

Shared Care Hub

April 22, 2022



Guelph
Wellington
Ontario Health Team

Welcome & Purpose

To provide an overview of the Shared Care Hub process and outcomes

Opportunity ask questions



How Did We Arrive At A Shared Care Hub?

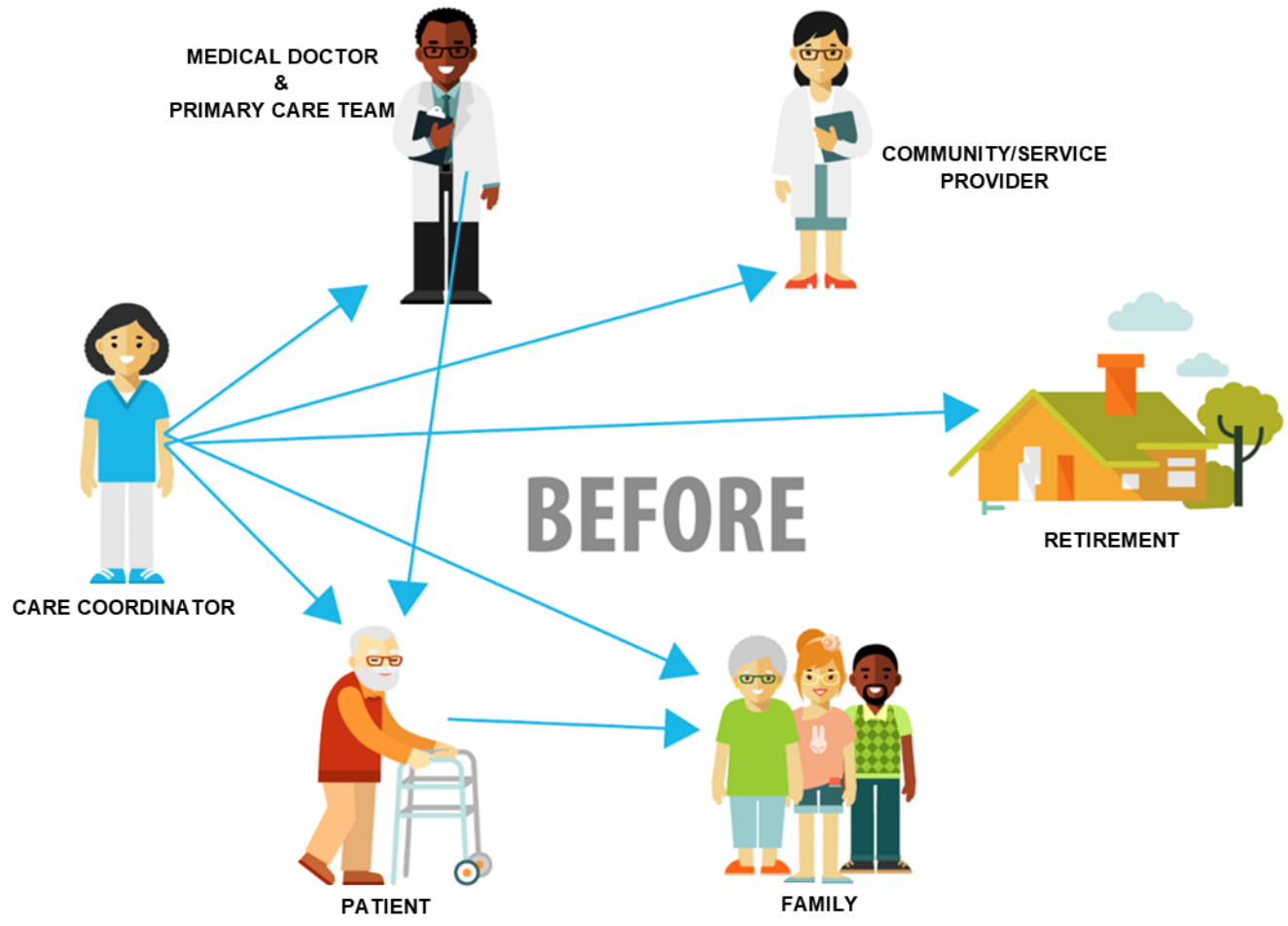
- ▶ Ontario Health West Created a Waterloo-Wellington ALC to LTC 90-Day Plan To:
 - ▶ Reduce the number of ALC patients in hospital while waiting for a LTC bed
 - ▶ Reduce hospital re-admissions and ED visits.
- ▶ Former Rural Wellington OHT Steering Committee discussed options to reduce the number of ALC patients and determined a shared care hub an appropriate approach
- ▶ We are building on this model in Guelph & Area to include patients in Guelph community, Acute and Post acute sites who are complex and would be supported by a shared care hub

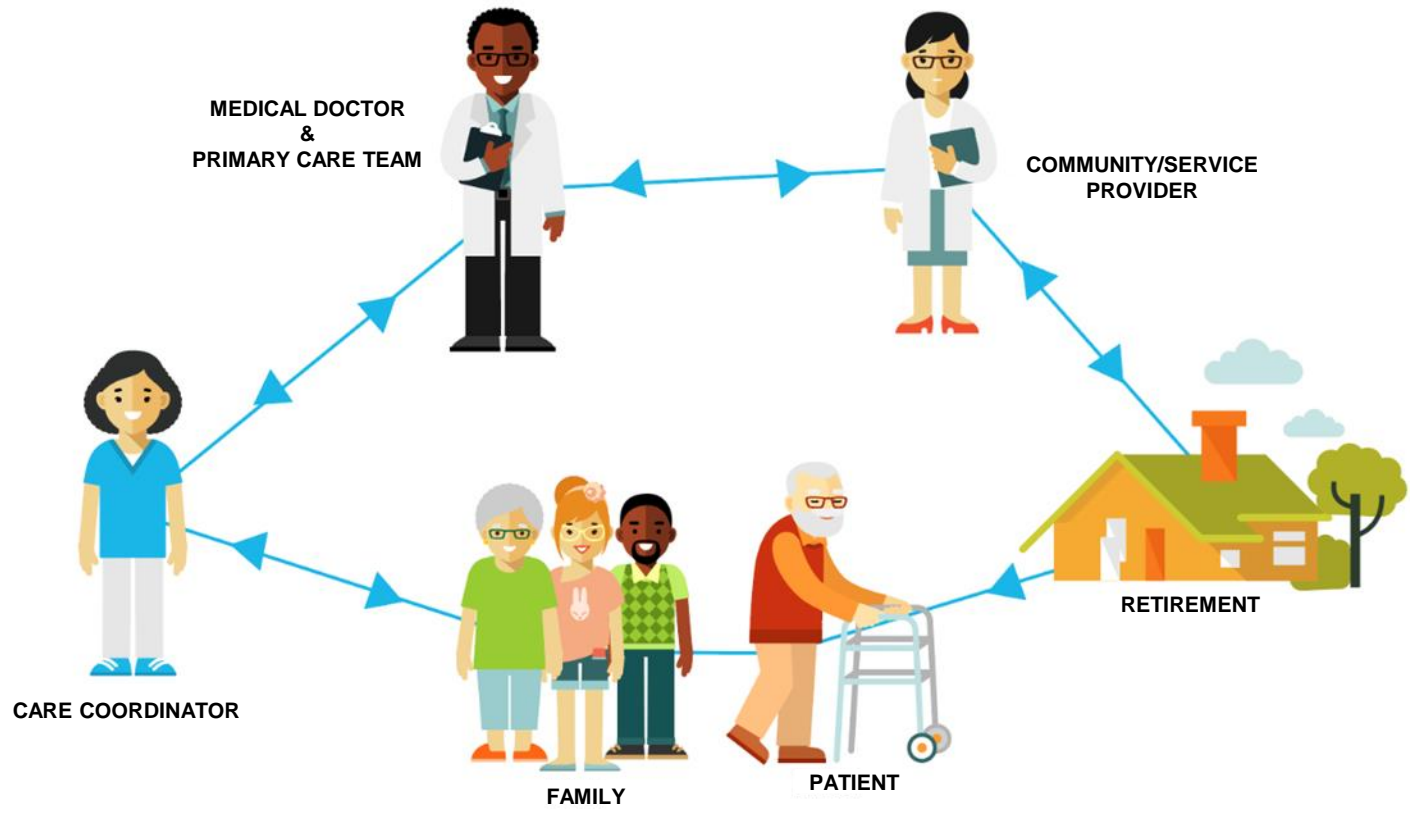
Create a Shared Care Hub

Target Audience:

Patients who are ALC or at risk of being deemed ALC (in hospital or in community)

- ▶ Keep patients safe and reduce risks while improving the well-being of patients by keeping them in the community
 - ▶ Provide wrap-around care & includes family members as part of the solution
 - ▶ Supports the function of discharge planning and Care Coordination
 - ▶ Create/update Coordinated Care Plan





AFTER

Criteria for a Shared Care Hub Patient

- ▶ A person is identified as a candidate for an Alternative Level of Care share care planning hub when they are:
 - ▶ Medically or socially complex
 - ▶ Limited or no social supports
 - ▶ Strong likelihood of the patient being re-hospitalized and/or an ED visit or an increased number of 911 calls
 - ▶ Patient is awaiting long term care crisis category (as per legislation).

A candidate would meet a minimum of 3 of the 4 criteria, using clinical judgement.

Exclusion Criteria: A patient who resides outside of Guelph-Wellington AND does not have primary care provider in Guelph Wellington

Who is Involved/Invited?

- ▶ Health Care Provider - person who is most involved with patient's current health care needs
- ▶ Patient/Family member
- ▶ Participants:
 - ▶ **Core Group** - CMHA/IGSW, Guelph Wellington Community Paramedicine, Home & Community Care Support Services, Hospital, Primary Care
 - ▶ **As Required** - Hospice Wellington, VON, other health service providers(e.g. Retirement Home, Service Providers)
 - ▶ **Facilitator** - supported by CMHA WW



Responsibilities

Role	Responsibilities
Core Group	<ul style="list-style-type: none">Prioritize meetingIdentify alternate representation if unable to attendSupport evaluation of the effectiveness of the hub
Health Care Provider	<ul style="list-style-type: none">Person most responsible for patient's care - identifies the patient who would benefit from coming to the ALC hub discussionObtains expressed consent from patient/SDM to meetPrepares the Referral form/Patient ProfileCompletes & shares the Coordinated Care Plan
Facilitator (CMHA WW)	<ul style="list-style-type: none">Ensures good conversation flow and engages all participantsEnsures clear goals/outcomes addressed/identify roles & timelines
Patient/SDM	<ul style="list-style-type: none">Prepares self/family for discussion and how they are able to/continue to support patient
All Participants	<ul style="list-style-type: none">Review the Referral Form ahead of timeActively participate in discussion with solution-based goal
Admin Support	<ul style="list-style-type: none">Creates calendar invitationDisseminates the Referral Form to all who are attendingCancels meetings that are not required

Process

- ▶ Calendar Hold for all Core Organizations as needed - Wednesdays 1:00 - 3:00 p.m. for patient discussion (Start date TBC)
- ▶ The Provider that brings patient forward completes one-page profile & ensures patient consent
- ▶ One-page profile shared with providers who comes to Hub prepared to offer supports/services
- ▶ Patient consent documented in the presenting agency health record
- ▶ If a partner is personally connected (e.g., relative, neighbour, acquaintance) declares conflict of interest
- ▶ Facilitator will guide the conversation at the Shared Care Hub
- ▶ Create/update Coordinated Care Plan & share with the patient and care providers

Documents Page

- ▶ What to expect
- ▶ [Patient Profile](#)
- ▶ Patient Terms of Reference Document
- ▶ Core Group Contact Information Sheet
- ▶ Facilitator Agenda

www.guelphwellingtonoht.com

Questions?

