

Coordinated Care Management

Identify Patients: Use a Combination of Clinical and Data Driven Strategies

Released June 2016

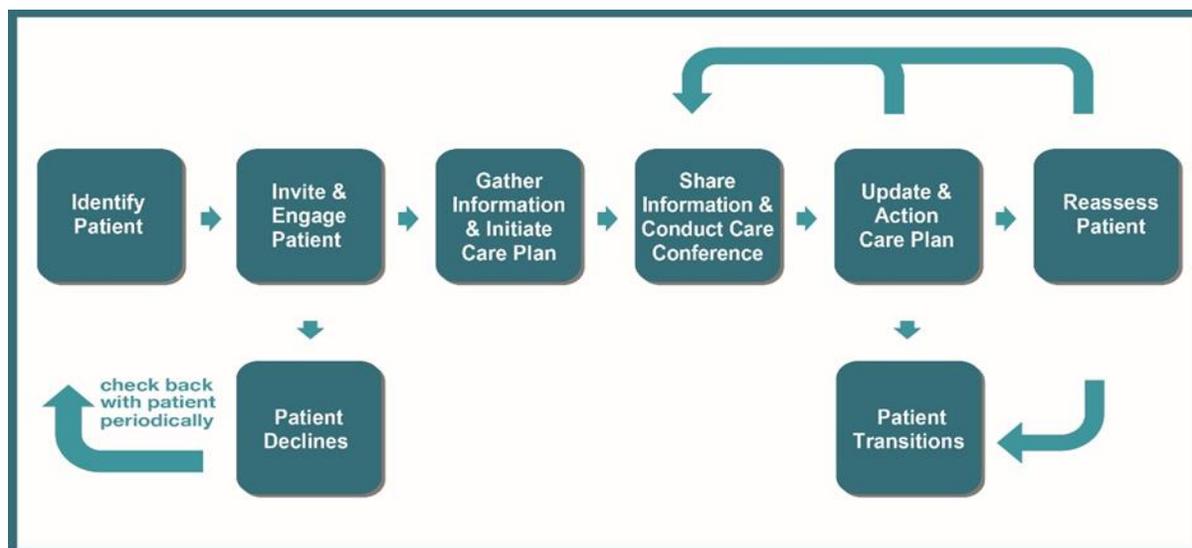


Figure 1: Approach to Coordinated Care Management

While this approach to Coordinated Care Management is generally accepted across the province, there is **significant variation in the practices within each process step**. Although each practice, organization, region, and/or Health Link may have varying areas of foci, the following collection of Innovative Practices and implementation supports are designed to **support teams to improve care for patients within the Health Link, and to support the ongoing alignment and advancement of consistent practices at a provincial level**. For additional information on Quality Improvement, please visit: qualitycompass.hqontario.ca/portal/getting-started.

Innovative Practice	Innovative Practice Assessment ¹	Clinical Reference Group Endorsement for Spread
Identify patients with multiple conditions and complex needs through clinical level assessments and data driven case finding methods at any point in the patient's healthcare journey.	EMERGING	Provincial spread with reassessment using the Innovative Practices Evaluation Framework in 1 year (June 2017).

Use clinical level patient identification mechanisms to support identification of patients during a service encounter. For example, as each patient presents to a health or wellness organization or program to receive care, the provider may identify that the patient may benefit from a Health Links/Coordinated Care Management approach. To *further* support clinical decision making, the provider may then administer a standardized risk assessment tool, if indicated.

¹ For more information about the Innovative Practices Evaluation Framework assessments, please go to the following link: <http://www.hqontario.ca/Portals/0/documents/qi/health-links/innovative-practices-evaluation-framework-overview-en.pdf>

Use data driven case finding mechanisms to support prospective identification of patients with multiple conditions and complex needs using utilization data to identify complex patients. For example, triggers such as the number of visits to the emergency department, number/length of admissions to hospital within a specified time frame, or patients with specific diagnoses or conditions can be built into the electronic medical record or can be managed by targeted data extraction and analysis methods, to support the identification of potential Patients with multiple conditions and complex needs.

Implementation		
Steps for Implementation	Tools and Resources	Additional Enablers
<p>1) The clinician uses the “Patient Identification Decision Support Tool” (see Appendix A) as part of their assessment, and administers the relevant risk assessment tool to support clinical decision making.</p> <p>2) Provider organizations routinely apply data driven case finding methodologies to inform and support decision making.</p> <p>3) Providers/organizations share data to ensure a comprehensive view of the population and patients who may benefit from Health Links.</p>	<ul style="list-style-type: none"> • Patient Identification Decision Support Tool (see Appendix A) • “Identifying Patients for Care Coordination” Webinar (Health Quality Ontario Webinar; September 9, 2015); available at: http://www.hqontario.ca/portals/0/documents/qi/health-links/ccp-webinar-step-1-en.pdf • Guide to the Advanced Health Links Model; Ministry of Health and Long-Term Care, available at: http://www.health.gov.on.ca/en/pro/programs/transformation/docs/Guide-to-the-Advanced-Health-Links-Model.pdf • LACE (Length of Stay, Acuity of Admission, Comorbidities, Emergency Room Visits); available at: http://www.hsprn.ca/?p=33 • PRA (Predictive Repetitive Admission); available at: https://www.nygh.on.ca/HealthLink • DIVERT (Detection of Indicators and Vulnerabilities for Emergency Room Trips Scale); available at: http://www.hqontario.ca/Quality-Improvement/Tools-and-Resources 	<p>Data Sharing Agreements may help facilitate the sharing of information and communication across organizations/sectors. If using a Data Sharing Agreement ensure that it meets all legislative, legal, regulatory criteria. A number of resources regarding the development of data sharing agreements, etc. can be found in the Resources section of the Information and Privacy Commissioner of Ontario website, available at: https://www.ipc.on.ca/english/resources/</p>

Measurement

Quality Improvement Measures are used to help with monitoring progress in implementation of a change and determining whether that change is leading to improvement. Just as a health care provider may monitor heart rate or blood pressure to determine a patient’s response to treatment, collecting information relating to processes for the improved provision of care allows the team to know whether they are consistently moving towards a high reliability care environment. *For more information on **Quality Improvement and Measurement** please visit qualitycompass.hqontario.ca/portal/getting-started.*

The following measures have been developed to help to determine: 1) if the Innovative Practices relating to Coordinated Care Management are being **implemented**; and 2) the impact of these practices on Health Links **processes** and the **outcomes** of care at the patient, population, or systems level.

Health Links, organizations, and/or providers that elect to implement one or more of the Coordinated Care Management Innovative Practices are **strongly encouraged to collect data on the associated measures and report them to Health Quality Ontario**. This will enhance analysis at the next review (June 2017), which will benefit all of the Health Links.

Suggested Measures

(please see Appendix B for additional details)

Suggested Outcome Measure	Suggested Process Measures	Additional Information
% of patients identified as meeting Health Link criteria who are offered access to Health Links	<ul style="list-style-type: none">% of Health Links reporting that (in at least one care setting (e.g., Hospitals, Community Care Access Centre, Primary Care) patients are identified using a combination of risk assessment, data-driven case finding, and/or clinical judgement	<ul style="list-style-type: none">Recommend that Health Links collect and report data for a minimum of 3 months.QI RAP templates will be available if the Health Link chooses to use them.All patients who are receiving care through the Health Link are included in the sample.

References

- Costas AP, Hirdes JP, Bell CM, Bronskill SE, Heckman GE, Mitchell L, Poss JW, Sinha SK, Stolee P. Derivation and Validation of the Detection of Indicators and Vulnerabilities for Emergency Room Trips Scale for Classifying the Risk of Emergency Department Use in Frail Community-Dwelling Older Adults. *J Am Geriatr Soc.* 2015;63(4):763-9.
- Ministry of Health and Long-Term Care. Guide to the Advanced Health Links Model [Internet]. Ontario: Ministry of Health and Long-Term Care [cited 2016 May]. Available from: <http://www.health.gov.on.ca/en/pro/programs/transformation/docs/Guide-to-the-Advanced-Health-Links-Model.pdf>
- Pacala JT, Boulton C, Boulton L. Predictive Validity of a Questionnaire that Identifies Older Persons at Risk for Hospital Admission. *J Am Geriatr Soc.* 1995;43(4):374-377.

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Appendix A: Patient Identification Decision Support Tool

Released June 2016

How is this decision support tool used?

This tool was designed to support Health Links and Providers within the Health Link to implement the practice of identifying patients for a Health Links/Coordinated Care Management approach using **clinical level assessments and data driven case finding methods** at any point in the patient’s healthcare journey. This tool is intended to **support (not replace) operational and clinical decision making** in the Health Link and in clinical identification of patients for Coordinated Care Management, and must be considered alongside with other contextually relevant information.

Which clinical assessment should be used?

A *single*, cross-sectorial clinical level risk assessment tool/method with adequate sensitivity and specificity to capture every patient who would benefit from a Health Links/Coordinated Care Management approach was *not* identified. However, the following risk assessment tools were highlighted by Health Links during the environmental scan, and are presented here for consideration based on the practice setting. The decision to implement/administer one of these tools must be considered alongside other contextually relevant information.

Clinical Level Assessments		
Name of Tool	Overview	Considerations
LACE <i>(Length of Stay, Acuity of Admission, Comorbidities, Emergency Room Visits)</i>	<p>LACE is a validated tool used within the hospital sector to assess risk of readmission. The LACE considers factors such as length of stay, acuity, comorbidities, involvement in programs with community care access centres (CCACs) or primary care.</p> <p>It takes less than 5 minutes to administer the LACE, and is typically completed by a health care professional.</p>	<ul style="list-style-type: none"> LACE was developed using Ontario-derived data and has been shown to be accurate in predicting acute care re-admissions (notably 30-day readmissions). LACE tool is available online at the Health System Performance Research Network website: http://www.hsprn.ca/?p=33
PRA (Predictive Repetitive Admission)	<p>PRA is used to help family physicians within the primary care sector to support decision making regarding whether or not a patient would benefit from Health Links/Coordinated Care Management approach.</p> <p>Typically, patients with a PRA score of 50% or higher are considered likely to benefit from a Health Links/Coordinated Care Management approach.</p>	<ul style="list-style-type: none"> The North York Central Health Link has this tool posted on their website: https://www.nygh.on.ca/HealthLink/

	It takes less than 5 minutes to complete the PRA, and may be self-administered by the patient, or with support from the health care professional, as needed.	
DIVERT Scale (Detection of Indicators and Vulnerabilities for Emergency Room Trips Scale)	<p>DIVERT (Detection of Indicators and Vulnerabilities for Emergency Room Trips) Scale is used to help Providers in the home and community care sector to predict unplanned emergency services use among home and community care clients.</p> <p>Typically, patients with a DIVERT score of 6 or more are considered likely to benefit from Health Links/Coordinated Care Management.</p> <p>DIVERT is typically completed by the Care Coordinator, and can be derived from the InterRAI Home and Community Care Instruments at no additional cost. A screening Model is also available for those not running the interRAI platform.</p>	<ul style="list-style-type: none"> DIVERT Brief Guide posted on Health Quality Ontario's in Health Quality Ontario's Tools and Resources Section, with permissions, at: http://www.hqontario.ca/Quality-Improvement/Tools-and-Resources

Are there any examples of how to implement the practice of using data driven case finding methods to identify patients?

A Health Quality Ontario webinar presentation entitled "Identifying Patients for Care Coordination" delivered on September 9, 2015 focused on data driven case finding methods to identify patients. To view a recording of this webinar presentation, please visit www.hqontario.ca/portals/0/documents/qi/health-links/ccp-webinar-step-1-en.pdf. One example of the implementation of this practice was presented by North East Toronto Health Link. This Health Link has implemented this practice by identifying patients using a real-time, information management system. Within this information management system patients are "triggered" when they reach: 1) 4 visits to the Emergency Department; **OR** 2) 3 inpatient visits within six months at Sunnybrook Health Sciences Centre; **AND** 3) live within the Health Link geography. Patients meeting the above criteria, are "triggered" at registration, therefore providing *all* patients with equal opportunity to be engaged, enrolled and participating in Coordinated Care Management.

What might using both clinical level assessments and data driven case finding methods "look like"?

The following process was developed to demonstrate what the practice of using both clinical level and data driven case finding to identify patients may look like when implemented. It is for demonstrative purposes only, and can be adapted to regional processes and practices.

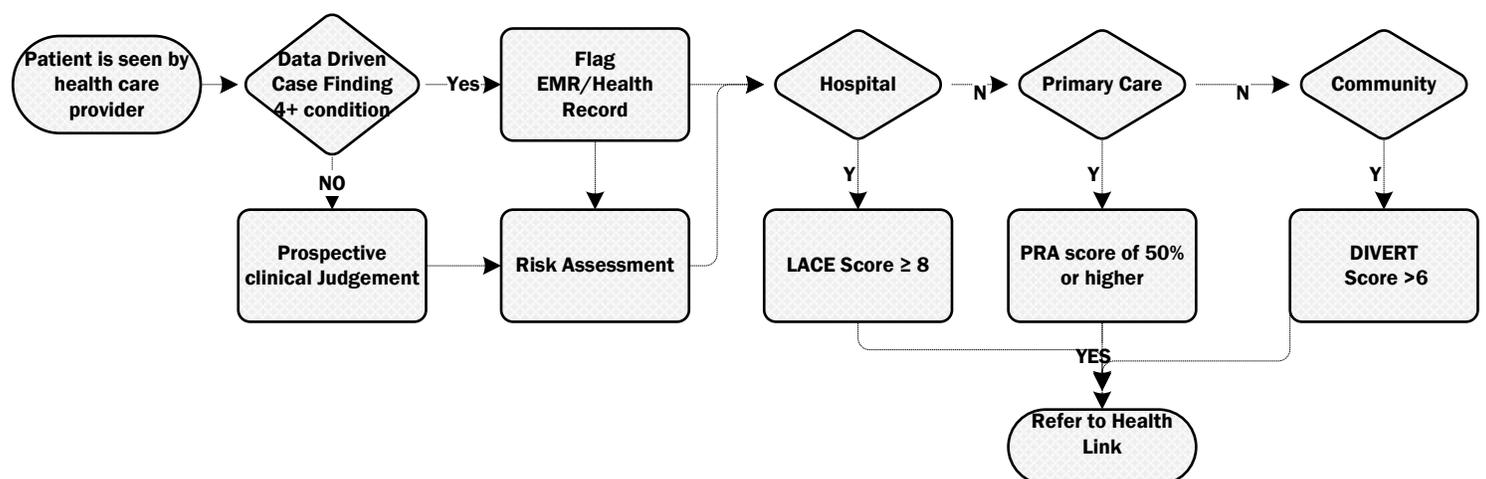


Figure 2: Process Map for Using Clinical Level Assessments and Data Driven Case Finding Methods

References:

- Costas AP, Hirdes JP, Bell CM, Bronskill SE, Heckman GE, Mitchell L, Poss JW, Sinha SK, Stolee P. Derivation and Validation of the Detection of Indicators and Vulnerabilities for Emergency Room Trips Scale for Classifying the Risk of Emergency Department Use in Frail Community-Dwelling Older Adults. *J Am Geriatr Soc.* 2015;63(4):763-9.
- Health Quality Ontario. "Identifying Patients for Care Coordination" Webinar [Internet]. 2015 September 9 [cited 2016 May]. Available from: <http://www.hqontario.ca/Portals/0/Documents/bp/bp-identifying-patients-en.pdf>
- Ministry of Health and Long-Term Care. Guide to the Advanced Health Links Model [Internet]. Ontario: Ministry of Health and Long-Term Care [cited 2016 May]. Available from: <http://www.health.gov.on.ca/en/pro/programs/transformation/docs/Guide-to-the-Advanced-Health-Links-Model.pdf>
- Pacala JT, Boulton C, Boulton L. Predictive Validity of a Questionnaire that Identifies Older Persons at Risk for Hospital Admission. *J Am Geriatr Soc.* 1995;43(4):374-377.

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Appendix B: Measurement Specifications for Identify Patients Using Clinical and Data Driven Strategies

Released June 2016

Percentage of patients identified as meeting Health Link criteria who are offered access to Health Links

Step for Coordinated Care Management	Identify Patient
Innovative Practice	Identify Patients with multiple conditions and complex needs through a combination of clinical level assessments and data-driven, case-finding methods
Measure	% of patients identified as meeting Health Link criteria who are offered access to Health Links
Type	Outcome Measure
Definition/Description	Identify Patients with multiple conditions and complex needs through clinical level assessments and/or data-driven case-finding methods sourced from multiple points in the patient's healthcare journey, including acute care, hospital and community care. Dimensions: Effective, Efficient, Equitable, Timely Direction of Improvement: ↑
Additional Specifications	<u>Numerator</u> : Total number of patients offered access to the Health Link <u>Denominator</u> : Total number of patients identified through clinical level assessments and/or data-driven case-finding methods sourced as meeting HLs criteria <u>Exclusion Criteria</u> : Patients who meet the criteria but who are not offered access to the Health Link because they have moved beyond Health Link catchment area, or have died.
Reporting Period	Recommend that Health Links collect and report data for a minimum of 3 months. QI RAP templates will be available if the Health Link chooses to use them.
Data Source	Manual data collection by participating primary care, hospital and community care providers within the Health Link.
Sampling Plan	All patients who are receiving care through the Health Link are included in the sample.
Comments	<ul style="list-style-type: none"> Selected outcome measures will help to evaluate the impact to patients of the efforts to introduce innovative practices into coordinated care management. We recognize that patients who meet these criteria may not need Health Links, and patients who need Health Links may not be flagged through these criteria. However, following this combination of clinical level assessments and data-driven, case-finding methods will optimize the Health Link's ability to identify as many patients as possible who may benefit from Coordinated Care Management.

Percentage of patients identified as a result of clinical level assessment and data driven case finding approaches

Step for Coordinated Care Management	Identify Patient
Innovative Practice	Identify Patients with multiple conditions and complex needs through clinical level assessments and/or data driven case finding methods
Measures	% of Health Links reporting that (in at least one care setting (e.g., Hospitals, Community Care Access Centre, Primary Care) patients are identified using a combination of risk assessment, data-driven case finding, and/or clinical judgement
Type	Process Measure
Definition/Description	Assess the number of Health Links that report that patients are identified using clinical and data driven strategies in at least one hospital, Community Care Access Centre, or Primary Care settings. Dimensions: Effective, Efficient, Equitable, Timely Direction of Improvement: ↑
Additional Specifications	<u>Numerator #1</u> : Number of active Health Links within a LHIN reporting that they DO use clinical and data driven case finding strategies <u>Denominator #1</u> : Total number of active Health Links within the LHIN. <u>Exclusion Criteria</u> : Patients who meet the criteria but who are not offered access to the Health Link because they have moved beyond Health Link catchment area, or have died.
Reporting Period	Recommend that Health Links collect and report data for a minimum of 3 months. QI RAP templates will be available if the Health Link chooses to use them.
Data Source	Manual data collection by participating primary care, hospital and community care providers within the Health Link.
Sampling Plan	All active Health Links are included in the sample.
Comments	<ul style="list-style-type: none"> • Selected Process Measures help Health Links draw on the fields of Improvement Science and Implementation Science as they are implementing these practices. • Process Measures are used to assess: <ol style="list-style-type: none"> 1. Progress in implementation components such as reach (how often the practice is being used); 2. Adherence (fidelity) to the specifications of the steps that must be in place for a program or practice to operate; and 3. Sustainability of the process as designed so that it will continue once the initial attention has waned. • We recognize that patients who meet these criteria may not need Health Links, and patients who need Health Links may not be flagged through these criteria. However, following this combination of clinical level assessments and data-driven, case-finding methods will optimize the Health Link's ability to identify as many patients as possible who may benefit from Coordinated Care Management.