HEALTH LINKS

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

STEP TWO:

Engaging the Patient in Care Coordination and Obtaining Consent to Share Information with the Health Links Care Team

September 22, 2015

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

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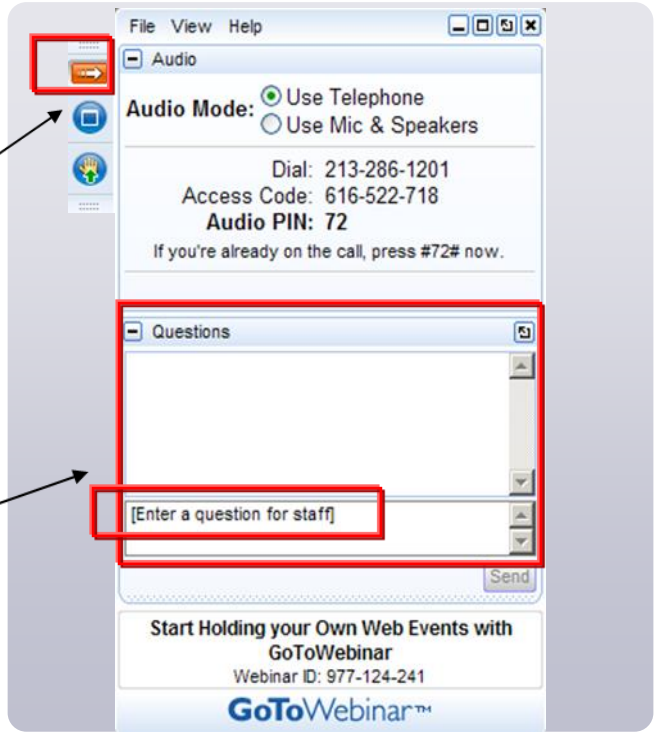
PARTICIPATING IN THE WEBINAR

- 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.



WEBINAR PANEL

HEALTH QUALITY ONTARIO (HQO)

- **Sandie Seaman,** *Manager, QI and Spread*
- **Kamal Babrah**, *Quality Improvement Specialist, QI and Spread*

GUEST PANELISTS

- **Craig Robinson**, *Senior Manager, LHIN Initiatives at Central East CCAC, Central East LHIN*
- **Shelley Kapitan**, *Project Manager South Georgian Bay Health Link, North Simcoe Muskoka LHIN*
- **Emily Rashotte**, *HL Care Coordinator, Rural Hastings Health Link, South East LHIN*

WEBINAR OBJECTIVES

Purpose

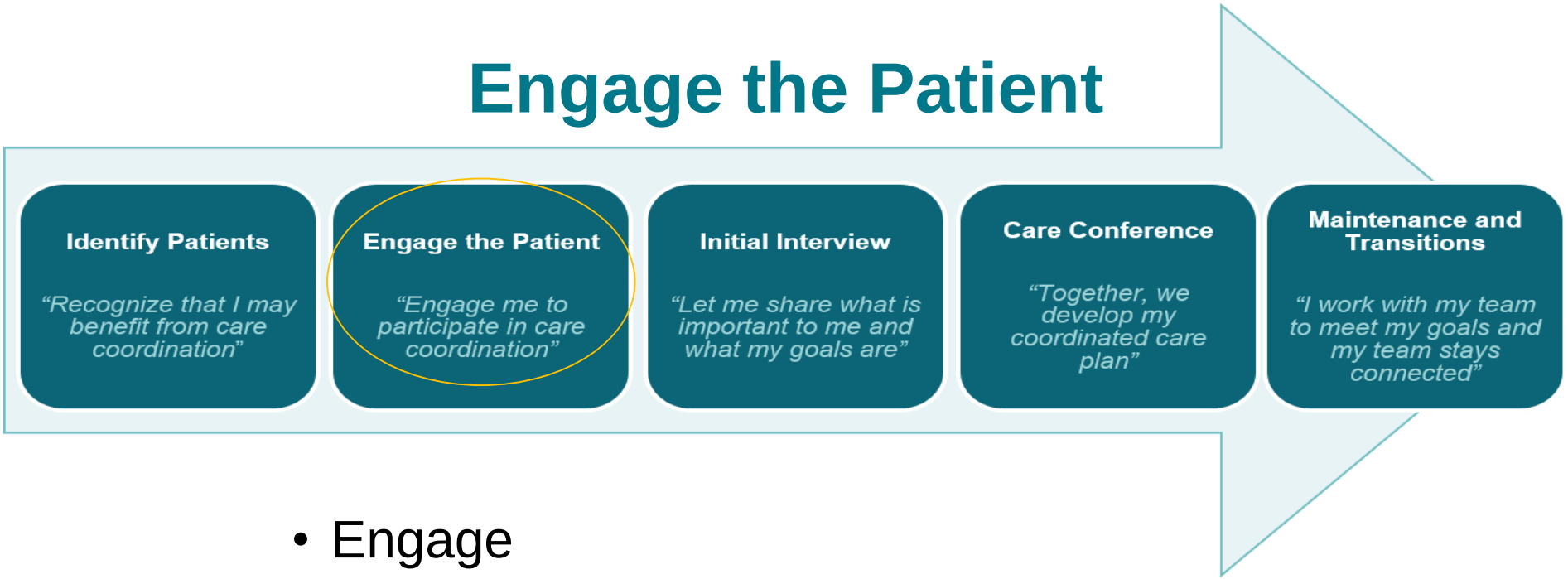
To review the current provincial landscape for Health Links as it relates to best practices and innovations in Care Coordination, and to facilitate Health Link to Health Link learning and discussion.

Specifically, this webinar will aim to:

To provide the opportunity to share and learn from one another:

- **Health Links processes of engaging the patient in care coordination**
- **The process of obtaining consent for Health Link partners and the circle of care to share information and data**

Engage the Patient



- Engage
- Obtain consent
- Outline next steps: Arrange initial interview

Engage the Patient

Considerations:

1. Patients are more likely to participate in care planning if approached by a health care provider with whom they have a positive relationship

2. If it is not possible to involve someone the patient knows, a warm handoff can increase the likelihood that the patient will be interested in the process

3. Use a script or elevator speech to ensure that your message is clear

4. Be clear about the purpose of Health Links
   a) Develop a letter or brochure targeting patient/families
   b) Provide similar information for the health and social support partners

5. Obtain consent to share information amongst the circle of care at the beginning of the process i.e., when inviting the patient to participate

Ineffective Practice: Cold calling a patient

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South Georgian Bay Community Health Link

Shelley Kapitan, *Project Manager*

About SGBC Health Link

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Serves Collingwood, Wasaga Beach, Clearview, Stayner in NSM LHIN
Early adopter under way in September 2013

Strategy:

- Build upon existing collaboration amongst local community leadership
- Build for scalability: multi-navigator approach
- Find ways to engage as many local providers as possible for most creative solutions
  - participation built into the collaborative process

Approach:

- Work with high-users as they present, not via 'bulk' data analysis identification
- Initial PDSA cycles with one navigator (from NSM CCAC) and patients of Physician Lead
- First scaling up in January 2014 (family physician referrals and navigators from GBFHT and NSM CCAC)
  - Referrals received, assigned and tracked by Health Link Coordinator
- Next level of scaling up currently under way (multiple navigators, multiple referral sources)

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The invitation is currently made by:

1) Family physicians – in person
2) CCAC – in person plus handout
3) Hospital ED/inpatient – printed brochure-style invitation

Scaling up:

1) Other health providers and other community providers e.g. Housing)
2) Self-referrals and other Health Links

Coming soon:

1) EMS referrals

Some learnings to date:

1) Can take a number of discussions to build the trust before patient is comfortable with moving forward
2) Big variation in how well Health Link is explained to patients

- Adopted a two stage process: invitation to learn more issued by referrer followed by navigator visit(s) to explain, build trust and gain written consent

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Navigator is assigned :

1. 'Most responsible' provider organization provides the navigator
2. Currently have navigators from : CCAC; FHT; CHC; Hospice and CSS
3. Navigator explains the Health Link in detail at initial visit and gathers signed consent after making sure the patient fully understands the sharing of the information, with health and other community providers

Some learnings to date:

1. Early Privacy framework initiative with comprehensive DSA allowed navigators to feel secure in sharing information
2. Patients have not been reluctant to consent to sharing of information
3. Patients have still refused Health Link
   - Some ED high-users prefer to use ED

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Thank you!

South Georgian Bay Community Health Link contact:

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Health Link Project Manager
Georgian Bay Family Health Team

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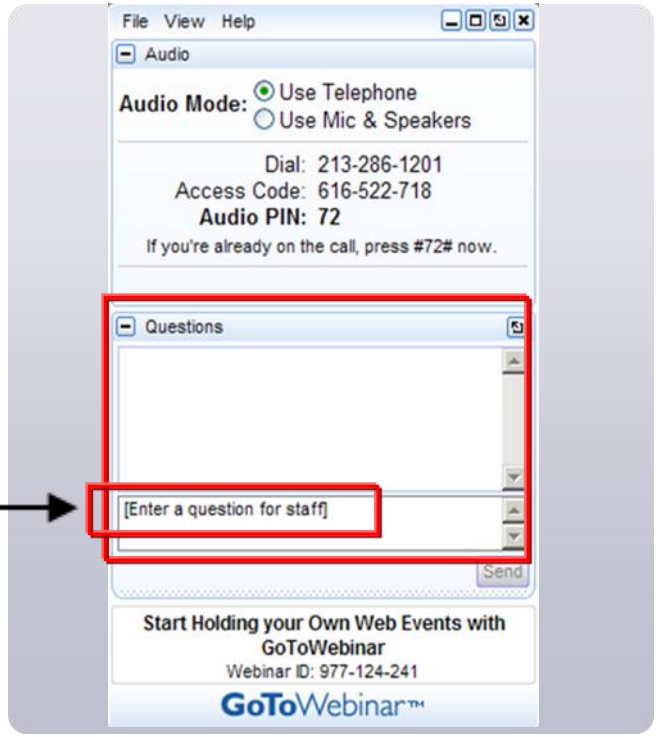
Question Period

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



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Rural Hastings Health Link

Emily Rashotte, HL Care Coordinator

Principles of the Rural Hastings Health Link

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✓**One point of contact for the patient's care team -** The conduit between Primary Care Practitioners and the broader health sector partners participating in the patient's plan of care.

✓**Gain Consent & Establish Coordinated Care Plan –** Capture the patient/family voice in establishing their plan of care.

✓**Build close relationships with patients, their families and caregivers –** Primary contact for patients.

✓**Monitor the Coordinated Care Plan and exchange information with the care team -** Timely communication back to Primary Care Practitioner on status of the patients coordinated care plan and medical plan of care.

System Navigators: Engaging Patients in Care Coordination

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Engaging Patient:

- ✓ System Navigator meets with physician to review concerns and medical plan of care
- ✓ Facilitate meeting between patient, and system navigator.
- ✓ Gain consent from patient and develop coordinated care plan

Care Planning:

- ✓ *Assessment:* Nursing clinical assessment, Identify existing care team, Identify socio-economic barriers, Patient Safety, Engage physicians and client in establishing patient goals, Link patient goals with medical plan of care, Advocates on behalf of patient and family, Integrate patient social support network into plan of care
- ✓ *Patient Voice:* Shifting the conversation between the provider and patient, Capturing the patient/family voice in establishing their plan of care, Integrating patient goals into care and treatment options, Empowering patient to play an active role in their plan of care and expected outcomes, Listening and responding to patient feedback

Transitions in Care:

- ✓ Follow up with all complex patients 7 days post hospitalization
- ✓ Right service – right time – include organizational referral contacts in CCP and EMR
- ✓ Connectivity – acts as a liaison between transitional points of care – family, primary care and service supports
- ✓ Working within a system framework between organizations
- ✓ Single point of contact for primary care
- ✓ Monitor interruptions in care of treatment

Engaging Patients: Patient Engagement, in Working Groups & Committees

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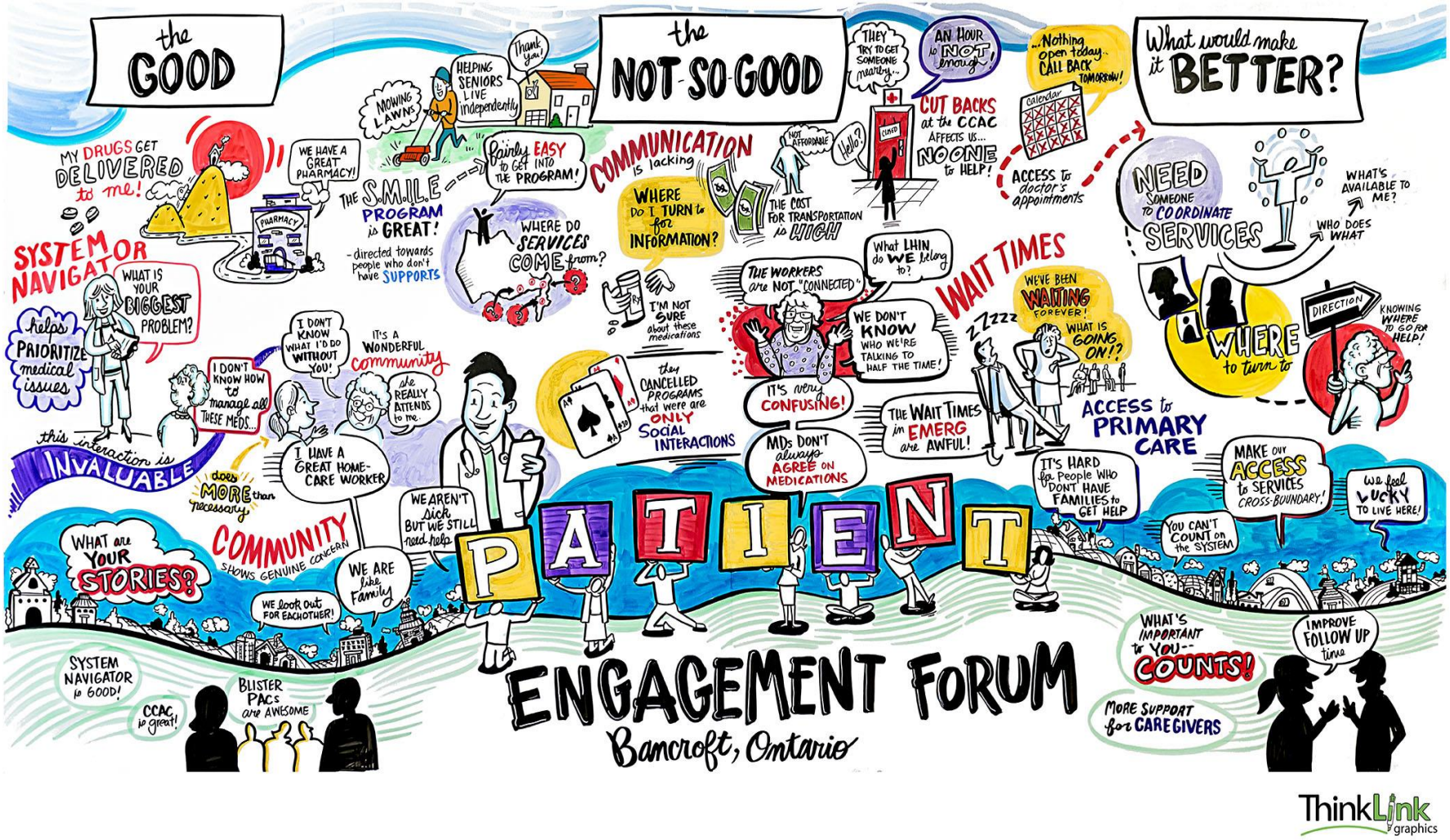

ThinkLink graphics

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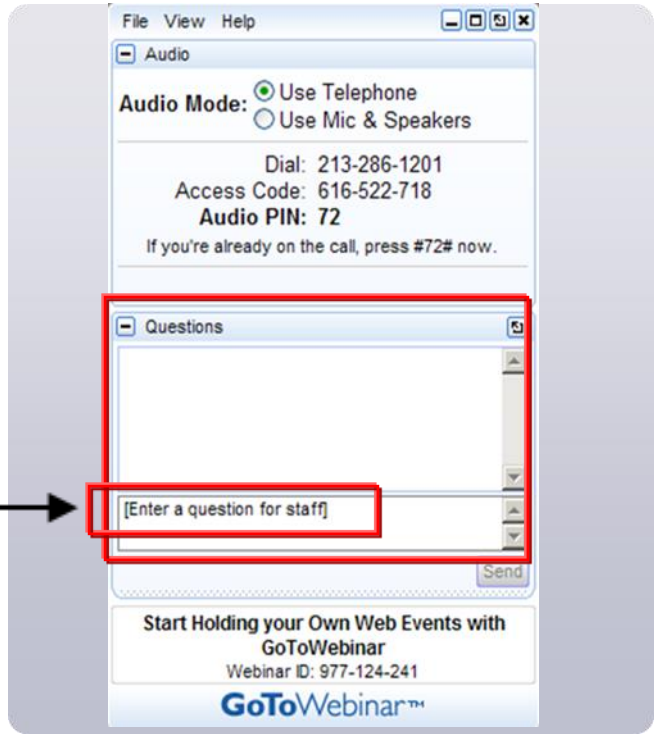

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Central East LHIN Health Links

Craig Robinson, Senior Manager,
LHIN Initiatives at Central East CCAC

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'Engaging the Patient';
CE LHIN Processes and Practices

1) The Development of the Consent Form
2) Roles and Responsibilities for Engaging the Patient in CE Health Links.
3) Resources used to support the process

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Factors that led to the development of the consent form

- Initially, consent process was driven by the need to gather and share patient stories for the purpose of business planning. Evolved into coordinated care plan consent process.
- Adapted a consent form that one of our partners had developed for client consent that involved multiple health service providers.
- Needed to meet the needs of multiple organizations, conforming with their business processes and being vetted by multiple privacy officers.

Stages of Development

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High level steps in the development of a consent

form that met needs of all stakeholders

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PHL Consent and Information Sheet

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Peterborough Health Link – Coordinated Care Plan Information Sheet

What is Peterborough HealthLink?

The Province of Ontario has created *Health Links* to improve co-ordination of care for seniors and people with complex conditions. *Health Links* are part of the government's Action Plan for Health Care, which is based on providing the right care, at the right time, in the right place.

The Peterborough *Health Link* is one of 19 across the province to be initially rolled out. This new *Health Link* will encourage greater collaboration and co-ordination between a patient's different health care providers as well as the development of personalized care plans. This will help improve patient transitions within the system and help ensure patients receive mo
care that addresses their specific needs with the support of a tightly knit team of p

The Peterborough *Health Link* is an initiative of the Central East Local Health Int
Network (Central East LHIN) and is being coordinated by the Central East Comm
Access Centre. It also includes representatives from a number of health care pr
community agencies (Canadian Mental Health Association – Haliburton Kawart
Branch, Central East Community Care Access Centre, FourCAST, Peterborou
Social Services, Peterborough Network of Family Health Teams, Peterborough
Centre, Victorian Order of Nurses, 360 Degree Nurse Practitioner Led Clinic, V
Nurses Peterborough, Victoria & Haliburton, St. John's Centre Retirement Ho

The goal of Peterborough *Health Link* is to measure results and develop plan
access to family care, reduce avoidable Emergency Room visits and re-adm
reduce referral time to specialists, and improve the patient's overall experie
health care system.

Peterborough Health Link – Coordinated Care Plan

With a goal of improved care the Peterborough Health Link partners are w
develop Integrated Individualized Care Plans. These care plans support
outcomes by allowing patients, with assistance and/or recommendations
providers, to set goals that identify and address your health care needs.

You have been identified by one of your current care providers as meet
patient group. To this end, you are being asked to participate in the dev
Integrated Individualized Care Plan and share your health information
Peterborough Health Link.

Your participation is entirely voluntary and you may choose to withdra
Participation will not impact in any way upon the care and treatment
the health care providers.

Developing an Integrated Individualized Care Plan

You are being asked to consent to the collection, use and disclosu
health information as follows:

Peterborough Health Link Coordinated Care Plan Initiative
Multi-Agency Consent for the Collection, Use and Disclosure of Personal Health Information

I, _____ (print full name of patient or substitute decision maker),

Of _____ (address) hereby authorize

_____ (name of agency) to

☐ Release to and/or ☐ Request the personal health information of

_____ (name of patient and date of birth), from the following Peterborough Health Link agencies:

Agency	Consent Given (initial each agency for which consent is given)
Canadian Mental Health Association – HKPR	
Central East Community Care Access Centre	
Four Counties Addiction Services Team	
Peterborough Network of Family Health Teams	
Peterborough Regional Health Centre	
VON 360 Nurse Practitioner Led Team	
Peterborough County-City Social Services	
Community Care Peterborough	

The personal health information exchanged will be limited to only what is required for the community agency to provide care and services:

- Physical health treatment I/the patient have received
- Diagnosis and/or assessment of medical conditions
- Psychiatric and/or psychological diagnosis/assessment
- Mental health assessment and treatment I/the patient have received
- Substance Abuse assessment and treatment I/the patient have received
- My/the patient's history of using the health care system as documented by the providers authorized above

nd that the identified health service providers noted above will use my/the patient's ealth information to develop an integrated individualized care plan. I understand atient will be consulted during the development of this plan.

f the identified service providers will share information about me/the patient, ecessary for them to plan, provide and evaluate the services that I/the requested and/or received.

hat this consent is valid as long as I/the patient am participating with Health Link, and use of my/the patient's personal health information beyond will require my additional consent. By signing this form I do not waive any ts.

y personal health information collected as part of the *Peterborough Health* ndividualized Care Plan initiative will be held in confidence and maintained dance with Personal Health Protection Act (PHIPA) by the participating or the CECCAC project office.

ty/the patient's personal health information will only be shared for the g my/the patient's care and improving the health care system; and all nonymized for the purposes of evaluating services.

ay refuse to provide my consent or that I can withdraw my consent at g the primary provider. I understand also that there will be no he patient's personal health information for research purposes without

Substitute Decision Maker* _____ Date _____

Witness _____ Date _____

decision maker is a person authorized under PHIPA to consent, on behalf of the to the collection, use or disclose of personal health information about

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Roles and Responsibilities; Engaging the Patient

- Shared care model (multiple providers, within multiple organizations/ programs will lead patient through the FULL CCP process (with only few exceptions)
- Provider who identifies patient, also engages patient, and obtains, stores consent form
- Benefit for patient is continuity with provider

Challenges and Considerations

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- Length of the form can be troublesome for patients with complex issues seen via Health Links
- Literacy level; difficult to meet accepted reading requirements, yet meet the needs of legislation and privacy policies
- Communication to all stakeholders that consent has been obtained and information can be shared requires processes
- Storage of the consent form must be determined and agreed up by multiple organizations and providers
- Health Information Custodians and non-Health Information Custodians
- Adapting Consent to reflect an electronic sharing environment

Lessons Learned

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- Engage privacy experts early with the process, not after the fact
- Clearly define and understand interpretations of privacy and consent; there may be varying expectations, requirements, policies, etc.
- Ensure that there is foundational knowledge relating to PHIPA, Circle of Care, Expressed vs. Written vs. Implied consent, professional regulations/obligations, etc.
- Processes for obtaining and storing consent must be clearly communicated to all providers within partner organizations.

Communication, Education and Training are vital for success…

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Resources to Aid Engage/ Consent Process

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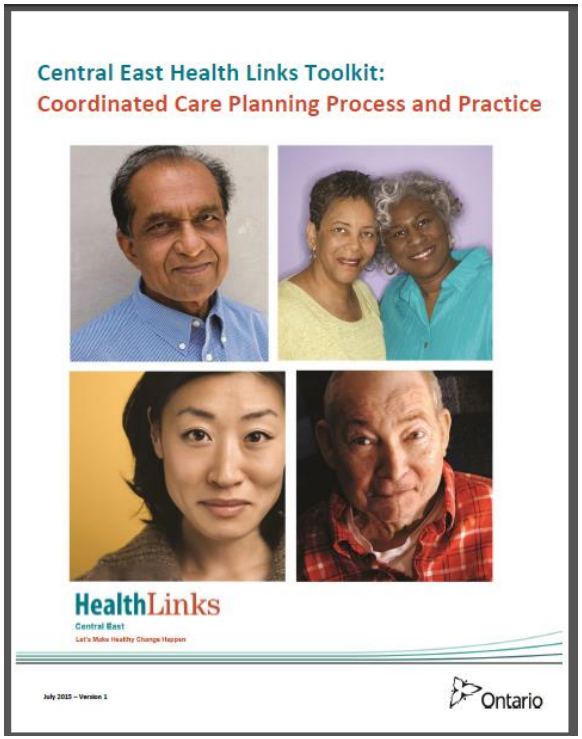

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Resources to Aid Engage/Consent Process

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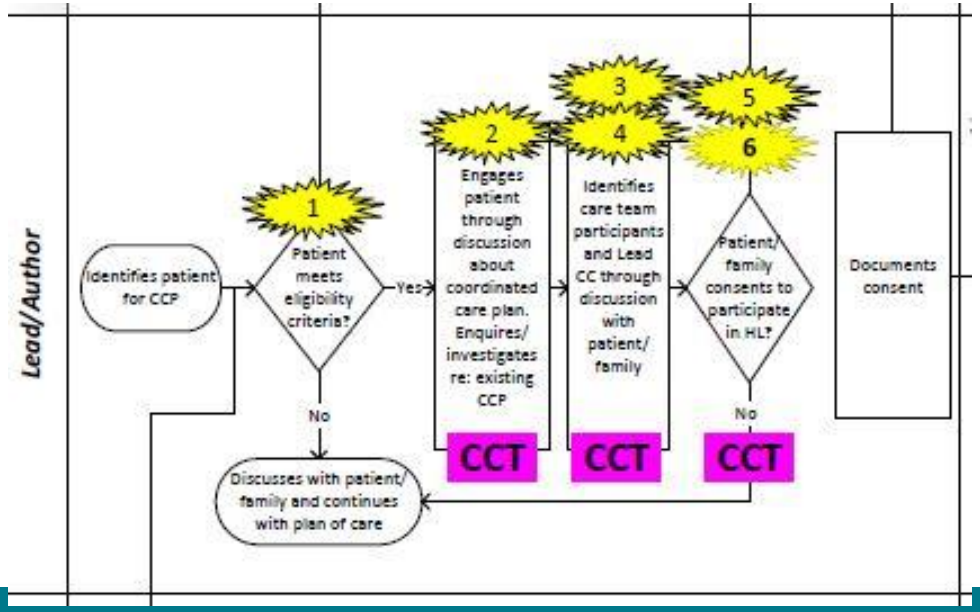
- Develop clear Process Maps
- Create "Business Rules" that can be referenced and provide guidance



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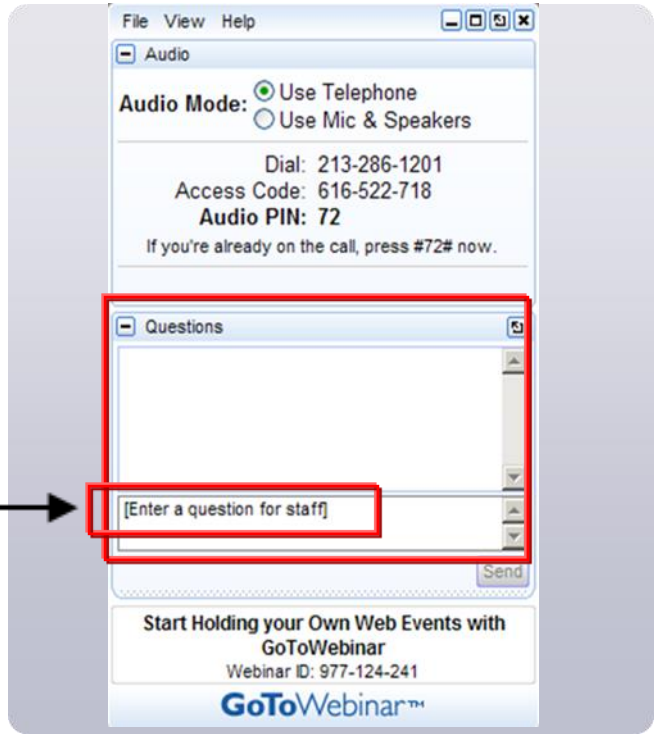

HEALTH LINK COMMUNITY OF PRACTICE:
WEBINAR SERIES

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	**Wednesday October 21, 2015**
Webinar 5: CCP - Maintenance and Transitions	**Tuesday November 10, 2015**

AND ALSO…

Health Quality Transformation, Health Links Lunch and Learn Abstract Session	Wednesday October 14, 2015

Health Quality Transformation 2015

Partnering to accelerate best care, best health, best value

October 14, 2015

Metro Toronto Convention Centre- South Building

REGISTRATION IS NOW OPEN

www.hqontario.ca

Lunch and Learn Session:

'Improving Care for Patients With Complex Conditions'

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