Benefits Realization Case Study: Flexibility of the Health Links approach allows clinicians in Guelph to provide patient-centred care within their local contexts

Background

Health Links was initiated by the Ontario Ministry of Health and Long-Term Care in 2012 as a more broad approach to care for complex patients. There are now over 80 Health Links in Ontario [1]. While the overall concept of Health Links — as coordinating care for Ontario's most complex patients and developing coordinated care plans — remains consistent across the province, each Health Link is given freedom to determine how this approach is delivered, resulting in practice variations. This flexibility allows providers to develop their own ways of coordinating care, based on their local context and patient population. This is also referred to as self-organization, a process whereby local interactions give rise to patterns of organizing rooted in what is required to accomplish tasks on the ground [2].

The Health Link team in Guelph have developed a few processes within their approach that provide an example of the potential to make the Health Links approach patient-centred for their population. Patient-centredness can be achieved by combining the professional knowledge of the care provider with the personal preferences of the patient to provide care that meets two of the main needs of the patient group: 1) patient involvement in their care, and 2) more individualized care for the patient [3, 4]. Research has found that when these two needs are met, both patient satisfaction and patient adherence to treatment plans increases [5].

Health Links flexibility leads to great patient engagement and satisfaction

Value Proposition

The flexibility inherent in the Health Links approach allows providers to determine their own processes that have the ability to promote patient-centred care, resulting in greater engagement and satisfaction for Health Links patients.

We asked Guelph Family Health Team (GFHT) providers, what does Health Links mean to you?

"The patient is at the centre, setting goals and directing care. Communication between health care organizations is key with a holistic approach to care."

"Planning care with the patient and their care team/family's involvement to meet the needs and goals of the patient. Looking outside the box and finding ways to meet needs for complicated/ complex patients. Being the patient's "go to" person and communicating the patient's plan with the rest of their care team (primary care and community supports)."

"Wrap around care, providing patient with a copy [of their coordinated care plan] to help them lessen the amount of times they need to 'tell their story' as well as giving them a reference to either refer to or track their health care supports."

What were the Benefits?

The Guelph Health Link team has developed several tools and processes that have the potential to support patient-centredness in identifying Health Links patients, producing the Coordinated Care Plan (CCP), and providing coordinated care for 1,793 GFHT Health Link patients.

The 'Health Links tool bar' that is embedded in the patient chart within the Guelph Family Health Team's electronic medical record (EMR) was developed to aid primary care providers to identify Health Link patients for care team members and to capture discussions held with team members and patients. Health Links patients can be identified in the EMR and their CCP is accessible to all within the circle of care, which allows for care to be coordinated between multiple providers.

Health Link "guides" engage their patients to create a CCP (also known as a Health Link passport), which only contains information most relevant to patients. Health Link guides will often offer the passport to patients and many patients accept it, demonstrating that it may provide value to them. This allows the Health Link patient to play an active role in their care plan. They feel more involved in their care, resulting in greater engagement and satisfaction.

Here's what patients said about their Guelph Health Link provider*

100%
is very helpful

93%
Acts in ways that are sensitive to their needs and preferences

82%
Involves them as much as they want to be in decisions about their care and treatment

96%
- Explains things in a way that is easy to understand
- Treats them with dignity and respect

89%
- Listens to their concerns
- Works together with them to create goals and a plan to achieve them
- Gives them an opportunity to ask questions about recommended treatment
- Spends enough time with them

** Patients (n=28) survey results*

Program Details

Healthcare spending is highly concentrated: the top 1% and top 5% of health services users accounted for 34% and 66% respectively of health cost in Ontario in 2007/8 [6]. These high health care users are likely to be patients with complex care needs and/or multiple chronic conditions. The Ontario Ministry of Health and Long-Term Care recognized the need to better coordinate care for these most complex patients within the community in order to improve health outcomes and drive health system efficiencies, and thus initiated the Health Links approach to care in 2012.

The Waterloo Wellington Local Health Integration Network (WWLHIN) is in the process of conducting an evaluation of the Health Links approach to care within the region. The eHealth Centre of Excellence (eCE) has supported this evaluation by conducting a Benefits Realization (BR) study in each of the four sub-LHIN geographies within the WWLHIN. The eCE's work focused on the impact of the Health Links approach to care by conducting a pre-post Coordinated Care Plan (CCP) comparison of acute care use and developing clinical narratives to highlight the clinical value enabled through the Health Links approach. This BR case study is one of the outcomes of the eCE work.

Works Cited

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If you are interested in participating in a future BR case, please contact eCE BR Practice Lead Lori-Anne Huebner at: Lori-Anne.Huebner@eHealthCE.ca

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HealthLinks

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Published: June 2017

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