Brave New World: CCACs on the Health Links Landscape

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North Etobicoke-Malton-West
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June 9, 2014
Agenda

• Health Links: The First 18 Months
  • The provincial mandate
  • Central West: Our context for Health Links
  • North Etobicoke-Malton-West Woodbridge

• Care Coordination: An Evolving Role

• Integrated Care Planning
  • Local and provincial tool development
  • Building an inter-professional approach

• Primary Care Integration: Health Links as an Accelerant

• Progress to Date
The mandate for Health Links as described by the Ministry of Health and Long Term Care:

- Delivering on “the right care at the right time in the right place” requires patients and providers to work together more closely

- Partnerships going beyond a relationship between a LHIN and a hospital or a hospital and a CCAC; patient will be at the centre, with primary care community partners linked in to support

- Primary care providers are essential to transformation: keeping people well, screening for chronic diseases and managing care

- Flexibility to deliver services differently, in a way that best meets the needs of communities; moving resources between providers; being held to account for better outcomes for patients

- Local (sub-LHIN) partnerships to deliver better value for money, ensure higher-quality of care, and improve access. Deeper engagement with patients and commitment to a true patient-centred focus to the system
• Health Links Video
### Health Link Model: Core Features

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

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

• Ensure the development of care plans for all complex patients.

• Reduce the time from primary care referral to specialist consultation for complex patients.

• Reduce the number of avoidable Emergency Department (ED) visits for patients with conditions best managed elsewhere.

• Reduce unnecessary admissions to hospitals

• Ensure primary care follow-up within 7 days of discharge from an acute care setting

• Enhance the health system experience for patients with the greatest health care needs

Central West
Five Health Links:

- Bramalea & Area
- Brampton & Area
- Dufferin & Area
- North Etobicoke - Malton - West Woodbridge
- Bolton - Caledon
North Etobicoke-Malton-West Woodbridge is home to 25% of the LHIN’s population, with 200,973 people. Unique features of each catchment area:

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<tr>
<th>North Etobicoke</th>
<th>Malton</th>
<th>West Woodbridge</th>
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| • Relatively young, < 19 years (30%), 20 to 49 years (42%), 50 to 64 years (18%), greater than 65 (14%)  
• Almost 60% were immigrants, 66% being visible minorities  
• Rexdale: highest rate of unemployment (8.2%) in LHIN  
• Highest proportion of people (24.3%) living in low income within LHIN  
• Rexdale: lowest proportion of people (86.1%) with a regular primary care physician, Central West LHIN average (91.7%)  
• Proportion of people reporting physical inactivity (64.1%)  
• North Etobicoke high prevalence rates of diabetes (9.1%) and high blood pressure (17.3%). | • Overall population growth of 5.5% between 2006-11. The most substantial increase of 25% was seen in those >65 years  
• Approximately 64% were immigrants, almost 80% visible minorities  
• Rate of unemployment (8%)  
• Proportion of people living in low income (21.6%)  
• Approximately 91% of the Malton population had a regular physician  
• Almost 60% reported physical inactivity, 53% of the population >18 years were overweight or obese  
• High prevalence rates of high blood pressure (15%), and approximately 5% had heart disease. | • Decline in people aged 0-19 and 20-49 between 2006 and 2011. Substantial increase in adults aged 50-64 and aged >65, 15%, and 32% respectively  
• Almost 40% of population made up of adults >50 years of age  
• Approximately 42% were immigrants, 16% visible minorities  
• Unemployment rate: 4.5%, and 9.4% were living in low income  
• Approximately 98% had a regular physician. Almost 60% reported physical inactivity and 50% >18 years of age were overweight or obese.  
• Prevalence of high blood pressure (18.5%)  
• Prevalence of heart disease was the highest at 5.4%, compared to LHIN average of 3.8%. |
A cross-organizational chart review exercise – our version of a Living Lab

Focused on shared high users (common to multiple providers)

All Health Link providers invited and welcome

Providers reviewed charts in advance through common review tool

Cases anonymized for larger group discussions

Case Review: Understanding High Users
WHAT did we Quickly Learn?

- Information sharing is essential, yet happens too infrequently and generates significant missed opportunities for improved patient experience and outcomes
- Primary care connection needs to be strengthened (e.g., through care planning)
- Social determinants of health are a big part of the picture for these patients
- Better linkages to services, supports would improve experience, outcome
- Advance Care Plans are generally not in place
- Caregiver burn-out is a contributing factor
- Culturally competent care is key to developing a meaningful plan
- Teaching to support self-management presents a huge opportunity
- Timely referral to and follow-up with specialists requires greater attention
- The highest users tend to be end-stage patients who may benefit less from care plans
The “who”: Evolving Care Coordination Role

The “how”: Coordinated Care Plan
Care Coordination

• Creating a seamless experience for patients
• Guiding people through the system and walking with them on their care journey
• Being flexible and responsive partners with our patients, their families, and other members of the care team
Guiding Principles for Care Coordination in the Health Link Arena

- Patient Focused
- Care Coordination for Complex Populations
- Collaborative practice with Primary Care
- Interprofessional practice across the continuum and across organizations
- Coordinated Care Planning where the Care Coordinator has a role in identifying an individuals’ health and life goals and then coordinates services to meet those goals
Key Care Coordination Competencies

• Personal and professional accountabilities

• Systems thinking

• Facilitate creative thinking

• Effective communication with all stakeholders

• Focus on building of relationships with patients, families and other stakeholders

• Support patient in self management and prevention practices
Care Coordination in the Health Links Model

- Transform the way we work collaboratively as health providers to wrap services around the Patient and Primary Care
- Integrated care planning across the system, across the “virtual care team”
- Active coordination to ensure all aspects of the plan are being fully engaged, monitored, adjusted as required
- Improved communication between players with assistance of “quarterback” care coordinator
- Leverage current and future technology to facilitate information sharing and care planning including CHRIS, HPG, Data repository, eReferral, IAR etc.
What is a Care Plan?

A Care Plan is....

- Documented up to date summary of information pertinent to the holistic care of patient
- Goals-based patient focussed point of care service plans crafted by interprofessional teams = action plan for achieving goals
- Outline major health issues and care needs to assist with care coordination
- Efficient and accurate tool to bring all healthcare providers up to speed

A Care Plan is not......

- A comprehensive electronic medical chart
Integrated Care Planning in the Field

Central West Collaboration between CCAC, Primary Care and System Partners

- **Engaged primary care providers** of high risk patients to gain insight in the patient experience and potential improvement opportunities from a systems perspective
- Created a **common review template** to conduct interprofessional, interorganizational chart reviews on patients identified as high users/complex patients
- **Distilled common themes** from these reviews as areas to focus to facilitate integrated care planning
- Conducted **patient engagement** to validate identified common themes and inform future integrated care planning
- Created a **cross organizational, interprofessional working group** across all Health Links in the Central West Region to work on developing an integrated care plan

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**Central West**

**Patient Centred**
- Founded on patient goals
- Includes Advanced Care Planning
- Supports self management and health prevention

**Interprofessional Focus**
- Integrated with Primary Care
- Involves all members of the patients care team
- Available in primary care, community and hospital
- Guide for care coordination and disease management
- Roles and responsibilities are clearly articulated

**Timely**
- Flexible plan that is updated as circumstances change
- Includes emergency planning and identification of risks
Success of Health Links
Care Planning

• Strong respected relationship between patient, Primary Care and Care Coordinator

• Valuable information is shared between all parties in real time

• Patient feels they are at the centre of the plan

• Patients are connected with whatever care they need

• Care Coordinator facilitates communication between all internal and external care team members

• Care Coordinators can capture examples of gaps in service and quantify in order to share with system partners
Lessons Learned

• Strong change management approach required

• Investment in Care Coordinator Co-Design supports the transition toward future state

• Creative Communication and Engagement is required across the entire organization

• Strategic Physician Engagement practices are required

• Relationship building with new and existing community partners is required

• Interprofessional practice approaches are foundational

• Leverage existing tools and explore need for new tools

Central West
Health Links Fit with Primary Care

Central West
Our Provincial CCAC Collective Goal

Advance a primary care integration strategy and implementation plan, across the province that ensures:

- Leadership, support and adoption across all 14 CCACs
- Supports high level consistency across the province in our approach to primary care integration
- Aligns with Ministry/LHIN priorities
- Positions CCACs to deliver value in the context of Health Care system transformation

In other words...Our goal is to ensure every primary care physician in Ontario is connected to a CCAC Care Coordinator.
Primary Care Team
• 11 Care Coordinators connected to 72 Primary Care providers

Health Links Care Physician engagement
• Health Links Care Coordinator recruitment with Primary Care engagement focus

Northern Integrated Care Team pilot
• April 2014

Primary Care notification systems
• May 2014
Building on our strong foundation of quality patient care, we are evolving our care coordination approach in the Northern geography of Central West through our “Northern Integrated Care Team” (NICT). We are aligning our Care Coordinators with all physicians in the Dufferin Area Family Health Team, retirement homes, HHCC and other community service partners.

The satellite office in Orangeville is close for many of the Primary Care physician offices.

- Focused geographic location of Dufferin and Caledon will:
  - increase Care Coordinator’s knowledge of the services and community partners (by name) in the NICT “hub”
  - increase engagement with other neighbourhood health care providers, such as local pharmacists, EMS
Each physician/Care Coordinator relationship is different and depends on:

- Physician approach
- Technology
- Capacity
- Flexibility in building the approach
**Patient Benefits**

- Improved health care team collaboration and communication
- Greater understanding of available multi-disciplinary services
- The patient only has to tell their story once.
- When patient visits physician’s office the physician is fully aware of all service that the patient is accessing.
Physician Benefits

• Regular Physician and Care Coordinator face to face meetings to review and exchange patient information.

• Opportunity to share & review current care plans and active community provider information

• Increased awareness of CCAC programs & services and other available community support services

• Opportunity to move and link patients more efficiently through the health care system
System Benefits
So far....

- Consistent points of contact for integrated care team
- Leverage current structures and organizational capacity
- Over 500 HL patients supported across LHIN supported by the Central West CCAC Care Coordination
- Increased interprofessional and interorganizational collaboration
- Improved early identification of at risk patients