Supporting the Patient with Complex Needs

Working Collaboratively with our Partners to Improve the Patient Experience

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Association of Family Health Teams of Ontario – 2012 Conference

Demonstrating and Celebrating the Value of Family Health Teams

Presenters

Dr. Thuy-Nga (Tia) Pham

Lead Physician

South East Toronto Family Health Team; Toronto East General Hospital

Stephanie Sanders

Care Coordinator, Integrated Care Team

Toronto Central Community Care Access Centre

Jodeme Goldhar

Lead, Health System Integration for Complex Populations and Primary Care

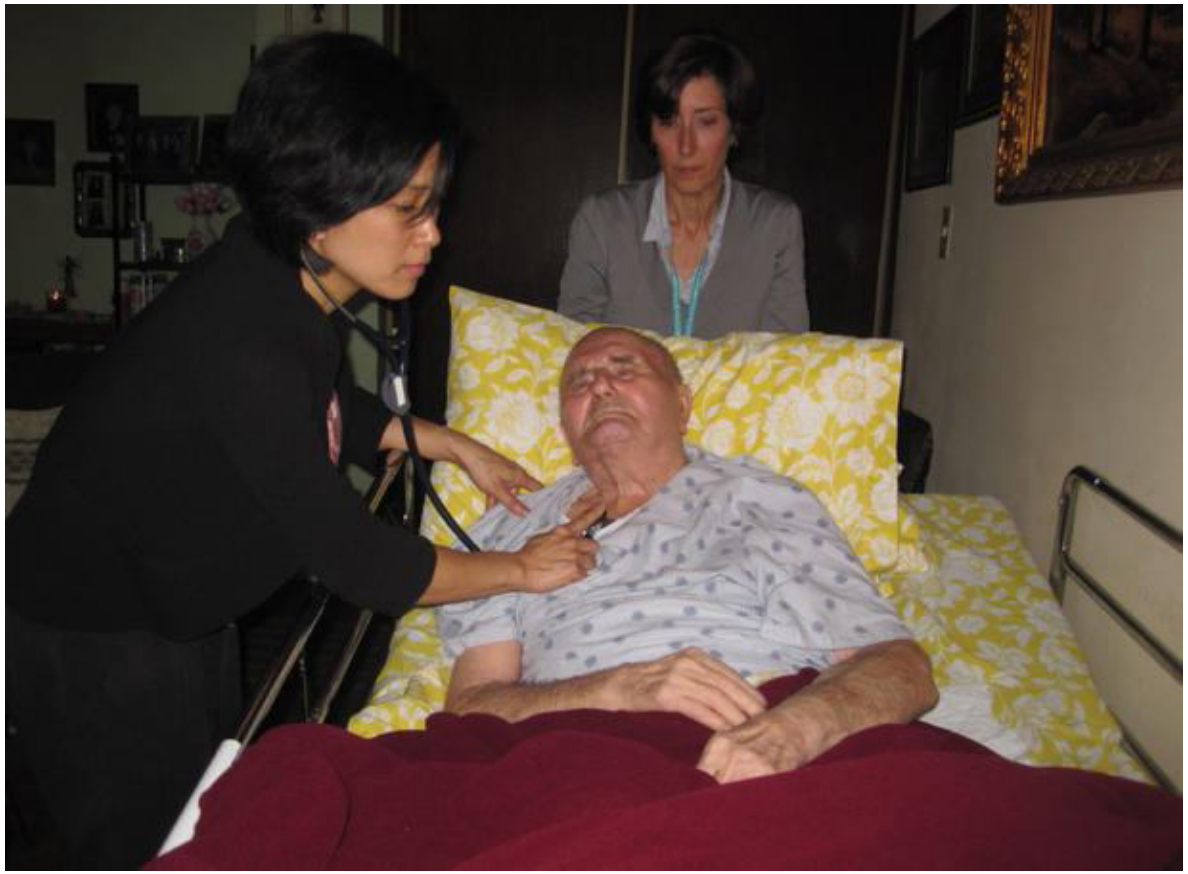
Toronto Central Community Care Access Centre

John Klich

Superintendent, Community Paramedicine Program

Toronto Emergency Medical Services

The Patient Story –
Right Provider at the Right Place at the Right Time



A Patient Story…one of many

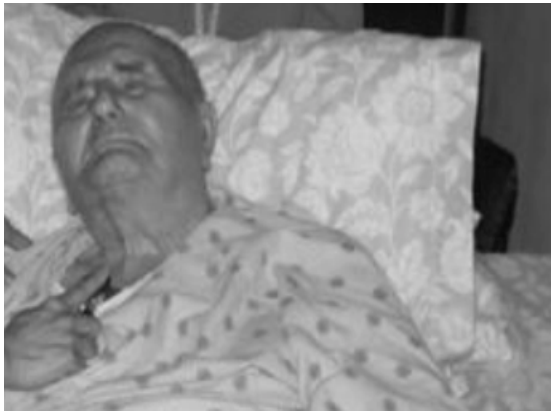
Mr. D:

2 admissions in the last year for CHF and urinary tract infection.

Discharged home with instructions to follow up with his doctor after discharge…

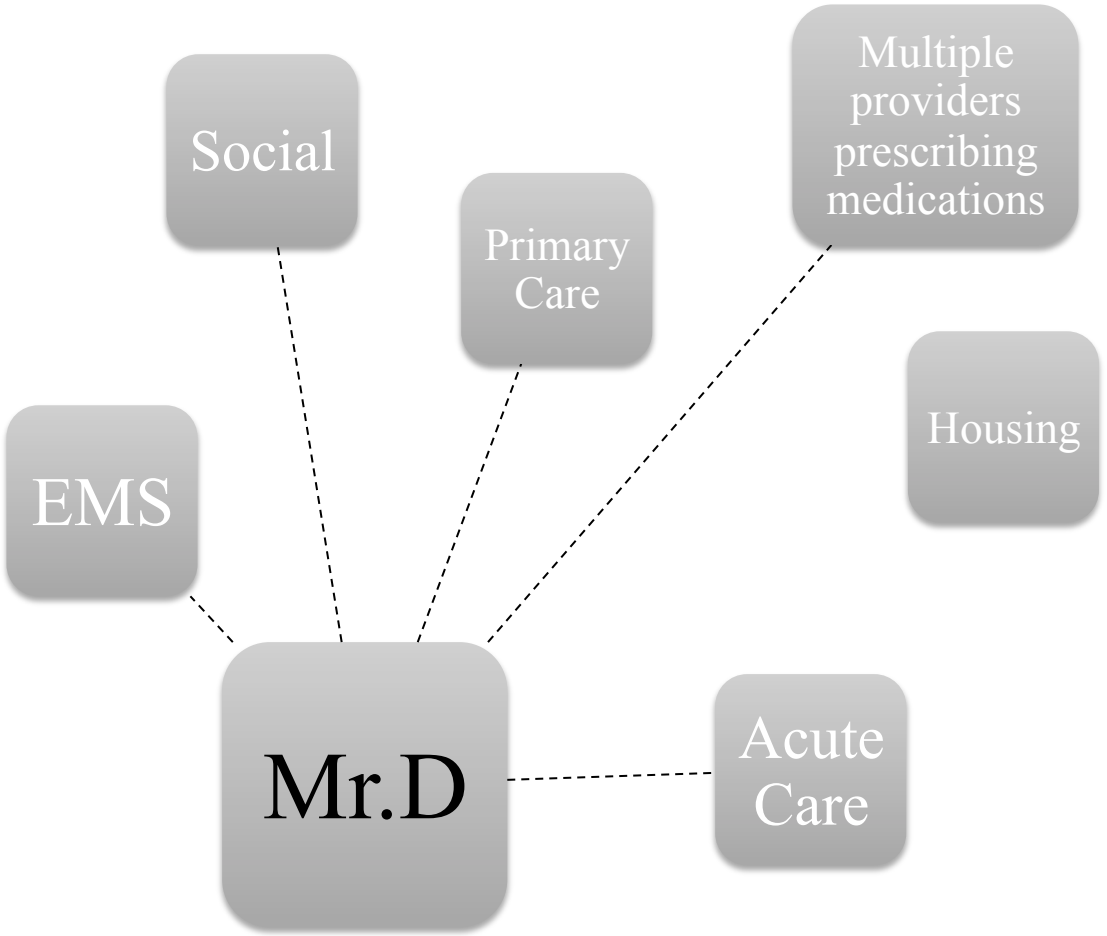
The only caveat:

He is completely paralyzed and cannot leave his bed at all. He therefore has not seen his doctor in 2 years. His ankles have become more swollen – what is his elderly wife supposed to do now?



Mr. D's Care…

- Was he capable of choosing to live at risk?
- His health system was **fragmented** with **multiple unconnected providers responding to crises**
- Is **reliant** on EMS and Hospital Visits.



Ontario Health Care Context

The Case for Change: Moral…Fiscal Imperative

Ontario Healthcare Context

Excellent Care for All Act

Finally…

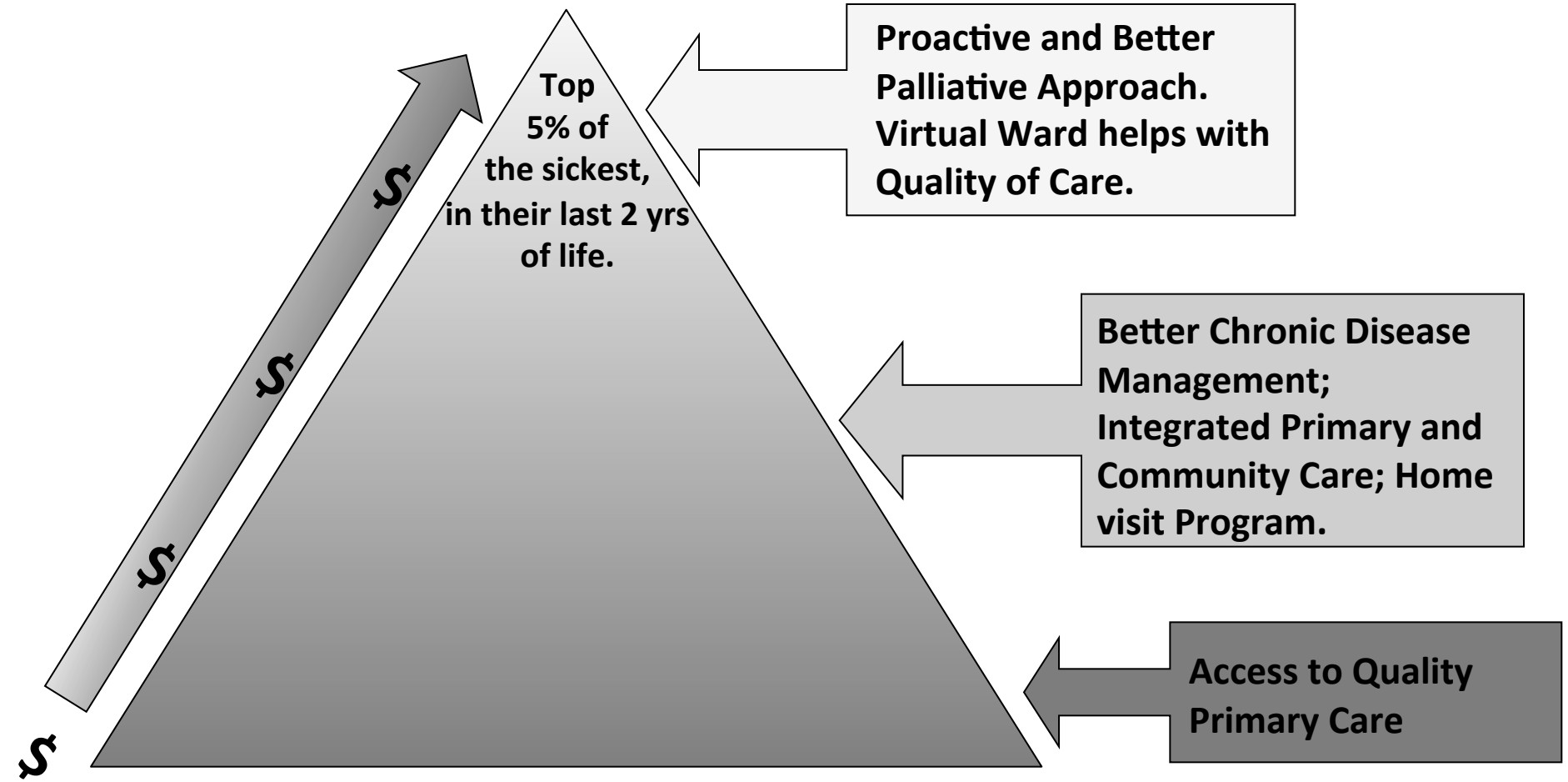
The Patient is at the centre of the health care system.

Care must be organized around the patient to support his or her health.

<u>But:</u>

Is our current system set up to foster **collaboration** and seamless **communication** between the various sectors that are involved in a patient's care?

For Complex Patients - Better System Integration Is Required



A Concrete Example of Collaboration in East York, Toronto

Primary Care:

South East Toronto Family Health Team

Community Care:

Toronto Central Community Care Access Centre

Transitions:

Toronto EMS

Acute Care:

Toronto East General Hospital

New Technology:
Ontario Telemedicine Network

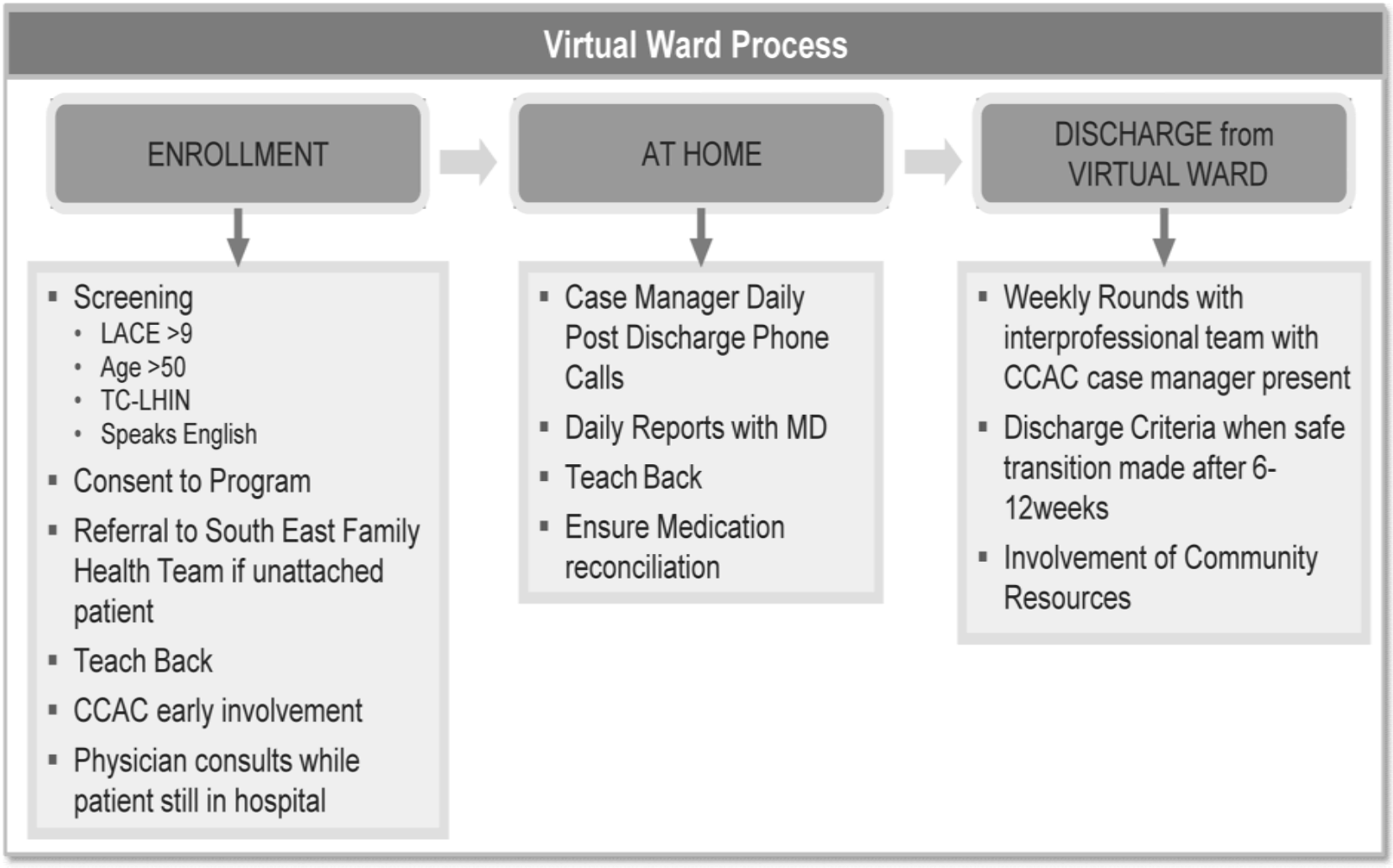
Virtual Ward - SETFHT-TEGH Goals

- Collaboration between Family Health Team and Community Hospital to provide population at high risk for re-admissions with improved follow-up care after discharge.

- Admit these patients to a Virtual Ward in order to improve the transition back home from hospital and reduce avoidable readmissions.

- Identify and assist a growing population of unattached patients who do not have access to primary care and thus are at increased risk for hospital usage.

SETFHT TEGH Virtual Ward



Toronto Emergency Medical Services EMS

South East Toronto Family Health Team

Ontario Toronto Central Local Health Integration Network

Toronto Central CCAC CASC Community Care Access Centre

The Team within the FHT

Physician Assistant (PA)	• Works as the clinical case manager • Meets patient the day before discharge at TEGH • Identifies patients needing intervention: • Arranges for FHT visits or with specialists
Supervising Physician	• Clinical supervision of the team's work
Care Navigator	• Arranges transportation, community supports, lab work at home if required
Pharmacist	• Reviews/adjusts medication
Nurse Practitioner	• Provides home visits and chronic disease management
Mental Health Addictions Counsellor **CCAC Care Coordinator**	• Arranges for mental health and addiction supports • Participates in weekly case conferences • Collaborative home visits with team members

Using Technology for more efficient and effective Communication

FHT EMR - Instant messaging across the team about a patient

Electronic Hospital Record

Virtual Ward patient weekly data entry

OTN vital sign monitors guide urgency of home visits / planned ED consults

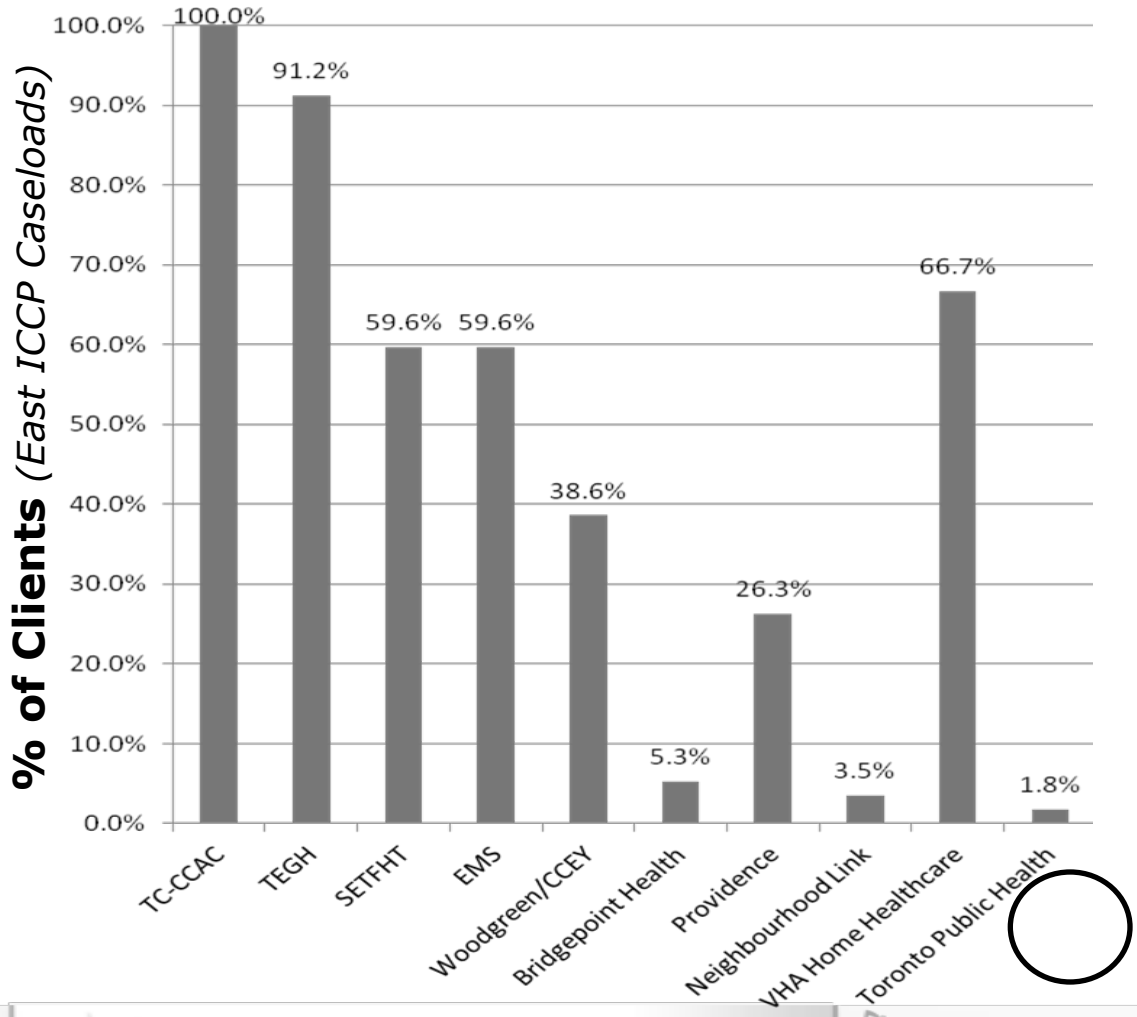
Teleconferencing involving specialists

Text/email/phone for urgent specialist consults

Telehomecare – Making Use of New Technology

The Ontario Telemedicine Network provides equipment for remote monitoring of vital signs through their Telehomecare program.

Making Connections – Complex Patients See Many Providers



Health System Transformation

Layer on new solutions

Restructure system

TODAY → FOREVER

What is ICCP?

Multi-Year Toronto Central LHIN-Wide System Strategy and Quality Improvement Effort which aims to drive the highest possible level of care integration for those who need it most:

Older Adults With Complex Needs

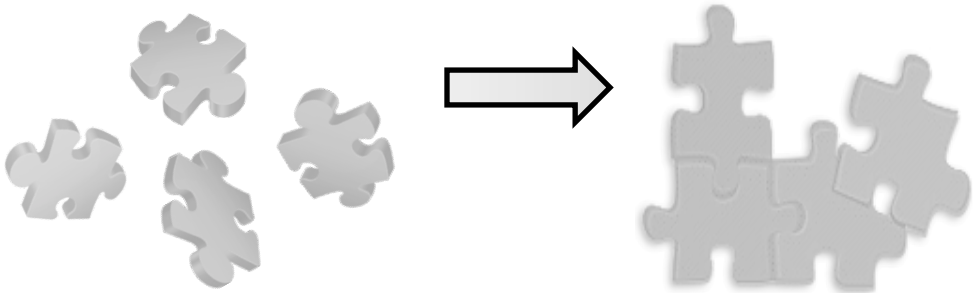
What is the Aim?

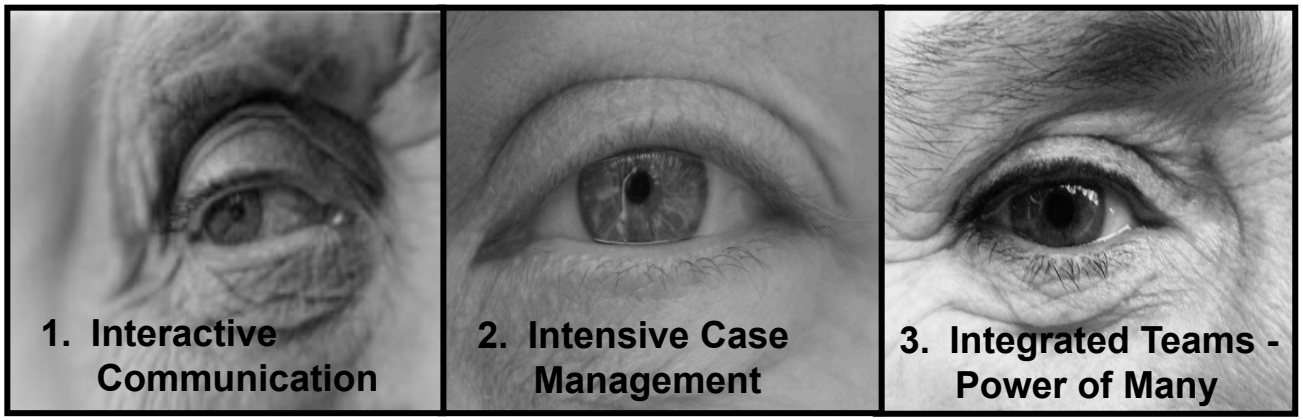
To help older adults with complex needs remain at home and in their communities.

Point of Care Integration Disrupts the Status Quo

Point of Care Integration

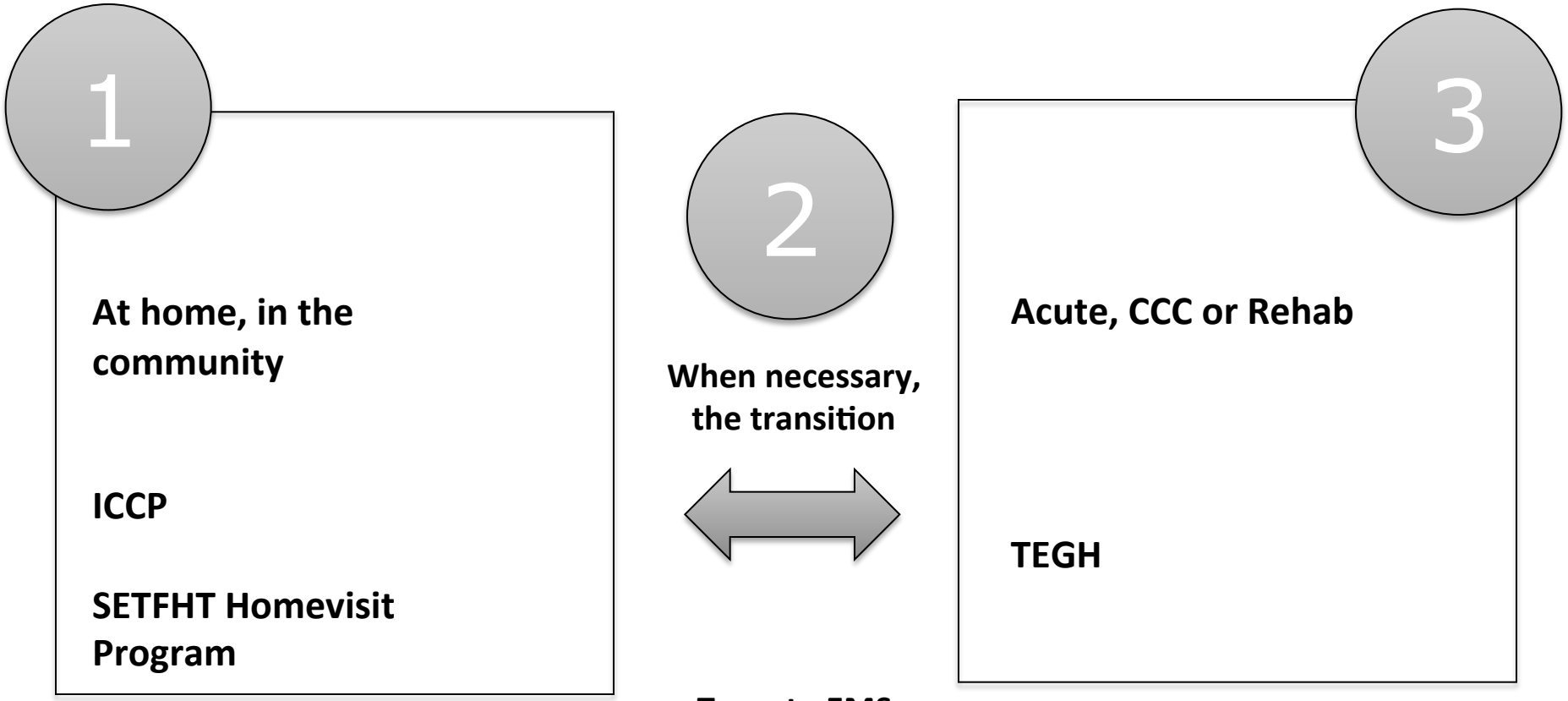
Interdisciplinary, inter-organizational teams coming together at the point of care





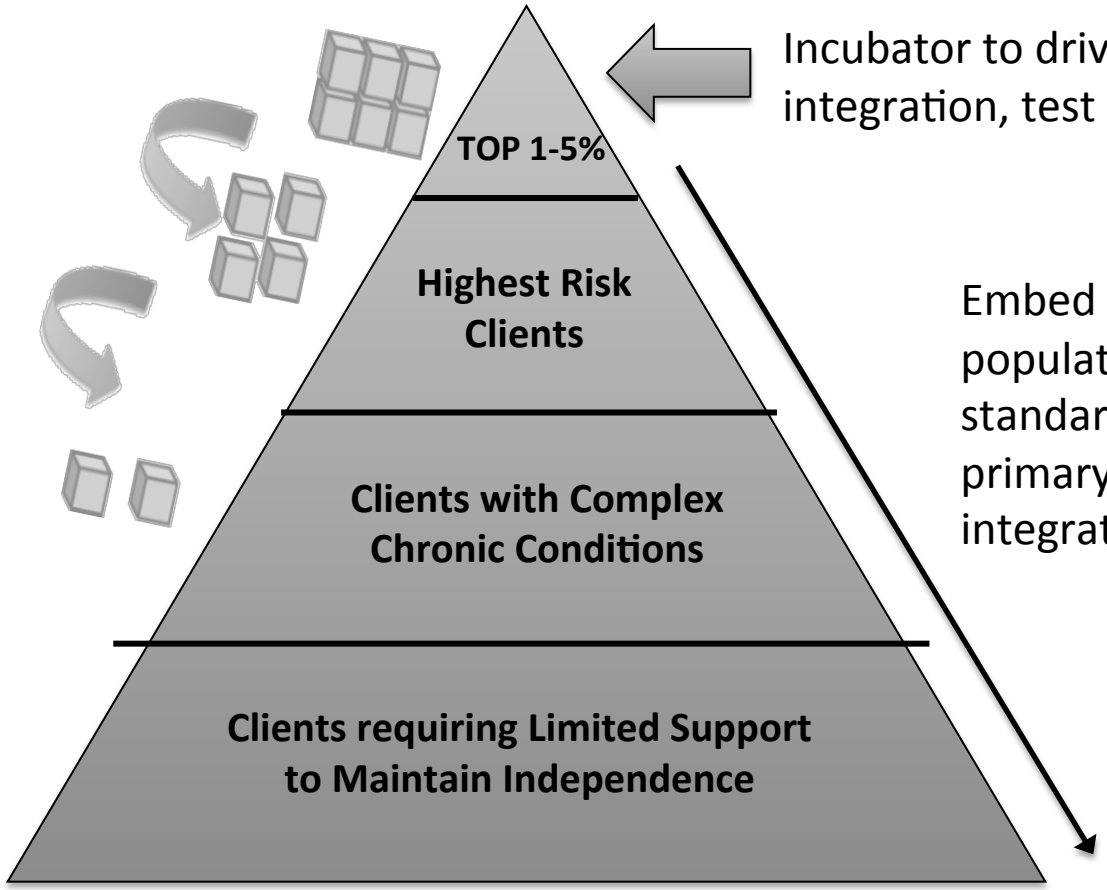
ORGANIZATIONAL ALIGNMENT

What we learned about delivering integrated care, within 3 key domains



Toronto EMS
SETFHT TEGH Virtual Ward

Starting with the most complex clients, testing integration and embedding in other populations

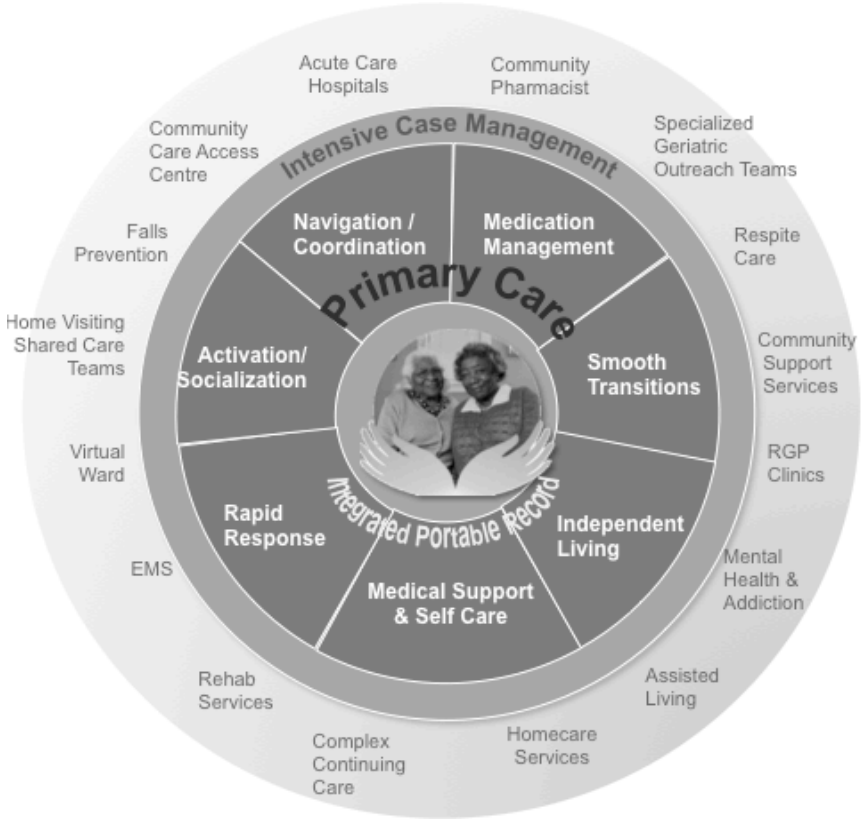


Incubator to drive the tightest integration, test and learn

Embed Learning's to all population and develop standards of care for primary care integration

Enabling strategies (technology, tools, staffing, etc.) vary by sector

ICCP Framework and Target Population



ICCP elements of integrated care

7 design elements, plus the central roles of Primary Care, Intensive Case Management and the Portable Record

Initial Target Population

Older adults with complex needs

- 2 or more ACSCs
- Admission to acute care in the last year
- RAI assessment/score
- 65 years +
- TC LHIN resident

and….Home Bound, high risk and frail older adults

Scope

TC LHIN Wide, Multi-sector

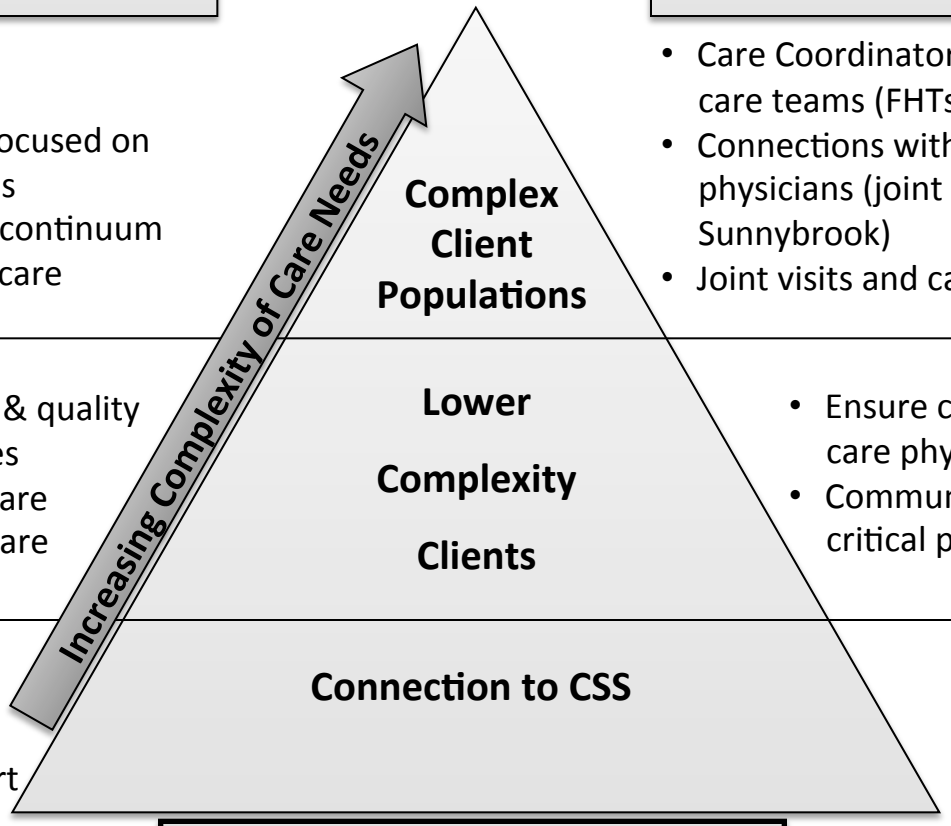
Population-Based Care Coordination & Integration with Primary Care at the Toronto Central CCAC

Focus of Care Coordination

- Cross system navigation
- Intensive case management focused on client and family centred goals
- Care Coordination across the continuum
- Joint care plans with primary care

Connection with Primary Care

- Care Coordinators embedded in primary care teams (FHTs, CHCs, group practice)
- Connections with solo-primary care physicians (joint work with UHN, Baycrest, Sunnybrook)
- Joint visits and case conferences



- Monitoring health outcomes & quality measures and system linkages
- Ensuring linkage to primary care
- Transitions & Right place of care

- Ensure clients are linked to primary care physicians
- Communicate to primary care at critical points in the client's care

- Information and Referral
- Linkage to primary care
- Linkage to community support

Key Enablers: Health Care Connect, Communication and Access

Toronto Emergency Medical Services EMS | South East Toronto Family Health Team | Ontario Toronto Central Local Health Integration Network | Toronto Central CCAC CASC

Driving Standards for Innovation
"Hard Wiring the Change"

Care Coordinators Providing Intensive Case Management	• Increased Home Visits and Case Conferencing • Increased Role in System Navigation and Transitions
Primary Care	• Weekly Case Conferencing and close communication with CCAC around Complex Patients' Care • Home Visits for homebound patients
Acute Care Involvement	• Identification of high risk patients • Enhanced Transition communication, Flagging • Virtual Ward intensive case management

Driving Standards for Innovation
"Hard Wiring the Change"

Pharmacy Engagement	• Moving to a Single Pharmacy for each patient
Caregiver Support	• Focused experienced based training for Care Coordinators to support caregivers and address caregiver burden
Emergency Medical Service (EMS) Engagement	• Enhanced Communication around ICCP Clients • Emergency Department Transfer Package • Hospital Repatriation System through EMS

Video Clip

Improvement Strategy – Driving Change

Key Lessons

- Focus on right care, right time, right place
- Steadfast despite political context
- Small tests of change to inform provincial strategies
- Shared Accountability
- Balance the need for scientific evidence and outcomes with quality improvement frameworks for complex and disruptive change processes

Meeting Government Priorities

- Encourage integrated delivery of care by **aligning and leveraging resources for the functional redesign of practice at the point of care**

- **Integrated home visits** by primary care providers, specialists and community resources since many at risk patients have mobility issues or lack transportation

- **Offering seamless transition from community and primary care to acute care and then back to primary and community care** with the most suitable social and community services

Meeting Government Priorities *continued…*

- **New technologies** to monitor a patient's health through virtual means (i.e. Telehomecare)

- **Quality improvement** approach to improving patient outcomes; and

- Opening the doors to new health care professionals (ex: **integration of a Physician Assistant in primary care** – less physician intervention needed*)*.

Which of our patients need more?

- Homebound patients:
  - Need for more integration of services at the point of care and clinical consults and services, treatment of acute conditions in the patient's home if patient prefers treatment at home.

- End-of Life:
  - Identify patients in their last 1-2 years of life, improve non-cancer palliative services in the community, document Advance Care Directives.

- More mental health and community supports for patients with borderline cognitive impairment who live alone without any family support.

Policy Implications

- **Provide Incentives for Collaboration** across sectors:
  - Acute care hospital/community care agency/primary care groups need to work together on the common goal to support people to live at home successfully and when required to improve the transition from hospital back to the community

- **Encourage Communication**:
  - Create Electronic health records that can be shared by all care provider across different locations (ex: e-Health)
  - Move to billing practices encouraging phone and electronic conversations between care providers, between patients and care providers, and between different health care sectors

- Ensure proper funding is in place to **collect patient outcomes** and apply quality improvement methodology to develop programs that best meet the needs of the patient/**maximize IT to drive the quality agenda**

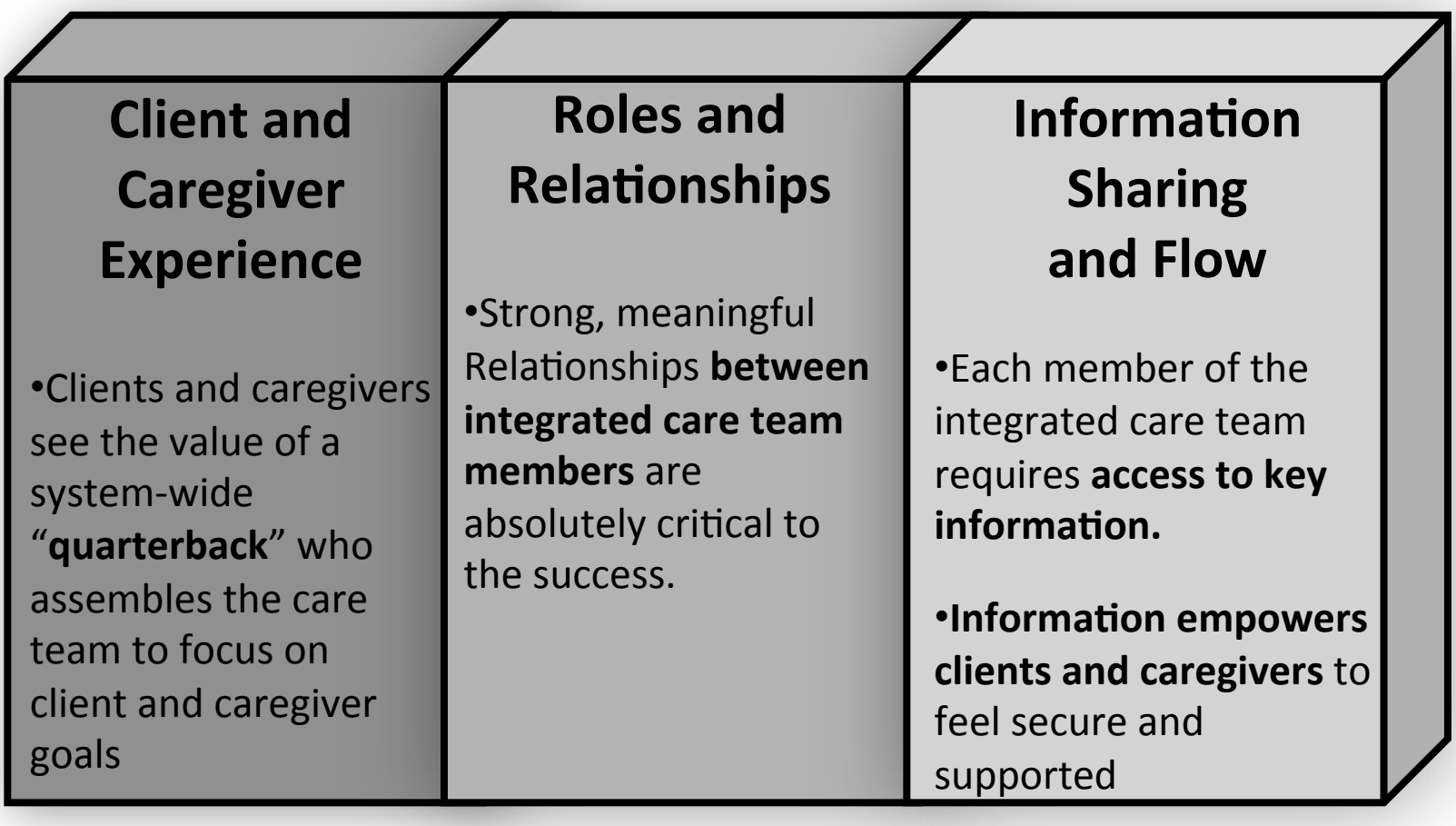
Policy Implications *continued…*

- **Inter organizational integrated Team-based approach to complex patient care in the community** has now become available in Ontario through the creation of Family Health Teams and the leadership driven to integrate with other providers
  - foster spread across FHTs, and linkages between hospitals, CCAC and FHTs

- Remove barriers to **Home Visits** – challenge of encouraging high volume = increasing access in primary care, versus reaching out to the frail patient at home (time intensive)

- Develop **computational capacity** across province to calculate primary care based risk-score for admissions (as modelled in the UK) in order to target patients at risk for admissions BEFORE they decompensate and require admission

Three system-wide pillars to reflect on key learning

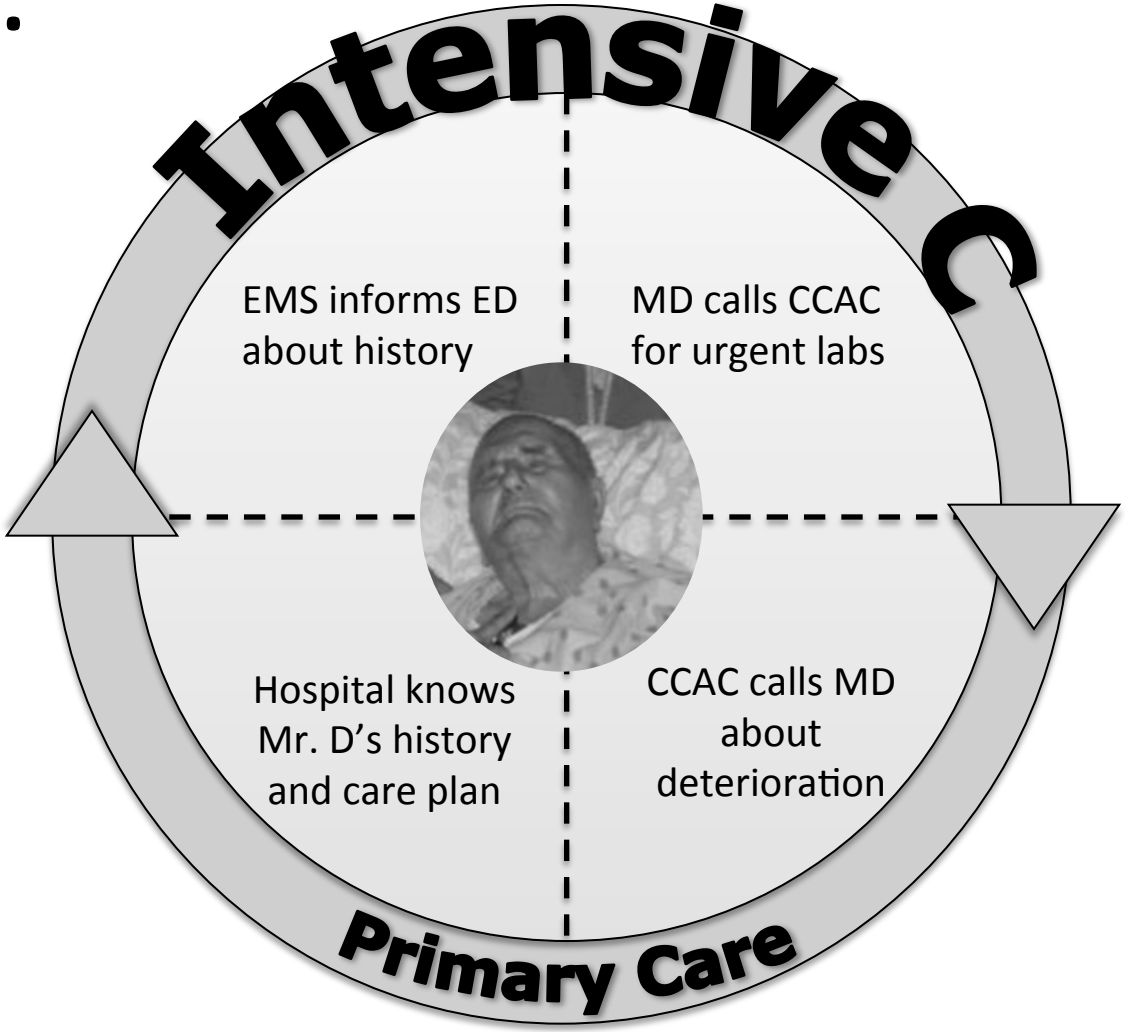


The Driver of All Care Planning: The Client and Caregiver

- Building the care team
  - Primary care
  - One local pharmacy
  - Community support services
  - Neighbours
  - Faith communities
  - CCAC
- Case conferencing with all team members
- One shared care plan
- Advance care planning
- Accompany the client and family through the system
- Integration with primary care
- EMS partnership
- Proactive crisis response plans
- Caregiver respite plan
- Acute care engagement
- Virtual Ward

Mr. D's Care…

Mr. D and his family know to call the team for help.



Through the Eyes of Clients and Caregivers

- "But prior to this program if an ambulance took my father to [hospital] which is the closest to his home, and they were fully booked, he would either be left in the hall for 34 hours as he was last year, or he would be sent to [another hospital]. Now with this new program there is an assigned hospital and that is where they go and it is [hospital] for that entire home and that is where my father will go. And they have everything: DNR, POA, Visa card imprint, the whole thing. So that, for frail seniors in a huge city, is a brilliant idea." Caregiver

- "What I understood is [the ICCP program] is just basically to make things run smoothly, to make sure the EMS guys have all the information, to make sure at the hospital when they are admitting her that they have all the information, and to make things run smoothly and also to avoid unnecessary trips to the hospital or the emergency room." Caregiver

Through the Eyes of Primary Care Physicians

- "The [Care] Coordinator acts as your eyes. You don't need to see those patients as often."

- "The Coordinator works with other professionals to collect information, so I just have one person to contact. It saves me time."

- "That's terrific … all the other things you have done for him to help him stay at home, against all odds. He's lucky to have you and your team helping him"

Thank You