“Health Links”

(Patient Care Networks)

CONFIDENTIAL

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What Stakeholders Have Told Us

- Ontario's Action Plan is ambitious.
  - Delivering on this agenda including the right care at the right time in the right place requires that patients and providers work together more closely than they have in the past.
- The partnership required goes far beyond a relationship between a LHIN and a hospital or a hospitals and a CCAC; it needs to include the person at the centre, primary care providers, and community partners.
- Primary care providers are essential to transformation, whether its taking more responsibility for keeping people well, screening them appropriately for chronic diseases or managing their care when they are sick.
- But it's not only providers that are essential – patients need to be part of transformation as they experience the system and know better than anyone where and how the system can improve.
- Stakeholders have asked for the flexibility to deliver services differently, in a way that best meets the needs of communities, to move resources between providers and to be held to account for better outcomes for patients.
- There is consensus around the need for local (sub-LHIN) partnerships that would come together to deliver better value for money, ensure higher-quality of care, and improve access. They can also allow for deeper engagement with patients and help develop a true patient-centred focus to the system.

An Early Focus – High Users

- The Ministry is proposing to focus on high users in the first phase of transformation. According to ICES:
  - 5% of the users (685,000 people) account for approximately $15.2 B in health care costs, approximately 40% (2007$)
  - If we could achieve a 10% reduction in the costs of the 5% highest users we would save $1.5 B (2007$) and approximately $2 B in 2012$.
- Despite the high cost, in several cases the patient experience and quality of care is not improving.
  - Over 271,000 emergency room visits were made to Ontario hospitals that could be treated in alternative settings (2010/11).
  - Over 140,000 instances of patients being re-admitted to hospital in Ontario within 30 days of their original discharge (2009/10).

Fred – the high user

Fred is 66 and lives alone. He has 24 different conditions, and has been in and out of hospitals for much of the year, including a lengthy stay in acute care, complex continuing care, rehabilitation, and homecare. He also had 3 ER visits. Fred has seen 16 doctors - **nobody is responsible for Fred's journey**.

The cost of his care was over $900,000 in one year. Much of these costs could have been avoided if Fred had received better support to manage his chronic diseases. Access to coordinated primary and specialist care as well as mental health/addictions services could have helped manage his chronic conditions and prevent complications. Repeat visits to hospital might have been prevented with appropriate follow-up care at home after his discharges from hospital.

Strengthening Execution & Integration – The Problem

The Problem:

- Too many instances of siloed providers only focused on a patient's care within their segment of care.
- No single provider takes responsibility for the patient's full journey as they move through the system.
- Many patients (particularly high users) are navigating the system alone, seeing a myriad of unconnected providers who are unaware of patients' past experiences, leading to duplication of diagnostics and care.

Symptoms:

- Unnecessary funds spent through repeated tests, and care in more acute, costly settings (like EDs).
- Some patients are receiving care in the hospital because of inadequate care at front-end (primary care) and lack of integration at the back-end (community care).
- System-level metrics (ED wait times, ALC, 30-day readmission) are too slow to improve with diffuse accountability among providers across patient journey.

Strengthening Execution & Integration - Solutions

- Introduce a new model of care at the clinical level where all providers in a community, including primary care, hospital, community care, are charged with coordinating plans at the patient level.

Health Links – Partnering for Patients

- Health Links will be designed around, and accountable for system-level metrics established by the province.
- Their initial focus will be on the high users, as we know that this segment of the population use a disproportionate amount of care at a cost which is not sustainable, nor appropriate for their needs.
- Health Links will be accountable to the LHINs and will initially be voluntary, beginning with those partnerships that meet specified requirements. Over time, the entire province would be represented.
- Leadership, governance, composition and integration initiatives will be flexible based on local need. Robust primary care participation is a critical success factor.
- LHINs will work with providers that form the Health Link to ensure they put collaborative initiatives in place that will allow for a measurable, positive impact on patient care:
    - Improvements in care delivery (e.g. appropriate system utilization, care coordination)
    - Improvements in patient experience
    - Reduced costs

Health Link Model: Our Commitment

- As an incentive to partner with us through transformation, the ministry is proposing to commit to removing many of the barriers that have to date frustrated the sector and stifled innovation.
- Historically the ministry has used funding as an incentive for change. However funding is no longer an option – more needs to be done with less.
- By removing barriers, we allow our partners greater flexibility to customize care planning to meet the needs of their patients.
- The Health Links would be the first to identify any barriers to their work; these would be brought forward to the attention of a specified team (ministry/LHIN) who would review them and bring them forward for decision making (see Appendix for further information).

Examples of Existing Barriers

Access to primary care after hours: The ministry has typically not permitted integrated after-hours care (different physician groups provide after hours services through joint after hours clinics). Removing our barriers will incent providers to work together to advance person-centred care.

Financial processes: The ministry has rules around what funding can be used for; allowing some flexibility to move funding around to where it is needed, allows organizations to address the needs of the people in their community.

Access to data: Primary care providers often lack data on how their patients are accessing other parts of the system, limiting their ability to influence patient behaviour. By improving data sharing, providers can better support their patients and reduce inappropriate use of the system.

Service maximums: Dying patients have their home care reduced if they live longer than expected. Extending care to patients at the end of life will help avoid more expensive hospital deaths and meet the preferences of most patients and their families.

#1 + #2: Adding Up to Short-Medium Term Success

- *Patients & providers coming together voluntarily to work as partners*
- *Improving care & the patient experience*

- *Removing barriers and allowing greater flexibility to enable patient-centred care*
- *Aligning incentives*
- *Overseeing accountability*

- *Connections are strengthened to improve transitions in care*
- *People are cared for in the right place*
- *Funding is moved to where it is most needed*

What does it mean for the patient?

- ✓ A better experience where patients have more immediate access to their care teams
- ✓ Improved outcomes so people lead healthier lives
- ✓ High users get the benefit of a coordinated care plan designed to help them

What does it mean for the system?

- ✓ Fiscally sound system (ministry manages within 2% growth)
- ✓ Captured savings to reinvest in priority areas (e.g., community)
- ✓ Better quality of care, based on evidence and best-practice

Health Link Model: Core Features

An evolutionary model that will initially focus on improving patient care and outcomes for the high user population cohort through enhanced local integration among health care providers, while delivering better value for investments

Person-Centred	Activities centred on the needs of the high use population cohort (1-5%) with the goal of improving their care and their experience at better value.
Local Focus	The scale is at the sub-LHIN level, defined by existing health service utilization patterns and includes a minimum of 50,000 people.
Voluntary Partnerships	Requires voluntary participation from providers involved in the care of high user group, which at a minimum includes hospital, CCAC, primary care, specialists. Health Links to put collaborative initiatives in place to improve care at lower cost.
Robust Primary Care Participation	Requires involvement of primary care providers (all delivery models) within the community.
Measurement and Results	Robust information management practices required to identify and track improvements for the high use population. Identification and tracking is a joint responsibility of all Health Link participants.
Leadership	Leadership is required by all participants of the Health Link. Each Health Link will have a Lead, based on their ability and capacity to engage providers and focus activities on achieving results.