Ontario’s Health Links initiative was announced by Minister of Health and Long-Term Care Deb Matthews in November 2012. It is aimed at better meeting the healthcare needs of that small percentage of individuals who are attempting to manage multiple chronic conditions such as diabetes, depression, congestive Heart Failure (HF) and Chronic Obstructive Pulmonary Disease (COPD). These individuals struggle to manage their conditions successfully in a highly fragmented system, often ending up in the emergency department or admitted to hospital because of uncoordinated primary and specialty care. This population also consumes a disproportionate share of healthcare resources, ultimately putting system sustainability at risk.

The essence of strategy is the focused application of resources against an important organizational or system opportunity or problem. The high users of a healthcare system present both a problem and a potential opportunity. Focusing on meeting their needs may result in both better healthcare and also system savings. Whether the cut-off point is the top 1% of users or the top 5%, we know that they use a vastly disproportionate share of system resources. This is not an original idea (see Kaiser Permanente’s pyramid and a multitude of other examples), but it may be a timely one. One clinical leader told me recently that this is the first major public policy initiative he has seen where there is virtual unanimity that we are pursuing the right goal and the right target population. In hundreds of conversations over the past year he has not heard a single dissenting voice signaling that this is the wrong public policy objective.

So we have the right target. How are we doing on execution?

Following the Minister’s announcement, the Ministry picked 19 pilot sites across the province and should get full marks for its choices. The essence of care for high system users is coordinating and integrating care for these individuals across primary care, acute care and home care. A lead organization was designated for each of the 19 projects and they were chosen from a selection of primary care (family health teams and community health centres), acute care hospitals and home care (community care access centres). Primary care is potentially the most problematic because it is so fragmented in many communities, so again the Ministry chose wisely in picking communities like Barrie and Peterborough, which both have large and inclusive family health teams, to be part of the initial wave of projects.
The Ministry also required each of the Health Links projects to have its business plan signed off by its regional Local Health Integration Network (LHIN) before it was submitted. The Ministry provided little direction on the contents required in the business plans, and there was a wide variety of interpretations taken by the LHINs on their level of involvement in coordinating the submissions. At one end of the spectrum, some LHINs allowed the lead organization to in fact lead, and the key primary care, acute care and home care organizations to self-organize to come up with a proposal to address the needs of high system users. At the other end, some LHINs effectively assumed the lead role, mandating who should be at the table and what the direction of the business plan should be. Unfortunately, some lost the thread – too many players at the table is not always helpful. Marginalizing acute care organizations, which happened in a number of instances, means that Health Links projects cannot and will not succeed. The three-legged stool of primary, acute and home care is essential to the public policy objective being achieved. A two legged stool tips over!

Ontario has also created a very challenging environment in which to implement new policy initiatives because it has not chosen a regional health authority approach like that adopted by other Canadian provinces. The end result is a multiplicity of delivery and planning organizations with competing and overlapping mandates. The author has written elsewhere about the challenges of the Ontario approach, but rolling-out a major change initiative such as Health Links will put coordination across multiple organizations to a true test (see LHINs at Five Years – What Now? Healthcare Quarterly, 2011 and Local Health Integration Networks: Will “Made in Ontario” Work? Healthcare Quarterly Vol. 9 No. 1, 2006).

The second provincial challenge is one of measuring success. Ontario has spawned a variety of agencies that impose a variety of reporting demands on healthcare organizations. These requirements are in addition to Ministry and national (Canadian Institute for Health Information) requirements, and have resulted in literally hundreds of aspects of healthcare delivery and outcomes being measured and presumably monitored. The danger for Health Links is that there needs to be just a handful of critical measures agreed to and reported, so that public accountability is clear for an initiative that will be critical but also expensive.

There are also Health Links projects chasing technological solutions that will almost certainly fail because they do not adequately take into account the needs of clinicians. Zero or minimal disruption to clinical workflow is essential. This means single-sign-on through either the Electronic Medical Record (EMR) for community-based clinicians or through the Clinical Information System (CIS) for hospital-based providers. Next, providers want only the clinical information that is essential to treating their patients. Time after time clinicians identify the big four categories as: medication history, lab results, diagnostic images and summary reports, such as discharge summaries and radiology reports. Finally, clinicians want complete data sets. If they can’t trust the information because something may be missing, they won’t use it.

The Ministry has correctly identified that some aspects of Health Links are better done provincially (or perhaps regionally) rather than locally. Ontario has invested major taxpayer resources in a variety of healthcare technology initiatives. In most instances it may be better to complete what we’ve started rather than invest in something new. The Ontario Telemedicine Network is working on developing an effective Home Health Monitoring (HHM) solution and has learned many of the hard lessons along the way. Most, if not all, of the Health Links projects will want to incorporate home monitoring as part of clinical oversight of their identified patients. Even the Ontario Laboratory Information System (OLIS), a historic money pit, is showing signs of life and, more importantly, clinical utility. It may prove useful as the Health Links projects move to implementation.

Finally, the Ministry, the LHINs and the first wave of project managers need to remember that Health Links fundamentally needs to be a clinical initiative. Primary care, acute care and home care are the key actors. The handful of chronic diseases that require focused attention are the same across all projects, although the chosen starting point may be different. A diabetes patient in Toronto is no different than a diabetes patient in Prince Edward County. Some of the infrastructure to support these patients may vary, but we must not lose sight of this reality.

Health Links has the potential to be a game-changer for patients who need it most and a key measure in ensuring the sustainability of our overall healthcare system. It is critical to get this right.

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