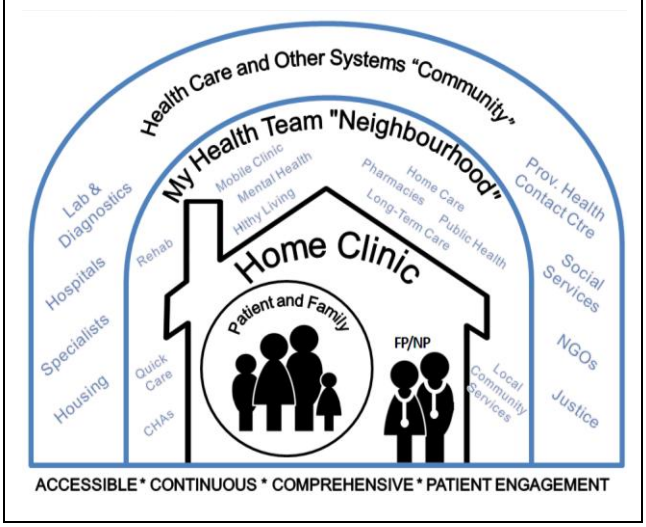
SERVICE COORDINATION FRAMEWORK

CONTEXT|PURPOSE OF FRAMEWORK: This framework is based on existing research and feedback collected at the 2013 Stakeholder Engagement Day, which demonstrated a need for collaboration between Manitoba Health, Seniors and Active Living (MHSAL), Regional Health Authorities (RHAs), fee-for-service (FFS) providers, and other health system and community partners to facilitate the sharing of knowledge, decision-making, and accountability, the active involvement of all health system members, and the forging of strong linkages between parts of the health care system

This work was used to define service coordination, as well as associated standards and leading practices This was validated by a similar audience in 2015 at the Service Coordination Workshop, as we sought feedback to ensure the clarity and relevance of the framework, and in 2016 at the Primary Health Care Day, to brainstorm priorities related to its implementation. Going forward, this framework will be used as the basis for a common language while implementing service coordination within MyHTs, and with partner organizations, programs, and services across health care.

Figure 1. Depiction of Service Coordination in Manitoba



The vision outlined in the Primary Health Care 2016/20 Strategic Plan is that all Manitobans will have knowledge of, and access to, high quality and cost-effective primary care services. Strong evidence demonstrates that the provision of quality care requires both a focus on both health service delivery and health system policies conducive to primary care practice.[1, 2]

It is expected that My Health Teams (MyHTs; i.e., primary care networks) and Home Clinics (i.e., patient-centered medical homes) will act as central points for coordinating primary care based on individuals' needs and preferences. They will play a key role in ensuring quality service delivery by providing a environment that supports the collaboration and alignment of existing 'siloed' services. Furthermore, it is also planned that MyHTs will lend themselves to integrate primary care with other program areas in service delivery. Mental health, continuing care, public health, and health living were identified as preliminary key areas to focus on (see Figure 1).

According to Starfield and colleagues, the delivery of quality primary care services is reinforced by the development of supportive primary care oriented government policies.[3] As a result, in its role of examining evidence-based practice and standards, Manitoba Health Seniors and Active Living offers this framework to guide the development of policy that will support the implementation of service coordination within health care, especially as it relates to MyHTs.

DEFINING SERVICE COORDINATION: Though there are multiple ways of defining service coordination, for the purposes of this framework, we base our definition off of that of the Agency for Healthcare Research and Quality and define service coordination as a set of activities performed collaboratively by two or more participants (including the person/patient) and programs to plan, implement, communicate and evaluate services in order to provide coordinated care for individuals accessing care.[4]

SERVICE COORDINATION STANDARDS[5]: the characteristics of coordinated care that people value and/or can come to expect when accessing health and social services (which align with MyHT's Core Features[6]).

1. Accessible Services: Manitobans experience access to timely and quality services and information.
*Patients will have access to **timely** (within 24 to 48 hours) and **quality** services (includes care in person, by telephone, by email, via Telehealth, at home, and/or access to self-management resources), at a date and time that is convenient to them. This includes ensuring **access to information** so patients are aware of available services and programs, as well as know what provider to see, when, and for what reason*.
2. Comprehensive Person-centered Services: Manitobans experience care that is sensitive to their unique contexts and comprehensively addresses their unique needs and preferences.
*Comprehensiveness of services is dependent on patients feeling that their needs are addressed in a **holistic** manner across the life cycle, regardless of their cultural or spiritual backgrounds, social determinants, geography, spectrum of clinical needs, or points in the treatment or management of their illnesses and injuries (e.g., health promotion to chronic disease management).[7] In other words, patients experience **equal access to services** and **opportunity for good health**, as treatments and the approach to service delivery are **adapted** to be **user-friendly** and **compatible with each person's particular needs, preferences, and personal circumstances** (e.g., culturally sensitive, preferred language). As a result, care plans will be multifaceted and vary by patient, and will coordinate care in a way that facilitates access to a broad group of experts, from health to social/community service providers (e.g., addictions, education).*
3. Engagement & Self-Management: Manitobans are empowered with information and supports to make informed choices and engaged as integral participants in their care; to the degree they are willing and able
*Delivering services in a way that empowers individuals to take a lead role in the management of their health and care, in order to make the process of navigating the system and accessing services more **person-centered, straightforward, and user-friendly**. By adequately **informing, connecting, and engaging** patients during patient-provider interactions and care planning, they are more aware of available services and other options. In addition, by providing the right level of support, removing system barriers, and supporting the concept of "every door is the right door," patients are better able to autonomously access services and engage in self-management of their health based on their willingness and capacity to do so. In these interactions, patient views and preferences are recognized and respected (e.g., cultural).*
4. Continuous Services: Manitobans are confident in the reliability of their medical information (i.e., how it is collected, stored, shared), provider relationships, and seamless access to services.[8]
To support a seamless 'wrap-around' approach to care via: - ***Informational Continuity:** complete, concise, consistent, and timely **transfers and uptake of (clinical and non-clinical) information between providers and with patients/families** to inform future care decisions, promote 'safe handoffs', and reduce repetition, service duplication, and oversights in care.[9]* - ***Relational Continuity:** an **ongoing therapeutic relationship** a patient builds with 1+ provider(s)* (i.e., most responsible provider)*, with whom he/she can build a sense of trust and confidence.* - ***Management Continuity**: the extent to which services delivered by different providers are timely and complementary, such that **care is experienced as connected and coherent**. Wrap-around processes with "warm handoffs" and ongoing touch points will provide an opportunity to check-in with patients to ensure they felt informed, engaged, and satisfied with the follow-through on their care plans.*

SERVICE COORDINATION LEADING PRACTICES: action-oriented activities service providers engage in, which may be invisible to the community, to meet service coordination standards. [10]

1. Inter-professional Accountability: Service providers take responsibility for the interests and care coordination of individuals both within their own service, as well as across the service system as a whole.

*Inter-professionalism builds capacity, given that a team benefits from a range of expertise to ensure that the right services are delivered by the appropriate provider; thereby increasing accessibility of services to those who need them, when they need them. Participants involved in a person's care should work to their full scope of practice, clearly assuming accountability for care and coordination related to their area of expertise, while also being directly involved in coordinating with other team members when patients must go elsewhere for care.[11, 12] As such, **all providers are equally responsible for connecting patients to the right resources and services**, as suggested in the saying "every door is the right door." That being said, once enrolled to a provider, there is a commitment by the **most responsible provider to take the lead role in ensuring management continuity in their patient's care and system navigation**.*

2. Person and Community-centered: 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.

*Service delivery should consider and document the needs, priorities, and goals of individuals, their families, and communities (even before the needs of the system).[13, 14] A range of approaches could be used to **target the unique needs seen across different population groups**; from more hands-on guided support with coordinating services related to disease management and harm reduction, to more routine and upstream approaches for linking people with prevention, health promotion, or early identification and intervention resources.[15] Furthermore, consideration of a person's input (e.g., preferences) and social determinants of health (e.g., language, ability, geography, income, education, employment, social status) will lend itself to providing individualized care plans that offer equal opportunity to access health services and increased opportunity for good health, in a way that is **patient-informed and user-friendly**.*

3. Collaboration, Integration, & Partnerships: Service providers reach out to collaborate, build alignment and relationships, as well as establish agreements with partners within and across sectors.

Service coordination requires the establishment of team-based collaboration[16]:

Within a Clinic	*WITHIN* a MyHT's services and programs	*BETWEEN* organizations, programs, and services *OUTSIDE* of a MyHT- *as appropriate*
e.g., a Home Clinic	e.g., primary care, mental health, public health, home care etc.	e.g. acute, speciality, and tertiary care, ambulatory care

*The alignment of players in a person's care ensures cohesive functioning in the delivery of effective, sustainable, and integrated services.[17] Through steady relationship building with partners and the use of existing resources (e.g., community events, resource toolkits, care pathways), providers have an improved **understanding of each other's role, scopes of practices, programs and services**, enabling them to better connect patients to existing resources as a coordinated team.[18] Developing close ongoing working relationships, respect, and trust within and across other sectors (to overcome the fragmentation of services from silos and transitional barriers) also requires ongoing bi-directional **communication and collaboration with both people and providers**, particularly as it relates to streamlining relationships and referrals.*

4. Standardized Documentation & Transmission of Information: Timely, complete, and reliable documentation and transmission of information is offered as a basis to consistently coordinated services.

*The standard use of **processes, tools and technology** for efficient information exchange (e.g., care plan, shared Electronic Medical Record systems, web-based e-referral system, care pathways, patient portals)[19] to facilitate provider's awareness of resources, as well as the **expectations around timely, complete, and reliable documentation and transfer of information** about individuals and their care between providers. By standardizing leading practices, this has the potential of streamlining and improving continuity of services by increasing providers' awareness of what has happened, what needs to happen, who is responsible, where to refer, and when activities are 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, efficient, and accountable in their care planning with patients.*

5. Continuous Quality Improvement Processes: A culture where opportunities to improve the efficiency, effectiveness and quality of service delivery and office practices are sought out on an ongoing basis.

*Regular **measurement of outputs and outcomes** is important to determine if targets are being met (*e.g., primary care quality indicator data and reports). ***Standard proactive review of processes** also facilitate discovering, testing and adapting solutions to practical problems in support of efficient service delivery and office practices. This involves sharing (i.e., offering and accepting) lessons learned with from successful and unsuccessful service coordination experiences with peers across the system and within communities of practices (e.g., Advanced Access; Process Engineers trained in LEAN management; MB e-Health Peer-to-Peer Network and Peer Supporters).*

SYSTEM ENABLERS: The factors within the system, which are critical for successful service coordination. An annual review, ideally tied to the MyHT reporting and other measures of performance, can assess what core enablers are in place, which require further development and those that are missing.

THEMES	DEFINITION	EXAMPLES
E-Tools	Increasing and optimizing the use of interoperable, efficient, and effective technologies, equipment or products to enable standardized information documentation and sharing.	- Electronic Medical Records (EMR); EMR Pathways; eChart; Patient portals; Health Links; eReferrals; Centralized Repositories, and other Digital Health System Solutions.
Culture	A culture supportive of service coordination standards and leading practices.	- Designated leadership and team members that are committed to service coordination principles, functions, and goals; - Promotion of patient engagement through public access and understanding of information, services, and resources available to them (e.g., Care plans, patient portals, patient reported outcome measures) - Leveraging others' expertise and sharing lessons learned (e.g., MyHTs; Daily Huddles; Manitoba Peer-to-Peer Network and Peer Supporters). - Change management if necessary

Role Clarity	Facilitating alignment and widespread awareness of scopes of practice, information on resources and services, as well as role clarity amongst partners to promote an understanding of existing programs and services, how to connect, and encouraging their use as part of usual practice.	Interprofessional education/training/team-building opportunities or resources re: - Practice profiles, goals and objectives, core features and enablers etc. (e.g., education, toolkit) - How partners foresee sharing resources and services across the MyHT in a way that benefits all parties and optimizes on economies of scale. - Who to call for questions re: system navigation (e.g., Primary Care Connectors; Health Links).
Standardize	Formalizing agreed-upon partnerships, agreements, expectations, and responsibilities amongst partners.	Implementing standards, leading practices, policies, procedures, agreements, protocols, guidelines, processes, pathways, and/or workflow maps, such as those related to: - Accreditation Standards - Roles and activities; - Processes to identify the appropriate resources; - Clinic support and resource sharing; - Physician remuneration (e.g., CCM Tariff); - Communication and information sharing (e.g., Primary Care Working Group form development process) - Legislation, policies, and initiatives supportive of service coordination (e.g., MyHTs; Home Clinics); or - Documentation, monitoring, and evaluation.
System Efficiencies	(In the event that a program area is without capacity:) Engaging in practice or organizational improvement processes to analyze whether services are being delivered, and system workflow is being carried-out, in the most cost-effective, cost-efficient, and sustainable way.	Continuous quality improvement processes, such as: Advanced Access: - Practice improvement training to help clinics remove unnecessary waits and delays, and redesign service delivery to maximize efficiency of service deliver and health outcomes for patients. LEAN management: - An approach aimed at organizational improvement to deliver services and programs of high value to the customer with the least amount of waste. - E.g., Reducing unnecessary barriers related to sharing personal health information among providers. - E.g., Better align research with clinical and policy goals related to primary care and service coordination. Plan-Do-Study-Act: - A method that conducts regular tests of change and implements those that demonstrate improvement. E.g.,http://www.manitoba.ca/health/mpan/pdf/nurseled_telehealth.pdf E.g., Primary Care Quality Indicator Data and Reports

NEXT STEPS: The focus of this Framework was to develop a common language and vision related to standards and leading practices while implementing service coordination within MyHTs, and with partner organizations, programs, and services across health care. Feedback collected, suggests overwhelming support for the proposed standards and leading practices presented. This work will be used to inform next steps related to Service Coordination across MHSAL and for key partners (e.g., RHAs, community organizations, FFS practices), including 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. These represent but a few examples of implementing the framework. Please feel contact the PHC Branch (PHC@gov.mb.ca) if you have any questions or concerns, or would like a presentation on the Service Coordination Framework.

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