MIDDLESEX LONDON
Ontario Health Team

MLOHT Integrated Clinical Pathways

Applying a Population Health Management Lens to Support Integrated Clinical Pathways

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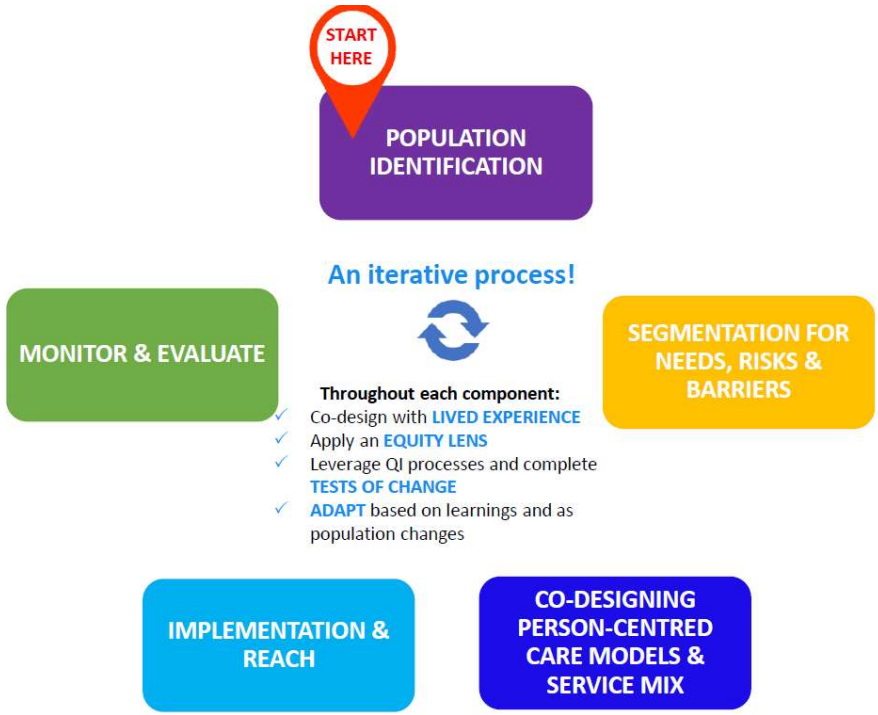
Today's Objectives

- Share the MLOHT approach to ICP development and implementation
- Reflect on lessons learned and key challenges
- Introduce a new approach to scaling and spreading ICPs

Population Health Management



Population Identification

Data-Informed Decision-Making

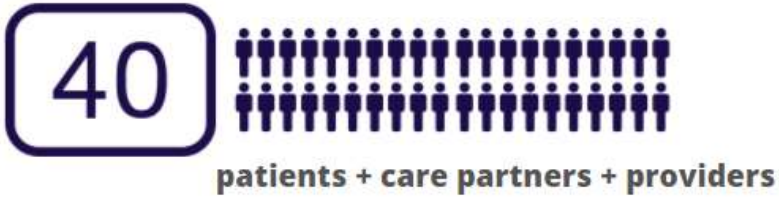
- Share the MLOHT approach to ICP development and implementation
- Reflect on lessons learned and key challenges
- Introduce a new approach to scaling and spreading ICPs

Using Co-design

Co-design is the act of intentionally creating a solution with the people who will experience it. In healthcare, this might include healthcare providers, people accessing care, families and caregivers, employees, and leadership.

Co-Design Approach

- We held individual and group discussions with patients, caregivers, and health care providers in Middlesex London to understand their current experiences with the health care system. We asked questions like:
  - What is working well right now in the health care system?
  - What are some areas of opportunities for health care improvements?



- We looked at all of the information from these discussions and came up with “themes” – themes are ideas and statements that mentioned in multiple discussions

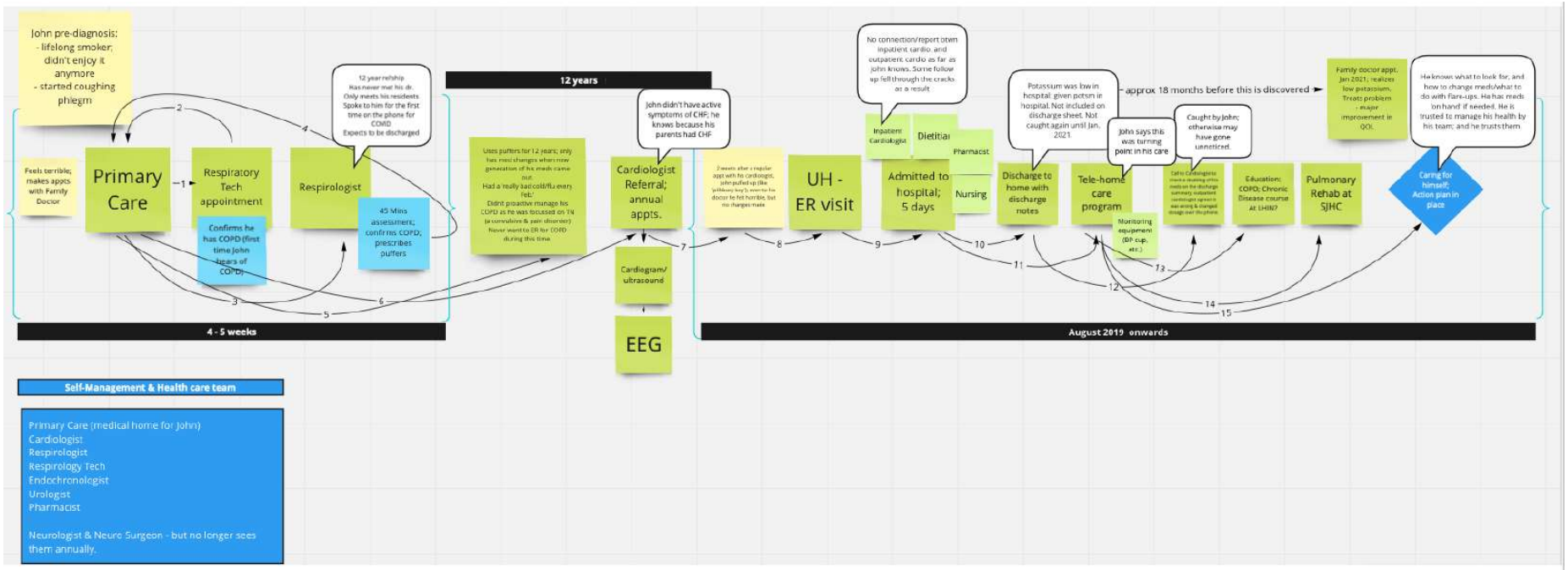
MLOHT Co-Design Themes

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

Elgin OHT Co-Design Themes

- **Empowering People**: to manage their COPD better on their own day-to-day through knowledge and support
- **Improving Awareness**: about available programming (patient and health worker) around smoking cessation, supports, education, and exercise
- **Social Supports**: so people have what they need to live with stability and, in so doing, are better able to manage their COPD
- **Proactive Testing for COPD**: being more proactive about testing to help diagnose COPD sooner
- **Emotional Support**: peer and/or professional support to help cope, feel less lonely, and encourage smoking cessation
- **Equal, Consistent Access**: to health services and COPD programs
- **Maintaining Connection to Supports**: when you don't have a family doctor, or maybe even a home
- **Reduce Culture, Language, & Gender Barriers**: so that health teams build more trust and connection with people who have COPD

Patient Journey Mapping

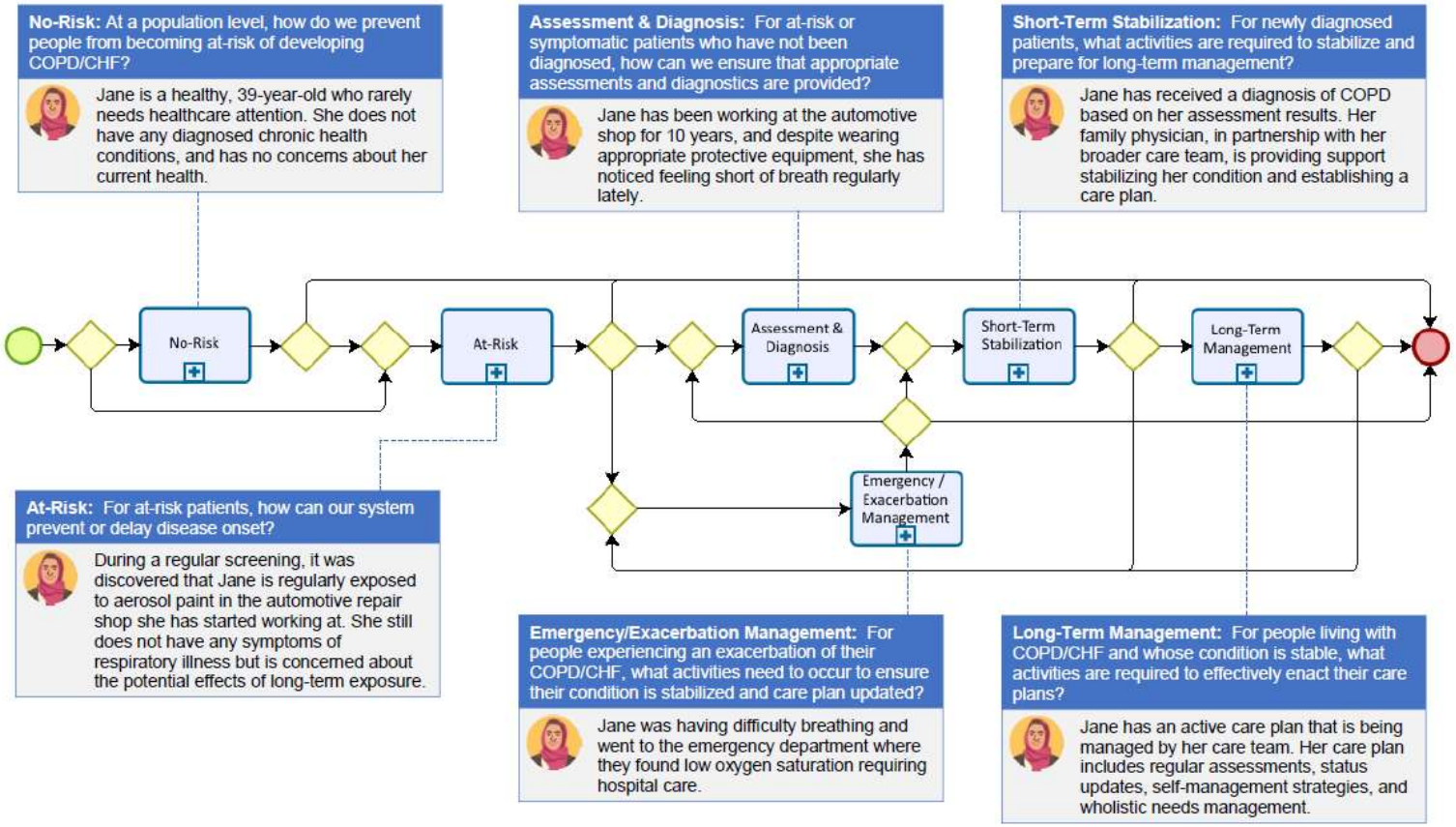


Priority Populations

- Identified by Ontario Health:
  - Francophone
  - FNIMUI
  - 2SLGBTQIA+
  - Older Adults
  - Low Income
- Additional population identified by MLOHT:
  - Individuals with no/limited access to primary care
  - Individuals with no/limited access to stable housing

Segmentation

MLOHT “Always for Everyone” Events



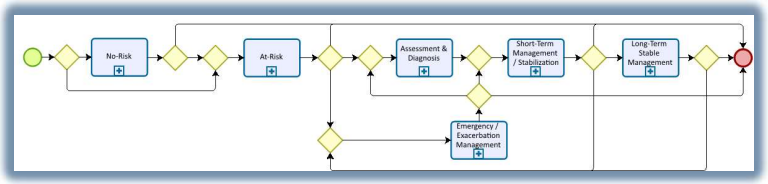
- Identified standard care plan activities across a patient care journey
- Highlighted need for preventive screening, mental health/social determinant screening, and spirometry
- Can be used to build standard care pathways

At-Risk – Care Pathway Activities

	Current State Opportunity *In your opinion, is this a potential area of improvement?* *1=well-delivered, requires no focus* *5=large opportunity for improvement*					**Role** *(Who delivers this activity?)*
Assessments						
Medical History *(GOLD 2022)*	1☐	2☐	3☐	4☐	5☐	Choose an item.
Vaccination History *(GOLD 2022)*	1☐	2☐	3☐	4☐	5☐	Choose an item.
Quality of Life Measure *(GOLD 2022)*	1☐	2☐	3☐	4☐	5☐	Choose an item.
Wholistic Needs Screen *(Co-Design)*	1☐	2☐	3☐	4☐	5☐	Choose an item.
Care Planning						
Goals of Care / Advance Care Plan *(HQO 2015, VA 2021)*	1☐	2☐	3☐	4☐	5☐	Choose an item.
Caregiver Support Screen *(HQO 2015)*	1☐	2☐	3☐	4☐	5☐	Choose an item.
Self-Management Education						
Education & Lifestyle Support *(GOLD 2022, HQO 2015)*	1☐	2☐	3☐	4☐	5☐	Choose an item.

Always for Everyone Events

- 6 states of health care journey
  - No risk, at risk, assessment & diagnosis, short-term stabilization, long-term management, emergency/exacerbation management



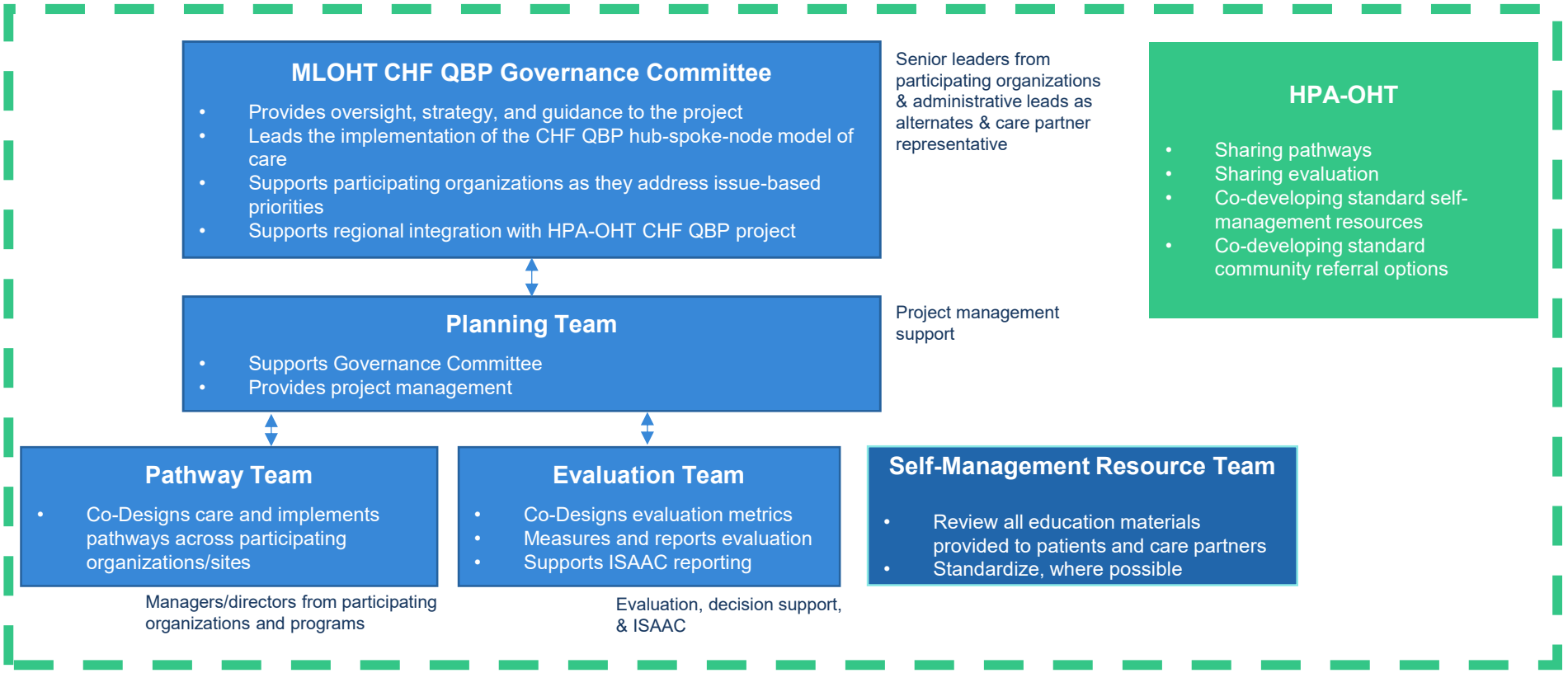
- 'Always for everyone events'
  - From co-design findings, Advisory Committee input, best practice guideline review, and Delphi survey results

- Co-design

> *"I said, 'did anybody tell you what to do?' And he said, 'No, they said, just go and do whatever you can.' So **I don't think we've ever had a care plan**."*
>
> *- Care Partner*

Care Model Design

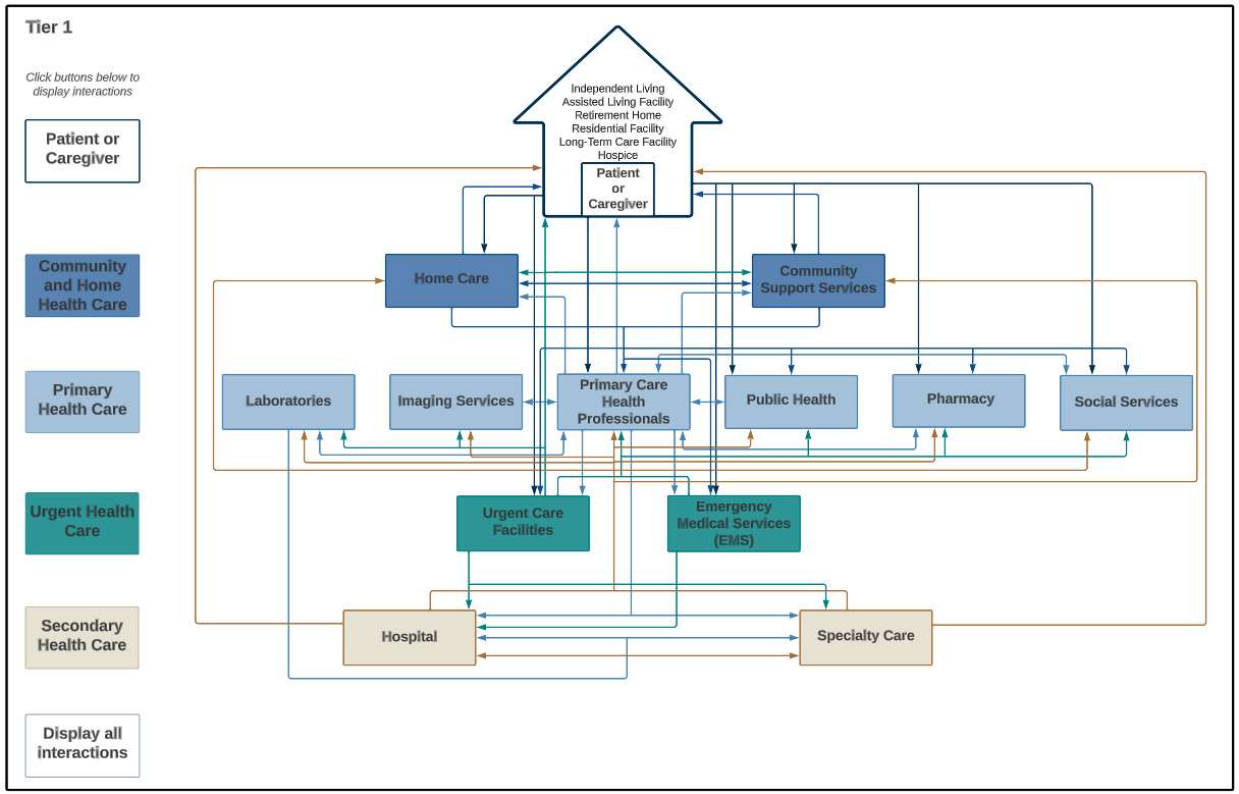
Collaborating for Integrated Care



Care Pathways – Goals

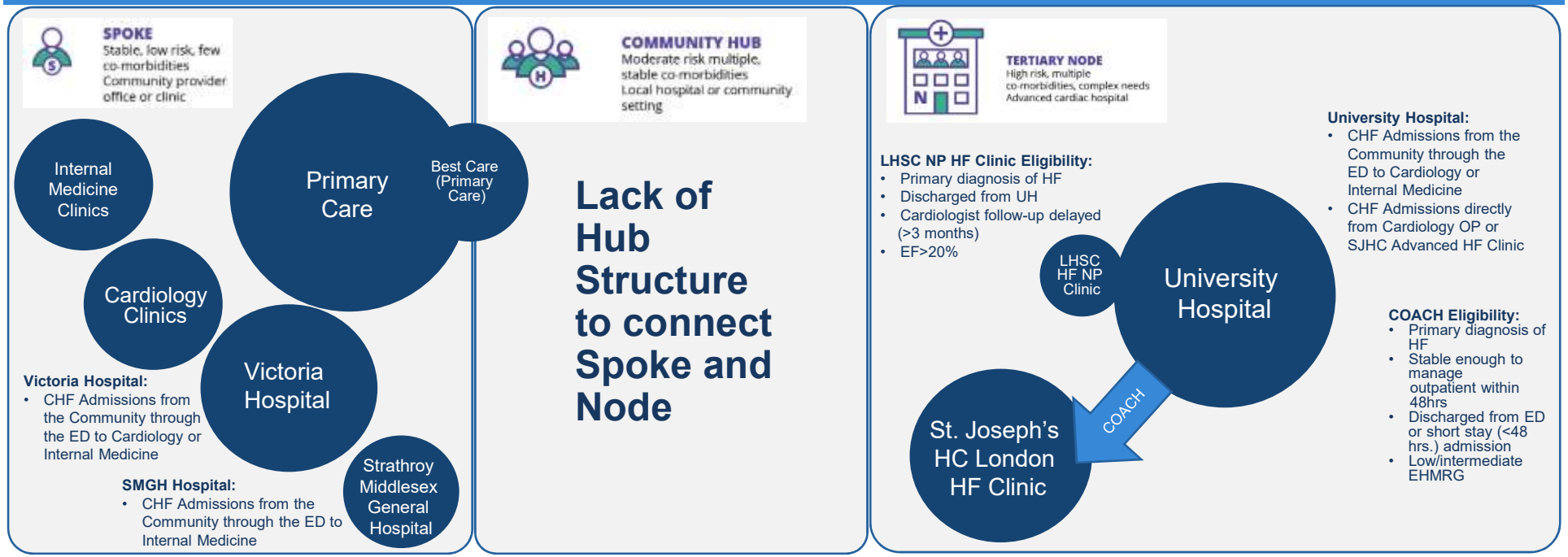
- Ensure all patients have equitable access to a minimum standard set of care activities or ‘always for everyone events’
- Identify patients at risk of COPD/CHF earlier in the process and connect them with supports to manage their condition
- Inform system health human resource requirements to support MLOHT system capacity planning
- Enable effective population health management through use of digital tools (i.e., early identification dashboards, EMR tools for flagging patient needs, etc.)

Ecosystem Mapping



- Identified key sectoral components, inter-component interactions, and care requirements
- Identified that independent system-wide navigation is limited, primary care is central to the accessibility of nearly half of the identified care elements, and resources are not equitably distributed
- Core activities included in Tier 2, highlighting “always for everyone” events
- Can support current state assessment
- LINK

Middlesex/London Heart Failure Current State



SUPPORTIVE SERVICES

Community Paramedicine
- HF patients on active LTC waiting lists

Community Para-Medicine (CP)

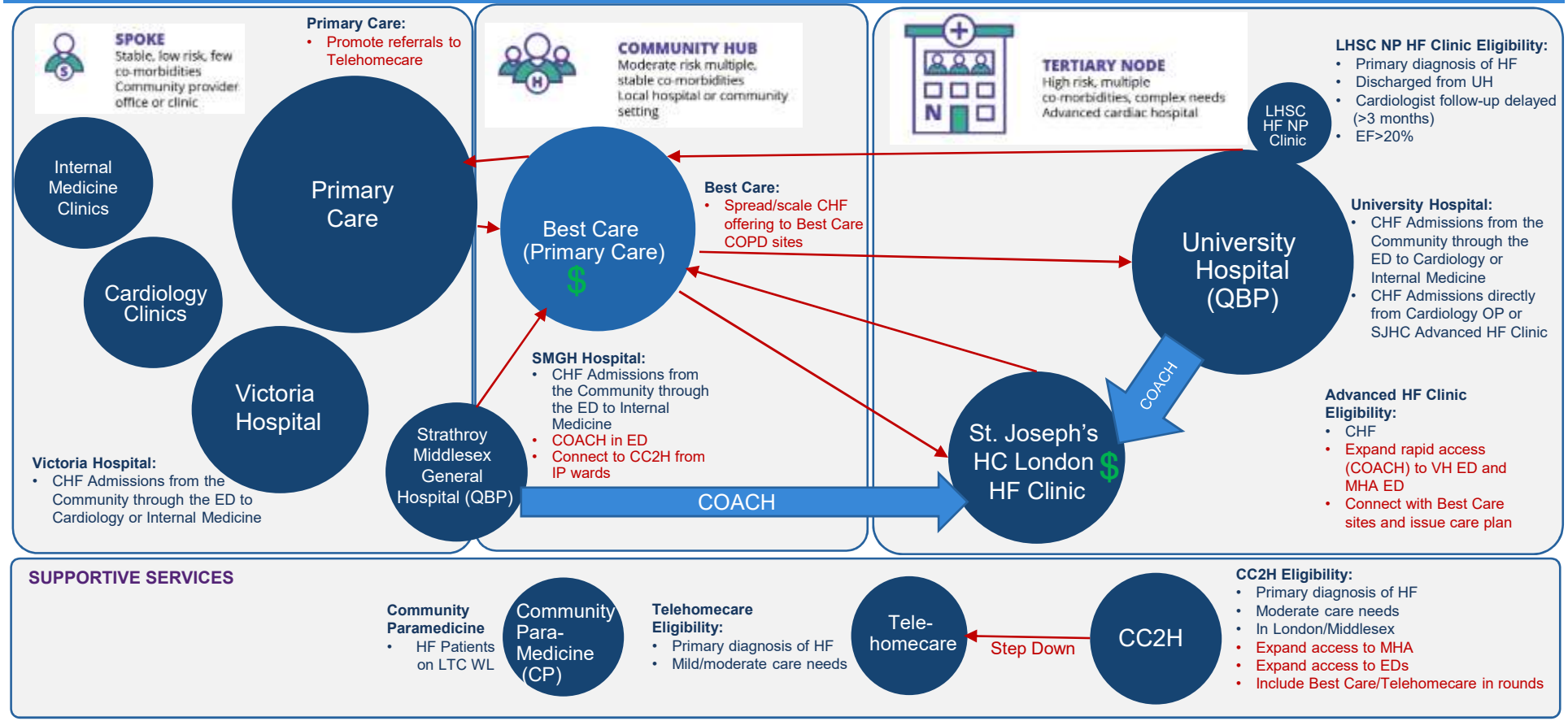
Tele-Homecare Eligibility:
- Primary diagnosis of HF
- Mild/moderate care needs

Tele-homecare

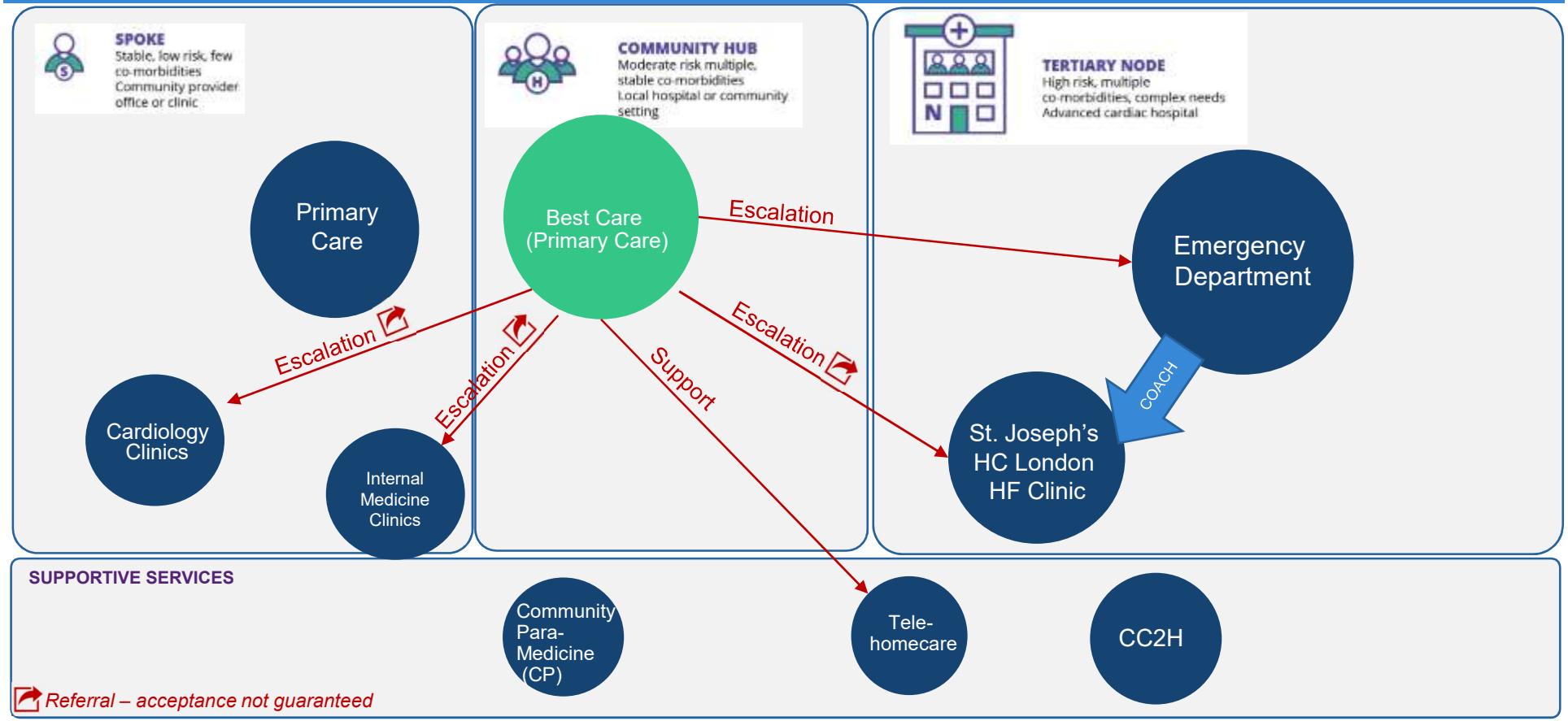
Connecting Care to Home Eligibility:
- Primary diagnosis of HF
- Moderate care needs
- In London/Middlesex
- Discharged from UH/VH

CC2H

Middlesex/London Heart Failure Future State

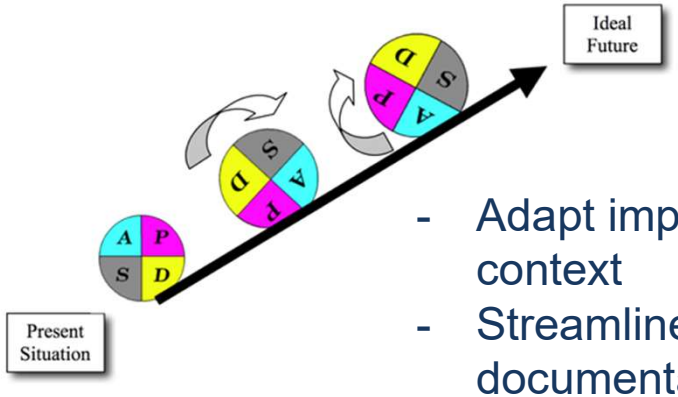


Best Care

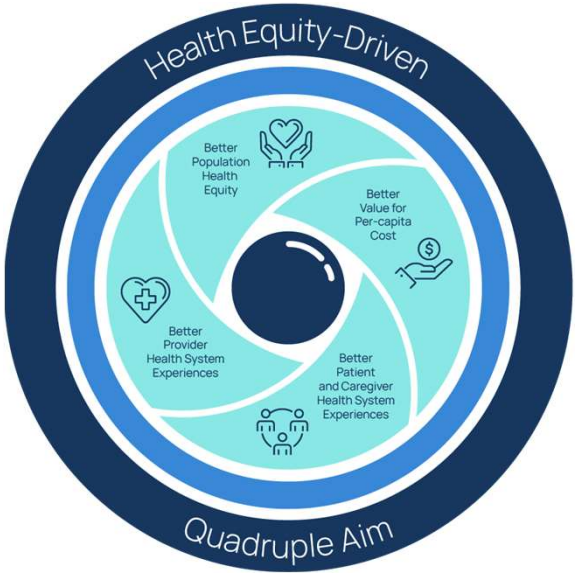

SPOKE
Stable, low risk, few co-morbidities
Community provider office or clinic
COMMUNITY HUB
Moderate risk multiple, stable co-morbidities
Local hospital or community setting
TERTIARY NODE
High risk, multiple co-morbidities, complex needs
Advanced cardiac hospital
Primary Care
Best Care (Primary Care)
Emergency Department
Escalation
Escalation
Escalation
Escalation
Support
COACH
Cardiology Clinics
Internal Medicine Clinics
St. Joseph's HC London HF Clinic
SUPPORTIVE SERVICES
Community Para-Medicine (CP)
Tele-homecare
CC2H
Referral – acceptance not guaranteed

Implementation & Reach

Principles – we will work with you to:



- Adapt implementation to your local context
- Streamline workflows/avoid double documentation
- Assist in finding/developing programs/resources to meet gaps
- Support ongoing learning/capacity development
- Ground the work in a PDSA and health-equity driven quadruple aim



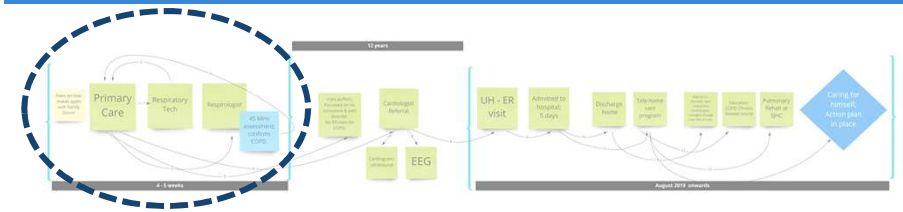
What will be different?

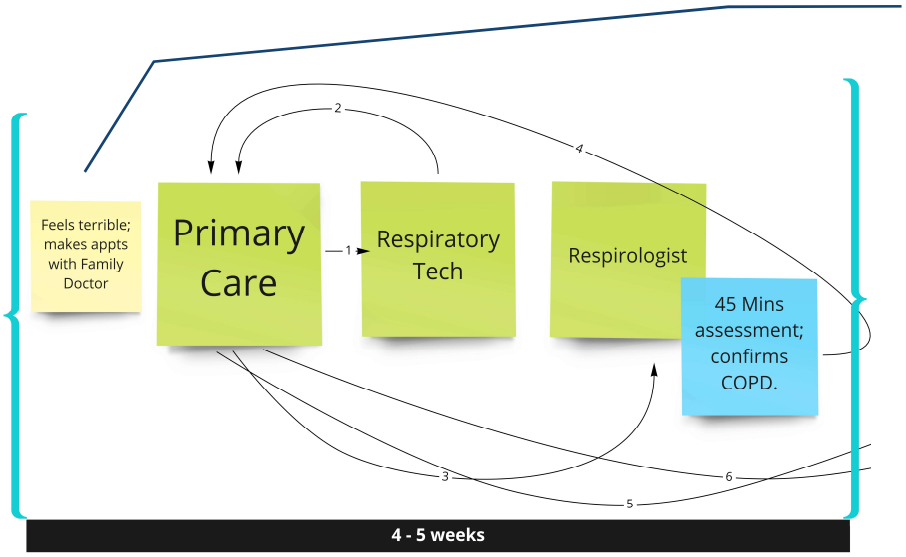
	Description
Integrated Care Pathways	• Evidence-based, co-design-validated ‘always for everyone’ events • Work with co-design network to support primary care and ensure all activities are available to all patients • Address any system pain points
Role Clarity	• Identify preferred and/or optional roles for each activity • Co-design workflow to flag activities for care team members
Case Identification	• EMR-enabled search tool to identify patients at-risk of COPD/CHF earlier
Activity Reminders	• EMR-enabled tool to flag when patients are due for ‘always for everyone’ events
Navigation Pathways	• Facilitate community partnerships to connect patients to external resources • Facilitate improved communications to primary care • Facilitate reduced barriers to care for patients going to external providers
Capacity Planning	• Analyze capacity needs to fulfill ‘always for everyone’ events for individual sites

MLOHT COPD Pathway Early Adopters

- Experience with LIHC implementing COPD care pathways:
  - Prioritizing preventative care is challenging given high immediate needs: need new mechanisms to deliver preventive screening
  - Difficult to access medical history, vaccination history, smoking history in an easily reviewable/visible way
  - Smoking status not captured consistently in EMR
  - Goals of Care/Advance Care Plan not documented consistently
  - LIHC patients require support to communicate/attend specialist appointments

Henry's Story – At-Risk





Henry was seeing his family physician for trigeminal neuralgia, and mentioned that he had quit smoking 2 years ago but was still coughing up sputum. This led to a COPD assessment and referral to respirology.

Henry's Story – At-Risk

Bright Spots

- Talking to a trusted helper: *"My family doctor is the most important person in my care. She is the gateway to everything."*
- Primary care team was able to provide a comprehensive COPD assessment in-house

Pain Points

- Henry had to initiate consult and waited until symptoms had progressed
- Missed appointment resulted in fee that Henry was unable to pay
- Specialist was unable to follow-up with Henry due to change in phone number
- Notification of referral rejection was not provided to primary care team

- **Integrated Care Pathways**
- **Role Clarity**
- **Case Identification**
- **Activity Reminders**
- **Navigation Pathways**
- **Capacity Planning**

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Self-Management Education						
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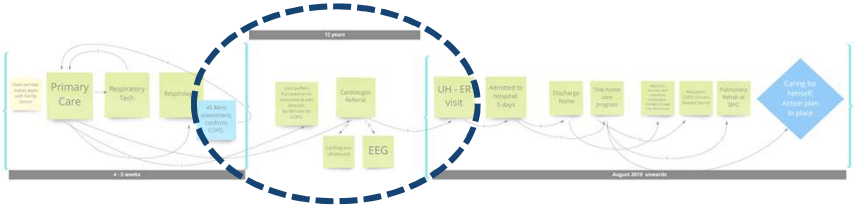
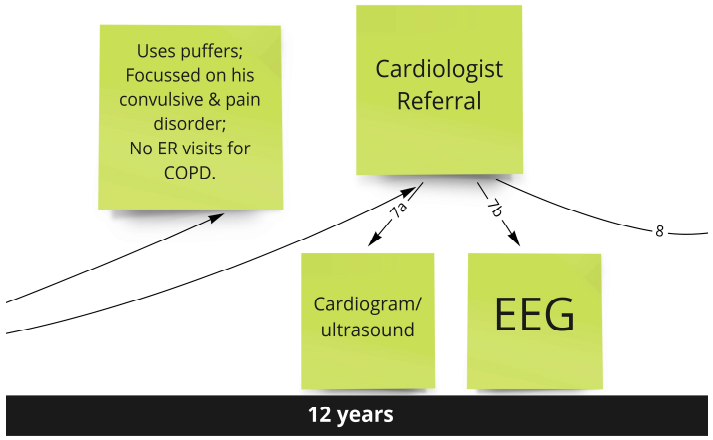
Henry's Story – Diagnosis





Henry didn't have active symptoms of CHF and was diagnosed late in his journey.

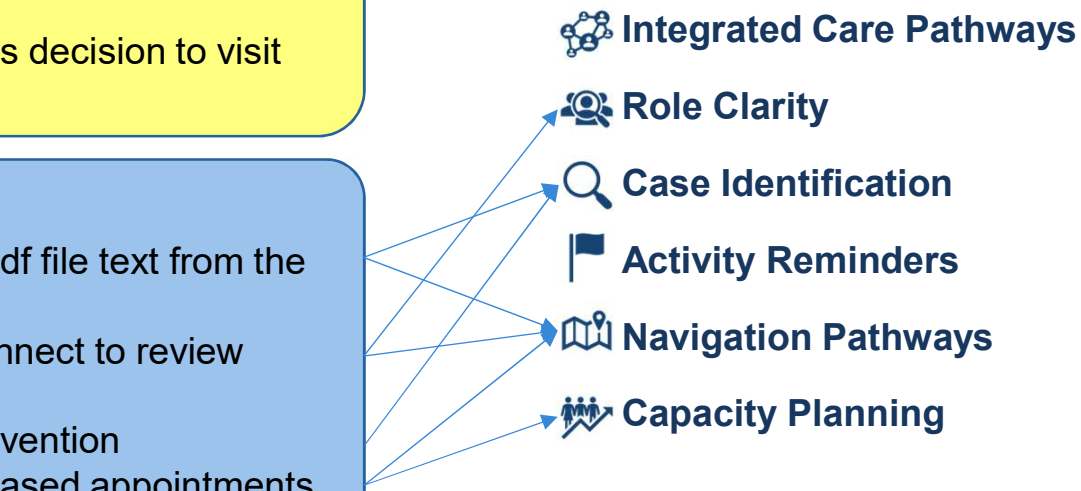
Henry's Story – Diagnosis

Bright Spots

- Henry's primary concerns (trigeminal neuralgia & COPD) were being well-managed
- Henry's COPD action plan supported his decision to visit hospital for HF symptoms

Pain Points

- Case finding algorithms did not catch .pdf file text from the hospital
- RTs could not easily access Clinical Connect to review hospital reports
- Delay in diagnosis prevented early intervention
- Henry had difficulty attending hospital-based appointments



Diagnosis – Care Pathway Activities

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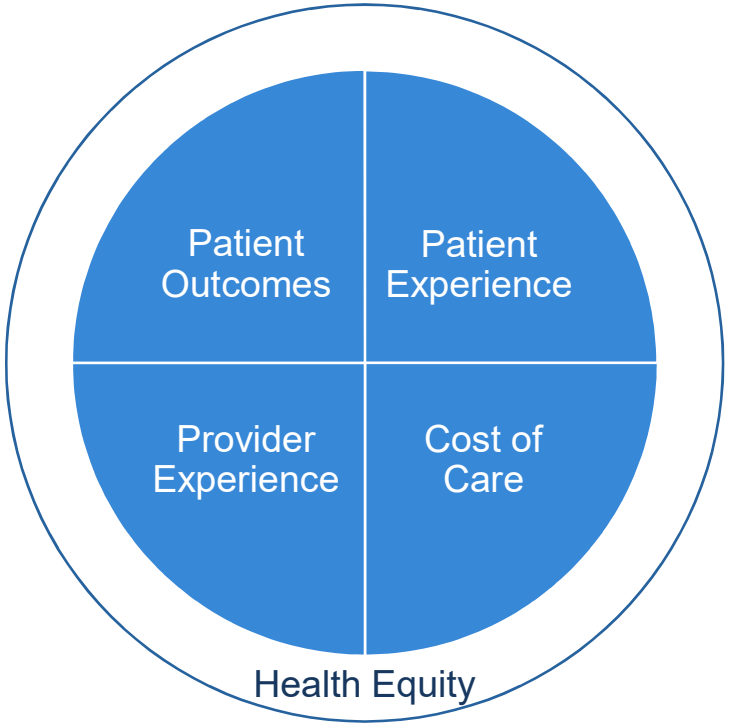
Assessments		
Medical History *(CCS 201)*	1☐ 2☐ 3☐ 4☐ 5☐	Choose an item.
Vaccination History *(CCS 2017)*	1☐ 2☐ 3☐ 4☐ 5☐	Choose an item.
Physical Exam *(AHA 2017, CCS 2017)*	1☐ 2☐ 3☐ 4☐ 5☐	Choose an item.
Quality of Life Measure *(MLOHT)*	1☐ 2☐ 3☐ 4☐ 5☐	Choose an item.
Wholistic Needs Screen *(Co-Design)*	1☐ 2☐ 3☐ 4☐ 5☐	Choose an item.
Spirometry *(GOLD 2022)*	1☐ 2☐ 3☐ 4☐ 5☐	Choose an item.

Evaluation & Monitoring

Primary Objectives

- KCCQ-12
- Medication optimization

- Provider experience measure



- Patient experience measure
- Early Identification of mild to moderate heart failure in Primary Care

- Reducing hospital admissions
- Reducing hospital readmissions
- Reducing hospital length of stay
- Reducing emergency department revisits
- ED transitions to hospital

Scale & Spread

Current State Challenges

- Design and implementation of various Integrated Care Pathways (ICPs) for each OHT

Current Challenges
There is a need for education, capacity building, and implementation support (including practice facilitation) within primary care for quality improvement, standardized care, and care pathway development.
Primary care buy-in for disease-specific pathway implementation is low due to limited number of patients with that disease each day/week.
Implementation of individual integrated care pathways requires significant effort designing, customizing, and linking digital enablers across multiple EMRs.
Fragmented approach to care pathway design and implementation across the province – no consistent ”place to go” for care pathways.
Integrated care pathways will quickly become out of date without ongoing review and updates.

HealthPathways New Zealand

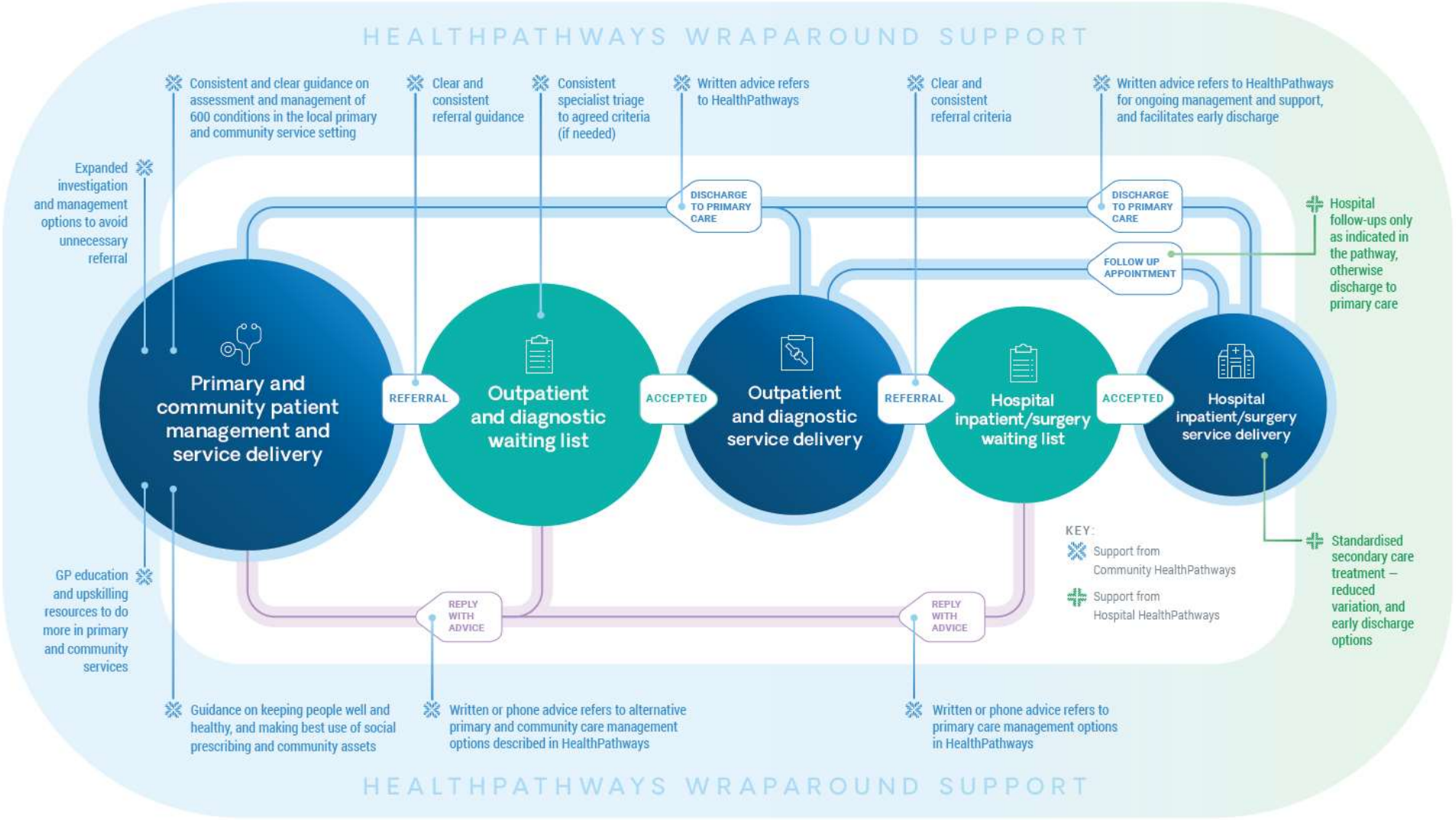
Designed and developed in Canterbury – clinically led pathways developed by primary and specialist services for local health systems

- *Provides a standardized model of care for patients*
- *Supports timely, high-quality care*
- *Regularly reviewed by clinical teams*

700+ Community pathways
485 Hospital pathways

Now used in 54 health regions in four countries,
Supporting care for 40+ million people

HealthPathways


HEALTHPATHWAYS WRAPAROUND SUPPORT
Consistent and clear guidance on assessment and management of 600 conditions in the local primary and community service setting
Clear and consistent referral guidance
Consistent specialist triage to agreed criteria (if needed)
Written advice refers to HealthPathways
Clear and consistent referral criteria
Written advice refers to HealthPathways for ongoing management and support, and facilitates early discharge
Expanded investigation and management options to avoid unnecessary referral
DISCHARGE TO PRIMARY CARE
DISCHARGE TO PRIMARY CARE
FOLLOW UP APPOINTMENT
Hospital follow-ups only as indicated in the pathway, otherwise discharge to primary care
Primary and community patient management and service delivery
REFERRAL
Outpatient and diagnostic waiting list
ACCEPTED
Outpatient and diagnostic service delivery
REFERRAL
Hospital inpatient/surgery waiting list
ACCEPTED
Hospital inpatient/surgery service delivery
KEY:
Support from Community HealthPathways
Support from Hospital HealthPathways
Standardised secondary care treatment – reduced variation, and early discharge options
GP education and upskilling resources to do more in primary and community services
REPLY WITH ADVICE
REPLY WITH ADVICE
Guidance on keeping people well and healthy, and making best use of social prescribing and community assets
Written or phone advice refers to alternative primary and community care management options described in HealthPathways
Written or phone advice refers to primary care management options in HealthPathways
HEALTHPATHWAYS WRAPAROUND SUPPORT

Discussion