Connecting Care Coordination With Primary Care Settings

Association of Family Health Teams of Ontario (AFHTO) Conference

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Ontario

Objective

1. Describe the **provincial context** for improving linkages between primary care and home care care coordination functions.

2. Identify **principles, common approaches and models for connection** that would support improved connections between home care and primary care.

Context – Patients First

- A key priority in the Patients First: Action Plan for Health Care is making it easier for Ontarians to connect with and access the services they need.
- The *Patients First Act, 2016* and the associated enhanced role LHINs gives LHINs the tools needed to improve access in a manner that is grounded in local population need.

What we set out to achieve:

Expanded Role of LHINs for More Effective Service Integration, Greater Equity

Timely Access & Better Integration of Primary Care

More Consistent and Accessible Home & Community Care

Stronger Links Between Population & Public Health and other Health Services

Better planning to address the needs of the Indigenous Population and Franco-Ontarians

LHIN Mandate Letter

The Minister's Mandate Letter to LHINs identifies, 'as a priority', the need to improve connections between care coordination and primary care:

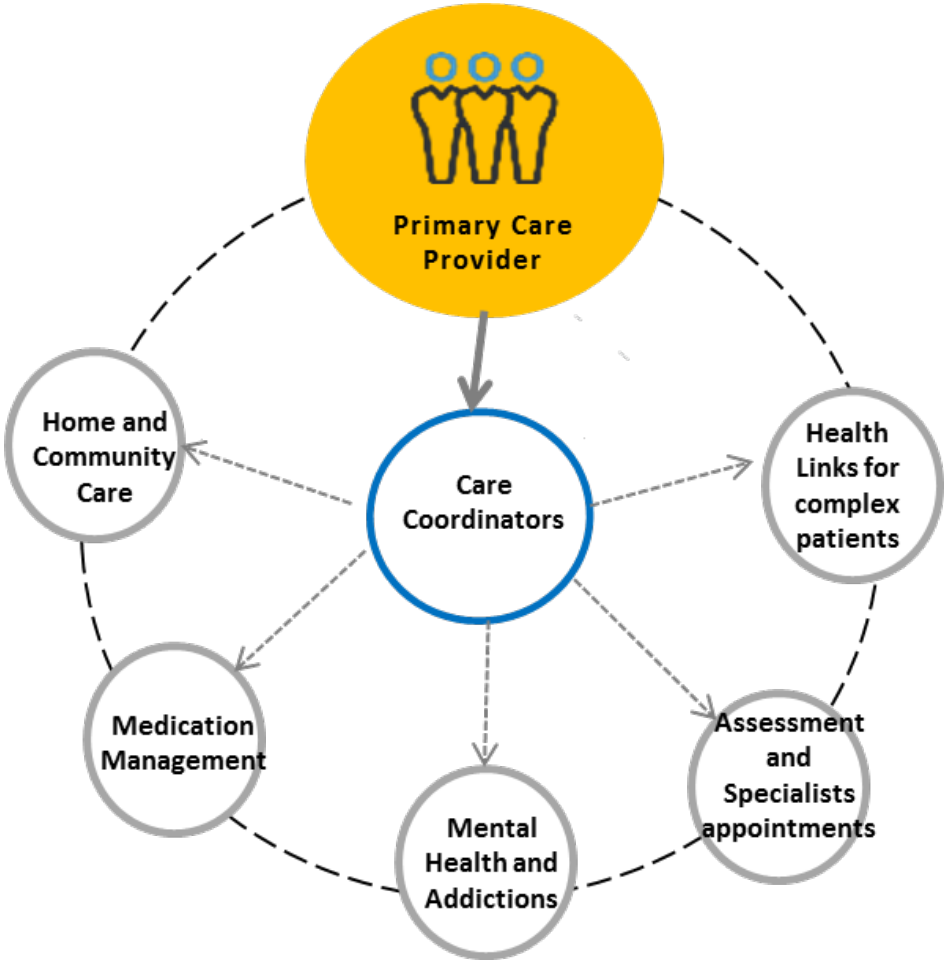
As a priority, develop and implement a plan with input from primary care providers, patients, caregivers and partners that embeds care coordinators and system navigators in primary care to ensure smooth transitions of care between home and community care and other health and social services as required.

Current State – Care Coordination

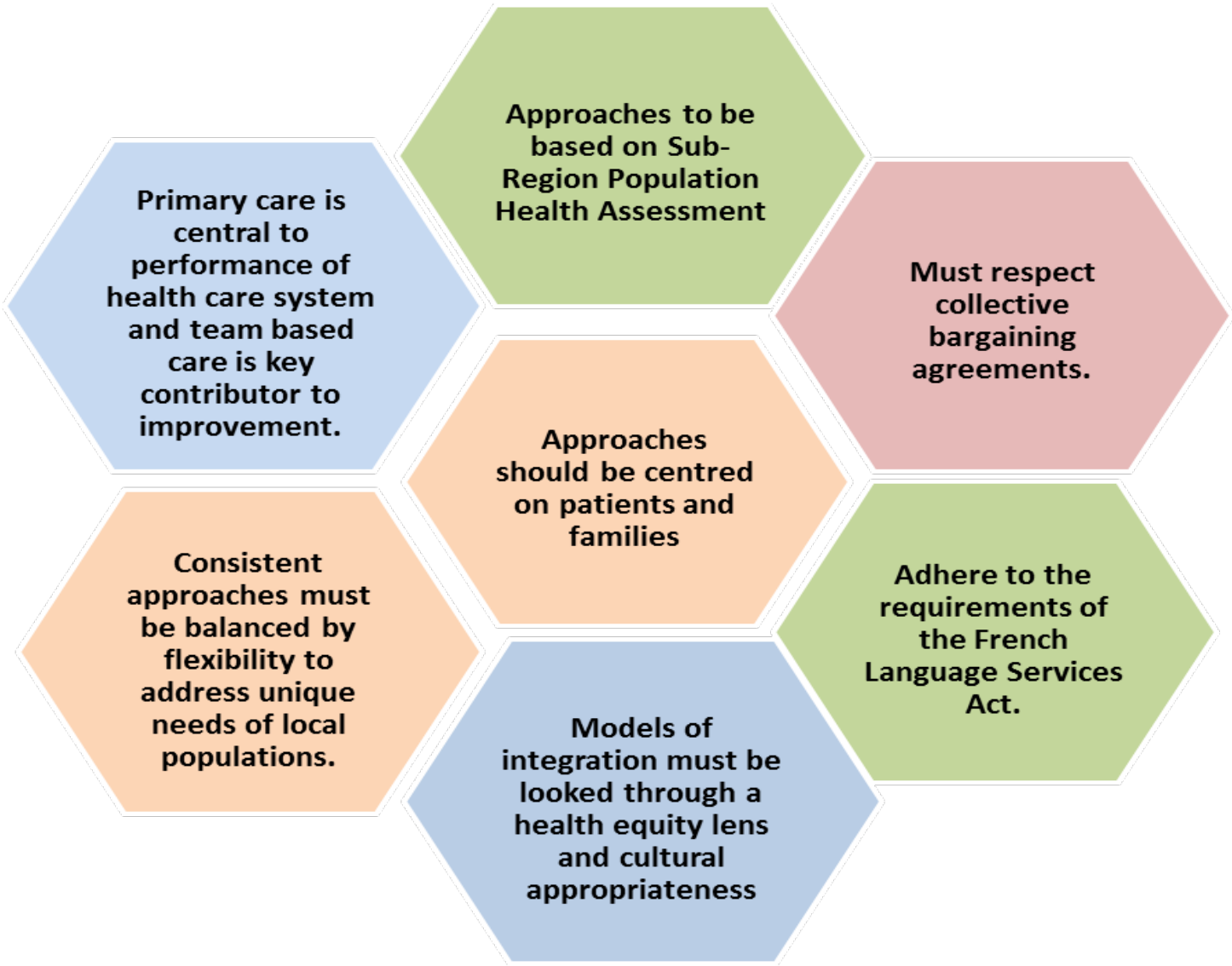
- Care coordinators are regulated health professionals – the majority of which are registered nurses.
- There are over 4,100 LHIN care coordinator positions across the province.
- LHIN care coordinators determine eligibility of clients to a ‘basket’ of home and community care services ensure access to these services.
- The role of care coordinators can be leveraged to support integration in the health system beyond home and community care, starting with integration with primary care.

Why Connect Care Coordination with Primary Care?

- Primary care providers are the ‘front door’ to the health system for most Ontarians.
- Over half of all patient interactions with Ontario’s health care system are with primary care and home care.
- Transitioning CCACs to the LHINs provides an opportunity to strengthen care connections.
  - The majority of group practices have 3-6% of their roster identified as home care clients.
  - Most home care referrals come from hospital, schools and other community sources; 14% of home care clients were referred from primary care.
- Connecting sectors can have substantial patient benefit:
  - Convenient access;
  - Continuity of care;
  - Support for complex patients.



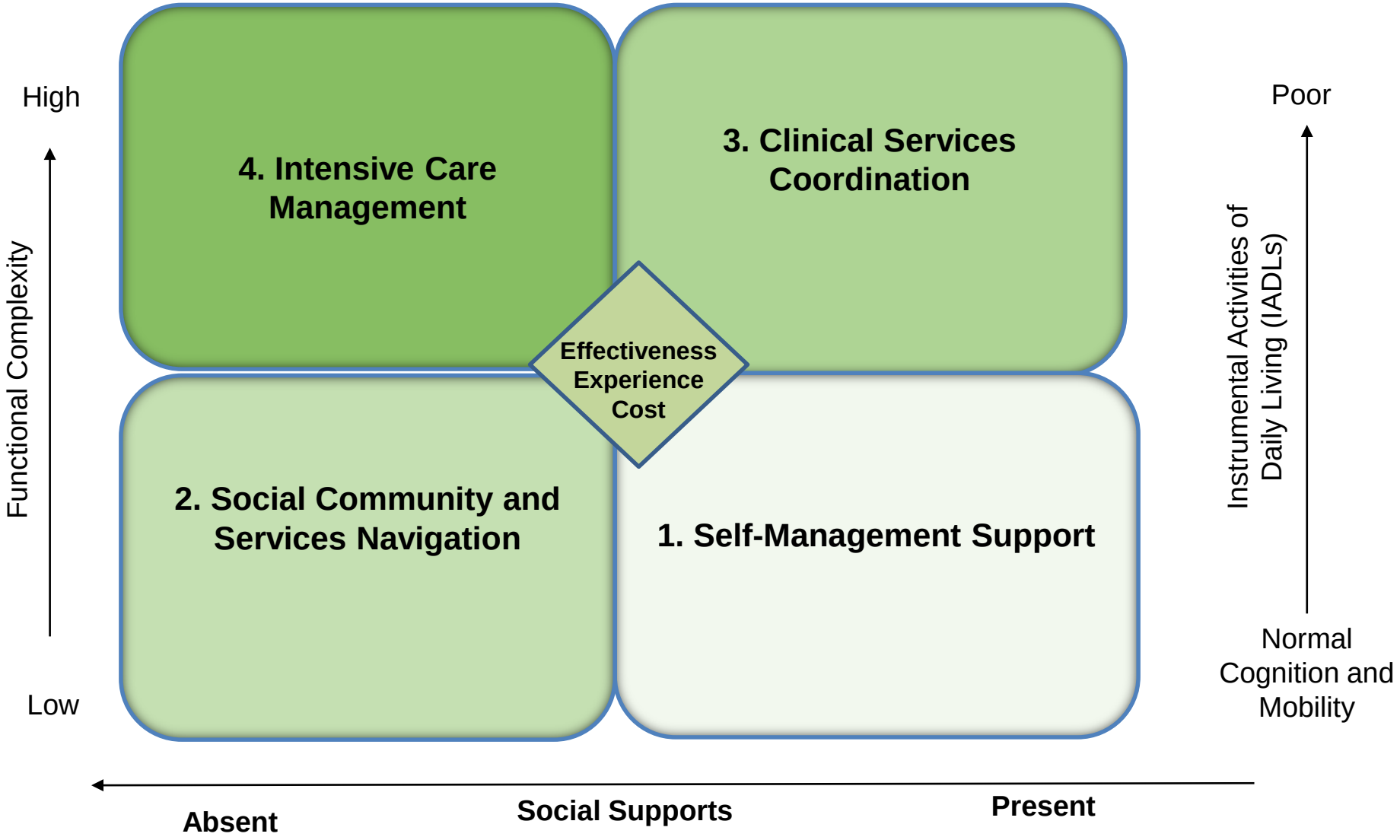
Guiding Principles on Strengthening Care Coordination



Common Approaches for LHINs

1. Plan	2. Engage	3. Assess	4. Design and Implement
• Baseline inventory of connections between home care care coordinators and primary care settings. • Determine population need within sub-regions.	• Consult bargaining agents to ensure adherence to collective agreement requirements. • Engage patients, caregivers, and health care providers through 'co-design' to identify models.	• Undertake health equity assessment. • Assess capacity of primary care settings (EMR, space, etc.)	• Identify 'connection types' that are appropriate to the patient and practice profile'. • Engage bargaining agents prior to implementation. • No changes to employment in the short-term.

Models for Connection



The above scheme was adapted from the Toronto Central LHIN and describes a needs-based approach to determining the type and intensity of care coordination functions.