Maintaining Excellence During the COVID-19 Pandemic: The State of Care Coordination in Ontario Multidisciplinary Health Teams

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Background

- Research prior to COVID-19 demonstrated inadequate care coordination in patients with multiple chronic health conditions
- Ontario Multidisciplinary Health Teams (MHTs) are equipped with resources to handle increased demand for care coordination, however there is a paucity of studies examining care coordination practices within MHTs

Objective

To determine team leads' perspectives on care coordination in Ontario MHTs *prior to* and *during* the COVID-19 pandemic

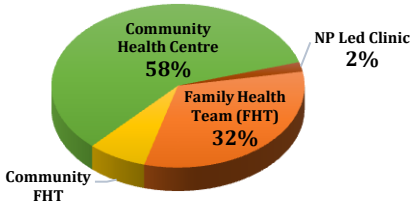
Methods

- An online survey of Ontario MHTs was conducted using the validated Medical Home Care Coordination Survey for Healthcare Teams (MHCCS-H)

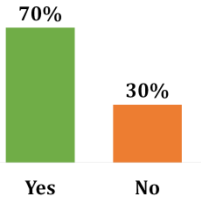
Results

Response Rate:
58/241 surveys completed = 24%

Organization Type:



Using at Least One Validated Method to Identify High Risk Patients:



8 Domains of Care Coordination	% MHTs Agreed Before COVID	% MHTs Agreed During COVID
1. Accountability •MHT works with patients to help them understand their roles and responsibilities in care	97%	98%
2. IT Capacity •MHT used electronic data to identify patients with complex health needs	88%	81%
3. Plan of Care •MHT asks for patients' input when making a plan for their care	98%	100%
4. Follow Up Plan of Care •MHT follows through with the care plan	96%	90%
5. Self-management •MHT has peer support readily available for patients as part of routine care	44%	37%
6. Communication •MHT helps patients understand all of the choices for their care	98%	95%
7. Link to Community Resources •MHT connects patients to needed services (e.g., transportation, home care)	95%	93%
8. Care Transitions •When patients are discharged from hospital, MHT is informed about care patients received in hospital	82%	76%

Discussion

Although MHTs maintained high ratings in care coordination during COVID-19, we recommend that to further improve care coordination during the pandemic and beyond, providers should consider increasing the use of validated tools to identify patients with complex needs as well as incorporating peer support systems.