Navigating Health System Silos – Promoting Innovative Policies and Best Practices

Monday, October 17, 2016

MaRS Discovery District, Toronto

CAPT ACTP

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)

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Francesca Grosso

CAPT ACTP

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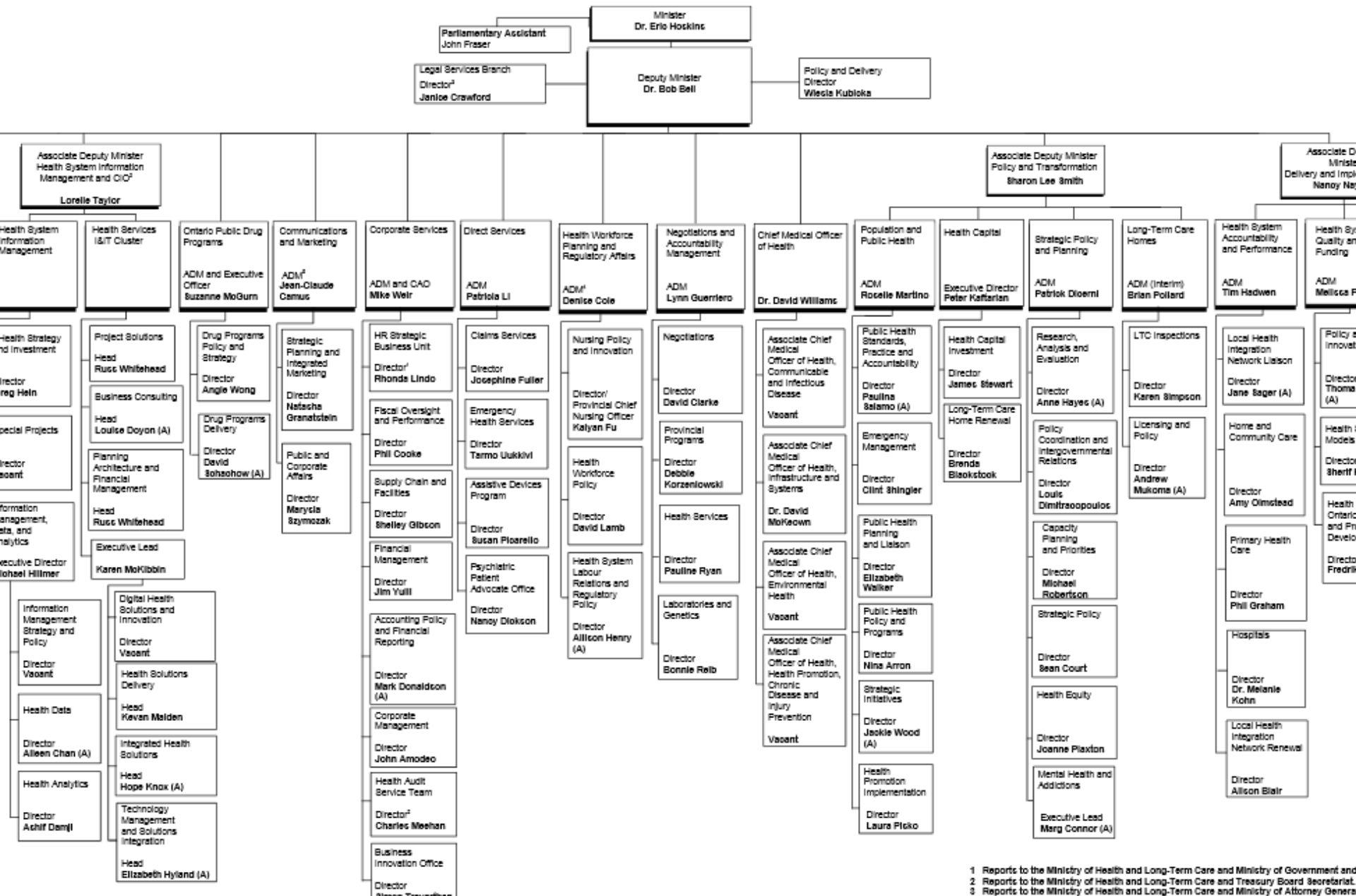

1 Reports to the Ministry of Health and Long-Term Care and Ministry of Government and
2 Reports to the Ministry of Health and Long-Term Care and Treasury Board Secretariat.
3 Reports to the Ministry of Health and Long-Term Care and Ministry of Attorney Genera
4 Reports to the Ministry of Health and Long-Term Care and Ministry of Training, College
5 Reports to the Ministry of Health and Long-Term Care and Cabinet Office.

Navigating a Health System Silos: A Government/Health System Perspective

Presented by Glenn Monteith

October 2016

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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.

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Navigating Health System Silos Promoting Innovative Policies and Best Practices

CAPT Annual Conference

Toronto, ON. October 17, 2016

Walter P Wodchis

HSPRN
health system performance research network

What can we learn from others?

HSPRN

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

Working Paper Series
Volume 2
June 2013

The King's Fund

HSPRN

Authors
Nick Goodwin
Anna Dixon
Geoff Anderson
Walter Wodchis

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 nurtured over time. Initiatives often have to navigate and overcome existing organisational and funding silos.
- There is no single organisational model or approach that best supports integrated care. The starting point should be a clinical/service model designed to improve care for people, not an organisational model with a pre-determined design.
- Fully integrated organisations are not the end (goal).
- Greater use of ICT is potentially an important enabler of integrated care, but is not a necessary condition.
- Professionals need to work together in multidisciplinary teams (with clearly defined roles) or provider networks – generalists and specialists, in health and social care. However, patients with complex needs that span health and social care may require an intensity of support that goes beyond what primary care physicians can deliver.
- Important service-level design elements of care for older people with chronic and multiple conditions include holistic care assessments, care planning, a single point of entry, and care co-ordination.
- Success is more likely where there is a specific focus on working with individuals and informal carers to support self-management.
- Personal contact with a named care co-ordinator and/or case manager is more effective than remote monitoring or telephone-based support.

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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

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INTRODUCTION

Decision-makers in Canada and across the industrialized world face the dual challenges of meeting the needs of growing numbers of persons with multiple chronic health and social needs, while sustaining already stretched healthcare systems. There is a compelling need to transform the health system by restructuring the provision of care to deliver integrated patient-centred care for individuals with complex care needs. Integrating the many care services provided by a diverse array of providers has been identified as a key pillar of a Canadian healthcare strategy (Monieson Centre, 2013). This paper provides evidence-based recommendations for action by government, providers, and patients to better integrate care.

Internationally, a growing number of models of integrated care are being implemented to improve the quality and outcomes, particularly for individuals with complex needs who are high volume users of the healthcare system. Some of these programs have the potential to improve patients' experience of care and the health of populations, and reduce system costs, by minimizing the occurrence of adverse events and by creating efficiency through reducing fragmentation and duplication of services.

On the demand side, people are living longer. While aging is strongly associated with the rise of multiple chronic conditions, recent data from the Canadian Institute for Health Information (CIHI) show that utilization is increasing across all age groups (2011a). Most costs are related to people with multiple and complex needs that are higher among older persons, particularly amongst those over 85 years of age (Commonwealth Fund, 2012). This oldest-old population group is also now increasing very quickly in absolute numbers, driving most projections of very high future healthcare spending rates. Less remarked though is the fact that there are also growing numbers of children with complex medical conditions who, due to advances in medical technology, will live into adulthood outside of hospitals, requiring a range of community-based health and social supports. Similarly, more persons with disabilities, who would have previously lived all of their lives in institutions, are now aging in the community.

On the supply side, it is increasingly understood that fragmented "non-systems" of hospital-centred acute care are poorly equipped to support persons of any age with multiple chronic health and social needs in an appropriate, cost-effective manner. A series of recent policy reports and statements in Ontario have highlighted a number of persistent system problems, such as the high number of alternate level of care (ALC) beds in hospitals (Born & Laupacis, 2011; Access to Care, 2014). ALC beds are defined as those occupied by individuals who no longer require hospital care, but who cannot be discharged because of a lack of appropriate community-based discharge options. In his insightful analysis of the ALC problem in Ontario, Walker observed that a lack of coordinated community-based care options too often results in hospitalization and long-term residential care, as costly and often inappropriate "default" options for older persons (Walker, 2011), this impacts negatively on older persons themselves, and on the health system opportunity costs of providing care at too high of an intensity.

Funded with generous support from the Joseph S. Stauffer Foundation.

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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 front line providers and remove barriers to this activity

- It takes time for integrated care approaches to develop and mature, with most programs constantly evolving

Implications for Providers

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

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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

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Implementing Health System Innovations

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

Recommended Step
1. Establish Clear Aims
2. Develop an Explicit Theory of Change
3. Create the Context Necessary for a Test of the Model
4. Develop the Change Strategy
5. Test the Changes
6. Measure Progress Toward Aim
7. Plan for Spread

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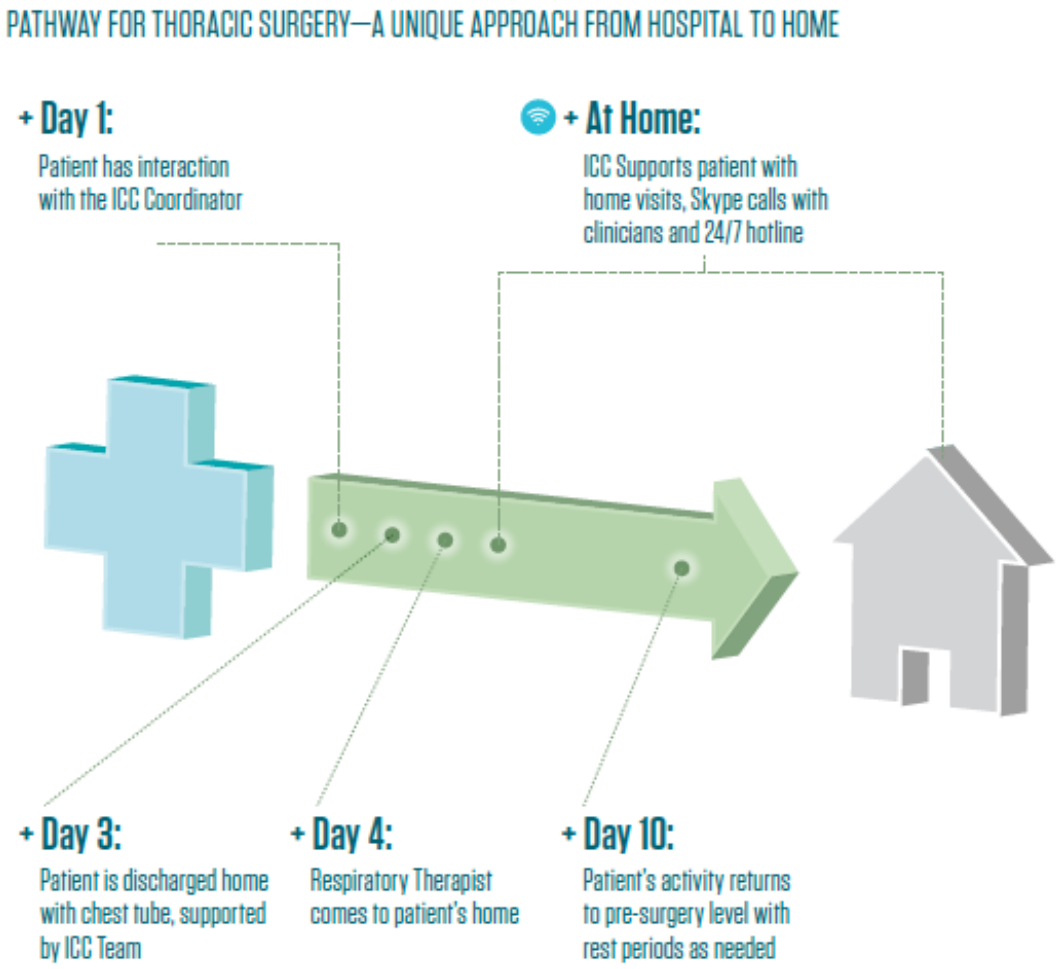
Integration in Ontario: Health Links

Coordinated and integrated care is the heart of Health Links

- Health Links launched Dec. 2012
- **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



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St. Joseph's HEALTH SYSTEM

Implementing Health System Innovations

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

Recommended Step	Health Links	IFM
1. Establish Clear Aims	✓	✓
2. Develop an Explicit Theory of Change	✗	✓ (Local)
3. Create the Context Necessary for a Test of the Model	✗	✓
4. Develop the Change Strategy	?	✓ (Local)
5. Test the Changes	✓ (Late)	✓
6. Measure Progress Toward Aim	✓ (Late)	✓
7. Plan for Spread	✓	✗

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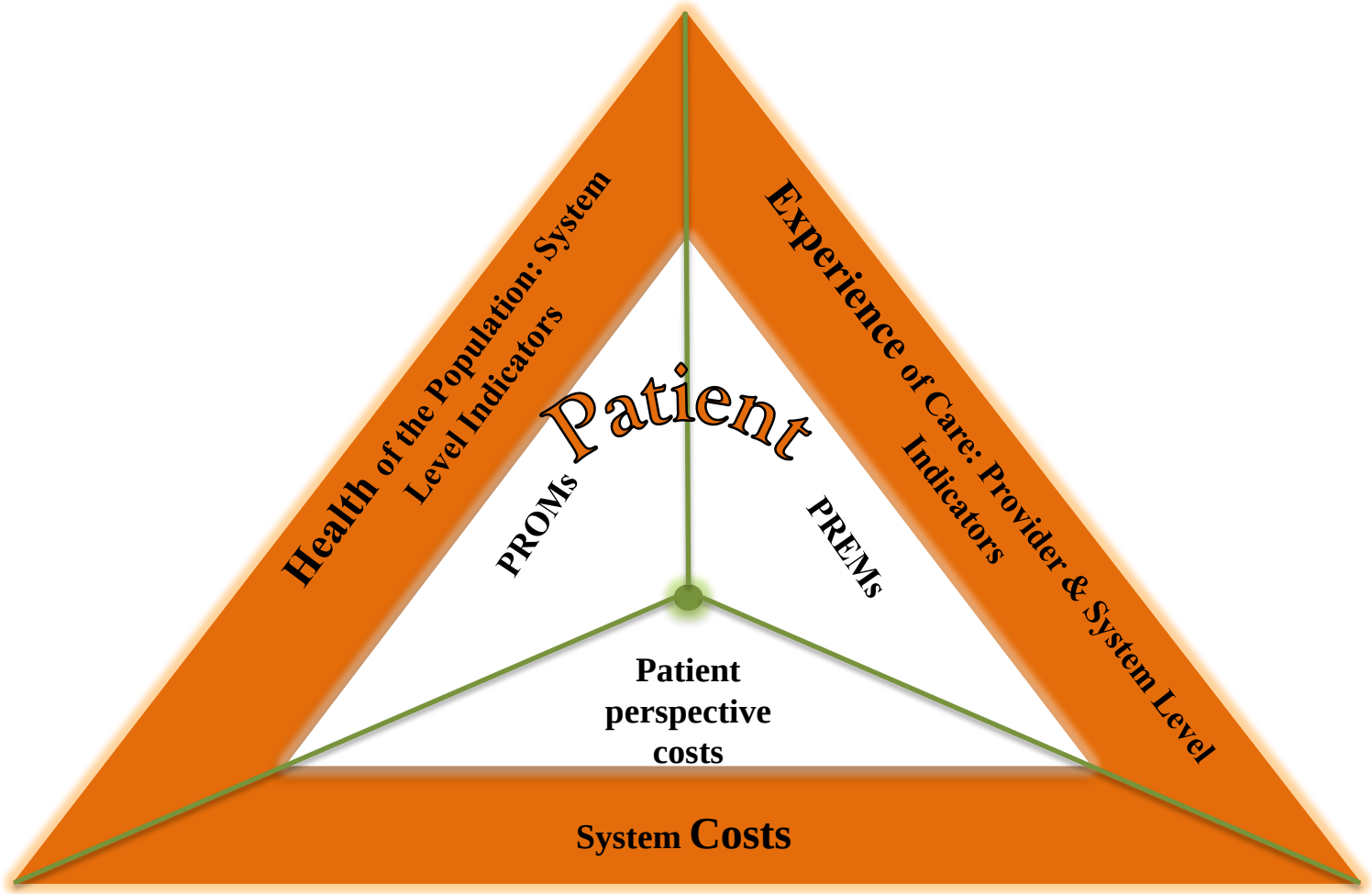
Evaluating Health System Innovations



Triple-aim performance framework for BEACCON

Performance Measures

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

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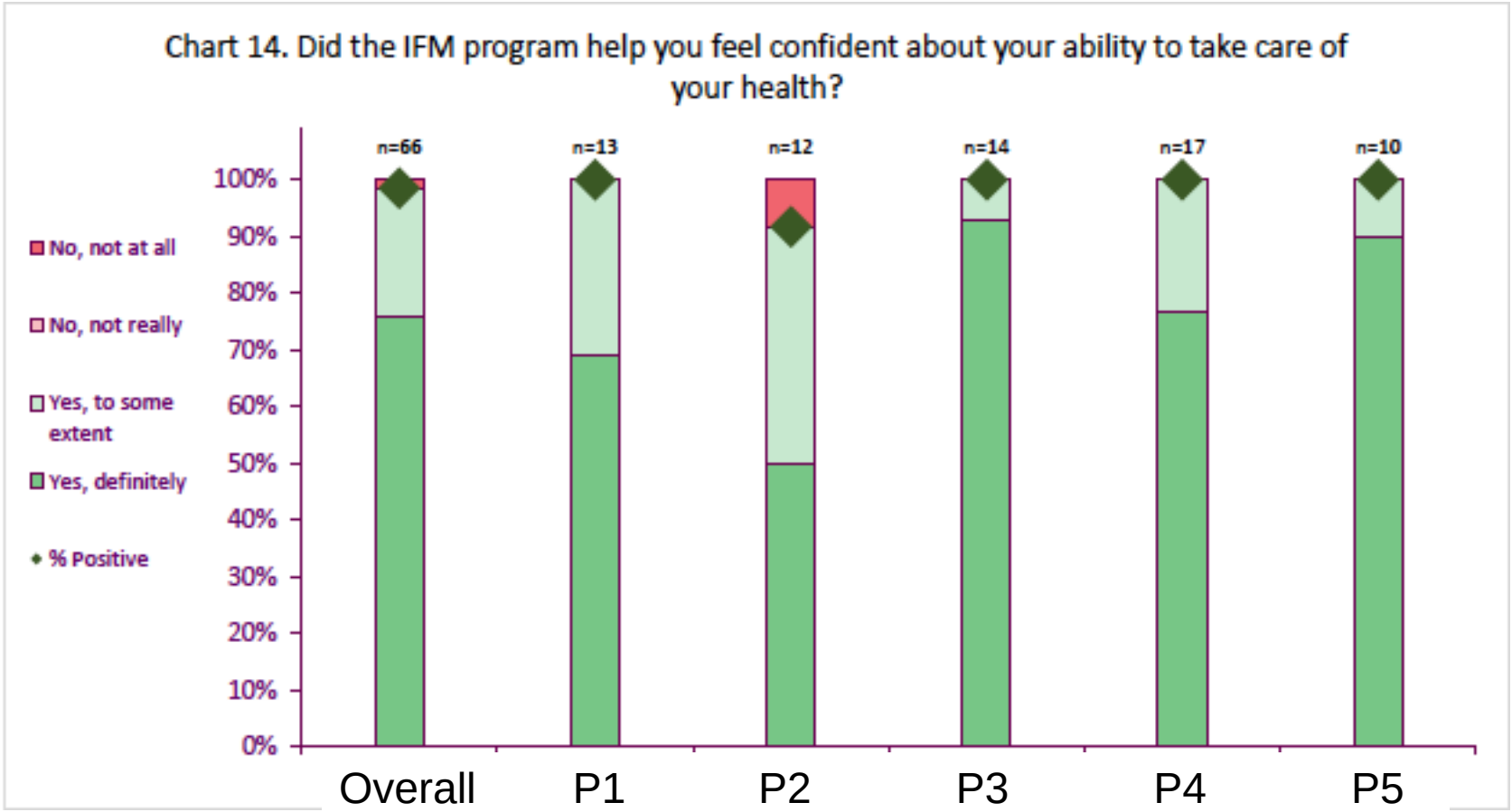
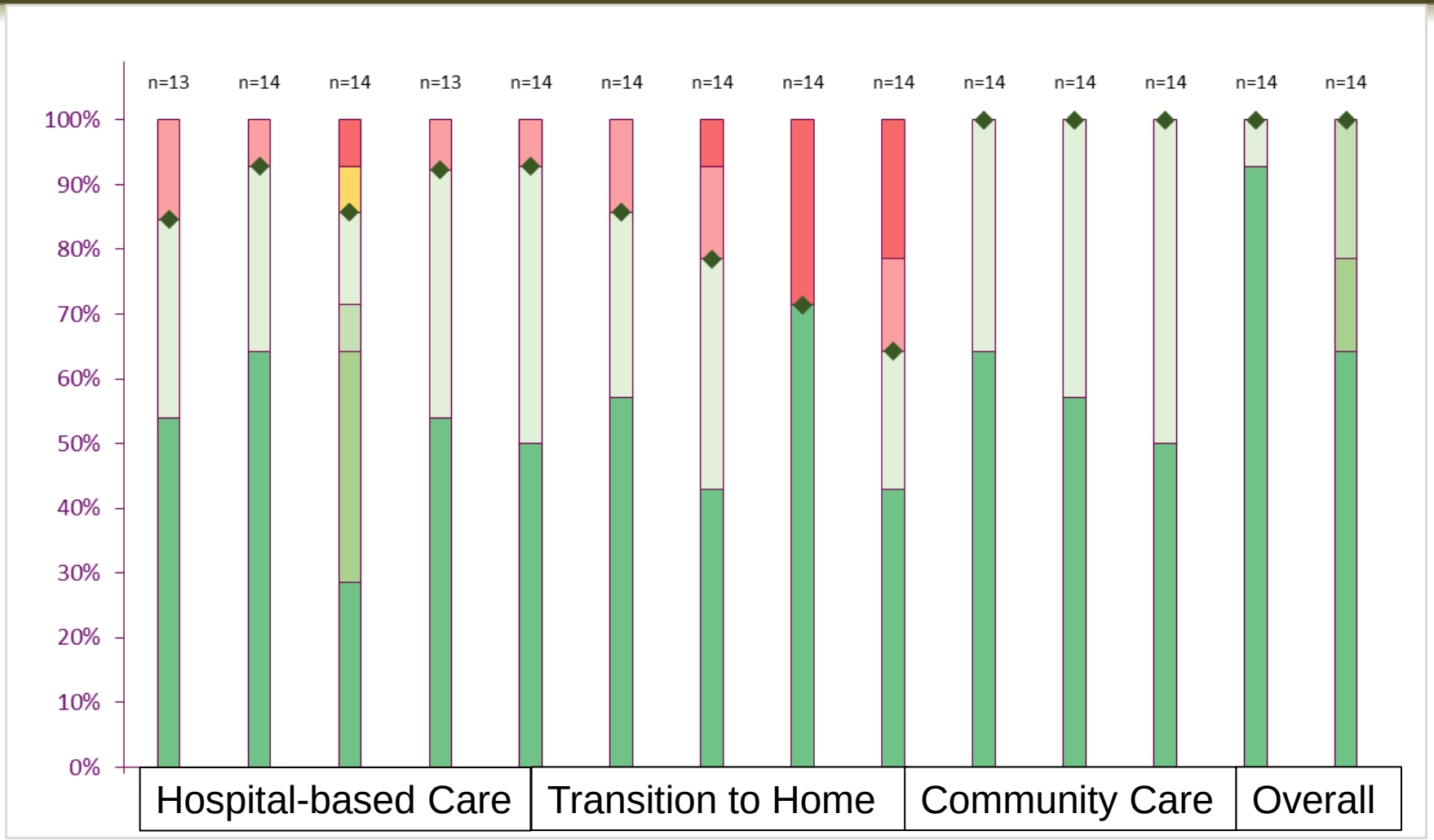
e.g. IFM Early Patient Experience



e.g. IFM Early Patient Experience



Key system approaches to success *

1. Physician engagement (clinical and financial)
2. Shared health information platforms.
3. Population based management.
4. Public health initiatives and support for self-activation, healthy eating, active living.
5. Person-oriented performance measurement.

❖ Stable housing / income support.

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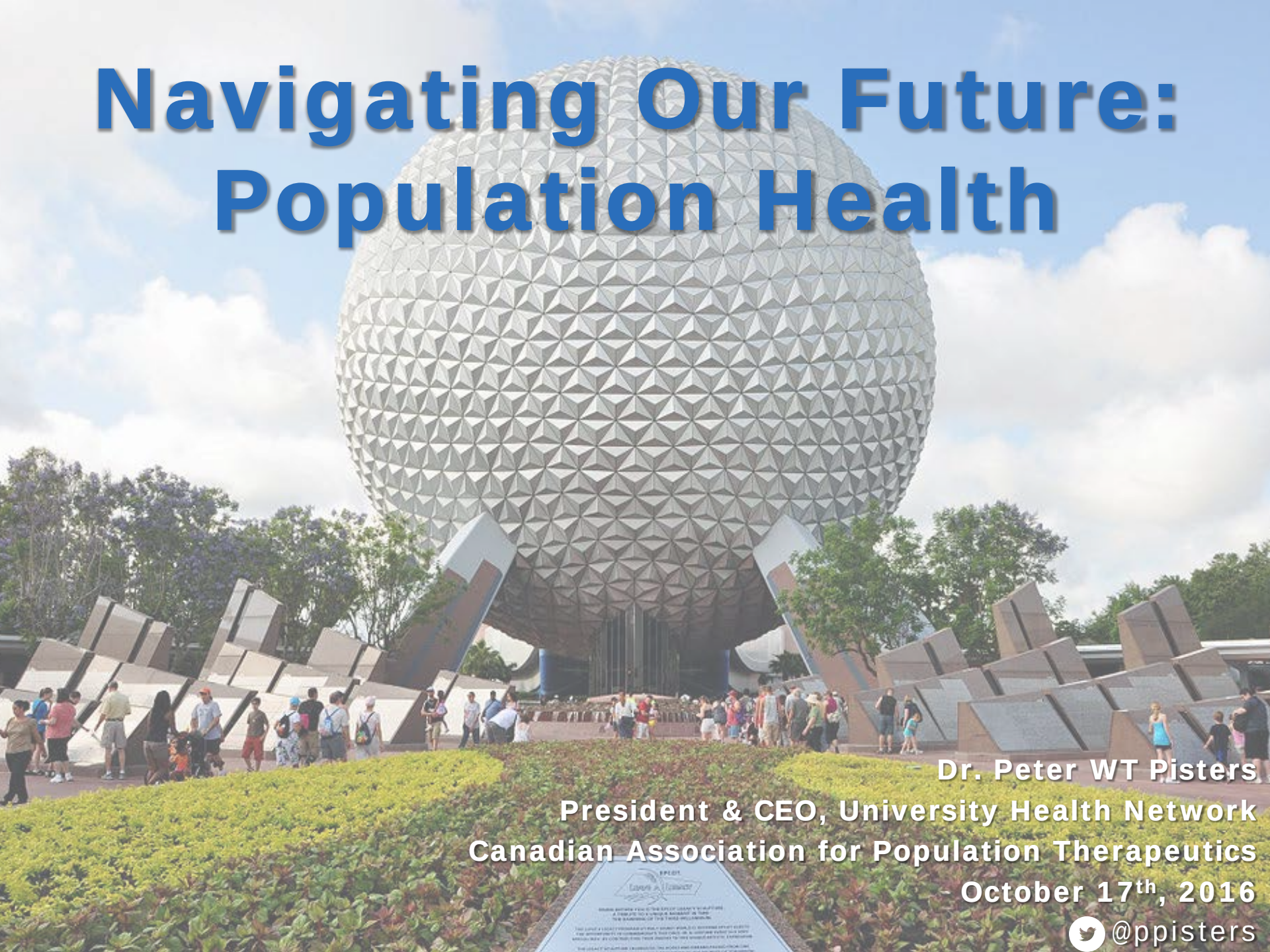
Navigating Our Future: Population Health



Dr. Peter WT Pisters

President & CEO, University Health Network

Canadian Association for Population Therapeutics

October 17th, 2016

@ppisters

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)

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Integrated Delivery Systems and The Continuum of Health

Public Health
Prevent. Promote. Protect.

Public Health

Community and Home Care

Acute Care

Post-acute and Palliative Care

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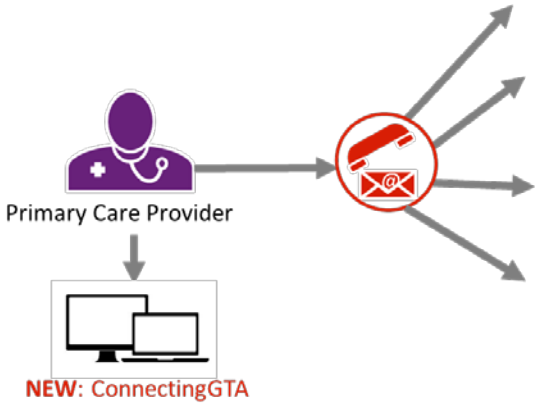
TC LHIN & UHN

- 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

TIP
Telemedicine IMPACT Plus

HealthLink

SCOPE
SEAMLESS CARE
OPTIMIZING THE PATIENT EXPERIENCE



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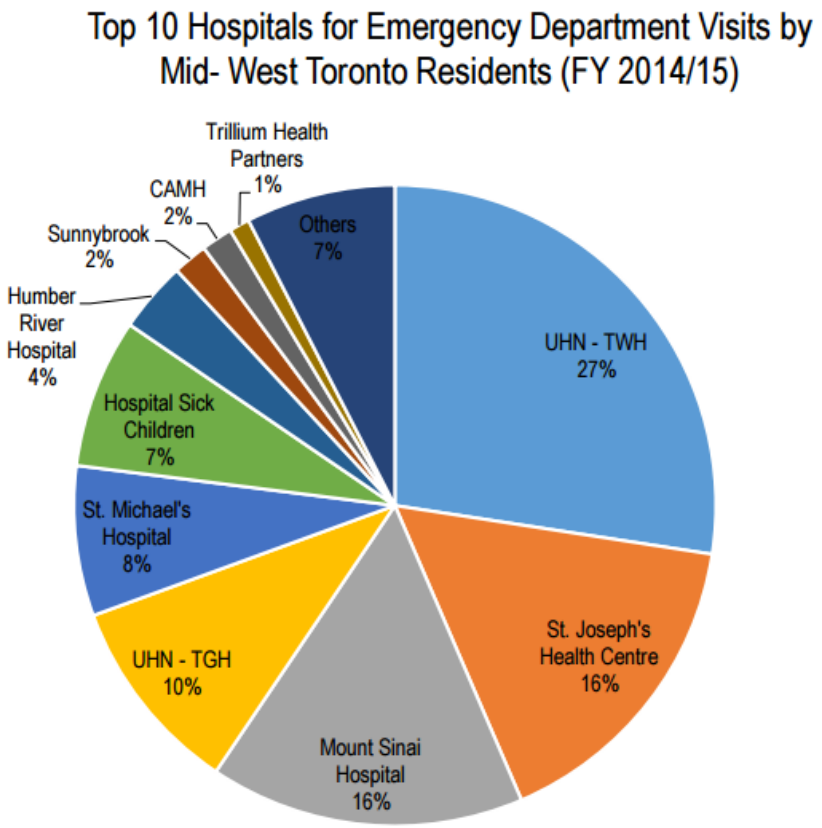
Bringing Care to Patients

- 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



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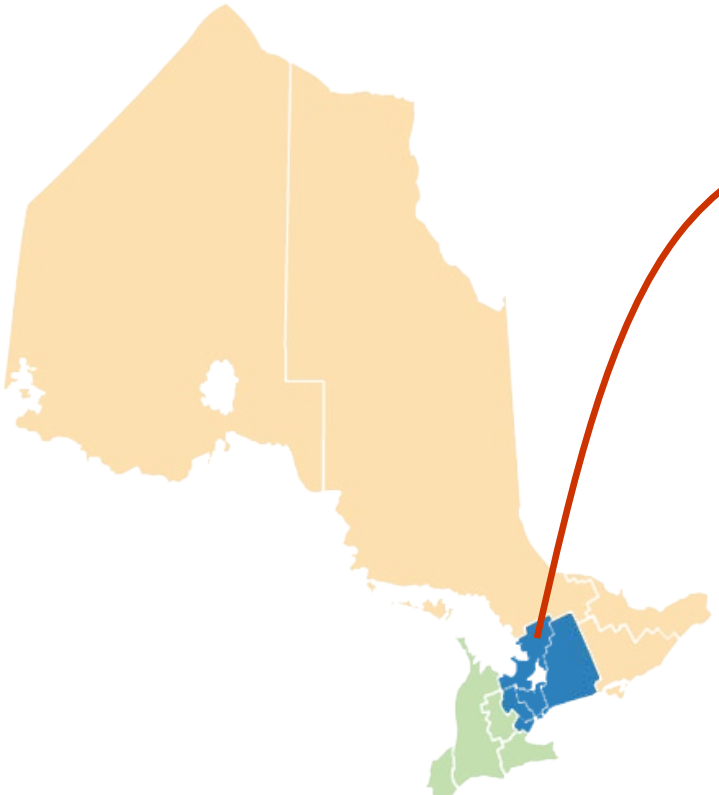
ConnectingGTA

- 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

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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

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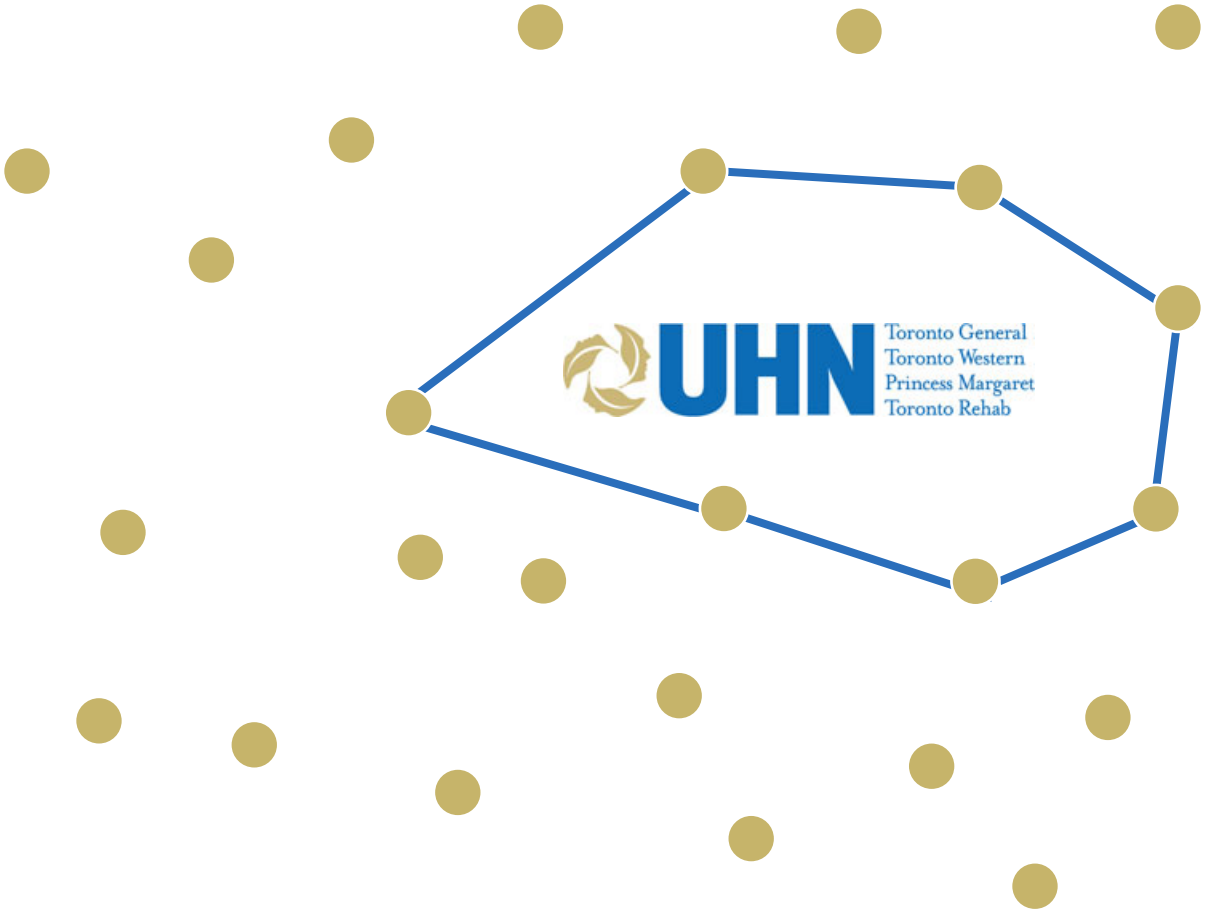
Current State



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

50% of Centers for Medicare & Medicaid Services (CMS) payment by 2018

Future State

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

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Fundamental Changes Needed

	Volume-Based	Value-Based
Payment	Fee for Service	Outcome-Based
Incentives	Volume	Value
Focus	Acute Episodes	Populations
Role of the Provider	Single Episodes	Care Continuum
Information	Retrospective	Predictive