

INNOVATIVE PARTNERSHIPS TO IMPROVE PATIENT CARE AND ADDRESS SOCIAL DETERMINANTS OF HEALTH



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Presenter Disclosure



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- **Relationships with commercial interests:**
 - **No disclosures**

Agenda/Learning objectives:



- How to identify and develop partnership and clinical integration opportunities leading to improved patient and caregivers care
- Review examples of innovative partnerships
 - Pre-post natal care
 - Newcomers Program, Dental program
 - Seniors care/care for patients with frequent ER use (Integrated Homebased Primary Care Program, Integrated Client Care Project, Health Links etc.)
- Lessons learned from partnerships

Community Partnership



- A partnership is a **process** in which stakeholders invest themselves in terms of **ideas, experiences, and skills** to **collectively** bear on the problem through mechanisms for **joint decision making and action** (Mangaung-University of the Orange free State Community Partnership Programme, circa 1995)
- Potential **benefits** of collaboration include the **support and acceptance** of the partnership's work (Schlaff, 1991), **added resources**, increased **credibility** and greater **sustainability** for the partnership's work (Bracht, 1990), and **attaining the desired outcomes** (Rich, 1980; Zapka et al., 1992).

Pre-Postnatal Care

- **Canada Perinatal Nutrition Program (CPNP)**
- **Partners:** Toronto Public Health, Central Toronto CHCs, Mt. Sinai Hospital, St. Stephen's Community House and Scadding Court Community Centre
- Provide **education** and practical **support** for 300 pregnant women and new moms annually with >95% satisfaction, 84.4% breastfeeding initiation.
- Partner with Evergreen College to provide **postnatal Personal Support to at risk moms for one month postpartum period.**
- 10 at risk moms received care with high satisfaction with the support and care in the critical postpartum period in one year.



Newcomer Program

- Partner with Local Immigration Partnership, Scadding Court Community Centre and Great Start Together Perinatal Program to **improve access to primary care for those newcomers without family doctor**

- **Screenings on physical health and social determinants** for each newcomer patient
- Provide **support and referrals** to address financial, social and community health needs.
- Result: 30 newcomers received care in one year



Healthy Child Screening Day

- Partner with Central Toronto Community Health Centers and local agencies to organize Healthy Child Screening Day 2 times a year for **early identification and intervention** for children aged 2 – 6 with health and developmental needs.
- Screenings: **dental, speech and language, physical, nutrition, hearing, social/emotional needs**

- Approx. 70 children screened each year.
- 36% referred to dentist; 23% SLP; 9% dietitian; 5% family doctor; 5% social worker



Social determinants of health – Dental care

- Established **West End Oral Health Clinic** with Partners for Parkdale Health Network and Toronto Oral Health Coalition to provide **free basic dental care for adults aged 19 – 64**
- Referred children and seniors to TPH Dental Program
- 110 low income adults/seniors/children received free dental services a year



Family Medicine Inpatient Service (FIS)



- **Interdisciplinary team at based at the Toronto Western Hospital Family health Team**
- **MRP on team is Family Physician from TWH FHT**
- **Has two primary goals**
 - Aims to improve continuity of care for FHT/Non FHT patient admitted to hospital
 - Trainee education

Inpatient Medicine: Challenges for the future

- **Big Challenges are ahead of us:**
 - Increasingly complex patients
 - Aging population
 - Need to improve continuity of care during/after admission to hospital

Patient Complexity

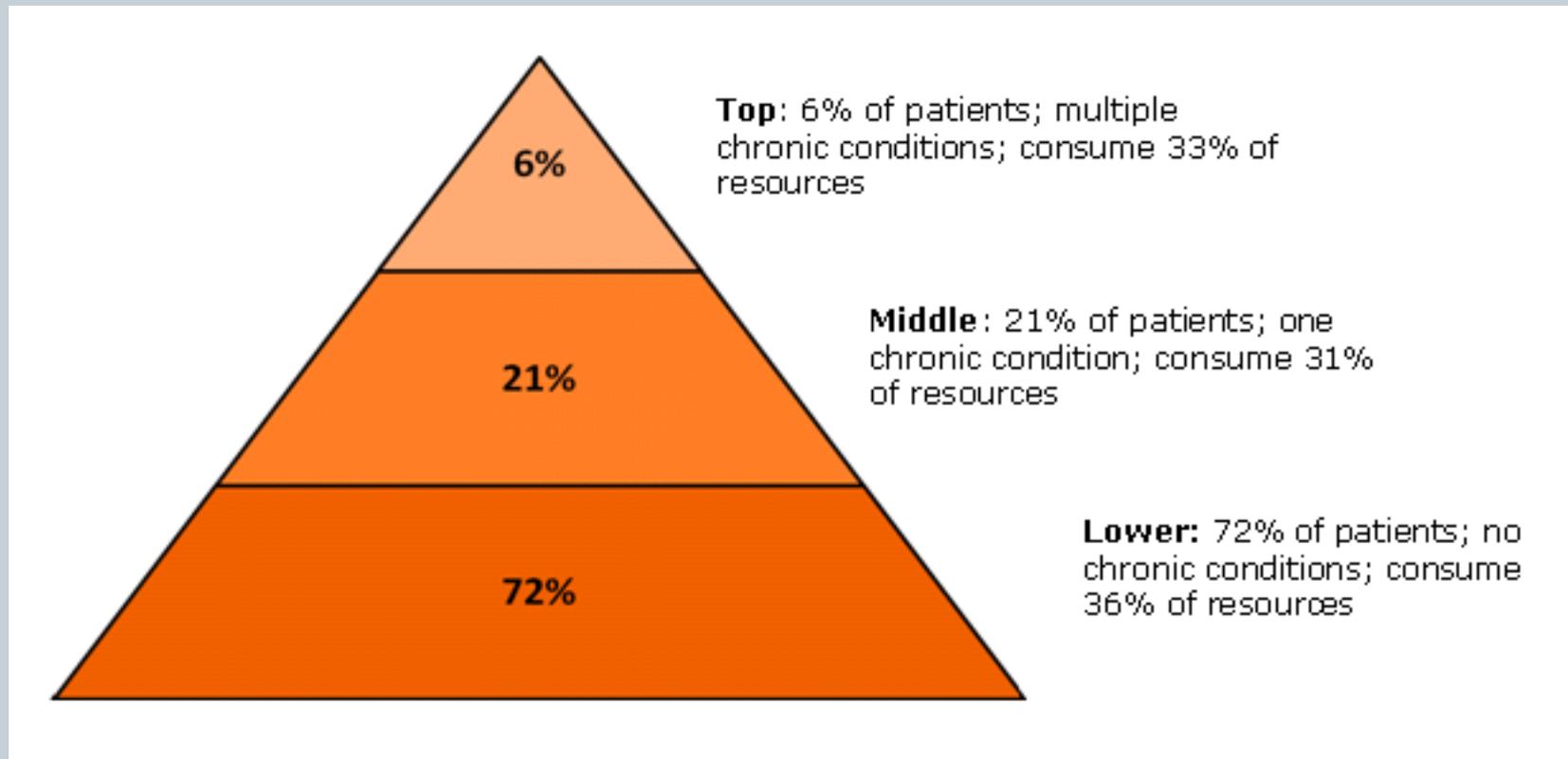


- **Multiple chronic co-morbid illnesses**
 - 70% of patients over the age of 45 with chronic disease have co-morbid illnesses¹
 - Associated with longer stays in hospital and increased risk of readmission²
 - Increased risk of mortality²
 - Increased financial cost to the system²

1. Canadian Community Health Survey (CCHS) - Cycle 1.1. Statistics Canada, 2003.

2. Rochon et, al 1996

Resource Utilization



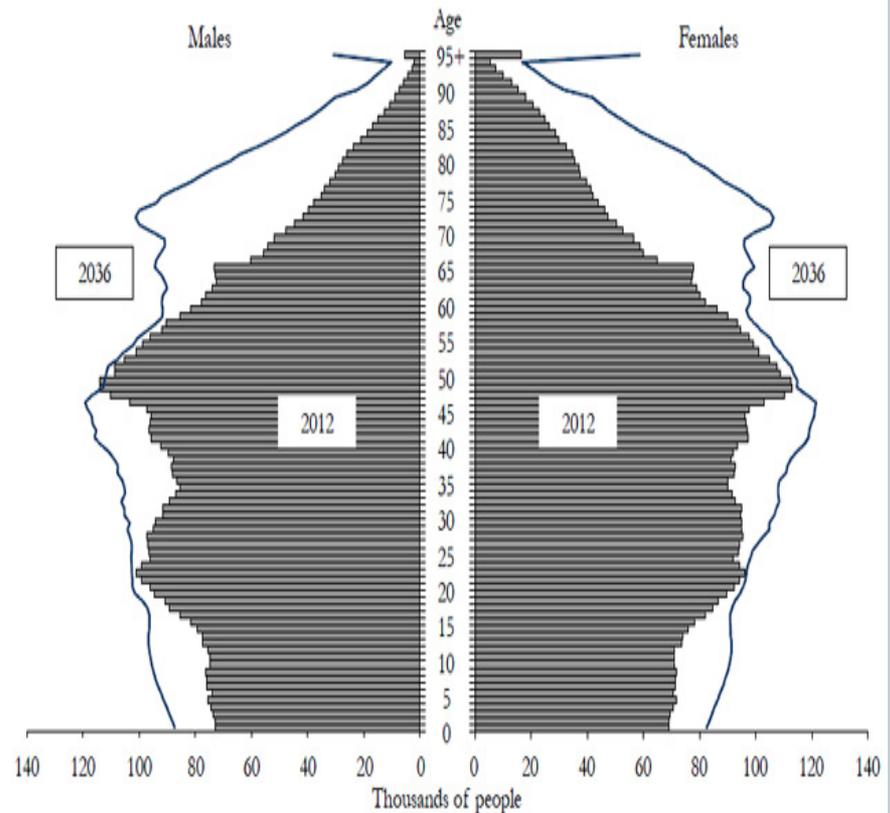
Aging Population



- Complex care needs
- Housing and supports
- Consent and capacity
- End of life care

Chart 4

Age pyramid of Ontario's population, 2012 and 2036



Sources: Statistics Canada, 2012, and Ontario Ministry of Finance projections.

Patient Complexity



- **Addressing bio-psycho-social factors impacting patient complexity**
 - ✦ **Modifying risk factors**
 - ✦ **Connecting patients with primary care**
 - ✦ **Leveraging community resources**
 - ✦ **Issues with care givers**

Using Partnerships to address Patient Complexity and Aging

- Patient H: 76 yo female, pt of HBCP
- Pmhx: Dementia, Venous Stasis, Urinary and Fecal incontinence, OA, Cataracts, Deafness, Delusional Disorder NYD
- Sochx: Lives alone in apartment, No Family involved in care, ambulates with assistive device, unable to complete ADLs, comes to hospital to eat meals
- 5 admissions in the last year for failure to cope/recurrent cellulitis
- Referred to CCAC on discharge, each time pt. refuses to allow CCAC in over time

Patient H



- Routine visit from HBCCP, pt. found at home confused, wandering around in feces, with acute cellulitis
- Pt. admitted to hospital and transferred to FIS
- In hospital capacity assessment done, pt. found capable to make decisions re: personal care

Patient H



- Inpatient attending in discussion with HBCP attending decided pt. capacity to make care decisions was questionable
- Findings of capacity assessor challenged by FIS attending with CCB, using notes from previous admissions as well HBCP provider notes
- Pt. deemed incapable and arrangements made for placement in supportive housing

Continuity of care



High risk of adverse events during discharge

- Medication errors
- High risk of readmission
- Lack of communication between PCP and hospital



Breaking Down the Silos



- **How do we partner with hospital based providers**
 - Patients who would do not have community based primary care
 - Patients who would benefit from primary care approach to their hospital admission

Breaking Down the Silos



- **How do we partner with Primary Care Providers**
 - Providers from our practice inform us when their patients have been admitted to hospital
 - ✦ Allows us to leverage medical and Social history to develop more robust patient care plan
 - Contact Providers when patient admitted to hospital
 - ✦ Gain invaluable information about patients which may not be otherwise obtainable
 - Liaise with Providers on discharge from hospital
 - ✦ Update provider on patient's course in hospital
 - ✦ Co-ordinate post discharge care with primary care provider

Toronto Western FHT: Home Based Primary Care

Optimizing Interprofessional, interorganizational care

3



News / Insight

Doctors to visit elderly patients at home if Ontario Liberals re-elected

Health Minister Deb Matthews promised to spend \$60 million annually to make it happen.

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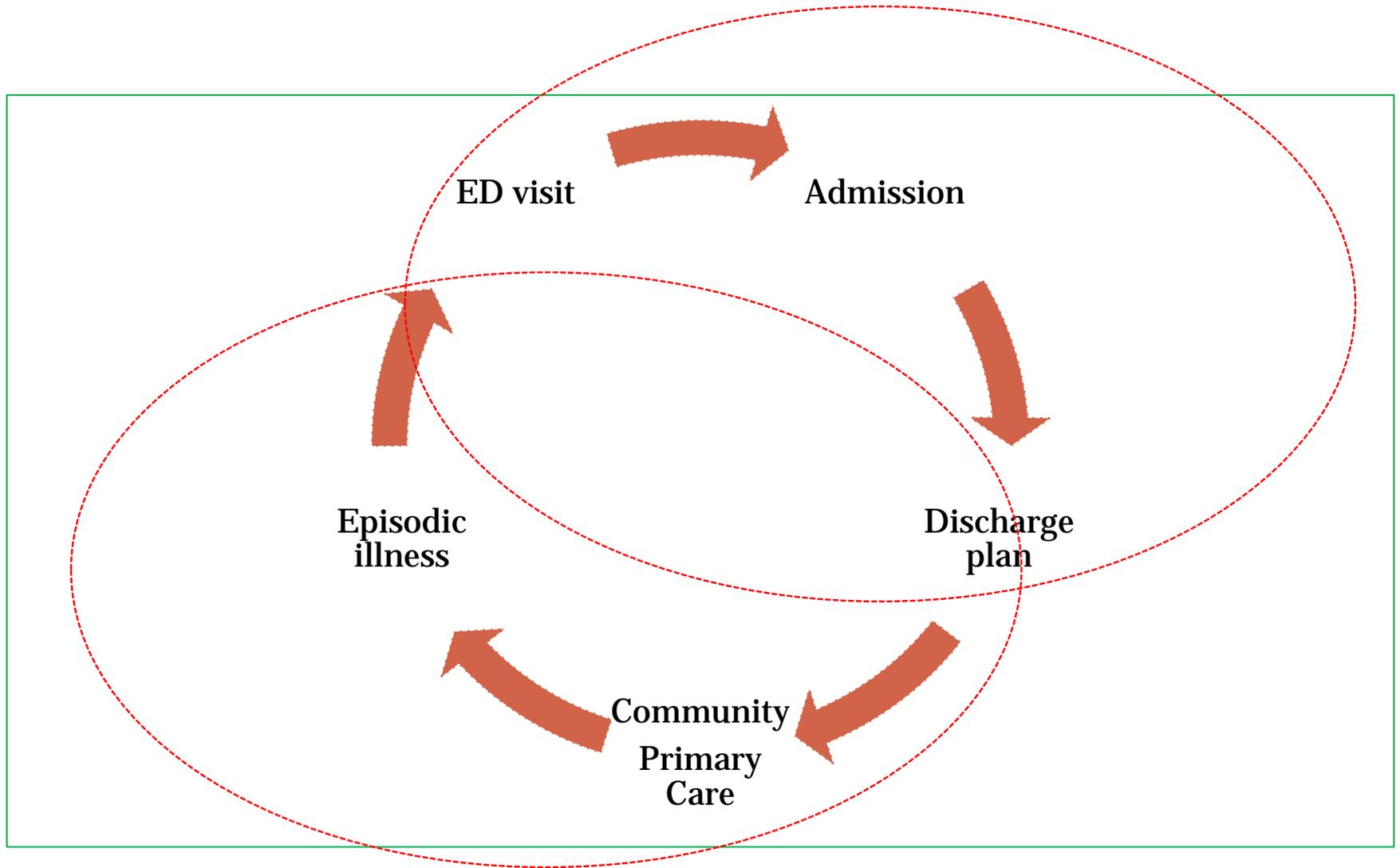


TARA WALTON / TORONTO STAR

Heather James, 79, receives a house call by Dr. Sabrina Akhtar.

By: Sandro Contenta Feature Writer, Published on Sat Sep 03 2011

Transitions of Care



2009: A Star is Born





Mr. J.N.



- 76 y/o Portuguese speaking father, living alone in 1 bedroom apartment over a store
- Medications:
 - 14 regular meds, 1 requiring monitoring, 1 daily dose adjustments
 - 4 PRN meds and 1 patch
- Diagnoses:

A LOT!!!

Mr. J.N



CHF (Grade 4) / CAD	DM2
Atrial fibrillation	Prior CVA (R. hemisphere)
Hypertension	Hyperlipidemia
Chronic Kidney Disease	Gout
OSA	Metabolic syndrome
Anemia	Chronic constipation

= Polymorbid, polypharmacy

Mr. J.N.



- **FHT patient**
- **2012 : Frequent ER visits + 3 Admissions >14d.**
 - † Sequential discharges to 2 geriatric rehab institutions
- **Team confusion about medication management**
- **FHT physician presents case at HBCP rounds**

Interprofessional HBCP Rounds



Improving our circle of care



- **CCAC Integrated Client Care Project (ICCP)**
 - Flagging ER visits
- **Patient arm bands**

middle blue bands (pms300) text in white



I receive care at home. For ER visits,
contact for care plan: 416-603-5800 x 3614

HBCP@uhn.ca



Mr. J.N.



- 76 y/o Portuguese speaking father, living alone in 1 bedroom apartment over a store
- Diagnoses:
A LOT!!!
- Medications:
A LOT!!!

Choosing to live at risk



- Family expressed grave concerns about self care during geriatric rehab stay in 2012
 - home with CCAC support
- Supportive housing (Portuguese) secured
 - pt declined
- Patient estranged from family
- Personal friend is emergency contact

First Home Visit



...Red flags flutter



- Medication management by Crisis Outreach Nurse Practitioner (temporary)
- Pt falls...and calls EMS to get up
- Functionally deaf
- 3 storey walk up, key at hardware store
- Cluttered, unclean home
- Lifelabs refusing to do bloodwork due to access
- Extreme deconditioning
- Low mood

Back at Rounds



- High risk medications were discussed and stopped
- Extremely poor dentition flagged
- At risk: Mr. J.N. suggested theft of \$
- OT and SW arrange home visit



OT and SW Assessment

- Using cane to pull self out of bed
- Propelling on wheelchair only
- Walker at bottom of stairs
- Pt hasn't left the apartment since discharge
- One meal purchased by friend daily
- Toilet seat too low and too small
- Saska pole pulls off ceiling





Community partnerships flourish



- **CCAC coordinator confirms St. Christopher House is involved**
 - Housekeeping (no longer...)
 - Assisted Living applications had been made (and declined)
- **VHA Home HealthCare coordinator**
 - Provides additional assistance for access to services (escort, volunteers, phonecalls)

Small Successes...and More work...



- **Dental exam arranged at home**
- **OT locates a larger donated raised toilet seat**
 - But LifeLine is declined
- **Seniors Building apartment offered and patient accepts**
 - Only friend becomes gravely ill
 - Mr. J.N has feud with son and refuses volunteer driver
- **And then...**
- **911 called: Short of breath and unresponsive**

Back to business...



- **ICCP notification flags ER visit :**
 - FIS shares discharge planning
- **CCAC Rapid Response Nurse referral**
- **CCAC Telehomecare program referral**



More connections every day!



- **Collaboration with VHA**
 - escort to MSH for uneventful tooth extraction
- **Finances**
 - Institute of Chartered Accountants of Ontario offers an accountant who will visit client at home (for FREE)
- **Patient has not been to ER since**

iHBCP: Growing Community Integration

Toronto EMS CREMS

Psychogeriatric
Consultant

Ministerial visits at
home

Affordable home
chiroprody

Behavioural Support
Outreach Services

iPods for dementia
patients

Shared-care palliative
resources

CCAC Ethicist

Community support
service collaboration

Public Guardian and
Trustees Office



Integrated Care for Complex Populations

Driving Transformation By Seeing The System Through
The Eyes of Patients/Clients and Their Families





How do we continue to advance an integrated system of care for populations with complex needs across the TC LHIN and across the province?

Our Aim

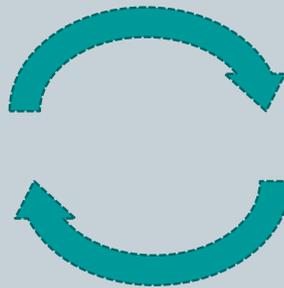


Supporting populations with complex needs with better care at home in their communities, utilizing existing resources

Our Approach: Creating One Team

For the client/family

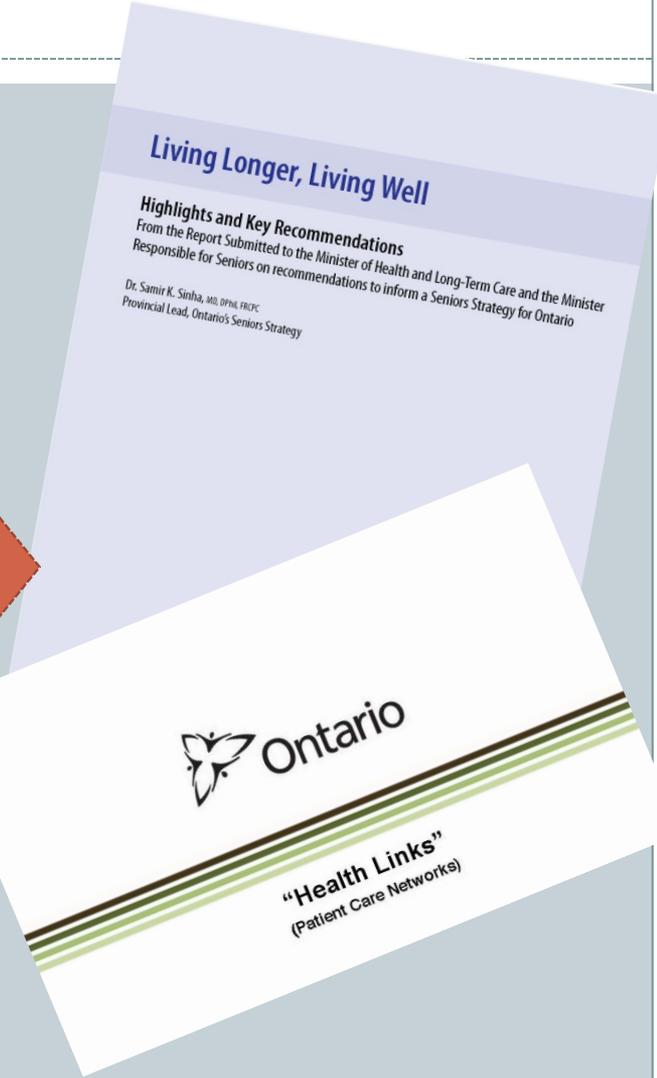
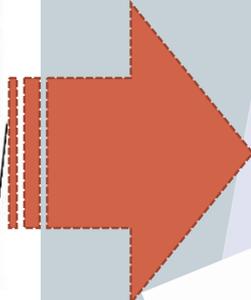
- Seamless care
- One team approach



For the providers

- One team approach
- Built around client and family needs

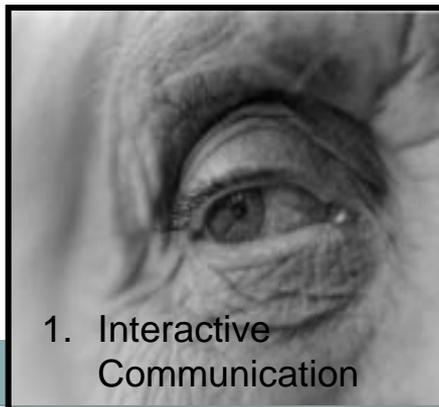
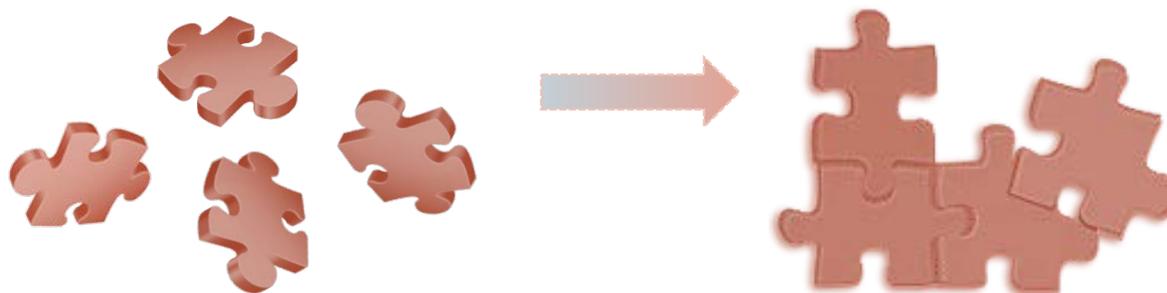
Ontario Healthcare Context



Point of Care Integration Disrupts the Status Quo

Point of Care Integration

Interdisciplinary, inter-organizational teams coming together at the point of care



1. Interactive Communication



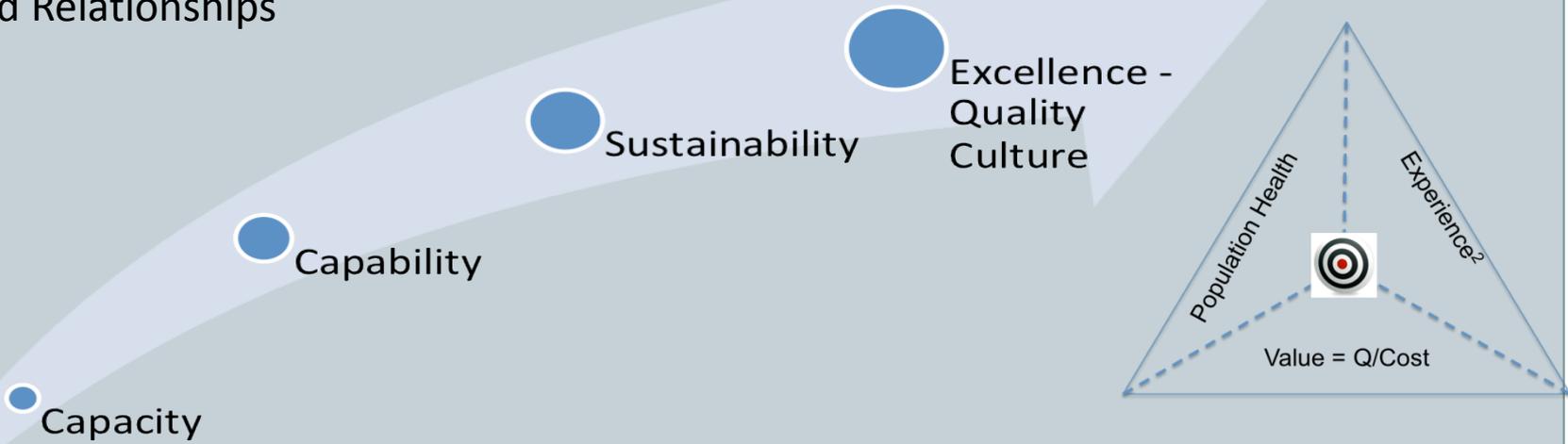
2. Intensive Case Management



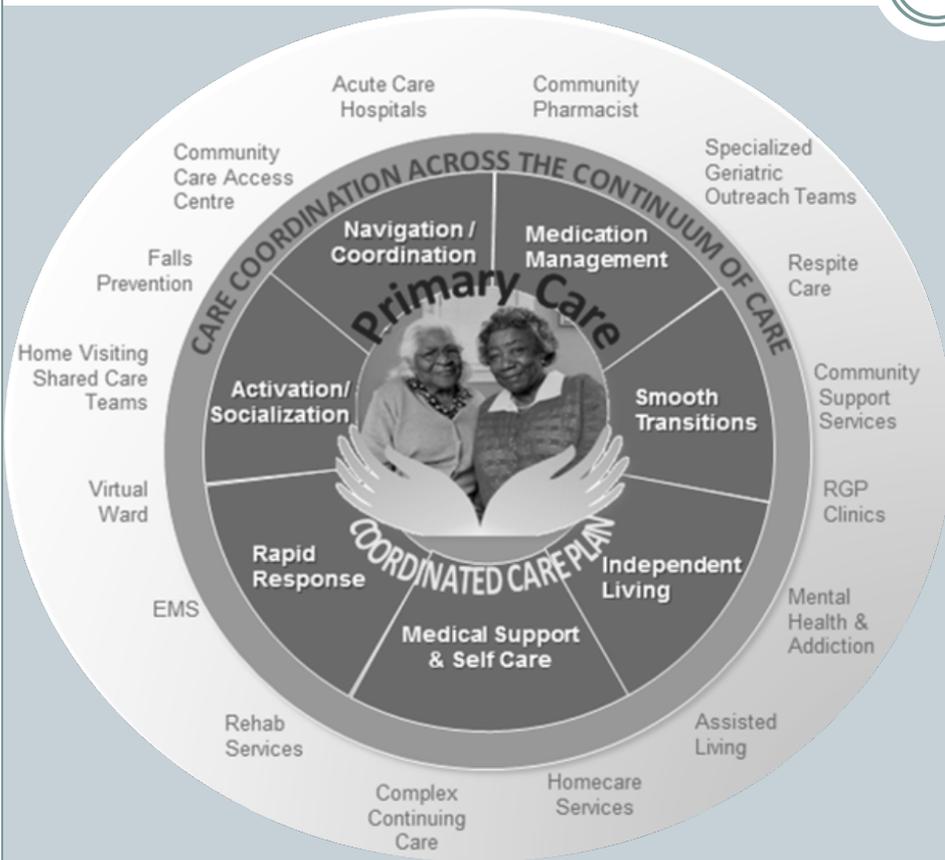
3. Integrated Teams - Power of Many

Principles and QI Framework

- Focus: Right Care, right time, right place
- Start with small tests of change
- Demonstrate value on the ground
- Do not wait for complex solutions
- Empower front line staff: Inspire creativity, remove barriers
- Balance the needs for scientific evidence and outcomes with quality improvement frameworks
- Regional design and local customization
- Generalizability and sustainability
- Shared accountability
- Build Relationships



ICCP Framework and Target Population



Initial Target Population

Older adults with complex needs

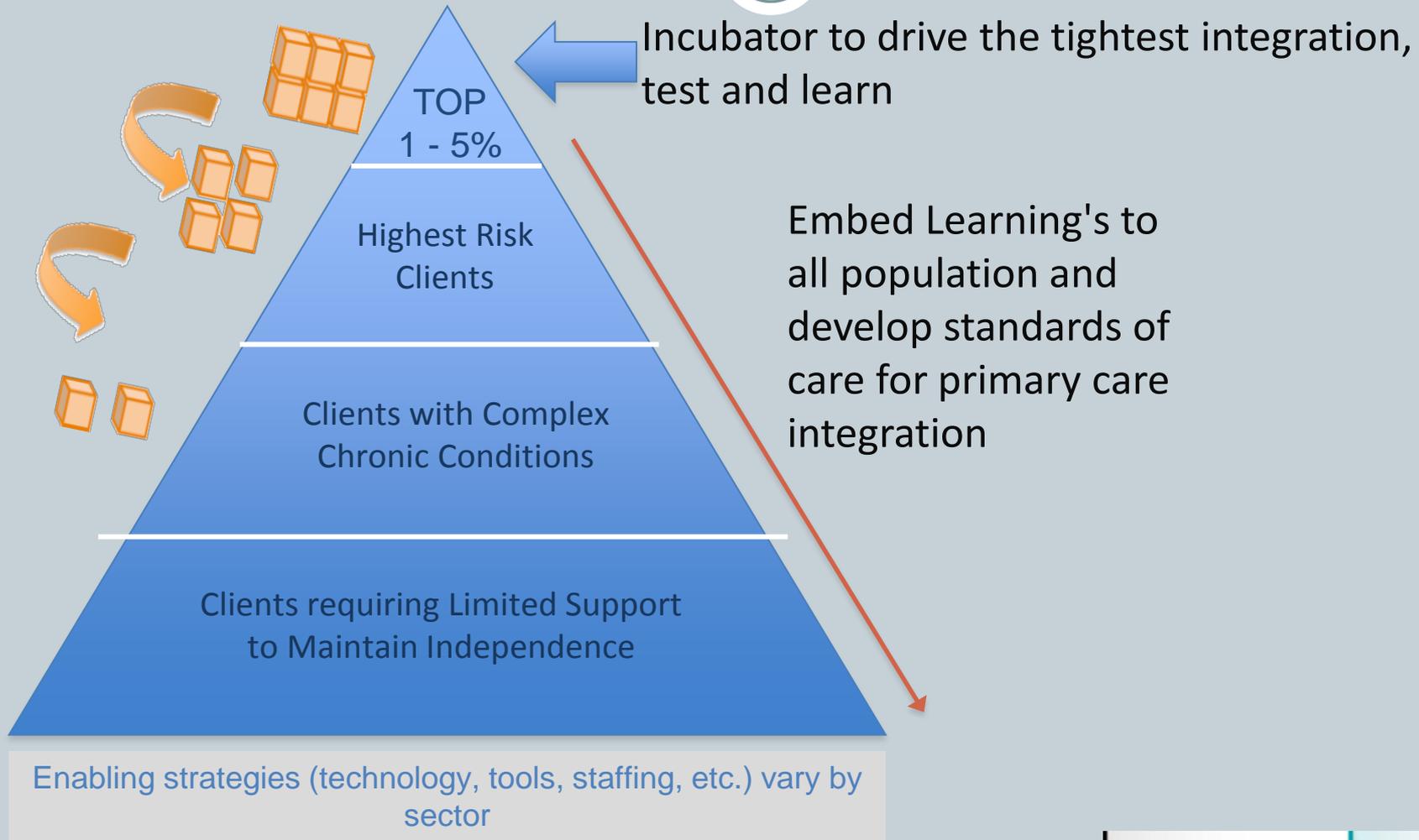
- 2 or more Ambulatory Care Sensitive Conditions (CHF, COPD, DMII, Asthma, Angina, HTN, Epilepsy)
- Admission to acute care in the last year
- RAI assessment/score
- 65 years +
- TC LHIN resident

and....Home Bound, high risk and frail older adults
Scope

TC LHIN Wide, Multi-sector

ICCP elements of integrated care
7 design elements, plus the central
roles of Primary Care, Intensive Case
Management and the Portable Record

Starting with the most complex clients, learning what works and embedding in other populations



Driving Standards for Innovation

“Hard Wiring the Change”

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"Hard Wiring the Change"]; Title --- Circle(( )); Circle --- DashedLine[ ]; DashedLine --- Box1[Care Coordinators Providing Case Management Across the Continuum of Care]; DashedLine --- Box2[Partnership with Primary Care]; DashedLine --- Box3[• System Navigation and Coordination  
• Client/Caregiver Quarterback  
• Building the interdisciplinary, inter organizational care team  
• Shared assessments, care plans, joint home visits, regular rounds]; DashedLine --- Box4[• Working Hand-in-Hand with the CCAC  
• Weekly Case Conferencing and close communication with CCAC around Complex Patients' Care  
• Home Visits for homebound patients];
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Care Coordinators Providing Case Management Across the Continuum of Care

- System Navigation and Coordination
- Client/Caregiver Quarterback
 - Building the interdisciplinary, inter organizational care team
 - Shared assessments, care plans, joint home visits, regular rounds

Partnership with Primary Care

- Working Hand-in-Hand with the CCAC
- Weekly Case Conferencing and close communication with CCAC around Complex Patients' Care
- Home Visits for homebound patients

Driving Standards for Innovation

“Hard Wiring the Change”

Acute Care

- Identification and Flagging of high risk patients
- Coordinated Communication between Acute, Community and Primary Care
- Inter-disciplinary, inter-organizational teams supporting transitions (Virtual Ward)

Pharmacy

- Moving to a Single Pharmacy for each patient

Caregiver Support

- Focused experienced based training for Care Coordinators to support caregivers and address caregiver burden

Emergency Medical Service
(EMS)

- Enhanced Communication around ICCP Clients
- Emergency Department Transfer Package
- Hospital Repatriation System through EMS

Three System-Wide Pillars to Reflect on Key Learnings



Client and Caregiver Experience

- Clients and caregivers see the value of a system-wide “quarterback” who assembles the care team to focus on client and caregiver goals

Roles and Relationships

- Strong, meaningful Relationships between integrated care team members are absolutely critical to the success.

Information Sharing and Flow

- Each member of the integrated care team requires access to key information.
- Information empowers clients and caregivers to feel secure and supported

Lessons learned



- **Benefits**

- TWFHT integrated our inter-professional team beyond the FHT to provide comprehensive health care .(**added resources**)
- Both clinicians and community partners expressed high **job satisfaction** in providing our services with a concerted effort
- **Patients** expressed very high satisfaction and improved outcomes

- **Cost/ Challenges**

- **Time** spent on finding the **right partners** to create innovative solutions to address certain problems or issues.
- Level of **commitment**
- Sense of **Ownership** of partnership
- **Effectiveness in reaching desired outcomes**

BENEFITS > COST?

(Ansari W.E. & Phillips C.J., Health Promotion Practice 2004 5:35)

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