Health Links: Excerpts from the 2018/19 Q4 Report

JUNE 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

“As a health care practitioner, I think we sometimes enter a person’s home with a predetermined inventory of what we feel that they will need based on their medical history. The coordinated care plan process forces us to abandon our own presumptions, and really actively engage the person in conversation, asking what is important to *them.* One example of how the CCP process directed such individualized care was in the case of a young woman diagnosed with end-stage respiratory disease and multiple other comorbidities, including severe crippling rheumatoid arthritis. When I asked what it was that was important to her, it was not pain and symptom management, which I expected to hear, but rather that she had always wanted to learn to knit. Armed with this information, we were able to link this woman with a hospice volunteer who visited her home and taught her to knit, despite her severe joint deformities. The woman said that these visits were the some of the only times she felt like a person rather than a disease—two mothers sitting chatting about their children while sipping tea and knitting scarves.”

—Provider, Central East LHIN

The Health Links Quarterly Report

- Highlights how patients are benefiting from a Health Links approach to care
- Provides a summary of data on six indicators that measure spread, scale, and integration of the Health Links approach to care
- Offers a deeper understanding of Health Links maturity across the province and progress on sub-region transition to date
- 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 the 2018/19 Fiscal Year

- **18,563** patients have a new coordinated care plan (CCP), for a provincial total of **79,673** (24,812 in 2017/18)
- **2,057** patients are newly attached to a primary care provider (PCP)—**65%** of the 3,158 unattached patients reported in this fiscal year
- **82%** of individuals are reporting timely access to a PCP
- **69%** of newly identified individuals waited 7 days or less for initiation of their CCP
- **1,151** organizations across the province are identifying individuals for the Health Links approach to care
- **27%** of patients have a CCP and a recorded confidence score

Impact of Coordinated Care

Sarah and Mark,* a homeless couple, presented themselves to the local Community Health Centre with a history of drug abuse. They were referred for the Health Links approach to care and attached to a social worker for support and navigation. Their care coordinator helped them find a primary care provider.

Sarah and Mark signed up for the opioid treatment program and were later diagnosed with Hepatitis C. Case conferences were set up at the regional centre and treatment started. Transportation, ODSP services, and housing were arranged for the couple as they continued their treatment.

A year later they were declared clear for Hepatitis C. As their health concerns stabilized, their CCPs were updated. They expressed the wish to start a family and relocate west. They were referred to a smoking cessation program, a family planning counsellor, and a dietitian.

As things were progressing, the apartment building where Sarah and Mark lived closed down, leaving them homeless again. With the help of a situation table that included local police, the district services board, the township, emergency medical services, and the health unit, temporary housing was provided.

Once Sarah and Mark began to achieve their goals of care, they no longer required ongoing support. Earlier this year, transportation was arranged for Sarah and Mark to relocate west.

— From: Ignace

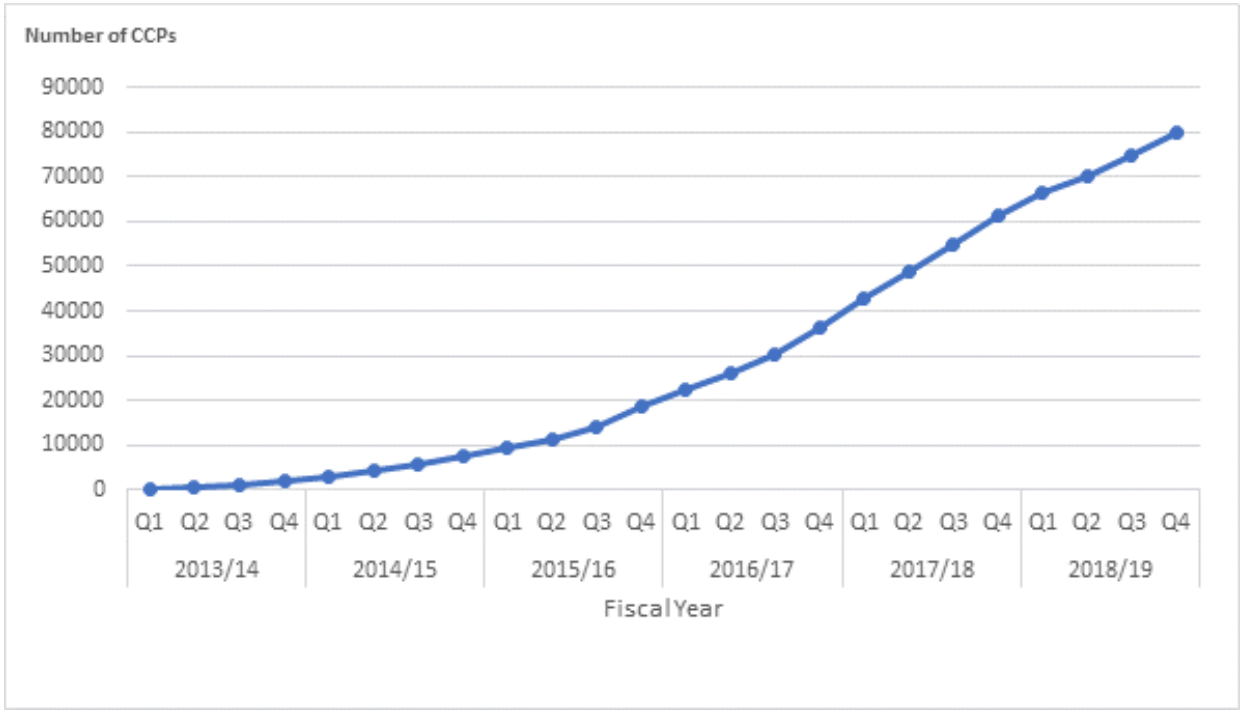
**Not their real names*

Highlights from this Quarter

- **79,673** CCPs have been completed to date, with **5,083** patients with a new CCP initiated in Q4 (4,530 in Q3)
- **65%** (2,057) of the 3,158 unattached patients reported in Q4 were newly attached to a PCP (1,836 of 2,715; 68% in Q3)
- **78%** of individuals surveyed in Q4 reported timely access to a PCP (75% in Q3)
- **68%** of individuals newly identified as benefiting from the Health Links approach to care waited 7 days or less to initiate their CCP (52% in Q3)
- **603** organizations across the province identified individuals for the Health Links approach to care over the past 6 months (538 in Q2)
- **28%** of patients have a CCP and a recorded confidence score (25% in Q2)

Impact of the Health Links Approach to Care – Q4 Update

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



A total of 5,083 individuals had a new, first CCP created this quarter, an increase of 553 (12%) from Q3. The cumulative total of individuals with a CCP in Q4 is 79,673, compared with 74,590 in Q3. Based on the overall estimated target population (patients with 4+ conditions), 11.9% (79,763 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 Coordinated Care

John* has a history of diabetes, mental health issues, suffers complications from previous colon cancer surgeries, and has a current diagnosis of lung cancer. He's isolated and has tax arrears and arrears for propane gas for his home. He requires support for his medical and social concerns.

Since being referred for the Health Links approach to care, his care coordinator ensures John's pre-chemo bloodwork gets done and that he is fit for chemotherapy before he travels to the regional center for treatment (in the past he had been sent back several times as he was unfit for chemotherapy). The Ontario Disability Support Program (ODSP) provides medication benefits and John receives travel grant for his treatment—the coordinator has set up a reminder with the local drug store for medication refills. John has a regular meeting with a social worker for counselling services and weekly touchpoints with his care coordinator.

With the help of the ODSP, the propane arrears were paid. The Office of the Township of the Chief Administrative Officer continues to provide tax relief.

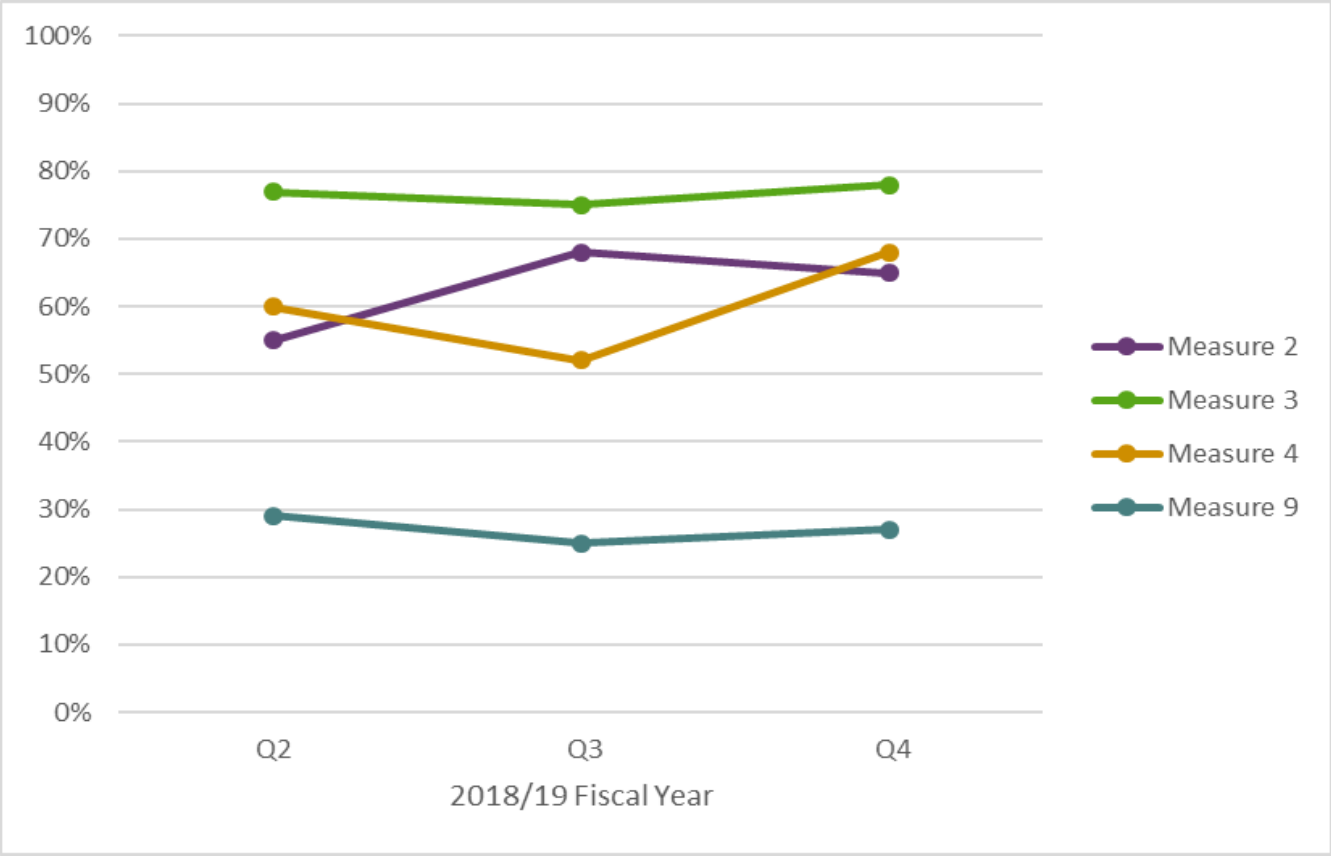
John has expressed that having one person to turn to help with planning has alleviated a substantial amount stress in his day-to-day routines.

— From: Schreiber/Terrace Bay

**Not his real name*

Impact of the Health Links Approach to Care – Q4 Update

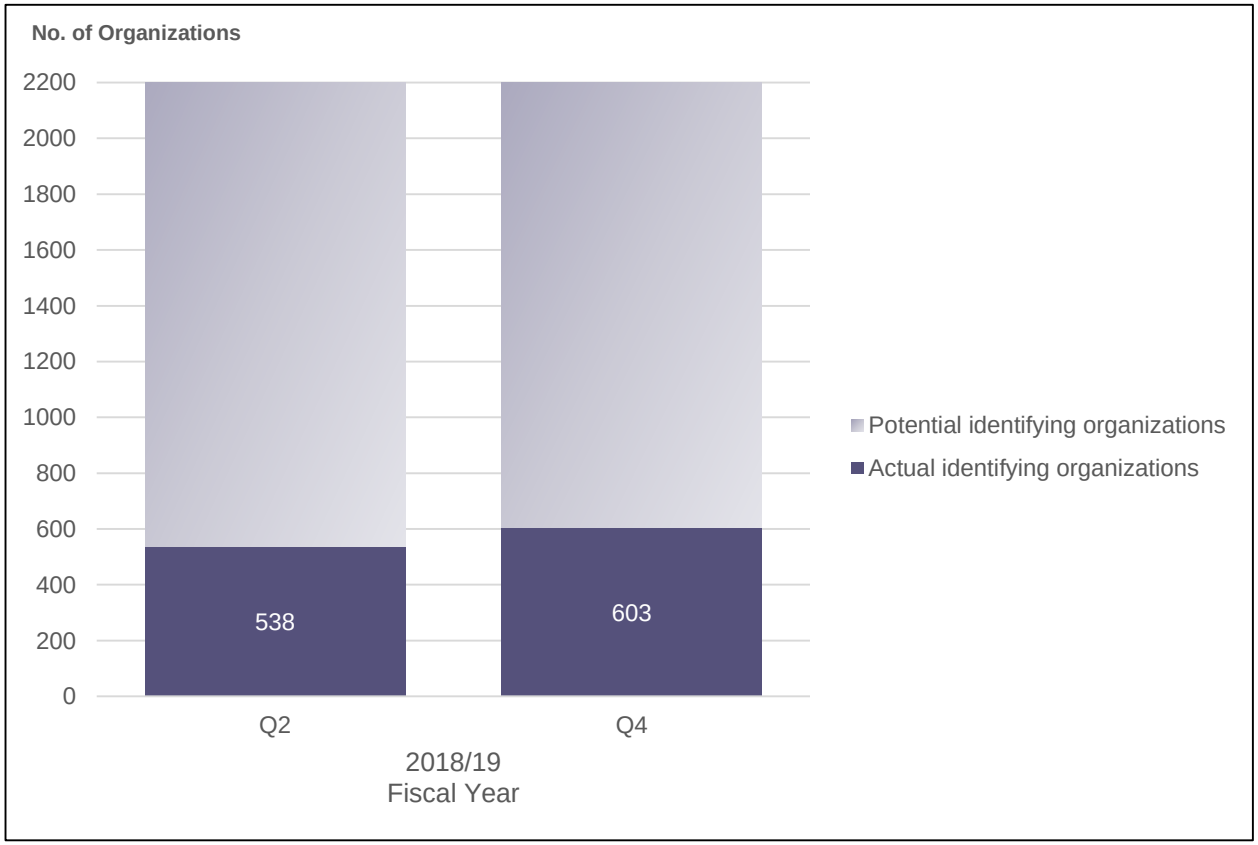
Figure 2: A Q2 to Q4 comparison of measures 2, 3, 4, and 9: Percentage of individuals attached to a PCP, reporting timely access to care, who waited 7 days or less before initiation of their CCP, and with a patient confidence score, respectively



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

Impact of the Health Links Approach to Care – Q4 Update

Figure 3: Proportion of organizations within the sub-region that are involved in identifying individuals living with multiple chronic conditions and/or complex needs who might benefit from the Health Links approach to care



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

Impact of Coordinated Care

We have a patient with legitimate health issues who is very anxiety ridden and who, as a result, sees multiple health care practitioners at the family health team, hospital emergency department, and physician's office, repeatedly. She also has a mental health worker that comes to her home. She has memory challenges and has a perceived idea about her health, which is actually quite better than she believes.

After a case conference with her physician, dietitian, pharmacist, occupational therapist, and nurse practitioner, we have developed a system in which she has planned visits with these professionals weekly for a period of 4 months so that we are all in the loop about her care and she feels supported.

We have created a binder for her health issues, with information on her conditions and ways that she can attempt resolve various issues on her own before making further appointments or making unplanned emergency department visits. This includes reminders about her weekly appointments.

We have also done a MOCHA (Montreal Cognitive Assessment—Dementia) and will likely be referring her to the memory clinic.

We are trying to anticipate her needs in hopes of alleviating her anxiety, which in turn should lessen her need for contact with so many health care providers, alleviating the unintended burden on the health care system.

It is a work in progress that would not have been possible without the focus and tools offered by the Health Links approach to care.

— From: Kenora

Maturity Model and Sub-Region Transition Survey

- In March 2018, the LHIN Health Link leads were sent a survey asking them to assess both the state of their transition from Health Link to sub-region geographies and the maturity of the Health Links approach to patient care in each geography (Figure 4 and Figure 5)
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- Successful transition will ensure coordination of care aligns with population health planning and needs assessments, resulting in **improved care** for patients with complex needs

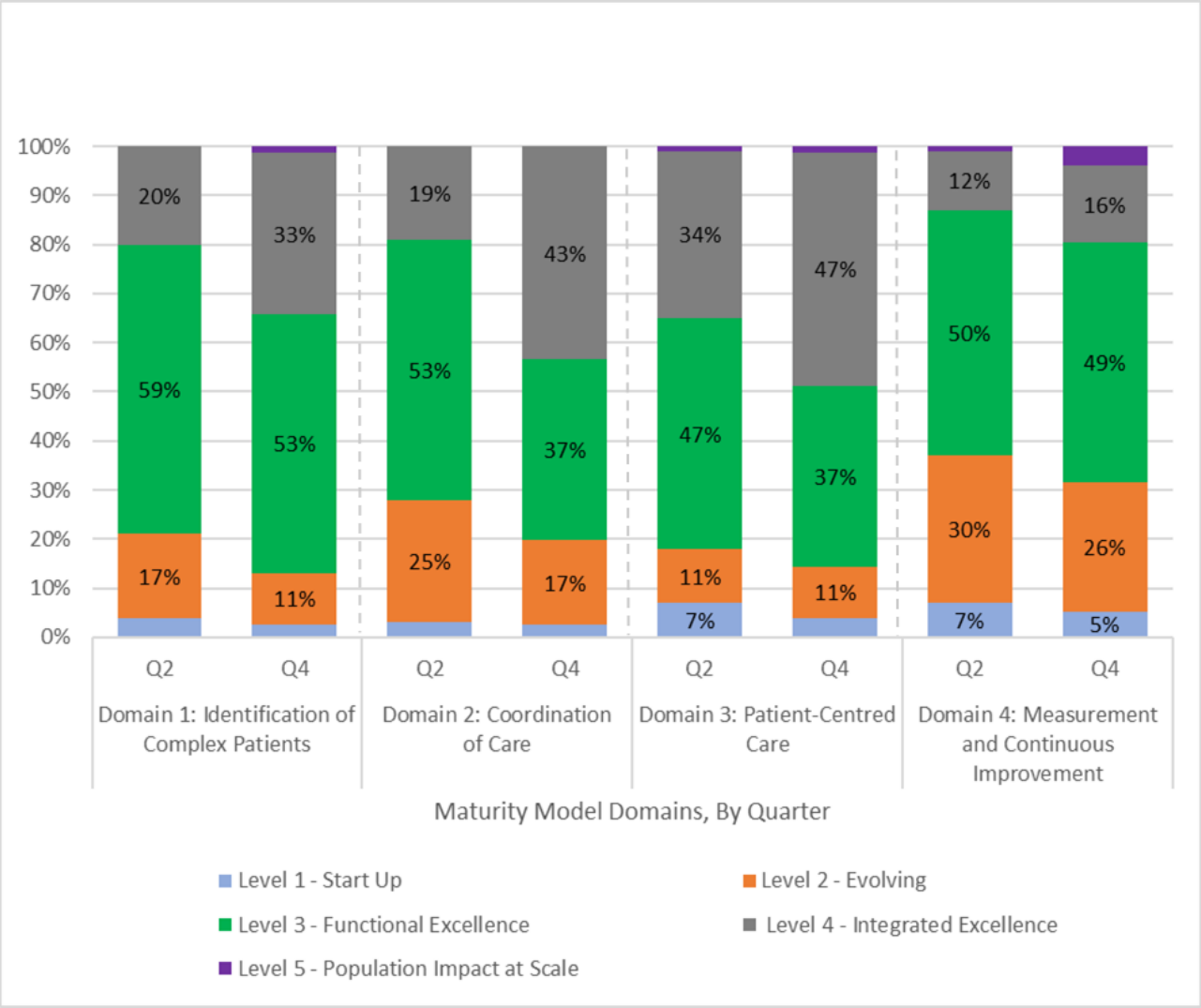
- Increased maturity ensures smoother processes, better access to care, increased identification of new patients with complex needs, and care that places **patients' wishes, values, and goals** at the forefront.

- Different areas of the province are becoming more consistent in how they assess both maturity and transition status

- Maturity and transition alignment status have been assigned a score (percent maturity and alignment reached) and compared against the percent of target population reached, by LHIN, in an effort to determine the relationship between maturity, transition status, and number of CCPs created (Figure 6)

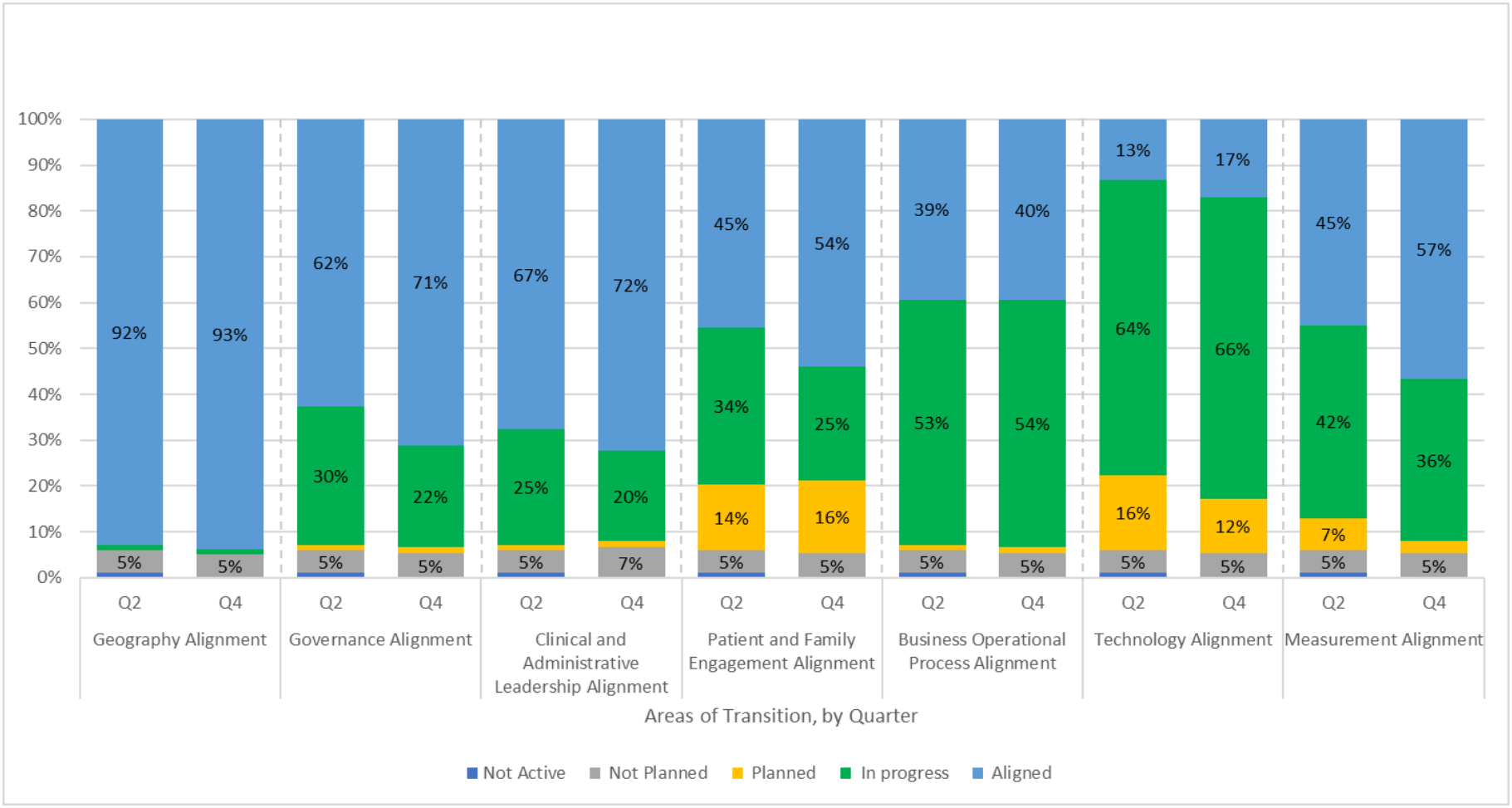
Maturity Model Survey Results

Figure 4: Maturity: a Q2 and Q4 comparison across four domains (n=76)



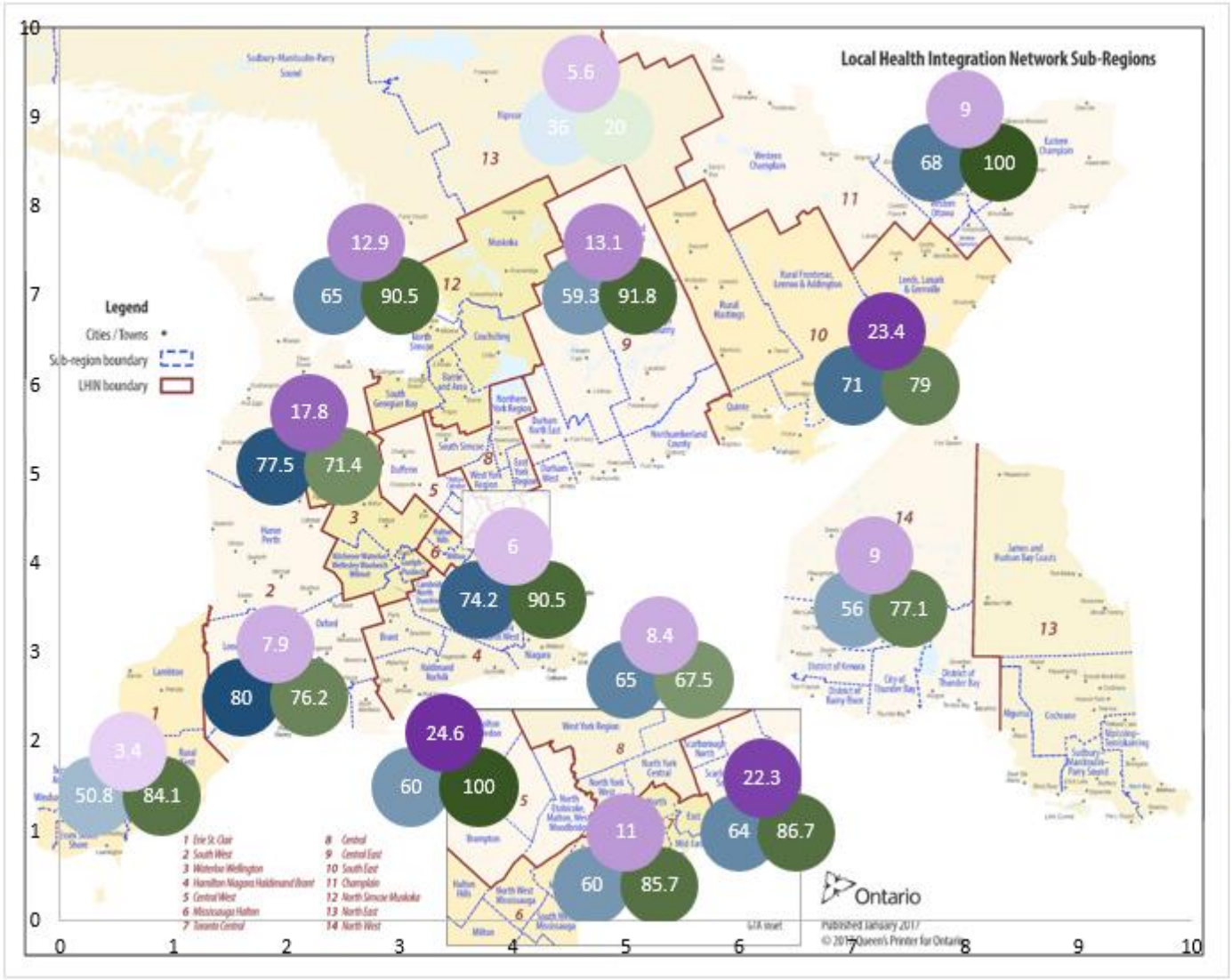
Sub-Region Alignment Survey Results

Figure 5: Transition status: a Q2 and Q4 comparison across seven areas (n=76)



Pulling it all Together: Alignment, Maturity, and Population Reached

Figure 6: Comparison between sub-region transition score, maturity score, and new CCPs (% of target population reached), by LHIN region



LEGEND

Percent maturity toward complete population impact at scale

Higher — Lower

Percent toward complete sub-region alignment

Higher — Lower

Cumulative total of CCPs as % of target population

Higher — Lower

Thank you.

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