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BRIGHT LIGHTS AWARDS

2018

The "How-to" Stream

Mount Sinai Academic Family Health Team

HIPS Home based Interdisciplinary Primary care for Seniors: for medically complex, socially isolated seniors

Hip, hip hooray for HIPS, the collaborative Home-based Interdisciplinary Primary Care for Seniors created by Mount Sinai Academic Family Health Team and the interdisciplinary team that made it possible: physicians, nurse-practitioners and registered nurses, working side-by-side with pharmacists, volunteers and home care service providers. By creating a tight network among providers, HIPS has been able to successfully enhance social supports, promote healthy behaviours and improve health access for medically complex, socially isolated seniors.

Medical complexity, frailty and declining cognition among seniors makes it more difficult for them to access care in a clinical setting. Mount Sinai Academic FHT had an initial goal of providing in-home primary care to reduce emergency room access for routine care and premature long-term care placement. However, the team soon recognized there was a significant amount of social isolation, poly-pharmacy and lack of access to other health services. To address this issue, the team collaborated with community partners to create HIPS to provide in-home friendly visiting, pharmacy services and intensive case management through home and community care.

The success of the HIPS program is both palpable and quantifiable. In a two-year period, the number of HIPS patients increased from 24 to 70. Approximately half of these patients live alone, many with limited social supports. Each patient is encouraged to accept a referral for a volunteer visitor, receive periodic pharmacy visits, and all have access to a Care Co-ordinator through the LHIN. Knowing the team is available to them, patients report an increased level of support. Patients have expressed that with the team's involvement they feel safer, less anxious, and that "living at home has been a rewarding and satisfying experience" – in essence, their quality of life has improved.

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One key to the program's success, growth and evolution is drawing on the skills of individuals who are already part of the healthcare or social service systems. This success highlights the value of strong interprofessional communication and of effective collaboration with pre-existing service providers. By working with existing community agencies and programs, HIPS meets the needs of patients without incurring additional costs to the system. HIPS is also focused on continuous improvement and relies on daily phone contact, bi-weekly rounds, and yearly retreats for planning, with all innovations based on the needs of patients and their caregivers. Nor does HIPS take improvement for granted-staff are using QI and program evaluation initiatives to determine if any gaps in services exist. Both patients and caregivers are part of QI projects, and evaluations are underway.

HIPS accepts referrals from both inside and outside the FHT, so the numbers of patients served continues to increase. Congratulations to HIPS for an excellent "how-to" lesson for creating a successful, expandable, scalable program.

Key Facts:

- Reduces need for premature long-term care placements
- Tight communication network among all providers, including pharmacists, volunteers and homecare service providers
- By relying on services that already exist, obviates need for additional costs
- Addresses key social determinants of health
- Expanded care team through partnerships
- Number of patients served has nearly tripled in two years