Ontario
Health Quality Ontario

HealthLink

Health Links Quarterly Report

September 2019

Reporting Period: April 1 to June 30, 2019

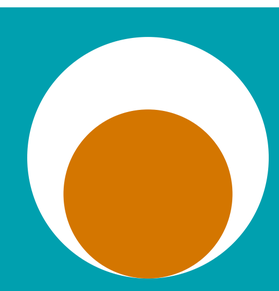
84,707

people with **chronic conditions or complex needs** across the province have coordinated care plans (CCPs*)

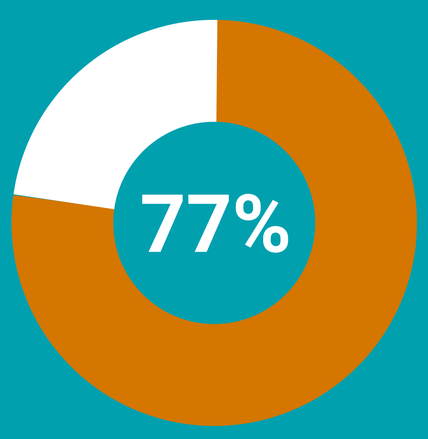
*A CCP is a plan for care that is developed with the patient and shared among providers in different care settings.

5,034

people had a CCP created this quarter



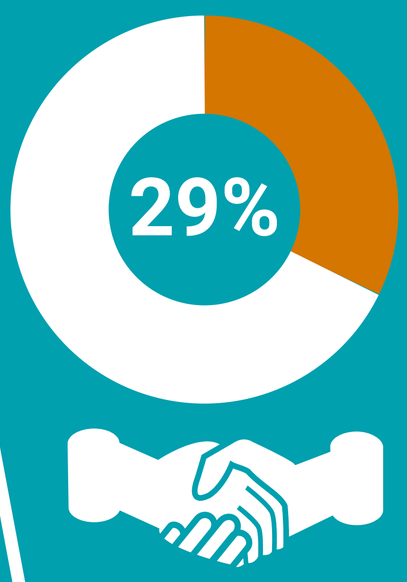
49% of **4,959** unattached patients found a **new primary care physician** this quarter



of patients surveyed reported **timely access** to a primary care physician

68% of newly identified patients **waited 7 days or less** to initiate their CCP

603 organizations across the province **identified individuals for the Health Links approach to care** over the past 6 months



of patients with a CCP have a **recorded confidence score***

*This score reflects, on a scale of 1 to 10, how confident the patient is that they can achieve the goals outlined in their CCP; a score of less than 7 should initiate review of the plan.

Quarterly Report: Measurement

PATIENT IMPACT

Figure 1: Number of patients with a first, new coordinated care plan, by quarter

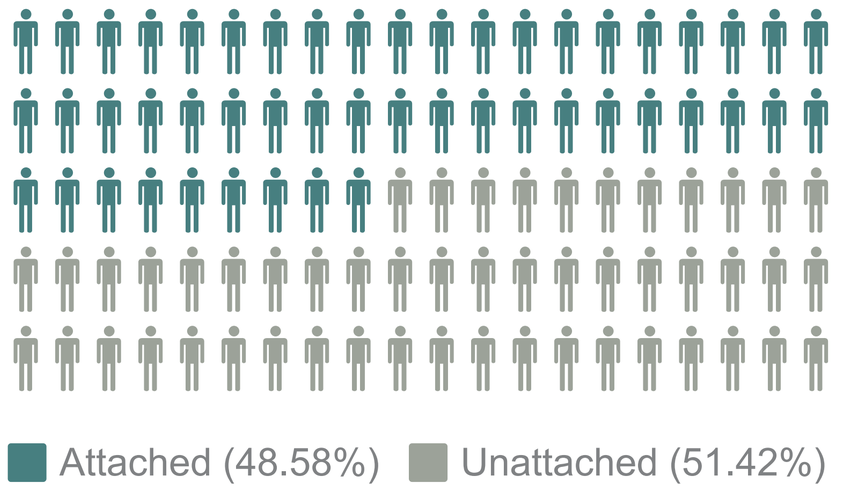
In Q1, 5,034 patients had a new, first CCP developed, a 1% decrease from 5,083 CCPs in Q4. The LHINs that reported an increase attributed this to strong partnerships and embedded processes; however, impending funding changes and increased focus on the development of Ontario Health Teams have made it difficult to keep stakeholders engaged and to prioritize the Health Links approach to care.

5,034
patients had a new, first CCP created this quarter

49
fewer CCPs were created this quarter (Q4: 5,083, Q1: 5,034)

↓1%
decrease from last quarter

Figure 2: Percent of identified, unattached patients newly attached to a primary care provider



To date, 2,409 of 4,595 (49%) identified individuals* with chronic conditions and complex needs who are in need of primary care have been attached to a primary care provider (352 this quarter). Variation in attachment rates across the province are primarily attributed to different levels of primary care resources and engagement with the Health Links approach.

*"Identified individuals" refers to those with chronic and complex conditions who have been identified by their care provider or an organization as benefiting from the Health Links approach to care.

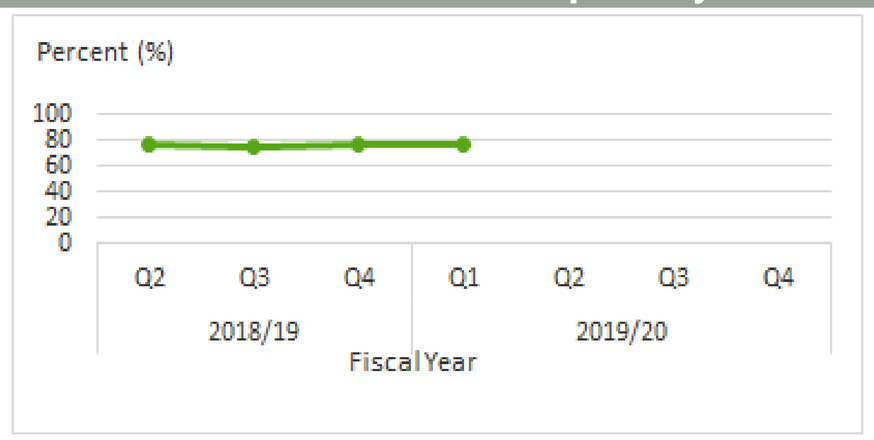
352
patients were newly attached this quarter (Q4: 2,057, Q1: 2,409)

1,801
unattached patients were newly identified t his quarter (Q4: 3,158, Q1: 4,959)

2,409
patients have been attached to a primary care provider to date

PATIENT EXPERIENCE

Figure 3: Percent of patients reporting timely access to primary care

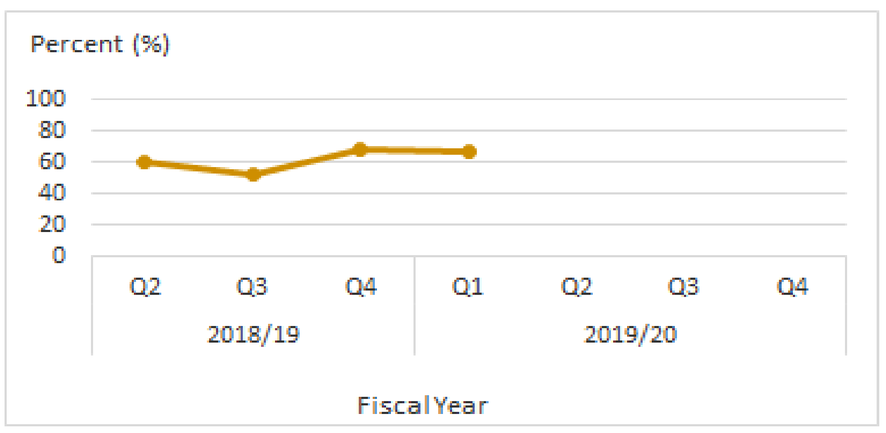


Of those surveyed, 77% (1,634 of 2,134) of patients with a new CCP reported timely access to primary care. Regions that reported an increase in the number of patients surveyed noted continued refinement of data collection methods and onboarding of additional health service providers.

77%
of surveyed patients with a new CCP reported timely access to primary care (1,634 of 2,134)

42%
of patients with a CCP were surveyed

Figure 4: Percent of patients reporting a wait time of 7 days or less to CCP initiation



The wait times from referral to initiation of a CCP were determined for 6,109 individuals. Sixty-eight percent (4,133 of 6,109) waited 7 days or less for initiation of their CCP—no change from the previous quarter. Regions can leverage this baseline to identify opportunities to improve access (reduce wait times).

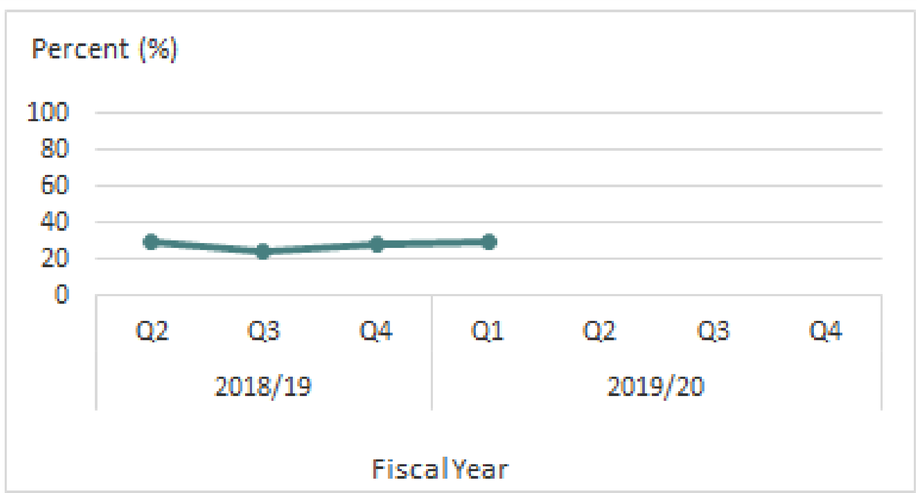
6,109
patients with a recorded wait time

4,133
(68%) patients waited 7 days or less from identification to CCP initiation

Quorum

The Health Links Approach to Care Community of Practice on Quorum, Health Quality Ontario's online quality improvement community, continues to grow, with members sharing resources, ideas, and tools. These can be found on the activity feed, as well as under the attachments tab on the group page. New this quarter: samples of patient brochures shared by Health Link teams across the province.Thank you to all who share and contribute to Quorum!

Figure 5: Percent of patients with a recorded confidence score



In Q1, 1,477 (29%) individuals had a recorded confidence score; LHINs continue to report challenges posing this question due to limited uptake from providers and variation in data collection methodology.

1,477
of patients had a recorded confidence score

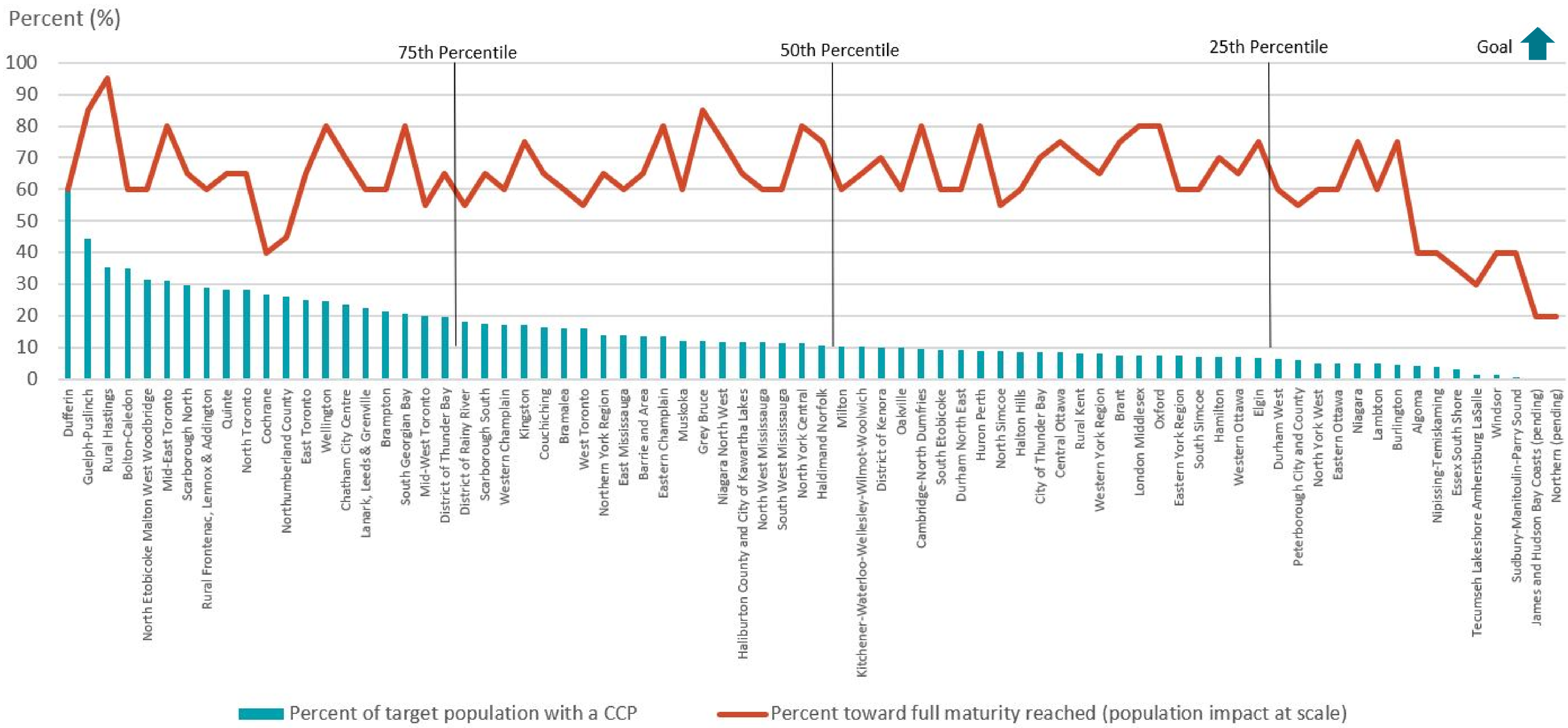
29%
(1,477/5,106) of patients were surveyed in Q1

Variation in Ontario

Figure 6 shows the distribution across sub-regions, and frequency distribution, for two key measures: number of CCPs created (percent of target population reached) and self-reported maturity (with 100% maturity reflecting population impact at scale).

Factors that may contribute to the variance observed include relative rurality/urbanity; number of individuals in the target population in that region; when the sub-region received funding and began the work of coordinating care; and business processes employed by the sub-region (centralized or decentralized).

Figure 6: Cumulative number of CCPs created and self-reported level of maturity, by sub-region (N=76)



Note: Sub-regions were assigned a score between 1 to 5 across all four domains of maturity (identification of patients, coordination of care, patient-centred care, and measurement and continuous improvement), based on their self-reported levels of maturity in these four domains. A sub-region that has a score of 20 points (100%) is one that is fully mature and has reached population impact at scale.

This figure shows that increased maturity has not yet led to increased numbers of CCPs created. Once a certain level of maturity is reached, how can specific regions begin increasing the scale and spread of coordinated, integrated care for this vulnerable population?

Quarterly Report

Lessons from Health Links

How to improve integrated care

Health Quality Ontario has gathered lessons learned from Health Link teams across the province, with input from the Regional Quality Improvement Specialists who have supported the implementation of the Health Links approach to care. A number of these may be applicable to Ontario Health Team (OHT) development—some LIHNs have had the opportunity to share their experiences on a local level with OHT leadership. To lend support, Health Link leads or project managers in some sub-regions are actively involved in the OHT application process, while in others, Health Link steering committees have worked together to compile lessons learned for distribution to OHTs in their regions.

Vision

- Articulate a vision for the future
- Clearly define the target population
- Develop parameters around low rules and standardization

Partnerships

- Engage patients in system design
- Develop collaborative, trusting relationships with providers, patients, and caregivers
- Break down barriers and be innovative in service delivery

Funding

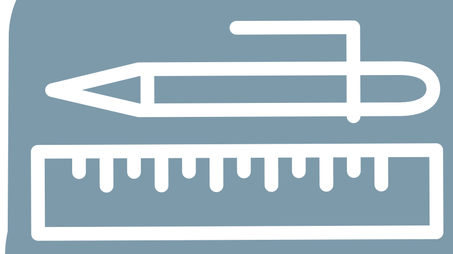
- Ensure aligned, multiyear funding for stability and progress
- Understand the barriers for remote geographies

Coordinated Care Management

- Consider system navigation, organization, and advocacy for patients, caregivers and providers
- Address social determinants of health
- Leverage quality standards, innovative practices, and coordinated care plans

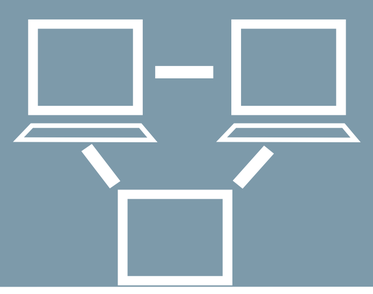
Sustainability

- Design sustainable care and business operations



Quality and Measurement

- Define measurement processes early
- Articulate technical specifications from the outset
- Integrate quality improvement into work processes
- Automate data collection



Technology

- Develop digital solutions to seamlessly support the exchange of information across platforms
- Access, privacy, and consent processes must support timely information-sharing
- Grant patients access to and input into their records
- Reduce reporting burden and redundancy
- Use algorithms to identify target population sooner

Capacity Building

- Standardize care coordination education and sustainable resources
- Start a Community of Practice to foster information-sharing and support implementation

Communication

- Make more information available to the public and providers
- Standardize communication earlier

Focus Question ?

Each quarter, regions are asked a set of focus questions on timely issues related to their progress spreading, scaling, and sustaining the Health Links approach to care. A summary of the responses from this quarter is shared below.

1. Given impending funding changes and emerging OHTs, how will your team continue to coordinate the care of individuals living with multiple chronic conditions and/or complex needs?

2. Have you been sharing lessons learned with OHTs in your regions?

Given the impending funding changes to the Health Links program and emerging Ontario Health Teams (OHTs), LHINs have been exploring sustainability strategies that will support the continued coordination of care for individuals living with multiple chronic conditions and/or complex needs.

Many Health Link leads, organizations, and representatives from sub-regions have been actively contributing to OHT applications in their geographies. The Health Links approach to care is closely aligned with the vision for the OHT model and we anticipate that many aspects of the Health Links approach will be embedded into emerging OHTs. In the meantime, sub-regions are working on sustainability plans that include further embedding care coordination into standard work—curricula, technology, and business processes at the organizational level. Existing partnerships and networks that have been built through the Health Links approach to care are being leveraged to support both the development of OHTs and the establishment of new structures that will aid ongoing coordination between care providers and care settings.

With respect to funding changes, some sub-regions are strategizing about how to support funded positions and leverage existing resources to ensure individuals continue to have access to coordinated care while organizations transition to OHTs.

Quarterly Report

In closing…

Ontario Health Teams and the Health Links approach to care both aim to provide high-quality, collaborative, integrated care for **patients, their families, and their caregivers.**

They are aligned in their overall goal to offer an improved patient experience, seamless transitions, and localized care.

As Health Links transfer to Ontario Health Teams, it is important that continuity of care is maintained, that patients with chronic conditions and complex care needs, including mental health and addictions conditions are prioritized, and that this vulnerable population continues to benefit from coordinated care with their wishes, values, and goals at the forefront.

IMPACT OF COORDINATED CARE

When Joe, age 58, went to his local homeless shelter, the David Busby Centre in Barrie, for help, he had unmanaged diabetes and a wound on the stump of his recently amputated limb. Staff didn't know if he had been taking his medications as prescribed. His blood sugar was extremely high, and he suffered from sciatica, memory loss, and vision impairment. The David Busby Centre contacted Collaborate Barrie to provide an intervention plan, and when he agreed to go to the emergency department they called the Barrie Health Links team to help coordinate his care

A Health Links Navigator went to the hospital with Joe and met with the attending physician. Over the course of the year, the Health Links team supported Joe through several visits in and out of hospital, met with the local hospital's Risk Management and Privacy Office after some interactions with law enforcement, organized a developmental services assessment, and connected Joe with LOFT Community Services and LHIN Home and Community Care for assistive devices. They helped him address barriers to accessing care as a homeless person and coordinated medical and mental health services, which often could not be accessed in the same location.

With the help of Health Links Barrie, Joe is now living in assisted living, a safe and supportive environment where his physical and mental health needs are being met.

Thank you to Health Links Barrie for submitting this patient story. Printed with permission.

Helpful Links

The following resources are available to help sub-regions successfully implement the Health Links approach to care, collect data on the enhanced measures, and progress in their maturity journey.

Health Links Community of Practice

Health Quality Ontario hosts a number of webinars directed at improving integrated care for patients with chronic conditions and complex needs. Upcoming webinars are listed on our website. Webinar recordings are available on Quorum. Our next webinar is scheduled for Fall 2019.

Quality Standards

Quality standards are a go-to resource for quality care. They are concise sets of easy-to-understand statements based on the best evidence. The quality standards for early pregnancy complications and loss, chronic pain, transitions between hospital and home, alcohol use disorder, anxiety, obsessive-compulsive disorder, and diabetes are currently in development.

Patient Engagement

Health Quality Ontario has developed a quick guide on how to become a "patient partnering all-star" and overcome common challenges. This guide might be useful in your quality improvement efforts related to collecting data on the enhanced measures and involving patients in their CCP development.

Quorum

The Health Links Approach to Care Community of Practice on Quorum, Health Quality Ontario's online quality improvement community, continues to grow its membership and resources.

A new group may also be of interest to those implementing a coordinated care approach: In the Palliative Care Implementation Support Group, Quorum members can access tools and resources, and engage with colleagues across other organizations and sectors who are working on the early identification and assessment of patients who might benefit from the palliative approach to care.

Ontario