Complex Care Coordination

Delivering Efficient Service and Quality Health Outcomes

Presented by

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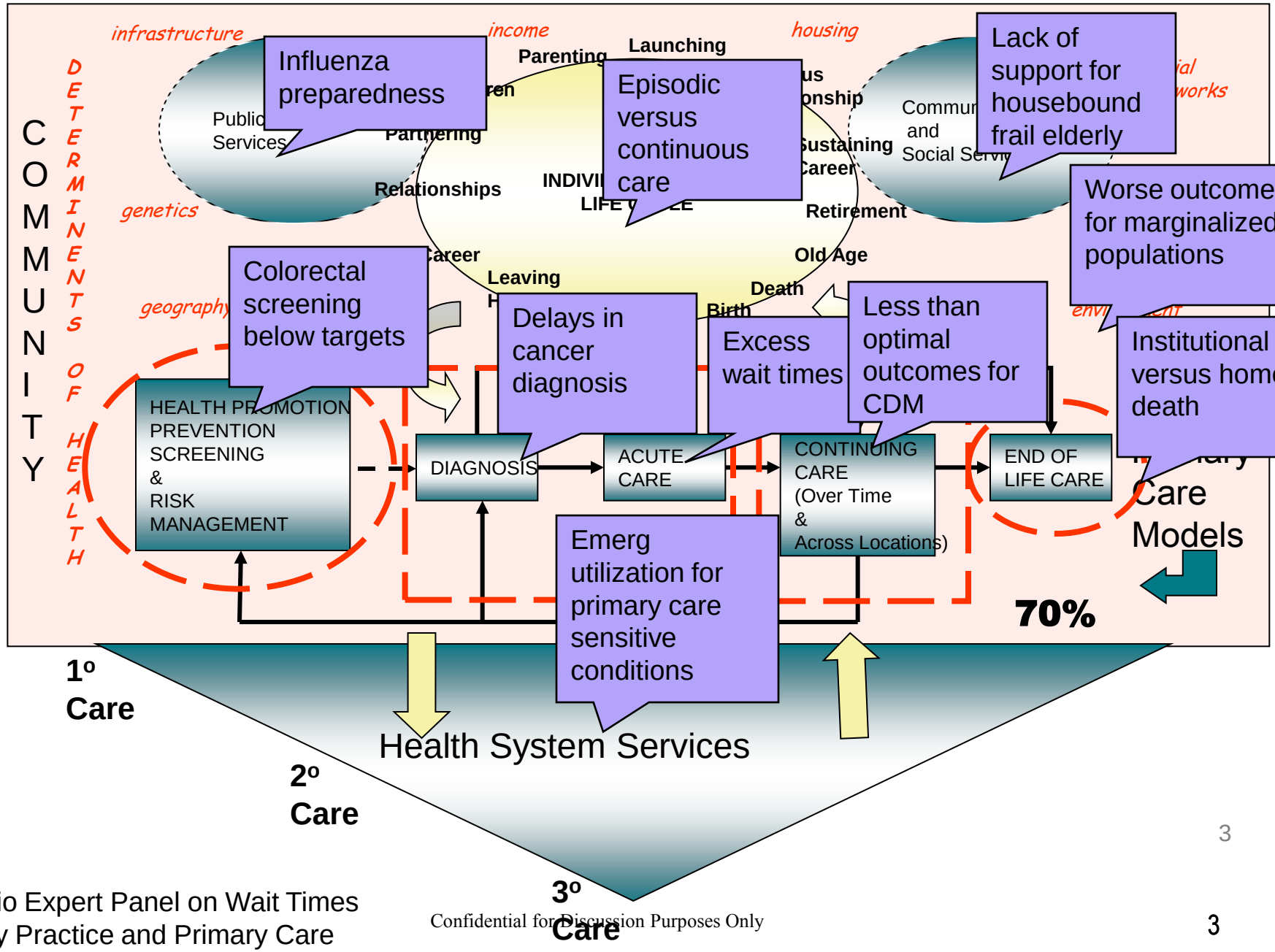
June 6, 2016

Objectives

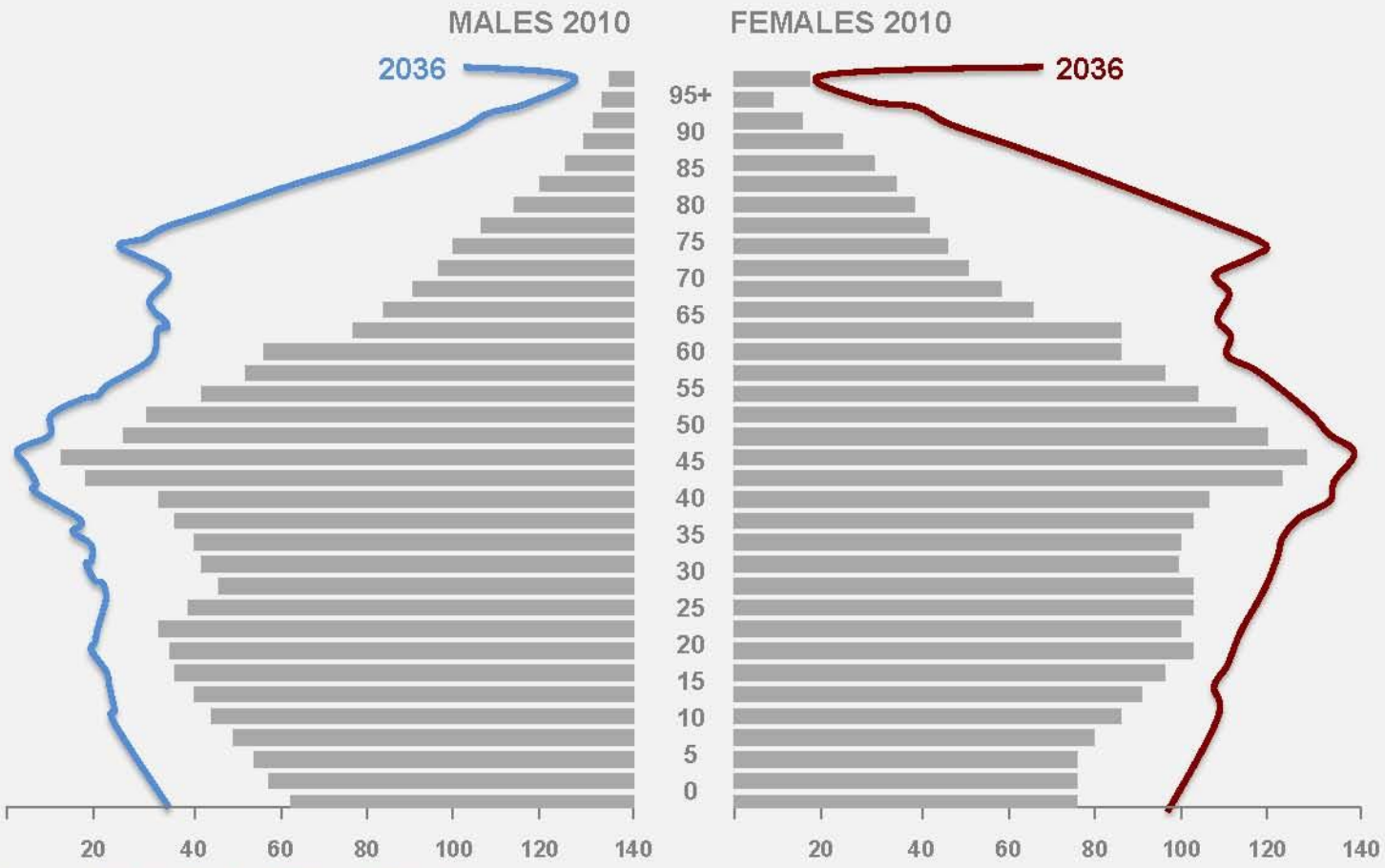
In this session, participants will learn:

- How an easily implemented connectivity solution is benefiting all stakeholders
- How the solution empowers and engages complex patients in their own healthcare
- The planning and process that was required to get providers and patients to use the solution



Ontario Expert Panel on Wait Times
Family Practice and Primary Care

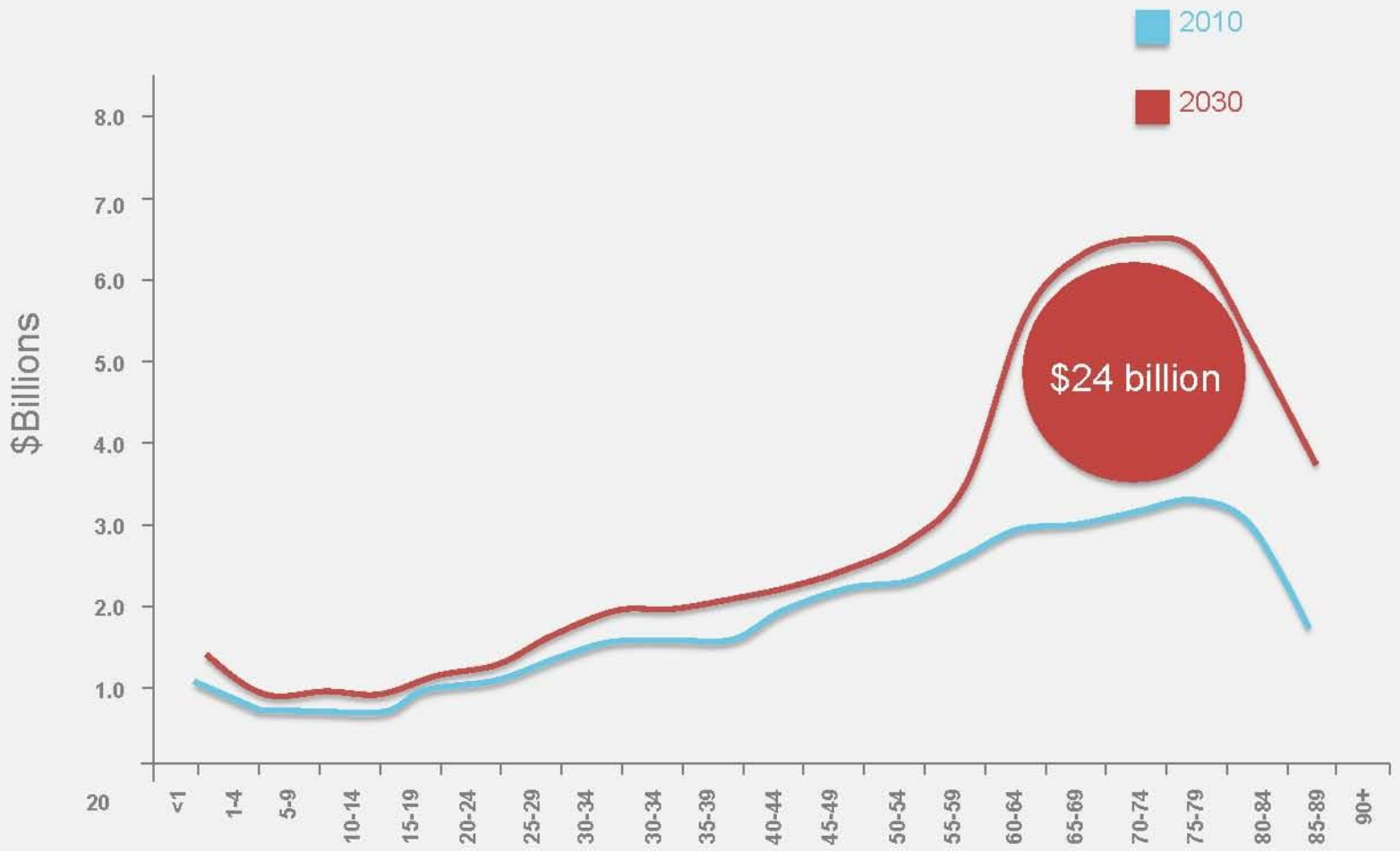
The Demographic Challenge



Source: Statistics Canada, 2010, and Ontario Minister of Finance projections.

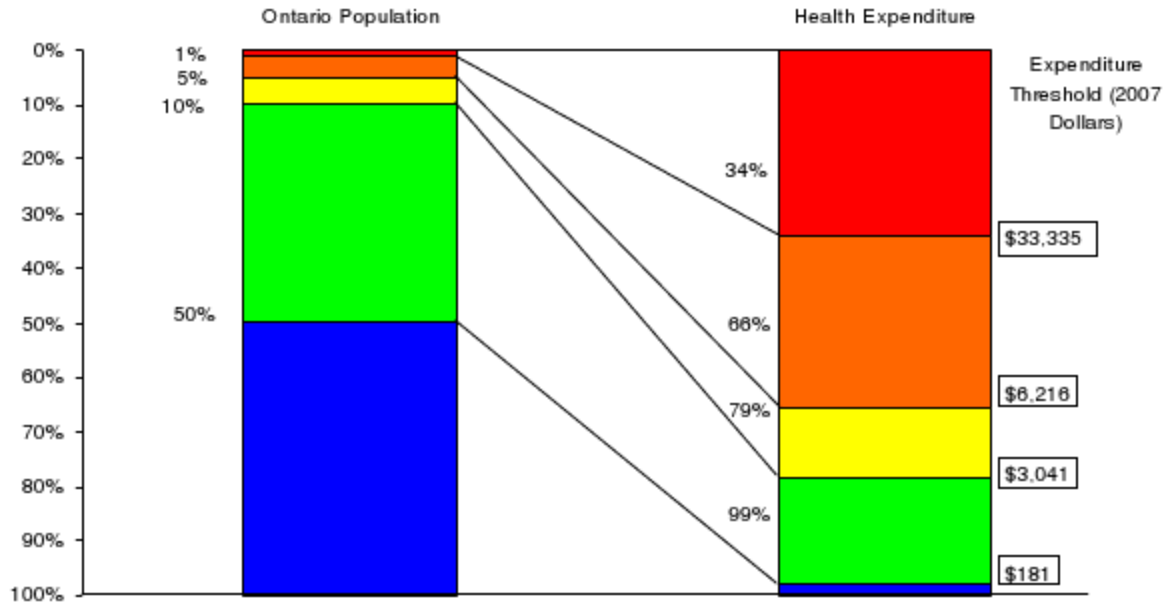
The Demographic Challenge

Health costs by 2030



Who are we innovating our health systems for?

Figure 1. Health Care Cost Concentration:
Distribution of health expenditure for the Ontario population, by magnitude of expenditure, 2007

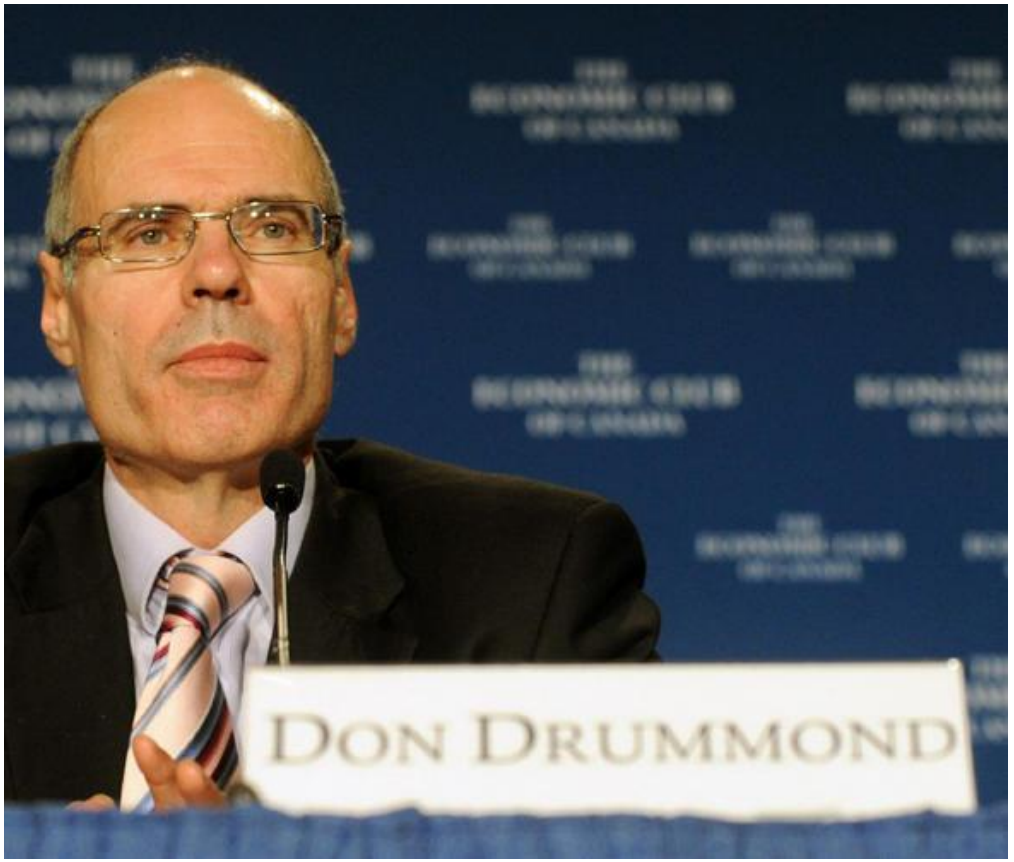


On average, health care spending is highly concentrated with the top 5% of the population (ranked by cost) accounting for 66% of expenditure

EFFICIENCY

1% of the population accounts for 49% of hospital and home care spending, with 10% accounting for 95% of such costs

10% gain in efficiency – through better integration and expansion of community and chronic care or mental health services — could save $1.5 billion a year



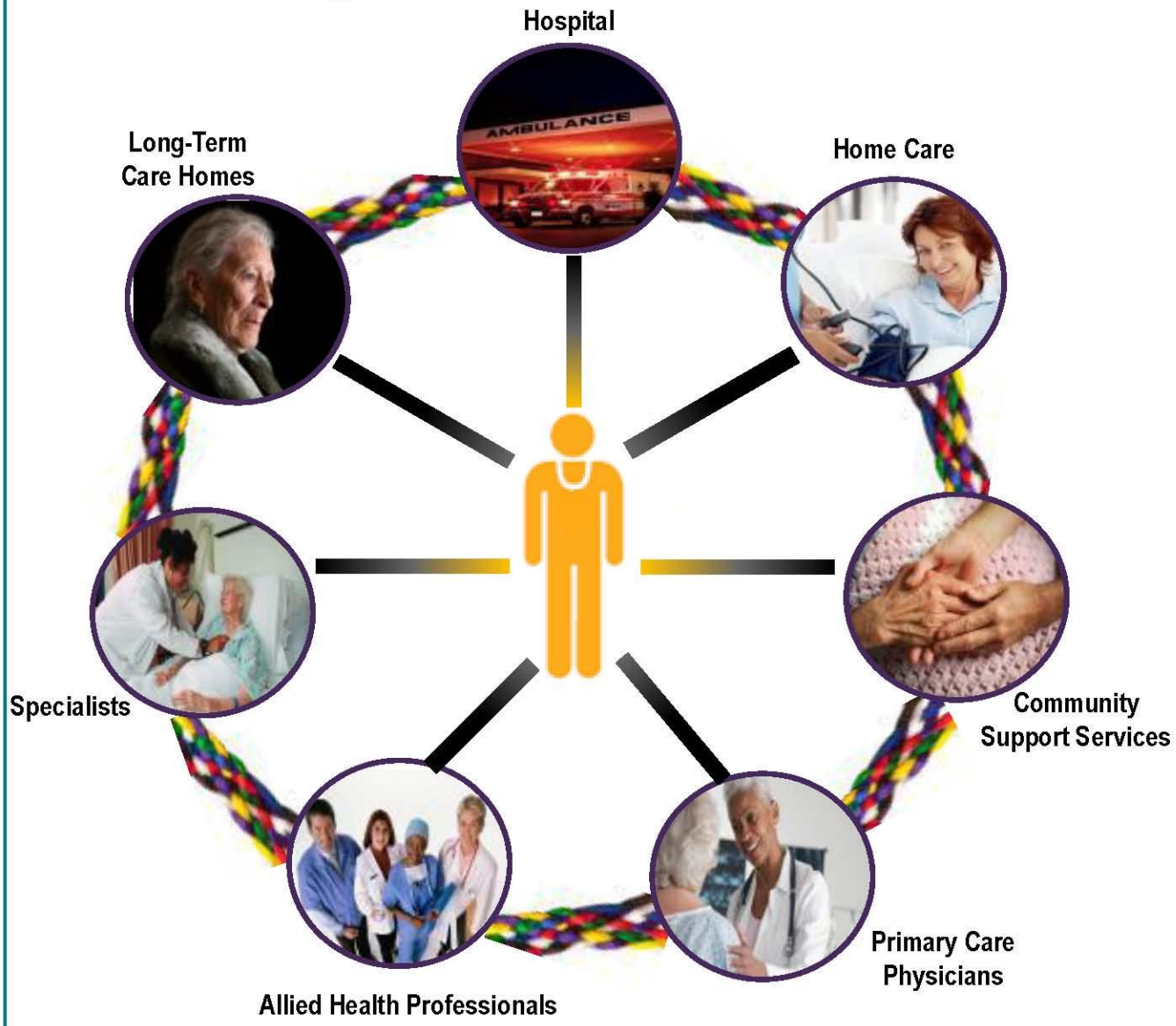
The Minister of Health's Vision

"Network of linked healthcare providers to work as a team to collectively manage the needs of those patients, with the greatest needs, in partnership with family and community, so they move smoothly through the system, always confident that they are being looked after."

Core Features…

Patient Centered	Initial activities centered on improving care & experience of high users at better value
Local Focus	SubLHIN areas defined by existing health service utilization patterns Minimum of 50,000 people within a Health Link
Voluntary Partnerships	Voluntary participation from providers involved in care of high users Includes primary care, CCAC, specialists, hospital and Community Support Services
Robust Primary Care Participation	Requires involvement of 65% of primary care providers from all delivery models within the community (organized and unorganized)
Measurement & Results	Joint accountability for targets and metrics; required to identify & track improvements for high use population; evaluation built in from start
Leadership	Each Health Link will have an administrative lead based on ability & capacity to engage providers & focus activities on achieving results

Better Integration: Health Links



Coordinated and integrated care is the heart of Health Links

- Health Links launched Dec. 2012
- New model of to improve care for high needs patients
- All providers working at the local level to integrate clinical care and coordinate plans at the patient level
- Initial focus on people with complex health conditions

Health Links Core Requirements

- The Ministry has **engaged with Health Links** to better understand how best to meet their care coordination needs to fulfill their core mandates
- The Health Links identified the following key needs:
  - Gather reliable **information about patients**, including patient goals so that this information can be known to the entire care team;
  - Create, maintain and share **standardized, high-quality care plans** so care can be delivered in the most effective and appropriate way; and
  - **Communicate quickly and securely** with providers across different sectors of the health system to manage issues as they arise

Health Links themselves defined the CCP

Journey to a Care Coordination Tool

Step 1

Coordinated Care Plan (CCP)

Objective:
Establish a coordinated care plan template that can be used by providers for patients within a Health Link

Products:
- A paper version of the coordinated care plan
- Business requirements needed to begin development of an electronic version

Draft CCP Completed

Step 2

Secure Access

Objective:
Work with Health Links to setup key providers within Health Links with access to a dynamic, online coordinated care plan

Products:
- Dynamic web-enabled care plan
- Secure messaging within a Health Link
- Visibility of a patient's Circle of Care
- Business requirements needed to begin development of an electronic version

Care Coordination Tool

Step 3

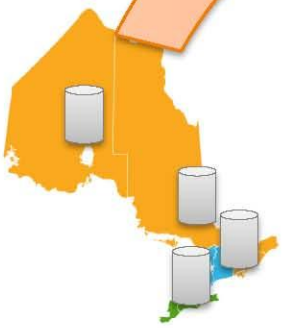
EMRs

Hospital Info. systems

Objective:
Integrate key ehealth solutions within Health Links into the CCT solution

Products :
- Bi-directional updates between CCT and local Point-of-Care systems (within HL)
- ED Notification and Discharge Summary
- Partial automatic update of Care Plan based off interface feeds

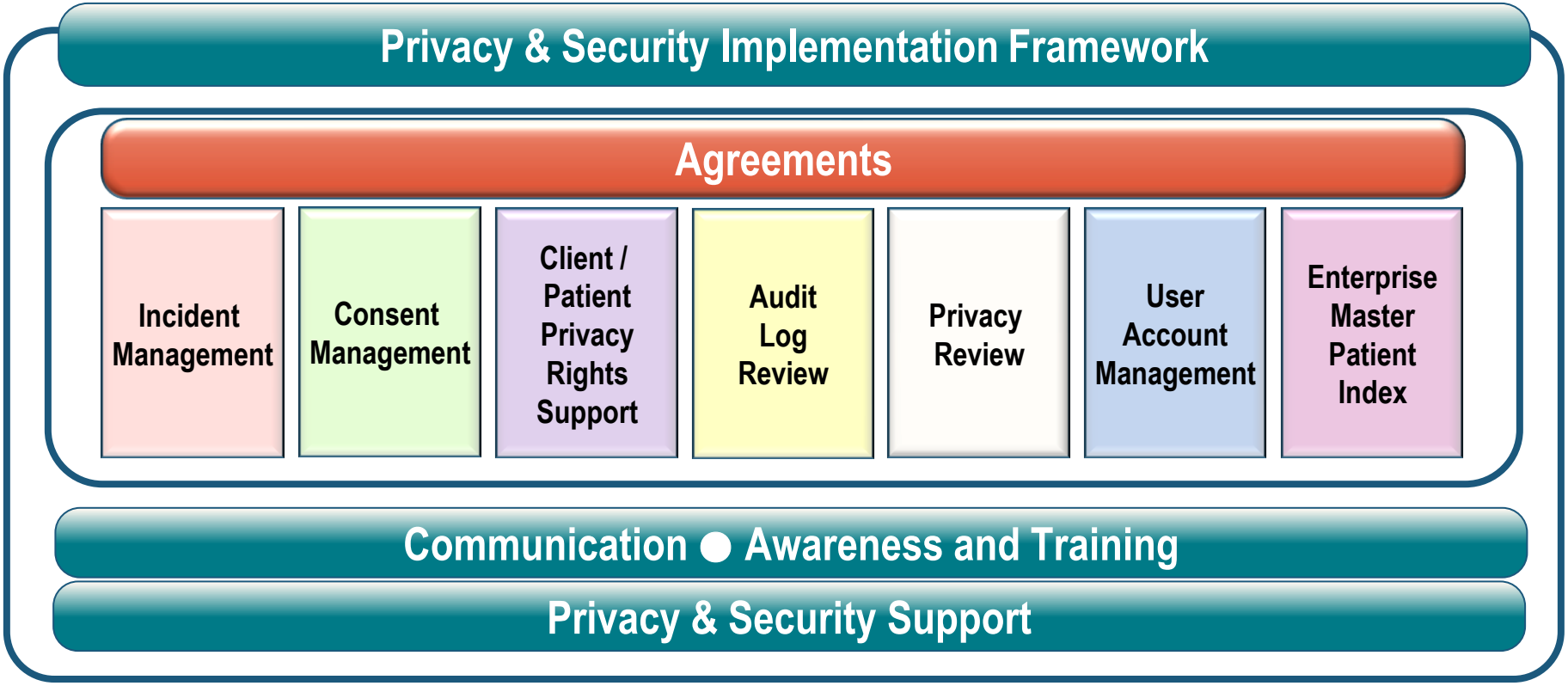
Step 4



Objective:
More robust integration with other provincial sources of data

Products (forecasted):
- Community assessments populating areas of the coordinated care plan
- EMR upload of visit summaries / cumulative patient profile
- Consumption of provincial cornerstone systems (Client/Provider Registry)

Common Privacy Framework Components



Patient / Provider Portal

Barrie and Community Family Health Team

Supported by

The Barrie Health Link

The Health Links Strategy Outlines Three Priorities

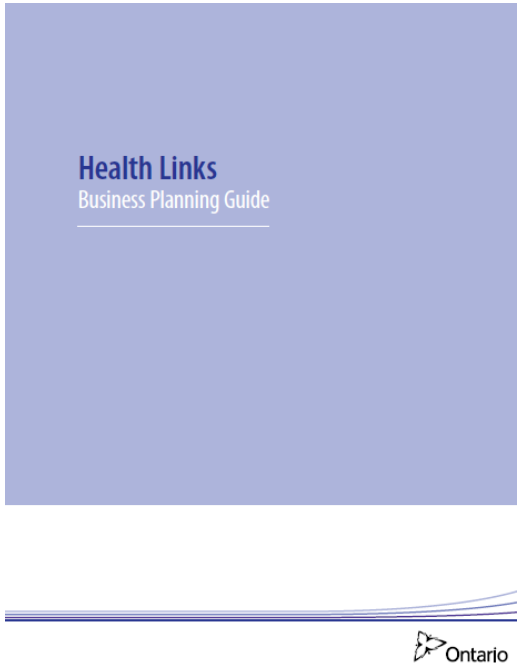
- **Data sharing**
  - Ensuring all levels of care have the same view of the patient: primary, ambulatory, acute and community

Care Coordination

- Secure communication among circle of care

Patient/Family Engagement

- Provide tools so patients can self manage their care



RFP Process / How We Arrived At Where We Are

Nov. 2012	BCFHT I.T Infrastructure Strategic Planning
Dec. 2012	BCFHT chosen lead organization for Health Link (HL) Barrie
Jan. 2013	BCHL Business Plan included an I.T Communication Project
Jan. 2013	HL Business Plan – Signed off by FHT Board
Feb. 2013	RFP developed using community partner input
Mar. 2013	MOHLTC places all HL I.T Project funding on hold
Apr. 2013	BCFHT received approval from MOHLTC and e-Health to explore Patient Provider Portal opportunities
Sept. 2013 – Jan. 2014	Initial engagement with Canada Health Infoway (CHI) processes

The Journey Continues

Feb. 2014	First Proposal draft to CHI
Feb. – Jun. 2014	(8) Revisions to Proposal and accompanying RFP for CHI
Jun . 2014	Presentation and approval to e-Health Business Review Committee
Aug. 2014	Final approval of Project from CHI
Aug. 2014	CHI Contract – Signed off by FHT Board
Aug. 2014	RFP opened to market / closed Aug. 31, 2014
Sept. 2014	Vendor evaluation began
Oct. 26, 2014	Preferred identified

Pilot Project Overview

FOCUS:
Enhancing and streamlining the communication between patients and their providers

INITIAL TARGET POPULATION:
High Users and patients participating in Chronic Disease Management and other FHT Programs

Secondary benefits include market evaluation of Consumer Health Solutions capabilities to support care coordination efforts such as Ontario Health Links

- Improved patient health outcomes
- Increasing patient engagement in care management and achieving care plan objectives
- **Reduce utilization of expensive health system resources**
- Improve office work flow with patients

Evaluation Process

STAGE 1	STAGE 2		STAGE 3A: General Categories					STAGE 3B: Experience and Qualifications			STAGE 3C	STAGE 4: Pricing Evaluation			TOTAL SCORE	
Mandatory Requirements	Mandatory Consumer Health Information		Support	Technical Deliverables	Project Timelines	Acheivement of BCFHT Outcomes	Alternate Innovative Strategies or Solutions	Bidder Experience	Bidder references	Bidder Corporate Profile	Product Demonstration and Technical Interviews	Individual Component Costs	Pricing Methodology and Assumptions	Pricing Clarification (as needed)		
		SCORE	10	30	15	15	5	17.5			20	37.5			150	

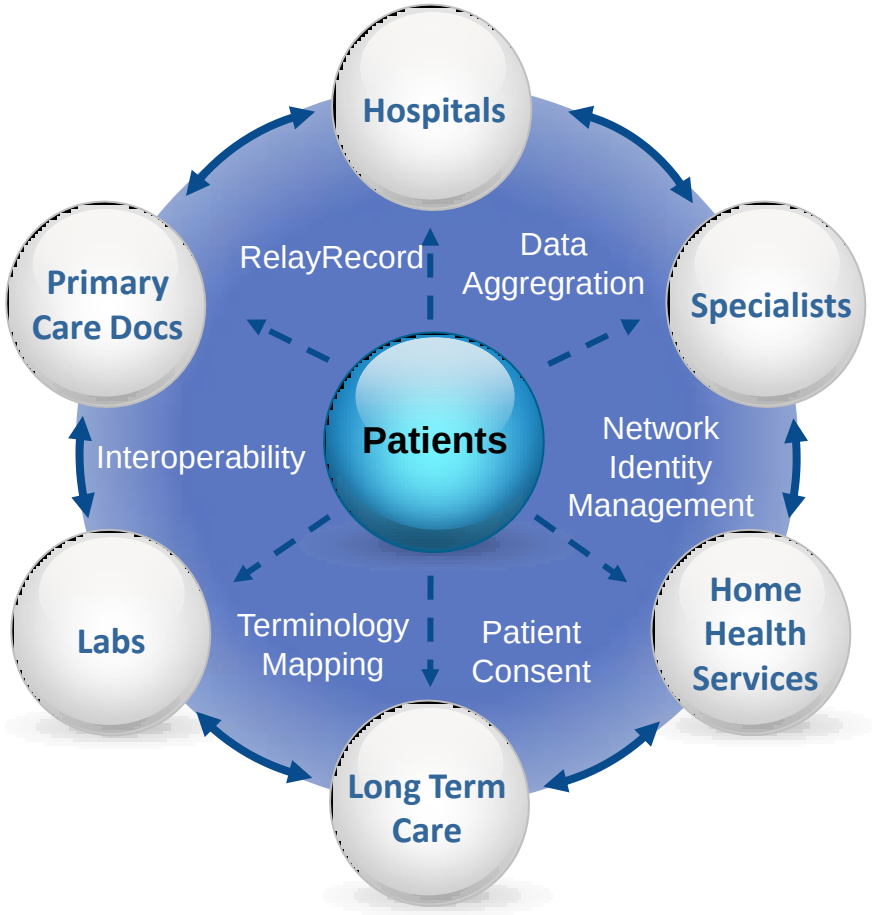
Why Did We Choose RelayHealth?

- **Rapid deployment**
  - SaaS model allows clinicians to use the solution immediately
- **Proven solution**
  - 14 years of refining the solution to match customer needs
- **Designed for care coordination**
  - Secure communications, patient access, longitudinal health summary
- **Safe partner**
  - Largest IT healthcare services company in the world
- **Leverages existing provincial investments**
  - RelayHealth is a widely deployed Health Information Exchange and is focused on interoperability

McKesson's RelayHealth Focuses on Connecting the Patient to the Care Team

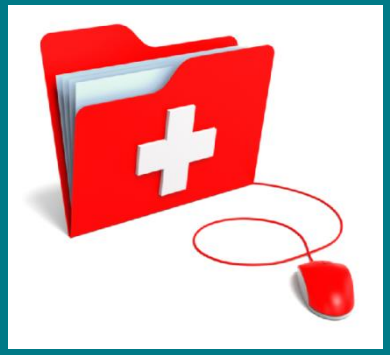
RelayHealth provides:

- Secure communications to all members of the care team (via application integration or through a web browser)
- A summary view of the patient record for the complete care team
- Patient access including secure messaging to the care team



What the Relay Health Portal Will Do:

Secure messaging between patients and their care team for **online consults (e-visits)** and **prescription renewals**



Enable **patient self-tracking of important health information** such as vitals in order to support management of care plans (e.g., diabetes management)

Provide patients **<u>Physician approved access</u>** to Personal Health Information

Benefits of Provider to Patient Communication

System Navigation

a) Reminders of appointments; Specialist, other team members etc.
b) Reminders of diagnostic testing
c) Reminders for periodic assessments in diabetes

Care Pathway Reminders

a) Diabetic protocols
b) Influenza vaccination for COPD, CHF etc.

Diagnostic Reports

a) Normal results – reassurance
b) Abnormal results with instructions for next steps
c) Results requiring adjustments in care plans, including:
- INR and anticoagulant adjustments
- HbA1c and diabetes medication adjustments
- Electrolyte changes and diuretic therapy in CHF

Community Wide Communication

a) Outbreaks of Influenza
b) Medication recalls
c) New Service Opportunities

Benefits of Patient to Provider Communication

System Navigation

a) Cancellation of appointments
b) Requests for assistance in system navigation
- Test prep
- Location, timing of appointments for diagnostics, other care team providers
- Other service needs e.g. Meals on Wheels

Requests for Assistance in Care Plan Mgmt

a) Medication renewal
b) Symptom Mgmt
c) Verification of indication to start action plan in COPD

Reporting on Self Mgmt Aspect of Care Plan

Weights for CHF
- Blood glucose levels for diabetes
- Side effects on new medication starts
- Vitals – BP, pulse

Thank You!

Questions?