Coordinated Care Management

Invite and Engage: Use Person-Centred Communication Strategies

Released June 2016

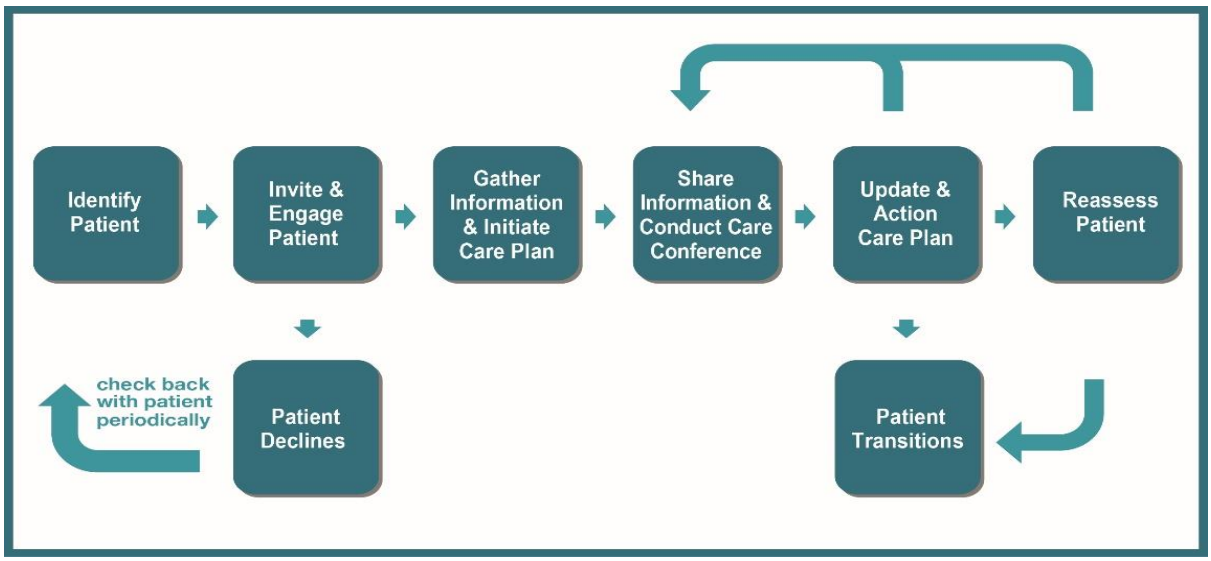

Figure 1: Approach to Coordinated Care Management

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[1]	Clinical Reference Group Endorsement for Spread
Use person-centred communication strategies to invite and engage the patient in coordinating their care with the Health Links team.	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.

Implementation		
Steps for Implementation	**Tools and Resources**	**Additional Enablers**
1. Determine the most appropriate person to extend the invitation. When a patient has been identified as someone who may benefit from Coordinated Care Management, it is recommended that *rapport* is established with the patient *prior* to extending the invitation: **a) Preferred Option:** the person with whom the patient has an *existing* relationship. **b) Alternative Option 1:** the person who is likely to develop an ongoing relationship works to establish rapport, then extends the invitation. **c) Alternate Option 2**: where neither a nor b are possible, the person inviting the patient should work to establish some degree of rapport prior to extending the invitation. **Ineffective:** a person without a relationship, and without first establishing rapport, extends the invitation without follow up. ***2. Extend the invitation***. The invitation may be extended in person, or by telephone. Where appropriate processes exist, the most appropriate method of extending the invitation is by the patient's preferred communication method (in person, telephone, email, text, etc.).	• **Patient Invitation Decision Support Tool** *(please refer to Appendix A)* • **"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*** • **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 and extending the invitation must reflect the regional approach. Health Link partners are encouraged to work collaboratively to develop standard work flow processes.

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 statement: *"I feel that the invitation to participate in Health Links was completed in a way that allowed me to clearly understand what was being offered to me."*	% of patients who report that the invitation is extended to them by someone with whom they have an existing relationship or will potentially develop an ongoing relationship with % of patients who report that consistent messaging and/or resources are being used when inviting patients to participate in Health Links/Coordinated Care Management	• 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:
Patient Invitation Decision Support Tool

Released June 2016

How is this decision support tool used?

This tool was designed to support Health Links and Providers within the Health Link to implement the practice of **extending person-centred invitations** to participate in Health Links/Coordinated Care Management. This tool is intended to **support (not replace) operational and clinical decision making** in the Health Link and in inviting patients to participate in Coordinated Care Management, and must be considered alongside with other contextually relevant information (such as established best practices relating to patient transitions, etc.).

Who should extend the invitation to the patient?

The following process was develop to demonstrate what the decision making process ***may*** look like when determining who should extend the invitation to participate in Health Links/Coordinated Care Management. It is for demonstrative purposes only, and can be adapted to regional processes and practices.

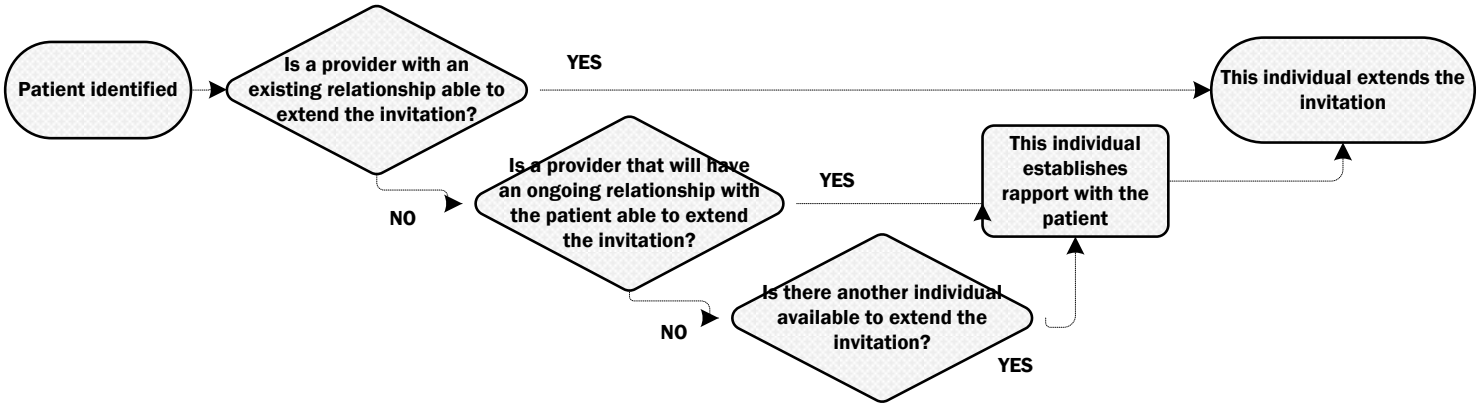

Figure 2: Decision Making Process for Person-Centred Invitation

How might a provider/carer approach extending the invitation?

The invitation may be extended **in person, or by telephone**. Where appropriate processes exist, the most appropriate method of extending the invitation is by the **patient's preferred communication method** (in person, telephone, email, text, etc.). The provider/ organization must ensure that selected method of communication meets **all associated requirements (legislation, regulatory, etc.).**

When extending the invitation, it is suggested that one uses standardized, consistent messaging and/or resources that include **adequate information** for the patient to understand Health Links and Coordinated Care Management, **while not overwhelming the patient with information**. For example, some Health Links have developed key messages, scripts, patient pamphlets, etc., to support individuals to extend the invitation to Health Links. Samples can be found in the Central East Health Links Toolkit; Coordinated Care Planning. Available at: ***http://healthcareathome.ca/centraleast/en/who/Documents/Health_Links/toolkit/CEHealthLinks-Toolkit-V2.pdf***

Are there any examples of how Health Links have implemented person-centred communication strategies to invite and engage the patient in coordinating their care with the Health Links team?

Health Quality Ontario supported a webinar presentation entitled "Engaging the Patient in Care Coordination and Obtaining Consent to Share Information with the Health Links Care Team" on September 22, 2015. *To view a recording of this webinar presentation, please visit* ***www.hqontario.ca/portals/0/documents/qi/health-links/ccp-webinar-step-2-en.pdf****.* One example of the implementation of this practice was presented by the Central East LHIN Health Links. All of the Health Links identify patients when patients present for a clinical encounter with an existing or new provider. The provider that identifies the patient also engages the patient, extends the invitation, and obtains informed consent for participation in Health Links/Coordinated Care Management.

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 B:
Measurement Specifications for Person-Centred Invitations

Released June 2016

Percentage of patients who report that they "Agree" or "Strongly agree" that the invitation to participate in Health Links was completed in a way that allowed them to clearly understand what was being offered

Step for Coordinated Care Management	**Invite and Engage**
Innovative Practice	Use person-centred communication strategies to invite and engage the patient in coordinating their care with the Health Links team.
Measure	% of patients who report that they "Agree" or "Strongly agree" with the statement *"I feel that the invitation to participate in Health Links was completed in a way that allowed me to clearly understand what was being offered to me."*
Type	Outcome Measure
Definition/Description	• The invitation is extended using patient's preferred communication method (in person, telephone, email, text, etc.). • A standardized, consistent message is used, including adequate information for the patient to understand Health Links and Coordinated Care Management, while not overwhelming the patient with information. Dimensions: Effective, Equitable, Patient-Centered, Safe Direction of Improvement: ↑
Additional Specifications	Numerator: Number of patients who report that they "Agree" or "Strongly agree" with the statement *"I feel that the invitation to participate in Health Links was completed in a way that allowed me to clearly understand what was being offered to me."* Denominator: 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 report 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 report that the invitation is extended to them by someone with whom they have an existing with or will potentially develop an ongoing relationship with

Step for Coordinated Care Management	**Invite and Engage**
Innovative Practice	Use person-centred communication strategies to invite and engage the patient in coordinating their care with the Health Links team.
Measure	% of patients who report that the invitation is extended to them by someone with whom they have an existing relationship or will potentially develop an ongoing relationship
Type	Process
Definition/Description	Dimensions: Effective, Equitable, Patient-Centred, Safe Direction of Improvement: ↑
Additional Specifications	Numerator: patients who report that the invitation is extended to them by someone with whom they have an existing or will potentially develop and ongoing relationship with Denominator: Total # of patients invited to participate in HLs 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 report data for a minimum of 3 months. QI RAP templates will be available if the Health Link chooses to use them.
Data Source	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. • We recognize that patients who meet these criteria may not need Health Links, and patients who need Health Links may not be flagged through these criteria. However, following this combination of clinical level assessments and data-driven, case-finding methods will optimize the Health Link's ability to identify as many patients as possible who may benefit from Coordinated Care Management.

Percentage of patients who report that consistent messaging and/or resources are being used when inviting patients to participate in Health Links/Coordinated Care Management

Step for Coordinated Care Management	**Invite and Engage**
Innovative Practice	Use person-centred communication strategies to invite and engage the patient in coordinating their care with the Health Links team.
Measure	% of patients who report that consistent messaging and/or resources are being used when inviting patients to participate in Health Links/Coordinated Care Management
Type	Process Measure
Definition/ Description	Dimensions: Effective, Equitable, Patient-Centred Direction of Improvement: ↑
Additional Specifications	Numerator #1: Number of patients who accepted invitation to participate in HLs Denominator #1: Total # of patients invited to join HLs by someone with whom they have an existing relationship (including those who refuse) Numerator #2: Number of patients who accepted invitation to participate in HLs Denominator #2: Total # of patients invited to join HLs by someone with whom they do not already have an existing relationship (including those who refuse) 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 report data for a minimum of 3 months. QI RAP templates will be available if the Health Link chooses to use them.
Data Source	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.