Health Quality Transformation 2014

Partnering to accelerate best care, best health, best value

Quality on the Frontlines:

Coordinating Care Across Sectors and Achieving Better Outcomes

Presenter Disclosures

- **Moderator:** Dr. Walter Wodchis
- **Presenters:**
  - Jocelyn Bennett
  - Mark Fam, Tory Merritt
  - Dr. David Daien
  - Laurie Poole

- Relationships with commercial interests: None

Disclosure of Commercial Support

- The presentations in this session have received no commercial support.

- Potential for conflict(s) of interest: None

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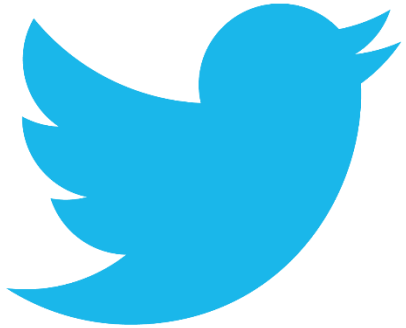

Use hashtag

#HQT2014

Learning Objectives

By attending this breakout session, participants will:

- Learn about innovative initiatives which have improved transitions between different health care settings and fostered coordinated care across sectors.

- Engage in stimulating discussions and discover change ideas and improvement strategies that may be implemented in any sector of the health system.

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Establishing the Effectiveness of an Acute Care for Elders (ACE) Strategy Delivery Model in Delivery Improved Patient and System Outcomes

Dr. Samir Sinha, Director of Geriatrics
Jocelyn Bennett, Senior Director, Urgent and Critical Care
Tyler Chalk, Senior Manager Quality and Performance
Joanne Bon, Senior Manager Clinical Utilization

MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex
Bright Minds. Big Hearts. The Best Medicine.

Geriatrics at Mount Sinai

- In 2010, Mount Sinai established Geriatrics a core strategic priority.

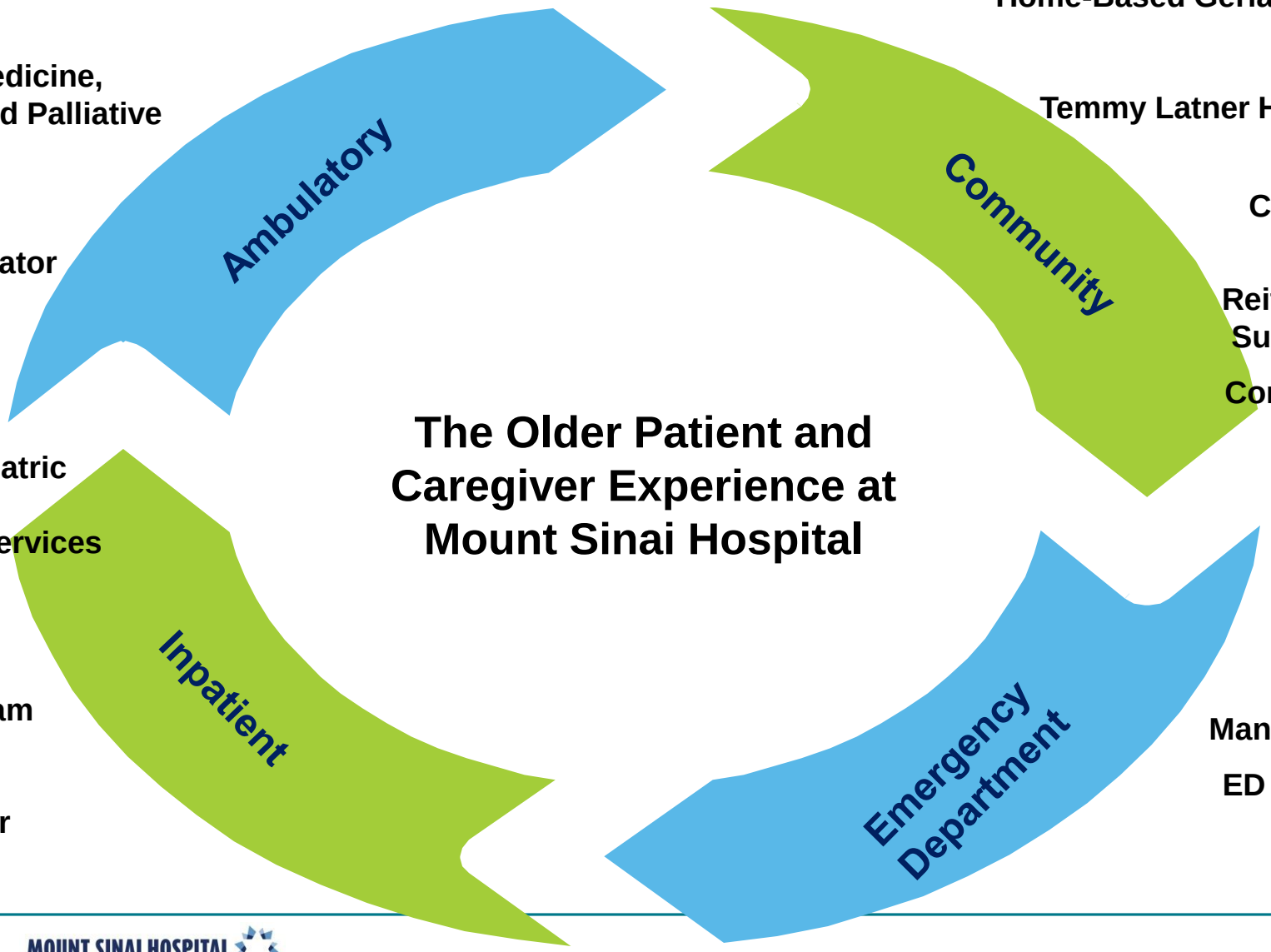
- The ACE Strategy is operationalized through the implementation of a comprehensive and integrated strategic delivery model that utilizes an interprofessional team-based approach to patient care.

- Our strength relies on the robust partnership of our hospital's geriatric, emergency, and primary care providers with local community support services and home-care agencies that often work with the same high needs and high cost patients.

Acute Care for Elders (ACE) Strategy

- Redesigns or establishes new sustainable evidence-based approaches that seek to enhance and improve upon current service models.
- Requires a shift in traditional thinking that currently underpins the administration and culture of most traditional care organizations.
- Is not adverse to identifying risk factors and needs and in intervening early to maintain independence.
- Is committed to rigorously monitoring and evaluating its outcomes to support continuous quality improvement.

The Mount Sinai Geriatrics Continuum



Outpatient Geriatric Medicine, Geriatric Psychiatry and Palliative Medicine Clinics

Telemedicine Clinics

CCAC – Clinic Coordinator

Home-Based Geriatric Primary/Specialty Care Program: House Calls

Temmy Latner Home-Based Palliative Care Program

CCAC – Integrated Client Care Project (ICCP) Site

Reitman Centre for Alzheimer's Support and Caregiver Training

Community and Staff Education Programs

Community Paramedicine

ISAR Screening

Geriatric Emergency Management (GEM) Nurses

ED Geriatric Mental Health Program

Geri-EM.com

Geriatric Medicine, Geriatric Psychiatry and Palliative Medicine Consultation Services

Orthogeriatrics Program

ICU Geriatrics Program

MAUVE Volunteer Program

ACE Unit

CCAC – ACE Coordinator

ACE Tracker

Safe Patients/Safe Staff

NICHE, RNAO BPSO

Evaluating Mount Sinai's ACE Strategy

Measure (Age 65+)	F2009/10	F2013/14
Patient Volumes	1573	2155
Total Length Of Stay	11.5	*8.25* (-28%)
ALOS/ELOS Ratio	95.6%	72.8 (-24%)
% Return Home At Discharge	71.1%	79.1%
Average ALC Days Per Patient	2.0	1.6 (-20%)
Medicine Bed Counts	88	80
Readmission W/N 30 Days	14.8%	12.8%
Catheter Utilization Ratio	56%	14.7%
Pressure Ulcer Incidence		down 93%
Patient Satisfaction	95.4%	96.9%

Cost savings through more efficient and quality care Est $6.7M (net savings)

Next Steps…

- Further partnerships to advance care and integration into the community

- Share our learnings and learn from others as we continue to innovate care, particularly in light of HSFR and continuing volume pressures

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Enhancing Patient Experience While Reducing Hospital Utilization: A Health Links Success

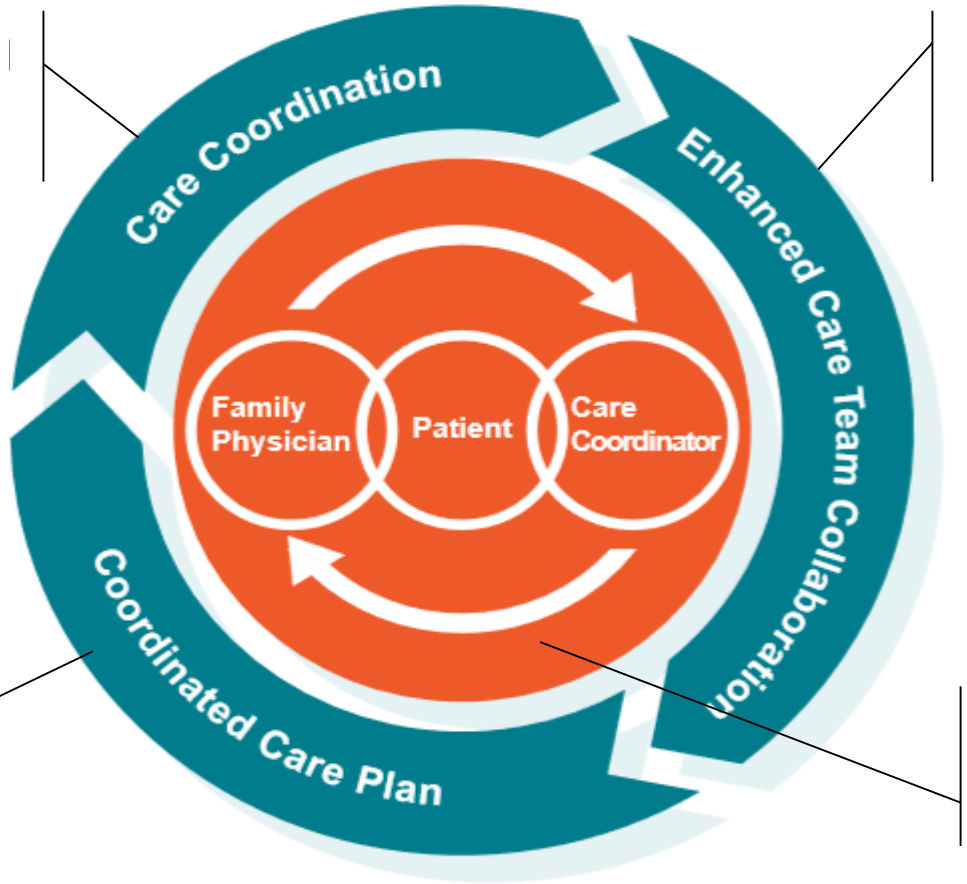
Mark Fam & Tory Merritt

North York Central Health Link is a partnership across many sectors

- Organizations have come together to improve care to individuals with complex care needs living in our community
- Partners include NYGH, Central CCAC, FHT, Toronto EMS, Community Support and Mental Health and Addiction agencies

NYCHL delivers intensive care coordination supporting an enhanced medical home model

Providing dedicated care coordinators



Facilitating communication across the healthcare system

Documenting and maintaining a care plan that is shared with the care team

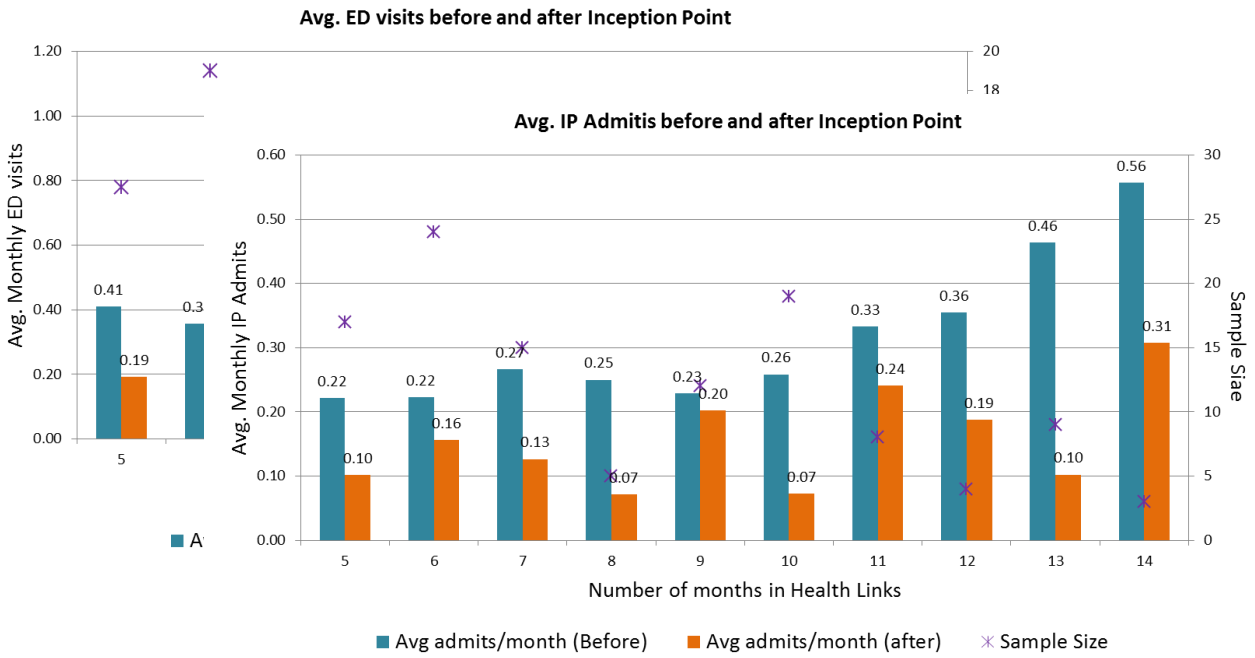
Bringing the patient back to the medical home

NYCHL patients are identified in real-time

Inpatients	• LACE score of 10 or higher • 2 or more admissions in ~ 6 months • 2 or more co-morbidities
ED	• 5 or more ED visits in last 12 months • MH or suspicion of MH diagnosis
Primary Care and Outpatient Clinics	• PRA score of 50% or higher
CCAC	• Admission within last 90 days • DIVERT score of 6 • COPD or CHF
Community Support Services	• Recent visit to NYGH or call to 911 • COPD or CHF • DIVERT score of 6

NYCHL is improving hospital use, patient and provider experience

Decreased **ED visits** by ~4 visits and **admissions** by ~2.25 annually per patient across the Central LHIN Health Links



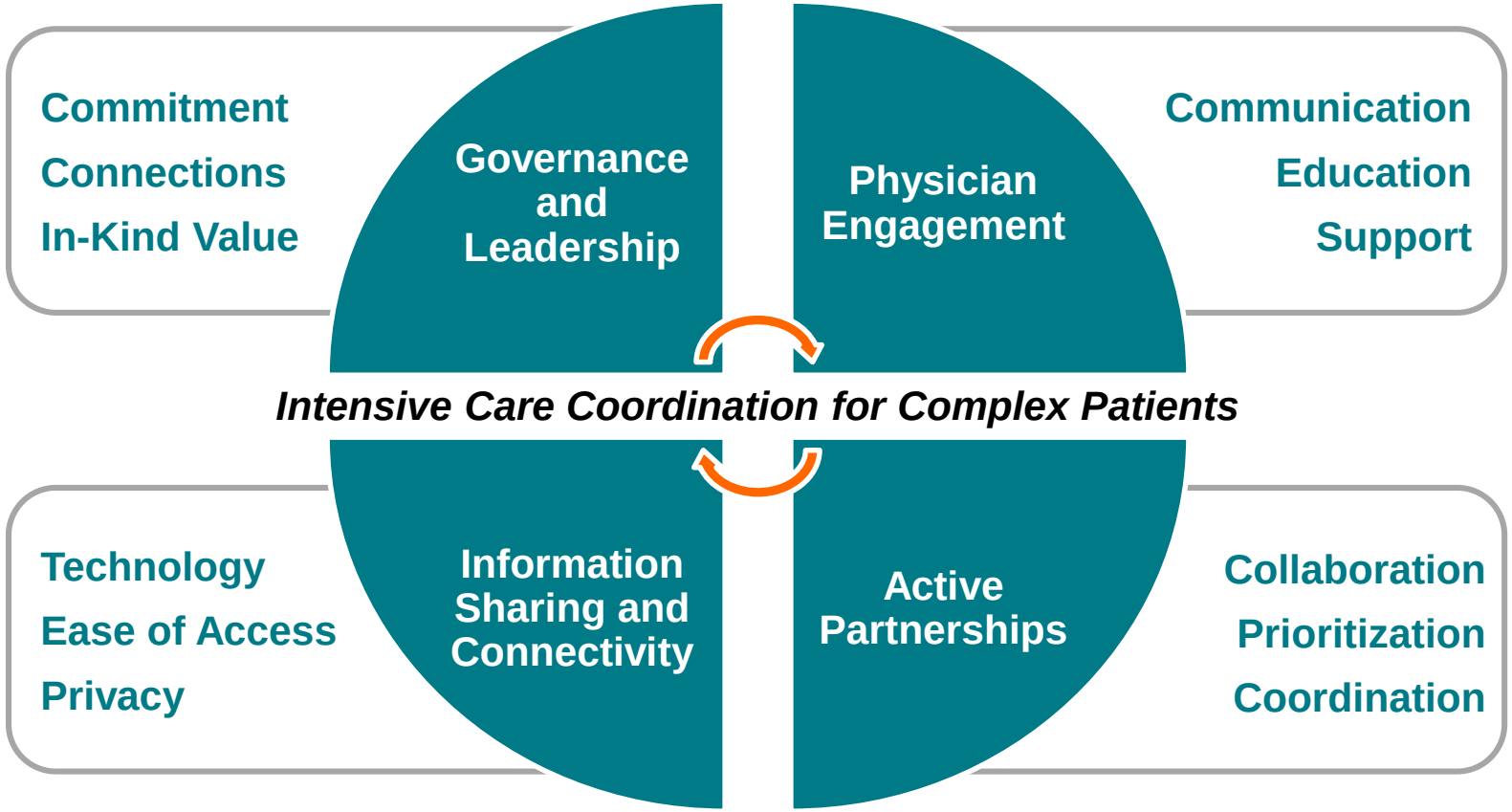
Patient Feedback

- After 4 months of being on the program they feel more valued and supported by health care team
- More assured that health care providers are working as a team

Physicians Feedback

- Over 80% find Health Links helps in managing patient care
- Rate case conferences as the most beneficial aspect of Health Links

NYCHL is focused on the following areas to mature the Health Link



THANK YOU

North York Central Health Link Team

HealthLinks@nygh.on.ca

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Connecting with Primary Care for Complex Patients

Dr. David Daien

Co-Lead

East Mississauga Health Link

November 20, 2014

SUMMERVILLE Family Health Team

Trillium Health Partners Better Together

Mississauga Halton CCAC Community Care Access Centre

EAMP

Nucleus Independent Living

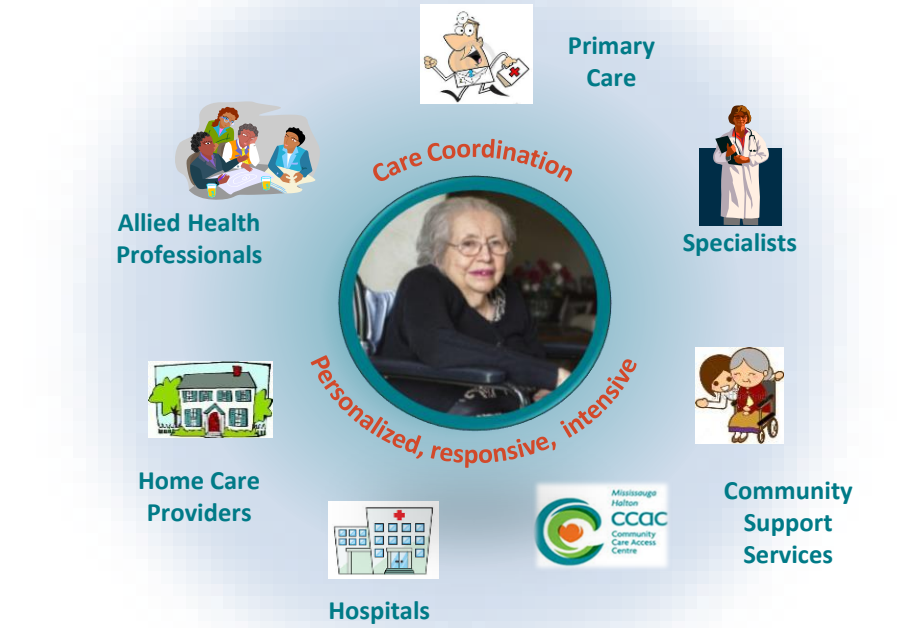
Canadian Mental Health Association Ontario Mental health for all

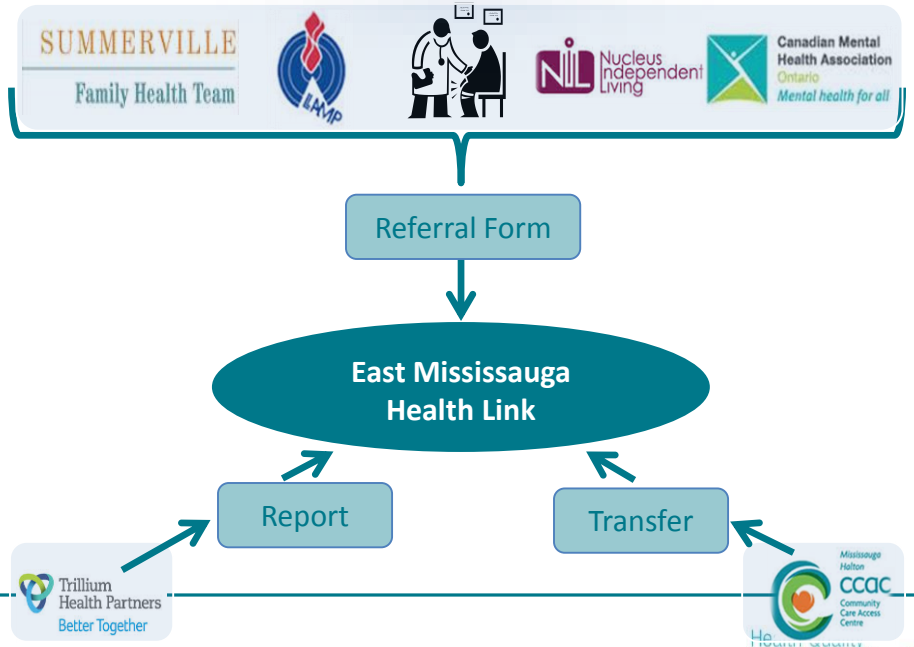
Ontario Mississauga Halton Local Health Integration Network

Ontario Health Quality Ontario

East Mississauga Health Link

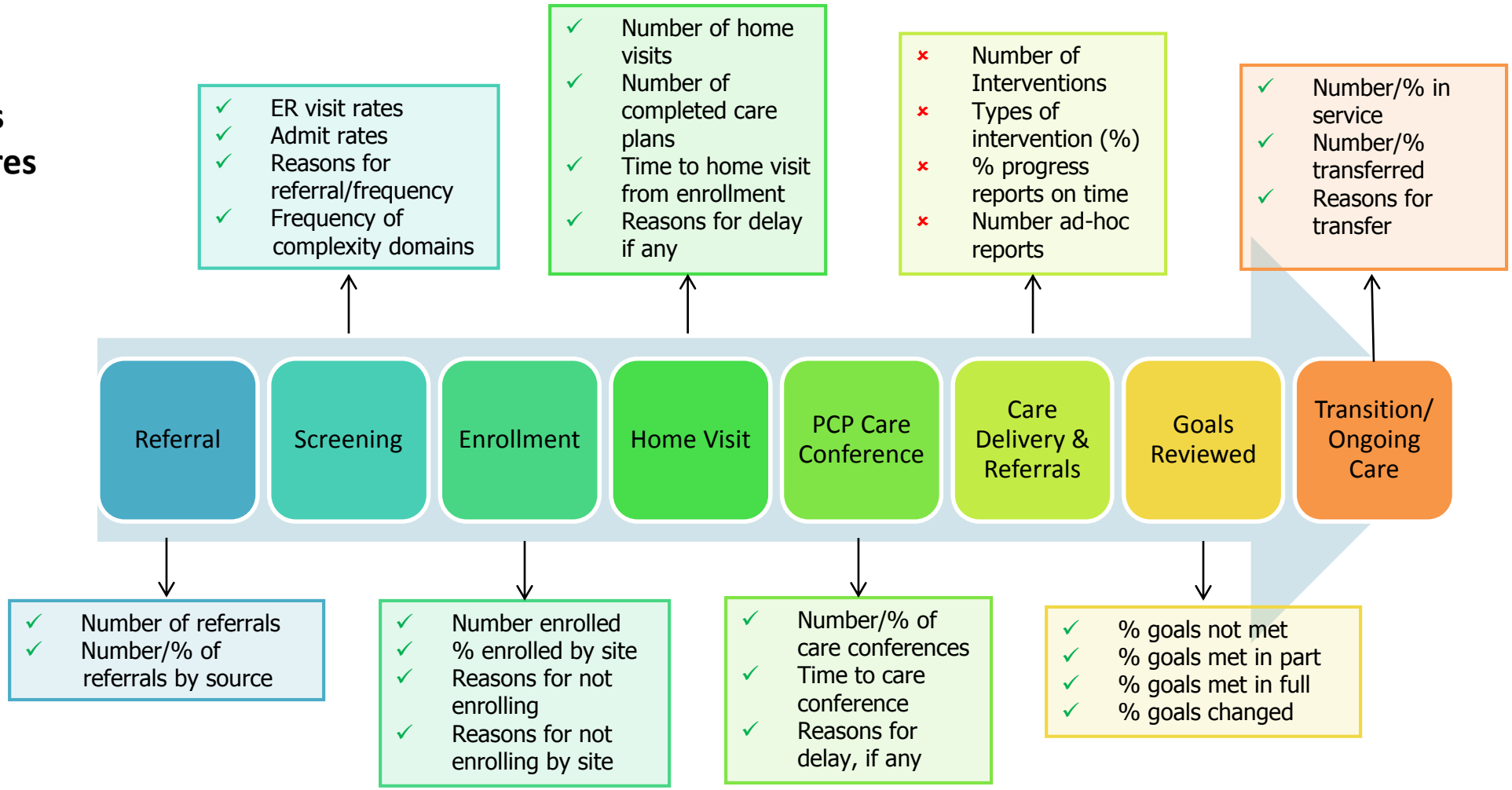
- One of the early adopters of Health Link, co-lead by Summerville Family Health Team and Trillium Health Partners
- Intensive care coordination role within the Mississauga Halton CCAC
- Patients served include:
  - ✓ Adults who are medically and/or socially complex (may include mental health conditions)
  - ✓ 3 or more visits to the ED or admissions to hospital in the last 6 months
  - ✓ **Needing intensive care coordination to avert further ED visits or admissions**
- Referrals accepted from hospital, primary care and community service providers





Clinical Pathway and Model for Evaluation

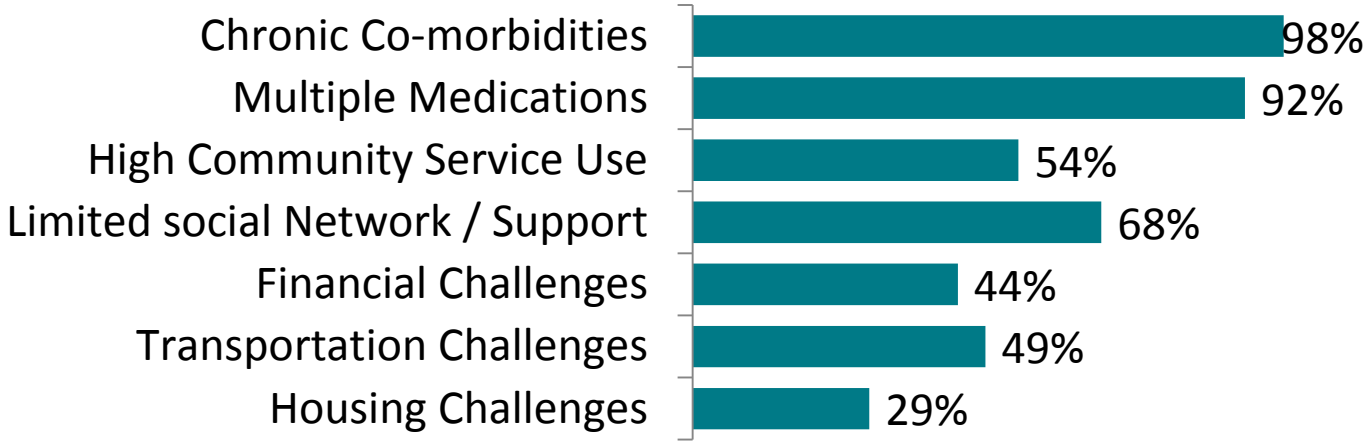
Process measures



Outcome measures: Utilization pre and post, Patient experience, Provider satisfaction

Characteristics of Enrolled Patients

Characteristic	September 30, 2014
Age (range)	73.7 (20-99)
Female (%)	59 (54%)
Co-morbidities (Range)	7.4 (2-19)
LACE score (expected probability of readmission or death within 30 days)	13.8 (21%)

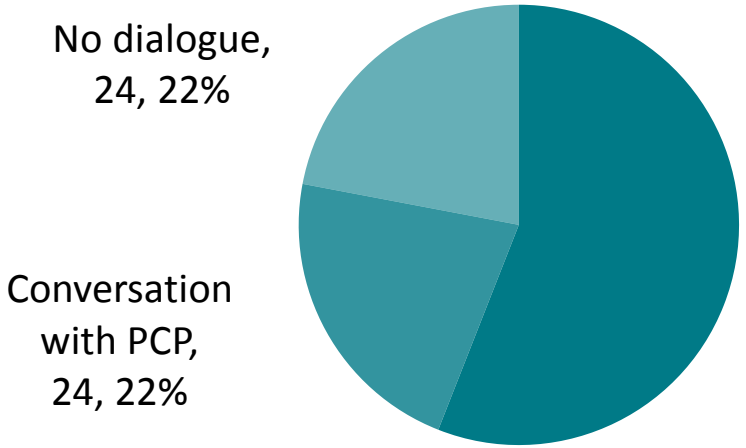


Acute care utilization in 6 months prior to referral
- ✓2.88 ED visits/6 month
- ✓1.35 Admissions/6 month

Results

September 30, 2014, N=109

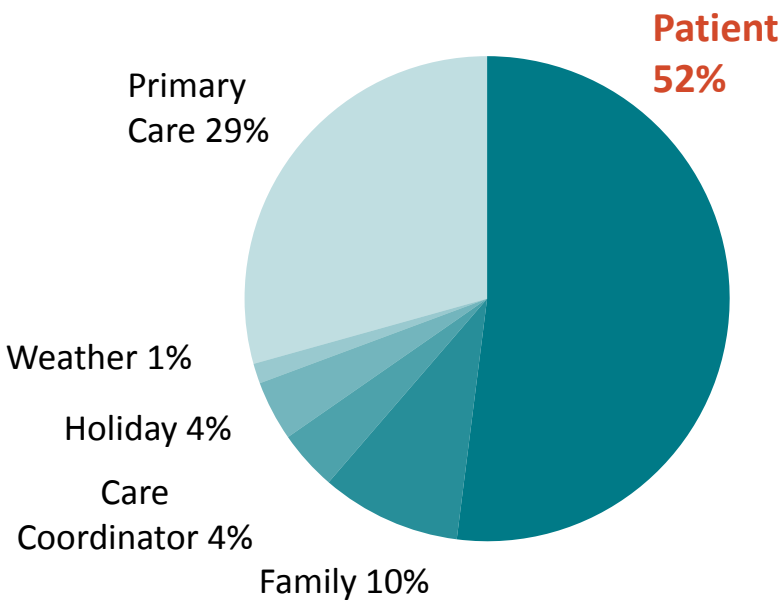
Communication with Primary Care



Care Conference, 61, 56%

- **Includes patient, care coordinator, primary care (at min)**
- **25% within 7 days**
- **Average was 13.2 days**

Reasons for Case Conference Delay



Time to Service

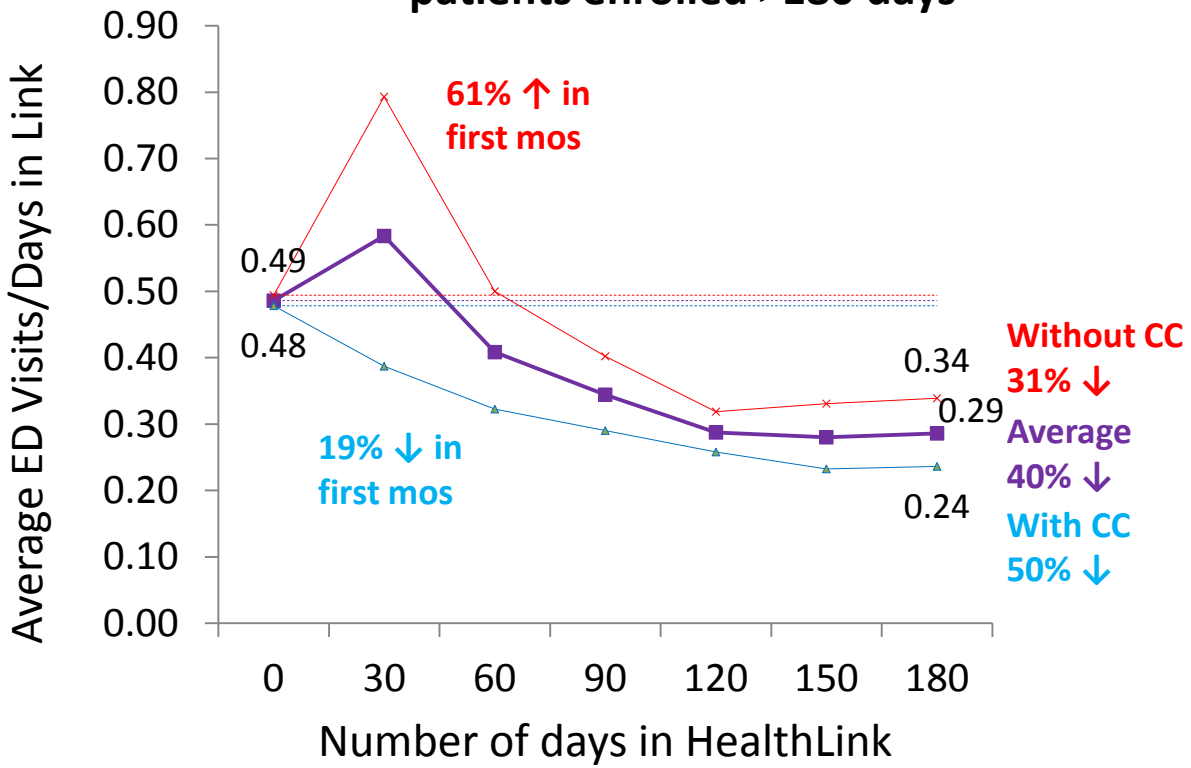
Home visit — Days **4.1** Business Days **2.9**

Case conference with Primary Care — Days **13.2**

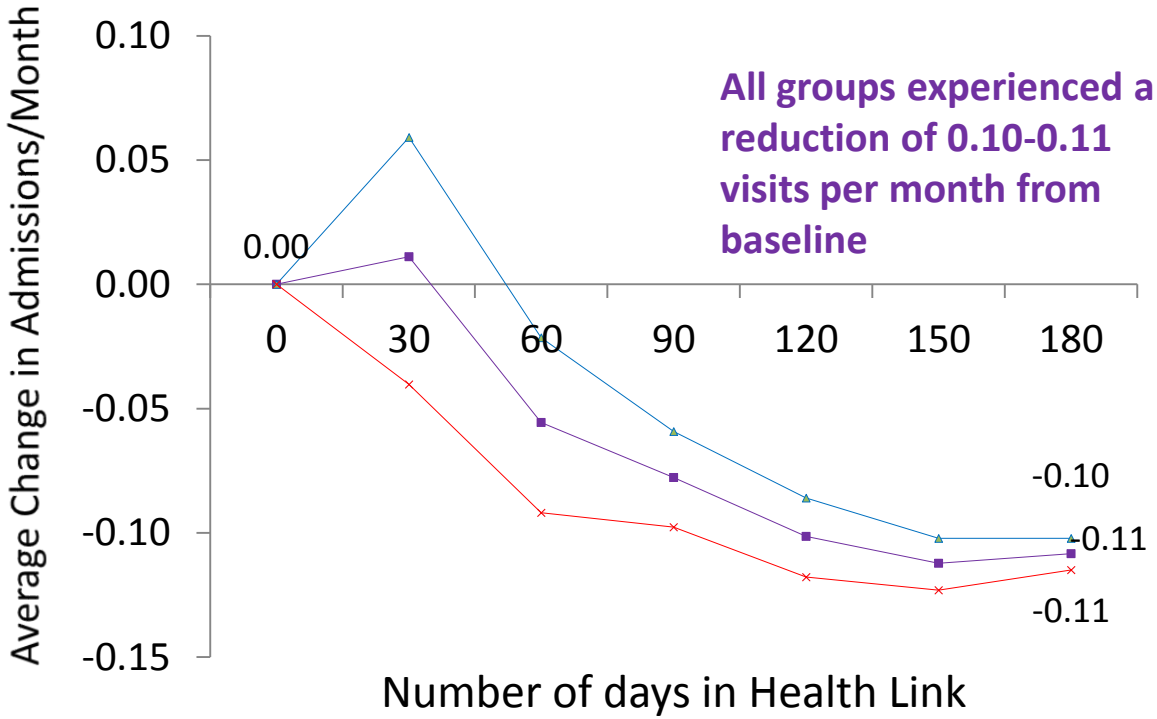
Conversation with Primary Care — Days **13.1**

Utilization Outcomes by Care Conferencing

Average Monthly ED Visits over time for patients enrolled >180 days



Average Monthly Admissions vs. Baseline over time for patients enrolled >180 days



Group Baseline
With Case conference group baseline
Without Case Conference baseline
Group Admissions (N=60)
With Case Conference (N=32)
Without Case Conference (N=28)

Care Conferencing

- Significant effort is required to achieve care conferences involving care coordinators, family, patient and family physician
- Our model of intensive care coordination reduces both ER visits and in-patient admissions
- Early care conferences appear to further reduce ER visits but not in-patient admissions

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Telehomecare: Improving Care Transitions across Health Care Sectors and Reducing Health System Utilization through Remote Monitoring and Health Coaching for Patients with Chronic Diseases

Laurie Poole, BScN, MHSA
Vice President, Telemedicine Solutions

otn telehomecare
Better Health. At Home.
http://rxtelehomecare.ca/

BPSO RNAO BEST PRACTICE SPOTLIGHT ORGANIZATION CANADA

Ontario Telemedicine Network: TELEHOMECARE

- Independent not for-profit corporation funded by the Government of Ontario
- Provincial telemedicine network supports the delivery of care and collaboration between providers and patients, enabled by various technologies
- Telehomecare: chronic disease management intervention with a focus on remote home-based patient monitoring, health coaching and self-management support for COPD and CHF patients

MISSION

To develop and support telemedicine solutions that enhance access and quality of health care in Ontario, and inspire adoption by health care providers, organizations, and the public

VISION

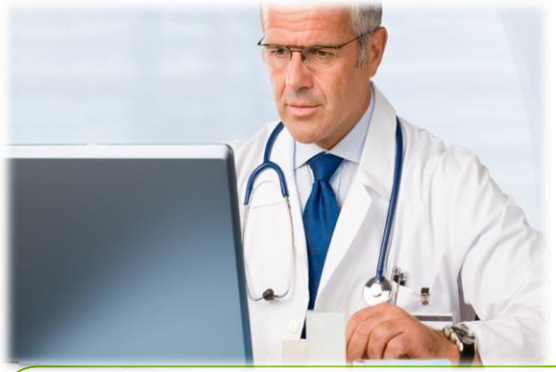
To be a mainstream channel for health care delivery and education

Telehomecare: A Patient Centred Model

Clinician Health Coaching:
Teaching the Patient how to self-manage & meet their goals

Remote Patient Monitoring:
Weekday Feeds & Alerts

Patient Empowerment:
At home; Sets Personal Goals; Submits vitals/ health responses



Most Responsible Provider Engagement:
Clinician provides regular updates, consults as required

Simple Technology in Home:
Tablet, BP Cuff, Scale & Pulse oximeter

How OTN Supports Telehomecare Practice

Clinical Process & Quality Leadership

- RNAO Best Practice Spotlight Organization
- Implementation and evaluation of relevant clinical best practices
- Collaboration with host organization partners to create quality framework, plan & deliverables
- Incorporation of best practices in provincial software (documentation & reporting)

Training and Professional Development Curriculum

- Mandatory Telehomecare Providers Training Curriculum
- Professional Development Curriculum (i.e. Knowledge Boosters)
- Telehomecare Adaptation Framework

How Telehomecare Clinicians Support Patients

Remote Monitoring
Alerts Management

Health Coaching & Self-Management Support
Self-Care Education, Goal-Setting, Problem-Solving

Care Navigation

Physiological Parameters

- Weight
- O2 Saturation
- HR
- BP

Health Questions

- Signs and Symptoms
- Medications
- Lifestyle and Behaviours
- Screening for Depression

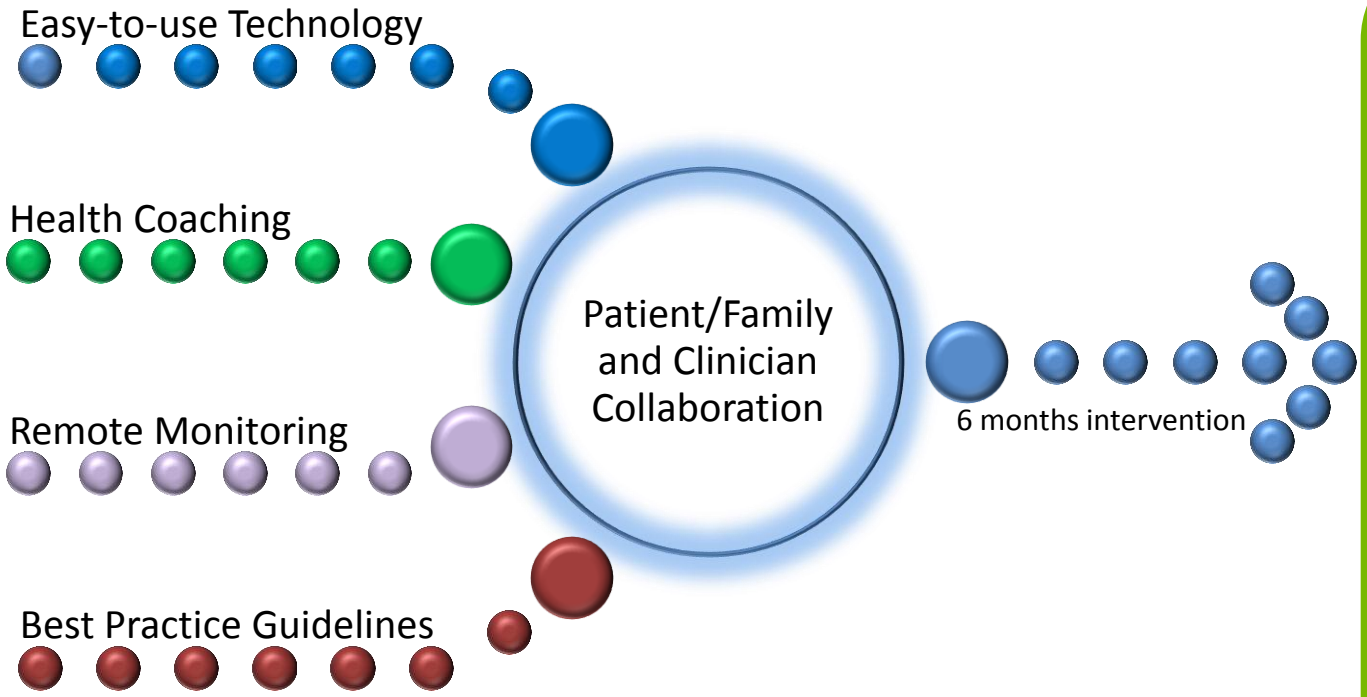
Self-monitoring and Symptom Management	Medication Management *(incl. bronchodilator therapy, class of medications)*
Nutrition *(incl. meal planning, sodium/fluid/potassium intake)*	Physical Activity
Promote pulmonary/cardiac rehabilitation	Smoking cessation, alcohol and other substances
Screening for Depression	Anxiety, Stress Management and Sleep
Goal-Setting, Action-Planning, and Problem-Solving	Promote Vaccinations – Flu, Pneumococcal

Circle of Care

Primary Care

Community Programs

Quality Measures and Outcomes



THETA EVALUATION OBJECTIVES

- Using a multi-level framework:
- Explore the org factors which facilitate or impede the *adoption* and *implementation* of THC
- Assess how various models of THC enabled patient self management *impact* patient outcomes, participant's experiences and system costs for chronic disease management (CHF and COPD)

- ✓ Hospital Inpatient Admission Incidence Rate
- ✓ Emergency Department Visits Incidence Rate
- ✓ Patient Self-Management Survey
- ✓ Patient Satisfaction Survey
- ✓ Provider Satisfaction Survey
- ✓ Process/ Outcomes Measures

Ongoing Quality Improvement

Quality Framework, Quality Plan and Evidence Base Research

Key Learnings

Target the right patients	• Target chronic disease patients that can have measurable benefits; this includes severity of disease and ability to participate in a self-management program
Make it easy for providers	• Work directly with clinical leaders to **integrate** Telehomecare into care delivery for CDM patients. Embedding Telehomecare in care pathways, patient order sets etc. assists in better transitions of care
Partner with the health care system and related orgs	• Develop partnerships with organizations for alignment with system priorities • Work collaboratively with other organizations that serve similar populations

Introducing a new type of patient care that depends on integration within a complex, multi-stakeholder health system requires a coordinated, multi-faceted approach that is managed and adapted over time.

THANK YOU!

For more information contact:

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Moderator Discussion Questions

Dr. Walter Wodchis

Selecting Patients

Please discuss your approach, importance, and any associated challenges to selecting patients/clients for your initiative.

Connecting with other Providers

To what extent did you have to connect with other providers?

What was the most significant barrier to connecting and how did you resolve that barrier?

Case Conferencing

Case conferencing is a common theme in these initiatives.

How did you use case conferencing and how was it a facilitator?

Enabling Technology

What is the role of enabling technology in your intervention?

What form of technology is most important for your intervention?

Robust Evaluation

How are you evaluating the intervention?

How robust can your evaluation be?

What role does that evaluation play in the future of the intervention?

Audience Questions

Questions?

Thank you