Timmins Health Link: Practical Applications of Patient Engagement

AFHTO Conference

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Presenter Disclosure

Presenters:

Jennifer McLeod, Executive Director, Timmins FHT

Andrea Griener, Project Manager, Timmins Health Link

Julia Peart, Care Coordinator, Timmins Health Link

Presenter Disclosure

Relationship with Commercial Interests, commercial support and potential for Conflict of Interest:

We do not have any relationship with any commercial entity, such as pharmaceutical or medical device companies. We do not have an affiliation and are not receiving any commercial (financial or otherwise) support for this presentation. Therefore, there is no potential for conflict of interest in our presentation or in our interaction with conference participants.

Timmins Health Link Partners

Timmins Family Health Team

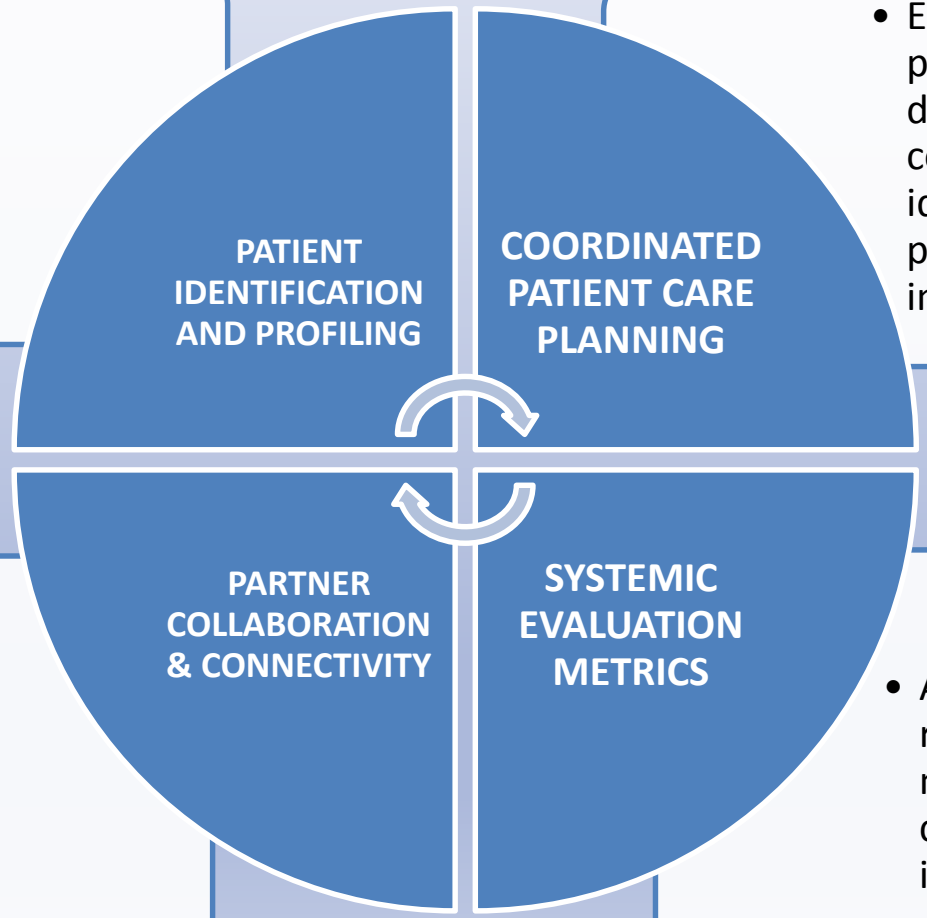
(Lead Organization)

- Timmins & District Hospital
- East End Family Health Team
- Canadian Red Cross
- Porcupine Health Unit
- Community Care Access Centre
- VON
- Misiway Community Health Centre
- Timmins Native Friendship Centre

- Canadian Mental Health Association
- Alzheimer Society
- Community Facilitator – Leclair Consulting
- South Cochrane Addiction Services
- Jubilee Substance Abuse Centre
- Access Better Living
- DSSAB – Housing
- Work of partnership supported by the NE LHIN

Implementing Timmins Health Link Framework

- Identify and profile high users with complex care needs to inform Health Link improvements and interventions.

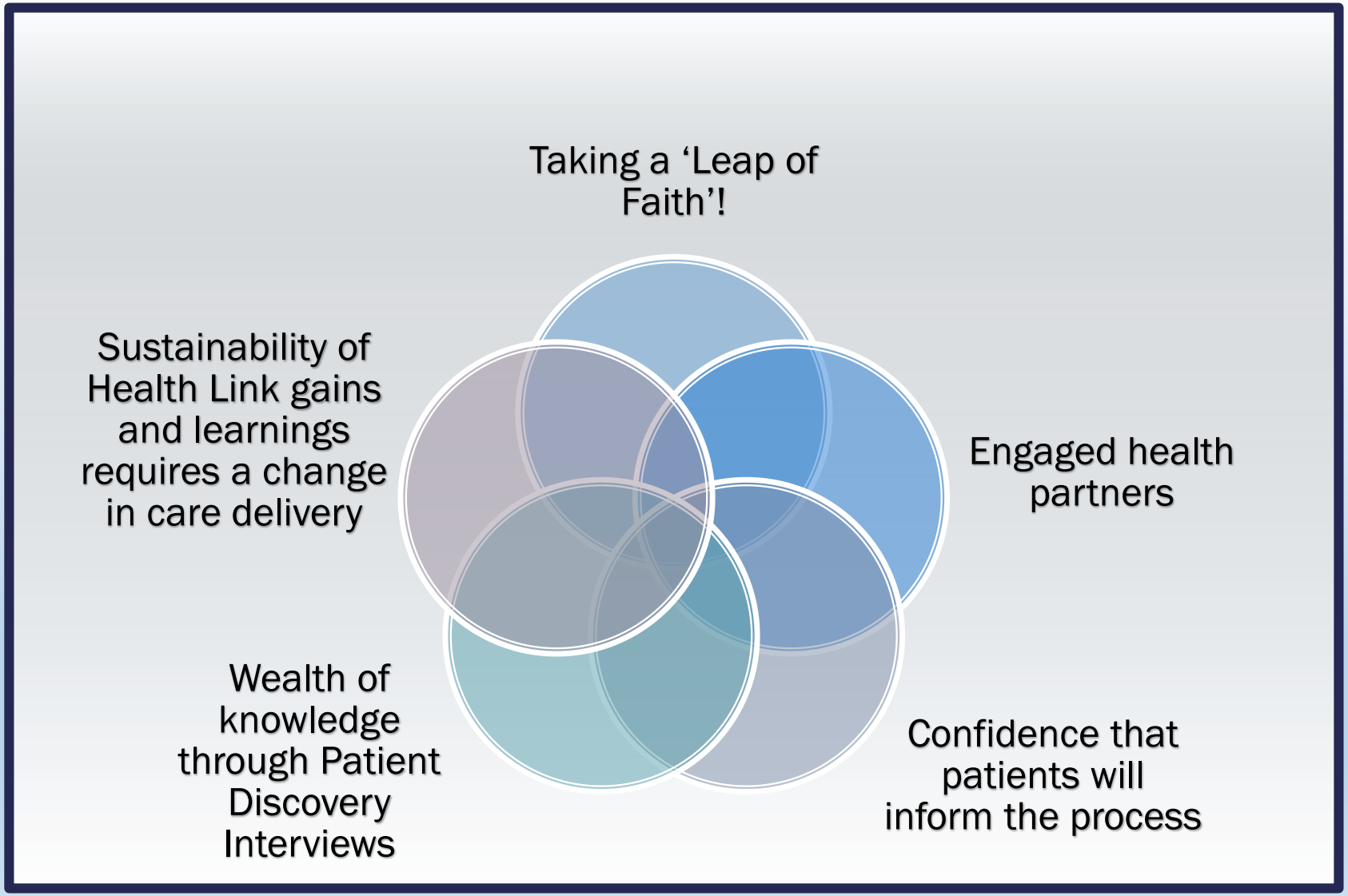


- Engage patients and partners in care in the development of coordinated care plans, identification of supportive processes, and interventions.

- Develop capacity to collect, analyze and share target patient data and respond to identified needs as a coordinated system.

- Assign, monitor and report on evaluation metrics and leverage continuous quality improvement resources.

Health System Transformation



Health System Transformation

- **Development of Primary Care Model for Care Coordination**
  - PCPs asked to coordinate care for their own patients
  - These are patients we know!
  - Linking patients without PCP to provider
- **Implementing a HL Approach in Primary Care Environment**
  - Early Identification of high users through hospital data or EMR data
  - Engagement of PC team to assist
  - Training of nursing staff to complete patient discovery interviews on home visits & in effective patient centred care coordination techniques

HL Process for Primary Care Office

Hospital

- Identified as high user from hospital data
- Hospital sends notification of increased frequency to FHT HL trained office nurse

FHT Office

- Nurse contacts patient to set up home visit
- Nurse conducts chart review and prepares for HL assessment
- Nurse meets with PCP before home visit

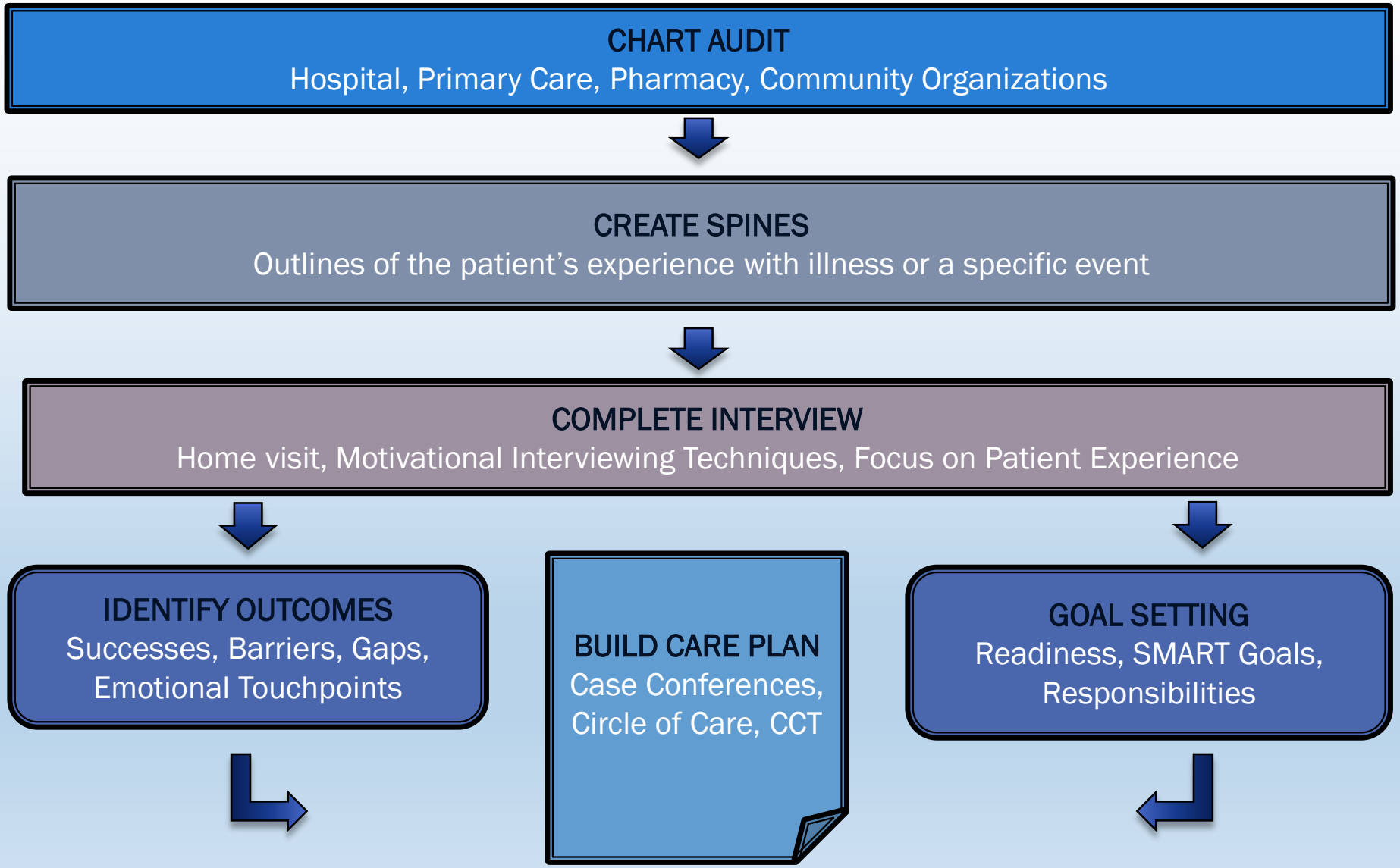
In Home

- Nurse conducts HL assessment and fills in documentation using a laptop computer

FHT Office

- Nurse plans and leads case conference if required
- Nurse updates and maintains care plan
- Nurse maintains communication with circle of care
- Nurse provides follow up as needed for client needs

TIMMINS HEALTH LINK:
THE PATIENT DISCOVERY INTERVIEW



TIMMINS HEALTH LINK:
THE PATIENT DISCOVERY INTERVIEW

CHART AUDIT

- Hospital
- Primary Care
- Pharmacy
- Community Organizations

TIMMINS HEALTH LINK:
THE PATIENT DISCOVERY INTERVIEW

CREATE SPINES

- Outlines of the patient's experience with illness or a specific event

Example of the PDI Spine

(Name of Disease Process/Event lived) "COPD"	
Outline of experience	**Patient's Perspective**
Thinking something was wrong	"I started to have trouble breathing at night"
Seeing the Primary Care Provider	
Having test to figure out what was wrong	
Being told what was wrong	
Receiving treatment	
Living with your condition	
Getting follow up	
Successes: Supportive family	
Challenges/Barriers: Difficulty affording medications on a consistent basis	
Gaps: No primary care provider	
Emotional Touchpoints: (Emotions experienced with associated triggers) Emotion: Confused Trigger: When being discharged home, no one explained my list of medications	

TIMMINS HEALTH LINK:
THE PATIENT DISCOVERY INTERVIEW

COMPLETE INTERVIEW

- Home visit
- Motivational Interviewing Techniques
- Focus on Patient Experience

TIMMINS HEALTH LINK:
THE PATIENT DISCOVERY INTERVIEW

IDENTIFY OUTCOMES

- Successes
- Barriers
- Gaps
- Emotional Touchpoints

TIMMINS HEALTH LINK:
THE PATIENT DISCOVERY INTERVIEW

GOAL SETTING

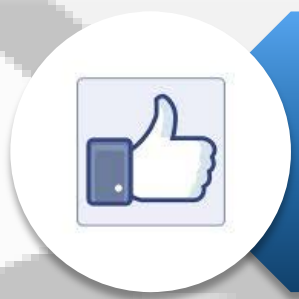
- Readiness Assessment
- SMART Goals
- Responsibilities

TIMMINS HEALTH LINK:
THE PATIENT DISCOVERY INTERVIEW

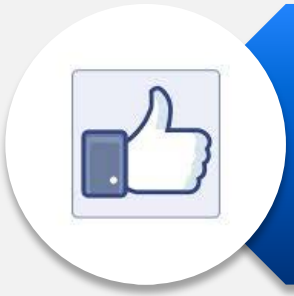
BUILD CARE PLAN

- Case Conferences
- Circle of Care
- CCT

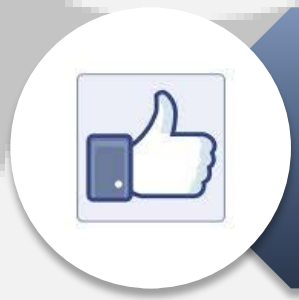
Using the Interview: Patient Benefits



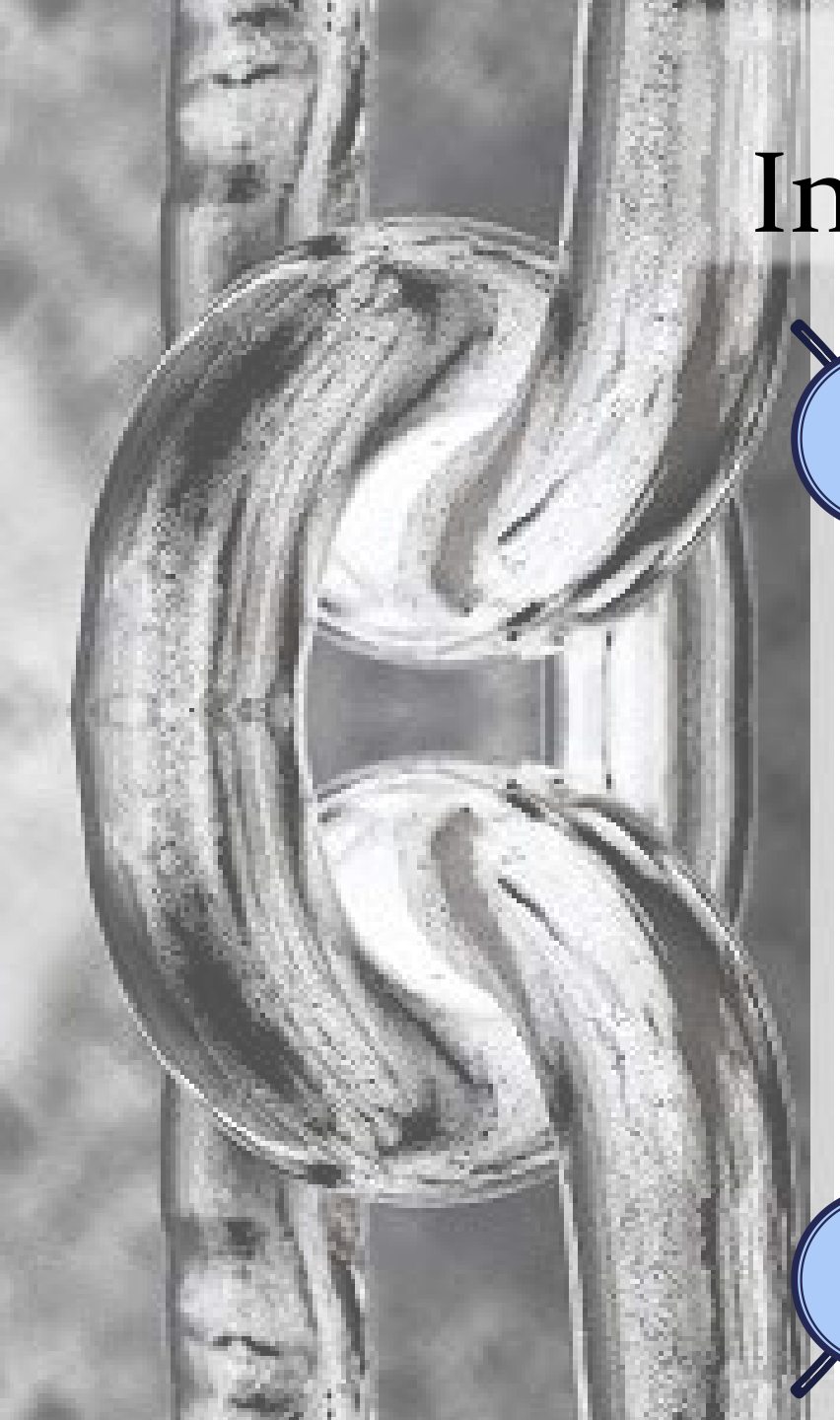
Customized care plans co-designed with patient and are lead by patient directed needs



Patient feels heard and experience is improved



Outcomes are improved and gains are measurable



Using the Interview: Institutional and Systemic Benefits

- Patient Engagement
- Thematic Analysis of Real Experiences
- Identifying Gaps
- Quality Improvement
- Future Planning

John's Story

- Epilepsy
- No family doctor
- 90 ER visits in last year

"No one listens, or cares"

Clinical Assessment Tool (CCT)

Dx: Frequent reoccurring seizures

Actions: TC to Neurologist for reassessment

Outcome: Continued ER visits and epileptic episodes

Patient Discovery Interview

Dx: Severe anxiety related to isolation

Actions: Referral to CMHA and planned support with family

Outcome: Reduced anxiety, ER visits, epileptic episodes

Experiential Findings from PDI…

Timmins Top 5

1. **Poor mobility or function limits ability to leave the home**

   Resulting in inability to access services or PCP

2. **Limited Access to PCP**

   No PCP, No home visits, related to hours of operation

3. **Limited Finances**

   Can't afford medications, equipment, treatment or assistance needed

4. **Poor service from hospital or community program staff**

   Needed equipment not available, no support from staff, judgement from care providers

5. **Lack of access to information about available community health/social resources**

14 primary themes identified as reasons for high usage (tagged in the interview script as barriers, challenges or gaps in care)

Timmins HL Statistics

Criteria for HL assessment:

- 15+ Emergency Dept. visits or
- 4+ Admissions

Start date for HL assessments:

Dec 2013

Number of Patients assessed by Sept 2014:

45

Timmins HL Statistics

Age range of HL Clients:

1-100

Average age:

52

Primary diagnoses:

40% Mental health (incl. dementia)

Diabetes, COPD, addictions,

heart & kidney issues

Secondary diagnoses:

Mental health- anxiety, depression

Referred but not assessed

14 of the 62 referrals (22.5%)
did not proceed with HL

Reasons

- Refusal to participate (7)
- No response (4)
- Death (2)
- Moved (1)
- ALC (1)

Timmins HL Statistics

Connection to PCP

- Solo practitioners: 33%
- Timmins FHT: 42%
- East End FHT: 2%
- VON: 2%
- Health Unit: 2%
- CMHA: 2%
- No PCP: 15%

Patients' Reported Experiences

What helps people meet their needs

- Supportive & accessible primary care providers
- Informal & formal community supports
- Pleasant staff
- Access to treatment for ailment
- Supportive pharmacy

HL observations of HL Clients

Perceived Challenges/Barriers/Gaps to meet needs:

- 50% have housing that is unsafe; not affordable; not accessible
- 50% have low income: can't afford medication, equipment
- 70% lack of information about community resources
- 37 % have poor informal supports

Patient's Reported Experiences

Perceived Challenges/Barriers/Gaps to meet needs:

Housing Issues

I can't go see my PCP

70% lack of information

50% low income

- 25 % cannot get timely access to PCP
- Have limited personal mobility
- No PCP home visits conducted
- Limited access to transportation

37 % poor informal supports

Tracking HL Clients

Measuring Success:

- Reduce use of Hospital ED & Admissions
- Reduce HL clients without a PCP
- Help clients meet their goals

Tracking HL Clients

For clients assessed from Dec 2013 to May 2014

Of 37 clients assessed by HL, **4** are still high users:

- 2 frail elderly
- 1 significant mental health challenges
- 1 no PCP (visits stopped in July when acquired PCP)

Of the 4 who refused Health Link assessment, **3** are still high users of TADH.

Sustainability

HL trained 25 staff at 9 agencies in the HL approach

13 nurses were trained to conduct HL assessment as part of their ongoing duties at:

- 2 FHTs
- 1 CHC
- 1 CMHA

Sustainability

Supports:

- training manual
- filmed training session
- one-on-one support
- trained peers in community
- specialized training for MH, addictions & frail elderly
- community resources

Sustainability

Next steps for Timmins HL

- Working Committee will be set up to identify solutions to support patients of Solo docs and those with no PCP


Questions?