CHCA Project ECHO
Integrated Seniors Care

All Teach, All Learn

Bridging the Knowledge Gap in
Home and Primary Health Care

Strengthening Team Communication Through Role Clarity

Subject Expert:
Madelaine Meehan, MPA, BAH, Project Manager, Kingston Health Sciences Centre

Panelists:
Judy Stewart, RPN, Manager, Home and Community Care –SMILE Program, VON
Karen Bell, MBA, PMP, Health System Performance Consultant

Host: Jennifer Campagnolo, CHCA
October 1, 2025

Canadian Home Care Association

Land Acknowledgement

Artist Credit: Patrick Hunter

We recognize with humility and gratitude that Canada is located in the traditional, historical and ceded and unceded Lands of First Nation, Inuit and Metis Peoples. On behalf of us all, we acknowledge and pay respect to the Indigenous peoples past, present and future who continue to work, educate and contribute to the strength of this country.

Reminders

- Say “Hello!” and introduce yourself via the chat! Remember to select “Everyone”.
- Use the chat function if you have any comments or are having technical difficulties.
- Captioning is available and can be activated through your Zoom options.
- Microphones are muted. **Please use the Q&A function to ask the panelists questions.** We will be taking time to answer any questions at the end of the presentation.
- This session is being recorded and will be available at **https://cdnhomecare.ca/chca-project-echo-integrated-seniors-care**
- Remember not to disclose any Personal Health Information (PHI) during the session.

Reflect on What You Hear...

As you listen to the presenter and panelists, think about opportunities to improve communication within your teams.

Where can the skills, knowledge and attitudes discussed today be tested or incorporated in your daily care or practice?

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Collaborative Care Planning

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Role clarity enhances an integrated approach to care planning for older adults and their families, and strengthens team communication by:

- Establishing shared accountability and avoids duplication
- Building trust and respect across disciplines
- Improving communication flow and decision-making
- Enhancing patient and family engagement
- Supporting proactive, person-centered planning

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Introductions

Madelaine Meehan, MPA, BAH
Project Manager,
Kingston Health Sciences Centre

Judy Stewart, RPN
Manager, Home and Community Care
SMILE Program, VON

Karen Bell, MBA, PMP
Health System Performance Consultant

Primary Care Management Pathways

Improving role clarity through project management

October 1st, 2025

Madelaine Meehan, Project Manager

Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Hôpital Hotel Dieu Hospital

KGH Hôpital Général de Kingston General Hospital

Presentation objectives

- Present a brief overview of primary care management pathways in the Frontenac, Lennox, & Addington (FLA) Ontario Health Team region
- Describe project management principles and processes utilized during implementation
- Reflect on how project management can support enhanced communication and role clarity in care coordination

Primary Care Management Pathways

Frontenac, Lennox, and Addington Ontario Health Team Region

Opening comments

- Reflective of local efforts specific to the Kingston, Frontenac, Lennox, and Addington (KFLA) region
  - Kingston Health Sciences Centre – southeastern Ontario's tertiary, regional centre for specialized care
  - Regional primary care community – representing FLA OHT region
- Initiative began prior to Ontario Health Integrated Care Pathways (ICPs)
- Structure, connections, experiences may vary by region
- Principles, tools, lessons learned can be applied objectively

The Initiative to Eliminate Wait Times

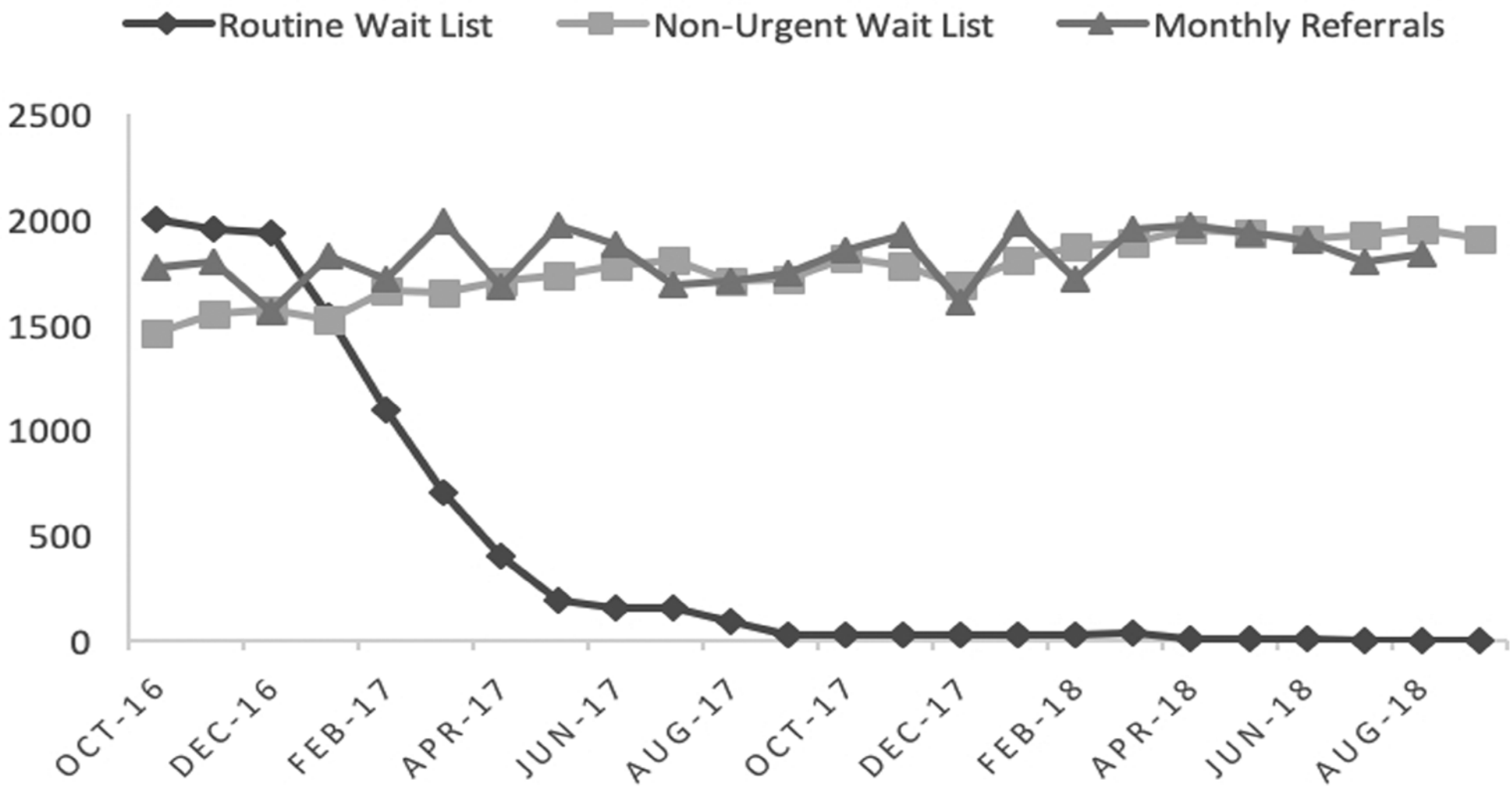
- Established in 2020 as part of the KHSC Innovation Portfolio
- **Enhance capacity and reduce the need for face-to-face consultation by deploying a suite of evidence-based innovations regionally**
- Five working groups, each with their own objective
  - Working group #2: **Optimize referrals by creating primary care management pathways**

Optimizing Referrals by Creating Primary Care Management Pathways

- Focused on developing easy-to-follow primary care management pathways for common conditions for which long wait times exist
- Co-developed by primary care and relevant specialist groups – expert guidance and support to manage a condition, highlighting:
  - when to refer,
  - send eConsult,
  - call a specialist if issues arise

Why pathways? Evidence of IMPACT

GI Group in Calgary *- Routine and non-urgent clinic monthly wait list volumes*



J Can Assoc Gastroenterol, Volume 2, Issue Supplement_2, March 2019, Pages 42–43, https://doi.org/10.1093/jcag/gwz006.021

Optimizing Referrals by Creating Primary Care Management Pathways – ***which conditions?***

- Several conditions identified based on:
  - **Survey input** from primary care and specialists
  - Criteria:

✓Non-urgent condition	✓Safe/appropriate for primary care to manage
✓Current long wait times	✓Specialty wants to develop pathway with primary care

- Initial list of **nine conditions for which pathways developed:**

MGUS	**GERD**	**Irritable Bowel Syndrome**
Parkinson's Disease	**Dyspepsia**	**Chronic Diarrhea**
Dizziness	**Non-Alcoholic Fatty Liver Disease**	**Iron Deficiency Anemia**

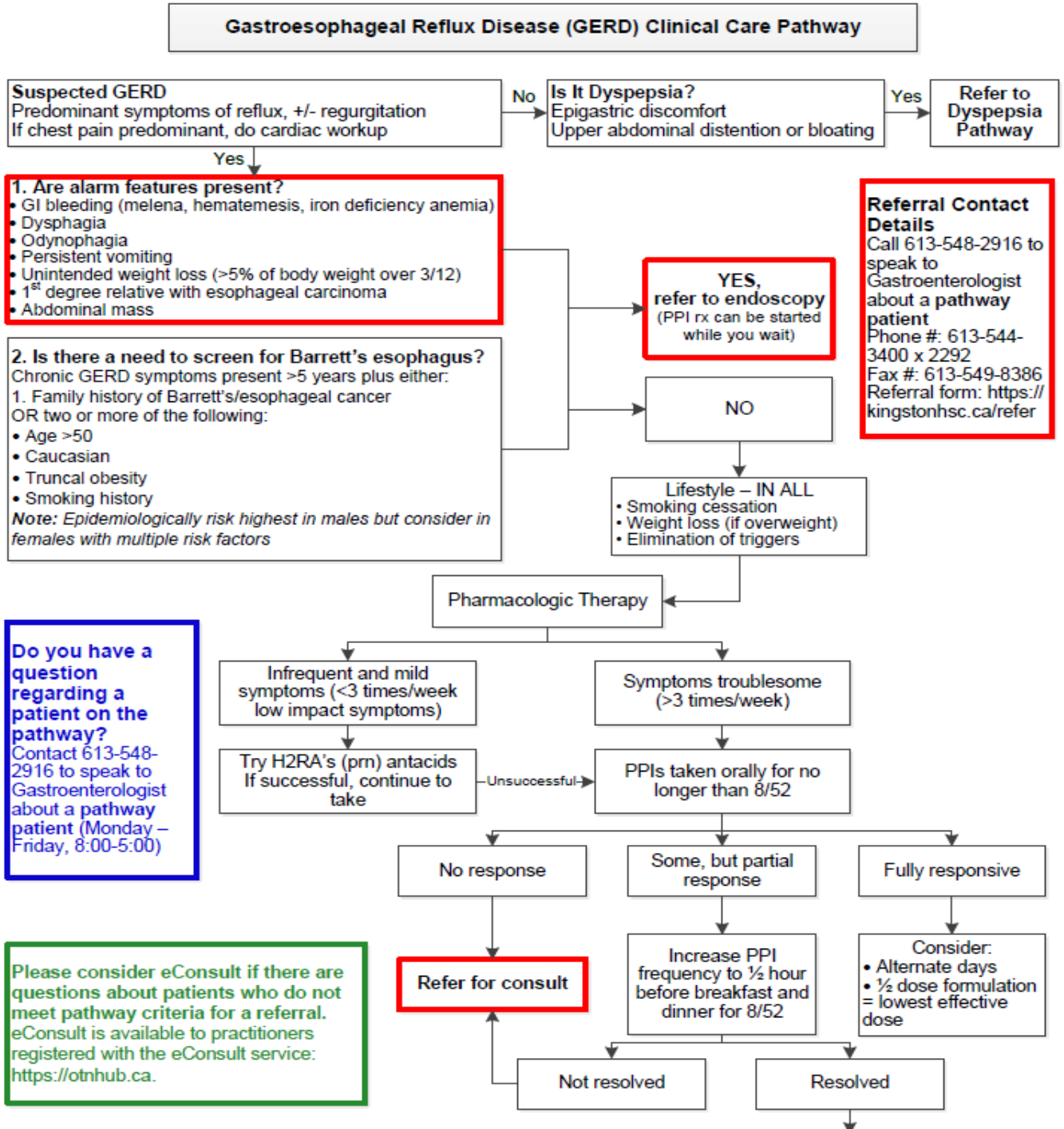
✚ Heart Failure (aligned with Ontario Health-driven ICPs)
Lymphocytosis

Pathways are co-created between primary care physicians and specialists

- Pathway development groups include primary care physicians, specialists, and in some cases learners and patient advisors
- Primary care physicians provide input throughout the process, using real cases to inform the development of the pathway
- Agreement with KHSC labs to do specialized tests for pathway patients who might have to pay for non-OHIP funded community testing

Collaboration and co-development between primary care and specialty groups is critical to success!

- **Pathways launched via accredited CPD events for primary care**



- Each pathway contains flow diagram of what to do, alarm features, and specialist contact information
- Pathways indicate **how to make contact with specialist if questions arise** or **how to refer urgently**
- Pathways will also highlight where **eConsult can be utilized**

Example: Gastroesophageal Reflux Disease (GERD) Pathway

Refer a Patient to KHSC | KHSC Kingston Health Sciences Centre

Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

EN / FR

+ Visiting Or Attending KHSC + Areas Of C

Home > Refer a Patient to KHSC

Refer a Patient to KHSC

This is a new section of the site, currently being consolidated and still under development, so check back often for updates and new additions.

+ **Care Management Pathway Quick Reference List**

Please select a department or subspecialty from the list below for the full pathway:

Medicine

+ Cardiology
+ Endocrinology
+ Gastroenterology
+ General Internal Medicine
+ Hematology

Primary Care Management Pathways – Gastroenterology

+ Chronic Diarrhea
  + Chronic Diarrhea Primary Care Management Pathway
  + Chronic Diarrhea Laboratory Requisition
+ Dyspepsia
  + Dyspepsia Primary Care Management Pathway
  + Dyspepsia Laboratory Requisition
+ Gastroesophageal Reflux Disease (GERD)
  + GERD Primary Care Management Pathway
+ Irritable Bowel Syndrome
  + Irritable Bowel Syndrome Primary Care Management Pathway
  + Irritable Bowel Syndrome Laboratory Requisition
+ Metabolic-Associated Steatotic Liver Disease (MASLD)
  + MASLD Primary Care Management Pathway
  + MASLD Laboratory Requisition

Contact information for primary care physician to discuss a patient on pathway:

1. Submit an eConsult to the "SE Regional Gastroenterology Pathways" Group via OTN.

Measuring Impact through Evaluation

- **Quantitative and qualitative data collected**
- Referral data collected by specialist office to **measure referral trends over time**
- Observations:
  - Referrals redirected to the pathway represent the # of patients that otherwise might be waiting to be seen by specialist - **now supported by appropriate management within primary care home**
  - Improved quality of information provided on referrals, better flagging of those with higher risk symptoms - specialists better able to identify and quickly see these pts
  - Use of **eConsult has been well-received by primary care**

Project Management Processes to Support Communication and Role Clarity

What can we learn from the pathways project?

- Demonstrates impact of **interprofessional communication**, **clear understanding of roles**, and **collaboration** between care settings
- Implementation of the pathways, and project success, was supported by strong project management processes

What did these tools and processes look like during the project?

Effective communication and role clarity begins with a strong foundation

- As interest holders embark on an initiative, consider what tools should be developed to support the work:
  - Establish a **project charter**
  - Define roles and responsibilities (**RACI matrix**)
  - What kind of governance is required?
    - Leverage existing table or establishing something new
      - **Terms of Reference**

Tools should be flexible and evolve over time

Use visual tools to support shared planning

- Build a **project plan** to guide shared and collaborative efforts
- Ensure continuous communication through frequent check-ins, status reporting (**RAG chart**)
- Make **course corrections** as needed to adapt to real-time changes
- Maintain an accessible space for **mutual sharing of documentation**

RAG Chart (Red, Amber, Green) supports status reporting on components of a project

Communication is key!

- Ensure there are **clear and frequent opportunities to collaborate and communicate** around a shared table
- Kick-off meetings, regular check-ins, one-on-one conversations, governance meetings
- Acknowledge that there may be **different communication requirements or approaches depending on the task or decision** required

Reflections from the pathways project

Supporting strong care coordination and communication

- **Project management tools and processes provide structure and guidance** to support success
- **Clear approaches to communication** between providers and/or organizations **is critical** (shared understanding of how / where)
- Care coordination is strengthened when there is **clarity around clinician roles**, as well as **delineation / exit points between services**
- Need to clearly articulate the **value proposition**
- **Medical leadership is essential**

Remember the shared "WHY?"

delivering safe, high-quality, patient-centred care

Kingston Health Sciences Centre

Meet Mrs. Amina Khan

- Mrs Amina Khan is an 82 year old woman and widow who immigrated to Canada over 40 years ago and currently lives in an apartment with her adult son, who travels frequently for work, with her primary carer and support being her adult daughter who does not live with her (but is nearby).
- Her primary language is Urdu, and although she understands English, she prefers to speak in Urdu when discussing personal or complex matters.
- Mrs. Khan has multiple health issues including T1DM, CHF, HTN, early stage CKD, and osteoarthritis, and cognitive decline.
- She receives publicly funded home care supports (personal care provider, medication management and currently, wound care for diabetic foot wound).

Meet Mrs. Amina Khan

Current Care Planning and Communication Challenges:

- **Cultural and language barriers:** Engagement fluctuates due to caregivers not speaking Urdu or sharing her cultural background, limiting communication and increasing discomfort during care interactions.
- **Strained care relationships:** Responsive behaviours have triggered a formal care plan review, with home care staff expressing concern over escalating distress and inconsistent cooperation during visits.
- **Fragmented care teams:** Primary care, specialist care, home care team, family support.
- **Coordination gaps/over lapping boundaries:** medication management, daughter unsure of who to contact, no shared care plan or regular communication schedule.

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Panel Discussion

Q&A

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Upcoming TeleECHO Clinics

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cdnhomecare.ca/chca-project-echo-integrated-seniors-care

Join us for future ECHO Integrated Seniors Care Clinics featuring:

- *Early Identification and Coordinated Transitions in Dementia and Multimorbidity*
- *Navigating Autonomy and Safety in for People with Complex Needs at Home*
- *Respecting Spiritual and Cultural Needs in Decision-Making*
- Applying the Comprehensive Geriatric Assessment (CGA) in Team-Based Care
- *Recognizing and Responding to Caregiver Burden*

Plus more exciting topics, speakers and panel discussions!