Health Links: Excerpts from the 2018/19 Q1 Report

SEPTEMBER 2018

Health Quality Ontario

Let's make our health system healthier

Health Links:

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

The Health Links Quarterly Report

- Provides a summary of data reported by Health Links in each quarter
    - *Two quality indicators are currently measured: number of patients with a coordinated care plan (CCP) and number of patients connected to a primary care provider (PCP)*
- 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

Impact of the Health Links Approach to Care – Q1 Update

Figure 1: Cumulative Total Number of Coordinated Care Plans Completed

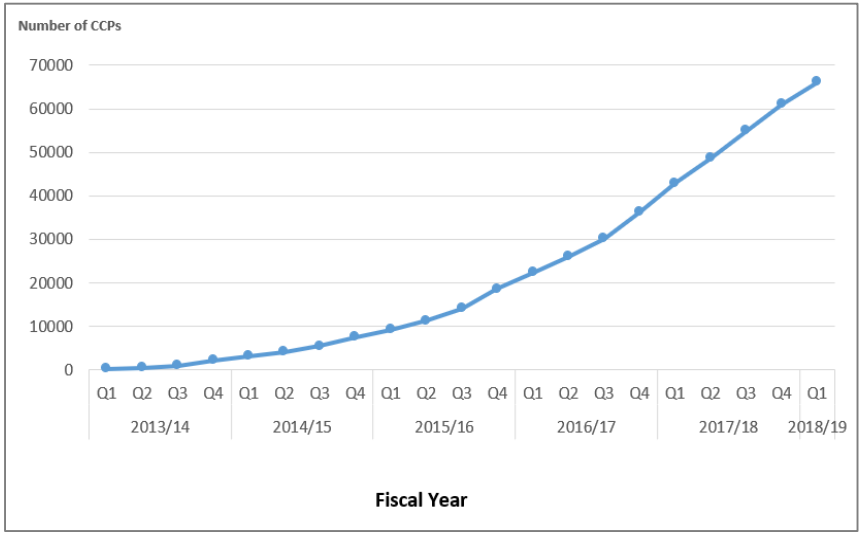
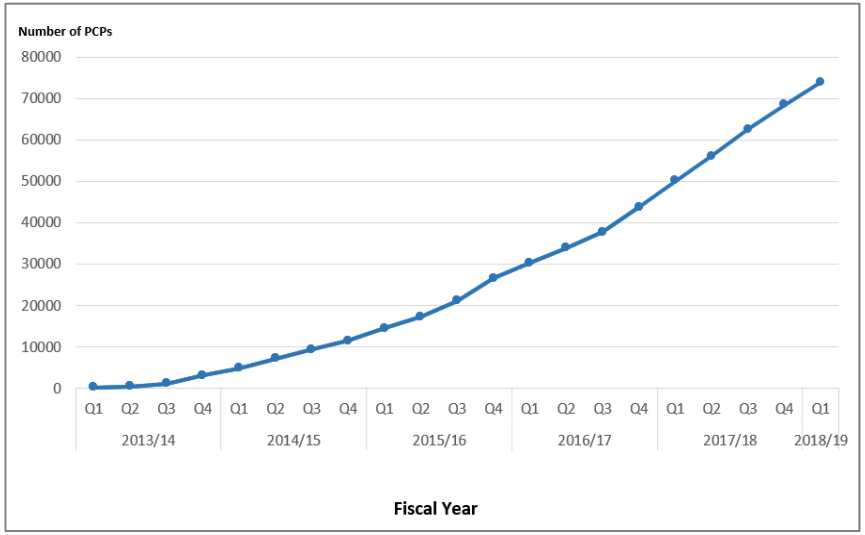


Figure 2: Cumulative Total Number of Patients with Access to Primary Care Providers



66,223 patients with chronic conditions and/or complex needs have been provided with coordinated care plans through the Health Links approach to care to date.

73,594 patients with chronic and/or complex needs have been connected to regular and timely access to primary care to date.

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

Highlights from this Quarter

Performance Measures: Ongoing Spread and Scale

- This quarter, LHINs transitioned from reporting by Health Link to reporting by sub-region; **74** sub-regions (of 76) reported data on the two indicators currently measured by Health Quality Ontario

- **5,113** CCPs were created for patients this quarter, compared with 6,174 created in Q4 of 2017/18

- **5,085** patients were connected to PCP this quarter compared with 5,853 patients in Q4 of 2017/18

- Changes in numbers reported compared with the previous quarter might be a result of the following:

    - New reporting geographies: realignment to sub-regions may have resulted in merging or splitting data as well as data audit and reconciliation

    - Some LHINs only reported CCPs that were developed using the refreshed template (CCP v. 2)

Quarterly and Cumulative Data – Q1 Update

LHIN	No. of Sub-Regions		Target Population for Sub-Regions (Data Source: MOHLTC Health Analytics Branch, 2016)*		Quarterly Targets Identified by LHINs	No. of Patients with a Completed Coordinated Care Plan			No. Patients with Regular and Timely Access to a Primary Care Provider		
	No. Actively Recruiting Patients	Total No.of Sub-Regions Planned	Total No. of Patients	No. Target Population (4+ conditions)		No. Sub-Regions Reporting	Q1 Actual	Cumulative Total Actual	No. Sub-Regions Reporting	Q1 Actual	Cumulative Total Actual
ESC	6	6	546,005	39,480	N/A	6	143	797	6	184	562
SW	5	5	780,480	45,375	378	5	491	3025	5	476	2,698
WW	4	4	619,075	28,370	N/A	4	168	4,534	4	163	4,746
HNHB	6	6	1,206,900	82,815	N/A	6	159	3828	6	149	4,462
CW	5	5	810,510	41,450	N/A	5	393	8,668	5	393	9,641
MH	7	7	1,028,450	48,445	N/A	7	545	4814	7	539	5873
TC	5	5	1,016,705	61,100	N/A	5	619	11,682	5	618	16,838
C	6	6	1,583,765	82,085	N/A	6	668	5,813	6	736	6,080
CE	7	7	1,349,270	81,800	N/A	7	742	9,051	7	727	9,559
SE	5	5	410,680	27,395	386	5	396	5,394	5	373	5,220
Champlain	5	5	1,090,570	59,630	513	5	485	3389	5	457	2832
NSM	5	5	387,815	24,080	N/A	5	182	2572	5	155	2610
NE	4	5	474,615	34,570	N/A	4	54	1844	4	48	1665
NW	4	5	191,810	12,040	N/A	4	68	812	4	67	808
Total	74	76	11,496,650	668,635	1,277	74	5,113	66,223	74	5,085	73,594

CCP—coordinated care plan, C—Central, CE—Central East, CW—Central West, ESC—Erie St. Clair, HL—Health Link, HLGs—Health Link geographies, HNHB—Hamilton Niagara Haldimand Brant, LHIN—Local Health Integration Network, MH—Mississauga Halton, MOHLTC—Ministry of Health and Long-Term Care, NE—North East, NSM—North Simcoe Muskoka, NW—North West, SE—South East, SW—South West, TC—Toronto Central, WW—Waterloo Wellington.

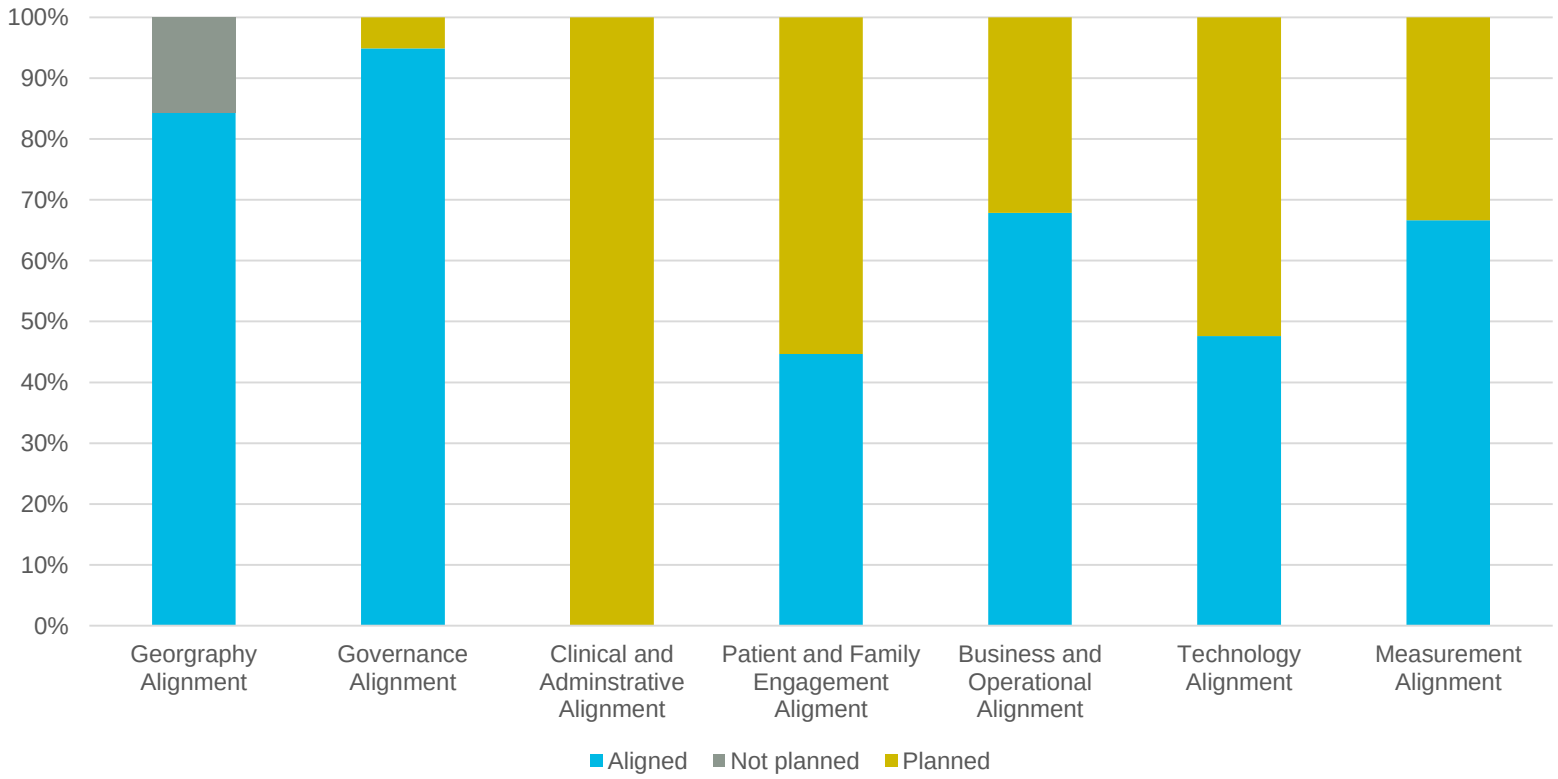
**These data are self-reported and may subject to historical adjustment for increased accuracy as Health Link geographies transition to sub-region boundaries.*

Health Link–Sub-Region Transition Survey

- In April–May 2018, the LHIN Health Link leads were sent a survey asking them to provide an assessment of their current state of alignment with the 76 sub-regions.
    - *Successful transition will ensure coordination of care aligns with population health planning and needs assessments, resulting in **improved care** for complex patients*
- Responses were received from **88 geographies**: some reflect new sub-region geographies while others reflect former Health Link geographies
- 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*
- Data are self-reported; as a result:
    - *There was anticipated variation in how each geography defined their state of alignment*
    - *There was significant variation in when transition is expected to be completed—from June 2018 to March 2020—across all domains*

Health Link–Sub-Region Transition Survey

Figure 3: Provincial sub-region transition status, by domain of transition (n=88)*



**As Health Links move to 100% alignment across all domains of transition to sub-regions, they will become a key enabler in work to support population health needs; as a result, complex patients will receive improved coordination of care and services.*

Health Link–Sub-Region Transition Survey

Provincial-Level Data Interpretation

- Nearly all sub-regions are geographically aligned. Areas listed as “not planned” are a result of geographic considerations and those listed as “planned” will be completed by the end of Q1 2018/19.
- In other domains of transition, the majority of sub-regions are “in progress” toward alignment, with dates for expected completion ranging from summer 2018 to March 2020.
- Patient and family engagement alignment is largely in the planning stages across most geographies, with many reporting that this work requires careful preparation.
- Many risks, and risk mitigation strategies, were identified:
    - *Risks: Lack of technology enablers, competing priorities, change fatigue, difficulty spreading and scaling to non-HIC organizations, inconsistent data sharing agreements*
    - *Mitigation strategies: Developing champions in each region, engaging local and provincial partners, standardizing use of OHIP billing codes for coordinated care work, involving staff and unions early on*

Patient Story: Lucy

Thank you to the Central LHIN for sharing this story.

Background

Lucy* is a 52-year woman who lives in supportive housing (LOFT Bradford House in Simcoe County). Lucy has suffered many personal tragedies in her past, and has been in and out of hospital care for most of her adult life. She has had approximately 237 inpatient hospitalizations, primarily for mental health conditions; the longest hospitalization lasted for 1 year.

Lucy has diagnoses of bi-polar disorder, schizoid-affective disorder, post-traumatic stress syndrome, dependent personality disorder, and Stockholm syndrome. She has had several instances of suicidal ideation. She has two children with whom she had lost contact due to her health issues.

She also has a variety of physical health issues, such as GERD, type 2 diabetes, hypertension, hyperthyroidism, high cholesterol, sleep issues, a history of cellulitis, skin fungus, obesity, and mobility issues (she now uses a walker).

_____

**Not her real name.*

Patient Story (continued)

Health Links Support

Lucy was identified as someone who would benefit from the Health Links approach to care during her last hospitalization at Mackenzie Health in 2016. Although she had a history of physical and mental health conditions, as well as behaviour challenges, housing was the biggest issue she faced. As a Health Links client, she was connected to a number of programs and services: Assertive Community Treatment (ACT) teams, home and community care, and LOFT behavioural support services.

With the help of the hospital's mental health outpatient clinic, the care team worked in partnership with Lucy and her substitute decision-maker. Lucy successfully transitioned to LOFT Stouffville's reintegration program, then eventually to Bradford House in Simcoe County.

With a support plan in place to manage her behavioural challenges and after a medication review, and with the guidance of her care team led by LOFT, she has successfully been able to maintain her own housing since August 2017. This has been a life-changing experience.

The team also developed a coordinated care plan with Lucy and her substitute decision-maker. Through case conferences, ongoing communication and collaboration, intensive care coordination, and cooperation from all members of the interprofessional care team, Lucy's goals were set and met.

Patient Story (continued)

Today

All partners involved in Lucy's care have worked with her to enhance her quality of life and help her live as an active member of her new community.

Today, Lucy enjoys being around people, playing cards, arts and crafts, eating, and listening to rock music. She attends many social activities, in and outside of her home. During the recent holiday season, she attended special events and tours. She continues to enjoy the company of her new friends at Bradford house, enjoys travelling to the city of Toronto to shop, see movies, and visit restaurants, and has re-established a relationship with her children.

Thank you.

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