Muskoka & Area ONTARIO HEALTH TEAM

Grand Rounds - Huntsville

January 8, 2025

Agenda – MAOHT PCN, Best Care and SCOPE

Speakers: Drs. David Mathies and Sarah MacKinnon

1. The formation of a Primary Care Network within MAOHT (David)

2. A new service from MAOHT – Best Care Program for CHF an overview (David)

3. SCOPE and Best Care Case Studies (Sarah)

Disclosure:

I am paid for my time by the Muskoka Area OHT.

- Dr. David Mathies

Primary Care Network – why now?

- The Ministry and Ontario Health have recently announced guidance materials and information on Primary Care Network development and in addition has indicated that ***Primary Care Network formation is a requirement of all OHTs*** and must be in place prior to OHT designation under the Connecting Care Act.

- Ontario Health has provided strong indications that funding flowing from Ontario Health to OHTs for Primary Care programs will be prioritized to practices who are either part of a PCN or in process of joining a PCN.

- The province continues to emphasize the importance of the Primary Care Sector inclusive of the recent announcement of Dr. Jane Philpott as the chair of the Primary Care Action Team with a mandate to connect every person in Ontario with Primary Care within 5 years.

- MAOHT is recognized currently within its governance structure as primary care driven with Clinical leadership as co-chair positions on both the Alliance Council and Collaborative Steering Committee. In addition, approximately 74% of all MAOHT committees, councils, working groups have a family physician and or nurse practitioner participating. Forming a PCN will provide the formal mechanism to ensure a continuing strong primary care voice as MAOHT moves to maturity in the formation of a not for profit entity governance model.

- Registration of Primary Care Providers to a MAOHT PCN will provide strength to Primary Care leadership within MAOHT that it clearly represents the Primary Care voice within MAOHT and at Regional and Provincial tables.

Primary Care Network – Status

As per the approved MAOHT Operations Plan – the MAOHT is to:

The formation of a formal PCN for December 2024 with an enrolment drive commencing in Q4 of FY 24-25.

Key Milestones/Activities:

- PCN task force established - *completed* April 2024
- Primary Care Newsletter established – *completed* July 2024
- PCN Clinical Leadership established – PCN Task Force to be interim leadership – *completed* 2024
- PCN Terms of reference approved inclusive of membership method and criteria finalized – *completed* December 2024
- Commencement of formal PCN membership drive in January 2025 – ***in process***

Primary Care Network – Vision and Objectives

Vision

- PCNs will connect, integrate, and support primary care clinicians within MAOHT to improve the delivery and coordination of care for patients (OH), families and caregivers. (MAOHT-PCN)

Objectives

- Organize the local primary care sector in OHT planning and provide a voice in OHT decision- making
- Serve as a vehicle to support OHTs in the implementation of local and provincial priorities.
- Articulate, advocate and drive local primary care priorities (MAOHT – PCN)
- Develop and implement an engagement strategy across the Primary Care sector (MAOHT – PCN)
- Provide for effective and efficient two-way communications with primary care network members from PCN leadership on opportunities, information to assist practices and ensure the voices in the field are heard. (MAOHT – PCN)

Primary Care Functions

1. Connects primary care within the OHT
2. Serves as a vehicle for providing the primary care sector's voice in OHT decision making
3. Supports OHT clinical change management and population health management approaches
4. Facilitates access to clinical and digital supports and improvements for primary care
5. Active collaborates through the MAOHT HHR task force on primary care health human resource planning(MAOHT-PCN modified OH), inclusive of establishing and fostering linkages with educational partners and ongoing learning opportunities for members. (MAOHT-PCN)
6. Represent primary care at Provincial and or Regional Planning tables (MAOHT-PCN)
7. Provide for effective, efficient communications to assist Primary Care Practices and act as a gateway to connect Primary Care to MAOHT (MAOHT-PCN)
8. Identifies gaps and service issues within Primary Care and the Health System (MAOHT-PCN)
9. Review and identify leading practices for adoption within the OHT (Primary Care) (MAOHT-PCN)
10. Provide advice and consult on MAOHT initiatives impacting Primary Care Practices (MAOHT-PCN)
11. Review and approve PCN submission requirments to Ontario Health on behalf of the MAOHT (MAOHT-PCN)
12. Represent Primary Care at MAOHT governance leadership tables as MAOHT moves to a Not for Profit entity (MAOHT-PCN)
13. Provide guidance and clinical input on data analysis in regard to the Primary Care sector for the MAOHT attributed population (MAOHT-PCN)

Primary Care Network - Membership

- The initial membership of the Primary Care Network for a period of two years (which may be amended as per membership direction) will be comprised of Family Physicians, Nurse Practitioners and Midwives.

- Membership will be voluntary and will require a simple registration process by members using existing information found within SCOPE registration where applicable

Classification of Memberships

- ***Members with Voting Rights*** will be comprised of members (GPs, NPs and midwifes) who are currently practicing within MAOHT.

- ***Non Voting Members*** will be GPs, NPs or midwifes who are licenced practitioners who are not actively practicing, who currently reside within MAOHT and previously practiced within MAOHT.

MAOHT Primary Care Network

Coming Up…

MAOHT PCN Registration Link:

- Primary Care Providers within Muskoka and Area will be invited to register to the MAOHT PCN through a simple process using existing SCOPE membership information on file (where applicable).
- A registration link will be distributed via the Primary Care Newsletter in mid January inclusive of an invite to an upcoming PCN Virtual Launch Event
- If your not already receiving, you can register for the Primary Care here (add link)

MAOHT – Best Care program for CHF

Overview by Dr. David Mathies

Gap Analysis

A

KEY STEPS TO BRIDGE GAP

B

PREVIOUS STATE

- Patients travelling outside the Region to receive specialty Heart Function Care services
- Overwhelming workload for Primary Care Providers
- Siloed resources
- Significant human health resource challenges

INTERIM STATE

- ✓ Recruit Clinical Leader for the Heart Function Clinic (Lisa Dufour, Nurse Practitioner)
- ✓ Integrate the *Best Care* Program to spread the Resource across the community
- ✓ Arrange an escalation pathway for the Advanced Cardiac NP to refer patients to a Cardiologist for complex case management
- ❑ Resume Heart Function Clinic Services at the SMMH site
- ❑ Begin initial integration of the Best Care Program into PCP offices who are early adopters

FUTURE STATE

- ❑ Widespread integration of *Best Care* in Primary Care Practices
- ❑ Follow up care with either the SMMH HFC **OR** a patient's PCP with *Best Care*, post discharge from MAHC for Congestive Heart Failure patients
- ❑ Provide up stream, and up scoped Heart Failure Care in Primary Care offices with *Best Care's* support
- ❑ SMMH Heart Function Clinic receiving referrals for advanced cardiac care needs, and Primary Care Providers supported to provide routine Heart Function care.

What is the *Best Care* Program?

Best Care is a complete, guideline knowledge translation module that utilizes **team care** with a **Case Manager** and a **Primary Care Provider** to deliver all of the elements of evidence-based care defined by provincial, national, and international guideline standards.

- **An effective model of care for chronic disease management**
- **A repeatable platform for multiple chronic diseases**
- **An instrument of health system transformation that empowers primary care**

The model emphasizes in-person, whole-of-person, evidence-based care that is proactive, preventative, and upstream-focused, aiming to reduce hospitalizations and emergency department visits. This trusted approach to care is endorsed by 1,300 healthcare professionals (HCPs) across 12 Ontario Health Teams (OHTs) and serves thousands of patients. Additionally, it supports system integration by building from a strong foundation in primary care.

What is the Purpose of the *Best Care* Program?

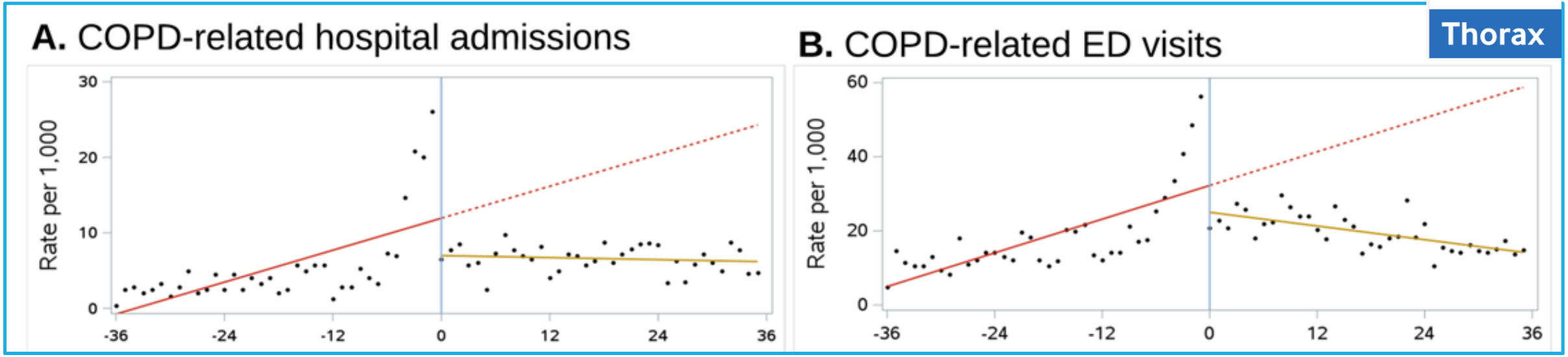
- Vast majority of patients are managed in Primary Care
- There are significant capacity limitation in Primary Care
- The current health system is more reactive, than proactive/preventative
- Chronic disease management is complex – requires a team
- Purpose of Best Care is to provide a structures, standardized, chronic disease management strategy to improve patient outcomes and health system performance

Best Care supports **Primary Care Providers** to deliver exceptional evidence-based team care to improve quality-of-life, patient experience with the health system, and lowers the chances of patients having flare-ups- potentially leading to the hospital or emergency room. The program includes regular follow up visits, medication management, treatment, self-management strategies and education delivered by the Best Care team, working with family physician's and nurse practitioner's. Best Care delivers comprehensive care and support for COPD, Asthma, Heart Failure, Atrial Fibrillation, and Lung Cancer Screening.

A WORLD LEADING PRIMARY CARE PROGRAM

- Delivering the Quadruple Aim (Proven effective, highest levels of scientific evaluation)
  - Provider Experience (Two peer-reviewed publications and 1,300 physicians fiscal 2023-2024)
  - Patient Experience (Two direct peer-reviewed publications and four QoL studies)
  - Improves Health Outcomes (Five peer-reviewed publications, highest levels of scientific evaluation)
  - Lowers Costs (Two peer-reviewed cost-effectiveness studies examining 4 countries)
- Impact of Best Care on the Ontario Health System

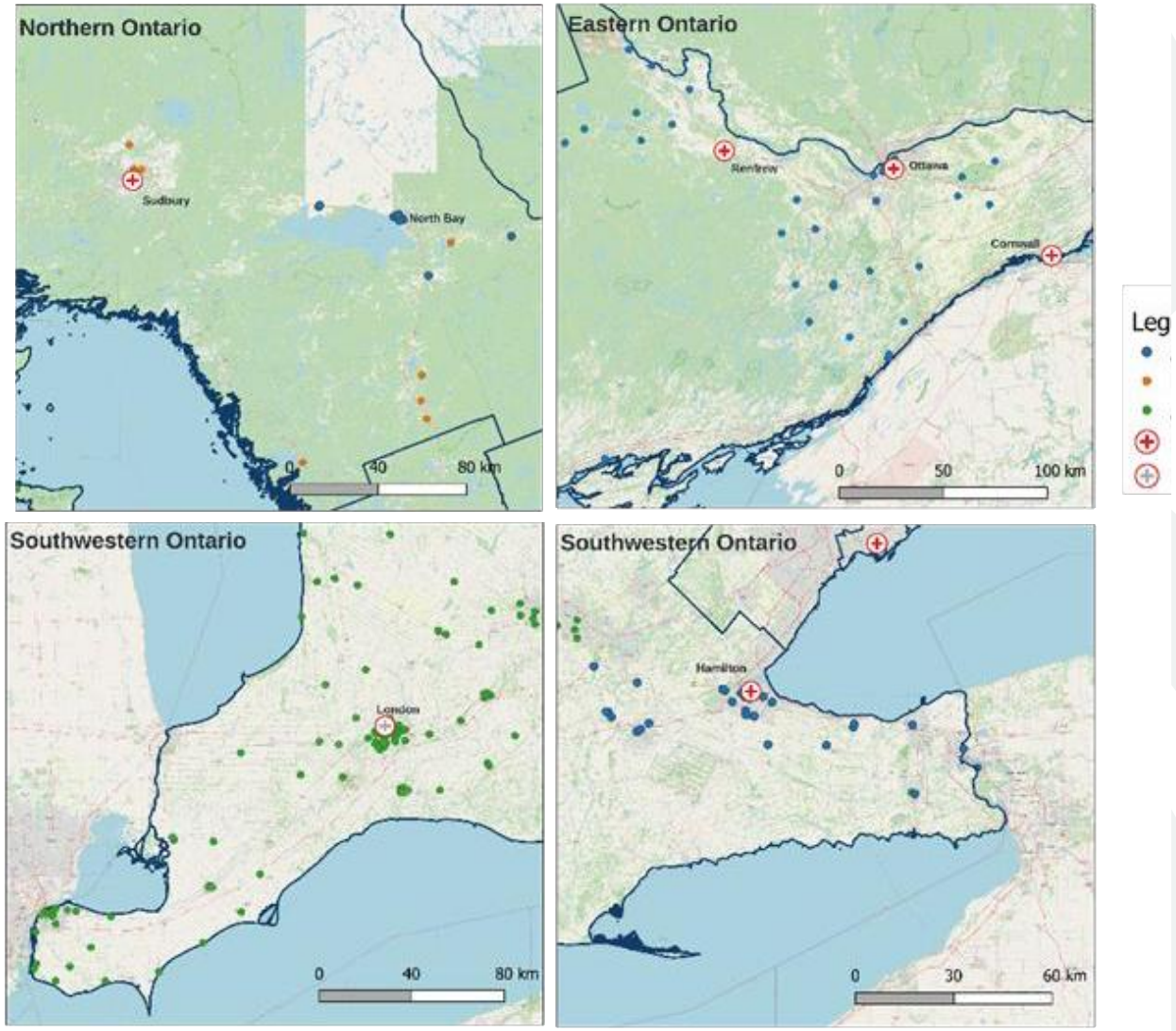
BMJ Journals
Thorax



NORTHERN EXEMPLAR - NORTH BAY - HEALTH SYSTEM TRANSFORMATION

EXISTING REMOTE OLSP + BEST CARE + ONE-LUNG EARLY DIAGNOSIS

- Existing OLSP – Sudbury (126km) - expect low penetration – The only OLSP in the north
- Started Best Care HF - in 18-months - 800 visits, 300 patients
- Created a network of primary care clinics in North Bay, Mattawa, Sturgeon Falls, Indigenous Hub, Powassan.
- Shared Care –specialist Dr. Jari Tuomi
- Unattached patient clinic at the hospital .
- 2024 + COPD Case Manager / Educator
- 2024 + Early Diagnosis COPD / Lung Cancer Screening



MAOHT CHF Program Deliverables

- Continue to provide integrated, coordinated care for patients with Congestive Heart Failure (CHF) across partners including primary care, community, and hospital-based care through a hub, spoke and node model.
- Last fiscal year, provided care to 74 patients
- Goal with the Best Care integration going forward is to serve 200+ patients per year

Increasing the Reach

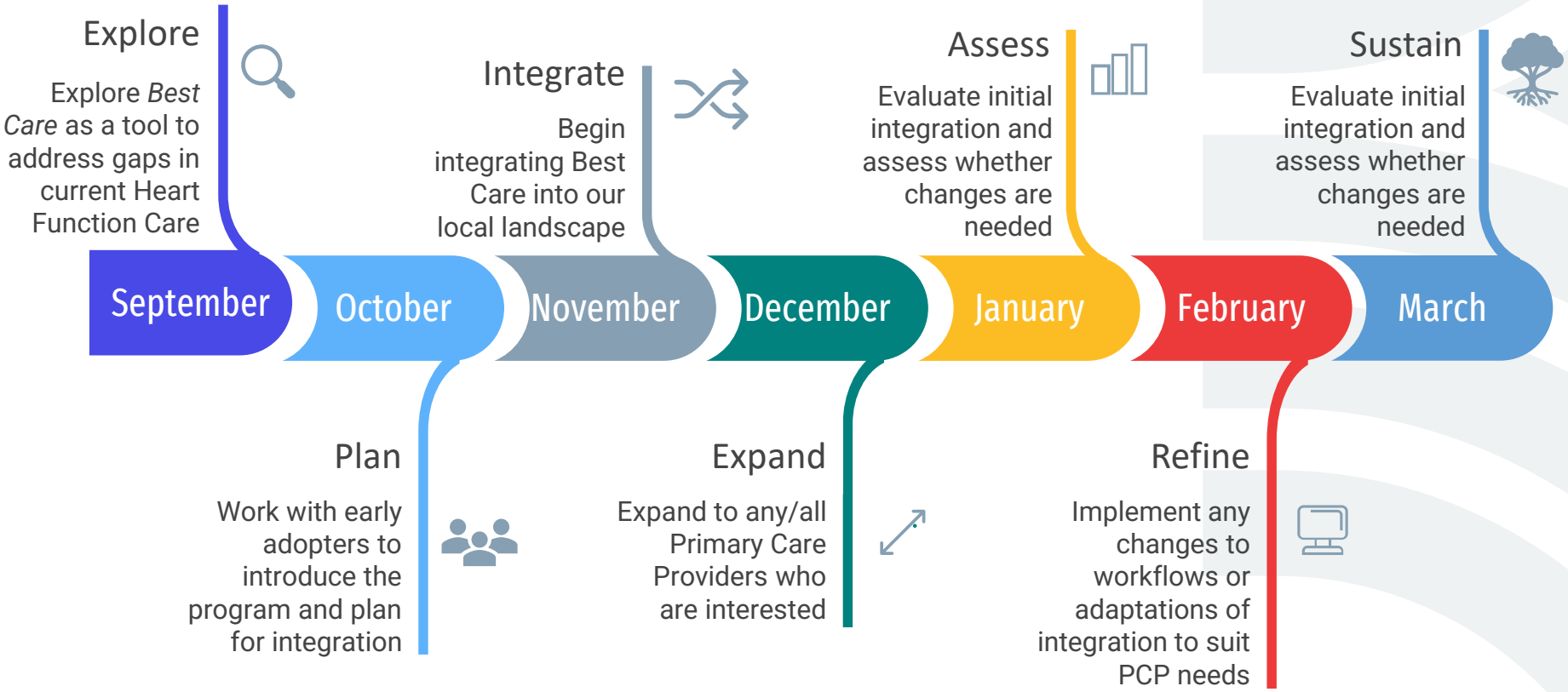
Previous State

Localized resources, central to the Hospital Site Heart Function Clinic

Future State

Resource is spread across the region, and has become a Community Resource

Timeline of Best Care Local Integration



Did you know?

MAOHT: What have you done for me lately?

...

Dr. Sarah MacKinnon, MD, CCFP, FCFP
Lead Physician, Sundridge & District Medical Centre
Member of MAOHT

Disclosure

- The Sundridge & District Medical Centre (SDMC) is a partner of the Muskoka & Area Ontario Health Team (MAOHT)
- I represent the SDMC at the MAOHT
- I am paid an honoraria to participate in various meetings
- I have no other conflicts to declare

Muskoka & Area Ontario Health Team

- Gravenhurst to Sundridge
- **Vision** - Transforming health services together with people at the centre
- Mission
  - Efficient & Equitable Care
  - Health Improvement & Well-Being
  - Participation & Engagement
  - Partnerships & Collaboration
  - Accountability & Transparency
- MAOHT is Primary Care driven
- www.maoht.ca

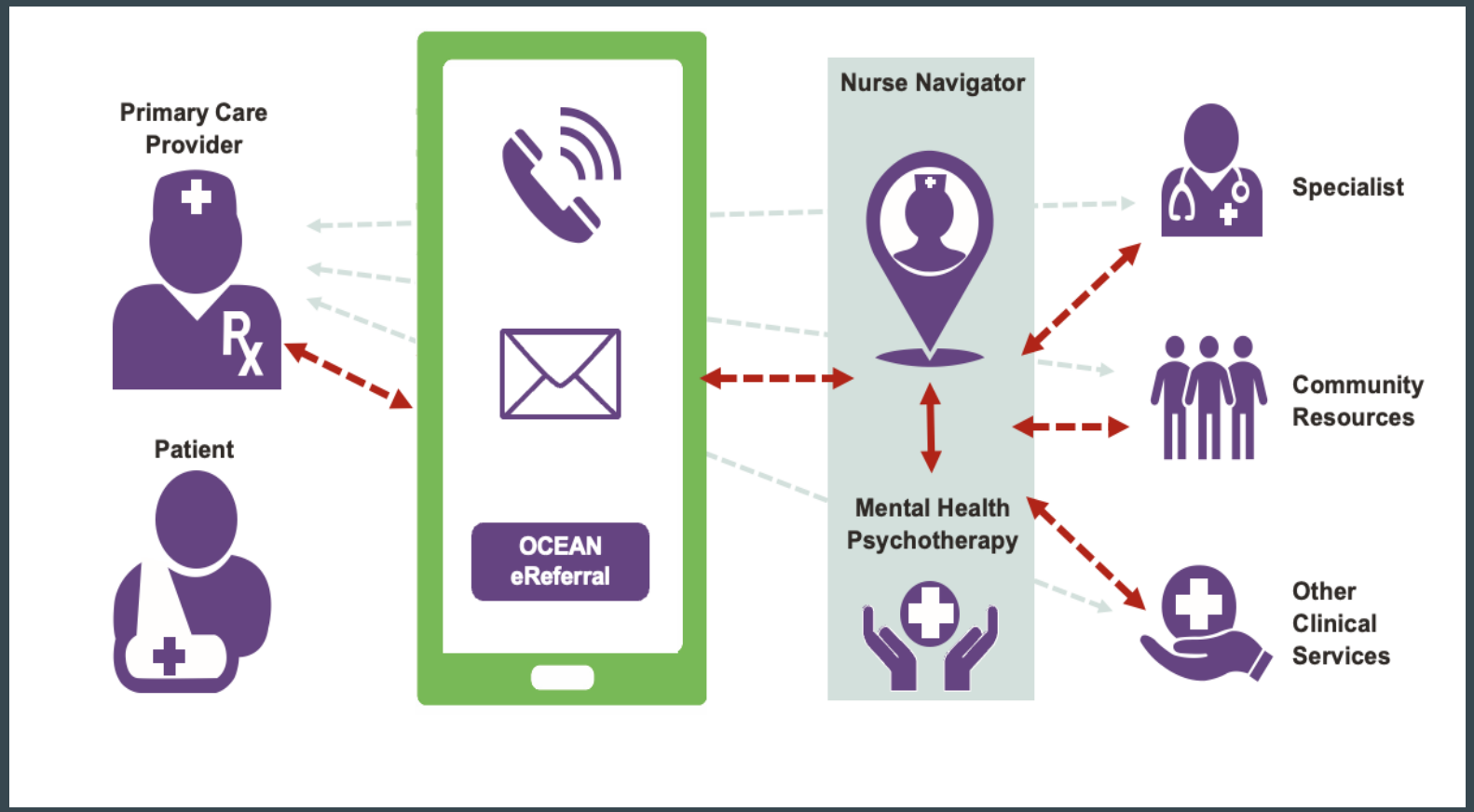
My Story

- Family physician x 25 yrs
- Lead MD Sundridge
- Joined MAOHT: I needed HELP

MAOHT: Resources

- SCOPE
- Best Care
- Recruiter
- Website
- Primary Care Network

Muskoka Area SCOPE Services:



Accessing SCOPE is easy:

Send a referral through Ocean eReferral Platform.
Search for “Muskoka and Area OHT – SCOPE Nurse Navigator” or “Muskoka and Area OHT – Mental Health”

or

Call 416-603-6418; Select option 6 for Muskoka

86 Primary Care Providers registered to MAOHT SCOPE.

Case 1 - Mr. D

- 76 yo male with intermittent cognitive challenges
- English is not his first language
- Cochlear implant 1 ear, hearing aid in the other ear
- Significant stress due to legal issues
- Lawyer trying to prepare him for legal conference and patient cannot focus and cannot answer questions
- Patient and wife request cognitive assessment, testing, imaging

Case 1 - Mr. D

- I contacted SCOPE Nurse Navigator Catherine Hansen to request options for cognitive testing in the patient's language of origin and for a patient with reduced hearing
- No options for cognitive testing in language of origin, however options for cognitive testing for reduced hearing provided at Sunnybrook and through North East Specialized Geriatric Clinic
- Patient and spouse requested MRI head

Case 1 - Mr. D

- I contacted SCOPE for assistance in arranging MRI head for patient with cochlear implant - Sunnybook does this
- Patient was told 1+ year wait - I contacted SCOPE for other options
- SCOPE Nurse Navigator contacted Sunnybook colleague to request sooner testing, which was completed
- Artifact from cochlear implant was significant

Case 2 - Ms. C

- 56 yo woman with chronic depression
- She was seen by CAMH Psychiatrist for ADHD assessment
- ADHD confirmed however this patient has CAD so ADHD medications were not an option
- Psychiatrist suggested to change to different SSRI more compatible with ADHD diagnosis
- 6 months later, patients moods significantly lowered, ++suicidal ideation

Case 2 - Ms. C

- Urgent referral to Nicole Brumpton, SCOPE MSW, for MH therapy
- Patient was already involved in CBT Bibliotherapy via Ontario Structured Psychotherapy (OSP)
- Nicole has been able to liaise with OSP to ensure no duplication of services
- Nicole offered referral to SCOPE Psychiatrist

Case 2 - Ms. C

- We transitioned patient back to her previous SSRI and she has stabilized
- She is receiving therapy every 2 weeks with Nicole which she has found very helpful

SCOPE - There is No Issue Off Limits

LONG COVID support
Expedite diabetic foot referral
Chronic fatigue syndrome
Plastic surgeon for breast reduction
Psychiatrist
Urogynecology
Hematology
MSK U/S
Orthopedic surgeon
Fibromyalgia self-care resources
Rheumatology
Trauma counseling
Update virtual foot care
Denture financial support
Support for social isolation
Endocrinology for Trans health
Sensory pain management
MRI prostate

Pain and Sensory support
Access to psychiatry in Simcoe
CBT mental health counseling

Pain specialist in Barrie
Wound care in Whitby
Transgender health
CBT and Addiction
Perinatal Loss supports
Funded physio

Hand surgeon
Autism assessment
Gastroenterology
OCEAN support
ADHD youth mental health
Mental health
Joint injection
Neuro ophthalmology
Gynecology

Requires HCC for infusion
Navigation for CBT
Navigation for DBT
Social and Mental health supports

F/U Neurology
HIV treatment in Kapuskasing
Urogyne
OB in Barrie
ENT
Grief support for teen
Trigeminal Nerve specialist
Respirology
Rheumatology
Plastics for Dupuytrens
Sleep clinic in GTA
Urology
Urgent transport to Humber Hospital for vascular surgery

Domestic violence support
Mental health safety
ENT specialized in PVFMD
CBT and DBT mental health counseling
Access to Mental health
Psychotherapy
Endocrinology
Mental health and social support
Semi Urgent PTSD counselling
Neurology
RD for picky eater
Pain clinic
Lymph node transplant
Ostomy care

Case 3 - Mr. A

- 81 yo male fit in urgently for chest tightness and increasing SOBOE for 2-3 months
- Phx CABG x4 (2000), NSTEMI (Sept 2016), Stents (2016, 2017), A fib, CHF, HTN, CKD, DMT2, LV embolus July 2020
- Echo June 2024 LVEF 40%
- Meds: Empagliflozin 25 mg od, Apixaban 5 mg bid, Rosuvastatin 40 mg od, Telmisartan 80 mg od, Furosemide 20 mg od prn, Metformin 500 mg od, Bisoprolol 2.5mg od

Case 3 - Mr. A

- OE: BP: 146/75, HR: 53, HR as low as 40 at home, chest clear, hs normal, no SOA
- Added amlodipine 2.5mg od, BW, ECG and CXR ordered
- Urgent re-consult requested with his cardiologist
- BW ok, ECG ok, CXR showed pneumonia - doxycycline added
- 1 week later, CP improved but SOBOE ongoing
- I consulted with Best Care team and they suggested adding MRA for CHF

Case 3 - Mr. A

Best Care: Heart Failure Program – Initial visit HFrEF

Initiate and continues with medications as prescribed by Dr. MacKinnon

- ARNI/ACEi/ARB: consider initiation of Sacubitril/Valsartan 24/26mg BID after review of lab work completed today and discontinue Telmisartan
- Beta-blocker: Bisoprolol 2.5mg daily - Not at target, heart rate 62 bpm today, patient reports lower HR at home at rest, patient advised to bring blood pressure and HR to next appointment

Case 3 - Mr. A

Initiate and continues with medications as prescribed by Dr. MacKinnon (cont'd)

- Mineralocorticoid receptor: Spironolactone 12.5mg daily - started 1 week ago, bloodwork to be completed today
- SGLT2 Inhibitor: Empagliflozin 25mg daily - at target dose DM
- Sinus Node Inhibitor: None - HR 62 in office today
- Diuretic: None - advised to start action plan today, 3+ pitting edema legs

Case 3 - Mr. A

- Other relevant cardiac medications: Rosuvastatin 40mg daily, Apixaban 5mg BID, Amlodipine 2.5mg daily
- Investigations/Referrals/Recommendations today:
  - Recommend blood work today, Spironolactone initiated 1 week ago
  - Prevnar 20 vaccination given today
- YELLOW ZONE for HF: Start Furosemide 20 mg daily for 2 - 3 days for increase in edema. Occasionally weigh themselves agrees to start daily dry weights, tracker provided.

Case 3 - Mr. A

- Respiratory: Will perform spirometry in office at a future visit
- Exercise / Activity: Currently limited by shortness of breath started approximately started 6 months ago
- Nutrition/Fluid status: Reviewed the importance of low sodium diet and maintaining less than 2 litres of fluid daily. Currently consuming 2L soup daily.
- Follow up booked with Best Care HF Program in 2 months.

Case 3 - Mr. A

- Patient has added MRA, daily weight, furosemide sliding scale based on Best Care plan and is feeling much better
- We added entresto at the last appointment
- Cardiology urgent consultation scheduled for mid January 2025

Muskoka
& Area
ONTARIO
HEALTH TEAM