HEALTH LINKS

Community of Practice: **Coordinated Care Planning Series**

STEP THREE:

Interviewing the Patient

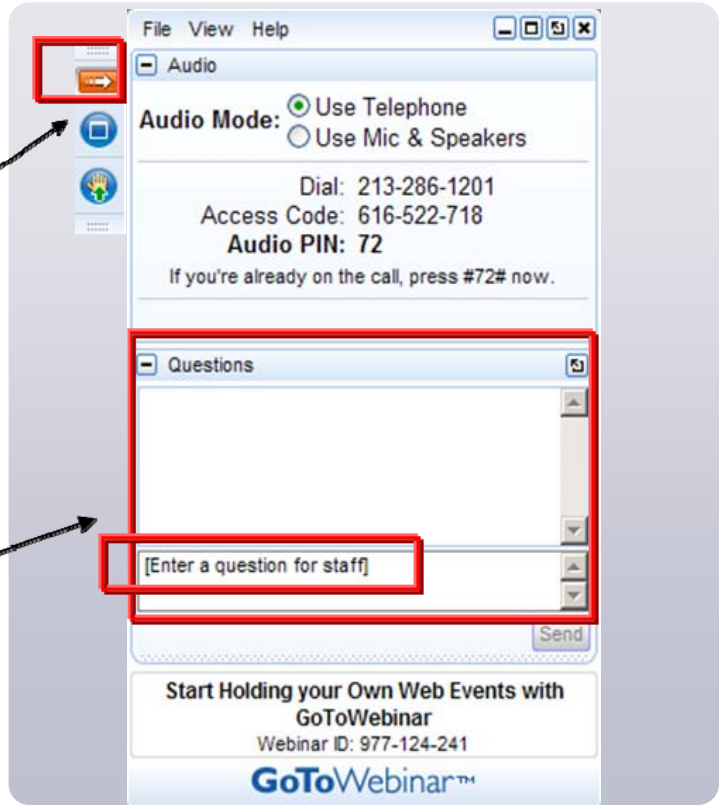
October 7, 2015

Health Quality Ontario
The provincial advisor on the quality of health care in Ontario

Ontario
Health Quality Ontario

PARTICIPATING IN THE WEBINAR

- This webinar is being *recorded*.
- ALL participants will be muted (to reduce background noise). You can access your webinar options via the orange arrow button.
- Discussion period post presentation, please type your questions for the presenter after each presentation.



WEBINAR PANEL

HEALTH QUALITY ONTARIO (HQO)

- **Sandie Seaman,** *Manager, QI and Spread*
- **Jennifer Wraight**, *Quality Improvement Specialist, QI and Spread*

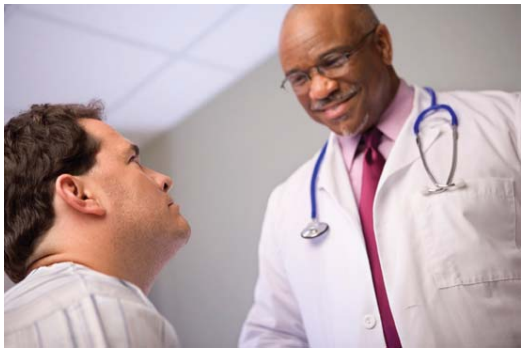
GUEST PANELISTS

- **Chris Archer,** *Project Manager,* North Simcoe Health Link
- **Tracy Koval,** *Registered Nurse, Clinical System Navigator, North Simcoe Health Link*
- **Dwayne O'Connor**, *Clinical Manager, Barrie & Community Health Team*
- **Aasif Khakoo**, *Director, East Toronto Health Link*
- **Nina Mugo**, *Transitional Case Manager and Care Coordinator, East Toronto Health Link*
- **Jennifer McLeod**, *Executive Director, Timmins Family Health Team*

WEBINAR OBJECTIVES

Purpose

To review the current provincial landscape for Health Links as it relates to best practices and innovations in Care Coordination, and to facilitate Health Link to Health Link learning and discussion.

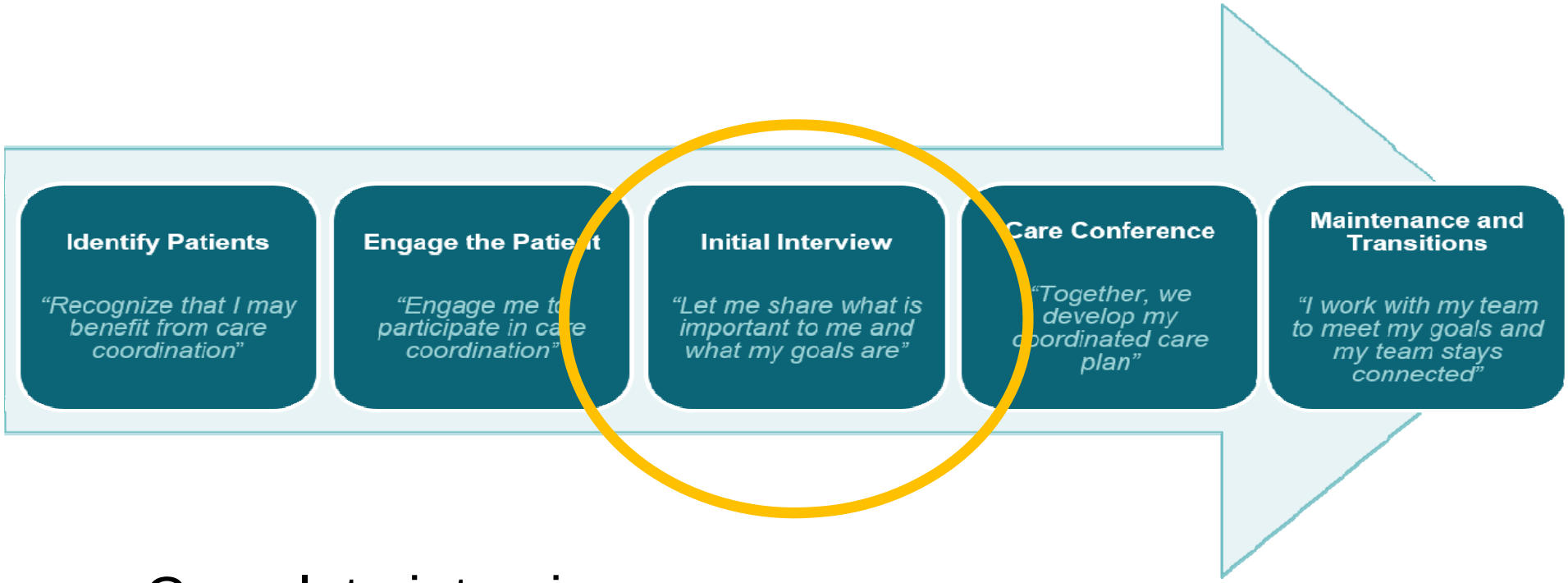


Specifically, this webinar will aim to:

To provide the opportunity to share and learn from one another:

- **Health Links processes and practices relating to patient interviewing.**
- **Lessons learned so far, in the field.**

INTERVIEW THE PATIENT



- Complete interview
- Identify vision, goals, strengths, etc.
- Identify Health Links care team
- Begin planning care conference

INTERVIEW THE PATIENT

Themes from ‘lessons learned’, so far:

1) Approach the interview as a way to truly understand the ***patient’s perspective***.

2) Draw on ***theories or techniques***, to create standard work and/or focus generally on ***clinical skillsets/ capacity building.***

3) Support ***patient-centred empowerment***.

4) ***Location, location, location***. Seek to strike a balance between efficiency with patient preferences.

Ineffective Practice: Approaching the interview as a form filling exercise.

HealthLink
North Simcoe Community

Chris Archer,
Project Manager, North Simcoe Health Link

Tracy Koval,
Registered Nurse, Clinical System Navigator, North Simcoe Health Link

HealthLink
North Simcoe Community

Interactive Web Based Map…Intake Process

Initial Meeting Process

- Part of this involves explaining to clients that although many people believe that health is the absence of disease and physical health concerns, we view overall well-being as more than that. We understand that one's wellbeing is not merely achieved with the absence of disease but we recognize that many other things impact one's health. For example (using the map as a visual aid) all these factors have the ability to impact your health and wellbeing.

Patient Centric

- Examples 1. Without transportation you cannot attend appointments and even get to the grocery store to get food to survive 2. Food-without proper nutrition, you will not have the strength to function daily or the required nutrients vital to good health 3. Without education and literacy, it can be difficult for someone to read a food label and understand the impact of food choices on their health

Social Determinants of Health

- At Health link, we manage physical and mental health but we also pay attention to many other areas that impact your health and help you work on these areas so that you feel better and have a better sense of overall wellbeing.

Interactive Map

- I would like you to take some time to look at the map and think about your current situation. Questions asked after a few minutes:
  - What areas on the map can you identify as most important to you and that you would like to work on together?
  - When you think about the area you identified, what do you hope to achieve?
- Note: even if clients only identify 1 area that they would like to work on at the time, we encourage the client to bring home the copy of the map to reflect on other areas that we can work on.

Be Well Survey

- In the initial appointment, clients are also provided the “be well” survey to complete at home and then are advised we will review it together the following week. The survey is used to help guide clients to create goals. For example, if clients state that they have difficulty affording food, we ask them if they would like to work on approaching other resources in the community so that they do not have to feel this pressure.

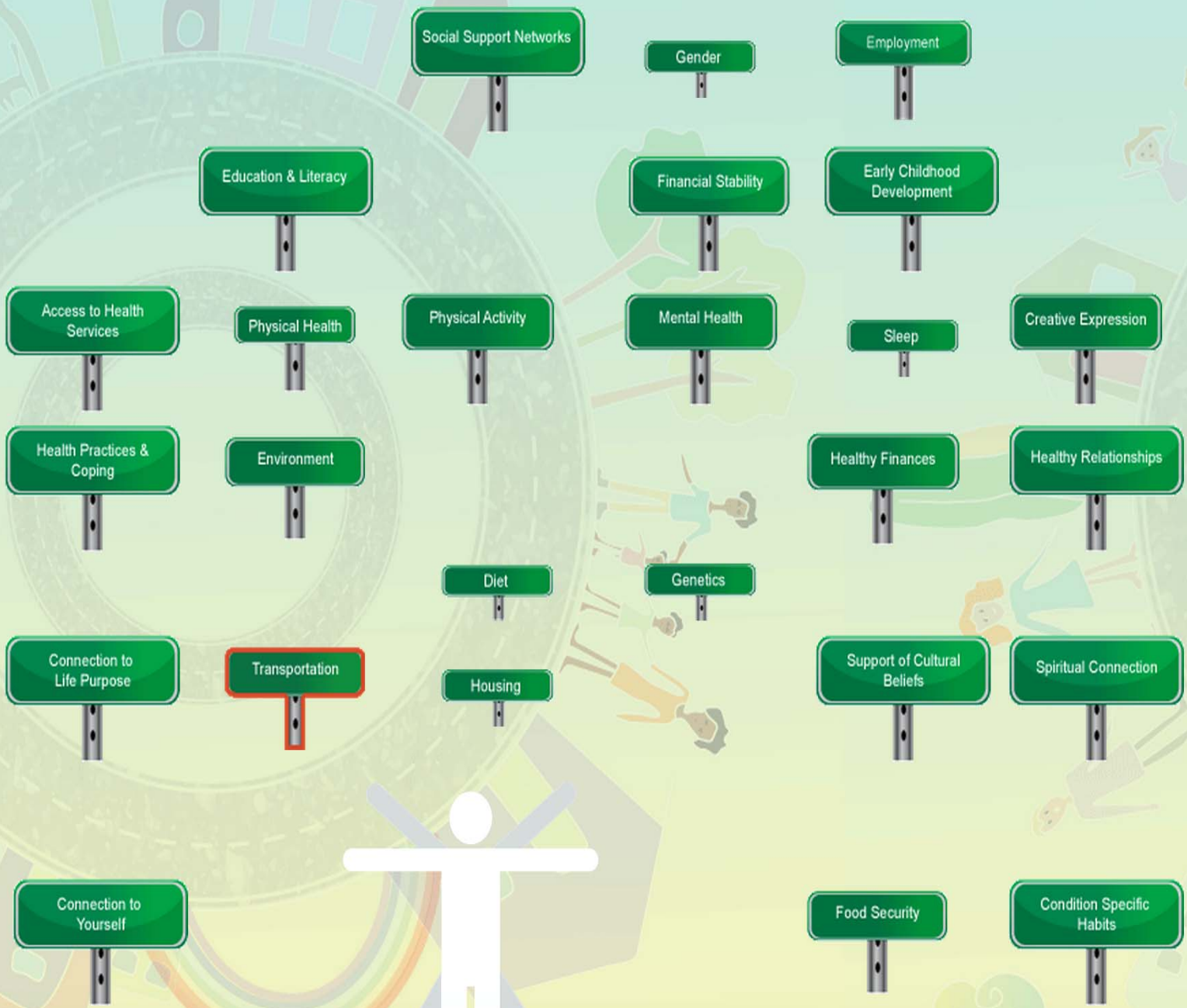
Follow up

- Using the map and the “be well “survey, we then work with the client in the second appointment to complete the clients care plan that is focused completely on their goals.

Determinants of Health

Website Instructions

Mobile Instructions



Transportation Resources in North Simcoe, Midland, Penetanguishene

North Simcoe is a rural community with minimal public transit. As such there are challenges for the elderly, persons with disabilities, those living out of town trying to gain access to employment, community resources, medical appointments, etc.

The social impact of restricted access to transportation can have a negative impact on physical and mental health.

(NOTE: Each link will open in a new window, just close the browser window by clicking the "X" in the top right corner to get back to the Health Link web page)

Canadian Cancer Society	Provides transportation for local patients to travel for cancer treatment in-town and out-of-town.
Royal Canadian Legion Penetang-Homeless Veterans Assistance	Emergency Transportation for Veterans
Community Reach	Transportation Linking Communities (TLC) provides non-emergency transportation by volunteers.
Town of Midland	The Town of Midland provides a wheelchair accessible transit service managed by Community Reach North Simcoe.
Metis Nation of Ontario-Community Support Services	Escorted transportation services.
Huronia Seniors Volunteer Care Team - Wheels 4 Wheels	A volunteer run wheelchair accessible transportation service available to those in the community who travel via wheelchair and are unable to use traditional modes of transportation.

Contact North Simcoe Health Link

North Simcoe Community Health Link
Chigamik Community Health Center

845 King Street, Unit 10
Midland ON L4R 0B7

General Inquiry
Phone: 705-527-4154 ext. 255

Registered Nurse/Clinical System Navigator
Phone: 705-527-4154 ext. 205

Fax: (705) 526-2870

Ontario Trillium Foundation / Fondation Trillium de l'Ontario
An agency of the Government of Ontario. Relève du gouvernement de l'Ontario.

Community Health and Wellbeing
Shift the conversation

"Be Well"
A Survey of Your Wellbeing

This survey covers many important aspects that affect your health and wellbeing. The information you provide will help your health organization develop a better understanding of what is keeping you well and what will help support the best health and wellbeing for everyone in Ontario. This survey will allow us to better connect people and communities with the programs, services and opportunities that can strengthen their health and wellbeing.

This survey will take approximately 16 - 20 minutes of your time.

Your Participation is Voluntary: Your participation is completely voluntary. You may stop participating, or refuse to answer any question. Your decision on whether or not to participate will not affect the nature of the services you receive at this organization.

Your Responses are Confidential: All information you provide will be kept completely confidential. Your name will not appear in any report or publication resulting from this survey. This is not a research activity. Your experiences will contribute to improving the quality and effectiveness of the services, programs and initiatives in your community health organization.

If you have any questions, or concerns please ask the receptionist or a staff member or contact The Association of Ontario Health Centres, Wendy Banh, Be Well Survey Coordinator, Tel: 416 236-2539 ext. 246 email: wendy@aohc.org

Thank you for your participation.

When completing the survey, please mark your selections by filling out the bubbles completely like this: ● (Correct)	Please do NOT fill the bubbles like this: ✓ ⊘ ⊗ (Incorrect)
When completing the survey, in the sections for written responses, please write inside the box like this: (Please specify):	Please DO NOT write outside of the box like this: (Please specify):

NSCHL Contact Information

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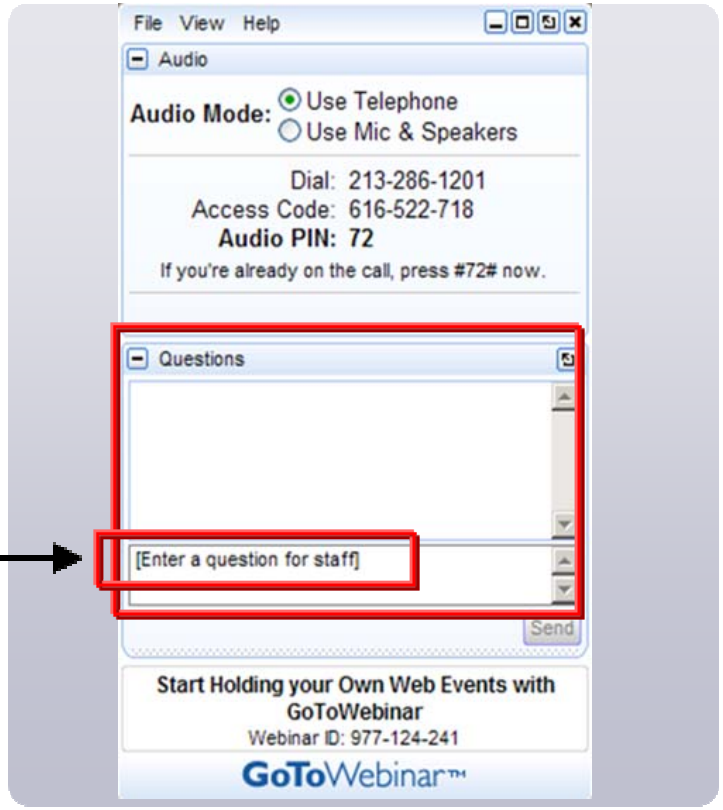
WEBSITE
www.nschl.ca

Question Period

- If you would like to submit a question or comment at any time, please use chat box feature.



Barrie Community HealthLink

Dwayne O’Connor,

Clinical Manager, Barrie and Community Family Health Team

Barrie Community HealthLink

ABOUT THE PRACTICE

- Patient Based Interviewing
- Our interviews are case by case
- In addition to our standard tool we use;
  - An Allied Health Screening Tool
  - An Allied Health Assessment for OT and Social Work

ABOUT THE PRACTICE

Barrie Community HealthLink

Our patients are seen on a Case by Case basis.
This includes:

- *A Telephone Triage call to get basic information and qualifying the patient based on the initial referral*
- *An in-person Intake with IHPs working together in the same room with the patient to access their needs*
- *The interview tools are then utilized*

Barrie Community HealthLink

PRACTICE CONTINUED

1. We evaluate and review the reasons for the referral with the patient to get more detail
2. We ask and request more information as to the challenges the patient has experienced in care
3. We document these concerns and identify different IHP's within the clinic who can assist
4. We interview further to identify other services in our community utilized by the patient and communicate with those community partners what is happening currently with the patient

Barrie Community HealthLink

LESSONS LEARNED

- Understand the Social Determinant's of Health
- Be aware of all aspects of the patient's needs
- Be aware that the patient interview will often take longer than 1 hour

CONTACT INFO

Barrie Community HealthLink

Our phone number is 705-792-2151

Our FAX number is 705-792-2153

Question Period

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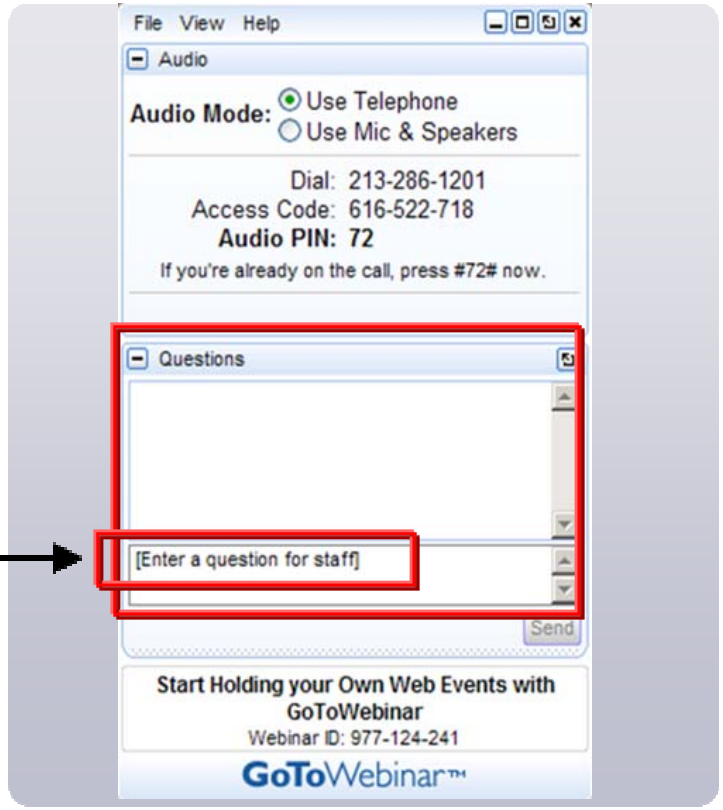

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East Toronto Health Link

Let's Make Healthy Change Happen

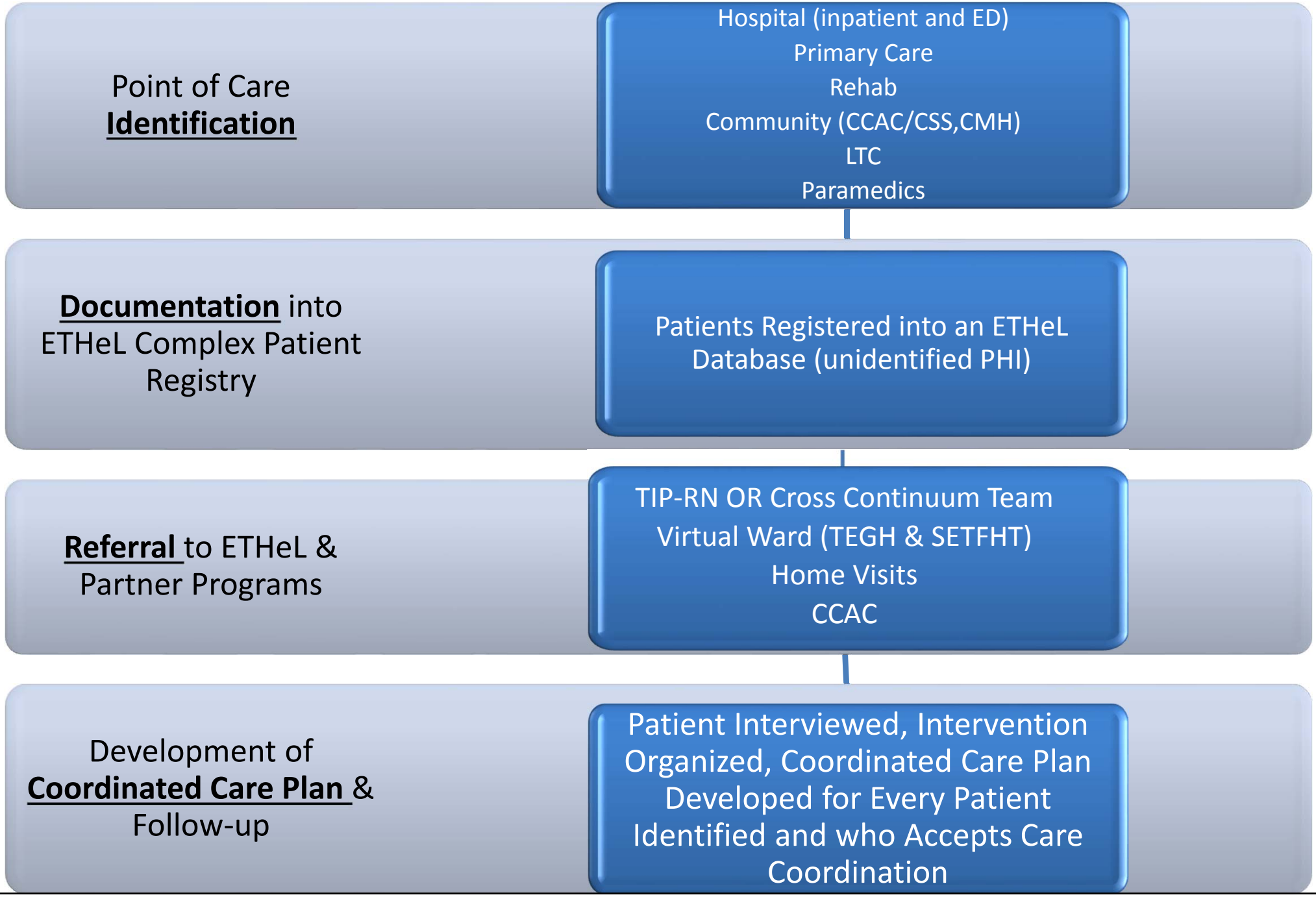
Systematic Approach to Care Coordination

Patient Interview Process & Techniques

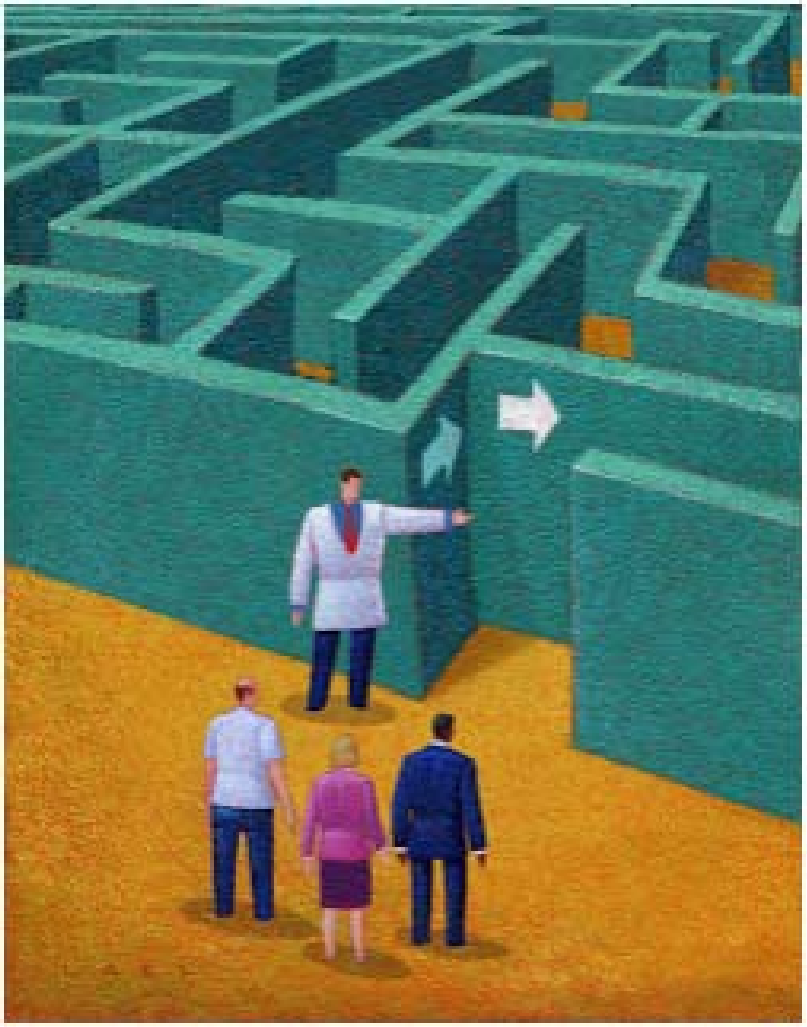
Aasif Khakoo, Director, East Toronto Health Link

Nina Mugo, Cota Transitional Case Manager &
ETHeL Care Coordinator

Pathway for Referral to ETHeL Programs



You Try to Find Help for Your Complex Patients



Key Themes in Engaging Patient

1. **Assume accountability**
   a. Identify key partners and create generative relationships
   b. Infrastructure in place to close loop, track referrals
2. **Provide patient support**
   a. Help patients identify sources of services (esp. community resources)
   b. Help patients access appts.
   c. Ensure transfer of information
3. **Develop connectivity**
   a. Standardized info and interactive communication
   b. Develop ways to make e-referrals, access timely consultations

Dr. Ed Wagner, Director, Improving Chronic Illness Care

Prepare for Patient Interview

Driver 2a: Understand the Individual

- What Matters Most to the Individual?
- Why is this Important?
- Do you ask this question or one like it?
- Who knows the story?
- Does your team understand the Individual's story?
- Does the Community based provider know this?
- What about the family caregiver views and undestanding?

Process of Completion of Patient Interview

- Referral made to ETHeL (e.g. TEGH ED, Virtual Ward, Community Support Agencies, CCAC)
- Contact with patient made within 48 hours
- Intervention planned within 7 days with feedback to patient/caregivers, primary care and other referring sources
- Intervention implemented (e.g. case conference with existing and **new** care team **with** patient & caregiver present

Patient Interview #1 – Home Assessment

- Post patient consent & referred, ETHeL Care Coordinator/Cota TCM conducts a in-home assessment
- Patient interview Tools
  - **OCAN** Consumer Self-Assessment (self-care, food, housing, physical/mental health, safety, etc.
  - **Coordinated Care Plan** (what is most important to you, is there a SDM, current meds, etc.
  - **HARMS 8 (**Hospitalization Risk Screening Tool for Primary. Care Providers and Teams)

Patient Interview #1 – Home Assessment

- Patient Caregiver (SDM)
  - Relationship with patient
  - What is important to them for the patient
- Physical Setting
  - Living condition (safety, clutter, etc.)

Patient Interview #2 – Cross Continuum Team Case Conference

- Patient & Caregiver put at ease
- Patient expresses concerns, goals, etc.
- Care team asks questions/discussions with patient/caregiver
- Key next steps identified
- Care team lead is identified with specific goals
- Subsequent steps in patient transfer also identified
- Process to ‘report’ back to ETHeL/Cota Care Coordinator discussed

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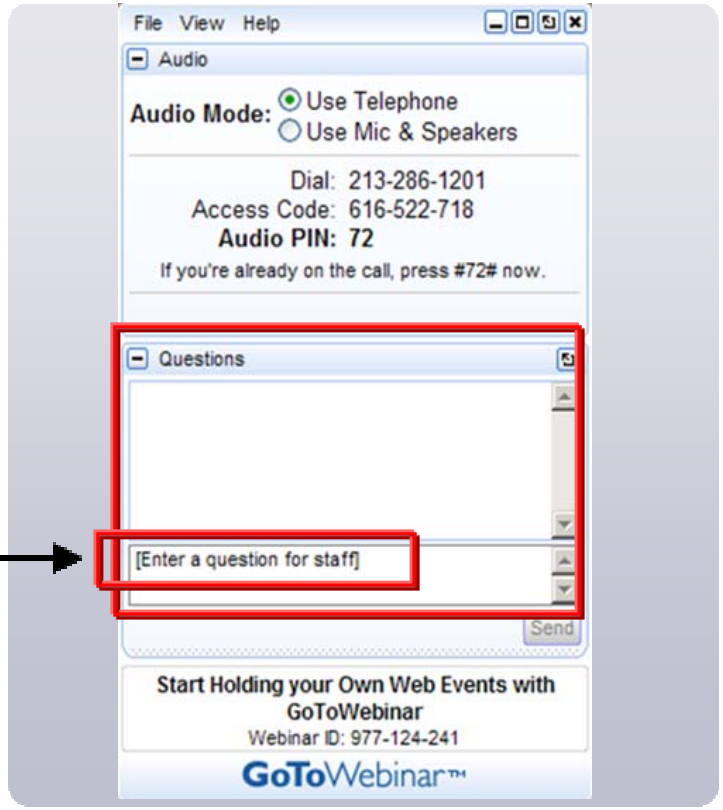

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Timmins Health Link

Jennifer McLeod,
Executive Director, Timmins Family Health Team

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Patient Care Coordination Utilizing a Primary Care Approach

- Patient Population - Identified through hospital reports
  - 15 or more ER Visits in 12 months
  - 4 or more hospital admissions in 12 months
- Patient Discovery Interview completed by Primary Care RNs in the home setting
- Results of interview discussed with patient's PCP and health service providers within patient's circle of care
- Coordinated Care Plan developed that incorporates an integrated approach to care that meets the needs of the patient as identified by the patient
- Follow-up by patient's primary care team

TIMMINS HEALTH LINK:
THE PATIENT DISCOVERY INTERVIEW

CHART AUDIT

CREATE SPINES
Outlines of the patient's experience with illness or a specific event

COMPLETE INTERVIEW
Home visit, Motivational Interviewing Techniques, Focus on Patient Experience

IDENTIFY OUTCOMES
Successes, Barriers, Gaps, Emotional Touchpoints

BUILD CARE PLAN
Case Conferences, Circle of Care, CCT

GOAL SETTING
Readiness, SMART Goals, Responsibilities

Patient Discovery Interview: Example of Spine

(Name of Disease Process/Event lived) "COPD"	
Outline of experience	**Patient's Perspective**
Thinking something was wrong	"I started to have trouble breathing at night"
Seeing the Primary Care Provider	
Having test to figure out what was wrong	
Being told what was wrong	
Receiving treatment	
Living with your condition	
Getting follow up	
Successes: Supportive family	
Challenges/Barriers: Difficulty affording medications on a consistent basis	
Gaps: No primary care provider	
Emotional Touchpoints: (Emotions experienced with associated triggers) Emotion: Confused Trigger: When being discharged home, no one explained my list of medications	

Patient Discovery Interview Con't

Other Information that surfaced during the PDI:				
What is most important to the patient right now?				
Action Items				
Top Three SMART Goals	Readiness (Red, Yellow, Green)	Action Required	Person Responsible	Follow Up Date

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Timmins Health Link

LESSONS LEARNED

- Patient Benefits
  - Customized care plans co-designed with patient and led by patient directed needs
  - Patient feels heard and experience is improved
  - Outcomes are improved and gains are measurable
- Time needed for home visit and PDI difficult for primary care offices
- Training & capacity building needed for PC RN staff
- Process effective but needs continued follow-up for sustainability

CONTACT INFO

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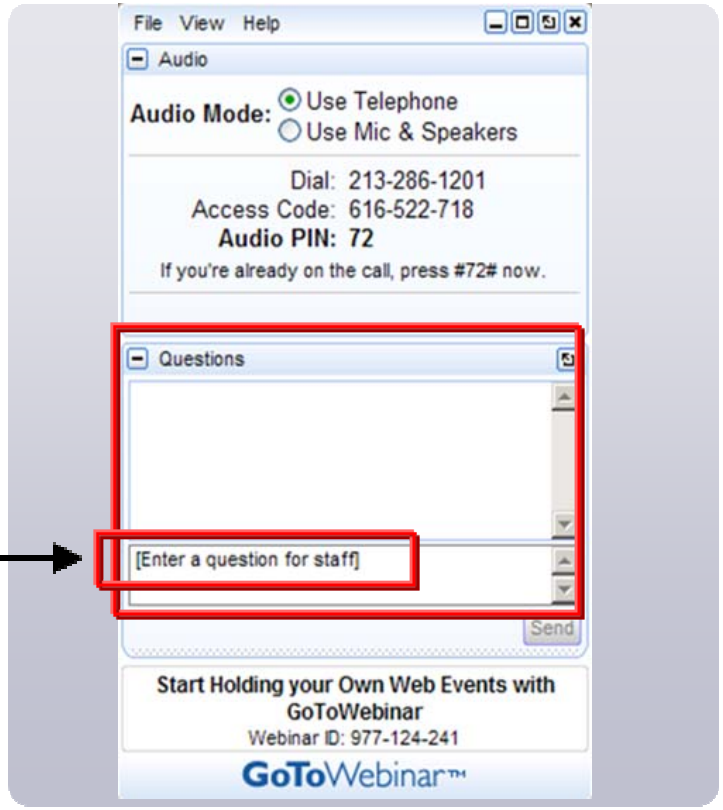

HEALTH LINK COMMUNITY OF PRACTICE:
WEBINAR SERIES

Topic	Date
Webinar 1: CCP – Identify the Patient	Wednesday September 9, 2015
Webinar 2: CCP – Engage the Patient	Tuesday September 22, 2015
Webinar 3: CCP – Initial Interview	Wednesday October 7, 2015
Webinar 4: CCP – Care Conference	**DATE CHANGE:** **Tuesday October 20, 2015** **DURATION:** ***1.5 hours***
Webinar 5: CCP - Maintenance and Transitions	**Tuesday November 10, 2015**

Health Quality Transformation 2015

Partnering to accelerate best care, best health, best value

October 14, 2015

Metro Toronto Convention Centre- South Building

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