Applied Health Research Questions (AHRQ) Summary of Findings Form

Applied Health Research Question: What are the underlying causal factors of coordinated care benefits and costs through investigation of the lived experience of organizational leaders and providers?

Name of Research Provider Organization: Health Services and Policy Research Institute

Title of AHRQ: Evaluation of Health Links in the Southeastern Local Health Integration Network

RAEB Research, Analysis & Evaluation Branch
Evidence to Action

Ontario

Primary Focus of AHRQ: Health System Integration and Performance

Type of Response: Research Project

Types of relevant evidence identified (check all that apply):	Methodology: [e.g., analyses of administrative data, randomized controlled trial, qualitative research, etc.] Qualitative research
☐ Systematic review(s) (e.g., Cochrane reviews) ☐ Randomized controlled trial(s) (RCTs) ☐ Quantitative research other than RCTs in peer-reviewed journals (e.g., administrative database studies, experimenter controlled studies) ☒ Qualitative research in peer-reviewed journals (e.g., descriptive research) ☐ Grey literature (e.g., technical reports, working papers from research groups or committees, government reports, abstracts from conferences, proceedings) ☐ Commentary and editorial articles published in peer-reviewed journals ☐Other (please specify):___________	

Key Findings:

Question: What are the causal factors of Coordinated Care Planning benefits and costs from lived experiences of managers and providers?

Methods:

- We conducted semi-structured interviews with managers and providers in three primarily rural and some urban geography areas in Southeastern Ontario. Snowball methodology was used to recruit participants.
- Information was analyzed using emergent thematic coding and NVIVO 12. Transcripts were reviewed and coded individually by members of the research team line by line to determine key concepts. Themes emerged from the data. The research team met to discuss coding.

Summary of Key Findings:

From the **evaluation of coordinated care planning**, we found that there was need for a **formal structure** for continued **bridging** of care, especially between **health** and **social services;** there were perceived **benefits** from **information sharing** among organizations (with continuing efforts towards electronic records **integration** and

uptake), while ensuring **flexibility** of implementation; and a need for **primary care physician engagement** for coordinated care planning.

Key Findings:

Seventeen interviews were conducted with participants from three coordinated care planning sites in Southeastern Ontario. The interviewees included 5 organizational leaders and 12 healthcare providers (Table 1).

Table 1. Interviews conducted at coordinated care planning sites

Coordinated Care Planning Site	Quinte	Rural Hastings	Thousand Islands	Total
Organizational Leaders	2	1	2	5
Providers	3	4	5	12
Total	5	5	7	17

The themes that emerged from the data were similar for both the organizational leaders and healthcare providers. Thus, the themes from both groups are presented together. Four themes emerged and participants' perspectives regarding each theme are presented. Participants' perspectives regarding each topic are presented. Participants' comments were condensed into codes reflective of their lived experiences. Quotations from participants are provided.

1. Integration between health and social services

There was widespread agreement that formal processes could be developed to address the coordination of services between health and social services. As a project lead remarked, just as "working relationships improved over time" between coordinated care planning and home care, there is now impetus to enact the same level of commitment towards healthcare service provision and social services.

Role of social services beyond healthcare delivery. Participants believed that prior to coordinated care planning, there was a disconnect between physical health and socio-economic needs, as remarked by a program manager: "…if you don't address that side of it, you are not going to be able to minimize their demand on the health system as a whole." A project lead highlighted the role of coordinated care in serving patients' socio-economic needs that goes beyond the provision of primary health care services: "…we were able to solve issues that were not solvable by primary care physicians". An executive director added that "social complexities" had been an "impediment to achieving medical goals", and a general lack of insight regarding patients' other needs directly unrelated to health factors listed by participants included "food, security, transportation".

Bridging the gap between health care services and social services. There was a call for bridging the gap between healthcare and social services organizations, such as "Ontario Works" and "Ontario Disability", as a project lead remarked, patients may have seemed to cope when attending the physician's office, only to realize the that patient may lack basic needs, such as food or not having access to sanitation: "…they may not have enough food…. may not have a bathroom … because they can't get up the stairs." An executive director provided vivid examples of a gentleman who had not funds to purchase shoes for his inordinately large feet and the case of the diabetic patient with no food in the refrigerator.

2. Information Technology

Shared Health Integrated Information Portal (SHIIP). A client-centered approach was viewed to be essential. Communication appeared to be a resounding issue as there were perceived benefits from information sharing among organizations. This has been supported by electronic information sharing and coordination-through the Shared Health Integrated Information Portal (SHIIP), a portal aimed at sharing patient data between healthcare providers and to improve interdepartmental communication.

T**imely access to information/data in "real time"**. Participants described a main benefit of SHIIP in support of coordinated care planning to be timely access to data on complex patients that can support coordinated care so that patients can be followed in "real time", as remarked by a program manager: "to see when our clients are showing up at the hospital so that we can proactively meet that follow-up period".

Multi-sectoral communication and uptake. Participants believed that since early implementation SHIIP has been in charge of constant improvements, for example, formatting the technology so that it fits onto a cell phone screen so that healthcare providers can have access to "real time" information across communities and sectors. There was agreement that uptake could be improved. An Addictions and Mental Health provider indicated that this type of improvement would ensure continuity of care within patients and across settings and ensure uptake. A community support outreach worker added that SHIIP has allowed for the non "duplicating" of services and away from "working in silos".

Integration of information. The main concern has been the need for integration between the electronic medical records (EMR) and other solutions including SHIIP. A program manager remarked that currently there is a "double documentation process" and "there is no talking between the two."

3. Flexibility in the provision of healthcare resources

There was agreement that flexibility in coordinated care implementation was welcomed with a "no rule environment", since flexibility is needed to enable each community to cater to local resources, especially in relation to patients' particular requirements regarding type, number of visits and amount of time needed.

Structural guidelines in implementation. However, a mental health worker noted the importance of a “structural process” to enable “communication” and team “building”, while maintaining the flexibility of serving local needs. It is crucial that the “organization has your back”, remarked a complex case worker. A program manager added that what is needed is a general protocol with “workflows”, “formal processes” associated with “referrals” and “triage" that are disseminated regularly, “just like you would building codes”; these would form part of a staff “orientation” process. A system navigator emphasized the importance of developing associated “outcome measures”.

4**. Primary care physician engagement**

Provision of coordinated care services has been a long standing issue for primary care physicians. As stated by a complex case worker: “…make it easier for physicians to actually embed system navigators, care coordinators, complex case workers in their practices”, not solely external services available.

Availability of resources/self-sustainability - In light of the end of coordinated care planning funding, a complex case worker remarked that while physicians in group practices were able to “…embed system navigators, care coordinators, complex case workers into their practices”, physicians without a structural support system, such as solo practitioners, were not able to “invest” coordinated care funds into the development of ay self-sustainable models.

Primary care physician commitment/ buy-in - Given the nature of the contractual temporary arrangement for funding of Coordinated Care Planning, physician buy-in has not been universal, with a “few outliers”, as one Addictions and Mental health provider remarked: “…frustrating to get a client that you know is complex and can benefit from this plan, and there’s just no one to follow up on the plan even if developed”. This point is especially salient for solo practitioners who do not have a “ circle of care embedded into their practices” or “social determinants of health as part of their practice”, as highlighted by a program manager.

Equitable provision of healthcare resources – A program manager noted that, without an effort to build sustainability, there would not be any structures in place to continue to cater towards patients with complex conditions: “75% or 70% of our population will no longer have that support”. In addition, there was a sense of losing trust from the community, especially given unfulfilled promises for a program for which funding will seize reflecting the void it represents: “…and then all of a sudden not, with nothing to backfill…”, as a complex case worker shared.

Impact:

In one paragraph (~300 words), briefly describe the impact of your AHRQ on your knowledge user's work. Specifically, your statement should explain the reason why the AHRQ was impactful (e.g., changes in guidelines, informed policy-/decision-making, type of product, new technology, etc.), who was impacted (i.e., who the knowledge user(s) is/are), and how it impacted your knowledge user's work (e.g. the outcome/benefit to their work). If applicable, please specify the level at which the impact took place, e.g. provincial or larger, regional or LHIN, community, and/or institutional level.

The **impact** of this **AHRQ** on the knowledge user's work is to inform on the most salient findings from an evaluation of coordinated care planning based on **lived experiences of organizational leaders and providers** in Southeastern Ontario and to inform **healthcare policy-setting** at local, regional and national levels, especially in light of the current **Covid-19 pandemic**.

Summary of Recommendations: ***Chronic disease*** is to be viewed as a silent global epidemic. It is important to have processes in place to ensure formal ***integration between health and social services*****,** while maintaining ***flexibility*** catering to ***local needs*** backed up by ***structural guidelines***. There needs to be continued effort towards ***information technology uptake*** and ***integration*** of diverse ***electronic medical records*****.** Finally, it is imperative for there to be ***primary care physician engagement*** in coordination of care among different sectors.

<u>**Chronic diseases**</u> have been labeled as the **silent global epidemic**. While **COVID-19** urges governments to **rebuild** their collective **social welfare systems**, chronic disease has remained the leading cause of death in the world.

<u>**Integration between health and social services**</u>. Rather than only catering to individuals in times of a ***global pandemic***, government can opt for creative solutions to ***rebuild*** its collective ***social welfare system*** proactively in the long-run by ***bridging*** the gap between ***health and social services*****,** through various means including widespread use **of *information technology,*** while ensuring ***flexibility*** to cater to local needs and ***structural guidelines***.

<u>**Information technology sharing**</u>**.** As the ***COVID-19*** pandemic transforms how physicians deliver healthcare, through ushering the new wave of ***information technology*** and telemedicine, this AHRQ highlights the urgency to ***transcend*** from doctors' offices into the ***health*** and ***social services sectors***, by increasing physician uptake and continuing efforts towards ***integrating*** diverse electronic ***medical records*** systems.

<u>**Primary care physician engagement**</u>**.** Primary care ***physician engagement*** in coordinated care planning is needed in a sustainable manner to ensure continuity of

care for patients with complex and chronic conditions by ***embedding care coordinators*** and ***system navigators*** into their practices.