Enabling Evidence Informed Decision Making

Complex Accountability Frameworks – Regina's Experience

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Presentation Outline

1. Regina's Journey to Health Networks
   - Our Burning Platform
2. Accountable Community Care– as an anchor for the system
3. What does this look like in day to day operations for Home Care
4. System Outcomes

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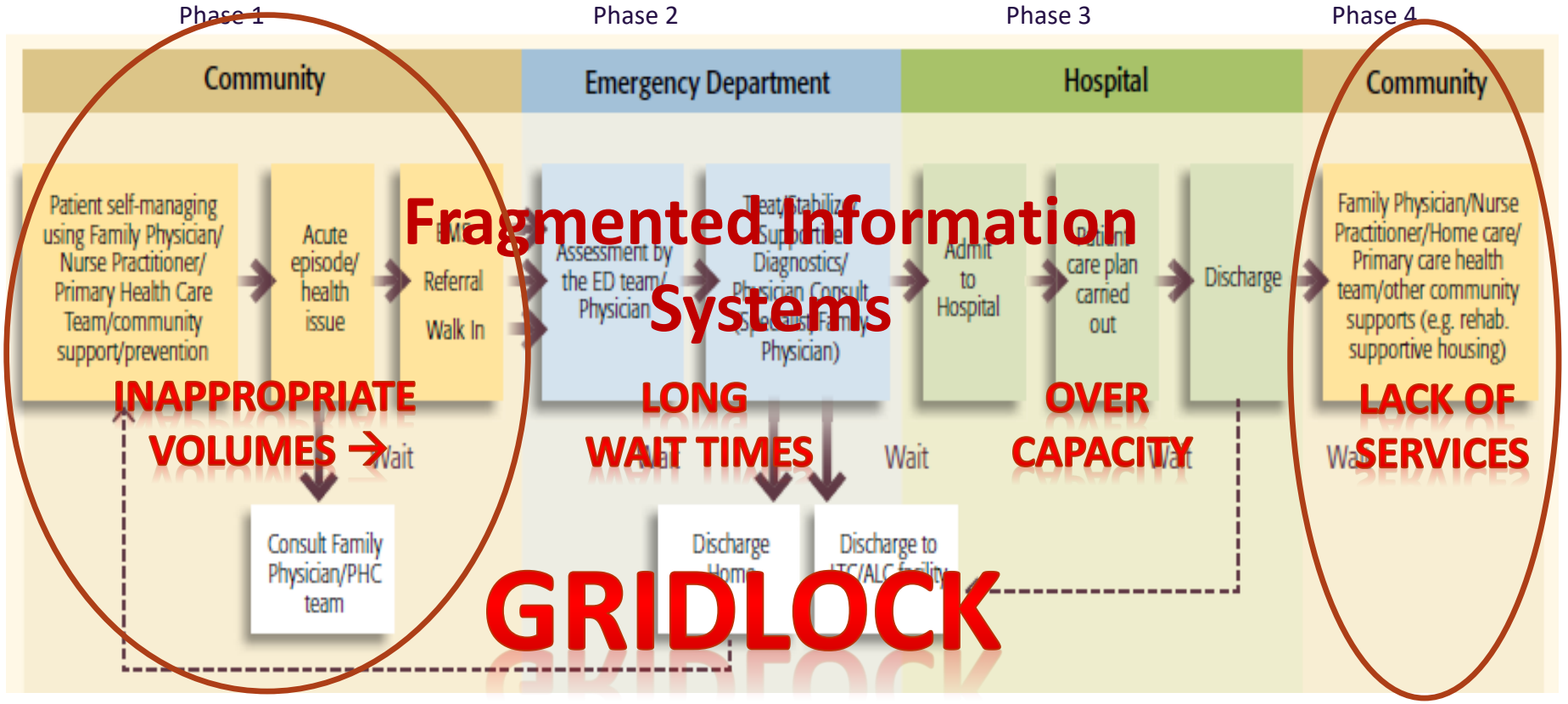
Ambulance Only


20-03

Wait Times in the Emergency Department - It's a System Problem



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SOONER SAFER SMARTER

Emergency Department Waits and Patient Flow Initiative
putting the Patient First

"North Star" Provincial Strategic Goal

- ***"No patient will wait for care in Saskatchewan Emergency Departments."***
  - **1st goal: 60% improvement in ED Waits**
    - ED Metrics a diagnostic tool for larger system performance
    - ED performance often a "defect" metric of other system element performance (including Regina's Home Care Services)
    - All areas could "cascade" performance outcomes to this metric

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2014 – Our "burning platform"…

Community Care Services

- Disjointed community programs and services
- Challenges with wait time for services,
- Lack of consistency of care for our clients
- Access to service very difficult to navigate
- Decreasing engagement of providers at all levels
- Waste and sub-optimization paired with rising demand
- Little focus on prevention and health promotion
- Heavy reliance on ER / Specialty Care
- Large provincial expenditures but poor health outcomes

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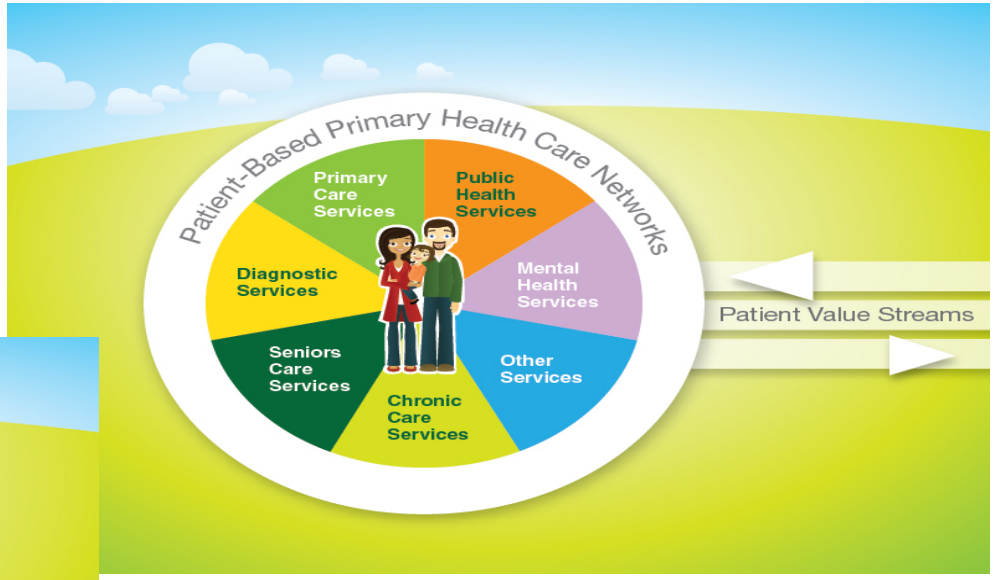
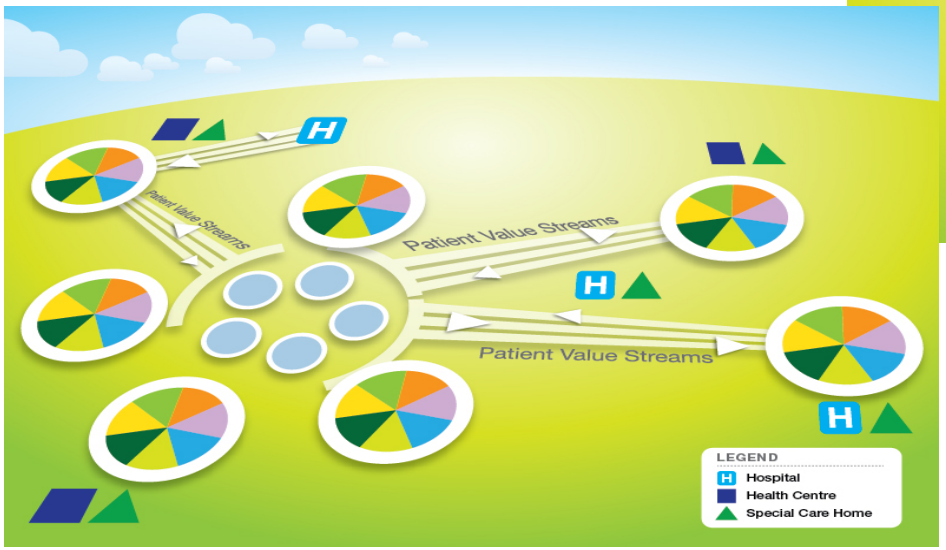
Background – Regina's Journey to Health Networks

Our Vision:

Improve the patient experience by realigning our services into Networks and delivering Accountable Community Care.





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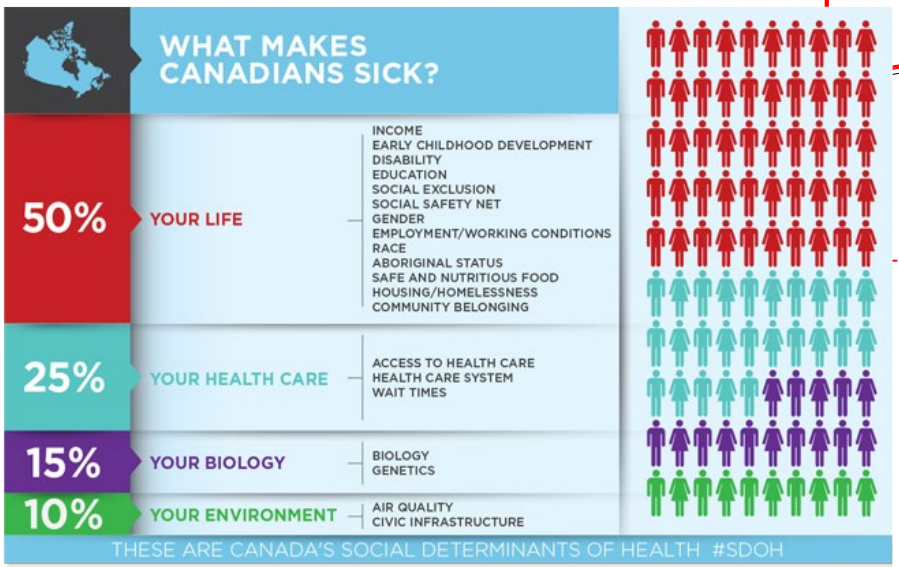
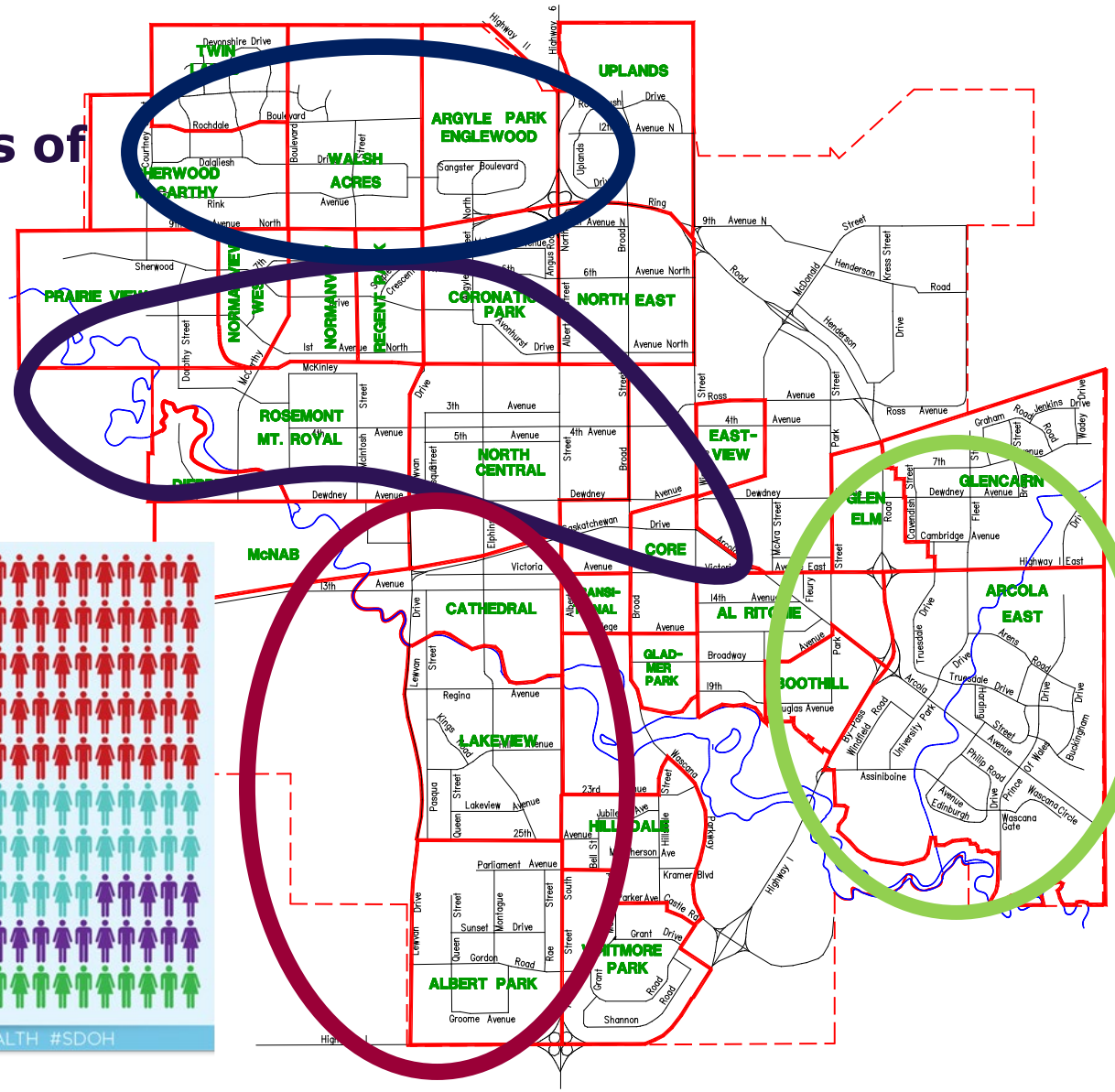
Networks are Rooted in Determinants of Well-Being

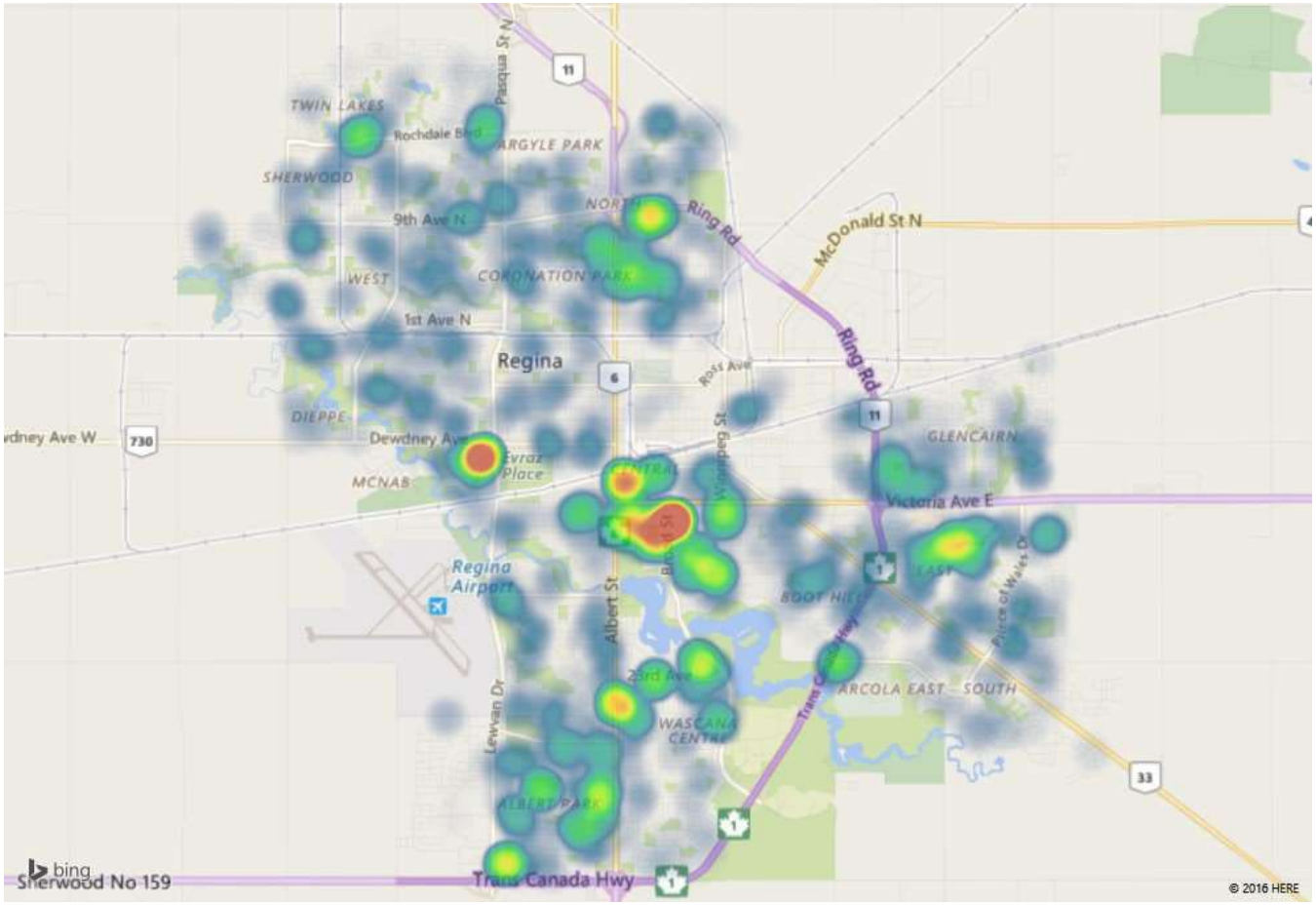
- Census data
- Social Determinants of Health
- Burdon of disease
- Hospital utilization

Equity does not mean equal





Apr - Aug 2016 ED Visits Seniors 65+ CTAS 1-5



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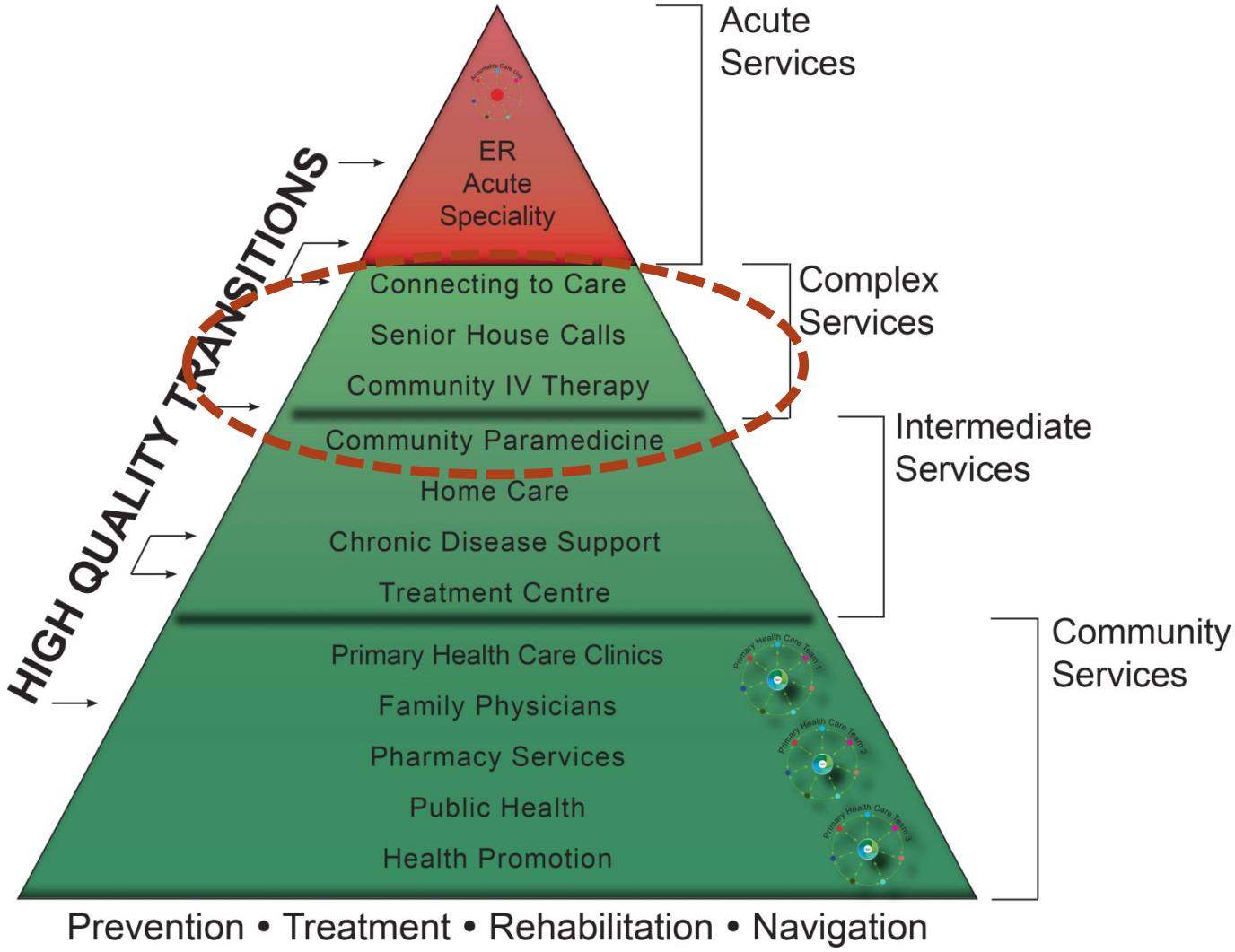
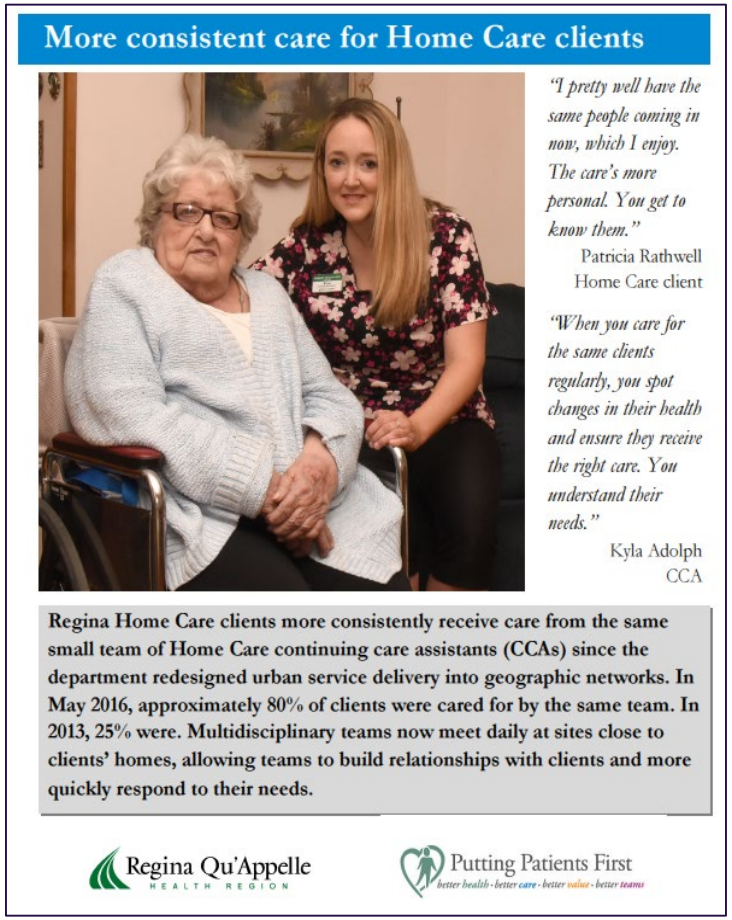
Anatomy of a Network



Home Care Accountability - To Our Patients and Families

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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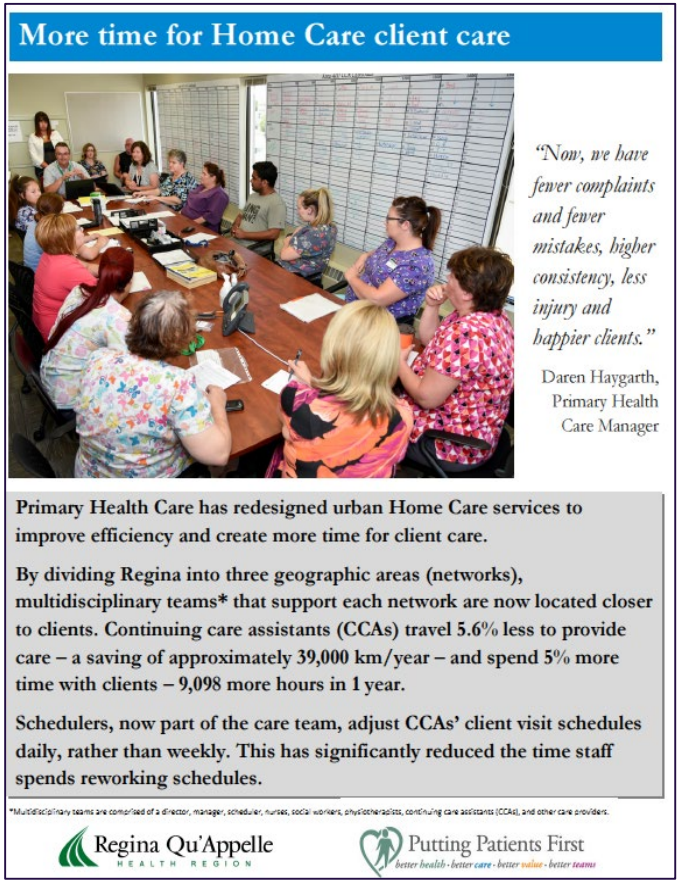
Home Care Accountability - To Our Providers

Accountable to Providers :

- *Co-located* teams
- *Access* to multiple service providers and disciplines
- 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 clients and families of the network, and to each other



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.

Regina Qu'Appelle HEALTH REGION

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

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Home Care Accountability - To Our Physician Partners

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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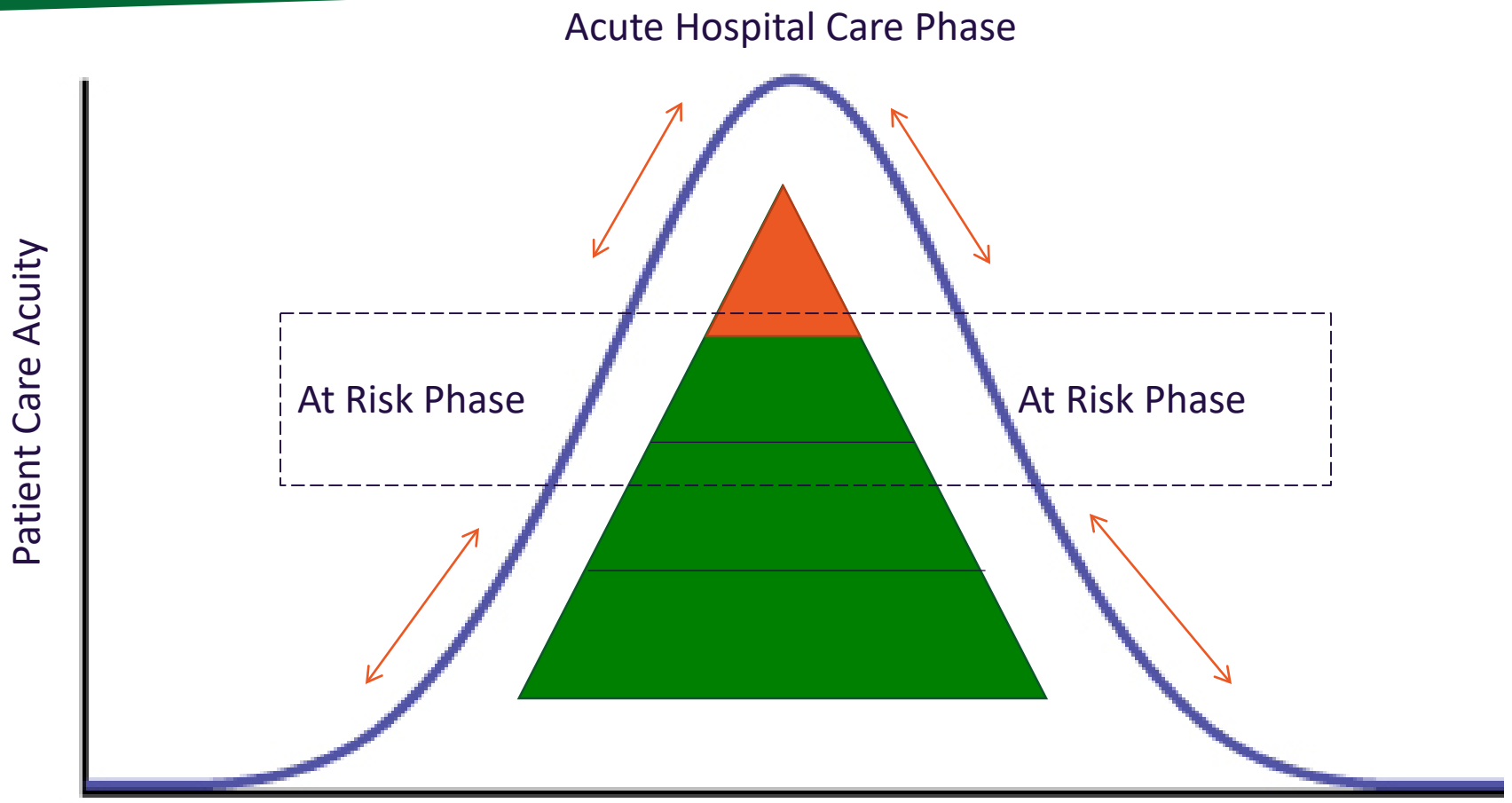
Client's Care Journey



Everyday Community Care supports – Longitudinal Support vs. Episodic Support

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How did we operationalize this?

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LEAN Tools: Daily Visual Management

Team Production Boards

- Huddles – start and end of shift
- Team Development
- Cross functional training

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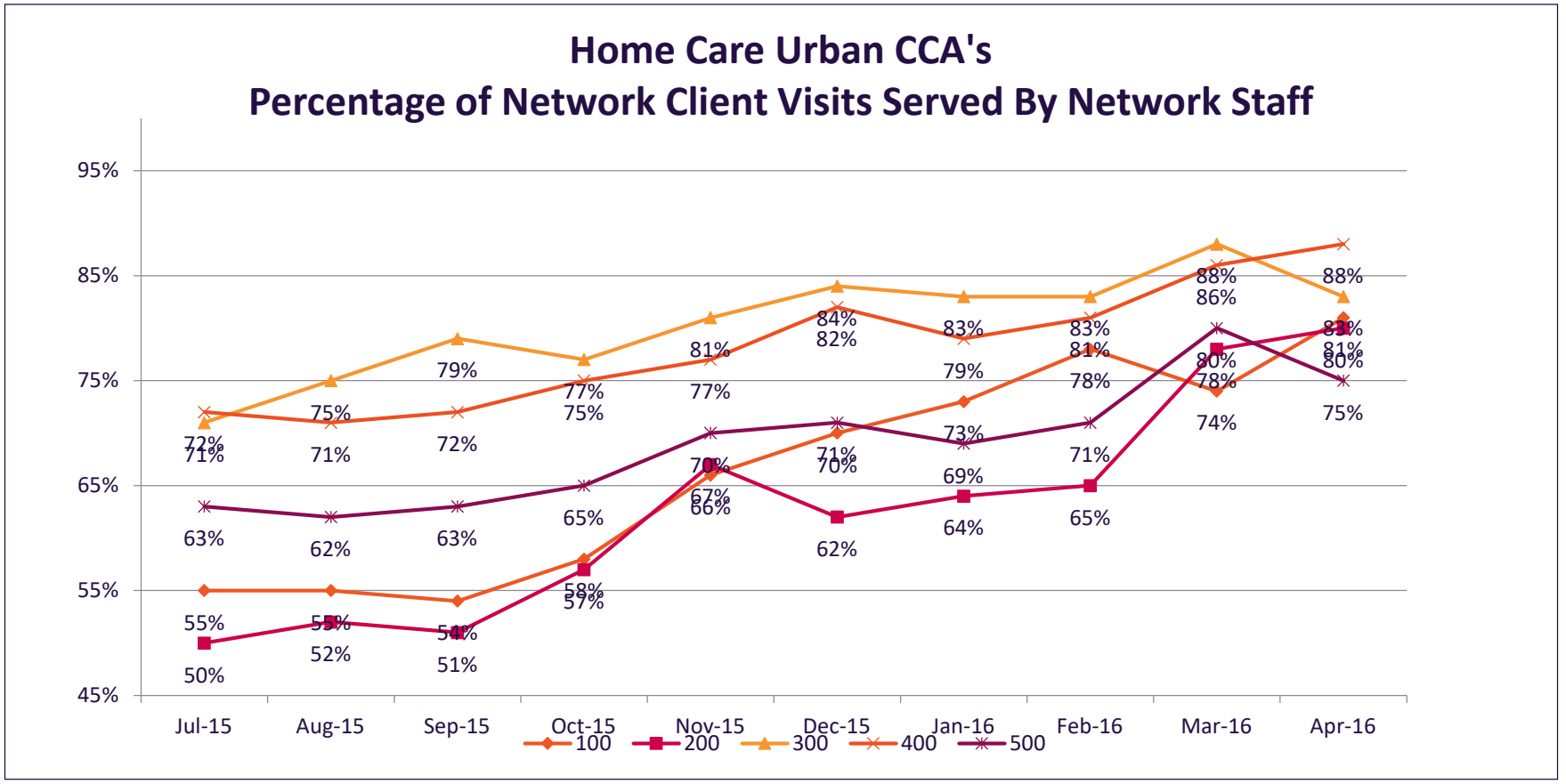
Home Care Consistency



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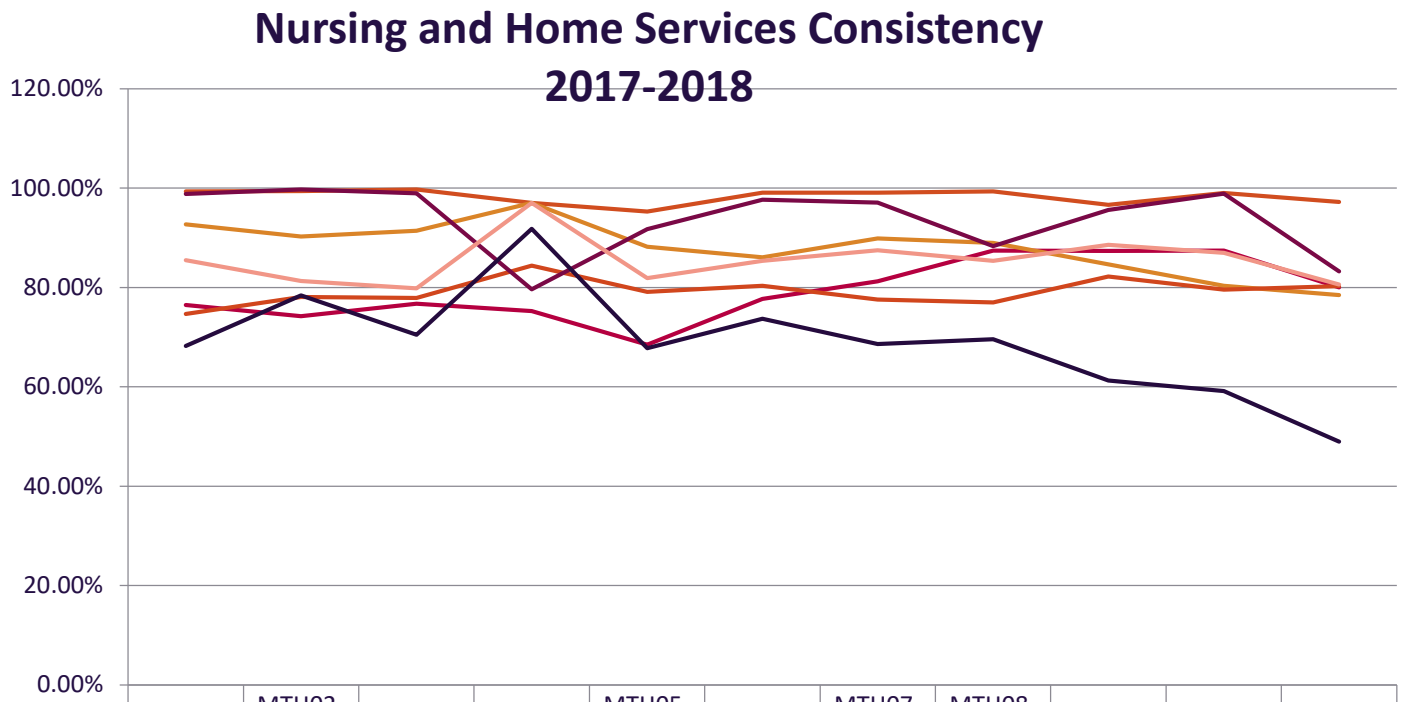
Home Care Consistency – Major Goal



Consistency is calculated by matching the leading number in the client area to the leading number in the employee area. This chart displays the percent of

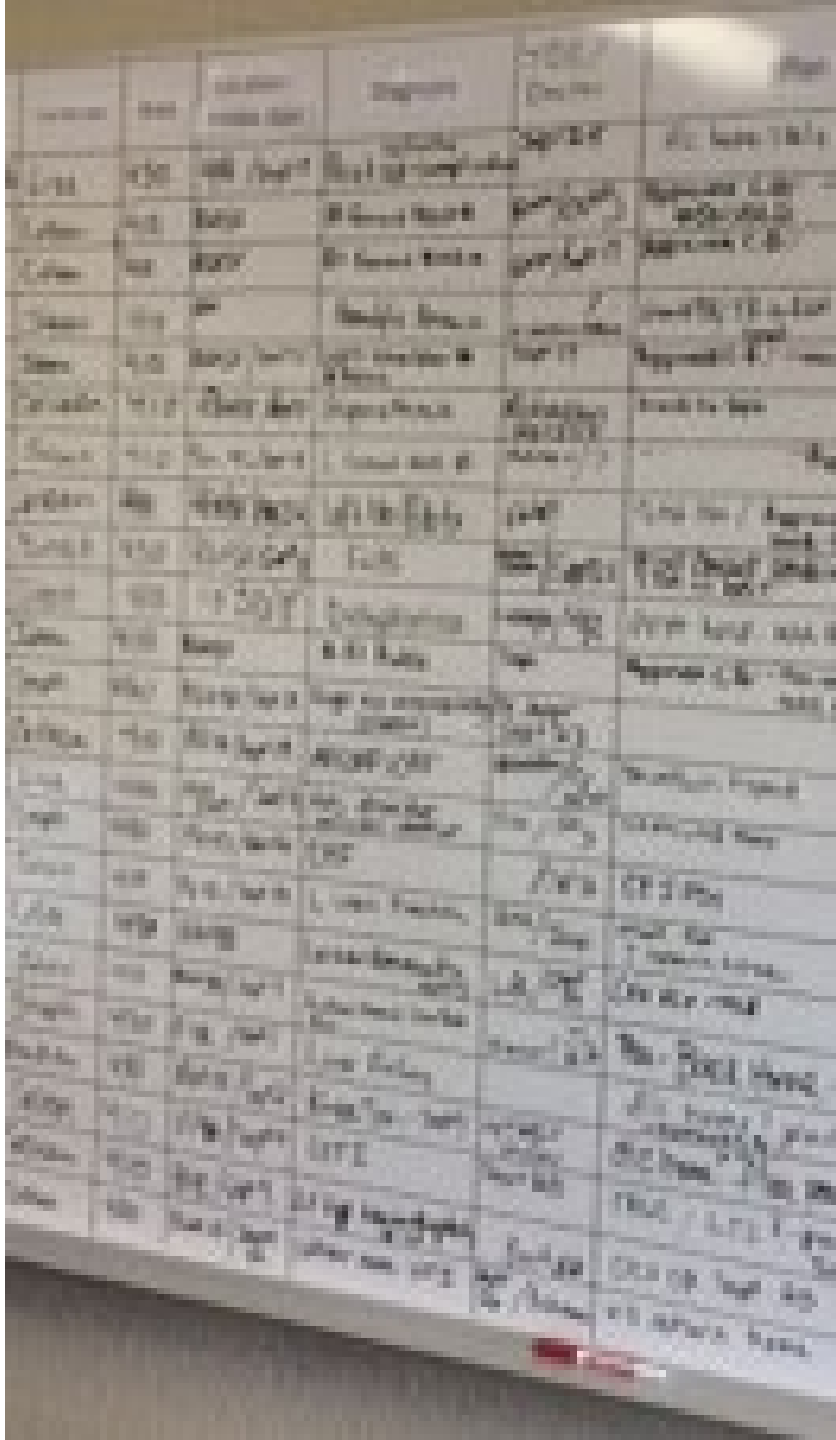
	MTH01-APR 2017	MTH02-MAY	MTH03-JUN 2017	MTH04-JUL 2017	MTH05-AUG	MTH06-SEP 2017	MTH07-OCT	MTH08-NOV	MTH09-DEC 2017	MTH10-JAN18	MTH10-FEB 2018
PRAIRIE EAST NETWORK	99.38									%	97.24%
REGINA CENTRAL NETWORK	76.45									%	80.00%
REGINA NORTH NETWORK	92.71									%	78.46%
REGINA SOUTH NETWORK	74.68									%	80.29%
TOUCHWOOD QUAPPELLE NETWORK	98.86									%	83.27%
TWIN VALLEYS NETWORK	68.20									%	48.95%
REGINA EAST NETWORK	85.52%									6%	80.58%

**Continuous improvement:
Moving to measuring # providers in caseload every 6 weeks….Goal 3-4 max
i.e. a more detailed measure of consistency

Connected Care Huddles

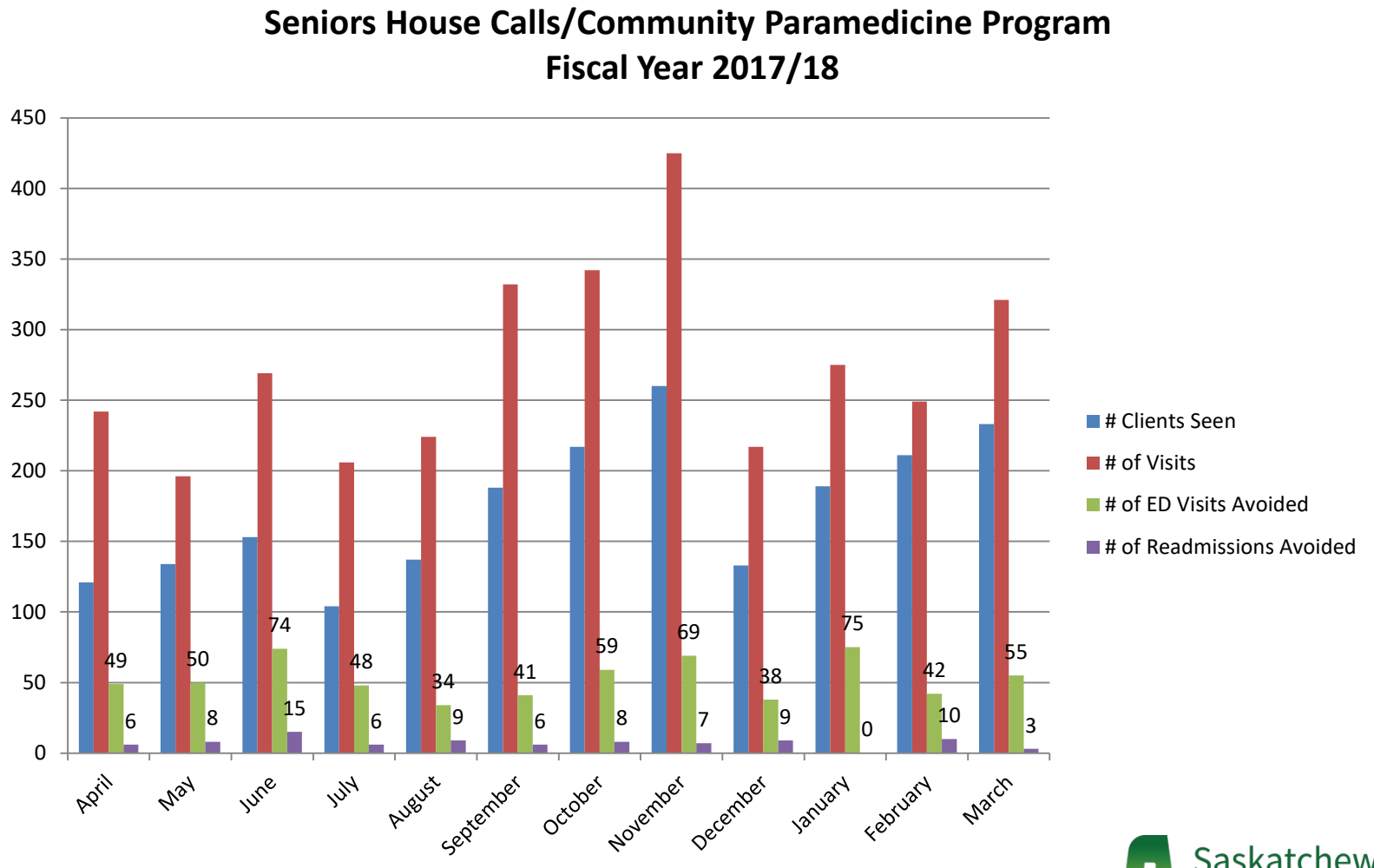
(**Network** Interdisciplinary Rounds – not just home care)

- Daily team rounds with Visual Management:
  - Clients at risk of deterioration – put action plan in place to meet their needs in community
  - Clients in acute – prepare for return and plan to prevent re-admissions



Senior's House Calls Outcomes

Intermediate Care Services



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High Quality Care Transition Activities

Adapted from: Burke et al. (2014)

System Measurement and Evaluation

- Defect Metrics: (We can measure today – Saskatchewan System)
  - CTAS 4,5 (and some 3's)
  - 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

  - Goal Metrics:
    - Those Above broken down by Network
    - Acute Admissions – Why?? identifying "gaps" in community care services
    - Hospital encounter data for clients identified as "attached" to programs: Home Care, Sr. House Calls, Chronic Disease Management - etc.

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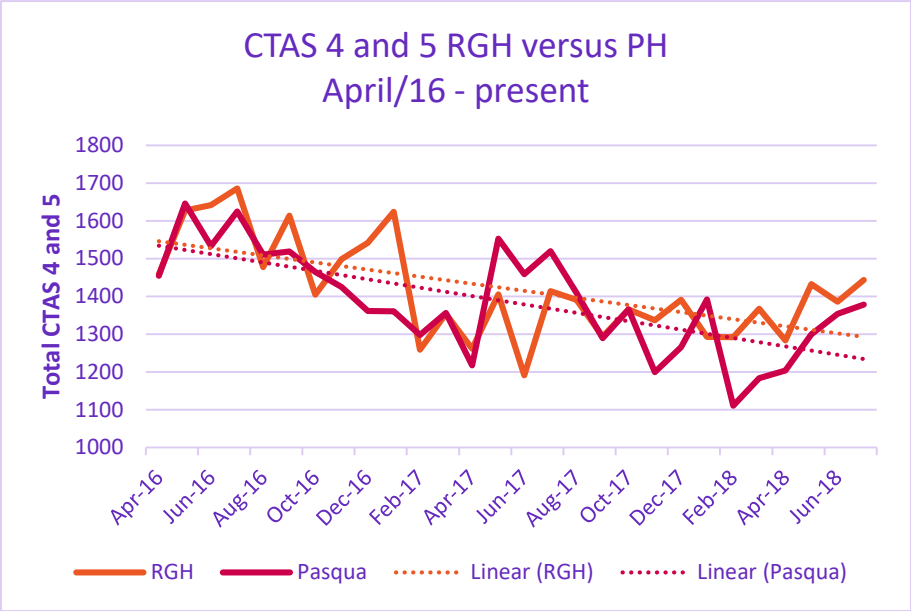
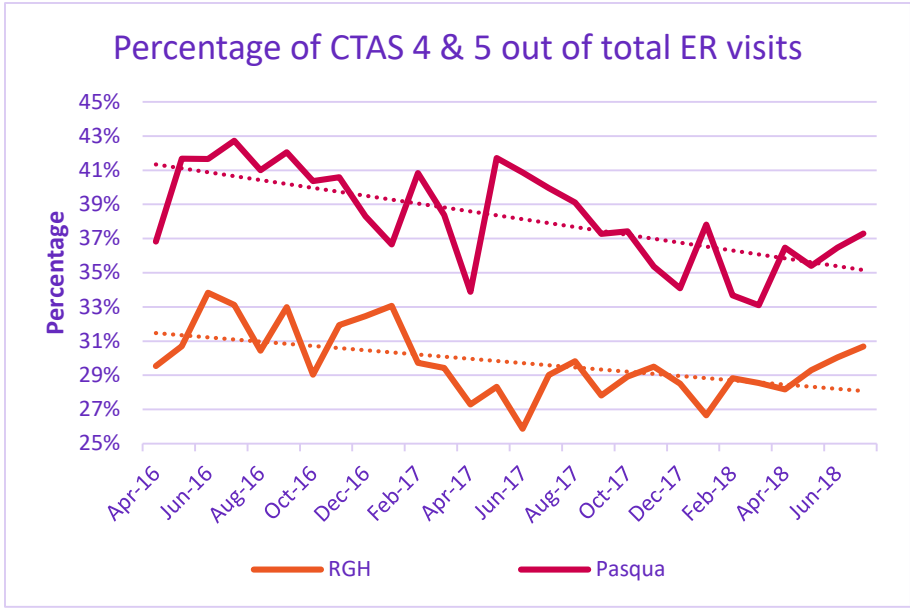
System Outcome Metrics:





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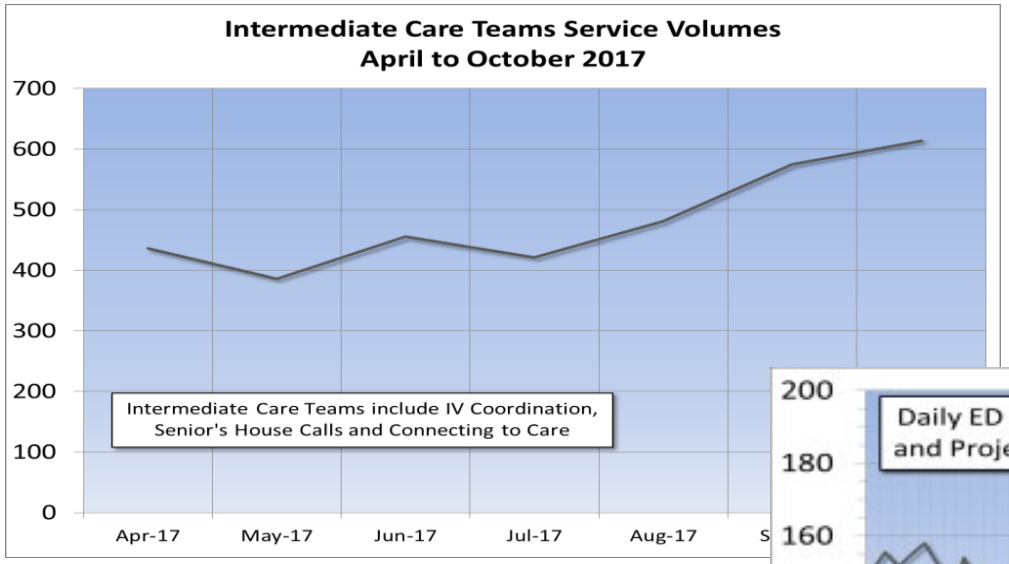
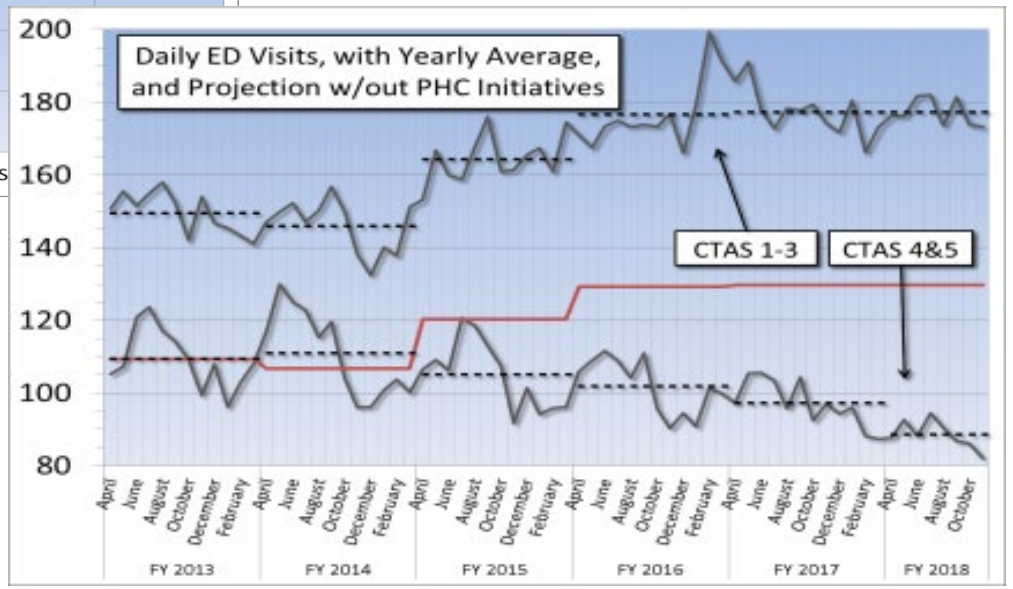
System Outcomes – Regina ED's





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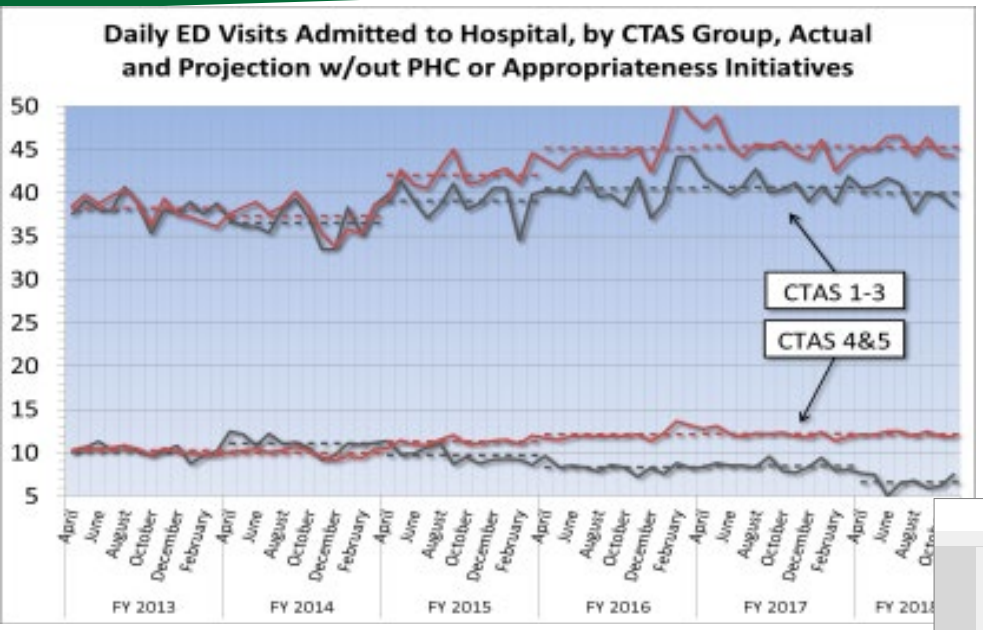

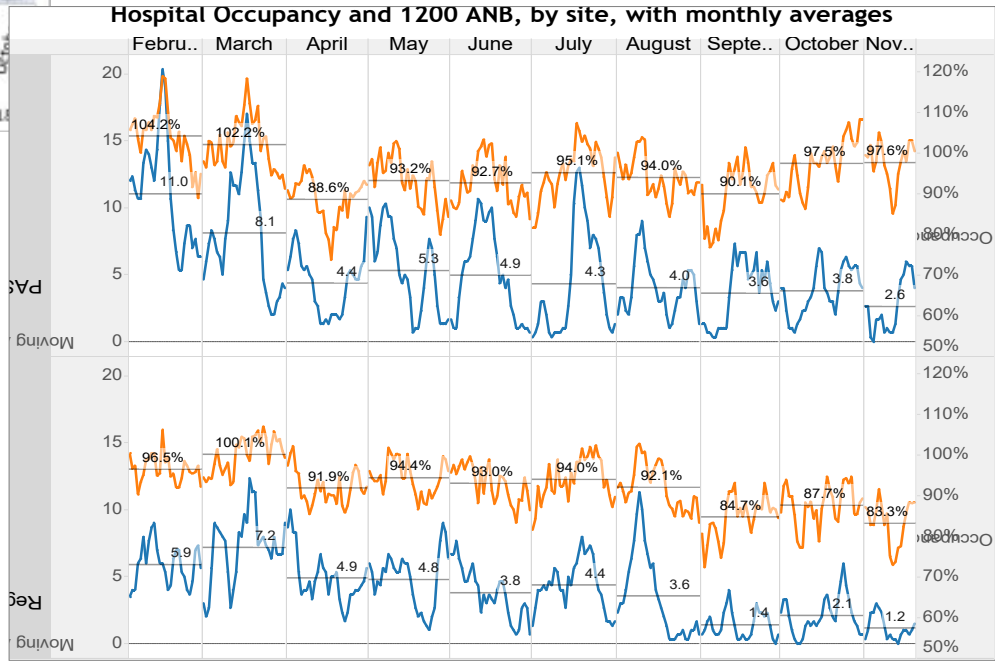

Questions?

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