

Transforming Health Care Through the Primary Care Home

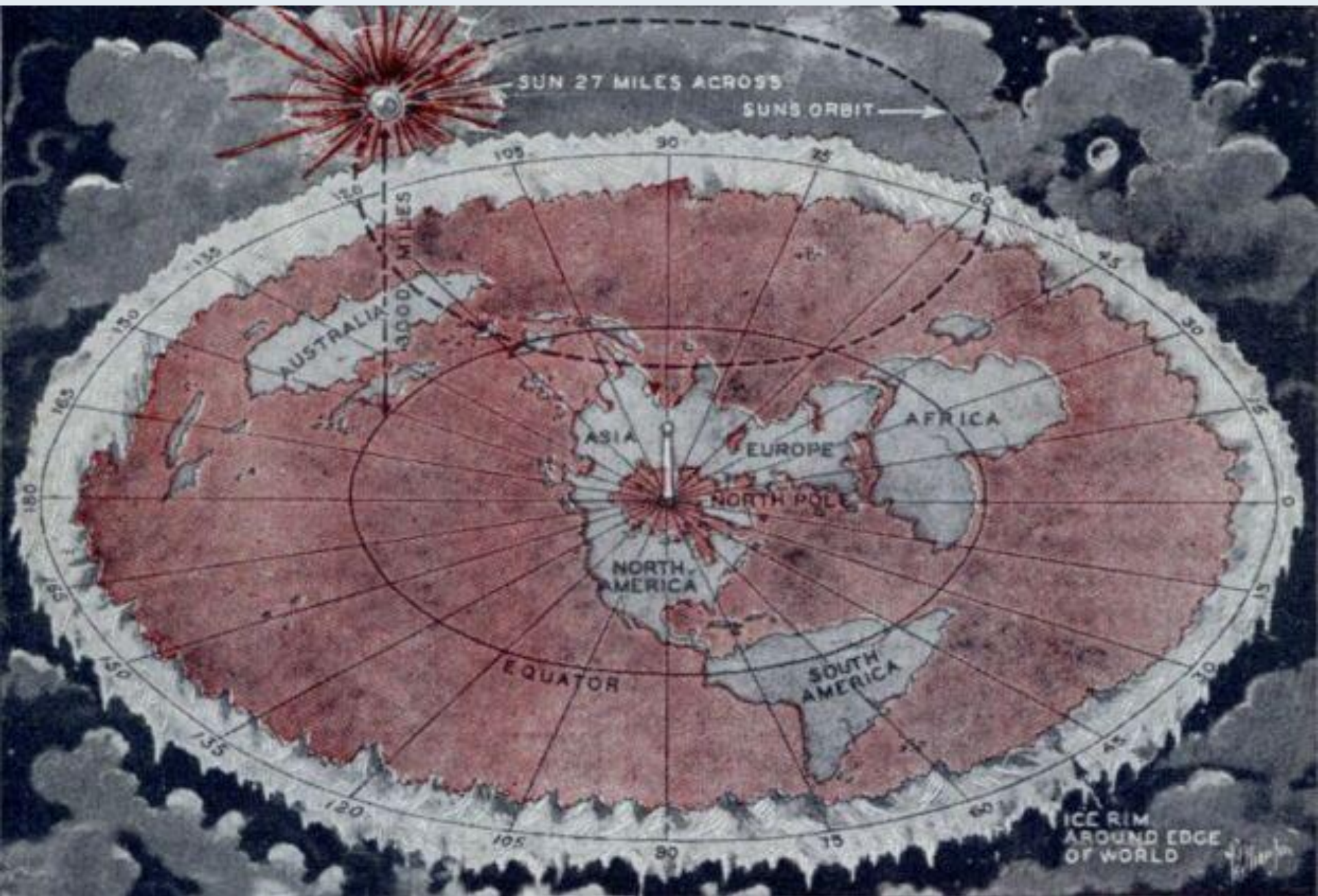
W.L. Clifford, MD, MScF, FCFP

November 23rd, 2012



One patient at a time

One provider at a time





IN NH Today

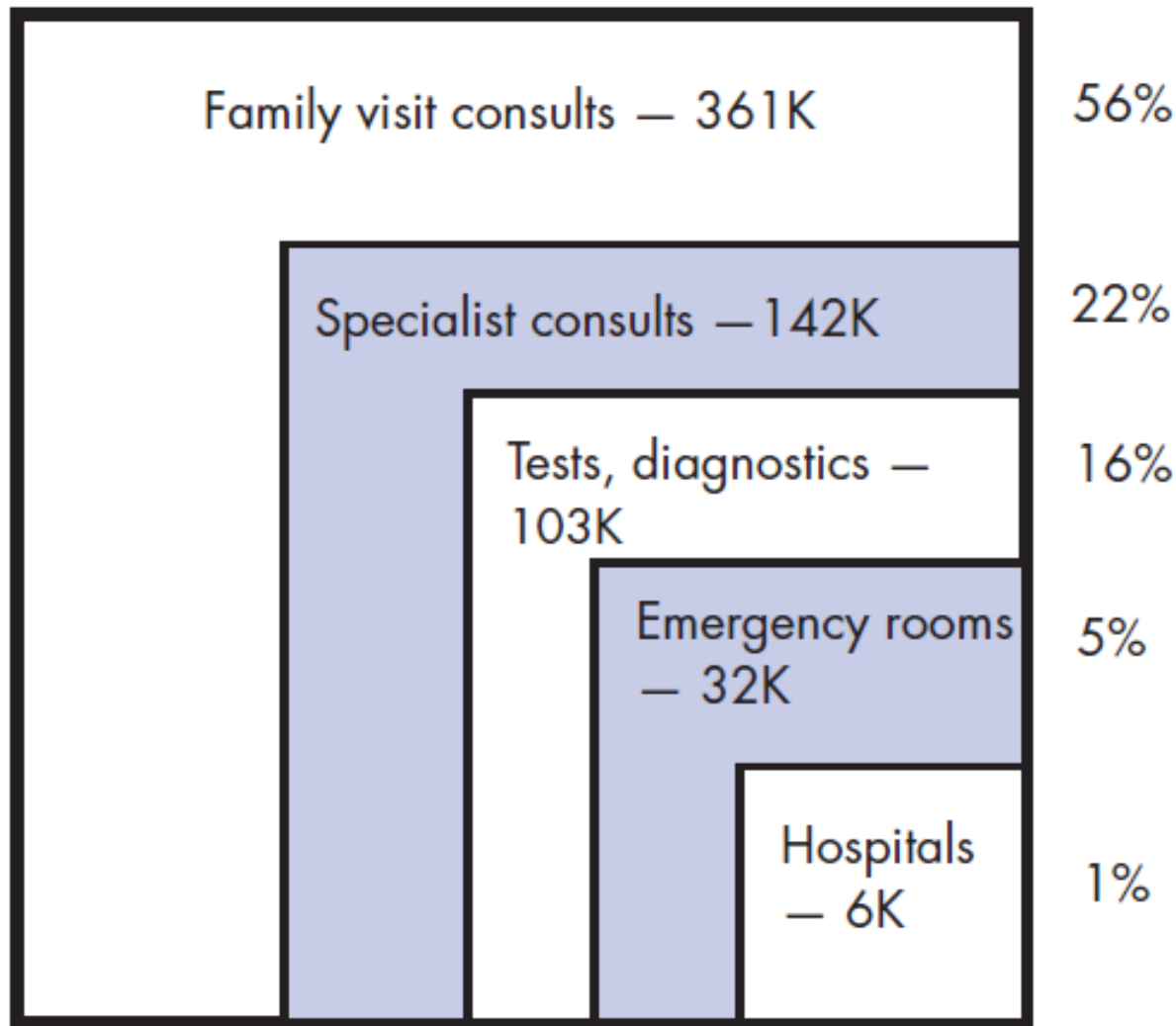
One patient can = 12
records*

*some paper, some electronic



- 79-10-0
- base oil from choice of SWC
- ~~ASA 81~~ - D/C - wt of lbs
- ~~Spencer~~ - done 7 days
- ~~Spencer~~ - 4 ft
- ~~idea~~ - 2.5
- ~~like~~ - present
- ~~glue~~ - medicinal
- ~~Spencer~~ - strong - various
- ~~unifast~~ - 3-12
- ~~posnow~~ - 2
- vision - 1
- add - 1
- add - 1
- neck
- tongue in the eye
- eye
- get to the point
- great due to
- red
- bone oil
- for oil
- days days - oil at back
- 10 pipe to fats
- cut p white
- find out of 6 - 5/2
- the day

Visits per day in Canada



Total: 644,000 visits

Source: Canadian estimates based on Ontario Ministry of Health data 2005. These distributions are based on work done by Green LA, Fryer GE Jr, Yawn BP, et al. The ecology of medical care revisited. *N Engl J Med* 2001;344:2021-5.

Health Care Transformation in Canada



Enhance The Health Care Experience

Patient-centred

Quality

Improve Population Health

Health promotion and illness prevention

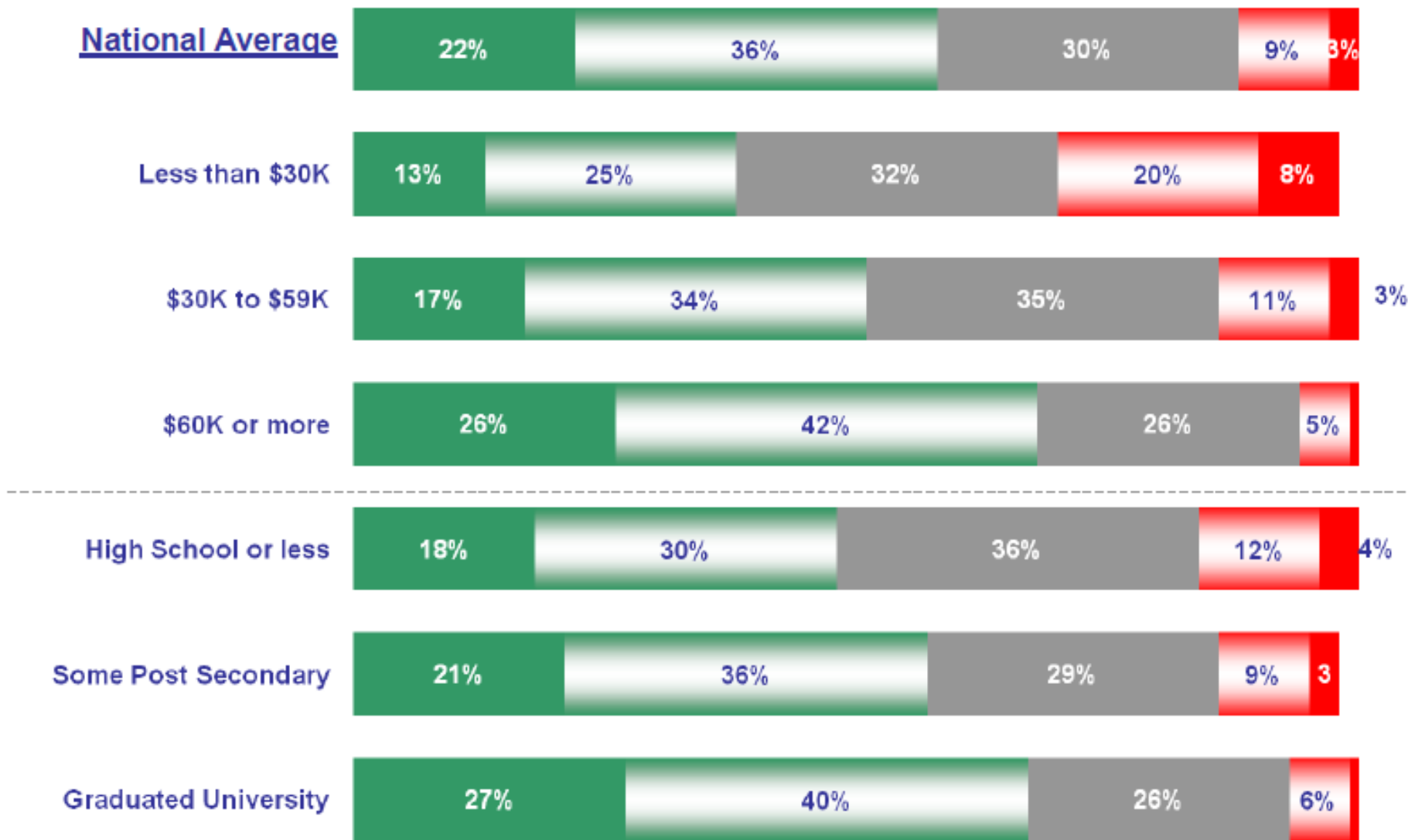
Equitable

Improve Value For Money

Sustainable

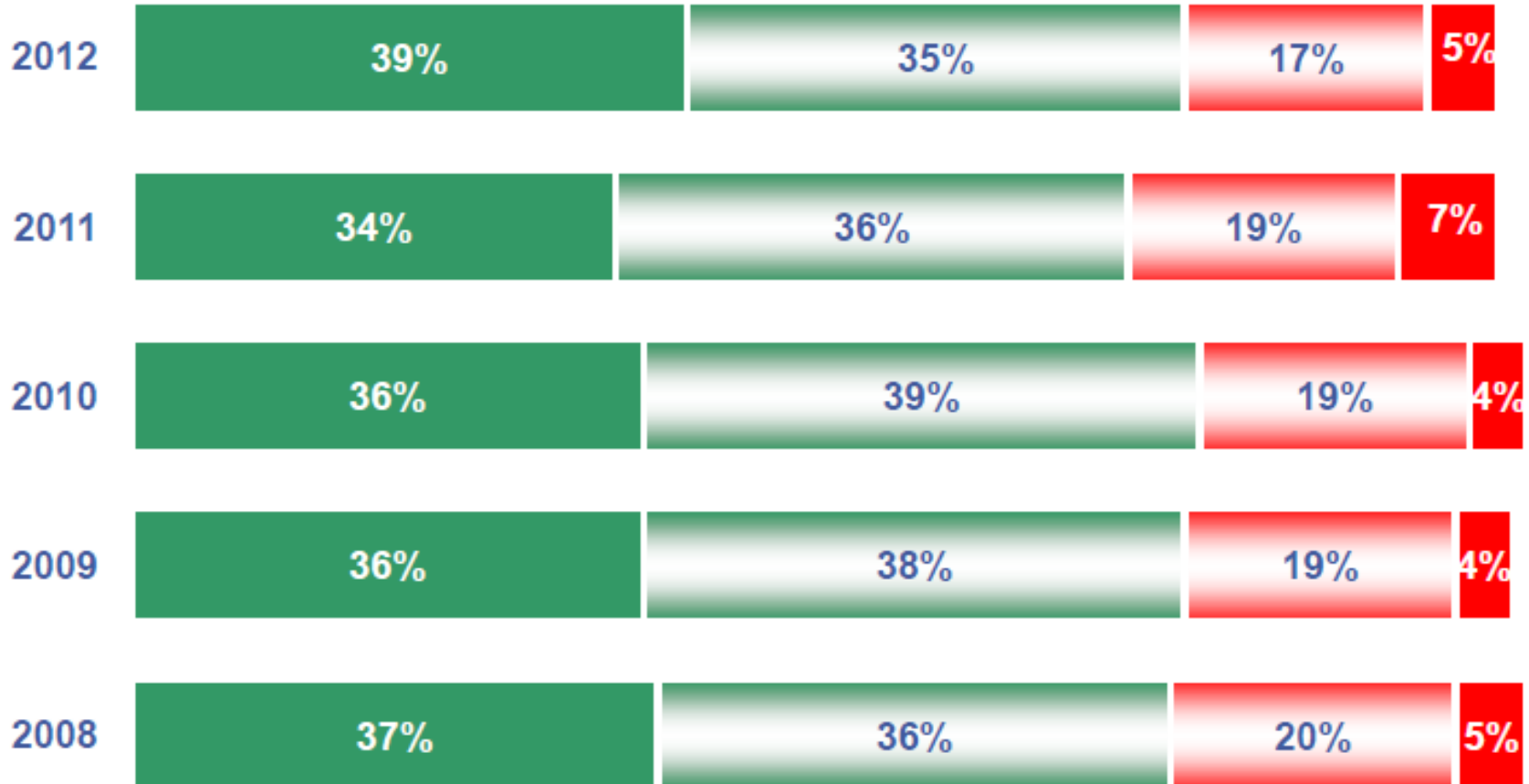
Accountable

In general, would you say your health is...? (Excellent, Very Good, Good, Fair, Poor)



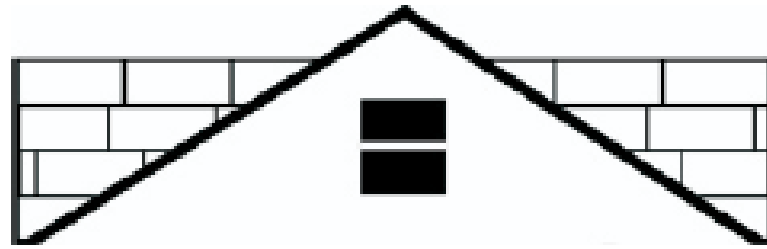
Base: All Respondents (n=1,200)

The overall quality of the health care services available to you and your family.



Those grading health services as “A” were more likely to:

- Have a family doctor (43% versus 23%)**
- Be age >55 or 18-35**
- Have less than high school education**

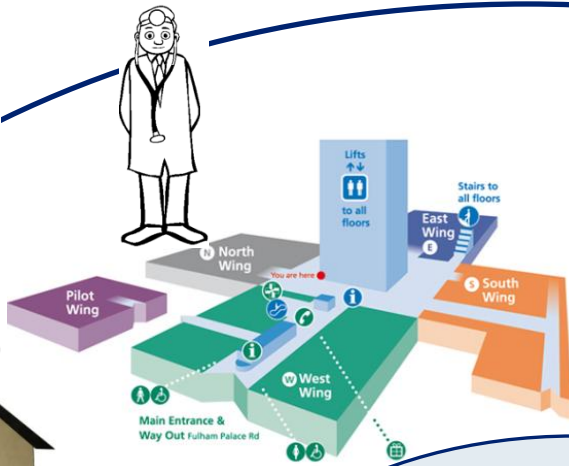


Patient-Centred Primary Care in Canada:

BRING IT ON HOME

“Care is coordinated, continuous and comprehensive with patients having access to an interdisciplinary team”

NH Community Care



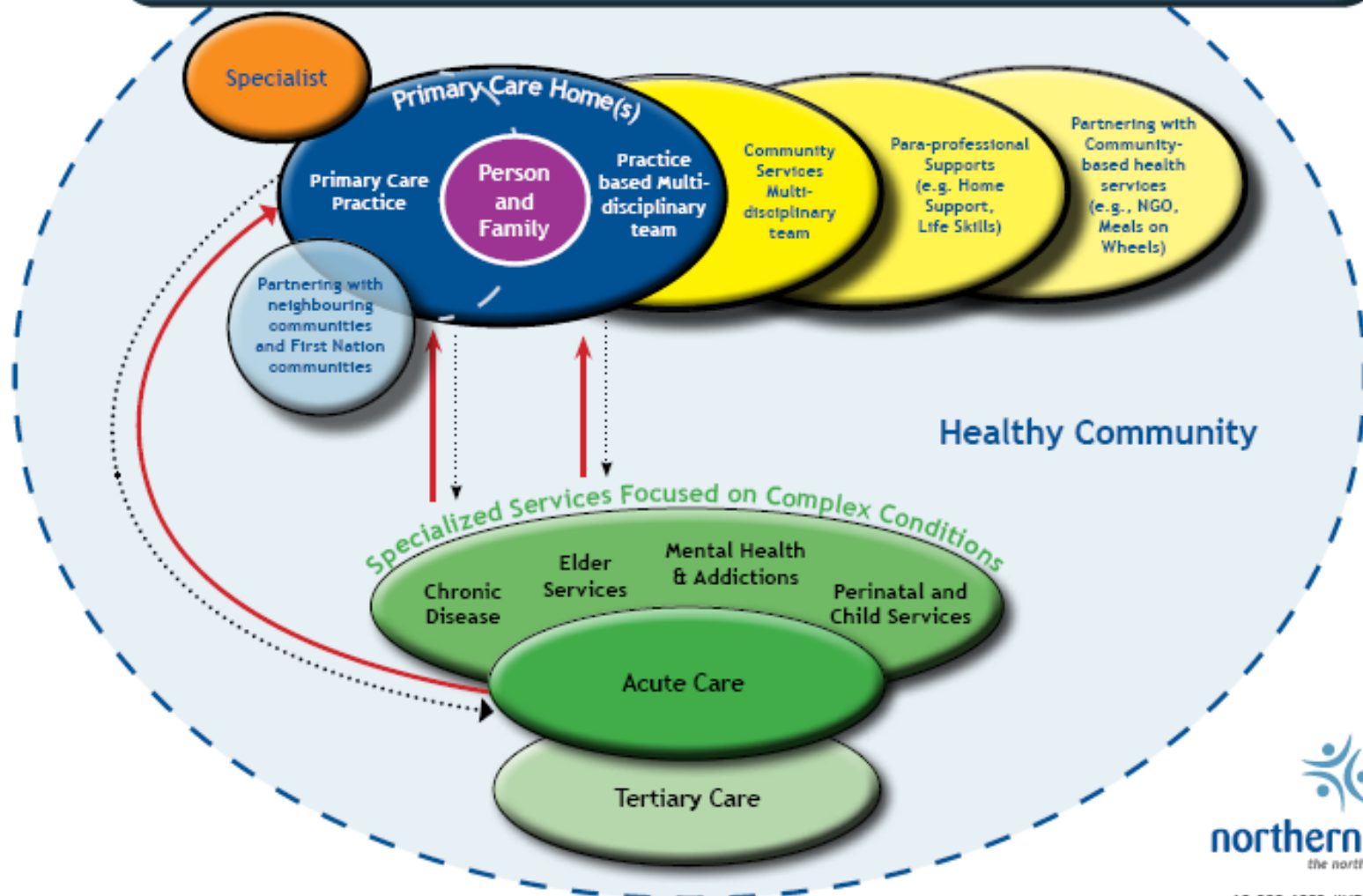
Shared

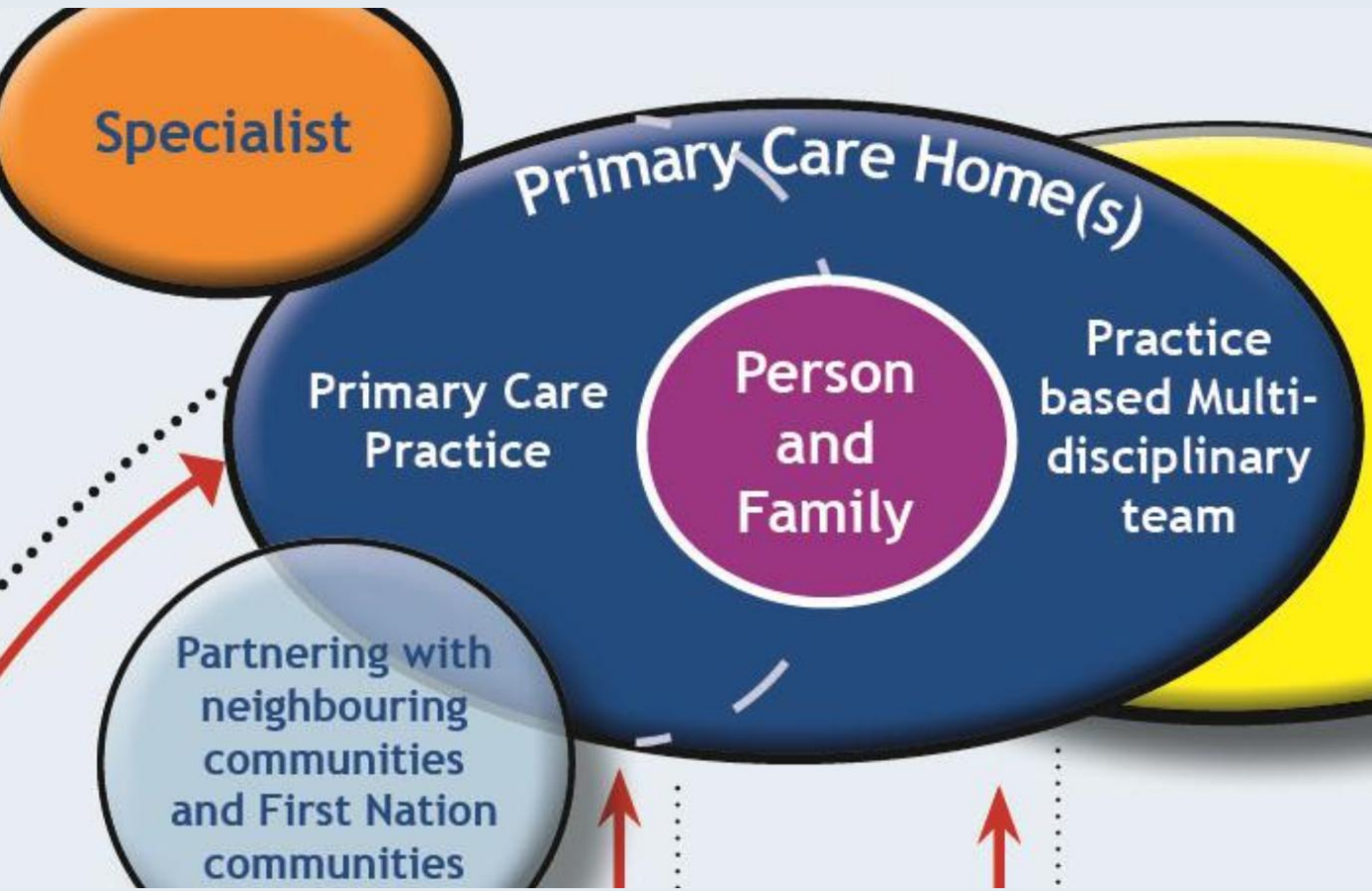
EHR

Idealized Northern Health System of Services Working Framework for Larger Community

Partnering to Build a Healthy Community

- Municipalities, Regional Districts, First Nations, School Districts
- Healthy communities, Healthy families, Healthy schools, Healthy workplaces, Healthy public policy
- Partnered initiatives with communities, industries, workplaces, school districts, etc.





Specialist

Primary Care Home(s)

Primary Care Practice

Person and Family

Practice based Multi-disciplinary team

Partnering with neighbouring communities and First Nation communities

Primary Care System Map

Mainstay Processes – Level 3 - Primary Care

Coordinate Care And Services

Partnering with Communities and Health System

Promote and Support Healthy Living (e.g. Prevention, Screening, Education)

Engage in Quality Improvement Activities

Support Self Management

Provide Input To and Liaise With Health Care Programs (e.g. Frail Seniors, Pregnancy Outreach)

Access

Conduct Triage / Scheduling Advanced Access

Conduct Group Medical Appointments

Provide After Hours Care

Provide Distance and / or Asynchronous Encounters (e.g. Email, telephone, Videoconferencing)

Manage Patient Transitions (e.g. Patient Journey, Travel, Interface Between Providers)

Call For Emergency Medical Services (Ambulance, Transfer, Respond to Disasters)

Evaluation, Diagnosis, Treatment And Support of Individuals

Evaluate / Manage New or Episodic Conditions (triage)

Manage Acute Events (Illness, Injury, inpatient care)

Manage Chronic Conditions

Order and Interpret Diagnostic Tests (Lab, Di, psychological, electrophysiological etc)

Assess Individual Health Status Create Care Plans and Facilitate Self Management

Refer to Specialist for Guidance / Treatment

Evaluate and Manage Disability (Risk, capacity, tolerance / rehabilitation)

Support Psychosocial Needs and Provide Mental Health Care in the Context of Family and Community

Create 3rd Party Documents (Insurance forms, medicolegal opinions etc)

Conduct Prevention And Screening

Perform Procedures On and Off Site

Support / manage care in community and residential care

Provide Reproductive Care

Provide End Of Life Care

Clinical Practice Management / Teams

Manage Panel / Registries for Care and Payment

Support Extrinsic Inter-professionals On Site For Management of Acute & Chronic Problems

Build and Maintain Intrinsic Inter & Intra Professional Workflow For Acute & Chronic Care

Co-Manage Chronic Conditions with Specialist

Work With Extrinsic Inter-professional Off Site – Focused Care and Complex Specialized Care/Manage Acute & Chronic Problems /

Knowledge Management

Conduct / Support Research Review / Analyze Evidence

Maintain Professional Education, Development and Decision Support (guidelines, standards etc)

Provide Learning Environment / Share Medical and Practice Management Learnings

Assess and Improve Quality (Acceptability, Appropriateness, Accessibility, Safety and Effectiveness)

Create and Maintain Documentation of Wishes, Events and Outcomes

H&CC Mainstay Processes

Support Coordinated Care, Services and Harm Reduction

Partnering with Citizens and Communities

Promote and Support Healthy Living (e.g. media and public presentations for prevention, education, falls prevention, E Learning, Info, Line etc)

Optimize independence (e.g. Meals on Wheels, Handyman Services, Life Line Services, Provincial Respiratory Outreach Program (PROF), Technology of Independent Living Program (TIL))

Support Self Management (including promotion of affordable housing through partnership with BC Housing, Private Operators and Communities, Transportation)

Promote & Support Healthy Living and Self Care (e.g. CLBC, MCFD, First Nations Seniors Advocacy Groups and NGOs)

Develop educational materials to Support Appropriate guideline based care for Palliative Care Patients (e.g. First Nations communities, hospice, acute care nurses)

Access

Scheduling of HCC Services - Home Support & Home Care Nursing Visits etc

Waitlist Management for Residential Assisted Living Facilities Assessment for Community services

Client/Resident Registration Management

Assessment and Care Management which includes needs assessments to meet criteria/eligibility

Receive and Process Referrals for Specialty Services

Evaluate clients financial obligations for services including financial assessments supplies and equipment, income assessment and rate setting (ARS, hardship waivers etc)

Evaluation Diagnosis Treatment And Support of Individuals

Provide Clinical Assessment (e.g. eligibility, specific identified needs)

Provide Residential Long Term Care for individuals with medical conditions and functional loss

Provide Long Term Treatment Support/Maintenance (e.g. SW, Nursing Care, Home Support)

Provide Respite Services (may include non medical home support or temporary residential care)

Provide Long Term Care Management (Home support, Adult day centers, respite services, residential long term care and education for self management)

Provide Episodic Treatment/ Intervention (e.g. home care nurse, OT/PT/SW, team visits) Wound Care Ambulatory Clinics

Provide Palliative Care (Hospice, Home Support & Home Nursing)

Provide Assisted Living

Knowledge Management

Analyze Data to monitor/ evaluate programs and services RAI, Procura, Palliative Registry, MIS

Provide Staff and Clinician Education/Development

Provide Minimal Reporting Requirements

Provide Clinical Decision Support through CDSTs and DSTs

Assess and Improve Quality (Acceptability, Appropriateness, Accessibility)

Public Health

Public Health Mainstay (PHC Homes) Processes

Support Coordinated Care And Services

Partnering with Citizens and Communities

Management of vulnerable populations eg maternal infant, child & youth, outreach to homeless population

Collaborate with partners in preventing communicable diseases eg physicians, pharmacists, municipalities, shelters for influenza.

Community advocacy eg active transportation, tobacco free grounds, zoning bylaws

Risk factor intervention eg tobacco control, healthy eating, harm reduction

Collaborate with partners to provide seamless care on child

Access

Provide outreach services to special target groups (e.g. wellness van; home visiting)

Link individuals to needed primary care or specialist services eg pregnancy terminations

Support individuals in addressing their own

Evaluation Diagnosis Treatment And Support of Individuals And Communities

Prenatal Care

Conduct prenatal psychosocial assessment / Perinatal screening eg prenatal depression

Screening for family/ parenting risk

Childhood screening for risk & disability eg infant hearing and speech; early development screening

Developmentally early child screening; Hearing & Speech assessments

Children with special needs assessments

Provide Immunizations / Immunization History

Infant and Child Care

Counseling eg infant safety; pregnancy; youth sexual health clinic

Individual counseling eg infant growth & development

Youth sexual and reproductive health assessments

Risk factor intervention eg tobacco cessation support; harm reduction supplies & education

Provide Immunizations / Immunization History

Youth Care

Provide sexual & reproductive health services for youth eg access to contraception

Youth sexual and reproductive health assessments

Risk factor intervention eg tobacco cessation support; harm reduction supplies & education

Nicotine Intervention Cessation Counseling / Brief intervention tobacco

Supply radon home testing kits

Adult Care

Assess risk factors relating to communicable disease e.g. biological factors and risky behaviours.

Provision of harm reduction supplies and disposal (needle exchange, crack pipes, condoms)

Nicotine Intervention Cessation Counseling / Brief intervention tobacco

Supply radon home testing kits

Community and Environmental Health

Institute public health measures to prevent spread of communicable disease eg restriction of food handlers, closure of schools

Test & treat for communicable diseases (TB, HepC, HIV)

Supply radon home testing kits

Supply radon home testing kits

Knowledge Management

Regularly review community assessment indicators and act appropriately

Conduct relevant community-based research

Create and Maintain Documentation of Wishes

Mental Health & Addictions - Mainstay Processes

Support Coordinated Care and Services (Harm-Reduction & Psycho-Social Rehab - Philosophy of Care)

Partnering with Citizens and Communities

(SP) Promote and Support Healthy Living (e.g. media and public presentations for prevention, education, addictions prevention etc)

(SP) Identify & Facilitate Resourcing of Social Determinants of Health (e.g. housing, income assistance)

(SP) Obtain Feedback on Services/Issues & Educational Needs (e.g. Provincial Patient Satisfaction Survey, Program Feedback Forms)

(SP) Consumer, Family and Stakeholder Input on Program Planning (e.g. Mental Health & Addictions Advisory Class, Consumer & Family Advisory Council)

(SP) Support Coordinated Care (e.g. AHIC, FNHB, MCFD, On Reserve services)

(PC) Participate in collaborative care framework with other ministries and community agencies

Access

(SP) Provide Triage to community and facility partners (e.g. home visits, homelessness, crisis response, hostel visits)

(SP) Provide Discharge / Transfer Planning to Community and Facility Partners

(SP) Provide Assessment and Waitlist Management for Residential Homes & Assisted Living Facilities

(A) Evaluate Needs for Financial Assistance (e.g. dental, Plan G, Accommodation Fees)

(A) Determine Eligibility for Service Facilities (e.g. Clinouses, Supported Independent Living (SILP), Residential Care, Assisted Living Facilities)

(A) Identify transportation options available for clinical/medical services (e.g. taxi, bus)

Evaluation Diagnosis Treatment And Support of Individuals

(PC) / (SP) Provide Clinical Screening and Assessment (eligibility, specific identified needs, e.g. depression)

(PC) / (SP) Provide Outreach (e.g. home visits, homelessness, crisis response, hostel visits)

(PC) / (SP) Provide Counseling for Events and Situations (e.g. substance misuse, mental, family)

(SP) Manage Acute Events (e.g. observation/stabilization, detox, early psychosis)

(SP) Provide Diagnostic Treatments (e.g. psychotropic evaluation)

(SP) Provide Specialist Consultation (e.g. Psychogeriatric, psychiatrists, psychologists)

(SP) Provide Acute Psychiatric Inpatient Care

(PC) / (SP) Support Self Management (e.g. medication compliance)

(PC) / (SP) Facilitate and Provide Care Management (e.g. shared care management, integrated care management, case conferences)

(SP) CONDUCT COMPARTMENTARY Review (e.g. competency, guardianship investigation/ reviews)

(SP) Provide Bio-psycho-social Rehab Services (e.g. vocational/ recreational rehab, consumer services)

(PC) / (SP) Manage Chronic Conditions (e.g. COAD, ACT, Elderly Services, Methadone, Development Delay & IHI, Acquired Brain Injury)

(SP) Provide collaborative group counseling in partnership with community organizations (e.g. substance use city program, First Nation organizations, etc.)

(SP) Provide Service Facilities (e.g. Clinouses, Supported Independent Living (SILP), Residential Care, Assisted Living Facilities)

(PC) / (SP) Provide Long Term Care Management (assisted living services, residential long term care and education for self management)

(SP) Provide Residential Long Term Care for individuals with severe Mental Health Issues

(SP) Provide Transportation for Activities of Daily Living, Group Activities (e.g. fleet vehicles)

Practice Management / Teams

(PC) / (SP) Integrate Services with Primary Care homes (e.g. CRU, specialists)

(SP) Integrate Services with Adult Care (provide services to patients in medical beds or ED with secondary mental health or substance use issues)

(SP) Registry Management - Identify individuals who need services within a collaborative care framework (e.g. services with other Ministries and Community Agencies - Homeless Integration Project, Provic, Offender Management Program)

Knowledge Management & Strategy Realization

(PC) / (SP) Provide Staff and Clinician Education and Development of Curriculum Materials

(SP) Provide Education on Legal Responsibilities (Mental Health Act, Adult Guardianship and Patient Property)

(A) Provide Minimal Reporting Requirements (MRR)

(A) / (SP) Analyze Data to evaluate programs and services (Research)

(PC) / (SP) Assess and Improve Quality (Acceptability, Appropriateness, Accessibility, and Effectiveness) (eg. Insk-Quality Review Committee)

(PC) / (SP) Provide Clinical Decision Support (e.g. policy and guideline development - DST)

(A) Evaluate/Monitor safety events for patients and employees (e.g. JCHO sites, PSL reporting)

(PC) / (SP) Identify community needs and allocating services and resources based on population health model

Intervention services (e.g. dental, van/ vanish)

Individuals in crisis (e.g. screening, waiting for children in violent situations)

Documentation of Wishes, Events and Outcomes

Community-Based Individual-Based

Create and Maintain Documentation of Events and Outcomes

Evaluation Diagnosis Treatment And Support of Individuals And

Prenatal Care

Conduct prenatal social assessment / fetal screening eg registry; perinatal depression

Screening for family/parenting risk

Infant and Child Care

Counseling eg infant safety; pregnancy; youth sexual health clinic

Individual counseling eg infant growth & development

Childhood screening for risk & disability eg infant hearing and speech; early development screening

Developmental/early child screening; Hearing & Speech assessments

Youth Care

Provide sexual & reproductive health services for youth eg access to contraception

Youth sexual and reproductive health assessments

Risk factor intervention eg tobacco cessation support;

Adult

Assess risk factors to communication e.g. biological risky beh

Provision of harm reduction supplies and (needle exchange pipes, co

Nicotine Int Cessation Co

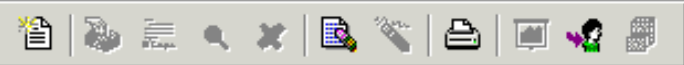


Population-Based



Individual-Based

Documents



Last 100 Documents : 7 out of 7 documents are accessible. (Document Count) In Error Documents Filtered

- Admission Notes
- Imaging
- Evaluation and Assessment
- History and Physical
 - 2010-09-28 08:26
- Management
- Plans
 - Shared Care Plan
 - 2008-11-23 1
 - 2009-09-17 1

Result Type: Shared Care Plan
 Result Date: 2008-11-23 16:17 PST
 Result Status: Auth (Verified)
 Result Title: Test Shared Care Plan
 Performed By: CLIFFORD, William on 2008-11-23 16:17 PST
 Verified By: CLIFFORD, William on 2009-09-17 11:28 PDT
 Encounter info: 000533223, Ft St John H, Diagnostic, 2008-08-22 - 2008-08-22

CARE PLAN SUMMARY

DATE OF PLAN: 2007/01/01

Frail Elderly Collaborative

NAME OF PATIENT: Mickey Mouse	PHN: 9999 999 999
DATE OF BIRTH: 1930/01/01	PATIENT PHONE: 250-565-0000
FAMILY PHYSICIAN NAME: Dr. Zhivago	PHYSICIAN PHONE: 250-565-0001
	PHYSICIAN FAX: 250-565-0002

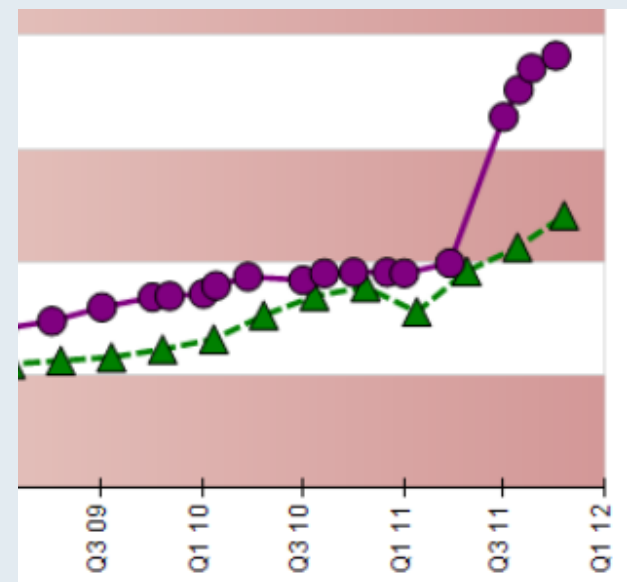
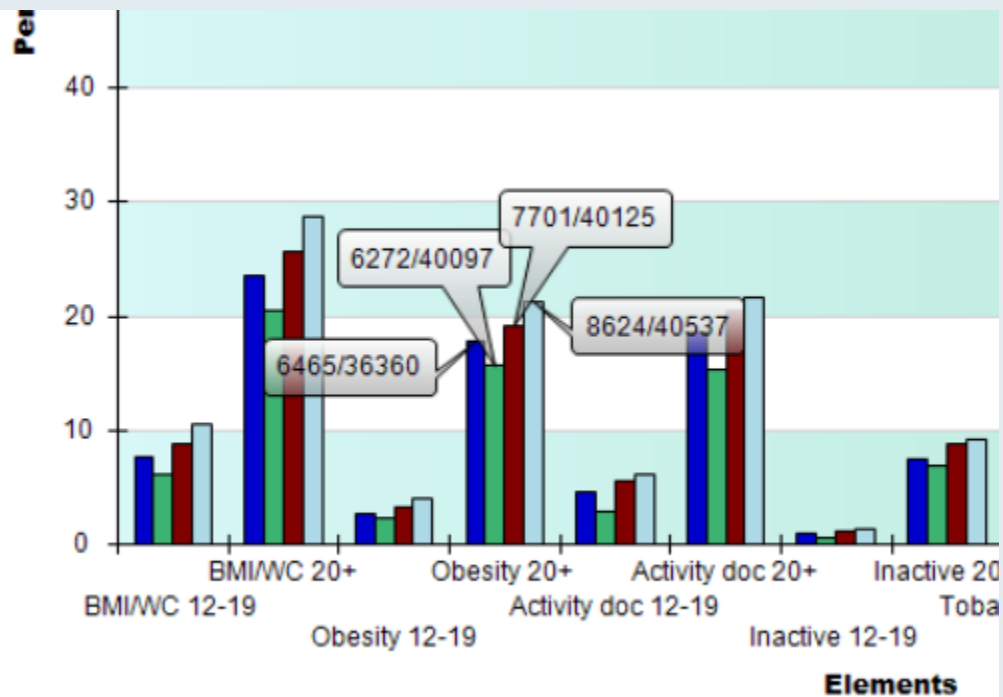
CASE MANAGER: Donald Duck	PHONE: 250-565-0003 FAX: 250-565-0004	CURRENT SERVICES/PROFESSIONALS: Community Rehab	CONTACT NAME/PHONE: Goofy Dog - 565-0006
DATE OF MOST RECENT RAH-CASSMT: 2006/04/04		Home Nursing Care	Daisy Duck - 565-0008
FAMILY / CAREGIVER NAME(S): Minnie Mouse		Rainbow Adult Day Centre	Pluto - 565-0007
PHONE NUMBER(S): 250-565-0009			

PROBLEM / RISK AREA	GOALS (Prioritized based on patient preferences)	STRATEGIES (Including referrals made)	RESPONSIBILITY	REVIEW DATE
1. Falls	Reduce # of Falls	- Increase PT involvement - needs work on hip extension	Goofy Dog (PT)	2007/03/31

- By type
- By status
- By date
- Performed by
- By encounter



SECTION	ITEM	PERFORMED/ PRESENT	ELIGIBLE POPULATION
Prevention	Current Tobacco use age 12-19	2	197
Prevention	Current Tobacco use age >19	106	1434
Prevention	Tobacco use documented in last 2 yrs age 12-19	13	197
Prevention	Tobacco use documented in last 2 yrs age >19	591	1434
Prevention	Overweight or Obese age 12-19	1	197
Prevention	Truncal Obesity age >19	45	1434
Prevention	BMI or WC documented in last 2 yrs age 12-19	5	197
Prevention	BMI or WC documented in last 2 yrs age >19	57	1434
Prevention	Physical inactivity age 12-19	5	197
Prevention	Physical Inactivity age >19	204	1434
Prevention	Activity documentation in last 2 yrs age 12-19	10	197
Prevention	Activity documentation in last 2 yrs age >19	430	1434

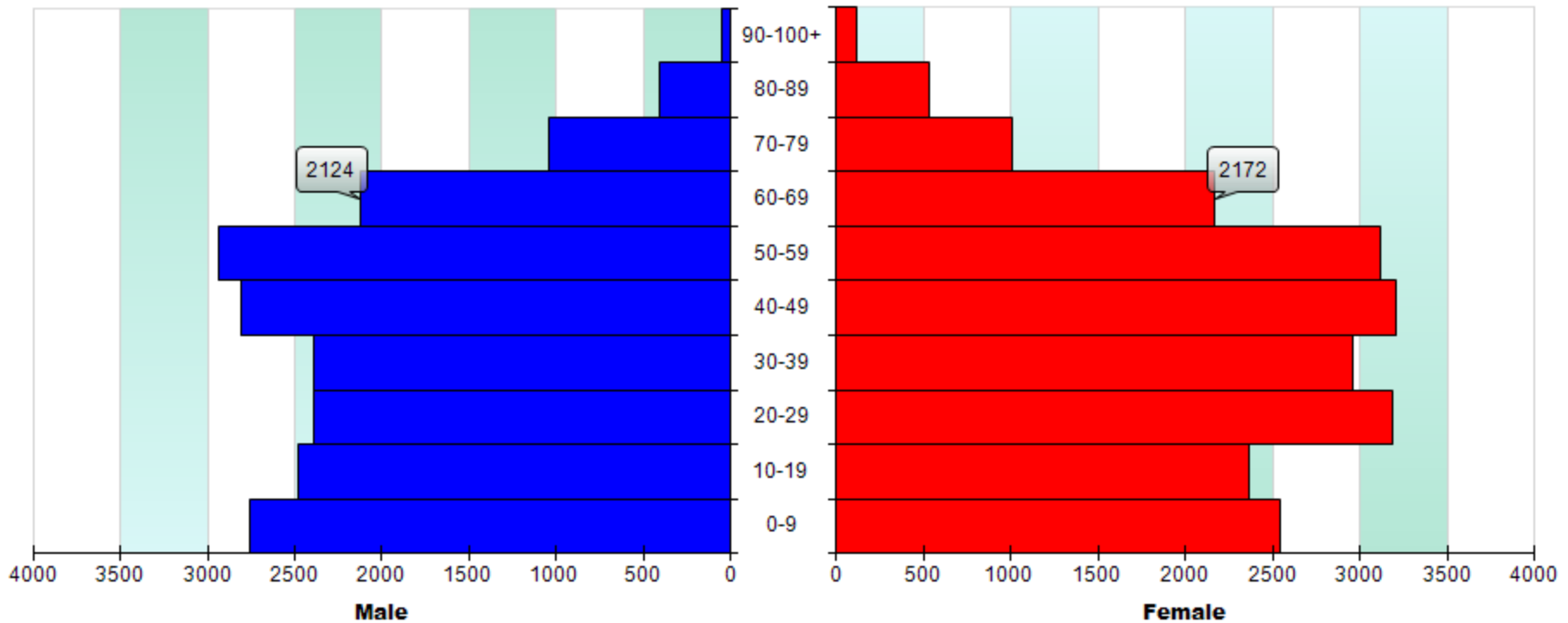


53,000 Patients Prince George

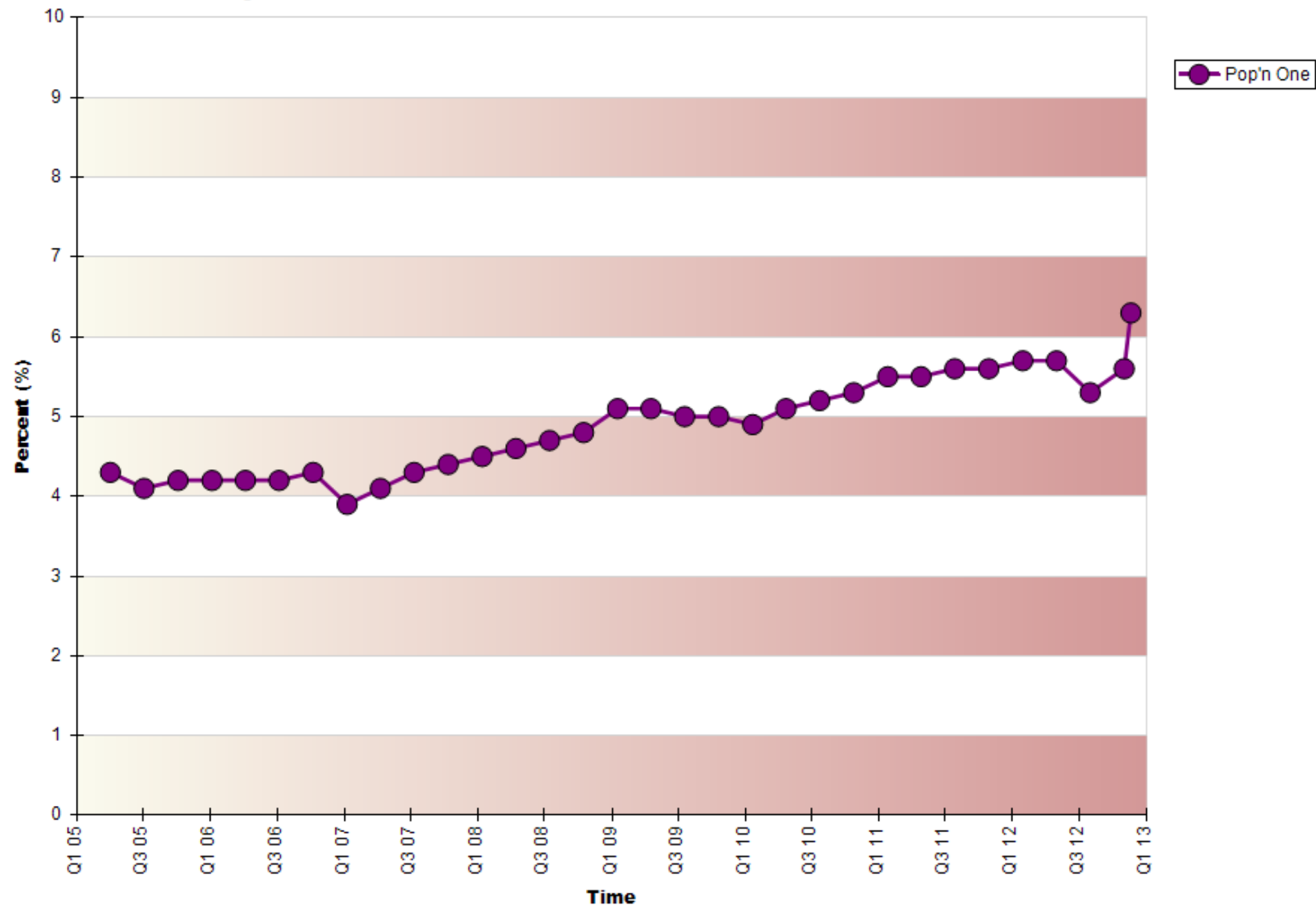
2012-10-31



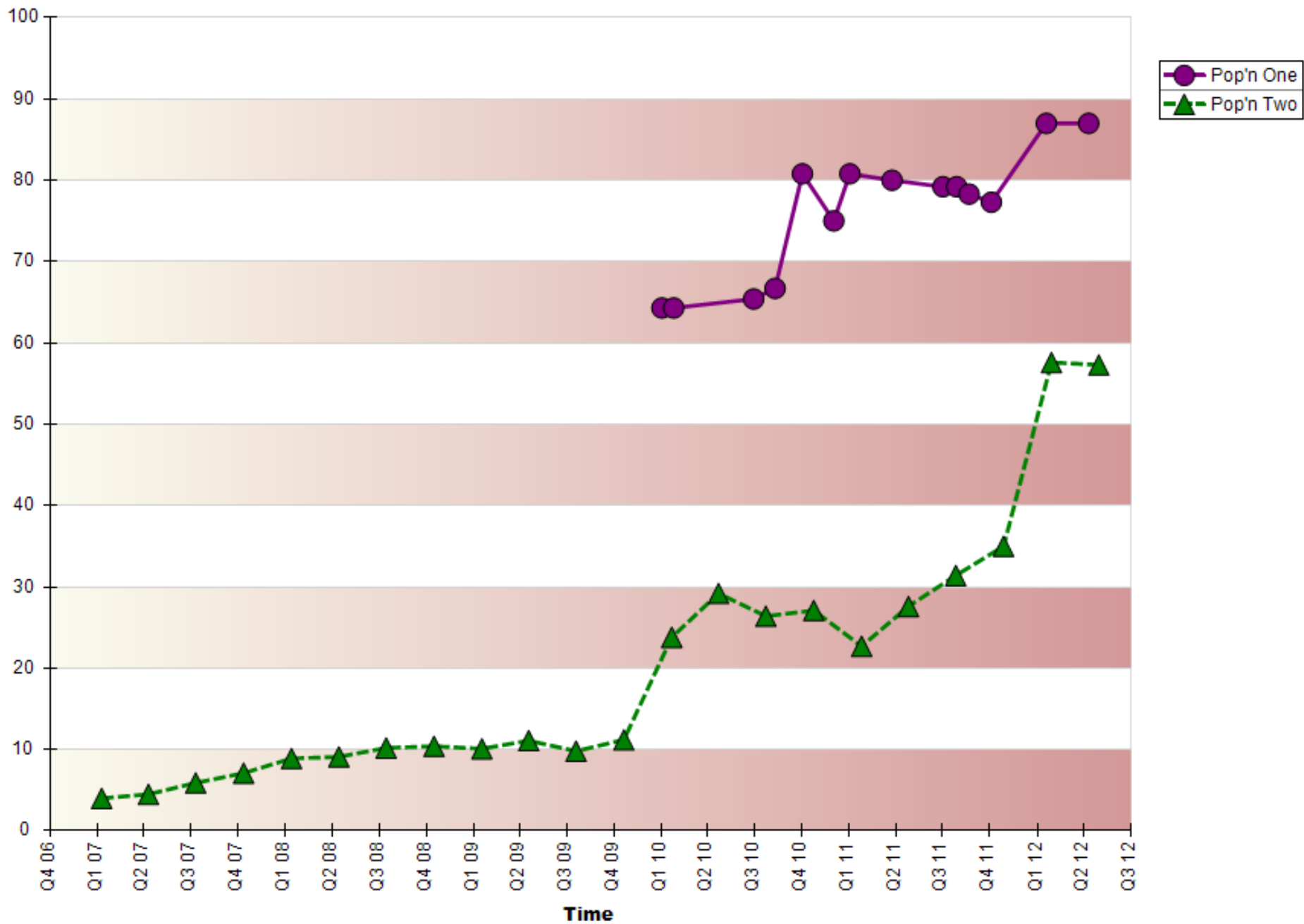
Age/Sex chart for Patients on 2012-10-31



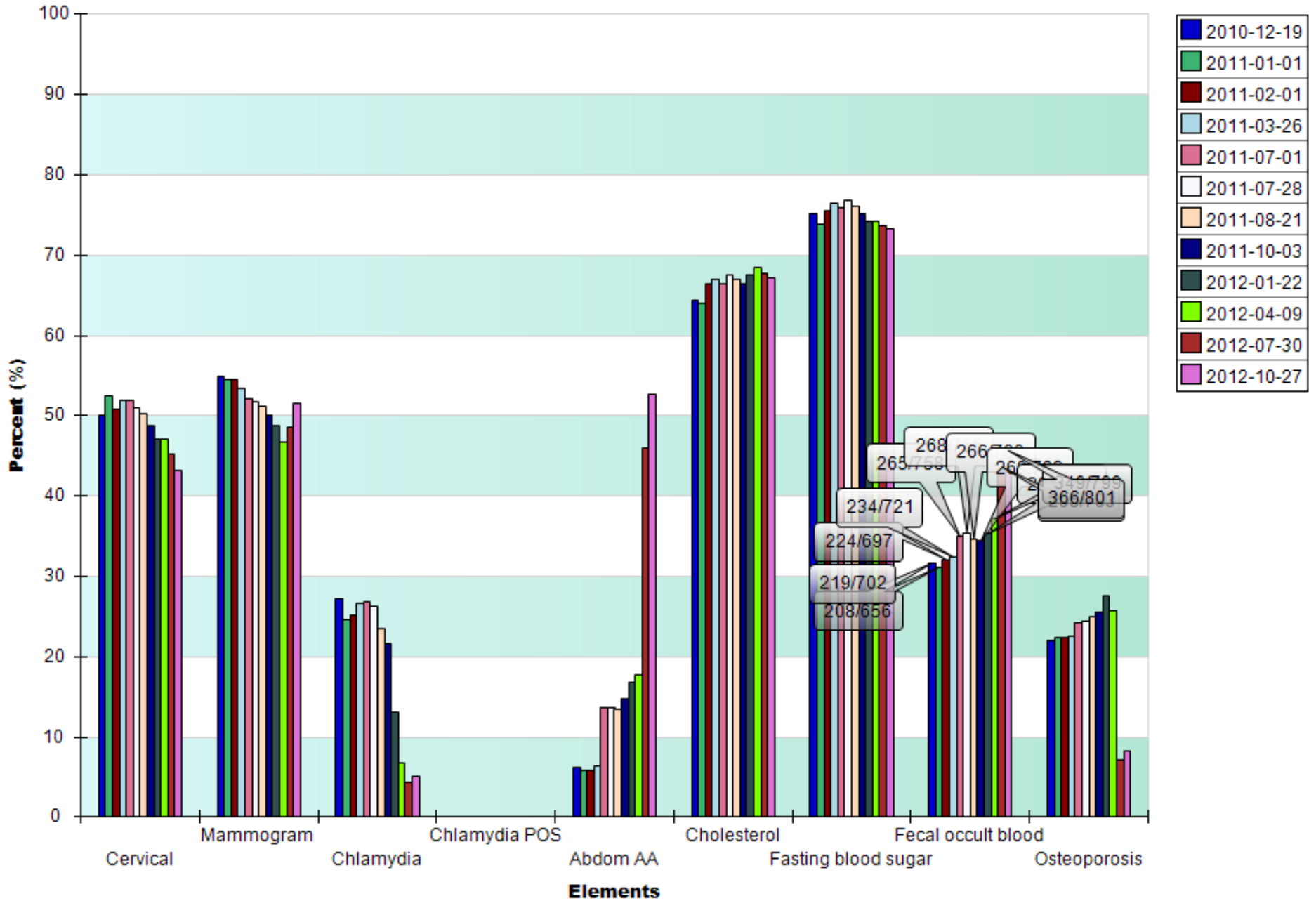
Diabetes prevalence



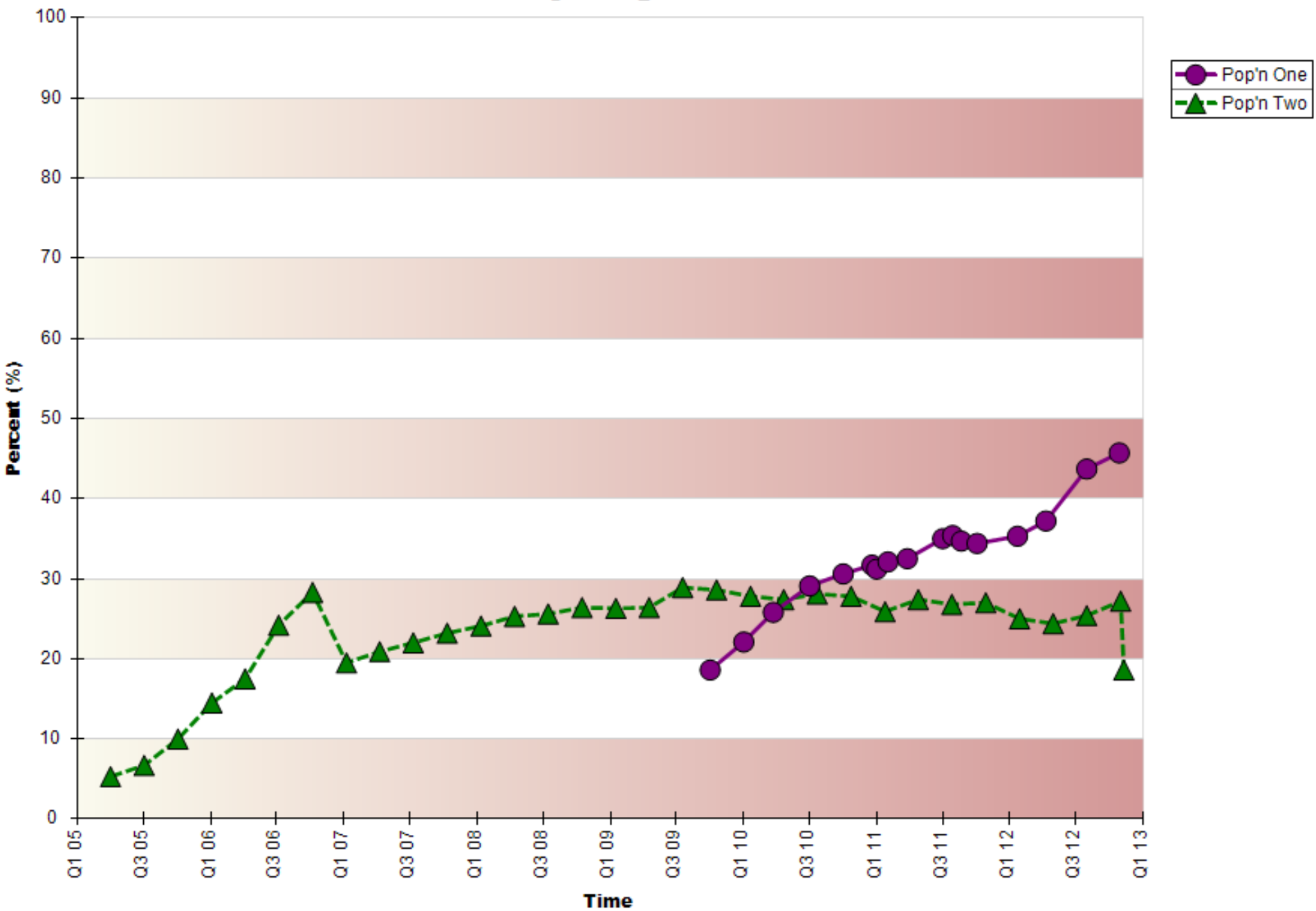
COPD and post bronchodilator spirometry at anytime



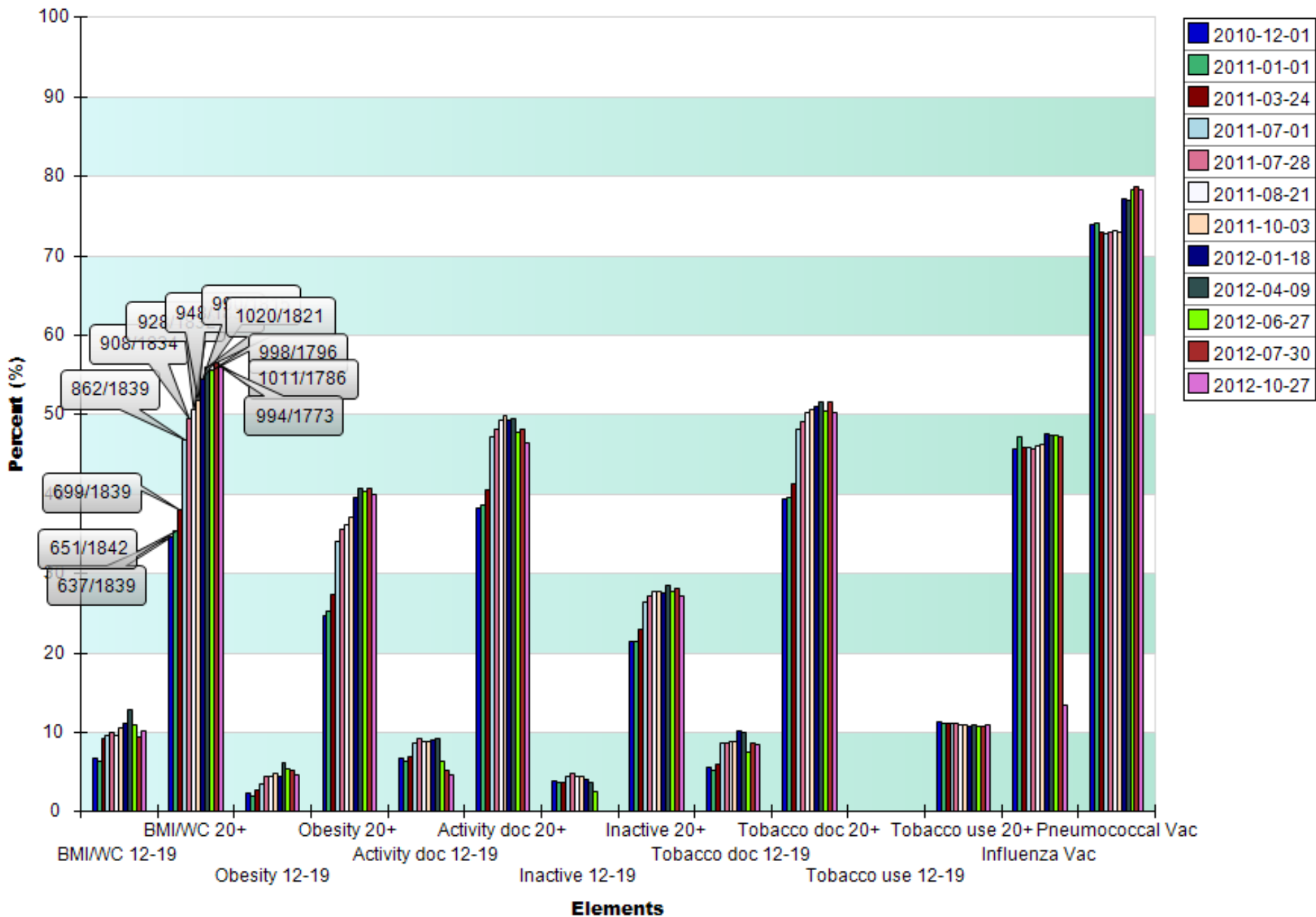
Indicators for Cancer Screening, STDs Screening, and Other Screen...



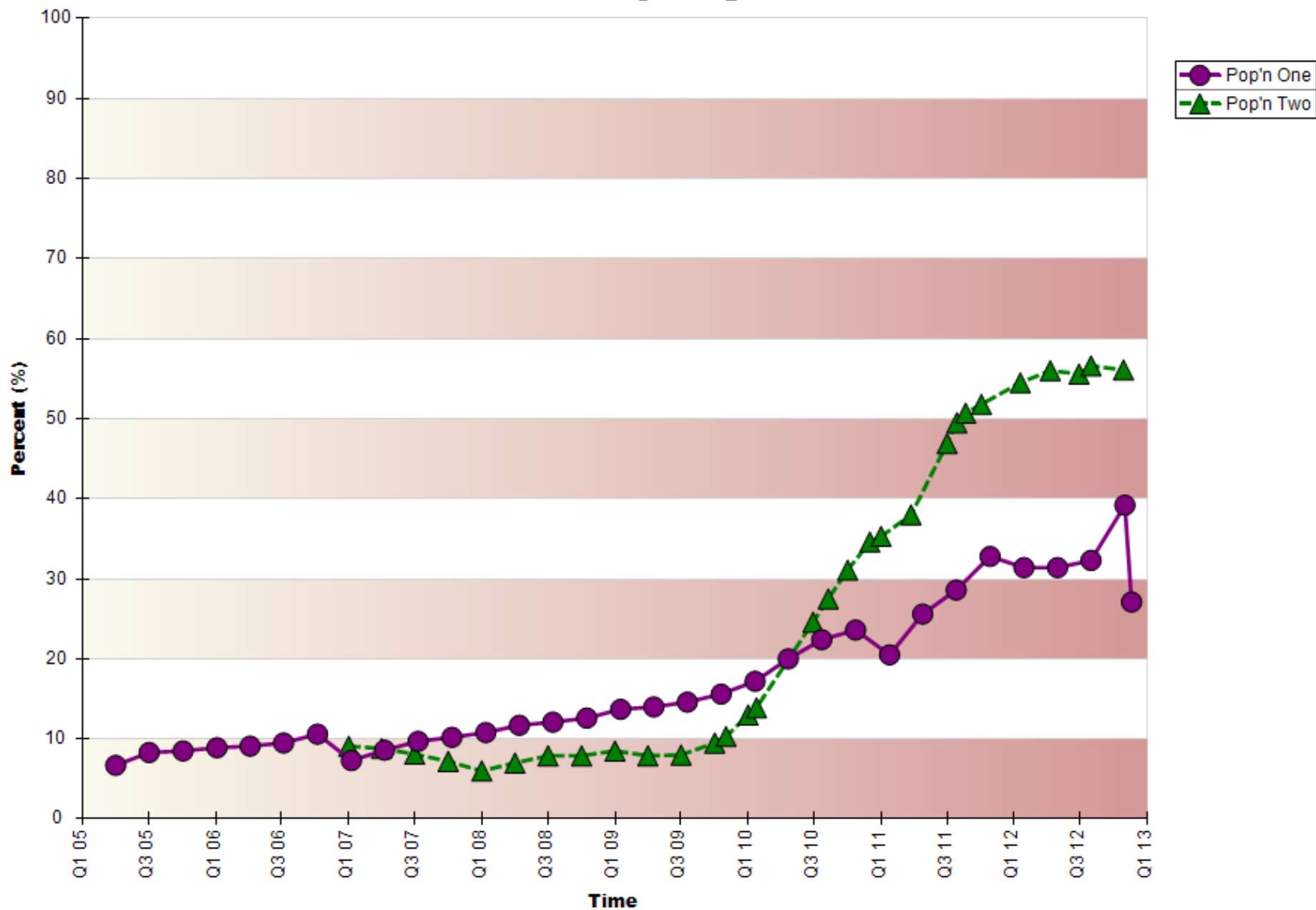
Fecal occult blood in last 2 yrs age 50-74



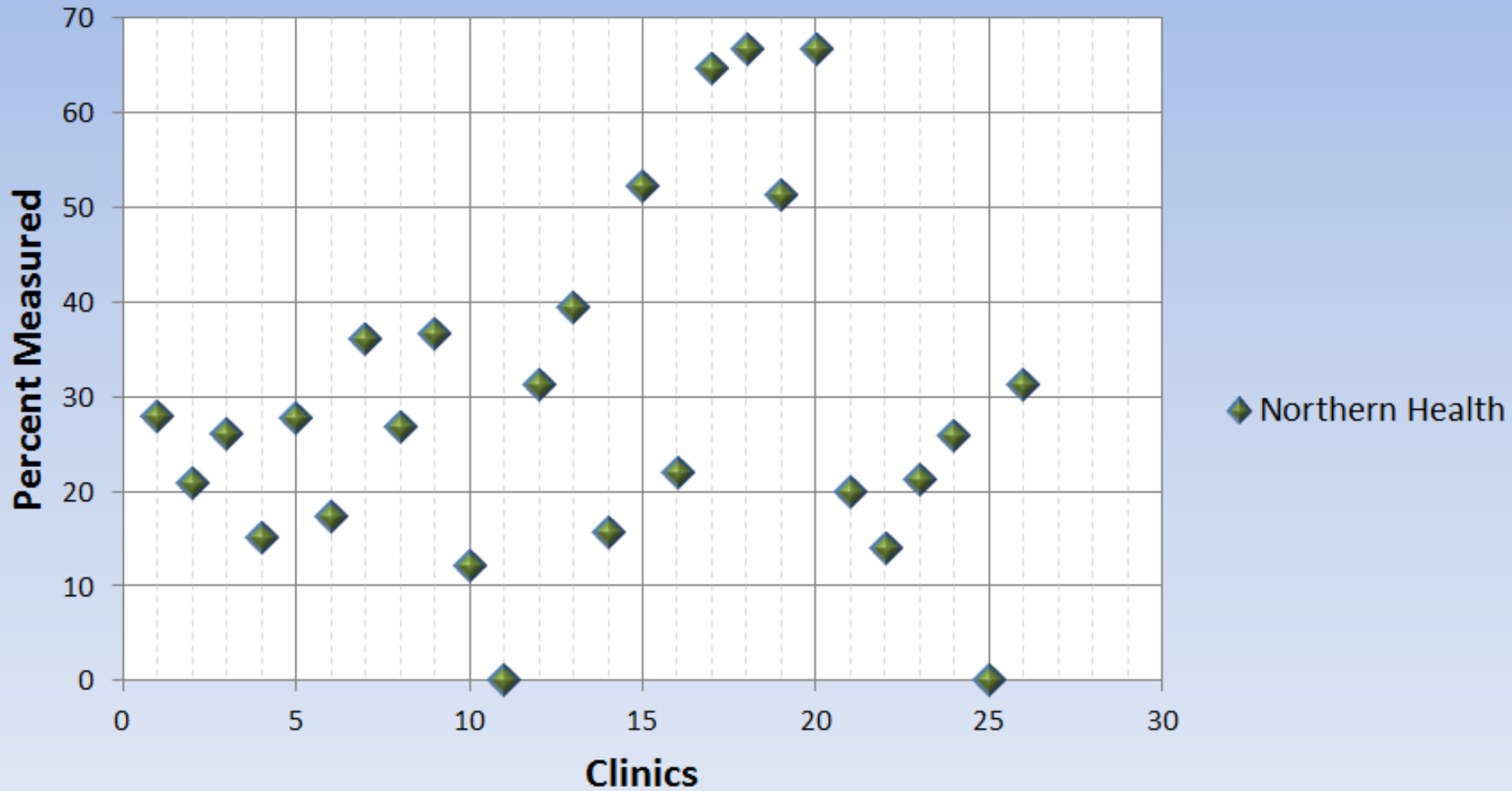
Indicators for Obesity/WC Prevention, Physical Activity Preventio...



BMI or WC documented in last 2 yrs age >19



HIV Screening in Association with STI and BBP Testing As of October 27, 2012 For Pop 100,000



HIV Screening Age 13 to 64 Male and Female As of October 27, 2012 for Total Pop 100,000

