HealthLinks

Case Study – Participant Copy
Learning Collaborative - Cohort 3 Session 1

Section 1– Introduction: Identification

Section 1A – Meet Dena

The details contained in this case study are fictitious. The term 'patient' was used in this case study which can be interchangeably used with 'client'.

Participants review the following case story:

Nurse Penny at the Health Centre is worried about Dena. Dena was scheduled for an appointment to see her family physician, Dr. Brown, for follow-up after being discharged from the hospital. Her husband, Monti, has just called to cancel the appointment. Penny speaks with Dr. Brown about her concerns and together they review Dena's chart. Immediately, they notice that Dena has not been seen in the office for over 6 months but during this period of time she has been to the local Emergency Department five times. On three of those occasions she has required admission to the inpatient medicine unit. After reviewing the Emergency Department records on file, and two of the three Hospital Discharge Summaries (one of the discharge summaries could not be located), they see that Dena presented to the hospital with various complaints including: shortness of breath, dizziness, lethargy, and pain. The Discharge Summaries also indicate that Dena's medications have been adjusted and changed to help manage exacerbation of her COPD, unstable blood sugars and hypertension. The last Emergency Department assessment had included an Assessment Urgency Algorithm (AUA) assessment with a scoring of 6, which suggests a Coordinated Care Plan be considered, among other interventions.

Additional information that Dr. Brown and Penny had collected over the years while caring for Dena and some of her family members is as follows:

Dena was born and raised in a First Nation community located within the South West LHIN geography. At age 6, she was removed from her family to attend a residential school, located 10 hours away from her home community, where she was institutionalized until she was able to leave school at the age of 15. After she left school, she moved back home and started dating Monti and they were married in their late teens. Their family home is located in the First Nations community. Dena became pregnant with their first of five children soon after their wedding. Monti worked as the meat manager at the local grocery store. Dena was kept busy caring for the children and did not work outside of the home.

At ages 77 and 79, respectively, Dena and Monti continue to live in their home where they raised their children. Four of their five children currently live in various locations across south western Ontario and one son lives nearby. Dena lives with Type 2 Diabetes, arthritis in both knees, hyperlipidemia, hypertension and Chronic Obstructive Pulmonary Disease (COPD).

Monti is retired and is Dena's main caregiver. Although their son lives nearby, he works full time so he is not able to spend a lot of time helping his parents. Dena and Monti have many nieces, nephews, and cousins who often drop in to check in on how they are doing. Monti ensures that Dena takes her medications throughout the day. He also makes the meals and maintains the house. He suffered a minor stroke two years ago that slightly affected his speech and mobility but he is still able to drive.

Dena and Monti have attended the federally funded Health Centre in their community for many years and have built trusting relationships with staff there, including Nurse Penny. They are fond of Dr. Brown, but they express frustration with the lack of access to him, as he is only available one day a week at the clinic. This has resulted in Dena's frequent use of the Emergency Department to manage acute health issues, even though she doesn't like going there. It takes 30 minutes to get to the hospital and she knows that Monti doesn't like driving. She's unfamiliar with the hospital staff and doesn't always feel she receives unbiased respectful care.

Medication: Metformin 750 mg twice daily (last hospitalization increased from 500 mg twice daily); Acetaminophen extra strength twice daily; Rosuvastatin Calcium 20 mg once daily; Perindopril 12 mg once daily (last hospitalization increased from 8mg); Prednisone 5 mg once daily (added 2 hospital admissions ago); Lorazepam 2mg as-needed;

Salbutamol Sulfate 2 puffs as needed; Fluticasone / Salmeterol 1 puff twice daily and Aclidinium bromide / formoterol fumarate dihydrate 1 inhalation twice daily prescribed upon discharge from the most recent hospitalization.

Section 1B– Presentations

1. 'Coordinated Care Planning' presentation provides participants with foundational knowledge about the Coordinated Care Planning process. Content includes information provided in the document "Coordinated Care Planning – Information for Health and Social Service Providers" and "Intro to Health Links Approach to Coordinated Care Planning" slide deck. The graphic "Coordinated Care Planning – Process Map" is presented to show participants a high level overview of the process.
    - 8 minute duration, presented by: Rebecca Sutcliffe & Jeni Millian. Presentation is 5 minutes + 3 minute Q&A = 8 minutes.

2. 'Understanding the Challenges of Indigenous Peoples' presentation discusses the intergenerational impacts on those who attended residential school. Presentation discusses health equity and describes resources available to best support the Indigenous population. Presentation inspires participants to register for the Indigenous Cultural Competency training.
    - 25 minute duration, presented by: Jan Martin & Marianne Hebb. Presentation is 18 minutes + 7 minute Q&A = 25 minutes.

3. Health Equity' presentation discusses how our health is heavily influenced by race, gender, social status, education and physical environmental factors. The presentation highlights the impact of the social determinants of health and discusses poverty, housing and food security as predictors of potential high-cost users of health care.
    - 10 minute duration, presented by: Lynn Beath. Presentation is 8 minutes + 2 minute Q&A = 10 minutes.

4. 'Assessment Urgency Algorithm Tool' presentation discusses the benefits of using the AUA tool to identify patients who may require specialized geriatric services. The AUA tool can be leveraged to identify individuals who would benefit from Coordinated Care Planning.
    - 10 minute duration, presented by: Shelly Billings. Presentation is 8 minutes + 2 minute Q&A = 10 minutes.

Section 1C – Exercise (5 minutes)

1. Review the following documents:
    - Poverty Screening package
    - AUA tool
    - Coordinated Care Planning – Information for Health and Social Service Providers
    - What is the difference between Care Conferencing/Patient Rounds vs. Health Links approach to Coordinated Care Planning?

Section 2 – Identification/Referral process

Section 2A: Initial Engagement with Dena

Nurse Penny calls Dena at home. Penny expresses concern about Dena and her well-being. Penny asks if CCAC has arranged a home visit with her following discharge from the hospital. Dena states "I told the hospital Nurse that I didn't need that because Monti helps me". Penny talks to Dena about a referral for a Coordinated Care Plan and explains why it would be helpful and what is involved in the process. After some discussion, Dena agrees to a Coordinated Care Plan if Nurse Penny and Monti can be in attendance with her. Penny completes and faxes the referral form to the CCAC.

Within a couple of days of referral, Maggie, a Care Coordinator from the CCAC, who is assigned to work with the First Nations in the area, contacts Dr. Brown for further information. He expresses his concern about Dena's non-compliant behaviour related to treatment and follow-up. Dr. Brown indicates he is very worried about Dena and provides the information related to Dena's frequent Emergency Department admissions. Dr. Brown recommends that Nurse Penny accompanies Maggie for the initial interview since Penny and Dena have developed a long-standing, trusting relationship with each other.

The Care Coordinator, Maggie, later contacts Dena and arranges for a home visit to obtain consent, identify her goals and determine who should be invited to the Coordinated Care Plan conference. Penny accompanies Maggie to the first in-home visit to help build the relationship between Dena and Maggie.

Section 2B– Presentations

1. 'Coordinated Care Planning' presentation is presented to highlight the stage where identification and referral occurs. The presentation discusses the need to gain informed consent from the patient for coordinated care planning to proceed. Community Care Access Centre (CCAC) referral form is referenced and participants are provided with information that's required to be documented on the form. Presentation discusses the necessity of explaining the Coordinated Care Planning approach to the patient to ensure the patient is not surprised by the initial call made by the CCAC. Timelines for follow-up with the patient and the referring provider by the CCAC are discussed. Participants are requested to follow up with CCAC if they don't receive a response within the timelines.
   - 8 minute duration, presented by: Rebecca Sutcliffe & Jeni Millian. Presentation is 5 minutes + 3 minute Q&A = 8 minutes.

2. 'Clinical Connect' presentation discusses how providers can identify people experiencing 5+ ED visits in one year. Presentation highlights how to electronically share the Coordinated Care Plan and how providers can view the patient's interactions with the healthcare system for ongoing monitoring. Presentation describes the spread of Clinical Connect across the South West LHIN geography and describes who is using Clinical Connect.
   - 13 minute duration, presented by: Alysson Korver. Presentation is 10 minutes + 3 minute Q&A = 13 minutes.

Section 2C – Exercise (5 minutes)

1. Review the "Coordinated Care Planning – Information for Clients and Caregivers" document. How could this document be used in your workplace?

2. Discuss with your table what your next steps would be if you were Nurse Penny and Dena said 'no' to the offer of Coordinated Care Planning.

3. Discuss with your table what you would do if you were Maggie and you didn't feel you had enough information on the referral form to proceed with completing a CCP.

Section 3 – Initial Interview with Dena

Section 3A – Dena's story

Nurse Penny introduces the Care Coordinator, Maggie, to Dena and Monti. Together they explain the benefits of how Coordinated Care Planning can support Dena in reaching her goals. They provide Dena with a copy of the "Coordinated Care Planning – Information for Clients and Caregivers" document. Dena provides consent to the process and to the sharing of information between the care team members.

During the home interview, Maggie notices a wheelchair and asks Dena about it. Dena states that she often uses a wheelchair when leaving the house due to knee pain. Monti shares with them that he finds driving in town stressful and no longer feels comfortable driving at night. Since his stroke, he finds that he tires easily and his strength and mobility have decreased. His declining physical condition makes it difficult to clean the house and help Dena transfer in and out of her wheelchair and the car. He finds it challenging to cook meals from scratch so he often relies on prepared meals from the grocery store.

Monti reports they have a hard time making ends meet on his Canada Pension Plan and Old Age Security income. He states that Dena has no income and his limited income impacts their access to healthy food and the ability to pay for Dena's medications, many of which are paid for out-of-pocket. When they experience mechanical problems with their car, they don't always have the funds to fix it right away which intermittently eliminates their access to transportation.

Their older bungalow home has a wood stove in the kitchen as the main heat source. Maggie notices watermarks and mould on the ceiling near the chimney and kitchen table. There is a bucket positioned near each spot, to catch rain when the roof leaks. Dena often sleeps on a day bed in the kitchen since this is the warmest place in the house. She typically has a sponge bath in the kitchen sink as she finds it too difficult to get in and out of the bathtub. Dena reports coughing a lot more than usual during the night, which wakes her up, and that the dry hacking cough is not the same as the productive one she gets when her breathing is "really bad". Maggie notes a small ulcer developing on Dena's foot.

Maggie reviews Dena's current medications. She compares the medication bottles and inhalers at the home with the list of current medications provided by Dr. Brown. She notes the dosage on the Metformin bottle was 500 mg twice daily, (not 750 mg two times a day); Rosuvastatin Calcium 20 mg once daily; Perindopril 8mg once daily (not 12 mg once daily); Prednisone 5 mg once daily; and the Lorazepam 2mg bottle was empty. The Salbutamol Sulfate inhaler had expired. Dena had no aero-chamber nor the most recently prescribed inhaler Fluticasone / Salmeterol or Aclidinium bromide / formoterol fumarate dihydrate. Monti stated they could not afford the new prescriptions until they received payment from the First Nations and Inuit Health Benefits (FNIHB) plan which would not occur until the next month.

Dena discusses her personal goals during the home visit which include regularly visiting her sister in a neighbouring community, having a weekly bath, getting her hair cut, and attending a monthly visit with the Traditional Healer from the Southwest Ontario Aboriginal Health Access Centre (SOAHAC). Maggie documents these goals on the Coordinated Care Plan.

Penny suggests that the Traditional Healer is invited to the Coordinated Care Plan conference and that their son also attend. Dena likes these ideas and feels that Penny is best suited to the role of Lead Care Coordinator due to their relationship with each other. Maggie asks Dena if there are any specific cultural or community support people that she would like to include on the care team; for example, a Personal Support Worker from the community's Home and Community Care Program, a traditional Elder from the community, a person from the local church, one of her nieces or nephews, or her sister. Together they develop the care team list.

Section 3B– Presentations

1. 'Coordinated Care Planning' presentation where the graphic "Coordinated Care Planning – Process Map" is presented to show participants where in the process the initial interview occurs. This step in the process includes consent, goal setting and identification of the care team. Presentation discusses the necessity for building a rapport with the patient and leveraging existing relationships.
   - 8 minute duration, presented by: Rebecca Sutcliffe & Jeni Millian. Presentation is 5 minutes + 3 minute Q&A = 8 minutes.

2. 'Motivational Interviewing' presentation discusses the importance of guiding people to the creation of their own personal goals and discusses the clinician's role in supporting people to make change they can achieve. Content highlights successful motivational interviewing techniques.
   - 12 minute duration, presented by: Gilles Brideau. Presentation is 10 minutes + 2 minute Q&A = 12 minutes.

Section 3C – Exercise (8 minutes)

1. Using the motivational interviewing techniques demonstrated in the last presentation, practice developing an action plan with the person sitting beside you. One person will be the patient and the other will be the health care provider. Pick one of Dena's goals and help your partner develop an action plan to achieve this goal. (Dena's goals included: visiting her sister in a neighbouring community, having a weekly bath, getting her hair cut, and attending a monthly visit with the Traditional Healer.)

Section 4 – Pre-Conference Meeting & Coordinated Care Planning Conference

Section 4A – Dena's story

Maggie calls the care team members and arranges a pre-conference meeting at the Health Centre. She pre-populates some of Dena's information into the Coordinated Care Plan including demographics, medications, etc. The care team meets and shares their knowledge, based on their interactions with Dena and her health history. Maggie drafts this information into the Coordinated Care Plan.

At a later date, Maggie and Penny attend the full team conference from Dena and Monti's home so they do not need to travel to the Health Centre. They link with the care team at the Health Centre via OTN. During the meeting, Penny confirms Dena's goals and encourages her and Monti to provide additional comments. As a group, they work together to develop a plan to support Dena in reaching her goals and she supports this plan.

Maggie completes the Coordinated Care Plan and commits to providing a copy to each member of the care team within a few days, including a copy for Dena, her son and the elder. Penny asks that everyone update her as action items are completed or if changes are made so the Coordinated Care Plan can be kept up to date.

Maggie encourages all care team members to provide feedback about their experience with Coordinated Care Planning and she provides them with the link to the Provider Feedback Summary:

https://www.surveymonkey.com/r/HL_Provider_Feedback

Maggie mentions to Dena that a Patient Care Assistant from the CCAC will call her in the next couple of weeks to ask if she would like to complete a Patient / Client Feedback Survey over the phone.

Section 4B– Presentations

1. 'Coordinated Care Planning' presentation where the graphic "Coordinated Care Planning – Process Map" is presented to show participants where in the process the pre-conference and conference occurs. Presentation provides participants with knowledge about the pre-conference and conference and how there is flexibility in this part of the process (e.g.: pre-conference may occur days prior to the conference, one hour before the conference or may be combined with the conference).
   - 8 minute duration, presented by Rebecca Sutcliffe & Jeni Millian. Presentation is 5 minutes + 3 minute Q&A = 8 minutes.

2. 'thehealthline.ca' presentation highlights the features of thehealthline.ca, with a particular focus on the microsites and an overall review of how it can be leveraged to find services across the South West LHIN and the sub-regions.
   - 8 minute duration, presented by: Barb Hagarty. Presentation is 5 minutes + 3 minute Q&A = 8 minutes.

3. 'Care Bundles' presentation describes the common Care Bundles that have been reviewed at previous Learning Collaboratives and how these interventions can be applied to Coordinated Care Planning.
   - 8 minute duration, presented by: Dr. Kellie Scott. Presentation is 5 minutes + 3 minute Q&A = 8 minutes.

Section 4C – Exercise (15 minutes)

1. Discuss with your table how you would align Dena's health care needs with her personal goals. Brainstorm a possible care plan for Dena and document it on a flip chart. Include all health (traditional and non-traditional), social, personal, and community supports, and non-healthcare related resources that could help Dena reach her goals.

2. Discuss with your table who should attend the Coordinated Care Planning conference, based upon the care plan you developed. Document this care team on the flip chart.