HEALTH LINKS

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

STEP FIVE:

Maintenance and Transitions

November 10, 2015

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

Ontario
Health Quality Ontario

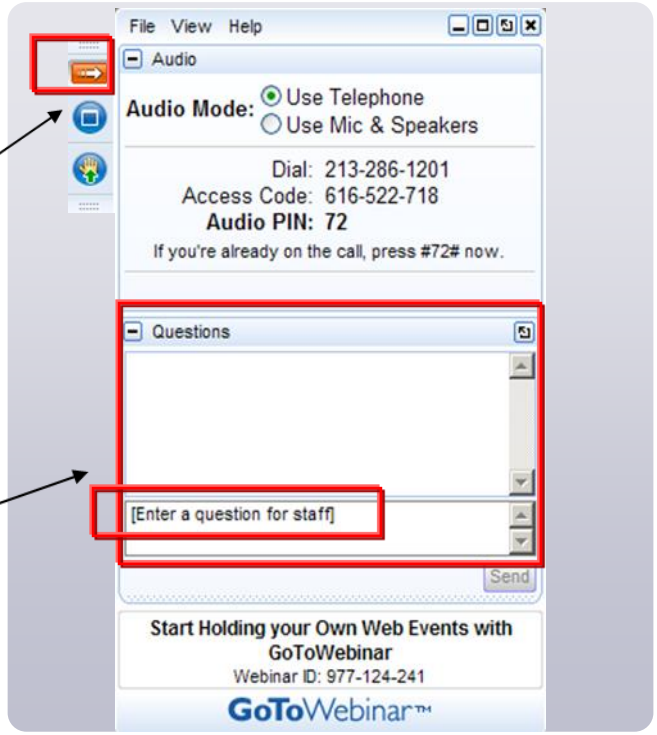
PARTICIPATING IN THE WEBINAR

- This webinar is being *recorded*.

- ALL participants will be muted (to reduce background noise). You can access your webinar options via the orange arrow button.

- Discussion period post presentation, please type your questions for the presenter after each presentation.

- Unable to utilize the ‘raise your hand’ feature.



WEBINAR PANEL

HEALTH QUALITY ONTARIO (HQO)

- **Sandie Seaman,** *Manager, QI and Spread*
- **Jennifer Wraight**, *Quality Improvement Specialist, QI and Spread*
- **Stacey Bar-Ziv**, *Team Lead, QI and Spread*

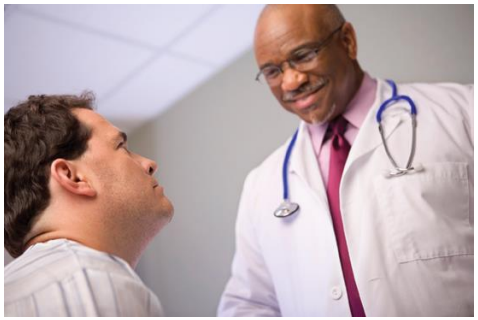
GUEST PANELISTS

- **Ana MacPherson**, *Clinical Coordinator,* South Simcoe and Northern York Region Health Link, Central LHIN
- **Jennifer Mackie**, *Director Organization Development, Project Manager*, Guelph Health Link
- **Megan Jaquith**, *Health System Planner,* South East LHIN
- **Dianne McIntyre**, *Coordinator Mental Health Program*, Upper Canada Family Health Team, and *Care Coordinator*, Thousand Islands Health Link
- **Sherri Fournier Hudson,** *Project Manager*, Thousand Islands Health Link

WEBINAR OBJECTIVES

Purpose

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



Specifically, this webinar will aim to:

Provide the opportunity to share and learn from one another, regarding:

- **Health Links processes and practices relating to the *'Maintenance and Transitions'* Step.**
- **Lessons learned so far, in the field.**

MAINTENANCE AND TRANSITIONS

- Share and communication the plan
- Implement the plan
- Update the plan
- Ongoing team communication

MAINTENANCE AND TRANSITIONS

Established best practices around transitions and collaborative care:

1) ***Medication Reconciliation occurs at transition points.***

2) ***Health Literacy is assessed/ addressed.***

3) ***Teach back is employed to enhance patient learning***.

4) ***Warm handoffs occur between providers.***

MAINTENANCE AND TRANSITIONS

Additional Health Link specific considerations that have emerged so far:

1) ***Explore and implement interim electronic solutions to share and update the Coordinated Care Plan, and/or utilize a human resource to synthesize data.***

2) ***Establish standard business processes for communication with the team, and ensure the Coordinated Care Plan is current.***

3) ***Establish a process to support patients moving from intensive support to self-management.***

HealthLink

South Simcoe & Northern York Region

Let's Make Healthy Change Happen

Ana MacPherson, *Clinical Coordinator,*
South Simcoe and Northern York Region Health Link

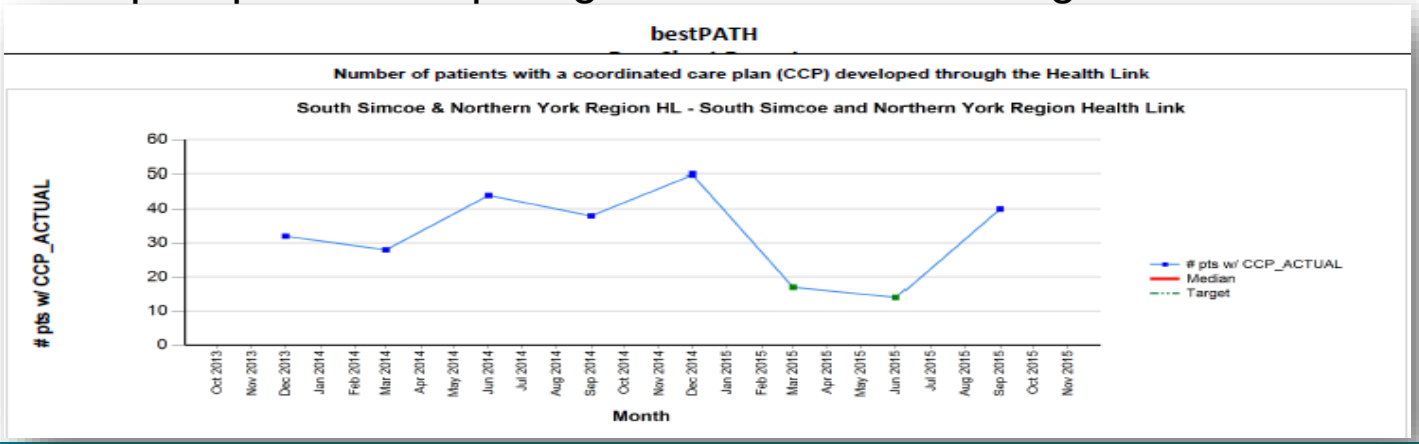
ABOUT OUR PRACTICE

SOUTH SIMCOE NORTHERN YORK REGION MAINTENANCE AND TRANSITIONS THEN, NOW AND FUTURE

HealthLink
South Simcoe & Northern York Region
Let's Make Healthy Change Happen

- **Then: (2013- Feb 2015)** 2 dedicated CCAC HL Care Coordinators
  - 60-70 intensive cases, > 80% CCP activated
- **Now: (Feb 2015- Aug 2015)** 30 CCAC HL Care Coordinators
  - 130 combination of general and intensive cases
  - < 80% CCP activated
  - Working with other programs to increase CCP activation for our complex patients (e.g. MCP)
    - Improved on targeted enrolled clients with CCP (**Figure 1**)
- **Future:** (**Sept 2015 onward)** - HL Care Coordinators (HLCC e.g. LOFT, CMHA, SRHC) - HL Care Coordinators- educated on HL/standardized processes to identify and care for complex patients requiring intensive case management

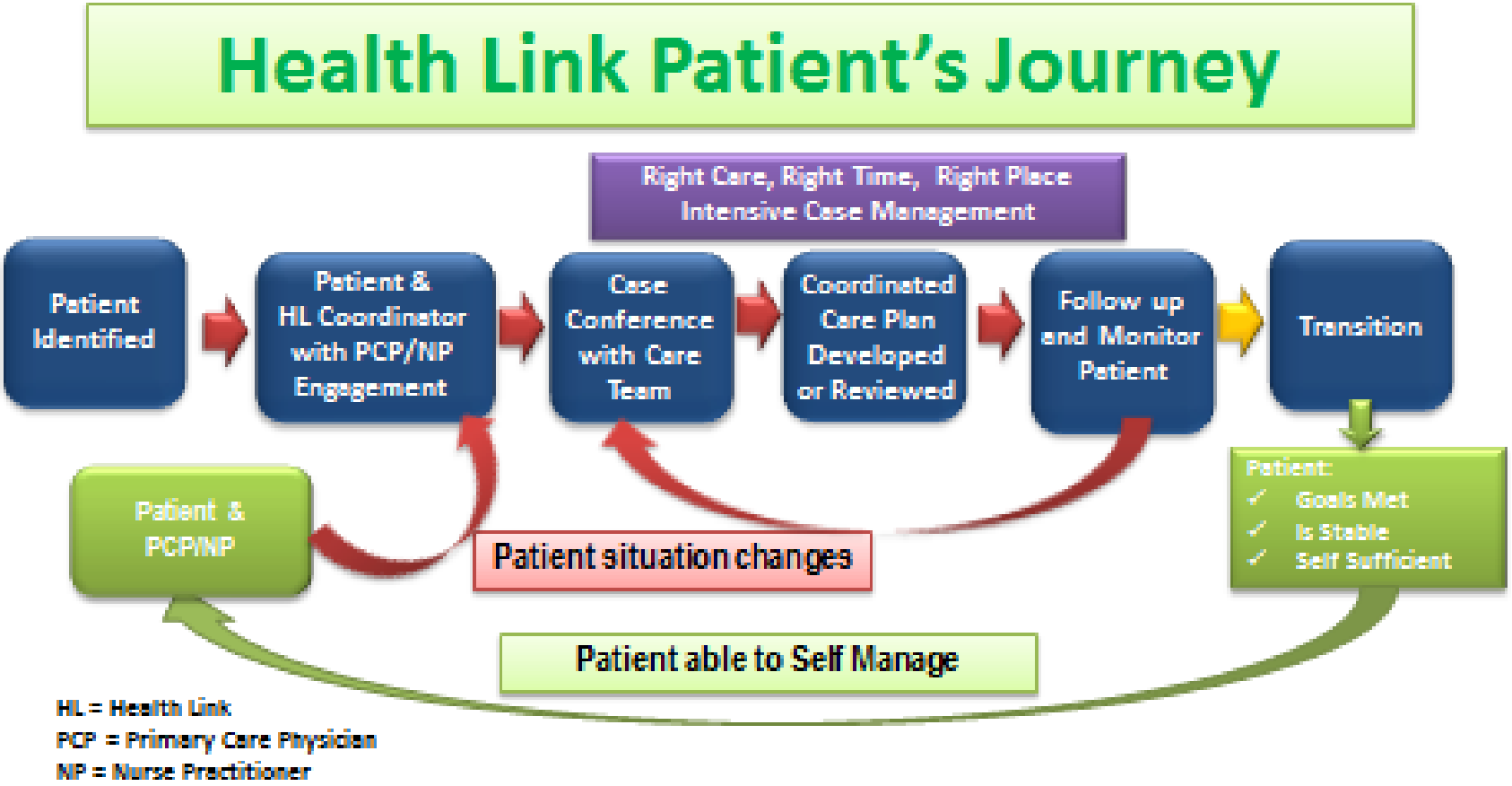
FIGURE 1



ABOUT OUR PRACTICE

HealthLink
South Simcoe & Northern York Region
Let's Make Healthy Change Happen

CENTRAL HEALTH LINKS



HealthLink
South Simcoe and Northern York Region
Let's Make Healthy Change Happen

Health Link Client/Substitute Decision Maker (SDM) Checklist

These are the steps to follow for Health Link Clients for Intensive Case Management and Coordination.

✓	STEP	ACTIVITY	Update CCP
	1	**HL Care Coordinator (CC) contact client/SDM to set up Home Visit – (24-48 hours)** - Informed Consent obtained from Client /SDM as per consent management - Send Health Link Administrator (HLA) via secure messaging client's Name/HCN/PCP or NP – HLA will send Introductory Letter to PCP/NP	document consent agreement
	2	**HL CC contacts PCP/NP (2-4 days)** - Request for a Cumulative Patient Profile (CPP), Initiate CCP - Determine if pre-conference with PCP/NP is required	Initiate or update
	3	**HL CC conducts home visit (3-5days)** - Reviews history, medication, providers, goals, other factors, conducts RAI-HC (if not yet done) - Initiate or continue with CCP (if not initiated by HLA) - Document Patient Experience (survey provided by HLA)	Initiate or update
	4	**HLCC contacts circle of care team members within 1 week of referral to arrange case conference (1 week)**	
	5	**HLCC leads preconference w/out client if necessary (1 week)**	
	6	**HLCC leads Case Conference should be done with client/SDM and all members (if possible) (7-10 days)** - Introductions/reviews roles of all Circle of Care Team, discuss expectation - Clients/SDM will help develop a plan to achieve their goals for care - Reviews the CCP to gather input from the circle of care - Create an Action Plan for any one issue at this time - Enter into CCT (if HLCC is non author/viewer – then provide information to HLA) - HLCC shares CCP with Client/SDM as per update agreement	update
	7	**HLCC follows up with actions from case conference (10-14 days)** - Reassess patient, monitor for ED/hospitalization (HLA provides ED/hospitalization notification to Care Team Members) - Discus: actions required with Care Team Members (i.e. referral needed) then update CCP (send note to HLA as appropriate) - Share CCP with Client/SDM as per update agreement	update
	8	**HLCC to review outcome of CCP and determine the following: (21-30 days)** - Client's Goals have been met, condition stabilized and have avoided 30-day re-admit ED/hospitalization with sufficient community provider support in place/ self sufficient - Client is admitted to another care setting - Client is deceased	update
	9	**HLCC prepares client/SDM for Transitioning (30-60 days)** - Provide or review an Action Plan for any health issues as required - Provide client/SDM/PCP/NP with most current CCP	update
	10	**HLCC provides client/SDM contact information if there is status change to reactivate HL**	Update

*For CCT POC Only: If updating CCP – need to publish/share with Care Team Members. Notify HLA if Care Team Member is a Non Author/Viewer.

Draft October 21, 2015

HealthLink
South Simcoe & Northern York Region
Let's Make Healthy Change Happen

STANDARDIZED HEALTH LINK CLIENT/SDM (Substitute Decision Maker) CHECKLIST 10 STEPS

LESSONS LEARNED

HealthLink
South Simcoe & Northern York Region
Let's Make Healthy Change Happen

Standardization of practice: reviewed current state, developed practices for future state – moving forward- agreements- (IT, processes) from all partners will be laid out prior to engagement…

- ❑ Patient Journey – Flow Process
- ❑ Standardized Client/SDM Check list
- ❑ Business Processes:
  - Consent Management- following legislation
  - Sharing CCP/CCT for both authors/viewers and non authors/viewers via secured messaging:
    - email – ONE Mail, docs password protected
    - Future State: CCT publishing to Circle of Care with any updates – shared with client/SDM as agreed upon

CONTACT INFO

HealthLink
South Simcoe & Northern York Region
Let's Make Healthy Change Happen

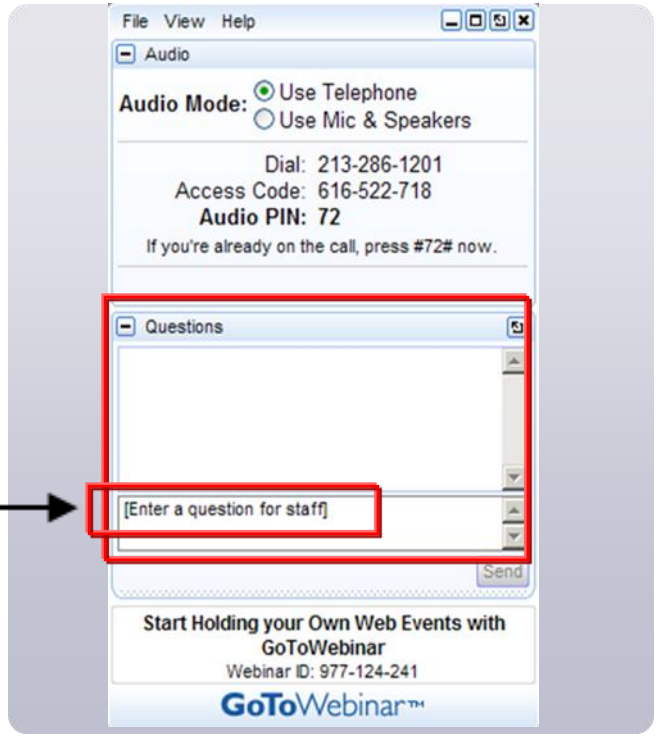
Rosalyn Gambell, RN, BScN, MN
Manager Health Links, Telehomecare, Medicine OutPatient Services, & GEM Nurses

Ana MacPherson, MASc, RRT, CRE, CTE
Clinical Coordinator
South Simcoe Northern York Region Health Link

amacpherson@southlakeregional.org
905-895-4521 ext 5326

Question Period

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



HealthLink Guelph

Jennifer Mackie,
Director Organization Development, Project Manager,
Guelph Health Link

HealthLink Guelph

Care Plan Sharing and Updating

- Primary Care HL Guide – PCAH or PCNC (primary care nurse clinician) authors the care plan and ensures updates based on HLM, FP, care team member input: FP reviews prior to publishing
- Q monthly, Q3mo, Q6 month OR as changes happen
- Ongoing changes captured on paper passport, in chart for care plan/passport update with admin support
- Key sections requiring timely update include medications, conditions, care team members, ADL changes, new / revised action plans

HealthLink Guelph

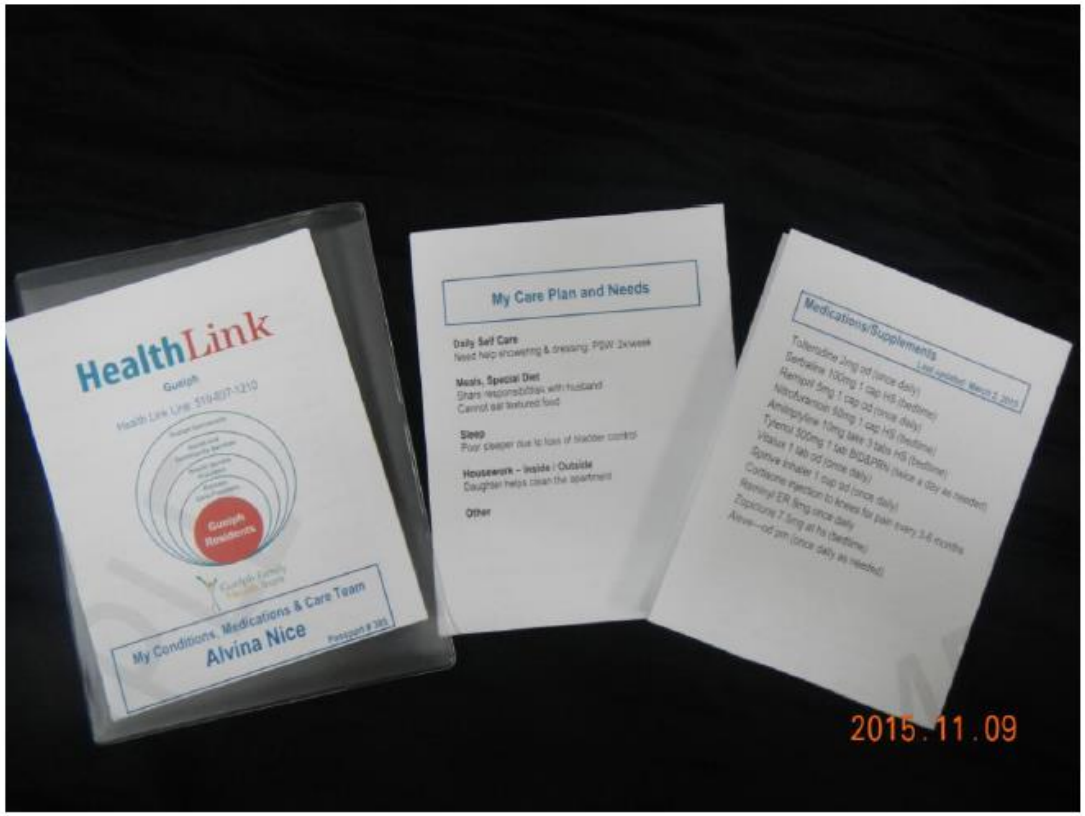
Care Plan Sharing and Updating

continued

- Outside of the EMR, we created a HL database that logs HL team, cohort (palliative, frail elderly, MH/A, MH/A + CD, CDs) of HL Member (HLM), SDOH, check ins, ED/Admissions, status, transfers / linkages to other primary care clinicians or community resources
- HL database will enable HHR planning and workflow process adjustments and aggregate view of HLMs
- Established processes with discharge staff (hospital, CCAC) when HLMs return home and connect with primary care

HealthLink

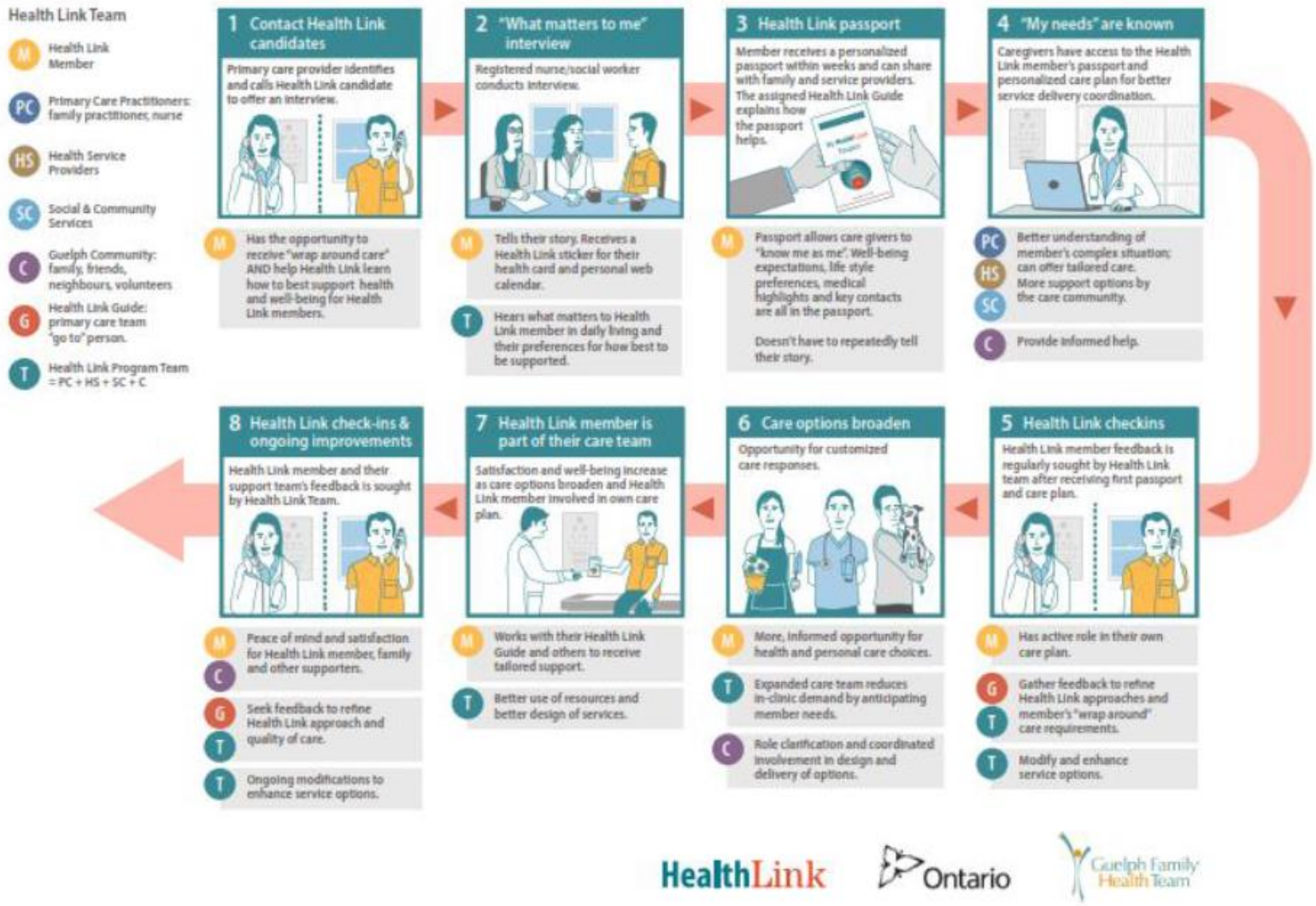
Guelph Health Link Passport = Care Plan



-For HLMs interested
-Not used by GCHC

Guelph Health Link - Everyone Has a Role

Guelph Health Link will enable the Guelph care community to provide coordinated "wrap around" care by health, social and community service providers for individuals with complex needs.

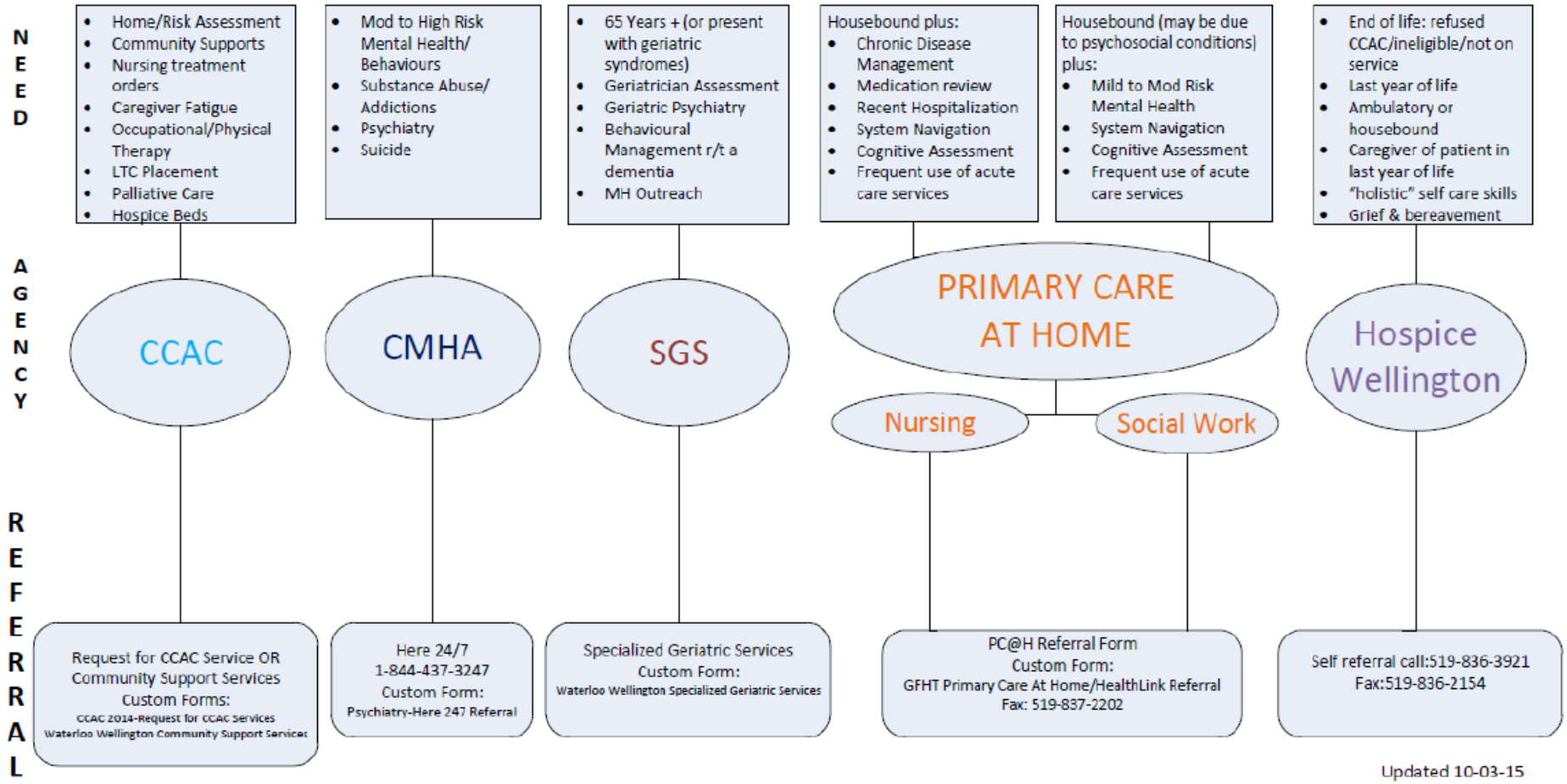


HealthLink Ontario Guelph Family Health Team

REFERRAL FLOW CHART

Guelph Family Health Team

HealthLink



Updated 10-03-15

HealthLink Guelph

LESSONS LEARNED

- Established Primary Care at Home RNs and SWs as an extension of the family practitioner enabled initial care plan completion and mini care conferences
- Single electronic medical record (PSS) enable shared planning within primary care team members
- Strong local relationships with acute and mental health hospital resources, CCAC, CMHA, community service organizations
- Initial care plan, ongoing med rec's and care plan updating still work in process
- Our clinical pharmacists and community pharmacists are key to med rec support

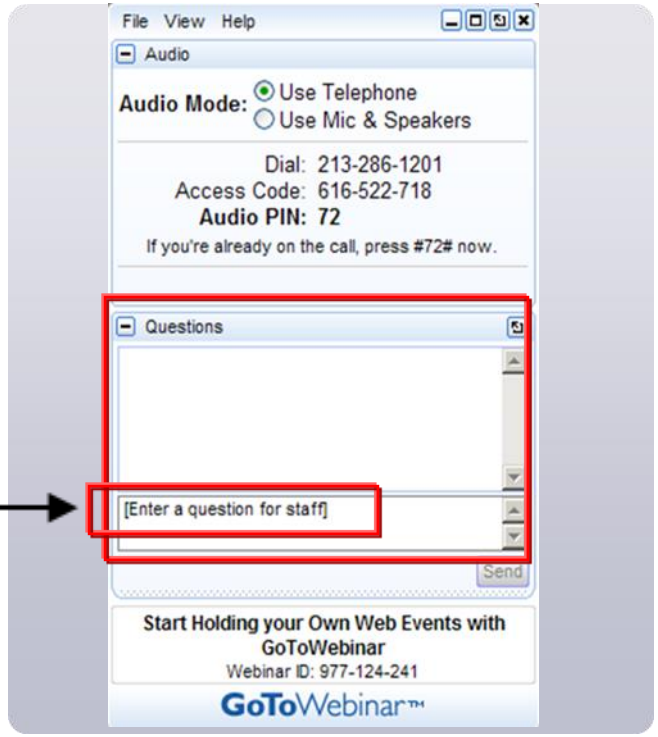
HealthLink Guelph

CONTACT INFO

Jennifer Mackie, RRT MBA
Guelph Health Link Project Manager
jennifer.mackie@guelphfht.com *519 837 4444 x 233*

Question Period

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



HealthLink Thousand Islands

Megan Jaquith, *Health System Planner,* South East LHIN

Dianne McIntyre,
Coordinator Mental Health Program, Upper Canada Family Health Team,
and *Care Coordinator*, Thousand Islands Health Link

Sherri Fournier Hudson, *Project Manager*, Thousand Islands Health Link

HealthLink Thousand Islands

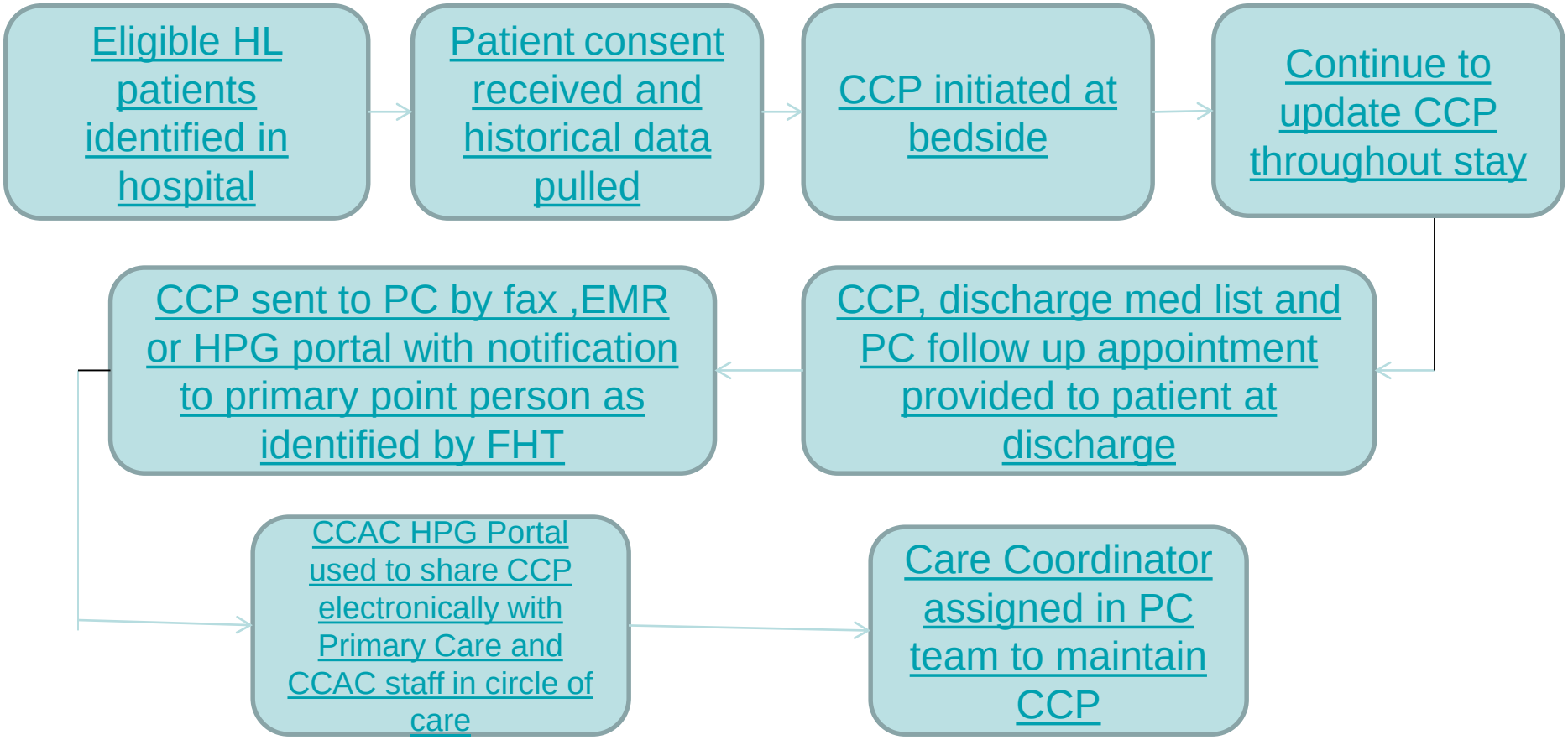
ABOUT THE PRACTICE

HOW OUR HEALTH LINK MANAGES MAINTENANCE AND TRANSITIONS

A CCAC Hospital Coordinator has been seconded to the Health Link to work in the hospital to initiate CCPs and coordinate CCAC services while a patient is in hospital

- By attending Rounds in hospital the coordinator is better able to support the hospital and patient through discharge planning
- Access to CHRIS and the Primary Care EMR (Electronic Medical Record) improves communication on the patient's status and their CCP (Coordinated Care Plan) initiation

ABOUT THE PRACTICE



HealthLink Thousand Islands

ABOUT THE PRACTICE

- There is a dedicated role of Nurse Navigator from the FHT (Family Health Team) that works out of BGH (Brockville General Hospital)
- When a patient with a CCP is admitted to BGH, the Nurse Navigator will up-date the patient's plan, informing the Care Coordinator of any changes. The Nurse Navigator also communicates the patient's discharge, including follow up plans, to the Care Coordinator

HealthLink Thousand Islands

ABOUT THE PRACTICE

- A Registered Nurse from the FHT and Health Link are at BGH, Garden Street Site once per week to attend rounds, identify patients that meet Health Link criteria and to initiate a Care Plan
- This plan is then assigned to a Care Coordinator with the patient's Primary Care Team to maintain the CCP once discharged from hospital

HealthLink Thousand Islands

ABOUT THE PRACTICE

- A Registered Nurse from the FHT and HL (Health Link) are also working closely with Addictions & Mental Health Services at BGH
- Either the RN from the FHT or HL contact the family physician who works with this service once weekly to discuss possible referrals to Health Link.
- The client will then be offered a CCP. This CCP will then be transferred to a Care Coordinator within the client's Primary Care Team when the client is discharged from BGH.

LESSONS LEARNED

HealthLink Thousand Islands

- A clear transition plan for the CCP to be maintained by primary care is needed.
  - Identify the key contacts in primary care (such as team leads)
  - Try to match an IHP (Interdisciplinary Health Professional) with a patient based on the patient's current health concerns and goals
  - The HPG (Health Partner Gateway) portal (within the CHRIS system) allows for a secure transition of the CCP
  - Tracking tools help to ensure that no one falls through the cracks

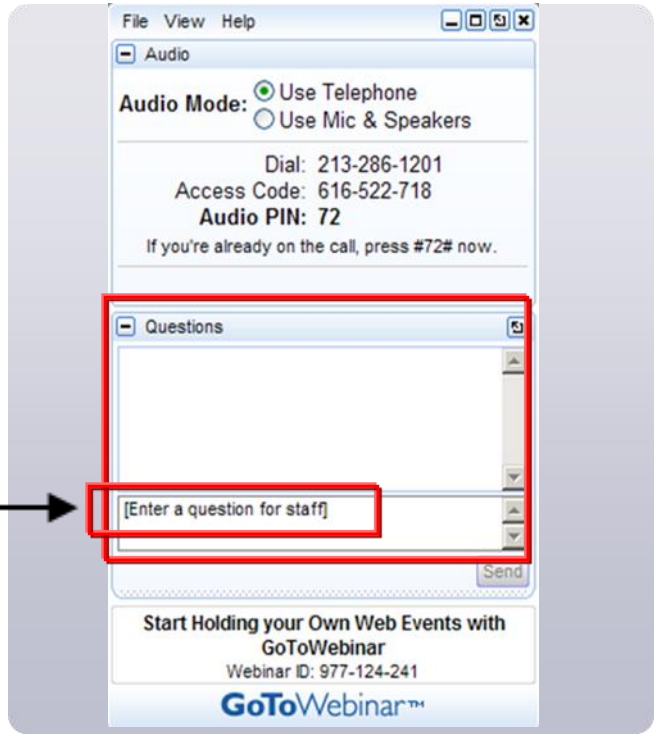
HealthLink Thousand Islands

Contact Information:

Sherri Fournier Hudson
Project Manager
shudson@ucfht.com

Question Period

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



SUMMARY- MAINTENANCE AND TRANSITIONS

General Best Practices*:

- Medication Reconciliation at transition points
- Health literacy assessed/ addressed.
- Teach back is employed to enhance patient learning
- Warm handoffs occur between providers.

**Resources: http://www.hqontario.ca/Quality-Improvement/Health-Links/Improvement-Packages*

Health Link specific considerations:

- Explore and implement interim electronic solutions to share and update the Coordinated Care Plan, and/or utilize a human resource to synthesize data.
- Establish standard business processes for communication with the team, and ensure the Coordinated Care Plan is current.
- Establish a process to support patients moving from intensive support to self-management.

Practices Recommended for Spread:

- **Coming Soon.** *Following review by the Clinical Reference Panel.*
- Additional practice support from Health Quality Ontario re: Transitions expected for early 2016.

REGIONAL QUALITY IMPROVEMENT TEAMS

Region/LHINs	QI Specialists	Email address	Telephone number
Southern Ontario			
LHINs: ESC, SW, WW, HNHB	Gina DeSouza	Gina.DeSouza@hqontario.ca	289-218-8216
	Linda Hebel	Linda.Hebel@hqontario.ca	519-318-6578
	Julie Nicholls	Julie.Nicholls@hqontario.ca	519-502-5164
Central Ontario			
LHINs: MH, CW, TC, Central	Kamal Babrah	Kamal.Babrah@hqontario.ca	416-571-7668
	Laurie Hurley	Laurie.Hurley@hqontario.ca	416-722-0735
	vacancy		
Eastern Ontario			
LHINs: CE, SE, Champlain	Monique LeBrun	Monique.LeBrun@hqontario.ca	613-293-6843
	Dana Summers	Dana.Summers@hqontario.ca	613-327-1427
	Jennifer Wraight	Jennifer.Wraight@hqontario.ca	647-237-0098
Northern Ontario			
LHINs: NSM, NE, NW	Tracy Howson	Tracy.Howson@hqontario.ca	705-927-3165
	Sue Jones	Sue.Jones@hqontario.ca	647-523-7510
	vacancy		

Central & Eastern Ontario

Manager: Sandie Seaman
Sandie.Seaman@hqontario.ca
416-508-3115

Team Lead: Kim Kinder
Kim.Kinder@hqontario.ca
647-521-5109

Northern & Southern Ontario

Manager: Shannon Brett
Shannon.Brett@hqontario.ca
1-866-623-6868 x299

Team Lead: Stacey Bar-Ziv
Stacey.Bar-Ziv@hqontario.ca
416-938-1182

Ontario

Health Quality Ontario

www.HQOntario.ca

HLHelp@HQOntario