Hamilton Niagara Haldimand Brant **LHIN**

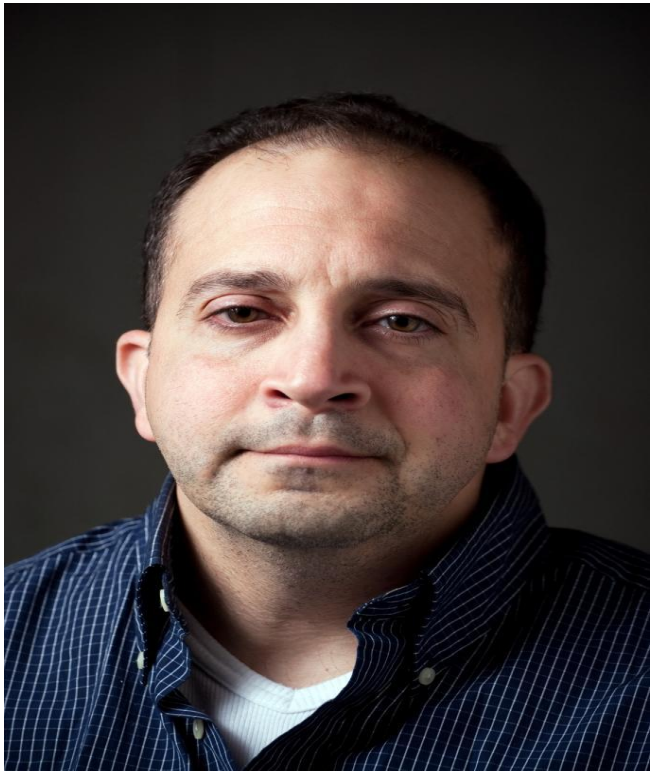
An Introduction to Health Links

Ontario
Local Health Integration Network

“IT’S AMAZING WHAT YOU CAN ACCOMPLISH IF YOU DO NOT CARE WHO GETS THE CREDIT”

Harry S. Truman

Meet Bernice and Marcus



Vision Statements

Provincial Vision

- Ontario – the healthiest place in North America to grow up and grow old
  - *Support to become healthier*
  - *Faster access and stronger link to family health care*
  - *The right care, at the right time, in the right place*

LHIN Vision

- A health care system that helps keep people healthy, gets them good care when they are sick and will be there for our children and our grandchildren.

HNHB LHIN Strategic Aim

Dramatically improving the patient experience through Quality, Integration, and Value.

Ministry Direction: Strengthening Execution & Integration

- The ministry, through the LHIN, is introducing a new model of care at the clinical level where **ALL** providers in a community, including primary care, hospital, long term care, community care, are charged with coordinating plans at the patient level

Health Links – Partnering for Patients

- Health Links will be designed around, and accountable for system-level metrics established by the province.

- Their initial focus will be on the high users, as we know that this segment of the population use a disproportionate amount of care at a cost which is not sustainable, nor appropriate for their needs.

Strengthening Execution & Integration cont'd…

- Health Links will be accountable to the LHINs and will initially be voluntary, beginning with those partnerships that meet specified requirements. Over time, the entire province would be represented.

- Leadership, governance, composition and integration initiatives will be flexible based on local need. Robust primary care participation is a critical success factor.

Strengthening Execution & Integration cont'd…

- LHINs will work with providers that form the Health Link to ensure they put collaborative initiatives in place that will allow for a measureable, positive impact on patient care:
    - Improvements in care delivery (e.g. appropriate system utilization, care coordination)
    - Improvements in patient experience
    - Reduced costs

Health Links Indicators – across the Province

Operational Metrics (Setting the Stage for Coordinated Care Straightaway)

1. Ensure the development of coordinated care plans for all complex patients
2. Increase the number of complex patients and seniors with regular and timely access to a primary care provider

Results based Metrics (Moving the Needle)

1. Reduce the time from primary care referral to specialist consultation
2. Reduce the number of 30 day readmissions to hospital
3. Reduce the number of avoidable ED visits for patients with conditions best managed elsewhere
4. Reduce time from referral to home care visit
5. Reduce unnecessary admissions to hospitals
6. Ensure primary care follow-up within 7 days of discharge from an acute care setting

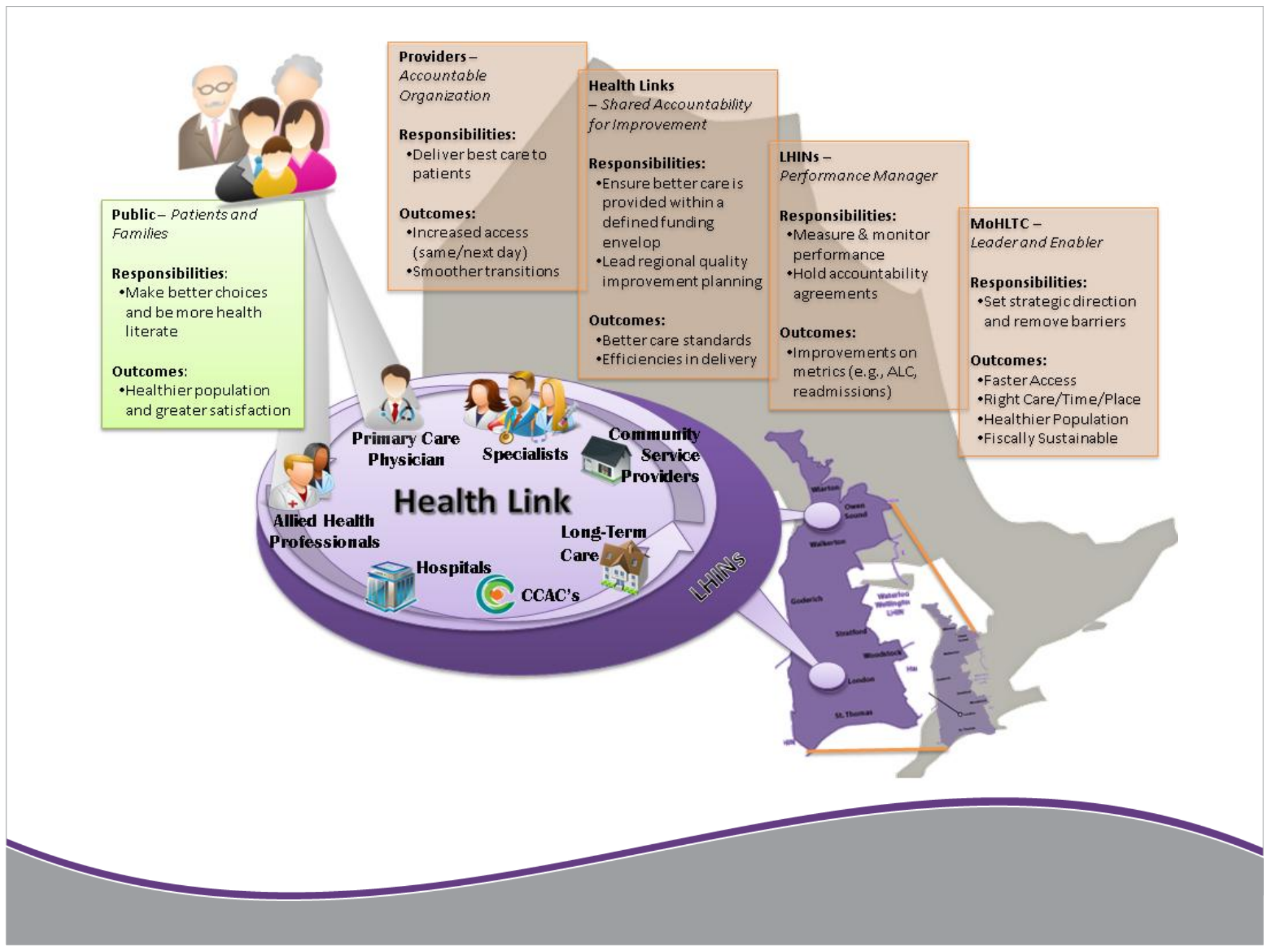
Evaluation Based Metrics (How you'll know you've arrived)

1. Enhance the health system experience for patients with the greatest health care needs
2. Achieve an ALC rate of 9 per cent or less
3. Reduce the average cost of delivering health services to patients without compromising the quality of care

Health Links – A Common Framework & Principles

While the networks will look different in every region, they will be based on a sound framework with specific principles consistent across all, to ensure provincial goals and outcomes are prioritized:

1. Person-centred planning with strong mechanisms in place for patient voice to be heard
2. Build on existing delivery organizations and leverage current capacity and best practices
3. Representation across sectors with joint accountability for attainment of results
4. Common targets and metrics (e.g., high users, ALC, ED wait times & use, readmission rates)
5. Evaluation built in from the start
6. Funding remains flexible to ensure resources are focused where they can be used to deliver results


Public – Patients and Families
Responsibilities:
•Make better choices and be more health literate
Outcomes:
•Healthier population and greater satisfaction
Providers – Accountable Organization
Responsibilities:
•Deliver best care to patients
Outcomes:
•Increased access (same/next day)
•Smoother transitions
Health Links – Shared Accountability for Improvement
Responsibilities:
•Ensure better care is provided within a defined funding envelop
•Lead regional quality improvement planning
Outcomes:
•Better care standards
•Efficiencies in delivery
LHINs – Performance Manager
Responsibilities:
•Measure & monitor performance
•Hold accountability agreements
Outcomes:
•Improvements on metrics (e.g., ALC, readmissions)
MoHLTC – Leader and Enabler
Responsibilities:
•Set strategic direction and remove barriers
Outcomes:
•Faster Access
•Right Care/Time/Place
•Healthier Population
•Fiscally Sustainable
Primary Care Physician
Specialists
Community Service Providers
Allied Health Professionals
Health Link
Long-Term Care
Hospitals
CCAC's
LHINs

Health Link Model: Core Features

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

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

Short-Term Mandatory Requirements

The following features must be in place to be eligible for Health Link implementation in the short-term

1. Must be focused on, or prepared to focus on, a defined region with a minimum population of 50,000, organized around natural health service utilization patterns.
2. Must include health care providers/organizations involved in the care of the high use/high need population cohort, which at a minimum includes hospital, Specialists, CCAC and primary care.
3. Member providers must already show a high degree of collaboration and must be willing to sign written agreements formalizing their participation in the Health Link.

Short-Term Mandatory Requirements cont'd

4. Member providers need to have the ability to identify and track the high use/high needs population cohort (some assistance can be provided).

5. Collaborating providers include minimum of 65% (TBC) of primary care providers in the region.

6. An identified and accepted Lead Organization in good standing as it relates to accountability and governance.

Health Link Implementation – Medium Term

1. Readiness Assessment	An assessment of the degree of readiness of particular provider groupings based on their alignment/potential alignment with essential features of the Health Link model.
2. Approval to Proceed	Based on the readiness assessment, Health Links will be awarded and approved to proceed to the next stage of development.
3. Business Plan Development	Each approved Health Link will collaboratively develop a business and resource plan identifying the initiatives that will be put in place.
4. Business Plan Approval	Business plans will be amended and approved, as necessary. Resources will be assigned to each Health Link to support their business plan commitments.
5. Accountability & Management	Health Links will be accountable to LHINs; LHINs will manage and provide support to each Health Link.
6. Performance Monitoring	Health Links will provide monthly reports to the LHINs on results to date and other agreed upon updates.
7. Evaluation	Third party review of the model to inform continuous improvement.

Health Links – Supports & Enablers

Provincial Health Link Advisory Table

- To consist of sector, ministry and LHIN representatives; will serve as sector 'champions' and will guide implementation.

Health Quality Ontario (incl. best PATH)

- Tool kits, on-the-ground facilitation, coaching.

Leadership Training

- Clinical leadership development for Health Link representatives, alignment with HSFR (QBPs), transitions through care.

Removing Barriers

- 'One Number to Call" approach to removing barriers (ministry/LHIN) that stand in the way of integration (see Appendix).

Support Enablers cont'd…

LHIN/Ministry expertise

- Supporting clinical integration, on-going performance management and guidance.

Funding

- Grant funding to support targeted clinical integration initiatives such as EMR/data integration, with potential for smaller scale on-going financial support.

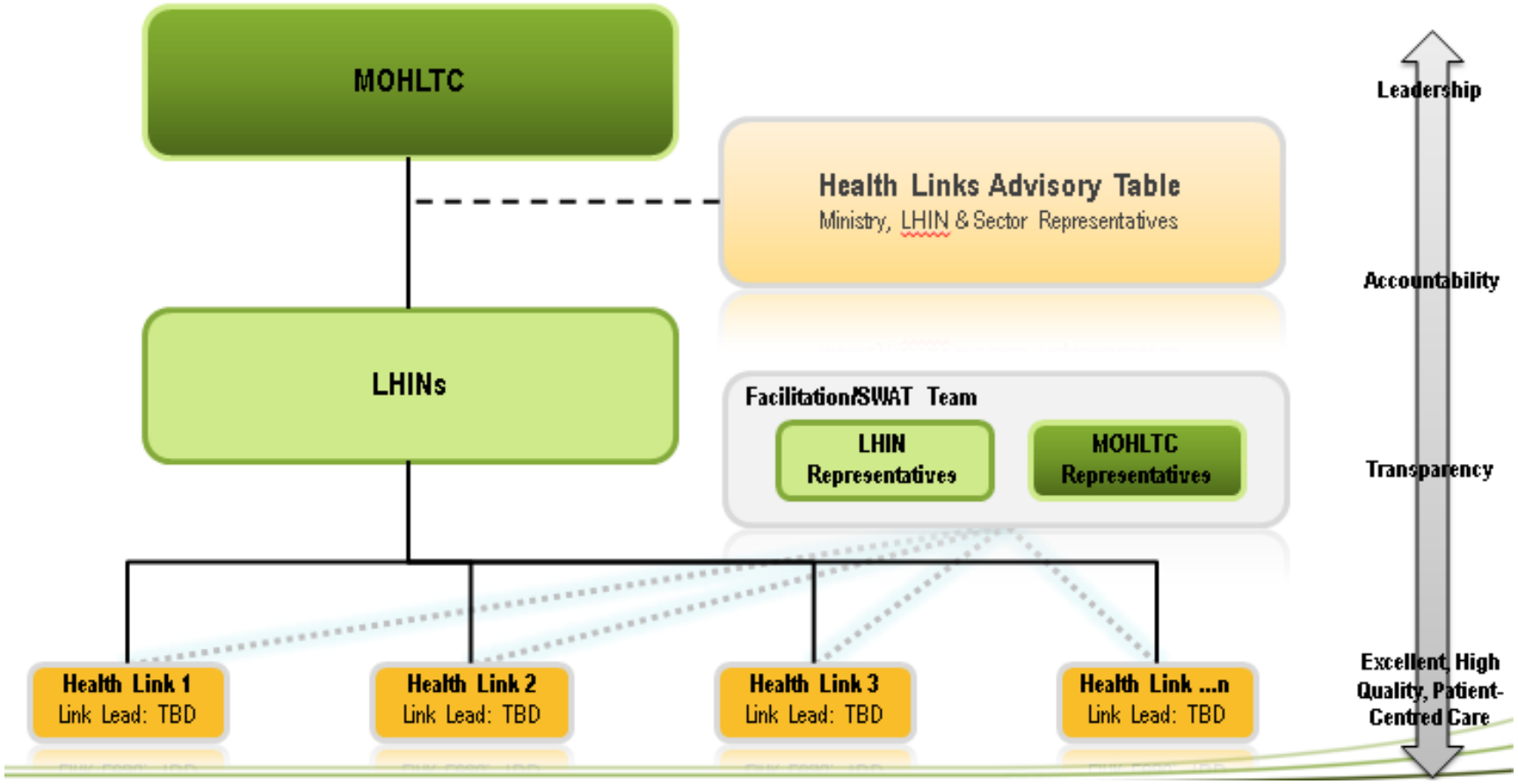
Evaluation

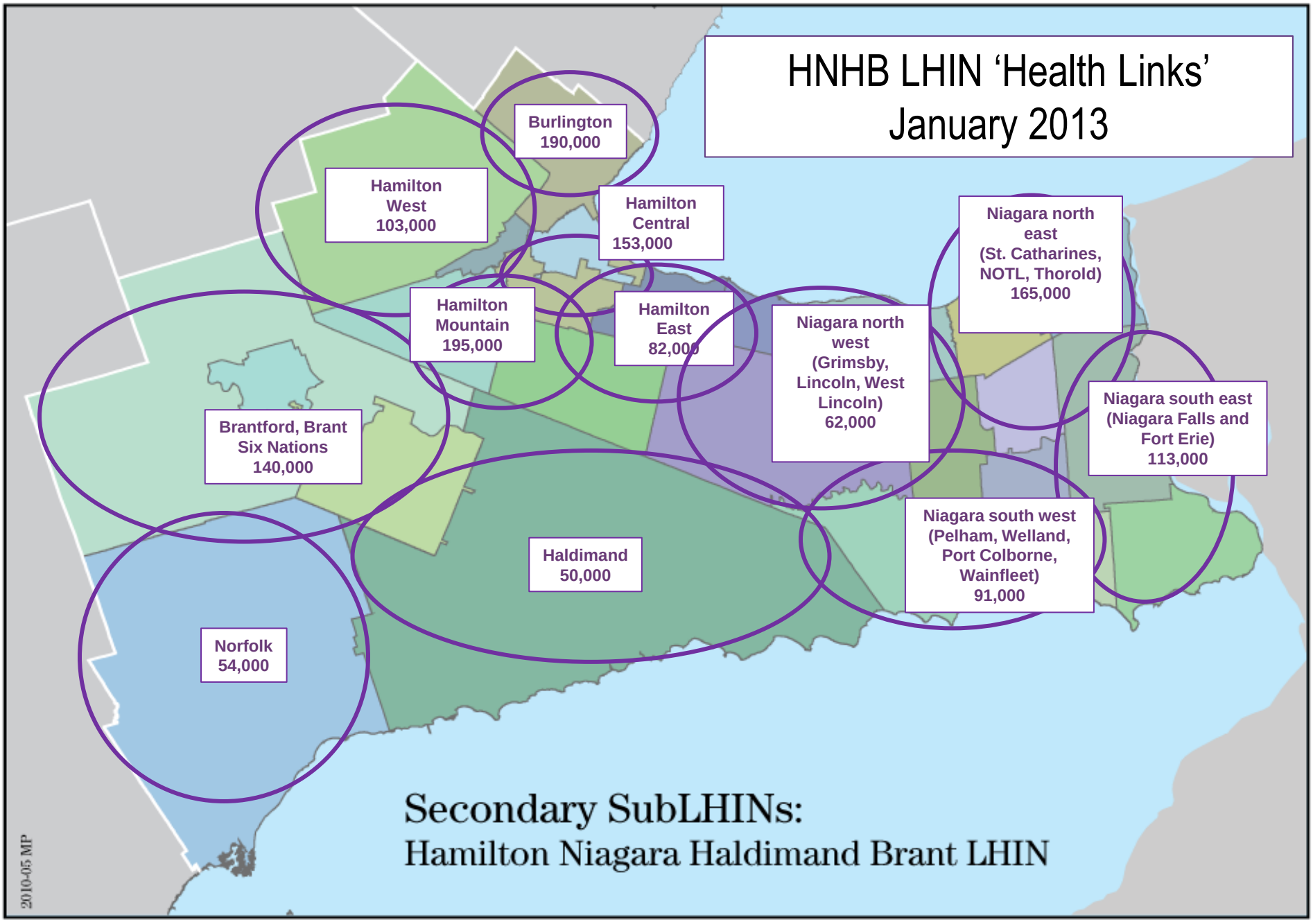
- Evaluation of Health Links to inform continuous improvement.

Communications Support

- To ensure a common Health Link 'brand' and clear messaging on patient benefit.

Health Links Governance Structure




HNHB LHIN 'Health Links'
January 2013
Burlington
190,000
Hamilton
West
103,000
Hamilton
Central
153,000
Hamilton
Mountain
195,000
Hamilton
East
82,000
Niagara north
west
(Grimsby,
Lincoln, West
Lincoln)
62,000
Niagara north
east
(St. Catharines,
NOTL, Thorold)
165,000
Niagara south east
(Niagara Falls and
Fort Erie)
113,000
Brantford, Brant
Six Nations
140,000
Haldimand
50,000
Niagara south west
(Pelham, Welland,
Port Colborne,
Wainfleet)
91,000
Norfolk
54,000
Secondary SubLHINs:
Hamilton Niagara Haldimand Brant LHIN
2010-05 MP

HNHB LHIN Strategic Aim

Dramatically improving the patient experience through Quality, Integration, and Value.

An Early Focus – High Users

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

Implementation Steps

- Initial engagement with **ALL** providers
- Readiness assessment completed
- Focus on the high users/implementation
- Business case completed
- Operations
- Evaluation and Expansion

Questions???