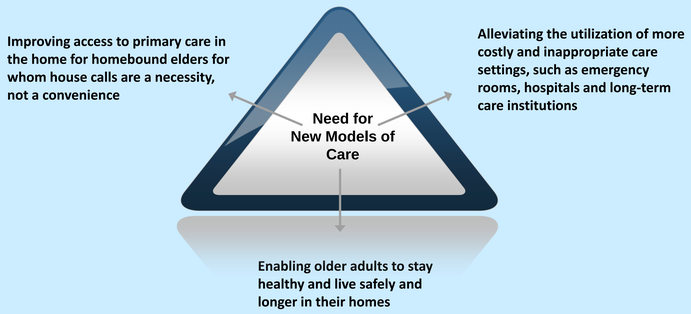
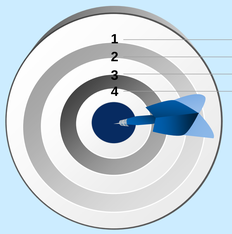
Integrated Home Based Primary Care (IHBPC) Project

Need for Better Models of Care

We need more innovative community-based primary care models that can deliver the three goals of:



IHBPC Patient Enrollment Criteria



1. 65 Years or older (age limitation applies only to research study)
2. Health Care needs not adequately served by traditional office-based primary care
3. Patients cannot be living in a retirement or nursing home facility
4. Needs not better met by palliative care services

High Priority given to Patients who are:

1.Unattached to a primary care provider

2.Recent discharge from an acute hospitalization within the last 30 days

3.Two or more emergency room visits in the last 6 months

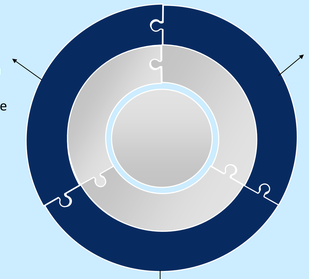
Quality Improvement and Research Measures

Process Measures	Outcome Measures
Quality Improvement Measures ▪Time to first home visit and # of subsequent visits ▪Time to medication reconciliation ▪Time to advance directives documented ▪Vaccination and Death at Home Rates ▪Time to completion of RAI-HC /and reassessments ▪Time to intervention after call for urgent concern ▪Time to first team meeting about patient and # of subsequent meetings	**Quantitative Measures** ▪ED Visits ▪Hospitalizations and Hospital Days ▪Rates of Avoidable ED Visits, Hospitalizations, LTC admissions **Economic Analysis** **Qualitative Analysis** ▪Patients and Caregiver Experience ▪Team Experience ▪Stakeholder Analysis

IHBPC Models

Ontario Family Health Team Model

- Family Health Teams providing comprehensive primary care enroll homebound patients that benefit from a home-base interprofessional team (family physicians, nurse practitioners, physician assistants, socialworkers, pharmacists) with integration of a dedicated CCAC care coordinator into the primary care team. The model leverages the existent expertise and resources of the FHTs and CCAC.



Community Support Services Model (SPRINT House Calls Model)

-Primary Care Team (Full time dedicated family doctor, nursepractitioner, occupational and physiotherapists, social worker, team coordinator etc.) embedded in a CSS agency allowing for an integrated basket of services

-Early analyses show 67% of patients die at home, and 14% and 29% lower hospital readmission rates at 30 and 90 days

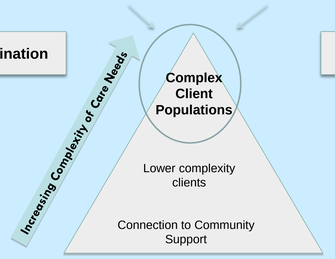
Emerging Community Health Centre/Hospital Models - In development

Leveraging the Toronto Central – Community Care Access Centres (CCAC) Population-Based Care Coordination & Integration with Primary Care Strategy

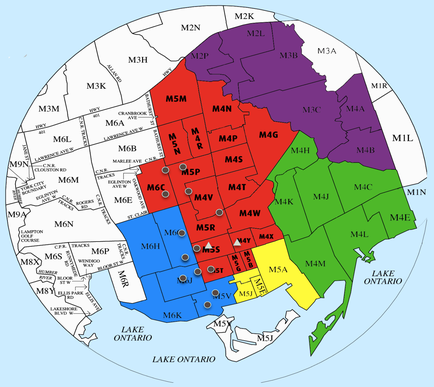
•Each IHBPC Client will be a CCAC Client
•Embed 1 CCAC Care Coordinator in each FHT/ House Calls
•TC-CCAC Creating a Registry of Homebound Clients and Network of Providers to support homebound clients

Enhanced Focus of Care Coordination

Connection with Primary Care



IHBPC Reaching Patients across Toronto



Catchment Areas are porous

- South East FHT
- St. Michael's FHT
- Sunnybrook FHT
- Toronto Western FHT
- House Calls Program
- Toddle Creek FHT
- MSH FHT

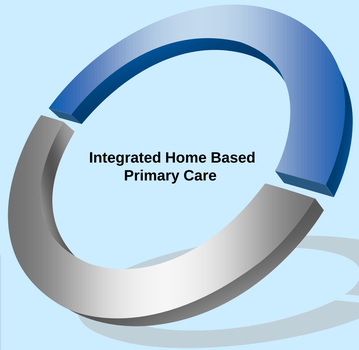
Patients Enrolled in IHBPC Project

Family Health Teams & House Calls Team	Patients Enrolled at Go Live Date (July 1, 2012)	Patients Currently Enrolled (October 2012)
SPRINT CSS House Calls Team	97	256
Mount Sinai Hospital FHT	5	14
South East Toronto FHT	22	36
Sunnybrook Hospital FHT	11	41
Taddle Creek FHT	15	24
Toronto Western Hospital FHT	34	38
St. Michaels Hospital FHT	0	9
TOTAL	**184**	**418**

Supporting the Scalability of IHBPC Across Ontario

- Leverage primary care funding models, with operational and educational support to increase the capacity to provide IHBPC
- Consolidate partnerships between Primary Care Teams and their local CCACs.
- Build capacity within Local Health Integration Networks and CCACs to increase the scope of urgent clinical services and end-of-life care provided in the community (and thereby avoid unnecessary hospital visits).
- Leverage and Integrate Telemedicine and Telehomecare investments to better monitor homebound patients

IHBPC Project – Next Steps



- Ontario Ministry of Health and Longterm Care, University of Toronto BRIDGES Study ongoing until Spring 2013
- CCAC Establishment of Additional Infrastructure to Support IHBPC Best Practices
- Development and Dissemination of the IHBPC Operations Toolkit to other Primary Care Teams wanting to provide IHBPC in Canada

- Dissemination of IHBPC Training Curriculum to family physicians of the future across the 6 Toronto Academic FHTs and House Calls.
- Establishment of Network of Specialists and Family Physicians across Ontario dedicated to IHBPC

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