or acquiring digital health solutions or services that:

- would duplicate in functionality or purpose required provincial digital health solutions, or would require the development of new registries, data repositories, or other digital health solutions that are available in whole or part from the Ministry of Health, Ontario Health or other delivery partners; or
- would duplicate digital health solutions or services for which existing pilot programs are in place provincially (e.g., digital identity services), and remote care management