EVALUATION OF THE HEALTH LINKS IN THE SOUTH EAST LHIN

INTERIM REPORT

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EXECUTIVE SUMMARY

'Health Links' is a new model of care that brings together local health care providers (e.g. primary care, hospitals, mental health services and community care) with a focus of providing patient-centered care. Providers work together with a common interest to develop coordinated care plans (CCPs) for patients with complex needs[1]. It is believed that coordination of care for these patients will result in better care and significant health system savings that can be devoted to all patients, ultimately improving the sustainability of the health care system.

There are seven Health Links in the South East Local Health Integration Network (SE LHIN) including five early adopters (Quinte Health Link, Rural Hastings Health Link, Kingston Health Link, Rural Kingston Health Link and Thousand Island Health Link) and two newer Health Links (Salmon River Health Link and Rideau Tay Health Link). Together, the seven Health Links cover the entire SE LHIN geography and a portion of the Champlain LHIN.

This document reports on interim findings from an evaluation of the Health Links within the SE LHIN. It includes information collected between January 2014 – June 2014, primarily drawn from focus groups with service providers in five Health Links and a review of available initiative documents.

As the evaluation is in progress, conclusions are preliminary and this document's primary value lies in informing ongoing quality improvement. A final evaluation report will be completed in spring 2015.

Findings: Design and implementation

The seven Health Links in the SE LHIN intend to deliver more coordinated, seamless and integrated care thereby preventing complications, reducing duplication of services, and ensuring that services are provided by the most appropriate healthcare professional. The end result should be a more sustainable healthcare system where patients, especially those most vulnerable, experience improved health for lower costs.

The Health Links are in the early days of realizing this vision, focusing on key interventions (e.g., mental health, palliative, transitions between care settings, congestive heart failure/cardiovascular (CHF/CV) rehab, home health, attachment/access) for complex patients. This work is supported by a high level of collaboration and information sharing across the LHIN. A region-wide leadership group is supporting collaboration across the Health Links as well as

[1] A definition of 'complex patient' is currently under development. A proposed definition within the SE LHIN Health Links includes individuals with: >3 acute care admissions in the past 2 years; >20 days in hospital in the past 2 years, <8 emergency department visits in the past 2 years; complex medical conditions; or at risk of frequent and prolonged admissions.

collaboration with partner organizations. The Health Links are also pooling expertise/resources in order to develop common tools such as:

- **The Southeast Information Implementation Portal (SHIIP)**, an IT solution that will allow for patient information (i.e., Coordinated Care Plans) to be shared between hospitals and primary care providers.
- **A communications plan** describing key messages regarding Health Links and how these will be communicated to relevant audiences.

Each Health Link operates in a unique context. As such, aspects that one group experiences as a challenge may be a strength or merely matter of course for another group. Commonly experienced challenges and success factors are presented in the following table.

Common challenges	Common success factors
Information sharing – Lack of a standard privacy agreement and electronic communication/CCP system slows down provider communication as well as discourages some providers from using the CCPs. **Protected time** – Most stakeholders are 'working off the sides of their desks' and may not be able to fully engage in Health Links. **Clarity on the initiative** – Some stakeholders may have fuzzy understandings of what the Health Links will accomplish, for whom, and how. This may make it challenging to communicate the value of the initiative and encourage engagement. **Short term funding** – Some Health Links find it challenging to make long term plans and recruit and retain talent with short term funding. Some organizations may be waiting to see if Health Links will be maintained long term before committing to involvement.	**Champions**, and key leaders, particularly well-respected physician and nurse practitioners (NPs), help encourage engagement by peers and enhance credibility. **Human connections** – Creating opportunities for genuine human connections has helped to develop stronger relationships and build momentum. Where feasible, this may be most effective in-person. **Self-direction** – A grassroots approach to developing priorities enables each Health Link to respond to their community's unique needs and increases engagement. **Sharing resources** – The LHIN's collaborative approach enables sharing knowledge, tools, and resources between Health Links. This reduces the work for individual Health Links and allows them to learn from the success and challenges of others.

The above challenges are connected with healthcare providers being less involved in/enthusiastic about the initiative than ideal and correspondingly slower progress. The success factors generally contribute to generating greater ownership of the initiative, ensuring that each Health Link appropriately meets the needs of its community and finding opportunities for efficiencies.

Findings: Early impact

The Health Links in the SE LHIN are still relatively new to implementation and so limited impacts have been recorded to date. It should also be noted that a common definition of complex patient is still in progress. The following changes have been noted:

- Approximately **300 Coordinated Care Plans (CCPs)** have been developed.
- Anecdotal information suggests that **patients are more engaged in making care decisions** and are **less likely to have avoidable emergency department (ED) visits.**
- **Providers** report **better understanding of the patient experience.**
- Service providers are **more aware of available services, service gaps, and areas of opportunity.** Efforts are underway to better integrate care.
- **New services and programs** are being developed collaboratively (e.g., a voluntary Influenza Vaccination Campaign has been launched across all seven Health Links).

Findings: Sustainability

Limited information is currently available regarding the Health Links' ongoing sustainability. A HL regional sustainability plan, as well as HL-specific sustainability plans, was under development at the time of this report. These plans will be finalized by October 2014.

Focus group participants agreed that while the groundwork has been laid for sustainability (via lead organization meetings/planning), several challenges must be addressed. Some stakeholders were concerned about the uncertainty caused by a lack of long-term funding. Some were also concerned about the potential for 'Health Links fatigue' as many partners are working off the sides of their desks.

However, others believed finding new and different ways to offer services using existing resources will set them up for greater success once funding is no longer available. Stakeholders also felt that showcasing early patient success stories would contribute to building momentum for the initiative.

Opportunities and recommendations

Based on the above findings, the following opportunities may support Health Links' ongoing success:

- **Prioritize Health Links actions** in order to move cornerstone activities forward in a timely manner. Success in a small number of activities may encourage greater involvement from a wider group of stakeholders.
- Ensure that key positions (e.g., HCPs involved in developing Coordinated Care Plans, representatives from organizations that should be involved in planning HLs activities) have **sufficient protected time** for Health Links activities. This may require reallocating other workload and/or hiring new staff.
- **Adopt an adequate definition of complex patient** until/unless the Ministry provides other direction. This will allow the Health Links to measure success in a more concrete manner, and better identify ongoing improvement opportunities. Consider advocating to the Ministry to adopt this definition, minimizing the chances that a change in definition will be needed.

- **Prioritize finalizing and rolling out the Southeast Information Implementation Portal (SHIIP)** across the LHIN in a timely manner.
- **Document SHIIP's benefits to HCPs and patients** (e.g., time savings, improved experience) through initial testing, and develop a plan to communicate benefits to intended users.
- **Update and implement the LHIN wide communication strategy**. This strategy should include consistent messaging for healthcare providers on:
    - How Health Links will improve patient and provider experiences as well as healthcare outcomes
    - What the Health Links are and which activities are part of Health Links
    - The content and value of coordinated care plans

  It should also include a patient education component in order to empower patients to ask to be involved in the program. The strategy could be tailored to individual Health Links and their populations as appropriate.
- Develop a deliberate strategy to **identify and nurture champions** and provide them with the supports needed to be fully effective. Ensure that key HL staff have the skills to identify and nurture champions.
- Whenever possible **use in person meetings** with extra time **for relationship building**, generating excitement, and sharing ideas informally. Create opportunities for those outside of the core implementation group to engage in these experiences.
- **Continue to gather information on early impact**. Consider re-ordering evaluation data collection to complete care recipient interviews early as this may support the initiative's communication strategy.
- **Continue sustainability planning**. Where possible, develop strategies that allow organizations to leverage existing resources without relying on external funding.

1. BACKGROUND: THE REPORT

This document reports on interim findings from an evaluation of the Health Links within the South East Local Health Integration Network (SE LHIN). It includes information collected between January 2014 – June 2014, primarily drawn from focus groups with services provides in five Health Links and a review of available initiative documents. The evaluation will continue for another year and develop to include information from a much broader range of sources.

As such, conclusions are preliminary and this document's primary value lies in informing ongoing quality improvement. A final evaluation report will be completed in spring 2015.

2. BACKGROUND: THE INITIATIVE

2.1. NEED FOR HEALTH LINKS

In Ontario, health system spending is highly concentrated on five percent of the population. These are generally individuals with many health concerns who, as a result, have numerous encounters with the health care system and many different heath care providers. For instance, a recent study reports that 75% of seniors with complex needs who are discharged from hospital receive care from six or more physicians and 30% get their medication from three or more pharmacies.[2] Additionally, too many of these individuals default to the emergency department for care when more appropriate and often better care is available for them in the community.

Providing care for such individuals is complex and requires coordinated care planning. Health care providers must work together to ensure that appropriate services are provided to such individuals and that there is no overlap of services. In other words, they must work together to ensure continuity of information and coordinated care with other service providers.

To address this challenge to Ontario's healthcare system, the Ministry of Health and Long Term Care (MOHLTC) has developed a new model of care through provincial Health Links. These Health Links bring together local health care providers (e.g. primary care, hospitals, mental health services and community care) with a focus of providing patient-centered care. Providers work together to coordinate care plans at the patient level in an effort to:

- Improve services for patients with complex needs;
- Reduce gaps in services;

[2] www.southeastlhin.on.ca

- Reduce the likelihood of readmission to hospital;
- Increase communication among providers and between providers and patients;
- Improve transitions of care;
- Improve patient outcomes;
- Improve patient experiences; and
- Improve provider experiences.

It is believed that coordination of care for these patients will result in better care and significant health system savings that can be devoted to all patients, ultimately improving the sustainability of the health care system.

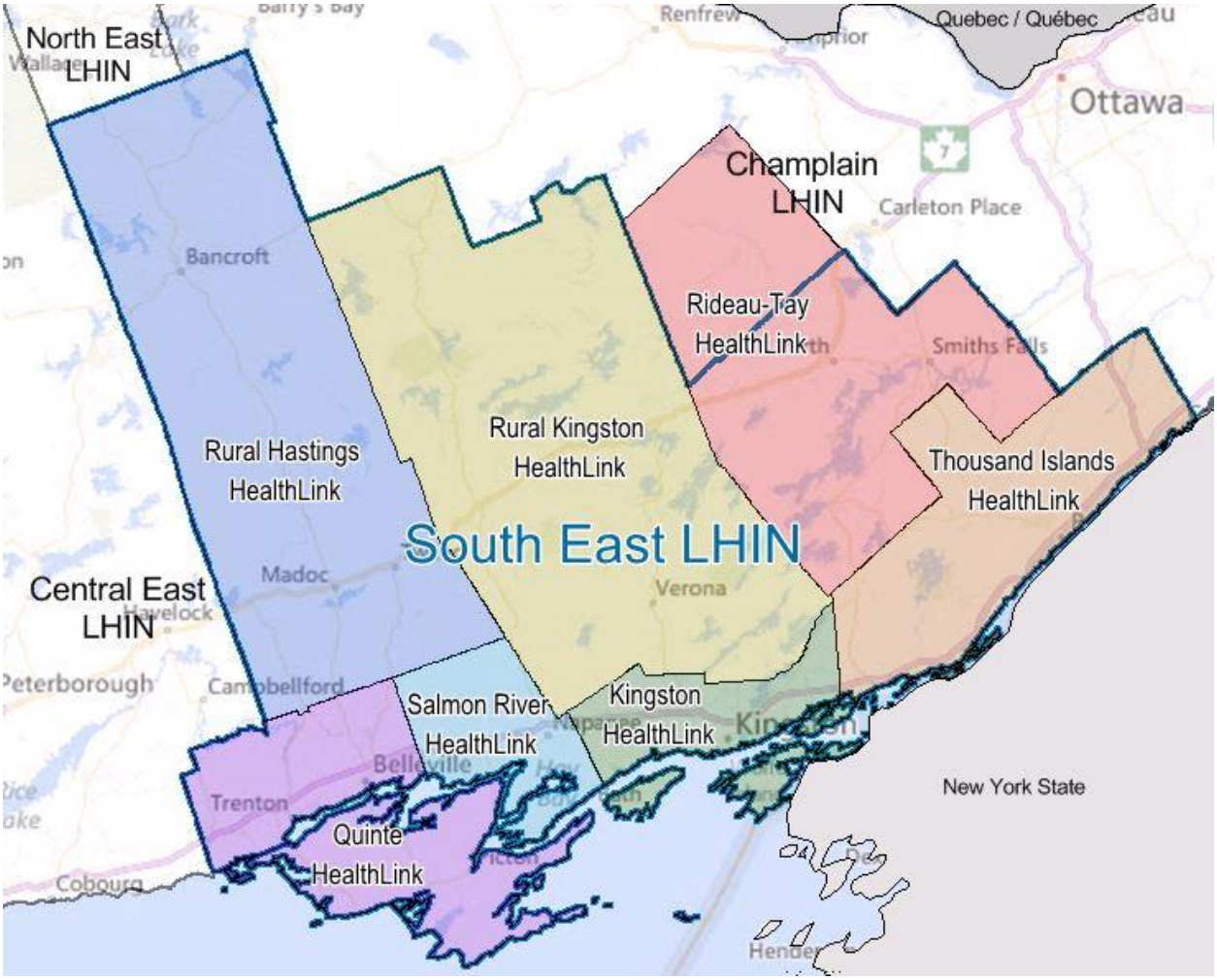
2.2. HEALTH LINKS IN THE SOUTH EAST LHIN

The SE LHIN is divided geographically into seven Health Links. Five of these Health Links are early adopters, meaning that their business plans were developed and approved by the Ministry of Health in fall 2013. These include:

- Quinte Health Link (QHL);
- Rural Hastings Health Link (RHHL);
- Kingston Health Link (KHL);
- Rural Kingston Health Link (RKHL); and
- Thousand Islands Health Link (TIHL).

The South East's remaining two Health Links, Salmon River Health Link (SRHL) and Rideau Tay Health Link (RTHL), completed their business cases in January and April 2014, respectively. The following map shows the catchment areas of the SE LHIN Health Links. Together, the seven Health Links cover the entire SE LHIN geography and a portion of the Champlain LHIN.

Figure 1: Map of SE LHIN's Health Links



3. BACKGROUND: THE EVALUATION

3.1. EVALUATION OBJECTIVES

The regional evaluation of the Health Links within the South East LHIN is intended to provide a solid basis of evidence that is both formative and summative. In other words, it is examining the development of the seven Health Links as well as their early outcomes.

The evaluation will be used by the Health Links and their direct partners (including the LHIN) to:

- Provide information that can be used by the Health Links to **support ongoing quality improvement and sustainability** (e.g., enablers, barriers, and opportunities for improvement)
- **Build an evidence base** that shows the extent to which the Health Links model and SE LHIN's approach to implementation (e.g., demonstrate the link between model/approach and outcomes) is effective.
- **Encourage involvement in and ownership of** the Health Links (with current partners, potential partners, and patients) by describing Health Links components and their early impact.

3.2. EVALUATION QUESTIONS

By answering the following guiding questions, the evaluation is expected to provide the Health Links with the information needed to meet the above objectives. It should be noted that while each line of inquiry will contribute to answering these questions, stakeholders may not be asked these exact questions directly.

Evaluation questions are shown below along with their alignment to the evaluation objectives.

Encourage involvement and ownership Build an evidence base	**1. How well designed and implemented are the Health Links (Health Link and LHIN level)?** ▪ What are the components, characteristics and activities of the Health Links? ▪ What are the persistent barriers to implementing the Health Links? ▪ What are the key success factors and enablers to implementing the Health Links? ▪ How has the collaborative, LHIN-wide approach supported the development and implementation of the Health Links? ▪ What works well and what could be improved?
Encourage involvement and ownership Build an evidence base	**2. What has been the early impact of Health Links (Health Link and LHIN level)?** ▪ What progress has been made towards accomplishing priority metrics? ▪ How have the Health Links impacted the patient experience? ▪ How have the Health Links impacted the provider experience? ▪ How have the Health Links impacted relationships/collaboration across the SE LHIN? ▪ What other impacts have the Health Links had?
Support quality improvement and	**3. How can the Health Links be made more sustainable?** ▪ What are the key components of sustainability for the Health Links?

sustainability	▪ To what extent are the Health Links sustainable? ▪ What interferes with sustainability? ▪ What could be leveraged and/or strengthened to enhance sustainability?
Support quality improvement and sustainability	**4. What are the opportunities and recommendations for improving Health Links?**[3]

3.3. SCOPE OF THE EVALUATION

The evaluation will include information on the implementation and impact of the Health Links from their initiation in 2013 until March 2015.

The evaluation will leverage, rather than duplicate, other measurement and evaluation efforts, such as the province wide evaluation and Health Link specific data collection.

3.4. EVALUATION METHODOLOGY

The following section describes the methods used to plan and implement the evaluation.

Planning

Initial evaluation planning included:

- Interviews with key stakeholders to identify their data needs; and
- Development of a detailed evaluation plan.

Adjustments to the evaluation plan are made on an ongoing basis with guidance from the Health Links Evaluation Committee. This group includes representation from each Health Link.

Data collection

This evaluation uses a combination of quantitative and qualitative methods. Data collection is staggered with preliminary data collection completed in year one and additional information collected in year two. A detailed evaluation matrix showing alignment between evaluation questions and data collection methods is provided in *Appendix A.*

Data collection completed to date (and included in this report) includes:

[3] Opportunities and recommendations will be developed based on a synthesis of information gathered through other evaluation questions.

Logic model development
Representatives from each of the seven Health Links, the SE LHIN and the local Community Care Access Centre (CCAC) participated in a workshop to develop a common logic model for Health Links within the SE LHIN (shown in *Figure 2*). This workshop involved discussion of common Health Links activities, objectives, and the ways in which they are connected. Following the workshop, the logic model was refined with input from the Evaluation Committee.

Focus groups with Health Links members
Partners from all five early adopter Health Links were invited to participate in focus groups (May 2014) in order to learn about members' perceptions on Health Links early implementation. Topics of discussion included success factors/enablers, barriers, effective practices, early impacts and opportunities to enhance sustainability. Focus groups ranged in size from five to nine participants, and lasted up to 1.5 hours.

Focus groups with the remaining two Health Links will be held in fall 2014.

Document review
Key Health Links documents were reviewed in order to understand how the Health Links were intended to be and actually were implemented. Documents were selected/provided by evaluation committee representatives and include:

- Business plans for all seven SE LHIN Health Links;
- News releases and other descriptive information available online;
- PowerPoint presentations describing the SE LHIN Health Links; and
- Health Links administrative documents, including quarterly reports and meeting minutes

Additional data collection to be completed in the second year of the evaluation includes:

Survey of Health Links members
This online questionnaire will be administered in order to gather feedback from Health Link member organizations about the implementation and impact of the Health Links. The questionnaire will be designed to gather more information on trends identified in the member agency focus groups, a) testing how wide spread these perspectives are; and b) exploring any changes in these perspectives in the second year.

Interviews with care recipients
A purposeful sample of complex care recipients (7-10 per Health Link) will be interviewed in the second year in order to collect qualitative, in depth information on care recipients' experiences with Health Links. Interviews will last up to 45 minutes and will be conducted either via telephone or in person, depending on the respondent's preference.

Priority metrics
Each Health Link will be collecting information on priority metrics identified by the Ministry of Health and Long Term Care. Definitions and data collection processes are currently under development by a separate Data Leads Working Group.

Analysis

Qualitative information (i.e., document review, focus groups, interviews) was uploaded into NVivo qualitative analysis software and analyzed according to evaluation question and theme. Within each evaluation question, we code information to identify emergent themes as well as unique perspectives. Quantitative data (i.e., survey, priority metrics) will be analyzed using SPSS or Excel for descriptive statistics as appropriate.

Prior to developing this report, representatives from each of the seven Health Links (Evaluation Committee members as well as project managers) were provided with a high level summary of evaluation findings. The group then met to discuss findings, their implications/logical recommendations, and any additional context that may be necessary for appropriate interpretation of these findings. Notes from this meeting were used to guide the development of this report.

3.5. EVALUATION STRENGTHS AND LIMITATIONS

This evaluation used a highly consultative and collaborative approach designed to fully engage key stakeholders in understanding evaluation findings and putting them to use. In addition, the evaluation collects information from multiple data sources and stakeholders. Where multiple data sources or stakeholders agree, we can be more confident in the findings.

However, this report draws only on information from focus groups and document review. As such, it has not yet had the benefit of multiple data sources. Furthermore, focus group participants were proposed by lead organizations and then participated on a voluntary basis. It is possible that those who are less engaged in the process were also less likely to participate in the focus group.

Given these limitations, conclusions should be interpreted as preliminary. As such, this document's primary value lies in informing ongoing quality improvement.

4. FINDINGS: DESIGN AND IMPLEMENTATION

This section describes the design and implementation of the SE LHIN Health Links, including detailed information about the collaborative approach taken to development and implementation.

4.1. COMPONENTS, CHARACTERISTICS AND ACTIVITIES

While each of the seven individual Health Links within the SE LHIN is unique and may contain differing components, characteristics and activities, they all share similar logic and ultimate goals.

Logic of the SE LHIN Health Links

The diagram in *Figure 2* provides an overview of how the activities of the SE LHIN Health Links are intended to lead to desired short- and longer-term outcomes. The pale grey arrow at the top of the diagram represents the collaborative leadership at the regional level (described in the previous section), which is intended to establish conditions needed for the Health Links to be effective and sustainable. The following text provides additional description about the other sections of *Figure 2*.

Resources

The Ministry of Health and Long-Term Care has provided dedicated funding for the Health Links. The intended use of the funding is for the seven Health Links within the SE LHIN to support staff positions (e.g., coordinators) as well as to support collaborative leadership across the LHIN. However, at least one Health Link has indicated that they have not used all of the funding received and may return most of it.

In addition, there are existing resources within the broader health system that will impact the Health Links activities. For example, the availability of different types of health providers (primary care providers, specialists, and allied professionals) will impact the Health Links outcomes (coordination of care is much more difficult when primary care providers are stretched too thin, or when specialist wait lists are too long).

Activities

For the first few years, the Health Links activities will focus on the 5% of patients with the most complex needs. This patient population is currently defined as individuals with:

- More than 3 acute care admissions in the past 2 years;
- More than 20 days in hospital in the past 2 years;
- More than 8 emergency visits in the past 2 years;
- Complex medical conditions – CHF, CVD, Palliative, COPD; or
- At risk of frequent and prolonged admissions (e.g. end of life).[4]

The Health Links coordinators will reach out to primary care providers to identify the most complex patients. Where needed, they will work with system partners to ensure all of the identified patients are linked with a suitable primary care provider. They will also undertake activities that will build health care provider capacity to provide coordinated/integrated patient centered care.

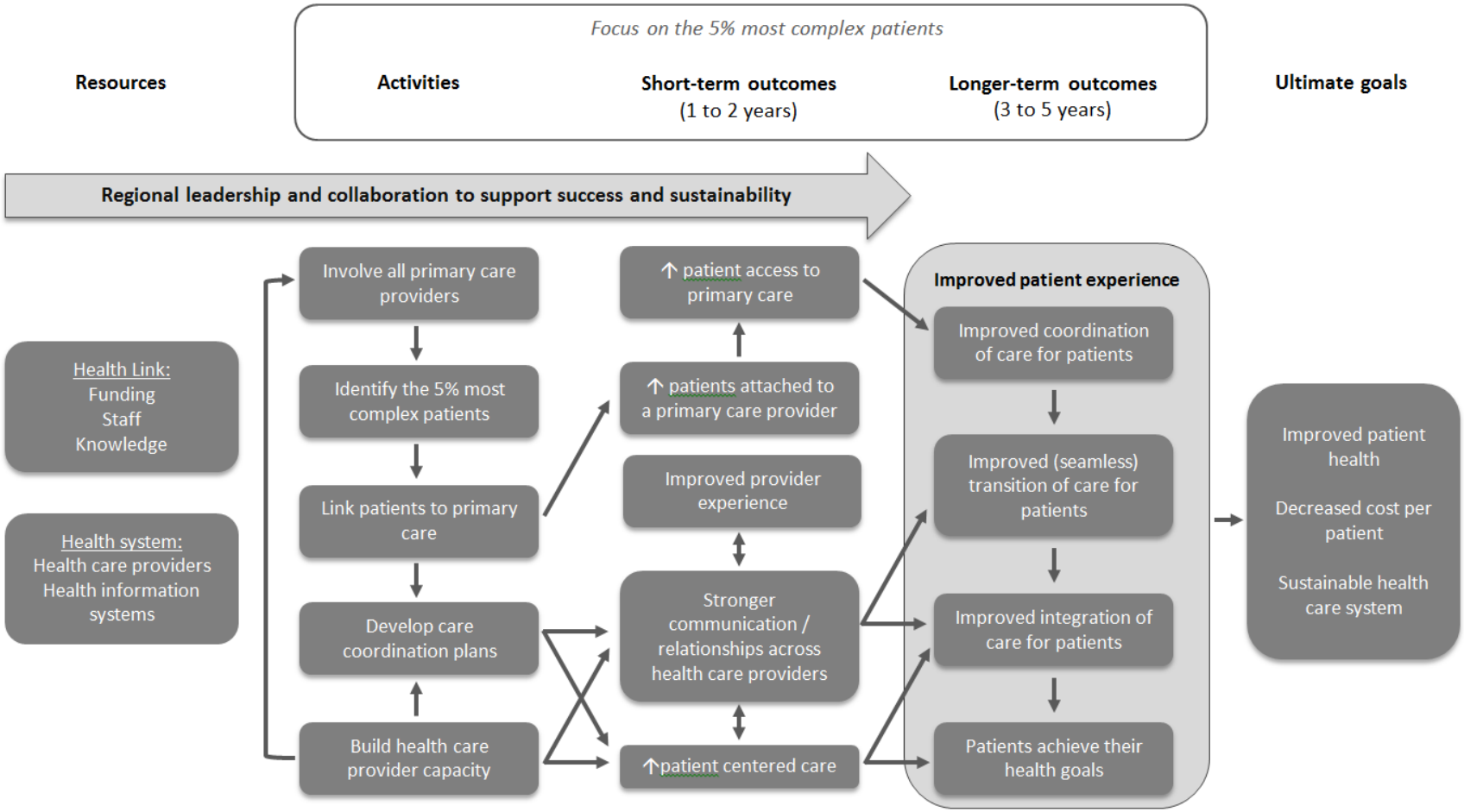
A key activity of the Health Links is to develop care coordination plans (CCPs) for the targeted patients. The Health Links coordinators will support the primary care physicians and the patient in creating these plans.

[4] To date the Ministry of Health has not issued a provincial definition for complex patient. This definition was developed by the Quinte Health Link and is being adopted by other Health Links in the LHIN.

Short-term outcomes

The short-term outcomes of the program are immediate benefits of the Health Links activities. They should be seen (for the 5% of patients with the most complex needs) within one or two years.

Figure 2: Logic of the SE LHIN Health Links



Linking patients with primary care is expected to increase patient attachment and ultimately access to appropriate care. Care coordination planning, along with the capacity building efforts, are expected to increase communication across health care providers. This should in turn result in stronger relationships across health care providers, and an improved provider experience. The care coordination planning and capacity building should also help providers shift toward increasingly patient-centered care.

Longer-term outcomes

Over the longer term, it is expected that improved access to primary care, stronger communication among health care providers, and increasingly patient centered care will contribute to an **improved patient experience** for the targeted patients. Aspects of the patient experience that are of particular interest include four interrelated outcomes, which have been defined as follows:

1. **Improved coordination of care**: There is deliberate coordination of roles and responsibilities for the patient's care (e.g., identifying who is involved and who is responsible, planning for the exchange of information among the participants).
2. **Improved transition of care**: Transitions between health care professionals or organizations are smoother for the patient, with less disruption in treatment (e.g., little or no wait times, smooth transfer of patient information).
3. **Improved integration of care**: Health care providers and the patient work collaboratively to optimize the patient's care, with real-time (or almost real-time) exchange of information.
4. **Patients achieving their health care goals**: It is important to note that the patient's goals may be different from those of the health care provider.

It should be noted that improved coordination, transition, and integration of care are closely related concepts that do not currently have commonly agreed upon definitions. The relationships and boundaries between these outcomes will be explored through the evaluation.

Ultimate goals

Ultimately, it is hoped that more coordinated, seamless and integrated care will contribute to improving patient health. It should also decrease health care costs by preventing complications, reducing duplication of services, and ensuring that services are provided by the appropriate health care professional. The end result should be a more sustainable health care system.

Because so many other factors affect these ultimate goals, it is not expected that the Health Links will have a short-term measurable effect on them. It is nonetheless important to include them in the diagram as a reminder of the ultimate aim of the initiative.

Individual Health Links

The following table summarizes the main partners, the primary areas of focus, and the planned and completed activities of each of the seven individual Health Links. It is important to note that the individual Health Links are at different stages in their development and implementation, and therefore have different levels of activities completed to date.

The SE LHIN has also developed a snapshot of coordinated care activities underway as of spring 2014. A table summarizing activities is included in *Appendix C.*

Main partners	Areas of focus	Key activities
Kingston Health Link		
Lead organization: Maple Family Health Team Other partners: ▪ Kingston FHT ▪ Loyalist FHT ▪ Queen's FHT ▪ Frontenac Medical FHG ▪ Newton FGH ▪ Greenwood FHO ▪ Islandview FHO ▪ Kingston CHC ▪ Hotel Dieu Hospital ▪ Kingston General Hospital ▪ Providence Care Hospital ▪ SE CCAC ▪ Public Health	▪ Complex vulnerable adults over the age of 18 ▪ Reduction in hospital readmission rates ▪ Preventable emergency department (ED) visits	Activities to date: ▪ CCP implementation in progress across 9 organizations ▪ Kingston Health Link Patient Journey Day (February 2014) ▪ Unattached patients working group (goal of engaging physicians to use Health Care Connect Link regularly) ▪ Initial stages of developing a rapid access clinic for complex patients Planned activities: ▪ Ensure a booked appointment with primary care provider/specialist post leaving hospital for patients with complex conditions ▪ Develop patient engagement strategy ▪ Develop communication strategy to inform patients of care options in the community
Rural Kingston Health Link		
Lead organization: Rural Kingston Family Health Organization Other partners: ▪ Kingston General Hospital ▪ Hotel Dieu Hospital ▪ Providence Care ▪ Lennox & Addington County General Hospital ▪ SE CCAC	▪ CHF/CV rehab ▪ Complex seniors ▪ Mental health ▪ Transitions between primary and tertiary care settings	Activities to date: ▪ Implementation of CHF clinics (September 2013) ▪ CCP implementation in progress ▪ Development of RKHL supplementary questions for the CCP ▪ Recommendations for direction of mental health program prepared and presented (January 2014) ▪ Development of plan for effective and efficient interactions between SE LHIN, CCAC and rural practices. Planned activities:

Main partners	Areas of focus	Key activities
▪ KFL&A Public Health ▪ Centre for Studies in Primary Care (Queen's University) ▪ Community Partners		CHF/Cardiac Rehab ▪ Develop COPD clinic modelled on CHF ▪ Implement Stanford Chronic Disease Self-Management Program for patients with chronic disease entities Mental health ▪ Develop a standardized diagnostic and care path for patients with dementia ▪ Identify high risk groups by age, geography and barriers to access ▪ Develop shared model of inter-professional care including a full mental health plan for establishing a comprehensive rural mental health/addictions program ▪ Develop standardized inter-agency communications and records-sharing protocols ▪ Community engagement through community mental health and education sessions ▪ Develop standardized method for charting risk factors and determinants Transitions ▪ Post-discharge on-call service for transitions sub group within primary care ▪ Post-discharge visit within 48 hours for frail, elderly and complex patients ▪ Improve integration of home care with primary care settings ▪ Establish one-number 7/24/365 post-discharge on-call service for frail elderly and complex patients ▪ Develop protocol to optimize patient and family experience in care for target population ▪ Value stream mapping to profile and identify further integration plans

Main partners	Areas of focus	Key activities
Quinte Health Link		
Lead organization: Belleville and Quinte West CHC Other partners: ▪ Belleville Nurse Practitioner Led Clinic ▪ Belleville Physicians FHO ▪ Belleville Queens FHT ▪ Brighton Quinte West FHT ▪ Prince Edward FHT ▪ Quinte Health Care ▪ SE CCAC ▪ Prince Edward County Community Care for Seniors Association ▪ VON Canada South East District ▪ Mental Health Services Hastings Prince Edward ▪ Mental Health Support Network ▪ Addictions Centre Prince Edward Inc. ▪ Hospice Prince Edward ▪ Hospice Quinte ▪ Southeastern Ontario Health Collaborative ▪ Regional Geriatric Psychiatry & Behavioural Health Service Providence Care	▪ Vascular health ▪ Hospice palliative care ▪ Mental health and addictions	Activities to date: ▪ Implementation of CHF clinic in Belleville ▪ CCP implementation in progress ▪ Oral health/dental services offered in Belleville to high needs/ low-income clients, with broad communication to partners ▪ Stakeholder engagement via regular steering committee and working group meetings Planned activities: ▪ Introduce wound/foot care services ▪ Spread and sustain coordinated care strategy ▪ Expand on patient engagement activities
Rural Hastings Health Link		
Lead Organization: Gateway Community Health Centre	▪ Care coordination ▪ Chronic disease prevention &	Activities to date: ▪ CCP implementation in progress (includes patient engagement and follow ups with primary care provider)

Main partners	Areas of focus	Key activities
Other partners: ▪ Gateway CHC ▪ Bancroft FHT ▪ Central Hastings FHT ▪ North Hastings FHT ▪ Community Care for Central Hastings ▪ Community Care North Hastings ▪ Mental Health Services ▪ Mental Health Support Network ▪ SE CCAC ▪ Quinte Health Centre (QHC) ▪ Heart of Hastings Hospice ▪ Moira Place LTC ▪ SE LHIN	management ▪ End of life/palliative care ▪ Data quality & privacy	▪ Documenting pre and post system navigation with CCPs on patient determinants of health ▪ The role of embedded System Navigators (SN) is established within all four RHHL primary care sites. SNs work closely with all broader healthcare partners. ▪ Explored and preparing for case study participation with the BRIDGES incubator program with OMA-MOHLTC ▪ Established self-management training (Stanford Model) for all primary care sites in RHHL including providers and volunteers for peer support ▪ Oral health services offered at Gateway CHC to high needs, low-income patients within the RHHL region. The referral process between oral health and SNs is now implemented. ▪ Ongoing collection of patient stories on the impact of system navigation. ▪ Implemented real time data from key internal and external databases (e.g. QHC, EMRs, etc.) to identify complex patients. All RHHL physicians have agreed to participate in the receipt of the real time data. ▪ Participation in provincial working group to review/revise the care coordination tool and Integrated Assessment Records ▪ Exploring potential to use the knowledge exchange platform used by Behavioural Supports Ontario ▪ Developed RHHL Sustainability Plan in collaboration with and unanimous approval from the RHHL Steering Committee. ▪ The referral process between oral health and SNs is now implemented. *RHHL Working Groups* ▪ Use of SELHIN Quality Improvement (QI) Coordinator and QI tools (IDEAs, Lean, value stream mapping, etc.) to map out processes and best practices in care coordination working group and end of

Main partners	Areas of focus	Key activities
		life & palliative care working group ▪ *Care Coordination Working Group* is established and working to integrate seamless care coordination between primary care and other healthcare delivery systems. ▪ *End of Life & Palliative Care Working Group* mapping processes and leveraging CCAC Palliative NP role. Developing framework to trigger palliative and end of life patient referrals. ▪ *Data Quality & Privacy Working Group* established to assist with metrics identified from the working groups as well as support RHHL with feedback on performance results report to the HealthLink, MCDP and SELHIN. This group is also addressing privacy and confidentiality requirements. Planned activities: ▪ Early adoption of SHIIP and other BI tools ▪ End of Life & Palliative Care Working Group plan to identify existing and potential resources to support the patient/family and primary care providers in providing palliative care support ▪ Various conference presentations regarding impact of system navigation on complex patients requiring CCPs ▪ Ongoing process mapping of healthcare systems of our RHHL partners and how they interface with primary care
Thousand Islands Health Link		
Lead Organization: Upper Canada Family Health Team Other partners: ▪ Community and Primary Care FHT (Brockville and Gananoque) ▪ Comstock FHO ▪ Prescott FHT	▪ CHF Clinic ▪ Access and ER diversion ▪ Specialist referrals ▪ Mental health ▪ Zero unattached patients	Activities to date: ▪ CCP implementation in progress ▪ Implementation of CHF pilot clinic (April 2014) ▪ Specialist referral committee's process mapping presentation developed, to be presented to specialists and primary care providers ▪ Addictions and mental health surveys sent out to key stakeholders to reach patients not currently engaged in mental health and

Main partners	Areas of focus	Key activities
▪ Thousand Islands FHO ▪ ACT Team of Leeds, Grenville, South Lanark ▪ Alzheimer's Society ▪ Brockville General Hospital (BGH) ▪ Children's Mental Health of Leeds and Grenville ▪ SE CCAC ▪ Community Pharmacies ▪ Geriatric Mental Health Community Team ▪ Health Care Connect ▪ Leeds Grenville Mental Health ▪ Leeds, Grenville & Lanark District Health Unit ▪ Merrickville CHC ▪ Stroke Network of Eastern Ontario		addictions system ▪ Medication Reconciliation Committee in process of developing a pilot project where a pharmacy technician reconciles every discharge medication list ▪ Community engagement/education on Health Links Planned activities: CHF clinic (piloting in progress) ▪ Conduct patient/family and provider/staff satisfaction surveys for CHF clinic ▪ Identify all high cost users who have CHF ▪ Develop mechanism to support transition of admitted patients back into community ▪ Support hospital discharge for all patients admitted to BGH for CHF ▪ Establish tiered support model for CHF clinic Access and ER diversion ▪ Develop a collaborative, patient centred model to meet with high cost user patients and their care-givers/family and identify mechanisms to avoid ER visits ▪ Develop a mechanism to track patients who return to ER within 7 days of discharge from the hospital and resolve common issues resulting in said revisits Specialist referrals ▪ Develop system for referrals and trial system ▪ Meet with orthopedic specialists at BGH and roll out orthopedic referral system Mental health

Main partners	Areas of focus	Key activities
		▪ Develop central intake and uniform consent form for all mental health referrals ▪ Develop a collaborative, seamless, integrated mental health plan for the TIHL community Zero unattached patients ▪ Create a process to roster all patients registered with Health Care Connect with a primary care provider ▪ Identify unattached patients not registered with Health Care Connect
Salmon River Health Link		
Lead Organization: Kingston Community Health Centres (Napanee Area CHC) Other partners: ▪ Richmond and Might Docs FHO ▪ L&A portion of Reddendale FHL ▪ Solo physicians ▪ SE CCAC ▪ L&A Addictions and Community Mental Health Services ▪ Lennox & Addington County General Hospital ▪ Mohawks of the Bay of Quinte Community Wellbeing Centre ▪ KFL&A Public Health ▪ Providence Care ▪ Lennox & Addington Seniors Outreach Services ▪ Southeastern Ontario Health Collaborative	▪ Patient and community engagement ▪ Unique health and health coordination needs of First Nations people	Planned activities: ▪ Meet regularly with the SRHL steering committee. ▪ Establish patient/community members advisory group to inform SRHL service design decisions ▪ Establish a process and criteria to identify an initial 50 complex clients to focus on ▪ Implement the use of client engagement tools and activities to assess patient experience and needs; ▪ Meet the providers of the complex clients as an integral part of developing the coordinated care plans ▪ Develop population prevalence and service/supports needs profiles for the anticipated patient groups

Main partners	Areas of focus	Key activities
Rideau Tay Health Link		
Lead organization: Rideau Community Health Services Other partners: ▪ Alzheimer Society of Lanark County ▪ Broadview Nursing and Retirement Centre ▪ Patient/family experience advisors ▪ Community and Primary Health Care (CPHC) ▪ Community Home Support – Lanark County ▪ Country Roads Community Health Centre ▪ Dignity House Hospice ▪ Hilltop Manor Nursing Home ▪ Lanark County Mental Health ▪ Lanark Renfrew Health & Community Services ▪ Leeds & Grenville Mental Health ▪ Leeds, Greenville & District Health Unit ▪ Nurse practitioners ▪ Perth and Smiths Falls District Hospital ▪ Private and CHC physicians ▪ Restorative Health, Smith Falls ▪ Smith Falls and Perth Family Health Organizations ▪ Smiths Falls Nurse Practitioner Led Clinic ▪ SE CCAC ▪ TriCounty Addiction Services	▪ Coordinated care across transitions ▪ Advanced illness management ▪ End of life care	Planned activities: ▪ Ensuring every complex patient is assigned to a primary care provider ▪ Attach care coordinators to specific primary care providers ▪ Launch working group to identify changes needed for advanced illness medicine ▪ Patient journey mapping for advanced illness and end of life patients ▪ Create a charter to guide improvements in patient and family experience at the end of a patient's life ▪ Formalize RTHL governance process by creating Transformation Council and establishing administrative support

4.2. COLLABORATIVE APPROACH

The SE LHIN has deliberately taken a region-wide, collaborative approach to the development of the Health Links (depicted in *Figure 3*). A region-wide leadership group is supporting collaboration across the Health Links as well as collaboration with partner organizations. This collaboration will create opportunities for the various Health Links and their system partners to align their activities and put in place the necessary resources/supports for Health Links to be successful.

The Health Links are led mainly by primary care providers; patients and system partners will also be involved in the planning. This is intended to foster a sense of collaborative ownership of the Health Links, with all of these populations feeling engaged.

The leadership group for the Health Links has expressed a strong commitment to ongoing quality improvement based on monitoring and evaluation. The Health Links intend to build capacity for quality improvement throughout the system. Combined with a sense of collective ownership, this enhanced capacity will provide opportunities for ongoing learning and improvement at the system level, as well as within the Health Links structures.

By aligning efforts across the LHIN, encouraging a sense of shared ownership for the Health Links, and instilling a culture of continuous improvement, the leadership group hopes to foster the conditions needed for Health Links to be increasingly effective as time goes on, and sustainable in the long run.

This collaborative approach has allowed the Health Links and the SE LHIN to pool expertise and resources to develop common tools and resources such as:

- **The Southeast Information Implementation Portal (SHIIP)**, an IT solution that will allow for patient information (i.e., Coordinated Care Plans as described under *Activities* below) to be shared between hospitals and primary care providers. SHIIP will also help identify patients who frequently access hospitals and emergency departments in real time. SHIIP is currently under development.
- **A communications plan** describing key messages regarding Health Links and how these will be communicated to relevant audiences.

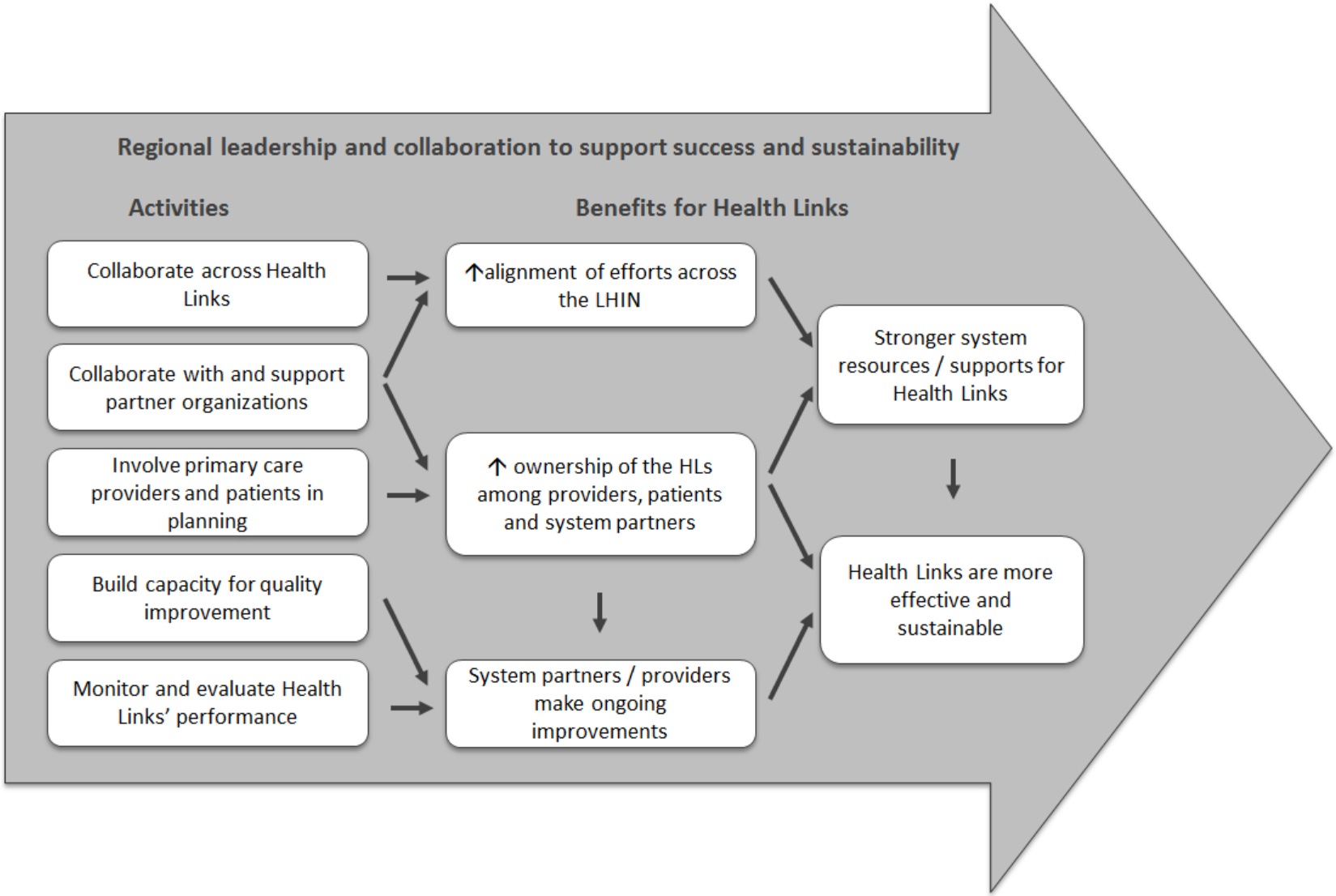
The LHIN-wide collaborative approach has also allowed each Health Link to learn from the experiences of others. Similarly, resources developed in one Health Link can often be used by others; for example, a care plan process map developed by Quinte Health Link was shared with the other Health Links in the SE LHIN. LHIN-wide collaboration has also been valuable for knowledge management, with project

> We don't want to reinvent the wheel. But at the same time, we are a Health Link because we have a commonality amongst all of us… [Something] may work in our HL, and we can share that story with the HL next door, but it may not work for them because they might not have the same small town dynamic.
>
> - Health Link partner

coordinators and care coordinators from the Health Links forming a learning community.

An additional benefit of the LHIN-wide collaborative approach has been a perceived reduction in competition between the Health Links, both for financial and human resources. This 'collaborative spirit' was evidenced when some Health Link partners commented that they may transfer funding between Health Links if needed. Respondents also felt that the standardization of job descriptions, contracts and compensation across the Health Links helped to ensure that the different communities are not competing against one another for the same talent.

Figure 3: The SE LHIN's collaborative approach to the Health Links



4.3. BARRIERS AND CHALLENGES

Health Links represent a significant change in traditionally siloed models of healthcare. As such, it is expected that the initiative will experience challenges along the way. The challenges and barriers identified in this section reflect concerns raised by service providers in the five early adopter Health Links through focus groups.

The most commonly noted challenges, described below, relate to:

- Information sharing (technology and privacy);
- Protected time;
- Clarity about initiative; and
- Short term funding.

These barriers and challenges are connected with healthcare providers being less involved in/enthusiastic about the initiative than ideal and corresponding slower progress. This can in turn reinforce seemingly slow progress at achieving visible impacts, which may be in itself a barrier to encouraging involvement. That is, potential Health Links partners may be waiting to see the benefits of the initiative before engaging. However, at least one stakeholder cautioned that slow progress is to be expected with this type of initiative until a critical mass has been achieved.

It is important to note that each Health Link operates in a unique context, shaped by its catchment area, client needs, leadership team, available services, and available resources. For example, the Kingston Health Link's catchment area includes an urban center with major hospitals and greater population density. In contrast, Rural Kingston Health Link serves a large geographic area with a more dispersed population and relatively few service providers. Because of this, what may be experienced as a challenge in one Health Link may be experienced as a strength or merely matter of course in another context.

Information sharing

Health Links partners identified concerns related both to the privacy and technology aspects of information sharing. They indicated that the lack of a standard privacy agreement for sharing patient/client information slows down communication between healthcare provider organizations.

> I find it fascinating that if you mail a package you can go online and find out exactly where it is; we do things to people's lives in health care yet we can't communicate. We are all doing our best, but there's no common place to go – we hear its coming! These care plans are going to be difficult to manage without the technology support.
>
> - Health Link partner

Closely connected with information sharing, stakeholders also frequently identified the lack of appropriate/efficient information sharing

technology as a challenge that slowed progress. For example, where information sharing agreements already exist, the absence of a real time communication system continues to be a barrier, resulting in missed opportunities to assist patients, and challenges identifying individual complex care patients due to the information lag. Furthermore, some stakeholders expressed concern that healthcare providers (primarily physicians) are unwilling to use the coordinated care plan (CCP) as long as it is a paper document, which is difficult to share and update among care providers. This means that key healthcare providers within the LHIN are reluctant to engage in one of the main components of Health Links.

The Southeast Information Implementation Portal (SHIIP), which is currently being prepared for piloting, will allow for patient information to be shared between hospitals and primary care providers and will help identify patients who frequently access hospitals and emergency departments in real time. While some stakeholders feel that SHIIP will be a critical enabler and driver for Health Links, multiple stakeholders raised concerns that SHIIP does not integrate with the EMRs currently in use, and will simply add to provider workloads. Some stakeholders also expressed concerns that SHIIP is a temporary measure that stakeholders will have to learn to use, but will then eventually be replaced by a provincially-endorsed system.

Protected time

Health Links stakeholders believed that the time needed for frequent Health Links meetings (and associated travel), completion of CCPs and administrative work required to coordinate the Health Links was a challenge. They expressed concern that time spent in meetings and coordination was time spent away from direct patient care.

Respondents also commented that many stakeholders do not have protected time to dedicate to Health Links work, are 'working off the sides of their desks' and working additional hours to be involved in Health Links. Some stakeholders emphasized that completing CCPs is a time-consuming process. Dislike of any activities that take time away from direct patient care may be reducing physician and nurse enthusiasm for Health Links as a whole.

> As a physician, all of the hours that we spend on HL are pro-bono/unpaid. The government needs to realize that they get what they pay for…I don't mind doing it for a few months, especially in the early stages because I buy into the HL, I am passionate about it. But at the end of the day, when I'm taking 2-3 hours off for a meeting when I could have been seeing patients and bringing money back for my own family…that won't continue.
>
> - Health Link partner

Some respondents also commented that Ontario's physician compensation model does not recognize Health Links-related activities. However, it should be noted that Comprehensive Care (including collaboration) is a component of the Alternative Funding Arrangements under which most primary care physicians are compensated.

Clarity regarding the initiative

Several focus group respondents found it difficult to articulate a clear description of Health Links, its components, and its target population. This was largely due to the evolving nature of

the initiative, which some stakeholders find it difficult to stay up-to-date on. Some respondents believed that an evolving message of what the Health Links are attempting to achieve makes it particularly difficult for physicians to engage in the initiative.

It is important to note that other stakeholders did not feel that the objectives of the Health Links have changed. Others believed that the lack of clarity has been beneficial for individual Health Links to be able to create systems at the local level, as opposed to having a provincial model imposed.

In the absence of a standard definition of complex patients, individual Health Links have established interim definitions. These may differ across the SE LHIN (although Quinte Health Link's interim definition, described in *Section 5.1* is gaining traction and will be used during initial SHIIP implementation). Stakeholders expressed frustration and concern that, if a definition is established at the LHIN level, the Ministry may ask them to change the definition later.

Short term funding

Some stakeholders cited the lack of long-term funding as a barrier to effective planning and ongoing sustainability. Delays in receiving funding, uncertainty about future funding amounts, and the fact that different sources of funding are released in an uncoordinated manner have slowed down the progress of implementing the Health Links. Some Health Links felt that it was difficult to attract high quality candidates for short-term contract positions. Due to this concern, some Health Links have decided to proceed without involving new staff, relying instead on reallocating existing resources. In these cases, the Health Links expect to return some of their funding allocation or, if possible, transfer funds to other Health Links in the LHIN.

Some organizations and/or service providers seemed unwilling to fully commit to involvement when they believe Health Links may not be maintained.

> We can't afford to build a structure we can't sustain over the longer term. [You] can't hire people you can't keep on. Why are we doing this if it's short term?
>
> - Health Link partner

It should be noted that leadership from at least one Health Link has expressed that their group is determined to make the initiative work, despite funding uncertainties. Other stakeholders commented that expecting or waiting for ongoing funding commitments may be holding the Health Links back.

Other barriers and challenges

Other factors that were mentioned as barriers and challenges for implementation include:

- Concern that there has been a gradual shift from a grassroots to a top-down model. For example, some focus group respondents were concerned that the Coordinated Care Plan templates were developed by the Ministry of Health and not the Health Links and, as a result, some components are not relevant. Others made more general comments about

how Health Links were originally intended to be primary care driven but have increasing direction from the Ministry of Health. This may prevent the individual Health Link from responding to local needs in the most effective way.

- Concern that the Health Links model may be too narrowly focused on complex care patients (as opposed to prevention). Other stakeholders responded to this concern by emphasizing the importance of managing the initiative's scope by starting with complex patients and only later moving onto preventative care.
- Concern that Health Links may discourage patients from actively self-managing (i.e., they may become reliant on additional case coordination where not necessary).

4.4. SUCCESS FACTORS AND ENABLERS

Regardless of the differences between Health Links contexts and strategies, several commonalities were identified in the factors that enable the Health Links to smoothly implement their plans and, in theory, achieve success.

The most commonly noted enablers, described below, relate to:

- Champions;
- Human connections;
- Self-direction; and
- Sharing resources.

Overall, these success factors/enablers contribute to encouraging greater engagement in the initiative, ensuring that each Health Link appropriately meets the needs of its community, and finding opportunities for efficiencies in the implementation of the individual Health Links.

Champions

Champions are appointed individuals who promote the implementation process by encouraging, coaching and/or convincing others to accept the innovation.[5] Stakeholders agreed that engaging physician and nurse practitioner champions, particularly those who are respected and credible within their groups, has been a key enabler for the spread of the coordinated care plan (CCP) and encouraging engagement in Health Links as a whole. Care provider engagement has been spreading from physician to physician and nurse to nurse. Stakeholders have agreed that nurturing champions who can promote the Health Links initiative at the local level will be an important component moving forward.

> If it was a different person who took this on, it could have unfolded differently. I think the characteristics of key leaders need to be recognized.
>
> - Health Link partner

[5] Castiglione, S.A. & Ritchie, J.A. (2012). Moving into action: We know what practices we want to change, now what? An implementation guide for health care practitioners. Canadian Institute for Health Research.

In addition, individual leaders and their leadership styles were believed to be key in implementing the initiative. For example, the leadership of specific key players was mentioned by several stakeholders as being a critical success factor for engaging essential Health Link partners and enhancing the credibility of the initiative.

Recent research on implementation facilitation confirms the importance of the champion role, which it refers to as *internal facilitation.*[6] (Seers et al., 2012). According to this literature, the following characteristics are important to take into consideration when selecting an appropriate internal facilitator:

- Has some knowledge and interest in the topic area,
- Knows co-workers,
- Knows the environment,
- Knows the organisation,
- Occupies a clinical leadership position,
- Possesses effective communication skills,
- Is self-aware and resilient, and
- Is reliable and dependable.[7]

Human connections

It was widely agreed that creating opportunities for genuine, human connection has helped to develop stronger relationships between key stakeholders and build momentum for the initiative. This may take place during a lunch meeting between two individuals, a special event, or most commonly through regular meetings.

> We could have had a phone meeting with everyone in the group and it would have taken us six months to get to know each other.
>
> - Health Link partner

Most stakeholders believed that it is particularly important to hold face to face meetings. In person meetings may contribute to developing trust, a sense of common goals, and a sense of shared responsibility more effectively and more quickly than teleconferences. For example, stakeholders from one Health Link mentioned that that the relationships developed through face-to-face meetings are particularly important for enabling partners to work together towards change instead of becoming bogged down with issues that other Health Links have identified as challenges (e.g., obtaining resources). However, other

[6] Seers, K., Cox, K., Crichton, N.J., Edwards, R.T., Eldh, A.C., Estabrooks, C.A., Harvey, G., Hawkes, C., Kitson, A., Linck, P. McCarthy, G., McCormack, B., Mockford, C., Rycroft-Malone, J., Titchen, A., & Wallin, L. (2012). FIRE (Facilitating Implementation of Research Evidence): a study protocol. *Implementation Science*, 7, 25

[7] Ibid.

respondents, particularly those in rural communities, felt that teleconferences are preferable as they minimize travel time (i.e., time away from patients).

Respondents also stressed the importance of each meeting having a concrete purpose in order to ensure that time is well used, and encourage full participation. Finally, they believed that including a wide variety of healthcare providers has been important for generating credibility.

Several stakeholders also commented that it is important to build on existing relationships. For example, one Health Link commented that implementing the Health Link was (relatively) smooth because of longstanding relationships within those communities.

Self-direction

Focus group participants felt that a grassroots approach to developing priorities for each Health Link was important because:

- Each Health Link must respond to the unique needs and context of their community, and
- Local stakeholders are more likely to engage in a self-directed initiative.

There is general agreement that learning across Health Links, and standardization where commonalities exist is desirable. However, representatives from the seven Health Links (during interpretation of interim findings) all agreed that maintaining an environment with few rules and minimal specifications is critical to the success of the Health Links initiative. As mentioned in *Section 4.3* above, some stakeholders believed that having an open definition of the Health Links and their goals allowed individual Health Links to create systems that are appropriate at a local level.

Sharing resources

As discussed in *Section 4.2*, one of the benefits of the SE LHIN's collaborative approach to Health Links has been the sharing of knowledge and resources between individual Health Links. For example, a cross-Health Links communication plan was developed, and has been shared with all seven Health Links. Additionally, lessons learned by the early adopters have been used to inform the implementation of the Health Links that are in an earlier stage of development. Stakeholders agreed that, moving forward, they will continue to look for examples of success and learnings from Health Links that are further along in their development.

Other success factors and enablers

Other factors that were mentioned as enablers to success include:

- Health Links' high degree of visibility and support from the province, which has helped with generating momentum for the initiative and support from across the LHIN.
- Inclusion of a wide variety of healthcare providers in the initiative has been important for generating credibility.

5. FINDINGS: EARLY IMPACT

The following section describes the early impact of the Health Links in the South East LHIN.

5.1. PRIORITY METRICS

The Ministry of Health and Long Term Care has identified several priority metrics which should act as signposts for the success of Health Links. These metrics are in the process of being finalized and operationalized. Metrics currently include:

- Increase in the number of complex and senior patients with regular and timely access to a primary care provider;
- Development of coordinated care plans for all complex patients;
- Reduction in the time from primary care referral to specialist consultation for complex patient;
- Reduction in the number of 30-day readmissions to hospital;
- Reduction in the number of avoidable Emergency Department visits for patients with conditions best managed elsewhere;
- Reduction in the time from referral to home care visits for patients;
- Reduction in unnecessary admissions to hospital;
- Primary care follow-up within seven days of discharge from an acute care setting;
- Reduction in the average cost of delivering health services to patients without compromising the quality of care;
- ALC rate of nine per cent or less; and
- Enhancement of health system experience for patients with the greatest health care needs.

It should also be noted that a common definition of complex patient is still in progress. Quinte Health Link has developed a definition that may be adopted by the other Health Links in the SE LHIN. Inclusion criteria include:

- More than 3 acute care admissions in the past 2 years;
- More than 20 days in hospital in the past 2 years;
- More than 8 emergency visits in the past 2 years;
- Complex medical conditions – CHF, CVD, Palliative, COPD; or
- At risk of frequent and prolonged admissions (e.g. end of life).

The definition excludes neonates or patients that have died.

Access to primary care provider

As a common definition of complex patient is still in progress, consistent information on the number/proportion of complex patients with regular and timely access to a primary care provider is not currently available.

Development of coordinated care plans

The following table shows the number of coordinated care plans developed in each Health Link as of June 2014. As a total number of complex patients has not yet been identified, it is not possible to assess the percent of complex patients with coordinated care plans. Instead, information on the total number of people living in the catchment area is provided as context for the size of the community.

Health Link	# of CCPs	Size of community[8]
Quinte Health Link	103	129,000
Rural Hastings Health Link	56	34,000
Kingston Health Link	30	141,000
Rural Kingston Health Link	90	35,000
Thousand Islands Health Link	35	71,000
Rideau Tay Health Link	-	53,000
Salmon River Health Link	-	24,000
Total	*314*	*487,000*

5.2. PATIENT EXPERIENCE

Patient representatives have been engaged at multiple levels of the Health Links initiative, including on working groups and steering committees, and patients have reported that they are excited to be engaged with Health Links processes.

Service providers involved in focus groups believe that, as a result of the patient-centered approach, patients have more control and choices regarding their care, and feel that their wishes are being heard. For example, focus group respondents said that coordinated care has been instrumental in uncovering and honoring a

> What I've heard from others is [that the Health Links are] increasing the confidence in the system. Clients have confidence in who is working with them.
>
> - Health Link partner

[8] Information on community size for early adopter Health Links extracted from Demographic, census, and utilization profiles (MOHLTC March 2013). Information on Rideau Tay and Salmon River Health Links community size extracted from their respective business plans.

patient's end-of-care wishes.

Focus group respondents also shared several stories of improved patient outcomes, including a case where the CCP was called the 'game changer' for a patient who had 10 emergency department visits and 4 admissions last year, but none this year. One Health Link reported that preliminary data has indicated that emergency department visits and admissions are down for Health Link patients and that some Health Link patients' health has improved to the point of no longer needing to be attached to Health Links.

More detailed information on changes to the patient experience will be collected through patient interviews in winter 2015.

5.3. PROVIDER EXPERIENCE

Most changes to provider experience were linked to improvements in relationships and collaboration (described in *Section 5.4* below). In addition, some focus group participants indicated that Health Links has changed their approach to care and that they now have a better understanding of the patient experience.

> Having this come out of the primary care groups was really powerful. This said 'we are working together, not competing for patients but working for same population or community'. This is the first time primary care groups had ever done that.
>
> - Health Link partner

Health Links has resulted in several professional development opportunities for care providers, including a SE LHIN sponsored Advanced System Leadership program through the University of Toronto's Rotman School of Management as well as various training events to build local capacity for Quality Improvement (QI).

Additional information on changes to the provider experience will be collected through provider surveys in fall 2014.

5.4. RELATIONSHIPS/COLLABORATION

Focus group respondents consistently credited Health Links with improving the quality of communication between service providers and between communities, which has helped to increase awareness of existing services, service gaps and areas of opportunity. Respondents indicated that healthcare providers feel more like a team, and Health Links has helped to formalize the linkages between primary care and other sectors.

Respondents also believed that Health Links has helped to bring new focus to improving service coordination and transitions in care. Efforts have been underway to better integrate Community Care Access Centres (CCAC) roles and programs with Health Links. For example, one Health Link

> There was awareness and communication before… but they weren't functioning as a team or really looking at things from a population system level.
>
> - Health Link partner

has formed a multidisciplinary team of clinicians and partners to deliver care to medically complex patients in partnership with the CCAC and community mental health agencies; in addition, the clinic attends emergency department meetings in order to increase coordination for patients involved.

Some care providers have also begun to view the CCP as a communication tool between patients and multiple care providers. One respondent said that the patient-centered care plan reveals valuable information that would not necessarily be discovered by simply doing a medical care plan.

5.5. OTHER IMPACTS

In addition to the impacts noted above, several new services and programs have been established or are being developed as a result of Health Links. For example, Quinte Health Link focus group participants attributed the community's new congestive heart failure (CHF) clinic to the fact that during the planning for the Health Link, all stakeholders voted that vascular health would be a priority. Meanwhile, the QI Champion Strategy, which endeavors to build on existing expertise within the region while also acting as a driver for change and sustained improvement, resulted in the launch of a voluntary Influenza Vaccination Campaign across all seven SE LHIN Health Links.

6. FINDINGS: SUSTAINABILITY

The following sections describe stakeholder perceptions regarding the extent to which the Health Links will be sustainable (i.e., can be maintained beyond the current round of funding) as well as the factors that contribute to/detract from this sustainability.

Given the early stage of Health Links implementation, many stakeholders offered limited comments on the initiative's sustainability. As such, it will be important to ensure that this topic receives sufficient focus on the upcoming member survey and document review.

6.1. CURRENT SUSTAINABILITY

Limited information is currently available regarding the Health Link's ongoing sustainability. Representatives from the lead organizations met in April and June 2014 in order to define sustainability, create a vision for what the Health Links would look like in the future, and identify core elements and priorities to put into place. A HL regional sustainability plan, as well as HL-specific sustainability plans, was under development at the

> We'll do the work whether we have money or not, all our partners agreed on this. You have to make the decision when funding is not guaranteed.
>
> - Health Link partner

time of this report. These plans will be finalized by October 2014.

Focus group participants felt that regardless of whether Health Links continues in a formal capacity, the communication and dialogue between healthcare providers will carry on. One respondent said that sustainability of Health Links lies in new knowledge gained about community resources and services through the Health Link, which will continue to be applicable down the road.

6.2. BARRIERS AND ENABLERS TO SUSTAINABILITY

Focus group participants agreed that while the groundwork has been laid for sustainability, several challenges must be addressed, the most significant of which is the uncertainty caused by a lack of long-term funding. Respondents stressed that the initiative must be appropriately resourced in order to be sustainable, and that it will be important to maintain certain Health Links-related staff positions, such as the Health Link project manager, data manager and system navigator. Other focus group respondents believed that a contributing factor to long-term sustainability is the fact that individual Health Links have found new and different ways to offer services by reallocating existing resources rather than hiring additional staff or relying on more funding. These stakeholders believed that not relying on external funding set them up for greater success once funding was no longer available.

Stakeholders also felt that while there is an appetite to sustain the initiative, the lack of protected time for Health Links work could hinder long-term sustainability. Several stakeholders indicated that their participation in Health Links is above and beyond their regular responsibilities and that there is a limit to how much more can be asked to be done at the side of their desks. Focus group participants agreed that 'Health Links fatigue' is a real possibility.

> You have to prove that something is making a real difference, and the sustainability is there. If it makes a difference, if it makes the management and care and life of that person a little bit better, then the appetite to sustain will be there. But you can't do much more on the side of your desk.
>
> - Health Link partner

Respondents commented that there is an opportunity to build on current Health Links momentum by showcasing early patient success stories in order to encourage engagement, particularly among physicians. They also believed that it will be important to demonstrate to healthcare providers the benefits of Health Links for their own work in order to generate more enthusiasm for the initiative.

7. CONCLUSIONS: OPPORTUNITIES AND RECOMMENDATIONS

The following section summarizes key lessons from the evaluation to date. Each 'lesson' is associated with one or more opportunities for ensuring the ongoing success of the Health Links.

It should be noted that many of these 'opportunities' involve continuing processes that the Health Links in the SE LHIN have already begun.

Lesson	Opportunities
A (relatively) small group of key organizations and key individuals within those organizations has been consistently involved in Health Links implementation. In some cases, these individuals are involved in Health Links 'off the sides of their desks' and find it difficult to move forward all facets of such a complex initiative. Some stakeholders may be hesitant to engage in Health Links and some Health Links may be hesitant to hire new staff without further information on the sustainability of the initiative. Physicians may be hesitant to become fully involved due to the belief that they will not be compensated for this time.	Prioritize Health Links actions in order to move cornerstone activities forward in a timely manner. Success in a small number of activities may encourage greater involvement from a wider group of stakeholders. Ensure that key positions (e.g., HCPs involved in developing CCPs, representatives from organizations that should be involved in planning HL activities) have sufficient protected time for Health Links activities. This may require reallocating other workload and/or hiring new staff. Develop communication materials that provide direction on how physicians can access compensation for HL related activities.
Health Links are currently operating without a finalized definition of complex patient. While Quinte Health Link has created a definition that is being adopted by many other SE LHIN Health Links (and will be used in piloting SHIIP), stakeholders are concerned that they will later be expected to switch to a definition created by the Ministry.	Adopt an adequate definition of complex patient until/unless the Ministry provides other direction. This will allow the Health Links to measure success in a more concrete manner, and better identify ongoing improvement opportunities. Consider advocating to the Ministry to adopt this definition, minimizing the chances that a change in definition will be needed.
Lack of electronic systems for sharing information (particularly the coordinated care plans) decreases the utility of Health Links activities as well as enthusiasm for the initiative. While the LHIN is currently in the process of developing an IT solution (SHIIP), stakeholders are concerned that it may create additional paperwork.	Prioritize finalizing and rolling out SHIIP across the LHIN in a timely manner. Document SHIIP's benefits to HCPs (e.g., time savings) and patients (e.g., improved experience) through initial testing, and develop a plan to communicate benefits to intended users.
Some healthcare providers in the area (particularly hospital staff and independent physicians) have little to no knowledge of Health Links. Where HCPs are aware of Health Links, they may have only a fuzzy understanding of the initiative's objectives, activities, and value. As a result, engagement in Health Links varies greatly across HCPs.	Update the LHIN wide communication strategy to include consistent messaging for healthcare providers on: ▪ How Health Links will improve patient and provider experiences as well as healthcare outcomes. ▪ What the Health Links are and which activities are part of Health Links. ▪ The content and value of coordinated care plans.

Lesson	Opportunities
	It should also include a patient education component in order to empower patients to ask to be involved in the program. The strategy could be tailored to individual Health Links and their populations as appropriate.
Healthcare provider engagement in Health Links is often attributed to interpersonal relationships and the work of effective champions and/or leaders.	Develop a deliberate strategy to identify and nurture champions and provide them with the supports needed to be fully effective. Ensure that key HL staff have the skills to identify and nurture champions. Whenever possible use in person meetings with extra time for relationship building, generating excitement, and sharing ideas informally. Create opportunities for those outside of the core implementation group to engage in these experiences.
Limited information is available on the early impact of Health Links. This information is eagerly awaited as it is believed that sharing success stories (and challenges) may encourage commitment to Health Links.	Continue to gather information on early impact. Consider re-ordering evaluation data collection to complete care recipient interviews early as this may support the initiative's communication strategy.
The Health Links are currently in the process of sustainability planning. Some stakeholders are concerned about sustainability without long term funding while others believe the ability to implement Health Links without long term funding is a strength.	Continue sustainability planning. Where possible, develop strategies that allow organizations to leverage existing resources without relying on external funding.

APPENDIX A: EVALUATION MATRIX

Evaluation Question	Sub questions	Lines of Inquiry			
		Data / Document Review	Member Focus Groups	Member Surveys	Care Recipient Interviews
How well designed and implemented are the Health Links (HL & LHIN level)?	What are the components, characteristics and activities of the Health Links? (e.g., interventions, relationships between providers and organizations; communication processes; committees; patient/community engagement)	✓			✓
	What are the persistent barriers to implementing the Health Links?		✓	✓	
	What are the key success factors and enablers to implementing the Health Links?		✓	✓	
	How has the SE LHIN's collaborative, region-wide approach supported the development and implementation of the Health Links?		✓	✓	
	What works well and what could be improved?		✓	✓	✓
What has been the early impact of Health Links (Health Link and LHIN level)?	What progress has been made towards accomplishing priority metrics?	✓			
	How have the Health Links impacted the patient experience?				✓
	How have the Health Links impacted the provider experience?		✓	✓	
	How have the Health Links impacted relationships/collaboration across the SE LHIN?		✓	✓	
	What other impacts have the Health Links had?		✓		✓
How can the Health Links be made more sustainable?	What are the key components of sustainability for the Health Links?	✓		✓	
	To what extent are the Health Links sustainable?	✓	✓		
	What interferes with sustainability?		✓	✓	
	What could be leveraged and/or strengthened to enhance sustainability?		✓	✓	
What are the opportunities and recommendations for improving Health Links?	*Recommendations drawn from other evaluation questions*	✓	✓	✓	✓

APPENDIX B: ACRONYMS AND ABBREVIATIONS USED

Health Links

HL	Health Link
KHL	Kingston Health Link
QHL	Quinte Health Link
RHHL	Rural Hastings Health Link
RKHL	Rural Kingston Health Link
RTHL	Rideau Tay Health Link
SRHL	Salmon River Health Link
TIHL	Thousand Islands Health Link

Organizations and locations

BGH	Brockville General Hospital
CCAC	Community Care Access Centre
CHC	Community Health Centre
ED	Emergency Department
ER	Emergency Room
FHG	Family Health Group
FHO	Family Health Organization
FHT	Family Health Team
HPEC	Hastings/Prince Edward Counties
KFL&A	Kingston, Frontenac and Lennox & Addington
LHIN	Local Health Integration Network
OMA	Ontario Medical Association
MOHLTC	Ministry of Health and Long Term Care
PCO	Primary Care Organization
QHC	Quinte Health Centre
SE CCAC	South East Community Care Access Centre
SE LHIN	South East Local Health Integration Network, also referred to as 'the LHIN'

Other terminology

ALC	Alternate Level of Care
CCP	Coordinated Care Plan
CHF	Congestive Heart Failure
COPD	Chronic Obstructive Pulmonary Disease
CPHC	Community and Primary Health Care
CQI	Continuous Quality Improvement
CV	Cardiovascular
CVD	Cardiovascular disease
HCP	Healthcare provider
LTC	Long Term Care
NP	Nurse Practitioner
OTN	Ontario Telemedicine Network
QI	Quality Improvement
RN	Registered Nurse
SHIIP	Southeast Information Implementation Portal
SN	System Navigator
VON	Victorian Order of Nurses

APPENDIX C: SUMMARY OF CARE COORDINATION ACTIVITIES

The following summary of care coordination activities was developed by the SE LHIN and validated with each Health Link in July 2014.

Activities	Rural Hastings	Quinte	Salmon River	Kingston	Rural Kingston	Thousand Islands	Rideau Tay
Health Link priorities							
Completing coordinated care plans	✓	✓		✓	✓	✓	
Matching unattached patients to primary care				✓	✓	✓	
Medication reconciliation				✓	✓	✓	
Acute care - ER/Inpt diversion for conditions best managed elsewhere				✓	✓	✓	
Palliative/end-of-life	✓	✓			✓		
CHF		✓			✓	✓	
Addictions/mental health	✓	✓		✓	✓	✓	
Pilot SHIIP when available (will be rolled out to all HLs)		✓		✓	✓		
Who is testing the Coordinated Care Plan							
Primary Care RNs and/or Chronic Disease RNs		✓		✓	✓	✓	
CCAC – Care Coordinators		✓		✓			
CCAC-Rapid Response Nurses				✓	✓		
Physicians	✓	✓			✓		
Community Support Service Agencies							
Mental Health Care Professionals (ACT team; AMH Nurse)				✓	✓	✓	
Social Worker		✓				✓	
Nurse Practitioners	✓	✓		✓	✓	✓	
Nurse Navigator/System Navigator	✓			✓		✓	

Medical students					✓		
Setting for point of initiation of CCP							
Primary Care – office setting	✓	✓		✓	✓	✓	
Acute Care - In patient		✓				✓	
Acute Care - Out patient				✓		✓	
Rehabilitation (Providence Continuing Care)							
In Home	✓	✓		✓	✓	✓	

Rural Hastings

The RHHL has embedded 4 RN System Navigators (SN) within 4 of the primary care sites in the RHHL. The SNs are funded through the Medically Complex Demonstration Project and document directly into the EMR where the CCT has been uploaded. This embedded role has been very successful in allowing for communication with the Primary Care Provider and creating a 'point person' for patients to contact. System navigators are completing the CCT either in the office or in the home, on patients who are identified as complex via specified criteria.

SNs ensure that all existing (Year 1) and current complex patients with CCPs are followed up for urgency, stability and for discharge. Reassessment targets and criteria are being established for clients identified as stable and discharged. The system navigators are supporting individual patient goals with medically complex issues and socio-economic impacts for the marginalized complex patient population.
Ongoing Q1 system transformation activities are being developed with our partners on the RHHL working groups: End of Life & Palliative care, Care Coordination, and Data Quality and Privacy.

End of Life & Palliative Care
Using quality improvement methodologies, the working group is mapping out critical pathways, key resource roles and communication vehicles to optimize support for palliative and end of life patients while ensuring all providers are updated in a timely and effective manner. This includes optimizing referral processes, timely communication, communication methodologies, structured and coordinated care in the home. The working group is also exploring resources for palliative education for patients and their families.

Care Coordination
Using quality improvement methodologies, the working group is mapping out the access interactions between Community Support Services (CSS) and primary care leveraging CSS's Nesda EMR system to identify and plan out how referrals are managed, assessments shared and how patient information is updated especially during transitions of care. Addictions and mental health services are being reviewed as to how processes (including their LHIN wide system redesign) and communication can support Health Link clients.

Data Quality & Privacy

The data quality & privacy working group has enabled this HealthLink to access and receive real time Admission and Emergency Visit data from QHC and is working toward similar access from other regions (e.g. Central East LHIN hospitals, KGH, Lennox & Addington).

The spread within RHHL has included all physicians and nurse practitioners agreeing to HealthLink access to their patients.
RHHL will be an early adopter of the South East Health Integrated Information Portal post pilot phase.
System Navigators and Data Management Coordinators are using their respective EMRs and Excel tools to identify and track HealthLinks patients, their CCP, follow ups, medical plan, and the social determinants of health. This will help provide information to develop the complex patient profile for this HealthLink.

Salmon River

Activities to start soon!

The Project Manager position was filled in Q1 2013-2014.

Quinte

The areas of focus for the QHL have been:

- Preliminary Data Extraction and analysis of characteristics of complex pts (i.e. # meds used, # of comorbidities,
- Patient engagement through newsletter story and having patients on working groups or as guests
- Enrollment in the Better Health Lower Cost IHI Collaborative

The following concepts within the coordinated care process have been or are planned to be tested:
(105 CCTs have been completed to date)

Coordinated Process	Already tested	Future concepts to test
Identification	1. Using pt cost reports from QHC limited as in past, not in future 2. Professional judgment/intuition engages providers and is quite accurate 3. Diagnosis (CHF, End of Life) 4. Not based on age (1-97 yrs range)	1. SHIIP
Invitation	1. Script and consent letter	1. Do we require PCP consent or just patient Inpatient and unable to contact PCP)

CCT	1. Completed by NPs initially, now 34 different providers are doing them 2. Has been embedded into 3 EMRs 3. Have faxed completed copy to specialists and others in circle of care	1. CCAC care coordinators of supportive care caseload starting to do CCTs 2. How to engage the PCPs of the Belleville FHO to start doing them
Case Conferencing	1. Has been sporadic, limited to those "in need" determined by professional judgment	1. How to define 'in need' of case conferencing (eg. # of providers, type of care required using the 2x2 matrix based on medical complexity and social determinants of health capacity)
Implementation	2. PEFHT has designated a care coordinator within PCP for Hospital @Home, CHF, and complex patients	
Updating	1. Once CCT has been initiated and the first version implemented, care coordination is being handed off to most appropriate care coordinator depending on skill set required, rather than professional role	1. What skills are essential to successful coordination of different groups of patients?

Kingston

The Kingston Health Link (HL) is testing the CCP process in the primary care setting. Complex patient data based on 13-14 inpatient hospitalizations is being rolled out to primary care providers in the KHL to facilitate identification of the complex patient.

Primary care providers are reviewing these lists specific to their practice and applying the agreed upon HL criteria to determine their complex patients. A CCP roll-out plan has been created to track progress on the number of care plans initiated as compared to established targets over the 9 participating organizations (FHTs/FHGs/FHOs). A database of complex patient characteristics is being maintained and includes such factors as:

- Basic demographics
- Chronic conditions (type, number)
- Medication reconciliation (# of discrepancies)
- Risks identified (i.e. falls)
- Social determinants (i.e. literacy, education, food security, social isolation, transportation needs)
- Circle of care partners
- Patient goals
- Hospital visits

PDSA cycles currently in progress include:

1. Primary Care RNs (Queens FHT, Loyalist FHT) and NPs (KCHC) *initiating* the coordinated care plan within their own practice. When the complex patient is identified, the RN and/or NP will contact the patient to initiate the CCP process. Some of the items being tested are patient interview setting (home, office or both), number of patient encounters, workload activities, etc.
2. Primary Care RNs (Maple FHT) *expanding their existing role* to include Health Link care coordination activities. In this test of change, the RNs will work with the patient to follow through on the patient's action plan on their CCP.
3. CCAC Rapid Response RNs *expanding their role* for complex medical patients between specialty clinics and primary care setting. Specific PDSAs as yet to be determined.
4. Practical Assistant Worker (PAW) at KCHC to work with all 9 participating organizations (FHTs/FHGs/FHOs) to assist complex patients navigate community social services. Testing includes screening for PAW referrals at different points along the CCP process e.g. chart review, implementing the patient's action plan, team conference and updating the CCP tool.
5. Hospital-based NP at Hotel Dieu Hospital working in an ambulatory virtual rapid access clinic for complex patients. Specific PDSAs will be developed to test what activities and functions could reduce complex patient usage of ED and prevent unnecessary hospitalizations.
6. Community Health Link care coordinators (CCAC & Providence Care). Testing includes how the HL coordination components differ from current care coordination activities, enhancing information access for Primary Care etc.
7. Unattached patient strategy - PDSAs to be tested include: a). Partnership with Ontario Medical Association and distribution of consolidated information on billing options associated with enrolling new patients via Health Care Connect (HCC) compared to non-HCC enrollment; b). Implementing a 'transfer-to-HCC' strategy for doctors who are currently maintaining their own list of patients wanting to enroll; c) partnership with Health Force Ontario to roll out succession planning for doctors planning on retiring
8. Testing SHIIP on a small scale when it becomes available (anticipated date - fall 2014). Currently collecting baseline data on discharge notification from acute care (emerg, urgent care, in-patient hospitalization) and follow-up in primary care at 2 sites – KCHC and Maple FHT

Rural Kingston

The Rural Kingston Health Link has focused on a number of priority areas since its inception, including:

- Completion of coordinated care plans (CCPs)– approximately 90 CCPs have been completed as of July 2014
- Congestive Heart Failure (CHF)
- Mental Health
- Patient Transitions
- Patient Engagement

Some concepts that have been tested and/or are part of upcoming tests of change include:

1. Identification of complex clients. Lists of potential complex patients based on KGH hospital activity from January 2011-March 2014 have been distributed to individual providers within the RKHL to enable identification of complex patients, along with provider judgment. In addition, SE CCAC provides regular reports to enable triangulation of complex clients. Future refinement to the complex patient database may include a data pull from other hospitals, namely Perth & Smiths Falls, L&A County General, and possibly Renfrew hospital. Agreement to pilot SHIIP on a small scale when it becomes available (anticipated date - fall 2014). SHIIP (South East Health Integrated Information Portal) is designed to identify complex patients, transmit real-time information from acute care (initially) regarding activity at individual client and aggregate practice level, and facilitate ongoing management of complex clients in primary care through enabling early awareness of client activity within acute care (i.e. ER activity, in-patient admissions, discharges, etc.)
2. Establishment and distribution of an access database template for individual providers to keep track of their complex patients. Future test of change will look at trialing a common database with input by multiple HL providers across sites to track complex pts
3. Testing different providers initiating and conducting ongoing CCP activity, including NPs, Chronic Disease Management RNs, Physicians, Medical Students
4. Testing the initiation of coordinated care plans for different complex patient populations, including cardiology, complex mental health, clients with dementia, other
5. Establishing a cardiology clinic in Rural Kingston; identifying clients with CHF who reside in the RKHL geography and connecting them to Dr. McCans' rural cardiology clinic
7. Linking and embedding CCAC within primary care, with an initial focus on Rapid Response Nurses completing medication reconciliation activities for patients transitioning from hospital to home and primary care
8. Patients with Complex Mental Health needs– PDSAs include a) partnership between primary care and Providence Continuing Care involving the identification of patients with complex mental health needs and the initiation of care plans for patients with dementia, b) exploration of barriers in health care through the use of community case studies, involving such community partners as OPP and EMS, c) community awareness and educational initiative on depression -a joint initiative with Salmon River HL with representation from community social service agencies, d) provision of psychiatry services to Northern clinics
9. Focus on patient transitions from hospital to home and primary care, and on ways to reduce avoidable readmissions to hospital
10. Patient engagement – Patients are engaged on an individual basis throughout the CCP process. On a wider scale, the aim of the RKHL is to pilot HQO patient experience survey this fall.

Thousand Islands
The Thousand Islands Health Link has focused on specific priority populations to test and refine the CCP process. Service utilization patterns and provider experience indicated that key conditions for initial focus are addictions and mental health (AMH) services and congestive heart failure (CHF). The CCP process has been piloted in the primary care setting for complex patients living with AMH problems who are referred to Health Links by their Primary Care Provider. AMH RNs complete the CCP through an interview held in the patient's home or the primary care setting. Extensive testing has been done to develop and refine an interview script to allow the patient to tell their story and capture the complexity of AMH care in a sensitive and patient-centred way. The interview is coordinated with a follow-up appointment with the primary care provider within one week to review and confirm the goals the patient has identified for their care. Services are coordinated by the AMH RN (acting as the care coordinator) to fill any identified gaps and the circle of care is brought together to identify how to best support the patient. Tests of change are underway to explore the transition of the care coordination role to a member of the patients' existing circle of care. Further work is also being done to refine the complex patient identification process using objective measures such as rate of acute care admissions, length of acute care admissions, and multiple co-morbidities in conjunction with AMH. CCPs will also be developed in the acute care setting for patients admitted to BGH with a primary or secondary diagnosis of CHF. The Health Link has embedded a Social Worker in the hospital to act as a Care Plan Coordinator to initiate the CCP process during the patient's stay in hospital. The Care Plan Coordinator will work collaboratively with the NP in the Heart Function Clinic, BGH staff, Primary Care and the CCAC to ensure services are coordinated and a care coordinator is identified. Further tests of change will refine this process and explore potential sustainable methods for care coordination. The CCP process has also been rolled out in the Primary Care setting for CHF patients. The Upper Canada Family Health Team (UCFHT) is piloting a primary care-based education and self-management program for rostered patients with a diagnosis of CHF which will complement the Heart Function Clinic at BGH. An RN has been delivering education sessions to patients with the CCP being drafted subsequently. This program and process will be refined further before spreading to other primary care providers.
Rideau Tay
Rideau Tay Health Link has developed the position of Care Coordinator (seconded from the CCAC) to develop and implement a model of Care Coordination for the Health Link. The Care Coordinator will review the various models of care coordination currently in practice throughout the South East, including the CCAC, and will support the development of a sustainable model for the purpose of the Health Links mandate. Key considerations in the development of the care coordination model for Rideau Tay will be the requirements of Care Coordination needed to achieve the Health Links purpose and goals through research, the input of patients/families and key stakeholders, the completion of coordinated care plans, and providing system navigation to patients and families.