IMPROVING VALUE IN TRANSITIONS OF CARE

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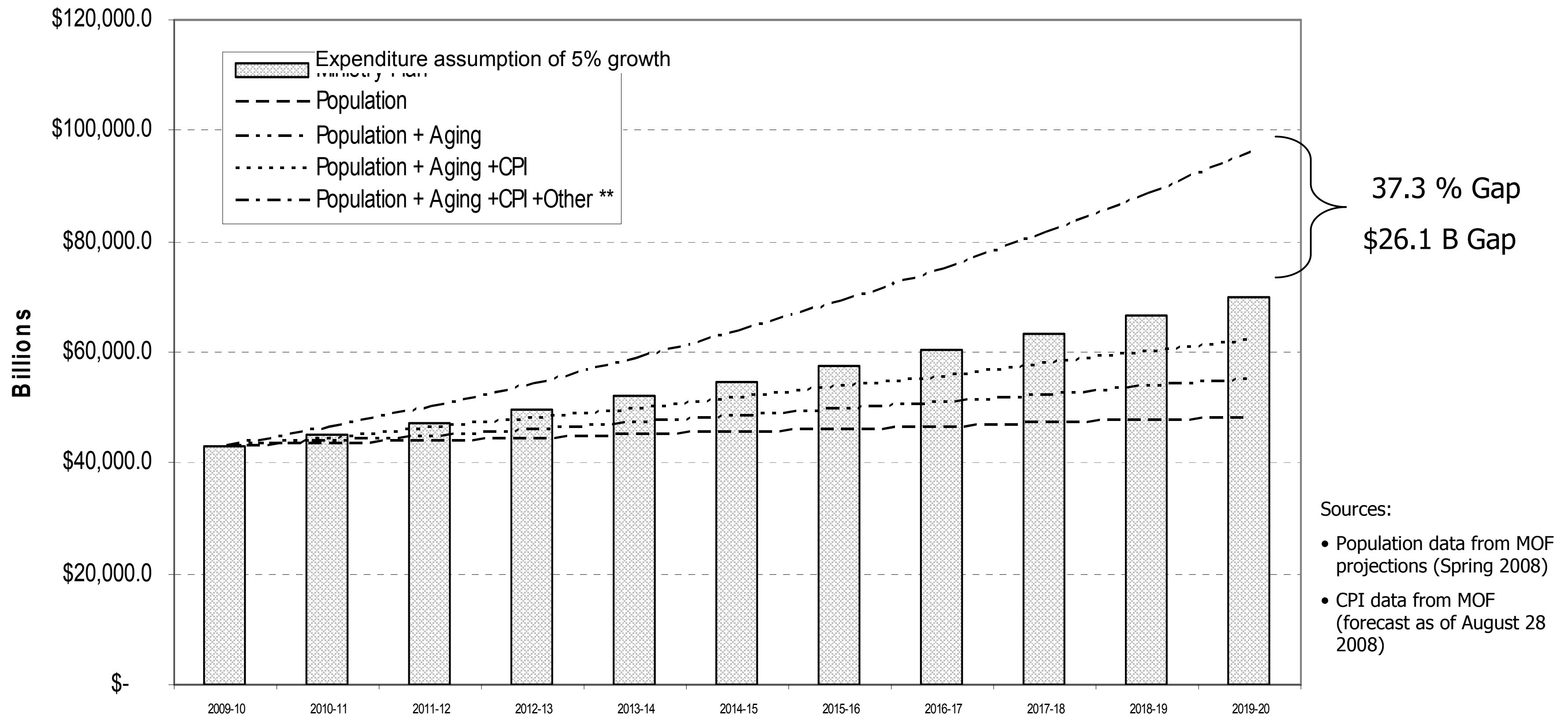
Purpose

- To position improving *transitions of care* as an important component of the Value Strategy
- To examine some key areas for research and policy development
- To examine how areas for improvement in *Transitions in Care* support other aspects of the value strategy
- To receive feedback on opportunities to strengthen partnerships and accelerate change

It begins with sustainability - the gap between the demand for services and available funding will widen



* Estimated growth for Ministry's operating expenditures based on 5.0% annual growth

** "Other" includes utilization of services, new medical/drug/IT technologies, policy/program interventions, etc.

Note: The starting base includes operating, capital, and consolidations

To achieve Ontario’s priorities of healthier Ontarians and sustainable health care delivery, Ontario’s health system needs to focus on increasing value.*

VALUE =

Improved client health outcomes
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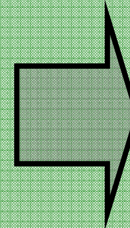
Total cost of care for the client’s condition



END GOAL:

Healthier Ontarians and Communities
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Sustainable health care expenditures

The overall goal of public health systems must be increased value, not containing costs or improving access

- Focus on value will result in healthier Ontarians and improved population health outcomes
- Value needs to be measured and tracked at client and population levels
- High-quality, appropriate care drives up value, as care should be less costly overall - use quality improvement to improve value and make best use of available resources
- The interventions used to help achieve the desired outcomes are evidence-informed

*Adapted and extended from Redefining Health Care by Michael E. Porter and Elizabeth O. Teisberg, Harvard Business School Press, 2006.

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For a more client centred, outcome focussed transition of care need to change up how we deal with key elements

- Care Management and Roles
- Client/Patient Centred Focus
- Supports to the Participants
- Effective Information Transfer
- Accountability
- Quality Improvment

Care Management and Roles

- Patient, Caregiver, Practitioners/Care Team Members
  - What are you doing?
  - Who is the right person to do it?
  - What should you be doing?
  - How does the relevant information exchange occur?

Client/Patient Centred - Voice and Choice

- System, products and services organized around and for the benefit of the client with an emphasis on client-focused delivery
- Resources and tools that will enable them to participate in the formulation of their transition care plan
- Structures, incentives and systems to facilitate client engagement, informed choice, and client-directed or self-managed care
- Appropriate balance between informed client choice and client flow

Supports

- Adequate technological and information supports
- Adequate organizational/agency capacity
- Service and support literacy
- Client/Caregiver engagement competencies
- Strong systems for peer support, informal caregivers and volunteers
- Self-management tools

Effective Information Transfer

- Identify information needed to provide high quality care
- Timely and effective information transfer between parties
- User friendly information transfer processes

Alignment to other Prioritie

- Client Centred Care
- Integrated Community Care
- ALC and Virtual Ward
- Caring for Caregivers
- Patient Safety

Where could we start?

Through Specific Interventions Targeting

	72 Hour Readmits	30 Day Readmits	Ambulatory Care Sensitive Conditions
	Readmits that could be avoided through enhanced hospital discharge / safety practices	Readmits that could be avoided through enhanced system planning / transitions in care	Hospitalizations that could be prevented through more effective disease management and patient self-management
Setting (s) for Intervention	Hospitals	Hospitals Community Sector Long-Term Care Homes Sector Primary Care	Primary Care Public Health
Areas to investigate before determining intervention	•High volume conditions •Benchmarks / evidence from other jurisdictions	•High volume conditions •Population cohorts •Variability between hospitals / LHINs •Benchmarks / evidence from other jurisdictions	•High volume conditions •Population cohorts •Benchmarks / evidence from other jurisdictions
Linked Strategies	•Most Responsible Physician Collaborative Funding component of Physician Services Agreement	•ER/ALC •Aging at Home •Other LHIN-led Interventions	•Chronic Disease Prevention and Management •Diabetes Strategy •Other Primary-led Interventions

Questions