HealthLink
Rural Kingston
Let's Make Healthy Change Happen

HealthLinks and Primary Care Collaborative

Ontario's Best Practice Exchange Catalyst Event

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James Chau, FP & Annie Campbell, RN

Ontario

Acknowledgements

Mary Woodman

David Harvey

Kathy Hickman

Learning Objectives

1. Move toward a shared understanding of what Coordinated Care is and why it is a beneficial person-centred practice.
2. Explore ways to begin to use/enhance use of Coordinated Care Plans in Primary Care and Health Links for older adults with complex care needs due to mental health, substance use, dementia or other neurological conditions.
3. Begin to identify best practices for making sure that Coordinated Care Planning is person and family-centred.

Intro and context

- HealthLinks is a provincial initiative with 69 HLs to date
- Aligned with the Minister's action plan *"Patients First"*
- It is an approach or process, not an organization

Goals of Health Links

1. better outcomes for patients / families
2. improved patient experience (and provider experience)
3. reduced utilization of hospitals to lower overall cost

HealthLinks: a new philosophy and approach

HL is all about improving quality of care

We know we can do better.

We need to address the fact that a very few people – 5% of the population is using 66% of the health budget.

We need to re-design care for those patients

At the patient level and at the system level

This represents big **change** for providers

Integration & Coordination of Care

- **Requires *integration* at the system level**
  - Integrating sectors and organizations across the continuum of care
  - Improved collaboration between health and social service providers
- **Requires *coordination of care* at the patient level**
  - HealthLinks will begin by focusing on the patients who have the most complex needs: high medical and high social needs

Target populations

"Complex" as defined by MOH

- 4+ co-morbidities/conditions
- Unmet social needs
- Overlay of hospital utilization

Sub –populations

- Frail and elderly needs
- End of life needs
- Addictions & Mental Health needs

Objectives

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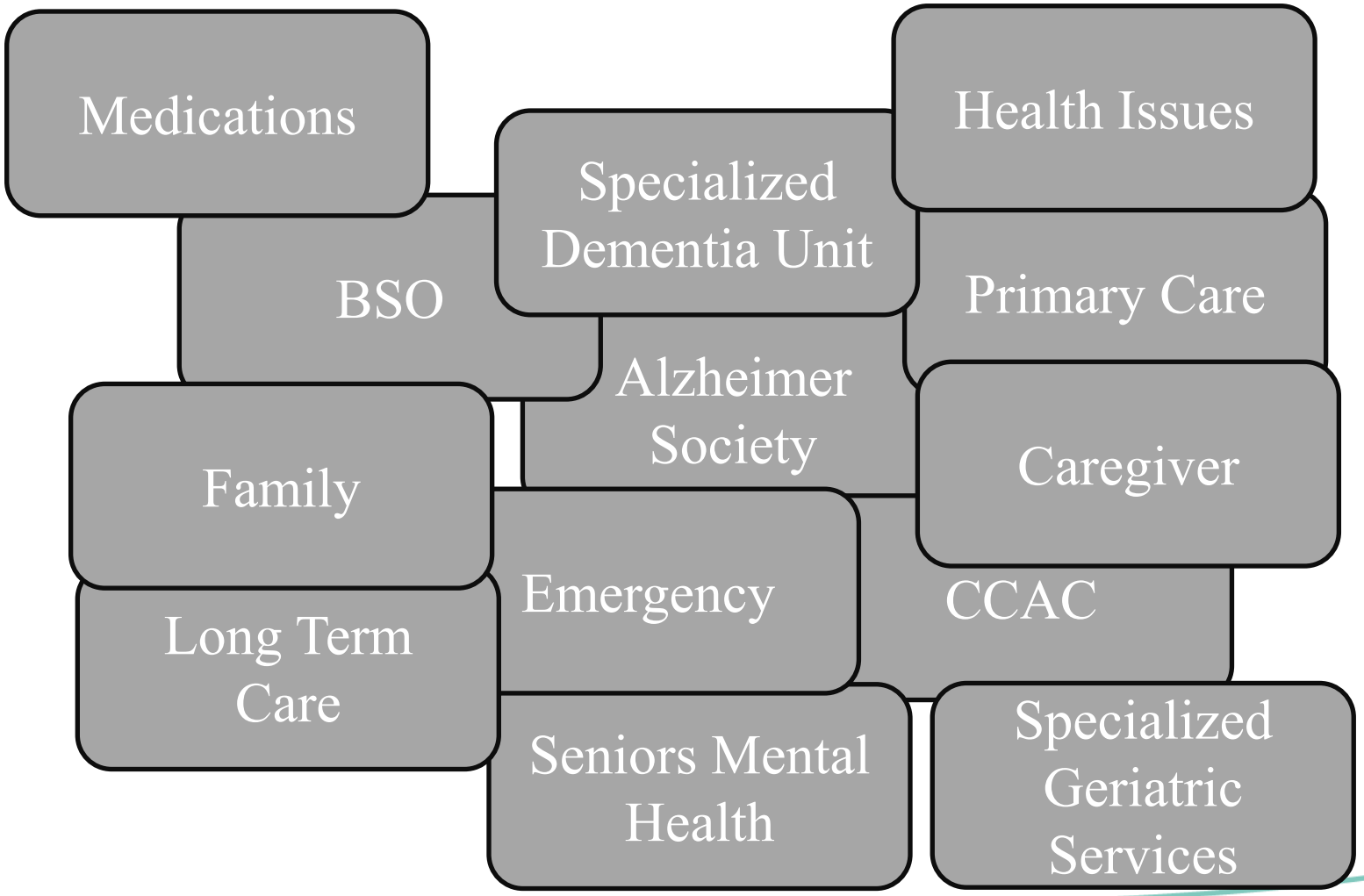
Medications
Health Issues
Specialized Dementia Unit
BSO
Primary Care
Alzheimer Society
Family
Caregiver
Emergency
CCAC
Long Term Care
Seniors Mental Health
Specialized Geriatric Services

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Coordinated Care

Core Competencies Required for Care Coordination

- ✓ Philosophy or values consistent with this approach
- ✓ True patient centred care; QI
- ✓ Exemplary communication skills
- ✓ Interview skills for difficult conversations
- ✓ Counselling skills
- ✓ Facilitation skills – aid in transitions and meetings
- ✓ Networking & Navigation skills
- ✓ Linkages to community resources
- ✓ Advocacy role
- ✓ Analytical skills
- ✓ Ability to determine needs and gaps in care
- ✓ Flexibility

Coordinated Care – Primary Care


Notes
Health Passport
Things you must know about me...
These things are important to me...
My likes and dislikes...


Notes
Extra notes can be mad
Complete
NHS
Halton Clinical Commissioning Group
NHS
St Helens Clinical Commissioning Group
Health Passport
Nursing and medical staff please look at my health passport before you help me.
My name is:
I like to be known as:
Stick your photo here!
Things you must know about me.
These things are important to me.
My likes and dislikes.
My ethnicity:
Contact Number:

Coordinated Care

HealthLink

Health Link CCP Process

"Short time span of intensive care coordination"

Coordinated Care Plans and Guiding Principles

- A CCP must be a reflection of the patients voice
- This is not a medical visit or nursing assessment
- Patient Advisory Committee members suggest:
  - “Ask for my opinion”
  - “Speak in plain language”
  - “Be honest about my prognosis”
  - Do not label me with “dementia” on front page
  - Do not TELL me what I need – just ASK me!

Provincial Health Link Coordinated Care Plan

HealthLink

<<PATIENT NAME>>'s Coordinated Care Plan

v0-6-2

My identifiers	Last verified:	Last verified by:
Given name:	Preferred name:	Surname:
Gender: Choose an item.	Date of birth:	Health Link:
Address:	City:	Province:
Postal code:	OHIP insured: Choose an item.	Health card #:

Special notes or instructions:

My plan to achieve my goals for care	Last verified:	Last verified by:
Care team members who contributed to this plan:		
What is most important to me right now:		
What concerns me most about my healthcare right now:		

What I hope to achieve	What we can do to achieve it	Who will be responsible	Expected outcome	Barriers and challenges	Results achieved so far	Review date

Case Study

- Walk through CCP
- People involved, services involved, time
- Engage client, family, POA or trusted friend
- Parkinson's ; fearful of memory loss, general anxiety re health, and spouses health ; including burden on her.
- Confused and frustrated that specialists do not see me as a person.

What made the difference?

- What was different with this approach to care?
- Interview with patient & family?
- Having them co-design care?
- Working with community partners?
- Case conferencing to identify needs and resolve issues?

Discussion/ Questions

- What do you think about the HealthLinks Coordinated Care Plan?
  - What do you like?
  - How could the way it's used be improved to better meet the needs of older adults with complex care needs due to mental health, substance use, dementia or other neurological conditions?
- How could this tool or parts of it be used in your setting to improve care & service?
- How can we make sure Coordinated Care Planning is person and family-centred?

Next Steps/Future Directions

- Surface other processes and tools for Coordinated Care Planning
- Continue to build the resource bank
- Review and summarize key elements/success factors of various coordinated care planning processes and tools
- Begin to identify best practices for making sure that Coordinated Care Planning is person and family-centred.

For more information:

Annie Campbell….

Dr Laurel Dempsey

Lori Van Manen , QI facilitator

James Chau

David Harvey