QUEBEC'S EXPERIENCE AND CHATHAM-KENT HEALTH LINK HIGH USER MANAGEMENT:

BETTER RESULTS FOR THE POPULATION

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OBJECTIVES

1. RESULTS
2. HOW WE STARTED
3. OPERATIONALIZED IN ONTARIO
    i. CHATHAM-KENT MODEL
4. OUR RESULTS

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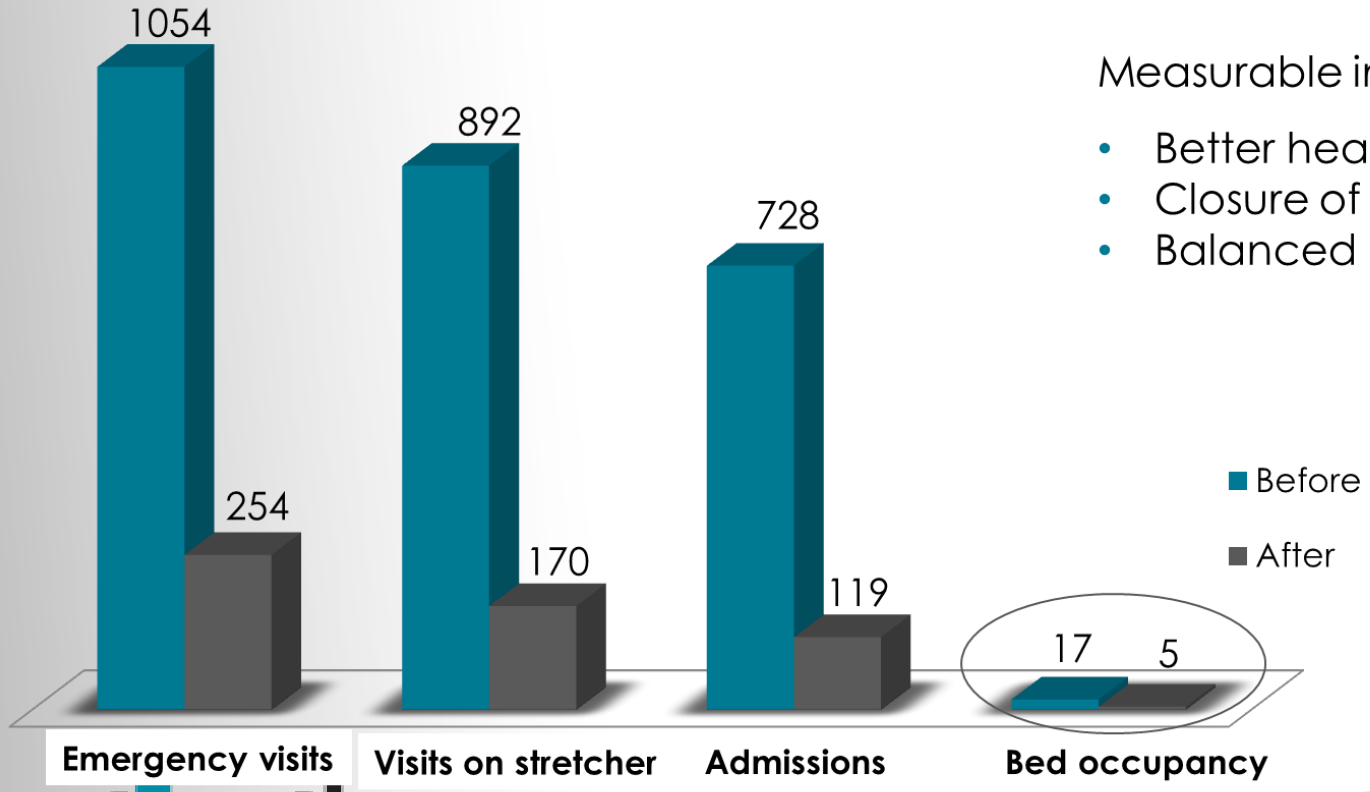
QUEBEC'S EXPERIENCE : RESULTS FOR THE 200 MOST FREQUENT USERS OF A LOCAL HEALTHCARE NETWORK



Measurable impacts :

- Better health status (SF-36)
- Closure of 10 % of acute care beds
- Balanced budget

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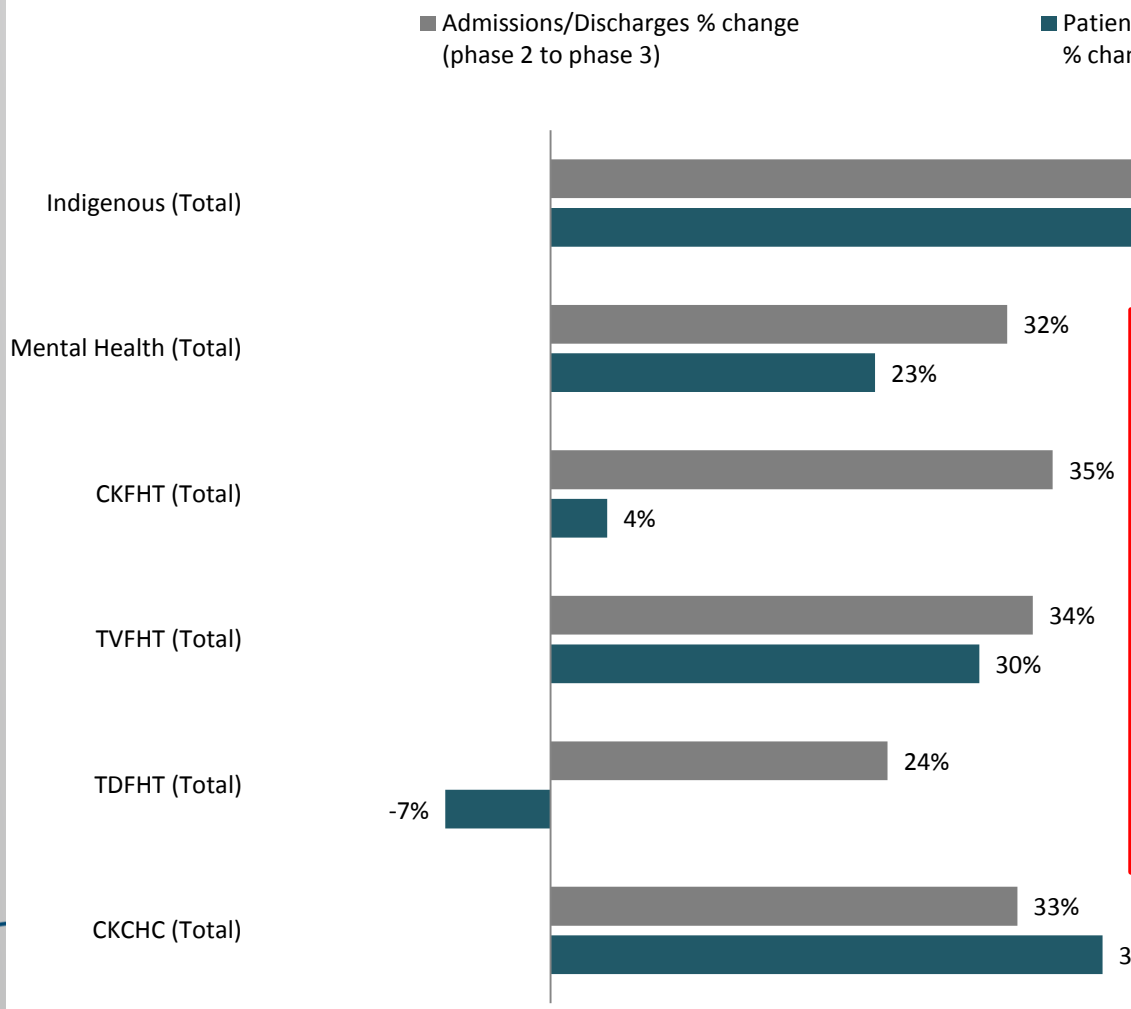
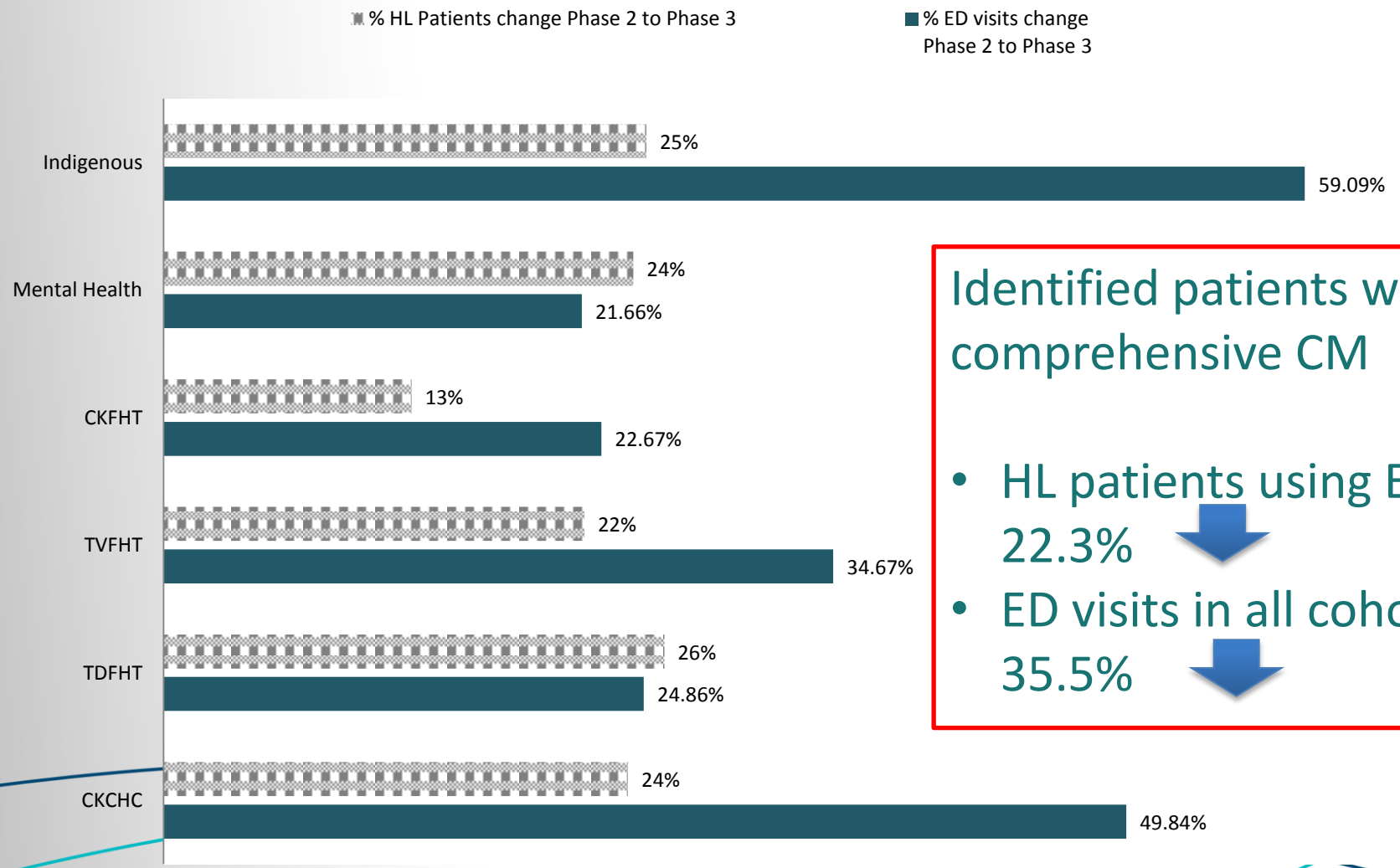
Chatham Kent Integrated Health System
High User Management
Percent Reduction of Admissions/Discharges & Patient Days
Phase 2 (April 15 - Sept 15) & Phase 3 (October 15 - March 16)



Identified patients with comprehensive CM:

- admissions in all cohorts : ↓ 36.4%
- bed days for majority of cohorts : ↓ 28%

Chatham Kent Integrated System
Percent reduction in Emergency Dept Visits
Phase 2 (Apr 15 - Sept 15) Phase 3 (Oct 15 - March 16)



Identified patients with comprehensive CM

- HL patients using ED: 22.3%
- ED visits in all cohorts : 35.5%

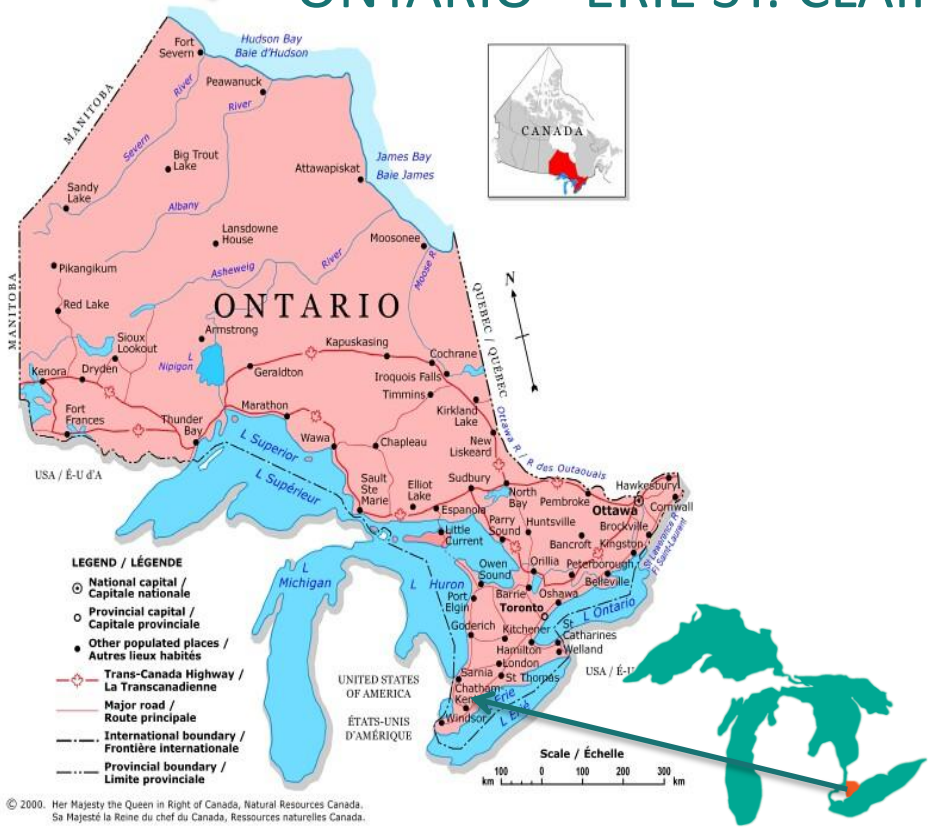
"DÉFI SANTÉ" IN ACTION

France Laframboise, M.Sc. RN, Director of Nursing and Quality of care

Jean Mireault, MD, MSc, Chief Medical Officer, mentor to France Laframboise

- Stratify frequent users
- Encounter, evaluate and care collaboratively
- Introduce new role of complex case manager
- Community care working directly with the family physician and non traditional community partners
- Support teams
- Measure results *continuously*

SOUTHWESTERN ONTARIO - ERIE ST. CLAIR



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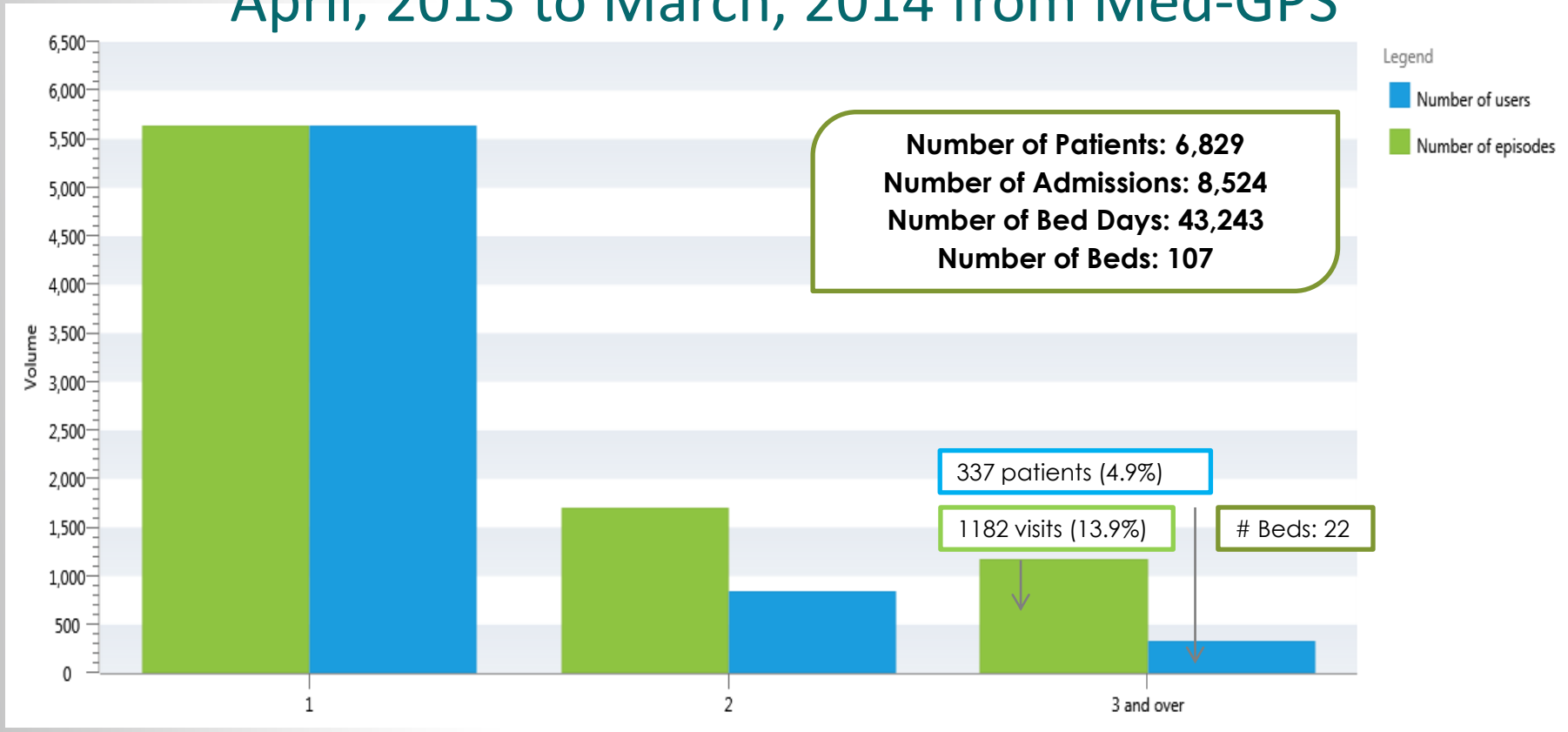
Chatham-Kent Health Alliance
Hospital Portrait
Number of Admissions by Frequency from April, 2013 to March, 2014 from Med-GPS



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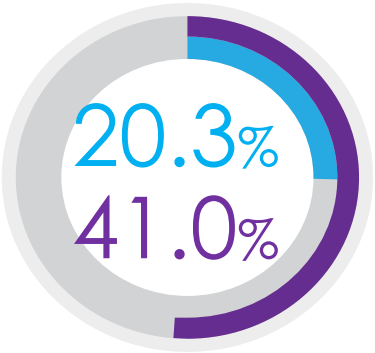
CKHA
ED VISITS & ADMISSIONS

For one year **For three years**

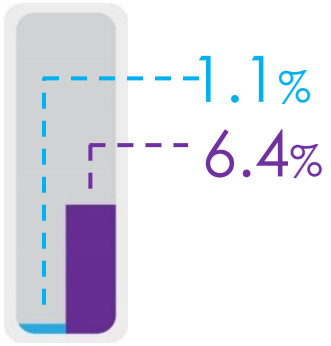
High users

1 729
6 655

People with 5 visits or more



% of total visits

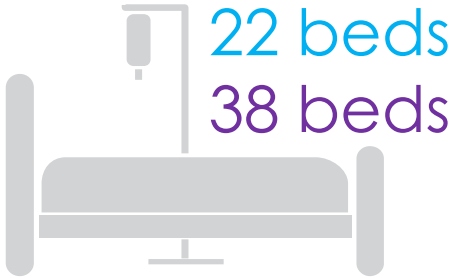


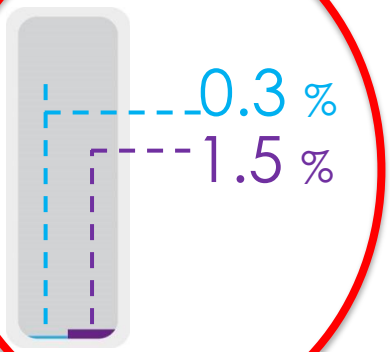
% of the population

High users

337
1 548

People with 3 admissions or more





% of the population

Annual budget: estimated at **$51.6M** including **$28.9M** of nursing costs for a total cost of **$8.7M** for 3 admissions or more

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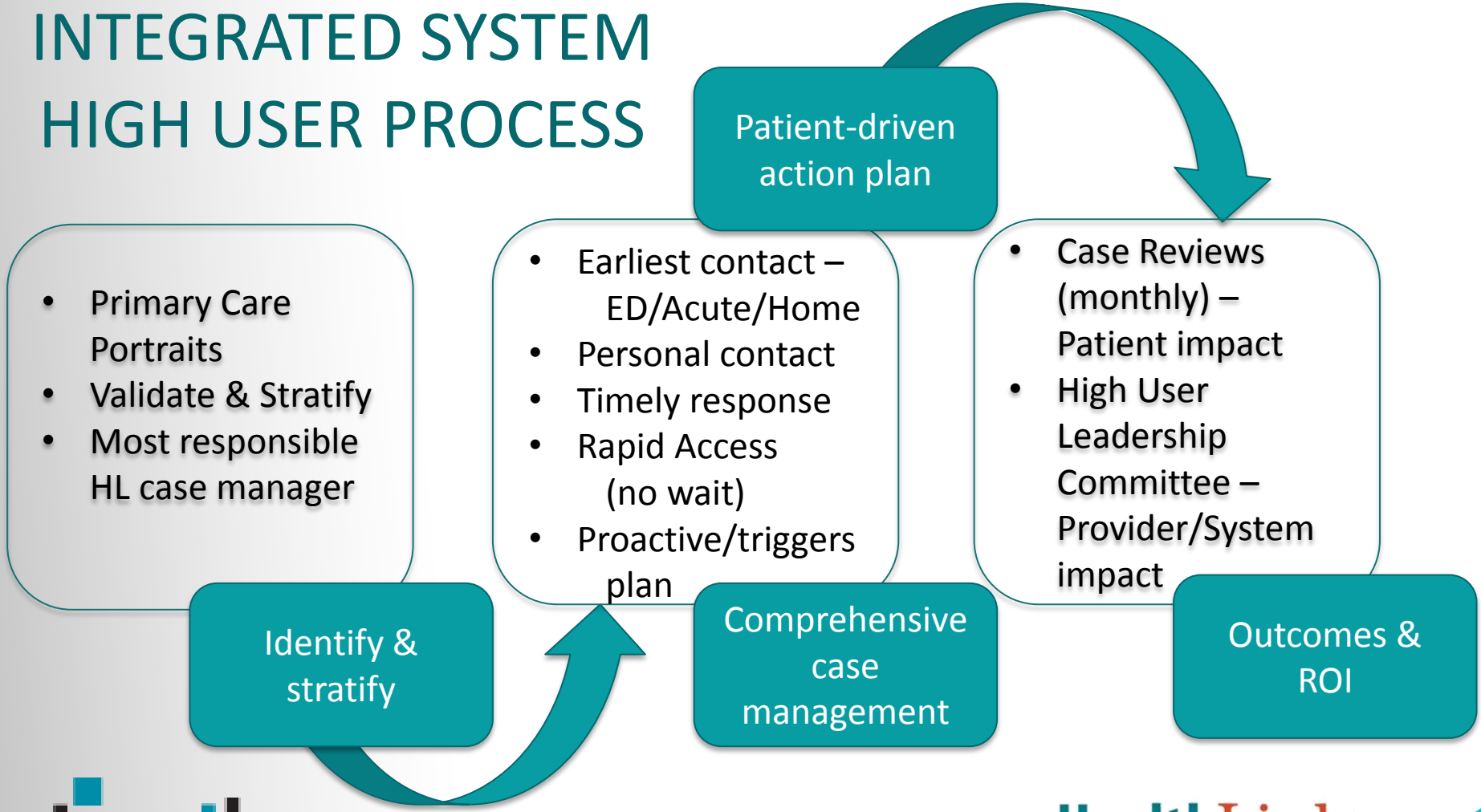
CHATHAM-KENT INTEGRATED SYSTEM HIGH USER PROCESS



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IDENTIFY MEET JANICE……

CKHL Case Manager

Synopsis

- 8 ED visits & 5 Admissions – 12 months (2 admissions & 4 ED visits/ 4 weeks)
- 19 bed days (all critical care admits)
- Rostered to a PCP
- Community services:
  - COPD; CHF
  - Home oxygen – tubing issue; managing own O_2
  - Family issues
  - Smoker
  - Access to PCP

COMPREHENSIVE CASE MANAGEMENT

- STRATIFY FREQUENT USERS
- PERSONAL CONTACT – RAPIDLY; INTENSELY
- PATIENT DRIVEN – ASK THE PATIENT WHY? WHAT DO YOU NEED?
- STABILIZATION – FIND THE TRIGGER POINT
- SIMPLIFY: COMPLEXITY OF ONTARIO SYSTEM
- COORDINATE & COMMUNCATE: INTERPROFESSIONAL INTERAGENCY PATIENT CARE TEAM

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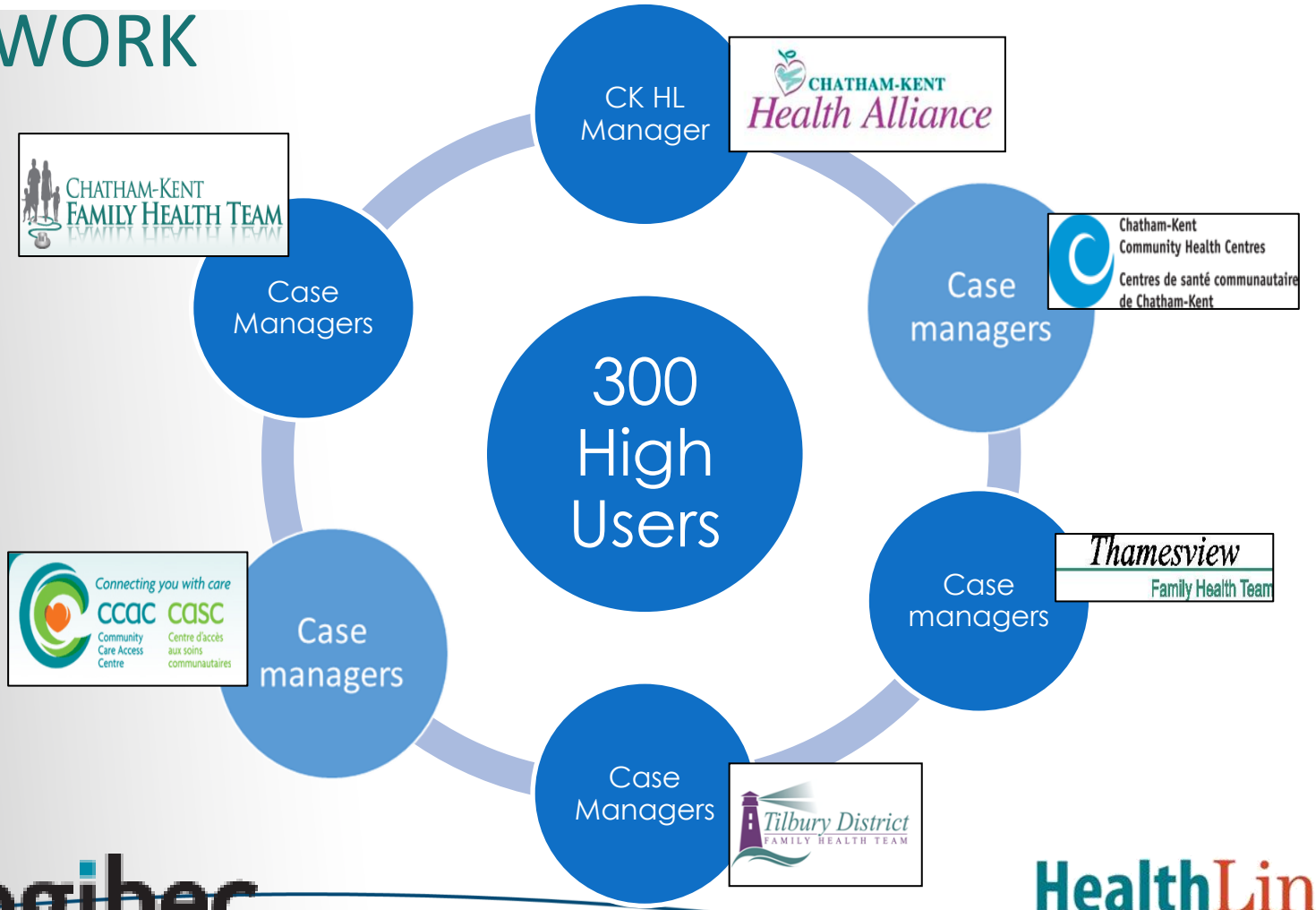
COMMUNITY OF PRACTICE COMPREHENSIVE CASE MANAGERS NETWORK



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SHIFTING FROM PROVIDER & DISEASE-DRIVEN……

TO PATIENT-DRIVEN CARE!

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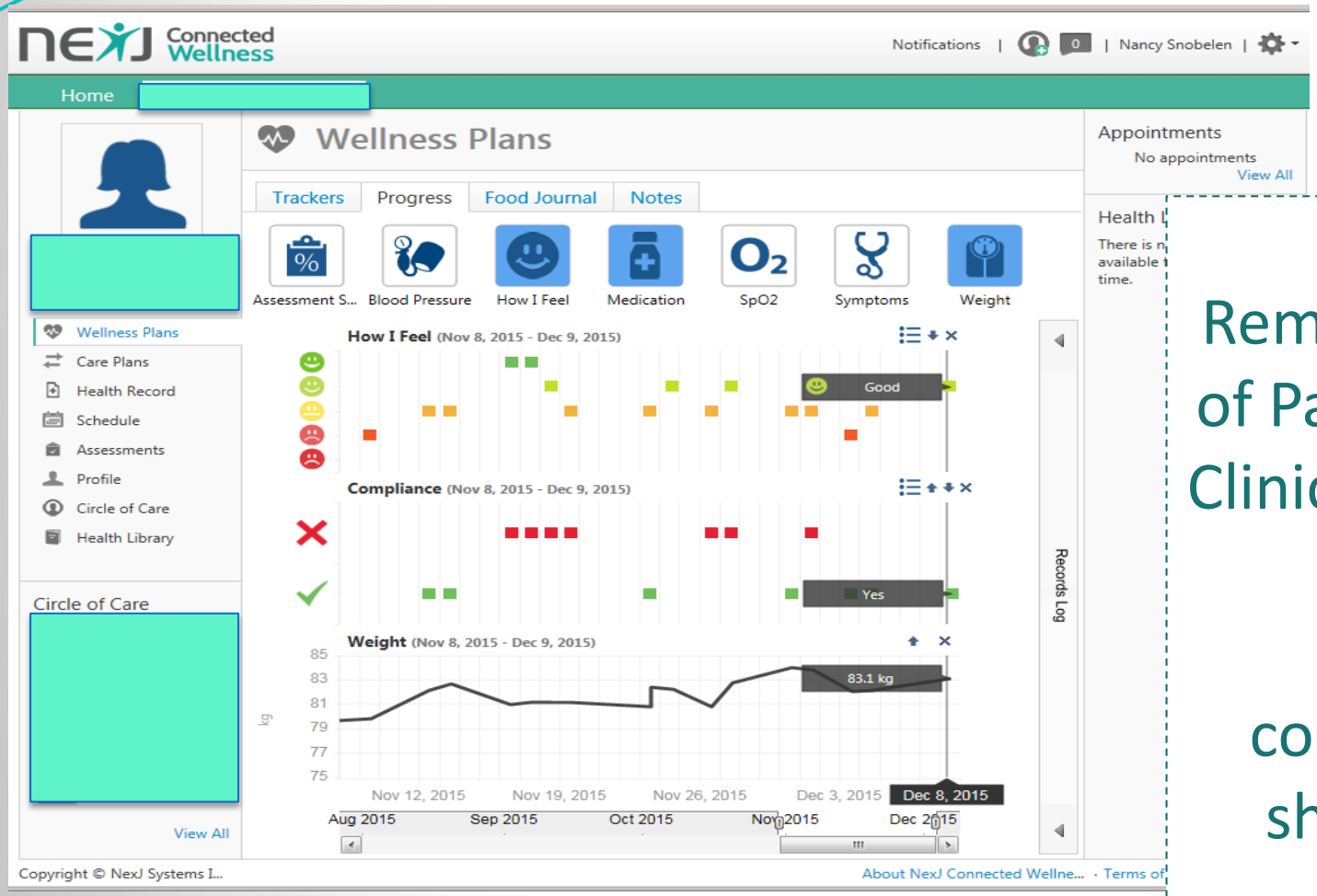
NexJ Connected Wellness™



Remote tracking of Patient-driven Clinical indicators

Team collaborative share space

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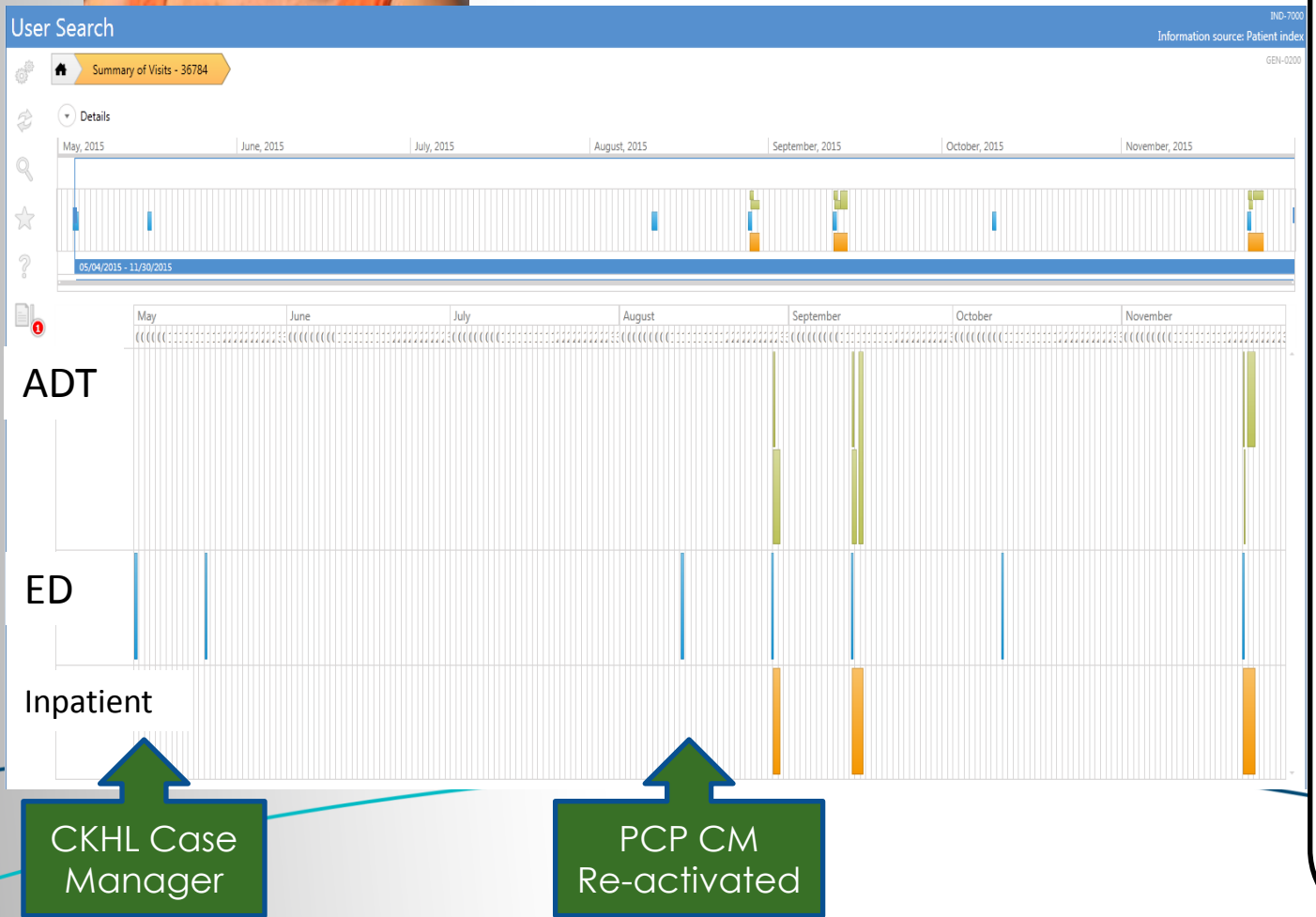
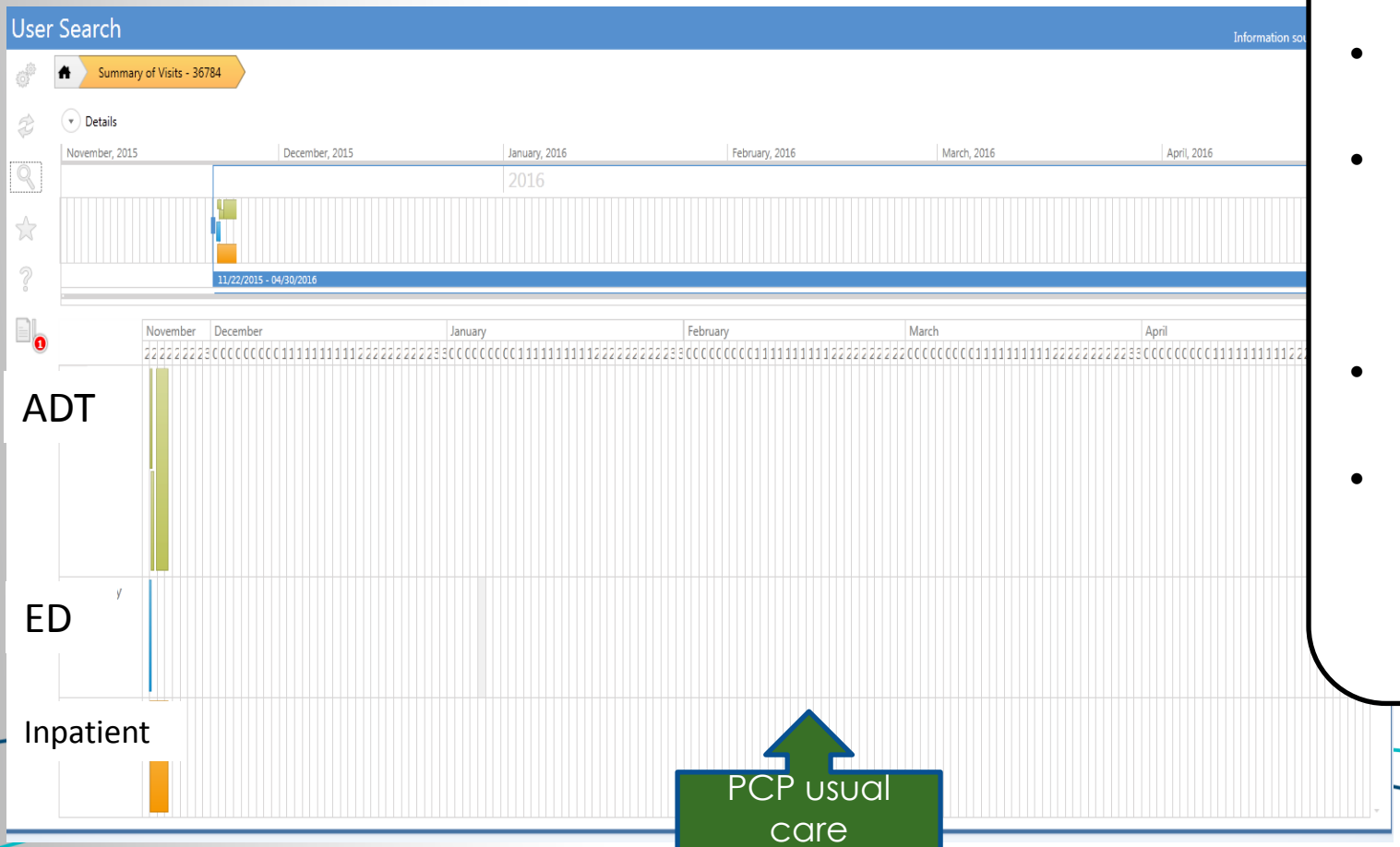
MEASURE JANICE……
6 MONTHS LATER



Synopsis

- 7 ED visits & 3 Admissions – 6 months (12 weeks w/out visit or adm
- 7 bed days (1 critical care admit)
- Rapid access to PCP
- Oxygen tubing
- Patient-driven action plan (Nexj)
- Community Paramedic Program
- Changed to usual care

JANICE…… NOW



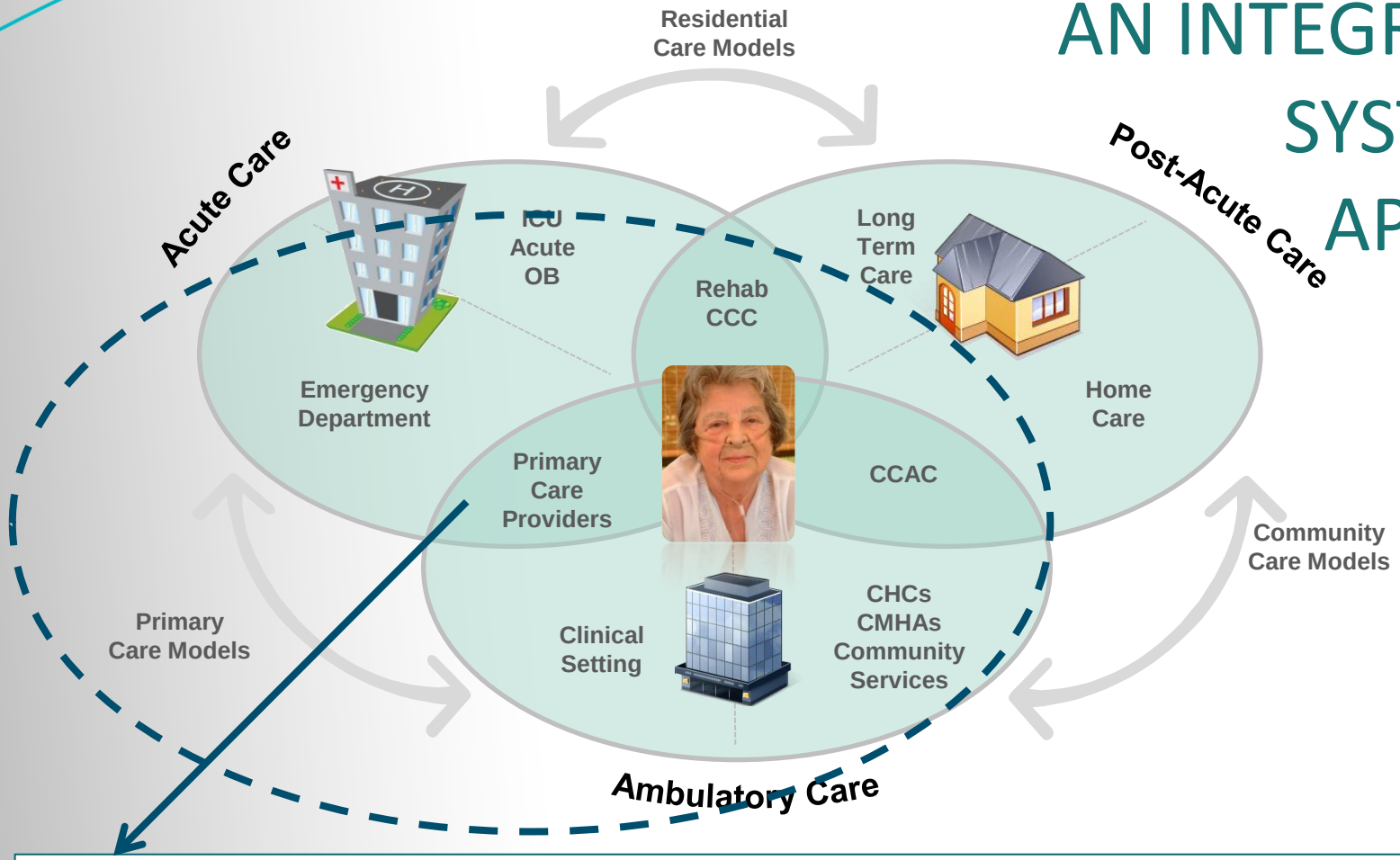
PCP usual care Re-activated

Synopsis

- 0 ED visits & 0 Admissions in 6 months
- 0 bed days
- Considered stable on this action plan
- Changed to usual care
- Continued monitoring by CK HL Manager

MEASURING RESULTS

CREATING AN INTEGRATED SYSTEM APPROACH



Primary Care as "most responsible provider" or "conductor of care"

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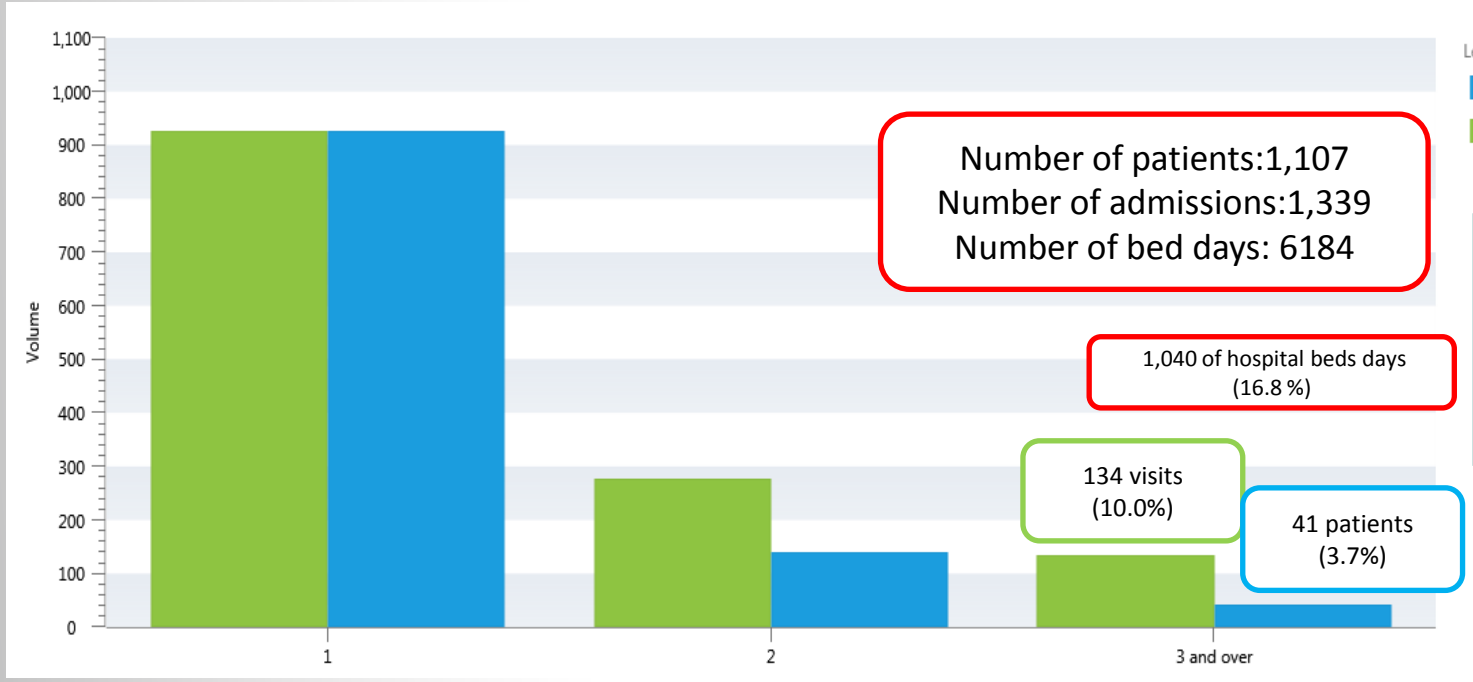
THAMESVIEW FAMILY HEALTH TEAM ADMISSIONS PORTRAIT FROM MAY 2015 - APRIL 2016



Data in the hands of the clinicians in real-time for immediate action

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Thamesview Family Health Team

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BY PRIMARY CARE PRACTICE COHORTS (APRIL 2016)

Care Cohort (FTE)	TOTAL (Active + Inactive monitored patients)	ACTIVE (hospital use w/in past 3 months) **	INACTIVE (no hospital use w/in past 3 months)	DEATHS	NUMBER OF ADMISSIONS W/IN PAST MONTH WITH ED VISITS ASSOCIATED	NUMBER OF BED DAYS	NUMBER OF ED VISITS W/IN PAST MONTH	CTAS 1, 2,3	CTAS 4, 5	CTAS NOT AVAILABLE
CKCHC (0.5)	94	40	54	1	11 (N = 10) *10 ED	77	19 (N= 15)	12	4	3
TVFHT (1.0)	98	40	58	0	6 (N = 6) *3 ED	63	20 (N = 14)	9	9	2
CKFHT (2.0)	136	68	68	1	14 (N=13) *12 ED	55	29 (N= 22)	21	3	5
TDFHT (0.5)	71	29	42	2	7 (N = 7) *9 ED	45	19 (N= 13)	14	4	1
INDIGENOUS (n/a)	23	14	9	0	0 (N= 0) * 0 ED	0	8 (N= 6)	3	2	3
MH (n/a)	42	23	19	0	2 (N = 2) *1 ED	21	15 (N= 9)	13	2	0
	464	214	250	4	40 (N= 38) *35 ED	261	110 (N = 79)	72	24	14

*n/a = not available

** includes all known deaths within month

464 patients identified; 250 with no hospital use >3 mo.
214 under active comprehensive case management; 4 deaths
38 patients (18%)admitted; 40 admissions per month
261 bed days
38% of active patients had ED visit

LESSONS LEARNED

Key Success Factors	
Address “life project” or whole person goals (including all social determinants of health)	√
Identify, stratify, monitor and track patients using real-time data	√
Right Primary Care Practitioners	√
Advance Care Planning for quality end of life	√
Patient drives action plan and circle of care	√
Data in hands of clinicians	√
Create a culture of urgency & rapid response with processes to assist	√
Set ROI targets and accountability processes for QI	√
Chronic Disease Management Model - prevent high users by using data for earlier detection and proactive planning	√

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EVIDENCE AND SCALE

LESSONS LEARNED

Key Challenge Factors

- Innovation is iterative
- Think & act beyond reactive status quo care
- Adaptive Leadership
- Knowledge translation, knowledge integration
- Capacity
- Clinicians and technology

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EVIDENCE AND SCALE

NEXT STEPS

- EVALUATION – relevant to primary care; system level
- SCALABLE approach across Erie-St. Clair Local Health Integration Network
- PROJECT MANAGEMENT OFFICE – funded through Office of Chief Health Innovation Strategist (OCHIS)
  - Regional Project Management
  - Clinical Expertise Model
  - Shareable IT infrastructure

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THANK YOU!

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