Rideau Tay Health Link

Two Years IN!

It has been two years since Rideau Tay Health Link (RTHL) has been operational. The operations of the RTHL have been guided by the RTHL Business Plan of April 2014 entitled*, Initiating Collective Action: Working Together to Improve Our Local Health Care System*. This plan was developed using a collaborative, community engagement approach involving many of the existing members of the RTHL Steering Committee.

The intent of this brief report is to provide an update of the progress to date of the 2014 RTHL Business Plan and the movement toward outcomes articulated in the 2016/17 RTHL Business Plan. As stated in the original business plan "*In late 2012 and throughout 2013, health care providers and patients formed RTHL and articulated their shared purpose:*

> ***to redesign local health care delivery to provide residents, especially the sickest and most vulnerable, with improved care that makes the best use of health care resources."***

It further stated:

"In the first two years we will move toward these changes by planning and piloting initiatives in relation to three health care areas:

1. Coordinated Care across Transitions
2. Advanced Illness Management
3. End of Life Care

In addition the Steering Committee and office will coordinate work on the two other drivers of success:

D. Communication

We will **communicate deliberately and regularly** to keep all parts of the local **system**, including health care providers and the general public, up-to-date and **inspired** on the progress of this transformation journey.

E. Leadership and Transformation Training

We will **develop our people**, exposing them to **leadership training, systems thinking**, and other tools that will improve the way we think and work, and create a **culture** of constantly moving the **system** toward the achievement of our shared purpose.

The Business Plan identified the positions required, in addition to the Care Coordinator, in order to effect system change. One of the key positions to support the change management at a system level was that of a Patient and Provider Engagement Lead. This position supported the outreach and communication efforts to engage health system partners and subsequently other partners in the social services sector. Recognizing that Health Links is as much a change in philosophy as it is a process, the RTHL Team provided three in-depth training sessions to individuals in other organizations both within the geography of the RTHL and the broader geography of the SE LHIN with a focus on communication, collaboration and patient centred care.

During the establishment of the two ongoing working groups, the ***Hospice Palliative Care*** and ***Transitions*** the membership composition and goals were formulated to reflect the purpose of RTHL with the drivers of **communication, leadership and training** at the forefront of the groups' mandate. The following is an overview of each working groups' initiatives that reflect this thinking:

Hospice Palliative Care Working Group

- Composition of membership inclusive of the broad health care sectors, hospital, community home support, CHCs, CCAC, patient advisor with lived experience
- Offered a nationally recognized 2 day training program on palliative care to Primary Care Practitioners in Fall of 2014, with subsequent annual education days which were well attended by primary care and health service providers in RTHL
- Offered and funded Advanced Care Planning courses to individuals in partner organizations including hospital, CCAC, CHC and Health Link staff (9 individuals)
- Ongoing representation on SE LHIN Steering Committee

Transitions Working Group

- Composition of membership includes hospital (patient flow and emergency department), Lanark County Mental Health , Lanark County Social Services, Rideau Community Health Services, Rideau Valley Diabetes Services, Primary Care, North Lanark and Country Roads CHCs, Community Home Support, Telemedicine, CCAC (rapid response nurse and care coordinator), Nurse Practitioner-led Clinic, patient/caregiver representative
- Need identified to ensure "cross pollination" of each organizations function to better serve patients
    - Outcome – establishment of "Lunch and Learns" in hospital but open to all
- Broad attendance at Lunch and Learns including nurses from the units at both hospitals, ICU, palliative care, dietitians, admin assistants, hospital physiotherapist and community based organizations such as The Table, Lanark County Mental Health, Community Home Support, Primary Care

Operationally the RTHL Team has always recognized the intended population for Health Links is the top 1 to 5% of the health care consumers but many of the broader system issues identified through the completion of the Coordinated Care Plan (CCP) affect all those accessing care. Hence, the RTHL deliberately developed a "System Tracker" to catalogue barriers to an integrated system of care. The barriers are at various policy levels and thus the ability of RTHL to effect change can be limited. However, when it is in an area that we can possibly affect change we work in that direction. For instance, one area that has been identified is the variability of medical supplies between the hospital and the CCAC. Patients and care givers may be taught to use a certain type of supply in the hospital only to find it is different when they are at home and the supplies are provided by the CCAC. This causes patient and caregiver stress and creates issues of transition from hospital to home. In addition this variation in supplies often causes unnecessary intervention and use of resources (waste). The SE CCAC is now reviewing the compendium of supplies in conjunction with the hospitals to try and align them better. This is a positive system change that will improve care for all those transitioning from hospital to home, not just the Health Link patients. Another example of positive system change is the commitment by the South East Regional Cancer Program (SERCP) to use Telemedicine to improve patient centred care by providing follow-up consultations through video conferencing. One of the first HL patients in Rideau Tay was required to travel to Kingston for a follow-up appointment which left her exhausted with a resulting hospitalization. Following this the RTHL Team worked with the Telemedicine Services and the SERCP to "test" the use of video appointments. Subsequently, the SERCP identified this as a priority in their recent strategic plan to improve equitable access. It states, "Embrace new technologies to improve our performance specifically in the areas of telemedicine (OTN) and social media"

An additional area that has been identified in the system tracker is the impact of policies in the social service and mental health sector that influence the health of patients. The RTHL Team has reached out to this sector and as a result has received an increased number of referrals from social housing, victim services, developmental services and Lanark County Mental Health. The RTHL Team now works more closely with many of these organizations in support of HL patients.

In the Rideau Tay Health Link a spirit of cooperation and collaboration has occurred at all levels of the system. There has been commitment at the Board level including 5 Board to Board meetings unique to Rideau Tay; Senior Management commitment including 10 Steering Committee meetings; Front line staff has been engaged through the Palliative Care and Transitions Working Groups, lunch and learns with Primary Care and 3 training sessions.

The RTHL Team is committed to the Health Link Philosophy of patient centred care and more effective communication and collaboration. We have utilized the client Care Conference to supplement the Coordinated Care Plan. The Care Conference is focused on patient goals and provides an opportunity for providers to connect and problem solve together with the patient voice at the centre. Providers included in the circle of care are invited to participate in the Care Conference including the individual's primary care provider. Not only have Care Conferences generated viable solutions for a variety of issues, but evaluation from participants has shown greater provider satisfaction and great

understanding of each organization's function within a patient centred system. Care Conferences are connecting providers in a lasting way.

We continually strive to not only meet our performance metrics but to promote change within our system that will have a lasting impact for patients. In some instances, patients identified through the CCP process require ongoing support from the Care Coordinator as their goals change as a result of the progression of their chronic conditions.

The current performance metric for Health Links counts the number of new CCPs completed. However, we do have patients who we continue to support which is resource intensive and not captured by this metric. Likewise there is no metric which measures system improvement over time or recognition of change management among partners in the system.

Moving forward with the support of the RTHL Steering Committee the RTHL Team will continue the work accomplished in the first two years in anticipation the work of system change will be more fully recognized. Reflecting back to the introduction of the initial Business Plan it states:

> *This transformational change will take many years to achieve, and the health service providers of RTHL hope support will continue beyond 2016, and believe a lot can be done within two years. No organization working alone can achieve these goals; even the united leadership of all organizations isn't enough. Success depends on multiple providers, front-line and leadership and patients working together to transform the system.*

In Paul Huras' presentation to the SE LHIN's May 2016 Board meeting about the Sub-LHIN Regions as articulated in the "Patients First Document" he stated:

> **What is the purpose of a Sub-LHIN?**
> To make care more integrated and responsive to local needs and improve performance of the system and the patient experience overall.
>
> **How does a sub-LHIN differ from a Health Link?**
> A Health Link delivers improved, coordinated care for complex patients while a sub-LHIN region delivers improved, coordinated care for everyone.

Because the initial Business Plan for the RTHL was focused on system change with an emphasis on the top 1-5%, the ground work for the Sub-LHIN Regions has been laid.

By The Numbers --Two Years IN!

Coordinated Care Plans Completed to September 30, 2016

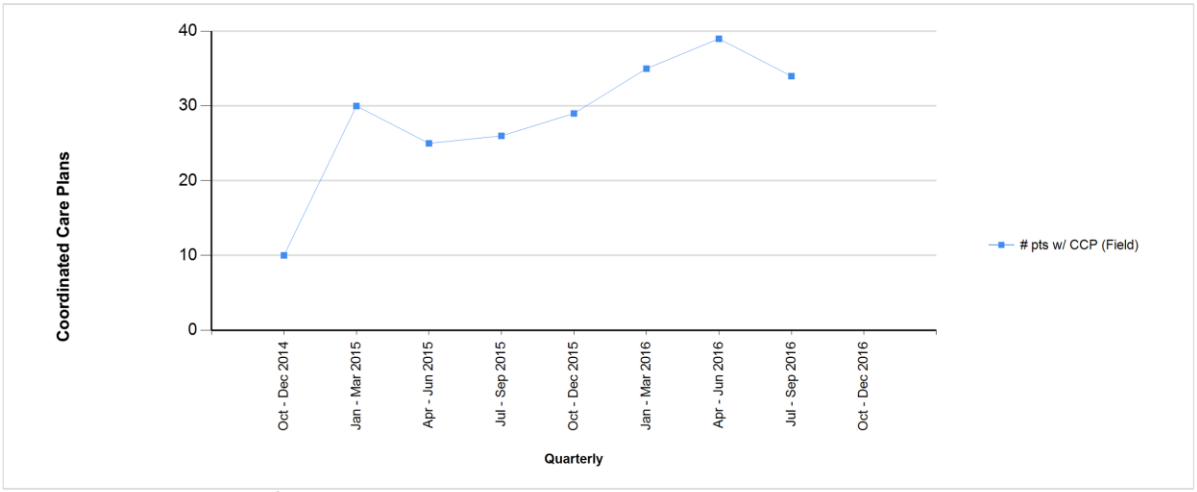
Health Links submit the number of Coordinated Care Plans initiated each quarter to Health Quality Ontario. The following chart shows RTHL's progress to September 30, 2016 (224 cumulative total). In the 2016/17 Business Plan the target number of CCP is 200 (Q1 – 45, Q2 – 35, Q3 – 60, Q4 – 60). To the end of Q2, 73 CCPs have been completed (92% of target).

Health Link Dashboard Report

Rideau Tay Health Link

Coordinated Care Plans

Reporting Period: 12/1/2014 - 10/7/2016



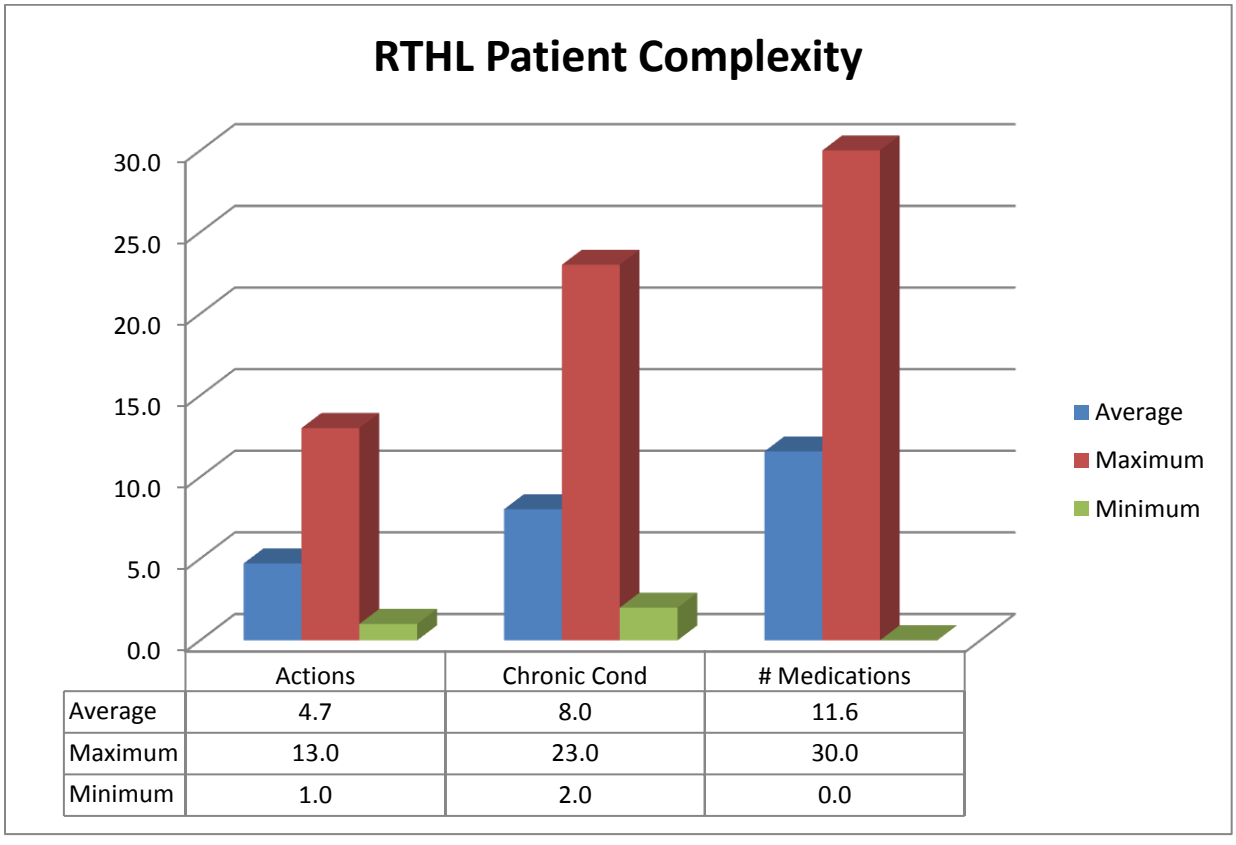
Direction of Improvement: ⬆

Page 1 of 6

Report run on 10/7/2016 10:07:55 AM

RTHL Patient Complexity

The intent of Health Links is to focus on those who consume 67% of health care resources who are the most complex patients that typically have four or more chronic conditions. Recent research, entitled, "Who Are the High-Cost Users? A Method for Person-Centred Attribution of Health Care Spending" [1] using ICES data has concluded that 58.5% of the cohort of high-cost users had eight or more distinct comorbid conditions and 54.7% were prescribed 10+ different drugs. An analysis of patients with the RTHL is consistent with this research as indicated in the graph below. This validates the process by which RTHL identifies patients and that the appropriate patients are being connected with the RTHL Team and a Coordinated Care Plan developed. When the Coordinated Care Plan (CCP) is completed there are a number of "Actions" identified which support the patient's goals. Included in the Actions is the most responsible individual within the circle of care who will follow through. As indicated below, the maximum number of Actions in one CCP was 13, with an average of 4.7 per CCP.



	Actions	Chronic Cond	# Medications
Average	4.7	8.0	11.6
Maximum	13.0	23.0	30.0
Minimum	1.0	2.0	0.0

Mental Health as a Comorbidity

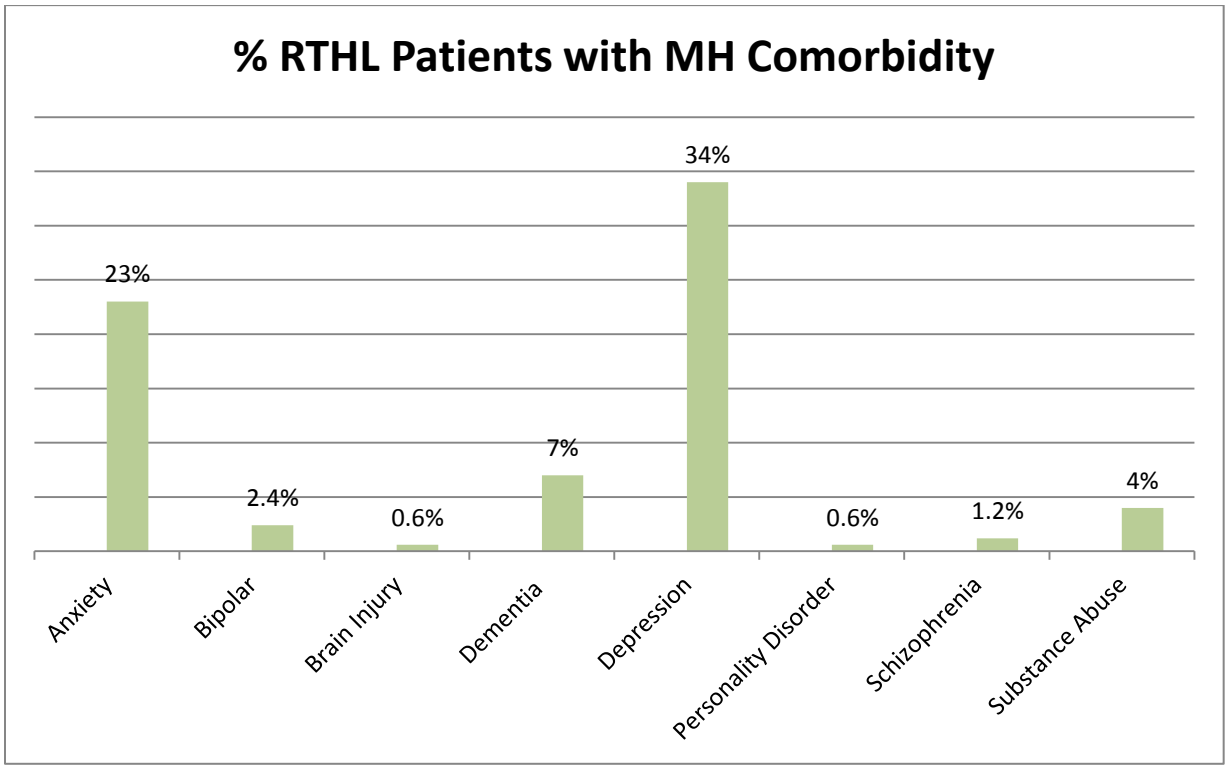
A provincial analysis of the Target Population for Health Links completed in 2015 states the following:[2]

Results show there is substantial overlap between the Target Population and:

- ✓ *Mental health patients (**over half of patients** in the Target Population have mental health conditions)*

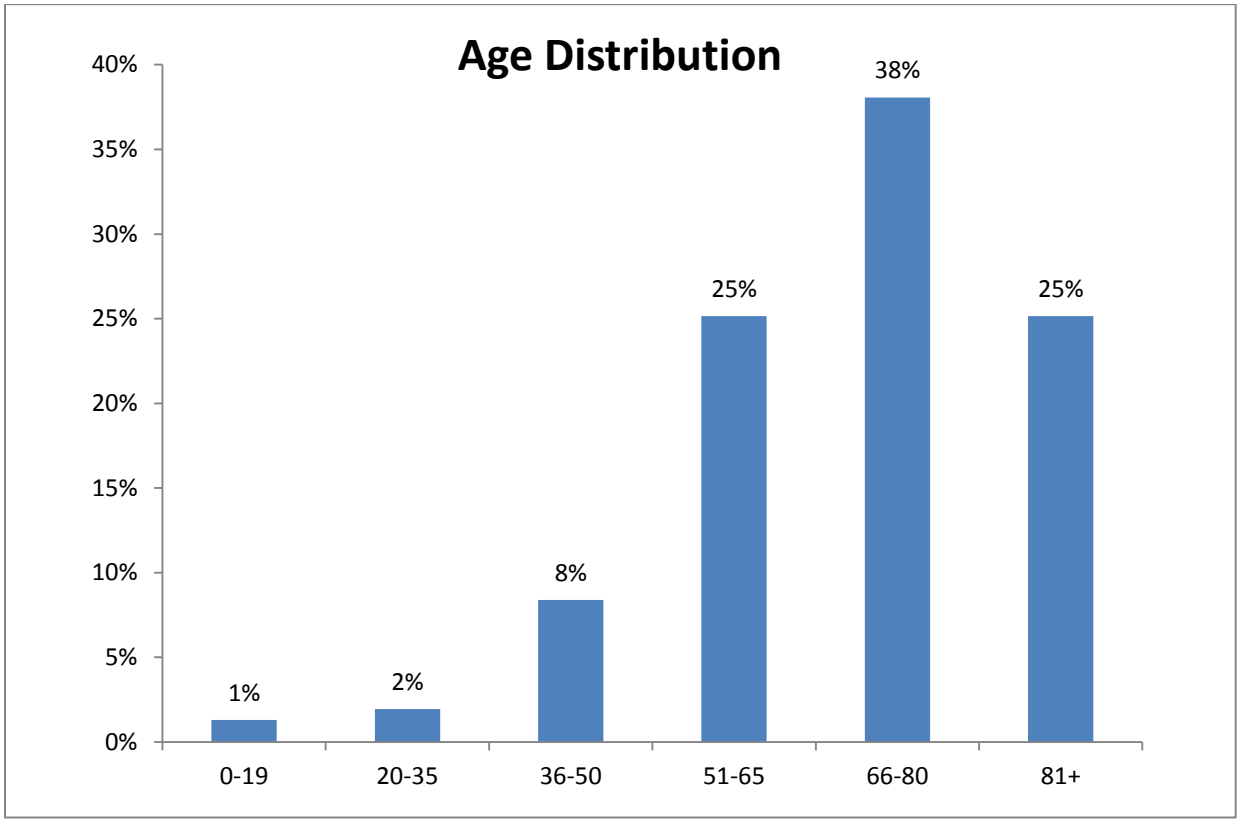
An analysis of the RTHL patients to date bears this out. Of the 26 Care Conferences done by the RTHL Team to date, 14 were for individuals who were also Lanark County Mental Health clients. Another 3 had a mental health diagnosis. Lanark County Mental Health (LCMH) has been a full partner in supporting these very complex individuals.

Looking at the diagnosis of the individuals who have a Coordinated Care Plan and have one or more mental health diagnosis indicates the two most frequent diagnoses are depression and anxiety. These individuals may not fit the criteria for LCMH services and as such the RTHL Team tries to connect them with other community based services such as counselling at the CHC or with the social worker through the CCAC but these resources are often scarce and time limited.



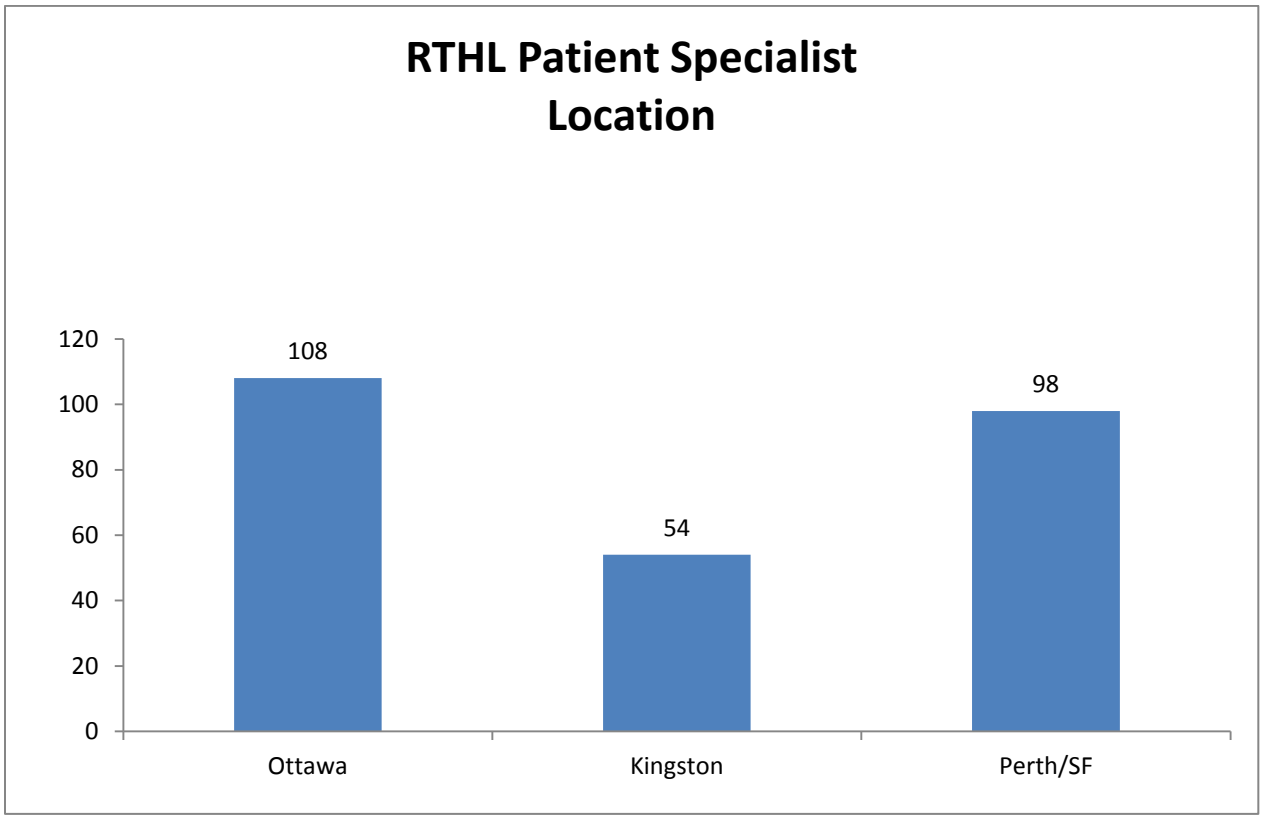
Age Distribution of RTHL Patients

As indicated in the following graph the majority of HL patients are in the 66 – 80 age category. This is consistent with provincial ICES data. There is however a large cohort in the 51-66 age category who based on observational data, are very complex medically and socially. Further analysis of this cohort will be forthcoming.



Access to Specialists

The majority of HL patients had one or more specialists involved in their care. Of particular interest to the RTHL geography is the location of these specialists. As indicated in the following graph there is a 2:1 ratio of specialists in the Ottawa area as opposed to Kingston. This presents unique challenges in terms of data analysis and services for these clients. For example, some local services such as kidney dialysis and chemotherapy are provided by Kingston and only those patients with specialists in that location can access these local services.



RTHL Pre-Post Data Analysis

Evidence from other Health Links and a recent study by the Health System Performance Research Network has shown a reduction in emergency and hospital usage after Health Link intervention, concluding that Health Links are showing a positive Return on Investment (ROI)[3]. Due to the geographical location of RTHL with patients using the emergency and acute care services Perth and Smiths Falls District Hospital as well as adjacent hospitals and the two tertiary care centres data is not available to do this analysis for the RTHL patients. Data sharing agreements exist between the RTHL and the Perth Smiths Falls District Hospital but not with the other hospitals. This would require extensive privacy protocols as the data must be patient specific to do a thorough analysis.

Health Link Training and Spread

The intent of Health Links has been to work with partners to embed the philosophy of Health Links into the health care system. To this end, the RTHL Team has provided 3 orientation sessions to date with a fourth planned for October 2016, which will include the two patient flow coordinators from the Perth Smiths Falls District Hospital as well as representatives from the organizations participating in previous sessions. The following provides a summary of attendance at these sessions by organization both within RTHL and other areas.

HL Orientation Training - 3 Sessions

Within RTHL

Lanark County Mental Health	3
Rideau Community Health Services	7
North Lanark CHC	3
Country Roads CHC	5
CCAC	2

Other Areas

CCAC	7
Other HL -SELHIN	3
Champlain HL	1
Lanark County	2
Health Quality Ontario	1
SELHIN Planner	1

Data will continue to help inform, support and verify that the RTHL Team is reaching the intended population for the Health Links initiative.

References:

1. Guilcher SJT, Bronskill SE, Guan J,Wodchis WP (2016) *Who Are the High-Cost Users? A Method for Person-Centred Attribution of Health Care Spending*. PLoS ONE 11(3): e0149179.doi:10.1371/journal.pone.0149179

2. DETERMINING HEALTH LINKS TARGET POPULATION APPROACH AND PROCESS, Nam Bains, Manager, Capacity Planning and LHIN Support, MOHLTC , August 2015

3. Mondor L, Song K, Wodchis WP. *Assessing Value in Ontario Health Links. Part 5: Health System Performance Trends in Health Links Populations*: 2012-2014. Toronto: Health System Performance Research Network; 2016