South East **LHIN**

Advancing Quality Through Regional Clinical Governance

Uncovering The Building Blocks: What Do Recent Projects and Initiatives Show Us About What Works and What Does Not?

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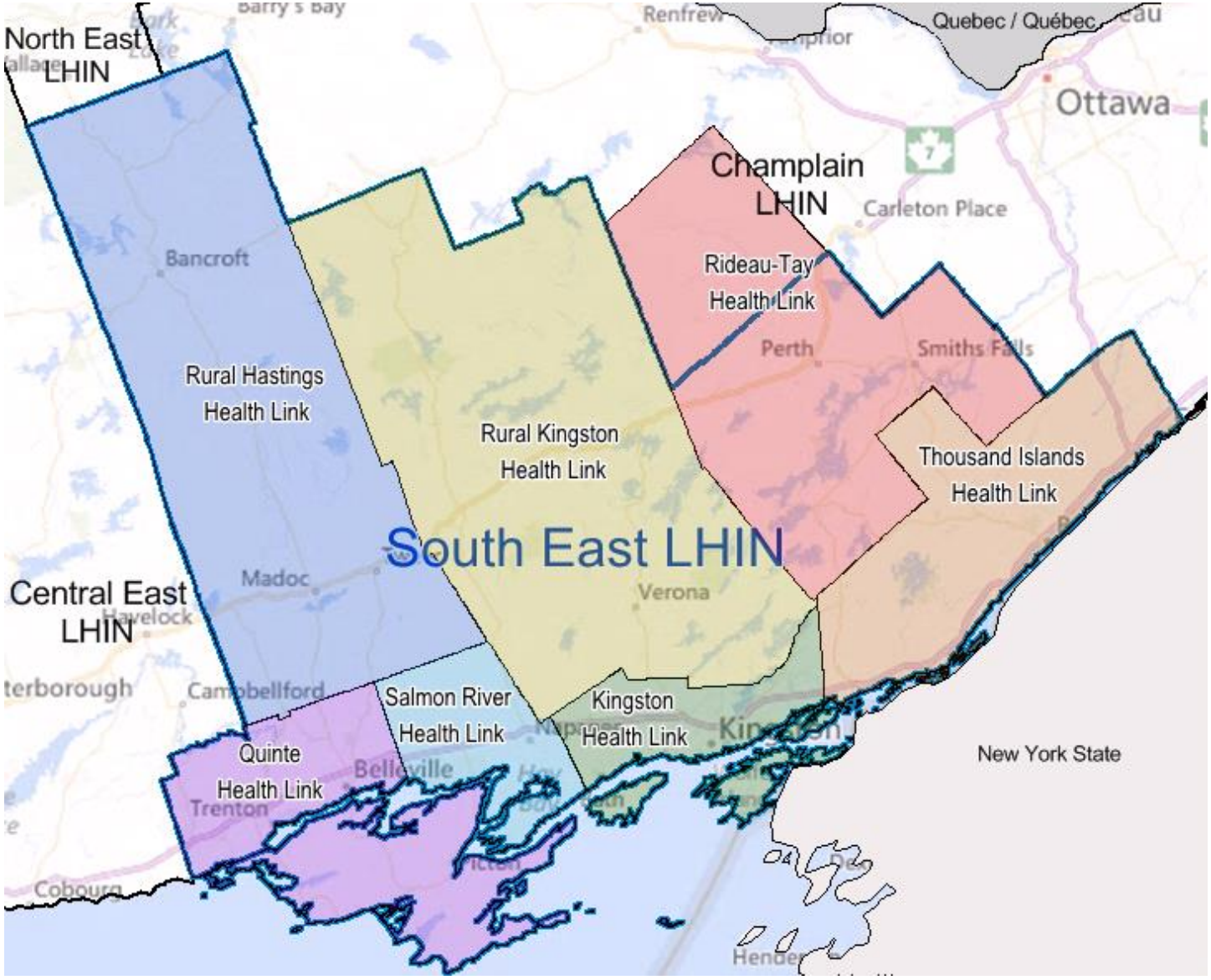
Presenter Disclosure

- Employed by the South East LHIN
- Relationships with commercial interests: none.

The South East LHIN Health Links

- Provincial initiative – patients with complex needs – 4+ chronic conditions.
- To date approximately 2,000 patients have received coordinated care in the SELHIN and 99% plus are attached to a primary care provider:
  - Have an individualized, coordinated plan, with the "patient voice"
  - Have support to ensure they are taking the right medications, particularly in transitions of care
  - Have a care provider they can call who knows them, is familiar with their situation and can help
- 3 Primary Care Co-leads (Initially one Lead)
- 7 Health Links cover the South East LHIN region (started 2013/14)

South East Coverage Map



Building Blocks

- Primary Care led
- Flexibility fostered by the South East LHIN:
  - “Own self identity and culture”
  - “Empower local innovation” (which was then shared)
- People working together with collaborative ownership of initiative.
- Which has resulted in “COMMON”
  - Definitions
  - Identification
  - Care coordination / System Navigation
  - SHIIP electronic tool

SHIIP Dashboard Overview

A A Search

Home | Dashboard | Indicators | All Patients | Andrew Everett

Patient Roster Summary

Combined Acute Inpatient & Emergency Department Activity

Status	#last 7 days	#last 30 days	#last 365 days
Total Patients	57	146	671
Complex/High Needs Patients	0	1	9
With Active Coordinated Care Plans	4	5	25
Patients discharged to residence with home care supports	0	0	2

Active Inpatient Activity

Status	#last 7 days	#last 30 days	#last 365 days
Total Patients	27	44	204
Complex/High Needs Patients	0	0	8
With Active Coordinated Care Plans	4	4	18
Patients discharged to residence with home care supports	0	0	0
Readmissions	4	8	108
Intensive Care Unit	1	1	8

Average Acute Length of Stay (days)	0.0	0.0	6.3
Average Alternative Level of Care Length of Stay (days)		n/a	

Emergency Department Activity

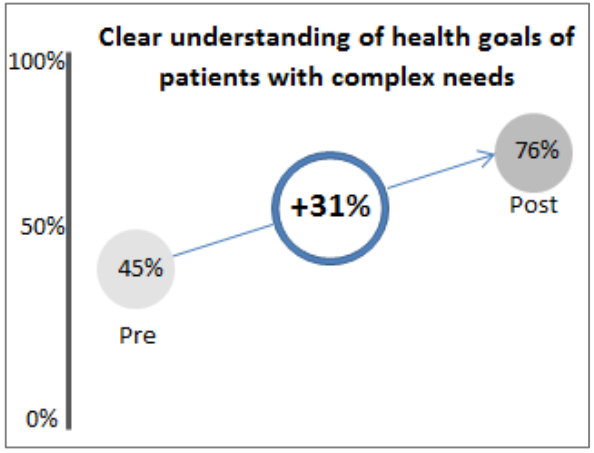
Status	#last 7 days	#last 30 days	#last 365 days
Total Patients	36	119	562
Complex/High Needs Patients	0	1	6
With Active Coordinated Care Plans	3	5	18
Patients discharged to residence with home care supports	0	0	2
Repeat Visits	4	17	155
Visits for CTAS 1-2	8	26	153
Visits for CTAS 3	22	72	387
Visits for CTAS 4-5	7	28	203

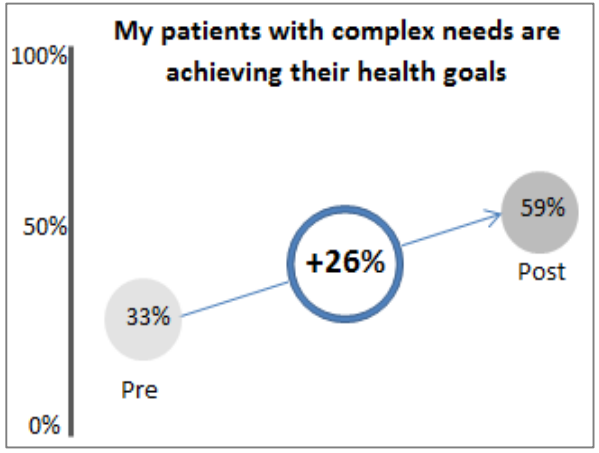
Number of patients admitted as inpatient	14	15	100

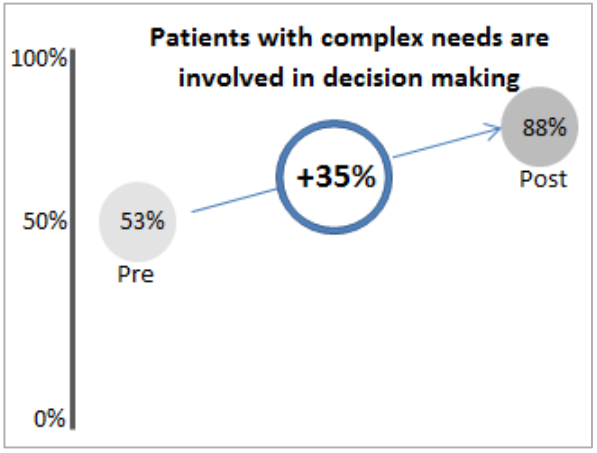
So What?

- South East LHIN funded a third party formative evaluation of Health Links:
  - Improved patient centred care for patients.
  - Improved experience for patients, their families and providers.
- Numbers showing decreased hospital utilization (4 Health Links reporting utilization data).

Improvement in Patient-Centred Care







Providers understanding patient goals

Patients achieving goals

Patients involved in decision-making

Source: Partner survey, N=108-113

Patients and Families – Improved Experience

- Report their healthcare experience as:
  - ✓ Less **fragmented**
  - ✓ More **consistent**
  - ✓ More **personal, respectful, and compassionate**

- They appreciate the **care coordinator role,** especially related to communicating with multiple health care providers

- "This approach is the best thing that's happened to my health – you don't want to be like a ping pong ball bouncing between providers."

- - Health Link patient

- "Respect and dignity - she treats everyone with the utmost respect; She doesn't talk down to [name of family member] or [name of family member]. The whole process has been very respectful."

- - Health Link patient

Decreased Acute Hospital Utilization

Pre-post coordinated care planning (CCP) comparison

Measure	Rural Hastings Health Link	Thousand Islands Health Link	Quinte Health Link	Kingston Health Link
# emergency dept. visits	↓ 85.0%	↓ 47.0%	↓ 39.4%	↓ 29.2%
# acute care hospital admissions	↓ 80.0%	-	↓ 49.2%	-
# hospital 30-day readmissions	↓ 94.0%	-	↓ 55.6%	-
Length of stay (days)	-	-	-	↓ 22.8%
Urgent care visits	-	-	-	↓ 42.6%
Data description • # patients • # mths pre & post CCP implementation	103 patients 12 mths pre & 9-12 mths post	49 patients 6 months pre & post	72 patients 12 mths pre & post	126 patients 6 mths pre & post

What's Not Worked?

- Some tests of change e.g. that focused on a single disease
- Disincentives to sharing
- Exposed the lack of vertical and horizontal integration

Where More Attention is Needed

- Sharing information with specialists
- Sharing information in real time within the circle of care
- Equitable access to healthcare services

Uncovering the Building Blocks & Delivering Better Care Together

Flexible Leadership

Commitment to Building Relationships

Primary Care Led