HSPN Health System Performance Network

Advancing the Learning Health System in Ontario

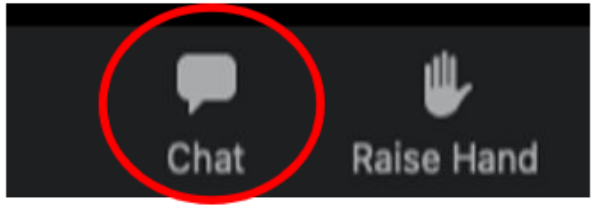
Part 2: Analytics and population insights

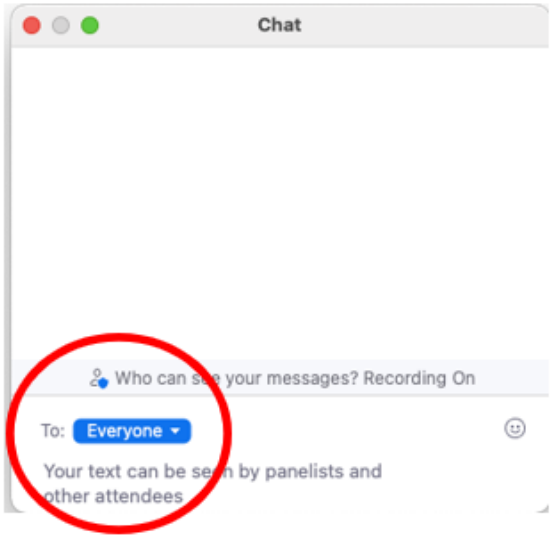
HSPN Monthly Webinar

May 28, 2024

Welcome & thank you for joining us!

Please let us know who you are by introducing yourself (name & OHT or other org)





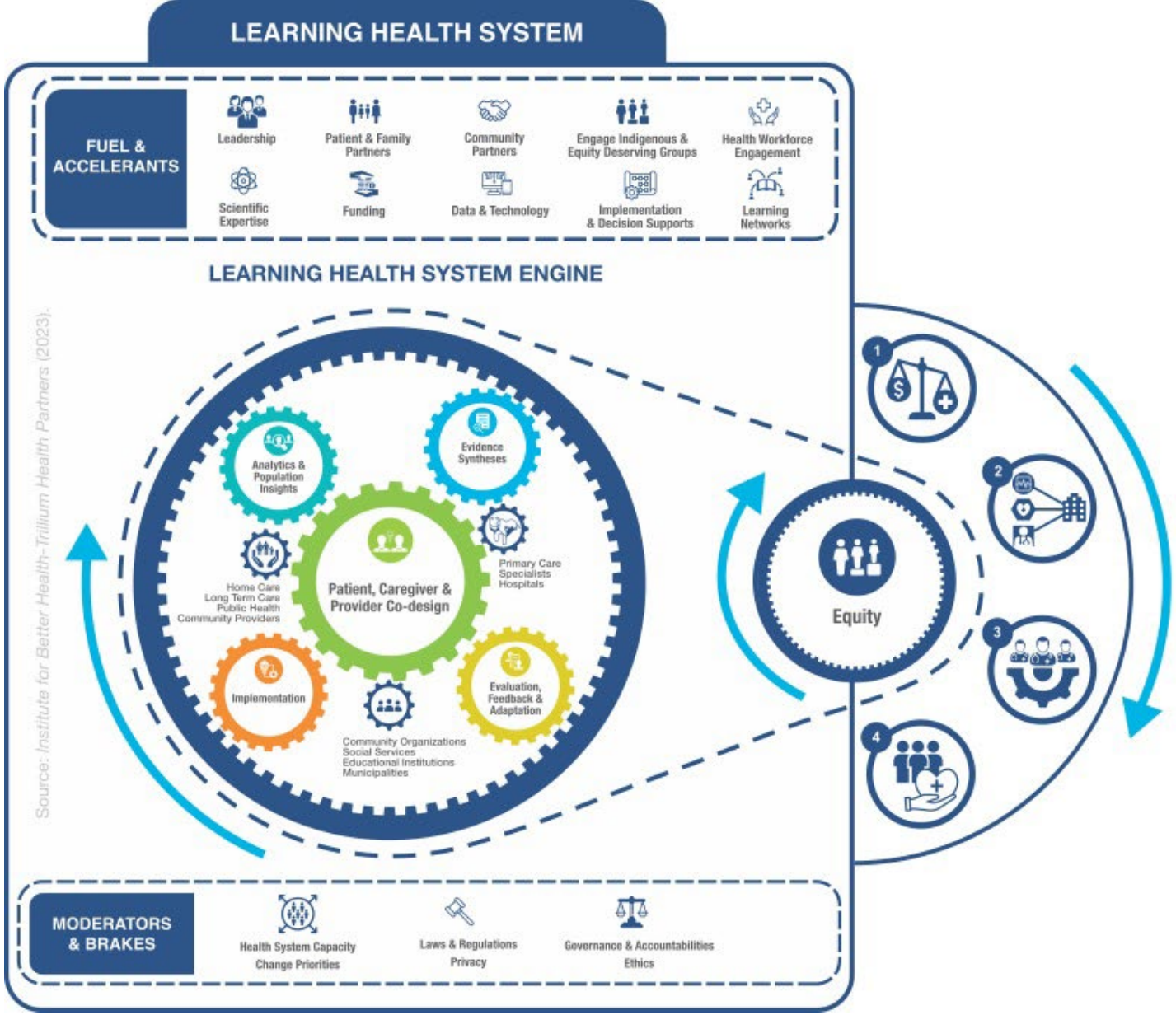
➢Open Chat

➢Set response to everyone in the chat box

Land Acknowledgement

We wish to acknowledge this land on which the University of Toronto operates. For thousands of years it has been the traditional land of the Huron-Wendat, the Seneca, and the Mississaugas of the Credit. Today, this meeting place is still the home to many Indigenous people from across Turtle Island and we are grateful to have the opportunity to work on this land.

LEARNING HEALTH SYSTEM ACTION FRAMEWORK



1. Health System Affordability
2. Integrated Care Experiences
3. Health Workforce Sustainability
4. Population Health & Quality Care

SOURCE*: Institute for Better Health-Trillium Health Partners* (2023).

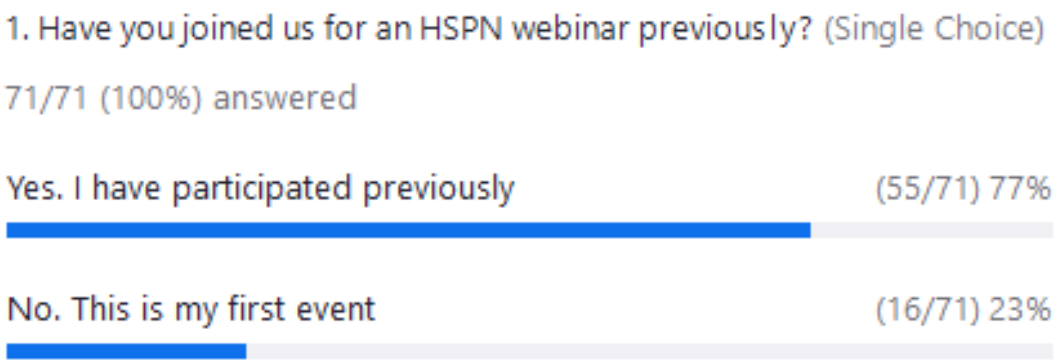
Learning Gear 1: Analytics & Population Insights

Description: Using comprehensive data (quantitative & qualitative) and advanced analytic approaches on populations served to understand health service needs, gaps, inequities, preferences & aspirations.

Sample Questions: Where are system gaps & what's driving them? Where are the inequities? What priorities are we addressing (or what problems are we solving)? What are patient, caregiver, community preferences & aspirations?

Health System Affinities: business intelligence functions, data decision & analytics supports, program planning groups, clinical informatics, patient and family advisory councils, etc.

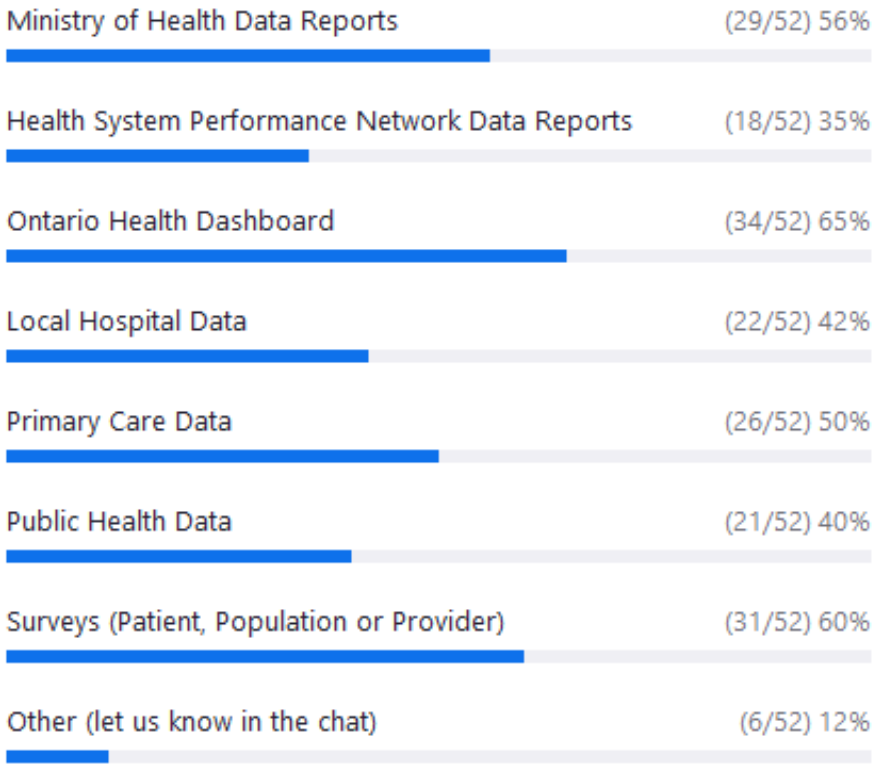
Poll 1


1. Have you joined us for an HSPN webinar previously? (Single Choice)
71/71 (100%) answered
Yes. I have participated previously
(55/71) 77%
No. This is my first event
(16/71) 23%

Poll 2

1. What sources of data have you used to understand your OHT population? (check all that apply) (Multiple Choice)

52/52 (100%) answered



HSPN Health System Performance Network

Today's event
LHS Analytics and Insights

Host

Dr. Walter Wodchis
Principal Investigator
HSPN

Presenters

Dr. Matthew Meyer
Senior Director of Population Health Management
London Health Sciences and London-Middlesex OHT

Emmi Perkins
Director of Transformation
Guelph-Wellington OHT

Dr. Sara Shearkhani
Scientist
Michael Garron Hospital and East Toronto Health Partners

Sarah-Grace Bebenek
Project Manager
South Georgian Bay OHT

AGENDA

Intro to using analytics from the HSPN

and more in-depth OHT examples:

1. Understanding our population needs : Middlesex London
2. Understanding our neighbourhoods: East Toronto
3. Using patient experience data: South Georgian Bay
4. Going deep with linked data: Guelph-Wellington

HSPN Health System Performance Network

Understanding our population needs : Middlesex London

Presenter: Matt Meyer

May 28, 2024

MIDDLESEX LONDON
Ontario Health Team

Advanced analytics and Population Insights

Experiences of a growing OHT

May 28th, 2024

Outline

- Brief introduction to the MLOHT and our philosophy
- Illustration of how we've used population data
- Key insights
- How we've supplemented the numbers with other information

What is our Middlesex London Ontario Health Team's (OHT) Shared Purpose?

PATIENTS/CLIENTS/CARE PARTNERS & PROVIDERS

Improving our healthcare experience together -

IMPROVEMENT, ACTION-ORIENTED

COLLABORATION, CO-DESIGN, CO-CREATION

where people are heard, care is connected, and

PATIENTS/CLIENTS/CARE PARTNERS & PROVIDERS

WE ASK AND WE LISTEN, BECAUSE WE CARE

SEAMLESS, DIGITAL HEALTH ENABLERS, CARE MANAGEMENT

whole health is possible for everyone.

PHYSICAL, SPIRITUAL, MENTAL, EMOTIONAL, ENVIRONMENTAL, SOCIAL, CULTURAL, ECONOMIC

EQUITY, INCLUSION, DIVERSITY

What We Know

Slides shared with the MLOHT (then Western OHT) Coordinating Council in 2019

Our attributed population (MoH data unless otherwise stated)

- 514,024 people
  - 92,045 (17.9%) >65yrs
  - 199,332 (38.7%) >50
  - 23,011 Frail Adults >65 (Canadian Frailty Network projection)
- 148,784 (28.9%) live outside of London
- 9,252 (1.8%) Francophone (SW LHIN)
  - Arabic most common language besides English
- 87,384 (17%) visible minority (SW LHIN)
- 88,412 (17.2%) living in poverty (SW LHIN)

What We Know

Our Indigenous Population (SOAHAC)

- 17,108-22,155 Indigenous adults in London (2x census)
  - ~ 26% >45 yrs
- 51% in London reported 1+ chronic condition
- 28% Indigenous adults (20 years +) in London were experiencing multimorbidity (2+ chronic health conditions)
- 15% diagnosed with diabetes by their provider
- 7% COPD
- 6% Heart Disease
- 17% High Blood Pressure
- 16% Arthritis

- 90% live in poverty (below LICO)

What We Know

MoH OHT Data:
Health Conditions present:

- COPD – 6,389
- Heart Failure – 4,836
- Chronic Disease – requires further assessment

Acute care (total population)

- 29,083 patients admitted
- Acute days 221,672
- ALC days 23,624

Inpatient Rehabilitation

- 1,019 patients
- Rehab days 33,589

Complex Continuing Care

- 495 patients
- 33,823 days

Long-Term Care

- 3,284 residents
- 757 people on wait list

What We Know

OHT Top 10 HPG Ranked by Total Cost

Top #	Top HPG	HPG Population	HPG Total Cost	OHT Cost/User
		A	B	C=B/A
1	Q007	3,883	$147.9M	$38,100
2	S001	2,596	$132.3M	$50,974
3	E004C	1,685	$50.7M	$30,061
4	R002	1,302	$43.9M	$33,705
5	Q009	1,538	$38.7M	$25,142
6	J003C	1,281	$34.3M	$26,747
7	I002C	747	$33.2M	$44,469
8	P002A	1,155	$32.2M	$27,918
9	Q002	722	$32.2M	$44,534
10	J032A	15,732	$31.5M	$2,001

Legend for Top 10 HPGs' Description	
1	Dementia (incl. Alzheimer's) w sig comorbidities
2	Palliative State (Acute)
3	Heart failure with CAD/Arrhythmia w sig comorbidities
4	Metastatic Cancer w sig comorbidities
5	Delusional Disorder (incl. Schizophrenia) w sig comorbidities
6	Diabetes/hypoglycemia with PVD/Oth Chronic Vasc Dx w sig comorbidities
7	Skin Ulcer (incl. Decubitus) w sig comorbidities
8	Sepsis w sig comorbidities
9	Mental Disorder Resulting from Brain Injury or Other Illness w sig comorbidities
10	Diab/hypoglyc w/o Chronic Kidney Dis or PVD/Chronic Vasc Dx w/o sig comorbidities

- 8/10 include sig comorbidities
- Total spend on these 8 = $413.1M

What We Know

LHSC Decision Support data from IDS (16/17-18/19)

- Residents of Middlesex County >40 yrs admitted to hospital with 1 of 5 Chronic Conditions (CHF, COPD, Diabetes, Cancer, Ischemic Heart Disease)
- Average annual values
  - Patients admitted to hospital 7,934
    - 98% LHSC, SJHC, MHA
  - Admissions/patient 1.4
  - Conservable bed days (19,067)
  - ALC bed days (10,640)

Key lessons – by the numbers

- 514, 024 – Our population consists of people, yet we don't know who they are
- ~~6,389~~ COPD, ~~4,836~~ CHF– Population-based prevalence estimates suggest closer to 30,000 and 10,000
- Approx. 65,000 – the estimated number of people in our population who don't have Primary Care

Outline

- Brief introduction to the MLOHT and our philosophy
- Illustration of how we've used population data
- Key lessons learned
- How we've supplemented the numbers with other information

Population Selection Process

OHT signing partners were emailed about this process on August 1st

August 1-7th Partners asked to communicate with staff, patients, and partners about potential populations

August 8-14th Dr. Matthew Meyer and Dr. Shannon Sibbald met with interested partners

August 15th The Population Health Coalition met to select up to 3 populations for further exploration.

August 16-28th The Population Health Coalition to work with partners to better describe the proposed populations

August 29th Final proposals brought to the Coordinating Council for decision.

Results

- 7 population suggestions were received
  - 1 – Parents and infants up to 12 weeks postnatal (4th trimester), especially high-risk and marginalized
  - 6 – Older Adults with Chronic Disease requiring system-level care coordination/navigation

Population Health Coalition

- Community researchers, system experts and patient/caregiver representatives with no formal affiliation to any of the partner organizations. They represent the following groups:
  - Schulich School of Medicine and Dentistry (Departments of Family Medicine, Epidemiology and Biostatistics, Public Health)
  - Western's Indigenous Health Laboratory
  - IVEY's International Centre for Health Innovation
  - The Centre for Research on Health Equity and Social Inclusion
  - Patient and Caregiver advocacy groups
- Met August 15th
- Recommendation: Consider **Older Adults with Chronic Conditions requiring system-level care coordination/navigation**

Population Recommendation

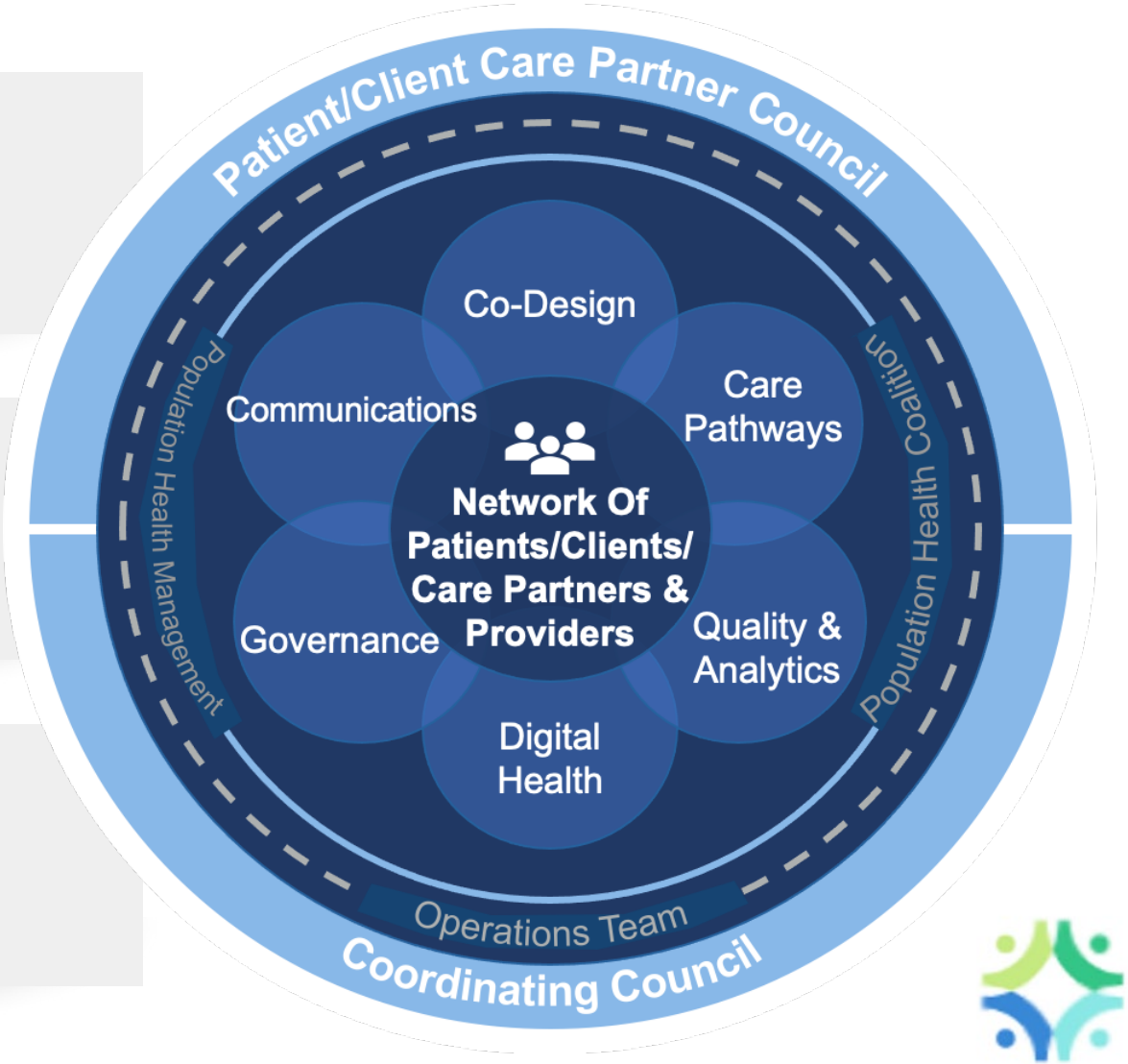
1. Who will you be accountable for at Maturity?
   - Our attributed population (514,024 people)

2. Who will you focus on in Year 1?
   - **Older adults with Chronic Conditions in need of system-level** ***care coordination and navigation***
   - *Sub-populations:*
     - ***High-risk patients with COPD and/or CHF***
     - ***Older adults at risk of institutionalization***

3. Are there specific equity considerations within your population?
   - Francophone, Indigenous, Visible minorities, Non-ESL families, New comers to Canada, Rural residents, People living in poverty or homeless

INVOLVING PATIENTS, CLIENTS & CARE PARTNERS

- Development of a Patient/Client Care Partner Council
- Meaningful engagement of patients/clients and care partners in all aspects of work
- Development of a ‘Network’ of patients/clients, care parents and providers



PATIENT, CLIENT, CARE PARTNER MATRIX

PATIENT & CARE PARTNER GROUPS

- Urban and rural
- Immigrants and newcomers
- Various age categories
- Various genders
- Various sexual orientations
- Various racial or ethnic groups
- Various languages
- Various income level
- People with disabilities
- People who act as care partners
- People without access to personal transportation
- People without access to care partners
- People with various states of disease severity

PROVIDER GROUPS

- Primary Care
- Community Care
- Addiction and Mental Health
- Home Care
- Acute Care
- Rehabilitation
- Long-Term Care
- Palliative care
- Emergency Medical Services
- Social Services
- Emergency Department
- Pharmacy

EMERGING THEMES: CHALLENGES

Through our interviews with patients, care partners, and providers, we identified system challenges that our Ontario Health Team and partners can build solutions for, including:

Access to and Awareness of Services	Patients and care partners are not regularly being referred to available community supports and programs. Providers have difficulty keeping track of all available services and programs in our community.
Care and Action Planning	Care plans (*documents that include important health and social information about the patient, including goals and next steps in care*) are not always provided to patients. Providers found that accessing key information about patients can be time-consuming and challenging.
Care Partner Support	Care partner (family/friend caregiver) needs are not always considered in care planning and management for the patient. Care partners want more education and information.
Case Management and Coordination	Care coordination and navigation is essential for many patients, but is not always available.
Communication Between Providers	Providers don't always have access to the information they need to support patients and care partners, and sometimes information is difficult to find. Providers find it challenging to connect with other colleagues in the system to discuss a patients' care.
Early Diagnosis Process	Patients are regularly diagnosed only after a significant health event. Providers need tools to identify patients earlier who may have Chronic Obstructive Pulmonary Disease and/or Congestive Heart Failure
Promoting Self-Management	Patients value programs and education that can help them manage their own care, but some patients do not find out about these programs early enough.
Patient-Centred Care	Providers need to understand individual patient circumstances, preferences, and home environment in order to plan their care effectively.
Goals of Care	Patient goals of care need to be regularly assessed, incorporated into care plans, and communicated across care teams.
Sustained Care Relationship	Patients, care partners and providers talked about the importance of establishing strong care relationships as patients move through the system.

Our Decision Tool

- At the MLOHT we have adopted a decision tool for project/initiative selection that includes request for description/context and alignment with:
  - Quintuple Aim
  - Purpose
  - Co-design themes
  - Prioritized populations
  - Scalability
  - UN sustainability goals
  - Collaboration

Takeaways

- You can learn a lot from the numbers
- You can also learn a lot from the absence of numbers
- Context matters

MIDDLESEX LONDON
Ontario Health Team

Thank you!

For more information, please contact Matthew.Meyer@LHSC.on.ca

HSPN Health System Performance Network

Analytics from the HSPN

A review of HSPN data and analytics for OHTs

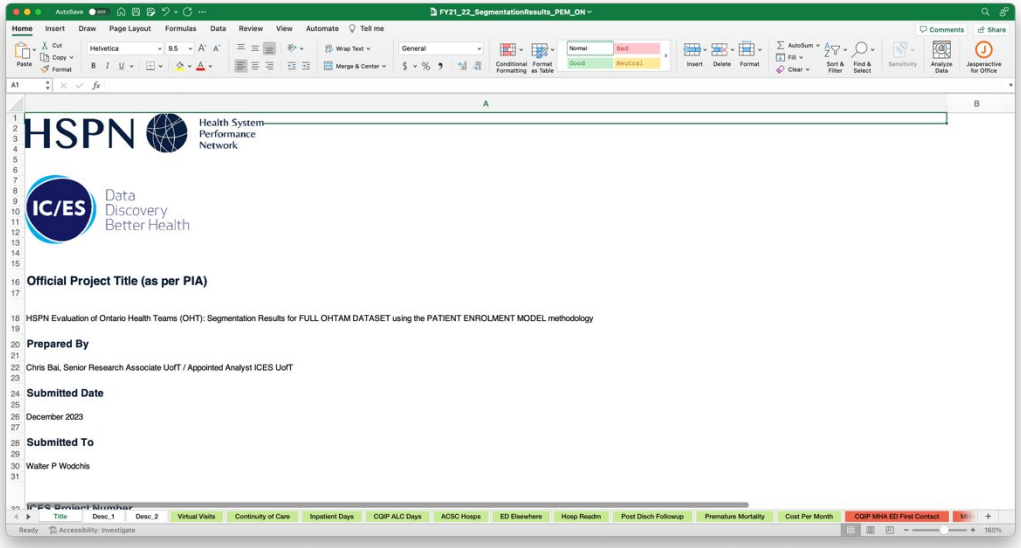
1 Powerpoint Presentation & 3 Excel Spreadsheets

HSPN Health System Performance Network

HSPN OHT Improvement Indicators & Population Segmentation

"Your OHT" Results

January 2024



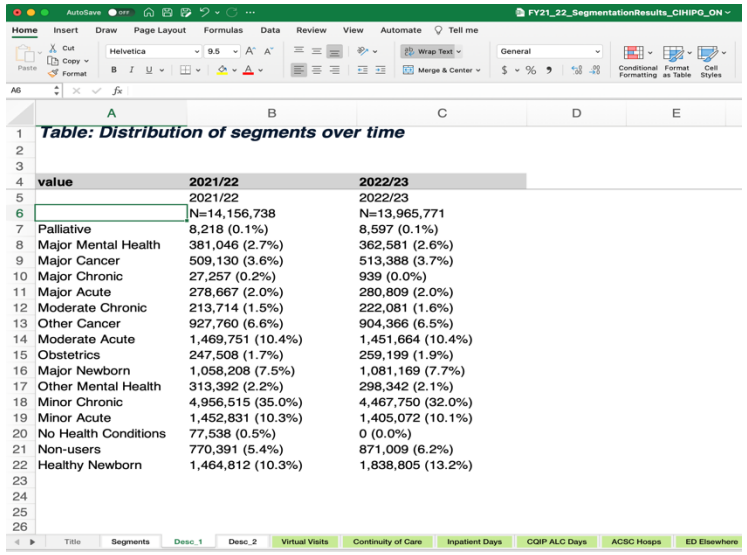
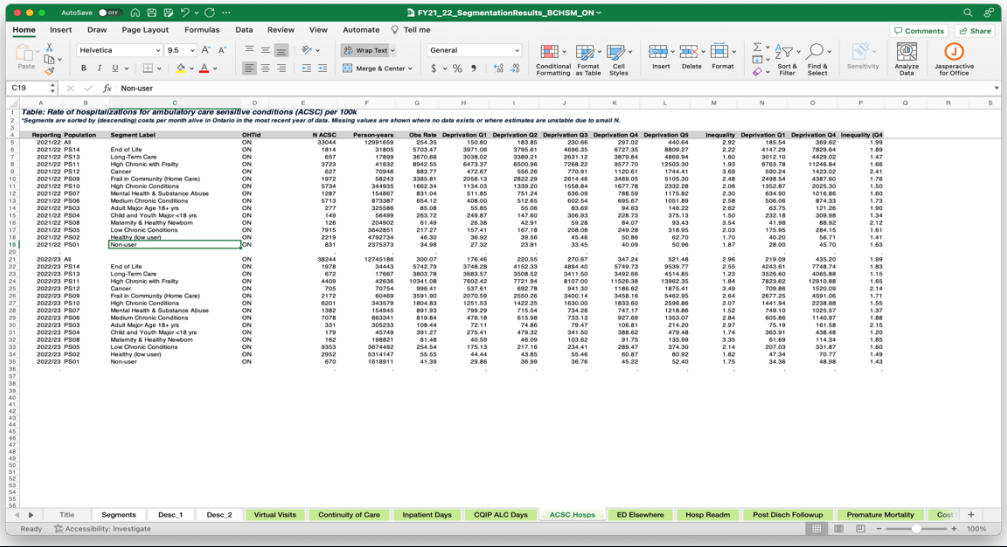
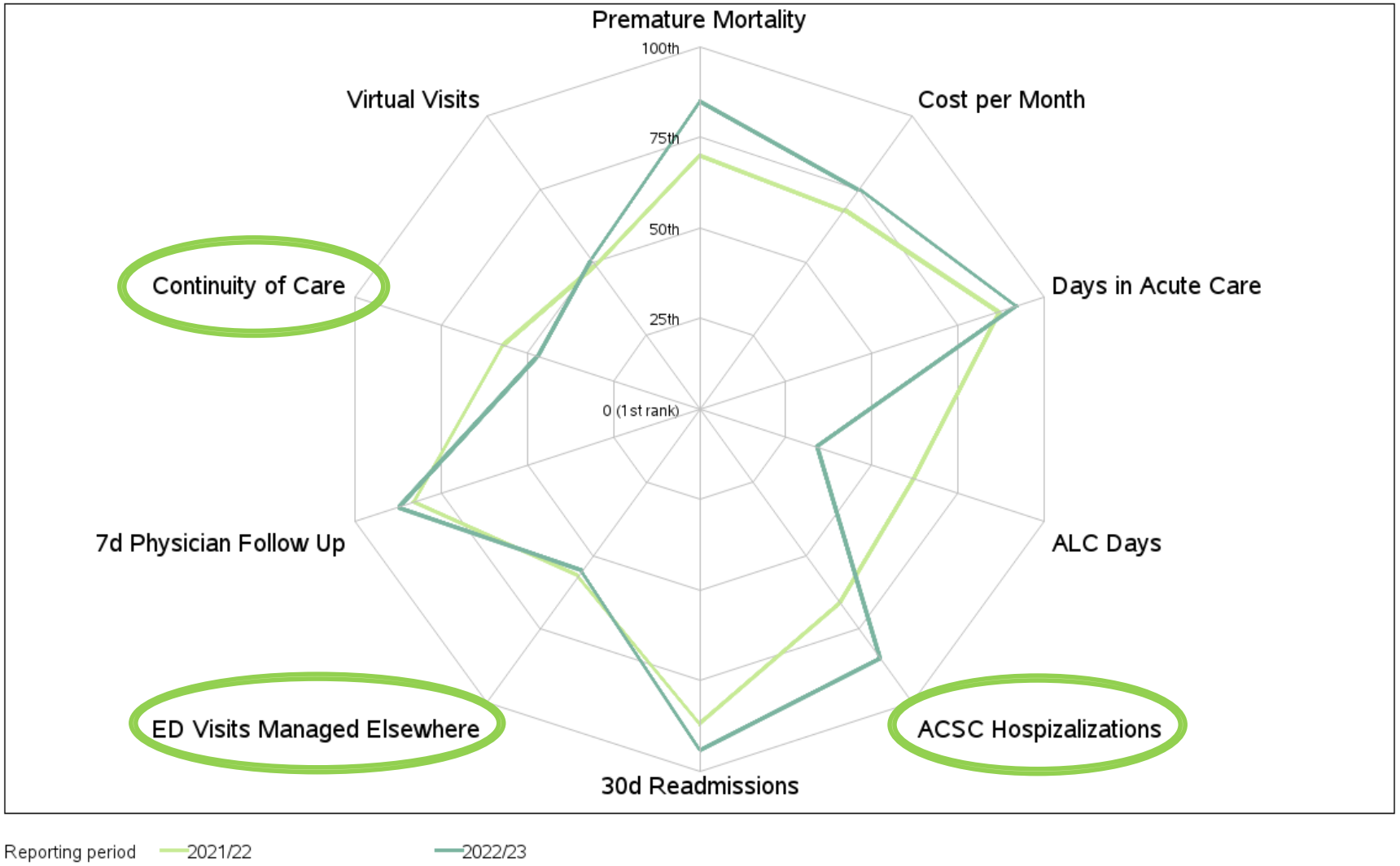


Table: Distribution of segments over time

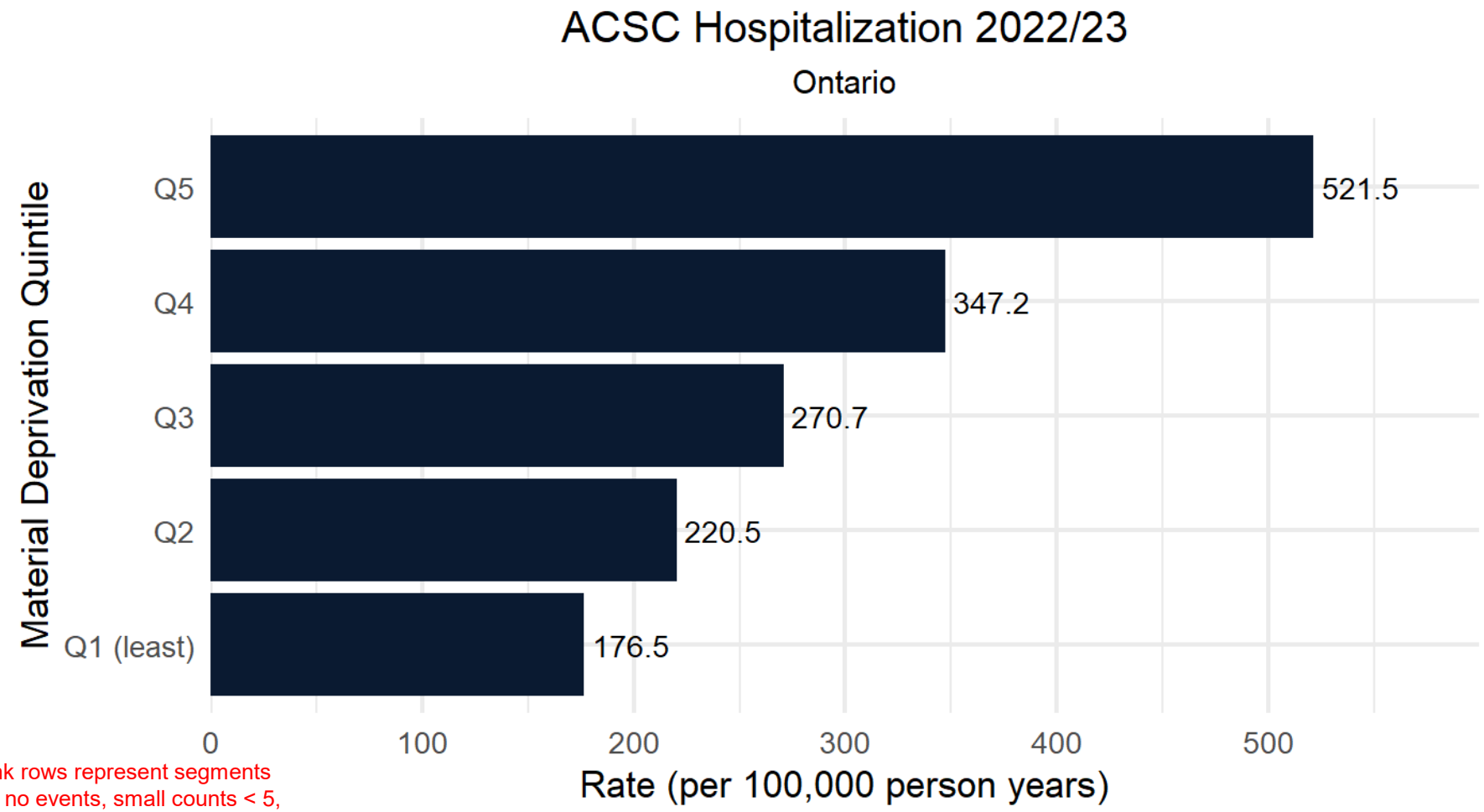
value	2021/22	2022/23
	2021/22	2022/23
	N=14,156,738	N=13,965,771
Palliative	8,218 (0.1%)	8,597 (0.1%)
Major Mental Health	381,046 (2.7%)	362,581 (2.6%)
Major Cancer	509,130 (3.6%)	513,388 (3.7%)
Major Chronic	27,257 (0.2%)	939 (0.0%)
Major Acute	278,667 (2.0%)	280,809 (2.0%)
Moderate Chronic	213,714 (1.5%)	222,081 (1.6%)
Other Cancer	927,760 (6.6%)	904,366 (6.5%)
Moderate Acute	1,469,751 (10.4%)	1,451,664 (10.4%)
Obstetrics	247,508 (1.7%)	259,199 (1.9%)
Major Newborn	1,058,208 (7.5%)	1,081,169 (7.7%)
Other Mental Health	313,392 (2.2%)	298,342 (2.1%)
Minor Chronic	4,956,515 (35.0%)	4,467,750 (32.0%)
Minor Acute	1,452,831 (10.3%)	1,405,072 (10.1%)
No Health Conditions	77,538 (0.5%)	0 (0.0%)
Non-users	770,391 (5.4%)	871,009 (6.2%)
Healthy Newborn	1,464,812 (10.3%)	1,838,805 (13.2%)



Spider Diagrams for Total Population Indicators



2022/23 Rate of hospitalization for ambulatory care sensitive conditions (ACSC) per 100k by Material Deprivation Quintile



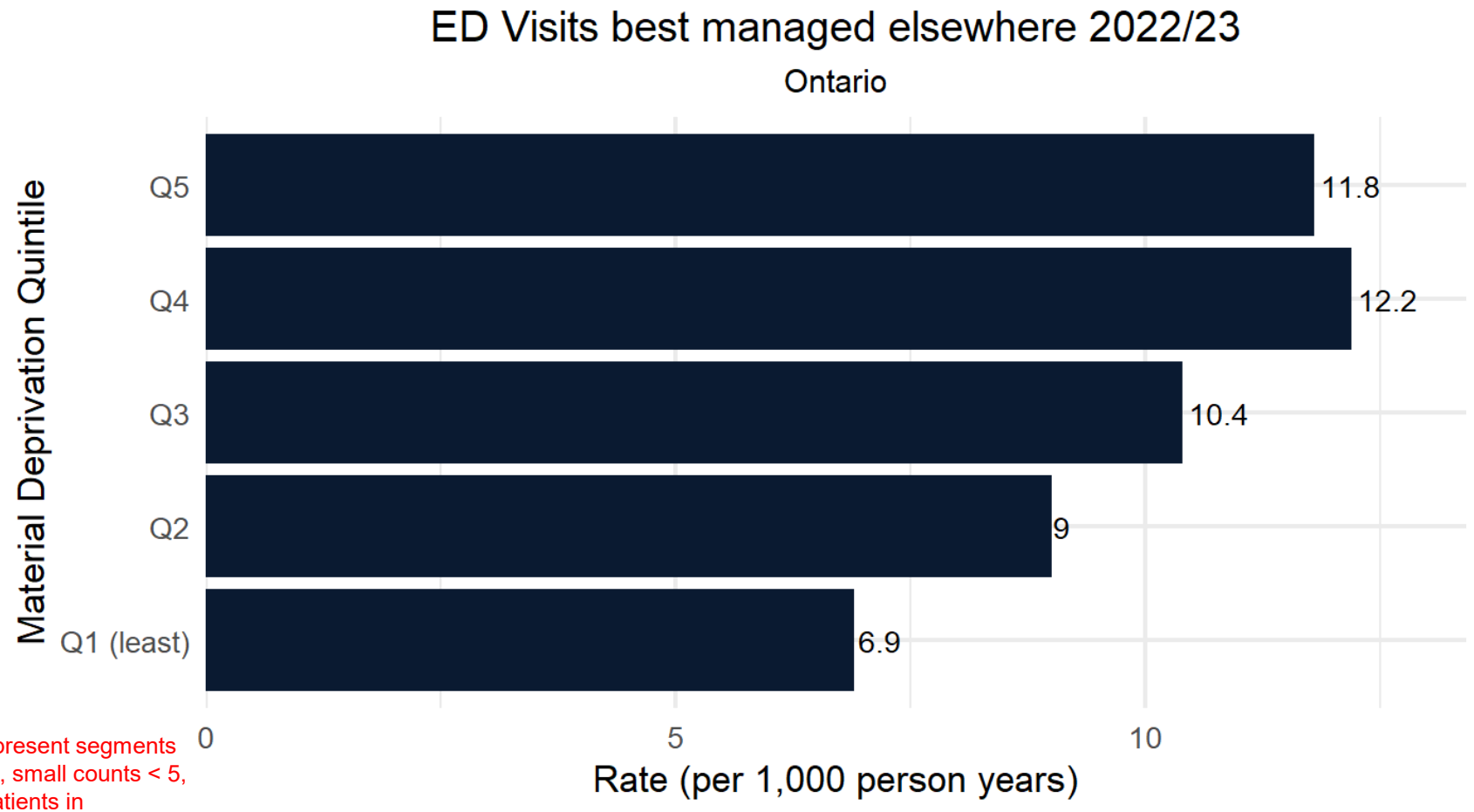
Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:
*Rate of ACSC hospitalization per 100,000 person years is shown at the end of the bar.
*Data are suppressed for segments with small counts.
*Overall rate per 100,000 person years in Ontario = 300.1.

Horizontal axis presents rate of hospitalization for ambulatory care sensitive condition per 100k:

- Ontario average indicated in figure footnote.

2022/23 Rate of ED Visits best managed elsewhere by Material Deprivation Quintile



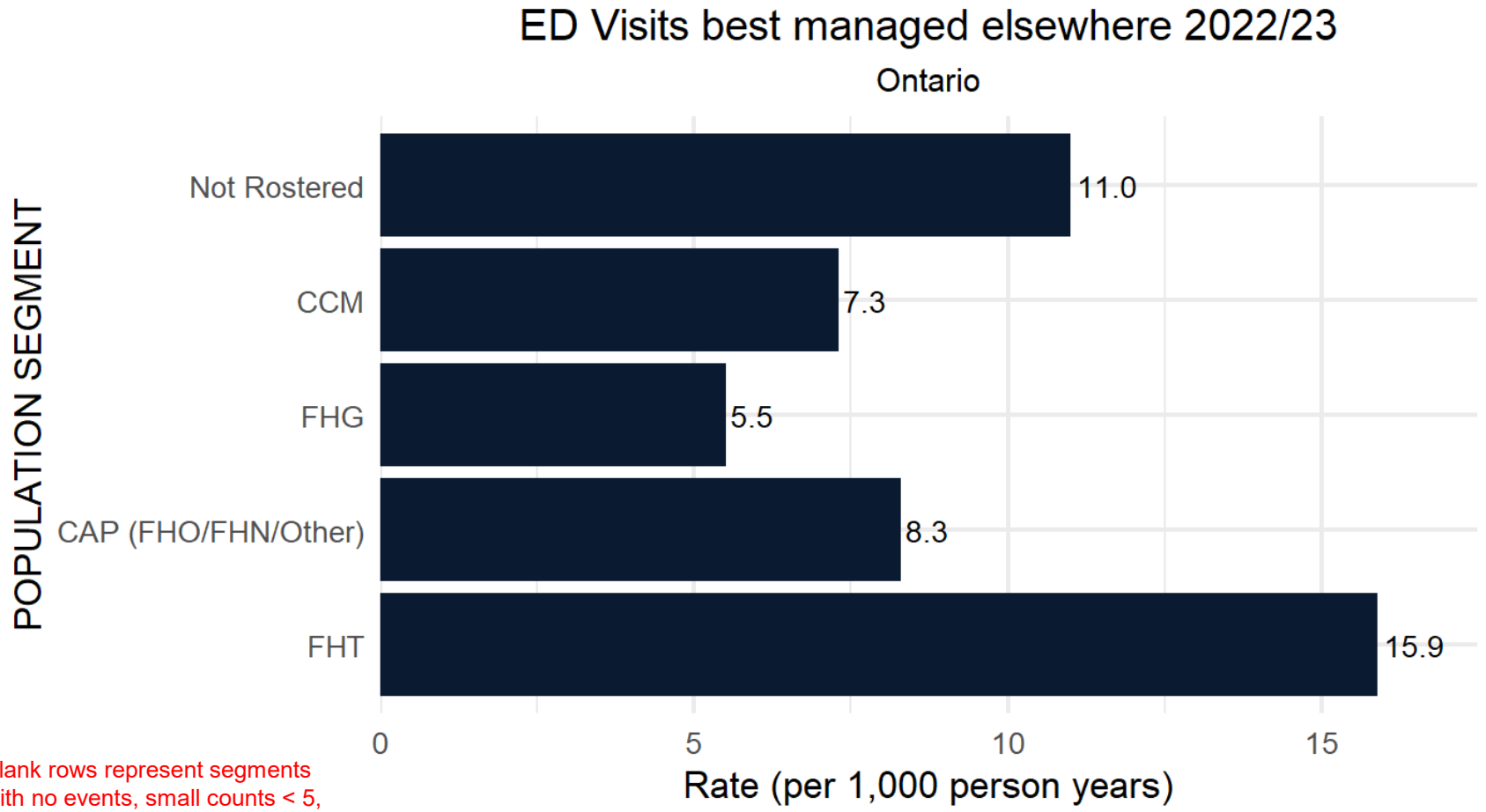
Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:
*Rate of ED visits per 1000 person years is shown at the end of the bar.
*Data are suppressed for segments with small counts.
*Overall rate per 1000 person years in Ontario = 10.1.

Horizontal axis presents rate of ED visits per 1000 person years that could be treated in alternative primary care setting.

- Ontario average indicated in figure footnote.

2022/23 Rate of ED Visits best managed elsewhere by Primary Care Model



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:
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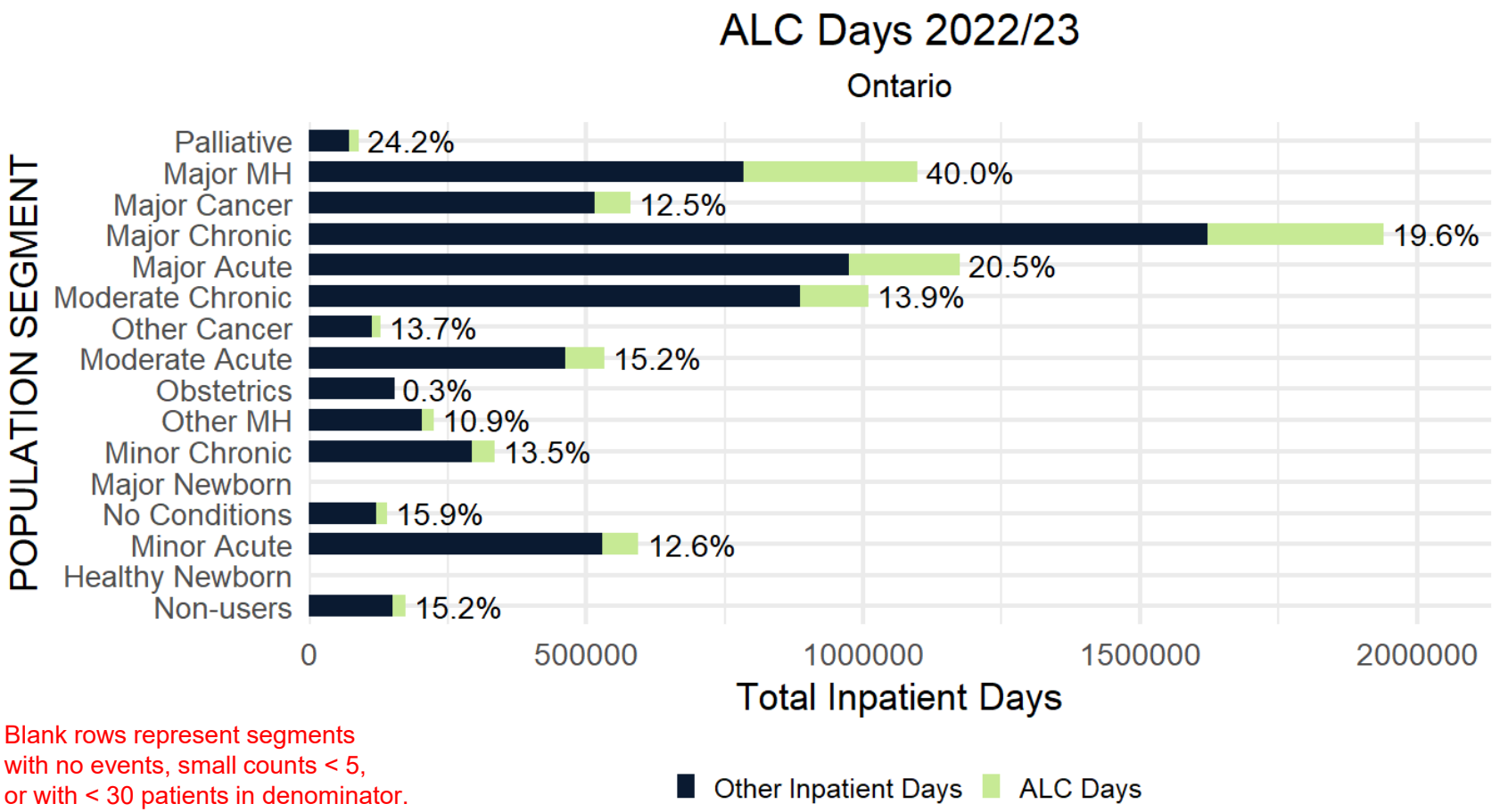
*Data are suppressed for segments with small counts.
*Overall rate per 1000 person years in Ontario = 10.1.

Horizontal axis presents rate of ED visits per 1000 person years that could be treated in alternative primary care setting.

- Ontario average indicated in figure footnote.

2022/23 ALC Days (percent of acute days) in acute hospitals by CIHI Population Grouping Methodology



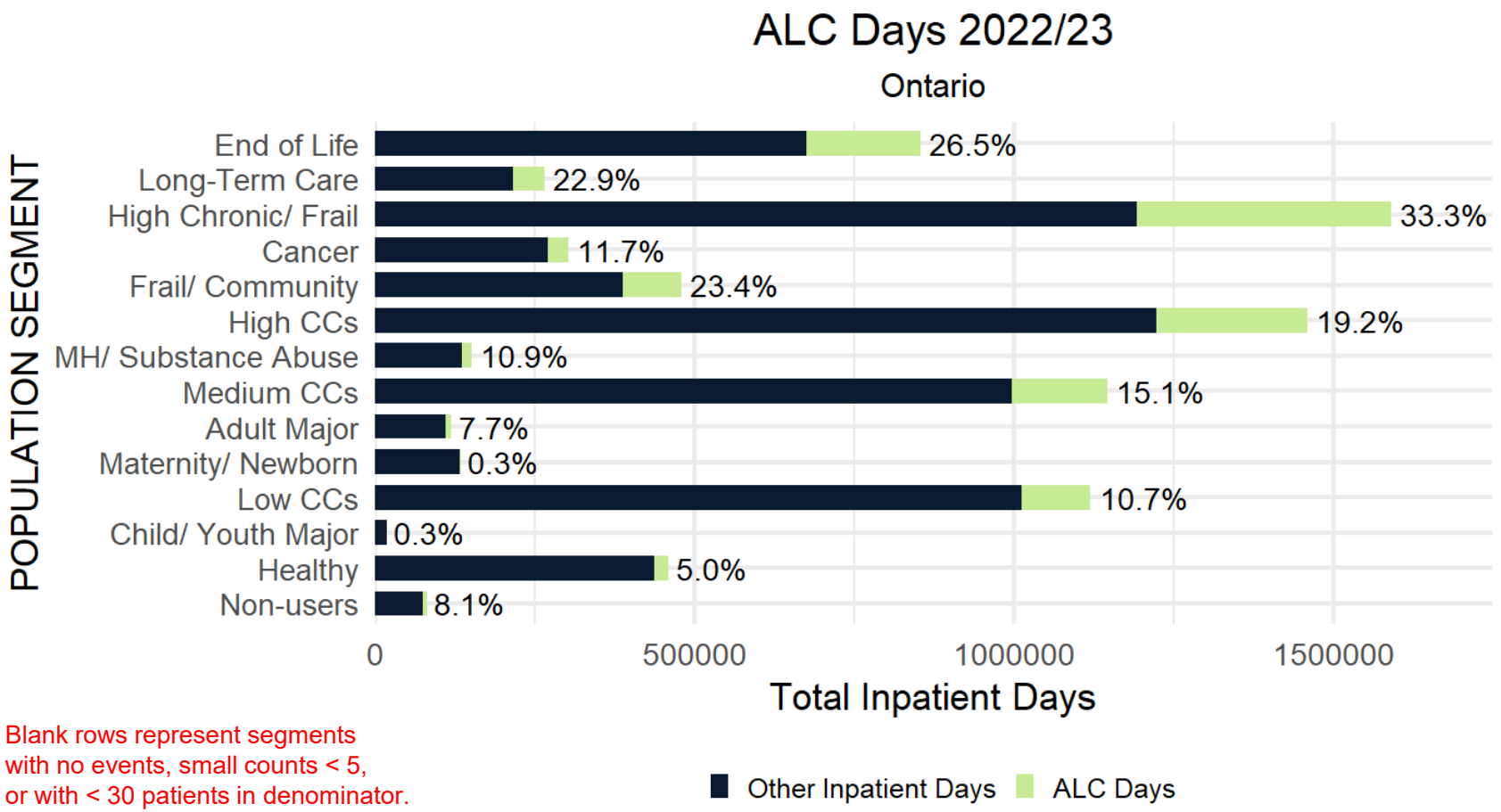
Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:
*Proportion of inpatient days designated as ALC is shown at the end of the bar.
*Data are suppressed for segments with small counts.
*Overall ALC Days in Ontario = 18.8%.

Horizontal axis presents total inpatient days:

- Bright green indicates ALC days;
- Dark blue represents non-ALC inpatient days;
- Percentage to the right is the proportion of inpatient days designated as ALC.
- Ontario average indicated in figure footnote.

2022/23 ALC Days (percent of acute days) in acute hospitals by BC Matrix Segment



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:
*Proportion of inpatient days designated as ALC is shown at the end of the bar.
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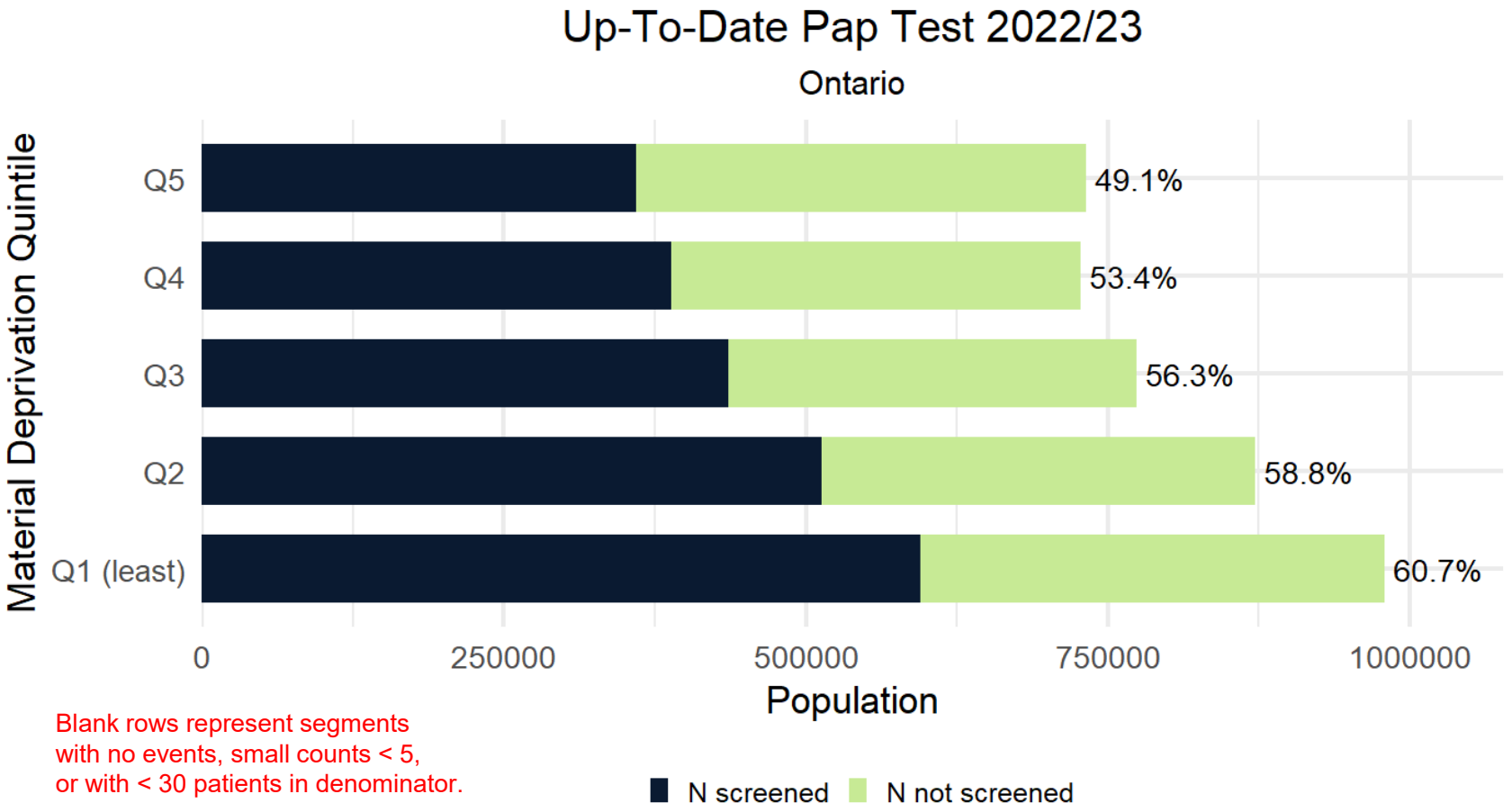
*Overall ALC Days in Ontario = 18.8%.

Horizontal axis presents total inpatient days:

- Bright green indicates ALC days;
- Dark blue represents non-ALC inpatient days;
- Percentage to the right is the proportion of inpatient days designated as ALC.
- Ontario average indicated in figure footnote.

Percentage of screen-eligible patients (women 23-69 yrs of age) up to date with Cervical Cancer Screening (Papanicolaou/Pap tests) on March 31, 2023 by Material Deprivation Quintile



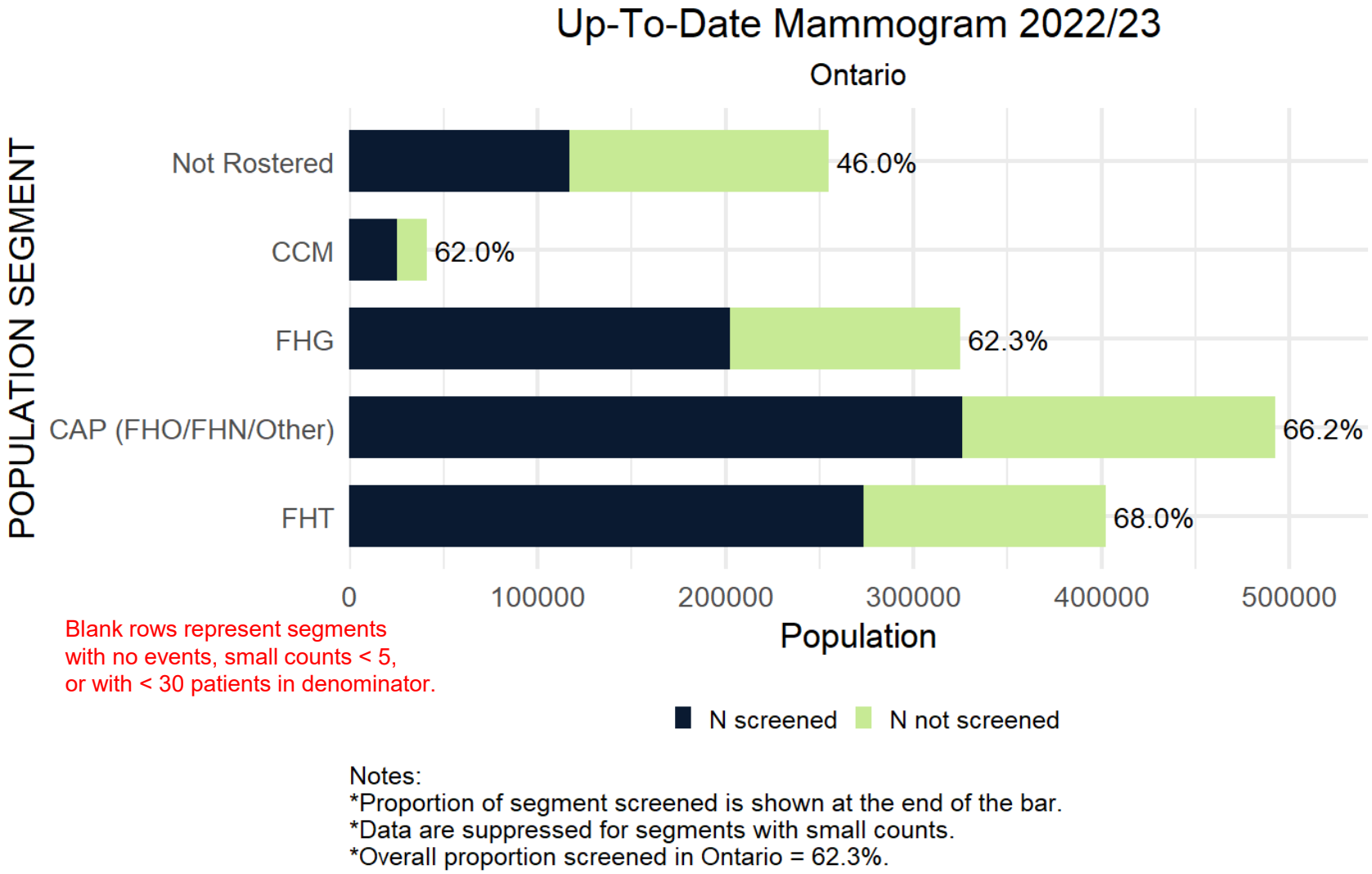
Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:
*Proportion of segment screened is shown at the end of the bar.
*Data are suppressed for segments with small counts.
*Overall proportion screened in Ontario = 56.0%.

Horizontal axis shows the number of women 23-69 years

- Bright green indicates number of women not screened;
- Dark blue represents number of women screened;
- Percentage to the right is the proportion of each segment screened.
- Ontario average indicated in figure footnote.

Percentage of screen-eligible patients (women 52-69 years of age) up to date with a Breast Cancer Screening (Mammogram) on March 31, 2023 by Primary Care Model



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:
*Proportion of segment screened is shown at the end of the bar.
*Data are suppressed for segments with small counts.
*Overall proportion screened in Ontario = 62.3%.

Horizontal axis shows the number of women 52-69 years:

- Bright green indicates number of women not screened;
- Dark blue represents number of women screened;
- Percentage to the right is the proportion of each segment screened.
- Ontario average indicated in figure footnote.

Central OHT Evaluation Team

Co-Leads

Dr. Walter P. Wodchis

Dr. Kaileah McKellar

Team Members

Dr. Gaya Embuldeniya

Chris Bai

Nusrat S. Nessa

Priyanka Gayen

Trisha Martin

Vijay Kunaratnam

Emily Charron

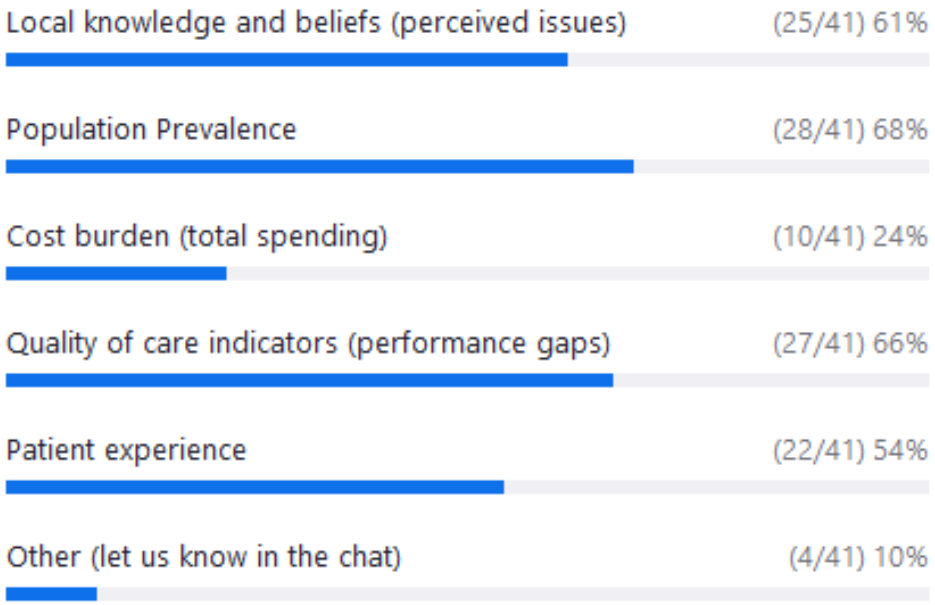
Victor Rentes

HSPN

Poll 3

1. What type of information have you used to choose priority populations? (check all that apply) (Multiple Choice)

41/41 (100%) answered



HSPN Health System Performance Network

Understanding our neighbourhoods: East Toronto

Presenter: Sara Shearkhani

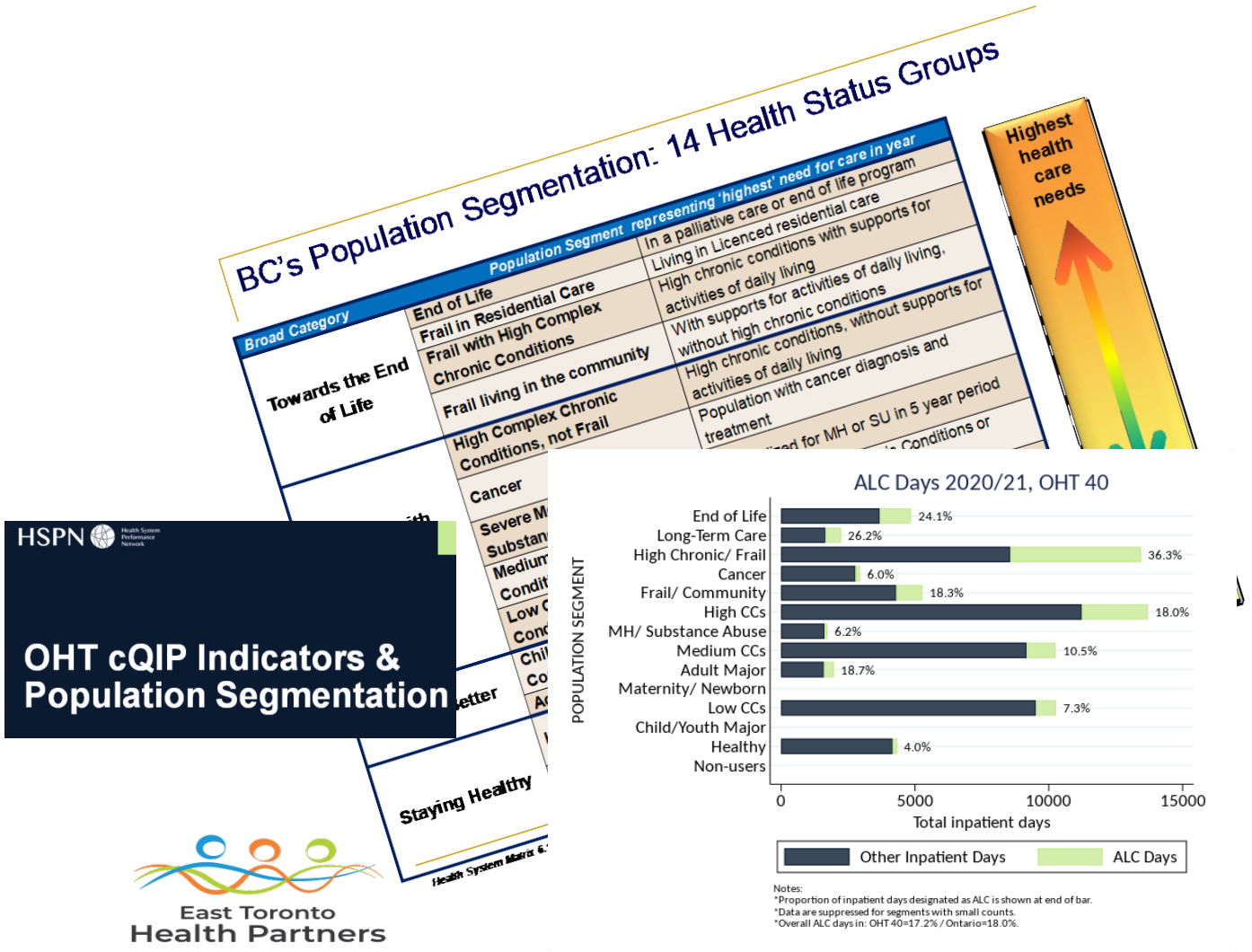
May 28, 2024

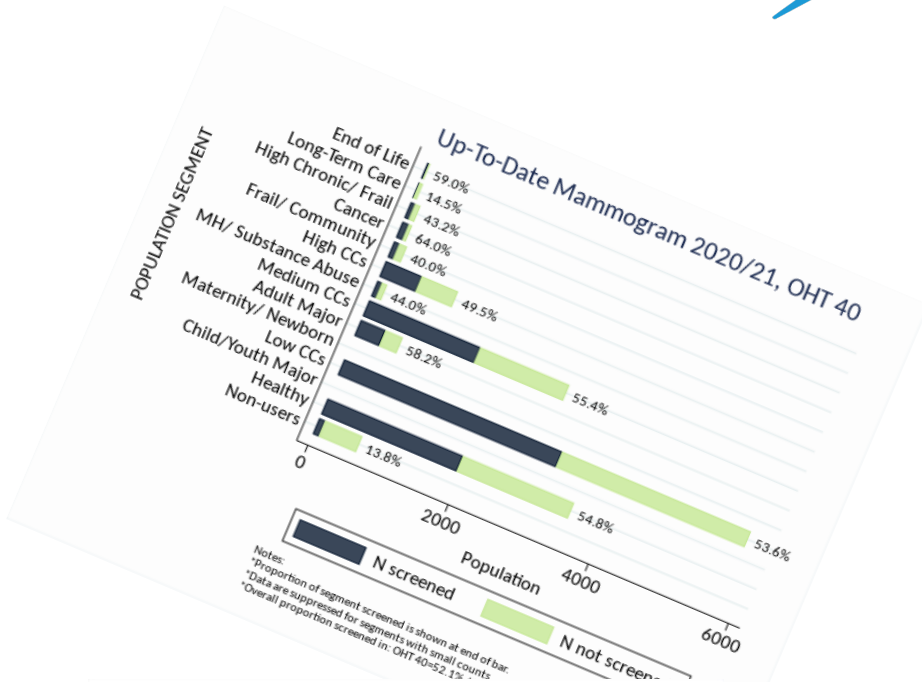
East Toronto Health Partners

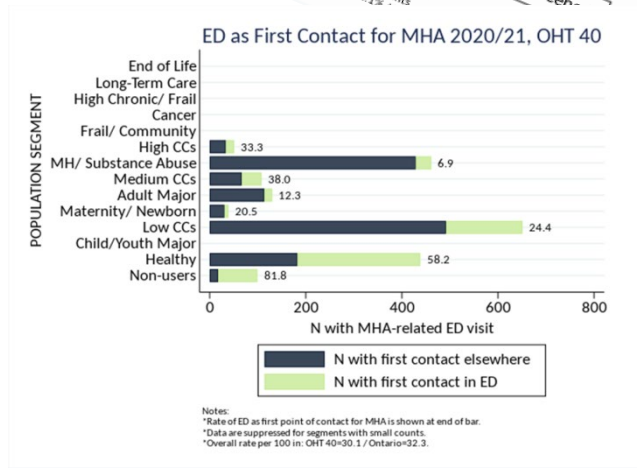
Data for Improvement

A collaborative effort to improve cancer screening rate in East Toronto

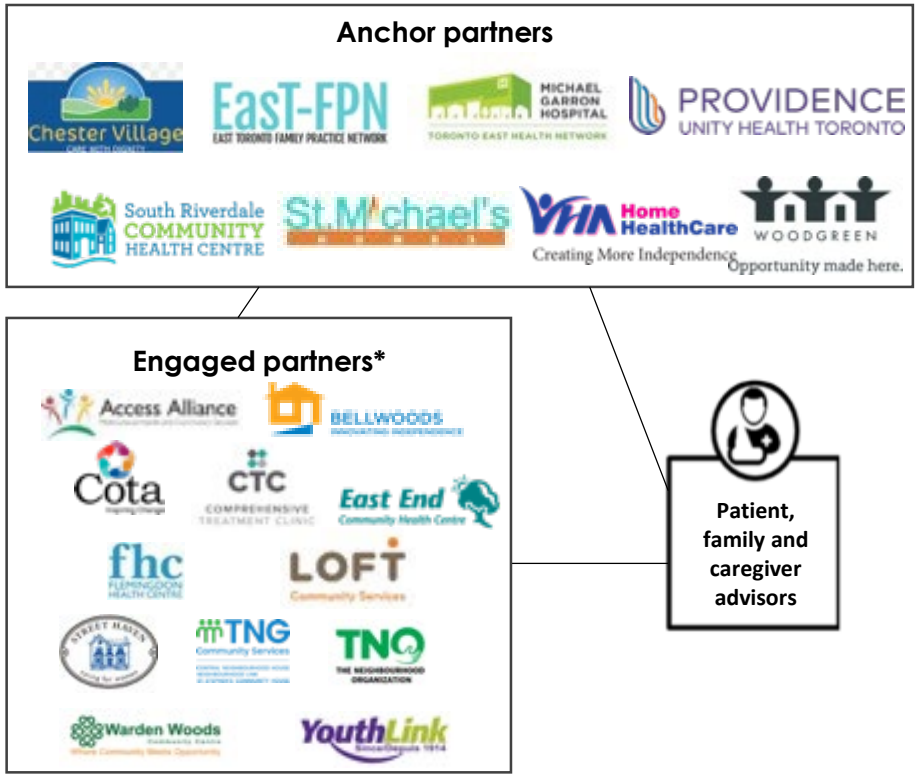
OHT cQIP Indicators & Population Segmentation







It takes a community. We are #OneEastToronto



*See a full list of ETHP members at ethp.ca/partner-organizations

East Toronto Health Partners

East Toronto Health Partners (ETHP)

- Group of **100+ community, primary care, home care, hospital and social services organizations** in East Toronto working together to create an integrated system of care across our communities
- Patients, family members and caregivers are partners in every aspect of the development of ETHP, working together to **improve the way East Toronto residents find and get care close to home**
- Together, we are East Toronto's **Ontario Health Team**

East Toronto: Who we serve

We serve

350,000+

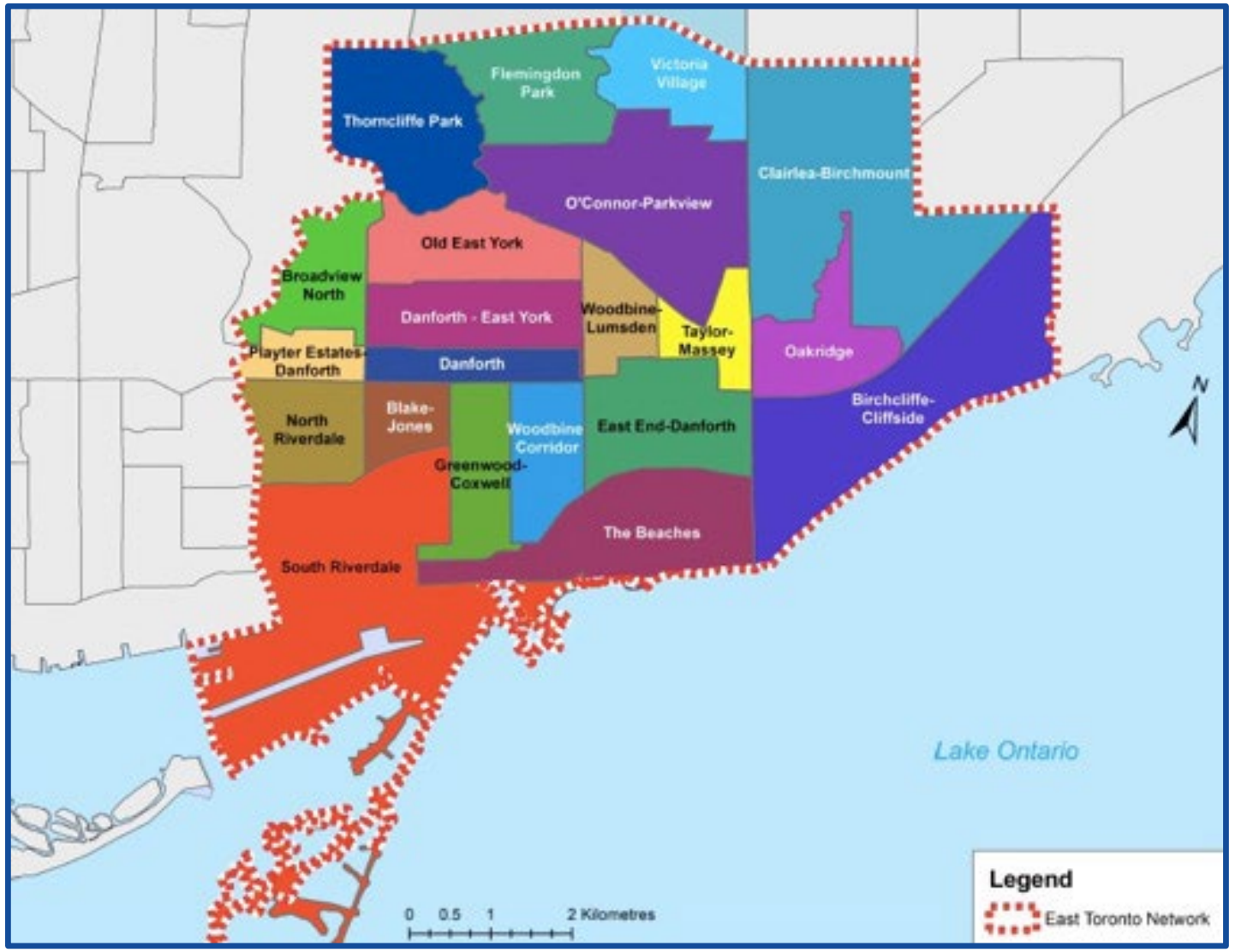
people who live in East Toronto and who choose to receive care here

Child/Youth (age 0-19): **23.1%**
Seniors (ages 65+): **13.7%**
Seniors living alone: **32%**

21 Diverse Neighbourhoods

50+ languages spoken

5 Designated Neighbourhood Improvement Areas



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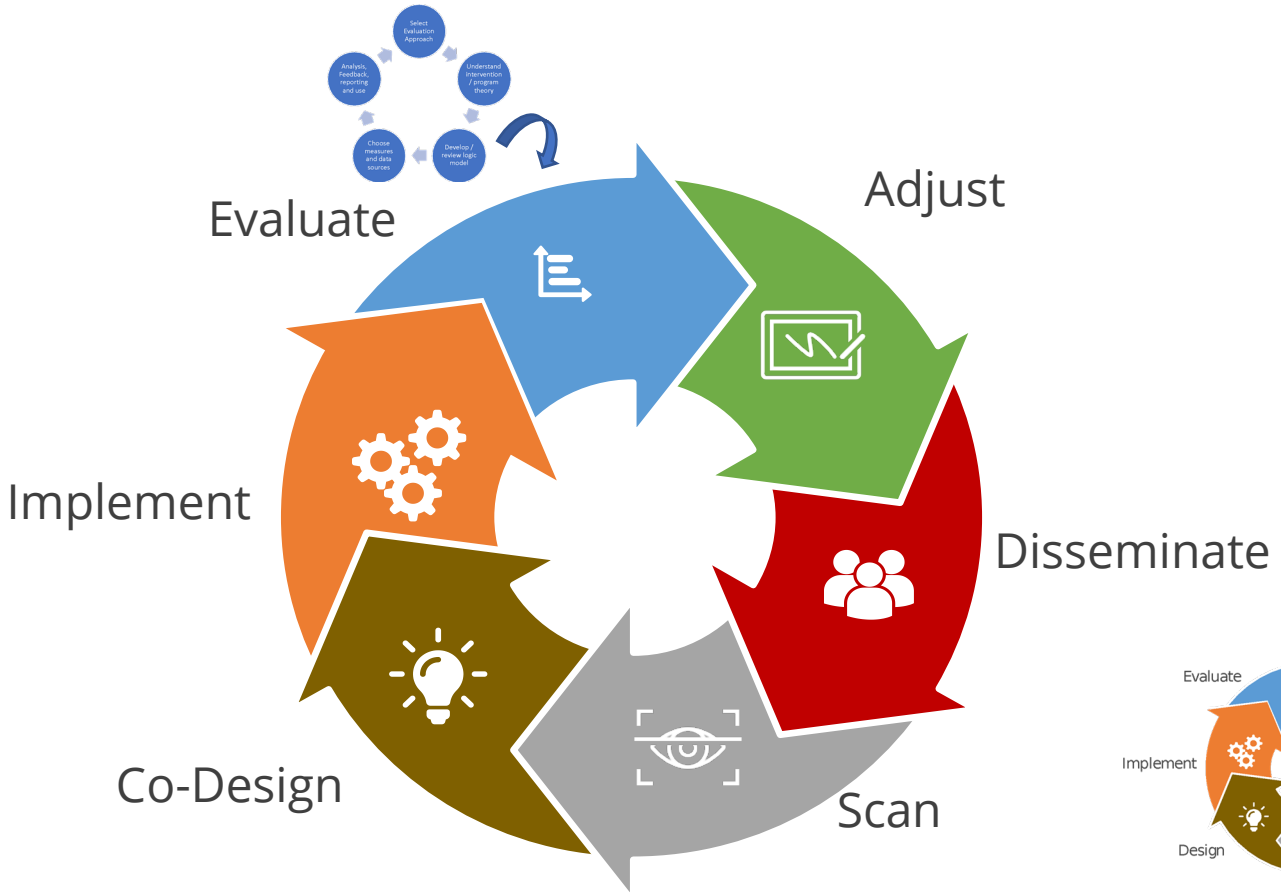
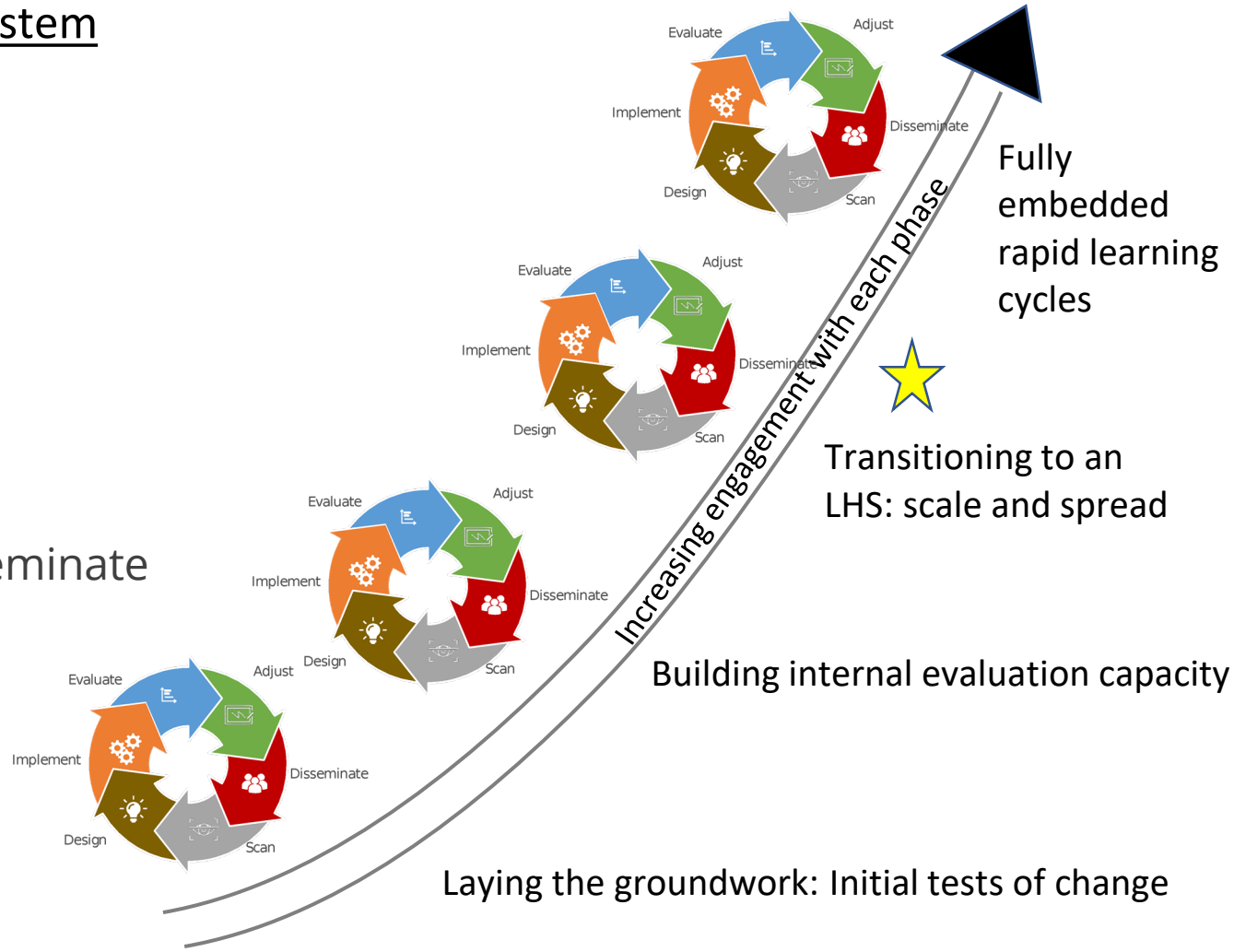
Building a Learning Health System

The Six Phases of a Rapid-Learning Health System





East Toronto Health Partners

Greene SM, Reid R & Larson E. Implementing the Learning Health System: From Concept to Action. *Ann Int Med 2012:* 157: 207-210

Rapid Cycle Evaluation

Descriptive Qualitative Process

Shift

Developmental evaluation Formative Process

Another Major shift

01

2018/19

- External evaluation
- 12 projects

- Divert from Hospital
- Reduce time in ED
- Safe transition to home

02

2019/20

- External evaluation
- 25 projects

- Divert from Hospital
- Reduce time in ED
- Safe transition to home

03

2020/21

- Internal evaluation
- 15 projects
- LHS approach
- Building eval capacity
- Eval steering committee

- Divert from Hospital
- Reduce time in ED
- Safe transition to home

- Evaluation workshops
- Evaluation templates

04

2021/22

- Internal eval
- 5 projects
- LHS
- Operation committee

- Building capacity in the community

- Evaluation toolkit
- Implementation templates

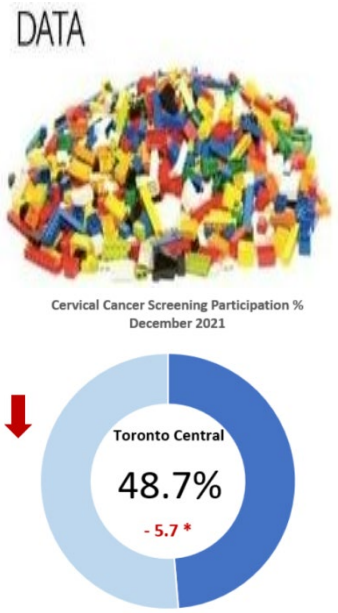
Data for Improvement

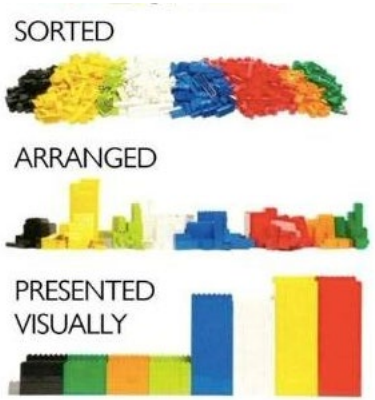
East Toronto
Health Partners

Data for Improvement

East Toronto
Health Partners

Cancer Screening



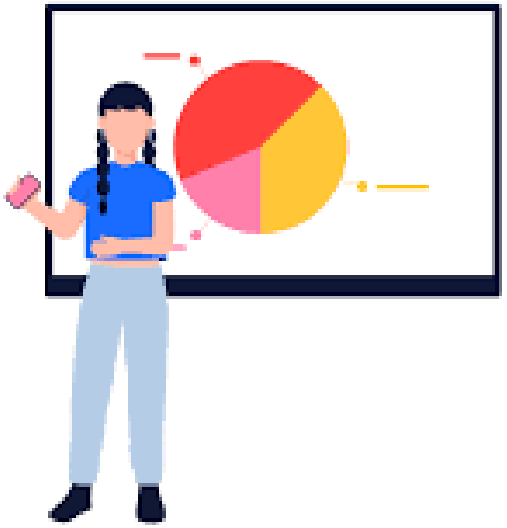


Population Segmentation

Co-design

East Toronto Health Partners

Data for Improvement



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Data Knowledge Translation

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Pickleball!

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Health Partners

Pickleball in my Community Centre

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What is data?

- Information, such as facts and numbers, collected to be examined and considered and used to help decision-making
- Quantitative and qualitative
- Data represents people's encounters with the care system
- By the time we have access to data, conduct our analyses, and discover trends, people have already lived through those experiences.

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Data for Improvement

Key Principles

- Co-design
- Understanding the data
  - What is data?
  - Tell a compelling story using data
  - Facilitate participants to draw connections to their lived experience
- Understanding the approach
  - Simplify
  - Explain complex concepts using simple visualizations

Summary of the Key Massages

- **Challenge:**
  - The cancer screening participation has decreased during COVID19
  - While participation is increasing, there are still opportunities for improvement
- **Aim:** We would like to co-design strategies to increase the cancer screening participation
  - One size does not fit all- different strategies are needed for different populations
  - We need to identify:
    - Different patients/clients populations with lowest cancer screening rate
      - Those who are relatively healthy (unattached; nonusers)
    - Different neighborhoods with lowest cancer screening rate
      - Priority neighborhoods

East Toronto Health Partners

Co-designing Interventions

- 2 workshops focused on data, quality improvement, evaluation
- Use the knowledge and expertise in the community
- Partnership with external partners (cancer screening)
- MaRS Innovation Challenges:
  - plans to expand an existing community health ambassador program to educate target populations about colorectal cancer. This approach also incorporates bot technology to identify eligible clients and send screening reminders to those with a primary care physician.

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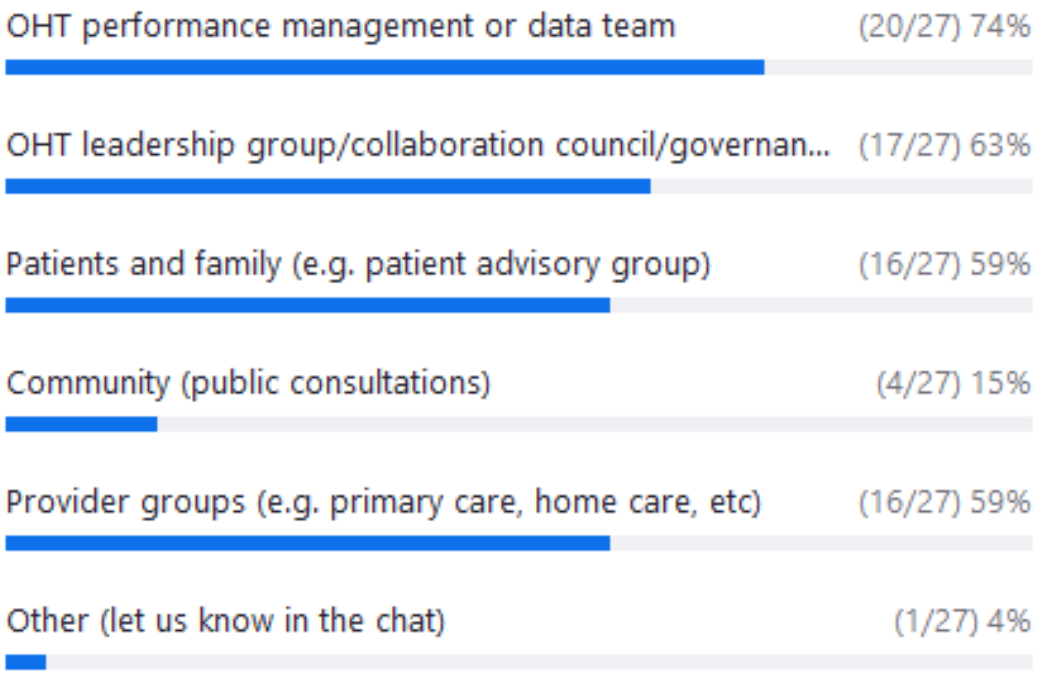
Poll 4

1. Who have you involved in interpreting data? (check all that apply)
(Multiple Choice)

27/27 (100%) answered



Discussion Topic

1. What is your biggest barrier to using data for population insights? (use “-” as leading text in the chat. E.g. “- no access”)

2. What is your biggest enabler for using data for population insights? (use “+” as leading text in the chat. E.g. “+ Business Intelligence team”)

HSPN Health System Performance Network

Using patient experience data: South Georgian Bay

Presenter: Sarah Grace Bebenek

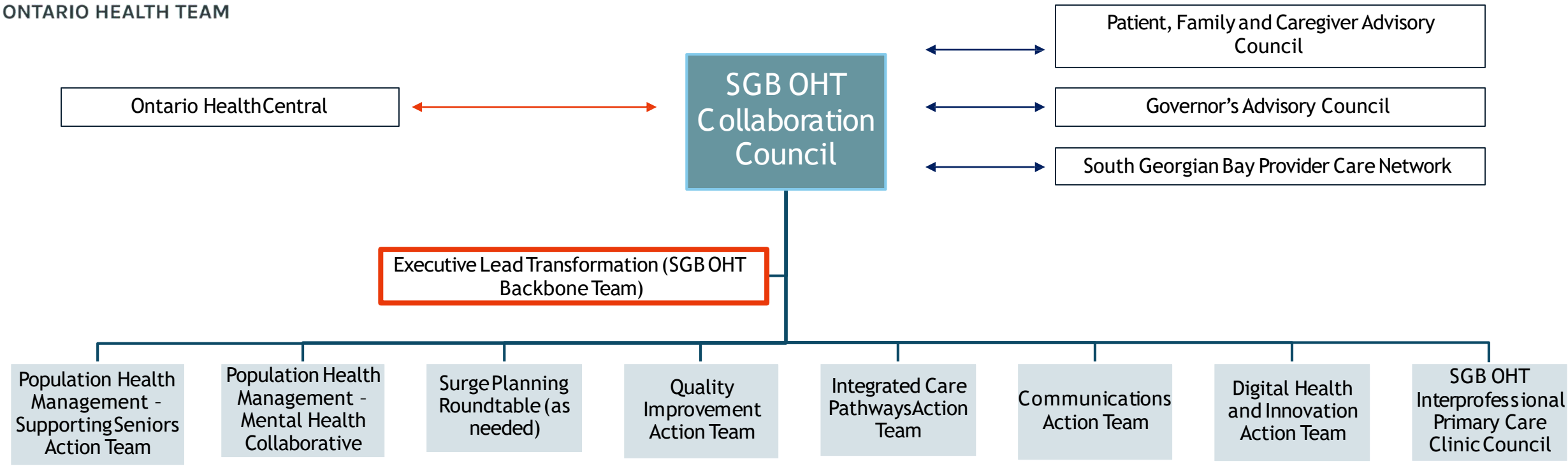
May 28, 2024

South Georgian Bay Patient Experience Survey

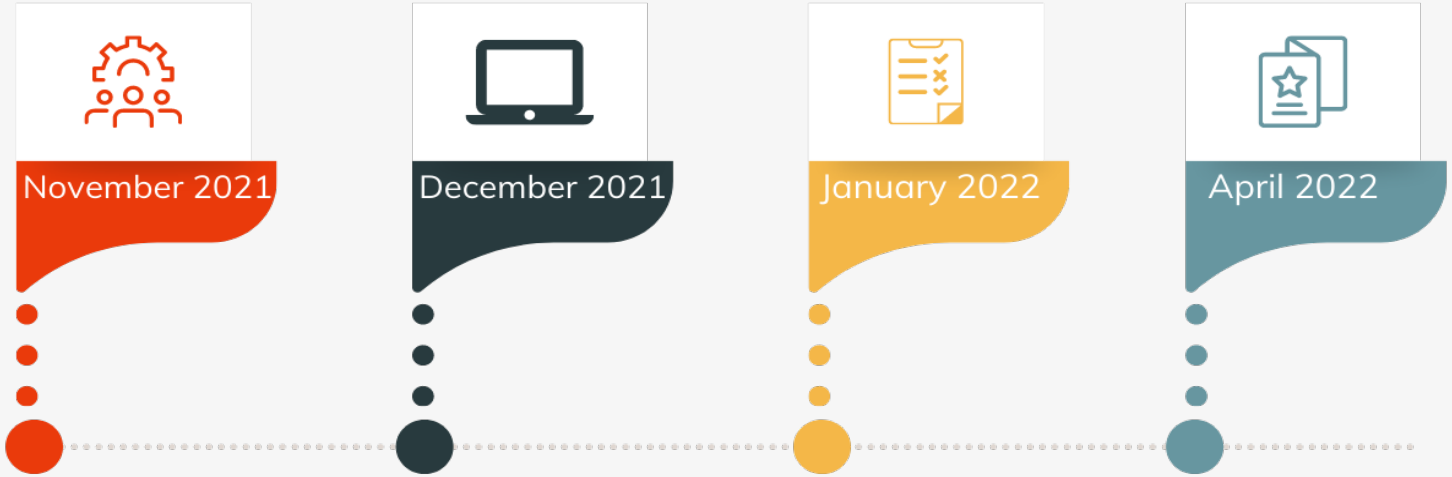
Sarah Grace Bebenek, SGB OHT

Objectives

- Overview of the SGB OHT
- Understand the background behind the Patient Experience Survey
- Review a summary of survey results
- Understand how these results have informed the work of the SGB OHT PFAC and the broader OHT


Ontario HealthCentral
SGB OHT Collaboration Council
Patient, Family and Caregiver Advisory Council
Governor's Advisory Council
South Georgian Bay Provider Care Network
Executive Lead Transformation (SGB OHT Backbone Team)
Population Health Management - Supporting Seniors Action Team
Population Health Management - Mental Health Collaborative
Surge Planning Roundtable (as needed)
Quality Improvement Action Team
Integrated Care PathwaysAction Team
Communications Action Team
Digital Health and Innovation Action Team
SGB OHT Interprofessional Primary Care Clinic Council

2022 Patient Experience Survey Background



Step One

SGB OHT PFAC reviewed the HSPN Survey and recommended it to be used as a tool to evaluate the patient experience in South Georgian Bay, as a baseline to inform future work

Step Two

Survey distribution list developed based on data collected from the South Georgian Bay community EMR. Those who had a primary care appointment in the last two years were included in the survey distribution.

Step Three

All patients with an email recorded in their chart, and consent provided, were emailed the survey link through the secure Ocean platform, via the SGB OHT license. A random sample of those with no email were mailed a copy of the survey with a return envelope

Step Four

Collect survey results from HSPN, and meet as a PFAC to explore how we can work together to improve patient experience in South Georgian Bay

2022 South Georgian Bay Survey Responses

38164
SURVEYS EMAILED SECURLY THROUGH OCEAN

350
SURVEYS SENT BY MAIL TO THOSE WITH NO EMAIL

6018
SURVEY ENTRIES/CLICKS

3600+
COMPLETE SURVEY RESPONSES

Planning for the Second Patient Experience Survey

- After receiving the results from the 2022 Patient Experience Survey, the PFAC was engaged to review the survey results and provide feedback to be incorporated into the next survey.
- The SGB OHT worked with HSPN to add customized questions to the survey to reflect localized services.
- Patients who accessed unattached services such as cancer screening clinics were included in the survey distribution list for 2023.

2023 Survey Responses

35,000+

SURVEYS EMAILED SECURELY THROUGH OCEAN

350

SURVEYS SENT BY MAIL TO THOSE WITH NO EMAIL

3000+

COMPLETED SURVEY RESPONSES RECEIVED

Patient Experience Survey Outcomes

Survey Themes

- How to help support patients who are marginalized/vulnerable
- Assessing the patient experience for those with no family doctor or nurse practitioner
- Access to services/care
- Patient/caregiver involvement as a member of the care team
- Use of digital tools to support care
- Understanding the demographics of our population

Actions

- SGB OHT Clinic for unattached population
- Development of a patient handbook
- Furthering patient and caregiver advocacy work
- Patient tools to support use of digital tools
- Improving accessibility to communications around services
- Data to inform SGB OHT decision making and resource allocation

SOUTH GEORGIAN BAY
ONTARIO HEALTH TEAM

Questions?


SOUTH GEORGIAN BAY
ONTARIO HEALTH TEAM

Discussion Topic

How are you engaging with patients/family/caregivers and/or community in understanding patient needs or priorities?

HSPN Health System Performance Network

Going deep with linked data: Guelph-Wellington

Presenter: Emmi Perkins

May 28, 2024

Advancing Primary Care-Based Population Health Management in Guelph Wellington OHT

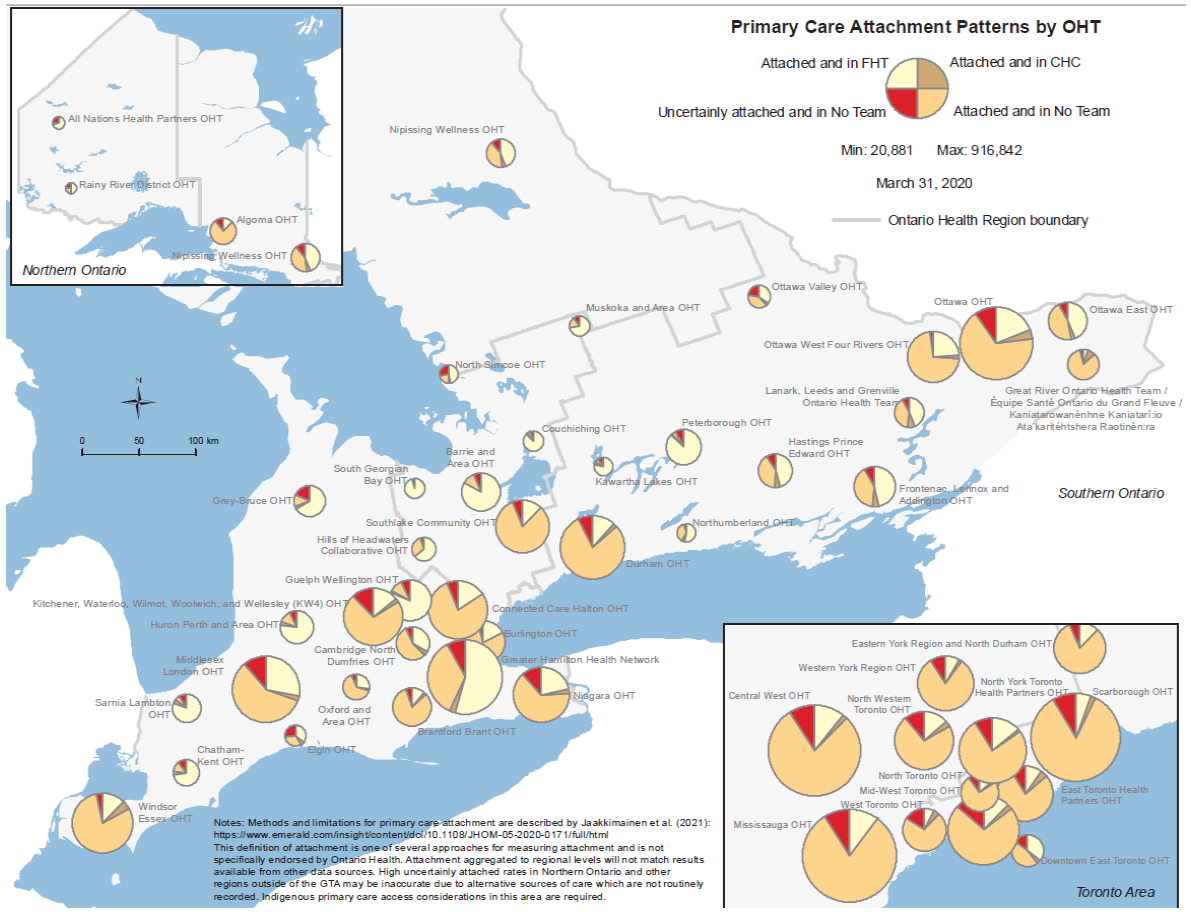
May 2024

IDS Integrated Decision Support

Guelph Wellington Ontario Health Team

Our Story

- **~ 95% of primary care physicians practice in team-based models** – 5 Family Health Teams, 1 Community Health Centre
- **All primary care physicians use the same EMR** (albeit unique, separated instances)
- Relatively **high primary care attachment rate**
- Champions for improving data



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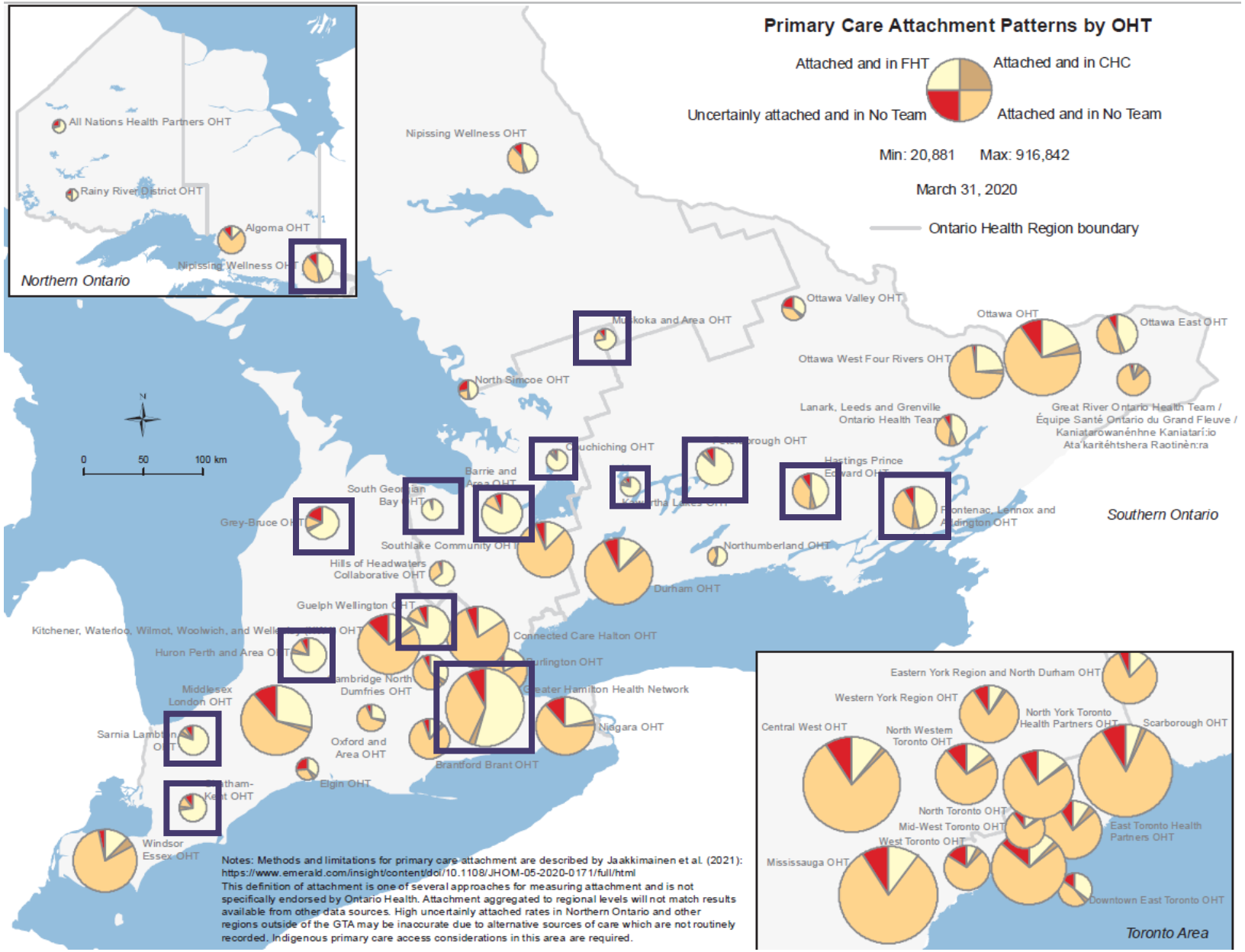


Guelph Wellington Ontario Health Team

Patient Scenario

Jane's Care Team Pre-Integrated Patient Care Team (IPCT)

Housing
(Charting: Hifis)

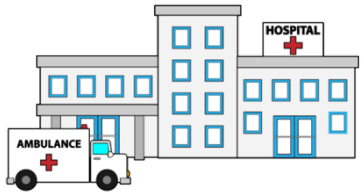
MH&A
(Charting: Caseworks, other EMRs)

Care Coordinator
(Charting: CHRIS)

In-home Nurse
(Charting: Separate system)

In-home PSW (Charting: Separate system)

Primary Care Team
(Charting:Telus)



Acute Care Team
(Charting: Meditech)

Palliative Care
(Charting: Paper, Telus, other EMRs)

Guelph Wellington Ontario Health Team

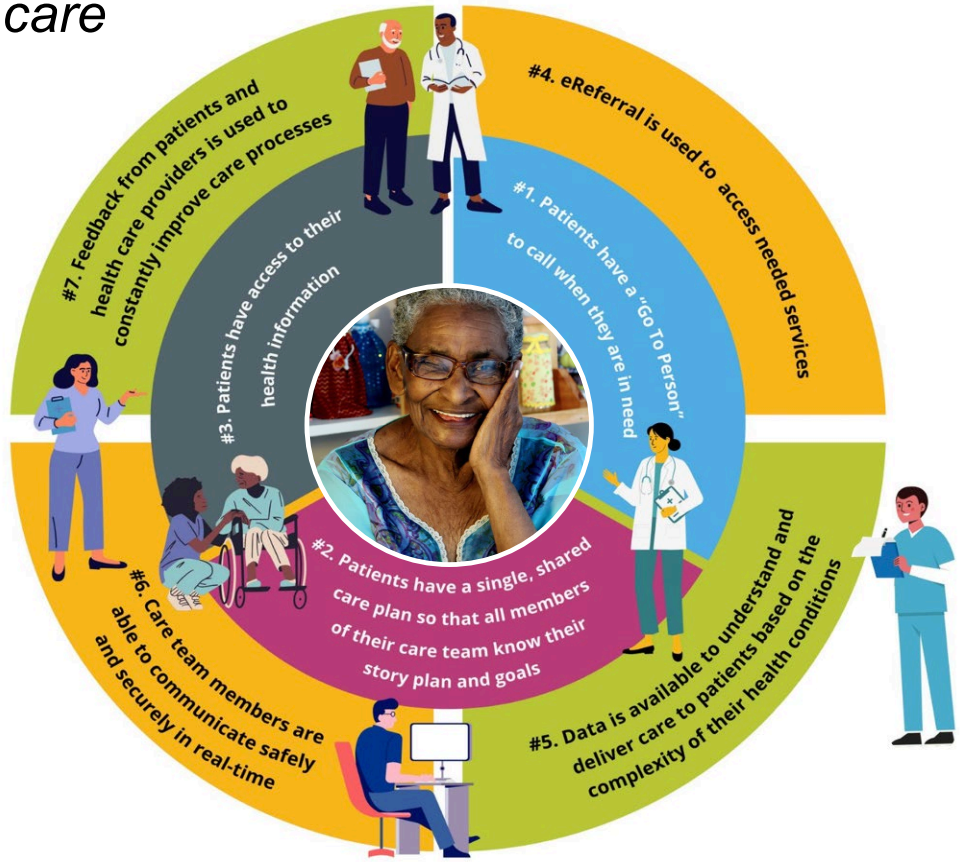
Jane's Integrated Patient Care Team (IPCT)

Jane experiences a single care team of dedicated, integrated providers who are collectively dedicated and accountable to meet all her care needs. Jane is a central member of her care team.

Comprehensive primary care including:

- Palliative care
- MH&A
- Care coordination
- In-home service delivery
- Acute care
- Housing, etc.

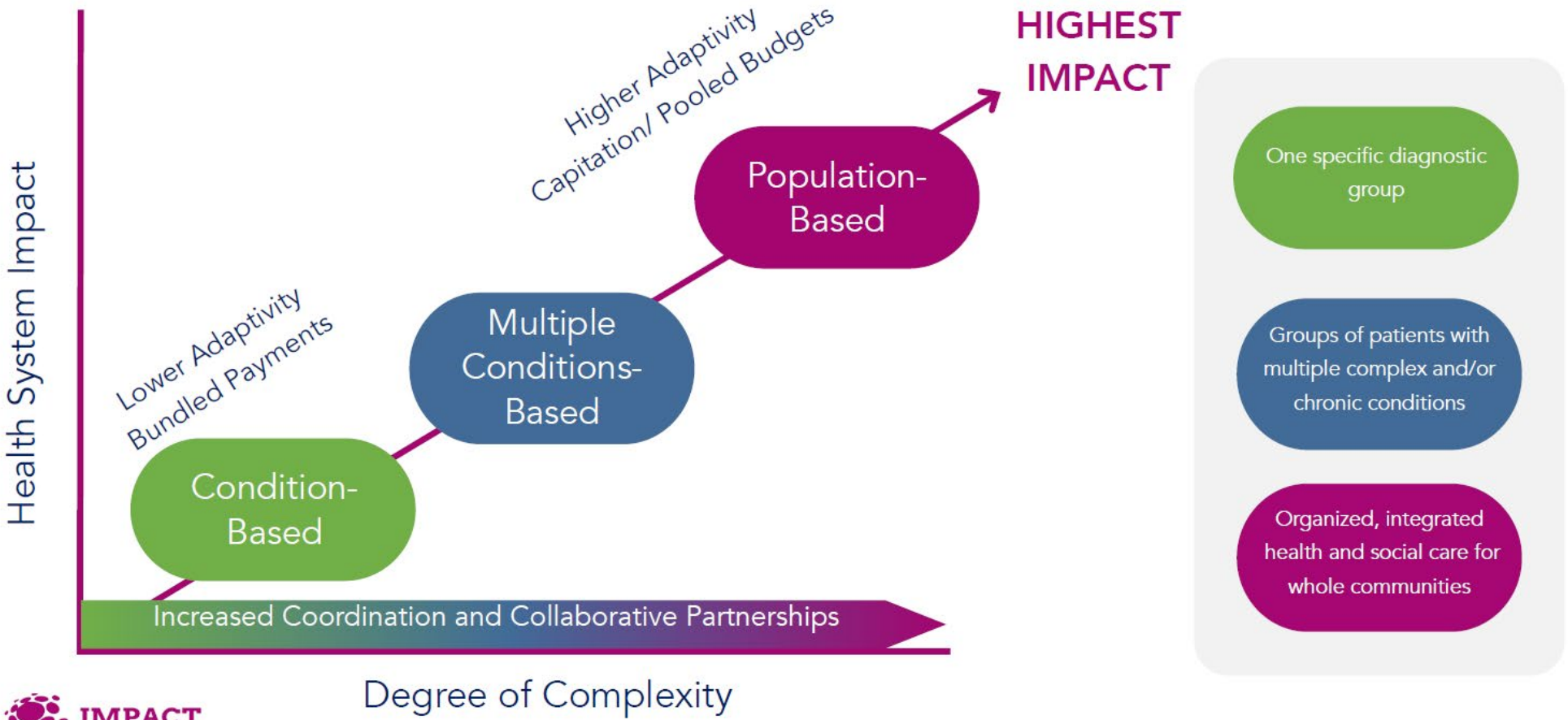
Integrated Documentation, Harmonized Privacy Policies & Practices



Guelph Wellington Ontario Health Team

Integrated Health Systems

Transition from Health Conditions to Population-Focused



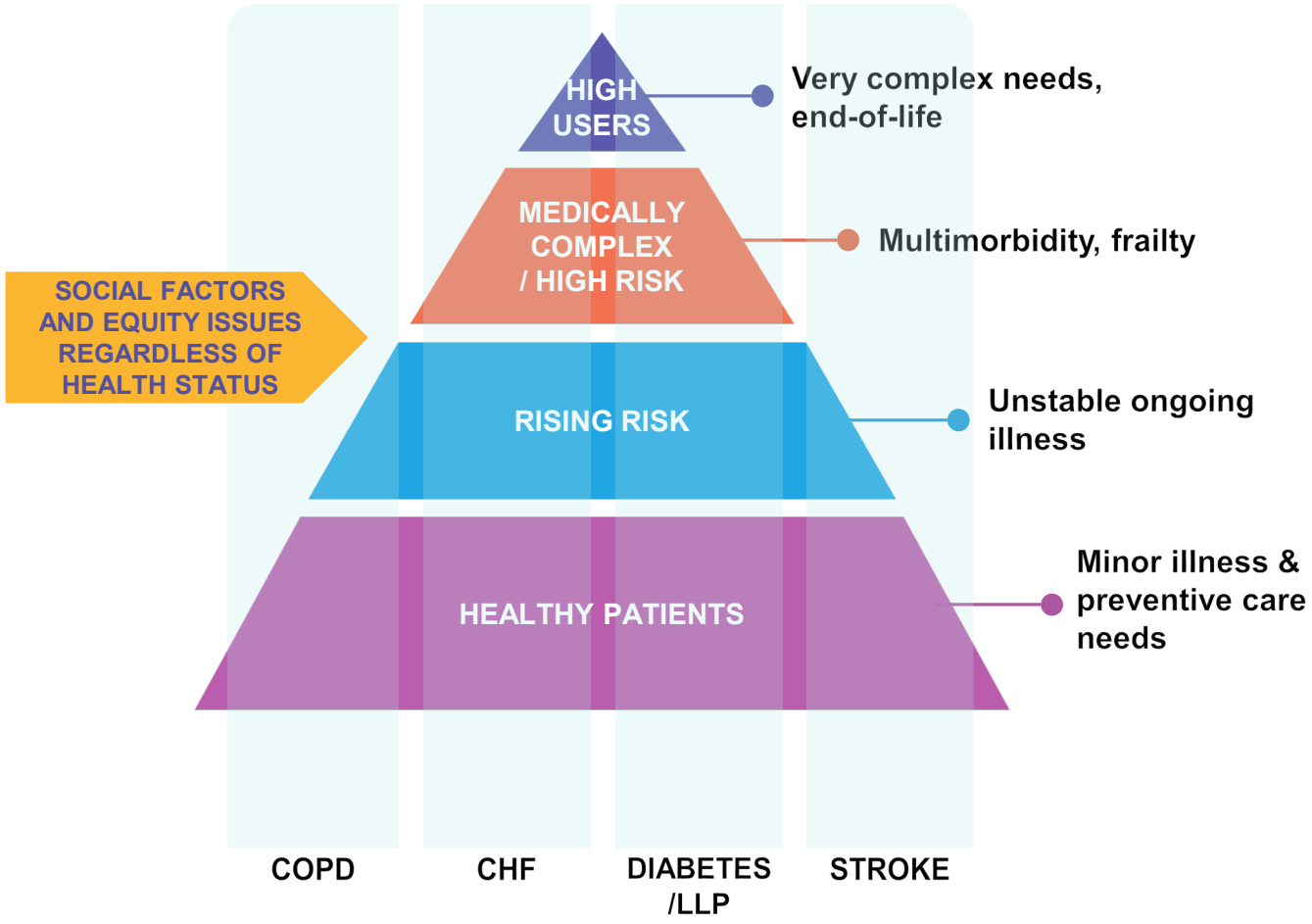
- One specific diagnostic group
- Groups of patients with multiple complex and/or chronic conditions
- Organized, integrated health and social care for whole communities

4C IMPACT

Guelph Wellington Ontario Health Team

GW OHT Approach to Segmentation

Integrated Care for Full Attributed Population



Segmenting Based on Complexity of Needs

- The CIHI Population Health Grouper methodology was chosen to segment each IPCT population. This is done via IDS at the team, physician and patient level.
- Each physician's roster is segmented according to the most complex/high users, medically complex/high risk, moderate/rising risk and healthy.
- The complexity of a person’s care needs change over time – so should the intensity of their care.

Guelph Wellington Ontario Health Team

The Problem

- Primary care data is not easily accessible, and therefore, often missing from system-level, population health analyses.
- Available data is disease-specific and at the OHT/neighbourhood level. Segmentation based on holistic complexity at the patient and provider level was needed.
- **The solution:** Invest in Integrated Decision Support (IDS)

IDS
Integrated
Decision
Support

Guelph
Wellington
Ontario Health Team

Our Investment in Population Health Segmentation

Guelph Wellington (GW) OHT acute and post-acute hospitals, home care, community health centres, and public health all shared into IDS when the GW OHT was created.

GW OHT has invested in:

- The development and annual costs for an EMR (Telus) extraction tool/report to enable the contribution of primary care data to IDS
- CIHI Population Health Grouper license
- IDS on-boarding fees for early adopter primary care sites/physicians
- IDS on-boarding fees for CMHA WW
- Annual IDS license fees are paid by the provider/organization
- Other partners are considering the contribution of their data to IDS

Guelph Wellington Ontario Health Team

Benefits of IDS Data

IDS combines data from multiple health system sectors to enable a comprehensive population health planning and management approach.

This allows OHTs to understand both the overall health of their population and the health status of individual patients.


Hospitals


Home Care


Primary Care


CHC


Paramedic/EMS


CMHA


Community Support Services (CSS)
Pilots


LTC


Ontario-Marginalization Index


Population and Geography

IDS Integrated Decision Support

Guelph Wellington Ontario Health Team

Benefits of IDS Data

Clinical Value

Health Assessment and Targeted Interventions

IDS data can be used to identify/prioritize patients on a physician's roster who are most complex/highest risk and enables clinicians to target prevention and self-management interventions to those who are less complex/healthy.

Organizational Value

Risk Stratification and Development of Equitable Models of Care

IDS data enables the segmenting of patients according to the population health triangle and the subsequent development of care models that equitably distribute available resources across the rostered population (e.g., according to complexity of need).

System Value

Population Health Management/ Quintuple Aim

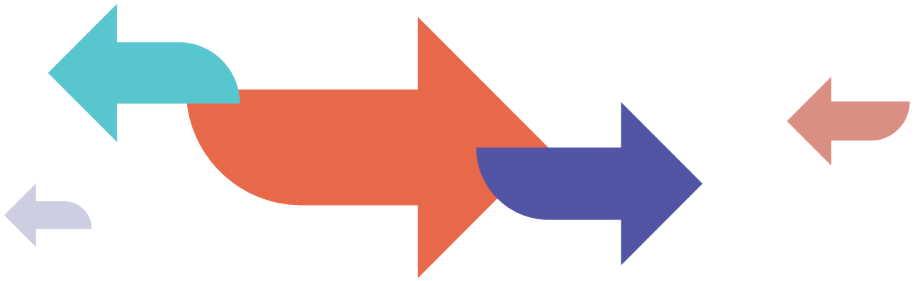
IDS data enables collaborative leadership/shared decision-making regarding resource allocation to optimize health and well-being and equitable outcomes for an attributed population.

IDS Integrated Decision Support

Guelph Wellington Ontario Health Team

Considerations

- **Variable HIC models** across primary care teams (e.g., FHT is the HIC in some, physicians are the HIC in others). **HIC level agreement is required** in to order to share primary care data with IDS
- **Costs**
- **Privacy –** Monitoring for PHIPA compliance

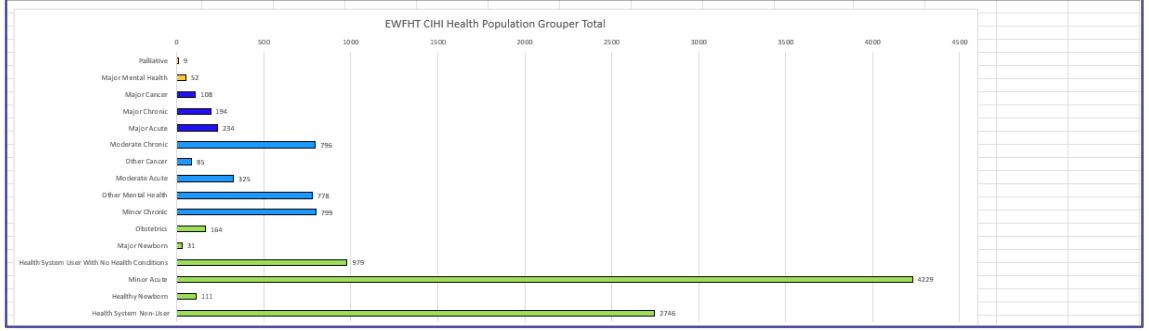


Guelph Wellington Ontario Health Team

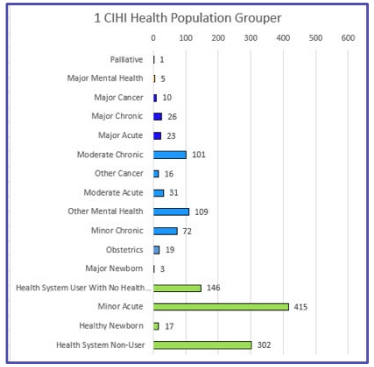
IDS in Action

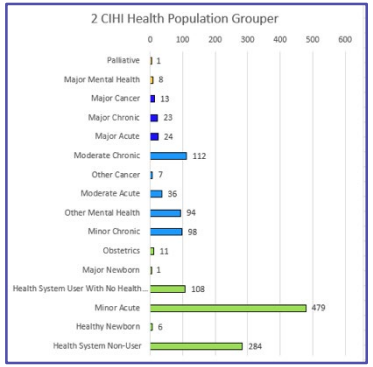
Step 1: Segmentation by Complexity

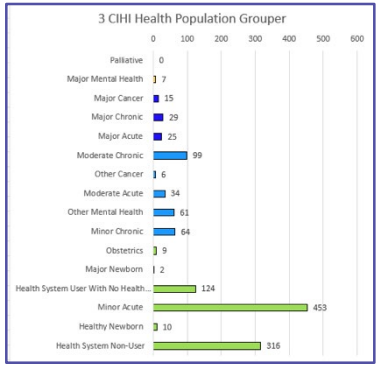
Segment	EWFHT	IHP 1	IHP 2	IHP 3	IHP 4	IHP 5	IHP 6	IHP 7	IHP 8	IHP 9	IHP 10	Other Doctor	Inactive
Palliative	9	1	1	0	2	1	0	1	0	0	3	0	70
Major Mental Health	52	5	8	7	3	2	9	2	4	5	7	2	19
Major Cancer	108	10	13	15	15	10	13	10	11	1	10	3	34
Major Chronic	194	26	23	29	29	17	16	11	17	13	13	3	43
Major Acute	234	23	24	25	23	26	24	25	26	20	18	2	54
Moderate Chronic	796	101	112	99	105	57	75	53	74	57	63	11	71
Other Cancer	85	16	7	6	13	14	7	9	3	7	3	0	3
Moderate Acute	325	31	36	34	28	37	50	30	33	14	32	4	34
Other Mental Health	778	109	94	61	79	73	81	61	114	48	58	2	51
Minor Chronic	799	72	98	64	102	55	90	76	100	71	71	5	52
Obstetrics	164	19	11	9	21	19	27	12	21	7	18	1	30
Major Newborn	31	3	1	2	4	4	6	4	4	2	1	0	0
Health System User With No Health Co	979	146	108	124	75	100	94	53	111	73	95	1	62
Minor Acute	4229	415	479	453	336	411	547	387	473	376	350	18	327
Healthy Newborn	111	17	6	10	16	12	13	7	15	7	8	0	6
Health System Non-User	2746	302	284	316	218	288	289	255	255	285	254	47	507
Total	11640	1296	1305	1254	1071	1126	1341	996	1261	9	1004	99	1369



Using the CIHI Population Health Grouper, the most complex clients' health profile on each primary care physician roster are identified and then validated via a chart review by the team and/or by a discussion with the physician.





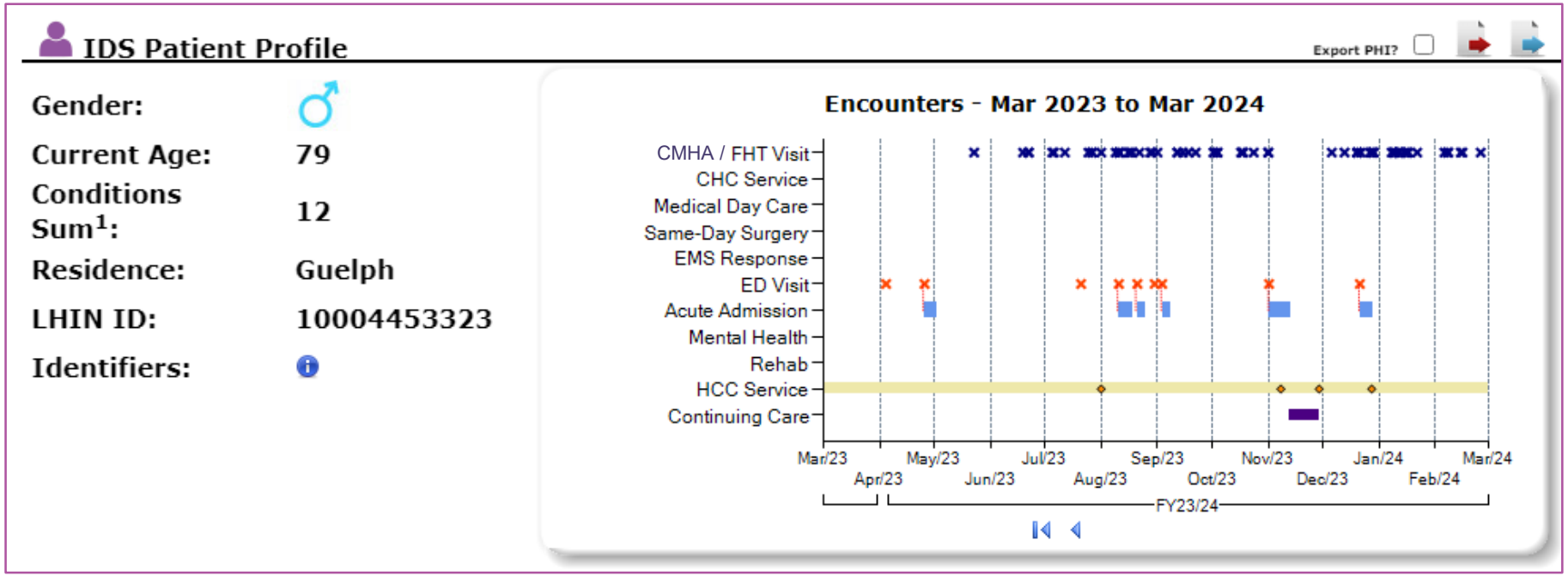


IDS Integrated Decision Support

Guelph Wellington Ontario Health Team

IDS in Action

Step 2 : Patient Journey Map



Once clinically validated (the CIHI classification matches the clinical profile of the patient), an IDS 'Patient Journey Map' is created to identify other services that the patient is receiving (i.e., other members of the patient's care team) and better coordinate care.

IDS Integrated Decision Support

Guelph Wellington Ontario Health Team

IDS in Action

Step 3: Shared Care Planning

- Appropriate providers from the identified services/organizations are then brought together to review the client's case and current treatment plans.
- A single, shared care plan is created by the team of providers. This shared care plan is “quarter-backed” by the patient’s “Go-To-Person”.
- The shared care plan is shared via Robotic Process Automation (RPA) between the primary care EMR (Telus) and CHRIS.

IDS
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Decision
Support

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Ontario Health Team

IDS in Action

Predicting Palliative Care Needs

- Through IDS, the HOMR tool (Hospital One Year Mortality Ratio) is being used to identify patients who are likely to die in the next year and who would benefit from a palliative approach to care.
- Once identified, the primary care physician and team validate against the patient's clinical profile, and if appropriate, initiate an integrated care plan that includes all aspects of a palliative approach to care, including advanced care planning, serious illness and symptom management conversations, etc.
- Beneficial at both patient level (to address person-centred needs) and the system level (to predict required palliative care capacity to meet palliative care needs across the GW population).
- HOMR score is now also available to the IDS network of subscriber via IDS's 'once for many' approach.

What is HOMR?

The HOMR tool is an algorithm that uses data routinely collected by hospitals to accurately and reliably calculate a patient's risk of dying within the next 12 months.

IDS Integrated Decision Support

Guelph Wellington Ontario Health Team

Thank you

Guelph Wellington Ontario Health Team

Discussion Topic

How are you engaging with front line providers (physicians, nurses, community workers) in determining what do do about emergent/identified patient needs or priorities?

Up Next

- HSPN webinar series
  - 4th Tuesday of the Month: 12:00 – 1:30 pm

Upcoming June to October 2024:

Advancing the Learning Health System in Ontario: Parts 3 - 5

Can you share some feedback? Scan here! (or click link in chat)

THANK YOU!

@infohspn

hspn@utoronto.ca

The Health System Performance Network

hspn.ca

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