WATERLOO WELLINGTON LHIN CARE COMMUNITY MODEL FORMATIVE EVALUATION 2020

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Executive Summary

The WWLHIN has recognized the need to provide efficient, integrated care to their patients by facilitating the redesign of patient-centred care. To support this need, the WWLHIN implemented the Care Community Model in the region in July 2019 and had requested the eHealth Centre of Excellence to perform a formative evaluation of three Care Community Model elements. Streamlined Access to Care via Carestreams, Bundled Care Funding, and the Campus Model at Fairview Mennonite Home for PSW services were observed for progress in implementation, and care provider, staff and patient satisfaction with the model as of February 2020, 8 months after initiation. Each element is reported separately throughout this document.

A formative evaluation was the most appropriate method for the stage of Care Community Model during the evaluation period. Data collection was primarily qualitative and included interviews and focus groups with key stakeholders such as LHIN and Fairview Mennonite Home Leadership, Intake and Care Coordination staff, clinical care providers, and patients of bundled care funding and the Fairview community. The goals of the engagement were to gain a snapshot of the current state of model implementation on what is going well, what could be improved upon, what data is currently collected and stakeholder recommendations as to what should be measured to indicate model success in the future. Quantitative data was provided in aggregate form after being extracted from available databases and analyzed by WWLHIN decision support staff. These data were used to provide supportive evidence of the current progress of model elements.

A review of the current state was completed in three WWLHIN offices implementing Carestreams into their daily routine. From July 2019-February 2020, 226 individuals had been placed on Home Care Carestream caseloads, approximately 3% of all referrals to Home and Community Care for the same time frame. A key recommendation to enhance communication between WWLHIN leadership and front-line staff members including care coordinators and team assistants emerged as the most prominent finding to facilitate improvement of the model. Implementing team-based learning for standardized job aids and facilitating open communication and reassurance about upcoming changes for team members were recommended to overcome staff concerns.

Bundled care funding has been provided to cover the cost of care for 167 joint replacement patients in the region since July 2019 (until at least February 2020 when the report was completed). Although there were concerns regarding communication across the continuum of care between the bundle holder and other stakeholders, it did not appear that the patients interviewed during this evaluation (n=4) were effected negatively by these concerns, as overall high satisfaction was reported when discussing their transition from hospital to home after surgery. Key recommendations included ensuring that the needs of staff and patients are met by streamlining communication between stakeholders and the bundle holder, and continuous monitoring of patients' ability to maintain an in-clinic therapy schedule.

The Campus Model of Care at the Fairview Mennonite Home was seen as a success by all participating parties. WWLHIN leadership staff, Fairview Community Leadership and PSWs Staff, and the residents all reported a noticeable improvement to the delivery of PSW services as a result of the Campus Model. Success was attributed to the strong leadership, communication, and excellent execution strategies taken on by all parties. Highlights of the model included PSW job satisfaction, resident satisfaction with care, and reduced rates of missed care. Recommendations to advance the model to other service categories

such as therapy and nursing and expanding to other geographies or retirement communities include adopting the same philosophy of strong communication and team building, rooted in passion to achieve a common goal.

This evaluation was able to provide a snapshot of the current state of implementation activities for the Care Community Model in WWLHIN. As the model progresses, planning for increased collection of data to populate key indicators of success or flags of areas for improvement is needed to produce evidence to support changes in patient, staff, and care provider outcomes.

Introduction

Health care system integration is at the forefront of Ontario's plan to improve the patient experience with care [1]. The Waterloo Wellington Local Health Integration Network (WWLHIN) aimed to deliver the highest quality of care possible to meet the needs of their diverse population of patients. They have recognized the need to provide integrated care to patients, as delivering improved coordinated care was identified as a key deliverable to connect health care stakeholders in the WWLHIN's most recent integrated Health Service Plan for 2016-2019 [2]. Efficient coordination of patient care amongst health care providers is an essential factor in creating continuity for patient-centred care [3]. Digital health technology has been seen to enhance communication between a patient's care team members, facilitating better connections [3] [4]. Recognizing this, the WWLHIN has made efforts for care coordination and service distribution to be restructured in the region to allow all individuals to have the access to care they need, when they need it.

In 2018, Care Communities (the Care Community Model) were introduced into the region to achieve their coordination goals. The Care Community Model is a multifaceted approach in improving population health in Waterloo Wellington. It aims to incorporate all aspects of care, including Home & Community Care, Hospice Palliative Care, Mental Health & Addictions, Public Health, Social and Community Services, and Specialists, Hospitals and Diagnostic Services. The model considers primary care to be 'home base' for health care and supports cultural diversity and indigenous health and wellness programs [5]. The Care Community Model activities included in this report are organized into three main buckets of work and are discussed below:

1. Streamlining access to care
2. Bundled care funding
3. Community models of care

Logic models **(Figures 1-3)** for each bucket of work were developed through engagements conducted during this evaluation, as well as Care Community Model information and documents provided by the WWLHIN prior to the initiation of evaluation activities. Each logic model reflects the efforts of the WWLHIN and associated partners to achieve the goals summarized and the intended outcomes.

Streamlining Access to Care

For patients to receive the care they need, when the need it, care communities aim to streamline the intake, referral, and care coordination processes for Home & Community Care services. Since July 2019, at intake, patients requiring a lower degree of care coordination have been organized into Carestreams, which assigns them to a particular caseload depending on the degree of care coordination services they require and who is best to provide it. Organizing those who need less coordination services into a Carestream at points of access to service is intended to streamline the patient experience (e.g. reducing duplication of assessment) and increase the capacity of care coordinator time for patients who require more intensive care coordination. In Wellington Region, care coordinators have begun organizing existing patients on their caseloads into Carestreams to free up capacity to work with the more complex patients. Additionally, the care community model aims to digitally enhance the referral process with electronic referrals (eReferrals) and Direct Referrals, which aim to reduce administrative leg work and increase accuracy of the referral information by limiting the need for faxed referrals, using mandatory fields in eReferral for Home & Community Care services, and by reducing the amount of interactions required between care providers and care coordinators to facilitate the referral (increasingly timeliness of access

to service for patients). **Figure 1** is a high-level logic model developed through this formative evaluation of the WWLHIN's approach to streamlining access to care.

Bundled Care Funding

Bundled care, or integrated funding models, is an approach in which a group of care providers receive a single payment, controlled through a single bundle holder, to be distributed over all the costs associated with a health issue across all sectors of care [6]. Within the WWLHIN Care Community Model, bundled care for select joint replacement surgeries (hip, knee, and/or shoulder) has been implemented as of April 2019, into three regional hospitals: Cambridge Memorial Hospital, Guelph General Hospital, and Grand River Health Centre. The Care Community Model is incorporated into bundled care at the point of a patient's transition from hospital to home, after the surgery is complete. The goal of bundled care is to enhance the patient experience when transitioning from hospital to home with better coordinated services, ensuring a seamless transition when patients require post-operative Home & Community Care services. **Figure 2** is a high-level logic model developed through this formative evaluation of the WWLHIN's approach to incorporating bundled care funding for patients utilizing Home & Community Care services after a joint replacement surgery.

Community Models of Care

To enhance the patient and provider experience with Personal Support Worker (PSW), Nursing, and Therapy services provided in the homes of residents and in long-term care, the Care Community Model has implemented 'Community Models of Care' to better distribute services to be more efficient when delivering care to patients, by organizing services based on geography. The WWLHIN has implemented two Community Models of Care: The Campus Model at the Fairview Mennonite Home (FMH), and the Waterloo Neighbourhood Model for the distribution of PSW services within a specific geographic region. An evaluation of the Neighbourhood Model was completed in June of 2019, therefore, this evaluation focused on the assessment of the Campus Model in FMH and makes references and comparisons to the Neighbourhood Model evaluation where applicable.

The FMH is located in Cambridge and encompasses long-term care, retirement residences, and assisted and independent living apartments. They have on-site health service providers and aim to incorporate a 'one-team approach' to care by eliminating external service providers for PSW, nursing, and therapy Services. At the time of the evaluation, they had incorporated this approach for PSW services (as of October 2019), and had planned to continue implementation for both nursing and therapy services. The community model approach aims to strengthen each patient's care team by enhancing communication between service providers, FMH leadership, and the patients. **Figure 3** is a high-level logic model developed through this formative evaluation summarizing the intended activities, outputs and outcomes of the Campus Model of care at FMH.

Figure 1: Logic Model for WWLHIN Care Community: Streamlining Access to Care

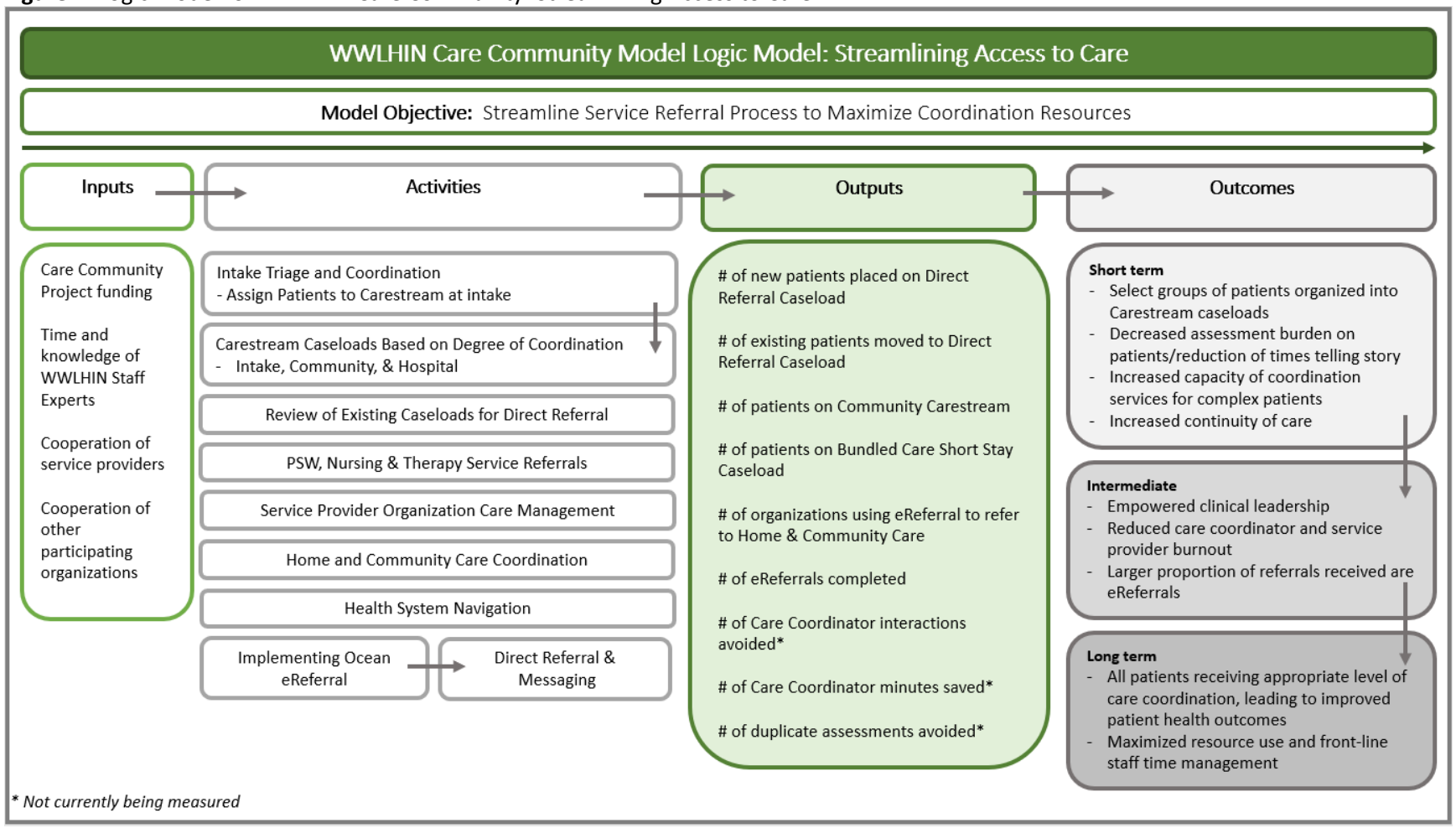


Figure 2: Logic Model for WWLHIN Care Community: Bundled Care Funding

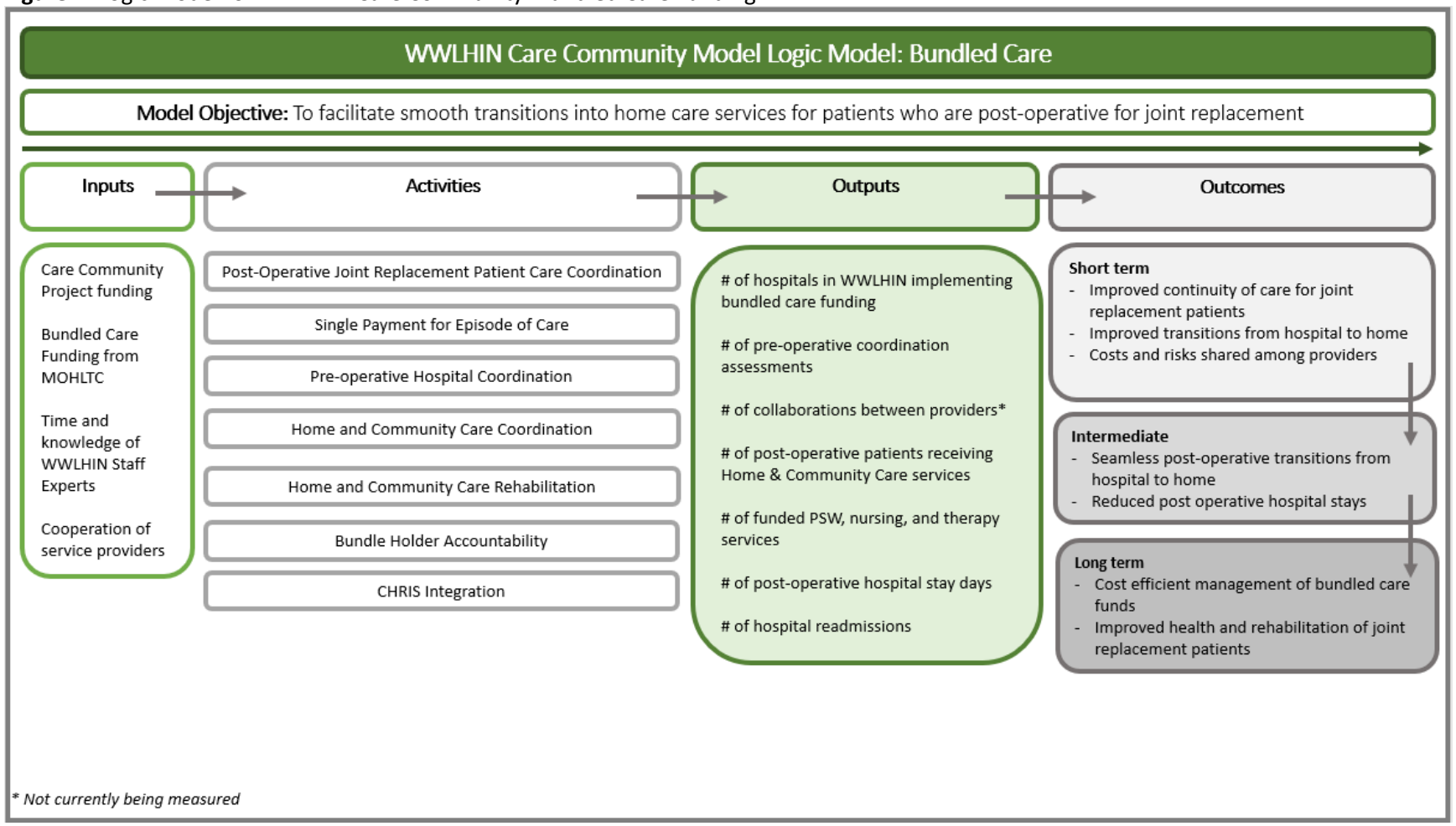
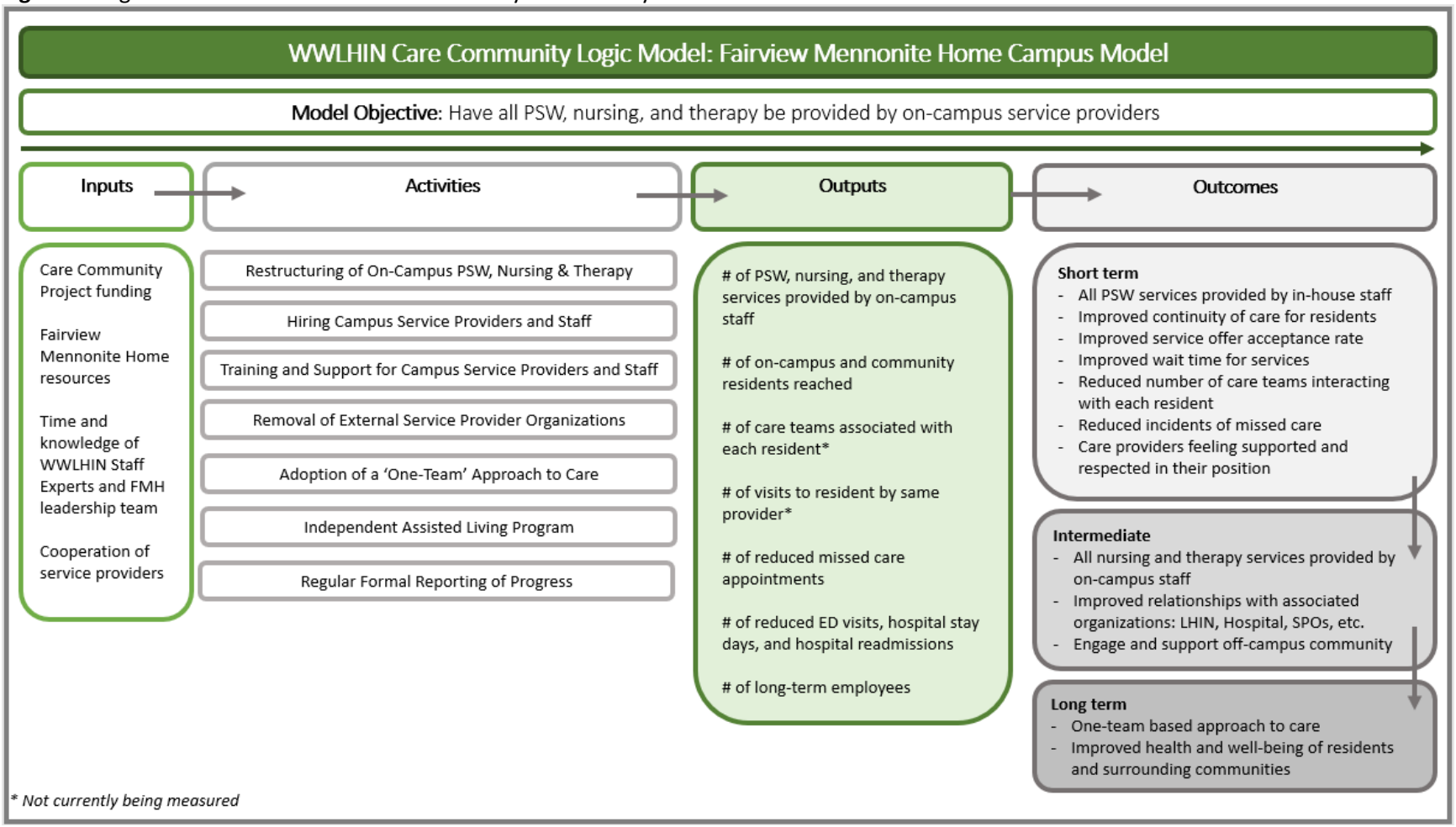


Figure 3: Logic Model for WWLHIN Care Community: Community Models of Care



Project Background and Objectives

The eHealth Centre of Excellence (eCE) was contracted by the WWLHIN to conduct a formative evaluation of the Care Community Model in the region. A formative evaluation was chosen as the most appropriate type of assessment at the state of the implementation of the Care Community Model at the time of the evaluation (February-March 2020), as it aligns with the goals of the evaluation; to better understand aspects of the model to establish appropriate adjustments as the model moves forward [7].

Within the context of the three elements of the model outlined above (Streamlining Access to Care, Bundled Care Funding, and the Campus Model of Care), the following evaluation objectives were explored:

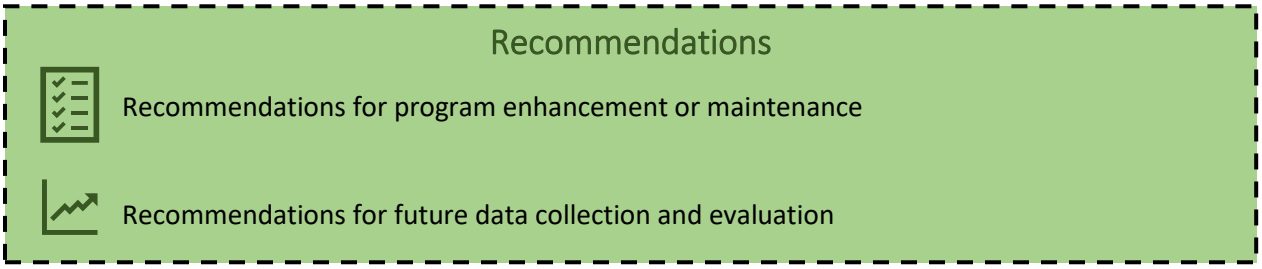
- The degree of functional, clinical, and service integration, compared to planned integration
- Patient/caregiver satisfaction and experience
- Health care provider and front-line staff satisfaction and experience

Additional measures were considered but limited by program maturity, these measures are reported where information was available and supported by the preliminary quantitative information accessible at the time of the evaluation. Subsequent observation of these measures is needed to capture an accurate reflection of work, performance, and goal achievement as the model progresses.

- Degree of functional and clinical outcomes associated with integration
- Quality of care (effectiveness, patient outcomes, safety)
- Timeliness of access to care
- System and provider efficiencies
- Digital health integration using digital health maturity framework
- Cost-effectiveness/value for money

This document reports each of the three care model elements separately and highlights recommendations in coloured boxes at the end of each section, which are organized into the categories described in **Figure 4**:

Figure 4: Example of Recommendation Box



A Note on Ontario Health Structure and the Pandemic Response

At the time of this evaluation, Ontario was going through a process of health care re-structuring. The WWLHIN was becoming a part of the larger geographic region of Ontario Health – West Region. As a part of the new structure, geographic regions were being considered to build Ontario Health Teams (OHTs).

Each of the subregions in WWLHIN (Cambridge North Dumfries, Guelph, KW4, and Rural Wellington) were in different stages of the application process to become an Ontario Health Team. For more information on Ontario Health Teams, visit the Ministry of Health and Long-Term Care's Website [8] . Where applicable in this report, notes and recommendations have been made to support WWLHIN subregions in their application and implementation process.

Additionally, at the time of the evaluation, a legislation had been proposed for the rebranding of Local Health Integration Networks, if passed, LHINs will be focused solely on home and community care services and will be given the new name of Home and Community Care Support Services (HCCSS) [9]. At the time of this evaluation, all Care Community Model activities took place prior to the rebranding and will therefore be referred to under the terminology of the LHIN. However, as the rebranding is set to occur in the months following the completion of this evaluation, recommendations will be made to support HCCSS and/or other supporting organizations and may not refer to the LHIN. For more information on the government's plan to modernize home and community care in Ontario, background information can be found here.

Due to the COVID-19 pandemic largely effecting Ontario beginning in March of 2020, the finalization of this evaluation was put on hold until September of 2020. Therefore, although the report was published in the fall, all numerical results, and qualitative discussions do not take into account any changes made for the pandemic response. Further evaluation may be necessary to address the impact of COVID-19 on Care Community Model Activities within the WWLHIN.

Methods

This evaluation used a mixed methods approach to capture the current state of the Care Community Model elements. As formative evaluations are best measured with qualitative engagements of key participants [7], the methods used to fulfill the evaluation objectives emphasize semi-structured communication with Care Community Model stakeholders. Firstly, key informant interviews took place to gather information from WWLHIN and leadership from different model elements. These interviews/group discussions included two or more participants, and were instrumental in finalizing the evaluation plan, identifying front-line staff, care providers, and patients for subsequent discussions. Secondary interviews/focus group discussions took place with staff and care providers identified in the key informant interviews. Finally, after discussions with staff and care providers, patients of bundled care funding and residents of FMH were interviewed to gain insight into the patient experience. Specific engagements are explained in the Qualitative Engagement section below. Results are reported in summary format organized into common themes.

To compliment the information gathered through qualitative engagements, quantitative data were provided by WWLHIN Care Community Model team members and WWLHIN Decision Support team members. All data were transferred in aggregate form, without any personal identifiers. Specific data elements used in this analysis are described in the Quantitative Data Collection and Analysis section below.

Information gathered for this evaluation was compared to existing evaluations, literature, and best practices where applicable to form observations on the current state of successes and areas for improvement of the Care Community Model. Recommendations were formed after the analysis and interpretation of all information gathered from evaluation activities.

Qualitative Engagements

Key Informant Interviews

A total of five key informant interviews/focus groups were completed with internal WWLHIN staff and subject matter experts on the elements of the Care Community Model. Initial interview participants were identified by WWLHIN and eCE evaluation team members. The goals of these interviews were to gain a knowledge base on the current state of the Care Community Model elements, identify related care providers and/or patients to speak to, and to identify gaps and needs for growth or measurement in future evaluations. Engagements were completed with sixteen (n=16) participants including:

- Three WWLHIN internal staff members regarding data collection, organization, and availability of the model elements (no scripted questions),
- Three members of the eCE team supporting eReferral,
- Two WWLHIN internal staff members supporting bundled care funding and streamlined access to care/Carestreams,
- Four WWLHIN internal staff members supporting community models of care; the campus model and neighbourhood model, and,
- Four Fairview Mennonite Home staff members regarding the campus model of care.

All key informant interviews were conducted in person, with three focus groups having at least one participant calling in over the phone. Each of the key informant interviews were conducted with a focus on specific care elements but included similar questions to allow for consistency in reporting. Modifications to scripted questions were made to account for the unique aspects of each element of the model being explored, and the roles and responsibilities of the participants within each engagement. The base outline for scripted questions is shown in **Appendix A,** no modifications are shown in the appendices.

Care Provider and Front-Line Staff Experience Engagement

Front-Line Staff

Front-line WWLHIN staff were interviewed in focus group settings to gain their perspective on streamlining access to care and bundled care funding. The goals of the focus groups were to identify any changes to their workflows as a result of this model, discuss what is working well, and any factors that could be improved upon. Four focus groups took place, with a total of thirteen (n=13) participants including the following roles:

- Seven Administrative/Intake Team Assistants
- Two Resource Care Coordinators
- One Triage Intake Care Coordinator
- One Hospital Care Coordinator
- One Community Care Coordinator
- One Patient Services Manager

All four focus groups were conducted in person at WWLHIN offices with a call-in option and had 1-6 participants. The outline for scripted questions is shown in **Appendix B**.

Clinical Care Providers

It was recommended that engagement with clinical care providers using Direct Referrals, eReferrals, and associated with bundled care funding take place over email. Therefore, an email with five relevant questions (available in **Appendix C**) was sent to and received by one (n=1) occupational therapist associated with Direct Referral, eReferral, and Bundled Care funding.

The care provider experience with the Campus Model of care was measured by interviewing PSWs at Fairview Mennonite Home; two individual interviews (n=2) took place at the Fairview Mennonite Home main campus. The scripted questions for these interviews are available in **Appendix D**.

Patient Experience Engagement

Patient experience with bundled care funding was captured during phone interviews for post-operative patients who were given home care services when returning home (n=4). The goal of these interviews was to gain knowledge regarding their experience of their transition from hospital to home. Due to time and privacy constraints, these interviews were conducted over the phone by a student chosen at the discretion of the WWLHIN. The scripted questions for these interviews are available in **Appendix E.**

Four individual interviews (n=4) of Fairview Mennonite Home residents took place about their experience with receiving PSW services. The interviews were conducted at the residents' homes in the Fairview

community, one-on-one with an eCE evaluation team member. The questions asked were a combination of questions asked for a pre-implementation survey and new questions developed through this evaluation. The scripted questions for these engagements are available in **Appendix F**.

Qualitative Limitations

The qualitative engagement participants for this evaluation were selected by WWLHIN staff and Campus Model Leadership based on availability, appropriateness, and/or knowledge of the Care Community Model. Because the participants are a convenience sample selected by the WWLHIN associated personnel, there is a risk of potential selection, self-serving, and self-report bias associated with these engagements. Although this risk exists, it is the opinion of the authors that the participants in these engagements were encouraged to speak without pressure, intimidation, or fear and that they were able to provide honest answers to the questions requested. All participants were given the opportunity to contact the authors privately to provide more information or to have their answers removed. In addition, the participants had an interest in uncovering the true current state of the program and were not swayed to bias their reporting for self perseveration.

The sample sizes for clinical care providers (n=3) were low due to model maturity and participant availability. For this reason, we can not infer that the perspectives highlighted in this report are representative of the entire population of clinical care providers and patients affected by the Care Community Model. For the purposes of this evaluation, the information provided by these engagements was used to support other qualitative and quantitative evidence, and to highlight areas for future review at model maturity. Data collection tools or questions provided in the appendices of this report can also be incorporated into future assessments of model performance when there is an opportunity to engage more participants.

Quantitative Data Collection and Analysis

The WWLHIN Decision Support Team and Internal staff provided the quantitative metrics available at the time of the evaluation project. Data were provided in aggregate form, where applicable, for the purposes of a current state assessment of the metrics that are currently recorded and/or reported by the model elements.

Streamlining Access to Care via Carestreams, and Bundled Care Funding

Metrics to capture the current state of streamlining access to care and bundled care funding included information on the number of patient cases that have been put onto Carestreams caseloads, including home care and bundled care. Data were transferred by the WWLHIN decision support team to the eCE in aggregate form, and included all referrals placed into Carestreams from July 2019 to February 2020.

eReferral and Direct Referral

Metrics reporting the progress of eReferral and Direct referral use were sent to the eCE by WWLHIN internal staff and Decision Support in aggregate form, and supported by further information from the eCE staff, who are responsible for the deployment of eReferral for Waterloo Wellington region. The data included the total number of eReferrals received by the WWLHIN Home and Community Care Services from July 2019-March 2020. Additional information provided with these data included the type of care

requested in the referral, Clinician using eReferral, and the number of referrals from each of the four sub-regions in WWLHIN.

Fairview Mennonite Home Campus Model

Rates of missed care, offer acceptance rates, and hours volume and cost were extracted from June 2019-February 2020 for Personal Support Worker services at FMH. These measures were reported as supporting quantitative evidence of success of the Campus Model for this evaluation. All information was transferred from the WWLHIN to the eCE in aggregate form, and graphs were created for the purposes of this evaluation.

Campus Model Pre-Implementation Resident Satisfaction Survey

Prior to the implementation of the campus model at FMH, the WWLHIN conducted a resident satisfaction survey with fourteen (n=14) FMH residents. The results of this survey are used to provide a relative comparison to the resident satisfaction elements that were measured in the resident interviews conducted for this evaluation. The questions repeated for this evaluation were answered as a 5-point Likert scale measurement of agreement ranging from strongly agree to strongly disagree, including: 'I am familiar with the people on my care team,' 'When I have a concern about my care, I know who to go to for the best response,' and 'I am notified when a change in my schedule is made.'

Quantitative Limitations

The data provided for this evaluation is used to support observations of the current state of Care Community Model elements and not an accurate reflection of the volume or quality of work that has been applied into the implementation of the Care Community Model. Therefore, the numbers in this report are not an evaluation of the effectiveness or value of the Care Community Model, but a snapshot of the measures currently being used to track the progression of the model towards maturity. For this reason, and due to sample size, there are no statistical analyses performed to infer significant improvements or maintenance in patient, provider, or financial outcomes. These measures are used to provide recommendations for future assessment of the model's impact.

Although information on acute care usage for FMH residents was available to be extracted at the time of the evaluation, limitations due to the COVID-19 pandemic prevented the team's ability to complete an analysis to the highest quality standards, therefore, it is suggested these measures are reported in subsequent evaluations of the model and they are not seen in this report.

Figure 5 is a visual summary of which methods were used to capture each of the evaluation objectives for the different buckets of work.

Figure 5: Summary of Data Sources for each Model Element

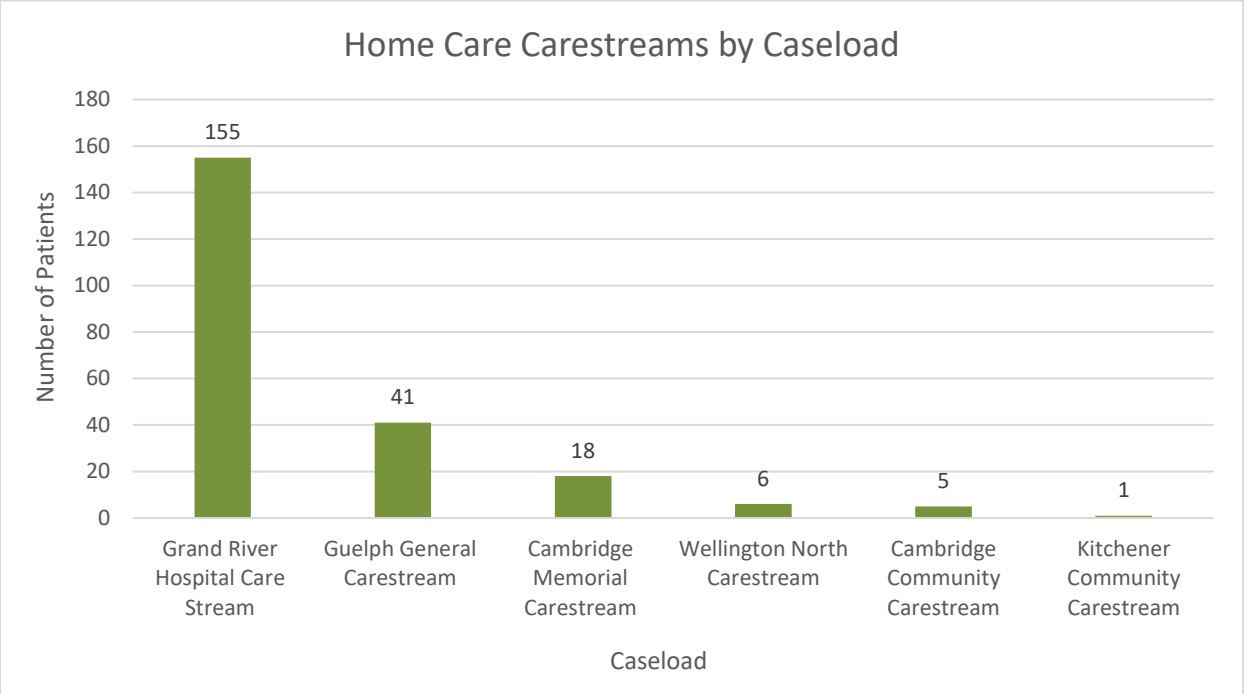
Measure	Stream-Lining Access / Carestreams	Bundled Care Funding	Campus Model of Care
Qualitative Engagements			
Key Informant Interviews	X	X	X
Front Line Staff and Care Provider Engagement	X	X	X
Patient Experience Engagement		X	X
Quantitative Analysis			
Progress/ # of uses/ # of patients	X	X	X
Reduction in inefficiencies			X
Value/Cost			X

Results

Streamlining Access to Care

Waterloo Wellington LHIN has been implementing Carestream caseloads as a function of the Care Community Model since July of 2019. Since it's initiation until February 2020, 388 unique patients have been organized into Carestream caseloads. In the same timeframe, a total of 12,247 referrals were made for unique patients to Home & Community Care, indicating that just over 3% of referrals get distributed to Carestream caseloads, and the remaining referrals are distributed to regular caseloads. The WWLHIN Decision Support team was able to extract data to display the number of patients on each of the Carestream caseloads. This section will address the current state of the number of cases organized into home care Carestreams (n=226), and the following section on Bundled Care Funding will address the patient cases who have been organized into Bundled Care Funding Carestreams (n=167). **Figure 6** shows the number of patients who have been put onto each Home Care caseload as of February 2020. Most patients are within the Grand River Hospital Carestream (n=155), followed by the Guelph General Hospital Carestream (n=41). Included in the Carestreams are patients who are moved to a Direct Referral caseload, all patients reported to be in the Direct Referral Carestream are discussed below.

Figure 6: Number of Patients in Home Care Carestream Caseloads (July 2019-February 2020)

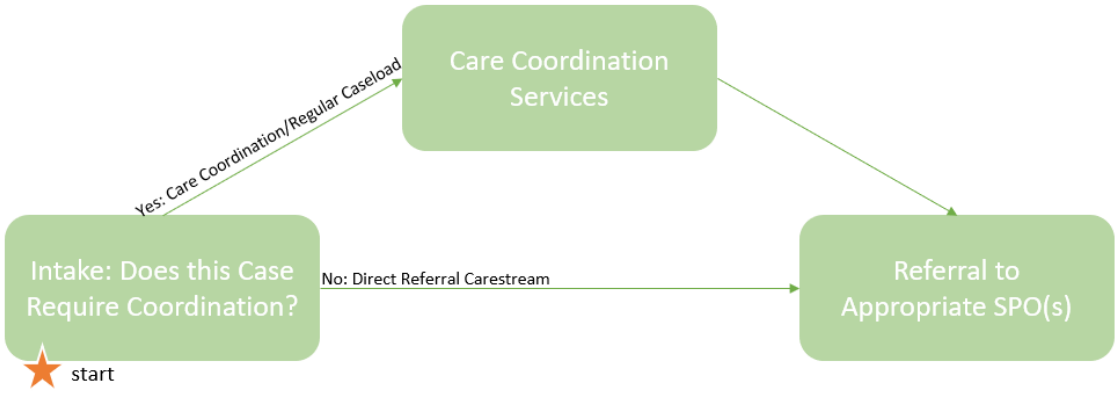


Direct Referral

The Care Community Model aims to maximize care coordination resources and streamline the experience for patients (e.g. reduce duplication of assessment) by matching patients with the level of care coordination they need; freeing up care coordinator capacity to provide more intensive care coordination to those who need it most. The WWLHIN has initiated this by identifying patients who either do not need, or no longer need coordination services through a dedicated care coordinator, and assigning them to a direct referral Carestream caseload with system navigation and care support provided by the Home &

Community Care service provider (e.g. therapist, nurse, PSW supervisor). A subset of these patients was identified as appropriate for a direct referral to Home & Community service provider. These are patients where the referral information provided by the Primary Care Practitioner or Allied Health team provides the necessary background information to support understanding of patient's needs and relevant background information. The service referrals are sent to the appropriate service provider organization(s) instead of being assessed by an Intake care coordinator using the RAI-CA assessment tool reducing the number of steps, time, and resources needed to complete the appropriate referral and time for patients to access the services they need **(Figure 7)**. Typically, patients who are assigned into the Direct Referral Carestream require short term, episodic care and need fewer, less complex services than those who require care coordination. Initially, Direct Referral Carestreams focus on rehabilitative services associated mobility assessments and home safety assessments; with the intent to spread to other therapy and nursing pathways.

Figure 7: High-Level Conceptual Model of Direct Referral Carestream



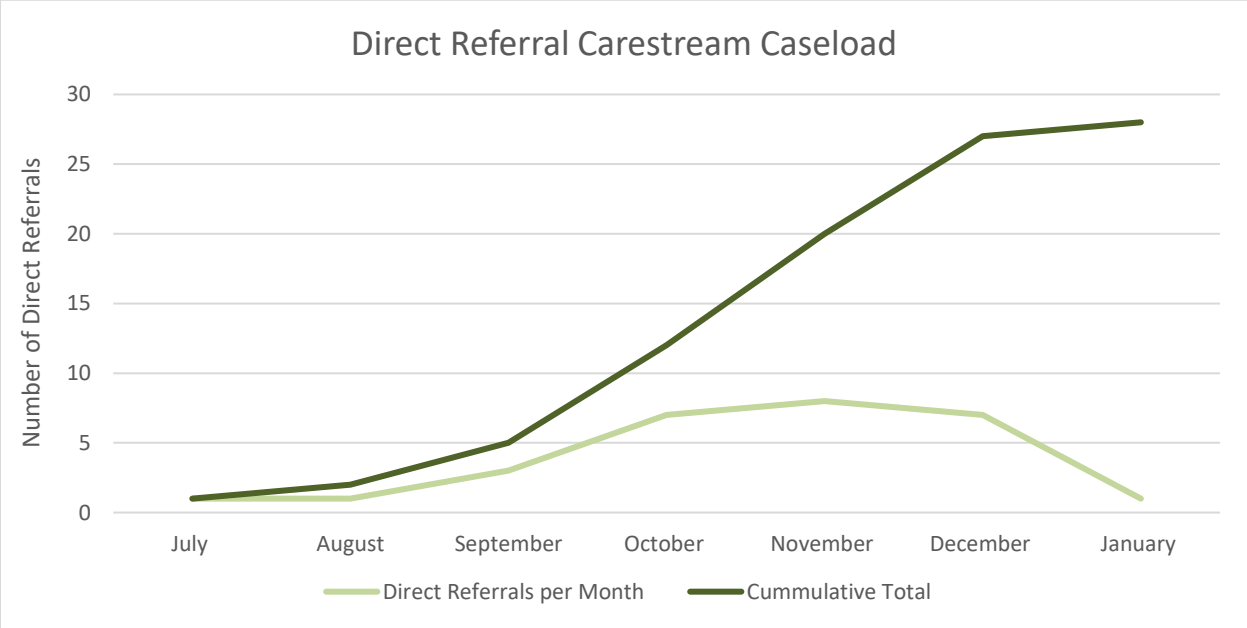
The Direct Referral Model has been implemented in the Cambridge North Dumfries sub-region of Waterloo Wellington Region since July of 2019, and since initiation, 29 referral requests have been assigned to the Direct Referral Carestream Caseload, with the most common service types being wound care (37.9%), and mobility assessments (20.7%) **(Table 1)**.

Table 1: Direct Referral Service Type (July 2019-January 2020)

Service Type	Total number of eReferrals
n (%)	
Medical Order: Wound Care	11 (37.9%)
Mobility Assessment	6 (20.7%)
Home Safety Assessment	5 (17.2%)
Long Term Care Assessment	3 (10.3%)
Request for Other Services or N/A	2 (6.9%)
Care Coordination	1 (3.4%)
Nursing Other	1 (3.4%)
Cognitive Assessment	0
Medical Order: Injection	0
Total	**29 (100)**

Since implementation, the month with the most recorded direct referrals was November 2019 (n=8) and has decreased until January 2020 (n=1) **(Figure 8)**. In the Wellington Region, care coordinators have begun to reassign patients on their caseloads to the Direct Referral Carestream if they feel as though they no longer need coordination services (data not shown), this is discussed in greater detail in the 'Staff Perspective on Assigning Patients to Direct Referral Carestream from Existing Caseload: Wellington Office' section on page 24.

Figure 8: Direct Referrals Completed per Month in the Cambridge North Dumfries Region Only (July 2019- January 2020)



Electronic Referrals (Ocean eReferral)

A key aspect to streamlining access to care for providers and patients is the adoption and use of digital health solutions. The Care Community Model has recognized the need for a digital approach to receive service referrals and has adopted Ocean eReferral (electronic referral) into practice. eReferrals also support the Direct Referral process of streamlining access to care. The Ocean eReferral Network is an electronic system that allows care providers to send and receive service referrals over a secure platform. The WWLHIN Home & Community Care team has become a destination site for eReferrals, meaning they accept incoming referrals for services if sent electronically by other health care providers. The Think Research Consortium is supported by the eHealth Centre of Excellence's System Coordinated Access program to implement eReferral, and as part of this evaluation, three eCE team members were interviewed in a focus group setting regarding eReferral and its role in the Care Community Model in Waterloo Wellington. They were also able to provide quantitative information on the number of physicians and other clinicians who have adopted eReferral in Waterloo Wellington region.

As of January 2020, 408 General practitioner physicians (GPs) have sent at least one eReferral within WWLHIN, along with 70 nurse practitioners (NP), eight IHPs, six medical residents, and three physician assistants. There are 575 General Practitioners who have electronic medical records (needed to send an eReferral) in WWLHIN, therefore, approximately 71% of physicians in the region had started to adopt

eReferral into their practice. Currently, a total of 48 General/Nurse Practitioners (10.0% of active eReferral GP/NPs) have sent at least one eReferral to Home & Community Care Services.

WWLHIN Home & Community Care went live as an eReferral destination site in July 2019, and as of mid March 2020, there had been 193 eReferrals for services received for more than 15 different service types. The most common type of service for which an eReferral has been made is a medical order for wound care (30.6%), followed by mobility assessments (17.6%) **(Table 2)**.

Table 2: Number of eReferrals to Home and Community Care by Service Type (July 2019-March 2020)

Service Type	Total number of eReferrals
n (%)	
Medical Order: Wound Care	59 (30.6%)
Mobility Assessment	34 (17.6%)
Home Safety Assessment	14 (7.3%)
Other Nursing Services	14 (7.3%)
Long Term Care Assessment	12 (6.2%)
Personal Support Services	9 (4.7%)
Care Coordination	7 (3.6%)
Medical Order: Injection/Infusion Therapy	5 (2.6%)
Mental Health Nursing Services	5 (2.6%)
Transition to/Shared Care with Palliative Practitioners	5 (2.6%)
Dietetics/Nutrition	4 (2.1%)
Eligibility Assessment for Long-term Care	3 (1.6%)
Medical Order: Urinary Catheter Insertion/Care	3 (1.6%)
Cognitive Assessment	2 (1.0%)
Other	*10 (5.2%)*
Missing/No Reason Reported	*7 (3.6%)*
Total	**193 (100%)**

The number of eReferrals to Home and Community Care per month has increased since the go-live date in July 2019, with the most eReferrals being sent in the most recently recorded full month, February 2020, with 36 referrals, the month of March was not completed at the time of this report **(Figure 9).** WWLHIN Home & Community Care Services are most likely to receive an eReferral from Family Physicians/GPs (83.9%), and Nurse Practitioners (7.8%) **(Figure 10)**.

Figure 9: Trends in eReferrals to Home and Community Care per Month (July 2019-March 2020)

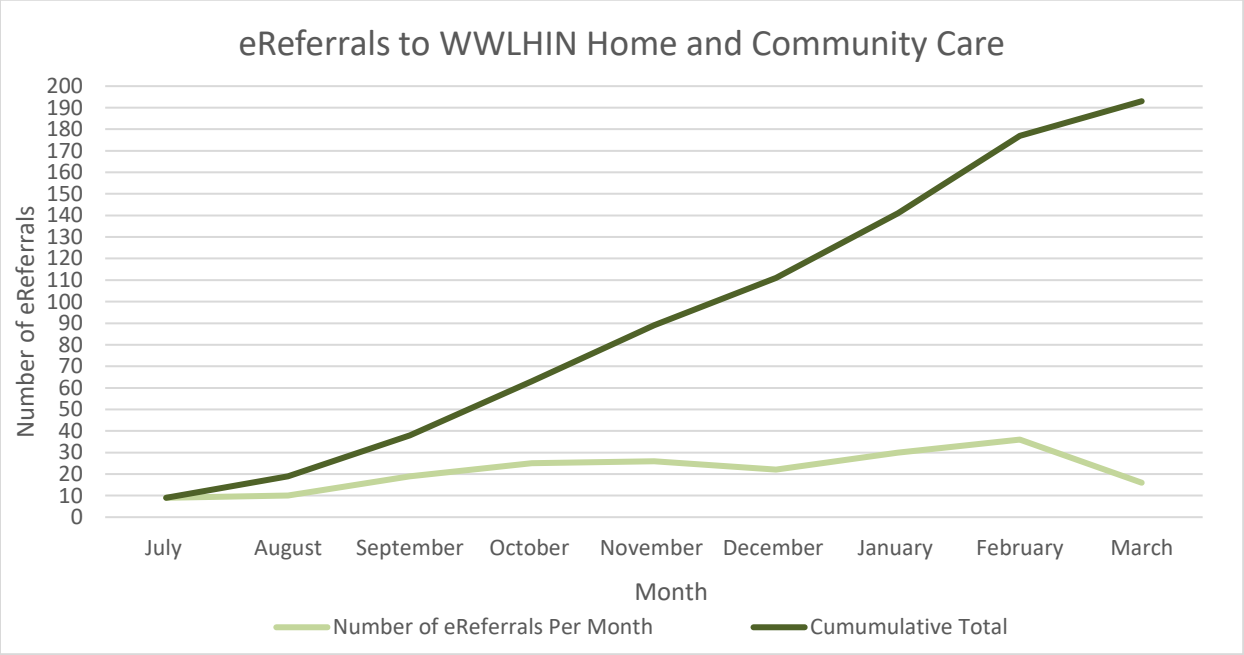
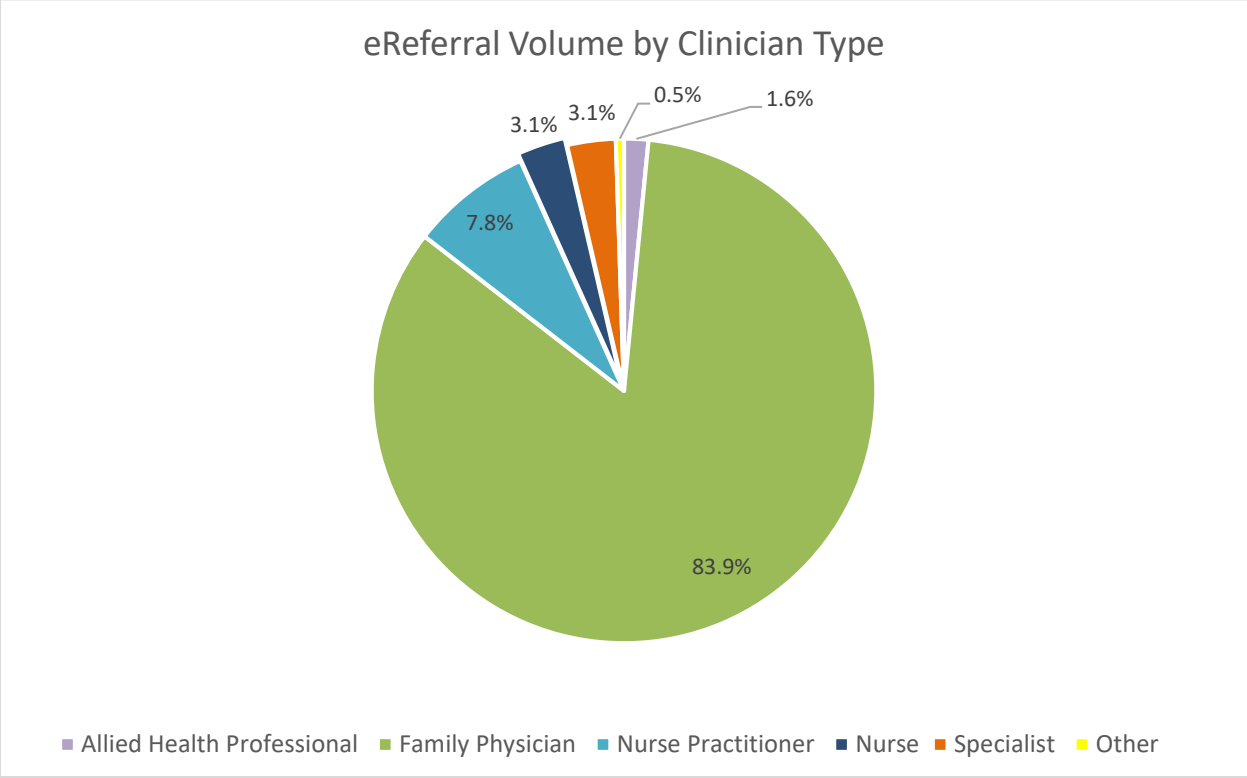


Figure 10: eReferral Volume by Clinician Type (July 2019-March 2020)



Discussion: WWLHIN Leadership and eCE Expert Perspective

The data shown above are examples of the type of information that is collected for the Care Community Model Carestreams and streamlining access to care, which are available for extraction from WWLHIN Decision Support. Continued monitoring of these elements could help determine the rate at which patients are being added or transferred to Carestream caseloads. More data collection and analysis are required to determine if these caseload placements are efficient and appropriate for the patient.

A focus group with Carestream leadership at the WWLHIN highlighted that as patients are assigned the appropriate amount of care coordination services, there will be less duplication of assessments, reducing the number of times patients have to tell their story, and freeing capacity for care coordinators to support more complex patients. This will increase and enhance patient access to the right services, at the right time, and having the right organization be accountable for patient care. These outcomes could be indicators for future measurement in an outcome focused evaluation of the Care Community Model.

It was stated that although the WWLHIN is proud to be a point of contact for patients with concerns, they recognize that other service providers can take on some of the responsibility to ensure their patients have coordinated care. They stated that there is a change management process that needs to take place to assure care providers that they can participate in coordination, and that a secondary person isn't always needed. The change management process is also a factor for the care coordinators, within the direct referral process, as they must learn to release the responsibility of specific patients' care to other service providers. Moving forward, leadership stated that for the Carestream process to work more efficiently, all steps, including eReferral, should be integrated into Client Health & Related Information System (CHRIS), allowing for easier adoption and enhanced communication between providers, and reducing the administrative step to add patient level data into CHRIS for new referrals and supporting easier direct referrals to Home & Community Care service provider organizations.

There is substantial room for growth of the use of eReferrals to refer patients to Home & Community Care services, as currently 10% of the physicians actively using eReferral at the time of this evaluation had sent at least one eReferral to Home & Community Care services. The use of eReferrals has the potential streamline access to care, as was highlighted by the focus group of eCE eReferral team members. Streamlining occurs as patients are kept up to date on the status of their referral via email, which enhances communication between care providers and the patient, in real time. This will allow patients to have a better understanding of their care, and potentially limit the need for care coordinator intervention. eReferrals have the potential to save time for intake staff as they can reduce the number of lost referrals, and are typically more complete, with less errors than paper/fax referrals as they have mandatory fields to be populated before sending. Evidence suggests that eReferrals take significantly less time to process at central intake for referrals related to musculoskeletal speciality care [10], and can also enhance communication between patients and providers, increasing patient satisfaction with care [11]. Messaging between the referral sender and receiver can also happen quickly, so any questions can be answered, and the referral can be processed sooner.

Overall, there is potential for the development, recording, and reporting of more indicators to support the monitoring and growth of the model as it progresses towards maturity. Potential indicators could include resource efficiencies for team assistants and care coordinators, proper placement of patients onto Carestreams, and continuing to track the use of digital health strategies. Monitoring important indicators

in real time, on a regular schedule could allow for the identification of issues as they arise, to be mitigated quickly.

Front-Line Staff and Care Provider Experience

To acknowledge the perspective of the front-line staff who are implementing Carestreams into their daily routine, we engaged in focus groups with staff in a variety of roles and stages of Carestream implementation. Focus groups were held for staff from the Waterloo, Cambridge, and Wellington offices to speak about what is working well, what could be improved, and what should be measured to capture success as the model moves forward. A total of 13 participants were consulted in these engagements. Each of the offices were at a different stage or took a different approach to the implementation of this model, allowing for a variety of perspectives. The following themes were highlighted as a result of these engagements.

Staff are Knowledgeable about the Goals of Carestream Caseloads

In all engagements, when asked about the concept and goals of Carestream caseloads, all staff were knowledgeable regarding the intended purposes for the new model. They noted the intended purposes of Carestreams are to reduce duplicate assessments, to reorganize care coordinator capacity to focus on complex patients, have more complete information, and to organize patients into streams that would ensure they get the most suitable care. They are also aware that one of the functions of Ocean eReferral is to have forms that require completed information. Because the staff were knowledgeable, they were able to provide well-informed reflections and educated recommendations for future measurement and advancement of the Care Community Model.

Transition to this Model of Care Has Come with Challenges for Front-Line Staff

For team assistants, it was noted that they felt left out of the planning and implementation of this new model that would drastically change their workflow and responsibilities. Because of this, they believe key factors affecting their day-to-day routine were not considered, and therefore the transition has had a negative impact on their work. For example, it was noted that they were given 'job aids' which are instructional documents that are intended to be used as guidelines on how to sort incoming patients into Carestreams. However, it was stated that the job aids were not straight forward and had room for many exceptions, leading the TAs to have to make judgements that, in some cases, they were not completely comfortable making. They felt that the number of new job aids to learn was over whelming and time consuming. Because of these concerns, it was noted that they could benefit from more standardized, clear guidelines for directing patients into proper Carestreams.

When speaking about eReferrals, they noted that although the eReferrals have the potential to be more complete than fax referrals, they require an addition to their workflows with having to log onto Ocean to check for incoming referrals on top of their regular responsibilities for organizing the incoming faxed referrals. Focus group participants also noted that they have received feedback from those using the referral platform that there is a large volume of incoming emails with updates on the referral status, and some providers/senders find sorting through these emails time consuming. They noted that having a plan to manage the amount of emails would be helpful with the adoption and use of eReferral.

Concerns for Front-Line Staff Job Satisfaction, Security and Morale

A care coordinator spoke to their concerns regarding direct referral and how this may affect their workday. They recognize that omitting an extra intake assessment completed by the care coordinator will reduce resource use, however, when this happens the care coordinators feel that they are left to work with only complex, high-stress cases for their entire day, making their job much more difficult.

Secondly, staff voiced concerns related to the automation process and its potential impact on their job security. With more of their work becoming digitized, and with their awareness of robotic process automation on the horizon, team assistants noted concern that they would no longer be needed in their roles and could potentially lose their jobs. They felt as though they were kept out of the conversations regarding this process and are not aware of how this new type of software will affect their job security. Because of this, along with the other factors making their jobs more difficult, they feel like employee morale is low.

Staff also indicated a concern for the loss of human component with advancing digital care, they believe that although these aids do help with efficiency, that they need to be paired with human decision making to ensure patient needs are met.

Staff Perspective on Assigning Patients to Direct Referral Carestream from Existing Caseload: Wellington Office

One of the focus groups took place with five staff members from the Wellington Office in WWLHIN. This region implemented a different approach to Carestream organization, as Care Coordinators reviewed their existing caseloads, and moved patients to the direct referral Carestream who they felt did not require full coordination services. Care coordinators moved patients into this Carestream if they were well supported and there was no value added to the patient from being assigned to a community caseload. The goal of this approach was to reduce the number of routine assessments for patients and care coordinators.

The group was asked to discuss any changes to their workflow as a result of the model being implemented. This type of implementation was reported to be a smooth transition for the care coordinators. They were able to review each patient on their caseload at their own pace and make clear decisions on who to transfer. They noted that it didn't make a big impact on their work, as the patients who they transferred over did not require a lot of work prior to be transferred, as they were stable. A care coordinator noted that now her more complex patients take up her time. The resource care coordinator noted that this model does add another item to check to her to-do list, but stated that she is already monitoring tasks, so it does not add much to her daily workflow. The team assistant present during the focus group added that she may have more patient interaction than she used to, because the transferred patients no longer have a set coordinator to contact, but she has been able to manage this and mitigate requests quickly. Finally, the hospital care coordinator noted that she has not noticed any changes to her workflow as the implementation of the model is still in an early phase.

The introduction of new care coordinators was brought up as a potential challenge. When a new employee joins the team, they won't be as familiar with the patients on their caseload as other long-standing employees, and therefore may struggle to assign patients to caseloads at the beginning. The team in this focus group recommended having a set of standard characteristics that would help care coordinators decide which Carestream would be best suited for their patients.

As part of the transition, patients were notified when they were being transferred off their care coordinator's caseload. A team assistant contacted all patients over the phone to explain the change and gave them a phone number to use in case they were in need of more assistance. They believe that this did help the patients be informed of the change to their care, however in some cases it caused undue confusion as they were concerned that either their care was changing, or action was required on their part, which was not the case. This issue was mitigated by reassuring patients that no changes to their care were being made and confirming their new contact number.

The participants in this focus group believe that the model is progressing towards the goals that it had originally intended. They noted that this model allows for fluidity across the Carestreams, and that if a patient had a change in their health status, they could be transferred back onto the community caseload, so the risk to the patients is low. The services are still available when needed, they are just provided on an 'as needed' basis instead of actively monitoring the patient. Although they believe that this model is working toward freeing up care coordinator capacity, it was still hard for them to tell if there had been any measurable impact in efficiency as the implementation is still new. They believe that more time is needed in order to measure the degree of the impact this type of caseload organization will have for the outcomes of LHIN staff and patients, but staff indicated that they would be interested to measure the amount of time savings realized when the model is functioning optimally or at full capacity after everyone is transferred onto their appropriate caseloads.

Questions and Concerns for Starting the Process: Cambridge Office

The Cambridge office staff were in a unique position at the time of the evaluation as they had not yet implemented Carestream activities into their daily routine. Although they were familiar with the concept and goals of Carestream, they were unsure on how their roles would be affected as a result. The following are questions that arose during the discussion. Answers to these questions may assist staff in feeling more comfortable regarding the transition to implement the Carestream process into their daily practice.

- Who (Care Coordinators, Resource Coordinators, etc.) will be responsible for transferring patients onto Carestream caseloads?
- Who is responsible for following up with the patient to ensure their needs have been met? Would it be the care providers?
- Will patients on the Direct Referral Carestream still be getting regular RAI assessments?
- They stated that they believed staff were getting a telephone number to give to patients when they need to redirect their concerns, is this still the case?

In addition to questions, the following concerns and potential solutions were raised during the discussion:

- First and Foremost, concerns regarding workload were brought up. Staff are concerned that these changes will bring more work into their already busy week. Specifically, they are concerned there will be additional forms to monitor (eReferral), more phone calls to manage, and that there will be difficult, subjective decision making required to assign patients to the correct caseload.
    - To combat this disruption, they proposed the idea of one person being responsible for the organization of all Carestream caseloads on a rotating schedule. This way, all staff are trained and able to take on the responsibility when needed, but the everyone is aware who is responsible for this task at each time.
    - It was also suggested that managers and other leadership staff could 'job shadow' the front-line staff to gain knowledge on how certain changes will affect their workflows. They

stated this has been done in the past and they felt as though it was an excellent way to show managers the work that they do and raise concerns.

- There were concerns about the ability to organize patients into the correct caseloads/ Carestreams. Currently, there is uncertainty on how to decide to which each patient belongs. Staff believe that it takes more investigation than it should to decide a patient's correct direction. One factor that contributes to these concerns is the naming system, it was proposed that having more descriptive names for each Carestream and caseload could allow staff to make efficient, more confident decisions.

Benefits to Providers are Not Yet Realized

As noted by staff in the focus groups and the clinical care provider engaged via email, any benefits of Carestreams have not been realized by the providers who have participated in its implementation. When explained further, it was noted that the number of direct referrals has been low to the providers since the launch. For an occupational therapist, it was noted that the changes made as a result of the model don't have much effect on their administrative staff either, as they still receive the information via Health Partner Gateway (HPG) and don't need to interact with any new software or modes of accepting referrals.

Although there hasn't been significant change to clinical care provider experience based on this model at its current state, the care provider was able to offer insights on what might be useful to measure in the future. For example, it was stated that specialized services such as occupational therapy and physical therapy may benefit from connecting directly with primary care physicians via Ocean, minimizing steps. As the responding clinician was an occupational therapist, they noted that they would be interested in hearing the opinion of primary care providers on increasing direct contact from service provider organizations and could benefit from discussions about the best way to accomplish this.

Recommendations for program advancement, and potential indicators and measures to be considered for future evaluations are discussed below.

Recommendations

Streamlining Access to Care

Recommendations for program advancement or maintenance

- Enhance communication and training to all staff when new models or programs are being introduced, and address concerns to increase job satisfaction and implementation success.
    - Implement standardized education and training, with clear instructional job aids for intake and team assistant staff. Their understanding of roles and responsibilities was noted as essential to their success and job satisfaction.
    - There is evidence to support that team-based learning aids in the successful implementation and adoption of new technology in health care settings [18]. Team-based learning was emphasized as a good learning mechanism in staff engagements for this evaluation. Suggestions included consistent inclusion of new programs as agenda items in team engagements, whether it be in existing team meetings or other group settings. It would be helpful to create a scheduled time for staff to ask questions and learn from one another as the model progresses. This could also allow staff to consider and learn from the questions and solutions from other staff members, preparing them to mitigate similar issues quickly, should they arise.
    - Communication could also help with staff reassurance; concerns were brought up as employees were unaware of how new changes would affect their jobs. Having transparency regarding changes to their position would allow them to feel more cognisant and prepared for upcoming changes.
- Increasing the use of digital health options is a priority identified by the MOHLTC as part their Digital First for Health Strategy that was set into motion in the fall of 2019 [19]. Noted as a facilitator of this strategy, eReferral is supported in the Digital Health Playbook to assist OHTs to develop their digital health plan [20]. Continuing the use of eReferral and integration with CHRIS and other digital strategies such as robotic process automation, while communicating to staff the importance of new technologies and addressing staff concerns regarding job security could increase the likelihood of successful adoption and job satisfaction for employees implementing digital tools into their daily routines.

Recommendations for future data collection and evaluation

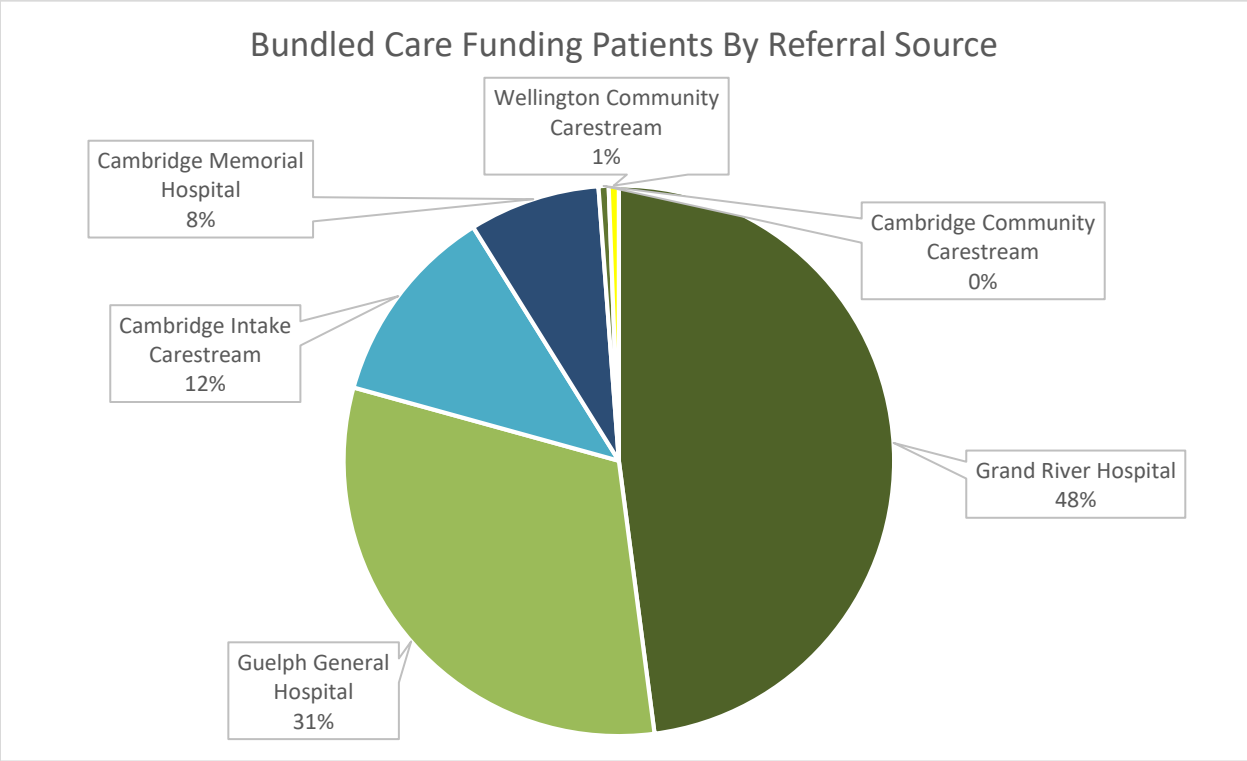
- Patient satisfaction after transition away from Care Coordination Services needs to be measured to ensure they have selected the correct cohort of patient for the Direct Referral Carestream. It was noted by multiple focus groups that an investigation needs to be done to ensure patient needs continue to be met after the change of coordination services. This could be achieved by integrating a patient survey into subsequent digital or phone communication with the patient, or communicating the need for the specific patient feedback to primary care providers of patients on the Direct Referral Carestream, ensuring that patients have an opportunity to provide feedback to inform the enhancement of the program.
- Continue to include Front Line Staff such as Team Assistants, Resource Care Coordinators, and Care Coordinators in the planning, implementation and evaluation of this model and other programs. TAs stated that they appreciated getting the opportunity to speak about their concerns in the focus groups, and that sometimes they feel like their opinion was not considered. Utilizing their first-hand knowledge will not only highlight important topics of consideration when changes are made but could also increase job satisfaction.
- Calculate estimates of time savings using eReferrals by limiting errors and reducing the number of incomplete forms. Using the task tracker that TAs and Care Coordinators currently used was identified as a potential method of capturing these data elements.
    - Once time savings can be accurately tracked, there will be potential for the measurement of resource use efficiencies and cost savings.
- Continue to track the progression of the number of patients being assigned to each caseload/Carestream and strive toward CHRIS integration to allow for more in-depth analysis of patient characteristics and outcomes as a result.
    - In addition to enhancing communication between providers, CHRIS integration may increase opportunity to track patient overcomes overtime.

Bundled Care Funding

To capture the current state of bundled care funding, we spoke with two lead managers at the WWLHIN, WWLHIN intake and coordination staff, a clinical care provider who receives referrals and treats patients under bundled care, and four patients who have had joint replacement surgery under bundled care funding. In addition, we received secondary, aggregate data from the WWLHIN Decision Support team to report the number of patients who have received care under bundled care funding, the types of services they received, and the place of referral to bundled care.

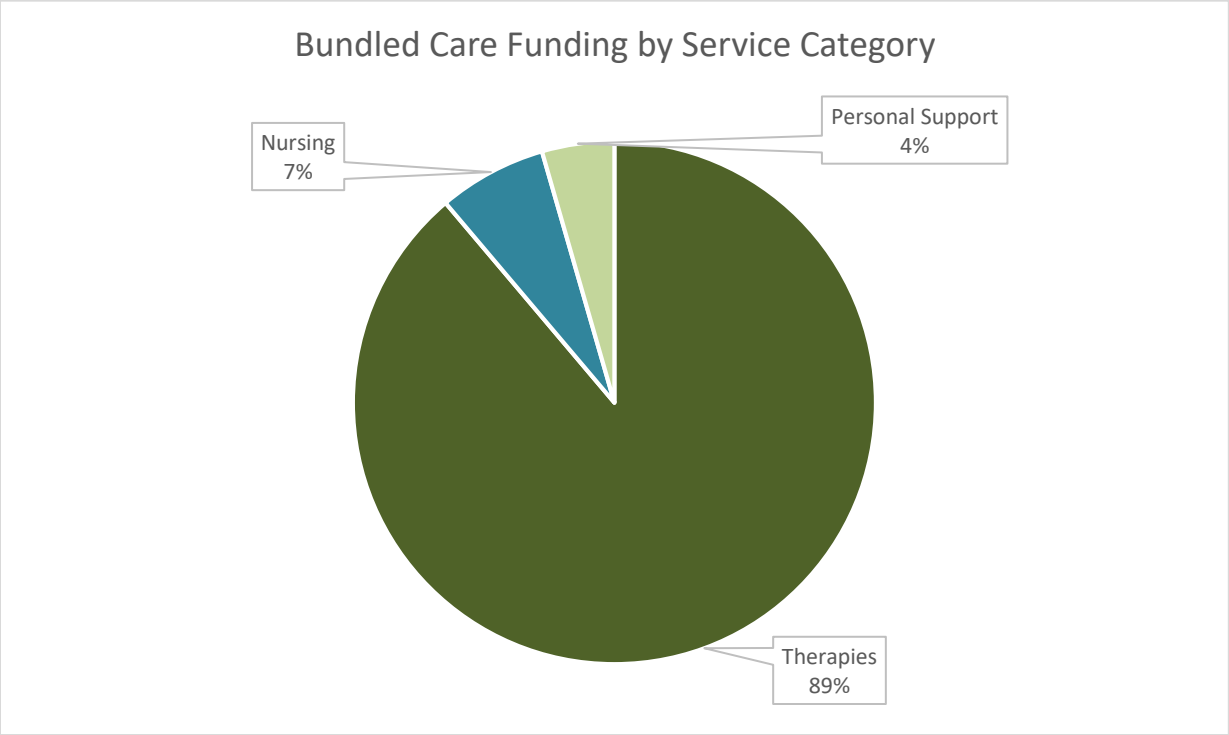
Bundled care funding for joint replacement surgery has been applied for 167 unique patients in the WWLHIN since its initiation in July of 2019 until February 2020. The most frequent referral source for bundled care funding is the Grand River Hospital Carestream (47.9%), followed by the Guelph General Hospital Carestream (31.4%) **(Figure 11)**. Two patients were referred to bundled care funding by two separate sources, making the total number of referrals 169 up to and including February 2020.

Figure 11: Bundled Care Funding Patients by Referral Source (July 2019- February 2020)



Of the 167 unique patients, 159 (88.8% of all referrals) were referred to therapy services, 12 patients (6.7% of all referrals) were referred to nursing services, and 8 patients (4.5% of all referrals) were referred to personal support services **(Figure 12)**. Patients can be referred to more than one service, therefore, there are more referrals than the number of unique patients.

Figure 12: Bundled Care Funding by Service Category from (July 2019 – February 2020)



WWLHIN Leadership and Front-Line Staff Perspective

Bundled Care Funding Concept and Goals

It is the goal of bundled care funding to provide more accountability for service providers to support the patient experience with joint replacement surgery. Because funding is provided by one holder, the hospital, they are responsible to ensure all aspects of the surgery, including pre-operative instructions and post operative care, meet patient needs. As such, this has transitioned administrative work from the LHIN, and has been assigned to the bundle holders. This approach is thought to create a stronger linkage across the continuum of care and all other clinical pathways involved in patient recovery.

Current State: Successes and Challenges so Far

When speaking with leadership staff, they stated that bundled care funding has shown an increase in positive patient outcomes. They have seen reports of shorter stay in acute care, which reduces the chance for infection, and a greater percentage of patients utilizing physiotherapy clinics, which helps them re-engage in the community and have better access to appropriate rehabilitation equipment. It has also helped hospitals understand what is happening with patients outside of the hospital, as they are accountable for reporting back to The Ministry of Health and Long-Term Care (MOHLTC). Although no quantitative data to report on these measures was available for the current evaluation, these may be good indicators of success to report for an outcome evaluation of the Care Community Model in the future.

A challenge that was stated by leadership staff has been timely communication with the bundler holder, these challenges were said to be between both the patient and the bundle holder, and service providers and the bundle holder. In order to move forward with services for patients, they need to be approved by the bundled holder, which can cause a delay. Leadership explained that they aren't sure that the staff at the bundle holder organization have the same lived experience with patient care as those in Home & Community Care, indicating that further advancement of communication is needed to ensure that patients get the services they need, when they need them, after leaving the hospital.

Team assistants and care coordinators also recognized communication with the bundle holder as an area for improvement in their daily workflows. This is particularly true when processing requests from out of region hospitals, stating that different bundled holders have different procedures for processing referrals. Learning and applying the correct procedure for each hospital is time consuming, leading them to believe that bundled care is not yet decreasing resource use for their team. Team assistants also receive calls from patients inquiring about services, that need to be redirected to the bundle holder.

A (former) total joint replacement team assistant at the WWLHIN who participated in this focus group noted that she believes this model could benefit everyone if they were able to overcome these challenges. She stated that having a set of provincial standards that all hospitals follow would limit the confusion when processing requests from out of region hospitals. The WWLHIN leadership staff mirrored this recommendation, stating that the implementation process would have been smoother if there was direction from the MOHLTC on how hospitals were to communicate their internal process to outside partners.

Patients Would Benefit from a Distinct Point of Contact Person Regarding their Pre and Post Surgical Care

A goal of the bundled care funding approach is to give patients continuity within their care team when having joint replacement surgery, allowing them to have the same point of contact throughout all their care associated with joint replacement. It was noted by multiple focus group participants that prior to bundled care funding initiation, that the LHIN was a patient's point of contact to obtain information regarding pre and post surgical instructions and inquiries regarding their care. With the implementation of bundled care, the hospital (bundle holder) is now responsible for providing these instructions and answering questions for patients, as this promotes continuity for all aspects of surgical care. The LHIN continues to receive phone calls, as they report some patients are unsure who to contact, indicating that effective communication may not have been in place to ensure patients have the contact information of the best person to call as their care transitioned from the hospital into the community and vise versa. Because of this, the LHIN has been using resources to connect the appropriate organizations to receive authorization for services.

"This process can be time consuming and may cause unnecessary delays and frustrations for families trying to navigate the systems." – *WWLHIN Care Coordinator*

This confusion was thought to stem from patients not receiving a phone number for a person at the hospital they can talk to regarding their care. Therefore, if patients were given a point of contact phone number to the bundle holder, their confusion may be limited, and resources and time may be saved for team assistants and care coordinators. Further, it was noted that that clarity is needed regarding the information staff can share with family members (i.e., care provider phone numbers), as sometimes it is

the family calling on behalf of the patient. To limit further delays and hardships for the family, being clear on what information they can provide could be helpful.

Clinical Care Provider Perspective

As predicted by WWLHIN internal staff, at the time of this evaluation, the model had not made a large impact on the care provider experience with bundled care funding to reflect an accurate measure of model success, as the volume of patients was too low, given the timeframe, to have had an impact on their workflows. We reached out to an Occupational Therapist implementing bundled care funding, and although he was aware of bundled care funding and knowledgeable of the process, he believed that it was too early to speak to any changes to his workflow, and expressed that he believed his colleagues would feel the same. WWLHIN leadership staff noted that as the model progresses, clinical care providers may notice an increase in patients being referred to in-clinic services as this is the planned trajectory as more patients receive care under bundled funding.

Patient Perspective: Bundled Care Funding

To capture patients' preliminary experience with bundled care funding four (n=4) phone interviews took place inquiring about the patients' satisfaction with the services and the communication from their care providers and the bundle holder. These interviews were the only qualitative engagements in this evaluation not facilitated by the author of this report, and therefore results were summarized by each question asked in the telephone interview, as no follow up questions or discussions took place.

'Would you be able to talk to me a bit about your surgery and the types of services you receive(d)?'

All four patients required physiotherapy after their joint replacement surgery. Two noted that they received home care, and one noted that the service in the hospital was amazing. Once participant stated that they were upset with the hospital as they would not send them to their preferred location for physiotherapy, this caused the patient to seek private physiotherapy services.

'Before having the surgery, did you know what services you would receive when you returned home?'

Three patients stated that they were aware of which services they would receive when returning home from the hospital. One patient explained that they received lots of information, another patient stated that they knew they would not be getting any services.

The fourth patient stated that they were not aware that they would be receiving services.

'Did you feel ready to come home from the hospital?'

One patient stated that they were ready to come and received lots of information, one patient stated that they were wanting to come home earlier, and the third patient stated that one more night in the hospital would have been better for them. The fourth patient stated that they somewhat knew what services they would get, but changes occurred.

'Do you feel like you were involved with the planning of the care you would receive once you returned home from the hospital after surgery?'

Two patients stated that they were not involved with their care planning. One patient further explained that they felt very prepared with the amount of information they were given. The third patient stated that they were given opportunities to be involved with the care planning but didn't really want to be involved. The fourth patient noted that were involved on some level because of the physiotherapy.

'Were you aware who your doctor and other care providers were for your surgery and care afterwards?'

All four patients reported being aware of who their care providers and doctor were for their surgery.

'Do you, or did you know who to contact if you had a question regarding your care?'

All four patients reported to know who to contact when they had a question regarding their care. Two further explained that they would contact their doctor, or that they were still in contact with their surgeon.

'Did you or do you currently have any challenges or difficulties with your care related to the surgery? If so, please explain,' 'Did you have any troubles contacting someone for assistance?'

All four patients responded 'No' to this question. One patient further explained that they did, however, not know when home care was coming.

'Do you feel like the care you received met your needs?

All respondents indicated that the care met their needs. Further expanding, one patient stated that the hospital was 'awesome' and home care was 'good,' another stating everyone was friendly and helpful.

'What do you think went well?'

Two patients indicated that 'everything' went well. One further explaining that they were referring to their surgery, home care and physiotherapy. Two patients indicated that their surgery went well, and one patient also added that their physiotherapy at home was appreciated.

'What could have gone better or should be improved so others who undergo similar surgeries have a better experience?'

One patient respondent that in-home physiotherapy would have been ideal. Another patient responded that they would have liked to have more visits or home care, but they need to have approval for more visits. The remaining two patients indicated that the waiting list for surgery was too long.

'Is there anything else you'd like to mention about your care after your joint replacement surgery?'

Patients stated that they felt great after surgery, that everything was well, felt great once they got home, and that they were very happy overall. One patient also mentioned that a 'gain ready machine' was the best tool, and that it helped with their recovery.

Discussion: Patient Experience with Bundled Care

The patients interviewed for this evaluation appeared to be satisfied overall with the care they received through bundled care funding. Although the results for this evaluation can not be generalized to the entire bundled care funding population due to sample size, they highlight some areas that are going well, and some that may need to be improved upon.

Contrary to what was reported by WWLHIN leadership and front-line staff, patients reported feeling like they were aware of who to call if they had a question about their care, which was highlighted as a potential issue during the focus groups. This could be due to the small sample, but could also be due to patients not being aware of any changes to their proper contact person, so they still feel as though they are prepared to call the LHIN if they have an issue, and therefore did not experience the confusion that was emphasized during the focus groups. In addition, the group of patient participants indicated little complications, therefore, they may not have had to contact anyone for guidance. Further evidence that patients are provided with the appropriate amount of information is supported in patient claims that most patients knew what services they would receive, and who their care providers were.

Patients noted that more in-home physiotherapy would be useful during their recovery. During the staff focus groups, they noted that in-clinic physiotherapy services would be more common. This could be an example of a small number of patients who are finding it hard to manage going to the clinic for their therapy need and may highlight a need for supports to ensure patients are managing their physiotherapy schedule. However, one patient did note that the use of a specific machine was the best tool to their recovery, providing lived-experience evidence for the leadership staff's claim that in-clinic physiotherapy would provide patients with better access to equipment.

The results of this evaluation provide evidence that although there have been some challenges with implementing bundled care funding for leadership and front-line staff, that the patients have yet to feel the consequences of those challenges. Providing reassurance that good quality of care is being maintained through the transition to a new care model. Ensuring that procedural challenges of the staff and are addressed in a timely manner to reduce the chance of burnout, frustration and poor job satisfaction could have positive implications for staff and limit the risk of patients being affected by those challenges.

Recommendations

Bundled Care Funding

Recommendations for program improvement or maintenance

- Efforts to enhance timely and effective communication between all parties could be beneficial.
    - It was noted that enhanced communication about hospital procedurals could improve the efficiency of intake and triage team assistants when processing referrals for bundled care funding. Standardized procedures set by governing health organizations could limit unnecessary resource use when processing referrals from hospitals out of region, or those newly referring to the Waterloo Wellington HCCSS.
    - Ensuring patients have a clear point of contact and a phone number to call at the bundle holder organization was noted to be important to limit patient and family confusion, as well as reduce resources.
- Ensure the needs of the staff are being considered in the development and implementation of models that will have an impact on their daily routine. This could increase job satisfaction by mitigating potential issues and increasing employee morale.
- Continue to assess patient therapy schedules to ensure that that in-clinic physiotherapy is manageable within the patient's abilities and schedule.

Recommendations for future data collection and evaluation

- Collecting information that is available for extraction to track acute care usage such as hospital stay days and readmissions, the number of services used, and the percentage of patients using in-clinic therapy services to be tracked over time, will prepare for subsequent evaluations reporting outcomes of the model.
- An assessment of patient experience integrated within the patient journey of care could be beneficial to ensure patient needs have been met, and when they haven't been, it would be beneficial to have flags within the system to ensure continuous monitoring and enable ongoing improvement opportunities.
- Continue to engage front line staff in subsequent evaluations as their perspective acknowledges the challenges associated with implementing a new model and provides supportive evidence to quantitative indicators that report on the amount of resources saved as a result of this model.

Community Models of Care

To capture the current state of the Campus Model of care at the Fairview Mennonite Home, we held key informant interviews/focus groups with stakeholders in four different categories: The Campus Model Project Team at WWLHIN (n=5), the Campus Model Leadership Team at FMH (n=4), Personal Support workers employed at FMH (n=2), and Residents at FMH who receive PSW services (n=4).

WWLHIN and FMH Leadership Team Insights

The following themes emerged from two focus groups including the Campus Model Project team at WWLHIN and the Campus Model Leadership team at FMH. Each group was interviewed separately, however consistency was seen across the answers to questions, therefore, the results of these focus groups are reported together.

There is a Clear Vision for the Model

While planning the implementation of the Campus Model to FMH, a clear vision was established from the beginning and maintained for all activities throughout. The model aims to fulfil the goals of the quadruple aim outcomes, which are to improve the patient and care provider experience, maximize resource use and improve costs, and improve population health [12]. It was noted that this vision for the model has been at the forefront of all planning, giving direction and guidance to all participating organizations.

A specific goal of the Campus Model is to consolidate PSW services within the campus to provide consistency and continuity of care for their residents. Their resident-centred approach aimed to have residents feeling like they are part of a community, that they are cared for, and that they will have support when they need it. They aim to enhance staff experience by staffing in innovative ways, creating a positive atmosphere, and supporting PSWs in daily activities. This aligns with their goal to improve staff retention, therefore creating strong relationships and consistency for residents.

The new model will maximize resources by creating efficiencies in service delivery, reducing the number of repeated assessments, missed care, and refusals, as well as improving transitions from hospital to home for residents, decreasing the risk of readmission and hospital emergency department visits.

Finally, they aim to contribute to population health by expanding the Campus Model services to the surrounding communities, allowing more residents to have excellent access to services in their own homes.

Strong Communication has been a Key Factor to Implementation Success

Focus group participates feel confident that the model implementation has been successful. Strong communication between all associated parties was noted as a key factor leading to the success of the Campus Model. Focus group participants spoke of being well-informed of all implementation planning and process components from the initial phases of development, through to when the focus groups took place. They believed that consistently informing all associated staff helped to clarify roles and responsibilities and created opportunities to establish risks. Because risks were identified early, strategies were developed to address them, leading everyone to be prepared to be responsive to challenges, and therefore concerns were mitigated quickly. It was noted that team members met regularly and had

regular check-ins and communication between meetings. At the time of the evaluation, model progress was being tracked in monthly meetings.

As a result of having open, regular communication within and between teams, they feel that they have built positive strong relationships between the LHIN, FMH leadership, Cambridge Memorial Hospital, PSWs and residents of FMH and the surrounding community. This is seen as an improvement from past relationships and a facilitator of success.

Team On-boarding, Support, & Retention

The members of the focus groups noted the model's success in hiring and maintaining an exceptional staff of PSWs and leadership to move forward with the Campus Model, because they apply the model's mission and values into their daily routine. Firstly, the employment of the program director was noted as an excellent addition to the staff. The person in this position leads with a policy of open communication and has a team-based approach to the deployment of all Campus Model activities. Having the director as a point of contact person for people with questions or concerns has been an invaluable resource for other team members. Other members of the team have been noted to go 'above and beyond' to ensure that the model's implementation runs smoothly and have all been essential in supporting one another in their roles.

Secondly, it was noted that when hiring care provider staff (i.e., PSWs) that the mission statement, values, and goals were discussed with potential candidates during the hiring process. WWLHIN team members noted that the Campus Model leadership team at FMH did an outstanding job selecting care team members whose personal working goals aligned with the goals of the model. In addition, it was noted that there was excellent communication between staff and the leadership team when new staff was brought into their new role, as the team adopted a philosophy to ensure that every team member feels supported throughout the transition process. The FMH leadership team also empowers PSWs to work independently and encourages autonomous decision making, which they feel has provided a balance of feeling in control as well as supported by a group. This course of onboarding and encouragement throughout employment has led to high staff retention and minimal turnover, indicating employee satisfaction. The care provider experience engagements mirror these statements and are discussed on page 40.

Moving Forward and Over Coming Barriers

Although it was stated that they were able to overcome barriers with minimal struggle, the focus group participants shared some of the challenges they had faced. Firstly, they anticipated that the transition to a new model would be difficult for some residents as they had been receiving care from the previous service provider organization for upwards of ten years. They were able to mitigate this risk by facilitating open communication with residents about upcoming changes, and since the implementation, the staff have seen little issues and few complaints from the transition to new providers.

Secondly, the Campus Model leadership at FMH is a close-knit team of four individuals. They work very closely together to ensure all the program's needs are met. However, because they are a small team with ambitious goals and values, they have taken on a lot of responsibility. In order to prevent falling behind when a team member needs to take time off, each team member is crossed trained on multiple roles so the other team members can fill in in their absence. Although this is currently working well, plans to expand the model would require additional team members to limit the risk of burnout.

Increasing the use of eHealth technologies was highlighted as a need within the FMH and the campus model. Their current system was seen as a barrier to their success, as they noted a need to better organize referrals coming from the community. They would also like to be able to leverage current electronic systems to report resident and provider outcomes, for example, to use currently reported PSW tasks to measure continuity of care for residents across multiple PSW visits.

Future Measures of Success & Recommendations for the Future

Focus group participants were asked what they recommend for future indicators of success regarding the model. Answers were given for a variety of measures that were both qualitative and quantitative in nature. The first and most commonly noted recommended measure was the happiness of the residents. This is central to the mission of the FMH and will always be at the forefront of measures of success. Continuing to collect information on resident health and satisfaction as the Campus Model progresses will be essential to establishing model success. Specific indicators discussed included that patients fee like they have good relationships with their care providers, and if they are content with their living situation. Another measure of resident health that was of interest was the length of time a resident is able to live well, or live-well independently, as ideally with improvements in care, a resident will be able to remain independent and/or in relatively good health for longer periods of time.

FMH staff efficiency was also highlighted as a potential measure of success. A specific measure that could capture both patient satisfaction and time efficiencies is recording the number of resident complaints with PSW services. Both focus groups have noticed a decrease in complaints made by residents regarding PSW care since the implementation of the model. Participants noted that this is an efficiency as it reduces the time spent addressing resident complaints and frees capacity for other responsibilities. An average amount of time the address a complaint could be calculated, and reductions could be estimated by multiplying that amount of time by an estimated number of reduced complaints.

Focus group participants recommended continuing to measure care provider and patient outcomes, such as rates of staff retention, missed care and refusals, along with reduction in acute care usage. In addition to these measures which are already being collected (reported below pg. ##), a need for a measure of continuity of care was highlighted. Specifically, FMH leadership staff were interested in observing the percentage of visits to the same resident, that were made by the same care provider (i.e., resident A is seen by PSW A for 50% of their PSW visits, and seen by PSWs B and C for the remaining 50% of PSW visits). This measure would provide insights into the ability of residents to build relationships with their care providers, and have consistency in their care routines, which was noted to benefit both residents and care providers. This measure could be repeated as other on-campus services are introduced into the model, such as nursing and therapy. It was suggested that this may be possible using their scheduling software to extract this information.

Care Provider Experience at FMH

Two PSWs were interviewed at FMH, each who had several months of experience providing care for patients within the Campus Model of Care and experience as a PSW in other care settings prior to their time at FMH. Each PSW was interviewed separately. PSWs were asked about providing care on campus and asked to identify any successes or challenges they may have experienced. The following were themes that emerged as a result of the interviews:

PSWs Feel Like Part of a Team at FMH

The PSWs who participated in the interviews both expressed feelings of being 'a part of a team' when caring for residents at FMH. The PSWs felt supported by the FMH Campus Model Leadership staff. They stated that the communication between themselves and the leadership is fantastic, and that they feel supported, not intimidated, when talking to their leadership. They feel that the leadership team is accommodating and understanding to their needs. When compared to previous places of work, they stated that there was a lack of communication or it was untimely between PSWs and other staff, which isn't the case at FMH.

PSWs are Proud of the Work they do at FMH

Each PSW was confident that they were providing excellent care to FMH Residents. The PWS felt that they were able to build relationships with residents, to get to know them, and to provide them with the care they need. They stated that they are happy with their positions and they are able to do a better job caring for the residents because they feel like they have the time to do so, and don't feel rushed to move onto the next patient. One participant said that she plans to stay working at FMH as long as possible, the other participant stated that she would want to live there when she gets older, indicating both job satisfaction and trust in the care team. One PSW mentioned that she has not heard of a single negative comment regarding care since she started, and that is something that she, and other PSWs, can be proud of.

FMH Provides Resident-Centred Care

Statements were made that speak to the resident-centred approach to care the Campus Model supports. The PSWs mentioned that FMH feels like home, and not an institution. They believe that the residents also feel like part of the community and that they are fully supported by the care team as well as the leadership team. The PSWs stated that resident happiness is at the forefront of their goals when providing care, and that it should be a measure of model success. A PSW also stated that she feels that the residents' emotional needs are met in addition to their physical health needs, and that is important to her. Another aspect of care that enhances the residents' well-being is the PSW's ability to do wellness checks or drop in to see a resident if they had indicated they would like to visit them later in the day. This makes her feel like she is providing them with enhanced care that makes the residents feel safe and secure.

Discussion: Provider Experience

There was consistency in responses between the care providers at FMH, the leadership team at FMH, and the Campus Model Project Team at the WWLHIN. The PSW's reports of high job satisfaction and wanting to continue working at FMH are mirrored by the low staff turnover rate reported by the FMH leadership team and the WWLHIN. This information is opposite to what had been reported in a 2019 evaluation of the Neighbourhood Model in Waterloo Region, in that they experienced a high turn over rate, an

increased rate of unplanned absenteeism, and low care provider job satisfaction [13]. This emphasizes the positive aspects of the Campus Model as strengths and best practice methods for hiring, training, and supporting care team staff when implementing community models of care. Although the sample sizes of PSW engagements were low for both the previous (n=4) and current evaluation (n=2), staff and leadership expressed knowledge of a vast difference in the observed care provider experience between the two models, adding reliability to the findings.

Resident Experience with the Campus Model of Care

Four residents were interviewed separately in their homes in the Fairview Mennonite Home Community. Each resident was asked the same questions, and interviews took between 20-45 minutes for each participant. Three participants were female, and one was male. One participant lived with her husband in their apartment, and the remaining three lived in their residences alone. One participant's wife was also living at the Fairview Community, but in a separate Long-Term Care room. The interview participants reported to have been residents at the Fairview Community between five months to over three years. The sections presented below are themes that were summarized from these discussions.

Overall, Residents are Very Satisfied with Care from their PSWs and the FMH Community

A common theme discussed with the residents was how they felt about their PSWs. Participants listed the activities PSWs do to help them, which included to assist with bathing and personal hygiene, to make their beds, cooking and preparing meals. It was also mentioned that the PSWs 'always ask if there is anything else that they can do for them' when they are there, indicating that they are helpful and concerned for the residents' well-being.

Residents feel safe and content in the care of their PSWs and in the Fairview community. Each person stated positive characteristics of the PSWs who help take care of them. They thought that they were polite, cheerful, and happy to be there. One participant noted that she 'is happy that there is someone to take care of her' and another stated that having the PSW there makes him feel safer in the bathtub, because he doesn't want to fall. Another participant was grateful that there would be someone to take care of her when she returns home from the hospital after a surgery she was scheduled for in the coming week. She noted that she is confident she will get good care when she comes home, and that being at home at Fairview is much better than being in the hospital.

Residents enjoyed the community feeling at Fairview. One participant stated that there is always someone to talk to, that Fairview 'rejuvenated' him. Another participant noted that she chose Fairview over other retirement communities, and that she would not ever want to be any where else. She also noted that her late husband would have loved to be there and wishes he could have been able to live there with her. Other amenities that were mentioned to be enjoyed by the participants were the exercise classes, the pool, the fishpond and sitting area, and the 'fantastic meals' that are included with their fees each month. It was clear that the residents interviewed were enjoying their time at Fairview and felt as though they were part of the community.

Some residents were aware that changes were made to the way they receive PSW services and noted that they like the new model more than when the PSWs came from external sources. For example, a resident stated, 'before [the PSWs] used to come from the street, anywhere, they didn't know me.' Now, she has more continuity with the PSWs who visit her to make her lunch, and she likes that much better. Secondly, a participant wondered why they used to send different people all the time prior to the Campus Model, stating 'it was awful before.' Therefore, there is evidence to suggest that residents have noted a positive shift in their care since the initiation of the Campus Model of care.

When compared to the patient satisfaction results of the evaluation that was completed for the Neighbourhood Model pilot in 2019, the results found in this evaluation were similar, as the neighbourhood model reported 'overwhelming satisfaction of patients' [13].

Resident Knowledge about Care has been Maintained or Improved Post-Campus Model Implementation

The WWLHIN conducted a pre-implementation survey with residents prior to the Campus Model being launched at FMH. LHIN staff requested that we ask three questions during the qualitative engagements for this evaluation that were also asked in the pre-implementation survey, to identify if there has been a trend of improvement since the Campus Model's initiation. Each participant was asked to state their level of agreement with the three statements listed below. Each question is compared between the two question periods.

Statement 1: '*I am familiar with the people on my care team'*

All four of the residents who participated in the interviews agreed (n=1) or strongly agreed (n=3) that they were familiar with the people on their care team. During the pre-implementation survey (n=14), most people also either agreed (46.2%) or strongly agreed (15.4%) that they were familiar with the people on their care team, however, there was a difference in the additional comments provided. After the campus model implementation, resident's comments were more positive, stating 'thank goodness it is the same person every time' and 'I know everyone, it is homey.' Others added that although they have new PSWs coming to help sometimes, that everyone is nice and pleasant, and they make a point to learn the PSWs' names so they get to know them. The pre-implementation survey comments included more concerns, such as they were 'not sure who is going to provide [her] care week to week' and 'A lot of change over in staff.' Further evidence of familiarity is provided with comments about the other staff at Fairview that residents wanted to share, such as that the residents feel like they are part of a community, that the staff know them and care about them, and the staff are able to say hello to them by name when they are walking in the hallway.

Statement 2: *'When I have a concern about my care, I know who to go to for the best response'*

During the pre-implementation survey, most respondents would agree (53.9%) or strongly agree (7.7%) that they knew who to talk to if they had a concern about their care. Similar results were seen in the resident interviews, with three out of four residents stating that they would strongly agree with this statement. These residents either stated that they have a card with a number on it (n=2) in a visible place, such as their fridge, or a button to push (n=1) if they need to call for help. The fourth resident stated that she would not know who to contact if she had an issue with her care, and that nobody had told her who to contact. This issue was later mitigated as the leadership team was able to replace her contact card to put on her fridge and instruct her who to call.

Statement 3: *'I am notified when a change in my schedule is made'*

The pre-implementation results of this question were varied, with 20.1% of people each who would agree, disagree, or were unsure if they were notified when a change to their schedule was made. The remaining respondents noted that this question was not applicable to them, as they had never had a change in their schedule. The results of the interviews for this evaluation were similar, with two participants strongly agreeing that they would be notified, one unsure, and one who strongly disagreed. When asked to explain further, a participant noted that the PSWs come to help them when they say they will come, and that she is not sure if they have ever been late. Another participant stated that sometimes they are either late or

don't show up, and nobody ever tells her about it. This statement highlights a potential area for improvement surrounding communication of a schedule change.

Potential Areas for Improvement

When asked what could make their care at FMH even better, most of the residents stated that they could not think of anything that needs to be improved. However, there were a few comments made that highlight potential areas from improvement. It was noted by a participant that they would like their PSWs to come on time, or she would like to know exactly when they are coming. Secondly, it was noted that a participant had requested that her hair be washed once a week, and she doesn't believe that it is. She thinks this is because the PSW might be in a hurry, so it doesn't get done. When asked how these issues affect her day, she responded that sometimes she will miss a morning class that she likes to participate in if she is still waiting for her PSW, or that it will delay her getting dressed. One resident stated that it would be helpful if all PSWs always wore their name tags, in case she forgets their names. Although these areas were highlighted as suboptimal, the vast majority of comments were positive from residents, and they did not feel the need to contribute anything further for areas of improvement or recommendations to make their care better.

Discussion: Resident Experience with the Campus Model of Care

Continuity of care is an important factor to build strong patient relationships and increase positive health care outcomes [14] [15]. The Campus Model at FMH aims to provide care that allows residents to build a relationship with their care providers and other FMH staff, and the results of this evaluation show that the Campus Model is fulfilling these goals from a resident perspective. Residents felt as though they were familiar with their PSWs, were grateful for their care at FMH, and that their care made them feel safe and cared for. Therefore, the model could lead to improved health outcome for residents if continued as it is currently arranged. Using a similar method of implementation and service organization for other clinical care providers, such as nursing and therapy, as planned, may even further increase resident satisfaction with care for those who receive more complex services.

FMH Campus Model: Supporting Quantitative Evidence

Volume, costing, and acute care use data were transferred by the WWLHIN decision support team in aggregate form. These data are used as an example of indicators that are available for extraction and could potentially be tracked for future outcome evaluations. Results are compared to the Neighbourhood Model Pilot Evaluation completed in 2019 for reference, were applicable.

Hourly PSW rates for the Campus Model at FMH from June 2019 to July 2020 range from $33.16-$33.51 per hour. These rates are $1.93-$2.28 per billable hour less than what was reported in the Neighbourhood Model Pilot Evaluation in 2019. The number of residents receiving PSW services from FMH has increased from 20 residents in June 2019, to 90 residents in February 2020, which was the last full month of data recorded at the time of the evaluation **(Figure 13)**. The average number of PSW services provided to residents increased after the implementation of the campus model in the fall of 2019, the month with the highest average of services was December 2019 with an average of 29.3 hours of PSW service per month **(Figure 14)**.

Figure 13: Number of Unique Patients at FMH, and Hours of PSW Service (June 2019-Febrary 2020)

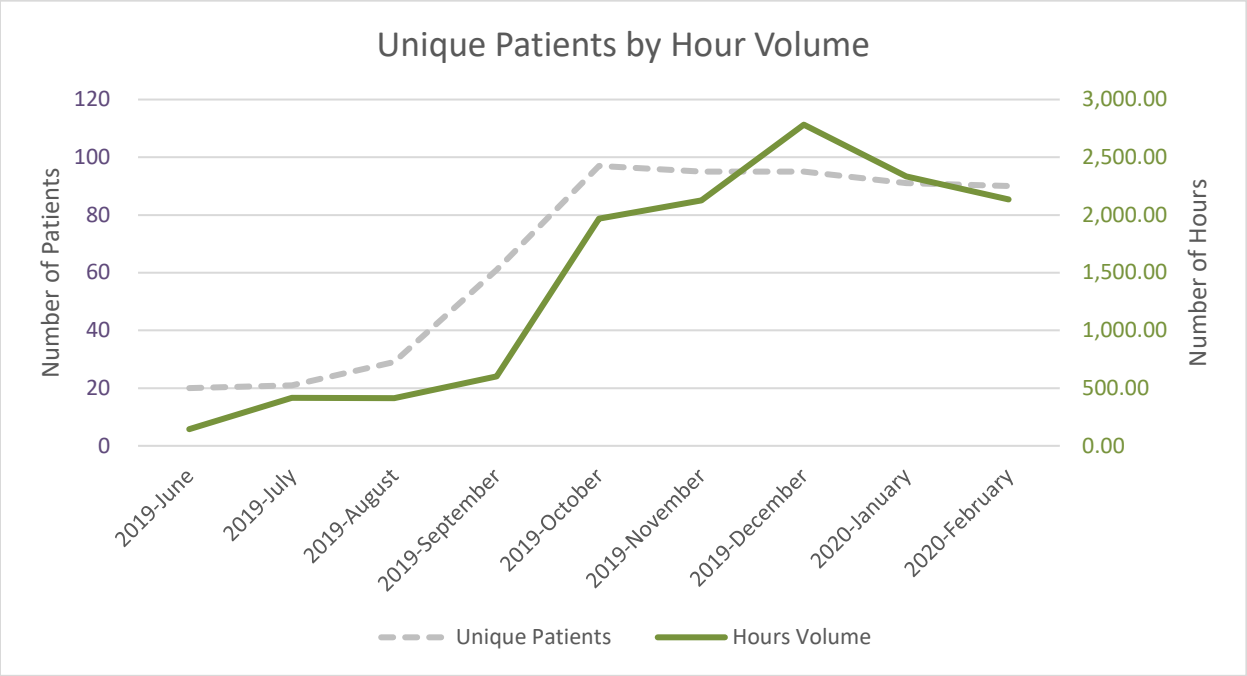
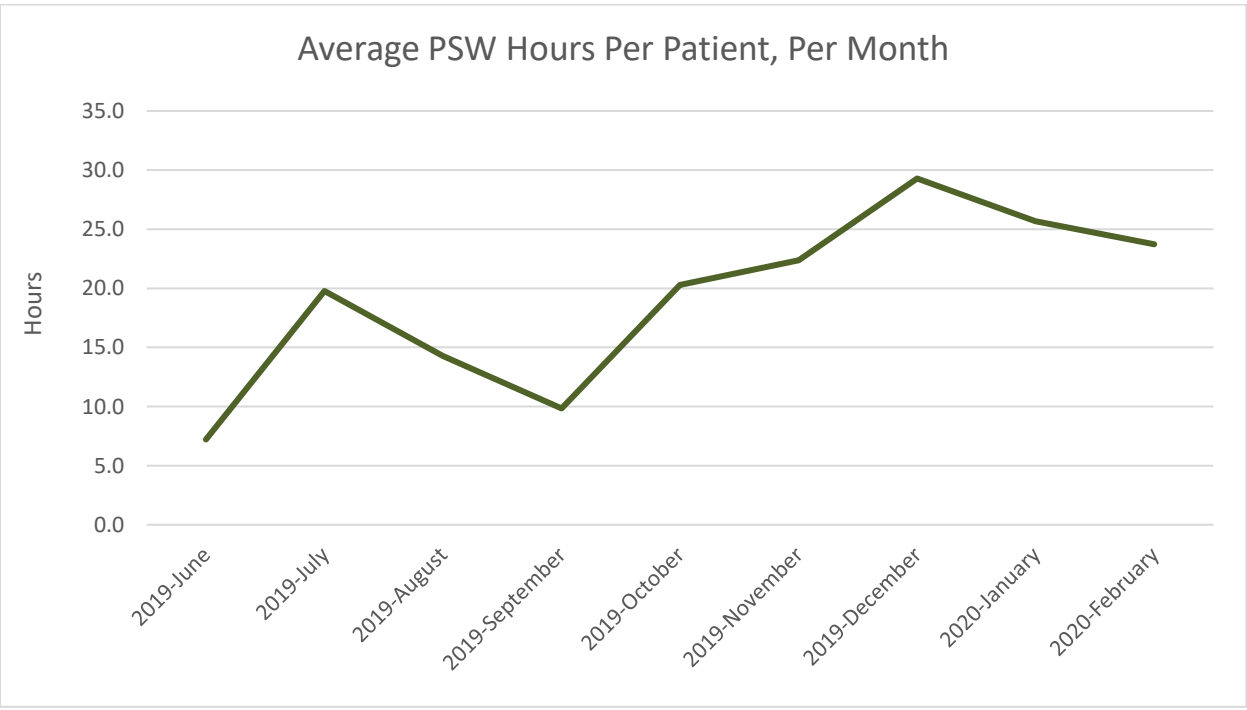


Figure 14: Average Number of PSW Hours per Patient, Per Month (June 2019-February 2020)



The FMH reported zero missed care aside from one incident in February of 2020, where 0.5 hours of missed care were reported (0.004% of all care). Comparatively, these rates are lower than what was reported for the Neighbourhood Model Evaluation (1.63%), and the baseline comparison group (0.15%) used for the same evaluation. This rate is also far below the target rate of missed care set for the Neighbourhood Model evaluation of 0.05%, illustrating the success in completing all necessary care.

Further evidence supports patient access to care as FMH have a care acceptance rate of 98.6%, only refusing 2 cases during this time frame. With nearly no missed care and a high rate of acceptance, patients at FMH can count on having access to the personal support services they need, when they need them.

Discussion: FMH Campus Model

The Fairview Mennonite Home Campus Model was determined a success from the perspectives of those who participated in evaluation engagements. The WWLHIN staff, FMH leadership, PSWs, and residents all have observed notable benefits of implementing this model for PSW services. Consistent positive responses were seen across all qualitative engagements, providing strong support for the success of this type of service integration. Although the teams were confident in their success, they credited the strength and readiness of their team to take on a large change as critical to the achievements they have made so far. They recommend that before other retirement homes, long term care homes, or other communities decide to change to this type of model, that they do a readiness assessment of their team and supporting stakeholders. To assist in this process, it was recommended that stakeholder who have already participated in implementing the model successfully meet in person with new organizations wanting to adopt the approach to emphasize important considerations when deciding if their team is prepared to support the change and model once it is implemented.

Further collection and analysis of data regarding the volume of hours, costs, and patient outcomes are needed to evaluate financial benefits or improvements in resident health outcomes associated with this model of care. Implementing regular surveys for residents to complete, or interactive voluntary questions displayed on touchscreens (taking all necessary sanitary precautions) in common areas could provide a simple way to collect data on a continuous basis, allowing for real-time identification of changes to resident satisfaction and reporting of longitudinal outcomes with minimal disruption to resident schedules.

Overall, lessons learned from the implementation of this service delivery model for PSWs can be brought forward as examples of a successful execution under ideal conditions, and further evaluation is needed to determine if these efforts have resulted in significant improvements in desired outcomes.

Recommendations

Community Models of Care: Campus Model at FMH

Recommendations for program improvement or maintenance

- Continue to support consistent communication of goals, tasks, challenges, and changes as the model progresses. Communication amongst all involved parties from the beginning of project planning through until the model is functioning at capacity is essential for successful implementation of a program or model of care change. Strong communication was noted, in this model, to lead to:
    - Staff and leadership being aware of what they are responsible for and what others are responsible for.
    - Participating organizations building or strengthening relationships for open communication and problem solving.
    - Early identification of risks and timely strategizing to overcome them.
- Have a peer support person or team who has successfully implemented the model available to answer questions and highlight areas of risk for new organizations that want to adopt a campus or community model of care.
    - Discussing the lived experiences of those who have implemented the model could allow new teams to prepare themselves while making decisions about their readiness to take on a large change.
- Adopt the appropriate procedures to expand this model to other clinical services as applicable to continue to improve resident and staff experience.

Recommendations for future data collection and evaluation

- Continue to engage all stakeholders (leadership, care providers, and residents) into the planning, implementation and evaluation of future community models of care.
- Continue to measure and regularly report resident outcomes for acute care use, falls, and complaints, to capture success and potential areas that may require investigation.
- Consider implementing continuous digital satisfaction engagement with residents to capture real-time successes and areas for improvement.
- Explore implementing a measure of care continuity (i.e., percentage of visits with same provider) that would allow campus models of care to track progress over time and provide insight into resident experience with their care providers.
    - Information can be extracted from the working logs of PSWs and could potentially be used to auto-populate an indicator of continuity for each resident.

Key Findings and Conclusions

This report summarizes a formative evaluation of three elements of the Care Community Model in Waterloo Wellington region implemented in July 2019. Qualitative engagements were performed as the key data collection method to capture a snapshot of the current state of model activities from a variety of key stakeholders as implementation occurred. Supporting data elements were provided by the WWLHIN Decision Support team as examples of potential indicators to capture specific measurements of progress in future evaluation of Care Community Model outcomes.

Carestream models had been implemented in some capacity in three LHIN offices across the region. Key messages taken away from this evaluation were that some staff members felt as though they were not being including in decision making regarding their roles, and that they would benefit from two-way communication during the development of new initiatives. With input from all stakeholders being considered, staff members believed that the goals of this model have a greater chance of being achieved as it moves toward maturity.

Bundled Care funding has provided care for 167 unique patients in the region. Although similar issues regarding communication were highlighted as areas for improvement by staff, patients feel as though they were provided with good quality of care. This was emphasized in four patient interviews who believed they were well-informed regarding all aspects of their care and who to contact should they have questions.

The implementation of the **Campus Model at the Fairview Mennonite Home** was considered a success for all participating parties. A highlight of the many successes found during the implementation of this model was the strong relationships built through continuous thoughtful communication between the LHIN, the hospital, the leadership and clinical staff at FMH, and the residents. All parties felt as though there had been minimal hardships as risks were identified and communicated early, allowing for quick mitigation to extinguish any issues.

The current state of the Care Community Model did not allow for a comprehensive assessment of the care provider perspective for streamlined access to care or bundled care funding. It was identified during key informant interviews and engagement with a clinical care provider that any impacts to care providers would not yet be realized at this stage of the model maturity. Therefore, future engagement with care providers as the model continues to grow is needed to determine any impacts to their workflows as a result.

Evaluation focused data sourcing and collection in advance to formal evaluations for a set of pre-determined indicators would allow the development of a framework for subsequent evaluations of model outcomes. This report emphasized areas for consideration for future assessment of outcomes regarding patient care and satisfaction, staff and care provider satisfaction, cost/benefit calculations, and overall impact of the model, using the quadruple aim framework [12] as a guide. Given the numerous elements of the Care Community Model, future evaluations would benefit from in-depth focus on each of the dimensions, provided that recommendations for building evaluation capacity outlined in this report are utilized to ensure an abundance of data that allow for more complex analytics to inform conclusions. Levering a perspective from a learning system [16], the models of care are encouraged to integrate data

collection within care provision workflows that align with quadruple aim priorities to build a foundation that enables ongoing monitoring that support continues quality improvement.

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Appendix A – Scripted Base Questions for Key Informant Interviews

Key Informant Interviews: Base Questions

Project Background: The eHealth Centre of Excellence has been contracted by the WWLHIN to do a formative evaluation of the Care Community Model (CCM) in WW Region. As part of this project, we are talking to subject matter experts regarding different elements of the model. We will be doing key informant interviews like this one, and we are also speaking with care providers and patients. You were identified [participating LHIN staff] as someone who would be great to talk to regarding bundled care funding as well as streamlining access to Home and Community care services.

Focus group goals: To assess the current state of the Care Community Model Elements in the region: specifically, [Carestreams, bundled care funding, and/or the campus model of care], to discuss what is currently being done to track progress, and your recommendations for strengthening the model and future evaluations.

1. To start, could you explain a little bit about your role within the CCM context related to [Carestreams, bundled care funding, and/or the campus model of care]?

2. From your perspective, can you describe the concept and goals of [Carestreams, bundled care funding, and/or the campus model of care]?

3. Do you think that the current state of these elements is working towards goals of streamlining access to care for patients and providers? Can you explain?
    a. Have there been any challenges?
    b. What are its strengths?

4. How do you think [Carestreams, bundled care funding, and/or the campus model of care] is benefiting patients and providers?
    a. Are there any risks or have you been aware of any unintended negative consequences for patient or providers associated with this model of care?

5. What would you recommend be implemented to either limit future challenges, or advance the capacity of the model?

6. Regarding [Carestreams, bundled care funding, and/or the campus model of care], what metrics are currently recorded in the context of transitions to home and community care from the hospital?

7. What would you recommend be observed to measure the success of this element of care in the future?

a. What would be a practical way to measure this?

8. Is there anything else you'd like to discuss regarding the Care Community Model, that would provide us with a more comprehensive understanding of the current state?

Scripted Questions for eCE Staff Regarding eReferral

Discussion Objectives: We would like to talk today about your work with eReferral within the Care Community Model context, your thoughts on the progress of the model, and how you think eReferral aligns with the Care Community goals.

1. To start, at a high level, can you explain your roles with eReferral, within the context of the Care Community Model?

2. What defines a 'Care Community eReferral'? I.e., How do the eReferrals performed under the care community model umbrella differ from other eReferrals that are occurring in the same area?
   a. How is the funding for eReferral accounted for in the Care Community Model compared to the rest of eReferrals occurring?
   b. Is an eReferral equivalent to one destination site? Does the Care Community Model fund the referral?

3. The following are the current numbers provided by the WWLHIN for eReferrals under the care community model, is there any other information that is tracked that could be used to monitor the progress of the spread or scale within the model?

eReferrals								
	July	Aug	Sept	Oct	Nov	Dec	Jan	**TOTAL TO DATE**
Care Coordination	0	0	0	2	4	1		**7**
Connitive Ax	0	2	0	0	0			**2**
Home Safety Ax	0	3	1	5	3		3	**15**
LTC Ax	1	1	1	0	2	1	2	**8**
Medical Order: Injection	0	0	1	0	1	1		**3**
Medical Order: Wound Care	0	2	5	8	11	12	8	**46**
Mobility Ax	1	0	6	4	3	2	10	**26**
Nursing Other	0	0	3	3	0		4	**10**
Request for Other Services or N/A	2	1	2	3	4	5	3	**20**
TOTAL	**4**	**9**	**19**	**25**	**28**	**22**	**30**	**137**

4. How do you think eReferral will help the Care Community Model reach its goal of streamlining access to care services?

5. Do you think the progress made so far is currently working towards these goals? Why or why not?
   a. I.e., barriers and enablers
   b. Challenges with provider adoption? (if not mentioned already)

6. Can you provide insight on how this model increases the rates of adoption of eReferral into primary care?

a. Based on the rate of adoption/progress so far, what time frame would you project to reach full goal capacity for eReferral?

7. What additional resources would be required to get eReferral to the full goal capacity?

8. What metrics would you suggest on monitoring progress and the outcomes of this initiative for future evaluations?

9. Would you be able to recommend provider(s) we could talk to who are using eReferral under the Care Community Model?

10. Is there anything else you would like to discuss about eReferral and the Care Community Model?

Appendix B – Scripted Questions for Front-Line Staff Experience Engagement

Care Coordinators and Intake Coordinators – WWLHIN offices (Waterloo, Cambridge, Wellington)

Project Background: The eHealth Centre of Excellence has been contracted by the WWLHIN to do a formative evaluation of the Care Community Model (CCM) in WW Region. As part of this project, we are talking to subject matter experts regarding different elements of the model. We will be doing focus groups like this one, and we are also speaking with other care providers and patients. You were identified by [Participating Staff] as people who would be great to talk to regarding [bundled care funding/ streamlining access to Home and Community care services/Carestreams].

Focus group goals: To assess the current state of [streamlining access to care by transferring patients to into caseloads/bundled care funding], how this has affected your workflows, and discuss any recommendations you have for improving or evaluating the process in the future.

You can choose to answer or not answer any question you wish; you are not obligated to answer any questions you don't want to, your names or identifying information will not be used in the final report. You are free to leave or stop participating in the interview at any time.

Do you have any questions before we begin?

1. To start, can you each tell me about your roles within the context of the Community Model?

2. From your perspective, can you describe the concept and goals of [bundled care, Carestream caseloads and/or Direct Referral]?

3. Do you think that the current state of assigning patients to caseloads is working towards the goals of streamlining access to care?
    a. Have there been any challenges?
    b. What are the strengths?

4. Have there been any changes to your workflows as a result of implementing the care community model?
    a. Can you describe the process of implementing Carestream caseloads into your daily routine?

5. How do you think Carestream [caseloads/bunded care funding] is benefiting staff, providers, and patients?
    a. Are there any risks or have you been aware of any unintended negative consequences for patient or providers associated with this model of care?

6. What would you recommend be implemented to limit future challenges, or advance the capacity coordinators to work more efficiently?

7. What would you recommend be observed to measure the success of assigning patients to caseloads in the future for patients and intake coordinators?
    a. What would be a practical way to measure this?

8. Is there anything else you would like to about regarding assigning patients to [Carestream caseloads/bundled care funding]?

Appendix C – Emailed Questions for Clinical Care Providers

Care Community Model Provider Engagement Questions

Project Background: The eHealth Centre of Excellence has been contracted by the Waterloo Wellington LHIN to do a formative evaluation of the Care Community Model in Waterloo Wellington Region. The key objectives of the evaluation are to assess the current state of activities, establish what is working well and what could be improved upon, assess the measures are currently being used to track progress, and develop recommendations for future model development and evaluation.

As part of this project, we are talking to subject matter experts regarding different elements of the model. In addition to reaching out to care providers via email, we have planned key informant interviews with subject matter experts from internal staff, front-line care providers, and patients to observe the current state of model elements.

We appreciate your participation in this data collection process and any information you are able to provide to us will be useful in fulfilling our evaluation objectives. Please answer the questions below to the best of your ability, and feel free to leave any question blank that you do not wish to contribute information to, or if they aren't relevant to your area of work.

1. Can you describe your role in providing care to patients within the Care Community Model?

2. Have you noticed any changes in your workflow since the implementation of Care Community Model activities such as bundled care, or Carestream caseloads/Direct Referral?

3. Have you sent or received electronic referrals (eReferrals)? Can you speak to how they impact your workflow efficiency?

4. What would you recommend be changed, stay the same, or be implemented to enhance continuity of care?
    a. To improve the patient experience with care

    b. To improve the care provider experience with providing care

5. Do you have any recommendations regarding indicators of success for care continuity that could be measured in future evaluations?

6. Do you have anything else you would like to share regarding the Care Community Model?

Appendix D – Scripted Questions for FMH PSWs

Community Models of Care, Fairview Mennonite Home Staff – Personal Support Workers

Project Background: We are doing a formative evaluation of the Care Community Model in the WWLHIN, in which the Campus model of care at the FMH is a branch of. We are looking to gain the perspective of care providers who are working under this model of care to get a picture of how it is going so far.

You can choose to answer or not answer any question you wish, you are not obligated to answer any questions you don't want to, your names or identifying information will not be used in the final report. You are free to leave or stop participating in the interview at any time.

Do you have any questions before we begin?

Attendees:

1. How (if at all) has the campus model of care changed the way you deliver care to your patients?

2. Has this model affected, or have you noticed any changes to, efficiencies in your workflows or day-to-day activities recently?

3. Have you had any challenges in providing care to your patients as a result of scheduling?

4. How would you measure successful care for patients?

5. Is there anything else you'd like to discuss regarding the Campus Model of Care at FMH?

Appendix E – Patient Experience Questions: Bundled Care Funding

WWLHIN Care Community Model Evaluation
Bundled Care Funding - Patient Engagement

Note:

These questions are intended to be *asked by a PA to patients* who have received joint replacement surgery under bundled care funding.

Background/reasons for questions (intended to be directed toward patient):

We are looking to talk with some people who have received a joint replacement surgery to learn what went well, and what could have gone better regarding your care after surgery. The answers you share with me today will help us form recommendations for providing care to other people in the future.

Verbal consent/op-out:

During the discussion, you are free to answer or not answer any question you wish, and you can stop the discussion at any time. You are not obligated to complete the questions. Your name or any identifying information will not be shared with anyone or used in any reporting.

Do you have any questions before we get started? Are you ready to start the questions now?

Questions of interest:

1. Would you be able to talk to me a bit about your surgery and the types of services you receive? ***(If the PA is familiar with the patient, they could fill out this question to reduce patient needing to tell their story, but confirmed with patient for consent)***

2. Before having the surgery, did you know what services you would receive when you returned home?
    a. Did you feel ready to come home from the hospital?

3. Do you feel like you were involved with the planning of the care you would receive once you returned home from the hospital after surgery?

4. Were you aware who your doctor and other care providers were for your surgery and care afterwards?

5. Do you, or did you know who to contact if you have a question regarding your care?

6. Did you or do you currently have any challenges or difficulties with your care related to the surgery? If so, please explain.

    a. Did you have any troubles contacting someone for assistance?

7. Do you feel like the care you received met your needs?

    a. What do you think went well?
    b. What could have gone better or should be improved so others who undergo similar surgeries have a better experience?

8. Is there anything else you'd like to mention about your care after your joint replacement surgery?

Thank you for answering these questions.

Please direct all responses and/or questions to:
Lisa Harman
Quality Improvement and Knowledge Translation Specialist
eHealth Centre of Excellence
email: lisa.harman@ehealthce.ca
phone: 1 (519) 221-0786

Appendix F – Patient Experience Questions: FMH Campus Model

Fairview Mennonite Home – Resident Questions

Project Background: My name is Lisa Harman and I work for the eHealth Centre of Excellence in Waterloo. We are doing an evaluation of how you receive care from your personal support workers in your home here in the Fairview Community. Some activities that your personal support workers may do with you are to help with bathing or getting dressed. We want to talk to you today to see what you like about your care from the personal support workers and what you think would help make the care you receive better.

I have some questions to guide us and will be taking some notes, but please feel free to share whatever you would like to or are comfortable with. Your name or any identifying information will not be shared in the reporting of your answers. You can stop participating in the discussion at any time, and you do not have to answer questions if you don't wish to share information.

Please feel free to let me know if you have any questions throughout the discussion or would like me to repeat any questions.

Do you have any questions before we get started?

1. Would you be able to tell me a little bit about yourself; how long you've been a resident at Fairview, and anything else you'd like to share about yourself and your care?

Next, I'm going to ask a few questions about the care you receive from your personal support workers.

2. What types of personal health care supports are available to you? Can you tell me a bit about them?
    a. Thinking back about those supports, do you feel that when you need supports, they are available to you?

For the next section, I will read three statements to you, and then read some answers for you to choose from based on how much you agree with the statement, you are also welcomed to explain your answers if you would like to.

Question	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree	N/a or Comments
I am familiar with the people on my care team						
When I have a concern about my care, I know who to go to for the best response						
I am notified when a change in my schedule is made						

3. What are some strengths of the personal supports that are provided at Fairview?
4. How can the personal support be even better to meet the needs of residents at Fairview?
5. Is there anything else you'd like to talk about regarding your care?

Do you have any questions for me?