CONNECTING CARE COORDINATION WITH PRIMARY CARE SETTINGS:

GUIDANCE TO ONTARIO'S LOCAL HEALTH INTEGRATION NETWORKS

Foreword

The 2017/18 Mandate Letter from the Minister of Health and Long-Term Care to Ontario's Local Health Integration Networks (LHINs) identifies as a priority the need to "develop and implement a plan with input from primary care providers, patients, family 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." Embedding care coordinators to primary care, including co-locating, is a key aspect of *Patients First: Action Plan for Health Care*, as the intended outcome is to provide faster access to the right care and to deliver coordinated and integrated, person-centred care in the community, commensurate with the holistic needs of individuals and families.

Taking action in connecting, and where possible locating, care coordinators to primary care is a priority associated with both short-term and longer-term activities. Longer term activities are driven by a future vision for care coordination and system navigation, which is to ensure that every person in Ontario receives services that are coordinated and navigated by primary care effectively and seamlessly throughout the health and social services system, based on a robust assessment of needs and deep engagement of patients and family caregivers. While there will be continued engagement about the future vision in 2018/19, there is agreement that effective care coordination and navigation would ensure that clients receive timely access to services, health professionals work collaboratively and that their activities place people at the centre of care planning and delivery.

In the short-term, the transitioning of the Community Care Access Centres (CCACs) to the LHINs provides an opportunity to strengthen care coordination connections with primary care by enhancing relationships with home and community care, including co-locating care coordinators in primary care where possible. Primary care is the entry point into the health system for many Ontarians and, as such, plays a unique role in enabling care coordination for patients and family caregivers. Access to home and community services is a critical part of care coordination services, and the delivery of these services will need to continue to ensure that patients receive the supports and services they need. The improvement of these services, including improving consistency, will be guided by *Patients First: A Roadmap to Strengthen Home and Community Care*. Care coordination is foundational to these changes.

This Guidance Document to Ontario's LHINs is a key short-term step towards fulfilling this future vision. While balancing the need for provincial consistency and local customization, this Guidance Document provides detailed considerations, and planning and implementation steps so that LHINs can move forward in enhancing care coordination in primary care with an early focus on the coordination of home and community care.

Partners involved in the development of this Guidance Document recognize that short-term work is needed to provide operational guidance to primary care practices and organizations across the province on key implementation questions such as space, labour relations, information technology and more. This is expected to be done in partnership with primary care associations and LHINs as a supplement to this work.

As a priority, LHINs are to develop and implement plans and targets that further integrate care coordination in primary care in 2017/18 and beyond. Also as a matter of priority, LHINs should engage with existing interprofessional team-based models for consideration for early adoption, as features of these models of care, such as their familiarity with interprofessional teams, organizational infrastructure, and patient populations may be conducive to early successes as

part of LHIN implementation plans. Activities will be on-going with respect to the monitoring of progress and assessing lessons learned, including the extent to which this work is resulting in real, tangible progress towards connecting care coordination with primary care consistent with the future vision for care coordination.

1.0 Purpose of Document

In the 2017/18 Mandate Letter provided to Ontario's Local Health Integration Networks (LHINs) by the Minister of Health and Long Term Care, LHINs are expected to "as a priority, develop and implement a plan with input from primary care providers, patients, family 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". In addition, as an important step towards health system transformation, this document will look to promote health equity and reduce health disparities and inequities through the delivery of care coordination and system navigation.

With this in mind, the purpose of this document is to guide Ontario's LHINs in developing their plans to embed, including co-locate, care coordinators in primary care settings. The guidance aims to clarify the role and function of care coordination, summarize the evidence and best practices in this area, establish guiding principles and outline various models available for LHINs to pursue in collaboration with patients, family caregivers and providers.

The document also outlines considerations specific to Indigenous communities and identifies next steps for implementation, including a target-setting and monitoring process.

2.0 Outcome Statement

People living in Ontario are able to access person-centred care coordination in their primary care setting in a manner that is responsive to their needs and through an approach that is based on patient, family caregiver and provider engagement and local assessment of capacity.

For the purpose of this document, the term "care coordination" broadly refers to an effective, seamless, and continuous transition between providers and across the health system throughout a person's life span. It is acknowledged that, in the short-term, care coordination will primarily focus on developing and implementing plans, with input from clients, family caregivers and providers, and primary care organizations that connect, and where possible locate, care coordinators within primary care settings and ensure timely access to comprehensive services and seamless transitions of care between all sectors.

3.0 Background

The *Patients First: Action Plan for Health Care*, enabled by the *Patients First Act, 2016*, aims to transform Ontario's health care system around the needs of patients. This includes structural reforms that aim to yield improved integration of services that have historically been delivered in a fragmented fashion. Key areas of focus for these structural reforms are the primary care and home and community care sectors and the role that Local Health Integration Networks (LHINs) can play in developing more integrated service models, enabled by an enhanced role for the LHINs prescribed under the *Patients First Act, 2016*.

Achieving better system integration between primary care and home and community care, and improving health system planning, is foundational to *Patients First* and is the basic tenet behind the development of sub-regions. This will provide patients, especially those from vulnerable populations, improved access to equitable, continuous, high quality primary care and home and community care services.

Effective the end of June 2017, the responsibility for the delivery of home and community care was transitioned from Community Care Access Centres (CCACs) into LHINs. This includes the responsibility for employment of care coordinators as well as the contracts for third party service providers. In addition to this structural reform, functional changes are also being pursued, as described in *Patients First: A Roadmap to Strengthen Home and Community Care*.

Patients First: A Roadmap to Strengthen Home and Community Care reflects key government priorities in home and community care, including the development of a Levels of Care Framework. Two of the most commonly heard concerns from patients and family caregivers regarding home and community care are the need for better consistency and transparency with respect to the equitable access and receipt of services across the sector. The Levels of Care Framework will utilize evidence-based client and family caregiver assessments, provincial-wide care standards, and sector performance indicators to ensure that home and community clients with similar needs receive similar levels of service across Ontario.

Ensuring care coordination is embedded, and where possible co-located, in primary care aligns with *Patients First* priorities, including the Levels of Care Framework, through integrated service planning and delivery and the implementation of standardized and coordinated assessment and care planning processes that support improved consistency and transparency in home care.

The 2017/18 Mandate Letter provided to Ontario's LHINs reflects this. It establishes expectations in several areas, including improving the patient experience, equity informed population-based planning and outcomes-based delivery, acknowledging primary care as the foundation for the health system, completing the transition of CCACs into LHINs, further advancing *Patients First: A Roadmap to Strengthen Home and Community Care* and as priority, developing and implementing plans to transform care coordination around the needs of patients and family caregivers.

3.1 Care Coordination Function in Home and Community Care: Current Status

Care coordination is essential to the home and community care system by ensuring that patients receive the care that they need in a timely manner. Care coordinators are regulated health professionals – the majority of which are registered nurses in addition to occupational therapists and social workers. There are over 4,000 care coordinator positions across the province. All are unionized positions and deliver front-line services to patients.

The current role of care coordinators[1] is to determine eligibility of clients to a 'basket' of home and community care services and to ensure access to these services. They also promote access to community support services.

[1] For the purpose of this document, "care coordinators' refer to LHIN employees (former CCAC employees) who undertake the coordination of home and community care services.

Specifically, care coordinators are responsible for supporting home and community care clients through the following activities:

- Assessing client needs and eligibility for services, including services related to post-acute/post-discharge and specialized LHIN-wide programs such as palliative care.
- Determining care plans.
- Arranging services in compliance with care plans.
- Reviewing and reassessing care plans, as required.
- Long-term care home placement.

For services external to programs historically managed by CCACs, such as adult day programs, LHIN care coordinators refer clients to other agencies available within their community and provide support with applications. Care coordinators also help clients navigate community services, such as Meals on Wheels, transportation, or visits provided by Community Support Services Agencies, funded directly by LHINs.

3.2 Care Coordination and System Navigation Across the Health System

Care coordination, in general, is a function that extends beyond home and community care that supports seamless and continuous transition between providers and across the health system throughout a person's life span. Care coordination services may involve the coordination of specialist appointments and referrals, facilitation of medication management through partnership with community pharmacies and upstream supports to address issues such as housing, employment and other factors impacting one's health. Some primary care models provide this type of care coordination/system navigation within their practice, particularly oriented towards socially complex patients.

These services may be provided by a variety of care providers, including care coordinators, system or patient navigators, discharge planners, or care coordinators at community service agencies, among others. Some Health Links, for example, have implemented a navigator/coordinator role embedded in a primary care practice that develops a care plan and works closely with a range of providers within the circle of care to ensure that care plan is followed and that care is coordinated.

4.0 Guiding Principles

A collaborative provincial approach to care coordination is essential to ensuring there is a consistent definition of care coordination and that clients, across the province, have common expectations of their care coordinator's role and function. As such, a set of common principles is instructive to guide LHINs in their approaches to connecting, and where possible locating, care coordinators in primary care. Common principles can be drawn from foundational work that has been undertaken in this area, including the *Patients First: Action Plan for Health Care*, the Statement of Values for Home and Community Care and the Position Statement: Care Coordination in Primary Care, developed by the Ontario Primary Care Council. Please see Appendix A for additional details. The principles that will guide this work include:

A. Planning needs to be informed by local (sub-region) population needs assessment and equity and must include the engagement of, clients, family caregivers[2], client advisory groups and health care providers and their organizations.

B. Primary care is central to the performance of the health care system and collaborative inter-professional teams working to full scope of practice are key contributors to improvement.

C. Care coordination emphasizes the timely and continuous delivery of high-quality, equitable and continuous services and programs that are comprehensive, evidence-informed, culturally competent and appropriate. Care coordination focuses on the provision of comprehensive services across the health and social services continuum as needed and is an activity that must be client-centred.

D. Efforts must be made to ensure services are delivered where people live. Acknowledging that providing choice for a client on how and where they receive care is critical to their well-being.

E. Change management supports for care coordinators should be put in place to ensure the workforce is equipped and supported through the change process.

F. Primacy should be placed on continuity of care for existing home care clients while connections to primary care are developed and strengthened.

G. Approaches to connecting, and where possible locating, care coordinators in primary care settings should be based on the tenets of *Patients First: A Roadmap to Strengthen Home and Community Care*, including the Levels of Care Framework, and aligned with the Statement of Values for Home and Community Care in addition to other provincial home and community care initiatives.

H. Client, family caregivers, providers and LHIN partners should work collaboratively to implement care coordination approaches/models that ensure consistency and transparency in care coordination across LHINs. Additionally, LHIN care coordinators will remain under the employ of the LHINs and are to remain well connected with their LHIN employers and co-workers to ensure consistency.

I. Approaches to integrate primary care and home and community care must respect collective bargaining agreements and related labour relations requirements as well as other current legislative and operational requirements.

J. Consistent provincial approaches to integrate primary care and home and community care must be balanced by reasonable flexibility to address the unique needs of local populations.

[2] Refers to a person who takes on an unpaid caregiving role for someone who needs help because of a physical or cognitive condition, an injury or a chronic life limiting illness (Carers Canada - http://www.carerscanada.ca/carer-facts/)

K. Models of integration must apply a health equity lens with a goal to address the root causes of health inequities and recognize the impact of social determinants of health in order to reduce or eliminate health disparities. This includes:

- Indigenous-specific equity considerations and Indigenous Cultural Competency to respect traditions, cultures and languages;
- Approaches that comply with the requirements of the *French Language Services Act* and, among other activities, ensure Francophones are provided with an active offer of health services in French;
- Culturally safe and competent services for diverse communities including racialized communities, ethno-specific communities, the LGBTQ community, and people living with disabilities;
- Non-insured; and
- Unique requirements of people who live in precarious housing situations, are homeless, or are under-housed.

5.0 Guidance for Local Health Integration Networks

The integration of care coordination with primary care settings can help ensure that patients, especially those with complex needs, receive accessible, continuous, high quality, primary, and home and community care.

When developing a plan to enhance care coordination in primary care, there are several factors that should be considered and steps to be undertaken. These include the following:

Phase 1: Planning

A. Current State Assessment

(i) Immediately conduct a baseline inventory of the LHIN care coordinators in primary care settings. The Baseline Inventory & Targets Tool in Appendix B will assist LHINs in gathering and reporting on this information. As part of the assessment, please identify the extent of existing connections based on the functional descriptions included in Appendix C, distinguishing between co-location and virtual connections.

(ii) The ministry will make available to each LHIN, upon request, data that identifies the clients currently receiving home and community care services. This data will require local validation and augmentation.

B. Review of Human Resources and Labour Relations Implications

(i) As part of planning, design and implementation, LHINs – as employers of care coordinators – must consult with their respective bargaining agents to ensure human resource, retention and recruitment planning, occupational health and safety and collective agreement issues are discussed and addressed, and respect obligations under Collective Bargaining Agreements and related labour relations requirements.

(ii) When locating care coordinators within primary care settings, LHINs will maintain them as employees.

C. Patient, Family Caregiver and Provider Engagement[3] and Empowerment

(i) As part of the planning phase, engage patients, family caregivers and health care providers, primary care organizations and other partners as appropriate to identify models that work for the communities within the LHIN boundaries. This acknowledges the success of models of integration will depend on local factors, such as how primary care is organized, population demographics and density, language considerations, etc. It is recommended that LHINs undertake this engagement at the LHIN sub-region level.

[3] Engagement is a multi-directional process that should include feedback loops and regular information sharing with all those involved.

(ii) Although engagement may occur in various forms, a promising practice is a LHIN-sponsored “Co-Design” approach which involves patients/family caregivers, home and community care providers, primary care providers, primary care organizations and others.

D. Indigenous Engagement and Indigenous Determination in Health

(i) Indigenous partners will require a unique engagement process, led by Indigenous health stakeholders to ensure that integration models are effective in contributing to measurable improved Indigenous health outcomes and accelerating Indigenous health gains.

(ii) Engagement efforts should not interfere with Indigenous rights to determination in health and existing Indigenous-governed health care agencies, their partnerships and initiatives.

(iii) Efforts should consider the Truth and Reconciliation Calls to Action as they relate to health care, apply an equity lens and consider Indigenous cultural safety within the engagement processes while respecting established Indigenous community traditions and cultural practices.

(iv) Engagement should not inadvertently create new cultural unsafety within Ontario’s health care system for First Nations, Métis and Inuit (FNMI) communities and respect Ontario’s commitment to reconciliation with Indigenous people.

(v) Indigenous engagement must be inclusive of FNMI people, communities and providers no matter where they are situated; on and off-reserve, in rural and urban settings.

E. Capacity, Health Equity and Targets Assessment

(i) Assess the state of readiness to take on care coordination for each primary care practice/organization.

(ii) LHINs should take into account office space requirements and any accompanying costs associated to locating care coordinators within primary care settings.

(iii) Use the MOHLTC Health Equity Impact Assessment (HEIA) or other health equity assessment methodologies to identify diverse communities within a sub-region to determine the unique care coordination requirements to meet their needs. Diverse communities include Indigenous populations, Francophones, racialized communities, ethno-specific communities, new immigrants, LGBTQ, those living on low incomes, and individuals living in rural and remote communities.

(iv) Provide preliminary targets for improving connections, including co-location where possible, between care coordination and primary care settings for 2017/18 Q4 and 2018/19 by **January 31, 2018** and to provide final targets by **February 28, 2018**.These targets should be accompanied by quarterly progress reports with the next reporting scheduled for **March 30, 2018**.

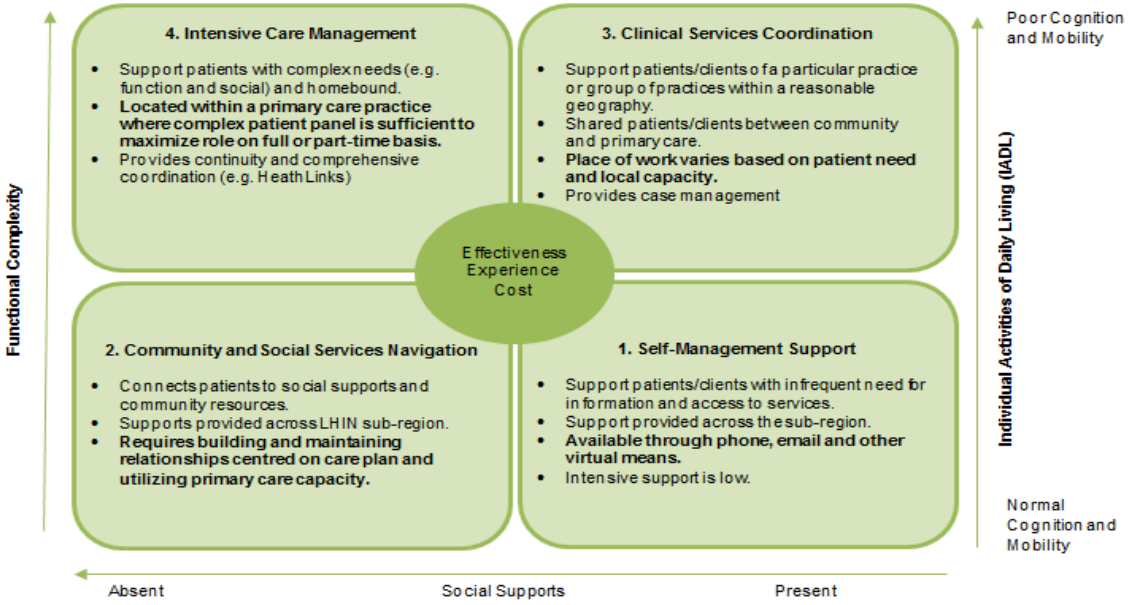
Phase 2: Design

Following the planning phase and influenced by feedback from patients, family caregivers, providers, and primary care organizations, LHINs should identify the level of integration that is the 'best fit' for embedding, including co-locating, care coordinators in primary care within the local context of their respective communities. Based on the complexity of the client roster, there are varying levels of integration and associated functions that care coordination could provide in support the Outcome Statement in section 2.0:

Ontarians are able to access care coordination through their primary care provider or team in a manner that is responsive to their needs and through an approach that is based on patient and provider engagement and local assessment of capacity.

An implementation model for connecting care coordination with primary care must be anchored in a team-based approach that is flexible and adaptable to client and family caregiver needs while simultaneously taking into consideration the functional complexity of patients and clients. The model must also respect existing Collective Bargaining Agreements, and LHINs being the employers of care coordinators. To this end, there is a spectrum of design models available that should guide LHINs in their engagement of providers to determine the right model(s) for particular primary care settings.

The below scheme was adapted from the Toronto Central LHIN and describes a needs-based approach to determining the type and intensity of care coordination functions. The scheme identifies functional complexity, social supports and Instrumental Activities of Daily Living (IADL) measures as drivers of the type of care coordination activities that could occur within primary care settings. These functions could include support for self-management, community and social services navigation, clinical services coordination and intensive care management.
It is important to note that these activities may not be mutually exclusive within a primary care setting. In other words, based on the patient/client characteristics of a primary care setting, a range of care coordination functions could be available. This is further described in Appendix C.



Adapted from the Toronto Central LHIN
Note: Variations may be needed depending on demographic and geographic considerations.

Phase 3: Implementation

At the implementation phase, LHINs continue to engage with patients, family caregivers and providers on how best to implement the desired model of integration. LHINs should consider engaging with existing interprofessional team-based models for consideration for early adoption as existing features of these models of care, such as their familiarity with interprofessional teams, organizational infrastructure, and populations they serve may be conducive to early successes as part of LHIN implementation plans.

Although the implementation steps will differ depending on the model most suitable for the community/LHIN sub-region, the following are important considerations that may be common to all models:

A. Respectful Workplaces

(i) Engagement of bargaining agents, where needed, as well as with employees to ensure to ensure human resource, retention and recruitment planning, occupational health and safety and collective agreement issues are discussed and addressed, and that the model under consideration and the process to implement is consistent with obligations under Collective Bargaining Agreements.

(ii) Ensure that important considerations such as workplace health and safety are accounted for (including safe home visits).

B. Information Management and Privacy

(i) Ensure that primary care providers and care coordinators have access to the necessary information required to maximize benefits for clients and facilitate

electronic sharing of client information across providers. Since this will involve personal health information (PHI), due diligence is required to ensure information is collected, used and disclosed within the parameters of relevant legislation and data sharing agreements. Care coordinators must have access to confidential work space if they are located in primary care to maintain patent privacy.

(ii) In particular, emphasis must be placed on practice-based Electronic Medical Records (EMRs) as well as the Client Health-Related Information System (CHRIS) and other systems used by system navigators, care coordinators and providers to promote electronic sharing. Care coordinators are responsible for significant reporting requirements for home care clients.

C. Setting-Specific Considerations

(i) Contingent on the integration model, LHINs should consider the setting-specific factors associated with implementation including:
- The type of **primary care practice model** may determine the experience a particular practice has with integrating different health care professionals within the primary care setting.
- The type of **geography** that exists, such as rural or rural settings, may impact factors such as driving time, long distance charges via phone, access to internet or other factors.
- **Linguistic and cultural** safety, including obligations under the *French Language Services Act*.
- **Patient access to services** may vary by community and preference should be given to adapting to existing patient access patterns as opposed to having patient access patterns adapting to the integration model.
- **Indigenous models** of primary health care, like Aboriginal Health Access Centres, will include interface with Indigenous healers, Elders and other interprofessional staff.

D. Evolution of Home and Community Care

(i) Integration models should support initiatives related to the provincial commitment to strengthen home and community care, including improved consistency, quality and transparency of home care assessment and service delivery. Models should be consistent with the ongoing reforms to home and community care as set out in the Roadmap, including the Levels of Care Framework.

Phase 4: Implementation Tracking

To ensure LHINs are on track in successfully connecting, and where possible locating, care coordinators in primary care settings, LHINs will be asked to develop and identify baseline inventory and proposed preliminary targets for 2017/18 Q4 and 2018/19 by **January 31, 2018** and final targets by **February 28, 2018.** These targets will be identified by two approaches. The first method requests LHINs to identify baseline inventory and targets for the number of care coordinators connected to primary care settings. The second method requires LHINs to provide baseline inventory and targets for the number of primary care practices that are connected with a care coordinator. These targets should be based on, informed by, and regularly tracked

through engagement with bargaining agents, patients/clients, family caregivers, providers and relevant organizations. The next reporting on these targets is **March 30, 2018**.

Quantitative targets should be augmented by specific qualitative information in regards to health equity and plans to meet the needs of diverse populations, engagement of Indigenous partners and adherence to requirements under the *French Language Services Act*. Tools such as the Health Equity Impact Assessment Tool can be used for this purpose.

Phase 5: Evaluation

As described in Section 7.0 "Next Steps", the ministry will be evaluating the progress LHINs are making in improving connections between primary care and care coordination starting in the 2017/18 fiscal year and on an on-going basis. Evaluation will occur first with an initial focus on the linkages between primary care and home and community care, followed by an approach that evaluates linkages with care coordination more broadly. A separate evaluation framework for the latter will be developed following the review of the functions of care coordinators.

LHINs will work with the ministry and other partners to put in place a pan-LHIN evaluation framework to assess the effectiveness of implementation model adopted. The evaluation framework is recommended to include:

- Percentage of LHIN's care coordinators connected, or located, in primary care;
- Measures of client, family caregiver and provider experience;
- Measures of access, including timeliness, appropriateness and health equity considerations;
- Measures of resource use, including caseloads/volumes, types of services delivered;
- Measures of health outcomes for specific conditions that have been identified as a priority for the particular LHIN, LHIN sub-region or neighbourhood/community; and
- Measures of culturally safe services.

As part of continued implementation planning the LHINs will work with key partners to ensure evaluation of the full range of primary care-based care coordination functions are positively impacting patient/client health outcomes, utilization trends and patient/client experience. Possible indicators to track the extent to which objectives are being met include:

- Reduced Emergency Department Visits;
- Reduced ALC and Re-admissions to Hospitals;
- Referral to Home Care Services/Personal Supports within 5 Days;
- Reduction of Social Barriers to Care Coordination (e.g. Transportation to follow-up appointments);
- Provider Satisfaction; and
- Client Satisfaction.

6.0 Care Coordination for Indigenous Peoples

The ministry has worked closely with Indigenous communities to improve access to primary health care and the broader health system. Currently Ontario funds ten Aboriginal Health Access Centres (AHACs), most of which are regional providers serving First Nations, Métis and Inuit (FNMI) people both on and off-reserve in rural and urban areas in the North and South. Ontario also supports five Indigenous governed Community Family Health Teams (CFHTs), three Aboriginal Community Health Centres (ACHCs), one Indigenous-governed Nurse Practitioner Led Clinic (INPLCs) and two northern regional hospitals mandated to also provide primary health care.

The Indigenous population (First Nations, Métis and Inuit) is one of five key population groups who experience the highest levels of health inequality and face numerous challenges, including:

- Significant number of the Indigenous population live in urban centres and many, often smaller populations, live in rural and very remote areas;
- High percentage of the Indigenous population are people with low incomes;
- Indigenous people have higher rates of chronic disease; and
- Indigenous people have very vulnerable male and female populations (e.g. missing and murdered Indigenous women; higher rates of male mental health and addiction; higher rates of youth suicide).

Ontario's models of Indigenous primary health care delivery recognize Indigenous rights to self-determination in health, Indigenous traditional healers and healing approaches, and blend them with culturally competent, western clinical practices to address prenatal and maternal care, primary care, mental health and wellness, addictions and chronic disease prevention and management. AHACs, for example, address the health and wellness needs through all the life stages from pre-natal to Elder and incorporate a comprehensive continuum of care from health promotion and prevention to treatment and rehabilitation. These models also recognize the importance of the interconnectedness of individuals, families, Nations, environment and spirit world within our life support system.

Each LHIN must consider how to address the significant, long standing gaps in care coordination to First Nations on reserve and in urban settings by engaging with the Indigenous community and health leaders to ensure the development of adaptive, innovative solutions which have flexibility to consider and meet the needs of Indigenous peoples. Similarly, LHINs must also consider a needs assessment for their staff to ensure they can meet the needs of Indigenous populations.

7.0 Next Steps for 2017/18

LHINs:

1. Meaningful consultation with bargaining agents to fully take into account obligations under Collective Bargaining Agreements and related labour relations requirements.

2. Actively engage in the planning and design phases described in sections 5.0 and 6.0 of this document, including activities focused on engaging Indigenous peoples and communities, diverse populations, and ensuring requirements under the *French Language Services Act* are adhered to.

3. Actively engage with primary care providers to assess the state of readiness for primary care practices/organizations to take on care coordination.

4. By **January 31, 2018** complete and submit a baseline assessment of care coordination connections with primary care settings, and the number of primary care practices that have a connection with a care coordinator, with proposed preliminary targets for 2017/18 Q4 and 2018/19.

5. Continued active engagement described in steps 2 and 3 above.

6. By **February 28, 2018**, and based on continued engagement, identify final targets for embedding, including co-locating, care coordinators in primary care settings for 2017/18 Q4 and 2018/19. See Appendix B. These will be reviewed as part of regular ministry-LHIN accountability process (i.e. stock-take).

7. Implement models of connecting care coordination with primary care settings.

   Note: Established team-based models of primary health care (including Aboriginal Health Access Centres, Community Health Centres, Family Health Teams, Nurse Practitioner-Led Clinics and others) may have the organizational features necessary to allow for early implementation. As such, and to assist in meeting your targets, LHINs are encouraged to engage these organizations for early implementation.

8. By **March 30, 2018**, report on the defined targets for 2017/18 Q4.

9. Participate in quarterly monitoring meetings with the ministry (i.e. stock-take) to report on implementation progress.

Primary Care Associations:

1. Primary care associations and other relevant stakeholders have agreed to support their membership in providing leadership to enable LHINs to move forward with guidance on mechanics and operational details.

2. As described in Appendix E “Critical Path”, primary care associations and other members of the Care Coordination Table that contributed to this Guidance Document will reconvene to assess implementation progress and identify lessons learned. This

meeting will occur in June 2018.

Ongoing Provincial Supports:

1. Development of a provincial evaluation framework for the integration of care coordination in primary care including patient-centered and system measures for system navigation and care coordination by 2017/18 Q4.

2. Ensuring mutual access to CHRIS and EMRs and other Connecting Ontario platforms to enable access to the Circle of Care for appropriate information.

3. The ministry to work with Health Shared Services Ontario (HSSO) to identify capabilities and/or changes required to data and reporting to enable the tracking of the number of home care clients by the setting in which care coordinators are connected with.

APPENDIX

APPENDIX A: Guiding Principles

Ontario Primary Care Council's (OPCC) Guiding Principles for Care Coordination

OPCC GUIDING PRINCIPLES	OPCC GUIDING PRINCIPLES FOR CARE CO-ORDINATION	PROPOSED GUIDING PRINCIPLES
Primary care is central to the performance of whole health system effectiveness.		✓
Planning for the system needs to be based on population needs.	Care co-ordination requires a population needs based approach to planning.	Planning for the system needs to be based on population needs.
Programs and services must be appropriate, accessible, timely, high-quality, comprehensive, continuous, evidence-informed, equitable and culturally competent.	Care co-ordination will emphasize the timely and continuous delivery of high-quality, equitable and continuous services and programs that are comprehensive, evidence-informed, culturally competent and appropriate.	Care co-ordination will emphasize the timely and continuous delivery of high-quality, equitable and continuous services and programs that are comprehensive, evidence-informed, culturally competent and appropriate.
Care co-ordination is a core function of primary care.	Care co-ordination is a core function of primary care and a hallmark of a high-performing primary care system.	Improved integration between primary care and home and community care will improve access to the right care in the right place, delivering better coordinated care and will improve system transparency. This requires that primary care and home care providers: • Contribute to care planning; • Are informed of care decisions; and • Work together to facilitate transitions and the coordination of care between sectors.
Collaborative inter-professional teams working to full scope of practice are keys to success.	Care co-ordination is predicated on collaborative inter-professional teams working to full scope of practice.	Collaborative inter-professional teams working to full scope of practice are keys to success.
	Care co-ordination is patient-centred and includes communication and planning with the patient and family.	✓
	Care co-ordination focuses on the provision of comprehensive services across the health and social services continuum as needed.	✓

OPCC GUIDING PRINCIPLES	OPCC GUIDING PRINCIPLES FOR CARE CO-ORDINATION	PROPOSED GUIDING PRINCIPLES
		Providing care at home supports people's independence and is often a more cost effective alternative than care in hospitals and long-term care homes.
		Models to integrate primary care and home and community care must be flexible enough to address the unique needs of local populations, and must respect current legislative and operational requirements for care co-ordination.

Objectives of the *Patients First: Action Plan for Health Care*

- **Access:** Improve access – providing faster access to the right care.
- **Connect:** Connect services – delivering better coordinated and integrated care in the community, closer to home.
- **Inform:** Support people and patients – providing the education, information and transparency they need to make the right decisions about their health.
- **Protect:** Protect our universal public health care system – making decisions based on value and quality, to sustain the system for generations to come

Statement of Values for Home and Community Care

The ministry and our home and community care partners will deliver:

"*Patient-centred home care that is responsive, collaborative, transparent and flexible"*

This means providing care in partnership with patients and family caregivers that is:

- **Reliable** in the delivery of high-quality and consistent care for patients across the province.
- **Accessible** in a way that is easy for people in all communities with different levels of need.
- **Respectful** of and sensitive to a person's identity, including their culture, language, background, and values.
- **Integrated** with other parts of our healthcare system to support easier transitions and collaborative care planning.
- **Accountable** to patients and family caregivers in day-to-day service delivery and care planning.

APPENDIX B: Baseline Inventory and Target Tool, and Reporting

The purpose of the Baseline Inventory and Target Tool is to enable a common approach for LHINs to assess the extent of connections between LHIN Care Coordinators and primary care settings and also to identify targets that support improved connections. LHINs are requested to populate the baseline inventory and propose preliminary targets for 2017/18 Q4 and 2018/19 by **January 31, 2018** and to provide final targets by **February 28, 2018.** These targets should be accompanied by quarterly progress reports with the next reporting scheduled for **March 30, 2018**.

LHIN Name:	
Key Contact:	
Date of Completion:	

Existing Client Load:	
Number of LHIN Care Coordinators:	

Baseline Inventory and Proposed Targets:

Intensive Care Management:	Care Coordinators located within a primary care practice that supports patients/clients with complex needs through coordinating the circle of care (e.g. Health Links).									
	Baseline		**Preliminary Q4 17/18 Target:** (due January 31, 2018)		**Preliminary 18/19 Target:** (due January 31, 2018)		**Final Q4 17/18 Target:** (due February 28, 2018)		**Final 18/19 Target:** (due February 28, 2018)	
	Co-Located	Virtual	Co-Located	Virtual	Co-Located	Virtual	Co-Located	Virtual	Co-Located	Virtual
Total Number of Care Coordinators involved in Intensive Care Management with primary care settings										
Total Number of Clients (if available, see page 16, #3)										
Aboriginal Health Access Centre:										
Community Health Centre:										
Family Health Team:										
Nurse Practitioner Led Clinic:										
Physician Group:										
Solo Practitioner:										
Other:										

On-going Monitoring:

Intensive Care Management:	Care Coordinators located within a primary care practice that supports patients/clients with complex needs through coordinating the circle of care (e.g. Health Links).					
	17/18 Target:		**18/19 Target:**			
	18-Mar	18-Mar	18-Jun	18-Sep	18-Dec	19-Mar
	Co-Located	Virtual	Co-Located	Virtual	Co-Located	Virtual
Total Number of Care Coordinators involved in Intensive Care Management with primary care settings						
Total Number of Clients (if available, see page 16, #3)						
Aboriginal Health Access Centre:						
Community Health Centre:						
Family Health Team:						
Nurse Practitioner Led Clinic:						
Physician Group:						
Solo Practitioner:						
Other:						

Baseline Inventory and Proposed Targets:

Clinical Services Coordination:	Care Coordinators that support patients/clients of a particular practice or group of practices within a reasonable geography. Patients/clients typically shared between primary care and community care settings. Place of work varies based on patient/client need and local capacity.									
	Baseline		**Preliminary Q4 17/18 Target:** (due January 31, 2018)		**Preliminary 18/19 Target:** (due January 31, 2018)		**Final Q4 17/18 Target:** (due February 28, 2018)		**Final 18/19 Target:** (due February 28, 2018)	
	Co-Located	Virtual	Co-Located	Virtual	Co-Located	Virtual	Co-Located	Virtual	Co-Located	Virtual
Total Number of Care Coordinators involved in Clinical Services Coordination with primary care settings										
Total Number of Clients (if available, see page 16, #3)										
Aboriginal Health Access Centre:										
Community Health Centre:										
Family Health Team:										
Nurse Practitioner Led Clinic:										
Physician Group:										
Solo Practitioner:										
Other:										

On-going Monitoring:

Clinical Services Coordination:	Care Coordinators that support patients/clients of a particular practice or group of practices within a reasonable geography. Patients/clients typically shared between primary care and community care settings. Place of work varies based on patient/client need and local capacity.					
	17/18 Target:		**18/19 Target:**			
	18-Mar	18-Mar	18-Jun	18-Sep	18-Dec	19-Mar
	Co-Located	Virtual	Co-Located	Virtual	Co-Located	Virtual
Total Number of Care Coordinators involved in Clinical Services Coordination with primary care settings						
Total Number of Clients (if available, see page 16, #3)						
Aboriginal Health Access Centre:						
Community Health Centre:						
Family Health Team:						
Nurse Practitioner Led Clinic:						
Physician Group:						
Solo Practitioner:						
Other:						

Baseline Inventory and Proposed Targets:

Social Services and Community Navigation:	Care Coordinators connect patients/clients to social supports and resources across a LHIN sub-region. Builds/maintains relationships and works with providers across a circle of care to execute a care plan.									
	Baseline		**Preliminary Q4 17/18 Target:** (due January 31, 2018)		**Preliminary 18/19 Target:** (due January 31, 2018)		**Final Q4 17/18 Target:** (due February 28, 2018)		**Final 18/19 Target:** (due February 28, 2018)	
	Co-Located	Virtual	Co-Located	Virtual	Co-Located	Virtual	Co-Located	Virtual	Co-Located	Virtual
Total Number of Care Coordinators involved in Social Services and Community Navigation with primary care settings										
Total Number of Clients (if available, see page 16, #3)										
Aboriginal Health Access Centre:										
Community Health Centre:										
Family Health Team:										
Nurse Practitioner Led Clinic:										
Physician Group:										
Solo Practitioner:										
Other:										

On-going Monitoring:

Social Community and Services Navigation:	Care Coordinators connect patients/clients to social supports and resources across a LHIN sub-region. Builds/maintains relationships and works with providers across a circle of care to execute a care plan.					
	17/18 Target:		**18/19 Target:**			
	18-Mar	18-Mar	18-Jun	18-Sep	18-Dec	19-Mar
	Co-Located	Virtual	Co-Located	Virtual	Co-Located	Virtual
Total Number of Care Coordinators involved in Social Services and Community Navigation with primary care settings						
Total Number of Clients (if available, see page 16, #3)						
Aboriginal Health Access Centre:						
Community Health Centre:						
Family Health Team:						
Nurse Practitioner Led Clinic:						
Physician Group:						
Solo Practitioner:						
Other:						

Baseline Inventory and Proposed Targets:

Self-Management Support:	Care Coordinators support patients/clients with infrequent needs for information and access to services with support provided across the LHIN sub-region. Available to providers via telephone, email or other virtual means. Provides information resources such as toolkits, apps, etc. Does not involve intensive client/patient support.									
	Baseline		**Preliminary Q4 17/18 Target:** (due January 31, 2018)		**Preliminary 18/19 Target:** (due January 31, 2018)		**Final Q4 17/18 Target:** (due February 28, 2018)		**Final 18/19 Target:** (due February 28, 2018)	
	Co-Located	Virtual	Co-Located	Virtual	Co-Located	Virtual	Co-Located	Virtual	Co-Located	Virtual
Total Number of Care Coordinators involved in Self- Management Support with primary care settings										
Total Number of Clients (if available, see page 16, #3)										
Aboriginal Health Access Centre:										
Community Health Centre:										
Family Health Team:										
Nurse Practitioner Led Clinic:										
Physician Group:										
Solo Practitioner:										
Other:										

On-going Monitoring:

Self-Management Support:	Care Coordinators support patients/clients with infrequent needs for information and access to services with support provided across the LHIN sub-region. Available to providers via telephone, email or other virtual means. Provides information resources such as toolkits, apps, etc. Does not involve intensive client/patient support.					
	17/18 Target:		**18/19 Target:**			
	18-Mar	18-Mar	18-Jun	18-Sep	18-Dec	19-Mar
	Co-Located	Virtual	Co-Located	Virtual	Co-Located	Virtual
Total Number of Care Coordinators involved in Self- Management Support with primary care settings						
Total Number of Clients (if available, see page 16, #3)						
Aboriginal Health Access Centre:						
Community Health Centre:						
Family Health Team:						
Nurse Practitioner Led Clinic:						
Physician Group:						
Solo Practitioner:						
Other:						

Baseline Inventory and Proposed Targets:

Other Care Coordinators/ Navigators:	Care Coordinators/Navigators that are currently located in primary care settings to support care coordination programs and initiatives (e.g. Health Links).									
	Baseline		**Preliminary Q4 17/18 Target:** (due January 31, 2018)		**Preliminary 18/19 Target:** (due January 31, 2018)		**Final Q4 17/18 Target:** (due February 28, 2018)		**Final 18/19 Target:** (due February 28, 2018)	
	Co-Located	Virtual	Co-Located	Virtual	Co-Located	Virtual	Co-Located	Virtual	Co-Located	Virtual
Total Number of Care Coordinators involved in Other Care Coordination or Navigation functions with primary care settings										
Total Number of Clients (if available, see page 16, #3)										
Aboriginal Health Access Centre:										
Community Health Centre:										
Family Health Team:										
Nurse Practitioner Led Clinic:										
Physician Group:										
Solo Practitioner:										
Other:										

On-going Monitoring:

Other Care Coordinators/ Navigators:	Care Coordinators/Navigators that are currently located in primary care settings to support care coordination programs and initiatives (e.g. Health Links).					
	17/18 Target:		**18/19 Target:**			
	18-Mar	18-Mar	18-Jun	18-Sep	18-Dec	19-Mar
	Co-Located	Virtual	Co-Located	Virtual	Co-Located	Virtual
Total Number of Care Coordinators involved in Other Care Coordination or Navigation functions with primary care settings						
Total Number of Clients (if available, see page 16, #3)						
Aboriginal Health Access Centre:						
Community Health Centre:						
Family Health Team:						
Nurse Practitioner Led Clinic:						
Physician Group:						
Solo Practitioner:						
Other:						

Baseline Inventory and Proposed Targets:

Primary Care Settings:	Primary care settings that currently have Care Coordinators/Navigators to support patients/clients through coordinating the circle of care.									
	Baseline		**Preliminary Q4 17/18 Target:** (due January 31, 2018)		**Preliminary 18/19 Target:** (due January 31, 2018)		**Final Q4 17/18 Target:** (due February 28, 2018)		**Final 18/19 Target:** (due February 28, 2018)	
	Co-Located	Virtual	Co-Located	Virtual	Co-Located	Virtual	Co-Located	Virtual	Co-Located	Virtual
Percentage of Primary Care Settings with Care Coordinators										
Total Number of Clients (if available, see page 16, #3)										
Aboriginal Health Access Centre:										
Community Health Centre:										
Family Health Team:										
Nurse Practitioner Led Clinic:										
Physician Group:										
Solo Practitioner:										
Other:										

On-going Monitoring:

Primary Care Settings:	Primary care settings that currently have Care Coordinators/Navigators to support patients/clients through coordinating the circle of care.					
	17/18 Target:		**18/19 Target:**			
	18-Mar	18-Mar	18-Jun	18-Sep	18-Dec	19-Mar
	Co-Located	Virtual	Co-Located	Virtual	Co-Located	Virtual
Percentage of Primary Care Settings with Care Coordinators						
Total Number of Primary Care Settings (if available, see page 16, #3)						
Aboriginal Health Access Centre:						
Community Health Centre:						
Family Health Team:						
Nurse Practitioner Led Clinic:						
Physician Group:						
Solo Practitioner:						
Other:						

Health Equity

Please provide a description of the LHIN's plan to ensure the needs of diverse communities are captured in planning and implementing models of connecting care coordination with primary care settings, including considerations with respect to the social determinants of health.

Indigenous Engagement

Please provide a description of the LHIN's plan of engaging Indigenous peoples and communities in planning and implementing models of connecting care coordination with primary care settings.

French Language Services

Please provide a description of the LHIN's plan of ensuring compliance with the *French Language Services Act*, including the requirement for an 'active offer' in French, in planning and implementing models of connecting care coordination with primary care settings.

APPENDIX C: Functions of Care Coordination

The following are models of primary care and care coordination integration that LHINs should consider in their planning for how to make care coordination services available to patients through the primary care setting. Note that these models are part of a spectrum and depict the functions that Care Coordinators perform and are aligned with patient complexity and need.

1. Intensive Care Management

- Typically oriented towards patients and primary care practices that are assessed as being complex, from both a health and social stand-point, such as home-bound seniors.
- Care Coordinator(s) are embedded within a primary care practice, where many clients within the patient panel require intensive care management.
- Could be a Community Health Centre (CHC), Family Health Team (FHT), Aboriginal Health Access Centre (AHACs) Nurse Practitioner-Led Clinics (NPLCs), large group practice or other primary care model.
- In this model, the primary care setting would be a place of work for the Care Coordinator(s) – the amount of time of which would be based on patient need and local capacity.

2. Clinical Services Coordination

- Typically oriented towards patients and primary care practices that are assessed as medium complexity, from both a health and social standpoint, where place of work and method of engagement are based on need and capacity.
- A team of Care Coordinators whose primary role is to support the patients of a particular primary care practice or group of practices within a neighbourhood or LHIN sub-region.
- Place of work would vary based on patient need and local capacity; team members may be stationed part-time within a particular primary care setting, rotate across primary care settings or a mix between primary care co-location and other settings.

3. Self-Management Support

- Could be oriented towards patients and primary care practices across the spectrum of complexity, both as a stand-alone function or as an adjunct to those functions described above.
- A phone or digital-based outreach mechanism for primary care providers to access a Care Coordinator or Care Coordinator team on behalf of their patients. Mechanism would be dedicated to primary care and separate from general intake.
- Would typically apply to primary care providers with a smaller proportion of home care clients on their patient panel and for those where co-location is not preferable.

4. Social Community and Services Navigation

- Through different means of connecting (likely a combination of 1-3), identification of Specialty Care Coordinators whose role would be to support primary care providers and practices whose patient panels include complex kids, renal, dementia, those with mental health and addictions or other specific patient populations.

- This function is more consistent with the vision for care coordination, described as services that are coordinated and navigated by primary care effectively and seamlessly throughout the health and social services system. This could be an employee of a primary care practice or organization who would not carry the caseload of a LHIN Care Coordinator and who works as part of the interprofessional team to assist high needs patients navigate through the health and social services system, including home care, specialist appointments, community and social services, housing, employment, etc.

Features of all Models

- Care coordinators would participate in routine case conferences with the primary care provider and his or her team members.

- Digital connections would be strengthened. For example, access to CHRIS would be offered/provided to primary care providers and their EMRs, and primary care providers would be added to the alert system that exists between CHRIS and hospital ERs.

- Care coordinators in these integration models would be closely linked with colleagues who work in hospitals and the LHIN, and could help arrange for follow-up visits. They would also be linked with care coordinators who manage community intake, and could facilitate the transfer of a self-referred or family-referred patient to their primary care provider and their integrated care coordinator.

- Care coordinators in these integration models would also link with colleagues who manage clients in cluster care settings such as retirement homes, seniors' apartments or assisted living.

APPENDIX D: Map of All Provincially Funded, Indigenous Governed Primary Health Care Agencies

APPENDIX E: Care Coordination Table Critical Path