South West LHIN

Primary Care and Care Coordination
LM PCA

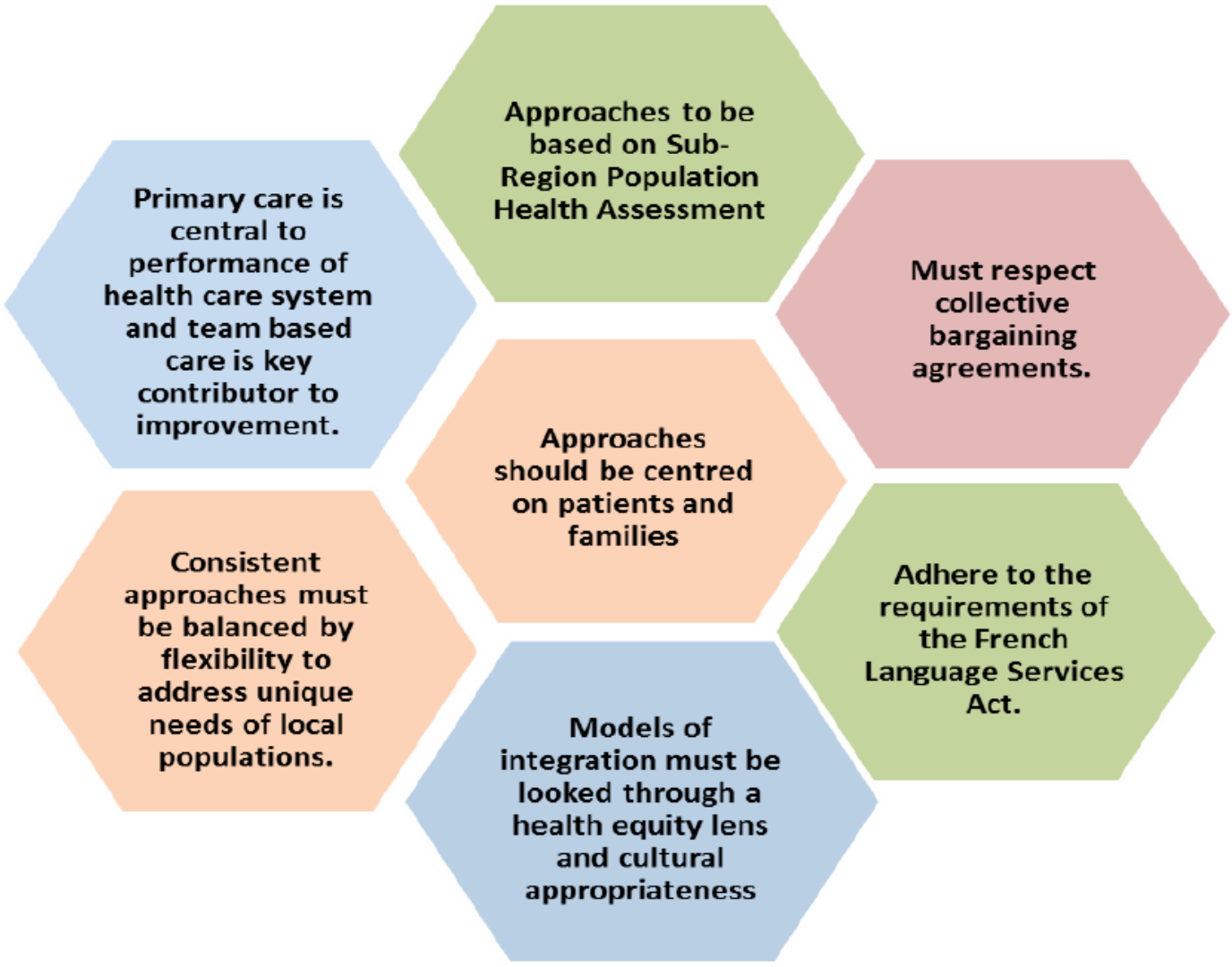
May 2018

Ontario
Local Health Integration Network

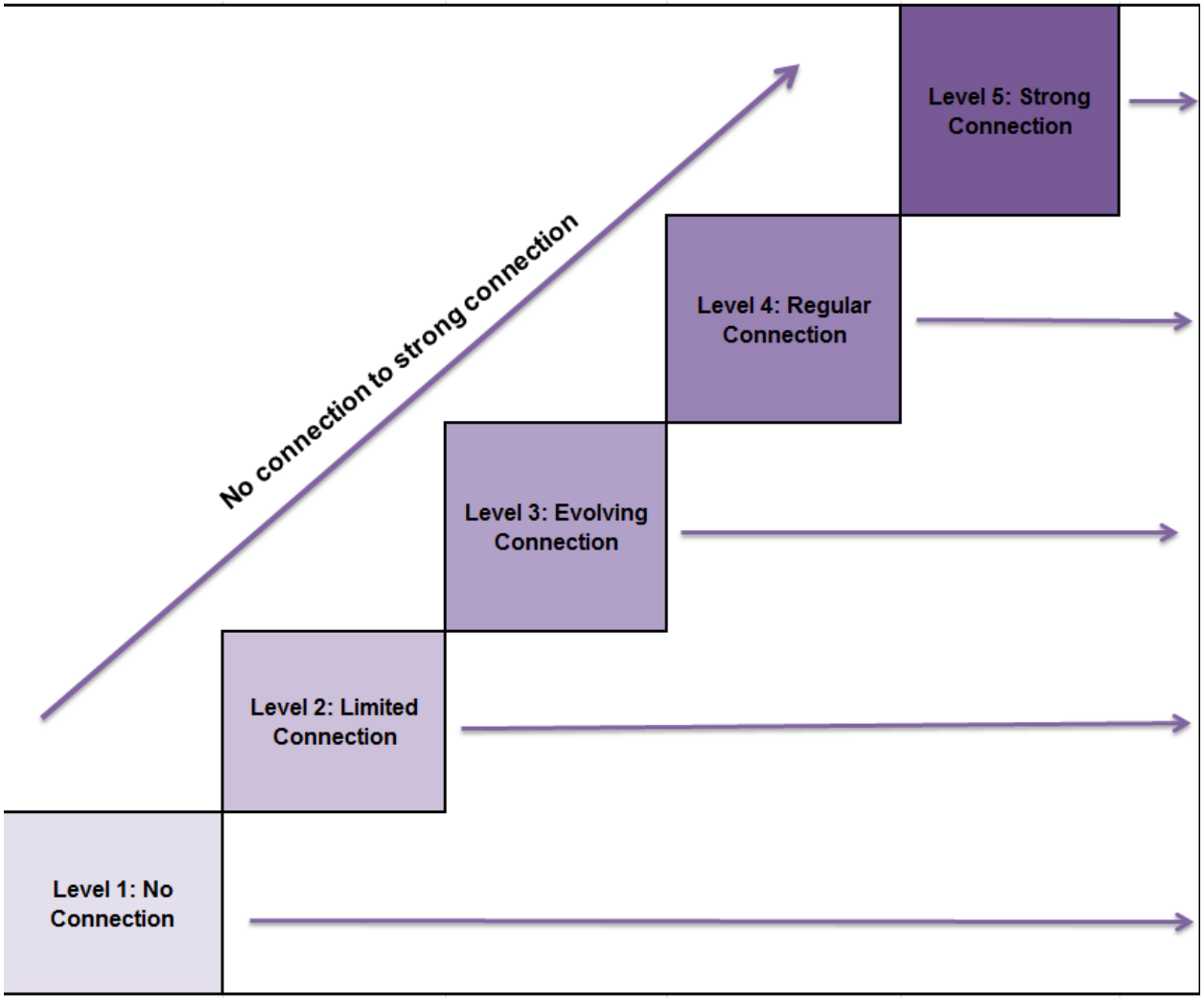
Purpose

- In November, the ministry released *Connecting Care Coordination with Primary Care Settings*.
- The goal is to **strengthen the relationship between Primary Care and LHIN Care Coordinators** as a means to improving transitions and improving access to care.
- LHINs completing a baseline assessment of current primary care-care coordination connection and targets for 2017/18 and 2018/19.
- LHINs are asked to consider a variety of models for connection, taking into account sub-regional planning, health equity, and provider readiness.

Guiding Principles



Levels of Engagement



Levels of Engagement

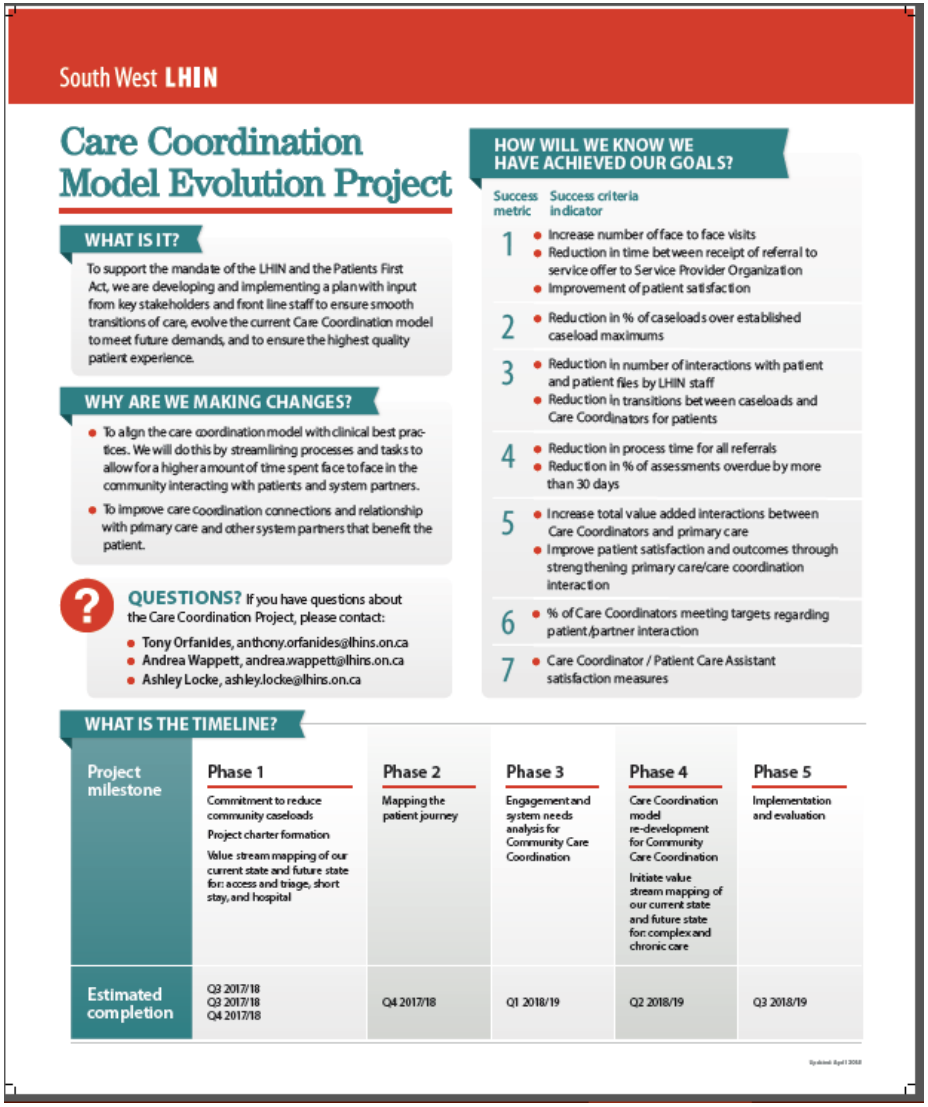
5	• Contact is made via phone with primary care provider and in-person meeting occurs. • Primary care provider embraces partnership and works to define the collaborative working relationship, which involves meetings/interactions that are both planned (pre-scheduled) and ad hoc, as required to support patient care. • Connections involve regular on-site touch points, regular case conferencing, joint home visits to support patient care. • Utilization of technologies to support virtual care in home visiting, care planning and care conferencing occurs regularly. • In this situation, the care coordinator may be co-located at multiple practice settings. • *Information sharing is formalized with access to patient record systems provided to the Care Coordinator (e.g. EMR)*
4	• Contact is made via phone with primary care provider and an in-person meeting occurs. • Primary care provider confirms open agreement to embark on partnership through regularly scheduled touch-points via on-site meetings, phone exchanges, case conferences and other means. • Care coordinator and primary care provider has confirmed communication and information exchange protocols and mechanisms. • Some level of use of technologies to support virtual care in care planning and care conferencing. • In this situation, the care coordinator may be co-located at multiple practice settings. • *Information sharing occurs regularly through a combination of physical (in-person) and virtual means.*
3	• Contact is made via phone with primary care provider. • Primary care provider receives positively and has shown willingness to engage when required. Shows potential to evolve into stronger connection. • Care Coordinator initiates connections through on-site meeting and contact information has been provided and offer made for future connection opportunities. • *Limited sharing of information when needed/as required and through phone or email with potential for more formal information sharing practices.*
2	• Contact is made via phone with primary care provider. • Primary care provider has shown willingness to initiate partnership on their terms and only when needed when required. No willingness to participate in regular care planning discussions. • Care Coordinator receives limited requests for communication. • Care Coordinator contact information has been provided and offer made for future connection opportunities. • *Limited sharing of information when needed/as required and through phone or email.*
1	• Contact is via phone with primary care provider. • Primary care provider has not yet expressed interest or willingness to initiate partnership. • Care Coordinator contact information has been provided and offer made for future connection opportunities. • *No sharing of information.*

Our Project

The South West LHIN is undergoing a project to evolve Care Coordination within the South West.

Focus on:

- Efficiency of "intake" process
- Redesigning the role of the Care Coordinator to better align with primary care



South West **LHIN**

Care Coordination Model Evolution Project

WHAT IS IT?

To support the mandate of the LHIN and the Patients First Act, we are developing and implementing a plan with input from key stakeholders and front line staff to ensure smooth transitions of care, evolve the current Care Coordination model to meet future demands, and to ensure the highest quality patient experience.

WHY ARE WE MAKING CHANGES?

- To align the care coordination model with clinical best practices. We will do this by streamlining processes and tasks to allow for a higher amount of time spent face to face in the community interacting with patients and system partners.
- To improve care coordination connections and relationship with primary care and other system partners that benefit the patient.

QUESTIONS? If you have questions about the Care Coordination Project, please contact:

- Tony Orfanides, anthony.orfanides@lhins.on.ca
- Andrea Wappett, andrea.wappett@lhins.on.ca
- Ashley Locke, ashley.locke@lhins.on.ca

HOW WILL WE KNOW WE HAVE ACHIEVED OUR GOALS?

Success metric	Success criteria indicator
1	• Increase number of face to face visits • Reduction in time between receipt of referral to service offer to Service Provider Organization • Improvement of patient satisfaction
2	• Reduction in % of caseloads over established caseload maximums
3	• Reduction in number of interactions with patient and patient files by LHIN staff • Reduction in transitions between caseloads and Care Coordinators for patients
4	• Reduction in process time for all referrals • Reduction in % of assessments overdue by more than 30 days
5	• Increase total value added interactions between Care Coordinators and primary care • Improve patient satisfaction and outcomes through strengthening primary care/care coordination interaction
6	• % of Care Coordinators meeting targets regarding patient/partner interaction
7	• Care Coordinator / Patient Care Assistant satisfaction measures

WHAT IS THE TIMELINE?

Project milestone	Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
	Commitment to reduce community caseloads Project charter formation Value stream mapping of our current state and future state for: access and triage, short stay, and hospital	Mapping the patient journey	Engagement and system needs analysis for Community Care Coordination	Care Coordination model re-development for Community Care Coordination Initiate value stream mapping of our current state and future state for: complex and chronic care	Implementation and evaluation
Estimated completion	Q3 2017/18 Q3 2017/18 Q4 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19

Engagement – Process and Outcome (Primary Care)

1. What are the **barriers** to meaningful connection between Care Coordination and Primary Care?

2. What are the **concrete actions** required to achieve stronger and value add relationships between a Care Coordinator and Primary Care Physician?

3. What **opportunities** exist to strengthen access for:
   - People facing health inequities
   - Unattached people
   - People facing mental heath and addictions


QUESTION &
ANSWER