A TRANSFORMATIONAL REDESIGN OF PATIENT CARE SERVICES

Central West Community Care Access Centre’s Transformational Journey to a Neighbourhood Model of Care
HEY NEIGHBOUR!

Central West Community Care Access Centre’s Transformational Journey to a Neighbourhood Model of Care
Agenda

■ Context and Vision
■ Building the Model
■ Go Live!
■ Physician Alignment
■ Health Links
■ Questions
THE CONTEXT AND THE VISION
The Environment

Why It’s Important for Primary Care and Community Care to Work Together

HEALTH SYSTEM TRANSFORMATION AGENDA

- Client and Caregiver Experience and Outcomes
- Primary Care Reform
- Wrap-around Care
- Seamless Transitions
- Integration, integration, integration

Home Care Panel Report
Minister’s Roadmap to Strengthen Home and Community Care
“To provide care that is more integrated and responsive to local needs.”

“Identify smaller regions as part of each LHIN to be the focal point for local planning and service management and delivery.”

“Seamless links between Primary Care and other services.”
We talked to Primary Care... What did we hear?

Our Primary Care Partners want:

- An understanding of CCAC services & supports
- Information about their patients
- Easy access to the CCAC
- Help for their complex patients
- Help with navigating other health care resources for their patients
- Teamwork with the CCAC Care Coordinator and the home care team
Today

- Structures lag behind population needs
- Shift from episodic illness to chronic disease
- Changing role of primary care
- Providers in silos

The Future

- Collaborative health system
- Holistic approach to wellness
- Continuum based care
- Integrated care teams
Reading the Tea Leaves
Question:
How could we organize our care coordination services differently to further support:

- working more closely with Primary Care?
- inter-professional/inter-organizational teams focused on patient care planning?
- strong working relationships with partners, addressing the unique needs of local geographies?

Answer:
Neighbourhood models of care...

- Align every Primary Care physician with a Care Coordinator.
- The development of trusting familiar relationships between care providers enhances care planning.
- Care planning approaches can be tailored to the needs of “the neighbourhood”.
Evolution of the Care Coordinator role over the Years

2007-2012
Geographic Alignment

2012 - 2014
Client Care Model

2015 +
Transformation: Primary Care Integration/Health Links/Neighbourhood Model
What does evidence-based literature tell us about integrated care coordination?

- Care Coordinators working closely with Primary Care has the potential to improve patient outcomes through improved continuity of care planning.
- Care Coordinators “extend the reach of Primary Care practitioners” through the development of long term relationships with patients in their home and community environment.
- Care Coordinators working with Primary Care practitioners can reduce ED utilization.
- Care coordination is a key element of effective primary care but is often too resource-intensive to be provided by the physician alone.
- Care Coordinators provide access to information about services that physicians are not always aware of.
- Care coordination programs flourish at the neighbourhood level where relationships with providers and community representatives can be leveraged.
- Organization of care coordination caseloads in “neighbourhoods” can create efficiencies due to less travel for the Care Coordinator and fewer partner meetings overall, with each meeting often of benefit to more than one patient.
- Care coordination benefits from a population needs based planning approach.
- Care coordination is most effective when seen as a service that is part of an inter-professional team.
Desired End State

- Each Neighbourhood is self supporting
- Responsive to urgent matters
- Care Coordinator out in the community as a priority
- Strengthened linkage to physician practices
- Flexible model (allows for local interpretation)
- Reduction in Hand-Offs
- Enhanced relationships across the system
BUILDING THE MODEL

How Did We Get There?
Guiding Principles

- There needs to be a clear benefit to patients for an element to be implemented
- Minimize patient and caregiver impact other than that which is most positive
- Optimize and further build on existing relationships between Care Coordinators, Primary Care providers and other community partners
- Engage staff and stakeholder input and feedback throughout all phases
- Utilize and incorporate patient feedback gathered during work on primary care integration corporate project
- Provide ongoing support, coaching, training and communication to and with Care Coordinators, Team Assistants and other key roles
- Maximize the scope of everyone’s practice within their role
- Take a system wide approach to planning; consider the entirety of the patient journey
- Health Links model of care as central philosophy
- Evaluate model as it evolves
Building the Model

- Analysis of active patient and primary care numbers
- Workload analysis of intensity of care coordination requirements
- Alignment with Health Links boundaries
- Analysis of community agencies in Health Links boundaries
- Plotting of Retirement Homes, Exercise and Falls prevention classes and other community services into “sub-LHIN regions” so that each Care Coordinator is not only aligned to Primary Care but also a variety of other locally specific services accessed by their patients
- Maintenance of existing relationships
- Testing of small scale model in Northern Integrated Care Team (Dufferin) and several Health Links alignments to Primary Care
- Redesign process flows and ensure maximization of all scopes of practice (enhanced Team Assistant administrative role)
Strategies for Success

- Application of strong change management principles
- Dedicated Project Management resources
- Guiding principles and regular check-ins
- Extensive staff engagement
- Leadership through a Steering Committee
- Development of leaders at all levels
- Significant partnership with and input from CW CCAC “back-office” functions
- Organization establishes Neighbourhood Model re-organization as number one priority for the year’s list of corporate projects
Engaging Stakeholders

- Patients
- Physicians
- Care Coordinators and Team Assistants
- Cross Functional areas in the CCAC – Business Intelligence, Human Resources
- Hospitals
- The LHIN
Identified Risks and Mitigations

- Data accuracy will impact the creation of new caseloads and neighbourhoods
  - Work with front line staff to embed understanding of the importance of data quality, and hold accountable through monitoring compliance at individual staff level

- Resistance to change by staff, bargaining agent and SPOs
  - Relentless commitment to change management over an extended period of time

- Ability to meet expectations of staff (flexibility, workload, staffing)
  - Engage staff representatives and champions every step of the way in planning

- Impact of changes to finance and accounting systems
  - Finance team engaged every step of the way; robust monitoring mechanisms in place already

- Limited internal resources to complete Digi Mapping
  - This project was prioritized as corporate priority

- Ensuring quality of care and patient satisfaction through change
  - Engage through our Patient Advisory Council
Evolving the Care Coordinator Role: Getting Ready to Transform!

- Utilization of Primary Care Experience Surveys (feedback on their satisfaction with the role and identification of foundational relationship imperatives)

- Training sessions offered for over 60 Care Coordinators that focus on relationship building with Primary Care as it pertains to integrated care planning
  - Robust communication materials developed with scenario planning in how to work with Primary Care
  - Role playing and coaching sessions between Care Coordinator and Manager
  - Development of a Working with Primary Care 101 Guidebook

- Care coordinators on all project teams, co-leading planning implementation work

- Expanding locations of the embedded Care Coordinator as per Neighbourhood models of care
Transformation to the Neighbourhood model was anticipated as primarily positive by many care coordinators. This enthusiasm was aided by:

- **Staff engagement at all levels of planning and development**
- “Buddying up” of Care Coordinators new to working with Primary Care with those who had done so for several years
- **Honoring the “old system” and what had been accomplished by them to date**
- **Demonstrating how the new model elements could address concerns embedded in the “old” model, such as the risk of burning out when caring for an entire caseload of high intensity needs patients.**
<table>
<thead>
<tr>
<th>Human Resource Functional Area Responsibilities</th>
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<tr>
<td><strong>Development and Finalization of Staff Transition plan</strong></td>
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<td><strong>Union consultation and endorsement of the Staff Transition approach and Team Lead role</strong></td>
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<tr>
<td><strong>Implementation of HR transition plan to Patient Care Services Staff (Community Team) and organization-wide update</strong></td>
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<tr>
<td><strong>Assignment of community care coordinators and team assistants to NEW Neighbourhood teams by competitive and non-competitive process</strong></td>
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<td><strong>Provide written communication to community Care coordinators and team assistants regarding position/team reassignment</strong></td>
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<td><strong>Integration and adoption of team and employee changes into the Schedule, Halogen and QHR</strong></td>
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Communication

- It is important to communicate frequently to stakeholders about what you are about to do:
  - No stakeholder is more important than the patient and their caregivers!
- The CW CCAC engaged in a three pronged approach to communicating with patients:
  - Patients who had a home visit or were part of a care conference or telephone call in the weeks leading up to “Go Live” were informed of a pending change in Care Coordinator and why.
  - Patients who were high risk, highly complex or where the Care Coordinator identified significant potential for heightened anxiety, received a “warm handoff” transition between Care Coordinators.
  - Everyone else received a letter informing them of the change
    - Unexpectedly a small number of patients did not want us working with their physician or misunderstood and thought their physician was being changed

(nb: Palliative patients were not transitioned)
Balancing Caseloads

- Patients on a physician’s caseload differ in terms of the intensity of care coordination they require. Balancing caseloads is about the needs of the aggregate and not just total numbers.
- The challenge is to balance workload while respecting the Care Coordinator-Primary Care provider alignment.
- Data used is already in CHRIS; did not want to create further workload for coordinators
- 2 level caseload assignment decision making - tool utilizes PCP alignment then workload alignment
- The CW CCAC is starting to map LTCHs and Retirement Homes to caseloads; this allows for a third level of caseload assignment logic when the physician is not inside the LHIN boundaries
Workload Measurement Tool

- Population Score
  1 point short stay, 2 points Comm. Ind., 3 points Chronic, 5 points Complex
- Health Links Score – 1 point
- SRC 95 Score – 1 point
- Placement Files Pending – 1 point
- Wait at Home LTC Score – 1 point
- Admit within 14 days Score – 1 point
- Crisis Placement Score – 1 point

Total Workload Score associated with a patient = Sum of the above
Critical Success Factors

- Data to support decisions – Decision support expertise at every step of development and on an ongoing basis

- Clean data is critical – Reports identified priority areas for clean-up e.g. many patients had multiple medical contacts listed and so the most responsible Primary Care physician needed to be validated with the patient

- Understand the human resources implications, be transparent with staff and involve them at every possible step – Close working relationship with Human Resources Department and keeping Union representatives informed and engaged.

- Expect the Unexpected on Transition Week (Go Live for Neighbourhood Model)
  - Staff at over-complement if possible
  - All leaders on site
Celebration!!!!
GO LIVE!

Our Neighbourhood Model Implemented
The Neighbourhood Model
There are many integrated components required to adequately service a neighbourhood, from a single point of first contact until a time the patient transitions out of CCAC services and supports. Each neighbourhood is made up of various integrated caseloads.
Central West CCAC

4 Neighbourhoods

- Initial Care Team
- Information and Referral/Health Care Connect
- Team Lead/Triage Role
- Health Links Navigator
- Team Pods (Multiple within each neighbourhood depending on population/partner needs)
  - Specialty Team Alignment
  - CCAC Care Coordinators (Mixed Caseload)
  - Primary Care
  - Community Partners and Service Providers
Initial Care Team

The Initial Care Team responds to urgent care needs for new patients or patients returning to our community and also to the different care coordination needs of our short stay patients.
Specialty Teams

SPECIALTY TEAMS:
These teams will maintain their specialist knowledge while helping to build strong neighbourhood relationships.
Transformation Means....

- Increased opportunities to develop collaborative relationships with community partner organizations in neighbourhoods.

- All Community Care Coordinators provide the Health Links intervention. (Care Planning and Case Conferencing in team based approach)
Care Coordinators and Physicians Working Together
Building Success One Relationship at a Time

Each physician/Care Coordinator relationship is different and depends on:

- Physician approach
- Technology
- Capacity
- Flexibility in building the approach
Patient Benefits

Experience

- Patient sees benefit of collaborative planning and provision of care and consistent messaging from providers
- Receives holistic care where all aspects of care are taken into consideration
- Comforted with the knowledge that their physician receives timely status reports from Care Coordinator regarding their goals, care plan, progress and outcomes
- Patient only has to tell their story once; has confidence that trusted physician and care coordinator agree on the plan
System Benefits

Efficiencies

- System navigation for patients, families and physicians
- Faster communication, completion of documentation and referral processing essential to achieving patient goals
- Collaborative advocacy for system supported resources and services to benefit the health of local communities
- Enhanced opportunities for integrated team to advocate for “local” needs
Physician Benefits

- Regular Physician and Care Coordinator face to face meetings to review and exchange patient information.

- Opportunity to share and review current care plans and active community provider information

- Increased awareness of CCAC programs and services and other available community support services

- Opportunity to move and link patients more efficiently through the health care system
Value of Primary Care Alignment

“Having our own dedicated Care Coordinator is an amazing and invaluable service. It is a great benefit to be able to talk to someone directly, who knows our practice and our patients, and can respond to our needs within a matter of hours. The ability to have direct follow-up in our offices on our mutual patients is very convenient.”...
Primary Care physician, Central West

“I really appreciate being invited to a care conference regarding my very complex patient. Having the personal support worker and the nurse who support him in the home and to see what is happening day to day was extremely helpful.”.....

Primary Care physician, Central West
NEIGHBOURHOOD MODELS OF CARE AND HEALTH LINKS
Health Links and Neighbourhoods

Health Links is transforming the way we work collaboratively as health providers to wrap services around the Patient and Primary Care.

- Easier to put Primary Care at the centre of the virtual team when already connected through our Neighbourhood model

A fundamental premise of Health Links is that care planning will be collaboratively carried out with the patient and the Primary Care physician who will “sign off” on the plan.

- This requires a trust between the Care Coordinator and Physician which is more solidly built through the Neighbourhood model.

Health Links is all about system partners working together better in the interest of excellence in patient care

- Neighbourhoods allow locally aligned partners to develop strong working relationships, aligned processes and protocols
When Patients are Complex

- The intensity and interdependency of the connection between Care Coordinators and Primary Care increases and may include:
  - Joint home visits
  - Regular care conferencing/care planning meetings
  - Leveraging technology
  - Care Coordinator rounding with Physician
  - Care Coordinator needing to ensure information exchange across multiple providers – everyone on the same page

All of these elements of complex patient care benefit from the Neighbourhood model of care approach to partnering in patient care!
Alignment of Neighbourhood Model with Health Links

- System level benefits to support creation of virtual care teams well integrated from hospital to primary care to community level
- Attachment models Co-designed with Primary Care (ongoing evaluation)
- Increase utilization of information enablers (CHRIS, standardized assessment tools and automated notification elements)
- Aligns and supports Health Links Rounds within neighbourhoods
- Model supports care planning as it enhances remuneration models for physicians (Billing codes working with CCAC)
- Community partners linking tightly with CCAC Care Coordinators can increase structure and face time with primary care
- Navigators will be able to fit well into this model with improved smaller teams
Extending the Partnership with Neighbourhoods

- CCAC/Canadian Mental Health Association (CMHA) Peel integrated care coordination role
- CCAC/Retirement Home clustered PSW services; opportunities being further explored
- OTN based Personal Video Conferencing technology for Health Links care conferencing, being extended as a tool across all caseloads
- Palliative care teams
- Exercise and Falls Prevention classes
- Assisted Living Hub and Spoke
- CHCs, community programs, culturally specific resources
Overlaying Personal Video Conferencing on Health Links and Neighbourhood Models of Care

- three unique pathways to scaled implementation optimizes learning and adapting
Considerations

- System Transformation: Changes to LHIN and CCAC governance structure
- Capacity: referrals continue to increase as primary care alignments increase
- Home visits outside of the Neighbourhood is a reality in a small proportion of the population
- Cross boundary models need to be tested with other CCACs
- Evolving primary care models
- Contracted Service Provider models to follow Neighbourhood model as well