

# **Service Coordination Workshop: No Door is the Wrong Door**

*Final Report of Proceedings and Findings*

**Canad Inns Polo Park  
Winnipeg, Manitoba  
Friday, October 30, 2015**

Friday, July 8, 2016

## EXECUTIVE SUMMARY

**BACKGROUND:** Manitoba Health, Healthy Living and Seniors (MHLS) hosted a half-day Service Coordination (SC) Workshop on Friday, October 30, 2015 at the Canad Inns Destination Centre (Polo Park) in Winnipeg. The workshop was meant to build on the outcomes of the initial SC Stakeholder Engagement Day held on September 20, 2013, where participants identified a need for collaboration between MHLS, Regional Health Authorities (RHAs), Fee-for-Service (FFS) providers, and other health system and community partners to facilitate improved SC across the health care system. This report serves as a record of the proceedings and input from attendees at the SC Workshop based on the following standards and best practices:

Standards	Best Practices
<p><i>S1. Accessible Services</i></p> <p><i>S2. Comprehensive Person-centered Services</i></p> <p><i>S3. Patient Engagement and Self-management</i></p> <p><i>S4. Continuous Services</i></p>	<p><i>B1. Interprofessional Accountability</i></p> <p><i>B2. Person-centeredness</i></p> <p><i>B3. Collaboration, Integration, &amp; Partnerships</i></p> <p><i>B4. Standardized Documentation and Transmission of Information</i></p> <p><i>B5. Continuous Efficiency Improvement Processes</i></p>

**SC FRAMEWORK:** A SC Framework was developed, which now acts as a high level lens of what patients can expect of their care, in the form of patient standards, and what activities are expected of providers to promote SC within MyHTs, Primary Care, and across sectors of health services, in the form of best practices. This work was intended to create understanding and alignment in the development of related policies that support shared primary health care initiatives.

**LEARNING OBJECTIVE:** To review and provide feedback on the four SC Standards and five Best Practices within the context of My Health Teams (MyHTs).

**FINDINGS:** Based on workshop feedback, participants provided overwhelming support for the proposed standards and best practices presented in the framework. In particular, participants highlighted the need

- to address barriers created by the Personal Health and Information Act and program criteria;
- to target healthy equity and upstream approaches for a more person-centered approach;
- to ensure shared accountability (i.e., no door is the wrong door) for continuous services;
- standardization of documentation and transmission of information (includes leveraging information technology) to systematically engage patients and promote continuity of care; and
- lastly provider awareness of available services and other provider’s scopes of practice.

In addition, participants recommended improving the SC Framework through the use of plain language; defining and quantifying for evaluative purposes; cross referencing with Accreditation Canada; strengthening the system standpoint (in addition to the focus on service delivery); taking into account cultural differences; acknowledging barriers can arise from resource or capacity issues, whereby SC is the solution not the problem; as well as considering the feasibility, sustainability and unintended consequences of standards and best practices.

**NEXT STEPS:** The findings of this report will be used to revise the SC Framework, as well as to inform the Service Coordination initiatives at a MyHT Level, through the Year 3 Service Plan; at a Primary Health Care level, through branch initiatives; as well as at a system level, informing future health care policy reform.

## I Introduction

MHLS hosted a half-day Service Coordination (SC) Workshop on Friday, October 30, 2015 at the Canad Inns Destination Centre (Polo Park) in Winnipeg. The workshop was able to build on the outcomes of the initial SC Stakeholder Engagement Day held on September 20, 2013, where participants identified a need for collaboration between MHLS, Regional Health Authorities (RHAs), Fee-for-Service (FFS) providers, and other health system and community partners to facilitate improved SC across the health care system.

MHLS developed a draft SC Framework that defined SC and its associated standards and best practices. This work created a greater understanding and alignment in the development of related policies that support primary health care initiatives. In turn, the proposed Learning Objective for the SC Workshop was to review and provide feedback on the SC standards and best practices within the context of My Health Teams (MyHTs). This report serves as a record of the proceedings and input from attendees at the workshop.

## II Purpose & Objective

The main objective for the SC Workshop was to develop a common understanding of the standards and best practices within the context of MyHTs. Presentations and group work were incorporated in the day's events to facilitate rich discussions re: what patients may expect from their primary health care, how best to deliver services to meet those expectations, and in turn, opportunities for SC that MyHTs may want to further explore and prioritize as part of their Year 3 SC Service Planning deliverable (See Appendix A).

## III Participants, Speakers, & Intended Audience for this Report

### Participants

112 individuals attended and participated in the SC Workshop. These represented:

- MyHT Planning/Steering Committee members
- RHA Primary Care, Public Health/Healthy Living, Continuing Care and Mental Health leads
- MHLS Primary Health Care Branch
- MHLS SC Advisory Committee

### Speakers

Both patients and providers were invited to deliver presentations, including:

- **Laura Morrison** (A/Director, MHSAL): offered an overview of MyHTs; the formal partnerships where a regional health authority (RHA), fee for service practice(s), and other community organizations share resources, information and responsibilities to collaboratively plan, develop and provide quality primary care services for their community in a timely, efficient and coordinated way.
- **Kristin Anderson** (Director, MHSAL): reviewed the definition of service coordination, why it is important, the purpose of the SC Workshop, as well as a description of the standards and best practices that make up the framework.

- **Michael Jordan** (Patient Advocate): spoke of his experience navigating the mental health system since the age of 13, including acting as a self-advocate in the process of obtaining counselling, medication, as well as other treatments and services for his depression.
- **Donna Bell** (Consultant, MHSAL): shared her learnings as a Primary Care Working Group executive member and previous Program Manager for the Uniting Primary Care and Oncology or UPCON program at CancerCare Manitoba, where she started her involvement in the In Sixty – Cancer Patient Journey initiative three years ago.
- **Dr. Kevin Coates** (Primary care physician, St. Boniface Clinic): reviewed the successes and challenges with primary care initiatives, as with Interprofessional Team Demonstrative Initiative (ITDI), Physician Integrated Network (PIN) clinics, and Primary Care Networks/MyHTs.

## IV SC Workshop Common Themes

During the SC Workshop, assigned seating was organized in advance so participants could sit with members from different professional backgrounds, program areas, and regions. This added diversity was intended to enhance the richness of conversations that took place during small group discussions, and that was reflected in participant evaluations (see Appendix B). There were two opportunities for group discussions in the agenda, whereby designated group facilitators were responsible for directing the discussions and designating a note-taker for their table. Overall, 57 pages in notes were collected, transcribed and analyzed for themes in this report.

This section summarizes of feedback on standards and best practices from the SC Framework, where

- **SC Standards** are factors that people and families value and/or expect from their experiences with accessing health and social services that are coordinated, which also align with MyHTs core features (i.e., accessible, comprehensive person-centered, continuous, coordinated care).
- **SC Best Practices** are action-oriented activities service providers engage in, which may be invisible to the community, to achieve service coordination.

Each subsection includes the original description of the standard or best practice, a textbox summarizing the support and recommendations for that standard or best practice, and finally a textbox with all the associated themes included in participants' feedback.

## **SC STANDARDS**

### **S1. Accessible Services**

SC enables access to timely and quality services. Equal access to services and opportunity for good health is fostered when the approach to service delivery and coordination are compatible with each person's particular needs. This includes easy access to information about services.

<b>FRAMEWORK FEEDBACK</b>
<p><b>SUPPORT FOR STANDARD</b></p> <p>Access appears to persist as a notable challenge in Manitoba, which is affected by wait times, patients' knowledge of available services and programs, their personal circumstances, system barriers (e.g., PHIA, eligibility criteria, jurisdictional barriers, fragmented system), and lastly whether or not there are providers or resources available to actually implement the program.</p> <p><b>RECOMMENDATIONS FOR IMPROVING THE STANDARD</b></p> <ul style="list-style-type: none"> <li>• Should be written in plain language.</li> <li>• Define and quantify standards. (What is timely? Within 48 hours? What is accessible?)</li> <li>• Cross reference with Accreditation Canada.</li> <li>• Consider addressing barriers from a system standpoint.</li> </ul>

<b>CRITERIA</b>	<b>THEMES</b>	<b>FEEDBACK</b>
Time	<p><b>Wait Times</b> <i>Primary Care Providers</i></p> <p><i>Referrals</i></p>	<p>Sometimes lasting up to 12 months for selected program areas (e.g., Mental Health), wait times was widely described as a result of poor SC. The one exception being more extreme cases (e.g., threats of self-harm). Shared care models, ITDI, MyHT, pathways, amongst other primary health care initiatives are successfully underway and addressing some of these issues; though it was said that these changes take time and have their own unique challenges.</p> <p>One table referred to wait times being an accepted sense of "reality," whereas others felt recent initiatives (e.g., IN SIXTY) contributed to increased patient expectations in regards to seeing the right doctor at the right time as the new benchmark for their care.</p>
Aware	<p><b>Patient Education</b> <i>Services Access</i></p>	<p>While services may physically exist, access cannot occur without proper knowledge of what services are available or how to access them. Consequently, workshop participants were in agreement that it was essential for patients to feel adequately informed, connected, and engaged via patient-provider interactions, or other outreach efforts maintained by MHSAL or RHAs (e.g., waiting rooms, TV, churches, malls, stores, schools, community hubs, social media) re: community health and social services.</p>
Barrier-Free	<p><b>Personal Circumstance</b></p>	<p>Personal circumstances (e.g., financial, physical, psychological) facilitate or impede access to services, whether relating to transportation, ability to self-advocate, affordability, etc. Herein raised the importance of health equity in the accessibility of health services (<i>See Health Equity, B2</i>).</p>

	<p><b>Personal Health Information Act</b></p>	<p>Overall, participants felt that some health professionals were overly-cautious when interpreting PHIA, which creates unnecessary SC barriers in terms of what and how providers can communicate with one another. From a technology standpoint, participants shared how they benefited from improved information sharing between providers via EMR, thus supporting improved efficiency and effectiveness of service delivery (e.g., provider/patient safety, reduced duplication). Some felt that PHIA itself should be updated (e.g., to include addictions workers as health workers), while others suggested revisiting the act with health professionals to ensure consensus is reached on the intended meaning of its components.</p> <p>Similarly patient-provider communication was reported as being affected by this act. Though we live in an increasingly technological world that promotes user-friendly and efficient practices, operational barriers prevent providers and patients from emailing, texting, social media, and other technologies for patient-provider communication. In particular, these technologies were identified as supporting person-centeredness (whereby patient preferences drive service delivery), as well as enhanced communication with patients/families people (which is supportive of self-management and engagement). In particular, people who work regular business hours and those without a permanent address or telephone number (whose social media account may be their only mode of communication- FN community) were seen as the most likely to benefit.</p>
	<p><b>Eligibility Criteria</b> <i>Postal Code</i> <i>Age</i> <i>Condition</i></p>	<p>Sometimes, the existence of services does not equate access. Rather than considering specific patient circumstances (e.g., transitioning between systems or needing to temporarily access care outside of the area), patients who would benefit most from a service can be excluded based on their age, postal code, or other restrictive criteria. In particular, service delivery based on postal codes was seen as an issue for those moving between regions and for rural residents who wish to avoid the stigma associated with accessing particular services in their closely-knit communities.</p>
	<p><b>Jurisdiction</b></p>	<p>Currently, the federal government has legislative authority over First Nation communities (under the Constitution, 1867, s. 91(24) Indians and Lands Reserved for Indians) and a fiduciary duty. The mandate of Health Canada’s delivery of services to First Nations and Inuit is derived through the 1979 Indian Health Policy not legislation at this time. The province has authority to make laws over health care (under the Constitution, 1867, s.92). Workshop participants felt that a lack of collaboration between these two levels of government has left First Nations people faced with barriers (e.g., funding) in accessing health services.</p>
	<p><b>Fragmented System</b></p>	<p>Being referred to the wrong provider was said to have consequences for patients’ experience accessing services, including delivering the wrong care or “ping-ponging” patients between providers (rather than referring them to the right provider the first time. For example, red tape surrounds access to outpatient IV clinics and therapeutic transfusions, whereby patients are redirected to wait for 12 hours in emergency services. See</p>

		<i>Shared Accountability (B1)</i> for more information.
Availability	<b>Primary Care Provider Attach Recruit/ Retain</b>	As the first point of contact, primary care providers are often essential to SC. Workshop attendees felt ongoing initiatives like Family Doctor Finder, ITDI, and MyHT’s Year 1 service deliverable were key efforts contributing to attachment in Manitoba and should be continued. However, rural and remote communities reported facing unique challenges with recruitment and retention of providers (due to geographic, work-life balance due to on-call and ER workload, the system). In addition, over-panelled physicians is a challenge across the province, affecting physicians’ ability to attach patients and provide continuous services.
	<b>Limited Resources</b>	<p>With a growing and aging population, participants saw limited resources as a challenge when trying to implement best practices, as upstream investments (e.g., health promotion), mental health, primary care in rural areas have been chronically under-funded areas. Without sufficient resources, the efficiency and fate of a program or service may be affected, which in turn determines whether a provider can refer their patients.</p> <p>Identifying how best to prioritize the allocation of scarce funds (moving away from historical-based funding to more needs-based funding), capitalizing on existing community and volunteer resources, as well as continuing to work on improving the efficiency of existing services (e.g., Advanced Access) were seen as opportunities to address these pressure points from a reactive approach for long-term improvements.</p>

## S2. Comprehensive Person-centered Services

Comprehensiveness of services is dependant on the providers’ ability to deliver services that meet the unique needs of their patients across the life cycle, with different social determinants, from different geographic locations, with a spectrum of clinical needs, and who may be at varying points in the treatment or management of their illnesses and injuries (e.g., health promotion to palliative care).<sup>i</sup>

FEEDBACK ON STANDARD
<p><b>SUPPORT FOR STANDARD</b></p> <p>While considering all aspects of one’s well-being was considered ideal in patient care, terms such as “comprehensive,” “holistic,” “person-centred,” “adaptability,” and “user-friendly” were used to indicate the need for unique attention to be paid to patients’ personal needs and preferences (in both their treatment decisions and how they access services).</p> <p><b>RECOMMENDATIONS FOR IMPROVING THE STANDARD</b></p> <ul style="list-style-type: none"> <li>• What are other jurisdictions doing?</li> <li>• Revisit “non-discriminatory.”</li> <li>• Define Comprehensive, Continuous services.</li> <li>• Acknowledge all are starting at different places with subjective interpretations of outcomes.</li> <li>• Include opportunities for cultural considerations within MyHTs (e.g., First Nations).</li> </ul>

CRITERIA	THEMES	FEEDBACK
Treatment	<b>Holistic</b>	<p>Considering the many facets of one’s well-being, as opposed to focusing on injuries or conditions was seen as ideal. To experience this holistic approach to care, patients would need to be able to access a broad group of experts, from health to social and community service providers (e.g., addictions, social work, education, welfare, justice, shelters, ACCESS Centres). It was believed that this could help with addressing some of the root causes of health issues, such as diabetes and low socioeconomic status.</p> <p><u>Recommendations for How to Address this Standard</u></p> <ul style="list-style-type: none"> <li>• Boston’s Hereditary Hemorrhagic Telangiectasia (HHT) Center</li> <li>• WRHA Integrated Model: <a href="http://wis.fsh.internal/pub/2008QRGFinal.pdf">http://wis.fsh.internal/pub/2008QRGFinal.pdf</a></li> </ul>
	<b>Person-centred</b>	<p>While multi-faceted, patients’ needs are unique to their own circumstances (e.g., culture, determinants of health, health status, geography) and preferences. As a result, a successful care plan will vary by patient. Knowing that one’s provider is aware and delivering on these unique needs appeared to be key standard for successfully coordinated care. (<i>See Health Equity and Patient Preference, B2</i>)</p>
System Navigation	<b>User Friendly</b>	<p>In addition to ensuring comprehensiveness and patient centeredness in treatment types, how patients access those services should make sense and be characterised by ease as well. This can include both generically improving the user-friendliness of the system (e.g., universal design; in <i>System Navigation and Engaged Patient, S3</i>), as well as more focused ways of designing and adapting a care plan at the service delivery level based on patients’ preferences.</p>



### S3. Engagement & Self-management

People are “empowered with the right information and assistance to make informed choices” and engage as integral participants in their care; to the degree that they are willing and able.

<b>FEEDBACK ON STANDARD</b>
<p><b>SUPPORT FOR STANDARD</b></p> <p>Similar to S2, ensuring that treatment decisions and patient navigation are informed by patients’ needs first was similarly identified as important for the purpose of patients’ engagement and self-management of their own care plans. Patients, who are willing and able, may be empowered to take a lead role in the management of their health and care, if they are adequately supported by service providers and if the process of navigating the system is sufficiently user-friendly.</p> <p><b>RECOMMENDATIONS FOR IMPROVING THE STANDARD</b></p> <ul style="list-style-type: none"> <li>Besides patient education and care planning, what are other ways of engaging patients?</li> </ul>

CRITERIA	THEMES	FEEDBACK
Engaged Patient	<b>Patient Informed</b>	<p>Feedback suggests patients should feel involved as experts and integral team members in their care planning (which includes patients feeling like providers are aware and open to their knowledge and direction). In addition, by increasing awareness and understanding of services available (as with <i>Aware, S1</i>), patients may feel empowered to make informed decisions about their care.</p> <p>On the other hand, some participants felt engagement and self-management had the potential of putting too much onus on the patient/family. Even as a “strong patient driver,” M. Jordan described the challenges of being a self-advocate in his own care, which could be overly exhausting or time-consuming for other patients (esp. vulnerable or complex groups). This highlights the importance of patient input and having them take a role in self-management based on their willingness and capacity to do so.</p>
System Navigation	<b>User-friendly Design</b>	<p>Though person-centeredness raises the need for personalized care plans, feedback also highlighted the importance of user-friendly system design. In other words, while the need for a navigator or case coordinator is sometimes essential for more vulnerable and complex patients, the majority of people should feel that the process for accessing services is clear and easy to execute on their own.</p> <p>The concept of “every door is the right door” or “no wrong door” (in <i>Shared Accountability, B1</i>) and technological advances (in <i>Technological Advances, B2</i>) are further described to demonstrate how system redesign was thought to contribute to greater patient experiences.</p>

## S4. Continuous Services

People are confident in the reliability and stability of their medical information (i.e., how it is collected, stored, shared, updated), provider relationships (i.e., most responsible provider), and access to services (i.e., seamless access to services).

<b>FEEDBACK ON STANDARD</b>
<p><b>SUPPORT FOR STANDARD</b></p> <p>Continuity of relationships, information, and care were all supported by workshop feedback. In particular, participants highlighted the need for a reliable and seamless wrap-around approach to act as a safety net in ensuring care plans are developed and carried out and gaps are addressed.</p> <p><b>RECOMMENDATIONS FOR IMPROVING THE STANDARD</b></p> <ul style="list-style-type: none"> <li>• Need to include component of care and trust.</li> <li>• Note, in some cases barriers may arise as a result of resource or capacity issues, whereby SC is the solution not the problem.</li> </ul>

CRITERIA	THEMES	FEEDBACK
Relationships	<b>Care &amp; Trust</b>	<p>Feedback suggests the desire for a consistent provider contact with whom patients can build a sense of trust and confidence. In these patient-provider interactions, communication that demonstrated respect and validation of patient preferences was seen as key, by contributing to patients' feeling "comfortable," "cared for," "heard", "believed," "understood," and "valued." In addition, the consistency of the patient-provider relationship would likely be associated with providers' understanding of patients, their preferences, and their care plan; thereby, reducing the need to repeat themselves at contact points within the system. See <i>Most Responsible Provider (B1)</i>.</p> <p>It was recommended that providers be trained on how to be compassionate and aware of cultural preferences in their interactions with patients (i.e., cultural competencies).</p>
Seamless Access (Mgmt)	<b>Wrap Around</b>	<p>Though system navigation is not standardized, the need for "better linkages" and "warm handoffs" to address gaps in care through wrap-around processes was seen as essential. In particular, participants felt patients who are unable to advocate for themselves sometimes fall through the cracks of an overburdened system. As a result, ongoing touch points and follow-up phone calls were seen as providing an opportunity to check-in with patients to ensure they felt informed, engaged, and satisfied with the follow-through on their care plans (not forgotten).</p> <p>Follow-up with other providers could also act as safety net to ensure patients or referrals are not blocked or lost from staff or technological errors. For example, communication between acute and primary care was seen as a significant gap in need of reform, particularly as it related to discharge planning and transition points between the two sectors. One group described a model service provider as someone who would "stay in touch and call until the appointment happens." While this may be ideal, resource limitations</p>

		(volume and complexity of patient load) may make this impossible. Requirements and benefits re: ongoing communication, feedback, or follow-ups are reviewed more in <i>Processes</i> (B4).
Reliable Info Sharing	<b>Providers</b>	With supporting <i>Seamless Access (S4)</i> , proper distribution and uptake of information between providers was said to influence patients' experience when interacting with their providers. In particular, participants felt most patients were under the assumption that their provider had access to their health information when in reality standardized information sharing processes were not in place. As such, a need to promote concise, consistent, and timely transfers of information between providers was identified in <i>Processes</i> (B4), in hopes of maximizing patients' experience (e.g., concern, repetition, service duplication, oversights in care).
	<b>Patients</b>	With the growing importance of patient engagement and self-management comes the challenge of ensuring information relevant to patients' care also flows to them in a timely and consistent manner.

## **BEST PRACTICES**

### **B1. Inter-professional Accountability**

Service providers take responsibility for the interests of individuals both within their own service, as well as across the service system as a whole.

<b>FEEDBACK ON BEST PRACTICE</b>
<b>SUPPORT FOR BEST PRACTICE</b> Findings show a need for all providers to be responsible for SC, with one who is most responsible.
<b>RECOMMENDATIONS FOR IMPROVING THE BEST PRACTICE</b> <ul style="list-style-type: none"> <li>• Coordinators were identified as a priority for particular complex patient groups, though many felt sustainability should be considered.</li> </ul>

<b>CRITERIA</b>	<b>THEMES</b>	<b>FEEDBACK</b>
Most Responsible Provider	<b>Attachment</b>	<p>Participants identified a need to have a provider take on the lead role in a patient’s care and system navigation. In general, participants recommended family physicians take on this role, given historical patterns of doing so. However, participants were also open to identifying other professionals within MyHTs to take on this responsibility.</p> <p><b>Service Coordinator/Connector/Case Manager:</b> Someone to manage and link patients and providers to appropriate resources and services was greatly endorsed as a way to support those with complex care needs or challenges navigating. For example, one group shared: “the liaison nurses in emerg[...] become the navigator for the crisis, but once the crisis is done, they’re back where they were. It would be wonderful to expand and enhance that.”</p> <p>That being said, funding a designated coordinator for all Manitobans would prove challenging. As indicated in <i>System Navigation (S3)</i>, not all patients require or desire this level of support. It was suggested to MyHTs or other practices to identify one member or train all members to act as case managers or service coordinators for patients with complex care needs “who can’t do it on their own.”</p>
Shared Accountability	<b>Shared Accountability</b>	<p>The concept of “every door is the right door” or “there is no wrong door” was seen as a best practice in support of <i>System Navigation (S3)</i>. This system design encourages each provider/staff (regardless of the most responsible provider) to be responsible for connecting patients to the right provider, as opposed to hiring staff devoted strictly to SC; meaning, QuickCare Clinics are just as responsible for getting patients to the next level of care as a Nurse at an ACCESS Centre. See <i>Collaboration, Integration, &amp; Partnerships (B3)</i> for more information.</p>

## B2. Person-centeredness

“Service delivery is driven by the needs of the consumers and the community rather than the needs of the system, or those who practice in it.”<sup>1</sup>

FEEDBACK ON BEST PRACTICE
<p><b>SUPPORT FOR BEST PRACTICE</b></p> <p>As with S2, there was great interest in supporting patient-informed and user-friendly services and programs, as a way of improving the patient experience, engagement, and self-management. Furthermore, “Upstream,” Early identification and intervention,” “Health Promotion,” “Prevention,” “Harm Reduction,” and “Maintenance” were concepts participants felt should be considered when defining and applying a Health Equity Lens and Principles of Harm Reduction to future primary care.</p> <p><b>RECOMMENDATIONS FOR IMPROVING THE BEST PRACTICE</b></p> <ul style="list-style-type: none"> <li>• How to develop outreach plan?</li> <li>• Person-centered: What does it mean in terms of moving forward?</li> <li>• Add family-centred.</li> <li>• Consider how increased volumes from outreach will influence access.</li> </ul>

CRITERIA	THEMES	FEEDBACK
Health Equity	<b>Target Vulnerable Complex</b>	<p>Participants extensively discussed the need to focus system redesign on what patients need (with patients faced with more barriers being the group with the most needs). Given that equal opportunity does not necessarily equate with equal access, it was suggested that providers proactively prioritize a) <i>vulnerable patients</i> needing extra support with removing barriers to access services or b) coordinating a multitude of services for <i>patients with complex care needs</i>. Participants felt a health equity lens should be developed to support systematic consideration of social determinants of health and demographics, which could be contributing to patients’ being disproportionately privileged or disadvantaged in accessing services.</p> <p><u>Recommendations for How to Address this Best Practice</u></p> <ul style="list-style-type: none"> <li>• Consideration of EMR Poverty Tool</li> <li>• Target low SES to promote prevention opportunities</li> <li>• Rural MyHT with SW or outreach worker</li> <li>• Mobile Clinics with Mobile Teams</li> <li>• Telehealth for care to rural and remote areas.</li> <li>• Transportation (Taxi Vouchers- “like gold”)</li> <li>• PC triage to prioritize complex/vulnerable patients.</li> <li>• Selected flex-appointments to allow for quick follow-up appointments for patients with multiple/complex issues.</li> <li>• Navigator, quarterback, facilitator to lead coordination efforts for</li> </ul>

<sup>1</sup> Primary Care Partnerships. (2012). *Victorian service coordination practice manual*. Melbourne, BC: Victorian Department of Health. Retrieved from: <http://www.blpcp.com.au/Victorian%20Service%20Coordination%20Practice%20Manual.pdf>

		vulnerable and complex clients who cannot on their own.
Prevention & Health Promotion	<b>Upstream</b>	<p>Though each person will have unique needs, participants felt strongly that a wellness component, such as in harm reduction, prevention of illness and injury, as well as health promotion and maintenance (e.g., education, early intervention efforts specific to a community’s particular need), should be included. Currently, participants felt that a lack of investments in early intervention have contributed to an increase in reactive health care for a number of potentially avoidable health conditions.</p> <p><u>Recommendations for How to Address this Best Practice</u></p> <ul style="list-style-type: none"> <li>• Partner with Healthy Living Healthy Populations to implement more screening opportunities (e.g., Screening and Brief Intervention Referrals, Early Development Instrument)</li> <li>• Train educators to target children, adolescents, and families</li> <li>• Increase community activities emphasizing health promotion</li> </ul>
Patient Preference	<b>Patient Informed</b> <b>User-friendly</b>	<p>Asking patients to identify their priorities within their care plans was seen as a way of making patients the “driver” in their own care. Participants overwhelmingly identified that providers should be responsive to patient preferences, which may be different than provider/clinic priorities.</p> <p>Technology was identified as supporting system navigation through other examples, including Family Doctor Finder, an enhanced version of a Health Links/PHCC, components of the Consumer Health Strategy (including an 811 service, online health portal, self-management support programs), traceable eReferrals, or a Phone Application. These would offer some level of direction to patients and providers re: accessing providers, referrals, programs/services, and other elements of system navigation.</p>

### B3. Collaboration, Integration & Partnerships

Service providers reach out to collaborate, build alignment and relationships, as well as establish agreements with partners within and across sectors.

<b>FEEDBACK ON BEST PRACTICE</b>
<p><b>SUPPORT FOR BEST PRACTICE</b></p> <p>Support for improving provider awareness (i.e., community programs and services, scopes of practice), teamwork and relationship building. Addressing funding and remuneration barriers to SC were identified as future opportunities for improving collaboration between providers.</p> <p><b>RECOMMENDATIONS FOR IMPROVING THE BEST PRACTICE</b></p> <ul style="list-style-type: none"> <li>• Recommend how to address overlap in scopes of practice.</li> <li>• Identify realistic ways to increasing accessibility of specialists.</li> <li>• Include Cancer Patient Journey as the model for collaborative practice.</li> </ul>

CRITERIA	THEMES	FEEDBACK
Awareness	<p><b>Trends</b></p> <p><b>Services/ Resources</b></p> <p><b>Processes</b></p> <p><b>Scopes of practice</b></p>	<p>Words, such as “disconnected”, “ridged”, “siloed” and “fragmented,” were used to describe how services are currently being delivered in silos. While a small number of providers were described as content with the current state of system navigation, participants generally felt they lacked the foundational knowledge of other programs and professions (e.g., scope of practice) necessary to ensure maximum effectiveness and efficiency when referring patients to other health and social services (<i>as described in B1</i>). For example, some described:</p> <ul style="list-style-type: none"> <li>• Being unaware of the difference between RNs and NPs,</li> <li>• Disconnect faced by health promoters and addiction workers,</li> <li>• Underutilization of social work and physician assistants due to not knowing scopes of practice, and</li> <li>• Fear of being treated as a “referral dumping group” (RHA staff).</li> </ul> <p><u>Recommendations of Approach to Address this Best Practice</u></p> <ul style="list-style-type: none"> <li>• <b>Community Service Events:</b> (e.g., block parties) to bring together groups to learn about community trends, resources, services, as well as other professions’ operating environments, referral processes, role clarity, and scopes of practice (e.g., myth-busting , inter-professional education) in one’s community.</li> <li>• <b>Resource Toolkit:</b> A standard tool, such as an enhanced version of Health Links, centralized repository, interprofessional toolkit, or catalogue of services, whereby providers can gather current snapshots and descriptions of available services and providers.</li> <li>• <b>Care Pathways:</b> Outlining anticipated care activities within embedded timelines and documentation requirements were seen as a way of streamlining access to care. Cancer Patient Journey was identified as a leader in pathways, which participants felt should be replicated across the health system.</li> </ul>

Collaborate	<b>Relationship/ Communicate</b>	<p>Developing “close knit relationships,” respect, and trust within and across other sectors through bi-directional communication and collaboration was emphasized as a best practice. Initiatives underway (e.g., MyHTs, ITDI, PIN) were seen as promoting interprofessional practice by streamlining relationships and referrals between the partners. By becoming more aware and building these relationships, providers have a better understanding of each other’s role and are able to better connect patients to existing resources.</p> <p><u>Recommendations for How to Address this Best Practice</u></p> <p><b>Communication:</b> Developing a communication structure was suggested to improve the transfer and uptake of information, as well as to address working in silos, including community partners and front-line clinic staff. See <i>Standardized Transmission of Information (B4)</i>. Rural areas described an increased ability to informally collaborate by being more connected and able to “work more outside of [their] mandate.”</p> <p><b>Co-location:</b> while identified as a possible solution, co-location without system integration was not seen as guaranteeing provider integration.</p> <p><b>Community Engagement &amp; Capacity Building:</b> Building capacity through community programs and volunteers was seen as an opportunity and possible alternative to funding a position. Offering training to existing key informal community supports, such as educators, parish nurses, Aboriginal Diabetes Initiative worker, bus driver, or local agencies who already play a role in connecting their community members to resources in informal ways (e.g., chronic disease, diet, activity, mental health) but whom would greatly benefit from additional education or training.</p>
Models of Funding	<b>Remuneration Incentives Siloed Funding</b>	<p>Suggestions were made regarding funding and remuneration for those coordinating services for patients with complex care needs:</p> <p><u>Recommendations for How to Address this Best Practice</u></p> <ul style="list-style-type: none"> <li>• Continued support for interdisciplinary teams through expansions of shared care and blended funding models.</li> <li>• Provide the right incentives for comprehensiveness and coordination (e.g., remuneration for working with teams, work-life balance, panel size) that are clear and won’t compete with incentives for access.</li> <li>• Business owners need support with planning to cover costs incurred once initial MyHT/ITDI funding ends.</li> <li>• Provide the right remuneration for serving complex patients: <ul style="list-style-type: none"> <li>○ Tariffs associated with “quality of care” or “quality of outcome” and not just “output” (e.g., palliative care).</li> <li>○ Paying nurses in FFS clinics for serving complex patients.</li> <li>○ Remunerate all aspects of care (not only face-to-face) to ensure maximum efficiency and effectiveness.</li> </ul> </li> <li>• Legislation to allow consent for electronic transmission of funds.</li> <li>• Address siloed department funding in MHSAL, where branches are working against one another.</li> </ul>



## B4. Standardized Documentation and Transmission of Information

Timely, complete, and reliable documentation and transmission of information is offered as a basis to consistently coordinated service delivery.

FEEDBACK ON BEST PRACTICE
<p><b>SUPPORT FOR BEST PRACTICE</b></p> <p>Generally, feedback reflected that in the absence of a standardized forms and processes for documenting and sharing information, everyone is left “coordinat[ing] differently,” with some relying on chance, advocacy, “one-offs,” or back doors to connect patients to the appropriate care and services. In terms of referral processes, many service areas continue to lack accountability re: wait times and feedback requirements; thereby negatively affecting the quality of care (esp. primary and acute).</p> <p><b>RECOMMENDATIONS FOR IMPROVING THE BEST PRACTICE</b></p> <ul style="list-style-type: none"> <li>• Need to explore unintended outcomes of technology, such as alienating patients, and recognizing that “sometimes you just need a human body,” as opposed to a phone or online resource.</li> <li>• How to implement these processes at a system level.</li> </ul>

CRITERIA	THEMES	FEEDBACK
Process	<p><b>Document</b> (What)</p> <p><b>Deadlines</b> (When)</p> <p><b>Transfer</b> (Who)</p>	<p>As described in <i>Awareness</i> (B3), pathways that outline anticipated care with embedded timelines and documentation requirements has the potential of streamlining and improving <i>Continuous Services</i> (S4) by increasing providers’ awareness of what has happened, what needs to happen, who is responsible, and when are activities supposed to occur by (e.g., when to expect a call, what test results to anticipate). Having the appropriate information may then allow providers to be more effective and efficient in care planning with patients.</p> <p>Similar benefits could be said for developing protocols re: information documentation and leveraging information technology. Alternatively, faxing was unanimously seen as contributing to what participants referred to as “the black hole of referrals,” whereby referrals are delayed or lost in transition. Besides being more user-friendly and increasing awareness of what pertinent information to include, EMRs now have the ability to prompt/remind providers of resources, treatments, documentation requirements, follow-ups, and timelines, in order to ensure continuous quality care.</p>
Tools	<p><b>Information Technology</b> (How)</p>	<p>Care pathways and “savvy IT systems” were highlighted as addressing some procedural disorganizations and delays between specialists (e.g., radiologists) and primary care providers. Some of these include:</p> <ul style="list-style-type: none"> <li>• <b>Shared EMRs:</b> Participants felt providers should have access to integrated EMRs and supports to facilitate meaningful use.</li> <li>• <b>eChart:</b> expand beyond specialty use</li> <li>• <b>eReferrals:</b> Participants described the need for a tool where providers and patients could track their referrals in real time. Others referred to the possibility of online patient booking.</li> <li>• <b>Telehealth:</b> expand to be accessible in more rural and remote areas</li> </ul>

## B5. Continuous Efficiency Improvement Processes

A culture where opportunities to improve the efficiency [and quality] of service delivery and office practices are sought out on an ongoing basis.

<b>FEEDBACK ON BEST PRACTICE</b>
<p><b>SUPPORT FOR BEST PRACTICE</b></p> <p>This best practice was supported through participants’ various requests for measurements (e.g., efficiency, cost-effectiveness, provider communication, patient satisfaction, service integration, complexity, quality, quantity, handoff reliability, team performance). This as well as other comments demonstrated support for ongoing evaluation and monitoring efforts for continuous improvements.</p> <p><b>RECOMMENDATIONS FOR IMPROVING THE BEST PRACTICE</b></p> <ul style="list-style-type: none"> <li>• Develop indicators.</li> <li>• Do not spend too much time fixing flawed relationships or a broken process.</li> <li>• Need to identify a logic model for continuous quality improvement.</li> </ul>

CRITERIA	THEMES	FEEDBACK
Measurement	<b>Tools</b>	<p>Participants recommended identifying and measuring anticipated outputs and outcomes to determine if we are meeting our targets.</p> <p><u>Recommendations for How to Address this Best Practice:</u></p> <ul style="list-style-type: none"> <li>• <b>“Triple Aim” approach:</b> measure against improvements to patient experience, the health of populations, and reductions in the per capita cost of health care.</li> <li>• <b>Plan-Do-Study-Act:</b> implement regular tests of change and implementing those that demonstrate improvement.</li> <li>• Require <b>Advanced Access</b> training</li> <li>• Build standards and practices as they weave into EMR to increase efficiency.</li> <li>• <b>Peer-to-Peer training</b> included in <i>Collaborate (B3)</i>.</li> <li>• Commitment to implement <b>LEAN project</b> for each site to help move through the implementation and process mapping</li> </ul>
Stakeholder Involvement	<b>Change Management</b> <b>Buy-In</b>	<p>Change management support was seen as one of the biggest barriers to implementing system redesign, given the challenge of getting physician buy-in. This will require much consultation with providers throughout (as well as consideration of the availability of providers and other relevant barriers). Furthermore, participants identified the need for a review of the framework from a public standpoint as well.</p>
Prioritization	<b>Ongoing Time</b>	<p>It was stated that continuous quality improvement will be ongoing and take time, thus requiring a process for prioritization. This process of decision-making should be informed by data.</p>

## V Next Steps

The focused learning objective for the SC Workshop was “to review and provide feedback on the four SC Standards and five Best Practices within the context of My Health Teams (MyHTs).” Based on workshop feedback, participants provided overwhelming support for the proposed standards and best practices presented in the framework. Feedback collected over the course of the day will be used to inform next steps related to Service Coordination across MHSAL and for key partners (e.g., regional health authorities, community organizations, fee-for-service practices). Specifically, feedback will be used to update and finalize the SC Standards and Best Practices, as well as inform the types of barriers and opportunities that will be prioritized, how they could be addressed (e.g., policy development) and evaluated/monitored (e.g., SC Indicators). This will be done in the context of MyHTs, through the Year 3 Service Plan; at a Primary Health Care level, through branch initiatives; as well as at a system level, informing future health care policy reform more broadly. In particular, participants highlighted the need to:

- Address barriers created by the Personal Health Information Act and program criteria;
- Increase focus on health equity and upstream approaches for a more person-centered approach;
- Ensure shared accountability (i.e., no door is the wrong door) for continuous services for patients;
- Standardize documentation and transmission of information (includes leveraging information technology) to systematically engage patients and promote continuity of care; and
- Increase provider awareness of available services and other provider’s scopes of practice.

These represent but a few examples of implementing the Service Coordination Framework. We would encourage all participants to bring these findings back to their own respective places of work to inform future priorities and planning related to service coordination. Kristin Anderson ([Kristin.Anderson@gov.mb.ca](mailto:Kristin.Anderson@gov.mb.ca)) and Monika Wetzel ([Monika.Wetzel@gov.mb.ca](mailto:Monika.Wetzel@gov.mb.ca)) are available to answer any questions or concerns, as well as to provide formal or informal presentation on the workshop findings and/or the Service Coordination Framework.

## VI Appendices

### Appendix A: SC Workshop Agenda

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# Primary Care

**SC Workshop**  
**Friday, October 30, 2015**  
**Canad Inns Destination Centre Polo Park - Winnipeg**  
**Ambassador Banquet Rooms 1 and 2**

**Intended Audience:**

- MyHT Planning/Steering Committee members
- RHA Primary Care, Public Health/Healthy Living, Continuing Care and Mental Health leads
- MHLS SC Advisory Committee members
- Manitoba Health, Healthy Living and Seniors
- Day 1 participants as desired

**Learning Objective**

1. To develop a common understanding of SC standards and best practices within the context of My Health Teams.

**Agenda - Friday, October 30, 2015 (AM only)**

8:00 AM	Registration and Continental Breakfast
8:30 AM	<b>My Health Team 101</b> (Introductory session for those new to My Health Teams) Presenter: Laura Morrison
8:50 AM	Break - 10 minutes
9:00 AM	<b>Welcome and Objectives for the Morning</b> Chair and Facilitator: Kristin Anderson
9:05 AM	<b>SC Framework Overview</b> Presenter: Kristin Anderson
9:30 AM	<b>Patient Experience: SC Standards</b> Presenter: Michael Jordan - Canadian Mental Health Association Group Discussion
10:50 AM	Break - 10 minutes
11:00 AM	<b>Provider Perspective: SC Best Practices</b> Presenter: Donna Bell - Cancer Patient Journey Presenter: Dr. Kevin Coates - St. Boniface Clinic Group Discussion
12:25 PM	<b>Closing Remarks and Buffet Lunch</b>

## Appendix B: SC Workshop Evaluation Results

### 39 Responses from 112 delegates - 35% response rate

#### 1) What type of organization do you represent? Check all that apply.

PIN Site	MyHT	FFS Clinic	RHA	MHLS	Other
6	10	7	27	1	4

#### 2) Overall, did you find the SC Workshop beneficial?

Yes - In what way?	No - Why not?
38	2

#### Comments:

- 😊 Very - collaboration is never bad! Appreciated the patient experience + Michael
- 😊 Laura's presentation on MyHTs was a good refresher to reflect on where we've come + still need to go
- 😊 Yes - liked the interprofessional approach at the tables - helped to have informed discussions
- 😊 I think it will be useful to policy makers more than to participants. Hopefully this info is used to improve the system.
- 😊 Yes - info sharing, priorities discussed
- 😊 New information presented, meet other colleagues in the province
- 😊 I have a better understanding of MyHT
- 😊 Yes - good exchanges of ideas and suggestions
- 😊 Opportunity to dialogue with various providers
- 😊 Yes - great background info on MyHT + SC. Great discussion. Solution focussed.
- 😊 Good opportunity to hear from + network with other clinics + MyHT/ITDI providers about things that are working well + challenges
- 😊 Great to hear the different perspectives and to have the group discussion
- 😊 Opportunity to discuss topics
- 😊 Beginning to understand SC + thinking about future planning for Y3 priorities
- 😊 Interesting + beneficial to hear perspective/experiences of primary care providers
- 😊 Talk about communities/interaction
- 😊 It was good to hear different people presenting their perspective
- 😊 Very! Lots of great collaboration + commonalities [unable to read word]
- 😊 Opportunity to think about how the community health centres fit into health system + can support MyHT
- 😞 Very broad discussions
- 😊 Learning about the work of other service providers
- 😞 I didn't have enough background to follow the presentations of the two service providers
- 😊 Better understanding of successes + challenges across the province
- 😊 Yes - good table discussion
- 😊 Yes - excellent discussions/sharing of ideas
- 😊 Small group discussions were very dynamic with excellent viewpoints from different areas + positions
- 😊 I think it was important to be here. We need to do more of this big picture thinking - there has been so much focus on task + patient attachment over quality of care + working together
- 😊 Good discussion topics
- 😊 Networking is excellent - the opportunity to discuss ideas and participate in larger vision planning is beneficial to every person in the province

- ☺ Recognize common themes of service inefficiencies
- ☺ Wonderful!
- ☺ Good discussion and presentations. Valuable to see different perspectives.
- ☺ Helpful to look at the GAPS in system + give feedback regarding opportunities to change
- ☺ Reinforcement of need to work as a team
- ☺ Insight to other areas/department issues - still not clear understanding of MyHT
- ☺ Patient experience session helped re-focus our planning discussions
- ☺ Very useful - opportunity to discuss issues of daily practice, to collaborate with other areas (public health, etc)
- ☺ Important to start engaging community service stakeholders

**3) Was the following objective achieved? Include specific feedback as applicable.**

Learning Objective	Not Met	Partially Met	Fully Met
Develop a common understanding of SC standards and best practices within the context of My Health Teams.	1	18	19

**Comments:**

- Learned a lot but wonder about what this means for primary care outside of MyHT
- We are on the way - good dialogue occurred
- Will take time
- We are getting there
- Will think about how our center fits into system
- We are getting there - good info/discussions, now need more info to put it into practice
- This just scratches the surface
- Very well done

**4) Was the location convenient?**

Yes	No
38	0

**5) What would you recommend for future topics?**

- Integration of public health + opportunities to increase focus on health equity
- Best practice models featured on SC, etc
- Discussion/presentation on FFS vs. contract service delivery
- MyHT Y3 planning themes + priority areas - learn from each other
- How MyHT can interact with community
- Community health centres
- How can we promote health equity? Coordination of social services along with health services
- Innovative success
- More workshops on the same topic
- Health promotion (with leadership from PH + HL)
- Regrouping in a designated time frame to reflect on what has been accomplished/further developed post today - what is next - need to keep it moving

- *Challenges facing rural vs. urban FFS clinics/providers – streamlining access to care across programs/clinics, etc*
- *Future opportunity to liaise, share resources, etc*
- *How to level the playing field so that Access Centres, community clinics + My Home Clinic share their resources with FFS doctors*
- *Ongoing dialogue with additional providers - at least for a portion of the day*

**6) Is there any follow-up information you would like from the PHC Branch or any of the presenters/facilitators? If so, please describe and include your name and address.**

- *I would very much appreciate what Michael Jordan's feedback would be for an improved mental health system*

**7) Any other comments?**

- *The small table dialogue was more engaging today, possibly because the topics were more focussed + we were able to relate to them, as well the strategic groupings were helpful for mixing + dialogue also*
- *Great job - very thought provoking*
- *Good meeting*
- *Very good morning*
- *Explore the concept of polarity partnerships - it isn't either/or but both eg. change/stability, transformation/continuity. Innovation/standardization - more focus on health equity approach*
- *Excellent 2 days*
- *Liked that you split us up to showcase different regions + programs*
- *Increasing focus on MH makes lots of sense - needs to include mental wellness + health promotion not only illness care which is found outside of mental illness care system - need greater focus on health equity*

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<sup>i</sup> The College of Family Physicians of Canada. (2011). Family Practice: The Patient's Medical Home.