Coordinated Care Management

Invite and Engage: Provide Patients with a Single Point of Contact

Released June 2016

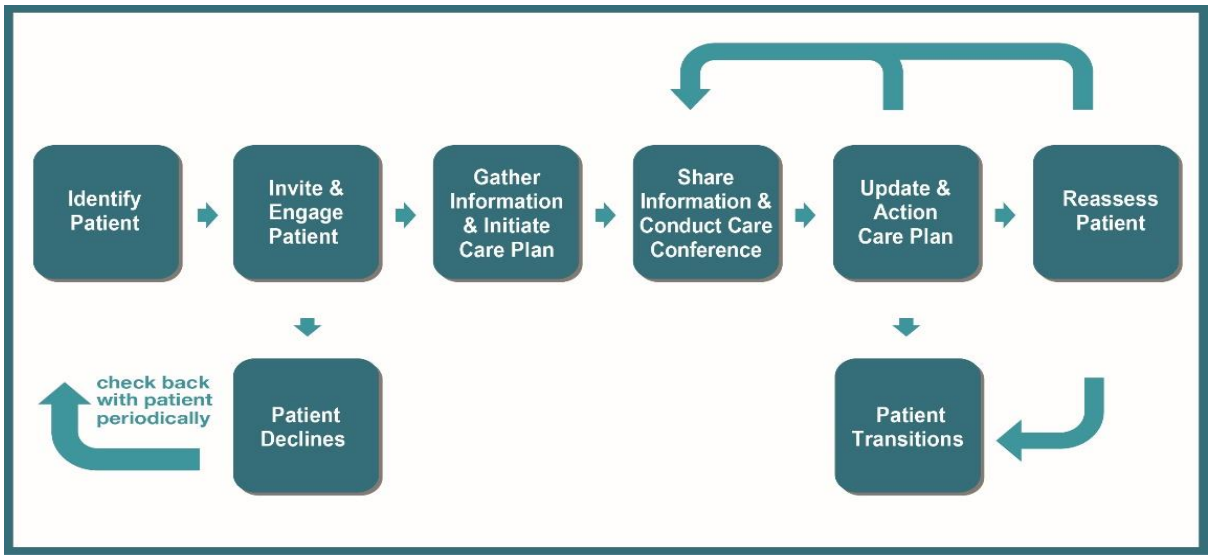

Figure 1: Approach to Coordinated Care Management

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
Provide patients with a single point of contact for all services included in their Coordinated Care Plan to support the patient in the coordinated care planning process, and the development and implementation of the Coordinated Care Plan. *Note: Primary Care/Other providers continue to remain integral to the care team, even if they are not identified as the single point of contact.*	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. *Identify a Single Point of Contact* It is recommended that the provider (or other known person) who extends the invitation to participate in Health Link continues on as the single point of contact for the patient. If that is not possible, then it is recommended that an individual who will establish an ongoing relationship with the patient assumes the role of single point of contact. This transition should include a *supported* transition between the inviting person and the person who will assume the role of single point of contact. **2. *Establish an alternate Single Point of Contact*** In addition to identifying a single point of contact, it is recommended that an alternate provider/contact is identified. This provider/contact will function as the main point of contact when the main single point of contact is unavailable (e.g., vacations, etc.). **3. *Ensure that the Single Points of Contact understand the role/responsibilities*** Ensure that the single points of contact understand their role in partnering with the patient through the Coordinated Care Management process, and that they will serve as the main point of contact for health and wellness issues relating to the Coordinated Care Plan. **4. *Communicate with the patient*** Ensure that the patient/family/caregivers can identify their single point of contact and alternate, know how to contact them, and understand the role and responsibilities of the single point of contact. **5. *Communicate with the care team*** Once the care team is established, ensure that the care team is aware of who the single point of contact is for that patient.	• **Single Point of Contact Activities Checklist Tool** *(please see 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***	• The process of determining the single point of contact within a Health Link should reflect the operational processes of that specific Health Link, and be acceptable to partners. For example, some Health Links introduced additional resources to the regional health system to assume these responsibilities, (such as "Navigators"), and others have leveraged existing providers (providers at a single organization such as the CCAC, or providers within various organizations within the region) or other people involved in the person's care. The determination of the single point of contact should reflect the regional approach. • If the single point of contact is not a Health Information Custodian, the provider, organization, and the Health Link must ensure that the management of health information and sharing complies with all associated legislation, regulations, etc.

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 Measure**	**Additional Information**
• % of patients who report that they first reach out to the single point of contact to support their Coordinated Care Management needs.	• % of patients who report that they agree (yes/no) that they know who to contact regarding their care plan, and how to reach them.	• 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:
Single Point of Contact Activities Checklist

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How is this Single Point of Contact Checklist used?

This resource was designed to support Providers within the Health Link to implement the practice of **providing patients with a single point of contact for all services included in their Coordinated Care Management. This person will support the patient throughout the coordinated care planning process, from development to implementation and reassessment of the Coordinated Care Plan.** This resource is intended to **support (not replace) operational and clinical decision making** in the Health Link and in the clinical care of patients.

Who should assume the role of the single point of contact?

Health Quality Ontario completed an environmental scan of practices underway within the Health Links that were operational as of late 2015. Through this environmental scan, and ongoing work with the Health Links, it was noted that **many Health Links adopted the practice of providing patients with a single point of contact** to support them through the Coordinated Care Management process and/or to serve as the main contact for the patient regarding his/ her health and wellness needs. However, there is **variability in *how*** this practice is operationalized within the provincial Health Links. For example, **some Health Links have leveraged existing providers** within the Health Link (either one provider/providers within an organization, or multiple providers across multiple organizations), while **others have introduced additional roles** to specifically perform these functions for Health Links (e.g., Navigators). Health Links are encouraged to provide patients with a single point of contact to support them with Coordinated Care Management; **the implementation approach continues to be at the discretion of the LHINs/Health Links.**

What activities may be completed by the "Single Point of Contact"?

Identify Patient

- ❑ Identify Patients with multiple conditions and complex needs through clinical level assessments and data driven case finding methods at any point in the patient's healthcare journey.

Invite and Engage

- ❑ Use person-centred communication strategies to invite and engage the patient in coordinating his/her care with the Health Link team.
- ❑ Use a comprehensive process and/or form that enables patients or substitute decision makers to provide consent for all elements of their coordinated care at one time (may be explicit or implied).
- ❑ Provide patients with a single point of contact for all services included in their Coordinated Care Plan, who will support the patient in the Coordinated Care Management process, and the development and implementation of the Coordinated Care Plan, and designate an alternative single point of contact.

Interview and Initiate Coordinated Care Plan

- ❑ Implement the "Patients as Partners" Bundle. The "Patients as Partners Bundle" includes:
    - Working to complete the patient interview in the patient's preferred location.
    - Eliciting the patient story, values, and goals from the patient's perspective.
    - Collaborating with the patient to determine members of the care team.
    - Providing a copy of the Coordinated Care Plan to the patient.

- ❑ Develop a care conference plan that considers the patient's preferences for timing, comfort, available space, location, and privacy, where possible.
- ❑ Develop a list of people who will be invited to the care conference and their contact information.
- ❑ Confirm that the patient understands, agrees to, and feels prepared for the next steps.
- ❑ Arrange Care Conference, which may include providing education to the Care Team Regarding Health Links, Coordinated Care Management, and their roles for the Care Conference and auctioning the Coordinated Care Plan.
- ❑ Confirm details with patient, once planning is complete.
- ❑ Begin to populate the initial DRAFT of the Coordinated Care Plan.

Conduct Care Conference

- ❑ Facilitate an introduction to the Care Conference (if indicated), which would include the purpose and objectives of the Care Conference, introductions and role clarification for the Care Team members, and a summary of the information collected during the interview.
- ❑ Facilitate the care conference while being responsive to the patient's experience of the Care Conference.
- ❑ Consider safety, housing, food, education, employment, spiritual, financial, psychological/emotional needs.
- ❑ Summarize the findings of the Care Conference, and confirm the elements of the Coordinated Care Plan with the patient and other Care Team members.
- ❑ Establish/clarify next steps, reassessment plan and/or arrange the next case conference.
- ❑ Complete the Coordinated Care Plan document, and disseminate it to the patient and the Care Team.
- ❑ Ensure that the Coordinated Care Plan is included in the Coordinated Care Planning Indicator Data, and the Primary Care Indicator Data is collected by the Health Link/ LHINs (this information is then reported to Health Quality Ontario on a quarterly basis).

Action the Coordinated Care Plan

- ❑ Develop interdisciplinary roles, responsibilities, accountabilities.
- ❑ Establish a two-way communication agreement or understanding between the single point of contact, the patient, and the remaining members of the Care Team, to foster information exchange and to build a trusting relationship.
- ❑ Use an evidence-based approach to coach patients how to self-manage their condition(s).
- ❑ Utilize tools to assist patient in understanding their condition and making appropriate choices such as S.M.A.R.T. (specific, measurable, attainable, realistic, and timely) goals, medication reconciliation, and health literacy assessment tools.
- ❑ Stay current with referrals, tests, and changes in status.
- ❑ Follow up regularly with patients to help them achieve their goals.
- ❑ Use technology such as videoconferencing and electronic messaging tools to automate and expedite team communication.

Reassess/Update Coordinated Care Plan

- ❑ Ensure that the reassessment plan (developed during the Care Conference), or "triggered" in other ways (e.g., after a certain amount of time, etc.) is completed as planned.
- ❑ Use technology such as videoconferencing and electronic messaging tools to automate and expedite team communication.

Transitions

- ❑ Prepare for, and prepare the patient for, *supported* transitions.
- ❑ Make sure the patient's information is also transitioned (in a timely manner); use standardized discharge summaries, clinical reports, and the Coordinated Care Plan, to facilitate transition of information.
- ❑ Ensure medication reconciliation occurs at transition points, where appropriate.
- ❑ Conduct follow up appointments with primary care providers and CCACs within seven days and five days of discharge from hospital, respectively.
- ❑ Consider contingency funds to handle crises (e.g., food crisis funds).
  Prepare for and stay on top of the patient's transitions, and be sure the patient's information follows them

Appendix B:
Measurement Specifications for Single Point of Contact Innovative Practice

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Percentage of patients who report that they first reach out to the Single Point of Contact to support their Coordinated Care Management needs

Step for Coordinated Care Management	**Invite Patient**
Innovative Practice	Provide patients with a single point of contact for all services included in their Coordinated Care Plan that will support the patient in the coordinated care planning process, and the development and implementation of the Coordinated Care Plan.
Measure	% of patients who report that they first reach out to the single point of contact to support their Coordinated Care Management needs.
Type	Outcome Measure **To align with PROVINCIAL PATIENT EXPERIENCE indicators** currently under development.
Definition/Description	Use a provider (or known person) with an existing relationship to introduce the patient to the Health Links approach. If this person is unable to serve as the single point of contact on an ongoing basis, they should provide a personal introduction to establish a relationship with the person who will provide that support prior to engaging the patient in the Health Link/coordinated care planning process. This will ensure that the Patients with multiple conditions and complex needs has a "go to" person who knows and understands their needs and that they feel they can trust and a back-up plan for when this person is unavailable. Dimensions: Effective, Efficient, Patient-Centred, Safe, Timely Direction of Improvement: ↑
Additional Specifications	Numerator: Number of patients who report that they first reach out to the single point of contact to support their Coordinated Care Management needs each quarter Denominator: Total number of patients surveyed each quarter 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 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 experience 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 to patients of the efforts to introduce innovative practices into coordinated care management.

Percentage of patients who report that they agree or strongly agree that they know who to contact regarding their care plan, and how to reach them

Step for Coordinated Care Management	**Invite Patient**
Innovative Practice	Provide patients with a single point of contact for all services included in their Coordinated Care Plan that will support the patient in the coordinated care planning process, and the development and implementation of the Coordinated Care Plan.
Measure	% of patients who report that they agree (yes/no) that they know who to contact regarding their care plan, and how to reach them.
Type	Process Measure
Definition/Description	Use a provider (or known person) with an existing relationship to introduce the patient to Health Links. If this person is unable to serve as the single point of contact on an ongoing basis, they will provide a personal introduction to establish a relationship with the person who will provide that support prior to engaging the patient in the Health Link/coordinated care planning process. This will ensure that the Patients with multiple conditions and complex needs has a "go to" person who knows and understands their needs and that they feel they can trust and a back-up plan for when this person is unavailable. Dimensions: Effective, Efficient, Patient-Centred, Safe, Timely Direction of Improvement: ↑
Additional Specifications	Numerator: # of patients who report that they "Agree" or "Strongly agree" that they know the name of their single point of contact for their care plan, and how to reach them. Denominator: Total number of patients surveyed each quarter 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 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 experience 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 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.