

**Family Health Team** 





Innovative Community Partnership Reduces ER Visits

#### Katherine Campbell, Director



## **Community Partnership Background**

- > 2009 funding received by Patricia Region Senior Services -PRSS - (Supportive Housing) from NW LHIN.
   • Position- Community Support Guide (CSG)
- > 2009 PG approached the Dryden Area FHT to partner.
  - It was determined that the position would be directed by the FHT on site and navigate the client through the community support services and acute / primary care services
- > 2010 position expanded role into acute care hospital (ER and in-patient).
- > 2011 PRSS receives annualized funding for the position

## **Senior Innovative Program**



- Developed to address senior community service needs providing the opportunity to access care outside of the ER department
- Focused on supporting seniors in their home setting of choice.
- > Evolved to assist in service integration

## Role / Responsibility of CSG



## **CSG Statistics**

Program	12 months April 1, 09-March 31, 2010	6 months April 1, 2010-Sept 31, 2011
Client/ Program Referrals		
Number of client referrals- physicians, ER, allied health providers	1041	536
Number of program referrals	November-February 445 (Nov 09 – March 10)	499
ER/ Acute DRHC referrals	N/A	327
CSG Senior / Caregiver Encounter	1076	1104

## **Activities Supporting our Seniors**

- Recently the DRHC has received funding to employ 2 additional Nurse Practitioners that are currently working with the FHT (Total 4 NPs providing increased access to care)
- The agreement with the MOHLTC, for the funded NP positions, is to increase access to care, reduce ER wait times and support patients that are managing a high level of disease burden.
- Specific patient populations include seniors and the First Nation's community.



## FHT Outreach Clinic

Purpose: To increase access to care for seniors and the First Nation community by providing outreach clinic settings.

Outreach Clinic's can include:

Nurse Practitioner Diabetes Team (RN and Registered Dietitian- RD) Vascular Team (RN and Registered Dietitian- RD) Mental Health Therapist Registered Practical Nurse

Team compliment will depend on need of the population served.

Patricia Garden Supportive Housing Outreach Clinic

- 7 outreach primary care clinics have taken place
- PRSS has received funding to purchase equipment / supplies for a medical room for the outreach clinic
- Outreach team members will depend on need of the patients
- Patients will be scheduled by the FHT
- PG will organize transportation from offsite locations to the outreach clinic location i.e. 10 Victoria, 330 Van Horne

Patients have reported that due to the increase in access they have not had to attend the ER Department

### Long Term Care - Community Partnership

Partnership agreed upon includes physician and NP
Physician / NP attend LTC home to provide patient care

 NP / Physician provide timely access to care ensuring meds, treatment/ management of patient is current

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· If resident attends ER department - NP follows up with LTC home

• OTN has joined the partnership with a linkage to the ER department and LTC home (LHIN funded equipment)

• Purpose: to avoid ER visits in the evening / night- LTC home with link with ER for physician consultation (commence Fall 2011)

## **Dryden Age Friendly Network**

Steering committee has broadened to include service / health care decision makers/ leaders to support the identified strategic direction of the network. Restructured as the System Integration Working Group.

Network has been responsible for activities that support seniors in their home. Network members are front line direct service providers in the community.

## Purpose of the Programs



### Focus Group: Learning Series Winter 2009

Opening event: GiiC series lead Dr. David Ryan: *"Patients, Families and Health Care Teams- caring for frail elderly in our community"* 64 health care professionals in attendance *"Aging well in our Senior Friendly Community"* 229 caregivers/ seniors in attendance

Leaning series hosted every two weeks Jan-April 373 in attendance

Total attendance for the learning series: 665



# Focus Group: 2009–2010 Directory

A directory of services was prepared and 5000 copies have been circulated.

Circulation has included Dryden, rural residents, First Nations Communities, Ignace and Vermilion Bay

The Directory was developed to assist seniors or caregiver's of seniors with pertinent information regarding senior care and interests.



### Focus: 2009–2010 Senior/ Caregiver Survey

A survey was developed and circulated during the winter learning series.

Top three areas identified by 204 Dryden seniors and caregivers:

Access to housing (supportive, LTC, senior community housing) Access to transportation Access to homemaking services Access to primary care appointments

## Learning Series: Winter 2010



Responsibilities of the Community Service Guide is to provide education and health promotion to the community. The CSG has utilized the framework that was established by the 2009 focus group.

#### Current:

- Dr. Mary Lou Kelley
- Aging Process
- Housing Options

- 41 health care providers / 87 seniors/ caregivers
- 80 seniors / caregivers
- 60 seniors / caregivers

## Focus: 2010-2011Ontario Telehealth Network

- Received approval from the NW LHIN to purchase a Tanberg unit which will be placed a Princess Court
- Princess Court will utilize this equipment to reduce ER visits (non essential transfers) and for education and administration
- Patricia Gardens will utilize this equipment for community clients that require alternate access for assessment i.e. gerontology mental health



## Focus: 2010-2011 Transportation



- Currently there is no public transportation system
- Community experiencing pressures as a result of the lack of a formalized system
- Community partners that provide existing services are coming together to review existing services and develop a plan for addressing the pressures and gaps in services

Organizations involved: Red Cross, Aboriginal, Metis, Patricia Garden, Volunteer Bureau, City of Dryden

## Focus Group: 2010–2011 Volunteer

- Create a sustainable volunteer program that supports multiple agencies
- Focusing on sharing resources and develop a volunteer program that is community based
- Reviewing of existing community programs that support volunteerism i.e. DRHC, Patricia Gardens, Grace Haven, LTC



## **Outcomes NP Clinics with PRSS**

- > Seniors are choosing to access care with their providers or NPs on site.
- Increased patient and caregiver satisfaction with on site care
- Tenants are redirected to clinic visits as opposed to ER visits
- PRSS are able to take a higher need client base as a result of the increased health supports
- Improved the health of seniors on the program because they are avoiding crisis situations
- Screening clinics with allied health has provided opportunity for early intervention
  - Seniors in the community are starting to request access to the clinics

### What we have Learned...

- Clients need to be managed from when they are introduced to health care system - intake can be from housing, primary care, acute care etc.
- When you support them at point of entry they exit the system with positive outcomes
- Education for all! Seniors, caregivers, staff, students, volunteers
- Education must be ongoing -typically people access service when the need arises
- Communication, Communication, Communication
- Seniors want to be healthy to be independent -they are engaged and educating themselves

## Questions

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