Integration of Physiotherapy in Primary Care in Community Health Centres in the TCLHIN

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Presenter Disclosure

**Presenters:** Chris Sulway, Kasia Filaber, Emily Stevenson

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- **Grants/Research Support:** None
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- **Other:** None
Learning Objectives

This presentation will explain the provincial and local (Toronto Central LHIN) context for recent physiotherapy investments in primary care, including:

• The framework guiding community based rehabilitation services that has been created/piloted by the TC LHIN
• The physiotherapy model of care and evaluation framework created and adopted by TC LHIN CHCs
• The implementation strategy and results to date
• Lessons learned and shared experience from the perspective of the providers and the patients
Context Setting – Provincial

- Patients First Legislation:
  - Integrated Home and Community System – with strong primary care integration
  - Focus on population health and patient experience

- 2017 LHIN Mandate Letter – focus on interprofessional team care in primary care

- Continue to leverage activity that followed Physiotherapy investments in primary care – 2015 investment in 38 FTEs
  - Community Health Centers (CHC) 22.6 FTE
    - 1 FTE in shared application with an AHAC
  - Nurse Practitioner Led Clinics (NPLC) 1.4 FTE
  - Family Health Teams (FHT) 14.3 FTE
Context Setting – Toronto Central LHIN

- Established hospital based network of outpatient rehabilitation clinics (2013-14)
- Investments in community based exercise classes
  - TIME program for higher acuity patient
- Provincial investments in primary care PT – CHC & FHT
- CHC – key resource in sub regions to support interdisciplinary care for primary care patient

- Building on the development of a Community Rehabilitation Framework (2015)
Community Rehabilitation Framework: Scope

- The intent of the framework is to encompass a broad spectrum of community based wellness and rehabilitation services delivered in many settings by multiple regulated and non-regulated providers, both LHIN and non-LHIN funded.

**Ambulatory rehabilitation services**
(e.g., hospital based outpatient rehabilitation, day hospital, specialty clinics)

**Primary care services**
(e.g., rehabilitation services in Community Health Centres and Family Health Teams)

**Health and wellness services in the home**
(e.g., Home Care and Community Support Services)

**Health and wellness services in the community**
(e.g., falls prevention, health promotion, exercise classes)

**Non-health services in the community**
(e.g., municipal wellness programs, community centres)
Cross-sector collaboration is key to meeting population needs today and in the future

- Meeting the population needs (volume and complexity of client) requires partnerships between TC LHIN’s existing ‘basket’ of health services and other key stakeholders

TC LHIN and other stakeholders are challenged to meet the needs of today’s population within a fixed funding envelope. Current challenges include:

- Barriers to access, especially for some populations
- Poor system navigation
- No centralized directory of services
- Lack of clarity in provider roles
- Lack of delineated organizational roles
- Little accountability for population need
- Poor integration and transitions between services
- System evaluation
Community Rehabilitation Framework: A model to support equitable access for evolving population needs

Assessment and navigation tools for clients and providers

Outreach programs for hard to serve populations

System enablers
Expansion of PT in TCLHIN CHCs

- Prior to April 1\textsuperscript{st}, 2015, 3.5 FTEs across 3 CHCs
- As of April 1\textsuperscript{st}, 2015, 14.5 FTEs across 11 CHCs

- CHCs were asked to develop a common model to be implemented across all sites
- Building of any available evidence and/or jurisdictional experience
Expand access to physiotherapy through a population health model (expand the “reach” of physiotherapy)
Oversight and Implementation Structure

Clinical Directors PT Implementation Working Group

Enabled by “PT Project Lead”

LHIN Liaison & Oversight Group

Participating CHCs’

Primary Care PT Network

Toronto Central LHIN
Six “Features” of the Model

- Clinic Care
- Case Management
- Integrated Care
- Shared Care
- Programming Consultation
- Outreach
## Evaluation Framework

**How will we track our progress and measure our success in the first year of implementation?**

<table>
<thead>
<tr>
<th>WHAT WILL WE MEASURE?</th>
<th>CONSIDERATIONS/COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLIENTS</strong></td>
<td></td>
</tr>
<tr>
<td>CLIENT SATISFACTION</td>
<td>- Metric to be taken from an existing CHC patient satisfaction tool already in place, and adapted to target physical therapy service provision.</td>
</tr>
<tr>
<td>(METRICS (2) FROM AN EXISTING CHC TOOL)¹</td>
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<tr>
<td>CLIENT ENGAGEMENT</td>
<td>- Metric to be taken from an existing CHC tool adapted to PT</td>
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<tr>
<td>(METRIC FROM AN EXISTING CHC TOOL)²</td>
<td>- Client profile should include PT diagnosis, client demographics and interventions received</td>
</tr>
<tr>
<td>PT CLIENT DEMOGRAPHICS</td>
<td>- Metric to be taken from an existing CHC tool adapted to include PT integration feedback</td>
</tr>
<tr>
<td>(CLIENT PROFILE METRICS (3) ALIGNED WITH EXISTING CHC REPORTING PARAMETERS)³</td>
<td>- Binary achievement (yes/no) to implementation timeline (with capture of reasons for variance)</td>
</tr>
<tr>
<td>EMPLOYEE ENGAGEMENT</td>
<td>- Reported total new PT client per service provider against pre-established targets.</td>
</tr>
<tr>
<td>(METRIC FROM AN EXISTING CHC TOOL)⁴</td>
<td>- Reported percentage of total PT client per service provider against pre-established targets for outreach and integrated care service delivery components.</td>
</tr>
<tr>
<td>PT SERVICE PARAMETERS</td>
<td>- Standardized outcome measurement reporting for (minimum 2) client populations across the CHCs</td>
</tr>
<tr>
<td>(# OF NEW CLIENTS RECEIVING SERVICES BASED ON PRE-ESTABLISHED TARGETS)⁵</td>
<td></td>
</tr>
<tr>
<td>PT MODEL ADOPTION</td>
<td></td>
</tr>
<tr>
<td>(ACHIEVEMENT OF MODEL ROLL OUT TO MILESTONES)⁶</td>
<td></td>
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<tr>
<td>SERVICE INTEGRATION</td>
<td></td>
</tr>
<tr>
<td>(% NEW INTEGRATED CARE SERVICE VOLUMES; % NEW OUTREACH SERVICE VOLUMES)⁷</td>
<td></td>
</tr>
<tr>
<td>PATIENT/PATIENT POPULATION OUTCOMES</td>
<td></td>
</tr>
<tr>
<td>(CLIENT OUTCOME METRICS (2) ALIGNED WITH EXISTING PT DOCUMENTATION STANDARDS INTEGRATED WITHIN NOD)⁸</td>
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</table>
• 1:1 PT care
  • Integration with primary care teams
  • Referral and prioritization system

• 2015/16
  • 2,451 clients
  • 11,713 encounters
1:1 Clients: Demographics/Profile

- Most clients between 35 & 64 (59%)

- Majority of clients (79%) seen for musculoskeletal issues
  - 15% Back
  - 9% Shoulder
  - 8% Knee
  - 6% Neck
Client Reported Outcomes

Global Rating of Change: 95%
- 83%: A very great deal better, A great deal better or Quite a bit better, Moderately better

Patient Specific Functional Scale:
- 77% up
- 16% sideways
- 7% down
# Client Reported Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased understanding of condition</td>
<td>96%</td>
</tr>
<tr>
<td>Self management strategies</td>
<td>95%</td>
</tr>
<tr>
<td>Improved mobility</td>
<td>89%</td>
</tr>
<tr>
<td>Reduced pain</td>
<td>92%</td>
</tr>
<tr>
<td>Reduced pain medication</td>
<td>61%</td>
</tr>
<tr>
<td>Overall satisfaction</td>
<td>93%</td>
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</table>

***73% of clients would not have been able to access physiotherapy elsewhere***
What clients said....

“It was transformative”

“I feel like I got my life back”

“What they are doing is so good and so hard to find. I think it is so amazing”

“It’s great, I’m astounded at how well it works”

“It would be great if more people had this service. I am very blown away”
• Opportunities
  • Variations in client volumes and revisit rate
  • Range # visits per client: 3.6 to 8.2 (avg 4.8)
  • Contributing factors?
    1. Client demographics/profile > Correlation analysis
    2. System/process factors > Process Mapping
    3. Physiotherapy practice factors > Guidelines
• **Guidelines for Individual PT Service Delivery**
  • Core: Education, self management and individualized exercise program (+progression)
  • Adjunct: Manual therapy, acupuncture/dry needling, modalities, taping, etc.
  • Frequency of appointments
  • Discharge criteria

• **Client Information Sheets (20 languages)**
• Standardized evidence-informed groups
  • Living Better with Pain, McMaster University
  • Back to Movement (Sherman et al 2005)
  • Strong and Steady, Four Villages CHC
• **Interdisciplinary 1:1 care**
  • Integration with primary care teams
  • Referral pathways for clients with or at risk of pelvic floor dysfunction
  • Concussion management capacity building

• **Interdisciplinary group programs**
  • Pre and Post Natal Programming
  • Diabetes Programming
• Direct access to physiotherapy services
• Medical directive for diagnostic imaging
• Inter-CHC referral process/PT Directory
- RNs and RDs from West Toronto Diabetes Program, DECNET
- TCLHIN Diabetes Educator “New Hires Program”
- PSWs from Woodgreen Community Services
- Recreation and Fitness Staff from City of Toronto (Regent Park Community Centre)
Outreach

• Group exercise for clients with mental health conditions at Bailey House

• Outreach team for Thorncliffe community

• Prenatal program at a shelter for abused women
• Partnering with local FHTs/solo practitioners/SPIN

• Collaborative partnerships with Crossroads Clinic

• PT programs delivered off-site in community
22% of clients served through the physiotherapy collaborative program are not rostered** to a primary care provider (MD or NP) at the CHC.
## Impact on Primary Care and Allied Teams

<table>
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<tr>
<th>Impact</th>
<th>MD/NP</th>
<th>Allied</th>
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</thead>
<tbody>
<tr>
<td>More comprehensive care</td>
<td>94%</td>
<td>98%</td>
</tr>
<tr>
<td>Improved quality of care</td>
<td>91%</td>
<td>96%</td>
</tr>
<tr>
<td>Improved my overall satisfaction providing care</td>
<td>88%</td>
<td>94%</td>
</tr>
<tr>
<td>Reduce # appointments for pain mgt/reduced function/mobility</td>
<td>76%</td>
<td>NA</td>
</tr>
<tr>
<td>Reduced amt of pain medication prescribed</td>
<td>58%</td>
<td>NA</td>
</tr>
<tr>
<td>More appropriate referrals to specialists</td>
<td>76%</td>
<td>NA</td>
</tr>
<tr>
<td>Reduced the need for diagnostic imaging</td>
<td>42%</td>
<td>NA</td>
</tr>
<tr>
<td>Overall satisfaction</td>
<td>97%</td>
<td>95%</td>
</tr>
</tbody>
</table>
What Primary Care and Allied Team members said......

“It has been a total success”

“It has been really fantastic”

“We are thrilled. We are greedy, we want more”

“It has been a huge asset for us”

“It has been amazing… it has been life transforming for me as a clinician and for patients”
Success Factors

1. Orientation and Team Building

2. The PT Network

3. The PT Lead Role
Limitations and Opportunities

1. Overwhelming demand
2. Unexpected administrative burden
3. Ongoing funding for PT Lead role
4. Building on the collaborative
Next Steps

- Expansion of Team Based Care model to primary care outside of CHC
  - Ideally moving to a broader rehabilitation service

- Capacity planning in the context of sub region planning and population need

- Continued integration with other rehabilitation services in the system
  - MOH MSK program – non surgical pathways
Discussion

reaction / questions / discussion

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