One Client One Plan (OCOP)

Quarterly Communique, #5, April 2019

PLEASE CIRCULATE TO YOUR TEAM MEMBERS!

What's New?

Here's a snapshot of some of the progress made on each of the themes identified by Home and Community Care leaders.

Design Single Point of Access

- The Access Work Group has brainstormed ideas and analysed existing access models i.e. "No Wrong Door"; a single point of contact; and a hybrid of the two. The group is working on a common intake process with the goal of making it as simple as possible for intake and referral to the appropriate provider(s), who would then do a more fulsome assessment.

Standardize Training and Forms

- Work continues on **standardizing consent** so all providers can use the same language to reduce burden on clients/families who are asked repeatedly for their consent.

Leverage Technology & Data Sharing

- Caredove software selected as a referral solution based on requirements analysis, research and evaluation.
- Inquiry was made into a **Robotic Process Automation** software solution that reduces duplicated manual data entry.
- **eNotification** is being expanded to Assisted Living provider agencies wishing to be notified when their clients present to the ER, are admitted to hospital, and then discharged.

Improve Information Sharing

- Red Cross is participating in a **Health Partner Gateway (HPG) Onboarding Process Pilot** that will provide them with read/write access to the Coordinated Care Plans via HPG.
- OCOP is leveraging work being done by the **Health Links project** on the Coordinated Care Plans.
- The OCOP **Care Coordination Work Group** has generated system improvement ideas that will streamline care coordination and assessments to build better partnerships.

Share Resources Among Providers

- The goal of the **Knowledge Exchange Series** is for agencies to share information about their local services. So far March of Dimes, Red Cross and Alzheimer Sudbury Manitoulin have done presentations. Stay tuned for more local information from other providers to come. Is there a provider you'd like to hear from?
- **Email OCOP-UCUP@lhins.on.ca.**

- **To read past communiques click here.**

Technology/Software Needs Analysis

Work continues by Stephanie Leclair (Alzheimer Society Sudbury) and Terry Caporossi (Alzheimer Society SSM) on a provider-agencies' specific *Technology/Software Needs Analysis* towards the goal of adopting a common health information system. Other HSPs are encouraged to contact kerri.mcmaster@lhins.on.ca to contribute their organization's technology requirements.

"In this time of health care transformation there are many unknowns. But what we do know is that the province is looking to more fully integrate health care, using digital technologies to create a more coordinated system of care for people. We continue to support the work of OCOP and its strong alignment with provincial priorities and improving the Northern patient experience."

-- North East LHIN CEO Jeremy Stevenson

OCOP Influencers/Influenced by ...

✓ **Neighbourhood Model, a client centred collaborative model** – supports shared care planning, maximizing information sharing, and reducing number of assessments.

✓ **Assisted Living** – supports information sharing to improve client experience and maximize CHRIS as a key platform. All assisted living client profiles are now in CHRIS. Thank you to all who helped with the data clean up!

✓ **Health Links** – many ways to support Health Links in spreading the use of the Coordinated Care Plan.

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North East Local Health Integration Network
Réseau local d'intégration des services de santé du Nord-Est

Caredove Software Selected for Seamless Referrals

Caredove offers an electronic referral solution to enhance access to information, connecting clients to North East LHIN-funded home and community services across the region, as well as supports OCOP's objectives to improve information sharing and transform Home and Community Care into one easily accessible sector.

The "ideal state" created at Betty's Journey Workshop in March 2018 indicates that we must not burden clients/patients with having to call providers to book appointments. Staff coordinating care must be well informed of available services and be able to seamlessly connect clients to all required services. Caredove has proven functionality to address this component of Betty's ideal state and has been highly recommended by other LHINs across the province.

Benefits:

- ✓ Identifies services that are (and are not) available within each client/patient's geographic location.
- ✓ Enables the person coordinating care to electronically book appointments.
- ✓ Allows health service providers to send electronic referrals.
- ✓ Tracks referrals between providers.
- ✓ Empowers clients/caregivers by allowing them to see appointment details as well as change/cancel electronically.
- ✓ Reduces duplication by letting the users make multiple referrals without having to input the same basic client information.
- ✓ Allows referrals from multiple sources such as: clients, family health teams, hospitals, Health Links, primary care providers, etc.
- ✓ Positions OCOP for future and other opportunities to integrate technical solutions.

Integrated Assessment Record (IAR) + More

OCOP has been surveying provider agency RAI users – asking:

- ✓ **How are they using the RAI assessment and IAR?**
- ✓ **When it comes to training staff, what are the processes and the challenges?**

We are looking for commonalities to standardize all of the above. Our goal is to map out the good parts of the current state that could be applied to all providers, as well as identify if training needs to be improved. Ultimately, we are working to make a strategy to make RAI and IAR better for all who use it = better for the client experience.

NE LHIN staff have also been provided with a refresher education on the importance of uploading to IAR.