Sustaining Change.
A FHT Structure that Works…for Population Health

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Executive Director

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Conflict of Interest

- No conflicts of interest to disclose

A FHT Structure That Works for Population Health

Presentation Outline

- Where we started
- Context for change
- Development of a population-based model
- Early results

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A FHT Structure That Works for Population Health

History

- What is a FHT?
- Learning to play together: professions and silos
- Something for everyone: doctors, patients and more

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A FHT Structure That Works for Population Health

New Context

- Quality Primary Care
- System Priorities
- Population Health

Guelph FHT

23 Victoria Road N

Dawson Road Family Medical Centre
83 Dawson Road
Suite 100 & 202

Diabetes Care Guelph
83 Dawson Road
Suite 101 & 102

GetFHT Clinic
83 Dawson Road
Suite 101

Westmount Road Family Doctors
77 Westmount Rd
Suite 306

Surrey Medical
21 Surrey Street W
Suites 101, 102, 103
108, 301 & 302

Downey Road Medical Centre
115 Downey Road

Westminster Woods Medical Centre
Diabetes Care Guelph
Foot Care Clinic
33 Farley Drive

Medical Offices
Old Quebec Street
55 Wyndham St N
Suites 207 & 208

Executive Office
Old Quebec Street
55 Wyndham St N
Suite 212
Psychiatry Clinic
Wellness Groups

WellServe Healthcare
112 Woolwich St

Diabetes Care Guelph
176 Wyndham St N

Norfolk Medical Centre
85 Norfolk Street
Suites 302, 305 & 311

Diabetes Care Guelph
683 Woolwich St

Yarmouth Medical Group
INR Clinic
21 Yarmouth St

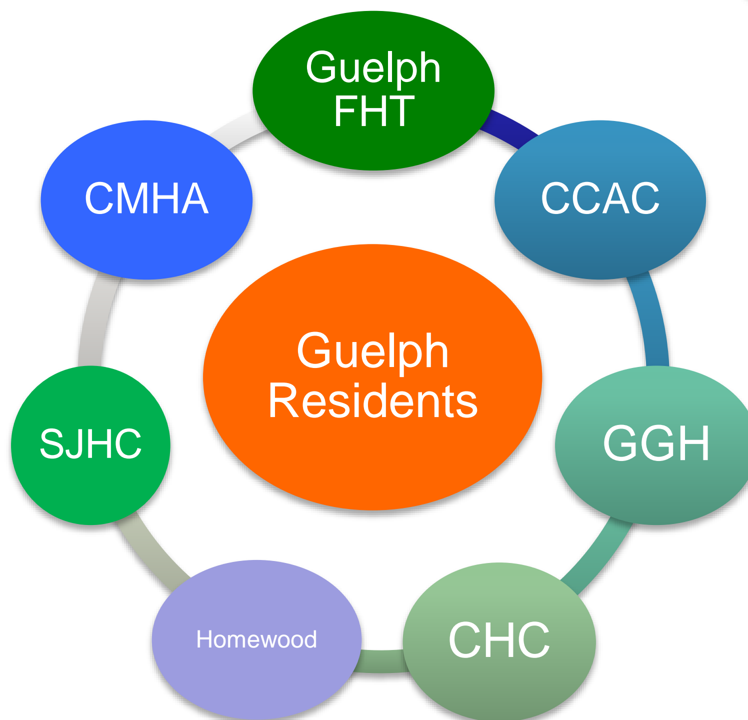
Arbour Medical Centre
281 Stone Rd E

LEGEND
- Highway
- Main Street
- Secondary Street
- Side Streets
- Railways
- Hiking/Walking/Biking Trail
- Hospital
- Police Station
- Tourism Information
- Park
- Conservation Area
- Commercial Area
- Industrial Area/Park

Guelph Health Care System: An Opportunity…

Guelph FHT

- Three FHOs
- 80 Family Physicians
- 69 Clinicians
- 13 buildings
- 20 practices
- 9 Specialty Clinics
- 110 k patients
- 1 EMR (PSS)



Community

- 1 FHT
- 1 Hospital
- 1 CCAC
- 1 CHC
- 1 MH service
- 1 Acute Psych
- 1 CCC/Rehab
- WWLHIN

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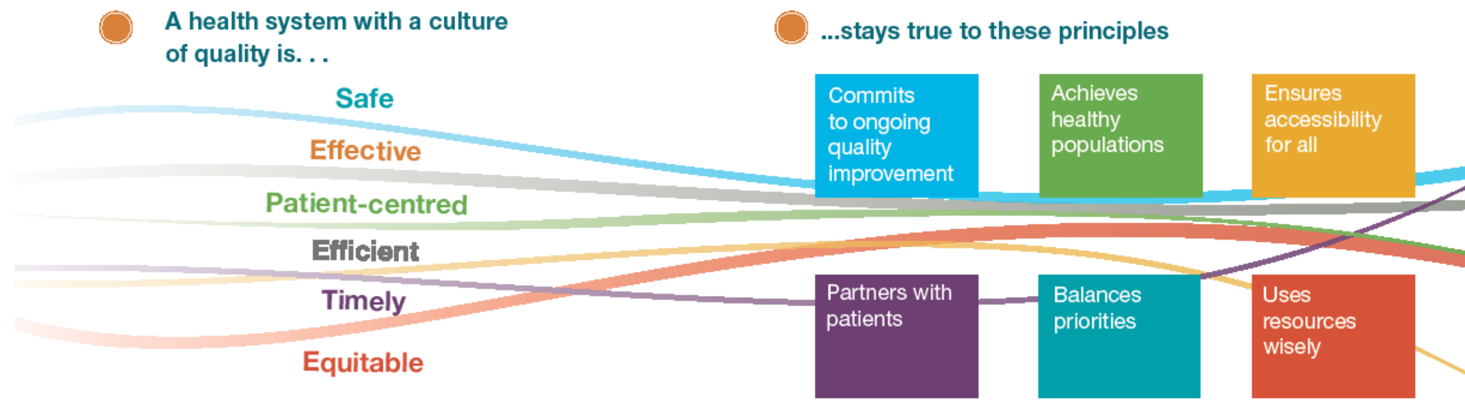
Quality: Our System Priority

Embrace Health Quality



. . . and can only happen when we

Read our vision for achieving a quality health system
Quality Matters: Realizing Excellent Care For All

www.hqontario.ca

Ontario
Health Quality Ontario

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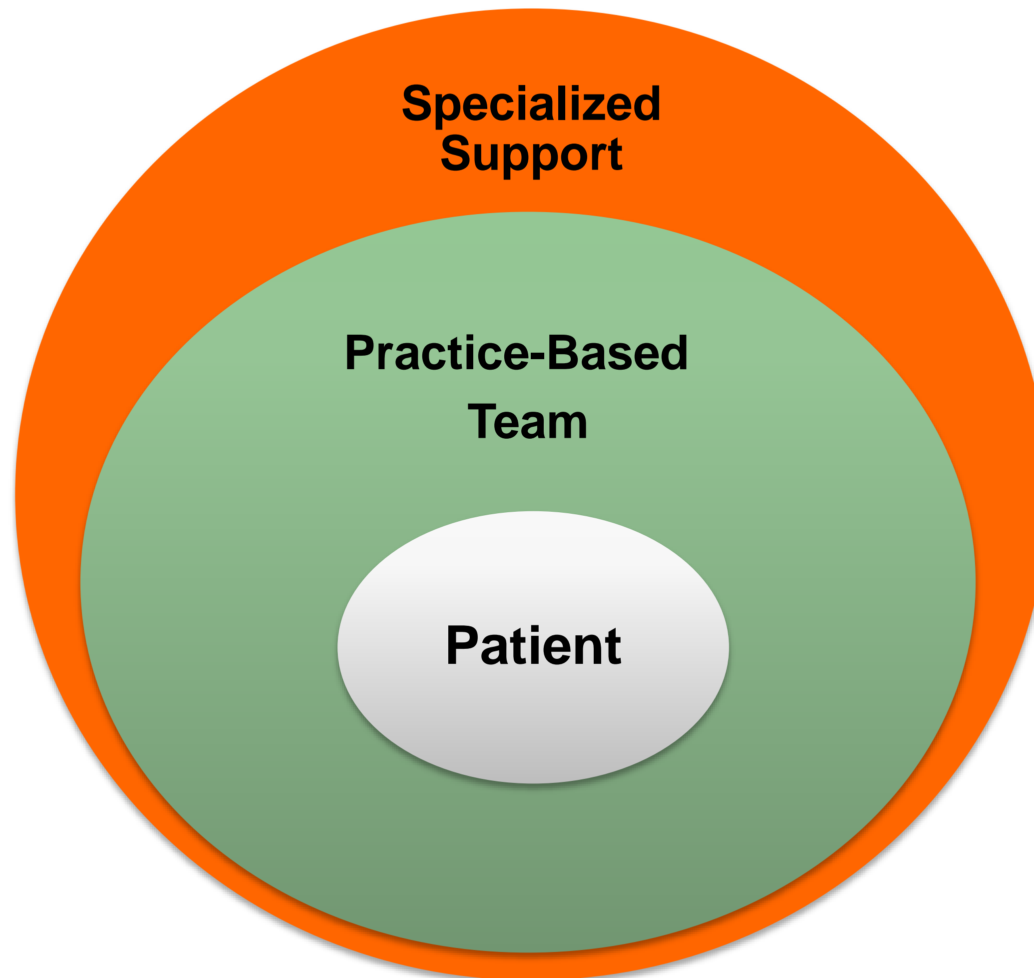
Guelph FHT
A Population Health Model



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A FHT Population Health Model: The (variable) Practice Teams

Family Physician

Primary Care Nurse Clinician

Nurse Practitioner

Practice Nurse

Practice Admin

Dietitian

Pharmacist

Mental Health

Care Coordinator

GFHT Clinic Coordinator

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A FHT Population Health Model: Specialized Practice Model

Family Physician/Team

Health Link

Primary Care at Home

Diabetes Care Guelph

Get FHT Program

INR Clinic

Foot Care

Chronic Pain Program

Wellness Programs

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A FHT Population Health Model: Key Focus

Physician-directed practice team AND extended Specialized Support team

- Patient Access
- Quality Improvement
- Disease Prevention & Management
- Complexity

A FHT Population Health Model: Centralized Infrastructure

- IT support
- HR management
- Quality coaching
- Clinical guidance

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A FHT Population Health Model: Prevention

Practice team-based priorities:

- Cancer
- COPD and CHF
- Diabetes
- HTN
- Smoking

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A FHT Population Health Model: Prevention

Measure	Actual	QIP Target
Colorectal	68%	70%
Cervical	78%	80%
COPD/CHF	61%	65%
HTN	84%	75%
Smoking Quit Rate (2015-16) **Note: n=751**	42%	30%

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A FHT Population Health Model: Access

Team support for access

- Quality coaching supply & demand
- Changed role of NPs
- More PCNC, MH, RD same day access including telephone
- Productivity targets

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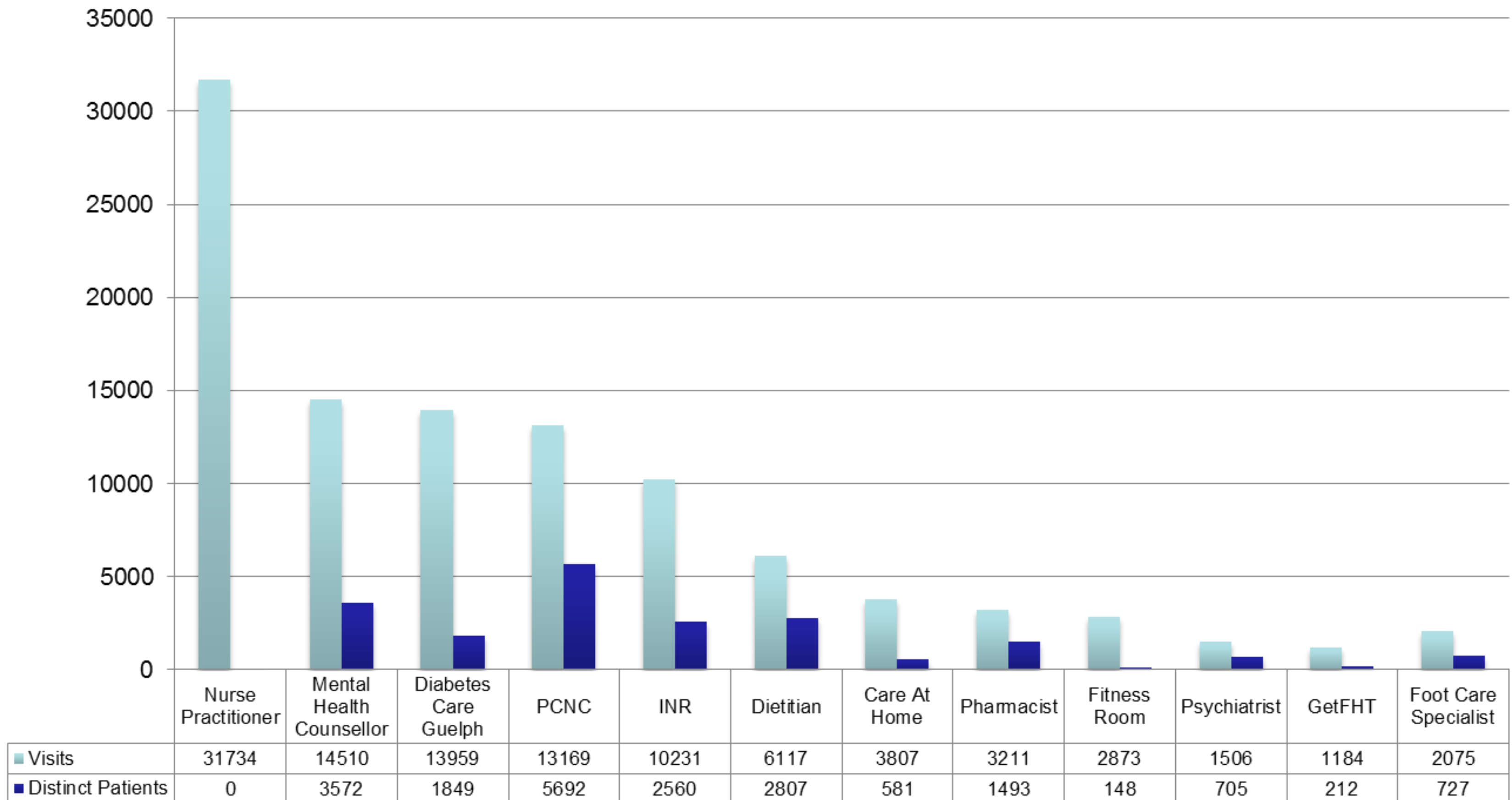
Improving Access



	Nurse Practitioner	Mental Health Counsellor	Diabetes Care Guelph	PCNC	INR	Dietitian	Care At Home	Pharmacist	Fitness Room	Psychiatrist	GetFHT	Foot Care Specialist
Visits	31734	14510	13959	13169	10231	6117	3807	3211	2873	1506	1184	2075
Distinct Patients	0	3572	1849	5692	2560	2807	581	1493	148	705	212	727

Source: Guelphfht IMS data July 2014-September 2015

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A FHT Population Health Model: Access

Measure	Actual	QIP Target
Patients: Same/next Appointment	59%	70%
Patients Seeking Physician	5	0
ED Use by CTAS 4&5 Per 1000	6.1	5.0

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A FHT Population Health Model: Complexity

PCNC embedded role:

- Focus on most complex patients
  - Health Link care planning
  - System Navigation
  - Memory/cognitive function screening
  - Chronic disease management
  - Patient education

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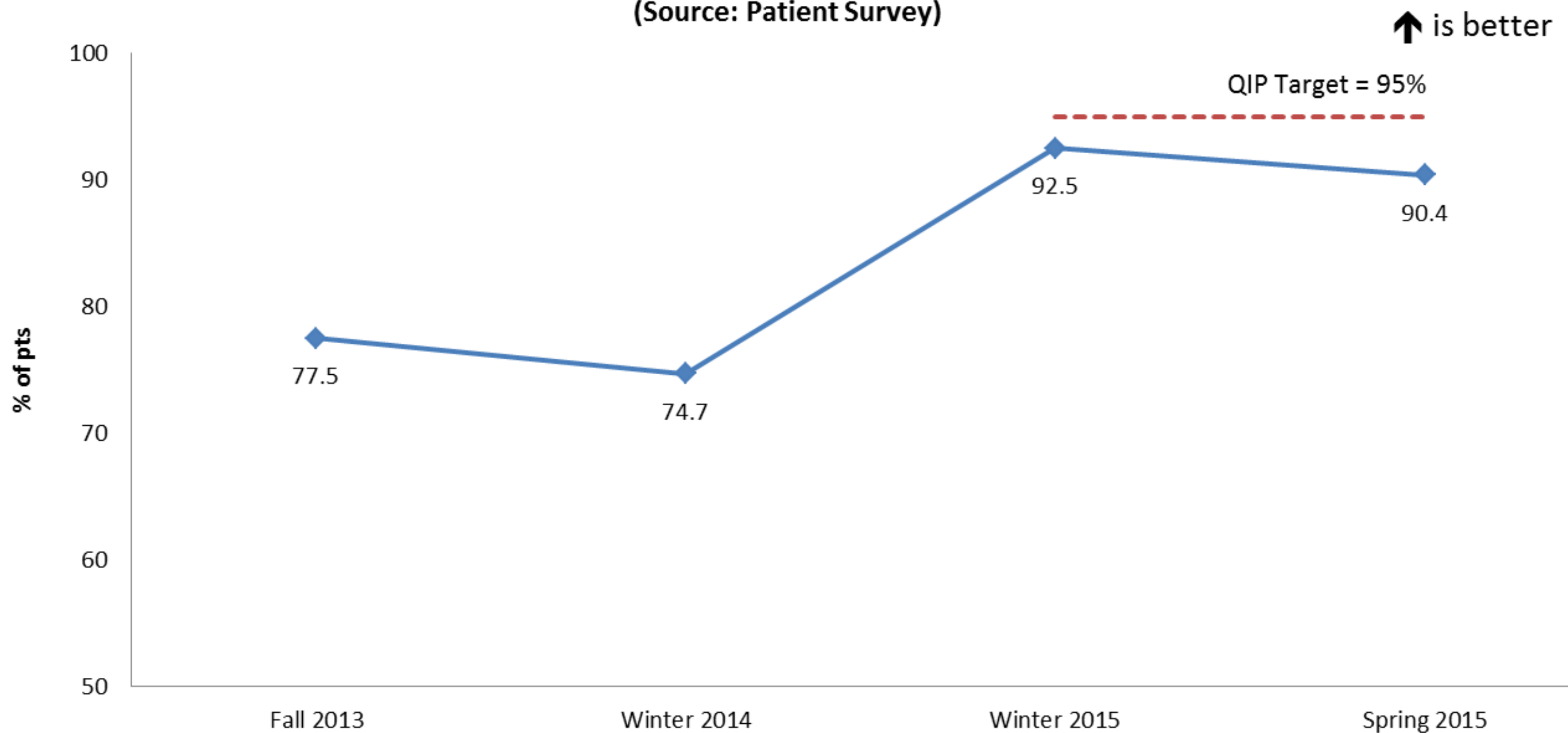
Patient Experience



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A FHT Population Health Model: Complexity

Centralized Comprehensive Programs:

- Diabetes Care :
  - Type 1 & 2 insulin starts
  - Pumps education and initiation
  - Gestational diabetes care repatriation from Acute setting
- INR point of care management
- Foot Care for frail elderly and complex chronic disease
- Enhanced support for patients with Chronic Pain

A FHT Population Health Model: Complexity

In-home Primary Care team:

- Health Link Coordinated Care Plan and Patient passport
- Focus on SDOH
- Advanced care planning

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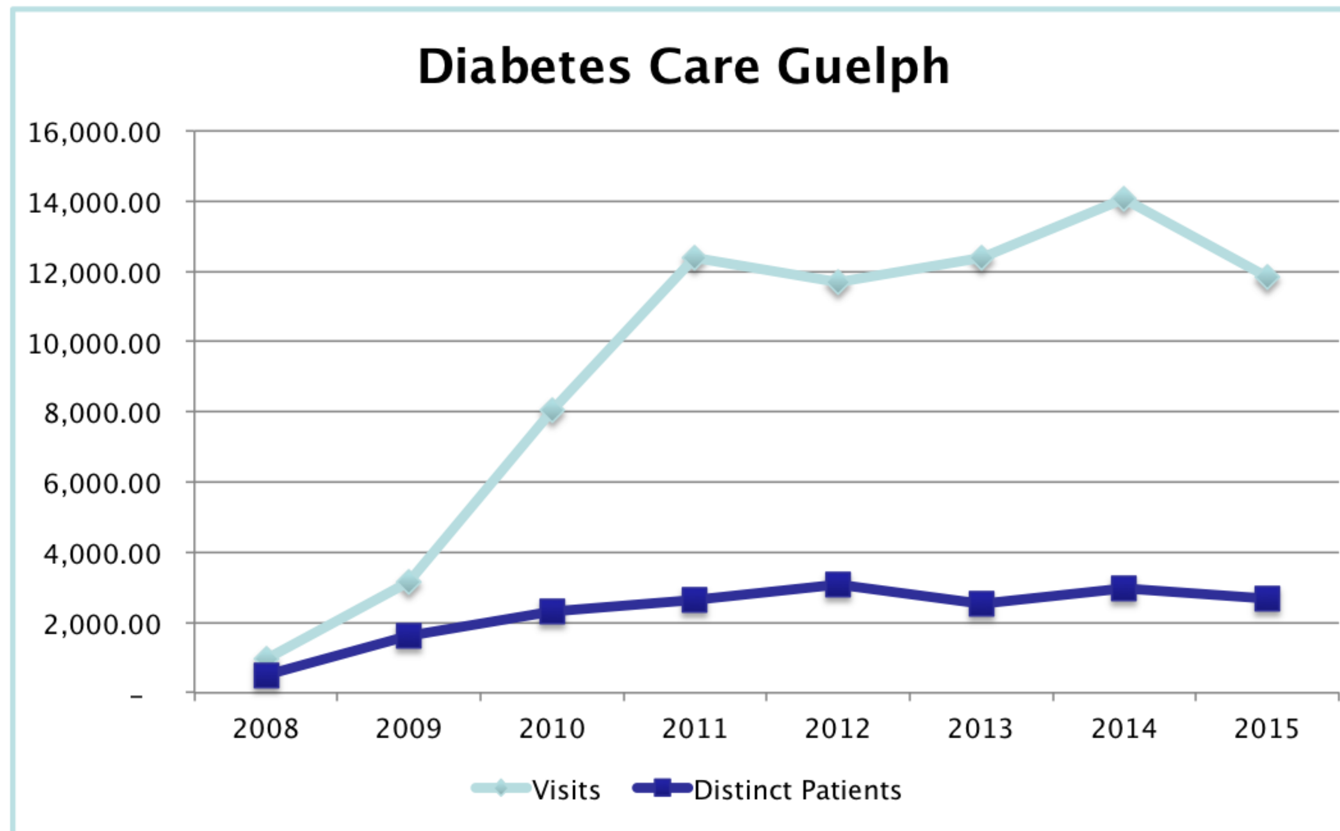
Diabetes Care Guelph Visits



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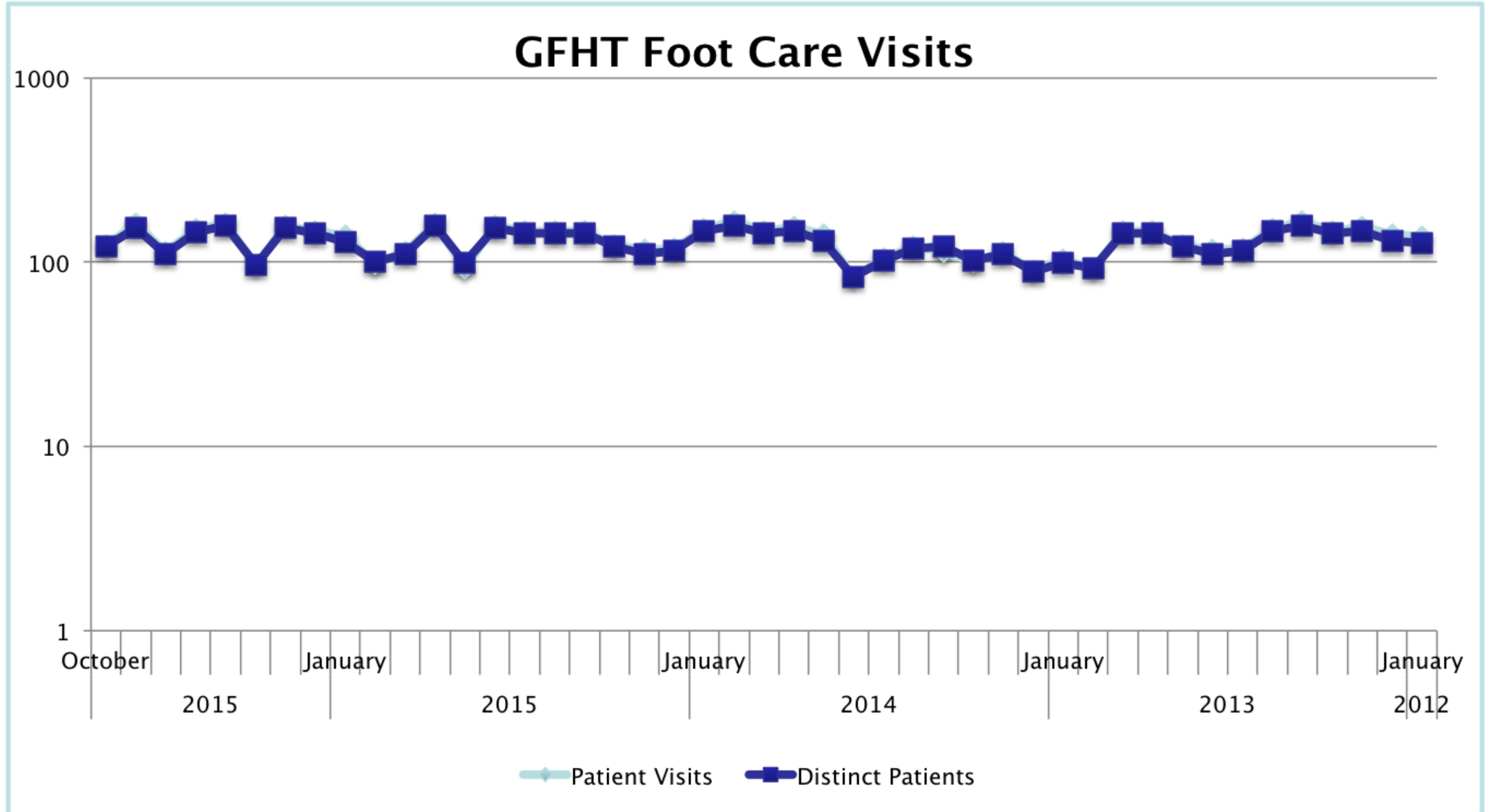
Foot Care Clinic



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INR Clinic

- ~40 new monthly referral
- ~2500 Patients on F/ups
- ~10,000 visits per year

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A FHT Population Health Model: Access

Measure	Actual	QIP Target
Diabetes Care Guelph 4bA/c in Range	75.6%	70%
DCG – Gestational Patients seen within 72 hours	98%	90%
Diabetes Patients re-admitted at GGH per quarter	<5%	0%
INR Patients in Therapeutic Range	82.3%	70%

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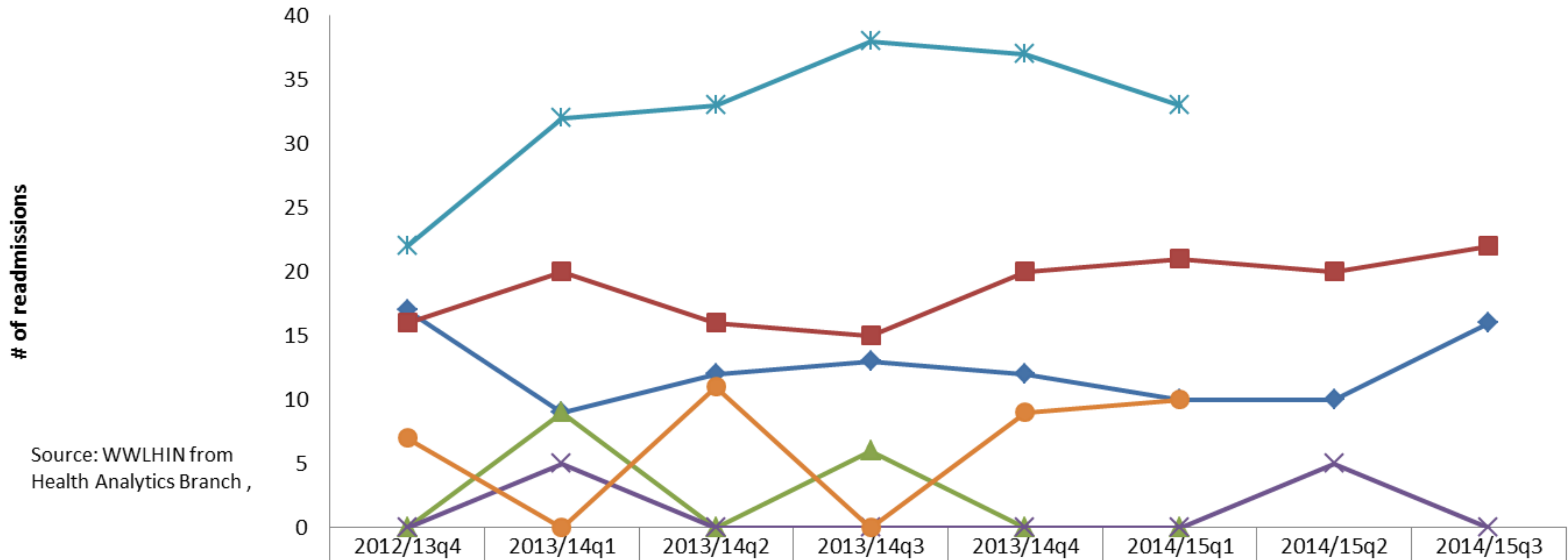
Hospital Readmission



	2012/13q4	2013/14q1	2013/14q2	2013/14q3	2013/14q4	2014/15q1	2014/15q2	2014/15q3
Congestive Heart Failure	17	9	12	13	12	10	10	16
COPD	16	20	16	15	20	21	20	22
Cerebrovascular Accident	0	9	0	6	0	0		
Diabetes mellitus	0	5	0	0	0	0	5	0
Gastrointestinal	22	32	33	38	37	33		
Pneumonia	7	0	11	0	9	10		

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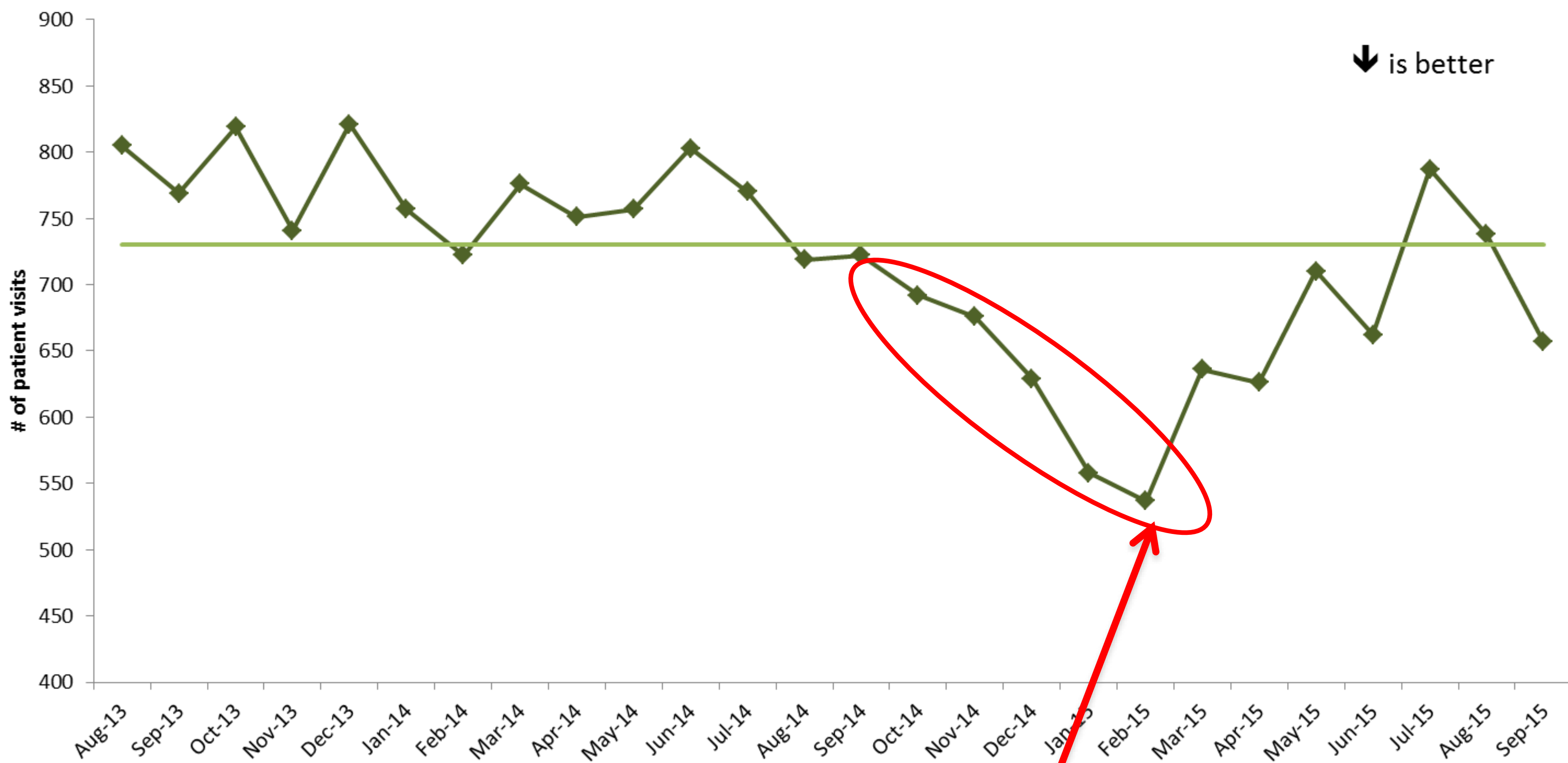
GFHT Patient Emergency Department Utilization
Number of CTAS 4 & 5 Visits Per Month at GGH



Trend
(non random signal of change)

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A FHT Population Health Model: Summary

- Culture change over time
- Recognition of Primary Care in achieving System priorities
- Population Health Focus with focus on complexity
- Accountability for results

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Thank You