HSPN Health System Performance Network

OHT Leading Projects

Pre-Implementation Phase

A Focus on Care Coordination: Early Learnings from Home Care Leading Projects Pre-Implementation Phase

New approaches to care coordination in home care: Ideas for change and their limits

Fall 2024

Overview

- Objectives
- Methods
- Levers of change
  - What care coordination will look like: A vignette
- Findings
  - Facilitator:
    - Test run - Identifying & resolving concerns
  - Challenges:
    - SPO procurement: Process & timeline
    - OH@Home & LP: Relationship & perspectives of the other
  - Care coordination in an ideal world
- Key takeaways

Objectives

Overall aim: To understand the process of developing & implementing the 7 LPs, as a way of testing new home care models & modernizing home care.

Guiding overall question:

- What are the facilitators & challenges of implementation experienced by the Home Care Leading Projects?

Focus on Care Coordination:

1. What are the key levers for modernizing care coordination in home care?
2. What helps and hinders care coordination plans?
3. What would care coordination ideally look like?

Qualitative Methods

Data Collection: April – October, 2024

Document Review

Applications, logic models, etc.

All projects (7)

Meeting Observations

Attend/participate in cross-OHT planning and eval meetings (≈bi-weekly/ monthly)

Project specific meetings (monthly)

Interviews

3 sets (5-12) throughout the evaluation period

(Includes leaders, providers & patients involved in co-design

Interview/Observ. cases (3)

Focus Groups

2-3 throughout the evaluation period, one per OHT/project

FG cases (4)

Reflective Check-ins

Ongoing check-ins with project leads

(≈monthly/ quarlerly)

All projects (7)

Levers of change

MOH-driven

- SPO selection
  - Replaces multiple service providers & fee-for-service structure
- Dual care coordinator accountability
  - Encourages team embedding, indirect care coordination
  - Care coordinator accountable to OH@Home & OHT/ HSP
- Providers have access to shared IT platform
  - CHRIS & local IT platforms often used together

OHT-driven

- Physical location of care coordinator
  - Embedded in primary care, neighbourhood hubs
- New roles, dual functions, training
  - Aimed at bridging care & coordination responsibilities
- Segmentation, early identification
- Rounds, case conferencing, shared care plan, assessments, 24/7 navigation

What care coordination will look like: A vignette

"In this model, **SPOs** will have greater responsibility and accountability for those **non-complex**. [...] So let's say we have [Gloria], 87 years old, multiple chronic conditions, referral for home care. The home care coordinator does the assessment, but then has a **conversation with the [Integrated Team**] and says, "this is what I'm seeing." [...] And then the others have an opportunity to say "Yes, and we also know that there's food insecurity" [and provide] context around it, so that they collectively create the **shared care plan** [...] So it's a collective decision, the care coordinator isn't directing it [...] but will be accountable to do the shared care plan. [...] At a **case conference** they had in one of the [...teams they] **broadened the circle of providers in the conversation** [...which] brought context that actually shifted it. [...] one of those providers who [would not typically be] in the circle of care said, "What are the patient goals? Let's back up and see what's going on." [...] And it actually reduced the number of services that were in that patient's home. [...While] the SPO [...has] more authority informing decisions, we're also recognizing that it's **not a [blank] cheque to write -** "Good, we get more PSWs. and therefore we get more money in because it's a business." [Instead, they will ask] "What's that sweet spot in there?" The SPOs taking more responsibility in the care of the non-complex, we hope will **free up more time for the care coordinators** to take on more clients. " *

** All participants were LP leaders. Further attribution provided only if relevant, to preserve anonymity.*

Key Facilitator

A test run: Identifying & resolving concerns

A palliative case study

- History of home care/ care coordinators embedded in primary care; extended to palliative care
- Allowed for hiring of 3 palliative care coordinators for dry run
- Concerns: Physician contact preferences not taken into account; physician early involvement reluctance; care coordinator awareness of role boundaries; dearth of care coordinators with palliative care training; compatibility between CHRIS & primary care EMRs
- Solutions developed: Receptionist at physician's office triaged questions, weekly team meetings to review issues, program policies developed (service increase protocol, communication processes, escalation levels), IT communication issues resolved with launch
- Impacts: Improved team communication, evidence of benefit fuelled desire for transformation

"… one of my biggest pain points […was] I didn't know when my patients would turn palliative sometimes. They'd be discharged from the hospital, they would be at home. I wouldn't have seen them in my primary care office. And then, all of a sudden, the nurse practitioners are involved, everyone's involved. And I'm like, 'What is happening? I had no idea.' That was very frustrating for me. So one of the biggest changes I've already seen is […] that communication. So now I'm involved. […] They are letting me know of any changes. Even on a daily basis sometimes, the palliative care coordinator comes to my office, and she'll be like, 'Can I talk to you about these three people?' […] So that now, all of a sudden, we're able to change things and make decisions quickly…" (Physician)

SPO procurement: Process & timeline

Key Challenge 1

- Experienced as key challenge by some LPs whose chosen SPO was new to area ⟹ impacted care coordination, as SPOs informed how teams worked together on the ground

"…it's clear that [current but unsuccessful SPO] is the only one really with the client data. […They] have been serving the [area] with what they call a [name] care team approach […] and the leading project was going to be a continuation of that approach.

"…for us, lesson learned is if we have a preference for people we're comfortable with, we shouldn't have opened it up further. But what differentiated the bids was our local SPOs are trying to not just get the work, but also make change in the model at the same time. And so they price themselves on the high end, whereas this new SPO was really competitive financially. And ultimately, from a valuation of the bid standpoint, there was just no comparison in terms of the money."

- Timeline & blackout period prevented involvement of previously engaged SPO partners, hindered progress with care coordination plans & change management

"We have been feverishly working with our [newly announced SPO] partner to figure out privacy, agreements, digital solutions. So we're now getting to, 'What is the transitional lead going to do? What is the care coordinator doing?' But because of the blackout period, we could not advance any of these conversations. We didn't know how well versed our SPO partner was going to be. […] I understand […] RFP and procurement rules – but just the way that the timing fell, it's an unfortunate situation."

Key Challenge 2

LP Perception of OH@Home

- Demands made of OHTs seen as untimely & overwhelming

"… now [that LP care coordinators are being hired or moving over] OH@Home is asking for the specific name of the EMR, the number of tenants, privacy impact assessments specific to the application, security assessments, proposed agreements, data flows, process maps. And we've had none of this in place except a data sharing agreement in those sites already that they drafted."

- Delays & lack of clarity [E.g. care coordinator job description]

"… we're going toss all this spaghetti at the wall in the next month when the peer coordinators are coming over. […] 'Here's […] how we've interpreted your ten-page job description.' […] What does it actually mean? We need to figure that out. […] it's information that is sucked up in a bit of a vacuum at OH@Home, they call it a service catalog. We've been asking for details on that since July."

- Limits to sharing & collaboration

"…is OH@Home truly a willing and contributory partner to these projects? […] they still hold a lot of power and sway over the outcome of the project. And we see hesitation in terms of how much buy-in we're getting. […] HSPs haven't done this before. I feel like they've asked us, 'Do you accept this set of services that we're offering?' And our response is, 'Yeah, that looks pretty good,' but we don't know what we don't know […] that just feels like an example of OH@Home saying, 'Sure, we'll do this, we'll do exactly what we're asked to do.' […] It would have felt more collaborative for there to actually be a conversation between the HSP and OH@Home to help them understand what's required to run home care."

OH@Home perspectives: Being valued

Key Challenge 2

- OH@Home participants thought that partners were not cognizant or appreciative of the range and complexity of the work they did, and the knowledge required to do it.

"I think our OHT is struggling a little bit because in the care coordinator guidance, it has "the care coordinator will do the determining of eligibility, first assessment, discharging of services, that kind of thing." And then the indirect is left to reassessing, adding on services. And I know they were trying to think, "well, for short stay, do we have to go that route? And can we not put them directly in touch with the short stay manager?" to learn that with a lot of homecare patients, things are not straightforward. You think it's a 60, 90 day. Then you start unpeeling the onion. And the reason that person has a wound or fell was because there's other issues around intoxication, homelessness, different kinds of things. [...] And our thought is, if you have a really good first [holistic] assessment and linking to resources, then the others can take [over]." (OH@Home leader)

What care coordination would ideally look like

- **Team members to provide care ordinarily provided by care coordinator, freeing up care coordinator time**

"Due to indirect care coordination guidelines, care integrators are not going to be able to do INTER-RAI assessments [for specific patient segment, as planned, allowing care coordinator to focus on direct referrals from FHTs, etc.] … So that goes back to the care coordinator […] increasing their workload. And instead of being a new model of care, it's going to be the same model, integrating one new member to support care coordinators."

- **Care coordinator to have nursing/ clinical care skills, for efficient patient care**
    - E.g. care coordinator to have clinical skill set to fill in for SPO nurse who can't get to patient immediately
- **Team-based approach – clinically & operationally**
    - Wanted to transition all hospital care coordinators to LP, "to create a hospital integrated discharge team as part of the work of shifting home care to the OHTs" with matrix reporting system in place

"… if the province is serious about home care moving to local teams, we thought the hospital team is a perfect place to test that. How can there be more integration and a stronger team-based care approach with care coordinators in the hospital closer to our hospital teams, rather than having different managers…?"

    - Perception of OH@Home last minute pushback – hospital can't oversee LTC placement; need for main CHRIS instance access as patients may be from beyond targeted neighbourhoods

"Hospital care coordinators "are not going to do their normal in person support for the people who are from the neighborhood who are in the hospital. […] Instead, it's going to have to go on a different path, direct to the community care coordinator who's not on site typically…"

What care coordination would ideally look like

- **Allowance for local adaptation**

"…the vision we had a year and a half ago has been limited somewhat by Ontario Health and maybe the Ministry of Health's requirement that we standardize across the seven leading projects and align with some guidelines. […] on what they want the care coordinators to do provincially. […] it's a little hard to redesign when essentially the role has to stay mostly the same. […] there is great benefit to having standardization in home care delivery across the province. […] But these were meant to be leading projects in tests of change. […] And the mandate within which we are operating [is] no longer entirely the vision of what we had wanted to do, but it's working within the guidelines that the province is allowing us."

"I think it's a simultaneous "change, but make it the same." […For example,] our region did not use the RAI. Our care coordinators had developed a new tool that they thought was better, more useful for them. But because of the data piece and the need to be able to standardize evaluation across all the leading projects […] the whole province is onboarded onto RAI. […] But from a flow perspective it's sort of a step backwards for our care coordinators to have to go back to using a tool that they had stopped. […] Whereas we used to have a tool [that allowed] different people fill in sections, but the RAI is more of a regulated tool…"

Key Takeaways

- Testing new ways of working together allowed concerns to be identified & resolved
  - In absence of ability to test, change management helped
- SPO procurement process & timeline could benefit from placing greater weight on local preferences
- Partner perceptions of each other hindered collaboration & implementation preparation
  - LPs' perception of OH@Home as unwilling collaborator
    - Scope for working on timely responses to requests, given interdependencies
    - Finger pointing may be mitigated by all stakeholders being on the same page about the legal framework within which OH@Home operates
  - OH@Home stakeholders' sense of not being valued
    - Scope for collaborative guidance provided to LPs/ HSPs to help them understand the intricacies of what is involved in delivering homecare?
- Until provincial regulations addressing care coordinator role scope is revised, ability to reform care coordination will be limited

Questions?

THANK YOU!

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