Health Links Leadership Community of Practice

September 13, 2016

Innovative Practices; Coordinated Care Management

Guest Speaker: **Jennifer McLeod RN, BNSc, MEd**

TODAY'S AGENDA

1. Overview of Innovative Practices; Coordinated Care Management

2. Patient Story; *Understanding the Impact of Coordinated Care Management on the Patient Experience*

3. "Patient Care Coordination Utilizing a Primary Care Approach"
   Guest speaker: Jennifer McLeod

4. Discussion: Implementing Innovative Practices in your Health Link

5. Polling – Evaluation

6. Upcoming Events

7. Closing

LEARNING OBJECTIVES

- Listen to and reflect upon a patient story
- Learn more about the Innovative Practices in Coordinated Care Management
- Collaborate with your colleagues, and hear about how these practices may be implemented in your Health Links
- Understand the purpose and approach for measuring the impact of the practices

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 chat box feature.

WEBINAR PANEL

Susan Taylor. *Director, Quality Improvement Program Delivery, Health Quality Ontario*

Jennifer Wraight. *Quality Improvement Specialist, Health Quality Ontario*

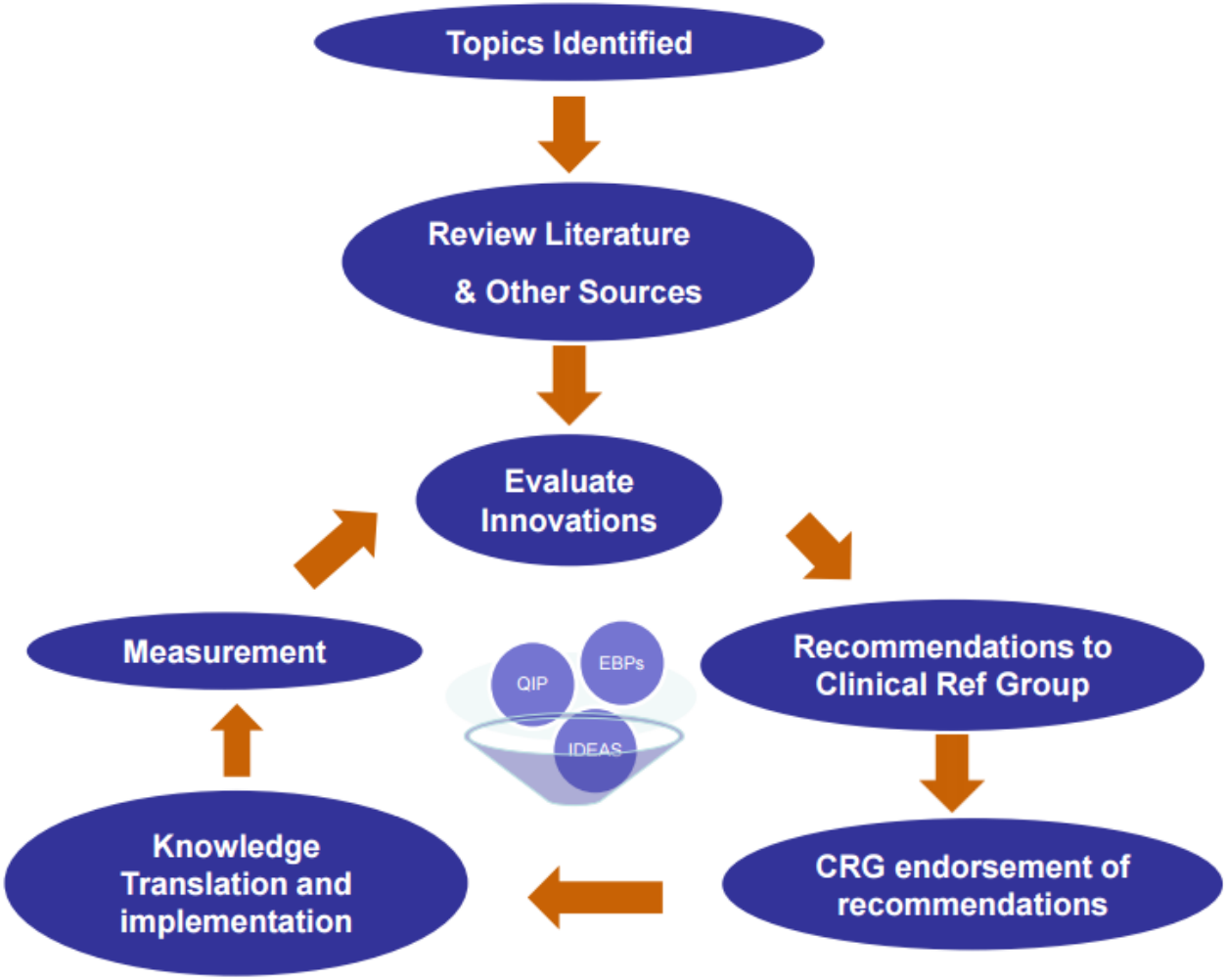
Jennifer McLeod. *Executive Director, Timmins Family Health Team. Lead for theTimmins Health Link.*

Monique LeBrun. *Quality Improvement Specialist, Health Quality Ontario (Moderating Discussion)*

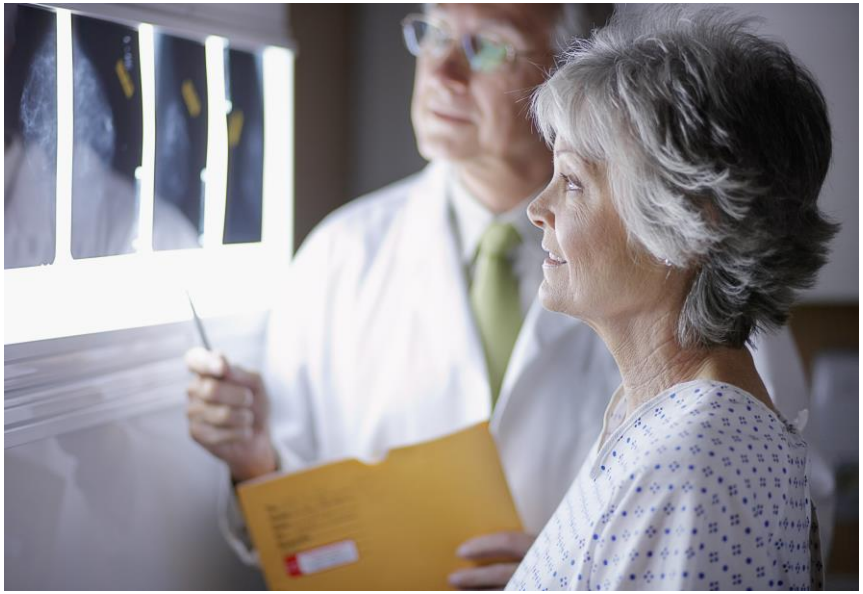
HEALTH LINKS LEADERSHIP COMMUNITY OF PRACTICE

'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



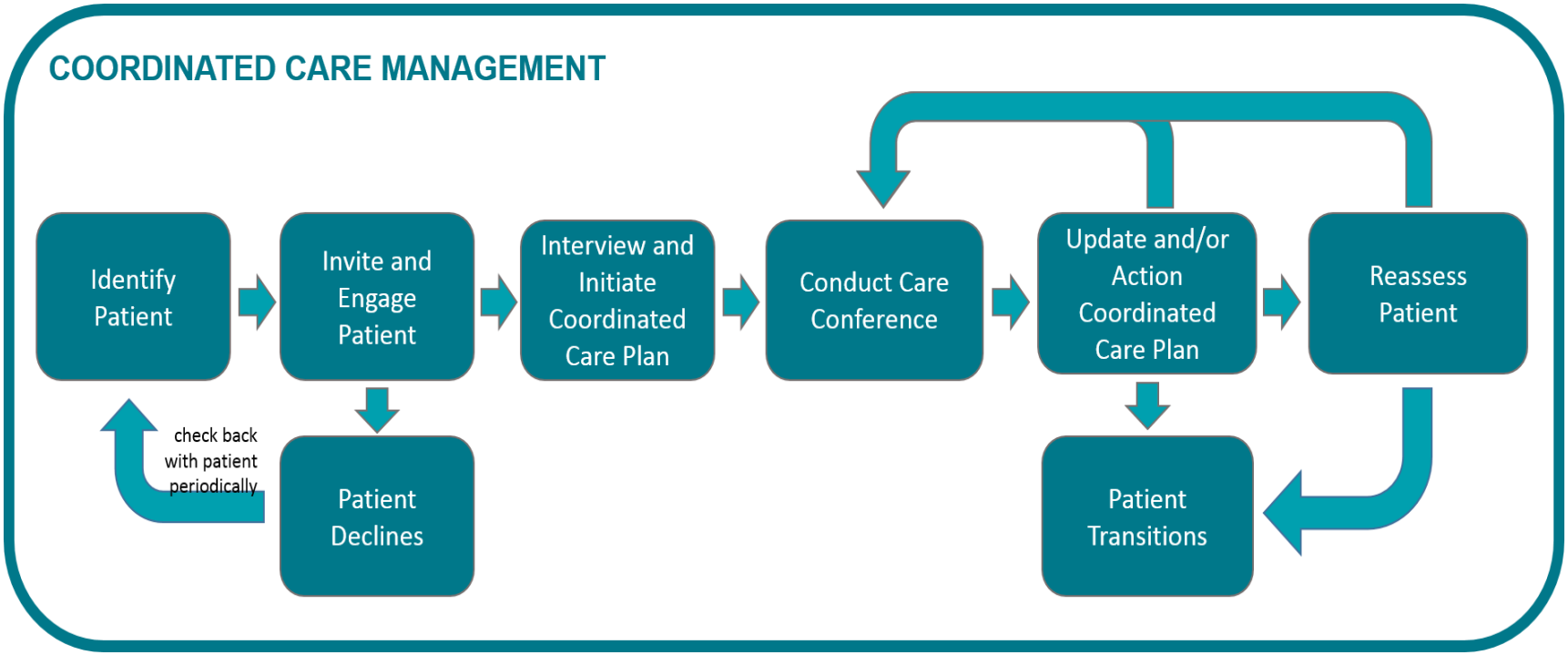
INNOVATIVE PRACTICES
Coordinated Care Management



"If everyone would work together on my issues it would be better care. You know…by looking at the whole person and all the issues. Especially when I don't feel well enough to manage all the pieces all on my own".

Diane, Patient

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	

COORDINATED CARE MANAGEMENT

Products at a Glance

Ontario

Coordinated Care Management

Identify Patients: A Combination of Clinical and Data Driven Strategies *Released June 2016*

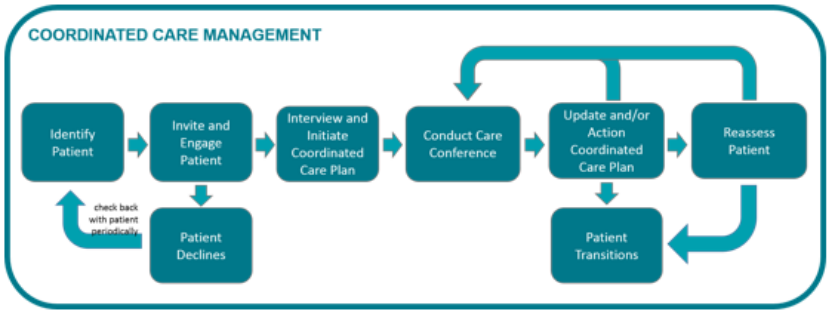


Figure 1: Approach to Coordinated Care Management

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	Clinical Reference Group Recommendation for Spread
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).

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 Health Links/Coordinated Care Management. To *further* support clinical decision making, the provider would then administer a standardized risk assessment tool, if indicated.

Use data driven case finding mechanisms to support prospective identification of Health Link patients 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 Health Link patients.

Implementation

Steps for Implementation	Tools and Resources	Additional Enablers
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. 2) Provider organizations routinely apply data driven case finding methodologies to inform and support decision making. 3) Providers/organizations share data to ensure a comprehensive view of the population and patients who may benefit from Health Links.	• **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* • **Health Links Target Population** Webinar, Ministry of Health and Long-Term Care (NEED LINK) • **Guide to the Advanced Health Links Model**; Ministry of Health and Long-Term Care: *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)* • **PRA** *(Predictive Repetitive Admission)* • **DIVERT** *(Detection of Indicators and Vulnerabilities for Emergency Room Trips Scale)* • Data Sharing Agreements	Data Agreements may help facilitate the sharing of information and communication across organizations/sectors. If using Data Agreements, ensure that the data sharing agreement meets all legislative, legal, regulatory criteria.

Measurement

Quality Improvement Measures are used to help with monitoring progress to implement 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.

Measurement
(please see Appendix B for additional details)

Outcome Measure	Process Measures	Additional Information
% of patients identified as meeting Health Link criteria who are offered access to Health Links	For identification processes in at least one care setting (e.g., Hospitals, Community Care Access Centre, Primary Care),	• Recommend that Health Links collect and report data for a minimum of 3 months.

COORDINATED CARE MANAGEMENT
Tools and Resources

Coordinated Care Management **Summary,** which outlines:

- Summary of Coordinated Care Management Innovative Practices
- Summary of Measures for the Innovative Practices

One brief, detailed summary document ***per*** innovative practice which includes details re:

- Innovative Practice and Clinical Reference Group Recommendation
- Implementation steps and links to Tools and Resources
- Appended: Tools to support implementation of the practice, as indicated- ***see below***.
- Appended: Measurement Specifications and Data Collection suggestions.

Clinical and Data Driven Strategies- **Patient Identification Decision Support Tool**
Single Point of Contact- **Activities Checklist**
Person-Centred Communications- **Patient Invitation Decision Support Tool**
Informed Consent Processes and Forms- **Developing a Comprehensive Informed Consent Process and/or Form**

PATIENT STORY

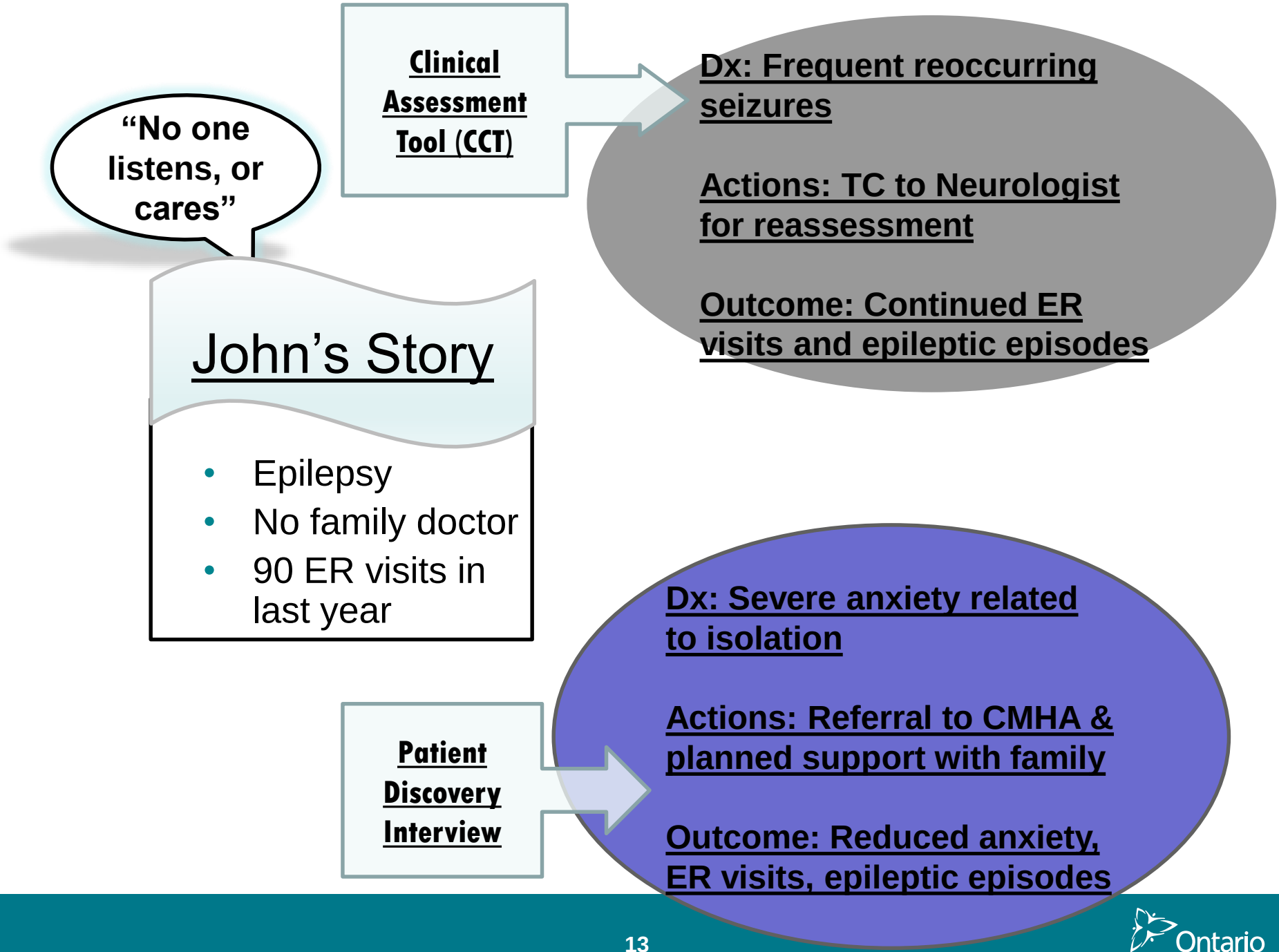
Understanding The Impact Of Coordinated Care Management on the Patient/ Caregiver Experience

and

"PATIENT CARE COORDINATION UTILIZING A PRIMARY CARE APPROACH"

Guest Speaker:

Jennifer McLeod RN, BNSc, MEd

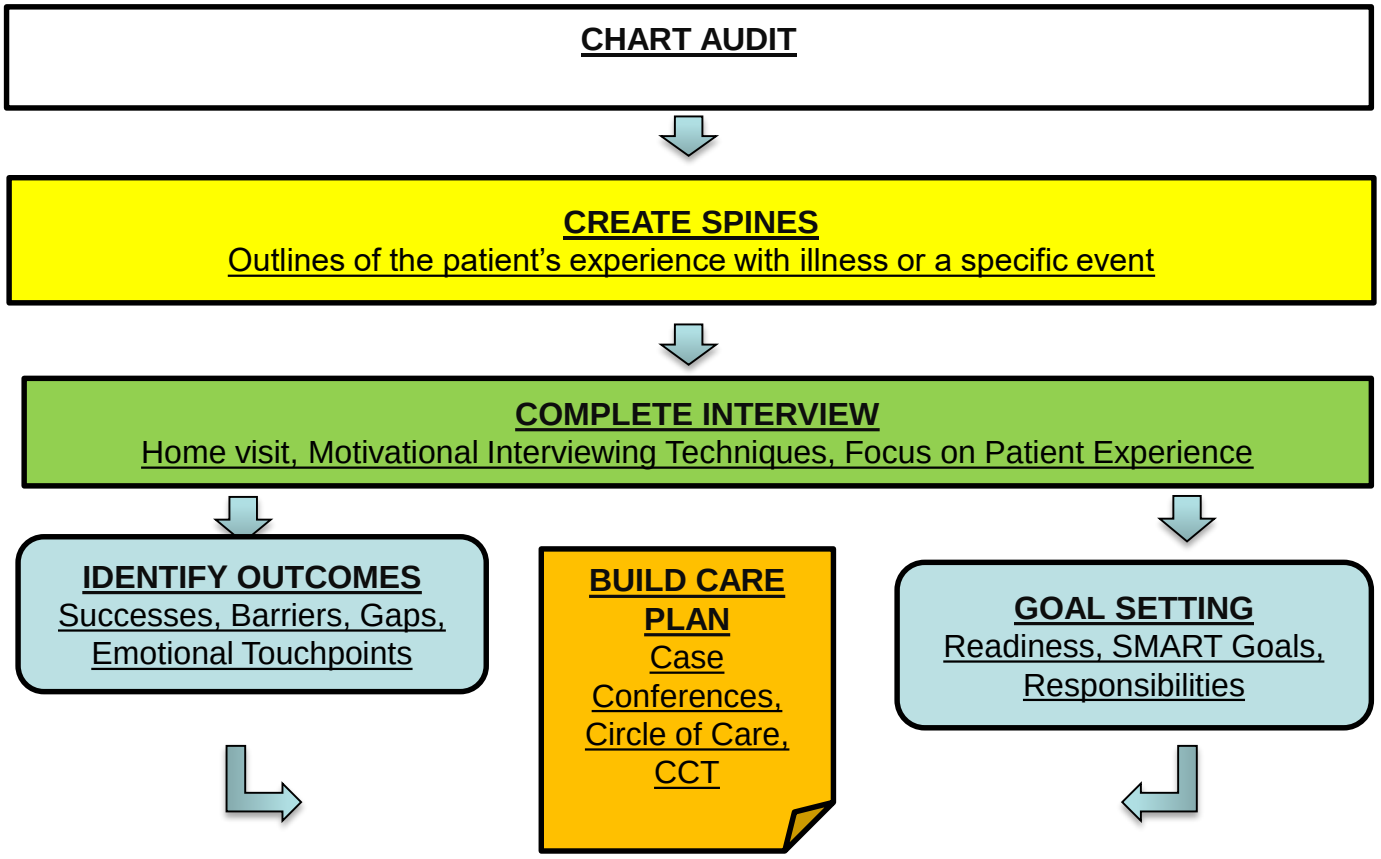

"No one listens, or cares"
John's Story
Epilepsy
No family doctor
90 ER visits in last year
Clinical Assessment Tool (CCT)
Dx: Frequent reoccurring seizures
Actions: TC to Neurologist for reassessment
Outcome: Continued ER visits and epileptic episodes
Patient Discovery Interview
Dx: Severe anxiety related to isolation
Actions: Referral to CMHA & planned support with family
Outcome: Reduced anxiety, ER visits, epileptic episodes

TIMMINS Health Link

Patient Care Coordination Utilizing a Primary Care Approach

- Patient Population - Identified through hospital reports and FHT Programs
  - 15 or more ER Visits in 12 months
  - 4 or more hospital admissions in 12 months
  - Frail Elderly & Palliative
  - 4 or more Chronic Conditions
- Patient Discovery Interview completed by Primary Care RNs in the home setting
- Results of interview discussed with patient, 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



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

Coordinated Care Management

- Care managed by Primary Care RN
- Care Conferences most often not a group of care providers sitting around a table with the patient
- Care Management occurs along a time continuum according to patient need
- Interactions through both home visit and/or clinic office visit
- Patient engagement through multiple interactions with providers

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

Final Thoughts

- A change is practice is required by all health service providers for Coordinated Care Management to be effective
- Coordinated care management is collaborative and health care providers must consequently relinquish/share ‘control’ with patient, their caregivers and other health care providers
- The impact on the patient’s health outcome is worth the effort of coordinating care well!

TIMMINS Health Link

CONTACT INFO

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IMPLEMENTING INNOVATIVE PRACTICES IN YOUR HEALTH LINK

Discussion;

Please submit questions to us, and your colleagues via the chat box.

2017/18 QIP and Health Links

NEW: 2017/18 QIP indicator for hospitals, primary care organizations, Home Care (CCAC)

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

Rationale:

- Maturity of QIP and Health Links; timing is right to more directly connect
- QIPs focus on system-level quality issues; this year, more specific focus on coordinated care planning
- Identification of patients who may benefit from coordinated care planning is a key step
- HQO Innovations Framework outlines concrete approaches and a variety of tools to support identification of patients with multiple conditions and complex needs
- Applicable to all organizations regardless of affiliation with a Health Link or local Health Link processes

HEALTH LINK LEADERSHIP COMMUNITY OF PRACTICE;

Resources and Events

NEXT TOPIC; *Transitions Between Hospital to Home*

Webinar PART ONE- **October 14th, 2016**

Webinar PART TWO- **November 16th, 2016**

Also…

Health Link Leadership Summit;

September 28th, 2016 ***please note that attendance to this event is by invitation only****

Health Quality Transformation 2016

October 20th, 2016. *Registration is open*

POLLING

Ontario

Health Quality Ontario

www.HQOntario.ca

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