Benefits Realization Case Study: Interprofessional, team-based care impacting outcomes for Health Links patients in Kitchener-Waterloo

Background

In Canada, the continuum of care flows across multiple, independent organizations for many services, which makes coordinating care challenging, particularly for complex patients with multiple chronic conditions [1]. Evidence suggests that interprofessional, team-based care benefits both providers and patients. In particular, interprofessional care and perceptions of collaborative relationships with other healthcare providers have been linked to provider job satisfaction and an improved work environment [2, 3]. It has also been reported that patients experience a higher quality of care when they are involved with an integrated interprofessional healthcare team [4-7].

The KW4 Community Ward Team (CWT) is an interprofessional team that coordinates and provides in-home care for complex, high users of the health care system, or individuals unable to access appropriate care who are otherwise "falling through the cracks" in the area. The team provides wrap-around care by integrating available family, home and community supports and coordinating access to additional resources based on patients' needs. The CWT is comprised of a variety of health professionals, including care coordinators, a chiropractor/mobility specialist, nurse practitioner, pharmacist, outreach worker, physician consultant, physician assistant, and a team assistant. These providers work together to provide care that is tailored to a patient's specific situation.

Value Proposition

An interprofessional, community based team approach for complex patients allows providers to offer collaborative, holistic care while addressing patients' connection with the wider system, resulting in more coordinated care and improved patient outcomes.

KW4 Health Link Patient Story

One Health Links patient was referred to the CWT during one of his frequent hospitalizations, due to his multiple medical problems, lack of social and financial support, and medication concerns. Since being connected with the team, they have helped him with managing each of these concerns. He had a fractured relationship with primary care due to the inconsistent prescription of an essential pain medication. Now, the team has connected him with a new physician and are in constant communication with them and the pharmacy to ensure that his pain medications are appropriately available.

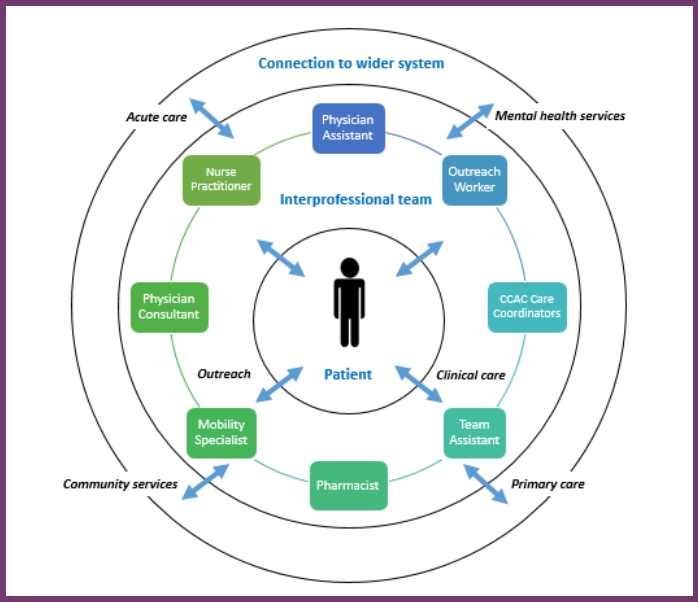
The team's support for this patient goes beyond clinical care into addressing his social determinants of health. The team contacted the Ontario Disability Support Program (ODSP) and the patient's landlord in order to maintain a roof over his head. They helped him to secure a nutritional benefit in order to purchase a meal replacement drink. They also provide him with the social support that he never had. His previous social isolation led to depression and he was "in a dark place" before being connected with the CWT.

This proactive, coordinated care has reportedly resulted in a reduction in emergency room visits and inpatient admissions for this patient since he was connected to the CWT.

> **"The words aren't out there to describe how I feel about [the team]… anything you want or need, they are there….they are such wonderful people, I can't say anything bad about them. Something changed when they came around… I was in a very dark place before."**
>
> **– KW4 Health Link Patient**

What were the Benefits?

The CWT team is composed of health professionals from various disciplines, which is an enabling factor in their ability to break down silos, access a wide range of health and social resources, and care for patients holistically. A unique aspect of the team is their co-location: when not out in the community, they are situated in a shared office space that enables ongoing communication, perpetually looking at situations from multiple perspectives, and real-time problem solving.



As one team member explained, the interprofessional approach gives the team the confidence to be able to "pull on everyone's strengths and erase their [individual] weaknesses." They are able to look at a case from different lenses and professional backgrounds. This combines to create a synergistic effect, in which all team members are involved in coordinating care. Another team member noted that "all the information is here. It's like being a part of a collective brain; I don't actually have to know it, but I know someone else does."

The team is the connecting body between the patient and the wider system, since the traditional system does not work for many complex patients. They are able to fill gaps and address barriers in a way that positively impacts their patients' mental and physical well-being.

Program Details

Healthcare spending is highly concentrated: the top 1% and top 5% of health services users accounted for 34% and 66% respectively of health cost in Ontario in 2007/8 [8]. These high health care users are likely to be patients with complex care needs and/or multiple chronic conditions. The Ontario Ministry of Health and Long-Term Care recognized the need to better coordinate care for these most complex patients within the community in order to improve health outcomes and drive health system efficiencies, and thus initiated the Health Links approach to care in 2012.

The Waterloo Wellington Local Health Integration Network (WWLHIN) is in the process of conducting an evaluation of the Health Links approach to care within the region. The eHealth Centre of Excellence (eCE) has supported this evaluation by conducting a Benefits Realization (BR) study in each of the four sub-LHIN geographies within the WWLHIN. The eCE's work focused on the impact of the Health Links approach to care by conducting a pre-post Coordinated Care Plan (CCP) comparison of acute care use and developing clinical narratives to highlight the clinical value enabled through the Health Links approach. This BR case study is one of the outcomes of the eCE work.

Works Cited

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If you are interested in participating in a future BR case, please contact eCE BR Practice Lead Lori-Anne Huebner at:
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