The Most Valuable Player (MVP) Clinic

The Barrie and Community Family Health Team

October 15th, 2014

Barrie and Community Family Health Team

Presenters:

- Shelley Cameron, RN, BScN, Clinical Manager
- Jennifer Handley, BSc (Pharm)
- Angela Lamothe, MScN, NP-PHC
- Stephanie MacGowan, RN, BScN
- Katherine Whiteside, MSW, RSW

Presenter Disclosure

- Presenters:

  Shelley Cameron, Jennifer Handley, Angela Lamothe, Stephanie MacGowan, Katherine Whiteside

- Relationships with commercial interests:
  - Not Applicable

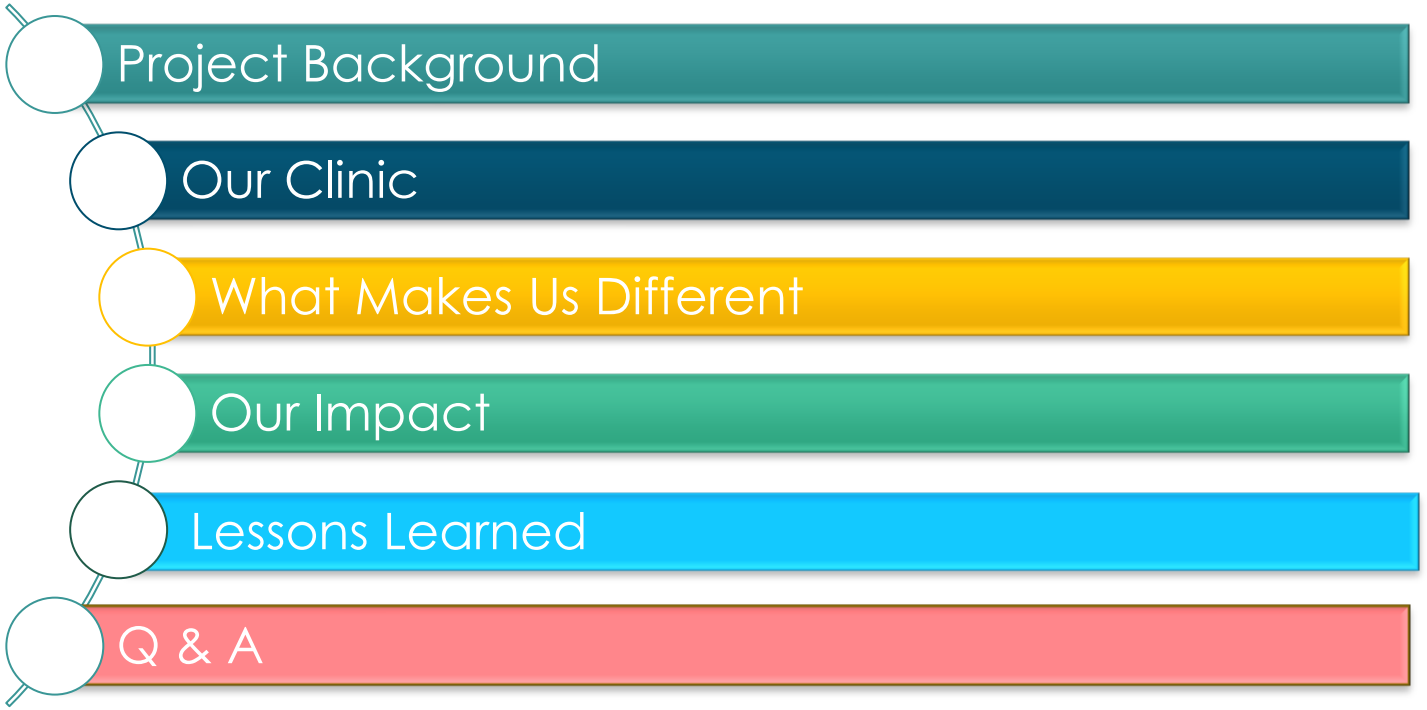
Disclosure of Commercial Support

- No commercial support

Mitigating Potential Bias

- Not applicable to this session

Agenda


Project Background
Our Clinic
What Makes Us Different
Our Impact
Lessons Learned
Q & A

Project Background

Barrie and Community Family Health Team

Mission

Working Together for Health and Wellness

- Improved Access to Care
- Improved Quality of Care
- Improved Partnerships
- Improved Team Based Care
- Improved People

Barrie Community HealthLink

- Improve care delivery by appropriate system utilization and care coordination
- Improve patient experience
- Deliver better value for money and reduce costs

Medically Complex Care Clinic

- Phase 1 of BCHL
- Interdisciplinary team of care providers
- Primary focus on unattached ‘high cost or high needs’ users of the system

Our Clinic

We embrace the philosophy that the patient is in fact the '*most valuable player*' in their healthcare.

Our Clinic Team

- The Patient
- Administrative Support
- Registered Nurses
- Nurse Practitioners
- Social Worker
- Occupational Therapist
- Pharmacist
- Physician support (hospitalist, family medicine, internal medicine)
- Registered Dietitian

Our Clinic Goals

- Use a collaborative approach to provide:
  - Holistic assessment (physical, mental, psychosocial)
  - Treatment & care coordination for multiple complex conditions
  - Linkages to new community supports
  - Assistance with patient goal setting for overall wellness
  - Support to meet patient goals
  - Linkage to primary care provider in the community

What Makes Us Different?

- Our Patients

Patient Criteria

- 2 or more chronic conditions
- Minimum 20 years of age
- High user of healthcare services

and/or

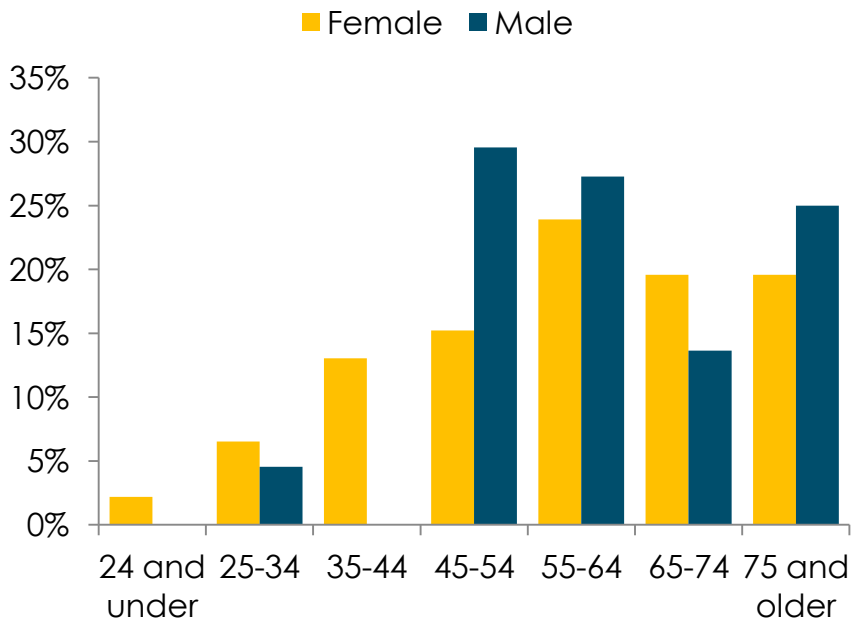
- Lengthy hospital stay (10 + days or recurrent admissions)

<u>Priority given to unattached patients</u>

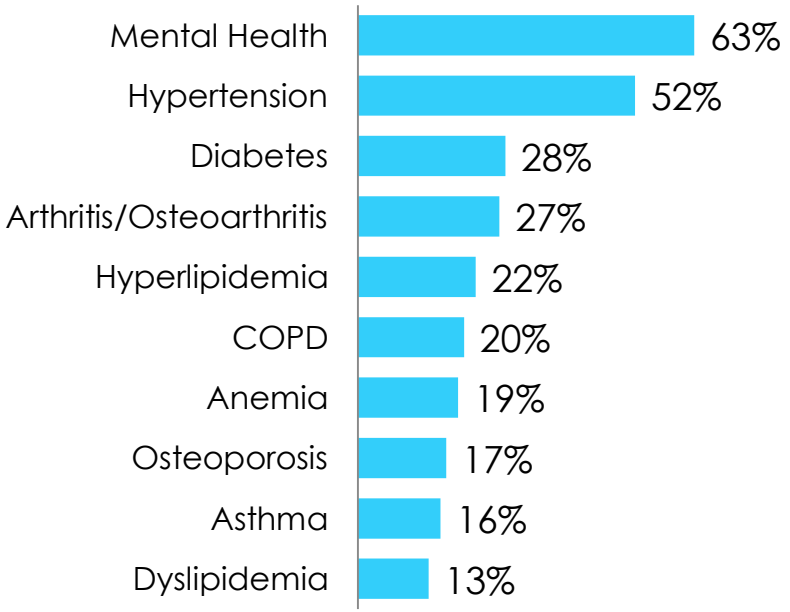
- Attached patients at risk of readmission

Types of Patients

Age Breakdown by Gender



Top 10 Diagnosis



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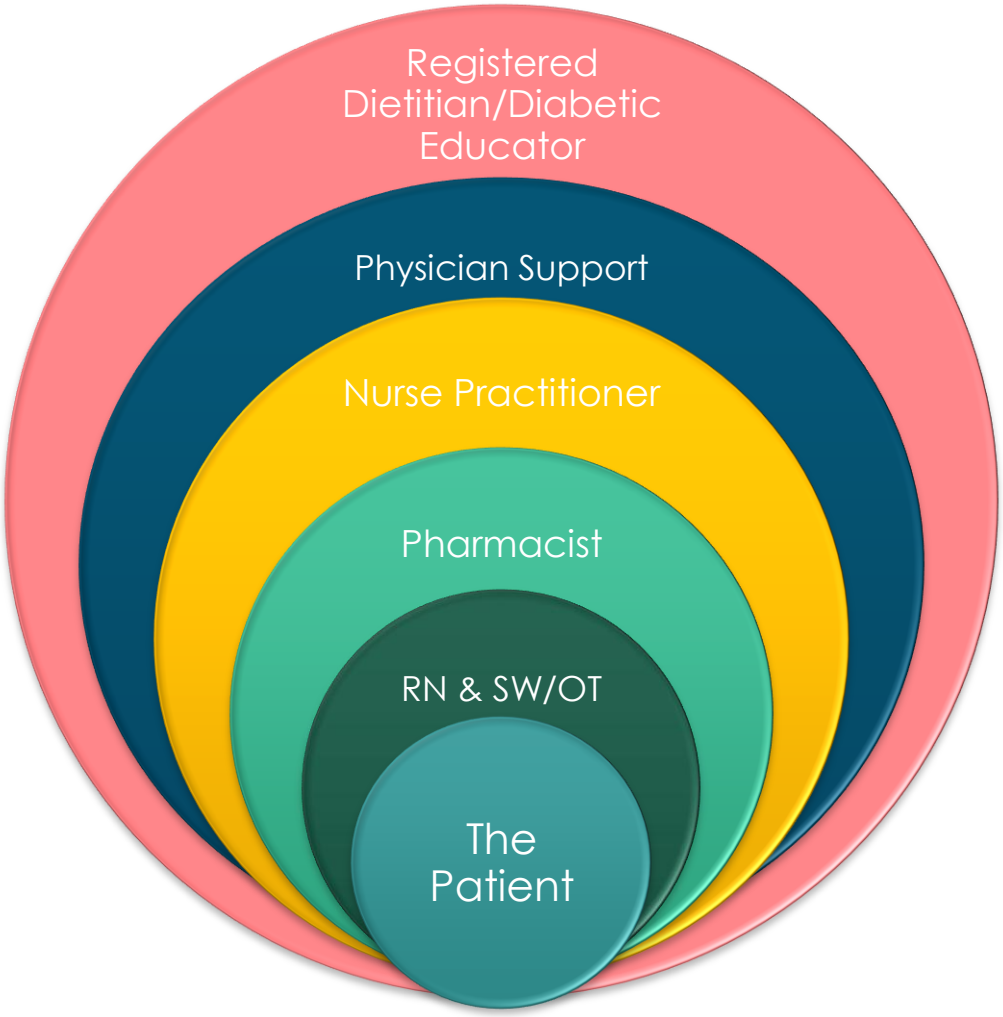
A Typical Patient

Health Conditions	• Type II Diabetes with Below Knee Amputation • Chronic Obstructive Pulmonary Disease • Coronary Artery Disease • Chronic Pain
Mental Health	• Depression • Addiction
Social Issues	• Housing • Food security • Social isolation • Low income
Other	• Mobility issues • No primary care provider • No advocate

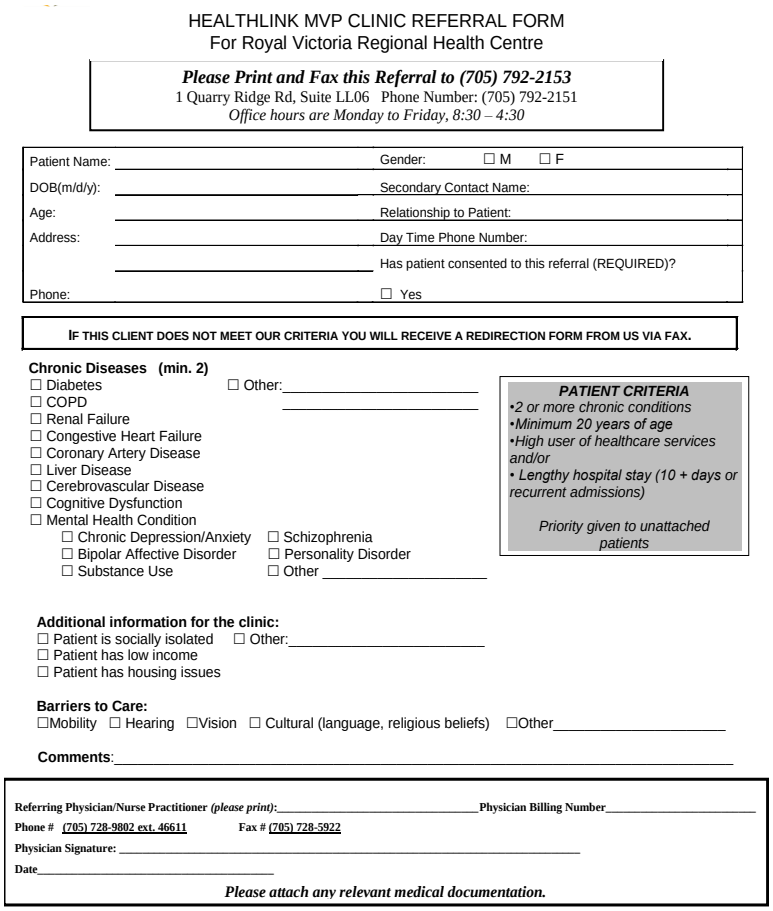
What Makes Us Different?

- Our Approach

Collaboration



Referrals



HEALTHLINK MVP CLINIC REFERRAL FORM
For Royal Victoria Regional Health Centre

Please Print and Fax this Referral to (705) 792-2153
1 Quarry Ridge Rd, Suite LL06 Phone Number: (705) 792-2151
Office hours are Monday to Friday, 8:30 – 4:30

Patient Name:		Gender:	☐ M ☐ F
DOB(m/d/y):		Secondary Contact Name:	
Age:		Relationship to Patient:	
Address:		Day Time Phone Number:	
		Has patient consented to this referral (REQUIRED)?	
Phone:		☐ Yes	

IF THIS CLIENT DOES NOT MEET OUR CRITERIA YOU WILL RECEIVE A REDIRECTION FORM FROM US VIA FAX.

Chronic Diseases (min. 2)
☐ Diabetes ☐ Other:_____
☐ COPD _____
☐ Renal Failure
☐ Congestive Heart Failure
☐ Coronary Artery Disease
☐ Liver Disease
☐ Cerebrovascular Disease
☐ Cognitive Dysfunction
☐ Mental Health Condition
☐ Chronic Depression/Anxiety ☐ Schizophrenia
☐ Bipolar Affective Disorder ☐ Personality Disorder
☐ Substance Use ☐ Other _____

PATIENT CRITERIA
•2 or more chronic conditions
•Minimum 20 years of age
•High user of healthcare services and/or
• Lengthy hospital stay (10 + days or recurrent admissions)

Priority given to unattached patients

Additional information for the clinic:
☐ Patient is socially isolated ☐ Other:_____
☐ Patient has low income
☐ Patient has housing issues

Barriers to Care:
☐Mobility ☐ Hearing ☐Vision ☐ Cultural (language, religious beliefs) ☐Other_____

Comments:_____

Referring Physician/Nurse Practitioner *(please print)*:_____**Physician Billing Number**_____
Phone # (705) 728-9802 ext. 46611 **Fax #** (705) 728-5922
Physician Signature: _____
Date_____
Please attach any relevant medical documentation.

- Hospital Referrals
  - ER
  - Out Patient Clinics
  - Discharge Planners
  - SW
- Community Referrals
  - CMHA
  - NP led clinics
  - Community services
  - CCAC
  - Walk-in clinics
- Family Physicians

Process

- Referral received
- Pre screen
- Triage
- Intake appointment
  - Interdisciplinary visit – RN & SW/OT
  - Intensive medical and social history review
  - Medication review by the Pharmacist
  - NP introduction/intervention
- All services under one roof
- Patient sets goals

Registered Nurse

MVP Clinic Allied Health Screen Tool

- Have you had any falls in the past year?
- Do you have any concerns around moving safely around your home?
- Do you have coverage for your medications?
- Do you have any conditions that require you to follow a special diet?
- Do you feel sad or have trouble coping?


Social Issues/ Isolation
Legal Issues
Financial
Transportation
Mobility
Psychiatric History
Community Supports
Previous Abuse or Trauma
Social Work

Occupational Therapist

- ADL's
- IADL's
- Falls Risk
- Cognitive Assessment

Pharmacist Role

Initial Visit

- Medication Reconciliation
- Safety/ Compliance

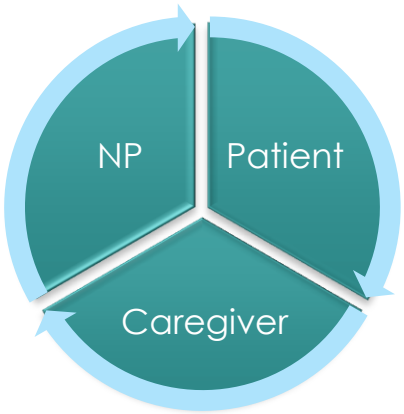
Follow Up

- Review lab results
- Access to medications

Ongoing

- Patient education
- Drug interactions

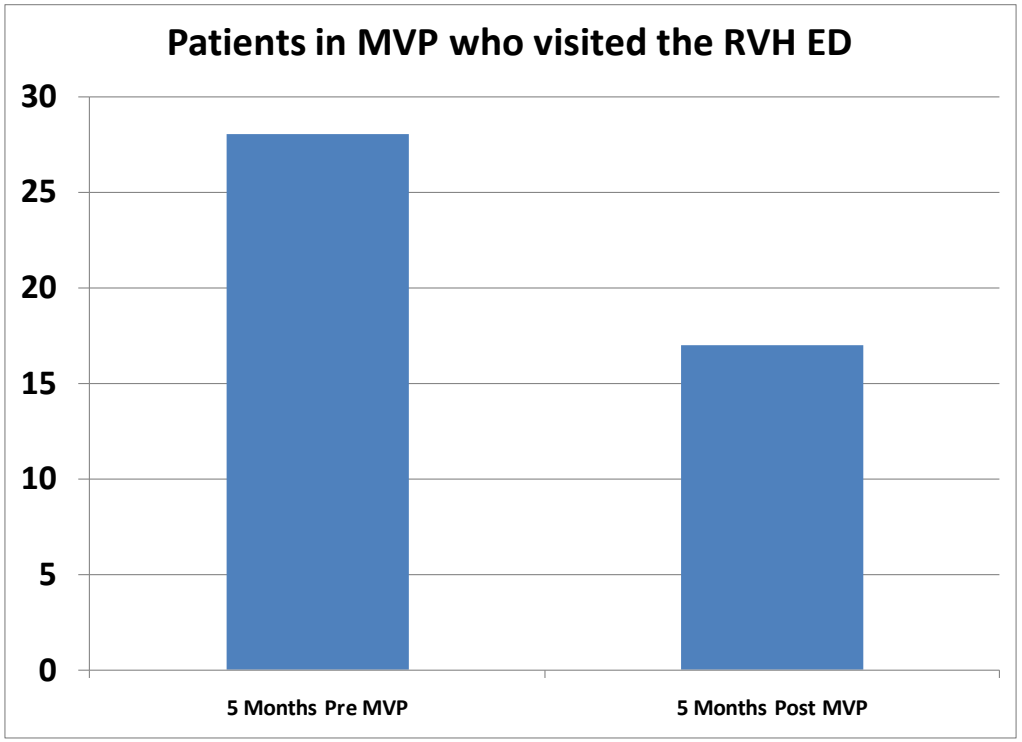
Nurse Practitioner

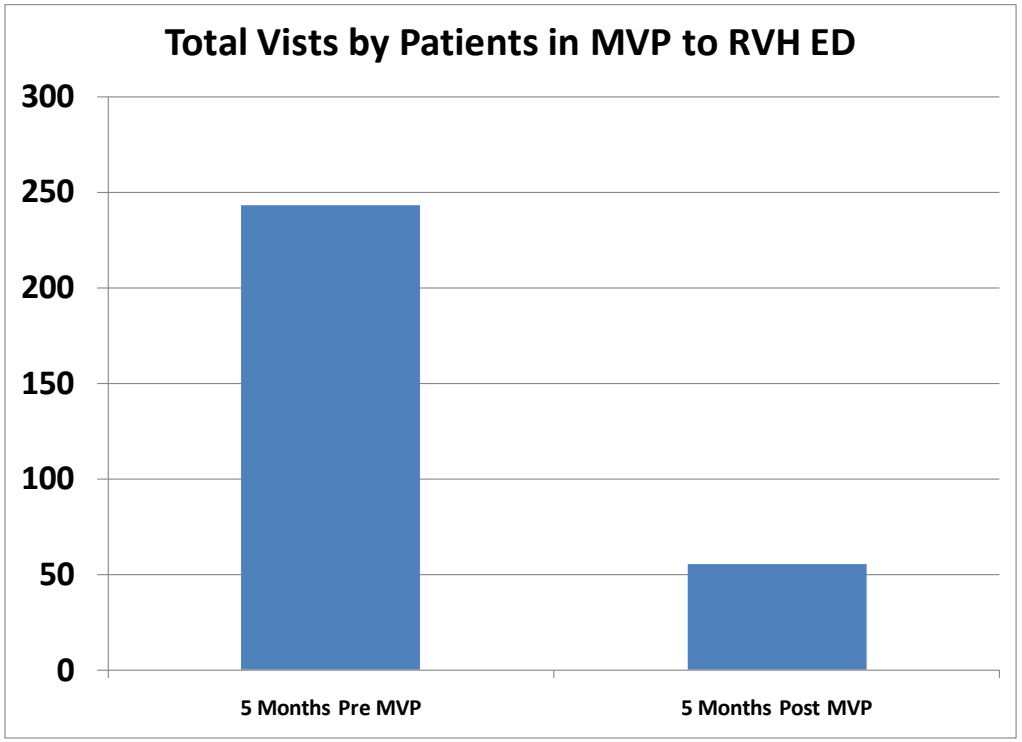


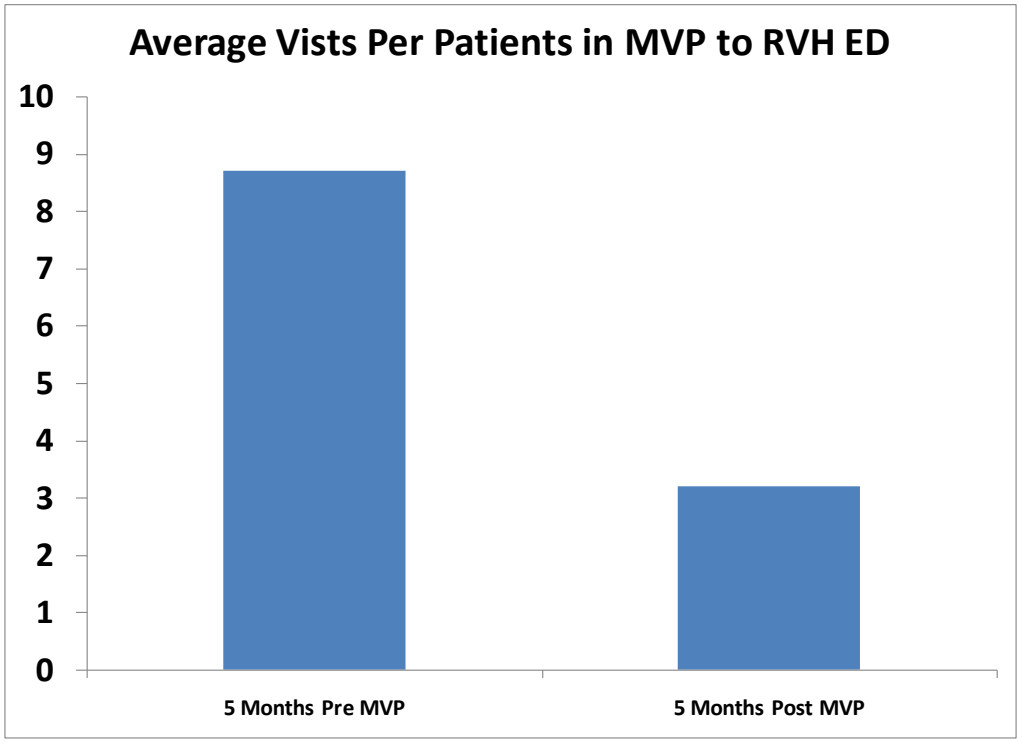
Our Impact

System Implications

- Reduced ER visits
- Reduced use of EMS services
- Reduced frequency of hospital admission
- Enhanced communication and collaboration among providers
- Shift from acute care to primary and community care
- Improved patient experience


Patients in MVP who visited the RVH ED
30
25
20
15
10
5
0
5 Months Pre MVP
5 Months Post MVP


Total Vists by Patients in MVP to RVH ED
300
250
200
150
100
50
0
5 Months Pre MVP
5 Months Post MVP


Average Vists Per Patients in MVP to RVH ED
10
9
8
7
6
5
4
3
2
1
0
5 Months Pre MVP
5 Months Post MVP

Primary Care

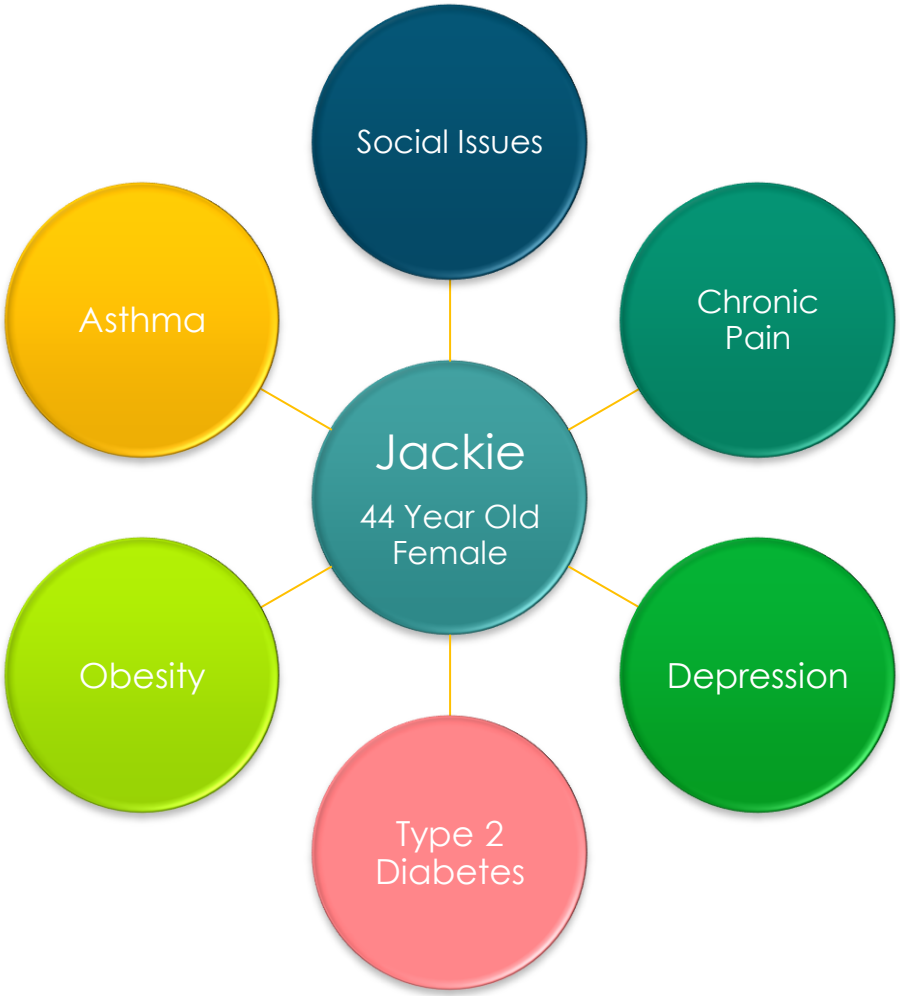
of Patients

- Discharged to a Family Physician -13
- Returned to Family Physician – 5
- Discharged to FMTU – 3
- Returned to NPLC – 1
- Attached to an NP led clinic - 2

Improved Partnerships

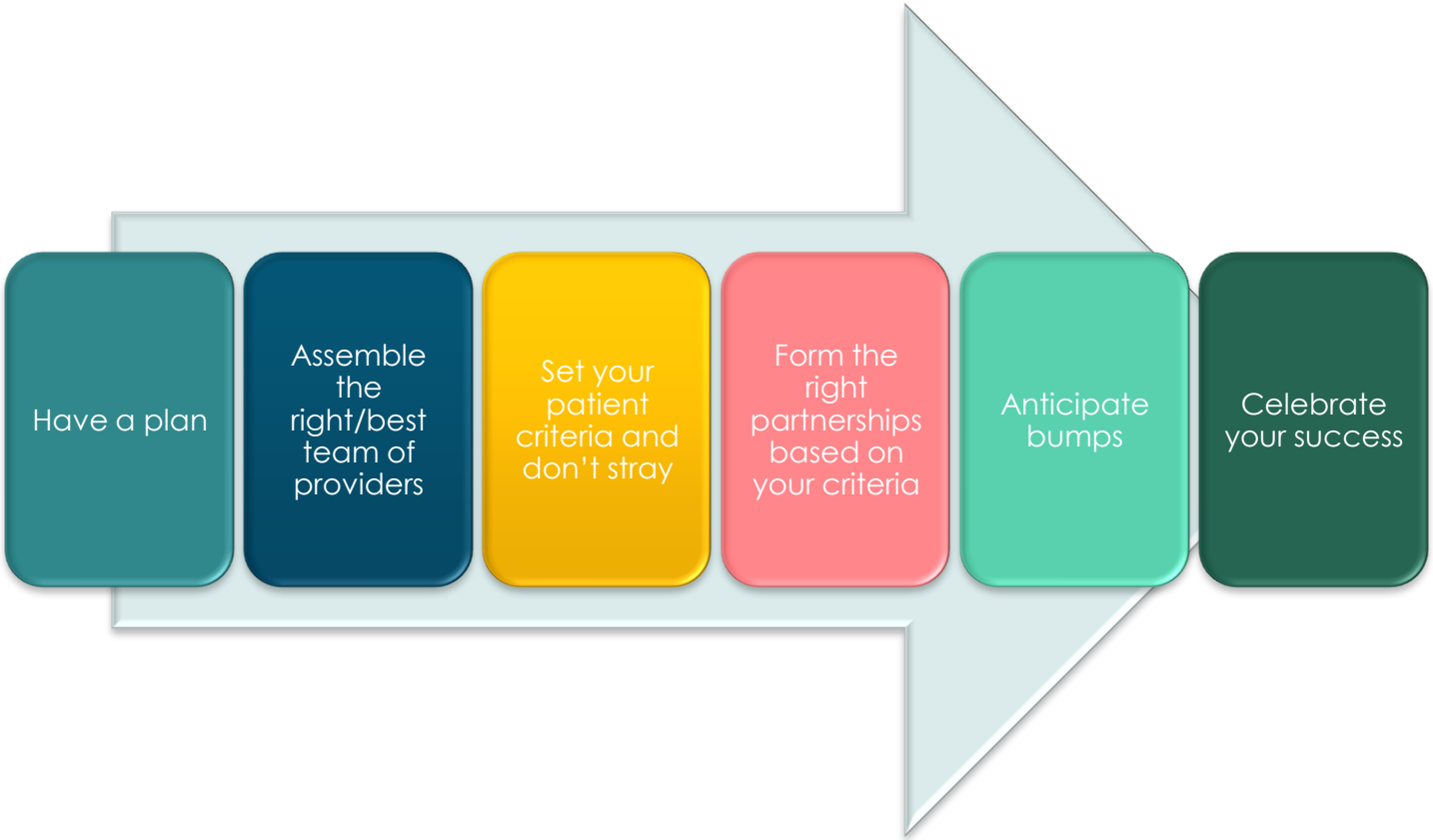
- RVH
  - ER, Dialysis, In-patient Units, Out-patient Clinics
- NSM CCAC
- Community MH services
- Healthcare Connect
- BANAC
- BCHC
- David Busby Street Centre
- County of Simcoe Social Services
  - ODSP/OW/housing

Jackie's Journey

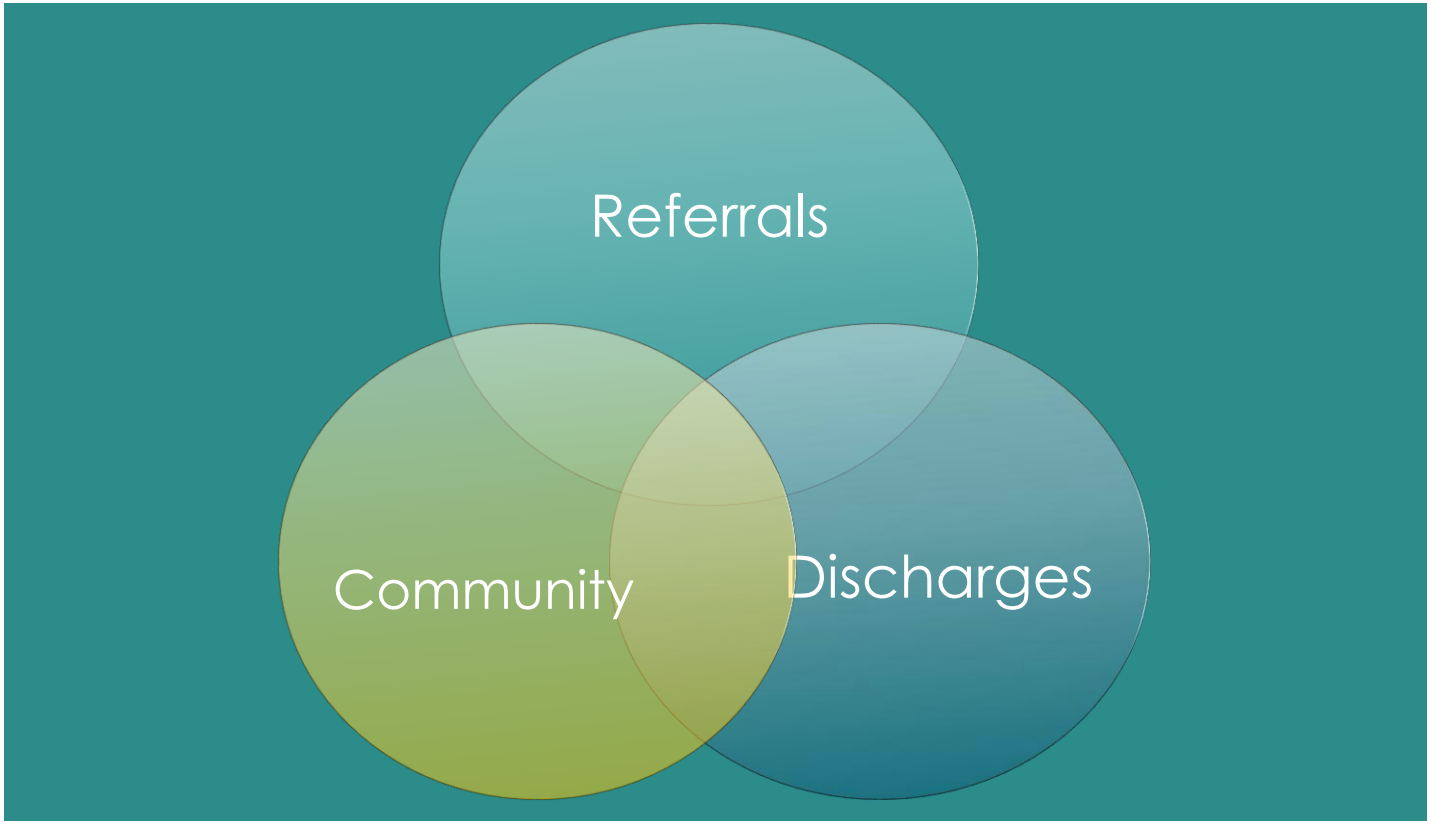


Lessons Learned

Moving Forward



Recommended Priorities



Q & A

'Health Link MVP has benefited me in many manners, including medical, social, emotional and pharmaceutical help. I visit the social worker and the nurse practitioner for medical and emotional support weekly. Not having a doctor for over 10 years, this program has given me the ability to access the help I need. Only being able to access walk-in clinics for the last 10 years has limited my ability to care for my body and mind.' – *MVP PATIENT*

Thank you!