VOLUME
32
Summer
2013

CRNCC
NEWSLETTER

e·news

Participants at the 2013 Health Links and Beyond: The Long and Winding Road to Person-Centred Care Conference

this issue

Special Health Links Issue

On Thursday, June 20, 2013, the Canadian Research Network for Care in the Community (CRNCC) in partnership with Solutions Healthy Connections, and Health System Performance Research Network (HSPRN), sponsored ***Health Links and Beyond: The Long and Winding Road to Person-Centred Care.*** Health Links, Ontario's latest strategic initiative, are touted as a new way of coordinating local health care for people, thereby remedying gaps or duplication in the care provided. By encouraging greater collaboration among primary care, specialist care, hospitals, long-term care, rehabilitation, home care and community supports, Health Links promise to make the leap from provider-centred to person-centred care while moderating system costs.

The symposium was another in a series of cutting-edge CRNCC/ Healthy Connections symposia around timely issues facing health care. It opened with keynote speaker, Jenny Billings (University of Kent, UK), who pointed to the considerable evidence of good practices in integrated care across 14 European countries. Next, Walter Wodchis (HSPRN) added that targeting services to those who may benefit from them the most will help increase value in the health system. Finally, Martha Greenberg (Director, Transformation Secretariat, MOHLTC) emphasized that local collaborative (as opposed to top-down prescriptive) initiatives will drive transformation in Ontario's health system. The next challenge will be to decide how to measure the effectiveness of integration within individual Health Links, the health system as a whole, as well as on patient experience.

The symposium then turned to take an initial look at the early adopters of Health Links with invited speakers representing different health sectors. They included: Seonag Macrae (Woodgreen); Jocelyne Maxwell (Temiskaming Community Health Centre); Dr. Tia Pham, (South East Toronto Family Health Team); and Dr. Tim Rutledge (North York General Hospital). Speakers were asked about the challenges and advantages of leading Health Links from their particular sector perspective. So, what happened? In this E-News, we summarize "who" said "what". For the full presentations, please see the archived and web-cast presentations in our virtual Knowledge Bank.

Have a sunny summer!

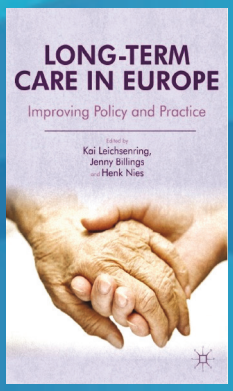
All the best from CRNCC Co-Chairs,

Janet Lum Paul Williams

Solutions/CRNCC/HSPRN Symposium

Health Links and Beyond
The Long and Winding Road to Person-Centred Care

To learn More



Long-Term Care in Europe: Improving Policy and Practice

Co-authored by Kai Leichsenring, Jenny Billings & Henk Nies

Driven by demographic and fiscal imperatives, policy-makers are rethinking how health care is provided and to whom. Ontario is implementing 77 Health Links across the province that aim to encourage greater collaboration across health care sectors. By starting with the highest cost users -- the 1% to 5% who account for 66% of health care spending -- and developing local approaches to providing "the right care, at the right time, and in the right place," Health Links aim to overcome system fragmentation, moderate system costs by avoiding unnecessary hospital visits, push new investments in primary health care, and make the leap from provider-centred to person-centred care.

Our half day symposium examined key challenges and opportunities faced by Ontario's Health Links as they attempt to build person-centred systems of care "from the ground up." It posed key questions. Is good will and collaboration enough to do the job? What "sticks" and "carrots" will be needed to ensure that resources move toward primary health care? If Health Links concentrate on the top 5% of health care users, what happens to the other 95%?


Jenny Billings

Jenny Billings (Applied Health Research CHSS, University of Kent, UK) summarized INTERLINKS, a study across 14 European countries of integrated care systems that aimed to create seamless, coordinated and cohesive care so that frail older people with multiple needs could remain independent in their own homes. She outlined how the interactive person-centred INTERLINKS framework was developed, and the role of evidence and knowledge while keeping sight of such important objectives as quality of care; prevention and rehabilitation; informal carers; and governance and financing. What did the study find? First, because of the complexity of home and community care, and the varying policy, organizational, financial, governance contexts across countries, good practices in one country may not be easily transferable to another country. Secondly, policy can and should also be informed by informal sources, firsthand experiences/ narratives and "pluralistic" approaches. Says Dr. Billings, "Sometimes you know an intervention works even though there is no evidence based on clinical trials or randomized control groups." This statement was indeed startling coming from a self professed "methodologist"! Finally, she noted that effective and meaningful evaluations for interventions should also be embedded at an early stage in the process in order to measure best practices.

Health Links and Beyond
The Long and Winding Road to Person-Centred Care

Walter Wodchis (Institute of Health Policy, Management and Evaluation, University of Toronto). Health system spending is highly concentrated among a few high needs people. The top 5% of high needs Ontarians account for about 66% of health spending while the bottom 50% spend less than 2% of health care dollars. Thus targeting services to those who may benefit from them the most will help increase value in the health system. As well, by studying the interventions that work for specific populations within the high needs user group (e.g., older people with multiple chronic conditions, people with mental health challenges, those requiring palliative care and children with complex care needs) since different populations require different policy and provider responses, it may be possible to prevent patients from entering into the 5% of high needs users. One slide that especially stood out asked: What Outcome Measures Matter? The answer: independence, followed by staying alive, pain relief and symptom relief!


Walter Wodchis

With forward looking optimism, **Martha Greenberg (Director, Transformation Secretariat, Ministry of Health and Long-Term Care)** highlighted Ontario's approach to transforming its health care system: it will rely on the collaborative initiatives that make sense in varying locals as opposed to top-down prescriptions from the Ministry. Regardless of the variations, patient experience is a key. Here she emphasized that "patient stories" will be a large part of meaningful evaluation. The next challenge for health links will be to establish the metrics for success. "How do you measure integration… how do you measure success?"

Martha Greenberg

Seonag Macrae (VP Community Care and Wellness for Seniors, Woodgreen Community Services) believes that there are distinct advantages of being a small health link with no acute care hospital in its catchment area: it can be nimble and can implement ideas quickly with few "turf issues" to confront. It is free to adopt a more community person-centered focus. Being a small health link within a densely populated area of the city has its challenges too: it is hard to define the population served. The partners within the health link are not necessarily serving people who live within their health area and those that live in the area are not necessarily using services within the health link. Seonag Macrae also advised conference participants that we should acknowledge that there is not always a lot that can be done for the most complex patients, but by listening to their individual stories, providers can learn how to prevent other patients from reaching a high level of complexity. Finally, she advocated that mental health needs should not be separated from other aspects of patient care.

From our Twitter Feed
#HealthLinks2013

@EastGeneral: Great & diverse panel to learn from @SETorontoFHT @NYGH_News @CHIGAMIK @WoodGreenDotOrg

@InfoRehab_UW: Happy to be at Ryerson for the #HealthLinks2013 event

@SarahPPT: So good to hear panel agree that patient engagement needs to be far reaching & tailored to a variety of complex realities

@OCSAtweets Health Links & Beyond - one size fits all solution for high spenders will not work #healthlinks2013

Health Links and Beyond
The Long and Winding Road to Person-Centred Care

To learn More

Event Presentations & Webcast

Jenny Billings

Walter Wodchis

Martha Greenberg

Jocelyne Maxwell

Event Webcast

As a rural Community Health Centre in a region with significant Francophone and Aboriginal populations, **Jocelyne Maxwell (Executive Director, Centre de santé communautaire du Témiskaming)** sees that equity issues have to be at the forefront of any system redesign. With over 95% of all primary care provided by the CHC and 5 FHTs, the Témiskaming Health Link is able to have a clear, district wide understanding of the community on the ground. The advantage of a CHC led Health Link is that it provides an appropriate and ready-made setting to bring patients and providers together to develop a common understanding from both perspectives. Listening to patient stories is the starting point for redesigning the system to support low-income seniors with few family supports in the region.

Panel presenters (from left to right): Dr. Tia Pham, Seonag Macrae, Jocelyne Maxwell and Dr. Tim Rutledge

Dr. Tia Pham (Lead Physician, South East Toronto Family Health Team) used the analogy of "something old, new, and borrowed" to describe health links. The "old" is primary care, which provides person-focused as opposed to disease-oriented care over time. It coordinates or integrates care provided elsewhere by others and is at the core of what health links want to achieve. The "new" in health links is the coordination of care, which should be integrated vertically across sectors and horizontally across health care providers and organizations so that clients can get a continuum of both preventative and curative services according to their needs over time, and across different levels of the health system. Putting in place effective information/IT systems to facilitate patient information exchange and collaboration are critical. "Borrowing" applicable ideas, methods, and evidence from anywhere also contributes to success. For Dr. Pham, a FHT led health link ensures physician integration and the involvement of physicians who are key players in any health reorganization.

For **Dr. Tim Rutledge (President & CEO, North York General Hospital)**, the advantage of having a hospital as the head of a Health Link is that hospitals possess valuable IT infrastructure and resources that can be harnessed by other health sectors for effective and meaningful collaborations toward person centered care. He also reiterated the point about the valuable lessons that can be taken from the top 5% of patient users to prevent the 95% from becoming the 5%. Finally, Dr. Rutledge cautioned that it would be a mistake to take funds out of the hospital sector. While all health sectors are stressed, the hospitals' capacity to continue to take care of the sickest patients should not be compromised.

Improving Health Outcomes Through Injury Prevention

The CRNCC received many tweets and comments during and after the symposium. Beth Hershfield attended the conference and offered the following insights.

Beth Hirshfeld

While effective care management of high-use patients and person-centred care through Health Links is one way to bend health care costs, preventative care, which includes keeping people safely in their own home for as long as possible, is another powerful cost-saving tool.

Hip fractures, for example, are very costly. As outlined during the Health Links symposium, not only is the immediate treatment expensive but the care costs in the following year average $30,000 -- making it one of the most costly health challenges. An appropriate person-centred care plan can substantially reduce the costs of treatment. In addition, consider the financial and emotional cost savings that could be realized if we could prevent the injury from happening in the first place.

One of the best places to start is in the home. Of the 1 in 3 older people who fall every year, almost half of these falls happen at home and many of these falls can result in hip fractures or other injuries. Research shows that an average home has more than 30 hazards and barriers that can threaten the health and well-being of an older individual. Fortunately, with some strategic adjustments, these health threats in the home can be proactively addressed.

Consider, for example, the issue of lighting. The Center of Design for an Aging Society notes that seniors need approximately 3 to 4 times more light within the home than younger individuals. But most homes do not accommodate for this reality. A recent study of seniors found that over 80% of the study's respondents were cooking in kitchens, reading in living spaces and showering in bathrooms that weren't sufficiently lit. Consequently, 70% reported bumping into things, and nearly half suffered some sort of fall.

Examples of seniors-appropriate home modifications .
Source: THRIVE by Design

Strategic and often easy-to-implement updates to home lighting can dramatically reduce the risk of falls and injuries. As an added benefit, improved home lighting also enables people to continue doing the activities and hobbies they enjoy, helping them to keep active and independent for longer.

Fundamental home improvements, such as enhanced lighting, can help older individuals live more safely and independently in their homes while reducing the number of costly injuries that put pressure on the health care system, thereby improving outcomes for all.

Beth Hirshfeld is a Certified Aging In Place Specialist in Ontario and the President of THRIVE By Design (www.thrivebydesign.ca), a home re-design company dedicated to helping older individuals beautifully re-design their homes to support an active and independent lifestyle.
Disclaimer: *The views and opinions expressed in this article are those of the author and do not necessarily reflect the official policy or position of the Canadian Research Network for Care in the Community.*

Did You Know?

Community Support System Navigator

CANADIAN RED CROSS

Like Health Links, the Community Support System Navigator project works in partnership with all sectors across the care continuum to remedy knowledge, infrastructure and resource barriers and gaps. In so doing, the System Navigator program not only helps clients, especially the frail elderly and their caregivers, maneuver across the health care sector but also seeks to uncover the barriers and solutions at the broader system level. Initially a pilot project, the System Navigator program now receives base funding from the North East LHIN.

Since March 2012, four System Navigators have been collaborating directly with Red Cross branches in North Bay, Sudbury, Sault Ste. Marie and Timmins.

To facilitate a seamless transition across the continuum of care, "beyond hospital walls", System Navigators work with discharge planners, acute care providers, community support services networks, CCACs, long term care providers-- almost all community stakeholders and service providers from Meals on Wheels to transportation to assisted living. The NE LHIN and Red Cross have published a categorized list of barriers and issues affecting patients within the system. Identified barriers include lengthy approval processes under the Assistive Devices Program; lack of integration between mental health and health services; shortage of mental health professionals; insufficient attention to regional disparities and cross cultural diversity; inadequate help for caregivers to prevent burnout; too few assisted living and supportive housing sites; insufficient public education regarding available programs; costs for clients who must utilize a service often (e.g., dialysis) and much more.

Community Support Service System Navigators (from left to right): Debbie Amarosa, Nancy Lacasse and Sandra Gagnon. *Source: North East LHIN*

Overall the program brings the community perspective into the design level in planning a seamless care to support frail older people and their caregivers on their journey. Like Health Links, System Navigators work within their particular location. The system gaps in northern Ontario may be unique to that region. Other issues may appear in other parts of the province. Nonetheless, with system shifts to deliver more services in the community outside institutions, innovative and collaborative projects like this undoubtedly mark a better way to care for our aging population.

With thanks to Russ DeCou, Heather Cranney, Tracey Browne, Tanya Elliott, Heather Bamford and Lori Holloway.

To learn More

'Navigators' help frail elderly after hospital discharge (CBC News)

The Community Compass: A Quarterly Community Support System Navigator Update (NE LHIN)

On the Radar

October 2013

8-10 | 2013 Canadian interRAI Conference
Presented by: Canadian interRAI 2013
Location: Westin Ottawa, Ottawa, ON

17-19 | Canadian Association on Gerontology 2013: Aging...from Cells to Society
Presented by: Canadian Association on Gerontology
Location: Westin Nova Scotian, Halifax, NS

17-20 | 2013 ONPHA Conference and Trade Show: Building on Our Strengths
Presented by: Ontario Non-Profit Housing Association
Location: Sheraton Centre Toronto, Toronto, ON

22 | Caring for People with Multiple Chronic Conditions: A Necessary Intervention in Ontario
Presented by: Health System Performance Research Network
Location: St. Andrew's Club and Conference Centre, Toronto, ON

22 | 7th Annual PSWs & PSW Supervisors Conference
Presented by: Personal Support Network of Ontario
Location: Hilton Suites Toronto/Markham Conference Centre and Spa, Markham, ON

23-24 | Together is Better! OCSA Great Ideas Conference 2013
Presented by: Ontario Community Support Association
Location: Hilton Suites Toronto/Markham Conference Centre and Spa, Markham, ON

November 2013

5-6 | Health Quality Transformation 2013
Presented by: Health Quality Ontario
Location: Metro Toronto Convention Centre, Toronto, ON

*We encourage you to check www.crncc.ca/events often as our calendar is continually updated

Coming Soon

Look for the new CRNCC In-Focus Backgrounder on Music Therapy and Dementia on the CRNCC website with exciting topics:

- What is music therapy?
- Music therapy on depression and anxiety
- Music therapy on agitation and aggression
- Music therapy on alert responses and communication
- Evidence on music therapy and dementia


in focus backgrounder

Music Therapy and Dementia

Music therapy is an emerging non-pharmacological intervention to manage the behavioural and psychological symptoms of dementia (BPSD). It is a low risk intervention that has been increasingly used and applied in the US and Canada. This backgrounder explores the science behind music therapy and the impacts on older adults with dementia.

Why is it important to manage behavioural and psychological symptoms of dementia?

The development of BPSD has been associated with caregiver burden (Coen et al., 1997; Matsumoto et al., 2007; Huang et al., 2012). Specific BPSD such as paranoia, aggression and sleep-wake cycle disturbances have been identified as important contributors to caregiver burnout and institutionalization (O'Donnell et al., 1992). To make matters worse, the BPSD can worsen the prognosis and can increase the rate of disease progression (Paulsen et al., 2000).

What are the behavioural and psychological symptoms of dementia?

Behavioural and psychological symptoms of dementia (BPSD) describe a heterogeneous collection of non-cognitive symptoms and behaviours that is associated with persons with dementia (Lawlor, 2002; Kar, 2009). Some examples of BPSD include depression, anxiety, apathy, agitation, delusion, hallucinations and sleep problems (Lawlor, 2002; Kar, 2009).

The reported prevalence of the BPSD varies depending on the type and severity of dementia, number of BPSD examined, environmental parameters and instruments used (Kar, 2009).

Studies have shown that:
- Depression is usually the most common BPSD (Vega et al., 2007; Lyketsos & Lee, 2004), followed by,
- Anxiety 35%–76% (Fuh, 2006); and
- Agitation 55.9% (Vega et al., 2007).

About two out of three persons with dementia experience some form of BPSD at any one time. However, the occurrence of BPSD differs in the community as compared to care in institutions:
- About one-third of persons with dementia in the community exhibit levels of BPSD in the clinically significant range (Lyketsos et al., 2000).
- A much higher level, about 80%, of the persons with dementia in care environments show such clinically significant level of BPSD (Margallo-Lana et al., 2001).

What is music therapy?

Music therapy is a form of non-pharmacological intervention that has been found to improve certain presentations of BPSD in persons with dementia. For instance, a study examining different forms of music therapy showed that patients with dementia in any music group (listening to preferred music, group-preferred music, classical music, or singing music) had significantly reduced agitated behaviours as compared to the control group (no music) (Zare et al., 2010).

Studies have also found that preferred music significantly reduced agitation during and following the preferred music session compared to classical music (Gerdner, 2000). Observations in some of the preferred music sessions suggested that persons with dementia were calmer, remained sitting longer and stopped shouting (Ragneskog et al., 2001).

CRNCC
Canadian research network for care in the community

RCRSC
Réseau canadien de recherche pour les soins dans la communauté

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CRNCC is committed to creating an open and accessible environment that offers current and relevant information. We welcome comments, questions, and concerns.

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CRNCC is funded by the Social Sciences and Humanities Research Council (SSHRC) of Canada through the Knowledge Impact in Society grant and Ryerson University. If you would like to be removed from this listserv, or know someone who would like to be added, please contact us at crncc@ryerson.ca.