Health Quality Transformation 2013
Qualité de la santé

Session 11: Learning from Success: Health System Collaboration and the Integration of Care

Moderator: Dr. Ross Baker

Presenter Disclosure

- **Session Name:** Learning from Success: Health System Collaboration and the Integration of Care
- **Presenters**: Dr. Ross Baker (moderator), Cathy Szabo, Marilyn ElBestawi, Karyn Lunsden, Katherine Campbell, Amir Afkham, Dr. Pauline Pariser

- **Relationships with commercial interests:**
  - Not Applicable

Disclosure of Commercial Support

- This session has received no commercial support

Mitigating Potential Bias

- Not applicable

Session Objectives

1. Discover how health system providers and leaders across Ontario have transferred knowledge into practice and learn of innovations and initiatives that have successfully transformed health care delivery
2. Engage in stimulating discussions and obtain ideas and information that may be implemented in any sector of the health system

Central CCAC Community Care Access Centre
Centre d'accès aux soins communautaires du Centre

A Collaborative Model for Medication Management for High Risk Care Transitions in the Community

Cathy Szabo
Chief Executive Officer

In the patient's shoes

- Discharged, happy to be home, but exhausted
- Overwhelming medication to-do list
- 70% of patients do not adhere to their discharge medication orders, often leading to unnecessary pain and hospital visits or readmissions
- On average, one-two medication discrepancies identified per discharged patient in the high risk group
- MMSS was an opportunity to design a service around patient need
- Acknowledges and values important role of caregivers
- Provides education and resources to improve quality of life and enhance patients' ability to self-manage

Meeting the challenge of increasingly complex care needs

- Growing demand for Central CCAC services
- Increasing complexity of care needs
  - 16% of the total high needs patients provincially
  - 69% of our patients have very high or high needs, compared to just 56% two years ago
- 58% of our patients come directly from hospitals, compared to 52% just four years ago
- Medication issues remain one of the biggest challenges and opportunities in community care

Central CCAC's Medication Management Support Services (MMSS)

- One of Canada's first community medication programs
- Accreditation Canada-designated Leading Practice
- 2013 Canadian Innovative Best Practice Award Winner
- Pharmacist-led home visit model improves communication, medication coordination and follow-up by inter-professional team
- Provides better quality care to patients through
  - Safety *(reduced falls)*
  - Science *(improved pain management)*
  - Service *(in-home pharmacy visits)*
- Supports patient flow from hospital to community

Patients tell us they simply feel better

"I have a better chance of living longer, being healthier and enjoying my life if I am on top of my medications. Central CCAC's MMSS helps me to do exactly that."

- 1,679 patients received MMSS in 2012-2013
- Of 569 patients/caregivers surveyed:
  - 67% reported a decrease in ED visits
  - 62% reported a decrease in falls
  - 55% reported a decrease in pain
  - 97% rated ability to self-manage as good/excellent
  - 99% rated MMSS as good/excellent
- RAI-HC data shows improved falls/CHESS scores

Building on the success of MMSS

- Supporting patients returning home from hospital who are at risk for falls, ED visits and hospital readmissions due to medication-related issues
  - MMSS pharmacists (2009–2013)
- Helping other complex patients with medication management needs through MMSS database
  - Rapid Response Nurses (2013)
  - Palliative Nurse Practitioners (2013)
  - Contracted Vendors (2013)
- Re-investing in technology to help more patients
  - 2012 ImagineNation Outcomes Challenge Award
  - Modifying the database for use by other organizations

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Development of a Novel Tool to Predict Decline for Institutionalized Elderly to Avoid Hospitalization

Marilyn R. El Bestawi RN, BSc, MSHSA, CHE, CFHI EXTRA Fellow

Canadian Foundation for Healthcare Improvement EXTRA
Fondation canadienne pour l'amélioration des services de santé FORCES

UHN Toronto General Toronto Western Princess Margaret Toronto Rehab
COURAGE LIVES HERE

Background

In Ontario

- 76,000 people reside in LTC facilities
- In 2005 – 25% of LTC residents visited an ED at least once, 25 % of those visits were classified as preventable

At UHN

- Increasing numbers of Long Term Care residents being sent to ED
    - Many suffering iatrogenic complications as a result (pressure ulcers, dehydration, deconditioning, delirium)
- Average length of stay of those admitted (71%) = 6 days

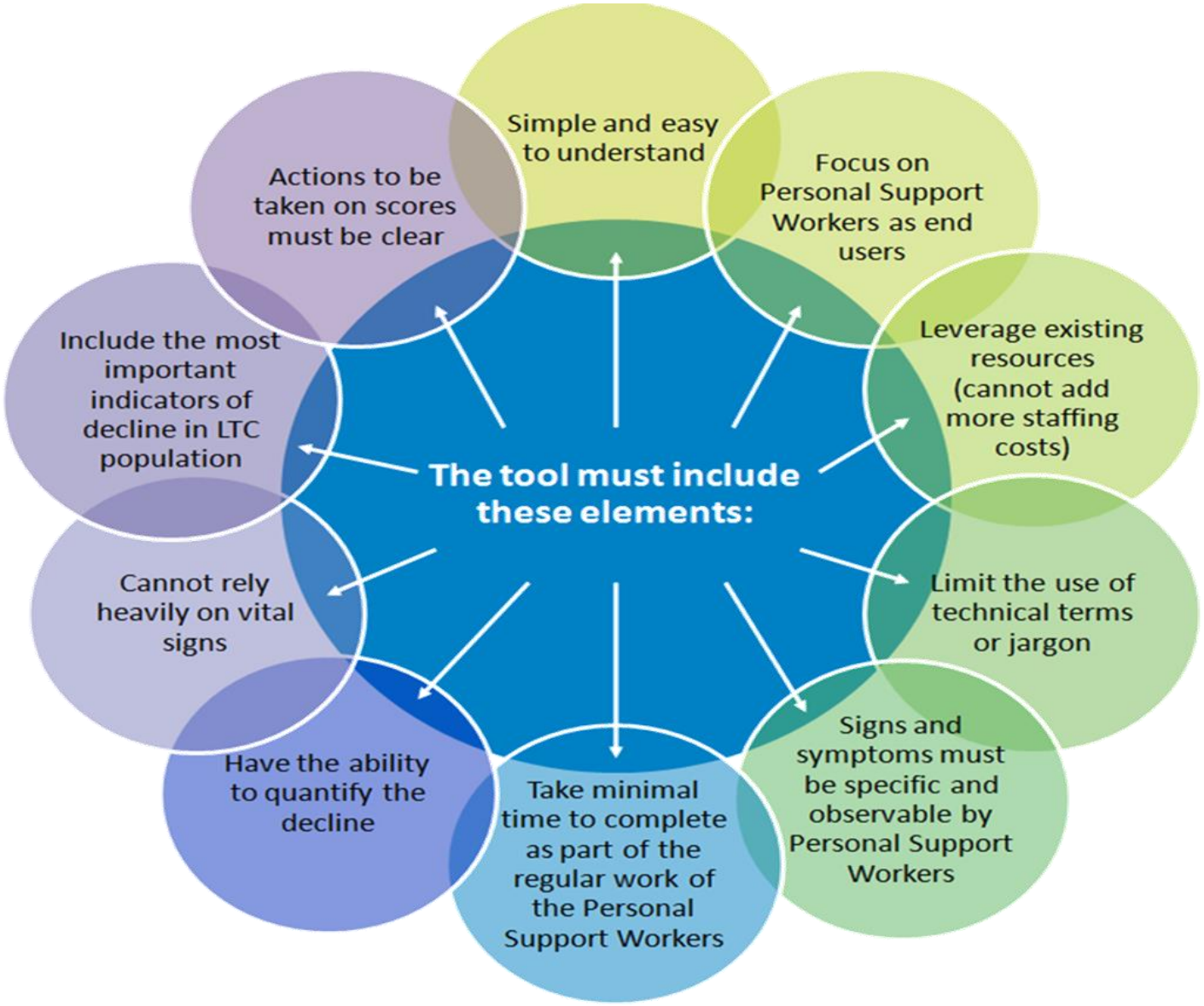
Objectives

- Identify, implement, and evaluate/measure, a system/method to identify early decline in health status of LTC residents by January 2013.

- Reduce/eliminate transfers to ED/Hospital for preventable (ambulatory care sensitive) conditions in LTC residents at Lakeside LTC facility by 25%.

Solution

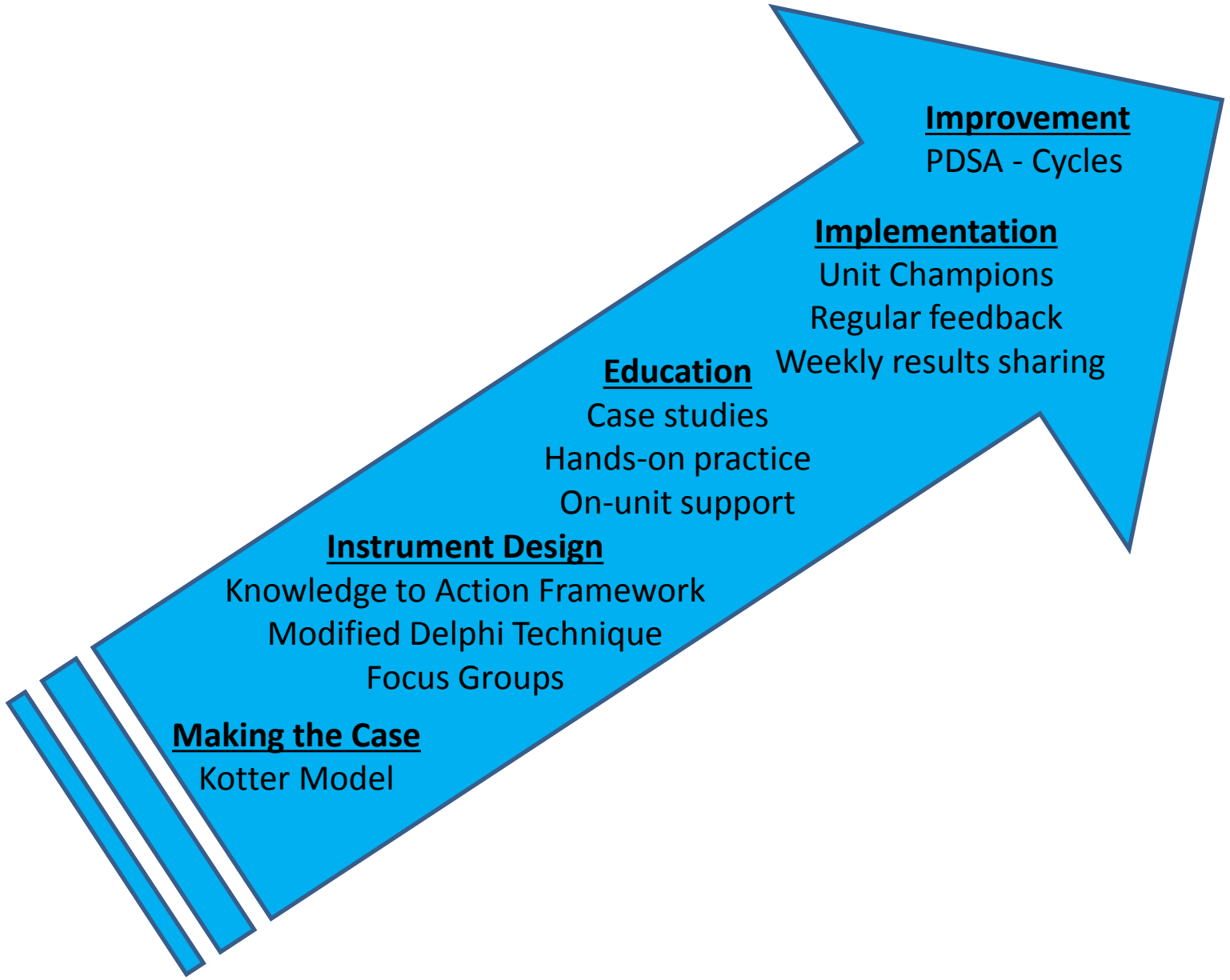
Development of an elder specific tool to predict decline in LTC residents.



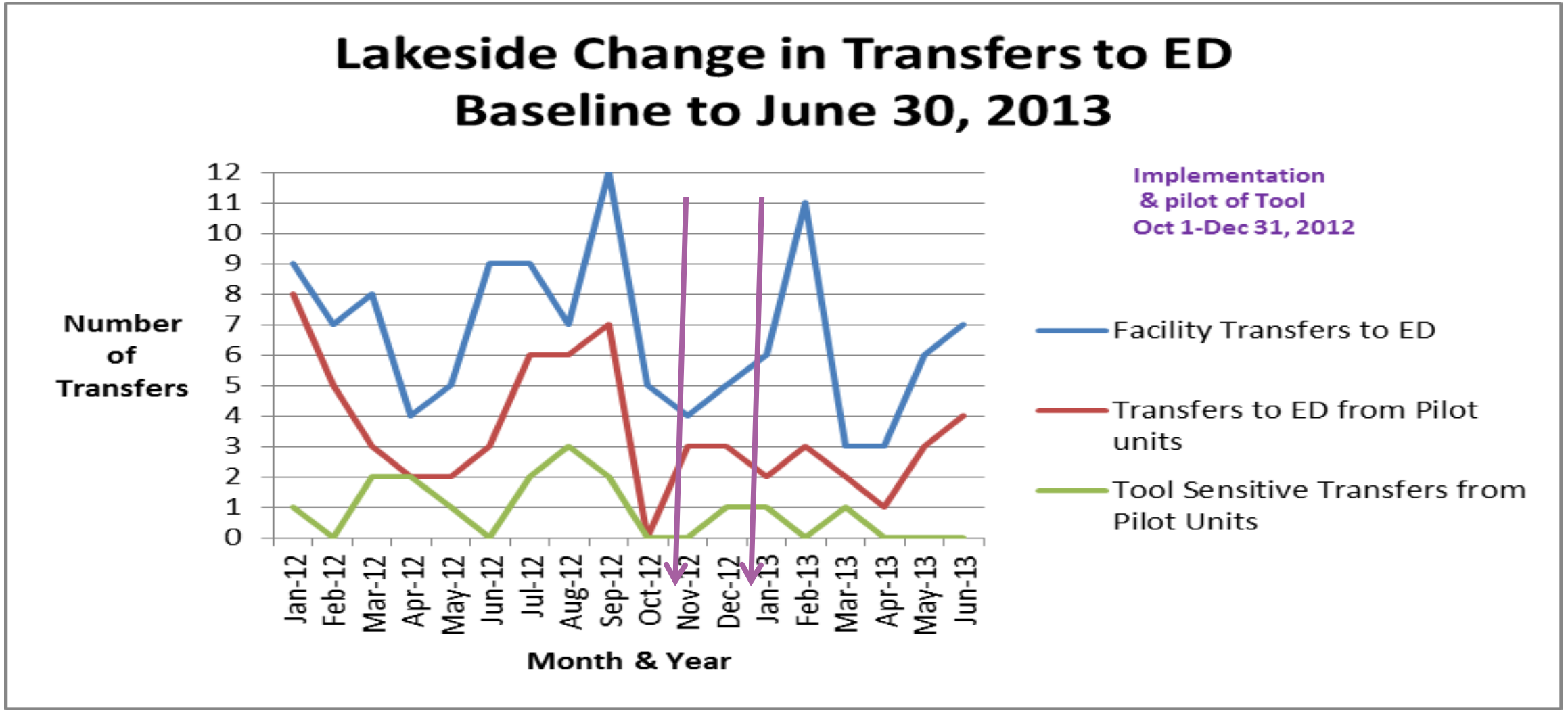
Key Measures

- Baseline and change in transfer rate
- Frequency of residents triggering the tool
- Frequency of completion of the tool by PSWs
- Time required for PSWs to complete the tool

Change Concepts and Tools Utilized



Results


Lakeside Change in Transfers to ED
Baseline to June 30, 2013
Number of Transfers
12
11
10
9
8
7
6
5
4
3
2
1
0
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Month & Year
Implementation & pilot of Tool Oct 1-Dec 31, 2012
Facility Transfers to ED
Transfers to ED from Pilot units
Tool Sensitive Transfers from Pilot Units

Potential for Spread

Applicability to:

- Other populations e.g.,
  - Home Care, Rehab, Complex Continuing Care, Residential Care

- Other jurisdictions, locally, nationally, internationally
- Potential standard tool for LTC - scalable

Lessons Learned

- A larger study would be beneficial
- LTC facilities are challenged to engage in additional quality initiatives beyond compliance requirements
- Physician involvement is key, but limited due to compensation challenges
- PSW's felt their work was being valued
- Tool assists communication for staff who speak English as a second language

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The Central West CCAC Home Independence Program: Successfully Optimizing the Wellbeing of Seniors in their Home through Inter-professional Restorative Care

Karyn Lumsden, Vice President, Client Services
Central West CCAC

Home Independence Program
A Restorative Approach

A philosophical shift in the delivery of home based services from a predominantly "maintenance and support" focus to a "restorative" care approach with an emphasis on wellness and capacity building for all patients.

Restorative Approach Goals

- Maximize functional independence, choice and quality of life
- Adopt a wellness, capacity-building restorative approach to care
- Emphasize a holistic, person-centred approach to care, which promotes patients' active participation in decisions about care
- Reduce or delay the need for ongoing support

Home Independence Program: Inter-professional Team

Critical for Success:

- Reorganization of home care staff from individual care providers into an integrated, coordinated, interdisciplinary team with shared goals.
- Regular team meetings to review service users' progress and adjust goals.
- Specific training for all team members on goal setting and rehabilitation techniques.
- Reorientation of the focus from primarily treating diseases and "taking care of" patients toward working together to maximize function and independence.
- Provide extra time for aides to work with clients – "doing with" takes longer than "doing for". The most important role is the optimized Personal Support Worker.

Home Independence Program Protocols

- The Program is designed to support Personal Support Workers (PSWs) in providing the care and interventions under the guidance of the rehabilitation professional.
- Standardized protocols developed include:
  - Exercise Protocols
  - Falls Prevention
  - Dressing and Grooming
  - Bathing
- Interventions and education focus, as needed, on skin integrity, falls prevention, medication management and nutrition
  - Nursing is included in care plan when necessary

Client Demographics

- n= 180
- 64% Female
- Average age 79 yrs. 90th percentile 89 yrs.
- Average utilization
  - 10 hrs. PSW
  - 3 visits PT
  - 3 visits OT
- Initial Assessment (RAI)
  - 12% low acuity
  - 43% moderate acuity
  - 40% high acuity
  - 5% very high acuity

Patient Outcomes

- 56% discharged within targeted 60 days
- 82% discharged within 90 days
- Admit mean TUG score 27.7 seconds
- Discharge mean TUG score 18.5 seconds
  - Statistically significant improvement
  - ≤20 seconds = good mobility
- 47% of Home Independence Program patients reported fall within 2 months prior to program participation
- 6% of Home Independence Program patients reported fall within 2 months after program participation
- Narrative comments on surveys indicated satisfaction with the program
- 71% of clients were discharged with goals met
- 14% of clients were discharged with goals not met

Patient Outcomes

- 15% were still active on services
- Patients readmitted after discharge from the program(out of 180):
  - 0-30 days – 6
  - 30-60 days – 5
  - 60-90 days – 4
  - 90+ days – 8
    - Total 23
- Upon admission, 40% of patients identified their health as good or excellent. None identified as very good.
  - Upon discharge, 78% of patients identified their health as good, very good or excellent
- Upon admission, 20% of patients identified their health as poor
  - Upon discharge, 0% of patients identified their health as poor

Patient Follow-Up Survey

- Feels stress concerning health conditions – 24%
- Believes will remain independent because of the Home Independence Program – 82%
- I have been able to be dependent because of the Home Independence Program – 85%
- I rely less on family & friends to deal with my health problems because of the Home Independence Program – 81%
- As a result of the program my ability to perform ADLs - 87%
- As a result of the Home Independence Program my ability to care for myself has improved – 90%
- Recommend the Home Independence program – 97%
- Satisfied with the Home Independence Program – 97%

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Reducing COPD/ CHF Hospital Readmissions

Katherine Campbell, MHS
Dryden Regional Health Centre

DRHC
Dryden Regional Health Centre
hospital and community care

Program Aim

Aim

To create a seamless transition from hospital to home for patients accessing services in the Dryden Regional Health Centre (DRHC) Emergency Department (ED) or Inpatient Unit (IU).

Specific

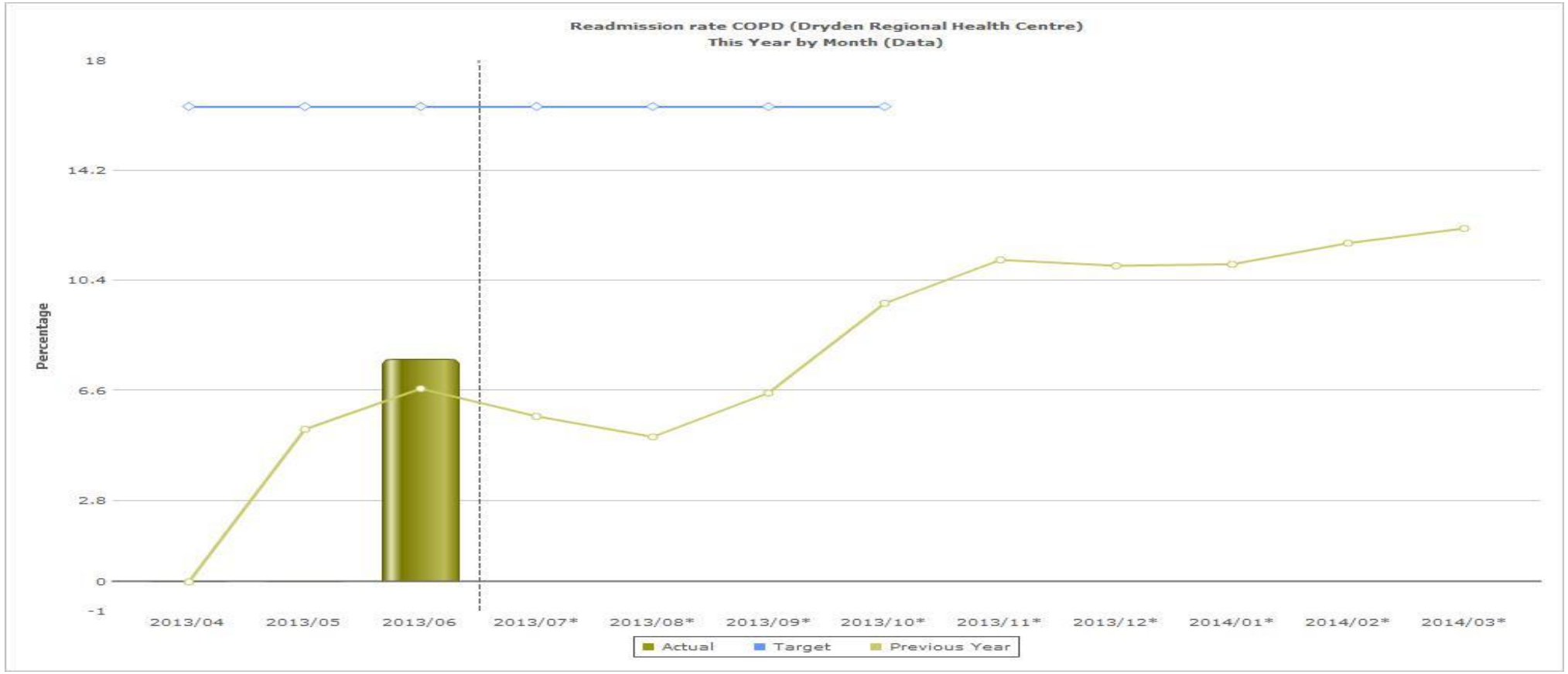
Reduce hospital readmissions for patients living in the community of Dryden with a diagnosis of COPD/CHF.

Change Idea

- Family Health Team Registered Nurses will provide a:
  - Visit to all inpatients of the DRHC that have a diagnosis of CHF or COPD.
  - Focused home visit within 48 of discharge
    - ✓Ensuring patients have the tools necessary for self management.
    - ✓Appropriate referrals to community services
  - 7 Day telephone discharge call home

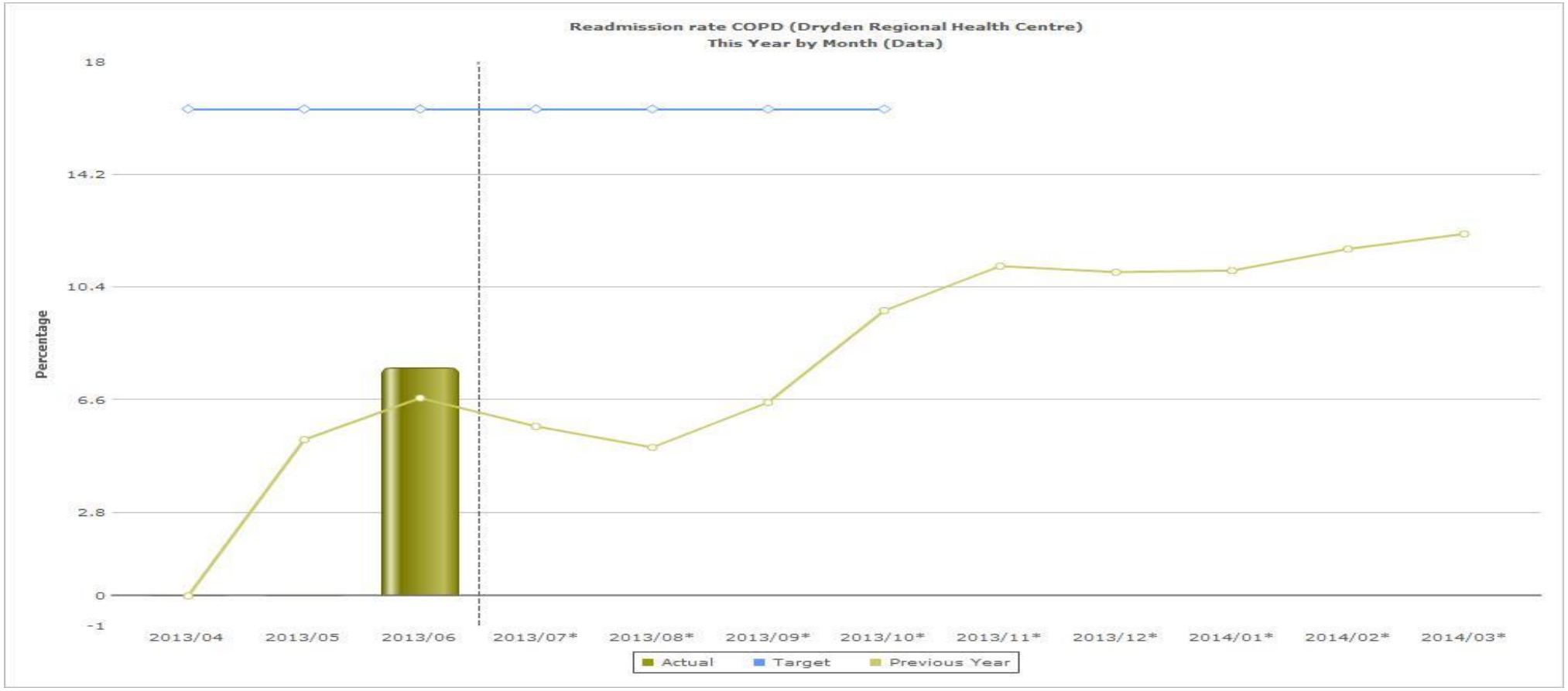
CHF: Did we make a difference on readmits?

2012-2013 fiscal year: 31% to 7.5%



COPD: Did we make a difference on readmits?

2012-2013 fiscal year: 20% to 12.2%



Process Improvements

- Identification of patients living with a diagnosis and would benefit from program
- Implemented the Canadian Respiratory Guidelines COPD action plan and the Heart and Stroke CHF patient best practice education material.
- Referral to the OTN telehome program in partnership with Thunder Bay Regional hospital.

Measurement/Feedback/Outcome

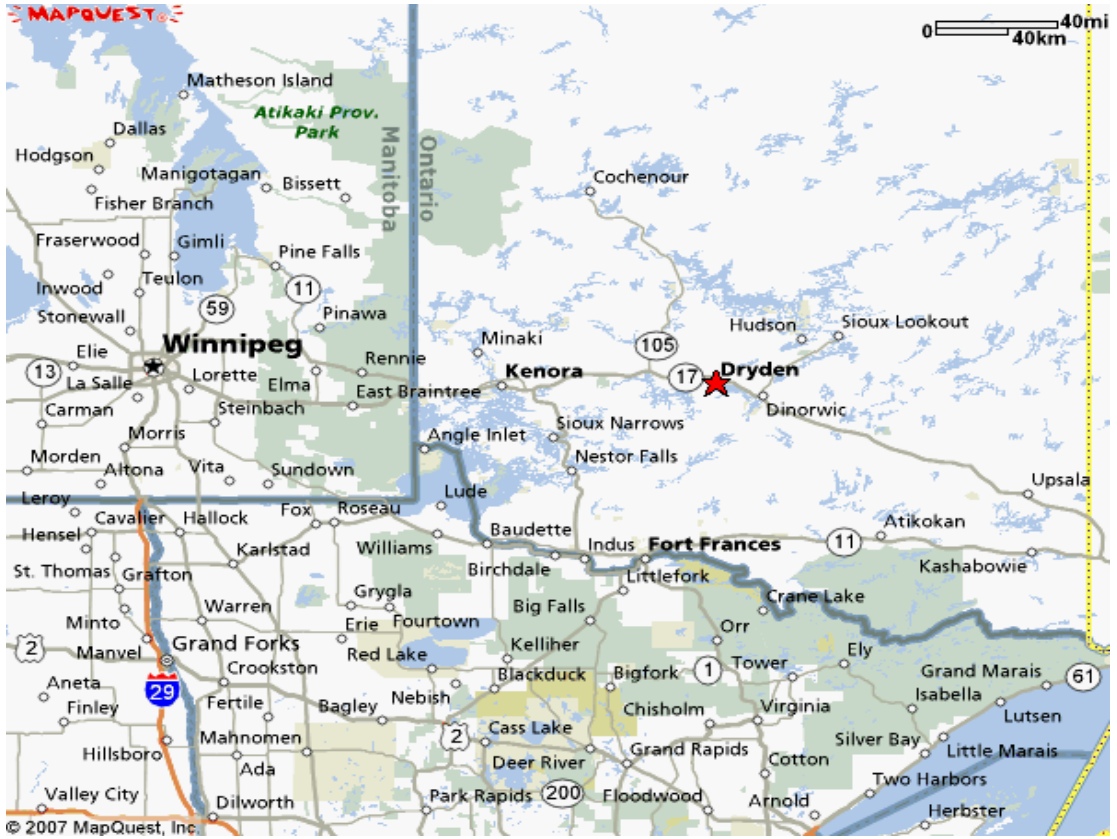
- Measurement
  - 90 % of pts seen prior to discharge with CHF or COPD
  - 83.3% of pts seen in the home- post discharge with a diagnosis of CHF or COPD.

- Patients have reported:
  - they have a better understanding of their disease to prevent their condition from becoming worse and accessing care to prevent hospitalization
  - they have a better understanding of the medications and how to properly take their medications
- The team has implemented an action plan that makes it simpler for providers to prescribe antibiotics or steroids if needed reducing ER visits.

- Expand to additional chronic diseases
- Enhancing the role of the Community Service Guide- Telephone Home Service
- Continued focus on the enhancement of community outreach services

Questions

For example: Where is Dryden? ☺



Dryden is 360km from Thunder Bay….
320km from Winnipeg.

Champlain "BASE" Project

"Building Access to Specialists through eConsultation"

Successful Implementation, Adoption, & Impact Assessment

of an

Integrated Care Delivery Process

between

Primary and Specialty Care

Amir Afkham
Senior Project Manager

Ontario
Champlain Local Health Integration Network
Réseau local d'intégration des services de santé de Champlain

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The eConsultation Team

A collaboration between:

The Ottawa Hospital (TOH)

The Bruyère Research Institute (BRI)

Winchester District Memorial Hospital (WDMH)

Champlain Local Health Integration Network (LHIN)

Funding:

TOHAMO AFP Innovation Fund

Champlain LHIN

eHealth Ontario

Overview

❖Background

- Challenges associated with traditional consultation/referral process (eg. access, delay, wait time, transportation, appropriateness, better work-up/prep, etc.)
- A Possible Solution: eConsultation (spearheaded in 2010 by Specialist Lead (Dr. Erin Keely) & Primary Care Lead (Dr. Clare Liddy), funded by TOHAMO
- Service was enhanced and began expanding in 2011, with funding support from eHealth Ontario and Champlain LHIN

❖Objectives: Assess value for clinicians/patients and impact on referrals

❖Target Indicators:

- Rate of face-to-face referrals avoided
- Specialist response intervals
- Value of service per case (rated by Primary Care Provider - PCP)
- Growth & usage trends

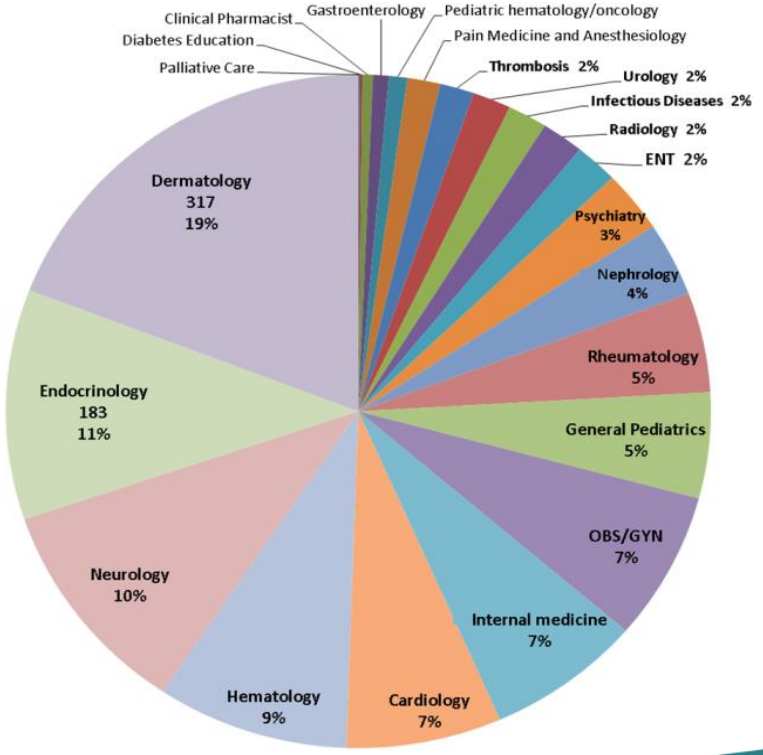
Change Concepts

- Design => Conceived and led by clinical champions (primary and specialty care), and leverage the LHIN's existing secure web-based collaboration system
  - a simple web-based form designed by the clinicians
  - an automated workflow and action notification
  - Well organized page to present all data securely to a user
- Operation => Request initiated by PCP to a "Specialty Area"
  - assigned to appropriate specialist based on rotation/availability schedule
  - Specialist reply within a week or less (reply, request more info, or suggest referral)
  - PCP can follow up with additional information, clarification, and/or question
  - PCP ultimately responds to brief survey and closes the case
- Deployment => Proof-of-concept in 2010, followed by enhanced version in 2011
  - validated approach & incorporated user feedback, ensuring:
    - ✓ Simplicity (joining, training, operation, support, specialist remuneration)
    - ✓ Responsiveness (to support needs and suggested improvements)
    - ✓ "Mandatory", but short, training/orientation

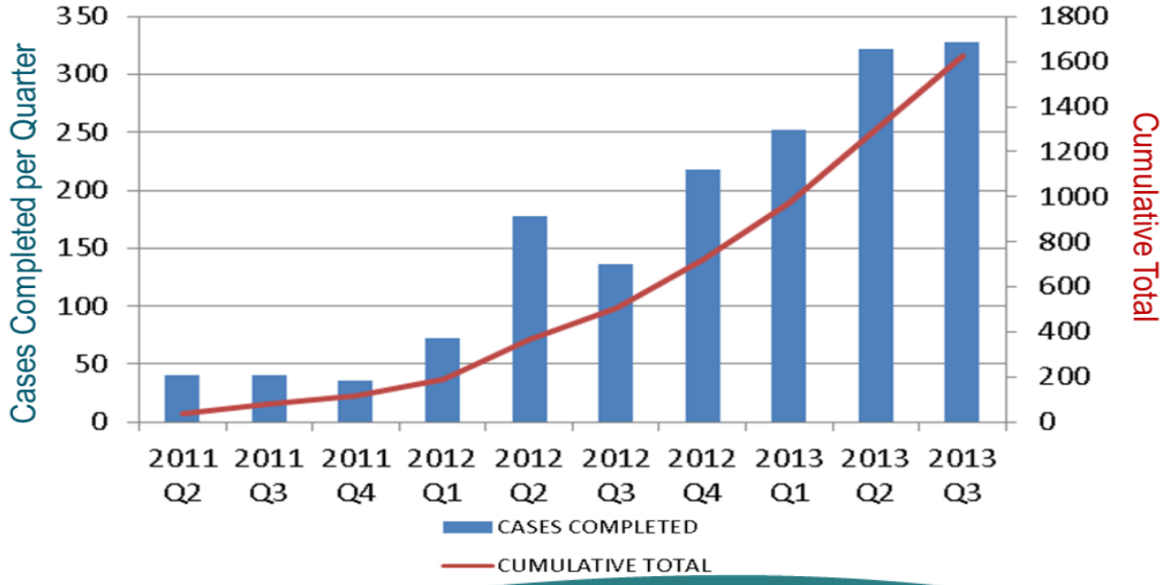
Results & Observations *(as of October 15th, 2013)*

- Expanded to 26 specialty services (based on PCP demand)
- ~ 350 PCPs registered (MDs, NPs, and delegates), 65 clinics, 30 different towns
- 1656 cases closed in Phase 2 [1736 in total]
- Specialist response interval:
  - Median: 0.7 days
  - Average: ~ 2days
  - 90th Percentile: ~ 6 days
  - Fastest response: 6 minutes! *(Neurology)*

Specialty Distribution

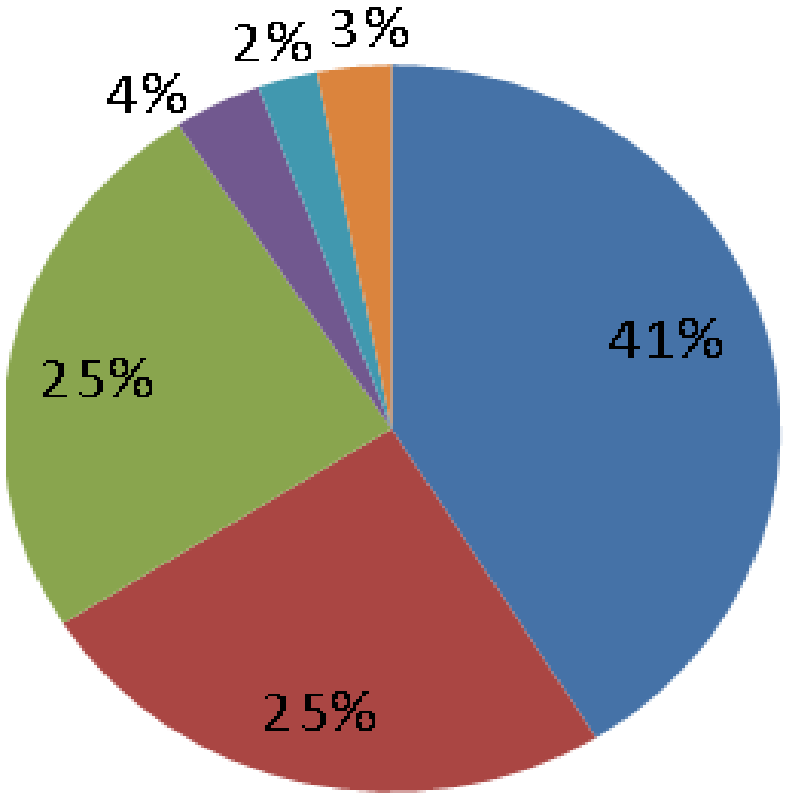


USAGE TREND



Impact of e-Consultation on Referral

[*from PCP survey responses completed for each case*]



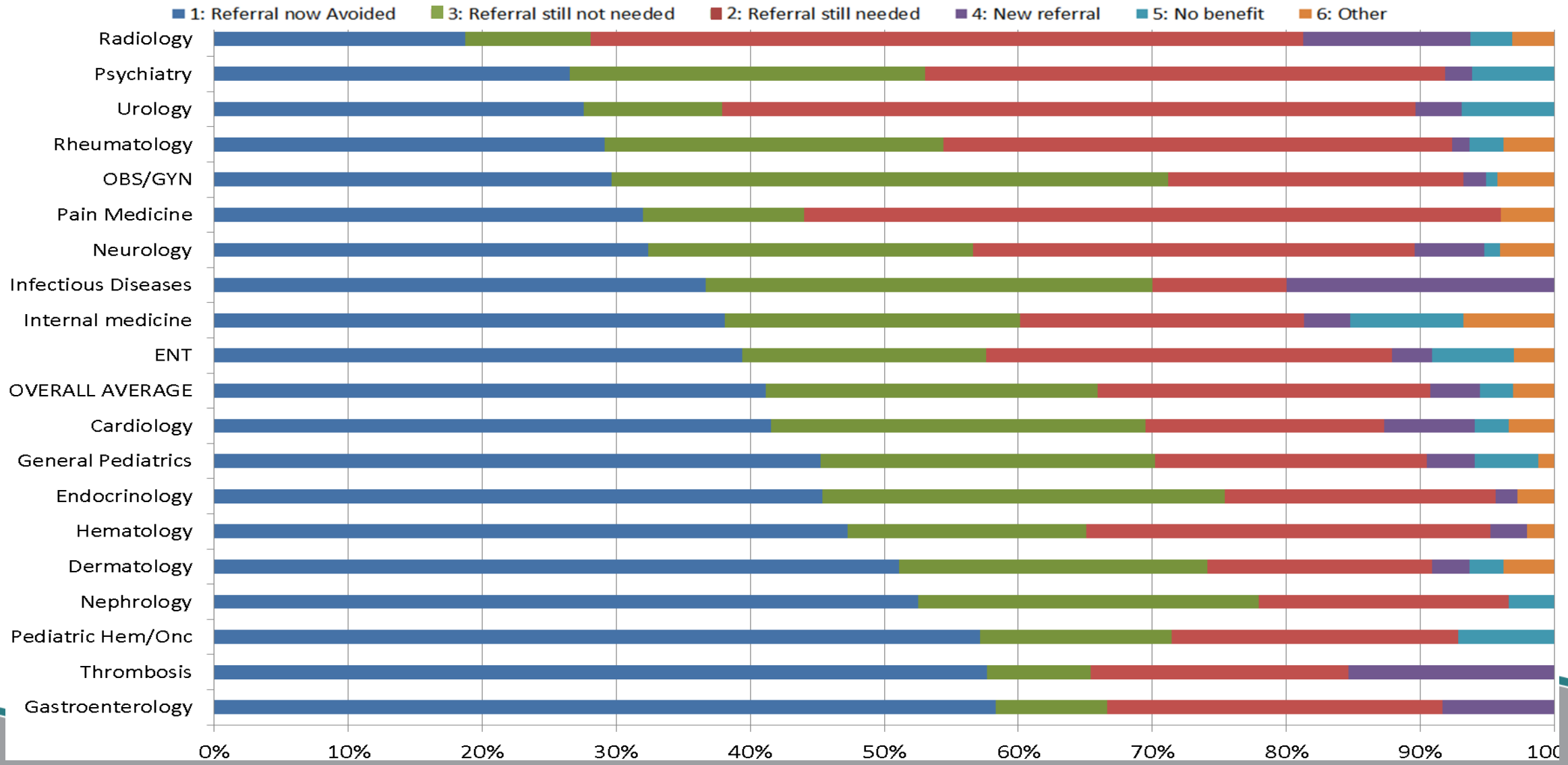
N=1656 cases

1. Referral was originally contemplated but now avoided at this stage
2. Referral was originally contemplated and is still needed - this eConsult likely leads to a more effective visit
3. Referral was not originally contemplated and is still not needed - this eConsult provided useful feedback/information
4. Referral was not originally contemplated, but eConsult process resulted in a referral being initiated
5. There was no particular benefit to using eConsult in this case
6. Other (please comment)

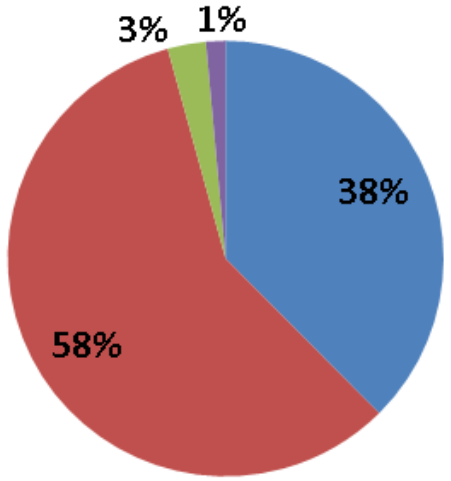
41% of cases led to a referral being avoided

Impact of e-Consultation on Referral -

Comparative Results for 10+ Cases Completed (15 October '13)



Clinical Value



- 1. I was able to confirm a course of action that I originally had in mind
- 2. I got good advice for a new or additional course of action
- 3. I did not find the response very useful
- 4. None of the above (please comment)

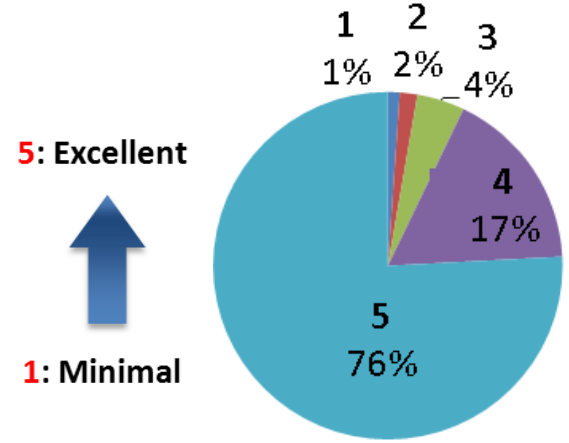
CLINICIAN:

- Direct access to specialist expertise
- Highly valued advice in a timely manner
- Good educational value – opportunity for dialogue
- Reduction in unnecessary visits and wait
- Much more effective communications
- 93% rated it as high or very high value

PATIENT:

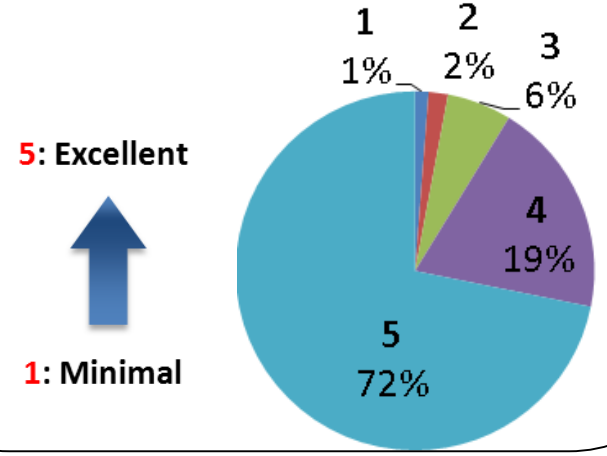
- Eliminate travel to specialist
- Dramatically reduce wait time
- Appropriate treatment starts quickly, avoids deterioration
- Reduced anxiety
- 91% as high or very high value

Overall Value of the eConsult Service



for PCP (AVG.: 4.65/5)

for PATIENT (AVG.: 4.59/5)



** from PCP survey responses completed for each case*

Opportunities

- "BASE" eConsultation service has proven extremely popular and valuable within our physician community.
- The service has demonstrated excellent results in:
  - reducing unnecessary face-to-face referrals
  - significantly shortening the interval for receiving specialist advice for delivery of appropriate care
- Key elements of success to facilitate "easy" extension/replication:
  - Physician Champions
  - Keep it simple (joining, training, operation, support, specialist remuneration)
  - Reliability & Responsiveness
  - Solution built using simple elements on commercial off-the-shelf platform

- ADDITIONAL INFO -

Sample Comments from PCPs in the Optional Survey Input Field

(Jul. 1 – Sept. 30, 2013)

Sample Comments from PCPs July 1 to Sept. 30, 2013 *(1 of 2)*

- "The ability to consult with the hematologist was amazing. Quick response and valuable knowledge provided. A true asset to providing care to my patient."
- Very helpful advice to help with ongoing FU of patient.
- Suspect part of the problem is my own lack of clarity about where to send the request for information
- "This is an excellent demonstration of value of this approach to delivering consultative services. It is also clear that Dr. [InternalMed] is quite skilled at this modality.
- The response time of hours was fantastic. Thank you.
- Thanks for reviewing the pathology, and the advice.
- “Learned of a new area of expertise - combined derm/rheum"
- “Very quick response allowed me to avoid un-necessary investigations"
- “Please extend my gratitude and appreciation to cardiologist for his speedy reply with a most thorough and applicable as well as helpful reply; please continue with e-consult services as it will save on health dollars in the long run and will assist in improvement of patient care ."
- You are awesome!
- Absolutely amazing. Response from specialist two hours after consult created. This is an incredible programme.
- "Thanks very much to the cardiologist for the clear answers and great explanations/interpretations of her symptoms and diagnostic testing! It's great learning for me (the PCP) and it saves the patient from having to go out to a specialist appointment. Thanks!"

Sample Comments from PCPs July 1 to Sept. 30, 2013 *(2 of 2)*

- "Here an adult psychiatry answered a child psych question by consulting another colleague. Ideally if we could have an econsult category dedicated for child psychiatry that would be great. There is a huge gap in pediatric mental health in the community- very limited psychiatric services. Econsult here would be a boon."
- Please extend my thanks to Dr. [Derm] for this help. There is no way anyone here would have diagnosed this! The client and I are most grateful.
- Very very useful and fast!
- This is exactly the kind of guidance that I needed.
- Clear course of action provided. Glad to have reassurance
- It's good to be told the most useful people to refer to, specifically. Thank you.
- So pleased to have access to specialist - we were all scratching our heads here.
- Very helpful. Thanks! Referral still being done is to psychiatry for diagnostic clarification, not to the pain clinic at this stage.
- Did not change management--but helpful to know no tests needed prior to assessment.
- I am so pleased to have this excellent, efficient and effective mode of specialist consultation available to primary care and to our patients.
- Fast response to a problem I had not encountered in 30 years and I did not appreciate how serious it was, very helpful

"love love love this service SO prompt"

THANK YOU!

Dr. Erin Keely
Chief, Division of Endocrinology and Metabolism, The Ottawa Hospital
ekeely@toh.on.ca

Dr. Clare Liddy
The Ottawa Hospital Academic Family Health Team, Bruyère Research Institute
cliddy@bruyere.org

Amir Afkham
Senior Project Manager, Champlain LHIN
amir.afkham@lhins.on.ca

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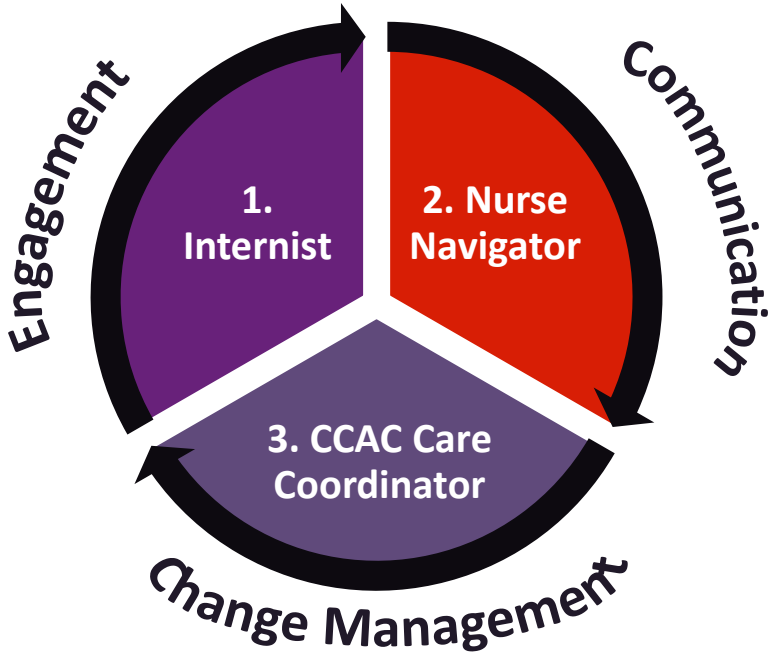
S.C.O.P.E.
Seamless Care Optimizing the Patient Experience
A Primary Care Integration Project

Pauline Pariser MD, CCFP, FCFP

SCOPE

SEAMLESS CARE
OPTIMIZING THE PATIENT EXPERIENCE



- Partnership with UHN, WCH and TCCCAC.
- Goal is to reduce avoidable ED visits and hospitalizations.
- Supports 30 primary care providers (PCPs) in caring for their complex patients.

Joint Governance Structure

UHN, WCH and CCAC

One-Number-to-Call services

1.General Internal Medicine Specialist On-Call
2.Navigation Hub Nurse Navigator
3.Navigation Hub CCAC Care Coordinator

Patient Results Online

Online access to hospital test results and discharge summaries

ED Flagging

Instantaneous notification to hub team when SCOPE patient arrives at ED

UHN Toronto General Toronto Western Princess Margaret Toronto Rehab COURAGE LIVES HERE
WCHH WOMEN'S COLLEGE HOSPITAL Health care for women | REVOLUTIONIZED
Toronto Central CCAC Community Care Access Centre

Increasing Usage of SCOPE

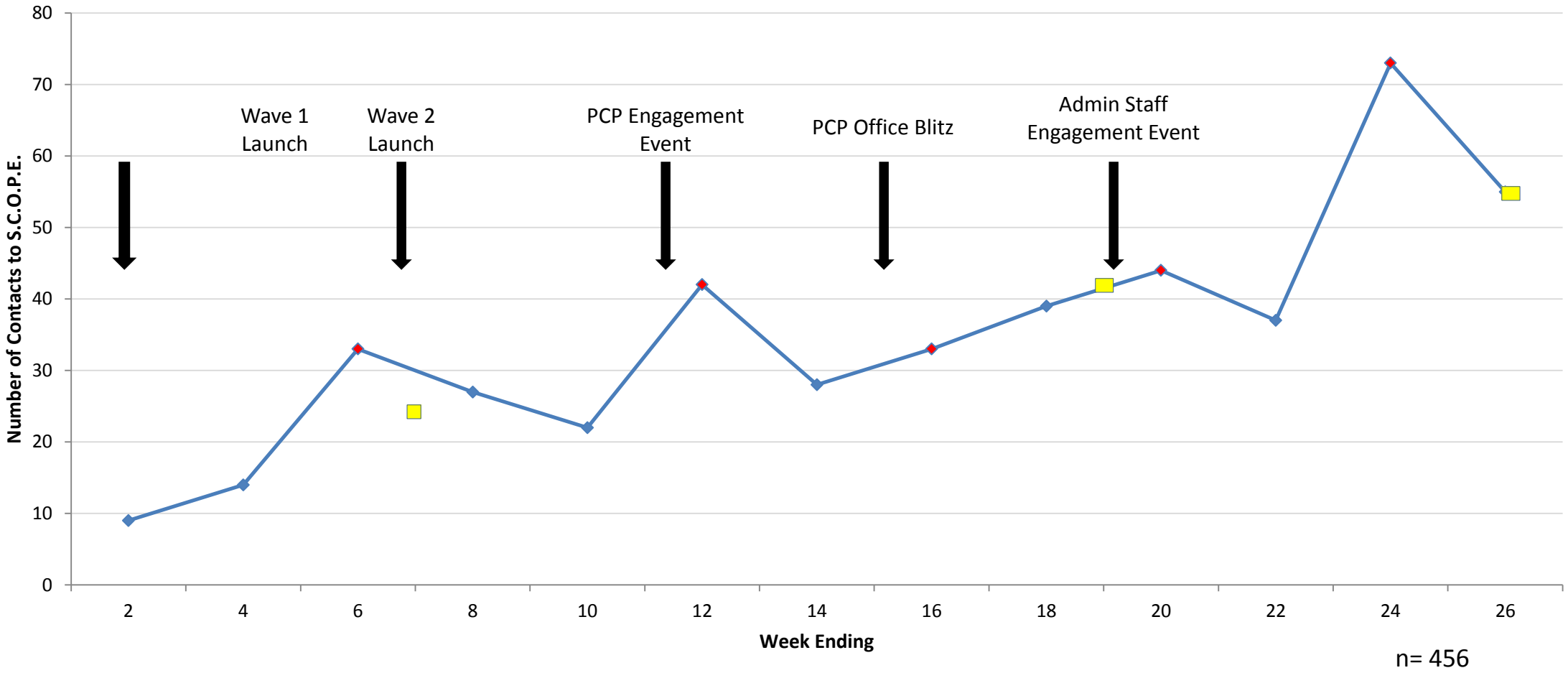
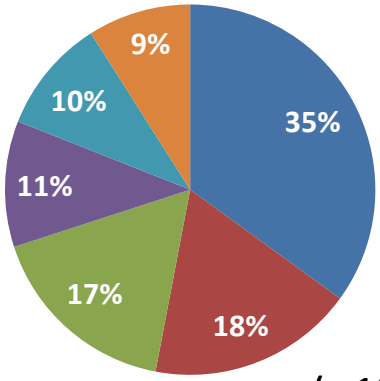


Figure 1. Contacts to S.C.O.P.E. resources (Navigation Hub nurse, Navigation Hub CCAC Care Coordinator, and GIM on-call) from September 24, 2013 – March 31, 2013.

Reasons for Calling SCOPE

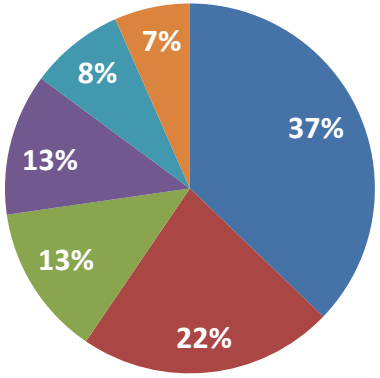
Internist On-Call



(n=148)

- Fever/Infection (Cellulitis, Pneumonia)
- Pain (Abdominal, Headaches)
- Chest Pain/Arrhythmia
- COPD/SOB/Respiratory Infections/Asthma
- Abnormal Test Result
- DVT/PE Investigations

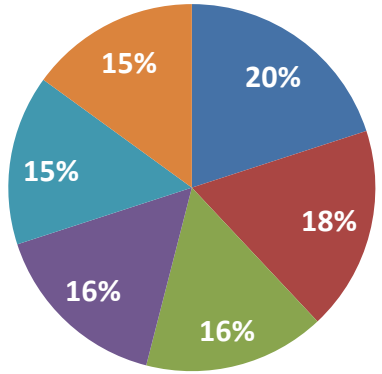
Navigation Hub Nurse



(n=225)

- Diabetes Education and Management
- Mental Health & Addiction
- Injury/Wound/Fracture
- Specialist Referrals
- Case Management/Patient Follow-up
- Diagnostic Test/Procedure

Community Coordinator



(n=111)

- Requires Community Supports
- Dementia/Cognitive Decline
- Mental Health/Depression
- Multiple Co-morbidities
- Diabetes Management
- Case Management/Patient Follow-up

Lessons from the Literature

Dearth of papers examining success factors for engaging solo MDs or small practices in QI projects.

General principles from US, UK and Canadian experience:

- **Governance structure:** facilitates a shared agenda
- **Grassroots (bottom-up) approach:** informs the design
- **Inclusive leadership style:** values distributed leadership
- **Iterative project adaptations:** based on clinician feedback
- **Multiplicity of communication:** repeated, personalized outreach strategies
- **Regular feedback of data**

SCOPE Physician Engagement Strategy

Building an Effective Launch

- Physician survey identified opportunities to strengthen connections
- Respected Primary Care Lead from local community experienced in change management
- Engagement events with input from PCPs, specialists and senior management from participating organizations
- Identified community physician champions

Encouraging Affiliation

- Branding: name, logo, vision statement
- Physician Advisory Group
- Leveraging physician champions
- Regular office visits by navigation hub
- Coaching by Primary Care Lead
- Supporting other members of the team-i.e. admin assistants
- Two PCPs co-edit monthly newsletter
- Following through on physician asks e.g. Portuguese Diabetes Group

Sustaining Ongoing Engagement

- Regular reports on patient status and MD status comparing SCOPE use vs. ED visits
- Educational events and case conferencing
- Practice management improvement

Feedback from SCOPE Physicians

Engagement Survey:

- SCOPE PCPs asked to rate the most important factors influencing their ongoing engagement:
  - Positive personal experience with SCOPE
  - Positive experience for my patients with SCOPE

Engagement Events:

- 6 well-attended engagement events held for physicians and front-line staff.
- Agenda covers SCOPE updates, feedback from PCP offices, and related educational topics.
- Over 90% of attendees indicated event content was relevant to their practice.

Lessons Learned

Keys to Success

- Balance of push versus pull engagement strategies.
- Single point of access to resources.
- Collaboration with primary care physicians and specialists.
- Communication through multiple channels.
- Commitment from senior management.
- Regular tests of change.

Ongoing Challenges

- Relationship between practice management and ED use.
- Patients who self-refer to the ED.
- Facilitating practice improvement with late adopters.

Question & Answer

- Dr. Ross Baker (moderator)