Coordinated Care Management

Interview and Initiate Coordinated Care Plan: Implement the "Patients as Partners" Bundle

Released June 2016

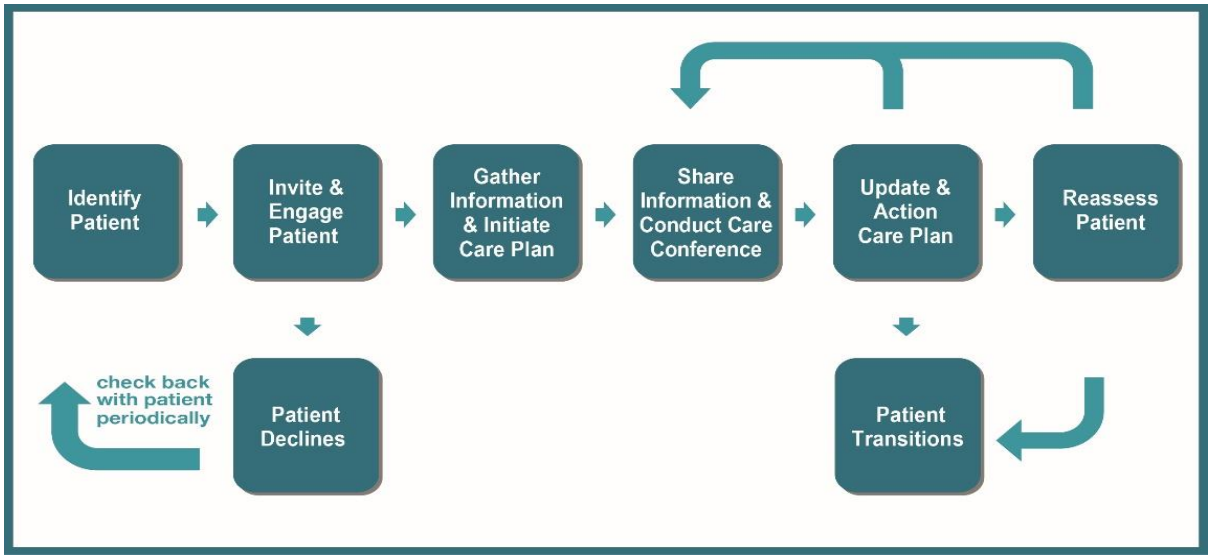

Figure 1: Approach to Coordinated Care Management

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[1]	Clinical Reference Group Endorsement for Spread
Implement the "Patients as Partners" Bundle with all patients in the Health Link, including: 1. Conducting the patient interview in the patient's preferred location; 2. Eliciting the patient story, aspirations, and goals from his/her perspective, using a person-centred interviewing approach; *AND*	EMERGING	Provincial spread with reassessment using the Innovative Practices Evaluation Framework in 1 year (June 2017).

[1] *For more information about the Innovative Practices Evaluation Framework assessments, please go to the following link: http://www.hqontario.ca/Portals/0/documents/qi/health-links/innovative-practices-evaluation-framework-overview-en.pdf*

The material for Coordinated Care Management was developed in collaboration with Health Links and the Clinical Reference Group.

3. Partnering with the patient to identify which organizations or disciplines will be members of their care team.		

The Single Point of Contact refers to the provider/carer who serves as the patient's primary contact regarding the services in their Coordinated Care Plan. This person supports the patient in the Coordinated Care Planning process and in the development and implementation of the Coordinated Care Plan.

Implementation		
Steps for Implementation	**Tools and Resources**	**Additional Enablers**
1) Engage the patient in determining their preferred location for the interview, and support the arrangements, as indicated. 2) Use a person-centred interviewing approach to elicit the patient story, values, and goals. 3) Collaborate with the patient to identify members of the care team (may include non-health care professionals, at patient's discretion), and to make decisions regarding the care conference, where indicated. 4) Provide the patient with a copy of the plan once the Coordinated Care Plan is complete (or during development, if requested).	• **"Engaging the Patient in Care Coordination and Obtaining Consent to Share Information with the Health Links Care Team"** (Health Quality Ontario Webinar; September 22, 2015). Available at: ***http://www.hqontario.ca/portals/0/documents/qi/health-links/ccp-webinar-step-2-en.pdf*** **"Interviewing the Patient"** (Health Quality Ontario Webinar; October 7, 2015). Available at: ***http://www.hqontario.ca/portals/0/documents/qi/health-links/ccp-webinar-step-3-en.pdf*** • **"The Care Conference"** (Health Quality Ontario Webinar; October 20, 2015). Available at: ***http://www.hqontario.ca/portals/0/documents/qi/health-links/ccp-webinar-step-4-en.pdf*** • **Central East Health Links Toolkit; Coordinated Care Planning**. Available at: ***http://healthcareathome.ca/centraleast/en/who/Documents/Health_Links/toolkit/CEHealthLinks-Toolkit-V2.pdf*** • **Planning Your Care Patient Workbook**. North East Toronto Health Link. Available at: ***http://sunnybrook.ca/uploads/1/welcome/about/netl/150610_planning_your_care_patient_workbook.pdf***	• Decisions regarding engaging patients as partners must reflect the regional approach. • Health Link partners are encouraged to work collaboratively to develop standard work flow processes. • Health Links are also encouraged to solicit patient engagement when planning for implementation of the patients as partners bundle. *For additional information about Patient Engagement, please visit:* ***http://www.hqontario.ca/Engaging-Patients***

Measurement

Quality Improvement Measures are used to help with monitoring progress in implementation 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.

Suggested Measures ***(please see Appendix B for additional details)***		
Suggested Outcome Measure	**Suggested Process Measures**	**Additional Information**
% of patients who report that they agree or strongly agree with the following statements: • *"Patient interview took place in my preferred location";* • *"Goals in my care plan were developed with me, and reflect what is important to me";* • *"I feel the decision about who is on my care team was ultimately mine."*	% of patients who received a copy of their Coordinated Care Plan % of patients interviewed for purposes of initiating a care plan, where there is documented evidence of: a) Conducting the patient interview in the patient's preferred location; b) Eliciting the patient story, aspirations, and goals from his/her perspective, using a person-centred interviewing approach; *AND* c) Partnering with the patient to identify which organizations or disciplines will be members of their care team.	• Recommend that Health Links collect and report data for a minimum of 3 months. • QI RAP templates will be available if the Health Link chooses to use them. • All patients who are receiving care through the Health Link are included in the sample.

References:

- Ministry of Health and Long-Term Care. Guide to the Advanced Health Links Model [Internet]. Ontario: Ministry of Health and Long-Term Care [cited 2016 May]. Available from: *http://www.health.gov.on.ca/en/pro/programs/transformation/docs/Guide-to-the-Advanced-Health-Links-Model.pdf*

Appendix A:
Measurement Specifications for Patients as Partners Bundle Innovative Practice

Released June 2016

Percentage of patients who reported satisfaction with "Patients as Partners" bundle

Step for Coordinated Care Management	**Interview and Initiate Coordinated Care Plan**
Innovative Practice	Implement the "Patients as Partners" bundle with all patients in the Health Link.
Measure	% of patients who report that they agree or strongly agree with the following statements: • *"Patient interview took place in my preferred location";* • *"Goals in my care plan were developed with me, and reflect what is important to me";* • *"I feel the decision about who is on my care team was ultimately mine."*
Type	Outcome Measure
Definition/Description	Engaging "patients as partners" is central to the overall focus on person-centred care, patient engagement, and improved patient experience within Heath Links. It is fundamental that patients are accepted as partners in their care and throughout the coordinated care planning process. When patients are partners, they actively establish priorities, participate in planning, implement and evaluate the plan of care, identify key members of their care team, and determine next steps. The coordinated plan of care is one that represents the patient's aspirations and needs. <u>Steps for Implementation</u>: 1) Engage the patient in determining their preferred location for the interview, and support the arrangements, as indicated. 2) Use a person-centred interviewing approach to elicit the patient story, values, and goals. 3) Collaborate with the patient to identify members of the care team (may include non-health care professionals, at patient's discretion), and to make decisions regarding the care conference, where indicated. 4) Provide the patient with a copy of the plan once the Coordinated Care Plan is complete (or during development, if requested). Dimensions: Effective, Equitable, Safe, Patient-Centred Direction of Improvement: ↑
Additional Specifications	<u>Numerator #1</u>: Total number of patients who answered "Agree" and "Strongly agree" to the statement *"Patient interview took place in my preferred location."* <u>Denominator#1</u> : Total number of patients interviewed <u>Numerator #2</u>: Total number of patients who answered "Agree" and "Strongly agree" to the statement *"Goals in my care plan were developed with me, and reflect what is important to me."*

	Denominator#2 : Total number of patients interviewed Numerator #3: Total number of patients who answered “Agree” and “Strongly agree” to the statement “I feel the decision about who is on my care team was ultimately mine.” Denominator#3 : Total number of patients interviewed Exclusion Criteria: Patients who meet the criteria but who are not offered access to the Health Link because they have moved beyond Health Link catchment area, or have died.
Reporting Period	Recommend that Health Links collect and review weekly data for a minimum of 3 months. QI RAP templates will be available if the Health Link chooses to use them.
Data Source	Patient survey; Manual data collection by participating primary care, hospital and community care providers within the Health Link.
Sampling Plan	All patients who are receiving care through the Health Link are included in the sample.
Comments	Selected outcome measures will help to evaluate the impact of the efforts to introduce innovative practices into coordinated care management.

Percentage of patients who received a copy of their Coordinated Care Plan

Step for Coordinated Care Management	**Interview and Initiate Coordinated Care Plan**
Innovative Practice	Implement the "Patients as Partners" Bundle with all patients in the Health Link.
Measure	% of patients who received a copy of their Coordinated Care Plan
Type	Process Measure
Definition/Description	Engaging "patients as partners" is central to the overall focus on person-centred care, patient engagement, and improved patient experience within Heath Links. It is fundamental that patients are accepted as partners in their care and throughout the coordinated care planning process. When patients are partners, they actively establish priorities, participate in planning, implement and evaluate the plan of care, identify key members of their care team, and determine next steps. The coordinated plan of care is one that represents the patient's aspirations and needs. Steps for Implementation: 1) Engage the patient in determining their preferred location for the interview, and support the arrangements, as indicated. 2) Use a person-centred interviewing approach to elicit the patient story, values, and goals. 3) Collaborate with the patient to identify members of the care team (may include non-health care professionals, at patient's discretion), and to make decisions regarding the care conference, where indicated. 4) Provide the patient with a copy of the plan once the Coordinated Care Plan is complete (or during development, if requested). Dimensions: Effective, Equitable, Safe, Patient-Centred Direction of Improvement: ↑
Additional Specifications	Numerator: Total number of patients who report that they received a copy of their coordinated care plan Denominator: Total number of coordinated care plans completed Exclusion Criteria: Patients who meet the criteria but who are not offered access to the Health Link because they have moved beyond Health Link catchment area, or have died.
Reporting Period	Recommend that Health Links collect and review weekly data for a minimum of 3 months. QI RAP templates will be available if the Health Link chooses to use them.
Data Source	Patient survey; Manual data collection by participating primary care, hospital and community care providers within the Health Link.
Sampling Plan	All patients who are receiving care through the Health Link are included in the sample.
Comments	• Selected Process Measures is to help Health Links draw on the fields of Improvement Science and Implementation Science as they are implementing these practices. • Process Measures are used to assess: 1. Progress in implementation components such as reach (how often the practice is being used); 2. Adherence (fidelity) to the specifications of the steps that must be in place for a program or practice to operate; and 3. Sustainability of the process as designed so that it will continue once the initial attention has waned.

Percentage of patients interviewed for purposes of initiating a care plan

Step for Coordinated Care Management	**Interview and Initiate Coordinated Care Plan**
Innovative Practice	Implement the "Patients as Partners" Bundle with all patients in the Health Link.
Measure	% of patients interviewed for purposes of initiating a care plan, where there is documented evidence of: a. Conducting the patient interview in the patient's preferred location; b. Eliciting the patient story, aspirations, and goals from his/her perspective, using a person-centred interviewing approach; AND c. Partnering with the patient to identify which organizations or disciplines will be members of their care team.
Type	Process Measure
Definition/Description	Engaging "patients as partners" is central to the overall focus on person-centred care, patient engagement, and improved patient experience within Heath Links. It is fundamental that patients are accepted as partners in their care and throughout the coordinated care planning process. <u>Steps for Implementation</u>: 1) Engage the patient in determining their preferred location for the interview, and support the arrangements, as indicated. 2) Use a person-centred interviewing approach to elicit the patient story, values, and goals. 3) Collaborate with the patient to identify members of the care team (may include non-health care professionals, at patient's discretion), and to make decisions regarding the care conference, where indicated. 4) Provide the patient with a copy of the plan once the Coordinated Care Plan is complete (or during development, if requested). When patients are partners, they actively establish priorities, participate in planning, implement and evaluate the plan of care, identify key members of their care team, and determine next steps. The coordinated plan of care is one that represents the patient's aspirations and needs. Dimensions: Effective, Equitable, Safe, Patient-Centred Direction of Improvement: ↑
Additional Specifications	<u>Numerator</u>: Number of times there is documented evidence of "Patients as Partners" bundle used in the process of coordinated care plan <u>Denominator</u>: Total number of coordinated care plans completed <u>Exclusion Criteria</u>: Patients who meet the criteria but who are not offered access to the Health Link because they have moved beyond Health Link catchment area, or have died.
Reporting Period	Recommend that Health Links collect and report data for a minimum of 3 months. QI RAP templates will be available if the Health Link chooses to use them.
Data Source	Existing source in the organization—Health record
Sampling Plan	All patients who are receiving care through the Health Link are included in the sample.
Comments	• Selected Process Measures is to help Health Links draw on the fields of Improvement Science and Implementation Science as they are implementing these practices. • Process Measures are used to assess: 1. Progress in implementation components such as reach (how often the practice is being used); 2. Adherence (fidelity) to the specifications of the steps that must be in place for a program or practice to operate; and 3. Sustainability of the process as designed so that it will continue once the initial attention has waned.