Communication, Coordination, Collaboration

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PRESENTER DISCLOSURE

- **Presenter:** Dianne Delva
- I have no conflicts of interest
- I have no relationships with **:**
  - **Grants/Research Support:**
  - **Speakers Bureau/Honoraria:**
  - **Consulting Fees:**

Objectives: *At the end participants will:*

- Identify common barriers to preventing effective care
- Describe the role of primary care in an integrated health care system
- Assess approaches to effective collaboration and coordination of care in our LHIN

Who am I?

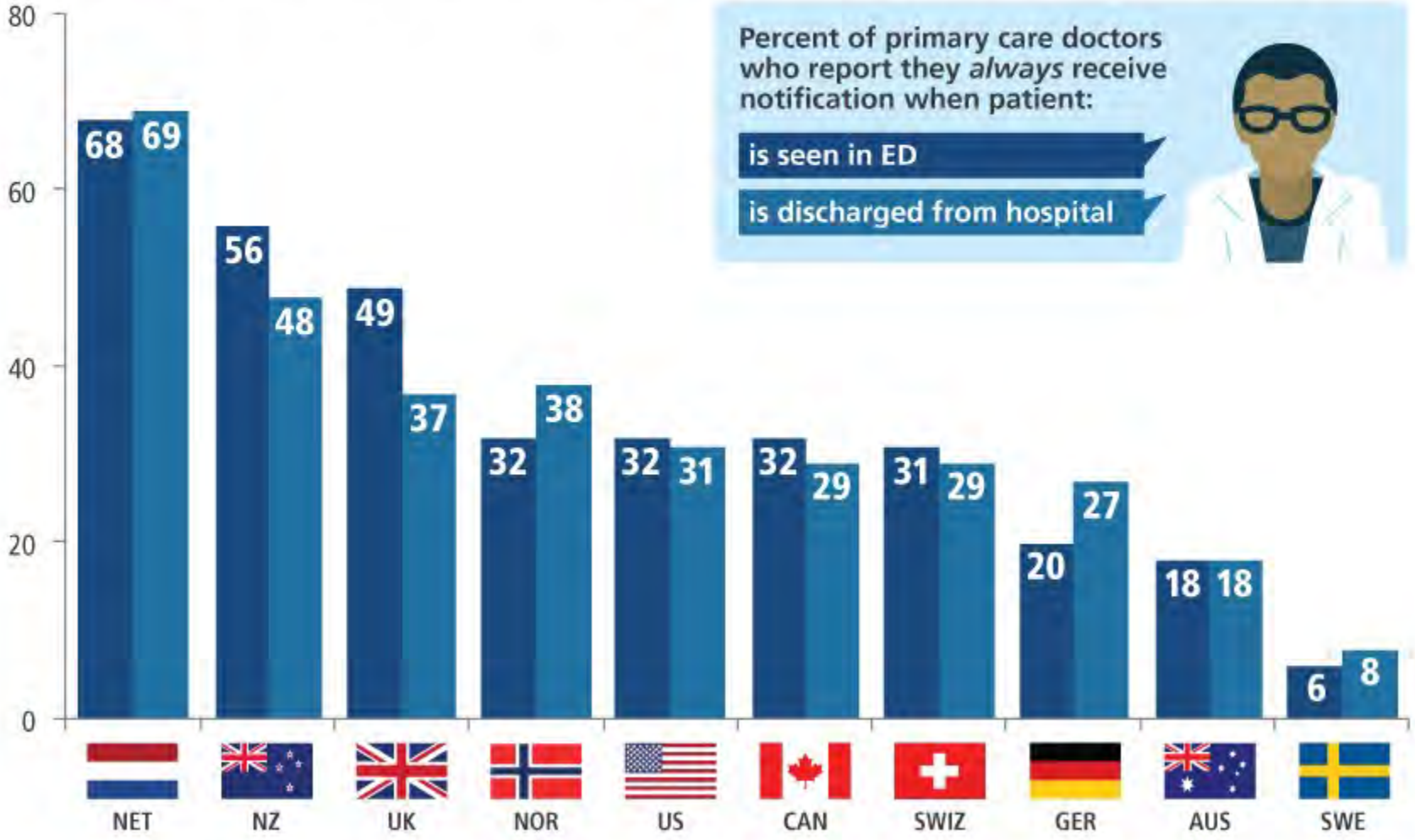
- Practice in Kingston x 25 years: EFPO, Teamwork, CCC, SARS
- Nova Scotia: tacit knowledge, PGME, UGME, H1N1
- North York: SARS, Family Medicine and the hospital, Health Links

What are the issues?

- Increasing costs of health care.
- Aging population/ complex chronic care
- Small number of patients using the largest proportion of health care dollars.
- Poor integration of the system/silos.
- Every Family physician has a few patients that are a challenge to serve effectively.

All Nations Face Challenges Coordinating Care

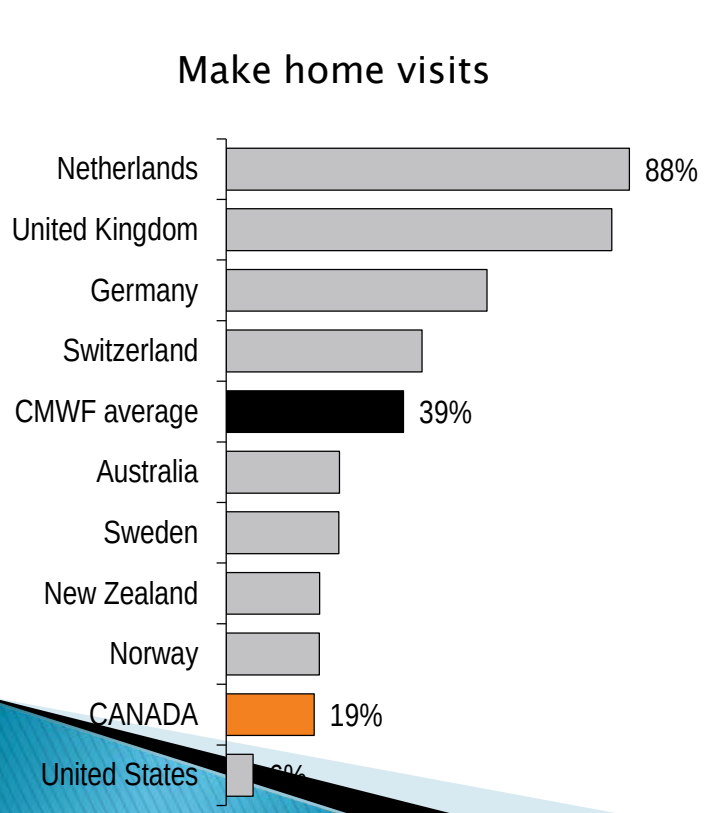
Doctors in every country in a 10-nation survey reported that their practices struggled to coordinate care and communicate with other health providers, which is key to managing patients with complex care needs.

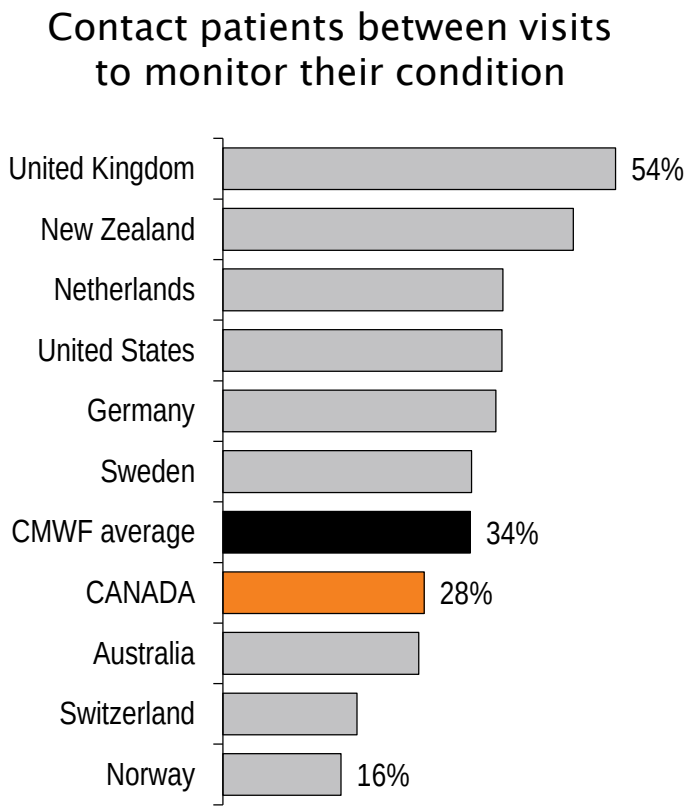


Source: 2015 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

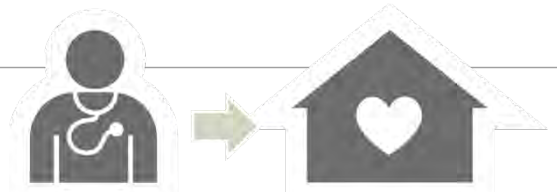
Home contact with patients is less frequent in Canada

Proportion of primary care doctors who reported that they or other personnel in their practice **frequently** provide care in the following ways:



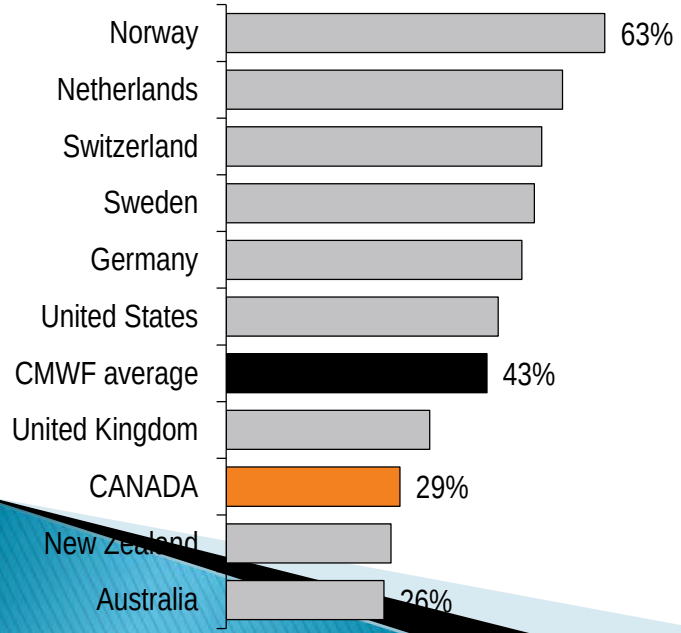


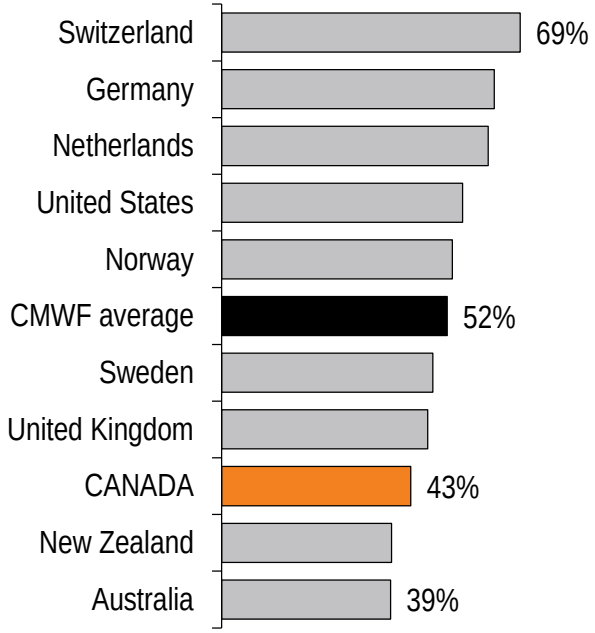
Primary care and home care services not as integrated in Canada



Practice **routinely** communicates with a case manager or home care provider about a patient's needs when a patient is receiving home care services

Primary care doctors are **routinely** advised of a relevant change in the condition or health status of their patients who are receiving home care services

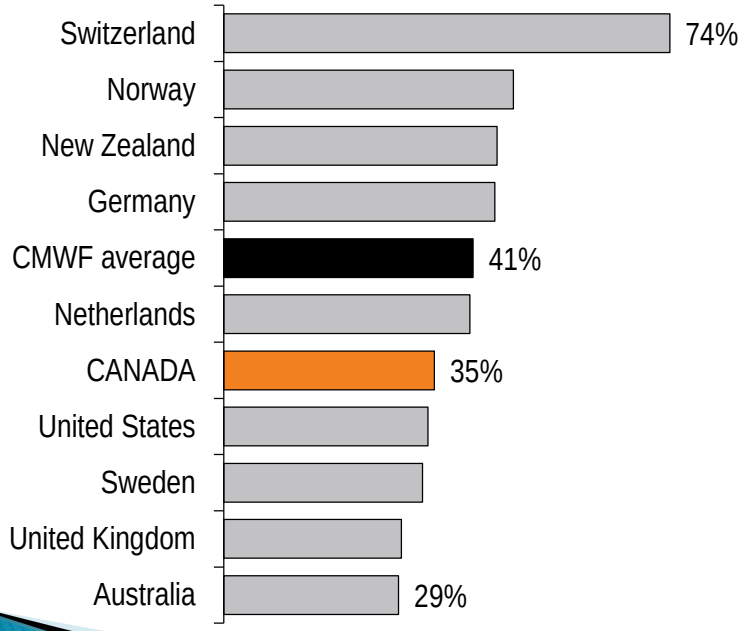




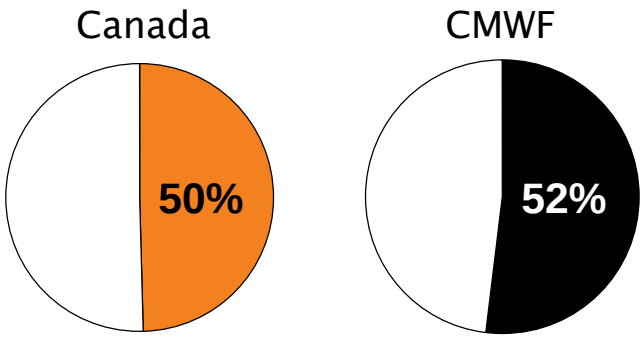
Coordinating care with social services not always easy in Canada

35% of Canadian primary care doctors thought it was **easy or very easy** to coordinate their patient's care with social services or other community providers when needed (e.g., housing, meals, transportation).

How does Canada compare (2015)?



50% of primary care doctors **frequently** coordinate care with social services or other community providers



Inefficiencies resulting from poor coordination high in Canada and across most countries

During the past month, the following has occurred with at least one of their patients	Canada	CMWF average
A patient's medical record or other relevant clinical information was not available at the time of the patient's scheduled visit	61%	65%
Tests or procedures had to be repeated because results were unavailable	28%	30%
A patient experienced problems because care was not well-coordinated across multiple sites or providers	50%	53%

Compared with the CMWF average results

Above average · Same as average · Below average

Interpretation note: Above-average results are more desirable relative to the international average, while below-average results often indicate areas in need of improvement.

A Story of Failure

- Young woman (33)new to my practice Fall /14
- Discharged from the Addictions program for alcoholism and is abstaining
- Discuss challenges, send for records and ask her to return
- Few appointments in 2014 for medical problems (no records)

Visit March 2015

- Disheveled and admits to relapse
- Reasons related to family issues
- Invite fiancé to come in and discuss roles in abstaining
- Discuss return to addiction counseling
- Ask her to return in one week, returns in 2 weeks
- In meantime, discharged from Schizophrenia program and advised to return to Addictions program

Next 9 months

- 17 hospital admissions (last discharge Jan 29)
- 25 ED visits
- 7 chest x-rays, 3 Head CT scans

- Multiple issues: seizures, pancreatitis, esophagitis

- Note on discharge: “THIS PATIENT NEEDS FOLLOW-UP WITH ADDICTION SERVICES, GRAVE PROGNOSIS” (June 2015)

Return to FP

- Feb 2016: to clinic with community support worker, inebriated
- Declares she wants to quit drinking
- We discuss options: provide diazepam
- Ask her to return in one week
- No show

Comments?

- What went wrong?

- Many discharge summaries
- No warm handover
- Challenge with Mental Health resources

Coordination

- Between Hospital, Mental Health, Primary Care and Community Care

Collaboration

- Patient
- Community Health Care worker
- Addiction services
- Primary care


MAGNETI MARELLI
Alice
V-Power

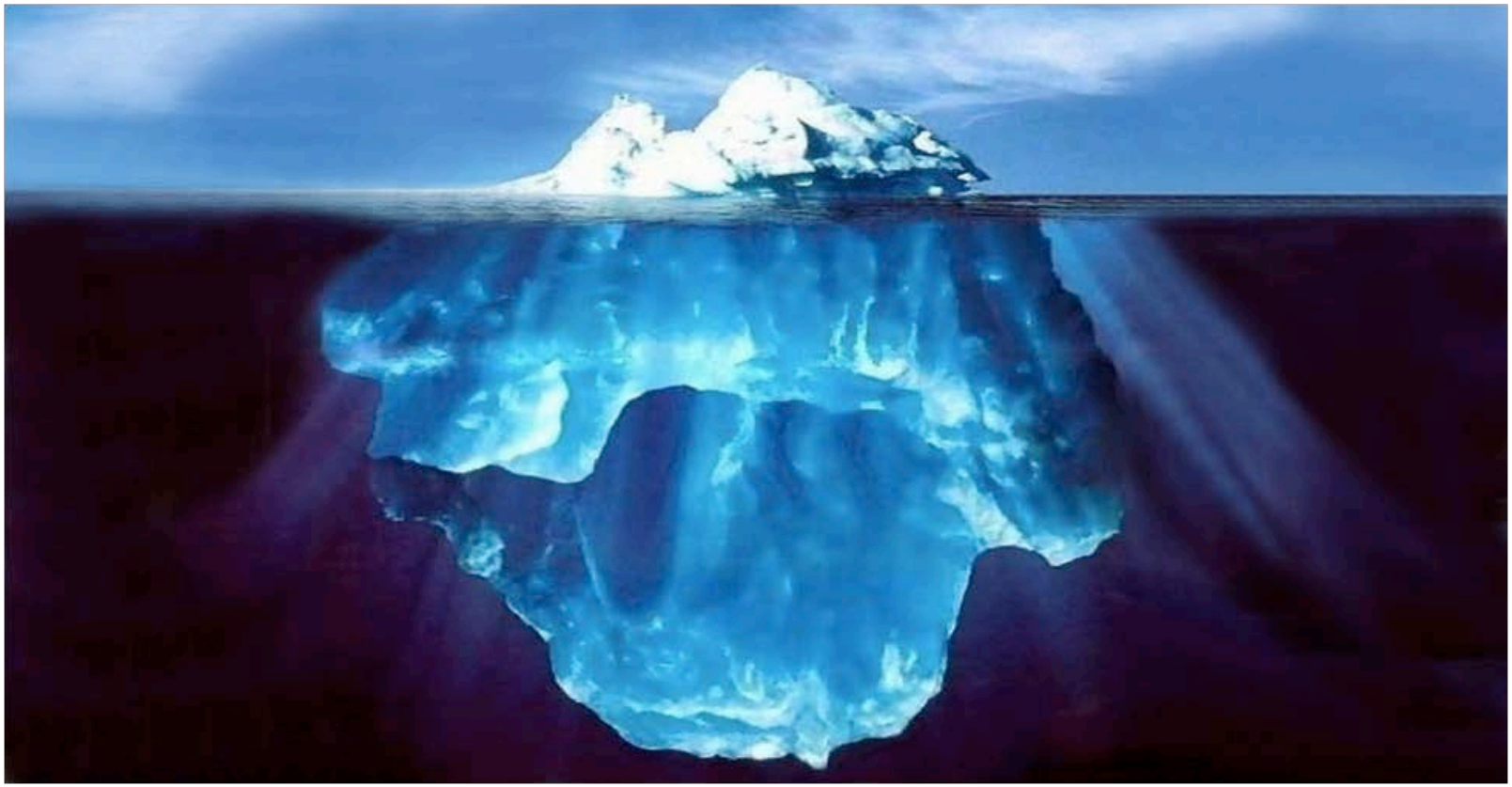

Marlboro
Marlboro

Some good news!

- Access to care is improving but still a challenge for many Canadians
- New models of primary care delivery appear to be making a difference
- Big improvement in the use of EMRs

Innovation

- E-consult: improved communication between FP and specialists and improving wait times and reduce unnecessary referrals
- Potentially Inappropriate prescribing
- Choosing Wisely Canada



NYGH Health Links

- Two populations who are high users of the hospital
- ED: ≥10/yr, average age 40-50 and multiple issues usually with mental health problems
- Hospital readmission ≥4/yr: older, COPD, CHF and EOL

NYGH Health Links

- Partnerships: Hospital, CCAC, Paramedics, Family Physicians (NYFHT), Community agencies, Community Mental Health
- Patient advisory council
- Planning using the data and what each group could bring to the table
- Pilot: Care Coordinators, Patient Care Plans

Health Links

- Identify high needs patients
- Meet with all players
- Develop coordinated care plans
- Must involve FP
- Pilot for 70 patients

Principles

- Patient-centered approach to care planning
- Circle of care: all care providers
- Develop a care plan with patient and care providers focused on patient goals
- Not disease focused

What have I learned?

- Patient's goals may not be health care provider goals
- Care coordination is essential
- The health care team varies over problems, over time
- Some problems are hard to address
- Community Mental Health services are difficult to navigate, may need changes to meet needs
- Community agencies often have much to offer

Thank-you