HEALTH LINKS

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

STEP FOUR:

The Care Conference

October 20, 2015

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

Ontario
Health Quality Ontario

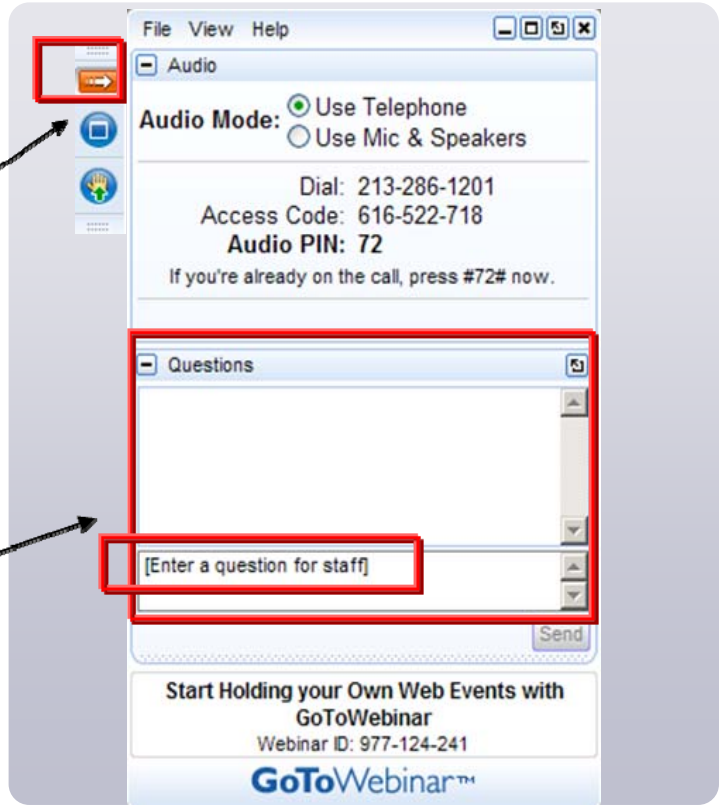
PARTICIPATING IN THE WEBINAR

- 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*

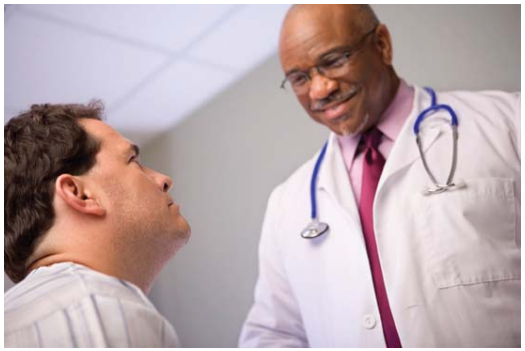
GUEST PANELISTS

- **Chris Archer**, *Project Manager,* North Simcoe Health Link
- **Tracy Koval**, *Registered Nurse, Clinical System Navigator,* North Simcoe Health Link
- **Anne McKye**, *Project Manager,* East Mississauga Health Link
- **Queen Young-Nwafor**, *Care Coordinator,* Mississauga Halton CCAC
- **Robin Griller**, *Director,* Mid-East Toronto Health Link
- **Mary Wheelwright,** *Director, Health System Integration*, Headwaters Health Care Centre
- **Sharon Howlett,** *Provincial Lead- Health Links and Telemedicine Nursing,* OTN

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.

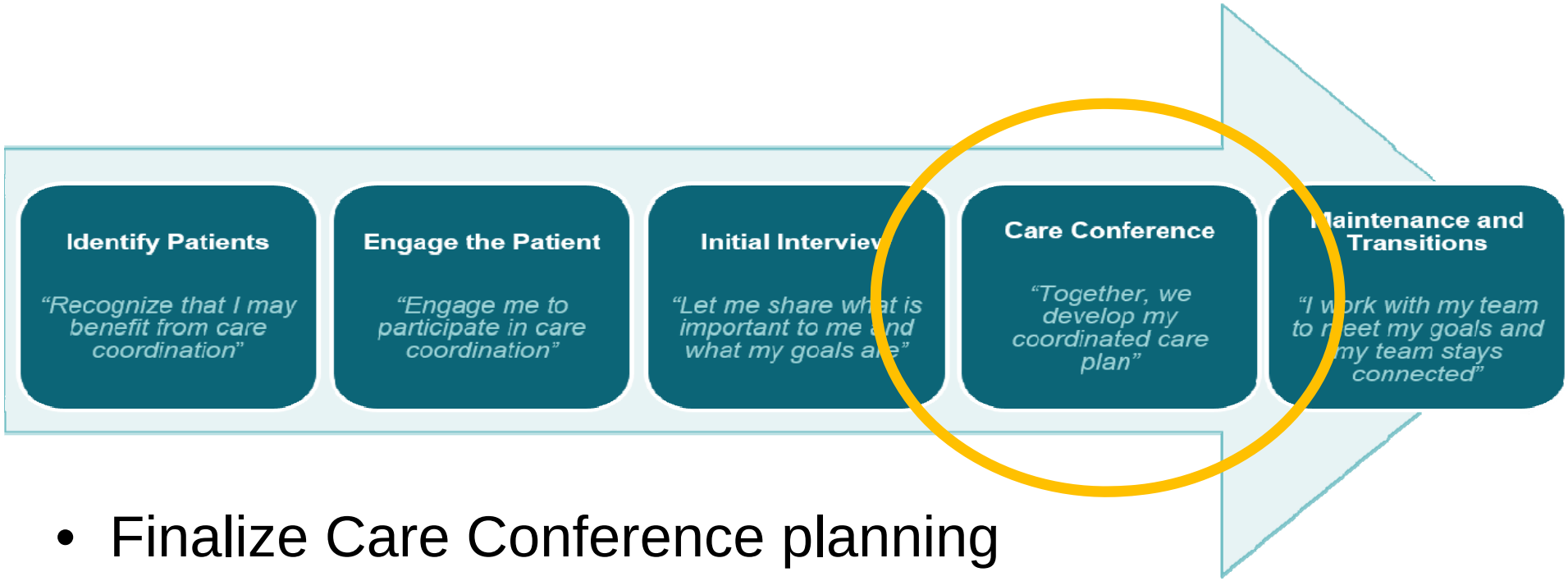


Specifically, this webinar will aim to:

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

- **Health Links processes and practices relating to the Care Conference.**
- **Lessons learned so far, in the field.**

The CARE CONFERENCE



- Finalize Care Conference planning
- Care Team meets
- Identify relationships and roles
- Review vision, goals, and strengths
- Explore services and supports
- Develop coordinated care plan
- Determine next steps.

CARE CONFERENCE

Additional considerations that have emerged so far:

1) ***Consult and accommodate patient wishes.***

2) ***The logistics of the care conference.***

3) ***Plan the Care Conference <u>early</u>***, where possible.

4) ***Optimize communication during the care conference.***

5) ***Ensure agreement*** with plan and expectations***.*** Also, ***determine next steps.***

HealthLink
North Simcoe Community

Chris Archer,
Project Manager, North Simcoe Health Link

Tracy Koval,
Registered Nurse, Clinical System Navigator, North Simcoe Health Link

HealthLink
North Simcoe Community

Interactive Web Based Map…Intake Process

Initial Meeting Process

- Part of this involves explaining to clients that although many people believe that health is the absence of disease and physical health concerns, we view overall well-being as more than that. We understand that one's wellbeing is not merely achieved with the absence of disease but we recognize that many other things impact one's health. For example (using the map as a visual aid) all these factors have the ability to impact your health and wellbeing.

Patient Centric

- Examples 1. Without transportation you cannot attend appointments and even get to the grocery store to get food to survive 2. Food-without proper nutrition, you will not have the strength to function daily or the required nutrients vital to good health 3. Without education and literacy, it can be difficult for someone to read a food label and understand the impact of food choices on their health

Social Determinants of Health

- At Health link, we manage physical and mental health but we also pay attention to many other areas that impact your health and help you work on these areas so that you feel better and have a better sense of overall wellbeing.

Interactive Map

- I would like you to take some time to look at the map and think about your current situation. Questions asked after a few minutes:
  - What areas on the map can you identify as most important to you and that you would like to work on together?
  - When you think about the area you identified, what do you hope to achieve?
- Note: even if clients only identify 1 area that they would like to work on at the time, we encourage the client to bring home the copy of the map to reflect on other areas that we can work on.

Be Well Survey

- In the initial appointment, clients are also provided the “be well” survey to complete at home and then are advised we will review it together the following week. The survey is used to help guide clients to create goals. For example, if clients state that they have difficulty affording food, we ask them if they would like to work on approaching other resources in the community so that they do not have to feel this pressure.

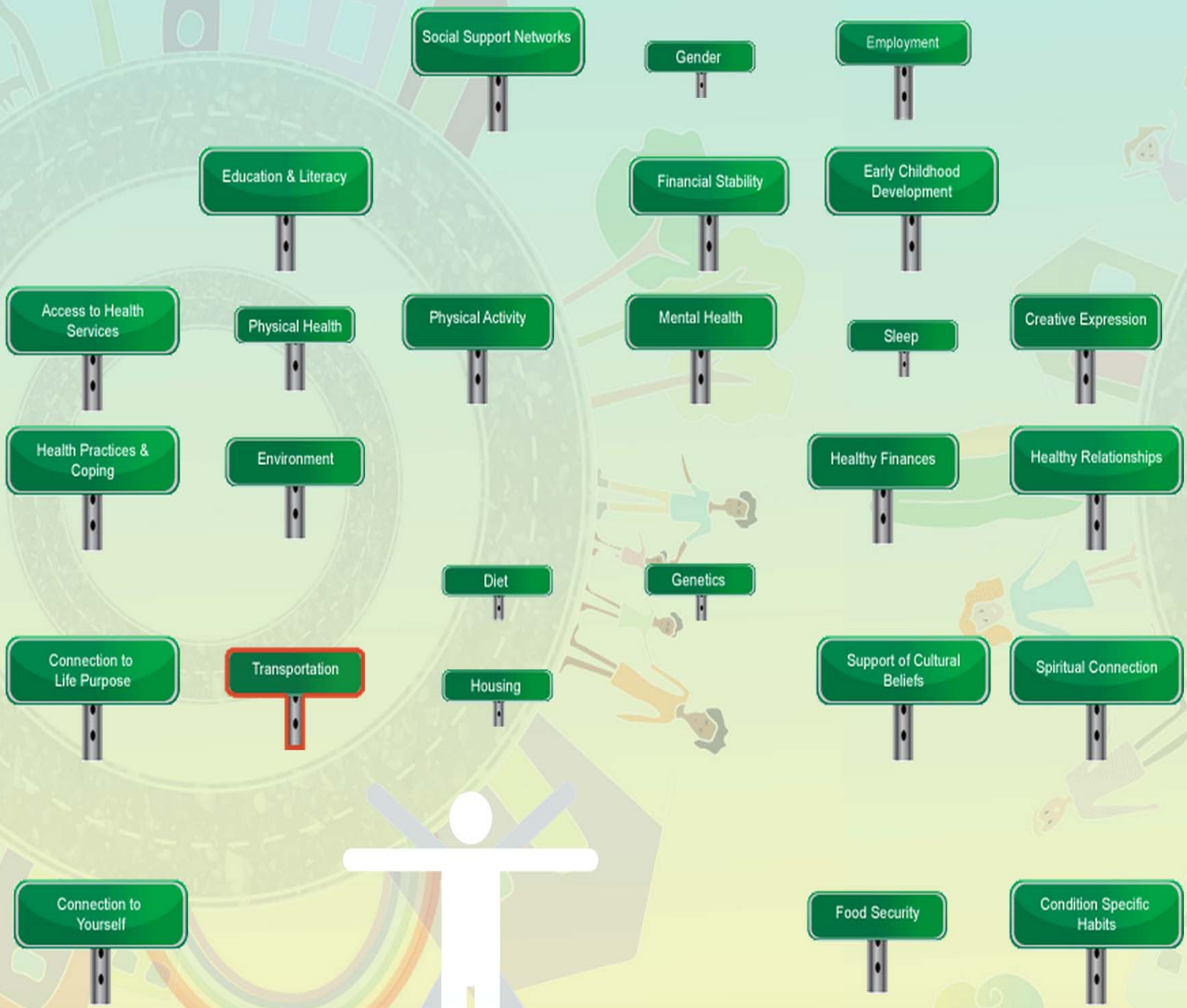
Follow up

- Using the map and the “be well “survey, we then work with the client in the second appointment to complete the clients care plan that is focused completely on their goals.

Determinants of Health

Website Instructions

Mobile Instructions



Transportation Resources in North Simcoe, Midland, Penetanguishene

North Simcoe is a rural community with minimal public transit. As such there are challenges for the elderly, persons with disabilities, those living out of town trying to gain access to employment, community resources, medical appointments, etc.

The social impact of restricted access to transportation can have a negative impact on physical and mental health.

(NOTE: Each link will open in a new window, just close the browser window by clicking the "X" in the top right corner to get back to the Health Link web page)

Canadian Cancer Society	Provides transportation for local patients to travel for cancer treatment in-town and out-of-town.
Royal Canadian Legion Penetang-Homeless Veterans Assistance	Emergency Transportation for Veterans
Community Reach	Transportation Linking Communities (TLC) provides non-emergency transportation by volunteers.
Town of Midland	The Town of Midland provides a wheelchair accessible transit service managed by Community Reach North Simcoe.
Metis Nation of Ontario-Community Support Services	Escorted transportation services.
Huronia Seniors Volunteer Care Team - Wheels 4 Wheels	A volunteer run wheelchair accessible transportation service available to those in the community who travel via wheelchair and are unable to use traditional modes of transportation.

Contact North Simcoe Health Link

North Simcoe Community Health Link
Chigamik Community Health Center

845 King Street, Unit 10
Midland ON L4R 0B7

General Inquiry
Phone: 705-527-4154 ext. 255

Registered Nurse/Clinical System Navigator
Phone: 705-527-4154 ext. 205

Fax: (705) 526-2870

Ontario Trillium Foundation / Fondation Trillium de l'Ontario
An agency of the Government of Ontario. Relève du gouvernement de l'Ontario.

Community Health and Wellbeing
Shift the conversation

"Be Well"
A Survey of Your Wellbeing

This survey covers many important aspects that affect your health and wellbeing. The information you provide will help your health organization develop a better understanding of what is keeping you well and what will help support the best health and wellbeing for everyone in Ontario. This survey will allow us to better connect people and communities with the programs, services and opportunities that can strengthen their health and wellbeing.

This survey will take approximately 16 - 20 minutes of your time.

Your Participation is Voluntary: Your participation is completely voluntary. You may stop participating, or refuse to answer any question. Your decision on whether or not to participate will not affect the nature of the services you receive at this organization.

Your Responses are Confidential: All information you provide will be kept completely confidential. Your name will not appear in any report or publication resulting from this survey. This is not a research activity. Your experiences will contribute to improving the quality and effectiveness of the services, programs and initiatives in your community health organization.

If you have any questions, or concerns please ask the receptionist or a staff member or contact The Association of Ontario Health Centres, Wendy Banh, Be Well Survey Coordinator, Tel: 416 236-2539 ext. 246 email: wendy@aohc.org

Thank you for your participation.

When completing the survey, please mark your selections by filling out the bubbles completely like this: ● (Correct)	Please do NOT fill the bubbles like this: ✓ ⊘ ⊗ (Incorrect)
When completing the survey, in the sections for written responses, please write inside the box like this: (Please specify):	Please DO NOT write outside of the box like this: (Please specify):

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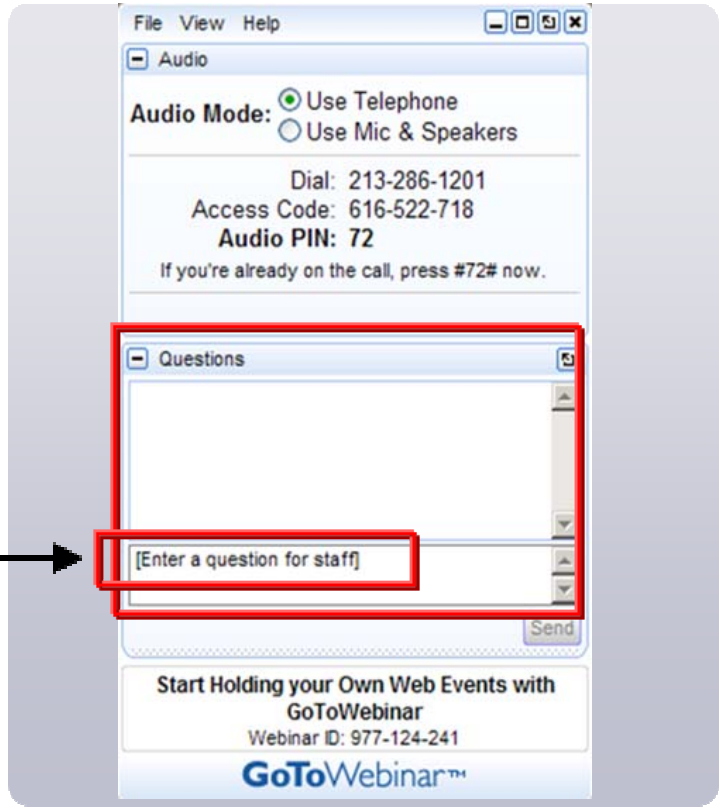
Question Period

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



East Mississauga Health Link

CARE CONFERENCING

Queen Young-Nwafor, Care Coordinator, Mississauga Halton CCAC
Anne McKye, Project Manager, East Mississauga Health Link

East Mississauga Health Link

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East Mississauga
Let's Make Healthy Change Happen

- Our model of care emphasizes intensive care coordination with a focus on patient-self identified goals and care conferences with primary care to address the needs of complex patients
- CCAC provides care coordinators who complete the initial visit within 3 days of referral in the patients home (or location of patient's choice)
- Referrals are accepted from hospital, primary care, CCAC and other community service providers

Care Conferencing

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- Simultaneous conversation with patient and family, primary care provider and Health Link Care Coordinator (at a minimum), and occurring at the primary care provider's office, patient's home or via video/teleconference
- Our goal is for patients to have a primary care conference within 7 days for hospital referrals and 14 days for community referrals

Leading a Care Conferencing

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- **Patient's concerns and goals expressed/reviewed and a plan of care set collectively**
- Care conference could be led by:
  - ✓ Primary Care Provider (PCP) – when s/he has initiated referral to HL
  - ✓ Health Link Care Coordinator (HLCC) – when patient is referred to HL from hospital or the community and the primary care provider is unaware of purpose or process
  - ✓ Patient/Family – when patients are eager to drive their own health care
- HLCC informs PCP of HL process and scope, reviews CCP (including medications, goals, circle of care and follow up appointments)
- Location: Most often in PCP office, but also in patient's home, sometimes PCP makes home visits with HLCC when they would not normally do so

Experience of Care Conferencing

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Patient

- Empowered – gives them a voice
- Enhances relationship with PCP; breaks down barriers
- Believes PCP gives them more time and attention in subsequent visits
- HLCC gets things moving; makes changes happen

Primary Care Provider

- More informed of issues and services
- Assistance to address complex patient issues
- Responsive point of contact in the community; easy communication

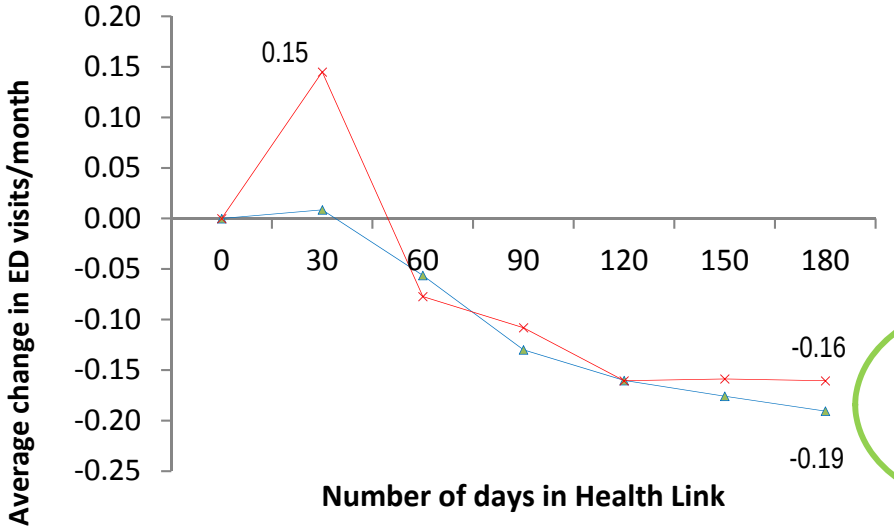
Health Link Care Coordinator

- Building positive relationships with PCP; enabling easier access
- Get issues addressed more quickly; kick starts care

Care Conferencing

- Care conferencing (CC) is achieved 55% of the time
- Most frequently, care conferences are declined or delayed due to patient choice
- 39% of patients receive CC within the targeted time frame

ED Visits vs. Baseline for Patients Enrolled >180 days ago (n=131)

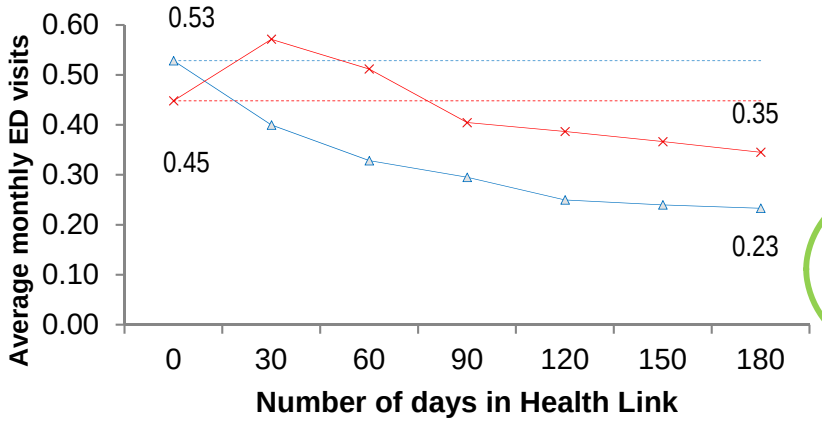


32% ↓ without care conference (n=54)

39% ↓ with care conference (n=77)

ED visits stratified by timeliness of care conference

(n=77, patients enrolled minimum of 180 days ago)



23% ↓ when CC is beyond target # days (n=42)

56% ↓ when CC is on target # days (n=35)

Lessons Learned

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- Personalization of care has a great effect on the patient

  "Next time, I won't go to the ED."

- HLCC does not take initial "*no*" from receptionist – requests that they actually ask the family doctor
- Family doctors need clarification on remuneration options for care conferencing
- Primary care conferencing is effective in reducing ED visits and meeting patient goals, however difficult to achieve for all complex patients
- The impact is greatest when care conference occurs early

CONTACT INFO

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Mid- East Toronto Health Link

Robin Griller,
Director, Mid-East Toronto Health Link

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Background

Mid East Toronto Health Link's Care Coordination Pilot

- METHL launched its Care Coordination Pilots in January-February of this year with a focus on clients living with mental health and addiction challenges
- We are using a dispersed model in which clients with health complexity are being identified and engaged in care coordination in a range of settings
- Our goal is build capacity for care coordination in multiple organizations so that when individuals are identified (wherever that may be) as requiring coordinated care, the existing providers in their circle of care are able to implement the care coordination process

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Implementation

Mid East Toronto Health Link's Care Coordination Pilot

- Six programs began care coordination with clients identified in their own programs by February
- An additional ten settings joined the pilots in April - June
- Further organizations are joining in as they are ready
- These settings include Community Mental Health, Community Support Services, Primary Care, and Hospital
- MH includes ACT, ICM, Supportive Housing, etc.
- A number of care plans have included the hospital and formal identification and engagement of clients at the hospital is now under way

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The Case Conference

- Dispersed model and limited HL resources means there isn't a formally standardized practice but…
- Key elements to an efficient and productive care planning meeting include:
  - Focus on the Client's Goals and Choices:
    - What does the client hope to accomplish?
    - Who does the client want in the room?
  - Flexibility in the case conference to allow the client to participate in the manner they choose
  - Waiting for perfection will be a long wait

The Case Conference focuses on two areas:

- 1. Goals and Actions:
  - What are the client's goals
  - What activities need to be undertaken to accomplish those goals
  - Who will take responsibility for carrying out or supporting the client to undertake each activity
- 2. Roles and Responsibilities:
  - Agree who will be the Care Coordinator: completes and distributes the care plan; 'go to' person for client and team
  - Team Members: public commitments to carry out actions agreed, keep care coordinator up to date, and to remaining engaged in client's care

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LESSONS LEARNED

- Identify and engage the client where they feel safe
- Structure the case conference to be responsive to the individual's preferences about how (or if) to participate
- Complete as much of the care planning template as possible outside the case conference so that the case conference can focus on the plan
- Have a broad definition of what is a health-related goal
- Focus on client goals is different from focusing on practitioner goals for the client and may require flexibility and negotiation on the part of health care providers
- Different organizations and teams will experience different challenges in care coordination and so require different supports to have success

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CONTACT INFO

Feel free to contact me to discuss this further ….

Robin Griller
Director, Mid East Toronto Health Link
Email: robing@regentparkchc.org

Question Period

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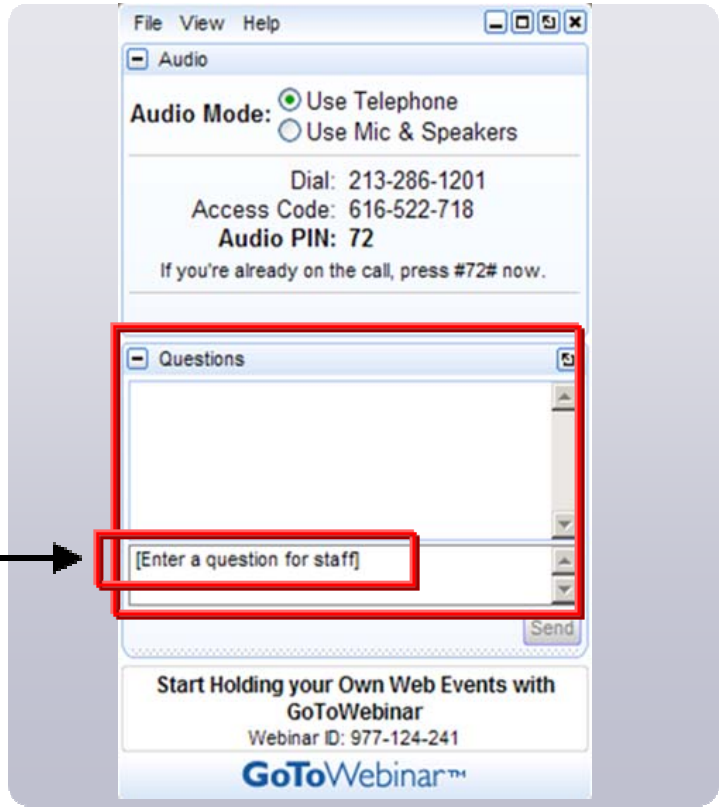

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Dufferin and Area Health Link

Mary Wheelwright, *Director,* Health System Integration
Headwaters Health Care Centre

ABOUT THE PRACTICE

- Engaged broad range of community partners & sought commitment to participate in weekly care planning rounds

- Leverage space available within Dufferin Area Family Health Team clinic locations to increase ease with which Primary Care Providers (PCPs) can participate & patients/caregivers can attend as required

- Ensure that patient, their goals & PCP are at center of circle of care & care planning

CHANGE CONCEPTS

- Central West CCAC aligned Care Coordinators with PCPs. Easier for community partners because as long as they know patient's PCP they know which Care Coordinator should attend rounds.

- Care planning was already happening in community but did not include all partners & rarely included PCPs. Recognizing barriers to PCP participation an effort to combine rounds & host them at PCP clinic locations proved to increase attendance.

- Some community partners were reluctant to commit to participating in rounds every week but after a few they realized that because patient's care team is together during discussion it eliminated need for multiple follow-up calls. Also helped community partners & PCPs strengthen partnerships and improve communication outside of rounds environment.

LESSONS LEARNED

- Rounds attended by variety of community partners can pose some patient privacy related concerns. Important to recognize & manage concerns to ensure ongoing participation by partners & patient comfort with being discussed.

- Sharing care plans with multiple providers involved with patient can be difficult. Starting to use electronic tool to facilitate care plan creation & sharing as part of proof of concept implementation. Will also help with resolve issue where caregivers weren't always aware of services their patients were already receiving.

- Through rounds community partners & PCPs become more familiar with supports & services they each offer, however sometimes required services not available. Need to be able to track & report on system gaps.

CONTACT INFO

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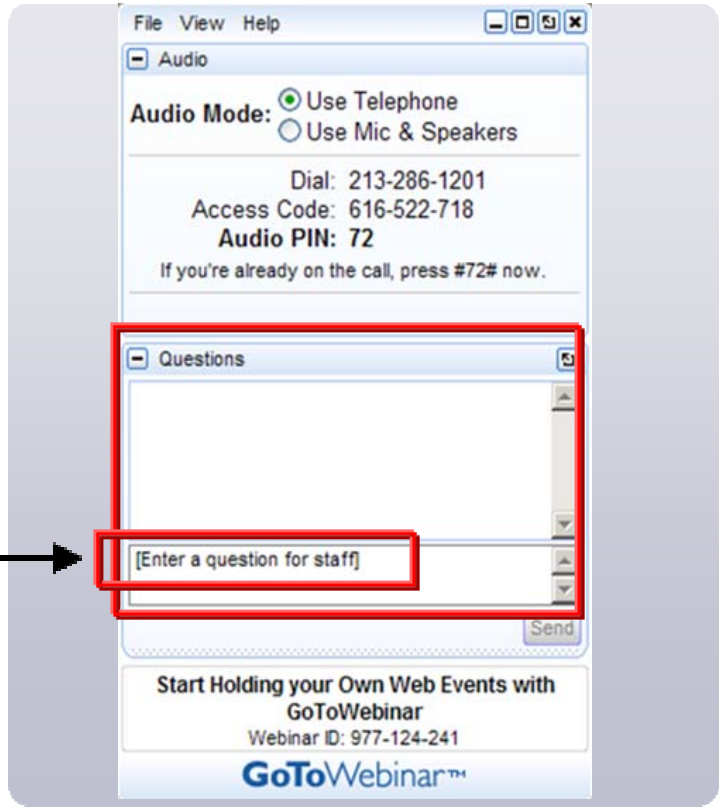

Sharon Howlett
Provincial Lead- Health Links and Telemedicine Nursing,

OTN & Health Links:

Utilizing eVisits for Care Conferences

- **OTN eVisits:**
  - Room-based videoconferencing
  - OTN Connect (personal videoconferencing and mobile videoconferencing)
  - OTN Invite (personal videoconferencing and a secure link)

OTN & Health Links:

Utilizing eVisits for Care Conferences

Care. Connected.

OTN & Health Links:

Utilizing eVisits for Care Conferences

KEY BENEFITS:

- ✓ Enables you to bring care ***to*** **the patient** instead of bringing the patient to care
- ✓ Eliminates costly and time-consuming travel
- ✓ Makes scheduling a case conference, **easier** and **faster**
- ✓ **increases** your **capacity** to provide coordinated, effective care for patients
- ✓ empowers a **more efficient** Health Link

OTN & Health Links:

Utilizing eVisits for Care Conferences

Care. Connected.

Telemedicine Enabled Health Links: An Innovative Solution to Coordinated Care.

Toronto Central LHIN's Telemedicine IMPACT Plus Model of Care

How telemedicine is used to increase collaboration between patients, their family physician and specialists to deliver high quality patient-centred care in the right place, at the right time.

On May 13 2015, Mackenzie Health's Chronic Kidney Disease program completed their first remote specialist consult with an elderly patient identified by **Southwest York Region Health Link**, living in the Maple Community. A 92 year old patient living in a retirement home who, for the last 14 years since the passing of his wife, the patient has relied on the time and effort of his family members and caregivers to get him to his appointments. A fifteen minute appointment with his Nephrology specialist would typically take six hours of preparation requiring family members to take time off work l, long commutes and in-house wait time that would leave the patient and caregiver exhausted.

HealthLink
Southwest York Region
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OTN & Health Links:

Utilizing eVisits for Care Conferences

For more information:

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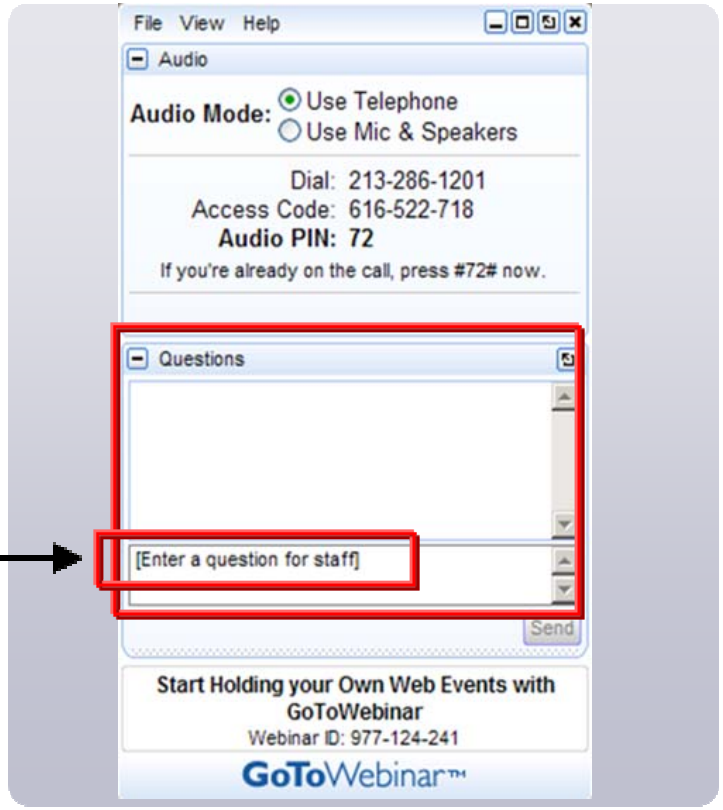

HEALTH LINK COMMUNITY OF PRACTICE:
WEBINAR SERIES

Topic	Date
Webinar 1: CCP – Identify the Patient	Wednesday September 9, 2015
Webinar 2: CCP – Engage the Patient	Tuesday September 22, 2015
Webinar 3: CCP – Initial Interview	Wednesday October 7, 2015
Webinar 4: CCP – Care Conference	DATE CHANGE: Tuesday October 20, 2015 DURATION: *1.5 hours*
Webinar 5: CCP - Maintenance and Transitions	**Tuesday November 10, 2015**

REGIONAL QUALITY IMPROVEMENT TEAMS

Region/LHINs	QI Specialists	Email address	Telephone number
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	Julie Nicholls	Julie.Nicholls@hqontario.ca	519-502-5164
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LHINs: MH, CW, TC, Central	Kamal Babrah	Kamal.Babrah@hqontario.ca	416-571-7668
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	vacancy		
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	Jennifer Wraight	Jennifer.Wraight@hqontario.ca	647-237-0098
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