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Office régional de la santé de Winnipeg

Silos to Integration: A Process Continuum

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Integrated Palliative, Primary, and Home Health Services

The Process Continuum

Integrated Care

Collaborative Care

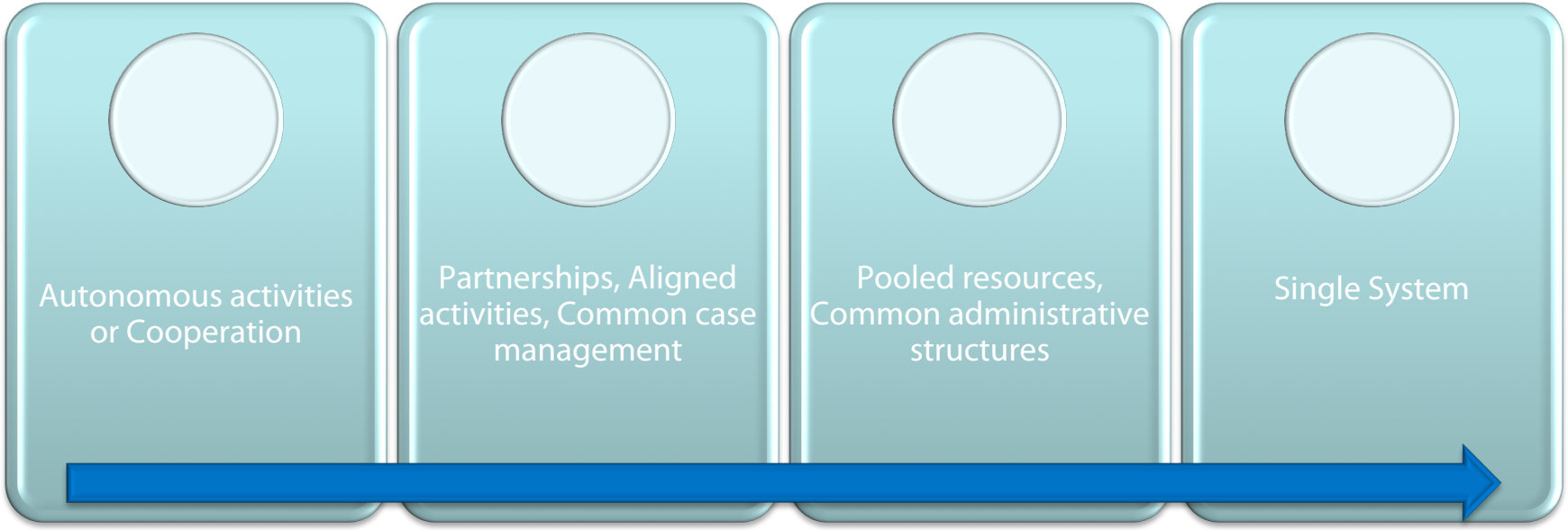
Coordinated Care

Program Silos

Patient Service Experience and Outcomes

Leadership and Service Provider Mindset Shift

The Process Continuum



Strengthen Primary Health Care

Primary care refers to first-contact care, in which the majority of health problems are treated. It is the foundation of any health care system, and nations with strong primary care seem to have better health than those without.

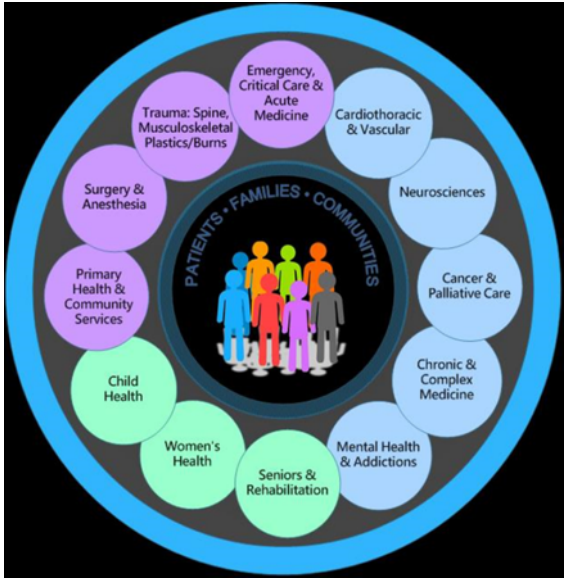
Primary Health Care is a broader concept. In addition to primary care services, it includes health promotion and disease prevention, and also population-level public health functions. It reflects the approach to service provision for a community proposed in the WHO 1978 Alma Ata Declaration

Reference: http://www.med.uottawa.ca/sim/data/primary_care.htm

Manitoba's Provincial Vision

https://www.gov.mb.ca/health/primarycare/homeclinic/index.html

Manitoba's Provincial Clinical and Service Planning



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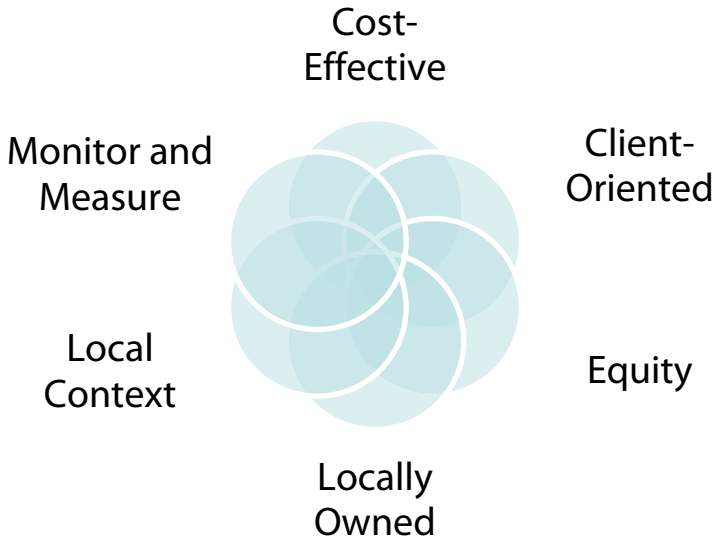
Vision to Reality

Excellence in Community Health: Provincial Vision and Strategy to Local Operations



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Simple Steps

Single Point Person in Home Care Project

Current State of Challenges Between Home Care and Primary Health Care in the WRHA – Clinician's Perspective

Key Themes

- Partnerships
- Coordination/ Collaboration
- Navigation
- Communication

Project

Goal: Every Primary Care Home Clinic (PCHC) in Winnipeg will be connected to a single point person in Home care to enable partnerships, build stronger relationships, improve communications, and help with community service navigation.

Strategy: Initiative to be offered initially to PCHC's participating in the Winnipeg My Health Teams to ensure an understanding of a variety of practice styles and to leverage existing relationships.

Pilot: commenced with one private fee for service clinic with a Primary Care RN as the clinic contact and one Home Care Case Coordinator.

Main Results

- Pilot resulted in very little extra work for Home Care Case Coordinator (CC)
- Very positive feelings from both RN and CC about the approach and benefits
- RN appreciated the responsiveness – did not have to wait on the phone; could leave a message and get a response!
    - Having a consistent HC point person made communication easier and efficient
    - Also helped build a relationship with the CC and have constructive and creative care planning conversations or service option discussions

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Microteam-Based C.A.R.E. Model

A Relationship-Centered, Team-Based, Integrative Service Delivery Model

Key Contact for this Initiative :
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WRHA Regional Director – Housing, Supports and Service Integration
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Microteams

Refers to the core team complement of primary care resources (primary care assistants, primary care nurses, nurse practitioners and physicians) that a service recipient considers their home base for primary care

Patient is the captain of their team and service providers are coaches

C.A.R.E. Process

- Check-In
- Assessment
- Referral
- Evaluation

The Broader Team

- Micro Team help link, connect, or navigate other health, social services or housing support (Macro Team)
  - Sandwich to a health care specialist
  - Health and Social Services in community area are becoming better integrated – phone call to most needed service for immediate engagement rather than traditional referral

COMMUNITY AREA INTEGRATED PRIMARY HEALTH HUB

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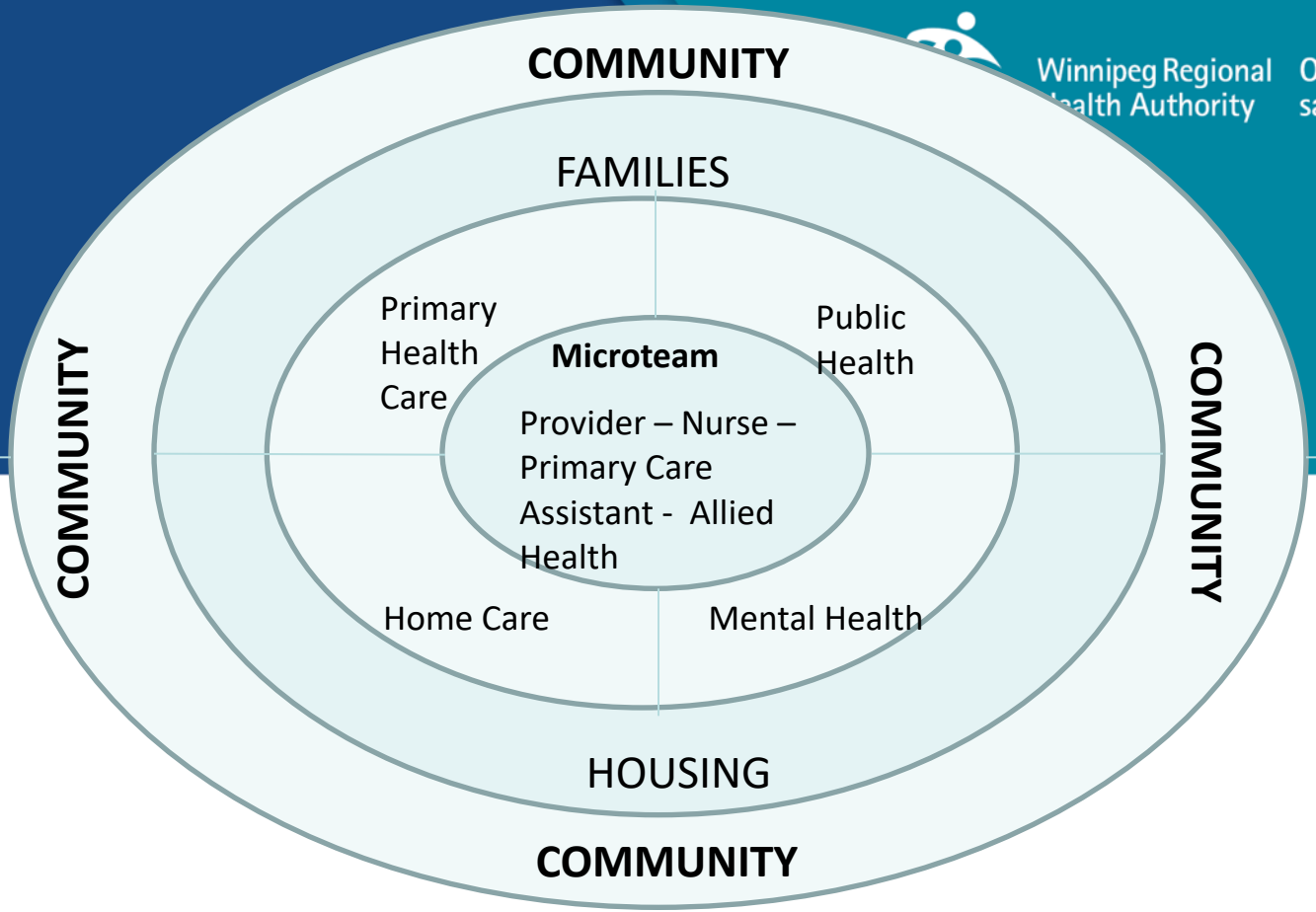
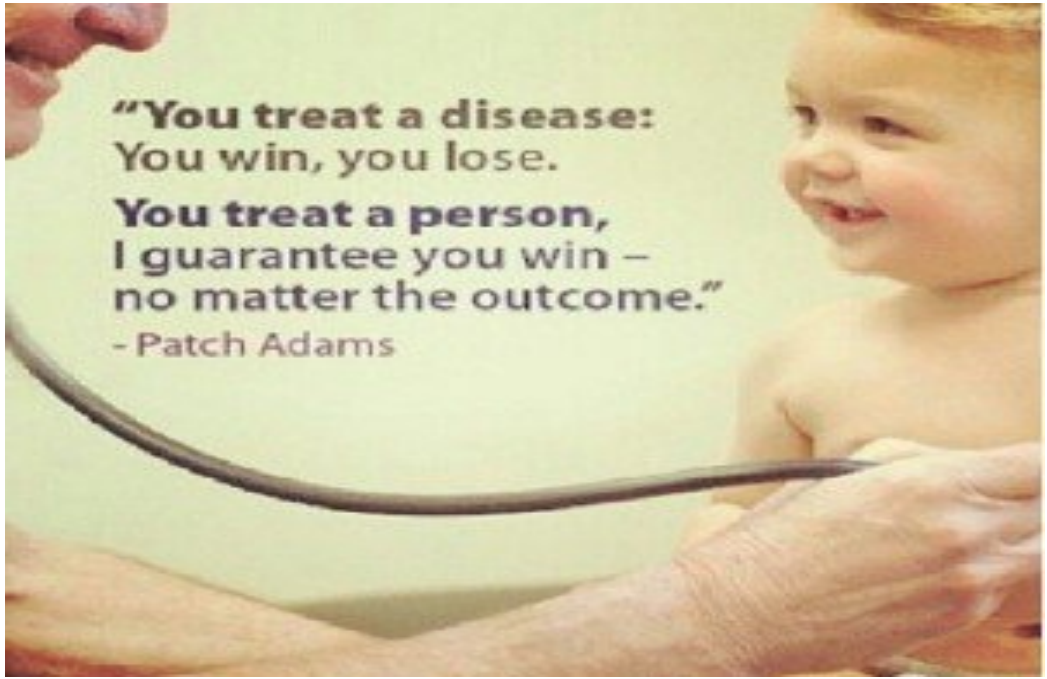


Operating Model

Operating Model

C. Check-In **A.** Assessment **R.** Referral **E.** Evaluation

From Patient-Centered to Relationship-Centered



"The lack of patient engagement is the Achilles Heel of health care delivery."

Adapted from quote by Terry McGeeney, MD

The problem is not so much that patients are unengaged

...but rather that providers are not always very engaging

From Provider-Patient to Team-Based

PANEL/PROVIDER ∝ PANEL/TEAM

From Patient Complexity to Integrative Care

COMPLEXITY

CARING FOR HEALTH

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Microteam-Based C.A.R.E. Model Evaluation

- In – process
  - C.A.R.**Evaluation** component data analysis underway
  - Provider and Clinicians focus group completed; report pending
  - Key measures & metrics and Team-based performance indicators – under review


Thank You!