HSPN
Health System Performance Network

Advancing the Learning Health System in Ontario

Part 7: Measuring LHS capabilities + Enablers and Barriers

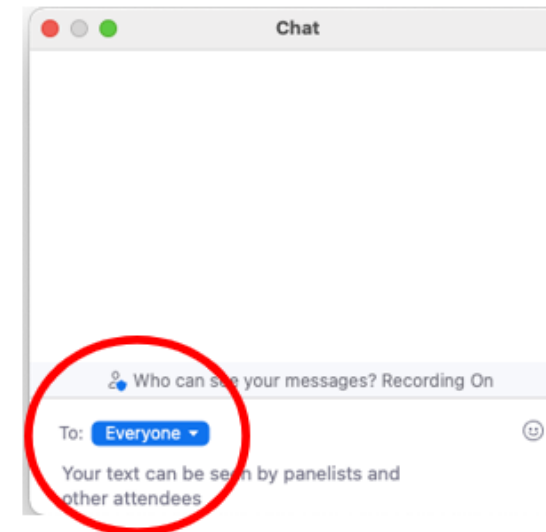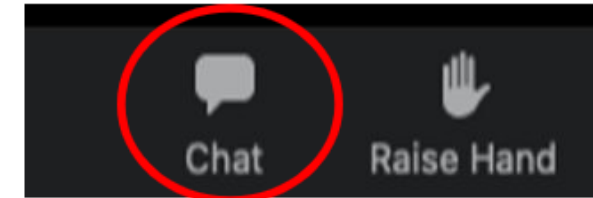### (Fuel, Accelerants, Moderators and Brakes)

HSPN Monthly Webinar

January 28, 2025

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 <mark>everyone</mark>

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.
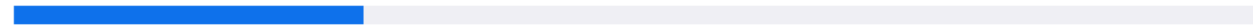
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Poll 1

1. Have you joined us for an HSPN webinar previously? (Single choice)

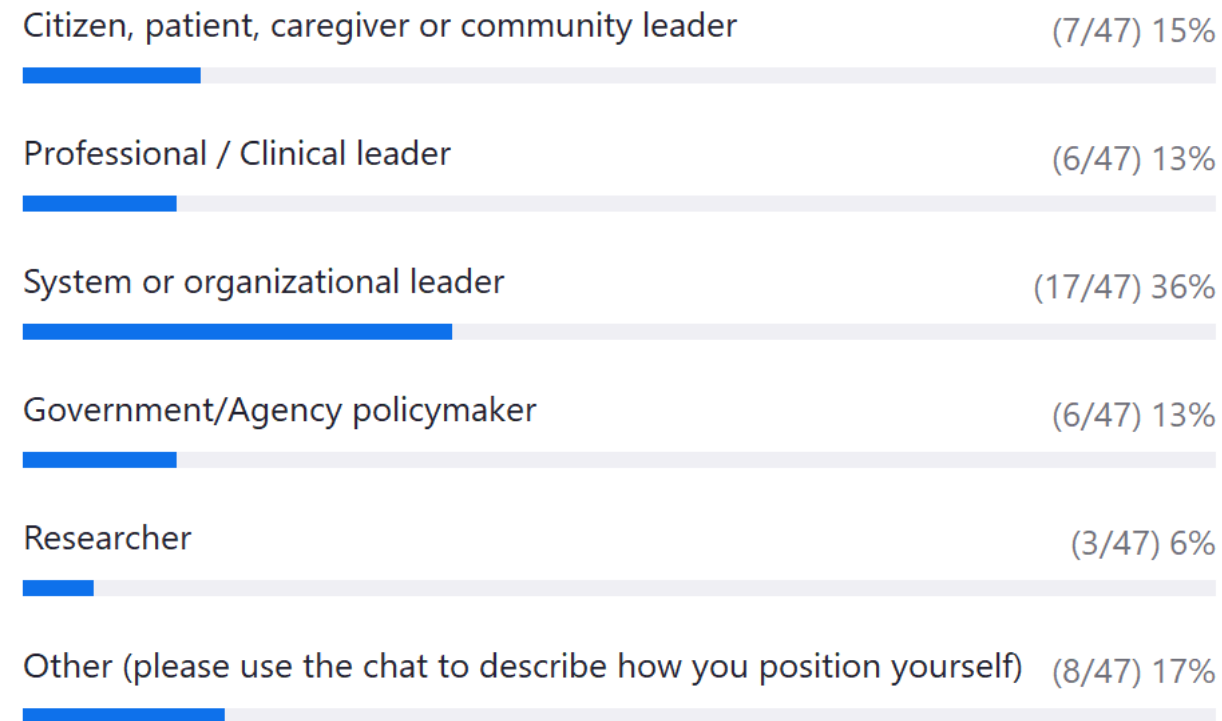43/43 (100%) answered

Yes. I have participated   (31/43) 72%

No. This is my first event   (12/43) 28%

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Poll 2

1. What role do you primarily play, or could you primarily play, in a learning health system? [select one option] (Single choice)

47/47 (100%) answered

Citizen, patient, caregiver or community leader (7/47) 15%

Professional / Clinical leader (6/47) 13%

System or organizational leader (17/47) 36%

Government/Agency policymaker (6/47) 13%

Researcher (3/47) 6%

Other (please use the chat to describe how you position yourself) (8/47) 17%
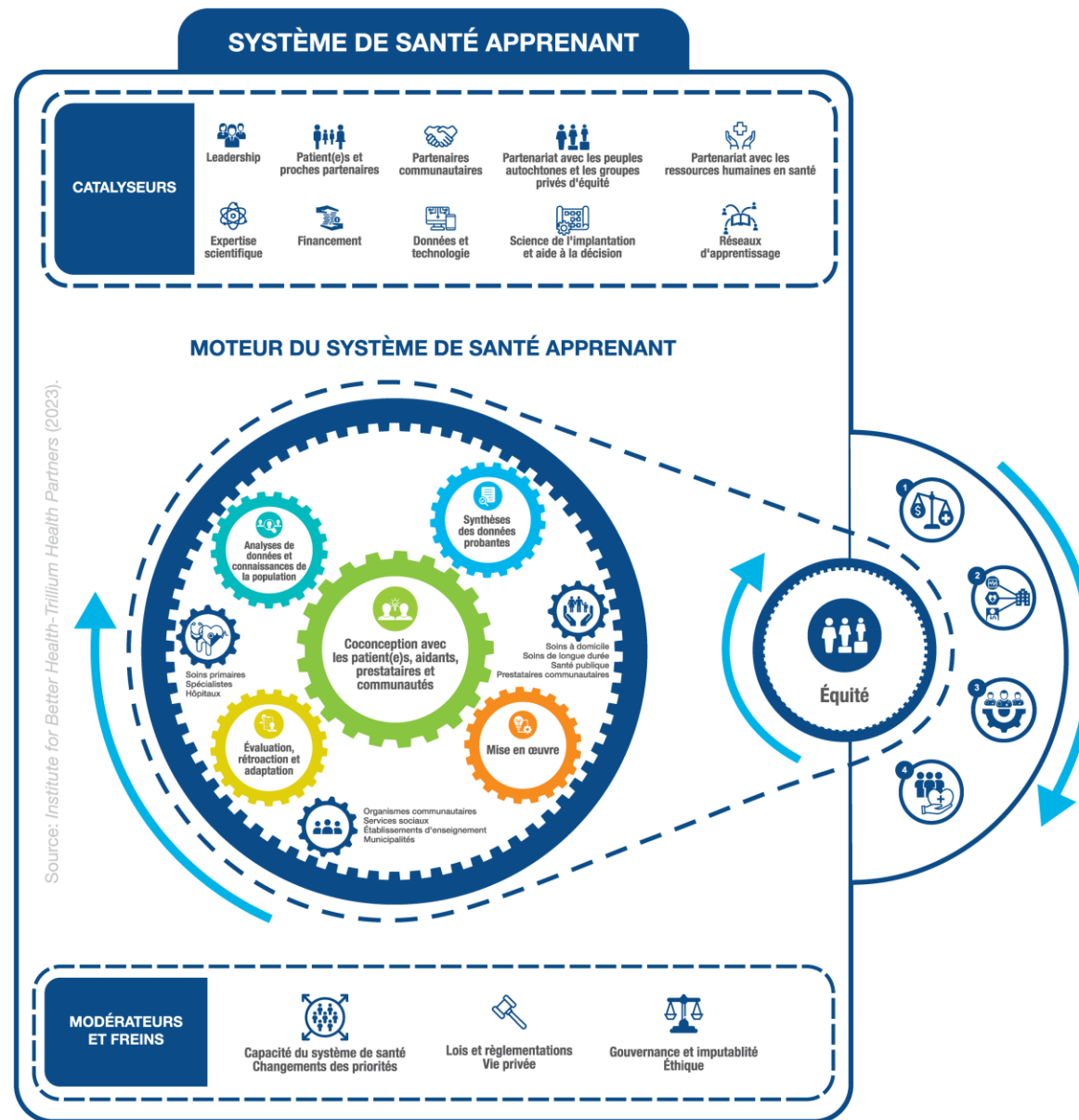
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LEARNING HEALTH SYSTEM ACTION FRAMEWORK
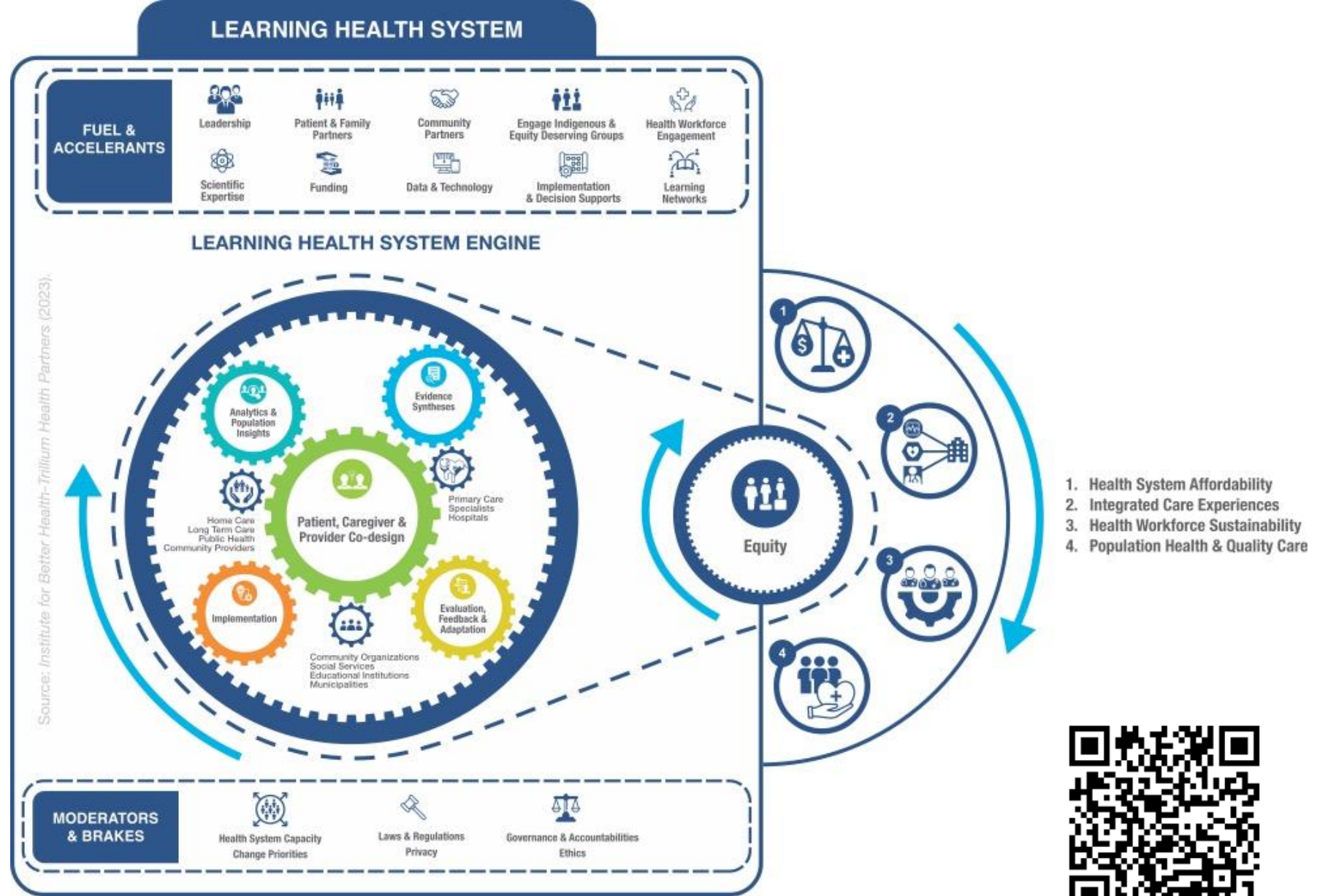
SOURCE: *Institute for Better Health-Trillium Health Partners* (2023).

AUSSI DISPONIBLE EN FRANCAIS

(merci Soutien Quebec)

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

We Can Assess Capability on this Framework

- **Introduction to LHS Capability Assessment Instrument**
    - Purpose
    - Structure
    - Development methods
    - Pilot test results

- **Discussion Topics & Feedback**
    - Data visualization options
    - Application methodology
    - Results: planning for improvement

What does it do?

- Measures LHS capabilities: **mapped across the LHS "gears"**

- To be completed by **interprofessional collaborators** (executive leaders, managers, frontline clinicians, implementation & QI leads, evaluation/data, researchers, operational supports, etc.)

- Enables LHS self-assessments for a **shared understanding of current state of development** (team, program, or organizational level)

Measurement Instrument

Gears (top to bottom): Analytics & Population Insights; Evidence Synthesis; Patient, Caregiver, Provider & Community Co-Design; Implementation; Evaluation, Feedback & Adaptation

How is it structured?

- **Survey instrument**
  - Understandable terminology across disciplines
  - Generalizable across settings
  - Easy-to-use, low measurement burden (~20 minutes)

- **Likert-scale, 40 items:**
  - <u>Quantitative:</u> measures of capability levels (i.e., extent to which LHS gears are enacted in practice)
  - <u>Qualitative:</u> open-ended comments (i.e., barriers, opportunities, challenges, facilitators, change ideas, examples)

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Section A – Analytics & Population Insights

Definition: In an LHS, multiple data sources and information inputs (e.g., regional, provincial, or national administrative databases, local EMR data, patient and provider surveys, qualitative insights, etc.) and a range of analytical methods are used to routinely assess performance (e.g., quality, access, cost, wait times, etc.), understand underlying causes of performance gaps against strategic objectives, and prioritize patient populations for improvements in care delivery. Throughout data collection and analyses, it is important to actively engage with patients, family members, caregivers, frontline providers, system leaders, managers, and researchers and effectively understand the needs of equity-deserving groups to mitigate health inequities.

The questions in this section assess the extent to which <u>analytics & population insights</u> are regularly used to identify performance gaps in your organization.

Please answer the questions below to the best of your ability.

		We never do this	We are starting to do this	We do this sometimes	We do this often	We do this (nearly) all of the time	Don't Know
1	We use available administrative (e.g., regional, provincial, or national databases) or local EMR data to measure quality outcomes and prioritize patient populations according to performance gaps	○	○	○	○	○	○
2	We use patient survey methods (e.g., mail, phone, digital, mixed methods surveys) and data to assess patient experience and/or reported outcomes for improvement purposes	○	○	○	○	○	○
3	We use qualitative methods (e.g., conversations, unit visits, focus groups, interviews, rapid thematic analyses, ethnographic studies) to gather input and understand patients' needs and experiences	○	○	○	○	○	○
4	We use data modelling (e.g. predictive, causal, and multi-level analyses, including machine learning & artificial intelligence) to identify causes of performance gaps and health inequities	○	○	○	○	○	○

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		We never do this	We are starting to do this	We do this sometimes	We do this often	We do this (nearly) all of the time	Don't Know
5	We use equity analyses (e.g., marginalization/deprivation indices, relative inequality analyses) to identify inequities and prioritize equity-deserving groups	○	○	○	○	○	○
6	We actively engage with a diverse array of partners (e.g., patients, family members, frontline providers, system leaders and managers, and/or researchers) as appropriate to inform problem definition, prioritization, and selection of data collection and analysis methods	○	○	○	○	○	○

7. Do you have any comments related to **analytics & population insights** you would like to provide for additional insights and/or context? (i.e., examples of work you've done, barriers, challenges, and/or enablers you've encountered, suggestions for improvement in your organization, etc.)
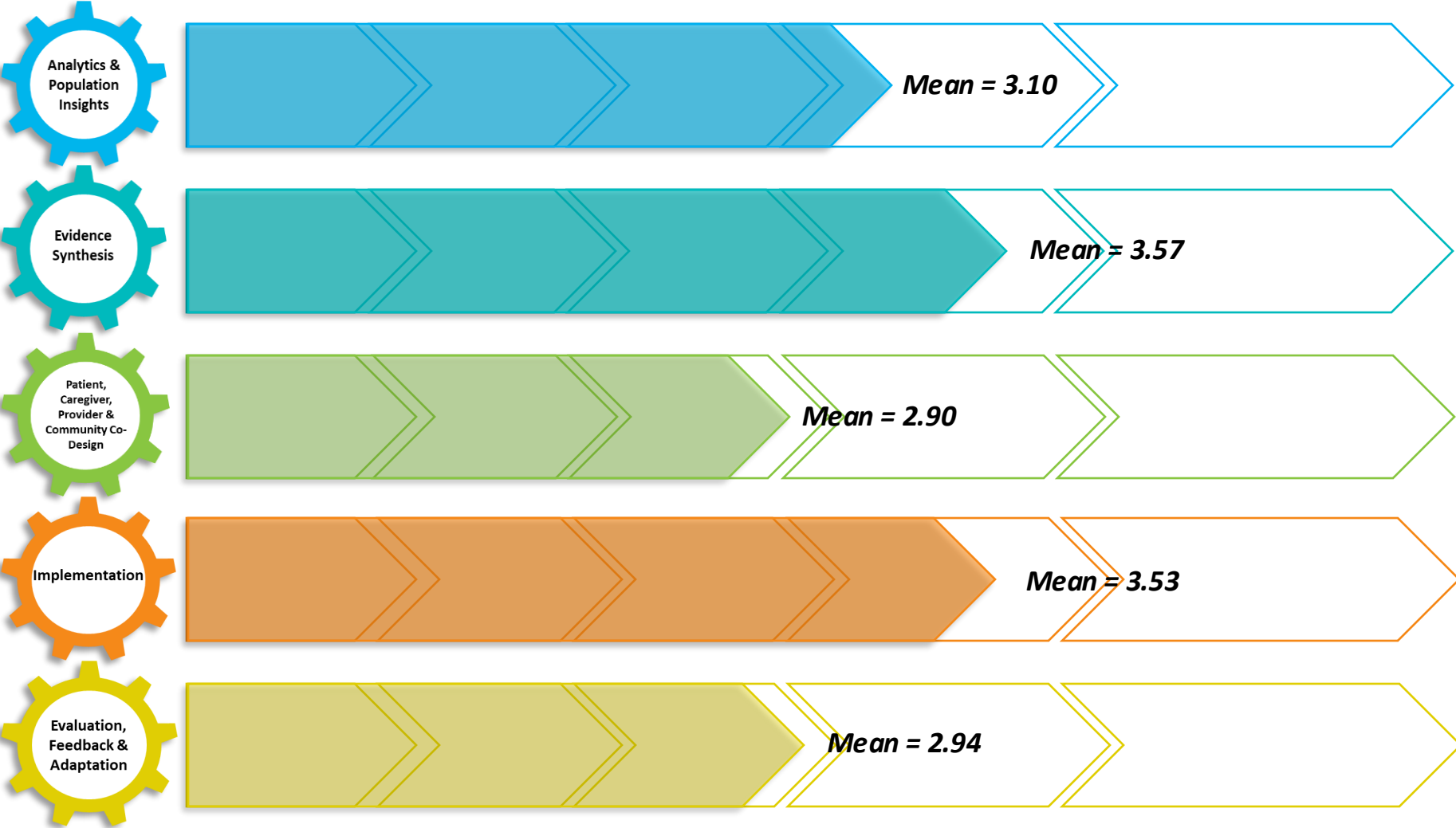
Open-Ended Comments

Measurement Instrument: Capability Assessment Attributes

1. Analytics and Population Insights	2. Evidence Synthesis	3. Patient, Caregiver, & Provider Co-Design	4. Implementation	5. Evaluation, Feedback, & Adaptation	6. Organizational Enablers
Descriptive Clinical-Administrative Data Analysis	Evidence Syntheses Question Definitions	Engagement with Partners for Co-Design	Implementation Solutions Alignment	Evaluation Methods	Leadership and Strategy
Patient-Reported Data Analysis	Evidence Syntheses Methods	Co-Design Methods and Techniques	Operational Support for Implementation	Evaluation Agility and Frequency	Operational and Technological Supports
Qualitative Data Analysis	Use of Evidence Syntheses Findings	Mitigation of Participation Barriers and Power Imbalances	Resources and Accountability for Implementation	Use of Evaluation Findings	Community Engagement and Learning Networks
Data Modelling	Engagement with Partners for Evidence Syntheses		Participatory Leadership for Implementation	Evaluation Scope	Short-Term and Long-Term Funding
Equity Analysis			Engagement with Partners for Implementation	Engagement with Partners for Evaluation	Laws, Regulations, & Ethical Oversight
Engagement with Partners for Analytics					

Pilot Test – Health Care Network

Horizontal

| 1. We never do this | 2. We are starting to do this | 3. We do this sometimes | 4. We do this often | 5. We do this (nearly) all of the time |

LHS Gears

- Analytics & Population Insights — Mean = 3.10
- Evidence Synthesis — Mean = 3.57
- Patient, Caregiver, Provider & Community Co-Design — Mean = 2.90
- Implementation — Mean = 3.53
- Evaluation, Feedback & Adaptation — Mean = 2.94

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Advancing the Learning Health System:
7 Part Series

1. Introduction to Learning Health System Action Framework and 5 gears

2. Gear 1: Population data insights

3. Gear 2: Evidence gathering and synthesis

4. Gear 3: Co-design

5. Gear 4: Implementation

6. Gear 5: Evaluation and Feedback

7. Review
   + Enablers and Barriers: Fuel, Accelerants, Moderators and Brakes
   + Measuring capabilities for Learning Health System

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Advancing the Learning Health System:
7 Part Series

Seven features of a learning health system

The combination of a health system and research system that, at all levels, is

- anchored on **patients' / clients'** needs, perspectives and aspirations (1)
- driven by timely **data** (2) and **evidence** (3)
- supported by appropriate **decision supports** (4) and aligned **governance, financial and care / service delivery arrangements** (5)
- enabled with a **culture** of (6), and **competencies** for (7), **rapid learning and improvement**

Two actions at the heart of a learning health system

- Use '**learning and improvement cycles**' – in all 'layers' and especially with patients / clients (1), organized around tests of change, drawing on many forms of evidence (2 & 3), and involving research | operations | patient/client and family partnerships at the many 'coalfaces'

- Make 'any change for the better' **the 'new normal'** (and not yet another pilot project) – with appropriate decision supports (4), aligned governance, financial & care/service delivery arrangements (5), and both culture (6) and competencies (7)

Who are the evidence 'trades' supporting learning and improvement cycles and making any change for the better the 'new normal'?

- Data analytics (and modeling)
  - Who is providing the data analytics, including about equity-centred quadriple-aim metrics? (e.g., IC/ES, INSPIRE-PHC, RISE-NOSM)
- Evaluation
  - Who is doing the rapid evaluations of 'tests of change'?
- Behavioural / implementation research
  - Who is doing the behavioural / implementation research to address barriers to accessing care and to changing practice?
- Qualitative insights
  - Who is systematically capturing qualitative insights from patients/clients and citizens and from clinicians?
- Evidence synthesis
  - Who is providing ultra-rapid contextualized evidence syntheses? (e.g., RISE-MHF)
- Health technology assessments
  - Who is accessing reports from OTAC, CADTH, etc. or preparing their own?
- Guidelines
  - Who is sourcing, assessing and adapting OH quality standards and guidance documents or preparing their own?

Patients are more than data donors

- Learning health system (LHS): Embedding research into health systems, continuously learning from data and translating findings into care / services in real time – **means much more than data donors!**

- A scoping review of LHS articles from 2016 to 2020 found articles discussing the level of patient involvement in LHS were scarce

- No common language, tools or frameworks for discussing and operationalizing LHS exist, making it likely that many healthcare institutions are using this approach without explicitly naming it as such

- Tools that exist are often not suited to engaging people and communities with diverse voices and needs, particularly those from equity deserving groups

Source: Maureen Smith

Patients, Caregivers & Citizens **Health System Partners** **Researchers**
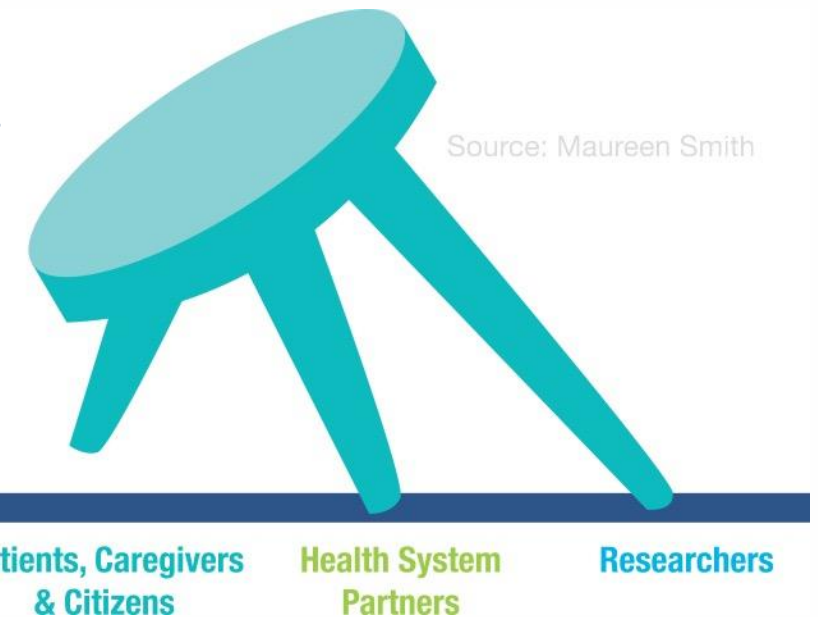
SOURCES:
Lee-Foon NK, Smith M, Greene SM, Kuluski K, Reid RJ. Positioning patients to partner: exploring ways to better integrate patient involvement in the learning health systems. Research Involvement and Engagement. 2023;9(1):1-5.
Zurynski Y, et al Mapping the learning health system: a scoping review of current evidence. Sydney: Australian Institute of Health Innovation. 2020
Kuluski K, Guilcher SJ. Toward a person-centred learning health system: understanding value from the perspectives of patients and caregivers. Healthcare Papers. 2019;18(4):36-46.

Review of the 5 Gears

Learning Gear 1: Analytics & Population Insights

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

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

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

HSPN Health System Performance Network

Today's event
LHS Analytics and Insights

Host

Dr. Walter Wodchis
Principal Investigator
HSPN

Presenters

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

Emmi Perkins
Director of Transformation
Guelph-Wellington OHT

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

Sarah-Grace Bebenek
Project Manager
South Georgian Bay OHT

HSPN Monthly Webinar

May 28, 2024

What We Know

Our attributed population (MoH data unless otherwise stated)
- 514,024 people
  - 92,045 (17.9%) >65yrs
  - 199,332 (38.7%) >50
  - 23,011 Frail Adults >65 (Canadian Frailty Network projection)

- 148,784 (28.9%) live outside of London

- 9,252 (1.8%) Francophone (SW LHIN)
  - Arabic most common language besides English

- 87,384 (17%) visible minority (SW LHIN)

- 88,412 (17.2%) living in poverty (SW LHIN)

What We Know

OHT Top 10 HPG Ranked by Total Cost

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

Legend for Top 10 HPGs' Description

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

- 8/10 include sig comorbidities

- Total spend on these 8 = $413.1M

Data for Improvement

DATA   LEADS TO   UNDERSTANDING   LEADS TO   ACTION

East Toronto Health Partners

Patient Experience Survey Outcomes

Survey Themes

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

Actions

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

Poll 3

1. We use data (any of administrative, medical records, surveys, qualitative) to identify where improvements can be in our attributed population. (Single choice)

58/58 (100%) answered

We never do this	(1/58) 2%
We are starting to do this	(3/58) 5%
We do this sometimes	(13/58) 22%
We do this often	(10/58) 17%
We do this (nearly) all the time	(9/58) 16%
Don't know [not engaged in direct OHT activity]	(22/58) 38%
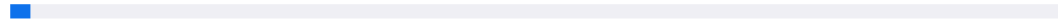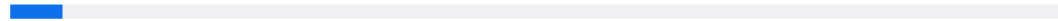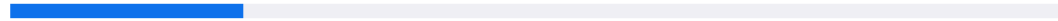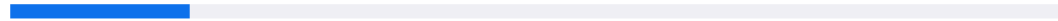
LHS Gears Capabilities – Analytics and Population Insights

Analytics and Population Insights

Legend:
- 0) Don' know
- 1) We never do this
- 2) We are starting to do this
- 3) We do this sometimes
- 4) We do this often
- 5) We do this (nearly) all of the time
- Mean

Categories and values:

Descriptive Clinical-Administrative Data Analysis — Mean 3.00
- 14% (4)
- 71% (3)
- 14% (2)

Patient-Reported Data Analysis — Mean 3.29
- 14% (5)
- 29% (4)
- 29% (3)
- 29% (2)

Qualitative Data Analysis — Mean 2.43
- 29% (4)
- 0%
- 57% (2)
- 14% (1)

Data Modelling — Mean 1.43
- 43% (2)
- 57% (1)

Equity Analysis — Mean 1.71
- 14% (3)
- 43% (2)
- 43% (1)

Engagement with Partners for Analytics — Mean 2.57
- 57% (3)
- 43% (2)

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Learning Gear 2: Evidence

Description: Rapid syntheses of existing evidence to understand the success or failure of solutions to similar problems tested elsewhere as well as barriers and promoters.

Sample Questions: What has worked and not worked elsewhere? What are key components & adaptable periphery? What conditions and contextual issues are key? What barriers need to be addressed?

Health System Affinities: Health system librarians, clinical guideline development teams, provincial & federal evidence synthesis supports, Cochrane collaboration, SPOR Evidence Alliance, global evidence consortia

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Areas of expertise

- Patient-oriented research & training (with an equity, diversity, inclusion, Indigeneity lens)
- Minority and marginalized populations
- Learning Health Systems (embedded partner in OHTs and member of the OSSU LHS WG)
- Health service access and use
- Human resources for health
- Digital / Virtual care

CRaNHR is an OSSU Centre under the Strategy for Patient-Oriented Research initiative. CRaNHR is the only such centre in northern Ontario.

Centre for Implementation Research

Established in 2018, assembles world-leading interdisciplinary implementation scientists with expertise in:

- Audit and feedback
- Decision aids
- Clinical practice guideline development/evaluation
- Evidence synthesis
- Integrated knowledge translation and community partnerships
- Health care professional behaviour change

- Behaviour change in patients/general public
- Health economic evaluation
- Qualitative, survey, and consensus methods
- Intervention evaluation
- Barriers/enablers assessment
- Intervention co-development

Five prompts for being systematic and transparent when drawing on existing evidence syntheses in rapid learning and improvement

1. Confirm that **research evidence** (or another type of information) is actually what is needed

2. Use a **framework** to generate a mutually exclusive and collectively exhaustive (MECE) list to work with

3. Leverage the right **evidence repositories** (and living evidence syntheses) for the form of evidence and topic area you're interested in

4. Know **what to look for** in the existing evidence, especially for evidence synthesis:
- currency (or recency)
- quality
- local applicability (e.g., including for equity-deserving groups)

5. Know where to go to find high-performing **evidence-support units**, by form of evidence and topic area, and how to set standards for those supporting the flow of new evidence

Keep in mind
- How far and how fast evidence support has moved
- How these new developments can help you do your work more efficiently and/or with greater confidence
- How easy it is for people outside your organizations to assess documents it puts in the public domain

An example of a two-page prompts sheet is available upon request

Poll 4

1. We use external evidence and ideas to select and guide initiatives (e.g. use or adapt what has worked elsewhere to solve problems). (Single choice)

41/41 (100%) answered

We never do this
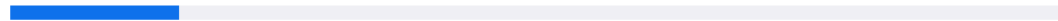(0/41) 0%

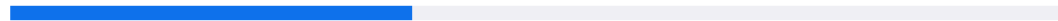We are starting to do this
(4/41) 10%

We do this sometimes
(10/41) 24%

We do this often
(8/41) 20%

We do this (nearly) all the time
(3/41) 7%

Don't know [not engaged in direct OHT activity]
(16/41) 39%
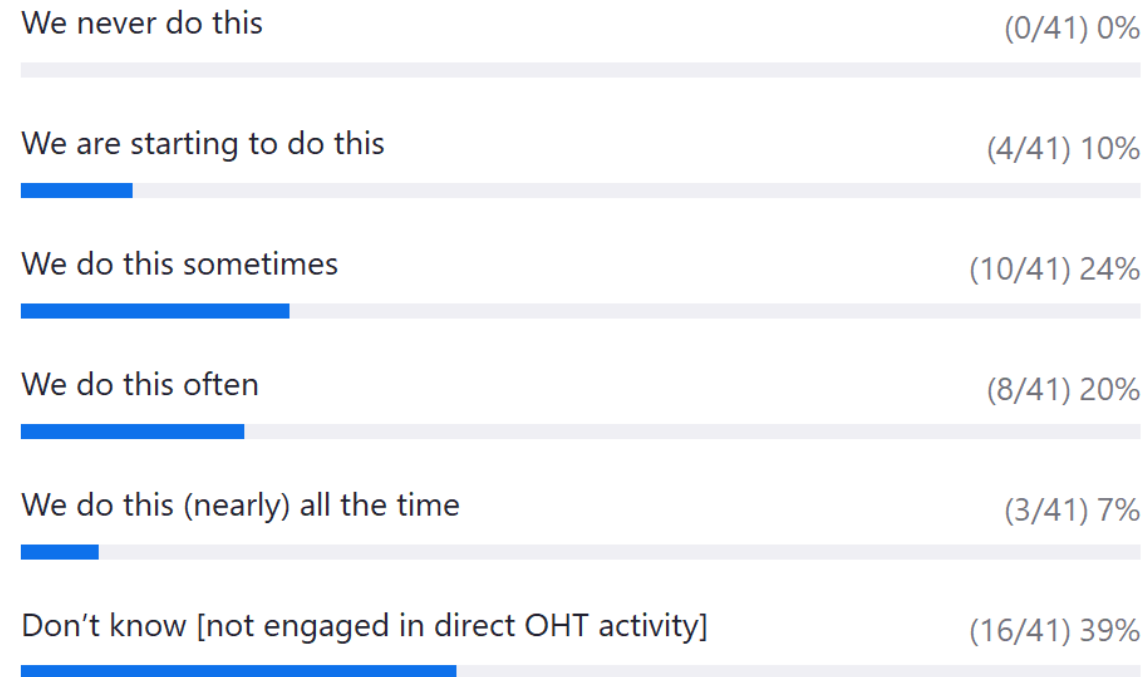
LHS Capabilities – Evidence Synthesis

Evidence Synthesis
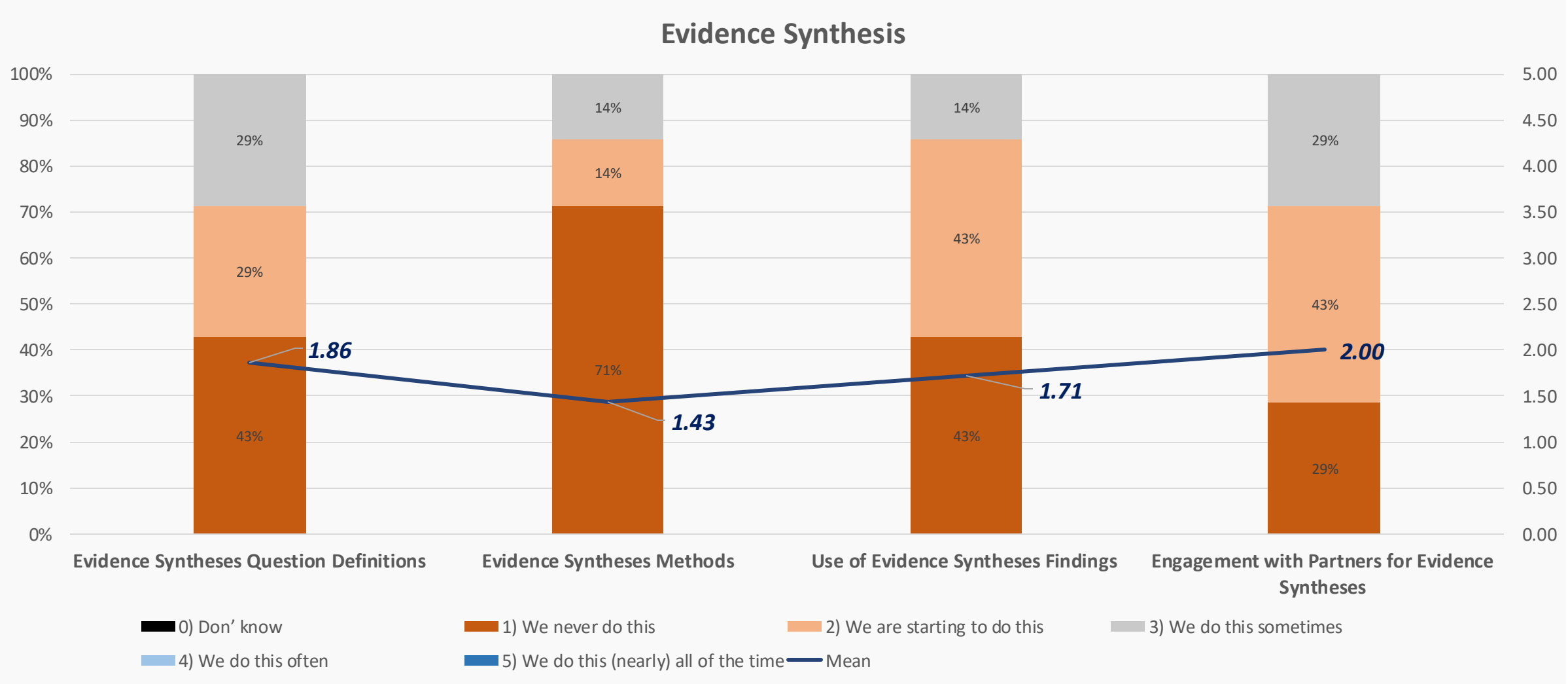
Learning Gear 3: Patient, Caregiver and Provider Co-design
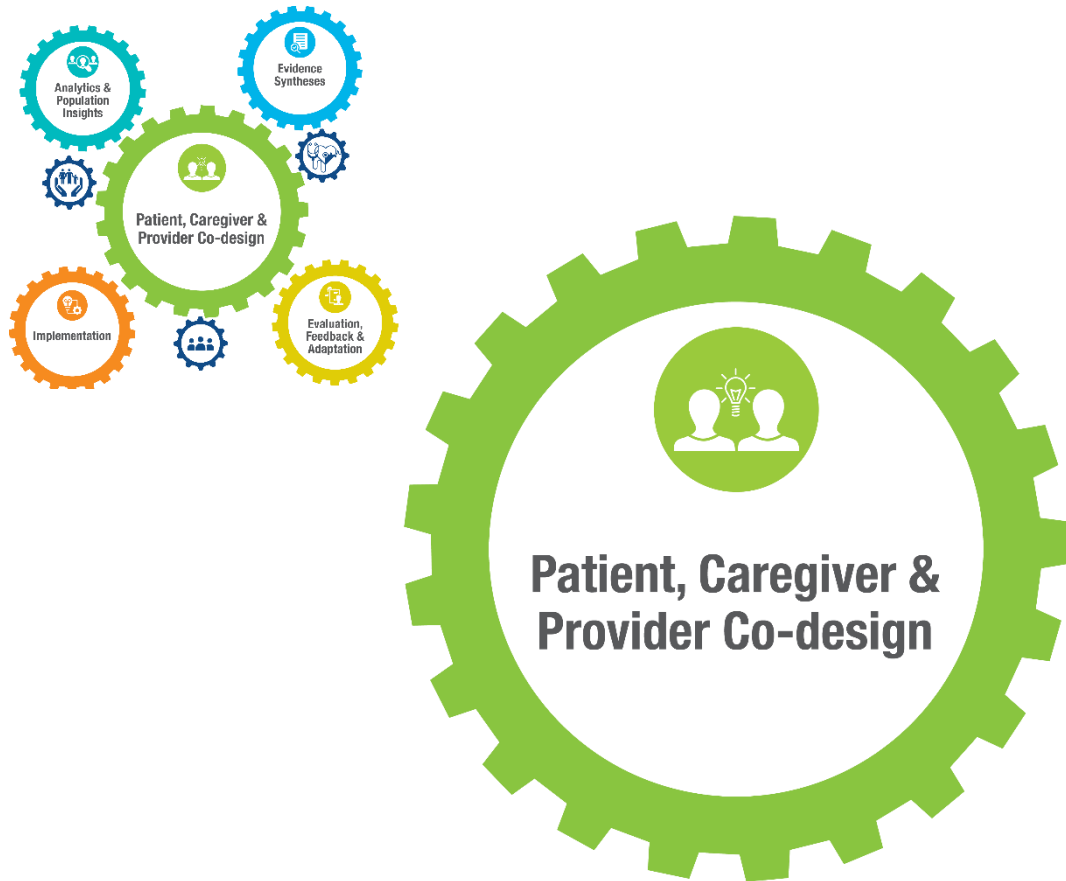
Description: Direct engagement and co-design with patients, caregivers, care providers and community members impacted by the health problem alongside those who can move co-designed services towards successful implementation.

Sample Questions: what are user centered design conditions (providers, patients, caregivers, community members)? What design considerations are most important? How can technology be used? How do requirements differ for equity deserving groups? What are the feasibility constraints?

Health System Affinities: innovation & user centered design experts/teams, clinical programs/networks, health informatics programs, patient & family experience councils, community groups, health system leaders/regulators etc.

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Today's event: Learning Health System Co-design with Patients, Caregivers and Providers

Host

Dr. Walter Wodchis
Principal Investigator
HSPN

Presenters

Dr. Kerry Kuluski
Associate Professor at the Institute of Health Policy, Management and Evaluation, University of Toronto

Frances Henderson
Caregiver Advisor for Mississauga Health

Dipti Purbhoo
Executive Director at The Dorothy Ley Hospice
Mississauga Health OHT

Dr. Laura Harild
Clinical Co Lead for Ontario Health, Central Region, Division Head and Medical Director Mississauga Health OHT

Yasmin Sheikhan
Vice Chair, Chair of Patient and Caregiver Advisory Council, Mid-West Toronto Ontario Health Team

Edward Aust
Director, Corporate Planning Mid-West Toronto Ontario Health Team Secretariat

HSPN Monthly Webinar

July 23, 2024

STAGES OF CO-DESIGN

Engage- build relationships, take steps to understand the problem

Plan- stages of the work, logistics, assess needs, **goals**, **methods to use**, etc.

Explore- learn about experiences and priority areas

Develop- co-design/co-redesign improvement (intervention, process, product)

Decide- what to prioritize and refine/seek additional feedback

Change- turn improvement ideas into action

Adapted from Kiss et al (2024)- see Figure 2

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CHECK OUT OUR TWO CO-DESIGN WEBINARS!

OHT learning series - Session #5: Preparing your Engagement Activities

https://www.youtube.com/watch?v=EA0A2QyK9rc

OHT Learning Series - Session #6: Engagement Methods

https://www.youtube.com/watch?v=FBk18YphCrY

To access the full 7-part series and workbooks:

https://www.instituteforbetterhealth.com/portfolio-items/patient-caregiver-and-community-engagement-learning-series/

Guiding Principles

Ministry of Health Patient, Family and Caregiver Declaration of Values
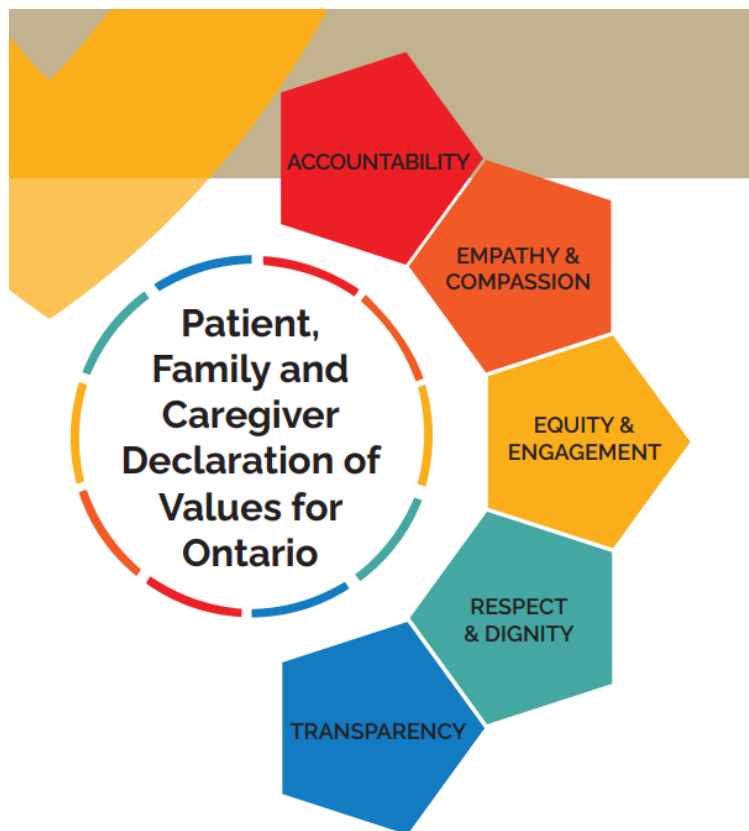
Mississauga Health Community Health Advisory Network

Purpose

To create space for the diverse voices of patients, clients, and their support networks to provide guidance on our journey of creating an inclusive care system that we can all navigate.

Role of a Community Advisor

- Share experiences and those of their communities
- Participate and inform key decisions and health system solutions
- Make recommendations on help make our care system better for all
- Review or help create resources/ materials
- Help the Mississauga Ontario Health Team engage with diverse communities
- Encourage members of our local communities to get involved in opportunities

Key Components of Co-Design

PROBLEM SPACE

SOLUTION SPACE

divergent

convergent

divergent

convergent

Discover
explore, empathize, understand

Define
synthesize, hone in, sharpen

Design
ideate, prototype, iterate, validate

Deliver
build, implement, integrate, refine
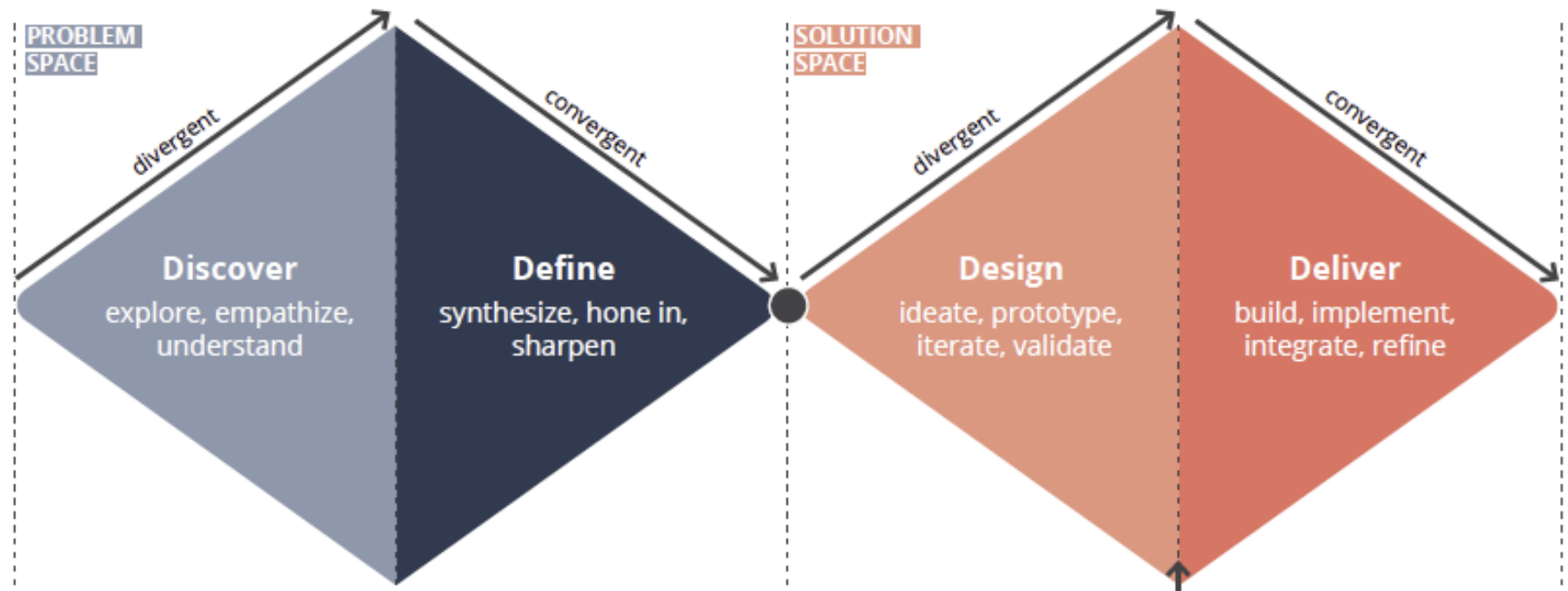
- Service asset mapping
- User engagement interviews
- Needs assessment review
- Literature and environmental scans
- Journey mapping

- Brainstorming
- Thematic analysis
- Visioning exercises
- Consultations
- Design brief

- Targeted user engagement interviews
- Team-based co-design activities
- User personas
- Navigator capacity survey
- Future state journey mapping
- Service blueprinting

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Poll 5

1. We use formal co-design methods such as structured deliberations and techniques (e.g. dialogues with partners, Delphi panels, future state mapping) with a diverse array of partners including patients and family and service/care providers in the co-design/co-creation of solutions. (Single choice)

50/50 (100%) answered

We never do this (1/50) 2%

We are starting to do this (8/50) 16%

We do this sometimes (9/50) 18%

We do this often (4/50) 8%

We do this (nearly) all the time (4/50) 8%

Don't know [not engaged in direct OHT activity] (24/50) 48%
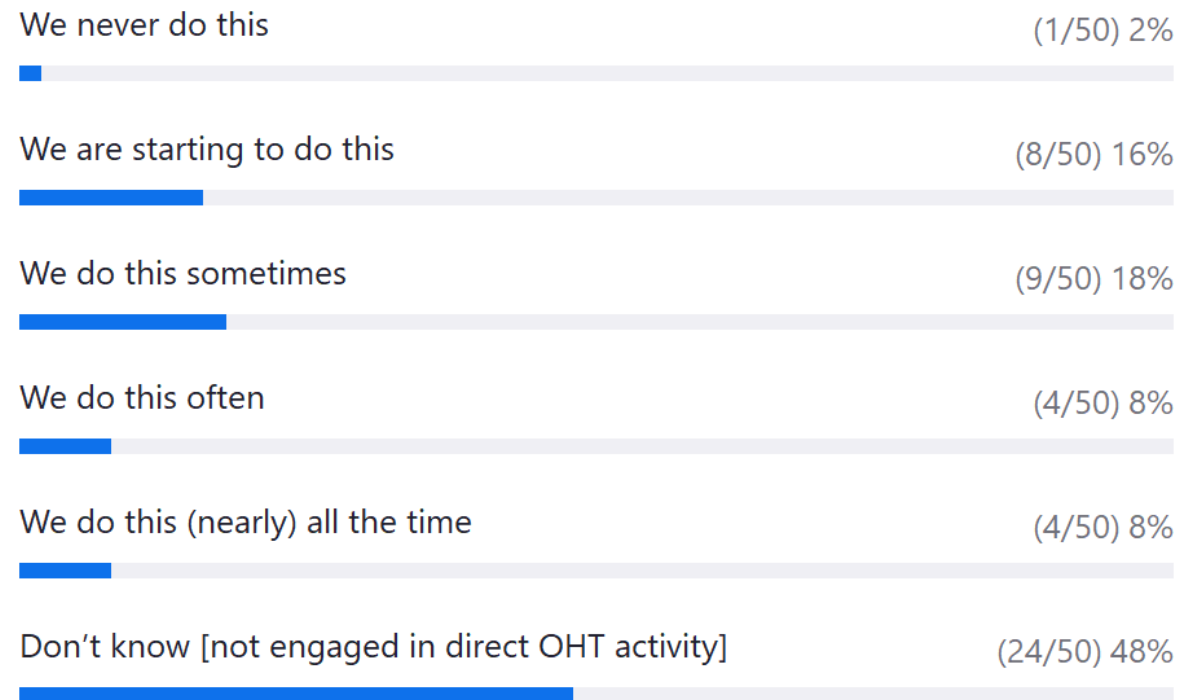
LHS Gears Capabilities – Patient and Provider Co-Design

Patient and Provider Co-Design

Engagement with Partners for Co-Design: 14%, 57%, 14%, 14%; Mean 2.29

Co-Design Methods and Techniques: 29%, 57%, 14%; Mean 2.00

Mitigation of Participation Barriers and Power Imbalances: 29%, 29%, 29%, 14%; Mean 2.29

Legend: 0) Don' know | 1) We never do this | 2) We are starting to do this | 3) We do this sometimes | 4) We do this often | 5) We do this (nearly) all of the time | Mean

IMPROVING HEALTH THROUGH RESEARCH AND INNOVATION

Trillium Health Partners | INSTITUTE FOR BETTER HEALTH

Learning Gear 4: Implementation
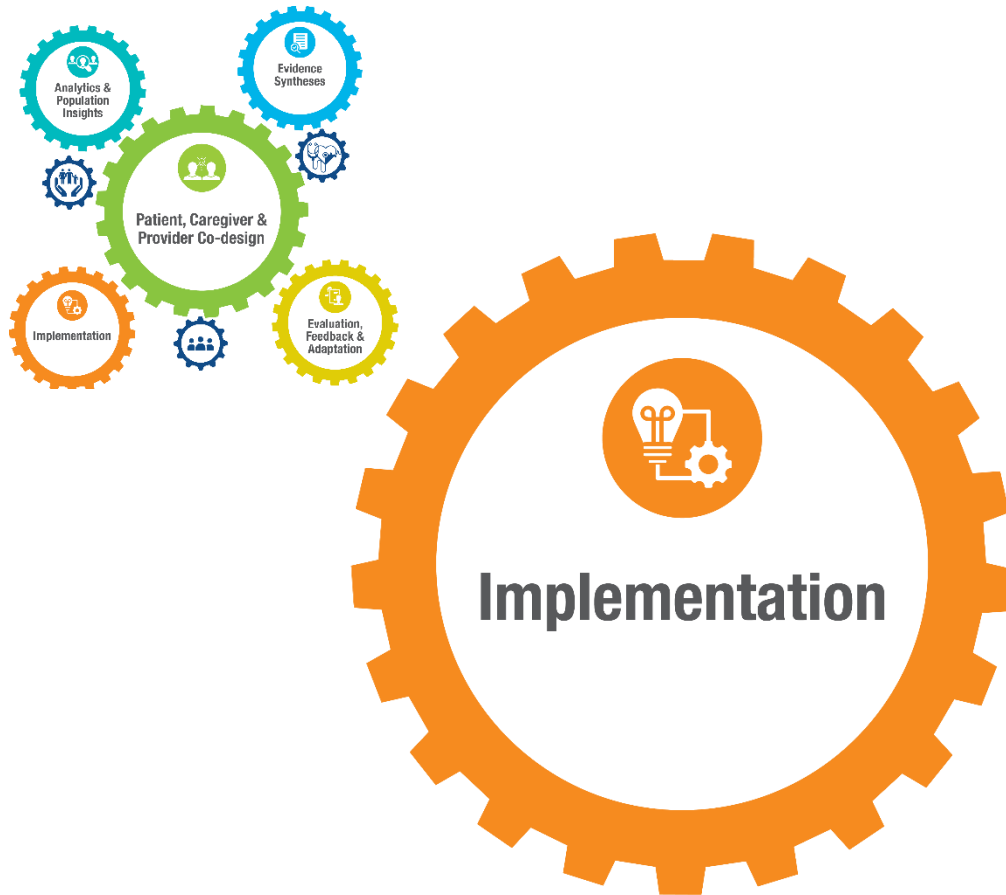
Description: Systematically converting research findings and other evidence-based practices into routine and "sticky" practices that enhance the quality and impact of health services.

Sample Questions: How to stage implementation? What implementation/change management methods & communication channels should be used? How can behavioral motivation built? How to best train people for new work, or new ways of receiving care?

Health System Affinities: Quality improvement teams, Lean/Six Sigma leaders, project management teams, health informatics, change management trainings etc.

Today's event: Implementation: From Research to Routine Practice

Host

Dr. Walter Wodchis
Principal Investigator
HSPN

Presenters

Dr Tina Fahim
Scientist
Knowledge Translation Program,
St. Michael's Hospital

Marjorie Hammond
Geriatrics Nurse Specialist

Jeanette Cooper
Research Coordinattor
Knowledge Translation Program,
St. Michael's Hospital

HSPN Monthly Webinar

September 24, 2024

The Knowledge-to-Action model describes a process for dissemination and implementation of research
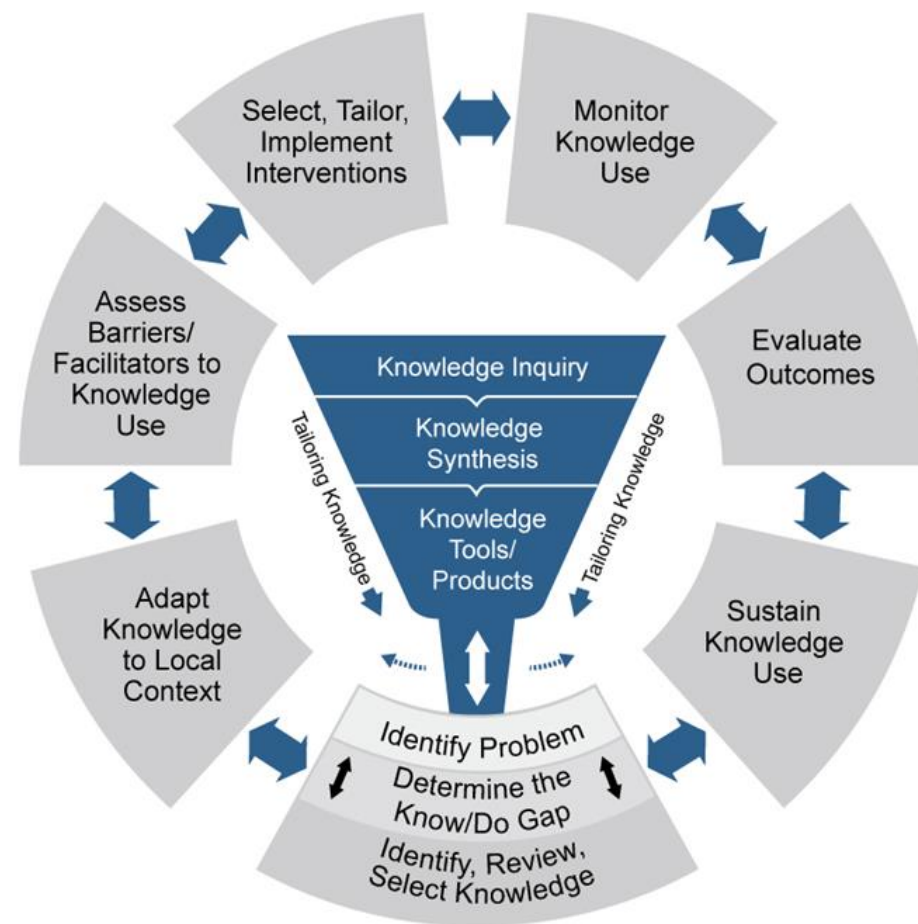
Graham ID, Logan J, Harrison MB, Straus SE, Tetroe J, Caswell W, Robinson N. Lost in knowledge translation: time for a map? J Contin Educ Health Prof. 2006 Winter;26(1):13-24. doi: 10.1002/chp.47. PMID: 16557505.

Why would people change (or not)?

- Organize barriers and facilitators using theoretical frameworks

- Use theories and frameworks to LINK barriers and facilitators to corresponding strategies
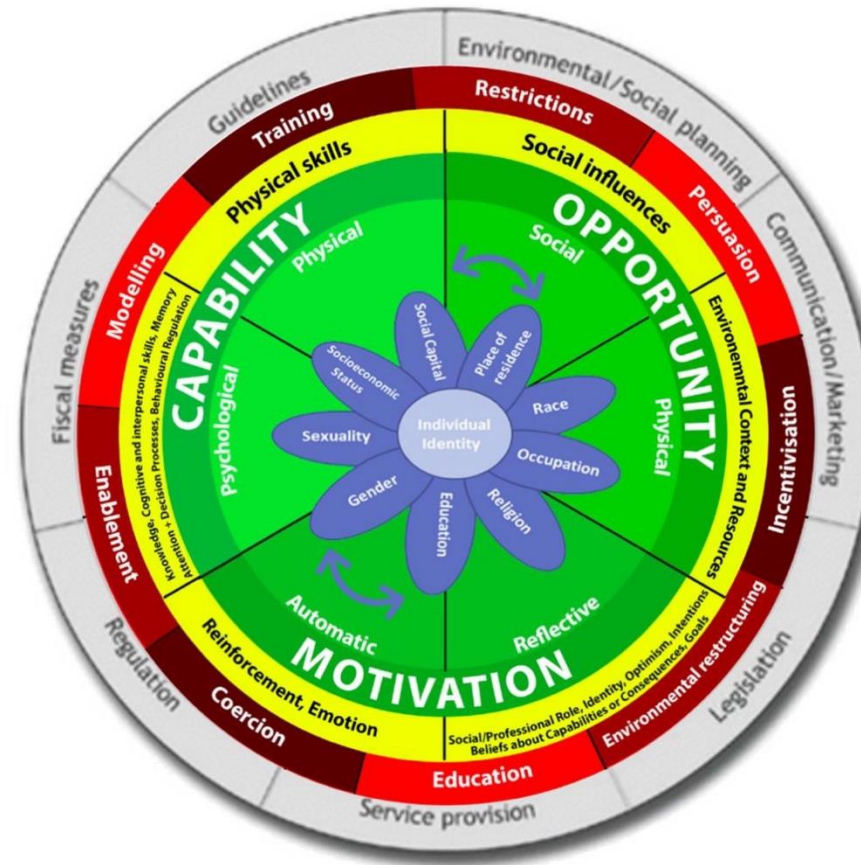
Source: Michie, van Stralen, & West (2011). Implementation Science; 6(1):42. doi: 10.1186/1748-5908-6-42.

Creation of a theoretically rooted workbook to support implementers in the practice of knowledge translation

Christine Fahim ✉, Melissa Courvoisier, Nadia Somani, Fatiah De Matas & Sharon E. Straus

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STEP 1: Identify your WHAT

STEP 2: Identify your WHO

STEP 3: Understand the WHY

STEP 4: Identify your HOW

STEP 5: PLAN for evaluation and sustainability

Poll 6

1. We actively engage with a diverse array of partners (patients & family, frontline providers, system leaders, researchers) to understand what drives behaviour and address foreseeable barriers to the implementation of programs. (Single choice)

36/36 (100%) answered

We never do this   (1/36) 3%

We are starting to do this   (2/36) 6%

We do this sometimes   (3/36) 8%

We do this often   (8/36) 22%

We do this (nearly) all the time   (3/36) 8%

Don't know [not engaged in direct OHT activity]   (19/36) 53%

HSPN
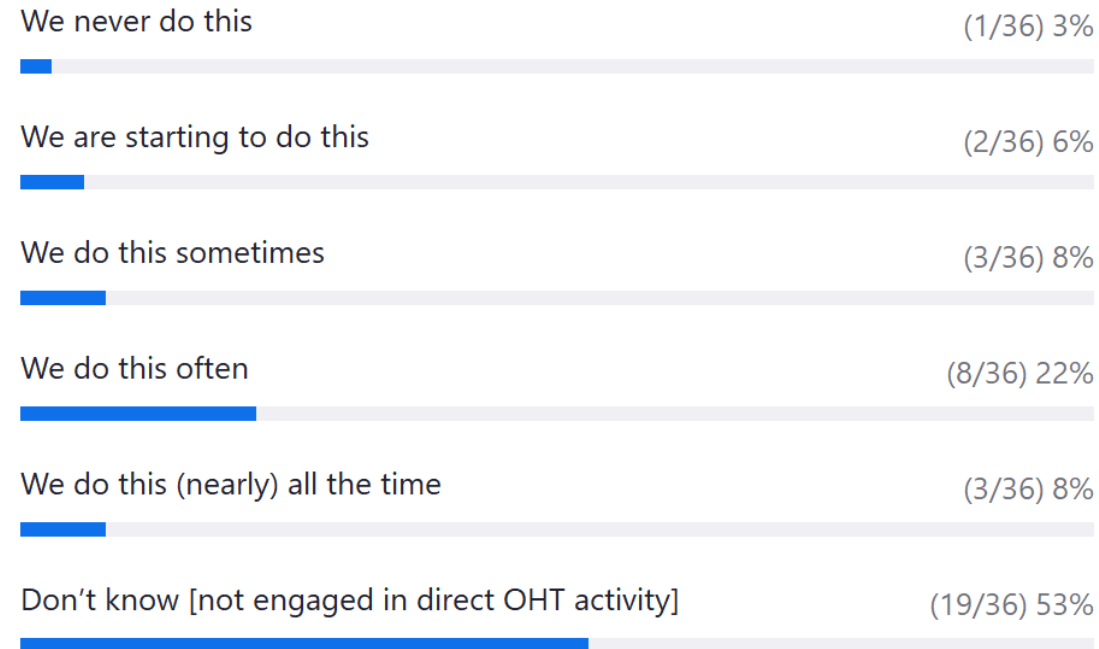
LHS Capabilities – Implementation

Implementation
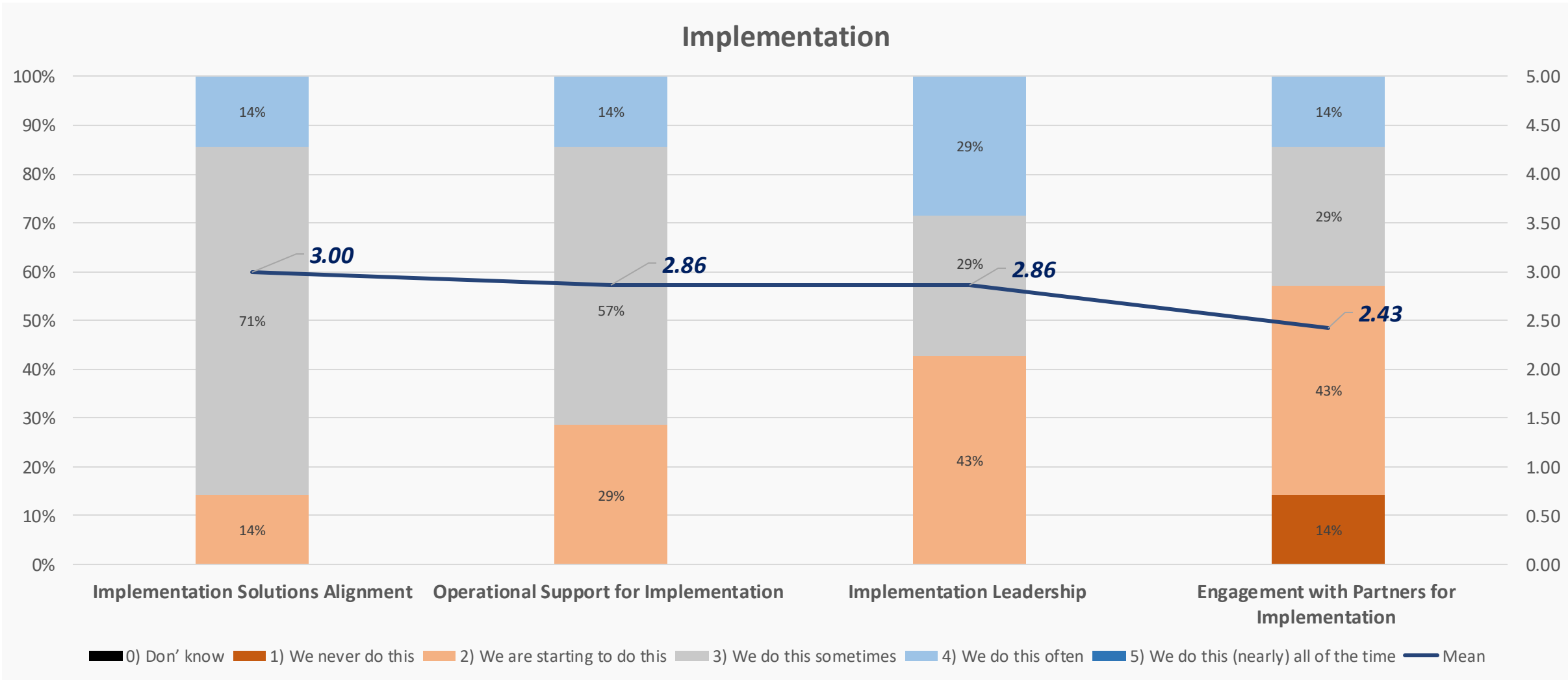
Learning Gear 5: Evaluation, Feedback & Adaptation

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.

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.

WORKING – DRAFT Logic Model

Aging Well @ Home

Inputs	Population	Activities		Outputs	

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 programs and services

- Maintain current list of programs and services
- Support interface that is easy to 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
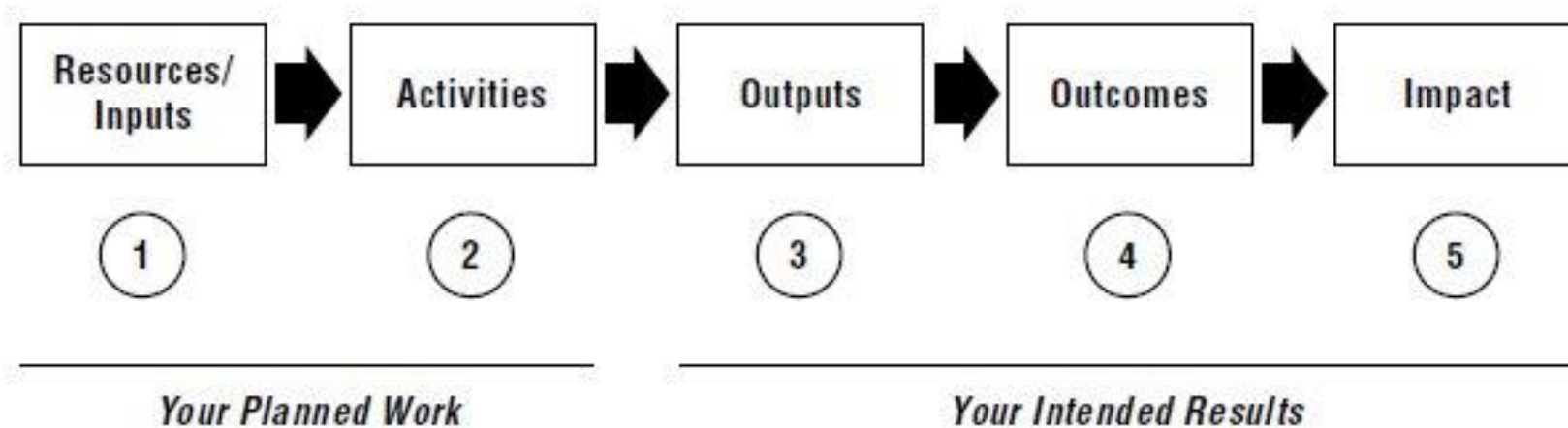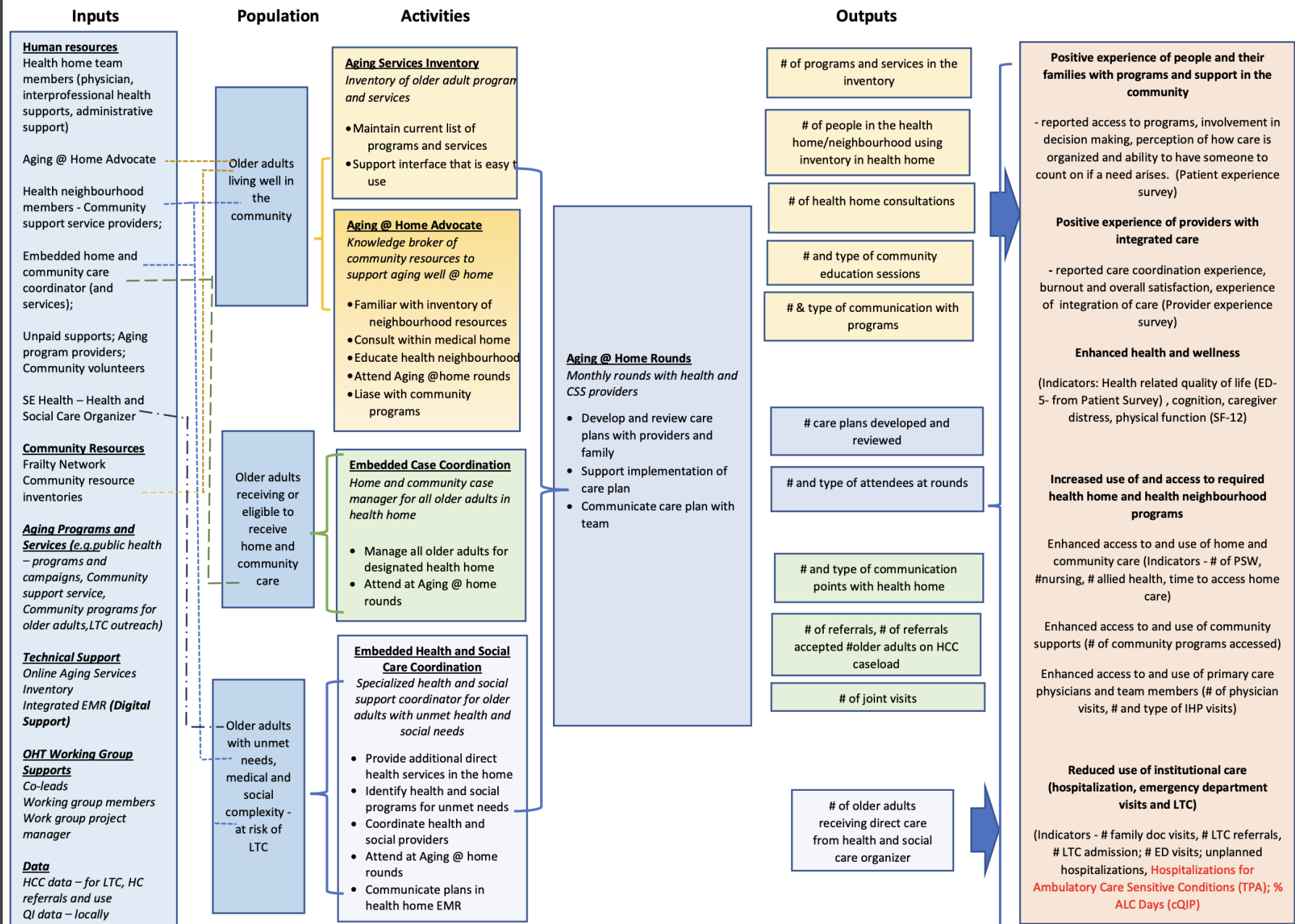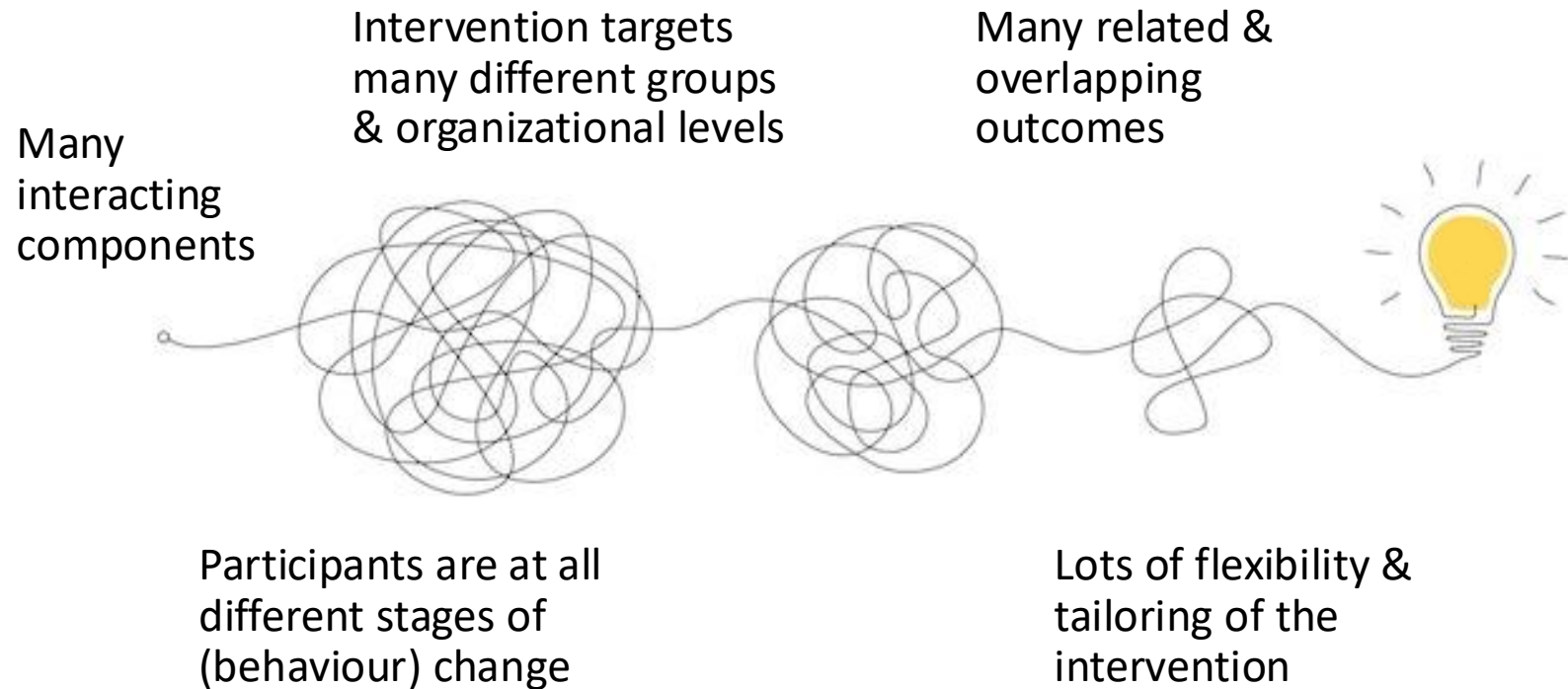*Monthly rounds with health and CSS providers*

- 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)

FLAOHT
Frontenac Lennox & Addington
Ontario Health Team

ÉSOFLA
Équipe Santé Ontario de
Frontenac, Lennox et Addington

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

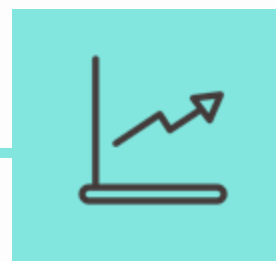# Learning from evaluation with Northern OHTs

Team-based works best

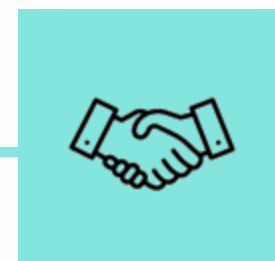Share the work, bring others along, use resources wisely

Make capacity-building part of the strategy
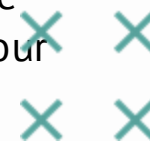
Helps to manage the power dynamics too

Data collection is inevitable

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

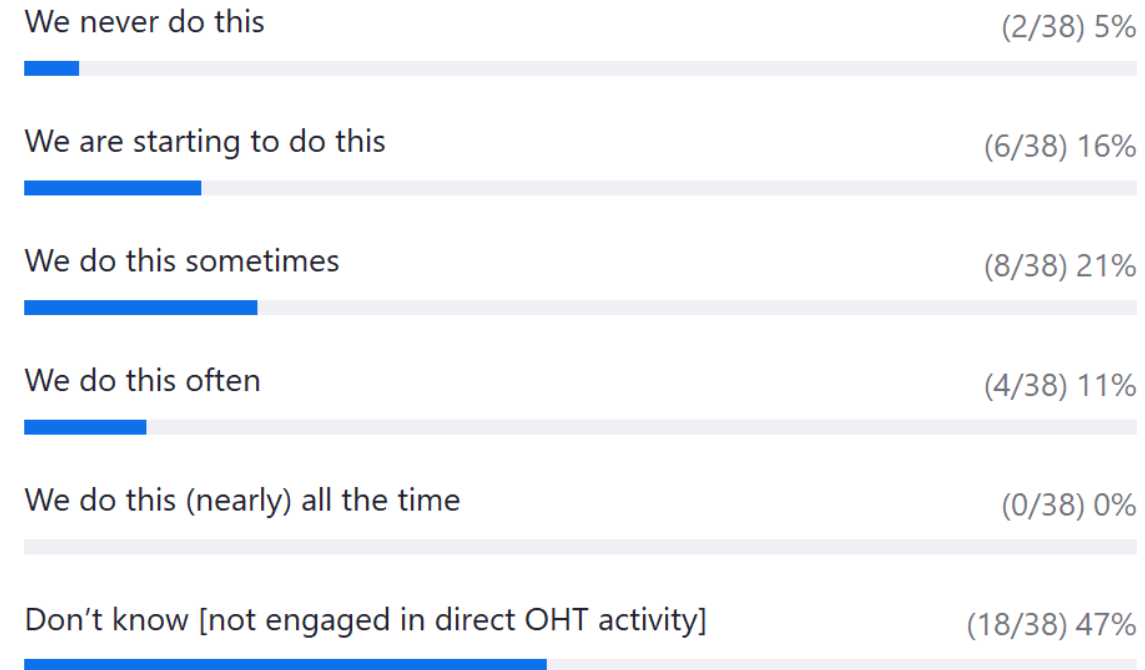## Know the "so what" ahead of time
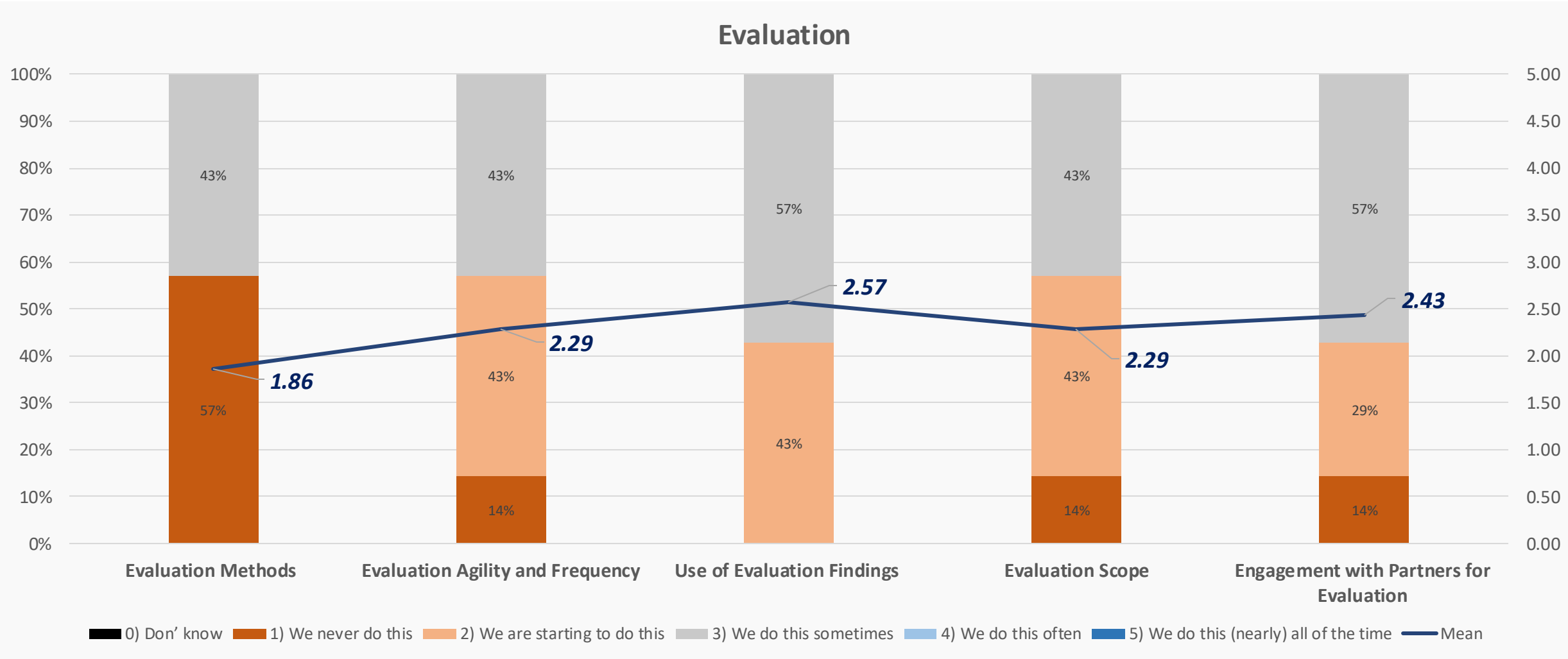
Commit to the action, know your why

Poll 7

1. We use formal processes with ongoing data and frequent cycles of evaluation and feedback to assess performance against our objectives. (Single choice)

38/38 (100%) answered

We never do this   (2/38) 5%

We are starting to do this   (6/38) 16%

We do this sometimes   (8/38) 21%

We do this often   (4/38) 11%

We do this (nearly) all the time   (0/38) 0%

Don't know [not engaged in direct OHT activity]   (18/38) 47%

HSPN

LHS Capabilities – Evaluation

Evaluation

Open-Ended Comments: Opportunities and Strengths

Action-Plans

Analytics & Population Insights

Inadequate staffing and high turnover: "*For work that impacts my area, inadequate staffing and lack of succession planning has been one of the many barriers for researchers requesting data for scientific investigations*" (Manager, Program 2)

- Investigate root causes of high turnover
- Make case for data analyst position
- Develop succession plan and resources to facilitate work of new-hires (e.g. training material)

Lack of resources for qualitative data analysis: "*One barrier is that we have many more resources dedicated to quantitative analyses compared with qualitative analyses*" (Director, Program 3)

- Make case for hiring qualitative data analyst
- Train analysts in qualitative analysis methodology

Evidence Syntheses

Systematic process for recommendation/guideline development: "*We have developed a phased approach to developing our program recommendations and guidance (…) which includes systematic reviews of the evidence (..) and quality of the evidence followed by an expert panel step (…) as well as people with lived experience to contextualize the evidence to the Ontario setting and inform program decisions* (Director, Program 2)

- Disseminate best practices for guideline development to ensure uptake across programs

Patient, Caregiver & Provider Co-design

Opportunity to engage with diverse patients, families, and caregivers in co-design activities: "*Improving the diversity of the patient and family advisors involved in co-design is an ongoing desire and challenge for us.*" (Vice President, Program 1)

- Pilot test co-design initiative for patient engagement: document and disseminate best practices

HSPN Health System Performance Network

Today's event:
Enablers and Barriers
(Fuel, Accelerants, Moderators and Brakes)
+ Measuring LHS capabilities?

Co-Hosts
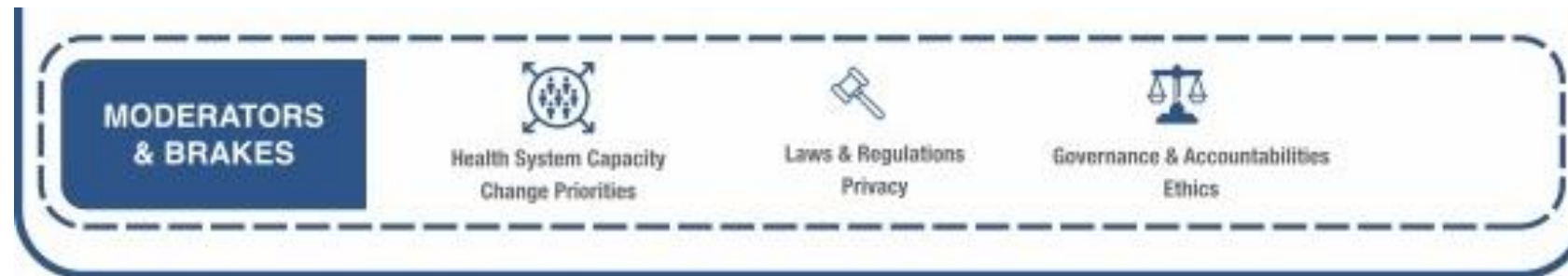
Dr. Walter Wodchis
Principal Investigator
HSPN

Dr. Victor Rentes
Post-Doctoral Fellow
HSPN

HSPN Monthly Webinar

January 28, 2025

Fuel, Accelerants, Moderators and Brakes

Building a sustainable infrastructure

Poll 8b

1. Which of the following are areas for improvement in your OHT? (check all that apply) (Multiple choice)

22/22 (100%) answered

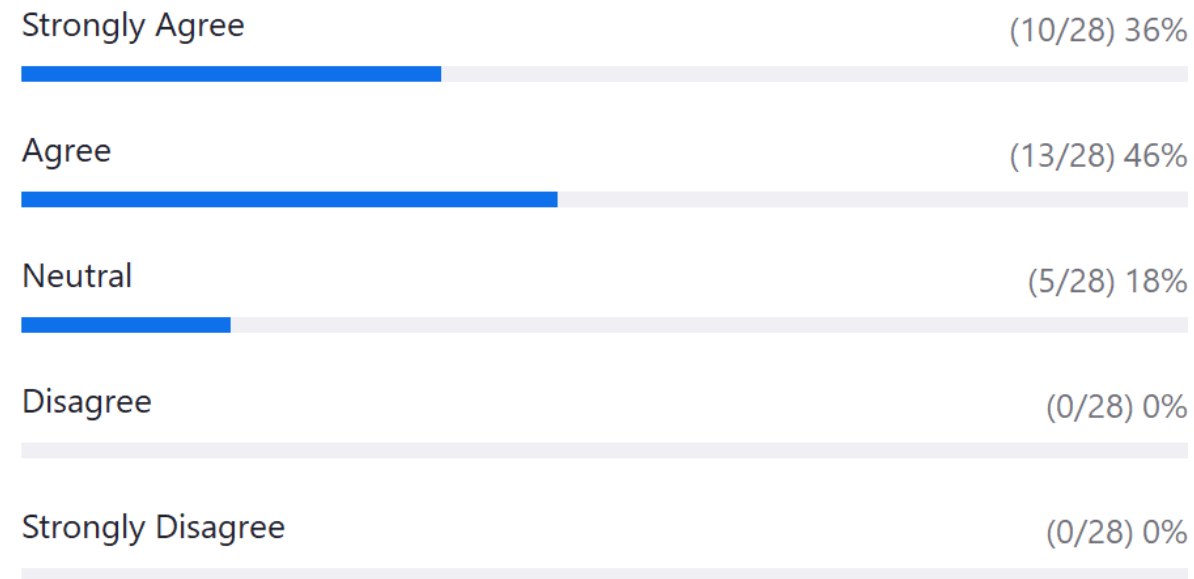Leadership   (8/22) 36%

Patient involvement   (13/22) 59%

Community engagement   (11/22) 50%

Engagement with Indigenous Groups   (10/22) 45%

Scientific/Research expertise   (11/22) 50%

Data and Technology   (16/22) 73%

Funding   (17/22) 77%

Governance   (4/22) 18%

Privacy   (6/22) 27%

Discussion Topic

1. What questions do you have about adopting a Learning Health System Approach to advancing your OHT priorities?

2. What challenges do you foresee in adopting a Learning Health System approach to your local OHT initiatives?

Many thanks to all the contributors to our series on Learning Health System

- Reham Abdelhalim (BOHT)
- Edward Aust (MWT OHT)
- Sarah-Grace Bebenek (SGBOHT)
- Jeanette Cooper (Unity)
- Catherine Donnelly (FLA OHT)
- Christina Fahim (Unity)
- Marjorie Hammond (Unity)
- Laura Harild (MOHT)
- Frances Henderson (MOHT)
- John Hogenbirk (CRaNR)
- John Lavis (RISE)
- Matthew Meyer (LM OHT)

- Kaelen Moat (RISE/MHF)
- Emmi Perkins (GW OHT)
- Justin Presseau (OHRI)
- Dipti Purbhoo (MOHT)
- Robert Reid (RISE)
- Victor Rentes (HSPN)
- Sara Shearkhani (ETHP OHT)
- Yasmin Sheikhan (MWT OHT)
- Kelly Smith (ETHP OHT)
- Maureen Smith (OSSU)
- Diana Urbanik (CRaNR)
- Brianne Wood (RISE/NOSM)

HSPN

Up Next

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

Upcoming February 2025:

Patient Reported Outcome and Experience Measures: Results from the OECD Patient Reported Indicator Survey (PaRIS)

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

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THANK YOU!

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