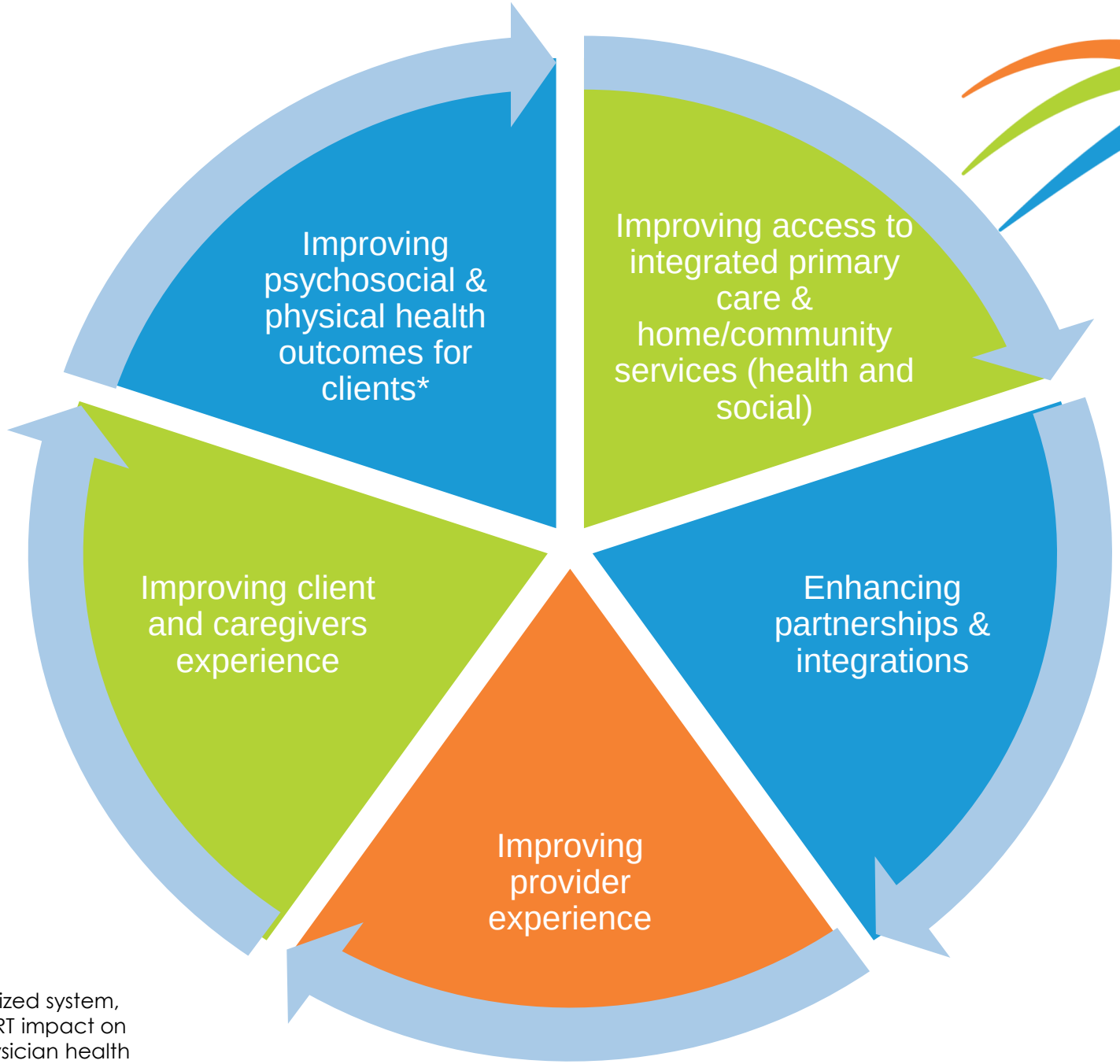
East Toronto
Health Partners

Primary and Community Care Response Teams (PCCRT)

Q3 Operational Report
(Oct 1, 2021 - Dec 31, 2021)
Prepared by Lori Sutton

Focus of Work
2021/22

Supporting System-Level Infrastructure, Accountability & Reporting



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*Given PCCRT's current anonymized system, we are unable to measure PCCRT impact on improving psychosocial and physician health outcomes for clients at this time

Link to 2021/22 PCCRT Work Plan

Improving Access to Integrated Care - Part 1

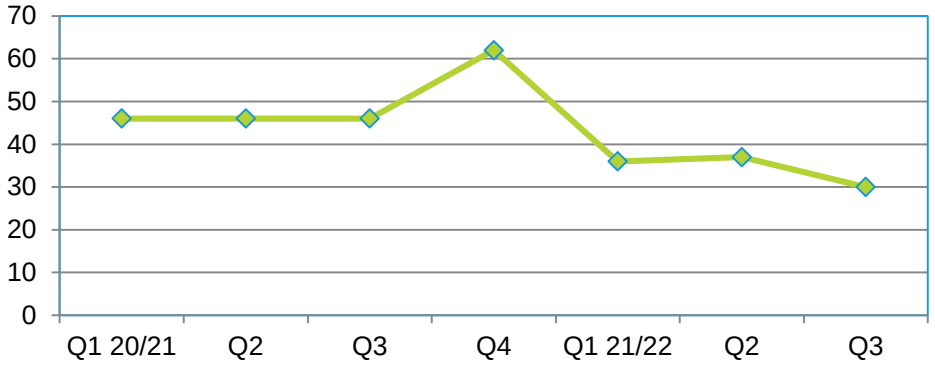
30 Referrals Submitted in Q3 (YTD=103)

97% (29*) resulted in a care plan

Reason referral cancelled: needs already met [1]

Referral Pattern Over Time

of referrals submitted per quarter



Distribution of Referrals

% (#) of completed referral to each PCCRT*

PCCRT	Q1	Q2	Q3	Q4	YTD
All	30	34	**29**	---	**93**
#1	25%(9)	11%(4)	**9%(2)**	---	**16%(15)**
#2	14%(5)	32%(12)	**17%(4)**	---	**23%(21)**
#3	22%(8)	30%(11)	**26%(6)**	---	**27%(25)**
#4	39%(14)	27%(10)	**48%(11)**	---	**38%(35)**

Who is Being Referred

%(#) of completed referrals by client demographic profile

Category	Demographic	Q1	Q2	Q3	Q4	YTD
Total completed referrals		30	34	29	---	93
Age	**Over 65**	81%(24)	73%(27)	**74%(17)**	---	**73%(68)**
	Over 85	18%(5)	14%(5)	**24%(7)**	---	**18%(17)**
Gender	**Female**	69%(21)	57%(21)	**66%(19)**	---	**66%(61)**
	Male	31%(9)	43%(16)	**31%(9)**	---	**37%(34)**
	Non-binary	---	---	**3%(1)**	---	**1%(1)**
Living Situation	**Lives alone**	58%(17)	59%(22)	**31%(9)**	---	**52%(48)**
Caregiver	**Has support** Of those, lives with client Of those, is a family member	61%(18) 68%(12) 100%(18)	30%(11) 82%(9) 82%(9)	**52%(15)** **87%(13)** **93%(14)**	---	**47%(44)** **77%(34)** **93%(41)**
Primary Care Attachment	**Has primary care provider (PCP)** Of those, PCP does home visits Of those, PCP is retiring soon	72%(22) 27%(6) 15%(3)	41%(15) 7%(1) 0%	**55%(16)** **19%(3)** **0%**	---	**57%(53)** **19%(10)** **<1%(3)**

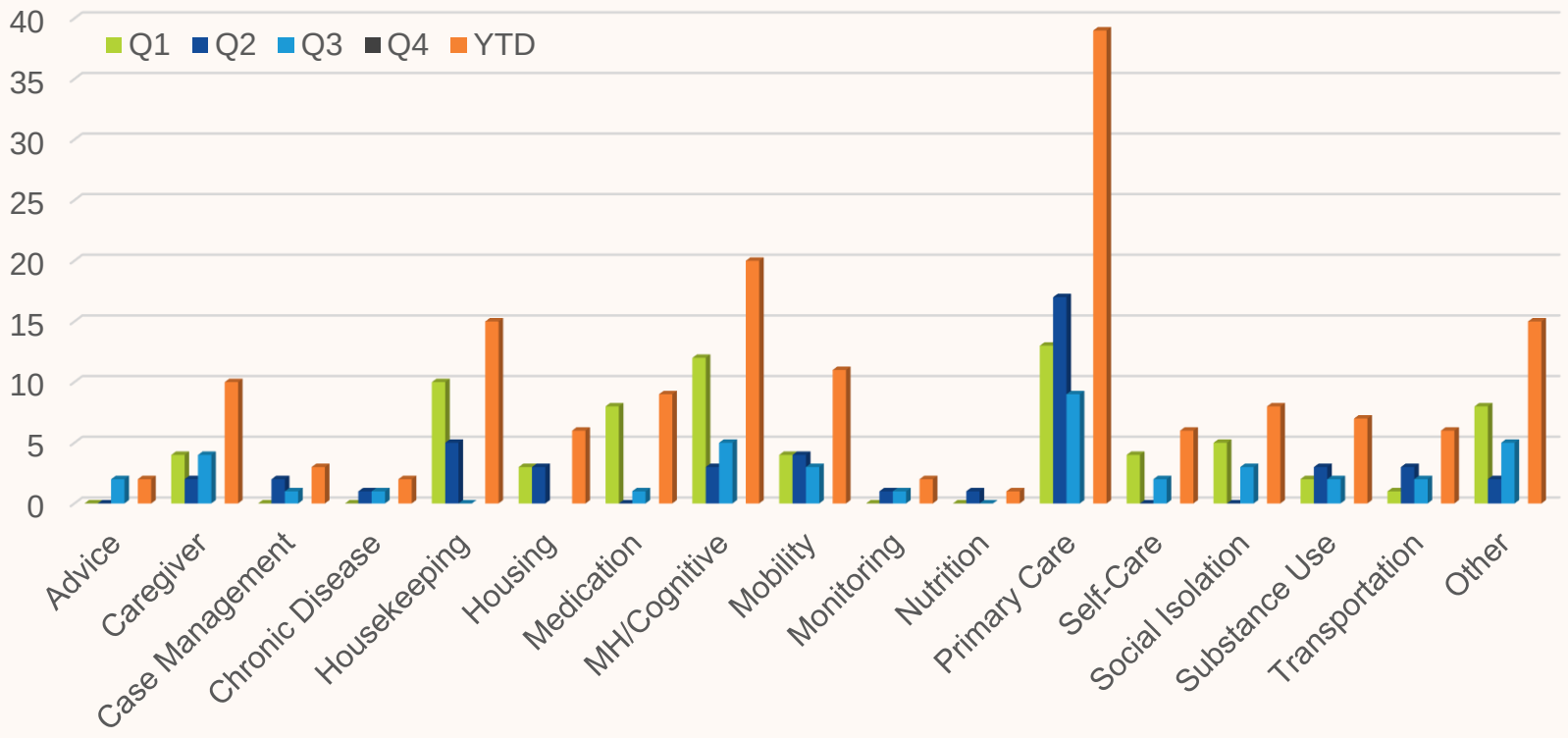
*See Glossary / Data Source: PCCRT Referral & Care Plan Data

Improving Access to Integrated Care - Part 2

41 Supports/Service Connections Resulting from PCCRT (YTD=167)

Types of Supports/Service Connections

of connections by type of support



Other includes: equipment(2), financial(2), foot care(1), legal(1), pain(2), pets(2), shopping(1), wounds(1)

Unique Care Plans Worked On

Care Plan Description	Q1	Q2	Q3	Q4	YTD
Total	70	49	**47**	---	**166**
Newly Created	35	28	**26**	---	**89**
Open (at end of quarter)	21	16	**23**	---	---
Closed (at end of quarter)	49	33	**24**	---	---

Care Planning Discussions

Description	Q1	Q2	Q3	Q4	YTD
Total Discussions	145	99	**103**	---	**347**
Initial	35	28	**26**	---	**89**
Follow-up	110	71	**77**	---	**258**
Range	1-4	1-5	**1-8**	---	**1-8**
Average	2.0	2.0	**2.2**	---	**2.1**
Geriatric Consultation	8	7	**0**	---	**15**

*See Glossary / Data Source: PCCRT Referral & Care Plan Data

Enhancing Partnerships and Integrations

98 Organizations/Groups Engaged/Reengaged This Quarter Through Outreach Activities[1]
New – ETHP* Community Advisory Council (CAC), ETHP* Engaged Partners, Toronto Paramedics, Toronto Police Services, and multiple housing organizations

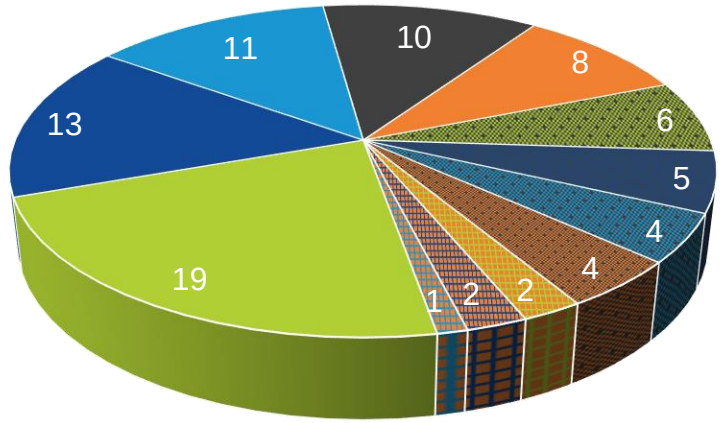
465 PCCRT* Web Page Views[4] (data re: unique views not available)
3 minutes and 13 seconds - average time spent on page

23 Unique Partner Organizations Involved[2]
84 Unique Members

18 Unique Organizations Referring[3]
12 unique organizations referred this quarter - 2 new (Habitat Services, Youth Link)
23 unique individuals referred

Membership within PCCRT Roles[2]

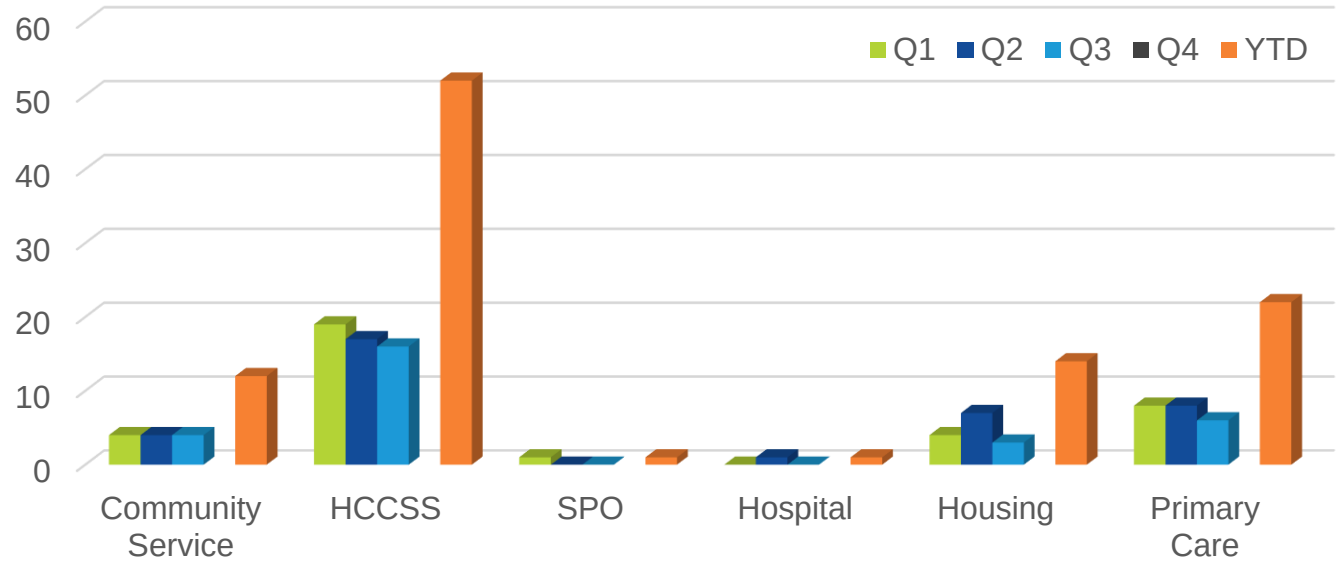
# of unique members in each PCCRT role



**10 MDs, 4 NPs, 1 RN, 4 administrators

Sectors Referring[3]

# of total referrals by sector/referral source category



18 Unique Referring Organizations / 12 this quarter (# completed referrals submitted): Bridgepoint FHT*, **EECHC*(2), FHC*(1), Fred Victor(1), Habitat Services(1-new), HATP*(1), HCCSS*(16),** HOTT*, **Mainstay*(1),** SETFHT*, **SRCHC(2)*,** TCHC*, **TNG*(1), TNO*(1),** UHN*, VHA, **Woodgreen(1), Youth Link(1- new)**

*See Glossary / Data Sources: [1]PCCRT Communication Plan, [2]PCCRT Contact List/Resource Toolkit, [3]PCCRT Referral & Care Plan Data, [4]ETHP Communications

Improving Client/Caregiver Experience

Community Involvement in PCCRT					
Type of involvement	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**
# Client/caregivers participating in PCCRT rounds[3]	0	0	**1**	---	**1**
# of Community members on PCCRT planning groups[5] Target=6 (2 on Steering Committee, 2 on Engagement & Outreach Work Group, 2 on Operational Processes & Tools Work Group)	1	5	**6**	---	**n/a**

- Including client experience question on PCCRT member/guest survey to collect third person reports of client experience/impact

Improving Provider Experience

- Finalizing annual PCCRT member/guest survey
- Creating analytical framework for annual PCCRT member/guest survey
- Planning education session focused on geriatric psychiatry

*See Glossary / Data Sources: [3]PCCRT Referral & Care Plan Data, [5]PCCRT Planning Group Membership

Supporting System Level Infrastructure, Accountability & Reporting

- Exploration, testing and implementation of long-term digital solutions to support integrated care continued
  - Phase 1 of Ocean integration
- Revision/improvement of evaluation/reporting tools & processes continued
  - Reporting templates, PCCRT data extraction/analysis tool and provider survey finalization
- OHT reporting – see Jan 2022 ETHP Report
- Planning started for 2022/23 (including sustainability planning)

System Level Barriers Identified Through PCCRT Care Planning

1. Extreme clean was unable to clean client's apartment because of soiled mattress blocking way
2. Challenge faced assisting clients with bed bug issues before and after spraying due to a higher number of referrals during the summer months
3. Client's model of primary care did meet their needs (i.e. MD didn't do home visits so client used Med-Visits that didn't have the required continuity of care)
4. Client, who was not well attached to primary care, was discharged by case manager without other care team members being aware. Had another provider not stayed peripherally connected to the client they would have slipped through the cracks and ended up evicted or in hospital

*See Glossary / Data Source: PCCRT Referral & Care Plan Data

Key Highlights from 2021/22 Q3

PCC Response Teams

Reporting

- Jan 2022 report submitted to ETHP

Operations

- Relatively stable referral volumes over last 3 quarters
- OCEAN eReferral phase 1 in process
- First experience with client/caregiver attending rounds
- New model of geriatric psychiatry consultations being developed (to be launched in Q4)

Engagement

- Onboarding tools & processes being finalized
- 2022 PCCRT member/guest survey and analytical framework being developed for use in Q4
- Partnerships being developed within new sectors (e.g. Police, EMS)

Key Project Links: Website, Project Charter, Governance Structure, Evaluation Plan, Work Plan, Glossary

East Toronto Health Partners

Additional data and program information can be obtained by contacting Lori Sutton, Project Facilitator, Integrated Primary and Community Care, South Riverdale Community Health Centre, lsutton@srchc.com