HSPN Health System Performance Network

Considering Evaluation

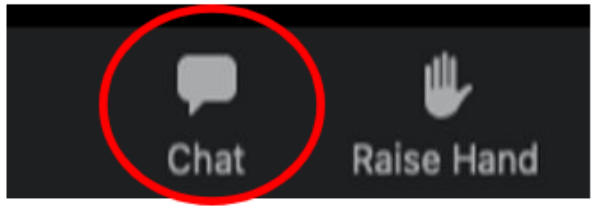
Learning Health System Series Part 6: Supporting Evaluation in Learning Health Systems: What do OHTs need to know?

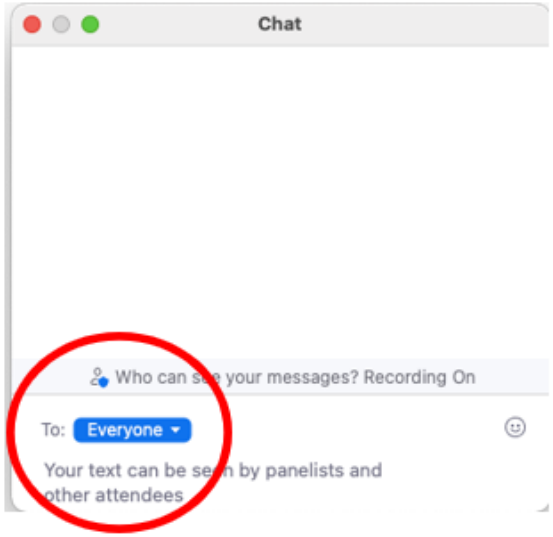
HSPN Monthly Webinar

November 26, 2024

Welcome & thank you for joining us!

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





➢Open Chat

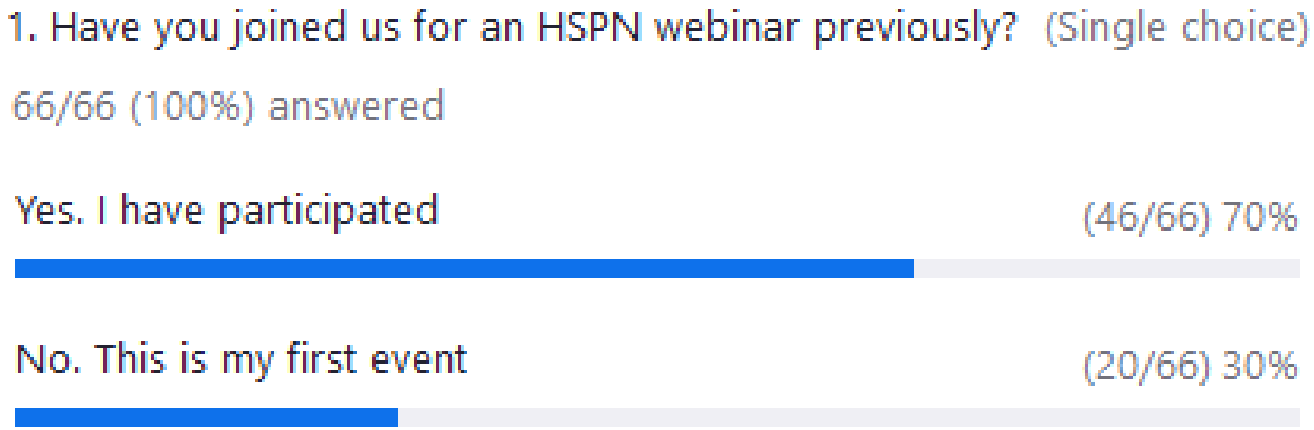
➢Set response to everyone

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.

Poll 1


1. Have you joined us for an HSPN webinar previously? (Single choice)
66/66 (100%) answered
Yes. I have participated
(46/66) 70%
No. This is my first event
(20/66) 30%

HSPN Health System Performance Network

Today's event: Supporting Evaluation in Learning Health Systems: What do OHTs need to know?

Host

Dr. Walter Wodchis
Principal Investigator
HSPN

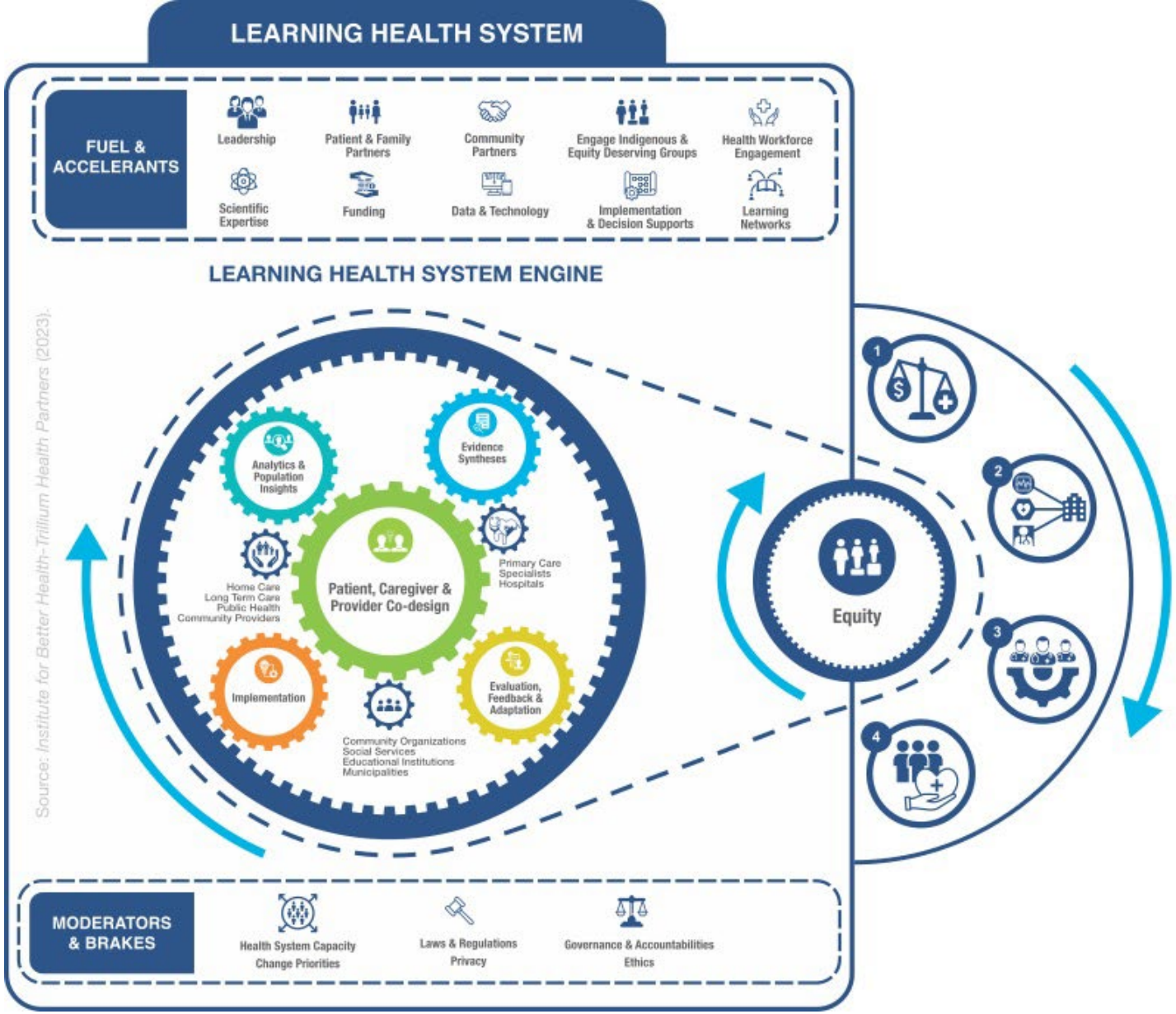
Presenters

Dr Catherine Donnelly
Associate Professor
Queen's University
FLA OHT

Dr. Reham Abdelhalim
Manager, Population Health and Evaluation
Burlington OHT

Dr. Brianne Wood
NOSM
RISE

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 5: Evaluation, Feedback & Adaptation

Description: Using multiple evaluation methods to measure how well a multicomponent intervention is working on a population and under what conditions. Constant feedback via intervention data is used to adapt the intervention to match patient needs.

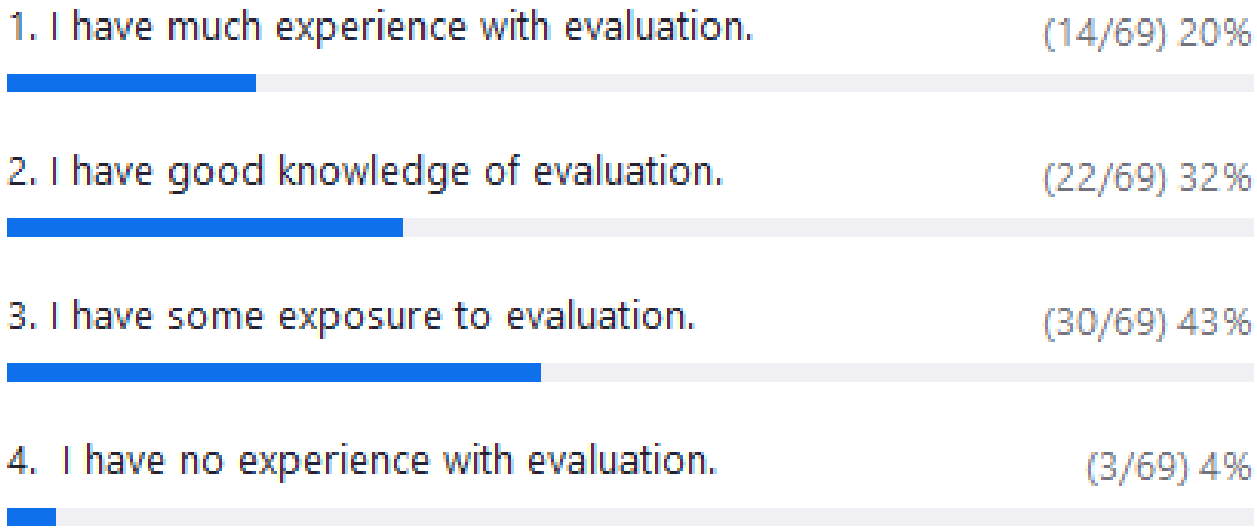
Sample Questions: What evaluation logic model should be used? Are change processes being cemented? What degree of "reach" across equity-deserving groups? Are hypothesized outputs/early outcomes being achieved? Are there unintended consequences? What adaptations are needed to cement & scale?

Health System Affinities: Quality Improvement teams, performance management, business Intelligence/decision support/evaluation teams, clinical informatics etc.

Poll 2

1. What is your experience with evaluation? (choose 1) (Single choice)

69/69 (100%) answered



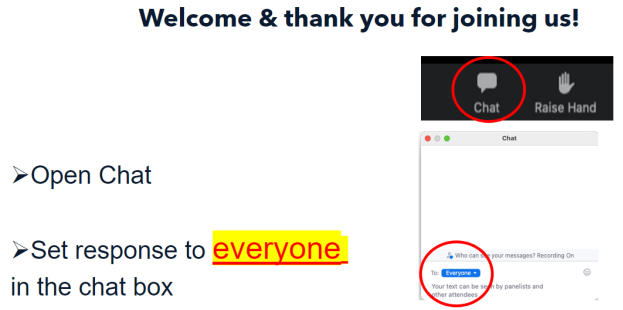
The Practice of Evaluation

A Brief Review:

- Logic Models
- Measures
- Study Design

Poll 3: USE THE CHAT FUNCTION !

Open text in the chat.



(think of a program that you are trying to implement)

What word(s) come to mind when I say:

“ You should evaluate your program! ” ?

Operationalizing Evaluation Using Logic Models

- Flashback to early HSPN programming:

- Logic Models: February 2020
  https://www.youtube.com/watch?v=HsJeisL92DY

  Measures for Logic Models: November 2020
  https://youtu.be/ARIDYwkbNS4

HSPN

What is a logic model?

- Logic models visually summarize how a program is expected to work by listing: what resources will be used, what activities will be completed, and how the activities will lead to outcomes

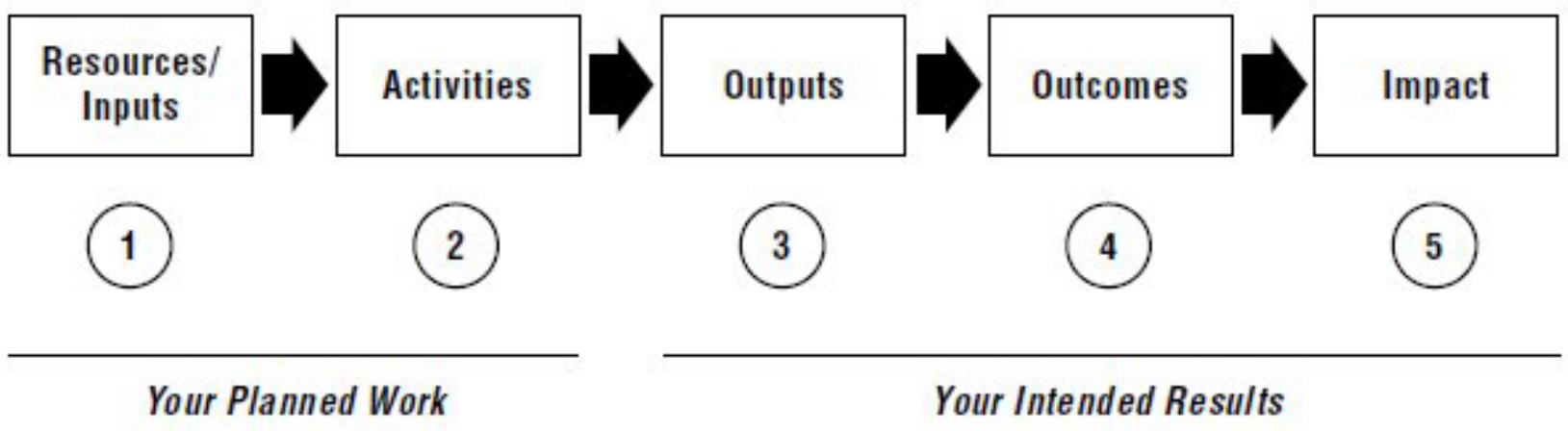


Figure 1. The Basic Logic Model.

HSPN

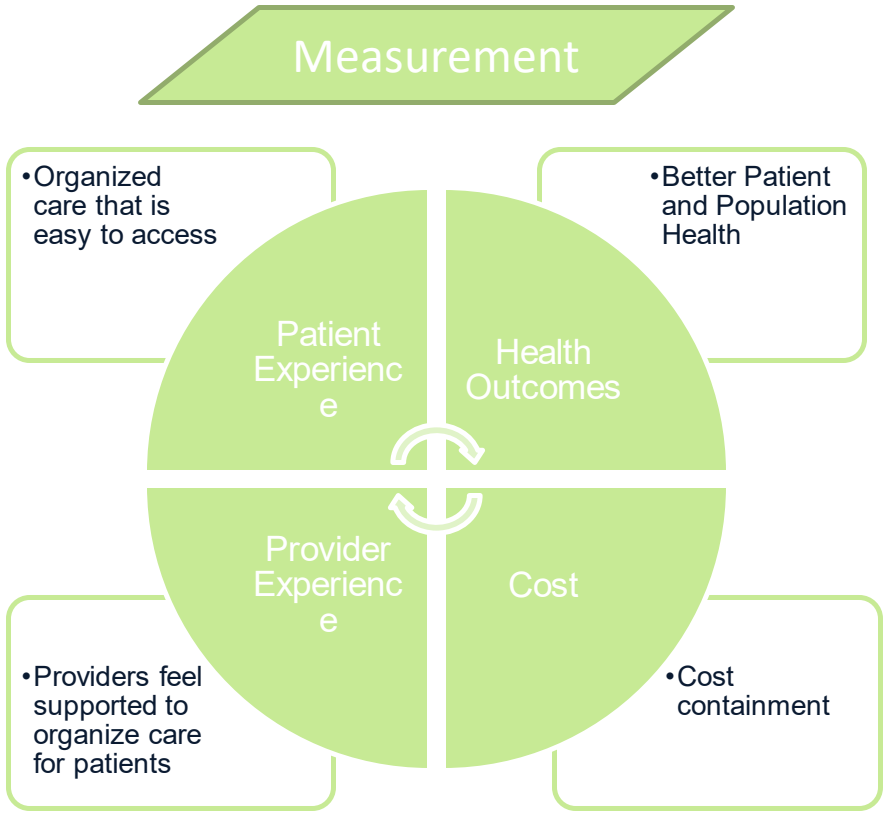
WK Kellogg Foundation: Logic Model Development Guide, 2004

Logic Model for <Title of Intervention>

Resources/Inputs	Activities/Strategies	Outputs	Outcomes (Short & Long-Term)	Impact
What resources will enable the set of activities?	In order to address the issue, we will conduct the following activities. These activities are required to achieve our desired outcome.	These outputs should help monitor progress towards outcomes. Once completed or underway, the activities will produce the following evidence of service delivery.	We expect that if complete or ongoing, these activities will lead to the following changes in 1-3 years then 4-6 years	What is the goal of the program? What issue are you trying to address? We expect that if complete or ongoing, these activities will lead to the following changes.
•	•	•	•	•

Available at https://hspn.ca/evaluation/oht/related/logic-model-resources/

Quadruple Aim Measurement

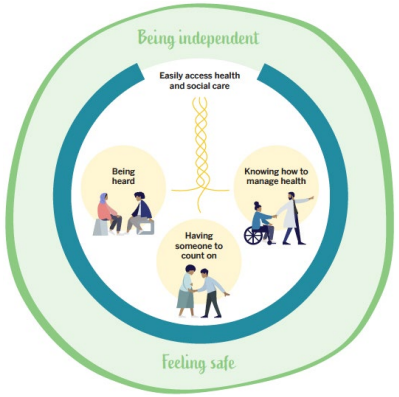


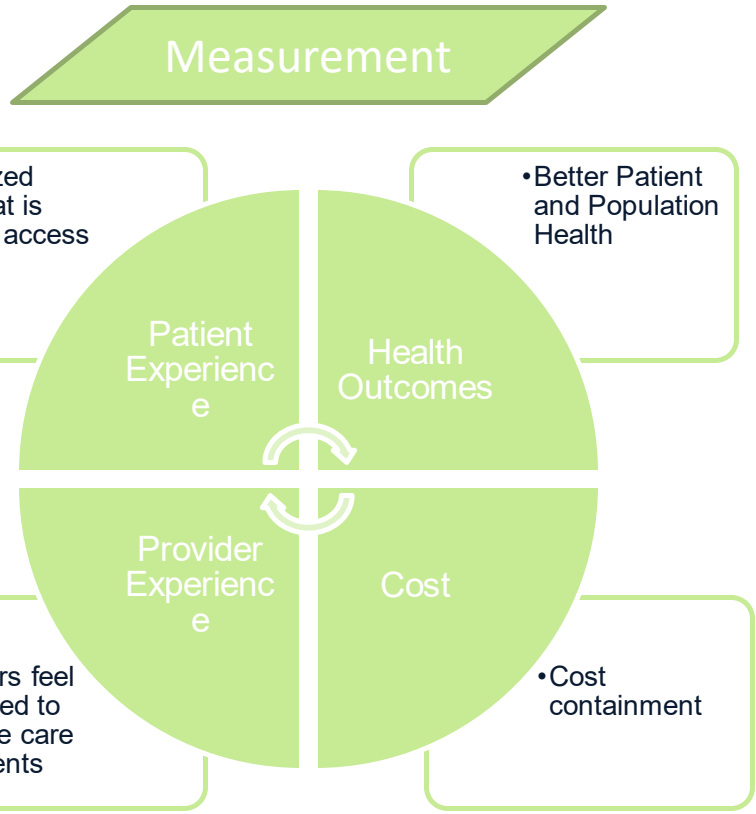
Equity assessed in Each Quadrant

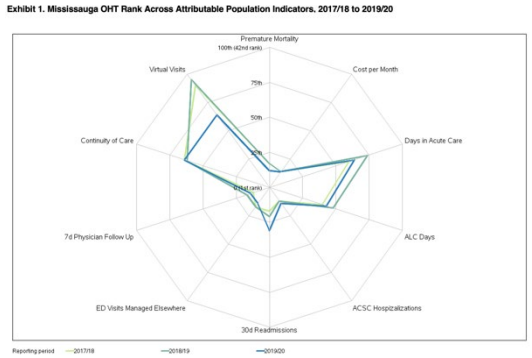
HSPN

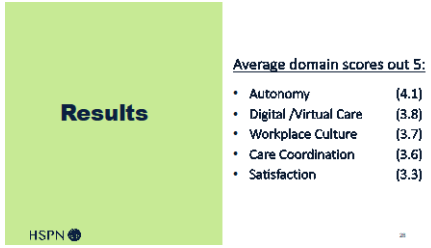
Meaningful indicators
Provided to teams at the front lines to monitor and adjust
+
Robust Evaluation

Quadruple Aim Measurement



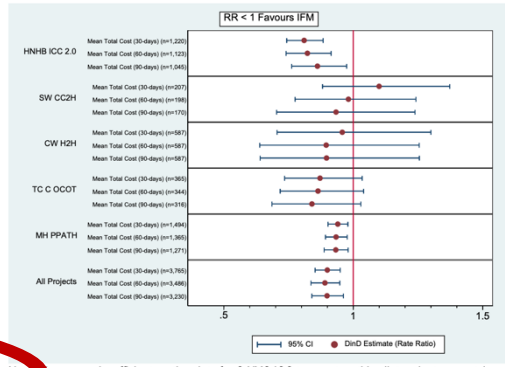






Average domain scores out 5:

- Autonomy (4.1)
- Digital /Virtual Care (3.8)
- Workplace Culture (3.7)
- Care Coordination (3.6)
- Satisfaction (3.3)



Equity assessed in Each Quadrant

HSPN

Measurement: Using Logic Models in Evaluation

Level	Inputs/ resources	Activities (Processes)	Outputs	Short-term Outcomes	Long-term Outcomes	Impact
Description of Logic Model component						
Measures (Definition)						
Data source						
Extraction/ Approach to data capture						
Frequency of reporting and audience						

HSPN

Available at https://hspn.ca/evaluation/oht/related/logic-model-resources/

Example designs for evaluation:

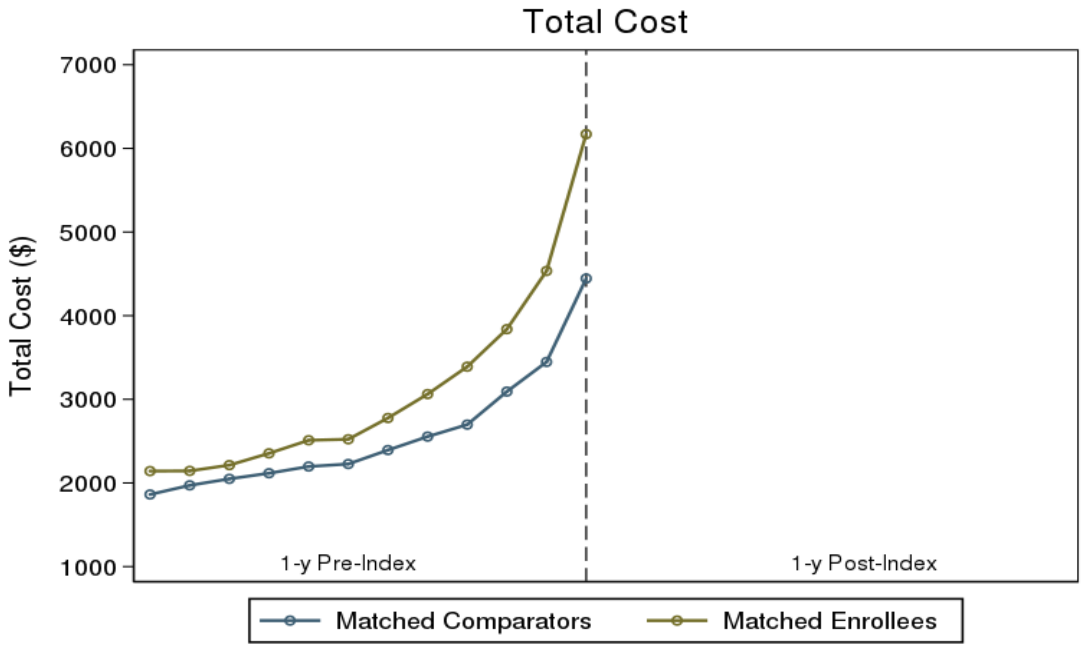
Case study: Study what happens during/after implementation

Before and After: measure twice and see if there is a difference

Quasi-experimental: Add a comparison group and/or time-series

Example: Deep Dive on 3 Health Links

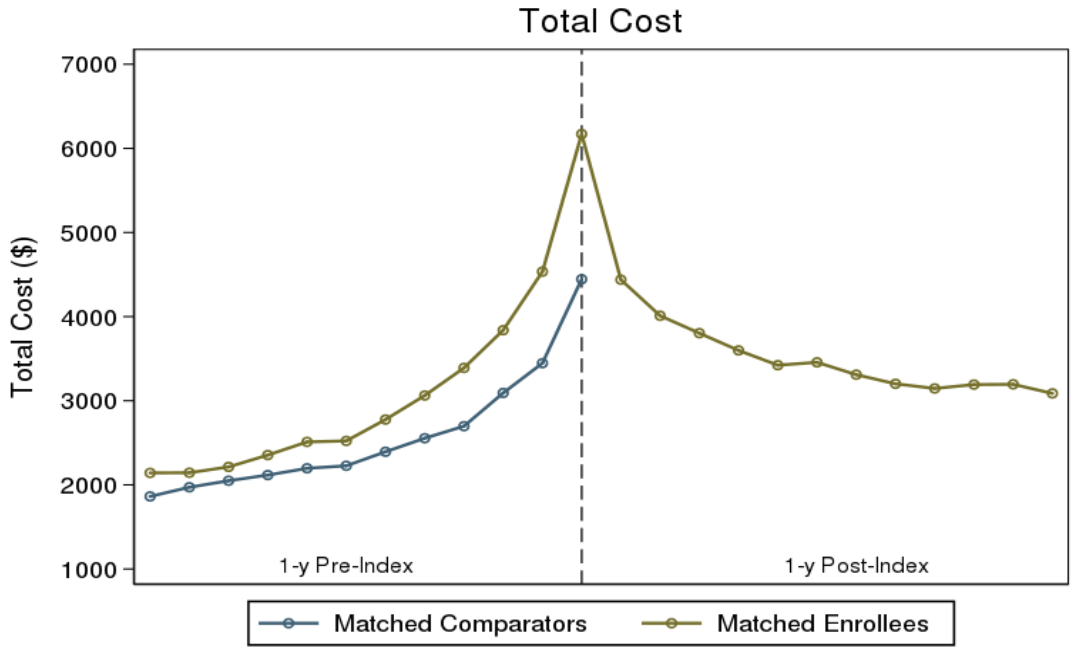
Comparable Pre-index Trajectories in Total System Cost



HSPN

Example: Deep Dive on 3 Health Links

Enrollee Costs Decline after Health Links Start Date

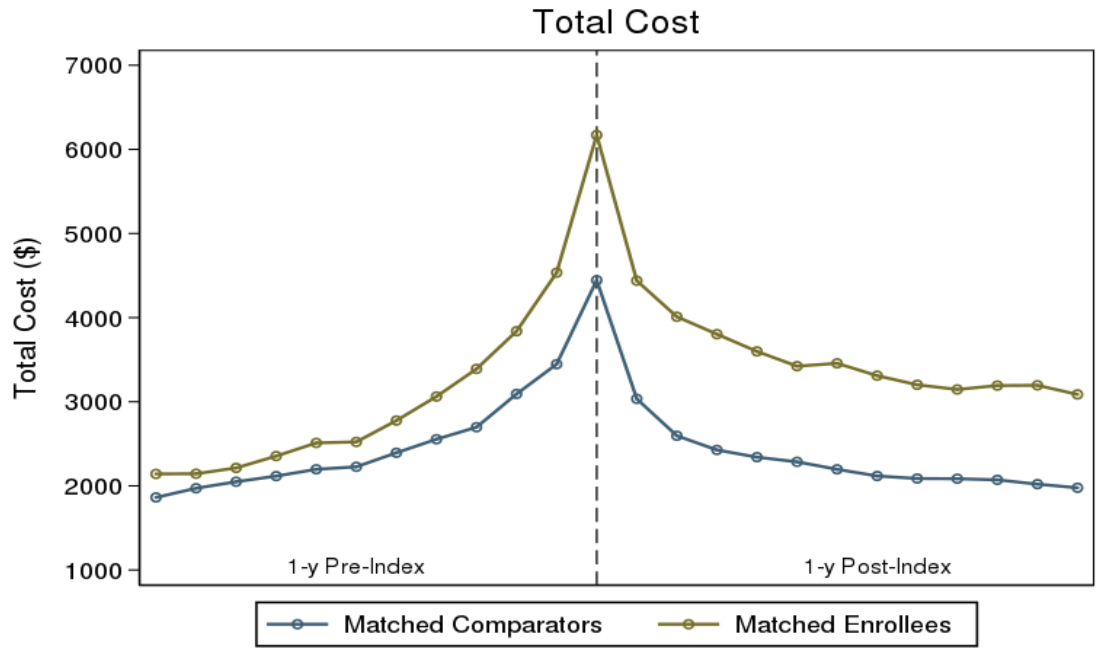


HSPN

Example: Deep Dive on 3 Health Links

Robust Evaluation ! Only known by having a comparator

Comparator Costs Decline More Than Enrollee Costs



FOR MORE INFORMATION SEE: Mondor L, Walker K, Bai YQ, Wodchis WP. *Evaluation of Health Links on health services utilization in the Central Ontario health region: a propensity-matched difference-in-difference study*. CMAJ Open (2017). DOI: https://doi.org/10.9778/cmajo.20170054

HSPN

Learn More: Community of Practice

Evaluation and Performance Improvement for OHTs

Who is it for?

- People working on evaluation and performance improvement in OHTs

What can members do?

- Share experience across OHTs
- Access and share evaluation and measurement resources
- Connect at monthly teleconferences
  - Second Tuesday of the month, 12:00 -1:00 pm
  - Past Topics included Using IDS, Evaluating Patient Engagement, Survey Methods

HSPN

Recent & Upcoming CoP meetings

2nd Tuesday of the month, 12:00-1:00 pm

Oct 8 *Assessing Learning Health System Capabilities: A Self-Assessment Tool for Continuous Improvement*

Nov 12 *Analyst Café: Sharing experience and challenges across OHTs*

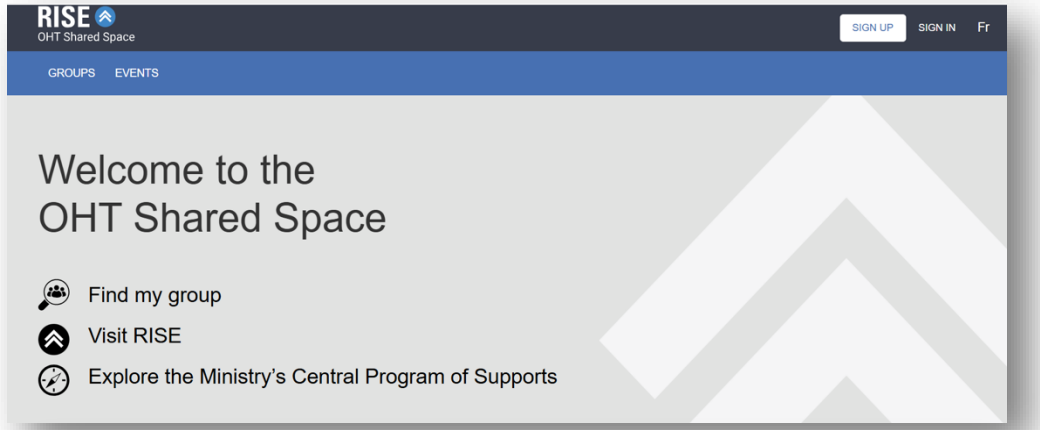
Dec 10 *Evaluating Digital Health and Virtual Care Solutions*

Check the OHT Shared Space for registration after our next meeting

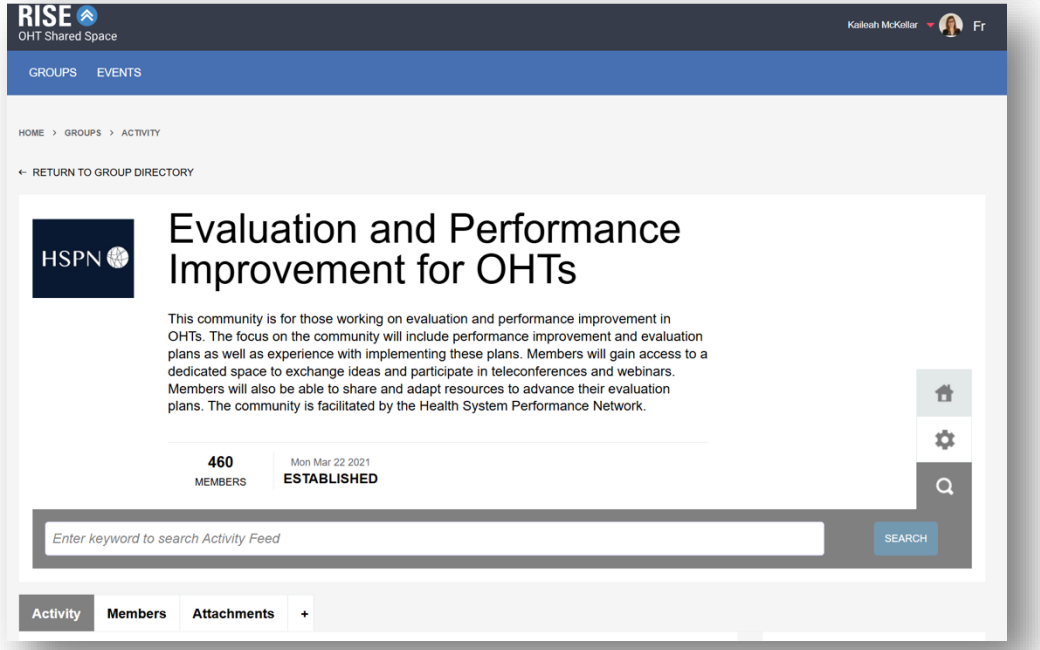
How do I join?

Check the chat box for links

1. Visit the OHT Shared Space and click the “Sign Up” button



2. On the Collaboratives page, look for the **Evaluation and Performance Improvement for OHTs** community of practice and click “Join Group”



HSPN

HSPN Health System Performance Network

Today's event: Supporting Evaluation in Learning Health Systems: What do OHTs need to know?

Host

Dr. Walter Wodchis
Principal Investigator
HSPN

Presenters

Dr Catherine Donnelly
Associate Professor
Queen's University
FLA OHT

Dr. Reham Abdelhalim
Manager, Population Health and Evaluation
Burlington OHT

Dr. Brianne Wood
NOSM
RISE

Evaluation: The foundation Health homes

…. A meandering path

Catherine Donnelly, PhD, OT Reg (Ont.)
Associate Professor, School of Rehabilitation Therapy
Director, Health Services and Policy Research Institute
Chair – QUEST – FLA-OHT

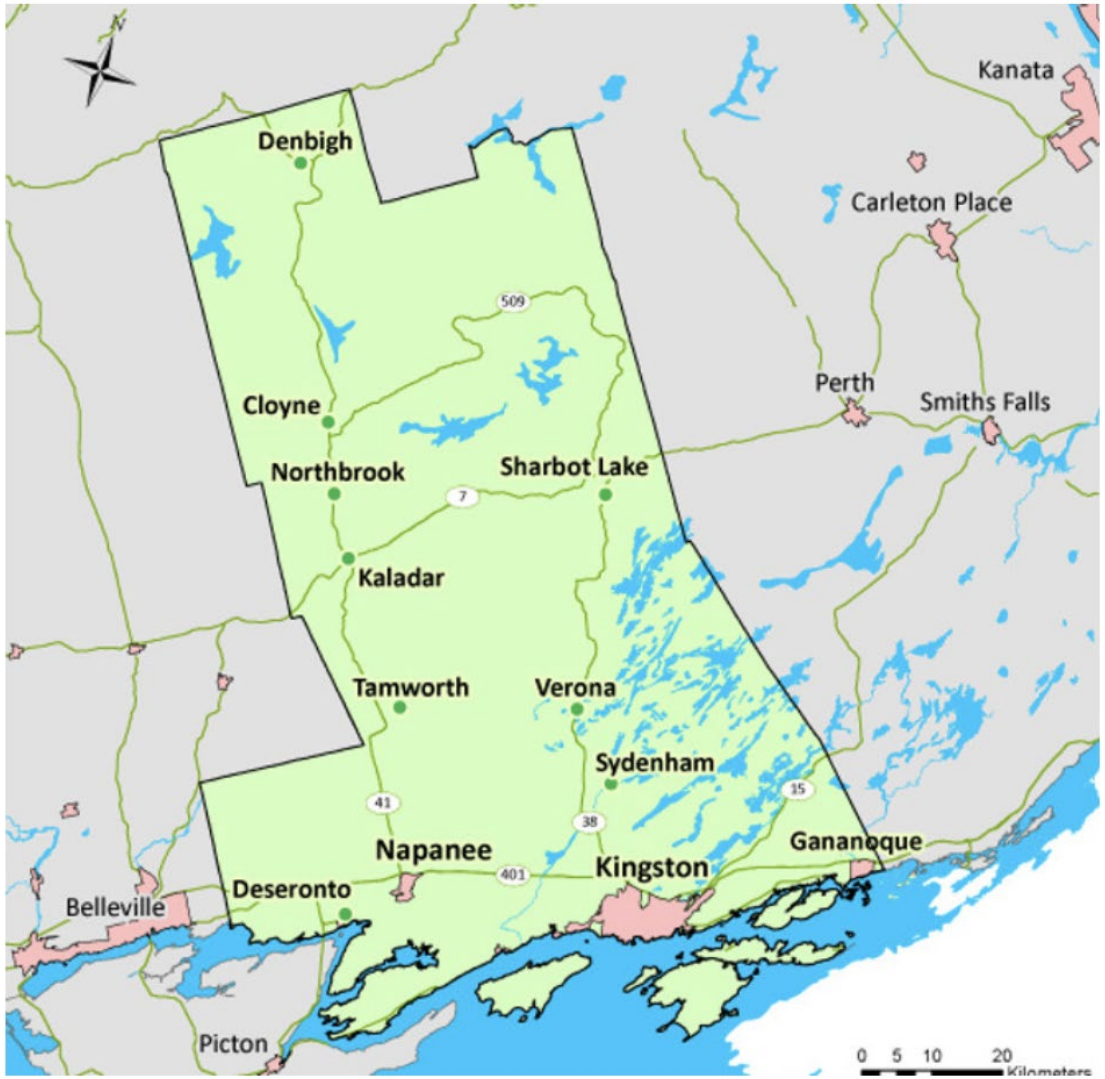
Queen's University
Health Services and Policy Research Institute

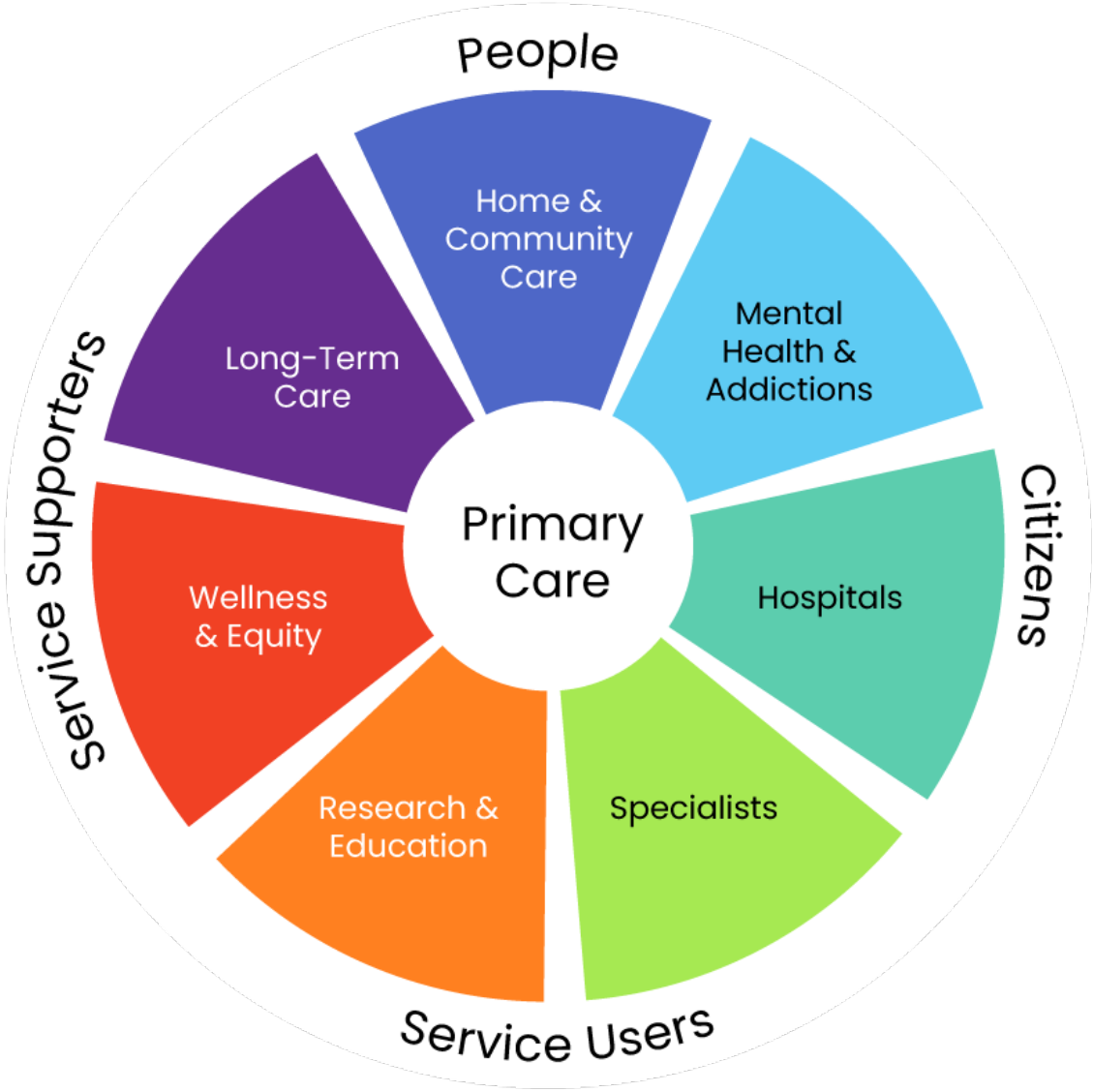
FLAOHT Frontenac Lennox & Addington Ontario Health Team

ÉSOFLA Équipe Santé Ontario de Frontenac, Lennox et Addington

Queen's University

Frontenac Lennox Addington OHT





FLAOHT | ÉSOFLA

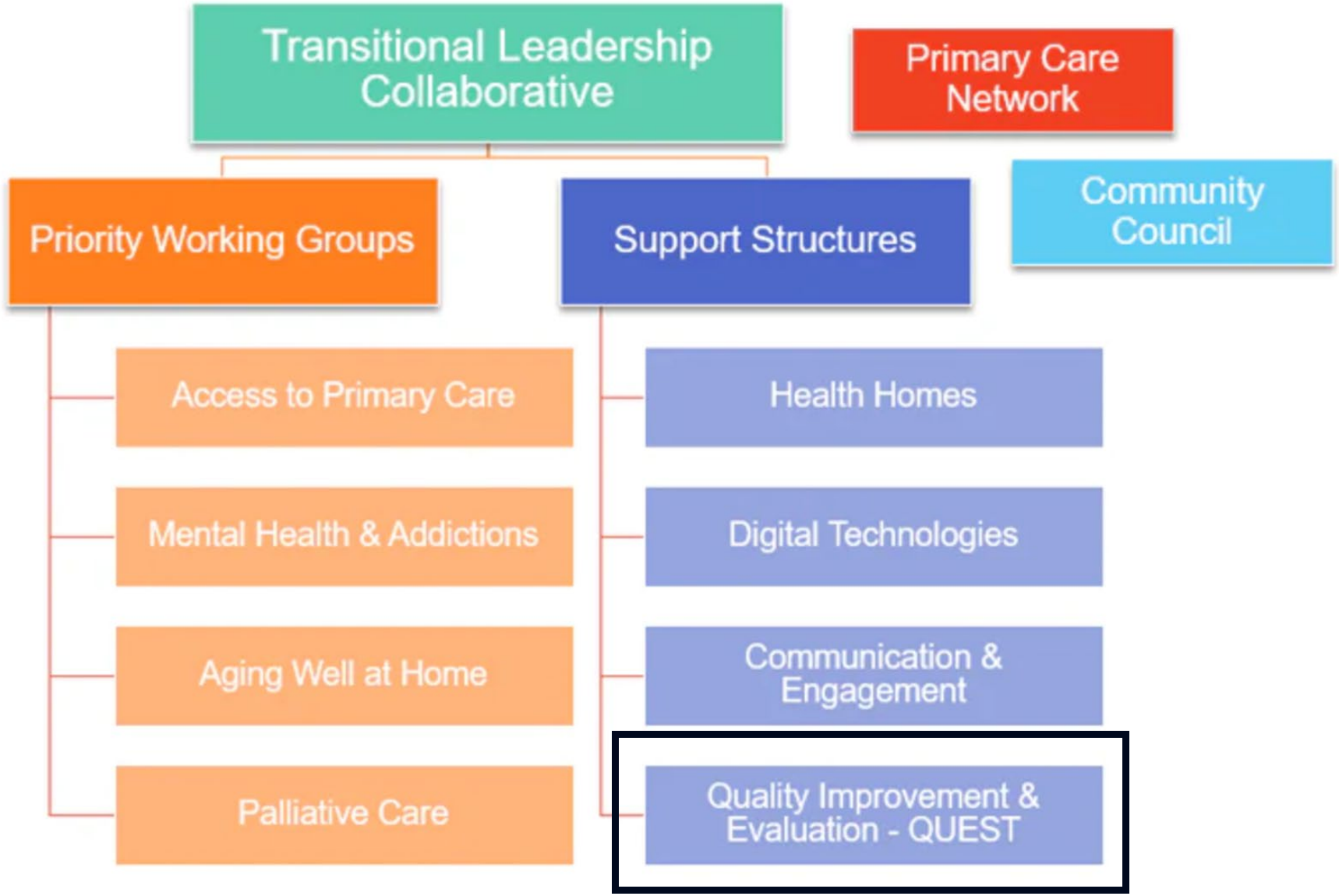
Our mission

A People-Centred Health Home for everyone in Frontenac, Lennox & Addington counties

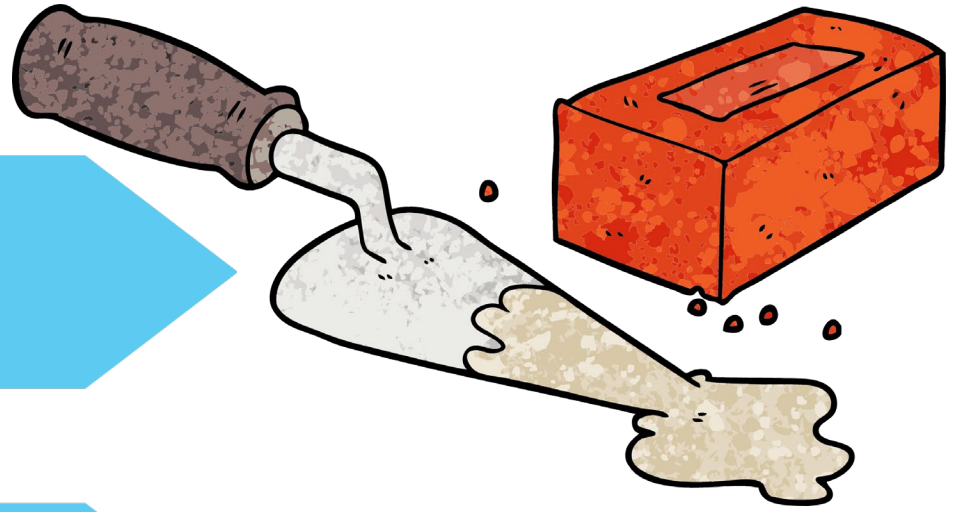
Our vision

A healthier community where we all have equitable access to high-quality care, services and supports that empower us toward Achieving our best health

FLA OHT Organizational Structure



Application: Priority Populations and Indicators



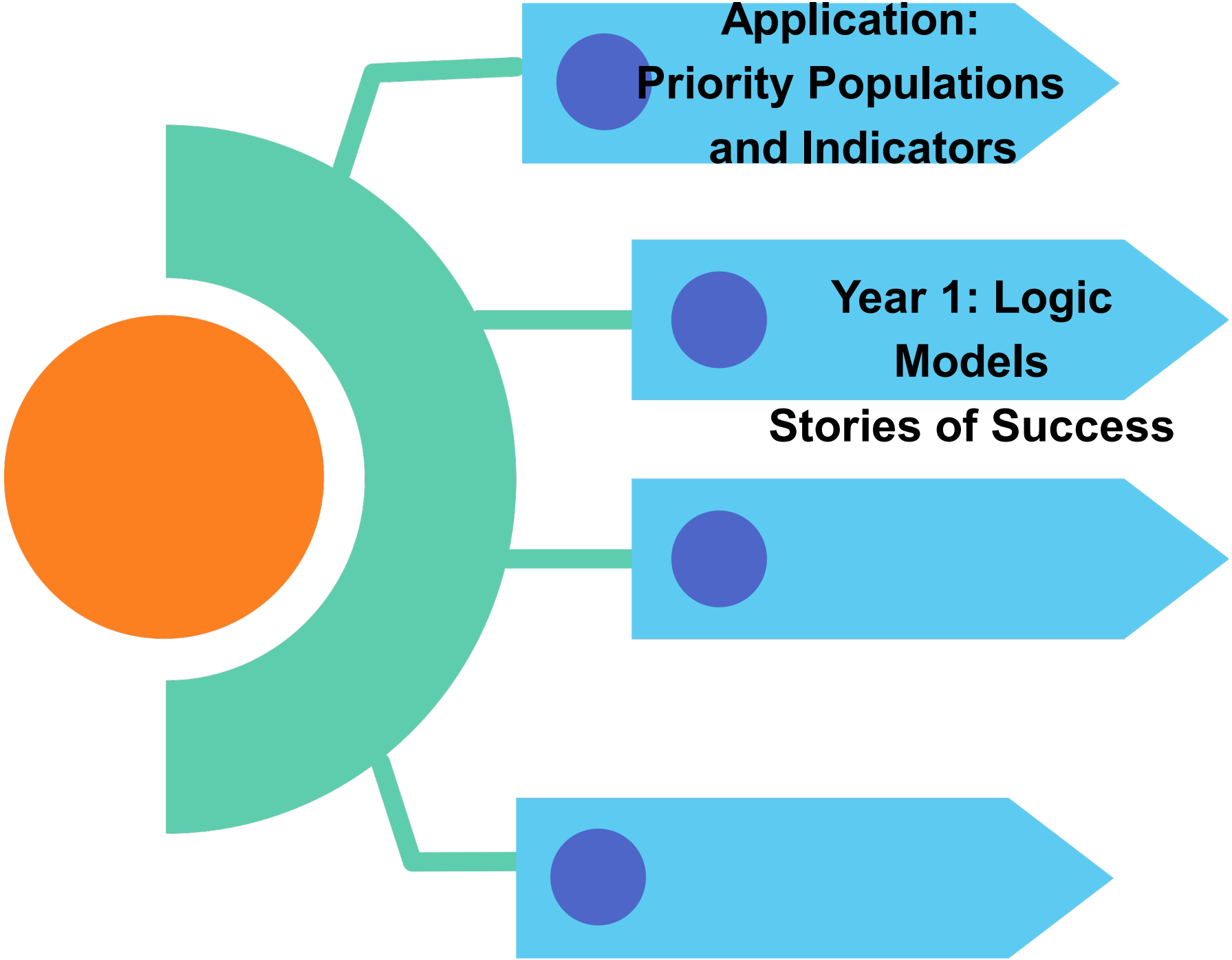
Application: FLA-OHT Priority Populations

People aging

People eligible for palliative services

People living with mental health

People at risk of hospitalization:



FLAOHT
Frontenac Lennox & Addington
Ontario Health Team

ÉSOFLA
Équipe Santé Ontario de
Frontenac, Lennox et Addington

Year 1: FLA-OHT Priority Populations

1. Community member
2. Primary care physician
3. Evaluation rep

People aging

People eligible for palliative services

People living with mental health

People at risk of hospitalization:

WORKING – DRAFT Logic Model

Aging Well @ Home

Inputs

Human resources
Health home team members (physician, interprofessional health supports, administrative support)

Aging @ Home Advocate

Health neighbourhood members - Community support service providers;

Embedded home and community care coordinator (and services);

Unpaid supports; Aging program providers; Community volunteers

SE Health – Health and Social Care Organizer

Community Resources
Frailty Network
Community resource inventories

Aging Programs and Services *(e.g.public health – programs and campaigns, Community support service, Community programs for older adults,LTC outreach)*

Technical Support
Online Aging Services Inventory
Integrated EMR ***(Digital Support)***

OHT Working Group Supports
Co-leads
Working group members
Work group project manager

Data
HCC data – for LTC, HC referrals and use
QI data – locally

Population

- Older adults living well in the community
- Older adults receiving or eligible to receive home and community care
- Older adults with unmet needs, medical and social complexity - at risk of LTC

Activities

Aging Services Inventory
Inventory of older adult program and services

- Maintain current list of programs and services
- Support interface that is easy t use

Aging @ Home Advocate
Knowledge broker of community resources to support aging well @ home

- Familiar with inventory of neighbourhood resources
- Consult within medical home
- Educate health neighbourhood
- Attend Aging @home rounds
- Liase with community programs

Embedded Case Coordination
Home and community case manager for all older adults in health home

- Manage all older adults for designated health home
- Attend at Aging @ home rounds

Embedded Health and Social Care Coordination
Specialized health and social support coordinator for older adults with unmet health and social needs

- Provide additional direct health services in the home
- Identify health and social programs for unmet needs
- Coordinate health and social providers
- Attend at Aging @ home rounds
- Communicate plans in health home EMR

Aging @ Home Rounds
Monthly rounds with health and CSS providers

- Develop and review care plans with providers and family
- Support implementation of care plan
- Communicate care plan with team

Outputs

- # of programs and services in the inventory
- # of people in the health home/neighbourhood using inventory in health home
- # of health home consultations
- # and type of community education sessions
- # & type of communication with programs
- # care plans developed and reviewed
- # and type of attendees at rounds
- # and type of communication points with health home
- # of referrals, # of referrals accepted #older adults on HCC caseload
- # of joint visits
- # of older adults receiving direct care from health and social care organizer

Positive experience of people and their families with programs and support in the community

- reported access to programs, involvement in decision making, perception of how care is organized and ability to have someone to count on if a need arises. (Patient experience survey)

Positive experience of providers with integrated care

- reported care coordination experience, burnout and overall satisfaction, experience of integration of care (Provider experience survey)

Enhanced health and wellness

(Indicators: Health related quality of life (ED-5- from Patient Survey) , cognition, caregiver distress, physical function (SF-12)

Increased use of and access to required health home and health neighbourhood programs

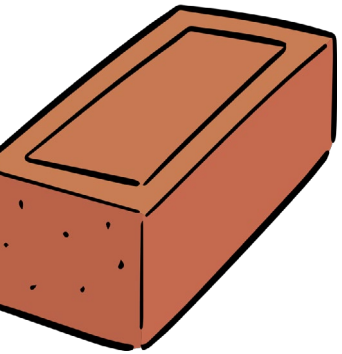
Enhanced access to and use of home and community care (Indicators - # of PSW, #nursing, # allied health, time to access home care)

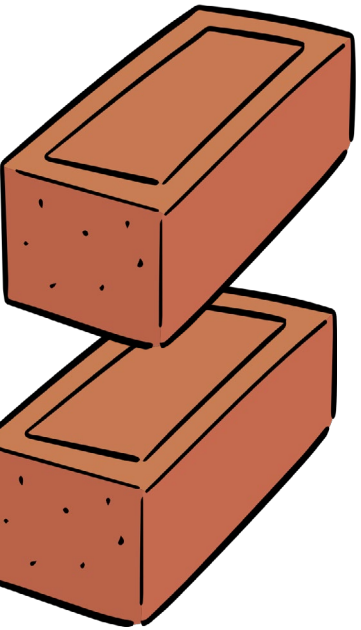
Enhanced access to and use of community supports (# of community programs accessed)

Enhanced access to and use of primary care physicians and team members (# of physician visits, # and type of IHP visits)

Reduced use of institutional care (hospitalization, emergency department visits and LTC)

(Indicators - # family doc visits, # LTC referrals, # LTC admission; # ED visits; unplanned hospitalizations, Hospitalizations for Ambulatory Care Sensitive Conditions (TPA); % ALC Days (cQIP)





WORKING – DRAFT Logic Model

OHT

Other cQIP indicators:
- # unattached individuals successfully attached

Other TPA indicators:
- % screening-eligible individuals up-to-date with cancer screening (Pap, mammogram, colorectal)

Inputs

- Human resources
- Community Resources
- Community Programs
- Community Engagement
- Technical Support
- Financial Resources
- Data
- Partnership Council
- Community Council
- Indigenous Circles
- Réseau
- Project Management and Administration

Support Structures

Digital Technologies
Single common electronic platform

Health Homes
Refinement of definition of health home
Support health homes to provide core services
Engagement with equity seeking groups

Communications and Engagement
Oversee and manage communication infrastructure & tools
Establish frameworks and plans to guide communications & engagement
Empower project groups with tools & support
Support OHT corporate communications
Monitor & provide advice re: contentious issues & government relations

Finance & Resources
Support management of budget
Facilitate OHT financial reporting to MOH
Support the costing of initiatives identified by the working groups
Identify funding models within the OHT & develop a budget model to support long term sustainability

Quality, Equity, Evaluation & Education

Activities

- Aging well at home
- Integrated addictions and mental health care
- Coordinated Discharge
- Palliative Care

Population

- Older adults
- Individuals with addiction or mental health related care needs
- Individuals discharged from FLA hospitals or at risk of hospital admission
- Individuals with palliative care needs

Short term Outcomes

- Increased use of and access to required health home and health neighbourhood programs
- Reduced hospitalization and admission to LTC
- % ALC days (cQIP)
- Hospitalizations for ACSC conditions (TPA)
- Positive experience of providers with shared care discussions (TPA)
- Rate of ED visits as first point of contact for MHA-related care (cQIP)
- Reduced inpatient readmission
- Enhanced health and wellness
- Positive experience of providers with integrated care
- Positive experience of individuals and their families with programs and support in the community
- Reduced emergency department visits
- Positive experience of clients and their families with the transition process
- Better Integration
- % ALC days (cQIP)
- Increased access to home visits
- Improved number of patients matched to preferred place of death

Medium term Outcomes

- Older adults living well for longer in their homes
- Improved addictions and mental health care
- More efficient and coordinated discharges
- Improved care for individuals with palliative care needs

Improving patient experience | Improving population health | Improving health care utilization | Improving Care team wellbeing

Aging Well @ Home

"beginning a cultural shift around aging to home"

"helped to ensure we were meeting our objectives... and we were consistent in our approach over the year"

"we are resourcing aging as a priority in our health home"

Starting a conversation about an alternative view of aging.

There is an alternative to long term care at all levels ... and the need for integrated care"

"bringin the FLA-OHT Aging community together"

Using a population approach to define interventions

Integrating resources in one health home to change how we support aging

AGING WELL @ HOME COMMITTEE; EMBEDDED HOME AND COMMUNITY CARE COORDINATOR. AGING @ HOME ADVOCATE. AGING @ HOME ROUNDS.

1. Increase focus on upstream interventions

2. Spread elements to other health homes

3. Garner organizational support for new ways of working to support aging

Sticky points ... hurdles to our work

- Current work in aging is fragmented
- Lack of an integrated EMR
- Risk of burnout of working group members
- Money and people to implement and sustain change
- Attitudes towards aging and doing things differently

FLA-OHT | ESOFLA

Addictions and Mental Health

Creation of a community of practice

"The relationships we've been building with ... primary care providers, and not just the family physicians, but ... their teams"

"We've created a community of practice to help with the sustainability of this"

Hearing and valuing lived experience

"The experience voice was very strong and diverse... whenever somebody spoke, everybody listened... That was the piece I felt most proud of [was] that everybody felt that their voice [was] heard"

Momentum and belief in vision

"Participating in something that was meaningful, that was going to [do] some good"

1.Continue to develop and build relationships with health homes and primary care providers

2. Include shared care discussions in all health homes

3.Expanding shared care discussions outside of primary care (e.g., integrated care hub, Kingston & Frontenac Housing Corporation)

Sticky points ... hurdles to our work

- Finding the right balance for group membership
- Need funding for lived experience advisors
- Tension between different partners
- Scope creep

FLA-OHT | ESOFLA

Coordinated Discharge

'The right people at the table at the right meeting ...that helped us move forward.

Community and Commitment

We have a really engaged core group

We have worked really hard as a group and there's going to be such beneficial things to the patient

they all come back to the driver diagrams that were created based upon those initial conversations

Change ideas built on Evidence, Standards and Concensus

They grew from that initial review of the literature, the standards and bringing everyone together

There was a consensus across a wide variety of care providers and organization of what the gaps were

Improvement Specialist

looking at the processes and structures ...to help us to identify action plans to move forward

1. Secure Resources to Implement Change Ideas

2. Identify metric of success in alignment with intervention

3. Identify additional change ideas to implement

Sticky points ... hurdles to our work

- Misalignment of resources with the change ideas - need to secure funds, resources and people
- Challenge to follow a quality improvement process
- Metric of success - primary care attachment - was not aligned with the change ideas of the working group.
- Digital health integration

There was no funding for us to try and move forward.

I didn't realize that after you give the mandate, you then had to go and find out somebody who is willing to pay for it.

The scramble for resources is something for me. It was totally unexpected.

FLA-OHT | ESOFLA

Palliative Care

"We really do want to see a system that's better for our patients, giving them better care and better services and better opportunities and better outcomes"

Increased level of engagement

"We've never had anything... with this much kind of power and engagement and ability to ... collaborate... and it hasn't died off"

Coming to a shared understanding

"We've come to a shared place of understanding around current national standards for palliative care... and then use that to inform our work"

Matching unrostered patients

"I'll put that call out and somebody will directly answer me and say 'yes, I could take that patient on'"

1. Identifying strategies to enhance the experience of Indigenous persons with palliative care needs

2. Increasing collaboration with the intergrated care hub

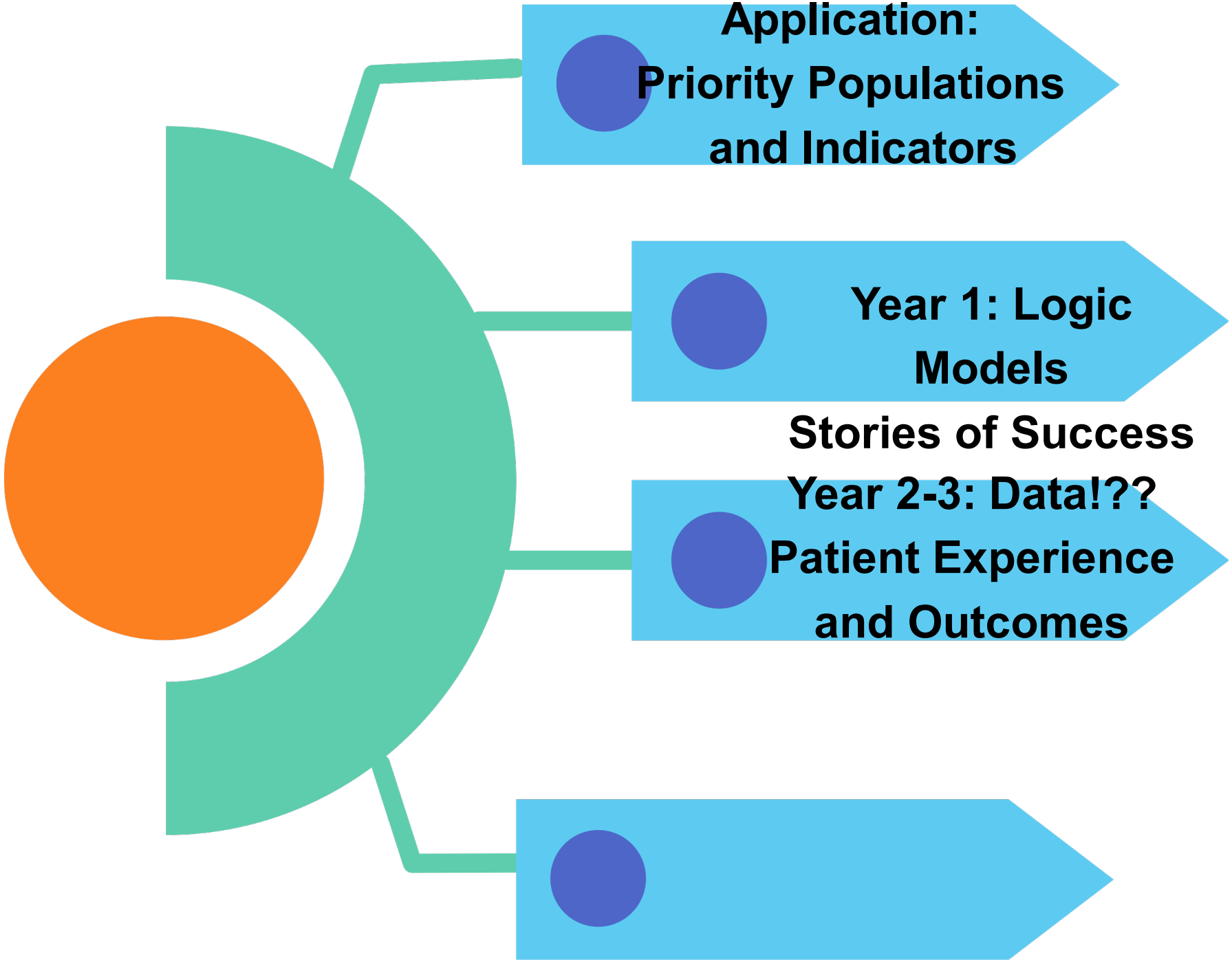
3. Discussions on how to provide palliative care monitoring to those in rural and remote communities

4. Development of a digital palliative care plan

Sticky points ... hurdles to our work

- Changes in group membership and project management
- The impact of COVID: fatigue and being pulled in many different directions
- The need for reallocation of funds to allow work to move forward
- Stakeholder politics: providers will need to change the way they are working

FLA-OHT | ESOFLA



FLAOHT
Frontenac Lennox & Addington
Ontario Health Team

ÉSOFLA
Équipe Santé Ontario de
Frontenac, Lennox et Addington

Learning health system ---- Where's the data??

Learning health system ---- Where's the data??

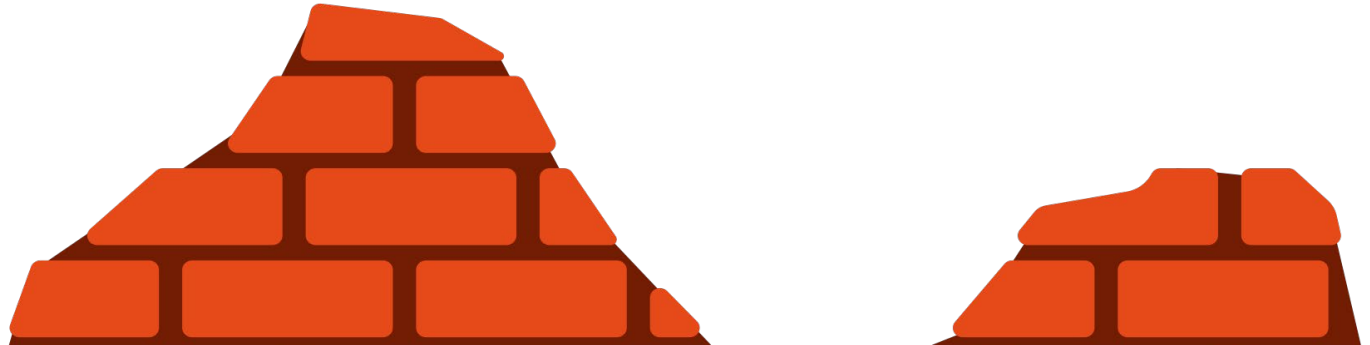
We collected out own!

We collected our own!
Focusing on patient outcomes and experiences

Over 1,200 patients completed survey (October 2022 to March 2023)

Participating sites					
	Primary care clinics				Public health
	Case 1	***Case 2***	***Case 3***	***Case 4***	***Case 5***
Survey platform	OCEAN	OCEAN	OCEAN	Qualtrics	Qualtrics
Distribution mechanism	Email	Email	Email	Tablets QR codes	Tablets QR codes
Frequency of survey distribution	Weekly	Weekly	Weekly	Immediately after visit	Immediately after visit
Frequency of reporting	Weekly	Weekly	Weekly	Biweekly	Biweekly
# completed surveys	493	389	102	24	206
Response rate	16.7%	14.9%	---	n/a	n/a

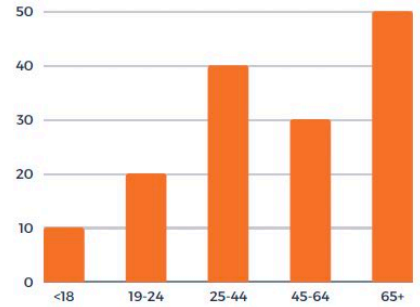
We gave clinics weekly/monthly data.



FLA-OHT PREM SURVEY

WEEKLY REPORT BY QUEEN'S FHT

Age distribution of the study participants



PREM STATS OVER THE PAST WEEK

According to the patients response 60% o the participants believe their care was well coordinated and 75% described that their health care concern was well addressed by the health care providers

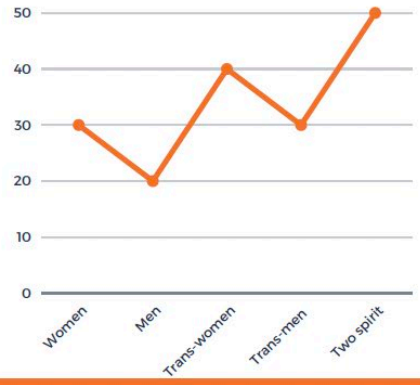
QUALITY OF LIFE OF PATIENTS

The majority of the patients, 95% have never felt isolated. However, more than 3/4th of them experienced a moderate level of pain/discomfort

QUOTE OF THE WEEK

My doctor listened to me very attentively. I felt understood. Thanks

Gender distributism of participants



256

Survey questionnaires completed

90%

Patients had excellent experience during their recent appointment

#200 OF 256

Prefer receiving care in person

Alliance for Healthier Communities
Alliance pour des communautés en santé

1 Flexibility

- One size fits all approach will not work
- Add questions for site-specific needs (e.g., local QI work) while also providing relevant data for population health planning

2 Supports

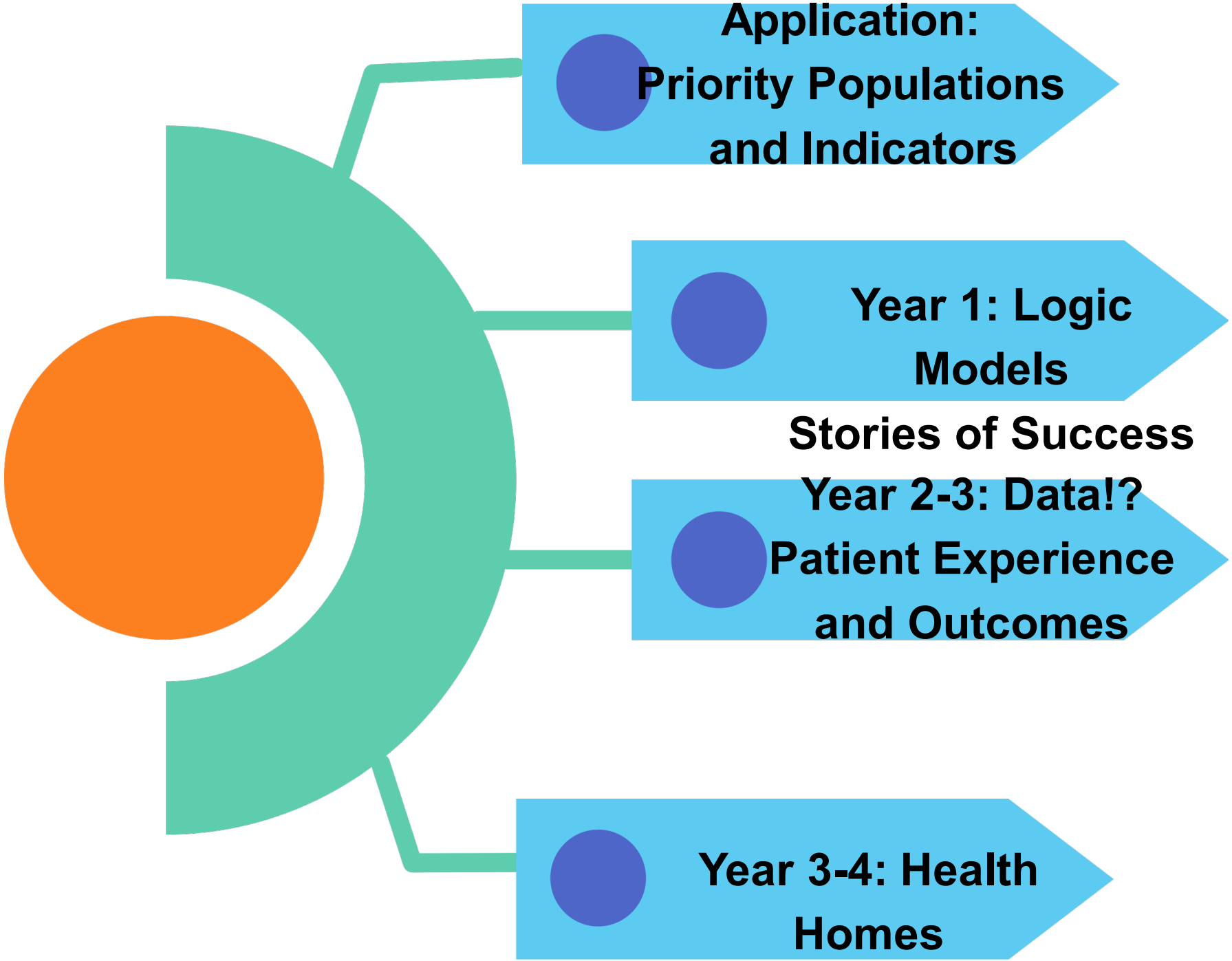
- Resources and supports to: implement data collection, utilize the data, and ensure resources exist to provide appropriate referral and support if necessary

3 Culture shift

- OHTs and partner organizations need to adopt a learning health system culture - the measurement of PREMs/PROMs is not enough
- It is critical to provide supports to close the loop and improve patient care. Providers cannot do this on their own – they need interprofessional teams and quality improvement support.

4 Building efficiencies: combing PREM, PROM, demographic data into ONE tool

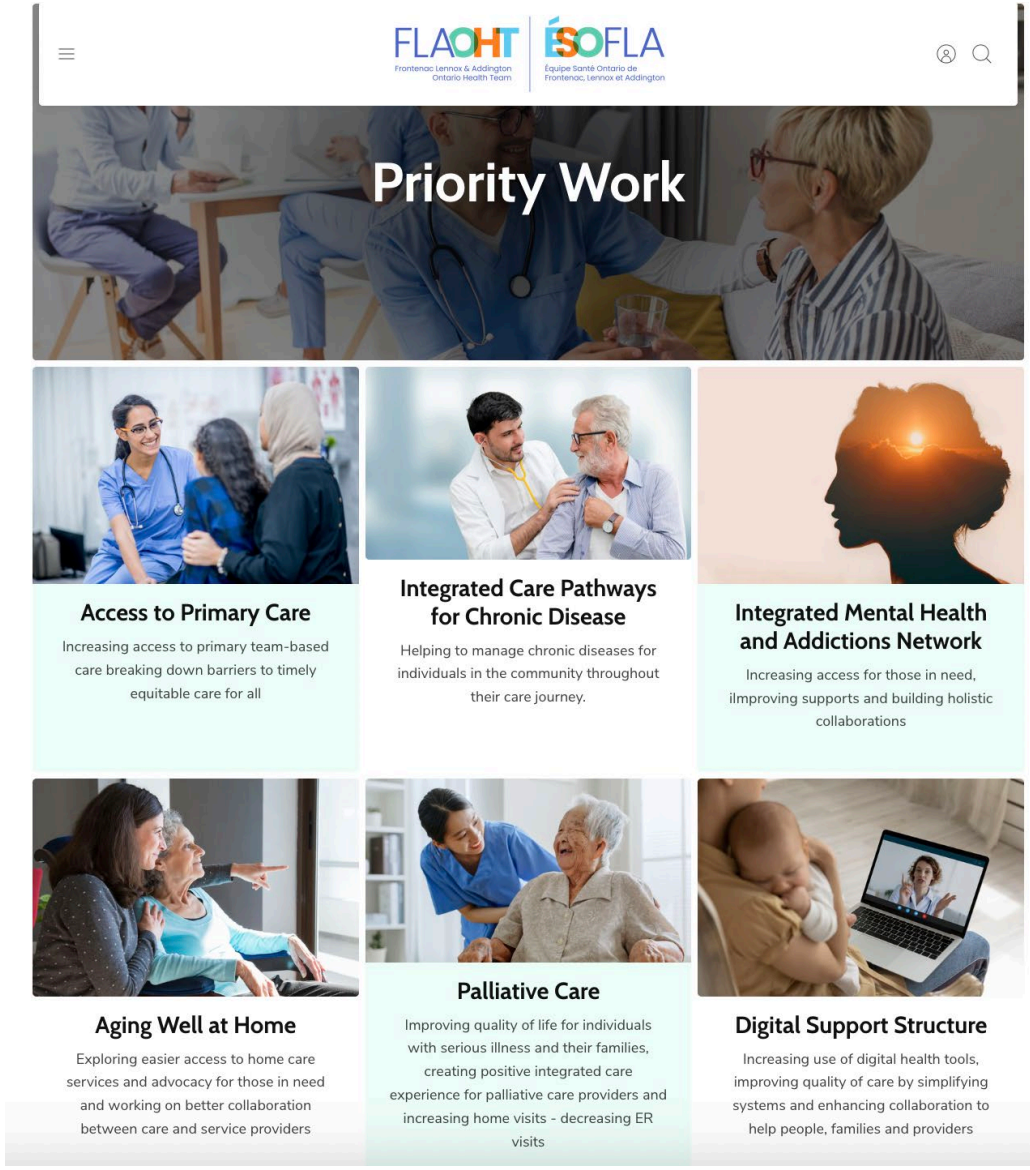
- Combination of PREM, PROM and data to identify equity-deserving groups into one tool to not overburden patients with multiple data captures from multiple places, audiences, or needs

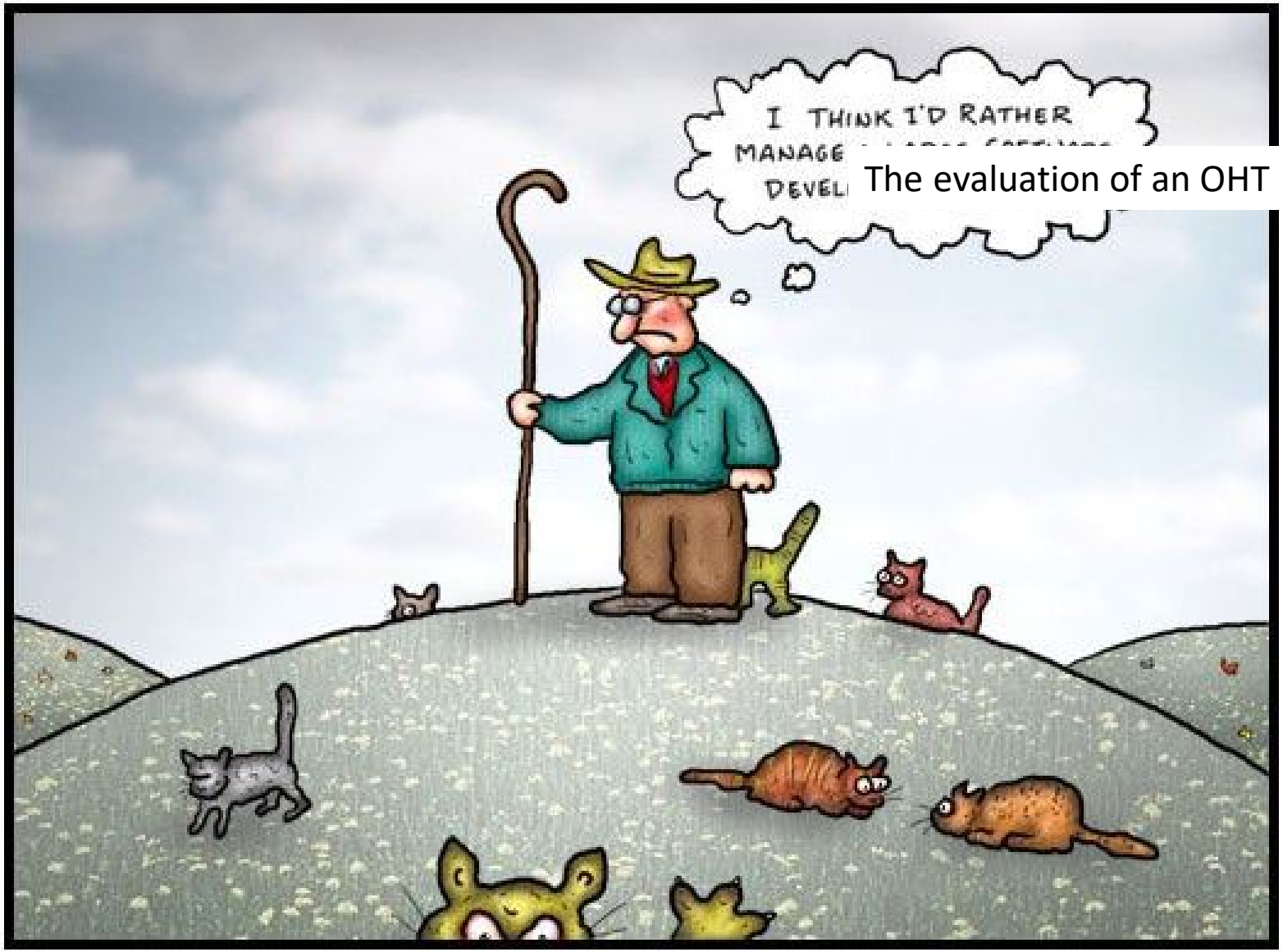


FLAOHT
Frontenac Lennox & Addington Ontario Health Team

ÉSOFLA
Équipe Santé Ontario de Frontenac, Lennox et Addington

Year 3 and 4: Time to regroup and refocus.



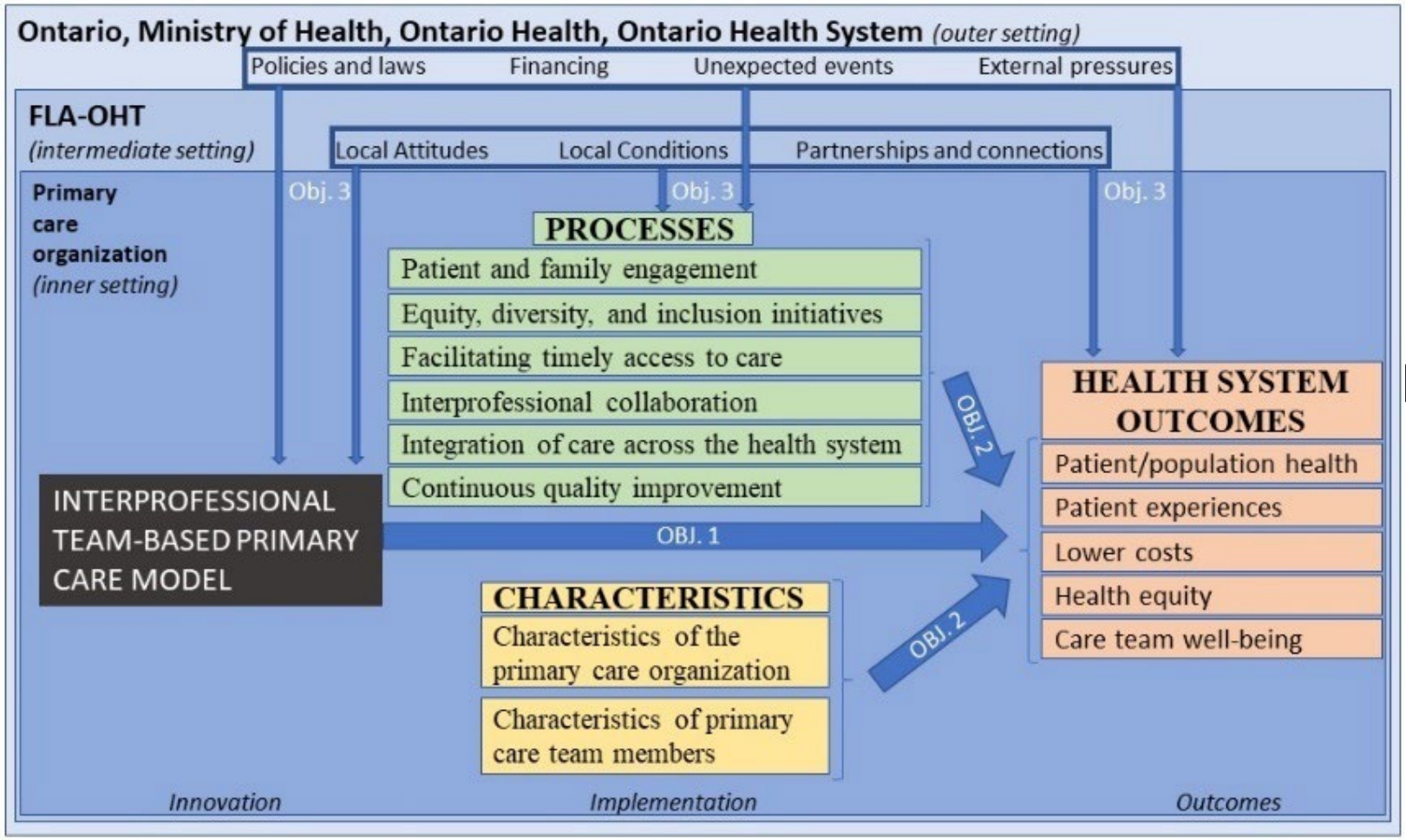


The evaluation of an OHT

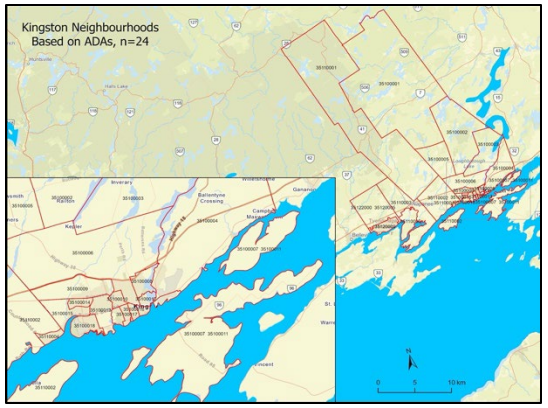
The daydreams of cat herders

Year 3 and 4: Time to regroup and refocus.

Year 3 and 4: Time to regroup and refocus.



FLA-OHT - Patient Experience and Wellness Survey



Neighbourhood Mapping

(Community Health Profiles Partnership)
https://www.ontariohealthprofiles.ca/

Current State Assessment of Health Homes

Goals and Focus

1. Alignment of outcomes and indicators across projects when possible
2. Work with partners to coordinate data
3. Leverage evaluations being conducted in our FLA -OHT
4. Routine deployment (with support) of FLA -OHT Patient and Wellness Experience Survey across all Health Homes.

1. Stay focused:Have a plan. 2. Bite sized projects. 3. Build on your work - slowly over time

Queen's UNIVERSITY

FLAOHT | ÉSOFLA

Our mission

A People-Centred Health Home for everyone in Frontenac, Lennox & Addington counties

Our vision

A healthier community where we all have equitable access to high-quality care, services and supports that empower us toward Achieving our best health

“It Is a Life-long Journey Of Measuring, Learning And Refining.” The Burlington OHT Approach to Evaluation as a Component of a LHS

Dr. Reham Abdelhalim
Manager, Population Health and Evaluation , BOHT

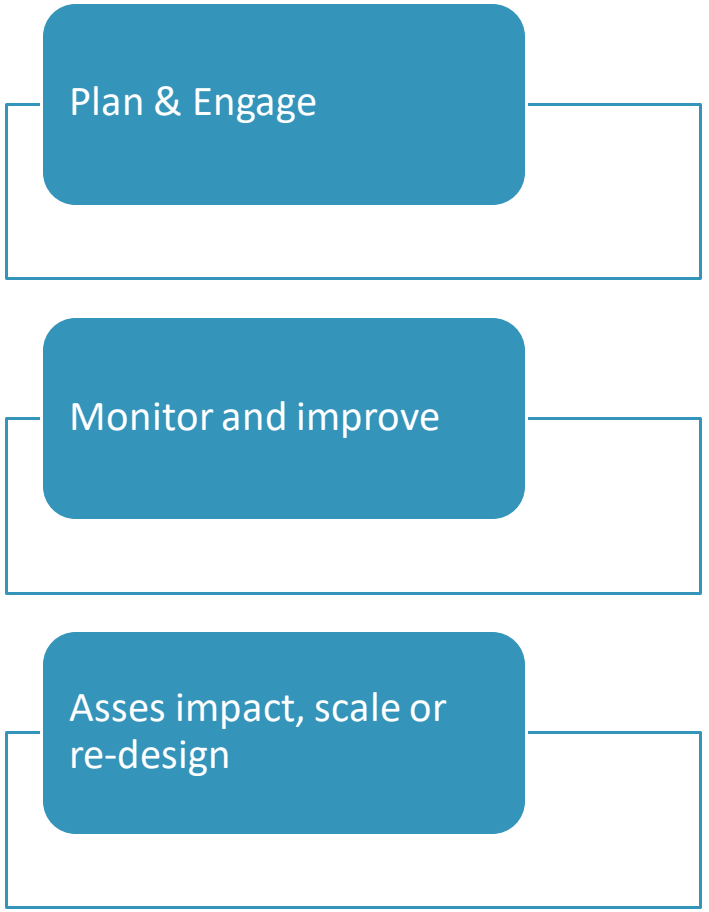
Community Wellness Hub

BURLINGTON ONTARIO HEALTH TEAM

About the Burlington OHT

- *230, 000 attributed population*
- *Mostly Urban*
- *25% of the Burlington OHT attributed population are 65+*
- *We have 72 NORCs in our Community*
- *Vulnerable seniors have been a priority population for the Burlington OHT since inception*

A team of two working within a culture of understanding and commitment to evidence-based decision-making, measurement and continuous improvement



Community Wellness Hub

BURLINGTON ONTARIO HEALTH TEAM

An example : The Community Wellness Hub

Community Wellness Hub (CWH) is an **alliance of health, housing, and social service providers** that coordinate and deliver services to seniors. CWHs are organized around naturally occurring retirement communities (NORCs)[1] or existing community housing facilities. This is an innovative approach to "aging at home" that centres:

Proactive, Holistic, & Integrated Care

Proactively addresses medical and social determinants of health, supporting preventative care and social prescribing

Interdisciplinary Teams, Trusted Relationships, & Person-Centeredness

Diverse experts coordinated through a central coordinator, intake-point, and care plan improves primary care attachment/access and meets seniors' complex needs

Serving Equity-Deserving Populations

Co-design with residents and an adaptable model helps meet specific cultural, language, and accessibility needs

Cost-Effectiveness & Scalability

Leverages collaboration efficiencies and reduces healthcare system pressures; CWHs have navigated funding silos, need few additional resources to implement, and are easily replicable

[1] NORC-Report-FINAL.pdf (NORC Innovation Centre

Community Wellness Hub

BURLINGTON ONTARIO HEALTH TEAM

The Community Wellness Hub Model | Structure

Burlington OHT, Halton Community Housing Corporation, and interdisciplinary CWH Partners offer **primary healthcare, housing, wellness and recreation, mental health**, and **system navigation** featuring:

- **On-site Community Connector** to identify member needs and connect members with service provider partners.
- **Interdisciplinary service providers** providing home-based or on-site 1:1 and group services at no or low cost to members.
- **Service providers that work as a team** to discuss member progress, address concerns, prevent service duplication, and provide HR and administrative resources (including in-kind).

We started with one Hub, now we are at four buildings in Burlington, collaborated with CCHOHT to implement two hubs and GHHN to implement another two

Community Wellness Hub

BURLINGTON ONTARIO HEALTH TEAM

Exciting? Promising? But the beginning was not like that, it took years!

Community Wellness Hub

BURLINGTON ONTARIO HEALTH TEAM

Community Wellness Hub
A Complex Intervention

Many interacting components

Intervention targets many different groups & organizational levels

Many related & overlapping outcomes

Did it work??

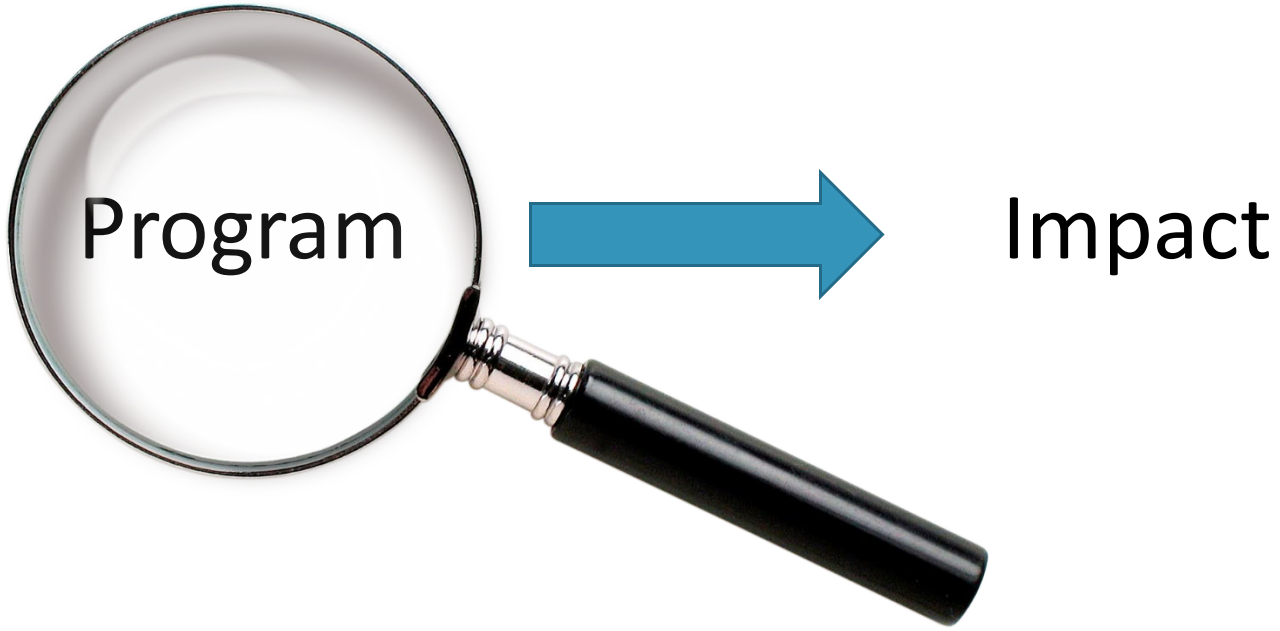
Participants are at all different stages of (behaviour) change

Lots of flexibility & tailoring of the intervention

Community Wellness Hub

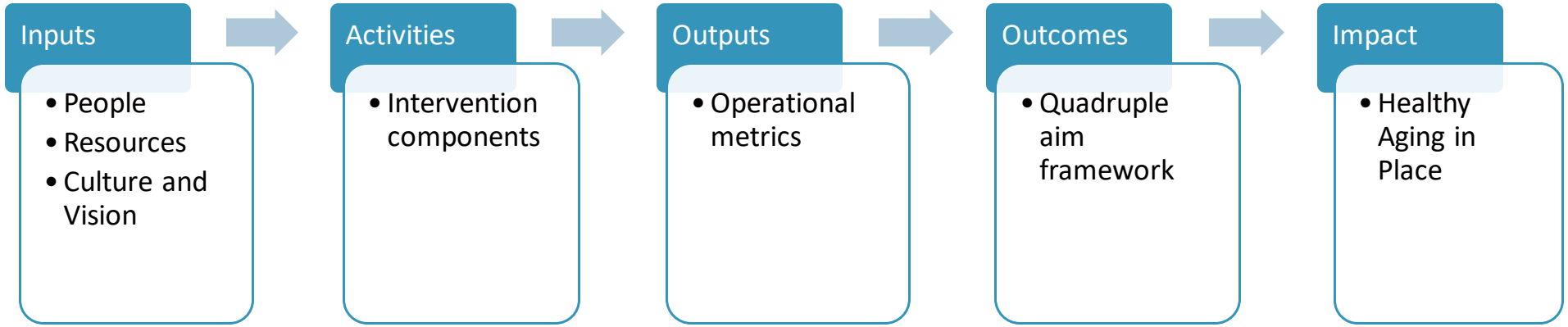
BURLINGTON ONTARIO HEALTH TEAM

Community Wellness Hub
A Complex Intervention



But this assumption ignores all the underlying complexity…

Evaluation
Using A Logic Model



Do we have what we need to implement & achieve our vision?

Did we implement the vision as planned? What do we need to revisit?

How are we doing?

Are we making a difference? Why & how?

Implementation Evaluation

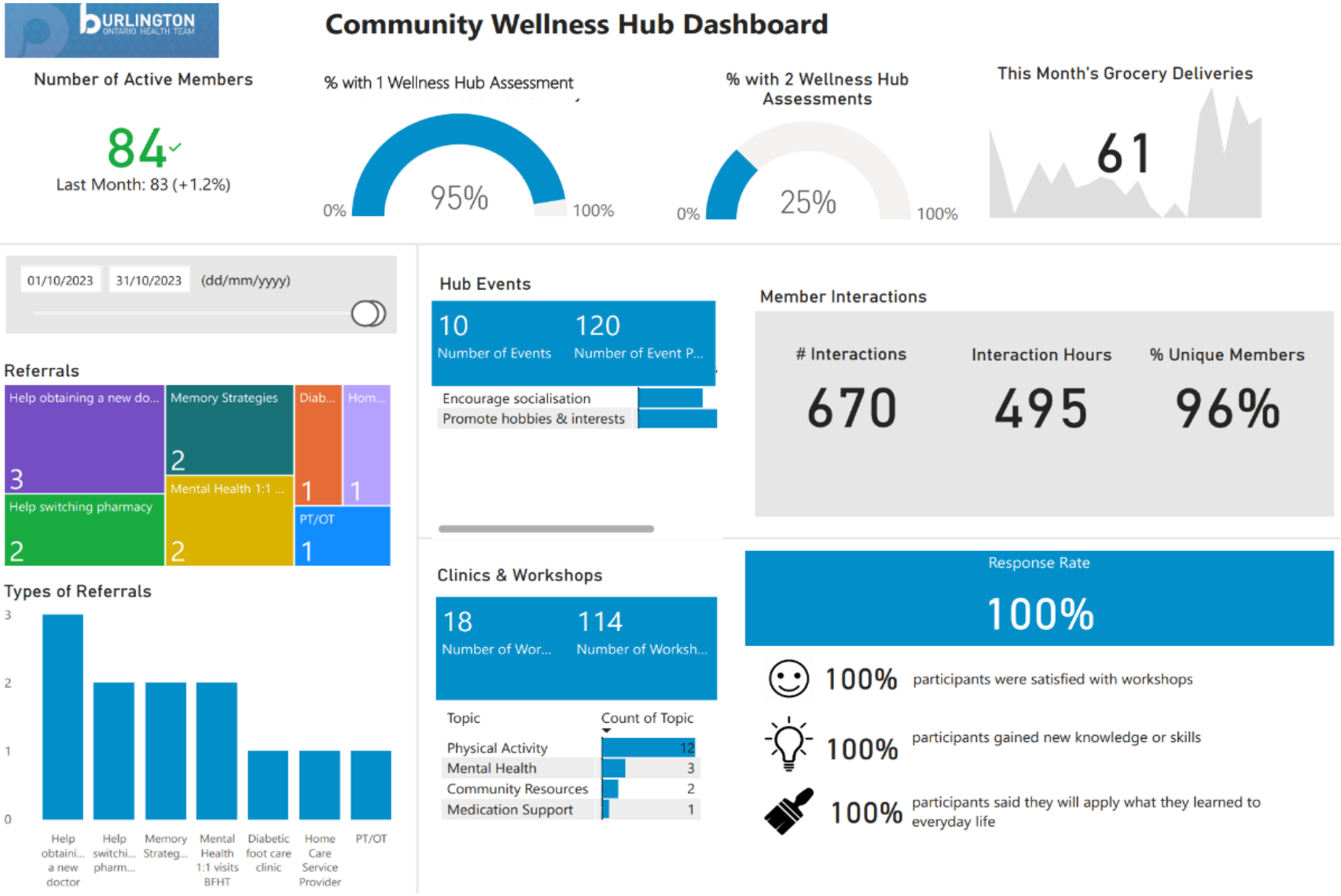
Continuous Performance Monitoring

Impact Evaluation

Community Wellness Hub

BURLINGTON ONTARIO HEALTH TEAM

Continuous Performance Monitoring



How are we doing?

Are we meeting our targets?

Any trends? Positive negative?

Why?

What next?

BURLINGTON ONTARIO HEALTH TEAM

Implementation Evaluation

Evaluation Questions:

- Do we have what we need to implement & achieve our vision?
- Did we implement the vision as planned? What do we need to revisit?

Evaluation Topics:

- Definition
- Vision
- Operations
- Impact

Methods:

- Focus groups with leaders and providers
- Document analysis
- Observations

Community Wellness Hub

BURLINGTON ONTARIO HEALTH TEAM

Why Evaluate?

Common Misconceptions	In Reality
Our program is **too complex**!	It takes time creating a **logic model** – but it's well worth your investment to understand how your program works and whether it's making a difference!
We **already know** what the problems are.	It's important to hear from **all stakeholders** and considering **all possible causes**.
I'm so focused on running the program, I **don't have time** to evaluate.	Evaluation is not just a thought exercise – the outputs should be applied to **improve the program**!

Community Wellness Hub

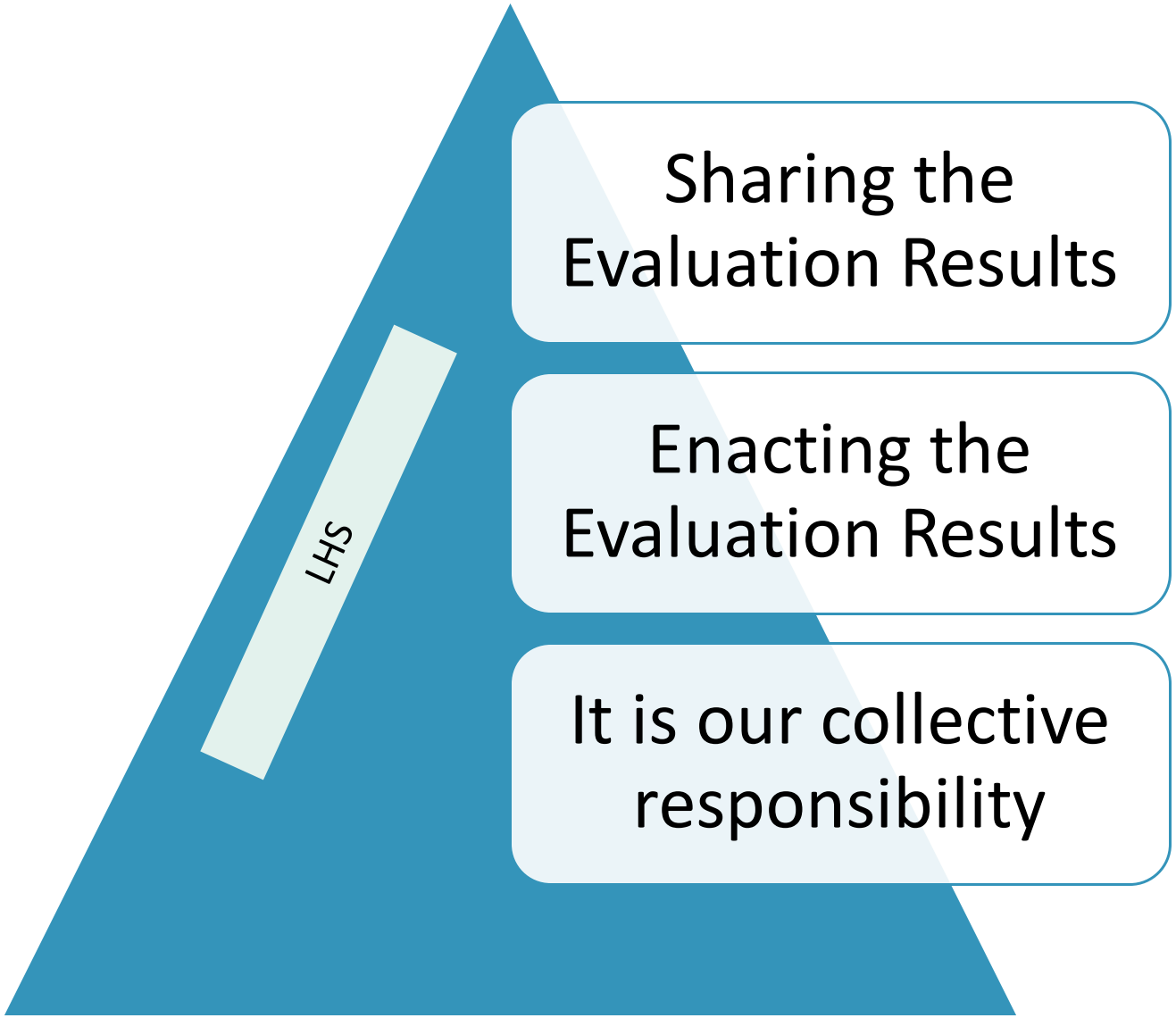
BURLINGTON ONTARIO HEALTH TEAM

Implementation Evaluation
Some Recommendations

- **Definition**
  - Create consistent branding; communicate widely
- **Vision**
  - Create shared vision, mission & value statements.
  - Stay consistent
  - Repeat
- **Operations**
  - Streamline operations; facilitate working as a team so we can provide more than the sum of our parts
- **Impact**
  - Create and implement an impact assessment matrix, collect data continuously and track over time

Community Wellness Hub

BURLINGTON ONTARIO HEALTH TEAM



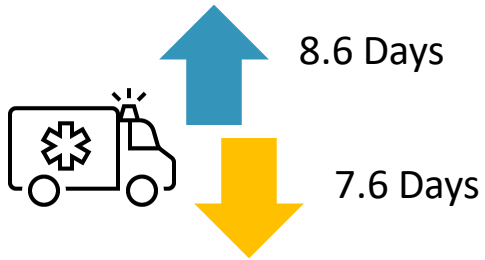
Community Wellness Hub

BURLINGTON ONTARIO HEALTH TEAM

Outcomes & Impact | Health Outcomes

Improved Self-Perceived Wellness[1]

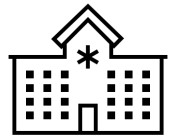
Despite aging and conditions that worsen with time, members reported **better or same** self-perceived health and wellness after participating in CWH



31% Lower Rate of Hospitalizations for ACSCs[2]

Non-CWH members, similar in frailty and in home care, were **1.4x more likely** to be hospitalized for ambulatory care sensitive conditions (ACSCs) with longer stays, compared to CWH members

The estimated cost savings per year for ACSC hospitalizations per 100k people is $89,720,019



14% Fewer Less/Non-Urgent ED[3] Visits[4]

CWH member ED visits that were less/non-urgent **= 6%**

vs

Ontario population aged 65+ ED visits that were less/non-urgent = **20%**[5]

[1] *Wellness indicators include general health, pain and/or discomfort, loneliness, physical health, mental health, and feelings of anxiety or depression.*
[2] *See Appendix for further details and calculations.*
[3] *ED refers to Emergency Departments, sometimes referred to as Emergency Rooms (ERs).*
[4] *Based on Canadian Triage and Acuity Scale (CTAS); less/non-urgent ED visits represent CTAS 4 & 5. Fewer CTAS 4&5 ED visits helps improve system-wide problems of staffing shortages, closures, wait times, and delayed/missed diagnosis.*
[5] *OH dashboard/ OHTs reports, 2024*

Outcomes & Impact | Member Experience & Equity

Accessible and adaptable services, trust and support, close-knit community[1]

HUB MEMBER DEMOGRAPHICS[2]

74
Average Member Age

$20,000
Average Member Income

7
Languages Spoken

11%
Hub Members with a non-English first language[3]

"As a **visually impaired person I find the assistance a huge asset**....I have used the Hub for help reading and sorting my mail, getting a new family physician, appointment assistance, and much more."

"We have monthly activities such as bingo, trivia, social teas, and arts & crafts. It's nice to gather in a social group again. This makes me **feel included and not alone**".

"This program encourages me to **get up and get active**. It has been a wonderful way to **be social** and get to know the people in the building."

"Having a person [Community Connector] available in the building daily is great for us, it's nice to have someone who can **help with things I find difficult** to do."

"I enjoy the fact that I can access most, if not all of the services onsite and **within the comfort of the community** I reside in"

Hear more from members and providers in our video at: https://www.burlingtonoht.ca/community-wellness-hub/

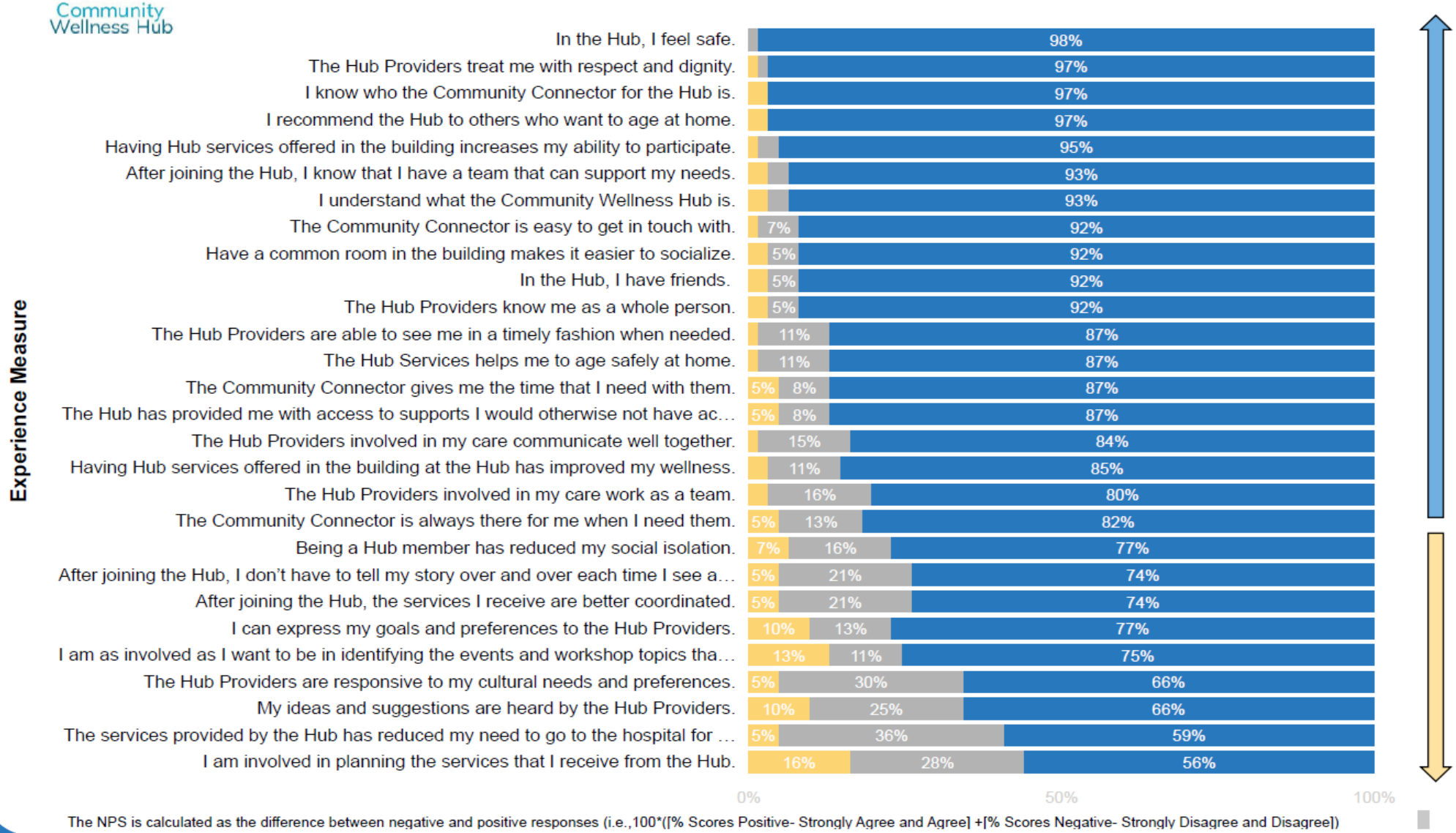
Community Wellness Hub

BURLINGTON ONTARIO HEALTH TEAM

Translated to 5 languages

Community Wellness Hub Member Experience Survey: Likert Scale and Net Promoter Score

Stacked bar chart for negative, neutral, and positive scores to indicate overall agreement or disagreement with each experience measure



The NPS is calculated as the difference between negative and positive responses (i.e.,100*([% Scores Positive- Strongly Agree and Agree] +[% Scores Negative- Strongly Disagree and Disagree])

BURLINGTON ONTARIO HEALTH TEAM

Outcomes & Impact | Provider Experience

Reduced travel, more patients served, improved communication, greater retention, collaboration efficiencies, economies of scale

"The Hub has allowed me to not only continue my patient care but **build stronger bonds with my clients**."

"I develop connections, and I see changes in **patient's health and mental well-being**, in real time."

"We are more aware of who is doing what, so we **do not to duplicate service or create redundancy**, which was definitely happening before."

"**Resource sharing** has been a huge success…we use each other and our unique strengths and knowledge to support residents in the best way possible."

"I get to work with many community partners who are experts into their fields, this has provided me with **valuable insights**, and I see the difference we are making."

"The Hub transformed our approach to providing care, we **work as a team**, not individual organizations. The hub helps us do our job more **efficiently**."

"Partnering with other agencies in providing care has **increased communication and awareness** of services and programs."

"…being seen daily lets the members know I [the Community Connector] am here to help them. It also helps me **build relationships** with other tenants and providers."

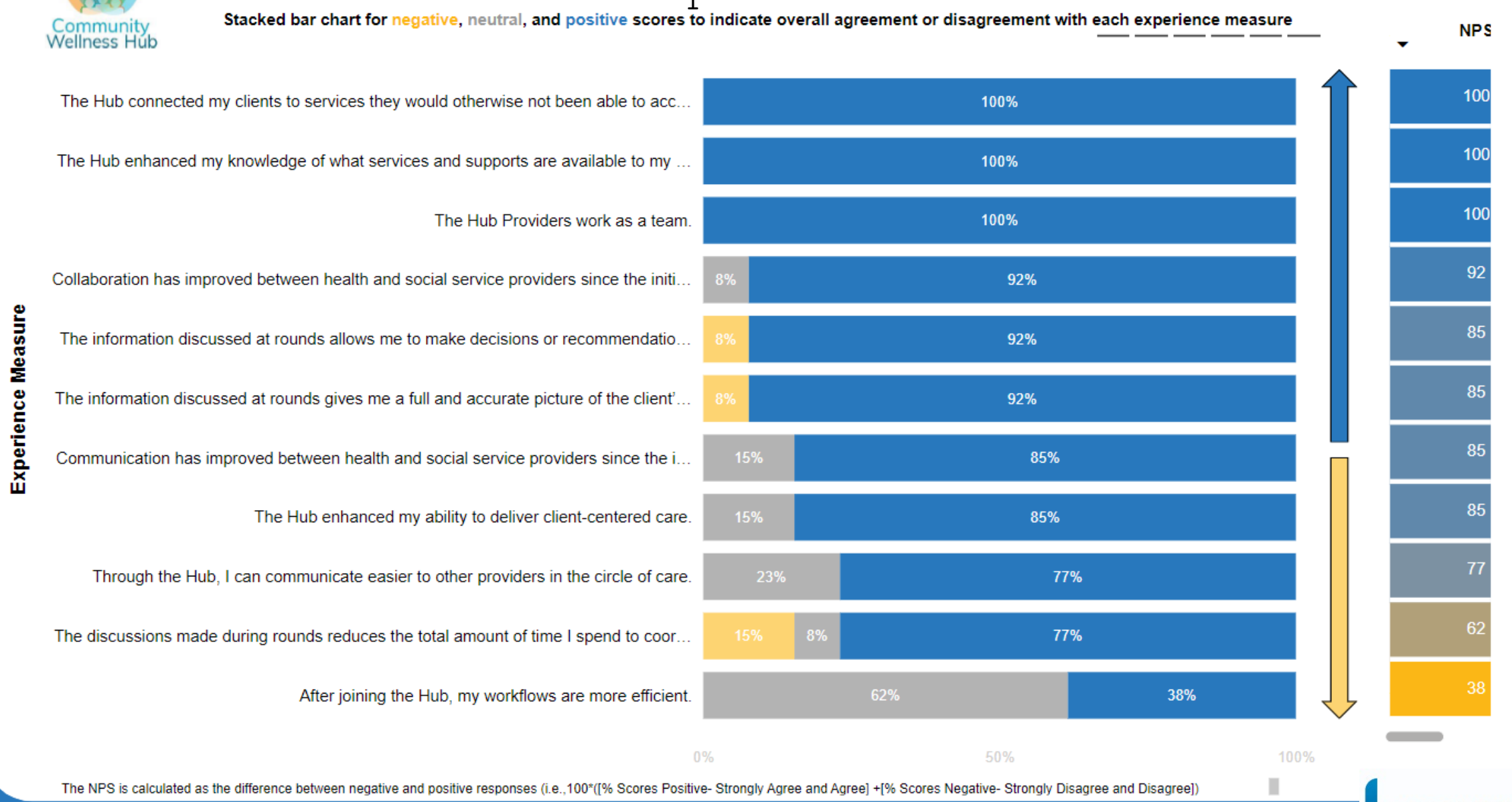
Hear more from members and providers in our video at: https://www.burlingtonoht.ca/community-wellness-hub/

Community Wellness Hub

BURLINGTON ONTARIO HEALTH TEAM

Community Wellness Hub Annual Provider Survey: Likert Scale

Stacked bar chart for negative, neutral, and positive scores to indicate overall agreement or disagreement with each experience measure



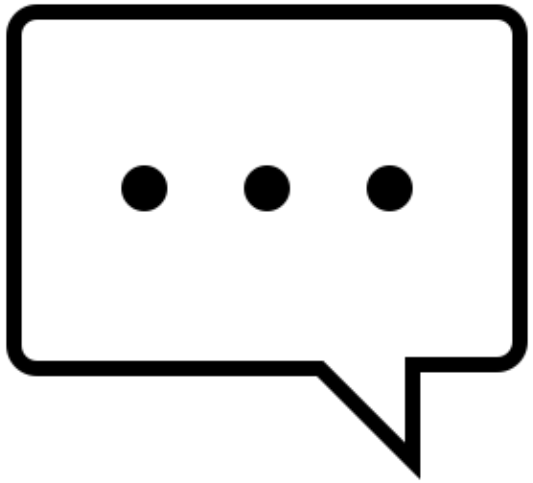
The NPS is calculated as the difference between negative and positive responses (i.e.,100*([% Scores Positive- Strongly Agree and Agree] +[% Scores Negative- Strongly Disagree and Disagree])

What does it take to implement evaluation findings?

Engagement from start to finish

Be open to innovation

A collaborative approach



Funding opportunities

Change management

Be open to fail forward

Create sense of urgency

Community Wellness Hub

BURLINGTON ONTARIO HEALTH TEAM

AGING AT HOME

NEWS | A15

An alternative to isolation and anxiety

This housing experiment for older adults has changed lives. It could also save Ontario millions

MOIRA WELSH
STAFF REPORTER

Anxiety crept into Donna Meloney's thoughts.

Sometimes, it ate into her sleep when Meloney, then in her mid-60s, lay awake at night, worrying about a future alone. More often, it arrived in the morning when the day ahead looked like an empty horizon.

With no one to rely on, Meloney, a retired retail manager living in a Burlington apartment, grew fixated on isolation and decline, determined to avoid a nursing home. It scared her.

A few blocks north, in the concrete and glass building that is Burlington City Hall, an accountant-turned-councillor named Paul Sharman was consumed with an idea that mirrored Meloney's fear: older adults need a better way to live.

The same age, but from different social circles, their goals would intersect in a promising new experiment, improving life for dozens.

Now, Sharman's plan to improve the lives of people over 65 is seen as a solution to the universal anxiety of Canadians who worry they will grow frail, with a lonely ending in a hospital or long-term-care home.

Since opening in 2018, the Community Wellness Hub has helped older adults in a Burlington community housing apartment building remain independent, in their own homes, by surrounding them with health care and social supports.

Housing program seen as missing piece for isolated seniors

The Halton Community Housing program has an on-site leader called a "community connector" to help residents find their way through Ontario's complex health-care system; organize social events; visit apartments to ensure there is food in the fridge; talk about medication and, organize the services of more than a dozen different agencies providing home care in the building. It is supported by the Burlington Ontario Health Team.

Meloney moved into the building as the Hub pilot began. To her, this new program was the missing piece and the nightly grip of anxiety lessened.

"Any time you had any problems, you could go to them," she said. "The door was never closed."

It is easy for Meloney to drop by the office and chat with staff about an issue she can't quite solve. She leaves feeling calm.

Weekly coffee conversations, about anything really, make her feel part of a community. And, on a win-

RICHARD LAUTENS PHOTOS | TORONTO STAR

Burlington resident Donna Meloney credits the Community Wellness Hub with reducing the anxiety she felt about aging in isolation and possibly ending up in a nursing home.

Before being elected to council in Burlington, Paul Sharman worked as an accountant. He saw the needs of an aging population as a new challenge for his skills.

100,000 older adults, it would save the health-care system nearly $90 million a year.

Similar housing models have blossomed in other jurisdictions

The goal of living and dying at home, surrounded by emotional, social and medical support, is nor-

social and medical support, is nor- of aging in other juris-

ing Corporation apartment, supported by the Burlington Ontario Health Team, specifically for residents over the age of 65.

The nine-story brick building overlooks a downtown parking lot used by patrons of Burlington's nearby "Village Square," a Tudor-inspired, car-free zone of restaurants, spas and chocolatiers.

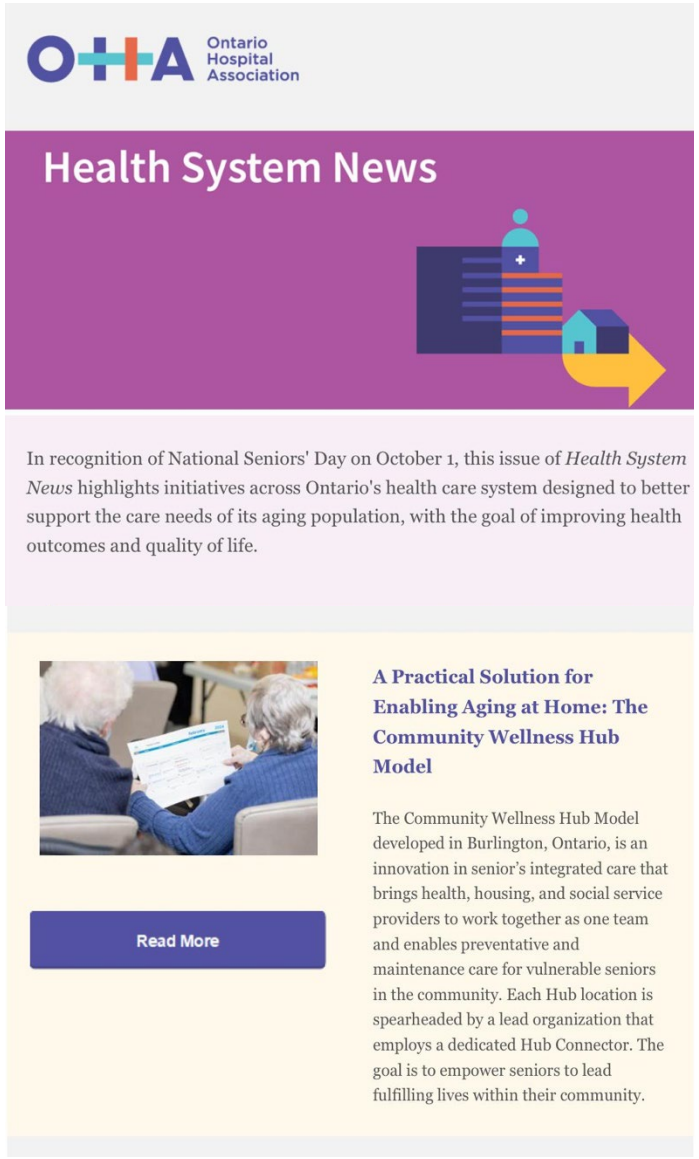
Inside the glass doors, is the office of Jennifer Johnstone, the "community connector" and unofficial den mother to more than 100 residents who signed up for the program. To Meloney, her presence is reassuring.

At the opposite end of the hall is the community room, with tables and chairs for card games or talks from the local pharmacist on good sleep and the avoidance of Lyme disease from Ontario's growing population of ticks.

Johnstone follows the near universal philosophy of NORC and PACE programs: Help people feel important. Be a good listener. Build trust.

She also organizes the health and social services work of more than a dozen community agencies that have been providing care in the building for years. Much of this work is done through the Burlington Ontario Health Team, one of the provincial government's new for-profit organizations that "p

Any time you had any problems, you



BURLINGTON ONTARIO HEALTH TEAM

Community Wellness Hub

50 presentations over the last three years

Please Connect

Reham Abdelhalim

rabdelhalim@burlingtonoht.ca

Meghan O'Neill

moneill@burlingtonoht

Evaluation in equity - centered learning health systems – experiences from Northern Ontario Health Teams

Brianne Wood, PhD
bwood@nosm.ca
@Brianne Wood

Land acknowledgment

Northern Ontario includes six treaty areas:
Robinson-Huron, 1850, north of Lake Huron including Manitoulin Island;
Robinson-Superior, 1850, north of Lake Superior;
Manitoulin Island Treaty, 1862, Manitoulin Island excepting Wikwemikong Unceeded Indian Reserve #2;
Treaty 3, 1873, southern part of Northwestern Ontario;
Treaty 5, 1875, portion of area extends into western Ontario from Manitoba; and,
Treaty 9, northern two-thirds of Northern Ontario.

Reconciliation is a practice. We recognize the importance and contributions from Elders, Knowledge Keepers, and Indigenous knowledge systems. We acknowledge that these are likely different from traditional research approaches and practices.

Today's talk

1

Learning Health Systems in Northern, rural, isolated settings

2

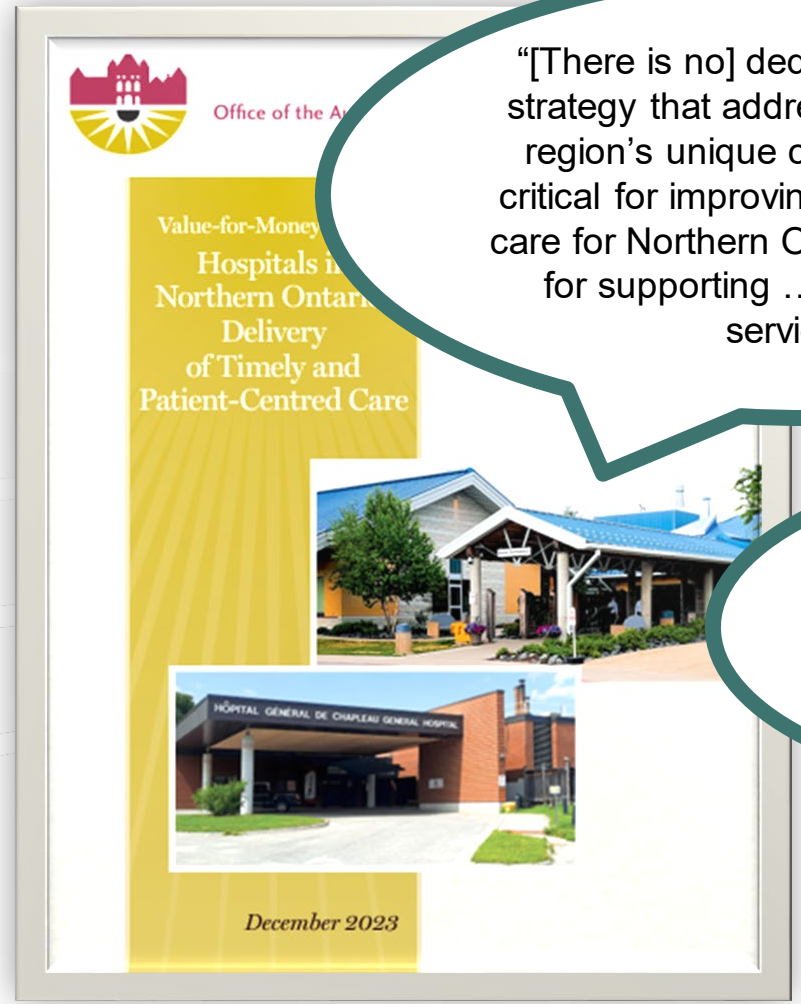
Two evaluation considerations

3

Learnings & take-homes

Motivation?

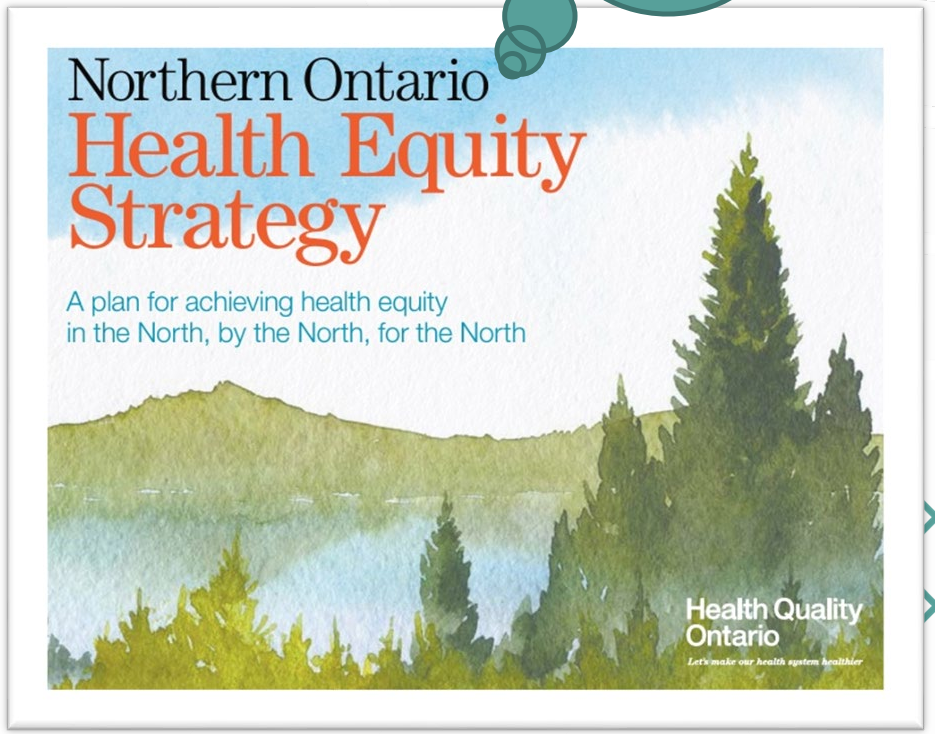
All of these recommendations still stand true 7 years later…



"[There is no] dedicated healthcare strategy that addresses all the north region's unique challenges; this is critical for improving access to health care for Northern Ontario patients and for supporting … the delivery of services."

"Programs for patients and health-care staff in Northern Ontario not regularly evaluated"

Ontario Auditor General's Report 2023: https://auditor.on.ca/en/content/annualreports/arbyyear/ar2023.html



Northern Health Equity Strategy: https://www.hqontario.ca/System-Performance/Specialized-Reports/Health-Equity-in-Northern-Ontario

What is our context?

11 OHTs

Range in size of patient population, partners, priorities. Three in i12.

Primary care

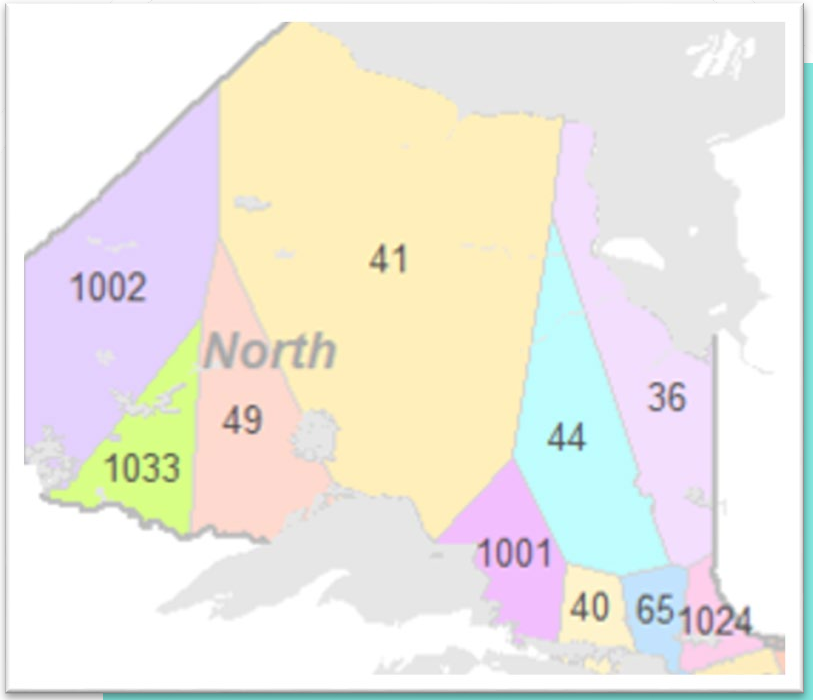
Is sometimes the only local care, and it might be delivered in unexpected places

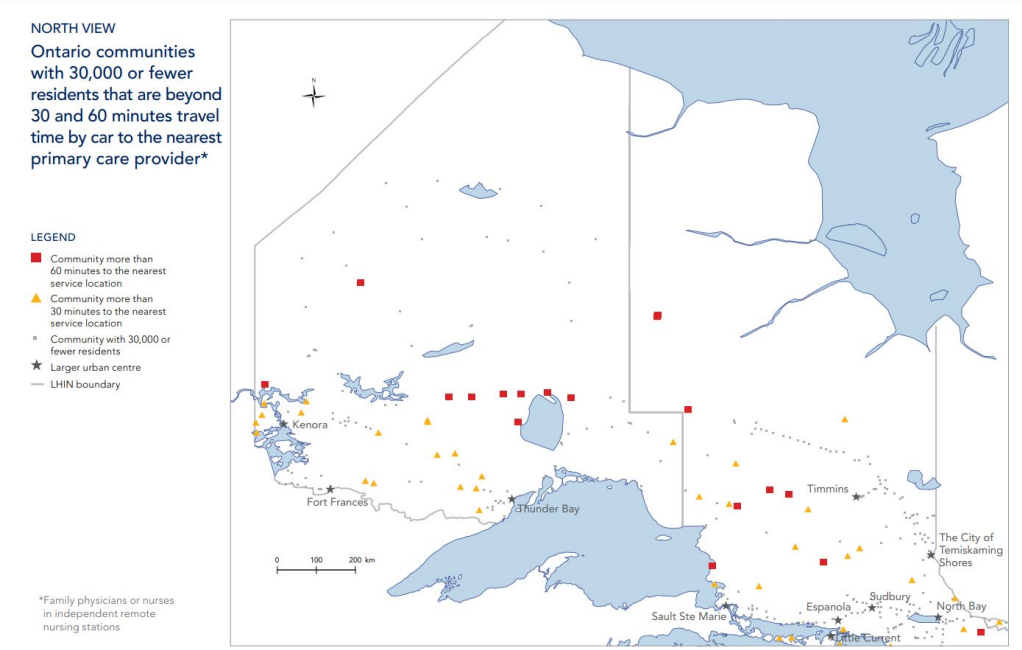
We collaborate

Because we need to, and we always have.

Diverse

Often painted as “the North”, we are not a singular population. We are also often “Othered” because of this.





What's unique about "learning" in northern, rural, remote contexts?

- Smaller workforce -> Generalist expertise
- Existing networks and relationships – working across OHTs
- Different population health profiles and priorities
- Academic institutions have explicit social accountability goals

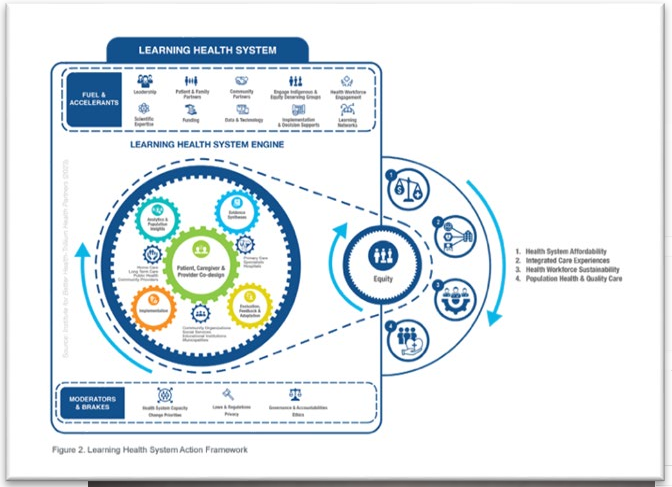


Figure 2. Learning Health System Action Framework

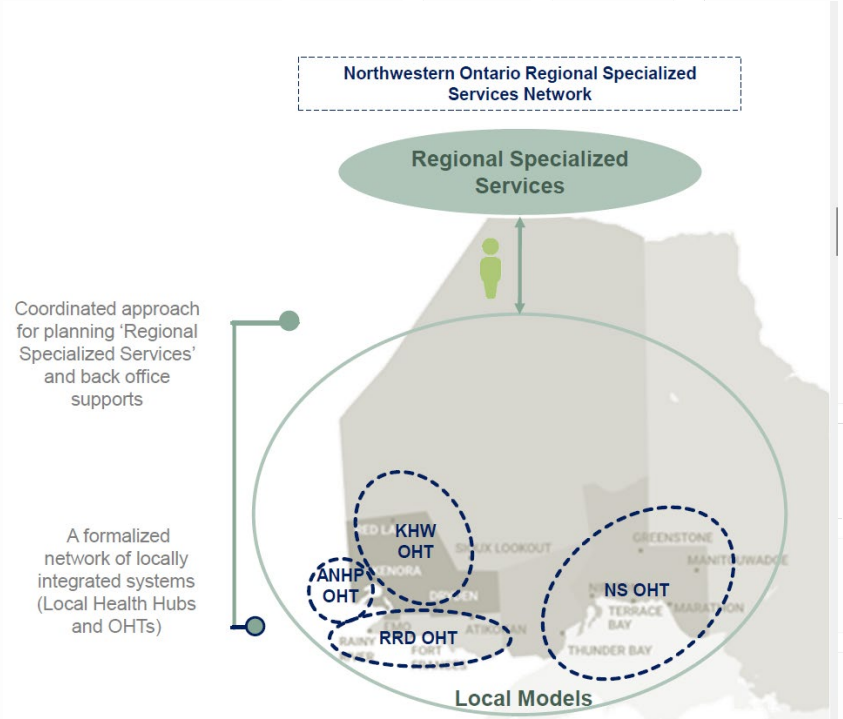
Case 1

The uniqueness of northern & rural health systems

Hassan A, Benlamri R, Diner T, Cristofaro K, Dillistone L, Khallouki H, Ahghari M, Littlefield S, Siddiqui R, MacDonald R, Savage DW. An App for Navigating Patient Transportation and Acute Stroke Care in Northwestern Ontario Using Machine Learning: Retrospective Study. JMIR Form Res. 2024 Aug 1;8:e54009. doi: 10.2196/54009. PMID: 39088821; PMCID: PMC11327622.

Situation: OHTs might not have (data, measurement) evaluation capacity on their team

- Idea: create a structure that facilitates evaluation support and advisory with data-related efforts
- Regional collaboration – a working group with a "Standing committee" of data, measurement, and evaluation expertise
- Standing committee meets with OHT data, quality improvement, project managers + working group leads to plan evaluation (and performance measurement), determine metrics, coordinate data collection, supplement or aggregate analyses, and guide reporting



Regional data, measurement and evaluation group

Successes

- Alignment across OHTs and “no one left behind”
- Filling important gaps and expertise
- Building capacity among others in the workforce
- Alignment with regional digital efforts

Hot spots

- Determining scope (OHTs are asked to do a lot of measurement, evaluation as part of PHM, on top of reporting for accountability)
- All the meetings
- Connecting local to regional in the right ways

Case 2

The uniqueness of the populations

Situation: data reports, estimates, and publications do not reflect our (health and care) realities

- Why? Small sample sizes across OHT, reliance on census data, OHIP billing, hospital, *provincial* data to infer population health status, large land mass
- **Indigenous data and knowledge sovereignty**
- Idea: Develop an equity-centered data strategy in collaboration with communities to supplement existing data sources to be <u>owned by the communities themselves</u>
- Strategy will focus on the types of information that is needed and approaches to acquire the information, while recognizing FAIR and CARE principles

ᒪᒪᐣᐤ ᐊᔨᒥᐅᐏᓐ
Mamow Ahyamowen

McConkey, S., Brar, R., Blais G., Hardy, M., Smylie, J. (2022). Indigenous Population Estimates for the City of Thunder Bay

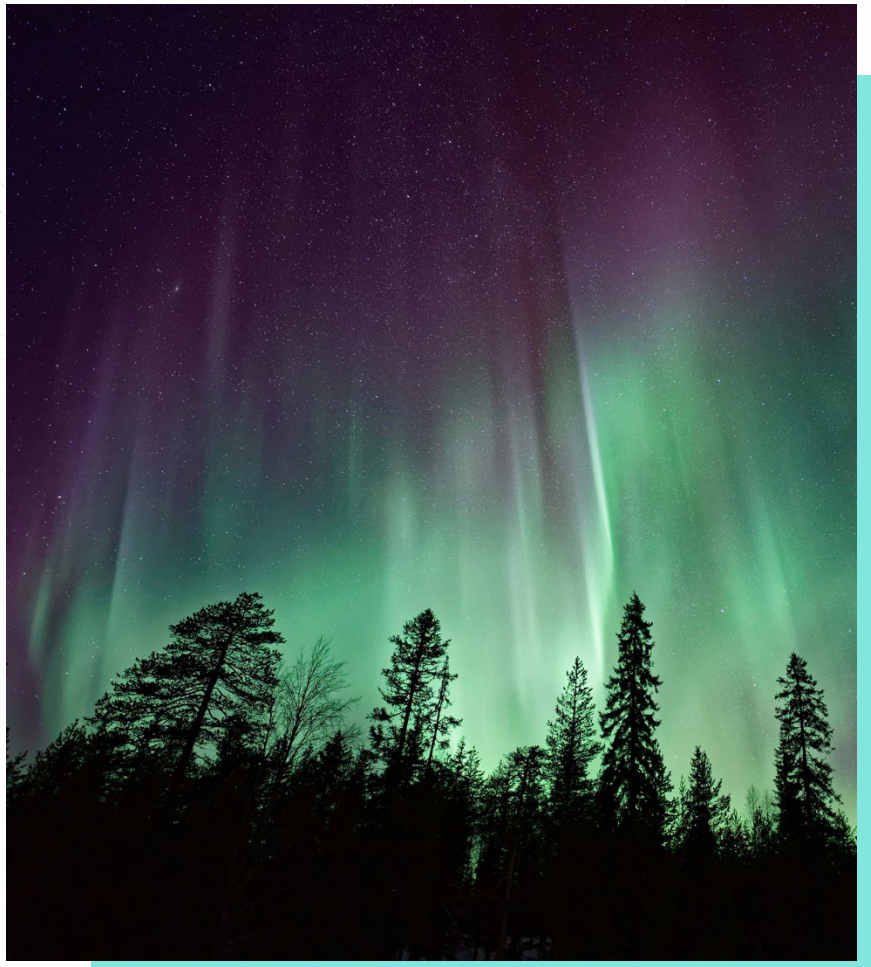
Northern data strategy

Successes

- Interest and commitment to collectively work on this
- Will allow us to answer questions about whether we make *meaningful* change
- A collective, coordinated approach to advance regional and provincial programs

Hot spots

- Sometimes "good enough" still isn't good enough (e.g., law of large numbers doesn't work when it's the wrong population)
- How do we resource this while still doing all of the other work?



Learning from evaluation with Northern OHTs

Team-based works best

Share the work, bring others along, use resources wisely

Make capacity - building part of the strategy

Helps to manage the power dynamics too

Data collection is inevitable

Needs to be done carefully, strategically, and with transparent governance.

Know the “so what” ahead of time

Commit to the action, know your why

Thank you for listening

Brianne Wood, PhD
Associate Scientist, Social Accountability and Learning Health Systems (bwood@nosm.ca)

NOSM UNIVERSITY UNIVERSITÉ EMNO

DR. GILLES ARCAND CENTRE FOR HEALTH EQUITY

Thunder Bay Regional Health Research Institute

RISE Rapid-Improvement Support and Exchange

Up Next

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

Upcoming January 2025:

Brakes and Accelerators for the Learning Health System

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

HSPN