Connected Care Strategy – The Saskatchewan Journey towards Accountable Care

Canadian Home Care Summit
Halifax, NS
November 15, 2017

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Saskatchewan Facts

- **Greatest Football Team and Fans on Earth**
- Population 1.15 M
- Saskatoon 265K, Regina 193K,
- 12 RHAs ***soon to be one***
- 5 Tertiary Hospitals (3 Saskatoon, 2 Regina)
- Rural and Remote challenges
- **Grey Cup Champions 1966, 1989, 2007, 2013, ??2017**

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Mandate

- **Original Goal: *"No patient will wait for care in Saskatchewan Emergency Departments."***
  - **How do we define "zero" waits?**
  - **Is it realistic or desirable?**
  - **Stretch target and attention getter**
- **Redefined Goal:**
  - **March 2019: 60% improvement in Emergency Department wait times**
- **Scope: Entire continuum of care**

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Health System Target

To improve access for patients and reduce Emergency Department waits by 60%, necessary improvements in key areas (primary health care, specialist consults, diagnostics, mental health & addictions, long term care, home care, and acute care) will be achieved by 2019.

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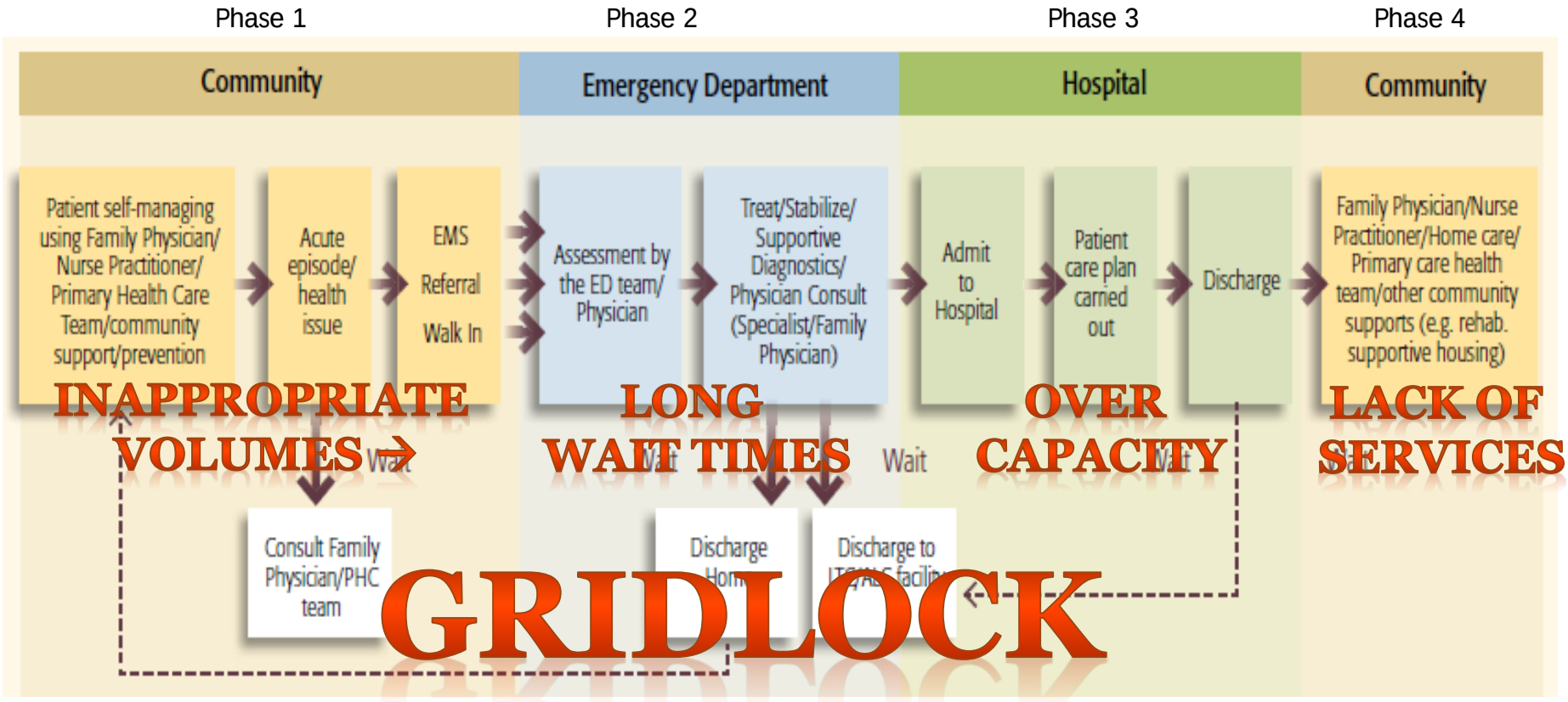
It's a System Problem



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State of the (Rider) Nation

- 30-50% of acute care beds are ALC
- High volume of low acuity presentations to emergency department
- High volume of avoidable admissions
- High 30 day readmissions and 7 day revisit rates
- Fragmented information systems

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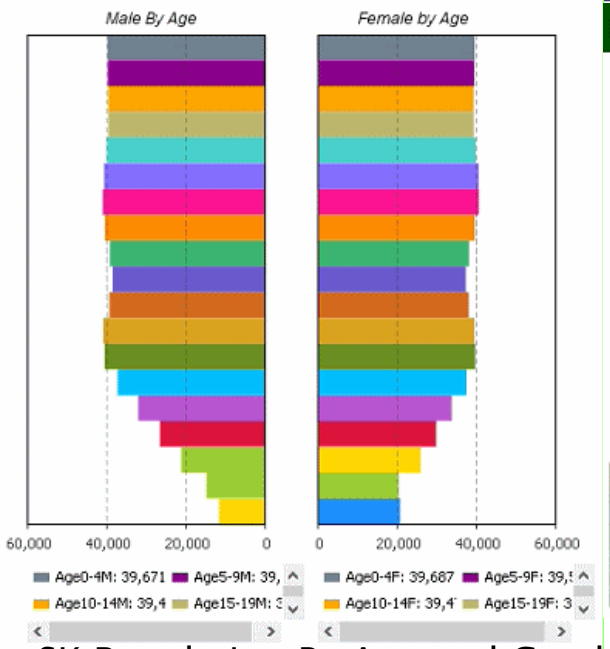
Where to Invest??

- Front door or back door?

- Emergency Department?
- Acute Care?
- Community?

Health System Modeling: Patient Flow in Saskatchewan

Emergency Department | Acute Care | Post-acute Care and Community



SK Population By Age and Gender

Demo of Royal University Hospital

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Health System Modelling: Results

Impact on wait time metrics:

- Low acuity presentations
  - Low impact
- Alternate level of care.
  - High impact
- Accountable care units.
  - High impact
- Ideal transitions of care.
  - High impact

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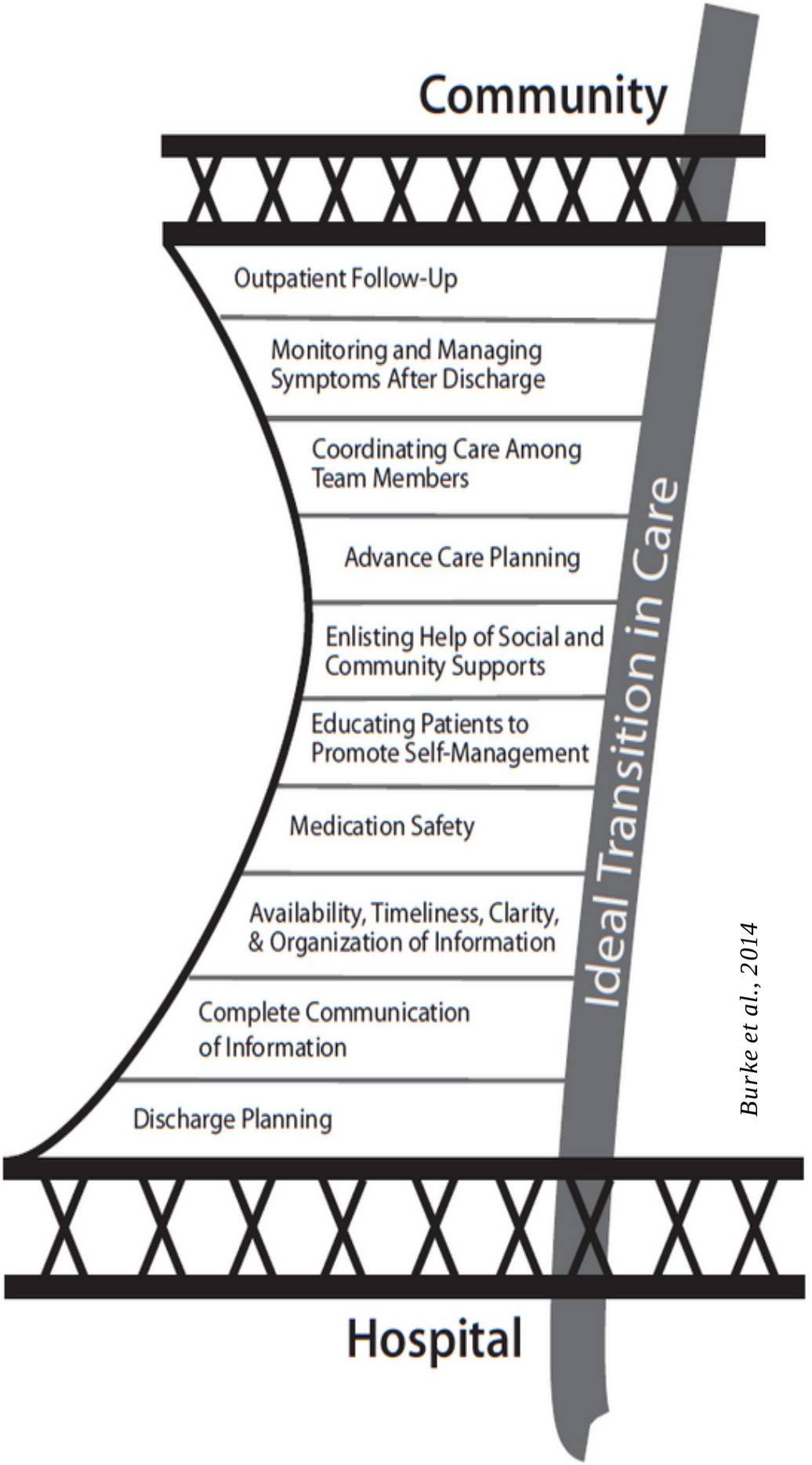

Burke et al., 2014

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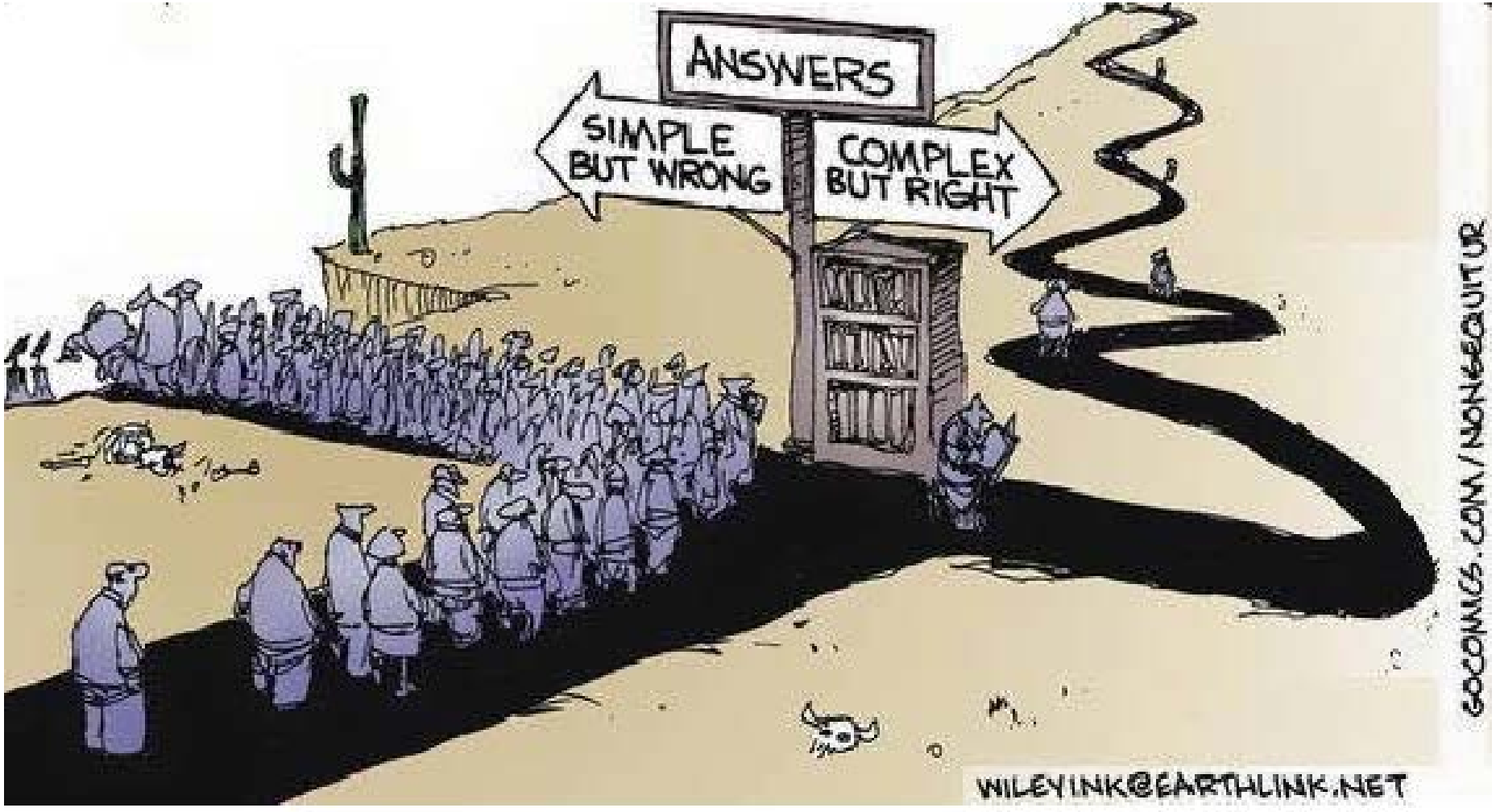

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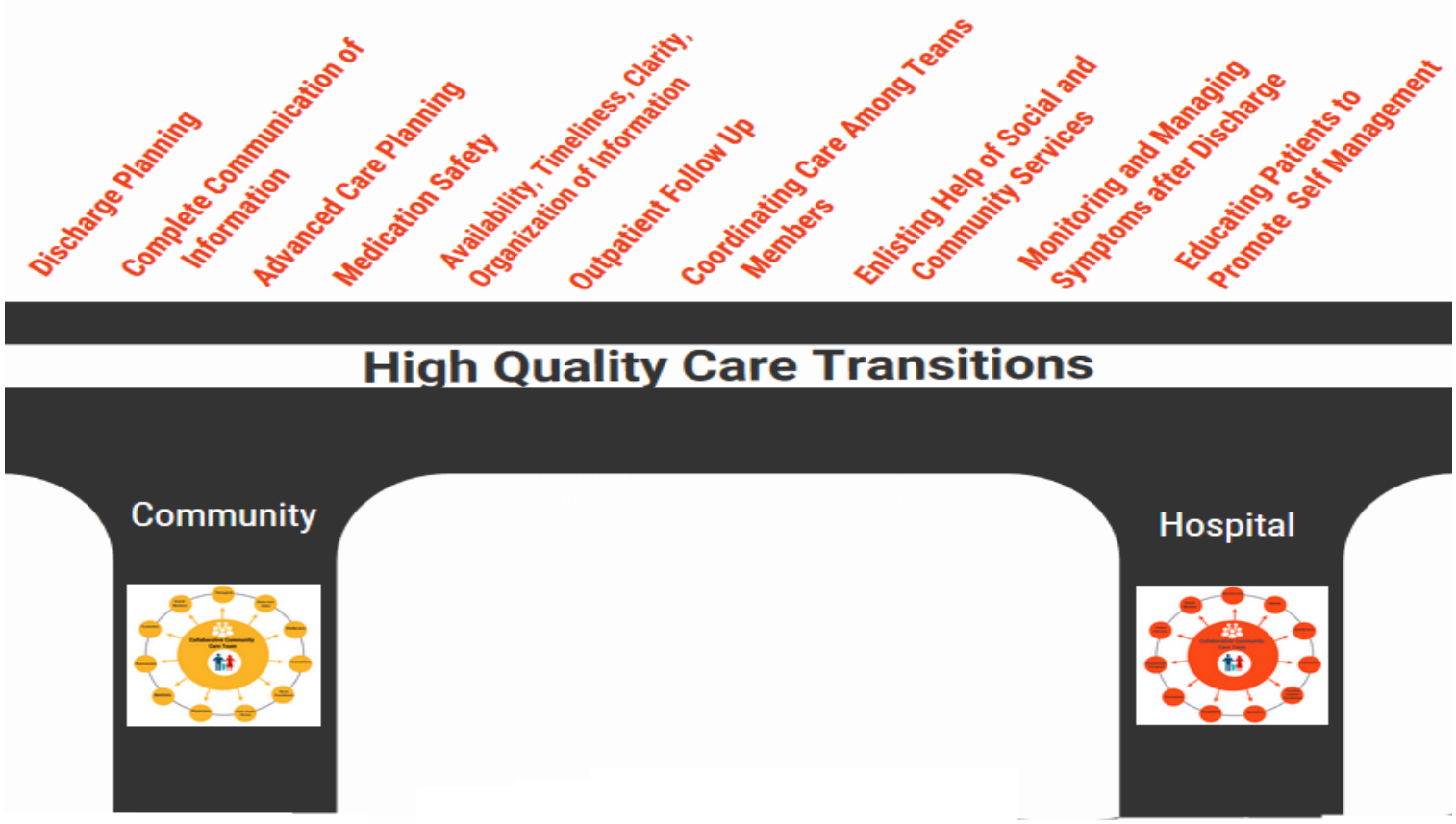
Connected Care Framework



Adapted from: Burke et al. (2014)

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Accountability in Healthcare

- What does it mean?
- Accountable for what? To who?
- Not the norm
- Transitions of care – “Discharge” vs. “Transfer”
- Language rubs some stakeholders the wrong way
- How?
  - Defined roles and responsibilities
  - Available data
  - Daily visual management
  - Defined teams and dedicated resources
  - Standardized processes

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Accountable Care = Connected Care

- Connections within and across teams
  - Trust and Relationships
  - Holding each other accountable

- Core components of high functioning teams:
  - Accountable to each other
  - Accountable to patients and families.
  - Accountable to their communities (wards and neighborhoods

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Connected Care Strategy

- ***Enhancing Team Based Care in the Hospital and Community***
- ***Evidence Based Approach to Transferring Patients from Care Team to Care Team (High Quality Care Transitions)***

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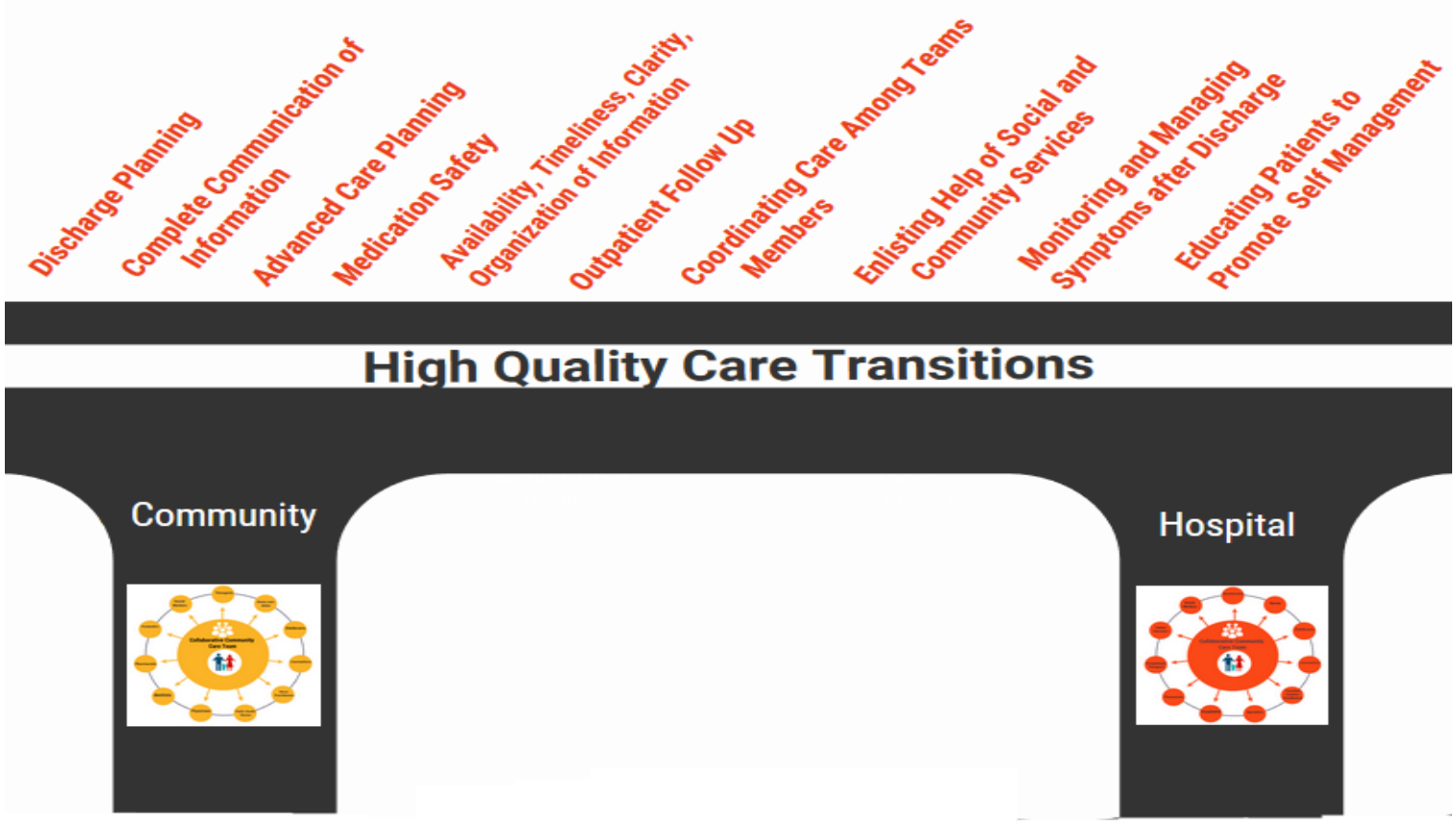

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Connected Care in Hospital:

- Nurse-physician co-leadership model
- Dedicated unit based teams
- Structured processes for shift handovers, communications and transfers
- Structured interdisciplinary bedside rounds
- Understanding & use of alternate level of care (ALC) data

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Connected Care in Community:

- Understand community needs (data analysis)
- Understand existing services
- Load level supply & demand
- Inter-professional team based care
- Co-location where possible
- Physician leadership
- Defined boundaries for which the team is accountable for community based outcomes

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Connected Care- Implementation

- Foundational Activities: (Unfunded)
  - Understanding our ALC population
  - Interdisciplinary Bedside Rounding (IDBR)
- Connected Care Strategy: (Funded)
  - Accountable (Connected) Care Units
  - Community Health Centres
  - High Quality Care Transitions

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Long Term – Ideal Future State

- Goal: Achieve a high functioning primary health care system that is connected, patient centered, and includes all community based services
  - ✓ Connected interdisciplinary team based care accountable for patient outcomes and stewardship
  - ✓ Improved access (right provider, right time, right place)
  - ✓ Enhanced medical leadership and accountability
  - ✓ Services tailored to local population needs
  - ✓ High quality care transition between hospital and community based services
  - ✓ Timely access to individual and population data to make informed clinical and resource decisions

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Evaluation and Early Results

- Defect Metrics:
  - Delayed transfers (ALC Days)
  - Acute Care LOS
  - Family Practice Sensitive Condition (FPSC) presentations to Emergency
  - Avoidable admissions for Ambulatory Care Sensitive Conditions (ACSC)
  - 30 day readmissions to acute care
  - 7 day revisit rates to Emergency

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Connected Community Care:
In the Regina Qu'Appelle Health Region

Sheila Anderson
Executive Director
Urban Primary Health Care Services
Regina Qu'Appelle Health Region

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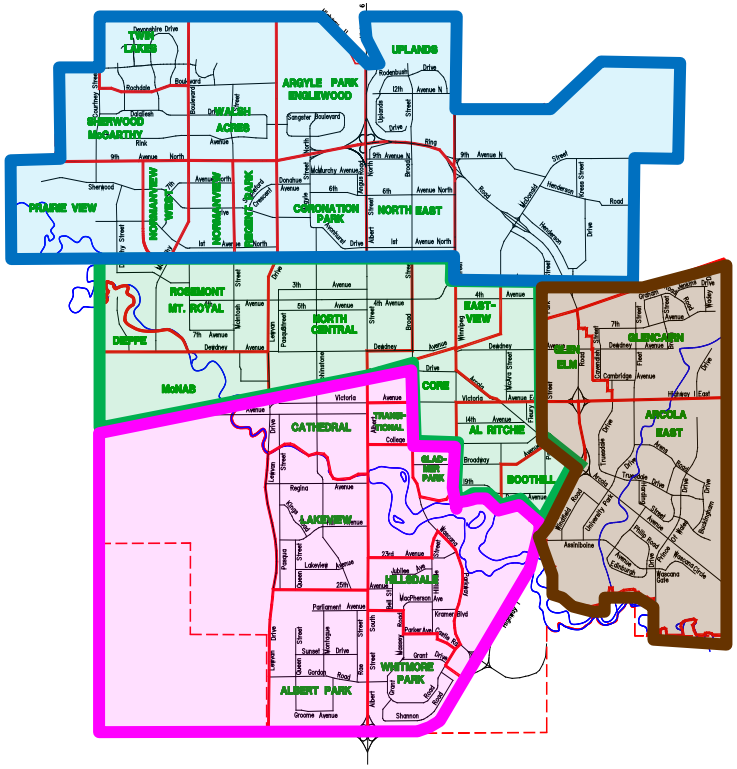
Accountable Community Care:

A Primary Health Care Network:

- Defined geographical area
- Integrated community based services
- Services designed to meet needs and closest to clients
- Inter-disciplinary team based services
- Coordinated, connected and accessible
- Culture of ownership and accountability



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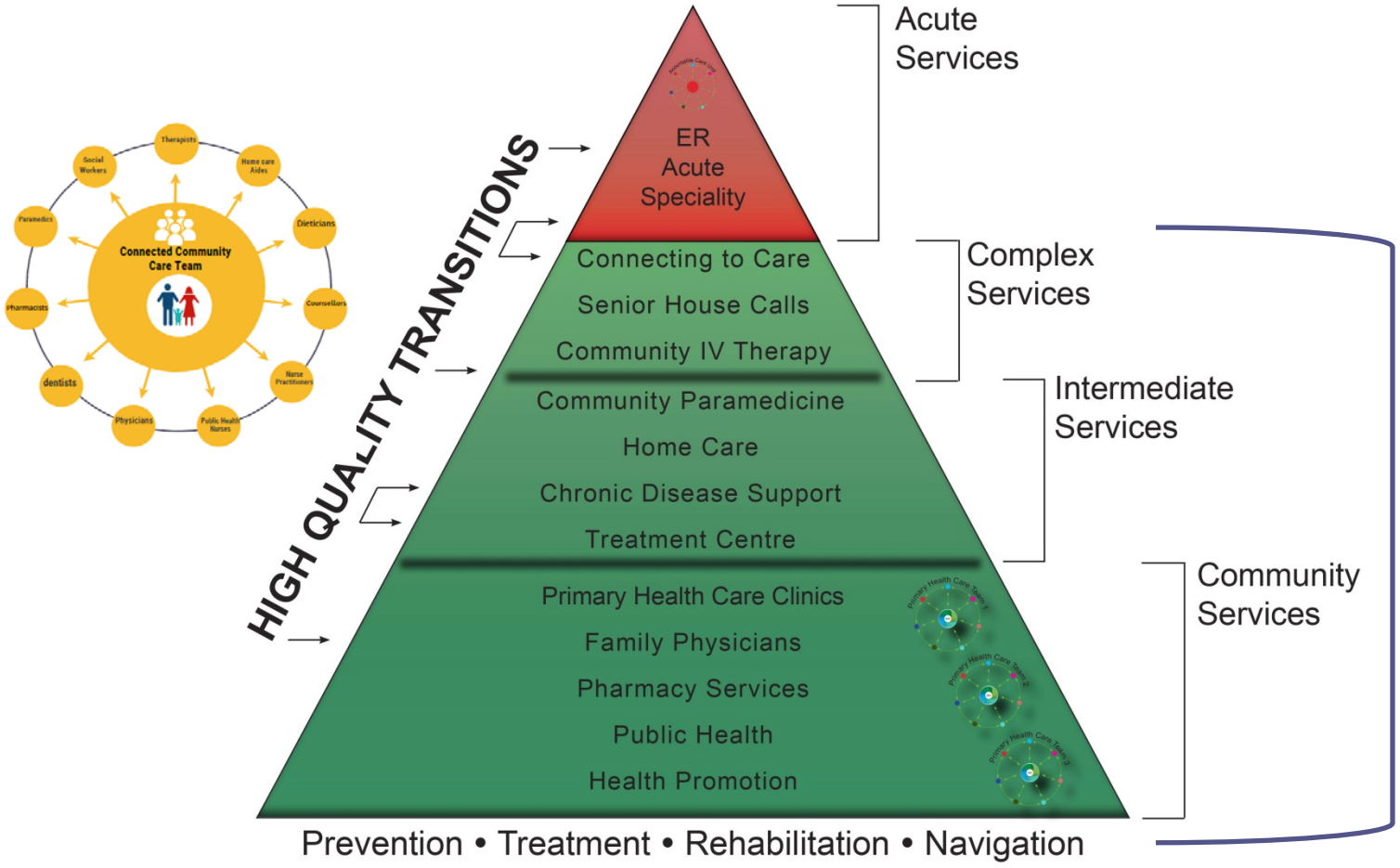
Anatomy of a Network



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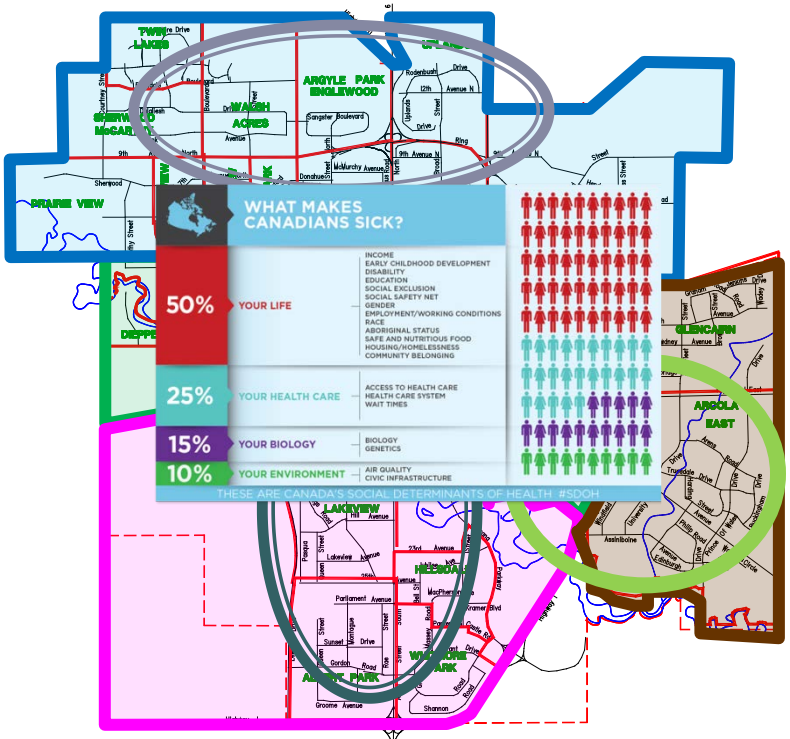
Accountable to the Community:

- Understand the unique needs of each neighborhood
- Assign providers to networks based on community need
- Connect to community agencies and supports
- Improve accessibility to health promotion and prevention, chronic disease and mental health services
- Ownership of clients residing within network boarders



Equity does not mean equal

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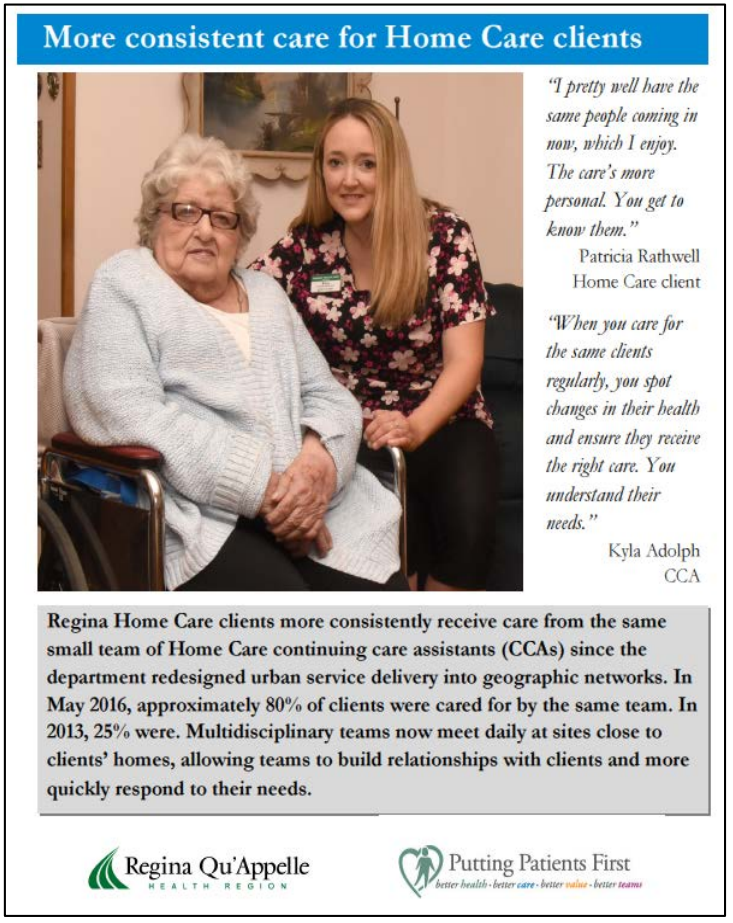
Accountable to Patients and families:

- Designed with and for patients
- Consistency of Care -providers assigned to a smaller geographical area
- Coordinated Care – Daily huddles and warm handoffs
- Timely resolution of care concerns
- Access to intermediate care services
- Access to community paramedicine program
- Post hospital follow- up visits
- Coordinated care with family physicians



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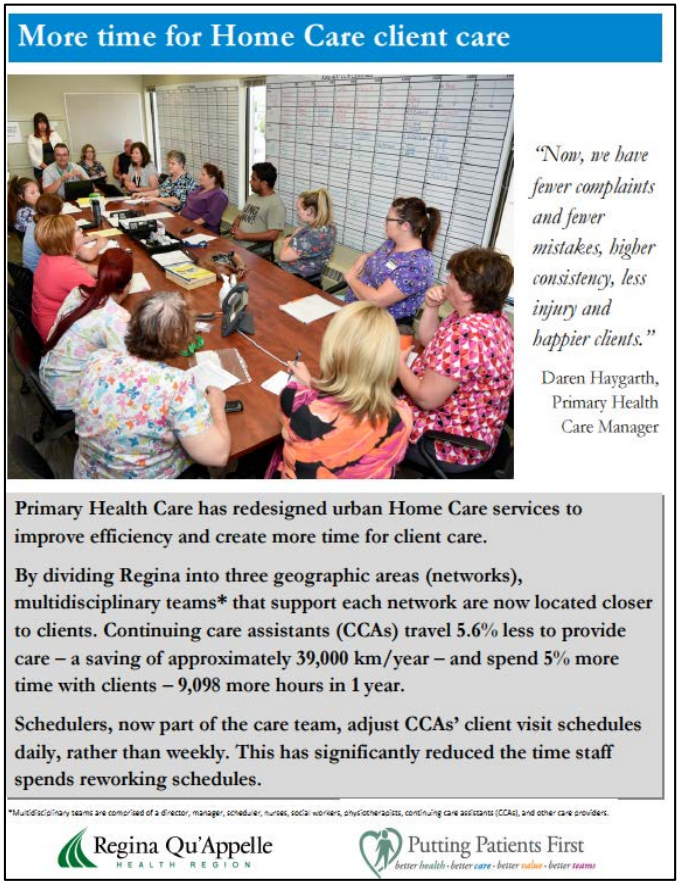
Accountable to Providers :

- Co- located teams
- Access to a multiple service providers
- Dedicated time to case conference
- Shared work load through daily visual management
- Decreased travel time
- Work at top of scope
- Mentorship and support
- Culture of accountability to each other
- Culture of accountability to clients and families of the network



More time for Home Care client care

"Now, we have fewer complaints and fewer mistakes, higher consistency, less injury and happier clients."

Daren Haygarth, Primary Health Care Manager

Primary Health Care has redesigned urban Home Care services to improve efficiency and create more time for client care.

By dividing Regina into three geographic areas (networks), multidisciplinary teams* that support each network are now located closer to clients. Continuing care assistants (CCAs) travel 5.6% less to provide care – a saving of approximately 39,000 km/year – and spend 5% more time with clients – 9,098 more hours in 1 year.

Schedulers, now part of the care team, adjust CCAs' client visit schedules daily, rather than weekly. This has significantly reduced the time staff spends reworking schedules.

*Multidisciplinary teams are comprised of a director, manager, scheduler, nurses, social workers, physiotherapists, continuing care assistants (CCAs), and other care providers.

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Putting Patients First
better health · better care · better value · better teams

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Accountable to Physicians:

- Co- leadership model – Administration & family physician
- All inclusive
- Local support and better access to resources
- Shared care plans
- Visiting services in family physician offices
- Co–design of community chronic disease programs

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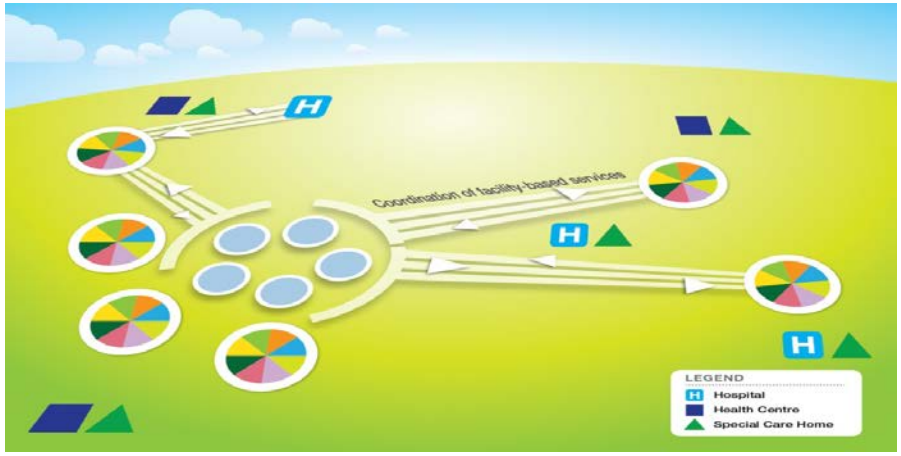
Accountable to the System:

- *Connected Care* through High Quality Care Transitions
- Greater understanding of flow from acute to community
- Reliable and consistent community care
- Commitment to invest in community care to sustain system



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