Care Coordination Program of Work
GUIDEBOOK

A guide for implementing a neighbourhood-based home and community care model
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**Note:** On May 31, 2017, the Mississauga Halton Community Care Access Centre (CCAC) became part of the Mississauga Halton Local Health Integration Network (LHIN) as a result of the provincial *Patients First* legislation, Bill 41. The work outlined in this Guidebook reflects the efforts of the legacy Mississauga Halton CCAC team.

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Background

Health care is a complex, fragmented system, relying on numerous organizations, agencies and services to deliver care to patients. As the population ages, and their care needs become increasingly chronic and complex, it will be more challenging to coordinate care across multiple providers to ensure patient and caregiver needs are met.

The Mississauga Halton LHIN region has one of the largest aging populations in Ontario, set to triple by 2035, with 189,900 more seniors residing in the region. Our Community Capacity Plan determined that unless significant changes and improvements are implemented, it will require two and a half times the current level of health care dollars to sustain the model of care we currently deliver to Mississauga Halton region residents. The Study highlighted the current and future needs of seniors and recommendations for how to meet those increasing needs.

A key finding of the Capacity Study was that care coordination reduces health risk, serving a key clinical function to ensure people receive the most appropriate level of care, and avoid skipping levels of care. The Study recommended that one person or entity should be responsible for coordinating care across all providers in a patient’s circle of care, as this is evidenced to improve patient experience and outcomes, as well as support more efficient use of health care resources.

A recent Client and Caregiver Experience Evaluation (CCEE) revealed that what patients and caregivers value most in their relationship and experience with our care coordinators was consistency. Based on that insight, we realized the necessity for our care coordinators to be better prepared to consistently provide and support optimal patient and family experiences, where patients are satisfied and feel their care is managed effectively.

OUR OPPORTUNITY

Care coordination was the core business of the legacy Mississauga Halton CCAC, and is now a key service offering for the renewed Mississauga Halton LHIN. It is the primary activity we provide to consumers, where consumers are defined as the patients and caregivers we support, or those who may need our support in the future. We recognized the need to continually demonstrate our value to those consumers, measured simply in their satisfaction (positive experience) with our organization and our ability to deliver on our vision.

Further, we needed to strive to align our organization to the provincial Action Plan for Health Care – Putting Patients First, focused on patient and family-centered care, meaningful connections with primary care, improved approaches to service delivery with particular focus on specific patient populations, and increased accountability for performance. Those themes were echoed in the 2015 Expert Group Report on Home and Community Care (Donner Report) recommendations to Ontario’s Ministry of Health and Long-Term Care (MOHLTC).
We articulated our intent to drive our organization forward to support those recommendations through the development of the legacy Mississauga Halton CCAC’s 2015-2020 Strategic Plan directions.

• We will make meaningful experiences and outcomes for people.
• We will modernize the health system.
• We will mobilize people and technology.
• We are making people the point of care.

Executing on those strategic directions required a “shift” in how we interact with all patients; it required us to re-focus on ensuring patient care needs are assessed and addressed consistently, looking at not only physiological needs, but also taking into account, in collaboration with all those in a patient’s circle of care, the interrelated medical and social determinants of health in order to support short-term and long-term care planning for patients. And while the initiative focused on the role of care coordination, it is important to note that every individual in the organization contributes to and supports the core business of providing and coordinating quality patient care, so all employees were engaged and motivated to be part of the collective success of this initiative.

The Care Coordination Program of Work was Year 1 priority work within the legacy Mississauga Halton CCAC’s Strategic Plan to help us facilitate this paradigm shift in how we deliver and coordinate care. We recognized the essential need to redefine and reimagine how we coordinate care to give our organization and staff the tools, confidence and ability to efficiently and consistently deliver quality patient care, and become the care coordinators for the health system. The Care Coordination Program of Work was the first step to help us achieve this vision.

**Care Coordination Program of Work Overview**

The goals of the Care Coordination Program of Work were to:

• Optimize our regional care coordination role
• Build and strengthen relationships with regional health and social support service providers and primary care practitioners to improve patient care

The program of work had three key projects:

1. Care Coordination Enhancement
2. Neighbourhood Realignment of care coordination teams and service providers
3. Connecting to Primary Care

Key deliverables for this initiative included developing a standardized, enhanced Care Coordination Framework with core competencies for all care coordinators, focused on teaching care coordinators how to practice within the full scope of their role. It also included new processes for completing a care plan and care conference – tools we know lead to better patient outcomes when performed consistently.

The second stream of the initiative worked to realign our care coordination teams and service providers to specified geographic boundaries, enabling our care coordinators to work with patients at the neighbourhood level, becoming experts on the social determinants of health and available resources that affect our ability to coordinate care in those communities. Service provider realignment enabled us to reduce the number of providers in smaller geographies, which aimed to strengthen relationships across the circle of care.

The third stream of this initiative targets connecting our care coordinators to primary care practitioners, again, at the neighbourhood level, to support continuity of care. The anticipated result of implementing this three-step approach will be a more patient-centred, integrated, local health system, with our care coordinators at the centre. The third stream will be implemented as a next step to this work in 2017/18.
Project Approach and Timeline

Research and Planning Phase

1. February 2015
   - Research and analysis of scope of work

2. June 2015
   - Development of Project Plan

3. August 2015
   - Executive Council endorsement

Design and Implementation Phase

4. September 2015
   - Care coordination enhancement
   - Project 1 launch
   - Refine professional practice framework

5. April 2016
   - Neighbourhood realignment
   - Project 2 launch
   - Framework and core competency training and quality practice validation

6. June 2016
   - Phase 1: Care coordination teams

7. July 2016
   - Phase 2: Service providers in alternate housing

8. September 2016
   - Phase 2 (cont’d): In-home service realignment
   - Peer mentoring implemented at neighbourhood level

9. January 2017
   - Peer mentoring implemented
   - Further core competency training/practice validation
   - Ongoing follow-up with patients impacted by realignment work
Section 2: Governance

Internal governance structure

Project Board (Executive Team)
- Executive Sponsor (Vice President, Patient Care)
- Project Sponsor (Director, Patient Care)
- Project Manager

Steering Committee (Cross-portfolio membership from leadership level)

Evaluation Committee (Cross-portfolio membership)

Working Group (Project 1: Care Coordination Enhancement)
- Dedicated Most-Responsible-Person (MRP)

Working Group (Project 2: Neighbourhood Realignment – Care Coordination Teams)
- Dedicated MRP

Working Group (Project 2: Neighbourhood Realignment – Service Providers)

Governance to Support Engagement With External Partners

- **Collaborative Steering Committee**: leadership from Mississauga Halton LHIN, Home and Community Care (formerly CCAC), and all contracted service providers
  - Purpose: collaborative decision-making body at the strategic level
- **Programs and Operations**: operations managers from Mississauga Halton LHIN, Home and Community Care, and all contracted service providers
  - Purpose: sharing operational updates; joint decision-making at the operational level
- **Retirement Home Forum**: leadership from Mississauga Halton LHIN, Home and Community Care, and regional retirement home partners
  - Purpose: sharing updates about Mississauga Halton LHIN projects, priorities or operational changes that may impact patients living in retirement homes

- **Connecting the Health Links**: co-lead organizations/individuals from regional Health Links, including primary care physicians, community support service organizations, hospitals and the Mississauga Halton LHIN
  - Purpose: sharing collective insights and identifying regional opportunities to support patients with complexity through fully optimized circles of care

*Note: These forums existed before the launch of the Care Coordination Program of Work, but were continuously leveraged throughout the initiative’s implementation to inform real-time information sharing and joint decision-making.*
Section 3: Project 1 – Care Coordination Enhancement

Care Coordination Framework

In an effort to facilitate a seamless, coordinated flow of information between patients, families and care team members, an evidence-based Care Coordination Framework was developed. The Framework leveraged leading practice evidence and emerging sector trends to elevate and enhance the care coordination discipline to become a key, sustainable method of clinical intervention for patients with complex needs. Framework components were informed and validated by patients/families, Home and Community Care staff from the Mississauga Halton LHIN, service providers and health system partners, such as hospitals and physicians. This led to the development of interdisciplinary care planning tools. Those tools enable all providers in a patient’s circle of care to update and work from one care plan, centred on goals identified by the patient.

The Framework includes eight care coordinator core competencies (aligned to professional practice standards), as well as new care planning and care conferencing tools. A complementary Quality Practice Validation Tool was developed and used as a clinical manager observed care coordinators during home visits, providing a standardized measurement approach for learnings within the Framework, while also giving care coordinators real-time feedback on their approach.

Care Coordination Framework tools and resources are included in the Appendix.

CARE COORDINATOR CORE COMPETENCIES

Core competencies are the measurable or observable knowledge, skills, abilities and behaviours that are considered critical to successful job performance.

It is expected that the competencies are relevant for all care coordinators, who are engaged in coordinating care for patients receiving home and community care services through the Mississauga Halton LHIN, irrespective of discipline or patient population. It is important to recognize that mastery of competencies relates to frequency of use. For example, a care coordinator working with a complex patient population may master leading care conference as compared to a care coordinator working with less complex patients, who less frequently require those cross-discipline interventions.

Core competencies also work to optimize and standardize patient experiences, ensuring no matter the complexity of a patient’s needs or where they live, he/she will receive the same quality of care as any other patient in the region.

The eight core competencies are:

- Assessment
- Communication
- Care Planning
- Care Transitions
- Navigation
- Collaboration
- Sustainability
- Patient Safety and Quality

![Diagram of Care Coordination Core Competencies]

Care Planning
Assessment
Communication
Care Coordination Core Competencies
Navigation
Sustainability
Patient Safety and Quality
Collaboration
COORDINATED CARE PLANNING

The coordinated care planning approach and associated documentation – the coordinated care plan (CCP) – were implemented to facilitate optimal understanding and management of chronic and/or complex health conditions by patients, their families, and their health care providers. This approach best supports those stakeholders to work in collaboration toward shared goals as it facilitates better communication and navigation across the health system and providers.

Further, in literature, effective care coordination of Complex and Chronic patients is evidenced to reduce avoidable readmissions to hospital and adverse health outcomes. That being said, coordinating care requires that all health care providers involved in a patient’s care:

- Have timely and easy access to each patient’s relevant health information;
- Understand what is most important to the patient and caregiver;
- Participates in team discussions with patients about how to best achieve their goals; and
- Communicate on an ongoing basis to monitor and update a patient’s care plan.

When the above criteria are met, the coordinated care planning approach is most successful.

A plain-language patient version of the CCP was also rolled out, so patients could continually keep track of and contribute to their own care planning, re-setting goals as milestones were achieved, or as their needs changed. And, a “welcome to home and community care services at the Mississauga Halton LHIN” letter was introduced as part of the care planning process. The letter articulated, in plain language, what patients/families could expect from their care coordinator as their lifeline to the health system.

Please see the Appendix for a copy of the CCP, patient care plan and welcome letter.

CARE COORDINATION FRAMEWORK TRAINING

In order to support ongoing development of care coordinators, training modules were developed and delivered to all care coordinators in interactive, classroom-style learning sessions. The training was focused on teaching, evolving and coaching care coordinators so that they consistently practice to full scope with skill and confidence. The training focused on “soft skills,” such as communication to elicit patient-specific goals, versus “hard” or “technical” skills, which was a new nuance for care coordinators. This required up-front coaching to help care coordinators understand the importance of those “types” of skills within their role.

The emphasis on soft skills was pursued based on feedback from patients and carers that they wanted their care coordinators to “support them in journey from illness to wellness, not by offering more services, but by becoming my most important point of care.” As such, core competencies, aligned to professional practice standards, were selected on the basis that those skills would work to improve care coordinators’ ability to communicate and collaborate with patients, families and system partners in a way meaningful to each stakeholder.

This learning laid the foundation for the transformational shift in care coordination from a model focused on brokering clinical services, to one focused on holistically addressing the social and clinical needs of patients across the health system.

QUALITY PRACTICE VALIDATION

Practice Validation is the ongoing monitoring of care coordinator practices through joint home visits, documentation review and participation in care conferences. Supporting a genuine and meaningful practice shift for our care coordinators was critical for the overall success of enhancing care experiences for patients and families through this initiative. Practice changes were supported through joint visits, discussions and documentation reviews including care plans and assessments, and observations of care conferences.
Practice validation provided an opportunity for staff to demonstrate newly learned skills and strengths while engaging in a process to help identify areas where practice enhancement was possible. Practice validation supported care coordinators in their learning journey within the refined Care Coordination Framework.

Adherence to the Care Coordination Framework standards measured during the Quality Practice Validation exercises was scored and recorded using a specially-designed Quality Practice Validation Tool. A copy of the Quality Practice Validation Tool is included in the Appendix.

- The Tool measured care coordinators’ progress from beginner, to experienced, to mastery levels for each component of the Care Coordination Framework, such as the ability to elicit patient goals.
- Trained validators – clinical managers and professional practice advisors – completed the validation exercises with care coordinators trained on the new Care Coordination Framework within a few weeks of training being completed.
- When needed, care coordinators scoring at the “beginner” level were offered follow-up coaching to support their professional development.

**Peer Mentoring**

With the introduction of the core competencies and subsequent quality practice validation, we made a pledge to our existing staff members to offer ongoing peer-to-peer mentorship to support further professional development and skill building within the enhanced Care Coordination Framework and core competencies.

Peer mentoring is a partnership and joint commitment to professional development where an individual with specific subject matter expertise supports a colleague/peer in achieving identified learning outcomes. Peer mentoring is focused less on performance maintenance and task completion, and more on relationship building and professional development. Mentees receive constructive feedback about professional practice from a peer they trust in a safe, supportive environment.

After completing an internal application process, the Program pairs eligible mentors and mentees for up to six months. Mentors are asked to participate in the program for up to 18 months.

Observed benefits of the Peer Mentoring Program include strengthening the organization’s professional practice infrastructure to support existing staff to build capacity and capability related to core competencies, and growing our people leaders through focused mentoring.

Peer Mentoring Program tools and resources are included in the Appendix.

**My Story Patient and Carer Information Package**

“I need a personalized map, plan and/or package in writing that can be shared with family and caregivers. Verbal plans are not remembered. I want to know and understand what will happen next.”

Based on feedback from patients and caregivers on the legacy Mississauga Halton CCAC patient and family advisory forum, Share Care Council, as well as those who participated in Health Link and the Mississauga Halton CCAC’s Seamless Transitions: Hospital to Home initiative, we designed My Story – a plain-language information package for patients/caregivers to help them keep track of their care, or a loved one’s care, at home.

Building on the successful rollout of the Patient Care Plan and “welcome letters” in the Care Coordination Framework, My Story includes those documents, as well as tools and resources to help patients better manage their care at home, understand the role of different providers involved in their care or who to call for help, and feel confident by knowing what will happen next in their health journey. The package is just one example of a tool that our care coordination teams can use to support the delivery of exceptional patient care.
MY STORY CONTENT AND FORMAT

The binder’s name, *My Story*, reinforces the concept of the patient’s ownership of their personal health information – an important nuance continually raised by *Share Care Council*. The award-winning *My Story* binder is a beneficial resource to help patients track and feel in control of their care, written in a way they understand, and customized to their personal needs or preferences.

The package comes assembled in a simple, plastic, three-ring binder, filled with information on: the role of the Mississauga Halton LHIN and other community providers; tips for managing medication, practicing hand hygiene, cleaning equipment and preventing falls; a copy of the patient’s personalized care plan; contact information for key service providers; instructions for filing a compliment or complaint; caregiver resources; and more. Eight sections, marked clearly with coloured, labelled tabs and a table of contents for easy navigation, help patients keep papers more organized than possible with a cardboard, two-pocket folder, which was previously used.

The binder’s simple look and feel was intentional to improve patient comprehension. The package’s content is written in a font size compliant with provincial accessibility guidelines, and includes many colourful graphics and icons, which are evidenced to improve understanding for adult learners. Content is written at a Grade 7 level, recognizing health literacy is an important factor to consider when developing patient education materials. Some clinical terms could not be simplified to a lower reading level; however, there is a glossary of medical terms included in the binder. Also, English is not the first language of many Mississauga Halton LHIN region residents, so simplifying language and adding graphics increases the likelihood of those patients/families comprehending materials.

One important component of *My Story* is the *Carer Support Guide – A Helping Hand While Caring for a Loved One*. The Mississauga Halton LHIN recognizes informal carers as our most important partners in care; our regional Community Capacity Study indicated that 2.6 hours of informal care are provided for patients per one hour of formal care in the community, with the demand for informal care hours exceeding supply by 700,000 hours by 2032. The Study recommends caregiver supports and services must be increased to reduce the informal care gap and caregiver burnout. In response, the Carer Support Guide was developed. The award-winning *Helping Hand* guide is a one-stop-shop where carers, at any chapter in their caregiving journey, can go to learn more about their vital role and how they can help their loved one live his or her best quality of life at home.

MY STORY DISTRIBUTION AND SCALABILITY

The package was first distributed to Complex and Chronic patients, recognizing those patients often receive care from multiple providers, and thus would benefit the most from having one, organized, dedicated place to keep track of their personal health information. Those patients receive a package from either our hospital care coordinators or community care coordinators, depending on how the patient is referred to home and community care services at the Mississauga Halton LHIN. The next version of *My Story* will include a section dedicated to Palliative resources.

Package distribution, or the potential reasons why a package was not distributed to a patient, was tracked in Mississauga Halton LHIN’s Client Health Related Information System (CHRIS). This monitoring supports quality improvement measures to ensure the package is continually refined to meet needs of patients and families.

The package is available electronically for patients/families seeking information in that format; however, *Share Care Council* expressed an appetite to have resources in print, especially for patients/families managing multiple care needs or agencies at once. Many *My Story* resources are relevant to patients/families outside Mississauga Halton LHIN region, making it scalable to other regions and provinces.

Please see the Appendix for sample materials from *My Story*. 
Section 4: Neighbourhood Realignment

Care Coordination Realignment

DETERMINING NEIGHBOURHOOD BOUNDARIES AND CARE COORDINATOR CASELOAD SIZES

A care coordinator workload study and analysis was completed to determine optimal caseload sizes. The goal was to determine the number of care coordinators (full-time employees/FTEs) that would be required to support implementation of a neighbourhood model of care coordination. The study revealed how many FTEs would be required per geography/Health Link area. Our region had previously been divided into seven sub-regions, called “Health Links” (see map below).

The multiple-month study also examined the care coordination process, from referral to care planning and monitoring, to determine the time it took to complete each task within the process, with a focus on understanding the varying intensity of care coordination required for different patient populations. This analysis informed our caseload weighting and caseload streaming.

An additional analysis of regional patient demographics was completed to inform neighbourhood and caseload boundary mapping (see Appendix for map). Patient density and volume across the region, as well as time it would take care coordinators to reach patients within neighbourhoods, were key factors in determining neighbourhood boundaries and caseload weighting, size and type. The neighbourhood boundaries were set within existing sub-region (Health Link) boundaries.
Based on the results of our care coordination study, we made the following changes.

<table>
<thead>
<tr>
<th>OLD MODEL</th>
<th>NEW “NEIGHBOURHOOD” MODEL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community (long stay) care coordinators:</strong></td>
<td><strong>Community (long stay) care coordinators:</strong></td>
</tr>
<tr>
<td>Pure caseloads were maintained, where community (long stay) care coordinators were dedicated to only Chronic patients, Complex patients, or Community Independent (CI) patients.</td>
<td>Blended caseloads were established, where care coordinators could have a caseload of Chronic and Complex patients, or Chronic, Complex and CI patients. This supported better continuity of care for patients because their care coordinator could continue to support them as their illness changed or progressed.</td>
</tr>
<tr>
<td>The number of patients on each care coordinator caseload varied based on patient population. For example, care coordinators with Complex caseloads had a lower number of patients on their caseloads compared to care coordinators with a CI caseload, based on the level of intensity of care coordination required for those respective patient populations. However, if a patient’s needs changed, they would be required to transfer to a new/different care coordinator whose caseload type matched the patient’s new needs. A caseload of a specific patient population had designated boundaries that define an area that does not overlap another caseload’s area. A significant change in patient population of a designated area can cause unbalanced caseloads. To address this issue, caseload boundaries would need to be redrawn and the impacted patients would need to be transferred.</td>
<td>Using evidence from the workload study, each patient population was weighted based on level of intensity of care coordination required to support those needs, where a Complex patient would hold a higher weighting within a caseload than Chronic or CI patient. And when geocoding was enabled (see next section), this feature ensured that new patients were assigned to the care coordinator caseload with the lowest weighting versus the lowest number of patients, taking into account the time required to adequately support patients with different complexity of care needs. This has created a platform for a team of care coordinators to have accountability for patients/carers within a neighbourhood.</td>
</tr>
<tr>
<td>Note: this change had significant “down-stream” impact where financial and managerial reporting had to be re-structured to accommodate change.</td>
<td></td>
</tr>
<tr>
<td><strong>Short Stay care coordinators:</strong></td>
<td><strong>Short Stay care coordinators:</strong></td>
</tr>
<tr>
<td>With an exception of oncology as pure caseloads, Short Stay caseloads were blended (rehab, acute, wound). Patients were assigned to oncology caseloads by designated regions (i.e. Central, East and West). Patients were assigned to the blended caseloads by their last names.</td>
<td>Pure caseloads were established that focused on type of referral, where care coordinators are assigned to specialized caseloads. For example, caseloads of only oncology patients were implemented (as with caseloads for acute care and wound care). By streaming patients based care coordinator clinical expertise, not by care coordinator caseload size, patients are able to receive better, more specialized care.</td>
</tr>
<tr>
<td>There were no structured neighbourhoods.</td>
<td>26 neighbourhoods were plotted based on volume of patients by patient population, population density and driving distance for care coordinators.</td>
</tr>
<tr>
<td>One community (long stay) care coordinator was assigned to a certain geographical area or cluster care setting (e.g. retirement home, assisted living, apartment building), which varied significantly across region based on population density and volume of patients by patient population.</td>
<td>Assigned multiple community (long stay) care coordinators per neighbourhood or cluster care setting to promote caseload balancing, coverage and neighbourhood familiarity. The same number of FTEs were used as in the previous model. This approach was replicated to realign other care coordination teams to the neighbourhood level, such as Palliative and Children’s Health Services; due to varying levels of FTEs and patient volumes, some of these care coordinators cover more than one neighbourhood area, but the neighbourhood boundaries remain the same across all teams.</td>
</tr>
</tbody>
</table>
GEOCODING

Geocoding refers to the automatic assignment of patients to a care coordinator caseload and service provider within our electronic health record, CHRIS. With this feature enabled, patients are automatically assigned to the right care coordinator and service provider more quickly, based on the neighbourhood where that patient lives, the complexity of their needs and care coordinator availability (based on caseload weighting). This also supported more equitable and balanced caseloads for our care coordination teams.

Prior to geocoding implementation, patients were manually assigned to care coordinators, with a staff member entering a patient’s postal code outside of CHRIS to generate the name of the care coordinator (based on complexity of patient needs) who covered that area. The new geocoding function enabled us to standardize and automate this process, eliminating steps at intake to save staff administrative time, which was then refocused on clinical conversations.

REALIGNING CARE COORDINATION TEAMS TO THE NEIGHBOURHOOD LEVEL

Once the neighbourhood boundaries were mapped, using on the parameters detailed above, care coordinator caseloads were mapped to each neighbourhood boundary. The paramount factor when making these decisions was continuity of care for patients. As often as possible, we sought to ensure patient care was not disrupted (i.e. we wanted to avoid, as much as possible, patients being required to change care coordinators as a result of caseload neighbourhood mapping). To do this, we attempted to keep the highest number of care coordinators within their existing caseload geography, despite the boundaries changing.

Note: This process could look very different for other organizations depending on your current state caseload mapping and sizes.

During this process, care coordinators “cleaned up” their existing caseloads by officially discharging patients who were no longer on service. Accurate and realistic data helped to ensure the best results for caseload balancing pre-and-post-realignment.

Once care coordinator caseloads were mapped to the neighbourhood level, two major steps remained:

1. Switching caseload naming/structure in CHRIS to align to new neighbourhood caseloads, and ensuring patients remaining with their existing care coordinator post-realignment are manually transferred in CHRIS to appropriate “new” caseload.
2. Supporting patients through smooth transitions to a new care coordinator, for those patients whose care coordinator would be changing based on the new neighbourhood assignment of caseloads.

Once caseloads were manually transferred in CHRIS, a three-month validation period occurred to ensure caseload mapping was successful. During this time, new patients were assigned to care coordinator caseloads using a specially-designed Caseload Locator Tool. With this Tool, patients are automatically assigned to a care coordinator caseload based on their postal code, which was manually entered by a staff member. This Tool would produce the caseload name, based on weighting and geography, but staff were still required to manually select that caseload in our CHRIS system to complete the referral. Once the validation period was complete, the geocoding function in CHRIS was enabled, eliminating those manual steps at intake to assign patients to care coordinators.

Continual monitoring and readjustments were made to ensure the right amount of care coordination resources were dedicated to each neighbourhood. This included ongoing education and confirmation with staff to promote frontline confidence in caseload equity and the geocoding process.
Service Provider Realignment

COLLABORATIVE PLANNING WITH OUR SERVICE PROVIDER PARTNERS

To support the delivery of more consistent, integrated care at the neighbourhood level, we realigned our 11 contracted nursing and personal support service providers to the neighbourhood level, after care coordination realignment was complete. In this model, no more than two nursing or personal support providers operate in each neighbourhood.

For rehabilitation, our four providers did not have contracts in place to deliver all services (i.e. physiotherapy, occupational therapy, speech-language pathology, social work, dietetics). Contracts were negotiated to ensure all of our rehabilitation service providers were able to deliver the “whole basket” of rehabilitation services.

In addition to the neighbourhood realignment, we reviewed all of our alternative care settings and aligned no more than two nursing/personal support providers and one rehabilitation provider to each building.

Guiding Principles for Service Provider Realignment

- Ensure the processes for patient transitions will be experienced in a supportive manner.
- Maintain stability in workforce by maintaining contracted volumes throughout geography, wherever possible.
- Where possible, the service volume will be split evenly in each neighbourhood (between two providers for each service).
- Support opportunities for integrated care to service providers with both nursing and personal support contracts through the assignment of both services to one service provider for patients within the neighbourhood.
- Where possible, achieve improved service integration opportunities via a single provider offering a full basket of service for patients in a neighbourhood.

NOTE: Early and continuous engagement with service provider partners was crucial to the success of this initiative.

- One year before service provider realignments took place, meetings with all nursing and personal support providers began to explore the opportunities and barriers of implementing the neighbourhood model, as well as to gauge service provider readiness and commitment.
- An in-depth analysis was completed to understand the service volumes across the 26 neighbourhoods. Service providers were then mapped to each neighbourhood taking into consideration their contracted market share and volume commitments.
- Barriers to success of implementing the neighbourhood model were explored collaboratively over a year. Together, we and our service provider partners came up with mitigation strategies to address those barriers.
- We were able to map an equitable service volume distribution across our newly defined neighbourhoods and received endorsement from the CEO at each service provider organization before we moved forward to implementation.

CURRENT VS. FUTURE STATE MODELING

When mapping service providers to specific neighbourhoods, several factors needed to be considered including contractual requirements, care provided in alternative care settings (retirement homes, condos, etc.) and capacity planning at each service provider organization.

We maintained our service provider contracts at a geographical level (Mississauga, Etobicoke, Halton), with neighbourhoods assigned within those geographies to fulfill our volume commitments. Whenever possible, we aimed to minimize patient disruptions.

In a neighbourhood where a service provider had at least 50% of existing service volume, the service provider would remain the provider for that neighbourhood. Similarly, if a service provider had a large volume in an alternative care setting, we tried to keep them in that specific neighbourhood to help minimize patient transitions to new providers.
Continuous engagement and co-planning with our retirement home partners helped to inform the process when we did need to change service providers.

Capacity considerations were important, especially in the rural areas, which influenced the decision to have two providers (for nursing and personal support) operating in a neighbourhood as a contingency measure. Similarly, continuity of care for patients was supported in situations where a service provider only offered nursing, or only offered personal support services.

In those scenarios, nursing and personal support agencies were consistently paired with each other to offer both types of services to patients. Unfortunately our CHRIS system, at present, does not have the ability to automatically match the service providers, so a Neighbourhood Locator Tool was developed that displayed the nursing, personal support and rehabilitation providers assigned to each neighbourhood to help the care coordinators with matching service providers. We are awaiting approval and feedback on a functionality enhancement request to enable this activity in an automated fashion, which was sent to the CHRIS Development Team at Health Shared Services Ontario (HSSO).
PHASED IMPLEMENTATION APPROACH

Through a series of engagement activities involving our legacy CEO, the CEOs of service provider organizations, and other leadership team members from each organization, we received formal endorsement of the neighbourhood model from all parties in order to initiate realignment (see Appendix for copy of Endorsement Letter). We were required to be flexible during these negotiations to ensure endorsement was achieved for all providers.

A phased implementation approach was agreed to, where service provider realignments would first be completed for alternate care settings, followed by realignments in the community at the neighbourhood level. This phased approach ensured proper care and attention could be given to patients impacted by the realignments. It also gave us and our partners an opportunity to reflect on lessons learned during the alternate care realignments, and apply those during the second phase of realignments at the neighbourhood level.

SUPPORTING PATIENTS WHO CHANGED SERVICE PROVIDERS

Before any patients were realigned to a new, neighbourhood provider, we consulted our patient and family advisory forum, Share Care Council, to understand what patients and carers would need their new provider to know about their (or a loved one’s) care and preferences to support a smooth, safe transition. Those recommendations directly informed the neighbourhood realignment approach (see Appendix), which was co-designed by the Mississauga Halton LHIN, Home and Community Care, its service providers and regional retirement home partners. That process was then taken back to Share Care Council who validated each step to ensure it was patient-centred.

Patients living in retirement homes, assisted living or alternate care settings were transitioned to new providers based on the alternate care go-live schedule (see Appendix) in June 2016. Realignments in the community, for patients receiving care in their homes, began in July 2016, and were completed by February 2017. In-home realignments first focused on patients with the most complex needs, recognizing those patients would require more time and planning to safely transition to a new provider. It was determined 24% of our patients would require realignment to a new provider between June 2016 and February 2017.

Note: Three-quarters of our patients were not impacted by Service Provider Realignment. This statistic was consistently reinforced in messaging to reduce risk of undue anxiety among other patients who, in reality, would not be impacted by the realignment changes.
### ALTERNATE CARE SETTING REALIGNMENTS
(i.e. for patients living and receiving care in retirement homes or assisted living facilities)

<table>
<thead>
<tr>
<th>Key Tactics</th>
<th>Tools referenced in this section can be found in the Appendix.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Binder completed by retirement homes</strong> containing information to help incoming service providers deliver seamless, quality care to patients (e.g. where to sign in/out, parking instructions, where to find new linens, where to dispose of garbage, daily schedule, name of retirement home Director of Care and contact information, and more)</td>
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<tr>
<td><strong>“My Story” summary of patient needs</strong> completed by care coordinator and outgoing service provider, in consultation with patient/family</td>
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<tr>
<td><strong>Phone scripts</strong> for care coordinator use when describing rationale, timing of service provider realignments to patients/families</td>
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<tr>
<td><strong>Letters to patients/families</strong> informing them of change in providers, timing and next steps</td>
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<tr>
<td><strong>Posters</strong> for retirement homes outlining names and contact information of each home’s dedicated service providers</td>
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<tr>
<td><strong>Go-live calendar</strong> (detailing day and time retirement homes would experience changeover of service providers)</td>
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<tr>
<td><strong>Thank-you cards</strong> for patients (distributed by outgoing service provider staff)</td>
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<tr>
<td>Jointly-created and endorsed document where roles and responsibilities of each member of the project team and circle of care were defined throughout realignment process</td>
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### NEIGHBOURHOOD REALIGNMENTS
(i.e. for patients receiving care in a personal dwelling)

<table>
<thead>
<tr>
<th>Key Supports</th>
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<tbody>
<tr>
<td><strong>Labour Relations:</strong></td>
<td>Dedicated SPO Realignment Liaison was key in maintaining the momentum of progress towards our completion goal; the liaison worked with service providers and care coordinators to ensure their and patients’ needs were being met; the liaison ensured all participants were following developed processes and timelines, hosting daily calls providers and LHIN (CCAC) Contracts team to keep everyone aligned and engaged; the liaison managed the direct work of day-to-day realignment planning and communicating issues and barriers to leadership to support issues mitigation</td>
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<tr>
<td>• Counsel to ensure realignment did not trigger Public Sector Labour Relations Transition Act (PSLRTA); the Act deals specifically with the labour relations issues arising from certain kinds of restructuring in the municipal, education, and hospital sectors</td>
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<tr>
<td>• Included all service providers in discussions about risks related to Human Resources (HR) changes in both unionized and non-unionized organizations to inform timing/rollout in compliance with varying service provider internal (employee) contracts</td>
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<tr>
<td>• Change management tools and resources</td>
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<tr>
<td>• On-demand, nimble, shared communications support – joint communication plan was implemented</td>
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</table>
MANAGING PATIENT COMPLAINTS

The realignment process design identified the need for a single point of contact for escalated complaints if patients/families continued to express concerns about changing service providers following initial discussions with the care coordinator. A detailed issues log was kept to track patient/carer and Minister of Provincial Parliament (MPP) complaints, with the goal of informing best practice mitigation strategies for future realignments.

The Patient Relations Associate acted as the Liaison with complainants to:

• Understand what specific concerns patients/carers had regarding realignment
• Identify particular skills/attributes of the existing provider to find a strong match with the incoming provider
• Reinforce that the intention of the initiative was not to disrupt individual routines, but to continue to provide high quality health care services
• Emphasize the LHIN’s (CCAC’s) commitment to working in partnership patients/carers to make the transition easier

See Appendix for graphic depicting complaint escalation process.

BUNDLED CARE PILOT

Building on the concept of integrated care teams at the neighbourhood level, a 10-month pilot project was conducted to explore integrated care planning and bundled service provision in retirement home settings to better understand the value to patients and to inform opportunities for spread across the home and community care sector. Four retirement homes and four service providers participated in the pilot project.

The goal was to test the effectiveness of a single provider offering the “full basket of services” (e.g. nursing, personal support, and rehabilitation) to patients living in retirement homes. We were looking for improvements in communication and relationships between retirement home partners, care coordinators and service providers to enable more seamless, coordinated care for patients.

This pilot also included testing the ability for providers across the continuum to contribute to a collaborative care planning tool, which reflected the patients’ goals for care, both from a technological and practical standpoint.
Section 5: Evaluation

Evaluating the Care Coordination Program of Work

Comprehensive logic models were developed by the initiative’s Evaluation Committee to measure process outcomes, as well as to track progress against short, mid, and long-term goals within each project deliverable and the broader initiative. Chart audits and surveys with care coordinators, service providers, patients and families were conducted as part of the evaluation. Highlighted results are below.

CARE COORDINATION FRAMEWORK

• Care coordinator attendance rate for Care Coordination Framework training was nearly perfect at 98%.

• 75% of care coordinators surveyed indicated that communication with patients/providers was improving, and can be attributed to the Framework’s enhanced care planning and care conferencing approach.

• The majority of care coordinators are performing at an “experienced” level as evidenced by the Quality Practice Validation activities.

• 81% of long-term patients/caregivers report the quality of communication with their care coordinator as a 4 or 5 out of 5.

• 91% of patients/caregivers said their coordinated care plan was “easy to understand.”

• 93% of patients/caregivers reported that they were asked to identify personal goals (a mandatory requirement of care coordinators in the Care Coordination Framework training).

• 53% of newly admitted patients/caregivers reported making progress toward personal goals.

• 100% of newly admitted Complex patients, who reported having a care conference, said the experience was beneficial.

NEIGHBOURHOOD REALIGNMENT (OF CARE COORDINATION TEAMS)

• 26 new geographic areas (i.e. neighbourhoods) were mapped across the region within existing sub-region (i.e. Health Link) boundaries.

• Approximately 14,500 patients were manually transferred to new care coordinator caseloads in electronic health record (note: this did not mean patients changed care coordinators; it was a back-end change to caseload naming that didn’t affect patient care).

• Approximately 5,800 patients were supported in smooth, safe transitions to a new care coordinator.

• 73% of Short Stay care coordinators indicated they were better able to support patients by having a specialized (pure) caseload.

SERVICE PROVIDER REALIGNMENT

• Market share report shows volume of each provider in each neighbourhood resting around 50% per provider, per neighbourhood, indicating the automatic contract assignment process in CHRIS is working.

• 67% of service provider survey respondents said that working in a specific geographic area increases the time they are able to dedicate to patient care.

• When asked about pros and cons of neighbourhood model, nearly 60% of service provider survey respondents said “there is reduced travel time between patients” without being asked directly; if asked directly, we anticipate this percentage to be much higher.

• 43% of care coordinators surveyed said that Service Provider Realignment resulted in increased verbal communication with providers. This is significant being the survey was conducted immediately following realignment. We anticipate continued monitoring would yield higher ratings. The indicator also measures
increased communication, so relationships between care coordinators and service providers, which had existing, good communication, would not be captured.

• **42%** of care coordinators surveyed said they experienced enhancements in their relationships with service providers. It is again important to consider this indicator measures **improvements**, so existing, good rapports would not be factored in.

• Over a year, **210 events (risk events or complaints)** were logged as a result of Service Provider Realignment. Of the 1,860 patients who experienced realignment to a new service provider, **11% escalated their dissatisfaction** with the process to LHIN (CCAC) management and no media stories stemmed from those complaints. Complaints were most often handled at the point of care.

**BUNDLED CARE PILOT**

• **75%** of service providers surveyed said that having one provider per retirement home increased provider familiarity with patients.

• **70%** of service providers surveyed indicated that rounds are more productive and efficient with one provider per retirement home.

• In an audit of coordinated care plans (CCPs) shared through the Health Partner Gateway (HPG) over a three-month period, **95%** of CCPs created by care coordinators were viewed by providers; **90%** of CCPs were updated/edited by the by service providers. In some instances, CCPs were being accessed and edited by service providers while care coordinators were finalizing the plans, indicating truly collaborative care planning and real-time updating.

**OVERALL GOALS**

<table>
<thead>
<tr>
<th>METRIC</th>
<th>OUTCOME</th>
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<tbody>
<tr>
<td>Improved patient experience</td>
<td>• <strong>80% of newly admitted</strong> Complex or Chronic patients surveyed rated their experience with their care coordinator as a 4 or 5 out of 5.</td>
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<td><strong>For long-term Chronic/Complex patients/caregivers:</strong></td>
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<tr>
<td></td>
<td>• <strong>84%</strong> rated their experience with their care coordinator as a 4 or 5 out of 5.</td>
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<td></td>
<td>• <strong>93%</strong> indicated they were involved in goal identification for their coordinated care plan (CCP).</td>
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<td>• <strong>91%</strong> indicated that their confidence in their care team has remained the same or improved over time.</td>
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<tr>
<td></td>
<td>• <strong>95%</strong> said their experience with being treated with courtesy and respect remained the same or improved over time.</td>
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<td></td>
<td>• <strong>93%</strong> said that being listened to or heard has remained the same or improved over time.</td>
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<td>• <strong>98%</strong> said that having things explained in plain language has remained the same or improved over time.</td>
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<td></td>
<td>• <strong>94%</strong> said that being informed about eligibility for services remained the same or improved over time.</td>
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<tr>
<td></td>
<td>• <strong>92%</strong> said that their experience with getting connected to services has remained the same or improved over time.</td>
</tr>
<tr>
<td>Better support for caregivers</td>
<td>• <strong>87%</strong> of long-term caregivers said they felt supported by the Mississauga Halton LHIN (formerly CCAC) in caring for their loved one.</td>
</tr>
<tr>
<td>METRIC</td>
<td>OUTCOME</td>
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<td>------------------------</td>
<td>-------------------------------------------------------------------------</td>
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</table>
| Better whole-person care| • 58% of long-term patients/caregivers said that they were receiving better whole person care than they were before.  
• 98% of long-term patients/caregivers said the care plan addressed their (or their loved one’s) health and social needs. |
| Reduced visits to the hospital | • For Chronic and Complex patients with a 60-day length of stay, there was a 33% reduction in emergency department (ED) utilization rates when admitted to Mississauga Halton LHIN (formerly CCAC) service, compared to ED usage prior to being admitted to the Mississauga Halton LHIN. |
| Staff retention         | • Despite large amount of change for care coordinator teams throughout the initiative, turnover rates did not show an increase in care coordinators leaving the organization. In fact, the annual turnover rate during the initiative’s rollout was the lowest it has been since 2013. |

**Lessons Learned**

**GOVERNANCE**

• Maintaining cross-functional Steering Committee worked well, where different lenses were applied during decision-making processes.

• Need to ensure executive champions are consistently managing and escalating issues to remove barriers to success.

• Need to establish commitment to honesty, where members are comfortable and open to sharing when things “went wrong” to inform quality improvement, rather than minimizing “failures” to avoid perception of failed leadership during project rollout. The group should remain committed to transparency, openness, shared accountability and learning.

• Members of Steering Committee need to be more transparent with members of their teams completing frontline project work to ensure milestones are achieved in timely manner.

• Having Communications as part of Steering Committee supported timely, nimble communication, where the Lead could see and hear executive voice in real-time to support messaging to internal and external audiences with a less robust “approval” process.

**CARE COORDINATION ENHANCEMENT**

• Interactive, classroom-style learning and enough time spent on explaining training’s focus on “soft skills” helped with care coordinator endorsement of enhanced Care Coordination Framework. Ensuring care coordinators quickly understood what they were being asked to stop/start/continue, in terms of workload to implement the Framework’s components, was essential to training.

• The Change Management Plan should be embedded and activated early to support frontline teams through large practice shift. Engage teams up-front to eliminate misconceptions. Change management function cannot be on a “consulting” or “advisory” basis – need tactical support to deliver change strategy components.

• Weekly touch-points were key to success of Quality Practice Validation activities.

• Ensure Program Logic Model method of evaluation is adopted to clearly identify and track metrics associated with each project component, especially metrics relating to improved patient experience.

• Celebrating shared successes for those who completed learning within the Framework garnered excitement across the organization before/during implementation (e.g. “celebration wall” and core competency certificates).
• Need to ensure all teams/individuals understand how supporting care coordinators in a meaningful practice shift within Care Coordination Framework was everyone’s responsibility, leading to overall improved patient and carer experiences.

CARE COORDINATION REALIGNMENT

• Endorsement and active, early, ongoing participation from all teams was integral, including senior leadership involvement to drive progress and decision-making. This collaboration focused on shared accountabilities and successes. And, it built trust that was leveraged later on in more challenging project work.

• Pre-work to understand neighbourhood geographies and demographics was foundational to success (e.g. patient population, SEC scores).

• Thorough understanding of time to complete care coordination tasks was vital when determining how many care coordinators to staff per neighbourhood.

• Need to consider impact of changes on role of Team Assistants (TAs).

• Labour Relations participation in planning and implementation helped identify areas of concern to enact strategies that quickly mitigated union issues associated with changing work locations of some care coordinators.

• Operations manager were most important champions who need to be engaged as early as possible and leveraged to communicate changes to teams.

• Ongoing, consistent, strategic communication via multiple channels to internal and external stakeholders was instrumental in achieving endorsement and maintaining momentum as initiative progressed.

SERVICE PROVIDER REALIGNMENT

• Early, ongoing, transparent and collaborative engagement with service providers, leadership and frontline (endorsement, strategic planning, process development and deployment) was essential to continued success.

• Exhaustive pre-work enabled successful implementation (i.e. in-depth analysis of service volumes by provider/service/geography to assign market share equitably).

• Well-defined shared communication and change management strategies garnered early endorsement and helped to maintain momentum.

• Phased implementation approach helped manage change with stakeholders, enabling ability to apply lessons learned to later stages.

• Timely reporting to inform-decision making is required.

• Training for impacted staff (realignment process, accountabilities) needs to happen in advance, with ongoing support from managers.

• A dedicated, full-time person to act as liaison between care coordinators and service providers was integral to success.

• Realigning patients in the community required hands-on approach for identifying mutually agreeable realignment dates for patients, in collaboration with families, patients and service providers.

• Ensure consistent contact with service provider leadership is maintained to gauge engagement, readiness and resistance amongst service provider frontline staff.

• Being able to respond to service provider flags or concerns in timely manner, and flexibility to adapt to barriers or flags identified in implementation approach, was key to progress.

• For Complex patients/or patients with complexities in their social sphere or actual care, incorporating a warm handoff or shadow shifts into the realignment was a great success and helped to ensure patient and provider confidence in executing the care plan.

• Patient and service provider complaints must be systematically tracked, monitored, resolved.

• Need to ensure a reporting process is in place for higher volume of patient/family complaints, especially those received from MPPs, or those escalated to leadership or ombudsman level.
Section 6: Replicating the *Care Coordination Program of Work*

Next Steps and Opportunities

<table>
<thead>
<tr>
<th>Care Coordination Framework</th>
<th>Bundled Care</th>
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<tbody>
<tr>
<td>• Improving the number/rate, percentage of coordinated care plans initiated in hospital.</td>
<td>• Exploring ways to integrate information across providers by means of an electronic patient chart.</td>
</tr>
<tr>
<td>• Developing a reliable, practical way to track whether CCPs are being “reviewed and updated” appropriately, including gaining consensus on the definition of “updated.”</td>
<td>• Revisiting procedures within retirement homes for after-hours contacts if a patient has a concern.</td>
</tr>
<tr>
<td>• Embedding practice validation and other auditing processes for high impact practices, including coordinated care planning and care conferencing.</td>
<td>• Implementing requirement of CCP “shared completion” with home care providers in retirement communities.</td>
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<tr>
<td>• Evolving terminology used in framework with advice from partners (including patients and family).</td>
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<tr>
<td>• Developing consistent, standardized way to track patients’ progress toward personal goals that are identified in the CCP</td>
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<tr>
<td>• We are seeing low participation rates in the Peer Mentoring Program. Opportunities exists to modify the initiative to attract more mentees.</td>
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<tr>
<td>• Developing a tool to track the rate at which patients reach their goals, as outlined in their care plan.</td>
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<thead>
<tr>
<th>Neighbourhood Realignment &amp; Integrated Care</th>
<th>Service Provider Realignment</th>
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<tbody>
<tr>
<td>• Completing audit of intake team processes to determine if geocoding function is being overridden resulting in inequitable or flawed caseload and service provider assignment for patients.</td>
<td>• Developing more consistent way to track rate of referrals to non-contracted community support services.</td>
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<tr>
<td>• Scoping neighbourhood care model delivery practices.</td>
<td>• Monitoring market share volumes to ensure 50/50 distribution is maintained in each neighbourhood.</td>
</tr>
<tr>
<td>• Testing primary care integration practices, models and approaches in sub-regions to identify different models of realizing benefits of embedded care coordination within primary care.</td>
<td>• Continued evaluation of communication, collaboration between service providers and care coordinators as neighbourhood care teams further establish rapports.</td>
</tr>
<tr>
<td>• Exploring practice changes at neighbourhood and/or sub-region level including, 24/7 patient/carer coverage by care coordination.</td>
<td>• Implementing flexible care model with personal support service providers.</td>
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<tr>
<td>• Exploring changes to management functional roles within <em>Patients First</em> lens to enhance integrated care delivery within sub-regions.</td>
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</table>
General opportunities:

- Following *Patients First* implementation, alignment of Health Links planning and implementation with ongoing strategic improvements in creating an integrated home and community care system will further anticipate benefits and strengthen the foundation created by *Care Coordination Program of Work* initiatives.

- For the Chronic and Complex patients who experienced a 33% reduction in visits to the ED, more research is required to determine what aspects of community care had the biggest impact on hospital utilization rate. For example, is it specific contributions of individual care team members, or the sum of the team’s interventions as a whole, which is helping patients stay out of hospital?

### Conclusion

The strategic, well-sequenced implementation of the *Care Coordination Program of Work* created a strong platform for enhanced, standardized care coordination regionally, evidenced to improve patient/family experience, as well as the delivery of integrated care, which enabled better patient and system outcomes. The initiative’s components are easily replicable across other regions or provinces, yielding immense opportunities for spread.

To build on the momentum of the initiative’s success locally, bold implementation timelines for the next steps identified above will be necessary to address system capacity pressures. And, further realignment of home care providers to the sub-region and neighbourhood levels, in support of the province’s *Patients First* agenda, will enable more patient/family-oriented business models, driven by patient/family choice and needs, versus resourcing, organizational scheduling or other non-patient-centric factors.

For more information on the *Care Coordination Program of Work*, please contact David Fry, Vice President, Home and Community Care, Mississauga Halton LHIN, by email at david.fry@lhins.on.ca.
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Our Access Care Team is available from 8:30 a.m. to 9:00 p.m.

We have offices and staff located in the following hospitals. No referral is required to contact them.

Trillium Health Partners
Mississauga Hospital, Queensway Health Centre, Credit Valley Hospital

Halton Healthcare
Oakville Trafalgar Memorial Hospital, Georgetown Hospital, Milton Hospital

310-2222 no area code required

www.mississaugahaltonlhin.on.ca
www.healthcareathome.ca/mh
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