Title:	**Chatham Kent Health Links**
Corresponding Author:	Andrea Atkinson
Affiliation:	Thamesview Family Health Team
Address:	465 Grand Ave. West Chatham ON N7L 1CS
E-mail:	Andrea.atkinson@thamesviewfht.ca
Telephone:	519-354-0070 x 611
Other Author(s)	1) Lisa Richardson
	2) Elizabeth Dulmage

Aim/ Objectives

By January 31st, 2017, the case manager(s) at Thamesview Family Health Team (TFHT) would collaboratively create and/or revise 10 Action Plans with clients and primary care providers (PCPs) to decrease unplanned acute care admissions by 25%.

Intervention/ Change Ideas

Historically the Chatham-Kent Health Link (CK HL) model had utilized Med GPS software to identify patients who were high users in acute care. Our theory was that if PCPs had a role in identifying patients who would benefit from case management their participation in care planning might increase.

Evaluation/ Measures

Utilizing physician-specific patient lists generated by Med GPS we asked PCPs who they thought were appropriate for HL case management, exploring their rationale. We surveyed PCPs to identify their understanding of CK HL model. What did they like about it? What were the opportunities for improvement? Finally, we analysed the number of patients deemed appropriate for case management, how many of them had an Action Plan/CCP and how many Action Plans/CCPs were created collaboratively.

Spread/ Sustainability

Spread has included partnering with other FHTs & CHCs within ESC LHIN's sub-regions, the creation of a Health Link Regional Governance Committee and collaboration with neighbouring LHIN's.

Health Link case management criteria now includes primary care referrals and HRM data which have been updated on the CK HL process map. CK HL continues with regular Community of Practice Meetings with a focus on knowledge exchange and case reviews. A sub-region committee has been created which includes ESC LHIN representation.

Key Lessons Learned

All stakeholders must be involved in the evolution of CK HL model of care and in creating CCP/Action Plans (PCPs, Case Managers, patients, family members, etc.). Improve marketing of demonstrated outcomes of HL CM model to enhance participation and collaboration.

Title:	**Embedding CCP into Family Health Team High Risk Groups**

Corresponding Author:	Jeni Millian
Affiliation:	Home and Community Care Manager South West LHIN
Address:	32 Centennial Dr., Seaforth Ontario
E-mail:	jennifer.millian@lhins.on.ca
Telephone:	519-641-5523
Other Author(s)	1) Paula Day, RN Thames Valley Family Health Team
	2) Llori Nicholls, RPN North Perth Family Health Team
	3) Heather Ross, OT New Horizons Rehabilitation Services

Problem

- Coordinated Care Plans (CCPs) were not being completed.
- Resources were not targeting the right people.
- Need to improve Primary Care involvement.

Big Dot Aim
To decrease avoidable ED visits and hospital admissions with the support of Coordinated Care Planning.

Project Aim
By Feb 2017 we will complete 10 CCPs through collaboration at patient point of contact in a Primary Care setting in the Thames Valley FHT (5) and North Perth FHT (5).

Intervention/ Change Ideas

- Identification of high risk patients by accessing patients enrolled in FHT programs.
- Initiate CCP at point of contact with patient.
- Engage community and primary care teams to co-facilitate the process.

Evaluation/ Measures
Outcome Measures: # Completed CCPs, # Achieved Goals
Process Measures: Time, Provider Involvement
Balancing Measures: New resource linkages, Patient and Provider Satisfaction

Sustainability/ Spread

- Information has been shared with Health Link tables across the South West and with a number of FHTs specifically in the Huron Perth sub-region and discussions are occurring as to how implement this process into similar programs.
- Strategies are being implemented to support access into CHRIS to support the completion and sharing of the CCP documentation.
- Use of CCP within the NPFHT Fall Prevention Program; the Palliative Care Program and looking at using this process in Lung Health Program at NPFHT as well as in CD programs and Memory Clinics within additional FHTs

Key Lessons Learned

- Patients are fearful of the agenda of the CCP team given changes in their health and changes in the system.
- Smaller groups and split conferences are proving to be less anxiety provoking for patients and providers.
- Improved understanding of roles and responsibilities of care team members.
- Team members gaining ideas of what is happening in other communities.
- Improved knowledge and navigation of community/health resources available to patients.
- Improved communication is imperative
- Coordinated Care Planning is NOT just a tool it is truly patient centered and collaborative care.

Title:	**Bridging the Gap in Health Disparities - Hospital Outreach Team Partners with Community Support Services to Improve Patient and System Outcomes**

Corresponding Author:	Kelly O'Halloran, Director Community & Population Health Services Lead, Hamilton West & Niagara North West Health Links
Affiliation:	Hamilton Health Sciences
Address:	711 Concession Street, Room G2 Hamilton, Ontario L8V 1C3
E-mail:	Email: ohallk@hhsc.ca
Telephone:	905-527-4322 ext. 46734
Other Author(s)	1)Trina Banko, Quality Specialist
	2) Lawna Paulos, Chief Executive Officer, Capability Support Service
	3) Steve Sherrer, Chief Executive Officer, Thrive Group/AbleLiving Service

Aim/ Objectives

Hamilton Health Sciences' (HHS) Outreach Team will partner with Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN) Community Support Services to deliver coordinated care to 40 patients while maintaining or improving patient and system outcomes.

Intervention/ Change Ideas

HHS' Outreach Team applies standardized criteria to identify highest risk patients. Patients are engaged through motivational communication and viewing patients through a trauma-informed lens. Results of routine screening of cognition and mood are communicated to primary care to trigger further assessment, diagnosis, and planning. Coordinated care plans are designed based on what matters most to patients. Patient action plans are executed in collaboration with patients, caregivers, families, hospital, primary care, specialists, homecare and community support services. Patients are assisted to access adequate nutrition, housing, medical equipment, supplies, transportation to appointments, and supported to self-manage their chronic conditions using teach-back and action plans written in plain language that patients find easy to read, understand, and use. In partnership with HHS' Outreach Team, Community Support Services' Personal Support Workers support patient goals identified in action plans such as monitoring medication adherence, providing reminder calls, accompanying patients to medical appointments, and other day-to-day activities.

Evaluation/ Measures

1) 25.2% reduction in ED visits; 2) 50.0% reduction in inpatient visits; 3) 55.8% reduction in 30-day readmissions and; 4) 41.9% reduction in ambulatory care sensitive conditions.

Spread/ Sustainability

Standardized screening, assessment tools, and decision making algorithms support consistent practice. Patients are assessed for readiness to safely transition to an Integrated Care Lead drawn from the patient's circle of care. HHS invites other partners to deliver elements of the outreach model of care, offering education, mentorship, and support. HHS is also partnering with organizations such as McMaster University, Mohawk College, the City of Hamilton – Public Health, and Emergency Medical Services to better understand the needs of this population, predict risk, and develop proactive strategies to reduce the impact of disparities for future patients.

Key Lessons Learned

Improvements in patient experience and cross sector partnerships are achieved through this model of care. Evidence of reductions in ED visits, readmissions, length of stay, and ambulatory care sensitive conditions is promising.

Title:	**Complex Inpatients Identification & Referral to Health Link Programs**
Corresponding Author:	Linda Robb Blenderman, RN, BScN, MSc,
Affiliation:	Maple Family Health Team
Address:	1036 Princess St, Unit D2, Kingston K7L 1H2
E-mail:	lrb@maplefht.ca
Telephone:	613-766-9836
Other Author(s)	1) Meghan McCourt, MSW RSW, Kingston General Hospital,
	2) Cindy Moser, RN, Home & Community Care at the SE LHIN
	3) Laura Cassidy, B. Comm, Maple Family Health Team, QI & Decision Support Specialist

Aim/ Objectives

By Jan 31st, 2017, 80% of complex patients on the Kingston General Hospital (KGH) internal medicine inpatient ward are identified and referred to Kingston Health Link (KHL)

Intervention/ Change Ideas

- Education on Health Links
- Algorithm developed and tested

Evaluation/ Measures

1. Total number of referrals
2. Staff pre and post surveys and focus groups

Spread/ Sustainability

- We were able to gather baseline data.
- Spread has occurred with inpatient psychiatry and the Renal Program.
- Shared success among teams
- Gained an understanding of the challenges and barriers of the different programs
- Hospital is engaged with Health Link champions at the Director and Program manager level
- Incorporated IDEAS project and established annual targets that are reported quarterly to the KHL and Hospital

Key Lessons Learned

- Presenting information in person to teams is more effective because staff are appreciative and we understand their challenges better
- Staff need to be part of the process from the ground up
- Process map aides in defining focus of change
- Each other's organizations culture, language, resources, and communication styles
- Change fatigue

Title:	**Care Coordination Clarity**
Authors:	Shelley Byers & Tanya Noguera
Affiliation:	Links2Care & North Halton Health Links Alliance
Address:	360 Guelph St. Unit #33, Georgetown
E-mail:	sbyers@links2care.ca tnoguera@nhhealthlinks.ca
Telephone:	905-873-6502

Aim/ Objectives

By March 31st, 2017, 80% of the clients who have been referred to Health Links (HL) and either Client Intervention & Assistance (CIA) or Community Support (CS) programs, will be able to identify their primary point of contact / LEAD for their care plan.

Intervention/ Change Ideas

Determine if clients know who their LEAD / primary point of contact for their care plan is.

Evaluation/ Measures

A tally sheet was created to track the following measures:
Process Measures - Number of clients with a LEAD assigned
Outcome Measures - Number of clients who identify that they have a LEAD, Number of clients who identify the correct person as the LEAD

Spread/ Sustainability

Care Coordinators in North Halton have partnered with Care Navigators in North Halton Health Links to navigate system barriers to ease access for people with complex needs and better enhance the client experience. This partnership allows for the responsibility of the goals identified in a client's care plan to be shared. The Care Coordinators and Care Navigators each share the responsibility of engaging and following up with all members of the circle of care to ensure optimal cross sector collaboration.

Key Lessons Learned

We have learned that to enhance the client experience and build system capacity, we should:

- Encourage cross-sector collaboration
- Encourage increased communication amongst the circle of care
- Empower clients to self-manage aspects of their care plan

All of which will result in less confusion and reduce duplication/ inefficiencies in the system.

Title:	**Improving Cross-Organizational Collaboration in the Care of Mental Health and Addictions Clients**
Corresponding Author:	Raechelle Devereaux
Affiliation:	Guelph CHC
Address:	176 Wyndham St. N
E-mail:	rdevereaux@guelphchc.ca
Telephone:	(519) 821-6638 ext. 353
Other Author(s)	1) Dwight Syms, CMHA Waterloo Wellington
	2) Lee-Ann Murray, Waterloo Wellington LHIN
	3) Kim Campbell, Guelph FHT
	4) Navjot Thandi, Guelph CHC
	5) Monika Niewiadomski, Guelph FHT

Aim/ Objectives

To improve collective shared care planning and associated communication between hospital, community mental health and addictions service providers and primary care.

Intervention/ Change Ideas

To test coordinated care planning conferences to broader cross-organizational participation. Explored current processes for identifying mental health and addictions (MHA) clients who would benefit from coordinated care planning. Identified six clients with MHA presentations who were also high Emergency Department (ED) utilizers. Tested the implementation of a pre/post care planning assessments focused on the clients' access to the Social Determinants of Health (SDOH) and also aggregated ED utilization to measure improvement over time.

Evaluation/ Measures

Outcome:

- ED Utilization – Tracking six months prior to care conference and six months following.
- SDOH assessments – Pre-conference and six months post conference.

Process

- Number of conferences held.
- Number of SDOH assessments completed.
- Percentage of care leads who found SDOH added value to care plan.
- Percentage of participants who found value in care conference.
- Percentage of participants who attended conference.

Spread/ Sustainability

Shared some of the learnings from our project during our community's c-QIP, Spring 2017. Sharing of our project outcomes has contributed to the use of the SDOH assessment tool within other programs/services in Waterloo-Wellington. Continue to measure the impact of conference on ED utilization, while exploring the development of a shared Guelph General Hospital data portal access for Health Links care leads.

Front line care coordinators are about to re-initiate a monthly network meeting to support shared care planning for complex populations. Various teams across organizations have begun using the SDOH tool to guide care planning. Project was successful in demonstrating that the value of care conferencing for complex MH&A clients mitigates the time investment needed**.**

Key Lessons Learned

Care conferencing can be challenging given the number of care partners who are often involved, but it can be both an effective and efficient care planning mechanism.

Dedicated administrative support and standard times for care conferences is essential to ensure the team members are able to participate.

Process mapping was a very valuable tool to understand the problem. Enabling hospital utilization data sharing across the care team will be critical to support real-time care planning responsiveness to SDOH barriers/crisis.

Title:	**Design of Sustainable Intake and Electronic Coordinated Care Plan Processes**
Corresponding Author:	Catherine Morland
Affiliation:	Project Manager
Address:	
E-mail:	catherinemorland2284@gmail.com
Telephone:	705-475-6341
Other Author(s)	1) Cynthia Désormiers
	2) Anna Gibson-Olajos
	3) Michelle Crépeau
	4) Amelia Roscoe

Aim/ Objectives

- 10% reduction in ED visits for all Health Link (HL) patients with a shared care plan by September 30, 2017.
- 80% of all Coordinated Care Plans (CCPs) that are created or updated are shared with all providers within 3 business days. This will happen by Jan 31, 2017.

Intervention/ Change Ideas

Resource/ Capacity

- 8 Agency Partners
- Assign Health Link Lead at each agency
- Secure CCAC Health Link Lead to oversee Care Coordination process and Care Plan development

Engagement/Education/Spread

- Awareness Presentations
- Coaching and mentoring Care Partners and Agency Leads
- Distribute Health Links information packages to Physician offices

Standardize Process

- Created central referral through CCAC
- Created a quick reference Checklist for Referral /Care Coordination
- Designed custom forms in Primary Care EMR to support integration of Health Link process into work flow
- Adopted CHRIS (Client Health Record Information System) platform to house and share Coordinated Care Plans

Evaluation/ Measures

# of days from Referral received to Care Conference
# of days from Care Conference to dissemination of CCP
# of ED visits
# of Admissions to Acute Care

Spread/ Sustainability

- Dedicated administrative support for Central Intake process
- Health Partner Gateway agreements for access to CHRIS (6 of 8 partners)
- Created custom reports in CHRIS to monitor metrics

Key Lessons Learned

Who are the most complex patients?

- The patients most in need of health links are those who face challenges related to social determinants of health
- Frequent users of the Emergency Department are not necessarily orphan patients, many have access to primary care

Process Development

- Involvement of patients and front end users in process design is vital to success
- Cross agency projects are challenging but can impact system change.

Title:	**Reconnecting Health Links Patients from Hospital to Primary Care**
Corresponding Author:	Raman Deol
Affiliation:	Central West Health Links
Address:	2100 Bovaird Drive East, Brampton, Ontario L6R 3J7
E-mail:	raman.deol@williamoslerhs.ca
Telephone:	(905) 494-2120 extension 59122
Other Author(s)	1) Carol Petryschuk
	2) Francisco Truong
	3) Tessa Vandenhoek
	4) Ghada Youssef

Aim/Objectives

Within the Central West Health Links, there was an inconsistent exchange of information and follow-up support for existing Health Link patients as they transitioned from one care provider to another. Specifically, in the Dufferin Area Health Link this problem was evident in the transition from hospital to primary care provider (PCP). Our aim was to have a 20% increase in the number of existing Dufferin Area Family Health Team (DAFHT) Health Link patients that were reconnecting in-person with DAFHT within seven calendar days of discharge from Headwaters Health Care Centre (HHCC).

Intervention/Change Ideas

To date we have tested the following change ideas:

1. Use of HHCC brochure inserts and hospital Care Coordinators to educate and remind patients of the importance of reconnect, and DAFHT communication reminding PCPs to reconnect with patients.

2. DAFHT Patient Services Coordinator calling patients post discharge to do an assessment and book reconnect appointments if patients have not done so already.

3. PCPs being reminded that they can use E080 billing code for post-discharge follow-up appointments within 14 days.

Evaluation/Measures

Process measure: % of existing DAFHT Health Link patients who had an in-person follow- up visit booked within 7 and/or 14 calendar days of discharge

Baseline: 10% within 7 days and 17% within 14 days

Results: 32% within 7 days and 45% within 14 days

Outcome measure: % reduction in 30 day readmissions to HHCC for existing DAFHT Health Link patients

Baseline: 12%

Results: 8%

Spread/Sustainability

Spread to PCPs outside of the DAFHT and to the rest of the Central West Health Links is planned however, the change ideas need to be tested further first. Need to ensure that only the interventions that have been tested and proven effective are being spread.

Key Lessons Learned

The data is promising but also points to the need to scale up Health Link identification and collect more data for Health Link and non-Health Link patient reconnects effected by the change ideas.

Title:	**Mid East Toronto Health Link (METHL) Virtual Hub: Improving Identification, Referral, and Care Coordination for Acute Care Patients with Complex Needs**

Corresponding Author:	Karen Woo
Affiliation:	Mid-East Toronto Sub-Region
Address:	410 Sherbourne Street, 3rd Floor, Toronto On, M4X 1K2
E-mail:	wooka@smh.ca
Telephone:	416-867-7460 x8373
Other Authors	1) Susan Anstice
	2) Michelle Bather
	3) Kelly Clarke
	4) Victoria Wen

Aim/ Objectives

By February 3, 2018, reduce avoidable 30-day hospital readmission rate to 13% for identified patients of St Michael's Hospital (SMH) General Internal Medicine (GIM) referred to Mid East Toronto Health Link (METHL) who participate in a Coordinated Care Plan (CCP) case conference.

Intervention/ Change Ideas

Use SMH Readmission Risk Screening tool with all patients admitted to GIM to improve timely identification of patients with complex care needs who are eligible for referral to Health Links. (Screening tool was created for congestive heart failure and chronic obstructive pulmonary disease patients)

Evaluation/ Measures

Outcome:
- Number of patients referred from SMH GIM to METHL
- Number of referred patients who consented to a CCP case conference

Process:
- Streamline identification of patients using SMH Readmission Risk tool
- Increase rate of identification compared to clinical judgement alone – prediction 30% of patients would be eligible
- Screen daily (M-F) for all newly admission patients using tool

Balancing:
- Number of patients eligible but not referred
- Time spent screening engaging and consenting patients for HL referrals

Spread/ Sustainability

- SMH Readmission Risk screening tool has now been improved to reflect SMH GIM population and embedded into our electronic health record system for all GIM patients admitted through the Emergency Department which has reduced workload for GIM CMs
- Dedicated Project Manager for METHL to help facilitate referrals and operationalize Virtual Hub team
- New goal for GIM referrals is 2 patients per week to METHL

Key Lessons Learned

Difficult to predict estimated date of discharge for GIM patients; challenging to provide warm handover. Potential for future test of change to provide warm handover with patient via telephone.