afhto association of family health teams of ontario

CASE STUDIES

CARE COORDINATION

Executive Summary

This document looks at how five Family Health Teams have effectively embedded the Care Coordinator role within primary care.

Their advice to other primary care teams, and the lessons they have learned in the process, include the following:

- Having a care coordinator as part of the team has a significant impact on quality and effectiveness of care.
- Pay attention to the principles of change management as new models of service delivery are rolled out. Change may be difficult, and it may take some time to build relationships and trust.
- With increased system coordination and collaboration there is a learning curve; it may take time but effective relationships are important to success.
- Learn from other FHTs and primary care teams about their approaches so that you can build on their experience to build a collaborative model that fits the profile of your team and leverages your strengths.
- Define the role broadly giving the Care Coordinator access to a broad array of providers and services.
- Have a home base for the Care Coordinator at your site, or dedicated on-site time when inter-professional providers can see and talk to them. This improves efficiency and builds a sense of collaboration and teamwork.
- Enable access to your EMR for the Care Coordinator.
- A quality improvement perspective will contribute to a broad understanding of the role.

Introduction

Effective coordination of patient care is commonly viewed as integral to good patient-centred care and to overall system effectiveness.

The Ontario Primary Care Council (OPCC) suggests that comprehensive care coordination "… reduces duplication, increases quality of care, facilitates access and contributes to better value by reducing costs. It ensures continuity of care for patients regardless of setting, including home, community, hospital, long-term care facility or their family practice[1]."

Both the OPCC and AFHTO[2] endorse the position that the role of care coordination should be led by the primary care sector, and further, that primary care provides a single point of contact to help patients and families navigate and access programs and services (including specialist and community care). The OPCC believes that care co-ordination requires recognition, dedicated funding and leadership support through training and education.

The OPCC has also identified that effective care coordination is best led by a person's primary care organization throughout his or her lifetime and that primary care is the critical link between the patient and specialty care (e.g. psychiatry, orthopaedics, dermatology etc.) and supportive services (i.e. social needs).

This document looks at how five Family Health Teams have effectively embedded the Care Coordinator role within primary care. All five FHTs have CCAC Care Coordinators working directly with FHT providers and patients. Please note that some FHTs use the term Case Manager instead of Care Coordinator. For the purpose of these case studies, we will use the term Care Coordinator exclusively to avoid confusion.

Following the case studies, the discussion will focus on advice and lessons learned.

Mount Forest Family Health Team

Background

Mount Forest Family Health Team (MFFHT) is a Wave 2 FHT (2006/2007) located in a rural setting. The FHT includes seven physicians (one FHO) and nine IHPs serving approximately 12,500 rostered patients. It is a mixed governance model. The MFFHT is the lead organization for the Rural Wellington Community Team, a collaborative program between four FHTs, Waterloo Wellington CCAC and CMHA Waterloo Wellington. This team provides support for people living with complexity who are attached to one of the four FHTs or who live in the geographic areas served by the four FHTs.

The Rural Wellington Community Team currently has one CCAC Care Coordinator whose time is shared among four FHTs. She is an employee of and reports directly to the CCAC. This Care Coordinator is included in the team's

[1]Position Statement: Care Coordination in Primary Care, Ontario Primary Care Council, November 2015

[2]AFHTO Policy Position: "Primary Care must lead care coordination", Association of Family Health Teams of Ontario, December 7, 2015

care planning with patients for whom the traditional process for referral has been tried and failed or when it is expected that a different approach is needed for successful connection to CCAC care coordination and services. The plan depends upon the needs of the patient or day-to-day contact and the ability of the CCAC care coordinator to respond to that level of need.

The Team also includes an Intensive Mental Health Care Coordinator (IMHCC) funded within the program budget and employed by and reporting to CMHA Waterloo Wellington. This care coordinator is also shared among the four Family Health Teams. This care coordinator focuses on providing support for people with complex needs who are also struggling with getting the care they need for mental health issues. The IMHCC role was added to the team in the second year of the program after it was noted that 65% of all referrals to the team included people with mental health issues. The IMHCC provides situational counselling and problem solving while patients wait for longer-term services; helps primary care providers assess mental health status in complex situations and provides mental health issue management coaching and education to the outreach workers.

Both of these care coordinators spend time in each FHT depending upon how many patients they are serving at the time.

In addition to these Care Coordinators, the Rural Wellington Community Team includes six outreach workers (4.8 FTE) who are employed by MFFHT; 1.2 FTE support the MFFHT and 3.6 FTE support the three other FHTs. The outreach workers are often referred to as the "professional family member". Most have lived experience and "walk with the patient", negotiate, translate, encourage engagement, provide warm hand off to other services, attend appointments with the patient. An outreach worker may facilitate the beginning of the relationship between the care coordinator and the patient and leave the relationship once the connection has been established. Or the outreach worker may continue to be a day-to-day contact point for the patient with the CCAC care coordinator also involved. According to the MFFHT, the outreach workers are the glue that sticks the person to the health system. This is a unique position in primary health care. Workers are employed by the FHT and paid for by the CCAC through the LHIN. They have had a significant impact, including a notable reduction in emergency department visits.

This model of care has taken about two years to develop, and continues to evolve. Currently the CCAC is realigning the way it provides service, and is moving to a geographic distribution of Care Coordinators. The Care Coordinator will manage the transitions in/out of hospital, and manage the LHIN boundaries so that services are based on where the patient lives and not the provider. Rather than assigning a specific Care Coordinator to the FHT, the Care Coordinator will vary according to where the patient lives and where they receive care. MFFHT is supportive of the shift to a geographic distribution of Care Coordinators and believes that this will reinforce a patient-centred approach to care.

The Motivation

Mount Forest Family Health Team provides patient care in a culture of collaboration and a philosophy of patient-centred care. The decision to incorporate CCAC Care Coordinators as part of the team was a logical extension of an existing approach.

The Process

The process began with acknowledgement of the need for improved coordination of care across sectors (primary care, specialist care, community care), and the need to better support patients. Discussion with the CCAC led to development of the model which includes one dedicated CCAC Care Coordinator, one dedicated mental health care coordinator and six Outreach Workers supporting four FHTs.

The Outcome

The FHT providers, CCAC and patients are all enthusiastic about the role of the Care Coordinator within the FHT.

Patients feel listened to and better understood. The need for multiple visits by different providers has been reduced.

The primary care providers love this model. Providers have suggested that "Now I will ask the questions that I know I should have been asking all along because I have someone to help me deal with the issues".

The model has worked for the CCAC as it allows for greater collaboration, better planning for patients, and more efficient use of resources. In discussing a patient who needs glucose readings, for example, the CCAC and FHT can agree that the readings are done at the FHT, rather than sending a community nurse to the patient's home.

Challenges

There were certainly challenges that had to be overcome – mainly cultural differences. It is challenging for provider agencies that base their care provision on eligibility criteria

to understand that primary care seldom 'discharges' anyone. The other big cultural difference was whether Care Coordinators were aware of the impact of the social determinants of health and trauma. For the population served by the FHTs, these two factors were strong influencers on patients' choices and behaviours. MFFHT found that the outreach workers brought that awareness to the team and it was embraced by everyone, which has made the team successful.

Enablers

A number of factors have been critical to the success of improved care coordination within the FHT. The following enablers were instrumental in ensuring the success of the initiative:

- **Flexibility:** Both partners exhibited flexibility to make this model work. For example, when CCAC eligibility criteria proved to be a barrier to service, the FHT identified ways to address the issue, to effectively work around the barrier.
- **Technology:** It was important that all parties were knowledgeable about privacy obligations - that they were clear about the truths and myths of privacy, and roles and responsibilities. The CCAC Care Coordinator was given 'read only' access to the FHT EMRs, and the CCAC provided 'read only' access to its CHRIS records. It was felt by the team that ability to chart directly in the EMR would become too complicated, but the process is underway to enable the Care Coordinator to add to the coordinated care plan.
- **Geography:** In some ways the rural setting made this model easier to implement. The reality of the social determinants of health is harder to ignore when people live in a small community and everyone knows one another.

Sunnybrook Academic Family Health Team

Background

Sunnybrook Academic Family Health Team (SAFHT) is a provider-led, academic FHT. The physician-led Board is committed to transitioning to a mixed governance model in the future.

The SAFHT evolved from a pre-existing Department of Family and Community Medicine and HSO. It has 13 physicians (all of whom deliver patient care and also have research and teaching responsibilities) and 13 IHPs (9 FTEs). The FHT works out of one site in a highly urban setting. The FHT provides care to approximately 9,500 patients.

The FHT has access to one CCAC Care Coordinator, who reports to the CCAC and who provides case management services to the most complex FHT patients. Approximately 50% of his time is spent with FHT patients. When he is not doing home visits, the Care Coordinator tries to be on-site as much as possible. He has a small office near the physician group, which helps to ensure face-to-face contact. He has become a member of the FHT by participating in FHT programs (e.g. he attends teaching rounds even when patients are not CCAC clients, and he participates in the Homebound Seniors' Program).

The Motivation

The FHT was established in 2011 (Wave 5) compared to earlier FHTs, was less well resourced. As a result, the FHT needed to find ways to supplement staffing, using partnerships to better serve its patients. Accordingly, the FHT has partnered with the CCAC, St. Elizabeth Health Care, and the hospital.

The Process

The FHT's Executive Director and Lead Physician led this initiative. The Board of Directors provided support and approval.

The Outcome

The robust Care Coordinator role has resulted in more consistent care for patients, greater collaboration, and more streamlined care. Communication between the FHT and the CCAC has improved; fewer calls go unanswered, and providers are now able to talk to the same Care Coordinator each time.

The physicians and IHPs welcome the support and expertise from the Care Coordinator. There is meaningful inter-professional discussion and providers are more confident that patients are receiving the community supports and services they need.

The Care Coordinator deals with the most complex patients, but is also able to consider patient needs in the context of the social determinants of health. This ability to provide full care increases the likelihood of positive health outcomes.

Challenges

CCAC staffing changes made the early years difficult.

Care Coordinators were being changed constantly which meant that it was difficult to develop a strong team and consistent approach.

Enablers

A number of factors have been critical to the success of improved care coordination within the FHT. The following enablers were instrumental in ensuring the success of the initiative:

- **Technology:** The CCAC Care Coordinator is able to chart directly in the FHT EMR and communicate with FHT clinicians through its messaging system.
- **Relationship building:** Face-to-face contact between the Care Coordinator and the FHT providers has strengthened the collaboration.

City of Lakes Family Health Team

Background

City of Lakes FHT is located in the Sudbury region, which is the largest municipality in Ontario covering about 36,000 square kilometres. It consists of both urban and rural populations.

The FHT was established in 2007, and has 15 physicians and 11 IHPs working out of three sites. The FHT is currently expanding, with plans to add four new physicians in a new location, expected later in 2016.

The FHT pilot project began with one Care Coordinator providing dedicated support to FHT patients. It is a traditional Care Coordinator role, using a CCAC job description and reporting to the CCAC. There are now three Care Coordinators (planning on expansion to a 4th) who work full time with the FHT. All three Care Coordinators work across all three sites, one Coordinator dealing specifically with patients who have complex care needs. At each FHT site, the Care Coordinator is provided with a workstation, computer, and phone, although they also bring their own laptop and phone as desired.

The Motivation

Physicians and IHPs were experiencing difficulties with the system of referrals and patient support. It was time consuming to reach the CCAC Coordinator, there was no consistency in who the coordinator would be, FHT providers never knew the status of their patients vis-à-vis CCAC care, and it was generally felt that patients were "falling through the cracks". Providers were frustrated and worried about their patients, particularly the frail elderly.

The Process

The Executive Director and Nurse Practitioner decided that a shift in the way of doing business was necessary and they reached out to the LHIN and the CCAC. At the same time, colleagues in other North East FHTs were also identifying that a shift in the relationship was necessary. The NE LHIN and NE CCAC were being approached by several FHTs at the same time, which strengthened everyone's case. The CCAC agreed to a pilot project and allocated a part-time Care Coordinator to work with the FHT. Now instead of faxing referrals and phoning, the process has changed to a face-to-face collaborative working relationship and has expanded from one position to three.

The Outcome

Both patients and providers are enthusiastic about the role of Care Coordinators in the FHT.

- Patient care has improved.
- There is improved consistency of care
- Care Coordinators have ready access to physicians and nurse practitioners
- Care Coordinators sometimes do joint home visits with physicians and NPs which reduces the burden on the patient of having several visits from different providers
- Communication breakdowns have largely been eliminated. Communication with Care Coordinators has become much easier and more effective.
- Collaboration has improved. Care Coordinators routinely participate on FHT committees.

Challenges

City of Lakes FHT found that initially there was some CCAC middle management resistance to the new model. Additionally, the new way of working did not align with the internal CCAC functional model, which took some time to adapt to.

Enablers

A number of factors have been critical to the success of improved care coordination within the FHT. The following enablers were instrumental in ensuring the success of the initiative:

- **Technology:** Care Coordinators have "read and write" access to the FHT EMR and use internal messaging to communicate with FHT providers.
- **Openness to Change:** Both the CCAC Care Coordinators and the FHT members were supportive and enthusiastic. They embraced the new process and were keen to try a new approach. The CCAC Care Coordinator was an early adopter and very good at building relationships.
- **LHIN Support:** It was important to have support from the LHIN for the early pilot.

Guelph Family Health Team

Background

The Guelph Family Health Team (GFHT) is a physician-led team established in 2006/2007. It is a large FHT comprising 80 physicians and approximately 70 clinical staff working out of more than 20 sites. About 110,000 patients live in this predominantly urban area.

The FHT and CCAC piloted one dedicated CCAC Care Coordinator who works in one practice group with FHT patients requiring CCAC services. It is a traditional Care Coordinator role, reporting to the CCAC and with a CCAC job description.

The Care Coordinator is not resident at the physician office but is on site weekly. She has 'read and write' access to the FHT EMR, and works on a virtual collaborative care plan. The ease of access to the EMR is a strong component of system integration.

The Motivation

Physicians and IHPs were experiencing difficulties with referrals to CCAC. It was time consuming to reach the CCAC Coordinator, there was no consistency in who the coordinator would be for the practice, and communication about patient status was lacking. The FHT was particularly concerned about its patients with complex needs.

The Guelph FHT is the Health Links lead agency in this region. When Health Links began, the CCAC and FHT undertook this pilot. The rationale was to better serve those patients who required more complex care.

The pilot project was in place for the better part of a year, with good results. The CCAC and the FHT continue to work successfully with this model. However, change is coming, as the CCAC is currently realigning its Care Coordinators based on a geographic allocation rather than an allocation of specific case management resources to providers.

The Process

The process began with discussions at the Health Links table. The FHT Executive Director was instrumental in providing leadership to a new partnership between the FHT and the CCAC. They agreed to pilot the project at one site with about 5,000 rostered patients.

The Outcome

Physician feedback from the FHT provides a resounding endorsement of the value of CCAC Care Coordinators to patient care: "This and the EMR are the best things that have happened to our FHT in recent years".

The Care Coordinator has become a critical resource to physicians and patients. Communication is easier and more effective. Communication breakdowns have largely been eliminated.

Patients have been well served.

- Patient care has become more focused.
- The Care Coordinator has become the go-to person, including for those patients she would not ordinarily be responsible for (e.g. palliative care, school programs).
- Improved consistency of care.

Enablers

A number of factors have been critical to the success of improved care coordination within the FHT. The following enablers were instrumental in ensuring the success of the initiative:

- **Technology:** The Care Coordinator has access to the FHT EMR, which eliminates the need for multiple assessments. Further, while the Care Coordinator is on-site about once a week, when she is off-site she is working remotely and is fully connected electronically to the care plan and the team.
- **Face-to-face meetings:** The Care Coordinator attends meetings with the FHT outreach nurses and social workers weekly; this has allowed her to effectively become one of the FHT team members.

With the CCAC's intention to realign its Care Coordinators based on a geographic allocation rather than allocating case management resources to providers, Guelph FHT hopes the benefits of this pilot will be retained.

South East Toronto Family Health Team

Background

The South East Toronto Family Health Team (SETFHT) began operations in 2006/2007. It is an urban, academic team with 23 physicians (all part-time with additional teaching and research responsibilities) and 23 IHPs. The FHT provides care to approximately 25,000 patients (18,500 are rostered). A Board of Directors comprising five physicians and four community members governs the FHT. There are two clinical sites and a small administrative office.

The Motivation

The FHT Board and providers felt that patient care was falling short. They were unaware of the status of their patients following referral to the CCAC, and they had no access to parts of the system that their patients were interacting with – for example, they had no relationship with the Personal Support Workers (PSWs) who were providing care to their patients in the community. The FHT staff and physicians had difficulty reaching the CCAC Care Coordinators, and vice versa. In short, they felt that patient care was unsatisfactory.

At the same time, the FHT's Strategic Plan had an emphasis on building partnerships. A partnership with the CCAC was a logical step to improve care by building a relationship with a different part of the system.

The Process

Closer collaboration with the CCAC was a process that occurred over time. It began with initiating a relationship, and allowed both parties (together) to do a thoughtful analysis of the struggles everyone was having connecting patients with the right care. The idea emerged organically, and then became a real quality improvement exercise. The process was a tandem effort by the Lead Physician and the Executive Director. The specific steps included:

- Working with the CCAC to assess how things could be done better. The CCAC began by redefining the geography for Care Coordinators so that there was more consistency for patients and primary care providers.
- Making the Care Coordinator part of the team. The Care Coordinator affiliated with the SETFHT geography became the contact for the home visit team, the virtual ward patients, and was the main point of contact to the CCAC. This person began to attend meetings at the FHT.
- Assigning the CCAC Care Coordinator an office at the FHT.

The CCAC then assigned a second Care Coordinator to the FHT, and two Care Coordinators have now been embedded at the FHT for five years. Each is at the FHT half a day a week and are out in the community four and a half days a week.

The FHT has a Care Navigator position that works very closely with the CCAC Care Coordinators. While the CCAC positions do system navigation across all parts of the system (e.g. the CCAC funded service providers), the FHT Care Navigator focuses on navigation within the entire health care system, regardless of whether or not they qualify for CCAC services, and is primarily used to help individuals with issues related to mental health or those struggling with finding ways to pay for their medications. These two positions work very well together with no duplication. Because the CCAC Care Coordinator attends FHT rounds, she may support some FHT patients who are not on the CCAC case list. Additionally, because she spends significant time in the community, she is able to refer patients to the FHT who have no primary care provider.

The Outcome

From the FHT's perspective, the CCAC is now one of its most important partners. The model has been very well received by both patients and providers, and has resulted in the following outcomes:

- An ongoing, consistent Care Coordinator.
- Easier contact with the CCAC.
- Ability to leverage the knowledge of the Care Coordinator for non-CCAC patients.
- Ability to attach patients to a primary care provider if they are in the community but without access to primary care.

Challenges

Early challenges included space, hesitation around access to the EMR, and role clarity (care coordinator vs. care navigator); these were solved quickly. A bigger challenge was the perception by both groups (primary care and CCAC)

that they were 'not wanting to play in the sandbox together'; in reality, everyone truly valued the concept of integrated team-based care and this challenge quickly dissipated.

Enablers

A number of factors have been critical to the success of improved care coordination within the FHT. The following enablers were instrumental in ensuring the success of the initiative:

- **Technology:** Care Coordinators are able to chart directly in the FHT EMR through the use of a data sharing agreement. Information from the CCAC system, CHRIS, is also uploaded into the EMR (through scanned notes).
- **Team Integration:** Whether it is the weekly virtual ward or home visit rounds or the fact that the CCAC Care Coordinators have office hours within the FHT, they have become true team members - providers and patients have now built strong relationships with them.
- **Collaborative culture:** All providers in East Toronto are part of a Solutions group hosted by the hospital with an emphasis on partnerships and integration of services to ensure seamless transitions of care for all members of the community. This helped to build a better relationship with the CCAC.

Advice and Lessons Learned

The five FHTs profiled have all experienced the value of dedicated Care Coordinators to the provision of enhanced patient-centred care. Their advice to other FHTs and primary care teams, and the lessons they have learned in the process, include the following:

1. **Don't wait**

   There is significant change occurring in the health care sector, and it would be easy to wait for the next iteration of CCAC service delivery, or Health Links, or primary care reform before moving forward with new projects. However, the advice of all five FHTs is that having a care coordinator as part of the team has a significant impact on quality and effectiveness of care.

2. **Manage change**

   Pay attention to the principles of change management as new models of service delivery are rolled out. Change may be difficult, and it may take some time to build relationships and trust.

   At the City of Lakes FHT there was some initial reticence from the CCAC. The pilot project began slowly, with the Care Coordinator gaining access to messages on the EMR. Over time, trust was built, and the partners recognized how the role could benefit the CCAC, the FHT, and most importantly, the patients. Greater collaboration was built on early successes.

   A primary care provider who becomes a champion will help to ensure success.

3. **Build relationships and collaboration**

   Successful change is more often an evolution than a revolution. The evolution starts by building effective relationships with stakeholders and potential partners, and exploring together how to make lasting system improvements. Patients are shared across a wide range of providers and partners; it makes sense to begin the conversation with the CCAC.

   It is also helpful to build a good relationship with your LHIN. Some LHINs are only peripherally familiar with Family Health Teams (as distinct from CHCs, for example); however, they are in a position to support system improvements and collaboration.

   With increased system coordination and collaboration there is a learning curve; it may take time but effective relationships are important to success.

4. **Tailor your model (to respond to unique needs)**

   Build a collaborative model that fits the profile of your primary care team and leverages your strengths. What works well for a small rural team may not work for an urban team. Primary care teams with existing staff dedicated to system navigation, for example, may find a different way of working with the CCAC Care Coordinator. But do your homework and learn from other teams and providers about their approaches so that you can build on their experience.

   One model will not fit all circumstances. The model you select will depend on your starting point, the population you are serving, and the resources you have.

5. Define the role broadly

Effective care coordination involves a broad array of providers and services; the Care Coordinator needs to be a community Care Coordinator with access to mental health services, specialists, cancer care treatment, and other community support services.

6. Co-locate where possible

By the nature of the job, Care Coordinators spend a lot of time in the community, visiting patients. However, having a home base at the team site, or dedicated on-site time when inter-professional providers can see and talk to them, improves efficiency and builds a sense of collaboration and teamwork. Providers get to know the person they are working with; s/he is not just someone on the other end of a phone line. This builds trust, strengthens relationships, and improves understanding about scope of expertise.

Many primary care teams do not have providers (IHPs or physicians) in their offices five full days a week. Try to schedule the care coordinator for a time when there is an empty office. Alternatively, some Care Coordinators have office hours in meeting rooms.

Virtual access to documents and EMR is important, but there is a need for face-to-face communication.

7. Enable access to EMR

Many FHTs found that one complete record for the patient is very important for the patient story. Patients want their primary care provider to hold their health information but there are so many different systems to integrate. Having Care Coordinators chart directly into the EMR allows for one story. Hesitation around non-FHT staff charting in the EMR can be addressed with the implementation of a data sharing agreement with the CCAC.

8. Quality Improvement

A quality improvement perspective will contribute to a broad understanding of the role, intended outcome, process, and measurement indicators that will ensure success.