

Patient Centered Care

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A GP for Me

- Research and gap analysis identified need in both divisions to improve care for vulnerable patients
- October, 2014:
 - East Kootenay hired 3 Social Worker and 1 Life Skills Worker
- April, 2015:
 - Sunshine Coast hired 1 Patient Navigator and 1 part time RN
- Both communities received Impact Funding



East Kootenay Division of Family Practice

- Population: 76 808 in 8 communities over 44 983 sq km
- Number of Physicians: 115
- Team Based Care: 3 Social Workers and 1 Life Skills Worker hired to develop and implement programs to improve care for vulnerable patients
- Family Physicians and Social Workers work together to improve care for patients whose health may be affected by social, financial and other stressors



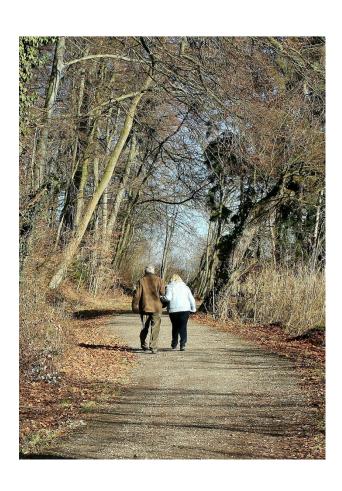
Sunshine Coast Division - Team Based Care

- Attachment Assessment clinic (April, 2015- Mar, 2016) created to support unattached patients. RN triaged unattached patients made referrals to GPs
- Patient Navigator works on mobile basis, providing follow-up to vulnerable patients works closely with GPs and community resources to improve care for patients impacted by social determinants of health





Team-based Care Goals



- Support patients with multiple health and social needs
- Increase the capacity of primary care

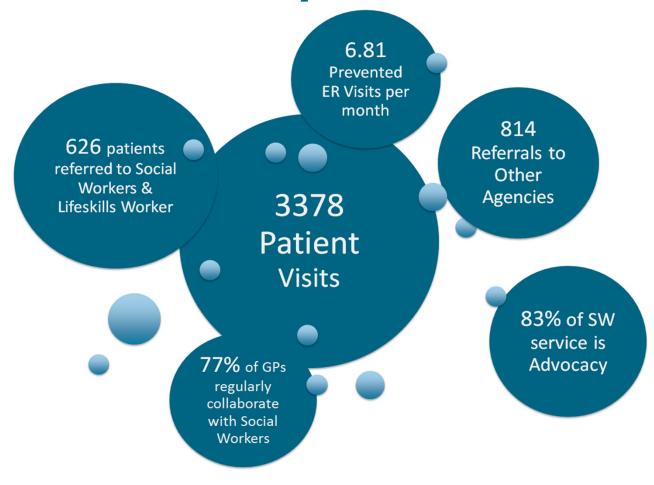


Team-based Care

- Advocacy: financial, disability, housing, food
- Coordination of health services
- Counseling
- Other Services including:
 - Patient centered care
 - Navigation
 - Leveraging of community resources
 - Promoting patient self care



East Kootenay Achievements





Sunshine Coast Achievements

514 unique referrals since April 2015

1164 total patient visits

Source of referrals:

- 41% from family physicians
- 18% community organizations
- 15% family or friends
- 13% health authority
- 12% self referral

Reasons for accessing Patient Navigator

- 37%: financial support
- 21%: health supports
- 15%: social supports
- 15%: housing/homelessness



Patient Demographics - Sunshine Coast

- 87% success rate in supporting patients with their identified goals
- 48% mental health or addictions
- 20% seniors
- 4% youth





Key Learnings

- People are incredibly resilient
- The systems to assist people are cumbersome and extremely difficult to navigate
- Community resources must work together for the betterment of all involved

Social Determinants of Health

Four reasons to address poverty:

- 1. Affects health on a gradient not just one health poverty line
- 2. Not always apparent. Need to be pro-active.
- 3. Poverty is pervasive.
- 4. B.C. has the highest poverty (15.3%) & child poverty rates (18.6%)
- People with low socio-economic status more likely to be hospitalized for conditions where hospitalization could be avoided with early disease management.
- Poverty Intervention Tool, Kootenay Boundary Division of Family Practice



Social Determinants of Health Interventions

- 1. Inquire about poverty when screening all patients
- 2. Include poverty as a health risk factor
- 3. Intervene to address poverty-related issues
 - MSP coverage
 - Income benefits
 - Child/Spousal Support
 - Rent Subsidies
 - Income Tax
 - Fair Pharmacare
 - First Nations Health Benefits
 - Disability benefits
- Poverty Intervention Tool, Kootenay Boundary Division of Family Practice

Physician Improvements Over 12 Months



- Collaboration with social and community services
- Clinical quality improvement
- Ability to delegate nonclinical tasks
- Patient's access to timely care



Impacts from the SW Perspective



"The patients feel they are a priority. They know that we (the FP and SW) are communicating, and working together to make sure their needs are addressed."

"As much as the physicians want to help these patients [with their personal challenges], they don't have the knowledge, or the time. Its just not in their scope, and that's where social work can be so helpful."

EK Social Workers



Impact Statement from Clinic MOA

Having a Social Worker to address situations and guide patients have eased the workload on both MOA's and Doctors for sure. But the biggest winner is definitely the patient. Some of our patients have had life changing outcomes facilitated by the Social Worker.

These outcomes are very hard to prove and even harder to keep statistics of, but if you look at individual "big picture" cases the evidence is there!! I hope we never have to face the day of not having a Social Worker as an important and valuable member of our clinic team.



Impact Statement from Community Care Nursing

In the Elk Valley, resources and support services are scarce, mental health issues rampant, high proportion of marginalized and socially isolated population, that require help with what some might consider simple tasks.

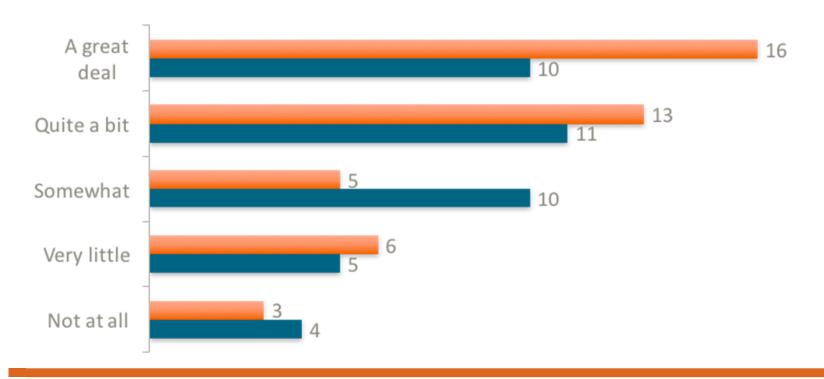
Specifically – filling out paperwork to access the few resources that are available, how to enhance and extend limited finances, navigate complex lives of already marginalized persons.

Social workers ask about funding, ask about what services are being used and are aware of resources that the general health care practitioner might not know about, and how to access these services. They can also follow-up in a more timely manner within the home setting, which enhances rapport, client trust, and client safety.



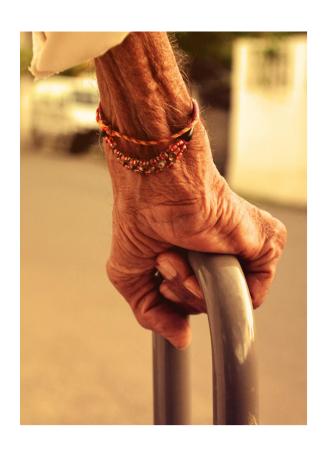
How much did the SW or LSW help you solve a problem or improve the coordination of your care?

■ Help Solve a Problem
■ Improve Coordination of Care





Value of Patient Centred Care



- Patient Support for Social Determinants of Health
- Patients better able to comply with appointments and care plan
- Physicians supported in caring for patients with complex and multiple needs
- Division has "tested" a team based care model
- Avoided ER Visits

East Kootenay Patient Experience



77% of patients felt that the Social Worker or Lifeskills Worker improved their experience of the healthcare system.



Case Study Example One

Marlene - Sunshine Coast

Presenting Issues	Interventions
Single mother of 2 children	Apply for Persons With Disabilities
Mental health (trauma)	Refer to counseling for Marlene and children
Legal battles	Child tax benefits
Fleeing abuse	Child Support
Eviction Notice	Assist with legal aid
	Appeal eviction
	Get restraining order



Case Study Example Two

Cliff – East Kootenay

Presenting Issues	Interventions
In hospital	Apply for Income Assistance
No income	Apply for CPP-Disability
Little stability, few supports	Apply for Persons With Disabilities
COPD	Income tax
Chronic health concerns, including COPD, Hep C	Health Supplements
	OAS/CPP/GIS
	Readjustment of Income
	Housing subsidies



Case Study Example Three

Alan - Sunshine Coast

Presenting Issues	Interventions
Homeless, no income	Apply for OAS/CPP/GIS
COPD	Refer to GP
Alcoholism	Apply for Pharmacare
No Pharmacare	Income tax
Anxiety/depression	Refer to treatment centre
No GP	Connect with driver
Senior	Apply for rental subsidy
	Refer for counselling



Case Study Example Four

Sheila - East Kootenay

Presenting Issues	Interventions
Extensive medical concerns: chronic kidney disease, diabetes,	Income assistance
Increasing dementia	Refer to Brain Injury Program
No local family	Apply for Persons with Disabilities
Vulnerable adult	Move to supportive housing
Acquired brain injury	Refer to Case Management
Limited income	Contact with family
	Support physician
	Health supplements
	Coordinate with community and Interior Health resources, i.e. Home Support, Occupational Therapy



Looking Towards the Future

- A GP for Me built the foundation for work to continue
- Team based care key attribute of Patient Medical Home/Primary Care Home models
- Importance of exploring sustainability options with health authority partners
- Roles have demonstrated improved health outcomes by addressing the social determinants of health



Questions?

Thank-you!

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