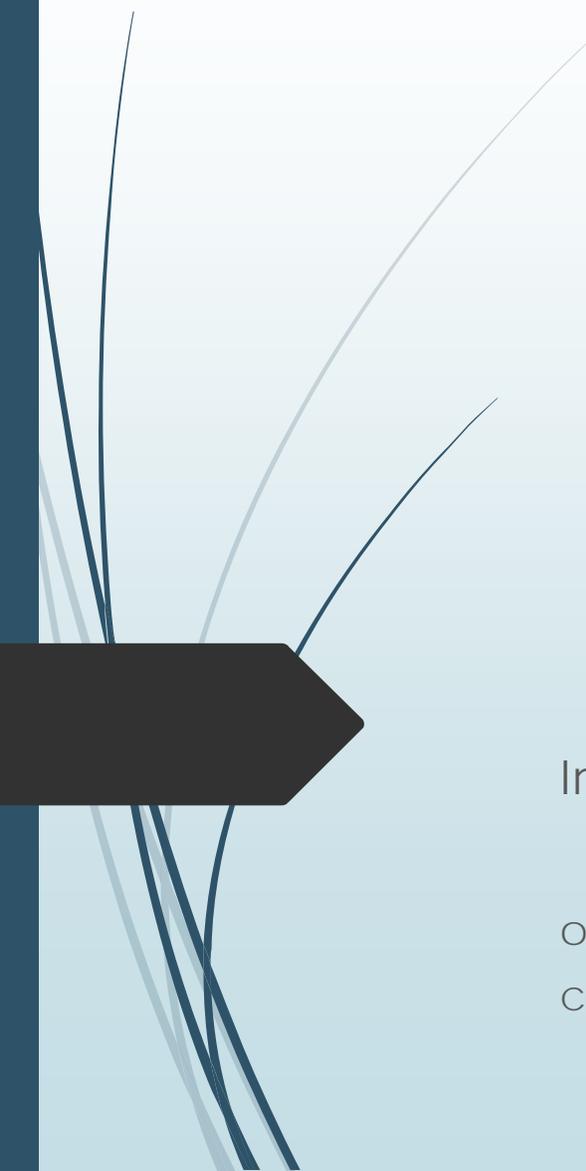


D2 Moving UPP



Improving access for unattached patients

October 26, 2017 presented by Betty Barber NP, Rona Cobean RN, Clinical Lead OSFHT

Contributing authors: Caroline Rafferty ED, OSFHT, Dr. Elyse Savaria, Kaitlin Low RN



your health. your plan. your team

Owen Sound
OSFHT FAMILY HEALTH TEAM

Faculty/Presenter Disclosure

- ▶ Betty Barber NP
- ▶ Relationships with commercial interests: not applicable
- ▶ Rona Cobean RN
- ▶ Relationships with commercial interests: not applicable



Disclosure of Commercial Support

- ▶ No commercial support



Mitigating Potential Bias

- ▶ Not applicable



Moving UPP – Improving Access for Unattached Persons

- ▶ Recognition of number of persons on Health Care Connect wait list for County of Grey-Bruce
- ▶ Long wait times recognized – up to 4 year wait

OSFHT Strategic Plan



Owen Sound
OSFHT FAMILY HEALTH TEAM

- ▶ Focus on delivering exceptional patient experience
- ▶ Provide fiscally responsible sustainable primary care services that meet community needs
- ▶ Provide leadership in advancing integration of primary care services within our community
- ▶ Enable staff to work as high performing team, exemplifying our values



Burden

- ▶ Health Care Connect (HCC): approximately 1000 patients registered – fluctuates regularly
- ▶ Local Walk In Clinic reports seeing approximately 6 – 8 new unattached persons per day x 5 days a week
- ▶ Local physician retirements in 2016/17
- ▶ Physician retirement in local smaller communities contribute to numbers (part of HCC numbers)
- ▶ 2016 population Grey – Bruce 161,977
- ▶ OSFHT services 35,000 patients for 20 physicians



Purpose

- ▶ Improve access for unattached persons to Health Care
- ▶ Support earlier detection of asymptomatic disease and risk factor screening
- ▶ Promote self management of health care concerns/risks
- ▶ Reduce Emergency Room visits



Perceived Benefits

- ▶ Reduction in unknowns for unattached persons and potential providers
- ▶ Screened participants remain on HCC wait list for suitable provider
- ▶ Limited level of follow up through UPP clinic based on risk assessment
- ▶ Assessment, screening, referrals done



Backgrounder

- Foundational program: Central East Local Health Integration Network, Unattached Patient Assessment, Triage and Referral Pilot Project developed 2008, implemented in 2009
- Samuel Berman: Project Manager, East Central LHIN
- Samantha Dalby: RN-EC, East central LHIN
- Developed as a screening and early prevention program
- Provided by interdisciplinary team



CNPS Review

- ▶ What are foreseeable risks?

Liability: following up on test results in timely fashion
call back system for patients to obtain results
medication reconciliation/tracking
employer insurance for vicarious liability
privacy and confidentiality requirements – EMR, paper chart
ongoing evaluation



Medical Associates of Port Perry North Durham FHT

- ▶ In 2016 initiated Unattached Patient Assessment Program based on Central East LHIN project
- ▶ Due to lack of human resource support project was abandoned after short period of time but has since resumed



OSFHT Integration

- ▶ Added to OSFHT schedule A
- ▶ no additional funding required, ties in to preventive care and Chronic Disease Management
- ▶ Champion NP, Md, ED developed framework
- ▶ added in IT – EMR forms, Nursing and reception support
- ▶ Involvement of HCC – link
- ▶ Identification of links within community for providers/resources for unattached persons



your health, your plan, your team

Owen Sound
OSFHT FAMILY HEALTH TEAM

Model

- ▶ NP triages persons based on information provided by HCC
- ▶ Begin with highest risk group
- ▶ Review health history, focused physical exam, immunizations, investigations, medication renewals, referrals
- ▶ Community providers/supports identified and referrals generated. Self management strategies provided
- ▶ Monthly statistical spread sheets are maintained
- ▶ Persons identified high, moderate or low risk of morbidity then further classified as complex or non- complex
- ▶ Telephone screening completed by clinic RN, and booked for appointment based on needs assessment
- ▶ NP consults with Champion Physician for investigation/treatment outside of NP scope
- ▶ As indicated based on the individual concerns



Process

- ▶ Triage
- ▶ Consent to treatment
- ▶ Obtain health history
- ▶ Update immunizations
- ▶ Provide focused physical exam
- ▶ Order investigations/screening as indicated
- ▶ Referrals to specialists/community programs
- ▶ Medication review/limited prescriptions
- ▶ Self management strategies



Forms

- ▶ Standardized telephone scripts
- ▶ Personal health information form
- ▶ Clinic Waiver
- ▶ Encounter forms for adult male/female physical, child/teen physical, and Rourke records for infants and children up to age 5. Ontario antenatal record
- ▶ Discharge information
- ▶ Health information handouts
- ▶ Participant service survey for each person seen



Owen Sound
OSFHT FAMILY HEALTH TEAM

Questions?

bbarber@osfht.ca

rcobean@osfht.ca

519-470-3030 Ext # 206