Welcome to the Leadership Summit 2018

Population Based Approach to Care

Building on the Experiences of Improving Care for Patients with Complex Needs

NOVEMBER 30TH 2018

WELCOME & OPENING REMARKS:

LEE FAIRCLOUGH, VICE PRESIDENT, QUALITY IMPROVEMENT, HEALTH QUALITY ONTARIO

PAUL HURAS, CHIEF EXECUTIVE OFFICER, SOUTH EAST LOCAL HEALTH INTEGRATION NETWORK

Leadership Summit

Sommet du leadership

#HQOLSummit2018

Health Quality Ontario

Let's make our health system healthier

Summit Objectives

- Learn about the patient experience and how care is coordinated and delivered for those with complex conditions and needs
- Discuss how the model of coordinated care has matured over time to create new opportunities to improve care for broader populations
- Discuss how to apply lessons learned to improving mental health and addictions care more broadly in Ontario
- Engage with thought leaders, patients, and like-minded clinicians to share, learn, and accelerate action on health system priorities

Building on the Experiences of Improving Care for Patients with Complex Needs

- Success made possible by the dedicated leadership in this room
- We continue to see progress and benefits to patients
- Going forward, we must increase focus on implementing key practices and supporting improvement initiatives among teams
- This approach to care is a collaboration between patients and teams, with support from the LHINs, Health Quality Ontario, MOHLTC, HSSO, and many others

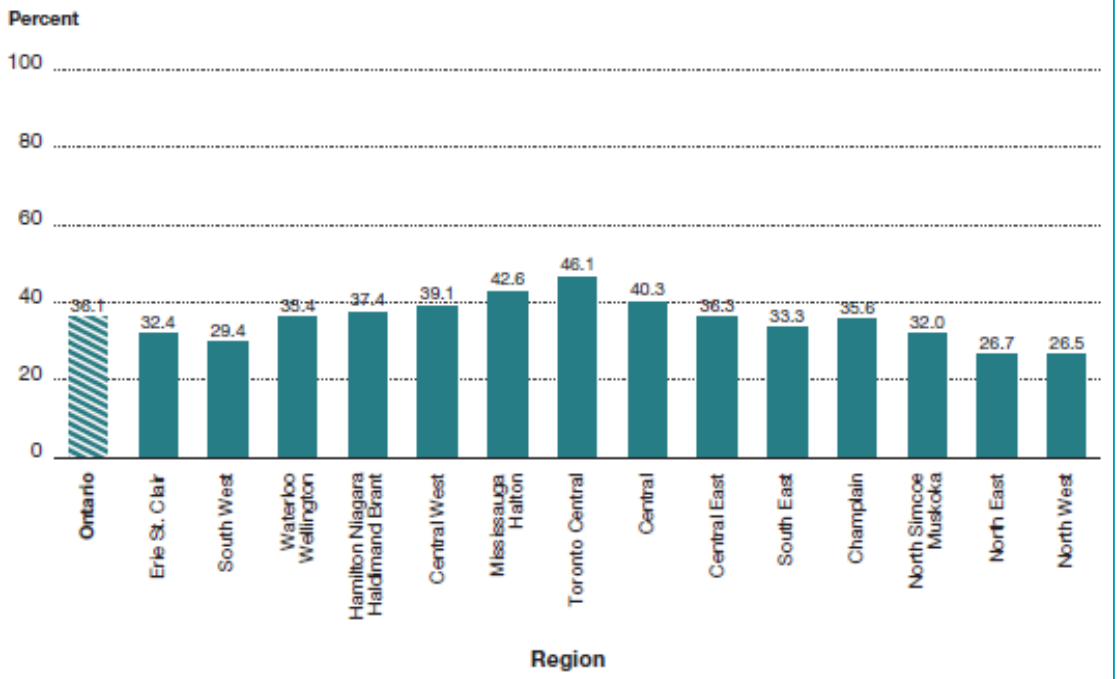
Key Achievements

- The number of patients being identified and receiving improved coordinated care planning continues to grow
- The way in which teams and providers are providing coordinated care is maturing, with a stronger patient-centred focus, increased access to care, and improved processes
- We have new ways of measuring and understanding the care provided and its impact

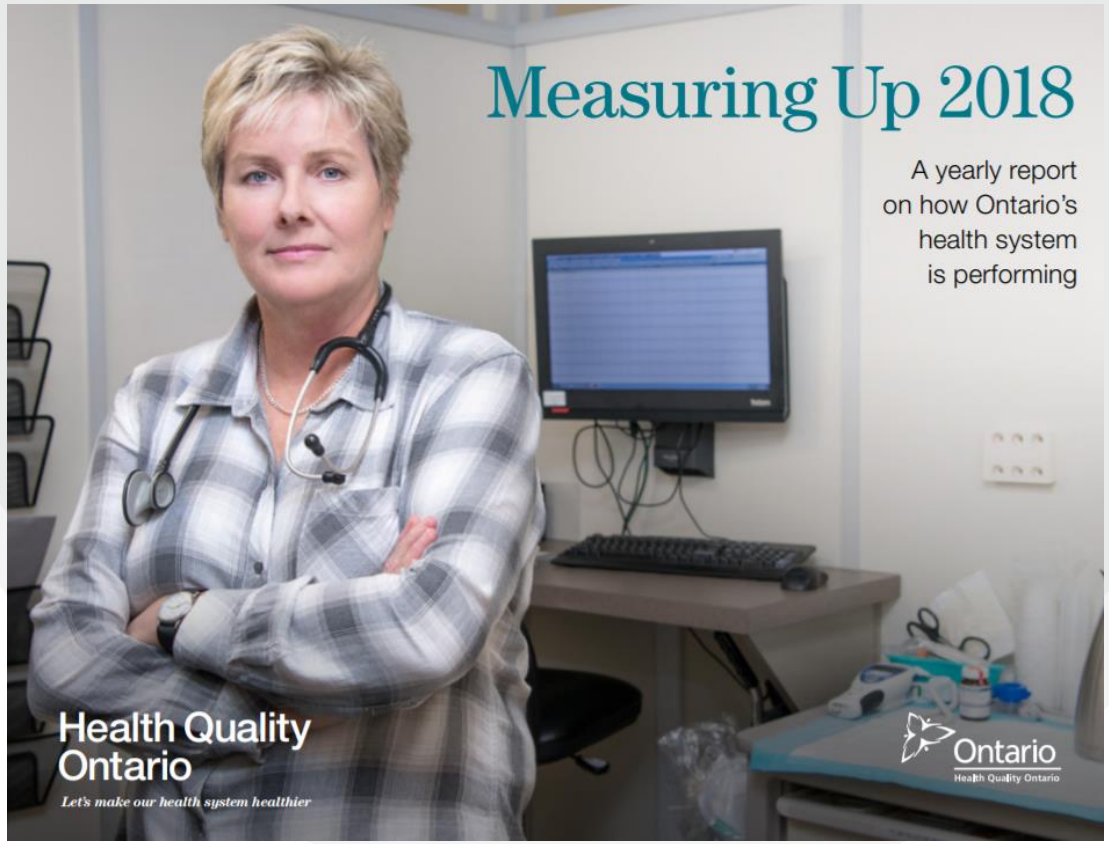
Focus: Mental Health and Addictions

Timeliness of follow-up visits with a doctor after hospitalization for a mental illness or addiction varies by region

FIGURE 5.2 Percentage of patients aged 16 and older who were seen by a general practitioner/family physician or psychiatrist within seven days of discharge after being hospitalized for a mental illness or addiction, in Ontario, by region, 2016



Data source: Ontario Health Insurance Plan Claims History Database, Ontario Mental Health Reporting System, Registered Persons Database, Discharge Abstract Database, provided by the Institute for Clinical Evaluative Sciences
Note: Age- and sex-adjusted



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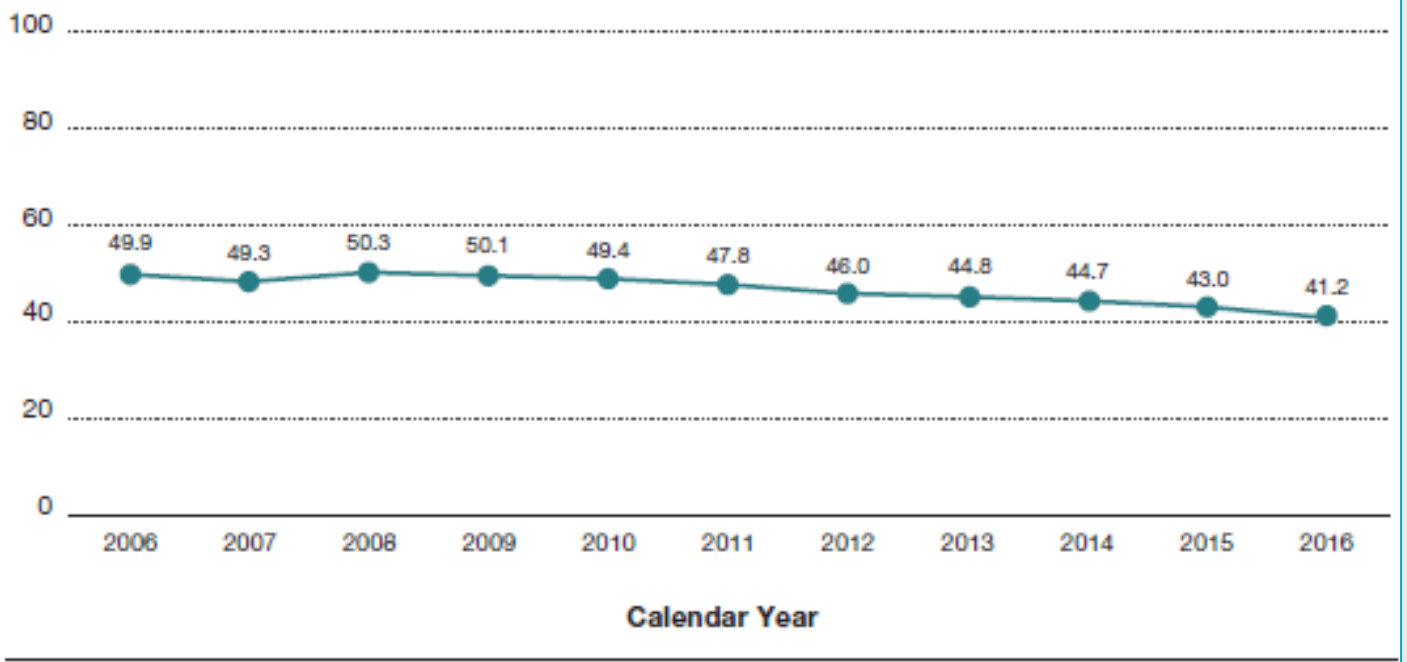
Fewer children and youths are receiving their initial point of contact for a mental health condition in the emergency room

FIGURE 5.1 Percentage of children and youths 0-24 years old who did not receive mental health care from a family doctor, pediatrician or psychiatrist in the two years preceding a visit to the emergency department for a mental illness or addiction, in Ontario, 2006–2016.

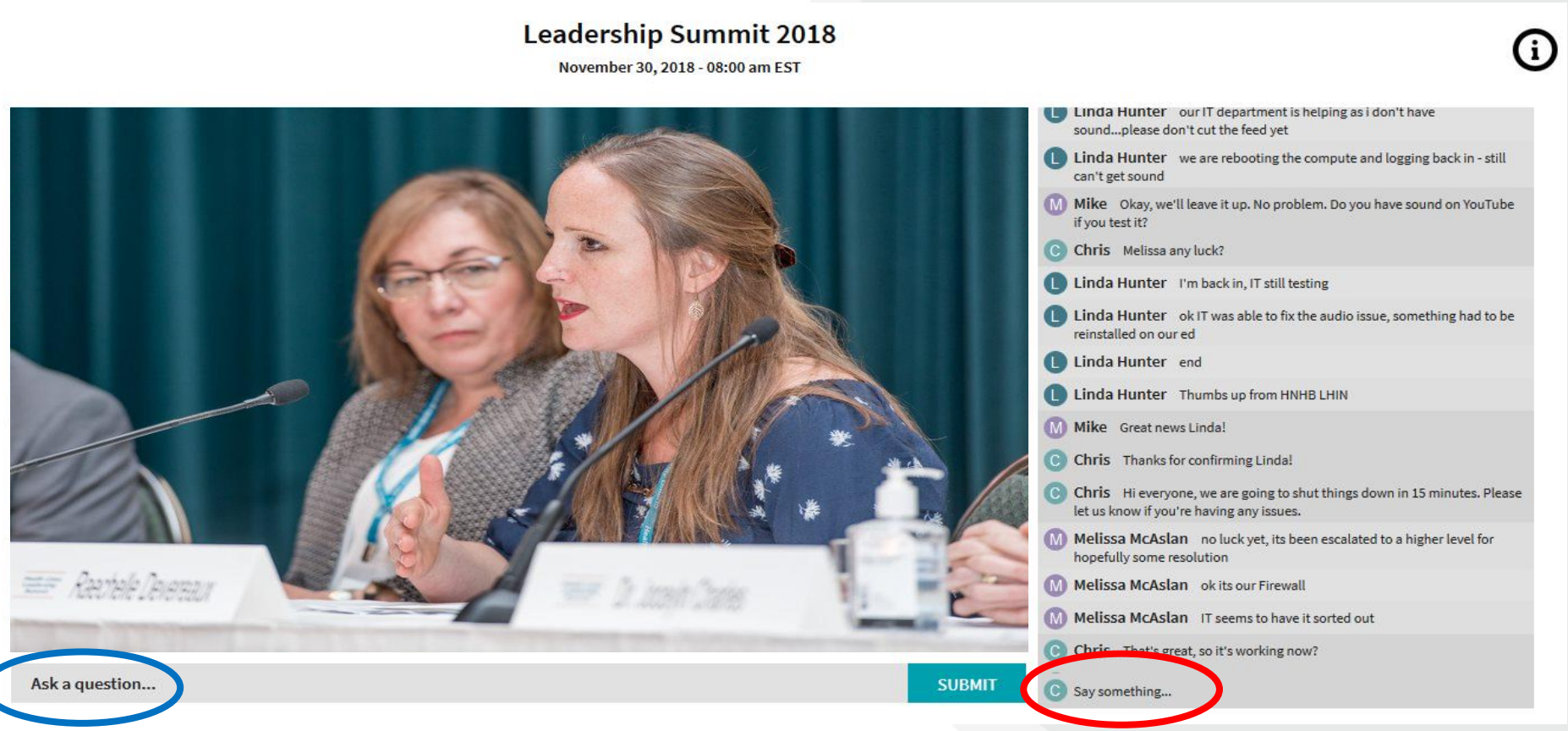


Data source: Ontario Health Insurance Plan Claims History Database, Ontario Mental Health Reporting System , Registered Persons Database, National Ambulatory Care Reporting System, Discharge Abstract Database, provided by the Institute for Clinical Evaluative Sciences
Note: Age- and sex-adjusted

Today's Agenda

Time	Session
8:30 – 8:55 a.m.	Introductory Remarks
8:55 – 9:55 a.m.	Plenary #1: Improving Patient Care through Successful Transitions and Coordination
9:55 – 10:30 a.m.	Remarks from the Deputy Minister, Ministry of Health and Long-Term Care
10:30 – 10:45 a.m.	Networking Break
10:45 – 11:30 a.m.	Plenary #2: Collaboration/Relationships enabling Partnerships
11:30 – 12:45 p.m.	Lunch
12:45 – 2:00 p.m.	Breakout Sessions: • Improvements in care coordination through digitally enabled technology • Benefits in care as patient identification and coordinated care progress in maturity • Joint efforts for quality improvement in Mental Health and Addiction care
2:00 – 2:15 p.m.	Networking Break
2:15 – 3:15 p.m.	Plenary #3: Applying Lessons Learned to Mental Health & Addictions in Ontario
3:15 – 4:15 p.m.	Plenary #4: Fireside Chat: Innovation designed to close the gaps
4:15 – 4:30 p.m.	Closing Remarks

Virtual Participants Can Join the Conversation



If you want to 'Ask a question…' to a presenter, please type your question below the Leadership Summit video stream.

If you want to 'Say something…" to your colleagues across Ontario, please type your thoughts below the public chat.

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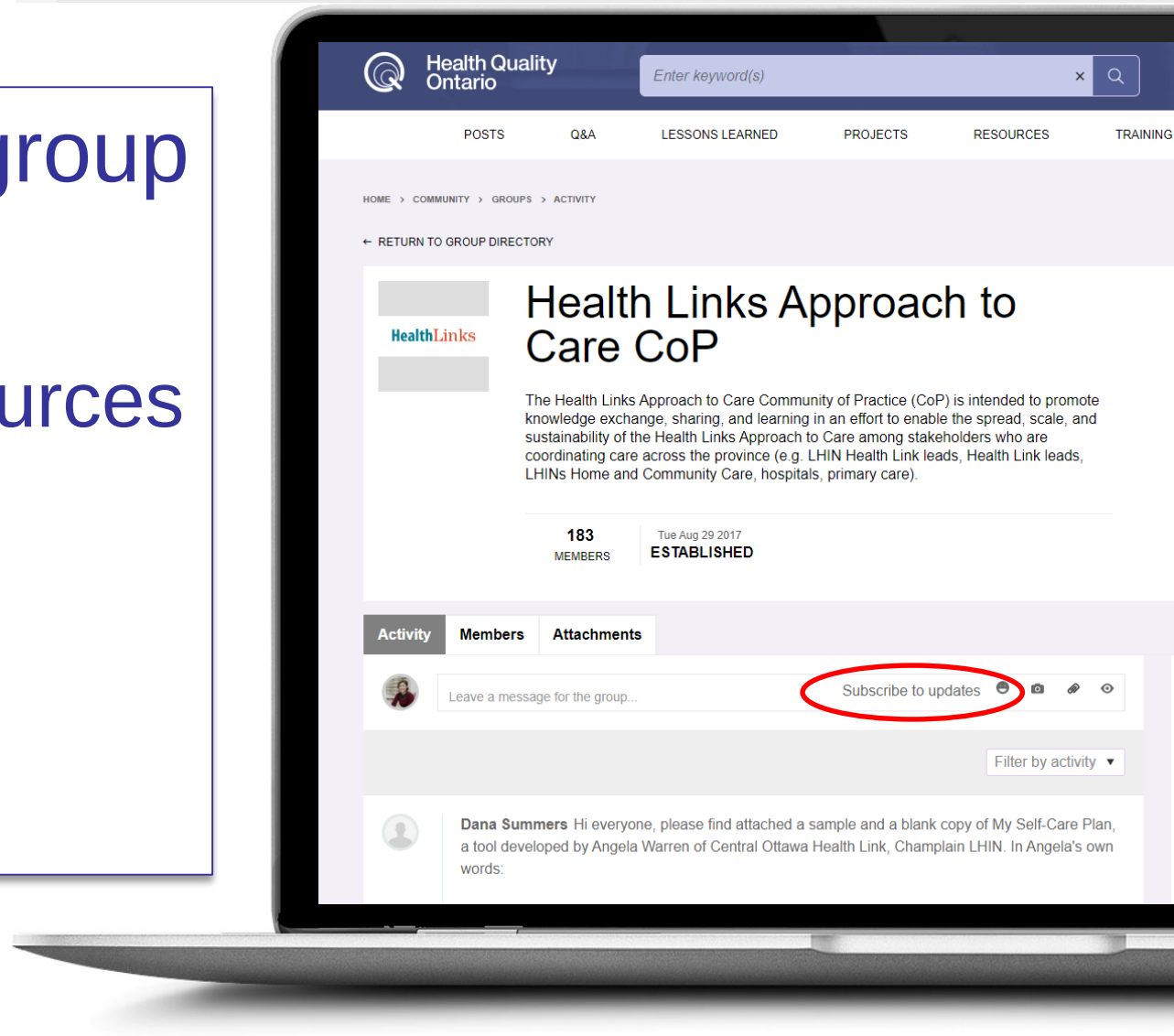
Health Links Approach to Care: Community of Practice on Quorum

Join and subscribe to the group to:

- ✓Find and share useful resources
- ✓Problem-solve with others
- ✓Share your work
- ✓Stay in the loop!



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Thank you.

- *Patients, Family/Caregiver and Public Advisors*

Thank you.

Planning Team

- *Kamal Babrah*
- *Annette Bradbury*
- *Connor Cleary*
- *Courtney Paxton*
- *Lorri Eckler*
- *Joanne Fernandes*
- *Phil Graham*
- *Trisha Gnaneswaran*
- *Paul Huras*
- *Sue Jones*
- *Kim Kinder*
- *Maya Kwasnycia*
- *Mandy Lee*
- *Jennifer Little*
- *Chris Maragh*
- *Julie Nicholls*
- *Dave Pearson*
- *Mark Simmons*
- *Julie Skelding*
- *Mel Patenaude*
- *Kim Sontag*
- *Tammy Stadt*
- *Dana Summers*
- *Nadia Surani*
- *Debbie Taylor*
- *Janine Theben*
- *Lesah Wood*
- *Jessica Wright*

Paul Huras

CHIEF EXECUTIVE OFFICER

SOUTH EAST LOCAL HEALTH INTEGRATION NETWORK

Improving Patient Care through Successful Transitions and Coordination

Objectives

- Learn how to empower patients to transition successfully across sectors/organizations using coordinated care plans
- Understand how addressing the social determinants of health impacts the success of patient care
- Using data to understand the system impact on patients with complex needs

Improving Patient Care Across Sectors
“Coordinating Care – creating successful transitions”

Tammy Stadt, **Patient**
tammy@stadt.ca

My Background

- Full disclosure: NOT a Health Links patient!
- Complex patient: Hypermobile Ehlers-Danlos Syndromes (hEDS)
- 20 years' experience in client navigation and health promotion at a community health centre
- Act as patient representative on Health Link steering committee
- Member of HQO's Clinical Reference Group for Health Links

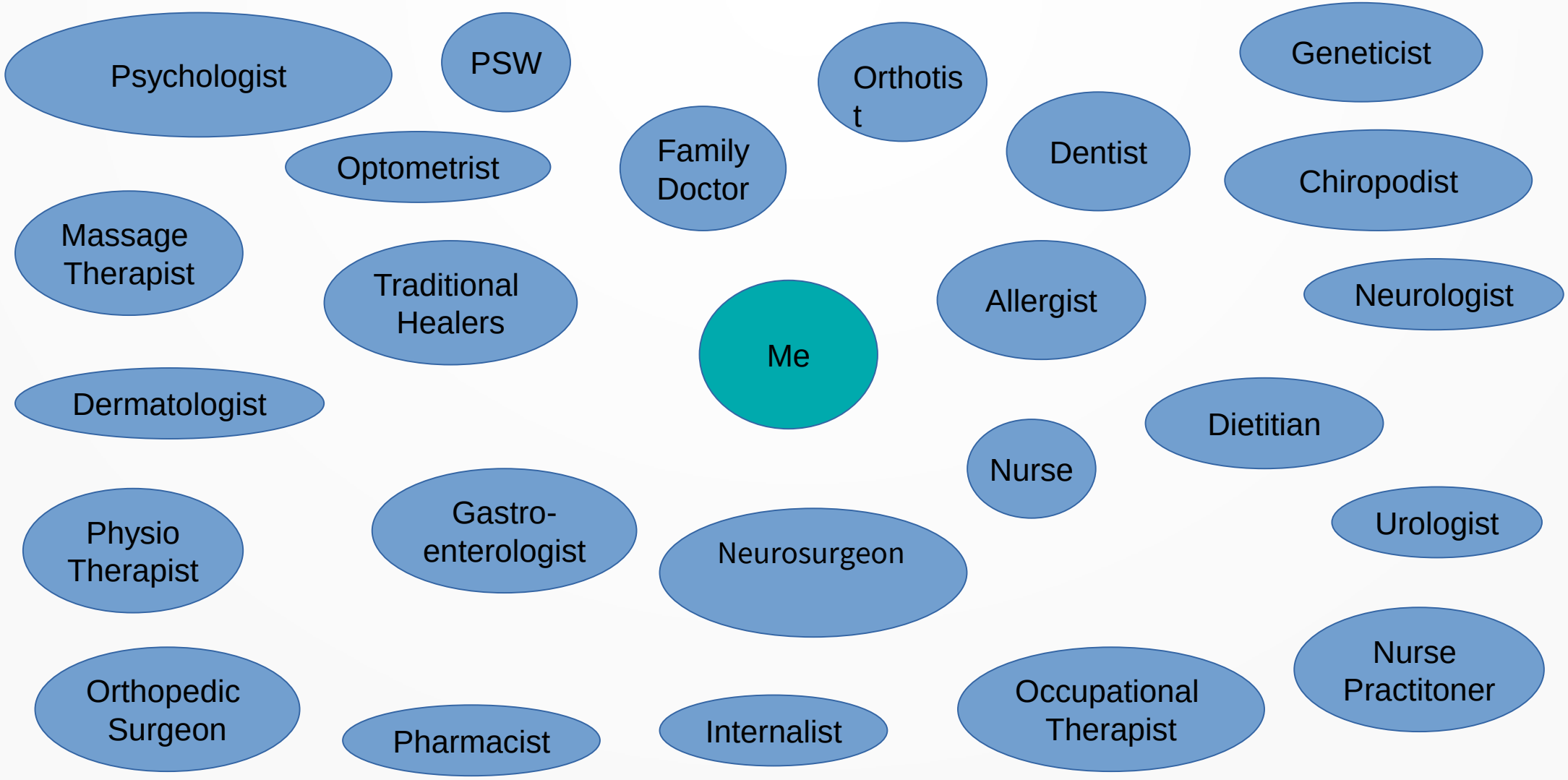
A Unique Perspective

My unique perspective: combination of complex patient with client navigation expertise and knowledgeable about Health Links

My experience provides insight into how people working in care coordination and system navigation can help patients:

- Become empowered self-advocates
- Manage their own health
- Transition more successfully across sectors
- Improve their wellbeing
- Reduce their use of health care resources

My Care Team


Psychologist
PSW
Orthotis t
Geneticist
Optometrist
Family Doctor
Dentist
Chiropodist
Massage Therapist
Traditional Healers
Me
Allergist
Neurologist
Dermatologist
Dietitian
Nurse
Physio Therapist
Gastro-enterologist
Neurosurgeon
Urologist
Orthopedic Surgeon
Pharmacist
Internalist
Occupational Therapist
Nurse Practitoner

Self Management Plans

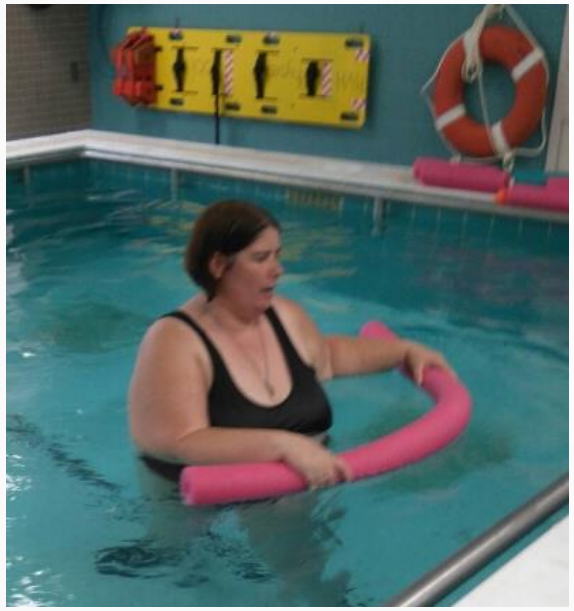
Self-management plans help me manage my care between appointments, and help me transition successfully across sectors

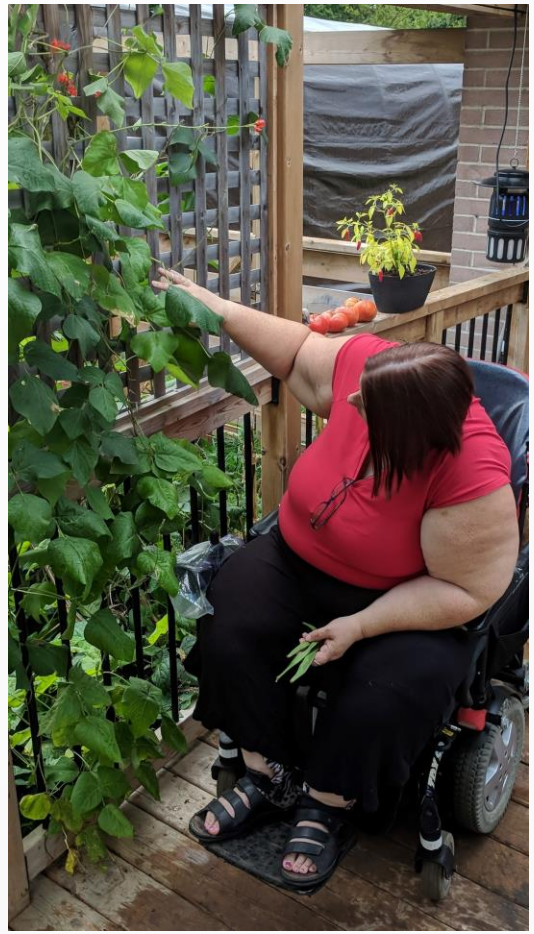
- Asthma Action Plan
- Food Allergy Management
- Medication Management
- Anaphylaxis
- UTI prevention/treatment
- Self Cathing when required

Lessons Learned

Empower patients to be at the centre of their own care by:

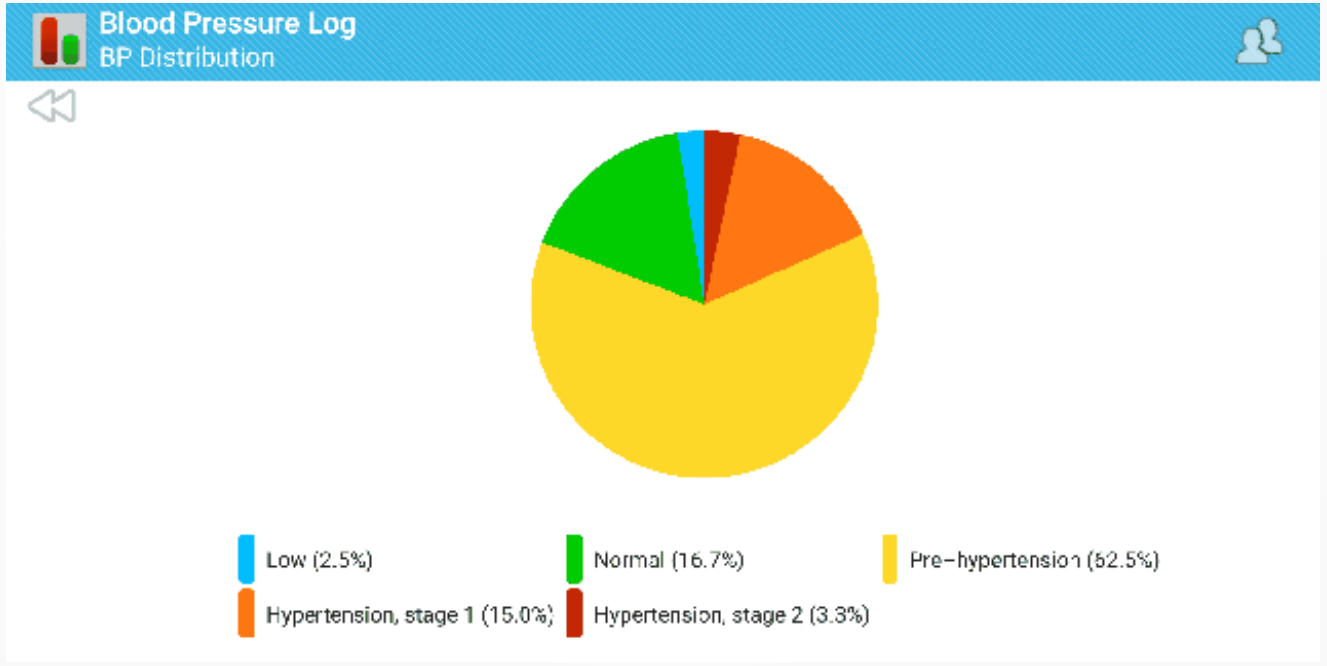
- Encouraging use of Chronic Disease Self-Management Program
- Encouraging use of 211 to aid navigation
- Encouraging wellness and prevention





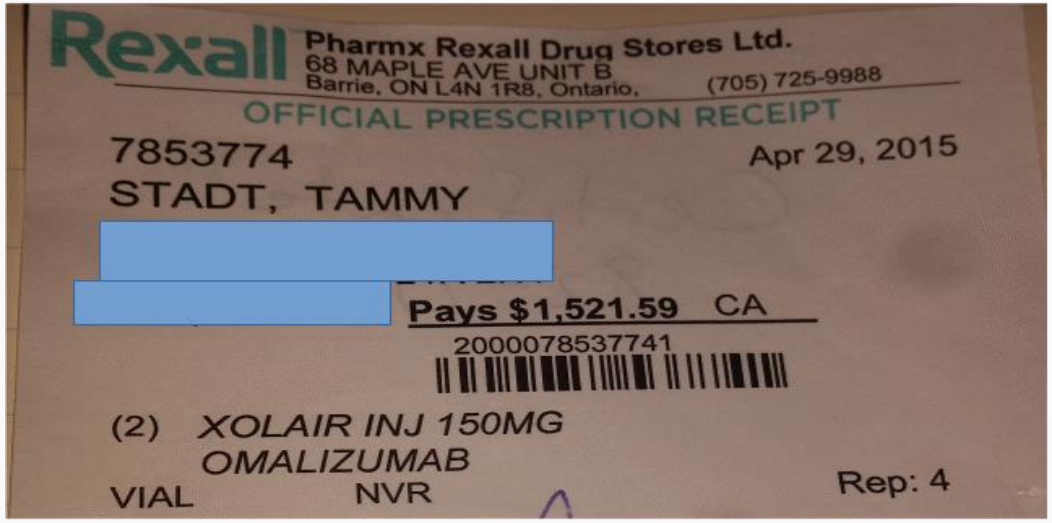
Lessons Learned

- Empower your patients to be an active partner, build on their resilience
- Use Coordinated Care Plans to assist in self-management- *I am looking forward to mine!*
- Use technology such as apps to track health changes



Lessons Learned

- Support pharmacare, help remove barriers to medication
- Encourage Peer Support
- Encourage community involvement- prescribe volunteering



System Navigation Coordinating Care Creating Successful Transitions Rural Hastings Primary Care Led Model

Leadership Summit
November 30, 2018
Presented by: Lyn Linton, Executive Director
Gateway Community Health Centre

Gateway Community Health Centre
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HealthLink
Rural Hastings Health Link
Let's Make Healthy Change Happen

Acknowledgements
Rural Hastings Transformation Team

Patient Representatives
Bancroft Family Health Team
North Hastings Community Family Health Team
Central Hastings Family Health Team
Gateway Community Health Centre
Dr. Janet Webb
Dr. Andrew Quinn
Dr. Carolyn Brown
Addictions and Mental Health
Community Care for Central Hastings
Community Care for North Hastings
Moira Place LTC
Quinte Health Care Corporation
SE LHIN
Home and Community Care
Heart of Hastings Hospice

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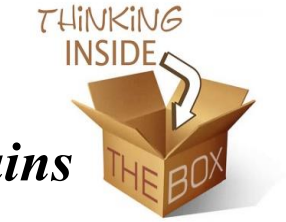
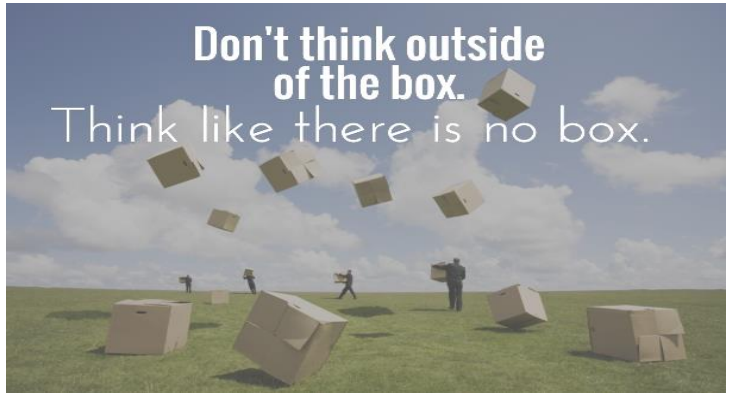
Change vs. Transformation

Think Like There Is No Box

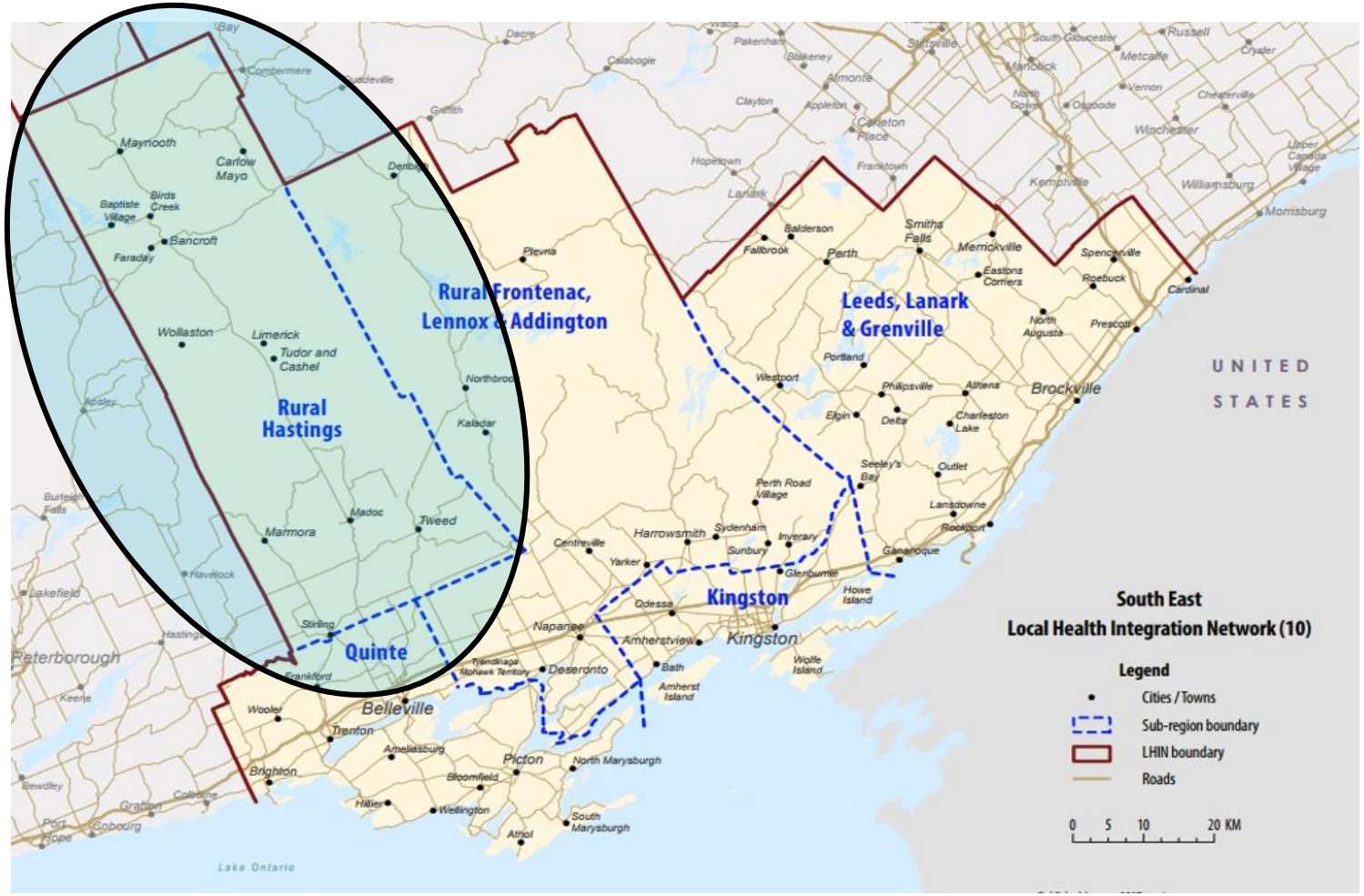


"Change, as a desire to improve the past, often lets the past direct what we do. The past sets the boundaries and constrains possibilities.



Transformation lets the future direct our actions and it is only the limits of our imagination and courage to move forward that will limit the possibilities "

System Navigation for Coordinating Care
Creating Successful Transitions
In Central and North Hastings



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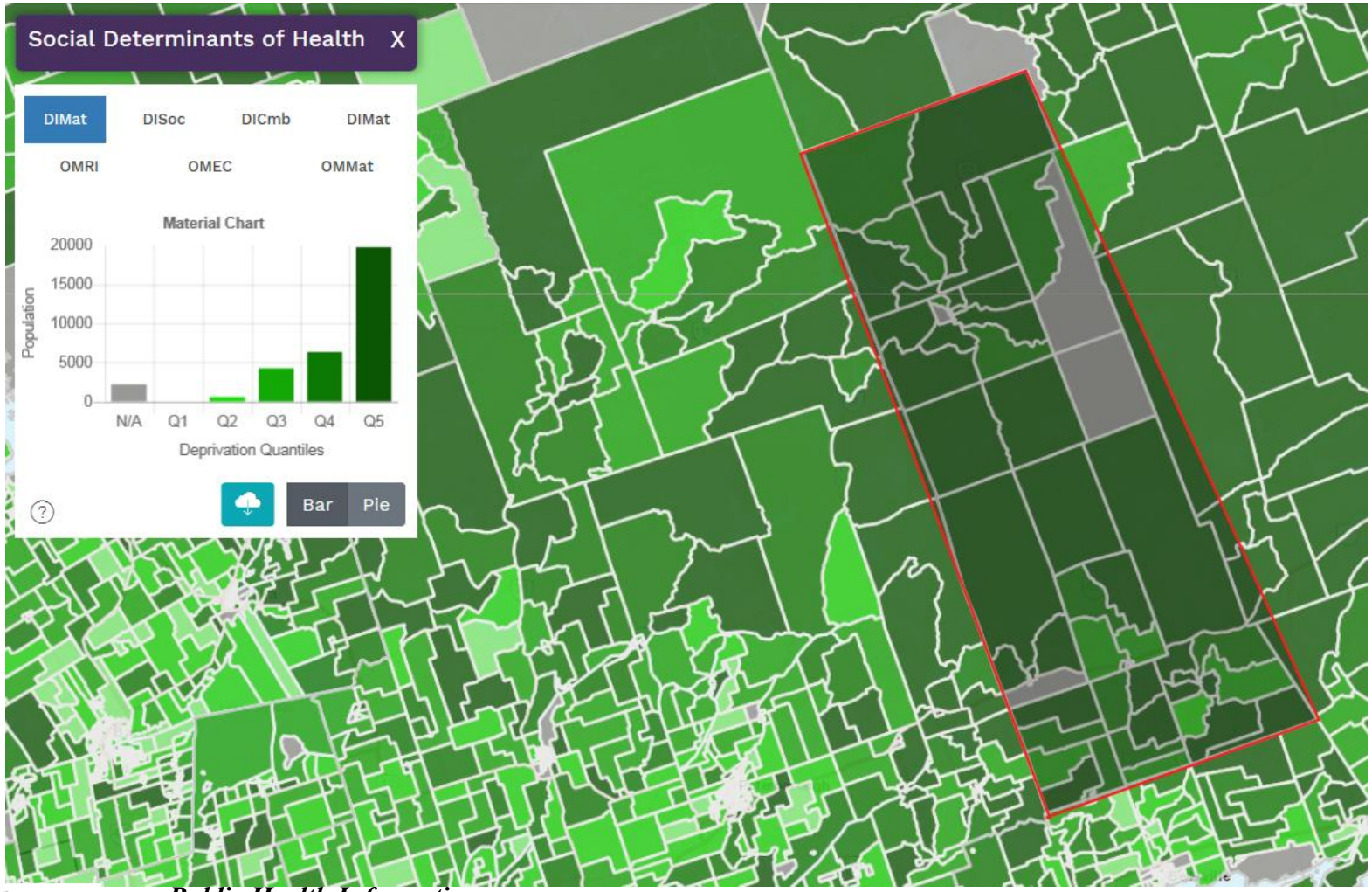
Rural Hastings Social Complexity

Income Stress



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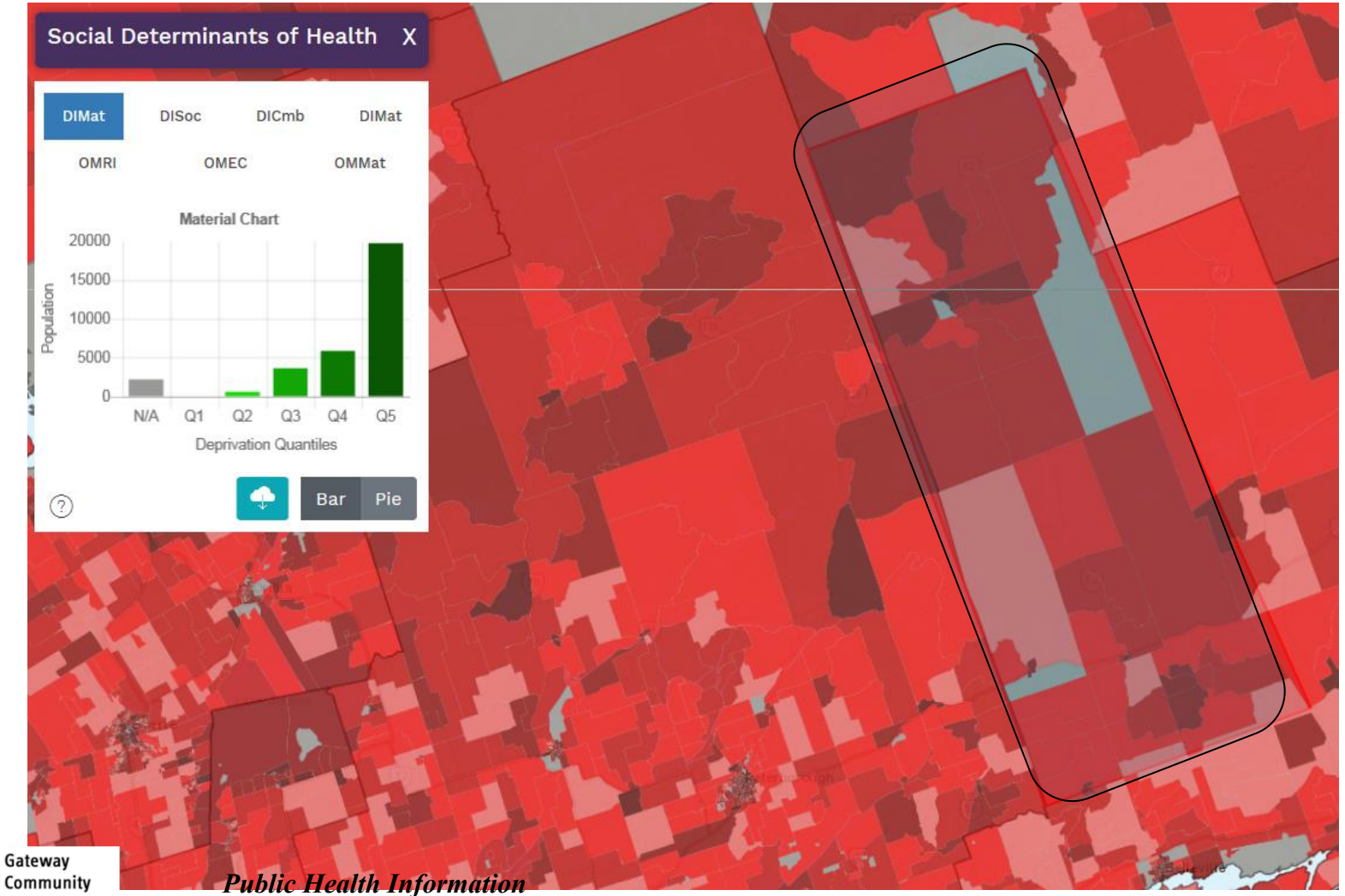
Public Health Information Management System, Kingston Public Health Unit – 2016 Census Data

Rural Hastings Social Complexity

Social Isolation



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Public Health Information Management System, Kingston Public Health Unit – 2016 Census Data

Impacting Social and Medical Complexities

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A **Registered Nurse System Navigator** was embedded in primary care:

Primary Care

- Conducts Home Visits - 100% of complex patients
- Medical and Social Plan of Care
- Navigates transitions in Care

- 7 day follow - up
- Medication reconciliation
- Monitors ED utilization, hospital admissions and discharges
- Shared-care planning
- Ongoing monitoring & evaluating

Social Supports

Home & Community Care

Community Support Services

Primary Care

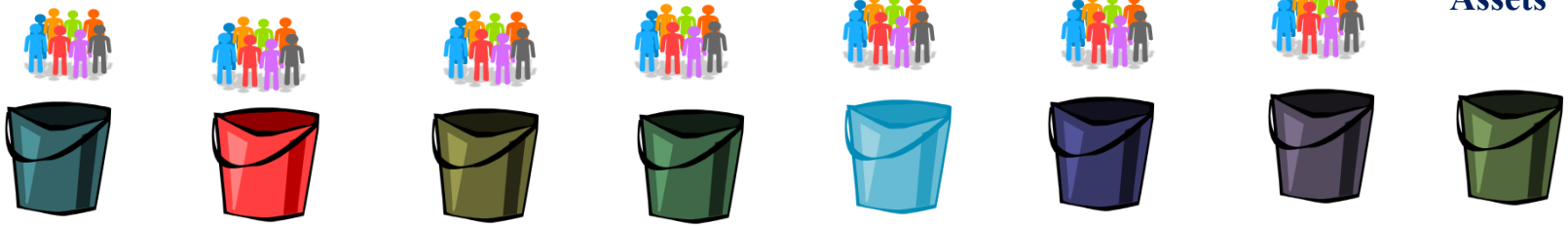
Hospice

Addictions & MH

Specialists

Community Assets

Solo Providers



Addressing Social Complexities

100% of complex patients we serve have social complexities

Leveraging Community Assets

- ✓Churches
- ✓The Legion
- ✓Service Clubs
- ✓Alzheimer's Society
- ✓Library

52% report Low Income

Connecting to Social Services

- ✓Provincial and Federal Income Support Programs
- ✓Legal Services
- ✓Housing (maintenance)
- ✓Community Support Services
- ✓Housing applications

Reducing Social Isolation

- ✓Home visits to assess home environment
- ✓Connecting to community social groups

56% Report Social Isolation

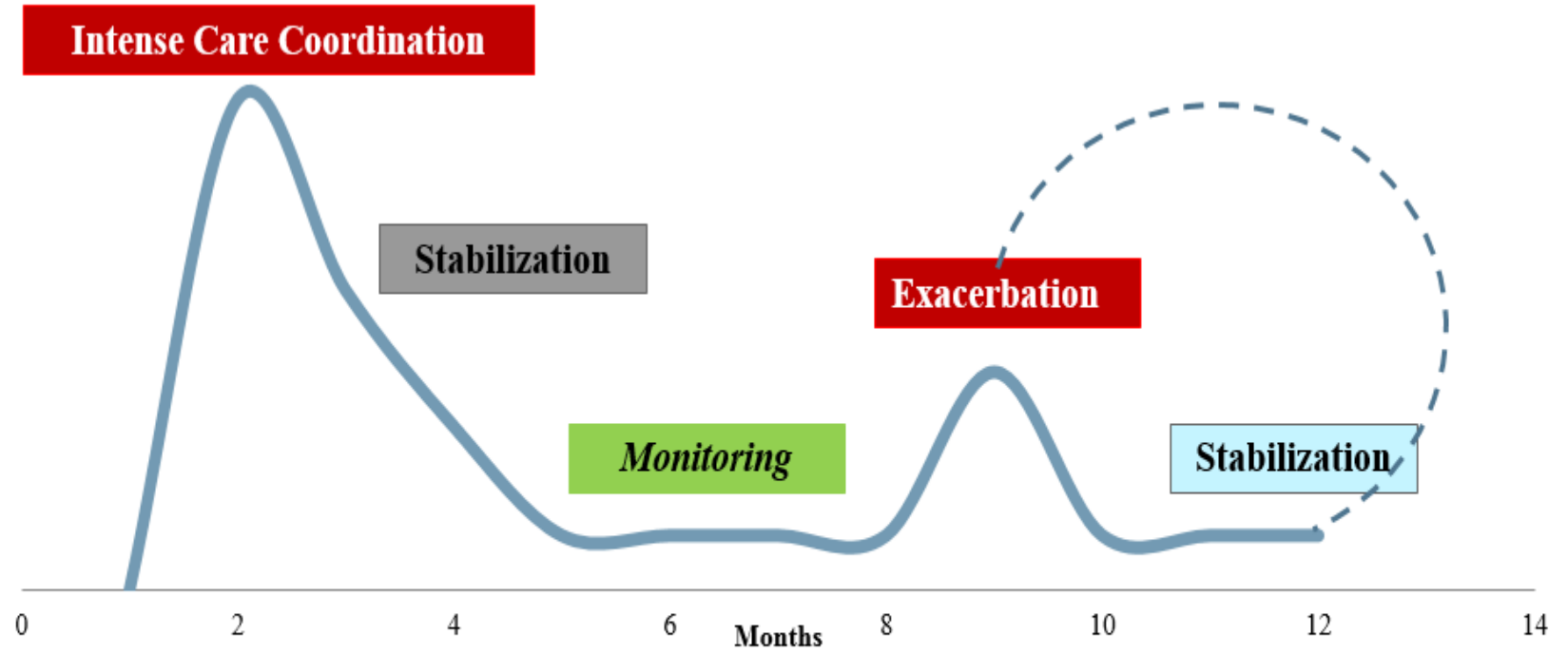
64% Transportation Barriers

55% report barriers to accessing and affording food

Ensure Food Security

- ✓Local food banks
- ✓Community diners
- ✓Meals on wheels
- ✓Meal planning on a limited budget

Monitoring Plan of Care



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Evolution of E-health Enabled Coordinated Care Planning

Past

- ✗ Low technology
- ✗ No platform to share CCP
- ✗ Limited access to information from across sectors

- ✓ Leveraged EMR for sharing of CCP
- ✓ Standardized collection of data for performance management
- ✓ Access to QHC database for real time hospital data and analytics

Present

Adoption of SHIIP as the Coordinated Care Planning Solution including access to:

- ✓ Real time hospital ED and admissions
- ✓ Notification of hospital discharge
- ✓ Addictions and Mental Health case notes
- ✓ Community Support Services case notes
- ✓ Home & Community Care data (Q4 2018-19)
- ✓ Enabling care pathways across sectors

SHIIP
SOUTH EAST HEALTH INTEGRATED INFORMATION PORTAL

RHHL System Navigator completed Coordinated Care Plan with Client

RHHL System Navigator upload Coordinated Care Plan to SHiiP

Care team members view care plans

✓ SHIIP enables providers to view and contribute to the CCP for a shared care planning approach

Measuring Performance

From October 1, 2013 to March 31, 2018 in Rural Hastings

Measuring System Navigator Performance

- ✓ **791** coordinated care plans created with patients and families
- ✓ **100%** of clients had a medication reconciliation and 7-day follow up post discharge from hospital
- ✓ **1245** referrals connecting patients to programs and services to support their medical and social complexities

Measuring System Outcomes

- ✓ **reduction** of ED visits of **85%**
- ✓ **reduction** in hospital admissions of **82%**
- ✓ **74% reduction** in length of stay

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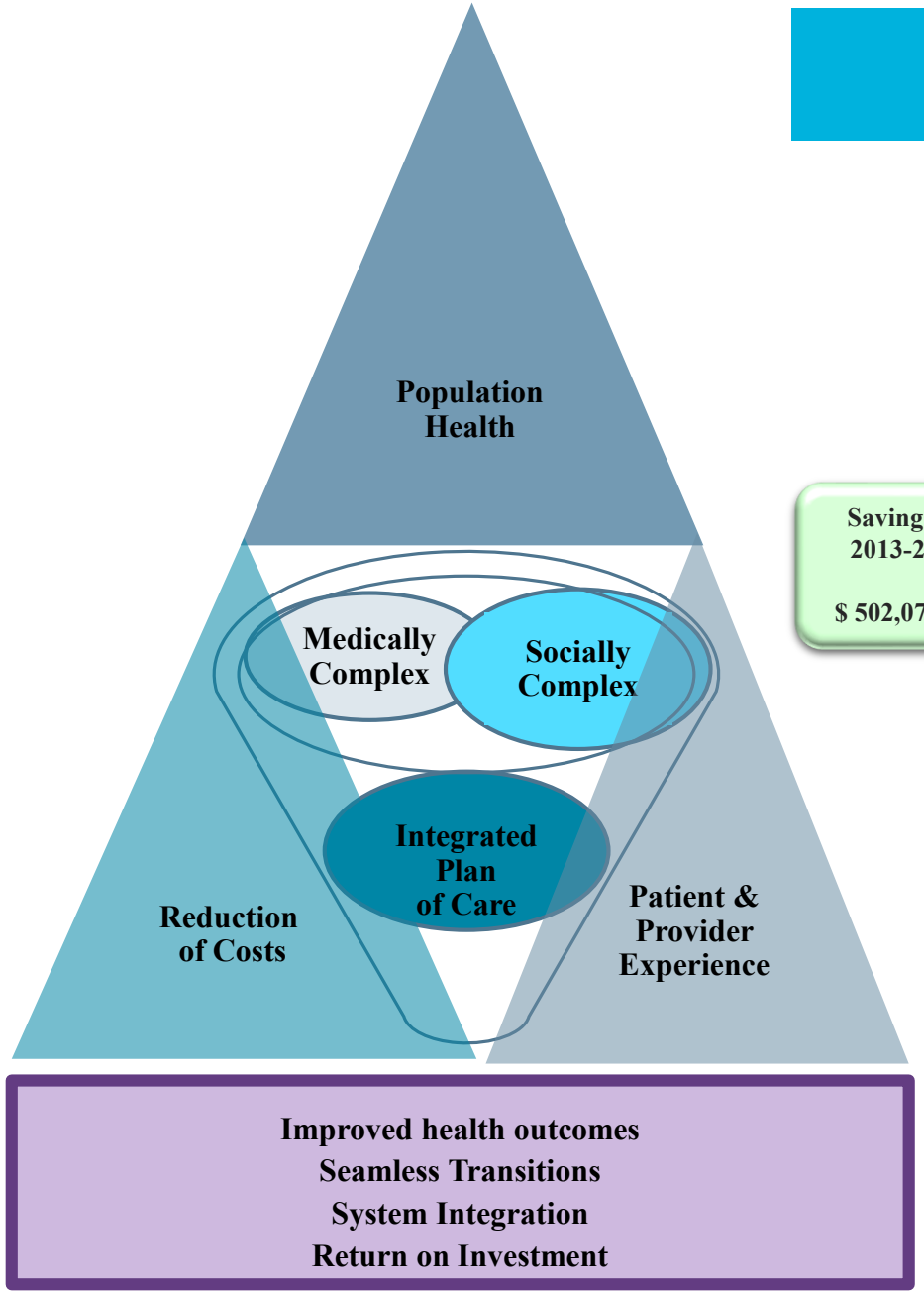

Return on Investment

From October 1, 2013 to March 31, 2018 in Rural Hastings

- ✓ Net program benefit or a cost savings of **$6,720,466.00**

Savings in 2013-2014	Savings in 2014-2015	Savings in 2015-2016	Savings in 2016-2017	Savings in 2017-2018
$ 502,073.00	$1,930,871.00	$1,206,124.00	$1,832,389.00	$1,249,009.00

- ✓ Return on investment of **348%,** or for every **$1 invested** we return **$3.48 back to the system.**

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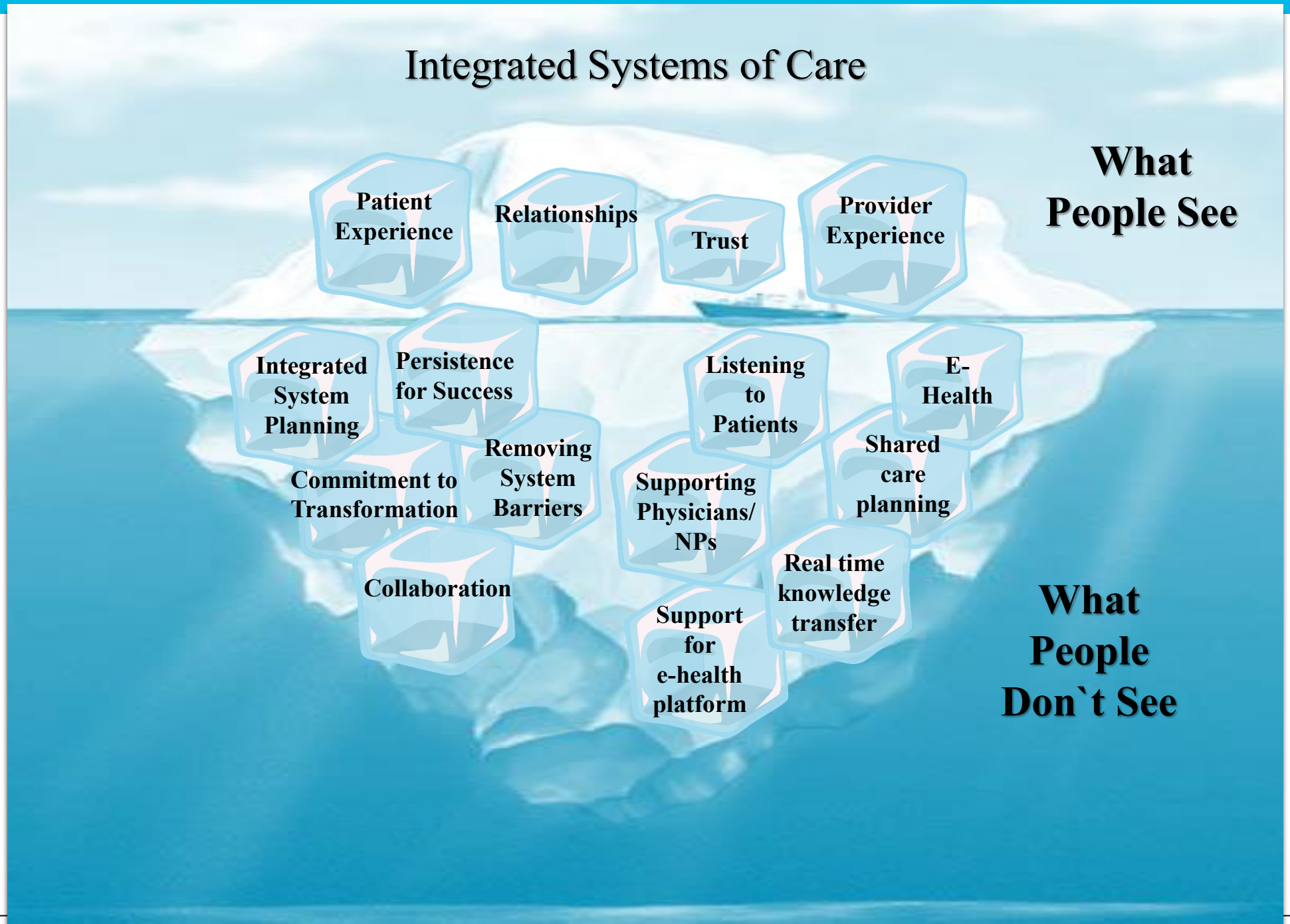
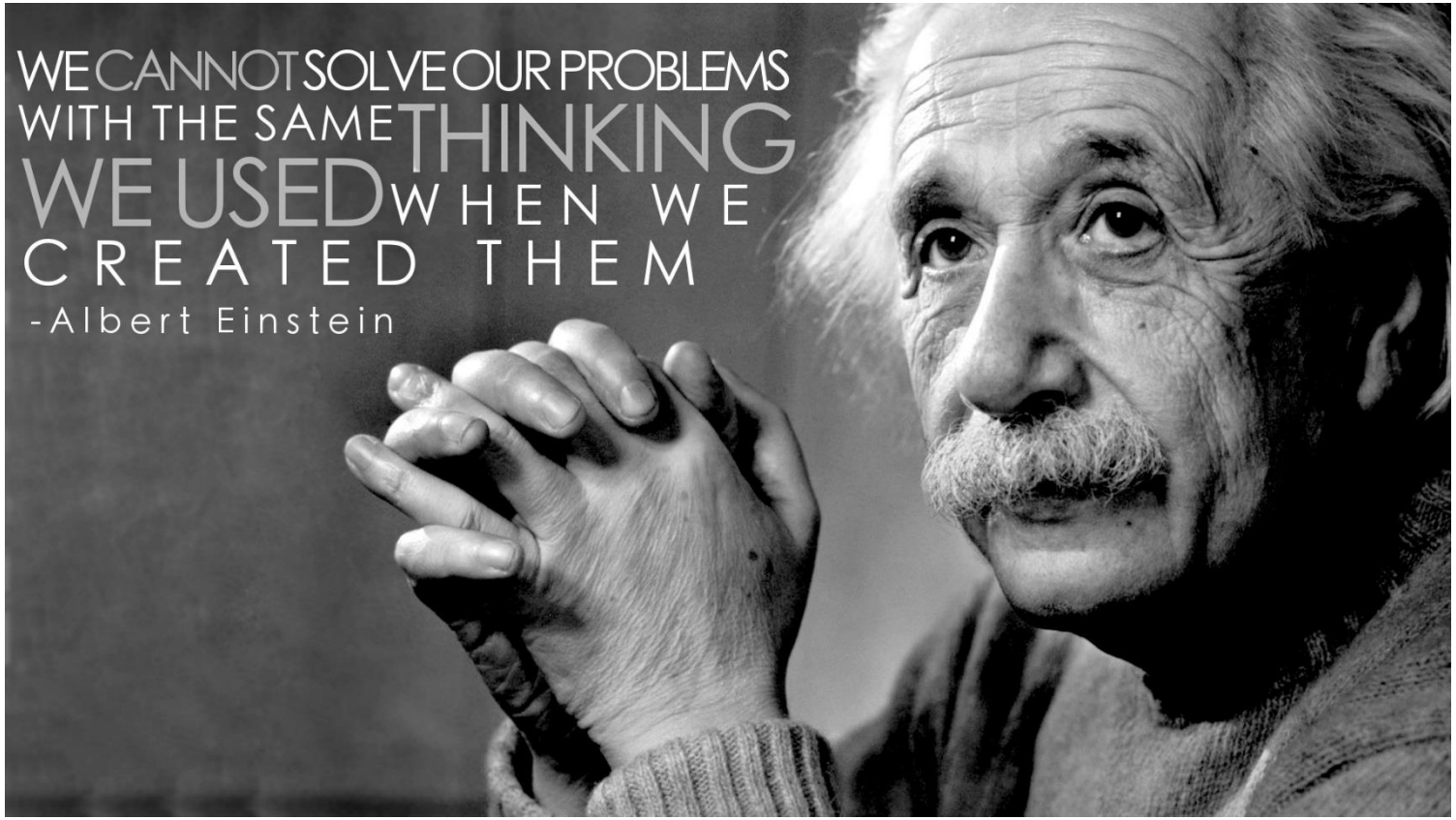
Integrated Systems of Care





Lyn Linton – llinton@gatewaychc.org

Using data to understand the system impact on coordinated care and transitions.

Walter P Wodchis (@wwodchis) & Luke Mondor

Leadership Forum
Toronto, ON

November 30, 2018

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health system performance research network

Overview

1. Context: What do we know about the implementation and effects of the Health Links approach to care?

Some results:

2. Summarize current data and Health Links participant characteristics.
3. Update on effect of Health Links on health care utilization.

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Context

Health Links aims to improve care coordination for individuals with complex health needs. How ?

1. **Segmentation**: identifying individuals with complex needs and matching resources to meet individual needs
2. **Coordination**: Developing new partnerships and trusting relationships amongst providers – new ways of working requires readiness for change and change management strategies.
3. **Engagement**: New approaches to care need to be patient-centred, flexible and adaptive to individual patient goals.

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Context

What were the early results for Health Links (< 2015) ?

1. In comparison to similar patients not enrolled in Health Links, HL enrollees had higher hospital use post-enrolment in health links. (Mondor et al., CMAJ Open 2017); ED visits reduced amongst survivors (Bielska et al., CMAJ Open 2018)
2. Desirable developments occurred only in some settings and failed to flow upward to higher levels, resulting in a piecemeal and patchy landscape. (Grudniewicz et al., SSM 2018)

Implications:

- We need courage and an effective, meaningful and instrumental approach to learn from success AND failure and adjust accordingly. Case studies may help.

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Knowledge Update

1. Determine the difference in average health services utilization among Health Links enrollees prior to and after starting Health Links approach to care over the period from 2013 to 2016.

2. Determine how outcomes compare to similar patients not enrolled in Health Links care

Part 1

To determine the difference in average health services utilization among Health Links enrollees prior to and after starting Health Links.

Methods to Address Objective 1

1. Obtained registry of individuals with Health Links start date tracked through OACCAC CHRIS database.
2. Linked patients with Health Links start date between April 2013 and March 2016 to health care databases at ICES.
3. Identified patient baseline characteristics: age, sex, chronic conditions, income quintile.

Methods to Address Objective 1

4. Examined individual enrollee use of health care in one year prior to and up to one year after Health Links start date (up to March 2017) for 6 HL measures:
    - ED visits
    - Acute Hospital Admissions
    - Hospital Readmissions within 30-days of Discharge
    - Total Acute Hospital Days
    - Primary Care Physician visit within 7-days of Discharge
    - Total Health System Cost
        - (all provincial costs including hospital, physician, outpatient lab medications, LTC and home care etc.)

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Data

1. Enrollees from CHRIS database included in analysis

– 10,368 Individuals from 72 Health Links with Health Link Start Date as at March 31, 2016

Context: This compares to population of 22,111 Completed Care Plans from 81 Health Links reported by HQO as at March 31, 2016

- Average of 68% coverage
  (25% of HLs with less than 22% coverage; 25% of HLs with more than 112% coverage).
- We are missing many enrollees but likely also have some false positives.

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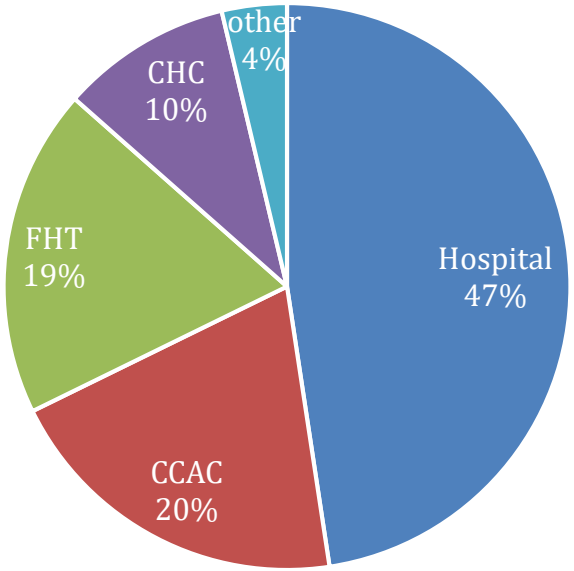
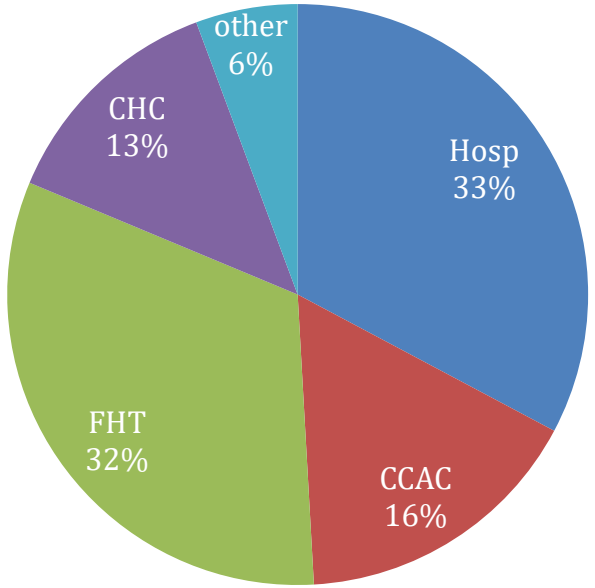
Data

Health Link Lead Organization
Study Sample (c2016)



Health Link Lead Organization
Ontario Population (c2016)



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Patient Characteristics

Age: 74 years

45% Female

80% Urban (becoming more rural over time)

25% in lowest income quintile (over-represented)

Clinical Needs (in 2015/16):

- 90% Major Acute conditions
- 80% Chronic unstable medical (declining over time)
- 60% Psychosocial (increasing over time)
- 22% Died within one year (down from 40% in 2013/14)

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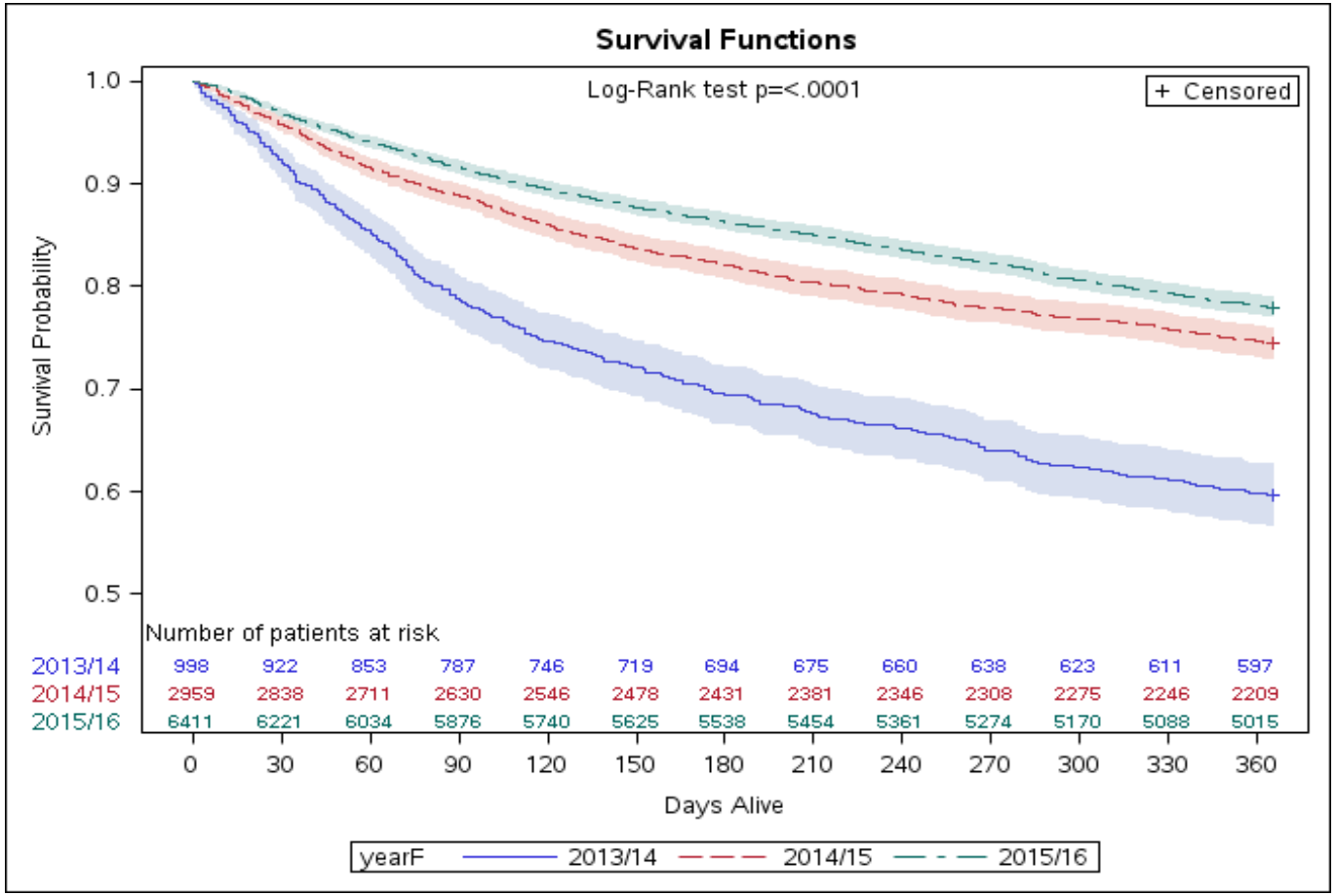
Patient Survival

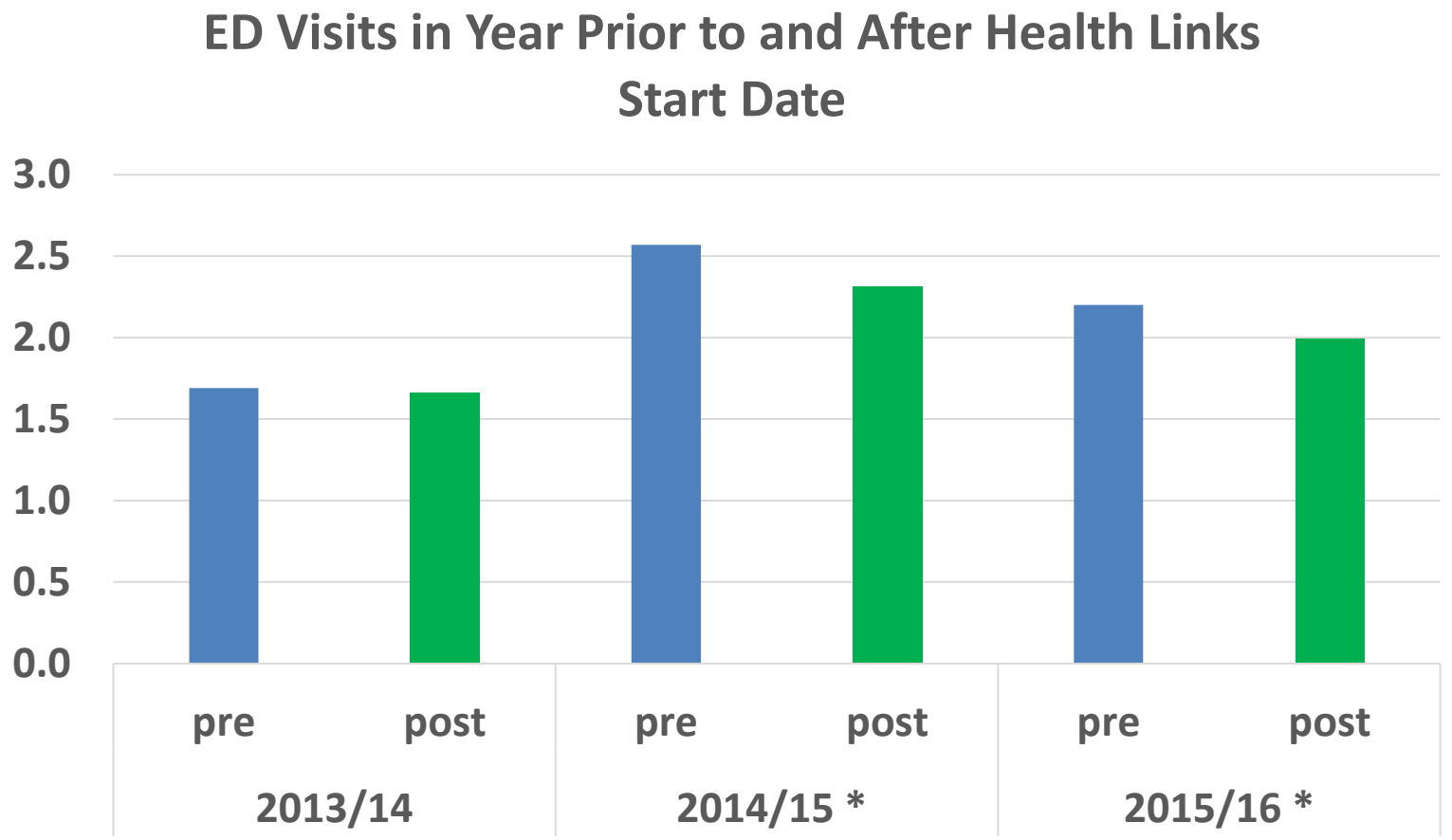
High mortality among Health Links enrollees



Patient Survival

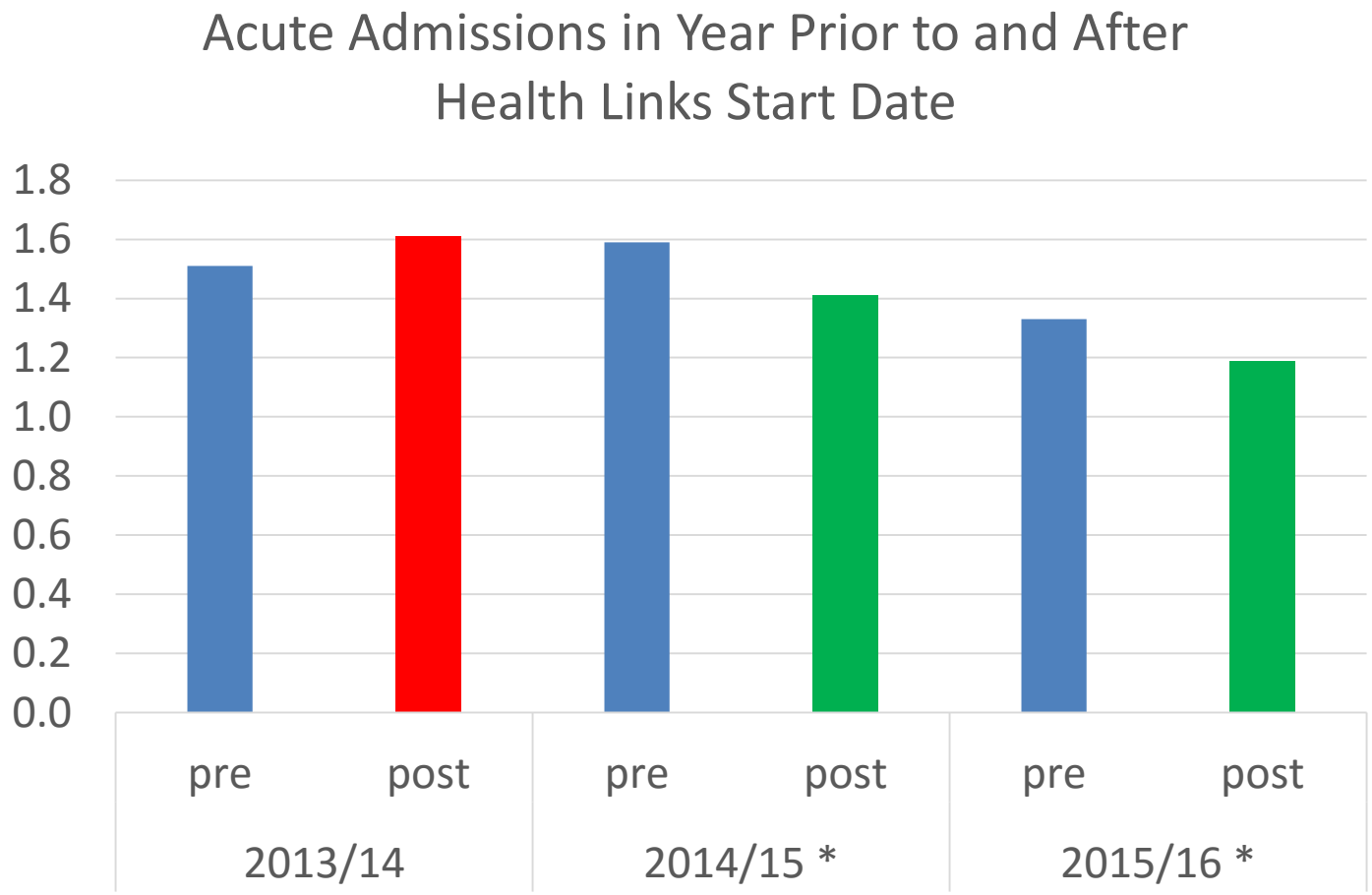
All Results Calculated Per Person-Year Alive

Results: ED Visits



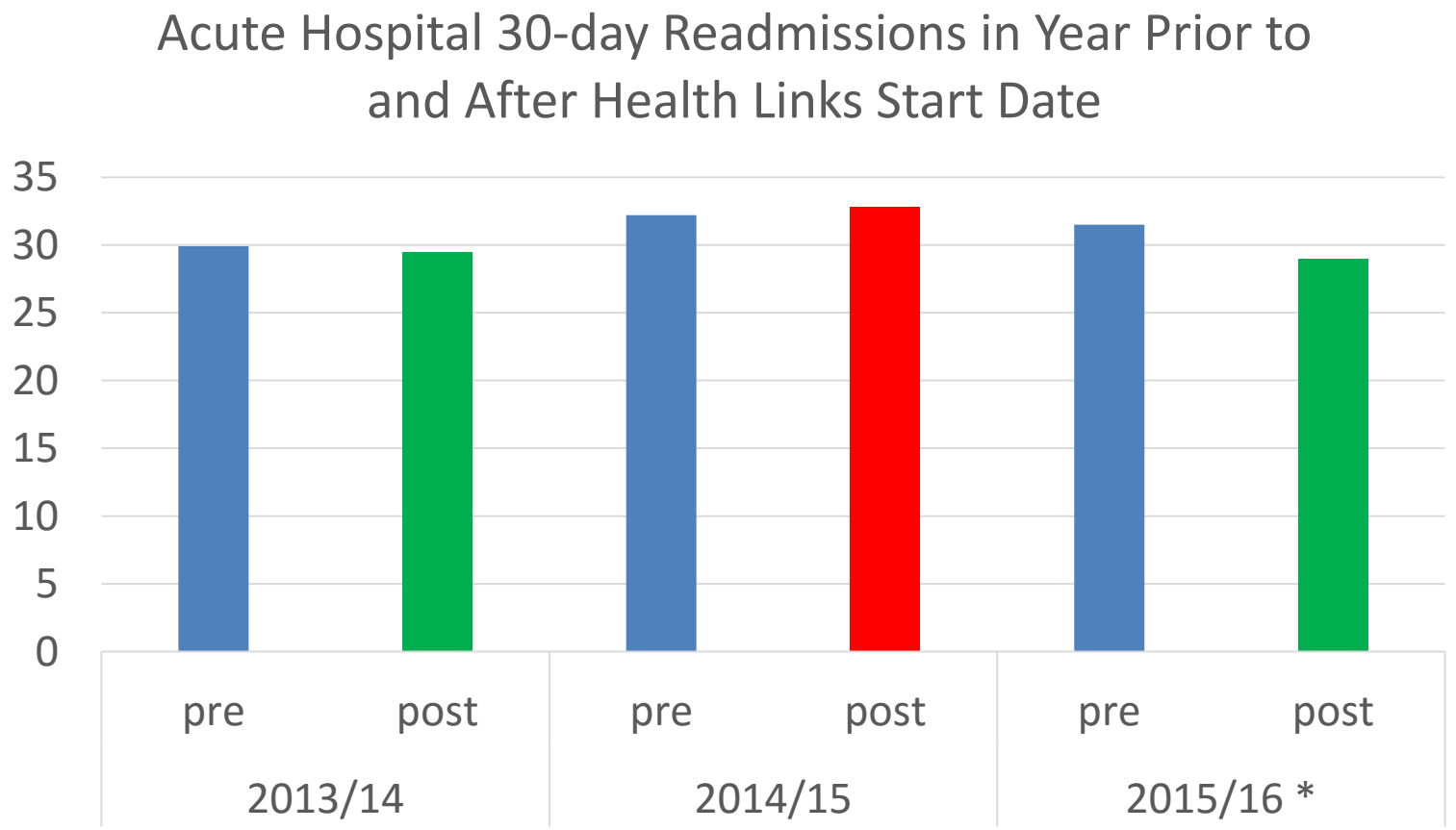
* Indicates statistically significant at p < 0.05

Results: Acute Admissions



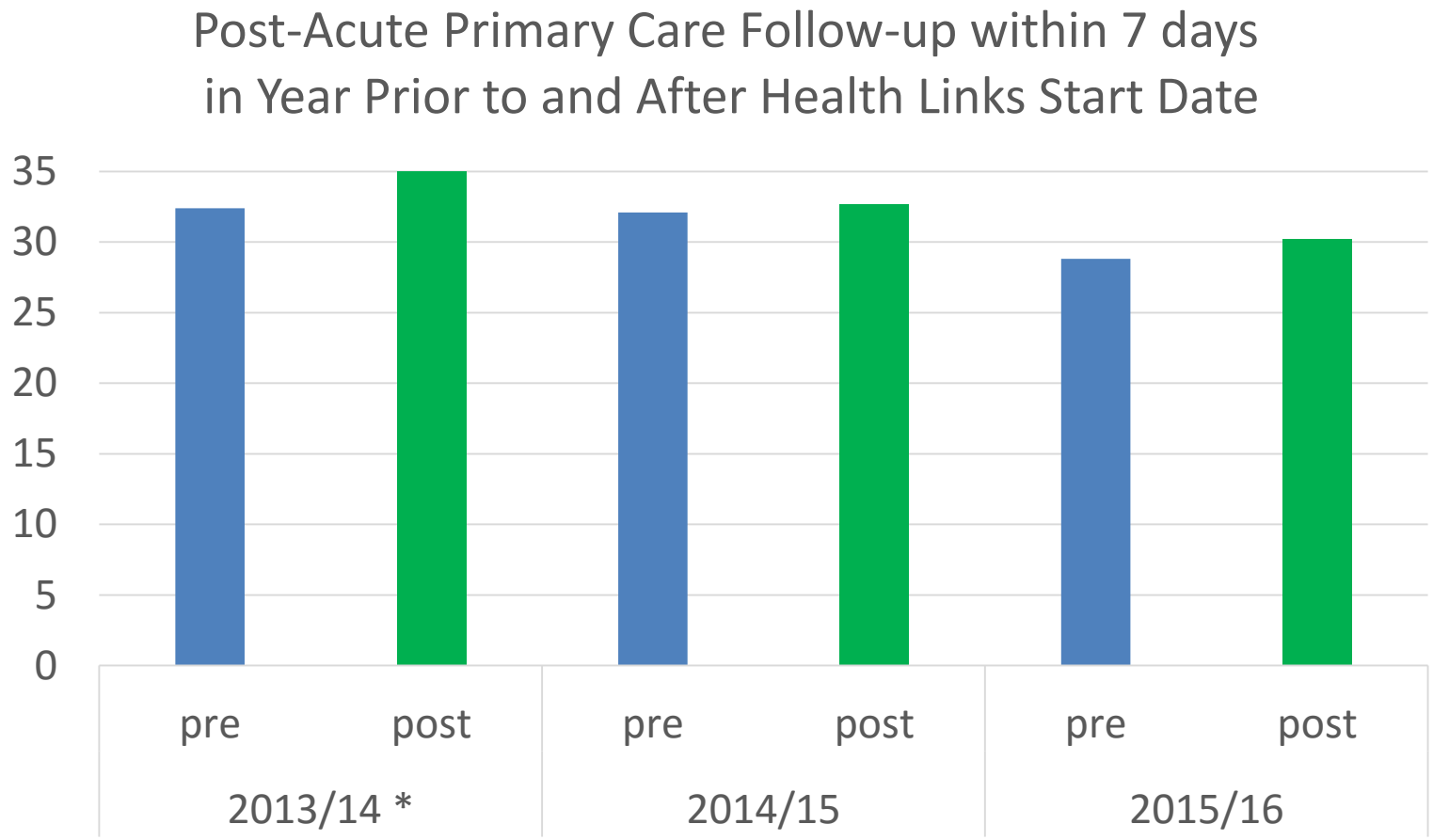
* Indicates statistically significant at p < 0.05

Results: 30-day Acute Readmission



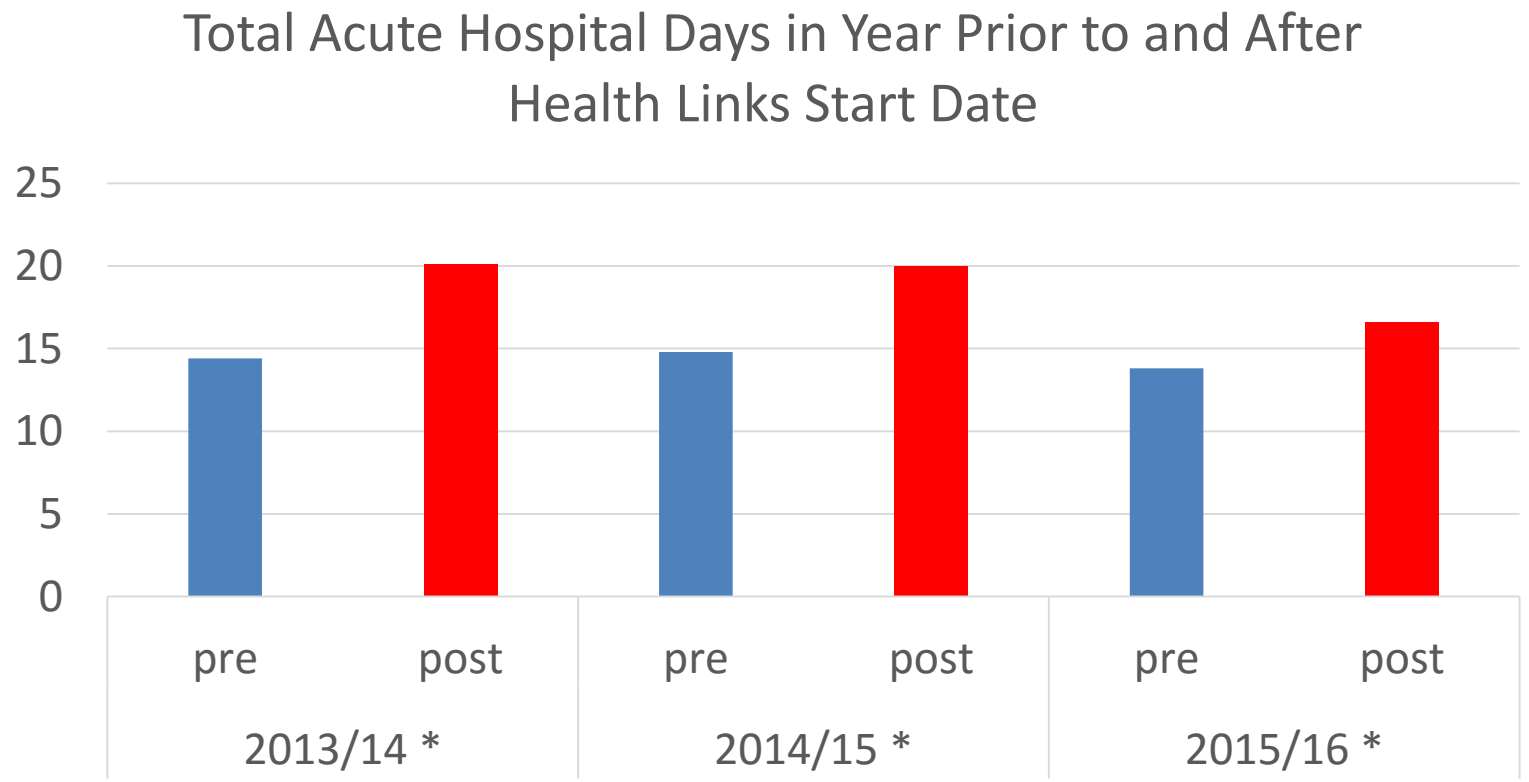
* Indicates statistically significant at p < 0.05

Results: 7d Primary Care Follow-up



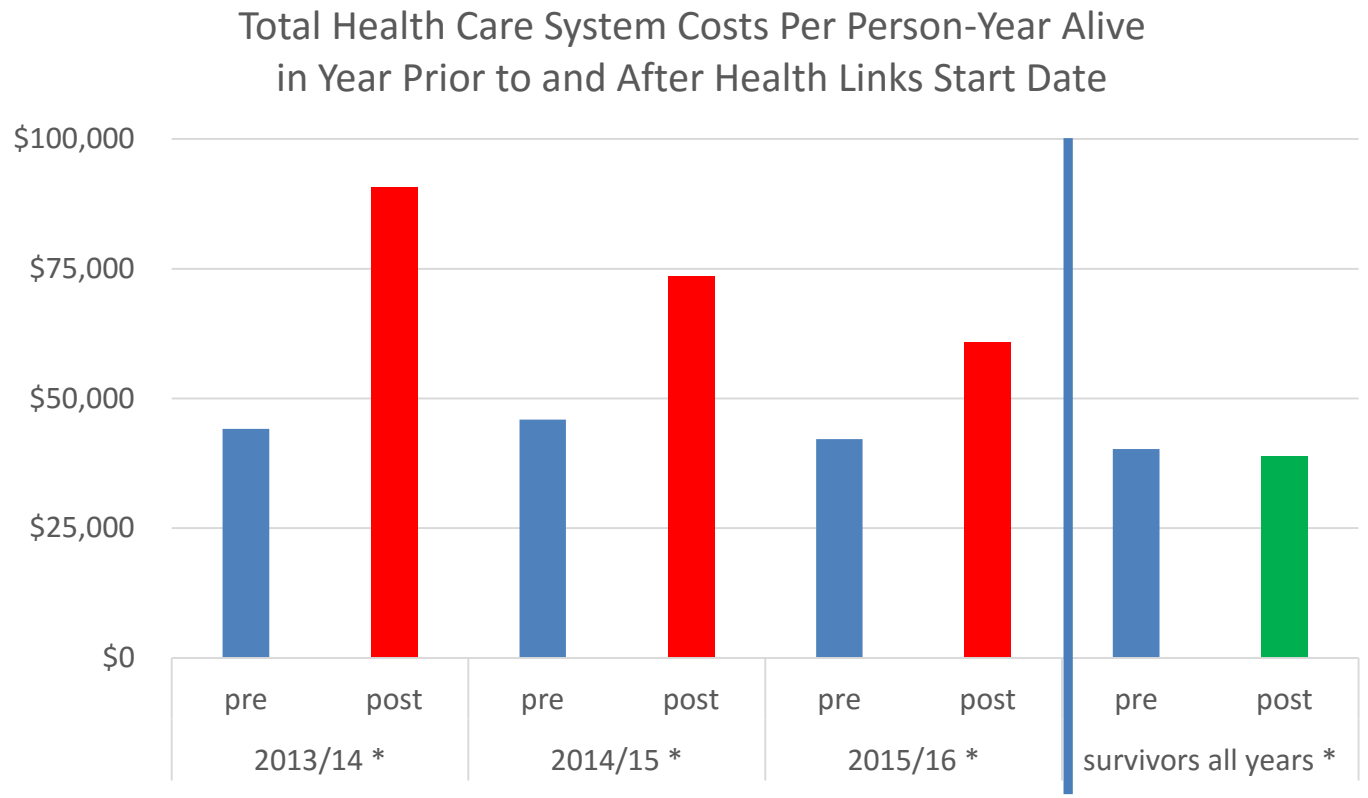
* Indicates statistically significant at p < 0.05

Results: Total Hospital Days



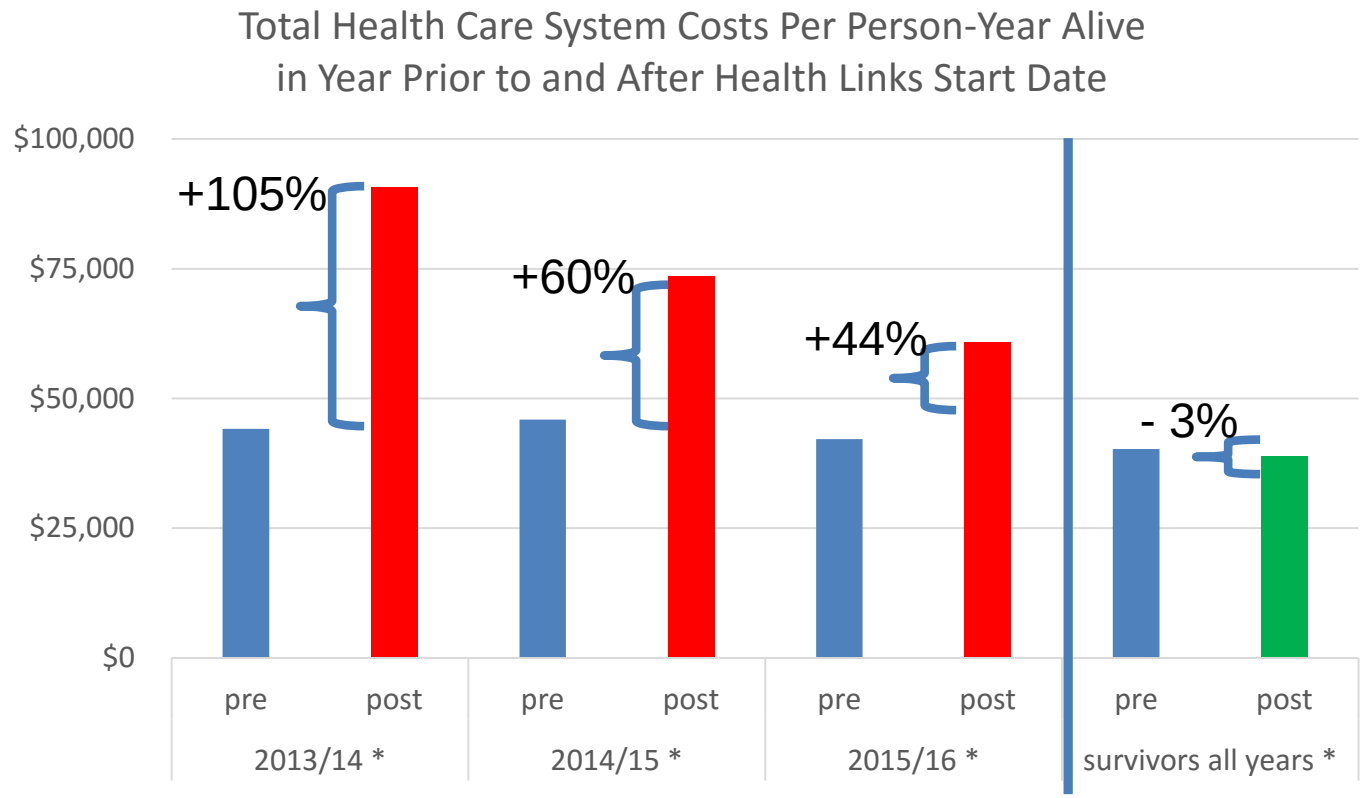
* Indicates statistically significant at p < 0.05

Results: Total Health System Cost



* Indicates statistically significant at p < 0.05

Results: Total Health System Cost



* Indicates statistically significant at p < 0.05

Study 1: Results

Pre/post enrolment utilization differences (relative scale)

	Hospitalizations	Days in Hospital	ED Visits
Full Population	0.90 (0.88-0.93)*	1.27 (1.21-1.33)*	0.91 (0.87-0.95)*
Survived 1-year (or more)	0.68 (0.65-0.70)*	0.72 (0.68-0.76)*	0.81 (0.77-0.85)*
High-Risk (LACE)	0.79 (0.76-0.82)*	0.92 (0.86-0.98)*	0.85 (0.80-0.90)*

	30d Readmissions	7d Follow-up	Total Cost
Full Population	0.96 (0.91-1.01)	1.05 (1.00-1.10)*	1.55 (1.51-1.60)*
Survived 1-year (or more)	0.81 (0.75-0.87)*	0.94 (0.89-0.99)*	0.97 (0.94-0.99)*
High-Risk (LACE)	0.94 (0.88-1.00)	1.08 (1.02-1.15)*	1.43 (1.37-1.49)*

* Indicates statistically significant at $p < 0.05$

Key Findings

- Very complex patients targeted at onset provincially
  - High comorbidity
  - Greater representation from low income neighbourhoods
  - High one-year mortality (HR=1.9 for enrollees in 2013/14 vs 2015/16)
- Overall, modest (<10%) improvements in hospitalization rate, ED visit rate and 30-day readmissions
    - greater improvements amongst survivors
- Total cost per person-year double post vs pre enrolment for 2013/14, but difference improved with each year
- Many enrollees die within one year and costs are very high in year of death as 47% of deaths occurred in hospital.

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Part 2

To determine how outcomes compare to similar patients not enrolled in Health Links care

Part 2: Methods Overview

- Quasi-experimental study design
- Identified a comparator (control) patients from ICES databases. Use propensity score matching (3:1)
- Outcomes evaluated using difference-in-differences approach:

	HL Enrollees	Comparator Group
Post-enrolment Period	A	B
Pre-enrolment Period	C	D
Pre-Post Difference	A-C	B-D
Incremental Effect of HL	(A-C) – (B-D)	

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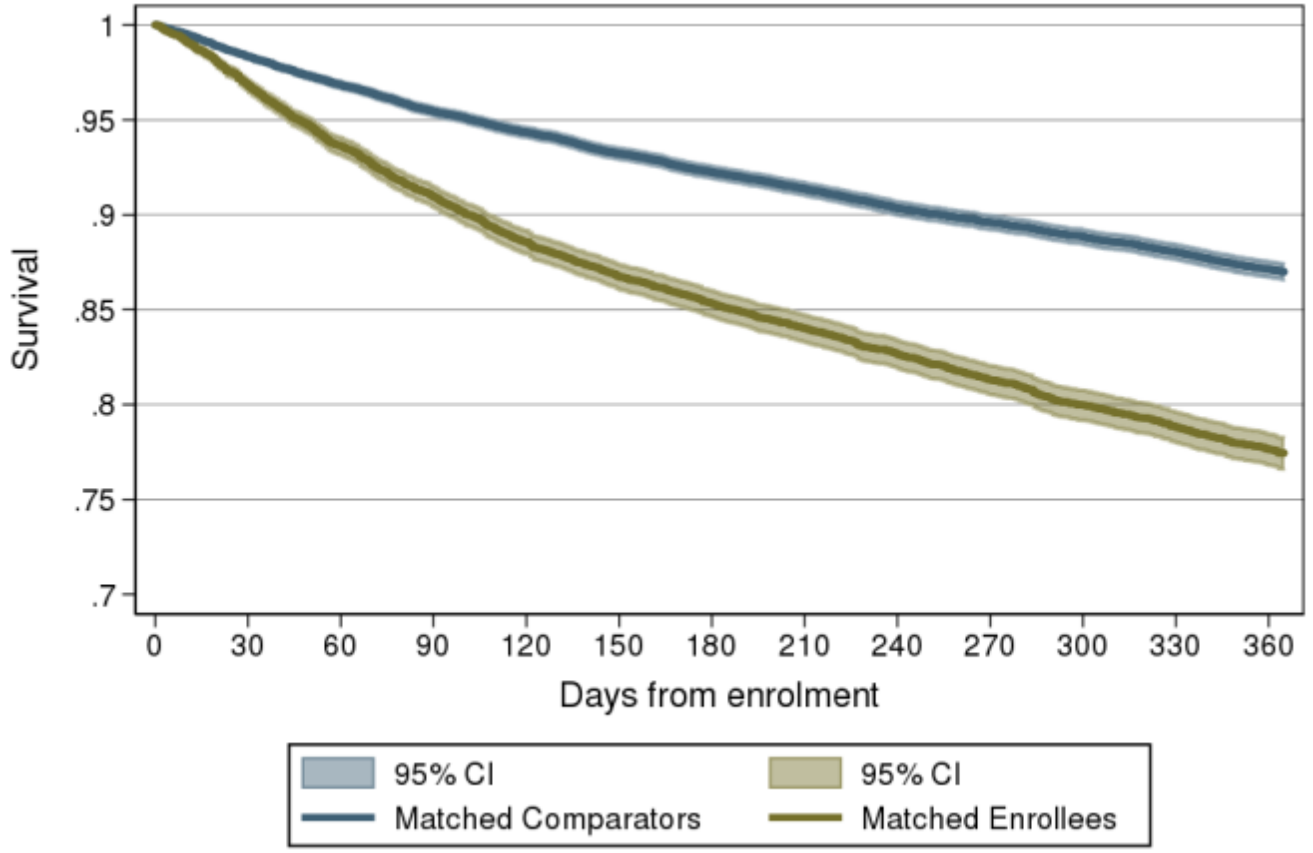
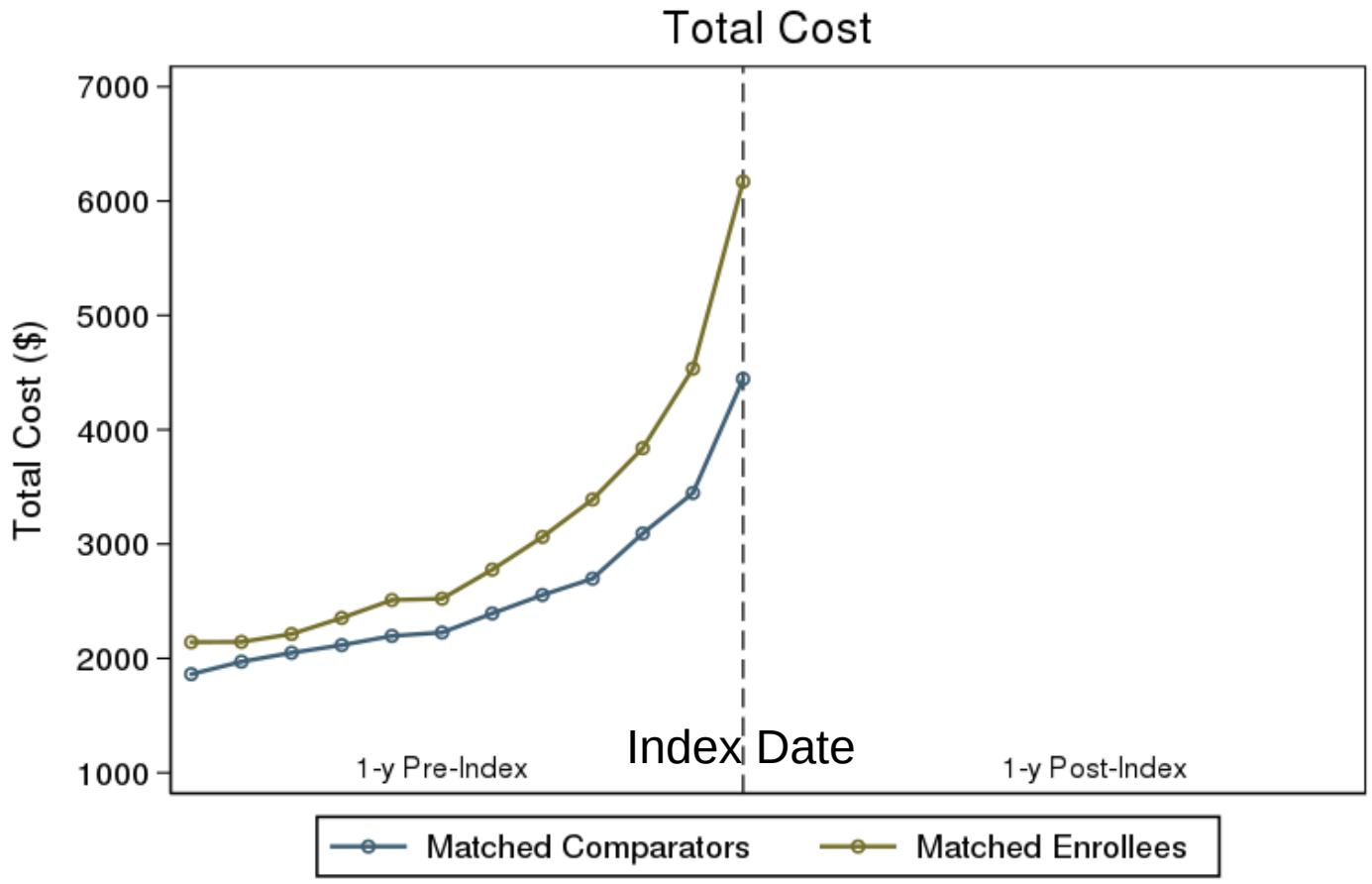
Part 2: Survival Differences

Differential 1-year mortality in matched set, despite similar baseline characteristics (HR = 1.54, CI: 1.45-1.64)



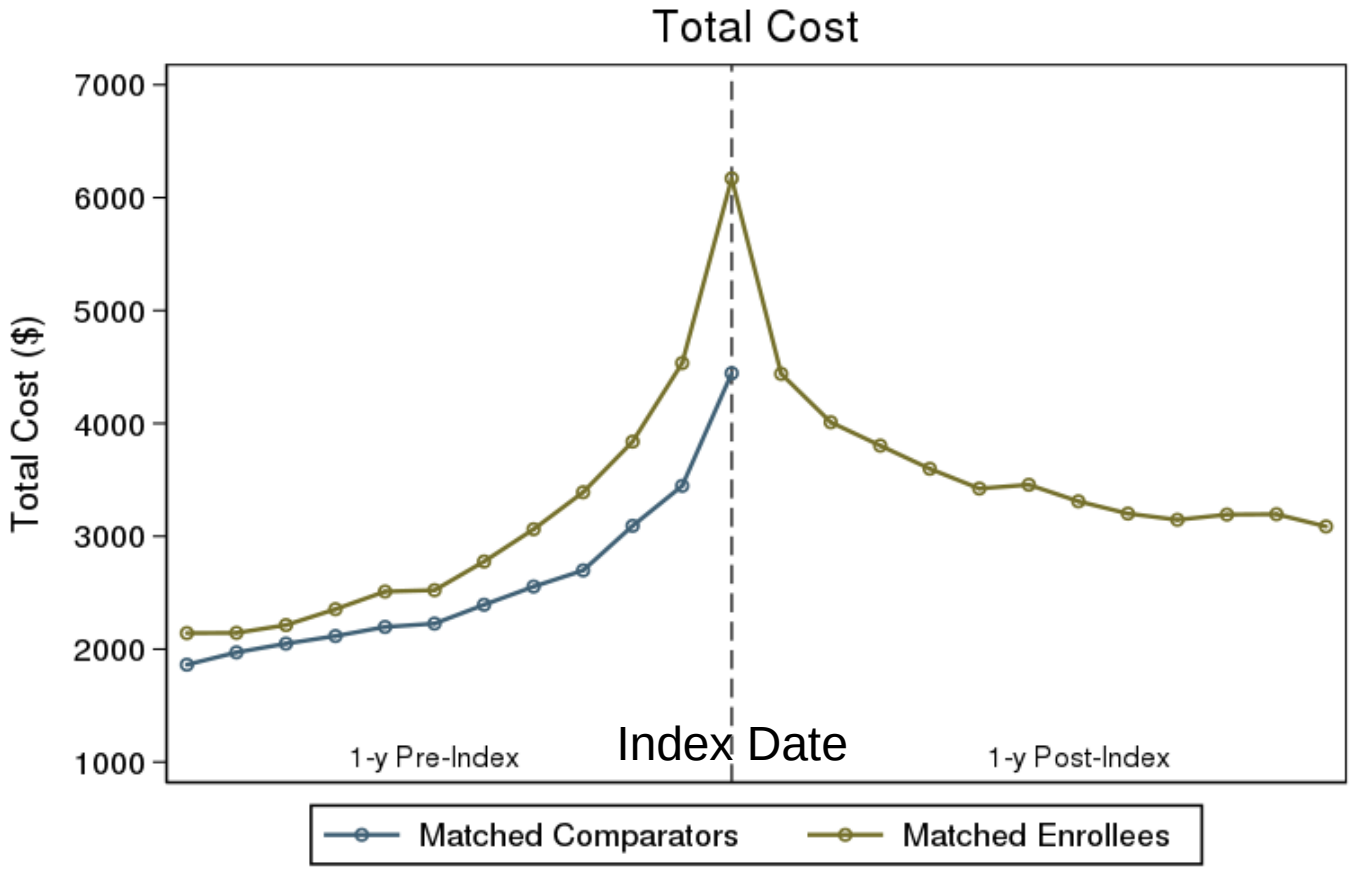
Part 2: Total Health System Costs

Comparable Pre-index Trajectories in Total System Cost



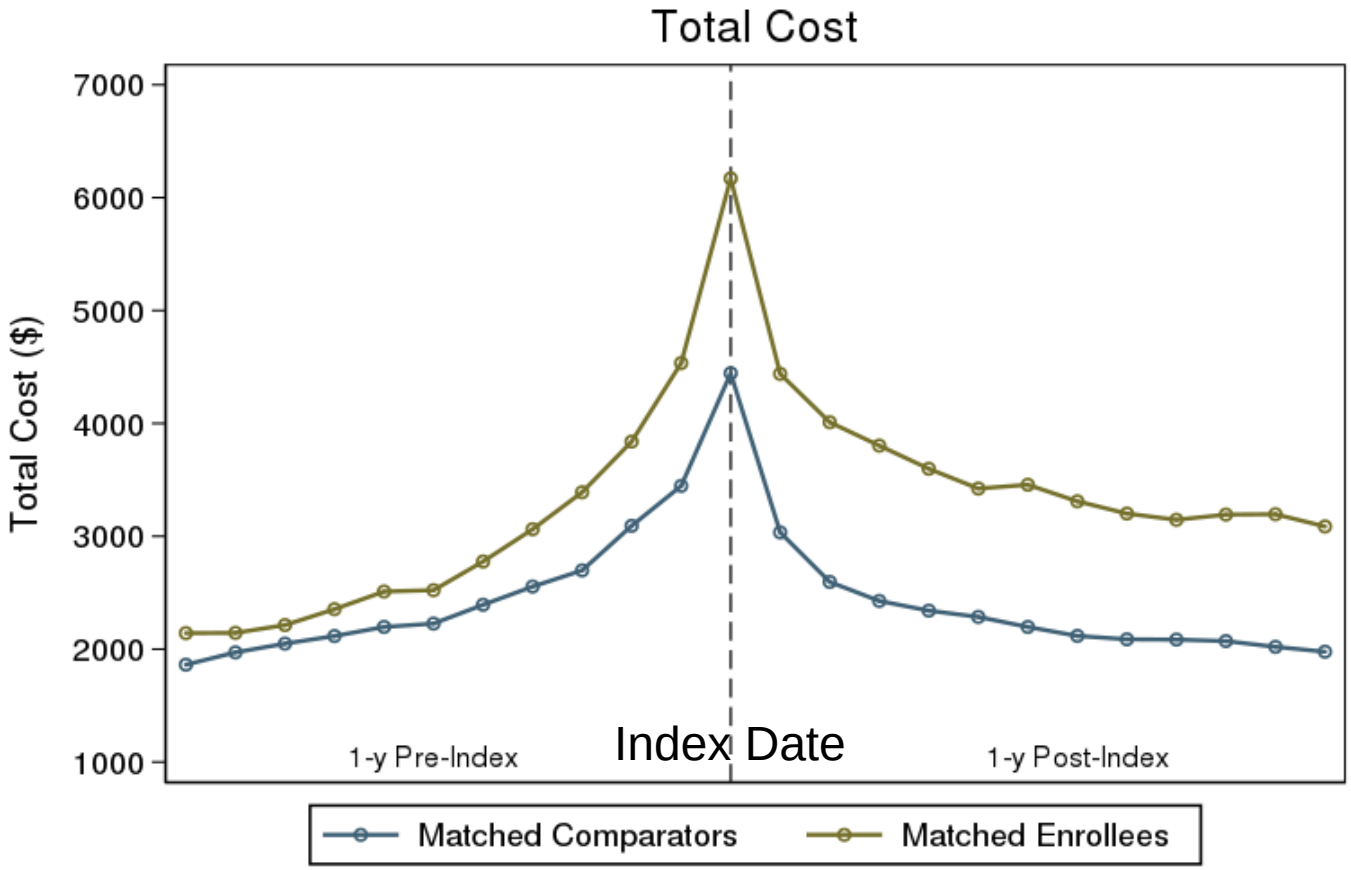
Part 2: Enrollee Health System Costs

Enrollee Costs Decline after Health Links Start Date

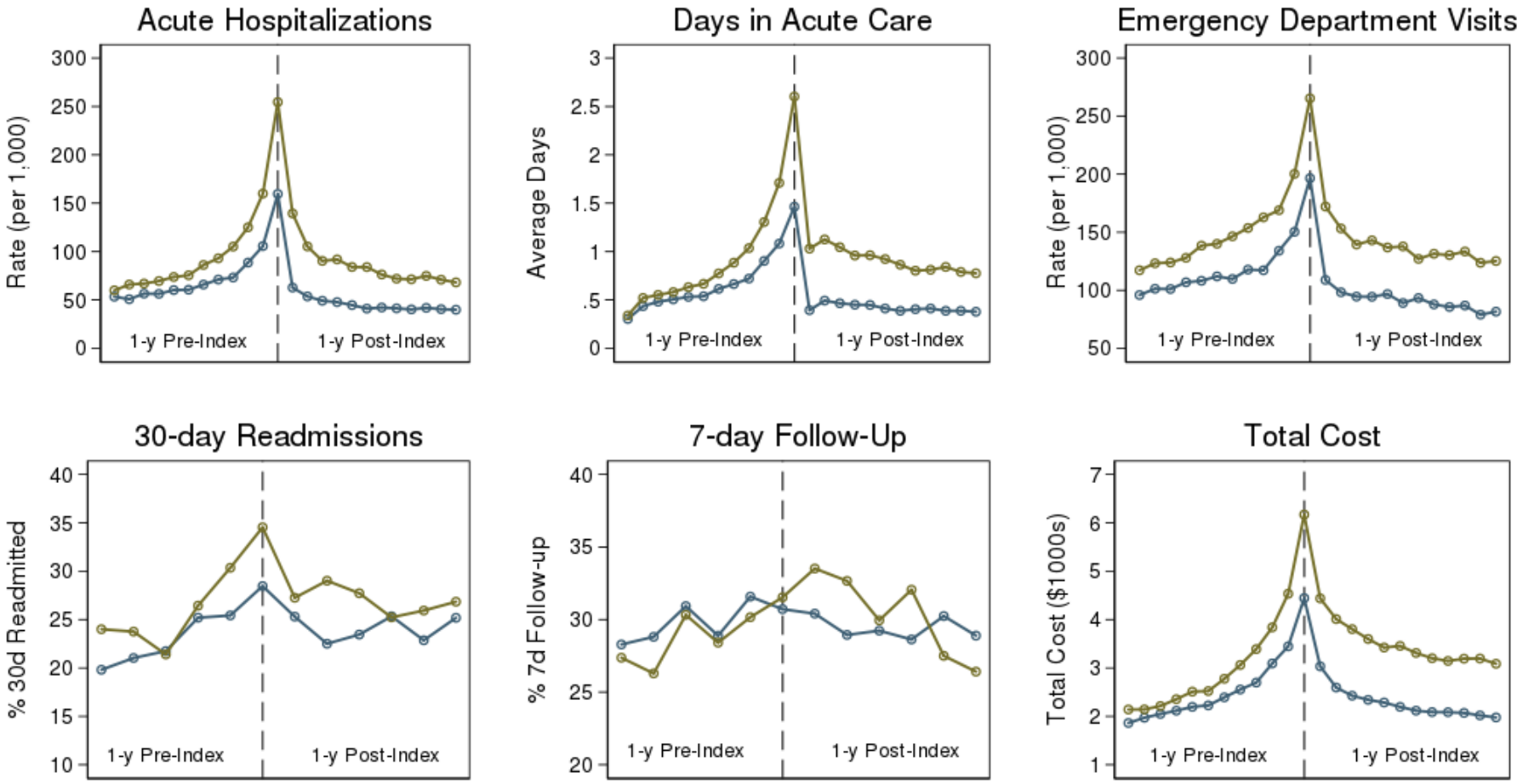


Part 2: Comparative Health System Costs

Comparator Costs Decline More Than Enrollee Costs



Part 2: All Outcomes



Part 2: Interpretation

- Greater reduction for comparators than enrollees in hospitalizations, LOS, ED visits, and costs
- No difference in 30d readmission or post-discharge follow-up

- Higher costs are associated with increased hospital use in the last year of life – long stays at the end of life.

Summary, Limitations & Conclusions

Summary

- Health Links are making important strides forward.
- A number of indicators of health care use show reduced use of hospital care after Health Links Start Date.
- Total acute hospital days and total costs are higher in the year after identification as a health links patient.
- Comparison to similar non-enrolled patients did not show an advantage to health links over no health links care.
- Mortality Bias: Health Links patients are spending substantial days in hospital at the end of life.

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Limitations

- Generalizability/ Selection Bias by Data Source
  - CHRIS vs. SHIIP vs. manual tracking
  - At present, 40/76 HLs still use 'manual tracking processes' (HQO)
- Data quality of existing HL Registry
  - *Health Link start date* was used, but *CCP completed date* is desirable
  - *CCP completed date* missing for 56% of all records analyzed (n=10,368), with large variation by HL/ sub-region (range: 0% to 98%)
  - HQO reports 22,111 CCPs initiated over same period (number of *patients* is unknown)
- 14% of Health Links "Registry" could not be matched
- No data on other outcomes relevant to the HL approach to care
  - ie, quality of life, patient experience/ satisfaction, health system access

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Implications and Future Work

- A valid database of patients treated with Health Links approach needs to be implemented with data sharing protocols to enable robust evaluations of the Health Links approach to care.
- There is substantial variation in performance of HL which we might begin to exploit to learn from.

- **Courage:** mental or moral strength to persevere, and withstand danger, fear, or difficulty (merriam-webster)

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Supplementary Slides

Study 1: Characteristics

Variable	2013/14	2014/15	2015/16	Compare*
	N=998	N=2,959	N=6,411	N=478,144
Socio-demographics				
Age at Index (mean, SD)	74.1 ± 13.6	72.7 ± 15.1	74.3 ± 14.7	60.7 ± 17.6
Male Sex	46.3%	43.0%	43.2%	45.0%
Urban (RIO <10)	86.0%	81.9%	76.5%	72.5%
Income Quintile				
Q1 (low)	25.7%	26.6%	23.8%	20.1%
Q2	21.0%	22.5%	22.0%	20.4%
Q3	19.3%	18.5%	20.3%	20.1%
Q4	15.5%	16.8%	19.4%	20.6%
Q5 (high)	18.4%	15.6%	14.6%	18.8%
Primary Care Model Enrolment				
Enrolled in FHT	27.5%	31.0%	28.5%	23.4%
Enrolled in FHG	27.3%	27.7%	29.2%	28.3%
Enrolled in FHO	22.1%	20.2%	21.4%	28.0%
Enrolled in Other Model	3.9%	2.3%	3.2%	4.7%
Not Enrolled in Primary Care Model	19.2%	18.8%	17.7%	15.6%

* Comparison is pool of non-enrolled patients with 2+ conditions (of 55)

Study 1: Characteristics

Variable	2013/14	2014/15	2015/16	Compare*
	N=998	N=2,959	N=6,411	N=478,144
Comorbidity (CADGs)				
Acute minor	87.8%	88.3%	86.0%	71.6%
Acute major	90.5%	92.3%	91.3%	74.9%
Likely to recur	70.0%	73.5%	70.5%	59.4%
Asthma	11.0%	10.2%	6.8%	7.8%
Chronic medical unstable	89.2%	84.2%	80.7%	53.3%
Chronic medical stable	78.4%	82.3%	79.7%	72.2%
Chronic specialty stable	6.7%	8.1%	8.7%	6.7%
Eye/ dental	13.4%	13.2%	11.9%	9.1%
Chronic specialty unstable	16.8%	19.3%	19.0%	12.7%
Psychosocial	53.3%	58.9%	60.9%	45.8%
Prevention, administration	46.3%	46.4%	44.7%	22.1%
Other Characteristics				
High-risk patient (based on LACE score)	42.9%	37.4%	36.3%	
Survived 1-year or more	59.7%	74.5%	78.0%	

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Study 2: Characteristics (select)

Variable	After Matching (1:3) Comparators	Enrollees	SDiff
	N=20,890	N=8,945	
Socio-demographics			
Age at Index (mean, SD)	74.4 ± 9.8	73.4 ± 14.8	0.079
Male Sex	42.7%	43.0%	0.006
Urban Residence (RIO <10)	80.6%	78.6%	0.049
Income Quintile			
Q1 (low)	25.2%	24.6%	0.015
Q5 (high)	14.7%	15.5%	0.021
Cormobidity (CADGs)			
Acute minor	85.4%	85.2%	0.006
Acute major	90.9%	90.2%	0.024
Likely to recur	68.5%	69.1%	0.013
Asthma	7.3%	7.7%	0.015
Chronic medical unstable	81.7%	80.3%	0.035
Chronic medical stable	78.5%	78.9%	0.011
Chronic specialty stable	8.3%	8.3%	0.003
Eye/ dental	12.8%	12.3%	0.016
Chronic specialty unstable	18.9%	18.5%	0.009
Psychosocial	58.3%	57.8%	0.010
Prevention, administration	42.7%	42.2%	0.009

Note: ** denotes SDiff > 0.10 indicating imbalance between groups

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Study 2: Characteristics (select)

Comparable healthcare utilization and cost prior to index in matched set

Variable	After Matching (1:3)		
	Comparators	Enrollees	SDiff
	N=20,890	N=8,945	
Prior Utilization (mean, SD)			
Received Palliative Care (n, %)	11.7%	11.5%	0.007
No. Home Care service-hours	114.7 ± 186.6	112.9 ± 206.1	0.009
No. Inpatient admissions	1.2 ± 1.0	1.3 ± 1.5	0.043
No. Days in acute care	13.1 ± 15.2	13.6 ± 22.4	0.023
No. ED Visits	3.0 ± 4.1	3.2 ± 4.5	0.039
No. Mental Health Hosps	0.0 ± 0.2	0.0 ± 0.4	0.043
No. PC claims	18.2 ± 12.4	18.1 ± 18.9	0.010
No. Specialist claims	36.1 ± 30.2	37.0 ± 40.2	0.025
Total costs ($2016CAD, yr)	$38,591 ± 31277	$37,669 ± 43680	0.024

Note: ** denotes SDiff > 0.10 indicating imbalance between groups

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Study 2: Comparative Results

	Pre	Post	Post v. Pre [REF]	Diff-in-Diffs
Hospitalization (Rate, 95% CI) †				
Matched Enrollees	1.15	1.03	0.90 (0.87-0.93)*	1.47 (1.40-1.54)*
Matched Comparators	0.94	0.58	0.61 (0.59-0.63)*	
Days in Acute Care (Avg, 95% CI) †				
Matched Enrollees	11.3	15.2	1.34 (1.27-1.42)*	1.64 (1.52-1.76)*
Matched Comparators	8.7	7.2	0.82 (0.78-0.86)*	
ED Visits (Rate, 95% CI) †				
Matched Enrollees	1.68	1.57	0.93 (0.89-0.98)*	1.18 (1.10-1.27)*
Matched Comparators	1.41	1.11	0.79 (0.75-0.83)*	
30d Readmissions (%, 95% CI)				
Matched Enrollees	27.0	27.5	1.02 (0.96-1.08)	1.01 (0.93-1.10)
Matched Comparators	24.3	24.4	1.00 (0.95-1.07)	
Post-Discharge Follow-up (%, 95% CI)				
Matched Enrollees	29.6	31.1	1.05 (1.00-1.11)*	1.06 (0.99-1.14)
Matched Comparators	30.1	29.9	0.99 (0.95-1.03)	
Total Cost ($2016CAD, 95% CI) †				
Matched Enrollees	37201	58823	1.58 (1.53-1.64)*	1.35 (1.30-1.41)*
Matched Comparators	32429	37962	1.17 (1.15-1.20)*	

Notes:

† Results presented per person-year

* Statistically significant (p<0.05)

Green = got better

Red = got worse (or unfavourable DID)

Study 2: Possible Selection Bias

Variable	Not Matched	Matched	SDiff
	N=1,423 (13.7%)	N=8,945	
Socio-demographics			
Age at Index (mean, SD)	76.2 ± 13.6	73.4 ± 14.8	0.198**
Male Sex	46.3%	43.0%	0.067
Q1 (low)	25.9%	24.6%	0.029
Cormobidity (CADGs)			
Acute minor	97.2%	85.2%	0.433**
Acute major	99.4%	90.2%	0.425**
Likely to recur	85.2%	69.1%	0.392**
Chronic medical unstable	96.3%	80.3%	0.515**
Chronic medical stable	89.2%	78.9%	0.283**
Chronic specialty stable	8.4%	8.3%	0.003
Psychosocial	70.8%	57.8%	0.275**
Prevention, administration	65.1%	42.2%	0.472**
Other (mean, SD)			
Received Palliative Care (n, %)	26.1%	11.5%	0.381**
No. Home Care service-hours	210.6 ± 344.2	112.9 ± 206.1	0.344**
No. Inpatient admissions	3.1 ± 2.5	1.3 ± 1.5	0.908**
No. Days in acute care	34.8 ± 34.9	13.6 ± 22.4	0.725**
No. Emergency Visits	7.8 ± 14.0	3.2 ± 4.5	0.443**
No. PC claims	29.1 ± 24.7	18.1 ± 18.9	0.501**
No. Specialist claims	77.2 ± 66.5	37.0 ± 40.2	0.732**
Total system costs ($2016CAD, yr)	72941 ± 60390	37669 ± 43680	0.669**
LACE: High-Risk	29.5%	28.8%	0.015
Died within 1y of Health Link start (n, %)	38.9%	22.5%	0.359**

**Standard difference ≥0.10 (covariate is not balanced between groups)

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Useful References

Grudniewicz A, Tenbensel T, Evans JM, Steele Gray C, Baker GR, Wodchis WP. 'Complexity-compatible' policy for integrated care? Lessons from the implementation of Ontario's Health Links. Soc Sci Med. 2018 Feb;198:95-102. doi: 10.1016/j.socscimed.2017.12.029.

Mondor L, Walker K, Bai YQ, Wodchis WP. Use of hospital-related health care among Health Links enrollees in the Central Ontario health region: a propensity-matched difference-in-differences study. CMAJ Open. 2017 Oct 12;5(4):E753-E759. doi: 10.9778/cmajo.20170054.

Bielska IA, Cimek K, Guenter D, O'Halloran K, Nyitray C, Hunter L, Wodchis WP. Change in health care use after coordinated care planning: a quasi-experimental study. CMAJ Open. 2018 May 31;6(2):E218-E226. doi: 10.9778/cmajo.20170053.

Evans JM, Grudniewicz A, Baker GR, Wodchis WP. Organizational Context and Capabilities for Integrating Care: A Framework for Improvement. Int J Integr Care. 2016 Aug 31;16(3):15. doi: 10.5334/ijic.2416.

Many more at HSPRN.CA -> our work -> Applied Health Research Questions -> Health Links
http://hsprn.ca/?p=101

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Questions

Remarks from Helen Angus, Deputy Minister, Ministry of Health and Long-Term Care

Leadership Summit Sommet du leadership

NETWORKING BREAK 10:30-10:45

Collaboration/Relationships enabling Partnerships – Moving from “I” to “We”

How partnerships improve care for patients

Leadership Summit Sommet du leadership

Objectives

- Provide participants with practical strategies to support both formal and informal partnerships
- How regional teams are leading partnerships to enable improved patient care
- Provide participants with the opportunity to have an interactive discussion around collaborative relationships

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BLUEWATER HEALTH

Collaboration/Relationships enabling Partnerships - Moving from “I to We” - how partnerships improve care for patients

HQO Leadership Summit-Nov 30/2018

Paula Reaume-Zimmer, DHA
Integrated VP, Mental Health and Addictions
Bluewater Health and CMHA Lambton Kent

Key Elements to Successful System Planning

- Building **relationships** and an improved understanding of each other's processes, pressures and common goals
- Establish a **common assessment** system
- Empower teams to be **innovative**
- Create **accountability** structures

BLUEWATER HEALTH

Building Relationships

- Shared leadership roles
- Integrated MH&A Leadership Council
- Modeling collaborative behaviour

BLUEWATER HEALTH

Current State; Assessment Tools for MH&A in Ontario

Acute Psychiatry

- interRAI MH; mandated for all acute care hospital admissions (Ontario Mental Health Reporting Systems-OMHRS)

Community Mental Health

- Ontario Common Assessment of Need (OCAN); “strongly recommended” for select programs and services

Addictions Services

- Global Appraisal of Individual Needs (GAIN); mandated with plans to transition from Admission and Discharge Assessment (ADAT)

Emergency Dept.

- Psychiatric Nursing Assessments (PAN) -nothing mandated, largely organization-customized risk assessment or interRAI ESP

Innovative System-Wide Solutions Needed to End Hallway Medicine

Government encouraging hospitals to imagine the "hospital of 2050"

Dr. Devlin said his long-term vision for the health care system is "simple": to imagine a hospital in the year 2050 where everyone was connected. This type of thinking around interconnectedness, efficiency and innovation will inform the decisions made by government and the future Premier's Council

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BLUEWATER HEALTH

Mental Status Indicators (MSI)
Ongoing measure throughout treatment

File ▾ Info ▾ Shortcuts ▾

B Sharp Health Centre

May 13, 2018

MSI Pivot Report

Client **Test, Patient (00012345) Male 37**

An * next to the indicator scoredenotes that a note was recorded when the indicator was documented.
Click on the underlined Indicator ID next to the Indicator description to view the notes and trending details

		2017-08-25	2017-08-31	2017-09-07	2017-09-14	2017-09-27	2017-10-04	2017-10-19	2017-11-13	2017-11-20	2017-11-29	2017-12-13	2017-12-18	2018-01-02	2018-01-09	2018-01-11	2018-01-15	2018-01-22	2018-01-30	2018-02-13	2018-03-05	2018-03-12	2018-04-10	2018-04-17	2018-05-07
Abnormal Thought	5411	1 *	2*	2*	2*	2*	2*	1 *	0	2*	2*	3*	1	0	0	2*	0	0	2*	0	0	2*	3*	2*	0
Anger	5418	0	0	0	0	0	0	0	0	0	0	0	1			0			0	0		0	1	0	0
Anhedonia	5413	2*	2*	0	2*	1 *	2*	2*	1 *	2*	3*	2*	0	0	1	2*	1	1	3*			2*	3*	2*	3*
Anxious Complaints	5402	3*	2*	2*	2*	3*	2*	3*	3*	3*	3*	3*	1	1	2*	3*	1	1	3*	3*	3*	3*	3*	2*	3*
Blunted Affect	5401	0	0	0	0	0	0	0	0	0	0	0	1			0			0	0		0	0	0	0
Command	5412	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Compulsive Behavior	5405	0	0	0	0	0	0	0	0	0	0	0	0			0			0	0	3*	0	0	0	0
Decreased Energy	5389	0	0	0	0	0	1 *	0	0	0	0	0	0			0			2*	0		0	2*	2*	0
Delusions	5410	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Difficulty in Falling	5433	0	0*	0	0	0*	0*	2*	0	0	0	0	0			0			2*	2*		3*	3*	3*	3*
Disorientation	5422	0	0	0	0	0	0	0	0	0	0	0	0			0			0	0		0	0	0	0

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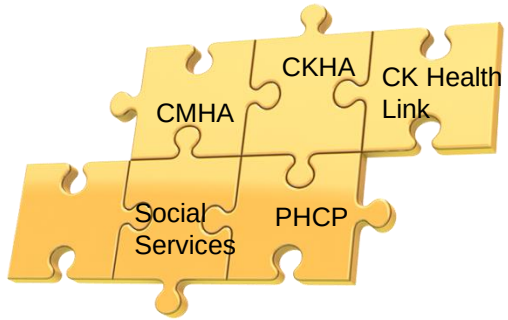
B Sharp Health Centre
May 13, 2018

MSI Details for Anxious Complaints

Client **Test, Patient (00012345) Male 37**

MSI Date	Score	Note
2017-10-19	3	Patient reports that anxiety symptoms are still present on a daily basis. Patient rated anxiety symptoms as a 4-5 out of 10 in regards to severity. Patient and his Nurse discussed coping strategies in regards to anxiety symptoms.
2017-11-13	3	Patient reports that anxiety symptoms are present and occur on a daily basis. Nurse and patient reviewed coping strategies in regards to managing symptoms of anxiety. Patient reports that anxiety symptoms have been more significant as of late since starting new employment
2017-11-20	3	Patient reports that anxiety symptoms are present and occur on a daily basis. Patient and Nurse discussed coping strategies in regards to managing symptoms of both anxiety and depression.
2017-11-29	3	Patient reports that he experiences anxiety symptoms on a daily basis. Patient rated anxiety symptoms as a 5 out of 10 in regards to severity. Patient and nurse went over coping strategies in regards to managing anxiety symptoms.
2017-12-13	3	Patient reports that he experiences anxiety symptoms on a daily basis, patient reports he will experience anxiety when he is at home and in a non-stimulating environment. Patient and nurse went over coping strategies in regards to managing symptoms of anxiety.
2017-12-18	1	
2018-01-02	1	
2018-01-09	2	Client reports that he does not trust mother-in-law client believes that she does not tell him all of the information he needs to know about his mental health.
2018-01-11	3	Patient reports that anxiety symptoms are present and experienced on a daily basis. Patient and nurse reviewed coping strategies in regards to managing symptoms of anxiety, patient

Innovative Partnerships

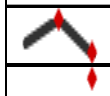
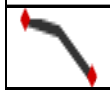


- The Community-Based MH Rapid Assessment, Intervention and Treatment Program (RAIT) will **partner** closely with **Primary Health Care Practitioners** (PHCP) and their respective teams.
- **Remove barriers to access**: there will be no intake process, a request for services will be accepted based on the PHCP or their team members' perceived need for RAIT involvement.
- **Offer a timely mental health intervention** and coordinate outreach services (specialized assessments, treatment, case management or support services)
- **Collaborate and communicate** with primary health care providers and their team to **coordinate** mental health needs at early onset, reducing the long term reliance on mental health services.

Shared Accountability

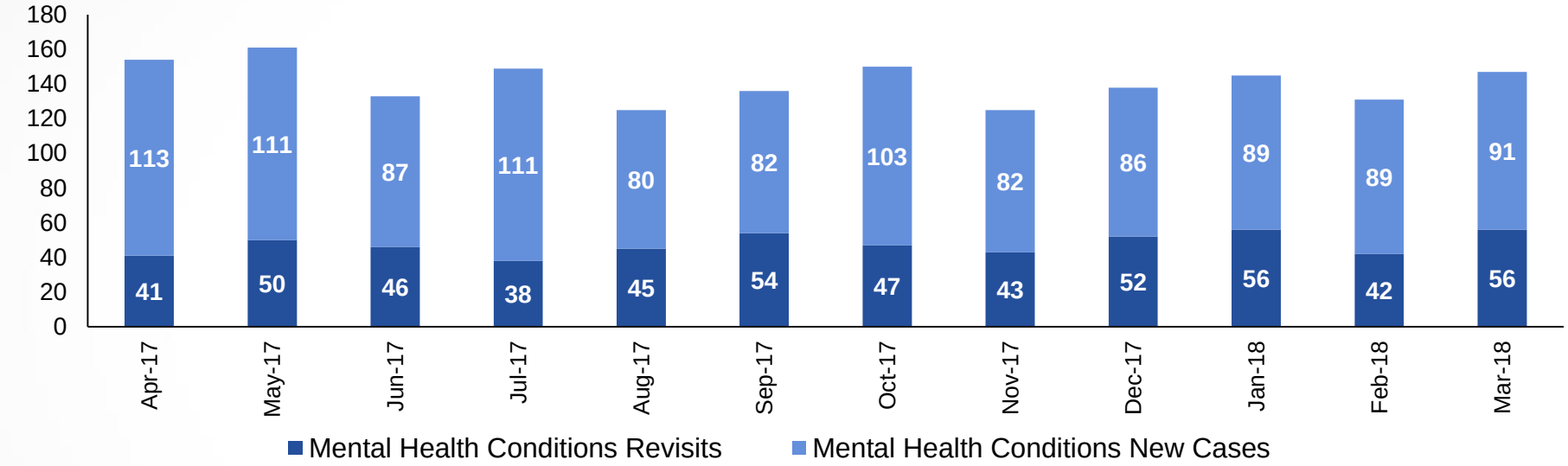
BWH Emergency Dept. Readmission Rates:

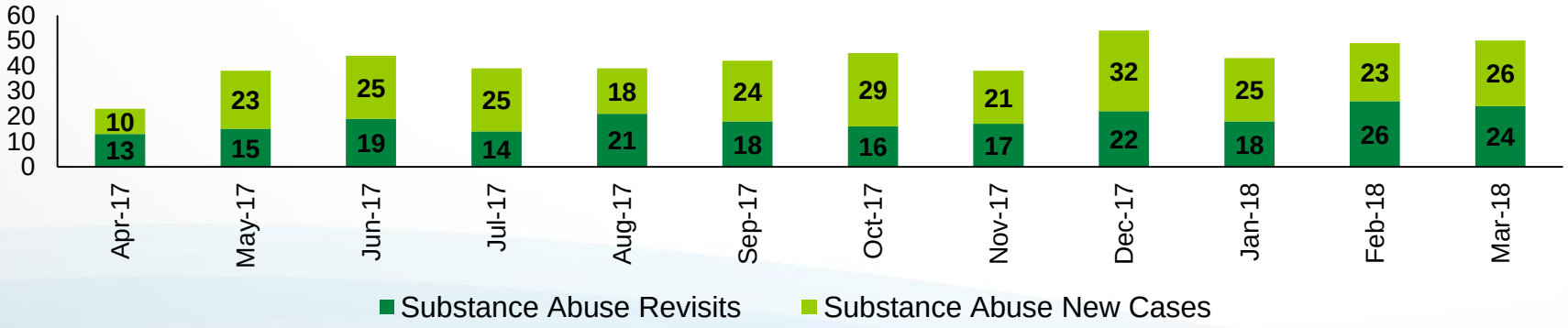
Repeat Visits within 30 days: Mental Health	%	Target	16.3	16.3	16.3	16.3	16.3	16.3	16.0	16.0	16.0	16.0	16.00	16.3
		LHIN	17.0	16.1	17.5	19.2	18.9	20.8	18.5	17.9	18.9	18.1	17.50	18.10
		BWH-Petrolia	14.6	14.6	10.0	16.7	10.8	11.0	20.0	18.9		14.9	13.30	13.40
		BWH-Sarnia	10.2	16.7	13.5	15.6	14.0	19.0	15.8	16.6	14.6	15.7	17.60	14.30
Repeat Visits within 30 days: Substance Abuse Blank Cells = Low Volumes	%	Target	22.4	22.4	22.4	22.4	22.4	22.4	22.4	22.4	22.4	22.4	22.40	22.40
		LHIN	25.4	24.2	25.9	23.9	25.3	32.5	29.1	35.8	35.1	31.3	35.00	29.20
		BWH-Petrolia												24.60
		BWH-Sarnia	23.1	20.2	21.8	21.4	31.8	36.8	43.4	30.1	37.1	36.6	34.60	26.60

	3%
	1%
	-19%
	0%
	-17%
	

BLUEWATER HEALTH

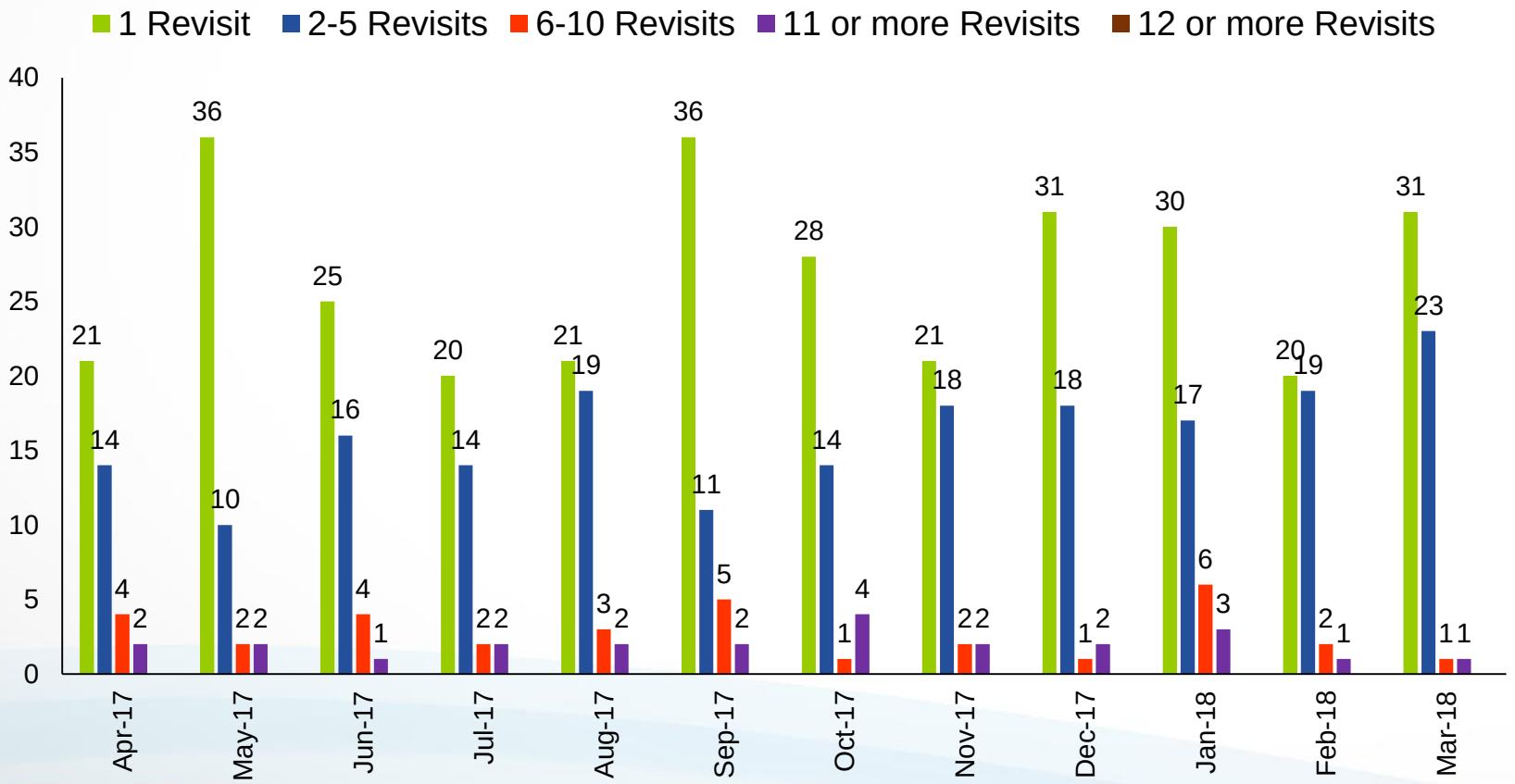
New vs Repeat Patients at the Sarnia ED for Mental Health/Substance Abuse Conditions in 12 month period FY 2017/18





BLUEWATER HEALTH

Number of patients visiting Sarnia ED with Mental Health Condition with more than 1 visit within past 12 months to Sarnia ED with Mental Health Condition



BLUEWATER HEALTH

Bluewater Health & Canadian Mental Health Association Lambton Kent; Leading Mental Health Partnerships and Integration: Implication for Client Care

- Integration supports ESC LHIN Strategic Plan
- Integration creates a Lead Agency model for MI
- Reduces duplication i.e. intake processes
- Reduces the footprint of real estate
- MH Providers partner with PHC
- Readiness to respond to CK Health Links
- Maintain expertise & quality care
- Challenges status quo in similar models, with similar partners in other communities

South Georgian Bay Community Health Centre

Every One Matters.

G&M HOSPITAL FOUNDATION

United Way Centraide Simcoe Muskoka

COLLINGWOOD G&M HOSPITAL

O.P.P.

Mental Health Response Unit

Breaking down Barriers

A JOINT VENTURE BETWEEN
THE COLLINGWOOD GENERAL AND MARINE HOSPITAL
AND THE ONTARIO PROVINCIAL POLICE

The MHRU consists of two plain clothes Police Constables (***Shannon Donnelly and Karen Viragh***) and one Mental Health Case Worker (***Alice Afram***)

The partnership is jointly overseen by :

Karen Fleming, CGMH VP Patient Experience & Chief Nursing Executive

Inspectors Philip Browne and Mary Shannon, Ontario Provincial Police

Anticipated Outcomes

- Mobilizing the mental health professional to calls in the home, school, street or clinic in a timely manner;
- Developing a management strategy focused on ensuring the dignity and respect of the individual in crisis
- Engaging in pre-emptive strategies to prevent further crises with individuals and their families
- Decriminalize Mental Health in the system
- ***Improving efficiencies in Police calls for service***
- ***Improving efficiencies in Hospital patient services***

What we do

- Telephone crisis response during regularly scheduled hours of work.
- Joint mobile crisis response to 911 dispatched calls
- Short term crisis management for the individual(s) experiencing the crisis (includes: follow-up of referrals, attending case conferences, advocacy, support and ongoing assessment and monitoring of mental status and behaviours as part of crisis resolution)
- Outreach as an intervention (referrals submitted by OPP, Hospitals, Community Agencies and individuals)

Partnering

- Identify areas of high-needs for patients in the community as per your organizations statistical analysis *(Dementia, Mental Health, Housing)*
- Brainstorm ways in which your organization can assist in creating efficiencies for the needs identified.
  - What are the gaps? *(funding restraints? Space?)*
- Identify key service providers in your community who assist in the above areas of need
  - Hospitals, Non-profit agencies, LHIN?
- Research any existing initiatives that address similar areas of need
- Connect with program developers/coordinators of your findings for additional information

Cont…

- Devise a rough sketch of ideas on how the researched initiatives can be incorporated into your agency/organizations plan of care/service
- Identify key stakeholders for execution of collaborative project
- Schedule an informal meeting with service providers in your area to discuss these collaborative efforts for change
  - Legal obligations, privacy concerns, funding, etc
- Schedule timely meetings for group updates, and timelines for important stages in project creation

Success

- MHRU's first year of operation demonstrated the following improvements in patient care:
  - Reduced number of Crisis patients to the ED
  - Reduced ED wait times by >70%
  - Cost savings for both systems (OPP – 79%)
  - Reduced number of police apprehensions by >6%
- MHRU was the recipient of the **Ministry of Health's Transformation Award in 2018**
- MHRU's impact on patient wellness has secured additional funding for our Fourth Quarter through the **United Way**
- MHRU was apart of the successful implementation of a Unit in the Midland and Penetanguishene area between local OPP and Waypoint Centre for Mental Health Care in 2018
- LHIN approved funding for MHRU model in 2019 budget

Table Discussion

- Group 1 Tables: What are some of the local examples or strategies that were successful in creating collaborative relationships?

- Group 2 Tables: How is collaborative leadership different from partners ‘just working well together?”

- Group 3 Tables: Based on the plenary discussion what ideas will you taking back to your organization?

11:30 – 12:45

12:45 – 2:00 p.m.
Breakout Session 1A: St. David Room
Breakout Session 1B: St. Patrick Room
Breakout Session 2: Ballroom East
Breakout Session 3: Ballroom Centre

Benefits in Care as Patient Identification and Coordinated Care Progress in Maturity

Breakout Session #2

Ballroom East

November 30, 2018

Leadership Summit | Sommet du leadership

Objectives

1. Learn how to improve care by maturing clinical processes to further integrate systems enabling patient identification and care coordination capabilities across regions
2. Understand how patients and caregivers are engaged in care coordination and how they are empowered to be active members of the care team
3. Learn how the analysis of data adds value to the system and drives improvement across regions

Benefits in Care as Patient Identification and Coordinated Care Progress in Maturity

November 30, 2018

Presented By: Anum Rafiq, Senior Manager, Quality Improvement LHIN Initiatives,
Central East LHIN

Ontario
Local Health Integration Network

Introduction:

- The Central East LHIN's Coordinated Care Planning Working Groups aligned their work plans with the deliverables identified in the Health Links Maturity Journey.

- The Central East LHIN's Coordinated Care Planning Working Groups were challenged with developing tangible activities based on these deliverables as descriptions were often broad and subjective.

Methods:

- Step 1: Environmental Scan of existing measures, practices and experiences related to the Health Links Maturity Journey;
- Step 2: Develop operational definitions for each deliverable in the five levels of maturity across the four domains;
- Step 3: Priority setting exercise leading to 14 Plan-Do-Study-Act cycles (PDSAs);
- Step 4: Project implementation for 3-6 Months; and
- Step 5: Project Evaluations/Maturity Journey re-assessment.

Project Titles:

Scarborough North & South

- CCP Review and Revision Process
- Coordinated Care Conferencing Strategy
- Patient Reported Outcome Measure Survey Strategy
- Patient SMART Goal Development

Northumberland County

- Journey of a Coordinated Care Plan
- Provider Experience Survey

Haliburton County City of Kawartha Lakes

- Patient Goal Setting/Creating Conversations
- Roles and Responsibilities Analysis

Durham North East & West

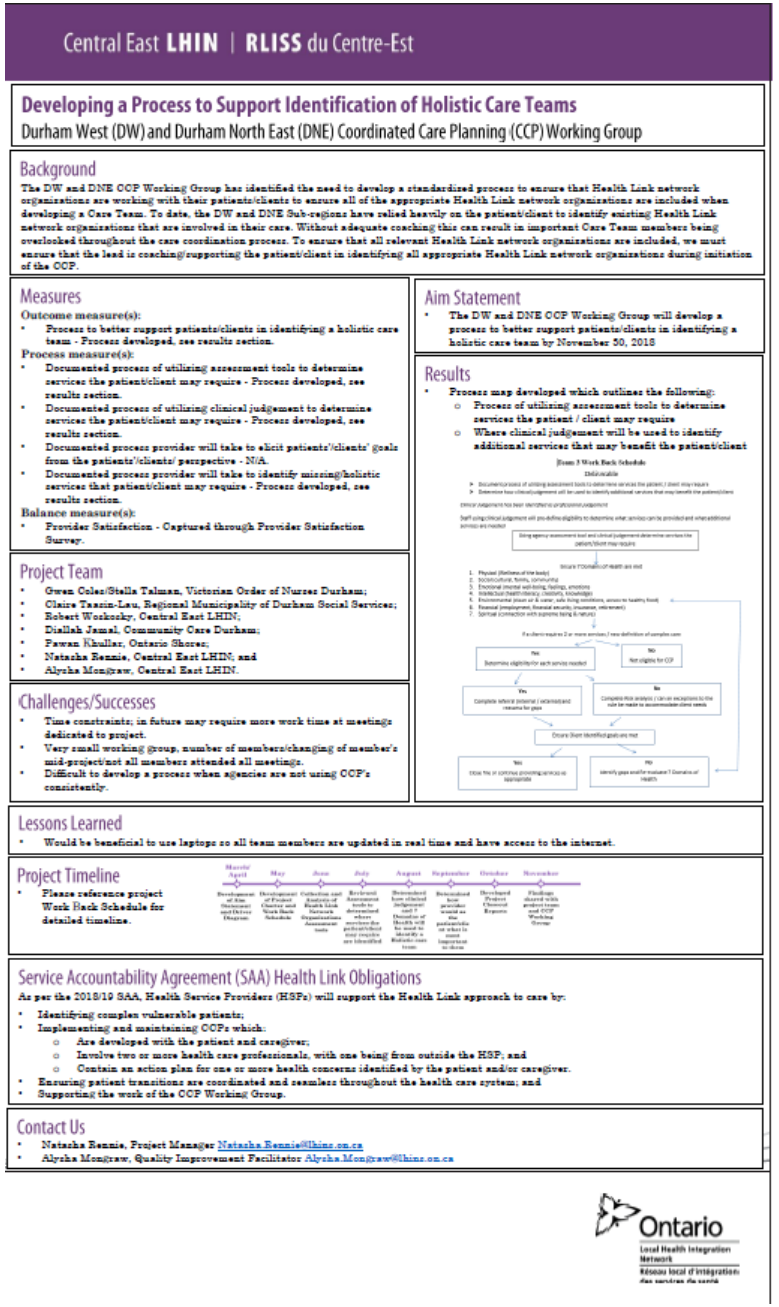
- Increasing the Number of Patient/Clients Identified for a Coordinated Care Plan (CCP)
- Ensure that Health Link network organizations have an Understanding of Each Other's Programs and Services
- Developing a Process to Support Identification of Holistic Care Teams
- Provider Experience Survey

Peterborough County

- Real Time Patient Identification
- Internal Communication and Education Plan

Results:

- Advancement to the next level of maturity within each Domain of the Health Links Maturity Journey achieved!
- Project Closeout Reports created for purposes of spread and scale;
- Better understanding of coordinated care planning processes amongst Health Link network organization; and
- Increased awareness of challenges, informing future phases of project planning.



Central East LHIN | RLISS du Centre-Est

Developing a Process to Support Identification of Holistic Care Teams

Durham West (DW) and Durham North East (DNE) Coordinated Care Planning (CCP) Working Group

Background

The DW and DNE CCP Working Group has identified the need to develop a standardized process to ensure that Health Link network organizations are working with their patients/clients to ensure all of the appropriate Health Link network organizations are included when developing a Care Team. To date, the DW and DNE Sub-regions have relied heavily on the patient/client to identify existing Health Link network organizations that are involved in their care. Without adequate coaching this can result in important Care Team members being overlooked throughout the care coordination process. To ensure that all relevant Health Link network organizations are included, we must ensure that the lead is coaching/supporting the patient/client in identifying all appropriate Health Link network organizations during initiation of the CCP.

Measures

Outcome measure(s):
- Process to better support patients/clients in identifying a holistic care team - Process developed, see results section.

Process measure(s):
- Documented process of utilizing assessment tools to determine services the patient/client may require - Process developed, see results section.
- Documented process of utilizing clinical judgement to determine services the patient/client may require - Process developed, see results section.
- Documented process provider will take to elicit patients'/clients' goals from the patients'/clients/ perspective - N/A.
- Documented process provider will take to identify missing/holistic services that patient/client may require - Process developed, see results section.

Balance measure(s):
- Provider Satisfaction - Captured through Provider Satisfaction Survey.

Aim Statement

- The DW and DNE CCP Working Group will develop a process to better support patients/clients in identifying a holistic care team by November 30, 2018

Project Team

- Gwen Coles/Stella Talman, Victorian Order of Nurses Durham;
- Claire Tassin-Lau, Regional Municipality of Durham Social Services;
- Robert Woskosky, Central East LHIN;
- Diallah Jamal, Community Care Durham;
- Pavan Khullar, Ontario Shores;
- Natasha Rennie, Central East LHIN; and
- Alysha Monjraw, Central East LHIN.

Results

- Process map developed which outlines the following:
  - Process of utilizing assessment tools to determine services the patient / client may require
  - Where clinical judgement will be used to identify additional services that may benefit the patient/client

Challenges/Successes

- Time constraints; in future may require more work time at meetings dedicated to project.
- Very small working group, number of members/changing of member's mid-project/not all members attended all meetings.
- Difficult to develop a process when agencies are not using CCP's consistently.

Lessons Learned

- Would be beneficial to use laptops so all team members are updated in real time and have access to the internet.

Project Timeline

- Please reference project Work Back Schedule for detailed timeline.

Service Accountability Agreement (SAA) Health Link Obligations

As per the 2018/19 SAA, Health Service Providers (HSPs) will support the Health Link approach to care by:
- Identifying complex vulnerable patients;
- Implementing and maintaining CCPs which:
  - Are developed with the patient and caregiver;
  - Involve two or more health care professionals, with one being from outside the HSP; and
  - Contain an action plan for one or more health concerns identified by the patient and/or caregiver.
- Ensuring patient transitions are coordinated and seamless throughout the health care system; and
- Supporting the work of the CCP Working Group.

Contact Us

- Natasha Rennie, Project Manager Natasha.Rennie@lhins.on.ca
- Alysha Monjraw, Quality Improvement Facilitator Alysha.Monjraw@lhins.on.ca

Ontario Local Health Integration Network / Réseau local d'intégration des services de santé

Questions?

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Quality Improvement LHIN Initiatives,
Central East LHIN
Anum.rafiq@lhins.on.ca
Telephone: 905 430 3308 x 5879
Cell: 905-626-4827

Central East **LHIN** | **RLISS** du Centre-Est

LOFT

A Dignified Life for Everyone

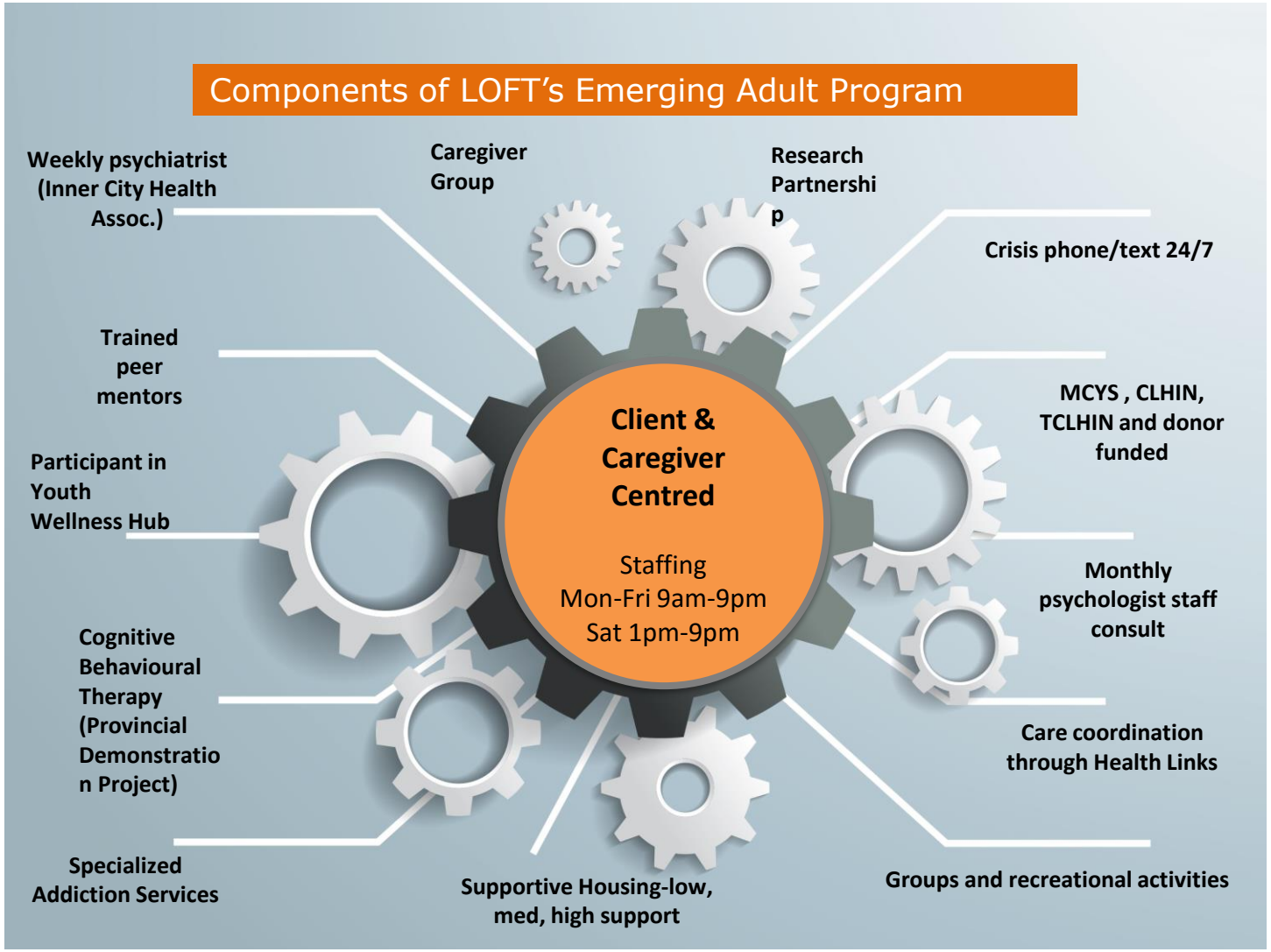
Coordinated Care Plans with Transitional Age Youth

Learnings

Presented by Karen O'Connor, Senior Director of Community Health Services

Koconnor@loftcs.org

LOFT


Components of LOFT's Emerging Adult Program
Weekly psychiatrist (Inner City Health Assoc.)
Caregiver Group
Research Partnership
Crisis phone/text 24/7
Trained peer mentors
MCYS , CLHIN, TCLHIN and donor funded
Participant in Youth Wellness Hub
Monthly psychologist staff consult
Cognitive Behavioural Therapy (Provincial Demonstration Project)
Care coordination through Health Links
Specialized Addiction Services
Supportive Housing-low, med, high support
Groups and recreational activities
Client & Caregiver Centred
Staffing
Mon-Fri 9am-9pm
Sat 1pm-9pm

The Pilot - TCLHIN

- Steering Committee - youth, primary care, providers
- The Health Link had a high number of TAY with MHA issues and high teenage pregnancy rates
- Assisted to develop communication strategy, common CCP training to serve youth
- LOFT and another youth providers for the pilot
- Referrals from inpatient, CMHO, shelters

Results

- 59 youth with serious and complex health conditions
- Common issues: unattached to needed supports such as psychiatry, substance use, homelessness and recent hospitalizations
- CCP process - postcard-sized info that outlined the process of the CCP, confidentiality
- After 12 months **feedback** was gathered re best practices from youth, family, staff, other service providers

Feedback

Successes

- The CCP provided a model for engagement with the youth, and working with other providers
- Case managers were considered ideal for supporting CCPs with TAY
- Educating other providers about developmental needs
- "The CMs go by a different tactic, which is not like 'Here are the services, what do you want?' but 'What do you need? And then...what can we support to access?'"
- Allowed for a deeper understanding of complexities "The CM helps me and other

Feedback

Challenges

- Regular contact with all the service providers in the CCP proved challenging; Primary Care challenging to find and to engage
- The tool focuses on end of life care. Youth future oriented
- Families need support and that needs to be strongly considered as part of the CCP planning

Improving Patients' Experiences of Transitions from Hospital to Home

Leadership Summit 2018

November 30, 2018

Carol Fancott

Patient and Citizen Engagement and Northern and Indigenous Health

Carol.fancott@cfhi-fcass.ca

Let's make change happen

The Canadian Foundation for Healthcare Improvement works **#shoulder2shoulder** with you to improve the health and care of all Canadians.

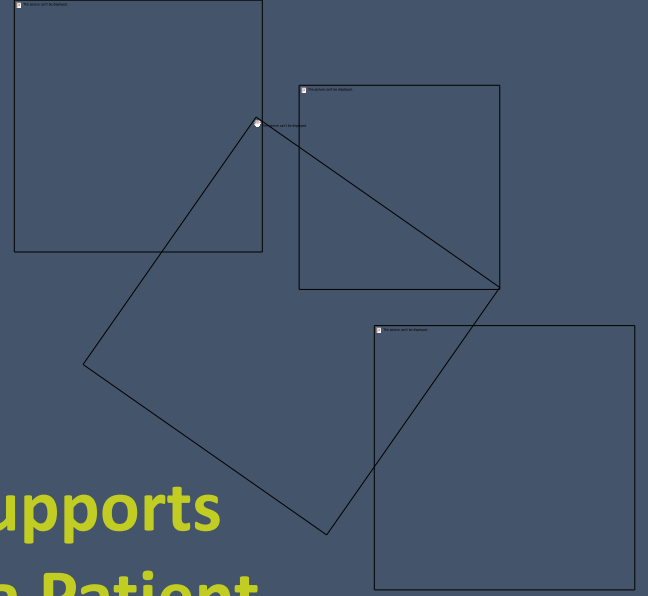
Identify proven innovations

Spread across Canada

SCALE UP throughout health systems

BRIDGE TO HOME

Partnering with patients and families to improve the patient experience in care transitions from hospital to home.



GOALS OF THE COLLABORATIVE

- ✓Improve the patient and caregiver experience of transitions from hospital to home/community care
- ✓Improve the confidence of patients (and caregivers) to manage their care as they transition to home
- ✓Improve provider experience of care
- ✓Reduce avoidable hospital readmissions
- ✓Enhance the ability of teams to effectively partner with patients and caregivers in improvement initiatives

This collaborative supports implementation of a Patient-oriented care transitions bundle:

- Patient oriented discharge summary (PODS)
- Patient education strategies
- Supporting families as partners in care
- Post-discharge follow up care


CONTINUUM
• Consultation • Involvement • Partnership / Leadership
LEVELS
• Direct Care
• Organization
• Policy
MOSAIC
of engagement
• Within CFHI
• Within improvement teams
© Sonia King 2008

Patient Engagement Resource Hub

Find tools to engage patients and families in improving health and healthcare

https://www.cfhi-fcass.ca/WhatWeDo/PatientEngagement/PatientEngagementResourceHub.aspx

Longwoods

COMING SOON....

Special Edition: Patient and Family Engagement for Improvement and System Re-design (Dec 2018)

Healthcare Quarterly

HealthLink South West
Let's Make Healthy Change Happen

Maillon santé Sud-Ouest
Favorisons la santé

Using Data to Inspire a Shift to Person-driven Care

Jennifer Mills Beaton & Amber Alpaugh-Bishop
Leadership Summit – November 30, 2018

Ontario

“Learn how the analysis of data adds value to the system and drives improvement across regions.”

- Housing all Coordinated Care Plans in CHRIS & creating a Centralized Tracking Sheet
- Collecting and analyzing patient/client/caregiver & provider feedback (online surveys)
- Building and sharing South West & Sub-Region dashboards for HL tables and 1 – pager for SRITs
- Sharing stories

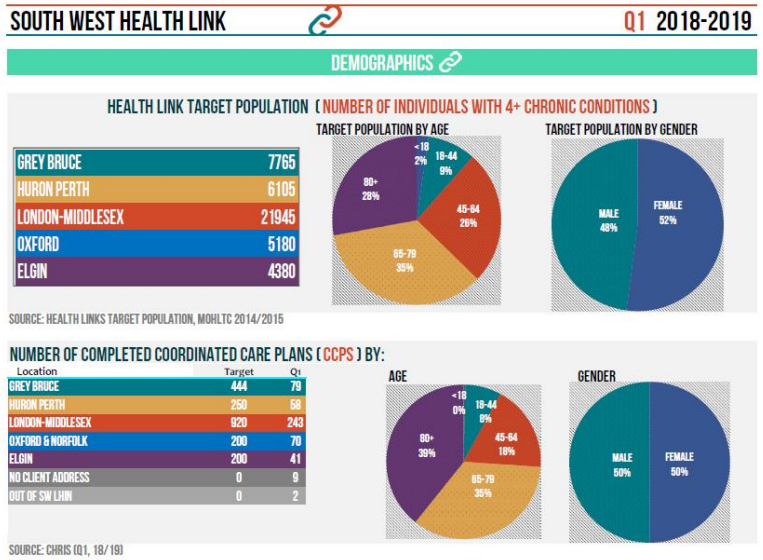
Centralized Tracking Sheet with > 90 columns of data

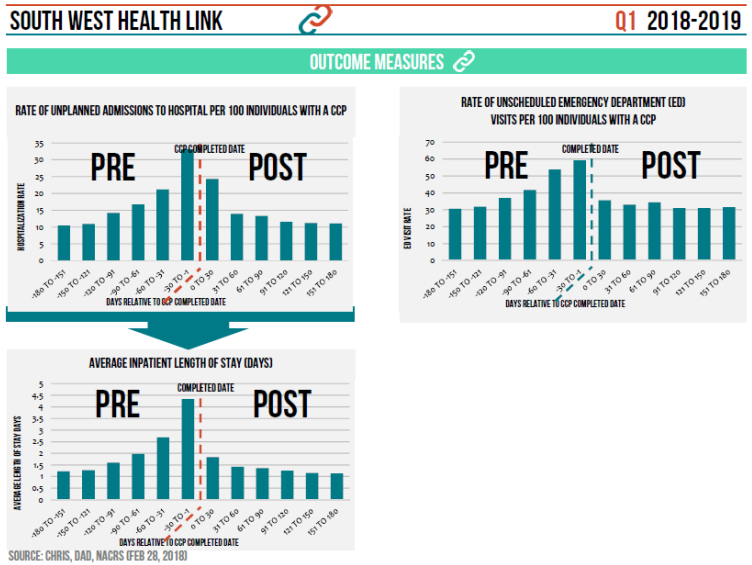
- Patient identifiers
- Sub population information (e.g. chronic, senior)
- Attachment to Primary Care
- Referral details
  - E.g. Sector, Dates
- CCP details
  - E.g. Creation, Conference, Completion dates
- Wait time calculations
- Coordinating Lead contact information
- Hospital Utilization
  - E.g. ED visits, Admissions, Length of Stay

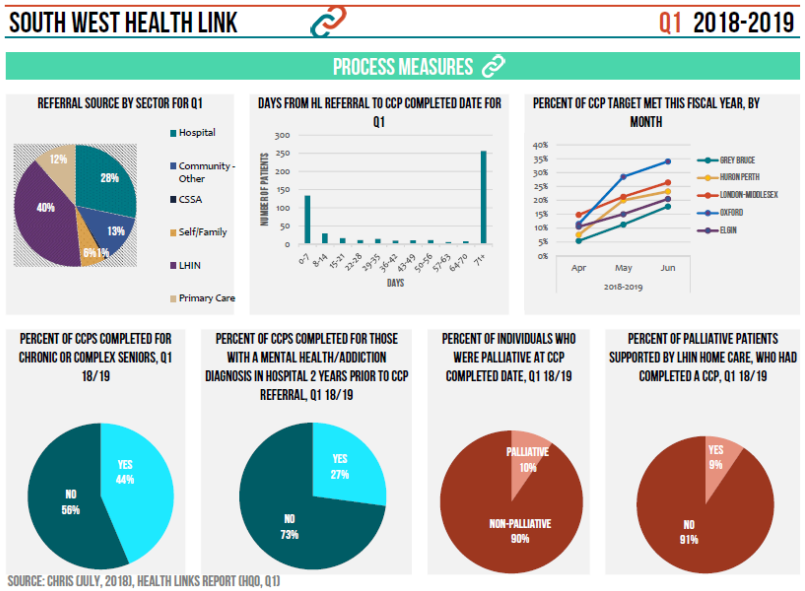
Online Surveys to Capture the Experience

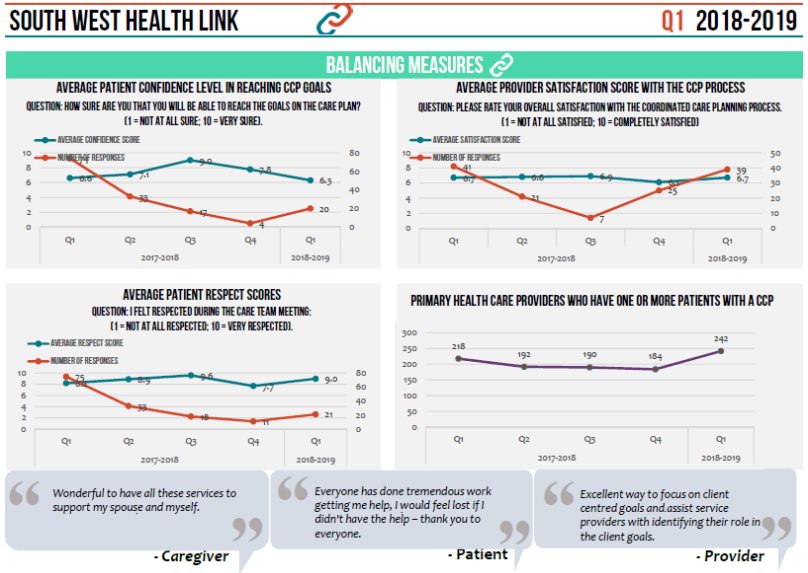
- Patient/Client/Caregiver & Provider surveys
- Survey Monkey platform
- Surveys promoted on Health Links websites & quarterly via eBlast newsletter
- Patient survey facilitated by Phone
- Provider survey link is embedded in Coordinated Care Planning meeting invites

South West Dashboard:







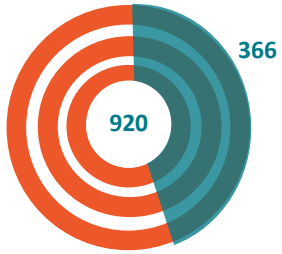


1 Pager -- Coordinated Care Planning is having an impact…

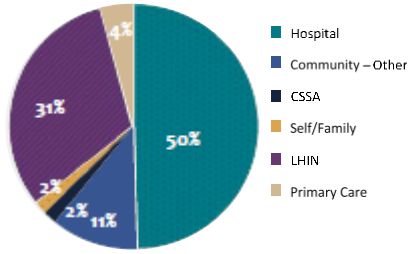
London Middlesex – Q2 FY 18/19 – Health Links Coordinated Care Planning Summary

1,344 people in London Middlesex supported by Coordinated Care Planning since 2015

3,218 people in the South West LHIN since 2014



Progress compared to target, 2018/19

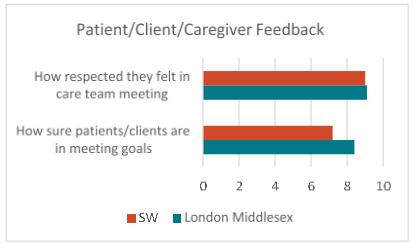


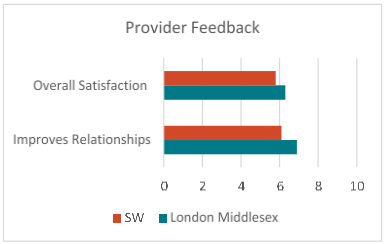
Referral source by sector, Q2 2018/19

Coordinated Care Planning (CCP) is making a difference…

	EMERGENCY Visits (rate per 100 patients)		Admissions (rate per 100 patients)		Average Length of Stay	
	London Middlesex	SW	London Middlesex	SW	London Middlesex	SW
3 months post CCP	40%↓	35% ↓	47%↓	40% ↓	6.0 days↓	5.7 days ↓
6 months post CCP	27%↓	26% ↓	43%↓	37% ↓	5.5 days ↓	5.2 days ↓

**Percentage change is the difference in rate of utilization 3 and 6 months prior to CCP date and 3 and 6 months post CCP date. Data is cumulative (2014-present). Source: CHRIS; NACRS; DAD.*





"Have been able to use the CCP tool to have some of my patients simply feel heard and for others to organize the chaos around them"
~Provider~

Knowing you have other people working with you, very experienced, come with knowledge and connections"
~Caregiver~

"I went from being miserable to happy"
~Patient~

HealthLink / Maillon santé

"I went from being miserable to happy"

"Literally, unlike anything I have ever participated in before – it's a dialogue instead of a monologue."

"I thought it was really helpful; as a caregiver, I was feeling overwhelmed and needed more respite time. I was feeling burned out and it was addressed"

Contact Information

- Jennifer Mills Beaton, Program Lead, South West Health Links, jennifer.millsbeaton@lhins.on.ca
- Amber Alpaugh-Bishop, Director, Planning and Integration, Elgin Sub-Region, amber.alpaugh-bishop@lhins.on.ca

Champlain LHIN

Using data to add value and drive ongoing quality improvement

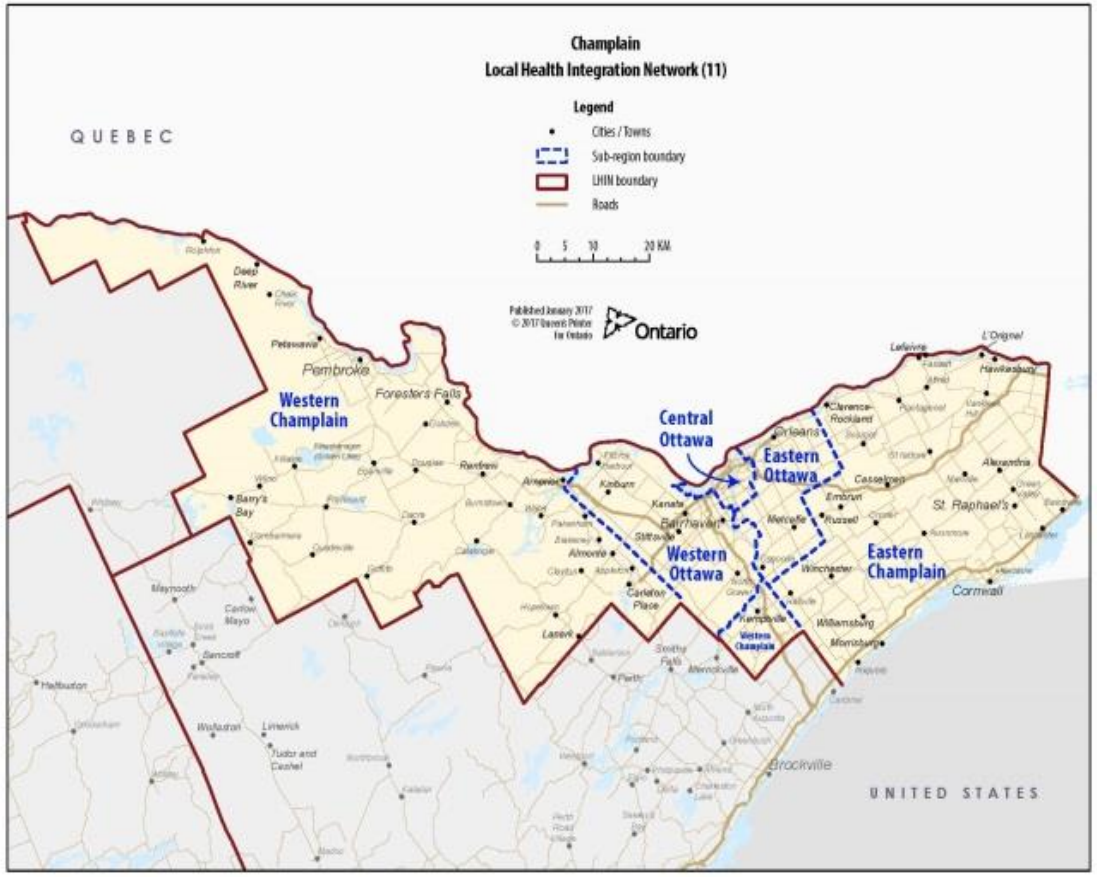
HQO Leadership Summit
November 2018

Paula Greco
Champlain LHIN

Ontario
Local Health Integration Network

The Champlain LHIN

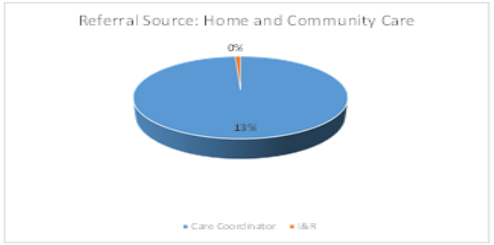
- 5 Health Link areas aligned with sub-region geographies
- Dispersed model care coordination
- 2018/19 - 4000+ patients with Health Links care coordinators
- Client Health Referral and Information System (CHRIS) adopted as common platform

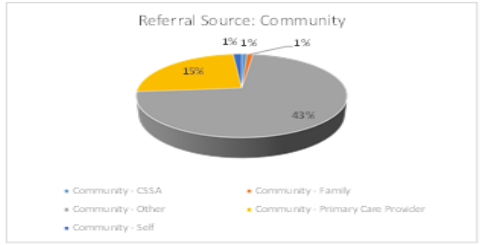


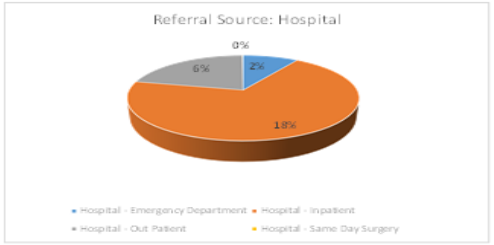
Sample Data Reports

Identification Source

Total Home & CC	13%
Total Community	61%
Total Hospital	26%



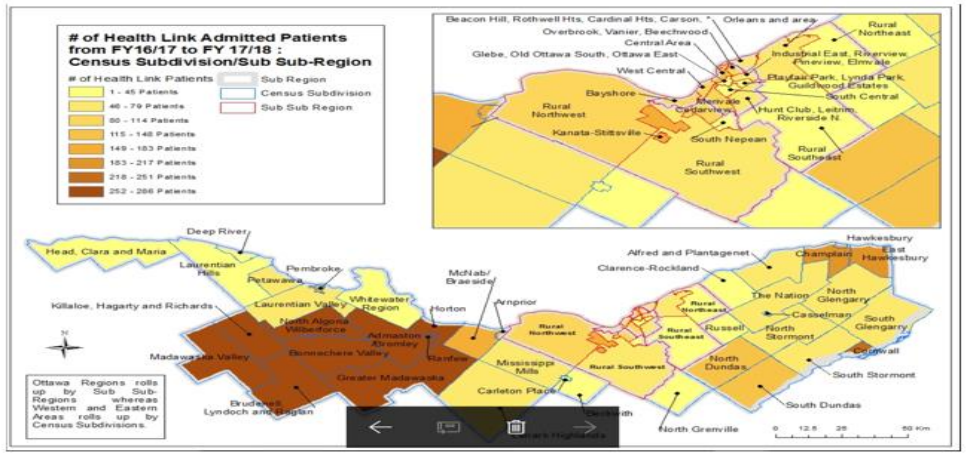




Overall average rate of increase is **15% or 129** patients per month. Rate of identification appears to **decreasing slowly over time**.

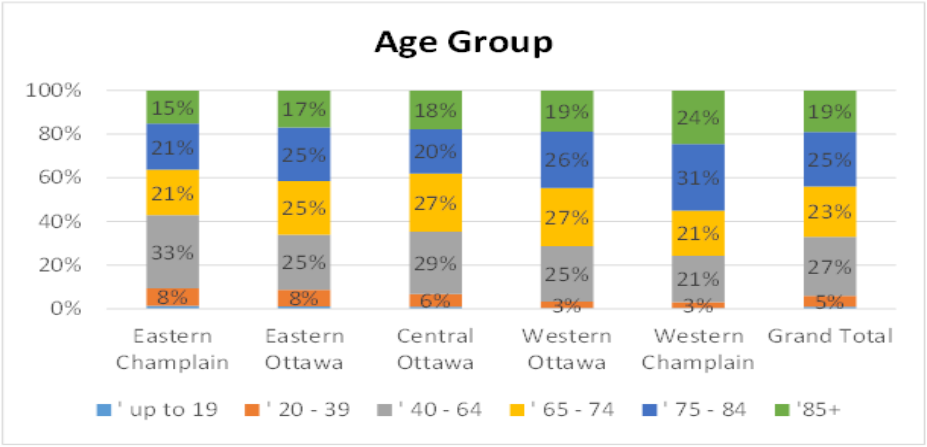
4

Patient Location



7

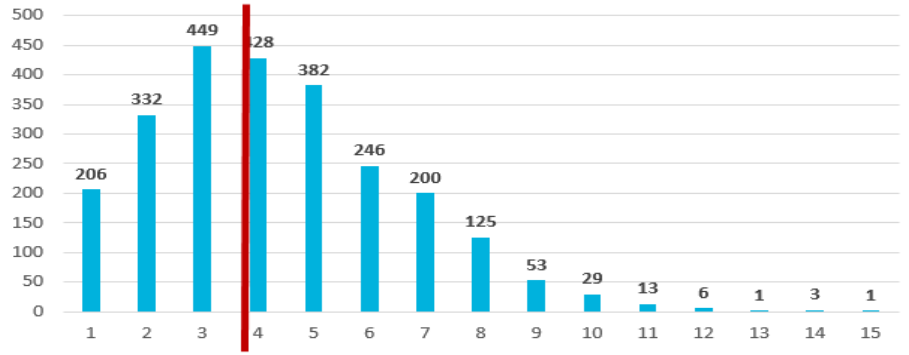
Age Group



Over 44% of HL patients are over the age of 75; 23% are between the ages of 65 and 74; 27% are between 40 and 64 years; 5% are 20-39 years; and less than 1% is under the age of 18.

11

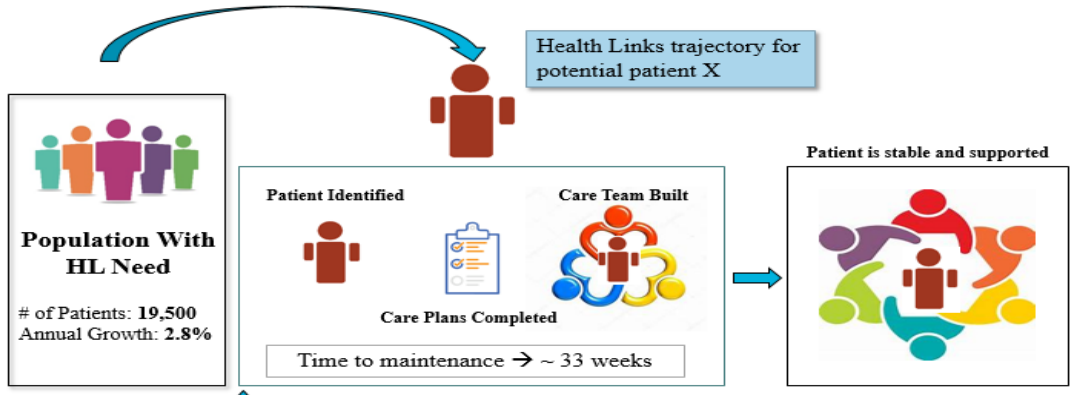
Number of Conditions



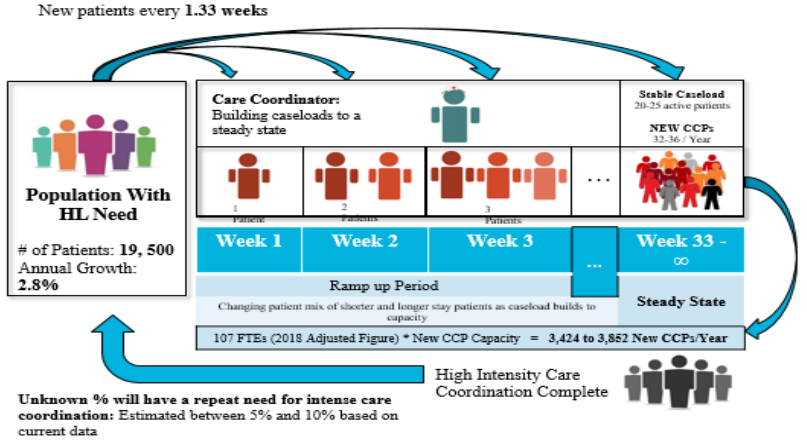
There is very little variation among sub regions. Range of patients with 4+ conditions is **58% to 65%.** The proportion of Health Links patients that have 4+ conditions has remained fairly stable over time.

15

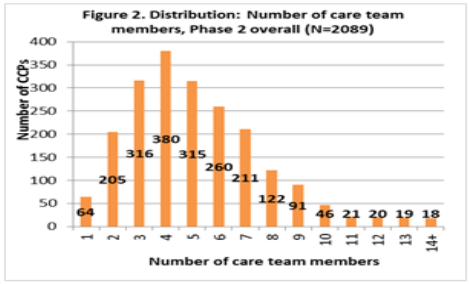
Health Links Trajectory of Care

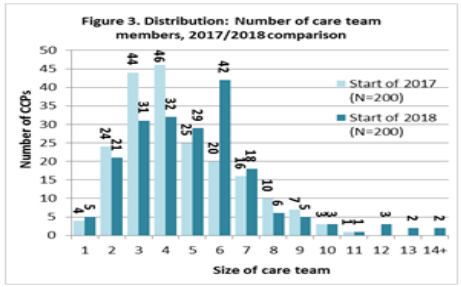


Conceptual Model: Building Health Links Caseloads to a Steady State



Care Team Size

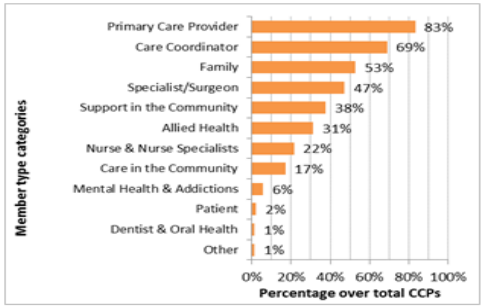


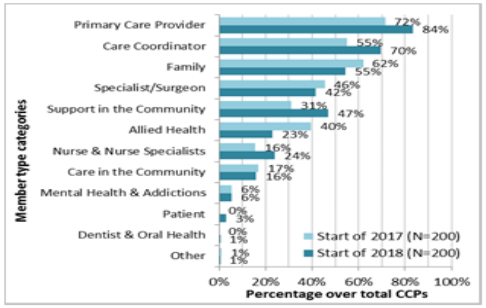


The mean number of care team members is 5.2, median of 5, range of 1-31. The median range across sub-regions 3-6.

A sizeable proportion (13%) of CCPs had only two members.

Care Team Composition



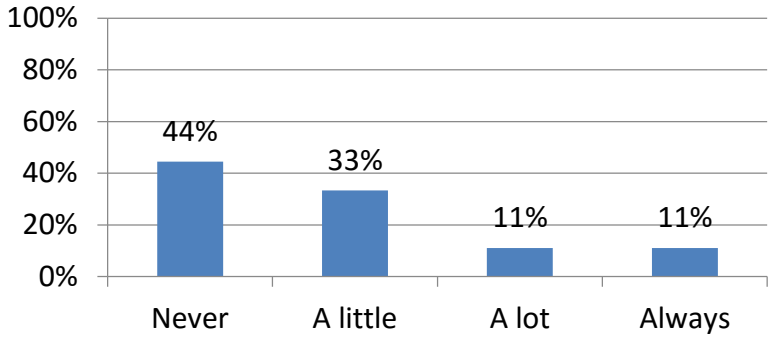


The great majority of care teams include at least one **Primary Care Provider** (83%) and this proportion has increased from **72% to 84%.**

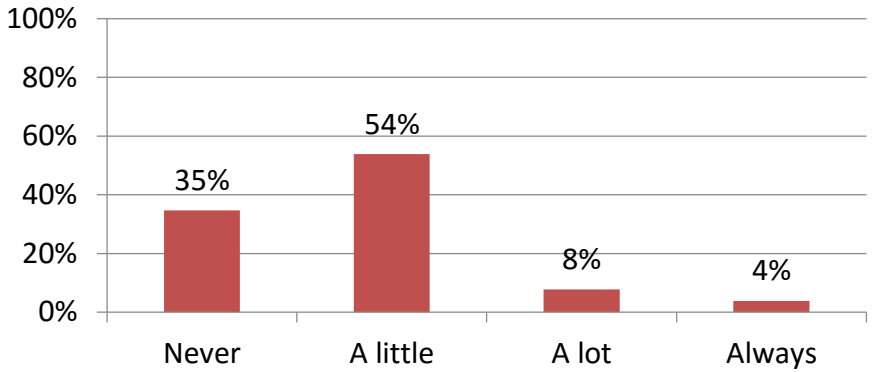
There is an increase in teams that include at least one member from a **Support in the Community** role (**31% to 47%** between 2017/2018)

Patients' Perspective on Care Integration

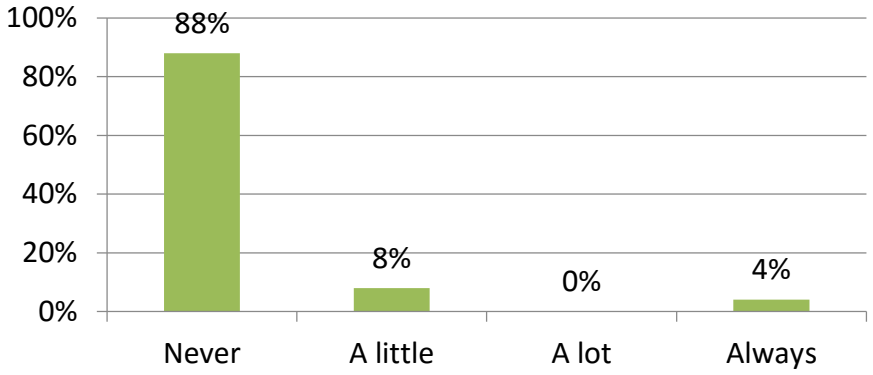
How often did you have to do or explain something because people did not share information with each other?



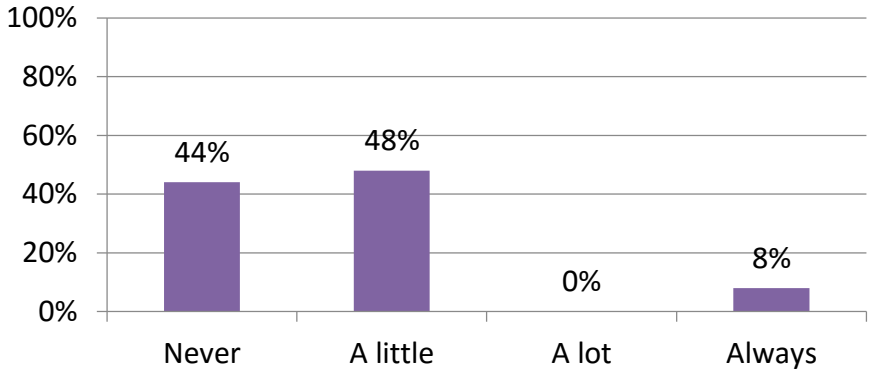
How often were you confused because people gave you conflicting information or advice?



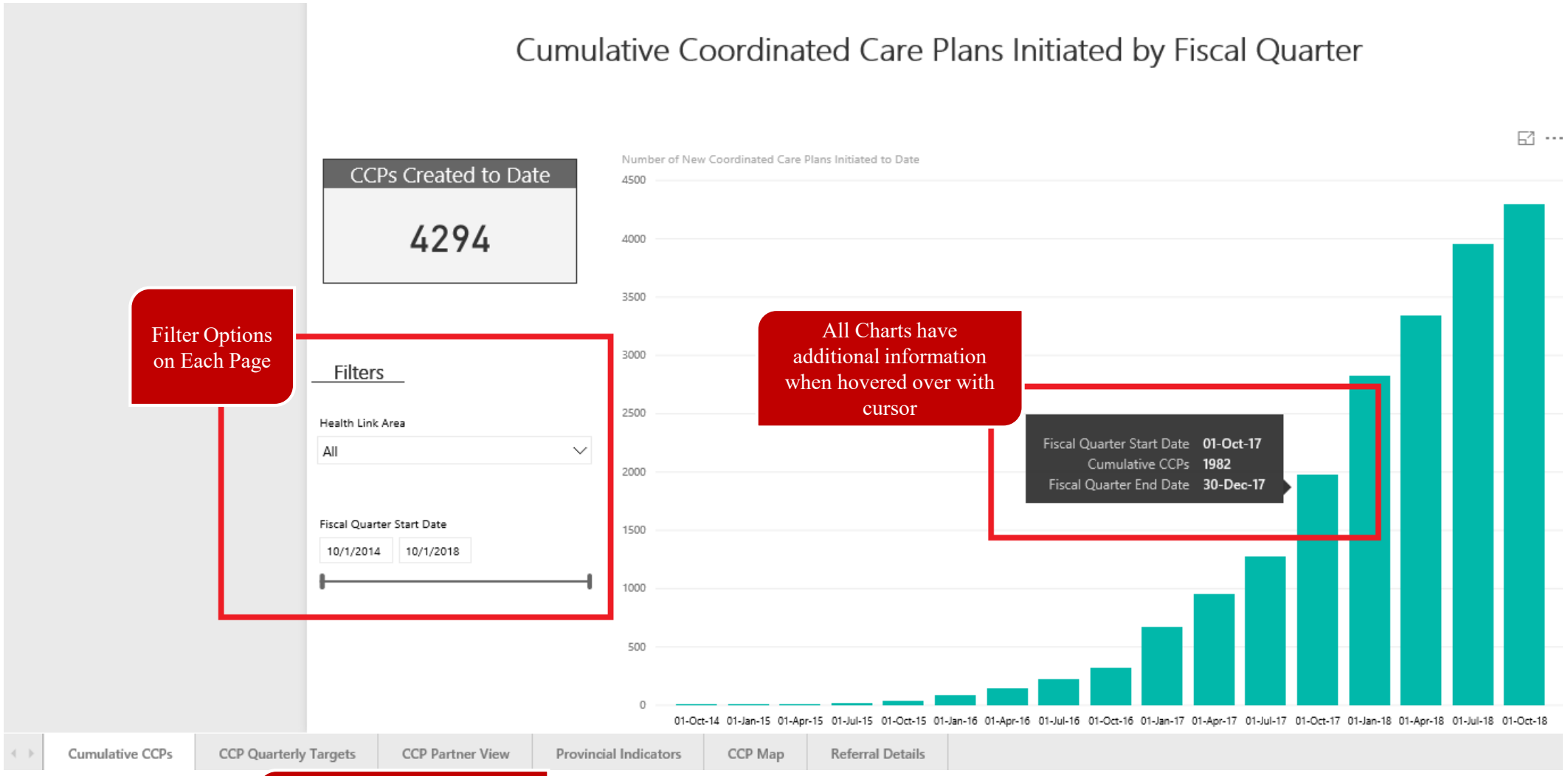
How often did you feel uncomfortable because people did not get along with each other?



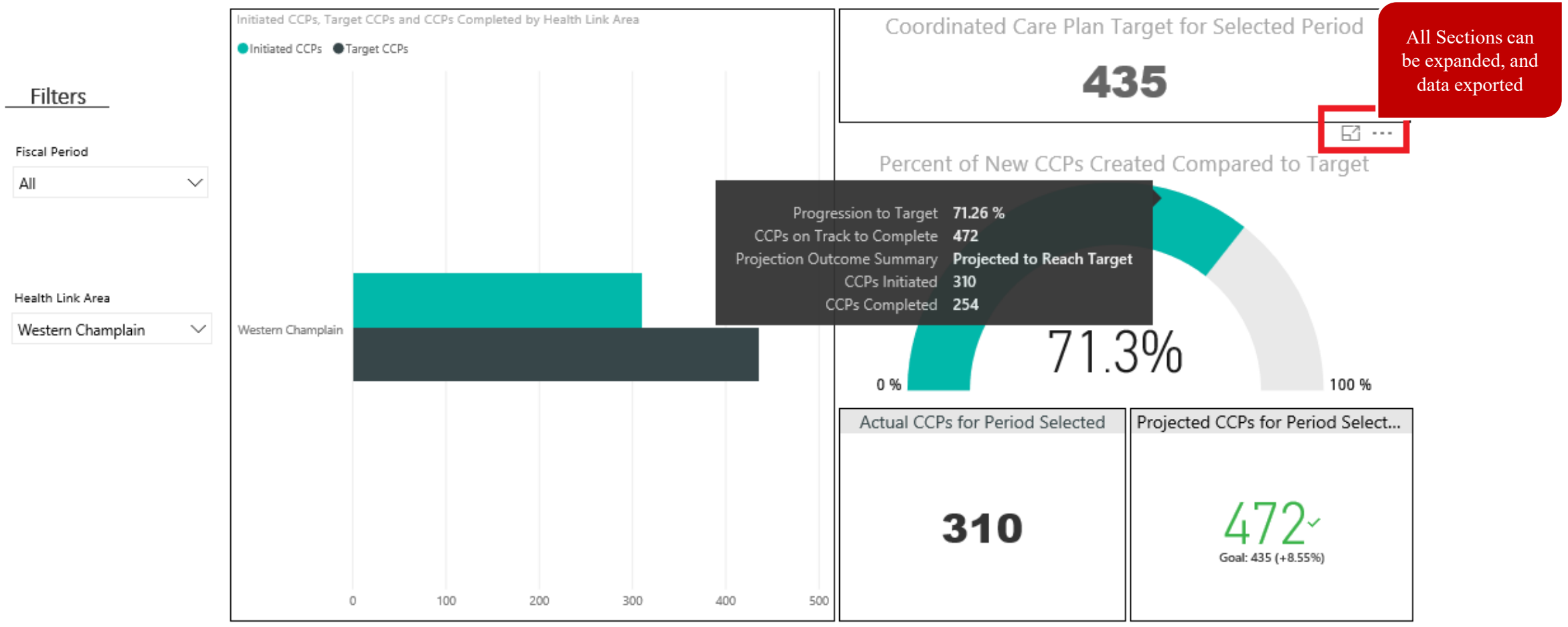
How often were you unclear whose job it was to deal with a specific question or concern?



Using Data in Real-time


Cumulative Coordinated Care Plans Initiated by Fiscal Quarter
CCPs Created to Date
4294
Filter Options on Each Page
Filters
Health Link Area
All
Fiscal Quarter Start Date
10/1/2014
10/1/2018
All Charts have additional information when hovered over with cursor
Number of New Coordinated Care Plans Initiated to Date
Fiscal Quarter Start Date 01-Oct-17
Cumulative CCPs 1982
Fiscal Quarter End Date 30-Dec-17
Cumulative CCPs
CCP Quarterly Targets
CCP Partner View
Provincial Indicators
CCP Map
Referral Details
Report sections separated by tabs along the bottom of the report

Actual CCPs versus Targets



CCP Partner View

Filters

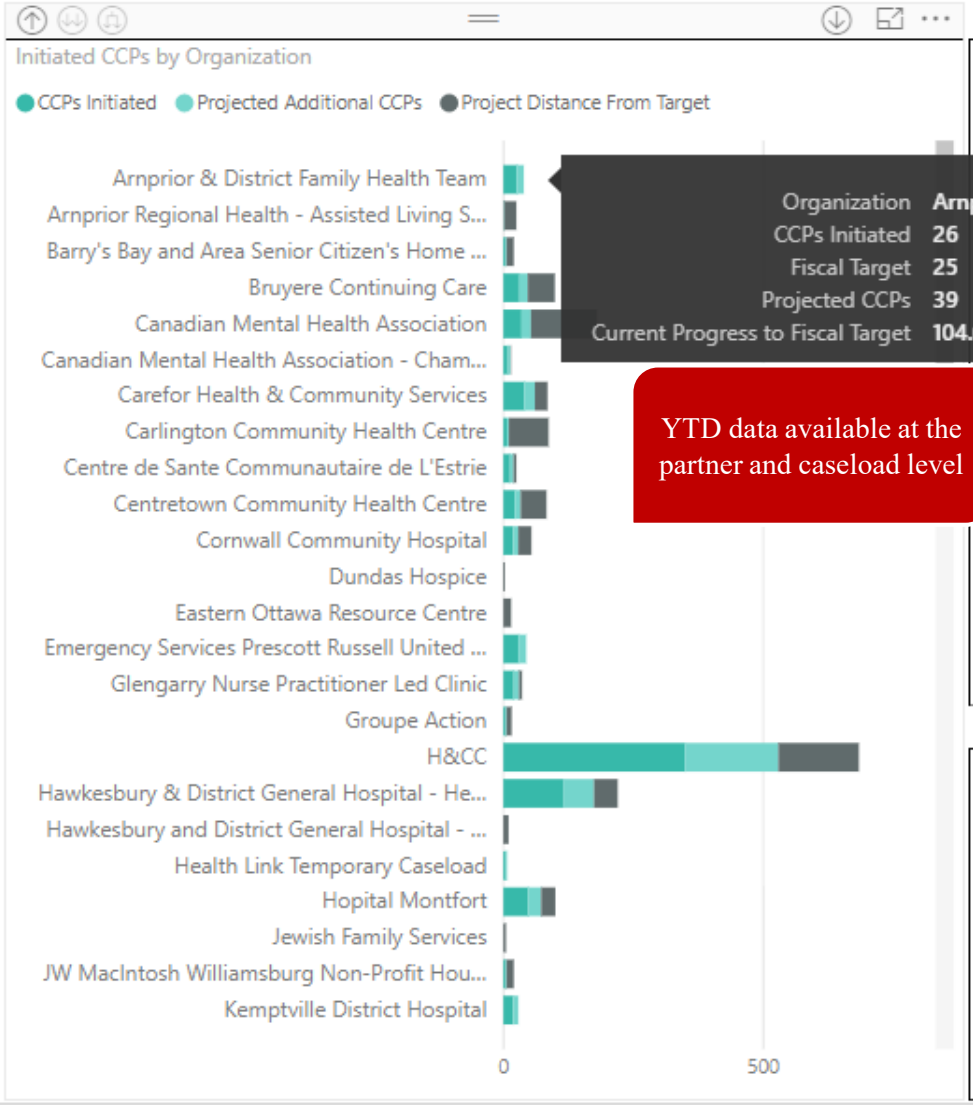
Fiscal Year
All

Fiscal_Quarter
All

Health Link Area
All

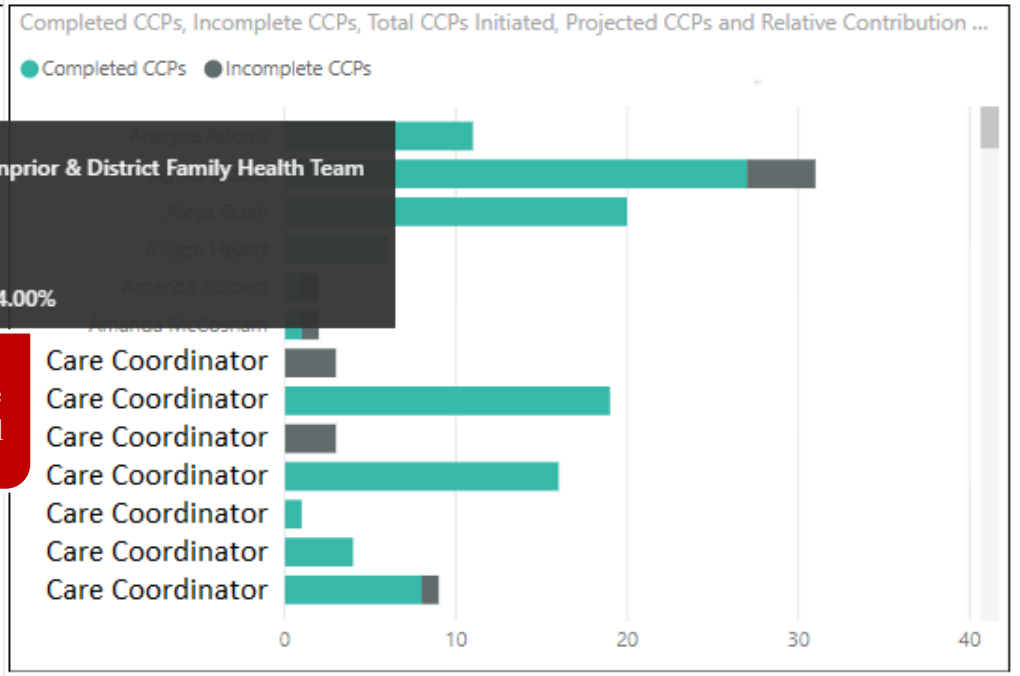
Organization
All

Caseload
All



Organization **Arnprior & District Family Health Team**
CCPs Initiated **26**
Fiscal Target **25**
Projected CCPs **39**
Current Progress to Fiscal Target **104.00%**

YTD data available at the partner and caseload level



Organization	Caseload_Name	Client #	CCP Creation Date	CCP Complete
Bruyere Continuing Care	Bruyere Continui...		2018-11-14	No
Bruyere Continuing Care	Bruyere Continui...		2018-10-24	Yes
Bruyere Continuing Care	Bruyere Continui...		2018-11-14	Yes
Bruyere Continuing Care	Bruyere Continui...		2018-05-30	No
Bruyere Continuing Care	Bruyere Continui...		2018-10-15	Yes
Bruyere Continuing Care	Bruyere Continui...		2018-06-19	Yes
Bruyere Continuing Care	Bruyere Continui...		2018-10-29	Yes
Bruyere Continuing Care	Bruyere Continui...		2018-10-30	No
Bruyere Continuing Care	Bruyere Continui...		2018-05-10	Yes

Provincial Quarterly Metrics

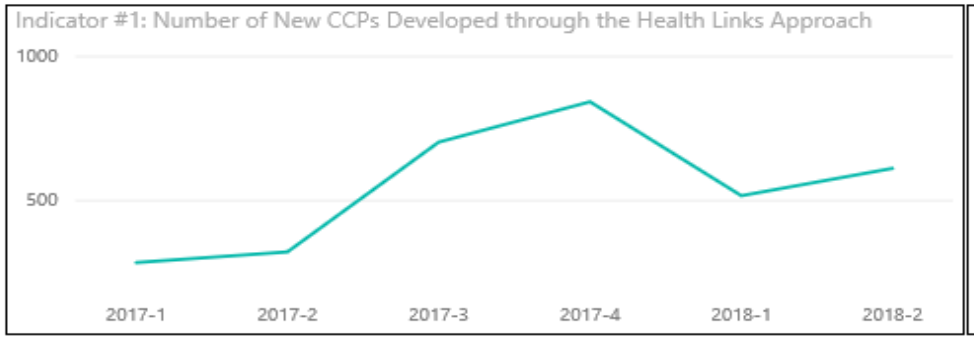
Filters

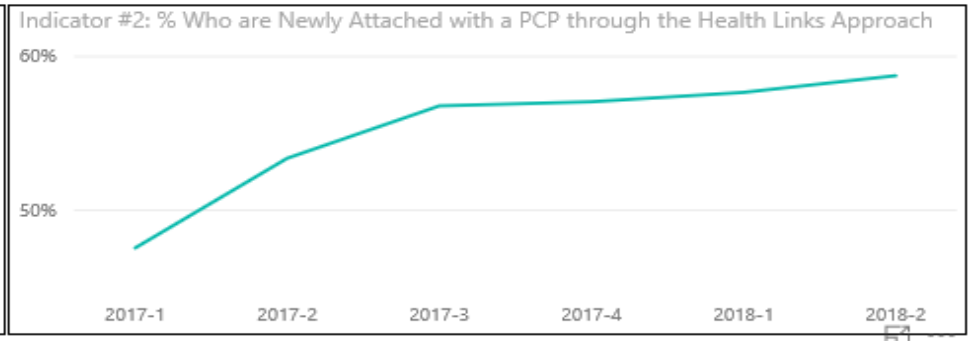
Fiscal Quarter

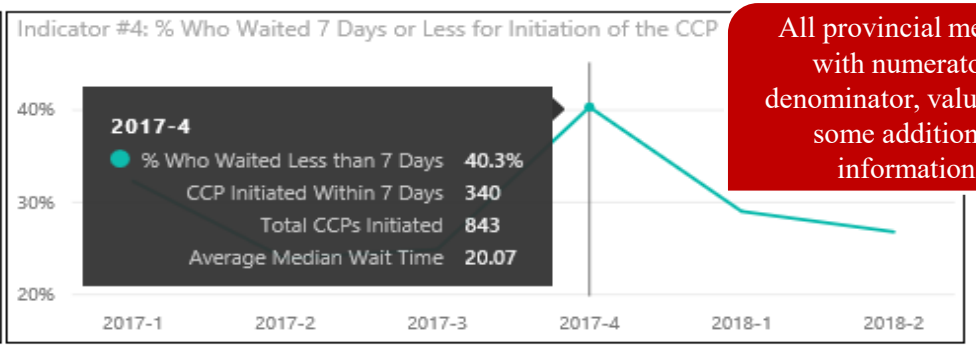
All

Health Link Area

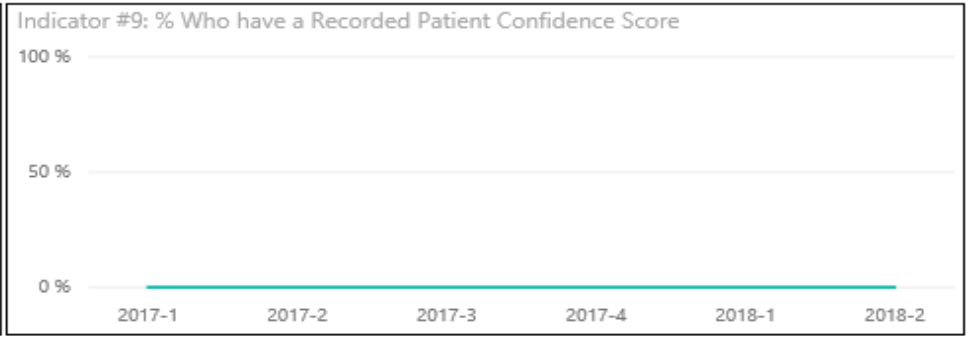
All







All provincial metrics with numerator, denominator, value, and some additional information



Geographic Coordinated Care Plan Summmary

New Coordinated Care Plans Created

1197

Filters

CCP Creation Date Range

4/1/2018 11/21/2018

Active CHRIS Client

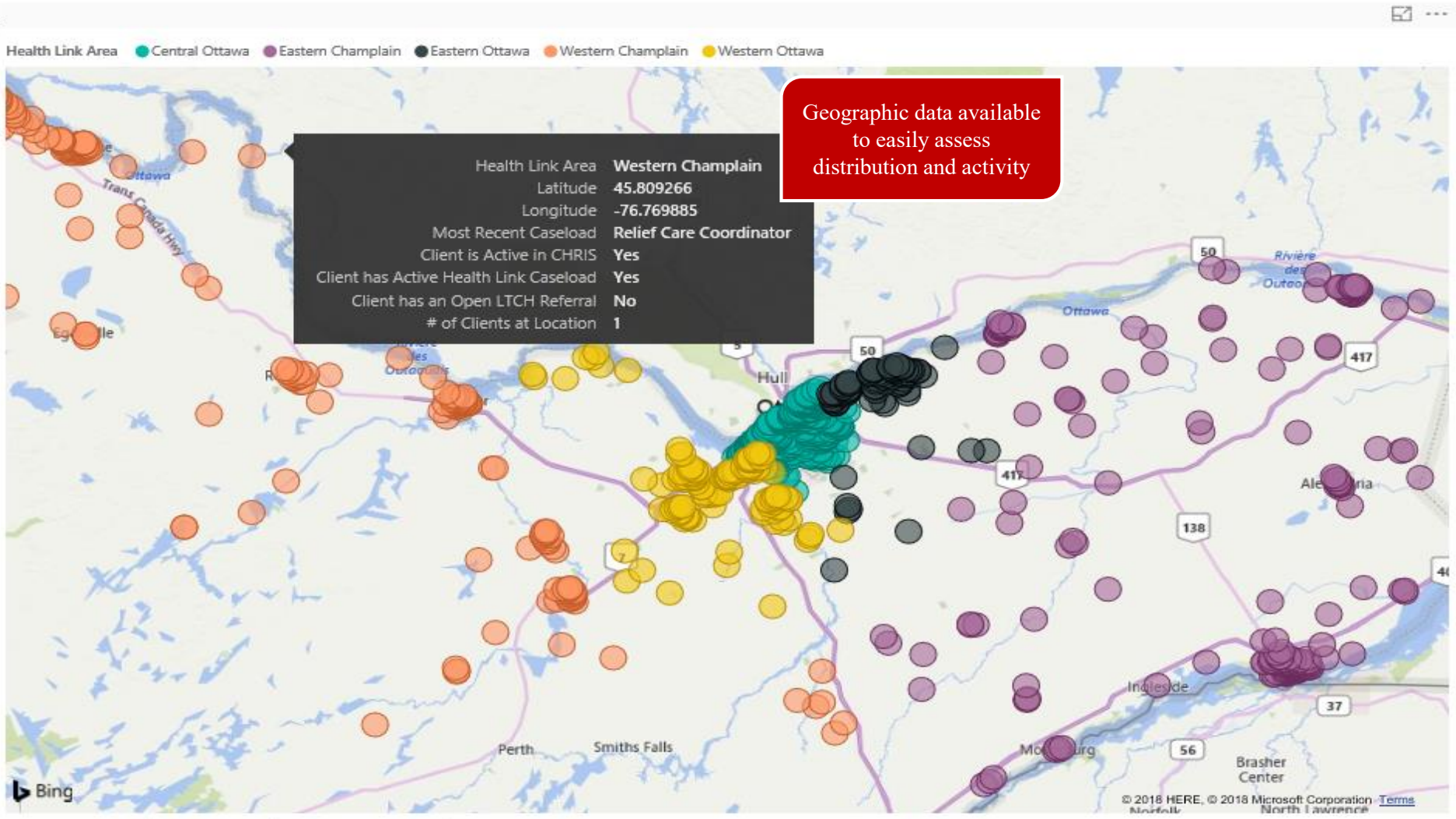
- No
- Yes

Active Health Link Caseload

- No
- Yes

Health Link Area

- Central Ottawa
- Eastern Champlain
- Eastern Ottawa
- No Residence
- Out of Region
- Western Champlain
- Western Ottawa



Health Link Referral

Create a full view by expanding report sections

Filters

Referral Date
4/1/2018 — 11/23/2018

Referral Status
All

Referral State
All

Health Link Area
All

Referral Source (General)
Hospital - Emergency...

Referral Source (Specific)
All

Total CHRIS Referrals Selected

33

Client List

Client #	Referral_Start_Date	Eligibility Date	Eligibility Outcome	Referral_S
[redacted]	20-Sep-18	05-Oct-18	Eligible - Health Link Patient	PEMBROK
	06-Sep-18	25-Sep-18	Eligible - Health Link Patient	HAWKESE
	19-Jun-18	04-Jul-18	Ineligible - Condition inappropriate	QUEENSV

Back to Report | CLIENT LIST

Caseload	Client #	Referral_Start_Date	Eligibility Date	Eligibility Outcome	Referral_Source_Specific	First CCP	CCP this Referral?	Days Spent Pending
CCP C	066-IHL-0011-PEM	20-Sep-18	05-Oct-18	Eligible - Health Link Patient	PEMBROKE REGIONAL HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Pembroke	09-Oct-18	Yes	15
	HL-EC-HGH-HLT-07	06-Sep-18	25-Sep-18	Eligible - Health Link Patient	HAWKESBURY AND DISTRICT GENERAL HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Hawkesbury		No	19
		19-Jun-18	04-Jul-18	Ineligible - Condition inappropriate	QUEENSWAY-CARLETON HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Nepean	25-Oct-17	No	15
	085-IHL-0026-BEL	08-Nov-18			QUEENSWAY-CARLETON HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Nepean		No	18
COR		08-Aug-18	04-Sep-18	Eligible - Client/Family Refused	CORNWALL COMMUNITY HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Cornwall		No	27
	HL-EC-EMS-PR-01	05-Oct-18	05-Oct-18	Eligible - Health Link Patient	HAWKESBURY AND DISTRICT GENERAL HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Hawkesbury		No	0
	HL-EC-HGH-HLT-07	20-Jul-18	23-Jul-18	Eligible - Health Link Patient	HAWKESBURY AND DISTRICT GENERAL HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Hawkesbury		No	3
HAW	L-EC-HGH-HLT-04	30-Jul-18	08-Aug-18	Eligible - Health Link Patient	CORNWALL COMMUNITY HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Cornwall	16-Aug-18	Yes	9
	083-IHL-0021-CWL	11-Oct-18			CORNWALL COMMUNITY HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Cornwall	23-Jan-18	No	46
	HL-CO-VHA-01	08-Oct-18	12-Oct-18	Eligible - Health Link Patient	QUEENSWAY-CARLETON HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Nepean	16-Oct-18	Yes	4
HOP	L-EC-HGH-HLT-04	10-Apr-18	09-May-18	Eligible - Health Link Patient	CORNWALL COMMUNITY HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Cornwall	24-Jul-18	Yes	29
	HL-EC-HGH-HLT-07	09-Aug-18	13-Aug-18	Eligible - Health Link Patient	HAWKESBURY AND DISTRICT GENERAL HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Hawkesbury	20-Aug-18	Yes	4
	058-IHL-0010-BEL	14-May-18	29-May-18	Eligible - Health Link Patient	QUEENSWAY-CARLETON HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Nepean	17-Aug-18	Yes	15
OTT	HL-WO-PQCHC-PCO-09	24-Sep-18			QUEENSWAY CARLETON HOSPITAL - Irving Greenberg Family Cancer Centre, ER, Day surg, OP, Clinics, Hospital - Nepean		No	63
		31-Oct-18			HOPITAL MONTFORT, ER, Day surg, OP, Clinics, Hospital - Ottawa		No	26
OT	066-IHL-0011-PEM	26-Sep-18			RENFREW VICTORIA HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Renfrew		No	61
	HL-EC-HGH-HLT-04	26-Jul-18	07-Aug-18	Eligible - Health Link Patient	CORNWALL COMMUNITY HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Cornwall		No	12
		09-Nov-18			QUEENSWAY-CARLETON HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Nepean		No	17
PEM	071-IHL-0014-BEL	14-Nov-18	22-Nov-18	Ineligible - Condition changed/Client deceased	QUEENSWAY-CARLETON HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Nepean		No	8
	HL-WO-KDH-01	06-Nov-18	22-Nov-18	Eligible - Health Link Patient	OTTAWA HOSPITAL (THE)-GENERAL SITE, ER, Day surg, OP, Clinics, Hospital - Ottawa	14-Nov-18	Yes	16
	HL-WO-PQCHC-01	07-Oct-18	25-Oct-18	Eligible - Health Link Patient	QUEENSWAY-CARLETON HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Nepean	30-Oct-18	Yes	18
QUE		22-Nov-18			CORNWALL COMMUNITY HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Cornwall		No	4
	HL-EO-HopMont-03	07-Nov-18			HOPITAL MONTFORT, ER, Day surg, OP, Clinics, Hospital - Ottawa		No	19
	HL-CO-SEOCHC-HLT-08	24-Oct-18			HOPITAL MONTFORT, ER, Day surg, OP, Clinics, Hospital - Ottawa		No	33
QUE	058-IHL-0010-BEL	07-Oct-18	08-Nov-18	Eligible - Health Link Patient	QUEENSWAY-CARLETON HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Nepean	08-Nov-18	Yes	32
	HL-CO-SEOCHC-HLT-08	21-Sep-18	02-Nov-18	Eligible - Client/Family Refused	OTTAWA HOSPITAL (THE)-CIVIC SITE, ER, Day surg, OP, Clinics, Hospital - Ottawa		No	42
	072-IHL-B015-LBL	18-Sep-18	22-Oct-18	Eligible - Health Link Patient	WINCHESTER DISTRICT MEMORIAL HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Winchester	23-Oct-18	Yes	34
REN	L-EC-HGH-HLT-04	24-Aug-18	06-Sep-18	Eligible - Health Link Patient	CORNWALL COMMUNITY HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Cornwall	06-Sep-18	Yes	13
		12-Nov-18			QUEENSWAY-CARLETON HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Nepean		No	14
	HL-CO-SEOCHC-HLT-07	20-Aug-18	17-Sep-18	Eligible - Health Link Patient	QUEENSWAY-CARLETON HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Nepean		No	28
WIN	L-EC-HGH-HLT-05	04-Apr-18	20-Apr-18	Eligible - Health Link Patient	CORNWALL COMMUNITY HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Cornwall	25-Jun-18	Yes	16
	HL-EC-HGH-HLT-03	25-Sep-18			CORNWALL COMMUNITY HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Cornwall	19-Mar-18	No	62
	HL-EC-HGH-HLT-04	11-Apr-18	09-May-18	Eligible - Health Link Patient	CORNWALL COMMUNITY HOSPITAL, ER, Day surg, OP, Clinics, Hospital - Cornwall		No	28

Next Steps

- Development of data integrity reports
- Hospital Outcome Impact Analysis – Quasi-experimental approach
- Pilot testing the use of IVR technology to gather patient experience information
- Qualitative study to assess care team collaboration

For more information…..

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Paula.Greco@lhins.on.ca
Champlain LHIN

Justin Ramsay
Justin.Ramsay@lhins.on.ca
Champlain LHIN

Questions

NETWORKING BREAK 2:00-2:15

Applying Lessons Learned to Improve Mental Health & Addictions in Ontario

Leadership Summit Sommet du leadership

Objectives

1. Learn from mental health and addictions care providers across the province, focusing on the patient perspective, provincial direction for mental health and addictions care and LHIN/sub-region collaboration to improve local-level care
2. Use quality standards as a guide to high-quality patient care for people with mental health conditions
3. Learn about regional strategies being developed and implemented in response to identified gaps

Quality Standards for Mental Health: Implementation at Ontario Shores Centre for Mental Health Sciences

Phil Klassen MD FRCPC
Vice-President, Medical Affairs
Ontario Shores Centre for Mental Health Sciences
Assistant Professor, University of Toronto

With thanks to Ilan Fischler, MD, Sanaz Riahi, PhD, Elizabeth Coleman, MD, Marsha Bryan, Sarah Kipping, Bethany Holeschek, Kelly Delaney, Terence Hedley, Jeff MacDonald, Susan Wei and Terri Irwin, and HQO

Psychiatry
UNIVERSITY OF TORONTO

Ontario Shores
Centre for Mental Health Sciences

Introduction

- Ontario Shores' approach to implementation
- Results of our gap analysis
- Key challenges and outcomes
- Next steps

Quality Standards – what are they?

- Concise sets of 5-15 strong (“must do”), measurable, evidence-based statements guiding care in a topic area
- Developed in topic areas identified as having high potential for better quality care in Ontario
- Each quality statement accompanied by quality indicator(s)
- Every quality standard will be accompanied by a plain language summary for patients and caregivers
- Strong emphasis on implementation through a variety of vehicles (monitoring/reporting, QBPs, Quality Improvement Plans, etc.)
- Strong emphasis on partnerships to support development and implementation

Quality Standards - the elements

The Statement

3

Individualized Nonpharmacological Interventions

People living with dementia and symptoms of agitation or aggression receive nonpharmacological interventions that are tailored to their specific needs, symptoms, and preferences, as specified in their individualized care plan.

The Audience Statements

OM PAGE 13

What This Quality Statement Means

For Patients

Non-drug treatments should be tried first.

For Clinicians

Before considering drug therapies, offer people at least three nonpharmacological interventions (described in the Definitions section of this statement) for managing their symptoms. Tailor nonpharmacological therapies to people's needs, symptoms, preferences, and history, as documented in their individualized care plan.

For Health Services

Ensure that hospitals and long-term care homes have the systems, processes, and resources in place to offer a variety of nonpharmacological interventions (described in the Definitions section of this statement).

Definition

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Nonpharmacological interventions

Effective nonpharmacological interventions may include the following:

- Aromatherapy
- Multisensory therapy
- Music therapy
- Dance therapy
- Pet-assisted therapy
- Massage therapy
- Reminiscence therapy
- Recreational activities
- Physical activity

This list is not intended to be exhaustive. Other nonpharmacological interventions may also be effective for some individuals.

The Indicators

3

Individualized Nonpharmacological Interventions CONTINUED FROM PAGE 14

Quality Indicators

Process Indicators

Percentage of people living with dementia and symptoms of agitation or aggression who are offered nonpharmacological interventions

- Denominator: total number of people living with dementia and symptoms of agitation or aggression
- Numerator: number of people in the denominator who are offered at least three nonpharmacological interventions
- Data source: local data collection

Percentage of people living with dementia and symptoms of agitation or aggression who receive nonpharmacological interventions as specified in their individualized care plan

- Denominator: total number of people living with dementia and symptoms of agitation or aggression who have an individualized care plan
- Numerator: number of people in the denominator who receive nonpharmacological interventions as specified in their individualized care plan
- Data source: local data collection

Structural Indicator

Availability of three or more evidence-based nonpharmacological interventions to manage the symptoms of agitation and aggression in people living with dementia

- Data source: local data collection

Why Quality Standards?

- There is marked variability of practice
  - Likely reflects local factors more than true patient variability
  - Lack of a measurement based culture
  - Likely affects quality
- There is a long gap from emergence of clinical evidence to its routine application at the service user level
- Patients and families need to know what they should expect
- The HQO Quality Standards are largely built off the NICE guidance, the most authoritative evidence-based guidance (AGREE II)

Quality Standards

Schizophrenia

Care for Adults in Hospitals

Quality Statement 1: Comprehensive Interprofessional Assessment	9
Quality Statement 2: Screening for Substance Use	12
Quality Statement 3: Physical Health Assessment	14
Quality Statement 4: Promoting Physical Activity and Healthy Eating	17
Quality Statement 5: Promoting Smoking Cessation	19
Quality Statement 6: Treatment With Clozapine	21
Quality Statement 7: Treatment With Long-Acting Injectable Antipsychotic Medication	24
Quality Statement 8: Cognitive Behavioural Therapy	26
Quality Statement 9: Family Intervention	29
Quality Statement 10: Follow-Up Appointment After Discharge	31
Quality Statement 11: Transitions in Care	33
Emerging Practice Statement: Nonpharmacological Interventions in Hospital	36

Quality Standards

Behavioural Symptoms of Dementia

Care for Patients in Hospitals and Residents in Long-Term Care Homes

Quality Statement 1: Comprehensive Assessment	8
Quality Statement 2: Individualized Care Plan	10
Quality Statement 3: Individualized Nonpharmacological Interventions	13
Quality Statement 4: Indications for Psychotropic Medications	16
Quality Statement 5: Titrating and Monitoring Psychotropic Medications	18
Quality Statement 6: Switching Psychotropic Medications	20
Quality Statement 7: Medication Review for Dosage Reduction or Discontinuation	22
Quality Statement 8: Mechanical Restraint	25
Quality Statement 9: Informed Consent	27
Quality Statement 10: Specialized Interprofessional Care Team	29
Quality Statement 11: Provider Training and Education	31
Quality Statement 12: Caregiver Training and Education	33
Quality Statement 13: Appropriate Care Environment	36
Quality Statement 14: Transitions in Care	38

Quality Standards

Major Depression

Care for Adults and Adolescents

Quality Statement 1: Comprehensive Assessment	8
Quality Statement 2: Suicide Risk Assessment and Intervention	11
Quality Statement 3: Shared Decision-Making	13
Quality Statement 4: Treatment After Initial Diagnosis	16
Quality Statement 5: Adjunct Therapies and Self-Management	19
Quality Statement 6: Monitoring for Treatment Adherence and Response	21
Quality Statement 7: Optimizing, Switching, or Adding Therapies	23
Quality Statement 8: Continuation of Antidepressant Medication	26
Quality Statement 9: Electroconvulsive Therapy	29
Quality Statement 10: Assessment and Treatment for Recurrent Episodes	32
Quality Statement 11: Education and Support	34
Quality Statement 12: Transitions in Care	36
Emerging Practice Statement: Nonpharmacological Interventions	39

Steps to Implementation

1. Select the Standard(s)/statements
   - *We implemented all statements*
2. Create the governance structure/team/partnerships
3. Undertake a gap analysis/es
4. Select the process adherence and outcome measures
   - *Based on the gap analysis*
5. Utilize informatics
6. Align therapeutic services
7. Monitor and support adherence
   - Physician transparency
   - Interprofessional engagement
   - Use of a physician assistant
   - Academic detailing
   - Performance appraisals
   - Use of technology
   - Communicate, communicate, communicate

Implementation Phase (2016-2017): The "Three Buckets"

- Strategy to implement the three mental health Quality Standards in order to close any gaps identified between our previous Clinical Practice Guideline work and the new Quality Standards.

1. Measurement Changes

- Things we were doing already but not documenting in a way to easily measure (e.g. comprehensive assessment)

2. Technology Enablers

- Things that we were not doing consistently but technology and forcing functions helped to drive the solution, with some measurement (e.g. EHR prompts to explain why not an LAI; focus on exception handling)

3. Service Changes

- Things that represented a very significant change in our business model, and required resource re-allocation, technology, change management and staff training or partnerships to accomplish (e.g. CBT for psychosis)

Step 5: Utilize Informatics
Physician Workflow in the EHR

Schizophrenia (Inpatient) Quality Standard
Quick Reference Guide for Physicians

Physician Documentation Workflow:

At Admission

- Physician Admission Assessment
- Screen for referral to 1:1 CBT for Psychosis
- If screens positive, refer to 1:1 CBT for Psychosis
- Assess for Substance Use Disorder and if applicable, refer to Concurrent Disorders Service

Within 28 Days

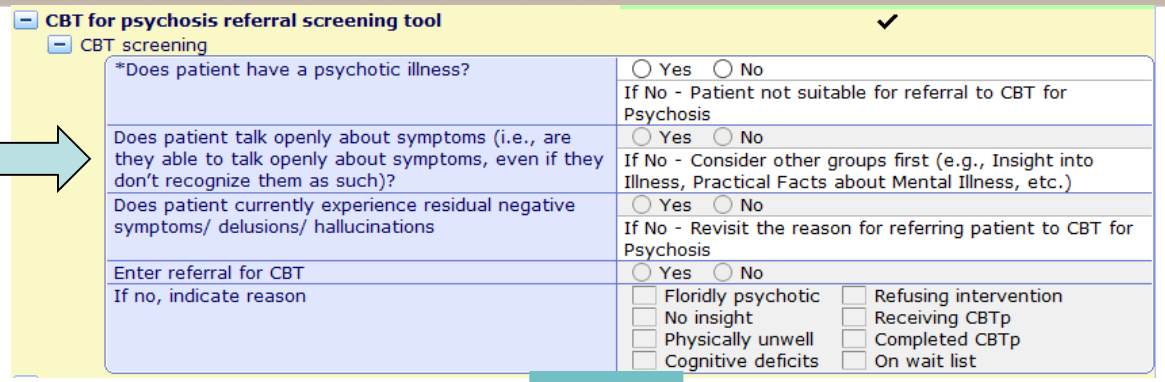
- Complete Schizophrenia Treatment Plan Note
- Offer LAI to all patients
- If meets criteria for Treatment Resistance offer Clozapine

At Discharge

- Complete Discharge Summary
- Recommend / arrange follow-up within 7 days

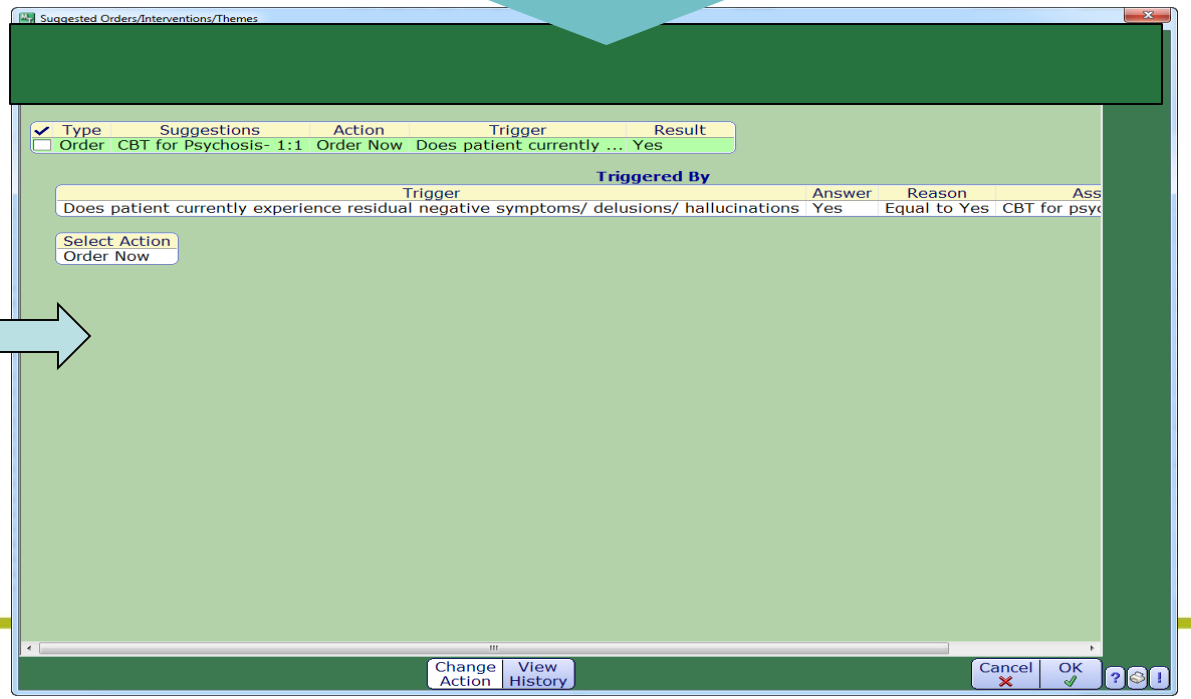
Step 5: Informatics
Use of the EHR ("Bucket 2")

CBTp screening tool embedded in clinical workflow with orders for 1:1 CBTp automatically triggered for completion by the clinician based on screening results.



System automation leveraged to support Quality Standards.

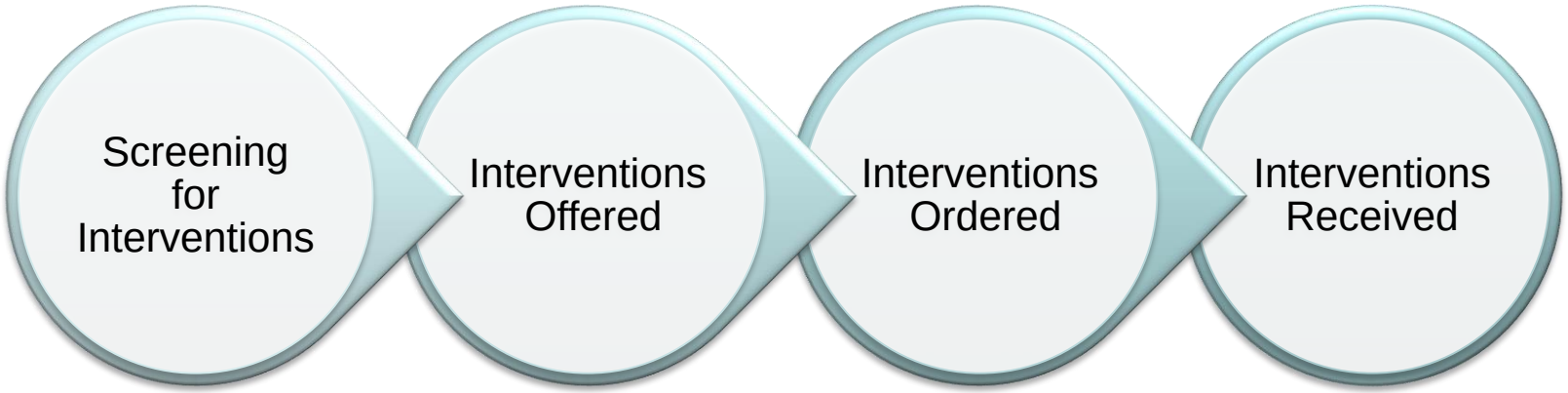
E.g. If all three questions in the CBTp screening tool are answered as "yes", an automatic order for 1:1 CBTp is triggered for completion by the clinician.



Step 6: Align Therapeutic Services ("Bucket 3")

- **Schizophrenia**
  - CBT for psychosis
  - Family therapy
- **Dementia**
  - Few
- **Major depression**
  - Time frames for assessment and treatment
  - Psychotherapy capacity

Step 8: Align Therapeutic Services; Schizophrenia
Where do we need to focus attention?



- Substance Use
- Smoking
- Cognitive Behavioural Therapy for Psychosis

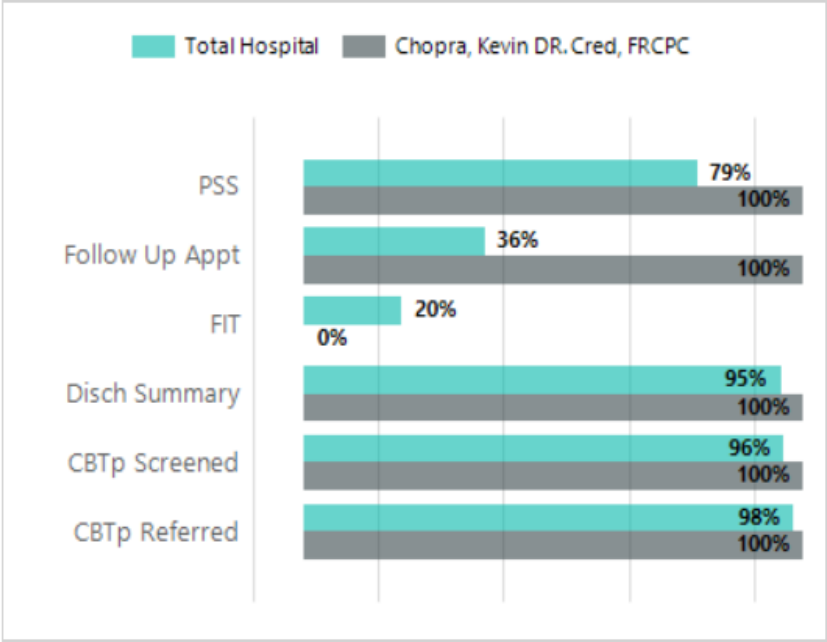
- Concurrent Disorder Services
- Smoking Cessation Supports
- Treatment with Clozapine
- Treatment with Long-Acting Injectable Antipsychotic Medication
- Cognitive Behavioural Therapy for Psychosis
- Family Intervention

- Concurrent Disorder Services
- Smoking Cessation Supports
- Treatment with Clozapine
- Treatment with Long-Acting Injectable Antipsychotic Medication
- Cognitive Behavioural Therapy for Psychosis
- Family Intervention

- Concurrent Disorder Services
- Smoking Cessation Supports
- Treatment with Clozapine
- Treatment with Long-Acting Injectable Antipsychotic Medication
- Cognitive Behavioural Therapy for Psychosis
- Family Intervention

Step 7: Monitor and Support Adherence
Physician-Specific Scorecards

SCHIZOPHRENIA INDICATORS



Category	Numerator	Denominator	Percent
CBTp Screened	6	6	**100.0%**
CBTp Referred	1	1	**100.0%**
FIT	0	1	**0.0%**
Follow Up Appt	1	1	**100.0%**
Disch Summary	1	1	**100.0%**
PSS	1	1	**100.0%**

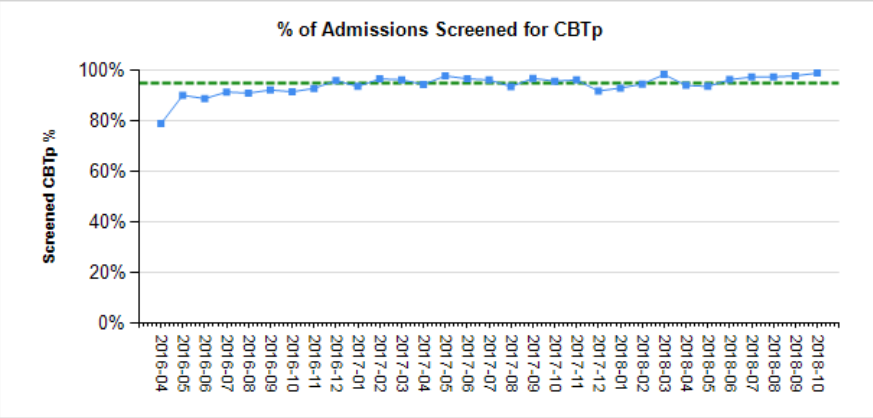
Outcomes

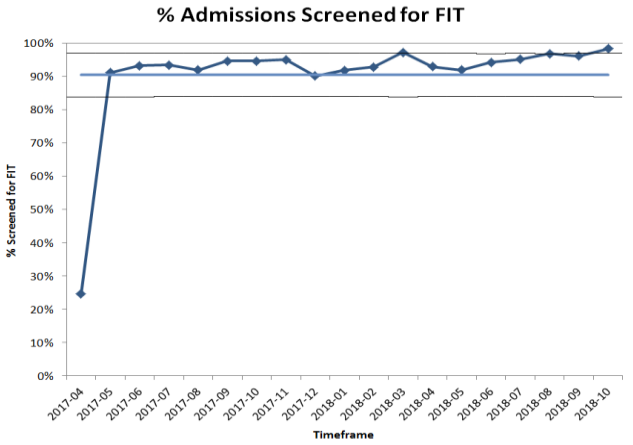
Priority Indicators Chosen: Schizophrenia

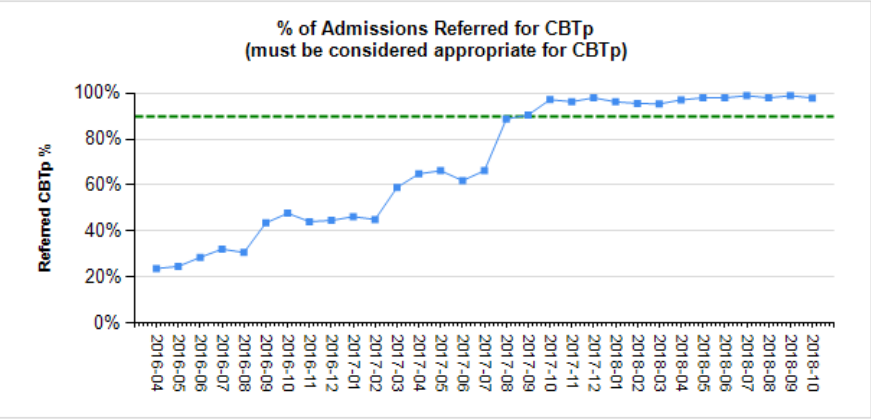
- **Process** (annual audit for the remainder)
  - Tracking
    - Percent screened for CBTp
    - Percent referred for CBTp
    - Percent received family intervention training (FIT)
    - Percent care plans shared with receiving providers within 7 days
    - Percent follow-up appointments within 7 days of discharge
- **Outcome**
  - Improvement in RAI-MH Positive Symptom Scale between admission and discharge

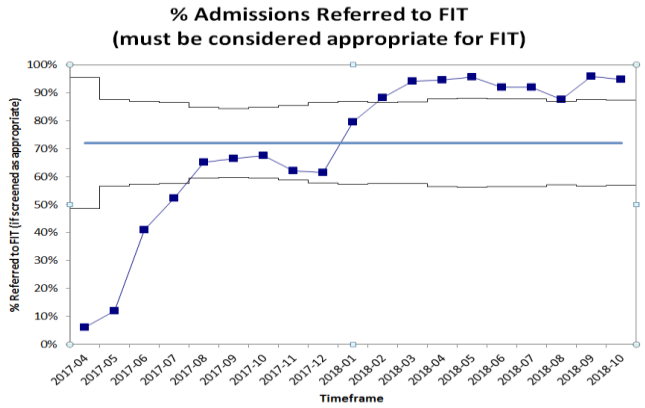
CBTp & FIT Screening/Referral Targets

- ✓ 95% or greater of all patients in scope for the Schizophrenia Quality Standard are screened for CBTp and FIT
- ✓ 90% or greater of all patients screened as candidates for CBTp and/or FIT are referred for service.









Schizophrenia Annual Audit Results

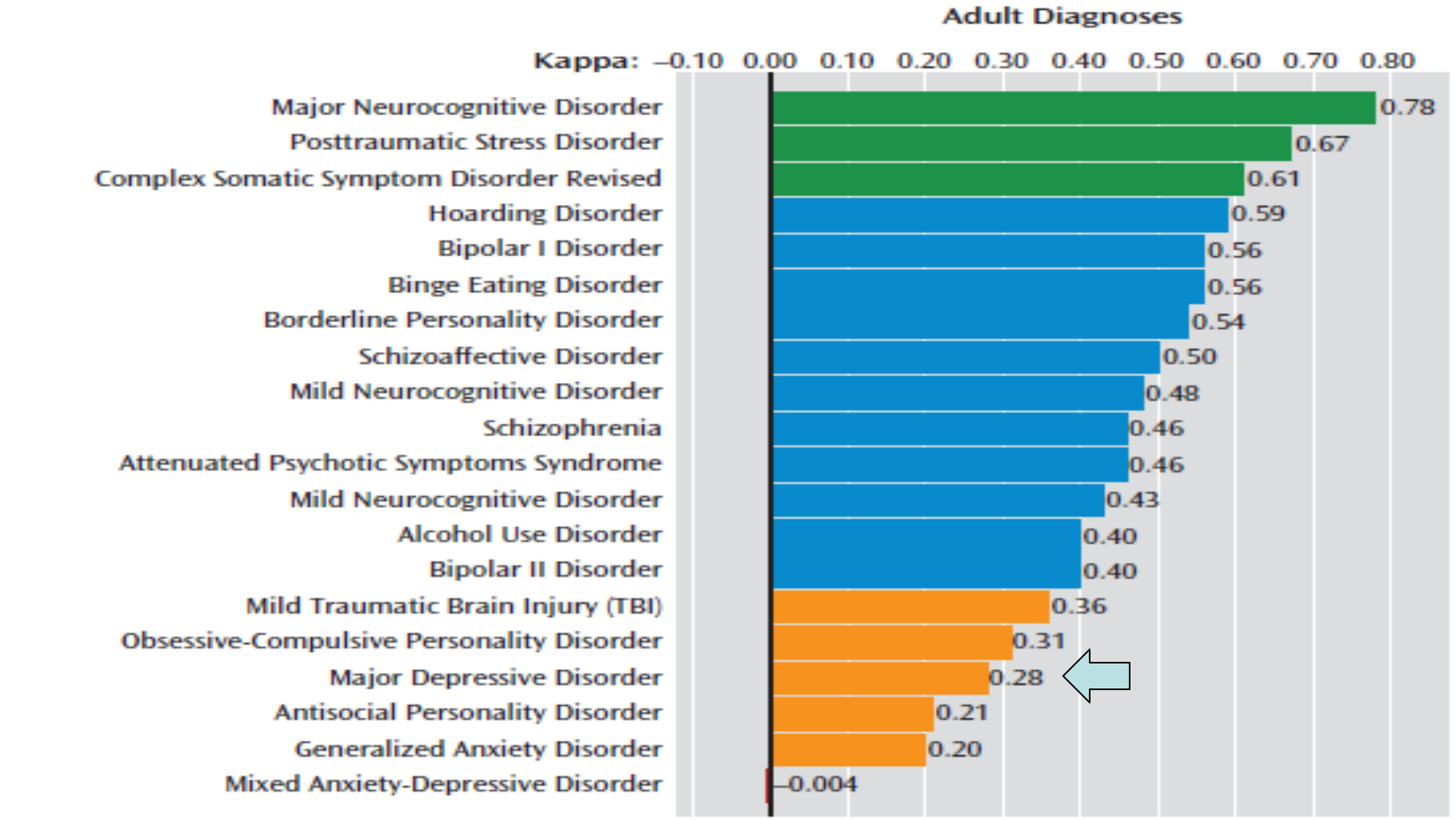
Schizophrenia Quality Standard Indicators	Performance (Dec. 2016 – Feb 2018)	Notes
Assessed for substance abuse	100%	Current screening with Admission RAI.
Offered treatment for concurrent disorders	59.8%	Screening approach identified as needing further refinement to more accurately identify patients that are candidates for concurrent disorders treatment. Our proposal would be to address this in Action Plan 4b (program review of concurrent disorders program).
Metabolic workup	88.8%	We propose to leave this as an audit.
Promoting physical activity and/or healthy eating	34.4%	Current capture in plan of care which is being revamped as of May 1, 2018. Proposal to leave this indicator in audit status.
Has clozapine offered	90.5%	Good; we propose to leave this as an audit indicator.
Has received clozapine	30.5%	Good; we propose to leave this as an audit indicator.
Has LAI offered	61.3%	Further investigation required; if the data is accurate, we would suggest an intervention against this.
Has received LAI	25.4%	As above.
Has follow-up appointment with physician within 7 days of discharge	19.9%	Includes follow-up with external providers. We recommend further work.

Meeting the Access Challenge: Major Depression

- **Time frames for assessment a challenge (7 and 28 days)**
  - How can we screen more effectively? (MDD)
- **Psychotherapy capacity; need to offer within 7 and 28 days**
  - Just enough therapy in the right time frame
    - Applications?
    - E-therapy?
    - Group or individual?

DSM Field Trials: Diagnostic reliability- adults

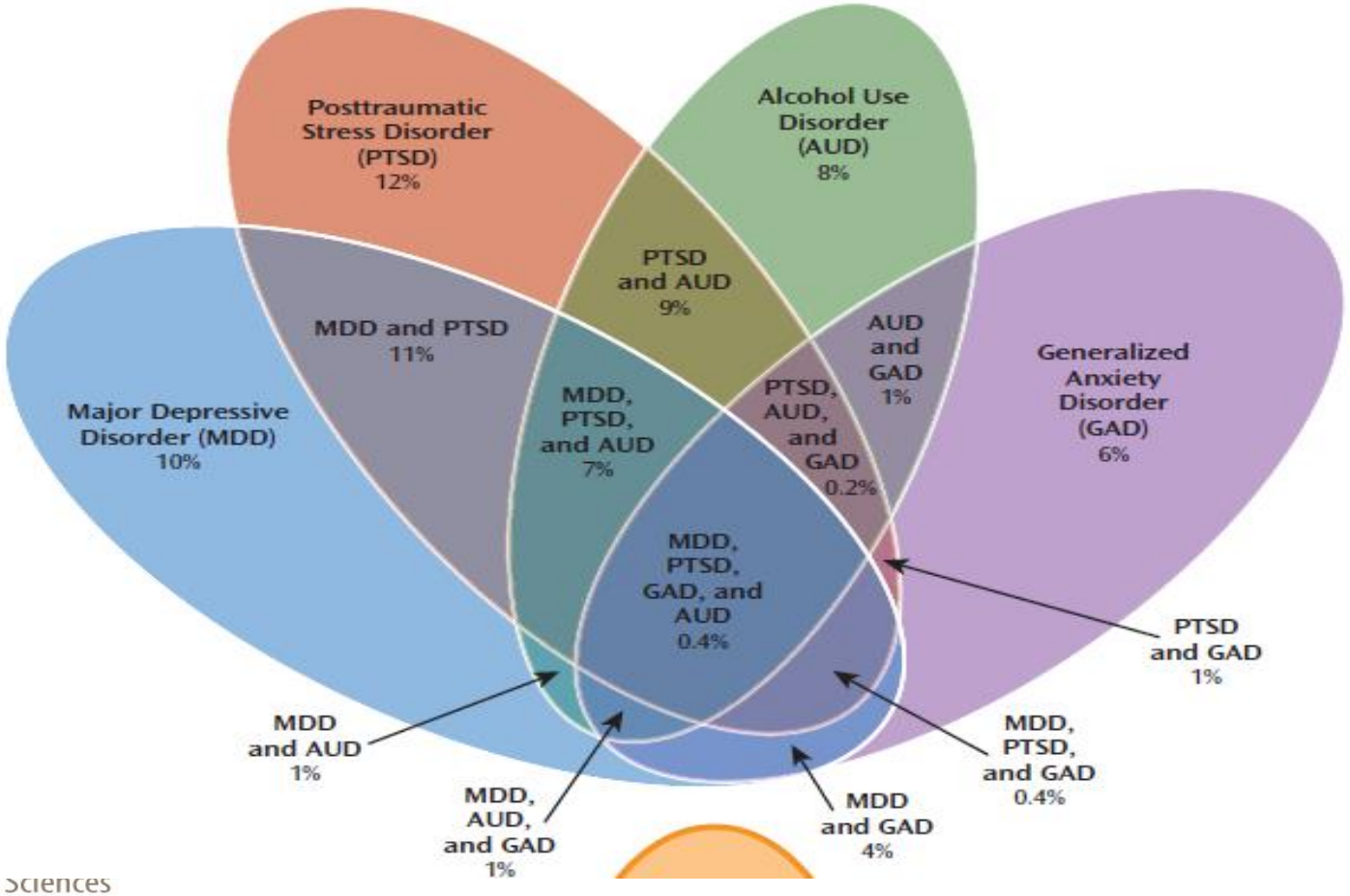
FIGURE 1. Interrater Reliability of Diagnoses From the Initial DSM-5 Field Trials[a]



Depression: co-morbidities complicate diagnosis

DSM-5 FIELD TRIALS TEST-RETEST RELIABILITY

FIGURE 1. Comorbidity of Major Depressive Disorder, Posttraumatic Stress Disorder, Alcohol Use Disorder, and Generalized Anxiety Disorder[a]



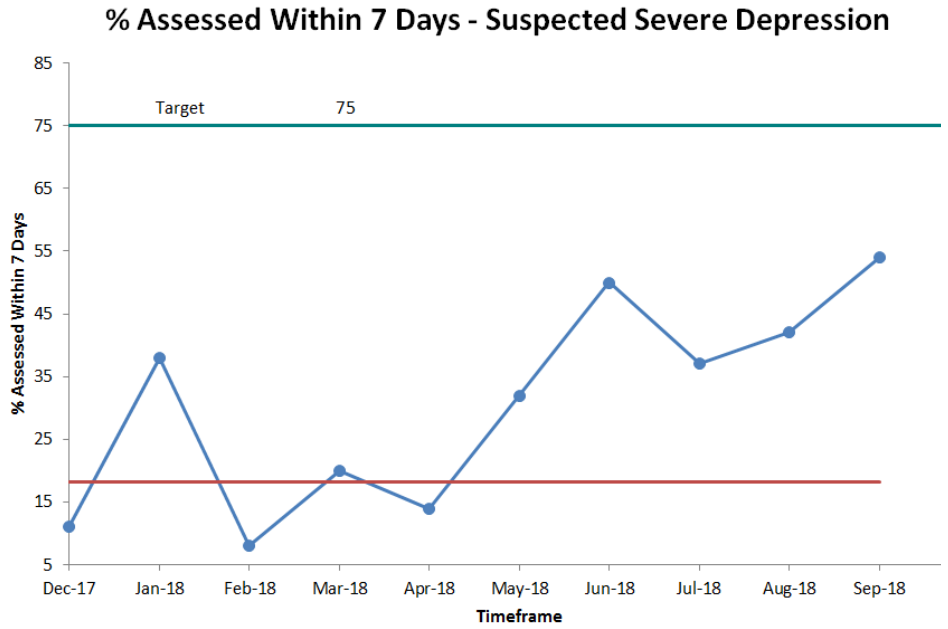
Finding True Positives in Major Depression referrals: Our Data

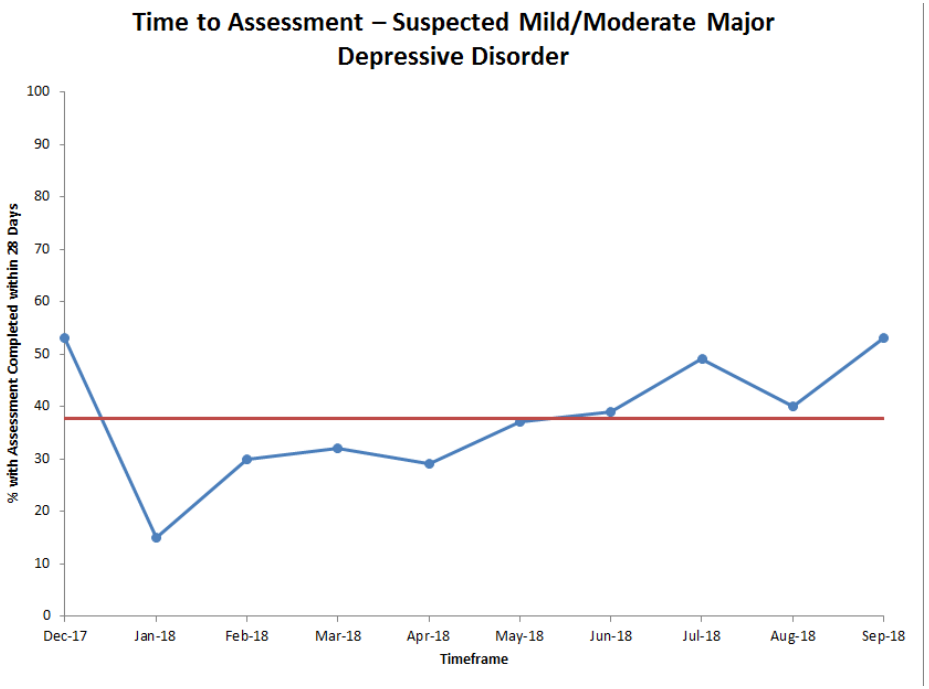
- Out of 274 primary care referrals with suspected Major Depressive Disorder:
  - 8 (3%) were diagnosed as Major Depressive Disorder (Severe)
  - 60 (22%) were diagnosed as Major Depressive Disorder (Mild/Moderate)
  - Only 25% had a primary diagnosis of depression after psychiatric assessment
  - PHQ-9 almost always high
  - 51 (19%) did not have a diagnosis specified
- Given mismatch, we have adjusted the filter (to be assessed based on clinical features rather than PHQ-9)

Other Diagnoses (with counts of 1-2) Include:

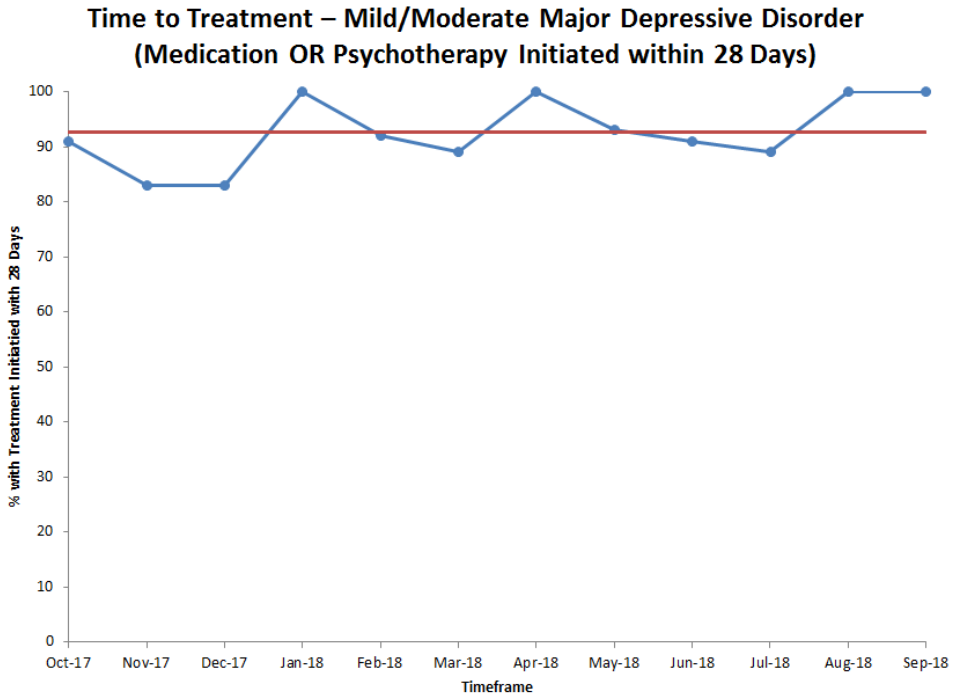
- Attention-deficit/hyperactivity disorder, predominately inattentive present
- Hoarding Disorder
- Major neurocognitive disorder due to another medical condition, With behavi
- Bipolar I disorder, Current or most recent episode depressed, In partial re
- Depressive disorder due to another medical condition
- Unspecified anxiety disorder
- Adjustment disorders, With mixed anxiety and depressed mood
- Other specified trauma- and stressor-related disorder
- Posttraumatic stress disorder
- Other specified schizophrenia spectrum and other psychotic disorder
- Adjustment disorders, With mixed anxiety and depressed mood
- Cannabis use disorder, Moderate
- Antisocial personality disorder
- Other specified neurodevelopmental disorder
- Amphetamine-type substance use disorder, Severe
- Other specified anxiety disorder
- Panic disorder
- Alcohol use disorder, Severe
- Other specified depressive disorder
- Bipolar and related disorder due to another medical condition
- Bulimia nervosa
- Obsessive-compulsive disorder
- Other specified personality disorder
- Cocaine use disorder, Severe
- Cannabis-induced anxiety disorder
- Schizoaffective disorder, Bipolar type

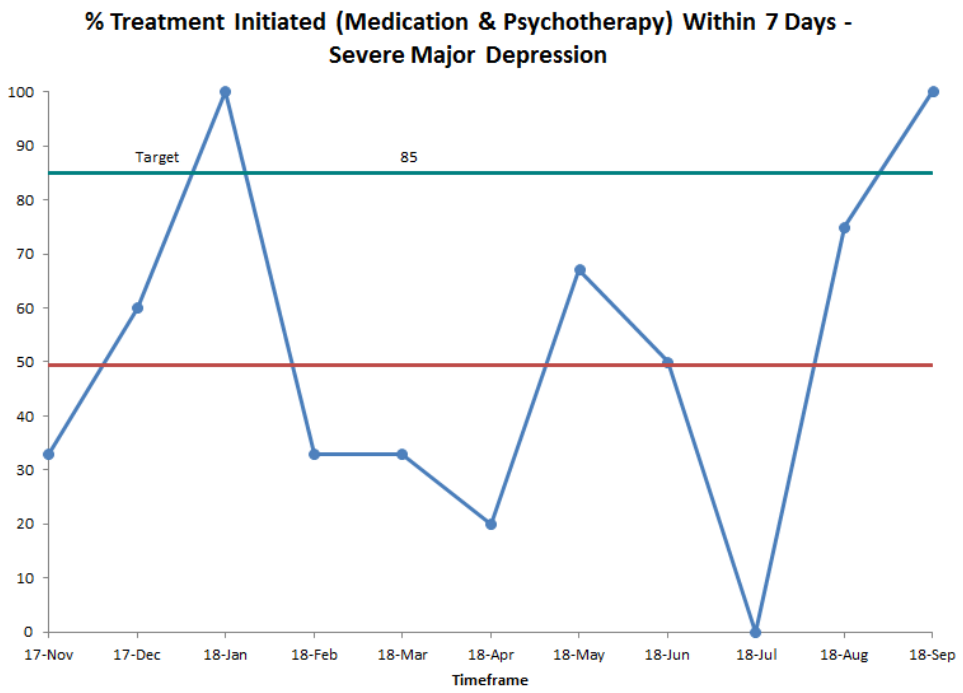
Major Depression – Timely Access to Assessment



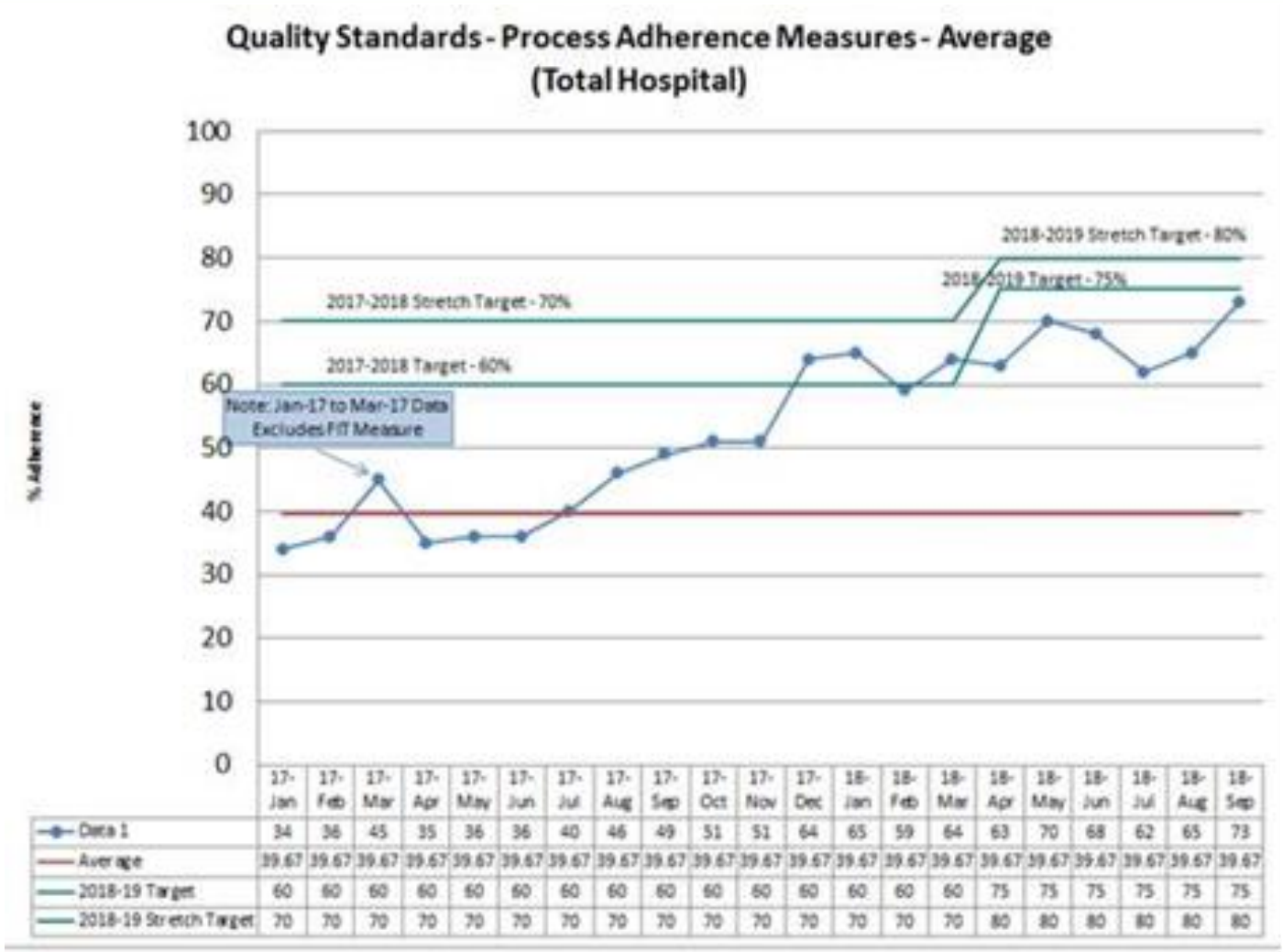


Major Depression – Timely Access to Treatment





Quality Improvement, Monitoring & Sustainability



	17-Jan	17-Feb	17-Mar	17-Apr	17-May	17-Jun	17-Jul	17-Aug	17-Sep	17-Oct	17-Nov	17-Dec	18-Jan	18-Feb	18-Mar	18-Apr	18-May	18-Jun	18-Jul	18-Aug	18-Sep
Data 1	34	36	45	35	36	36	40	46	49	51	51	64	65	59	64	63	70	68	62	65	73
Average	39.67	39.67	39.67	39.67	39.67	39.67	39.67	39.67	39.67	39.67	39.67	39.67	39.67	39.67	39.67	39.67	39.67	39.67	39.67	39.67	39.67
2018-19 Target	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	75	75	75	75	75	75
2018-19 Stretch Target	70	70	70	70	70	70	70	70	70	70	70	70	70	70	70	80	80	80	80	80	80

2018-2019

- Continue work to monitor and sustain improvements achieved and to realize improvements in areas still not at the desired levels, eg
  - Timely access targets (depression);
  - Psychotherapy wait times.
  - Depression outcome measure
- Support work on indicators of focus with CAMH, Waypoint and the Royal
- Explore other opportunities to share knowledge and learnings
  - with hospital and community partners

Key Learnings

- You learn a lot about your organization when you dive into major change efforts;
- Mental health facility culture has a long history….

Thanks!

- Klassenp@ontarioshores.ca
- riahis@ontarioshores.ca

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HQO Leadership Summit:

November 30, 2018

Camille Quenneville
Chief Executive Officer, Ontario Division, CMHA

CMHA Branches Provide Quality Care

CMHA stats at a glance

CMHA has **30** branches across Ontario

CMHA branches employ more than **3,900** people

CMHAs belong to a community-based sector that serves approx. **500,000** clients a year

What is community mental health and addictions?

"Canadian Mental Health Association branches provide wide-ranging wraparound services to meet the needs of individuals in our community living with mental health or addictions challenges.

Wraparound means we offer our clients services and programs that help them in various aspects of their life so that they can live in and contribute positively to the community."

What are some examples of wraparound services?

Housing

Employment Aid

Court Diversion

Clubhouses

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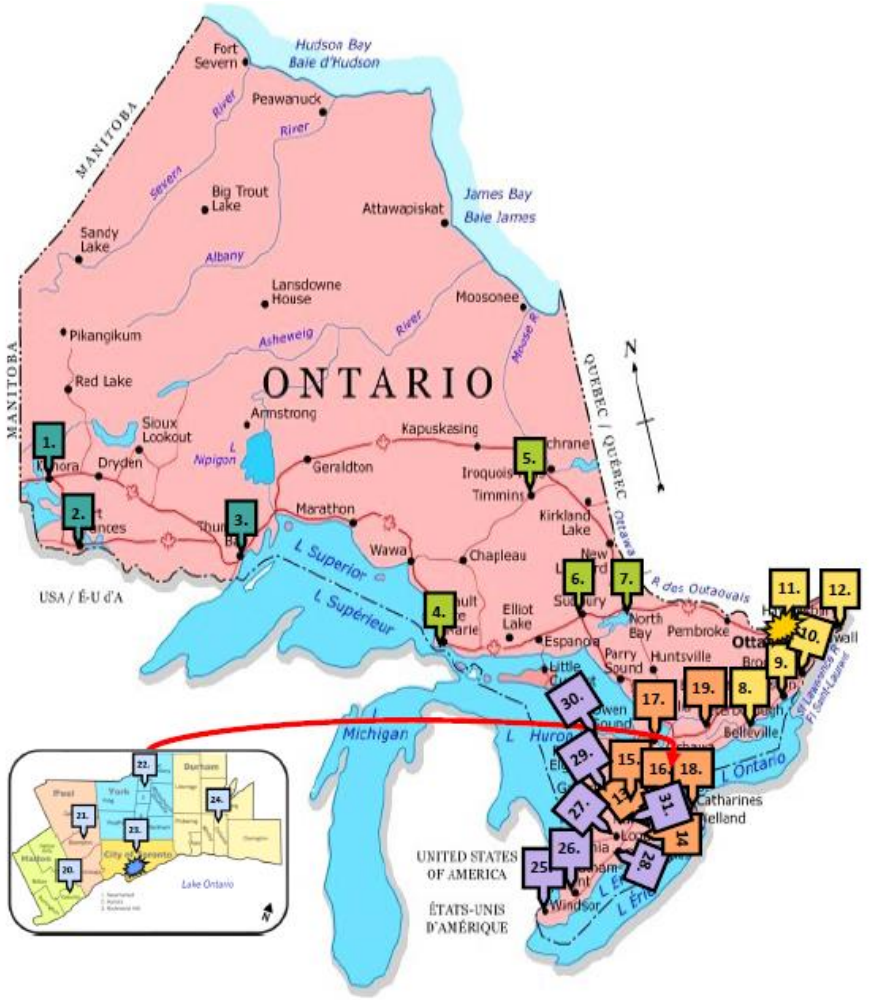
30 CMHA Branches in Ontario



Canadian Mental Health Association Ontario

Association canadienne pour la santé mentale Ontario

Agenda

1. Importance of Integrating Primary Care and Mental Health & Addictions and Collaborative Care
2. Primary Care and Mental Health & Addictions Task Group Survey Findings
3. Best Practice Examples from CMHA
4. Q&A

Integration

The Importance of Integrating Primary Care and Mental Health & Addictions and Collaborative Care

Collaborative mental health & addictions care is delivered by providers from different specialities, disciplines, or sectors working together to offer complementary services and mutual support.

Primary Care-MHA Integration allows for clients to seamlessly access the comprehensive services they need, when they need them, and brings us closer to a well-connected, non-siloed heath care system that is centered on the client.

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Survey Findings

Overview of Survey Participation

CMHA, Addictions & Mental Health Ontario and Children's Mental Health Ontario members were surveyed to gather information on their connections and innovative practices with Primary Care Providers. 96 individuals completed this survey.

A similar survey was sent out to the Association of Family Health Teams Ontario (AFHTO) members and Association of Ontario Health Centres (AOHC) members. 126 individuals completed this survey.

Survey Findings

For Community MHA Agencies:

What is Working Well

- Partnerships work well when there is an understanding between PCPs and MHA agencies about what services are being provided.
- Co-located models have highly coordinated and efficient care for clients and also works well in data sharing.
- Facilitators like formal agreements, protocols, MoUs, etc. allowed for positive partnerships but was dependent on the relationship.
- OTN was an enabler to enhance connections with primary care.
- Bringing primary care on site on a part-time basis was also noted as a positive outcome.

Survey Findings

For Community MHA Agencies:

Where there are Challenges

- Attaching unattached clients to primary care, especially those with complex mental health and/or addictions issues.
- Communications between community MHA agencies and PCPs, including the lack of EMR integration.
- Stigma and lack of understanding of mental health and addictions needs by PCPs, including what services community agencies provide.
- Easier to connect with team-based care models (FHTs, CHCs) than with other models of primary care.
- Too many primary care priorities – time to improve relationships is difficult when MHA agencies are invited to many community initiatives and priority tables.

Survey Findings

For Primary Care Providers:

What is Working Well

- Co-located mental health supports (like social workers, mental health workers) work well, especially as they share the EMR.
- Formal agreements were helpful as they helped determine accountabilities and client pathways.
- Face to face case conferences and planning tables were helpful to build effective partnerships.
- OTN is an enabler for psychiatric consultations as are shared care models for FHTs and psychiatrists.
- Responsive and engaged community agencies are important – trust and relationship building.

Survey Findings

For Primary Care Providers:

Where there are Challenges

- Waitlists to access community mental health and addictions supports, limited access to hospital-based programs.
- Eligibility criteria difficult to navigate (demographics, location).
- Lack of training/education for clients with MHA needs and often provide treatment for longer than they are comfortable (while their clients wait for services).
- Communication challenges (incompatible information systems, lack of care coordinators/system navigators).
- Challenges around child and youth services given they have multiple funding sources (hard to navigate).

Best Practice Examples

Nurse Practitioner-Led Clinic

CMHA Durham offers a Nurse Practitioner-Led Clinic on-site and integrates health promotion, disease prevention, chronic disease management and care coordination for clients of all ages and their families. Services include: annual health status review, diabetes prevention and management, immunization, screening and management of cardiovascular health, cancer screening, HIV/STD/TB testing, sexual health, prenatal health and care for babies, etc.

Best Practice Examples

City Centre Health Care

CMHA Windsor-Essex operates City Centre Health Care which offers primary care services for the health needs of individuals and families. The centre operates under a collaborative care model where an interdisciplinary team of family doctors, nurse practitioners, and other health care professionals including a registered practical nurse, dietitian, therapist, health promoter, and chiropodist, take a holistic approach to patient care addressing both the primary and the mental health needs of the population.

Best Practice Examples

MOBYSS Youth Walk-In Clinic

CMHA York Region and South Simcoe offers the Mobile York South Simcoe Youth Walk-In Clinic (MOBYSS), an innovative, mobile model of integrated primary and MHA care. MOBYSS travels around York Region and South Simcoe to meet youth's confidential health care needs in a safe, non-judgmental environment. Alongside services aimed at physical and sexual health, MOBYSS is committed to providing holistic, compassionate and youth-centered mental health services such as counseling, support and referrals. Providers are skilled in assisting youth with issues around depression and anxiety, substance use, suicide risk, bullying, harm and risk reduction, issues unique to LGBTQ youth, as well as many other aspects around mental health.

Best Practice Examples

BounceBack

- Telephone-based psychotherapy program
- Designed to help adults and youth 15+ to manage symptoms of depression and anxiety
- No waiting period
- Free to people living in Ontario who have a valid health card number
- Access to the program is by referral through a family doctor, nurse practitioner, or self-referral
- https://bouncebackontario.ca/

BounceBack® reclaim your health

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Contact Us

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Thank You!

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Working Towards Better Care for MH&A in South Georgian Bay…

Dr. Harry O'Halloran – *Physician,* Georgian Bay Family Health Team (Collingwood)

WHAT MAKES CANADIANS SICK?

50% YOUR LIFE

- INCOME
- EARLY CHILDHOOD DEVELOPMENT
- DISABILITY
- EDUCATION
- SOCIAL EXCLUSION
- SOCIAL SAFETY NET
- GENDER
- EMPLOYMENT/WORKING CONDITIONS
- RACE
- ABORIGINAL STATUS
- SAFE AND NUTRITIOUS FOOD
- HOUSING/HOMELESSNESS
- COMMUNITY BELONGING

25% YOUR HEALTH CARE

- ACCESS TO HEALTH CARE
- HEALTH CARE SYSTEM
- WAIT TIMES

15% YOUR BIOLOGY

- BIOLOGY
- GENETICS

10% YOUR ENVIRONMENT

- AIR QUALITY
- CIVIC INFRASTRUCTURE

THESE ARE CANADA'S SOCIAL DETERMINANTS OF HEALTH #SDOH

High-Performing Healthcare Systems

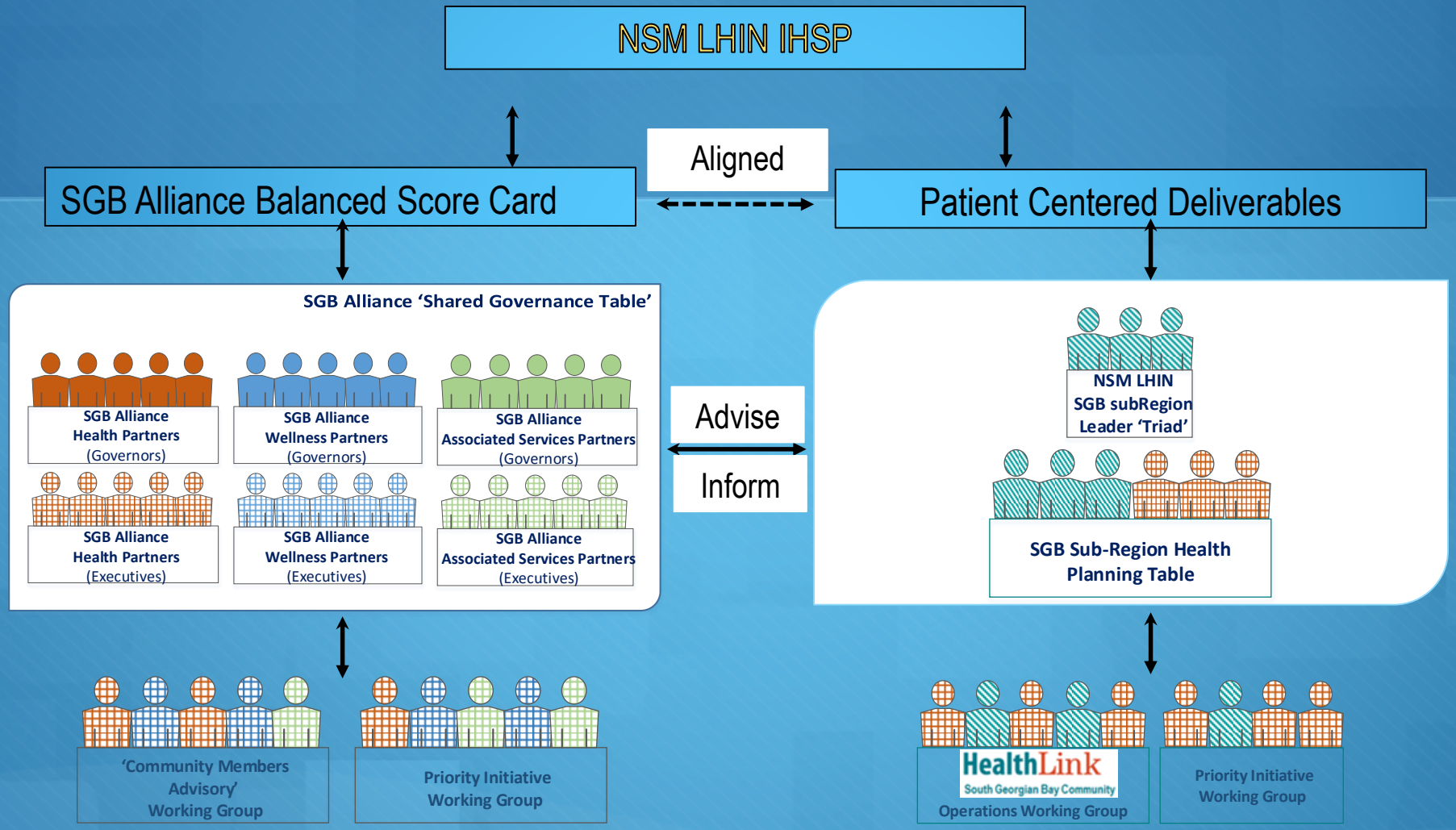
- Primary Care
- Quality Improvement
- Information Technology

- Performance is improved with (policy) emphasis on these three areas

Start where you are…

SGB Sub-Region Planning Table and SGB Alliance:

Collaborative Partnership



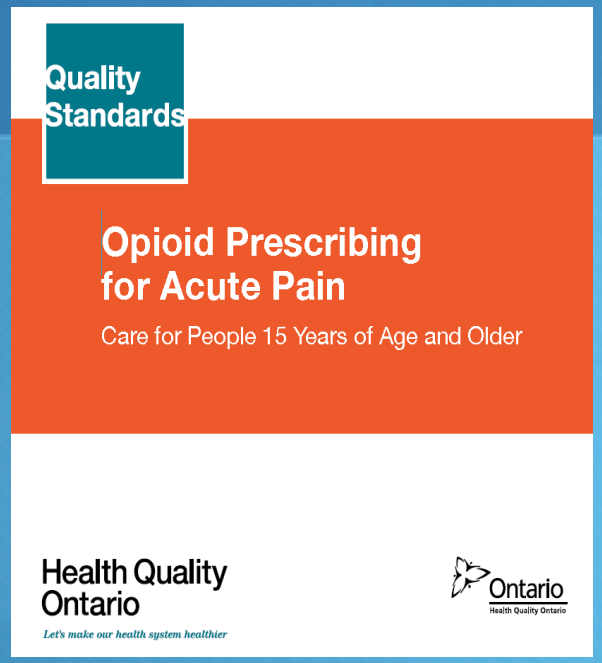
Use what you have…

Primary Care Evolution in South Georgian Bay

2002-2009	Family Health Group
	Family Health Network
	Family Health Organization and Family Health Team
2009-2011	Merged Physician Databases
	ePrescribing
	Access to EMR at CGMH (hospital)
2012-2014	Pilot Site for HRM (Provincial IT Project)
	EMR Access for local specialists
	South Georgian Bay Health Link created
	CHC Merged into EMR database
2015-2018	Provider portal created: 211, Breaking Down Barriers, LTC access to EMR, 2 way communication
	SGB Alliance created shared Quality Improvement Plans
	NSM LHIN Sub-region development

CURRENT COLLABORATIVE WORK UNDERWAY

Shared QIP 18/19



- Focus on HQO 'Acute Pain Standard'
- FHT MD Quality Lead and CGMH MAC (focus on ED, OR, Anesthesia)
- Specifically Quality statements
  - #1:Comprehensive Assessment
  - #3: Opioid Dose and Duration
  - #8: Tapering and Discontinuation
  - #9: Health Care Professional Education

Do what you can…

COAST
(Crisis Outreach and Support Team)

- Huronia West OPP
- 75 calls -> 63 referrals to community
- 548 total face to face contacts
- 2017 – 16 Crisis worker ride-alongs per month (1 FTE)

Leverage resources:

- Relationships!
- Opioid Screening tools and Dashboard
- Poverty Screen -> Community resource navigator
- 211 community referral
- Bounceback,Big White Wall, Strongest Families
- Websites (e.g. Mindyourmind.ca)


SLOAN

Thanks!!

Questions

Fireside Chat:

Innovation Designed to Close the Gaps

Leadership Summit Sommet du leadership

Objectives

1. Share innovations and a future mental health care system that will improve coordination of care, patient transitions across sector and overall outcomes of care
2. Hear about success stories around overcoming barriers
3. Hear from visionary leaders about what it means to reduce the gaps in mental health and addictions across the lifespan

Panel

- **Steve Keczem** – *Patient Representative*
- **Kimberley Moran** – *Chief Executive Officer*, Children's Mental Health Ontario (CMHO)
- **Dr. Paul Preston** – *VP Clinical, Sub-Region Primary Care Lead for Nipissing/Temiskaming; Clinical Quality Lead,* North East LHIN
- **Dr. Paul Kurdyak -** *Director, Health Outcomes and Performance Evaluation*, Institute for Mental Health Policy Research and *Medical Director, Performance Improvement,* CAMH

Steve Keczem

PATIENT REPRESENTATIVE

Help for parents of teens and young adults.

With practical plans and ongoing support parents learn to take control of their homes and build better relationships with their children.

Join

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www.apsgo.ca

APSGO

The Association of
Parent Support Groups in Ontario

Seven Caring Habits

1. Supporting
2. Encouraging
3. Listening
4. Accepting
5. Trusting
6. Respecting
7. Negotiating Differences

APSGO
The Association of
Parent Support Groups in Ontario

Seven Deadly Habits

1. Criticizing
2. Blaming
3. Complaining
4. Nagging
5. Threatening
6. Punishing
7. Bribing / Rewarding to control

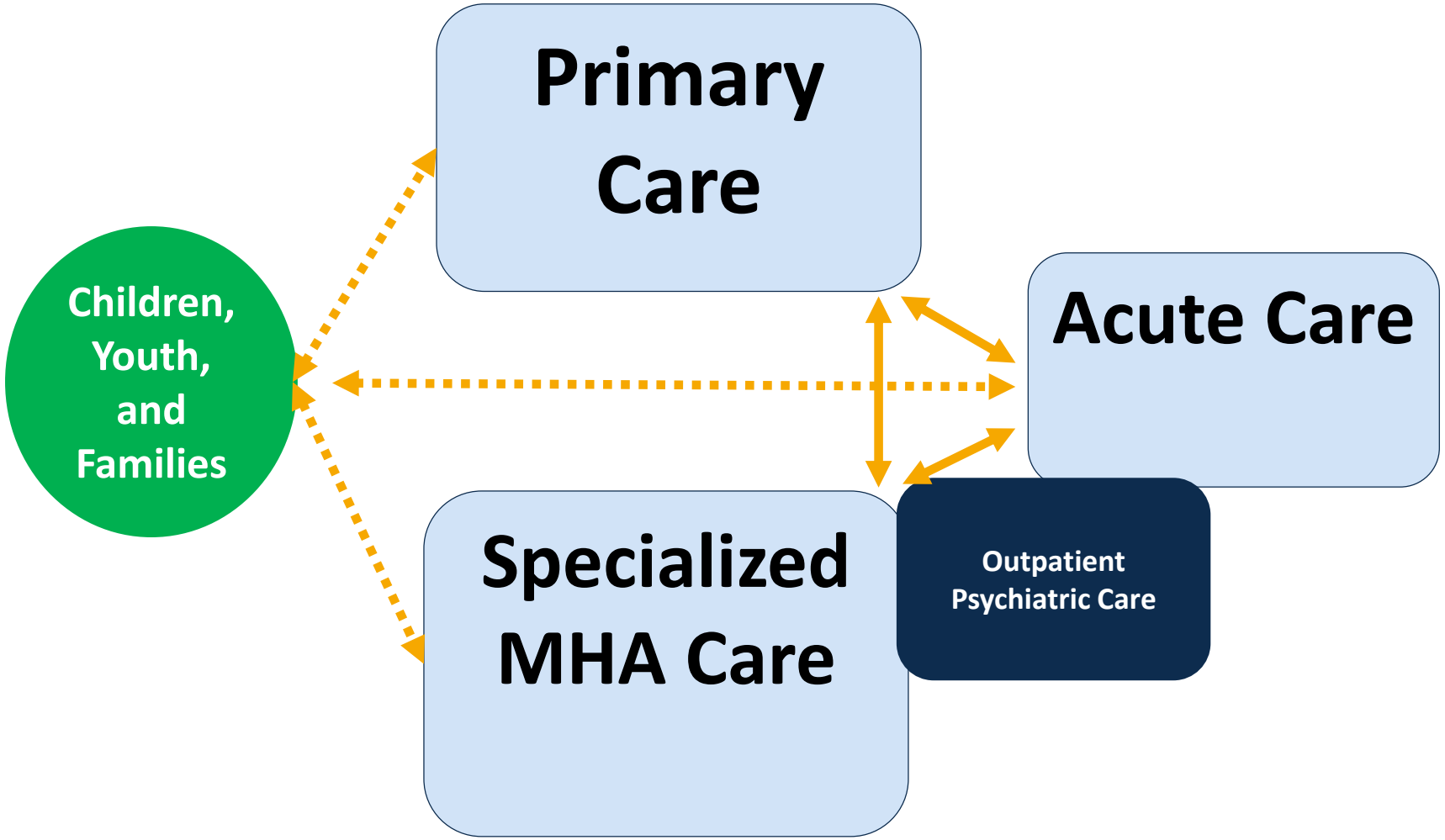
Kimberley Moran

CHIEF EXECUTIVE OFFICER

CHILDREN'S MENTAL HEALTH ONTARIO (CMHO)

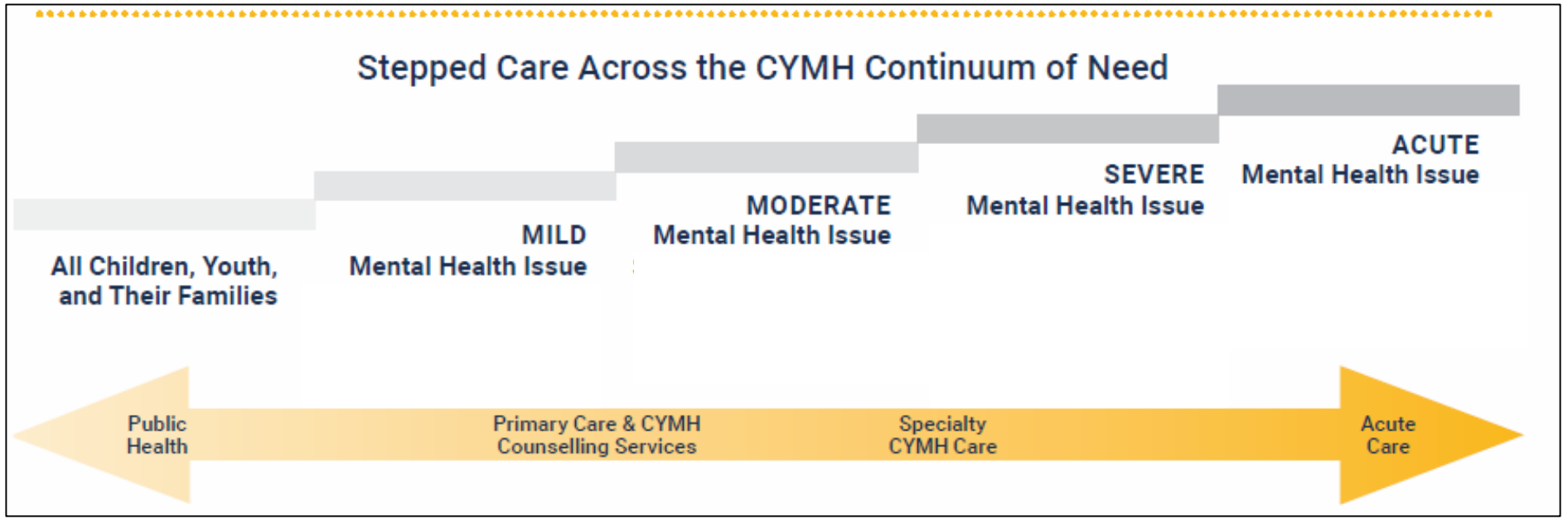
CMHO
Children's Mental Health Ontario
Santé mentale pour enfants Ontario

Ontario's Child and Youth Mental Health and Addictions System, 0-25



CMHO
Children's Mental Health Ontario
Santé mentale pour enfants Ontario

Stepped Care

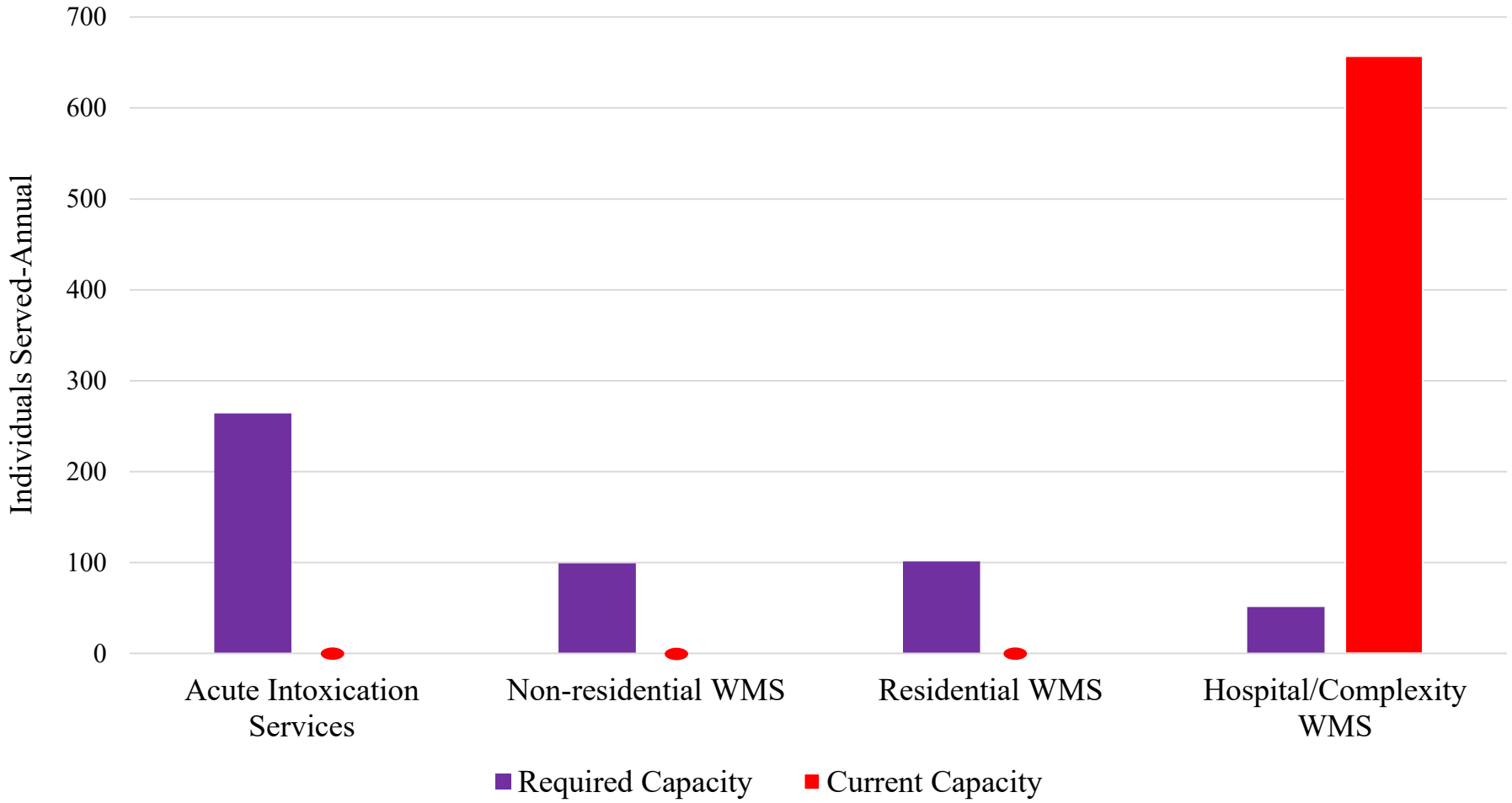


Health Links Leadership Summit 2018

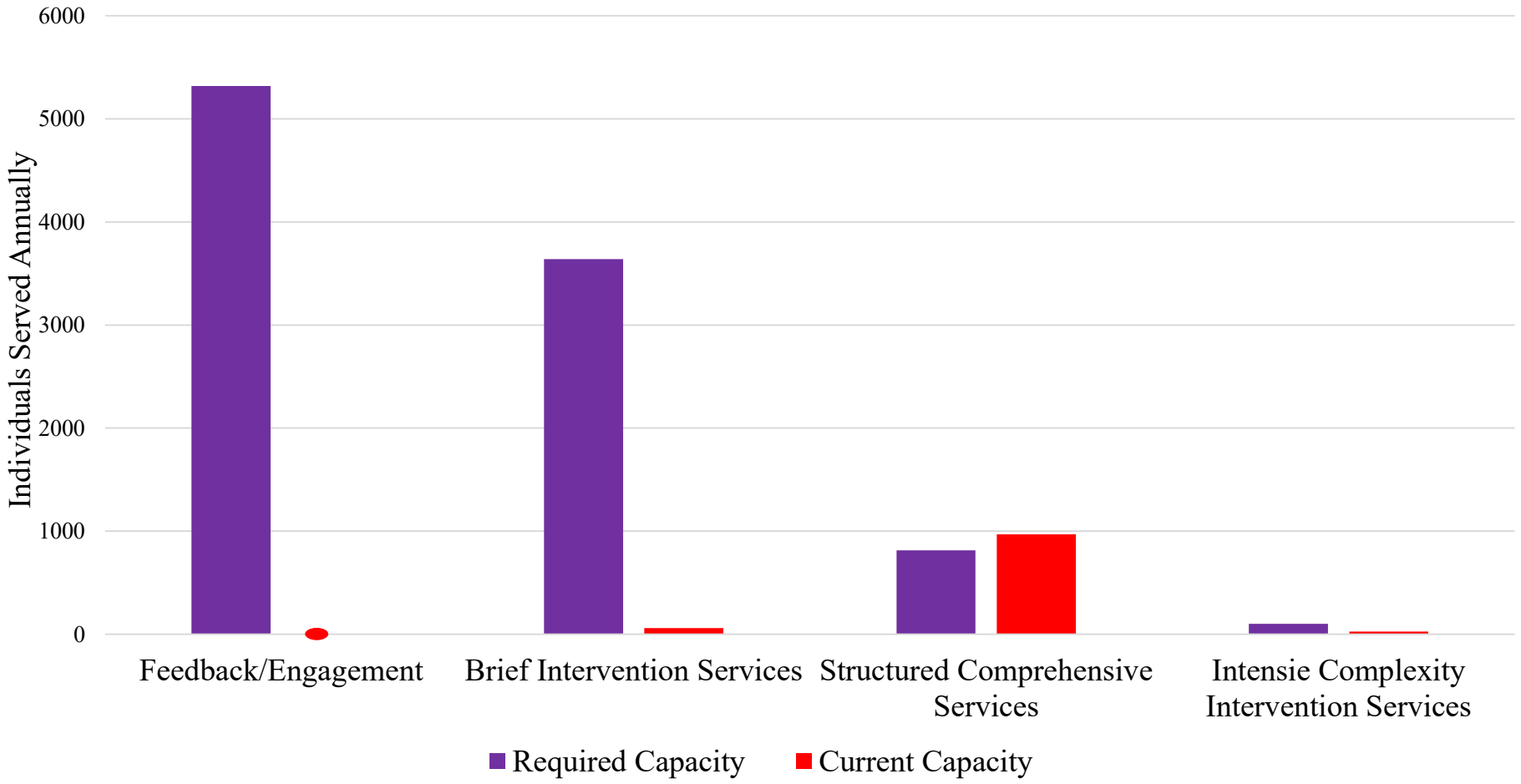
Paul Preston MD CCFP
Vice President Clinical

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

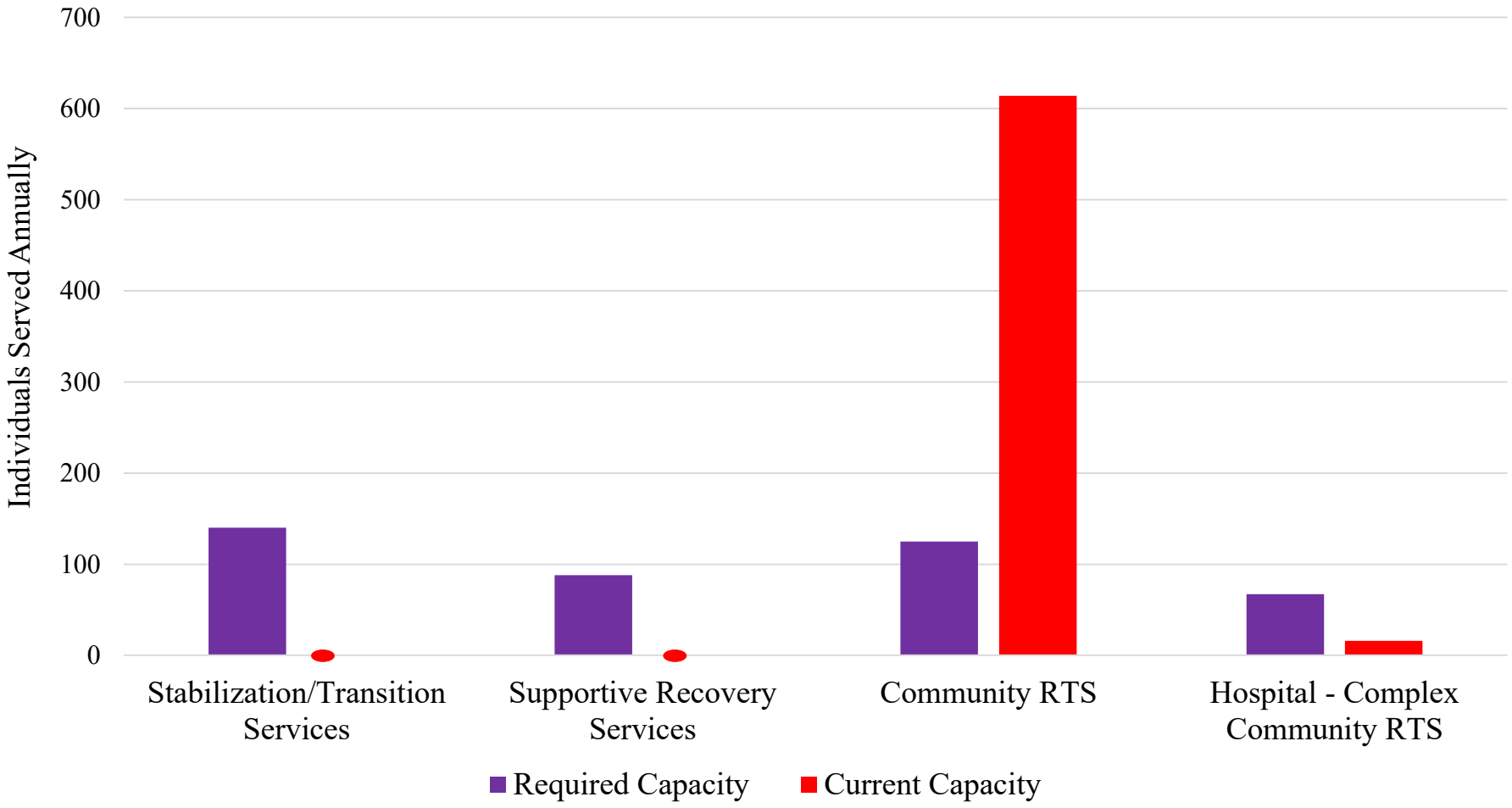
Withdrawal Management Services



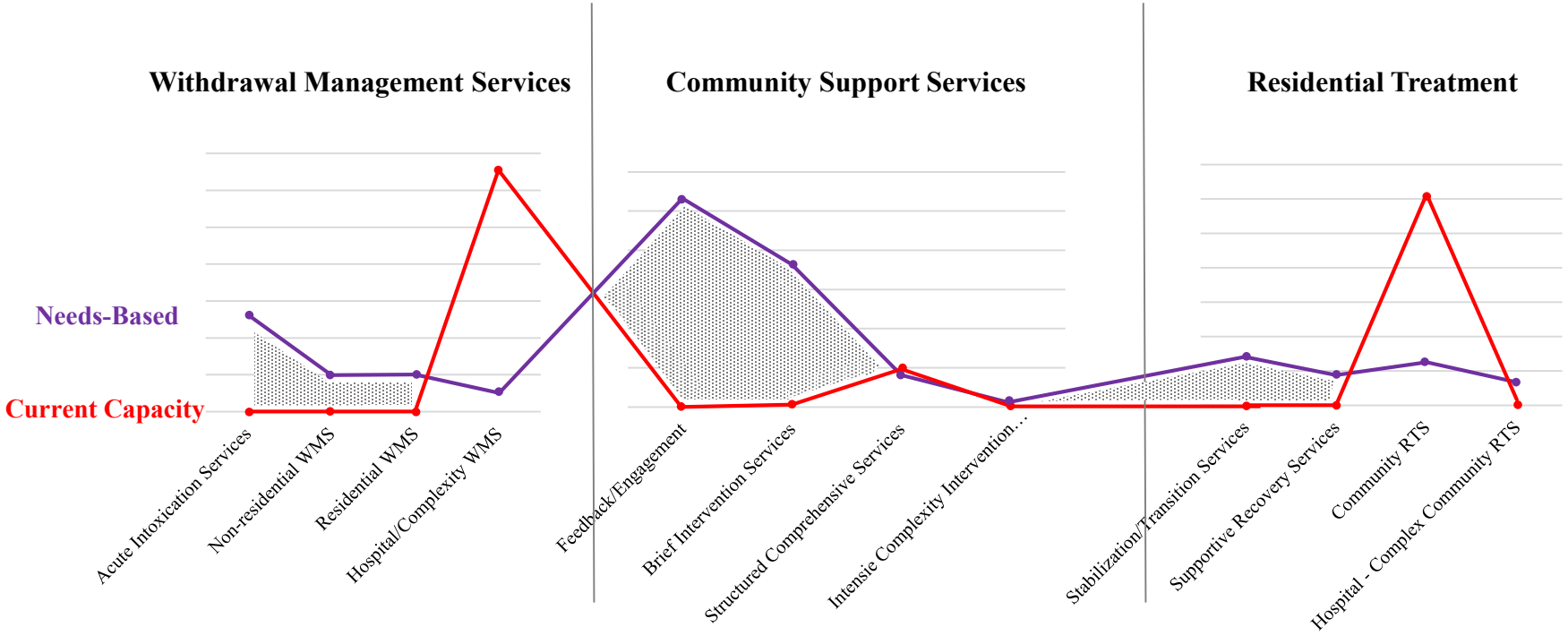
Community Support Services



Residential Treatment



Comparison


Withdrawal Management Services
Community Support Services
Residential Treatment
Needs-Based
Current Capacity
Acute Intoxication Services
Non-residential WMS
Residential WMS
Hospital/Complexity WMS
Feedback/Engagement
Brief Intervention Services
Structured Comprehensive Services
Intensie Complexity Intervention…
Stabilization/Transition Services
Supportive Recovery Services
Community RTS
Hospital - Complex Community RTS

Thank You
Merci
Miigwetch

Dr. Paul Kurdyak

DIRECTOR, HEALTH OUTCOMES AND PERFORMANCE EVALUATION

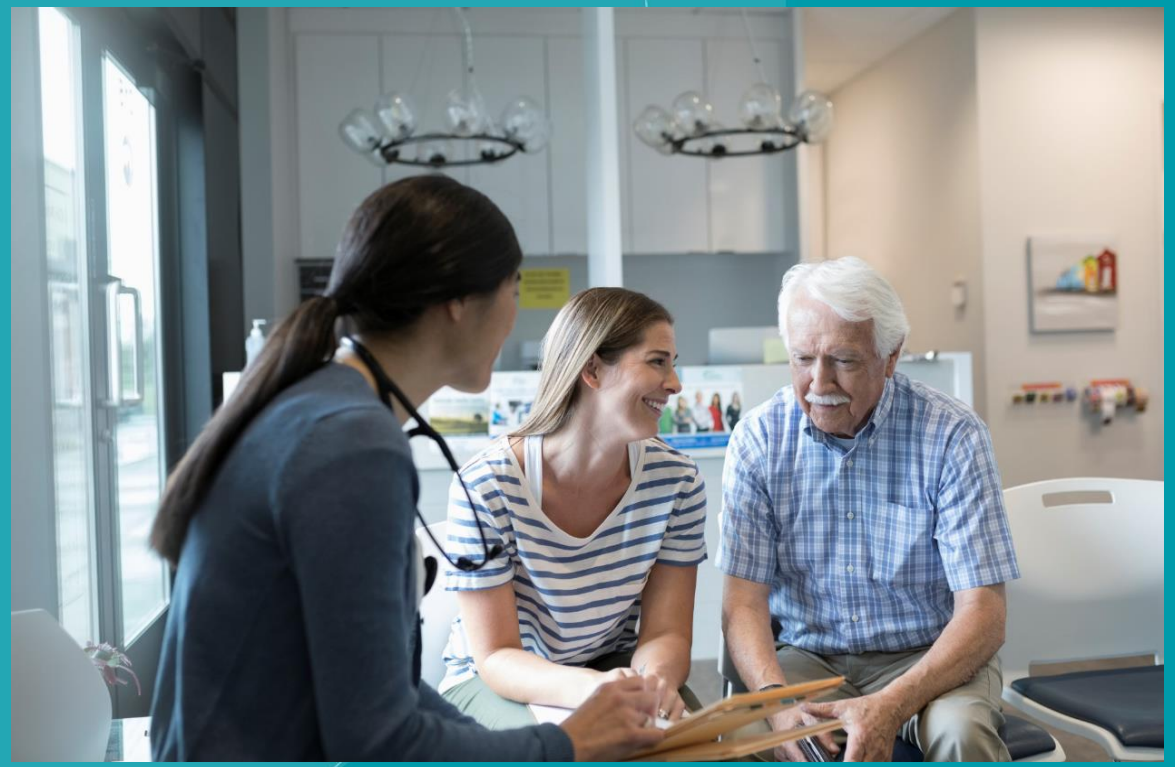
INSTITUTE FOR MENTAL HEALTH POLICY RESEARCH AND MEDICAL DIRECTOR, PERFORMANCE IMPROVEMENT, CAMH

Panel

- **Steve Keczem** – *Patient Representative*
- **Kimberley Moran** – *Chief Executive Officer*, Children's Mental Health Ontario (CMHO)
- **Dr. Paul Preston** – *VP Clinical, Sub-Region Primary Care Lead for Nipissing/Temiskaming; Clinical Quality Lead,* North East LHIN
- **Dr. Paul Kurdyak -** *Director, Health Outcomes and Performance Evaluation*, Institute for Mental Health Policy Research and *Medical Director, Performance Improvement,* CAMH

REFLECTIONS

Health Link Leadership Community of Practice
~ *Upcoming Webinar* ~



January 22nd 2019

12:00-1:00pm EST

To be confirmed

Patient Registry Information Session

If you are not already a member of the HL CoP, please email HLHelp@hqontario.ca to sign up for the invitation distribution list.

Evaluation

Coming soon to your inbox

Thank you.

- *Patients, Family/Caregiver and Public Advisors*

Thank you.

Planning Team

- *Kamal Babrah*
- *Annette Bradbury*
- *Connor Cleary*
- *Courtney Paxton*
- *Lorri Eckler*
- *Joanne Fernandes*
- *Phil Graham*
- *Trisha Gnaneswaran*
- *Paul Huras*
- *Sue Jones*
- *Kim Kinder*
- *Maya Kwasnycia*
- *Mandy Lee*
- *Jennifer Little*
- *Chris Maragh*
- *Julie Nicholls*
- *Dave Pearson*
- *Mark Simmons*
- *Julie Skelding*
- *Mel Patenaude*
- *Kim Sontag*
- *Tammy Stadt*
- *Dana Summers*
- *Nadia Surani*
- *Debbie Taylor*
- *Janine Theben*
- *Lesah Wood*
- *Jessica Wright*

Thank you.

Moderators and Speakers

- *Debbie Bang*
- *Jennifer Mills-Beaton*
- *Amber Alpaugh-Bishop*
- *Philip Browne*
- *Kate Dewhirst*
- *Michael Dunn*
- *Lorri Eckler*
- *Carol Fancott*
- *Joanne Fernandes*
- *Susan Fitzpatrick*
- *Paula Greco*
- *Helen Harris*
- *Dave Holmes*
- *Sherri Hudson*
- *Paul Huras*
- *Dr. David Kaplan*
- *Steve Keczem*
- *Dr. Erin Keely*
- *Dr. Phil Klassen*
- *Betty-Lou Kristy*
- *Dr. Paul Kurdyak*
- *Charmaine Lodge*
- *Lyn Lynton*
- *Danny Mainville*
- *Kimberley Moran*
- *Karen O'Connor*
- *Dr. Harry O'Halloran*
- *Dave Pearson*
- *Dr. Paul Preston*
- *Camille Quenneville*
- *Anum Rafiq*
- *Paula Reaume-Zimmer*
- *Rebecca Shields*
- *Todd Sholtz*
- *Michael Spinks*
- *Tammy Stadt*
- *Sandra Vaughn*
- *Cindy Wasyliw*
- *Walter Wodchis*

LET'S CONTINUE THE CONVERSATION:

- hqontario.ca
- @HQOntario
- HealthQualityOntario
- @HQOntario
- Health Quality Ontario

Health Quality Ontario

Let's make our health system healthier