Gateway Community Health Centre
Every One Matters.

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e Healthy Change Happen

HEALTH SYSTEM TRANSFORMATION

June 2015 – AOHC Conference
Lyn Linton, Executive Director
Julia Swedak, Director of Quality & Decision Support
Gateway CHC

HEALTH SYSTEM TRANSFORMATION



Improving patient care

Transitions In Care

Care Coordination

Cost

Sustainability

What do we bring to the table ?

Are we transformational Leaders?

Do we have a vision ?

Are we System Thinkers?

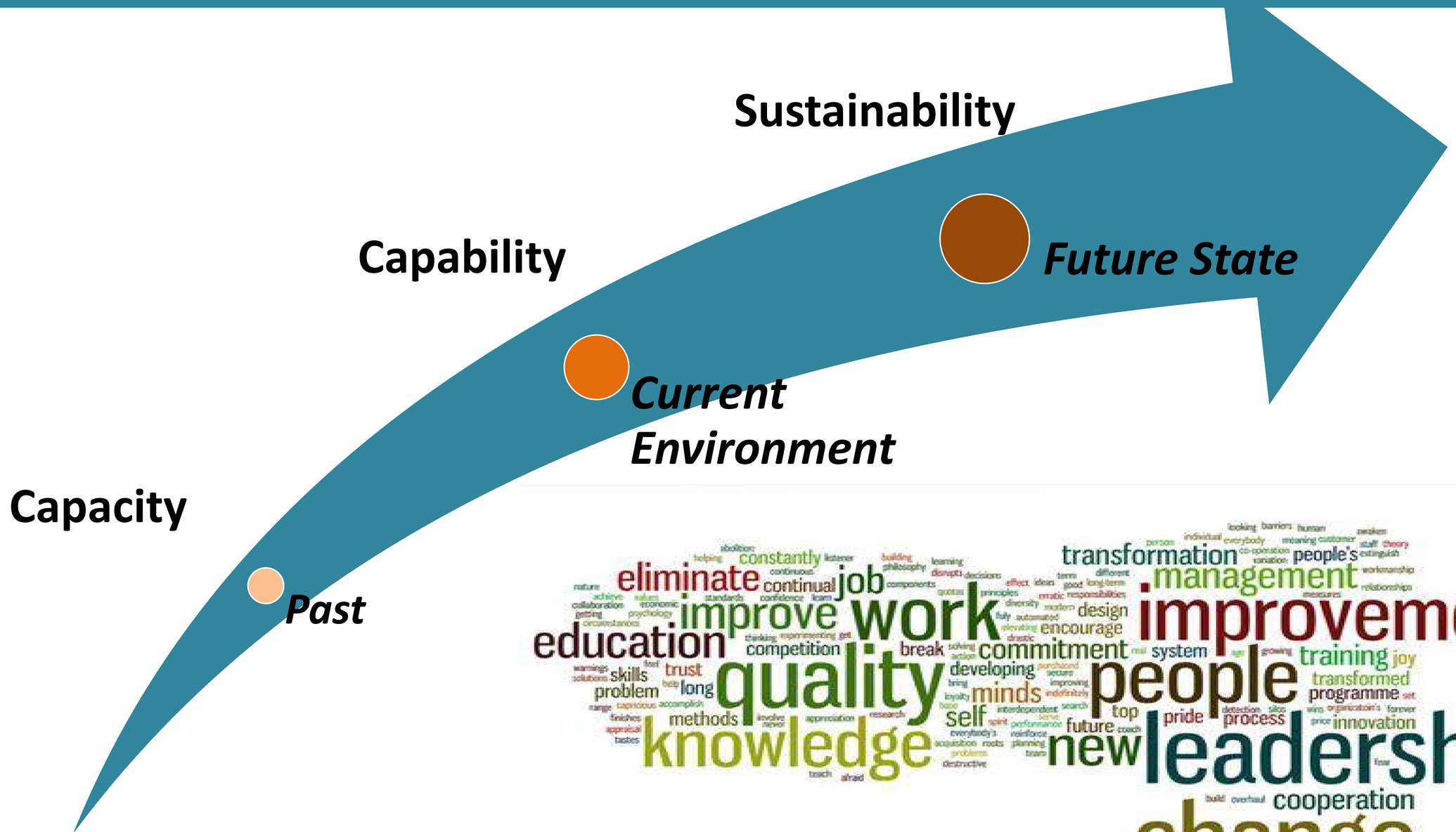
Are we ready to move into the future?

The Roadmap is Changing





HEALTH SYSTEM TRANSFORMATION

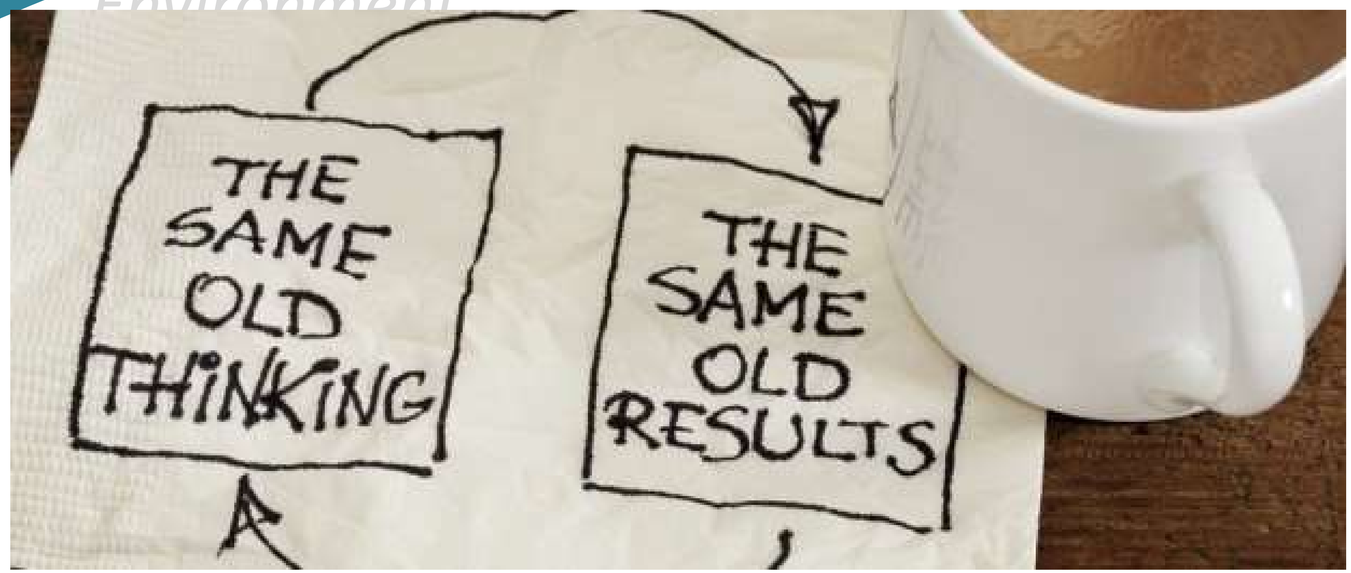


The Past is Important but…

Future State

Current Environment

Past



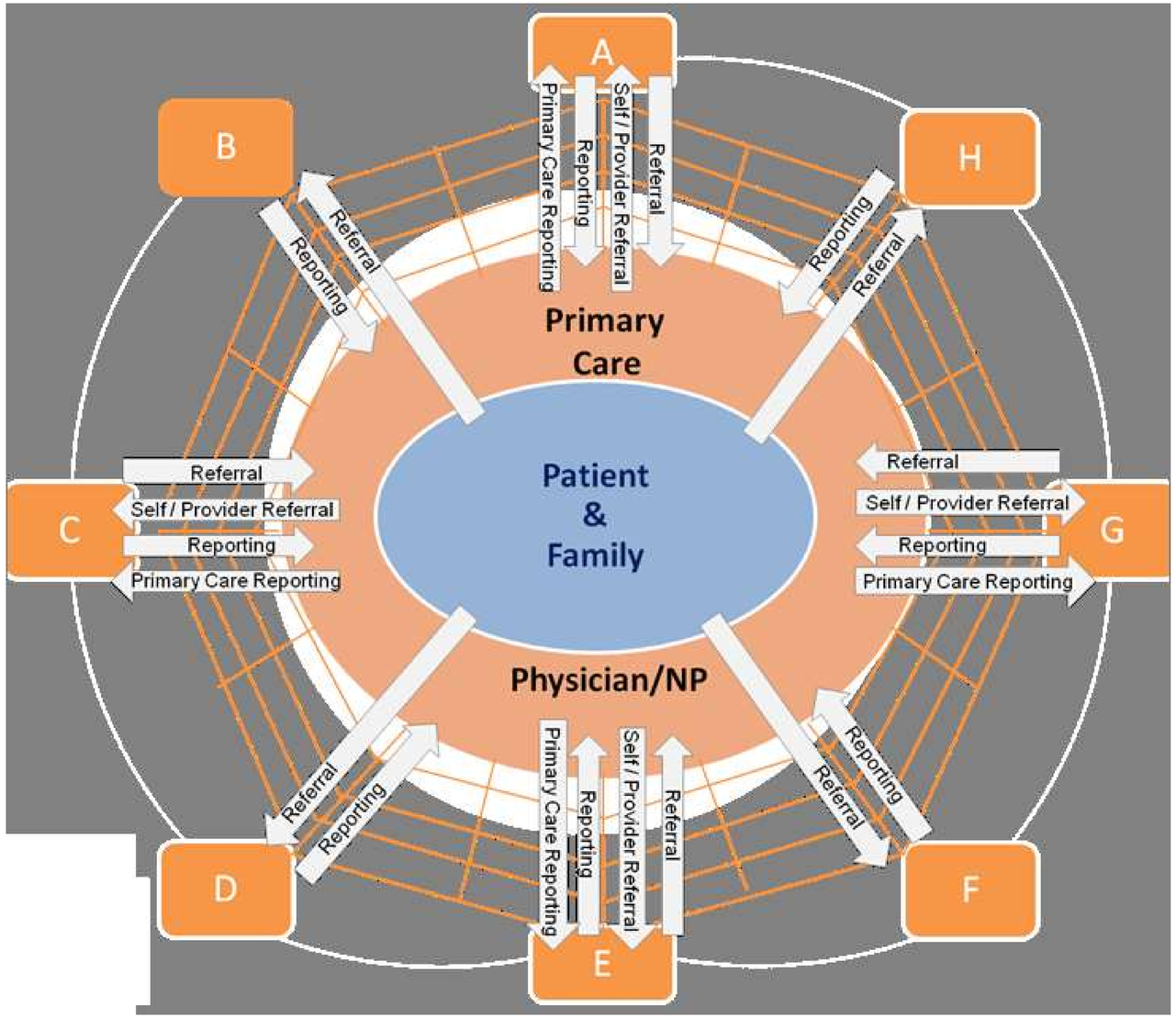
Community Health Centre's - What is in our toolkit?



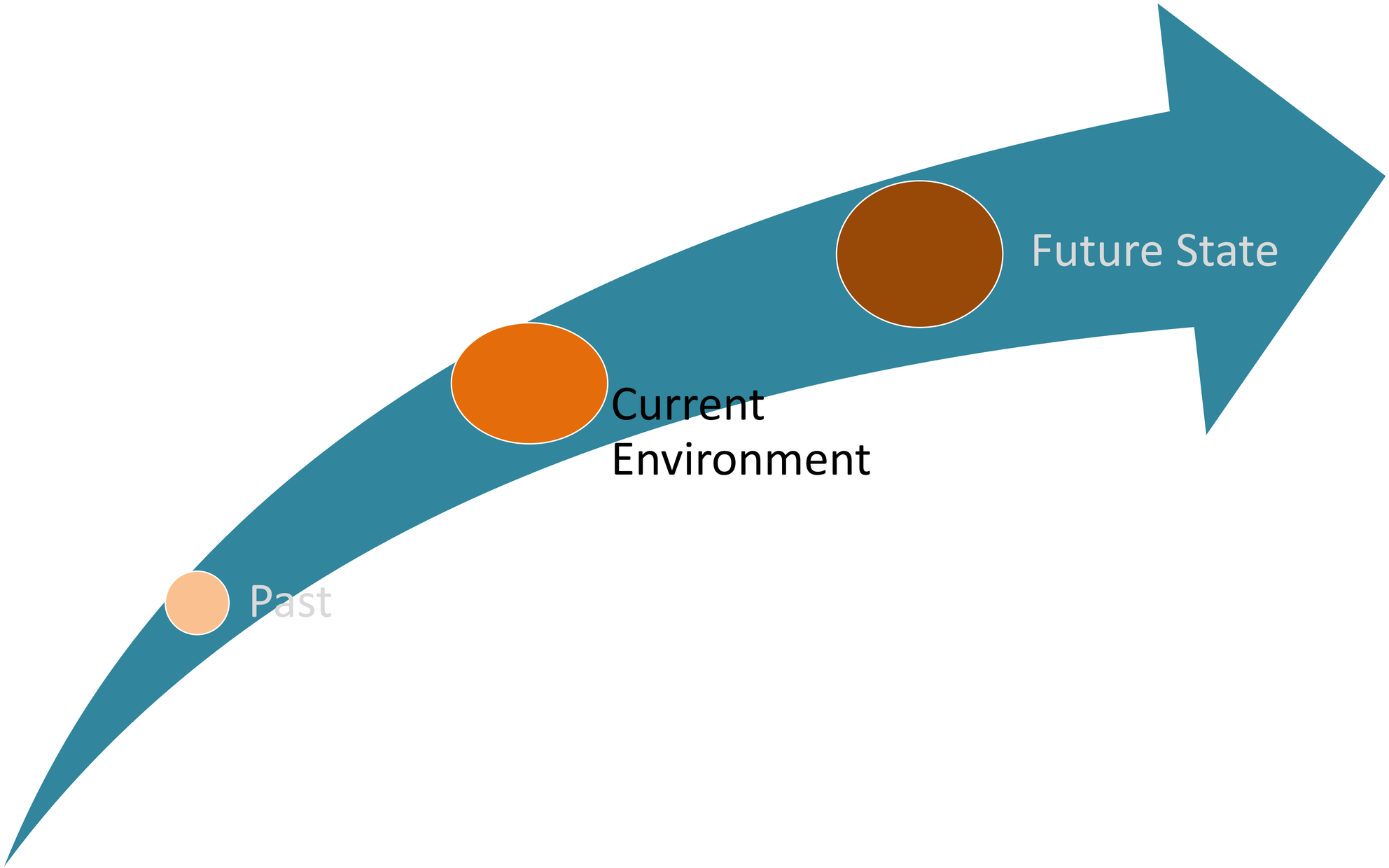
- **Providing care for medical/socially complex clients**
- ***Population needs based focused***
- ***Equity***
- ***Strong Performance Management capabilities***
- ***Inter-professional teams***
- ***Outreach***
- ***Community partnerships / relationships***
- ***Client engagement***
- ***Nimble***
- ***Community Governed***

CURRENT PATIENT MODEL – EXPORT /IMPORT
What Patient's are Saying

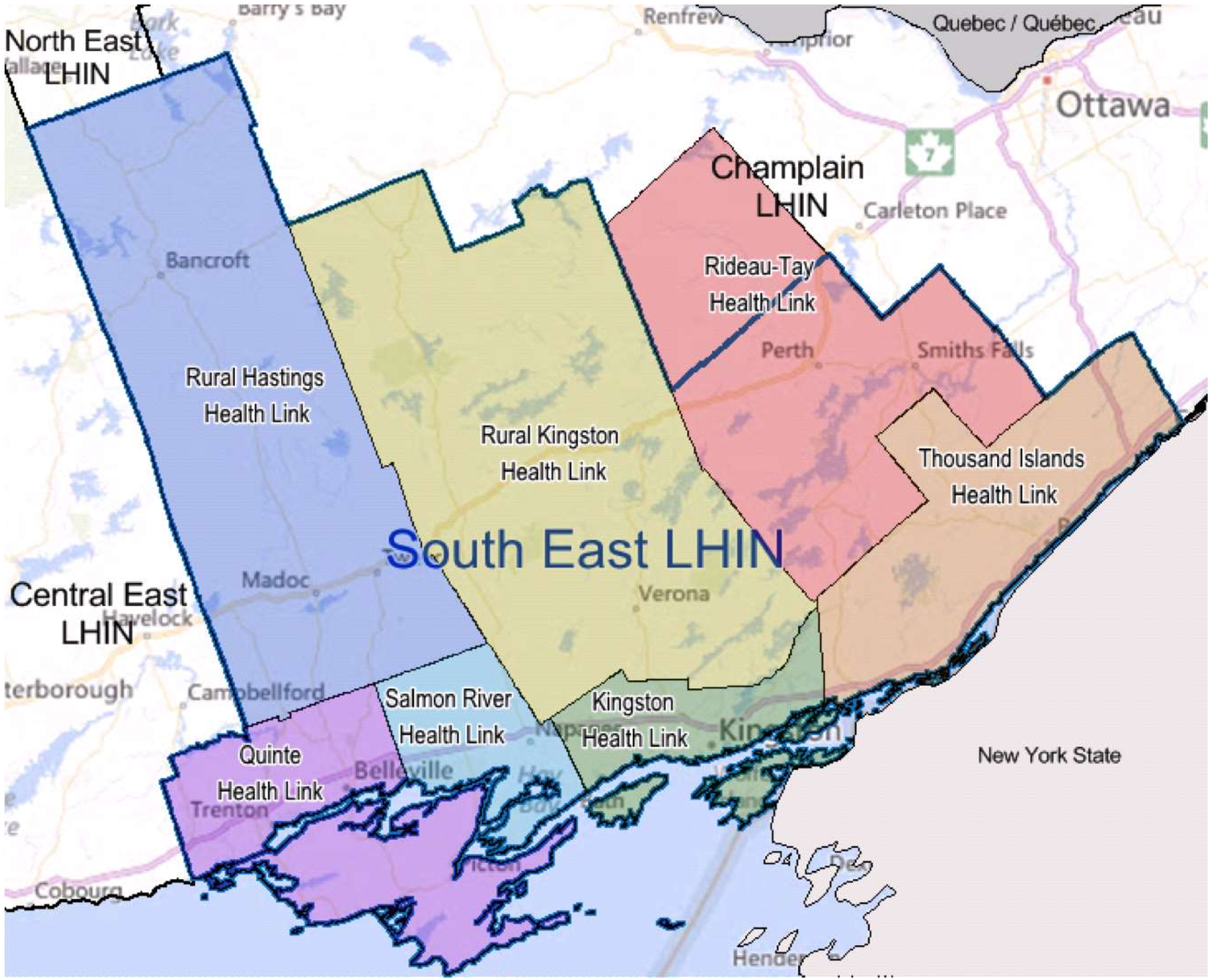
✓Workers not connected
✓Who do we belong to?
✓We don't know who we are talking to
✓Without family to help it is impossible
✓Very confusing system
✓Communication between those who provide the service and our doctor is poor
✓Need someone to advocate for us
✓ Help us find the right service and access the services we need
✓ When money runs out we we are left on our own



HEALTH SYSTEM TRANSFORMATION



SE LHIN HEALTHLINKS



QHL Working Groups

RHHL Working Groups

SRHL Working Groups

RKHL Working Groups

KHL Working Groups

TIHL Working Groups

RTHL Working Groups

Quinte Health Link Steering Committee

Rural Hastings Health Link Steering Committee

Salmon River Health Link Steering Committee

Rural Kingston Health Link Steering Committee

Kingston Health Link Steering Committee

Thousand Islands Health Link Steering Committee

Rideau Tay Health Link Steering Committee

7 South East Health Links

Health Link Coordinating Groups' Table

SE CCAC

Primary Health Care Council

South East LHIN

Evaluation Committee

Communications Working Group

Primary Care Leads

Health Link Lead

Improvement Facilitators

Patient Engagement Working Group

South East Health Integrated Information Portal (SHIIP)

KFLA PHU

Data Leads and Privacy Working Groups

Health Link Landscape

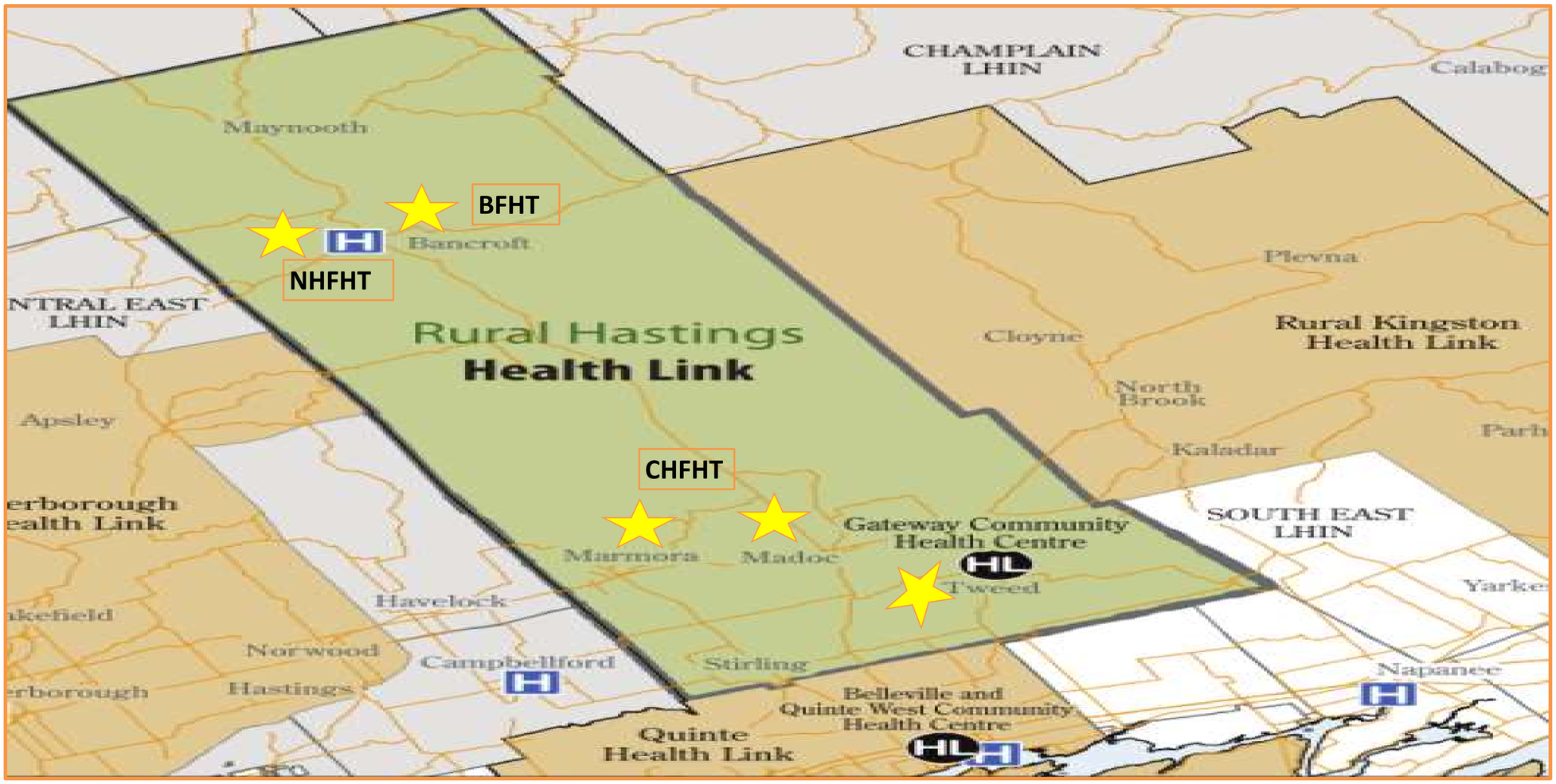
South East LHIN

HealthLink

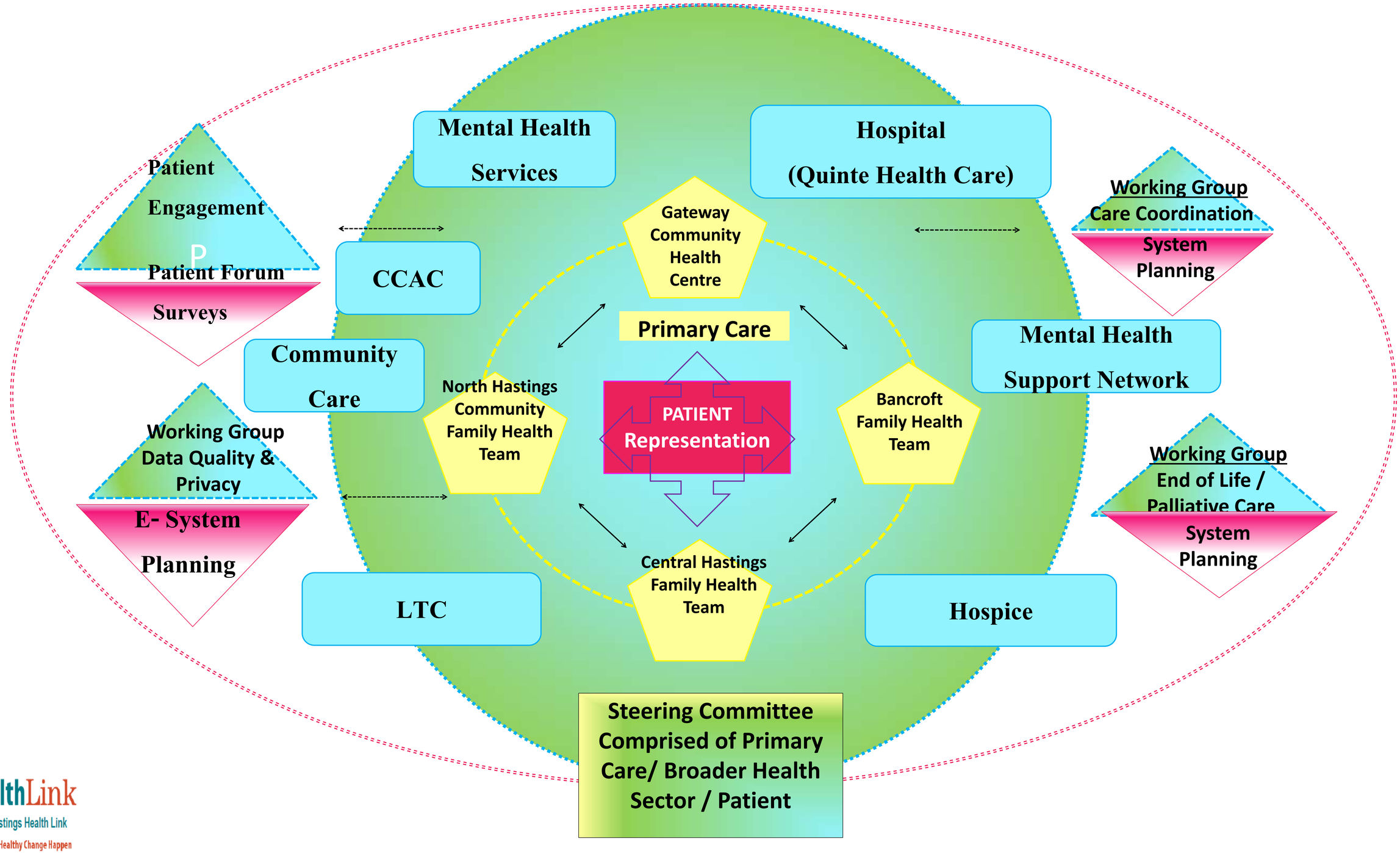
Rural Hastings

Let's Make Healthy Change Happen

Rural Hastings HealthLink



RHHL Coalition



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Vision Statement

We will *improve the health in our communities.* ***We will*** *provide care in partnership with providers, patients, and their families to achieve better health.* ***Together****, we will create a system that enable, promotes ownership and improves health through* ***engagement, leadership, innovation****, and* ***education.***

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AIM Statement

- Engage **medically/socially complex** patients whose needs represent the majority of health care spending

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- Improve coordination of care when **transitioning** from one part of the health care system to another

- Integrate the **patient's voice** into the medical plan of care through the development of a care coordination plan

- Improve the **patient experience** in navigating health and social systems

- Support the patient to **receive care at home**, rather than seeking support through the hospital system

- Improve the **physician experience** in supporting complex patients

- **Decrease ED and hospital utilization** to deliver a return on investment to the health system as a whole

Background – System Planning

A **Registered Nurse System Navigator** was embedded in each of our four RHHL sites. The role of the System Navigator focuses on:

- **Identifying** complex patients,
- **Collaborating** with primary care providers,
- Acting as a **liaison** between transition points in care,
- **Follow up** with patient's post-discharge from hospital,
- Ensuring that **medication reconciliation** has been completed after transitions in care,
- Identifying, integrating, and addressing **social factors** impeding the patient's ability to achieve optimal health outcomes,
- Facilitating **shared-care planning** between transition points of care,
- **Monitoring and evaluating** the patient's care coordination plan against expected outcomes,
- **Advocating** on behalf of the patient/family/caregiver, and
- **Creating spread** across the **continuum of care** by engaging practitioners and broader health and social sector partners.

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Performance Management

Embedded ***Data Management Coordinators (DMCs***) within primary care sites to support:

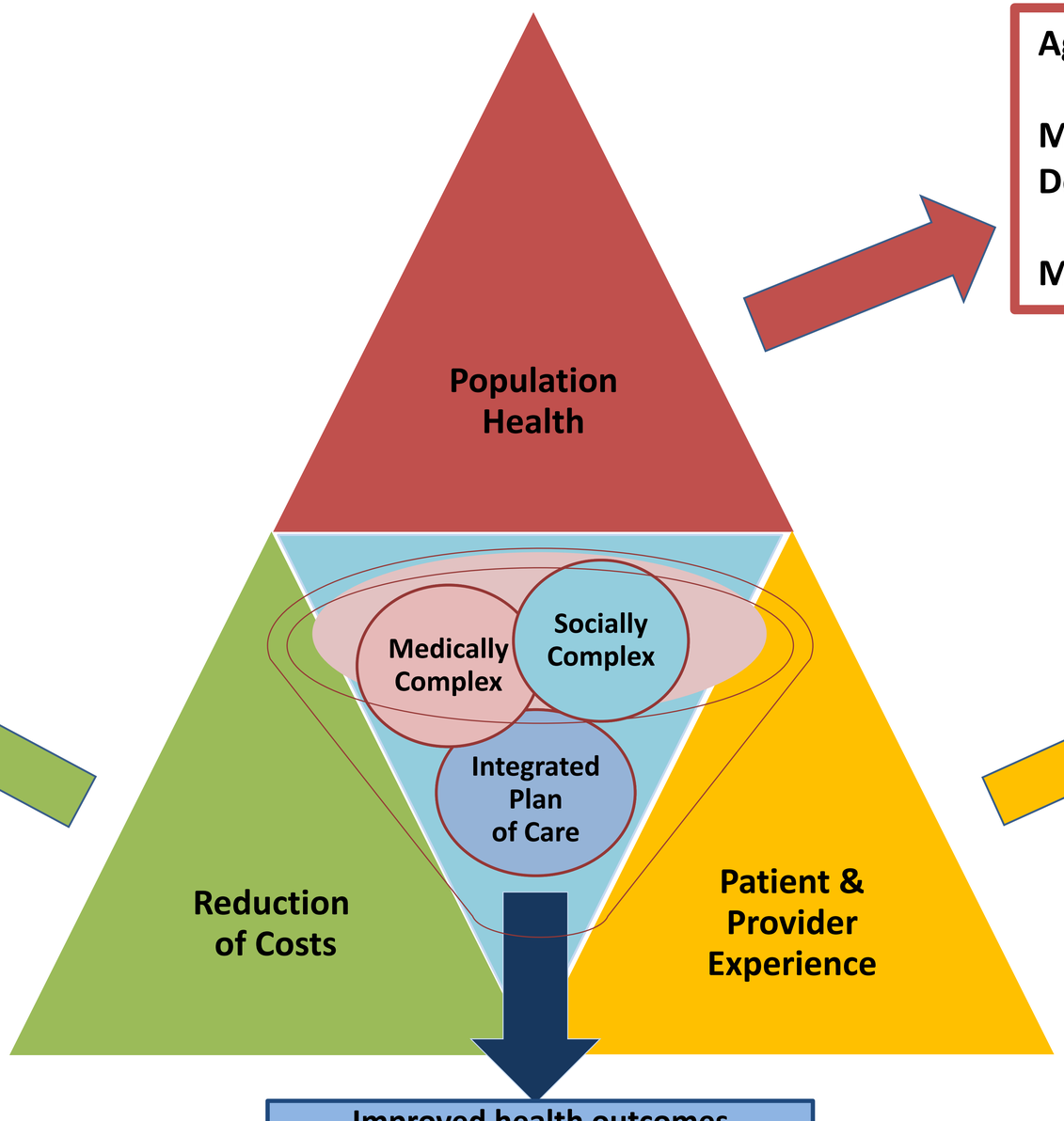
- Establishing **performance** indicators and common definitions,
- Data **integrity**, data **discipline** and data **collection** for the purpose of planning
- **Alignment, evaluation and reporting**
- Collaborate with sector partners to retrieve patient information for **real time access**
- Support **quality** best practices
- Enhance **e-connectivity**
- Align planning with the SE LHIN **e-health vision** – HRM, IAR, Nesda Vault

Triple Aim Approach

Age

Material & Social Deprivation

Medical Complexity



Listening and Understanding the Patient Experience

Improving Patient Experience through system integration, Care Coordination & Navigation

Maximize provider skill and time

Improve quality, communications and patient confidence in provider

System Costs

↓ ED Visits

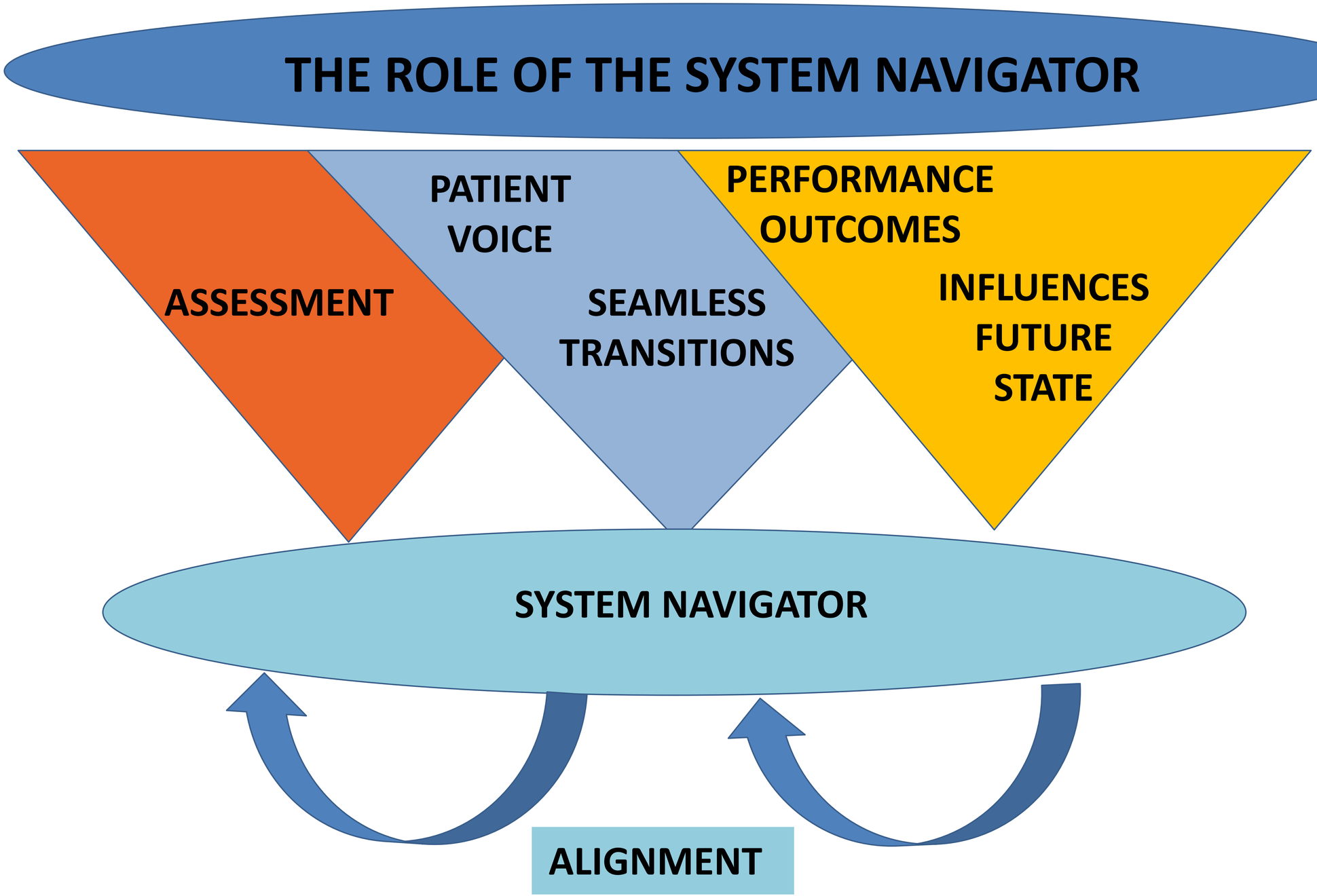
↓ Hospitalization

Right Patient, Right Place, Right Time

Improved health outcomes
Seamless Transitions
System Integration
Return on Investment

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Primary Care System Navigation



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Assessment

Investigation

- Identifies complex patients using real time ER and admission data
- Identify comorbidities, ED utilization, hospitalization, client record review – real time data
- LACE based on last hospital admission
- Consider other assessments (RAI Screener, RAI CHA, RAI HC, ADLs, OCAN)

Assessment

Engagement

- Meet with physician to review concerns and medical plan of care
- Determine need for home versus office visit
- Facilitate meeting between physician, patient, and system navigator

Assessment

Care Planning

- Nursing clinical assessment
- Identify existing care team
- Identify socio-economic barriers
- Patient Safety
- Engage physicians and client in establishing patient goals

Assessment

Implementation

- Link patient goals with medical plan of care
- Advocates on behalf of patient and family
- Integrate patient social support network into plan of care
- Determine requirement for case conference with internal and external care teams

Patient Voice

Listening

- Shifting the conversation between the provider and patient
- Capturing the patient/family voice in establishing their plan of care
- Integrating patient goals into care and treatment options
- Empowering patient to play an active role in their plan of care and expected outcomes
- Listening and responding to patient and provider feedback

Seamless Transition

Navigation

- Follow up with all complex patients 7 days post hospitalization
- Right service – right time – include organizational referral contacts in CCP and EMR
- Working within a system framework between organizations
- Connectivity – acts as a liaison between transitional points of care – family, primary care and service supports

Seamless Transition

Communication

- Single point of contact for primary care
- Building partner relationships – formal and informal
- Monitor interruptions in care of treatment

Performance Outcomes

Evaluation

Monitor and evaluate:

- **Patient goals/CCP against expected outcomes**
- **Hospital utilization – ED and admissions**
- **Removal of socio-economic barriers**
- **Patient and provider satisfaction**
- **Impact on patient wellbeing**
- **Patient knowledge of care team**
- **Number of referrals and action taken on referrals**

Future State

Moving Forward

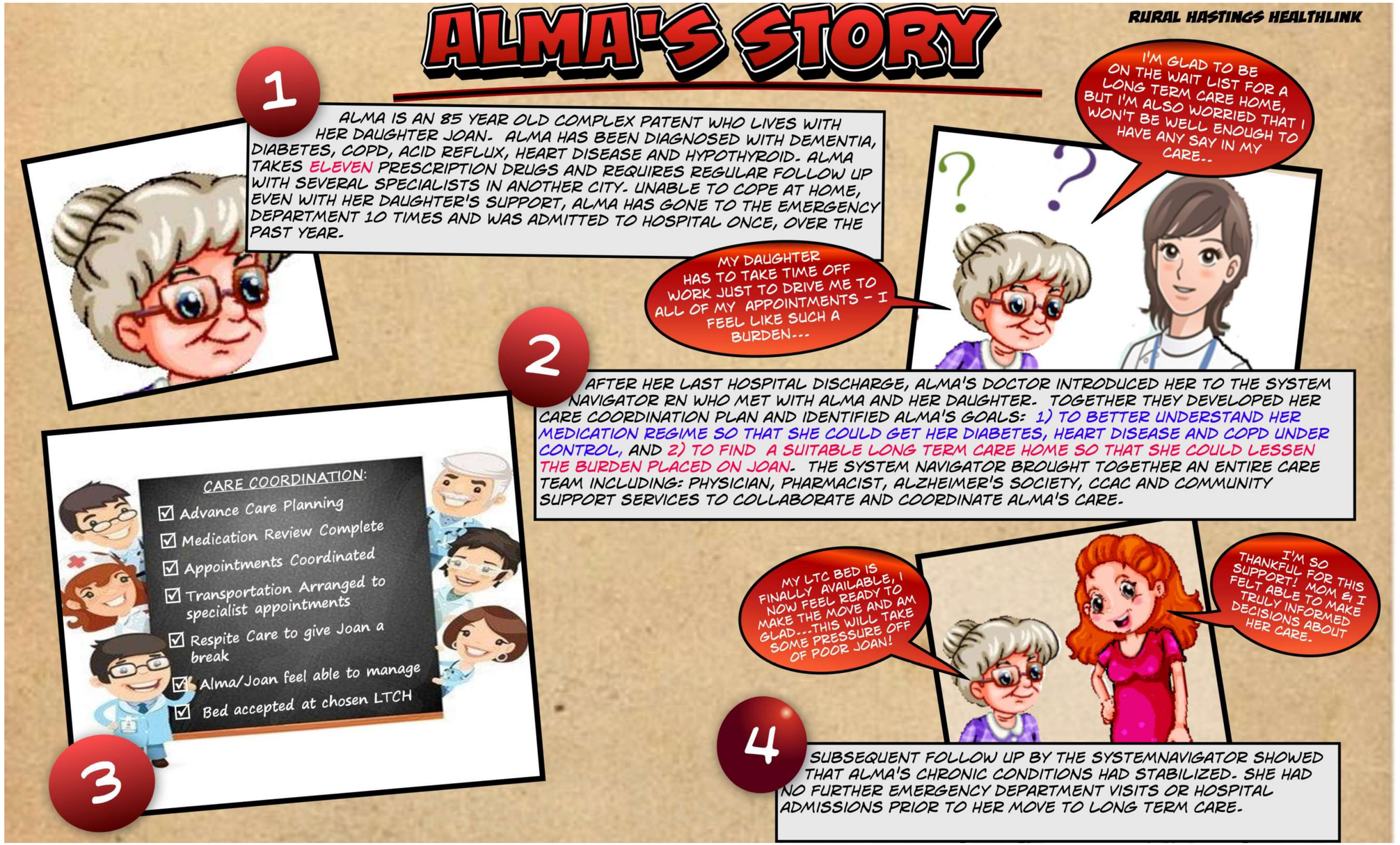
- Access to Meditech (HIS)
- Access to other assessments (RAI Screener, RAI CHA, RAI HC, ADLs, OCAN)
- Formal connectivity – NESDA,IAR, CHRIS/CHIP, HIS, SHIIP
- Prevent more to treat less
- Upstream Health promotion and prevention
- Address the next 10-30% of patients

Patient Stories and Engagement

Capturing the Patient Story

- ✓ **Patient Story Boards**
- ✓ **Listening to Patient Experience – Engagement**

Patient Story Board



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Patient Engagement Forums



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Conversation Guide

Patient Engagement Forum

Conversation Guide

Thank you for accepting our invitation to participate in this patient engagement forum.

We have included this conversation guide to help you think about how you felt at different stages in your journey through Ontario's healthcare system.

This will provide us with an understanding of what matters most to you and your loved ones.

Think back about two years ago and where you were with the healthcare system.

- Was your experience a good one?
- Did you know who to contact for services or help?
- Did you feel your concerns were heard?
- Did your family know what was going on with your health or treatment?

There are two main questions to think about before coming to the forum:

1) **What was your experience with the health care system?**

2) **What do you think would have made your experience better?**

List three things that you liked about your experience regarding your care

1. _____

2. _____

3. _____

List three things that you didn't like about your experience regarding your care

1. _____

2. _____

3. _____

What would have made your experience better?

_____

_____

_____

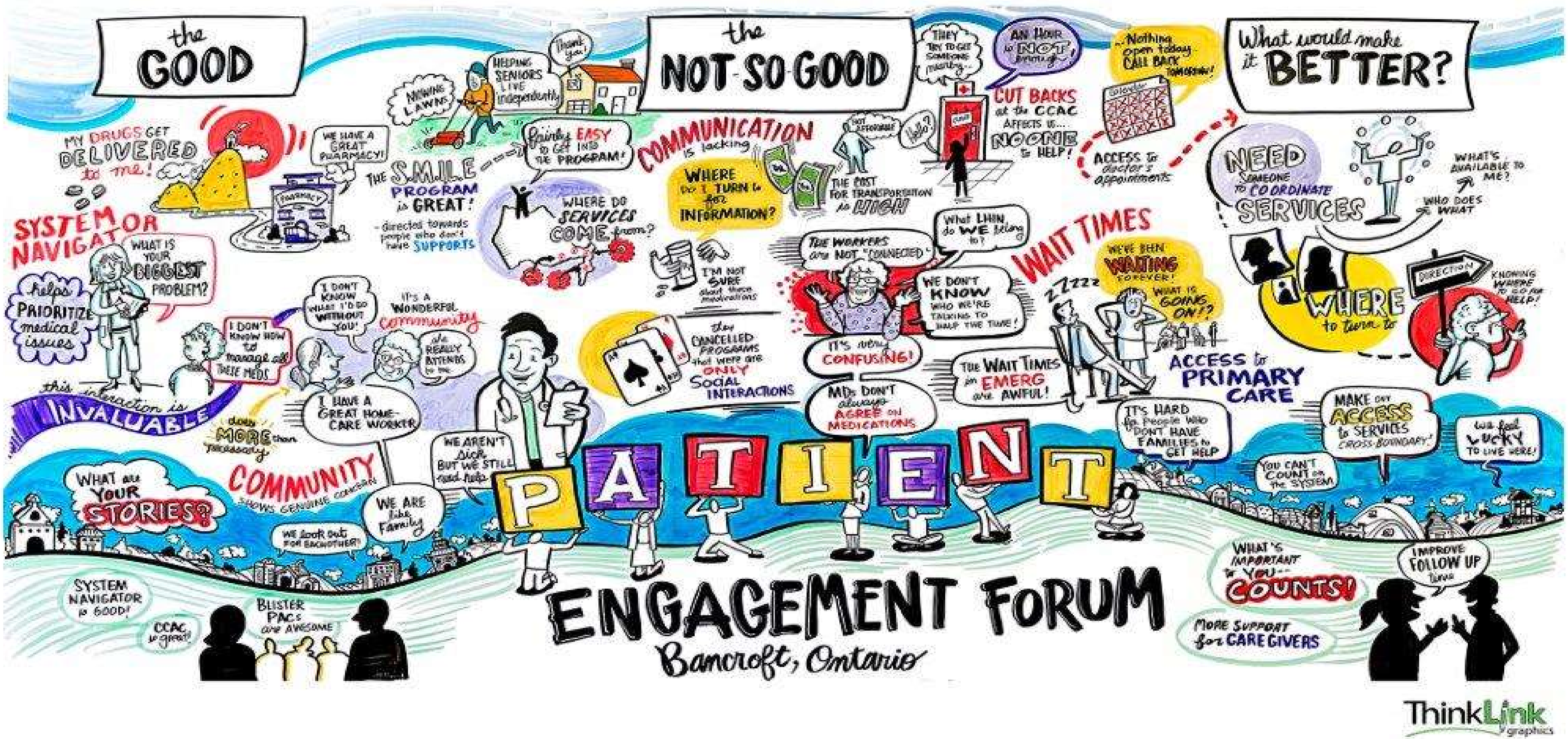
What to Expect at the Forum

February 19, 2015 in Tweed	or **February 20, 2015 in Bancroft**
The White Building	**Hastings Centennial Manor**
(9:00 to 11:00 a.m.	(9:00 to 11:00 a.m.
or 1:30 to 3:30 p.m.)	or 1:30 to 3:30 p.m.)

1) Welcome and registration
2) Coffee and tea
3) Introductions. Relaxed atmosphere. You won't be alone. There will be others who will also share their experiences.
4) There will be a break halfway through
5) We will be taking some notes but we won't be attaching names to those notes, so feel free to express your opinions.
6) After the forum: We invite you to stay for a Coffee or Tea Social to mingle a bit. We are happy to answer any other questions you may have during this time.

Thank you

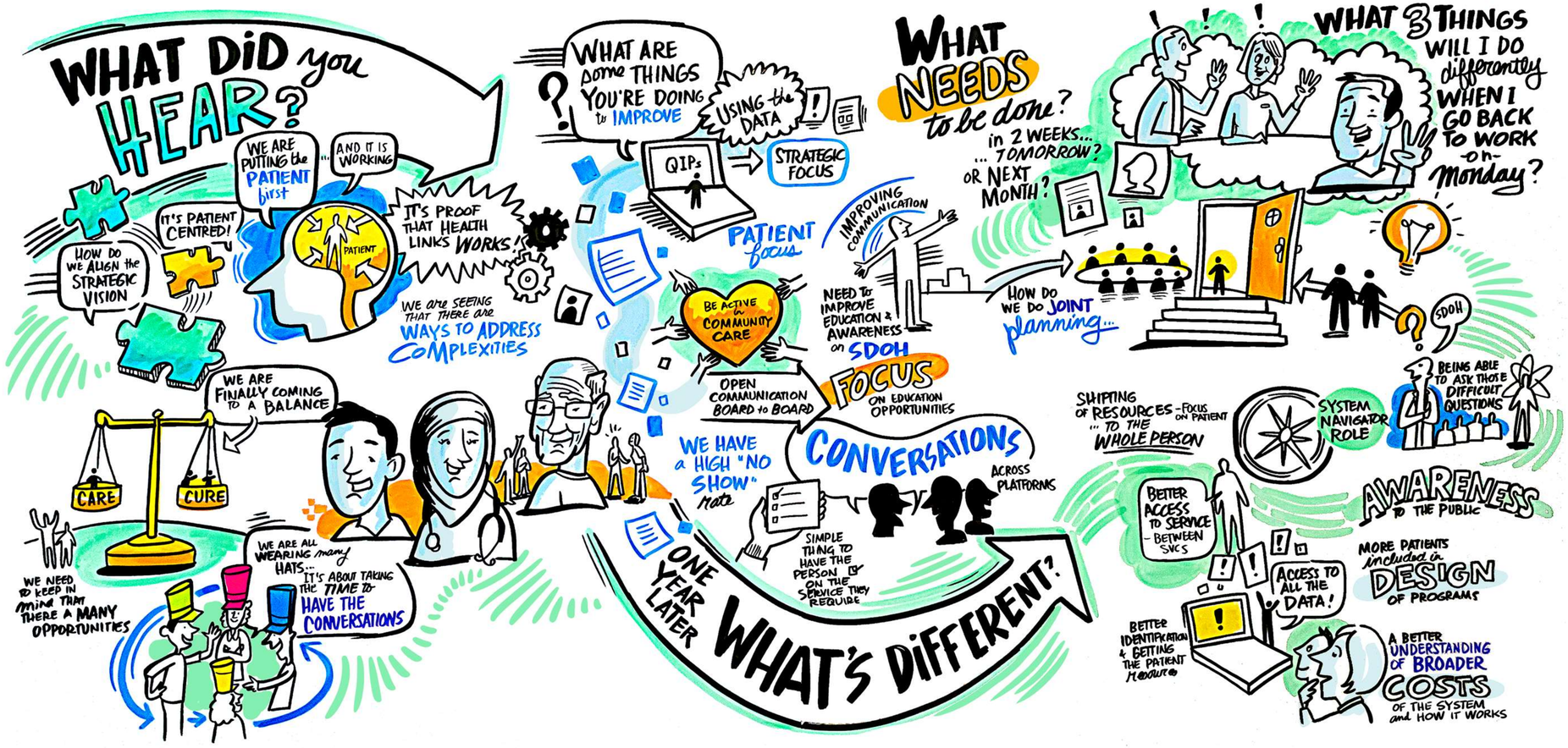
Having the Conversation



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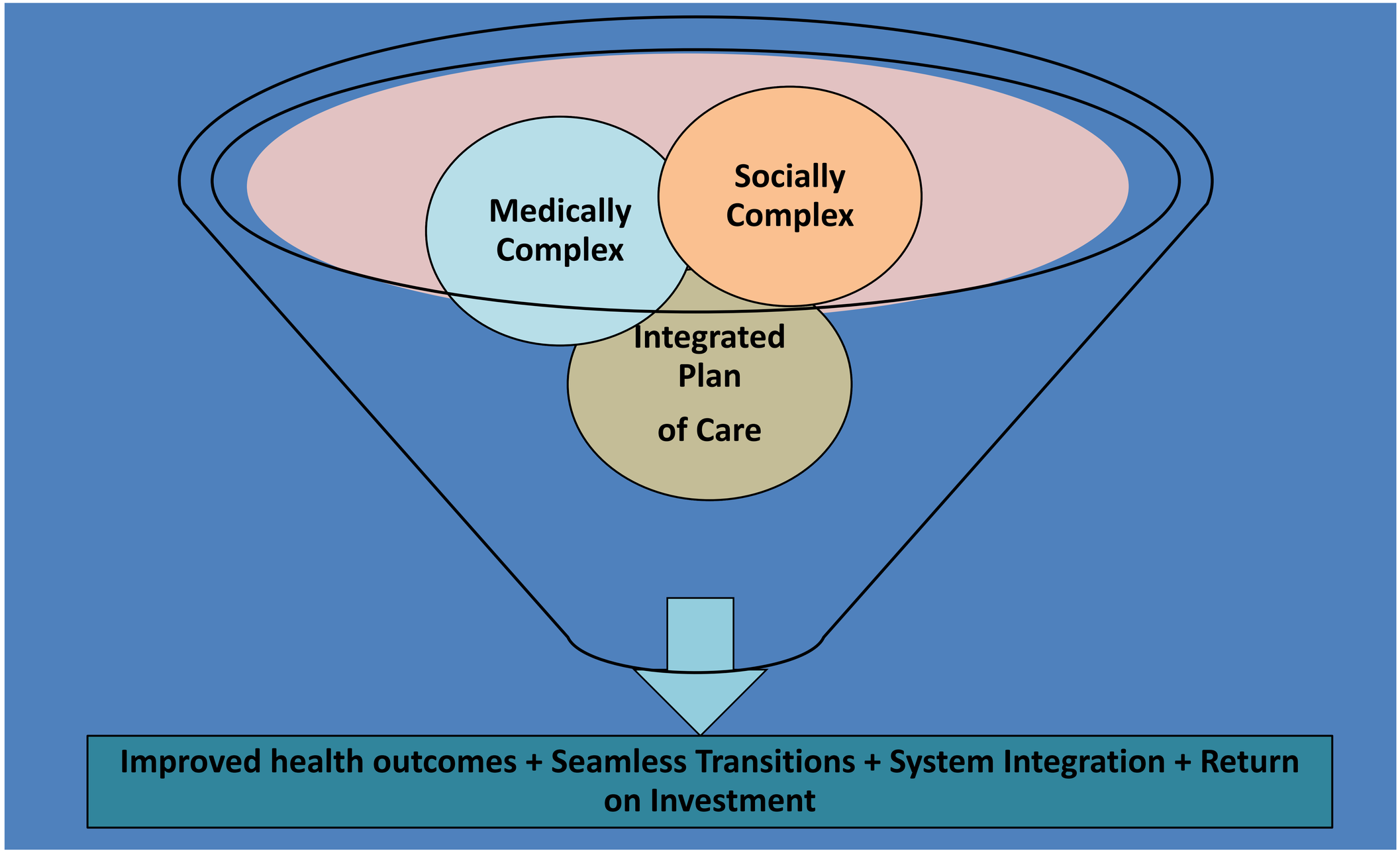
Engaging Governance

First meeting in March 2015 – Future meetings to evolve role of Governance in RHHL



ThinkLink graphics

RHHL Population Health Profile



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Rural Hastings Health Link Patient Population

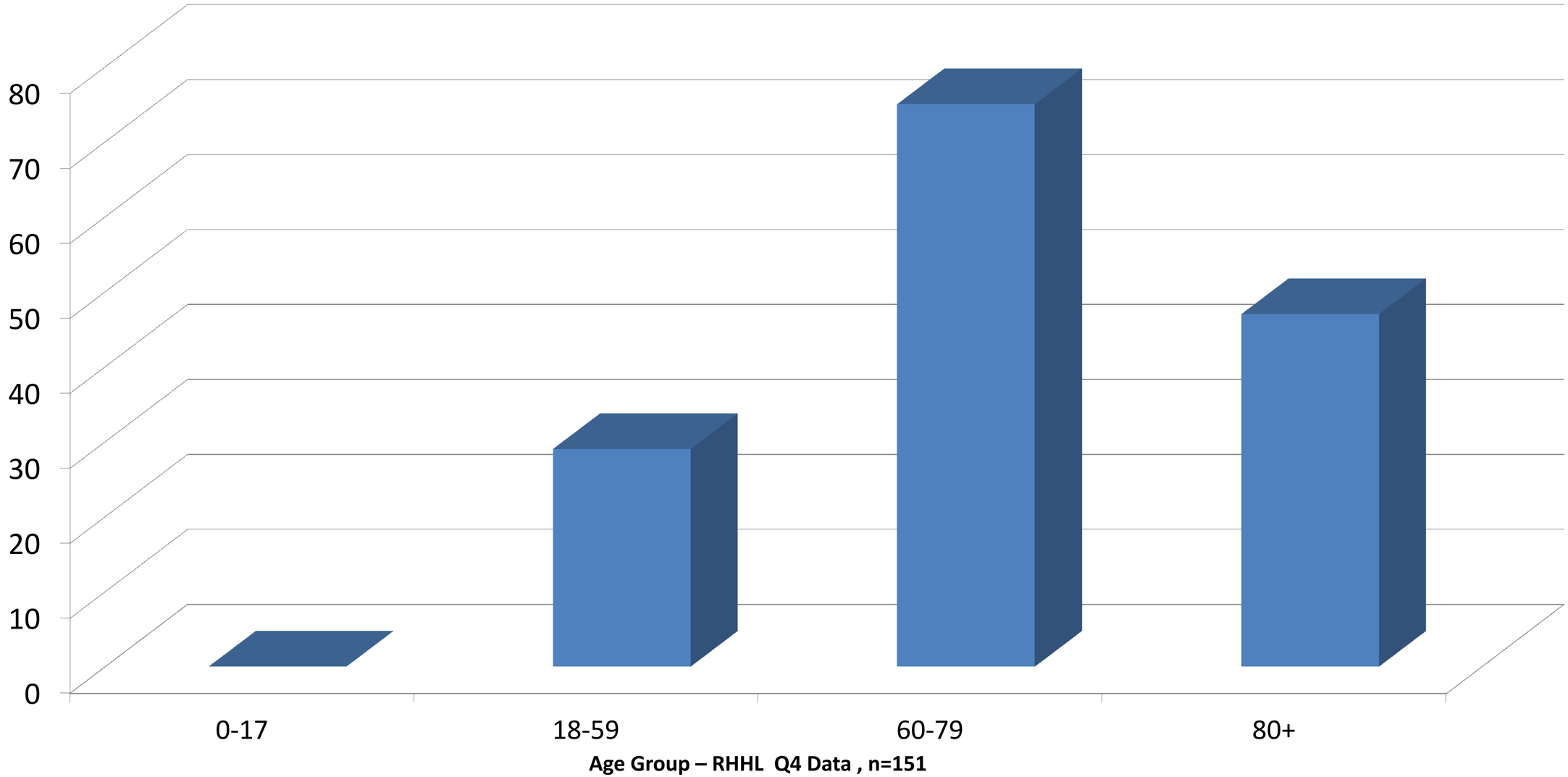
Legend

- CHFHT RHHL Patients
- BFHT RHHL Patients
- NHFHT RHHL Patients
- GCHC RHHL Patients
- NHFHT Location
- CHFHT Location
- BFHT Location
- GCHC Location
- Ontario Major Highways

RHHL Complex Client Criteria

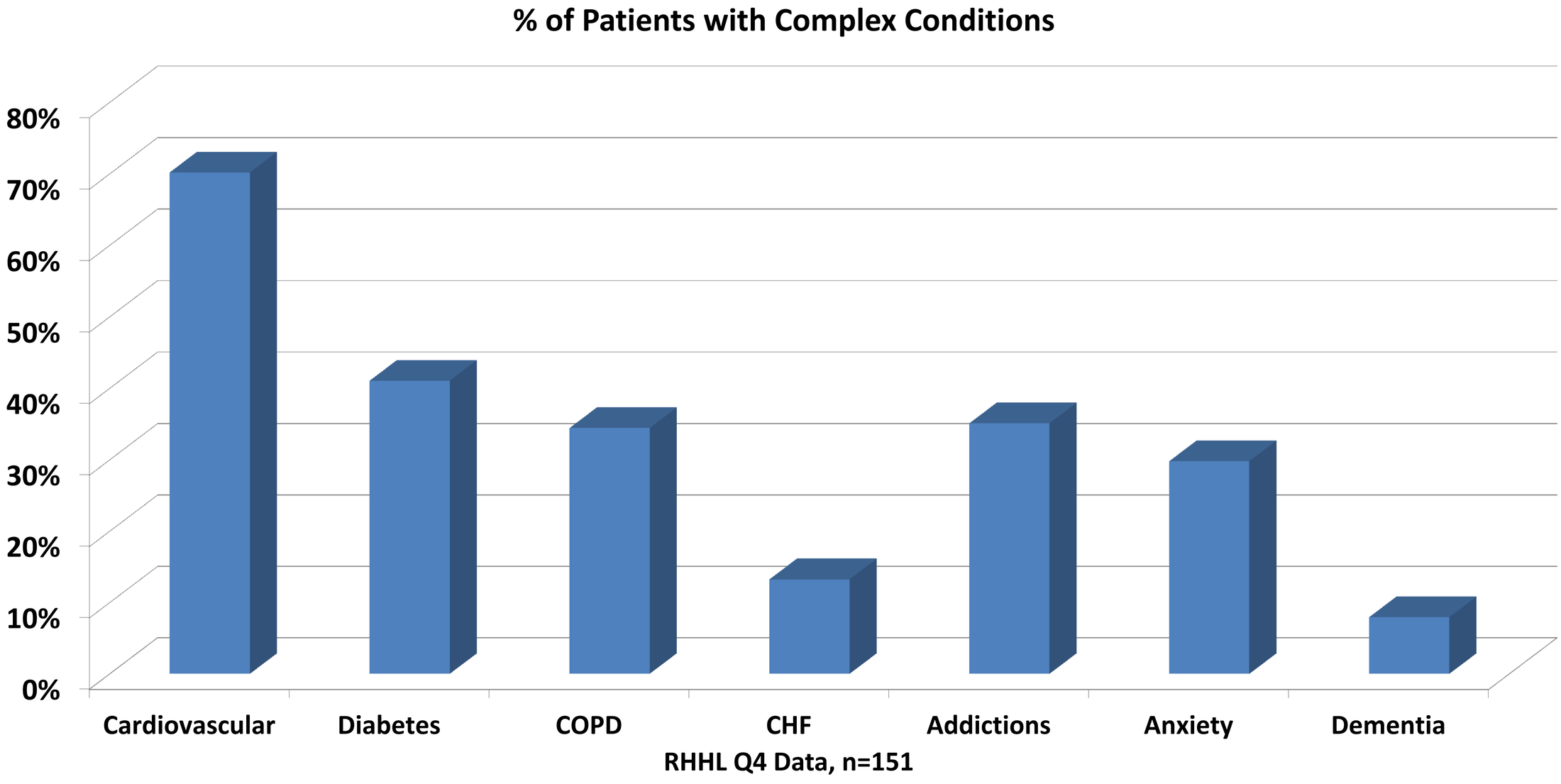
- 4 or more co-morbidities
- 3 or more Emergency Department visits in the past year
- 2 or more hospital admissions in the past year
- 5 or more prescription medications
- Palliative/End of Life

RHHL Complex Patient – Age Demographics



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RHHL Complex Patient - Co-Morbidities



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RHHL Patient Social Complexity - Q4 14/15

Housing

48% Live Alone

45% Live with Spouse

7% Live with Family

Food Security

26% Access food from other sources

Social Isolation

39% Report Isolation

Transportation Barriers

67% Depend on volunteers, neighbours or family

Employment

53% Under 65y unemployed

82% Under 65y on Social Assistance

58% Are Retired

Education

63% High School or Less

35% Post Secondary

2% University

Income

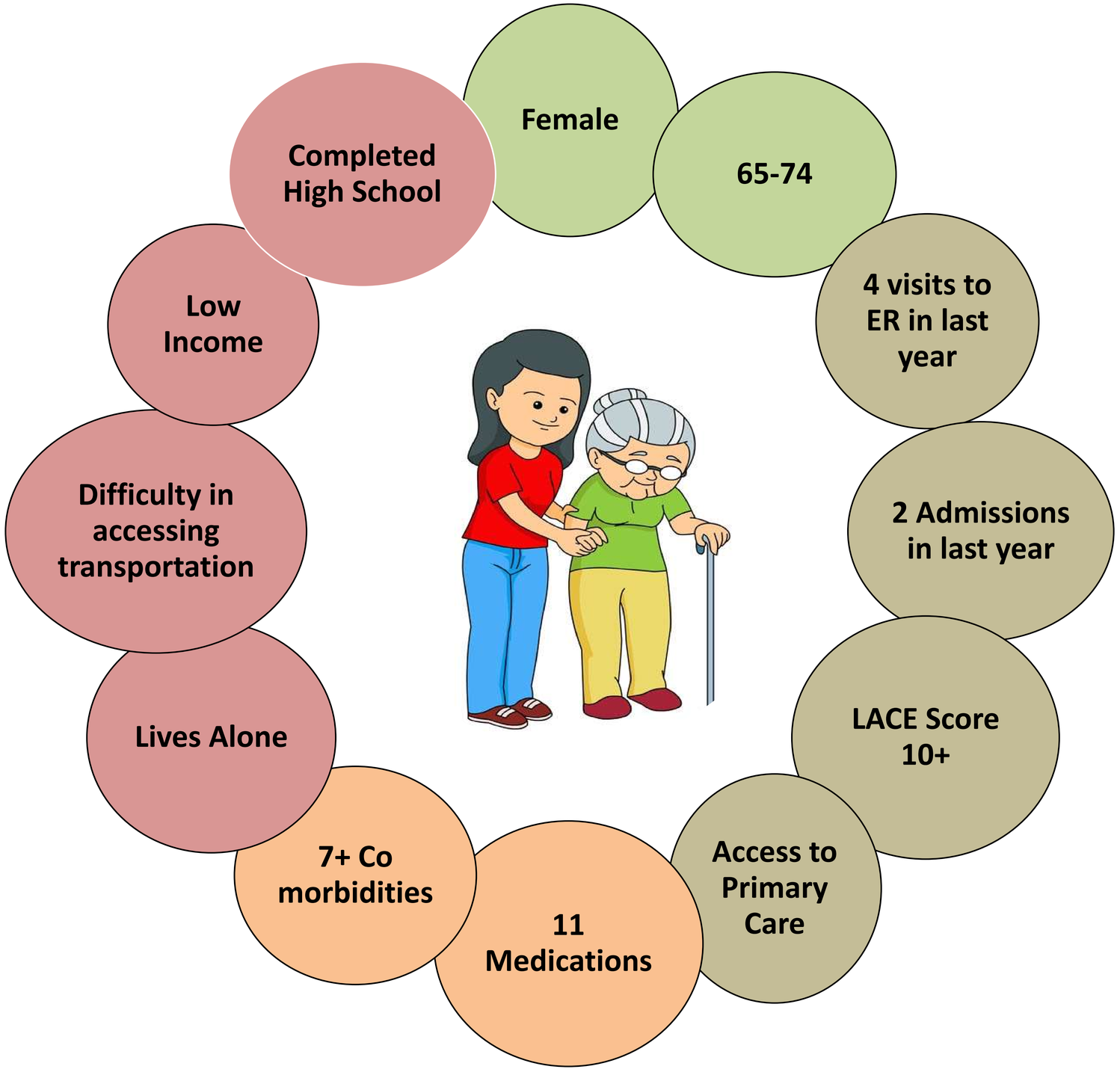
51% Low Income

34% Basic Pension

Socio-economic Demographics

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RHHL Client


Female
65-74
4 visits to ER in last year
2 Admissions in last year
LACE Score 10+
Access to Primary Care
11 Medications
7+ Co morbidities
Lives Alone
Difficulty in accessing transportation
Low Income
Completed High School

Patient Experience with System Navigator – Q4 14/15

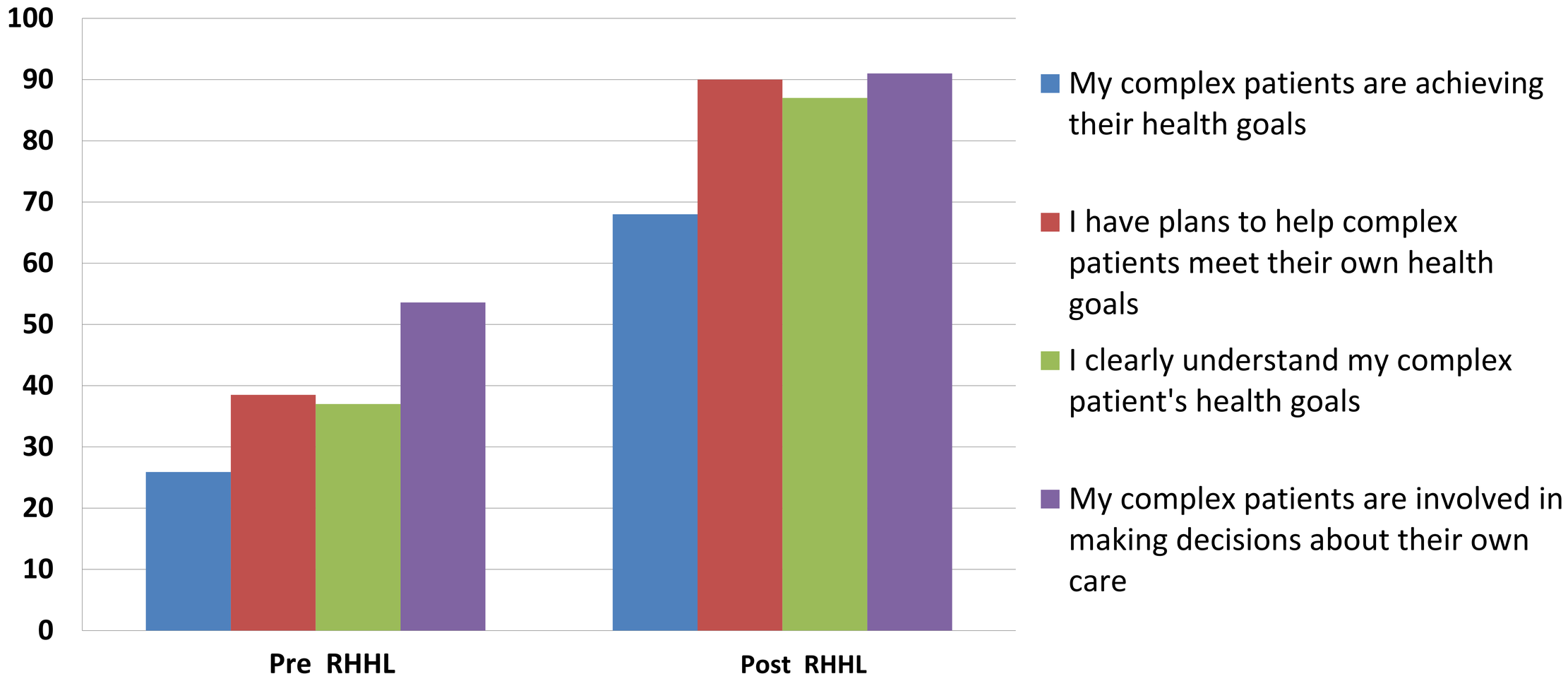
Time Spent with System Navigator
88% Very Good

System Navigator Explanation of Treatments
85% Very Good

System Navigator Listening to Patients
85% Very Good

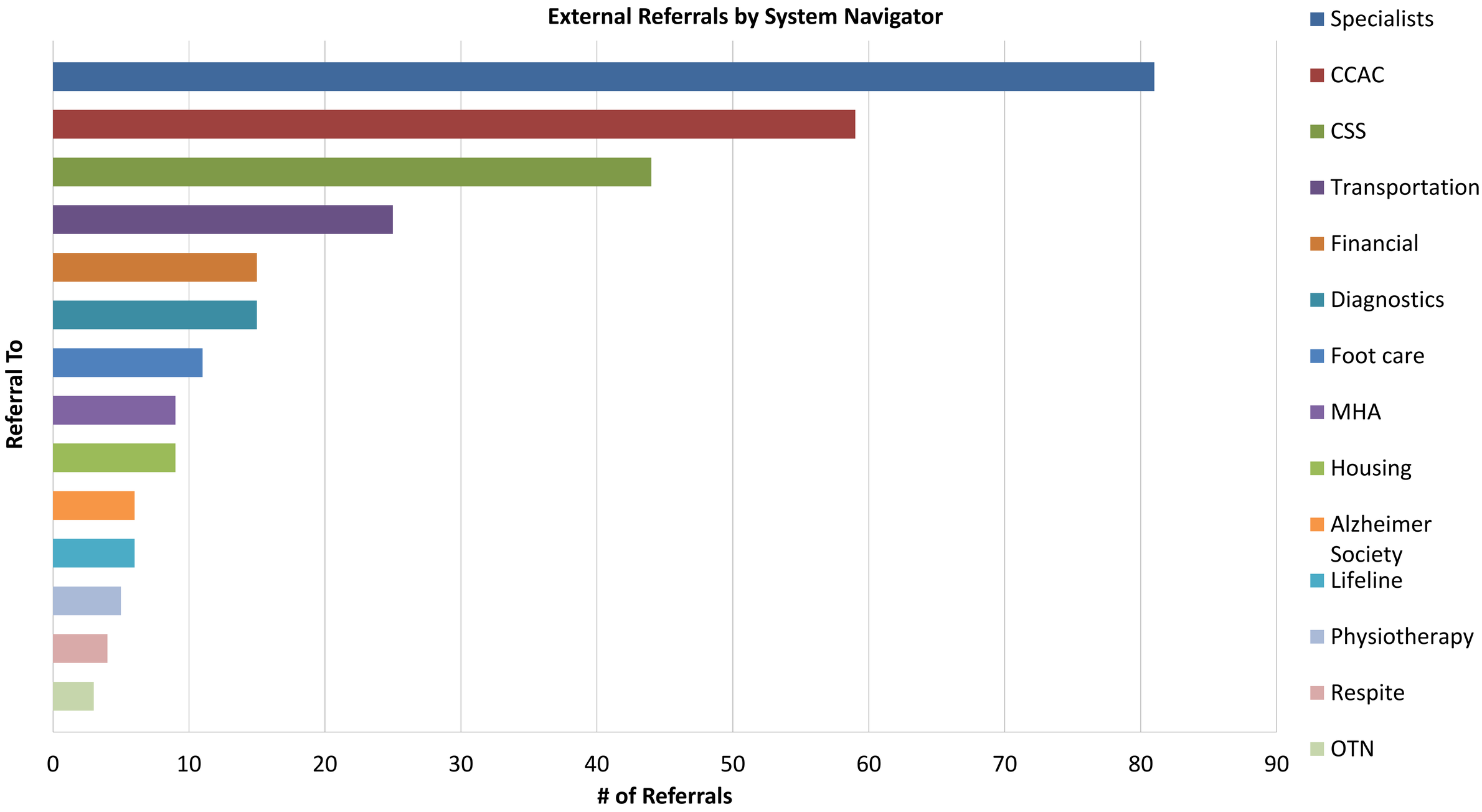
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Provider Feedback
Response to Complex Patient Health Goals



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Outcomes – External Referral Patterns



Outcomes – Q4 14/15



Number of Completed Care Plans
38 (FY 13/14) + 151 (FY14/15) = 189

Number of Complex Patients on Case Load
172

Physicians Utilizing System Navigator to Support Caseload
87% of RHHL Physicians

Complex Patients with Medication Reconciliation
100%

Return on Investment

The Return on Investment to the health system (real time data)has:

- ✓Decreased the number of avoidable ED visits **(87%)**
- ✓Decreased the number of admissions and/or re-admissions **(83%)**
- ✓ Decreased length of stay **(71%)**

For a total savings of:

$2,667,482.00

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"By accessing the RHHL program, I have been able to better manage the needs of my complex patients. I fully intend to continue to access this program on behalf of my patients"

- Physician

"I was going to go to emerg, but I realized that I could just call you"

- Patient to System Navigator

"I can see already the positive impact. Patients are getting appropriate care and I can trust that things are getting looked after"

- Nurse Practitioner

"I think the project has focused on thinking more clearly on how we all can be agents of change in providing better and more efficient care for our patients with complex needs"

-Physician

"When [the System Navigator] was first introduced as the Nurse Navigator for the North Hastings Family Health Team, and they explained her role, I wondered to myself. Oh Lord, what am I going to do with her?"
Now that I have learned the value of her role, I saw how well she functioned in her role and what a tremendous difference she made with the navigation of the complex patients, I am wondering to myself. Oh Lord, what are we going to do without her?"

- Physician

"Our approach with this family is a great example of how health care services should be collaborating, so that the whole family is included in the "circle of care". Thanks goes back to you [System Navigator] for your team approach to pull the Alzheimer Society in."

- The Alzheimer Society for Belleville Hastings Quinte

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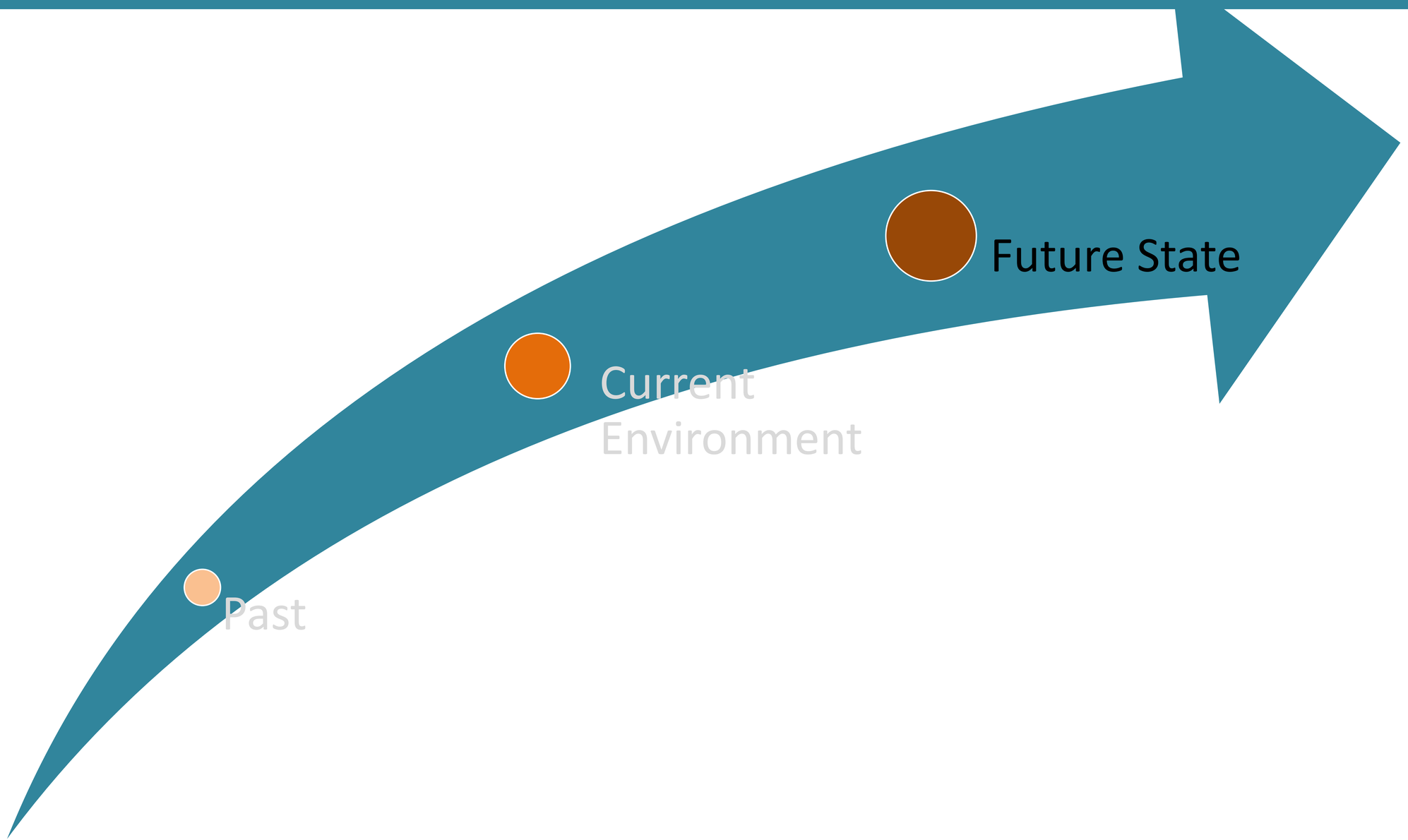
Challenges

GEOGRAPHY

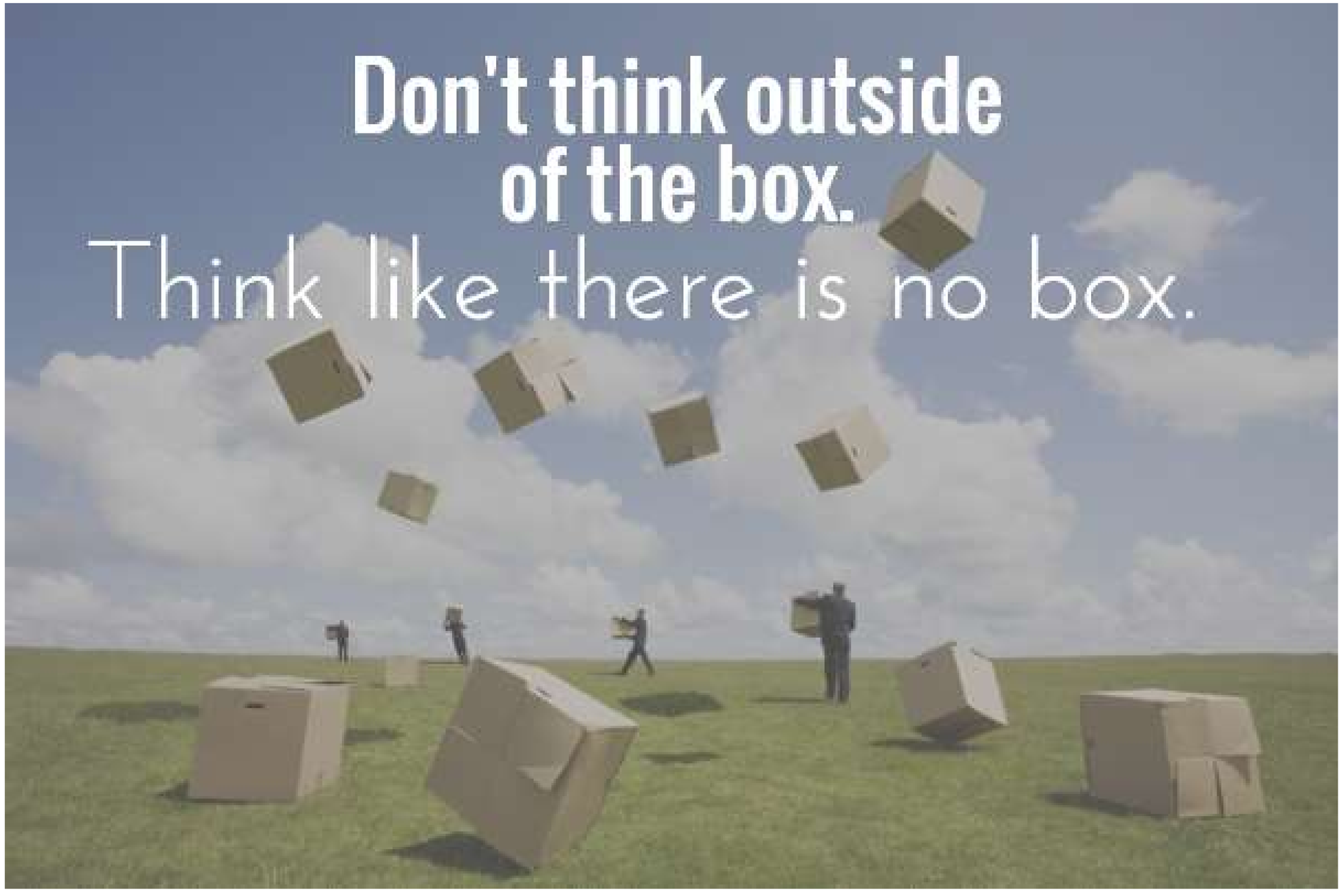
CAPACITY IN PRIMARY CARE

SUSTAINABLE FUNDING

HEALTH SYSTEM TRANSFORMATION



FUTURE STATE



FUTURE STATE

One **vision**

One **patient**

One **assessment**

Shared **Plan of Care/Coordination**

Seamless Transitions

Connectivity/ Communication - **Connections**

Build on Success - Influence the Future

- ✓ **BUILD** a ***structure*** for Primary Care Partners and Broader Health System Partners to strengthen relationships and integrate systems thinking into planning

- ✓ ***CONTINUE to engage*** and **capture the patient and families voice** through Care Coordination Plans (CPP) to improve patient outcomes, benefit providers and the health system as a whole & INTEGRATE INTO ORGANZATIONAL ENVIRONMENTS

- ✓ **INFORM AND INFLUENCE VALUE** for the role ***of*** **System Navigators** within Primary Care to support practitioners, patients and **connect and communicate** with other sector supports - navigate and advocate

- ✓ **EVOLVE THE ROI MODEL** to quantify the **Return on Investment**

- ✓ ***CONTINUE to Measured*** **Success**: Established a strong foundation for Data Collection & Evaluation within Primary Care sites

Possibility Thinking
What are patient's saying – Are we Listening?

? **Resources closer to home** – link to population health – regional needs – Right Resource/ Right time /Right place

? **Structure** – Collaborative Care Model - Coordinated Care – System Navigation – Advocacy

? **Accountability – who owns the patient**

? **Funding** – Integrated payment models? ROI Model

? **Sustainability –** Funding allocation, Resources, Organizational design, Culture

? **Connectivity –** Communication – Shared Care – Technology

? **Performance Management**

? **Communities of Practice –** Quality – Best Practices – Care Pathways

FUTURE STATE – Food for Thought

Advanced Healthlink Structure



QUESTIONS

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