Health Links Leadership Community of Practice

Feb 22, 2017

Hearing from Health Links IDEAS Teams on their experience implementing coordinated care management innovative practices

Today's Agenda & Objectives

- Review of Innovative Practices for Coordinated Care Management
- Hear how IDEAS teams identified, planned and implemented care coordination management in their Health Link using innovative practices
- Understand how quality improvement methods can be used to accelerate your Health Links work

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

WEBINAR PANEL

Shannon Brett, *Manager, Quality Improvement & Spread, Health Quality Ontario*

Stacey Bar-Ziv, *Team Lead, Quality Improvement & Spread, Health Quality Ontario (Moderating Discussion)*

Shawna Cunningham, *Quality Improvement Adviser, Health Quality Ontario*

GUEST SPEAKERS

HURON PERTH HEALTH LINK, LONDON MIDDLESEX HEALTH LINK

Jeni Millian, *Patient Care Manager, South West CCAC*

Paula Day, *RN Thames Valley Family Health Team*

Llori Nicholls, *RPN North Perth Family Health Team*

Heather Ross, *Occupational Therapist, New Horizons Rehab*

MID EAST TORONTO HEALTH LINK (METHL)

Kelly Clarke, *Client Services Manager, Toronto Central CCAC*

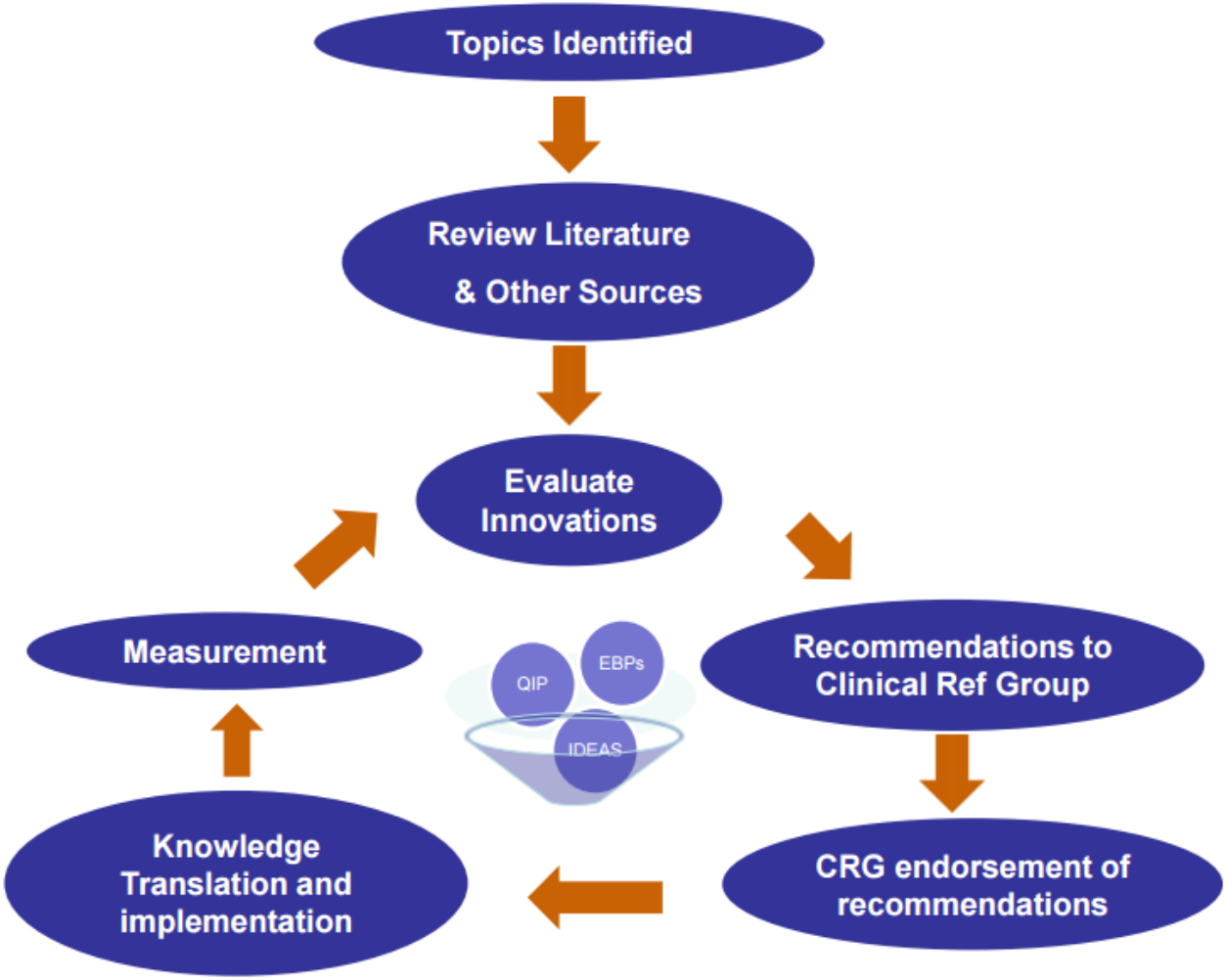
Michelle Bather and **Vicky Wen**, *Case Managers, General Internal Medicine Unit at St Michael's Hospital*

Susan Anstice, *Transitional Care Coordinator Mid East Toronto Health Link and Social Worker at WoodGreen Community Services*

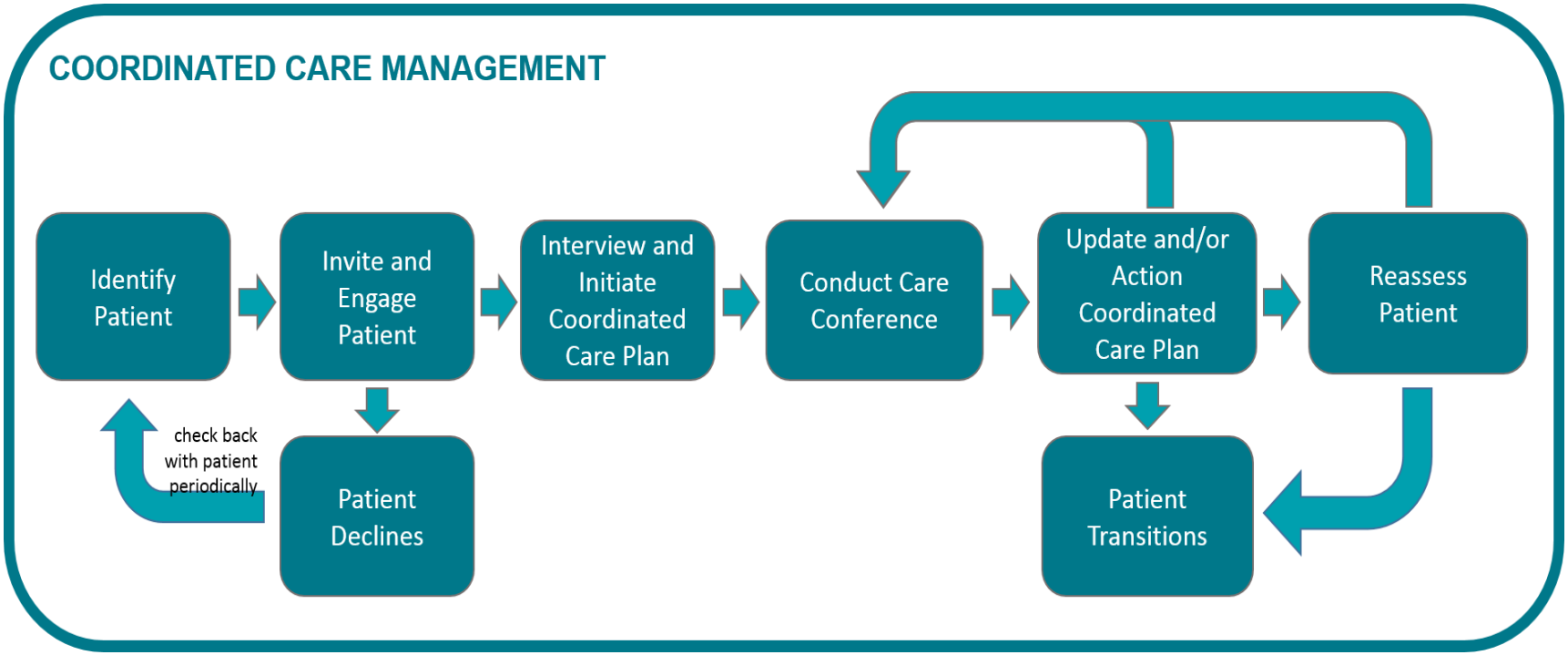
HEALTH LINKS LEADERSHIP COMMUNITY OF PRACTICE

'Communities of practice can be defined as groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly'

INNOVATIVE PRACTICES



COORDINATED CARE MANAGEMENT



http://www.hqontario.ca/Quality-Improvement/Our-Programs/Health-Links/Coordinated-Care-Management

COORDINATED CARE MANAGEMENT

Summary of Innovative Practices

Coordinated Care Management Step	Innovative Practice	Innovative Practice Assessment	Clinical Reference Group Recommendation for Spread
Identify Patient	Identify Health Link patients through clinical level assessments and data driven case finding methods at any point in the patient's healthcare journey.	EMERGING	Recommendation for provincial spread with reassessment using the Innovative Practices Evaluation Framework in 1 year (June 2017).
Invite and Engage	Provide patients with a single point of contact for all services included in their Coordinated Care Plan.	PROMISING	
	Use person--centred communication strategies to invite and engage the patient in coordinating his/her care with the Health Link team.	EMERGING	
	Use a comprehensive process and/or form that enables patients or substitute decision makers to provide consent for all elements of their coordinated care at one time (may be explicit or implied).	EMERGING	
Interview and Initiate Coordinated Care Plan	Implement the "Patients as Partners" Bundle with all patients in the Health Link.	EMERGING	

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Delivered in partnership and collaboration with:

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École de médecine du Nord de l'Ontario

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Funding provided by the Government of Ontario

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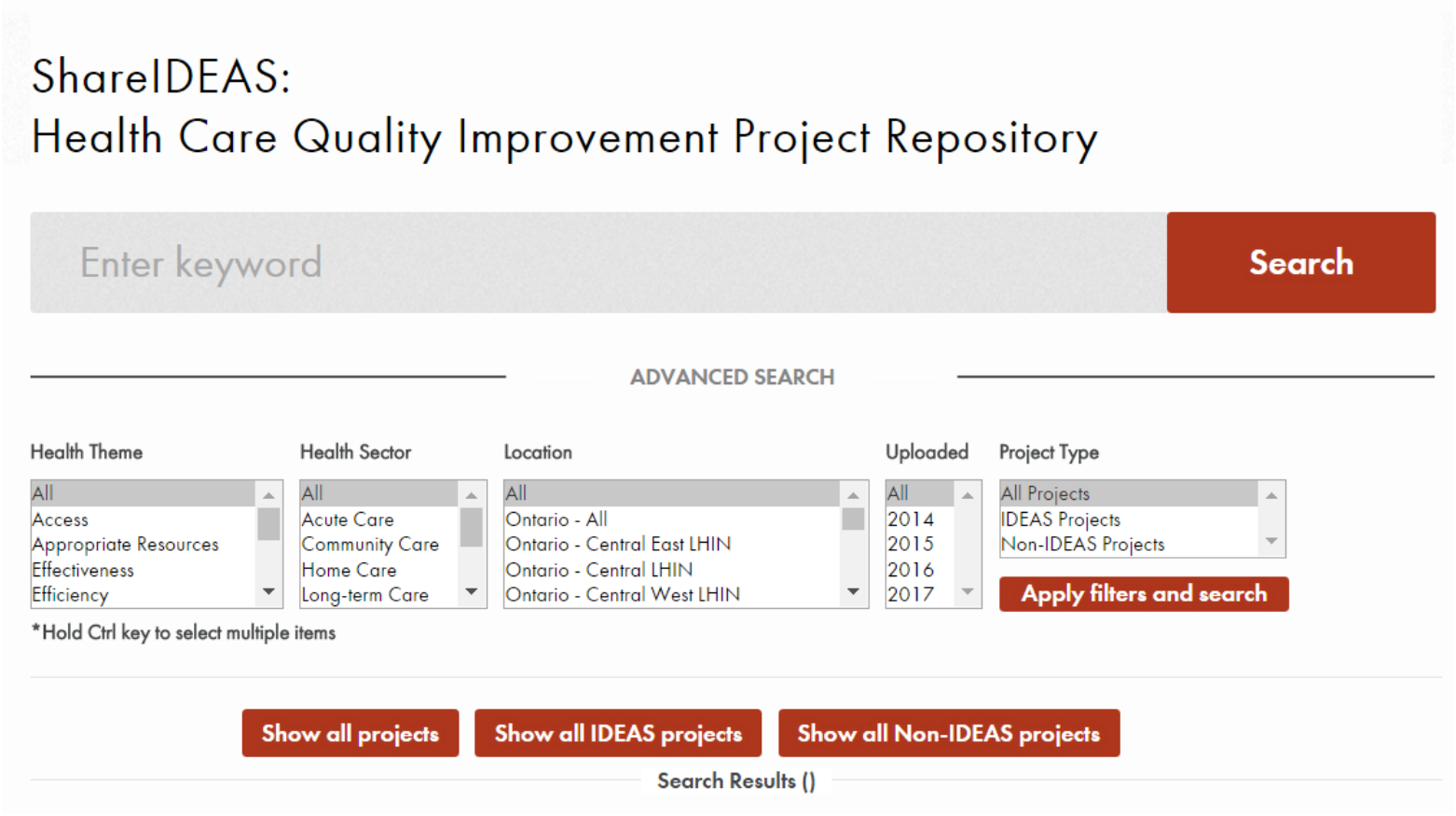


UPCOMING DATES

IDEAS application webinar: March 21 See IDEAS.ca for more details

Upcoming IDEAS-QI Webinars

WHEN	WHAT
Mar 07, 2017 at 12:10 - 1 PM EST.	Teaching QI in Real Time https://attendee.gotowebinar.com/register/4857616363467948546
Apr 25, 2017 at 12:10 - 1PM EDT.	**Quality Improvement - understanding the differences between data for research, QI and accountability** https://attendee.gotowebinar.com/register/3693936137583376898
May 16, 2017 at 12:10 - 1PM EDT.	**IDEAS Webinar: Quality Improvement Back to Basics** https://attendee.gotowebinar.com/register/4969071658152449538
Jun 20, 2017 at 12:10 - 1PM EDT.	**Engaging the Front Line in QI** https://attendee.gotowebinar.com/register/4874642301024354562

Improving & Driving Excellence Across Sectors

Mid East Toronto Health Link (METHL) Virtual Hub: Improving Identification, Referral & Care Co-ordination For Acute Care Patients With Complex Needs

Project Sponsor:

Ashnoor Rahim, Vice President
WoodGreen Community Services

IDEAS Applied Learning Project

Our IDEAS Project Team

MID EAST TORONTO HEALTH LINK (METHL)

Kelly Clarke MSW
Client Services Manager,
Toronto Central CCAC
Administrative & Community Resource Expertise

Susan Anstice MSW, MSc Transitional Care Coordinator (TCC) - METHL ,
Clinical Social Worker, WoodGreen
- Team Lead & Community Resource Expertise

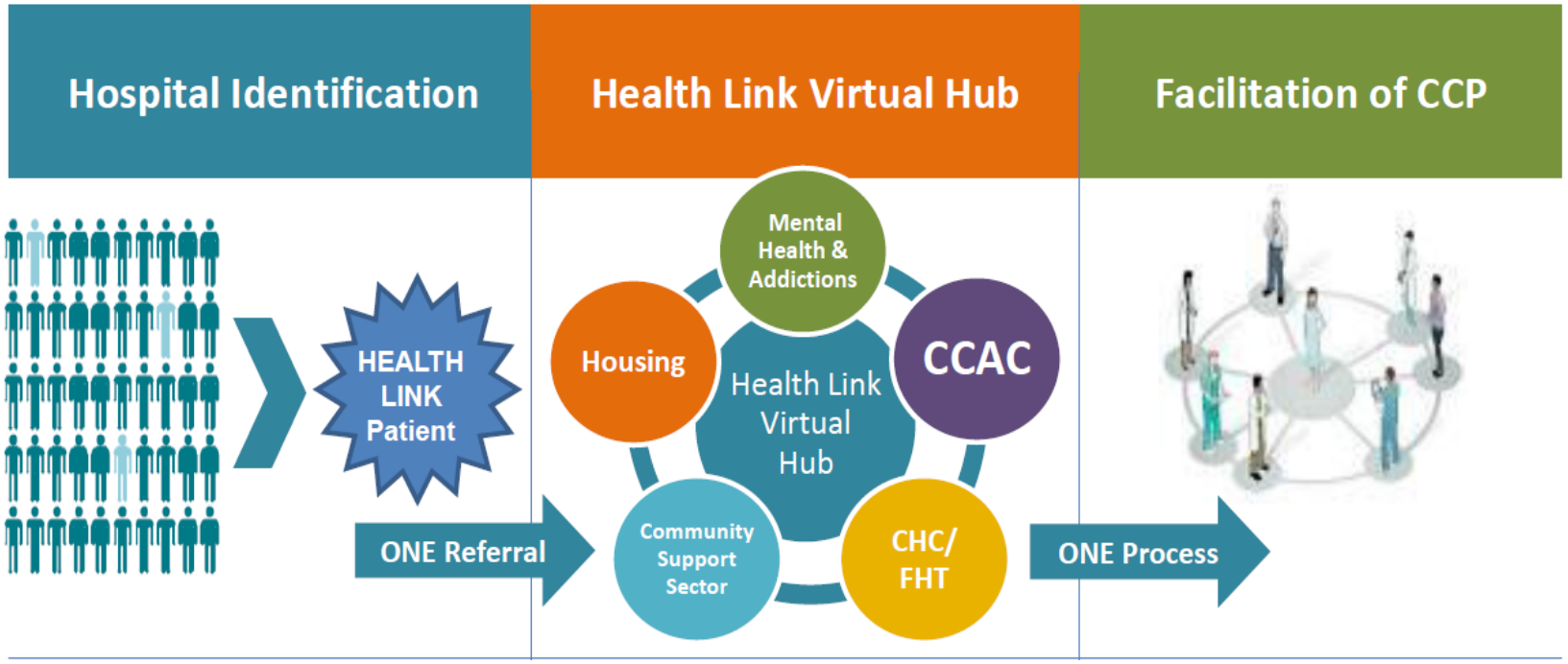
Michelle Bather RN
Case Manager,
St. Michael's Hospital General Internal Medicine (SMH GIM)
- Clinical Expertise

Victoria Wen, RN
Case Manager,
St. Michael's Hospital General Internal Medicine (SMH GIM)
- Clinical Expertise

Our Health Link Process

Improving care transitions across health sectors through Coordinated Care Planning

Virtual Hub Model



Why this QI Process?

Meet Mr. G.M.

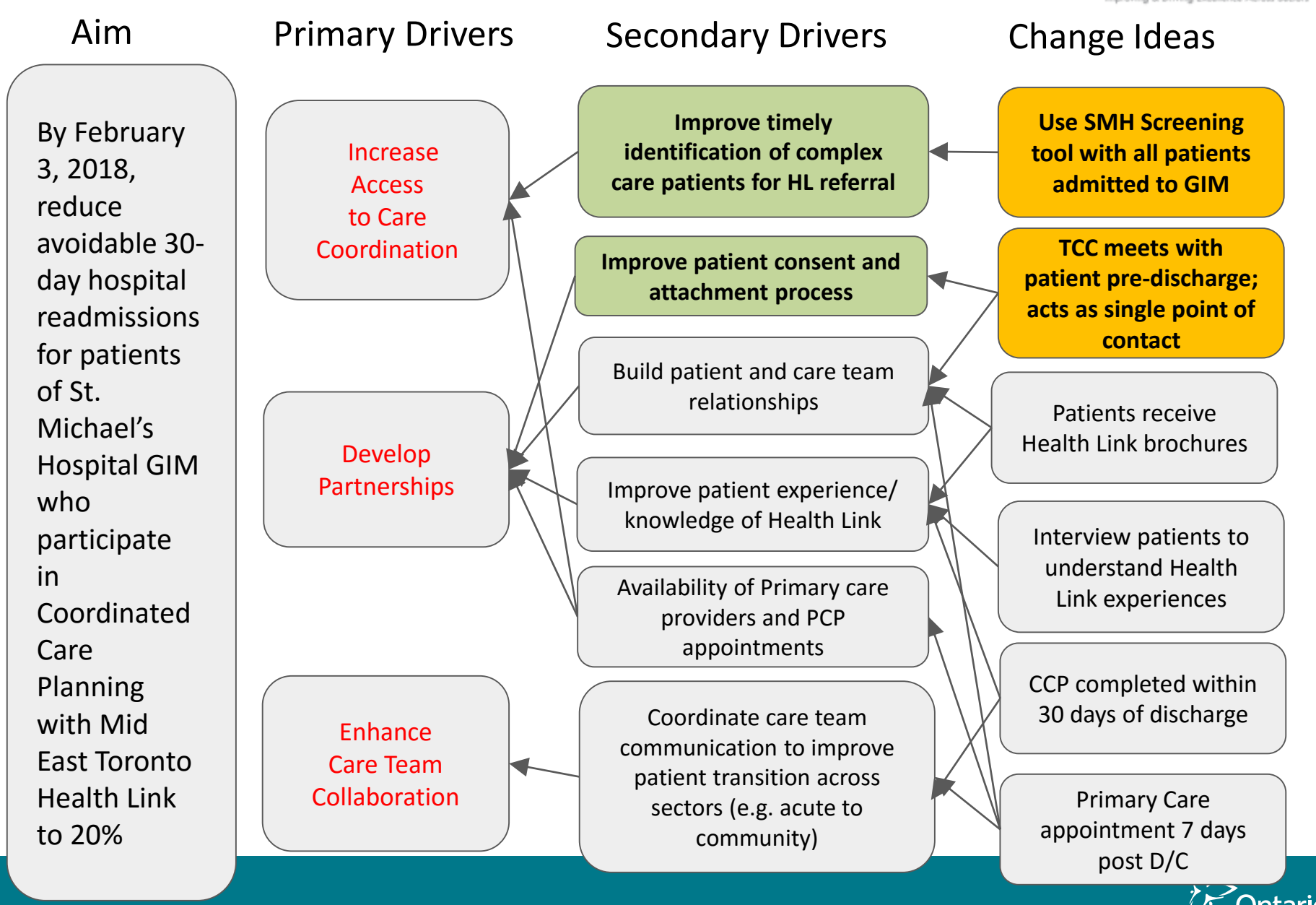
- Admission: 59 y.o. man; alcohol withdrawal, electrolyte imbalance, acute kidney injury
- PMHx: depression, CHF, Type II diabetes, cirrhosis
- Living in shelter, no community services

How Can We Improve?

- Systematically identify patients eligible for Health Link
- Identify the optimal time to approach patients
- Connect patients to METHL Transitional Care Coordinator (TCC) in hospital

Project Aim: By December 31, 2017, increase the percentage of identified SMH GIM patients referred to METHL who participate in a Coordinated Care Planning Case Conference within 30 days of discharge from 43% to 75%

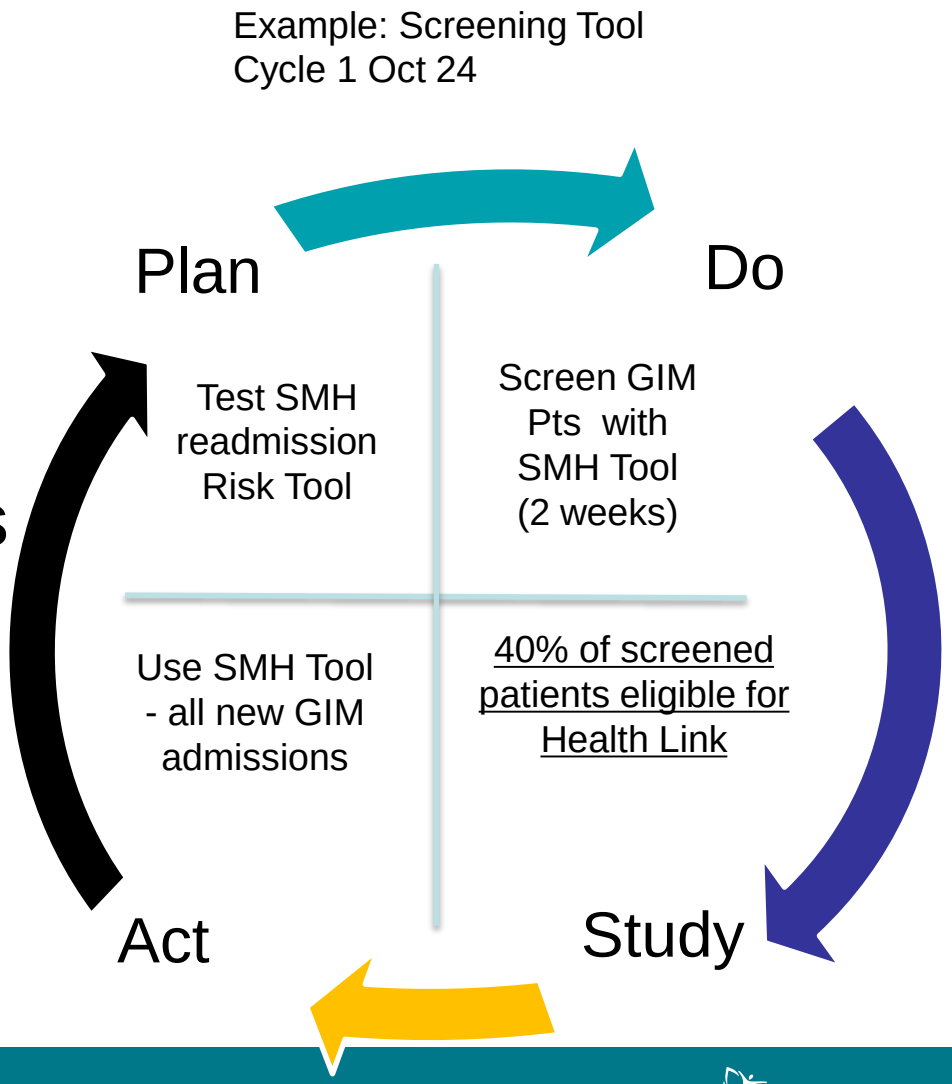
Virtual Hub – Change Ideas



PDSA Cycles

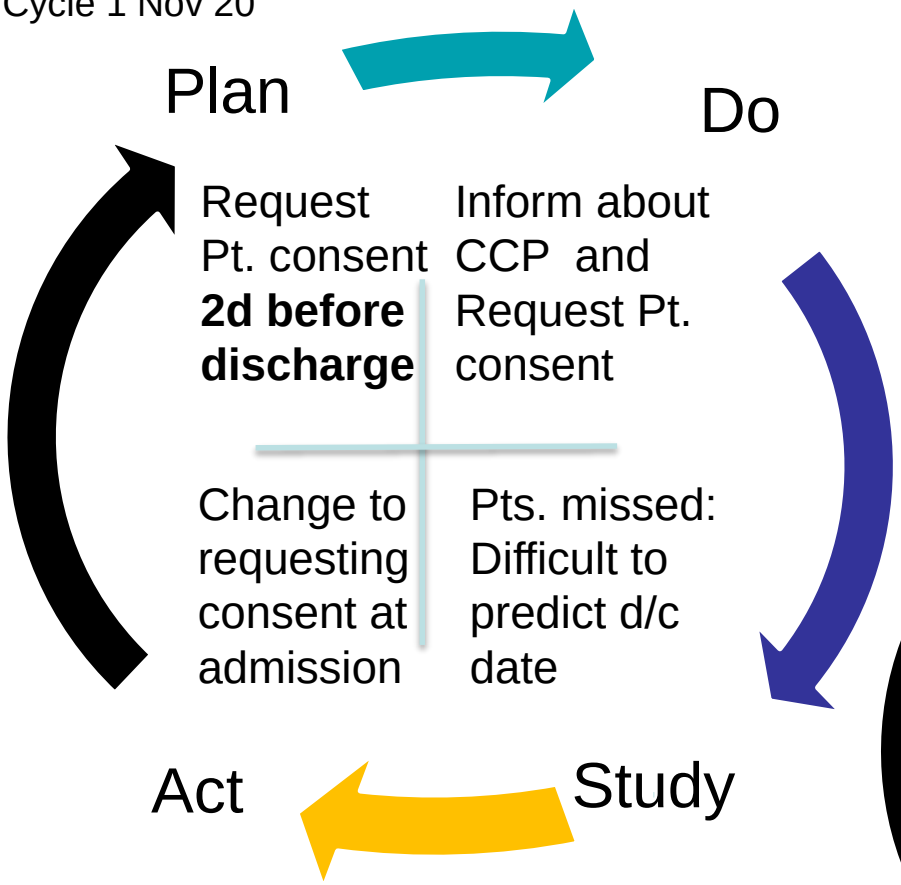
Tests of change/ cycles for:

1) Screening Tool
2) Screening Process
3) Patient Consent Process
4) HL Referral Process
5) Warm Handover to TCC

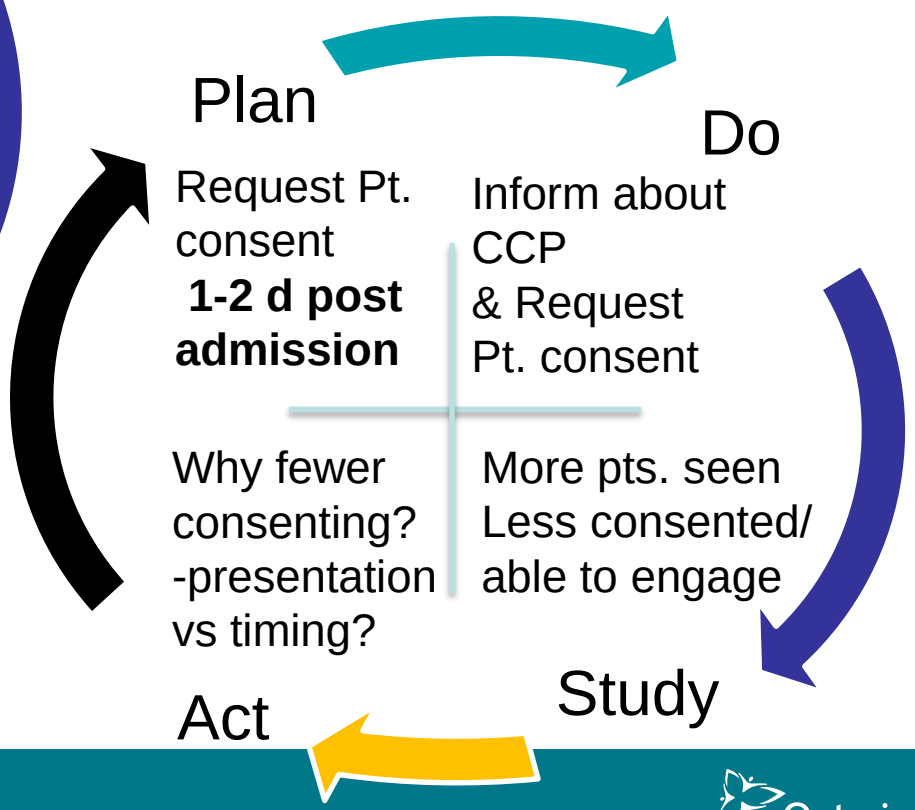


Patient Engagement and Consent

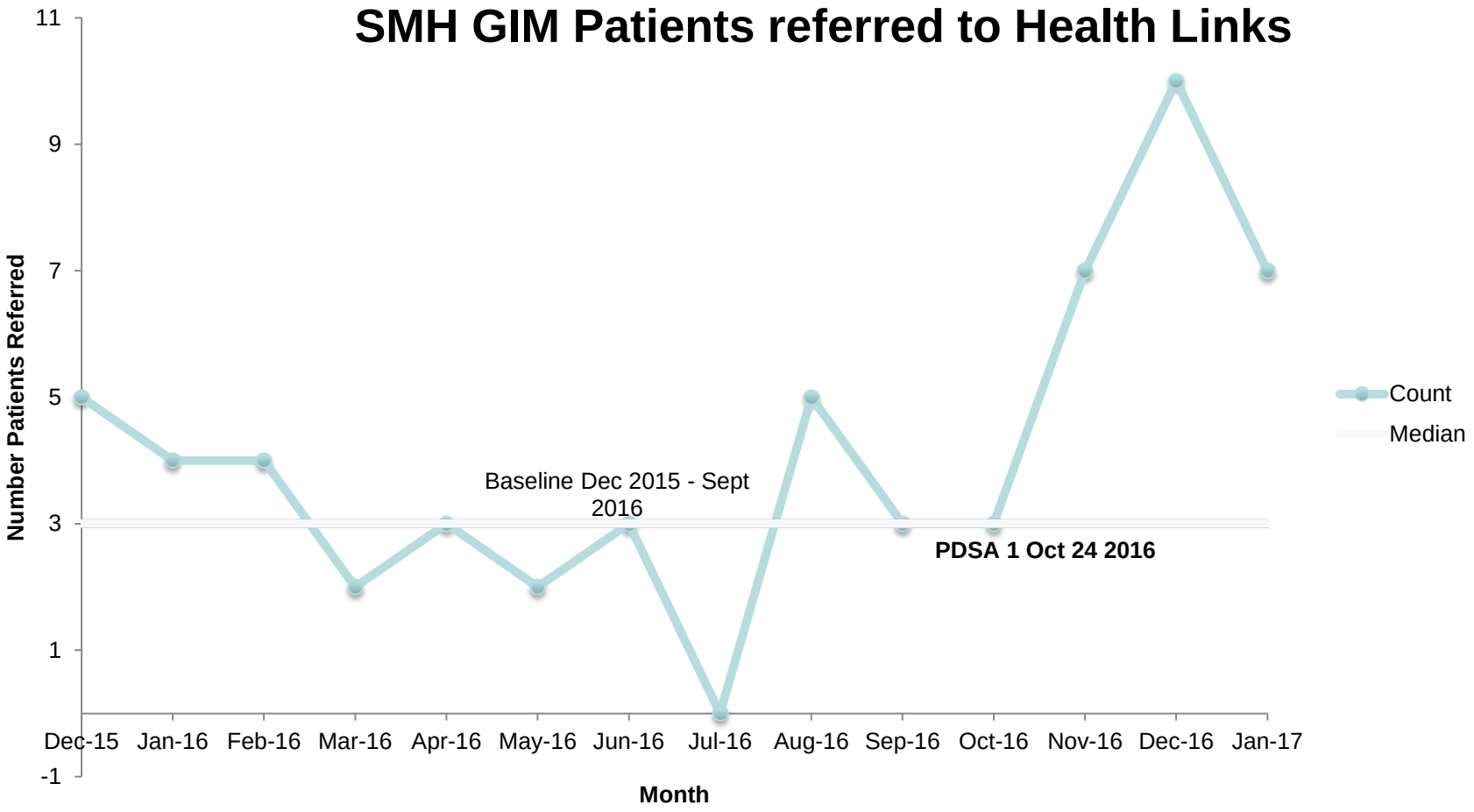
Cycle 1 Nov 20



Cycle 2 Dec 12



Results - Screening & Referral



CCP Consent Rate

SMH GIM Referrals October 2016-January 2017

TCC met patient prior to discharge?	Consent to CCP (count)	CCP Declined (count)	Consent Rate (%)
Yes	**6**	**1**	**85%**
No	2	4	**33%**
Total	8	5	**61%**

*excludes “consent in progress”

Impact – Meet Ms. MC

34 y.o. woman

- frequent suicidal ideation and diabetic ketoacidosis.
- history of PTSD
- spent the last 2 years at a Shelter

- Identified with SMH Screening Tool
- Met with METHL TCC while in hospital
- CCP Case Conference completed within 30 days

Overall Learning

SMH Screening Tool vs LACE Tool

- Identifies Health Links appropriate patients on admission
- Includes homelessness, mental health, family doctor
- For CHF and COPD; to be revised for general GIM population

Warm handover to TCC while in hospital

- Support for change theory: patient more likely to consent

Productive Range of Tension / Limit of Tolerance

Overall Challenges

- Sustainability – screening and patient engagement create additional workload
- Electronic information sharing – no single platform
- Predicting discharge date

Next Steps

Continue change ideas

- Sustain/Improve processes underway
- Additional change ideas including:

  CCPs completed within 30 days of referral, patient experience

Spread to other settings?

- Acute Care / Rehab Hospitals, other Health Links

Acknowledgements

Thank you to the following people
Without you this project would not be possible

- Yinka Macaulay, Toronto Central LHIN
- Ashnoor Rahim, WoodGreen Community Services
- Mary Eastwood, Mid East Sub Region
- Gayle Seddon, TC-CCAC
- Leighanne MacKenzie, St Michael's Hospital
- Kim Grootveld, St Michael's Hospital
- Joe Mauti, HQO
- Laura MacLagan, ICES
- METHL TCCs:
  Sandra Corrado, Xochil Amaya, Claire Bogomolny

Improving & Driving Excellence Across Sectors

Embedding CCP into the FHT

Jeni Millian Patient Care Manager, SouthWest CCAC
Paula Day RN TVFHT
Llori Nicholls RPN NP FHT
Heather Ross Occupational Therapist, New Horizons Rehab

Project Sponsor: Huron Perth Health Links
London Middlesex Health Links

Utilization reports does not always capture right patient!

GP not engaged in process !

CCP not being done !

Story: “Could it get any worse?”

- **Not on Med GPS**
- **Multiple healthcare agencies**
- **No family involved**
- **Only trust GP and plastic surgeon**

Who could be more in need of a CCP, must involve GP team

AIM and Measures

Aim Big Dot: Decrease avoidable patient ER visits and hospital admissions.

IDEAS project AIM: By Feb 2017 we will complete 10 CCP's through collaboration at patient point of contact in a primary care setting in the Thames Valley FHT(5) and North Perth FHT (5)

The proof is in the data

Outcome Measures: Number of completed CCPs
Process Measures: Patient and Provider Experience Survey, # Achieved Goals, Time
Balancing Measures: New resource linkages

Our Change Idea:

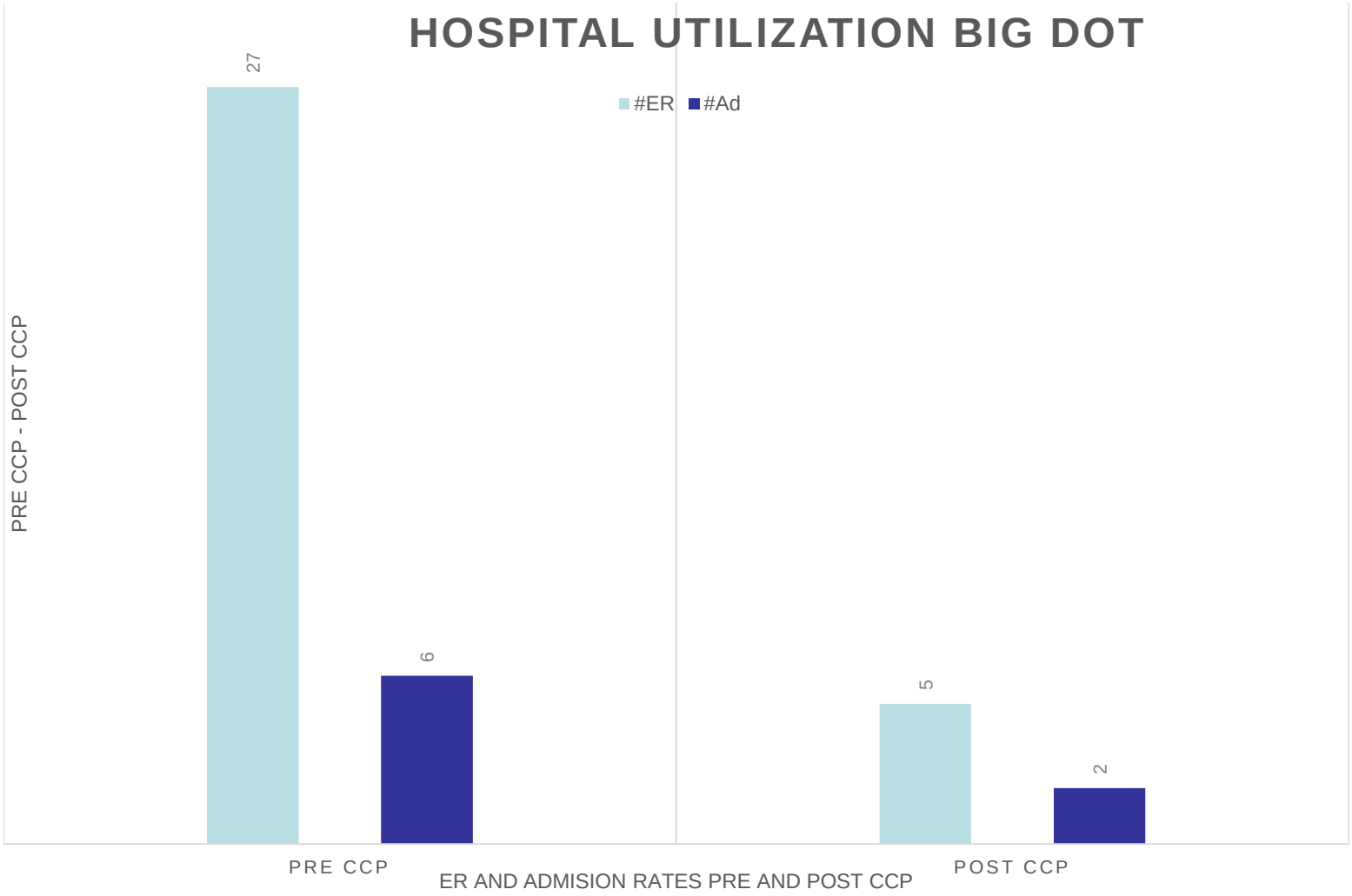
- Identification of high risk patients currently using programs within a FHT (family health team).
  - Our target populations: High risks patients involved with Fall Prevention Program and Home Based Primary Care Program.

- Initiate and complete CCP at point of contact with patient.
- Engage community and primary care teams to co-facilitate the process.

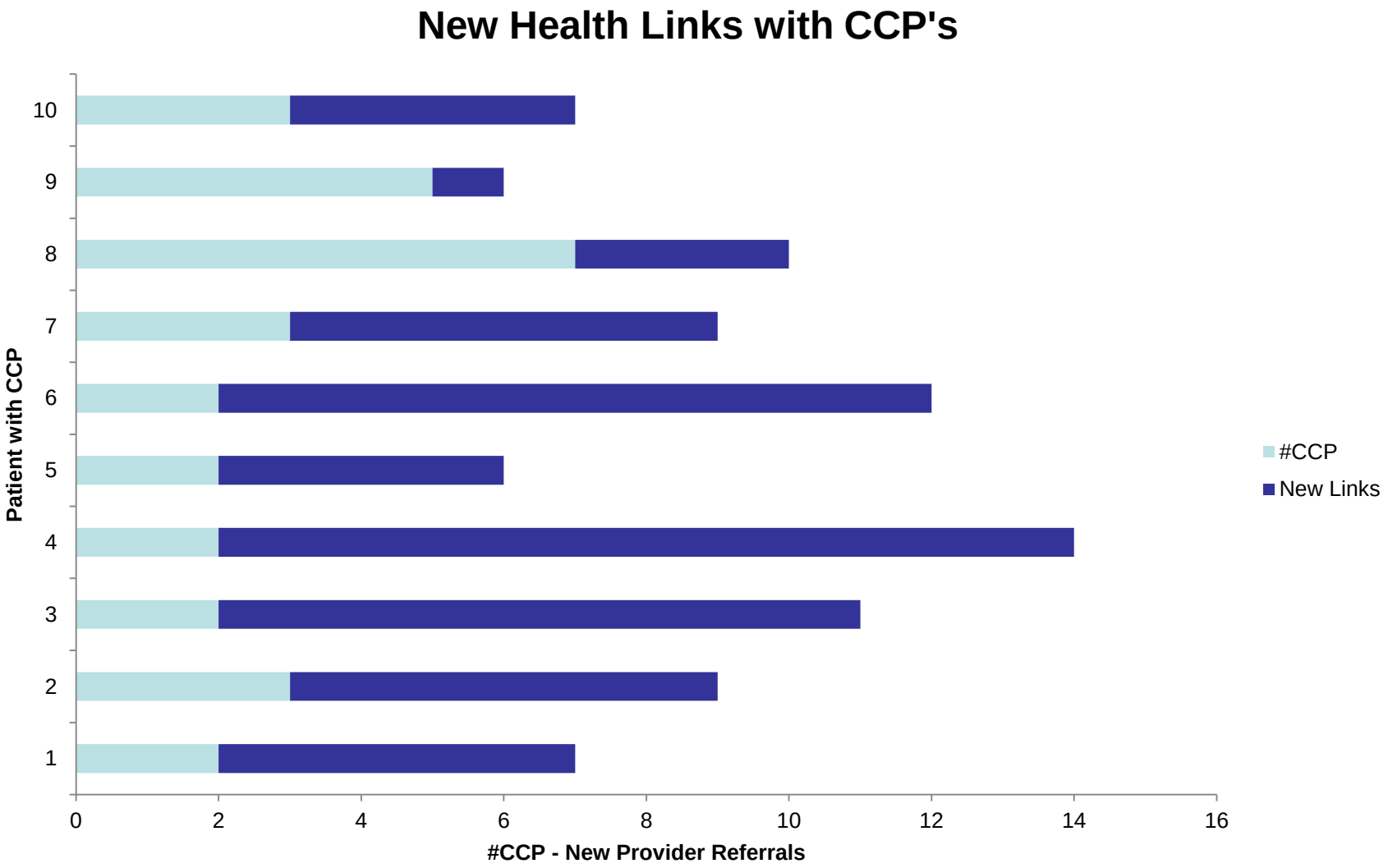
Lessons Learned PDSA:

- Identification
  - Easier and improved method for identifying appropriate patients.
  - Improved identification of team members
- Communication
  - Sharing information pre and post meeting.
  - Clear and concise information for patient
  - Working around technology and duplication remains an issue.
- Time management
  - Bringing team members in at the right time.
- Interdisciplinary roles and responsibilities

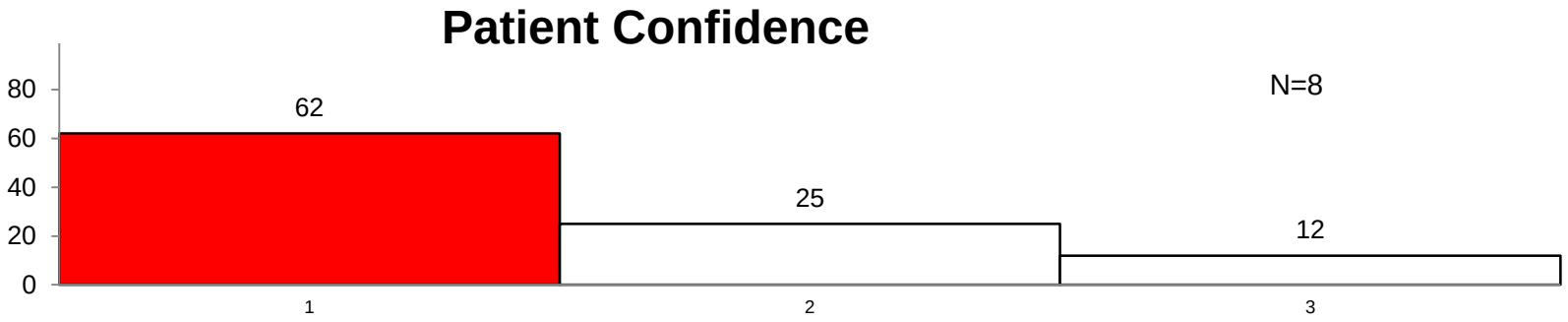
Results/Impact

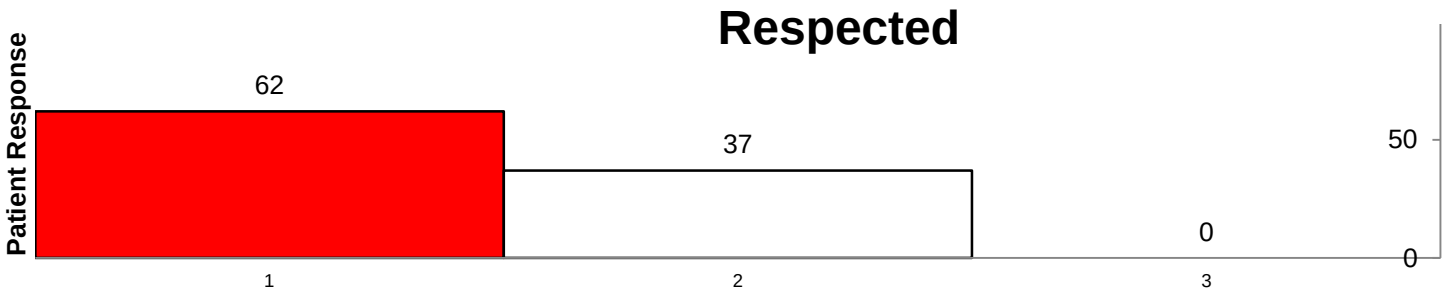


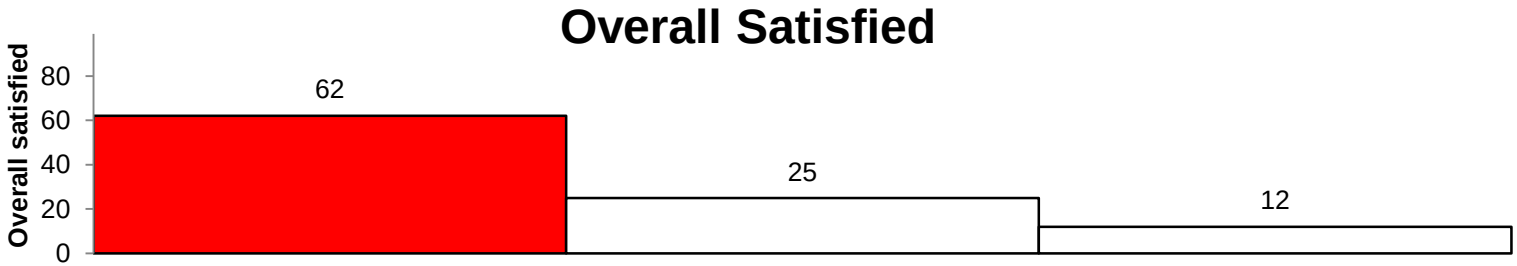
Results/Impact



Results/Impact







Patient Voice

Provider Feedback

Provider Feedback

Overall Learning

- Patients are fearful of agenda, health and change.
- Smaller groups and split conferences less anxious for patient and IHP involvement.
- Initiating CCP at point of contact in group.
- It is not just a tool !
- Improved understanding of roles and responsibilities of IHPs.
- Gaining ideas of what is happening in other communities.

Overall Challenges

- Multiple EMR and communication tools among providers.
- Patients with learning and mental health issues we need to continue to creative to help them identify and meet goals.
- IHP (inter health professionals) not wanting to participate, resources.
- Geographic diversity and transportation.
- Financial and staff resource in primary care.

Next Steps to Progress Improvement

- Looking at access to CHRIS to improve sharing of communication and prevent duplication of work.
- Adding CCP to ACCURO FHT EMR.
- Encouraging engagement of primary care practitioner in CCP for hospital transition and in the community.
- Spread coordinated care planning to other family health team programs i.e. palliative, memory.
- Creative ways to help patients plan their care.
- Continue to track the data and CCP utilization.

Discussion

Please submit questions to us via the "Question" box.

HEALTH LINK LEADERSHIP COMMUNITY OF PRACTICE;

Resources and Events

Next Webinars **Mark your calendars!**

Mar 22 12:00-1:00
Hearing from Health Links IDEAS Teams on their experience implementing Transitions in Care Innovative Practices

April 26th 12:00-1:00
Innovative Practices: Mental Health & Addictions, Part 1

- Developing an online web presence for the Health Link Community of Practice. More information will follow as this evolves

Learn more about upcoming program dates and deadlines to apply:

ideasontario.ca/programs/advanced-learning-program/

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WE WANT TO HEAR FROM YOU!

Your input is important and we'd like to hear from you!

Please send suggestions for

topics you would like to see or hear about in future webinars to

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