

The Medical Home:

DESIGNING PRIMARY CARE IN EAST TORONTO



EAST TORONTO SUB-REGION

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Foreword

...we like to imagine the possible.

As system designers, we like to imagine the possible. We envision a simple primary care system in east Toronto, one that all individuals are able to access and navigate with ease: a truly universal system that aligns with our national identity.

Our process follows the foundations of design thinking:

Discover & interpret, through which we learn about the specific health needs of east Toronto and translate our findings into opportunities.

Ideate & execute, through which we create, implement and refine our solution.

Measure & evolve, through which we analyze the impact and discuss future opportunities.¹

Throughout this process, we move between layers of the health care system. We meet both the individuals who require health services and the teams of professionals working to ensure their medical and social needs are addressed. We speak with those engaged at the sub-region level, where collaboration between primary care and all other types of care is constantly emerging. And we learn from each of these encounters that trusting relationships form the foundation of a strong system of care.

Over the past year, we have designed and implemented two medical homes in the Oakridge and Taylor-Massey neighbourhoods. Our hope is for these medical homes to one day form part of a larger, integrated primary care system in east Toronto.

—the East Toronto Sub-Region team

EAST TORONTO SUB-REGION TEAM

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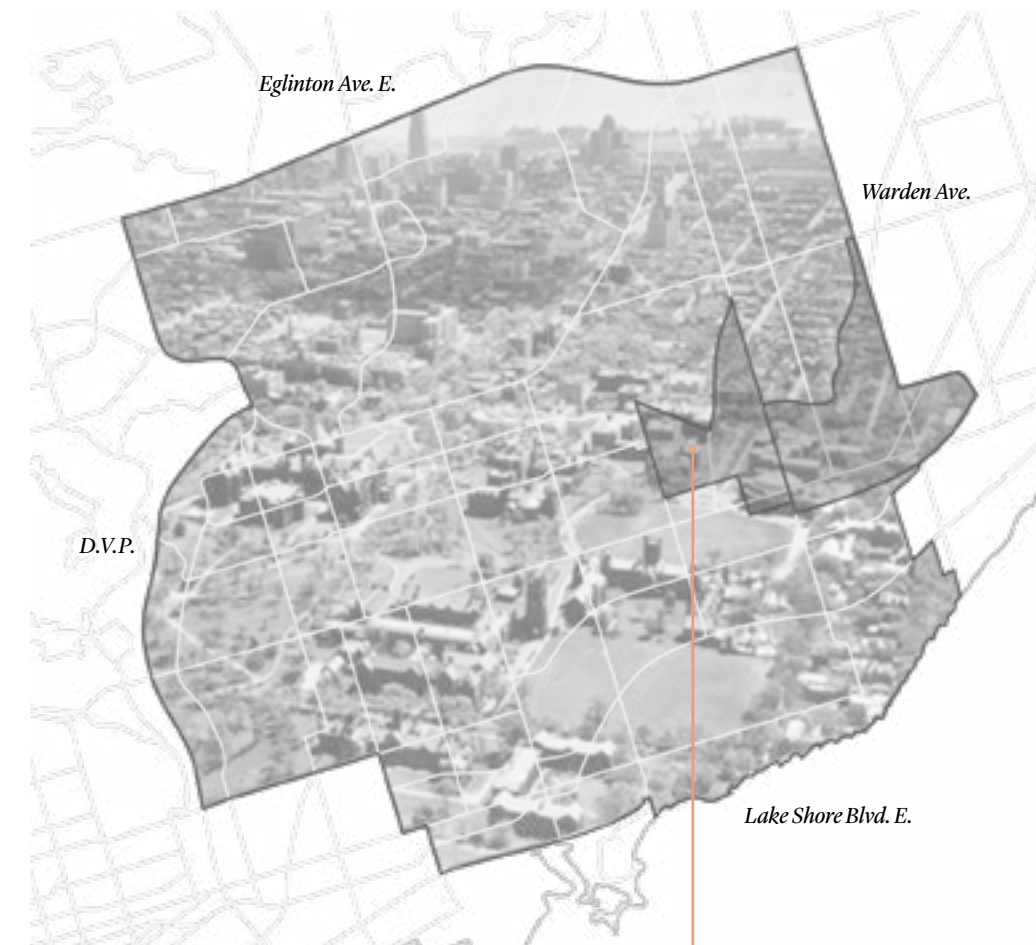
25 References

I: Discover & Interpret

- Learn about the specific health needs of east Toronto
- Translate findings into design opportunities

Overview of the East Toronto Sub-Region

275 family physicians practice within the sub-region, an area with approximately 300,000 residents.²



Areas of Focus

The Oakridge and Taylor-Massey (formerly Crescent Town) neighbourhoods are designated City of Toronto Neighbourhood Improvement Areas, ranking poorly in the following five areas:

- **Economic opportunity**—rates of unemployment, low income, and social assistance
- **Social development**—rates of high school graduation, post-secondary completion, and marginalization
- **Participation in decision making**—rates of municipal voting
- **Healthy lives**—rates of premature mortality, mental health, preventable hospitalizations, and diabetes
- **Physical surroundings**—walk score, and prevalence of community meeting places, health food stores, and green spaces³



Narrowing In

Oakridge

Neighbourhood

Oakridge is an area of low income adults and seniors living in social housing.

70% of the 13,800 individuals living in Oakridge reside within apartment buildings, many of which are owned and run by Toronto Community Housing (TCH). This population includes individuals who are likely to be of low income, recently homeless or from jail, immigrants, or seniors with psychogeriatric needs living alone.⁴

We sat down with a tenant representative from one of the TCH buildings. Over the past 16 years, the tenants have become his family and he is constantly concerned about their wellbeing. “So many things go astray,” he informed us.

He shared a story of a man who was suffering from schizophrenia and other serious health issues. A maintenance team entered his apartment while he was out one day, as it was evident his space was infested with bed bugs. Upon his return, the man went into hysteria when seeing his items removed and destroyed; he had no recollection of granting permission to enter. He was so distressed that he set his own apartment on fire. While the tenant representative tried to advocate for this man’s mental health needs, the police arrived on site, handcuffed him, and drove away.

A lack of trust prevents individuals from accessing proper care.

While it is clear that many Oakridge residents require medical and social services, a lack of trust in the system often prevents them from accessing these services. We met a family physician who has worked in the neighbourhood for over 25 years. She called the poverty in Oakridge, “a poverty of people you trust,” and explained that many of these tenants have likely suffered trauma in their lives, resulting in their isolation. “Accepting help is difficult,” she said. Over the years, she has worked incredibly hard to build trusting relationships with her patients, often going above and beyond to ensure these individuals have the necessary social services available to them.

Without proper care, these individuals frequently visit the local emergency department in crisis.

During the year 2016, Oakridge residents visited the emergency department at their local hospital 6,372 times, close to one visit every hour for the entire year.⁵



Narrowing In

Taylor-Massey

Neighbourhood

Taylor-Massey is community of immigrants suffering from poor mental health largely attributed to post-migration factors.

Out of the Toronto Central LHIN's 72 neighbourhoods, Taylor-Massey has the highest rate of mental health hospital visits per year. This is largely attributed to post-migration factors, such as job insecurity and discrimination, which are immense sources of stress and frustration in the life of a new immigrant.⁶

These individuals face stigma and often avoid addressing their mental health concerns.

We conversed with the office manager of Crescent Town Health Centre, a primary care clinic in Taylor-Massey. He explained that immigrant communities within Taylor-Massey adopt a collectivist mindset, meaning mental health disorders are collectively frowned upon. If people are experiencing poor mental health, they not only worry about themselves, but about their family's standing within the community.

This often results in one of two situations. Sometimes people will ignore their condition in order to avoid stigma for their family. But eventually things become intolerable and they head to the nearby emergency department. Other times, patients arrive at the clinic with a cold or headache, but through conversations with their doctors, they reveal symptoms linked to depression or other mental health disorders.

In response to this, the doctors at Crescent Town Health Centre will extend their appointments, allowing patients enough time to address all of their concerns. Unfortunately this adds stress for the doctors, who end up working extra-long hours to serve the neighbourhood.

IDENTIFYING A PROBLEM

Marginalized populations in east Toronto are gravely in need of health services that address both their medical and social concerns. Additionally, a lack of trust and stigma around mental health deter residents of Oakridge and Taylor-Massey neighbourhoods from accessing mental health and addiction resources.

II: Ideate & Execute

- Create, implement and refine design solutions

DESIGNING A SOLUTION

Create a medical home in both the Oakridge and Taylor-Massey communities to address the medical and social concerns faced by marginalized populations. These medical homes are designed to help individuals build trust with their care team through one-on-one relationships, while also enabling individuals to address their mental health concerns without fear of stigma.

The Medical Home Model



Team-based Primary Care

A team of health professionals, led by family physicians, offers comprehensive care to all patients of the medical home.

Integrated Social Services

Designated members of the care team are responsible for addressing the social determinants of health. For example, if a patient needs help obtaining benefits, a social worker will coordinate this service with a community provider outside of the medical home. This way the medical home acts as a central access point for all health issues, including those related to a patient's social conditions.

Population-based Care

The medical home care team differs depending on the needs of the local neighbourhood. The composition of the selected team of family physicians, nurses, social workers, and other health professionals is determined using both qualitative and quantitative neighbourhood-based data. For example, some populations have higher instances of mental health and addiction and require a greater number of social workers to offer both case management and clinical counselling.



Team Composition
2 family physicians • 0.2 FTE
1 registered nurse • 1.0 FTE
3 social workers • 3.0 FTE

The Oakridge medical home is led by Dr. Jane Pritchard, a long-time family physician in the area. The clinic is located in a TCH building.

Funding for one registered nurse and three registered social workers led to the establishment of the medical home in March 2017. Before this time, Dr. Pritchard practiced on her own, or with limited staff temporarily hired through grant funding. Another family physician, Dr. Robert Andrew Heyding, joined the team in September 2017.

The nurse helps build clinical capacity for both Dr. Pritchard and Dr. Heyding. The social workers offer behavioural and supportive counselling, as well as help patients navigate the many social services related to housing, income, food security, etc.

The medical home has adopted an electronic medical record (EMR) system, which enables the team to better keep track of their transient patient population. Importantly, the EMR is linked to local hospitals through Hospital Report Manager (HRM), meaning the team becomes aware of any hospitalizations.

As trust is a serious barrier to care for Oakridge residents, the team focuses their efforts on building one-on-one relationships. They offer drop-in hours each week, and host community barbecues and socials. They have also started group programs for women’s health and smoking cessation.



Team Composition
5 family physicians • 4.0 FTE
1 case counselor • 1.0 FTE

Crescent Town Health Centre is the site for the Taylor-Massey medical home, located centrally within the community.

Five family physicians work at the clinic and see approximately 26,000 patients, many of whom are newcomers to Canada. These physicians do what they can to help their patients, often arriving at the clinic early and staying late.

A case counsellor who specializes in settlement services joined the physicians in June 2017, forming the start of a medical home. In addition to settlement services, the counsellor provides mental health services, as the two often go hand in hand. This provides some relief to the physicians, who, prior to the arrival of the counsellor, were overwhelmed by the number of mental health and addiction cases. Now these physicians have a direct resource for their patients.

The counsellor reduces barriers to care by offering common language resources for care navigation and case management. Additionally, by working under the generic title of ‘case counsellor’, patients are more willing to meet with him.

PARTNERSHIPS

We use the term partnership to indicate a “collaborative relationship characterized by mutual commitment to operating in a high trust, high performing and highly innovative manner in order to accomplish a shared goal.”⁷

Both medical homes partner with WoodGreen Community Services, a local social service agency. WoodGreen has the ability to provide specialized, community-based services for marginalized populations. They are accountable and liable for the professional practice and clinical work of the registered social workers and the case counsellor.

The Oakridge medical home also partners with a local hospital, Providence Healthcare, to provide human resources and professional practice support for the registered nurse. Providence offers expertise in geriatrics, expediting access to resources for seniors living in Oakridge.

GOVERNANCE

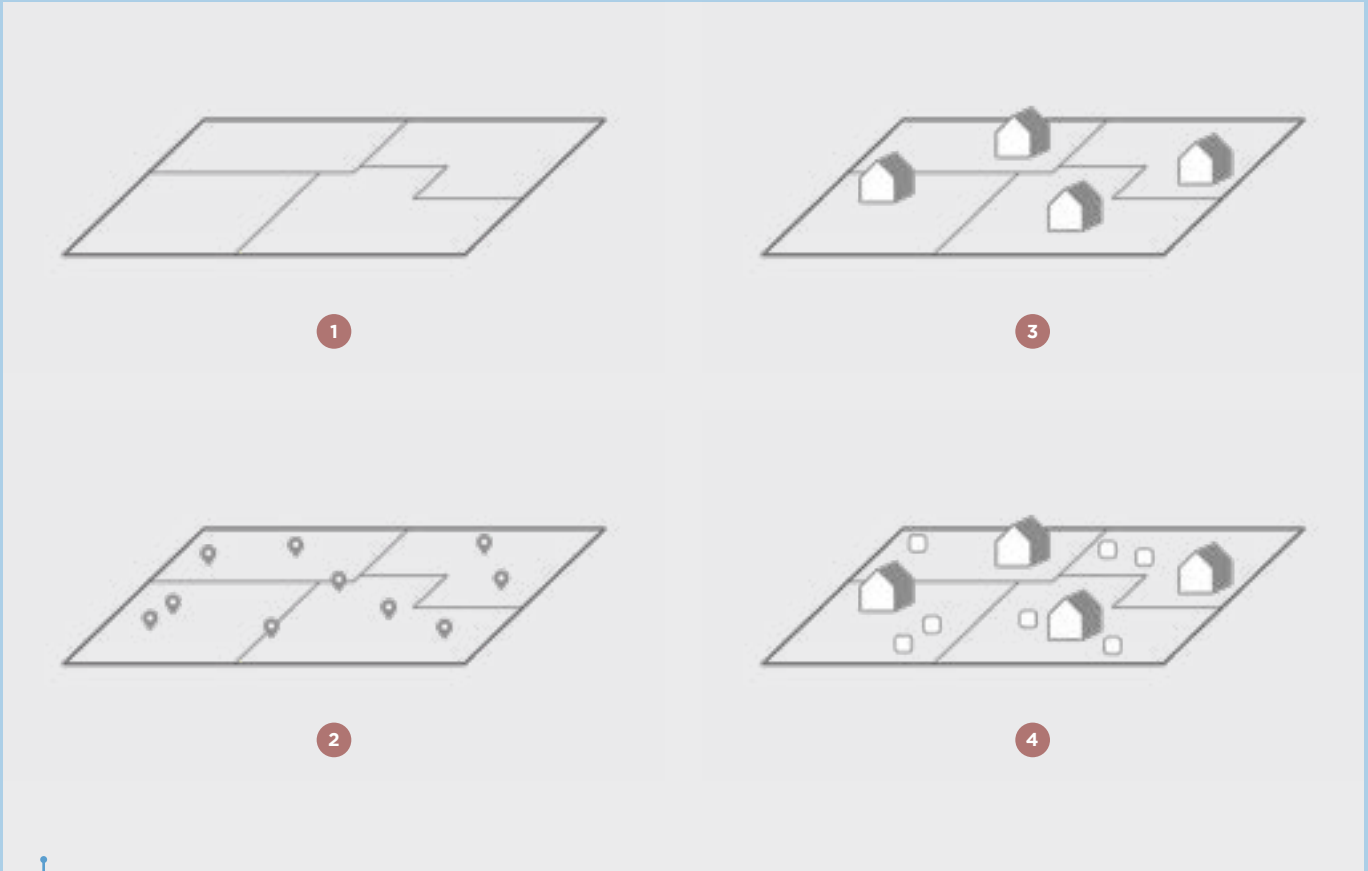
The Primary and Community Care Committee (PCCC) was established to advance the integration of primary care in east Toronto.

The PCCC provides knowledge and advice to the East Toronto Sub-Region team regarding population health needs, physician and community engagement, and resource planning. They act as a key link between the primary care sector and other elements of the health care system.

The PCCC is comprised of 15 administrative and clinical leaders representing various neighbourhoods and models of care in east Toronto.

An Integrated Primary Care System

Over time, the Oakridge and Taylor-Massey medical homes will form part of an integrated primary care system in east Toronto.



1. The east Toronto sub-region is divided into 21 neighbourhoods (four neighbourhoods shown here for illustrative purposes only).
2. Family physicians currently practice throughout the sub-region.
3. In time, these physicians will come together to form one medical home per neighbourhood. These physicians may choose to work under one roof or form a virtual medical home. Most importantly, each medical home will serve a unique group of patients.
4. An interprofessional primary care team, including nurses and social workers, will provide services for the various medical homes within the sub-region.

For further information, please watch *ACO Blueprint for East Toronto* (available on Vimeo).

III: Measure & Evolve

- Analyze the design impact
- Discuss future opportunities

Designing for Impact

The medical home model builds resiliency.

Studies on sustainability show that when a design intervention is characteristically “small, local, open, and connected” it has the ability to sustain over time.⁸ In other words, interventions that function on a human scale, involve local knowledge, resources and expertise, maintain transparency throughout their development, and connect to a larger system or network, are those which continue to thrive over time.

These characteristics are foundational to the medical home model:

- **Small:** We can conceptualize the scale on which the model operates: a handful of health professionals coming together to care for a group of patients.
- **Local:** These professionals bring together a comprehensive knowledge base that helps their patients stay healthy in the community.
- **Open:** The model is intentionally open source, meaning no one person has ownership over its design.
- **Connected:** We know the medical homes form part of an integrated primary care system in east Toronto.

Over the past year, the Oakridge and Taylor-Massey medical homes have evolved to better align with the specific needs of their patient populations. By making continuous revisions, while maintaining the model’s foundational characteristics, we see innovative solutions lead to better care and greater impact.

Patient

IMPACT

Patient Experience Survey

In January 2018, 25 patients from both medical homes completed a patient experience survey centered around one key question: “On a scale from 0 to 10, how likely are you to recommend this clinic to others?” The average response was 9.82, indicating high levels of patient satisfaction. The following comments were pulled directly from the surveys:

“Excellent service! [He] is a great counsellor. Before I met him, I went to six different social workers. They couldn’t help me. I was very depressed after the loss of my mother and I didn’t move on with my life. When I met with [him] after 2 sessions, he figured out my problems and connected me with the right resources. Now I’m back on track, and looking for jobs, attending grieving counselling that [he] connected me with. I would definitely recommend this service to anyone who needs help.”

“It is a good thing for the people.”

“Very convenient location. Friendly and they have your best interests at heart, would recommend to others.”

“I find it easy to talk to you. I also find you very helpful in many other ways.”



Visiting L

L is a woman in her early 60s living alone. She was found in a terrible state by the Oakridge medical home team. Entirely on her own for months, she was drinking excessively and not eating. Unable to use the toilet on her own, she was covered in urine and feces, as was her single mattress on the floor, her wheelchair and her landline phone. The entire apartment was infested with bugs.

It is clear that L does not trust people. She is cranky when her social worker and I first arrive, telling us that she felt disrespected by two workers cleaning the windows in her apartment that morning. The social worker has questions. When was the last time someone came in to bathe her? Had she paid her phone bill? Why did she insist on cancelling her Meals on Wheels program? I notice these questions seem to further irritate L.

But later the social worker tells me how much progress she has seen in such a short amount of time. She comments on how L had brushed her hair into a ponytail, wanted to have her toenails clipped, and asked for a cleaner wheel chair. This was such a contrast to the L of several months back; then personal hygiene was the furthest thing from L’s mind. Now she cannot stand dust on her windowsills. All of this makes the social worker smile. She trusts me to help her, she explains.

L is confined to her apartment. She’s unable to wheel herself over the raised threshold between her living room and the outside hallway, which means she spends all of her time inside. Her social worker is having the raised threshold removed. She’s also the one who had L’s apartment stripped, cleaned, and fumigated. She brings diapers, new clothes, and new snacks for L to try during this visit.

At one memorable point, L pulls out a ball of yarn and a crochet needle. The ball of yarn is attached to the most intricate crocheted tablecloth I have ever seen. L tells me she learned to crochet at the age of 12. She has multiple projects on the go, all astounding in detail. She had been encouraged to start crocheting by her social worker. This is one positive distraction from drinking that seems to be working well.

L’s story was incredible to witness, even just the parts I knew. What I saw was a woman desperately in need of someone trusting, and another woman, who had dedicated herself to fulfilling that role for a complete stranger.

To hear more of L’s story, please tune into We Care podcast (visit wecarepodcast.ca).

Provider

IMPACT

Working as a Team

When I meet the case counsellor, I immediately sense his dedication. He’s soft-spoken, gentle and takes the time to answer my questions thoughtfully.

The counsellor is happy to provide some relief to the family doctors working at Crescent Town Health Centre. He says they work together as a team. Now if patients share a social concern with one of the doctors, they will be referred to the counsellor. And vice versa; if an individual is concerned about a medical issue, the counsellor will send them to one of the family doctors at the clinic. Working in the same facility is highly useful for maintaining communication between him and the doctors.

From the case counsellor, I learn that settlement support takes many forms. It may include welcoming new immigrants at the airport, arranging temporary or permanent accommodation, enrolling them in English classes, helping them apply for provincial health cards and Social Insurance Numbers, and connecting them with job search services. But it can also involve a great deal of emotional supportive counselling.

During his first months at the clinic, the counsellor has already met many individuals suffering from depression and anxiety, some even dealing with suicidal thoughts. One man in particular came to see the counsellor over a month ago. He was referred to the counsellor by one of the doctors at the clinic after expressing his anxieties about his living situation.

Since that time, the counsellor has helped this man through his role as both a settlement worker, and as a mental health worker. Together they applied for a new passport, which meant that this individual could finally access his bank account. The counsellor helped him recover over \$10,000 in funding owed to him by the government. He also found funds to fumigate the man’s infested apartment. With all these changes, the counsellor has seen improvements in this individual’s mental state.

What we’ve come to learn is that by working together, team members are able to effectively and appropriately address both the medical and social concerns that an individual may be facing. We know that poor health can be the result of difficult social circumstances, so it is incredibly important that team members are able to support social needs in addition to medical ones.

To hear more of the case counsellor’s story, please tune into We Care podcast (visit wecarepodcast.ca).

KEY METRICS

April 2017–March 2019

OAKRIDGE
1 registered nurse • 1.0 FTE
3 social workers • 3.0 FTE

SPIs: **5,498**
Indv. Served: **227**
CCPs: **56**

TAYLOR-MASSEY
1 case counselor • 1.0 FTE

SPIs: **749**
Indv. Served: **162**
CCPs: **162**

Letters of Support

Below are excerpts from two letters of support written by members of the Oakridge medical home:

“As a nurse in my present job, my role is multi-faceted. On a medical level I conduct assessments, communicate changes to the MD, facilitate and ensure the plan of action takes place. I organize and facilitate patient referrals and appointments. I work with the LHIN coordinators in providing services. I provide one-on-one health education. When patients are ill and unable to come out I visit them at home. When I haven’t seen a patient for a while I check in to make sure they are well. I wear different hats as a nurse in the community, and in this process building therapeutic relationships is a key component to the effectiveness of my work. In these relationships, I am privileged to know more about patient struggles and refer them to resources. This is where the role of a social worker becomes vital.

Vulnerable communities are faced with numerous social determinates of health. The social workers are essential in addressing these factors and work on bringing stability to a client’s situation. Social workers have knowledge about resources available in the community and professional ties to finding more. They are also equipped to provide immediate counseling for anxiety, depression and

Number of Service Provider Interactions (SPIs):

A service provider interaction is reported each time service recipient activity is provided. If a service provider serves the service recipient multiple times, each interaction is reported.

Number of Individuals Served by Functional Centre:

A year-to-date total of the number of individuals served by the functional centre within the fiscal year. Individuals are counted only once, regardless of how many different services they have received.

Number of Initiated Coordinated Care Plans (CCPs)

A coordinated care plan is considered initiated when a patient or their caregiver plus two or more health professionals agree to develop a strategy for addressing one or more physical, mental, social, or spiritual issue(s).

addictions, which are a common struggle for my patients. Social workers are able to build community capacity through programming and group facilitation. Case management is a great need to navigate the social service sector, as well as the health sector. Social workers provide needed support in this area. As a nurse, my expertise is limited. The social workers provide the gap of care many of my patients need to achieve better health outcomes.”

“...now that we have the [nurse and] social workers attached to our team we are able to assist patients in ways that were not possible before. For some that means getting necessary surgical and medical treatment that had been indefinitely delayed by lost documents, inadequate communication and lack of transportation; for others, it has been to reverse eviction orders, and comply with standards required to retain their housing health outcomes.”

LOOKING FORWARD

Based on these findings, the East Toronto Sub-Region team will continue to support the design of medical homes in other areas of east Toronto. Our work will prioritize the neighbourhoods most in need of primary care resources.

We are confident that in time, medical homes will play an increasingly important role in system integration. We have already seen strong partnerships formed between primary care and other health service providers, including social service agencies and hospitals.

Our approach to design will remain the same; creating medical homes from the ground up by tapping into existing resources, infrastructure, and most importantly, relationships. So far, this has resulted in medical homes that are flexible and unique, reflective of the differences between the two neighbourhoods and their dynamic communities.

We look forward to further developments in primary care, and future collaborations with those who share our goal of bringing the right care to those who need it most.

REFERENCES

[i] IDEO (n.d.). A Virtual Crash Course in Design Thinking. Retrieved March 22, 2018, from <https://dschool.stanford.edu/resources-collections/a-virtual-crash-course-in-design-thinking> [ii] TC LHIN. (2015). East Neighbourhood Profiles (Placemats) (Rep.). [iii] City of Toronto. (2014). NIA Profiles. Retrieved Jan. 10, 2017, from <http://www1.toronto.ca/wps/portal/contentonly?vgnextoid=e0bc186e20ee0410Vgn-VCM10000071d60f89RCRD> [iv] Huynh, T. (2017). Oakridge's Very Own Food Truck. Retrieved March 15, 2018, from <https://thelocal.to/oakridges-very-own-food-truck-1c06930ce4a1> [v] MGH. (2016). Emergency Department: Population Analysis (Rep.). [vi] Lewsen, S. (2017). A Mental Health Crisis in Little Bangladesh. Retrieved March 15, 2018, from <https://thelocal.to/a-mental-health-crisis-in-little-bangladesh-410a1d3fa4f> [vii] Health Quality Ontario. (2010). Team Building Part A Resource Guide. [viii] Manzini, E. (2013). Small, local, open and connected. Resilient systems and sustainable qualities. Retrieved March 22, 2018, from <https://designobserver.com/feature/small-local-open-and-connected-resilient-systems-and-sustainable-qualities/37670>

THE MEDICAL HOME

