Coordinated Care Management

Summary of Innovative Practices

Released June 2016

> **"If everyone would work together on my issues it would be better care. You know…by looking at the *whole* person and *all* the issues. Especially when I don't feel well enough to manage all the pieces all on my own."**
>
> — Diane, *Patient*

In 2012, The Ministry of Health and Long-Term Care introduced Health Links, an initiative where a care team (including the patient, family, and health and community providers, and others) coordinates, plans and manages care to ensure that patients and families receive the care they need. This approach to person-centred health care is called Coordinated Care Management.

In late 2015, Health Quality Ontario completed a review of the best available information about Health Links and analysis of innovations related to Coordinated Care Management. In general, the approach to effective **Coordinated Care Management** was as follows:

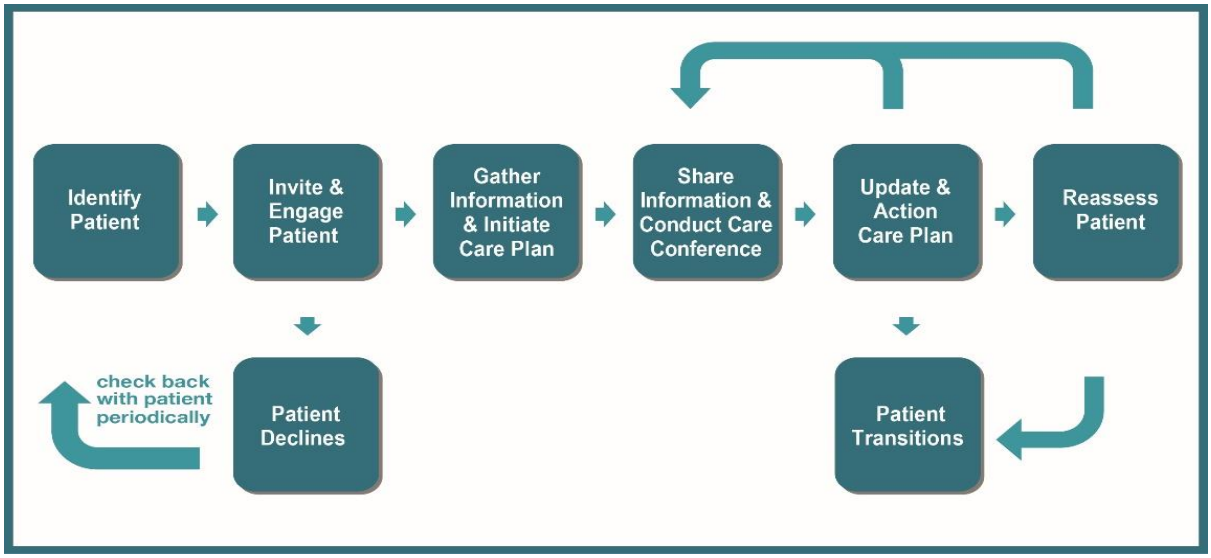

Figure 1: Approach to Coordinated Care Management

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**.*

Quality Improvement: Getting Started

Quality improvement (QI) offers a proven methodology for improving care for patients, residents and clients. QI refers to a team working **towards a defined aim**, gathering and reviewing data to inform their progress and implementing change strategies using rapid cycle improvements. QI science provides **tools and processes** to assess and accelerate efforts for testing, implementing and spreading QI practices, such as the Coordinated Care Management practices. *For additional information on Quality Improvement, please visit: **qualitycompass.hqontario.ca/portal/getting-started** or contact **QI@hqontario.ca** for access to e-learning modules.*

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

Innovative Practices

Innovative practices are based on the highest quality evidence and information available and have been defined and assessed by a Clinical Reference Panel[1]. It is suggested that Health Links draw upon this collection of Innovative Practices to create the foundation for supporting their Coordinated Care Management processes and improving care for patients within their Health Link.

Listed below you will find the selected Innovative Practices relating to Coordinated Care Management. These practices were selected using a comprehensive environmental scan, evaluated using the **Innovative Practices Evaluation Framework,** and reviewed by the **Health Links Clinical Reference Panel** in March 2016. *For additional information regarding this process and assessment criteria, please visit* ***http://www.hqontario.ca/Portals/0/documents/bp/bp-inovative-practices-en.pdf****.*

Coordinated Care Management Step	Innovative Practice	Innovative Practice Assessment[2]	Clinical Reference Group Endorsement for Spread
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.	EMERGING	Provincial spread with reassessment using the Innovative Practices Evaluation Framework in 1 year (June 2017).
Invite and Engage	Provide patients with a single point of contact for all services included in their Coordinated Care Plan.	PROMISING	
	Use person-centred communication strategies to invite and engage the patient in coordinating his/her care with the Health Link team.	EMERGING	
	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).	EMERGING	
Interview and Initiate Coordinated Care Plan	Implement the "Patients as Partners" Bundle with all patients in the Health Link.	EMERGING	

For additional information, please visit the Tools and Resources Tab in the Health Links section of the Health Quality Ontatio at: ***http://www.hqontario.ca/Quality-Improvement/Our-Programs/Health-Links****.*

[1] *The Clinical Reference Panel is composed of subject matter experts in Health Links, researchers, academia, and stakeholders from across the province.*

[2] *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

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.

Coordinated Care Management Step	Innovative Practice	Suggested Outcome Measures *Are the changes having the intended impact?*	Suggested Process Measures *Are the practices being implemented as planned?*
Identify Patients	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.	% of patients identified as meeting Health Link criteria who are offered access to Health Links	• % of Health Links reporting that (in at least one care setting (e.g., Hospitals, Community Care Access Centre, Primary Care) patients are identified using a combination of risk assessment, data-driven case finding, and/or clinical judgement
Invite and Engage	Provide patients with a single point of contact for all services included in their Coordinated Care Plan.	% 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 or strongly agree that they know who to contact regarding their care plan, and how to reach them
	Use person-centred communication strategies to invite and engage the patient in coordinating their care with the Health Link team.	% 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
	Patients/substitute decision makers use a single method to provide consent for all	% of patients who are provided with a single consent for all elements	• % of patients who provide a single consent for coordinated

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	elements of their coordinated care (may be explicit or implied).	included in their Coordinated Care Plan	care, obtained by the Health Link, that: a) Satisfies 100% of the stakeholders; b) Is shared with all members of the care team; *AND* c) Includes a mechanism for revising/withdrawing consent.
Interview, Gather Information, and Initiate Coordinated Care Plan	Implement the "Patients as Partners" bundle with all patients in the Health Link. The "Patients as Partners" bundle includes: • Conducting the patient interview in the patient's preferred location; • Eliciting the patient story, aspirations, and goals from his/her perspective, using a person-centred interviewing approach; *AND* • Partnering with the patient to identify which organizations or disciplines will be members of their care team.	% of patients who report that they agree or strongly agree with the following statements: • *"My patient interview took place in my preferred location";* • *"Goals in my care plan were developed with me, and reflect what is important to me"; AND* • *"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.