Improving & Driving Excellence Across Sectors

Embedding CCP into the FHT

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IDEAS Applied Learning Project

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Utilization reports does not always capture right patient!

GP not engaged in process !

CCP not being done !

Story: "Could it get any worse?"

- **Not on Med GPS**
- **Multiple healthcare agencies**
- **No family involved**
- **Only trust GP and plastic surgeon**

Who could be more in need of a CCP, must involve GP team

AIM and Measures

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Aim Big Dot: Decrease avoidable patient ER visits and hospital admissions.

IDEAS project AIM: By Feb 2017 we will complete 10 CCP's through collaboration at patient point of contact in a primary care setting in the Thames Valley FHT(5) and North Perth FHT (5).

The proof is in the data

Outcome Measures: Patient and Provider Experience Survey, # Achieved Goals

Process Measures: # Completed CCP, Time, Provider Involvement

Balancing Measures: New resource linkages

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Our Change Idea:

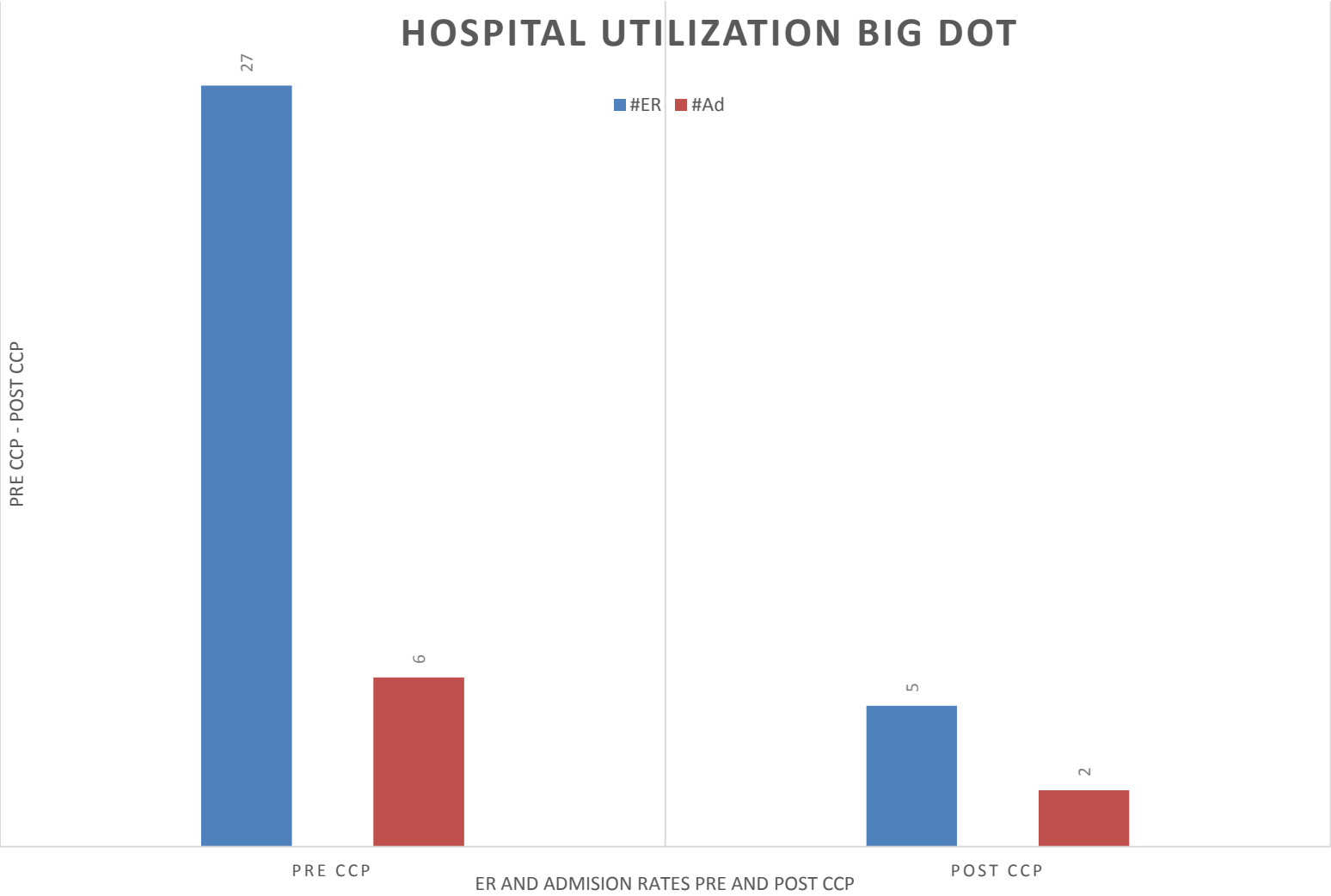
- Identification of high risk patients currently using programs within a FHT (family health team).
  - Our target populations: High risks patients involved with Fall Prevention Program and Home Based Primary Care Program.

- Initiate and complete CCP at point of contact with patient.
- Engage community and primary care teams to co-facilitate the process.

Lessons Learned PDSA:

- Identification
  - Easier and improved method for identifying appropriate patients.
  - Improved identification of team members
- Communication
  - Sharing information pre and post meeting.
  - Clear and concise information for patient
  - Working around technology and duplication remains an issue.
- Time management
  - Bringing team members in at the right time.
- Interdisciplinary roles and responsibilities

Results/Impact



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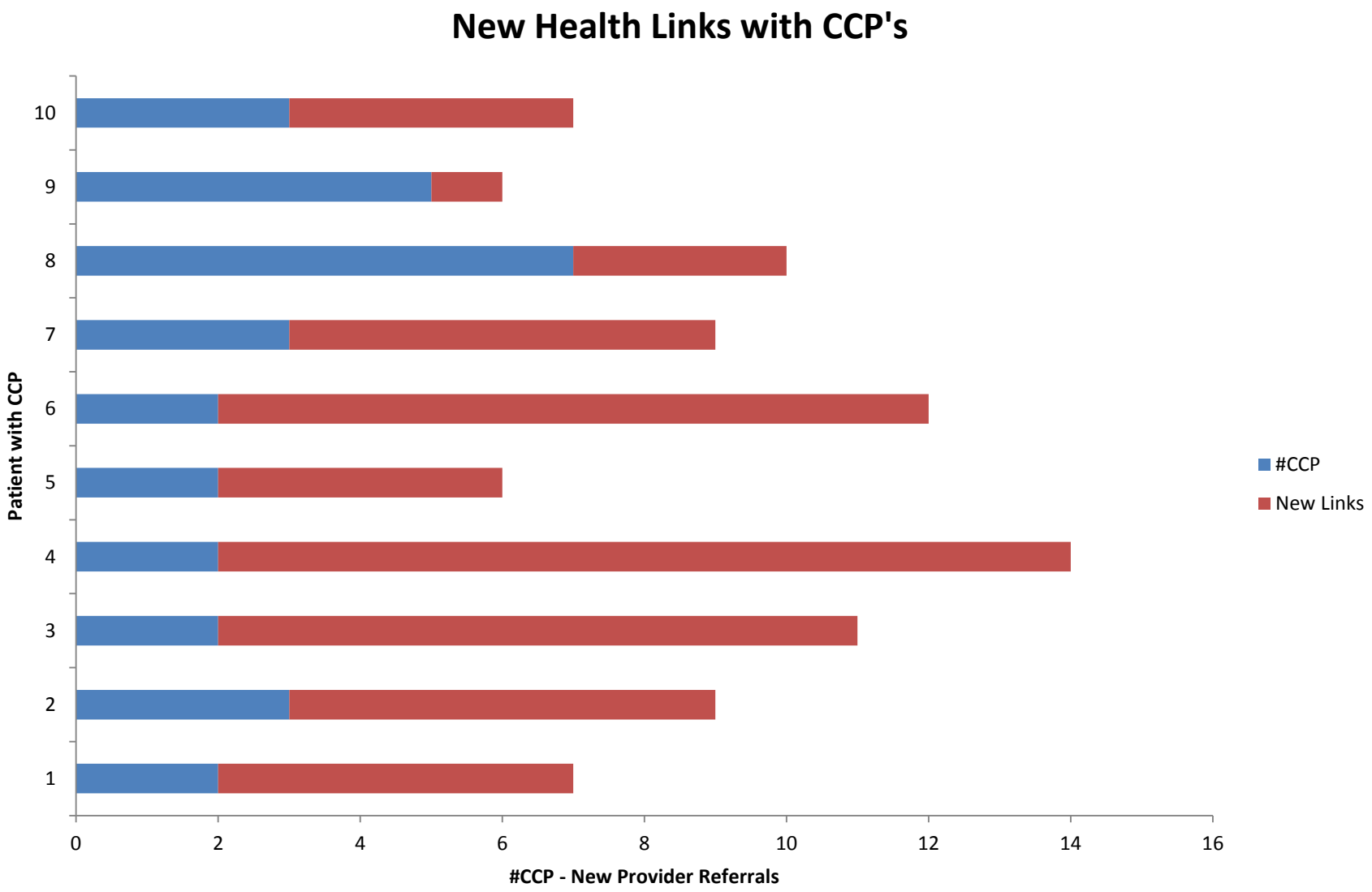

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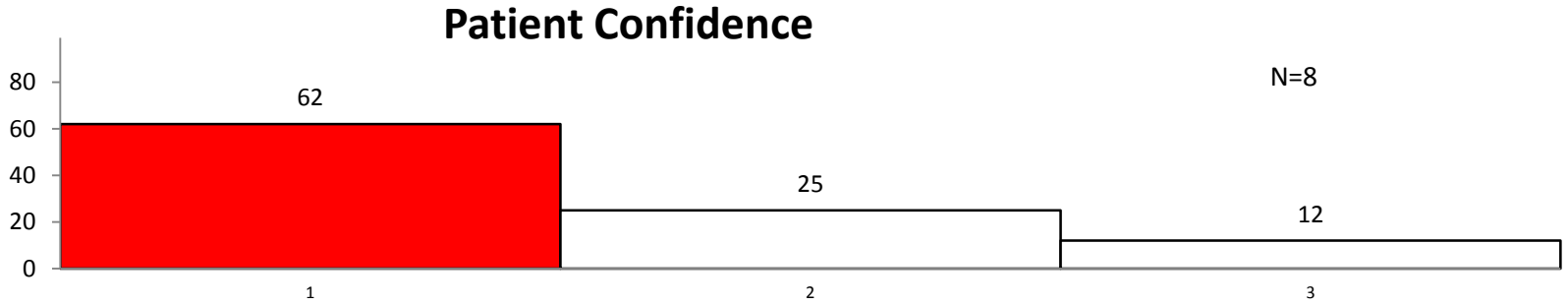

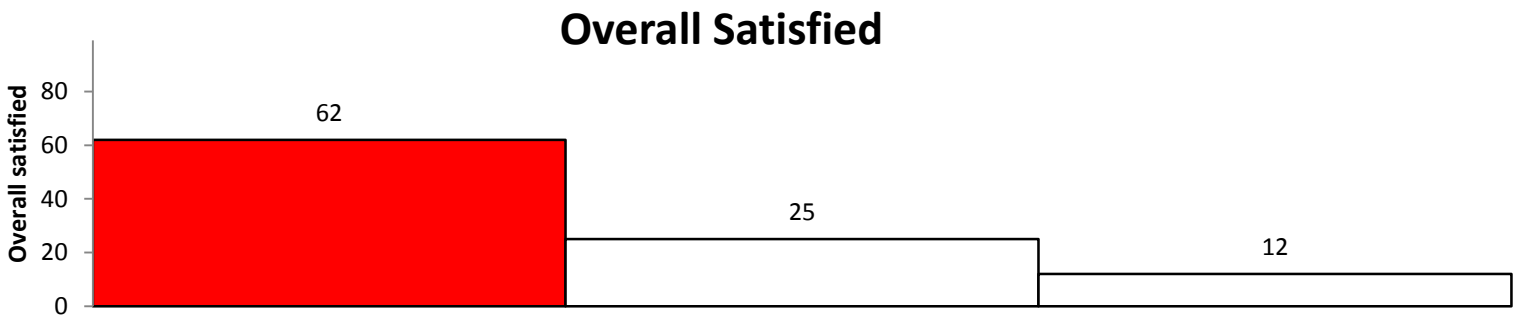

Overall Learning

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- Patients are fearful of agenda, health and change.
- Smaller groups and split conferences less anxious for patient and IHP involvement.
- Initiating CCP at point of contact in group.
- It is not just a tool !
- Improved understanding of roles and responsibilities of IHPs.
- Gaining ideas of what is happening in other communities.

Overall Challenges

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- Multiple EMR and communication tools among providers.
- Patients with learning and mental health issues we need to continue to creative to help them identify and meet goals.
- IHP (inter health professionals) not wanting to participate, resources.
- Geographic diversity and transportation.
- Financial and staff resource in primary care.

Next Steps to Progress Improvement

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- Looking at access to CHRIS to improve sharing of communication and prevent duplication of work.
- Adding CCP to ACCURO FHT EMR.
- Encouraging engagement of primary care practitioner in CCP for hospital transition and in the community.
- Spread coordinated care planning to other family health team programs i.e. palliative, memory.
- Creative ways to help patients plan their care.
- Continue to track the data and CCP utilization.