Using Canadian Case Studies to Improve Healthcare for Inner City and Marginalized Populations

Tirer profit des études de cas canadiennes pour améliorer les soins de santé prodigués aux populations des centres-villes et aux populations marginalisées

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Welcome & Get Social With Us

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#sdoh #cdnhealth #pophealth

Canadian Foundation for Healthcare Improvement

@CFHI-FCASS

Canadian Foundation for Healthcare Improvement

CFHIFCASS
Objectives

1. Profile exemplar inner city population health initiatives or cases, led by or involving healthcare delivery organizations, across Canada;
2. Understand factors that influence the success and sustainability of these cases, including engaging patients and community members in the design and delivery;
3. Highlight ways in which these cases are bringing about Triple Aim improvement to health (including the social determinants), care experience and value for money; and
4. Create connections between those pursuing or interested to pursue this kind of work across Canada.
Distribution of total expenditures across cost percentiles (< 50th, 50th–89th, 90th–94th, 95th–98th, 99th), by age group.

Overall, 5% of the population accounted for 65% of costs.
Design of a Triple Aim Health System

Define “Quality” from the perspective of an individual in the population

Healthcare Public Health Social Services

- Individuals & families
- Definition of primary care
- Integration
- Per capita Cost reduction
- Prevention and health promotion

System-level Metrics

Content developed by IHI
WHAT MAKES CANADIANS SICK?

50% YOUR LIFE
- INCOME
- EARLY CHILDHOOD DEVELOPMENT
- DISABILITY
- EDUCATION
- SOCIAL EXCLUSION
- SOCIAL SAFETY NET
- GENDER
- EMPLOYMENT/WORKING CONDITIONS
- RACE
- ABORIGINAL STATUS
- SAFE AND NUTRITIOUS FOOD
- HOUSING/HOMELESSNESS
- COMMUNITY BELONGING

25% YOUR HEALTH CARE
- ACCESS TO HEALTH CARE
- HEALTH CARE SYSTEM
- WAIT TIMES

15% YOUR BIOLOGY
- BIOLOGY
- GENETICS

10% YOUR ENVIRONMENT
- AIR QUALITY
- CIVIC INFRASTRUCTURE

THESE ARE CANADA'S SOCIAL DETERMINANTS OF HEALTH #SDOH
Taking Action to address SDoH

• Patient-level
  • Ask about social challenges
  • Refer to support services
  • Be a resource and advocate

• Practice- and system-level
  • Improve access and quality of care for hard-to-reach groups
  • Integrate patient social support navigators into the care team

• Community-level
  • Partner with community groups and leaders, public health
  • Use clinical experience and research evidence to advocate for change
Enabling Conditions for Success

1. Involve those with lived experience
2. View with an equity lens
3. Move to Reconciliation
4. Peoplize the data
5. Collaborate and partner
Case Studies of Canadian Initiatives that serve Inner City Populations and apply a Triple Aim Approach

Dale McMurchy

May 31, 2017
Case Study Methods

› Examples across Canada of various service models applying formal and informal Triple Aim approaches
› Data collection through interviews and questionnaires
› Collation, synthesis and verification
Community-based Primary Health Care
› HealthConnection Clinic, North Vancouver
› Boyle McCauley Health Centre, Edmonton

Institutionally-affiliated or Physician-led
› Inner City Health Associates, Toronto

Specialized
› H.E.R. (Healthy, Empowered, Resilient) Pregnancy Program, Edmonton

Indigenous
› Southwest Ontario Aboriginal Health Access Centre (SOAHAC)
Key Learnings and Success Factors
Thinking (and Acting) “Out of the Box”

› Innovative thinking and flexibility in program design and delivery

› Risk-taking

› Constantly learning and adapting to their environment, client needs and changing circumstances

Inner City Associates, Palliative Care for the homeless:
• “...opportunity to feel as good as you can given what's going on.”
• “Releases as much of the stress as possible....” Otherwise, he’d be “easily on the streets. There's nowhere else.”
• “My wishes are I didn’t want to spend what I have left alone...”
Partnerships

› Foster and leverage local partnerships and networks to ensure clients have access to necessary resources

› Work together to use limited resources in the most effective and efficient manner

› Range from close working relationships (e.g., sharing staff and office space) to affiliations and referrals

› Open dialogue and effective information exchange supporting clients across the continuum of health and social care
Boyle McCauley Partnerships

- **Main clinic**: 3 teams, medical and social services, dental, programs (yoga, art, women’s), housing supports, outreach
- **Kindred House** drop-in for women and transgendered female sex trade workers
- **HAART House** drop-in for homeless clients living with HIV
- **Youth Health Care Clinic** for traumatized youth at iHuman
- **Miyowayawin Clinic** at Native Healing Centre
- **Community Nursing Station** at men’s shelter
- **Women’s Centre for Health** at women’s emergency shelter
- **Pathways to Housing** for adults with a serious mental illness and chronic homelessness delivered mainly in the home
<table>
<thead>
<tr>
<th>Program Partners</th>
<th>Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Streetworks</td>
<td>Host program, harm reduction services, supplies, overdose prevention, drug education and outreach</td>
</tr>
<tr>
<td>Boyle Street Community Services</td>
<td>Access to a multitude of program areas</td>
</tr>
<tr>
<td>Crossroads E4C Outreach Van</td>
<td>Access to refer women in the sex trade for food, harm reduction supplies and outreach worker support, Referrals</td>
</tr>
<tr>
<td>Boyle McCauley Health Centre</td>
<td>Access to nurse practitioners, physicians, dental services, referrals</td>
</tr>
<tr>
<td>East Edmonton Health Centre Perinatal</td>
<td>Access to prenatal care, H.E.R. staff help find clients that the clinic is looking for program</td>
</tr>
<tr>
<td>ICC (Inner City Connections) – Children and Family Services</td>
<td>Consulting services prenatally, support post delivery, access to resources</td>
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<tr>
<td>STI Clinic</td>
<td>Access to STI testing, treatment and counselling, resources for clients</td>
</tr>
<tr>
<td>Northern HIV Clinic</td>
<td>Access to HIV monitoring and treatment</td>
</tr>
<tr>
<td>Enhanced Services for Women</td>
<td>Access to harm reduction and sobriety supports, parenting programs</td>
</tr>
<tr>
<td>Basic Babies</td>
<td>Access to baby supplies for first year</td>
</tr>
<tr>
<td>Health For Two</td>
<td>Milk coupons, vitamins and bus tickets, resources, referrals, staff training</td>
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<tr>
<td>Inner City Victim Services</td>
<td>Access to resources for women who are victims of crime</td>
</tr>
<tr>
<td>Jasper Place Health and Wellness</td>
<td>Access to resources like diapers and formula on an emergency basis</td>
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<tr>
<td>Women’s Emergency Accommodation</td>
<td>Access to a shelter for clients, if beds available</td>
</tr>
<tr>
<td>Centre (WEAC)</td>
<td>Refers women when applicable to the H.E.R. program</td>
</tr>
<tr>
<td>Birth Control Center</td>
<td>Referrals to H.E.R., Access to birth control, STI testing and treatment resources</td>
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<tr>
<td>Catholic Social Services</td>
<td>Access to shelter beds and housing supports</td>
</tr>
<tr>
<td>Covenant Health Maternal Methadone Use</td>
<td>For pregnant women who are using methadone</td>
</tr>
<tr>
<td>and Neonatal Abstinence Project (MMUNA)</td>
<td>Resources for clients</td>
</tr>
<tr>
<td>Mint Pharmacy</td>
<td>Supports for postpartum</td>
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<tr>
<td>Women’s Health Options</td>
<td>Access to birth control, depo dispensing and administration and IUDs</td>
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<tr>
<td>Kids Kottage</td>
<td>Respite care for infants up to three days, parenting resources</td>
</tr>
<tr>
<td>Bissell Center</td>
<td>Access to childcare, referrals to other community resources and programs</td>
</tr>
<tr>
<td>Kindred House</td>
<td>Place to meet women who are involved in the sex trade, client resources</td>
</tr>
</tbody>
</table>
Client-Focused

› Take a whole person and social determinants of health approach
› Provide a variety of services and programs
› Meet clients where they are (location and personally)
› Work at clients’ pace
› Trauma informed and harm and risk reduction approaches
› Deliver services and care in a culturally safe and appropriate manner
H.E.R. Pregnancy Program Photovoice

Prostitution and money. A lot of liquor. Trips to the liquor store. That was my old ways.

- Paula (Client)

This is actually my first time raising a little guy. He’s my third baby, but I never had custody of my other kids. He’s my first time custody. And it’s all really thanks to the H.E.R. [Pregnancy] Program.

- Paula (Client)
New clients are informed of their rights, given a copy and have it documented in the EMR:

- Culturally and physically safe and secure environment
- Part of decision-making in wellness plan and healing path
- Know risks and benefits of receiving services
- Information privacy
- Culturally safe and best practices from providers
- Respect for dignity and autonomy
- Recognition of individuality, needs and preferences
- Informed about available programs and services
- Can consent to or refuse recommended services
- Can express concerns and know the complaints process
Community-Focused

› Understand the needs of vulnerable populations in their community
› Community-wide activities
› Community boards

Southwest Ontario AHAC community engagement:

• “...robust commitment to engaging community members in shaping programs and services.”
• “Programs and service approaches are adapted to meet the cultures, ceremonies, practices and varied needs of different communities.”
Inner City Health Associates
The Staff

› Non-judgemental and compassionate
› Work deliberately to gain trust and respect of clients
› Interprofessional collaboration and case management
› Peer support from individuals with lived experience
› Services from those with cultural knowledge, e.g., elders
Triple Aim Measures

› Measure to identify gaps and support ongoing improvement
› Still a long way to go on clinical and population-based measures

<table>
<thead>
<tr>
<th>Outcomes:</th>
<th>Client experience:</th>
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<tbody>
<tr>
<td>› Utilization and clinical data</td>
<td></td>
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<tr>
<td>› Intake assessments with follow up</td>
<td></td>
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<tr>
<td>› Validated measures of health status</td>
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<tr>
<td>› Sector reports (Ontario QIP)</td>
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<tr>
<td>› Other: housing, employment, personal safety, etc.</td>
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<tr>
<td>› Surveys</td>
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<tr>
<td>› Wait time measures</td>
<td></td>
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<tr>
<td>› Participatory action research (H.E.R.)</td>
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</tbody>
</table>

Economic Impact:

› Emergency department, hospitalizations and readmissions
› Resource utilization bands (Ontario QIP)
› Social return on investment (H.E.R.)
# H.E.R. Pregnancy Program Indicators

<table>
<thead>
<tr>
<th>Evaluation Dimension</th>
<th>Key Indicators</th>
<th>Evidence supporting impact by data source</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Program Data</td>
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<tr>
<td>Reduced Risk Factors/Strengthened</td>
<td>Social Outcome Indicators</td>
<td></td>
</tr>
<tr>
<td>Protective Factors</td>
<td>Service connectedness</td>
<td>✓</td>
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<tr>
<td></td>
<td>▪ Clients accessing health services (i.e., testing/assessment, health</td>
<td>✓</td>
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<tr>
<td></td>
<td>products/material resources, interventions and referrals)</td>
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<tr>
<td></td>
<td>▪ Clients accessing social services (i.e., housing, mental health, cultural,</td>
<td>✓</td>
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<td></td>
<td>parenting programs, Children’s Services)</td>
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<tr>
<td></td>
<td>▪ Increased trust and connection to services and supports</td>
<td>-</td>
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<td></td>
<td>Substance use</td>
<td></td>
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<tr>
<td></td>
<td>▪ Awareness of the need to reduce or eliminate substance use during pregnancy</td>
<td>✓</td>
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<tr>
<td></td>
<td>▪ Safer or reduced substance use</td>
<td>✓</td>
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<td></td>
<td>Sexual practices</td>
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<tr>
<td></td>
<td>▪ Safer sexual practices</td>
<td>✓</td>
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<tr>
<td></td>
<td>Housing outcomes</td>
<td></td>
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<tr>
<td></td>
<td>▪ Improved housing outcomes</td>
<td>✓</td>
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<tr>
<td></td>
<td>Child care outcomes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Child in parental care</td>
<td>✓</td>
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<tr>
<td>Decreased Severity and Level of</td>
<td>Empowerment</td>
<td></td>
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<tr>
<td>Victimization</td>
<td>▪ Perceptions of client empowerment (i.e., self-esteem)</td>
<td>✓</td>
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<tr>
<td></td>
<td>▪ Client involvement in custody decisions</td>
<td>✓</td>
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<tr>
<td></td>
<td>Safety</td>
<td></td>
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<tr>
<td></td>
<td>▪ Enhanced client safety (i.e., greater awareness of personal safety and</td>
<td>✓</td>
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<tr>
<td></td>
<td>decreased levels of personal violence)</td>
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<tr>
<td>Increased Wellness Levels</td>
<td>Health Outcome Indicators</td>
<td></td>
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<td></td>
<td>Maternal health</td>
<td></td>
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<tr>
<td></td>
<td>▪ Increased wellness levels among clients</td>
<td>-</td>
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<tr>
<td></td>
<td>Infant health</td>
<td></td>
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<tr>
<td></td>
<td>▪ Perceptions of healthy babies</td>
<td>-</td>
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<tr>
<td></td>
<td>▪ Positive infant health outcomes (i.e., healthy gestational age and birth</td>
<td>✓</td>
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<tr>
<td></td>
<td>weight)</td>
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</tr>
</tbody>
</table>
Contact Information

› dale.mcmurchy@sympatico.ca
› http://www.healthconnectbc.ca/vch/programs/1741-healthconnection-clinic
› www.bmhc.net
› http://www.icha-toronto.ca/
› http://www.icha-toronto.ca/programs/peach
› http://www.streetworks.ca/pro/harmreduction.html
› www.soahac.on.ca
Community-based Primary Health Care for Vulnerable Populations

HealthConnection Clinic/Home Visiting
Sandra Edelman, Vancouver Coastal Health
HealthConnection Highlights

• Unmet health needs identified by doctors, community partners for the most vulnerable, homeless, disenfranchised

• A small working group of doctors and health authority staff was formed in 2012 to prepare a business plan for a high needs clinic

• No traction for the plan
HealthConnection Highlights, cont’d

- Took a risk and started “on a shoestring”
- Few resources, no formal funding but lots of passion to move from planning to execution, opened in July 2013 with morning drop-ins
- Leveraged community partnerships (NGOs) for design input, staff, and other resources; borrowed space
- Formally implemented Triple Aim objectives:
  - Improving health of vulnerable clients
  - Enhancing client experience
  - Reducing or controlling costs
- Measurement results would help secure sustainable funding from Vancouver Coastal Health Authority in April 2016
HealthConnection Clinic

• Serves unattached clients on Vancouver’s North Shore with complex medical, mental health, addiction and socio-economic challenges – becomes their primary care home

• Many Indigenous and vulnerable, elderly clients; average age early 50’s; majority of clients are male

• Accessible Drop-In and Appointment Based Clinic

• Home visiting services for housebound clients, including on-reserve

• Supported by community services and referrals

• Clinic staff include NPs, GPs, MOA, social support liaison, team lead

• Clinic supports psychiatric, medical, NP student placement
HealthConnection Clinic, Triple Aim

• From the start, applied Triple Aim objectives and ongoing measurement to:
  – Show value and viability
  – Support implementation and strategic decisions
  – Assess successes, challenges and lessons learned
  – Address social determinants of health; equity lens; complexity tool for screening and monitoring
  – Engage patients, partners in open houses, focus groups and interviews
HealthConnection, Triple Aim/Evaluation Outcomes

• Complexity tool to assess needs, develop care plans and measure clients’ and population improvement over time
• Reduction in ED visits, acute admissions, alternate levels of care, LOS; every 6 months evaluation results released
• Estimated cost savings of $1,100 per client; increase in acute capacity
• Client feedback and provider feedback consistently positive – the clinic is welcoming, clients come to socialize, have something to eat or drink – visits per client per year 0-100.
HealthConnection Next Steps

- Preparing business plan for expansion of days and hours of operation
- Introduction of sustainable ORT and HR services to respond to client needs and current opioid overdose deaths
- Implementation of a Patient Advisory Council
Client Engagement in Health and Health Care

Client engagement:
“the involvement of patients and/or family members in decision-making and active participation in a range of activities. Starting from the premise of expertise by experience, patient engagement involves collaboration and partnership with professionals.”

Baker et al., 2016
Client Engagement

Continuum of engagement

Levels of engagement
- Consultation
  - Client experience survey
  - Suggestion box
- Involvement
  - Key informant interviews
  - Patient advisory committee
- Partnership and shared leadership
  - Participatory & utilization-focused evaluation
  - Participatory action research (e.g. photovoice)
  - Peer support workers
  - Outreach workers with lived experience
  - Owning the program outside of institutional offering
  - Client representative on board of directors

Factors influencing engagement:
- **Patient** (beliefs about patient role, health literacy, education)
- **Organization** (policies and practices, culture)
- **Society** (social norms, regulations, policy)
# Recognizing and Addressing Factors Influencing Engagement

<table>
<thead>
<tr>
<th>Factors Influencing Engagement</th>
<th>Supporting the building blocks for engagement <em>(the what)</em></th>
<th>Example strategies to meaningfully engage <em>(the how)</em></th>
</tr>
</thead>
</table>
| **Patient** *(beliefs about patient role, health literacy, education)* | • Ensuring needs are met through the provision of care and referrals to community services  
• Building trust between patient and system  
• Recruiting and preparing clients to engage | • Ensure documentation is in plain language  
• Assign a resource support person to enable participation in improvement initiatives  
• Offer incentives to ensure, at minimum, their contribution is ‘cost’ neutral |
| **Organization** *(policies and practices, culture)* | • Commitment to client-centred care as a strategic priority  
• Recognizing the expertise in patients’ lived experience  
• Improving access to engagement opportunities | • Commitment that no decisions affecting clients are made without clients *(nothing about me without me)*  
• Ensure appropriate strategy for desired level of engagement |
| **Society** *(social norms, regulation, policy)* | • Advocating to support engagement  
• Leveraging community partnerships to advance engagement | • Model the engagement you expect to see in your own organization  
• Meet people where they are at |
Conclusions

› Client engagement in health system redesign can accelerate improved population health, costs and care (*patients and clients bring new and different ideas than providers working on their own*)

› In high-performing organizations, engagement activities are tailored to goals of the engagement process and occur at all levels of the engagement spectrum (from information seeking to shared decision-making)

› Vulnerable populations are willing and able to engage and require supports for meaningful engagement
Questions?

Please submit your questions/comments electronically using the “Chat Box” on the bottom of your webinar screen.
Looking Ahead

Seek first to understand and then to be understood.

Stephen Covey
Thank you!