Health Links: Excerpts from the 2018/19 Q3 Report

MARCH 2019

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: Julie

Thank you to the Toronto Central LHIN for sharing this story.

Julie* is an 87-year-old year old woman with a primary diagnosis of moderate dementia and heart disease and a history of type 2 diabetes, hypertension, and osteoarthritis. She is retired and lives in community housing (TCHC), where she pays subsidized rent and has daily housing services and support for activities of daily living. She relies on a rolling walker to prevent falls.

Julie does not have children and her only known relative is a niece who declined to be involved in her financial or future care planning. She socializes with neighbours and participates in the community dining program in her building. An elderly friend in another province was her power of attorney and helped with her financial and personal care, but recently resigned from this role.

In addition to the cognitive decline caused by her dementia, Julie's mental health has been challenged by the numerous bed bug preparation treatments that her unit has required over the years. There was suspected financial abuse from two friends, one of whom lived in the building and one who was staying in her apartment and putting her housing at risk.

**Not her real name.*

Patient Story (continued)

Coordinated Care Support

A social worker referred Julie for the Health Links approach to care and led the development of a coordinated care plan.

The social worker attended home visits with a lawyer and a capacity assessor so that Julie's finances could be fully managed by the Office of the Public Guardian and Trustee. She also organized monthly home appointments with a House Calls physician, who completed medication reconciliation and laboratory workups for Julie and ensured optimal physical health.

Julie enjoyed visits with a private personal support worker (PSW) every Friday afternoon for one-on-one socialization in addition to visits from SPRING Senior Care's PSWs, and continued with the community dining program in her building. Her mental health was supported and monitored by the PSW, who would call the social worker if they noted any changes or had any concerns.

An occupational therapist from House Calls:

- Arranged for cognitive testing
- Referred Julie to a dietitian through the Toronto Central LHIN.
- Helped Julie apply for long-term care support through the Toronto Central LHIN
- Referred Julie to a dentist

Patient Story (continued)

The Office of the Public Guardian and Trustee helped improve Julie's financial position in the following ways:

- Secured available funds to access food (e.g., grocery delivery, meals on wheels) and basic necessities of daily living
- Set up Lifeline, escorts to the bank, light housekeeping services, and SPRINT Senior Care transportation services.

Today

With the assistance of dietician 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. The SPRINT senior care team worked in tandem with TCHC staff and community police to help remove the friend living in Julie's apartment. 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.

The Health Links Quarterly Report

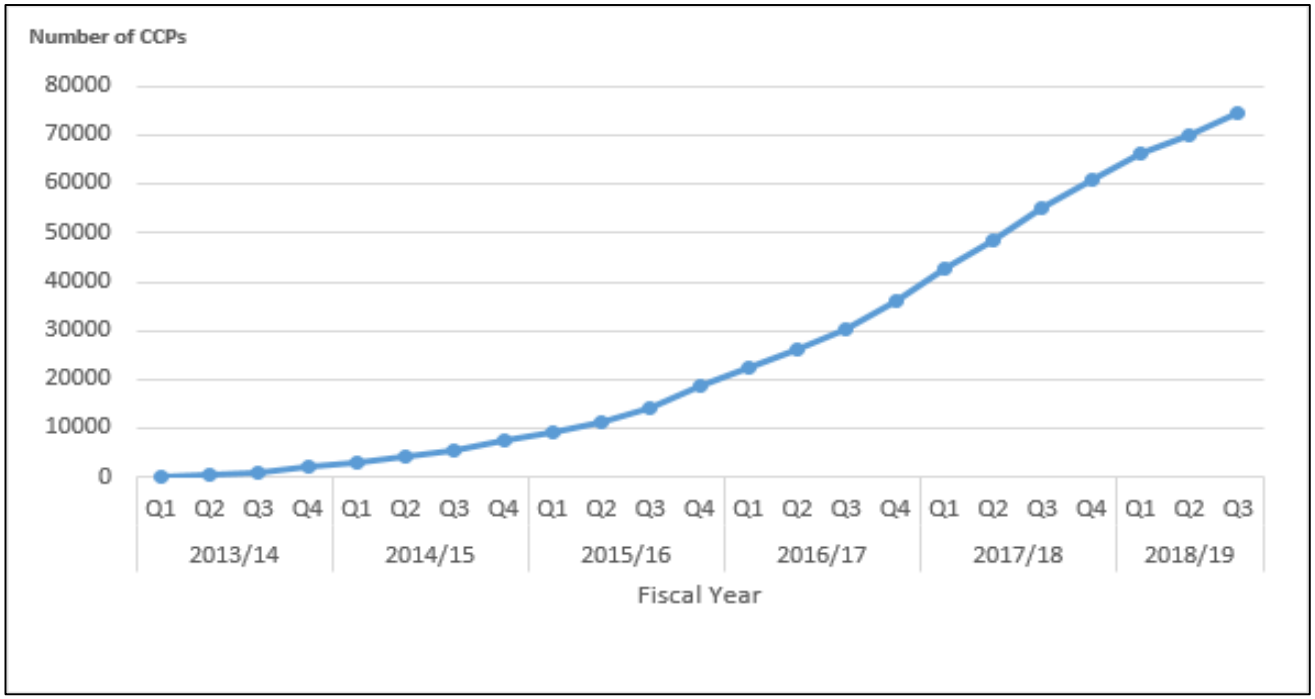
- Provides a summary of data reported by sub-regions in each quarter
    - *Five indicators that measure spread, scale, and integration of the Health Links approach to care are reported on this quarter*
- Highlights patients who are benefiting from a Health Links approach to care
- Reviewed by Health 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

Highlights from this Quarter

- 74,590 CCPs have been completed to date, with 4,530 new CCPs completed in Q3 (3,843 in Q2)
- 68% (1,836) of the 2,715 unattached patients reported in Q3 were newly attached to a PCP (1,298 of 2,341; 55% in Q2)
- 75% of individuals surveyed in Q3 reported timely access to a PCP (77% in Q2)
- 52% of individuals newly identified as benefiting from the Health Links approach to care waited 7 days or less to initiate their CCP (60% in Q2)
- 25% of patients have a CCP and a recorded confidence score (35% in Q2)
- Top five sub-regions (percent of target population with a CCP)
    - *Dufferin (56.0%)*
    - *Guelph-Puslinch (42.9%)*
    - *Niagara North West (39.9%)*
    - *Rural Hastings (34.0%)*
    - *Bolton-Caledon (29.9%)*
- Health Links Patient Registry will be ready for submissions in Q4

Impact of the Health Links Approach to Care – Q3 Update

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

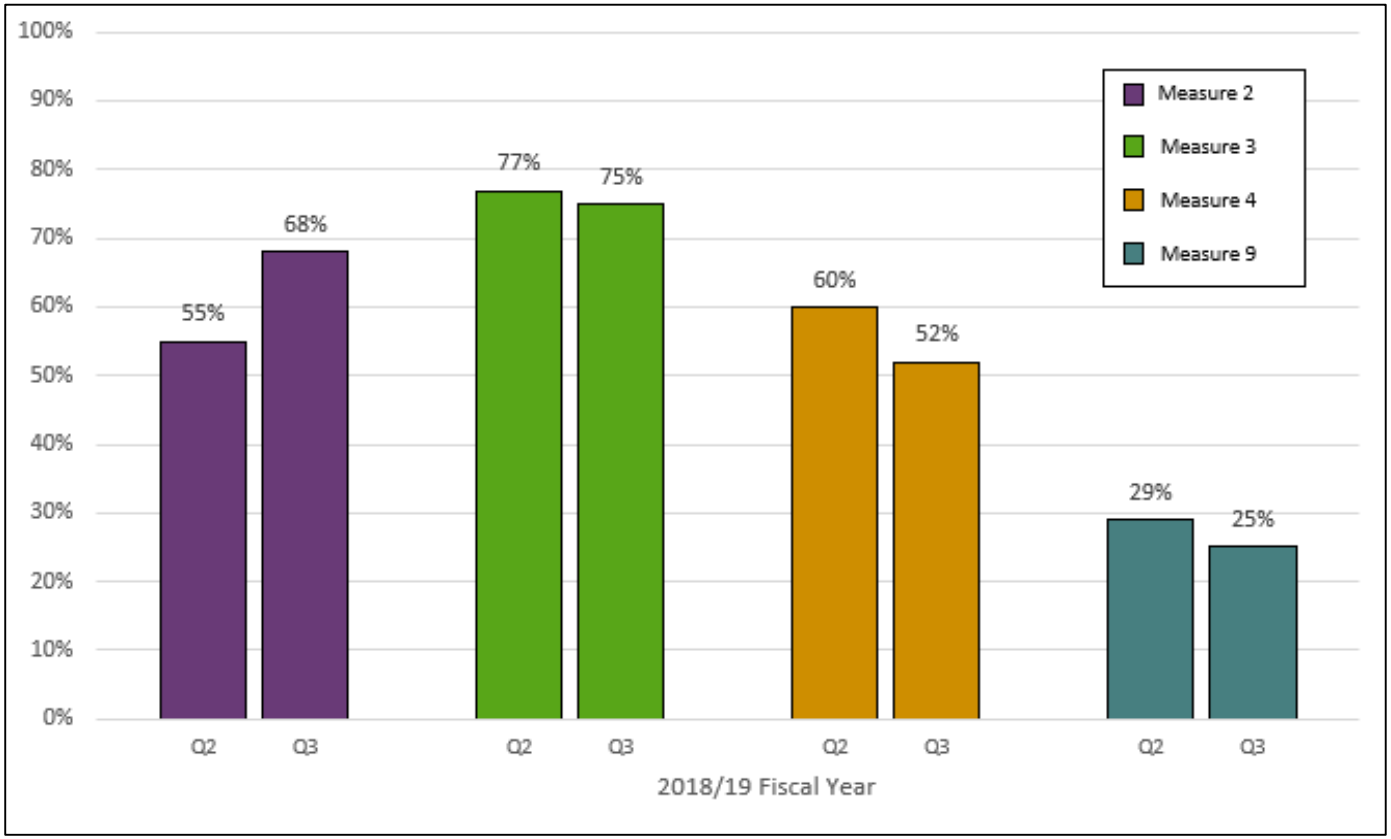


A total of 4,530 individuals had a new, first CCP created this quarter, an increase of 687 (18%) from Q2. The cumulative total of individuals with a CCP in Q3 is 74,590, compared with 70,060 in Q2. Based on the overall estimated target population (patients with 4+ conditions), 11.2% (74,590 of 668,635) now have a CCP created to support their care.

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 – Q3 Update

Figure 2: A comparison between quarter 2 and quarter 3 for measures 2, 3, 4, and 9: 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.

Thank you.

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