HEALTH TAPESTRY

# Collaborative Practice - Messy, Time-Consuming and Worth It !!

Funding for Health TAPESTRY provided by Health Canada with additional support by the Government of Ontario, LaBarge Optimal Aging Initiative, and McMaster Family Health Organization. Health Links is funded by the MOHLTC.

McMaster University FAMILY MEDICINE

Michael G. DeGroote SCHOOL OF MEDICINE

McMaster University FAMILY MEDICINE

McMaster Family Health Team

HEALTH TAPESTRY

Martha Bauer, Laura Cleghorn,

Kiska Colwill, Betty Delmore, Laura Doyle, Dan Edwards, Dale Guenter, Dajana Lukic, Doug Oliver, Glenda Pauw, Mike Spoljar, Alix Stosic, Ruta Valaitis

Funding provided by Health Canada with additional support by the Government of Ontario, LaBarge Optimal Aging Initiative, and McMaster Family Health Organization

McMaster University FAMILY MEDICINE

McMaster Family Health Team

# Disclosures

- Presenters:

  Martha Bauer, Laura Cleghorn, Kiska Colwill, Dan Edwards, and Mike Spoljar

- NO CONFLICT OF INTEREST

# Disclosures

- The Health TAPESTRY project is supported by funding from the following sources: A Health Canada Federal Innovations grant, the Ministry of Health and Long Term Care of Ontario, the Labarge Optimal Aging Initiative and the McMaster Family Health Team
- Health Links is a program of the Ministry of Health and Long-Term Care

- There are no competing commercial interests, or resale products being promoted in this presentation

# Learning Objectives

1. Describe Health TAPESTRY and Health Links
2. Describe implementation of an inter-professional team process
3. Describe what we have learned from “new eyes” looking at patients and how this has expanded our ability to provide a preventative health care plan
4. Present summary data from our experiences to date

# What is Health Links?

- Changing the way care is provided to individuals who **use the health system the most**
- Health Links represents a **philosophical shift** in the way care is organized and delivered
- Health Links brings social service and health services to the **same planning tables**


McMaster University FAMILY MEDICINE
McMaster Family Health Team
HealthLinks
HEALTH TAPESTRY

# Health Links 2014 - 2015

1000

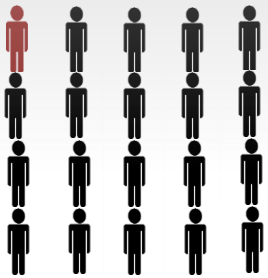
individuals in Hamilton represent the top 5% of ED use and hospitalizations

Major diagnoses include; COPD, Heart Failure, Diabetes

60%

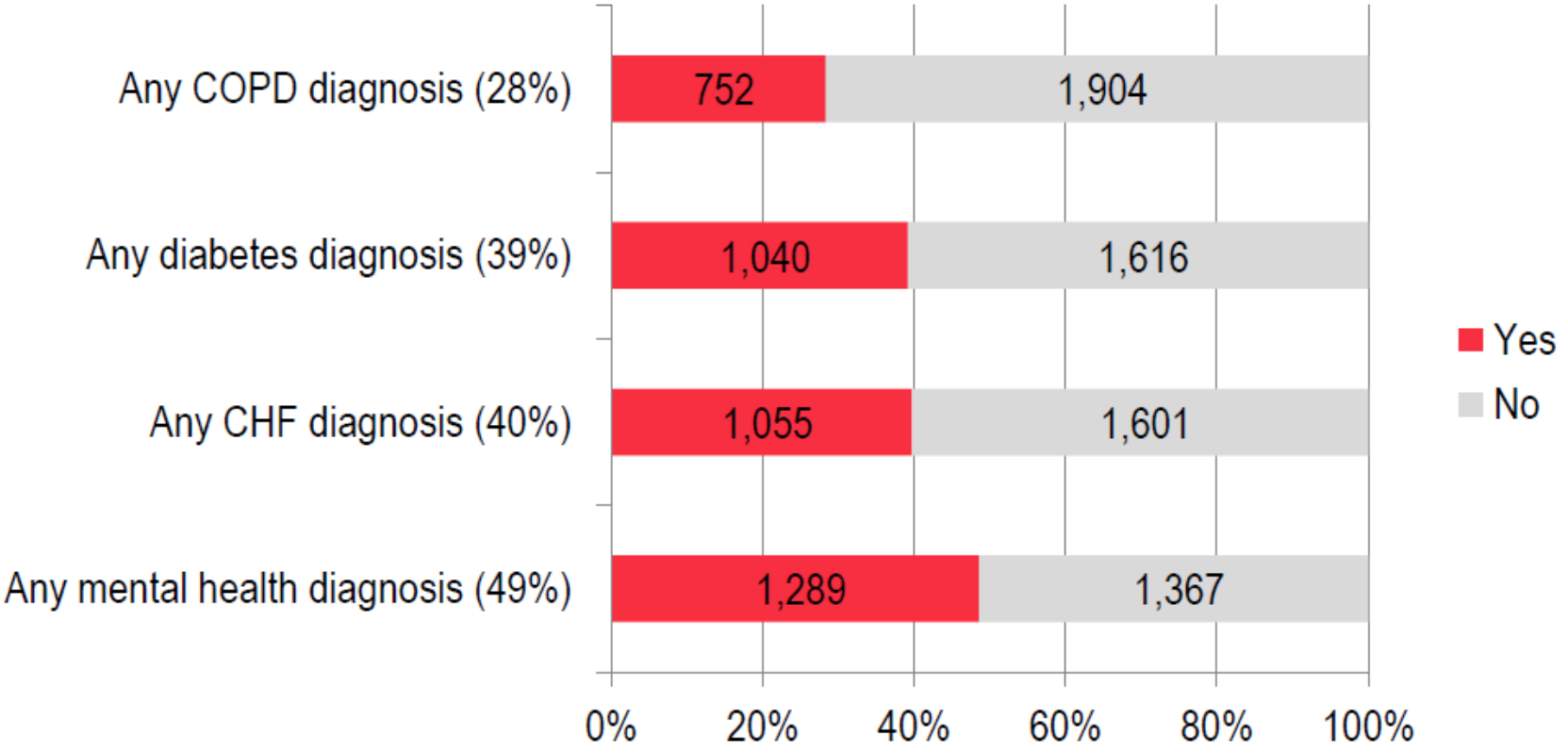
are over the age of 65

Individuals with addictions, mental illness



Learn from the 5% , make changes that impact the population

# Presence of 4 Selected Chronic Conditions for 2013 Health Links cohort –HNHB LHIN



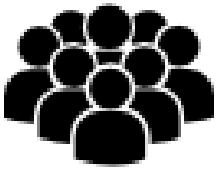

Source: IDS

# Health Links Cohort Process – 2014/2015
# McMaster Family Practice

HNHB LHIN IDS (Integrated Decision Support) ran a query for patients with 5+ ED visits and 3+ hospitalizations

**→ 1000 patients within the City of Hamilton**

Applied MFP physician list to separate MFP patients from city wide (within privacy constraints)



**→15 were MFP patients**

Brief chart reviews conducted. 4 had passed away, 2 had an acute issue that resolved

**→ 9 patients to work with**

**Learning: Retrospective data has its limitations, moving towards a referral process**

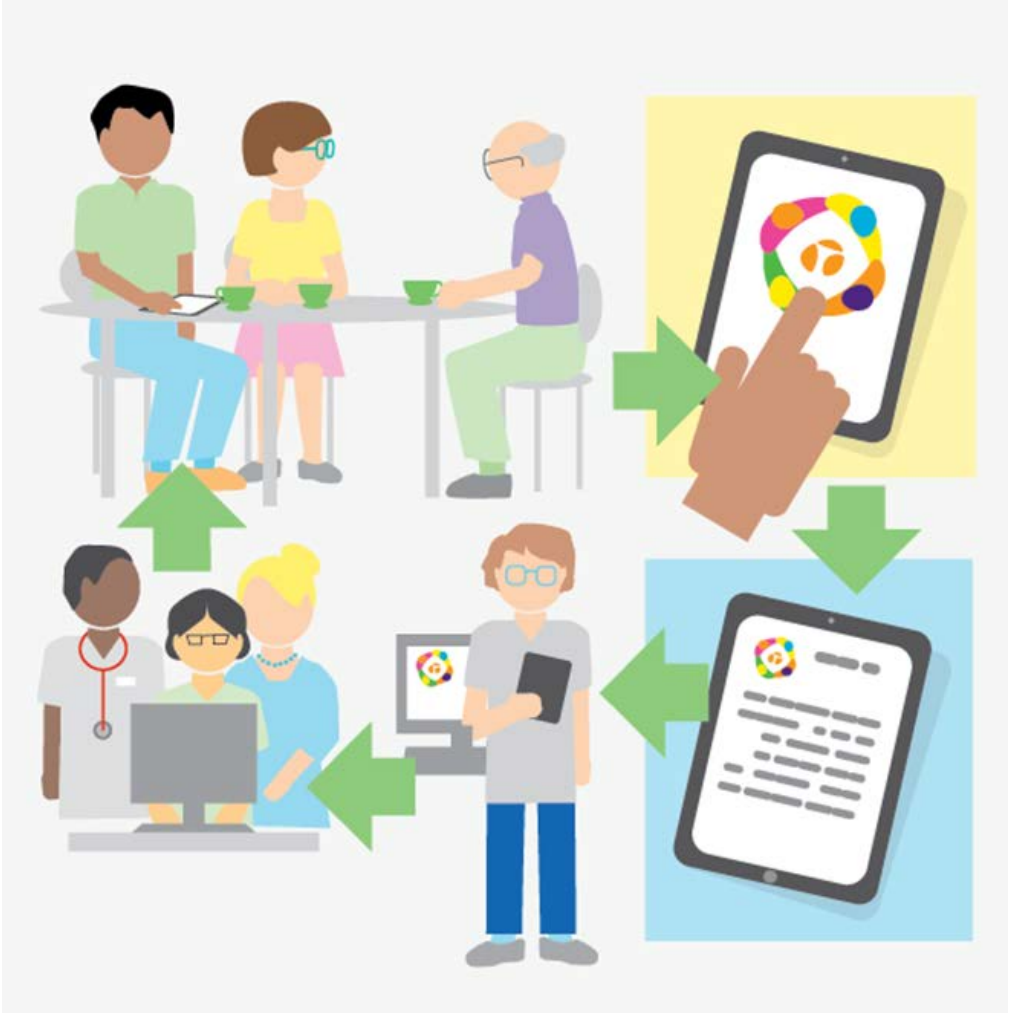
# What is Health TAPESTRY?

Teams Advancing Patient Experiences: Strengthening Quality

To foster **optimal aging** for older adults living at home using an interprofessional primary health care team delivery approach that **centres on meeting a person's health goals.**

# How do we do that?

- Trained volunteers visit older adults in their homes
- Collect health and social information on the TAP-App:
  - Screens for nutrition, mobility, frailty, memory, cognition
  - Identify clients' health and life goals
- TAP-App Report generated for the clinics
- TAP-Links Huddle Teams review 3-page Report and take action as required
- Volunteers follow up with clients at 3 months



McMaster University FAMILY MEDICINE
McMaster Family Health Team
HEALTH TAPESTRY

# Two Projects → One Approach

| | HEALTHLINKS | TAPESTRY |
|---|---|---|
| Objectives | MOHLTC program to maximize the health and health experience of individuals in our region who are high resource-users | Implementation of a complex intervention (pragmatic RCT) to foster optimal aging using an inter-professional primary health care team delivery approach |
| Outcomes | 1. Coordinated Care Plans<br>2. Efficient use of health and social services<br>3. Improved inte-rsectoral collaboration | 1. Goal attainment<br>2. Self-efficacy, EQ5D and others<br>3. Process evaluation of teamwork and collaboration |
| Population | All ages<br>2013 – 2014: N = 26<br>>5 Ed visits + >3 hospitalizations within a calendar year<br>2015-16: N=200+ | Older adults <70<br>Clients of McMaster Family Health Team<br>N=350<br>Two clinics – MFP and Stonechurch |
| Duration | January 2013 – March 2016 | April 2013 – March 2016 |

# Health TAPESTRY + Health Links = TAP-Links

**Overall Aim:**

Create processes which enable our clinics to seamlessly and appropriately manage care for any complex patient* whether identified through Health Links, Health TAPESTRY or any other manner

**medically or social complex, at-risk, vulnerable, high needs, or otherwise identified*

# So what's new about this?

- New information:
  - ✓ broad range of health and social information
  - ✓ 1 - 2 hour interaction (volunteers or clinicians)
  - ✓ Goals: What matters to you?

- New team approach for different kinds of information, conversations and outcomes

HEALTH TAPESTRY

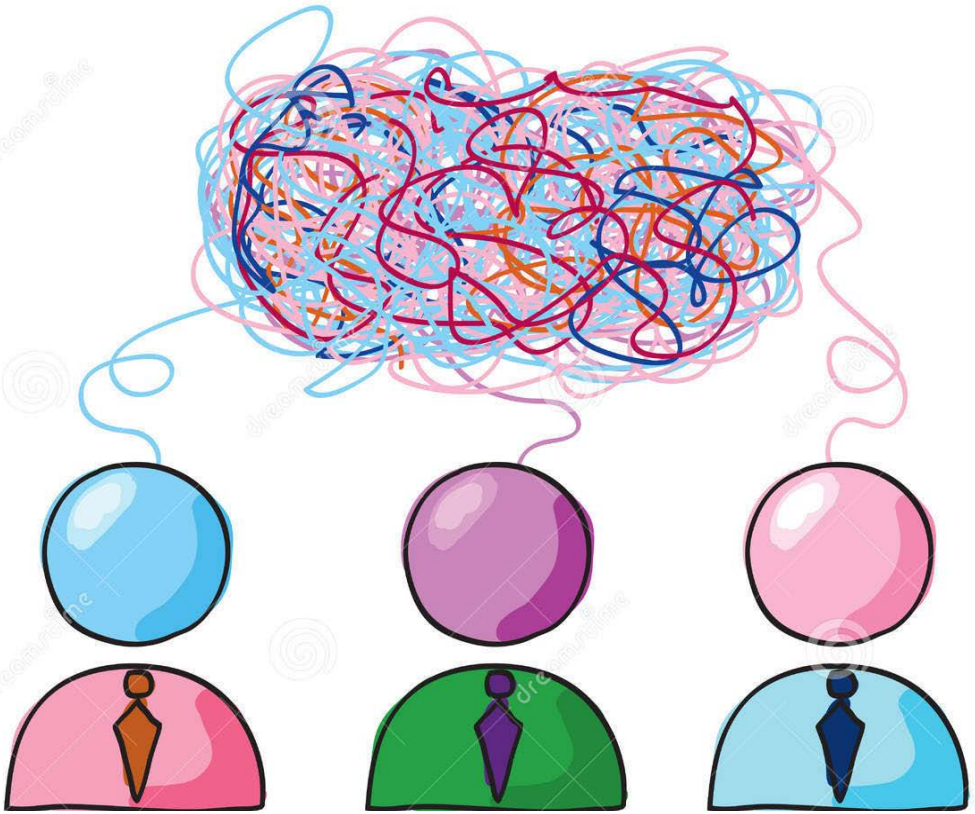
# Implementation

# What we know about implementing complex interventions in health care

- Adoption is a **messy** process (full of shocks, setbacks, surprises)
- The innovation should have: relative (clear) advantage, compatibility, simplicity (!), and **"trialability space"**
- It has potential to **improve team and task performance** and have knowledge that is easily transferrable
- It must be **adaptable**, open to tailoring and **reinvention** by teams
- **Opinion leaders** and **champions** invaluable, as is **organizational support** and leadership
- **"Slack" resources** also help

**Greenhalgh 2004**

# Initial Stages of Implementation



# Team Work

What team-based models and activities currently exist?

Who would like to participate?

What are the barriers to doing this work?

What are the facilitators to doing this work?

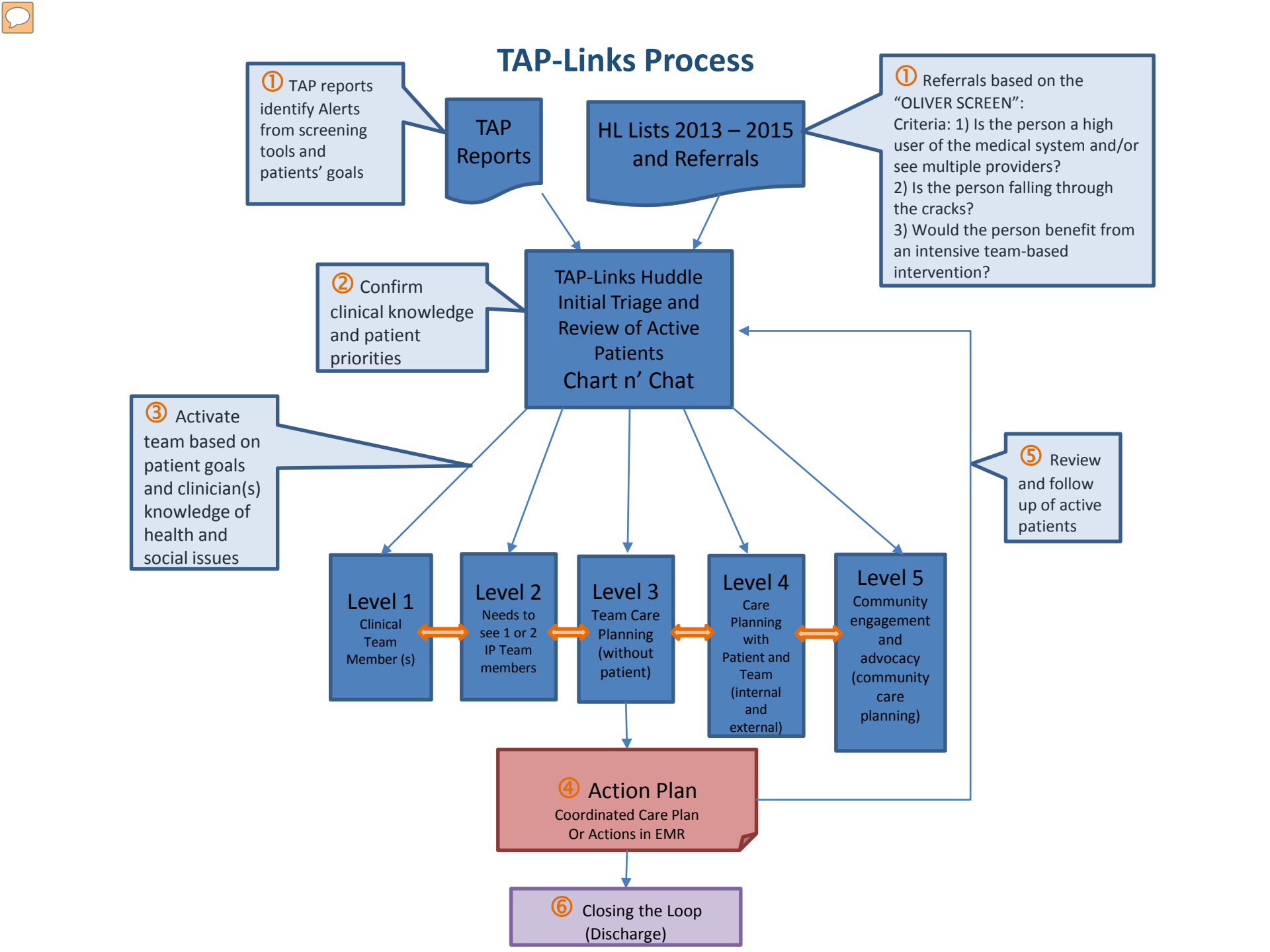
How do we fit this new work into our current workflow?

Who else should be at the table?

# Huddle Teams

- Pharmacist/Coordinator
- System Navigator/Coordinator
- Nurse Practitioners (2)
- Registered Dietician
- Occupational Therapist
- Registered Practical Nurse *
- Administrative Support*
- Physiotherapist *

* People who joined later


TAP-Links Process
① TAP reports identify Alerts from screening tools and patients' goals
TAP Reports
HL Lists 2013 – 2015 and Referrals
① Referrals based on the "OLIVER SCREEN":
Criteria: 1) Is the person a high user of the medical system and/or see multiple providers?
2) Is the person falling through the cracks?
3) Would the person benefit from an intensive team-based intervention?
② Confirm clinical knowledge and patient priorities
TAP-Links Huddle
Initial Triage and Review of Active Patients
Chart n' Chat
③ Activate team based on patient goals and clinician(s) knowledge of health and social issues
⑤ Review and follow up of active patients
Level 1
Clinical Team Member (s)
Level 2
Needs to see 1 or 2 IP Team members
Level 3
Team Care Planning (without patient)
Level 4
Care Planning with Patient and Team (internal and external)
Level 5
Community engagement and advocacy (community care planning)
④ Action Plan
Coordinated Care Plan
Or Actions in EMR
⑥ Closing the Loop
(Discharge)

# TAP-Links in Action

- https://vimeo.com/129566699

# The Health TAPESTRY Report

| | |
|---|---|
| **Patient:** | **Address:** |
| **MRP:** | **Date of visit:** |
| **Time:** | |

## TAPESTRY REPORT: [Name] (YYYY-MM-DD)

### PATIENT GOAL(S)

Goal 1 - Manage heart condition - decreased to no heart palpitation episodes
Goal 2 - Would like to learn to use iPad to better communicate with family and friends, as well as just figuring how to use the device
Goal 3 - Continue to walk the trails in the spring
Goal I Am MOST Willing To Work On Over The Next 6 Months: Goal 1

### Key Information

.Has fallen in the last year
.Edmonton Frail Scale score indicates high risk
.Patient uses 5 or more prescription medications
.Often feels sad or depressed
.Sometimes loses control of their bladder
.High Nutritional Risk
.Lost > 10 pounds
.Activity level is suboptimal
.Major Manifest Limitation in Walking

### Social Context

[PATIENT] is 82 years old. She has 3 children and is retired, She is living with her youngest son.
1. World traveller, family-oriented person
2. Strong, independent person, self-sufficient
3. Looking for an avenue to actualize, use her acquired knowledge

### Memory Screen

| | |
|---|---|
| Do you feel like your memory is becoming worse? | YES |
| Does this worry you? | NO |

### Advance Directives

| | |
|---|---|
| Are you interested in having a discussion with your family physician about advance care planning? | YES |
| Do you have a set of written advance directives? | YES |
| Have you spoken to your family doctor or any health care professional about advance care planning? | NO |

## WHAT MATTERS TO ME

**LIFE GOALS:**

Maintain contact with family (specifically her sons) over the phone and iPad
Maintain relationships with her friends (visit [NAME] and stay in contact with [NAME])
Attend McMaster instructions classes on using the iPad
Maintain her keyboard and piano playing

**HEALTH GOALS:**

Maintain current habits in order to conserve her strength
Keep going for walks to the corner and back (about 400 feet)- 3 times a week
Improve nutrition by working with a dietician to find a diet that suits her health needs.

## TAPESTRY QUESTIONS

| | |
|---|---|
| 1 | **Tell me a little about what your typical day looks like**<br>Haircut, massage, pedicure<br>Play bridge Monday, Wed, Fri<br>Majong once a week<br>drive to senior centre<br>Evenings are quiet, not like to go out when it's cold<br>Walk dog outside<br>Shopping<br>Visiting the doctor |
| 2 | **Who are your 'go to' people when you need help?**<br>Talks to a counsellor at Stonechurch and also has a best friend who lives nearby (walking distance for her friend, who comes to see her).; Friend knows her very well, been friends for a long time. Counsellor is very professional but is also very warm and doesn't ask too many questions. |
| 3 | **What does a good day look like for you?**<br>Just a regular day.<br>Sunshine is nice. Sun deprivation? Used to Florida weather.<br>Good day is when nothing breaks down, no new challenges, husband doesn't have a fall, no van problems. |
| 4 | **What is working well for you in managing your health concerns? What would help you to cope or manage better?**<br>Enjoying people and having a sense of humour. Good with letting go of the past, and living in the present. In hospital in December, having a personal approach would be better to help her work through things step by step, rather than just referring to other professionals.<br>Acknowledged that she may have not expresed the need for this one-on-one interaction.<br>Want to make sure will is in order, burial place is in order, funeral arrangements in order |

## Summary of TAPESTRY Tools

| DOMAIN | SCORE | DESCRIPTION |
|---|---|---|
| Functional Status | *Timed up-and-go test score = 1 (0-10s)*<br>*Edmonton Frail Scale score = 8 (Frail)*<br>*(Add 1 to this score if there are minor spacing errors in the clock and add 2 if there are other errors in the clock.)* | Edmonton Frail Scale (Score Key):<br>Robust: 0-4<br>Apparently Vulnerable: 5-6<br>Frail: 7-17 |
| Nutritional Status | *Screen II score = 39* | Screen II Nutrition Screening Tool:<br>Max Score = 64<br>High Risk < 50 |
| Social Support | *Satisfaction score = 12*<br>*Network score = 4* | Duke Social Support Index<br>(Score < 10 risk cut off), ranges from 6-18<br>Perceived satisfaction with behavioural or emotional support obtained from this network<br>Network score range : 4-12<br>Size and structure of social network |
| Mobility<br>Walking 2.0 km<br>Walking 0.5 km<br>Climbing Stairs | <br>*Major Manifest Limitation*<br>*Major Manifest Limitation*<br>*preclinical limitation using modifications* | Manty et al Mobility Measure-Categories:<br>No Limitation<br>Preclinical Limitation<br>Minor Manifest Limitation<br>Major Manifest Limitation |
| Physical Activity | *Aerobic Score = 1 under-active*<br>*Strength & Flexibility Score = 0* | Rapid Assessment of Physical Activity(RAPA)<br>Aerobic:ranges from 1-7(< 6 Suboptimal Activity)<br>Strength & Flexibility: ranges from 0-3 |

# Healthy Aging Series

FITNESS

NUTRITON

ADVANCE CARE PLANNING


FUNCTION

McMaster University FAMILY MEDICINE

McMaster Family Health Team

HEALTH TAPESTRY

# Health Links Care Planning

**My Situation**

- What Matters to Me
- People In My Life
- My Housing/Finances/ Transportation/Food
- My Function
- My Medical Conditions
- My Medications
- My Health Care

**What my Health Care Providers Think**

- My Health Care
- My Conditions
- My Medications

**Planning Next Steps**

- What I Can Work On
- My Housing/Finances
- My Function
- Changes in My Care / Helpers
- My Medications
- What I Can Do in a Crisis

McMaster University FAMILY MEDICINE
McMaster Family Health Team
HealthLinks
HEALTH TAPESTRY

# The Challenge of Complexity

"N**eeds that individuals have are <u>not complex</u> — they are remarkably simple, but often <u>numerous</u>…**

- transportation to appointments,
- a refrigerator for storing medications,
- a telephone to communicate with care providers,
- nourishing food,
- a place to call home.

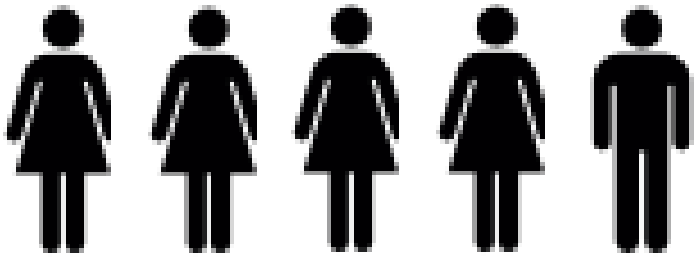
Specialty care for people with diabetes, cancer, or asthma, methadone treatment, mental health treatment, and issues with food security and housing stability are not in and of themselves complex challenges; **the complexity arises when the tasks of making connections among multiple care providers and linking each intervention to the individual's overall care plan fall in the lap of the individual alone without effective partnering or support.**"

**Institute for Healthcare Improvement, 2011**

HEALTH TAPESTRY

# Preliminary Data and Observations

# Health Links Clients and Actions



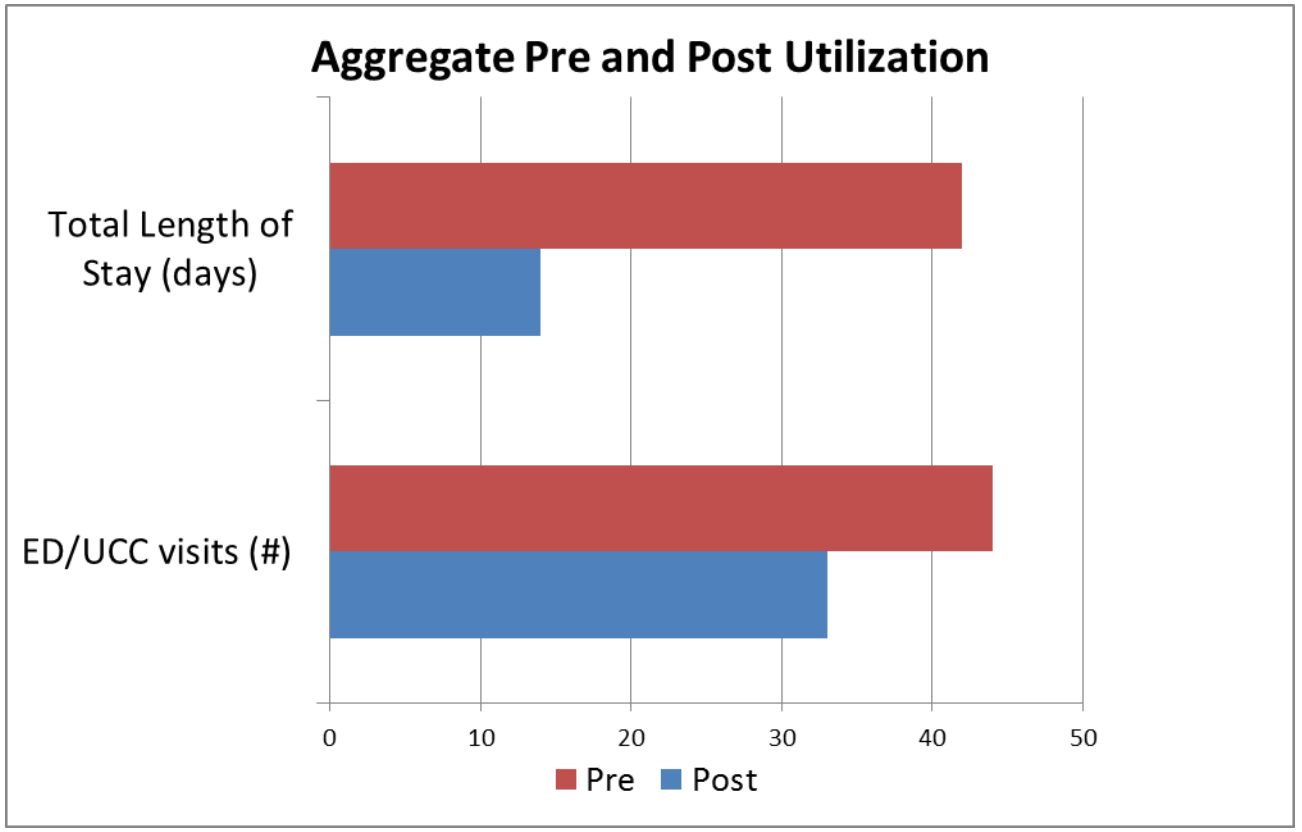
## Overview of Health Links Clients

- 4 females, 1 male. Ranging between 38 to 75 years old (avg: 44)
- 3/5 gastrointestinal disease
- 3/5 pain management
- 2/5 mental health

## Actions Taken

- Chart review revealed multiple diagnoses and multiple providers within the clinic and outside
- 4/5 had a specialist consult as an outcome
- Other referrals included YMCA exercise program, smoking cessation, dietitian

# Evaluation - Pre and Post Utilization



# TAP-Report Alerts (n=150)

| Alert | Frequency | Percentage |
|---|---|---|
| Had a fall within the last year | 36 | 24% |
| Edmonton Frail Scale score indicates high risk | 12 | 8% |
| Patient uses 5 or more prescription medications | 53 | 35.3% |
| At times, sometimes forgets to take prescription medication | 41 | 27.3% |
| More than 20s for timed up-and-go | 8 | 5.3% |
| Requires assistance for timed up-and-go | 5 | 3.3% |
| Often feels sad or depressed | 22 | 14.7% |
| Sometimes loses control of their bladder | 58 | 38.7% |
| High nutritional risk | 68 | 45.3% |
| Social Satisfaction at risk | 0 | 0.0% |
| Major manifest limitation in walking 2km | 23 | 15.3% |
| Major manifest limitation in walking 0.5 km | 15 | 10% |
| Major manifest limitation in climbing one flight of stairs | 12 | 8% |
| Suboptimal activity | 118 | 78.7% |
| Abnormal clock | | |
| Score of 1 ("minor spacing errors) | 39 | 26% |
| Score of 2 ("other errors") | 54 | 36% |
| Feels memory is getting worse and this worries them | 42 | 28% |
| Interested in discussing advance care planning with family physician | 86 | 57.3% |
| Identified with high caregiver burden | 7 | 4.7% |

# Client Goals (n=75)

| Goal Area | Examples | Frequency | Proportion |
|---|---|---|---|
| Diet/Nutrition | eat healthier, eat less unhealthy foods, manage weight using diet | 16 | 8.21% |
| Physical Activity | Exercise more, walk more, get out and get active more | 31 | 15.90% |
| Rehab | Managing pain, improving mobility and flexibility | 22 | 11.28% |
| Smoking/alcohol | Quitting smoking, decreasing alcohol intake | 3 | 1.54% |
| Medical | Managing medical problems, seeing the doctor, managing medication | 24 | 12.31% |
| Productivity | Getting work done, pursuing hobbies, being mentally active and productive | 23 | 11.79% |
| Social connection | Spending time with family and friends, going out and doing social activities | 26 | 13.33% |
| Mental health | keeping mental faculties, memory, preventing degradation | 9 | 4.62% |
| Maintain health | Staying healthy, staying at home | 25 | 12.82% |
| Other | faith, travel, advanced care planning/ wills | 18 | 9.23% |
| Total goals set by 75 clients | | 195 | 100% |

# Health TAPESTRY Process Evaluation

- Focus groups and interviews (volunteers, health care providers client)
- Field notes
- Chart review
- 3 month and 12 months

# Normalization Process Theory

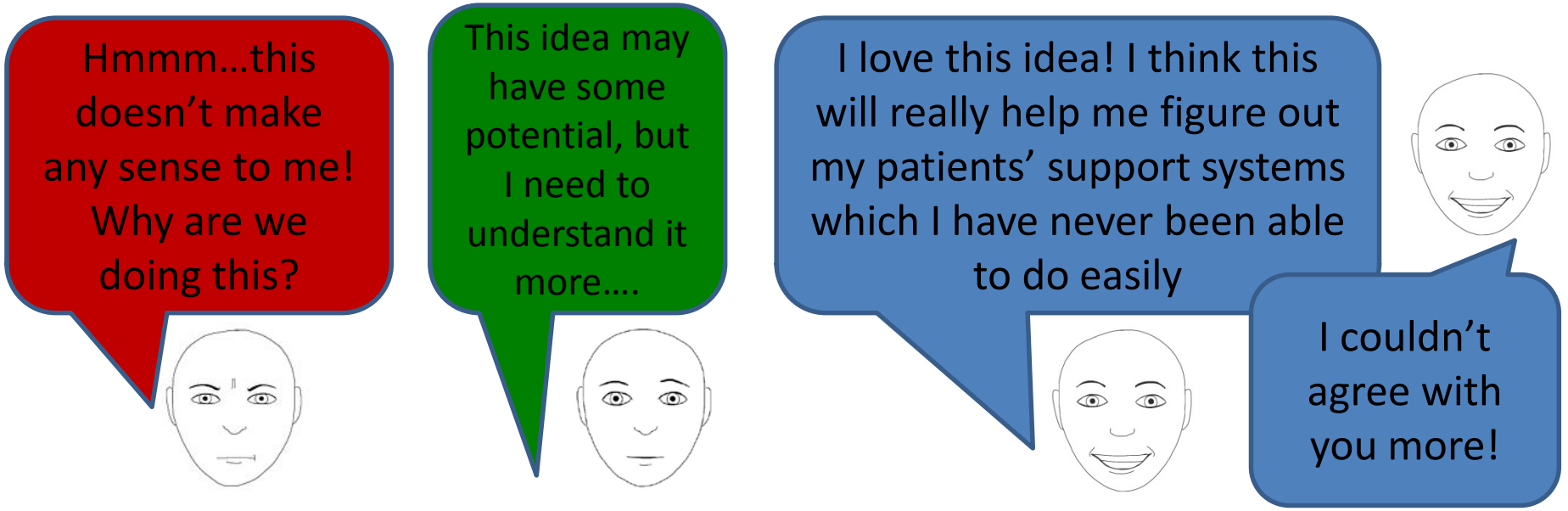
www.normalizationprocess.org

**Four Key Constructs:**

- How people *make sense of the work* of implementing and integrating a complex intervention → **coherence**
- How they engage with it, *commit* to it →**cognitive participation**
- How they *enact* it → **collective action**
- And how people *appraise* its effects → **reflexive monitoring**

# Coherence

- Individually and collectively make sense of the innovation when considering putting it into practice



# Cognitive Participation

- The relational work among individuals and groups to sustain a community of practice around the new practice

# Collective Action

- Operational work to perform the innovation which may involve a set of practices

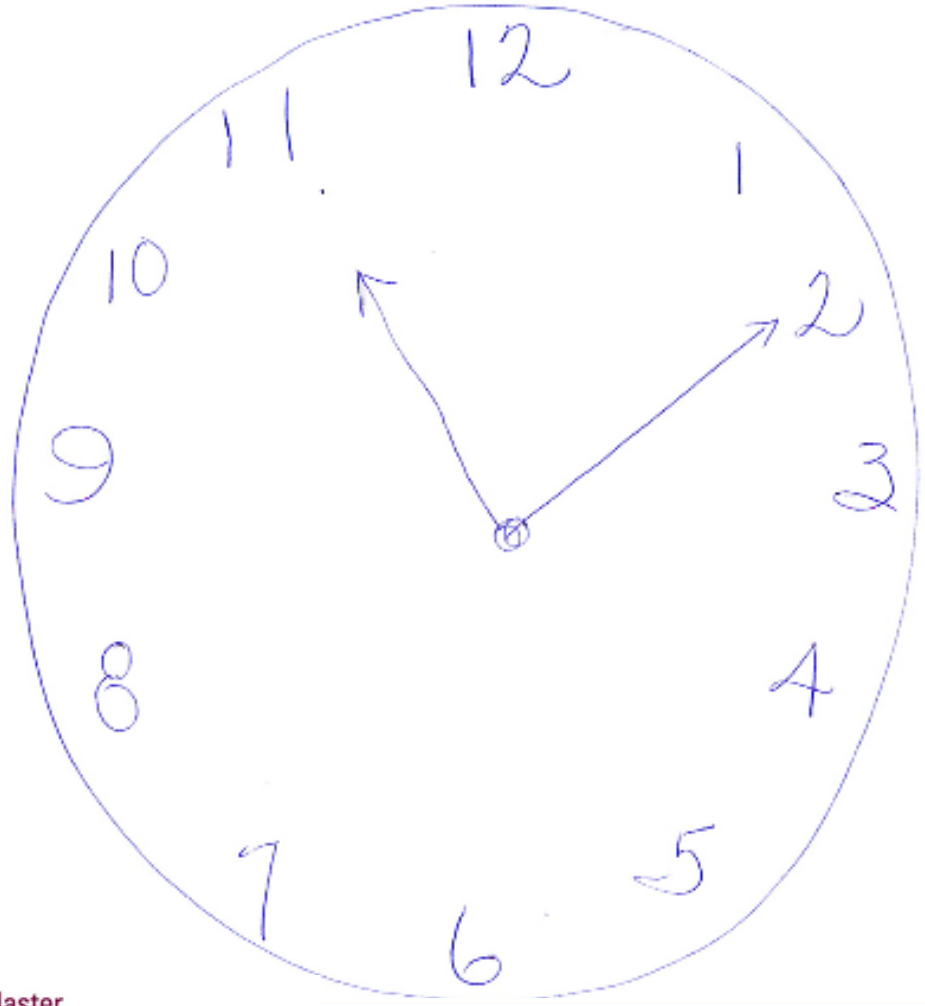
# Reflexive Monitoring

- Assessment and understanding of the intervention by those involved, leading to modifications

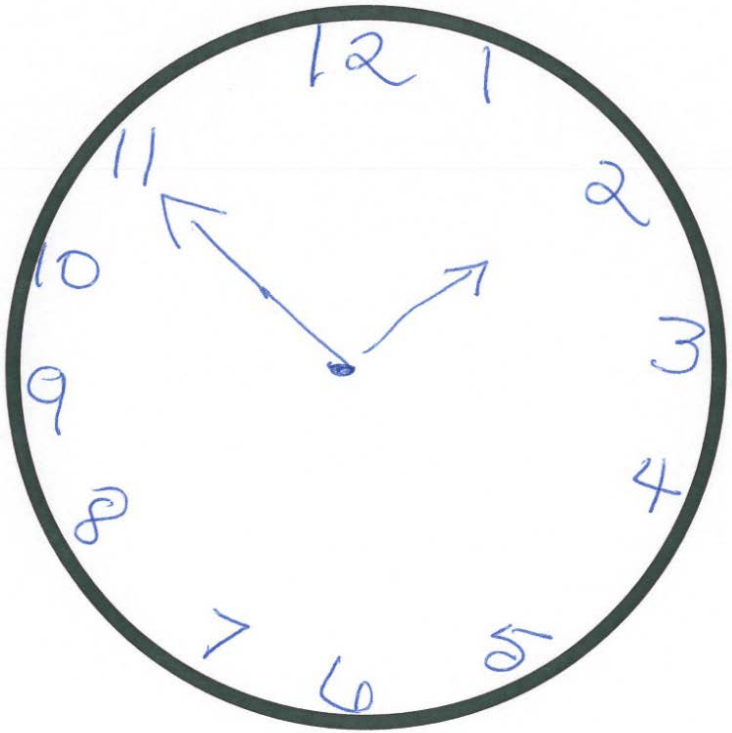
HEALTH TAPESTRY

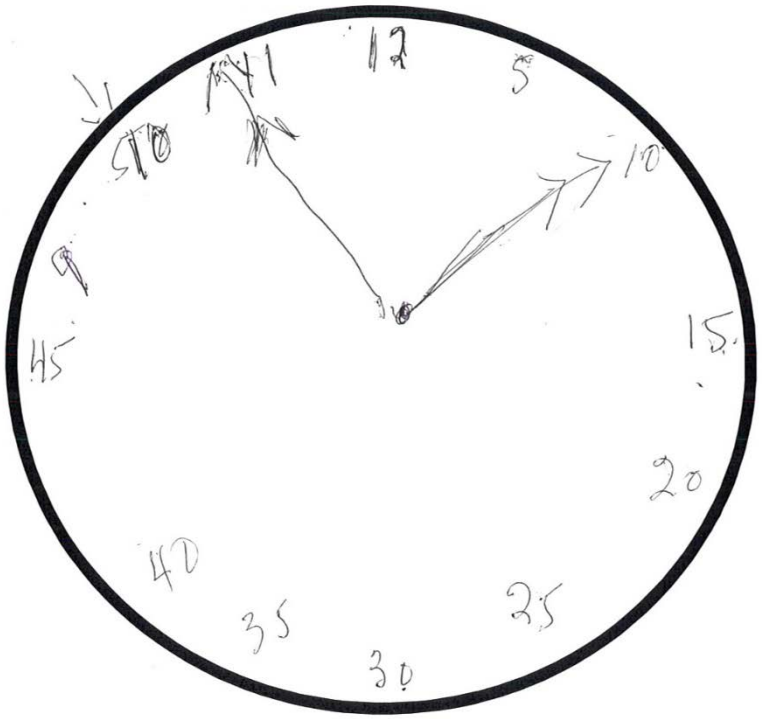
# Some things are still messy . . .

# Clocks …

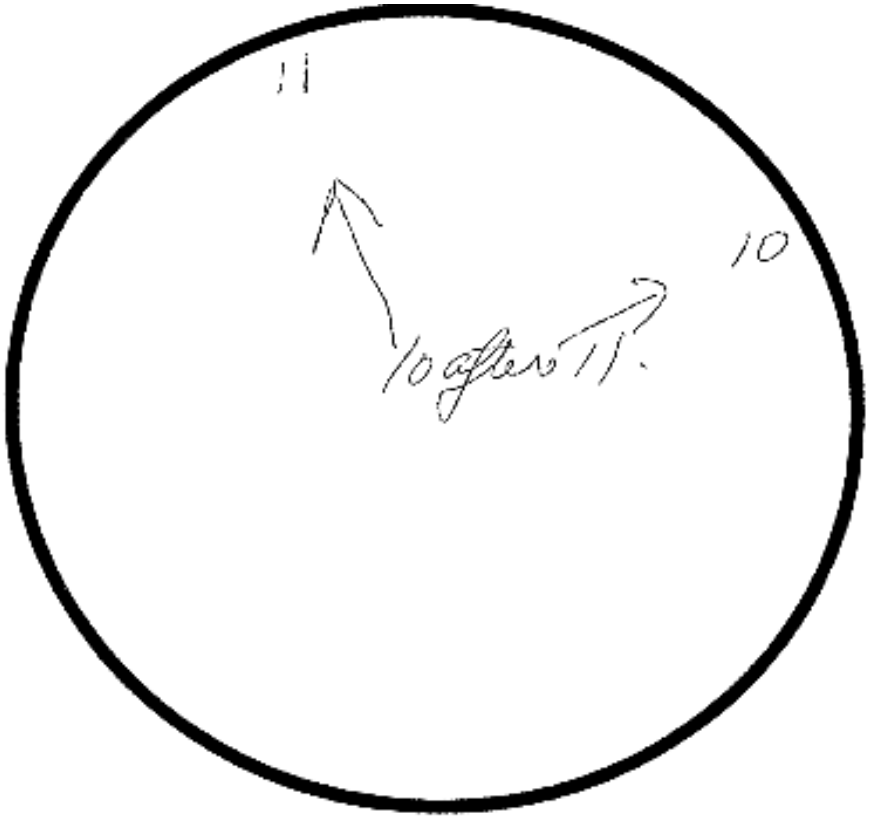


# And More Clocks …



# More Clocks …



# Next Steps

- Coordinated care plans being developed for 25 Health Links clients 2015 - 2016
- Piloting TAPESTRY program with younger and more complex (Health Links clients)
- Spread awareness and engagement of TAP-Links across the clinic
- Continued streamlining of clinic huddle processes (e.g. care planning, clinic-community links)