Health Links Leadership Summit

Wednesday September 28th 2016

#HLSummit2016

HealthLinks

Ontario
Health Quality Ontario

AGENDA

Time	Topic
8:00 – 8:30	**Registration and Networking**
8:30 – 8:50	**Welcome and Opening Remarks:** • Dr. Joshua Tepper (Health Quality Ontario) and Paul Huras (South East LHIN)
8:50 – 9:15	**Why Health Links? A personal story** • Kirk Mason (Caregiver)
9:15 - 9:55	**Patients First: How Health Links aligns with primary care and community care reform; imagining the future state** • Dr. Bob Bell (Ministry of Health and Long-Term Care)
9:55 – 10:30	**Panel: Progress on Health Links** • Lee Fairclough (Health Quality Ontario) • Phil Graham (Ministry of Health and Long-Term Care) • Kelly Gillis (South West LHIN)
10:30 – 10:50	**Networking Break**
10:50 – 12:15 Room 206	**Concurrent Session A: Coordinated care management** • Moderator: Lisa Bitonti-Bengert (Waterloo Wellington LHIN) o Stacey Bar-Ziv (Health Quality Ontario) o Dan Harren (Durham North East Health Link) o Chris Archer (North Simcoe Health Link) o Kittie Pang (North East Toronto Health Link)
10:50 – 12:15 Room 205	**Concurrent Session B: Transitions between hospital and home** • Moderator: Lee Fairclough (Health Quality Ontario) o Susan Taylor (Health Quality Ontario) o Aasif Khakoo (East Toronto Health Link) o Lori Richey (Peterborough Health Link) o Christine Thompson (IDEAS Alumni)
12:15 – 1:00	**Networking Lunch**
1:00 – 1:20	**Bringing together learnings from morning Concurrent Sessions** • Lee Fairclough and Lisa Bitonti-Bengert
1:20 – 2:25	**Panel: Perspectives of Health Links Leaders** • Moderator: Dr. Adalsteinn Brown (Institute for Health Policy, Management and Evaluation) o Kirk Mason (Caregiver Leader in Health Links) o Dr. Jocelyn Charles (North Toronto Health Link) o Dr. Walter Wodchis (University of Toronto) o Dr. Harry O'Halloran (South Georgian Bay Health Link)
2:25 – 2:45	**Networking Break**
2:45 – 4:15	**Panel: How does the Health Links approach fit in the future plans for Primary Care and Home Care?** • Moderator: Bill MacLeod o Nancy Naylor (Ministry of Health and Long Term Care) o Dr. David Kaplan (Health Quality Ontario) o David Fry (Mississauga Halton CCAC) o Paul Huras (South East LHIN)
4:15 – 4:30	**Closing Remarks** • Lee Fairclough and Paul Huras

MY PERSONAL STORY

Kirk Mason

How Health Links Align with Primary Care, Community Care Reform; Imagining the Future State

How Health Links Align with Primary Care, Community Care Reform; Imagining the Future State

Dr. Bob Bell

PROGRESS ON HEALTH LINKS

Progress on Health Links

Panel

Lee Fairclough

Phil Graham

Kelly Gillis

Health Links:

Improving integrated care for patients with multiple conditions and complex needs

Working Together to Advance a Health Links Approach

Health Links

Improving integrated care for patients with multiple conditions and complex needs

MOHLTC

- Sets the **strategic direction** for Health Links
- Provides overall funding to the LHINs
- Oversees the overall **performance** of the Health Links initiative to guide strategy
- Facilitates **operational success** by implementing provincial level tools and supports

LHIN

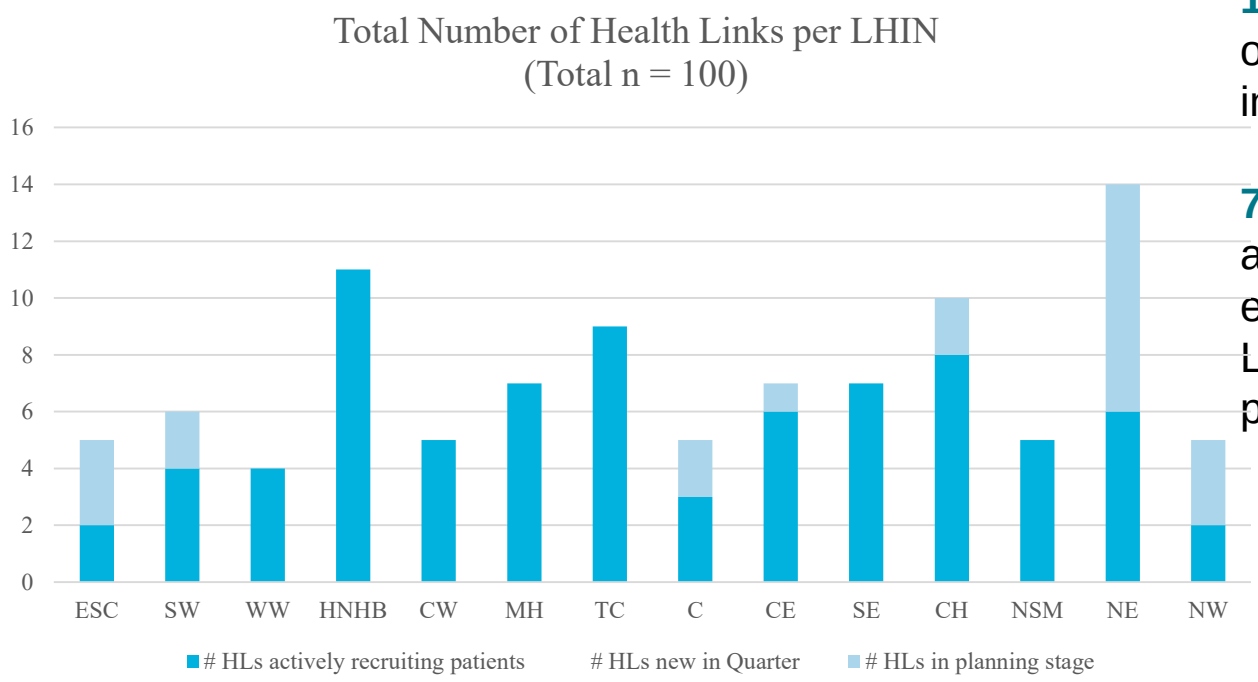
- Sets **regional priorities** for Health Links and ensure alignment with provincial priorities
- **Funds** Health Links in accordance with priorities
- Maintains **overall accountability** for Health Links performance, LHIN by LHIN
- Drives operations through implementation of plans and support for adoption of provincial tools
- Identifies and **implements** regional supports and tools as required

Health Quality Ontario

- Support data collection, timely reports and analysis
- Lead systematic identification of emerging innovations and best practices
- Increase rate of progress through standardization of best practices across all Health Links
- Support inter-Health Link sharing of lessons learned on regional or pan-provincial basis
- Connect LHIN Health Link Leads with other relevant provincial quality initiatives

Getting Started—Q1 Update

Health Links progressing from planning to recruiting patients



100 Health Links are planned in order to expand coverage to include all geographic areas

79 of 100 Health Links were actively recruiting patients by the end of Q1; The remaining Health Links continued with their planning

Data Source: Health Quality Ontario's Quality Improvement Reporting and Analysis Platform (QIRAP) – self-reported by Health Links

Health Links at a Glance – Q1 Update

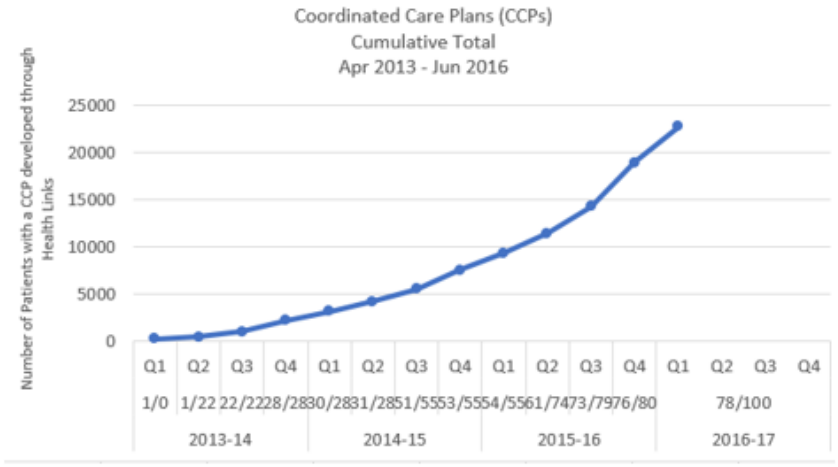
	Number of HLs actively recruiting patients	Number of Coordinated Care Plans (CCPs) completed	Number of patients connected to a Primary Care Provider (PCP)
2015-16 Q4	80	4,549* (reported by 76 of 80 Health Links)	5,711* (reported by 72 of 80 Health Links)
2016-17 Q1	79**	3,782 (reported by 78 of 80 Health Links)	3,668 (reported by 76 of 80 Health Links)
Cumulative total to date	79**	22,707	33,614

Note: This number was adjusted in Q1: CCPs previously recorded as 4,622; PCP previously recorded as 5,713. Adjusted due to error corrections.

****Note: This number was adjusted to reflect updated information from the ESC LHIN***

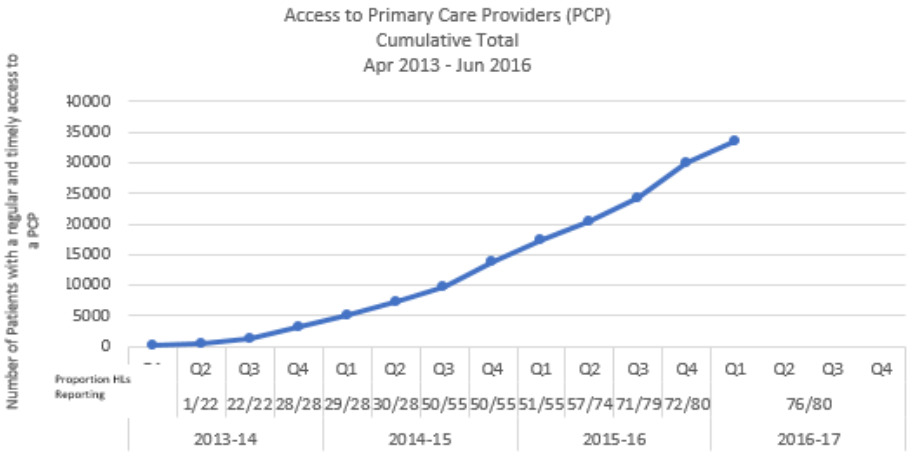
Impact of Health Links – Q1 Update

Coordinated Care Plans



22,707 complex patients have been provided with coordinated care plans through Health Links

Access to Primary Care



33,614 Health Links patients have been connected to regular and timely access to Primary Care

Data Source: Health Quality Ontario's Quality Improvement Reporting and Analysis Platform (QIRAP) – self-reported by Health Links

About Rob

Rob is a 54 year old gentleman with a history of hypertension, diabetes, high cholesterol, multiple heart attacks, and is developmentally delayed. He lived with his mother until she passed away and then moved into his own apartment as his siblings were unable to support him. Rob receives disability support and uses the local food bank. Rob rides the local transit bus from about 11 a.m. to 1 p.m. each day. A retired transit bus employee had been s helping with Rob's finances, but is unable to continue this support.

Between July 21 and October 24, 2014 Rob made 16 visits to the Emergency Department, resulting in 6 admissions. His last admission was from October 25, 2014 to March 23, 2015 (13 acute days + 137 alternate level of care days). Part of the reason for this extended hospital stay was that Rob was not taking his cardiac and diabetes medications and was not monitoring his blood sugar.

The hospital team waited for Developmental Supports Ontario to assist Rob and a referral was made to Hamilton West Health Link March 2015 where a Coordinated Care Plan was initiated.

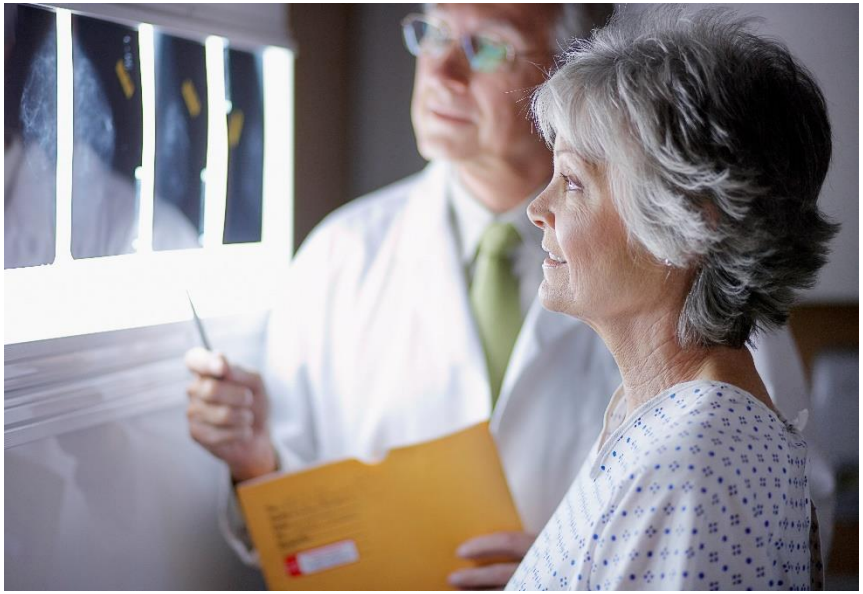
What matters most to Rob? "I want to stay in my apartment"

TOPIC	Sharing Ideas and Successes
Patient experience and/or engagement	• In Champlain LHIN, a Health Link Patient Experience survey was developed group comprised of patients (and representatives), caregivers, Health Links managers, the LHIN, and Health Quality Ontario. The survey was piloted an implementation with eight active Health Links. Preliminary results show pos from patients
Alignment to Patient's First	• In Mississauga Halton LHIN, the CCAC has geographically aligned care coord primary care • In Toronto Central LHIN, transition is underway to align Health Links to sub- primary care strategy • In Central West LHIN, there are increased linkages with primary care throug Link Resource Coordinators and alignment of dedicated CCAC care coordina primary care providers

e-Solution work	• In Central West LHIN, Health Links are engaged in using Ontario Tele-Medic Computer Video Conferencing (PCVC) for care conferencing as an alternative to in person care conferences.
	• In South East LHIN, South East Integrated Information Portal (SHIIP) continues to be rolled out
	  ○ At the end of Q1, there were 14 sites actively using this system
	  ○ Engagement with two other LHINs is underway to explore its use
	  ○ New features were recently added to enable Health Links to become an author of a CCP within the system and to enter CCP's, make changes to CCP's and to create a dashboard for indicators
	  ○ Migration of the tool to the Kingston General Hospital (KGH) from Brockville General Hospital is in final stages, and agreements for KGH to act as Health Information Network Provider are being reviewed
	  ○ The team is initiating the integration of post-Acute data, leveraging the Ontario Mental Health Reporting System (OMHRS), National Rehabilitation Reporting System (NRS), and Continuing Care Reporting System (CCRS) Canadian Institute

Discussion Topic	Comments from LHIN Health Link Leads
Is palliative/end of life care a focus of Health Links?	• 7 of 14 LHINs describe strong palliative care and Health Links ties; processes are in place to support palliative patients • 5 of 14 LHINs identified that palliative care work in Health Links is underway, or there are early discussions taking place • 2 of 14 LHINs identified that there was not currently a palliative focus and/or work underway is not tied to health links **Interpretation:** *Palliative care definitions and processes vary across the regions. There is consistency across LHINs that palliative patients are or will be eligible for Health Links (i.e., not excluded). More details will be available as regions continue exploring formal connections between Health Links and palliative care.* *Most LHINs have at least 1 Health Link working with Palliative Care patients. Some regions identified a palliative care commitment from the establishment of the Health Link through the business plan, while others introduced palliative care teams later on in the Health Link maturity, and have continued to engage providers and build capacity.*

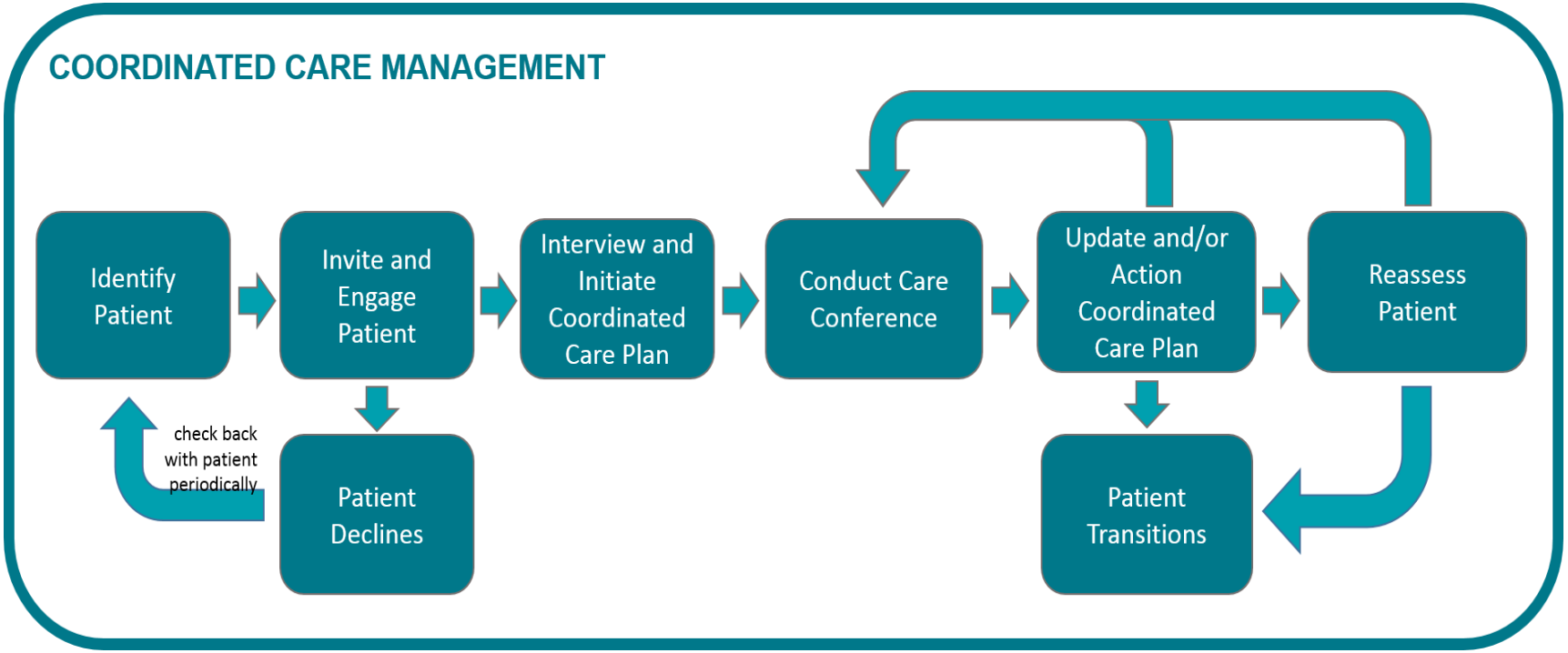
INNOVATIVE PRACTICES Coordinated Care Management



"If everyone would work together on my issues it would be better care. You know…by looking at the whole person and all the issues. Especially when I don't feel well enough to manage all the pieces all on my own".

Diane, Patient

COORDINATED CARE MANAGEMENT



http://www.hqontario.ca/Quality-Improvement/Our-Programs/Health-Links/Coordinated-Care-Management

COORDINATED CARE MANAGEMENT
Summary of Innovative Practices

Coordinated Care Management Step	Innovative Practice	Innovative Practice Assessment	Clinical Reference Group Recommendation for Spread
Identify Patient	Identify Health Link patients through clinical level assessments and data driven case finding methods at any point in the patient's healthcare journey.	EMERGING	Recommendation for provincial spread with reassessment using the Innovative Practices Evaluation Framework in 1 year (June 2017).
Invite and Engage	Provide patients with a single point of contact for all services included in their Coordinated Care Plan.	PROMISING	
	Use person--centred communication strategies to invite and engage the patient in coordinating his/her care with the Health Link team.	EMERGING	
	Use a comprehensive process and/or form that enables patients or substitute decision makers to provide consent for all elements of their coordinated care at one time (may be explicit or implied).	EMERGING	
Interview and Initiate Coordinated Care Plan	Implement the "Patients as Partners" Bundle with all patients in the Health Link.	EMERGING	

Improving Transitions between Hospital and Home

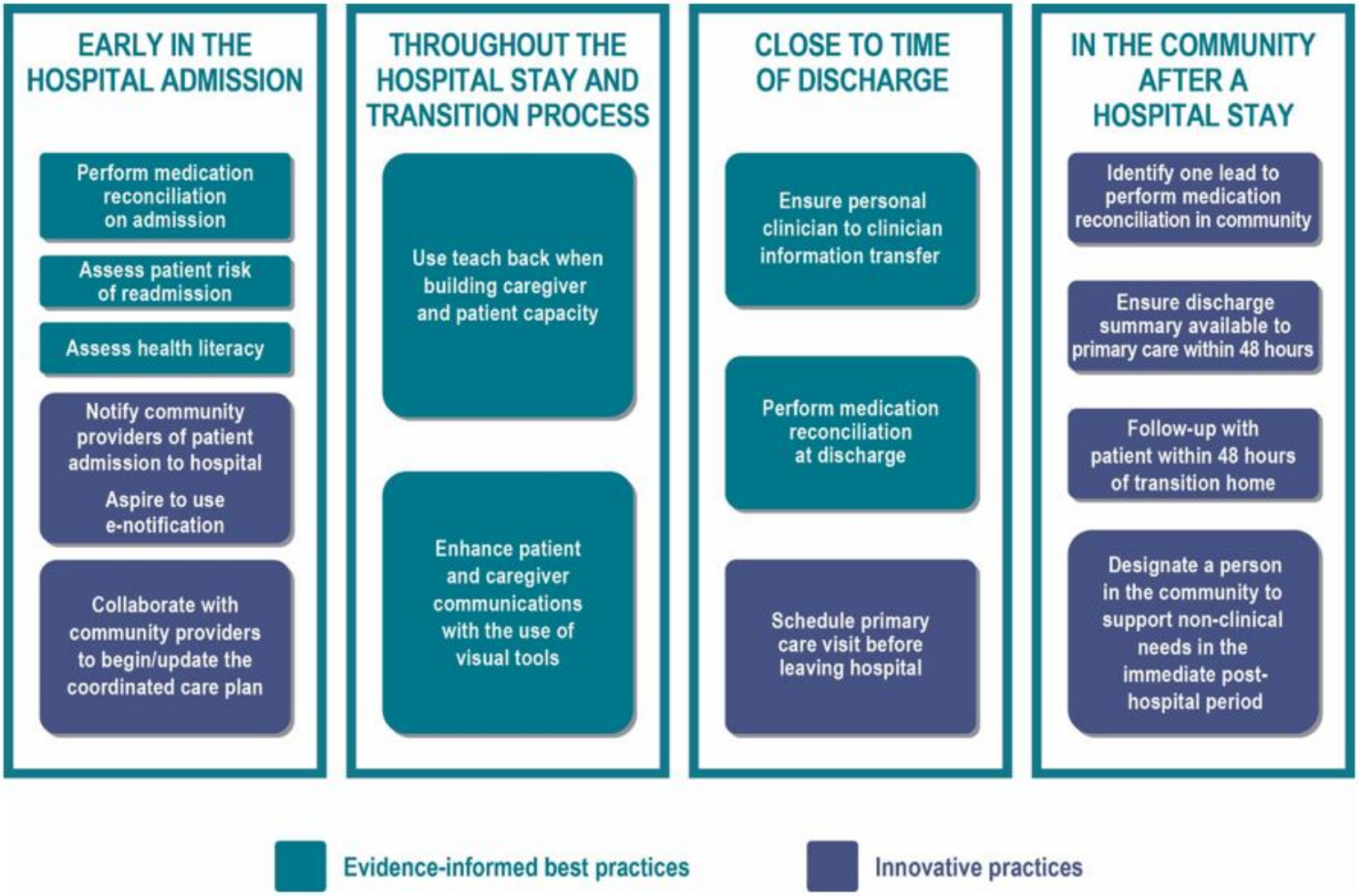
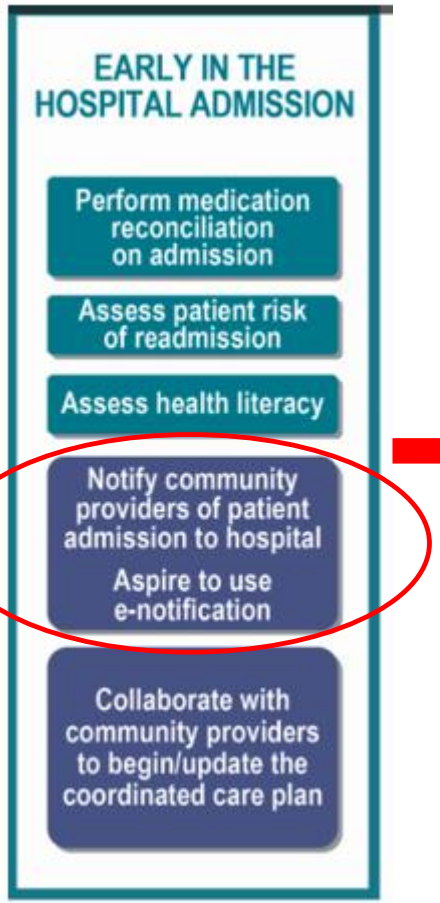


Figure 1: Practices to Improve Transitions Between Hospital and Home



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Transitions Between Hospital and Home

Early in the Hospital Admission:
Notify Community Providers of Patient Admission to Hospital
Aspire to Use e-Notification

Released September 2016

Patients who have multiple conditions and complex needs may require care across different health care settings (e.g., hospitals, family physicians, specialists etc.), which could potentially pose serious risks to their safety and quality of their care. Incomplete or inaccurate transfer of information, lack of comprehensive follow up care, and/or medication errors at the time of transition could be very dangerous and cause serious, preventable harm to patients. Furthermore, the impact of these risks may be intensified by patients and families who feel unprepared for self-management, and are unsure of how to access appropriate health care providers for follow-up.

Figure 1 is an outline of **innovative practices and evidence-informed best practices** that are designed to improve transitions between hospital and home.

The use of these practices varies significantly across the province. Teams are encouraged to prioritize the implementation of evidence-informed best practices before adoption of the innovative practices outlined in this document. When considering the adoption of innovations, *recommended practices* should be considered first, followed by *promising practices*, and then *emerging practices*.

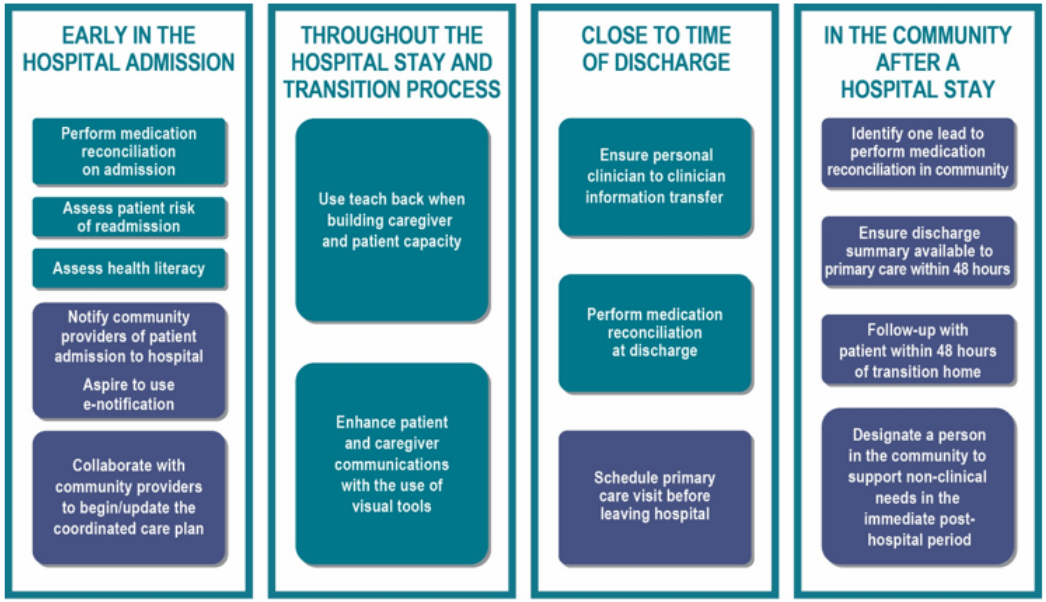
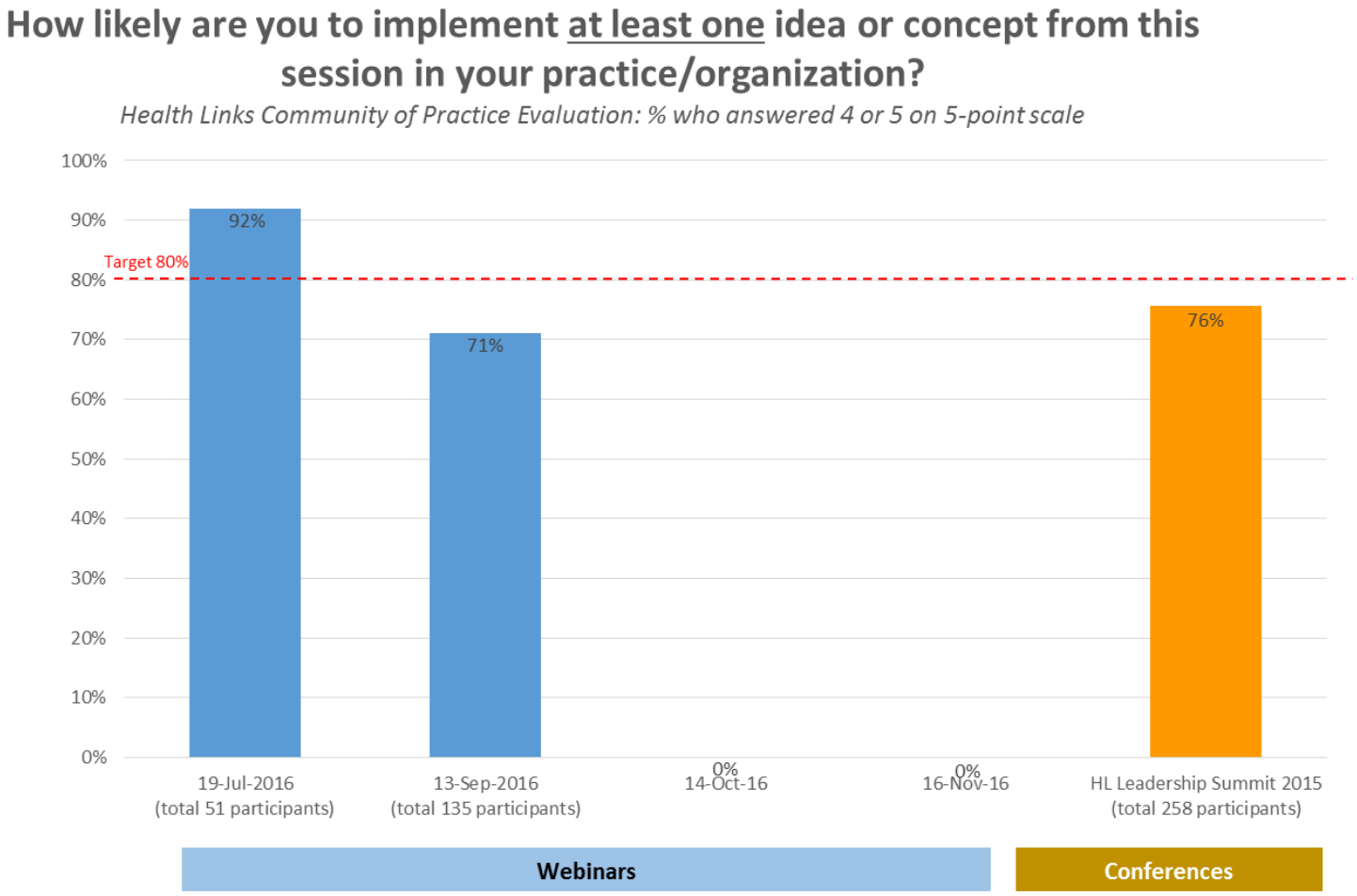


Figure 1: Practices to Improve Transitions Between Hospital and Home

HEALTH LINKS LEADERSHIP COMMUNITY OF PRACTICE

'Communities of practice can be defined as groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly'

Impact on Practice



COMING EVENTS

Transitions Between Hospital to Home

- Webinar PART ONE - **October 14th, 2016**
- Webinar PART TWO - **November 16th, 2016**

Health Quality Transformation 2016

October 20th, 2016. *Registration is open*

Special Thanks

Health Links: Progress to Date

Health Links Leadership Summit

September 28, 2016

Phil Graham

Ontario

Health Links – Your Achievements to Date

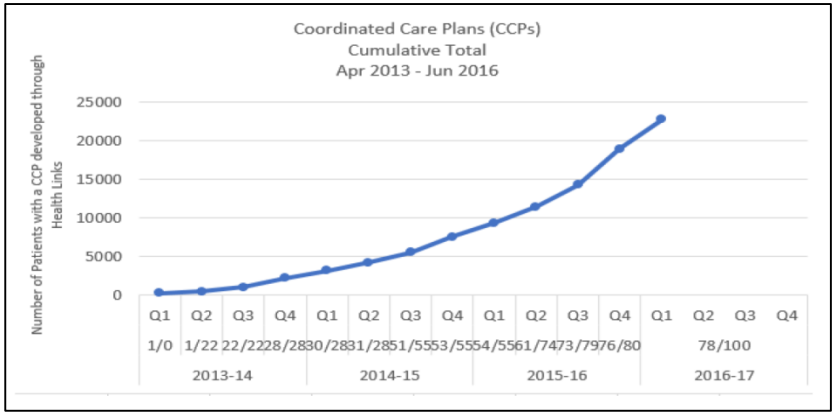
By the Numbers…..

Since the beginning:

82 provincially approved Health Links

22,707 coordinated care plans

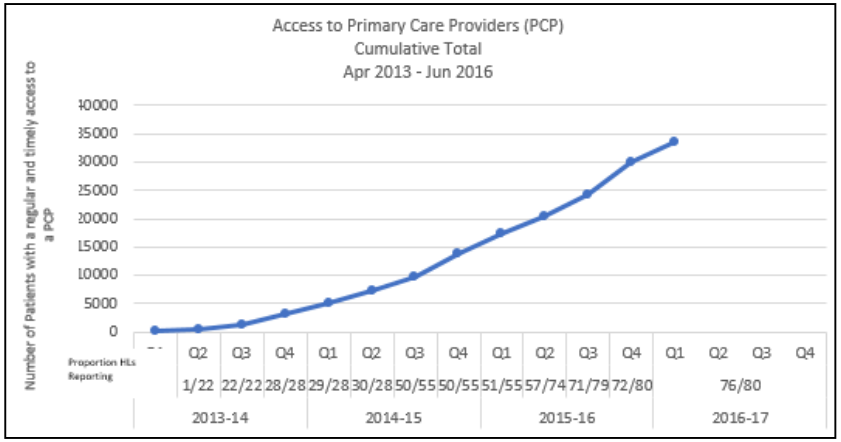
33,614 complex patients attached to primary care



As of the first quarter 2016/17:

3,782 new coordinated care plans

3,669 complex patients attached to primary care



Source: Health Quality Ontario's 2016-17 Q1 Report

Health Links - Key Learnings to Date

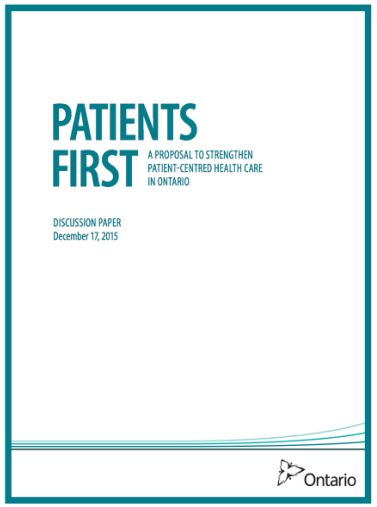
Health Links have ***challenged the status quo*** on **policy and program design** and taught important lessons:

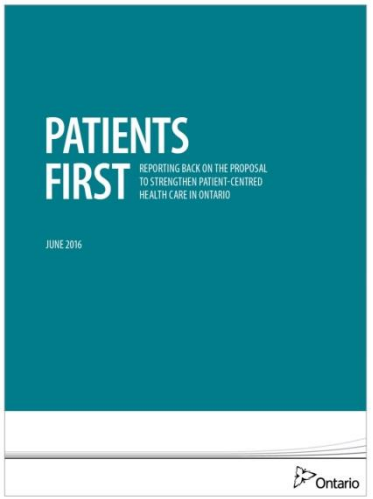
Enabling local innovation	• "Low Rules" and the need for built-in flexibility. • Sub-region focus and local ownership.
The Complexity of the Complex Patient	• Not a uniform group; ever-changing. • What makes is sick extends well beyond health care.
Patient-Centred Care in Action	• Does not 'fit' into traditional accountability models. • The best of the best practices.
Funding Model	• Ramp-up and maturity takes time; funding model should reflect this. • Gain sharing and sustainability – more to be done.

Health Links – Influence on Health System Transformation

HealthLinks

- Local focus through sub-regions.
- Local leadership and collaboration.
- Best practices in patient-centred care.
- Health equity and application of the social determinants of health.
- Patient, family and provider engagement





HealthLink
South West Health Links
Let's Make Healthy Change Happen

The Health Links Approach to Coordinated Care Planning: Working Better Together

Kelly Gillis, Senior Director, South West LHIN
September 28, 2016

Ontario

What guides the Coordinated Care Planning Approach in the South West LHIN?

What guides best practice in the Health Links approach to coordinated care planning?

Health Links Learning Collaborative

the ebd approach™

Community of Practice

Care Bundles (IHI)

HEIA Health Equity Impact Assessment

South West Self Management Program

Improving your health, together.

Education for patient and providers

Collaborating with other Initiatives = Success

- Told us he was “sick and tired of being sick and tired!”
- Experienced the Health Links Coordinated Care Planning approach through Connecting Care to Home
- His sons, wife, family physician, care coordinator, Telehomecare nurse, specialist and pharmacists were his care team

Ron

- Now, has confidence in himself to manage his symptoms and his medications
- He is still not feeling as well as he would like, but he is happy that he has not had to go back to the hospital

What has the early experience been for patients in the South West?

- Early data on a small group of patients/clients suggests:
  - Patients/Clients are confident/very confident in meeting **their** goals
  - Patients/Clients feel supported/very supported
  - Patients/Clients feel respected/very respected

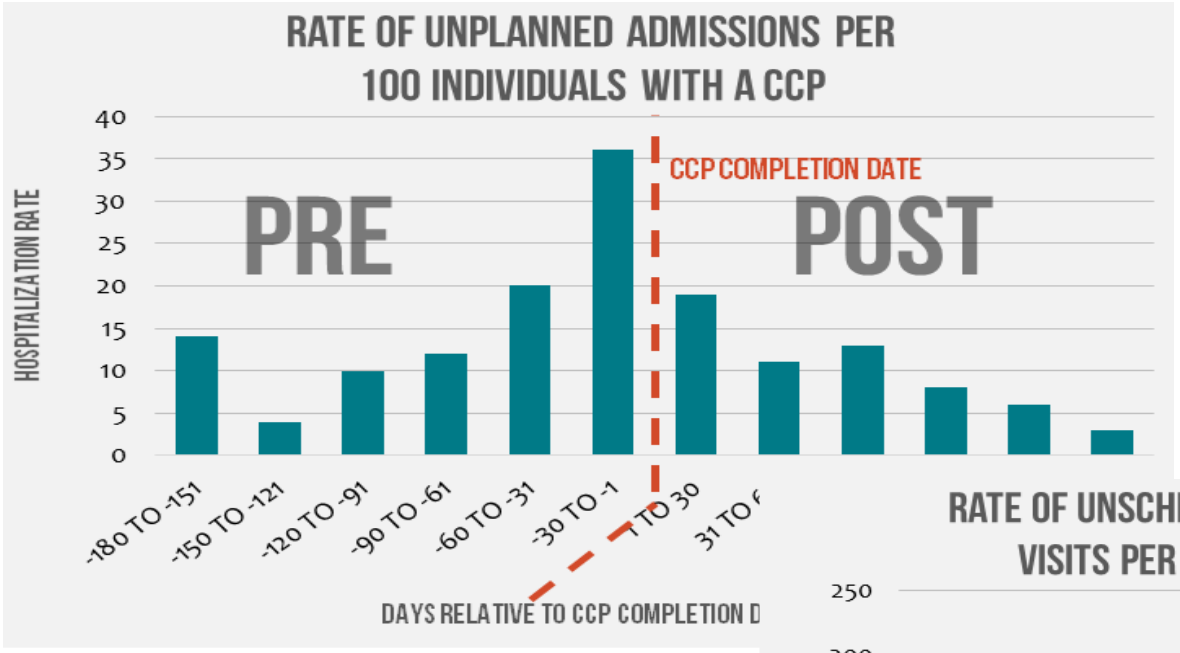
"I liked that there was representation from all the pieces of my care there and they told all their information; they all said helpful things"

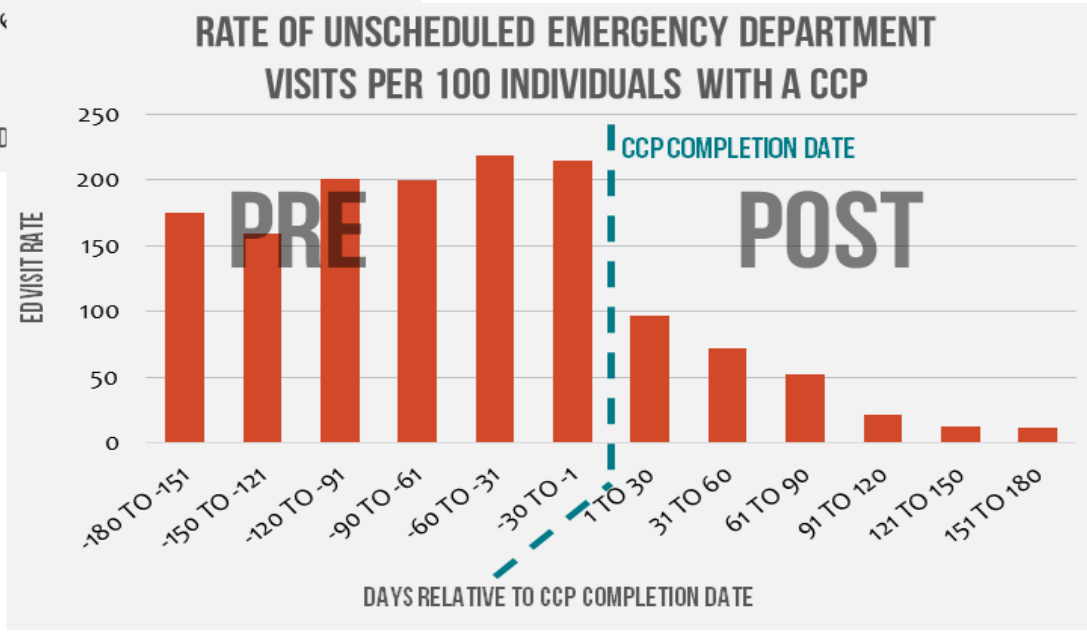
What has the early experience been for providers in the South West?

"After this coordinated care program, I have a much better idea of what the problems are and what supports are in place that hopefully will help avoid future poor communication and rapid deterioration. The program was a bit help to her - she had previously been feeling isolated and overwhelmed."

A London Physician

What has the early experience/impact been on hospital utilization in the South West LHIN?





How are we contributing at the provincial level?

- Participants in the LHIN Leads table comprised of Health LINKs Leadership from 14 LHINs
- Sharing promising practices with other LHINs
- Participating in Health Links IDEAS program

NETWORKING BREAK

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WELCOME

Concurrent Session A:
Coordinated Care Management
Room 206

Moderator: Lisa Bitonti - Bengert

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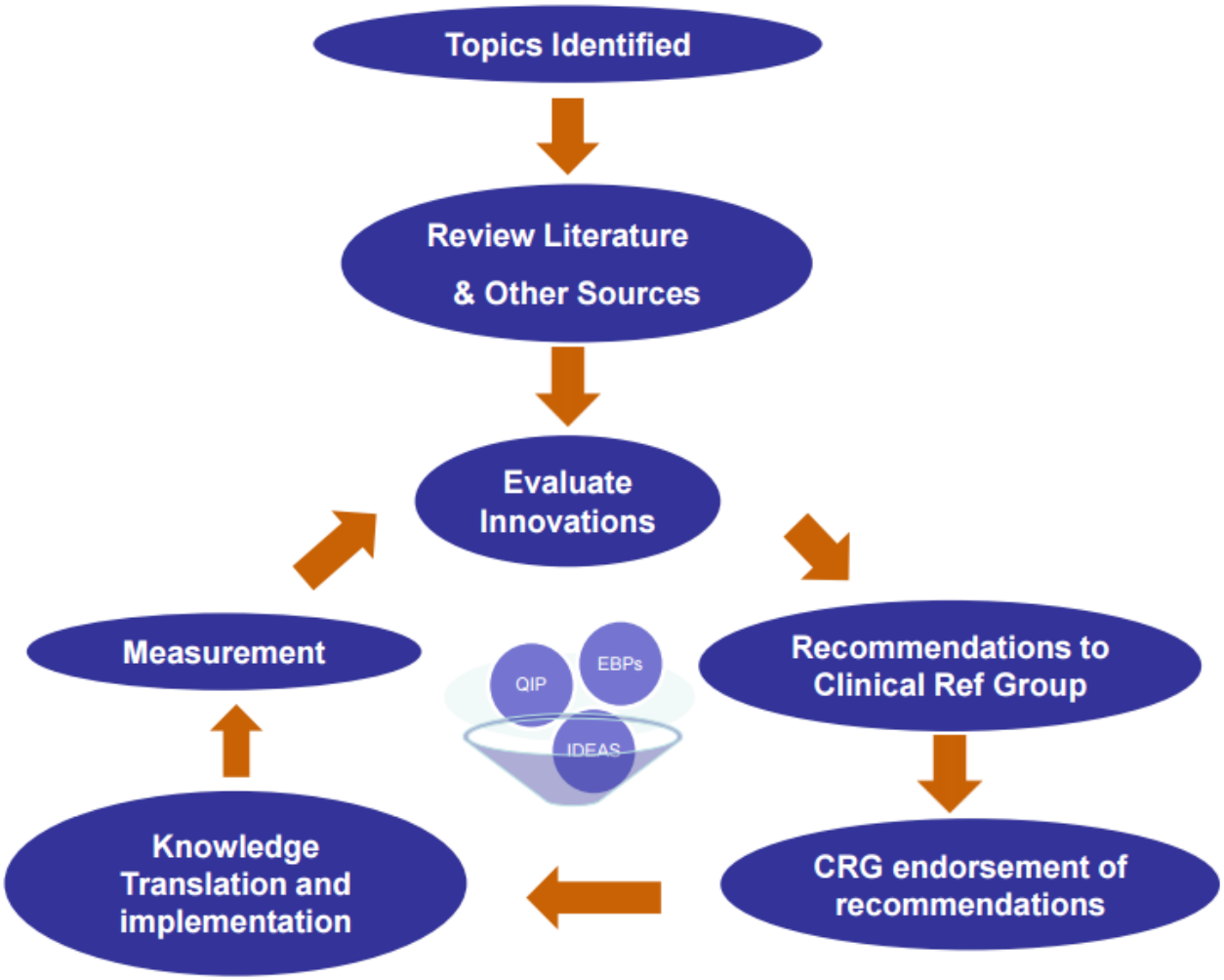
BREAKOUT SESSION OBJECTIVES

- Brief review of the Innovative Practices process for Coordinated Care Management & KTE resources
- Collaborate with colleagues, and hear about how these practices have been adopted in Health Links across the province
- Opportunity to participate in dialogue around the Innovative Practices and identify strategies to engage patients/caregivers in your Health Link

INNOVATIVE PRACTICES

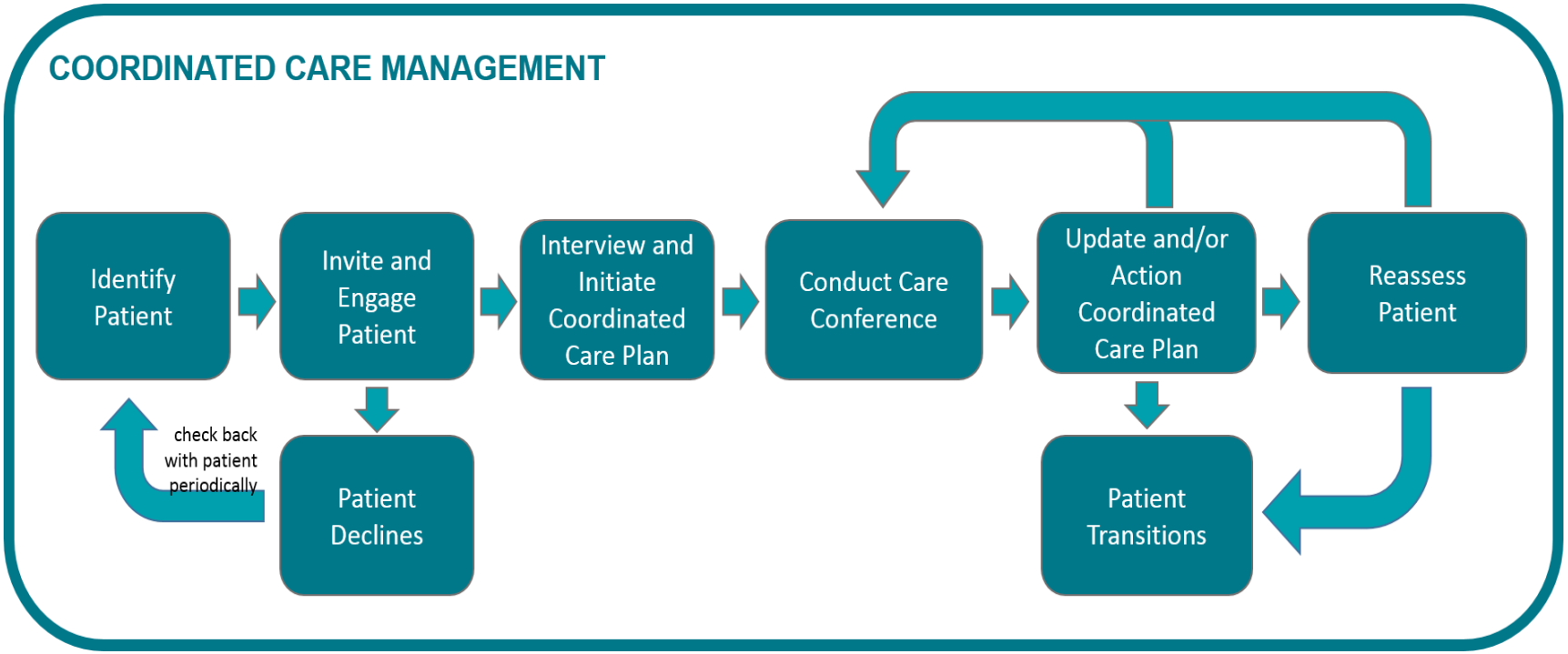


INNOVATIVE PRACTICES EVALUATION FRAMEWORK

	ASSESSMENT CRITERIA		
	Quality of the Evidence *The extent to which the evaluation of a practice has produced believable evidence.*	**Impact/Results** *The extent to which a practice demonstrates a positive impact and measurable impact on health outcomes and/or health care system performance.*	**Spread** *The extent to which the results of a practice have been replicated outside of its original setting.*
Recommended Practice	This practice is supported by moderate or high quality evidence, with consideration for other factors (value for money, contextualization by experts in the field, consideration of patient preferences, etc.) as well as deliberation by an expert advisory group.	Evaluations of the impact consistently produce results that demonstrate improvement on health outcomes or health care system performance.	The practice and its results have been successfully replicated in multiple settings beyond its original site.
Promising Practice	The practice has been evaluated through rigorous Quality Improvement or Implementation Science methodologies and will typically have shown statistically and clinically significant improvement, but there is still considerable residual uncertainty about effectiveness and/or value for money. The practice or theory behind the practice may have been published in a peer-reviewed academic journal or summarized formally and been presented as a peer-reviewed poster presentation at conferences or as part of a formal Learning Collaborative.	Preliminary evaluation through pilot studies, proof of concept or quality improvement methodologies indicates that the practice has made a positive impact on health outcomes or health care system performance. Outcome, process and balancing measures demonstrate statistical improvement over time according to accepted run chart or Shewhart chart rules.	This practice has been implemented in more than one setting outside of its place of origin, though results may vary given context.
Emerging Practice	The practice is being evaluated through quality improvement or implementation science methodologies. Data has been collected from observations, PDSA cycles, with increasing refinements. Early data may have been shared informally through Communities of Practice. Formal Quality Improvement evaluation is ongoing.	Results are emerging and reveal that the practice might have a positive impact on project-specific measures, cohort/ population outcomes, health-system processes or performance. Outcome, process and balancing measures demonstrate early signals of improvement according to accepted run chart or Shewhart chart rules.	The practice has been implemented only in the original setting. It has not yet been attempted in other settings but could theoretically be adopted in other settings.
Ineffective Practice	Available evidence does not support this practice or finds it ineffective.	The practice has made either no impact or has had a negative impact on health outcome or health care system performance.	The practice is not effective in any setting.

Overall Assessment:
A practice is assigned to an Overall Category (Recommended, Promising, Emerging, or Ineffective) if it meets two out of three evaluation criteria (from Quality of the Evidence, Impact/Results, and/or Spread columns). For practices that present with three differing assessment results, it is advised that the practice undergo further testing.

COORDINATED CARE MANAGEMENT



COORDINATED CARE MANAGEMENT
Summary of Innovative Practices

Coordinated Care Management Step	Innovative Practice	Innovative Practice Assessment	Clinical Reference Group Recommendation for Spread
Identify Patient	Identify Health Link patients through clinical level assessments and data driven case finding methods at any point in the patient's healthcare journey.	EMERGING	Recommendation for provincial spread with reassessment using the Innovative Practices Evaluation Framework in 1 year (June 2017).
Invite and Engage	Provide patients with a single point of contact for all services included in their Coordinated Care Plan.	PROMISING	
	Use person--centred communication strategies to invite and engage the patient in coordinating his/her care with the Health Link team.	EMERGING	
	Use a comprehensive process and/or form that enables patients or substitute decision makers to provide consent for all elements of their coordinated care at one time (may be explicit or implied).	EMERGING	
Interview and Initiate Coordinated Care Plan	Implement the "Patients as Partners" Bundle with all patients in the Health Link.	EMERGING	

COORDINATED CARE MANAGEMENT
Products at a Glance

Coordinated Care Management

Identify Patients: A Combination of Clinical and Data Driven Strategies

Released June 2016

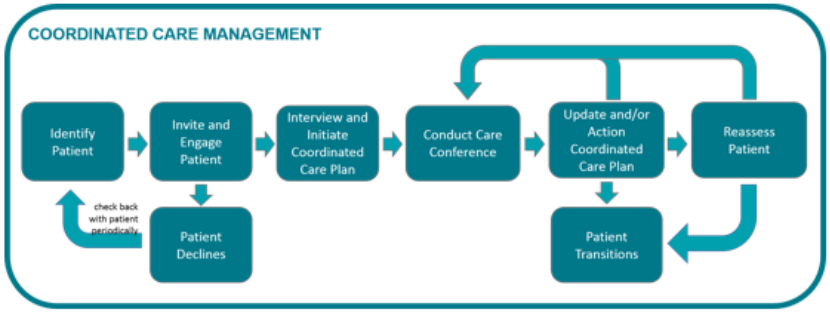


Figure 1: Approach to Coordinated Care Management

While this approach to Coordinated Care Management is generally accepted across the province, there is **significant variation in the *practices* within each process step**. Although each practice, organization, region, and/or Health Link may have varying areas of foci, the following collection of Innovative Practices and implementation supports are designed to **support teams to improve care for patients within the Health Link, and to support the ongoing alignment and advancement of consistent practices at a provincial level**. *For additional information on Quality Improvement, please visit: qualitycompass.hqontario.ca/portal/getting-started.*

Innovative Practice	Innovative Practice Assessment	Clinical Reference Group Recommendation for Spread
Identify Health Link patients through clinical level assessments and data driven case finding methods at any point in the patient's healthcare journey.	EMERGING	Recommendation for provincial spread with reassessment using the Innovative Practices Evaluation Framework in 1 year (June 2017).

Use clinical level patient identification mechanisms to support identification of patients during a service encounter. For example, as each patient presents to a health or wellness organization or program to receive care, the provider may identify that the patient may benefit from Health Links/Coordinated Care Management. To *further* support clinical decision making, the provider would then administer a standardized risk assessment tool, if indicated.

Use data driven case finding mechanisms to support prospective identification of Health Link patients using utilization data to identify complex patients. For example, triggers such as the number of visits to the emergency department, number/length of admissions to hospital within a specified time frame, or patients with specific diagnoses or conditions can be built into the electronic medical record or can be managed by targeted data extraction and analysis methods, to support the identification of potential Health Link patients.

Implementation

Steps for Implementation	Tools and Resources	Additional Enablers
1) The clinician uses the "Patient Identification Decision Support Tool" *(see Appendix A)* as part of their assessment, and administers the relevant risk assessment tool to support clinical decision making. 2) Provider organizations routinely apply data driven case finding methodologies to inform and support decision making. 3) Providers/organizations share data to ensure a comprehensive view of the population and patients who may benefit from Health Links.	• **Patient Identification Decision Support Tool** *(see Appendix A)* • **"Identifying Patients for Care Coordination"** Webinar (Health Quality Ontario Webinar; September 9, 2015); available at: *http://www.hqontario.ca/portals/0/documents/qi/health-links/ccp-webinar-step-1-en.pdf* • **Health Links Target Population** Webinar, Ministry of Health and Long-Term Care (NEED LINK) • **Guide to the Advanced Health Links Model**; Ministry of Health and Long-Term Care: *http://www.health.gov.on.ca/en/pro/programs/transformation/docs/Guide-to-the-Advanced-Health-Links-Model.pdf* • **LACE** *(Length of Stay, Acuity of Admission, Comorbidities, Emergency Room Visits)* • **PRA** *(Predictive Repetitive Admission)* • **DIVERT** *(Detection of Indicators and Vulnerabilities for Emergency Room Trips Scale)* • Data Sharing Agreements	Data Agreements may help facilitate the sharing of information and communication across organizations/sectors. If using Data Agreements, ensure that the data sharing agreement meets all legislative, legal, regulatory criteria.

Measurement

Quality Improvement Measures are used to help with monitoring progress to implement of a change and determining whether that change is leading to improvement. Just as a health care provider may monitor heart rate or blood pressure to determine a patient's response to treatment, collecting information relating to processes for the improved provision of care allows the team to know whether they are consistently moving towards a high reliability care environment. *For more information on **Quality Improvement and Measurement** please visit qualitycompass.hqontario.ca/portal/getting-started.*

The following measures have been developed to help to determine: 1) if the Innovative Practices relating to Coordinated Care Management are being ***implemented***; and 2) the impact of these practices on Health Links ***processes*** and the ***outcomes*** of care at the patient, population, or systems level.

Health Links, organizations, and/or providers that elect to implement one or more of the Coordinated Care Management Innovative Practices are **strongly encouraged to collect data on the associated measures and report them to Health Quality Ontario**. This will enhance analysis at the next review (June 2017), which will benefit all of the Health Links.

Measurement

(please see Appendix B for additional details)

Outcome Measure	Process Measures	Additional Information
% of patients identified as meeting Health Link criteria who are offered access to Health Links	For identification processes in at least one care setting (e.g., Hospitals, Community Care Access Centre, Primary Care),	• Recommend that Health Links collect and report data for a minimum of 3 months.

HEALTH LINK PANEL

Rapid Fire Descriptions of Select Practices

INVITE AND ENGAGE PATIENTS

Dan Harren

Central East Health Links

Central East Health Links

Coordinated Care Management: Invite and Engage Patients

Dan Harren, Project Manager
Central East Health Links

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Agenda

- Introduce the toolkit
- Care Planning Framework
- Central East Operational Guidelines
- "Coordinating Your Care" Document
- Developing Patient Goals
- Further Work

Central East Health Link Communities

HealthLink
Durham North East
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HealthLink
Durham West
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HealthLink
Scarborough North
Let's Make Healthy Change Happen

HealthLink
Scarborough South
Let's Make Healthy Change Happen

HealthLink
Peterborough
Let's Make Healthy Change Happen

HealthLink
Northumberland
Let's Make Healthy Change Happen

HealthLink
Haliburton County and City of Kawartha Lakes
Let's Make Healthy Change Happen

HealthLinks
Central East
Let's Make Healthy Change Happen

Ontario

Central East Communities Snapshot

As a geography, a Health Link defines the community of patients to whom efforts and resources will be directed.

The specific size and population for each Health Link is as follows:

Cluster	Health Link	Km2	%	Pop.	%	Density/k2
DURHAM	Durham West	449.1	2.7	320,400	21.1	713
	Durham North East	2,172.1	13.0	287,800	19.0	132
NORTHEAST	Haliburton County & City of Kawartha Lakes	7,893.8	47.3	89,310	5.9	11
	Northumberland	1,766.9	10.6	72,475	4.8	41
	Peterborough	4,215.2	25.3	135,085	8.9	32
SCARBOROUGH	Scarborough North	42.4	0.3	178,395	11.7	4,207
	Scarborough South	138.3	0.8	434,815	28.6	3,144
Totals		16,667.8	100.0	1,518,280	100.0	(Avg.) 91

Central East Health Links Toolkit

- The Central East Health Links Toolkit is for any individual/ organization that will be participating in coordinated care planning.

- The Central East Health Links Toolkit describes the Coordinated Care Planning Framework and provides front line staff with the tools and resources available to support the creation and maintenance of Coordinated Care Plans with an inter-disciplinary Care Team which includes the patient/caregiver as equal partners in the patients care.

Central East Health Links
Coordinated Care Planning Framework

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Legend
CCC = Coordinated Care Conference
CCP = Coordinated Care Plan

IDENTIFY AND INVITE	INTERVIEW	COORDINATED CARE CONFERENCE	INTERDISCIPLINARY TEAM MANAGEMENT
• Identify patient/ Patient self-identifies • Engage patient through discussions about coordinated care planning (including Coordinated Care Plan and Coordinated Care Conference) • Decide care team participants • Obtain consent	• Complete CCP demographics • Conduct patient interview/ explore patient's goals and needs	• Organize CCC • Invite care team • Conduct CCC • Determine action plan based on patient's expressed goals and needs • Determine Lead Care Coordinator • Determine communication and follow up strategy	• Lead Care Coordinator shares completed CCP and consent with care team/securely stores original copies • Proceed with actions and care as determined during CCC • Track/assess progress and update CCP as per the communication and follow up strategy

Central East Health Links Operational Guidelines

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Central East Health Links Operational Guidelines

Purpose: To provide a consistent high-level approach to the Coordinated Care Plan process across Health Link Communities in the Central East LHIN. These guidelines support the Central East Coordinated Care Planning Process maps and implementation of the CCP v.1.0.0. These guidelines were developed with input from all Health Link Steering/Design teams across Central East.

IDENTIFY and INVITE		
Topic	**Central East Health Links Recommendations**	**Care Coordination Tool (CCT) Considerations**

Identifying patients	**Target population is based on the definition as per MOHLTC**'s August 12th, 2015 webinar. The target will continue to focus on the top 5% of Ontario's Complex patients and the common process for identifying Health Links population include:
	• **Patients with four or more chronic/high cost conditions including:**
	  • **Vulnerable populations** (a focus on mental health and addictions conditions, palliative patients, and the frail elderly)
	  • **Economic characteristics** (low income, median household income, government transfers as a proportion of income, unemployment).
	  • **Social determinants** (housing, living alone, language, immigration, community and socials services etc.).
	  • Complex, high needs patients
	Note: Patients can be identified as complex and appropriate for Health Links based on clinical judgement as well.
	
	Examples of programs that lend themselves well to Health Links include:
	- Centre for Complex Diabetes Care
	- Hospital to Home
	- Family health team complex management programs
	- CMHA long term case management
	- CECCAC 1. Complex 2. GAIN 3. Palliative
		Same

Finding pre-existing Coordinated Care Plans (CCP)	**Patient/substitute decision maker (SDM) self-reports.**	**Initiating provider checks the viewing module for existing CCP.**
Agencies identified on the consent form	**All *active* care team members are identified.**	**Same**
When to identify the Lead Care Coordinator (CC)	**As soon as possible. When engaging the patient into coordinated care planning, the initiating provider should provide education on the role of the Lead CC and discuss who the patient feels, should or prefers to be the Lead CC.** **Lead CC should be:**	**As soon as possible as patient and team would benefit from having one consistent Lead CC to author the CCP in the CCT.**

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Coordinating Your Care

What is a Coordinated Care Plan?

A **Coordinated Care Plan** is a written or electronic plan that is created and maintained by you and your Care Team (i.e. family physician, care coordinators, specialists, community service providers, family member/caregiver, etc.) The Coordinated Care Plan outlines your short and long-term goals, coordination requirements, contact information, and who is responsible for each of your care needs.

How will this benefit me?

With a Coordinated Care Plan your journey through the health care system will be improved through more effective communication with your health care providers and more involvement in decision making. You will benefit by not having to continuously repeat your health story or answer the same questions every time you require care.

How is my information collected?

After one of your health care providers begins developing a Coordinated Care Plan, a meeting with you and/or caregiver and your Care Team (i.e. a Coordinated Care Conference) will be organized to ensure that everyone involved in your care is aware of your health care goals. Together, you and your Care Team will develop the Coordinated Care Plan and establish a plan to support you in achieving your health care goals.

Some items to consider when planning for a Coordinated Care Conference:

- Who is involved in your care?
- Which Care Team members should be invited to this meeting?
- Do you feel comfortable attending this meeting, or would you like a caregiver to attend?
- Suggested date, time and location of the meeting.

Consenting to a Coordinated Care Plan

To initiate a Coordinated Care Plan, you will be asked to sign a consent form which will allow your caregivers, health care providers and community service providers to share information regarding your care. The individuals and/or organizations chosen by you will be able to collect, use and share your personal health information.

Protecting your privacy

Any personal health information collected during the coordinated care planning process will be held in confidence by the participating organizations and maintained securely in accordance with the *Personal Health Information Protection Act* (PHIPA).

For more information about Central East Health Links and the Coordinated Care Plan
(905) 430-3308 Ext. 5871 or Toll-Free: 1-800-263-3877 Ext. 5871
Email: ce.healthlinks@ccac-ont.ca
http://www.centraleastlhin.on.ca

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Ontario

Developing Patient Goals

- Determine readiness to set goals
- Expressing needs and wants
- Simplify
- Develop an action plan
  - Informed by patient's goals
  - Include actions for Care Team members
  - Align patient goals with care needs/priorities

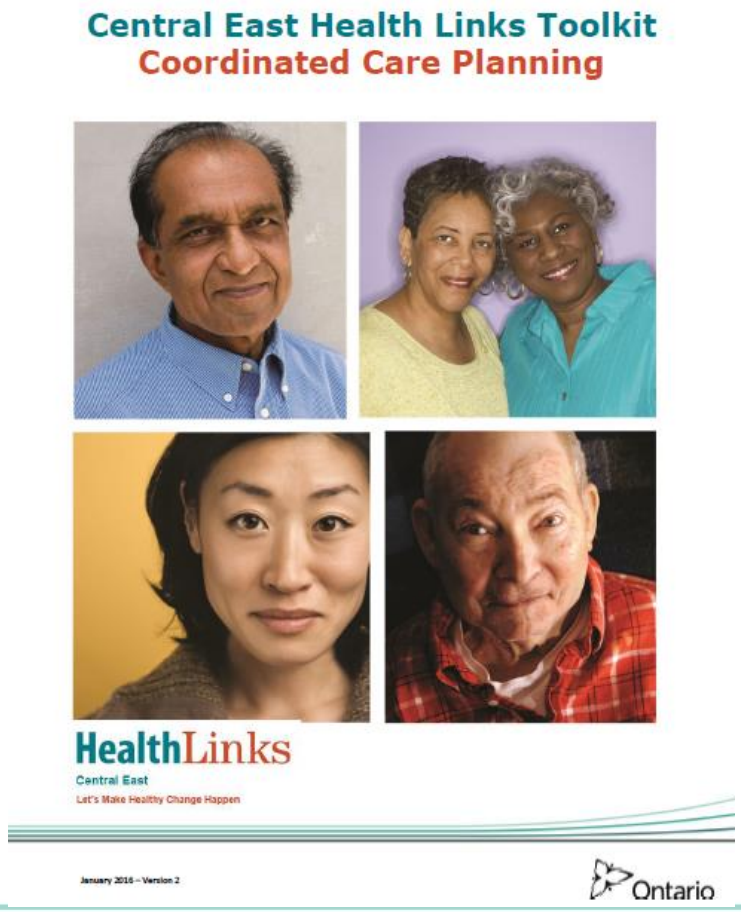
Example of an Action Plan

- **Example 1**
- Patient Goal: "I would like to be able to walk down the hall and back with my walker."
- Action Plan:
  - Providers: Physiotherapy to increase mobility; nursing to assess bladder control issues and bladder training techniques; OT referral to assess environment; nursing to evaluate pain
  - Patient/Caregiver: family assist patient with exercises

Further Work Being Done

- Consent form – less content on front page, less overwhelming.
- Scripts – using motivational interviewing, provoking questions.
- Care conferencing – streamlining.
- Patient stories – showing value, learning lessons.
- Toolkit Version 3

Where can I find the Toolkit?



Available for Download at:

http://healthcareathome.ca/centraleast/en/who/Documents/Health_Links/toolkit/CEHealthLinks-Toolkit-V2.pdf

For More Information

Daniel Harren, Project Manager, Central East Health Links

Daniel.Harren@ce.ccac-ont.ca

Central East Local Health Integration Network

www.centraleastlhin.on.ca

Ministry of Health and Long-Term Care

www.health.gov.on.ca

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Central East
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Ontario

PATIENTS AS PARTNERS

Chris Archer

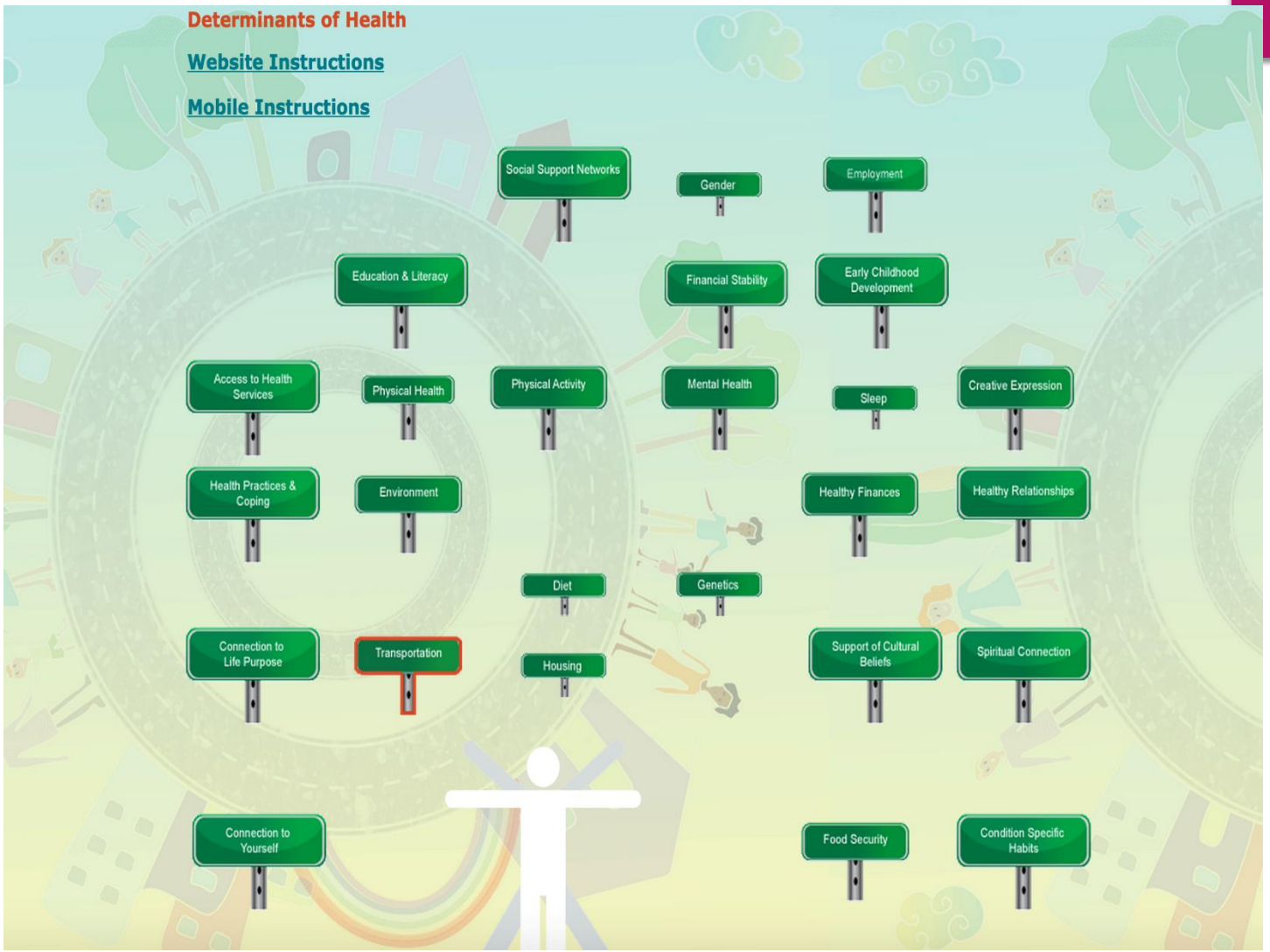
North Simcoe Community Health

Health Link Leadership Summit

PATIENTS AS PARTNERS

Patients as Partners

- Leadership to support patient centric care
- Training: Choices and Changes, Be Curious, Tell Me More
- Engagement: Location, Safety, Interactive Web Based Map, Be Well Survey, Transportation
- The Patient Story (Journey of small steps, Let them see success, Sense of belonging)
- Identifying the Care Team (Engagement, Primary Care, Community)
- Resource Binder and Care Plan


Determinants of Health
Website Instructions
Mobile Instructions
Social Support Networks
Gender
Employment
Education & Literacy
Financial Stability
Early Childhood Development
Access to Health Services
Physical Health
Physical Activity
Mental Health
Sleep
Creative Expression
Health Practices & Coping
Environment
Healthy Finances
Healthy Relationships
Diet
Genetics
Connection to Life Purpose
Transportation
Housing
Support of Cultural Beliefs
Spiritual Connection
Connection to Yourself
Food Security
Condition Specific Habits

Ontario Trillium Foundation / Fondation Trillium de l'Ontario
An agency of the Government of Ontario. Relève du gouvernement de l'Ontario.

Community Health and Wellbeing
Shift the conversation

"Be Well"
A Survey of Your Wellbeing

This survey covers many important aspects that affect your health and wellbeing. The information you provide will help your health organization develop a better understanding of what is keeping you well and what will help support the best health and wellbeing for everyone in Ontario. This survey will allow us to better connect people and communities with the programs, services and opportunities that can strengthen their health and wellbeing.

This survey will take approximately 16 - 20 minutes of your time.

Your Participation is Voluntary: Your participation is completely voluntary. You may stop participating, or refuse to answer any question. Your decision on whether or not to participate will not affect the nature of the services you receive at this organization.

Your Responses are Confidential: All information you provide will be kept completely confidential. Your name will not appear in any report or publication resulting from this survey. This is not a research activity. Your experiences will contribute to improving the quality and effectiveness of the services, programs and initiatives in your community health organization.

If you have any questions, or concerns please ask the receptionist or a staff member or contact The Association of Ontario Health Centres, Wendy Banh, Be Well Survey Coordinator, Tel: 416 236-2539 ext. 246 email: wendy@aohc.org

Thank you for your participation.

When completing the survey, please mark your selections by filling out the bubbles completely like this: ● (Correct)	Please do NOT fill the bubbles like this: ✓ ⊘ ⊗ (Incorrect)
When completing the survey, in the sections for written responses, please write inside the box like this: (Please specify): Please write inside the box like this. 5 years 2 months 9 days (Correct)	Please DO NOT write outside of the box like this: (Please specify): Please do NOT write outside of the box like this 5 years 2 months 9 days (Incorrect)

North Simcoe Community Navigation Team

Tracy Koval

(Nurse Navigator)

tracy.koval@chigamik.ca

Phone: 705-527-4154 Ext 205

Melodie Heels

Nurse Navigator

Melodie.heels@chigamik.ca

Phone: 705-527-4154 Ext 205

WWW.NSCHL.CA

IDENTIFYING PATIENTS

Kittie Pang

North East Toronto Health Link

Ontario
Toronto Central Local Health Integration Network

North East Toronto Health Link

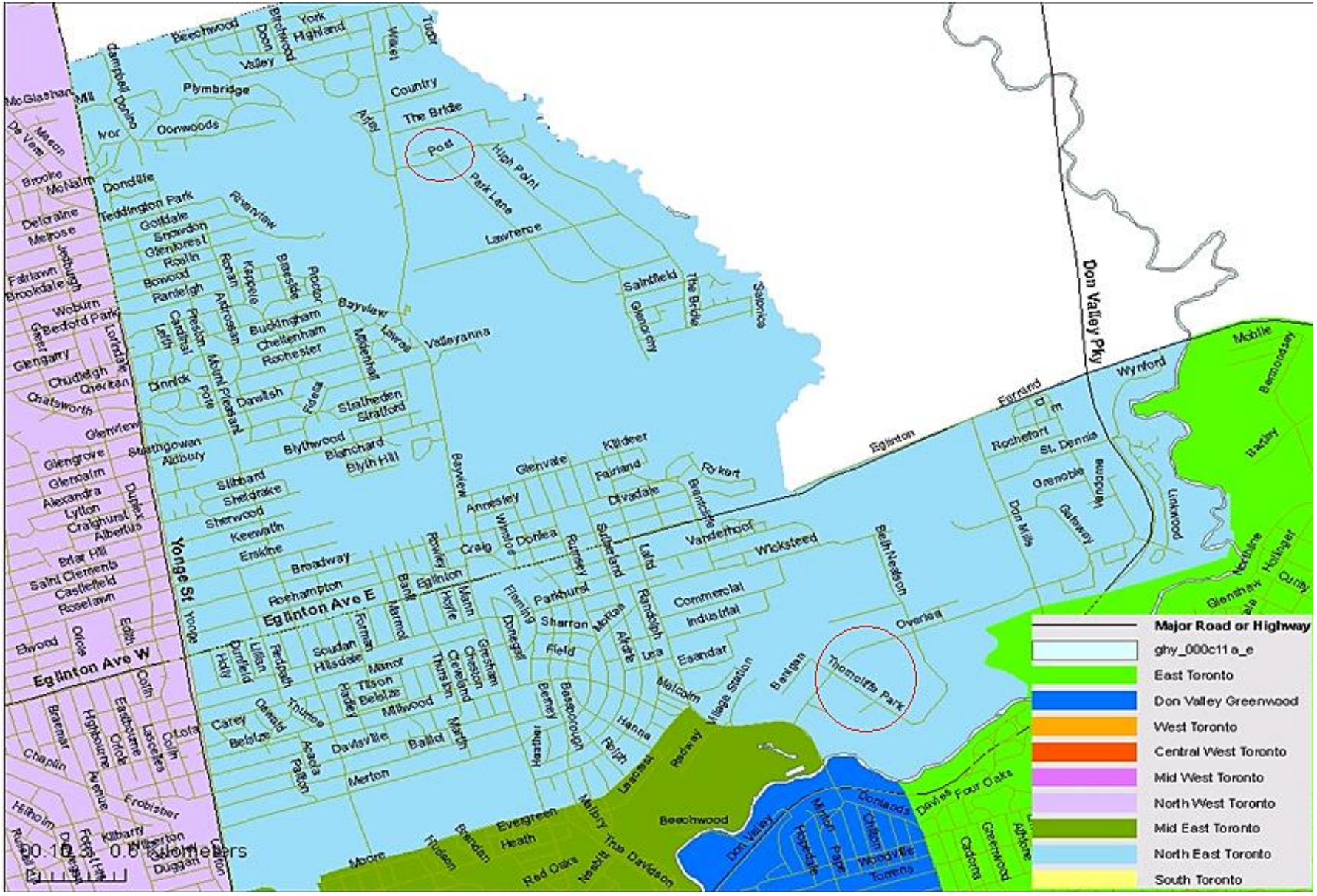
Identification, enrolment, flagging of patients

Presented by:
Kittie Pang, Project Coordinator, North East Toronto Health Link

HealthLinks

Ontario

North East Toronto Health Link



North East Toronto Health Link: Patients

ED Statistics - North East Toronto ED Visits during 6 months from 11/30/2014 to 5/31/2015	
Total # ED Visits:	364
Total Unique Patients:	71
Minimum # ED Visits:	4
Maximum # ED Visits:	24
Average # ED Visits:	5.1

Who would benefit from coordinated care management?

How do we identify complex patients?

How do we ensure equitable access?

Who is involved?

Senior Leadership

Clinical Lead

Patient's Advisory Council

Allied health staff

Community partners

Project management office

Privacy office

Legal office

And many more…

Better Care System

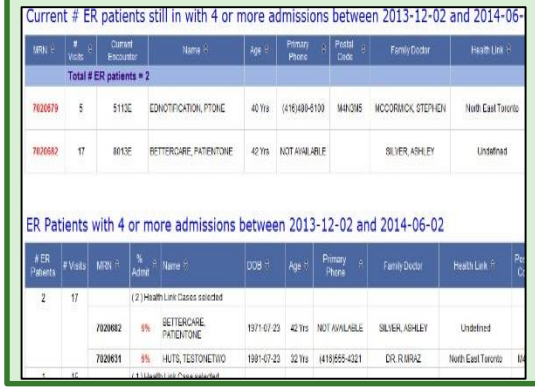
BETTER (Better Tracking and Triage for Equitable Resource) Care System

System Components

1) Identification & Reporting

Real-time identification & reporting based on predefined classification criteria (e.g. 4 ED visits in 6 months)

Online reports provide current patient status (e.g. location), drill-down visit level history, filtering/sorting


Current # ER patients still in with 4 or more admissions between 2013-12-02 and 2014-06-

MRN	# Visits	Current Encounter	Name	Age	Primary Phone	Postal Code	Family Doctor	Health Link
Total # ER patients = 2								
7020679	5	5113E	EDNOTIFICATION, PTONE	40 Yrs	(416)480-6100	M4N3M5	MCCORMICK, STEPHEN	North East Toronto
7020682	17	8013E	BETTERCARE, PATIENTONE	42 Yrs	NOT AVAILABLE		SILVER, ASHLEY	Undefined

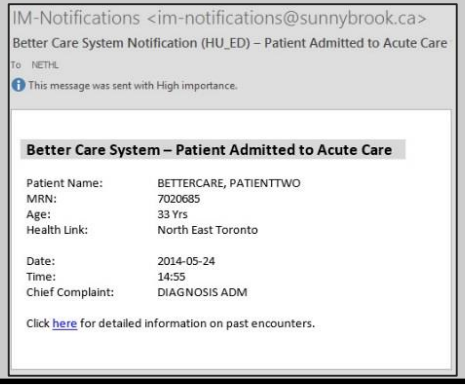
ER Patients with 4 or more admissions between 2013-12-02 and 2014-06-02

# ER Patients	# Visits	MRN	% Admit	Name	DOB	Age	Primary Phone	Family Doctor	Health Link
2	17			(2) Health Link Cases selected					
		7020682	9%	BETTERCARE, PATIENTONE	1971-07-23	42 Yrs	NOT AVAILABLE	SILVER, ASHLEY	Undefined
		7020631	9%	HUTS, TESTONETWO	1991-07-23	22 Yrs	(416)555-4321	DR, R MRAZ	North East Toronto

2) Notification

Real-time notification (for classified patients) of ED arrival, inpatient admission and ED/inpatient discharge.

Includes name, MRN, age, associated Health Link, date/time of event, and link to detailed visit-level report


IM-Notifications <im-notifications@sunnybrook.ca>
Better Care System Notification (HU_ED) – Patient Admitted to Acute Care
To NETHL
This message was sent with High importance.

Better Care System – Patient Admitted to Acute Care

Patient Name: BETTERCARE, PATIENTTWO
MRN: 7020685
Age: 33 Yrs
Health Link: North East Toronto

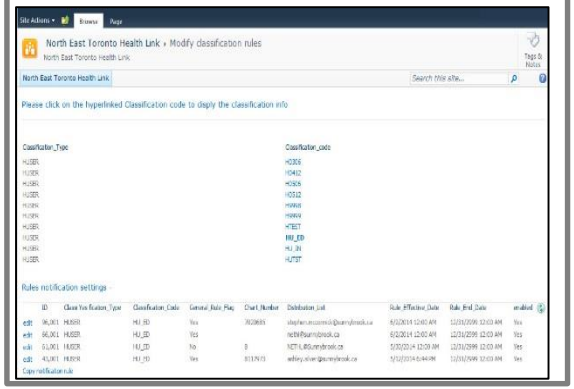
Date: 2014-05-24
Time: 14:55
Chief Complaint: DIAGNOSIS ADM

Click here for detailed information on past encounters.

3) Administrative Functions

Provides designation users (i.e. NETHL Program) to update classification rules & notification settings (e.g. distribution lists)

Updates can be made at the general rule level or at the patient level.
All system updates are logged for auditing purposes.


North East Toronto Health Link › Modify classification rules

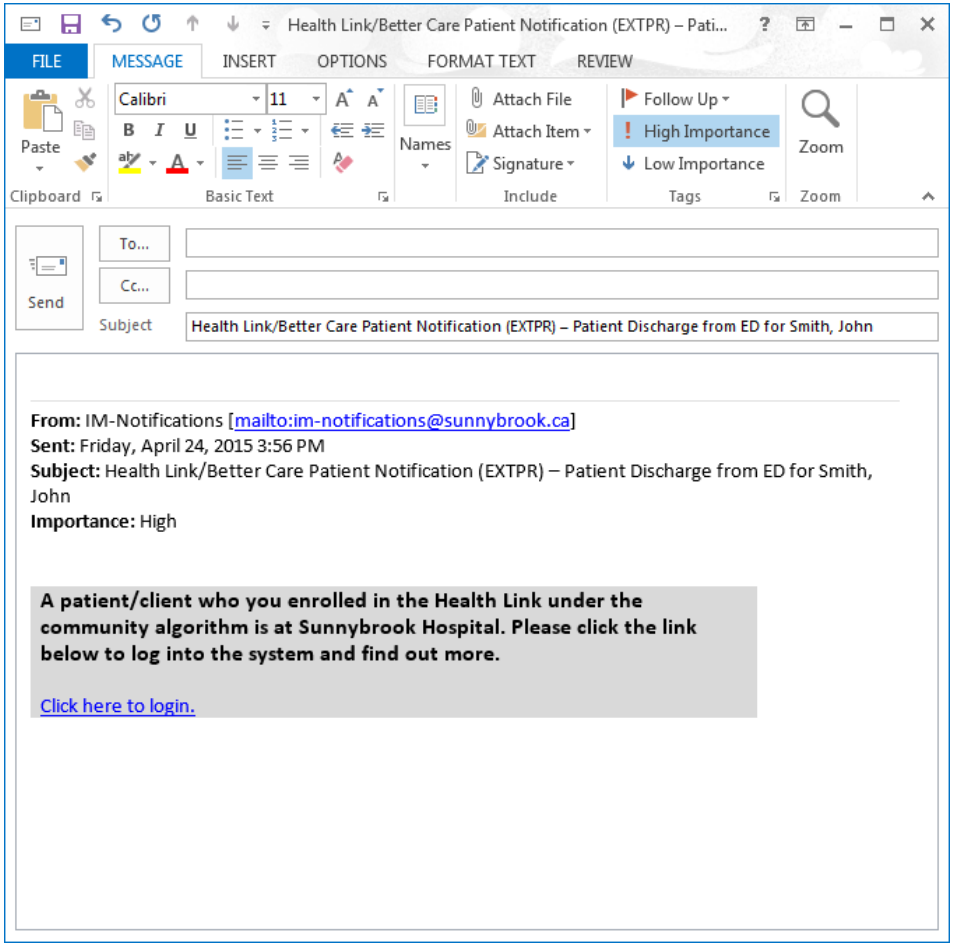
Better Care System Overview

Notification & Reporting Workflow

Step 1: The patient arrives to Sunnybrook and has trigger algorithm (4 or more ED visits/ 3 or more inpatients admissions within last 6 months) or is enrolled by community algorithm

Better Care System Overview

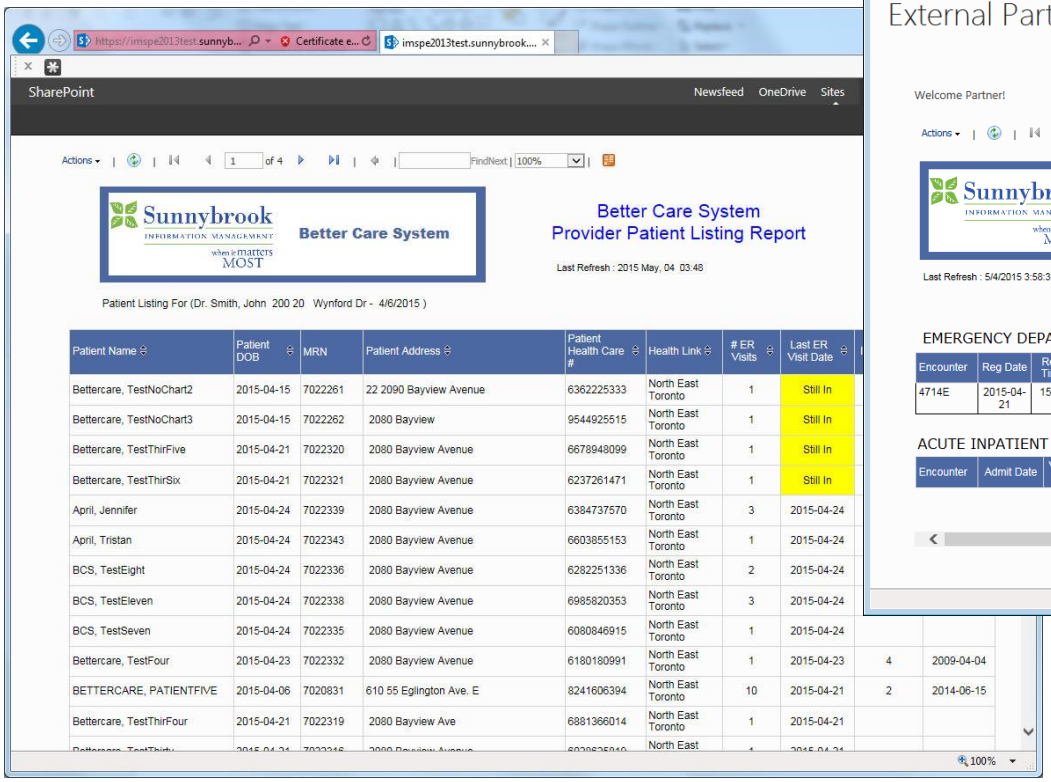
Notification & Reporting Workflow



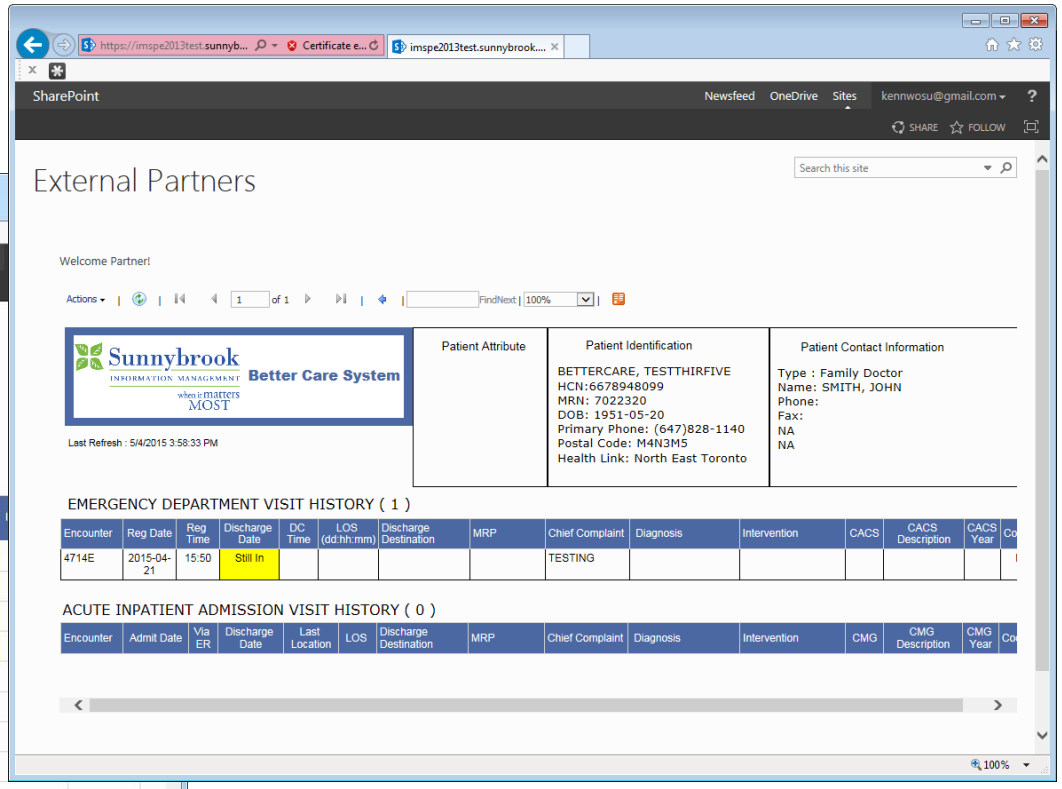
Step 2: Provider/Care Team immediately receives an email notification that one of their patients arrived to Sunnybrook.

Better Care System Overview

Notification & Reporting Workflow



Patient Name	Patient DOB	MRN	Patient Address	Patient Health Care #	Health Link	# ER Visits	Last ER Visit Date	
Bettercare, TestNoChart2	2015-04-15	7022261	22 2090 Bayview Avenue	6362225333	North East Toronto	1	Still In	
Bettercare, TestNoChart3	2015-04-15	7022262	2080 Bayview	9544925515	North East Toronto	1	Still In	
Bettercare, TestThirFive	2015-04-21	7022320	2080 Bayview Avenue	6678948099	North East Toronto	1	Still In	
Bettercare, TestThirSix	2015-04-21	7022321	2080 Bayview Avenue	6237261471	North East Toronto	1	Still In	
April, Jennifer	2015-04-24	7022339	2080 Bayview Avenue	6384737570	North East Toronto	3	2015-04-24	
April, Tristan	2015-04-24	7022343	2080 Bayview Avenue	6603855153	North East Toronto	1	2015-04-24	
BCS, TestEight	2015-04-24	7022336	2080 Bayview Avenue	6282251336	North East Toronto	2	2015-04-24	
BCS, TestEleven	2015-04-24	7022338	2080 Bayview Avenue	6985820353	North East Toronto	3	2015-04-24	
BCS, TestSeven	2015-04-24	7022335	2080 Bayview Avenue	6080846915	North East Toronto	1	2015-04-24	
Bettercare, TestFour	2015-04-23	7022332	2080 Bayview Avenue	6180180991	North East Toronto	1	2015-04-23	4	2009-04-04
BETTERCARE, PATIENTFIVE	2015-04-06	7020831	610 55 Eglington Ave. E	8241606394	North East Toronto	10	2015-04-21	2	2014-06-15
Bettercare, TestThirFour	2015-04-21	7022319	2080 Bayview Ave	6881366014	North East Toronto	1	2015-04-21		



Encounter	Reg Date	Reg Time	Discharge Date	DC Time	LOS (dd:hh:mm)	Discharge Destination	MRP	Chief Complaint	Diagnosis	Intervention	CACS	CACS Description	CACS Year	Co
4714E	2015-04-21	15:50	Still In					TESTING						

Encounter	Admit Date	Via ER	Discharge Date	Last Location	LOS	Discharge Destination	MRP	Chief Complaint	Diagnosis	Intervention	CMG	CMG Description	CMG Year	Co

Step 3: Provider logs into Better Care to see details regarding the patient encounter. A history of past visits (since enrolment) is also available.

Better Care System Components

Information Management:

1. **Scope and build a portal** where patient information could safely be accessed by NETHL partners and care team, including required administrative functions
2. Work with CPO to **ensure compliance with all privacy policies**, including completion of a Privacy Impact Assessment
3. **Develop Services Agreement for Better Care users** with CPO and Legal Office

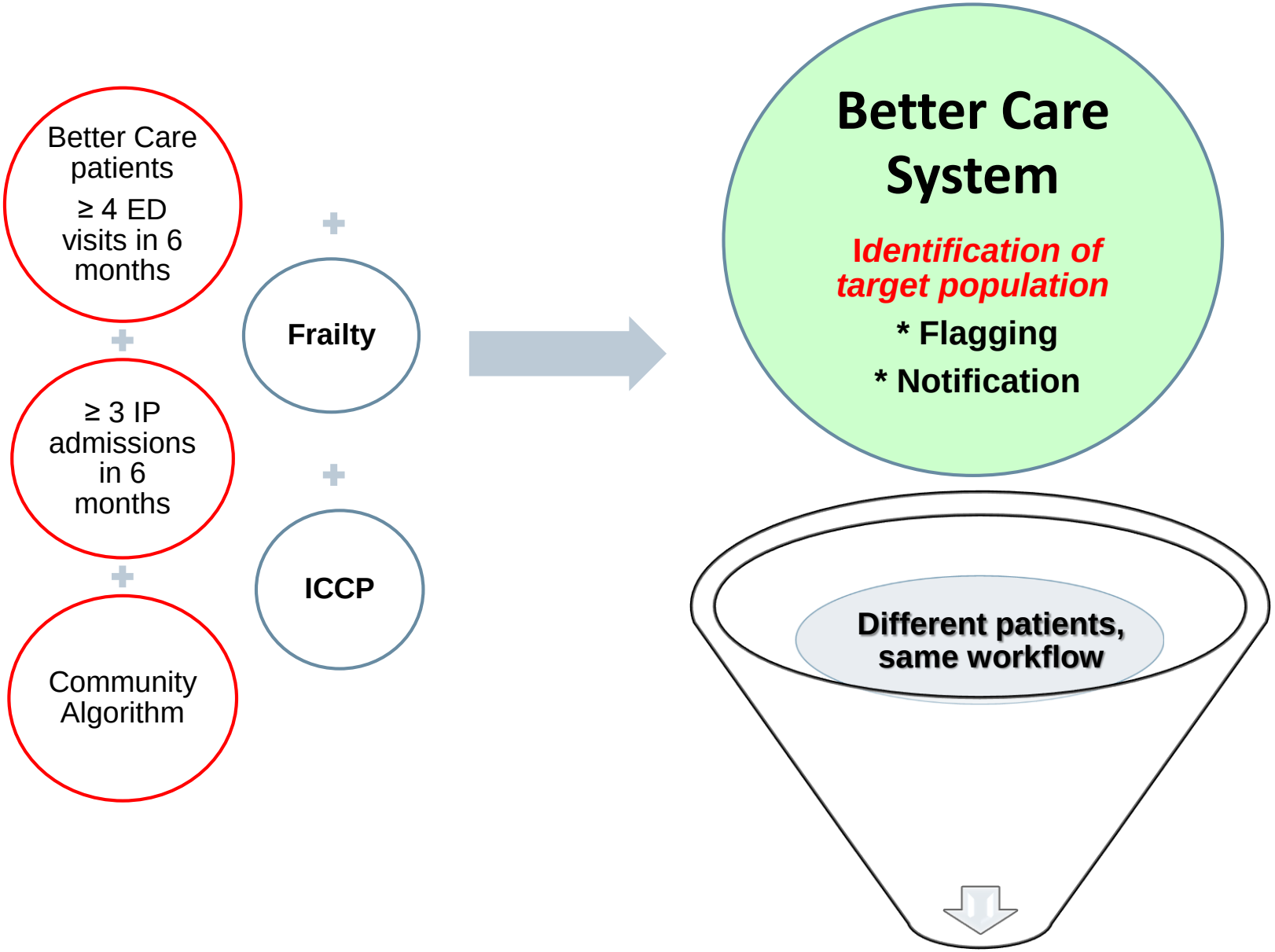
Partner Engagement:

1. **Develop a communication plan for NETHL community and end users**, including explanation on various agreements and system functionality
2. **Develop training and enrolment packages** for partners

Privacy and Consent:

1. **Work with NETHL partners to understand privacy protocol and consent for signing up patients**

Better Care System



Impact on Care

Equitable Access

- Multiple ways to enroll in program
- Not limited to just HL partners but anyone that fits the algorithm

Increased efficiency

- Increase efficiency at the identification level by using the automated system
- Care team can quickly assess potential patients by reviewing patient history

Real-time communication

- Real-time secure notifications for up-to-date information within the circle of care
- Provider can quickly adjust their care if required

Lessons Learned

Lessons learned on:

Assessment

Change Management

Workflow Integration

Program Evaluation

Privacy

Source: Smart Health Messaging

Appreciation

North East Toronto Health Link
Patients' Advisory Council

- Executive Lead: Malcolm Moffat, EVP Programs, Sunnybrook
- Medical Lead: Dr. Jocelyn Charles, Chief, Family & Community Medicine, Sunnybrook
- Administrative Lead: Lisa Priest, Director, NETHL
- Dr. Carole Cohen, Chair, Better Care Committee

NETHL Program Office:
- Linda Jones-Paul
- Kittie Pang
- Adwoa Rascanu
- Ashma Mohamed

Better Care Project Team
- Richard Mraz
- Navin Goocool
- Ashley Silver
- Ken Nwosu
- Anita Chan
- Mark Fu

NETHL Partners
- Anne Johnston Health Station
- Bellwoods Centres for Community Living
- Don Mills Family Health Team
- Flemingdon Health Centre
- Providence Healthcare
- Scarborough Academic Family Health Team
- Sunnybrook Academic Family Health Team
- Thorncliffe Neighbourhood Office
- Toronto Rehab Toronto
- Toronto Paramedic Services (EMS)
- TC-CCAC
- SPRINT Senior Care

- Kurt Rose, Director, Corporate Strategy & Information, Sunnybrook
- Jeff Curtis, Jason Raqueno, Privacy Office, Sunnybrook
- Rebecca Morison, Legal Counsel, Sunnybrook

TABLE ACTIVITY

Part 1 – Strategies to engage patients/caregivers

Part 2 – Enablers and barriers to implementation of innovative practices

Part 3 – Adoption of innovative practices

WELCOME

Concurrent Session B:
Transitions between Hospital and Home
Room 205

Moderator: Lee Fairclough

#HLSummit2016

BREAKOUT SESSION OBJECTIVES

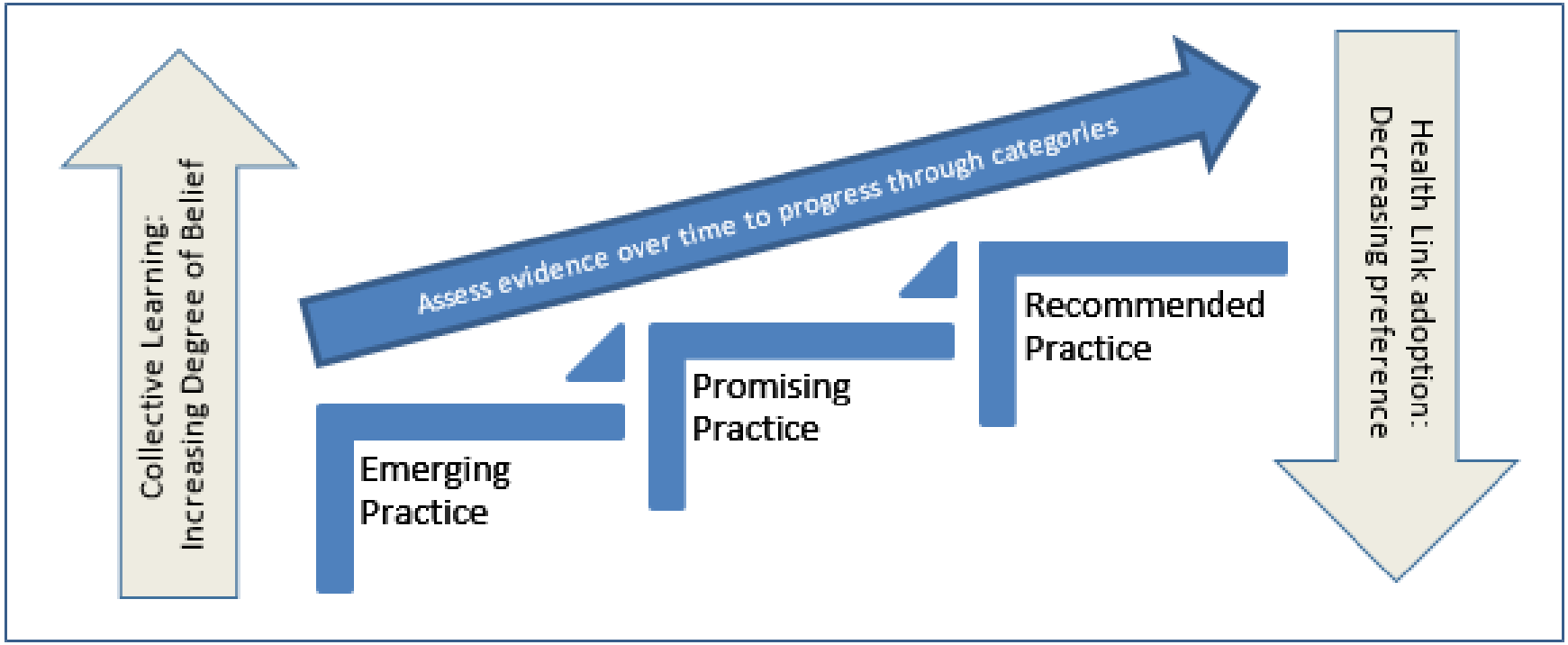
- Brief review of the Innovative Practices Process for Transitions Between Hospital to Home & KTE resources
- Collaborate with colleagues, and hear about how these practices have been adopted in Health Links across the province
- Opportunity to participate in dialogue around the Innovative Practices and identify strategies to engage patients/caregivers in your Health Link

INNOVATIVE PRACTICES EVALUATION FRAMEWORK

	ASSESSMENT CRITERIA		
	Quality of the Evidence *The extent to which the evaluation of a practice has produced believable evidence.*	**Impact/Results** *The extent to which a practice demonstrates a positive impact and measurable impact on health outcomes and/or health care system performance.*	**Spread** *The extent to which the results of a practice have been replicated outside of its original setting.*
Recommended Practice	This practice is supported by moderate or high quality evidence, with consideration for other factors (value for money, contextualization by experts in the field, consideration of patient preferences, etc.) as well as deliberation by an expert advisory group.	Evaluations of the impact consistently produce results that demonstrate improvement on health outcomes or health care system performance.	The practice and its results have been successfully replicated in multiple settings beyond its original site.
Promising Practice	The practice has been evaluated through rigorous Quality Improvement or Implementation Science methodologies and will typically have shown statistically and clinically significant improvement, but there is still considerable residual uncertainty about effectiveness and/or value for money. The practice or theory behind the practice may have been published in a peer-reviewed academic journal or summarized formally and been presented as a peer-reviewed poster presentation at conferences or as part of a formal Learning Collaborative.	Preliminary evaluation through pilot studies, proof of concept or quality improvement methodologies indicates that the practice has made a positive impact on health outcomes or health care system performance. Outcome, process and balancing measures demonstrate statistical improvement over time according to accepted run chart or Shewhart chart rules.	This practice has been implemented in more than one setting outside of its place of origin, though results may vary given context.
Emerging Practice	The practice is being evaluated through quality improvement or implementation science methodologies. Data has been collected from observations, PDSA cycles, with increasing refinements. Early data may have been shared informally through Communities of Practice. Formal Quality Improvement evaluation is ongoing.	Results are emerging and reveal that the practice might have a positive impact on project-specific measures, cohort/ population outcomes, health-system processes or performance. Outcome, process and balancing measures demonstrate early signals of improvement according to accepted run chart or Shewhart chart rules.	The practice has been implemented only in the original setting. It has not yet been attempted in other settings but could theoretically be adopted in other settings.
Ineffective Practice	Available evidence does not support this practice or finds it ineffective.	The practice has made either no impact or has had a negative impact on health outcome or health care system performance.	The practice is not effective in any setting.

Overall Assessment:
A practice is assigned to an Overall Category (Recommended, Promising, Emerging, or Ineffective) if it meets two out of three evaluation criteria (from Quality of the Evidence, Impact/Results, and/or Spread columns). For practices that present with three differing assessment results, it is advised that the practice undergo further testing.

INNOVATIVE PRACTICES EVALUATION FRAMEWORK



Assessing Innovative Practices

Transitions Between Hospital and Home

An important part of providing coordinated care to patients is improving patient transitions within the system to help ensure patients receive more responsive care that addresses their specific needs.

Overview of Innovative Practices
Transitions Between Hospital & Home

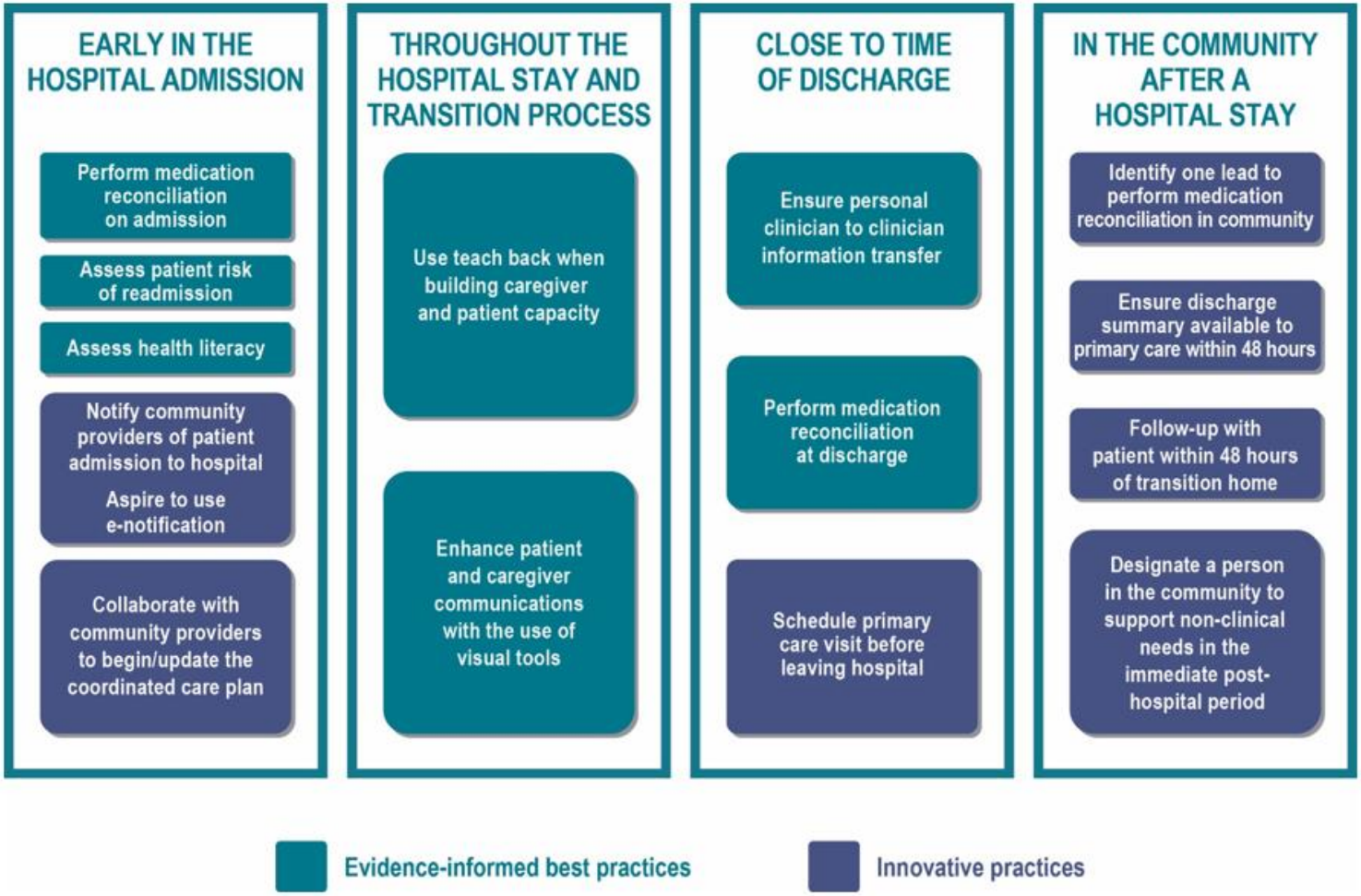


Figure 1: Practices to Improve Transitions Between Hospital and Home

TRANSITIONS BETWEEN HOSPITAL & HOME
Products at a Glance

Transitions Between Hospital and Home

In the Community Post Hospital Stay:
Ensure Discharge Summary Available to Primary Care within 48 hours *Released September 2016*

Patients who have multiple conditions and complex needs may require care across different health care settings (e.g., hospitals, family physicians, etc.), which could potentially pose serious risks to their safety and quality of their care. Incomplete or inaccurate transfer of information, lack of comprehensive follow up care, and/or medication errors at the time of transition could be very dangerous and cause serious, preventable harm to patients. Furthermore, the impact of these risks may be intensified by patients and families who feel unprepared for self-management, and are unsure of how to access appropriate health care providers for follow-up.

Figure 1 is an outline of **innovative practices and evidence-informed best practices** that are designed to improve transitions between hospital and home.

The use of these practices varies significantly across the province. Teams are encouraged to prioritize the implementation of evidence-informed best practices before adoption of the innovative practices outlined in this document. When considering the adoption of innovations, *recommended practices* should be considered first, followed by *promising practices*, and then *emerging practices*.

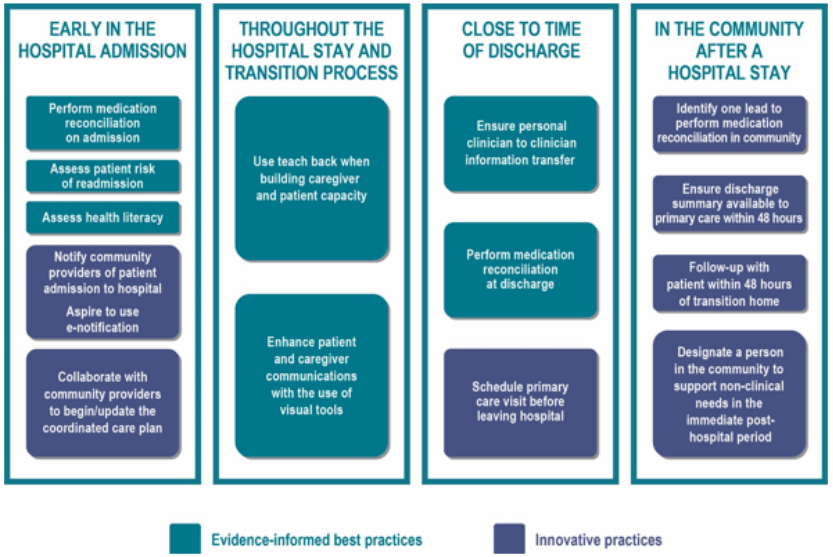


Figure 1: Practices to Improve Transitions Between Hospital and Home

Description of this Innovative Practice

A discharge summary is a written form of communication that generally contains a description of the hospital stay, diagnoses, interventions performed, and recommended action steps. Discharge summaries accompany patients after discharge from hospital and are written for care providers who will provide follow-up care. Created by the most responsible physician (MRP) from the inpatient stay, discharge summaries should be available to the primary care provider (PCP) within 48 hours of hospital discharge. This communication is critical to a patient's transition because it is relied upon to make ongoing clinical recommendations in their care.[1]

Innovative Practice	Innovative Practice Assessment[2]	Clinical Reference Group Endorsement for Spread
Ensure a discharge summary is available to primary care within 48 hours.	PROMISING	Provincial spread with reassessment using the Innovative Practices Evaluation Framework in 1 year (Sept 2017). ❖ This should be implemented in conjunction with the innovative practice to schedule a primary care visit before hospital discharge.

Implementation of the Innovative Practice

Steps for Implementation	Tools and Resources	Considerations
1. Create in-hospital processes to have discharge summary completed and sent within 48 hours. A discharge summary from provider-to-provider should be provided within 48 hours of discharge to support communication during the transition from hospital to home. Hospitals should align internal and external processes required to have discharge summary completed and sent within 48 hours. Hospitals should consider hospital policies, procedures and medical by-laws to ensure consistency in practice over the long term. ***2. Primary Care Provider (PCP) alerted of available discharge summary*** Primary Care Providers (PCPs) should be alerted by the hospital to the fact that a discharge summary is available for their patients with multiple conditions and complex care. Some hospitals successfully provide the discharge summary within 48 hours; however, without a	Examples of standard discharge summary templates: • **Toronto Central (TC) LHIN** developed and implemented a Standardized Discharge Summary (SDS) Template in 2013/2014 to facilitate consistency in information sharing between the hospital and PCP (see Appendix A for summary outline). • **Project RED (Re-Engineered Discharge)** is a research group from Boston University Medical Centre that develops and tests strategies to improve the hospital discharge process. Component 11 of their process focuses on expediting transmission of the discharge summary to clinicians accepting	• Developing a practice to have discharge summaries available in a timely manner requires collaboration between hospital and local PCPs. Ideally there would be one standard for obtaining discharge summaries however, due to primary care differences, there may be a need to have several processes to meet PCP needs. • Historically, providers dictate their discharge summaries, the summaries are typed into a letter format, and then the provider "authenticates" the accuracy of the transcribed letter. To ensure PCP receives information as soon as possible, some hospitals provide an early unauthenticated discharge summary and share with the PCP prior to receiving the final authenticated copy. When determining if an unauthenticated

[1] van Walraven C, Seth R, Austin PC, Laupacis A. Effect of Discharge Summary Availability During Post-discharge Visits on Hospital Readmission. J Gen Intern Med. 2002 Mar;17(3):186-192.

[2] *For more information about the Innovative Practices Evaluation Framework assessments, please go to the following link: http://www.hqontario.ca/Portals/0/documents/qi/health-links/innovative-practices-evaluation-framework-overview-en.pdf*

TRANSITIONS BETWEEN HOSPITAL & HOME
Summary of Innovative Practices

Steps for Transitions between Hospital and Home	Innovative Practice	Innovative Practice Assessment	Clinical Reference Group Endorsement for Spread
Early in the Hospital Admission	Notify community providers of patient admission to hospital Aspire to use e-Notification	**PROMISING**	Provincial spread with reassessment using the Innovative Practices Evaluation Framework in 1 year (September 2017).
	Collaborate in hospital with community providers to begin/update the coordinated care plan	**EMERGING**	
Close to the Time of Discharge	Schedule primary care visit before leaving hospital	**PROMISING**	
In the Community After A Hospital Stay	Identify one lead to perform medication reconciliation in the community	**PROMISING**	
	Ensure discharge summary available to primary care within 48 hours of discharge	**PROMISING**	
	Follow-up with patient within 48 hours of transition home	**EMERGING**	
	Designate a person in the community to support non-clinical needs in the immediate post-hospital period	**EMERGING**	

HEALTH LINK PANEL

Rapid Fire Descriptions of Select Practices

E-NOTIFICATION OF ADMISSION TO HOSPITAL

Aasif Khakoo

East Toronto Health Link

via South East Toronto Family Health Team

Transitions in the Care Continuum for Patients with Complex Needs in East Toronto

Aasif Khakoo, Director, East Toronto Health Link

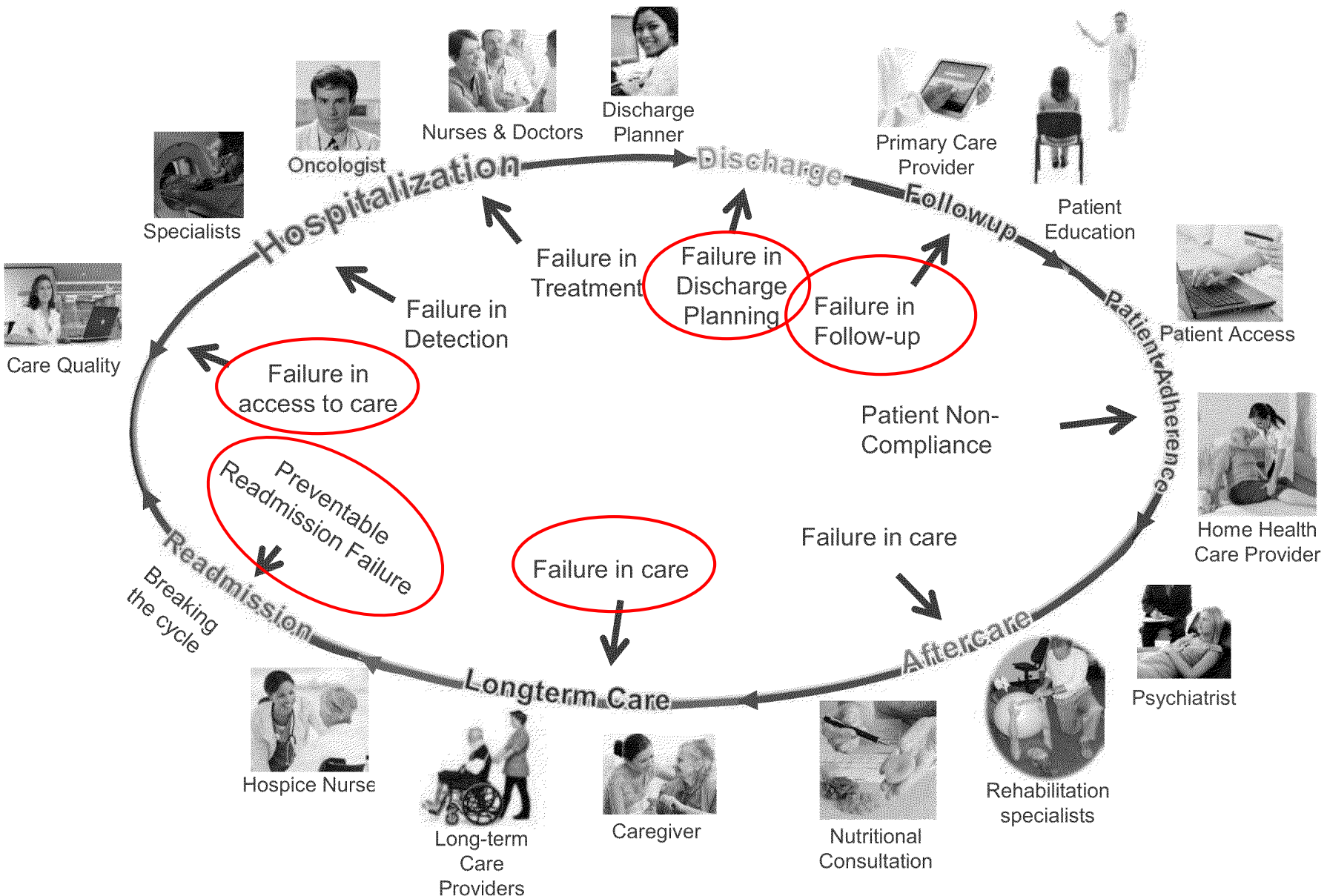

To-Do List…
✓ ETHeL 101
✓ Failure in Care Transitions
✓ Test of Change in ETHeL
✓ Potential Tech Solution
✓ Questions

East Toronto Health Link

- Population – 170,000 (12,000 Complex)
  - Highest population of children and youth
  - Highest population of seniors/seniors living alone
  - Large percentage of low-income clients
- High Needs Neighbourhoods
  - Large population of recent immigrants
  - Low socioeconomic status
  - High incidence of mental illness

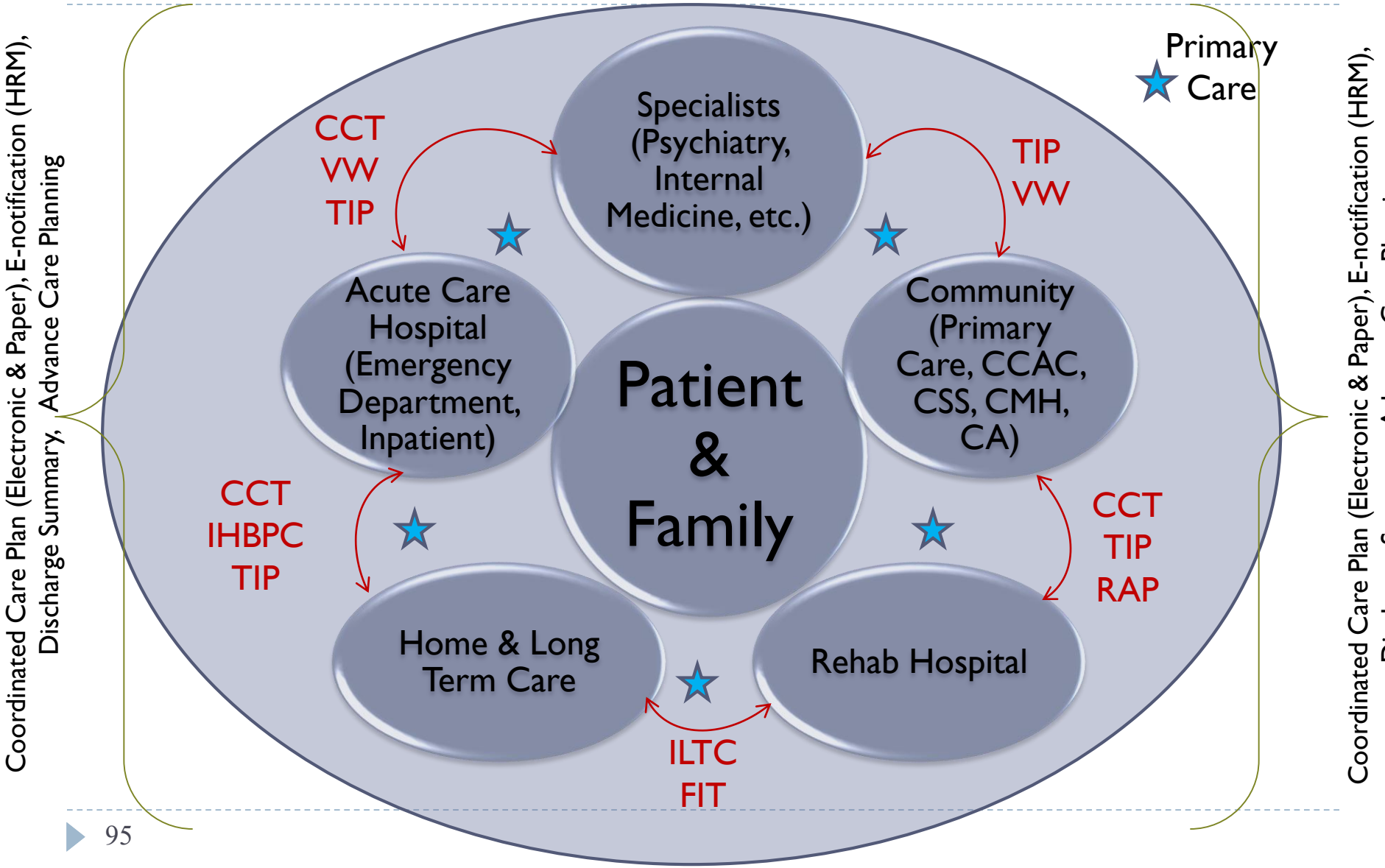
WE ALL CARE FOR A COMPLEX DEMOGRAPHIC

Failures in Care Transitions



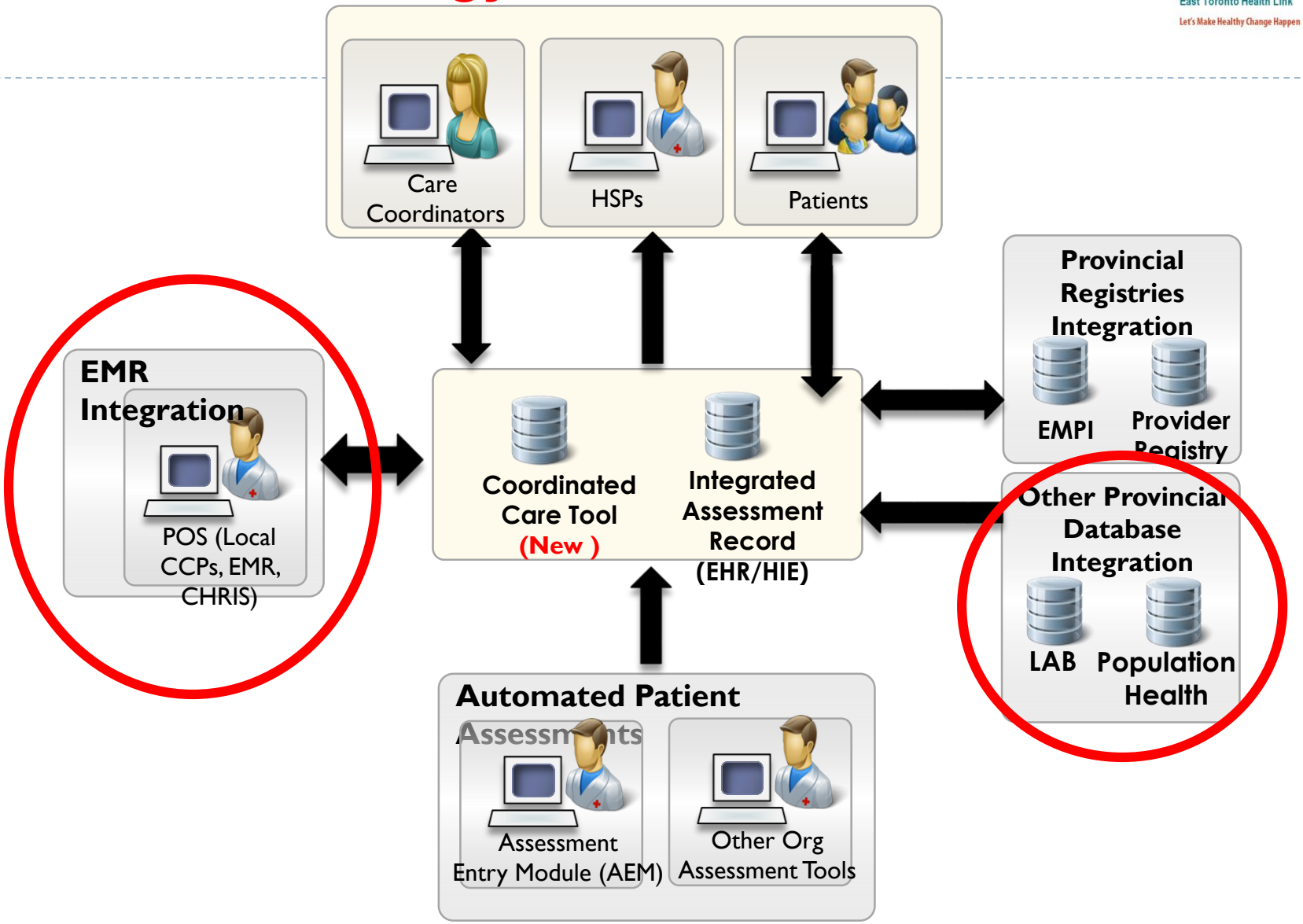
Passing the Baton Needs Collaboration

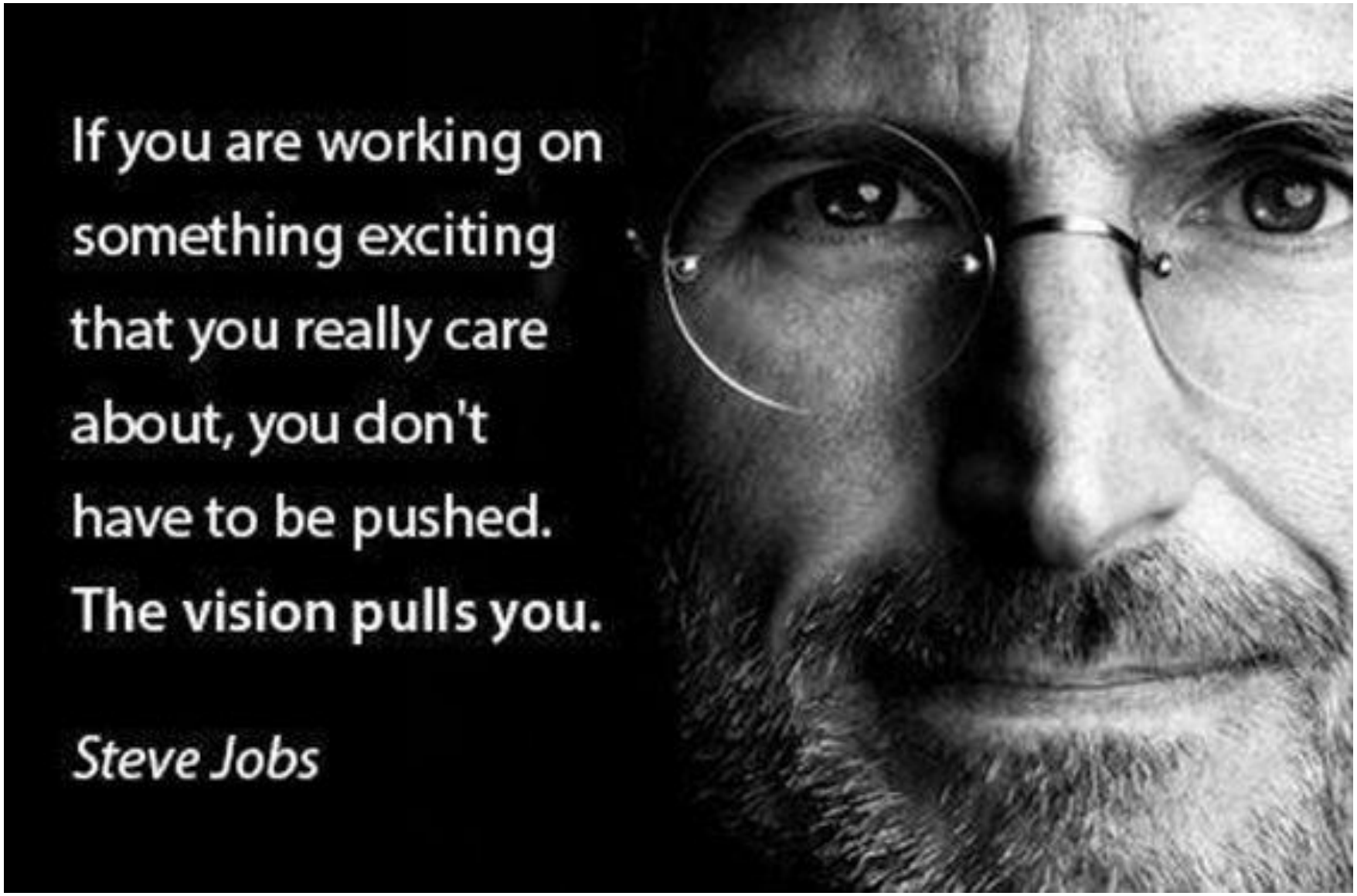
ETHeL Programs & Information Flow



Potential Technology Solution

HealthLink
East Toronto Health Link
Let's Make Healthy Change Happen




If you are working on
something exciting
that you really care
about, you don't
have to be pushed.
The vision pulls you.
Steve Jobs

SCHEDULING PRIMARY CARE VISIT BEFORE DISCHARGE

Lori Richey

Peterborough Health Link

Peterborough
FAMILY HEALTH TEAM

Connecting Patients with Primary Care

Transitions between Hospital & Home

Who are we?

- PFHT was established in 2006 as a Wave 1 FHT. We work collaboratively with 5 Family Health Organizations (FHO) in the City & County of Peterborough (all but 1 physician are part of the FHOs) , providing comprehensive, multi-disciplinary care to 115,000 patients, in 23 locations.

- We have an annual budget of 9.4 million, and 65% of this budget is directly related to patient care

- We are an active part of the Peterborough Health Link since 2013

- Current clinical staffing

89 Family physicians
22 Nurse Practitioners
16 Mental Health Clinician and Social Workers
6 Registered Dietitians
3 Pharmacists
22 Registered Nurses
4 Registered Practical Nurses

Target Population

We receive referrals from three sources:

- Patients of the Peterborough FHT that are discharged from Peterborough Regional Health Centre (PRHC) - currently working with 4 hospital floors A2, A4, B4 and MSSU

- Patients who have multiple complex chronic conditions and have difficulty accessing office appointments by family physicians requesting a home visit

- Patients with CHF referred by the CHF Centre (a collaborative program between PFHT, PRHC and the CHF Centre)

GOALS

- To provide a single point of contact for PRHC and CCAC to ensure patients receive follow-up care

- To provide patients with support and interventions for smoother transitions into the community and enhance communication between health care providers, PRHC, CCAC and primary care (where possible)

- To ensure patients discharged from hospital receive a follow-up appointment with MD or NP within 7 days for those with certain CMG conditions.

GOALS con’t

- Patients discharged from hospital who fall under OTHER category receive a follow-up appointment within 14 days
- To provide extra support where deemed necessary for patients with complex or chronic conditions by increasing communication between health providers, facilitating necessary coordination of services and enhancing the patient's health care needs
- To improve communication and coordination of care with the goal of reducing hospital readmissions and improving patient safety, quality and satisfaction
- To ensure patients referred by the CHF Centre receive a follow-up appointment with MD or NP within the recommended time period

Staffing Model

All staffing for this program is part of the annual FHT budget. We have requested and received small amounts of Health Links funding to support this program in the past.

Permanent Staffing

- .6 FTE (three days) of Nurse Practitioner
- 1 FTE (five days) of Registered Nurse
- Administrative support (varies upon needs)

Current Temporary Staffing (due to NP on mat leave and unable to find a replacement)

- .1 (half day) of Nurse Practitioner
- 1 FTE (five days) of Registered Nurse
- 1 FTE (five days) of Registered Practical Nurse
- Administrative support (varies upon needs)

Roles

Nurse Practitioner

- Home visits to complex patients including medication reconciliation
- Consultation with Family Physician
- Provide clinical support to other Welcome Home team members
- Recommends community supports that are then coordinated via the RPN
- Document in EMR

Registered Nurse

- Liaise with PRHC
- Sit on Health Links Design Team Committee
- Home visits to less complex patients
- Consultation with Family Physician
- Provide clinical support to other Welcome Home team members
- Recommends community supports that are then coordinated via the RPN
- Document in EMR

Roles con't

Registered Practical Nurse

- Home visits to assess social determinants of health
- Link patient with community resources
- Liaise with PRHC
- Sit on Health Links Design Team Committee
- Research and build understanding of community resources
- Knowledge of community waitlists
- Document in the EMR

Administrative Assistant

- Pull discharge data from Hospital Meditech system
- Follow up with primary care office re: appointment if needed

The Data

For the 2015/16 fiscal year, the Welcome Home data was as follows:

patients served = 1,151

patient encounters = 3,265

Performance Measures:

- Average days to follow-up appointment: **8.16**
- % of patients who are seen within 7 days after discharge from hospital for selected conditions (based on CMGs): **70%**
- % of patients who are seen within 14 days after discharge from hospital: **93%**
- % of patients who are readmitted to hospital within 30 after they have been discharged with a specific condition (based on CMGs)** **3%**
- # of Coordinated Care Plans (CCPs) created: **30**
- % of patients referred by CHF Centre who receive a follow-up appointment in the recommended time frame: **71%**

***Only includes readmissions that we know about, likely not all inclusive*

The Current Process

1. Discharge Data is pulled from PRHC Meditech system for all MD's with PFHT
2. The reason for admission is checked and compared against the Ministry of Health list of recommended CMG's to see what the recommended follow up is
3. Check notes for follow up appointment recommendations, check EMR to see if the appointment is booked within timeframe, if not follow up with office via the backline
4. Check to see if physician is copied on Discharge Summary – if not, screen shot and fax to their office
5. Provide a home visit if requested by physician
6. Link with community services if required and not done

Future State

The Welcome Home program duties seem to ebb and flow organically filling in the gaps, changing practice styles along the way. For example practices are now leaving spots to accommodate same day , next day and are automatically booking a follow up appointment following hospital discharge.

- We will be seeking to add the surgical floors of PRHC to the discharges that we monitor
- We are partnering with the Department of Paediatrics to ensure a timely return to primary care following an inpatient visit
- We continue to look for places that the “one-stop shop” service would assist with transitions of care
- We will work with and train the staff within the Primary Care offices to identify complex patients who would benefit from a Coordinated Care Plan

1 Lesson Learned & 1 Tip for Success

Lesson

- Very difficult to enact change using people in a large organization such as a hospital – too many staff changes, different levels of buy-in from each floor – build on existing systems and processes such as the computerized A/D/T info

Tip

- Spend time educating the medical secretaries in the family physician offices before starting – they need to understand why this is being done and that their physician is on board

Thank You!

For more information contact:

Lori Richey

705-749-1564 x 317

Lori.richey@peterboroughfht.com

DISCHARGE SUMMARIES WITH 48 HOURS
&
SCHEDULING PRIMARY CARE VISIT BEFORE DISCHARGE

Christine Thompson

St. Thomas Elgin General Hospital

IDEAS & Health Link

Optimizing the transitions of care from hospital to community

'Recipient of the 2015 IDEAs Alumni Award of Distinction'

HQO Leadership Summit, Sept 28, 2016

Christine Thompson, Emily Sheridan

The problem at a Hospital Level

St Thomas Elgin General hospital consistently experienced higher than expected readmission rates (~20% actual, compared to ~16% expected).

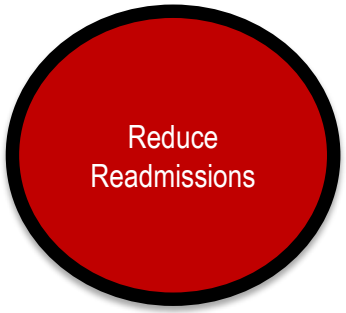
- As well, only 41% of discharge summaries were sent to primary care within 48 hours of discharge, and only
- 23% of patients with select CMG's were being discharged from hospital and seeing their primary care provider within 7 days.

data reported as of September 2014

Our Aim Statement

Improving & Driving Excellence Across Sectors

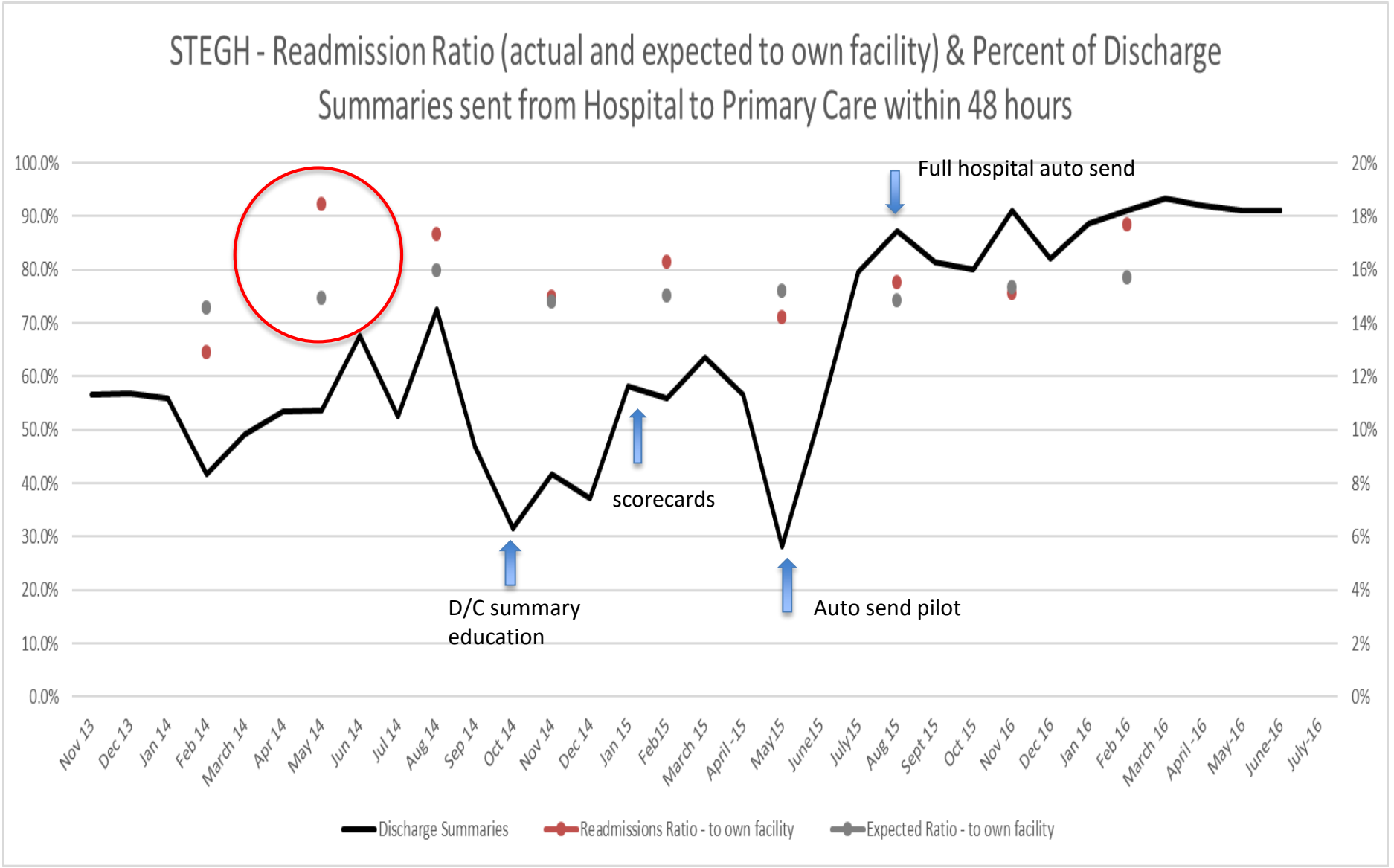
High level Aim (goal) – ***To optimize transitions of care for acute medical patients (hospital to community post discharge)***



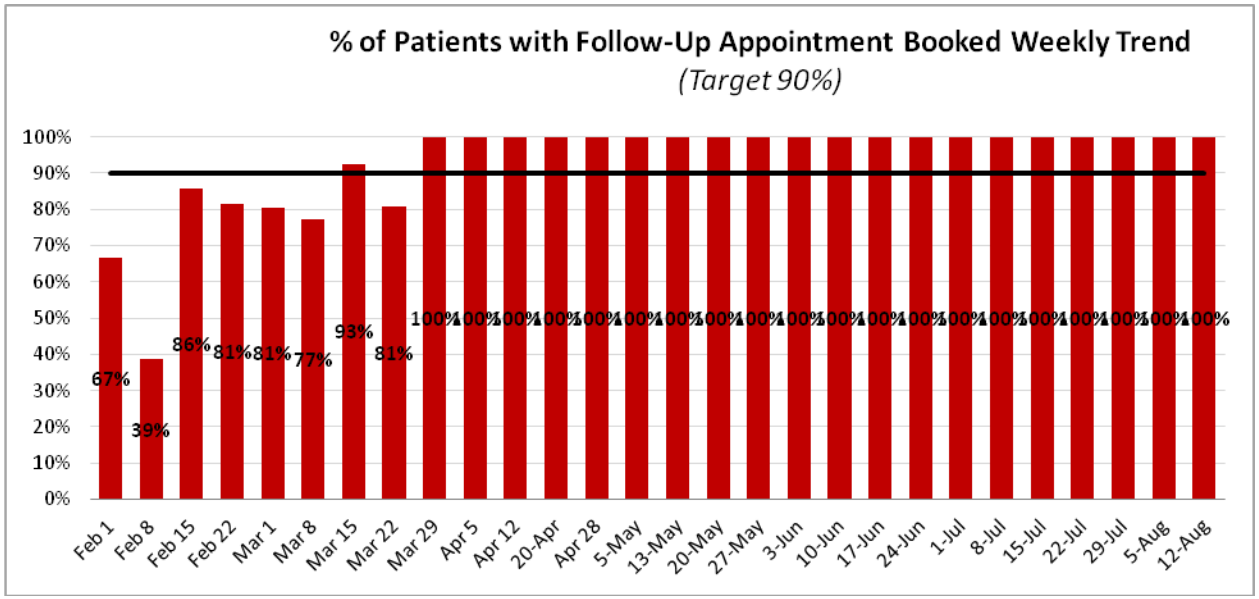
Aim – To increase the proportion of acute medical patients with select CMGs (as appropriate) discharged from St Thomas Elgin General Hospital seeing primary care provider within 7 days of discharge from ~23% to 30% by March 31, 2015

Aim – To increase the proportion of discharge summaries sent within 48 hours from St. Thomas hospital to primary care or community provider for acute medical patients from 41% to 80% by March 2015

RESULTS


STEGH - Readmission Ratio (actual and expected to own facility) & Percent of Discharge Summaries sent from Hospital to Primary Care within 48 hours
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
20%
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
Full hospital auto send
scorecards
D/C summary education
Auto send pilot
Nov 13
Dec 13
Jan 14
Feb 14
March 14
Apr 14
May 14
Jun 14
Jul 14
Aug 14
Sep 14
Oct 14
Nov 14
Dec 14
Jan 15
Feb15
March 15
April -15
May15
June15
July15
Aug 15
Sept 15
Oct 15
Nov 16
Dec 16
Jan 16
Feb 16
March 16
April -16
May-16
June-16
July-16
Discharge Summaries
Readmissions Ratio - to own facility
Expected Ratio - to own facility

Follow-up Appointments



- Originally focusing on select CMG's, then went to all medical patients receiving a follow-up appointment
- Spread within the organization February 2016 to all appropriate units, sustaining 98.3%

Successes

- We can credit much of our success to the buy-in from the organization:
  - Weekly Leadership Huddle: discuss follow up appointment booking, readmissions, discharge summary data from all units
  - Unit/Board Scorecards: a medium to present all data weekly/monthly to the organization
- Went from ~41% of discharge summaries dictated and sent to primary care within 48-hours to sustaining >85% since Oct. 2015
- Ward clerks easily able to take on follow up appointment booking
- Patient feedback positive – they appreciate having one less thing to do after discharge
- CCHC on board for accepting referrals for patients without a Primary Care Physician

Challenges

- Original trial of auto-send had bugs that needed fixing – set back ~ 6 weeks for initiation
- A select few Physicians unable to meet discharge summary dictation targets
- A select few Primary Care Physicians refusing to accept follow up appointment booking from our facility directly
- Jan. 2016 CCHC notified us that they were unable to take any new referrals due to staffing issues and waitlist
- Data not timely – always lagged
- Big Dot – Patients being re-admitted to hospital without utilizing CCAC resources first

Improving & Driving Excellence Across Sectors

Thank you

TABLE ACTIVITY

Part 1 – Strategies to engage patients/caregivers

Part 2 – Enablers and barriers to implementation of innovative practices

Part 3 – Adoption of innovative practices

NETWORKING LUNCH

#HLSummit2016

BRINGING TOGETHER MORNING LEARNING SESSIONS

Patient Engagement Strategies

- Collect and share patient/caregiver stories (e.g., create patient story video/at meetings/committees)
- Invite and support patients/caregivers to participate in decisions and co-design (e.g., process maps and steering committees, and patient and family advisory committees; eliminate barriers to participation)
- Engage patients as partners in their own care early on and throughout the process (e.g., self management and education)
    - An example- Bring patients to huddles between community, ED and EMS.

Implemented Innovative Practices*

Enablers

- Strong clinical/administrative leadership (Particularly physicians)
- Technology/shared EMR
- Data (outcome/utilization)- timely
- Audit and feedback- scorecards
- Patient Advisory Councils

Barriers

- Patient data management
  - privacy/sharing agreements
  - outcome data
  - technology/EMR
- Change management and culture shift
- Survey Fatigue
- Funding/capacity
- Process and practice variation
  -standardized materials/flow

*Some items are listed as enablers where they exist; the lack of them are regarded as barriers

Adopting a New Innovative Practice

What we heard today through the morning activity was that Health Link leaders have identified lessons learned and barriers from the implementation of previous innovative practices.

Leaders plan to continue to leverage what is working well and the key enablers *and* to address the barriers as they work to implement the new innovative practices.

What we heard in the discussions
Our community of practice

“If you email me- I will connect you”

“Can we have a list of a contact from each Health Link?”

“How can we connect with people who have implemented these practices?”

PERSPECTIVES OF HEALTH LINK LEADERS

Perspectives of Health Link Leaders

Panel

Kirk Mason

Dr. Jocelyn Charles

Dr. Walter Wodchis

Dr. Harry O'Halloran

Perspectives of a Caregiver

Kirk Mason

What is leadership?

Get Involved!

- Join a Patient and Family Advisory Committee
- Find out what else you can do
- Learn as much as you can
- Bring it home

Get Involvement!

- Get your patients involved
- Ask questions
- Be a champion
- Learn as much as you can

Continue the Conversation!

- kirkelmason@gmail.com
- @kirkemason
- #ptexp
- #healthlinks

Toronto Central **LHIN**

HealthLinks

The Experience in Toronto Central

Dr. Jocelyn Charles

Ontario
Local Health Integration Network

WE EXPLORE THE NEEDS OF OUR DIVERSE COMMUNITIES

Toronto Central LHIN serves 1.2 million people in Canada's largest urban centre.

- 2.6 million people
- Over 140 languages
- 26% living in poverty
- 41% immigrants
- 5,000 homeless
- 59,000 Francophones

- Rapidly growing urban Aboriginal population
- Largest community of lesbian, gay, bisexual and transgender people in Canada
- More than 200 distinct ethnicities

WE PLAN, FUND AND COORDINATE

services delivered by a large number of providers, including:

17 HOSPITALS

61 COMMUNITY SUPPORT SERVICE AGENCIES

36 LONG-TERM CARE HOMES

1 COMMUNITY CARE ACCESS CENTRE

17 COMMUNITY HEALTH CENTRES

70 COMMUNITY MENTAL HEALTH AND ADDICTIONS AGENCIES

HealthLinks

Promoting Collaboration & Engagement

- Around a single person
- Around the residents of one building
- Around a neighbourhood
- Around a population

HealthLinks

Collaborating Around a Patient

In one year, one person < age 50:

- 339 encounters- almost daily visits to hospital Emergency Departments
- 161 diagnostic imaging investigations:
  - 128 views of chest and abdomen
  - 19 CT scans

Bringing together multiple providers from multiple sites/sectors to understand the bigger picture and strategize on ways to improve care coordination

HealthLinks

Collaborating Around a Building with High EMS Calls

- Identified all providers going in to the building
- Clarified what each provider was doing & when:
  - Their successes & challenges
- Identified a cross-sector team at another site caring for similar residents in similar buildings:
  - How did they build their team?
  - What were their successful strategies?
- Facilitated regular meetings to coordinate care on an ongoing basis

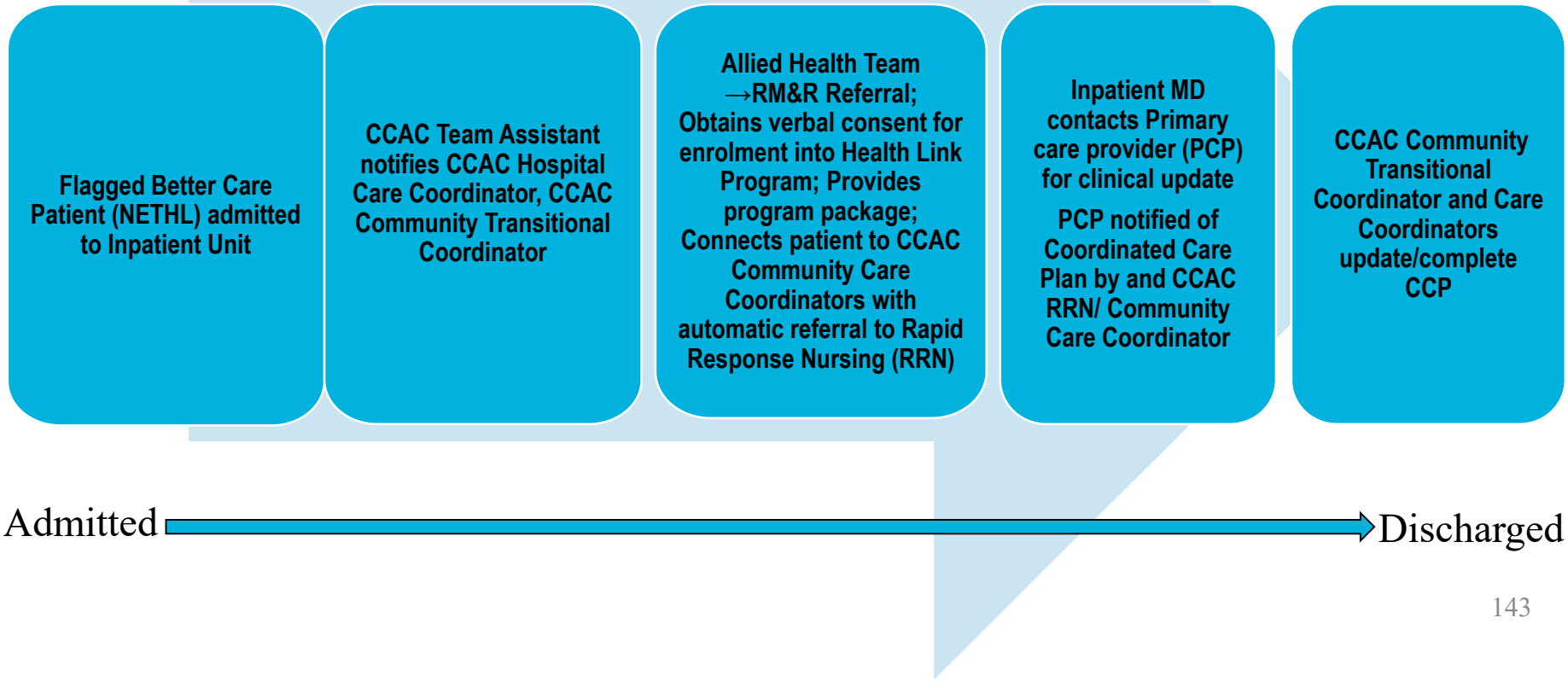
HealthLinks

Collaborating Around a Neighbourhood

Improving Access to Primary Care
for Homebound Seniors
in Thorncliffe Park

HealthLinks

Collaborating Around a Population: Frailty Pathway




HealthLinks
76% of care delivered is for people outside of catchment area
41% immigrants
26% living in poverty
OUR PEOPLE
80,000 urban aboriginals
170 languages spoken
Largest LGBTQ community in Canada
5000 homeless
1.2 million residents in catchment area
17 Hospitals
61 Community Support Service Agencies
17 Community Health Centres
1809 Family Physicians /13 Family Health Teams
70 Community Mental Health and Addiction Agencies
36 LTC Homes
1 CCAC

Evaluating the Performance of the Health Links – early findings

Design by: Walter Wodchis, Kevin Walker, Agnes Grudniewicz, Jenna Evans, Ross Baker

Health System Performance Research Network

September 2016

HSPRN
health system performance research network

Quantitative Summary

	SELECTED ENROLLEES	FULL CONTROL POOL 4+ conditions
	N=313	N=34,820
Prior 1-Year Utilization, Mean ± SD		
Primary Care visits	**24.7 ± 20.5**	**16.4 ± 14.2**
Specialist visits	**62.9 ± 46.7**	**25.8 ± 29.2**
Home Care services	**114.2 ± 171.6**	**22.7 ± 79.2**
ED visits, Mean ± SD		
1 year prior	**5.9 ± 7.0**	**1.5 ± 2.2**
1-3 months prior	**2.2 ± 2.3**	**0.4 ± 1.0**
4-6 months prior	1.4 ± 2.1	0.4 ± 1.0
7-9 months prior	1.1 ± 1.7	0.4 ± 1.0
10-12 months prior	1.0 ± 1.8	0.3 ± 0.9
Acute hospitalizations, Mean ± SD		
1 year prior	2.4 ± **1.7**	0.4 ± **1.1**
1-3 months prior	1.1 ± 1.0	0.1 ± 0.4
4-6 months prior	0.6 ± 0.9	0.1 ± 0.4
7-9 months prior	0.4 ± 0.7	0.1 ± 0.4
10-12 months prior	0.3 ± 0.8	0.1 ± 0.4

HSPRN
health system performance research network

Qualitative Summary

- Delivery of Care
  - Patient identification remains a challenge
  - Care plans are not shared with many team members
  - Mental health and social services are not effectively incorporated
- Clinician Engagement
  - Engagement split for physicians – ½ very willing; ½ impossible to engage
  - Low awareness, value of HLs not perceived, many solo practitioners, privacy issues
- Information Technology
  - Need ability to sharing patient information across partners (CCT important initiative)
  - Coordinating/sharing information with family physicians is generally weak
- Partnering & Network Design
  - Community rounds well received; spirit of collaboration
  - Hospital leadership is mixed blessing
  - Some partners over-exerted when spanning multiple HLs

HSPRN
health system performance research network

Key Questions

1. Is there a systematic, consistent and high fidelity approach to identifying individuals who are eligible for health links patient that is well understood by all providers who care for Health Links enrollees? Is it well understood by enrolled HL patients?
2. Are the care goals clearly articulated and shared for HL patients with all of their care providers? Are the patient-centred goals inclusive of short, medium and long term goals? What is the mechanism for sharing this information? What is the mechanism for discussion as to the appropriateness and common agreement to these goals?
3. Is there a systematic and effective approach to engaging with hospital, primary care and community care groups to share care plans for health links patients?
4. What is the approach to continued/sustained engagement with primary care physicians regarding the care of HL patients? How is the value of HL articulated to primary care providers?
5. How are care plans shared with primary care, specialist and community care delivery providers (not only care coordinators)?

6. Stretch goal … how would a hospital know that an admitted patient was part of Health Links and how should that affect the care and communication about hospital care with Health Links providers and the patient?

South Georgian Bay Health Link

Perspectives from Collingwood…
Dr. Harry O'Halloran

HealthLinks

Ontario
Health Quality Ontario

High-Performing Healthcare Systems

Primary Care

Quality Improvement

Information Technology

Performance is improved with (policy) emphasis on these three areas


SYSTEM
SAVER II
PELLETS
NEW LOOK!
windsor
SYSTEM
SAVER II
PATTISON


COLLINGWOOD
POPULATION 19500

The Collingwood Experience…

2002 – FHG
2004 – FHN (10 MDs)
2007 - FHT (2 FHNs)
2008 – FHO

2009 – Merged Physician Databases

2009 – Pilot site for ePrescribing
2010 – Access to EMR in Hospital
2012 – Pilot site for HRM
2013 – EMR access for local Specialists
2014 – Merged CHC into our database
2015 - Provider Portal

The Collingwood Experience…

Currently >58,000 rostered patients on single database across 18 sites

48 PC Physicians

- Some over 40 km apart
- Shared access with Hospital, ER, CCAC, local pharmacies, Specialists, Nursing homes, CHC, etc…

South Georgian Bay Health Link Initiatives

Think Tank
Same Day Health Clinic
iv antibiotics in LTC
Central CSS referral project
Provider Portal
Shared QIPs across organizations
Home for Life

HealthLinks

Ontario
Health Quality Ontario

Key Ingredients for Success

Have the right people at the table – Exec member needs to be able to hold their organization accountable

Culture of organization(s) (PC/Hospital/Community)

Patient involvement is a key step toward Patient Accountability

Shared PC database (ideally merged, at least cross-platform compatibility)

Shared QIPs (?)

Change Management

- Share Generously
- Steal Shamelessly
- Leverage Resources
- Little Change in Healthcare without Physician Leadership
- Need a Champion
- Build a team
- Culture of Collaboration

Cryptic Solutions…?

- Shirt consumed by fire – tell your friends (4,2,2)

  (Globe & Mail, Sept 24/16)

- Passion
- Passi-T-on
- Pass it on

(Not –so) Cryptic Solution…

- Put time into Health Links – inspire your colleagues (4,2,2)
- Passion
- PassiTon
- Pass it on

Questions???

Thank-you

hohalloran@sympatico.ca

NETWORKING BREAK

#HLSummit2016

How does the Health Links Approach fit in the future plans for Primary Care and Home Care?

How does the Health Links Approach fit in the future plans for Primary Care and Home Care?

Panel

Nancy Naylor

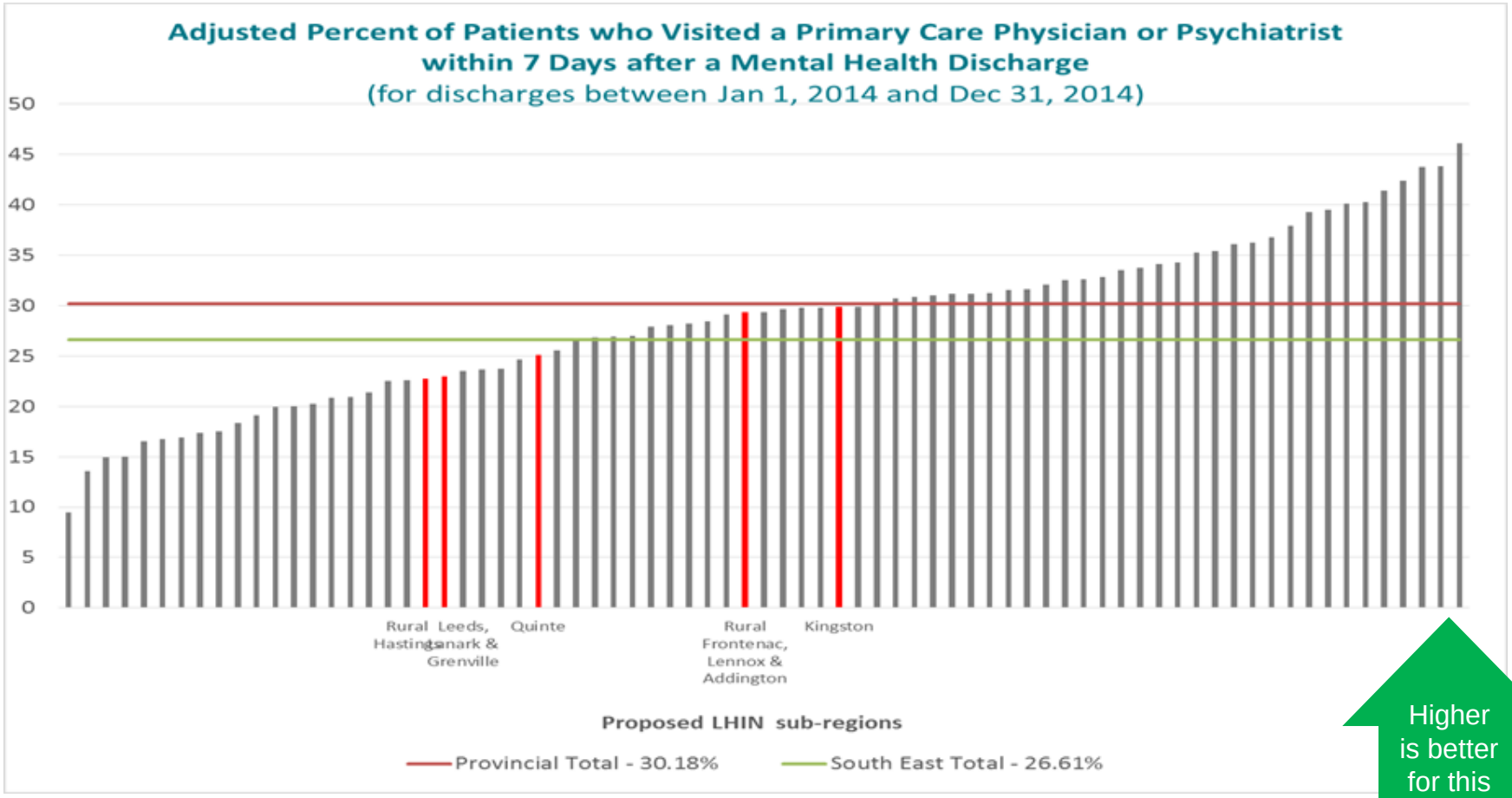
Dr. David Kaplan

David Fry

Paul Huras

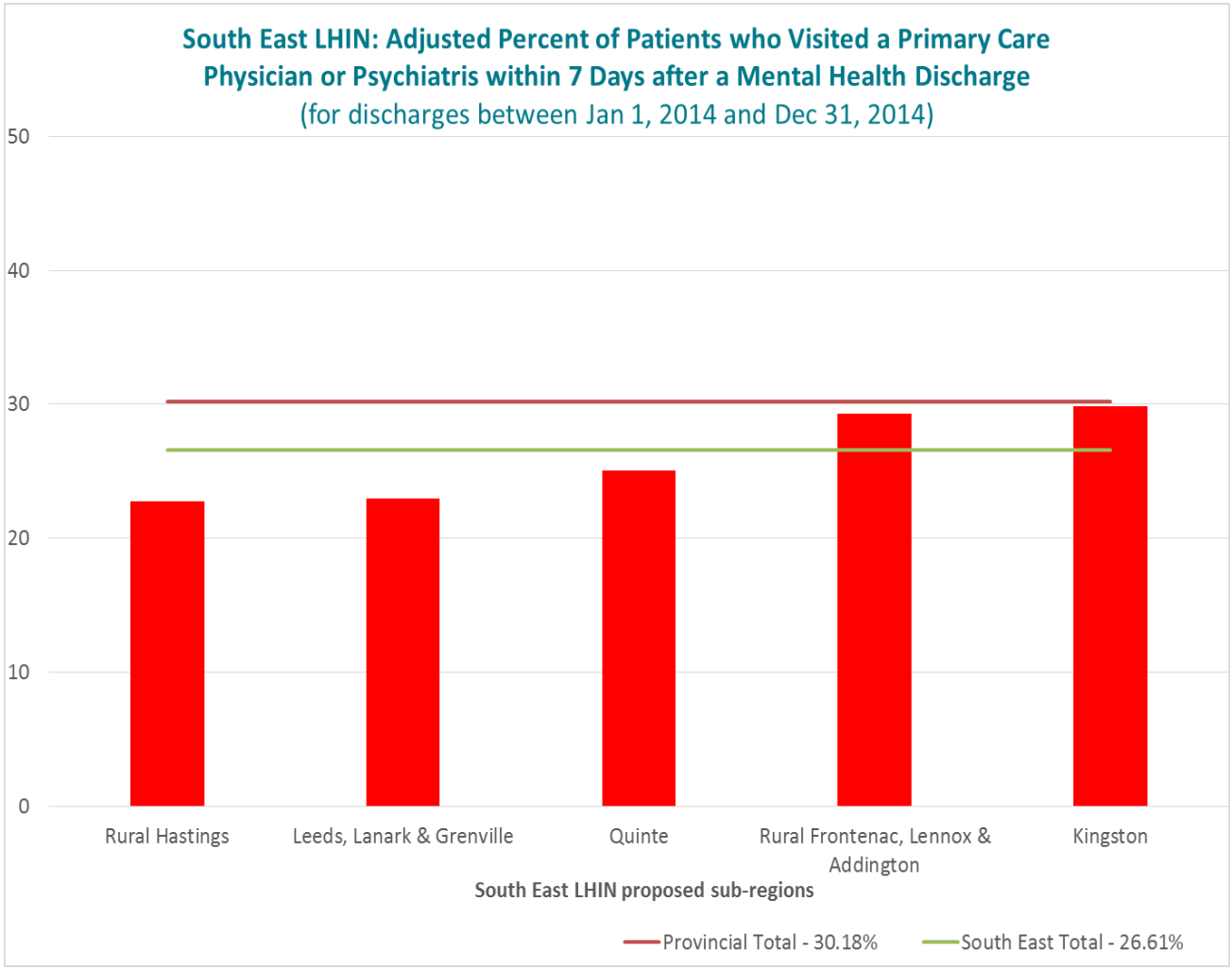
Health Links:
Improving integrated care for patients with multiple conditions and complex needs

Using data to look at provincial variation



Higher is better for this indicator

Understanding local variation



Higher is better for this indicator

CLOSING REMARKS

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