Health Links' Coordinated Care Planning Processes

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Purpose

The CCT focus group has expressed an interest in understanding how Health Links (HLs) have been gathering data, developing the CCP, and coordinating care.

Today's sharing of HLs' coordinated care planning processes:

- Provides an opportunity to help maximize the usefulness of the CCT
- Helps catalyze the development of best practices in care coordination
- Offers glimpses into efficiency tips & tricks (and possible things to avoid)
- Is part of the very valuable phase of considering how to design a good process before an electronic solution is implemented

Overview

We will review and discuss the similarities and differences of the following HLs' coordinated care planning processes:

- Barrie Community HL
- Peterborough HL
- Central LHIN HLs (NYCHL, SSNYRHL, & SWYRHL)
- Chatham City Centre HL
- East Mississauga HL
- Guelph HL
- Huron Perth HL
- North East Toronto HL
- Quinte HL
- South Georgian Bay HL
- Timmins HL

Overview

These HLs share in common the following steps of care planning, which will guide our review and discussion:

1. Identify & refer complex patient
2. Invite patient to participate in coordinated care planning
3. Conduct initial patient interview
4. Conduct interdisciplinary case conference (where needed)
5. Implement, evaluate, & revise CCP
6. Transition

1. Identify & refer complex patient

- Common factors that are considered when identifying complex patients that would most benefit from coordinated care planning include:
  - Potential to reduce health care costs
  - Likelihood of improved care
  - Involvement of a wide spectrum of providers

1. Identify & refer complex patient

- Referrals tend to come from the hospital or hospital data, with a focus on ED visits (e.g. ≥ 2 in 30 days), # of admissions, LACE ≥ 10, and/or cost data
  - Quinte HL focuses more on admissions than ED visits because admissions are more expensive
  - North East Toronto HL developed an ED Care Coordination Algorithm to capture complex patients coming through the ED

1. Identify & refer complex patient

- Referrals also come from primary care providers (PCPs) or community agencies
  - Quinte HL uses questions such as “Would you be surprised if this patient died within the next 6-12 months?” as an indication of whether a patient is a good candidate for coordinated care planning
  - Central LHIN HLs’ PCPs complete the Pra™ score, a screening instrument used to identify members of older populations who are at high risk for using health services heavily in the future

1. Identify & refer complex patient

- Particular populations/conditions have also been identified as good candidates for care coordination
  - Quinte HL focuses on hospice and palliative care patients, as many of them are amongst the top 1% of users
  - Peterborough HL focuses on seniors with CHF + one other comorbidity and patients with serious MHA concerns + one other comorbidity

1. Identify & refer complex patient

- Complex patients aren't always referred to a care coordinator (CC) after identification; sometimes the provider that identifies the candidate takes on the role of the CC, at least up until a case conference, at which point a CC with a stronger relationship with the patient may be selected
- Similarly, not all HLs have dedicated CC positions; some HLs have any member of the circle of care (the most appropriate one depending on the patient) take the role of the CC

2. Invite patient to participate in coordinated care planning

- This is typically done by the CC or PCP, in person or over the phone, and also includes setting up a date for a patient interview
- The CC or PCP asks for the patient's consent to share information collected during the CCP process with other members of the care team. Consent is asked again when the completed CCP is to be shared with the care team
- Quinte HL has developed a script to introduce and invite the patient to have their care coordinated
- North East Toronto HL has developed a brochure, "Working Together to Coordinate Your Care," that explains HLs and care coordination to patients

2. Invite patient to participate in coordinated care planning

- PCPs may also require an introduction to HLs and care coordination:
  - Central LHIN HLs send an introductory letter to the PCP and then determine with the PCP whether a preconference (a meeting before the patient case conference) is required. They tend to be needed when the CC is having challenges engaging the patient in developing a care plan
  - North East Toronto HL has developed another brochure, "Working Together to Coordinate Care with Our Patients," that explains HLs and care coordination to PCPs

3. Conduct initial patient interview

- Some HLs complete a partial draft of the CCP prior to the interview based on an EMR/chart review, and then update and verify the CCP during the interview
  - South Georgian Bay's EMR pre-populates the CCP automatically
  - Barrie & Community FHT's EMR (Accuro) has the CCP fields built in. They are populated by an RN and either an OT or SW when doing patient intake. A pharmacist reviews each case as well
  - North East Toronto HL CCs contact the patient's pharmacist to confirm the current medication list
- Others make a preliminary list of issues/risk factors to review before meeting with the patient but do not start a CCP draft until the patient interview

3. Conduct initial patient interview

- The patient interview is conducted in the patient's home or in clinic and is attended by the patient and family/caregivers, the CC, and sometimes the PCP
  - Some prefer conducting the interview in the patient's home because it gives a better indication of the patient's environment and supports
- East Mississauga HL aims to have the CC visit the patient at home within 24 hours of hospital discharge or 72 hours from community referral

3. Conduct initial patient interview

- Interview guides: Some HLs have modified their interview techniques to be very patient-centric, in order to maximize the value derived from coordinated care
- Timmins HL has developed a Patient Discovery Interview Guide that helps providers best elicit the information needed to populate the CCP
- Guelph HL conducts a “what matters to me” interview, where interviewers hear what matters to the patient in their daily living and their preferences for how best to be supported
- Quinte HL uses the “Understanding the Patient Experience” workbook by David Dunne as an interview guide

3. Conduct initial patient interview

- In the South Georgian Bay HL, after the initial patient interview is complete, a navigator prepares a de-identified patient case history summary for a “Think Tank” meeting held over the phone
  - A CC distributes this summary to attendees of the meeting, including various HSPs and community agencies
  - Attendees generate ideas to improve the support offered to the patient and their family
  - Once a draft care plan has been created based on the patient interview and Think Tank call, the patient is contacted to review and confirm their desire/approval to move forward with the plan

4. Conduct case conference

- Not all patients require a case conference
- Quinte HL determines a patient's need for a case conference based on medical & social needs. If the patient has high needs in both categories, they require a case conference
- South Georgian Bay considers a number of factors to determine which patients need a case conference, including number of services, patient condition, home circumstances, and/or overlap in services

4. Conduct case conference

- For most HLs, case conferences include the patient and family/caregiver, PCP, CC, and any other providers or agencies in the circle of care
- The CCP is updated during the conference to reflect this interdisciplinary input and collaboration
- The updated CCP is shared with the circle of care (with the patient's consent) and sometimes kept on an EMR
  - Barrie & Community FHT's CCP is kept on the EMR is used as a medical record
- Many HLs reconfirm or reselect the most appropriate CC at the case conference

4. Conduct case conference

- Barrie Community HL doesn't have a process for a full case conference because their interdisciplinary approach from intake meets their needs. They also discuss patient cases without the patient on Monday mornings as a team
- East Mississauga HL's case conferences are with the patient and family/caregiver, the PCP, and the CC. They aim to hold the conference within 7 days of agreement to participate for ≥ 80% of patients

5. Implement, evaluate, & revise CCP

- Overall, follow up intervals vary across HLs and patients and are dependent upon the patient's condition and needs
- Many CCs follow up daily, weekly, or monthly, depending on the needs of the patient
- East Mississauga HL CCs complete progress notes at 30 and 90 days (or more frequently as needed) and send them to the PCP. Also make weekly telephone calls for the first 30 days, monthly telephone calls from 30-90 days, and a home visit at 90 days. Goals are reviewed monthly

5. Implement, evaluate, & revise CCP

- Central LHIN HL CCs have weekly phone calls with the patient and monthly visits at minimum. If required, they are more frequent, with some patients needing daily phone calls
  - The care plan is updated any time there is a change in status or plan of care
- Since the Barrie & Community CCP is built into the FHT's EMR and used as a medical record, it is updated each time there is a change to medication, diagnosis, social circumstances, etc.

5. Implement, evaluate, & revise CCP

- In South Georgian Bay HL:
  - Providers can message updates through a portal, and the portal also allows the CCP to be updated as programs are completed or when any change in care occurs
  - The navigator usually makes weekly follow up calls until the patient is comfortable with the care plan and/or has stabilized
  - The patient keeps a Patient Care Journal in their home to ensure their understanding of the details of their care plan and promote better understanding of the lived experience
  - Four to six weeks after the CCP has been implemented, the navigator conducts an in-home interview, with results posted to the CCP, or, a survey is dropped off at the patient's home to fill out at their convenience

5. Implement, evaluate, & revise CCP

- In North East Toronto HL, all members of the circle of care, including the patient & family, are responsible for notifying the CC when updates or changes are required to ensure the CCP remains up-to-date and shared
  - A communication plan for sharing updates is put in place

6. Transition

- Most maps show or describe a process loop where the CCP is implemented, evaluated, and revised (as needed) continuously until the patient meets his/her goals
- Once goals are met, some describe discharge or transition to other, less intensive supports

6. Transition

- East Mississauga HL describes discharge, transition, or on hold:
  - Discharge
    - Goals met (no further coordination of care needed)
    - Transfer to LTC
    - Death
  - Transition (re-assessed at 90 days or earlier)
    - Goals not met & needs to remain on HL caseload. Complete PCP case conference and re-evaluate service plan in 30 days
    - Goals not met but stable enough for community transition to Chronic or Community Independent teams with patient/family consent
    - Palliative diagnosis acquired. Transfer to palliative team
    - Goals not met but moving to another region. Transfer to other CCAC
  - On hold
    - New/unavoidable condition or hospitalization > 14 days

Discussion & Questions

- Are there any new insights that you could use to adapt your current or planned coordinated care planning processes?
- Would it be beneficial to discuss a particular step/ approach in more detail at a future meeting?
- Are there any important steps that weren't addressed that you're doing or planning to do?

Thank You

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