Silo Busters: Ready for Health Links – Removing Barriers and Coordinating Care for Complex Patients Together

National Case Management Network

7th Annual Conference and Expo-
Raising the Bar for Case Management Together

September 26 & 27, 2013

Session Objectives

- Review approaches to integrated care coordination as it relates to complex patients and Health Links
- Explore methods required to successfully manage cross organizational “barriers” to joint care coordination through a case study example

"Case Management is a collaborative, client driven process for the provision of quality health and support services through the effective and efficient use of resources. Case Management supports the client's achievement of safe, realistic, and reasonable goals within a complex health, social and fiscal environment."

National Case Management Network Definition

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Centre d'accès aux soins communautaires

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The Vision for Integrated Care

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Case for Change

Structural Issues: funding, service delivery focussed on acute episodes of care, services organized by speciality

Professional or Collaboration Failures: multiple, disconnected providers which decreases the sense of accountability and enables siloed mindset

Enabling Systems Required: standardized tools or methods do not exist to capture and share information broadly

Source: HQO Literature Review

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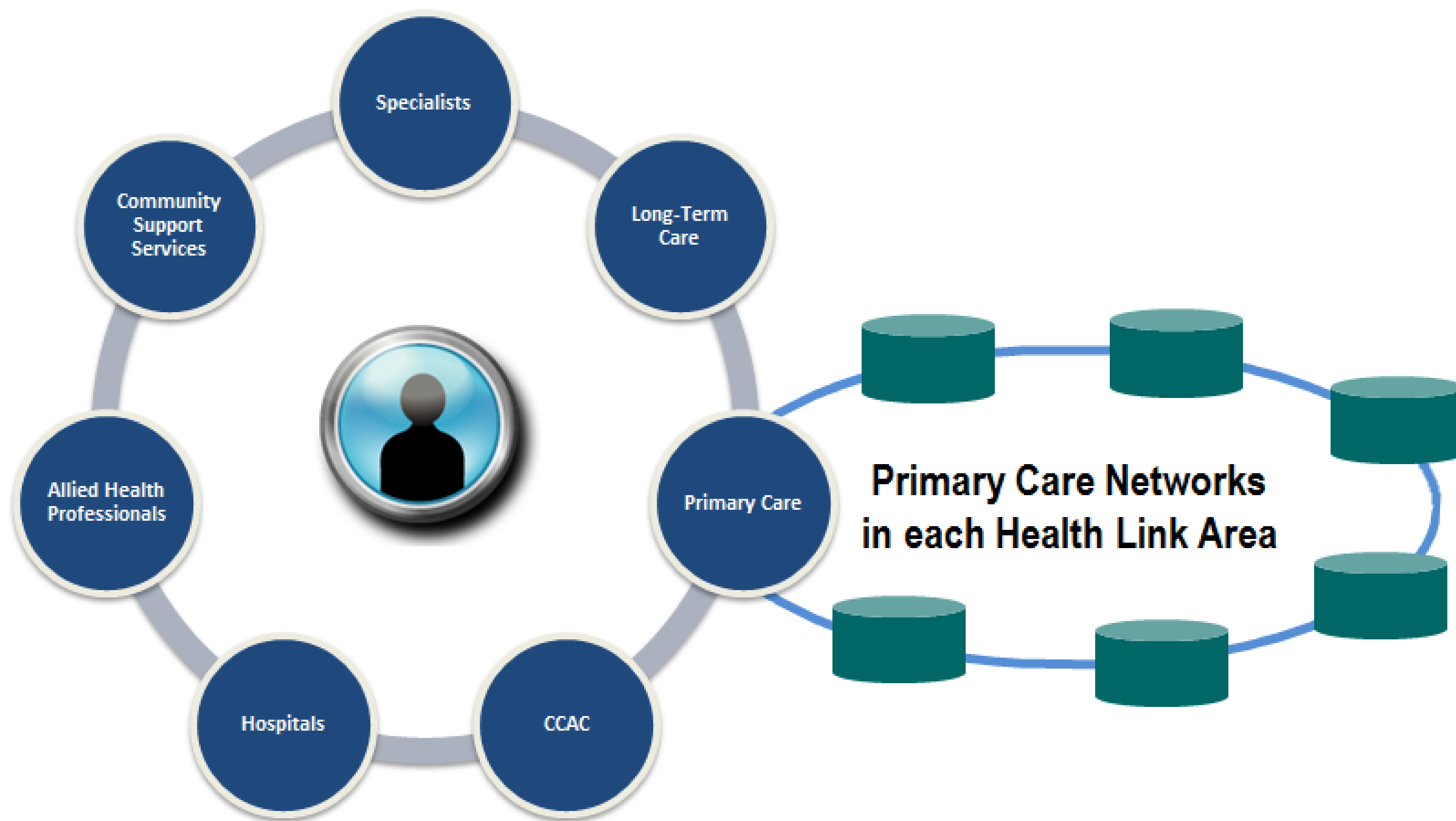
Health Links Fit with Primary Care



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Health Link Model of Care

A Few Health Link Aims

- *Ensure the development of care plans for all complex patients.*
- *Reduce the time from primary care referral to specialist consultation for complex patients.*
- *Reduce the number of avoidable Emergency Department (ED) visits for patients with conditions best managed elsewhere.*
- *Reduce unnecessary admissions to hospitals*
- *Ensure primary care follow-up within 7 days of discharge from an acute care setting*
- *Enhance the health system experience for patients with the greatest health care needs*

Guiding Principles for Care Coordination in the Health Link Arena

- Patient Focused
- Care Coordination for Complex Populations
- Collaborative practice with Primary Care
- Interprofessional practice across the continuum and across organizations
- Coordinated Care Planning where the Care Coordinator has a role in identifying an individuals' health and life goals and then coordinates services to meet those goals

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Key Competencies

- Personal and professional accountabilities
- Systems thinking
- Facilitate creative thinking
- Effective communication with all stakeholders
- Focus on building of relationships with patients, families and other stakeholders
- Support patient in self management and prevention practices

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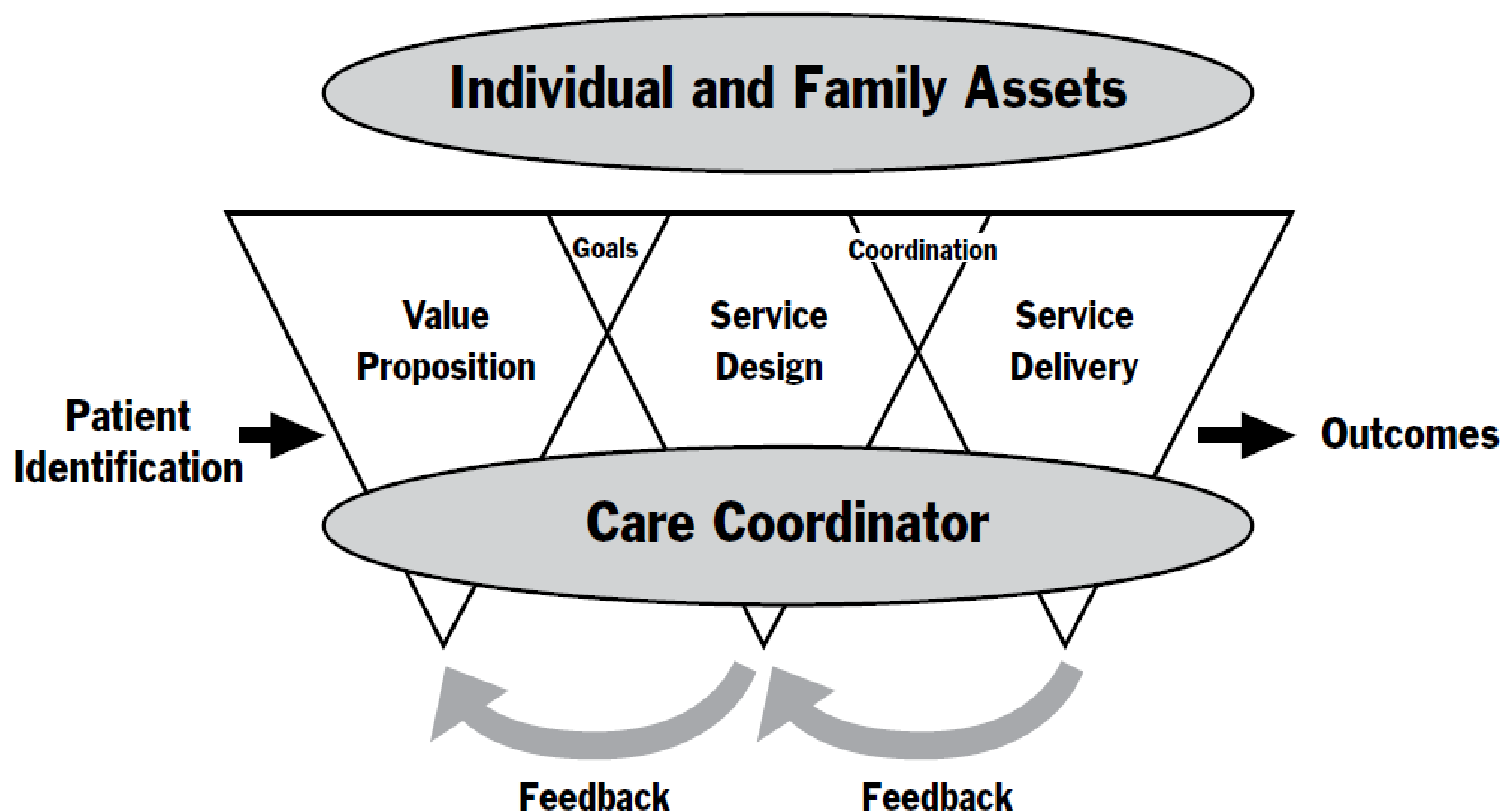

Source: Craig C, Eby D, Whittington J. *Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. (Available on www.IHI.org)

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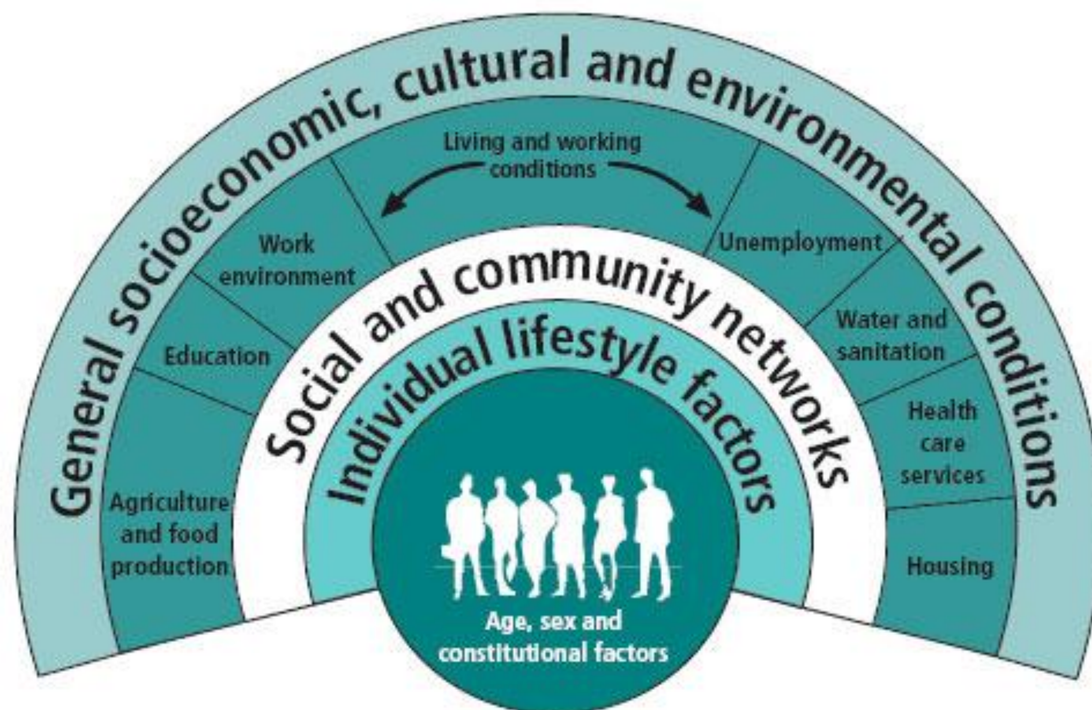

Source: British Medical Association. (n.d.). What are the Determinants of Health? *BC Health Communities*. September 17,2013. http://www.bma.org.uk/health_promotion_ethics/psychologicalandsocialneedsofpatients.jsp?page=3#.T68jQnlYv7A.

Integrated Care Plan

Collaborative Care Plan Executive Summary

Demographics

Patient Name:

Date of Birth: Age: Gender:

Health Card Number: Telephone #: Address:

Key Contacts

Next of Kin:

Substitute Decision Maker/POA:

Assigned Coordinator of Care (Responsible for contributing to this plan): (Name, Agency and Cont mber)

Risk for Re-admittance:

☐ **High**: Patient or family caregiver is unable to "Teach Back" or the patient or family caregiver has a low degree of idence f-care at home.

☐ **Moderate**: Patient or family caregiver is able to "Teach Back" most of the discharge information and has a m dera gree of ry out self-care at home

☐ **Low**: Patient or family caregiver has a high degree of confidence and can "Teach Back" how to carry out at

Acute Care Considera

(Unique and specific planned medical interventions if transfer to acute care is required including end of life

Medical ks Identified

lle

Medical Ov

S ituation:

B ackground:

A ssessment:

R ecommendations:

Goals of Care

Patient Goals:

Must be clear reed upo patient d/or the patient's caregiver, coordinator of care and the physician.

This section is to be c patient ership with the physician, coordinator and/ or care team. May include concerns about medical conditions, problems, barriers and/ d must i e actions, solutions, observations, current status and management of the goals and expected outcomes.

(This will be an expandabl

Patien	Action	Who is Responsible	Expected Outcome	Result

Declaration:

We (the physician and the patient/ patient caregiver) have discussed this care plan and the patient/ patient agent has received a written copy of it. A similar document has not been completed with another physician in the past twelve months.

Patient and/or Agent Names ______ Signature ______ Date ______

Physician Name ______ Signature ______ Date ______

Coordinator of Care ______ Signature ______ Date ______

DRAFT

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Case Study

Female, 37 years old, currently in community without housing, requires in-patient assessment and treatment to stabilize

Medical and psychosocial issues determined or assessed and to be investigated:

- Multiple mental health diagnoses (including Post Traumatic Stress Disorder (PTSD)) and antisocial personality traits
- Rare Acquired Brain Injury, unknown level of brain deterioration
- Polysubstance addiction
- Hyperphagia
- Forensic history of assault, starting in teens
- History of being sexually abused from age 9
- 7 recorded suicide attempts
- Disinhibition and poor sexual boundaries, has worked in the sex trade to fund her addiction
- Chronic homelessness
- Elopement
- Childhood Attention Deficit Hyperactivity Disorder (ADHD) and developmental delay

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Case Study

Medical Assessment Needs:

- Possible thyroid dysfunction, infectious disease, diabetes, medication management, dental care

Community Needs:

- Case management, behavioural support, psychology support, neuropsychiatric review, 1:1 staffing, 24hr supervision in secured care, crisis planning, meal time supervision, injury prevention strategies, support for medical and probation appointments, recreational activities and medication management.

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Case Study

- A cross-LHIN case management team has been created (Central West, Toronto Central CCACs, Peel Halton Dufferin Acquired Brain Injury Service, with Probation and Canadian Mental Health Association).
  The CW Director level has liaised with the LHIN and Ministry of Health to facilitate service for the client.

- The team has tracked the client successfully across 4 LHINs, reduced emergency visits, lengthened her duration of stay in each community location, obtained a General Practitioner and Health Card Number, a capacity assessment, a comprehensive file review, a medication regimen, neuropsychiatric medication review, intellectual testing.

- The team has reached out to 38 unique partners including: hospitals, rehabs, service agencies, detox programs, forensic services, mental health and acquired brain injury services have been approached to assist with care. Family have acted as Power of Attorney (POA) and attempted to house her.

Panel Perspective

- What makes Case Management so important when working with complex populations?
- What was the role of the CCAC Care Coordinator?
- How did you successfully work together to support this complex patient?
- What were some challenges or barriers faced?
- What were important elements to support interprofessional/cross organizational care coordination?
- How is Health Links the key to successful care coordination?

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Lessons Learned

- Support from Leadership is essential to cross the boundaries
- Primary Care Linkage is important
- Formalizing Care Planning including clarifying roles and responsibilities
- Technology solutions are required to share information
- Examination of resource and referral approaches (No Wrong Door)

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Lessons Learned Cont.

- Cross system –interprofessional training to support the new method of working and communicating together

- Maintenance and follow up in relation to care planning are imperative

- Partnerships and support are required to support the Care Coordinator in facilitating the creation of the integrated care plan

IT TAKES MORE TIME UP FRONT BUT ALLOWS US TO GET IT RIGHT

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