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.
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

**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 - 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%)
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
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
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
PACT Direct Referral Process

1. Physician assess the patient and consider that they will benefit from the services

2. Physician faxes referral form to Central Intake

3. Health Care Coordinator (HCC) redirects referrals to the appropriate location*

4. Health Care Navigator schedules health services and social services appointments at patient convenience

5. Health Care Coordinator notifies the physician patient's appointment information

6. Health Care Navigator intakes clients and clients receive services by allied healthcare providers

7. HCC sends a summary to the physician when service is complete
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
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)
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 caregivers

• Accessing resources and advocacy

• Data collection, analysis and reporting

Navigation is about recognizing barriers for individual patients and identifying strategies for eliminating them.
### Overall Performance Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>July 2018- September 2019</th>
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<tbody>
<tr>
<td># Physician referring</td>
<td>367</td>
</tr>
<tr>
<td># Patients referred</td>
<td>2119</td>
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### Type of Services Requested

<table>
<thead>
<tr>
<th>Service Requested</th>
<th>July 2018-September 2019</th>
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<tbody>
<tr>
<td>Physical Health &amp; Chronic Disease</td>
<td>1704</td>
</tr>
<tr>
<td>Mental health and/or addictions</td>
<td>466</td>
</tr>
<tr>
<td>Social</td>
<td>347</td>
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</table>
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.
Helen, 41, and pregnant was referred to Black Creek CHC by Humber River Hospital for follow up.

Upon intake, it was uncovered that Helen had severe financial issues. After losing her job nearly 15 years ago, she currently lived and was exclusively and financially dependent on 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 as 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
Thank you for your attention!

Questions? Comments?