30

YEARS OF CARING
ANS DE COMPASSION

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PACT –
People Accessing Care Teams

Team Based Care at Black Creek CHC

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Executive Leaders Meeting

Kingsbridge, Ontario

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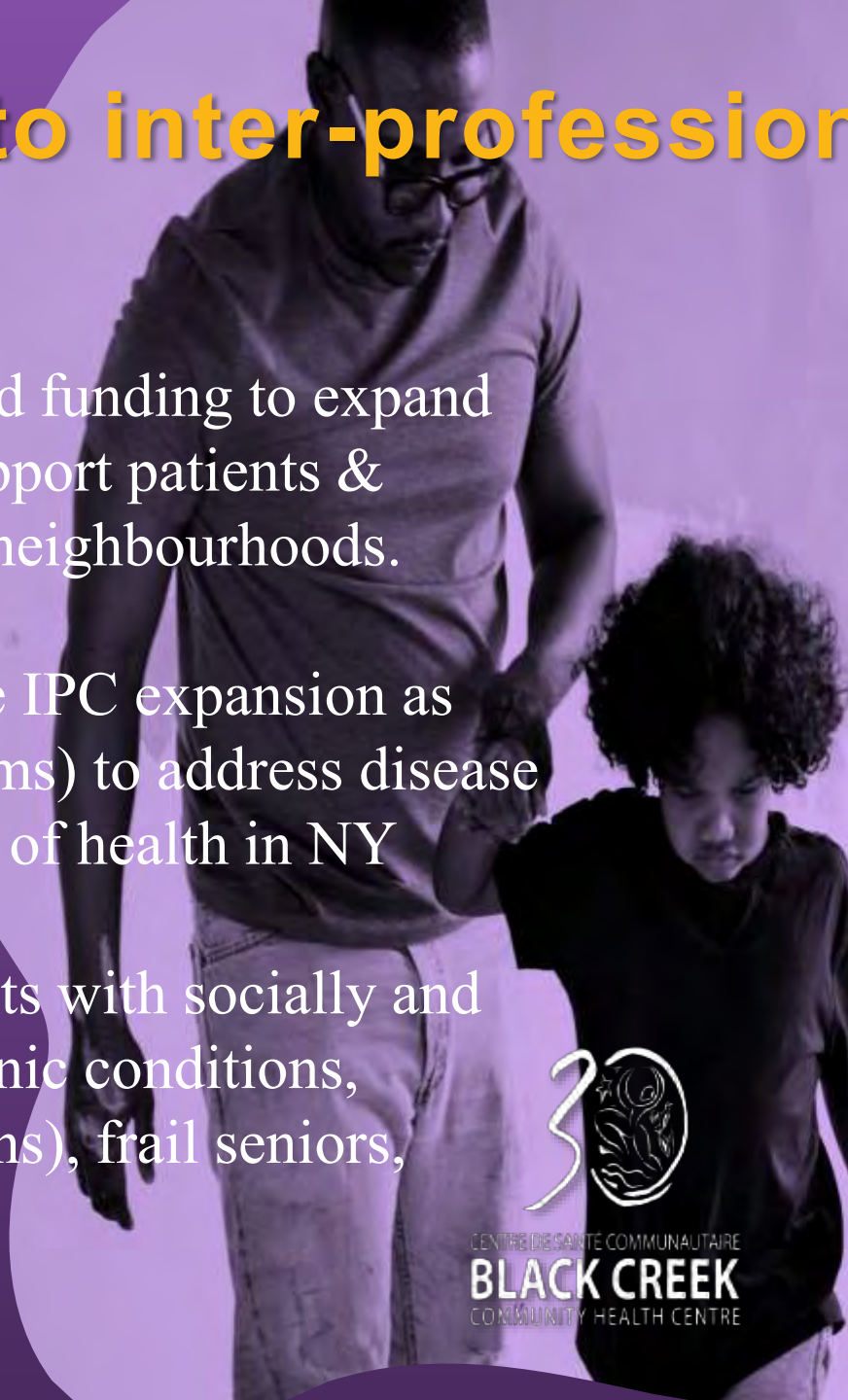
Increasing access to inter-profession care teams

- In 2018, Black Creek CHC received funding to expand inter-professional health care to support patients & providers in Toronto's North York neighbourhoods.
- Black Creek CHC implemented the IPC expansion as PACT (People Accessing Care Teams) to address disease prevalence and social determinants of health in NY
- PACT focuses on vulnerable patients with socially and medically complex needs (i.e. chronic conditions, including mental health & addictions), frail seniors, newcomers



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Population Characteristics

North York West

- Newcomers (56.1%)
- Visible Minorities (58.8%) provincial average 25.9%
- Lone-parent families(29.4%) provincial average 16.7%
- Living below low-income measure, after tax (21.8%) provincial average 13.8%

NYW = 284,700 people

- Diabetes - 15.6% (High)
- Asthma - 14.2% (High)
- High Blood Pressure - 29% (High)
- Mental Health physician visits – seniors (9.9%)
- Mental Health physician visits – adults, age 20-64 years (9.1%)

North York Central

- Newcomers (58.6%)
- Visible Minorities (54.2%) provincial average 25.9%
- Lone-parent families (29.4%) provincial average 16.7%
- Living below low-income measure, after tax (20.2%) provincial average 13.8%

NYC = 395,300

- Diabetes (12.3%)
- High Blood Pressure (25.3%)
- Asthma (12.5%)

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PACT Program Objectives

- To **reduce visits** to the Emergency Department (ED).
- To **improve access to team-based care** and decrease barriers to equitable access to care.
- To enhance coordination between primary care and allied health providers, thus **integrating care** around the patient and between providers.
- To bring **services that people need closer to their home** and create a circle of care.

PACT Services Provided at Black Creek CHC

- Social Worker /Therapist
- Physiotherapist
- Registered Kinesiologist
- COPD Education and Smoking Cessation
- Sexual Health Clinic
- Legal Services
- Community Support and Social Services
- Health System Navigation
- Lactation consultant
- Registered Dietitian
- Diabetes Education & Management
- Retinal Screening (TOP)
- Chiropody/Assessment & Screening
- Foot Care
- Harm Reduction
- Midwife

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PACT – People Accessing Care Teams

Eligibility Criteria: Medical + Social complexity

- Patient with/without OHIP coverage
- Patient without extended health coverage or WSIB
- Patient with social and/or medical complexities (e.g. 4+ comorbidities, chronic illness, disability, lone-parent, precariously housed)
- Patient lives in North York West and North York Central
- Patient doesn't meet any of the criteria listed but the primary provider believes that the patient will benefit significantly from the service

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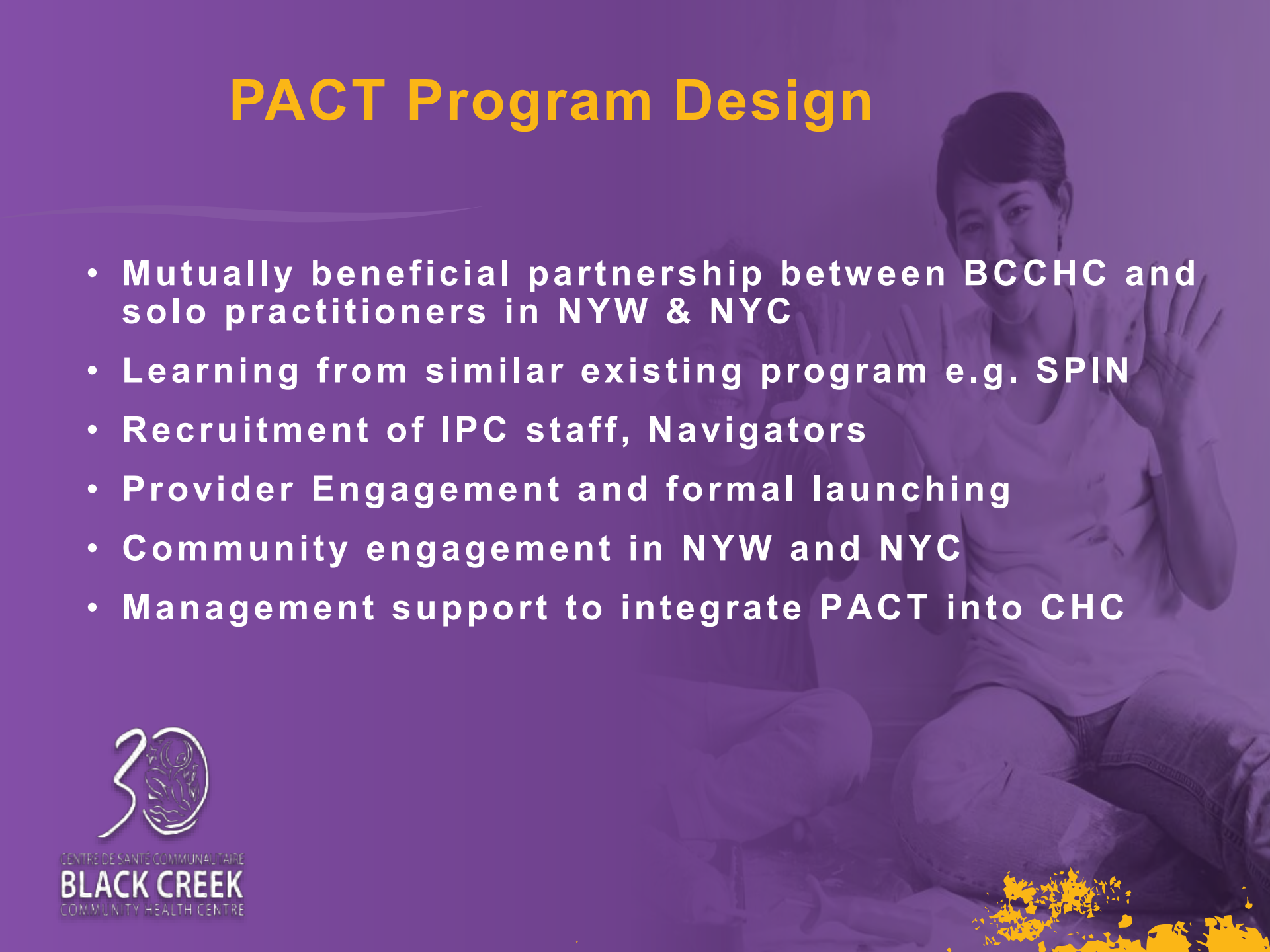
PACT Program Design



- Mutually beneficial partnership between BCCHC and solo practitioners in NYW & NYC
- Learning from similar existing program e.g. SPIN
- Recruitment of IPC staff, Navigators
- Provider Engagement and formal launching
- Community engagement in NYW and NYC
- Management support to integrate PACT into CHC

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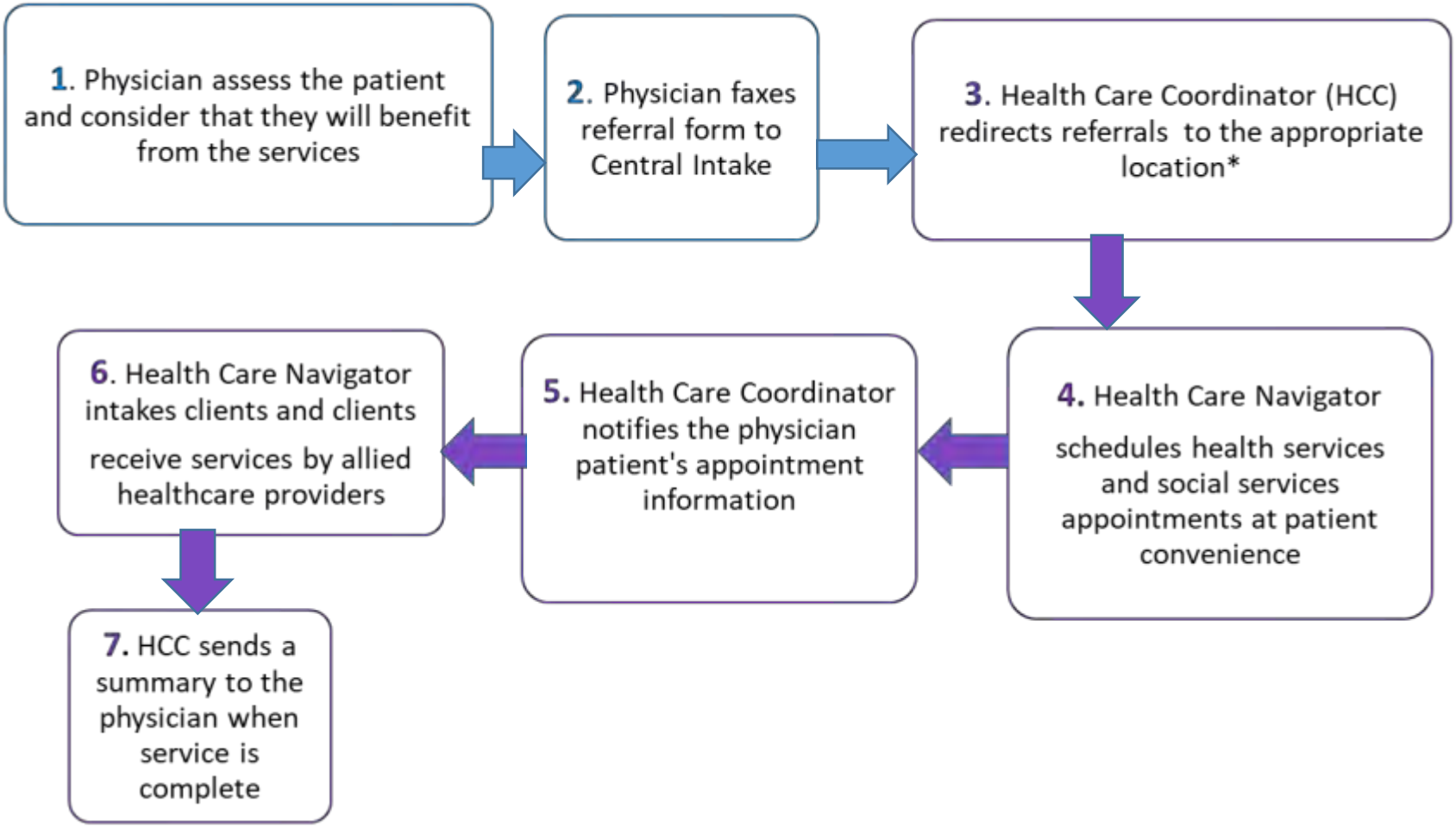
PACT Direct Referral Process



Implementation Challenges

- Getting solo practitioners on board
- Connecting with community members outside of BCCHC catchment area
- Different population groups/demographics
- Getting satellite spaces in NYC
- Connecting with MDs – usually busy
- Client discharge - physiotherapy and counselling services in particular

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Response to Challenges

- Face-to-face outreach to community practitioners
- Open house and Provider Experience Survey
- Building partnership with other agencies in NY
- Connecting with Community members
- Continues QI and increasing efficiency of the process to respond to higher demand
- Utilization of Health System Navigators to address SDOH barriers (in English, French, interpreters)

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PATIENT NAVIGATION

Contributes towards effective, equitable and patient-centred health care system.

Builds trusting, therapeutic relationships with clients and helps them self-manage their healthcare

Ensures ease of movement across healthcare system for continuity of care

PATIENT NAVIGATION
Why?

- Different approach to healthcare than a few decades ago
- Medical care increasingly sophisticated and more complex
-
- Numerous issues on the bio-psycho-social-cultural-economic levels
- Newcomers with little knowledge of Canadian system

PATIENT NAVIGATION
What?

- Effective liaison between patients and health care professionals
- Assist community members, especially vulnerable populations to:
  - Overcome barriers to healthcare
  - Bridge gaps in transition to care

PATIENT NAVIGATION
How?

- Serving as coordinator for the healthcare team
- Working with family members and care givers
- Accessing resources and advocacy
- Data collection, analysis and reporting

Navigation is about recognizing barriers for individual patients and identifying strategies for eliminating them.

PACT – People Accessing Care Teams

Program Performance

Overall Performance Indicators	July 2018- September 2019
# Physician referring	367
# Patients referred	2119

Type of Services Requested	July 2018-September 2019
Physical Health & Chronic Disease	1704
Mental health and/or addictions	466
Social	347

PACT – People Accessing Care Teams

Feedback from PACT MDs/NPs

- Happy is an understatement. PACT has provided my patients with rapid access to services that in many cases are unobtainable or associated with unacceptably long waiting lists. I have had extremely positive feedback from virtually all patients referred for all services. Patient encounter notes are thorough and appropriate. From my perspective, PACT has been practice changing in the most positive terms.
- Great service! Rapid respond time! Excellent reporting. Good feedback from patients.
- Very satisfied with program. Patients very pleased with services.
- Very happy with the services; very happy with the reports I receive; the speed of receiving assessments and patients upon request; the provision of a good range of services. Thanks.
- We are very happy for the services provided. Our patients have a very positive feedback. The wait time are short and accommodating. The providers make the patients comfortable and are very knowledgeable.

PACT – People Accessing Care Teams

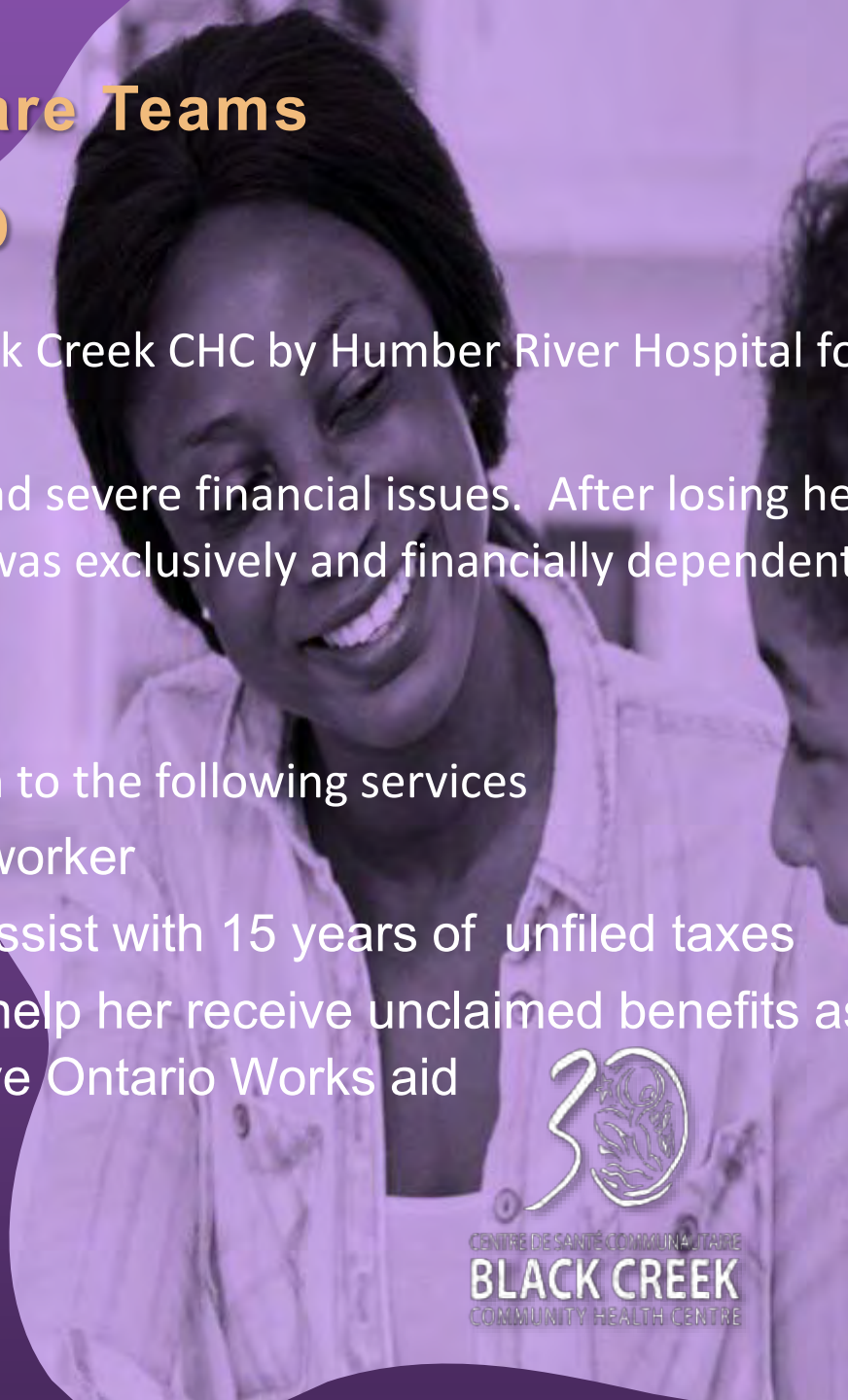
Partnership with Hospital ED

Helen, 41, and pregnant was referred to Black Creek CHC by Humber River Hospital fo follow up.

Upon intake, it was uncovered that Helen had severe financial issues. After losing he nearly 15 years ago, she currently lived and was exclusively and financially dependent her aging parents.

Black Creek CHC Navigators connected Helen to the following services

- counseling services through a social worker
- referral to a free income tax clinic to assist with 15 years of unfiled taxes
- connecting her with past agencies to help her receive unclaimed benefits a well as supporting her efforts to receive Ontario Works aid



Key Learnings & Sustainability

- Meeting the demand with adequate resources
- Client discharge strategy (especially from Social Work, Physiotherapy)
- Continuously improving efficiency of processes
- Partnerships strengthening, collaboration with HRH
- Continuous outreach and advocacy within community
- Self management approaches
- Implementation of feedback from clients & providers

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Thank you for your attention!

Questions? Comments?

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