Message from BRIDGES

The Departments of Medicine (DOM) and Family & Community Medicine (DFCM) at the University of Toronto (U of T) are together, for the first time, embarking on a ground-breaking partnership to promote the availability and rapid flow of information from research into policy and program development.

Over the past 10 months, we’ve made immense progress: we’ve amassed a strong and dedicated team, funded six projects, hosted a number of workshops and formalized our operational and governance structures.

As we move forward, we hope to maintain this rapid rate of change and further hope that this newsletter will help keep you abreast of our work, progress and current status.

We are highly optimistic of the work being done by BRIDGES and its potential to catalyze change in the health care system. We hope that you will continue to monitor our work and partner with us wherever possible to achieve our common goal of a more integrated, coordinated and effective health care system in Ontario.

Wendy and Lynn

Overview of BRIDGES

The Building Bridges to Integrate Care (BRIDGES) project is funded by the Ontario Ministry of Health and Long-Term Care (MOHLTC) and jointly led by the DOM and DFCM at the U of T.

BRIDGES is an incubator for models of care that are developed by front-line providers; link hospitals, primary care clinics and community services to provide integrated care for patients with complex chronic diseases; and target reductions in Emergency Department (ED) visits and hospitalizations.

Over the course of three years, BRIDGES will develop, implement and evaluate nine models of integrated care delivery. Proposals will be solicited from providers from within the U of T network, undergo a competitive selection process and be reviewed by the BRIDGES Scientific Advisory and Governance Committees.

BRIDGES will partner with successful project teams and provide support for study design, implementation, and process, outcome and economic evaluation.

Each project team will receive up to $200,000 per year for one to two years in order to evaluate its model of care.

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Story from the Field

About two months ago I was in my atrial fibrillation subspecialty clinic and saw a gentleman who had a heart rate of 160 in atrial fibrillation. He felt lousy, was in heart failure, and was unaware that he was having rapid palpitations.

It turns out that a month before he had hospitalized at University Health Network (UHN) – I ultimately found a note from his time at UHN which exquisitely, beautifully, detailed the care he’d received - the tests, the prognosis, the outcome, the management etc.

From UHN, he was referred to another clinic at Women’s College Hospital (WCH) but WCH didn’t have the information from his visit at UHN. He never filled that appointment because of language and other communications issues, and instead ended up in his family doctor’s office three weeks later.

The family doctor was unaware of the WCH follow up that had been scheduled, was unaware of his visit to UHN and therefore referred him back to me.

And so by the time I had seen this patient the second time, he had been seen in three different places by three different high-class physicians in the past month, none of whom had ever communicated with each other.

So then it occurred to me – and this is just one of many such anecdotes - “Houston, we have a problem.” So I think that’s where - at least for me - the nub of the issue starts; we need a better culture of care communication.

Dr. Paul Dorian
Innovate Atrial Fibrillation

Overview of BRIDGES

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In addition to this, project teams will also have access to central BRIDGES resources which include (i) the Applied Health Research Centre at Li Ka Shing Knowledge Institute (LKSKI) at St. Michael’s Hospital (SMH) for support with evaluation design, data management and, in partnership with the Institute of Clinical and Evaluative Sciences (ICES), data linkage and analysis, (ii) health economists at the LKSKI at SMH to lead the economic evaluation, (iii) access to a qualitative research associate for support in designing and conducting the qualitative evaluation, and (iv) access to a health services evaluator to support the performance and documentation of quality improvement cycles.

BRIDGES will also work with project teams to identify opportunities for and mechanisms by which effective models may be scaled to other regions of the province. In order to facilitate this work, BRIDGES is currently exploring partnerships with Health Quality Ontario (HQO), Council of Academic Hospitals of Ontario (CAHO), and Cancer Care Ontario (CCO).

To date, BRIDGES has approved funding to 6 projects: (1) Innovate Atrial Fibrillation (A Fib) which focuses on changing processes of care and better managing transitions for A Fib patients (2) IMPACT Plus which provides concurrent multidisciplinary assessment of complex elderly (3) Integrated Home-Based Primary Care which delivers primary care in the home (4) Program of Integrated Care For Chronic Obstructive Pulmonary Disease (COPD) that focuses on coordinating care for COPD (5) Reducing Avoidable Mental Health and Addictions (MH&A) Emergency Department Visits that connects MH&A patients to community services, and (6) Seamless Care to Optimize the Patient Experience (SCOPE) which targets non-Family Health Team or non-Community Health Centre physicians based in the community with patients who frequent EDs.
Spotlight Project – IMPACT Plus

The IMPACT Plus model of care seeks to integrate care by bringing providers (including the primary care providers), patients and caregivers together in real-time to assess the medical, functional and psychosocial concerns and needs of the patient, and jointly develop an integrated patient-centered care plan.

The model targets patients with multiple chronic conditions at high-risk of hospitalizations and Emergency Department (ED) visits, and the inter-professional team includes the family physician, a community nurse, a pharmacist, an occupational therapist, a dietician, a community social worker, a General Internal Medicine (GIM) specialist, a psychiatrist and a Community Care Access Centre (CCAC) navigator.

IMPACT Plus patients are scheduled for a 1.5 – 2 hour visit with the interprofessional care team during which (i) all the circumstances and concerns of the patient are ‘unpacked’ (ii) a care plan is developed with input from the family physician, patient, caregiver and inter-professional team (iii) a “to-do” list is created for the patient/caregiver including updated information on medications, recommendations from the care team and information on educational resources, referrals and follow-up appointments, (iv) a follow-up plan of care is developed for the family physician, and (v) an anticipatory care plan is developed for the patient/caregiver, Emergency Medical Services (EMS) and ED staff which provides recommended alternatives to the hospital and ED that have been discussed and accepted by the patient/caregiver.

The simultaneous nature of the IMPACT Plus model, both in time and space, across the continuum of primary and secondary care, and across hospital and community settings, optimizes direct communication, mutual decision-making, and concordance of the care plan with patient values, preferences and abilities.

Recent Articles of Interest

A list of some articles that we think may be of interest to our readers.

- A look at the impact of interactive communication between primary and specialist care on improving outcomes for ambulatory care patients.

- Integration at the macro, meso and micro levels
  - Curry, N., Ham, C. (2010) Clinical and Service Integration The Route to Improved Care The King’s Fund

- Defining integrated patient care
BRIDGES Workshop

Workshop Day 1

The workshop on March 27th brought together all project teams to share their interventions and discuss challenges encountered. All project teams and guest speakers engaged in discussions on potential solutions and ways in which models may be refined to achieve greater integration. Many common themes emerged throughout the day including the importance of: 1) primary care engagement and communication in order to coordinate care; 2) being able to spread models to less resourced providers; 3) understanding and appropriately targeting high user populations to accurately determine intervention effectiveness; 4) including the patient perspective in intervention design and decision-making activities.

Workshop Day 2

On March 28th, 2012, guest speakers and health system stakeholders engaged in interactive discussions on: i) Integrating hospital, community and primary care in the absence of formal linkages; ii) Engaging physicians in integration and qualitative improvement activities in a time of fiscal constraint; iii) Winning strategies to manage high-cost users of the health care system.

These discussions revealed many themes similar to those that also emerged from the March 27, 2012 workshop which include (i) the need for coordinated care between providers; (ii) the need for targeted physician-engagement strategies; (iii) the importance of relationships and partnerships both between patients and providers, and amongst providers themselves; (iv) the need to engage in both functional and structural reform in order to evoke change (vi) the need for leadership and accountability; and (vii) the importance of research and innovation.

BRIDGES GUEST SPEAKERS

Dr. Ed Wagner,
Director Emeritus,
MacColl Center
Group Health Research Institute

Dr. Jacques Lemelin
Chair, Department of Family Medicine
University of Ottawa

Dr. Martin Connor
Senior Policy Advisor and Head, Special Delivery Unit,
Department of Health, Republic of Ireland.