Learnings & Legacy

Key Messages of the Better Health Project, Rideau Community Health Services

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The Better Health Project of Rideau Community Health Services

Over a 10 month period beginning in 2011, Rideau Community Health Services brought 650 new individuals, each "orphaned" or "unattached" to an ongoing care provider, into their primary health care services located in Smiths Falls Ontario.

How they did so is a story with lasting lessons for primary health care redesign in Ontario.

Knowledge Transfer & Exchange (KTE): Key Messages

This report identifies several key messages culled from primary sources and secondary sources related to the Better Health Project (BHP) experience. Project resources, reports, presentations and evaluation documents were reviewed. In addition, several interviews were held with Rideau Community Health Services (RCHS) leadership and project management.

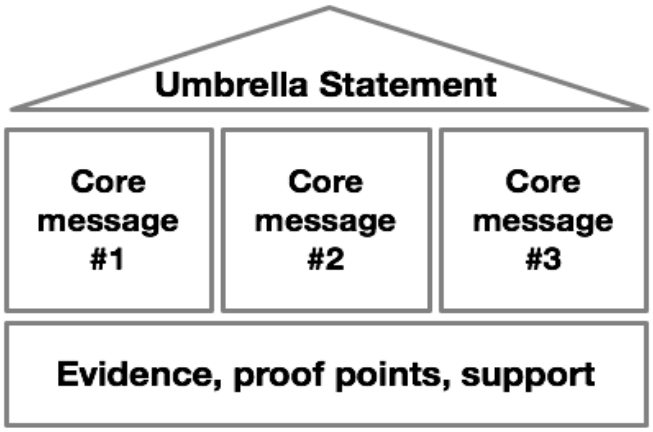
As a KTE tool, this report and the accompanying resources aim to articulate key messages from the BHP experience. Key messages are the statements the organization wishes to make about the BHP. These key messages articulate the "living legacy" of the project moving forward.

Three overall key messages emerged:

1. In health, no one should be left behind.
2. For better health, we need to do things differently.
3. Connections and the key to health.

This report utilizes a "message house"1 format to structure additional core messages. As a tool for developing marketing strategies, the message house template lends itself well to the "marketing" of the BHP legacy.

A message house explains how core messages, based in evidence, support a larger umbrella statement.



Legacy refers to the impact and contributions made beyond the natural life cycle of an entity. The key messages of BHP enter into the current dialogue on primary care redesign; in specific, they can and should influence the planning and decision making of Health Links across Ontario.

As a method to the ambitious goal of "transforming Ontario health care system" Community Health Links provide "coordinated, efficient and effective care to patients with complex needs"[2]. The BHP serves as a teachable microcosm on what effective system redesign looks like.

Background: "These were my neighbors' families"

Over several years, the Smiths Falls area, a region in eastern Ontario with approximately 50,000 citizens suffered significant job losses due to the closure of several major plants. Already reeling, the area then suddenly lost several of its family doctors due to retirement or sudden death. An estimated 5,000 individuals were left without a proper source of ongoing primary health care.

The geographic and population scale of the Smiths Falls area may be a contributing factor to the success of BHP. An area of such size allows for familiarity, knowledge, and manageability.

[1] http://www.messagehouse.org/
[2] http://www.health.gov.on.ca/en/pro/programs/transformation/community.aspx

A Radical Proposition: "No one left behind"

As a Community Health Centre, Rideau Community Health Services responded to community need by proposing to take on a planned 800 individuals who were otherwise "orphaned" by the loss of their primary care provider, "unattached" to any ongoing family practice, and whom where considered "complex" due to their multiple health care needs and lack of current and past care.

How could one primary health care practice take on so many individuals, many of whom had no medical notes to transfer? How could this be accomplished in a rapid, accelerated manner? Further, how could ongoing care be promised and provided with no additional funding?

In a 10 month period, RCHS took on an additional 650 "complex" individuals by utilizing group medical visits to accelerate intake, chronic disease self-management strategies to empower participants, and by using an innovative "one room" approach to inter-disciplinary care which embedded providers in a structure of constant communication, collaboration and ongoing improvement.

To fully appreciate the scope of this challenge, consider that of the BHP participants[3]:

- Most were 50 years of age and greater
- 1/3 lived alone
- 81% presented with 5 or more health complaints
- 69% reported being in chronic pain
- 89% had been experiencing drug related problems

How did they do it? As Ontario creates its Community Health Links initiative, the BHP provides a template for overall primary health care redesign and system improvement, one which would ensure that no one is left behind.

[3] The Better Health Project: An Update on the First Six Months", RCHS

Ahead of its Time: The Promise of System Redesign

Consider the promises of Ontario's Community Health Links

"Five per cent of patients account for two-thirds of health care costs. These are most often patients with multiple, complex conditions. When the hospital, the family doctor, the long-term care home, community organizations and others work as a team, the patient receives better, more coordinated care. Providers will design a care plan for each patient and work together with patients and their families to ensure they receive the care they need. For the patient it means they will:

- Have an individualized, coordinated plan
- Have care providers who ensure the plan is being followed
- Have support to ensure they are taking the right medications
- Have a care provider they can call who knows them, is familiar with their situation and can help."[4]

Key values of Health Links – individualized, coordinated, planned, supportive, familiar, helpful, and knowledgeable – are embodied in the principles, practices and outcomes of BHP.

Better Health Project description: "Everything's connected"

The goal of the Better Health Project, successfully achieved, was to ensure access to a health care team for individuals with multiple barriers to health who had no primary care provider.

Objectives

1. To provide health care to people who do not have a doctor
2. To connect participants to a permanent health care provider
3. To support clients to learn self-management skills and develop goals related to their health and wellness
4. To work collaboratively with Perth and Smith Falls Hospital, Community Care Access Centre and other community partners (Steps to BHP document)

[4] http://www.health.gov.on.ca/en/pro/programs/transformation/community.aspx

Program Components

The BHP was nurse practitioner led clinic. The team members included:

- Nurse Practitioner
- Physicians
- Nurses
- Pharmacists
- Medical Secretary
- Social Worker/ Project Manager

A CHC's mandate is to work with individuals and communities facing the greatest barriers to health care. BHP clients included:

- Unattached patients recently discharged from Smiths Falls Hospital with a chronic health condition
- Unattached patients with more than one visit to the hospital ED

The BHP team developed several key innovative tools and processes including

- A coordinated care plan for each participant
- A one room approach to integrating the entire inter-disciplinary team (they literally all shared one office)
- The use of group medical visits to accelerate intake
- Chronic disease self-management strategies
- Embedding the pharmacist role into the primary health care team

What occurred during the course of the BHP surprised many; "people rose far above what we thought"[5].

BHP is a story of a focused, motivated and high performing organization. It is also the story of the skills, capacities and sociability of a "patient population" that is far more than the "complex" labeling it has been assigned.

[5] Peter McKenna, ED, RCHS, interviewed 12/13

Key Messages: "People blew us out of the water; they rose beyond any assumptions we had of them"

There are three key messages from the Better Health Project experience:

1. In health, no one should be left behind
2. For better health, we need to do things differently
3. Connections are the key to health

On a more granular level, there are additional key messages pertaining to the nuts and bolts of the Better Health Project. These more granular key messages are articulated through the use of three message houses:

1. Better Health Project program design
2. Practices of the BHP
3. Principles of the BHP

Each message house contains:

- a unifying umbrella statement
- a description of the core components
- a basis in evidence to support the claims

Better Health Project Program Design

The goal of the Better Health Project, successfully achieved, was to ensure access to a health care team for individuals who have no primary care provider and who are most in need.

Practices:

Utilizing group medical visits, moving clients towards self-management, bringing together a collaborative multi-disciplinary primary health care team, data collection and review.

Guiding Principles:

Team Efforts: Being responsive to individual and community needs, working collaborative, integrating with other services; Participant efforts engaging clients to be active participants in their care (self-management, social basis)

Outcomes:

Primary health care services provided to those most in need, in a way which benefited not only the individuals, but the community as a whole and the health care system itself

Reduced Emergency Department visits, reduced problems with Rx's, attendance at GMVs, high client satisfaction scores, improved numbers of people with a primary health care provider

BHP **Practices**

The Better Health Project utilized tools, personnel and a program design which together provide a template for improved primary health care in Ontario.

Better health means doing things differently.

Tools:

The BHP used several innovative tools to provide rapid access to primary health care services to complex individuals who had no other source of care. These included:

1. **Group medical visits**
2. **Self-management strategies**
3. **Coordinated care plans**
4. **Prescription/drug reviews**
5. **Joint review of hospital data and ED visits to identify clients in need**

People:

The BHP used an innovative balance of diverse health professionals, integrated into one coordinated health care team, all housed in one room for maximum collaboration and communication. The BHP team:

1. **Worked to full scope of practice**
2. **Was nurse-practitioner led**
3. **Used the right profession at the right time**
4. **Integrated the role of pharmacist into the primary health care team**

Design:

Better Health was a targeted, driven initiative, focused on clear community need, and guided by a quality agenda of ongoing learning, evaluation and improvement. Implicit in the BHP were several key assumptions:

1. **That communication between health care providers was the key to coordinated care**
2. **A "one room" approach**
3. **That group medical visits were key to accelerated intake**
4. **That an existing primary health care practice could absorb a significant number of new patients by front-loading of resources**

Reduced Emergency Department visits, reduced problems with Rx's, attendance at GMVs, high client satisfaction scores, improved numbers of people with a primary health care provider

BHP Principles

The underlying principles guiding the BHP resulted in a highly motivated and effective staff team, and brought out the best of the skills, abilities and sociability of a "complex" patient population.
Connections create health.

Responsiveness:

The BHP was a situational response, undertaken quickly by a motivated agency willing to step up in response to community need; this "mission" focus resulted in a motivated staff group, and an organization determined to do things differently for the betterment of its community. The population scale of the Smiths Falls allowed for the knowledge and familiarity at the core of client-centred and community-based care.

Collaboration/Integration:

The BHP project team included the client as an activated participant, and combined the skills of various disciplines working seamlessly, in close quarters and with constant communication; further, BHP connected with the local hospital to ensure both that people had access to care, and that their health would improve. The myriad points of connectivity embedded in BHP resulted in a strong, supportive network unified by a common focus.

Redefining the Client:

Rather than treating the "patient" as an individual to whom service is provided, BHP participates were active, social agents, able to practice self-management skills and participate in group medical visits, strengthening the self-efficacy and social skills known to enhance resiliency.

Reduced Emergency Department visits, reduced problems with Rx's, attendance at GMVs, high client satisfaction scores, improved numbers of people with a primary health care provider

In Closing: Effective & Empathetic Primary Health Care

The Better Health Project provides a way forward to primary health care system redesign and improvement.

The scale and familiarity within the environment were key enablers.

The focus, motivation and unified mobilization of the organization drove the success of the program.

The redefinition of clients from "complex patient" to active participants helped provide individuals with new social connections and new self-management skills; such networks are known to encourage health.

The integration of the primary health care team in a "one room" office environment facilitated the ongoing communication and collaboration necessary to people-centered care.

The partnership with the local hospital brought different parts of the health care system together.

While a time limited project, the legacy of the Better Health Project continues:

In health, no one should be left behind. Better health means doing things differently. Connections are at the core of health.