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Learning From Our Past Successes

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The new *Health Links* are both a structure and a process.

They are a voluntary structure composed of *Health Service Providers* (HSPs), from across the continuum-of-care, who agree to be accountable to the LHIN for a set of strategic outcomes related to improved patient experience/satisfaction and quality indicators.

However, from another perspective, they are also a process that mobilizes health service provider partners to focus on achieving some bottom-line outcomes for the top 5% of health system users through the development of coordinated care plans for all complex patients.

So *Health Links* are a process designed to spark collaboration among system partners to achieve some agreed-upon outcomes for patients. In order to succeed, this process requires a lot of dialogue among the partners, and among these patient populations to understand the issues -- followed by some very focused action steps to improve care for a population that consumes 66% of the resources in healthcare. That's how you cause health system mobilization and that's how you engage patients in the design of their care.

So, does the Ontario healthcare system need a mobilization strategy at this point, and is *Health Links* the right strategy?

The fact is that we have now had three iterations of ***Integrated Health Service Plans*** over the past eight years, but we have not seen a lot of strategy execution and health reform implementation. While people have done a good job making incremental improvements and refining their local plan with their LHIN, *Health Links* could become the spark that ignites the mobilization of clinical staff to help redesign the delivery system across organizational boundaries in partnership with patients.

Evidence from successful transformations in health care suggests that: **if you create a good clinical plan for each patient -- and patient populations -- the quality-of-care will go up, and the cost will go down.** How do we know this approach will work? Is it true that patient satisfaction and quality-of-care can go up, while costs go down? In fact, we know it can.

While Ontario has spent hundreds of millions of dollars over the past 20 years conducting what Queen's Park has called "health system reform", we don't seem to have retained a lot of the "lessons learned" from our various successes and failures along the way.

The Ministers, Deputies, ADMs and DHC/LHINs/Local Office staff frequently change, and each new generation of leaders pulls together to "make major changes to the system" -- without much insight from past health reform efforts. Each generation ends up with yet another "structural quick-fix-that-fails" to deliver on the promised reforms which have always included <u>higher-quality</u>, <u>cost-effective</u> and <u>patient-focused</u> care.

However, much can be learned from the many successful innovations that we have undertaken in the name of "health system reform" in the past. One such group that the *Health Links* can learn from is: the *Children's Treatment Network* (CTN) in York/Simcoe.

Since only 30% of large-scale transformations ever succeed, *Health Links* leaders will want to know what it was that CTN did to achieve extraordinary results – from the perspective of patients/clients and their families -- as well as from taxpayers, who now get more and better services, for less money.

Like the *Health Links,* the *Children's Treatment Network* brings together a number of diverse players, including seven active care hospitals, two CCACs, four school boards and over 30 independent agencies. So how can a diverse set of partners gain a common understanding of what they agree to achieve together? How can they get aligned?

While the *Health Links* partners are bound by the ***Business Plan*** that they developed together collaboratively, at the *Children's Treatment Network,* they are bound by three key agreements: a ***<u>Memorandum Of Understanding</u>*** (MOU) -- which contains high-level commitments to the network vision, mission and philosophy of partnership; an ***<u>Information Sharing</u> <u>Agreement</u>*** **–** which sets out the responsibilities for data stewardship by each of the partners using an agreed-upon shared electronic record; and by ***<u>Service Agreements</u>*** – which are contained in 20 contracts for the delivery of clinical services. Similar agreements are in place for CTN's shared back office supports and leased space among the partners.

These three key formal agreements are the product of many conversations, and a lot of planning.

You might be imagining the CTN as a large organization occupying a lot of space to deliver all these complex services to over 5,000 families. However, CTN is a unique dispersed service model, with a small corporate structure and services spread across the organizations that are involved in delivering services to this "high/complex needs" population cohort covering Simcoe County and York Region.

In terms of scale, for only about $12 million annually, CTN mobilizes 82 FTEs in 20 host partner organizations to provide high-quality personalized rehab/clinical services for children with autism, developmental disabilities, dual diagnosis, and long-term rehabilitation needs – including specialized medical, communication, PT and OT services.

Think about that. You may know of parents of children who require very high levels of health system services just to provide them with some fairly basic support. These chronically ill children certainly fall into the category of the "*Top 5% of Health System Users*".

If you know families in these circumstances, you'll be familiar with the fact that often one parent quits their job to become a full-time facilitator, communicator, case manager, recorder and advocate for their child. Eighty percent of these families are affected by divorce. Parents of chronically-ill children lead very difficult lives.

As our first generation of *Health Links* go about exploring who their heavy health services users are, and what they are experiencing as patients/clients, they will uncover some amazing stories about how our fragmented healthcare services delivery system makes for absolutely horrible experiences for chronically ill people.

I work as the pro bono consultant for the 500,000 Ontarians who have environmental-related illness (FM, ME, MCS). This very unhealthy population cohort utilizes primary care physicians at eight to ten times the rate in the rest of the population. Why? Because there isn't a patient-centred "system" to provide them with the complex set of health and social support services that they need. So they keep seeking help for their illnesses as they get sicker and sicker. Taxpayers spend hundreds of millions -- and these folks receive terrible healthcare services at great cost. It is a horrible situation.

It was **MPP Kathleen Wynne** who convinced the Ministry of Health to invest $250,000 to create a *Business Case* for a patient-centred system of services that this high-use population needs to better meet their total healthcare needs, vs. the existing very expensive, poor-quality primary care services that they experience today.

The *Association of Ontario Health Centres* (AOHC) is now conducting the study. I believe that they could end up projecting that we can save as much as $300 million annually, if this population had an actual service delivery "system" – as close-to-home as possible. One that provides the health and social support services required to dramatically increase quality-of-care, while significantly reducing costs. Now that's transformation.

However, looking for the high volume/high-cost users also can't be allowed to become a "blame the patients" exercise by healthcare providers.

It is true that there are some individuals (maybe .01%) – the so-called "frequent flyers" -- who utilize healthcare services inappropriately. However, the *Health Links* will soon uncover chronically-ill population cohorts who are bounced around the delivery system (like those with environmental illnesses), because there really isn't a "system". There are only well-intended health service providers operating in rigid silos -- where most core processes are designed for healthcare providers, not patients.

Health Links will follow patients across those silos, by focusing on “the patient journey” across the continuum-of-care. That’s what CTN does. So, what did they learn?

Here are 10 critical success factors at CTN, that *Health Links* ought to think about:

- ☑ ***Shared Vision & Purpose*** – CTN invested many hours engaging their partners from across the continuum of services in *Facilitated Dialogues*, doing *Mind Maps*, and participating in *Open Space Conferences* with service providers and parents -- where the client/parent was the focus for designing a better health services delivery system for these children.

- ☑ ***Patient/Client-Centred Design*** – before he even hired his senior management team, the first CTN CEO, **Bob Morton** (now Chair @ NSM LNIN) brought together front-line service providers, middle managers and families to design the service delivery system. These cross-functional middle managers and front-line service providers partnered with patients and their families to design the service delivery system at CTN.

- ☑ ***On-Going Family Engagement*** – CTN produces high-levels of client/family satisfaction because of its deep commitment to family engagement. The input of families is essential to the successful outcome of their children’s *Single Plan Of Care* -- and ensures that parents and family members are welcome partners in the planning and delivery of CTN services.

- ☑ ***Service Delivery Team*** – with the client/family, teachers, principals, healthcare professionals delivering specific services. This team can meet together and online to engage in *case management* and *service planning dialogues* that address client/family issues and circumstances.

- ☑ ***Single Plan-Of-Care*** – is developed for each client. The plan is the product of the collective intelligence of the whole service delivery team, in conjunction with the parents.

- ☑ ***Shared Electronic Record*** – with data, team member comments, up-dates for all to see and know about the client and their family. CTN says this was a critical success factor in creating patient-centred care. And, what makes the record really innovative is that team members from health care, education and community organizations document in the *shared record* – CTN has addressed privacy and consent issues that are often seen as barriers to multiple sectors using a shared record.

- ☑ ***Capacity-Building & Co-Ordination*** – as CTN moved from planning to strategy execution, they focused on building people’s capacity to learn how to collaborate

better. CTN provides *Team Facilitators* through ongoing support of care plan coordinators, families and professionals who all participate in training and education programs that provides them with more capability to work inter-professionally as equal partners -- equally focused on providing the best outcomes for the child and family.

- ☑ ***Management Alignment*** – the initial work to mobilize middle managers and front-line service providers to collaborate with parents has continued with a structure that involves all partners with members of the CTN's *Executive Team's Management* in evaluative, monitoring, planning and quality improvement processes. Today, CTN CEO **Louise Paul** and her staff provide strategic direction, stewardship, coaching and love to the collective efforts of a very large and complex web of interconnections producing extraordinary results.

- ☑ ***Enlightened/Best Practice Governance*** – from the beginning, the CTN Board has been in *stewardship* to the staff, and to the service provider partners, in order to support them in their innovative efforts to improve care and support for these families.

- ☑ ***Enlightened/Public Servants*** – CTN was fortunate to have two outstanding public servants who, in the true spirit of "serving the public", embraced the problem of 5,000 poorly served families in York/Simcoe who required high levels of support just to manage. **Michael Klejman** from the local office of MOHLTC and **Graham Constantine** of the DHC linked arms with local CCAC CEOs in York and Simcoe, and with local Boards of Education Directors and others to ensure that these families got the services that they needed -- through enhanced collaboration – rather than building a "Bloorview Children's Hospital" for the two regions north of Toronto.

While Graham and Michael are retired, they continue to be "in service" to their public purpose files -- by serving as volunteer Board members and coaches to the Children's Treatment Network.

These two are not alone. There is a remarkable group of extraordinary former public servants out there – **Mary Catherine Lindberg**, **Darwin Kealey**, **Michael Innes**, **Bob Morton**, **Dan Burns**, **Jeff Quirt, Donna Segal, Scott Dudgeon** and many other true "public servants" who continue to contribute their wisdom, coaching and mentoring on the issues that are so dear to their hearts, and indeed, part of their very purpose.

Speaking of purpose, **Klejman** and **Constantine** ought to have a real sense of fulfillment in terms of their very positive impact on the quality-of-life of thousands of people who are impacted by chronically-ill children throughout York and Simcoe Regions. When you review the data on customer satisfaction, and the heart-felt stories and comments of

parents whose lives have been transformed because of CTN, you really get why these integration efforts are so essential; and what the outcomes can be when health providers shift the focus from provider-focused processes, to process focused on patients and their families.

Prior to 2006, these families described their experience as “frustrating, fragmented, confusing and overwhelming”. Finding services, battling waitlists, travelling long distances, briefing numerous professionals from different sectors on their child’s history and coordinating services from multiple agencies were just part of their day-to-day tasks. When *Health Links Partners* discover the “high users” in their system, they will discover people in similar circumstances.

In CTN’s case, often one parent has to quit their job to be facilitator, communicator, case manager, recorder and advocate for their child. If you know people in these terrible circumstances, you’ll be familiar with the fact that 80% of these families are further torn apart by divorce. These are difficult, hard lives that they lead.

The *Children’s Treatment Network’s* bottom-line challenge was to produce better outcomes for kids and families -- by bridging service gaps, bringing more critically needed services closer to home, and breaking down silos to create a true service delivery “system” that can provide family-centred, coordinated care efficiently and effectively.

Network partners today include over 60 healthcare, education, recreation and social service organizations that have joined together so they can take a team approach to each child’s care -- at home, at school and throughout the community.

While *Health Links* are not as diverse or complex as the CTN’s multiple partners, their success story suggests that diverse partners from across the service delivery system can in fact succeed -- when they are truly focused on the needs of the patient/client, and not on the organizational turf of the healthcare service provider organizations, or on the preferences of professionals.

Next week’s blog: *“**My Teacher From Gemba MICHEL LALONDE**”*.

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