

# **Guide to the Advanced Health Links Model**

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## INTRODUCTION

Health Links were introduced as a key commitment in the Ministry of Health and Long-Term Care (“the ministry”) 2012 *Action Plan for Health Care* to transform the system through increasing access to integrated, quality services to Ontario’s complex patient population.

Since their launch in December 2012, Health Links have made tangible gains in improving care coordination and transitions between services.

To date, Health Links have played a key role in attaching patients to primary care providers, improving coordinated care for patients living with multiple complex chronic conditions; and more meaningfully, engaging patients in their own health care. In addition, they have been crucial in strengthening relationships and communication between providers.

Moving forward, Health Links will continue to play an integral role in the health system landscape, as catalysts that will support the advancement of the *Patients First: Action Plan for Health Care*.

To continue the momentum of Health Links it is important for the program to evolve from the developmental stage to a more mature state of operation to support the delivery of care to all of Ontario’s complex patients.

*“Health Links will encourage greater collaboration and co-ordination between a patient's different health care providers as well as the development of personalized care plans. This will help improve patient transitions within the system and help ensure patients receive more responsive care that addresses their specific needs with the support of a tightly knit team of providers”*

**Announcement of the Health Links Initiative December 6, 2012**

## Purpose of this Guide

On June 18, 2015, the ministry and Local Health Integration Networks (LHINs) leadership co-hosted the Advanced Health Links webinar which articulated the shared vision for the future of Health Links and the enhancements that would be made over the course of the 2015/16 fiscal year to evolve the model.

The Guide to the Advanced Health Links Model (“the Guide”):

- Outlines the direction of the Health Links program, its objectives over the course of the 2015/16 fiscal year; and,
- Details the work the ministry, LHINs and Health Links will undertake to transition operations and processes to the Advanced Health Links Model across all Health Links in the 2016/17 fiscal year.

Over the course of the 2015/16 fiscal year, the ministry will engage the LHINs, Health Links and key partners such as Health Quality Ontario (HQP) to further scope out components of the Advanced Health Links Model and to increase the tools and resources to help LHINs and Health Links with transition.

## PART ONE - Current Status

In order to understand the future state of Health Links, it is important to explore the current context and how Health Links have evolved.

Health Links have been operational for over two years and while much of the development of the program has been experienced by the 26 early adopters, the program has grown considerably to the 82 Health Links that will be in operation by the end of 2015.

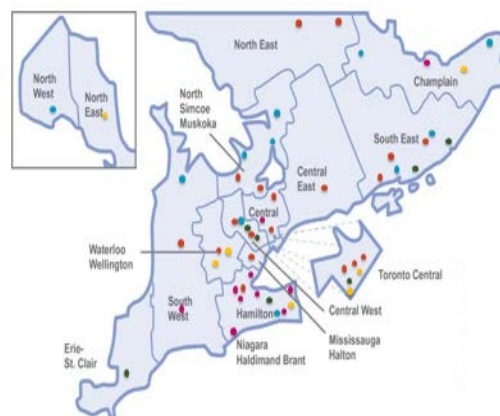
Since inception, Health Links have leveraged the early “low rules” environment to maximize their patient care networks, to enhance care coordination for complex patients and to improve transitions between services.

# 9,233

## CARE PLANS PRODUCED



# 20,660

 Attached Patients


## 1,800 Partners

 are engaged  
across health, community and social  
services sectors

### Operational Health Links have demonstrated success in a number of different ways:

- ✓ More patients have coordinated care plans;
- ✓ More patients are attached to a primary care provider;
- ✓ Patients have been engaged in their care to a much greater degree;
- ✓ Health Links are focusing on system gaps and how to better care for specific population sub-groups;
- ✓ Relationships and communication between providers have been strengthened in local areas; and,
- ✓ Providers are improving their ability to identify complex patients in their community.

The work of the early adopter Health Links has emerged as best practices in a number of operational areas including care coordination, and increasing access to primary care and patient engagement. Some examples are outlined in the chart below.

### A snapshot of Health Links' best practices

Area	Activity	Example	Health Link
Care Coordination	Care Planning	Creation of a tool kit to support more effective, standardized approach to Care Conference coordination.	Huron Perth Health Link
		Learning Circles: interaction with patients and providers to plan care.	Hamilton Centre Health Link
		Patient Passport Program: care plan which addresses patient goals and perceptions of care received.	Guelph Health Link
		Virtual MVP Clinic housing all allied professionals in one area to facilitate one-stop care for complex patients.	Barrie Health Link
	Vulnerable Populations	Advance Care Planning Resources	East Toronto Health Link
		Health Link's Emergency Department notification for complex patients with mental health concerns.	North York Central Health Link
		Social worker membership within Health Link's Circle of Care.	Don Valley Greenwood Health Link
Increasing Access to Primary Care	Patient attachment through Health Links	Using Health Care Connects to attach patients.	Hamilton Niagara Haldimand Brant LHIN
Patient Engagement	Connecting communities of providers to patients	Patient involvement on Health Links' steering committees.	Various
		Patient Engagement Days	

Health Links have also identified trends and subgroups within their target population, adapting care planning to accommodate vulnerable populations (e.g. individuals living with mental health conditions and/or addictions, the frail and elderly, and individuals living in precarious housing conditions, etc.).

By providing better care to vulnerable population groups and by leveraging partners from outside the health sector to bridge services between the health, social and community sectors, Health Links have taken on an increasingly prominent role in filling system gaps.

## Why Health Links Must Evolve: Health Links and the Action Plan

The ministry's *Patients First: Action Plan for Health Care* places Health Links at the forefront of the system. As illustrated below, Health Links will be instrumental in driving results across the ministry's four priority areas: **Access, Connect, Inform and Protect**.

### Access

- Continue to deliver coordinated care to all of Ontario's complex patients ensuring patients have timely access to quality primary care.
- Integrate care beyond the health care sector across the community, social services and housing sectors, and increase access to the justice sector.

### Connect (Home and Community Care)

- Larger number of services provided to a greater number of patients (complex and non- complex) in the community setting.
- Align ministry and sectoral efforts to strengthen primary care and modernize the home and community sector.

### Inform

- Focus on providing information to support health choices through primary care. Primary care is the entry point for receiving information, referrals and advice on chronic disease management, health promotion and disease prevention.
- Better integration of services to ensure primary care providers and patients are provided with the information and community supports needed to make informed decisions about their health.

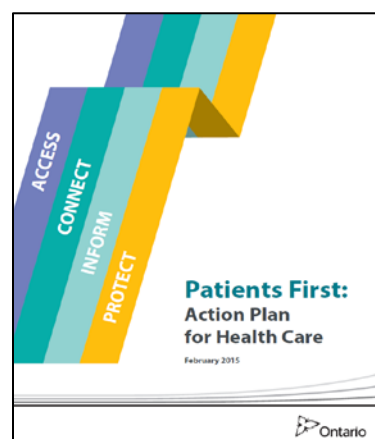
### Protecting Universal Health Care

- Maintain system expenditure growth below 2% reinforces the fiscal imperative.
- Health Links are crucial to wider system integration and therefore are key supports to initiatives aimed at improving quality of care while delivering on fiscal commitments.

*Health Links are a good example of how Ontario is working to bring together providers and health organizations to work as a team with patients and their families....Providers design individualized care plans, and work together with patients and their families to ensure they receive the care they need. But we have more to do.*

*...To further provide patients with faster access to the right care the Plan [also] includes: bringing health care providers together to better coordinate care for patients with complex medical conditions through more Health Links across the province.*

***Patients First: The Action Plan for Health Care, page 9***



## Why Health Links Must Evolve: Understanding our Challenges

While there has been significant progress in the field, concentrated energies are needed to grow the Health Links Model. The Health Links program is at an inflection point, which requires the ministry, LHINs and Health Links to ramp -up efforts to support a larger complex patient population. To enable this, future iterations of the Health Links Model must build on the experience and lessons to date.

The Rapid Cycle Evaluation (RCE), the Health System Performance Research Network (HSPRN) reports, consultations with the field, and Health Links' quarterly reports have helped the ministry understand the core challenges of Health Links and areas that require adjustment to support continued success:

### **1. *Low Rules drove creativity, now standardization must drive consistency and provide clarity***

The “low rules” approach was appropriate at the beginning of the Health Links journey as it helped to promote novel ways of coordinating care for complex patients. It also led to variability in terms of Health Links' governance and definition of the complex patient cohort which allowed Health Links to respond to their local context. However, as the number of Health Links grows, consistency and standardization is important in these areas to ensure operations can grow to scale across the province.

### **2. *Performance Management to support enhanced understanding of provincial, regional and local performance***

Health Links currently report on two indicators of the 11 that were devised at the beginning of the program. Reporting on a smaller indicator set allowed early Health Links to focus on establishing the program and support innovation. With two years of operations, the performance management framework must be enhanced to ensure:

- Health Links and LHINs understand the measures needed to advance care coordination for complex patients; and,
- The ministry, LHINs and Health Links can assess the long-term value of Health Links.

### **3. *Health Links Funding***

As the Advanced Health Links Model evolves, there is a need to refine the Health Links funding model to support provincial scale-up and empower LHINs to plan for their regional Health Links strategies for 2015/16 and beyond.

### **4. *Health Links and the Wider System***

As the Health Links program continues to mature, facilitating the delivery of the *Patients First: Action Plan for Health Care* and other government priorities (e.g., Poverty Reduction Strategy, Commission on the Reform of Ontario's Public Service, Minister Hoskins' Mandate Letter, etc.), consideration must be given to the following:

- How the Health Links Model can be adjusted to allow for greater coordination of services across health, community, social and justice sectors; and,

- How an Advanced Health Links Model supports and aligns with wider system reform and policy development (e.g. strengthened primary care sector and modernization of the home and community services sector, etc.).

## PART 2 – THE ADVANCED HEALTH LINKS MODEL

### a) Advanced Health Links Guiding Principles

The Health Links program is at a critical juncture where the ministry, LHINs and Health Links must have a shared vision and priorities. As such, the ministry has established the Advanced Health Links Model, to guide the collective efforts of the ministry, LHINs and Health Links by capitalizing on existing Health Links infrastructure and networks. The following principles have been established to guide this work:

1. **Regular and timely access to primary care for complex patients.** A central goal of Health Links continues to be regular and timely access to primary care providers. As most patients first interaction with the health care system is through their primary care provider, ensuring patients are attached to primary care providers is essential to the effective provision of coordinated care for all of Ontario’s complex patients.
2. **Effective provision of coordinated care for all of Ontario’s complex patients.** The focus of Health Links has not changed; the model is scaling up to reach all of Ontario’s target population.
3. **Consistent, quality care across the health care continuum and social services sectors.** Making the connection between the services Health Links provide and their connection to health, social, and community services.
4. **Focus on vulnerable populations (frail and elderly, mental health and addictions and palliative).** Health Links will capitalize on the work already being done to serve the complex patient population, and focus in on the most vulnerable and marginalized within that group.
5. **Evidence-based, measureable improvement of the patient experience through enhanced transitions in care.**
6. **Maximize coordinated care to generate system value, sustain the Health Links Model and strengthen care coordination processes to realize greater efficiencies.**

For 5 and 6, emphasis will be on understanding the value of Health Links on the ground and to the system and their impact at the regional and provincial level.

7. **LHINs accountability for performance.** LHINs provide oversight of Health Links and are accountable to the ministry for Health Links performance. LHINs will devise their regional Health Links strategy within their boundaries and ensure that Health Links have the supports they need to succeed. Refer to [Section V1: In-field supports](#) for comprehensive overview of HQO and ministry enabled tools to assist LHINs and Health Links with operations.

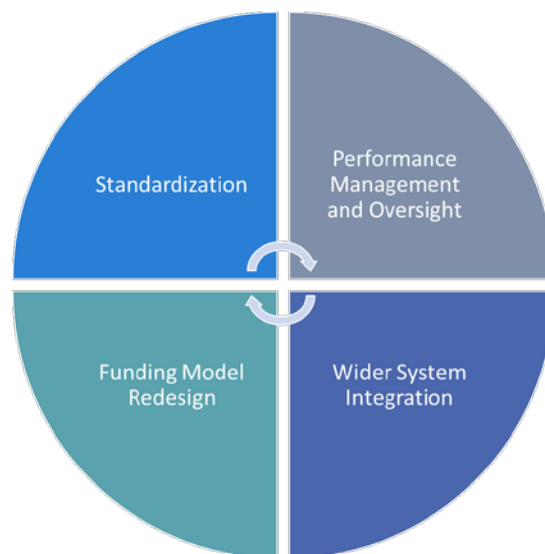


8. **Shared MOHLTC, LHIN and Health Links accountability for overall success.** The ministry, LHINs and Health Links will work together to ensure that Health Links continue to make positive impacts for patients and the system.

### b) Advanced Health Links Model Overview

The Advanced Health Links Model targets specific activities across the following four policy and operational areas:

1. **Standardization** to support common understanding of the target population, common measurement and common governance and accountabilities across all Health Links;
2. **Performance Management and Oversight** to enhance accountability for performance by strengthening the performance management framework;
3. **Funding Model Redesign** to support LHIN accountability, the scale-up of operations around the province and to realize true value to the system; and,
4. **Wider System Integration** to enable adaptation and alignment with other ministry and government priorities.



## **SECTION I: STANDARDIZATION**

As noted, the early stages of Health Links enabled local innovations and creativity that paved the way for successes in patient experience and transitions in care (see examples “**A snapshot of Health Links’ best practices” on Page 5**). The Advanced Health Links Model aims to standardize and embed many of these innovative practices across core areas of the Health Links model.

Standardization is not designed to create a homogenous, one-sized fits all approach to the delivery of Health Links across the province. Rather, it is designed to harness the lessons that have been learned from the ministry, LHINs and Health Links. LHINs and Health Links will continue to have the flexibility to determine “how” care will be delivered within their regional and local contexts, and standardized parameters.

In order for LHINs and Health Links to effectively plan how care will be delivered, it is vital they have a common understanding of the fundamental areas that impact the efficacy of Health Links. The Advanced Health Links Model defines these areas by standardizing the following:

- a) ***Common Target Population***: establishes a common approach to identifying the patient population, which will support the delivery of more responsive and targeted care, establish a common baseline and track performance and progress.
- b) ***Common Performance Measures***: a number of performance measures will be introduced over 2015/16 to help provide more context on the impact of Health Links.
- c) ***Common Health Links Structures and Accountabilities***: streamlines the governance and responsibilities of Health Links lead organizations to more accurately reflect the successes and realities in the field.
- d) ***Shared Best Practices***: HQO has established a formal framework and process to identify and disseminate existing and emerging Health Links best practices, tools and supports to assist LHINs and Health Links with adoption and uptake. More information can be found in [Section VI- In-field supports](#).

### **a) Common Target Population - Ontario’s “5%”**

A common target population addresses the need to establish a common starting point – who is our target and how are they identified? In the absence of a common population, measurement of progress is very difficult.

Based on analyses to date, identification of the complex patient target population remains one of Health Links’ major challenges. In an effort to overcome this barrier, the ministry has proposed guidelines to facilitate the identification of the target complex patient population.

This approach will enable Health Links to adopt best practices with respect to care coordination and other areas of activity, which is particularly important for the 56 Health Links that are close to the start line.

### *Complex Patient Identification Guidelines*

The number of patients identified should be **close to 5%** of the population, who are **responsible for 65% of health care use**. The complex patient target population should:

- Overlap substantially with high cost users, recognizing that not all high cost users are high needs patients (and vice versa);
- Include patients with high needs and/or complex conditions; and,
- Include patients with four or more chronic/high cost conditions, including a focus on individuals living with mental health and addictions, palliative patients, and the frail elderly.

However, recognizing nuances exist across communities, LHINs and Health Links are encouraged to adapt the patient identification criteria to their local context and population needs.

The 4+ chronic/high cost conditions patient selection criteria achieves a balance between capturing patients who are at risk of becoming high-cost users, and 60% of those who are high-cost users. Although 50% of patients with multiple chronic conditions are *currently not* high cost users, a coordinated care approach could *prevent* them from becoming high cost users.

The ministry will work with the LHINs and Health Links to integrate the social determinants of health perspective into the patient identification process as a means of facilitating service integration through Health Links for the poorest served populations.

### **b) Common Performance Measures**

Through the HQO enabled Quality Improvement Reporting and Analysis Platform (QI RAP) Health Links currently report on two program indicators:

- Number of patients with a coordinated care plan developed through the Health Link; and,
- Number of patients with regular and timely access to a primary care provider.

To support a better understanding of how Health Links impact patient and system outcomes, the following three new indicators will be introduced over 2015/16:

- Reduction of 30-day readmissions to hospital;
- Reduction in home care visits referral time; and,
- Reduction in the number of ED visits for conditions best managed elsewhere.

The three new indicators will enable a more detailed understanding of the impact of Health Links over the long-term. However, there is an immediate need to obtain a deeper understanding of Health Links impacts across core areas. As such, beginning in the second quarter of 2015/16, the ministry will introduce a number of short-term indicators that focus on patient enrollment, patient identification and care coordination. Many of the measures will only be collected once to establish a baseline then will be gradually refined or phased out in subsequent quarters.

### c) Common Health Links' Structure and Accountabilities

Since 2014, the ministry has undertaken substantial work to identify and understand Health Links practices, processes and structures that could optimize performance and facilitate the scale and spread of best practices. Through the RCE and HSPRN reports, Health Links' quarterly reports, consultations with LHINs, and the experience of the 26 early adopter Health Links, the ministry obtained:

- A catalogue of program successes and impacts;
- Insights into the key steps and activities needed to establish, operate and lead a Health Link;
- Insights into best practices, emergent innovations, lessons learned, barriers; and
- Approaches and steps to maximize the operations of existing Health Links and inform the development of future Health Links.

Through these findings, the ministry concluded the need to standardize Health Links structures and accountabilities, including the roles and responsibilities of the Health Link lead organization.

These inputs revealed Health Links that were led by hospitals, Community Care Access Centres (CCACs), and primary care teams (Family Health Teams (FHTs) and Family Health Organizations (FHOs), demonstrated high degrees of integration that strengthened care coordination processes. For example, hospitals had more intensive levels of integration for the complex patient population, creating specialized services and programs for this group, while primary care-led Health Links employed broad integrative processes that spanned across the virtual organization.

Evidence shows these organizations are best positioned to lead Health Links given: their existing networks, infrastructure and resources to mobilize efforts across multiple organizations and sectors; and, inter-disciplinary approach to care models the principles and approaches of the Health Links Model.

Evidence also points to the important role Health Links core partner organizations play in the execution of Health Links. For example, some of the primary care teams had a shared leadership model with core partners, which allowed them to leverage inter-organizational strengths and capabilities to deliver Health Links to their complex patient cohort.

As the Health Links program evolves beyond the 26 early adopters, these principles and organizational structures have shaped the Advanced Health Links Model and helped the ministry standardize Health Links lead organizations and their core functions.

#### i. Who can lead a Health Link

All **new** Health Links will be led by hospitals, CCACs, or primary care teams. A primary care team can be a FHT, Nurse Practitioner-Led Clinic, Aboriginal Health Access Centre, Community Health Centre or FHO.

Currently, a handful of Health Links are led by other organizations. These organizations have been important contributors to the Health Links program, and will remain at the helm of their Health Links.

## ii. Responsibilities of a Health Link Lead Organization

Although the Health Link lead organization is accountable to the LHIN for the Health Link's performance, the Health Link is a collaborative endeavour that involves the Health Link's lead organization and partner organizations sharing responsibility for achieving outcomes. All Health Link lead organizations will continue to perform responsibilities in these core functional areas: ***governance, establishment, operations and performance*** as outlined below.

However, although the lead organization is accountable to the LHIN for these functional areas, responsibility can be shared with Health Link partner organizations, who may be better positioned to deliver on these activities. These arrangements need to be formalized between the Health Link lead organization and partner organization through their Letter of Cooperation (formal agreement between Health Link lead organization and partner organization).

1. **Establishing Health Link's governance** which includes engaging core and supporting partners and crafting Letters of Cooperation as necessary to formalize arrangements
2. **Establishing a Health Link and developing the Health Link's virtual infrastructure**
  - Provide project management and administration responsibilities;
  - Define and identify the roles/responsibilities of the Health Link's partners;
  - Enable implementation of care planning processes, by working across the Health Link's partner organizations to define clinical flow of complex patients across organizations, and determine how the Health Link's infrastructure and networks will be organized to provide wrap-around, patient-centred care;
  - Develop a Health Link's business plan, in collaboration with their LHIN and Health Link's partners, the Health Link's lead organization will identify the resource requirements needed to achieve the Health Link's targets.
  - Ensure patient engagement; and,
  - Facilitate provider engagement.
3. **Health Link operations**
  - Work with the LHIN to identify the target population in accordance with guidelines;
  - Track the patient cohort;
  - Oversee care plan management/implementation;
  - Ensure the appropriate connection to health services and coordinated care planning;
  - Engage the network of providers within the Health Link to ensure providers have the necessary supports and resources they need to reach and service the target population, and ensuring there is a common understanding of the Health Link's objectives and priorities;
  - Adopt best practices to enhance implementation; and,
  - Ensure ongoing patient and provider engagement.

#### 4. Health Link performance

- Broker and setting targets with the LHIN and Health Link's partners where required or appropriate;
- Ensure that the operational plan is achieved; and,
- Report on performance to LHINs.

Over 2015/16, the ministry will work with LHIN leadership to embed the roles and responsibilities of the ministry, LHINs and Health Link's lead organization across all 2016/17 accountability instruments between: the ministry-LHIN, LHIN and Health Link lead organization, and Letter(s) of Cooperation between the Health Link lead organization and Health Link partner organization(s).

#### ***Standardization Key activities in 2015/16 to facilitate implementation in 2016/17:***

1. Ministry hosted webinar on the Target Patient Population on August 12<sup>th</sup>.
2. HQO to develop best practices to assist LHINs/ Health Links in integrating approach into existing processes.
3. Ministry to work with LHINs to devise the target setting process for performance measures and craft language to support inclusion of indicators into 2016/17 LHIN-Health Links accountability mechanisms.
4. Ministry, in collaboration with LHINs, to review and assess the Advanced Health Links Model accountabilities, and how they will be integrated into accountability mechanisms for 2016/17.
5. LHINs and Health Links work to integrate new requirements into the 2016/17 LHIN- Health Links accountability mechanisms.

## **SECTION II: PERFORMANCE MANAGEMENT AND OVERSIGHT**

As Health Links mature, an enhanced performance management framework is necessary to better understand the value and progress of the model from a Health Links, LHIN and ministry perspective, so that adaptations can be made to address local, regional and system level considerations.

This will help LHINs and Health Links engage in performance management discussions by pinpointing areas where Health Links may require LHIN level supports and what refinements may be needed to a LHIN's regional Health Links strategy.

An augmented performance management framework will be advanced through two avenues: a) enhanced performance measurement and b) focussed and appropriate performance management.

### **a) Enhanced Performance Management**

#### **i. Enhanced Performance Measures phased in over 2015/16**

The new performance measures, as outlined in the [Common Performance Measures section](#), are integral components to a robust performance management framework that will support sustained Health Links success as operations are scaled across the province.

Specifically, these measures will help anchor and guide progress conversations between LHINs and Health Links. Over 2015/16, the ministry, will engage the LHINs with the following criteria in mind:

- Consider how the performance measures will be more formally used in performance management; and,
- Ensure Health Links performance measures are aligned and advance other ministry priorities including a strengthened primary care sector and modernized home and community care.

#### **ii. Enhanced Process for Quarterly Reporting**

Since March 2015, LHINs and Health Links have used the HQO enabled [QI-RAP tool](#) to submit key performance measures on a quarterly basis. As the Advanced Health Links Model progresses, HQO will continue to strengthen and build the capabilities of QI-RAP enabling greater levels of automation and data analysis at the provincial, LHIN and Health Links level. Data reporting and review protocols will be established to promote availability of the highest quality data to monitor progress of the Health Links and regular consultations between LHIN Health Link leads and regionally based QI specialists will support interpretation and learning from the data.

### **b) Focused and appropriate performance management**

It is imperative that Health Links have the supports needed at the regional and local level to scale operations to serve all of Ontario's complex patient population. As such, the Health Links program will focus on the supports, processes and policies needed to assist Health Links with meeting their performance targets and priorities as they scale operations.

### i. **Ministry-LHIN Discussions on Regional Performance and Provincial Objectives**

Over 2015/16, the ministry and LHINs will work together to develop a policy that sets out the following:

- The parameters and framework to anchor Health Links performance conversations within the context of regional and provincial objectives;
- The frequency of meetings; and,
- The existing channels and forums that could be leveraged for these discussions.

### ii. **LHIN- Health Links -Performance Management**

LHINs and Health Links will be expected to continue to work together to develop the following:

- Processes that assess the performance of individual Health Links with the goal of understanding the challenges and barriers that may impede performance; and,
- Formal and/or informal strategies to improve performance as required including the deployment of provincial tools and use of HQO supports.

#### **Key activities in 2015/16 to facilitate implementation in 2016/17:**

1. The ministry will engage LHINs to:
  - Develop the performance management framework including the phasing in of three new performance measures, referenced in the [Common Performance Measures section](#), and the development of a target setting process for incorporation into the ministry-LHIN and LHIN-Health Links accountability mechanisms for 2016/17;
  - Develop performance management policies to set out the process for Ministry-LHIN and LHIN-Health Link performance monitoring for implementation in 2016/17; and,
  - Provide advice on any common frameworks for LHIN-HL performance management protocols.
2. The LHINs will work with Health Links within their geography to develop their own performance management protocols.

## **SECTION III – HEALTH LINKS FUNDING REDESIGN AND SUSTAINABILITY PLANNING**

### **a) Funding Health Links up to 2014/15 – A Developmental Approach**

Over the course of two years, the number of Health Links has rapidly grown from the original 26 to the 82 that will be operational by the end of 2015. Early funding levels reflected the start-up and developmental phases. As the Health Links program enters the next chapter, funding must evolve to match the maturity of the model.

Starting in 2015/16, Health Links led by health service providers funded by a LHIN, shifted to a LHIN-managed funding approach where LHINs were provided with a single Health Links allocation, and granted the flexibility and discretion to plan and fund Health Links according to their regional priorities. Health Links led by primary care teams continue to be funded directly by the ministry, and work collaboratively with their respective LHINs to ensure alignment with regional Health Links priorities.



Over 2015/16, the ministry and LHINs will work collaboratively to progressively update the Health Links funding approach in a manner that:

- Builds on the learnings of the ministry and LHINs and the capacity that has resulted from the creation of Health Links; and,
- Considers Health Links long-term sustainability within the system.

## **b) Sustainability Planning**

As the Advanced Health Links Model progresses, greater provincial, regional and local attention will focus on understanding what sustainability means within the Health Links context and how Health Links will harness their inter-organizational collaborations and care coordination processes to maximize regional investments and create opportunity for cost avoidance.

Over the course of 2015/16 the ministry, with LHIN involvement, will craft a guide that will scope out what sustainability means and how it can be demonstrated by LHINs and Health Link lead organizations. The sustainability guide will be a vital resource as LHINs and Health Links develop a sustainability plan, which will be an essential requirement in the 2016/17 ministry-LHIN and LHIN-Health Links accountability mechanisms.

### **Key activities in 2015/16 to facilitate implementation in 2016/17:**

The ministry will consult with the LHINs to craft a sustainability guide and determine the language and requirements for inclusion in the 2016/17 Ministry-LHIN and LHINs-Health Links accountability mechanisms.

## **SECTION IV – HEALTH LINKS WITHIN THE BROADER SYSTEM**

The ministry's 2015 *Patients First Action Plan for Health Care* emphasizes the creation of a home and community sector that provides a greater selection and volume of services to a wider population at home or close to home.

Health Links have introduced new care approaches that extend to sectors beyond health, where local partners work to support the needs of complex patients, engaging over 1,800 partners across health, community and social services. Therefore, Health Links valuable lessons learned and best practices can be leveraged to support a number of ministry priorities:

1. **Strengthened accountability and performance in primary care:** work will be done to situate and align the Advanced Health Links Model with the work underway to support a strengthened primary care sector.
2. **Understanding how Health Links would work within the Northern/Rural circumstance and context:** over the past few months, the ministry has worked to understand what adaptations would be needed to adjust the Health Links model to address Rural/Northern realities.
3. As a template to support **Wider System Integration Across Sectors:** the ministry will work to facilitate and encourage greater coordination of health, social and community services through Health Links, by driving integration at the government level. These efforts will match and mirror the efforts at the provider level with respect to connectivity (e.g., creation of Connectivity Tables).

The ministry will continue to advance these streams of work, ensuring alignment with broader ministry and government initiatives and strategic directions. In addition to Health Links, the ministry is collaborating with a number of ministries to ensure alignment and coordination across areas of shared responsibility. For example, the ministry is working with the Ministry of Community and Social Services on the Dual Diagnosis Framework; the Ministries of Children and Youth Services, Community and Social Services, and the Poverty Reduction Strategy Office, Treasury Board Secretariat, on the Low Income Dental Integration Program; and the Ministries of Education and Municipal Affairs and Housing to advance work on community hubs.

## **SECTION V – ROLE OF THE MINISTRY AND LHINS**

This section outlines the role of the ministry and LHINs in driving the Advanced Health Links Model forward.

### **a) Role of the Ministry – The Provincial Perspective**

The ministry sets the provincial direction for Health Links, ensuring alignment with critical provincial priorities. The ministry also works in tandem with HQO to develop provincial tools and supports through the best practices framework.

## b) Role of the LHINs

The LHINs play a dual role of providing oversight to Health Links: they are accountable to the ministry for the performance and execution of their regional Health Links Strategy; and ensure the strategy aligns with provincial priorities.

As summarized below, both parties maintain vital responsibilities across program strategy, operations, performance management and communications.

### Ministry and LHIN Health Links Responsibilities at a Glance

Ministry	LHIN
<b>Program Strategy</b>	
<ul style="list-style-type: none"> <li>• Sets the provincial priorities (e.g. performance, target population for Health Links).</li> <li>• Identifies opportunities to support Health Links as they mature.</li> </ul>	<ul style="list-style-type: none"> <li>• Drives Health Links within provincial priorities.</li> <li>• Sets regional priorities for coordination of care for complex patients through Health Links.</li> <li>• Facilitates and manages development of Health Links within its geographical boundaries.</li> </ul>
<b>Operations</b>	
<ul style="list-style-type: none"> <li>• Overall funding envelope to LHINs.</li> <li>• Leads sustainability planning with the LHINs.</li> <li>• Supports effective operations through provision of provincial tools.</li> <li>• Roll-out of the Care Coordination Tool (CCT) across Health Links.</li> <li>• Provincial best practices framework with HQO.</li> </ul>	<ul style="list-style-type: none"> <li>• Allocates funding as required to support operations across the LHIN.</li> <li>• Sustainability planning with Health Links within boundaries.</li> <li>• Works with Health Links on its budgets and operational plans in accordance with provincial and regional priorities.</li> <li>• Supports implementation of provincial tools and supports.</li> <li>• Identifies supports and implements regional tools and supports.</li> </ul>
<b>Performance Management</b>	
<ul style="list-style-type: none"> <li>• Monitors overall program performance.</li> <li>• Conducts provincial evaluation of Health Links.</li> </ul>	<ul style="list-style-type: none"> <li>• Performance management of Health Links within boundaries: <ul style="list-style-type: none"> <li>• Assesses performance of Health Links through quarterly reporting, etc.</li> <li>• Reports on performance to the ministry.</li> <li>• Conducts informal/formal performance improvement planning with Health Links as required.</li> </ul> </li> </ul>

**Communications**

- Provincial communications.
- Regional communication and stakeholder engagement.

## **SECTION VI – IN-FIELD SUPPORTS**

This section explores the in-field supports and tools that will help LHINs and Health Links transition to the Advanced Health Links Model by 2016/17.

### **a) Role of Health Quality Ontario (HQO)**

Through the Best Practices Framework (“The Framework”) HQO is a key partner in facilitating the adoption of the Advanced Health Links Model. The Framework will provide a number of practical tools and in-field supports, as described below, to assist LHINs and Health Links with deploying the Advanced Health Links Model on the ground.

HQO may contact the LHINs and Health Links regarding performance and practices; this engagement is intended to inform the development of best practices and to help LHINs and Health Links transition from current operations to the Advanced Health Links Model in a more focussed manner. These touch points are not part of the LHINs and Health Links accountability reporting requirements, rather, they are designed to support quality improvement efforts within a LHIN or Health Link’s geography.

#### **i) Quality Improvement (QI) Specialists**

HQO’s QI Specialists are located across the province and are trained to help Health Link communities achieve their quality improvement goals. The QI Specialists work closely with the LHINs to review and analyze reports on provincial, LHIN and Health Link level data in order to: identify opportunities for improvement; support the sharing of lessons learned between Health Links; and to facilitate the spread of emerging and leading innovative practices. An overview of the cycle of data review can be found in the document “Health Links Data Reporting and Review Protocols”.

#### **ii) Best Practices Framework**

The Health Links’ early low rules environment fostered the culture that enabled healthcare teams to develop new and better ways to integrate healthcare delivery for Ontarians with complex chronic illness. As Health Links transition to the Advanced Health Links Model, LHINs and Health Links need a way to translate these ideas into scalable innovations, standardizing those best practices.

The HQO Framework is a systematic process to harvest, evaluate, implement, measure and adapt innovative practices. The Framework is predicated on the Innovative Practices Evaluation Framework (Health Council of Canada, [http://www.healthcouncilcanada.ca/accord\\_framework.php](http://www.healthcouncilcanada.ca/accord_framework.php)), a tool designed to categorize practices as “emerging,” “promising” or “leading” based on four criteria: quality of evidence, impact, applicability and transferability).

Innovative practices are identified through broad consultation with LHINs, Health Links, and analysis of Quality Improvement Plans, IDEAS project work, and Health Quality Transformation Scientific Abstracts. Innovative practices are to be considered for large scale implementation are reviewed by the Clinical Reference Group (CRG) comprised of subject matter experts in Health Links, academia and representatives from across the province.

The CRG, a key element in the Framework, is an action-oriented, functional body designed to assess the quality of evidence, impact, applicability and transferability of existing practices within Health Links for

the purpose of identifying suitability and readiness for spread. By consistently and rigorously following the Innovative Practices Evaluation Framework, the CRG will inform recommendations and advise HQO in the creation of implementation packages that will simplify and accelerate the uptake in Health Links that have a similar context and need.

A knowledge translation strategy will be developed for all practices endorsed for pan-provincial implementation. The strategy includes discussion and shared learning in the Health Links Community of Practice (CoP), reference materials, tools, resources, and local support from the regionally based HQO QI Specialists. The measurement plan ensures that key indicators are monitored and practices adapted to meet HL goals.

### iii) **Community of Practices (CoP)**

The Health Links CoP is designed to accelerate the identification and spread of innovative practices; and is a group of LHIN and Health Link participants who share a passion for improving the care of Ontarians with complex/high needs.

The CoP interacts regularly to learn how better to care for Health Links patients and their families. The Health Link CoP is intended to achieve the following:

- Build inter-link relationships;
- Learn and develop improved practices;
- Carry out tasks/project work; and
- Create new knowledge.

The Health Links CoP meets regularly through webinars (see [www.HQOntario.ca](http://www.HQOntario.ca) Events), is supported by the QI Specialists, and provides reference materials, resources and tools on the HQO website (see [www.HQOntario.ca](http://www.HQOntario.ca) Quality Improvement – Health Links).

#### HQO's key best practices to be developed in 2015/16

- Identification of HL patients
- Coordinated care planning
- Consent, privacy, data sharing
- Building cross sector teams
- Transitions in care
- Palliative and end of life care
- Persons with mental health and addictions conditions

### b) **Coordinated Care Tool (CCT)**

The CCT is an electronic solution that will allow Health Link clinicians to create, maintain and share coordinated care plans and exchange secure messages quickly and easily within a patient's circle of care. The detailed requirements for CCT were developed in partnership with HQO through extensive consultation with LHINs and Health Links in 2013 and 2014. CCT leverages the ministry's existing investment in the Community Care Information Management (CCIM) and the Integrated Assessment

Record (IAR) systems by allowing Health Link clinicians working across the circle of care to access coordinated care plans.

A proof of concept project is currently underway and a lead vendor (Orion Health Ltd.) has been secured to deliver CCT in partnership with Health Links, under the ministry's oversight. The main goal of this project is to determine whether CCT addresses the core Health Link needs identified and help determine what improvements are necessary, going forward. To that end, CCT is being implemented in a flexible way with the ministry, LHIN and vendor working with each participating Health Link to help Health Links optimize their use of CCT to support existing care coordination models. The proof of concept project is taking place from January to December 2015.

**As of September 2015, 17 Health Links from 9 LHINs are participating in CCT:**

- Wave 1: Three Health Links have been implementing CCT since the beginning of the year.
- Wave 2: Four Health Links are also at advanced stages of implementation and are forecast to begin using CCT in November.
- Wave 3: Ten additional Health Links have recently begun working with the ministry and vendor.

Wave 1 and 2 Health Links have also contributed over two dozen clinicians to a user working group that provided detailed feedback on early iterations of CCT. Together, the user working group participants provided over one hundred unique suggestions for improvement, the majority of which will be incorporated and implemented for the proof of concept this year. Two major improvements include:

- Secure messaging in CCT has been enhanced in a number of ways, such as the ability for clinicians to more easily receive and send updates about changes made to patient care plans; and,
- An interface between CCT and an Electronic Medical Record (EMR) will be piloted by one Health Link's main FHT so that care plans can be more easily created and updated by clinicians in the FHT for sharing with other clinicians in the Health Link.

The proof of concept will be evaluated to measure the adoption, use and benefits of CCT, and uncover opportunities for improvement. The evaluation will be one of the key inputs informing the best approach to meet Health Link needs beyond the proof of concept. The ministry will also consider how CCT fits into a refreshed ehealth strategy for Ontario, called eHealth 2.0. The ministry will ensure that Health Links are engaged throughout the process and expects that more information on future direction for CCT will be available early in 2016.

Given the progress being made on CCT, 2015/16 Health Link funding includes a more stringent approval process for LHINs who wish to use Health Link funding to pursue interim care coordination solutions. This is being done to ensure that any investments in interim solutions are appropriate given the provincial work underway, while providing opportunities to evaluate those systems in a comparable way to CCT.

## **SECTION VII – CONCLUSIONS AND MOVING FORWARD**

This Guide represents the beginning of the work to move the Advanced Health Links Model forward. Over 2015/16, the ministry will engage LHINs and Health Links in the development and execution of an implementation plan that will provide both LHINs and Health Links with the tools needed to transition to the Advanced Health Links Model in 2016/17. The plan will be collaborative and rely on the collective efforts of the ministry, LHINs, Health Links, HQO and the sector to marshal resources to continue to scale and spread operations to serve all of Ontario's complex patients.

### **Who to Contact**

Direct any questions about the content in the Guide to your Health Links LHIN Lead or email the ministry Health Links Team at [Healthlinks@ontario.ca](mailto:Healthlinks@ontario.ca).



## **APPENDIX A: SUMMARY OF RCE AND HSPRN FINDINGS**

The foundational work done through the RCE and HSPRN has shown significant overlap in terms of challenges and successes.

### **Health Links RCE: October 2013- March 2014**

The RCE conducted from October 2013 to March 2014 was an important first step in understanding whether Health Links were making inroads to serving the complex target population and to gauge Health Links progress.

The RCE focussed on how patients were being identified, how their care was being coordinated, and how that care contributed to their overall experience:

- Health Links were proving to be a useful interface for providers and were facilitating care coordination;
- Providers and organizations within Health Links were making use of their networks to ensure that care was being well planned and this was having a good impact on transitions for patients;
- Health Links had taken the concept of heightened patient engagement to heart, involving patients not only in their care but in the design of the Health Link; and,
- In the absence of a common definition for complex patients, Health Links faced stumbling blocks when initially defining and identifying their target population. While Health Links were resourceful in utilizing available information to help identify their target population, it was a blind spot that warranted provincial guidance.

### **HSPRN: November 2014 - January 2015**

The HSPRN research confirmed the findings from the RCE that early Health Links results were promising and were fostered by innovative local approaches. Some of the greatest early successes were in improvements in patient-centred care through the provision of coordinated care and communication between providers, as captured below.

#### **Early Successes**

- Creation of virtual networks - an achievement which led to greater collaboration between providers facilitating care delivery within the Health Link and beyond.
- Improved coordination of care through the creation of common care plans and communication between providers.
- Enhanced patient experience through participation in care planning.
- Improved access to primary care.
- Small scale improvements in health outcomes for high users – including reductions in ED use and hospital admissions.

#### **Conclusions**

- Health Links took advantage of a low rules environment to improve care for complex patients.
- Successes have been small in nature but show opportunities for scale up and spread across the province.
- Not all Health Links have been equally successful:
  - Health Links in urban settings and or high socio-economic areas are performing better.
  - As a result, integration of clinical and broader social services in rural and lower socio-economic population will be critical for success in those areas
- Further evaluation of patient groups through Health Links is required to understand conditions necessary for scale up and the growth of Health Links.