



STRATEGIC APPROACHES TO POPULATION HEALTH PLANNING

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Presenter Disclosure

- **Presenters:** Chantelle Botscheller & Nadya Zukowski
- **Relationships with commercial interests:**
 - Not Applicable

Disclosure of Commercial Support

No Commercial Support

Mitigating Potential Bias

Not Applicable

PRESENTATION OVERVIEW:

- ABOUT US
- POPULATION HEALTH PLANNING AT WINDSOR FHT
- POPULATION HEALTH PLANNING AT SUMMERVILLE FHT
- KEY POINTS
- QUESTIONS
- CONCLUSION



ABOUT US...



- 6,000 enrolled patients (10,000 active)
- 4 Physicians
- 3 Nurse Practitioners
- Allied health: 0.5 RN, 2 RPNs, 0.5 RD
1.5 SWs, 0.5 HP
- 1 Main location + 2 Satellite sites



- 50,000 patients
- 37 Physicians, 18 Residents
- 7 Nurse Practitioners
- Allied health: 10 RNs, 1.5 RDs, 1.5
Pharmacists, 4 SWs, 1.5HPs
- 5 Locations



Windsor FHT

MACRO Umbrella Perspective

*Big picture to population health
planning approach*

Summerville

FHT

MICRO

Perspective

*Targeted
planning &
interventions*

POPULATION HEALTH PLANNING AT WINDSOR FHT





Our Team

A Road Map to Health Promotion Planning



1. Assess: What do the stats say?

We look at the Chronic diseases/ conditions in:

- Canada
- Ontario
- our LHIN
- our local Health Unit
- our FHT

[Stats Canada Link](#)

We look for trends and narrow these conditions down to our.....



2. Review: What did we offer last year?

- Look Back
- Will our programs from last year cover all of our top 10 topics this year?

3. Explore: How do we address the topics that are not covered?

- Add-on to existing programs
- Create new programs
- Reach Out



4. Reach Out: Is there another local organization that offers programs on this topic that we could partner with?

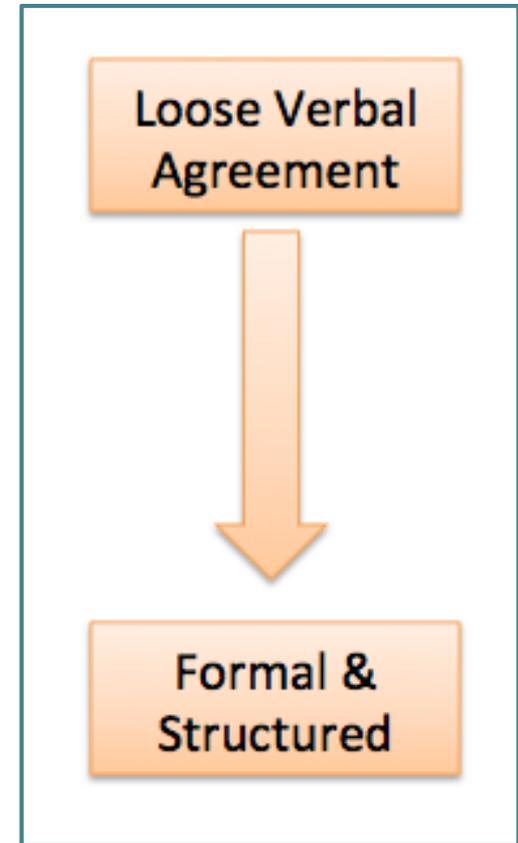
- Learn about other organizations in your community and what programs or services they offer



5. Partner: How do we partner with other organizations?

3 Types of Partnerships:

1. Promote services and refer patients
2. Share staff
3. Co- create and lead



Some of our Partners...



ST. CLAIR
COLLEGE



The Arthritis Society



familyservices
WINDSOR-ESSEX
COUNSELLING & ADVOCACY CENTRE



WINDSOR REGIONAL HOSPITAL

OUTSTANDING CARE - NO EXCEPTIONS!



ASTHMA RESEARCH GROUP
WINDSOR-ESSEX COUNTY INC.



Windsor Essex Community Health Centre
Centre de santé communautaire de Windsor Essex

weCHC
Supporting the Vulnerable



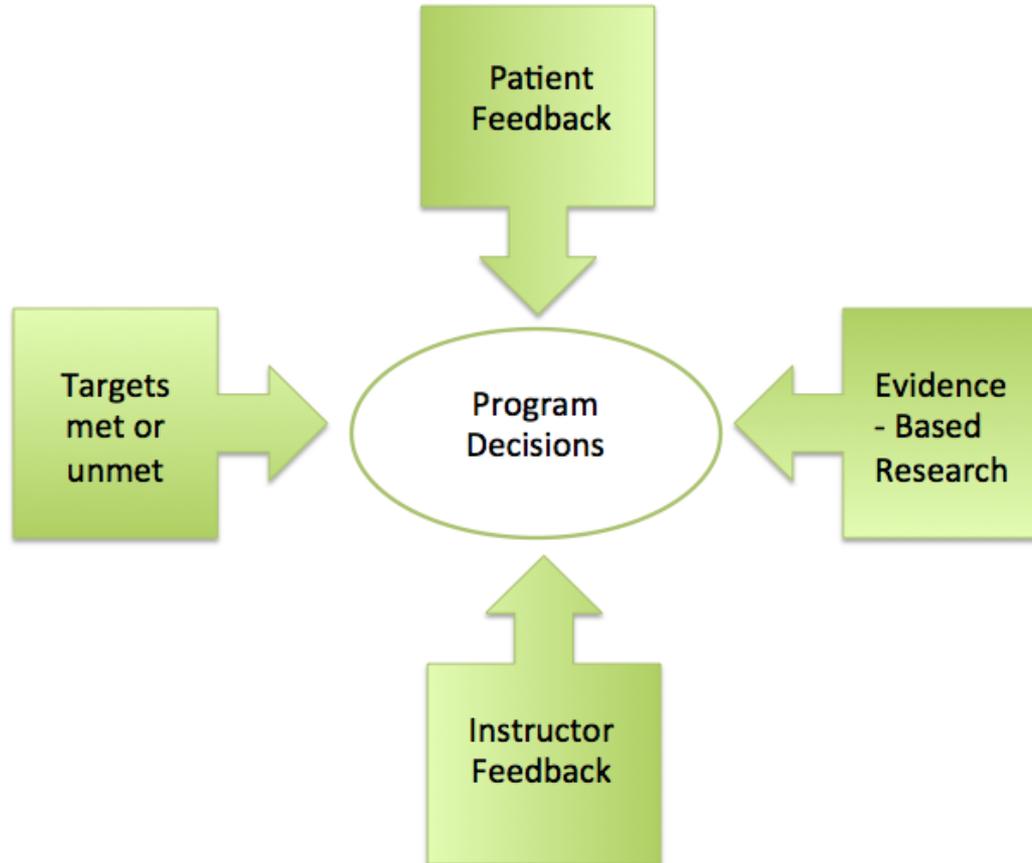
University of Windsor

@ Canadian Diabetes Association

WINDSOR
Family | Health | Team

6. Revise or Create: How do we revise our programs/services from last year or create new ones?

- We look closely at our Programs and Services from the previous year



Targets Met and Unmet

Program/Service Name	Type	Priority	Staff Involvement	Target # of Patients	Actual # of Patients (YTD)	Patient Encounters (YTD)
Healthy Eating and Exercise for Weight Management	Health Promotion	Obesity/ Nutrition	.025 FTE RD .0025 FTE SW .025 FTE HP .001 FTE RPN	40	31	95
COPD/Asthma Program	CDM	Lung Health	.179 FTE RT .01 FTE NP .01 FTE HP	70	8	29
Depression Management and Treatment Program	CDM	Mental Health	.027 FTE SW .0018 FTE HP	13	1	
Gender Journeys	Health Promotion	Mental Health	0.03 FTE SW	6		
Arthritis and Fibromyalgia Rehabilitation and Education Program	CDM	Other	.019 FTE HP .004 FTE NP .024 FTE OT	60	9	18

Target Population	Goals	Performance Measure	Performance Target	Actual	Comments
WFHT clients and clients of affiliated health care partners that have a BMI of 25+	<ul style="list-style-type: none"> • Increase knowledge on healthy eating, physical activity and emotional eating. • Improve patient lifestyle behaviours through group education. 	<ol style="list-style-type: none"> 1) Number of participants who will obtain a score of 90% or greater on the weekly knowledge evaluation quizzes. 2) Number of people who will indicate on a Likert scale that they have made positive behaviour changes by week 4. 3) Number of participants who have a weight loss and/or a decrease in their waist/hip measurement by end of program. 	<ol style="list-style-type: none"> 1) 30 2) 20 3) 20 	<ol style="list-style-type: none"> 1) 21 2) 22 3) 6 	This workshop will be offered in January for 5 weeks based on post workshop feedback. Of the 31 participants only 8 chose to be measured and weighed week 1 and week 4. 6 Lost weight, 2 gained muscle mass but did not lose weight on scale.
WFHT patients and St. Clair college students or staff who are currently diagnosed with COPD, those who are suspected of having COPD, smokers, ex-smokers. WFHT patients, St. Clair college students and staff who are diagnosed with asthma or breathing problems	<ul style="list-style-type: none"> • Improve control of asthma through education and follow up visits with a Respiratory Therapist. • Improve knowledge of proper inhalation device techniques. 	<ol style="list-style-type: none"> 1) Number of patients with written COPD "action plan". 2) Number of patients with improved spirometry values. 3) Number of patients able to demonstrate proper inhalation device technique as evaluated by RT. 	<ol style="list-style-type: none"> 1) 30 2) 50 3) 60 	<ol style="list-style-type: none"> 1) 8 2) 2 3) 8 	High no show rate (16) and cancellation rate (4). The spirometry results were only tested on two individuals at this time. The others will be tested as treatment continues.
WFHT patients 18 years plus with primary diagnosis of depression who have been referred to clinical social worker.	<ul style="list-style-type: none"> • Reduce symptoms of depression and/or improve ability to cope with existing symptoms. 	1) Patients with a reduction of 1 category in PHQ9 scores through the course of the program	1) 11	1)	Final results will not be available until March 31, 2016.
Patients over 18 identifying as transgender.	<ul style="list-style-type: none"> • Address challenges of living as a transgender person 	1) Patients who complete a program evaluation questionnaire	1) 90%	<ol style="list-style-type: none"> 1) 2) 	Wait list has been established for patients interested in this program. Program to run when enough individuals interested.
WFHT and Windsor community patients, St Clair College staff and students who are diagnosed with arthritis, Fibromyalgia or related conditions.	<ul style="list-style-type: none"> • Improve pain control for patient's with arthritis or fibromyalgia. • Improve knowledge on how to manage Fibro/ Arthritis at home. 	<ol style="list-style-type: none"> 1) • The number of patients who answer "agree" or strongly agree" on the Client Centered Rehabilitation Questionnaire (CCRQ) to the following question: "My physical pain was controlled as well as possible." 2) The number of patients who answer "agree" or strongly agree" on the Client Centered Rehabilitation Questionnaire (CCRQ) to the following question: "I learned what I needed to know in order to manage my condition at home." 	<ol style="list-style-type: none"> 1) 30 2) 30 		Final results will be available at the end of the 2015-2016 year.

HEALTH TOPICS QUESTIONNAIRE

The completion of this questionnaire will assist the Windsor FHT in planning future programs to best address the needs of our patients. Responses are completely anonymous. Your cooperation is greatly appreciated!

Gender: Male Female Gender Variant

Age Range In Years:

- | | | |
|--------------------------------|--------------------------------|---------------------------------|
| <input type="checkbox"/> 18-20 | <input type="checkbox"/> 41-50 | <input type="checkbox"/> 71-80 |
| <input type="checkbox"/> 21-30 | <input type="checkbox"/> 51-60 | <input type="checkbox"/> 81-90 |
| <input type="checkbox"/> 31-40 | <input type="checkbox"/> 61-70 | <input type="checkbox"/> 91-100 |

How convenient is the Windsor Family Health Team location for you to be able to take part in our programs:

- Able to travel to Windsor FHT without difficulty
 Difficulty with transportation issues to attend programs at the Windsor FHT

Please indicate all the health topics that are of particular interest/ concern to you:

Check all topics of interest to you	Check best method of learning		
	Home Learning	Web learning	In Person Workshop
<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Child Care/ Pediatric Care/ Parenting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heart Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mental Health (topic): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sexually Transmitted Diseases/Sexual Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Smoking Cessation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Men's Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Women's Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stress Reduction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Weight Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chronic Pulmonary Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Back Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Muscle/Joint Mobility/Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cooking on a Budget	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cooking for One or Two	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Vitamins/Minerals/Supplements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other topics: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Feedback

7. Measure: How do we encourage ongoing evaluation?

- The knowledge evaluation



- The program evaluation



Knowledge Evaluation Form

Circle The Correct Answer/s

1. To save on food costs, it is best to purchase "less prepare" foods.

True False

2. A healthy meal includes a food item from each of the four food groups at every meal.

True False

3. End of aisle displays do not necessarily mean that these items are on sale.

True False

4. Grade "A" and Grade "B" meat and chicken have the same taste as well as the same nutritional value but they are different in appearance.

True False

5. Calcium helps your muscles work and is important for your kidneys.

True False

THANK YOU FOR PARTICIPATING IN TODAY'S PROGRAM.

Program Evaluation Form

What did you think of group?

	Strongly Agree				Strongly Disagree
	1	2	3	4	5
◆ I would recommend this group to others:					
◆ The instructor presented and used the materials effectively:					
Jaclyn	1	2	3	4	5
Paula	1	2	3	4	5
◆ The presenters incorporated time for input & questions:					
◆ I am satisfied with this program:					

Given the topics, was this program: Too short Right length Too long

Please rate the following:

	Excellent	Very Good	Good	Fair	Poor
Visuals	<input type="checkbox"/>				
Acoustic	<input type="checkbox"/>				
Meeting room	<input type="checkbox"/>				
Handouts	<input type="checkbox"/>				
The program overall	<input type="checkbox"/>				

What was the most valuable information you learned throughout the program?

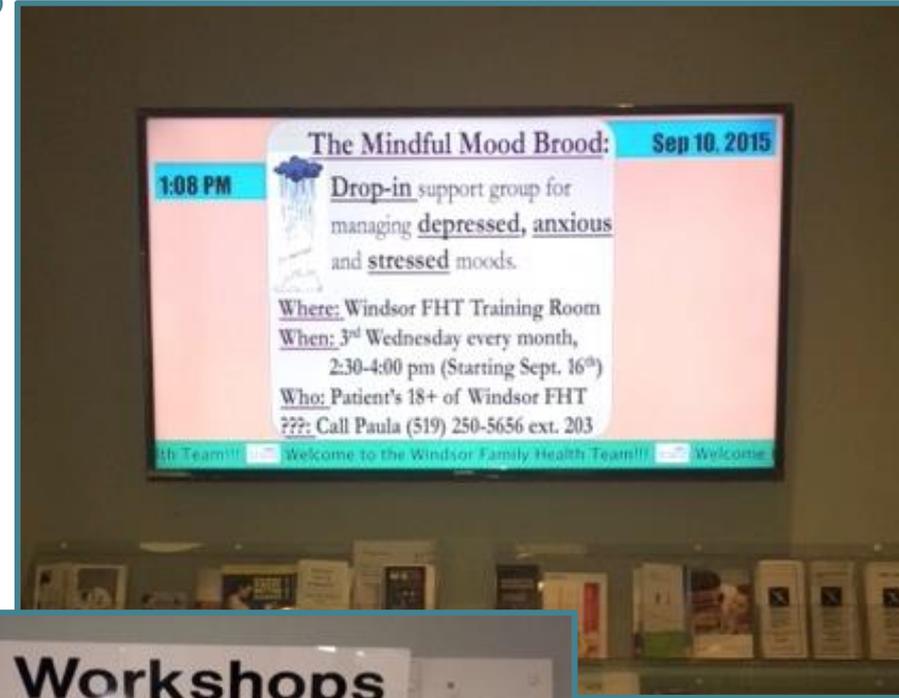
Do you have any suggestions for program changes? Time? Number of presentations?

Comments:



8. Promote: How do we promote our programs?

- Website
- Flyers
- Waiting room TV's
- Partner's offices
- Exam room screensavers
- Team meeting updates



COOKING ON A BUDGET

Monday September 21, 2015

6:00 - 7:30 p.m.

Place: Nana's Bakery

2936 Dominion Blvd, Windsor

Presentation by:

*Doug Romanek, Owner Nana's Bakery &
Chris Wellington, RD, MS, Bsc Windsor FHT*

With some planning and preparation, you and your family can enjoy great tasting, healthy food on a budget. Come and learn new recipes for meal preparation and how to create exciting "leftover" meals.

To Register: Call Chris at the Windsor FHT

519-250-5656 x206



9. Implement: Time to run our programs and services

ready. set. go!

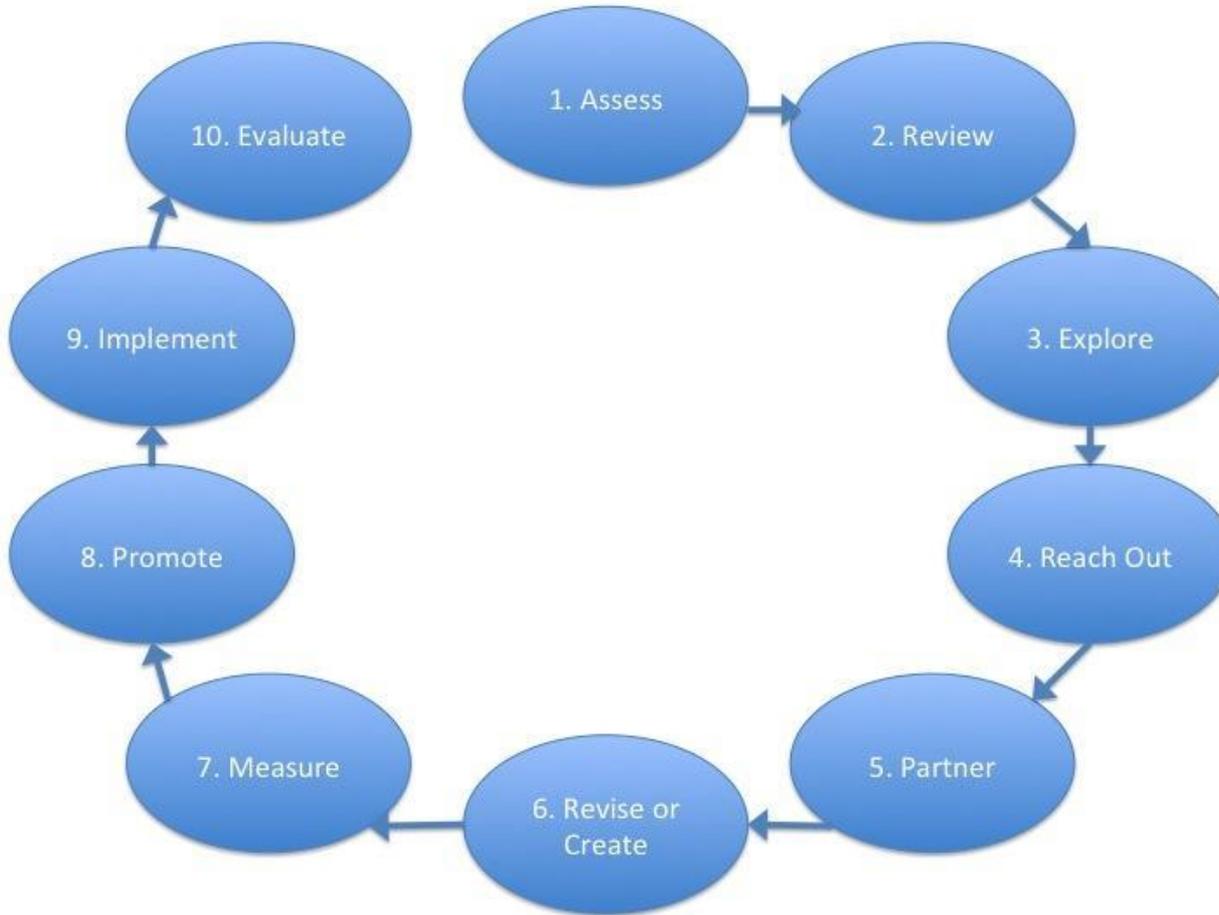


10. Evaluate: How did we do?

- Hand out the evaluations
- Track the results



Repeat the process again next year.



Positive Outcomes for Windsor FHT Patients:

2014/ 2015:

- 17 programs and services
- Reached over 7000 people
- 78% of patients said our programs and services helped improve their health and wellbeing



Positive Outcomes for Windsor FHT Patients:

2015/ 2016:

- 21 programs and services
- 10 community partners
- Hoping to exceed 7000 served



2015- 2016 WFHT Health Promotion Services

- **Arthritis Workshop**
- **Fibromyalgia Workshop**
- **Healthy Eating and Exercise for Weight Management**
- **Cooking on A Budget Workshop**
- **Women's Health Workshop**
- **Gender Journeys**
- **IBS Workshop**
- **Diabetes Supermarket tour**
- **Stress Reduction and Management Workshop**
- **Healthy Heart - Don't Let Life Break Your Heart Workshop**
- **Depression Workshop**

Heart Supermarket Tour

2015-2016 WFHT Health Promotion Programs

- **Hypertension Management Program**
- **Depression Program**
- **Smoking Cessation Program**
- **Arthritis and Fibromyalgia Program**
- **Asthma/ COPD Program**

Positive Outcomes for Windsor FHT Patients:

9/10 chronic diseases at the WFHT have trended downwards in the past year



Patient's perception of their own health has been improving.



TOP 10 CHRONIC DISEASE/HEALTH STATUS STATISTICS WFHT VS ERIE-ST. CLAIR LHIN AND PROVINCE OF ONTARIO AS OF DECEMBER 2014

Disease/Health Status	Rank	# of Patients in 2014 (5722)	2014 % Clients	# of Patients in 2013 (5168)	2013 % Clients	Erie St. Clair LHIN 2013 %	WECHU & Health Profile Stats Canada Dec 2013	Ontario % (2013)	Canada Stats % (2013)
Mental Health	1	1364	23.8%↓	1356	26.2%	N/A	N/A	10.1%	N/A
Overweight/ Obesity	2	1150	20.1%↓	1156	22.4%	57.3%	56.7%	52.6%	52.3%
Hypertension	3	995	17.4%↓	931	18.0%	20.6%	19.3%	17.4%	17.5%
Gastric (GERD, IBS, Fatty Liver, enteritis, UC)	4	749	13.1%↓	730	14.1%	N/A	N/A	N/A	N/A
Arthritis/Fibro	5	689	12.0%↓	691	13.4%	20.8%	18.3%	17.2%	16.2%
Diabetes/ Impaired Fasting Glucose	6	535	9.3%↓	510	9.9%	9.3%	9.7%	6.9%	6.3%
Asthma	7	406	7.1%↓	410	7.9%	6.7%	6.1%	8.4%	8.3%
Cardiovascular Disease	8	375	6.55%↑	291	5.6%	5.2%	N/A	4.9%	N/A
Osteopenia/ Osteoporosis	9	283	5.0%↓	278	5.4%	N/A	N/A	N/A	N/A
COPD	10	187	3.27%↓	184	3.6%	5.8	5.5%	4.2	4.1%

Windsor FHT

MACRO Umbrella Perspective

*Big picture to population health
planning approach*

Summerville

FHT

MICRO

Perspective

*Targeted
planning &
interventions*

POPULATION HEALTH PLANNING AT SUMMERVILLE FHT





CHRONIC DISEASE MANAGEMENT COMMITTEE

Chair & Co-Chair

Executive Director

3-4 Physicians

Dietitian

Pharmacist

Social Worker

Health Promoter

Nurse Practitioner

Child Psychologist

Aim: representation from all Sites and Disciplines

STRATEGIC POPULATION HEALTH PLANNING TOOL

Hypertension
Smoking
Mental Health
Diabetes
Obesity
Dyslipidemia
Osteoarthritis
Osteoporosis
Asthma
COPD



PREVALENCE OF CONDITION

HEALTH CARE PROVIDERS' PERSPECTIVE

COMPLEXITY OF CARE

PROBABLE IMPACT OF A PROGRAM/INTERVENTION

EXISTING RESOURCES

IDENTIFIED GAPS

MINISTRY FEEDBACK & DIRECTION

PATIENT FEEDBACK

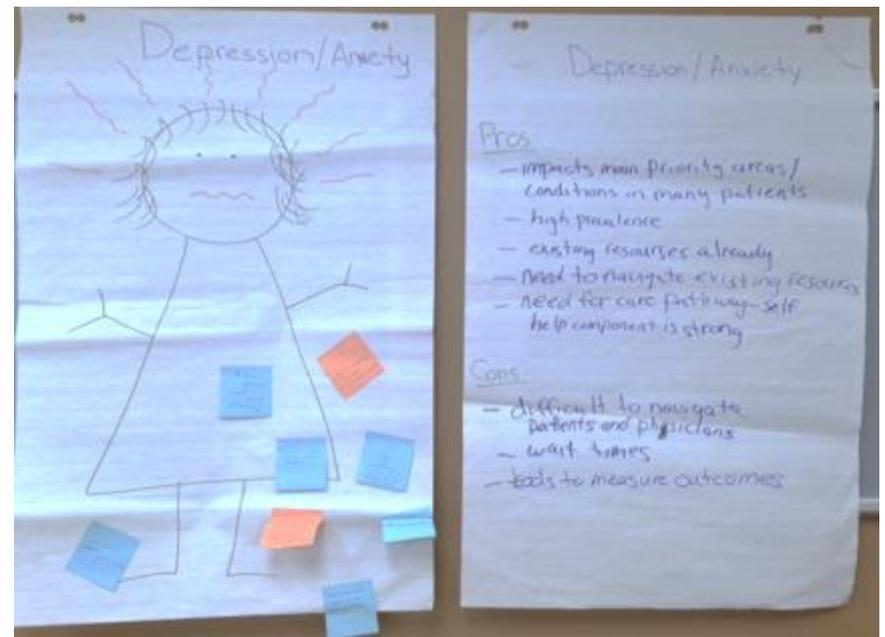
POPULATION HEALTH PLANNING TOOL

Framework to Inform Decision Making of Top CDMC Priorities – 2013

Completed by CDMC Working Group, January 2013

	Hypertension	Smoking	Mental Health	Diabetes	Obesity	Dyslipidemia	Osteoarthritis	Osteoporosis	Asthma	COPD (COPD, Chronic Bronchitis, Emphysema)
A. PREVALENCE OF CONDITION at SFHT¹	15.2% of roster, 7392 patients	10.2% of roster 4920 patients	9.1% of roster 4427 patients	6.9% of roster, 3326 patients	4.2% of roster*, 3125 patients *Likely under-reported	13.4% of roster, 6484 patients	7.0% of roster 3377 patients	6.4% of roster, 3125 patients	5.8% of roster 2822 patients	0.3% of Roster* 171 patients *Likely under-reported. Note: Prevalence of Smoking is 10%.
B. HEALTH CARE PROVIDER'S PERSPECTIVE (Expertise, Experience, Interest)	-Ranked 1 st in priority by SFHT Providers (2012) ² - 'Cardiovascular' Ranked 11 th by SFHT providers (2010) ³	-Ranked 4 th in priority by SFHT Providers (2012) ² -Ranked 4 th by SFHT providers (2010) ³	- Ranked 2 nd in priority by SFHT Providers (2012) ² - Ranked 1 st by SFHT providers (2010) ³	- Ranked 3 rd in priority by SFHT Providers (2012) ² - Ranked 7 th by SFHT providers (2010) ³	- Ranked 5 th in priority by SFHT Providers (2012) ² - Ranked 2 nd by SFHT providers (2010) ³	- Ranked 5 th in priority by SFHT Providers (2012) ² - 'Cardiovascular' Ranked 11 th by SFHT providers (2010) ³	- Ranked 6 th in priority by SFHT Providers (2012) ² -Ranked 5 th by SFHT providers (2010) ³	- Ranked 7 th in priority by SFHT Providers (2012) ²	- Ranked 7 th in priority by SFHT Providers (2012) ² - Ranked 8 th sby SFHT providers (2010) ³	- Ranked 8 th by SFHT providers (2010) ³
C. COMPLEXITY OF CARE for patients and providers: Low, Moderate, High	<i>Moderate</i> -Routine medical management with some complex cases. Large self-management component – need education to motivate -Co-morbidities -Lifestyle medically relevant and is a large component	<i>Moderate</i> - Patients' motivation very important - Supportive resources & follow-up very important - Annually recurring management: Ask, Advise, Assist, etc.	<i>High</i> -Lots of support needed – follow-up -Revolving management -Time & resource intensive -Lots connections to resources needed (both internal & external)	<i>High</i> -High burden of illness -Self-management very important -Requires significant number and wide scope of providers	<i>High</i> - High burden of illness - Social support important component - Chronic and extensive follow-up required	<i>Low</i> -Routine medical management -Education on lifestyle -Could be managed with a medical directive	<i>Low to Moderate</i> -High burden of illness -Requires outside referrals to specialists -Resource intensive for complex cases -Significant co-morbidities	<i>Low</i> -Prevention & education is very important -Could be managed by protocol -Majority of cases are routine -Complex cases need more in depth	<i>Moderate or High</i> -Action plan and self management is important -Children & parents involved in care -Condition may be labile -Prevention/ Education important	<i>Moderate</i> - Screening important - Treatment may be dealt with at hospital post-exacerbations - Further proper diagnosis required
D. PROBABLE IMPACT of a program on health outcomes	High	High	High	High	Low	Moderate	Moderate	Low	Low-Moderate	Low-Moderate

	Hypertension	Smoking	Mental Health	Diabetes	Obesity	Dyslipidemia	Osteoarthritis	Osteoporosis	Asthma	COPD (COPD, Chronic Bronchitis, Emphysema)
E. EXISTING RESOURCES: 1) Summerville *All conditions currently managed individually by Physicians and NPs. Site-specific programs are based on best available information 2) Within the Community	1) Heart Smart Program for education & self-management <i>Central:</i> Hypertension Management Program in Development : HSF Hypertension Management Program 2) Referrals are available for complex cases.	1) CAMH STOP with FHTs program: Group & 1:1 program for Smoking Cessation 2) Limited ⁴ . Smokers' Helpline-Telephone and Online support. William-Osler Health Centre "Kick It" program.	1)4.0 FTE Social Workers, 1.0 FTE Child Psychologist, 0.2 FTE Psychiatrist Programs: Manage Your Mood, Craving Change Program, Maximize, Your Health, Between Parent & Child, Teen Anxiety Group. 2) Trillium/Credit Valley Outpatient Groups, Telemental Health, Tangerine Walk-In for Children & Families ⁷	1) Variable coordinated programs at 3 sites. <i>Apple Hills:</i> Individual appointments with RN for education. <i>Etobicoke:</i> Group Visits <i>FMTU (2 rosters):</i> Round Robin Visits 2)Programs available in the community such as DMC and private clinics (for complex or routine DM management depending on provider)	1) Individual appointments with Physicians & Dietitians. Craving Change program (if related to emotional eating) 2) Many private programs Eg. Weight Watchers, Jenny Craig, Goodlife Fitness, etc.	1) Heart Smart Program for education & self-management <i>Central:</i> Hypertension Management Program in Development <i>Dr. Martin Kates:</i> HSF Hypertension Management Program 2) Referrals are available for complex cases.	1) Arthritis Program 2) The Arthritis Society for assessment, education and self-management	1) None 2) Falls prevention, CCAC, Seniors Centers, 'Break Through' education program potentially offered at the YMCA	1) None 2) Trillium Hospital PRIISME Program by GSK	1) None 2) Trillium Hospital PRIISME Program by GSK
F. IDENTIFIED GAPS IN RESOURCES: 1) At Summerville 2) Within the Community	1)No coordinated screening, clinical management and planned care of Hypertension 2) No organized referral programs available for routine patients. No education or self-management resources.	1) No coordinated identification/ screening program. 2)Limited Smoking Cessation resources in Mississauga, especially, ongoing, in-person support. ⁴ Peel Public Health Smoking Cessation strategies: currently in development.	1) Increased access and availability of Psychiatrist needed. Lack of ability (time) to MH Treatment groups (need a designated person). ⁷ 2) Psychiatry – more access needed. MDs perspective: more timely access to appropriate care needed. And, wait list for community health services (children and adult). ⁷	1) Coordinated/ planned Diabetes Management Programs is not at all 5 sites 2) None	1) No existing, long-term partnerships with community organizations. No group weight management program 2)No free or low-cost, individualized weight management programs	1) No coordinated screening, clinical management and planned care of Dyslipidemia 2) No organized referral programs available for routine patients. No education or self-management resources	1) More access to injections and procedural work 2) None	1) No education program, no organized recall program 2) No education program available	1) Building routine follow-up care organized with Trillium 2) None	1) Coordinated Screening & Diagnosis of COPD 2) None
G. MINISTRY FEEDBACK & DIRECTION	55% of FHTs delivering Hypertension programs ⁵	70% of FHTs delivering Smoking Cessation programs ⁵	62% of FHTs delivering Mental Health programs ⁵	- 80% of FHTs delivering Diabetes programs ⁵ - 2012 Feedback from Ministry to Summerville: Do you have Diabetes programs?	Not available	Not available	Not available	Not available	40% of FHTs delivering COPD programs ⁵	50% of FHTs delivering COPD programs ⁵
H. PATIENT FEEDBACK	n/a	n/a	Patients ranked 'Stress Management' 3 rd & 'Anxiety' 4 th based on interest of programs ⁶	n/a	Patients ranked 'Weight Management' 2 nd based on interest of programs ⁶	n/a	n/a	n/a	n/a	n/a



Top Priorities:

1st - Hypertension

2nd - Mental health

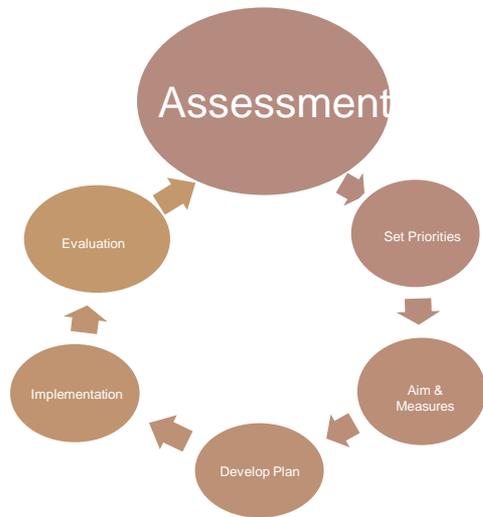
3rd - Smoking cessation

4th - Diabetes

5th - Obesity

Population health planning PROCESS:



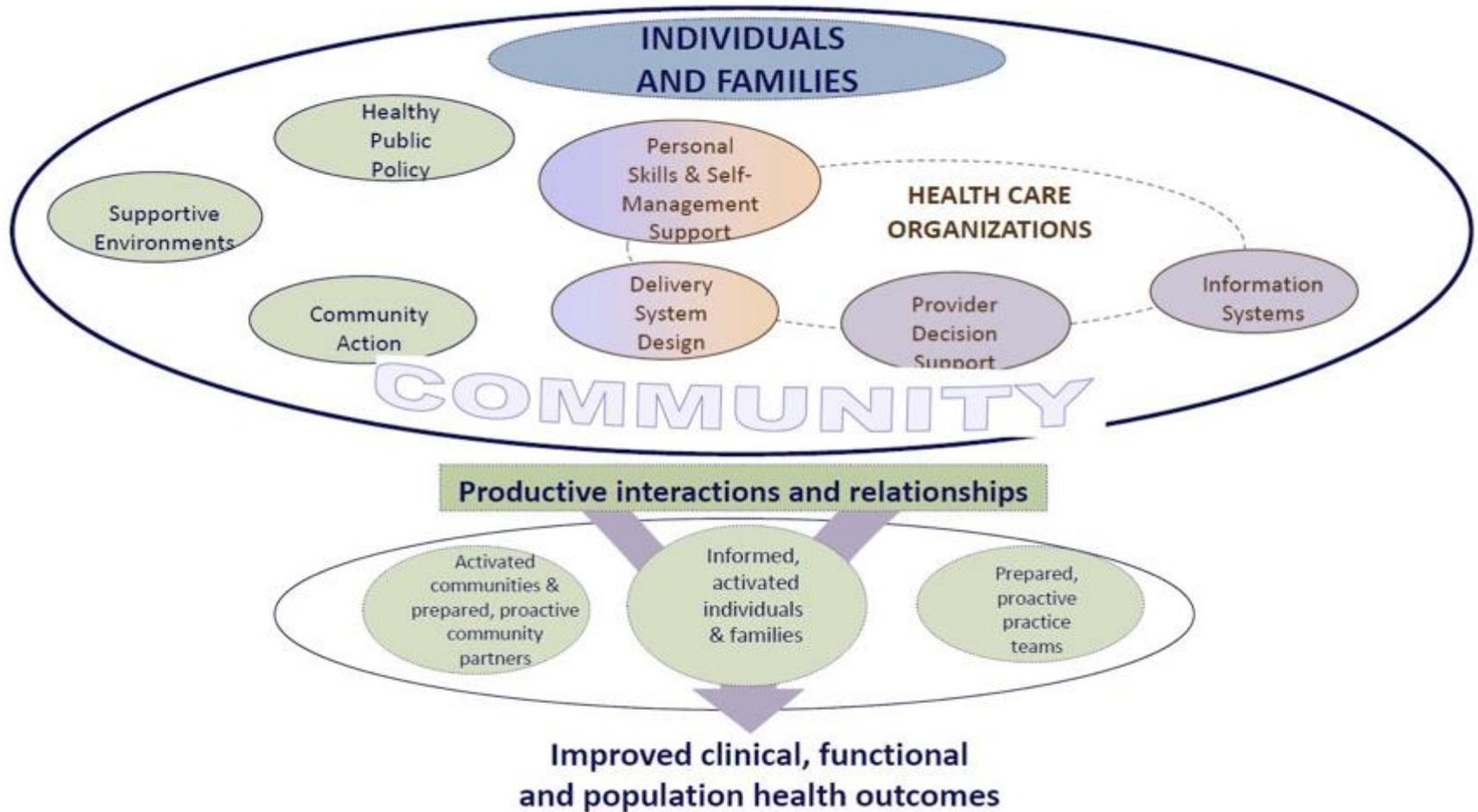


What are the opportunities to improve care and management of **hypertension?** **depression/anxiety?**

- Review:
 - Literature & Best Practices
 - Initiatives in other FHTs
 - Current practice, existing resources & gaps
- Gather feedback from Providers & Patients

Initiatives based on:

Ontario's CDPM Framework





HYPERTENSION

AIM:

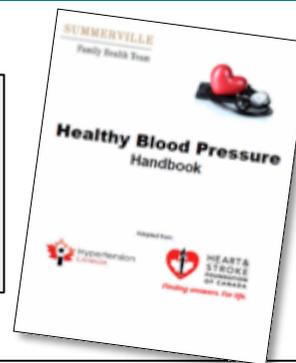
**PATIENT
EDUCATION &
SELF-
MANAGEMENT**

**TEAM-BASED
HYPERTENSION
CARE**

**PROTOCOLS
FOR
MANAGEMENT**

INITIATIVE:

**Healthy Blood
Pressure
Handbook
Adopted from CHEP**



**SFHT QIP Plan 2014-15
Population Health Measure: BP
Screening**

% of Adults \geq 40years with an office visit, and BP screening, in the past 2 years.

**Team-based RN Hypertension Visits at
Central location**

**Summerville 'Hypertension Algorithm +
Combination Pills' information added to EMR**

OUTCOMES:

750 Handbooks
given to patients, so
far

380 MORE Adults \geq
40yrs with an office visit
and BP check

112 Initials, **300** Encounters

Mean 13mmHg reduction in
SBP, and 7mmHg DBP
(n=89)

Positive Feedback from
Providers



Mental health

MENTAL HEALTH & WELLBEING SURVEY

1 in 5 people in Canada lives with a mental illness each year

SUMMERVILLE

Family Health Team

How can we help you prevent or manage stress, depression and/or anxiety?

Please take a moment to complete this questionnaire, your input is very important to us.

1. Have you experienced, or has your doctor said that you struggle with symptoms of stress, depression and/or anxiety for more than 2 weeks at a time, in the past year? YES NO

2. A) Have you used any of the following programs and services at Summerville? (check all that apply)

Services:

Programs:

- | | | |
|---|--|---|
| <input type="checkbox"/> Social Worker | <input type="checkbox"/> Manage Your Mood (for depression) | <input type="checkbox"/> Prefer not to say |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Craving Change | <input type="checkbox"/> Did not know they are available |
| <input type="checkbox"/> Child Psychologist | <input type="checkbox"/> Maximize Your Health | <input type="checkbox"/> No, but a family member has |
| | <input type="checkbox"/> STOP Program | <input type="checkbox"/> No, I do not feel that I need it |
| | <input type="checkbox"/> Child Psychology Programs | <input type="checkbox"/> No, I do not feel comfortable |

B) Are these programs and services *meeting your needs* for mental health & wellbeing?

- YES NO (please explain): _____

3. In addition to the programs & services that we already offer (listed above), what other Mental Wellness topics would you be interested in? Circle your TOP 3:

- | | | |
|---------------------------------------|----------------------|-------------------|
| Mindfulness | General Anxiety | Panic Attacks |
| Sleep Problems | Social Anxiety | Stress Management |
| Mental Strategies for Pain Management | Other (Pls specify): | |

4. A) Here at Summerville, and in the community in general, do any of the following keep you from using mental health programs and services? (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Cost | <input type="checkbox"/> Do not feel comfortable talking about my concerns |
| <input type="checkbox"/> Lack of transportation | <input type="checkbox"/> Worried that I will be judged |
| <input type="checkbox"/> Long waiting lists | <input type="checkbox"/> Do not know what's available in the community |
| <input type="checkbox"/> It won't help my concerns | <input type="checkbox"/> Do not feel comfortable in group programs |
| <input type="checkbox"/> No barriers | <input type="checkbox"/> My physical health symptoms (e.g. pain, lack of mobility, etc.) |
| <input type="checkbox"/> Other (please specify): | <input type="checkbox"/> My mental health symptoms (e.g. depression, lack of motivation) |

B) What can we do to help address these barriers?

5. What is the most important thing we could do to improve care and services offered at Summerville for stress, depression and/or anxiety?



Mental health

AIM:

↑ **KNOWLEDGE OF
COMMUNITY
RESOURCES**

INITIATIVE:

Resources added to EMR & Website:

- CMHA 'Quick Guide' for Peel & Toronto
- www.mississaugahaltonhealthline.ca
- www.torontocentralhealthline.ca
- Recommended MH *Treatment Programs*
- Recommended MH *Self-Management Resources*

Topics:

- Abuse
- Addictions
- Anger Management
- Anxiety
- Anxiety – Child/Teen
- Bullying – Child/Teen
- Depression
- Disordered Eating
- Distress Lines
- Childhood Behavioural Difficulties
- Family & Individual Counselling
- Grief & Bereavement
- Housing & Employment
- Mindfulness
- Mindfulness – Child/Teen
- Personality Features
- Relationships
- Self-Esteem
- Sleep Problems

OUTCOMES:

95% of respondents (n=37) said these resources:

“will help increase my knowledge of community resources”

“will be useful in my practice”





Mental health

AIM:

MORE GROUP PROGRAMS

ACCESS & TIMELY FOLLOW-UP

INITIATIVES:

New Group Programs:
 Stress Management 101
 General Anxiety Group
 MindGirl

Coming Soon:
 Mindfulness
 Sleep/Insomnia

SFHT QIP 2015-16 - Population Health Measure

% of people who recently started an anti-depressant, and had an office visit in the past 6 months

CAMH PARTNERs Project:

Telephone-based follow-up for people with depression, anxiety, or problematic drinking

Multi-Disciplinary Case Consultations with a consulting Psychiatrist

OUTCOMES:

Stress 101:
 Mean improvement of symptoms from moderate to mild on the Perceived Stress Scale and the DASS-Stress Scale (n=20).

3-year Randomized Control Trial (tbd)

↑ Capacity of Team
 Timely feedback
 Integrated Care Plans (tbd)



MENTAL HEALTH

AIM:

**REDUCE STIGMA
RELATED TO
MENTAL HEALTH**

INITIATIVES:



Waiting Room Campaign
"What does Mental Health mean to YOU?"

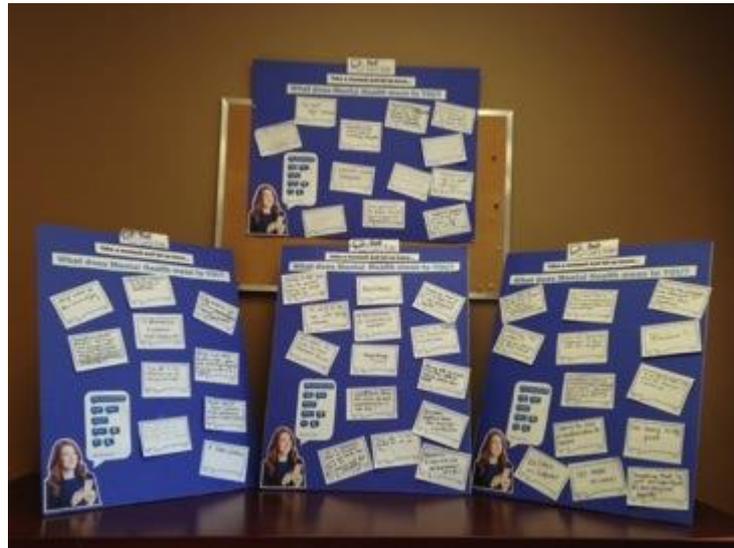
OUTCOMES:

**43 Responses from
both patients &
providers**

Something that is just as
important as our physical
health!

**Compassion without
Judgement**

*We need to get passed the
fear & stigma, so that we can
do the things we need to do
to get to mental wellness.*



**An illness that is often
misunderstood and under-
funded with long wait lists.**

**Being able to face
difficulties and ask when
you need help :)**

Everything

KEY TAKE HOME MESSAGES FROM:



SUMMERVILLE

Family Health Team

KEY TAKE HOME MESSAGES:

1. Do your research
2. You can't do it alone
3. Bring the people into the picture
4. There's value in completing the planning cycle
5. One size doesn't *FHT* all

QUESTIONS?



THANK YOU!

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