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

OPPORTUNITY AHEAD

Next Exit

Strategy  Vision  Attitude  Innovation
The Past is Important but...
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
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 are left on our own
SE LHIN HEALTHLINKS
RHHL Coalition

Mental Health Services

Gateway Community Health Centre

Primary Care

North Hastings Community Family Health Team

Central Hastings Family Health Team

Bancroft Family Health Team

LTC

Hospital (Quinte Health Care)

Community Care

CCAC

Mental Health Support Network

LTC

Hospice

PATIENT Representation

Working Group
Care Coordination

Working Group
System Planning

Working Group
End of Life / Palliative Care System Planning

Patient Engagement

Patient Forum

Surveys

Working Group
Data Quality & Privacy

E-System
Planning

Patient Forum

System Planning

Data Quality & Privacy

E-System Planning

Patent Engagement

Patient Engagement

Patient Forum

Surveys

Working Group
Data Quality & Privacy

E-System Planning

PATIENT Representation

Steering Committee Comprised of Primary Care/ Broader Health Sector / Patient
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.
AIM Statement

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

- 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
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.
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

Population Health

System Costs
- ↓ ED Visits
- ↓ Hospitalization
- Right Patient, Right Place, Right Time

Population Health

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

Reduction of Costs

Improved health outcomes
- Seamless Transitions
- System Integration
- Return on Investment

Patient & Provider Experience
Primary Care System Navigation

THE ROLE OF THE SYSTEM NAVIGATOR

ASSESSMENT

PATIENT VOICE

SEAMLESS TRANSITIONS

PERFORMANCE OUTCOMES

INFLUENCES FUTURE STATE

SYSTEM NAVIGATOR

ALIGNMENT

THE ROLE OF THE SYSTEM NAVIGATOR

ASSESSMENT

PATIENT VOICE

SEAMLESS TRANSITIONS

PERFORMANCE OUTCOMES

INFLUENCES FUTURE STATE

SYSTEM NAVIGATOR

ALIGNMENT
Assessment

- 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

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

Care Planning
Assessment

- 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

- 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

- 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

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
ALMA'S STORY

1. Alma is an 85 year old complex patient who lives with her daughter Joan. Alma has been diagnosed with dementia, diabetes, COPD, acid reflux, heart disease and hypothyroid. Alma takes eleven prescription drugs and requires regular follow up with several specialists in another city. Unable to cope at home, even with her daughter's support, Alma has gone to the emergency department 10 times and was admitted to hospital once, over the past year.

2. After her last hospital discharge, Alma's doctor introduced her to the system navigator RN who met with Alma and her daughter. Together they developed her care coordination plan and identified Alma's goals: 1) to better understand her medication regime so that she could get her diabetes, heart disease and COPD under control, and 2) to find a suitable long term care home so that she could lessen the burden placed on Joan. The system navigator brought together an entire care team including: physician, pharmacist, Alzheimer's society, CoC and community support services to collaborate and coordinate Alma's care.

3. My daughter has to take time off work just to drive me to all of my appointments - I feel like such a burden...

4. Subsequent follow up by the system navigator showed that Alma’s chronic conditions had stabilized. She had no further emergency department visits or hospital admissions prior to her move to long term care.

Rural Hastings Healthlink
Patient Engagement Forums
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 healthcare 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. 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
Engaging Governance

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

- Improved health outcomes
- Seamless Transitions
- System Integration
- Return on Investment

Integrated Plan of Care

Medically Complex

Socially Complex

Improved health outcomes + Seamless Transitions + System Integration + Return on Investment
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

Number of Patients in each age group

Age Group – RHHL Q4 Data, n=151
RHHL Patient Social Complexity - Q4 14/15

**Socio-economic Demographics**

**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
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
- RHHL Client
### Patient Experience with System Navigator – Q4 14/15

<table>
<thead>
<tr>
<th>Category</th>
<th>Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Spent with System Navigator</td>
<td>88% Very Good</td>
</tr>
<tr>
<td>System Navigator Explanation of Treatments</td>
<td>85% Very Good</td>
</tr>
<tr>
<td>System Navigator Listening to Patients</td>
<td>85% Very Good</td>
</tr>
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Provider Feedback
Response to Complex Patient Health Goals

My complex patients are achieving their health goals

I have plans to help complex patients meet their own health goals

I clearly understand my complex patient's health goals

My complex patients are involved in making decisions about their own care

Pre RHHL  Post RHHL

0  10  20  30  40  50  60  70  80  90  100

Before and after the implementation of RHHL, there is an improvement in the provider's feedback regarding the response to complex patient health goals.
Outcomes – External Referral Patterns

External Referrals by System Navigator

- Specialists
- CCAC
- CSS
- Transportation
- Financial
- Diagnostics
- MHA
- Foot care
- Housing
- Alzheimer Society
- Physiotherapy
- Respite
- OTN

Number of Referrals

Referral To
<table>
<thead>
<tr>
<th>Outcomes – Q4 14/15</th>
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<tbody>
<tr>
<td><strong>Number of Completed Care Plans</strong></td>
</tr>
<tr>
<td>38 (FY 13/14) + 151 (FY14/15) = 189</td>
</tr>
<tr>
<td><strong>Number of Complex Patients on Case Load</strong></td>
</tr>
<tr>
<td>172</td>
</tr>
<tr>
<td><strong>Physicians Utilizing System Navigator to Support Caseload</strong></td>
</tr>
<tr>
<td>87% of RHHL Physicians</td>
</tr>
<tr>
<td><strong># Complex Patients with Medication Reconciliation</strong></td>
</tr>
<tr>
<td>100%</td>
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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
“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

“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

“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

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Challenges

- Geography
- Capacity in Primary Care
- Sustainable Funding
Don't think outside of the box.
Think like there is no box.
FUTURE STATE

One vision
One patient
One assessment
Shared Plan of Care/Coordination
Seamless Transitions
Connectivity/Communication - Connections
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 ORGANIZATIONAL 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

- Enhanced Governance Structure
- Funding Models
- Quality Best Practices Framework
- Integrated Performance Management
QUESTIONS

llinton@gatewaychc.org
jswedak@gatewaychc.org

In the middle of a difficulty lies opportunity.

- Albert Einstein