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Assessing Value in Ontario Health Links. Part 2: A perspective from early adopter Health Links

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Executive Summary

Context

Ontario HLs are helping to improve coordination of care across multiple partner organizations for patients with complex health care needs; however, little is known about the value that HLs are creating at this early stage and the value that they can generate in the long term.

Objectives

The objectives of this research were to a) define value from the perspective of HLs; b) identify value that HLs may be currently creating; c) single out some of the practices and programs that HLs are currently implementing; d) explore the long term vision for HLs; and e) recognize barriers, enablers, and key resources needed to accomplish this long term vision.

Methods

We conducted a series of 11 interviews with 21 individuals in key positions within 10 HLs across Ontario. The sample was selected in collaboration with the MOHLTC Transformation Secretariat. We identified organizations that were more advanced in terms of program implementation, partner collaboration, innovation and promising practices, and that varied in terms of location, LHIN and type of lead organization.

Results

From the HL perspective, value may be defined concurrently with the aspects identified in our first paper as part of the *Framework for Assessing Value in Health Links*. Elements of value were clearly identified in the domains of patient/caregiver experience, patient care/outcomes, care coordination/integration, cost containment and adequate use of resources. Although domains related to population health were rarely mentioned in the current stages, they were clearly identified in the long term vision for HLs.

HLs have adopted different strategies in terms of governance structure, leadership, and approach to integration. The method that HLs use to identify their target population varies and has evolved over time.

Despite being at early stages of implementation, HLs may already be creating value in the following areas: integration between organizations; coordination of care (care planning and information sharing); patient experience of care; patient care/outcomes; and cost of care.

The most demanded resource by all interviewees was the availability of an IT platform for coordinated care where all providers can see and update the care plan and engage in secure communication.

Implications

Up to this point, HLs have focused their efforts into building productive relationships among partners and a culture of common purpose, with the needs of the client at the centre of the care arrangement. Value created in these areas may have already reflected in improved health care outcomes.

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Context

Currently on its second year since implementation, Ontario's Community Health Links (HLs) initiative has 47 HLs in operation (by July 2014), and more have been announced.[1] Ontario HLs are helping to improve coordination of care across multiple partner organizations for patients with complex health care needs, in accordance to their mandate. However, little is known about the value that HLs can generate for the health care system as a whole. Similarly, it is unknown whether HLs are already creating value to clients and communities, or even if it is possible at all to expect value being created at these early stages of program development.

In a previous report, the first of this three-part research series, we explored the potential for value creation by examining the way that US Accountable Care Organizations define value and comparing the ACO model to Ontario's HLs.[2] Beyond similarities and differences between these two initiatives, we concluded that integration among health care organizations has the potential not only to enhance patient care and reduce cost, but to improve the health of populations, possibly beyond high users.

In this second report, we summarize findings from a series of interviews in which we asked HL leaders to identify the value that is currently being created by their HLs, and the value that can be expected from this initiative in the long term. The third part of this research series will empirically explore value created by HLs through the analysis of applicable health system performance measures.

Objectives

This report responds to an Applied Health Research Question (AHRQ) from the Ontario Ministry of Health and Long-Term Care (MOHLTC) Transformation Secretariat, with specific interest in the identification of value that Health Links add to the health system, such as avoided hospitalizations, reduced complications of care, improved quality of life, etc. In this report we sought to:

- To define value from the perspective of HLs.
- To identify value that HLs may be currently creating.
- To single out some of the practices and programs that HLs are currently implementing and that can influence the potential for value creation.
- To explore the long term vision for HLs once fully developed and functioning.
- To recognize barriers, enablers, and key resources needed to accomplish this long term vision.

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[1] Ontario Ministry of Health and Long-Term Care website; last modified 214-07-31. http://www.health.gov.on.ca/en/pro/programs/transformation/community.aspx

[2] Assessing Value in Ontario Health Links. Part 1: Lessons from US Accountable Care Organizations. Available at: www.hsprn.ca.

Methods

Interview sample

Our purposive sample of Health Links (HLs) was chosen based on two criteria. First, we identified HLs that could provide the most useful information based on the study objectives. In collaboration with the MOHLTC Transformation Secretariat, we identified organizations that were more advanced in terms of program implementation, partner collaboration, innovation and promising practices. Second, we selected HLs from across Ontario that varied in terms of location (urban, suburban or rural), LHIN and type of lead organization. All selected HLs were early adopters of the program. Characteristics of the ten HLs chosen for interviews are provided in Exhibit 1.1.

Exhibit 1.1

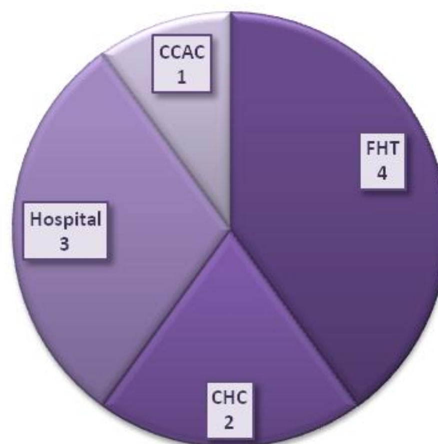
Health Link interview sample

1.1a Number of Health Links

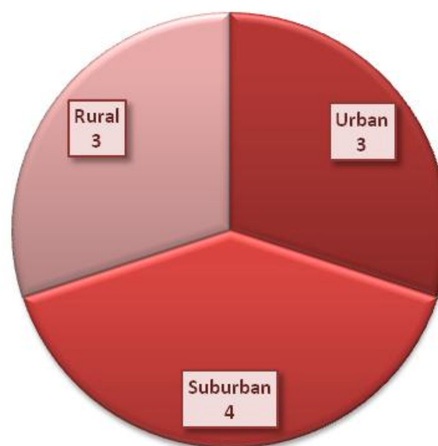
Lead Type*	Location	# HLs sample	# HLs population†
FHT	Urban	1	3
FHT	Suburban	2	6
FHT	Rural	1	7
CHC	Rural	2	5
CHC	Suburban	0	1
CSS	Rural	0	3
CSS	Urban	0	1
Hospital	Urban	2	2
Hospital	Suburban	1	5
Hospital	Rural	0	2
CCAC	Urban	0	2
CCAC	Suburban	1	2
Total		10	39

* One FHO was counted as FHT.
† Only partial data availability.

1.1b Lead Partner Type



1.1c Health Link Location



Interview questions

The interview guide was developed through a collaborative process with HSPRN researchers involved in other projects studying HLs, and individuals from the MOHLTC Transformation Secretariat. The interview guide was piloted with one individual experienced with the HLs program. This was done to ensure clarity of the interview questions and pacing of the interviews. Based on this pilot interview the order of the interview questions was changed, but wording of questions and the length of the interview remained the same. The final version of the interview guide contained 21 questions, each falling under one of three sections: Health Link Organization, Value, and Further Insights. The complete interview guide is included in Appendix 2.

Recruitment

The ten selected HLs were sent an email from partners at the MOHLTC Transformation Secretariat to inform them of the opportunity to participate in a telephone interview. A researcher in our team then followed-up with each HL by email to provide more information about the individuals from the HL sought for the interview, that the interview could be with one to three individuals from the HL, the length of the interview, and options for dates and times. Interviews with more than one participant and holding different positions within the HL were preferred, in order to obtaining the best available source of information and different perspectives that best represent each HL. All ten HLs contacted agreed to participate in the study.

Interviews

A total of 11 interviews were carried out by teleconference with participants from ten HLs between March 26 and April 11, 2014. Interviews were carried out by two of the researchers on our team. The first five interviews were carried out by two interviewers and the remaining six (representing five HLs) by one interviewer.

Four interviews were with one interviewee, four interviews were with two individuals, and three interviews were with three individuals, for a total of 21 interviewees. As shown in Exhibit 1.2, interviewees held different positions within their HL.

Interviews lasted between 45 and 90 minutes, with the exception of one 21 minute interview with a single interviewee. This shorter interview was a result of the interviewee's limited availability. Interviews were recorded with the permission of interviewees in order to ensure accuracy. Recordings were transcribed and each transcription was checked for accuracy by a researcher on our team. Transcripts from the interviews were the only source of data for this section of the study, although the analysis takes into account previous work and general knowledge of the researchers.

Exhibit 1.2

Roles of interviewees related to the Health Link

Organization	Position
Health Link	Executive Director (4) Project Manager/ Director/ Coordinator/ Lead (6) Steering committee member – Clinical (1) Steering committee member – CCAC (1)
Lead Organization	CEO/Executive Director (2) Executive Sponsor (1) Co-Director (1)
Partner Organization	Executive Director – Family Health Team (1) CCAC (2)
Other	LHIN (1) External Consultant – Facilitator (1)

Data analysis

Analysis of interview transcripts began by grouping text according to the corresponding interview question. The data was thematically analyzed by using the main interview question themes of 1) the population focused on, 2) value HL expect to create for the population focused on, 3) organization of HL, 4) practices HL are engaging in to create value, and 5) accomplishments at the present time. Within these main themes, the interview data was also thematically analyzed to find common sub-themes. The Triple Aim framework was also used to guide analysis of the definition of value provided by Health Links and their current value-creating activities.

Findings

Who are the Health Links focused on improving care for?

Target population

The focus of HLs has been on high users of the health care system, particularly seniors with multiple chronic conditions. HLs used hospital data to identify these individuals based on number of visits to the emergency department (e.g. over ten in a fiscal year) and/or number of hospital admissions (e.g. over four in a fiscal year). They also identified individuals based on health conditions, such as Chronic Obstructive Pulmonary Disease (COPD) and/or Congestive Heart Failure (CHF).

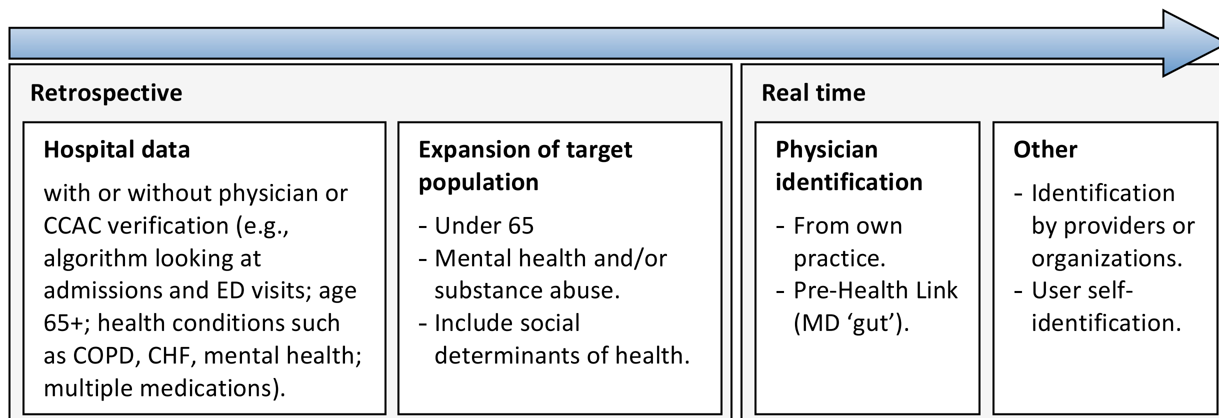
Health Links found that many of these high users had died by the time they had identified them because hospital data is retrospective. This highlighted the importance of earlier identification and many of the interviewed HLs have made efforts to identify patients in real time. Some HLs are including primary care physicians by asking them to identify those who would benefit from the HL. Some HLs are including other providers (e.g., social workers, nurse practitioners, etc.) in efforts to identify individuals who would benefit from more coordinated and integrated care.

Through identifying patients who were high users, HLs realized that other health conditions beyond COPD and CHF were common among high users. This led HLs to expand their target populations to include not only seniors, but younger Ontarians with multimorbidity. As well, HLs noticed that high users were often among individuals with mental health conditions and/or substance abuse, people requiring multiple medications, and individuals requiring supports due to inadequate housing or limited social support.

The stages that HLs may be moving through to identify their target population are summarized in Exhibit 2.1.

Exhibit 2.1

Health Links' process of identification of target population



What value do Health Links expect to create for their target population?

Health Links Value Framework

Health Links were created in Ontario to deliver integrated health care services to high users of the health care system and those with complex health care needs. The value that integration can potentially create is however not limited to a high users alone. Through the interviews, we explored how HLs define value and what value they expect to create for individuals or at any level of the health care system.

Some HLs have explicitly adopted the task of defining their own value framework. In one exemplar case, a collaborative working group was organized, including clients and providers, tasked to specifically define value for their HL, resulting in the following:

> *"As a client I value being treated respectfully, with honesty and trust and as an equal. Valued for who I am and what I am. I value knowing that I will be taken care of with the right service, at the right time, at the right place, in the language of my choice. I have a right to feel safe, to understand and to choose my care and to know that my information will be protected."*

However, in most cases the interview data reflect the personal perspectives of interviewees and, on occasion, responses based on a quick review of the literature by respondents in preparation for the interview. The popular concept of a 'triple aim' was often mentioned, yet with diverse definitions of what interviewees understood that term or framework to mean. For that reason, we rather decided to focus on the content and meanings of HL descriptions of value. Themes and concepts of value were grouped following the *Framework for Assessing Value in Health Links,* previously presented in the first report in this series.[3] A summary of the definition of value from the interviews and the alignment with the framework are presented in Exhibit 2.2.

Patient or client experience of care

A key component highlighted in every interview was the 'patient or client experience of care'. This may be considered a domain of value from the patient/client perspective. Important aspects of value mentioned were:

- timely access to services,
- patient/client satisfaction,
- relationship of trust with individual providers, and
- participation and shared decision making in care plans and goals.

Patient or client care / outcomes

A second key element consistently mentioned by interviewees was patient care, defined in terms of quality of care and sometimes patient safety. Quality of care and patient safety were often linked to patient outcomes when these elements of value were described by interviewees. In Exhibit 2.2, this value domain involves elements from both the patient/client and provider perspective.

[3] Assessing Value in Ontario Health Links. Part 1: Lessons from US Accountable Care Organizations. Available at: www.hsprn.ca.

Integrated and coordinated care

A third element often mentioned was the value of providing integrated seamless care, coordinated among provider organizations. Key elements mentioned were reducing fragmentation and duplication. This value domain includes elements from the patient/client perspective (experience of care), provider perspective (experience of practice), and health care system perspective (use of resources).

Cost of care

The domain of value related to health care costs was considered by every HL in our study, either from the perspective of the cost of care, efficiency, sustainability, or reduction in hospital use. This may be considered a domain that falls into the system perspective.

Population health

The population perspective was almost absent from the definition of value provided during the interviews. Only one interview pointed out the role HLs can have in improving the living conditions of their communities and local populations. In that case, the interviewee(s) indicated that HLs may create value by shifting the health care paradigm towards addressing social determinants of health.

Exhibit 2.2

Value defined by Health Links and alignment with the Framework for Assessing Value in Health Links

AIM	Domain	Perspective	Definition of Value
Better Care for Individuals	**Patient/Caregiver Experience**	**Patient**	Timely access, satisfaction, trust, shared decision making.
	Patient Care/Outcomes	**Patient and provider**	Quality of care and patient safety.
	Care Coordination/ Integration	**Patient, provider and system**	Integrated seamless care, coordination among provider organizations.
Better Health for Populations	**Preventive care**	**Population/community**	Not described
	Healthy lifestyle	**Population/community**	Focus on the social determinants of health
	Target population outcomes	**Population/community**	Not described
Lower Growth in Health Care Cost	**Cost containment**	**System**	Cost reduction, efficiency, sustainability.
	Adequate use of resources	**System**	Reductions in ED visits and hospital admissions.

How are Health Links organizing to create value?

Governance structure

Most early adopter HLs were created by a group of 'core' partner organizations with existing collaborative relationships. Core partners usually include the CCAC, primary care, and acute care hospitals, along with a limited number of other health and social care organizations. All HLs have to designate a lead partner organization when they are first established.

Health Links described a third layer to their organizational structure, including several other partner organizations with various roles in care provision and coordination. The degree of the involvement of these other partners generally depends on the specific population of focus for the HL, the types of programs being carried out, or the commitment of the partner organizations' leaders. These other partners include organizations such as public health units, Emergency Medical Services, police, or even the local municipal government.

Governance of the HL is usually structured around a steering committee, with representatives from most but not all partners, and a variable number of working groups with involvement of key partners depending on local conditions and priorities.

Leadership

Health Link leadership is centralized to different degrees in the lead partner organization or shared among core partners. A few lead partner organizations followed a top-down leadership style by deciding upon objectives, goals, and what programs and activities the HL will carry out. In contrast, other HL lead partners retain the administrative role of leaders, but rely on a more horizontal approach and share leadership among core partners.

Findings from the interviews suggested that HLs led by larger organizations, such as large hospitals or CCACs, had a lead organization that was more dominant compared to the other core partners. On the other hand, interview findings suggested that HLs led by primary care organizations tended to share leadership with core partners. These findings are not surprising given the differences in size, volume of patients, infrastructure, and access to financial and human resources in these organizations.

Leadership may be divided up in terms of three basic roles: administrative, strategic planning, and coordination of care.

- Administrative: this role is generally carried out by the lead partner organization, regardless of the type of organization.
- Strategic planning: this role is either carried out by the lead organization (more the case with larger organizations) or shared by the lead and other core partner organizations (more the case with primary care).

- Coordination of care: CCACs are usually highly involved in this role, given their general mandate. Primary care and hospitals have various levels of involvement depending on who the lead partner is or how involved the core partners are in general.

While primary care practices are more dependent on CCAC and hospital resources to organize a HL, these larger organizations may feel less inclined to collaborate when leading a HL. This may be particularly the case for CCACs, which have carried out most of the care coordination activities in Ontario. While every HL needs to collaborate with the local CCAC to coordinate care, the latter is less dependent on other organizations for care coordination.

In addition to concentrating on care coordination, most CCACs have a history of collaborating with other organizations for certain provincial programs (e.g. collaborating with hospitals for Ontario's *Aging at Home* program). While this can create some advantages, CCACs may not recognize the need to change their current practices when leading a HL.

Among core partner organizations, primary care practices were less engaged in pre-Health Link collaborative activities. Although family physicians often practice in local hospitals, their historical involvement with the LHIN and CCACs has been low. HLs have brought primary care to the table as a major player, and frequently as the lead partner organization. Primary care representation in HLs has been dominated by group practices, such as Family Health Teams (FHTs), Community Care Centres (CHCs), and one Family Health Organizations (FHO). Interviewees revealed that solo-practice family physicians have been more difficult to engage, which represent a particular challenge in regions where solo practices are more prevalent. One HL interviewed highlighted the role of primary care physicians leading the HL in facilitating the engagement of other physicians.

Intensity of Integration: Scope and Breadth

Scope of Integration

Scope of integration refers to the extent to which processes and organizational structures are transformed in order to achieve integration. It answers the question of whether this transformation only affects processes related to high users or whether it also affects partner organizations more broadly. Most HLs included in this study fall somewhere between these two points. The core activities common to all HLs were fairly limited in scope and included resources dedicated to defining and identifying their high user population, and working to complete and implement coordinated care plans.

Interview findings reveal that some HLs have focused exclusively on integrating care to manage their target high users. For example, creating special clinics where high users who meet inclusion criteria are transferred and enrolled to receive integrated care. This more narrow scope of integration is more likely when the lead partner is a large organization, such as a large acute care hospital.

At the opposite end, some HLs are implementing integrated processes that affect their overall activities. When the lead partner is a primary care organization, integration tends to be at a broader organizational level. For instance, some primary care partners have shared successful programs focused on chronic patients

that go beyond the management of the HL's target population. Others have attached care coordinators from the CCAC to every primary care physician or primary care team.

Another factor that influences the scope of integration is population density. HLs located in rural areas tend to involve organizations more broadly than those located in densely populated urban areas. The effect of population density may be related to the size of organizations, the strong pre-existing relationships among a smaller number of organizations and providers, and the higher interdependence among organizations in remote communities.

These relationships are summarized in Exhibit 2.3a

Breadth of Integration

Integration also varies among HLs in terms of the breadth of processes involved. While some HLs are focused almost exclusively on care coordination services, others have been able to put together interdisciplinary teams around coordinated care plans. These interdisciplinary teams can also vary from a few provider types from one or two partner organizations to a broad range of providers across several different organizations.

The relationship between Health Links' characteristics and the approach to integration

Lead partner organizations differ across HLs in terms of type of organization, type of leadership, approach to integration, and governance structure. These differences arise due to variations in local conditions and needs, and because of pre-existing relationships among partner organizations. What works in one jurisdiction does not necessarily work in others. The exploratory nature of this study does not provide evidence of one approach to integration being superior or preferable to others.

Nevertheless, exploring the intensity of integration in terms of scope and breadth, and in relation to leadership type or approach to integration may help the development of the HL program in the future. New adopters can better anticipate what their advantages and challenges to integration will be depending on local conditions.

Despite our small sample, we observed patterns in the relationship between HL characteristics and the approach to integration. These patterns are summarized in Exhibits 2.3a and 2.3b.

Exhibit 2.3a depicts the association that the type of lead organization and the HL's rural or urban location may have with the scope of integration. A broader scope of integration was apparent in HLs with smaller lead organizations (e.g., primary care practice) and those in rural locations. A more narrow scope of integration is likely when the lead organization is a large hospital and in urban areas. CCACs probably fall somewhere in between, and since generally combine urban and rural areas, they are not represent in this diagram.

Exhibit 2.3

Relationship between Health Links' characteristics and the approach to integration

Exhibit 2.3a Scope of Integration by Lead Organization and Geography

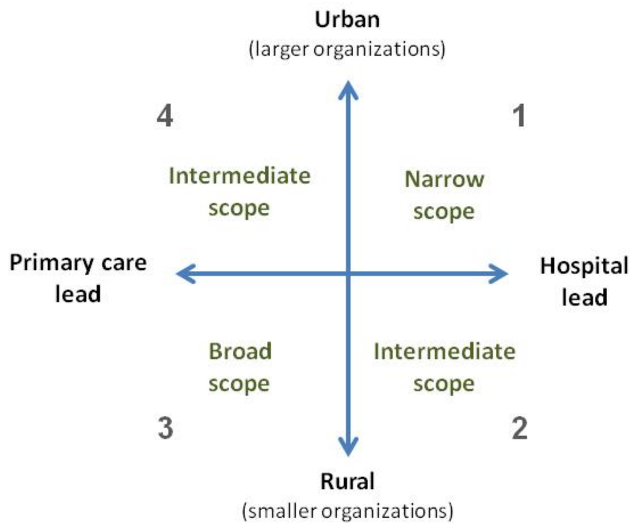


Exhibit 2.3b Integration approach by Breadth and Scope of Integration

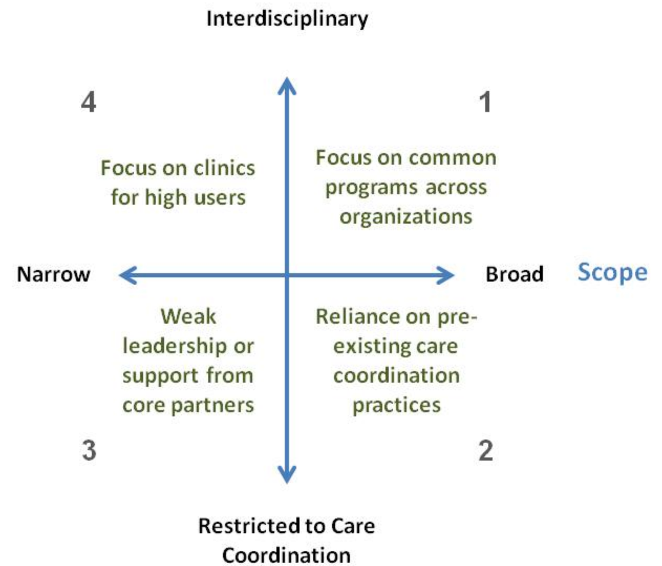


Exhibit 2.3b positions different approaches to integration that HLs have adopted in terms of breadth and scope of integration. Interview findings provide examples of initiatives engaged in by Health Links that fall into the four quadrants of Exhibit 2.3b. An example in Quadrant #4 is clinics for high users, which generally adopt an interdisciplinary approach that is narrowly focused on managing high user clients. In Quadrant #2, HLs where the work has been developed around the care coordination capacity of the CCAC, have a more restricted breadth of integration, but a broader scope of integration that affects processes for clients more broadly, beyond the highest users. Placed in Quadrant #1, HLs that share successful programs (e.g., chronic care programs) across organizations achieve greater breadth and scope, with an interdisciplinary approach affecting broad organizational processes. Represented in Quadrant #3, the combination of a narrow scope of integration also restricted to care coordination was observed in HLs with weaker organizational leadership or with low support from core partners.

Implementing integration among partner organizations is a complex and extensive work that needs to be carried out progressively. The starting point, trajectory, and steps in this process of integration are different for every HL. However, it is expected that newer HLs will have a more narrow scope and restricted breadth of integration and progress to a broader, more interdisciplinary approach.

What practices are Health Links implementing to create value?

We asked interviewees to identify practices implemented in their HL that may have a high impact in terms of value creation. We also identified practices mentioned at other times during the interviews that may be improving care or advancing integration and can be considered by other HLs for implementation. Value created through these practices can be classified according to the domains in our HL value framework. Some of the main practices identified from the interview data are highlighted in Exhibit 2.4, grouped by the domains in our HL value framework. The full list of HL practices identified is provided in Appendix 1.

Exhibit 2.4

Health Links Practices (highlights)

AIM	Domain	Health Link Practices
Better Care for Individuals	**Patient/Caregiver Experience**	- Including patient and family representatives in the HL's steering committee, working groups, and committees. - Conducting patient consultation rounds, through interviews and workshops, to capture their perspective and understand their care needs, before creating the HL's care strategy; e.g. for the care coordination tool. - Developing a secure patient-provider communication tool, a secure interface between patients and caregivers with providers to share messaging, if indicated by the patient. Patients may be able to access their own personal health record. The next step will be to link provider to provider around a circle of care.
	Patient Care/ Outcomes	- Obtaining quick wins using programs from partner organizations that are successfully working with complex patients and adapt them to spread and scale up to benefit the most people as quickly as possible; e.g. HL patients with COPD or CHF are referred to tele-home care program for COPD or CHF, which are not exclusive to HL patients. - Aligning HL programs to existing programs from partners that may be complementary into managing high users (e.g. CCAC's rapid response nurses).

	Care Coordination/ Integration	- Introducing flexibility in terms of the partner organization that leads the coordinator of care on a case by case basis (navigator). This is included in the care plan for every patient, according to individual needs, and with participation of the client and family. The other organizations that come to the table also vary for every patient depending on need. - Creating a primary care clinic operated by an interdisciplinary team to manage unattached high users, including care plans shared among partners. This clinic can then be extended to high users already attached to primary care physicians. - Attaching care coordinators to every primary care physician or primary care practice, as part of the same team. - Organizing coordinated care plan round table or conference sessions that involve interdisciplinary and inter-organizational providers. - Having FHTs advising and leading a HL strategy for physician engagement. - Creating a small 'secretariat' with strong expertise and leadership in care coordination and quality improvement that can advise and support all HLs in one region. - At the launch of the HL, bringing together all organizations potentially involved and using this opportunity to make them aware of and connected to the HL. Even if some of these partners may discontinue they participation if not relevant for their operations, it is easier to work with them afterwards if needed or to reintegrate them as partners if justified. - Bringing an external expert (consultant) to facilitate the implementation and initial operation of a HL governance structure (e.g. steering committee) and to facilitate stakeholder consultations with clients and providers.
Better Health for Populations	**Preventive care**	- Identifying HL patients in earlier stages of chronic disease through real time identification by family physician and other providers
	Healthy lifestyle	- Expanding criteria of HLs' target patients to include substance abuse, inadequate housing, limited social support, and other social determinants of health.
	Target population outcomes	- Using the LACE tool to identify target patients in hospital and primary care sectors and other tool based on RAI data to identify target patients in the community support sector. - Establishing a notification system to identify target patients with ED, EMS and CCAC.
Lower Growth in Health Care Cost	**Cost containment**	Not identified.
	Adequate use of resources	- Using a 'Risk of Readmission' tool to manage transitions between the hospital and the FHT aimed at reducing hospital readmissions. - Opening hospital rapid referral clinics for FHT patients intended to reduce ED visits and hospital admissions.

What have Health Links accomplished so far?

Value currently created

Beyond the value that HL can potentially create when fully functioning, we were particularly interested in the value that HLs may currently be creating in their early stages of operation. All interviewees thought it was too early in the HL program to find significant evidence of value creation in terms of outcomes. At this stage of development, HL have focused on growing partner relationships, identifying targeted high users and developing effective tools, programs and the necessary infrastructure to make care coordination and inter-organizational integration possible and effective.

Even though HLs are still in early stages of development, interviewees identified some early results from the implementation process that create value. The areas most commonly mentioned were:

Integration between organizations

- Strengthening previous relationships among partner organizations.
- Giving a new meaning to pre-existing relationships, around a common purpose and specific goals defined collaboratively.
- Developing new relationships among organizations that did not have a history of collaboration, especially between health organizations and providers of social services.
- Creation of a culture of collaboration among organizations that extends beyond HLs and high users.

Coordination of care (care planning and information sharing)

- Ability to create coordinated individualized care plans common to multiple providers across organizations.
- Engagement of family physicians.
- Provider awareness of resources and services available across the system.
- Medication reconciliation.
- Data sharing in care transitions.
- Improved communication and data sharing among partners.

Patient experience of care

- Overall satisfaction with the care received.
- Patient participation and empowerment.
- Access to primary care for unattached individuals.

Patient care/outcomes

- Improved patient outcomes among groups of high user individuals.
- Better patient outcomes for unattached high users.

Cost of care

- Reductions in ED visits and hospital admissions for groups of high user individuals (e.g. unattached patients – those individuals without a primary care provider).
- Making the infrastructure of hospitals and CCACs (e.g., data, decision support, IT) available to small partner organizations or solo-practice providers, which increases benefits over investment.

These early accomplishments are summarized in Exhibit 2.5, showing alignment with the definition of value by HLs previously introduced in section B of this report.

It is notable that most examples of value being created at this stage are in the domains of care coordination/ integration. The patient and caregiver experience of care is another domain where the value created may already be leading to improvements. Not surprisingly, these domains are the same ones with the highest number of practices, as highlighted in Section D of this report (exhibit 2.4) and in Appendix 1.

It is worth noting that no value was identified in the domains under the aim "better health for populations", despite the fact that several practices were identified (exhibit 2.4 and Appendix 1). This may be related to the relative absence of this dimension in the definitions of value provided by HLs (Section B).

Exhibit 2.5

Value currently created by Health Links and its alignment to the value framework

AIM	Domain	HL Definition of Value	Current Value
Better Care for Individuals	**Patient/Caregiver Experience**	Timely access, satisfaction, trust, shared decision making.	Patient satisfaction, patient participation and empowerment, respect to patients and trust to providers, access to primary care for unattached individuals.
	Patient Care/ Outcomes	Quality of care and patient safety.	Small scale improvement in health outcomes of high users. Spreading successful programs to benefit patients in other organizations.
	Care Coordination/ Integration	Integrated seamless care, coordination among provider organizations.	Individualized care plans, data shearing, medication reconciliation, stronger relationships among provider organizations, culture of collaboration and common purpose across the system.
Better Health for Populations	**Preventive care**	Not described.	Not described.
	Healthy lifestyle	Focus on the social determinants of health	Not described.
	Target population outcomes	Not described.	Not described.
Lower Growth in Health Care Cost	**Cost containment**	Cost reduction, efficiency, sustainability.	Not at this stage.
	Adequate use of resources	Reductions in ED visits and hospital admissions.	Reductions in ED use and hospital admissions for high users.

Moving forward

In order to identify critical issues that may enable or limit the advancement of HLs, we further explored ways that HLs are affecting inter-organizational relationships. We also explored the role that LHINs and CCACs may have at these early stages of HL development. We then inquired about HLs' long term vision, in order to better understand the direction that the current initiatives are taking. Finally, we asked interviewees about enablers, challenges, and necessary resources required for them to achieve that vision.

Organizational relationships

All HLs in this sample reported having strong previous relationships among core partners, along years of collaboration. This is not surprising given that our sample only included early adopters, and collaborative relationships with other organizations is a requirement for HL approval. However, interviewees highlighted four areas of improvement in their organizational relationships resulting from HLs:

1. Purposeful collaboration: Although core partners have collaborated for years, the HL initiative has given them a new, specific, and common purpose for collaboration. They have to develop common plans and programs, set common goals and address issues related to the same population group. This has advanced the culture of collaboration, beyond targeted users, and strengthened inter-organization relationships.

2. New organizational relationships: Another important achievement is the creation of relationships that did not exist previously, or strengthening those that were weak or sporadic. Many new relationships were mentioned during the interviews, including those among hospitals, CCACs, primary care practices, community care agencies, mental health, and other social care partners.

3. Incorporating primary care as a key partner: In regions with a strong tradition of collaboration, organizational relationships typically developed between hospitals and CCACs. Collaborative efforts generally had no or limited involvement of primary care, particularly from family physicians. Several interviewees mentioned that the HL initiative has brought primary care practices to the centre of inter-organizational collaboration, with the development of key relationships to integrate care and increase physician engagement.

4. Relationships between health and social organizations: A fourth achievement in organizational relationships is the fact that the majority of pre-existing relationships were between health organizations and did not include community agencies delivering social care. The HL initiative has led to the inclusion of a broader range of partners, has created more possibilities for collaboration, and expanded the potential to transform care.

The role of the LHINs and CCACs

Several LHINs have decided to adopt the HL model to integrate care across their whole region, and have covered (or plan to cover) the LHIN geography and population with a number of HLs (generally between five and seven). This strategy has frequently included a level of standardization, shared resources, and/or collaboration across HLs within a LHIN.

Health Links serve populations residing within LHIN boundaries where the partner organizations are located. However, many people obtain health care or social services from organizations that belong to more than one HL. Clients of large organizations, such as CCACs and hospitals, generally belong to different HLs (large hospitals' patients even to different LHINs). Moreover, family physicians have patients who may live in a different HL than where the physician is located. This situation imposes a challenge if different HLs within the same LHIN or region adopt different procedures.

Overlapping HLs is expected to be less likely and less of an issue in more rural areas. The geographic distance can make rural areas differ greatly from one another in terms of local conditions and population groups. Because of this, there is a stronger need to develop local solutions. The value of adopting common procedures across a LHIN is reduced in vast regions with low population density because standardized practices may interfere with locally developed solutions tailored to serve the particular needs of the local population.

CCACs play a crucial role in care coordination in all HLs. However, in some regions they have been given an overarching responsibility to standardize processes across HLs within a LHIN. On the other hand, CCACs were generally considered as just one more partner in HLs in rural locations.

Interview data provided us with some evidence of LHINs and CCACs playing a stronger role in areas that are more densely populated, but we cannot conclude whether or not this is a generalizable finding. This hypothesis is however important to keep in mind when planning the advancement of the project and when creating new HLs.

The issue of providers and organizations that serve populations across HLs' boundaries raises the question about whether HL populations should be determined by rostered individuals or by geographic areas. Because patients rostered to a particular primary care physician do not always obtain services from partner organizations within the physician's HL, assigning Ontarians to a HL based on where they live would require a change from current practice patterns. These questions were not explored further in the current study.

Vision for Health Links

Health Links have adopted different models of organization and care delivery to respond to local needs, including differences in available resources and in the relationships among partners. Because of these factors, and the freedom that HLs have been given to adopt their own solutions, the long term vision among HLs differ, particularly at these early stages of development. In order to identify commonalities, we asked interviewees about their long term vision for HLs once their HL is fully developed and functioning. Three recurring themes were found in how interviewees envisioned their HL:

1. A model of collaboration that is a vehicle to transform health and social services into an integrated seamless system of care, that persists over time and extends beyond the high user population, giving importance to prevention.

2. A system of care that is both patient/client-centred and patient/client-driven. This means a system centred on the needs of patients/clients but that also empowers them to become active participants in their own care and health maintenance. This participation and empowerment is not limited to the patient and caregiver but includes social supports in the community as another active partner in delivering better care and producing changes that are needed.

3. A system of care that delivers services individually tailored to meet care needs based on coordinated care plans; involves interdisciplinary teams of providers aware of the care delivered across the system; and is aligned across HLs in the same region.

Interviewees also noted that the vision of the HL once it is fully developed and functioning aligns with the value framework discussed above. This alignment will give mature HLs the full potential to create value.

How to get there?

With the vision of the HLs in mind, we asked interviewees about perceived enablers and challenges or barriers HLs are facing today or may face in the long run that would affect the advancement of the program. We also asked them about additional resources that they considered vital in order to successfully accomplish integration. It is worth noting that despite the fact that our questions differentiated between immediate and long run factors, interviewees focused almost exclusively on current issues, possibly because HLs are in the early stages of development and interviewees are actively dealing with current issues.

Enablers

The key aspects that were highlighted as currently enabling the advancement of HLs are grouped in the following three areas: the HL model; the HL partners; and information access.

The HL model

- The opportunity to find local solutions to local problems.
- Strong pre-existing working relationships.

The HL partners

- Provider engagement and core partners' involvement and leadership and particularly physician engagement through communication and motivation from peers.
- A change in culture of collaboration to become a real system of care. A philosophy of collaboration and common purpose.
- Early realization of the need to collaborate across HLs in the same region.

Information access

- Data sharing agreement, in the few places where it has been possible.
- Having all primary care connected to one EMR system.

In three interviews, the type of lead organization was mentioned as a key enabler. In one interview, having a CHC as the lead partner was referred as an advantage because the CHC model of care is closer to the HL model. In another interview, having a large hospital leading the HL was seen as advantageous because of the amount and diversity of resources that a large hospital has. Finally, having the CCAC leading all HLs in one LHIN could facilitate homogenization of processes and shared resources across HLs.

Challenges and Barriers

Multiple challenges and barriers to the advancement of HLs were raised during the interviews. These challenges and barriers were grouped in five categories: financial; legal; coordination; processes; and related to the Ministry.

Financial

- Billing or allocating cost to multiple organizations that share responsibility for patients.
- Provider compensation may need to change. There is a need to align funding to the goals of physicians and primary care. For example, funding for rostered patients from FHT, FHOs that will now be managed collaboratively with other organizations.
- Uncertainty in future funding and long-term funding model for HLs. Health Links have been mostly built from in-kind resources of partner organizations.

Legal

- Issues with privacy of information that affect sharing information between providers involved in the care of a patient.
- Medical and legal liability of multiple organizations that share responsibility over patients.
- Union resistance to inter-organizational practice and other flexibility in scope of practice.

Coordination

- Insufficient IT systems support. Lack of an IT tool to share care plans among partners.
- Organizational competition for dominance and control over areas of care delivery and leadership. In particular, it was mentioned that some hospitals have been resistant to the idea of having primary care as the HL lead partner.
- Duplication of integrating programs competing with HLs initiatives. They could be included as part of HLs (e.g., rapid response teams and Behavioural Supports Ontario from CCACs, or the discharge bundles project from hospitals).
- Provider engagement, particularly physicians and especially small practice physicians.
- The need for collaboration among HLs due to overlapping boundaries for target populations.
- Lack of awareness of HLs across the system.

Processes

- Care coordination is challenging for CCAC staff within the HL because it involves not only CCAC services but other levels of care, which demand new processes and expertise that have not been available broadly and effectively (e.g. CCAC does not generally manage mental health patients).
- Sustainability of scaling up Coordinated Care Programs as HLs grow.
- Inadequate reporting systems, with indicators that are not correctly focused.

The Ministry (of Health and Long Term Care)

- Skepticism among providers that the broad public system will allow the kinds of systemic transformation required; that the Ministry will be able to allow system transformation to happen locally.
- At the government level, it is necessary to break down some of the existing silos, for example, between health care and social services, or health care and education. The Ministry is even more fragmented than the providers are.
- Slow response from the Ministry to the challenges faced by HLs, even after asking for fast reactions from partner organizations to organize into HLs.
- Expectation of deliverables and the pressure to demonstrate advances when HLs are still building the infrastructure for system transformation.

Additional Resources

The most demanded resource by all HLs is IT support. The most important is the availability of an IT platform for coordinated care where all providers can see and update the care plan and engage in secure communication. Other IT resources that were mentioned include a patient-controlled health record with secure messaging, automatic admission and discharge notifications to primary care, and internet portals to spread what HLs do and services they provide to patients and other providers.

HLs also thought it was crucial to create a provincial strategy and agreement to eliminate barriers to sharing of information. Interviewees requested provincial level policies and support in areas of privacy and consent. Data sharing agreements should include all family physicians and primary care EMR data, together with hospital and CCAC data, shared in integrated data systems.

Another area mentioned by almost every HL was the need for additional human resources. The need to cover the time physicians and other providers spend on participating in care coordination and planning and insufficient care coordinators were the main two reasons given for needing additional staff. In addition, there is a need for a system to compensate physicians for the time they spend on care coordination. Another compensation issue brought up was that interaction between specialists and family physicians could occur more often but is currently hindered because payment to the specialist for consultation (e.g., email or telephone) about a patient cannot occur unless there is a patient referral.

Additional resources for social needs, such as housing, were also mentioned.

Conclusions

Health Links are still in the early stages of development. Achieving effective inter-organizational integration across the care continuum is a challenging process that numerous international examples have shown to require several years -even decades- to reach maturity.

Up to this point, HLs have focused their efforts into building productive relationships among partners and changing the paradigm of fragmented, provider-centred care to a culture of common purpose and collaboration among organizations, with the needs of the client at the centre of the care arrangement.

Although improving medical outcomes and reducing cost of care is essential, the value that can be created by HLs should not be understood exclusively from this perspective. The patient experience of care is an important dimension of value that can be enhanced at early stages of HL development. In addition, improving coordination of care, strengthening relationships between health care organizations, and increasing collaboration among health care organizations and social care organizations will generate value for both users and providers of health care services.

Despite the focus of the HL initiative on the high user population, it is clear that integration across organizations has the potential to improve care and create value for a broader population of clients, possibly all users of the health and social care system. HLs may not be aware or understand the full potential for improving population health. This is apparent in that interviewees rarely mentioned the population and community perspectives among the dimensions of value that can be created by HLs. However, interviewees envisioned HLs as delivering integrated care to all individuals, not only high users, in the long run.

The issue of targeting the high users remains challenging and a single preferred approach has not yet been identified. HLs have expanded their methods for identifying target patients, from identification of high risk patients using retrospective data to using real time identification. They have also expanded the criteria they use from solely based on hospital use and a few chronic conditions to include multimorbidity, mental health and substance use, and social issues. Questions still remain regarding the advantage of offering a broad basket of services to a defined population group or matching tailored services to specific patient groups that will benefit from them.

Health Links allow for local solutions to local problems, but interviews revealed that provider organizations want support and leadership from the Ministry. This support may be even more critical for new HLs, which may not start with strong pre-existing relationships among partner organizations. The availability of technology and regulations allowing patient information to be shared among providers is essential to effectively coordinate care across the continuum.

Lessons from the HL initiative on organizational collaboration can and should be learned by every organization in the health and social care system, including organizations in current and newly created HLs, the Ministry, and the LHINs. Nevertheless, achieving truly patient-centred, integrated health and social care may also require breaking down silos within and across ministries at the provincial government level, and beyond the MOHLTC.

Appendix 1: Full list of Health Links practices

AIM	Domain	Health Link Practices
Better Care for Individuals	**Patient/Caregiver Experience**	- Including patient and family representatives in the HL's steering committee, working groups, and committees. - Conducting patient consultation rounds, through interviews and workshops, to capture their perspective and understand their care needs, before creating the HL's care strategy; e.g. for the care coordination tool. - Defining value through a collaborative process including patients and provider. - Encouraging participation of the client and family in the design of individualized care plans. - Developing a secure patient-provider communication tool, a secure interface between patients and caregivers with providers to share messaging, if indicated by the patient. Patients may be able to access their own personal health record. The next step will be to link provider to provider around a circle of care. - Creating a Patient Advisory Council to bring the voice of clients to the HL, with participation of users and providers.
	Patient Care/ Outcomes	- Obtaining quick wins using programs from partner organizations that are successfully working with complex patients and adapt them to spread and scale up to benefit the most people as quickly as possible; e.g. HL patients with COPD or CHF are referred to tele-home care program for COPD or CHF, which are not exclusive to HL patients. - Aligning HL programs to existing programs from partners that may be complementary into managing high users (e.g. CCAC's rapid response nurses). - Organising primary care case review sessions (Learning Circle) that include HL patients and invite providers from key partner organizations to give their perspectives.

	Care Coordination/ Integration	- Embedding HL's operations within normal processes of partner organizations; e.g. HL patients get referred and are managed through usual CCAC processes. - Introducing flexibility in terms of the partner organization that leads the coordinator of care on a case by case basis (navigator). This is included in the care plan for every patient, according to individual needs, and with participation of the client and family. The other organizations that come to the table also vary for every patient depending on need. - Creating a primary care clinic operated by an interdisciplinary team to manage unattached high users, including care plans shared among partners. This clinic can then be extended to high users already attached to primary care physicians. - Attaching care coordinators to every primary care physician or primary care practice, as part of the same team. - Having pharmacists accessible to care coordinators. - Organizing coordinated care plan round table or conference sessions that involve interdisciplinary and inter-organizational providers. - Having specialists and family physicians come together and discuss how to improve communication across the hospital and the primary care setting. - Planning inter-organizational staff sessions to improve referral; e.g. mental health and ED staff. - Standardizing referral forms to interdisciplinary clinics from ED and other hospital services. - Asking patients to carry a summary of their health history and care plan with them, sometimes called a passport. - Creating data sharing agreement among partners; e.g. data sharing system between hospital and primary care for HL patients, expected to be extended to all patients. - Having FHTs advising and leading a HL strategy for physician engagement. - Having primary care physicians from partner organizations cross-appointed at the hospital department of family medicine. - Creating a small 'secretariat' with strong expertise and leadership in care coordination and quality improvement that can advise and support all HLs in one region.

		- At the launch of the HL, bringing together all organizations potentially involved and using this opportunity to make them aware of and connected to the HL. Even if some of these partners may discontinue they participation if not relevant for their operations, it is easier to work with them afterwards if needed or to reintegrate them as partners if justified. - Bringing an external expert (consultant) to facilitate the implementation and initial operation of a HL governance structure (e.g. steering committee) and to facilitate stakeholder consultations with clients and providers. - Giving coverage to a whole LHIN's geographic area with 5 to 7 HLs, with CCAC partnering with all HLs and large hospitals partnering with multiple HLs. HLs may be lead by middle size organizations, such as FHT or CHCs. - Implementing a System Navigation Community of Practice, an initiative by Public Health which is designed to elevate the skill sets and standardizes practices across system navigation in different agencies.
Better Health for Populations	**Preventive care**	- Identifying HL patients in earlier stages of chronic disease through real time identification by family physician and other providers
	Healthy lifestyle	- Expanding criteria of HLs' target patients to include substance abuse, inadequate housing, limited social support, and other social determinants of health.
	Target population outcomes	- Using the LACE tool to identify target patients in hospital and primary care sectors and other tool based on RAI data to identify target patients in the community support sector. - Establishing a notification system to identify target patients with ED, EMS and CCAC.
Lower Growth in Health Care Cost	**Cost containment**	Not identified.
	Adequate use of resources	- Using a 'Risk of Readmission' tool to manage transitions between the hospital and the FHT aimed at reducing hospital readmissions. - Opening hospital rapid referral clinics for FHT patients intended to reduce ED visits and hospital admissions.

Appendix 2. Health Link Interview Guide

	Introduction:	**Prompts (if needed)**
	Thank you for agreeing to speak with us today about *[name of Health Link]*. We are working with the **Transformation Secretariat at the Ministry** to understand what is working and what remains challenging for Ontario's Health Links and wanted to speak with you about your Health Link. We are investigators with the **Health System Performance Research Network**, which is a multi-institute University-based research network funded by the Ministry of Health and Long Term Care to develop and spread knowledge related to health system performance. Our area of research is different from work currently undertaken by the Ministry through Price Waterhouse Cooper and the Health Links Steering committees. We will focus on your Health Link and its activities and what you perceive to be the effective means by which your Health Link may **increase value** in the health system. Do you mind if we record this interview to ensure accuracy? The recording will be transcribed and then the audio file will be immediately deleted. *[If yes]* Okay, I'll turn the recorder on now. Do you have a copy of the questions in front of you?	
	Descriptive information *(only ask question if necessary)*	
	[Address by name] what is your role within your organization? Within your Health Link?	

	I. **Health Link Organization**:	
	1. What approach does your Health Link take to coordinate care among partners? What is your leading organization's role in this approach?	
	2. In general, how involved or active are partner organizations in your Health Link? • they are as involved as your lead organization is, they are co-leaders; • they are active followers of your lead organization's initiatives; • they collaborate but only partially; OR • they are part of the Health Link but participation is minimal.	
	3. What were the pre-existing relationships between your partner organizations, prior to the creation of your Health Link? • intense collaborators; e.g. co-leads in prior initiatives; • moderate collaboration; e.g. some minor common initiatives, patient transfers, or shared information; OR • minimal or no collaboration.	
	a. How long had these relationships existed?	
	b. Have those relationships become closer or have they remained the same after the formation of your Health Link.	
	4. Why does your Health Link have this particular composition of partners? (i.e. beyond the Ministry requirements)	
	5. What are some examples of how your partner organizations contribute to the operation of the Health Link?	• Participate in HL organizational planning, • Patient coordinated care plans, • Identifying patients in target population, etc.
	6. Do any organizations (lead or partner) provide more services to your Health Link's target population than others? If so, which ones?	Is this "imbalance" necessary? A problem?

II. <u>Value</u>:		
The MOHLTC Action Plan calls for "Better patient care through better value from our health care dollars". Health Links are one approach for achieving this action plan.		
	7. How would you define "value"?	*Let interviewee(s) answer. We are interested in what value means to the HL.*
	8. Would other partners in your Health Link define value differently? If so, how?	
	9. What value is your Health Link **currently** creating?	• improve target population outcomes, • reduce costs for target population, • benefits to other patient populations, • benefits to caregivers, • benefits to HC providers, • greater coordination/integration, • benefits to the HC system (reduced costs, reduced utilization, reduced ED visits, etc.) • Increased sustainability of the HC system
	10. What practices or activities would you highlight based on the value they create?	
	11. What practices or activities do **not** create value?	
	12. How do you define your target population?	
	13. How do you identify your target population? Do you think there is a better way?	*Will use data on population identification from the PwC spreadsheet when available to support this question*

	14. What do you think about identifying your target population earlier in their conditions' trajectory? • Is this beneficial? • Is this feasible? • How would you do it? • What would be needed?	Better tools, better data mining, use indicators, provider referrals, etc.
	We would like to let you know, just as a point of introduction, that HSPRN, in collaboration with the Institute for Clinical Evaluative Sciences (ICES) and with each HL, is very interested in being able to track the patient trajectory for patients who are included/enrolled in HLs. To do this, HSPRN needs to partner with HLs who would distribute a consent form (approved by an ethics board) to their enrolled patients asking them whether they would be willing to confidentially share their health card numbers. There is not obligation on the part of patients. This information would allow researchers to track their health care use to see the impact that the HL initiative is having on their care, by comparing their care over time and to similar patients who are not currently being enrolled in HLs. Would you be willing to be contacted by Dr. Walter Wodchis so he can follow-up with you and provide more information about this? (Yes or No)	
	Would you please share with us by email the list of indicators of performance that your HL is currently using?	
	15. What indicators/measures of performance are used by your Health Link to make sure you are creating value as you just defined it?	Any indicators other than those used by the Ministry?
	16. Are there other practices or activities that you currently implement or plan to implement that you think are successful or are promising?	• Activities that affect the target population? • Activities in partnership with other HL partners?

III. Further Insights:		
	17. What is your vision of your Health Link once it is fully functioning or developed?	
	18. What **current** enablers and challenges support or hinder the accomplishment of this vision?	• Identifying target population • Getting, sharing, and using data (patient data to identify/evaluate and/or best practice), privacy of data • Electronic health records (linkage?) • Identifying interventions to implement • Agreeing on care plans • Governance • Funding • Daily operational issues
	19. What additional resources would help your Health Link to achieve that vision? Are these resources likely to be available? *If the interviewee(s) ask about the meaning of 'successful' = producing value as discussed above*	• LHIN or MOHLTC support/guidance, • increased data availability/access, resources (HR – data analysis; financial), • tools (guidelines, communication of best-practices of other HL)
	20. What additional challenges might you face in the future?	
	21. Knowing what you know today, what might have been done differently in the launch of your Health Link to ensure success?	