



Health Links Journey

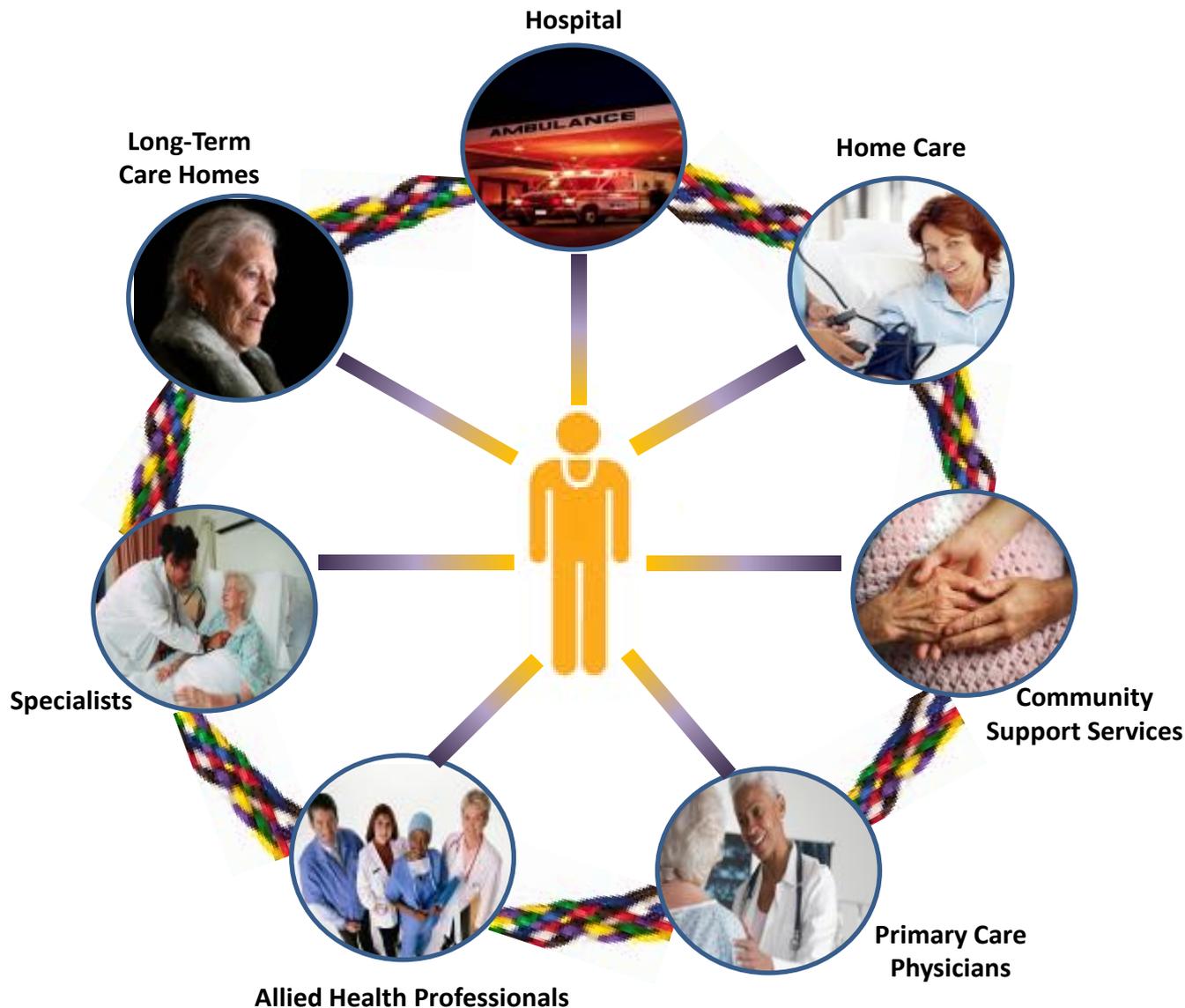
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Deputy Minister (A)
Ministry of Health and Long Term Care

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Better Integration: Health Links



Coordinated and integrated care is the heart of Health Links

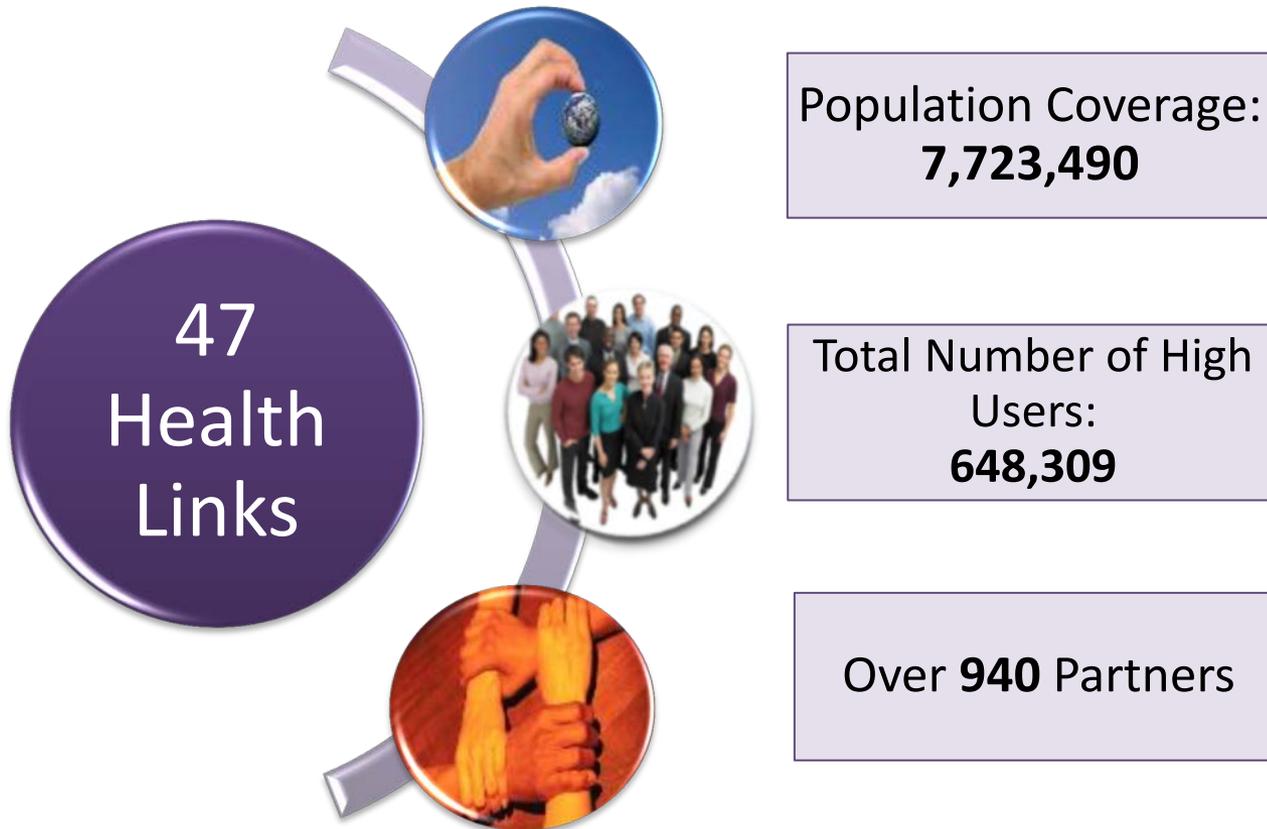
- ◆ Health Links launched Dec. 2012
- ◆ New model of to improve care for high needs patients
- ◆ All providers working at the local level to integrate clinical care and coordinate plans at the patient level
- ◆ Initial focus on people with complex health conditions

The Health Links Journey

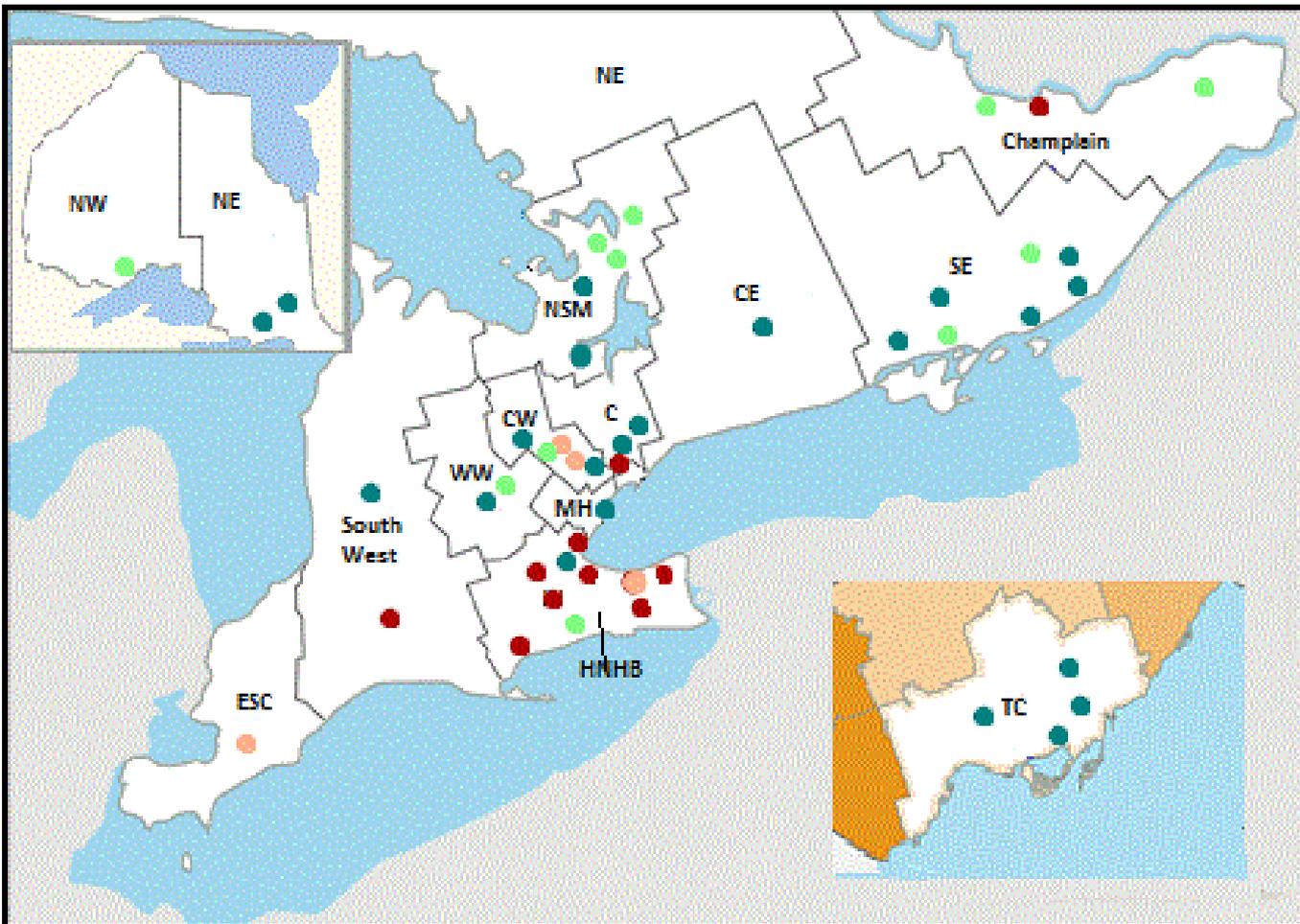


Health Links Today

- The response to Health Links in year one has exceeded expectation
- There is at least one Health Link in every LHIN and some LHINs have full coverage.
- Future: 90+ Health Links, providing full coverage across the province – we're already halfway there!
- The impact of other early successes have centred around local and regional innovations in programming, clinical pathways, and governance.



Where are Ontario's Health Links?



- December 2012
22 Health Links
- February 2013
4 Health Links
- October 2013
11 Health Links
- December 2013
10 Health Links

47 Health Links in Total

Health Links and LHINs Share Their Greatest Accomplishments To Date

“Establishing a collaborative, multidisciplinary team of clinicians who are patient centred, innovative and dedicated to delivering high quality coordinated care to their patients.”

“We have started to dismantle the silos, and initiated constructive dialogue between sectors.”

“Better and more cohesive relationships between the various sectors; more engagement of social services.”

“Inclusion of patient advocate at every stage of development, engagement”

“Many accomplishments, but our alignment as a LHIN with all the Health Links. We are one!”

“Awareness created between agencies regarding a coordinated, client-centred approach to care.”

“We have been able to shift perspectives of many providers to considering and value this new model.”

“Having a care plan template ready to use and being able to identify our high user patients.”

“Engaging and hearing patients' voices and perspectives.”

Some of Our Progress to Date



Care Planning

All Health Links are in the process of developing care plans



Attachment to Primary Care

Many Health Links have succeeded in attaching complex patients to primary care



Individual Care Plans

Many Health Links are conducting patient interviews and surveys to enhance individualized care plans



Patient Engagement

All Health Links are engaging patients on multiple levels of care planning



Patient Story – Jane

Description



Jane is a 60 year old woman with a history of alcoholism and mild mental health issues and without a permanent residence .

Issues



Jane frequently moves from one shelter to another and relies heavily on medications prescribed by her family doctor. She had not wanted to provide written consent to the Housing Workers she met at the shelters, but she did trust the Social Worker from a partner clinic of the Health Link.

Solution



The Social Worker decided to accompany Jane to her shelter in order to have a joint conference with the Housing Worker. Here it was decided what each party was going to do; one would identify potential permanent housing, the other would link Jane to relevant community programs and Jane would try to stay as long as possible at this shelter.

Benefit



Without the Health Link's partnership with the Clinic, the Social Worker would not have come into contact with Jane.

Work Underway



- Common principles for coordinated care plans so all complex patients will have the same experience
- Working with HQO to develop a guide to standardize elements of discharge planning through care transitions (including alternate levels of care)
- Undergoing a Rapid Cycle Evaluation to learn from our peers and provide the right supports

Supporting Successful Implementation

Engaging Our Links

- Provided weekly updates and milestone reports for year one of Health Links implementation.
- Modernizing communication channels through introducing a new monthly newsletter in 2014.
- Held 3 Health Links Days in year one to foster communication and relationship building.

Ramping Up Business Processes

- Conducting a rapid cycle evaluation to provide best practices and early learnings from year 1 of Health Links.

Care Coordination Tool Development

- Consulting with the sector to develop a tool that is patient centred, and user friendly.

Indicators of success

Moving the needle

1. Reduce the time from primary care referral to specialist
2. Reduce the number of 30 day readmissions to hospital
3. Reduce the number of avoidable ED visits for patients with conditions best managed elsewhere
4. Reduce time from referral to home care visit
5. Reduce unnecessary admissions to hospitals
6. Faster primary care follow-up after discharge from an acute care setting

Setting the stage for coordinated care straight away

1. All complex patients will have a coordinated care plan
2. Complex patients and seniors will have regular and timely access to a primary care provider

How you'll know you've arrived

1. Enhance the health system experience for patients with the greatest health care needs
2. Reduced ALC rate
3. Reduce the average cost of delivering health services to patients without compromising the quality of care



Rapid Cycle Evaluation (RCE) – Learning from our successes

Key Project Objectives:

- Conduct a Rapid-Cycle Evaluation (RCE) of Health Links
- Provide regular, actionable feedback on successes and challenges that iteratively inform further activities
- Establish a foundation to support longer term transformation objectives



Deliverables:

- Research Scan
- Refined RCCE Methodology
- Interim RCE Report
- Bi-monthly Rapid Reports
- Final RCE Report