Care Coordination:
Working Differently for Better Care

North East Toronto Health Link
&
East Toronto Health Link

Jocelyn Charles MD CCFP MScCH
Aasif Khakoo MHA CMA CPA CHE

Disclosure

- Faculty: Dr. Jocelyn Charles
- Relationships with commercial interests: none
- Potential for conflict(s) of interest:
  - None to declare
- Mitigating Potential Bias:
  - Not applicable

Objectives

1. What are current challenges in care coordination?
2. How do we identify complex patients?
3. What are some of the challenges for primary care providers in caring for this population?
4. What are the required principles and elements for coordinated care planning?
5. Can we identify alternate models using inter-professional teams & a more holistic approach?
6. How can we work differently together?

Objective #1:

CURRENT CHALLENGES IN CARE COORDINATION

Why is it more difficult to coordinate care?

- ↑ population with multiple chronic diseases
- Care more complex with shorter time frames
  - Limited human and financial resources
- Multiple specialists directing care for single diseases
- Evidence-based care for one disease often conflicts with evidence for another disease
- Single provider, serial consultation model of care
  - Office visits scheduled based on old fee-for-service remuneration model even in FHOs (Wagner, 2012)

Why don't we communicate better?

- ***Lack of clarity*** about ***who is doing what*** and ***how*** to communicate with each other
- FP unable to reach the treating MD in ED
  - Too busy or shift change so FPs stop trying
- Specialist unable to reach FP
  - Not answering phone, no secure email use so specialists stop trying
- Long wait times in ED: EMS can't wait

(Carrier et al, 2011)

Involvement of increasing number of medical specialists & increasing amount of diagnostic tests

Coordinated Care Plan Development: *Observations from the Field*

Providers:

- Unapproachable
- Inaccessible – after hours, telephone advice, email
- Lack of clarity re: expectations
- Communication b/w providers is inconsistent or non-existent
- Community providers not included in care conversations

Care Coordination:

- Lack of clarity of who's role it is
- Resource availability

Patients:

- Tell story repeatedly
- Expectations unclear
- Unsure of plan of care
- May not understand rationale for care provided

Families:

- Want flexibility of role in care-coordination
- Variable expectations
- Lack support
- Not available to support
- Low SES
- Difficulty accessing resources

Objective #2

IDENTIFICATION OF COMPLEX PATIENTS

System definition of a complex patient:

Complexity is defined as a composite of a number of reinforcing medical and psychosocial issues which can include the following co-existing conditions:

- Age (>65)
- Medically challenging chronic conditions (usually >2)
- Multiple medications
- Cognitive impairment and/or challenged by mental health and addiction issues
- Compromised, unsafe living situation either lacking in economic stability, housing and/or caregiver absence/at risk for burnout, refugee status
- High use of multiple health services including use of the Emergency Department

Problems with system definition:

- Guidelines don't always apply
- Multiple service providers
- System designed around specialists and single disease models no longer serves the people who most need hospital care
- Lack of mechanisms that make fragmentation a big issue for safety, cost, patient experience and provider satisfaction – e.g. med reconciliation
- Little research on the effects of fragmentation: more physicians = more fragmentation
- Access to care for patients with mental health conditions and substance use challenging
- Social supports for patients lacking

Who are our patients with complex needs?

- North East Toronto Health Link definition:
  - 3 or more hospital stays in 6 mos
  - 4 or more ED visits in 6 mos
  - RGP Frailty algorithm
  - Community definition:
    - 2 or more chronic conditions requiring more frequent assessments/changes to treatment
    - Complexity factor
    - Identified opportunity by pt/team to improve the coordination of care to reduce future acute care use
- Tracking and flagging system going live:
  - Better Care System

Community Definition

Complex =

2 or more chronic conditions
requiring more frequent assessments/ modifications to treatment

+

A complexity factor *

+

An identified opportunity by patient/team to improve the coordination of care to reduce the risk of avoidable acute care utilization

Note: Partners are required to start coordinated care planning before requesting patients be placed on the Better Care System

*Complexity factors include:
→**Social determinants of health deficiencies**
(i.e. housing, food, safety, finance, health literacy)
→ **Lack of support**
(i.e. lives alone, no caregiver support)
→ **Barriers to accessing care/services**
(i.e. language, culture, mobility)
→ **Mental health condition and/or addiction**
→ **Cognitive impairment/dementia**

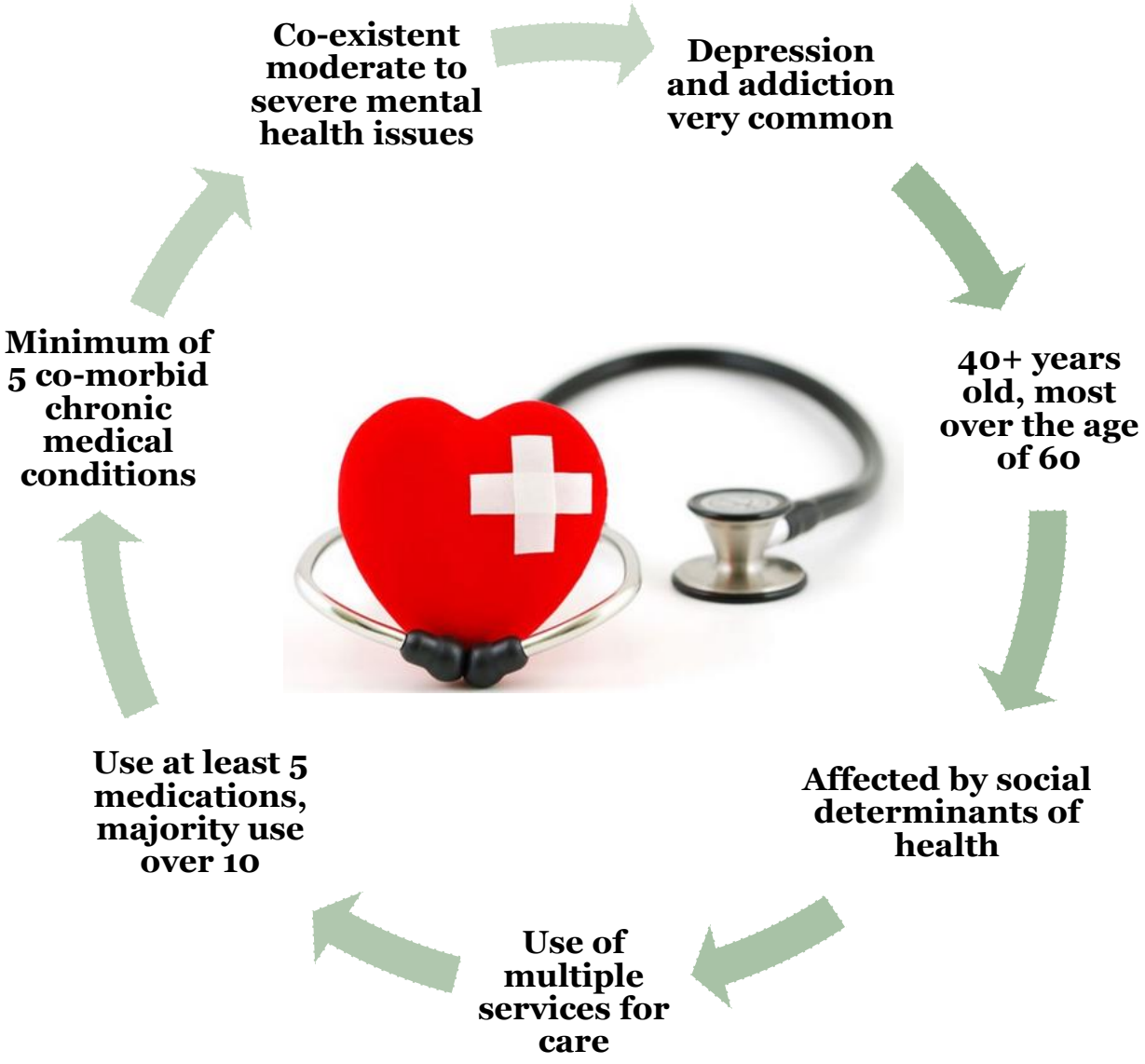
Who are our patients with complex needs?

- East Toronto Health Link definition:
  - Retrospective patient chart review
    - Rate of ED utilization and frequent hospitalization
  - Clinical intuition and judgment (Community Solo Doctors)
    - What patient keeps you up at night
  - ED physician assessment
    - Patient likely to return to ED; no community support or primary care provider; mental health; older adult with co-morbidities
  - Acute inpatient stay
    - LACE Index (Length of Stay, Acuity of Admission, Co-morbidities, ED visits). Score of >9 = Risk of Readmission

Who are our patients with complex needs?

- East Toronto Health Link definition:
  - Rehab/LTC
    - Risk of readmission and facilitating a coordinated discharges (Reducing ALC at Providence - RAP sessions)
    - Risk assessed during admissions as well as resident stays in LTC (NLOT and ILTC)
  - Community
    - Cross-Continuum Team (CCT) Rounds/Case Conferences
    - Monthly case management meetings identifying referrals within community and referrals with medical team
    - Community physicians referrals (TIP, VW)
  - Primary Care (FHTs and CHCs)
    - Physician practices identification based on clinical judgement

What factors do our complex patients share?



Objective #3:

CURRENT CHALLENGES FOR PRIMARY CARE PROVIDERS TO CARE FOR COMPLEX PATIENTS

Current State: Primary Care Providers

IHI Triple Aim Initiative

Better Care for Individuals, Better Health for Populations, and Lower Per Capita Costs

- Improve the patient experience of care (including quality and satisfaction)
- Improve the health of populations – focus on outcomes
- Reduce the per capita cost of health care

Additional Aim:

- How to reduce the burden of care for both patient and PCP?
- Empowerment of PCPs to care for complex patients

Objective #4:

REQUIRED PRINCIPLES/ELEMENTS FOR COORDINATED CARE PLANNING

It Takes a Village…

The Care Team in the Microenvironment

- Identification of the Frail Individual
- Composition of the team?
- Where is service delivered? Office vs. Home?
- Transitional challenges
- Community and Medical Providers collaboration –challenges and opportunities?

The Care Plan

Driver 2b: Develop and Implement a Negotiated Care Plan

- Validated geriatric assessment is done
- Senior Coach asks “What Matters Most to You”
- Develop a Person Centered Care Plan based on preferences and achievable
- Assess their confidence
- Set up action plan and followup
- Share plan with Interdisciplinary team
- Bring goals and action plan to PCP-Share decision making process

Components of Care Planning

- **Patient Engagement:**
  - Assessment of readiness to engage
  - Health literacy level
  - Patient education re: value of CCP
- **Physician engagement:**
  - Readiness to engage
  - Education re: value of CCP
- **Core Elements of CCP Process:**
  - Identification of patient's goals
  - Circle of care: membership, responsibilities
  - Care Coordinator
  - Team communication

How do we engage patients?

- Recognize patients who may benefit
- Introduce opportunity to enhance care coordination
- Patient education about benefits of Care Coordination
- Talk to other providers involved with pt:
  - FHT interprofessional health care providers
  - Specialists
  - CCAC Care Coordinators
  - Community Service providers
- Others?

How do we engage physicians?

- Education re: importance of CC, how to initiate a CCP
- Start with the willing
- Link FP with a single CCAC Care Coordinator:
  - Importance of ongoing relationship
- Identify key specialist resources to provide simple access points for advice/guidance
- Others?

Coordinated Care Planning – Provincial Principles

- Information is communicated to the patient with full access and understanding of information usage
- Developed with direct input from the patient in clear accessible language (in patient's own words)
- Accessible to patients and the circle of care in any setting where care may be delivered
- Actively used & reliably maintained according to the clinical practices established in each Health Link
- Based on current evidence and use generally accepted clinical guidelines

Coordinated Care Plan: Guiding Principles by Health Link Leadership

- All components are guided by patient's choice
- Goal directed
- Coordinated by an assigned lead
- Flexible & responsive to change
- Promotes self-management
- Built on existing resources & strategies
- Clear expectations & accountabilities
- Supported by technology-enabled communication & navigation systems

Care Coordination System Requirements:

- ***Real time communication*** between primary care, specialists and community providers at ***all points of care***

- ***Shared accountability*** for anticipating patient needs, planning care & educating each other

Critical Message…..

- A care plan is not a one-time document
- It is constantly changing and evolving
- Requires ongoing dialogue between the patient, the primary care provider and the whole circle of care
- To achieve this we all need to **work differently** together every day:
  - With our patients and families
  - Within our FHT
  - With our hospitals
  - With our community providers

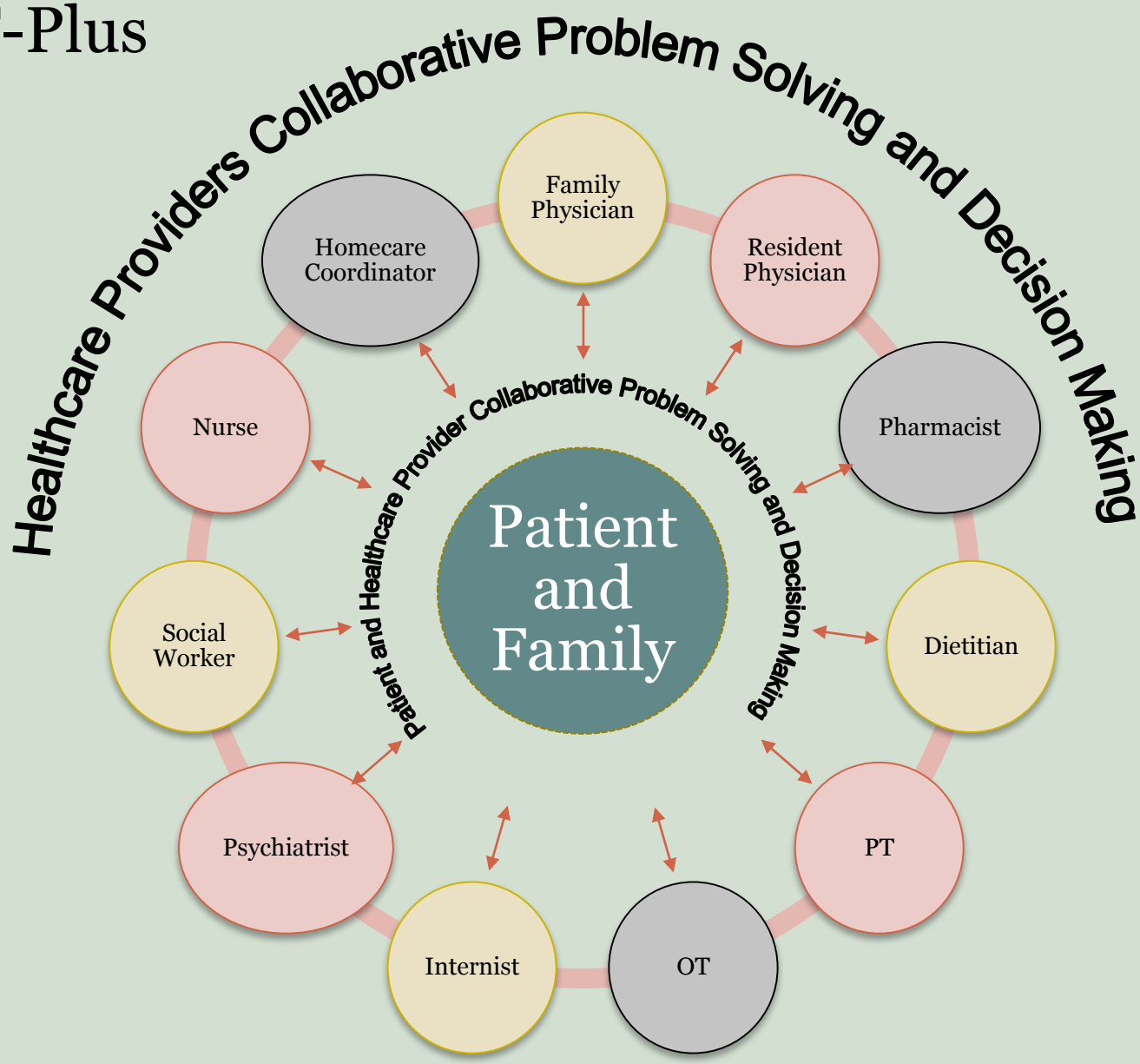
How Can We Coordinate Care?

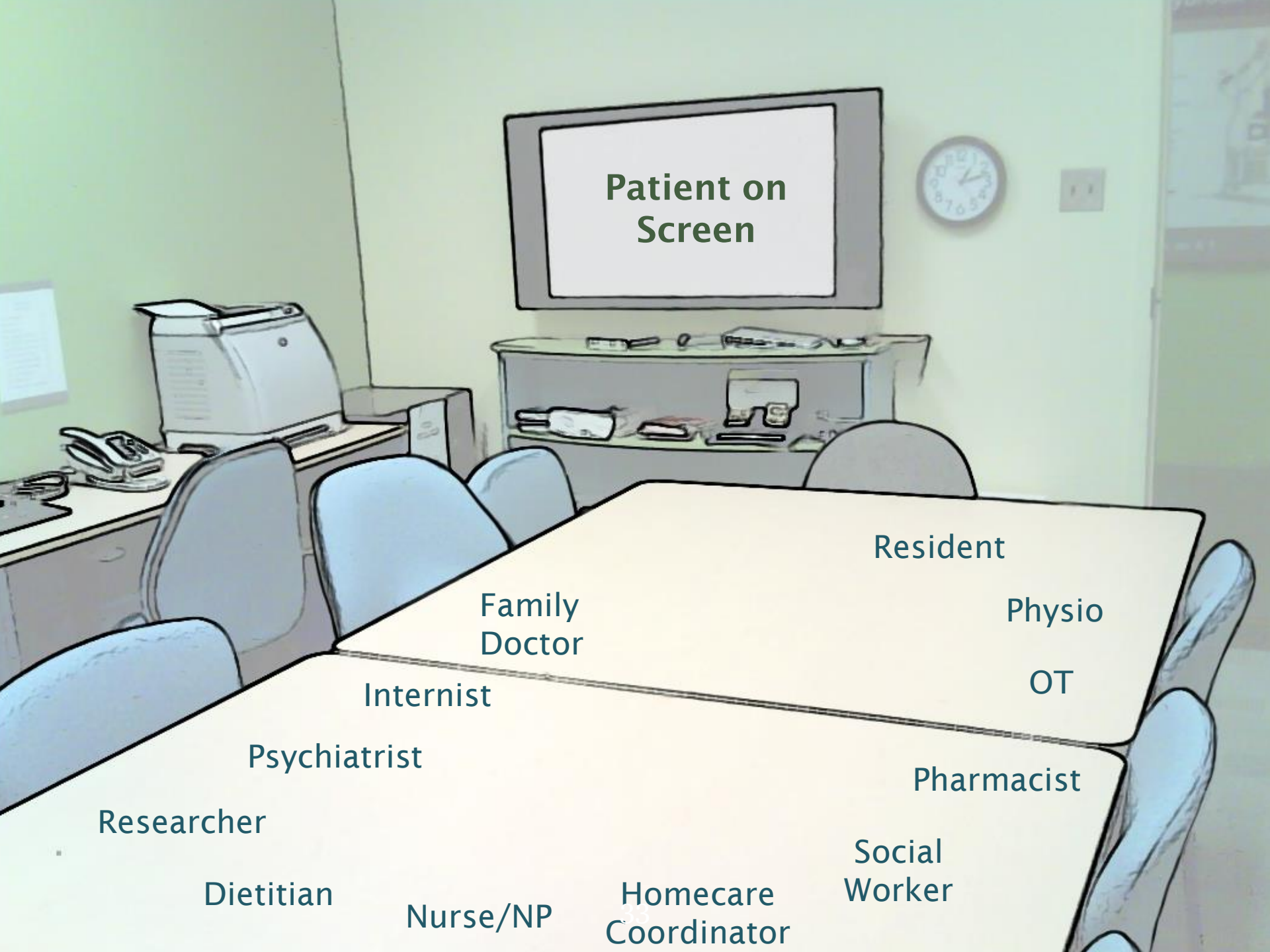
- Create opportunities for patients with complex care needs to talk to their providers:
  - At the same time
  - About what is important to them
  - Not just about their diseases and treatments
  - To engage in dialogue about options for their care
  - To know what everyone does and how to reach them

Objective #5:

IDENTIFYING ALTERNATE MODELS USING INTER-PROFESSIONAL TEAMS

IMPACT-Plus


Healthcare Providers Collaborative Problem Solving and Decision Making
Patient and Healthcare Provider Collaborative Problem Solving and Decision Making
Patient and Family
Family Physician
Resident Physician
Pharmacist
Dietitian
PT
OT
Internist
Psychiatrist
Social Worker
Nurse
Homecare Coordinator


Patient on Screen
Resident
Family Doctor
Physio
OT
Internist
Psychiatrist
Pharmacist
Researcher
Social Worker
Dietitian
Nurse/NP
Homecare Coordinator


ook Health Science C
Tim Hortons
3M
Daily

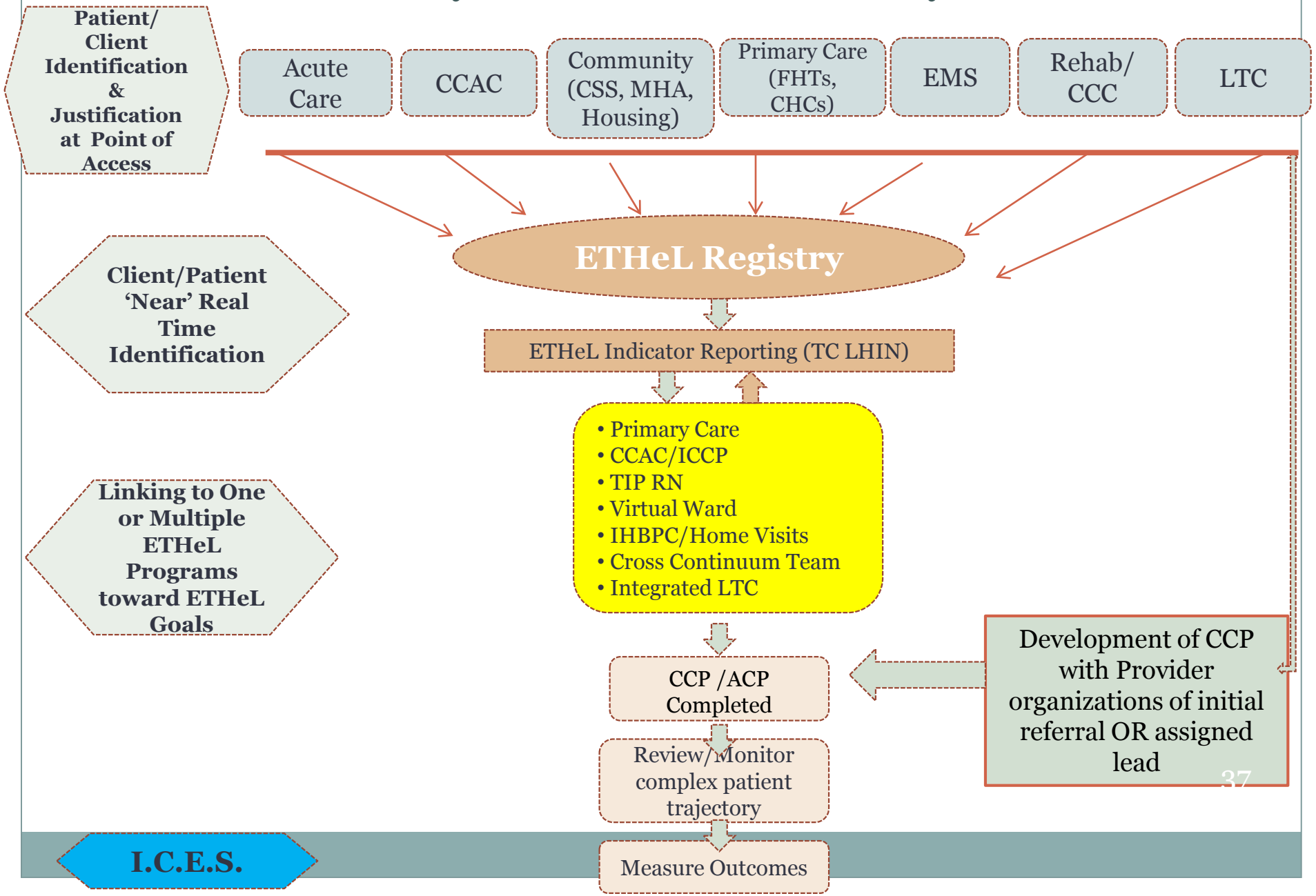
Telemedicine IMPACT-Plus

- Nurse facilitator identifies complex patient and offers care planning session with:
  - Pt's family physician
  - CCAC Coordinator
  - FHT Care Coordinator
  - Interprofessional team
- OTN link between patient, FP and team to discuss patient's goals and strategies

NETHL - ED Care Coordination

- OMA Medically Complex Demonstration project
- Complex patients flagged in ED
- GEM nurse and CCAC CC see pt right after triage:
  - Assess & identify barriers to managing in community
  - Teleconference with FP if available + community CCAC CC
  - Huddle with physician after physician assessment
  - Initiate Coordinated Care Planning:
    - Pt follows up with FP and CCAC-CC to finish Coordinated Care Plan

ETHeL: Building a Coordinated Care System for the Frail Elderly



How Will We Know We Have Improved?

- Patients report ↓ # of times need to repeat their story
- Circle of care knows:
  - Each patient's goals
  - Their role AND everyone else's
  - How to contact other members
  - When a patient has had a change in health/admission
- Less duplication of tests/services
- Fewer adverse events due to poor communication

Objective #6:

WORK DIFFERENTLY, TOGETHER

How Do We Start?

1. Recognize patients with complex needs:
   - Invite them to discuss their care goals
   - Ask who needs to be involved in planning their care
   - Schedule appointment to get started
   - Engage CCAC CC if appropriate

2. Shift from reactive, problem oriented care to proactive goal-directed care

   Move away from 15 min single provider appts for these pts

3. Create opportunities for more 2-way conversations with other providers in a pt's circle of care → to plan, monitor & update

Identify Complex Patients

Driver 2a: Understand the Individual

- What Matters Most to the Individual?
- Why is this Important?
- Do you ask this question or one like it?
- Who knows the story?
- Does your team understand the Individual's story?
- Does the Community based provider know this?
- What about the family caregiver views and undestanding?

The Care Plan

Driver 2b: Develop and Implement a Negotiated Care Plan

- Validated geriatric assessment is done
- Senior Coach asks "What Matters Most to You"
- Develop a Person Centered Care Plan based on preferences and achievable
- Assess their confidence
- Set up action plan and followup
- Share plan with Interdisciplinary team
- Bring goals and action plan to PCP-Share decision making process

How can **you** work differently?