The MedREACH Program

Medical Rapid Education and Assessment for Complete Health

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Presenter Disclosure

- Laurel Cooke
  - None

- Dr. Henry Siu
  - None

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Acknowledgements

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Outline

1) Program Description

1) Program Development

2) Program Evaluation and Results

3) Conclusions and Lessons Learned

4) Questions

Medically Complex Patients (MCPs) and MedREACH

Five per cent of Ontario's population, use two-thirds of the health care budget.

The Need

- In 2012, MOHLTC estimates that MCPs represent up to 5% of Ontario's population, but use two-thirds of the health care budget
- MCPs include seniors, those with multiple chronic diseases and those with mental illness and addictions

The Literature

- MCPs benefit most from coordinated, community-based, interdisciplinary care that involves both primary and tertiary care[1]

The Response

- Current MOHLTC initiatives include Health Links, and demonstration funding for Medically Complex Patient pilot projects, such as MedREACH

1. Bayliss, Ellis and Steiner, 2007 and Ruger, Richter and Spitznagel et al., 2004

Partners

Hamilton Health Sciences

Hamilton Family Health Team

Better care, together.

McMaster University HEALTH SCIENCES

Department of Family Medicine

McMaster Family Health Team

The MedREACH Project

- Collaborative initiative between the 3 partners
- Integration at both the management and the service delivery level
- MedREACH encompasses enhanced case management augmented by timely and integrated access to diagnostics as well as specialist care
- A graduated roll-out program strategy was employed

The MedREACH project involves 3 arms:

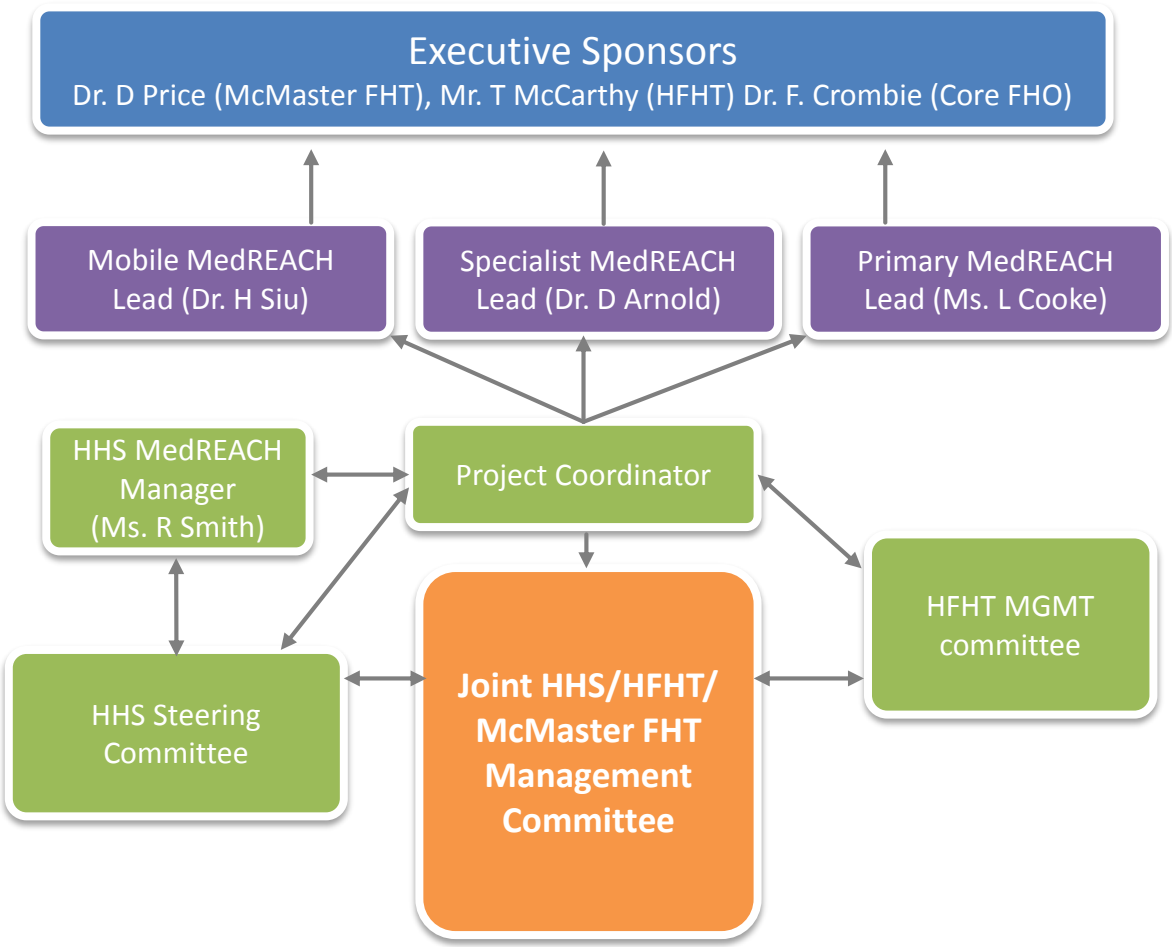
1. Primary MedREACH (Nursing Outreach)
2. Specialist MedREACH Clinic
3. Mobile MedREACH (Specialist Outreach)

Shared Care: Breaking Down the Silos

- "Silos" - uncoordinated nature of different health care organizations serving the same patient/patient population
- Results in fragmented care, redundancies, and increased patient morbidity
- **All program components communicate with Primary Care, throughout the duration of a patient's time in MedREACH .**

MedREACH Governance Model

- The partners involved worked collaboratively within a joint management and governance model to develop program policies
- Each organization remains independent and is accountable for the services they provide



Primary MedREACH (Nursing Outreach)

- Led by the Hamilton Family Health Team
- Consisting of a Nurse Practitioner and Registered Nurse(s), this team has the flexibility to meet patients in their homes or in the family practice
- Aims to remove accessibility barriers for medically complex patient
- For each patient:
  - Clinical assessment
  - Medication reconciliation
  - Generate a collaborative and comprehensive patient-drive care plan
- Liaise with primary care team to formulate action plans to help a patient achieve their health goals and effective navigation of the patient through the current health care system.

Specialist MedREACH

- Led by Hamilton Health Sciences Corporation
- Addresses the issue of MCP wait times because of multiple appointments, clinicians and investigations
- Clinic coordinates access to specialists, allied health professionals and investigation modalities over a streamlined number of visits
- A patient-focused discharge process was instituted
  - MedREACH specialists communicate directly with the primary care team regarding their medically complex patients
- Ultimately aims to integrate and improve communication between primary and tertiary care

Mobile MedREACH (Specialist MedREACH)

- Led by McMaster Family Health Team
- Addresses access barriers to specialist physicians for those patients that can not travel to the hospital
- The Mobile MedREACH team serves these patients by travelling directly to the family practice offices and to the patient's home
- Collaborative home visits, real time charting in the patient's primary care chart, telephone access and face-to-face interactions with Mobile MedREACH specialists aims to broaden the capacity of primary to manage MCPs

MedREACH Innovation

Improving Access
- Nursing and Specialist home visits to isolated patients
- Integrated “one-stop shop” specialist clinic

Patient Centred
- Patients determine their goals and location for care
- Holistic care addressing the social determinants of health

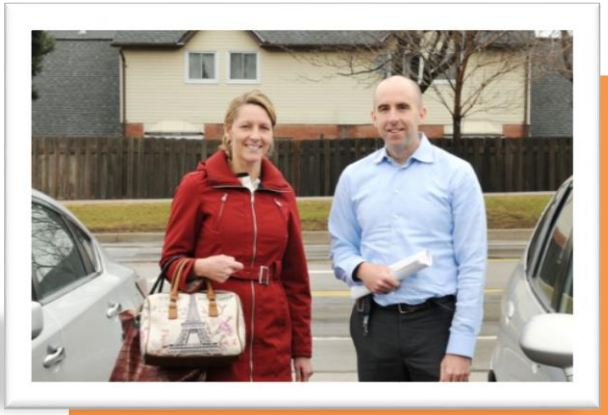
Shared Care
- Cross-referrals across project arms
- Primary-Tertiary care partnerships

MedREACH is available via the web (www.medreach.ca)
- Patient information and self-management strategies
- Physician information and referral form for Specialist MedREACH

Shared Care: Collaboration Across Agencies

Examples of integration in MedREACH include:

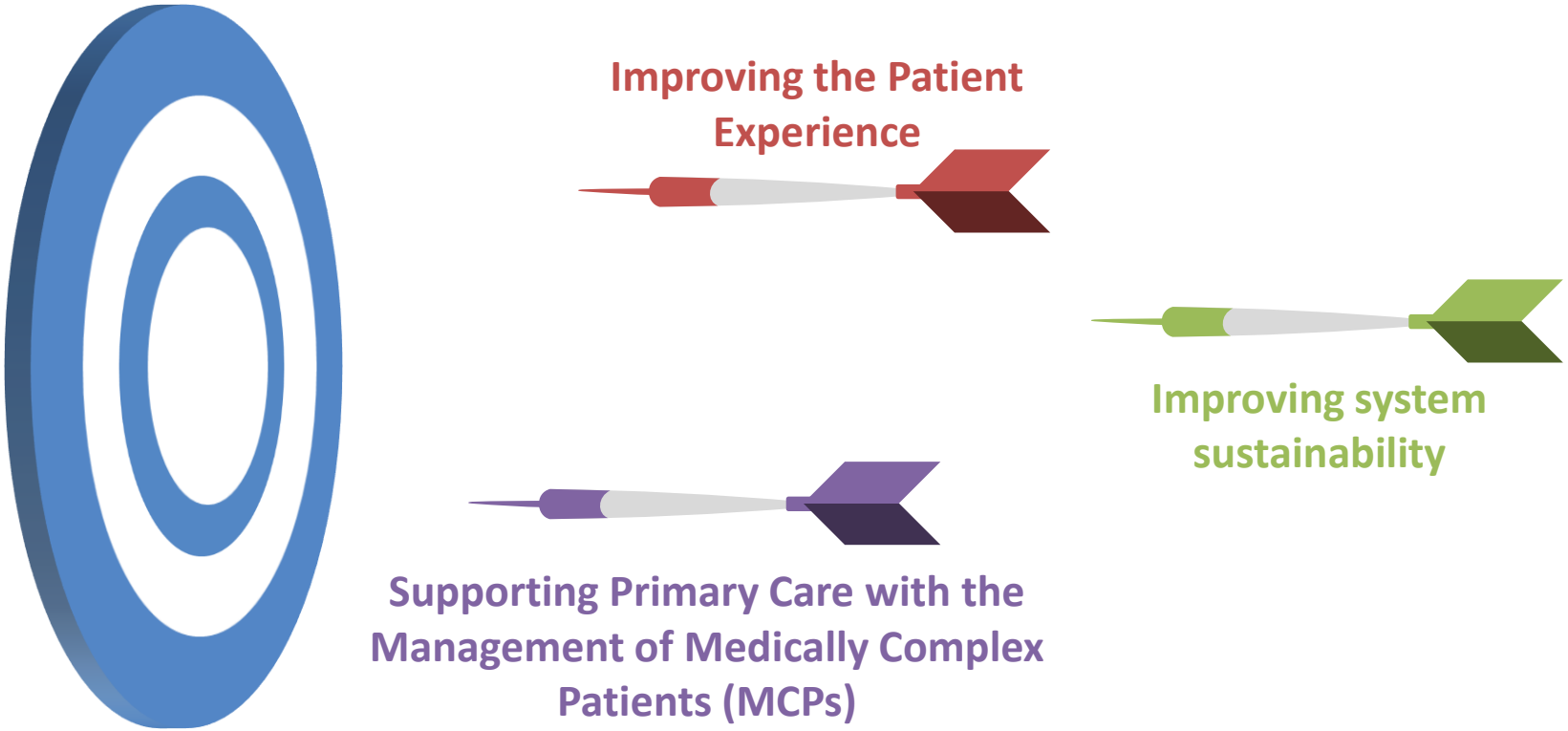
- Allied Health Staff at the Clinic ***(HHS)*** consulting with Outreach Nurses on joint patients ***(HFHT)***
- Mobile Specialists ***(McMaster FHT)*** partnering with the Outreach Nurses ***(HFHT)*** for home visits for those with serious barriers to access
- Specialists from the MedREACH clinic ***(HHS)*** consulting with GPs within the participating FHTs ***(HFHT*** & ***McMaster FHT)***



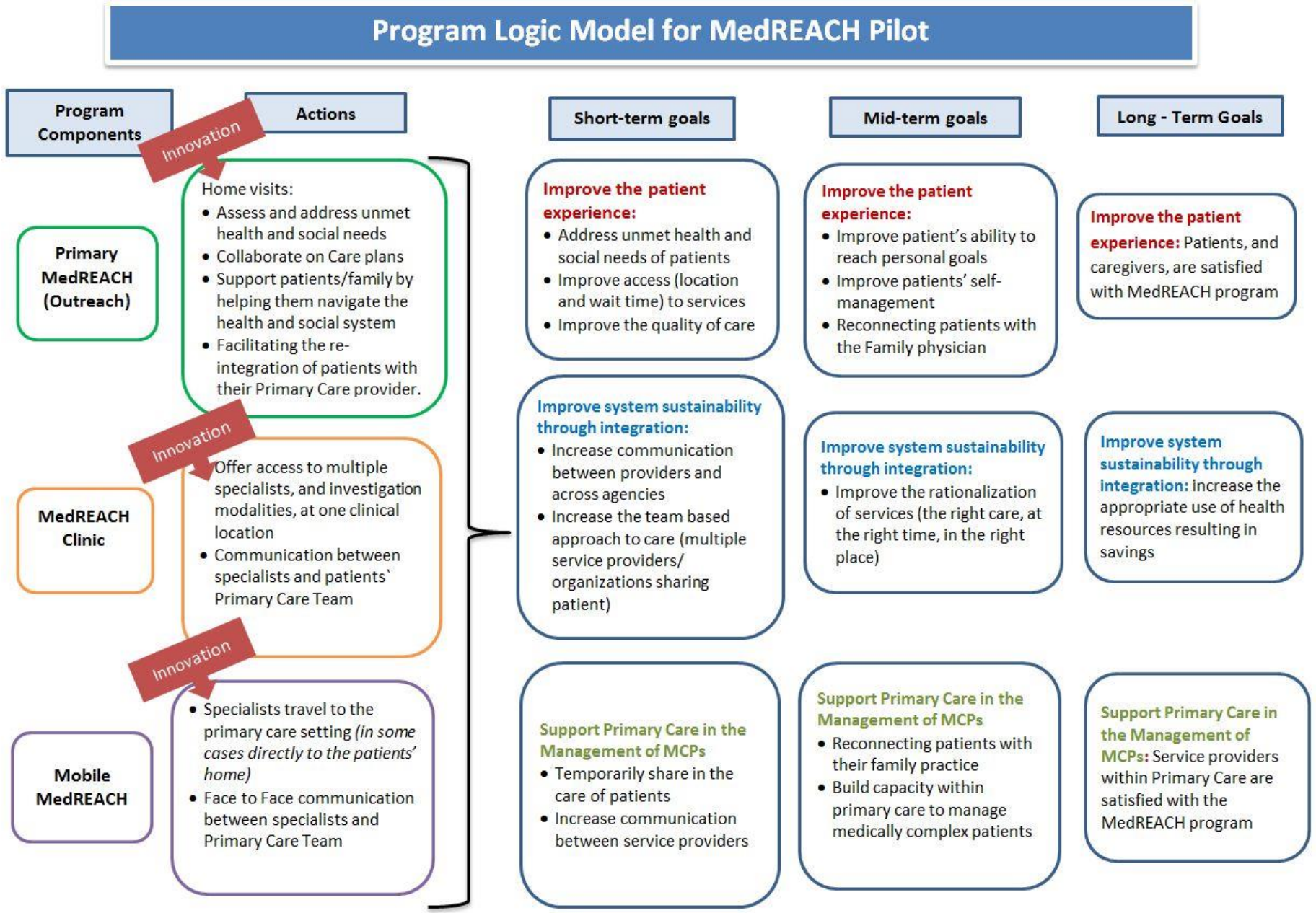
MedREACH patients can move between branches of the program based on the severity of their condition or their barriers to access.

MedREACH Program Objectives

There are three primary objectives of the MedREACH program.



MedREACH Program Logic Model



Evaluation Methodology

- The PLM informed the evaluation design
  - Logic models diagrammatically show the connections between a programs activities to it's anticipated outcomes

- Evaluation Design:
  - Process Measures – Chart reviews, Referral form audits
  - Patient Outcome Measures – Patient satisfaction surveys, GAS-Light
  - Provider Outcome Measures – Physician satisfaction surveys, Service provider satisfaction survey

- Each survey question was directly linked to an activity or objective from our PLM

MedREACH Process Outcome Measures

	Primary MedREACH	Specialist MedREACH	Mobile MedREACH
Total patients discharged	75	76	28 (18 Home visits, 10 on-site visits)
Average clinical visit/patient	3	1.63	1.2
Average time (weeks) from first assessment to discharge	10.7	2.3	0.93
Average time (min) for initial assessment	75 (including travel time)	Variable	60 (90 min including travel time for home visits)
Average time (min) for follow-up assessments	45 (including travel time)	Variable	30 (60 min including travel time for home visits)
Average time spent liaising with Primary Care	1 hr/week for all patients enrolled (telephone conversations/joint home visits)	Variable (telephone conversations)	Variable (face-to-face conversations/telephone conversations/point-of-care EMR charting)

Those We Surveyed

Patients

- N = 48 (out of 179 patients discharged) completed a telephone survey
- Patients were asked a series of questions related to quality of care, location of care, patient enablement, and ways to improve the program

Physicians

(Family Physicians and Specialists)

- N = 13 physicians completed the MedREACH survey (10 family physicians, 3 specialists)
- Physicians were asked a series of questions related to satisfaction with primary care support, patient care, communication and integration

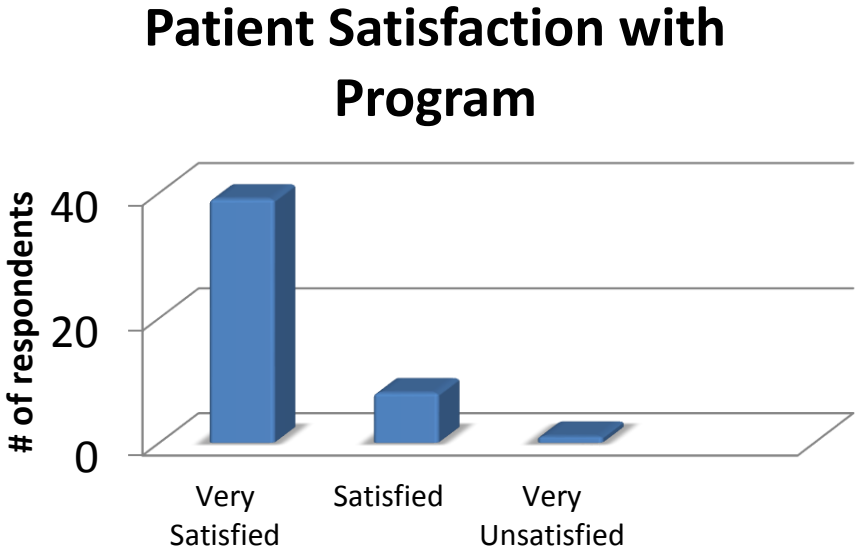
Service Providers

(Nurses, and Allied Health Professionals)

- N = 9 MedREACH service providers completed the survey
- Survey contained questions related to coordination, patients' use of hospital services and general satisfaction and recommendations for improvements

Evaluation Highlights:

Improving the Patient Experience



More than **97%** of patients surveyed said they were satisfied or very satisfied with the care they received in the MedREACH Program.

Other patient findings include:

- **98%** of patients surveys said they were satisfied or very satisfied with the location of the care they received
- **98%** of patients surveyed said they were satisfied or very satisfied with the amount of time the MedREACH care providers spent with them
- **79%** of patients surveys said their involvement in the MedREACH program made their experience with medical care better or much better.

Evaluation Highlights:

Improving the Patient Experience

- **MedREACH Clinic**
  - Positive attitudes of the team (23 respondent references)
  - Finding out what's wrong with medically and dealing with it (15)
  - All in one day with little wait time (8)
  - Personalized care (8)
  - The modern clinic space (7)

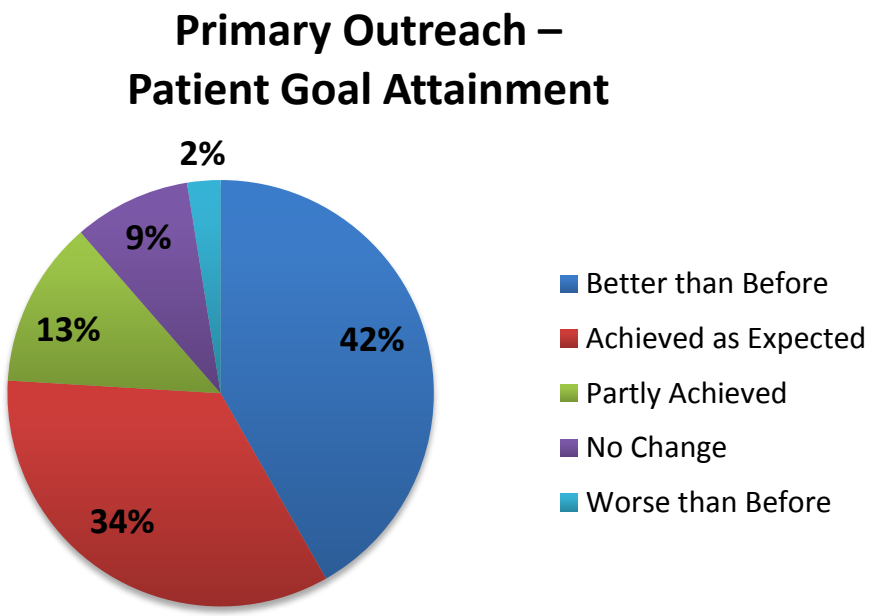
- **Primary (Nursing) Outreach**
  - The nurses and their positive attitudes (16)
  - Being able to talk to someone about what matters to the patient (15)
  - Connections to specialists and community resources (7)

- **Mobile (Specialist) Outreach**
  - Positive qualities of the visiting specialist (8)

"I felt amazed at how they took their time, there was no rush. It was personal - they were actually concerned about me, something I have not seen in many years."
MedREACH Patient, 2015.

Evaluation Highlights:

Improving the Patient Experience



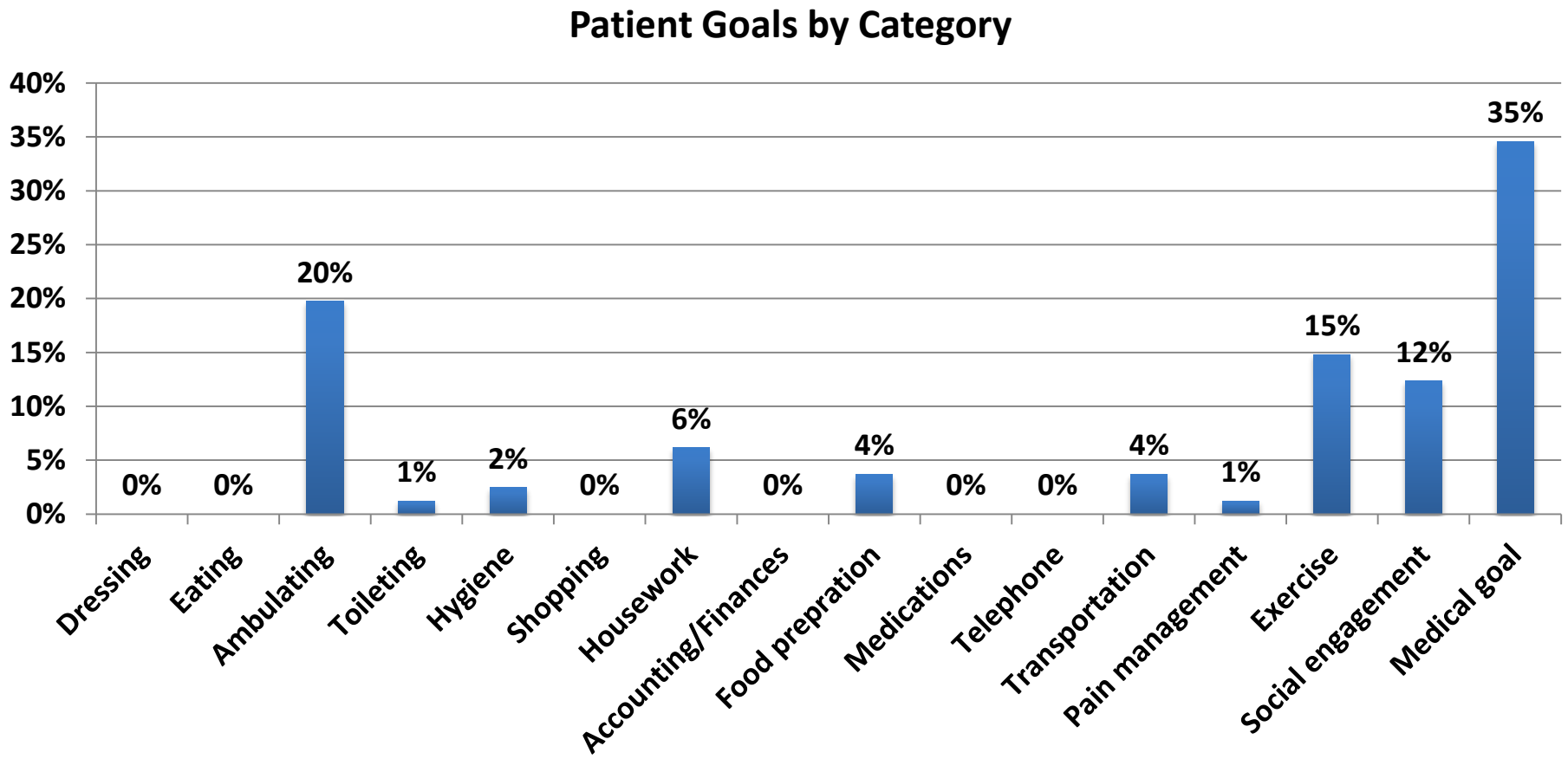
- **76%** of goals set were successfully achieved ***as expected or better than expected*** by patients involved with the Primary Outreach team
- A total of 79 goals, set by 28 patients, were assessed.

- The Primary (Nursing) Outreach team works collaboratively with the patient to develop personalized care plans
- **GAS-light version**[1] was administered to patients to help facilitate goal setting
- Patients were encouraged to set 2-3 **SMART goals** *(Specific, Measurable, Achievable, Realistic, Timely)*
- Follow-up with patients took place 2-3 months after initial encounter

1. Kiresuk, T., & Sherman, R. (1968). Goal attainment scaling: A general method for evaluating comprehensive community mental health programs. *Community Mental Health Journal,* 4, 443-452.

Evaluation Highlights:

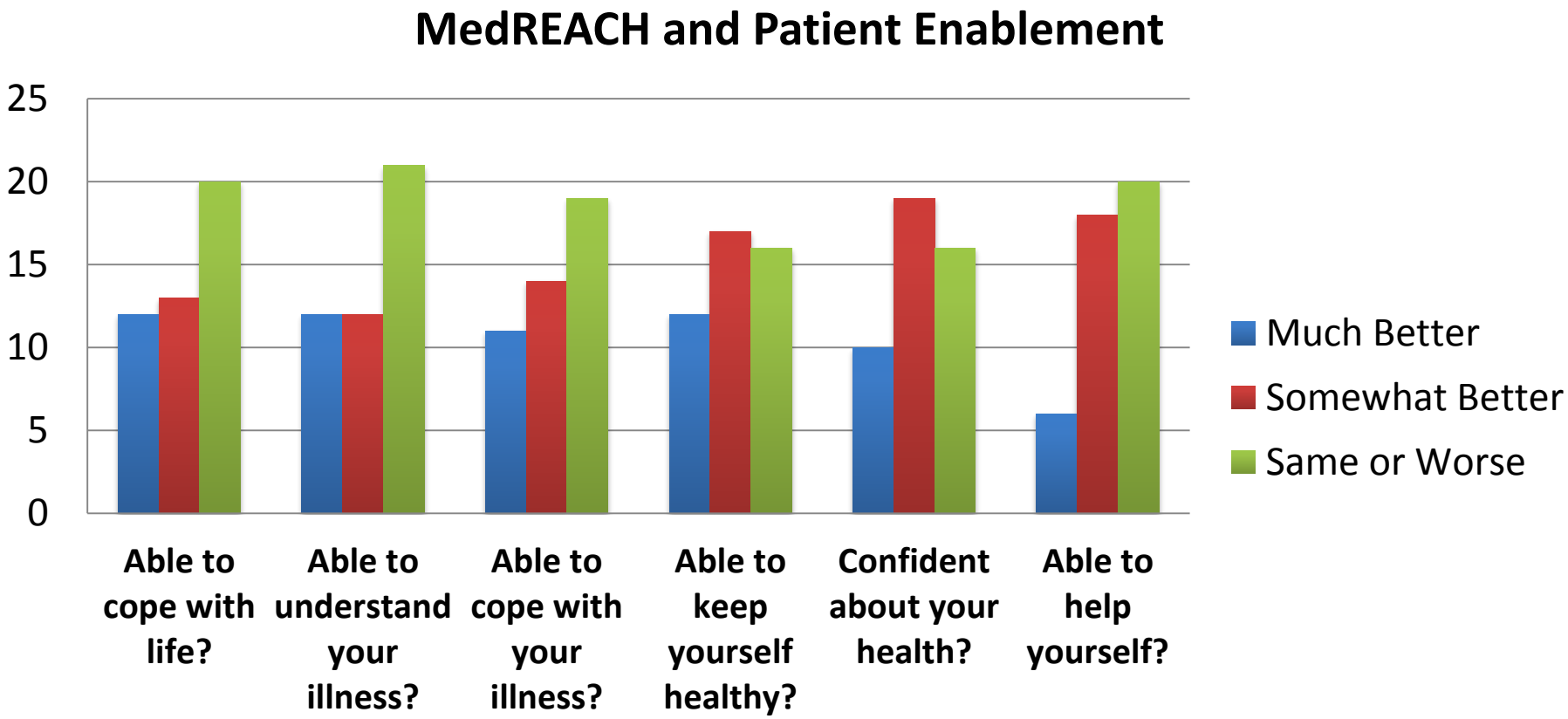
Improving the Patient Experience



- **23%** of all goals set related to improving activities of daily living (ADLs)
- The top 4 most frequently set goals included attaining a medical goal* (e.g. weight loss, routine follow-up with a certain doctor, smoking cessation), improving mobility/ambulation, increasing exercise and increasing social engagement

Evaluation Highlights:

Improving the Patient Experience

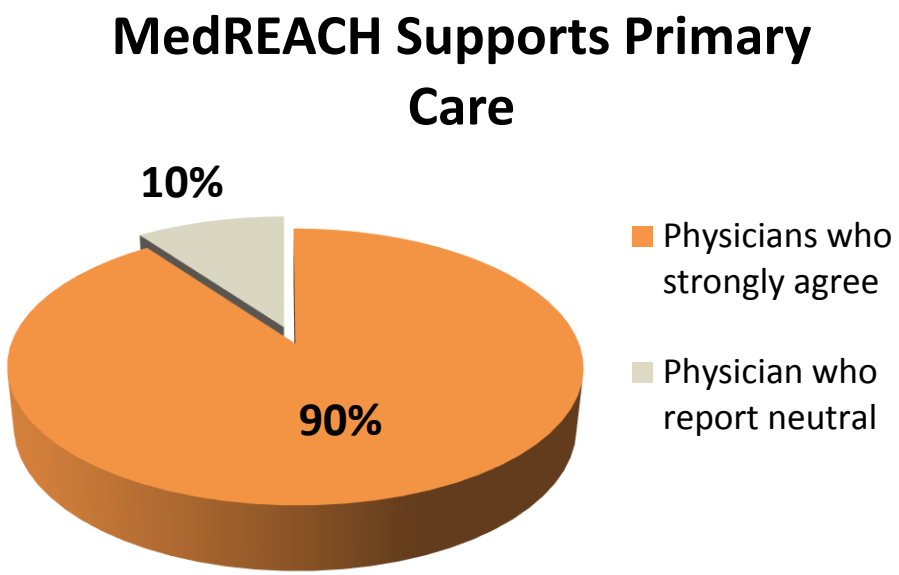


- Patient enablement index was embedded in our patient satisfaction survey[1]
- **> 50%** of respondents felt that MedREACH helped them be more confident about their health, to better keep themselves healthy and to better cope with their illness

1. Howie, J. G., Heaney, D. J., Maxwell, M, & Walker, J. J. (1998). A comparison of a Patient Enablement Instrument (PEI) against two established satisfaction scales as an outcome measure of primary care consultations. *Family Practice, 15*(2), 165-171

Evaluation Highlights:

Supporting Primary Care

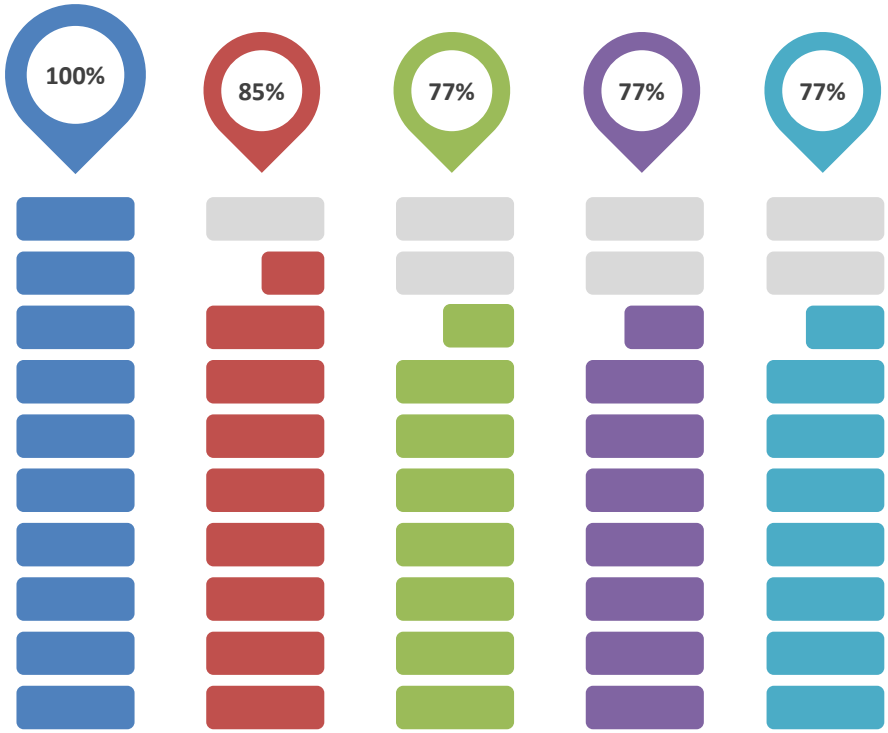


90% of family physicians surveyed said that the MedREACH project is a useful model for supporting family physicians in managing their medically complex patients in the community.

"Improved care and case coordination of some very complex and vulnerable patients - well beyond what I could otherwise provide."
Primary Care Physician regarding the MedREACH program, 2015

Evaluation Highlights:

Supporting Primary Care



100% of family physicians surveyed rated the quality of communication while their patients were receiving care in the program as good, very good, or excellent

85% of physicians surveyed said they were **VERY or SOMEWHAT satisfied** with the MedREACH process overall around the care of their patients

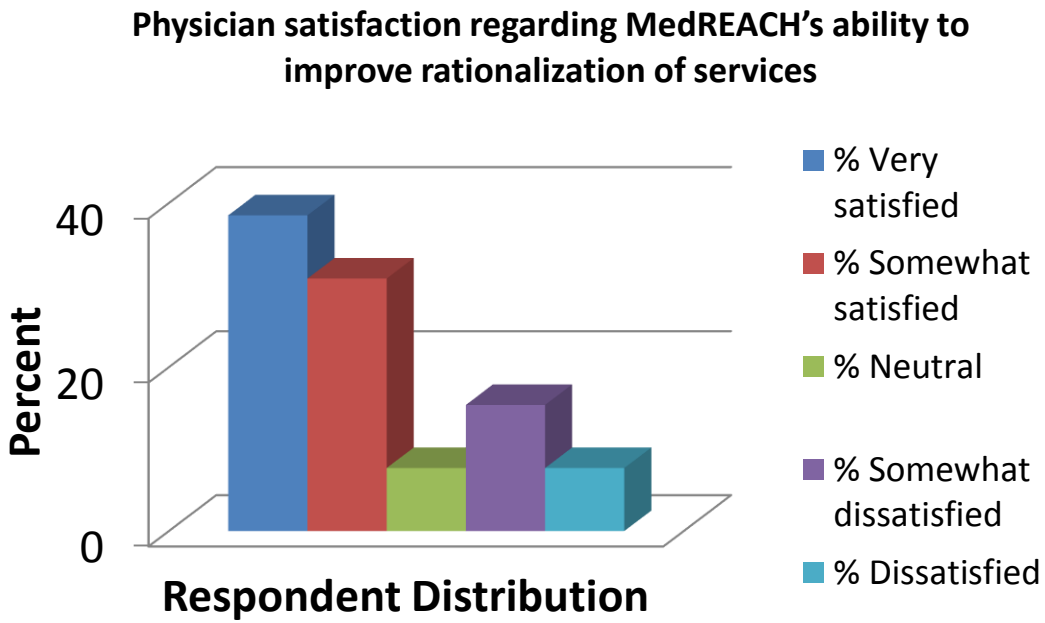
77% of physicians surveyed said they were **VERY or SOMEWHAT satisfied** with the project's ability to improve collaboration and integration of care for Medically Complex Patients .

77% of physicians surveyed said they were **VERY or SOMEWHAT satisfied** with the MedREACH project's ability to address the unmet complex health needs of their patients

77% of physicians surveyed said they were **VERY or SOMEWHAT satisfied** with the project's ability to improve access to services for Medically Complex Patients

Evaluation Highlights:

Improving System Sustainability



69% of physicians surveyed said they were either somewhat or very satisfied with the MedREACH project's ability to improve the rationalization of services.

Other related findings related to system sustainability:

- **70%** **of family physicians surveyed said that their interaction with the Specialist MedREACH Clinic enhanced their knowledge and confidence in the management of medically complex patients in the community**

Evaluation Highlights:

Improving System Sustainability

Qualitative Review of Service Provider Surveys
(Number of respondent references in parentheses)

- **Primary Benefits to Healthcare**
  - Building connections between fields (primary care/specialists, MedREACH branches, etc.) (12 respondent references)
  - Optimizing use of providers' time (11)
  - Comprehensive care (10)

- **Primary Benefits to Patient**
  - Comprehensive care with access to many fields (allied health, diagnostic testing & imaging, internal medicine, medication reconciliation) (17)
  - Seen quickly (6)
  - Home visits (5)

- **Decreasing Hospital Use**
  - Access to services at the MedREACH clinic (8)
  - Referrals to outside sources (7)
  - Medication reconciliation and education (4)
  - More open communication/education to family doctors (4)

Lessons Learned: Aspects Requiring Attention

According to Patients, Physicians and Service Providers

Patients' Lack of Clarity

Patients not always clear on why the referral was made, and what to expect from the program.

More of MedREACH

Patients would like to have more visits with the outreach teams, service providers want more patients in the day clinics and some would like longer-term relationship with patients .

Referral Processes

Scheduling and standardized referral processes were identified as needing some improvement by physician and non-physician service providers.

Cost of Parking

The cost of parking at the clinic (McMaster University Medical Centre) was identified as an unfavorable part of the visit.

Transitions

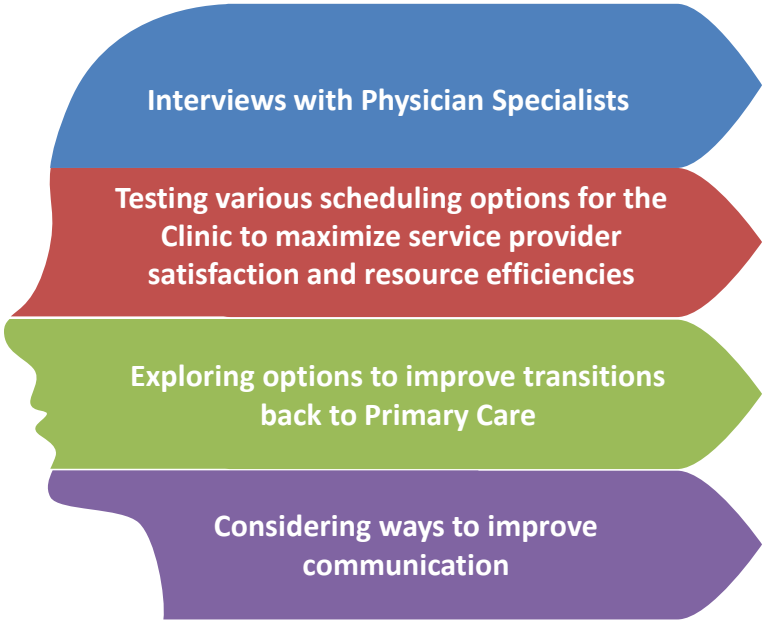
The transition of patients from the program back to primary care is sometimes not seamless.

The Tertiary Level of Intervention

Feedback from some physician specialists from the MedREACH Clinic indicate the need to reassess how the MedREACH clinic can best incorporate MCPs efficiently into existing clinical infrastructure.

MedREACH – Sustainability and Next Steps

- Disseminating and incorporating the lessons learned during this demonstration project into existing infrastructure and programs to better serve the MCP population

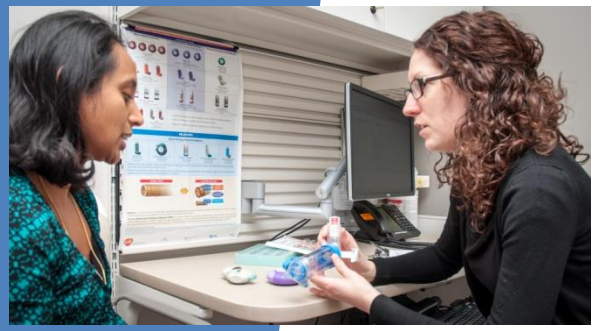


- Evaluating efficiencies of resource allocation (i.e. mental health services vs. other allied health services)
- Specialist physicians engagement in defining how specialist expertise can most effectively contribute to supporting MCPs
- Incorporating MCPs into existing clinics to provide more consistent access to specialist care rather than dedicating a clinical day when a critical mass of referrals is reached
- Expanding Primary MedREACH's role to serve as the liaison and patient advocates for MCPs to Specialist and Mobile MedREACH
- Access to patient's primary care charts by specialist consultants
- Engaged specialist physician leaders that model and welcome collaborative communication with primary care

The MedREACH Project – Summary

Project Milestones and Highlights include:

- Operational since September 2014 – June 2015
- A total of 179 patients were seen and discharged from all 3 arms of the project during this time
- Formalized link for communication between specialists and primary care
- Patients report:
  - High levels of satisfaction with the program
  - Increased abilities to meet their personal goals as a result of their involvement with MedREACH
- Primary Care Providers report:
  - Satisfaction with MedREACH and its ability to provide support with managing MCPs
- Areas for future attention:
  - Prioritizing resources to meet the psychosocial issues faced by MCPs will be crucial in delivering high quality health care management of MCPs
  - Process related factors (e.g. streamlining the referral process, and streamlining patient transition back to primary care)
  - Access related factors (e.g. the amount of time a clinician has with a patient, and parking)



Thank You!

Any Questions?