Embedding Care Coordination in Primary Care

Hamilton Niagara Haldimand Brant Local Health Integration Network (LHIN)

The Problem - How Patients and Families View and Experience the Health Care System

- Patients are not connected or find it difficult to get connected to a primary care physician;
- Difficult transitions across sectors eg. hospital to home;
- Patients have to tell and re-tell their stories;
- Little to no information to support patients in decision-making regarding their care options;
- Patients fall through the cracks;
- Fragmentation between sectors eg. Hospital, Mental Health, Social Services

"Ontarians want and deserve a health care system that helps them live independently at home."

The Problem **- What we hear from Primary Care**

- Trust & Relationships – lack of personal relationships and trust is a a barrier to transitions
- Enabling Technologies – need improved communication and IT systems that speak to one another between providers
- System Navigation – knowing what resources exist and how to use them. It is impossible to know all of the resources - where do we go so we don't waste time?
- Access to Care – need to make it easier for patients to access care – rather than go to ED / urgent care center to access services
- Structural/Operational Improvements – more consistent and reliable services, less variation between providers

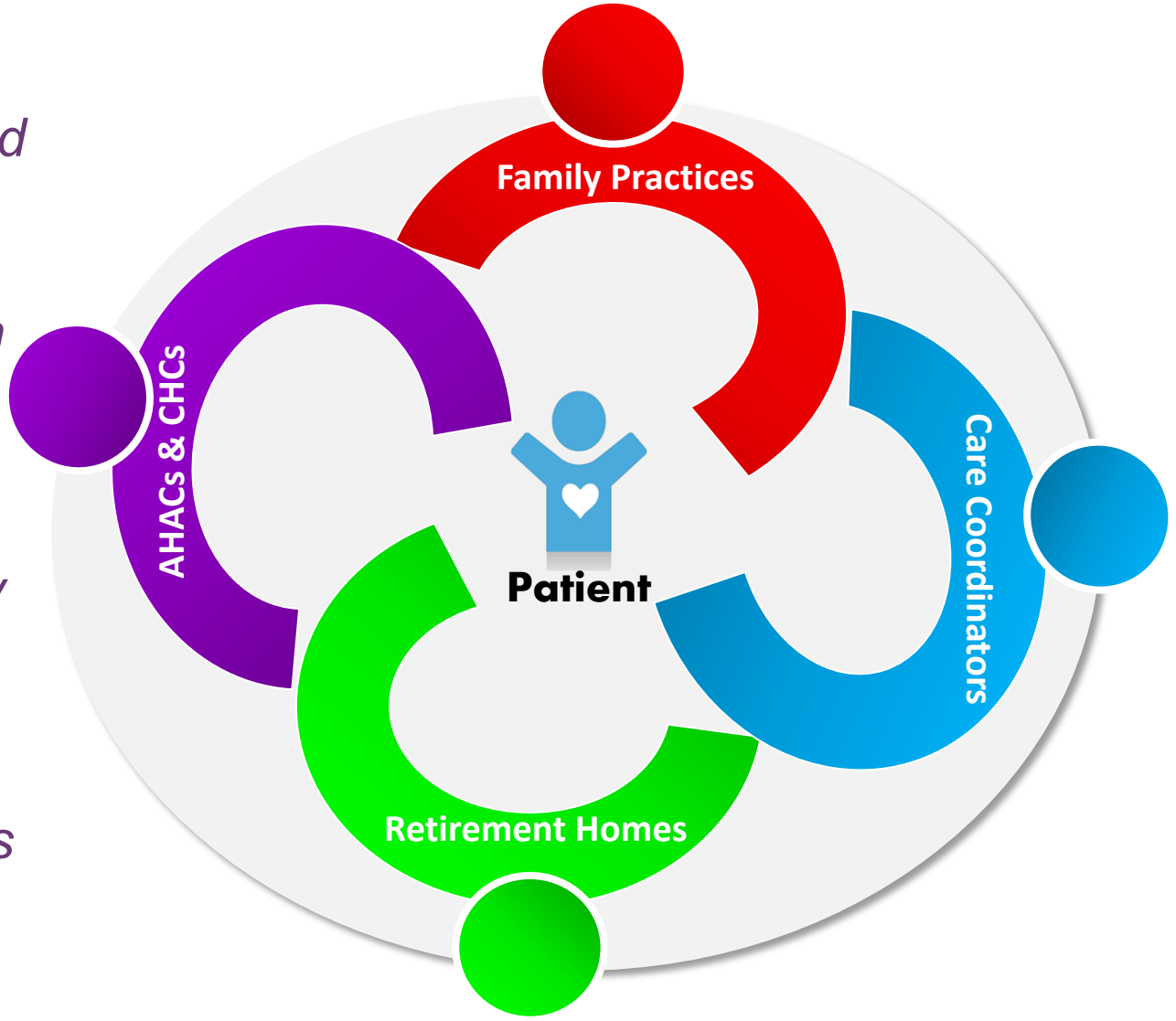
The Case for Change – Provincial Context

- Primary care providers are the 'front door' to the health system for most Ontarians, so it makes sense to connect services to this part of the health sector.
- The 2017/18 Mandate Letter to Local Health Integration Networks (LHINs) identified as a priority the need to "develop and implement a plan with input from primary care providers, patients, family caregivers and partners that embeds Care Coordinators and system navigators in primary care to ensure smooth transitions of care between home and community care and other health and social services as required."
- Embedding Care Coordination in Primary Care continues to be a priority for LHINs in 18/19 as a key enabler in health system improvements and improving the patient experience
- LHINs report the process of strengthening connections as an iterative process requiring extensive patient and provider engagement.
- Stakeholder engagement activities focus on providers, patients, Indigenous partners, Francophones, etc.
- Receptivity of primary care providers is variable across sub-regions and by primary care model. Also, new models of primary care continue to emerge which may influence connection type.

Our Call to Action - The Strategy

- *"The LHIN sub-regions would take the lead in integrating primary care with home and community care. The LHINs would work closely with primary care providers to plan services, undertake health human resource planning, improve access to inter-professional teams for those who need it most and link patients with primary care services."*

- *"Home Care Coordinators may be deployed into community settings, such as community health centers, family health teams and hospitals."*



Goal: Connect services by delivering better-coordinated and integrated care in the community closer to home

Guiding Principles

- Planning needs to be informed by local (sub-region) population needs assessment and equity, and must include the engagement of patients, family, caregivers, client advisory groups and health care providers and their organizations
- Primary care is central to the performance of the health care system and collaborative inter-professional teams working to full scope of practice are key contributors to improvement
- Care Coordination emphasizes the timely and continuous delivery of high-quality, equitable and continuous services and programs that are comprehensive, evidence-informed, culturally competent and appropriate.
- Care coordination focuses on the provision of comprehensive services across the health and social services continuum as needed and is an activity that must be patient-centred

Guiding Principles (Cont)

- Efforts must be made to ensure services are delivered where people live. Acknowledging that providing choice for a patient on how and where they receive care is critical to their well-being.
- Change management supports for care coordinators should be put in place to ensure the workforce is equipped and supported through the change process.
- Priority should be placed on continuity of care for existing home care patients while connections to primary care are developed and strengthened through new structural and operating models.
- Approaches to connecting, and where possible co-locating Care Coordinators in primary care settings should be a priority.

Guiding Principles (Cont)

- Client, family, caregivers, providers and LHIN partners should work collaboratively to implement care coordination approaches/models that ensure consistency and transparency in care provision.
- Approaches to integrate primary care and home and community care must consider labour relations requirements as well as other current legislative and operational requirements.
- Consistent approaches to integrate primary care and home and community care must be balanced by reasonable flexibility to address the unique needs of local populations **Not a cookie cutter approach

Guiding Principles (Cont)

Models of integration must apply a health equity lens with a goal to address the root causes of health inequities and recognize the impact of social determinants of health including:

- Indigenous-specific equity considerations and Indigenous Cultural Competency;
- Approaches that comply with the requirements of the *French Language Services Act* and, among other activities, ensure Francophones are provided with an active offer of health services in French;
- Culturally safe and competent services for diverse communities including racialized communities, ethno-specific communities, the LGBTQ community, and people living with disabilities;
- Non-insured; and
- Unique requirements of people who live in precarious housing situations, are homeless, or are under-housed;

Care Coordination & Primary Care

- Planning
- Assessment
- Design
- Implementation
- Tracking & Evaluation

Transforming how we work with Primary Care

Over half of all patient interactions with Ontario's health care system (~59%) are with primary care and home care providers; connecting these sectors can have substantial patient benefit:

- Convenient access;
- Continuity of care;
- Support for chronically ill and complex patients

Provincial Landscape – *Expectation across All LHINs*

- "People living in Ontario are able to access person-centred care coordination….
- ….through their primary care provider or team….
- …. in a manner that is responsive to their needs…
- ….and through an approach that is based on patient and provider engagement…
- …and local assessment of capacity."

Short-Term: Strengthen the relationship between primary care and home and community care coordination as a means to achieving a longer-term vision.

Longer-Term: Enable effective, seamless, and continuous transitions between providers and across the health system throughout a person's life span.

Current State of "Care Coordination" in Ontario

- Care Coordinators in Ontario are regulated health professionals – the majority of which are registered nurses in addition to occupational therapists and social workers.
- There are over 4,100 LHIN Care Coordinator positions across the province. All are unionized positions and deliver front-line services to patients.
- HNHB (Hamilton Niagara Haldimand Brant) LHIN has just over 554 Care Coordinators(community and hospital) and services 18,000 patients on any given day
- The legacy role of LHIN Care Coordinators was to determine eligibility of patients for a 'basket' of home and community care services and to ensure access to these services: client assessment and eligibility, development and coordination of care plans, on-going assessment, long-term care placement.
- The future role of Care Coordination can be leveraged to support integration in the health system beyond home and community care and across other sectors such as social services and housing - starting with integration with primary care.

LHIN Care Coordinator Functions: Overview

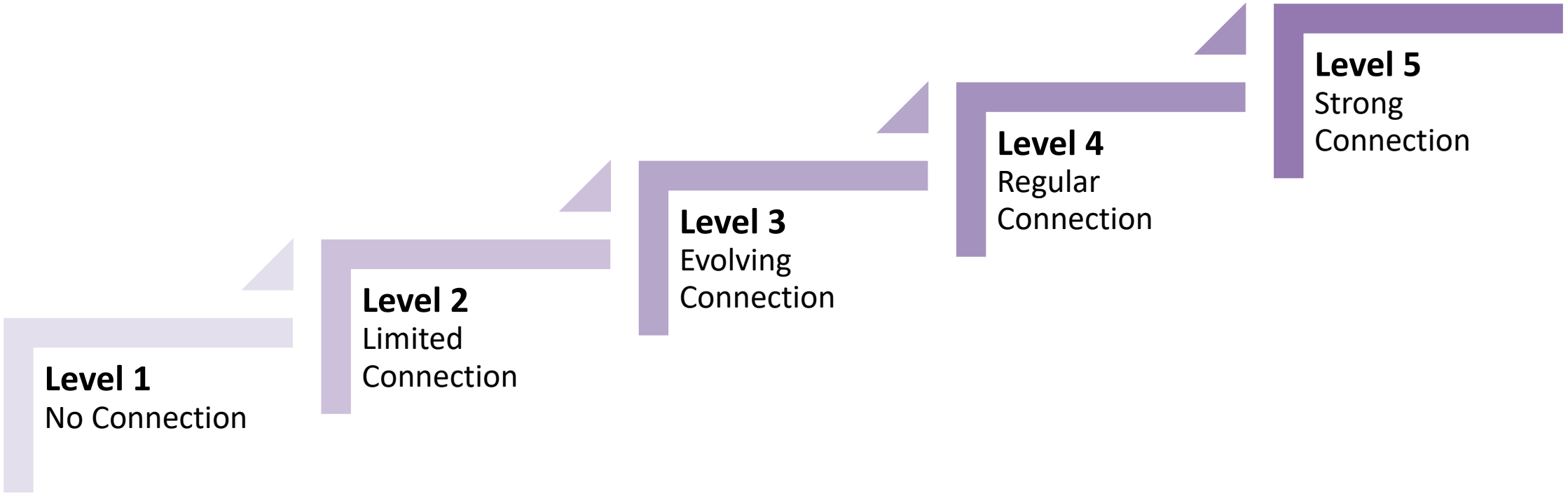
Care Coordinator Function	Description
Community (Long-Stay)	Those care coordinators involved primarily with long stay patients. Long-Stay Patients are home care patients categorized as either 'Maintenance', clients who require assistance with independent activities of daily living and are expected to remain stable, with less than four hospital admissions per year or 'Long-Term Supportive', patients with a noticeable and progressive decline in function lasting greater than three months.
Specialty areas	Those care coordinators involved in primarily providing support to short stay patient populations (e.g. acute/wound), palliative patients, complex children (children's health services), and other.
Access and Intake	Those care coordinators that are involved primarily in eligibility determination, initiation of care plans; often hospital based focused upon discharge planning and ensuring smooth transitions home.
Other	All other care coordinator functions that aren't captured in the above.

Approach to Embedding Care Coordination in Primary Care

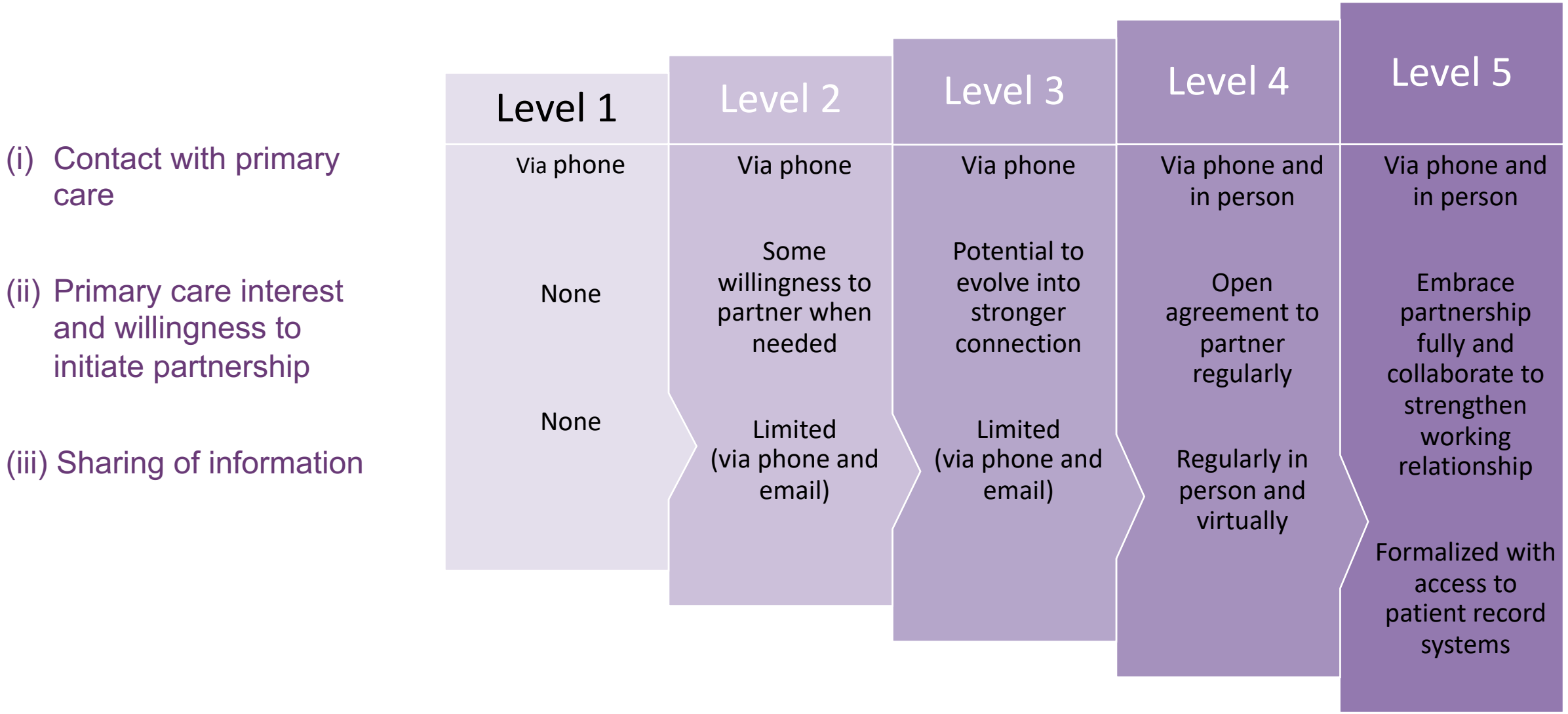
Plan	Engage	Assess	Design and Implement
• Baseline inventory of connections between home care, coordinators, and primary care settings. • Determine population need within sub-regions to inform approaches to strengthening the connection between home care and primary care.	• Consult bargaining agents to ensure adherence to collective agreement requirements. • Engage patients, caregivers, and health care providers through 'co-design' to identify models that work in communities and at the sub-region level.	• Undertake health equity assessment to ensure diverse populations, Indigenous peoples and the needs of Francophone Ontarians are appropriately incorporated into local LHIN planning. • Assess capacity of primary care settings (EMR, office space, etc.)	• Identify 'connection types' that are appropriate to the patient and practise profile. • Engage bargaining agents prior to implementation.

Tactical View of the change

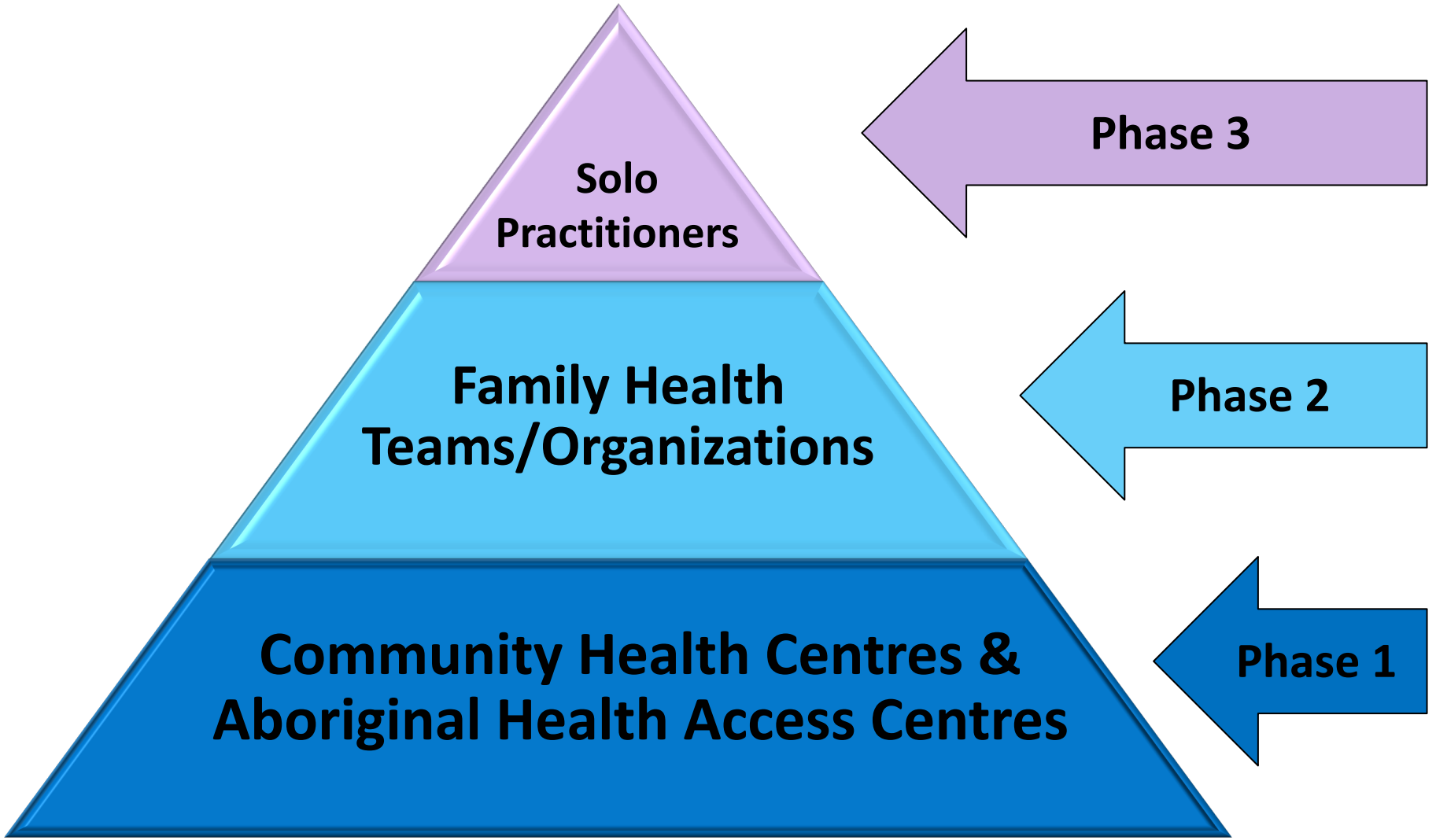
- Embed Care Coordinators and system navigators in primary care settings to ensure smooth transitions of care between home and community care and other health and social services as required;
- Strengthen connections between care coordinators and primary care teams



A Framework to Strengthen the Connection



HNHB LHIN Building Blocks to a Long Term Vision

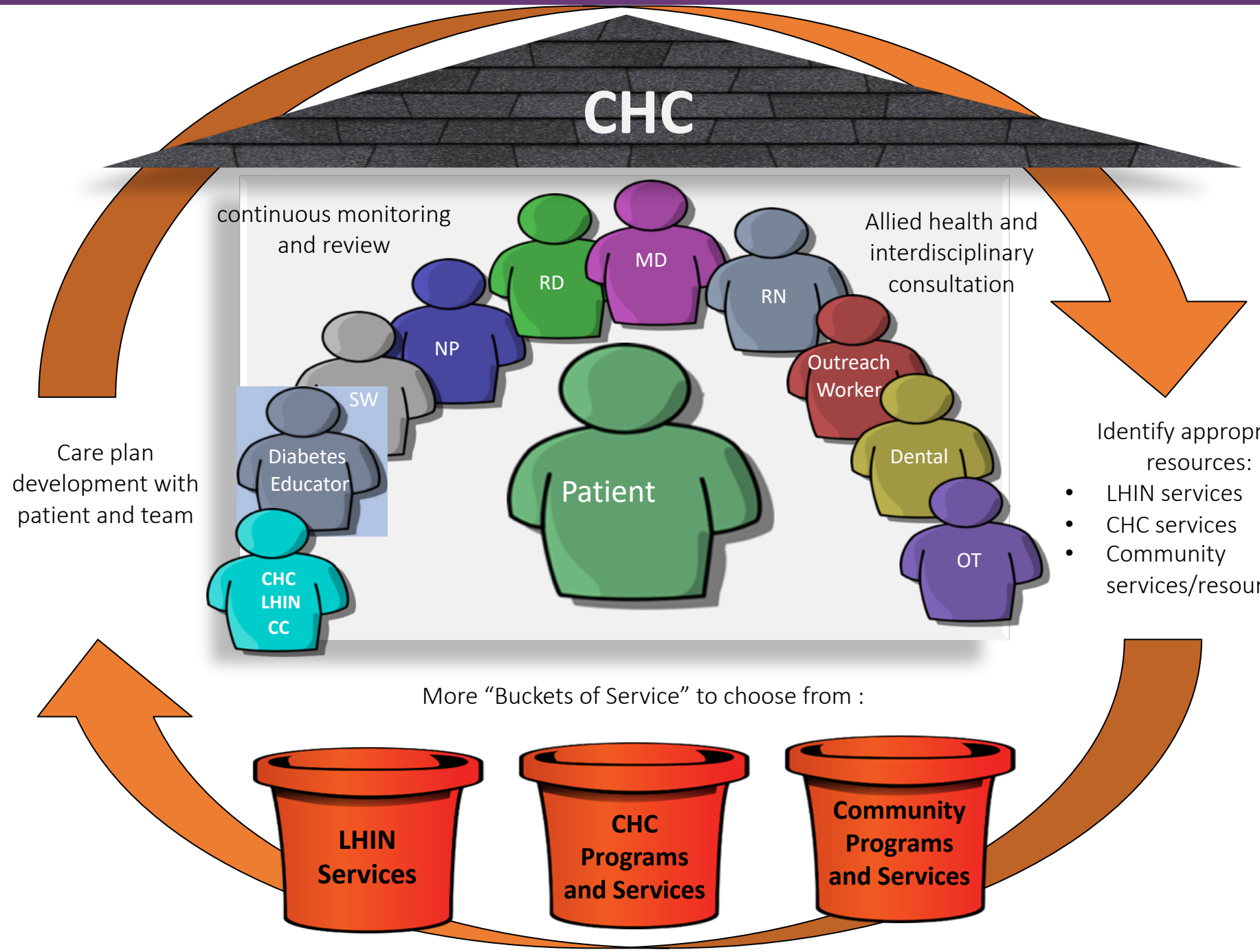


Phase 1: HNHB Embedding Care Coordinators in Community Health Centres and Aboriginal Health Access Centres

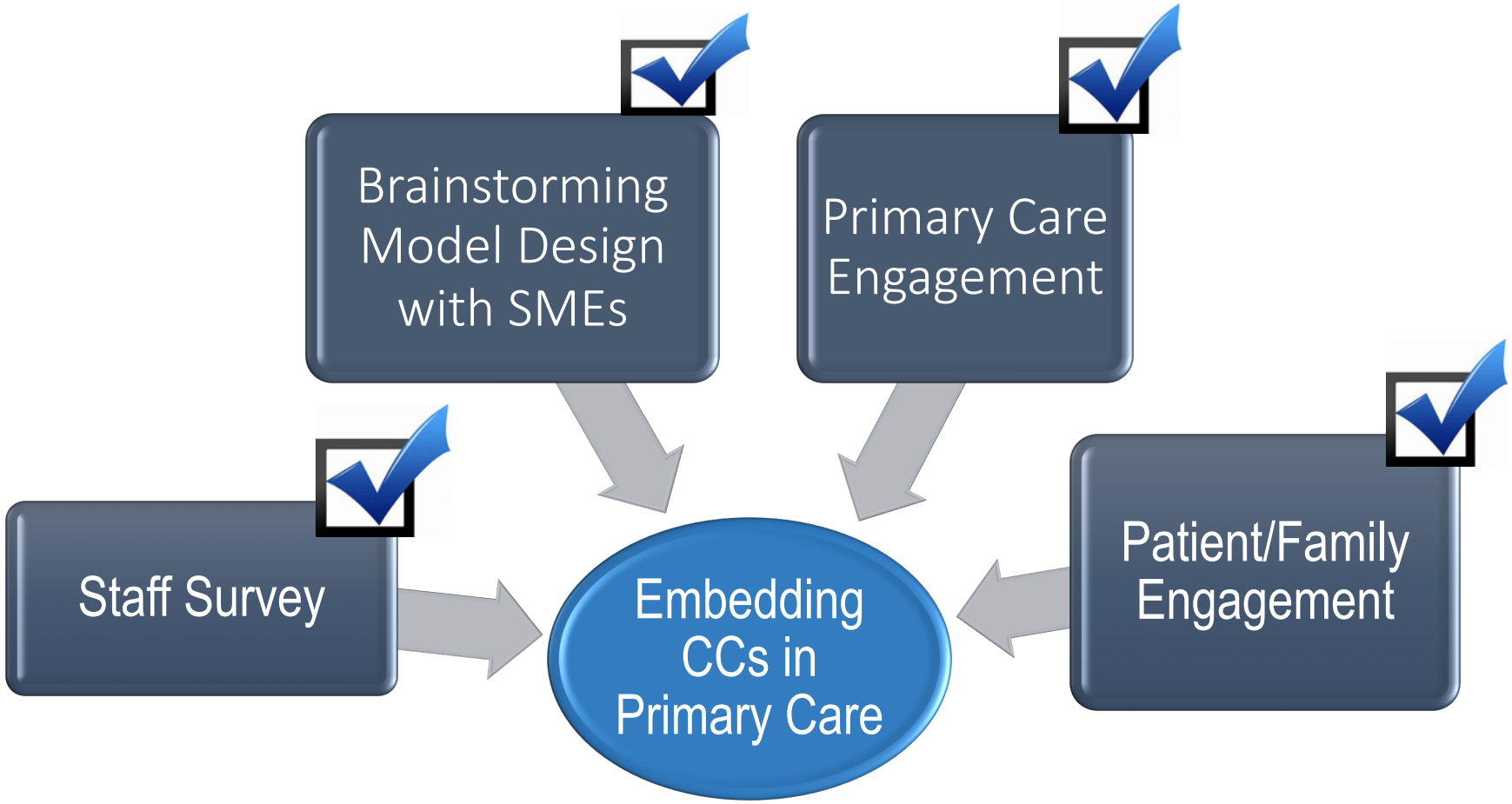
September 2018

Embedding CCs in CHCs/AHACs

- 8 CCs co-located in CHCs
- 2 CCs co-located in AHAC
- 1 CC co-located in Shelter Network
- Model co-developed with CHCs/AHACs/ Shelter
  - ✓ **Shared access to patient records**
  - ✓ **Single point of contact through consultative model**
  - ✓ **Joint orientation & education**
- CCs will work in partnership with CHC/AHACs/Shelter and LHIN leadership (H&CC and Sub-Region Directors) to evolve operational model and inform workflow practices


CHC
continuous monitoring and review
Allied health and interdisciplinary consultation
MD
RD
RN
NP
SW
Outreach Worker
Diabetes Educator
Dental
Patient
CHC LHIN CC
OT
Care plan development with patient and team
Identify appropriate resources:
• LHIN services
• CHC services
• Community services/resources
More “Buckets of Service” to choose from :
LHIN Services
CHC Programs and Services
Community Programs and Services

Our Engagement Approach with CHCs



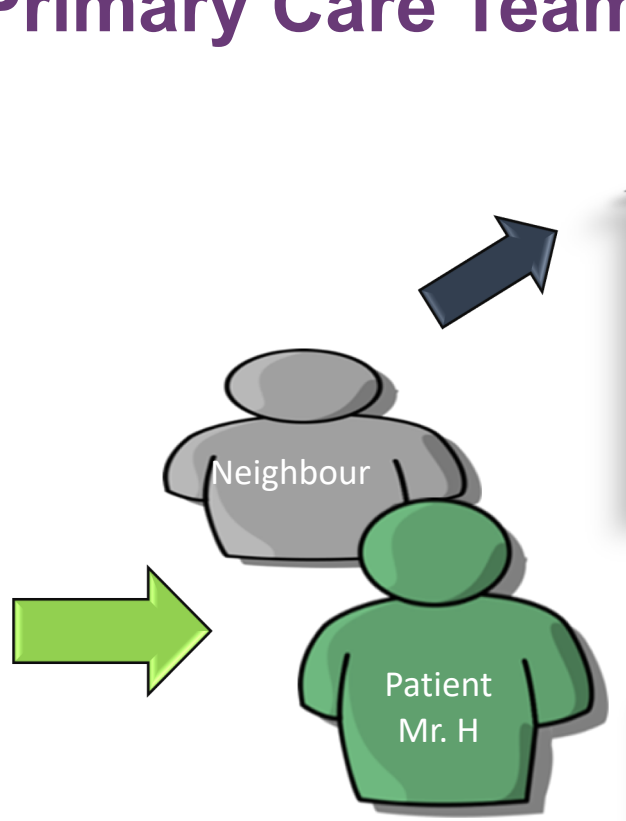
Challenge – *We have 834 Primary Care Providers across our LHIN all with unique needs and a variety of staff complement –* ***One size will not fit all!***

A Patient Experience

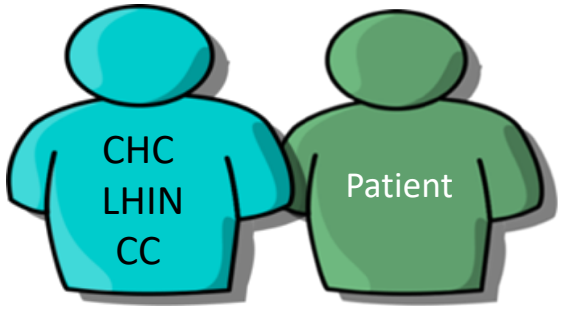
Case Study of Mr. H

- Mr. H is a 78 year old male who has COPD, long standing bipolar disorder and diabetes. Has had 6 emergency department visits and 2 hospitalizations over the last 3 months related to COPD and his infected diabetic foot ulcer. Mr. H uses home oxygen, smokes cigarettes, drinks 8 beers/day.
- His apartment is extremely cluttered and has only narrow pathway to the kitchen, sofa and bathroom.
- His only family support is a nephew who lives in Sudbury.
- Mr. H doesn't have a primary care provider and goes to walk in clinics or the emergency room.
- A neighbour who lives in the apartment building has brought Mr. H to the local CHC because he has noticed Mr. H has become more forgetful, has lost a significant amount of weight and has fallen 3 times over the last 2 weeks.

Primary Care Team Approach



Visit CHC
MD and RN and refers to LHIN CC (during rounds)



Initial face-to-face meeting in CHC or in the home

Assessment and discussion about Mr H's needs and goals

Interdisciplinary Consultation and Identification of Appropriate Services

LHIN	CHC:	Community Agencies:
• RRTT • PSW • OT • PT • NCC (DFU) • Specialized Geriatric assessment • CSSA	• Caring For Your COPD Program • Smoking Cessation • Mental Health counselling	• Seniors Community Programs and Support • Community housing supports

Shared Model of Care
- Coordinated Care Plan was development (Health Links approach)
- Documentation (EMR and CHRIS)
- ICL (Integrated Care Lead) identified

Continuous monitoring & Re-assessment by the team

What does this mean for the patient experience ?

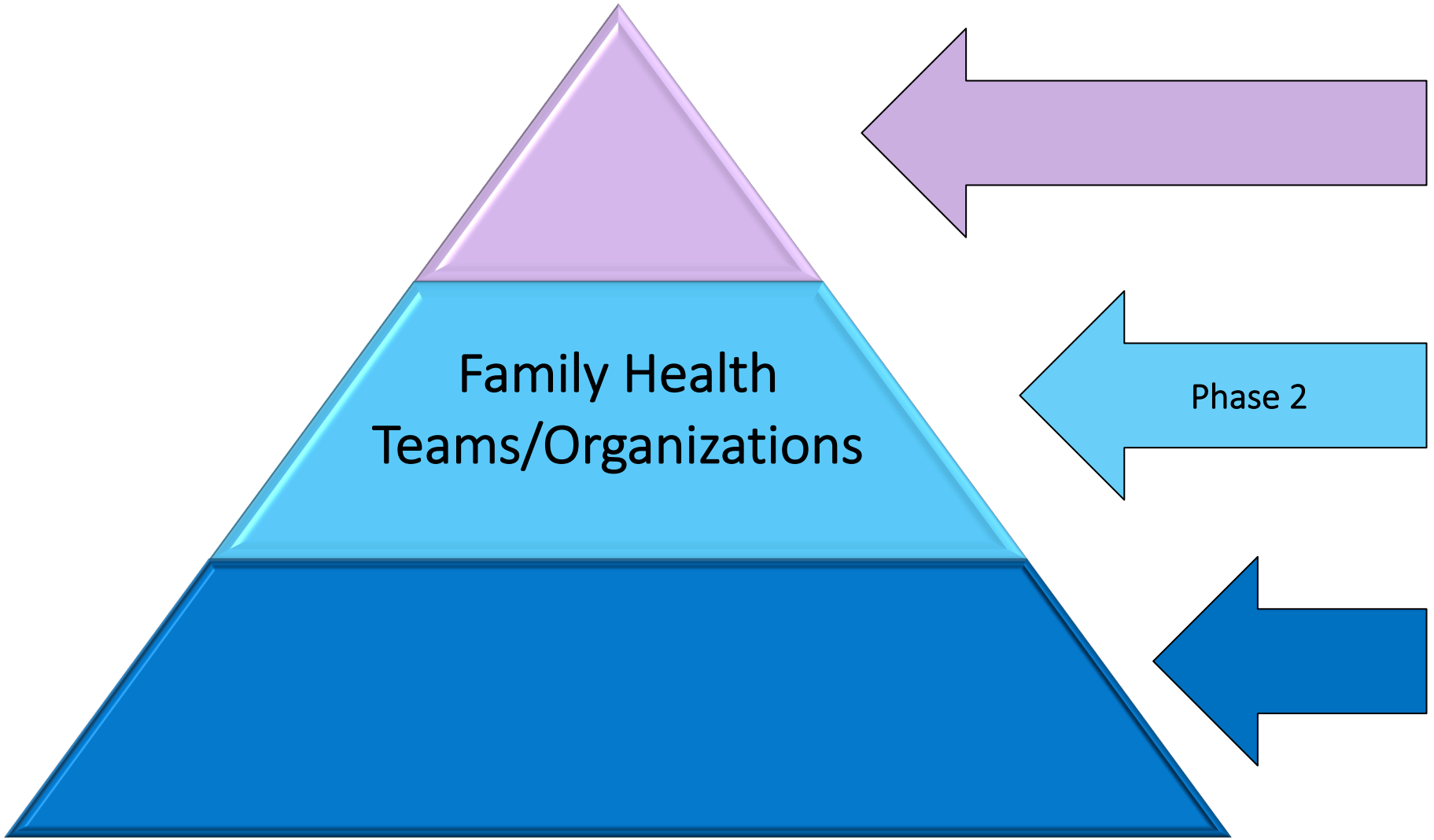
Mr. H will experience care that is wrapped around him when it is needed

- **Collaborative care team** – *knowing who to turn to when help is needed*
- **Joint assessments** – *reducing the number of times he has to tell his story*
- **Shared access to patient records** – *improved communication with Mr. H and between care team members*
- **Interdisciplinary Consultation** – *coordinated care planning – across sectors*
- **Building System Capacity** – *free up resources for patients to access care*

"We are excited to have Care Coordinators embedded at our CHC as this demonstrates a real commitment to collaborative work and provides better care" - CHC Partner

"I am thrilled to be part of a team that not only recognizes how the social determinants of health impact our community as a whole; but provides me with the tools, resources and flexibility to redefine boundaries and create new and innovative approaches to address healthcare needs in ways that is holistic and as unique as our patients" – CHC Care Coordinator

HNHB LHIN Building Blocks – Phase 2 next steps



QUESTIONS

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