Health Links:
The Experience in Central East LHIN

Ontario Long-Term Care Association

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Quality Improvement and Health Links in Central East LHIN

- Lead, Quality Improvement and Evaluation
  - Co-Lead, Long-Term Care
- Residents First
  - HQO lead, supported by LHINs
  - Internal to LTC
- Behavioural Supports Ontario
  - LHIN lead, supported by HQO
  - Integrated Care Team
  - Focus, Learn, Spread, Sustain
- Health Links
  - Patient experience, experience-based design
  - PATH

Questions for Consideration

1. How can Long-Term Care become involved in Health Links?

2. How can we leverage the Quality Improvement experience of Long-Term Care to support Health Links?

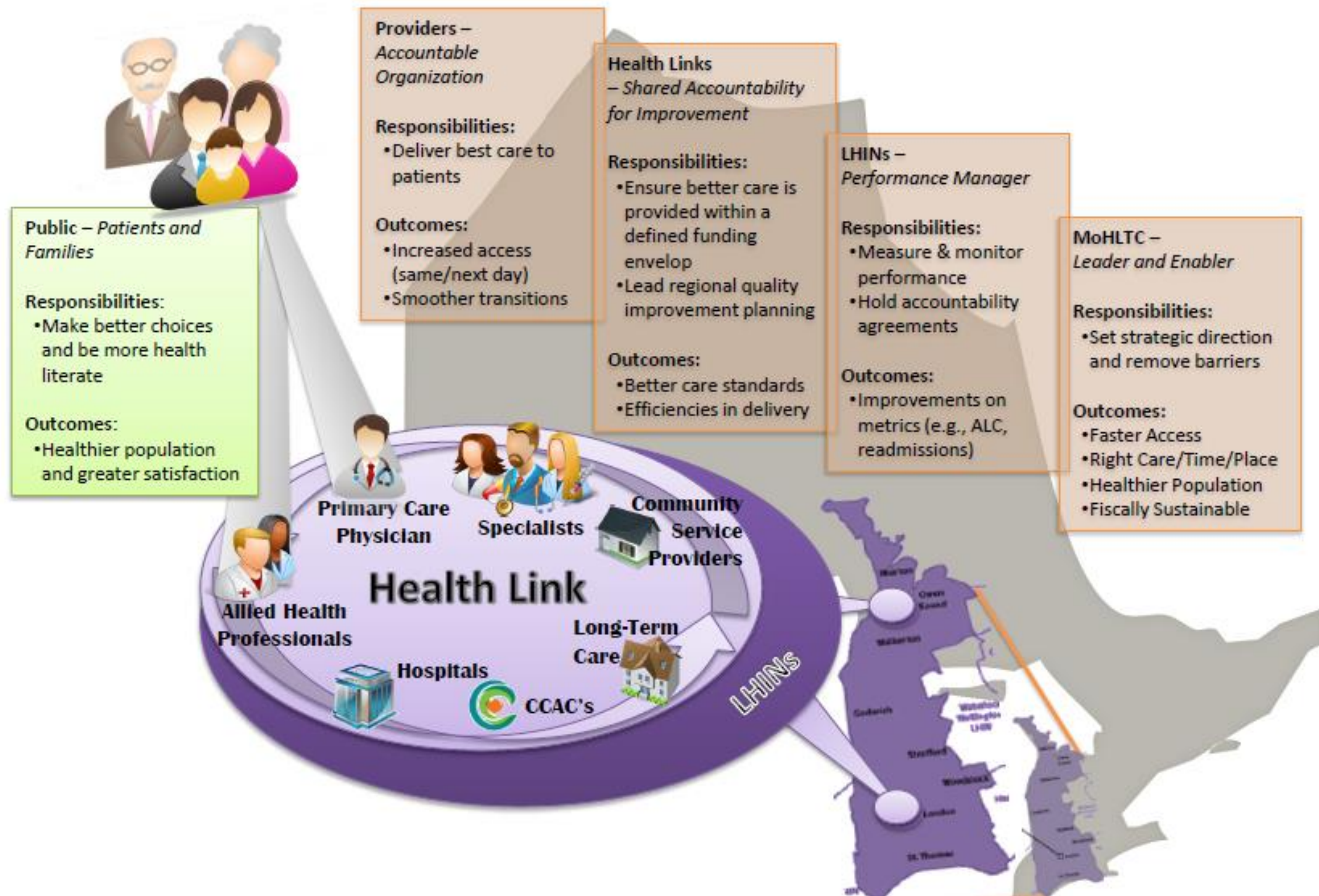
3. What opportunities exist for true patient-centered, integrated planning *and execution* at a local level? Is the system ready?

Health Links (HL)

A new model of planning and delivering care at the **clinical level** where all providers in a community, including primary care, hospital, community care, long-term care are involved. A Health Link will be:

- Patient centered;
- accountable for system-level metrics established by the province;
- focused on the high users initially (total population eventually);
- accountable to the LHINs;
- initially voluntary;
- flexible and based on local need; and
- required to involve primary care.

Health Link Roles and Responsibilities



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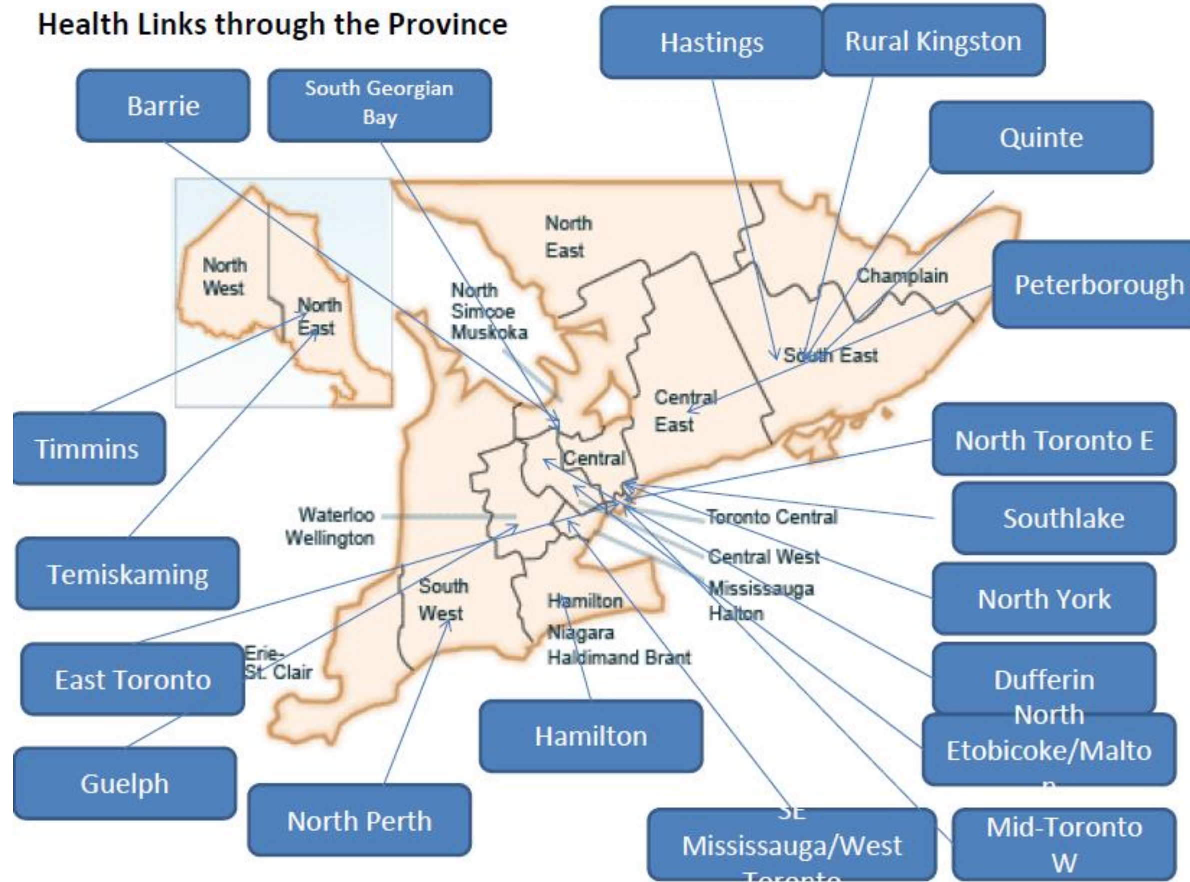
19 Early Adopters



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What Are Health Links

They are:

- Based on geographic population with an immediate focus on high users
- *Inclusive* of all providers involved in the provision of care for high users
- Focused on developing coordinated care plans that encompass the entire health care needs of the person
- Working to better integrate primary care into the full system
- Implementing initiatives that are tailored to their population and developed from the ground up
- Engaging patients, caregivers and families throughout the development and delivery of services

They are not:

- Focused on a specific disease population
- Made up of only those providers involved in an area of the continuum
- Developing care pathways for specific procedures or conditions
- Focused on integrating primary care into "itself"
- Implementing province wide initiatives mandated from the top down
- Provider dominated solutions forced in patient and families

Health Links Metrics

- Health Links will be expected to achieve outcomes that are cascaded from patient experience, provider performance, and system performance
- These metrics will need to be negotiated and aligned with the LHIN targets.

Operational Metrics (Setting the Stage for Co-ordinated Care Straightaway)

1. Ensure the development of co-ordinated care plans for all complex patients
2. Increase the number of complex patients and seniors with regular and timely access to a primary care provider

Results-Based Metrics (Moving the Needle)

1. Reduce the time from primary care referral to specialist consultation
2. Reduce the number of 30-day re-admissions to hospital
3. Reduce the number of avoidable ED visits for patients with conditions best managed elsewhere
4. Reduce time from referral to home care visit
5. Reduce unnecessary admissions to hospitals
6. Ensure primary care follow-up within seven days of discharge from an acute care setting

Evaluation-Based Metrics (How You'll Know You've Arrived)

1. Enhance the health system experience for patients with the greatest health care needs
2. Achieve an ALC rate of nine per cent or less
3. Reduce the average cost of delivering health services to patients without compromising the quality of care

Health Link Business Plan Requirements

- Each Health Link will be preparing a Business Plan for submission to the LHIN and Ministry for approval. The Business Plan will outline:
  - Health Link Profile;
  - Health Link Commitments (Metrics/Objectives);
  - Patient Engagement Plan;
  - Resource Plan;
  - Governance and Administration;
  - Confirmation of Commitment;

- Funding
  - up to $75k for preparation of the Business Plan
  - Up to $ 1M in one-time funding per HL

HEALTH LINKS IN THE CONTEXT OF SYSTEM CHANGE

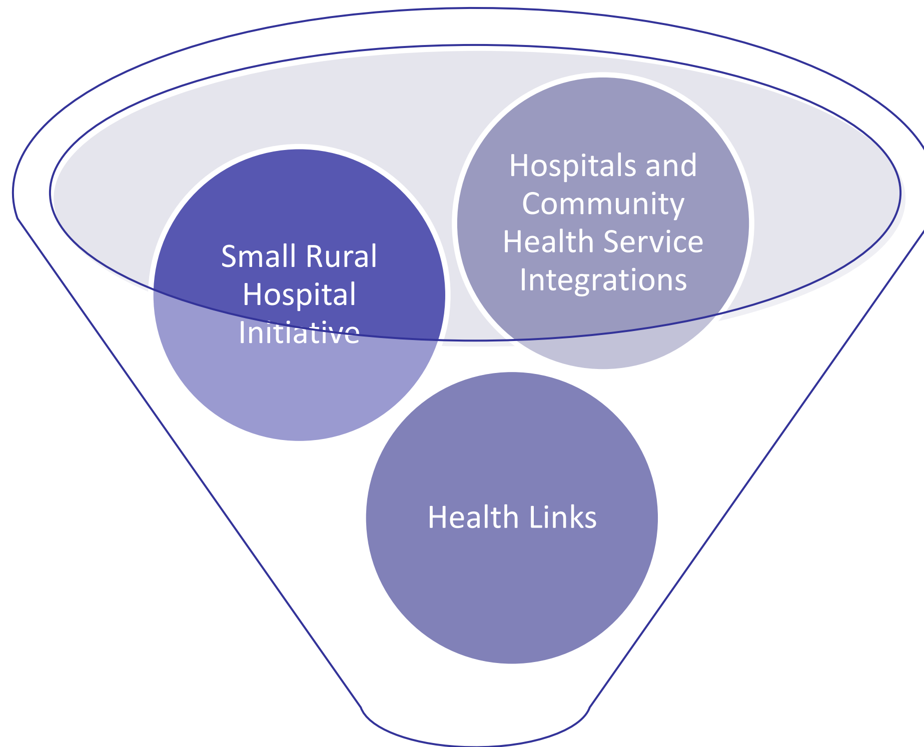
– INTEGRATION
– QI IN LTC

Health Links

- Health Links is a provincial initiative supported locally by Local Health Integration Networks.

- Health Links is one of three Integration Strategies currently active in the Central East LHIN:
  - Health Links
  - Hospitals and Community Health Services Integrations
  - Small Rural Northern Hospital Transformation Fund

- The strategic objectives and tactics of all three strategies are complimentary – and support the Central East LHIN IHSP Strategic Aim of *Community First.*



Coherent, Coordinated, Sustained Integration Strategy

Standardize the System. Customize the Client Experience.

Service provider integration and standardization supports solutions that better respond to the unique needs of clients.

"Customizer Intimacy"

- "The Cleveland Clinic cleverly uses standards to deliver operational consistency, reliability, and low cost. Yet at the same time they use these standards as a springboard for creating unique solutions for each customer based on a deep understanding of their needs. The result is a powerful combination that fulfills two customer value propositions at the same time."

(Brad Power, *Harvard Business Review*, On-Line, April 30, 2013)

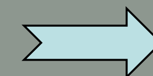
Factors Determining Health Links

- **Referral Patters between primary health care to specialist care (ICES Data)**
- **Administrative Simplicity:** Keep the fewest possible Health Links so to enable collaboration/integration/performance management.
- **Physician Engagement**: Right size to secure physician relevance/engagement
- **Standardization and Critical Mass:** Continue to drive standardization and efficiency agenda without creating unmanageable geographic and complex networks.
- **Enable Structural Integration:** Think forward to potential future integrations that will drive more value to the health care consumer.

Quality Improvement in LTC – BSO Client Successes

Based on success stories gathered throughout the year several re-occurring positive outcomes were identified:

- Decrease of behavioural incidents in clients with responsive behaviours
- Increased client cooperation with activities of daily care
- Improvements in quality of life determinants for both residents and caregivers
- Decrease in use of physical and pharmacological restraints to control behaviours
- Decrease in admissions of people with difficult behaviours from tertiary care settings and behavioural support units
- Decreases in the number of staff required to manage residents care and activities
- Increased and more effective utilization of Integrated Care Team (Psychogeriatric Resource Consultants, NPSTAT, Geriatric Mental Health Outreach Teams)

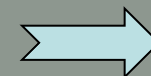


Learn

BSO in Central East – Quality Improvement What was Learned

During the year the value of the quality improvement-anchored BSO initiative was confirmed in a several ways:

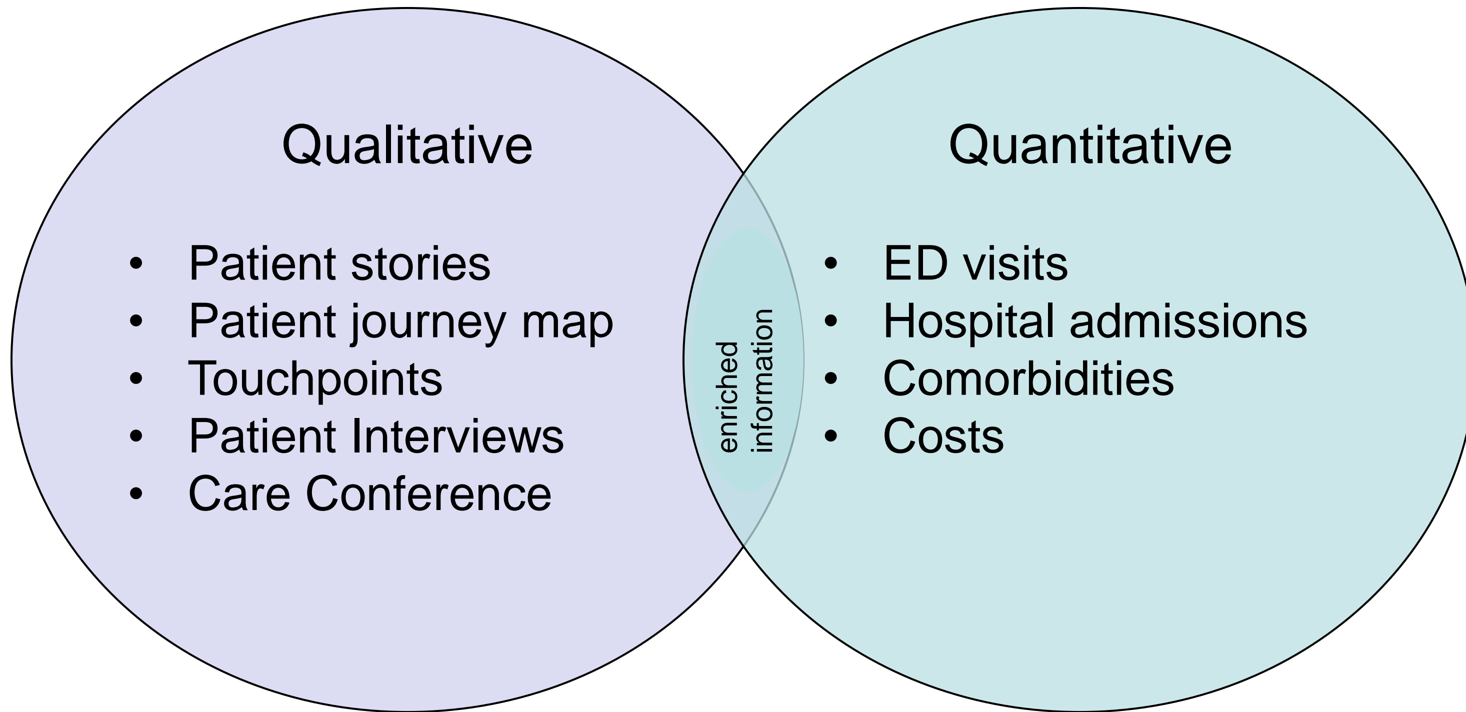
- Common tools, common training equals common language for collaborative problem solving
- Standard process and tools increase communication & collaboration
- Defined Value Stream Process provide context for utilizing new knowledge
- Visual process maps enable easy learning of new processes
- Staff interventions are initiated before behaviours escalate



PETERBOROUGH HEALTH LINK - UPDATE

Peterborough Health Link (PHL) - Priority Patient Cohort

- A Blended Approach



Peterborough Health Link (PHL) - Priority Patient Cohort

- Invitation to submit patient stories (70 stories in total)
  - Seniors
  - People with complex medical conditions
  - People representing the “1%” of patients readmitted to emergency rooms or hospital in the Peterborough region
- Facilitated half-day session based on Institute for Healthcare Improvement (IHI) processes and considering the following:
  - ability to impact substantial portion of population
  - potential to reduce health care costs
  - high likelihood of improved care
  - involvement of a wide spectrum of providers
- Team identified two priority high user cohorts

PHL Targeted Cohorts – a subset of High User population = Focus

- **Cohort 1**
  - Seniors with exacerbated congestive heart failure and at least one other co morbidity with the possibility of other complicating factors (such as inadequate housing or transportation, isolation, palliation, responsive behaviours, financial issues, caregiver support).

- **Cohort 2**
  - Patients with serious mental health and/or addictions and at least one other co morbidity with the possibility of other complicating factors (factors like inadequate housing or transportation, isolation, palliation, responsive behaviours, financial issues, caregiver support).

Cohort #1 CHF Patients

Source: DAD

- **Criteria**:
  - Based on diagnosis codes from CMG 195 Heart Failure with Coronary Angiogram & 196 Heart Failure without Coronary Angiogram
  - Most Responsible diagnosis and/or type 1 (pre-admit comorbidity), type 2 (post-admit comorbidity) or type 3 (secondary diagnosis) of
    - Congestive heart failure, Left ventricular failure, Heart failure, unspecified, Pulmonary embolism 65 years or older
  - Excludes newborn cardiac arrest

- **Results** (FY 2011/12):
  - 473 Discharges (Inpatient episodes of care)
  - 379 Unique Patients
    - Considerations: Change definition to align with QBP

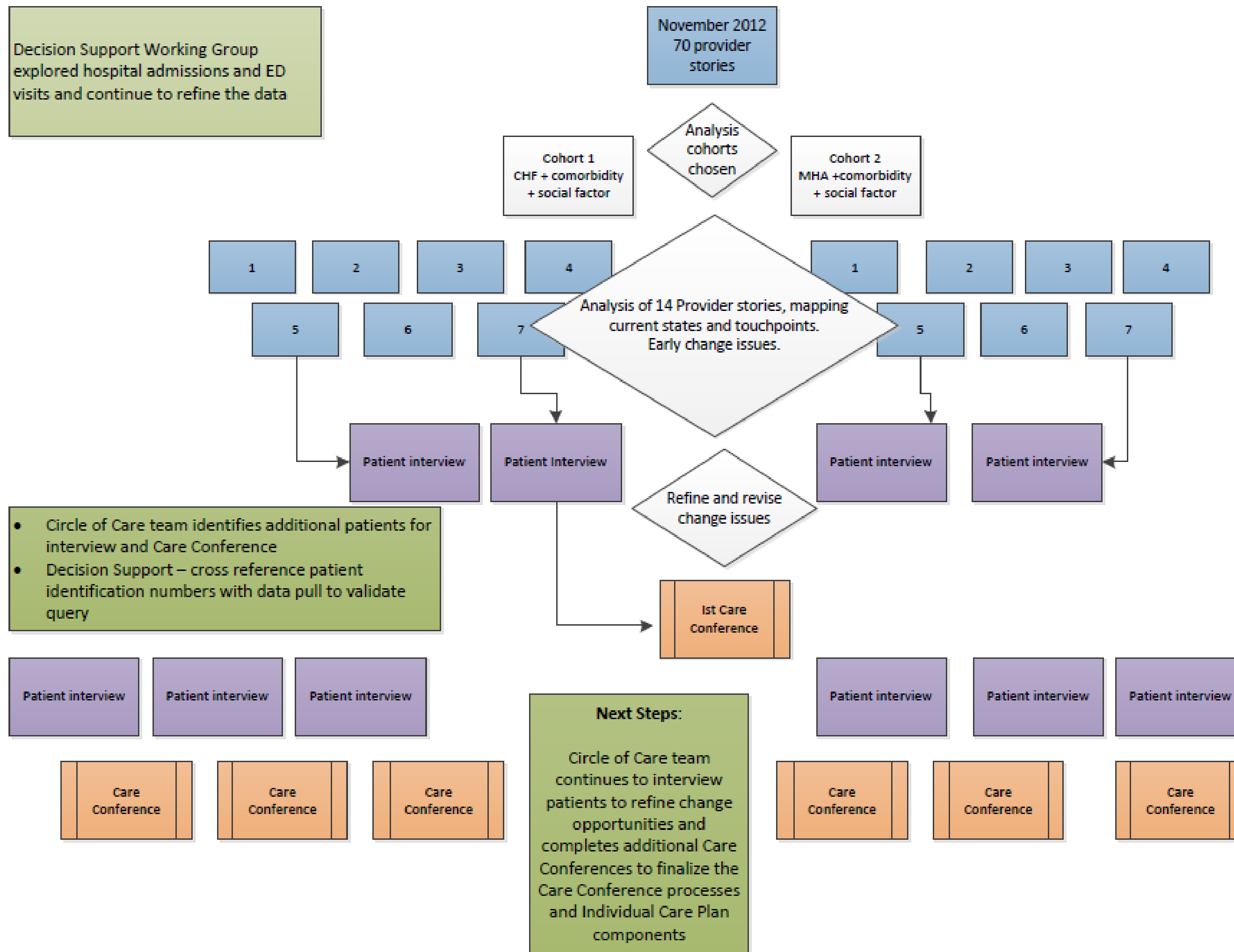
Cohort #2 MH and SA Patients

Source: NACRS

- **Criteria**
  - Based on ED visits with diagnosis codes of Mental and behavioural disorders
  - 18 years or older
  - Diagnosis of any of the following as most responsible diagnosis or other diagnosis of F06-F99
  - Excludes F00-F05 Dementia in Alzheimer's disease, dementia, Organic amnesic syndrome, Delirium.

- **Results** (FY 2011/12):
  - 3223 ED Visits, 2201 Unique Patients
    - Considerations: Exclude F06-F09 to be consistent with MH and SA H-SAA indicators

Patient-Focused Planning and Care



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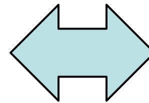
Relationship between Two Streams of Activity – Individual Care Plans and System Change

Individualized Integrated Care Plans

- Inter-professional/agency care conferences
- Pre-work
- Shared information
- Standard forms
- Communication protocols
- Shared responsibility for managed care
- Patient input



System Change Opportunities

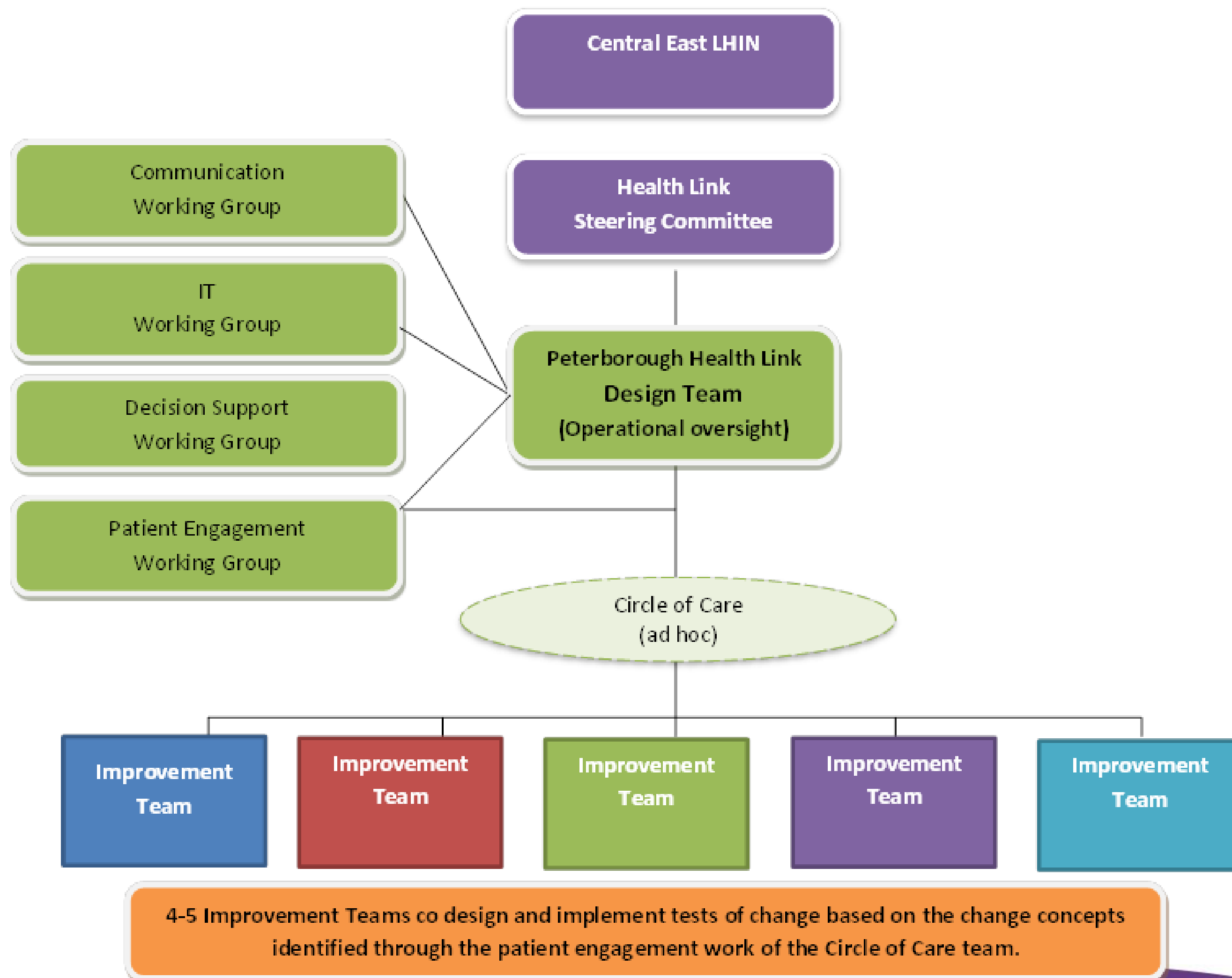
- Patient stories from the provider perspective
- Ongoing initiatives focused on system change
- Local intelligence
- Patient interviews

Peterborough: A Broad Coalition

LHIN Funded Health Service Providers
Alzheimer Society
Canadian Mental Health Association
Central East CCAC
Community Care Peterborough
Fairhaven LTCH
FourCast Addictions Services
Hospice Peterborough
Kawartha Participation Projects
St. John's Retirement Home Inc.
St. Joseph's at Fleming LTCH
Peterborough Regional Health Centre
Victorian Order of Nurses for Canada, Ontario – Peterborough

LHIN Non Funded Health Link Partners
City of Peterborough - Social Services
Community Living Peterborough
Peterborough EMS
Peterborough Networked Family Health Team
Peterborough Public Health Unit
VON NP Led Family Health Team
More to be added as client cohorts identified.

PHL Organizational Structure



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PHL Improvement Teams

1. Circle of Care – individualized care plans and processes
2. Transitions to and From Hospital – home care, primary care, long-term care, specialist referral
3. MHA Care in the ED – improved care and linkages internal and external to hospital
4. Congestive Heart Failure Care Pathway in and out of hospital – broadening the perspective of CHF Quality Based Procedures (QBPs) improvement plans
5. Chronic Disease Management – identifying best practices and clarifying the roles of patients and providers (including self-care) in the management of disease

Progress to Date

- November 2012 – Health Links initiated; Readiness Assessments prepared
- November 2012 - Early Adopter Health Links selected
- January 25th - Early Adopter Planning Day
- February 22nd - HL Business Plans submitted to MOHLTC
- March/April - MOHLTC feedback to HL and HL resubmission to Ministry
- April – Planning days held to discuss eHealth and Health Links
- April – announced funding to be split into "operational" and "initiative" (e.g. IT) envelopes
- May – additional HLs approved
- June – funding announcements pending
- June 17th – Ministry Health Links Day

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