# System Navigation

## Support for you and your patients

LONDON MIDDLESEX PRIMARY CARE ALLIANCE TOWN HALL

SEPTEMBER 26, 2023

**HOME AND COMMUNITY CARE**
**SUPPORT SERVICES**
South West

# Agenda

| | | |
|---|---|---|
| 7:00 – 7:05 | Technical Overview/Housekeeping | Melissa Linseman |
| 7:05 – 7:15 | Welcome & Introductions | Scott Courtice |
| 7:15 – 7:45 | System Navigation | Trudy DeVries, Jenna Prouse |
| 7:45 – 8:00 | Q & A and wrap-up | Scott Courtice |

# Housekeeping

To ensure everyone has a good meeting experience:

- Please stay on mute if you're not speaking
- Use the 'raise hand' feature to ask a question
- Chat available to everyone
- If you're signed in as "iPhone", please rename yourself so we can send you Mainpro+ certificate shortly
- Sign up for LMPCA newsletter to learn of future events and practical information

Meeting is being recorded; recording and slides will be available at www.lmprimarycare.ca

London Middlesex
Primary Care Alliance

# London Middlesex Primary Care Alliance (LMPCA)

*An inclusive network of primary care providers leading with a unified voice to improve the health of our community*

*Create a strong and united primary care network to*:

- **Lead** system change utilizing quintuple aim values
- **Drive** health equity and continuous quality improvement for the best possible experience and health outcomes
- **Advance** patient-centred equitable care in partnership with those we serve
- **Improve** integration of primary health services with public health and other social and health care partners

# Objectives

- ✓Learn about the Community Navigation Team
- ✓Learn about the Physician Hotline
- ✓Find out how you and/or a person you are supporting can get help to find health and social services

*This 1-credit-per-hour Group Learning program has been certified by the College of Family Physicians of Canada.*
*The program is part of a series that has been certified for Mainpro+ credits.*

# Disclosure of Financial Support -

This program has received in-kind financial support from TVFHT and MLOHT in regards to administrative and logistical support

**Potential for Conflict(s) of Interest**

- None

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# Speaker Disclosures

- Name: Trudy DeVries
- Relationships with financial sponsors:
  - Grants/Research Support: N/A
  - Speakers Bureau/Honoraria: N/A
  - Others: MLOHT Healthcare Navigation Planning Lead (seconded employee)

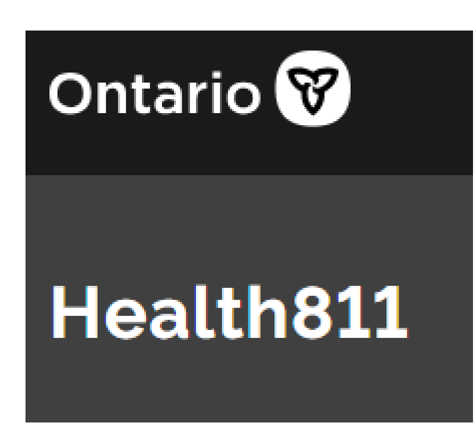
- Name: Jenna Prouse
- Relationships with financial sponsors:
  - Grants/Research Support: N/A
  - Speakers Bureau/Honoraria: N/A
  - Others: Manager, Program Development, HCCSS-SW

# MLOHT Localized Navigation Model

Trudy DeVries

September 26, 2023

# Navigation Resources



## Where to look for help

# Localized Navigation Model … Why

The Ontario Health Team was tasked with developing a navigation model to:

**Provide patients/clients, caregivers/care partners and providers with 24/7 access to system navigation services**

This model need to:

- Align with the provincial Health811 platform
- Ensure marginalized populations, in the Middlesex London region, will be connected with appropriate health and social services/supports.
- Facilitate seamless transitions between settings by providing warm transfers.

# Localized Navigation Model … How

MLOHT responded to this task by:

1. Creating the Middlesex London Navigators Collaborative (MLNC):
   - 50 different agencies joined the collaborative as members
   - LMPCA is represented as a member

2. Developing a “Front Door” approach.
   - After many co-design sessions, meetings with other OHTs, and engagement with community partners a decision was made to engage Home and Community Care Support Services (HCCSS) South West to be the lead agency to provide a navigation service

# Localized Navigation Model… “Front Door” approach

In order to meet the needs of you as primary care providers and the greater community, two phone lines were created.

1. **Re-launched** - The Physician hotline receives calls from primary care and is manned by Regulated Health Care Professionals.
2. **New-** The Community Navigation hotline receives calls from the community and is manned by patient care assistants, who are known as Community Navigators.

- Pathways were developed for incoming calls from both lines.

# Localized Navigation Model – Physician Hotline

**Physician Hotline**

- Was an existing line within HCCSS, but now is being relaunched in September 2023.
- Dedicated for physicians and/or any of their team
- For patients that are currently open with HCCSS
- Calls are answered by Care Coordinators who are Regulated Health Professionals to support clinical, non-clinical and/or social needs
    - ie. Support with medical orders or finding social services
- 7 days a week 8am to 8pm
- On Demand interpretation services will be available – currently only French

# Examples when Primary Care could call

1. During your visit you become aware that your patient is couch surfing and is struggling to make ends meet.
2. You have an elderly patient whose family is all out of town and needs support with transportation.
3. Your patient lets you know that she is struggling to feed her kids with the OW she gets monthly and needs help with getting groceries
4. An Indigenous patient discloses they feel they may be bi-sexual and does not know who to talk to.

- Call the Primary Care Hotline
- Give them the person's name and phone number, share the needs of the patient
- Ask the Care coordinator to follow up with the patient and to let you know the outcome of the call.

# Localized Navigation Model – Community Team

**Community Navigation Team**

- Soft Launch started July 11th, 2023, Monday-Friday 8:00 am to 4:00 pm
- For Middlesex London only at this time.
- Consists of 2 Patient Care Assistants/Community Navigators
  - Were introduced to different social agencies in the area
  - Will take the call and support the caller to find the help they need.
- Warm transfer is the important step – to decrease the amount of times a person has to repeat their story
  - Referral
  - 3-way call
  - Transfer call
- On demand interpretation services is available.

# Community Navigators
# 519-474-5774
# 1-888-888-6941 (toll free)

# Physician Hotline
# 1-844-222-2463

# Questions?

# Thank you!

For more information, please contact Trudy.devries@mloht.ca

# Primary Care Connections

# Primary Care Connections

- Home and Community Care Support Services has worked to realign our community caseloads to have primary care alignment.
- By aligning Care Coordinators to primary care practices, we are committing to partner to successfully address patients' needs and support with care planning.
- Primary care connections help us to better understand patients' needs and challenges, provide seamless quality care to patients, support with system navigation and provide more efficient health care support as a system.
- With primary care alignment, it is the expectation that the attached care coordinator is taking steps to build and foster strong primary care connections.

# Working Together To Improve Care

- Building and maintaining strong connections with primary care is important for HCCSS care coordinators to work effectively with our primary care partners.
- Strong connection between HCCSS and Primary Care emphasizes patient-centered care and leads to more effective care coordination for community patients, reducing duplication and increasing quality of care.
- With increased collaboration, the care team is able to facilitate care plans for patients to reduce ED visits, hospitalizations and help the patient remain in the community while addressing care needs.
- Developing a partnership allows us to keep our primary care partners informed of supports their patients are receiving.

# What defines a strong connection

- A partnership between HCCSS and Primary Care to support in connecting patients to services.
- Partnering together to address care needs
- Regular established connections with Primary Care Team (minimum monthly)
- On-site presence with Primary Care for relationship building
- Two-way communication to ensure patient is being referred for available supports and needs are being addressed

# Activities to Build Connections

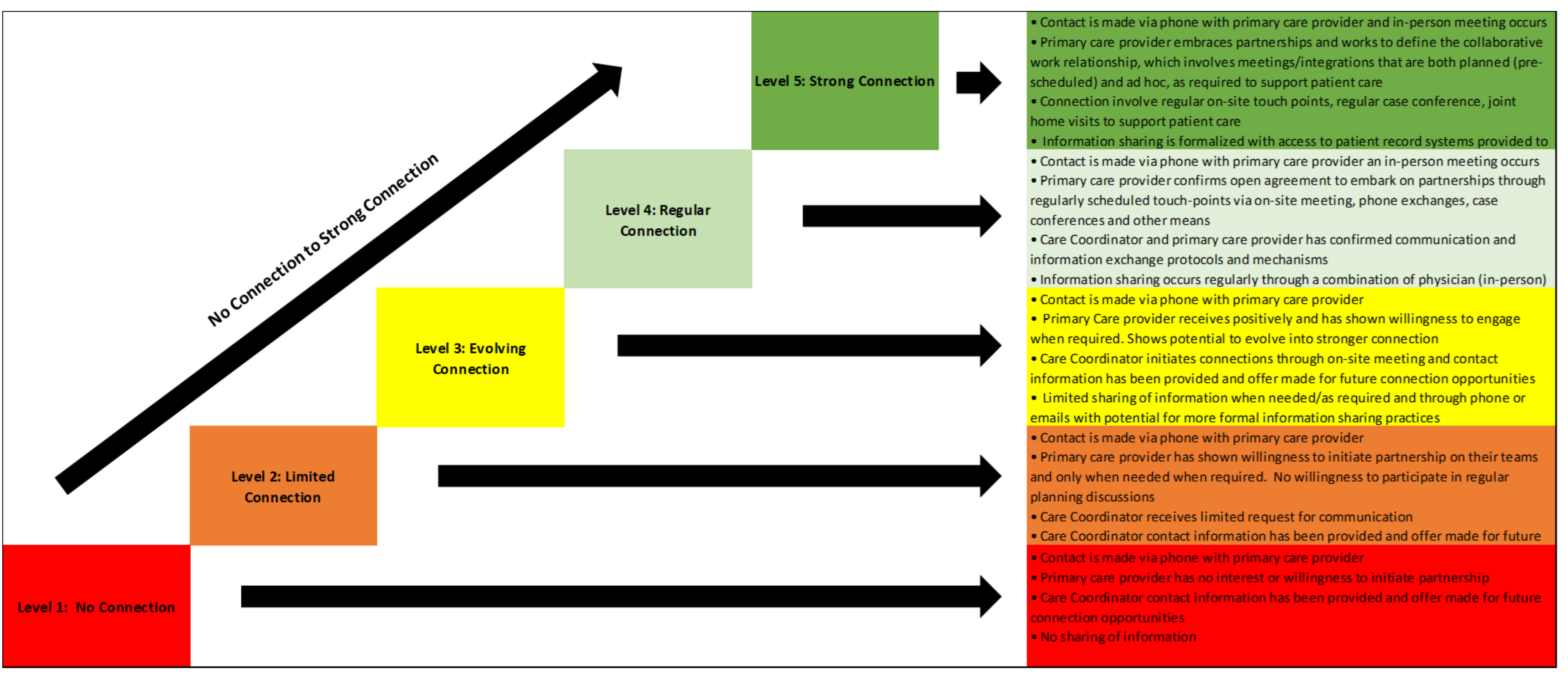
- Introduction meeting with Primary Care, providing available supports through HCCSS
- Establish regular meetings, connections to review patients receiving services and system navigation
- Provide and review the Patient-By-Physician Report during established meetings to inform physicians of their patients on service
- Information sharing including patient status updates, including notification patient services have been placed on the waitlist
- Participate in case conferences with the physician/NP and other members of the primary care team
- Participate in health care planning meetings
- Provide support for identified high risk patients
- Offer navigation and connections to services in the community
- Promote the Primary Care direct telephone line for live answer

# Primary Care Direct Line

- Did you know we have a direct line for Primary Care that is answered 8:00-20:00 by our In-office team?
- Home and Community Care Support Services has a direct phone line for primary care to connect with a live answer in office care coordinator for any immediate needs or for additional system navigation. Care coordinators should promote this telephone line during connections with primary care.
    - The telephone number is 1-844-222-24MD.
- Care Coordinators are to ensure primary care practitioners are familiar with this direct line.

# Measuring Successful Connections

# Levels of Connections



# External Engagement

# How are we engaging Primary Care

- Engagement meetings to highlight re-launch of primary care connections
- Memo to all primary care partners to inform of primary care connections, care coordinator alignment and what we can offer to build stronger partnerships
- Promotion of direct phone line for primary care

Home and Community Care Support Services South West is here to help with coordinating your patients' home and community care

It's easy – one number access to all community information.

- Connect with a care coordinator
- Ask about a patient currently receiving home care service
- Make referrals for patients with chronic and complex needs, as well as palliative care support
- Our services include nursing, personal support, physiotherapy, occupational therapy, and social work
- We support long-term care eligibility and applications
- Learn about available community resources and let us help with community service referrals

Ontario

# How to reach us

https://lmprimarycare.ca/

info@lmprimarycare.ca

@lmprimarycare