Health Links: Excerpts from the 2017/18 Q4 Report

JUNE 2018

HealthLinks

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 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 practices across the province and progress 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

Highlights from this Quarter

Health Links Maturity

- A maturity assessment of the Health Links approach to care was recently undertaken across the LHINS
- Beginning in this quarter, maturity data will be included in this report
- LHINs will self-report on the maturity of the Health Link geographies in their regions using the parameters defined in the Health Links Maturity Model
- The Health Links Maturity Model is a a roadmap to achieving population impact at scale
- Maturity will be assessed bi-annually, in Q2 and Q4 of each fiscal year, with the goal of tracking the maturity journey over time

Highlights from this Quarter

Performance Measures: Ongoing Spread and Scale

- This quarter, **88** Health Link geographies shared data on the two indicators currently measured by Health Quality Ontario
- **5,975** CCPs were created for patients this quarter, a decrease of 154 (2.6%) from Q3 and a slight year-over-year decrease (1%) from the 6,035 CCPs created in Q4 of 2016/17
- Although growth of CCP development has levelled off this quarter, more CCPs were created this fiscal year than any other to date
- **5,830** patients were connected to PCP this quarter, a 9% decrease from 6,386 patients in Q3 and a 3% year-over-year decrease from the 6,023 patients connected to a PCP in Q4 of 2016/17

Highlights from this Quarter

New Health Link Measures: Implementation

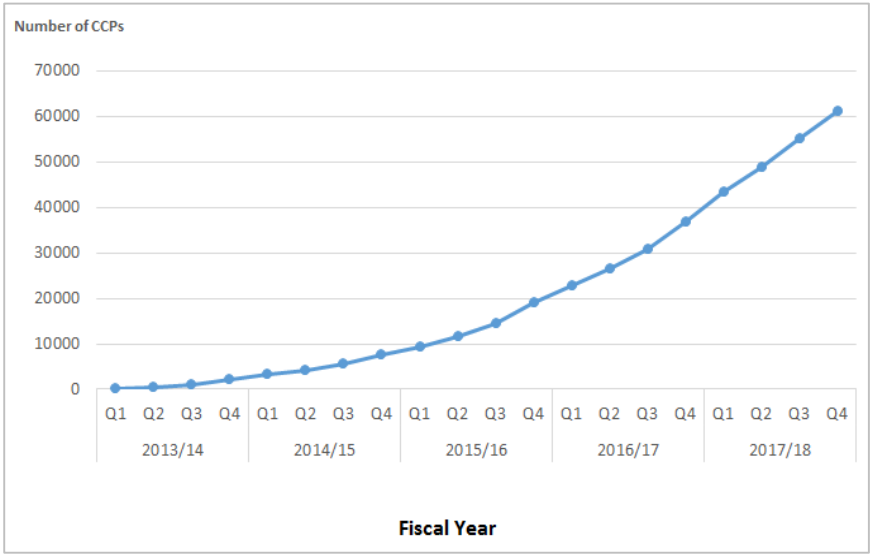
- A Health Link Measures Implementation Task Group has been created to refine technical specifications of the **new indicators** and work toward a consistent approach to provincial data collection
    - *Task group consists of representation from the LHINs, CHRIS and SHIIP electronic solutions, and Health Quality Ontario*
- Data collection for these new measures is slated to begin in Q2 of 2018/19
    - *In time, CHRIS and SHIIP electronic solutions will be used to facilitate streamlined data collection in most LHINs*
    - *Manual data collection methods will be employed in the short term as this new technology is updated (to support these new measures) and rolled out across the province*

Indicator Data at a Glance – Q4 Update

Fiscal Year, Quarter	Number of Health Link Geographies Actively Recruiting Patients	Number of Patients with a Completed Coordinated Care Plan	Number of Patients Connected to a Primary Care Provider
2017/18, Q1	79	6,518	6,443
2017/18, Q2	86	5,650	5,961
2017/18, Q3	86	6,129	6,386
2017/18, Q4	88	5,975	5,830
Cumulative Total to Date	**88**	**60,964**	**69,067**

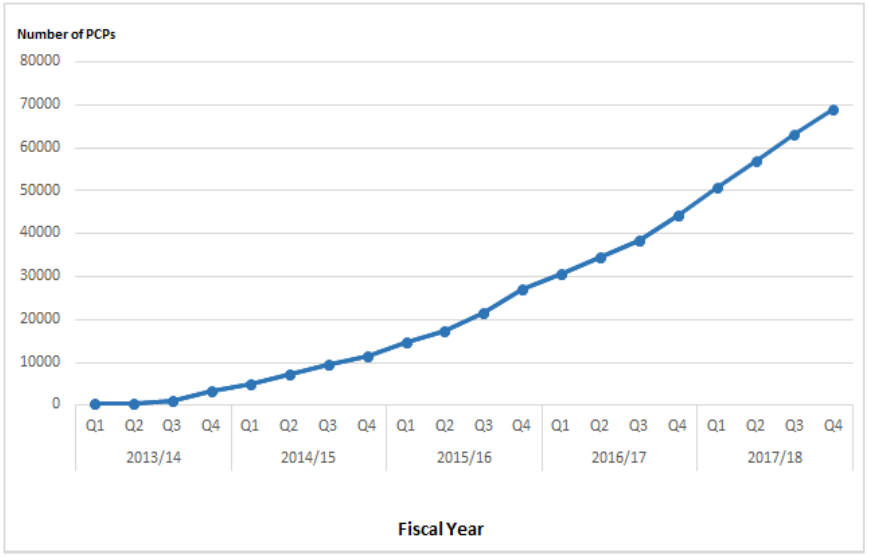
Impact of the Health Links Approach to Care – Q4 Update

Figure 1: Cumulative Total Number of Coordinated Care Plans Completed



60,964 patients with chronic conditions and/or complex needs have been provided with coordinated care plans through the Health Links approach to care to date.

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



69,067 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) – self-reported by Health Links.

Quarterly and Cumulative Data – Q4 Update

RLISS	Nombre de zones géographiques des maillons santé		Population cible des maillons santé (Source des données : Direction de l'analytique en matière de santé du MSSLD, 2016)*		Objectifs trimestriels selon les les RLISS	Nb. de patients avec un plan de soins coordonnés développé			Nb. de patients avec un accès périodique et rapide à un fournisseur de soins primaires		
	Nombre de ZGMS qui recrutent activement des patients	Nombre total de MS prévus	Nombre total de patients	Taille estimée de la population cible (4 affections et plus) en 2016		Nombre de ZGMS présentant des rapports	T4	Total cumulatif depuis le T1 de 2013/14	Nombre de ZGMS présentant des rapports	T4	Total cumulatif depuis le T1 de 2013/14
							Résultat réel	Résultat réel		Résultat réel	Résultat réel
ESC	5	5	92,847	6,160	67	5	123	654	5	123	564
SO	5	5	233,562	10,205	556	5	232	2475	5	218	2164
WW	4	4	53,219	2,185	0	4	188	4366	4	190	4583
HNHB	6	6	124,623	6,500	469	6	232	3669	6	219	4368
CO	5	5	1,565,436	79,485	0	5	583	8275	5	583	9248
MH	7	7	1,340,417	78,395	842	7	757	4269	7	741	5334
CT	5	5	413,366	26,895	750	5	728	11063	5	723	16220
C	5	5	1,565,436	79,485	510	5	546	5145	5	543	5344
CE	7	7	19,882	1,375	379	7	1145	8309	7	1136	8832
SE	7	7	178,516	8,325	453	7	300	4984	7	287	4837
Champlain	10	10	9,127	630	999	10	672	2831	10	628	2759
SNM	5	5	50,679	3,270	190	5	219	2390	5	208	2455
NE	13	14	11,346	585	0	13	77	1790	13	64	1618
NO	4	5	0	0	163	4	173	744	4	167	741
Total	88	90	5,658,456	303,495	5,378	88	5,975	60,964	86	5,830	69,067

**SW, ESC, NE, and CE LHINs have changed their target populations to the sub-region numbers released by MOHLTC in October 2017 while others have kept the numbers from May 2016. One Health Link in the NE LHIN does not yet have a target population. It should be noted that the "target population" listed, based on patients with four or more chronic conditions, refers to the number of patients that may benefit from a Health Links approach to care and is generally accepted to be approximately 5% of the population in each LHIN. LHINs set and enter quarterly targets in QI RAP so that they can be reported here as a reference point.*

These data are self-reported and are therefore subject to historical adjustment.

Health Links Maturity Model Survey

- In April–May 2018, the LHIN Health Link leads were sent a survey asking them to provide an assessment of the current state of maturity of the Health Links approach to care in their regions

- **Achieving maturity in the Health Links approach to care represents a commitment to patients to provide high quality, patient-centred care across the province**

- LHINs assessed their maturity based on a model that comprises four key domains: 1) Identification of Complex Patients; 2) Coordination of Care; 3) Patient-Centred Care; and 4) Measurement and Continuous Performance

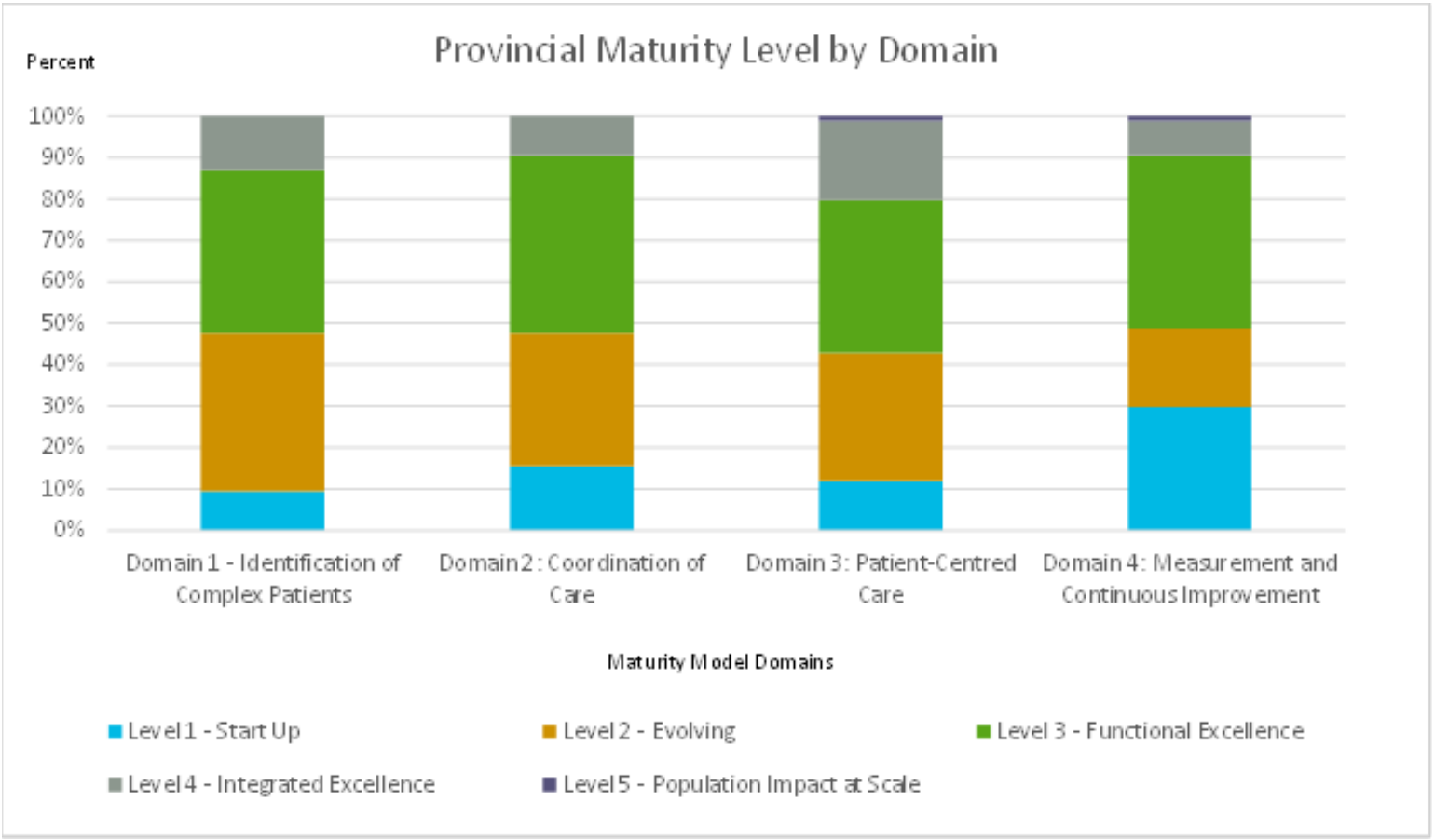
    - *There are five levels of maturity within each domain: 1) Start Up; 2) Evolving; 3) Functional Excellence; 4) Integrated Excellence; and 5) Population Impact at Scale*

- Self-reported data were provided for 84 Health Link geographies.

- This assessment will be conducted biannually, and will be reported in Q2 and Q4

Health Links Maturity Model Survey

Figure 3: Maturity Levels of the Health Links Approach to Care, by Domain, Across the Province, in Fiscal Year 2017/18, Q4



Health Links Maturity Model Survey

Provincial-Level Data Interpretation

- To date, more than 65% of all Health Link geographies are within the first three levels of maturity across all domains
    - *The most reported maturity level for each domain is Maturity Level 3, Functional Excellence*
- Domain 4 has one Health Link geography reporting at Maturity Level 5, but also has the highest number of geographies in the “Start Up” phase (Level 1)
    - *Interpretation: once work in this domain begins, efficient progress through the levels is possible*
- Coordination of Care (Domain 2) is the foundation of the Health Links approach to care, while Measurement and Continuous Improvement (Domain 4) depend on technological enablers, human resource capacity, and expertise in quality improvement science
    - *Interpretation: Given the depth and breadth of these two domains, it is not surprising that few Health Link geographies have achieved high levels of maturity in these two areas*

Health Links Maturity Model Survey

Enablers and Barriers to Reaching Maturity

- The number of years a Health Link geography has been active does not necessarily mean increased levels of maturity
- Relative urbanity or rurality or the state of health care partnerships within a given geography can impact progress
- The LHINs reported on barriers and enablers to increasing maturity in each of the four domains. Enablers for some LHINs were barriers in others:
    - *Technology — Some areas were using streamlined, standardized electronic solutions for data collection, while others had not yet been able to integrate the new platforms and were using manual and paper-based methods*
    - *Human resources—Dedicated human resources support helped some LHINs achieve levels of maturity in each of the four domains, but for others its absence (due staff turnover; inconsistent education, training, and follow up; and a perceived increased workload) stalled progress*
- Given the various factors that affect the maturity journey, we expect to see a steady but slow climb

Patient Story: Sharon

Thank you to the Mississauga Halton LHIN for sharing this story.

Background

Sharon* was referred to the Mississauga Halton LHIN by an acquaintance in the community. Sharon struggled with basic life skills: she did not bathe or clean her house. She had low literacy skills, and wore the same clothing daily, which she did not wash. Because of her poor hygiene, Sharon was alienated from the community, including local businesses, and was in danger of being evicted from her home. She did not have a social support system.

Sharon is clinically obese, with type 2 diabetes, and smokes cigarettes chronically. She experiences a developmental delay, and had previously been supported by Developmental Services Ontario (DSO), Community Living, and Family Services of Peel. However, at the time of her referral to the LHIN, she had declined all services and her files at these organizations had paused or closed.

_____

**Not her real name.*

Patient Story (continued)

Health Links Support

A care coordinator and a clinical practice lead at the Mississauga Halton LHIN worked with Sharon and began navigating through the system to identify and close gaps in her care, reinstating services (mental health, developmental, and clinical) wherever possible.

After extensive conversations, joint visits, and navigating barriers, the care coordinator and clinical practice lead confirmed that Sharon was able to resume services with Family Health Services of Peel. A new file was instated with DSO to secure funding for resources, such as housekeeping support.

Mississauga Legal Clinic was involved to address the pending eviction and Mary's Centre was contacted to help Sharon improve her life skills.

Education on managing incontinence led to a decrease in nighttime bowel incontinence, which helped with the patient's overall hygiene and retention of the newly instated community supports.

To help with medication nonadherence, medication delivery was set up and Sharon's medications were managed with the use of a blister pack. Given that homelessness was a possibility, Peel Outreach was engaged; Links2Care housekeeping was initiated to help mitigate risk of eviction.

In total, the LHIN organized and coordinated more than 15 referrals. A coordinated care plan was completed with Sharon and shared with partners as part of the Health Links approach to care.

Patient Story (continued)

Today

Sharon is now receiving care that supports her hygiene, which in turn improves her housing situation. After legal intervention, she no longer faces eviction. She is using funding from the DSO to access Mary's Centre services until her name comes up on the waitlist for no-fee services.

Although many issues still need resolving, and resource capacity is an issue, Sharon is now re-engaged with the community services available to her. The collaborative, Health Links approach has helped create a strong safety net for Sharon with respect to her care and will work to ensure that she remains engaged with this community support going forward.

Thank you.

LET'S CONTINUE THE CONVERSATION:

- hqontario.ca
- @HQOntario
- HealthQualityOntario
- @HQOntario
- Health Quality Ontario

Health Quality Ontario

Let's make our health system healthier