South East LHIN

Health Links in the South East LHIN

Ontario

South East Local Health Integration Network

Réseau local d'intégration des services de santé du Sud-Est

Stakeholders

HealthLink

Objectives

1. What are Health Links?

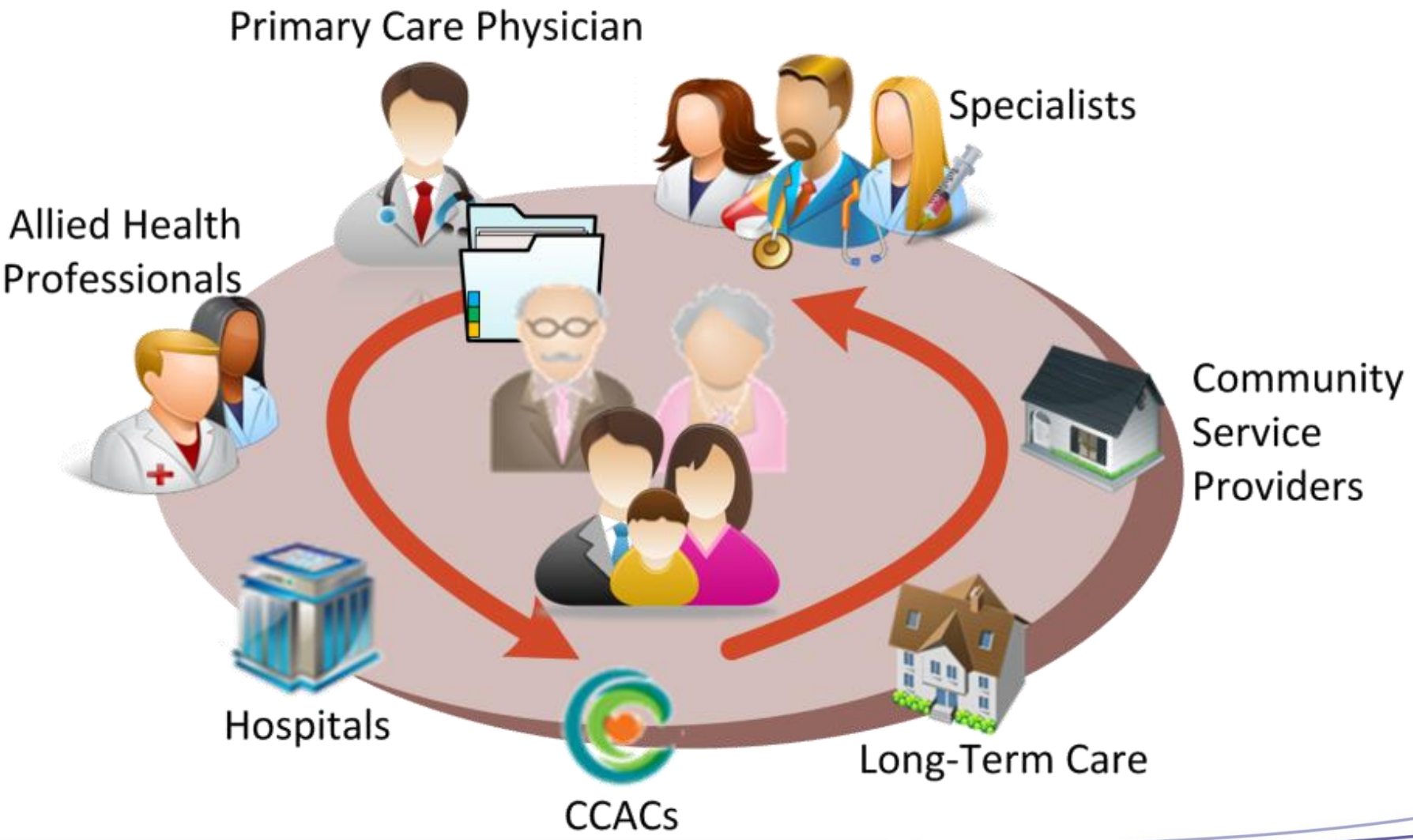
2. Why were Health Links Established?

3. Who is Involved?

4. How are Health Links Unfolding?

5. How are the Partners Working together?

Your Health Care Team, Working Together



Health Links: Partnering Around Patients

New Model of Care

- **New model of care**
- **Your Health Care Team will be working more closely together**

Target Group

- **Initial focus = improving patient care and outcomes for people with complex health conditions and seniors.**

Initial Success

- **Regions are already exhibiting a high degree of collaboration**
- **The goal is to have a Health Link in every Ontario community**

Role of LHIN's

- **Local Health Integration Networks (LHINs)will continue to assist identifying Health Links, supporting their development, and providing guidance for Health Links in their regions.**

Looking Forward

- **Health Links will eventually evolve to cover the entire province and expand beyond complex patients.**

Expected Outcome

- **Greater coordination of care for patients, improved patient outcomes, and better value for investment.**
- **Individual care plans, improved access, improved satisfaction / experience.**

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2. Why were Health Links Established?

"Fred"

Fred is 66 and lives alone.

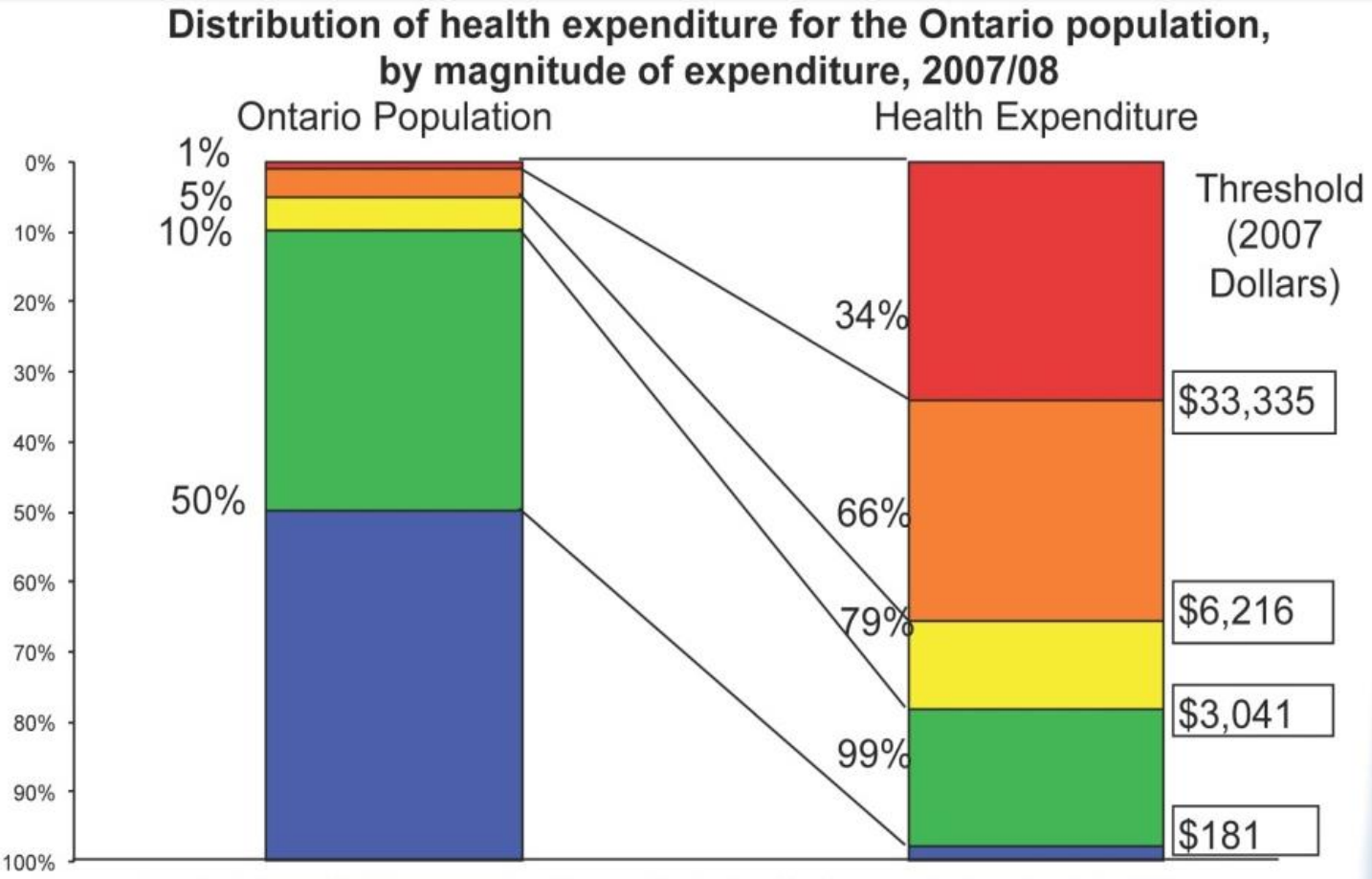
He has 24 different conditions, and has been in and out of hospitals for much of the year, including a lengthy stay in acute care, complex continuing care, rehabilitation, and homecare.

He also had 3 ER visits. Fred has seen 16 doctors.

The cost of his care was over $900,000 in one year.

- **High Users**
  - **1%** of the population accounts for approximately **34%** of Ontario's health care costs ($15.2 Billion)
  - **5%** of the population accounts for approximately **67%** of Ontario's health care costs
- **Is the system sustainable?**
  - **2013** → Health care consumes **>40%** of the provincial budget
  - **2030** → Health care is projected to consume **>80%** of the provincial budget

The Concentration of Healthcare Spending in Ontario

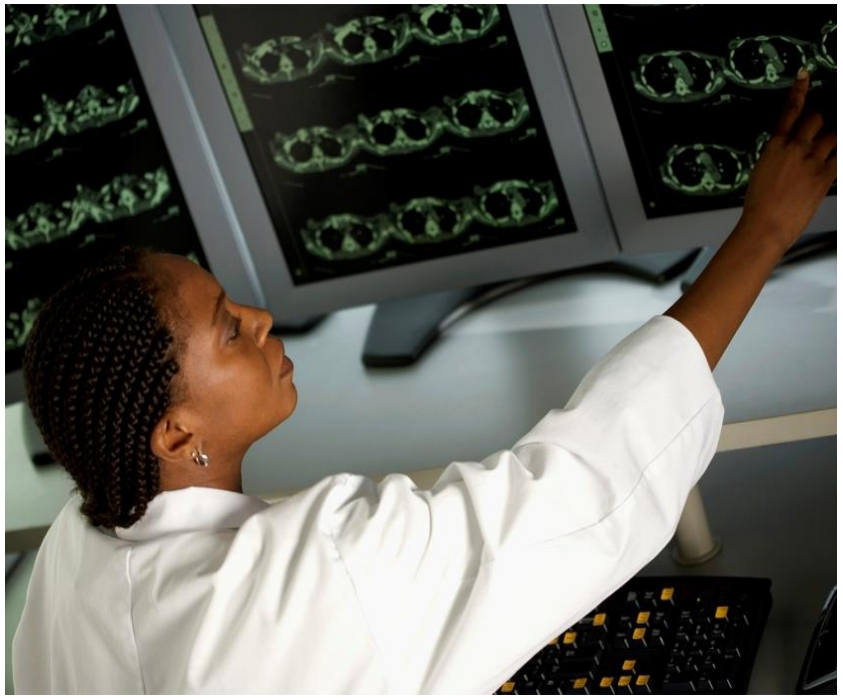


** Data from HSPRN/ICES

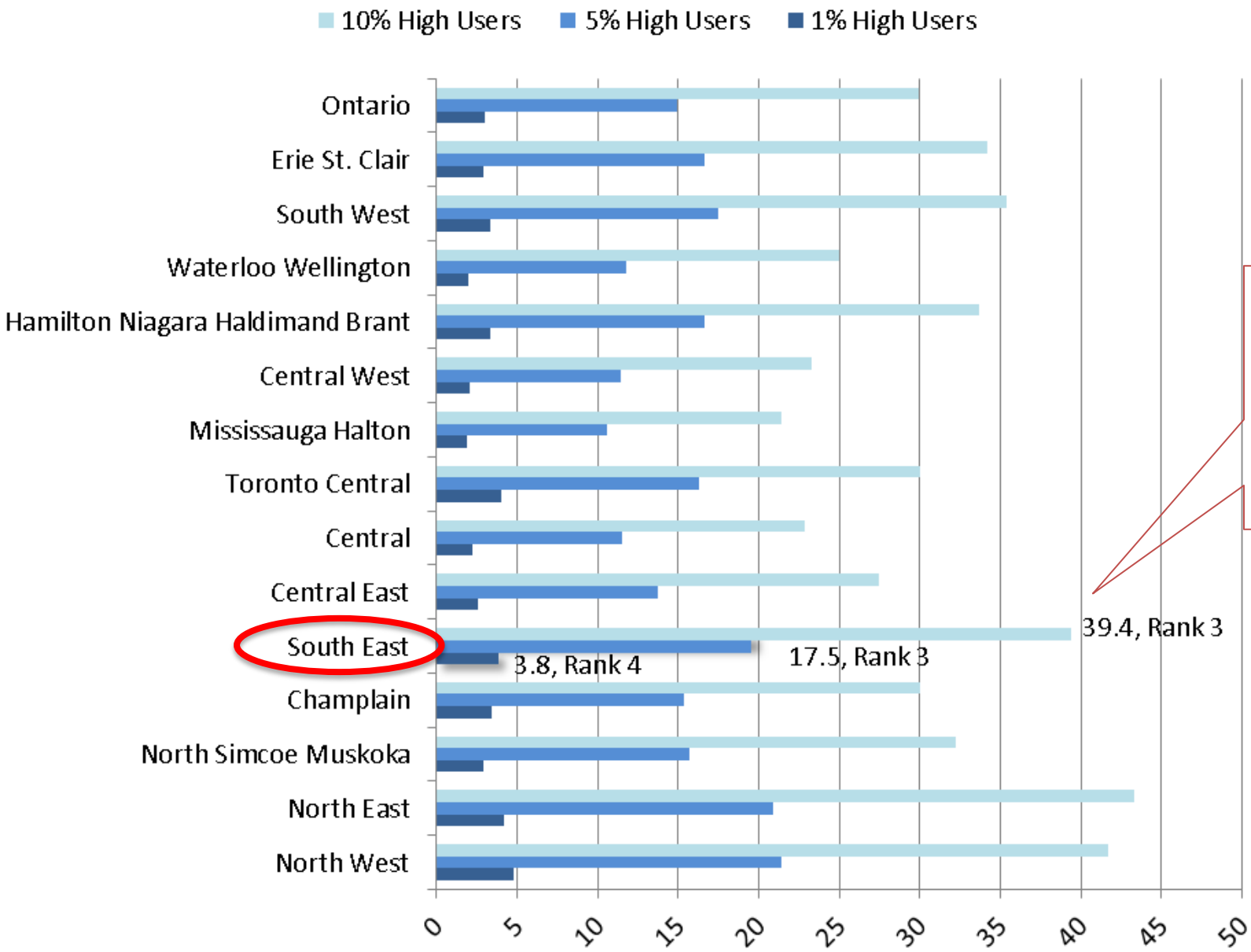
What Conditions Do They Have?

Conditions among the top 1% of users:

- **Mostly chronic disease:**
  - **Heart failure**
  - **COPD**
  - **Coronary Artery Disease**
- **Infection (pneumonia and urinary tract)**
- **Stroke**
- **Hip fractures**
- **End of life care / Palliative**
- **Cancer**



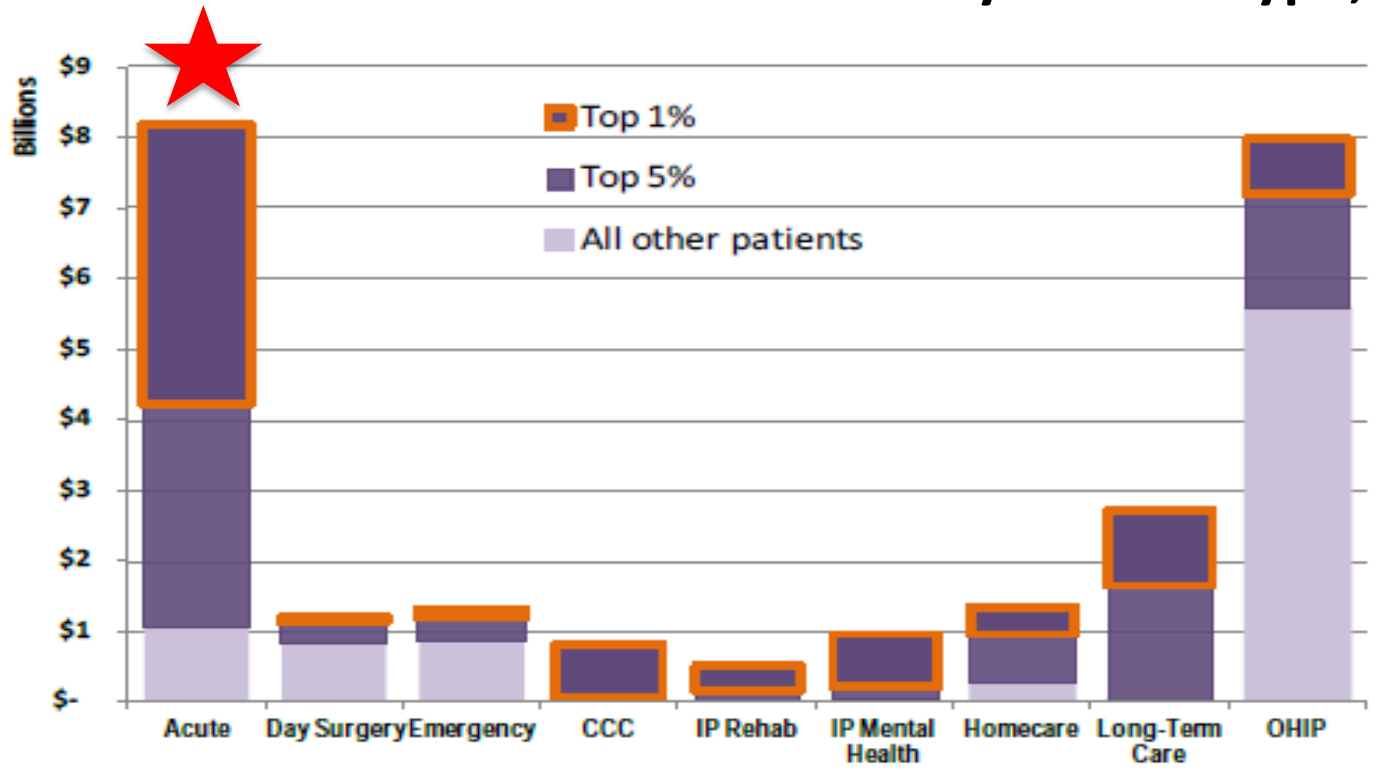
Rate of High Users per 1,000 population, All care types



SELHIN has among uppermost rates of high users per population: ranking 3-4 in all categories.

South East **LHIN**

Distribution of Health Care Spending by Service Type, 2010/11



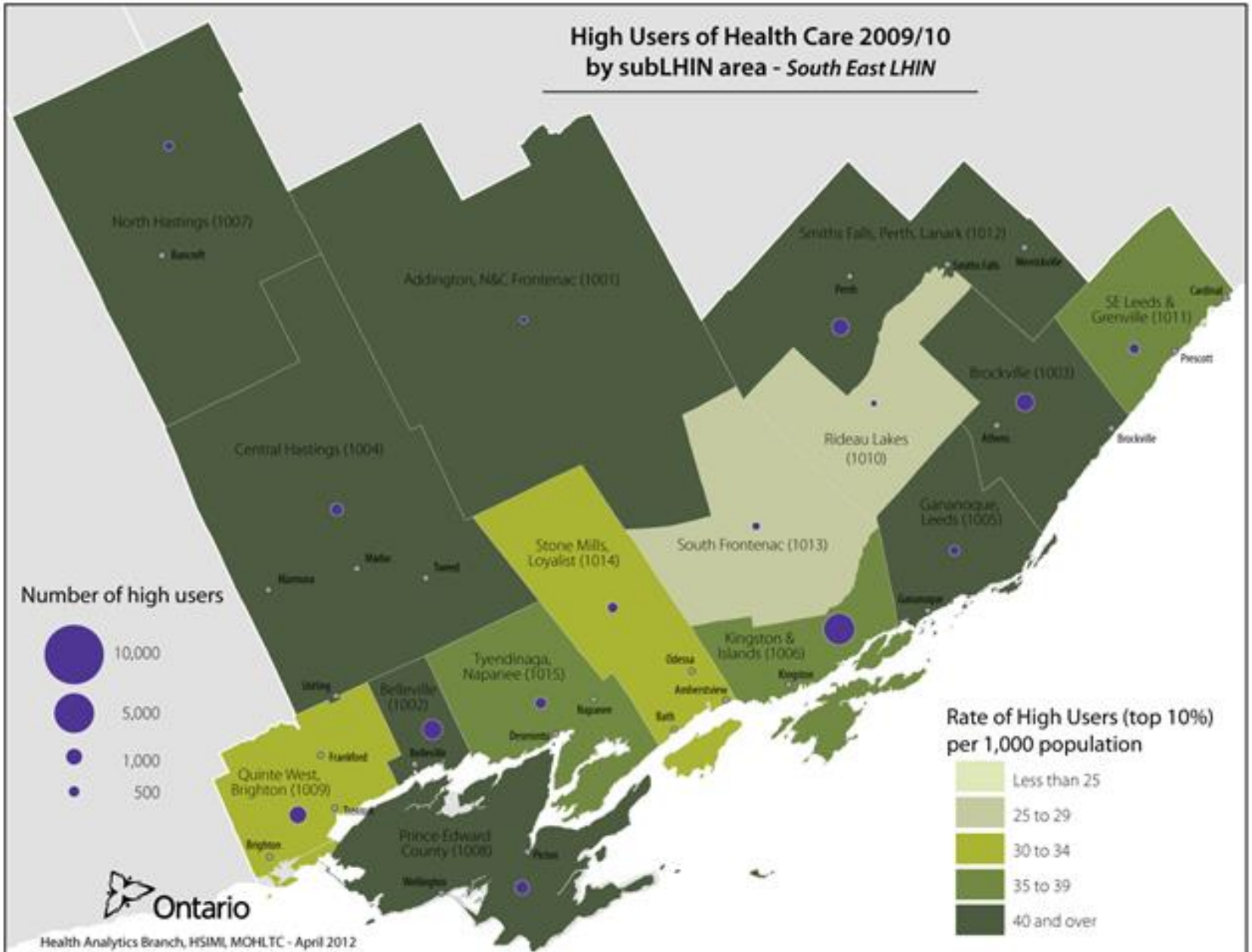
	Acute	Day Surgery	Emergency	CCC	IP Rehab	IP Mental Health	Homecare	Long-Term Care	OHIP
Top 1%	49%	5%	10%	94%	73%	77%	29%	40%	10%
Top 5%	87%	29%	34%	100%	100%	98%	79%	100%	30%

- The Top 1% of Complex Users → $4 Billion spent on acute care
  (out of a total of $8 Billion)

- The Top 5% of Complex Users → $7 Billion spent on acute care

South East **LHIN**

High Users Vary by Geography



Current State

Too many people receive care in the hospital when they can be better cared for in the community.

Too many people are having trouble navigating the system.

Too many people being readmitted to hospital within days of leaving hospital.

Access to primary care is uneven: many people do not get the benefit of a coordinated care plan.

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Health Links Around the Province

NSM LHIN
- Sth. Georgian Bay
- Barrie

South East LHIN
- Quinte
- Rural Hastings
- Rural Kingston
- Kingston
- Thousand Islands
- Rideau Tay
- Salmon River

CE LHIN
- Peterborough

NE LHIN
- Temiskaming
- Timmins

TC LHIN
- North Toronto E
- East Toronto
- Mid Toronto W
- DV/Greenwood

WW LHIN
- Guelph

Central LHIN
- North York
- South Simcoe North York

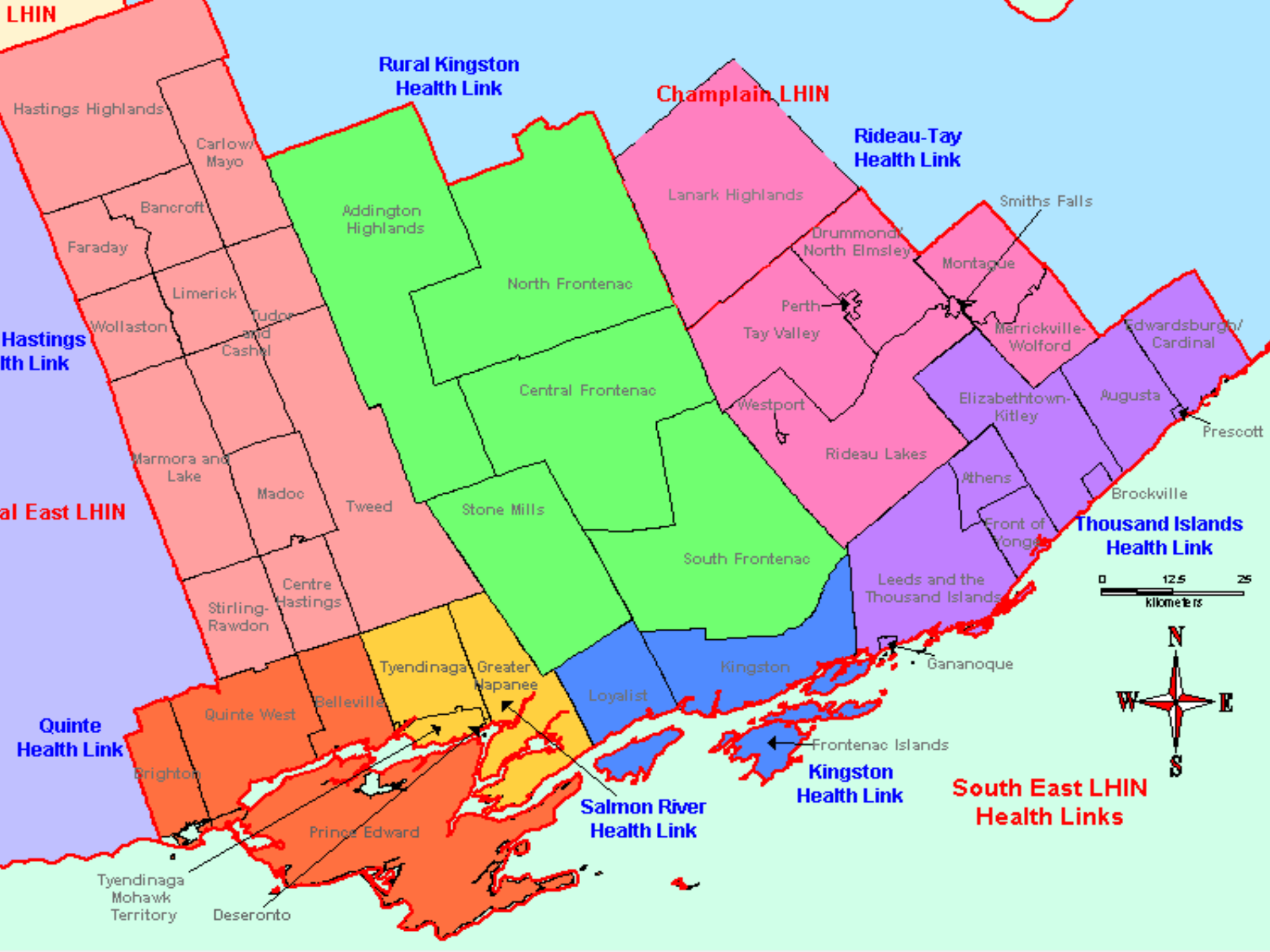
ESC LHIN
- Chatham City Centre

SW LHIN
- North Perth

HNHB LHIN
- Hamilton
- Niagara NW

MH LHIN
- SE Mississauga/West Toronto

CW LHIN
- Dufferin
- Nth Etobicoke-Malton-WW
- Downtown Brampton
- Bramalea


LHIN
Rural Kingston Health Link
Champlain LHIN
Rideau-Tay Health Link
Hastings Highlands
Carlow/ Mayo
Bancroft
Faraday
Limerick
Wollaston
Tudor and Cashel
Addington Highlands
North Frontenac
Lanark Highlands
Drummond/ North Elmsley
Smiths Falls
Montague
Perth
Tay Valley
Merrickville-Wolford
Edwardsburgh/ Cardinal
Central Frontenac
Westport
Rideau Lakes
Elizabethtown-Kitley
Augusta
Prescott
Marmora and Lake
Madoc
Tweed
Stone Mills
Athens
Brockville
Front of Yonge
Thousand Islands Health Link
South Frontenac
Leeds and the Thousand Islands
Centre Hastings
Stirling-Rawdon
Tyendinaga
Greater Napanee
Kingston
Gananoque
Loyalist
Quinte West
Belleville
Quinte Health Link
Brighton
Frontenac Islands
Kingston Health Link
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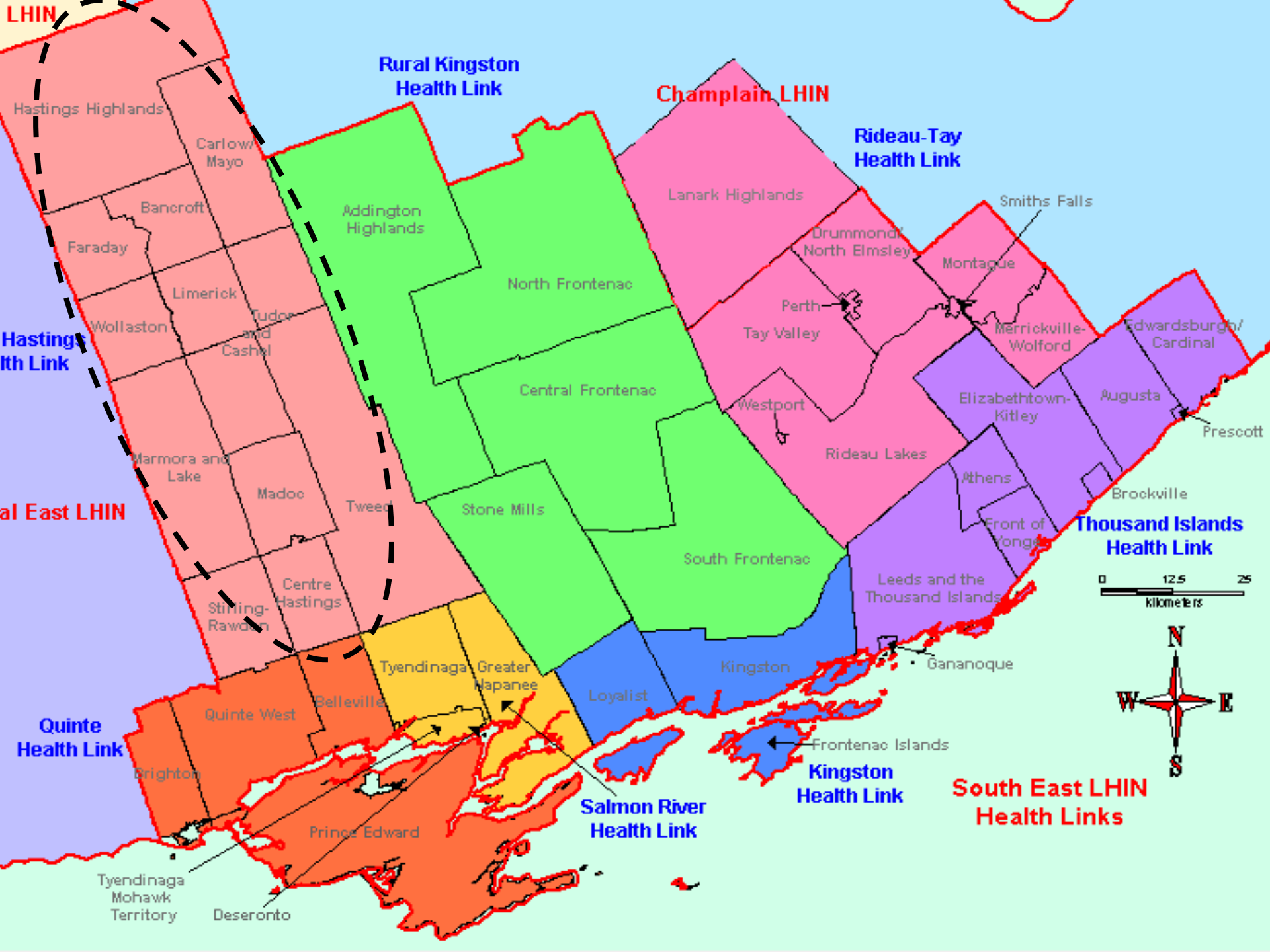
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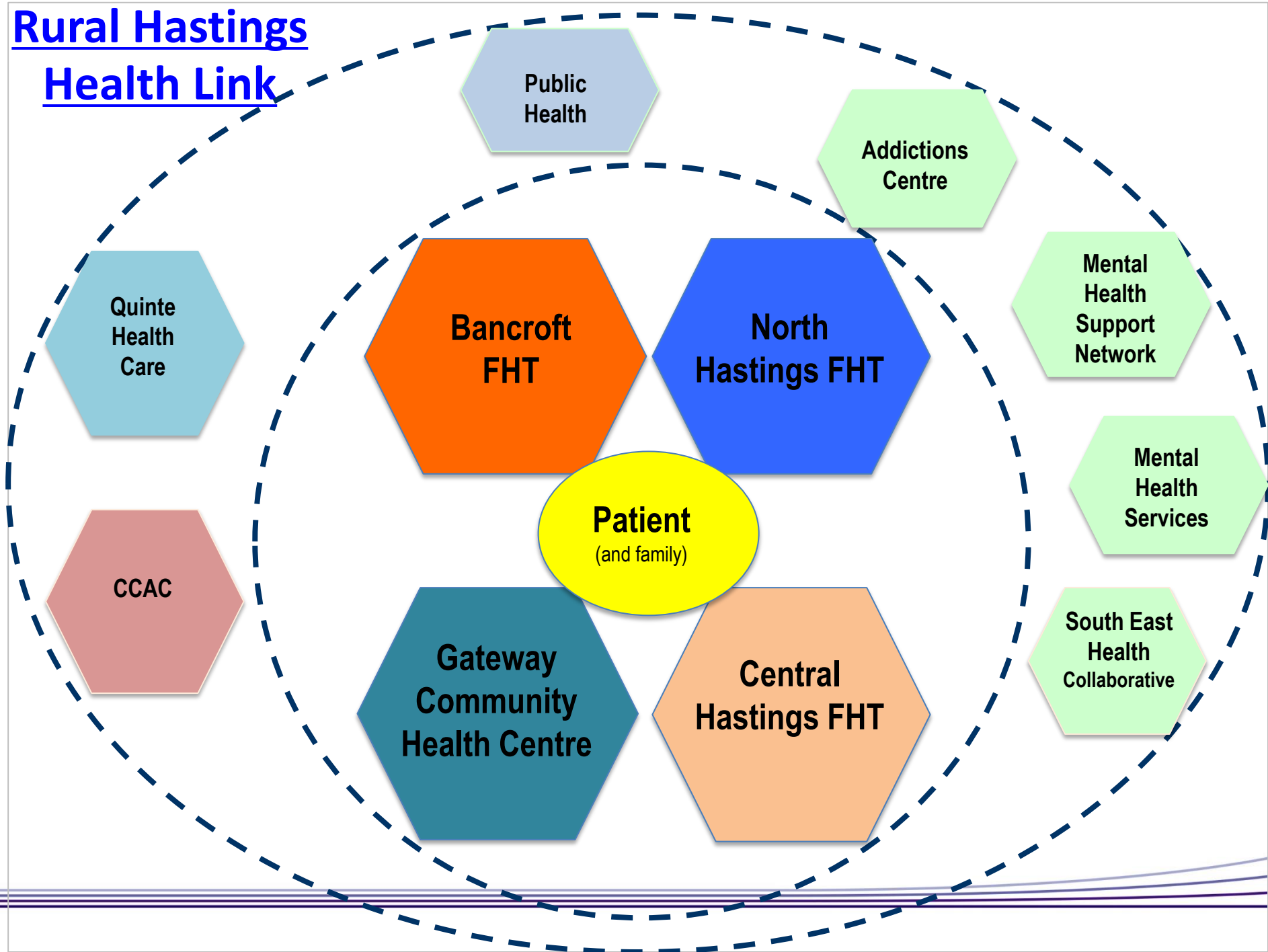

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WHAT:

Complex Patient Cohort

- Identifying patients with complex needs

Coordinated Care Planning

- Developing common principles
- Creating care plans for portion of the complex patient cohort

Attaching Complex Patients to PC

- Expanding on existing resources to attach complex patients to primary care (PC)

HOW:

Establishing the Health Links

- Cooperation between communities, LHIN, and Ministry of Health
- Address sustainability, reinvestment, and governance

EMR/IT Connectivity

- Establishing the right solution to enable coordinated care across Health Links

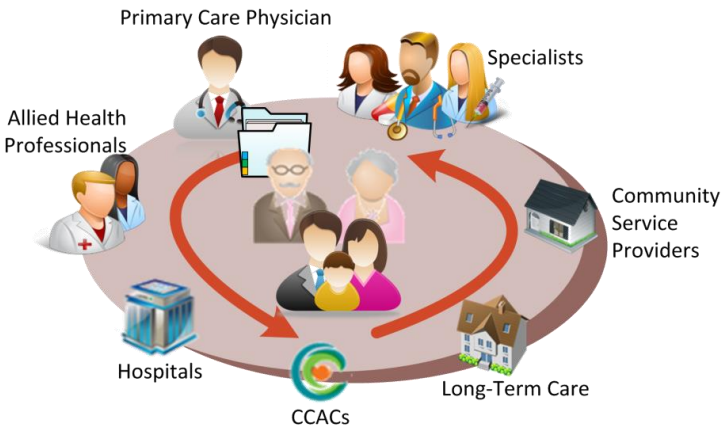
Patient Engagement

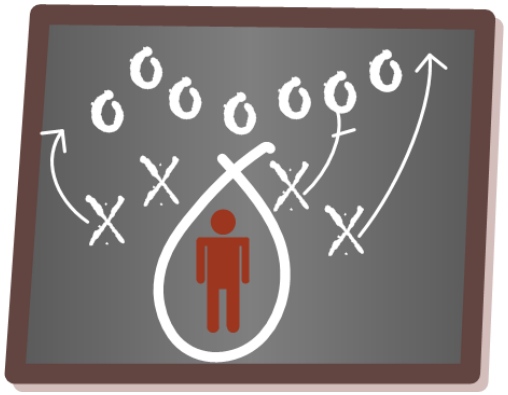
- Involve patients and families in the design and evaluation of Health Links

Health Links: Partnering Around Patients

- New model of care at the clinical level where **providers are developing with coordinating plans at the patient level**

- Initial focus on **improving patient care and outcomes for people with complex health conditions**, while delivering better value for investment





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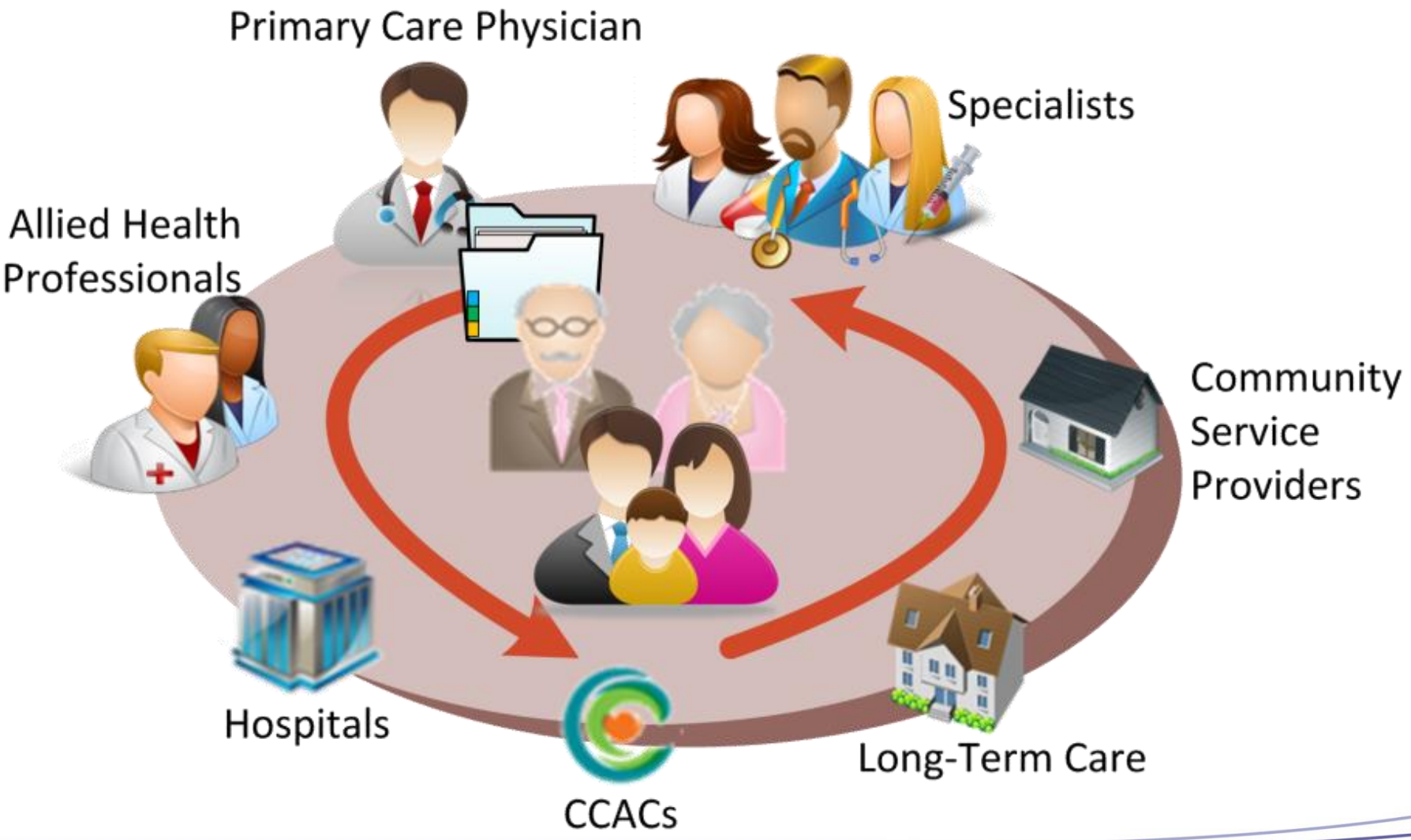
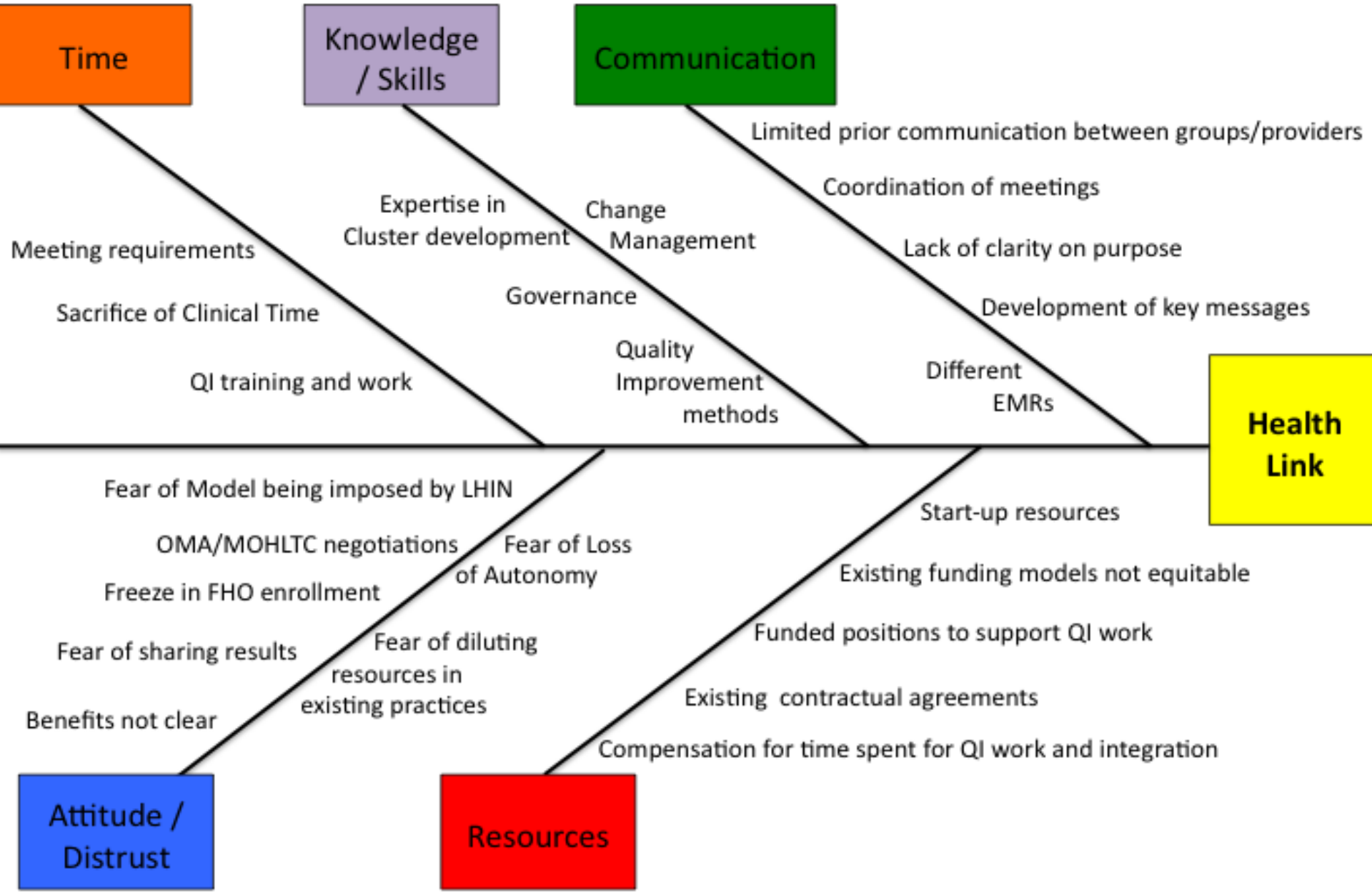
Coordinated and Integrated Care: the Heart of Health Links



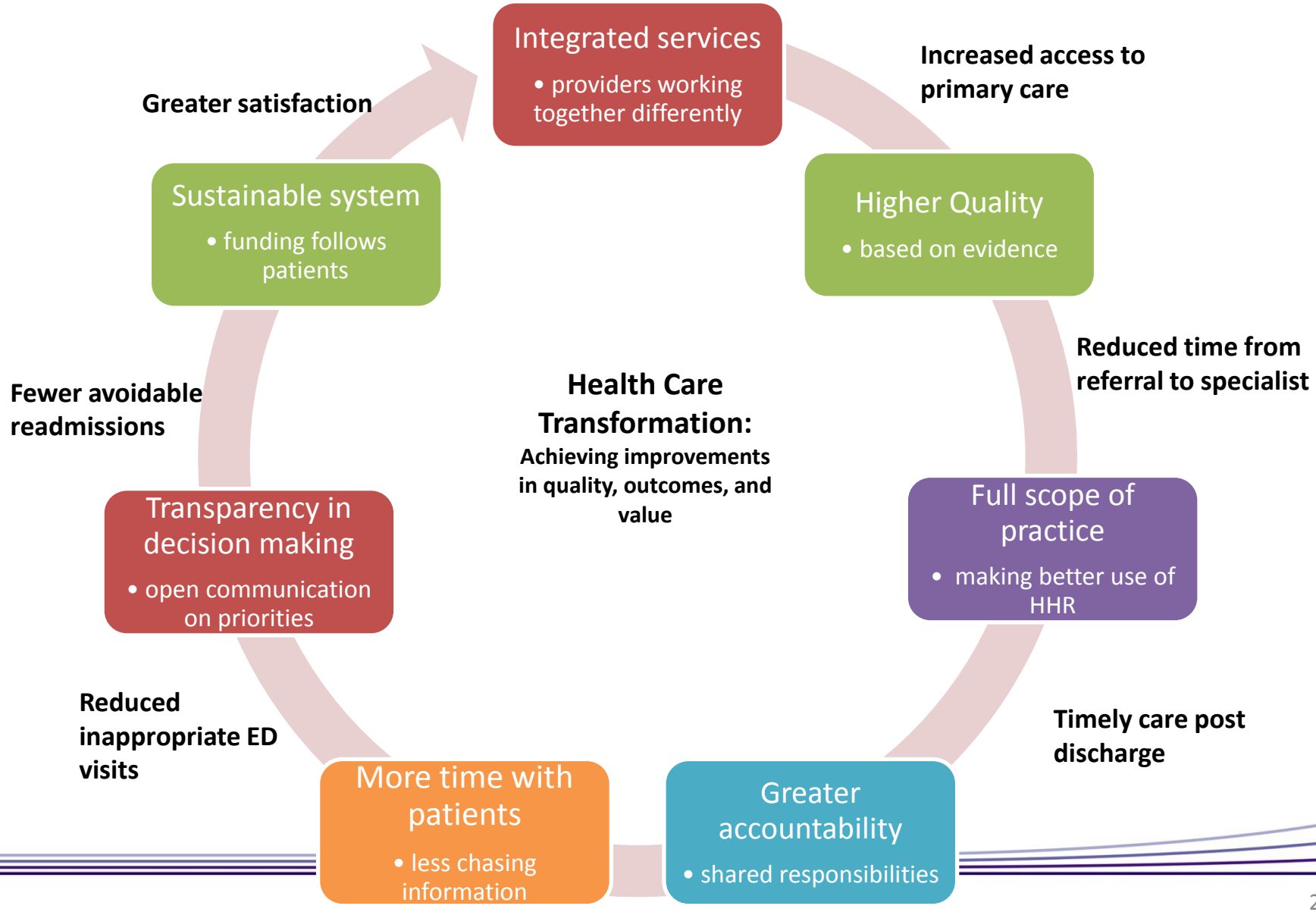
Potential Barriers to Primary Care Health Link formation



How Will We Support Change Together?

- Working together in a spirit of collaboration
- Shared vision amongst Heath Link partners
- Co-creating and co-producing the Health Care transformation
- Improve health care coordination and integration
- Delivering services differently
- Equity for patients and providers
- Local leadership
- Supported by the South East LHIN and Ministry of Health and Long Term Care

What Will Change Mean for the System



What Will Change Look Like?

Care Coordination and Care Plans

- **Innovative, transferable ideas to support care-coordination and identification of complex patients**
- Developing **common principles** for coordinated care plans so all complex patients in Ontario have the same experience
- Starting with **creating coordinated care plans for those complex patients**

Patient Engagement

- **Strong involvement of patients, families and caregivers in all stages of Health Links**
- Making the patient a part of the development of his/her individual care plan
- Developing patient stories
- Incorporating patient, caregiver and/or family perspectives into the coordinated care design process
- Ensuring patient/caregiver/family involvement in evaluation of model

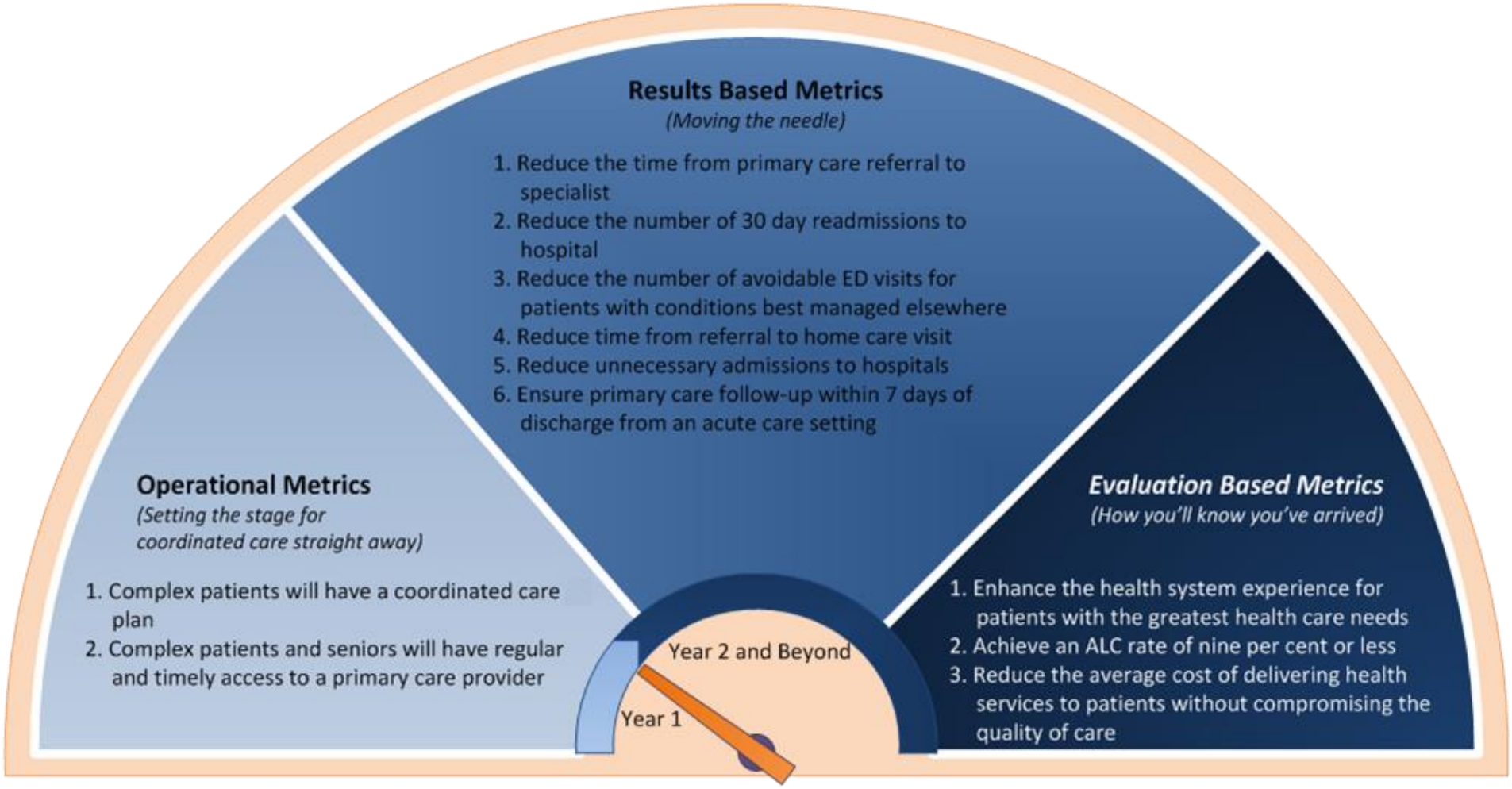
Alignment of Initiatives and Resources

- **Making use of existing resources to strengthen and align work**
- Aligning existing strategies to Health Links (e.g., Mental Health and Addictions, Seniors)
- Encouraging Health Links providers to build on existing innovations
- Working with agencies and associations to strengthen outreach and champion the Health Links Model
- Funding to support existing infrastructure and assets, not creating new ones

EMR / IT

- **Leveraging provincial assets for local solutions**
- Working with electronic health providers to align current assets with Health Links needs
- Emergency Department notification, tracking of complex needs patients is high priority

Indicators of Health Link Success



How the South East LHIN is supporting Health Links

1. **Human Resources**
    1. Health Links Lead
    2. Quality Improvement & Implementation Facilitators
    3. Primary Care Lead
2. **IT training and Enabling Technologies plan development**
3. **Quality Improvement training/capacity**
4. **System Leadership development**
5. **Sustainability Funding**

Potential Benefits of Health Links

- **Improved communication** between your family doctor/nurse practitioner, hospitals, homecare, and community agencies.

- **Easier transitions to/from hospitals and other services**

- **Improved health and quality of life**

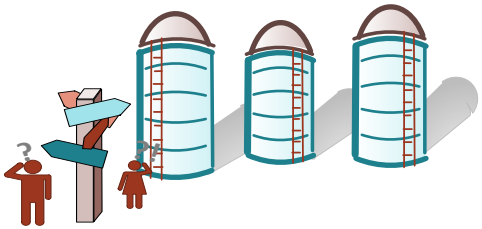
- **Increased efficiencies in the health care system**

- Activities will be directed by **community and population needs**

- **Improved patient and family satisfaction**

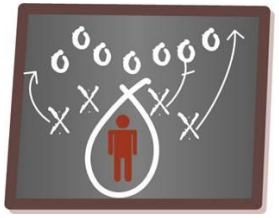
What Will That Mean for Bernice

Uncoordinated care with no game plan



- Bernice has multiple chronic conditions and sees over 16 providers
  - *The average annual system cost of a high user is ~$44,500 (2009/10)*
- She's alone at home, falls and calls 9-1-1, goes to the emergency department
  - No notification of the family doctor
- Undergoes surgery after 3 days
- Discharged home
  - No notice sent to family doctor regarding discharge plan
  - After two weeks Bernice's daughter contacts providers to confirm a follow up
- An assessment is completed and an insufficient amount of home care is available so family moves Bernice to a long-term care home

Coordinated care with a personalized game plan



- Bernice has a **care coordinator, a care team in place, and a coordinated care plan.**
- She's alone at home, falls and calls 9-1-1, goes to the Emergency department
  - ED sees she has a **care plan that includes primary care contact and summary of past issues and medications**
  - **Family doctor is notified electronically**
- Undergoes surgery next day
  - *Based on the provincial median for the total cost of a hospital stay, 2 days less in the hospital results in a savings of $2,084*
- Discharged home with discharge plan that is captured in **coordinated care plan and all care providers are notified of updated plan**
  - **Follow up with family doctor 2 days later**
- **Care coordinator ensures assessment is done and appropriate number of home care hours are provided**

For more information about Health Links:

Please go to the South East LHIN website below:

http://www.southeastlhin.on.ca/Page.aspx?id=8176