



Position
Statement:
Care Co-ordination
In Primary Care

November
2015

Contents

- Care Co-ordination in Primary Care..... 3
- Setting the Context: Ontario Primary Care Council 4
- Ontario Primary Care Council Position on Care Co-ordination 5
- Rationale for Primary Care Leading Care Co-ordination 5
- Defining Care Co-ordination 7
- Operating Assumptions about Care Co-ordination 8
- Principles of Care Co-ordination and Desired Outcomes 9
- Enablers for Effective Care Co-ordination 10
- Lessons Learned and Conclusion 13
- Appendix A..... 15
 - Examples of Care Co-ordination in Primary Care..... 15
 - Details of Primary Care Care Co-ordination Aligned to OPCC Principles..... 15

This document was developed through a collaborative process by the Ontario Primary Care Council. The OPCC is a group of associations who provide leadership, through relationships, to advance person-centred primary care in Ontario and develop actionable plans informed by pressing provincial priorities and trends.

The information, views and recommendations expressed in this document do not necessarily reflect the opinions of all individual member organizations involved in the Council

‘Position Statement: Care Co-ordination in Primary Care’ has been endorsed by:
Association of Family Health Teams of Ontario (AFHTO)
Association of Ontario Health Centres (AOHC)
Nurse Practitioners’ Association of Ontario (NPAO)
Ontario College of Family Physicians (OCFP)
Ontario Medical Association (OMA)
Ontario Pharmacists Association (OPA)
Registered Nurses’ Association of Ontario (RNAO)

Care Co-ordination in Primary Care

“Patients were coming to their doctor with issues that are not traditional medical problems. There is a wide range of services available in the community and it can be difficult to keep up with the changing programs and services. Relationships with other providers allows for warm hand off and simple transition.”

McMaster Family Health Team

“Holistic care is increased for vulnerable populations and individual clients of solo practitioners. Primary Care Physicians are able to tap into a full range of services through one referral form – don’t have to spend as much time learning about a referral, how to do it, finding the resource, etc.”

Access Alliance - Solo Practitioners in Need (SPiN)

“Patients are thrilled to be engaged and listened to. The process ensures the time required to listen, verify the patient’s concerns, establish goals important to them and ensure for ongoing follow up with the patient. Practitioners are equally pleased with having a resource to turn to who will take the time to ensure for the right service at the right time as well as keep the practitioner informed – improving their experience with the patient. “

Rural Hastings Health Link

“Many of the other service providers that we worked with had to build trust with their own agencies and with others on the team to feel secure in taking this patient centered approach as opposed to a more black and white, ‘here is what’s available’ approach.”

Rural Wellington Community Team

Setting the Context: Ontario Primary Care Council

The Ontario Primary Care Council (OPCC) is a partnership comprised of seven provincial associations who represent primary care models and providers in the province working together to strengthen the delivery of primary care:

- Association of Family Health Teams Ontario
- Association of Ontario Health Centres
- Nurse Practitioners' Association of Ontario
- Ontario College of Family Physicians
- Ontario Medical Association
- Ontario Pharmacists Association
- Registered Nurses' Association of Ontario

The Council's guiding principles include the following:

- Primary care is central to the performance of whole health system effectiveness
- Planning for the system needs to be based on population needs
- Programs and services must be appropriate, accessible, timely, high-quality, comprehensive, continuous, evidence-informed, equitable and culturally competent
- Care co-ordination is a core function of primary care
- Collaborative interprofessional teams working to full scope of practice are key to success

Linkage to the OPCC Strategic Framework

The OPCC have collectively developed and endorsed a strategic framework. This framework provides clarity by defining primary care and what constitutes a strong primary care foundation, guiding principles, functions of a strong primary care system and enablers to help achieve this desired end state.

The provincial government's efforts to improve quality, access and value for money in the province's health system can be enhanced by tapping into the Council's expertise. The Council's position statement on care co-ordination by primary care is intended to guide the development of ongoing health system transformation.

Ontario Primary Care Council Position on Care Co-ordination

The Ontario Primary Care Council (OPCC) affirms comprehensive care co-ordination as a dimension of quality primary care that is patient-centered and leads to effective and more seamless transitions between settings and among providers. Effective care co-ordination 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.

Care co-ordination is happening across primary care, with successful initiatives led by providers and teams for patients and families in Ontario. Whether establishing Health Links, supporting better integration through shared care models, implementing strategies for specific populations such as seniors or individuals who need access to mental health and addiction programs, or better management of chronic diseases such as COPD and asthma, primary care is playing an active and pivotal role in supporting patients and families to get the right care at the right time from the right provider. For care to be truly patient-centred, care coordination must happen across all parts of the health system.

OPCC asserts the role of primary care providers to lead care co-ordination. Primary care providers work to ensure access to interprofessional care for patients and identify a single point of contact to help patients and families navigate and access programs and services.

The OPCC believes care co-ordination requires recognition, dedicated funding and leadership support through training and education.

Rationale for Primary Care Leading Care Co-ordination

Effective care co-ordination is best led by a person's primary care organization throughout his or her lifetime. Patients in primary care are "patients for life" – reinforcing the concept of **comprehensive care from "womb to tomb"**.

Primary care is an **anchor for patients and families and is well positioned** to enable care co-ordination in the healthcare system. Primary care should be the **first contact or entry into the system** for all new needs and problems.

Primary care is the **foundation in healthcare that should organize and activate the deployment of healthcare resources**. Some patients with complex care needs require multiple services to manage their health. Others may require specialty care particularly when experiencing episodes of acute illness. Primary care is this critical link between the patient and specialty care (e.g. psychiatry, orthopedics, dermatology etc.) and supportive services (i.e. social needs).

Primary care providers **directly influence the responses of people to their health needs** by listening to the concerns and preferences and providing clinical evidence-based assessment and treatment recommendations.

The OPCC has identified co-ordination of care as an area of shared focus because of its **potential for significant positive impact on patient outcomes, healthcare delivery, and enabling Ontario's Action Plan for Health**. The Ministry of Health and Long-Term Care is transforming how care is delivered to Ontarians. The *Excellent Care for All Act* and the *Action Plan for Health Care* and the recently released *Patients First Action Plan for Health Care* aim to enable a health system that better responds to patient needs and delivers high quality care that is both accessible and affordable. Central to achieving elements of the *Action Plan for Health Care* is robust and well co-ordinated primary care.

Defining Care Co-ordination

Definition of Care Co-ordination

The key components of care co-ordination include:

Engagement and Assessment

- Building a relationship with patient (listening, exploring needs and values, information gathering and sharing, verifying concerns, establishing goals)
- Comprehensive assessment (inclusive of clinical/ medical needs and also the broader determinants of health)

Organization and Provision of Care/Services & Care Planning

- Developing a care plan by negotiating with patient about potential solutions and options
- Facilitating access to resources, programs/services, specialized care; matching needs with eligibility
- Working collaboratively and engaging with different types of providers (facilitating functioning to their maximum scope of practice)
- Connecting with other levels of care: secondary, tertiary and emergency care
- Reconciling therapeutic interventions, including medications
- Integrating care when there is more than one health need
- Exchanging the right information on a timely basis among participants responsible for different aspects of services the person requires¹
- Developing and keeping the care plan up to date and advising care team members of new information as relevant to their role
- Creating contingency plans (e.g. client safety/crisis plan, options and educating if after hours support is required)

¹ Definition is an adaptation of the RAO definition from “*Enhancing Community Care for Ontarians 1.0*” (www.rnao.ca/ecco) and the Agency for Healthcare Research and Quality (US) working definition of care coordination from “*Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol. 7: Care Coordination)*” 2007 Jun.

“*Integrated Complex Care model: Lessons Learned from Inter-organizational Partnership*” Cohen Eyal, Bruce-Barrett Cindy, Kingsnorth Shauna, Keilty Krista, Cooper Anna, Daub Stacy. *Healthcare Quarterly* (Vol. 14 Special Issue) October 2011

Learning from One-Day Session with Primary Care Members about Care Co-ordination and System Navigation, February 2015

- Advocating on behalf of the patient, family and caregiver

Ongoing Monitoring/Evaluation

- Monitoring and evaluating the patient's attainment of goals, clinical outcomes, satisfaction and unmet needs
- Managing (or acting as a liaison) at care transitions or changes in care status facilitating continuity of care (warm handoffs as patients transition in and out of hospital and/or specialist care)
- Being the point of contact for the patient with respect to any care co-ordination issues
- Organizing care conferences as needed to develop the care plan based on the patient's care goals
- An evaluation framework with targets and performance indicators should be developed to measure the effectiveness of care coordination

Operating Assumptions about Care Co-ordination

- ✓ Everyone needs care co-ordination
 - The level and extent differs over the course of the patient's journey through the healthcare system
- ✓ Care co-ordination is about the patient getting the right service at the right place by the right provider at the right time.
 - For this to occur, the right people need to get the right information and do the right things in the right order. It is acknowledged that there is not one organization, discipline or provider that can meet all the needs of a patient. The goal is to use the unique skills and expertise from a variety of disciplines as needed.
- ✓ A foundational element of care co-ordination is a holistic care perspective that includes addressing clinical/medical as well as the broader determinants of health
- ✓ The sustainability of our universal public healthcare system is a driving force behind this position statement (reduce duplication, evidence-based decisions guided by value and quality)

Principles of Care Co-ordination and Desired Outcomes

The six guiding principles of person-centred care co-ordination along with the respective desired outcomes are described in the chart below. These principles are shared by member organizations of the Council, and generally guide many primary care transformation initiatives.

Principles of Care Coordination	Desired Outcomes
1. Care co-ordination is a core function of primary care and a hallmark of a high-performing primary care system.	Care co-ordination is provided through the patient’s primary care organization throughout their life span.
2. Care co-ordination is patient-centred and includes communication and planning with the patient and family.	Patients are at the centre of their plan of care. Their perspectives (needs, concerns, values, language, culture, identity and preferences) are fully integrated in the formulation of this plan
3. Care co-ordination requires a population needs based approach to planning.	A comprehensive needs assessment that includes demographics, community resources, health planning data and human resources trends informs the development of the health system, primary care, care co-ordination and reduces health inequities
4. Care co-ordination will emphasize the timely and continuous delivery of high-quality, equitable and continuous services and programs that are comprehensive, evidence-informed, culturally competent and appropriate.	There is evidence that patients receive high quality care that reflects services and programs that are comprehensive, evidence-informed, culturally competent and appropriate.
5. Care co-ordination focuses on the provision of comprehensive services across the health and social services continuum as needed.	There is evidence that patients experience timely access to services and seamless transitions in care (right service at the right place by the right provider at the right time)
6. Care co-ordination is predicated on collaborative inter-professional teams working to full scope of practice.	There is evidence that patient care is optimized when all healthcare professionals are working collaboratively each at their full scope of practice; Strengthened partnerships amongst health service providers and primary care (e.g. better communications /information sharing, shared care)

Enablers for Effective Care Co-ordination

1. Aspirational goal-setting

- Inspiration and imagining the change or future that supports the commitment
- This aspiration for change needs to come from the frontline providers to ensure buy-in
- It is supported by change management that includes evidence, energy to change the system, and a plan to get there
- Collaborative goal setting among providers builds trust, changes culture, builds capacity – importance of communication

2. Patient engagement

- Patients are experts for their own lives and therefore involved in goal setting and care plans
- Involvement in project committee planning level
- Need to build buy-in and patient accountability which in turn will impact adherence to the care plan developed

3. An identified population

- Care co-ordination and system navigation can be targeted to an identified population in need as a starting point. System navigation can include helping overcome barriers to services by assisting patients in navigating the complex health and social services systems.
- Examples of identified populations included:
 - Persons who frequently present to the hospital emergency departments
 - Patients who keep providers 'up at night'
 - Persons with mental health and/or addiction issues
 - Frail elderly over the age of 70 who are at risk of falling
 - Persons at the end of life stage
 - Homeless and those with complex social needs

4. Creation of customized care co-ordination plans that are actively monitored

- Investigate needs; patients bring a broader list of issues that are most important to them
- Ensure incorporation of patient voice – listening, empowering, shifting the conversation, self-determination and participation in decision-making
- Understanding patient goals (including non-medical)
- Clarify who is doing what

- Developing structure and dedicated time to support the plan and make sure no one falls through the cracks
- 5. An organized entity with supporting infrastructure to carry out goals**
- Backbone support is essential to implement care co-ordination
 - Working together to pool resources and provide in-kind support to deliver patient-centred care
 - Team members are connected through collaboration and linking or sharing of resources (not necessarily co-location)
- 6. A team with a commitment by members to care co-ordination**
- An individual's health issues can be very complex and people need access to inter-professional teams staffed with different types of providers with distinct, yet complementary roles and responsibilities.
 - Team-based models have the capacity (e.g. structure, resources) to develop and deliver solutions (e.g. FHTs, CHCs, NPLCs, AHACs)
 - Care co-ordination is everyone's work and can be enabled by providers working to full scope on teams supported by ongoing training/education and clarity of roles
 - Co-ordination is about creating linkages in the community, with other care providers and system navigation across the health and social services system (vertical and horizontal integration)
 - Providers getting more involved in developing/incubating the approach from the ground up and developing plans
 - There is a common approach to patient care by providers (e.g. patient centred, broader determinants of health perspective)
- 7. A clear and identified lead for care co-ordination**
- Each patient requires access to a lead to enable care co-ordination
- 8. Ability to address the full continuum – comprehensive care and continuity of care – from “womb to tomb”**
- Primary care is ideally placed to follow people over time - including when individuals require episodic, acute or intensive interventions that are only needed for brief periods
 - Comprehensive ‘womb to tomb’ care co-ordination requires a regulated healthcare professional who maintains competencies, knowledge and skills in healthcare delivery, system structure and broader determinants of health

9. Systems, tools and practices

- Good care co-ordination and system navigation requires a mapping of existing assets
- Needs assessment and referral tools support better integration and identification of patient populations
- Simple processes for referrals to community resources to address determinants of health
- Support decision-making on referrals to community-based resources and maintain contact and follow up
- Best practice pathways of care are in place that are easy to use and shared by the team

10. Data and information systems that enable care co-ordination, performance metrics, reporting and research

- Data warehouses
- Data standardization
- EMR systems that talk to each other
- Real-time access to data
- System-wide access to the Client Health and Related Information System (a web-based patient management system used by CCACs)
- Solid communication mechanism: ability to relay accurate information in a timely way

11. Sustainable funding methods

- Health Links only providing for a small sub-set of population
- Grant or project funding is limited, however allows teams to get started and move toward shared or pooled resources

Lessons Learned and Conclusion

This position statement “Care Co-ordination in Primary Care” clearly articulates the OPCC’s rationale, principles, desired outcomes and enablers in moving toward a strong foundation of primary care in Ontario.

There were a number of lessons learned upon reflection of the examples of care co-ordination presented at a working session with primary care providers held in February 2015 (see Appendix A for specific details):

- **Collaboration:** Accessing local services to address social barriers to meet the patient’s range of needs. There is not one expert that has a handle on the comprehensive services that a patient needs.
- **Our Attitude:** Creating a culture for change is driven by relationships, a common vision, a collective will to listen and focus on patient goals not the obstacles.
- **Knowing & Maximizing Our Role:** Working within a collaborative interprofessional practice model where there is clarity of roles and each profession functions in way that maximizes their scope of practice.
- **Listening:** Developing a process that provides time to really listen, explore needs and values, gather information verify goals and establish goals important to the patient.
- **Safety & Support during the Transitions of Care:** Providing the patient with a virtual safe space to wait during the ‘warm hand offs’ across transitions so the patient knows when one provider stops and the other starts (which reduces knocking on multiple doors to find a solution)
- **Trusting Relationships between Professionals & Providers:** Developing trusting relationships and learning who has the knowledge and ability for different clinical situations is key to effectively co-ordinating care. This requires moving away from traditional working relationships and behaviours to creating a structure to support inclusion and collaborative planning and decision making.
- **Starting from Where the Patient is At:** Providing services that are responsive to the stage of change is more effective, efficient and wastes fewer resources across the system. Patients who are pre-contemplative are very different than patients who are contemplative or ready to take action and responsibility for their health.

Primary care is actively leading care co-ordination efforts across the province and more can be done to support further adoption and adaptation of best practices.

Sources

“Enhancing Community Care for Ontarians 1.0” (2012) and *“Enhancing Community Care for Ontarians 2.0”* (2014) RNAO (www.rnao.ca/ecco) and the Agency for Healthcare Research and Quality (US) working definition of care co-ordination from *“Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol. 7: Care Co-ordination)”* 2007 June

“Integrated Complex Care model: Lessons Learned from Inter-organizational Partnership” Cohen Eyal, Bruce-Barrett Cindy, Kingsnorth Shauna, Keilty Krista, Cooper Anna, Daub Stacy. *Healthcare Quarterly* (Vol. 14 Special Issue) October 2011

Learning from One-Day Session with Primary Care Members about Care Co-ordination and System Navigation, February 2015

OPCC Role of Primary Care in Care Co-ordination: Position on Principles of Care Co-ordination Leading to Seamless Transitions for Patients and Families, approved by Ontario Primary Care Council July 14, 2014

The Ontario Primary Care Council Strategic Framework, draft January 2015

Appendix A

Examples of Care Co-ordination in Primary Care

- A) Rural Hastings Health Link
- B) Rural Wellington Community Team
- C) Access Alliance - Solo Practitioners in Need (SPiN)
- D) McMaster Family Health Team

Details of Primary Care Care Co-ordination Aligned to OPCC Principles

The OPCC's Strategic Priorities Working Group held a one-day learning session on February 19, 2015 to hear directly from primary care teams about how care co-ordination initiatives align with the principles outlined in the position statement. The presentations clearly validated both the OPCC's strategic framework and the principles described. Four examples of care co-ordination led by primary care from across the province are profiled:

- E) Rural Hastings Health Link: prepared by Lyn Linton, Julia Swedak
- F) Rural Wellington Community Team: prepared by Suzanne Trivers, Executive Director, Mount Forest FHT
- G) Access Alliance - Solo Practitioners in Need (SPiN): prepared by Cliff Ledwos, Director, Primary Health Care AAMHCS, Pauline Pariser
- H) McMaster Family Health Team: prepared by Dan Edwards and Joy White

A) Rural Hastings Health Link (prepared by Lyn Linton Executive Director Gateway CHC, Julia Swedak Director of Quality and Decision Support Gateway CHC)

This care initiative focuses on the role system navigators within primary care who engage medically and socially complex patients. The different components include integrating the patient's voice into the medical plan of care, identifying socio-economic barriers to support their goals,

integrating upstream health promotion and prevention into the plan of care, improving the patient’s experience in navigating the health/social systems, and supporting the patient to receive care at home rather than seeking support through the hospital system. It also includes lessons learned in developing new behaviours, relationships and partnerships to communicate and coordinate care between disciplines, settings and organizations and how the role of system navigation delivers a return on investment to the health system as a whole.

I. Needs assessment, design and implementation

Principle	Care co-ordination requires a population needs based approach to planning
Outcome	A comprehensive needs assessment that includes demographics, community resources, health planning data and human resources trends informs the development of the health system, primary care and care co-ordination
<i>What problem or gap trying to solve for the people you serve?</i>	<p>The Rural Hastings HealthLink is one of seven regional HealthLinks with the South East LHIN. In collaboration with our primary care partners in Central and North Hastings (2 FHT/FHOs, 1 CFHT and 1 CHC) and broader health and social sector partners including but not limited to hospitals, CCAC, Community Support Services, Hospice, LTC we created a business model to create synergy, sustainability and performance success to address:</p> <ul style="list-style-type: none"> i) the delivery of co-ordinated care for the top 1 – 5% of the population whose needs represent the majority of healthcare spending ii) improving the patient’s experience by looking at new ways to communicate with and between the patient, provider and where service is delivered while maintaining the autonomy and integrity of our respective organizations iii) a framework to support integrated system thinking/planning between transition points in care iv) improving health outcomes including health promotion, self-management and determinants of health for the top 1 – 5% complex patients v) reducing health care costs associated with Emergency Department and Hospital utilization vi) integrating patient choice and patient personal goals to better reflect and evaluate the patient’s experience so continuous improvement can occur and provide the linkages between the patient’s goals and the medical and service plan of care vii) transformational change that moves health system partners away from traditional working relationships and

	<p>behaviours to a system that listens to the patient, improves patient outcomes, informs each other through information transfer at transitions points of care while preventing duplication</p> <p>viii) resources to strengthen the primary care practitioner role and ability to exact change, improve patient outcomes, improve provider access to real time patient information and improve patient / practitioner confidence</p>
<p><i>Describe the specifics of the solution you implemented</i></p>	<p>The Rural Hastings HealthLink (RHHL) created a coalition with the collective will and common vision to improve health in our communities, provide care in partnership with providers, patients and their families to achieve better health and create a system that enables, promotes ownership and improves health through engagement, leadership, innovation and education. To achieve transformational change partners within the RHHL coalition:</p> <ul style="list-style-type: none"> • Established a structure to support inclusion in integrated system thinking, planning, performance management, evaluation and accountability for continuous improvement. Coalition design included representation from primary care, sector partners and a patient. • Integrated Triple AIM as the framework for system planning and alignment • Embedded 1 Full Time Registered Nurse System Navigators within four primary care sites, funded through the Medically Complex Demonstration Project to identify complex patients, collaborate with primary care practitioners, act as a liaison between transition points of care, follow up with patient's discharged from hospital, ensure for medication reconciliation, identify and integrate social factors impeding the patient's ability to achieve optimal health outcomes facilitate shared care planning between transition points of care, monitor and evaluate the patient's care co-ordination plan against expected outcomes, create spread across the continuum of care by engaging practitioners and broader health and social sector partners and advocate on behalf of the patient/family/caregiver. • Integrated the Care Co-ordination Planning Tool as a mechanism to capture the patient/family/caregiver voice in care planning and engage practitioners in listening to patient concerns and personal goals for health improvement • Embedded Data Management Co-ordinator (DMCs) within three primary care FHT/FHO sites to support establishing performance indicators and common definitions, data integrity, data discipline and data collection for the purpose of planning, alignment, evaluation and reporting. Shared CHC Director of Quality and Decision Making resource to maintain integrity of evaluation framework, collect and evaluate data, collaborate with sector partners to retrieve patient information for real time access and align planning with the SE LHIN e-health vision. • Established two working groups focused on End of Life/Palliative Care and Care Co-ordination comprised of

	<p>patient(s) and service providers with a working knowledge from their respective organizations and who are committed to informing others, system planning, identifying barriers and applying improvement methodologies for identifying system change. Established one working group for Data Quality & Privacy focused on performance management and sector information systems.</p> <ul style="list-style-type: none"> • Planning linkages at the SE LHIN level that integrate or align strategies as provincial and regional systems evolve. <p>Established communication mechanisms to inform and engage practitioners, providers, organizations and patients/families (on-site presentations, feedback meetings, newsletters, patient engagement forums and governance education / feedback on HealthLink initiatives).</p>
<p><i>Was there a specific patient group you were you targeting?</i></p>	<p>A key focus of the Rural Hastings HealthLink (RHHL) was to mobilize the delivery of coordinated care for the top 1 to 5 percent of the population whose needs represent the majority of healthcare spending. Many of these individuals have complex and/or multiple chronic conditions that would benefit from improved co-ordination of care and supports when transitioning from one part of the health care system to another.</p> <p>The RHHL population exhibit higher rates of high risk behaviours and poorer health status than other populations in the SE LHIN. The burden of chronic illness is contributing to high utilization for in-patient acute care and emergency department. Some 60-64% of the population has at least one chronic condition including hypertension, diabetes, and arthritis, COPD, CHF and CVD.</p>
<p><i>What barriers did you overcome?</i></p>	<ul style="list-style-type: none"> • Shifting the culture from an organizational system approach to a patient focused system – move from problem thinking to solutions. • Engaging practitioners to participate in patient engagement using the Care Co-ordination Tool • Enhancing and integrating provider skills in improvement methodologies for system change • Providing key resources within Primary Care to lead and evaluate the process change for enhancing patient experience and evaluation • Ongoing sustainable funding
<p><i>What enabling factors helped?</i></p>	<ul style="list-style-type: none"> • Creating a structure to support inclusion and collaborative planning and decision making (coalition & working groups) • Training and education on performance methodologies – provider involvement in process mapping / identifying

	<p>gaps</p> <ul style="list-style-type: none"> • Patient participation on coalition and working groups • Supporting primary care with System Navigator and Data Management Co-ordinator resources • Creating buy-in and spread through positive experiences at the practitioner level • Reporting on performance targets – opportunities to align and or achievements • Understanding and appreciation for systems thinking • Understanding how social complexity influences the patient’s ability to improve health outcomes attaining our vision
<i>What additional resources were needed?</i>	The Rural Hastings HealthLink is resourced through in-kind contributions by primary care and broader sector organizations, funding through HealthLinks and the OMA – Medically Complex Demonstration Project.
<i>What existing resources/partners were brought together?</i>	<p>Participating partners in the Rural Hastings HealthLink (RHHL):</p> <p>Lead Organization & Transfer Payment Agency – Gateway Community Health Centre RHHL</p> <p>Coalition & Working Groups are supported by:</p> <ul style="list-style-type: none"> • RHHL Project Manager – Funded through HealthLinks • Executive Director – Gateway CHC (Lead Organization) – In Kind • Admin Support – Funded through HealthLinks • Working Group Process Facilitators – Gateway CHC – In Kind • Provider, Patient and Management Representation on Coalition and Working Groups – In Kind <p>Coalition Working Groups: End of Life / Palliative Care, Care Co-ordination and Data Quality & Privacy</p>
Principle	Care co-ordination includes communication and planning with the patient and family
Outcome	Patients are at the centre of their plan of care. Their perspectives are fully integrated in the formulation of this plan
<i>How were patients/families involved in the design</i>	Patients are engaged in the planning and decision making at the coalition and working group levels. Patient engagement forums and evaluation surveys are used to measure whether our efforts are making a difference.

<i>of this initiative?</i>	
<i>How are patients/families involved in the co-ordination of their care</i>	All identified complex patients have a care co-ordination plan. The plan is introduced to the patient/family through the System Navigator who engages the practitioner and patient / family in establishing their plan of care. The patient's care team (primary care & broader sector) is engaged in supporting the patient's plan of care either with the patient present as appropriate or through engagement by the System Navigator. Regular follow up by the System Navigator on monitoring the patient's goals and progress reinforces one of the goals for establishing relationships that improve patient satisfaction throughout their journey.
<i>Other observations related to this principle?</i>	Patients are thrilled to be engaged and listened to. The process ensures for the time required to listen, verify the patient's concerns, establish goals important to them and ensure for ongoing follow up with the patient. Practitioners are equally pleased with having a resource to turn to who will take the time to ensure for the right service at the right time as well as keep the practitioner informed – improving their experience with the patient.

II. Evidence of benefit to patients/clients and health system

Principle	Care co-ordination will emphasize the timely and continuous delivery of high-quality, person-centered, equitable, timely and continuous services and programs that are comprehensive, evidence-informed, culturally competent and appropriate
Outcome	There is evidence that patients receive high quality care that reflects services and programs that are comprehensive, evidence informed, culturally competent and appropriate
<i>List any indicators or observations applicable to this principle</i>	The System Navigator works closely with other members of the primary care inter-professional team or other organizations who support the patient. The patient remains an integral part of the care team working with them. Their role includes: <ul style="list-style-type: none"> • Ensures that access to the patient's plan of care is available and the status of the plan of care is clear for other

	<p>members of the care team</p> <ul style="list-style-type: none"> • Patient support is available through established after-hour protocols by each primary care site including same day access. • Conduct home visits for the complex patient either one on one or in collaboration with the primary care team and/or sector organization who is part of the patient’s care team <p>Monitor’s daily whether the patient has visited the emergency department, was hospitalized, utilized on call or has a same day or scheduled visit with their primary care practitioner and then follows up with the patient / family and practitioner</p>
	<p>The following indicators are currently being measured:</p> <ul style="list-style-type: none"> • % reduction of avoidable ED visits • % reduction of unnecessary hospital admissions • % reduction of 30 day re-admits to hospital • Primary care follow up within 7 days of discharge • # of home assessments completed <p>The System Navigator has invested time to research and developed a compendium of organizations and services available regionally and within their local areas to support patient’s in their homes including services to address socio-economic barriers such as; transportation, food security, housing, social isolation. For example, they have reached out to organizations that support patients with hearing and site impairment, dementia and advice on culturally competent care (aboriginal).</p>

Principle	Care co-ordination focuses on the provision of comprehensive services across the health and social services continuum as needed
Outcome	There is evidence that patients experience timely access to services and seamless transitions in care

<p><i>Please list any indicators or observations applicable to this principle</i></p>	<p>RHHL is monitoring the following indicators:</p> <ul style="list-style-type: none"> • # of complex patients with access to primary care provider • # of complex patients with a Care Co-ordination Plan • # of complex patient identified • # of complex patients who refused service • # of external referrals given by the System Navigator • # of internal referrals given by the System Navigator • # of external agencies involved pre-care co-ordination plan • # of external agencies involved post care co-ordination plan • # of complex patients with a self-management goal • # of medications complex patient is prescribed • # patients with 10 or more medications • # of complex patients receiving medication reconciliation after hospital discharge • # of complex patients enrolled in CDPM initiative <p>Ongoing refinement and adding performance indicators are reviewed quarterly and on an annual basis.</p>
<p>Principle</p>	<p>Care co-ordination is predicated on collaborative inter-professional teams working to full scope of practice</p>
<p>Outcome</p>	<p>There is evidence that patient care is optimized when all health-care professionals are working collaboratively each at their full scope of practice</p>

<p><i>Please list any indicators or observations applicable to this principle)</i></p>	<p>Each primary care site has a collaborative inter-professional practice model with physicians, nurse practitioners, dietitians, social workers, RPNs/RNs who function within their scope of practice and form part of the care team for the patient. In addition, broader sector partner organizations provide access to an inter-professional team, such as, expertise in mental health & addictions, palliative care, psycho-geriatrics and community home supports.</p> <p>Additionally, resources such as a pharmacist, chiropodist, respiratory therapist and CDPM educated professionals are drawn upon either as an internal resource or accessed externally. The System Navigator, in collaboration with the family practitioner and patient/family identify professional resources, either internal to primary care or through external referrals based on scope of practice and best practice standards.</p> <p>Often not recognized but vital to the patient are organizations and services available at the local level to address social barriers. Organizations such as Food Banks, Local Churches, Service Clubs, local Legions and the Salvation Army bring experience and an understanding of supporting individuals with social barriers.</p> <p>Tracking the utilization of various inter-professionals within primary care, the broader health / social sector and service supports focused on the determinants of health are identified in previously noted indicators as well as through patient stories.</p>
<p>Any other evidence of impact on health outcomes, experience of care or cost-effectiveness for the health system.</p>	
<p><i>Please list any other indicators or observations not yet covered</i></p>	<p>Providing two key resources, System Navigators and Data Management Co-ordinator embedded with primary care, has a significant impact on improving or sustaining health outcomes and RHHLs ability to measure our efforts and success. For example, for the period November 2013 to December 2014 RHHL System Navigators completed 120 Care Co-ordination plans and through their efforts have demonstrated an 87% reduction in ED visits and 84% reduction in hospital admissions post care plan implementation. Under estimating the cost for an emergency department visit or hospitalization, RHHL has provided a Return on Investment to the system at \$1,425,973.00 at the end of Q3 fiscal 14/15.</p>

III. Role of primary care in care co-ordination

<p>Principle</p>	<p>Care co-ordination is a core function of primary care and a hallmark of a high-performing primary care system</p>
<p>Outcome</p>	<p>Care co-ordination is provided through the patient’s primary care organization throughout their life span</p>
<p><i>As a primary care provider or team, how “easy” or “hard” was this to do in your community?</i></p>	<p>Primary Care is where the patient is connected before they are born until they die. Providers working across sectors aim every day to provide the best care and positive experience for the patient. For the most part primary care models and health sector organizations are designed for medical intervention and the health system is designed to export patients between primary care and other sectors of the system.</p> <p>The current system creates barriers for system integration through funding and policies which providers/ practitioners navigate to access the right service for the patient at the right time. This creates concern, frustration and a decrease in satisfaction among primary care practitioners and other members of the primary care team who want to access the right services and want to know how the patient is responding to care interventions. Therefore, the opportunity to improve on the patient and provider’s experience became the common driver for change and the purpose for their participation in HealthLinks.</p> <p>The potential value that System Navigators could bring to support the care team and the patient, added incentive to embark on the system transformation journey. We have learned valuable lessons throughout the journey:</p> <ul style="list-style-type: none"> • The Care Co-ordination Tool has changed how practitioners and providers listen and respond to patients/families/caregivers • When given the time and forum for planning, providers bring a wealth of experience and knowledge on system barriers and are eager to learn new skills that allow them to identify solutions through continuous improvement methodologies • Including the patient within planning and decision making forums has provided the “space” to listen rather than focus on current problems. Patients inspire providers to try harder and set the tone for problem solving.

	<ul style="list-style-type: none"> • That creating a culture for change is driven by relationship building, a common vision and a collective will to see the goal not focus on the obstacles. • Reward and recognition for efforts are provided through evaluation drawn from performance indicators and patient stories. Small successes gain great satisfaction.
<p><i>To what extent could this initiative be scaled up across the province? What would be needed to succeed?</i></p>	<p>The model proposed by the RHHL can be replicated across the province with modifications for rural versus urban settings. For example, the RHHL model works within defined primary care settings i.e. FHTs/FHOs/CHC. There are fewer solo physicians in the RHHL that are easier to support in rural settings.</p> <p>In urban settings the model could be re-created to share the System Navigation resource within smaller defined areas that would include solo practitioners and other smaller practice groupings.</p> <p><u>Opportunities to Succeed</u></p> <ul style="list-style-type: none"> • Leverage existing funding within the system to strengthen primary care role in supporting the patient at home through sustainable funding for the role of System Navigation in primary care • Build on experience and expertise within primary care to lead system planning and decision making • Using the Care Co-ordination Tool expand on provider training and the time required to listen develop new skills in patient engagement • Provide resources (Data Management Co-ordinator) within primary care teams to support data collection/extraction, data integrity and discipline and utilizing data to inform service and continuous improvement

B) Rural Wellington Community Team (prepared by Suzanne Trivers, Executive Director, Mount Forest FHT)

In December 2014, under a collaborative agreement signed by 4 rural FHTs, the WWCCAC, CMHA WWD, two rural hospital corporations and Homewood Health Centre (mental health facility), a team of outreach workers was launched embedded in primary care and attached to CCAC care coordination. This team provides support, coaching and care co-ordination to those residents who are hard to serve due to lack of resources, lack of skills and/or clinical presentation. The outreach workers act as ‘the glue’ to stick these vulnerable and at risk residents to the health and social service system.

I. Needs assessment, design and implementation

Principle	Care co-ordination requires a population needs based approach to planning
Outcome	A comprehensive needs assessment that includes demographics, community resources, health planning data and human resources trends informs the development of the health system, primary care and care co-ordination
<i>What problem or gap were you trying to solve for the people you serve?</i>	Through the pre-Health Link work that we had done as partners, we had identified a population of people who lacked the knowledge, skills and abilities to not only navigate the system, but also to develop and maintain effective relationships with primary health care providers. This group of people had a history of ineffective episodic interactions with the health care system resulting in multiple, repeated visits across the system; disjointed care; crisis telephone and face to face interactions that could not be solved in the timeframe expected by the individuals; and inconsistent or non-existent assessments. Most of this population were at the pre-contemplative level in relation to self-management.
<i>Describe the specifics of the solution you implemented</i>	As the project lead organizations, the Mount Forest FHT and WWCCAC created a team of outreach workers with lived experience with health system navigation or social service challenges, a dedicated CCAC Care Coordinator and (since October 2014) an Intensive Mental Health Care Co-ordinator. The Outreach Workers act as ‘professional family members’ for those vulnerable and at risk residents who do not have other supports available. The Outreach Workers provide facilitation and psychosocial service co-ordination to ensure the resident’s voice is heard and their perspective is understood and valued while the Care Co-ordinators provide more specialized clinical assessment and care co-ordination when necessary. The team is given permission to provide support and coaching for social determinants of health issues even in the absence of presenting health issues.
<i>Was there a specific patient group you were you targeting?</i>	Those residents who were at risk and vulnerable as a result of challenges related to social determinants of health and/or clinical complexity.

<i>What existing resources/partners were brought together?</i>	FHTs, CCAC, CMHA, hospitals, seniors services, housing, Ontario Works, ODSP, OPP, addictions services, local church groups, food banks, transportation services, community support agencies, public health had just produced a clear social determinants of health report that showed the challenges faced community by community
<i>If CCAC is involved, how are you working with them?</i>	The dedicated CCAC Care Co-ordinator works with the outreach workers to assess for needs and care planning for people needing functional supports to live their 'best day' in the community.
<i>What (if any) additional resources were needed?</i>	4.8 FTE outreach workers for a total population of 90,000; 1.0 FTE CCAC Care Co-ordinator; 1.0 FTE Intensive Mental Health Care Co-ordinator were all added as new resources. Funds flowed from the WWLHIN to the CCAC.
<i>What barriers did you have to overcome?</i>	<p>The main barriers were around approach to patient care and clarity of roles. Care co-ordination is a term that has been used to describe what actually a continuum of linked interventions is: engagement, information gathering/ assessment, exploring needs and values, presenting potential solutions and options, matching need to eligibility and care planning. In primary care, these interventions are most often provided within an established, often long term relationship. The primary care providers involved in the care of these residents place a strong value on relationships both with patients and other service providers. We recruited outreach workers who already held these same values.</p> <p>Many of the other service providers that we worked with had to build trust with their own agencies and with others on the team to feel secure in taking this patient centered approach as opposed to a more black and white, 'here is what's available' approach. There was some discussion required to clarify who in the system would provide what supports and services. This was more between social service and health provider e.g. housing implemented an outreach worker for people with mental health and addictions issues at about the same time as we started our program. Neither provider was aware of the other. Once they learned of each other, the front line staff created a workable solution that was shared with management at both agencies and approved.</p>
<i>What enabling factors helped?</i>	Lots of open and honest communication between providers and agency management. The main health service provider agencies had already developed formal problem solving mechanisms that included governance support for integration and collaboration. The WWLHIN provided flexible funding parameters and assistance for shared reporting of outcomes and effort.
<i>Additional</i>	The interventions required for people who are pre-contemplative are different than those required for people who are

<i>observations related to this principle?</i>	contemplative or ready for action. By providing services that are responsive to the stage of change, we are more effective and efficient and waste fewer resources across the system
Principle	Care co-ordination includes communication and planning with the patient and family
Outcome	Patients are at the centre of their plan of care. Their perspectives are fully integrated in the formulation of this plan
<i>How were patients/families involved in the design of this initiative?</i>	<p>We essentially began with a concept and not many firm processes. This concept was based upon two or three successful situations that took a patient centered problem solving approach to a high demand situation. We just took that idea and applied it across a broader range of people. Finding out what was working, what wasn't working and what was most important to the resident was the first step of the implementation plan.</p> <p>Now that we have been operating for over a year and have served almost 400 residents, we are beginning to see where we can implement system wide tools that will enable more people to meet those needs that present in a less complex way e.g. we are developing an EMR tool that will provide contact information based upon a presenting social need. If a patient notifies a primary care provider that they need food, the provider can choose 'food' in the tool and find what resources are available for the resident. The provider would ask the patient if they would like to make the contact themselves or have the outreach worker help with that. This will reduce unnecessary referrals to the outreach worker.</p>
<i>How are patients/families involved in the co-ordination of their care?</i>	Nothing without permission or agreement. If families are not in agreement, the team works to facilitate communication to ensure the patient's wishes are understood and valued.
<i>Additional observations related to this principle?</i>	Nothing about us without us.

II. Evidence of benefit to patients/clients and health system

Principle	Care co-ordination will emphasize the timely and continuous delivery of high-quality, person-centred, equitable, timely and continuous services and programs that are comprehensive, evidence-informed, culturally competent and appropriate
Outcome	There is evidence that patients receive high quality care that reflects services and programs that are comprehensive,

	evidence-informed, culturally competent and appropriate
<i>Please list any indicators or observations applicable to this principle</i>	Especially in rural communities where available resources tend to be significantly less than demand, the balance is always supply and demand. We have waitlists for services and the team works with the resident to create contingency plans. The team works with other providers to ensure urgent needs are met at least partially. The goal is not perfect support, but the best we can do with what we have.
Principle	Care co-ordination focuses on the provision of comprehensive services across the health and social services continuum as needed
Outcome	There is evidence that patients experience timely access to services and seamless transitions in care
<i>Please list any indicators or observations applicable to this principle</i>	<p>The team works with other providers to attempt to make ‘warm hand offs’ across transitions. This means ensuring that the resident knows when one provider stops and the other starts and that there is not a gap between these. The main approach is fluidity. Even if the provider who currently ‘holds’ the resident is not the ‘right service provider’ for that resident, that provider keeps in contact and provides what support they can until the ‘right service provider’ is available to them. This prevents the resident from knocking on multiple doors to find a solution since the resident feels that they have a safe location within which to wait.</p> <p>The outreach worker both provides the virtual safe waiting room and also continues to knock on the door to make sure that the resident is not lost in the queue. When waiting lists for service are long, this can be a labor intensive service; however our 1 year evaluation data does show that it has reduced both ER visits and hospital stays. Anecdotally it has also reduced non-productive primary care visits.</p>
Principle	Care co-ordination is predicated on collaborative inter-professional teams working to full scope of practice
Outcome	There is evidence that patient care is optimized when all health-care professionals are working collaboratively each at their full scope of practice
<i>Please list any indicators or observations applicable to this principle</i>	<p>For this specific team, we deliberately hired outreach workers who were not also regulated health professionals so that the facilitator/support role would not be confused with the health care service provider role. For those residents who require clinical support and coaching, the outreach worker helps the resident to articulate their values and needs with the broader health care team.</p> <p>Once a patient centred relationship as developed between a health professional and the resident, the outreach worker withdraws from providing service. In other words, the outreach worker helps to stick the resident to care then</p>

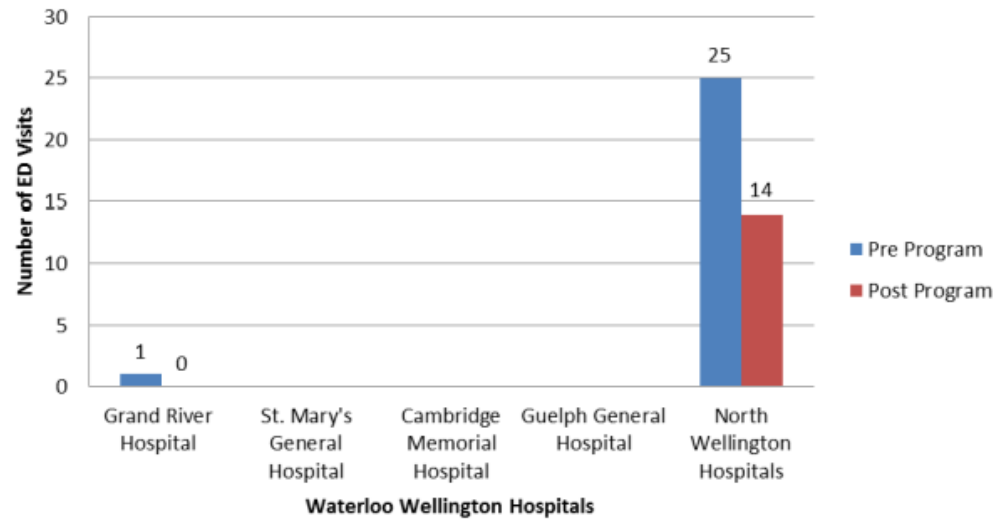
steps away when the glue has stuck firmly. Since different health providers have different skill sets with different personalities and clinical presentations, all health providers need to work to the broadest range of their knowledge, skills and abilities.

Across the team, the different service providers have learned who has what knowledge and ability for different clinical situations and this is used to coordinate the care team. There is always a conversation within the team working with a resident to determine who will do what. The resident may choose whichever team member they are most comfortable with to be their point of contact.

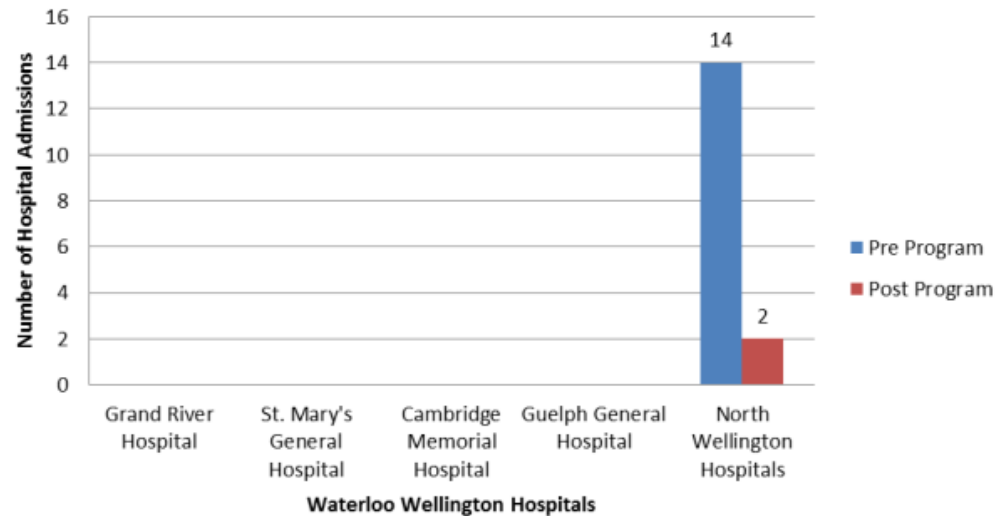
Any other evidence of impact on health outcomes, experience of care or cost-effectiveness for the health system.

Please list any other indicators or observations not yet covered (i.e. please share data that you've collected demonstrating impact on health outcomes).

Emergency Department Visits Rural Wellington In-Home Team



Hospital Admissions Rural Wellington In-Home Team



III. Role of primary care in care co-ordination

Principle	Care co-ordination is a core function of primary care and a hallmark of a high-performing primary care system
Outcome	Care co-ordination is provided through the patient’s primary care organization throughout their life span
<i>As a primary care provider or team, how “easy” or “hard” was this to do in your community?</i>	The implementation of the team took a lot of effort and communication. The need was definitely there and referrals were received quickly and steadily. Due to the 4 years of previous relationship building work done with system partners, it was ‘easy’ to do at this point. It would have been very ‘hard’ to do without that previous work.
<i>To what extent could this initiative be scaled up across the province? What would be needed to succeed?</i>	A desire to get started, even if the start is small and slow. A champion or two. A clear and simple definition of the vision. Ours was to provide the glue that will stick the hard to serve and vulnerable to the system. Targeted resources with flexible implementation plans but a shared, defined goal and outcome measures. At least nominal support to be involved in creating a solution on the part of most of the providers – a willingness to dip a toe in the water if not completely wade in. An understanding that you will never get everyone on board fully before you start so start with what you have and go from there.

C) Access Alliance SPiN (prepared by Cliff Ledwos, Director, Primary Health Care AAMHCS, Pauline Pariser)

Partners: Access Alliance Multicultural Health and Community Services, Mid West Toronto Health Links, 6Partner CHCs and 30+ PCPs

Program Description: Solo Practitioners in Need (SPiN) - connecting resources for better health outcomes

I. Needs assessment, design and implementation

Principle	Care co-ordination requires a population needs based approach to planning
Outcome	A comprehensive needs assessment that includes demographics, community resources, health planning data and human resources trends informs the development of the health system, primary care and care coordination
<i>What problem or gap were you trying to solve for the people you serve?</i>	Making a connection for vulnerable (medical and SODH complexity) populations to ensure primary care and other needed clinical and non-clinical services.
<i>Describe the specifics of the solution you implemented</i>	Solo primary care physicians (PCP) are able to make a timely referral for their vulnerable clients to available CHC resources including clinical and non-clinical services (not a PCP).
<i>Was there a specific patient group you were you targeting?</i>	Vulnerable populations - medical and SODH complexity, multiplicity of issues, numerous barriers to achieving and maintaining good health. In Health Links terms, the 1 and 5%.
<i>What existing resources/partners were brought together?</i>	6 CHCs and 30 + PCPs, the Health Link and other partners where appropriate
<i>If CCAC is involved, how are you working with them?</i>	At this point in a secondary role providing support with individual PCPs
<i>What (if any) additional resources were needed? If so,</i>	For the pilot phase staff time was needed to make solid referrals between the various partners that were also timely.

<i>who provided funding?</i>	
<i>What barriers did you have to overcome?</i>	Lack of clear pathways, different understandings of vulnerability, challenges with EMR as well as lack of system tools, lack of a coordinated system between two different resource groups
<i>What enabling factors helped?</i>	Willingness among partners to focus for impact on the client populations
Principle	Care co-ordination includes communication and planning with the patient and family
Outcome	Patients are at the centre of their plan of care. Their perspectives are fully integrated in the formulation of this plan
<i>How were patients/families involved in the design of this initiative?</i>	Patient representatives participated in discussions to establish/set up and implement the referral process/connection between the resource groups. Questions asked such as how would this benefit you as a client with a solo practitioner
<i>Additional observations related to this principle?</i>	In the case of this pilot project the first step was establishing the connections and making the referral process timely and meaningful. Collecting some data to determine the impact and gaps. The project establishes connections that will increase coordinated care to take place in a meaningful way.

II. Evidence of benefit to patients/clients and health system

Principle	Care co-ordination will emphasize the timely and continuous delivery of high-quality, person-centred, equitable, timely and continuous services and programs that are comprehensive, evidence-informed, culturally competent and appropriate
Outcome	There is evidence that patients receive high quality care that reflects services and programs that are comprehensive, evidence-informed, culturally competent and appropriate
<i>Please list any indicators or observations applicable to this principle</i>	Clients who participated in the pilot phase were able to access a broad range of services at CHCs and at times that increased their ability to access those services i.e. evenings, daytime and weekends.
Principle	Care co-ordination focuses on the provision of comprehensive services across the health and social services continuum

	as needed
Outcome	There is evidence that patients experience timely access to services and seamless transitions in care
<i>Please list any indicators or observations applicable to this principle</i>	Referrals to CHC services are made within specified time periods to reduce unnecessary wait times. Preferred language used with clients/patients is based on “accessing a part of the PCPs team”
Principle	Care co-ordination is predicated on collaborative inter-professional teams working to full scope of practice
Outcome	There is evidence that patient care is optimized when all health-care professionals are working collaboratively each at their full scope of practice
<i>Please list any indicators or observations applicable to this principle</i>	The expanded team for PCPs participating in the pilot include the full range of service providers at any CHC – counsellor/therapist, nutritionists, health promoters, settlement workers, community principle (i.e. health workers, peer workers, etc. In general the PCP remains the point of contact with the composition of person/family.
Any other evidence of impact on health outcomes, experience of care or cost-effectiveness for the health system.	
<i>Please list any other indicators or observations not yet covered</i>	Holistic care is increased for vulnerable populations and individual clients of solo practitioners. PCPs are able to tap into a full range of services through one referral form – don’t have to spend as much time learning about a referral, how to do it, finding the resource, etc.

III. Role of primary care in care co-ordination

Principle	Care co-ordination is a core function of primary care and a hallmark of a high-performing primary care system
Outcome	Care co-ordination is provided through the patient’s primary care organization throughout their life span
<i>As a primary care provider or team, how “easy” or “hard” was this to do in your</i>	Success hinges upon the willingness of a PCP to buy in, the identification of pathways that are going to be easy to use, increase good choices being made, correct information being available, a solid communication loop, EMRs that can converse, etc. community?

<i>community?</i>	
<i>To what extent could this initiative be scaled up across the province? What would be needed to succeed?</i>	The project can actually work better with more CHC and PCPs participating as well as other resources joining in. Focus for impact is critical – being able to identify the key impacts and sticking to them. If there is a good solid pathway is in place and fully usable tools are available the project can easily be scaled up as needed.

D) McMaster Family Health Team (prepared by Dan Edwards and Joy White)

Program Description: Introduction of a new System Navigator role in primary care to support patients in accessing resources and supports in the community around the social determinants of health and advocacy to ensure that the programs and systems are working for patients the way they should be.

I. Needs assessment, design and implementation

Principle	Care co-ordination requires a population needs based approach to planning
Outcome	A comprehensive needs assessment that includes demographics, community resources, health planning data and human resources trends informs the development of the health system, primary care and care co-ordination
<i>What problem or gap were you trying to solve for the people you serve?</i>	Patients coming to their doctor with issues that are not traditional medical problems. There was not an “expert” or go to person with the knowledge and expertise in social services and community supports, therefore it was taking a lot of time to help patients. Doctor’s felt unprepared to ask questions about things such as housing and income because they didn’t have the resources to help them.
<i>Describe the specifics of the solution you implemented</i>	Direct patient care, assessment and link to community
<i>Was there a specific patient group you were you targeting?</i>	No
<i>What existing resources/partners were brought together?</i>	System navigators have extensive knowledge of community resource and these were made known and available to the team/patients.
<i>If CCAC is involved, how are you working with them?</i>	The System Navigator works with CCAC as a community partner.
<i>What (if any)</i>	Funding was provided though the Ministry as part of our FHT.

<i>additional resources were needed?</i>	
<i>What barriers did you have to overcome?</i>	You have to build partnerships with community partners, sharing the role of System Navigator.
Principle	Care co-ordination includes communication and planning with the patient and family
Outcome	Patients are at the centre of their plan of care. Their perspectives are fully integrated in the formulation of this plan
<i>How were patients/families involved in the design of this initiative?</i>	Direct assessment, patient driven goals/needs matched to supports and resources.

II. Evidence of benefit to patients/clients and health system

Principle	Care co-ordination will emphasize the timely and continuous delivery of high-quality, person-centred, equitable, timely and continuous services and programs that are comprehensive, evidence-informed, culturally competent and appropriate
Outcome	There is evidence that patients receive high quality care that reflects services and programs that are comprehensive, evidence-informed, culturally competent and appropriate
<i>Please list any indicators or observations applicable to this principle</i>	We are not the expert nor do we provide all the comprehensive services that a patient needs. Accessing the programs in the community that provides the most appropriate service is the goal of the System Navigator role.
Principle	Care co-ordination focuses on the provision of comprehensive services across the health and social services continuum as needed
Outcome	There is evidence that patients experience timely access to services and seamless transitions in care
<i>Please list any indicators or</i>	Wide range of services available in the community. It can be difficult to keep up with the changing programs and services. Relationships with other providers allows for warm hand off and simple transition.

<i>observations applicable to this principle</i>	
Principle	Care co-ordination is predicated on collaborative inter-professional teams working to full scope of practice
Outcome	There is evidence that patient care is optimized when all health-care professionals are working collaboratively each at their full scope of practice
<i>Please list any indicators or observations applicable to this principle</i>	System Navigator role works as part of the inter disciplinary team with physicians, OT, dietician, SW etc.
Any other evidence of impact on health outcomes, experience of care or cost-effectiveness for the health system.	
<i>Please list any other indicators or observations not yet covered</i>	Difficult to measure the impact of System Navigator role on these outcomes however increasing someone's income, affordable housing or freeing up money for necessities by accessing resources has a big impact on patients.

III. Role of primary care in care co-ordination

Principle	Care co-ordination is a core function of primary care and a hallmark of a high-performing primary care system
Outcome	Care co-ordination is provided through the patient's primary care organization throughout their life span
<i>As a primary care provider or team, how "easy" or "hard" was this to do in your community?</i>	Very challenging. This was acknowledged with the decision to support the hire of a system navigator. The role of the health care team is enhanced by these relational/expertise of this person with the community.
<i>To what extent could this initiative be scaled up across the</i>	System navigation/navigators are responsible to link patients between health care and social services agencies. There is an acknowledgement that health care is only part of a patient's journey.

<i>province? What would be needed to succeed?</i>	
---	--