Measuring and Evaluating the Performance of integrated Health Systems for Complex Chronic Disease Patients

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Multispecialty Physician Networks

Chronic disease care is uncoordinated, costly; poor care leads to more readmissions, ED visits & higher longitudinal costs

Readmission is the single most expensive component of health care spending

Multispecialty physician networks shown to improve performance (fewer readmissions and ED visits) for chronic disease patients through*:

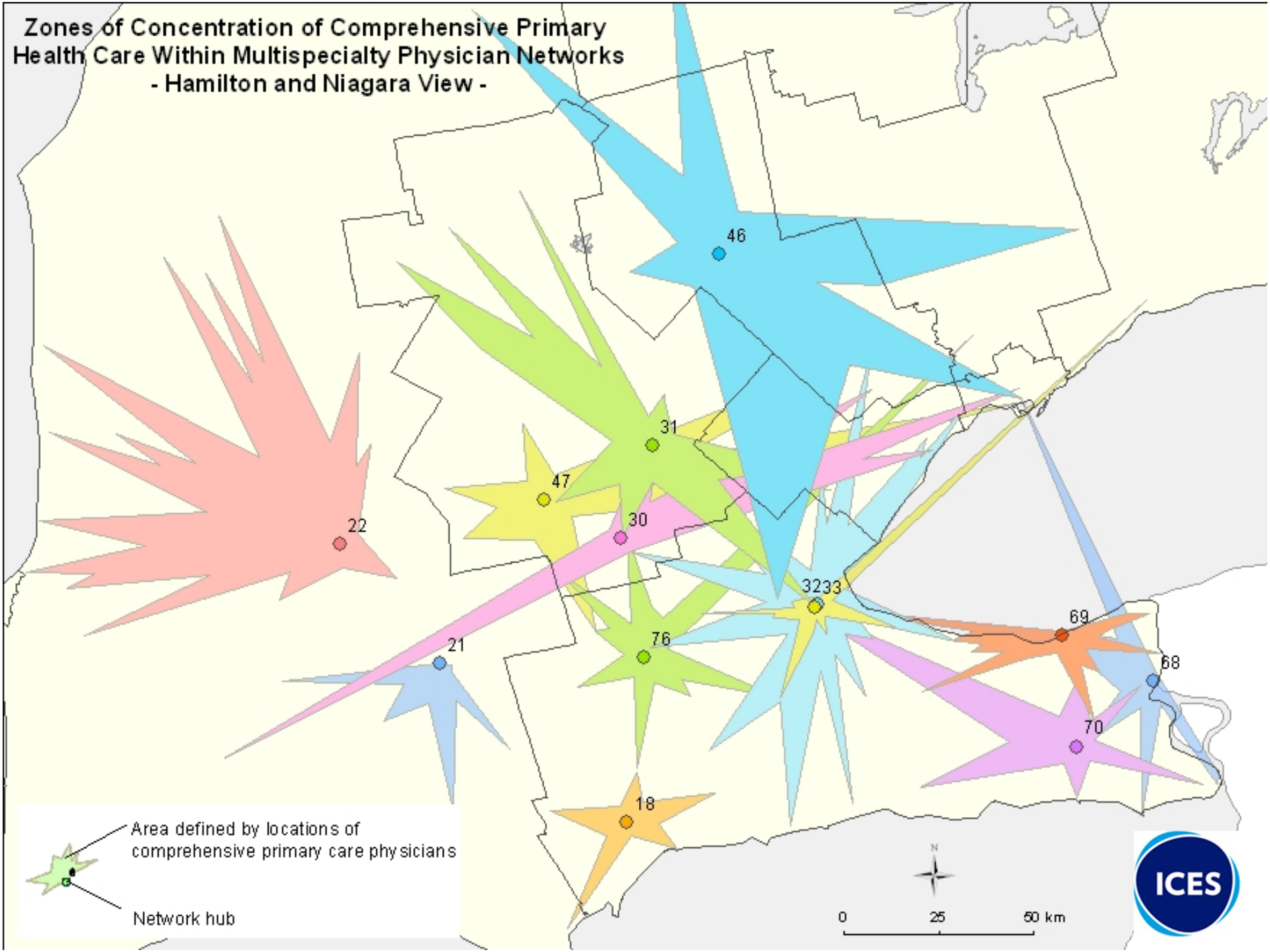
- Strong primary care (PC) systems
- Coordinated and integrated care among PC physicians, specialists, hospitals
- Engagement of interdisciplinary health professionals
- Focus on longitudinal efficiency (total spending over 1 year)

* Crosson, Commonwealth Fund, 2009

Multispecialty physician networks: Conceptual framework

- Focus is on chronic disease vs. acute care
- Provides most appropriate locus of shared accountability & performance measurement (Goldilocks problem)
  - LHINs/regions (too big)
  - Individual providers (too small)
  - Primary Care (PC) groups (do not include specialists, hospitals)
  - Multispecialty provider networks (just right)
- Alignment of hospitals, specialists, PC physicians and other providers to promote local input and planning, integration, shared accountability
- Platform for Accountable Care Organizations (ACOs) – system of care that collectively serves large panel of patients, can be held accountable for quality, performance measurement, ability to implement system QI

Stukel TA et al. Multispecialty physician networks in Ontario. *Open Med.* 2013;7:e40-55.


Zones of Concentration of Comprehensive Primary Health Care Within Multispecialty Physician Networks
- Hamilton and Niagara View -
46
31
47
22
30
3233
69
76
21
68
70
18
Area defined by locations of comprehensive primary care physicians
Network hub
N
0
25
50 km
ICES

Healthcare: The Current State

Too many people relying on Emergency Departments instead of receiving the right care in the community

Too many people are having trouble navigating the system

Too many ALC patients

Too many people being readmitted to hospital within days of leaving hospital

Ministry of Health and Long Term Care, June 25, 2013

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Transforming Ontario's Health Care System

Community Health Links provide coordinated, efficient and effective care to patients with complex needs

Five per cent of patients account for two-thirds of health care costs. These are most often patients with multiple, complex conditions. When the hospital, the family doctor, the long-term care home, community organizations and others work as a team, the patient receives better, more coordinated care. Providers will design a care plan for each patient and work together with patients and their families to ensure they receive the care they need. For the patient it means they will :

Transcript | Mobile

- Have an individualized, coordinated plan
- Have care providers who ensure the plan is being followed
- Have support to ensure they are taking the right medications
- Have a care provider they can call who knows them, is familiar with their situation and can help.

Read about evidence informed best practices in Transitions of Care, Optimizing Chronic Disease Management and Supporting Health Independence at bestPATH, a Health Links resource designed by Health Quality Ontario.

HealthLink LOGIN

For an example of how a community Health Link can make a difference in a patient's life, read Bernice's story.

The concept of a community Health Link is very similar to a project The Change Foundation is leading, supporting a project in Northumberland. Read more about this extraordinary community initiative.

ICES

http://www.health.gov.on.ca/en/pro/programs/transformation/community.aspx

Health Links' initial focus

WHAT:

Complex Patient Cohort

- Identifying patients with complex needs

Coordinated Care Planning

- Developing common principles
- Creating care plans for portion of the complex patient cohort

Attaching Complex Patients to PC

- Leveraging existing resources to attach complex patients to primary care (PC)

HOW:

Establishing the Health Links

- Leverage all provincial, LHIN and local assets
- Address sustainability, reinvestment and governance
- Funding

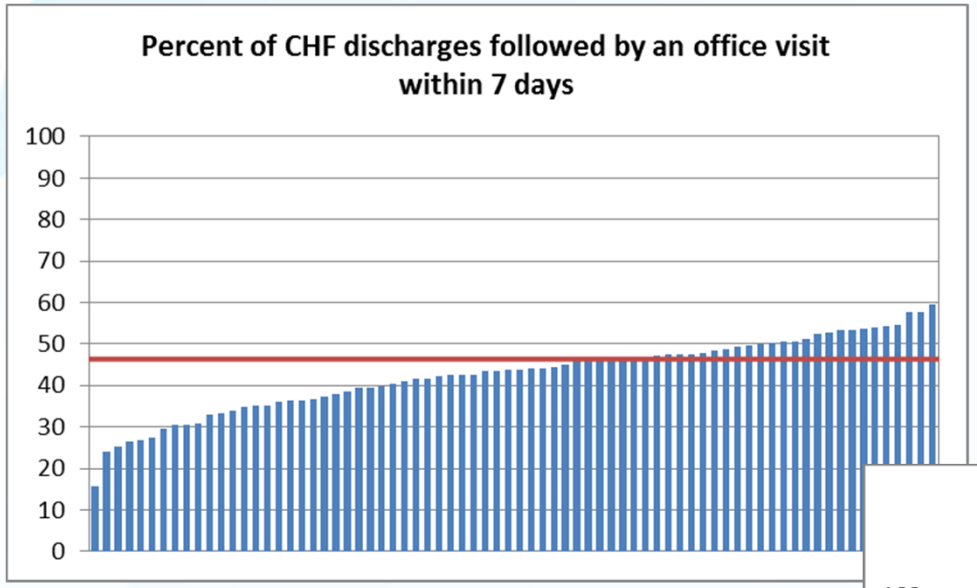
EMR/IT Connectivity

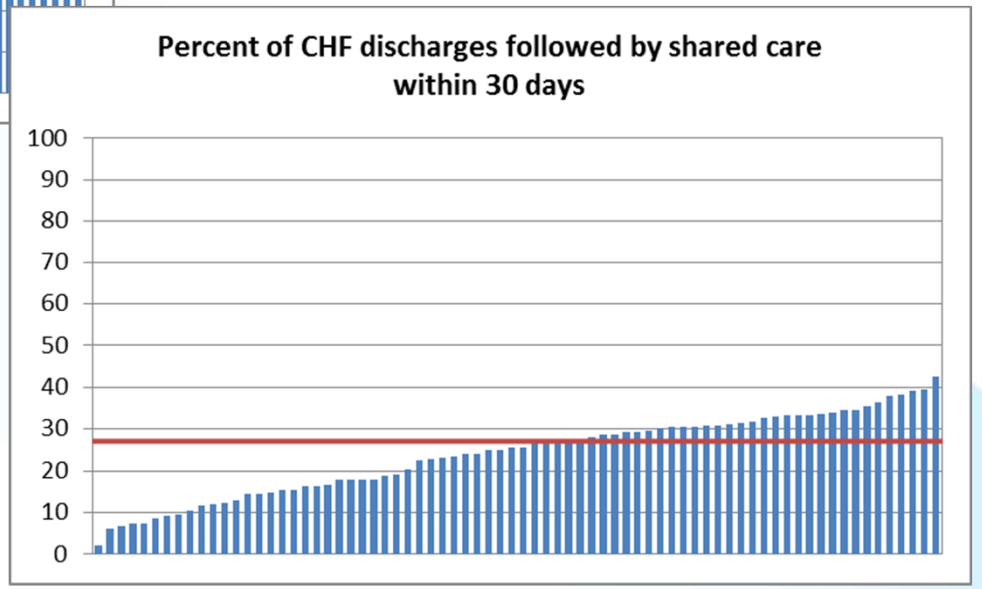
- Establishing the right solution to enable coordinated care across Health Links

Barrier Removal

- Review legislative/ regulatory, policies and procedures as they are raised

CHF: % with Follow-Up Visit Post-Discharge



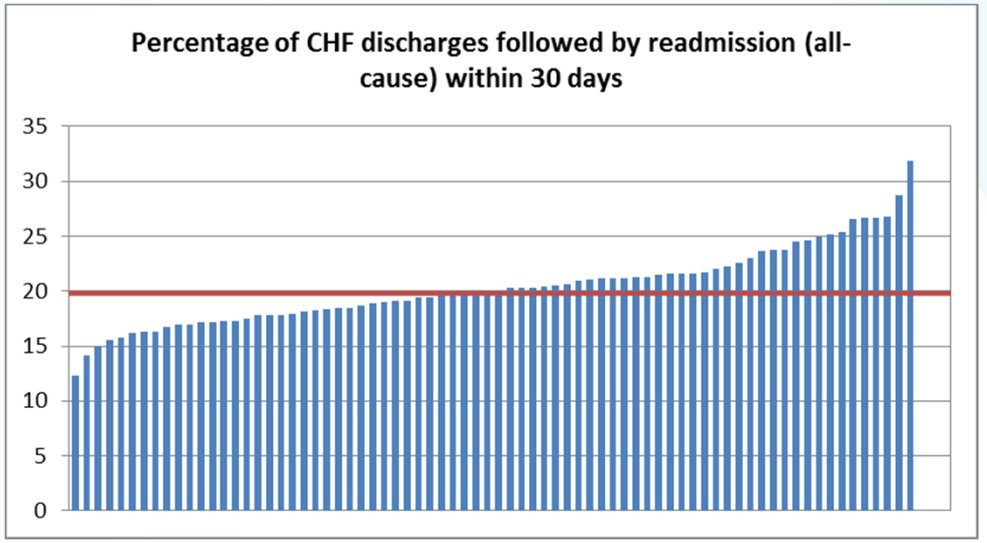


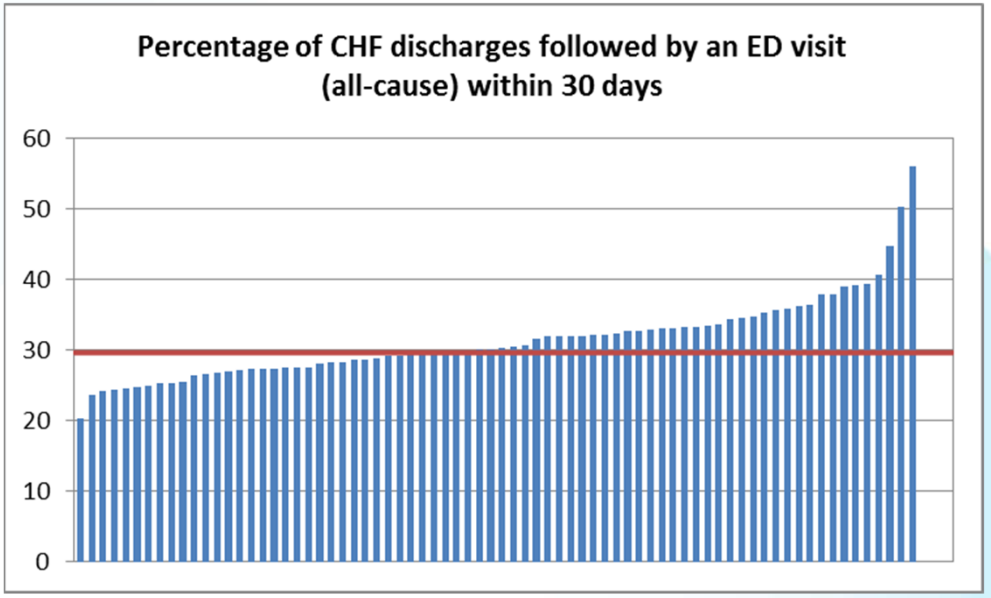
P4	Percent with office visit				
	10th	25th	50th	75th	90th
Any follow-up within 7 days	33.3	39.9	46.4	50.2	53.9
Shared care within 30 days	12.9	19.1	27.1	32.6	36.4

Stukel TA et al. (2016) Variations in Quality Indicators Across Ontario Physician Networks. https://www.ices.on.ca/Publications/Atlases-and-Reports/2016/Variations-in-Quality-Indicators-Across-Ontario-Physician-Networks

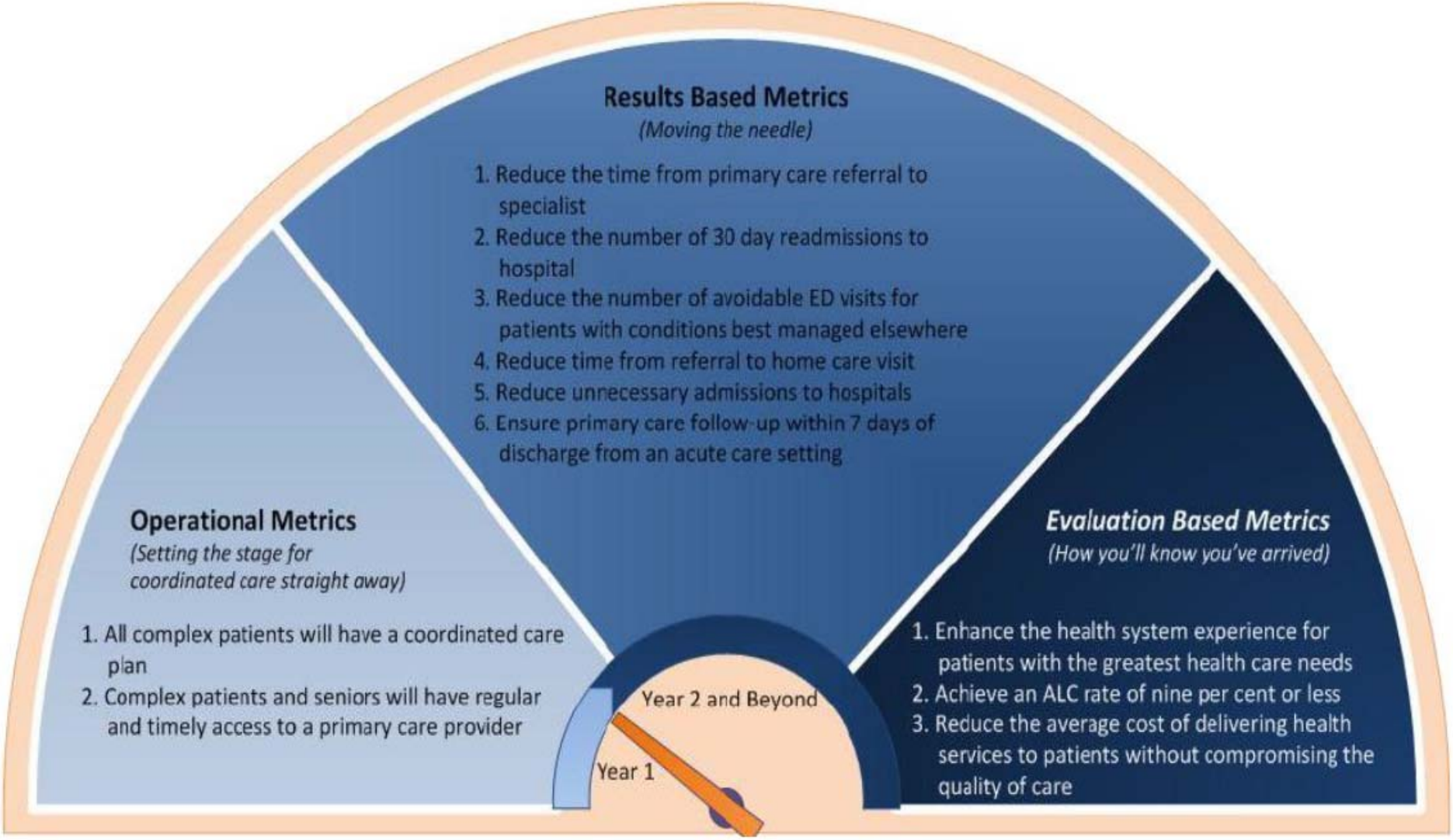
CHF: 30-day All-Cause Readmission and ED Rates

PA8	Percent of CHF hospitalizations with a readmission or ED visit				
	10th	25th	50th	75th	90th
All-cause readmissions	16.2	17.8	19.8	21.6	24.5
All-cause ED visits after discharge	24.8	27.4	29.7	33.1	35.9



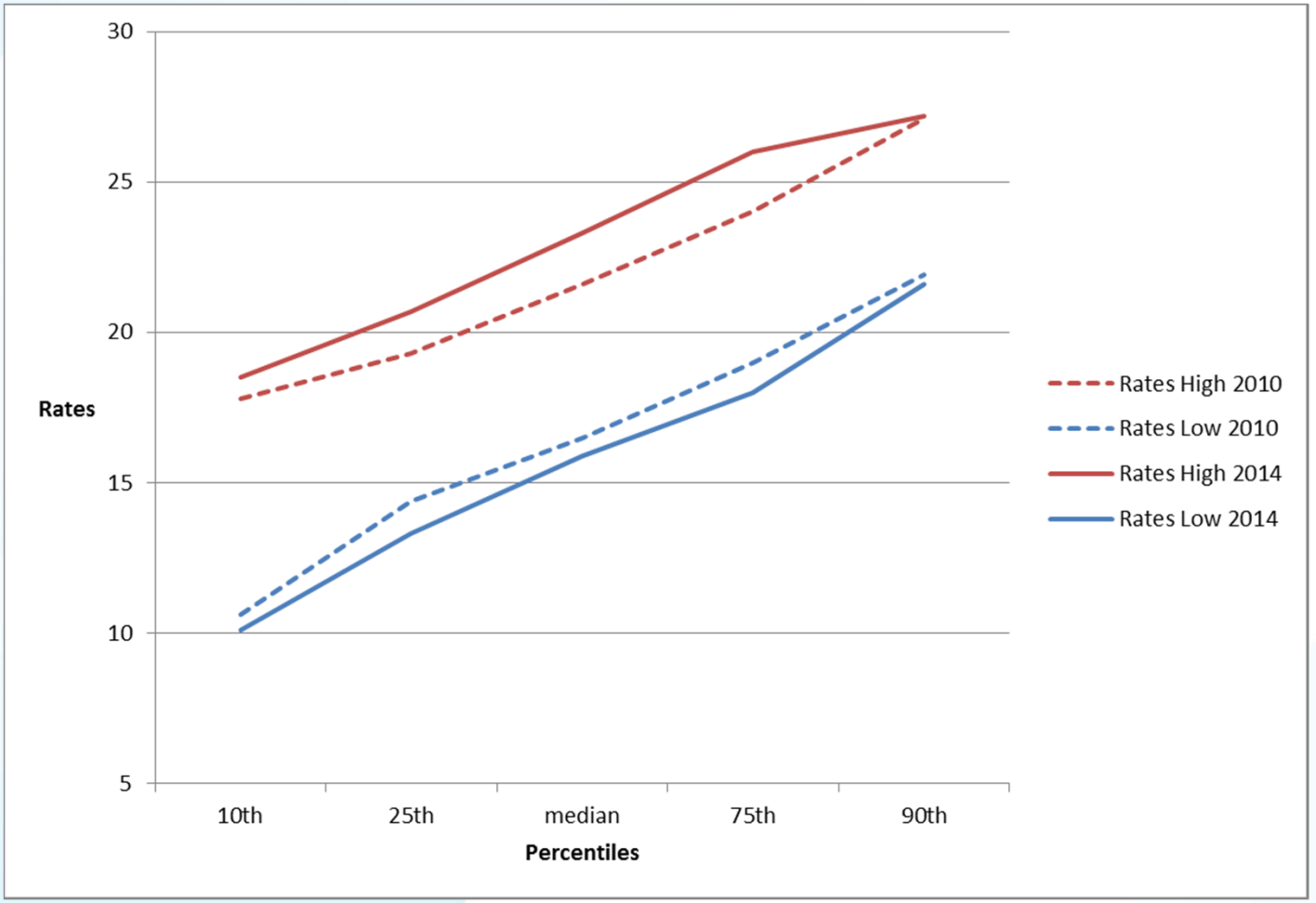


Indicators of success



Health Links: Work-planning & the Path Forward July 2013 Ministry of Health & Long-Term Care

30-day readmission after CHF hospitalization



Advanced Health Links