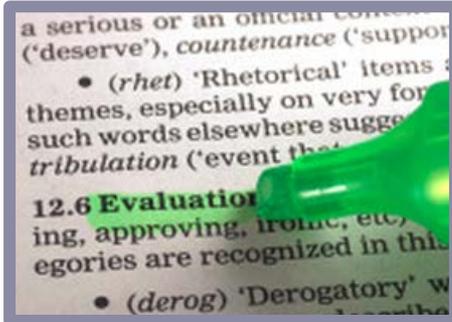


Interim Results: **Rapid Cycle Evaluation**

Anna Greenberg,
Director, Transformation Secretariat, MOHLTC

Current Evaluation Activities

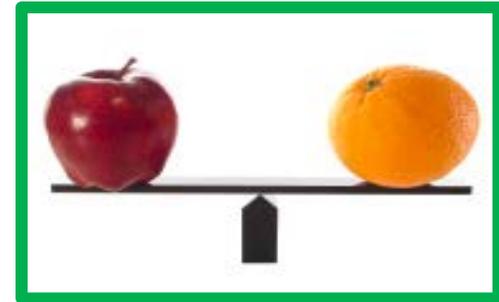


Rapid Cycle Evaluation

- Baseline conditions
- Early implementation results
- Model evolution, maturity
- Leading practices

Quarterly Reporting

- Implementation progress, barriers
- Performance against program indicators



Health Services Research

- MOHLTC-funded research, e.g.:
- Local capacity to coordinate care for high needs patients
- Economic burden of multi-morbidity
- Alignment of care goals: providers, patients, caregivers

Health Links Evaluation Sub-Committee

- **Co-Chair:** Cathy Fooks, Change Foundation
- **Co-Chair:** Stacey Daub, Toronto CCAC
- Gail Dobell, HQO
- Lisa Priest, Sunnybrook Health Sciences Centre
- Sanjeev Goel, Wise Elephant Family Health Team
- Walter Wodchis, University of Toronto
- Michael Schull, Sunnybrook Health Sciences Centre
- Dr. Alan Forster, Ottawa Hospital Research Institute
- Dr. Strasser, Northern Ontario School of Medicine
- Julie Gilbert, Cancer Care Ontario
- Dr. Harry O'Halloran, NSM LHIN
- Sanjeev Sridharan, St. Michael's Hospital
- David Colgan, Central West LHIN
- Allison Blair, MOHLTC

Rapid Cycle Evaluation

Methodology and Approach

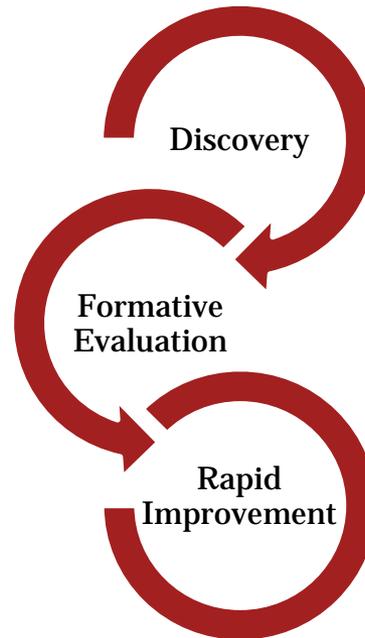
Early stage RCE enhances transformation trajectory as Health Links evolve

A structured mixed methods approach to data capture...

- Online Survey
- Consultations & Focus Groups (HL & Regional Stakeholders)
- Focus Groups with HL Patients
- Data Request to MOHLTC, Health Links, LHINs

Quantitative and qualitative data capture at provider and individual patient level

... and iterative ideation process refines the RCE...



...across four RCE domains

Domain / Overarching Metric	RCE Evaluation Categories	
	Quantitative	Qualitative
Identification of Complex Patients	✓	✓
Coordination of Care	✓	✓
Patient Care	✓	✓
Patient Satisfaction	✓	✓

Methodology and Approach

Data collection spans across the four key RCE domains

Each RCE domain area is described by a working definition to elaborate the scope of the domain:

Identification of Complex Patients: the process for defining, identifying and reaching a target population.*

Care Coordination: a person-centred, assessment-based, interdisciplinary approach to integrating health care and social support services in a cost effective manner.**

Patient Care: the facilitation of care through both the creation of care plans and the engagement of patients, families and/or caregivers in the coordination of care and creation of care plans.*

Patient Experience: the sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care .***

* derived from MOHLTC materials

** National Coalition on Care Coordination 2011

*** The Beryl Institute

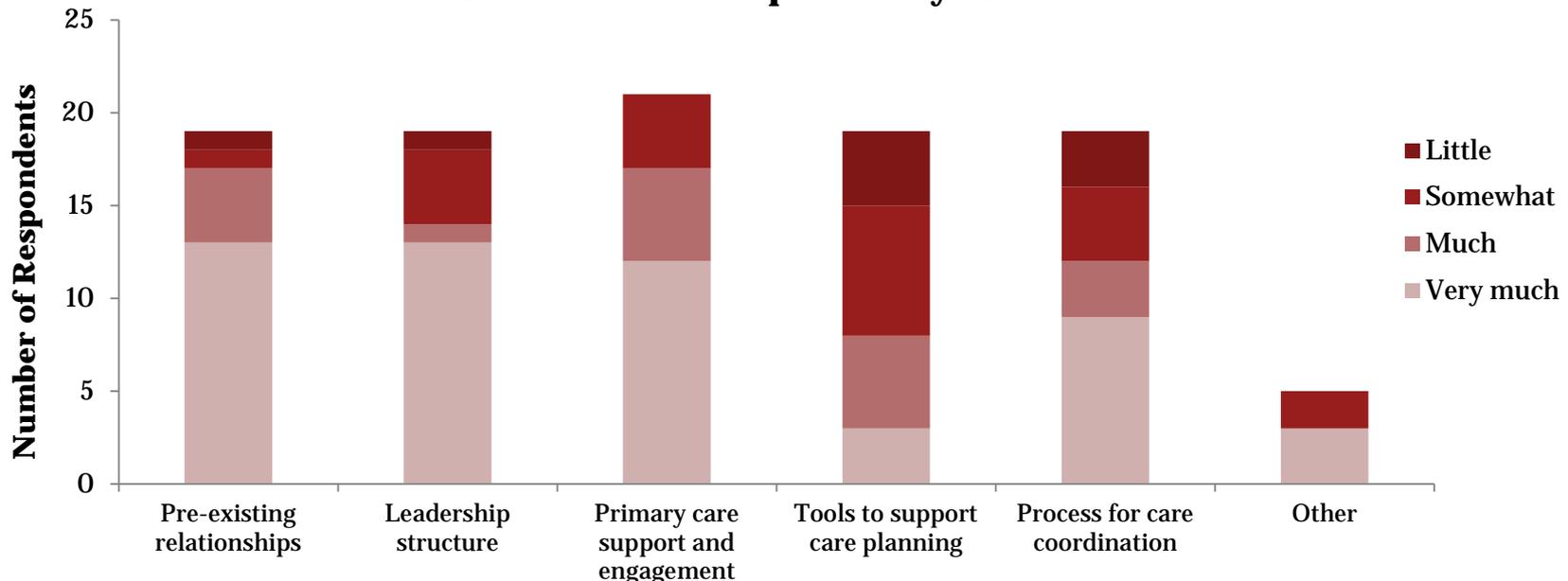
Rapid Cycle Evaluation: **Initial Findings**

Health Link Evolution: Foundational Elements

Core elements and accelerators include: pre-existing relationships, leadership structure, primary care engagement, care coordination process

- Pre-Health Link relationships, provider networks, recognized champions, governance, tools and processes are a major contributor / accelerator for progress in the early stages of development
- Tools to support care planning will likely increase in importance over time as Health Links move beyond planning and initiation begin to focus on core operational challenges

Contribution to the development of your Health Link



Defining Target Populations and Complex Patients

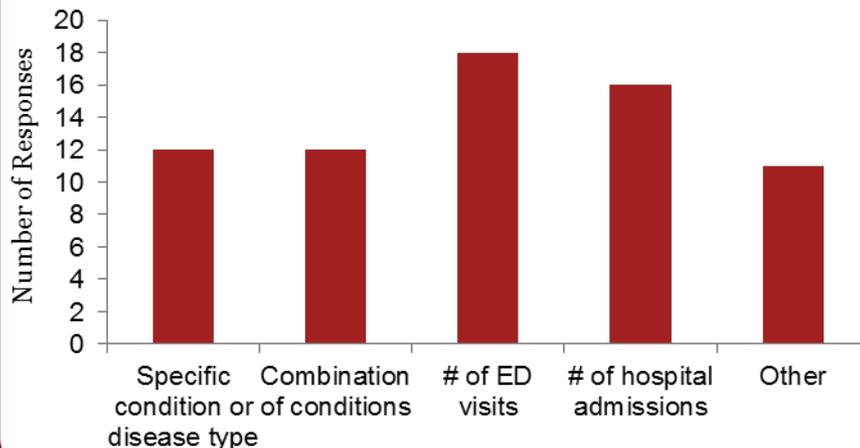
Health Links are using a variety of approaches, criteria, and tools as they work to define their target populations.

Have you defined your target population?

70% Yes

30% In Progress

Methods used to define target population



Emerging themes, opportunities, and/or challenges

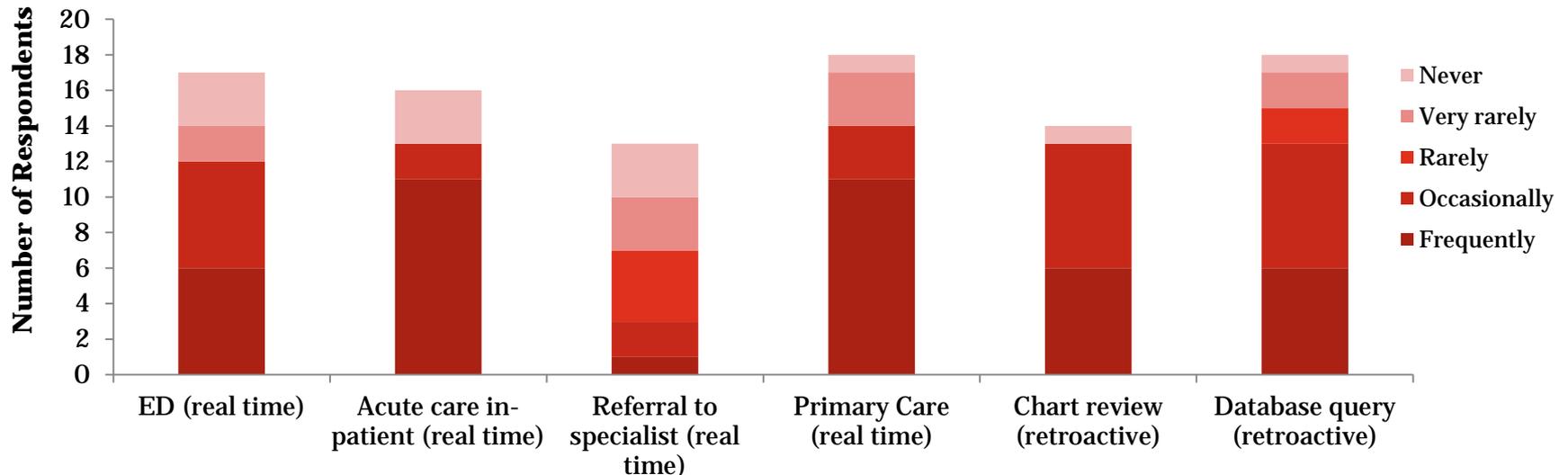
- Many Health Links are defining their target population iteratively and opportunistically using a wide variety of methods (see Appendix)
- Definitions of “target population” and “complex patient” not consistent across Health Links and sectors
- Availability of data is a key driver in defining target populations
- Sharing data across partners to help define populations has been an early challenge for Health Links

Identification of Complex Patients

Health Links see value in moving towards real-time ID of complex patients, but are challenged by availability and accuracy of predictive tools

- Most Health Links are currently using a combination of both real time and retrospective approaches to identify members of their target population
- Survey respondents most frequently identify members of their target population in acute care in-patient (real time) and primary care (real time) settings
- Focus group participants suggested that real time identification of high risk patients would be most effective since HL patients are complex and need for coordinated support changes over time

Location where target population is being identified

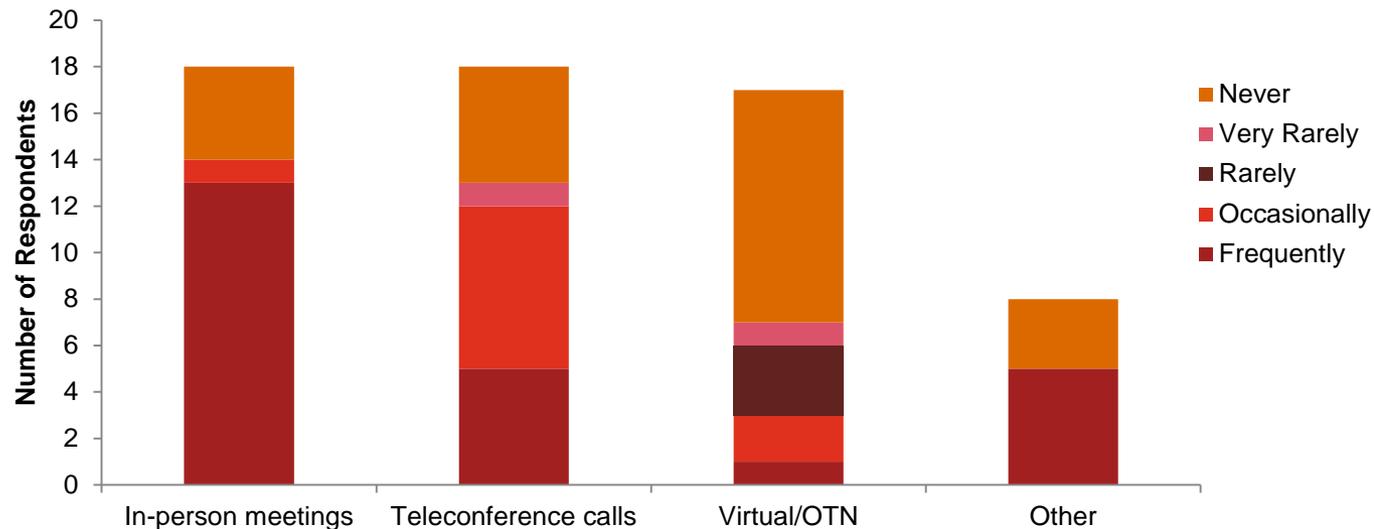


Care Planning

As Health Links scale, interprofessional care coordination & planning activities need to shift from in-person to virtual meetings for sustainability

- In-person, interprofessional meetings are the most common method used to coordinate care for patients
- Virtual/OTN is the least common; there is an opportunity to further increase participation of partners by increasing awareness to this technology
- Some respondents indicated fax, email, attending rounds as “other” methods; a few indicated they are still planning and not yet developing care plans with patients

Frequency of methods used to coordinate care for Health Links patients with partners

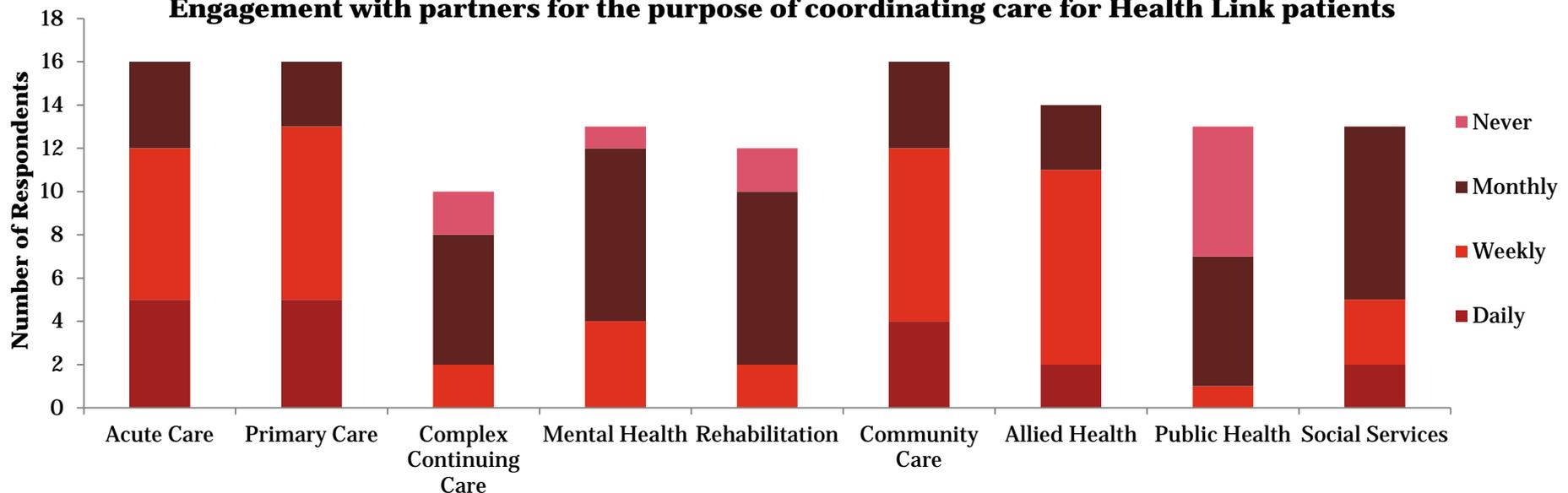


Provider Engagement

At present, lead organizations communicate most frequently with traditional healthcare delivery partners (and relatively less with non-medical partners)

- Lead organizations most frequently engage with acute care, primary care, community care and allied health for care coordination activities
- Respondents indicated a lower frequency of engagement with CCC, mental health, and rehabilitation sector partners
- Focus group participants have highlighted the critical role that social determinants of health play in the development of care plans. However, while there is some engagement with public health and social services, these partners are not yet as engaged as the more traditional medical partners.
- Generally, partner organizations demonstrate the closest links with social services

Engagement with partners for the purpose of coordinating care for Health Link patients



Patient Engagement

Health Links are being shaped by, and reshaping, the patient experience through patient engagement and co-design activities

- Patients and families complete a "what matters to me" interview prior to meeting their team for a care planning session
- Patient advisory groups, community participation panels, and patient engagement working groups are used to gather input on care plans, advanced care planning directives, and other tools
- A FB-like network , called Tyze, where calendars and notes are shared amongst the Health Link patient's care network (family, friends and care professionals)
- Informal patient feedback is collected as teams develop their care planning documents
 - “Here is something that were are working on...what do you think?”

Focus group participants suggested strategies to engage HL patients:

- Never talk about care plan without patient being present in the discussion
- Create fridge magnet care plans
- Patient experience advisors to be included in the team
- Educating patients about the changing healthcare space and it's impact on their treatments
- Let them share experiences and stories amongst other patients
- Be culturally sensitive while listening to them
- Revisit patients to check if the goals agreed upon are met
- Ask patients ‘how can I help’
- Quantify the results/efforts for the patients

Rapid-Cycle → Long-Term Evaluation

2013

2014

2016

2017

Rapid Cycle Evaluation (RCE)

To understand how HLs are working to inform ongoing program implementation

DESCRIPTION

Short, preliminary cycles of data collection that will be shared with the field to guide optimal implementation of Health Links.

METHODS

Mainly surveys, interviews, and/or focus groups. Some data may be analyzed.

EVALUATION FRAMEWORK DOMAINS

- Identification of high-needs patients
- **Coordination of care**
- **Patient care**
- **Patient Experience/Engagement**
- Ministry Performance
- Best Practices

RESULTS

- Identify best practices
- Guide implementation by identifying successes & challenges
- Provide early indications of results

RCE results will inform the evaluation design for the LTE

Adoption and integration of best practices identified through the RCE will be evaluated by the LTE



Post RCE Research on Value to System: Care Coordination with Patient Engagement. Focus for complex patients:

- Lessons from HLs transferrable to less complex
- Possible Global Reach as model for the "20%"

Long-Term Evaluation (LTE)

To understand the impact of HLs on health system performance

DESCRIPTION

Detailed evaluation of the implementation and effectiveness of Health Links.

METHODS

Primary data collection *plus* analysis of secondary data sets (clinical and health system data).

EVALUATION FRAMEWORK DOMAINS

- All RCE domains, *plus*:
- Health System Performance
 - Cost-Effectiveness
 - Sustainability

RESULTS

- Provide a detailed assessment of evaluation framework domain performance
- Determine how RCE results have affected CHL implementation
- Assess achievement of success indicators

Summary

- Strong focus currently on capturing initial evolution of the Health Link model
 - How are patients being identified, engaged?
 - How are providers working together across sectors, institutions?
 - What are the challenges, enablers to scaling up?
- Future evaluation will address impact of Health Link model on system performance
 - Value added to the health system
 - Impact on cost, patient experience, outcomes