Health Links Enhanced Measures – Frequently Asked Questions

**LM Note: I have highlighted in blue/yellow the updates. The blue is simply what new is added to the FAQ, the yellow is added but also new information.*

General

Question	Answer
1) **Individual's address:** Should sub-region be tracked by the individual who is receiving care's place of residence, or by their primary care provider's address?	The sub-region is assigned by the individual's place of residence. Local Health Information Networks (LHINs) and their sub-regions / Health Links will have to determine the process for informing other LHINs on how to repatriate or reconcile the reporting data about individuals who are receiving care. Some sub-regions may have to let other sub-regions know if an individual's address will affect their reporting data.
2) **Individual's address:** If an individual's home address changes during a quarter, to which sub-region should the individual be assigned? (e.g., address at end of reporting period, as of referral start date, etc.?)	Assign the individual to a sub-region based on their address at the time of referral start date / client code start date.
3) **Sub-region reconciliation:** If a Health Link serves an individual whose home address is not within their sub-region, how do they share the individual's data with the Health Link that must report that data?	LHINs will determine processes for reporting across sub-region boundaries. The expectation is that the data will be reported in the individual's sub-region based on the individual's home address; the individual's care or who provides it should not be impacted.
4) **Denominators:** Can you explain the difference between the numerator in Indicator 1 and the denominator in Indicators 4 and 9? Should all be the same number?	The numerator for measure (new CCP) is the number of individuals with a new, first CCP developed (completed) in that quarter. The denominator for measure 9 (confidence score) is the number of new CCPs developed (completed) in that quarter. The denominator for measure 4 (wait time) includes only CCPs "initiated" (not developed) in that quarter. Due to the nuances in the technical specifications, these numbers might vary.

Measure #1: Number of individuals living with multiple chronic conditions and/or complex needs with a new coordinated care plan (CCP) developed through the Health Links approach to care.	
Question	**Answer**
5) **Number of CCPs:** If an individual acquires a new disease or problem that requires a new plan of care, should they revise the CCP or create a new CCP?	The CCP should be considered a 'living document' to be updated regularly as individual goals are achieved or change over time. Each LHIN decides the process for updating or creating a new CCP.
6) **Number of CCPs:** If a year has passed since the last time the individual was seen by a provider, should the CCP be revised, or should a new CCP be created?	The CCP may be updated or a new one created, but only the first CCP per individual is counted.
7) **Number of CCPs:** If an individual has moved between sub-regions **within** a LHIN should any updates to their CCP be counted as a new, first CCP?	No. This measure tracks spread of the Health Link approach to care not workload. In CHRIS and SHIIP, a CCP developed in one sub-region is available to all sub-regions within the LHIN region. However, a CCP is not available across LHIN boundaries; a new, first CCP is counted only if a person changes LHINs.
8) **Two or more health care professionals:** What is the definition of a health care professional? Can the coordinating lead be counted as one of the health care professionals?	"Health care professional" includes all regulated health professions. Yes, the coordinating lead counts as one health care professional.
9) **Developed CCP:** When is a CCP considered "developed?"	In order to be applicable, CCPs must fit the following criteria: • A "new" CCP developed in this quarter • Created with the individual and/or the caregiver and two or more health care professionals • Contain a plan for one or more health issues (physical, functional, mental, social, etc.) • Follow the provincial CCP template (paper or electronic) • Available to the individual and/or caregiver and team members
10 **CCP template:** Must the exact CCP v2 or 2.1 template be used exclusively, or can something similar be used? For example, if 80% of the fields match, is that okay?	All organizations are expected to use the most recent version of the provincial CCP template exclusively to enable consistency in approach across the province and cross-boundary coordination.

Measure 2: Percentage of individuals with a CCP who are newly attached to a primary care provider (PCP) through the Health Links approach.	
Question	**Answer**
11 **PCP definition:** What is the definition of a PCP? Can a social worker, outreach worker, or registered nurse be counted?	For this measure, a "PCP" specifically refers to primary care enrolment model (PEM) physicians (as well as fee-for-service physicians or nurse practitioners). For the purposes of this measure, social workers, outreach work or registered nurses are not counted.
12 **When to record attachment:** If the individual does not have PCP attachment during the quarter when the CCP is completed, when does an individual get counted as having PCP attachment?	PCP attachment is reported cumulatively each quarter. The technical specification for this measure has been revised for clarity and collectability as per below. **Numerator:** Total number of individuals with a CCP who are newly attached to a primary care provider, by sub-region of residence (cumulative). **Denominator:** Total number of individuals with a CCP who are unattached to a PCP at the time of being identified/referred as potentially benefiting from the Health Links approach to care, by sub-region of residence (cumulative). The denominator excludes inactive individuals (see definition provided in question 12 below).
13 **Change in attachment:** Should an individual's PCP attachment status be removed if he or she becomes unattached? How would this be reported?	No. This measure only counts those who were unattached at the time of referral.

Measure #3: Percentage of individuals with a coordinated care plan (CCP) and attached to a primary care provider (PCP) who self-report timely access to PCP.

Question	Answer
14 **Inactive individuals:** What is the definition of an inactive individual?	An inactive individual is defined as: - a person who declines starting the CCP process; who starts the CCP process but declines to continue; who is deceased; or who moves outside of the LHIN boundaries. Given this definition, inactive individuals should not be included in the PCP access calculation.
15 **Expectation on Health Link Coordinating Leads:** If the individual does not select the answer "about right", what action is the care coordinator expected to take to address this?	The LHIN will decide the process for their region. The purpose of this measure is to understand why care was not considered timely and patient-centred and enable quality improvement.
16 **No answer:** Does "No answer" mean that the care coordinator did not actually speak to the individual?	"No answer" refers to individuals who were asked the question and declined to respond.
17 **Timing:** When should this question be asked?	There is a minimum and a preferred practice for asking the question. Minimum data requirement: The question must be asked the first time the provider meets with the individual after the CCP is developed. The aggregate of these responses will be entered into QI RAP. Preferred practice: The question should be asked whenever the individual's goals change, which promotes quality improvement over time.
18 **Timing:** Are the individuals receiving care being asked to reflect on their most current visit or is this a more general question?	It is not specified, so the question should be asked as written with no interpretations provided.
19 **Asking individuals from past quarter (before Q2 of 2018/19):** Could we ask this question of all individuals if we are doing a survey?	Yes; however, you can only report on the first instance that the question was asked/answered.

Measure #4: Percentage of individuals living with multiple chronic conditions and/or complex needs who waited 7 days or less from Health Links referral or identification to initiation of the coordinated care plan (CCP).	
Question	**Answer**
20 **Initiation:** What is the definition of initiation?	This has been defined in the most recent technical specification as the point in which the first face-to-face visit with lead coordinator occurs.
21 **7 Days:** Is 7 days the ideal wait time for the Health Links approach to care?	In the original work that was done regarding the measures, the majority of LHINs specified that 7 days was the most ideal. We are collecting a baseline to understand waiting times, using a time frame frequently used as a measure in other instances.
22 **Requirement for face-to-face:** Why must the meeting be face-to-face?	A face-to-face meeting is the preferred approach to enable the therapeutic relationship. “Face-to-face” also includes Ontario Telemedicine, but does not include phone calls to set up a meeting. This does not mean a phone call cannot take place in the interim, only that we will be measuring the face-to-face as that start point.
Measure #5: Proportion of total organizations within the sub-region that are involved in identifying individuals who might benefit from the Health Links approach to care.	
Question	**Answer**
23 **List of referring organizations:** Will the LHIN or sub-region provide updated quarterly lists to the Health Links for all of the health service providers in their area?	The LHIN will be responsible for creating and maintaining the list of referring organizations.
24 **Counting organizations:** How are referring organizations counted? For example, some hospitals may have multiple sites, but only one is referring to Health Links	The goal is to have a consistent practice. A hospital would be considered as one organization, regardless of site or department. There may be grey areas that need to be defined by the LHIN. For example, if a primary care physician in an emergency department refers an individual, the LHIN can decide whether it should be counted, either as a referral from the hospital or from the primary care practice.
25 **Adding organizations:** Can the Health Links add additional organizations to the master list?	The LHIN will be responsible for creating and maintaining the list. Requests for additions of organizations should be sent to the LHIN to be added on a quarterly basis.
26 **Referrals from outside sub-region / LHIN:** Can Health Links include organizations that are outside of the sub-region or LHIN geography that refer individuals?	No. It is not included in this measure at this time.
27 **Reporting to multiple sub-regions:** Multiple organizations may be reporting to multiple sub-regions (i.e. catchment areas cross sub-region boundaries). How would this be reported?	This indicator is measured by the sub-region of the individual residence. If the referring organization has 5 individuals in 5 sub-regions, each sub-region would report that organization as a referring organization.
28 **Referring vs. partnering:** Does this indicator include partnering organizations as well as referring organizations?	This indicator includes all organizations that identify individuals that may benefit from the Health Links approach to care.

Measure #9: Percentage of individuals with a coordinated care plan (CCP) who have a recorded patient confidence score.

<table>
<tr><th>Question</th><th>Answer</th></tr>
<tr><td>29 Purpose: Please clarify what this measure is meant to capture.</td><td>The measure focuses on evaluating progress of the Health Links approach to care, individually and provincially (by sub-region), by asking for and measuring individuals' confidence in their ability to meet their care goals.</td></tr>
<tr><td>30 Actual confidence score: Why isn't the individual's actual confidence score recorded?</td><td>If feasible, Health Links are encouraged to record the actual score locally in order to improve care; however, this is not required for tracking.</td></tr>
<tr><td>31 Timing: When should this question be asked?</td><td>There is a minimum and a preferred practice for asking the question.
<table>
<tr><td>Minimum data requirement</td><td>The question must be asked in the meeting whereby the CCP is developed, i.e., the action plan has at least one action item.

The aggregate of these responses will be entered into QI RAP.</td></tr>
<tr><td>Preferred practice</td><td>The question should be asked whenever the individual's goals or approach to their goals change, which promotes quality improvement over time. Only the first instance in which the question is asked is reported in QI RAP.</td></tr>
</table></td></tr>
<tr><td>32 Appropriateness of the question: Is this question suitable for all patient populations (e.g., palliative patients, patients with mental health and addictions conditions)?</td><td>It is recommend that clinicians who are leading the CCP process use their clinical judgement when determining the appropriateness of asking any question related to the coordinated care plan.</td></tr>
<tr><td>33 Declined to answer: If a patient declines to answer this question, should they be counted in the denominator?</td><td>Yes. The denominator counts all patients with a new CPP developed in the quarter, while the numerator counts those with a new CCP developed in the quarter AND a recorded patient confidence score.</td></tr>
</table>