Ontario Health Quality

HealthLink

Health Links Final Report

December 2019

89,342

people with **chronic conditions or complex needs** across the province have received coordinated care plans (CCPs*) as a result of the Health Links approach

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

The **Health Links** approach to care has been delivered in Ontario since 2013 to people with chronic conditions and complex care needs. Health care providers have come together to coordinate services and develop care plans for this patient population, prioritizing patients' goals and ensuring that they remain at the centre of their care. This final report captures the impact the approach has had over the past 6 years, highlighted by the large number of patients who have received a coordinated care plan; improved access to primary care as measured by the number of patients newly attached to a primary care physician and the number of patients reporting timely access to care; and numerous patient stories demonstrating how the approach has improved their overall sense of well-being.

Since July 2018, **49% of 5,392** unattached patients found a **new primary care physician**

77% of patients surveyed since July 2018 reported **timely access** to a primary care physician

Since July 2018, **64%** of newly identified patients **waited 7 days or less** to initiate their CCP, with a high of 70% in Q2 of 2019/20

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

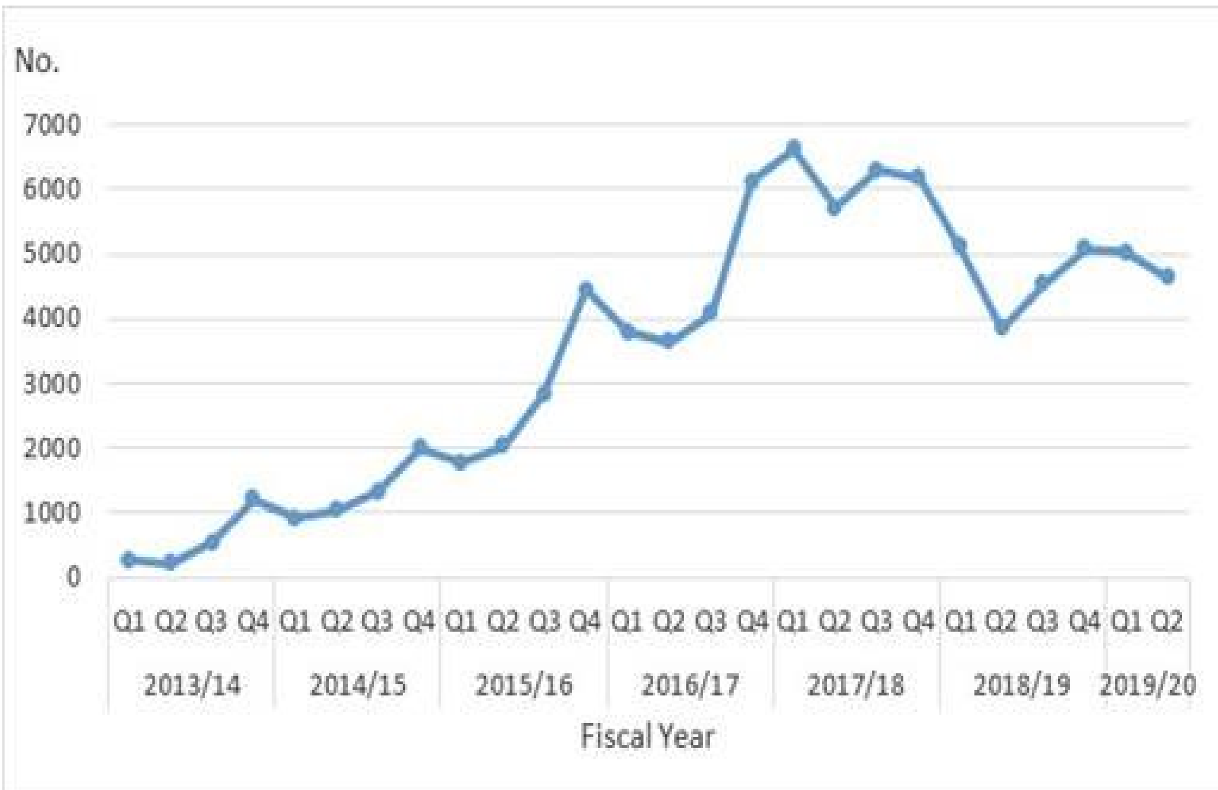
The impact of the **Health Links** approach to care is best described in the stories patients have shared.

Joe, 58, is homeless with unmanaged diabetes. [Health Links] 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 in assisted living, a safe and supportive environment where his physical and mental health needs are being met.

Final Report: Measurement

PATIENT IMPACT

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



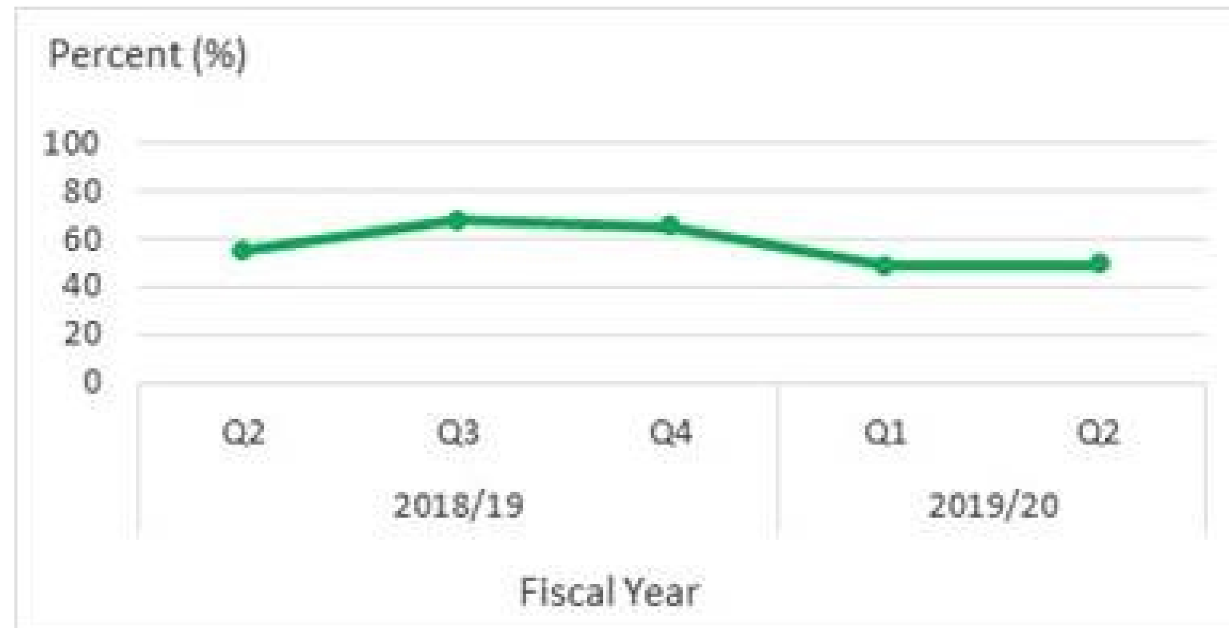
In Q2, 4,629 patients had a new, first CCP developed, an 8% decrease from 5,034 CCPs in Q4, for an overall total of 89,342 CCPs created. Many LHINs are working through their sustainability planning in anticipation of the end of Health Links funding and are shifting toward maintaining current service delivery rather than identifying new partners and spreading the approach.

4,629 patients had a new, first CCP created this quarter

405 fewer CCPs were created this quarter (Q1: 5,034, Q2: 4,629)

89,342 CCPs developed with patients over the life cycle of Health Links

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



Since July 2018, 2,636 of 5,392 identified individuals* (49%) with chronic conditions and complex needs who require primary care have been attached to a primary care provider (227 this quarter). We continue to see variation in attachment rates based on how patients are identified and demographic factors within each geography.

*"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.

435 unattached patients were newly identified this quarter (Q1: 4,959, Q2: 5,394)

227 patients were newly attached this quarter (Q1: 2,409, Q2: 2,636)

2,636 patients have been attached to a primary care provider to date

PATIENT EXPERIENCE

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

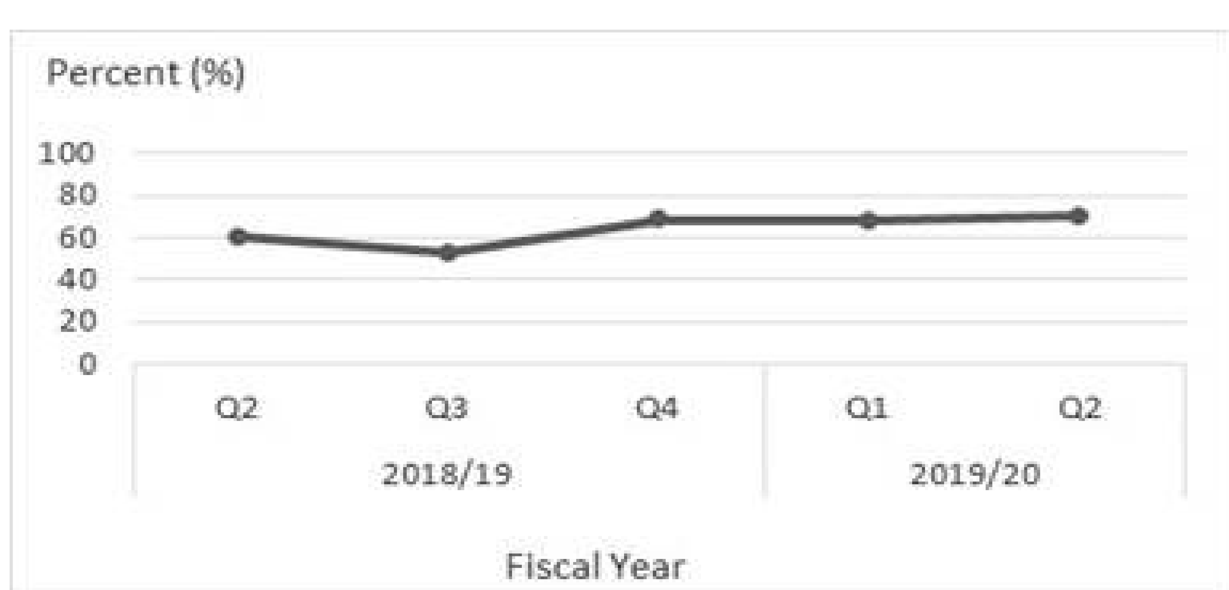
Of the 2,070 patients surveyed, 79% (n=1,634) of patients with a new CCP reported timely access to primary care. Each quarter, a slight increase in the number of patients surveyed is observed. This is due to improving data collection processes.

79% of patients reported timely access to primary care this quarter (1,634/2,070)

49% of patients with a CCP were surveyed

77% of patients, on average, reported timely access to primary care since July 2018

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



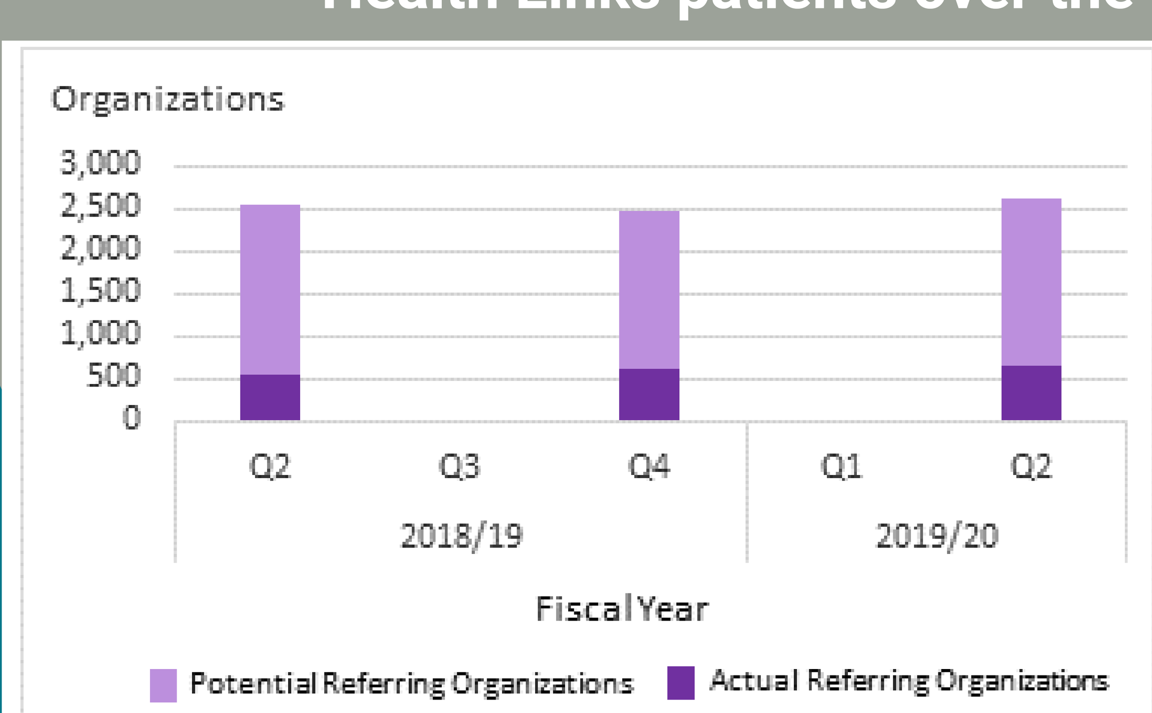
The wait times from referral to initiation of a CCP were determined for 5,522 individuals. Seventy percent (3,838 of 5,522) waited 7 days or less for initiation of their CCP—a slight increase (2%) from last quarter. The overall number of wait times recorded decreased by 10% (587 fewer) since last quarter, which may suggest a slowing of new patients identified.

5,522 patients have a recorded wait time

3,838 patients waited 7 days or less from identification to CCP initiation

64% of patients, on average, have reported a wait time of 7 days or less since July 2018

Figure 5: Proportion of organizations referring Health Links patients over the past 6 months



Over the past 6 months, the number of organizations with the potential to refer and those actually referring have both increased slightly (from 603/1,884 to 653/1,965). This suggests work continues to spread to new organizations as Health Links sustainability plans are being developed.

1,965 organizations had the ability to identify or refer patients for the Health Links approach to care

33% of these organizations (653/1,965) referred this quarter

598 organizations, on average, have referred within each reporting period since July 2018

Figure 6: Total number of patients with a recorded confidence score since July 2018

In Q2, more individuals were surveyed than in the previous quarter but the number of people who could be surveyed was smaller. Results of specific scores are confidential; however, those patients who conveyed a confidence score of less than 7 were given the opportunity to review and revise their CCPs. LHINs continue to report challenges posing this question due to limited uptake from providers and variation in data collection methodology.

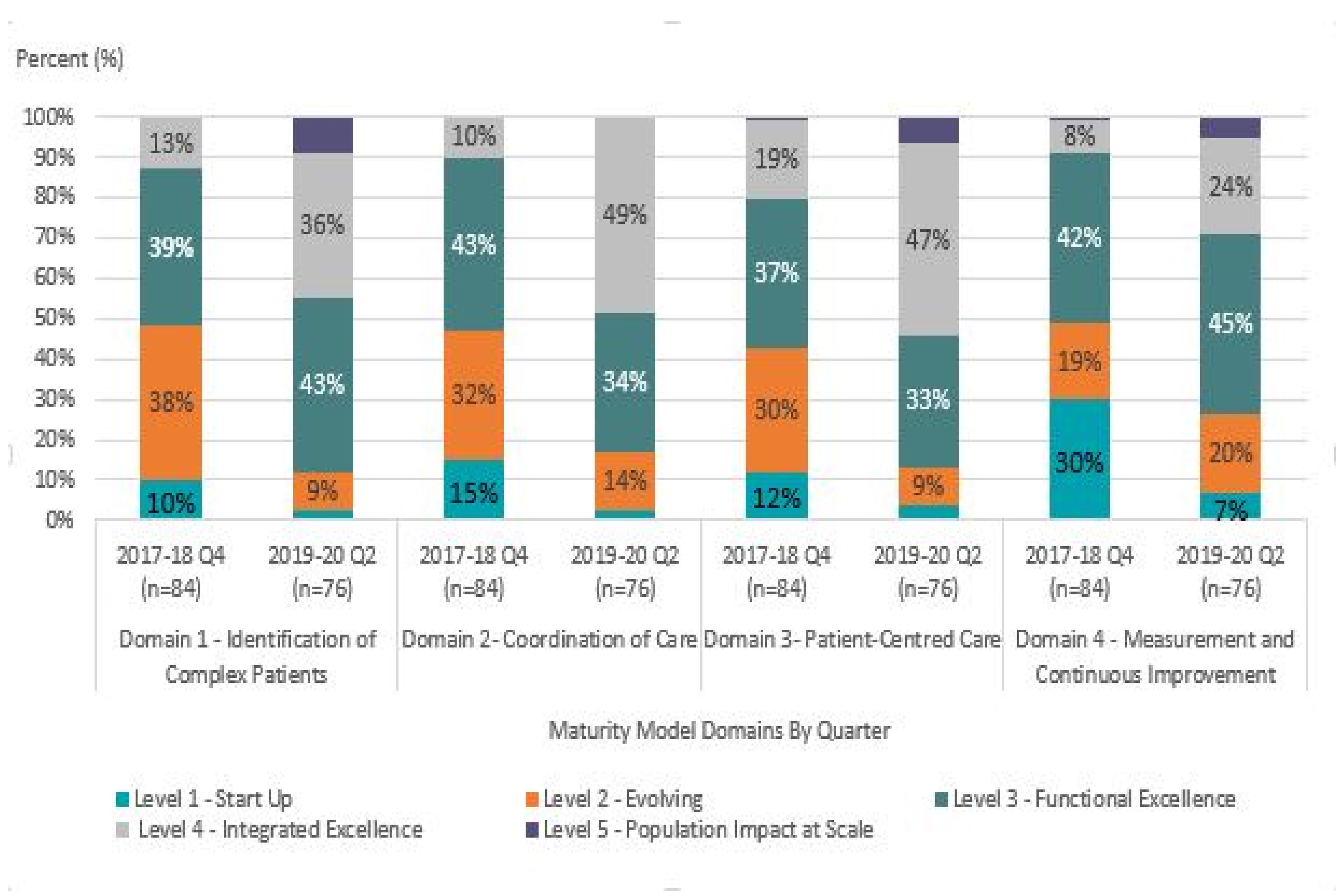
29% (1,358/4,653) of patients were surveyed in Q2

5,851 of 21,009 surveyed patients have a recorded confidence score

Final Report: Measurement

Maturity

Figure 7: Assessment of maturity across four domains, by quarter



*Note: Due to sub-region reporting realignment, the number of geographies reporting this measure changed from 84 to 76 after Q4 of 2017/18.

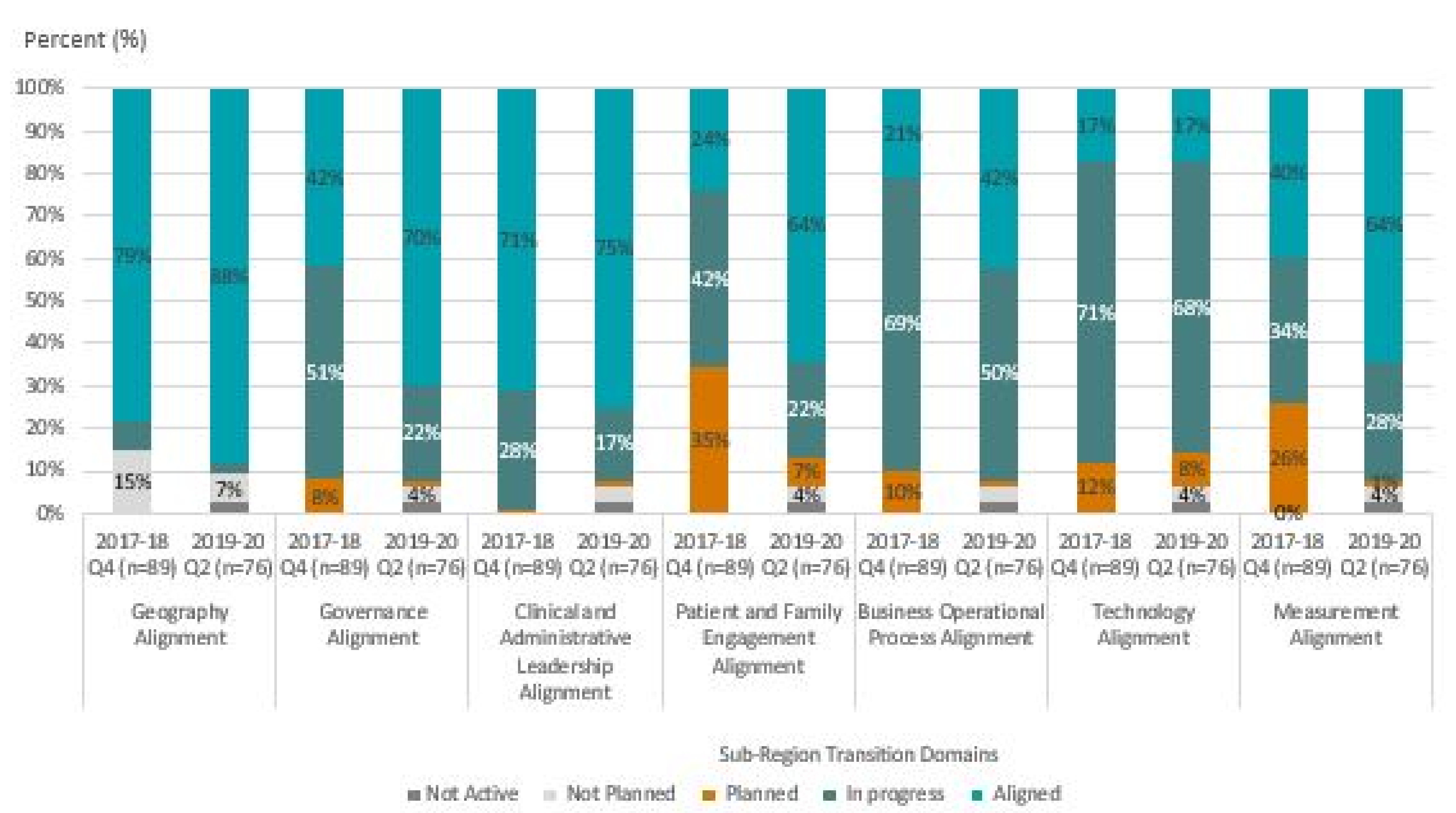
Since the first maturity and sub-region transition assessment in Q4 of 2017/18, an overall growth of maturity has been observed. At least one sub-region has attained a Level 5 (Population Impact at Scale) in each of the four domains. In order to achieve this growth, considerable work has been undertaken to standardize processes for identifying the target population, build relationships to embed coordination of care across all sectors, and enable patient engagement, including self-care approaches.

The largest growth in maturity has occurred in Domain 2 (Coordination of Care), where there has been an increase of 390% (from 8 to 37) in the number of sub-regions reporting a Level 4 (Integrated Excellence) since the first assessment. To achieve this, sub-regions would have likely used a standardized care model across multidisciplinary providers and will have had a strategy in place to support the rapid scale and spread of the approach.

Domain 3 (Patient-Centred Care) had the highest level of maturity across all domains, with 41 sub-regions (54%) achieving levels 4 or 5. The significant work in the Coordination of Care and Patient-Centred Care domains should set up a good groundwork for the key elements of success for new Ontario Health Teams.

Sub-Region Transition

Figure 8: Assessment of sub-region transition across 7 areas, by quarter



*Note: Due to sub-region reporting realignment, the number of geographies reporting on their transition status changed from 88 to 76 after Q4 2017/18. This number differs from those reporting maturity in the same timeline due to some geographies being in the midst of transition at the time of 2017/18 Q4 reporting.

In this most recent sub-region transition assessment, an overall increase in alignment across all areas since Q4 of 2017/18 has been observed.

The largest move toward total alignment occurred in Area 4: Patient and Family Engagement. There was a 166% increase from Q4 of 2017/18 to Q2 of 2019/20; this is due, in part, to work undertaken to include patients and their family members within Health Links governance systems and a push to collect routine feedback.

Technology continues to be a challenge for most sub-regions, with only 17% (n=13) aligned in this area—this remains consistent with results from the first assessment. Challenges are mostly due to difficulties negotiating data-sharing agreements, limited access to the technology platforms used for CCPs, and additional login information required for front-line care providers.

Key Accomplishments and Next Steps

Health Links is jointly supported by Health Quality Ontario, now the Quality business unit of Ontario Health, and the Ministry of Health. It launched in 2013 and has helped coordinate care for some of the province's most vulnerable people: those with chronic conditions and complex care needs.

In addition to the **89,342** patients whose care has been positively impacted by the Health Links approach to care (representing 13% of the target population estimated to benefit from the approach), a number of innovative practices have been developed, foundational cross-sector partnerships fostered, and key initiatives achieved. In particular:

· The development of a patient registry, in which all identified patients should be enrolled in order to gain a better understanding of the patient population receiving this approach to care
· The enhanced Health Links measures, which focus on patient satisfaction and outcomes
· Ongoing evaluation of the Health Links initiative to understand the effectiveness of coordinated care and leverage lessons for integrated care models

The momentum built through the Health Links approach will continue in the work of Ontario Health Teams, who will ensure that coordinated care is the standard for all patients and the crux of care delivery. In this transitional period, we will look to your leadership to ensure continuity of care for Health Links patients, including maintaining the patient registry and coordinated care plans and participating in ongoing evaluation work.

IMPACT OF COORDINATED CARE: PATIENT STORIES

The impact of coordinated care planning has truly been felt by patients, who have not only reported improved health outcomes, but also—and perhaps more importantly—an improved outlook for the future and their overall sense of well being. Below are excerpts from patient stories that have been published over the course of Health Links reporting.

Total kudos to ... the Health Links team. My client is truly a new woman. She is positive, optimistic, and really engaged in making her life better.

-Dr. Kim Morrison, SE LHIN

Julie is 87 years old with multiple health issues, such as dementia, heart disease, type 2 diabetes, hypertension, and osteoarthritis. She had unstable housing and was financially insecure. A care plan was developed to help identify and coordinate her needs in the community. With the assistance of a dietitian and dentist, Julie is able to eat healthier meals and keep her diabetes under control. She will be able to stay in her apartment until she is ready to move into long-term care. Her housing is no longer at risk and the suspected financial abuse has stopped. She now has accessible funds for the necessities of daily living, and can enjoy a safer, better quality of life.

* * *

Lucy has a history of physical and mental health conditions, as well as behavioural challenges; however, housing was the biggest issue she faced. All the 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.

* * *

Rob is a 54-year-old gentleman with a history of hypertension, diabetes, high cholesterol, and multiple heart attacks, and he is developmentally delayed. Between July 21 and October 24, 2014, Rob made 16 visits to the emergency department, resulting in six admissions. With the help of the Health Links team, he is currently doing well with his medications and the management of his chronic conditions. Having the care he needed in place when was he discharged in March 2015 helped decrease his lengths of stay during two hospital admissions in 2016. Most importantly, Rob is still living in his own apartment and has the supports he needs.

* * *

John has numerous health issues: diabetes, mental health conditions, previous colon cancer, lung cancer. He's isolated and experiences financial challenges. John has expressed that having one person to turn to for help with planning has alleviated a substantial amount of stress in his day-to-day routines.

IMPACT OF COORDINATED CARE: PATIENT STORIES

Before becoming a Health Links patient, Sharon struggled with basic life tasks: she did not bathe or clean her house and had low literacy skills. Sharon did not have a social support system and felt alienated from the community. After receiving care that supports her, Sharon is now re-engaged with the community services available to her and no longer faces eviction.

* * *

Margaret is a 60-year-old divorced woman with one estranged daughter. She has a complex health history that includes mental health conditions (bipolar, major depression with suicidal ideation, and borderline personality disorder), vision impairment, chronic back pain due to arthritis, an unresolved pressure ulcer on her left hip, and hypertension. Margaret is now receiving an appropriate level of support in her home and community. She has medical and mental health supports in place, is engaged in her own health care, and is becoming a part of her community once again. Margaret is on the Ontario Disability Support Program. She has been able to begin to repair the relationship with her daughter, and has been reunited with her pet dog in her apartment.

I can't say enough about what Health Links did for me ... I'm looking forward to things and I never did that before Health Links.

- Elizabeth (NW LHIN)

* * *

A 64-year-old First Nations woman suffered from multiple chronic illnesses. After her primary care physician and community team helped her build a coordinated care plan, they collectively agreed that in addition to organizing care for her medical illnesses she needed support in addressing her social issues. She now has the energy to visit a nearby centre and participate in culturally based seminars and activities that are important to her. Plans have been made through ODSP to provide her with a scooter to improve her mobility.

* * *

Randy was a palliative care patient with multiple complex care needs. He 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 his 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.

Helpful Links

The following resources are available to support teams as they ensure continuity of care for patients benefiting from the Health Links approach.

Rapid Improvement Support and Exchange (RISE)
As part of the Ministry of Health's central repository of supports for Ontario Health Teams (OHTs), RISE provides rapid access to resources tailored specifically for teams at all stages of OHT development and application.

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
A quick guide on how to become a "patient partnering all-star" and overcome common challenges is available for download. 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.

Health Links Community of Practice
A final webinar for the Health Links Community of Practice will be held in January 2020. It will feature key achievements and lessons learned from the Health Links approach to care. Recordings of previous webinars are available on Quorum.

Quorum
The Health Links Approach to Care Community of Practice is hosted on Quorum, an online quality improvement community. Quorum also houses a number of different resources, QI tools, and improvement posts.