Navigating Health System Silos – Promoting Innovative Policies and Best Practices

Monday, October 17, 2016
MaRS Discovery District, Toronto
Meet the Panel

Moderator:
- Janet Davidson (former Deputy Minister of Health of Alberta)

Speakers:
- Francesca Grosso (Patients Canada)
- Glenn Monteith (Innovative Medicines Canada)
- Walter Wodchis (University of Toronto)
- Peter Pisters (University Health Network)
Navigating Health System Silos – Promoting Innovative Policies and Best Practices

Monday, October 17, 2016
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Francesca Grosso
Navigating a Health System Silos: A Government/Health System Perspective

Presented by Glenn Monteith

October 2016
System Design Issues

The positives:
• Within each jurisdiction, every eligible resident has a ULHI.
• Programs and Services such as insured physician services, inpatient hospital services are universal
• Single Delivery entity (AHS) and huge investment underway in a CIS.
• Increased penetration of Electronic Health Records (EHRs) systems.
• Investment in the Personal Health Record.
Alberta Health Services – Cancer

• Patient navigators in Alberta as a regular services since 2009.
• Must be RN or enrolled in an RN degree program.
• Eight model program – six months to complete.
• For non-AHS employees, there is an $262.50 fee for the program.
Elements of the Program

1. Introduction to patient navigation
2. Effective and compassionate communication
3. Culturally competent patient care
4. Assessing patient needs
5. Navigating patients to resources and supports
6. Managing stress and avoiding burnout
7. Documentation
8. Toolkit
Why not elsewhere in the System?

- Cancer in Alberta is managed as a system within a system.
- Many other diseases and conditions are much more fractured/distributed regarding care.
  - Different services may be publicly available;
  - Different payer arrangements (public, private);
  - HIA legislation limitations;
  - Geographic challenges;
  - Upstream versus downstream in the disease state;
  - Less organized care;
  - HER/EMR/PHR issues;
  - Volume pressures (i.e., RN resources available);
  - Care culture and;
  - Financial incentives/disincentives.
Bringing research to life.

innovativemedicines.ca

@innovativemedicines
Navigating Health System Silos
Promoting Innovative Policies and Best Practices

CAPT Annual Conference
Toronto, ON. October 17, 2016
Walter P Wodchis
What can we learn from others?

Caring for People with Multiple Chronic Conditions: A Necessary Intervention in Ontario

Working Paper Series
Volume 2
June 2013

Authors:
Nick Goodman
Anna Dixon
Geoff Andersen
Walter Medchls

January 2014

Providing integrated care for older people with complex needs
Lessons from seven international case studies

Key messages

- Integrated care is a process that must be led, managed and monitored over time.
- There are no single right models or approaches that best support integrated care.
- Sponsors should be modelled or developed in a creative intervention.
- Fully integrated organizations are not the end goal.
- Greater use of ICT is primarily an important enabler of integrated care.
- Professional trust in working together in multidisciplinary terms often depends on good primary care providers.
- Proactive contact with local care coordinators and/or case managers is more effective than remote monitoring or telephone-based support.

Integrating Care for Persons With Chronic Health and Social Needs

WHITE PAPER - WORKING DRAFT

Walter P. Wodchis, A. Paul Williams & Gustavo Mery
Institute for Health Policy Management and Evaluation
Health System Performance Research Network

ACKNOWLEDGEMENTS

The views expressed in this report and any conclusions or recommendations are those of the authors and do not necessarily reflect the views of the organizations sponsoring this initiative.

INTRODUCTION

In Canada, as in other industrialized countries, the dual demands of aging and chronic illness are placing a new strain on the health system. The report provides evidence-based recommendations for action by government, providers, and patients to better integrate care.

Internationally, a growing number of countries are moving towards more integrated care. Some are more advanced than others, with different models of care being implemented in different settings. The report provides evidence-based recommendations for action by government, providers, and patients to better integrate care.

Funded with generous support from the Joseph S. Strouffer Foundations.
Key Insights

• Most effective initiatives to integrate care are bottom-up creations of providers, but ensuring their sustainability and spread requires top-down support

• The primary role for policy and decision makers is to focus on supporting integration activities of the frontline providers and remove barriers to this activity

• It takes time for integrated care approaches to develop and mature, with most programs constantly evolving
1. Focus on clinical integration rather than organizational or structural integration
2. Success appears to be supported by good communication and relationships amongst those receiving care and the professionals and managers involved in delivering care
3. Effective models employ multidisciplinary teams with well-defined roles with shared responsibility for care
Implications for Policy

1. Recognize the importance of addressing this agenda of integrated care
2. Provide stimulus through funding or other means to support the development of local initiatives to improve care for this group of people
3. Avoid a top-down policy that requires structural or organizational mergers
4. Remove barriers that make it more difficult for local organizations to integrate care, such as differences in financing and eligibility
7 suggested steps to manage change in the health system (Perla et al., JAMA 2015)

<table>
<thead>
<tr>
<th>Recommended Step</th>
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<tbody>
<tr>
<td>1. Establish Clear Aims</td>
</tr>
<tr>
<td>2. Develop an Explicit Theory of Change</td>
</tr>
<tr>
<td>3. Create the Context Necessary for a Test of the Model</td>
</tr>
<tr>
<td>4. Develop the Change Strategy</td>
</tr>
<tr>
<td>5. Test the Changes</td>
</tr>
<tr>
<td>6. Measure Progress Toward Aim</td>
</tr>
<tr>
<td>7. Plan for Spread</td>
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</table>
Community Health Links

Coordinated and integrated care is the heart of Health Links

- New model of care to improve care for high needs patients
- All providers working at the local level to integrate clinical care and coordinate plans at the patient level
- Initial focus on people with complex health conditions

Source: Health System Transformation
Health System Fund Research Program - November 1, 2013
Helen Angus - Associate Deputy Minister, MOHLTC
Integration in Ontario: Integrated Funding Model

Pathway for Thoracic Surgery—A Unique Approach from Hospital to Home

**Day 1:**
Patient has interaction with the ICC Coordinator

**At Home:**
ICC Supports patient with home visits, Skype calls with clinicians and 24/7 hotline

**Day 3:**
Patient is discharged home with chest tube, supported by ICC Team

**Day 4:**
Respiratory Therapist comes to patient’s home

**Day 10:**
Patient’s activity returns to pre-surgery level with rest periods as needed
Implementing Health System Innovations

7 suggested steps to manage change in the health system (Perla et al., JAMA 2015)

<table>
<thead>
<tr>
<th>Recommended Step</th>
<th>Health Links</th>
<th>IFM</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Establish Clear Aims</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>2. Develop an Explicit Theory of Change</td>
<td>✗</td>
<td>✓ (Local)</td>
</tr>
<tr>
<td>3. Create the Context Necessary for a Test of the Model</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>4. Develop the Change Strategy</td>
<td>?</td>
<td>✓ (Local)</td>
</tr>
<tr>
<td>5. Test the Changes</td>
<td>✓ (Late)</td>
<td>✓</td>
</tr>
<tr>
<td>6. Measure Progress Toward Aim</td>
<td>✓ (Late)</td>
<td>✓</td>
</tr>
<tr>
<td>7. Plan for Spread</td>
<td>✓</td>
<td>✗</td>
</tr>
</tbody>
</table>
Evaluating Health System Innovations

Triple-aim performance framework for BEACCON
### Performance Measures

<table>
<thead>
<tr>
<th>Aim</th>
<th>Objective Measures</th>
<th>Subjective Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>Potential Years of life lost Life expectancy</td>
<td>Self-reported health PROMIS, EQ-5D, or VR-12*</td>
</tr>
<tr>
<td></td>
<td>Disability-adjusted life years can incorporate both</td>
<td>Subjective health and Objective measures of life expectancy</td>
</tr>
<tr>
<td></td>
<td>Subjective health and Objective measures of life expectancy</td>
<td></td>
</tr>
<tr>
<td>Experience</td>
<td>Wait time for consultation, or other service</td>
<td>Continuity of care Involvement in care Coordination of Care Self-activation Caregiver experience</td>
</tr>
<tr>
<td>Cost</td>
<td>Health system cost Social service costs</td>
<td>Individual and carer opportunity cost including financial and non-financial</td>
</tr>
</tbody>
</table>
e.g. IFM Early Patient Experience

Chart 14. Did the IFM program help you feel confident about your ability to take care of your health?
e.g. IFM Early Patient Experience

[Bar chart showing hospital-based care, transition to home, community care, and overall percentages. Each category is represented with a bar divided into segments indicating various percentages. The chart includes data points for n=13 to n=14 in each category.]
Key system approaches to success

1. Physician engagement (clinical and financial)
2. Shared health information platforms.
4. Public health initiatives and support for self-activation, healthy eating, active living.
5. Person-oriented performance measurement.
   - Stable housing / income support.
Overview

• External Environment
• Scaling up of Foundational Initiatives
• Digital as a Critical Enabler
• Population Health: The Future State
• Summary
Policy Direction and Environmental Shifts in Ontario

- Ontario’s *Patients First* Initiative
- Bundling pilots
  - St. Joseph’s Integrated Comprehensive Care Program
  - Successful pilots prompting expansion
- There has been a shift towards local accountability for planning and integration of health services
  - Move towards population health
  - Designated sub-regions with hospital resource partners (HRP)
  - Scaling up of existing structures (e.g. Health Links)
Integrated Delivery Systems and The Continuum of Health

Public Health

Community and Home Care

Acute Care

Post-acute and Palliative Care
Integrated Delivery Systems and The Continuum of Health

Public Health

Community and Home Care

Acute Care

Post-acute and Palliative Care
TC LHIN & UHN

- TC LHIN is focused on whole episodes of care, which will require collaboration and shared accountability
  - Integrating hospitals, primary care, home and community care, and long-term care

- UHN will leverage existing infrastructure to lead projects in support of primary care priorities
Bringing Care to Patients

- Mid West and Central West Toronto Health Links share an area with little access to primary care services
  - Results in a high number of poorly-served individuals
  - Multiple ED visits and return in-patient admissions

- UHN Toronto Western Family Health Team Satellite
  - Recruit 12 FT physicians for a roster of 18,000 patients
ConnectingGTA

- ConnectingGTA has improved the patient and clinician experience by delivering a regional electronic health record for 6.75M individuals

6 Local Health Integration Networks
750+ Health Care Organizations
6,200 Family Physicians
6,900 Physician Specialists
49,900 Nurses

All sectors of care:
- Acute Care
- Community Support Services
- Complex Continuing Care
- Long Term Care
- Mental Health & Addictions
- Primary Care
- Rehabilitation
Key Enabler: Digital Health Platform

Priorities

• “One Patient – One Record – One Portal”

• Partnership to achieve HQO and Patients First goals

• Moving from client server to cloud based

• Analytics platform for population health

Impact

• Population health for Ontarians

• Economic development
Current State

Fragmented, regionalized, initiative-based model
Future State

Improving across the care continuum:

- Access
- Coordination
- Communication
Diabetes: From the Patient’s Perspective

Current State

- Diagnosis
- Prescription

Future State

- Outcomes
  - Blood sugar control
  - Complications of diabetes
- Care Coordination
  - Nutrition
  - Medical compliance
  - Complication prevention
  - Coordinated screening
- Smart Technology

50% of Centers for Medicare & Medicaid Services (CMS) payment by 2018
## Fundamental Changes Needed

<table>
<thead>
<tr>
<th></th>
<th>Volume-Based</th>
<th>Value-Based</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payment</strong></td>
<td>Fee for Service</td>
<td>Outcome-Based</td>
</tr>
<tr>
<td><strong>Incentives</strong></td>
<td>Volume</td>
<td>Value</td>
</tr>
<tr>
<td><strong>Focus</strong></td>
<td>Acute Episodes</td>
<td>Populations</td>
</tr>
<tr>
<td><strong>Role of the</strong></td>
<td>Single Episodes</td>
<td>Care Continuum</td>
</tr>
<tr>
<td><strong>Provider</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Information</strong></td>
<td>Retrospective</td>
<td>Predictive</td>
</tr>
</tbody>
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