Part 4

Health Links: turning the concept into reality

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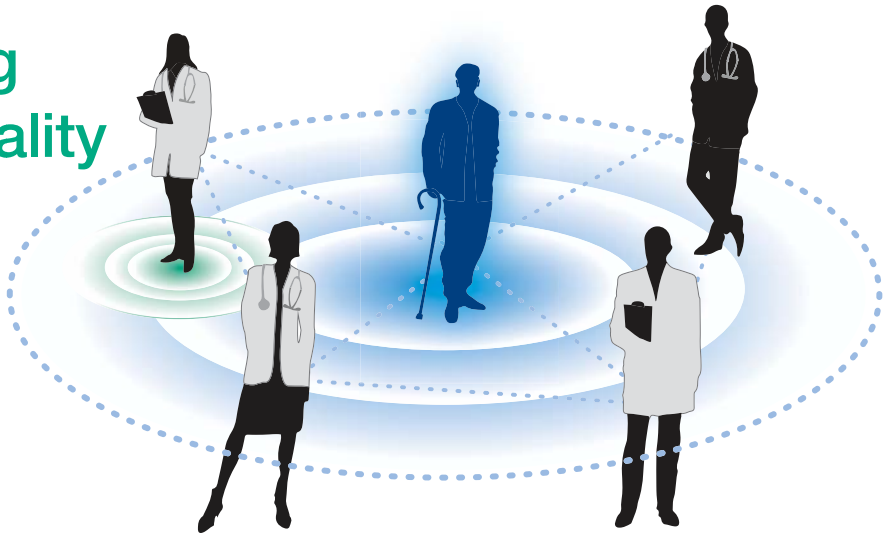

HEALTH LINKS AIM TO BETTER INTEGRATE CARE FOR ONTARIANS. THE CONCEPT OF BETTER INTEGRATION IS ONE THAT VERY FEW WOULD ARGUE WITH. AS HEALTH LINKS SPREAD ACROSS THE PROVINCE, IT IS IMPORTANT TO MOVE BEYOND SUPPORT OF THE THEORY, TO ARTICULATING THE REAL-LIFE EXPERIENCES OF THOSE WHO ARE MAKING IT A REALITY.

The Ontario Medical Association (OMA) undertook a jurisdictional review about health system integration efforts, which included input from New Zealand, Australia, the United Kingdom, Sweden, Alberta and British Columbia. The review, which was based on key informant interviews in combination with the literature, identified consistent findings about what was required to make integrated care initiatives like Ontario's Health Links successful.

Health Links is an innovative initiative that the Ministry of Health and Long-Term Care (MOHLTC) launched for the express purpose of enhancing the care of those people in Ontario who have the most complex health needs. Our research sought to identify key success factors in integrated care initiatives in support of Ontario's physicians as Health Links evolve across the province. The results pointed clearly to the idea that jurisdictions that succeed with structural reform have engaged providers in "rowing" the reform and they have recognized key enabling features required for success. This article views some of these enabling factors through the lens of real-life experiences of some of our early Health Links.

Health Links were announced in December 2012, with the objective of helping those Ontarians with complex medical needs. The problems we face as a health system providing care

> "The more I participate in the development of co-ordinated care plans with my own patients, the more I see it as a 'game changer' for patients, physicians, and the health care system."
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> *Dr. Jonathan Kerr, Belleville*

for these patients are complex, and the solution provided through Health Links has proven to be innovative and responsive to the needs of local communities. There are more than 40 established Health Links, now covering nearly half of the province. In the year following the introduction of Health Links, Ontario's doctors have taken an important leadership role in developing, implementing, and championing the initiative across the province.

These are their stories: what they have learned, what is working, what needs more work, what needs to be in place, and most importantly, how the Health Links initiative is changing the experience of care for Ontario's most vulnerable and high-needs patients.

Infrastructure That Is Fit For Purpose

Appropriate meso-level infrastructure needs to be in place to support providers on the "front line" of care delivery. This, in essence, not only helps in the development of meaningful integration initiatives, but it is vital in equipping providers at the micro level for success.

In the jurisdictions we examined in our research, New Zealand leverages among the most mature and developed meso-level support infrastructures based on organized primary care, for physicians who deliver care in an integrated care initiative. In that country, Independent Practitioner Associations (IPAs) have built strong primary care organizations both within and across general practices, while at the same time responding to change and reform. These physician-led networks provide useful insights for all those involved in the provision of integrated practice services.

A leading IPA-based primary care organization and its management arm can provide business and clinical leadership for several primary health care organizations. Given this capacity, it is clear that primary care networks with a strong physician foundation are able to manage alliance networks of considerable complexity, not unlike the complexity seen in Health Links.

In Ontario, we are in the early stages of organizing primary care through Primary Care Networks and through the primary care physician LHIN leads (PCPLL) at each of the province's 14 Local Health Integration Networks (LHINs). There are other meso-level infrastructure supports that are emerging as important sources of support for Health Links as they expand. Health Quality Ontario (HQO), for example, is consulting with physicians about its planned development of a suite of tools that will provide guidance to enhance quality of care through integration efforts in Health Links. As Health Links take shape, the continuing evolution of the primary care organizing structure will be essential.

Dr. S. Kennedy, Co-Lead of Harbourview Family Health Team (FHT) and Executive Vice-President of Medicine and Academics at the Thunder Bay Regional Hospital, shares his view of the integral role of appropriate infrastructure: "Health Links has tremendous opportunity to provide for an organizational structure at the primary care level. The delivery of primary care remains unconnected to a system of care that most medically complex patients require in order to enable effective change in their health outcomes. A functional governance structure at the primary care level will allow for a shifting and sharing of resources that will enhance the co-ordination of care for a select group of the most complex patients."

Currently, the physician leads from across the province work in their region and come together at a provincial level to co-ordinate and facilitate the integration efforts in Health Links. Each of the PCPLLs are working locally to facilitate implementation of the province's care integration efforts and to support emerging Health Links through the PCPLL infrastructure. Similarly, in areas where an organized Primary Care Network or Primary Care Council exists, these are being leveraged as supporting infrastructures for Health Links.

Dr. R. Drury, Chair of the PCPLL, is actively involved in ensuring that front-line primary care providers are engaged broadly across the province, and locally in their region. Relevant primary care engagement, which was initially a challenge in several areas, is enabled through the supports and infrastructure available. He tells of his recognition that there was nominal utilization of the PCPLL in the process of establishing the first Health Link in his region. With Dr. Drury's encouragement, the Central East (CE) LHIN changed the approach as it embarked on a second and then subsequent Health Links. Dr. Drury, in his role as the PCPLL, went out to the main primary care groups

"Health Links are a self-fulfilling opportunity — by needing to engage primary care for success, they de facto help to better organize the previously unorganized primary care sector."

Dr. Rob Annis, Listowel

and had one-on-one discussions with each of them. This process of setting the stage involved conversations with the nurse practitioner-led clinic, the two Community Health Centres (CHCs), and four large groups of primary care providers. The conversations drew upon the early education sessions from the OMA and talked about the why, the value, and the upside of Health Links. It also engendered honest dialogue about the status of relationships with the hospital, the Community Care Access Centres (CCACs) and other physician and specialist groups. These conversations prepared the care providers for the process of building a Health Link, and the approach was supported by the LHIN leadership who then visited the same groups about a month later to answer any administrative questions. Finally, the same primary care groups collectively were invited along with other organizations to an education session jointly sponsored by the OMA and the LHIN. As a result of this level of support, all seven primary care groups signed on to participate in the preparation of the readiness assessment, which gave the emerging Health Link robust primary care leadership. Foundational to success was utilizing the PCPLL to speak honestly and directly to primary care providers in the area. This method has been used with continued success as new Links have emerged in the region.

In the Hamilton Niagara Haldimand Brant (HNHB) LHIN, the Physician Lead for Clinical System Integration, Dr. J. Everson, has focused her efforts on providing the support necessary for physicians to improve patient care through clinical integration and identifying ways together to reduce clinical variation. The work she and her colleagues are doing leverages the existing infrastructures within the OMA, the two Academies of Medicine in the region, and the existing HNHB Primary Care Network. These organizations have helped to facilitate communication to and from physicians across the large geography of this LHIN. In her parallel role as PCPLL, one of the ways she is supporting Health Links is by having each of the 11 primary care physician leads for each of the region's Health Links join the Primary Care Network. This model encourages active and ongoing participation and bi-directional communication in a way that ensures that each Health Link physician lead is equipped to provide significant continuity and optimal communication for all of the family physicians in their Link.

The South West (SW) region of the province has a well-developed primary care organization in the form of the SW Primary Care Network. The development of the SW LHIN's first Health Link, the Huron Perth Health Link, gave rise to a double opportunity: to effectively engage the Huron Perth Primary Care providers in the Health Link process via the already formed SW Primary Care Network, and to expand the reach of that SW Primary Care Network locally into the Huron Perth area via the Health Link Initiative (see Spotlight on Success: Supporting Infrastructure, p. 13). Dr. R. Annis and his colleagues have spearheaded the Primary Care Network and they are building on Health Links in a way that realizes the additional opportunity to expand the reach of the Primary Care Network into more local communities.

Clinical Engagement And Leadership

Our international key informants told us that where integration has been successful, interactions with physician providers has not been episodic, but rather it has been iterative and purposeful throughout all phases of development and implementation. We know that clinical leadership is a key to success in an initiative such as Health Links. As well as the physician leadership demonstrated by the PCPLLs, there needs to be physician leadership and meaningful physician engagement throughout each and every community Health Link. Dr. D. Kaplan, the PCPLL for the Central LHIN and a member of the steering committee for the North York Central Health Link (NYCHL), believes that the early successes of the NYCHL are largely due to broad physician, community and hospital engagement and collaboration. While the four formal partners of the NYCHL are North York General (NYGH) and its Department of Family and Community Medicine, the North York Family Health Team (NYFHT), Central CCAC, and Toronto Emergency Medical Services (EMS), for the purposes of this article we will focus on the relationship with the hospital and the physicians. NYGH has a long history of strong relationships with its family physicians — in fact, the hospital's Department of Family and Community Medicine has approximately 300 family physicians as members. These family

"I remain very excited about Health Links and recognize that the weaknesses or gaps make it only as good as its weakest link — we will get there!"

Dr. Michael Kates, Mississauga

Spotlight On Success: Supporting Infrastructure

Dr. Annis describes how, over the last two years, the regionally based South West Primary Care Network has had considerable success in consulting and engaging with regional programs to improve their reach. For example, work was done to help Health Care Connect roster unattached diabetic patients, the CCAC's flex clinics were expanded, the referral system out of the general practitioner's office was improved, and HQO's Advanced Access Coaches were encouraged. A second mandate of the group — to grow locally into the LHIN's sub regions — proved more challenging.

With the December 2012 Health Link announcement that framed Health Links as local quality initiatives, the SW Primary Care Network has begun work on developing local Primary Care Networks in alignment with the Health Link geography. The Huron Perth Health Link is now informed by the Huron Perth Primary Care Network, which not only advises on Health Link issues, but other local issues of interest to primary care providers. As well, the local network elects a regional representative, and so has achieved a local as well as a regional voice.

These local Primary Care Networks will engage in the process of "plan, do, study, act" (PDSA) as Health Links and their supports develop and adapt across the region. So what does that look like? The Collaborative Care Tool, for example, will be "PDSA'd" in Stratford in one practice, and with lessons learned there, will then be "PDSA'd" in Listowel and Wingham practices. Then, the lessons learned at that point will be shared with the other Huron Perth practices, who will start their own PDSAs. The practices are reached through the Primary Care Network; which thereby helps build the Health Link from the ground up.

physicians have historically been early adopters of eHealth solutions and primary care renewal models.

Even prior to the Health Links announcement, one of the strategic initiatives of NYGH is "Connecting Care." Integrating with primary care is a primary component of this initiative. NYGH has taken many steps to better integrate with community-based physicians, and the Connecting Care initiative has enabled the NYCHL to keep physicians more informed when patients are using acute care services.

Because of these strong relationships, family physicians (of all payment and practice models) have had specific input into the development of the local Health Link model. In turn, the NYCHL is well supported by physician leaders from the community, including Dr. D. Delva, who has taken on the role of physician lead for the group. While the high-complexity users in the area have a good attachment rate to primary care (>95%), in the cases when a patient does not have a primary care physician, the NYFHT has offered to take on these patients.

The NYCHL Steering Committee includes a physician from a Family Health Organization (FHO) who is a critical member of the team. Dr. Delva ensures that established, historic forums for reaching engaged physicians are not relied on, but that the team stretches to seek out and engage with physicians who are not as strongly affiliated with the hospital and could more significantly benefit from Health Links.

Dr. Kaplan notes that the Health Link is still working through the best mechanisms to engage with primary care. As the PCPLL, he has led the LHIN-wide development of a common care plan and has done so based on extensive primary care and patient input. The NYCHL is using innovative ways to

"Primary care engagement is not going to happen with one encounter or one invitation, but from a multi-phased approach that involves the primary care physician LHIN leads, the LHIN leadership, and educational support from the OMA."

Dr. Rob Drury, Lindsay

keep in touch with physicians in the area and they use several communication vehicles, including the PCPLL's newsletter, which is a well-read information source for the physicians. Despite all of the efforts focused on engagement, the team recognizes that these are still early days and that success depends on ongoing meaningful engagement.

The physician lead for the East Mississauga Health Link, Dr. D. Daien, tells the story of an elderly gentleman who lives alone and who, despite having a supportive family, continues to be challenged with physical, social and mental health issues. When he developed an acute illness that required surgery and a prolonged stay in hospital followed by rehabilitation, he was enrolled in the Health Link — while he was still in rehab. As part of the co-ordinated care planning for this patient, timing of his discharge was carefully determined so that it met family and patient needs, therefore avoiding inappropriate timing that could have led to readmission. The patient's perspective was reflected in the care plan, and Dr. Daien notes the tremendous importance of broad clinical engagement and involvement when he recounts that two days after the patient's discharge, "for the first time in my 21 years of practice, we had a case conference with the patient, family members, the CCAC care co-ordinator and myself in my office. We were all working from the same plan and were able to share each other's perspectives and what could be done to address any outstanding issues."

Dr. J. Kerr is a family doctor in Belleville, a Health Link physician lead, the PCPLL for the South East LHIN, and President of the Ontario College of Family Physicians. He believes that clinical engagement and physician leadership are keys to success in Health Links. Sustainable success hinges on physicians taking ownership of the objectives of Health Links, not simply buying into them. In Dr. Kerr's words, "System transformation happens from the bottom-up, even when the concepts are derived at the MOHLTC and LHINs. Using an intentional complexity science approach (especially the use of minimum specifications), transformational change concepts can be introduced and nurtured."

Determining Optimal Scale And Scope

Our international review revealed the importance of identifying the optimal scope and scale of the integration initiative that physicians, as part of an interprofessional team, are meant to implement. Scope in an integration initiative refers to the breadth of the initiative, and in health care normally refers to the population(s) or the disease or condition of focus. It also refers to the specified range of services that are to be provided by the integrated providers.

Our research identified several jurisdictions that had embarked on primary care reform by building primary care infrastructure in the form of tripartite or bipartite alliances (ministry, district health board, providers). What is of note here is that these alliances establish structures

Spotlight On Success: MVP Clinics

The genius behind this story lies in the naming of the clinic — the MVP (Most Valuable Person) clinic is named as such because the patient is the most valuable member of the care team.

Dr. B. Elsey tells the story of how the Barrie Health Link has evolved over the past year. To approach the situation of complex patients, many of whom were unattached to a primary care provider, the Health Link team developed a multidisciplinary clinic for these patients. The allied health members providing care at the clinic include a nurse practitioner, a registered nurse, social worker, and pharmacist, with administration and managerial support. Family physicians provide support in diagnosis, care plan development, and linkage to other specialist support. The MVP clinic has internal medicine, psychiatry and geriatrician support. Increased ties have been developed with the local hospital's emergency department (ED) and discharge planning team.

Of note, in terms of the strengthening of key relationships, the ties to community mental health, crisis services and substance abuse care have also been strengthened. The clinical programs of the FHT are available to all these patients. The MVP clinic uses the same electronic medical record (EMR) as the 80 family doctors in the community and has access to the information at the local hospital EMR. Documentation in the EMR is standardized, allowing for data extraction and analysis.

In the future, patients will be transitioned to family doctors in the community, which is a true benefit to these individuals. The clinic will also act as a consultative opportunity for medically complex patients already attached to a primary provider.

The MVP clinic brings all the providers involved with these complex patients to the table to develop co-ordinated comprehensive care plans. The common EMR is the first step to developing secure, real-time communication between providers. The relationship with the local hospital, Royal Victoria Regional Health Centre, allows the first step to data sharing.

that enable clinicians, alongside managers, policymakers and others, to make decisions about scope — how to identify gaps, community needs and then apply resources to specific services to achieve the best outcomes. These collaborations recognize the importance of working directly with care providers and practices in local communities to accurately identify community need, promote physician ownership, and to increase the likelihood of success for patients and the system.

In the early-adopter Health Links, the primary focus has been on the 5% of the population who make the most use of the health care system, and whose care currently requires about two-thirds of our health care dollars. As Health Links have emerged, and as local community needs have become clarified in various areas, the definition of the highest needs patients has also evolved. This evolution recognizes the uniqueness of various neighbourhoods or geographies and encourages Health Link partners to identify their local need in terms of the patients that are the "highest touch" or "highest need," and then to work together to identify how Health Links can provide customized solutions to improve their care.

Identifying community need and what already works well in an area, or the ability to develop new solutions where needed, are among the most encouraging aspects of Health Links. The stories that have been shared about identifying the scope of each community Health Link have been wide-ranging, enlightening, and directly support the concept that these efforts must be "ground up" to be effective and to have local impact.

The Barrie and Community FHT was chosen as the lead organization for one of the 19 early-adopter Health Links, with Dr. B. Elsey as the lead physician. After examining the MOHLTC information in combination with data from other community sectors, such as the local hospital, the Health Links team decided to take an approach where they identified high-use patients by clinical need criteria. In this particular community it was apparent that many patients were unattached to a local primary care

Spotlight On Success:

Leveraging Existing Programs

To address gaps and build access to care in the high-density neighbourhood of St. James Town in downtown Toronto, the TC LHIN, in collaboration with partner organizations, spearheaded an initiative called Health Access St. James Town. Community leaders, physicians, and other providers were brought together to figure out first-hand what services the St. James Town community needed. Two necessary services rose to the surface from these honest discussions; a mobile dental clinic and a senior's mental health day program.

Acknowledging that dental care is an important aspect of general health, Health Access St. James Town brought a vital service to the community. The Mobile Dental Clinic is a dentist office on wheels — a bus that rolls into the community every two weeks to provide dental services to individuals who require care. As a result of this convenient and free service, over 120 clients have been served — people who may have otherwise not had the opportunity to visit a dentist.

To support seniors' quality of life and to encourage the aging-well-at-home philosophy, the St. James Town Mental Health Day program was launched. Offered three days a week, members participate in recreational activities, contribute to daily functions of the program and socialize with others. Since its launch in 2012, the program has welcomed more than 60 unique individuals.

With programs like these that answer to specific needs of a community, Health Access St. James Town has become an exemplar initiative that is transferable to other high-density neighbourhoods — a program that connects vulnerable populations to high-quality health care, and prevents worsening or increasingly complex illnesses among them.

provider. Dr. Elsey and his team determined that there would be considerable merit in finding a way to ensure these patients relied less on emergency department (ED) visits for their care and more importantly to ensure that these unattached patients did not allow chronic conditions to worsen to the point that hospitalization was required. Guided by the support for innovation in the Health Links model, and recognizing the important role of data sharing, the Barrie Health Link has designed an enhanced method of delivering care for these patients through a multidisciplinary clinic (see Spotlight on Success: MVP Clinics, p. 14).

The leadership of the Toronto Central (TC) LHIN has long recognized that issues and situational factors beyond health and the formal health care system have a dramatic impact on patients and those who will become patients. Toronto is an area of disparate neighbourhoods with equally divergent socio-economic factors at play in the health of each community. As such, the TC LHIN area has taken a deliberate approach to examine the broad range of factors that affect the well-being of citizens. Each of the emerging Health Links is being developed with community partners working together. The partners include not only those in the formal health care delivery system, but also include community representatives, and agencies that focus on addressing social determinants of health. The focus in the TC LHIN is to consistently use an equity lens to determine how Health Links can enhance the well-being of not only those who are currently high users of the system, but to enhance the well-being, and to prevent the development of complex health issues, for those who cannot access that same system.

In developing the Health Links for TC, the LHIN's existing experience in understanding the disparities in various neighbourhoods provides a strong place from which to start. Health Access St. James Town is an example of foundational work that can be leveraged and scaled to meet the needs of Health Links in the LHIN. St. James Town is a high-density neighbourhood in downtown Toronto, and is home to thousands of people. In this area there is a high concentration of newcomers, low-income families, and seniors living alone — vulnerable populations that often face barriers to health care. After an apartment fire displaced many residents in 2010, health disparities and service gaps were uncovered that impact the community's access to care. The TC LHIN took action to address these gaps and to build access to care in a way that foreshadowed the initiation of Health Links, and from which Health Links can build (see Spotlight on Success: Leveraging Existing Programs, p. 15).

Dr. Y. Abells, the PCPLL for the region, is thrilled that two of the Health Links in his area have identified at-risk children and youth as requiring the attention of Health Links. He sees these children who often have learning, social and/or emotional issues and he says that, as a physician, he is concerned when he sees a mother come into the office with a child like this because he knows that if their social, psychological and emotional difficulties are not dealt with at a young age, they are likely to become youth and adults with serious health issues. He believes firmly that the two Health Links that are focusing on this young at-risk population will see profound impacts — in terms of system efficiency and certainly in terms of patient outcomes. Keeping children well by meeting the entire spectrum of their needs and preventing them from developing health problems is an exciting objective that can be achieved through this initiative.

While there are stories about parts of the province that have considerable knowledge about the gaps and opportunities in a particular locale, others have focused their attention on validating or disproving assumptions about the needs or opportunities in their communities. All the emerging Health Links have undertaken efforts to identify and validate the needs or gaps in their areas. The Thousand Islands Health Link, for example, identified addictions and mental health as a priority in their region. The Addictions and Mental Health Navigation Committee was formed in July of 2013, with the goal of improving addictions and mental health across the Thousand Islands region, which encompasses Brockville, Athens, Prescott, Gananoque, Lansdowne, and Seeley's Bay. The committee chose to undertake a systematic approach to

> "We are inspired to continue this work using innovative patient-centred models to improve the health care of at-risk populations."
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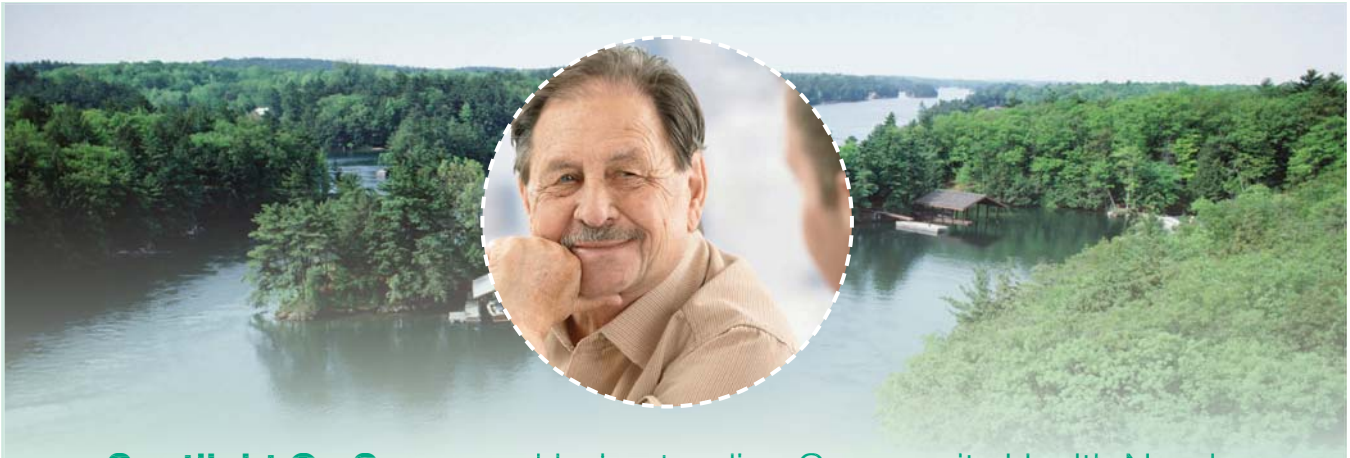
> *Dr. Pauline Pariser, Toronto*



Spotlight On Success: Understanding Community Health Needs

The Thousand Islands Health Link is composed of many partners, including those who form the Addictions and Mental Health Navigation Committee. Members of the committee include: the Upper Canada Family Health Team, Community & Primary Health Care – Community Family Health Team, Brockville General Hospital – Mental Health Services, Leeds Grenville Mental Health, Royal Ottawa Health Care Group – Brockville Mental Health Centre, TriCounty Addiction Services, and Children's Mental Health of Leeds & Grenville. Recognizing the need in their region to address addictions and mental health care, they came together to better understand the problem and to then develop solutions that would work for their citizens. The Health Links Committee used surveys and co-ordinated care plans to reach their goals.

They started by wanting to be specific about the areas that most need improvement, as well as to gather perspectives from different groups. The groups surveyed include: primary care providers, addictions and mental health care providers, specialists, administrative staff, and members of the community. The Health Link used FluidSurvey (online surveys) as well as paper surveys and have found the results to date, both "alarming and constructive." They heard stories from providers about how there are not enough resources for their patients, particularly children, and that their overall experiences in the referral process have been negative. They heard from community members that wait times to access services are unacceptable; waiting weeks to start counselling or treatment after requesting it is frustrating and disheartening for some. They also heard that members of the community found talking one-on-one with a provider is very helpful, and made them feel supported in the treatment process.

The Thousand Islands Health Link Addictions & Mental Health Navigation Committee has made great progress to date on the early steps of co-ordinated care planning. The Health Link has taken what they learned through the survey and used the information to determine gaps in the addictions and mental health care system in that area. The committee developed a patient consent form and intake form, and the Health Link is utilizing the co-ordinated care plan developed in the TC LHIN.

A request has been sent to physicians in the region to refer patients that they feel would benefit from co-ordinated care planning — those continually accessing the ED, their primary care provider, and various addictions and/or mental health resources, but who are not getting the individualized care they need or the outcomes they deserve. Two registered nurses on the committee are leading the co-ordinated care plans, and will assess patients that are referred by their provider. After assessment, the nurse/navigators will be responsible for finding the appropriate resources for these patients, whether that be referrals to services, assistance in housing, or assistance with navigating the system.

As the Thousand Islands Health Link Addictions & Mental Health Navigation Committee continues its work, they are very excited to see the results of the co-ordinated care plans, and the positive outcomes they will have for their patients. As well, they anticipate their work will lead to improvements to the addictions and mental health care system across the Thousand Island Health Link.

analysis of the needs that they had identified, and they did so through survey methodology (see Spotlight on Success: Understanding Community Health Needs, p. 17).

In health system integration initiatives, scale is an important feature that refers to the size of the population or geographic area around which care is centred and integrated. Our research showed that determining appropriate scale has been noted as a significant challenge for the jurisdictions we examined. The challenge of scale determination is that policymakers and providers are facing a trade-off between staying local and responsive versus being efficient and having the right size to exploit economies of scale to maintain necessary management support and handle service risk. In Ontario's Health Links initiative, the scale has been determined to have a minimum population base of 50,000 people and tends to have an upper limit of about 150,000. For some regions in Ontario, the issue of scale is of considerable importance because of geography and population distribution. If the scale is right, it means that the providers have "local enough" relationships that are already in existence to foster shared focus on the outcomes, while at the same time realizing the benefits of economies of scale. Issues of scale become apparent, for example, when considering the density of population in and near large cities such as Toronto, which require different approaches than those areas that are more remote or rural. In Ontario, those interested in participating in Health Links are working with their LHIN partners and the MOHLTC to appropriately identify the needs in their local community and to develop solutions to address those needs.

Support for local approaches that are tailored for a community, in the "low-rules" environment that has been

Spotlight On Success: Using New Ways To Engage

Let's face it, when it comes to communication between all the various providers of health care, there's room for improvement. Dr. J. Everson understands that these are busy people who barely have time to blink let alone convene to have deep conversations about the problems and potential fixes for the health system, and in this case, for our complex patients in the system. In November of 2013, the Hamilton Niagara Haldimand Brant LHIN and the OMA did just that.

The two organizations jointly developed and then hosted an event for family physicians, psychiatrists, medical students, and psychologists to explore what integrated care might look like in the region for complex high-needs mental health patients. Furthermore, they explored how Health Links can play a key role in increasing co-ordinated care for these individuals. With an even split between family physicians and mental health providers present, the conversation was rich and has since informed the HNHB LHIN in its Health Links work.

Recognizing the rare opportunity to get family physicians and psychiatrists in the same room, it was of utmost importance to ensure the discussion was facilitated in a meaningful way. Collaborating to develop the content, the OMA developed three fictional video scenarios to depict some of the "typical" characteristics of high-user patients and their journeys through the system, both with and without Health Links: an isolated senior with multiple chronic conditions and mental health issues who could not access primary care; a woman with chronic obstructive pulmonary disease (COPD) and depression whose family physician sends her to the ED for a rapid psychiatric assessment; and a man with an acquired brain injury showing signs of multiple physical and mental health issues, whose family physician was not aware that he relies on the ED so heavily. After viewing the videos, participants were separated into small groups and led through a modified TRIZ problem-solving exercise (TRIZ is the Russian acronym for this theory of inventive problem solving — *Theoria Resheneyva Isobretakelskehuh Zacach*). The participants first identified high-level system issues evident across the three videos, followed by the scenario-specific issues for each video respectively. Finally, and most importantly, groups identified and discussed "low-hanging fruit" solutions to these issues.

Most of the solutions identified are in fact core principles of the Health Links model: a co-ordinated, integrated model of care that brings together patients and providers from across the continuum in an in-depth care planning process. The HNHB LHIN is using what was learned through this innovative strategy to encourage the inclusion of these solutions in the roll-out of Health Links in real and tangible ways. In partnership with the LHIN, the Health Links are working on strategies that incorporate most, if not all, of the solutions that were brought to light at this event. Dr. Everson notes, "We are looking forward to continuing to work with the OMA in 2014 to bring family doctors and specialists together to identify solutions and innovative partnerships within our community Health Links."

facilitated by the MOHLTC's transformation secretariat, has resulted in Ontario's physicians being leaders in transforming the health system while improving the experience of patients with high needs. The low-rules framework adopted by the MOHLTC as Health Links have come forward has meant that there is considerable innovation being demonstrated locally and provincially. One of the areas where innovation has been exercised is through providing mechanisms for various groups to have open and honest, facilitated discussion about the needs of their region. There is a need to do things differently in the level of engagement and communication between family physicians and various specialists. If Health Links are to successfully integrate the care of complex patients, then primary care and specialty care must make the time to communicate and to develop solutions together. The HNHB LHIN has a focus on mental health and recognized a need to better engage mental health providers in the discussion about Health Links. Within the Health Links framework that supports innovation, Dr. J. Everson and her team partnered with the OMA to encourage this open dialogue (see Spotlight on Success: Using New Ways to Engage, p. 18).

Recognizing the importance of scale and keeping things local, with community input, has been an important part of the enthusiasm for, and early success of, Health Links. The Mid-West Toronto Health Link is situated in downtown Toronto and as such includes both an ethnically diverse population as well as a diverse range of health care providers, including close to 460 family practitioners and several regional centres, such as Centre for Addictions and Mental Health (CAMH), Hospital for Sick Children, and Princess

Spotlight On Success: Caring For Marginalized Patients In A Health Link

Dr. P. Pariser, Lead Physician in the Mid-West Toronto Health Link, writes:

In assessing patient complexity, our Health Link partners developed an algorithm that described the various factors that put patients at risk for high use of the health care system. Beyond being 65 or older, taking multiple medications and having multiple co-morbid medical conditions, what distinguished complex patients was also having a psychiatric condition or substance dependency, and not meeting the social determinants of health. These marginalized patients often do not have stable living circumstances, are challenged with respect to transportation, and lack supportive caregivers. They may lack attachment to a primary care provider or be poorly attached, in that they have difficulty accessing consistent care. These factors are associated with increased morbidity and premature death — on average, 25 years below life expectancy.

To address this health care crisis in our Health Link, we established a working group to address the needs of complex vulnerable patients, co-chaired by a survivor with lived experience of mental health challenges, and myself as the Lead of the Health Link, and with participation of a solo family physician who had been caring for marginalized patients, the CCAC and a number of community support agencies, Community Health Centres and Family Health Teams involved with this population. Together, we formulated a plan that would engage complex vulnerable patients in a peer-to-peer outreach strategy to help attach them to skilled and sympathetic health care providers, as well as hold a workshop to support primary care providers with resources to care for this population.

Our first peer-to-peer outreach event occurred at St. Stephen's Community Centre in Kensington Market on November 20, 2013, with four peers from a group called "Voices from the Street," and two family physicians presenting both the benefits and barriers to finding family physicians. Sixty people attended and sat almost spellbound listening to people, who like them, had lived on the street — one woman on the same park bench for 23 years! — and had survived and taken charge of their health. Twenty-two people are now in the process of being connected to primary care providers, with another 10 being assisted in obtaining identification to qualify for OHIP cards. Our plan is to hold two more similar events between now and the end of March 2014.

On December 2, we held a MainPro C accredited educational event entitled "Caring for Marginalized Patients: Practical Tools for Busy Family Docs." Thirty-five family physicians attended this combination of a seminar and small group breakouts facilitated by experts such as Dr. Gary Bloch, who has developed Poverty Assessment Tools for the Ontario College of Family Physicians, and our patient group from Voices from the Street. The evaluations of this event were very positive and there is interest in a further workshop to assist family physicians with resources to care for patients with addictions.

Spotlight On Success: Thinking About Integrated Care, Day To Day

At this point in time, Dr. M. Kates still sees patients in his practice whom he views as being potential Health Links patients, but who represent opportunities lost because they were not identified by the system for inclusion in a community Health Link. As such, he has identified some areas in the Health Link model that continue to need work, and he shares his story to ensure that we learn from these experiences.

One patient was recently discharged from hospital, and Dr. Kates tried to make the referral to Health Links while he was still in hospital. Unfortunately, the attending surgeon responsible for his in-hospital care was not aware of Health Links. The patient had undergone spinal surgery and needed rehabilitation, had co-morbidities to deal with, and when the surgeon became aware of Health Links, the patient had already been discharged and the "train had left the station," so to speak. This patient was lost to followup until he returned to the office, at which time he had forgotten to provide the discharge note because as the patient noted, "the doctor hadn't asked for it." Multiple issues had to be addressed at the appointment, including severe headaches, rehab problems, medication reconciliation and next steps in his recovery. His daughter raised her concerns about these issues and when Health Links were described to her, they shared the frustration of what could have been avoided with integrated care — what Dr. Kates refers to as a potential "Health Links Moment."

Another patient created considerable anxiety for Dr. Kates because of his health care trajectory: he was in hospital and discharged home with a LACE score of 13, meaning he had a higher risk of readmission based on the score alone. Dr. Kates received an electronic file on his EMR suggesting that the patient be seen within seven days. Unfortunately, without any conversation with his family physician, the patient was sent home with multiple concerns, including a heightened risk of falling. Perhaps not surprisingly, after he went home, and before he could be seen within the seven-day timeframe, the patient fell and unfortunately had to be readmitted. As Dr. Kates reflects on these events, he concludes that this patient had a "one-way ticket" back to the hospital because there was no "warm" handover, no co-ordinated care, and no community navigation — a definite Health Link opportunity lost.

Dr. Kates increasingly identifies these potential Health Links patients, but recognizes that, at times, the system still is not identifying them. As he continues to champion the integrated care model, Dr. Kates believes we will get there with Health Links, and he tells his story to help us to focus on the need to include patients in Health Links before they leave the institution.

Margaret Hospital, where the majority of patients come from outside the geographic boundaries of the Health Link. With scale in mind, this is one of the largest Health Links in the province. The Mid-West Toronto Health Link, led by Dr. P. Pariser, has devoted considerable energy and effort to understand what patient complexity means in their Health Link, and as a result have been able to keep the solutions meaningful in their local environment (See Spotlight on Success: Caring for Marginalized Patients in a Health Link, p. 19). They have taken a broad view of complexity, which encompasses factors beyond a purely medical model.

Patient-Centred Focus

Ultimately, at the core of the concept, Health Links are about providing better, more integrated care for patients, particularly those with complex needs. A key foundational principle is that the plan to enhance care for complex patients for each local initiative be patient centred. This means that throughout the development and implementation of Health Links, the focus remains on meeting the needs of people in their local communities. Dr. R. Drury of the CE LHIN talks about the power of patient centredness as a way of thinking that can overcome historic or previously insurmountable barriers. As Dr. Drury paved the way for Health Links in his LHIN by visiting with various organizations and groups of providers to talk about the problems they faced in caring for these patients, the needs associated with these challenges and the role of better integrated care to meet those needs, he found that it took very little time for the conversations to drift away from an emphasis on the organizational differences to the things they had in common and the needs of their complex patients that each were providing care for. As each of the participants listened to the patient stories together, the various stakeholders found they could agree on certain collective approaches. In this experience, Dr. Drury found that those team members who were closer to the front lines of care delivery found it easier to be patient centric rather than organization

Spotlight On Success: Changing The Patient Experience — One Patient At A Time

A physician in the North York Central Health Link tells the story of a young adult with a very complex medical profile: taking 24 medications and seeing 23 specialists in addition to her primary care physician. This young woman has multiple complex diseases that cause symptoms that affect her ability to manage independently in the community. Waiting for multiple specialist appointments has left her feeling frustrated and helpless. Ultimately, the patient's inability to manage this complex set of conditions results in frequent trips to the hospital ED, and a poor quality of life at home.

As a result of the purposeful physician engagement and resulting heightened awareness that was evident in the region, her primary care physician recognized that the patient was a suitable candidate for Health Links. After being enrolled in the Health Link, the patient met with a care co-ordinator from the Central CCAC, who organized a case conference. Participants in the case conference included the patient, the patient's spouse, the primary care physician, a diabetes nurse, the patient's wound care nursing provider, and a pharmacist who was needed for medication reconciliation. Once the care team jointly agreed upon priorities to manage the patient's care, a co-ordinated care plan was completed. The plan was reviewed by all members of the team to ensure they each understood their individual and collective responsibility to help better manage this patient's complex care.

After just a few weeks of close followup with the team of care providers and the care co-ordinator, the patient is learning to self-manage symptoms. Her diabetes is under control, and she takes fewer medications. She has lost weight and the wound on her foot has healed. Although complex medical issues remain, the patient now relies less on the ED and says that she "feels like a new person" due to her improved quality of life.

By being a part of the Health Link and having a team committed to providing co-ordinated care, the patient experienced a drastically different style of care as compared to her care prior to enrolment in the Health Link. The Health Link created a personalized care network that was characterized by improved co-ordination, information sharing and collaboration.

By putting the patient at the centre of the plan, the Health Link team learned that if we only measure ED visits and hospital admissions for complex patients, we are missing a tremendous opportunity that the Health Links model provides — a patient with more and better information about their care, a voice at the table, and an extended care team that feels they have been successful in delivering high-quality care. The care team saw first-hand how the delivery of care positively impacted this patient's life and care trajectory and they are motivated to continue that trend — not only with this patient, but with other similar complex patients. This patient's story shows how a collaborative and multidisciplinary approach yields positive results. The key is that these improved results are enjoyed by both the patients and providers alike. This patient made clear the value of Health Links when she said, "Health Links is the best thing that ever came about — you saved my life."

centric. Those involved in the process of initiating Health Links were aware that they needed to continuously return the conversation to be about the needs of the patients and not the needs of the organization — this has allowed them to move ahead successfully as they initiate Health Links in their region.

Our physicians in Health Links have talked about not only focusing on identifying patient needs in terms of populations, but there is a heightened awareness of individual patients who could potentially benefit from the co-ordinated care planning that is central to Health Links. Dr. M. Kates, the PCPLL in the Mississauga Halton (MH) LHIN, is a champion of Health Links and shares his experiences in his own practice as he sees and cares for his patients with complex needs (see Spotlight on Success: Thinking About Integrated Care, Day to Day, p. 20). He shares his stories of patients who continue to be missed in the early days of Health Links — those lost opportunities where he identifies a potential Health Link patient, but the system has not. His belief in the Health Link model is resolute, and his own experience has led him to recognize the gaps that need to be addressed in order to improve effectiveness.

Most importantly, better integrated care matters to patients and their families and caregivers. Patients who are living with complex conditions, and navigating a complex and multi-layered system, often without any assistance, face considerable difficulties and recognize the need for better co-ordination. Co-ordinated care matters to patients and matters to their caregivers. A story from the NYCHL clearly teaches a valuable lesson — that an individual with complex health conditions can see their quality of life and independence improve significantly when they and their health care providers come together as a team (See Spotlight on Success: Changing the Patient Experience — One Patient at a Time, p. 21).

As Dr. J. Kerr reminds us in his story (See Spotlight on Success: Patients at the Heart of Health Links, below), as long as the patient remains at the heart of Health Links, we will not only improve the efficiency of the system, but more importantly we will improve the experience of patients.

Summary

These stories from the early days of Health Links in Ontario help us to answer the question, "How do we co-ordinate and embed the enabling supports needed to create a more integrated system for all?" Interprofessional teams involved in integration initiatives must have access to the knowledge they require, be enabled to act locally, and be supported and equipped to operate within and between organizations with linked infrastructure. In the case of Health Links in Ontario, these teams need to identify ways to have shared assessments, common standards, care co-ordination and shared care plans for the most complex patients.

The experiences and needs of physicians and other providers working to integrate care in Ontario, as well as the patients they care for, are reflected in these stories. As Health Link partners organize to realize the benefits of interprofessional care for their patients, particularly those complex patients for whom we seek to enhance care, the OMA appreciates the willingness of leaders to share their successes and what they have learned from early attempts at integration so that we can continue to refine the Health Links model of integrated care for the benefit of all Ontarians. ■

For more information on Health Links, contact Maggie Keresteci, Senior Director, Health System Programs, at healthlinks@oma.org, or visit www.oma.org/healthlinks.

To view the three previous articles on the OMA's jurisdictional review about integrated care and Health Links, visit https://www.oma.org/benefits/healthlinks/pages/default.aspx. For a complete list of acknowledgments, please see "Health Links: Part 2 — The Importance of Infrastructure" (October 2013 OMR, p. 30).

Spotlight On Success: Patients At The Heart Of Health Links

"I am pleasantly surprised with how enthusiastic patients have been towards Health Links," says Dr. J. Kerr, Lead Physician for the South East LHIN. He goes on to tell the story of when he first introduced the Health Link concept to one of his patients, and when he realized the true power of the Health Links model:

"I began by outlining how the community is working together to wrap care around her. As I described the model of care behind Health Links she broke down in tears in my office. She was incredibly thankful that my colleagues and I were putting her interests and priorities at the forefront of the care planning process. During the first meeting of the entire care team with the patient and her family, the value of the Health Links initiative became apparent immediately. As it turned out, there were many aspects about her life and health that I did not know about, despite being her family doctor for many years. Knowing that complex patients require more care than I alone can provide as her family physician, I was thrilled to see this increased level of co-ordination in her care and the impact even the knowledge about the co-ordination has had on her experience with health care."