Health Quality Ontario

The provincial advisor on the quality of health care in Ontario

April 15, 2016

North East LHIN Regional Quality Session Summary

Ontario
Health Quality Ontario
Qualité des services de santé Ontario

Contents

North East Regional Quality Session Summary

In partnership with Health Quality Ontario (HQO), the North East LHIN hosted an interactive workshop on April 15th, 2016, with the aim of working together in LHIN Hub planning areas to:

- Connect the local Quality Community by bringing together regional leaders in quality improvement to support cross-sector collaboration;
- Have productive discussions about quality and how the local approach to quality intersects with provincial priorities;
- Build on existing partnerships and networks to support and actively pursue a common quality agenda; and
- Facilitate collaboration between Health Quality Ontario, LHINs, and health service providers in advancing quality together.

Four locations from the North East LHIN participated in the event: Sudbury, North Bay, Timmins and Sault Ste. Marie. Sessions and workshops were supported by on-site facilitators from the North East LHIN and Health Quality Ontario. Additional details about participation and facilitators are provided in **Appendix A**.

The morning started with opening remarks from Louise Paquette, CEO, North East LHIN, who welcomed and thanked participants for their commitment to quality care in the region. She provided an update on the North East LHIN Quality Table, including the introduction of the new Chair, Dr. Reena Dhatt, who greeted participants with a few words from Health Sciences North in Sudbury.

This was followed by a presentation from Lee Fairclough, Vice President, Health Quality Ontario, who provided an overview of the Quality Agenda in Ontario, including current report findings, recent progress with health system improvement initiatives and leading practices. Her presentation highlighted how Quality Improvement Plans (QIPs), Health Links, and the engagement of patients and providers can act as enablers to help improve care.

This document summarizes the highlights of the plenary sessions and workshops, along with ideas and discussions from each sub-LHIN area. Major themes discussed included embedding quality into practice, integrating care between providers, and partnering with patients. The agenda of the day's activities can be found in **Appendix B**.

Plenary Session 1: Embedding Quality into Practice

The first session of the day was a presentation from Danyal Martin and Arielle Baltman-Cord from Health Quality Ontario, who provided an overview of Quality Based Procedures (QBPs) and Quality Standards (QS), including some helpful resources to help health care organizations and providers with implementation.

Quality-Based Procedures

Quality-Based Procedures (QBPs) provide funding to hospitals based on the volume of services provided at a given price, which is calculated based on high-quality care. As of April 2016/17, there are 22 Quality Based Practices (QBPs) and 18 QBP Clinical Handbooks developed.

Quality Standards

Health Quality Ontario is collaborating with clinical experts, patients and caregivers across Ontario to introduce Quality Standards to the province this year. Quality Standards are a concise set of easy-to-understand statements (five to 15 in each Quality Standard) outlining the best care possible for patients with selected conditions, based on the best available evidence. The first three Quality Standards will be released in the fall 2016 and will focus on care for people with major depression, schizophrenia, and dementia (specifically for patients living with dementia who have symptoms of aggression or agitation).

Session Discussion

Following the presentation, participants in each Hub location engaged in a brief discussion about embedding quality into participants' organizations and practices. The discussions centred around the need to have standard tools for implementation and education, culturally and rurally sensitive models, aligning with standards already in place such as accreditation standards and having standards which define roles across sectors when implementing practice changes such as quality based procedures, quality standards, health links and patient flow strategies. There were excellent discussions regarding the work being done across sectors and further opportunities for cross sector work. The consolidated notes from these discussions can be found in Appendix C.

Workshop 1: Integration of Care

Beginning with a moving patient story presented by Jennifer Osesky from Sault Ste. Marie, this session highlighted the opportunities and challenges of navigating the health care system for patients with complex needs. Jennifer MacKinnon, Primary Care Officer in the Northeast LHIN, provided a summary of the current status of local integration initiatives in the regions; notably Health Links and Rural Health Hubs. This session included an update on the provincial Advanced Health Links Model and the upcoming introduction of Innovative Practices for Health Links. Phil Kilbertus from the North East LHIN then spoke of the Alternate Level of Care (ALC)/Patient Flow Strategy and the various performance metrics and projects embedded in this plan, highlighting the LHIN's emphasis on Integrated Care.

Session Discussion

Following the didactic presentations, each location broke into local discussion groups to participate in a workshop based on the Patient's Integrated Care Journey (**Figure 1**). Common themes in these discussions included the high volume of work currently underway at the mid-way points of the journey (e.g., ED visit, Admission and Discharge) and future plans to incorporate primary, rehabilitation, community and self-care.

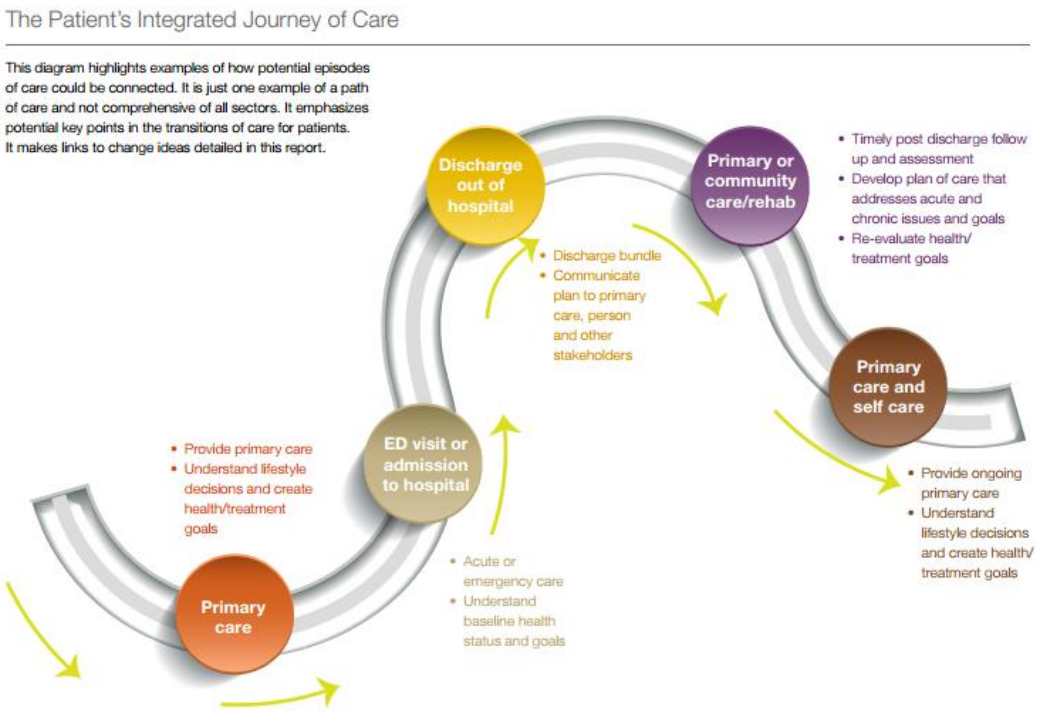

Figure 1: The Patient's Integrated Care Journey ("Journey Chart")

(Source: Advancing Integrated Care: Cross-sector perspectives from Ontario's health system, Health Quality Ontario, 2015)

Workshop 2: Partnering with Patients

The second part of the afternoon featured a presentation from Health Quality Ontario's Aman Sium, who provided an overview of patient engagement best practices and helpful tools and resources available from Health Quality Ontario. The presentation also highlighted the Continuum of Patient Engagement Framework (*Carman et al. Health Affairs, 2013*; **Figure 2**), which provided a helpful model to identify the depth and maturity of patient engagement activities from consultation, involvement to partnership.

This presentation was followed by an insightful overview from Leeann Whitney and Terri MacDougall who shared their IDEAS project to reduce pain for pediatric patients in their Nurse Practitioner Led Clinic in North Bay. This presentation highlighted learnings from the IDEAS curriculum, the results of the project to improve patient care, how patients were engaged, and how patient experience was impacted through the process.

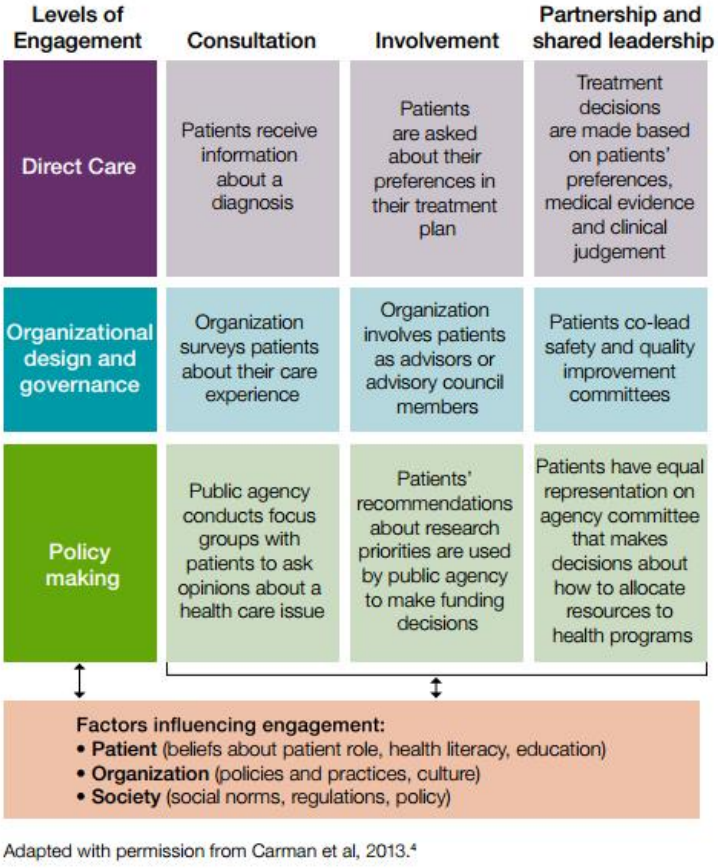

Figure 2: Continuum of Patient Engagement

Session Discussion

Following both presentations, each location participated in a final site-specific workshop to discuss current patient engagement strategies underway in each region. Key themes for consultation with patients included patients reviewing and providing feedback on Quality Improvement Plans, space, policies and practices, and through common structures such as focus groups, surveys or engagement sessions. At the involvement stage, participants spoke of patients having a more active advisory role, and being more involved in decision making in various capacities including quality committees, recruitment campaigns, care committees, councils, and quality improvement initiatives. Finally, at the partnership level, participants spoke of similar venues where patients have taken joint leadership roles in partnership with health care providers. The consolidated notes from these discussions can be found in Appendix E.

Conclusion (Reporting Back)

To end the day, Marie Paluzzi, Quality Improvement Lead with the North East LHIN, facilitated a wrap up where each site location was asked to share what they will do differently as a result of the day's activities. Specifically, participants were asked to provide three action items integrating the learning from the three different sessions: Embedding Quality into Care, Integration of Care, and Partnering with Patients:

Common themes related to *Plenary Session 1: Embedding Quality into Practice* included the interest in improved access and communication, as well as standardized tools, education and integration into existing structures and committees to improve implementation success.

For *Workshop 1: Integration of Care*, key themes included leveraging and expanding the great work already in progress, including Health Links and Coordinated Care Planning, as well as increase collaboration and sharing, notably around data and technology to accelerate improvement.

Discussion regarding patient engagement in *Workshop 2: Partnering with Patients* provided the opportunity to share the creative and dynamic initiatives underway in the region, including the integration of patient advisors and patient involvement in the continuum of care. With so many promising initiatives underway, the benefits to participating organizations in the LHIN to share and learn from each other were broadly apparent.

Detailed listings of participants' three action items for each of the day's themes are reported in the table on te next page.

Next Steps

A copy of this report will be posted on the North East LHIN website and those who attended will be encouraged to use the report in any cross sector discussions. This report will also inform the Regional Quality Table in the development of a Regional Quality Plan to accelerate quality improvement in the LHIN.

What will you do differently as a result of today's event?

TIMMINS		
EMBEDDING QUALITY INTO PRACTICE	**INTEGRATION OF CARE**	**PARTNERING WITH PATIENTS**
• Clear standard tools for implementation and education with a focus on community awareness with the appropriate resources to implement.	• More collaboration to accomplish the following: ○ Reduction of duplication of services; ○ Refocus on primary care; ○ Provide patient with one point of contact; ○ Integration of data systems, one EMR including mental health and addictions; ○ Spread and sustain health links philosophy; and ○ Pay equity for primary care HCP's in line with acute care.	• Create a sharing circle to give and get information from and for patients.
SAULT STE. MARIE		
EMBEDDING QUALITY INTO PRACTICE	**INTEGRATION OF CARE**	**PARTNERING WITH PATIENTS**
• One single standard of care that crosses all sectors and is culturally and demographically sensitive.	• Promote accountability around collaboration tied to agreements, or opportunities to understand each other's realities, create a culture of trust.	• Simple process to evaluate committees (with timelines; e.g., terms of reference flexible based on current need) – one community based committee versus multiple.
NORTH BAY		
EMBEDDING QUALITY INTO PRACTICE	**INTEGRATION OF CARE**	**PARTNERING WITH PATIENTS**
• For QBP's to be successful, work needs to be done to ensure equal access to care for all. Communication across the sectors also needs to increase. Access and Communication were the largest categories for embedding quality, however we had change ideas in other areas such as material resources, human resources and prevention strategies.	• As QBP's are adopted, there is an opportunity for consistency of care across sectors. This will require increased awareness and communication across sectors.	• Initiatives were shared with categories of Learning Centres, Health Links work with Integrated Coordinated Care Plan (ICCP), Innovative initiatives, partnerships with service /educational organizations, committees and networks.

SUDBURY		
EMBEDDING QUALITY INTO PRACTICE	**INTEGRATION OF CARE**	**PARTNERING WITH PATIENTS**
• Integration with accreditation standards • integrate in quality committees, technology and order sets • Sensitivity to cross culture and rural issues	• More sharing of data • Future initiatives re: prevention • Discussion re: billing codes that rep. whole health care team	• Patient advisory panels • Bedside rounding • Patients on Medical Advisory Committee

Appendix A: Sites, Registration & Facilitators

Site Locations

Sudbury/Manitoulin/Parry Sound:	*Health Sciences North*
Nipissing/Temiskaming:	*One Kid's Place Children's Medical Treatment Centre of Northern Ontario*
Cochrane:	*Timmins and District Hospital*
Algoma:	*Algoma Public Health*

Participation

Region	# of Participants Attended	# of Participants Registered
Algoma/Sault	28	20
Cochrane/Timmins	26	24
Nipissing/North Bay	29	28
Sudbury	51	55
TOTAL (105% attendance)	**134**	**127**

Facilitators

• Joanna de Graaf-Dunlop, HQO • Marie Paluzzi, NE LHIN • Jennifer MacKinnon, NE LHIN	*Sudbury*
• Sue Jones, HQO • Julie Nicholls, HQO • Christine LeClair, NE LHIN	*Timmins*
• Gina de Souza, HQO • Megan Waque, NE LHIN • Liseanne Boissonneault, NE LHIN	*North Bay*
• Shannon Brett, HQO • Nathalie Atkinson, NE LHIN	*Sault Ste. Marie*

Appendix B: Agenda

North East LHIN

Regional Quality Session

An interactive workshop where participants will collaborate using key tools (e.g. Quality Improvement Plans) to identify common areas of quality improvement focus within each the 5 hub regions: Sudbury/Manitoulin/Parry Sound, Nipissing/Temiskaming, Cochrane, Algoma, and James Bay & Hudson Bay Coasts

Please join the location where your organization resides or services. For those organizations that service all areas, please ensure participation at each site. Locations will be connected by OTN video conferencing. The Plenary session will be led from the Sudbury site.

Date:	**Friday, April 15, 2016**	**Time:**	**9:30 am – 3:30pm**
Locations:	**Sudbury/Manitoulin/Parry Sound** **Health Sciences North** 41 Ramsey Lake Rd, Sudbury, P3E 5J1 **Nipissing/Temiskaming** **One Kid's Place Children's Medical Treatment Centre of Northern Ontario** 400 McKeown Ave, North Bay, P1B 0B2		**Cochrane** **Timmins and District Hospital** 700 Ross Ave E, Timmins, P4N 8P2 **Algoma** **Algoma Public Health** 294 Willow Avenue, Sault Ste. Marie, P6B 0A9

Objectives

- To connect the local Quality Community by bringing together regional leaders in quality improvement to support cross sector collaboration;
- To have productive discussions around quality and how the local approach to quality intersects with provincial priorities;
- To build on existing partnerships and networks to support and actively pursue a common quality agenda;
- To demonstrate the collaboration between HQO, LHINs and Health Service Providers in advancing quality together.

Time	Agenda Item	Presenter/Moderator
9:30 am	Registration and light refreshments	
10:00 am	Welcome and Regional Quality Session Overview	Marie Paluzzi Northeast LHIN
10:10 am	Setting the Stage: "Leading Together"	Louise Paquette, CEO, North East LHIN
10:20 am	The Quality Agenda	Lee Fairclough, VP, Health Quality Ontario
11:00 am	**Embedding Quality into Practice** • Understand the cross sector involvement in quality based procedures and other standardized practice initiatives. • Quality Based Procedures (QBP) – how to drive adoption • Quality Standards – understand the opportunity to improve care in each sector, and role of providers, patients & families • **Breakout Session:** Explore change ideas, where is there alignment, and how can we work together, what innovative approaches have you used in your Quality Improvement Plans to embed Quality into Practice	HQO
12:00 pm	*Lunch Provided*	
Workshop #1 – Plenary via OTN, Facilitated Breakout Sessions at each Site		
12:30 pm	**Integration of Care** • Patient Story • Integration of Care through different strategies - Health Link / Rural Health Hubs / Regional ALC strategy • **Breakout Session:** Explore approaches in working together in Acute Care, Long Term Care, Community Care, Community Support Service Sector and Primary Care to have the most impact (What are the improvements? What are the cross sector indicators?, What are the best practices and innovations)	North East LHIN HQO

Workshop #2 – Plenary via OTN, Facilitated Breakout Sessions at each Site		
1:45 pm	**Partnering with Patients** • Patient Engagement and Experience Presentation (OTN) • Hear about successful IDEAS Project in the NE LHIN • **Breakout Session:** Explore current state, HQO resources and opportunities to support patient engagement and patient experience across transitions	North East LHIN HQO IDEAS Graduate(s)
Plenary Session – Facilitated at Main Site		

3:00 pm	Report back by Sub-LHIN area and next steps
	• What will you do differently based on the discussions you have had today
	• Each site to share 3 action items
	  ○ Embedding Quality Into Care
	  ○ Integration of Care
	  ○ Partnering with Patients
		North East LHIN Officers

3:20 pm	Closing Comments	Marie Paluzzi North East LHIN

Appendix C: Embedding Quality into Practice – Discussion Notes

1. What opportunities do you have to integrate QBPs and/or Quality Standards into your organization or practice?
• Provide consistent implementation across sectors with more supports and education available, while keeping in mind adaptations may be necessary for small/rural community challenges (e.g., Health Human Resource shortages) • Collaborate for consistency with documentation, monitoring and data collection/reporting • Integrate into existing order sets and workflow • Utilize system navigation • Integrate and/or align with existing committees and structures (e.g., quality committee, accreditation standards) • Involve patients/clients in processes
2. What do you need to help you implement QBPs and Quality Standards?
• Integration into electronic health records (EHR), order sets, and daily practice • Standard education resources and resource toolkits • Alignment with accreditation standards • Role clarity for key transitions points (e.g., role of agencies) • More collaboration with specialist physicians • Community of practice for Implementation Leads to share resources, knowledge, success stories, awareness, data and create a shared language • Improve communication across sector (e.g., to primary care, agencies)
3. Within your organization or practice, where do you see variation or opportunities to improve care?
• Management of chronic disease • Primary care practices • Communication with clients • Inclusion of Indigenous healing practices • Measurement and application of patient experience and engagement practices • Access to services (e.g., mental health and addiction services, dementia care) • Health prevention (e.g., diet/exercise in chronic disease, wound and infusion therapy)
4. General comments/observations about this session?
• Clarity needed for transition points in care to help patient and provider know what to expect • More awareness needed in community about QBPs and Quality Standards • More collaborate to gain momentum and make more progress • Standardize reporting for QBPs

- In development of QBPs and standards, realities of northern Ontario health system such as access to rehabilitation services needs to be considered
- More capacity building for quality improvement in all sectors (i.e. education)

Appendix D: Integration of Care Discussion Notes

1. What are the most significant initiatives you are currently working on to improve the integration of care for patients, and who do you collaborate with on this initiative?

TIMMINS				
PRIMARY CARE	**ED VISIT/HOSPITAL ADMISSION**	**DISCHARGE**	**PRIMARY/REHAB/COMMUNITY CARE**	**PRIMARY/SELF CARE**
• Timmins Palliative Care Resource Team • Community Care Access Centre (CCAC) Community Palliative Advisory Committee. Proposal for hospital and shared care team. Partner with various community partners (Family Health Team (FHT), hospital, family physicians)	• Stroke Quality Based Procedures (QBP) - Cross sector primary care, Emergency Medical Services (EMS), Hospital, CCAC, small hospitals, • Hip fracture - CCAC, outpatient physiotherapy, primary care, outlying physiotherapy	• Integrated resources hospital to primary care • Health Link with CCAC • Home care post discharge - working with Red Cross • Discharge Planning Project to ensure all Emergency Room (ER) visits are followed up within 7 days with the Chapleau Family Health Team to lower readmission rates • Stroke QBP Steering Committee • EDM Discharge Summary from Timmins & District Hospital (TADH) to Family Health Team (FHT)	• Internal system now rolling out provincially- gap with Mental Health & Addictions (MH&A) • CCAC improving community services in rural areas of Matheson/Iroquois Falls/Cochrane (MICs) • Ontario Telemedicine Network (OTN) screening and education • Assess and restore community, primary care, hospital care, LHIN	• QBP steering committee • Electronic Medical Record (EMR) access for FHTs
SAULT STE. MARIE				
PRIMARY CARE	**ED VISIT/HOSPITAL ADMISSION**	**DISCHARGE**	**PRIMARY/REHAB/COMMUNITY CARE**	**PRIMARY/SELF CARE**
• Transitional case management – Algoma Public Health (APH) • Common referral Form for Child/Youth Services – "no wrong door"	• Assess and restore pilot (Sault Area Hospital (SAH), CCAC, Algoma Geriatric Clinic (AGC), Palliative Care)	• Transitional case management APH • Complex case committee (table to review complex cases that fall in service gaps – we think outside our	• Moose Cree First Nation Assisted Living Complex – in construction – building a 30 unit supportive housing (16 apartments) 10 bedrooms with	

	• Redesigning patient flow to decrease time in emergency – LEAN project • Partnership with police • Cross-linking – IT systems (hospital to community care to primary care)	mandates and plan together for one service plan) • Community Support Services (CSS) mini-website, common referral • Local system planning group (East Algoma) – Health Services Providers, Shelters, Hospital, Algoma District Services Administration Board (ADSAB), schools, first nation, LHIN, Ontario Provincial Police (OPP), Children Aid Society, Family Health Team	dining, bath and laundry services, 2 palliative care rooms with a spiritual room for support of gathering of family, 2 bedrooms for respite, short term care with dining, bath and laundry services • Transitional case management APH • Integrated Assessment Record (IAR) Steering Committee – Ontario Common Assessment of Need (OCAN) • Walk in Counselling (Algoma Family Services (AFS), APH, CMHA) • Collaboration with every sector for Local Aboriginal Health Committee (LAHC), North Algoma Health Needs Assessment (NAHNA) – LHIN funded needs assessment, currently working on an integrated implementation	
NORTH BAY				
PRIMARY CARE	**ED VISIT/HOSPITAL ADMISSION**	**DISCHARGE**	**PRIMARY/REHAB/COMMUNITY CARE**	**PRIMARY/SELF CARE**
• Improve communication regarding hospital discharges and planning flu care • MH&A CSS Common Referral Form & Electronic Database	• ED visits for Canadian Triage Acuity Scale (CTAS) 4/5 • Primary Care Provider (PCP), hospital CCAC	• Public Health Unit (PHU) (in some cases), other hospitals • Healthy Eating, Active Living Collaborative with	• Strengthening services in home & community. Nursing, personal support, rehabilitation; physicians, surgeons,	• Healthy Eating, Active Living Collaborative with Primary Care, PHU and municipalities • Timiskaming Injury Prevention Older Adult Centre

& CSS and MH&A providers • Post-partum Mood Disorder Network North Bay Nurse Practitioner Clinic (NBNPLC), North Bay Regional Health Centre (NBRHC), and Health Unit) Health Links; Integrate with CSS; Mental Health & Housing • Baby Friendly Initiative – NBRHC, NBNPLC, Health Unit • Healthy Eating, Active Living Collaborative with PC, PHU and municipalities • Timiskaming Injury Prevention Older Adult Centre • Timiskaming Collaborative of health service providers • Seniors at Risk – Alzheimer's Society, Seniors MH, NBNPLC, CCAC • Gateway Community Mobilization Hub (police, CAS, NBNPLC, CCAC, hospitals including crisis intervention) • Health Links • Quality Improvement Management System – "More time to care". Internal & external partners & patients, as relevant. Emphasis on frontline	• CSS common referral form & electronic data base for CSS & MH&A pro Patient System Navigator – NBRHC videos • Healthy Eating, Active Living Collaborative with PC, PHU and municipalities • Timiskaming Injury Prevention Older Adult Centre • Timiskaming Collaborative of health service providers • Seniors at Risk – Alzheimer's Society, Seniors MH, NBNPLC, CCAC • Gateway Community Mobilization Hub (police, CAS, NBNPLC, CCAC, hospitals including crisis intervention) • Health Links • Quality Improvement Management System – "More time to care". Internal & external partners & patients, as relevant. Emphasis on frontline involvement and improvement, sustainment, management system • Increased networking: Canadian Institute for Health Informatics(CIHI), Registered Nurses	Primary Care, PHU and municipalities • Timiskaming Injury Prevention Older Adult Centre • Timiskaming Collaborative of health service providers • Seniors at Risk – Alzheimer's Society, Seniors MH, NBNPLC, CCAC • Gateway Community Mobilization Hub (police, Children's Aid Society (CAS), NBNPLC, CCAC, hospitals including crisis intervention) • Health Links • Quality Improvement Management System – "More time to care". Internal & external partners & patients, as relevant. Emphasis on frontline involvement and improvement, sustainment, management system • Increased networking: CIHI, RNAO, Other LTCHs, partnerships with community colleges, universities, NBRHC, CCAC	pharmacies, hospitals • Mattawa Hospital – Algonquin NH rebuild on hospital site • Housing support for long-stay mental medically complex mental health clients	• Timiskaming Collaborative of health service providers • Seniors at Risk – Alzheimer's Society, Seniors Mental Health (SMH), NBNPLC, CCAC • Gateway Community Mobilization Hub (police, CAS, NBNPLC, CCAC, hospitals including crisis intervention) • Health Links • Quality Improvement Management System – "More time to care". Internal & external partners & patients, as relevant. Emphasis on frontline involvement and improvement, sustainment, management system • Increased networking : CIHI, RNAO, Other LTCHs, partnerships with community colleges, universities, NBRHC, CCAC

involvement and improvement, sustainment, management system • Increased networking: Canadian Institute for Health Information (CIHI), Registered Nurses Association of Ontario (RNAO), Other Long Term Care Homes (LTCH), partnerships with community colleges, universities, NBRHC, CCAC	Association or Ontario (RNAO), Other Long Term Care Homes (LTCHs), partnerships with community colleges, universities, NBRHC, CCAC			
SUDBURY				
PRIMARY CARE	**ED VISIT/HOSPITAL ADMISSION**	**DISCHARGE**	**PRIMARY/REHAB/ COMMUNITY CARE**	**PRIMARY/SELF CARE**
• Health Link – CCAC • Convalescent care program • Behavioural Supports Ontario • Emergency Department Outreach • Northern Ontario School of Medicine (NOSM) • CCAC Integrated Model of Care – North East Specialized Geriatrics Centre (NESGC)	• Health Link – CCAC • CMHA, Health Sciences North & Health Links • Care Transitions • Population Health • ED Operating System (software/Meditech)	• Readmit discharge work group – discharge phone call follow up to reassess readmits • 'Polypharm' work group • Integrated discharge planning • Goals of care • Shared care team collaboration with symptom management clinic and nurse practitioner – working with hospice • Poste discharge med rec • E-notification through Hospital Report Manager (HRM) • PATH program – works with discharge planners,	• Health Links • NE CCAC Health Links • Patient Support Services (PSS) pilot project, CCAC, LHIN, other early adopters • CSS mini-site for information and referral • various working groups networks • North East Specialized Geriatric Centre (NESGC) • Assess and restore – primary care, CSS, rehab	• Health hubs – Espanola Regional Hospital and Health Centre (ERHHC), Ministry of Health and Long Term Care (MOHLTC), CSS, NE LHIN, FHT • Community and regional mental health • Working on using quarterly assessment times to focus on health promotion items to keep and get clients connected • Geriatric referral – Espanola FHT • Care summary for primary care – np clinic • Oaklodge, assist responsive residents who are not adjusting to LTC –

		CCAC, pharmacist, primary care, CSS agencies		transfer for intense assistance and transfer and reintegrate back to LTC • Involvement in establishing health link • Manitoulin Island Network of Care Providers (MINCP) – common goals and objectives – QIP • Chronic Obstructive Pulmonary Disease (COPD) action plans

2. In the future, what can you do to improve the integration of care? Who do you need to help or work with you on this?

TIMMINS				
PRIMARY CARE	**ED VISIT/HOSP ADMISSION**	**DISCHARGE**	**PRIMARY/ REHAB/ COMMUNITY CARE**	**PRIMARY/ SELF CARE**
• Electronic Medical Record (EMR) - for all - including community and mental health to be able to access • Need to reform primary care - have "pay equity" with hospitals, sway the scale back to primary care out of expensive hospital care • Success of health links has been found to be proportional with patient engagement and primary care involvement • Sustain Timmins Health Links with	• Data exchange with Timmins hospital • Increased staff mix and training for all. Make quality improvement (QI) part of everyone's roles.	• Hospital and CCAC discharge planning- get the CCAC discharge planning into the hospital more. Look at collaborating together daily instead of weekly. • Formalize process to coordinate agencies • CCAC frontline staff in the hospital • Exchange more data with Timmins hospital. • Patient flow strategy with CCAC • Change the way we provide rehab services	• Work with health system reform- introduce hub hospital model. Integrate CCAC with health teams and hospitals • Gather concurrent complex info/stats/clients/patients—are still in silos • Health partners working more collaboratively to address issues/improve/patient care and patient care experience without 'laying blame' on any one agency	• Leverage Health Links philosophy and ensure we are patient centered • Improve communication and fill gaps between visits to make it seamless (primary/self-care). • Dementia care- integrate regional initiatives (Behavioural Supports Ontario - BSO) into primary care

introduction of orphaned patient NP • Diabetes program- have a shared chart with primary care. • Improve flow of integration of providers- with an IT/IS solution • Patient navigators for vulnerable populations • MOHLTC & LHIN— recognition of 365 services			• Better utilization of OTN services to ensure patients (especially the elderly) are not travelling and unnecessary appointments. Primary care providers, OTN, surrounding hospitals • LHIN need of "halfway homes" Need nursing • Increased communication of care plans by CSS to primary care. • Convalescent care in Cochrane communities. • LHIN need long tern recovery home in Timmins. Add to Jubilee Services. • MOHLTC & LHIN. Equitable pay for patients/clients.	
SAULT STE. MARIE				
PRIMARY CARE	**ED VISIT/HOSP ADMISSION**	**DISCHARGE**	**PRIMARY/ REHAB/ COMMUNITY CARE**	**PRIMARY/ SELF CARE**
• Communication between different groups		• Partners/MOHLTC/ NE LHIN – agreements, sharing resources, supporting alignments, working together case management • Improve integration of care – Moose Cree First Nation – need to partner with WAHA (Mental Health, Physio, discharge, aging at home), NE Geriatric	• Consistently involve all partners around the social determinants of health (e.g., housing, social services, income, education, etc. • Collective willingness to put patients first • Funding accountability when partners refuse to play nice	

		Team, discharge planners at Timmins, Sudbury, Kingston, Ottawa, London, Toronto, NE LHIN, First Nations and Inuit Health Branch (FNIHB) – Federal Health Care	• Health Links Coordinated Care Plans • Opportunity to think beyond Ministry boundaries – e.g., mental health for child/youth • Remove silos within the Ministry of Health to increase LHIN freedom	
NORTH BAY				
PRIMARY CARE	**ED VISIT/HOSP ADMISSION**	**DISCHARGE**	**PRIMARY/ REHAB/ COMMUNITY CARE**	**PRIMARY/ SELF CARE**
• CSS Support to Primary Care Providers • Share Assessment records (Integrated Assessment Record). Collaborate through technology. Stop reassessing patients. Share results & tools • Making resource allocation decisions as one sub-LHIN • Health Links – Community Partnerships • Create Rural health hub (MOHLTC, NE LHIN) • E-Health Strategy • Timely & consistent access to psychiatry. Include geriatricians for more in depth geriatric assessments. • E-Health, medication reconciliations, QI, multi-disciplinary team), communication at every transition point, share	• E-health • Share Assessment records (Integrated Assessment Record). Collaborate through technology. Stop reassessing patients. Share results & tools. • More networking opportunities • Circle of care meetings with different providers • Discharge/admission seaming with hospital – community (both ways) • Increased communication & care conferencing • E-Health, med recs, QI, multi-disciplinary team), communication at every transition point, share resources, secure resources, HR plan	• Circle of care meetings with different providers • Discharge/admission seaming with hospital – community (both ways) • Increased communication & care conferencing • E-Health, medication reconciliation, QI, multi-disciplinary team), communication at every transition point, share resources, secure resources, HR plan	• Share Assessment records (Integrated Assessment Record). Collaborate through technology. Stop reassessing patients. Share results & tools. • Rural health hub (Mattawa Hospital) • Circle of care meetings with different providers • Discharge/admission seaming with hospital – community (both ways) • Increased communication & care conferencing • Advocate for improvement in IT/ • E-Health, medication reconciliation, QI, multi-disciplinary team), communication at every transition point, share resources, secure resources, HR plan	• More coordination (crisis sector supports) • One information IT for patient care • Circle of care meetings with different providers • Discharge/admission seaming with hospital – community (both ways) • Increased communication & care conferencing • Share Assessment records (Integrated Assessment Record (IAR). Collaborate through technology. Stop reassessing patients. Share results & tools • E-Health, medication reconciliation, QI, multi-disciplinary team), communication at every transition point, share resources, secure resources, HR plan

resources, secure resources, human resources (HR) plan				• Create rural health hub • Awareness of CSS in community •
SUDBURY				
PRIMARY CARE	**ED VISIT/HOSP ADMISSION**	**DISCHARGE**	**PRIMARY/ REHAB/ COMMUNITY CARE**	**PRIMARY/ SELF CARE**
• Sharing information between health organizations-LHINs • Share info and two way communication – CCAC • Share info and two way communication – primary care • Performance indicators need to be more team based – e.g., not based on billing codes • Engage primary care • Performance indicators need to be more team based care – not billing codes • Measure what we do • Shared EMR access	• Shared EMR access • Focusing on residents first then involve key partners • Focus on system improvement • Hospitals- share info and two way communication	• Breakdown silos • Shared accountability- common measures • Sharing info- especially hospitals and CCAC • Infrastructure for information sharing • Collaborative care planning • Health hubs-ERHHC • Shared EMR	• Transparent with data • IT infrastructure • Shared EMR access • Getting to know key partners amongst divisions – work with LHINs • Family health teams – share info and two way communication • CSS groups/agencies – share info and two way communication	• IT Support

Appendix E: Partnering with Patients-Discussion Notes

1. What types of patient, caregiver and public engagement initiatives are you involved in, or have you heard of, in your region/LHIN? Where do you think these patient engagement examples fit in the Carman et al. framework?

TIMMINS		
CONSULTATION	**INVOLVEMENT**	**PARTNERSHIP**
• Quality Improvement Plans (QIPs) in hospital • Patient focus groups (experience)	• Timmins Age Friendly Community Committee • Care planning	• Create a sharing circle to give and get information from and for patients
SAULT STE. MARIE		
CONSULTATION	**INVOLVEMENT**	**PARTNERSHIP**
• QIP development • NE LHIN Patients First Engagement (Pan-LHIN multiple site – 15) • Engaged Centre for Rural and Northern Health Research and McMaster to hold Citizen Panel to set strategic direction for NE CCAC – 45 individuals from access the region were engaged, 3 sessions (French, Aboriginal, General), results shared publicly • Patients/clients, seniors, elders – as our service develops, the Assisted Living Care Committee evolved, moved to the drafting of a new terms of reference, Senior Program Planning Committee – this has a time line of a year and a half to review their role before term is completed • Engagement of client/elders – culturally (Cree) take the visiting tea with Elders in their homes or taking questions to Elders Leadership Meeting or to community meetings, showcasing work and questions to deliver client focused care translated to Cree to prevent misinterpretation	• Patient and Family Advisory Committee (PFAC) participating on Hospital Committees (e.g., quality care committee) • PFAC involved in management recruitment • Patient and caregiver advisor to sit on local community support services network committee • Needs assessment at the community level	• Youth engagement – youth intern, youth summit • Resident surveys • Strategic planning • Resident/family councils • Client council – feedback survey

NORTH BAY		
CONSULTATION	**INVOLVEMENT**	**PARTNERSHIP**
• CCAC Patient Advisory Council Framework Development • Canadian Mental Health Association (CMHA): Ontario Perception of Care Tool (OPOC)	• Cassell Holme: "Having a Voice" Being able to speak up about the home. This initiative includes consulting, partnerships and engagement with family council, resident's council and person and family center care committee • Learning Centre: People for equal partnership in Mental Health • Temagami Great Northern Powassan FHT: Falls prevention Falls self-risk survey assessment initiative • Powassan and area FHT: Patient experience survey • Powassan and area FHT: 2/3 of small Board are patient/caregivers • Stand On Your Feet (SOYF) Regional committee Network: Getting message to older adults to get active to prevent falls. Age friendly strategies • Alzheimer's Society of Ontario (Sudbury/North Bay) "Minds in Motion" • Laurentian University and Alzheimer's Society: Research Initiative. Patient input in speech language pathology, pictogram, real pictures vs cartoons (which ones do dementia clients respond to the most/best) • Visual cues	• First Nation Health Care Connect Program (HCCP): More involvement with other health care providers. Increased networking, attendance of meetings, increase visibility of our program on reserve and get more direct referrals • Health Links: Integrated Coordinated Care Plan (ICCP)
SUDBURY		
CONSULTATION	**INVOLVEMENT**	**PARTNERSHIP**
• Involvement in planning (Medical Advisory Committee (MAC), Board of Directors, Program Councils) • Annual client surveys (internal and external) • Clients get to review care plan • Compliments and concerns box • Consultation (care delivery process) • Accreditation teams • Family Councils • Quality Councils • Resident Councils • Local committee Tables with client perspectives • Patient Satisfaction Survey	• Advisory Councils • ALC Client Care plans • LTC Councils • Day to Day problem solving within programs – involve the client in developing solutions • Discharge phone call survey • Family Councils • Focus groups • LHIN Community /Public consultations (surveys, in person, focus groups • Care conference • Patient focus groups • Public members on SOYF (falls prevention committee)	• Care conference • Client recreation Group • Community resource team • Health Links • Patient members on Board of Directors • QIP Committee • PFAC at Health Sciences Advisory Council

• Posters in community inviting engagement • Program related evaluation • Resident/family satisfaction surveys • Satisfaction Surveys • Strategic Plan • Feedback from public • Ministry • Long Term Care (LTC) Councils	• Quality Assurance • Rehab plan/service agreement • Residents Councils Accreditation teams • Family Councils • Quality Councils • Resident Councils • Improvement projects (i.e. NOD (Name Occupation Duty) , Advisor Led)	