Health Links: Excerpts from the 2018/19 Q2 Report

DECEMBER 2018

Health Quality Ontario

Let's make our health system healthier

The Health Links Approach to Care

Improving Integrated Care for Patients with Multiple Chronic Conditions and Complex Needs

Patient Story: Randy

Thank you to the North East LHIN for sharing this story.

When care coordinators first met Randy, he was 85 years old and was described by his family as an intelligent, family-oriented, athletic man. Randy enjoyed doing projects around his home in northeastern Ontario that he shared with his wife of more than 30 years, Mary.

Randy had a history of cardiovascular disease, including atrial fibrillation and hypertension, and he had a recent diagnosis of ß-cell lymphoma. In the year after his diagnosis, Randy began sleeping more and described himself as being in a fog or cloud. Daily tasks were becoming increasingly difficult. To manage fatigue, Randy and Mary decided to discontinue medication for atrial fibrillation and hypertension and, despite multiple visits to primary care, his fatigue progressed to dizziness, falls, and an inability to complete activities of daily living.

Randy was the father of two adult sons who resided a considerable distance away in southern Ontario and were not able to be directly involved in his care. As a result, Mary was Randy's sole caregiver and she was showing signs of fatigue and stress.

His primary care provider decided to refer him to the Health Links approach to care, and the North Algoma Health Link obtained consent to enroll Randy as a client. Together they created a coordinated care plan.

Patient Story (continued)

Health Links Support

It became apparent that there had been no formal supports in place to help Randy and Mary manage his care and his activities of daily living at home. Referrals were subsequently made to several agencies, including North East LHIN Home and Community Care for nursing and personal support, physiotherapy, occupational therapy, and social work, as well as to the Red Cross Friendly Visitors program. Relevant education and resources were also provided to Mary to provide much-needed support as Randy's sole caregiver.

With the additional supports in place, Randy was able to stay in his home until several months later when his health declined again and he was admitted to hospital. At this time, the Health Link assisted in coordinating a family meeting with Mary, one of their two sons, his primary care practitioner, the charge RN at the hospital, a representative from the Red Cross, the North East LHIN Home and Community Care lead, the Health Link RN, and a dietitian.

At this time Randy's care plan was updated to include palliative services.

Patient Story (continued)

Randy and his family made their wishes known for Randy to spend his last days at home and not in hospital. To achieve this, the care team put a collaborative palliative care plan in place, which included education for team members and family to effectively care for a palliative patient. Key partners included Red Cross Assisted Living, hospital and community nursing staff, and palliative care support and equipment from North East LHIN Home and Community Care. Throughout this difficult time, the care team worked closely together to ensure everyone was kept informed of best practices and—most importantly—the client's and family's values, wishes, and beliefs.

Today

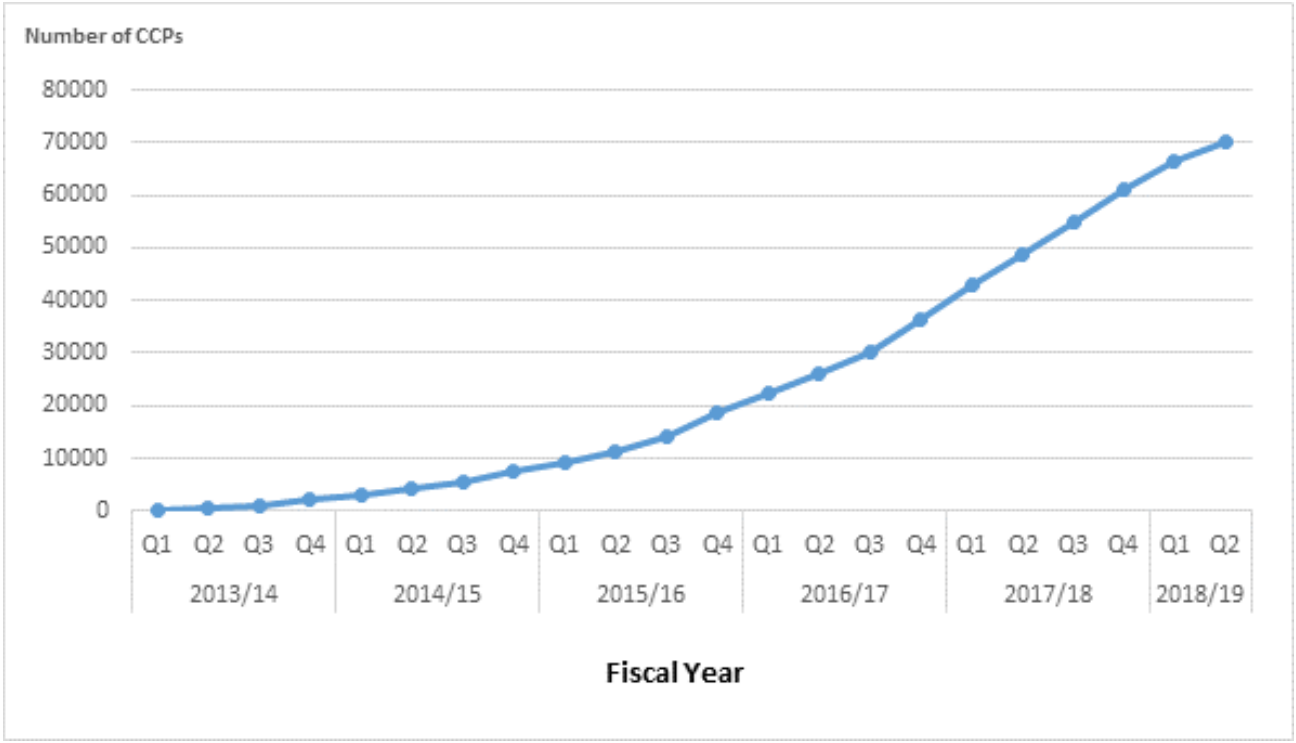
Randy passed away peacefully in February 2018, at home with family by his side. With the support and collaboration of the compassionate care team, informed by the coordinated care plan, it was possible to grant the wishes of Randy and his family. Since Randy's passing, his wife Mary has also become a Health Links client. With her own coordinated care plan, Mary is well supported to manage her grief from the loss of her husband and maintain and optimize her own continued wellness.

The Health Links Quarterly Report

- Provides a summary of data reported by Health Links in each quarter
    - *Six enhanced measures are reported on, five of which are or revised new this quarter, with data collection beginning in July 2018*
- Offers a deeper understanding of Health Links maturity across the province and progress on sub-region transition to date
- Highlights patients who are benefiting from a Health Links approach to care
- Reviewed by Health Link leads from all 14 LHINs and Health Quality Ontario Regional Quality Improvement Specialists
- Circulated to Health Link teams, LHINs, Health Quality Ontario, and the Ministry of Health and Long-Term Care
- Used to share observations, identify areas of interest, and guide conversations and planning
- Additional work to coordinate care for patients with complex conditions taking place across the province may not be included in this report

Impact of the Health Links Approach to Care – Q2 Update

Figure 1: Cumulative Total Number of Coordinated Care Plans Completed for Patients

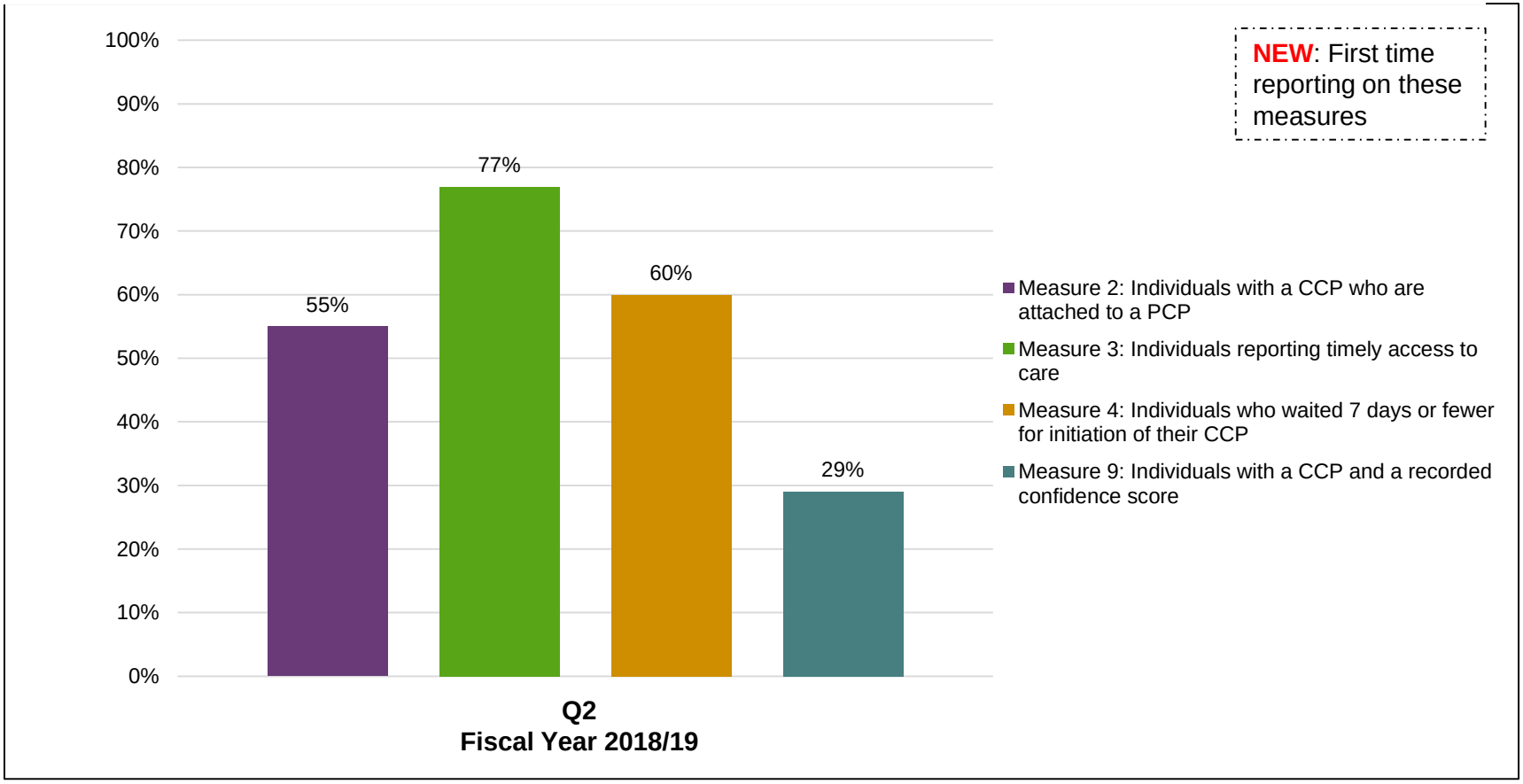


70,060 patients with chronic conditions and/or complex needs have been provided with coordinated care plans through the Health Links approach to care to date, with **3,843** CCPs completed in this quarter. To date, **10.5%** of the target patient population (**668,635** individuals,as estimated by the MOHLTC as recently as 2017) has been reached, a significant growth of **38%** over this past year.

Data Source: Health Quality Ontario's Quality Improvement Reporting and Analysis Platform (QIRAP), as self-reported by LHIN sub-regions.

Impact of the Health Links Approach to Care – Q2 Update

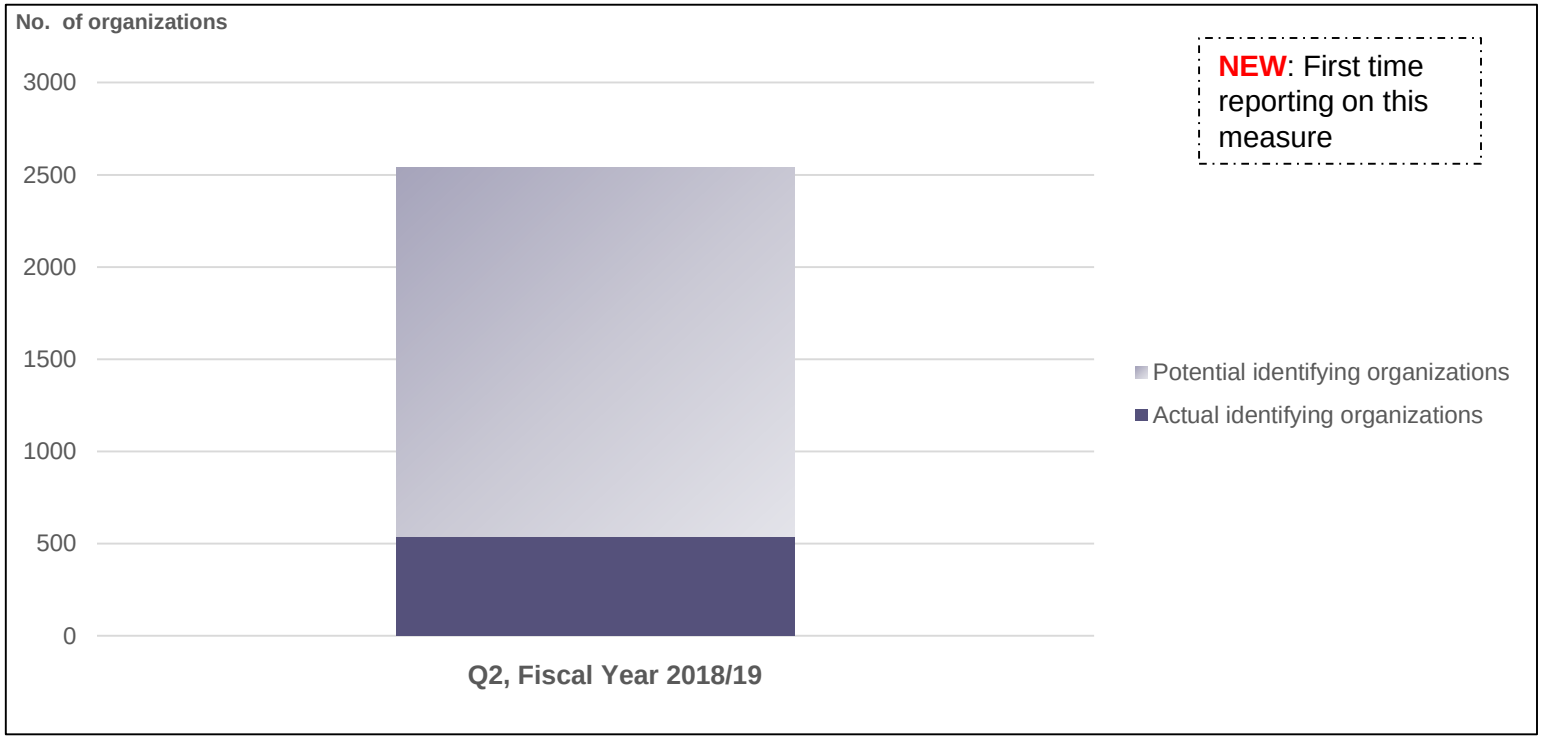
Figure 2: Percentage of individuals attached to a PCP, reporting timely access to care, who waited 7 days or less before initiation of their CCP, and with a patient confidence score, respectively



Data Source: Health Quality Ontario's Quality Improvement Reporting and Analysis Platform (QIRAP), as self-reported by LHIN sub-regions.

Impact of the Health Links Approach to Care – Q2 Update

Figure 3: Proportion of total organizations in the province involved in identifying Health Link patients



There are **2,003** organizations that have the potential to identify individuals who would benefit from the Health Links approach to care. Of these, **538** have identified individuals over the past 6 months. Data for this measure will be collecting in the second and fourth quarter of each fiscal year.

Data Source: Health Quality Ontario's Quality Improvement Reporting and Analysis Platform (QIRAP), as self-reported by LHIN sub-regions.

Sub-Region Transition and Maturity Model Survey Results

- In October 2018, the LHIN Health Link leads were sent a survey asking them to assess both the state of their transition from Health Link to sub-region geographies and the maturity of the Health Links approach to patient care in each geography
- Successful transition will ensure coordination of care aligns with population health planning and needs assessments, resulting in **improved care** for patients with complex needs
- Increased maturity ensures smoother processes, better access to care, increased identification of new patients with complex needs, and care that places **patients' wishes, values, and goals** at the forefront.
- Responses were received from 76 sub-regions
- Different areas of the province are becoming more consistent in how they assess both maturity and transition status

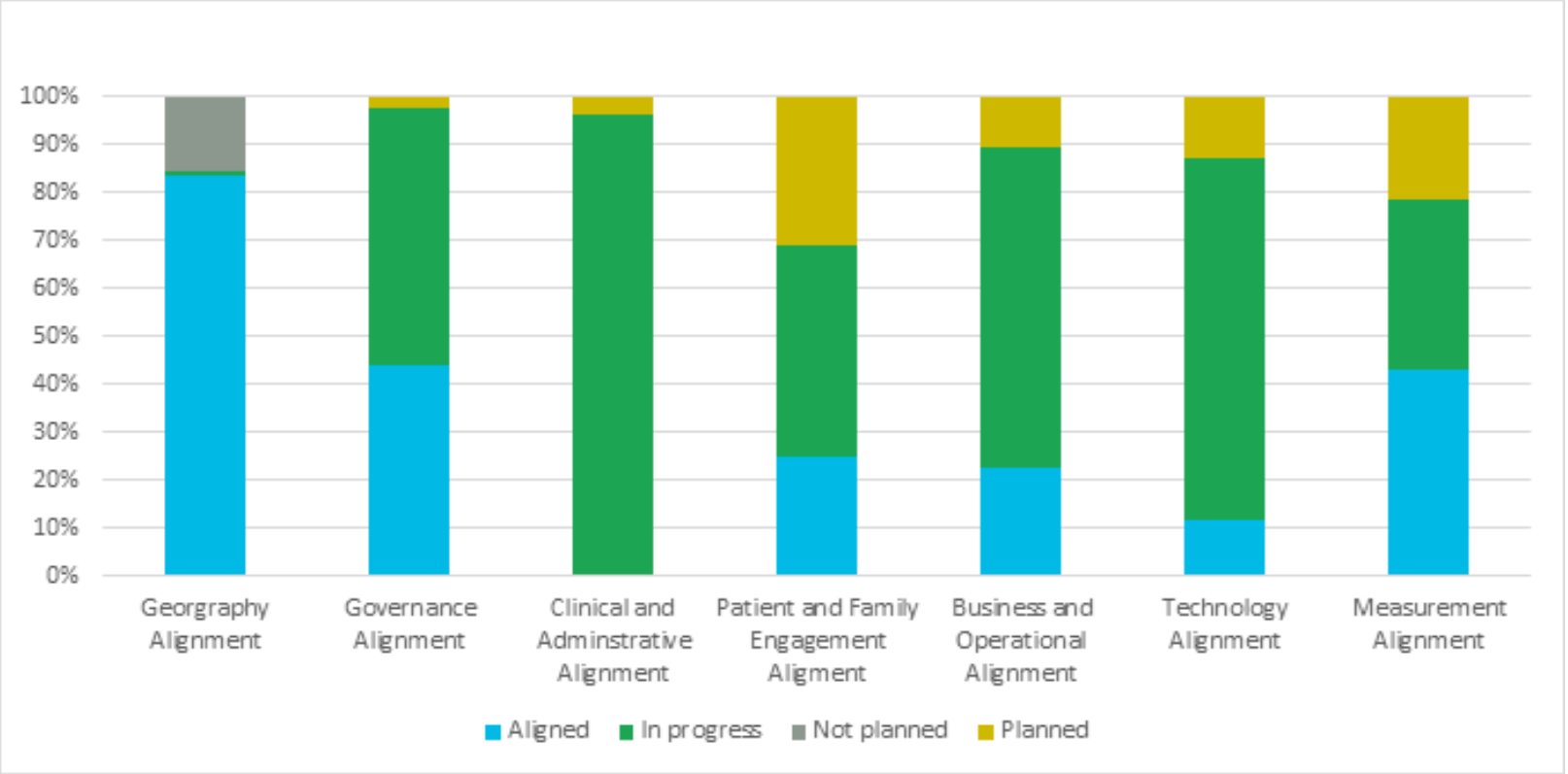
Sub-Region Transition Survey Results

Provincial Highlights

- Each geography was asked to rank themselves as “aligned,” “in progress,” “planned,” or “not planned” along seven domains of transition:
    - *1) Geography; 2) Governance; 3) Clinical and Administrative; 4) Patient and Family Engagement; 5) Business and Operational; 6) Technology; and 7) Measurement*
- Geographical alignment to sub-regions is almost complete
    - *North East LHIN has not yet aligned its Health Link geographies to sub-regions due to the unique challenges of the area*
- The largest growth in alignment has been in the domain of patient and family engagement
    - *Patients and their families are more connected to their care and are at the centre of health care decisions and goals*
- Technology is the least aligned domain due to challenges developing and implementing electronic platforms for CCPs

Sub-Region Transition Survey Results

Figure 4: Provincial sub-region transition status, by domain of transition (n=76)*



**Patients with chronic conditions and complex needs will receive improved coordination of care and services as Health Links move to 100% alignment across all domains of transition to sub-regions. Once aligned, sub-regions will become a key enabler in work to support population health needs.*

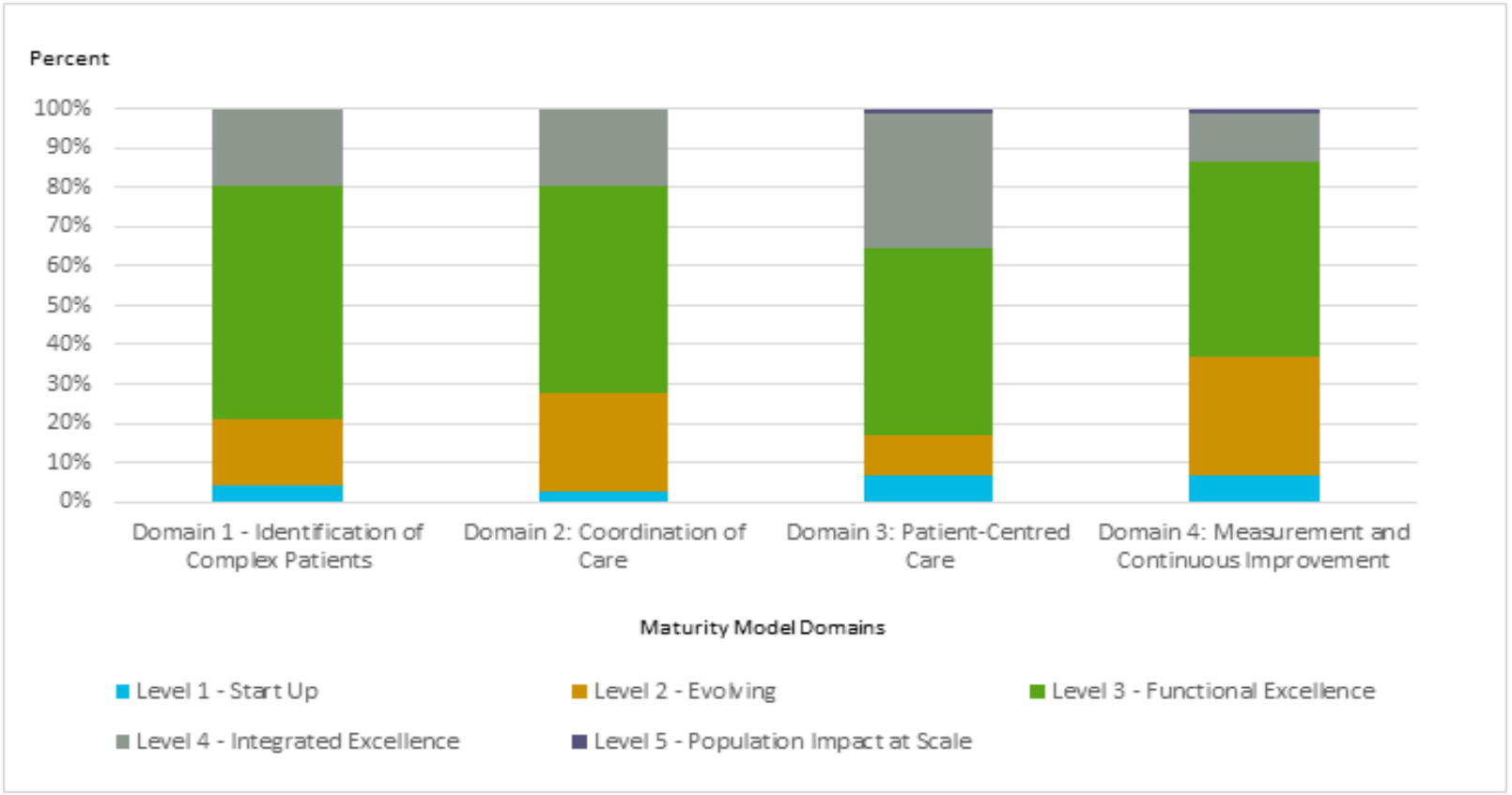
Maturity Model Survey Results

Provincial Highlights

- LHINs reported the maturity of the Health Link geographies in their regions using the parameters defined in the Health Links Maturity Model: a roadmap to achieving population impact at scale
    - *Five levels of maturity (Start Up, Evolving, Functional Excellence, Integrated Excellence, Population Impact at Scale) across four domains: 1) Identification of Complex Patients; 2) Coordination of Care; 3) Patient-Centred Care; 4) Measurement and Continuous Improvement*
- Maturity is assessed bi-annually, in Q2 and Q4 of each fiscal year;
- Since the last assessment, more sub-regions report a level of functional excellence (3) across all four maturity domains
- Patient-centred care shows largest rate of maturation of any domain
    - *Growth: 83% in levels 3–5 (compared with 57% in Q4, 2017/18)*
- Work on the enhanced measures has resulted in fewer sub-regions at a start-up level in the domain of measurement and continuous improvement

Maturity Model Survey Results

Figure 5: Provincial maturity level, by domains (n=76)



Quarterly and Cumulative Data – Q2 Update

LHIN	Target Population for Sub-Regions (complex patients)	Measure 1: New CCP					Measure 2: PCP Attachment			Measure 3: PCP Access		
		Q2	Q2	Q2	Cumulative Total	Cumulative Total	Q2	Q2	Q2	Q2	Q2	Q2
		Fiscal Quarterly Target	Actual	% Actual / Fiscal Target	Actual	% of Target Population (complex patients)	Actual (numerator)	Actual (denominator)	Percentage (%)	Actual (numerator)	Actual (denominator)	Percentage (%)
01. ESC	39,480	330	195	59	959	2	5	6	83	78	97	80
02. SW	45,375	473	186	39	3,211	7	37	39	95	20	31	65
03. WW	28,370		214		4,748	17	118	124	95	35	38	92
04. HNHB	82,815		167		4,013	5	0	0	0	35	46	76
05. CW	41,450		287		8,955	22	427	468	91	36	45	80
06. MH	48,445		160		4,974	10	240	963	25	0	0	No input
07. TC	61,100		661		12,343	20	68	72	94	0	0	No input
08. C	82,085		345		6,158	8	18	18	100	16	23	70
09. CE	81,800		456		9,507	12	0	0	No input	23	32	72
10. SE	27,395	386	324	84	5,718	21	9	22	41	164	206	80
11. Champlain	59,630	729	608	83	3,997	7	343	580	59	0	0	No input
12. NSM	24,080		111		2,692	11	0	14	0	89	101	88
13. NE	34,570		37		1,881	5	17	17	100	2	2	100
14. NW	12,040		92		904	8	7	18	39	22	55	40
Total	668,635	1,918	3,843	200	70,060	10.5	1,289	2,341	823	520	676	842

These data are self-reported and may subject to historical adjustment for increased accuracy as Health Link geographies transition to sub-region boundaries.
**Blank cells denote data that were not required; "no input" indicates that the LHIN region was unable to collect data on the measure; a numerator, denominator, and percentage value of 0 means that the ability to collect the data existed but the result was 0.*

Quarterly and Cumulative Data – Q2 Update

LHIN	Target Population for Sub-Regions (complex patients)	Measure 4: Wait Time			Measure 5: Referring Organization		Measure 9: Confidence Score		
		Q2	Q2	Q2	Q2	Q2	Q2	Q2	Q2
		Actual (numerator)	Actual (denominator)	Percentage (%)	Actual (numerator)	Actual (denominator)	Actual (numerator)	Actual (denominator)	Percentage (%)
01. ESC	39,480	95	195	49	29	166	144	195	74
02. SW	45,375	137	195	70	48	241	31	186	17
03. WW	28,370	127	246	52	40	149	21	102	21
04. HNHB	82,815	39	130	30	8	41	33	119	28
05. CW	41,450	262	316	83	55	304	58	582	10
06. MH	48,445	97	141	69	20	29	0	0	No input
07. TC	61,100	18	55	33	77	129	0	0	No input
08. C	82,085	290	442	66	11	26	1	119	1
09. CE	81,800	942	1,193	79	52	121	32	234	14
10. SE	27,395	158	318	50	39	127	165	315	52
11. Champlain	59,630	162	608	27	70	271	0	0	No input
12. NSM	24,080	50	111	45	49	115	79	111	71
13. NE	34,570	15	36	42	17	222	0	0	No input
14. NW	12,040	21	36	58	23	62	31	60	52
Total	668,635	2,413	4,022	751	538	2,003	595	2,023	29

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Thank you.

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