HEALTH LINKS

***Community of Practice;* Coordinated Care Planning Process Series**

STEP ONE:

'IDENTIFYING Patients' for Care Coordination

September 9, 2015

Health Quality Ontario
The provincial advisor on the quality of health care in Ontario

Ontario
Health Quality Ontario

PARTICIPATING IN THE WEBINAR

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WEBINAR PANEL

HEALTH QUALITY ONTARIO (HQO)

- **Sandie Seaman,** *Manager, QI and Spread*
- **Jennifer Wraight,** *Quality Improvement Specialist, QI and Spread*
- **Stacey Bar-Ziv,** *Team Lead, QI Best Practice Networks*

GUEST PANELISTS

- **Joshua Hambleton,** *Project Manager, Arnprior Region and Ottawa West Health Link (within Champlain LHIN)*
- **Tory Merritt,** *Project Manager, North York Central Health Link (within Central LHIN)*
- **Laurel Hoard,** *Quality Improvement & Implementation Facilitator, Quinte Health Link (within South East LHIN)*
- **Lisa Priest,** *Director, North East Toronto Health Link (within Toronto Central LHIN)*
- **Rosalyn Gambell,** *Manager Health Links, Telehomecare, Medicine Out Patient Services, and GEM nurses. South Simcoe Northern York Region Health Link (within Central LHIN)*
- **Ana MacPherson,** *Clinical Coordinator, South Simcoe and Northern York Region Health Link (within Central LHIN)*
- **Agnes Gibson,** *Project Manager, Central East LHIN Project Management Office (within Central East LHIN)*
- **Jodeme Goldhar,** *Chief Strategy Officer and Senior Director, Strategy and Planning, Toronto Central Community Care Access Centre*

ONTARIO MINISTRY OF HEALTH AND LONG-TERM CARE

- **Jade Woodruffe,** *Senior Advisor, MOHLTC. Capacity, Planning and Priorities Branch.*

WEBINAR OBJECTIVES

Purpose

To review the current provincial landscape for Health Links, and facilitate Health Link to Health Link learning and discussion.

Specifically, this webinar will aim to:

To provide a brief review of:

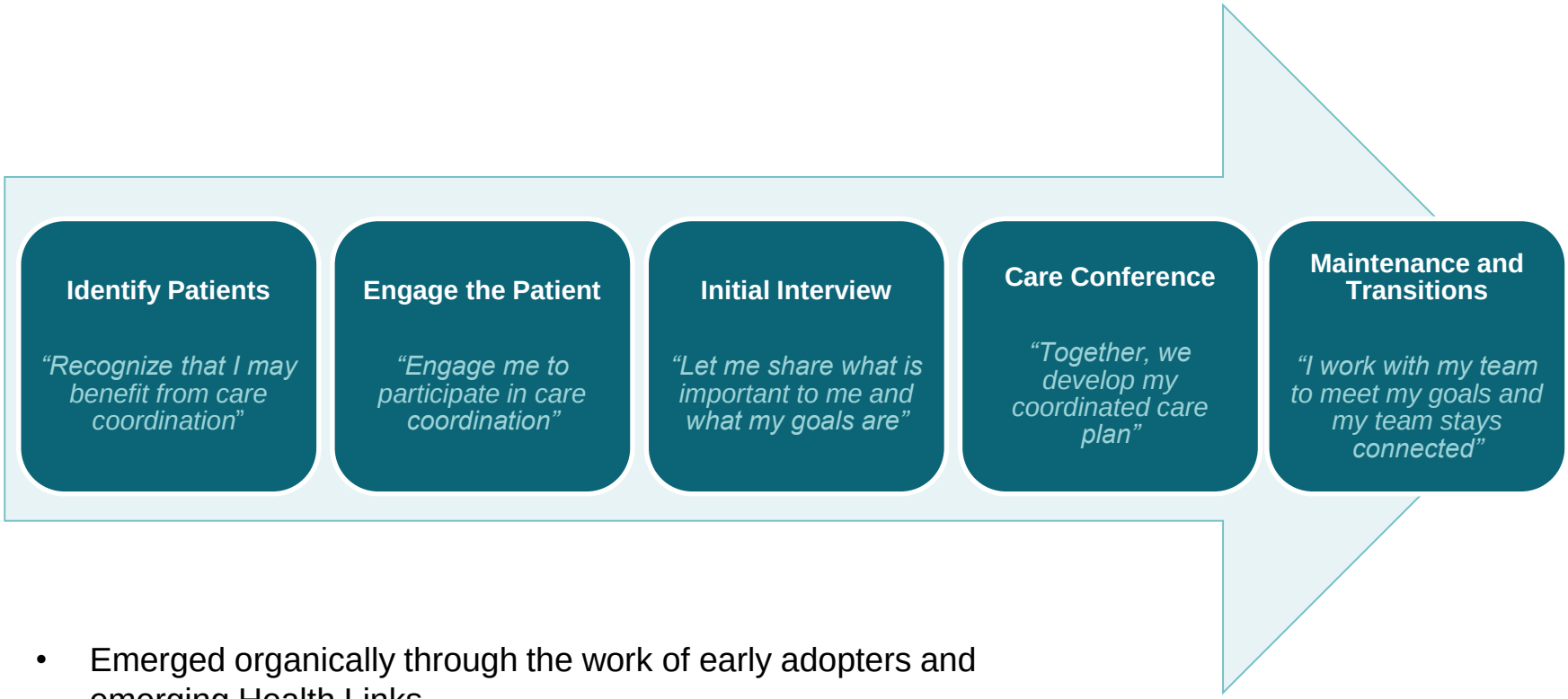
- **Health Links Target Population**; as per the Ministry of Health and Long-Term Care
- **The general practices and processes** that have evolved in Health Links across the province, so far.

Connect the Health Link Community to:

- Take a deeper dive into **selected practices** relating to the process step **'Coordinated Care Planning- Identifying the Patient'**
- Share and learn **from one another**

THE COORDINATED CARE PLANNING PROCESS

IN PROGRESS



- Emerged organically through the work of early adopters and emerging Health Links.
- Not mandatory- yet most Health Links have adopted or adapted some or all of these steps into their processes.
- Continues to evolve.

COMMON TARGET POPULATION:

Source: *'Health Links Target Population'* Webinar, The Ministry of Health and Long Term Care. *August 12, 2015*

Advanced Health Links Standardization: Common Target Population

A Common Process for Identifying Health Links Population:

- Staying with the 5% - Health Links will continue to focus on Ontario's Complex Patients.
- The common process will include:
  - Patients with four or more chronic/high cost conditions, including a focus on mental health and addictions conditions, palliative patients, and the frail elderly.
  - Economic characteristics (low income, median household income, government transfers as a proportion of income, unemployment).
  - Social determinants (housing, living alone, language, immigration, community and socials services etc.).
- Focus on adaptation of care planning for vulnerable populations (MHA, Frail/elderly and Palliative) to support strategic focus.

List of selected conditions that are chronic and/or high cost

97.6% of high cost users have at least one of these conditions

1	Sepsis	28	Ischaemic Heart Disease
2	Brain Injury	29	Cardiac Arrhythmia
3	HIV/AIDS	30	(Congestive) Heart Failure
4	Malignant Neoplasms (cancer)	31	Stroke
5	Blood disorders (anemia , coagulation defects)	32	Peripheral Vascular Disease and Atherosclerosis
6	Coma	33	Influenza
7	Diabetes	34	Pneumonia
8	Cystic Fibrosis	35	Chronic Obstructive Pulmonary Disease
9	Mental Health conditions	36	Asthma
10	Dementia	37	Ulcer
11	Substance-related disorders	38	Hernia
12	Schizophrenia & delusional disorders	39	Crohn's disease/colitis
13	Depression	40	Liver disease (cirrhosis, hepatitis etc.)
14	Bipolar	41	Arthritis and related disorders
15	Anxiety disorders	42	Osteoporosis including pathological bone fracture
16	Eating disorders	43	Renal Failure
17	Personality disorders	44	Low Birth Weight
18	Developmental disorders	45	Other Perinatal Conditions
19	Huntington's disease	46	Congenital Malformations
20	ALS (Lou Gehrig's disease)	47	Fracture
21	Parkinson's disease	48	Amputation
22	Multiple Sclerosis	49	Palliative care
23	Epilepsy & Seizure disorders	50	Pain Management
24	Muscular Dystrophy	51	Hip Replacement
25	Cerebral Palsy	52	Knee Replacement
26	Paralysis and spinal cord injury	53	Transplant
27	Hypertension		

Notes: The conditions included are those that: affect a large number of patients, are risk factors for other chronic conditions, or contribute to significant LOS and/or cost in one or more health care sector.

*Please refer to the original slide deck for details

SCAN of HEALTH LINKS PRACTICES

re: the “Identify Patients” step

Data driven case finding:

1) Electronic Medical Record (EMR)
2) Health Record/ Caseload analysis

Clinical level identification:

1) Emergency Department (ED) *(e.g. on admission to ED, discharge from ED)*
2) Hospital *(e.g. via admission/ contact with specific programs, etc.)*
3) Community Care Access Centre (CCAC) *(e.g. by caseload, triggered by involvement in certain programs, etc.)*
4) Primary Care *(e.g. by Primary Care Providers, allied health programs or providers, etc.)*
5) Community- other

May use

- Standardized tools (LACE, HARP, etc.)
- Prompt questions (does this person keep you up at night?)
- Clinical judgment
- Etc.

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AROW – Arnprior Region & Ottawa West

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ARNPRIOR REGION AND OTTAWA WEST HEALTH LINK

Joshua Hambleton, *Project Manager,*
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Tailoring to Sub-local Environments

Geographic Hubs of Activity

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- **Arnprior** – small rural hospital with GPs covering inpatients (FHT attached to hospital)
- **CARP** – Family Health Team & Community Paramedic Program
- **Kanata** – Community Hospital, large FHT, many community agencies (limited connections)

Evolving Identification Strategies

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- **Unattached** eReferrals via Hospital EHR
  - Discharge RN for admitted patients
  - GEM for ER visits
  - CCAC for community identification
- **Retirement Home**
  - Care Director identifies Health Link residents
- **FHT** Lead Physician Invite
  - Existing FHT resource introduces Health Links to referred complex patients & liaises with AROW team

LESSONS LEARNED

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- **Don't trust the data** - need to confirm current fit/situation of patient with someone who know them (GP, Care Mgr, etc)
- **Build multi-level commitment** – leadership buy-in does not translate into frontline support
- **Cultivate champions –** work with the willing and highlight successes to build peer relations

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NORTH YORK CENTRAL HEALTH LINK

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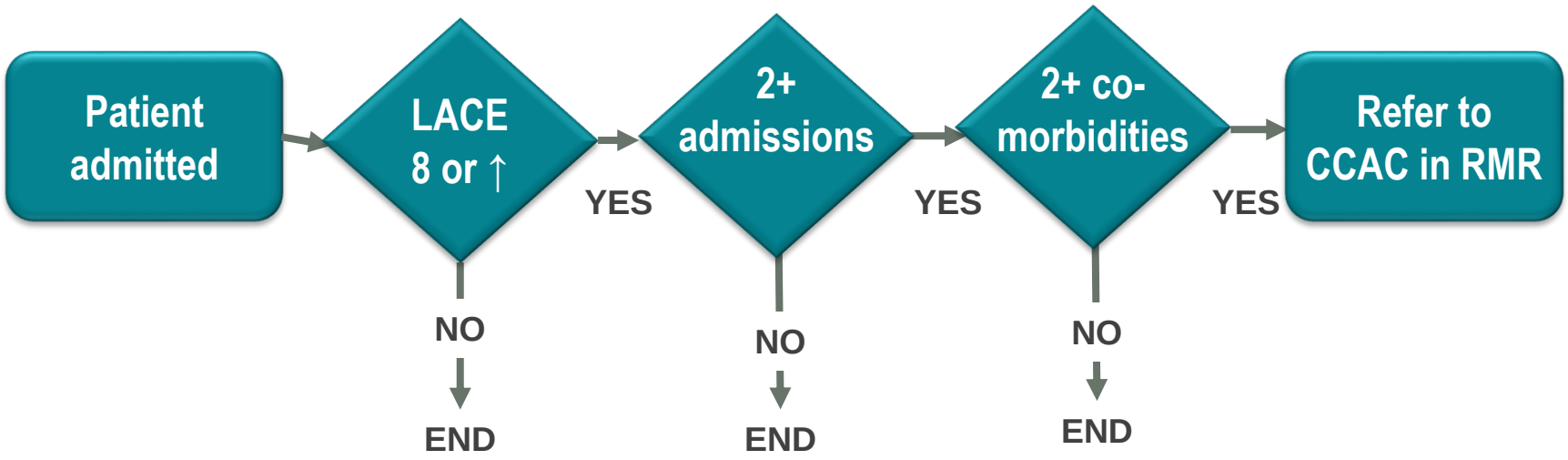
PATIENTS ARE IDENTIFIED IN REAL-TIME

Inpatients	• LACE score of 8 or higher • 2 or more admissions in ~ 6 months • 2 or more co-morbidities
ED	• 5 or more ED visits in last 12 months • MH or suspicion of MH diagnosis
Primary Care and Outpatient Clinics	• PRA score of 50% or higher
Community	• Admission within last 90 days • 2 or more co-morbidities • DIVERT score of 6

LACE FOCUSES ON RISK OF RE-ADMISSION



LACE identifies patients at risk of readmission within 30 days by considering:
Length of Stay, **A**cuity, **C**o-morbidities, **E**D visits

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LESSONS LEARNED

- Criteria should be simple + straightforward
- Criteria should not be too restrictive
- Patients who meet criteria may not need Health Links
- Patients who need Health Links may not be flagged through criteria
    - Lack of caregiver or capabilities of caregiver
    - Social Determinants of Health

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QUINTE HEALTH LINK

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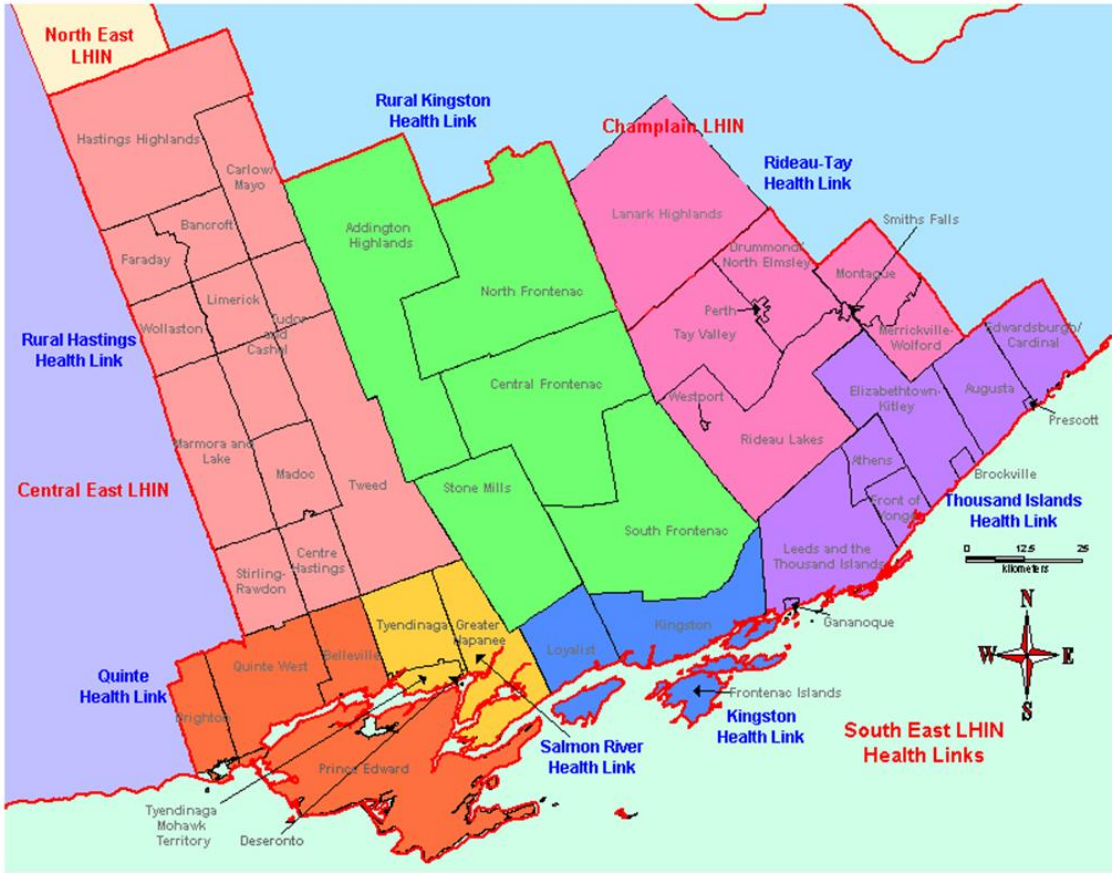
HealthLinks in the South East LHIN



- ✓ 7 Health Links cover 100% of our geography
- ✓ Primary care led
- ✓ QI approach over the last 2 years

Ontario

South East Local Health Integration Network

Réseau local d'intégration des services de santé du Sud-Est

Evolution of Interventions to Identify Individuals for Quinte HL Involvement

- **Test 1:** list of high cost patients from hospitals given to Primary Care

- **Test 2:** Stanford Tool – 4 questions for Primary Care Providers:
  1. Which patients do you worry about and keep you up at night?
  2. Which patients do you think are headed for a hospital admission?
  3. Who do you think is on a downward trajectory?
  4. For whom would you like to have extra eyes and ears in the home?

- **Test 3**: Hospital Patient Flow Coordinators identify people with 4+ chronic conditions and some social determinants of health challenges

- **Planning Test 4**: SHIIP & LACE

SHIIP
SOUTH EAST HEALTH INTEGRATED INFORMATION PORTAL

LESSONS LEARNED

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- Complex patients have unmet health AND social needs. Some have simple wishes.

- We need to consider the potential to make an impact when identifying people. Some will require more, some may require less and some we may not be able to help through HLs.

- The Care Coordinator role seems most effective when embedded within the primary care team.

- We scaled up too quickly focusing on numbers rather than processes and engagement, especially provider engagement.

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NORTH EAST TORONTO HEALTH LINK

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North East Toronto Health Link
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About the Practice

The North East Toronto Health Link identifies patients in real-time, using an innovative information management system (Better Care) and this objective measure: how many times they visited the emergency department or have been admitted over the past six months. This approach means all patients who hit the trigger have an equal opportunity to be engaged, enrolled and participate in the care planning process, creating equitable access for all patients to a basket of enhanced services: a virtual community care team.

- **Algorithm: 4 visits to the emergency department OR 3 inpatient visits in six months to Sunnybrook Health Sciences Centre who live in the Health Link geography as validated by a clinical advisory committee. *Frailty algorithm embedded.**
- **Patient engagement embedded in the clinical program: Patients are engaged and enrolled in real-time by a core care team based at Sunnybrook after hitting the trigger (registration)**
- **Privacy: Health Link patients say 'yes,' 'no, not now' or 'not ever' to care planning and being flagged.**
- **Data-sharing and participatory agreements are required among partners.**

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ED Statistics - North East Toronto ED Visits during 6 months from 11/30/2014 to 5/31/2015	
Total # ED Visits:	364
Total Unique Patients:	71
Minimum # ED Visits:	4
Maximum # ED Visits:	24
Average # ED Visits:	5.1
Triage Level (%)	
Triage 1	1.1%
Triage 2	29.7%
Triage 3	61.3%
Triage 4	7.7%
Triage 5	0.3%
Age	
Visits - Age < 65 yrs	56.6%
Visits - Age 65-74 yrs	12.9%
Visits - Age 75+	30.5%

Patient profiles:

Palliative:
- Cancer patients

Frail seniors:
Those biologically older "60"
- Living alone, isolated
- Falls
- "property rich" but financially living on the margins

Complex under 60:
- Pain
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure

Mental Health & Addictions:

- Severe persistent mental illness
- Repeated overdose
- Addictions
- Personality disorders
- Mental health conditions

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LESSONS LEARNED

- **Change Management**: Creating a care team and buy in from partners on helping "our patients" who live in "our geography."
- **Blending work**: Need to blend work and deliverables for those doing care planning to make it sustainable
- **Accountability:** Identifying and notifying alone are not enough. Health Link partners report back at Advisory meetings on care planning progress
- **Patient Engagement**: Patients evaluate the program for improvements based on questions developed by Health Link Patients' Advisory Council; patient engagement requires a strong governance structure
- **Program Evaluation:** Health Links patients evaluate the program
- **Data Sharing:** Agreements are critical to safely sharing information

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SOUTH SIMCOE AND NORTH YORK REGION HEALTH LINK

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ABOUT THE PRACTICE

- For this process to work, we need buy in from frontline CCAC Coordinator support on initiating the CCP
  - Education on criteria
  - Referral process needs to be simple
  - Authorship and Viewership of CCP should be made simple

ONGOING ENGAGEMENT & PROGRAM PROMOTION TO KEY PROVIDERS

- To include Education and Awareness:
  - Of Health Links Patient Criteria (LACE Score/ HL Checklist)
  - Health Links Process
- Community Support Rounds –introduced
  - Case discussions
    - Coordinated Care
    - Social Determinants
    - Mental Health

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LESSONS LEARNED

- Establish relationship with community partners
- Buy in from frontline staff
- Ongoing awareness or follow up:
  - HL criteria
  - HL successes and benefits to referring source/ potential referrers
- Future…
  - HL Target Population expansion to include Social Determinants of Health, MHA, low SES, frail elderly population.

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CENTRAL EAST LHIN REGION HEALTH LINKS

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ABOUT THE CENTRAL EAST LHIN HEALTH LINKS

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- Central East LHIN established a ***central Project Management Office*** to support all 7 Health Links in the region.

- Strong focus on ***leveraging existing resources*** in place, by embedding the CCP process into existing programs that serve patients with complex issues.

- Vision for implementation is a ***shared model for leading patients through the CCP Process*** (multiple providers across multiple organizations will be able to lead patients through the CCP process).

ABOUT THE PRACTICE

Patient level identification processes

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Example:

ABC Organization- XYZ Program

- Existing program already in place.
- Providers supporting patients with complex health and wellness issues already in place.
- Mechanisms for identifying patients with complex health and wellness issues in place (whole program or streams within a program, etc.)

To identify patients that may benefit from care coordination:

- Build on **existing** mechanisms in place (vary across organizations/ programs).

For example, if a program has a 'general' steam, and an 'intensive case management' stream, those requiring intensive case management automatically become patients identified as potential Health Links/ Care Coordination candidates.

LESSONS LEARNED

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Benefits of approach:

- Minimal change to processes for Health Link partner organizations
- Identifies patient *where they a*re, at a time when they may benefit from Coordinated Care Planning.
- Providers can continue to provide service to a complex patient population they are already working with, and have developed expertise around.

Limitations of approach:

- Patients selected may not match the description of the 'Target Population' exactly. *Next steps; additional 'lens' may need to be added.*
- May not capture patients who are not yet connected with appropriate providers. *Next steps: may explore additional approaches to identifying patients, to create multi-pronged approach.*

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ONE CLIENT- ONE TEAM

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ONE CLIENT - ONE TEAM

Advancing an Integrated System of Care Driving Transformation

&

Health System Integration Enabled Through Health Links

Presenter:

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Co-Developed with:

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Primary Care LHIN Lead

Primary Care Advisor, TC CCAC

Aim

Supporting populations with complex needs with better care at home in their communities, utilizing existing resources

Our Approach: One Client: One Team

For the client/family

- Seamless care
- One team approach

For the providers

- One team approach
- Built around what's most important for client and family needs

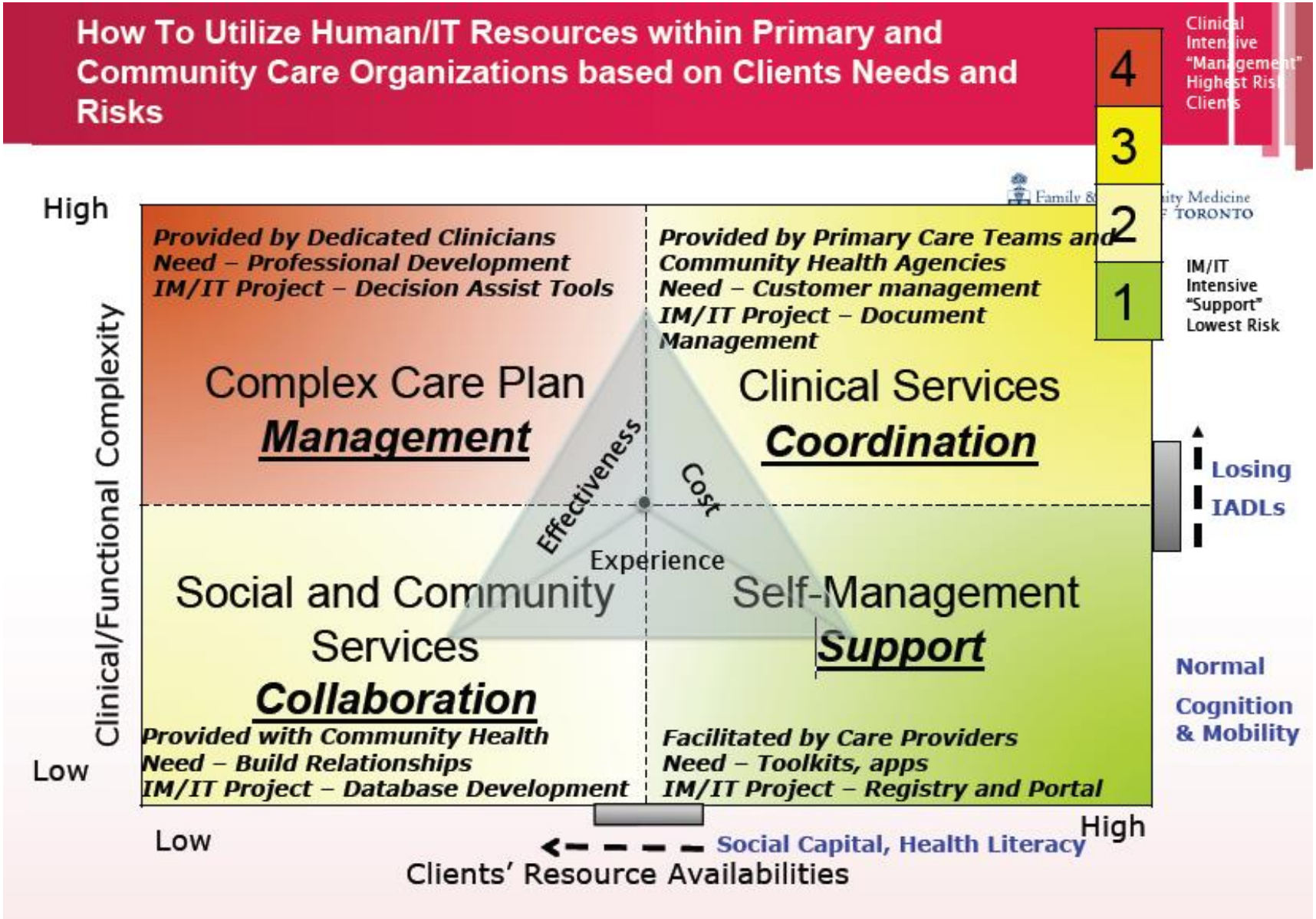
"I was so surprised the nurse already knew what the doctor had planned and that the care team speaks every day. It makes it easier for me as the caregiver: I don't have to make sure everyone has all of the information and it makes me more confident in the care team."

Caregiver

A framework for Implementation: Care Planning Matrix

A framework to guide discussion on the alignment of resources, human and technology, to the needs of clients/patients, in their circle of care – in primary care and in the community.

How To Utilize Human/IT Resources within Primary and Community Care Organizations based on Clients Needs and Risks



Lessons from the Integration Strategy

It's not complicated!

Pause…

- How does the patient and caregiver experience this
- Build meaningful relationships
- Value others contributions and perspectives
- Build 'leaderful' teams

But don't stop!

- Don't wait for complex or perfect solutions
- Incrementally build toward excellence
- Find comfort in ambiguity
- Leverage and align with system enablers
- Using and implementing the framework

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DISCUSSION

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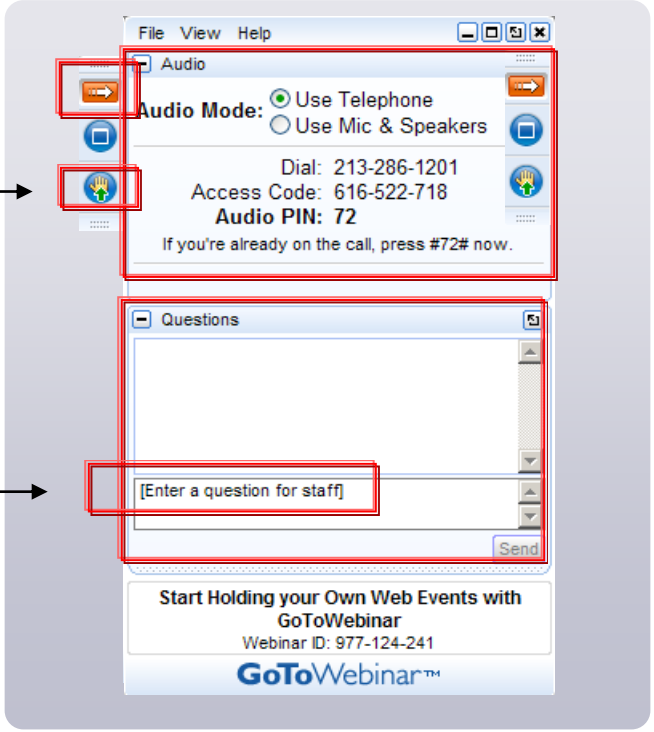

HEALTH LINK COMMUNITY OF PRACTICE:
WEBINAR SERIES

Topic	Date
Webinar 1: CCP – Identify the Patient	Wednesday September 9, 2015
Webinar 2: CCP – Engage the Patient	Tuesday September 22, 2015
Webinar 3: CCP – Initial Interview	Wednesday October 7, 2015
Webinar 4: CCP – Care Conference	Wednesday October 21, 2015
Webinar 5: CCP - Maintenance and Transitions	Tuesday November 10, 2015

AND ALSO…

Health Quality Transformation, Health Links Lunch and Learn Abstract Session	Wednesday October 14, 2015

Health Quality Transformation 2015

Partnering to accelerate best care, best health, best value

October 14, 2015

Metro Toronto Convention Centre- South Building

REGISTRATION IS NOW OPEN

www.hqontario.ca

Lunch and Learn Session:

'Improving Care for Patients With Complex Conditions'

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