

# Primary Care and Public Health Partnership in the NE LHIN

---

October 26, 2017

AFHTO Conference - Concurrent Session E  
Strengthening Partnerships Theme

Wendy Carew, Regional Coordinator – Stay on Your Feet Falls Prevention – NE LHIN  
Shirley Watchorn, Executive Director - Great Northern Family Health Team  
Kerry Schubert-Mackey, Director of Community Health – Timiskaming Health Unit



# Presenter Disclosure

## Presenters:

Wendy Carew, Regional Coordinator – Stay on Your Feet Falls Prevention – NE LHIN

Shirley Watchorn, Executive Director - Great Northern Family Health Team

Kerry Schubert-Mackey, Director of Community Health – Timiskaming Health Unit

## Relationships with commercial interests:

NONE

## Disclosure of Commercial Support

- This strategy has not received financial or in-kind commercial support
- In support of this program, there are no potential conflicts of interest .

# Integration to improve population health:

Case example: falls prevention for older adults

‘Knowing is not enough; we must apply.

Willing is not enough; we must do’

Goethe



---

## Group question:

What ways does your primary care team work with your public health units or your LHIN?

Do you have an example to share?

## At the end of presentation you will know how:

- ✓ Applying the pillars of trust can build strong relationships among those who typically do not work together
- ✓ About a case example linking the clinical work of primary care with community based efforts of public health to improve population health outcomes
- ✓ It can be done within current funds
- ✓ This approach benefits providers – by capitalizing on the unique expertise of partners
- ✓ This approach benefits patients and community!



*Marg – I improved my balance and fall proofed my home. It helped with my pain too.*



*Fred – it helped get my balance back, I am more limber and have a better range of motion, learned how to prevent accidents*



*Ellen - For a small town like ours we are very fortunate our family health team bring us the falls prevention program. My participation in the program was very beneficial to my well being. It has given me so much more strength that I didn't have before...*

# Local Health Integration Networks (LHINS)

## Patients First Act, 2016

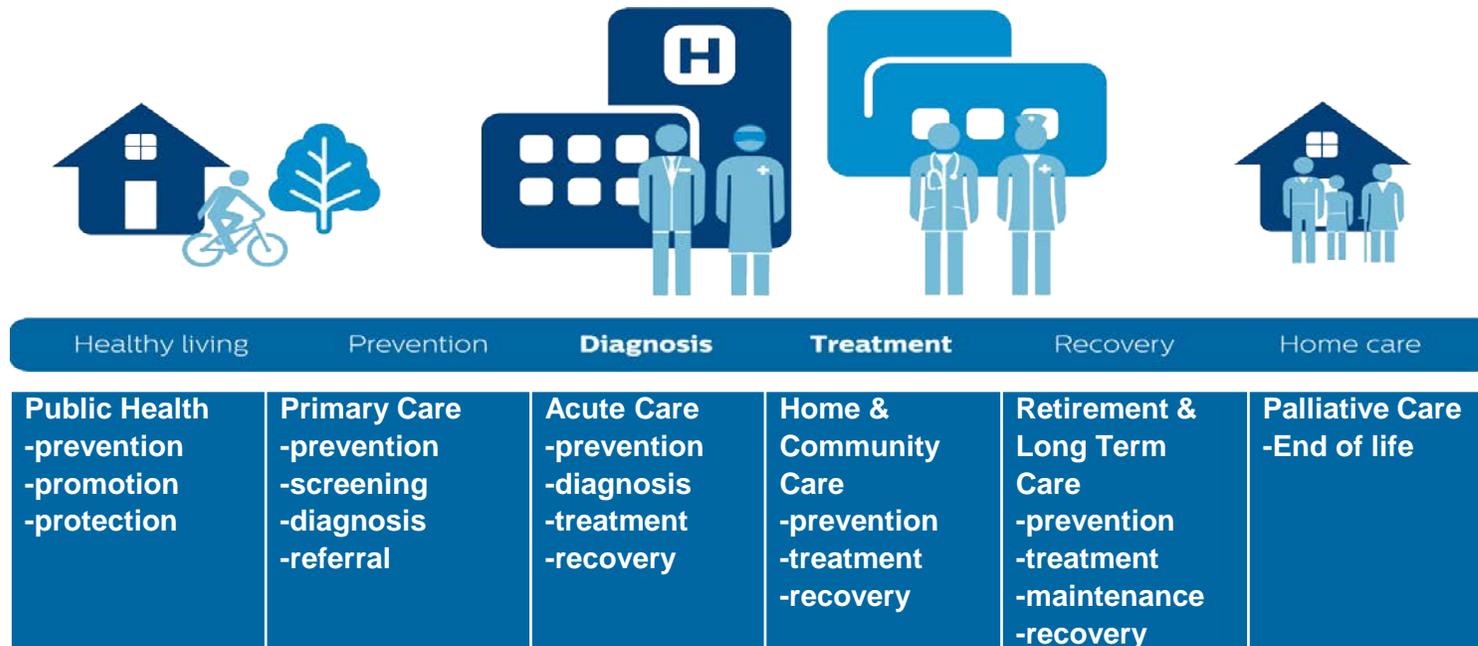
**On May 31, 2017**, home and community care services and staff transferred from the North East CCAC to the North East LHIN. As part of the Government of Ontario's *Patients First: Action Plan for Health Care*, this health system change ensures uninterrupted care and support for patients and home care clients through an:

- ❖ Expanded role for LHINs.
- ❖ Timely access to, and better integration of, **primary care**.
- ❖ More consistent and accessible home and community care.
- ❖ Stronger links to **population** and **public health**.
- ❖ Improving health equity and reducing health disparities.

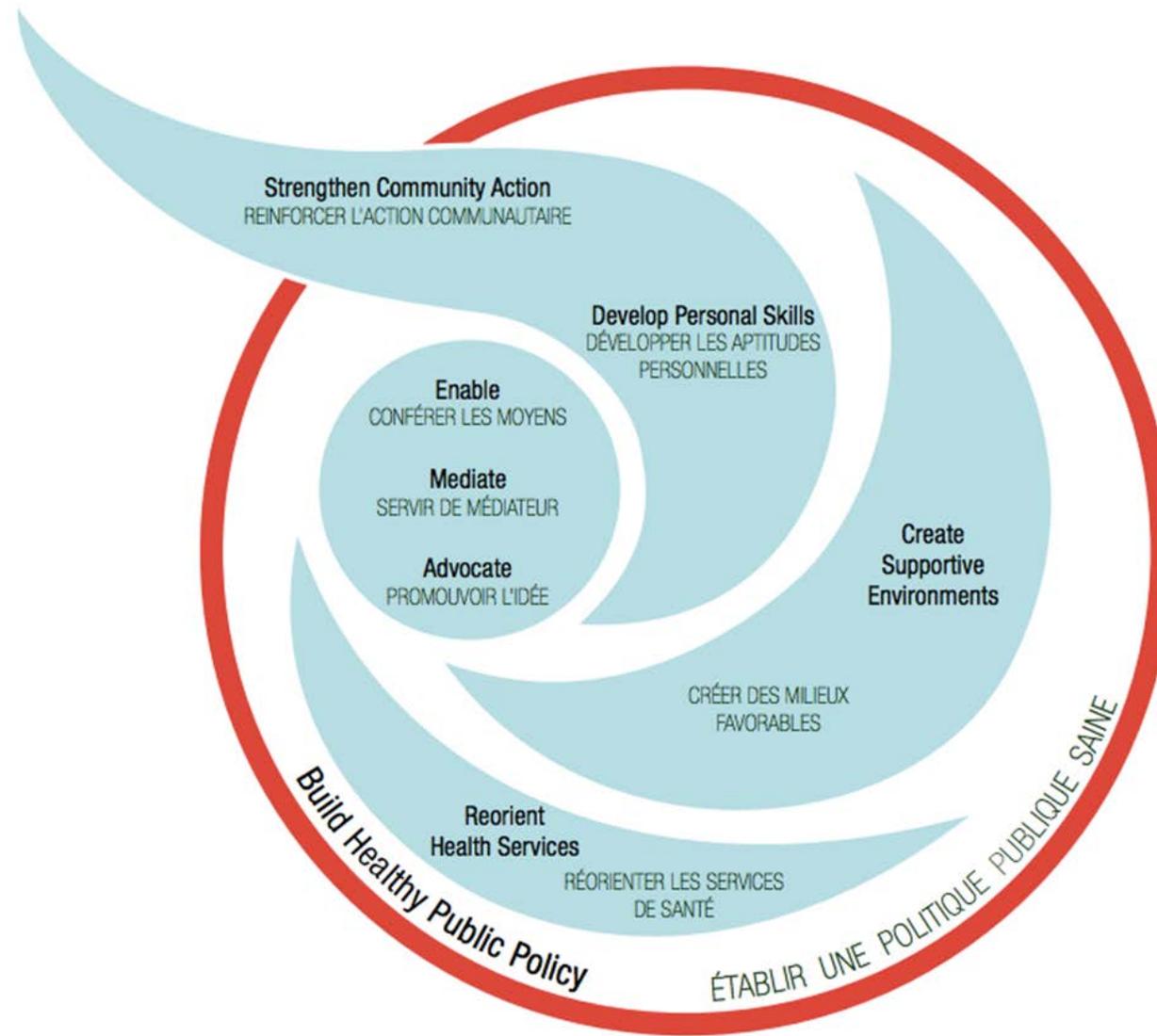


# Full Continuum of Health

To improve the health of the population of NE Ontario we need strong communities with a strong system of programs and services that span the full continuum of care – from health promotion, through primary, secondary and tertiary prevention to end of life care.



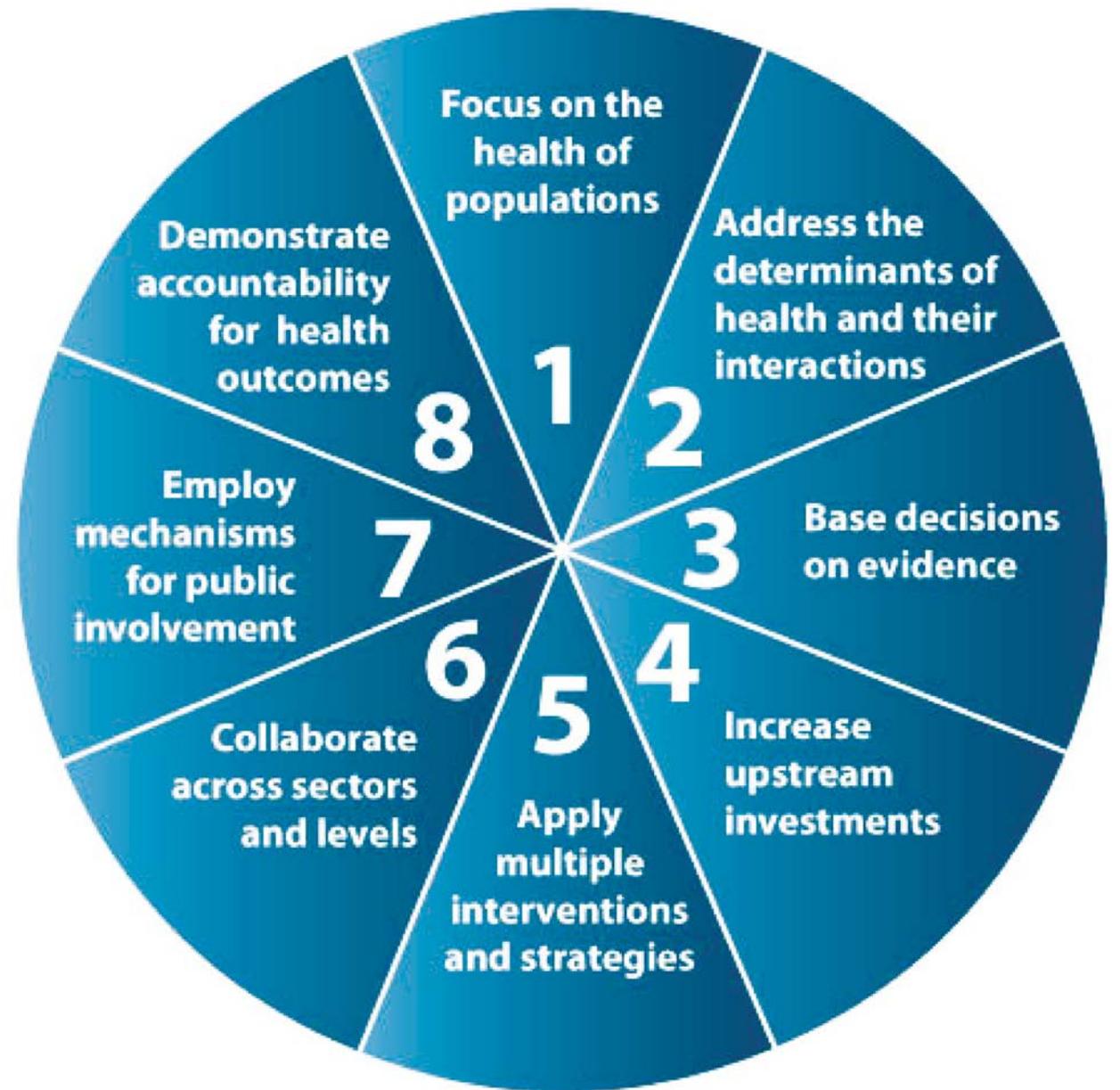
# Ottawa Charter for Health Promotion



# What is public health ?

<b>GOAL</b>	To improve and protect the health and well-being of the population of Ontario and reduce health inequities					
<b>POPULATION HEALTH OUTCOMES</b>	<ul style="list-style-type: none"> <li>• Improved health and quality of life</li> <li>• Reduced morbidity and mortality</li> <li>• Reduced health inequity among population groups</li> </ul>					
<b>DOMAINS</b>	Social Determinants of Health	Healthy Behaviours		Healthy Communities		Population Health Assessment
<b>OBJECTIVES</b>	To reduce the negative impact of social determinants that contribute to health inequities	To increase knowledge and opportunities that lead to healthy behaviours		To increase policies and practices that create safe, supportive and healthy environments		To increase the use of population health information to guide the planning and delivery of programs and services in an integrated health system
<b>ENABLERS</b>	Legislation	Funding	Evidence	Agencies & Associations	Municipal & Federal Governments	Partner Organizations

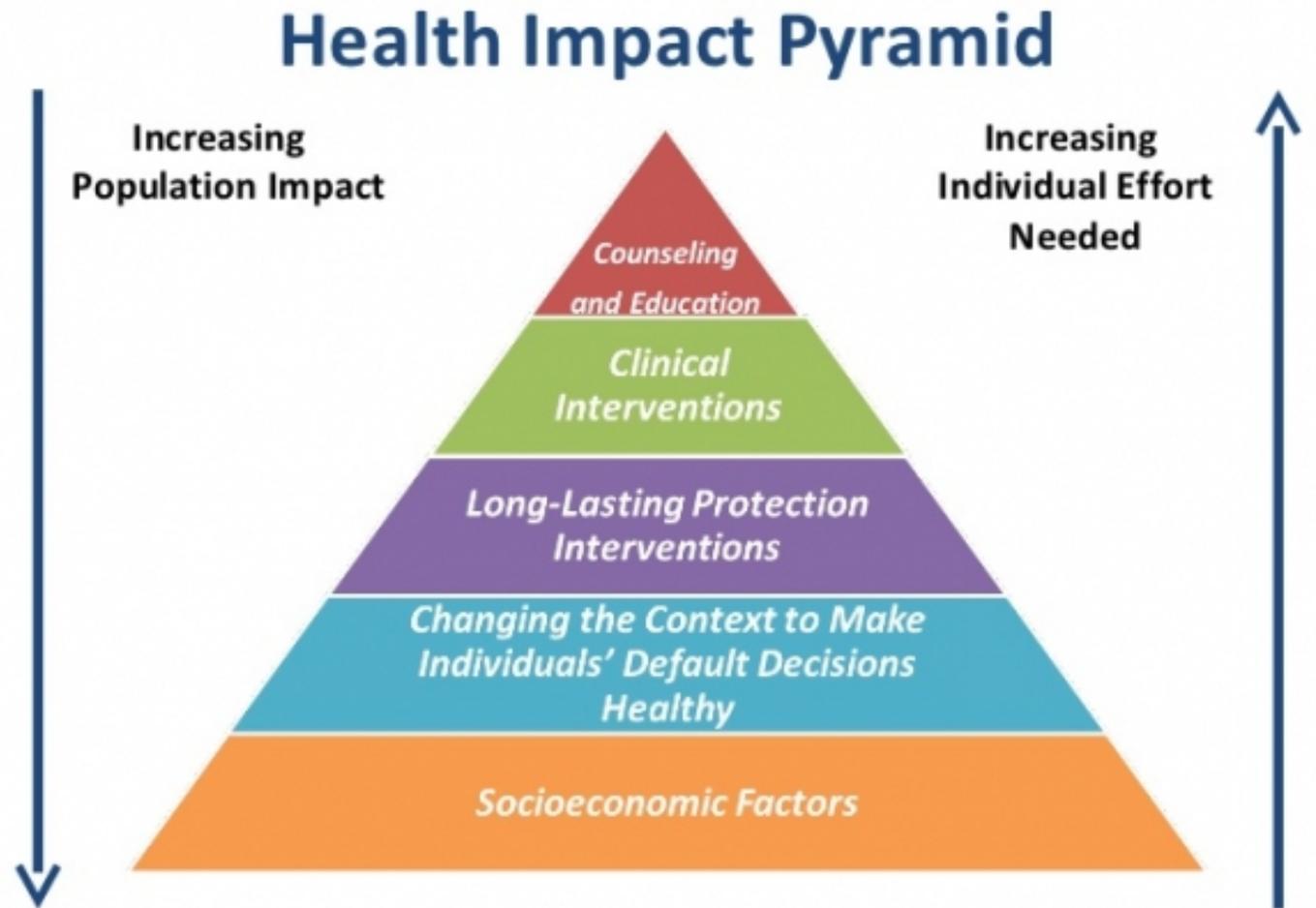
# A Population Health Approach



## Population health is ...

- the health of the whole population, measured by health status indicators
- influenced by physical, biological, behavioural, social, cultural, economic, and other factors
- a term also used to refer to the prevailing health level of the population, or a specified subset of the population
- describes the state of health

Source: Last J, editor. *A dictionary of public health*. New York: Oxford University Press; 2007.



Frieden T. American Journal of Public Health | April 2010, Vol 100, No. 4



# Levels of Prevention

Whole Population

Whole population  
Selected groups and  
healthy individuals

Selected individuals –  
high risk patients

Patients

## Primordial Prevention

Establish or maintain  
conditions to promote  
health

## Primary Prevention

Prevent disease or injury  
before it develops  
reduce risk factors

## Secondary Prevention

Early detection of  
disease or injury and  
interventions –reduce  
impact of existing  
disease or injury

## Tertiary Prevention

Treat established  
disease or injury –  
prevent, delay related  
complications.

Prevent risk factors  
themselves  
Health Public Policy  
Changes in environment  
Social Change

Primary care advice as  
part of routine  
consultation

Primary care screening  
& risk factor reduction.

E.g. cardiac rehab



# Primary Care Drivers in Healthcare System



- Entry into and foundation of the healthcare system
- Patient's medical home – person centered care
- Strong role in coordinating care within the system



**ACCESS**  
**CONNECT**  
**INFORM**  
**PROTECT**

**Patients First:**  
Action Plan  
for Health Care

# NE LHIN – why falls prevention

---

- ✓ Rate of visits to the ED and Hospitalizations due to falls among 65+ high in the NE
- ✓ Inter LHIN Collaborative Tool Kit (2011) – falls recognized as a growing problem needing a multi-factorial solution
- ✓ Aging at Home funded two PHUs to implement Stay on Your Feet - expanded to all five PHUs
- ✓ New focus on primary care
- ✓ Recognized importance of working with public health units as part of the health system
- ✓ Focus on changing population health outcomes

# Timiskaming Health Unit why falls prevention

---

Ontario Public Health Standards -2009 *“reduce the frequency, severity, and impact of preventable injury”*

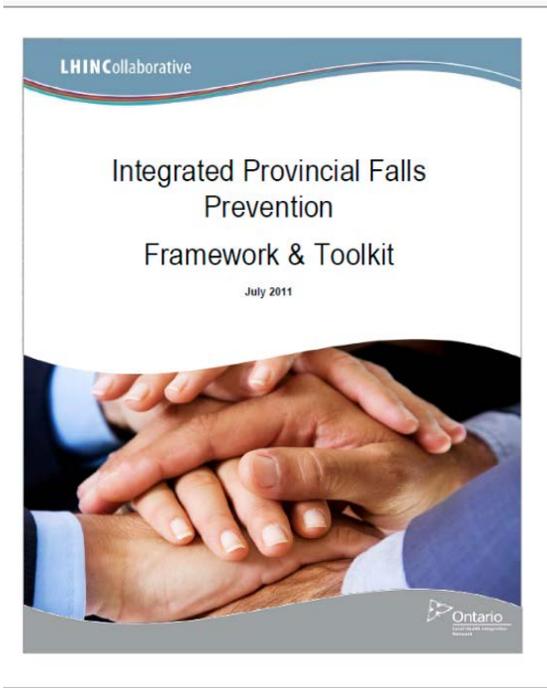
Integrated Provincial Falls Prevention Framework & Toolkit - **July 2011**

## **Test of NIC-P**

- Need – is this an issue of public health importance locally?
- Impact- are there interventions that can help?
- Capacity – are their local resources to address ?
- Partnerships and Collaboration – does anyone else care and want to help?



# Why is primary care driven to be involved in falls prevention?



- As Executive Directors of Family Health Teams, Great Northern and Temagami FHTs were asked by the Timiskaming Health Unit to present what we were doing in primary care to prevent falls. We did some research and quickly realized that it would be beneficial to our patients and our healthcare system to initiate some programming around falls prevention.
- From there, the issue of patients not being assessed in primary care for risk of falls was the problem opportunity for an **IDEAS (Improving and Driving Excellence Across Sectors)** Team.
- Asked to Chair the Regional Stay On Your Feet (SOYF) Committee at the NE LHIN.







## PRESCRIPTION FOR A HEALTHY INDEPENDENT LIFE

### Be Active

- Join a balance focused class such as Stand Up or Tai Chi
- Work on strength and balance with exercises at home
- Aim for at least 30 minutes of activity/day

### Manage Your Medicines/Health

- Have medications reviewed by a pharmacist
- Avoid medications that cause dizziness or drowsiness
- Take managing health conditions seriously such as  diabetes,  high blood pressure,  depression,  osteoporosis,  other \_\_\_\_\_

### Improve Your Balance/Walk Tall

- Be active to strengthen your muscles
- Be properly fit for a walking aid by a physiotherapist or occupational therapist

### Foot Care and Safe Footwear

- Choose proper footwear
- Visit a foot care provider/personal support worker (cut nails, deal with corns)
- Do foot exercises to maintain circulation

### Check Eyesight and Hearing

- Make an appointment to have vision tested
- Make an appointment to have hearing tested

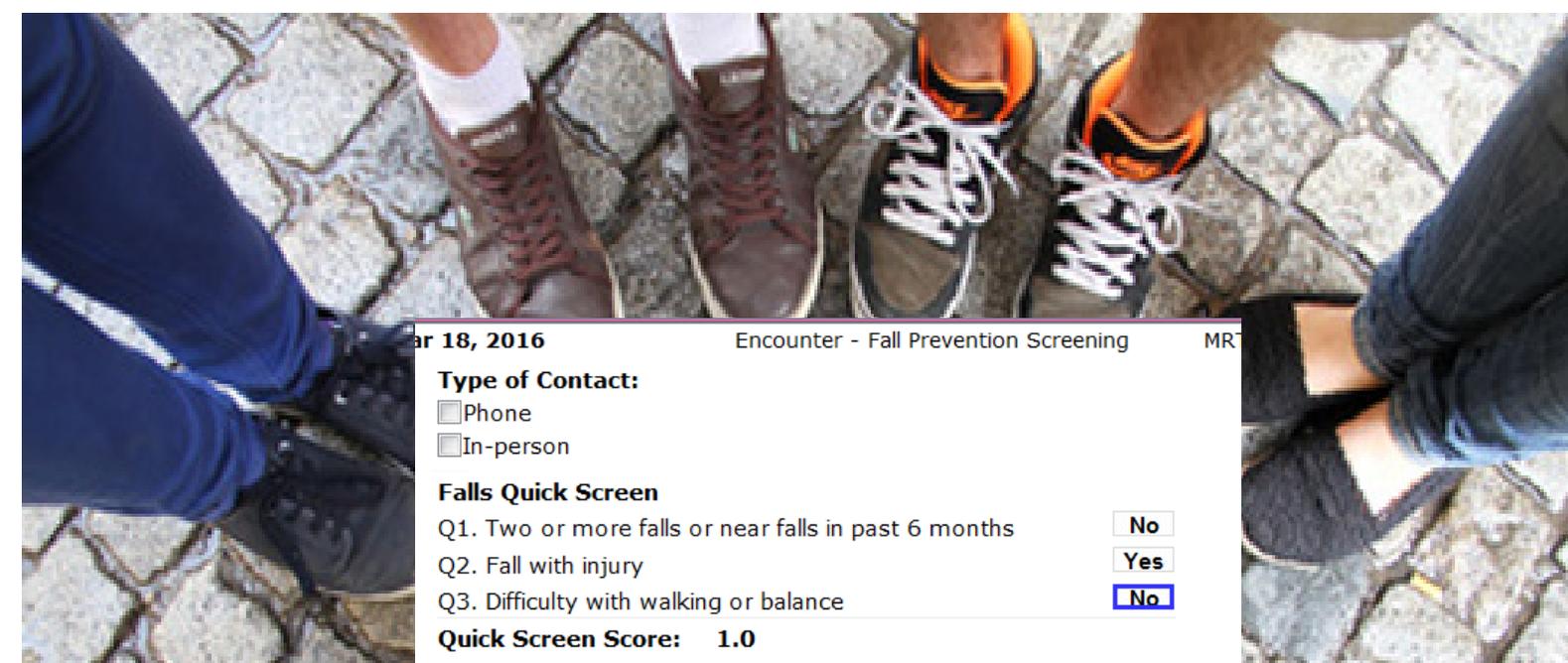
### Eat Well for Life

- Eat regular, balanced meals including foods rich in calcium and Vitamin D to keep bones strong
- Drink water often
- Take a regular Vitamin D supplement
- Make an appointment with a Registered Dietitian

### Identify and Remove Hazards

- Use the Independent Living Guide to identify and modify hazards in your home

Comments: \_\_\_\_\_



ar 18, 2016 Encounter - Fall Prevention Screening MR

#### Type of Contact:

- Phone
- In-person

#### Falls Quick Screen

- Q1. Two or more falls or near falls in past 6 months  No
- Q2. Fall with injury  Yes
- Q3. Difficulty with walking or balance  No

Quick Screen Score: 1.0

## Effects of exercise and diet on chronic disease

Christian K. Roberts, R. James Barnard

Journal of Applied Physiology Published 1 January 2005 Vol. 98 no. 1, 3-30 DOI: 10.1152/jappphysiol

Article

Figures & Data

Info

E-letters

PDF

### Abstract

Currently, modern chronic diseases, including cardiovascular diseases, Type 2 diabetes, metabolic syndrome, and cancer, are the leading killers in Westernized society and are increasing rampantly in developing nations. In fact, obesity, diabetes, and hypertension are now even commonplace in children. Clearly, however, there is a solution to this epidemic of metabolic disease that is inundating today's societies worldwide: exercise and diet. Overwhelming evidence from a variety of sources, including epidemiological, prospective cohort, and intervention studies, links most chronic diseases seen in the world today to physical inactivity and inappropriate diet consumption. The purpose of this review is to 1) discuss the effects of exercise and diet in the prevention of chronic disease, 2) highlight the effects of lifestyle modification for both mitigating disease progression and reversing existing disease, and 3) suggest potential mechanisms for beneficial effects.

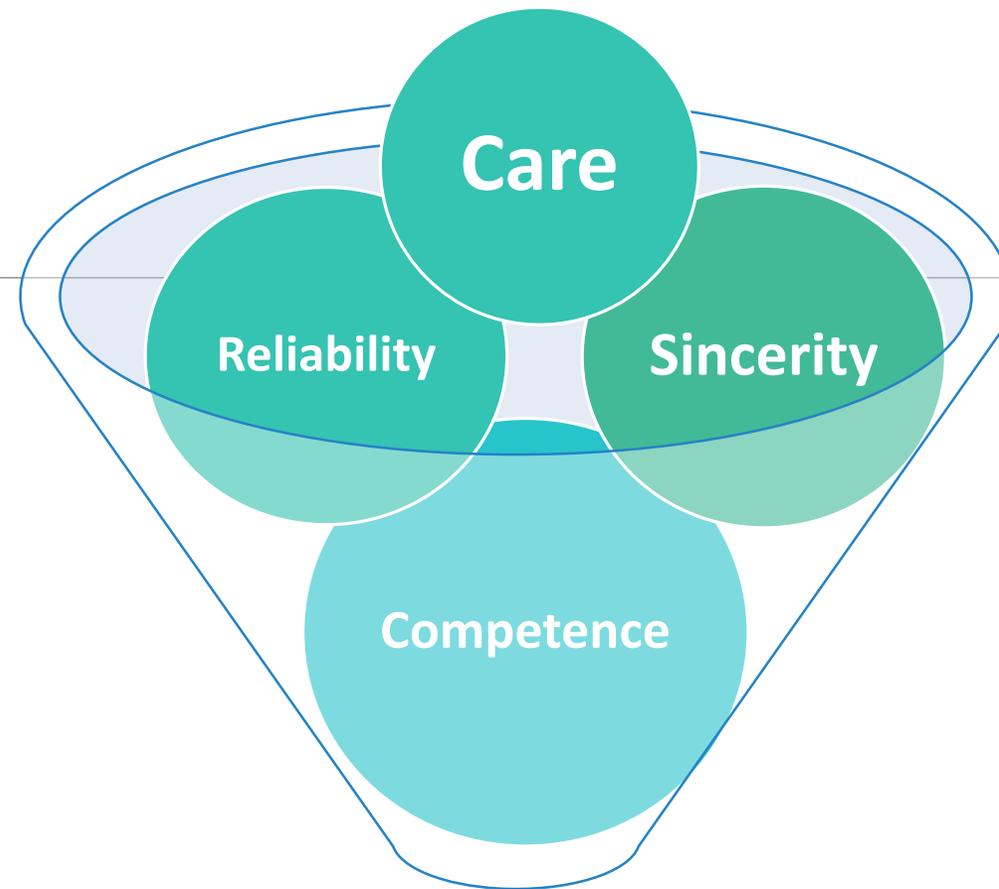
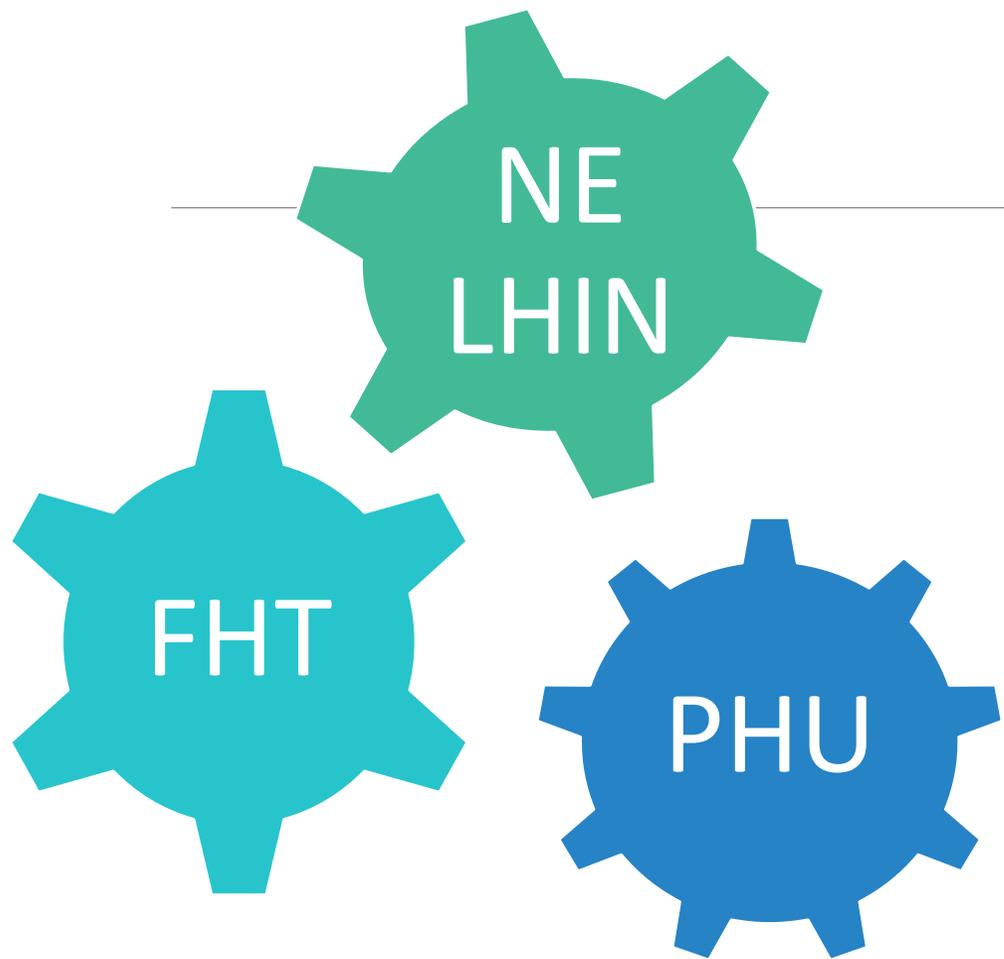
# Build and maintain partnerships

## Trust is the foundation

---

### Pillars of Trust

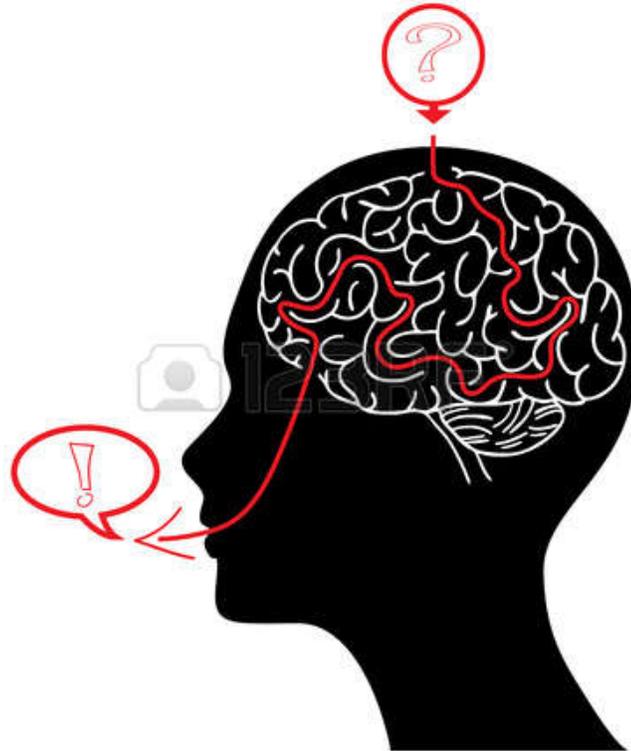
- ✓ sincerity
- ✓ reliability
- ✓ competence
- ✓ caring



**A working  
partnership**

Reference: Charles Feltman, *The Thin Book of Trust*, 2009

Sincerity – *“I mean what I say, say what I mean and act accordingly”*



Reference: Charles Feltman, *The Thin Book of Trust*, 2009

Competence - *“I know I can do this...I don't know if I can do that”*



Reference: Charles Feltman, *The Thin Book of Trust*, 2009

Reliability — *“you can count on me to deliver what I promise”*



Reference: Charles Feltman, *The Thin Book of Trust*, 2009

# Caring – *“we’re in this together”*



Reference: Charles Feltman, *The Thin Book of Trust*, 2009

### **Exercise Personal reflection 3 min**

- ✓ How trustworthy are you?
- ✓ How well do you practice each pillar in the process of building and maintaining partnerships?

### **Group Discussion 10 min**

- ✓ Identify a partnership where trust was low – what pillar(s) was missing? What were the results?

**OR**

- ✓ Identify a partnership where trust was high – what pillars made the trust high? What were the results?

# How we work together

---

- ✓ align the essentials for change – vision, competence/skills, resources, incentives ...
- ✓ utilize quality improvement – PDSA
- ✓ work along the continuum

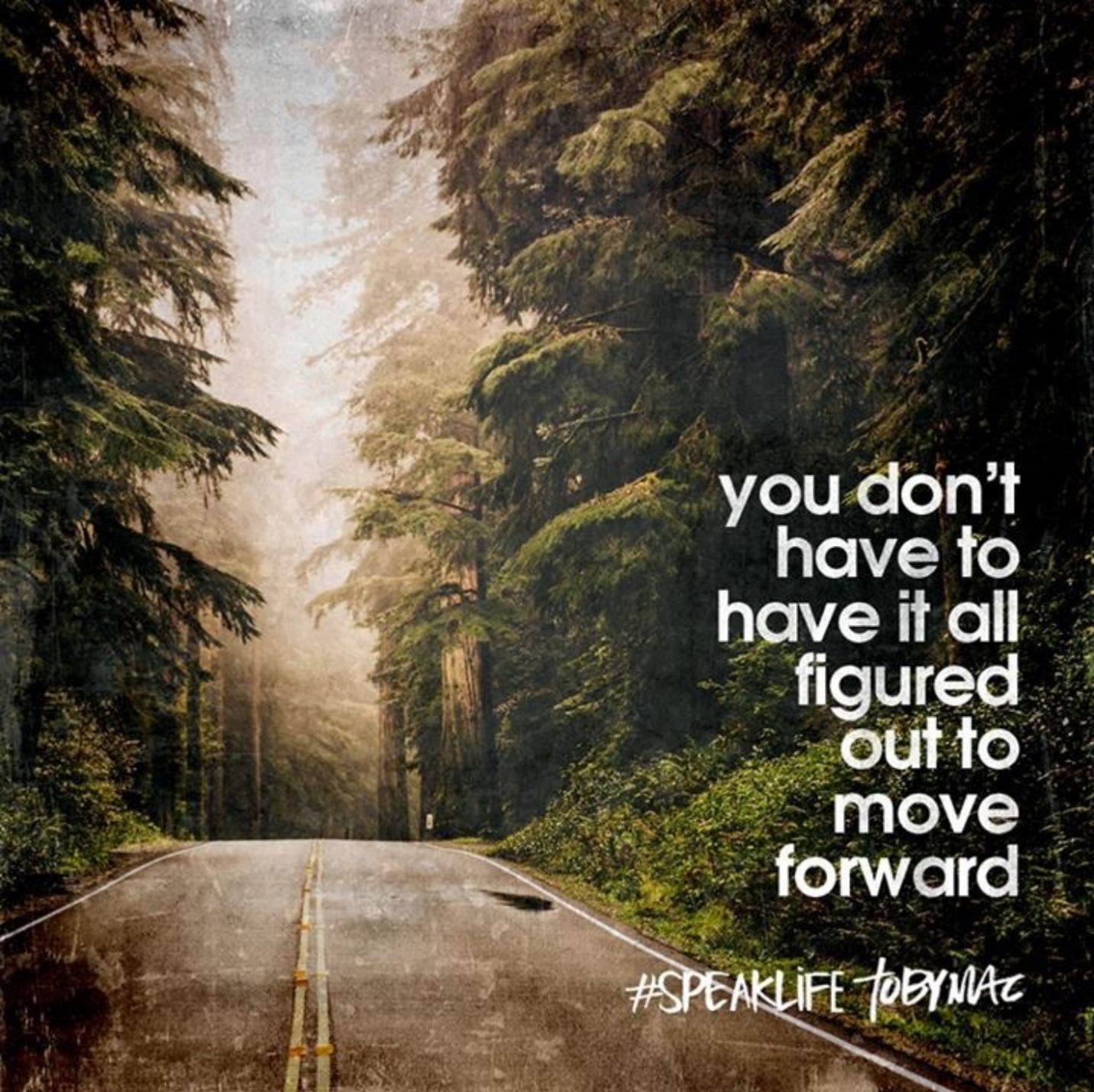


# Essential Ingredients for Change

1. Vision
2. Competence/Skills
3. Incentives
4. Resources
5. Plan – Implement, Communicate, Evaluate

Vision	Competence/Skills	Incentives	Resources	Plan	= Change
	Competence/Skills	Incentives	Resources	Plan	= Confusion
Vision		Incentives	Resources	Plan	= Anxiety
Vision	Competence/Skills		Resources	Plan	= Gradual/slow change
Vision	Competence/Skills	Incentives		Plan	= Frustration
Vision	Competence/Skills	Incentives	Resources		= False starts

Adapted from: [www.yvesdoyen.ca](http://www.yvesdoyen.ca)



you don't  
have to  
have it all  
figured  
out to  
move  
forward

#SPEAKLIFE TOBYMAC

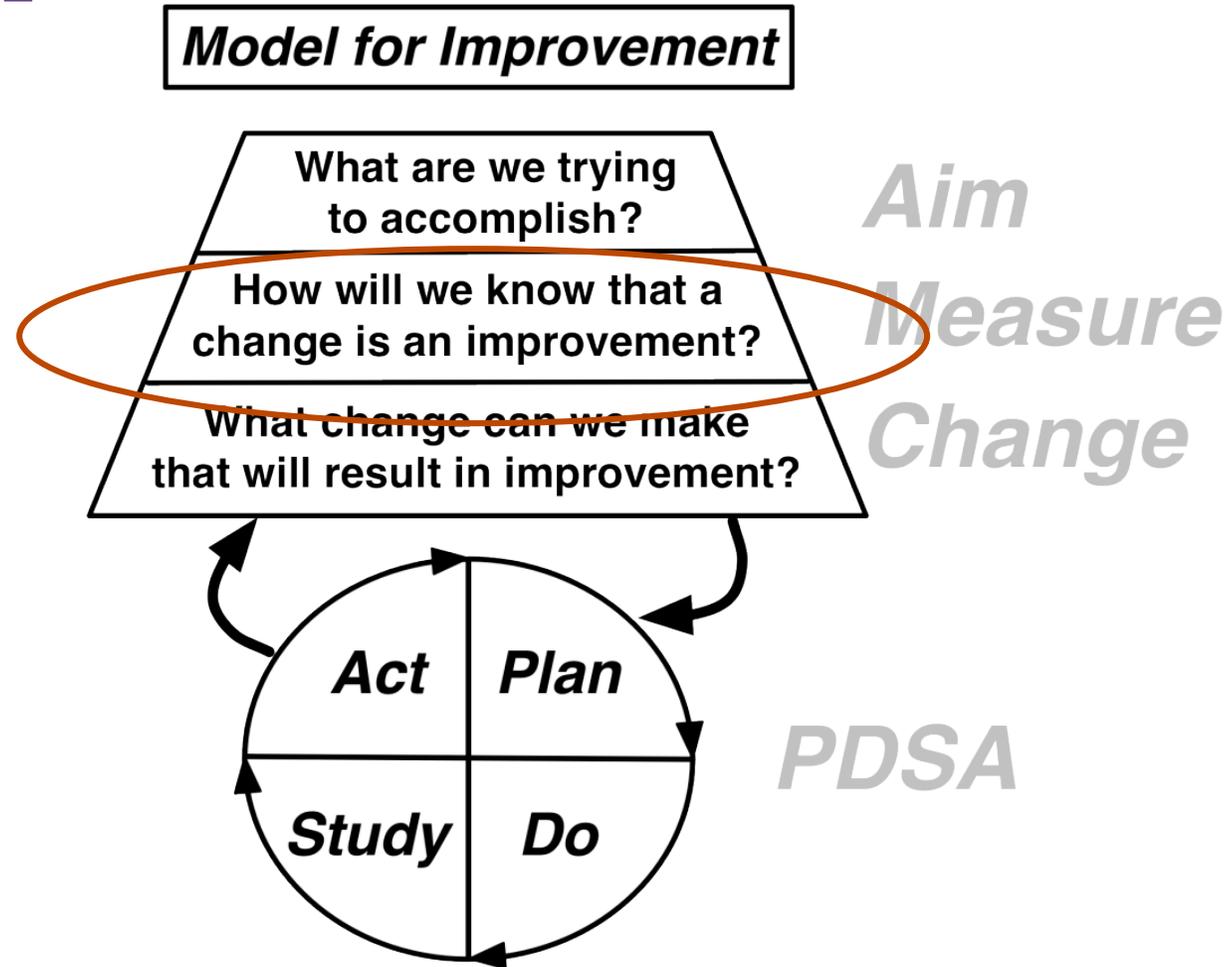


*Sincerity is the face of the soul.*

*--SANIAL-DUBAY*



# Model for Improvement



Langley, Nolan, Nolan, Norman, Provost;  
*The Improvement Guide*, 1996



Improving & Driving Excellence Across Sectors

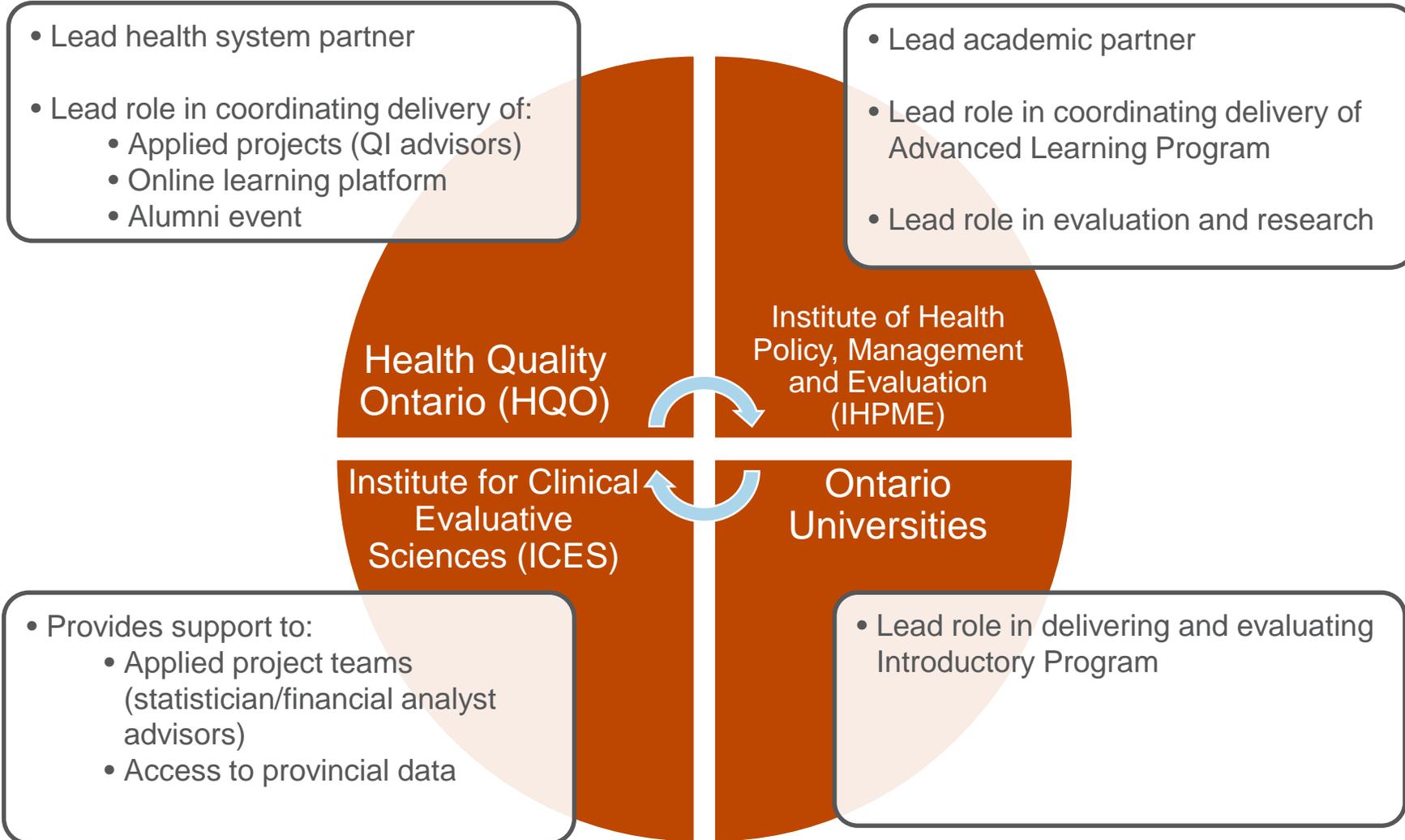
## Advanced Learning Program

- Are you leading or required to **lead** a QI project?
- Do you have responsibility for a challenging QI project within your organization or across several sectors?
- Are you looking for **advanced**, accredited learning and training in QI?
- Do you need a **deeper knowledge** and understanding of QI and practical experience applying that knowledge?
- Do you have the time to commit to a program over a **five-month** period?

## Introductory QI Program

- Have you been asked to **participate** in a QI project?
- Are you thinking about becoming part of a QI team?
- Are you looking for an **introduction** to QI that is offered in your region?
- Do you need a brief **refresher** of your QI knowledge in order to build a stronger foundation for your clinical work?
- Are you available for a **short-term** time commitment only?

# IDEAS Partners



# Courageous Leadership Three Buckets of Courage



# Success Factors for Collaboration



**Personal qualities, knowledge and skills** - experience/knowledge and leadership skills in collaboration

**Personal values, beliefs and attitudes** - willingness to collaborate – responsive to patient & community needs

**Role clarity** – flexible, adaptable

**Effective Communication**

**Trusting relationships**

**Shared values, beliefs, & attitudes**

# Success Factors for Collaboration



**Vision and goals for collaboration**

**Collaborative organizational culture and approach**

**Coordinated communication between partners**

**Organizational and system leaders – collaborative champions**

# Summary

1. A working partnerships needs good relationships
2. Good relationships are grounded in TRUST – you can intentionally build trust
3. Improving the health of populations – is everyone's business, everyone plays a role across the continuum
4. Paying attention to the ingredients of change – promotes success
5. Using quality improvement approaches helps keep the partnership focused and the initiative manageable
6. Come with a open mind and a caring approach – you need one person to say I will try!

**1. HOLDING THE SPACE:**

Listen to what life calls you to do

suspending

**2. OBSERVING:**

Attend with your mind wide open

redirecting

**3. SENSING:**

Connect with your heart

letting-go

OPEN MIND

OPEN HEART

OPEN WILL



letting-come

**4. PRESENCING:**

Connect to the deepest source of your self and will

Who is the Self?  
What is my Work?

**7. PERFORMING:**

Play the "Macro-Violin"

embodying

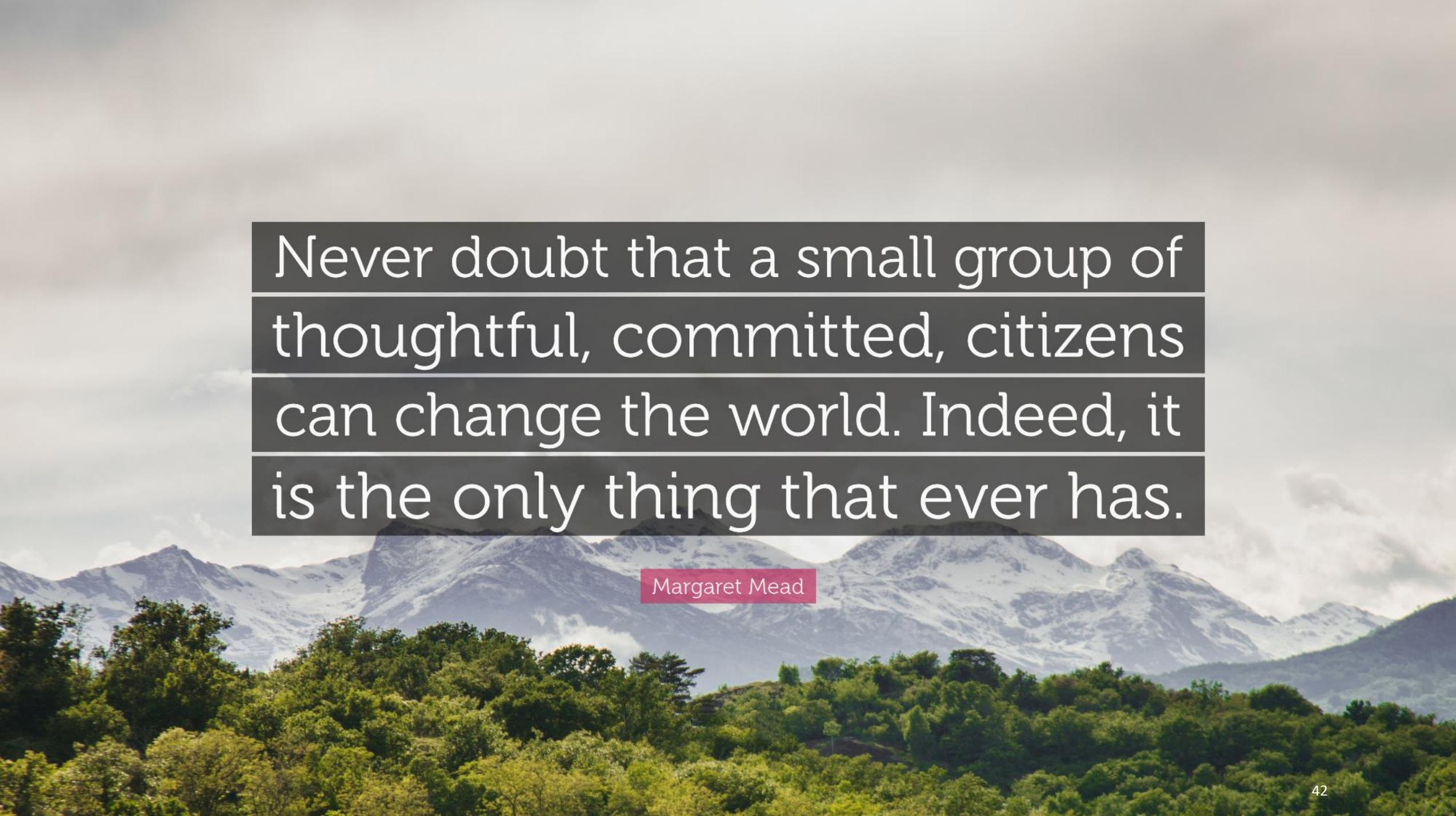
**6. PROTOTYPING:**

Integrate head, heart, hand

enacting

**5. CRYSTALLIZING:**

Access the power of intention



Never doubt that a small group of thoughtful, committed, citizens can change the world. Indeed, it is the only thing that ever has.

Margaret Mead

Wendy Carew, [wendy.carew@lhins.on.ca](mailto:wendy.carew@lhins.on.ca) 1-705-840- 1610

Shirley Watchorn, [swatchorn@greatnorthernfht.com](mailto:swatchorn@greatnorthernfht.com) , 705-647-6100

Kerry Schubert-Mackey, [schubertmk@timiskaminghu.com](mailto:schubertmk@timiskaminghu.com), 1-866-747-4305



[www.nelhin.on.ca/stayonyourfeet](http://www.nelhin.on.ca/stayonyourfeet)