Poster Board 11:

Upstream Population Health for Clinical Pathways-Lower Limb Preservation

Presenters:

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Description:

WellFort CHS is a member of the Central West OHT and an active primary care partner developing integrated population health interventions. With a comprehensive whole community focused Diabetes Education Program, WellFort is leveraging its interprofessional care excellence while also now building an upstream, integrated, whole community health promotion and outreach model of care. This session will describe the planning, partnership and clinical elements that have been actioned while also reviewing key learnings that impact community primary care integrated pathways.

Poster Board objectives and learning outcomes:

- Sharing Partnership Lessons to Advance and Integrate Population Focused Clinical Pathway
- Foot Screening Best Practices
- Sharing Primary Care Outreach Successes and Challenges

Full description:

Challenge:

The Peel community has one of the highest rates of diabetes in the province. With a current rate of 1 in 10 people having diabetes it is expected that this rate increases to 1 in 6 by 2025. A richly diverse community, Peel residents represent a population that requires health care offered in a culturally competent way.

The opportunity to leverage comprehensive primary care with the competencies of the Model of Health and Well-Being and the organization's focus on health equity and the social determinants of health, has positioned WellFort as a champion of integrated system leadership. In addition to the focus on preventative clinical care, the team has also committed to support additional primary care practices in improved upstream foot screening and navigation to services that can support culturally appropriate health and social supports.

Action:

The WellFort team has increased direct clinical and outreach roles to be able to identify individuals at risk of lower limb amputation and immediately offering health teaching with a focus on health literacy as well as navigation to key services. In addition, the WellFort team has been able to increase its working relationship on a clinical basis with the local acute care, home care and specialized services that is improving trust between the teams as well as aligning clinical approaches to care.

A cross organizational team has been established with a specific preventative care approach while jointly working alongside the treatment stream of this project. Together the leadership offered around the preventative care stream and treatment focus is allowing these integrated

system partners to work as a continuum and improved stratification of client need to ensure the client is navigated to the right serviced. This approach is expected to utilize care pathways for the right needs with the appropriate intensity of care at the right time.

Impact:

The program is in its initial stages currently. The learnings from the experience of trying to establish shared goals across all sectors in the system has been deep. Several challenges have required attention in this project, and it is the learnings from these experiences that offers insight to support other primary care teams as we strive to integrate care and utilize primary care as the foundation to care. A focus on self management and prevention care specialists is being tested in this integrated care approach. Specifically, utilizing prevention care specialists is being tested. The experience in embedding this model of care and new role within the community-based team may allow for improved care by supporting primary care clinicians and thereby releasing time to care for more complex care needs of the patients served.

Trajectory:

The WellFort team along with the Central West OHT partners are expected to continue to advance all elements of the prevention model of care. The journey to date will be shared with the audience and skill building for community-based foot screening will be shared including the testing and implementation of a population-based chiropody care model.

The outreach to support other primary care practices will be implemented as well as a commitment to complete self management care plans that leverages elements within the CHC model care such as a focus on health equity, health promotion and social determinants of care.

This model and the experience to implement it may be used as learnings for other community-based teams to be successful in providing integrated clinical pathways in primary care.