Partners Advancing Transitions in Healthcare

Delivering Value, Improving Outcomes and Patient Experience Through Authentic Engagement

Southlake Regional Health Centre
6th Annual Geriatric Clinic Day
April 16, 2016

Presented by:
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PATH Executive Lead
What is PATH?

Partners Advancing Transitions in Healthcare

Funded by The Change Foundation

Test a totally new approach for Ontario - EBCD and Community Partnerships - to prompt system-wide change

A partnership of patients, caregivers, and health care providers

A partnership who are working together to understand the experiences at key transitions in the healthcare system

Grounded in engaging patients and their caregivers in experience based co-design (EBCD)
Northumberland Community

The Northumberland community is located about 1 hour east of Toronto on the northern shore of Lake Ontario.
Demographics

Age Distribution > 65 Years

1. Cobourg: 26.40%
2. Port Hope: 20.20%
3. Hamilton: 15.70%
4. Alnwick/Haldimand: 18.00%
5. Cramahe: 16.20%
6. NHH Catchment: 20.70%
7. Northumberland CD: 21.80%
8. Ontario: 14.60%

Source: Statistics Canada 2011 Census
PATH Target Population: Seniors living with chronic health conditions

Tier 1: Top 1%
- Frequent acute care, transitions
  - 120 Northumberland residents
  - 32% of all acute services

Tier 2: Top 2 - 20%
- Periodic acute care, transitions
  - 2,300 Northumberland residents
  - 66% of all acute services

Tier 3: Bottom 21-100%
- Very rare acute care, transitions
  - 9,600 Northumberland residents
  - 2% of all acute services

PARTNERS ADVANCING TRANSITIONS IN HEALTHCARE

Using Innovative Enablers to Enhance Patient Experience Across the Continuum of Care
Innovative *Enablers* to Enhance Patient Experience Across the Continuum of Care

1. It Starts with a **Non-Traditional Partnership**
2. Refocusing - **Person Centred Care**
3. Moving Beyond LEAN – **Experience Based Co-Design**
4. Putting the ‘Heart’ Back to Healthcare - **Hearing the Stories**
5. Weaving **Best Practice** into Everything we Do
Northumberland Community Partnership

Patients and caregivers recruited from the Northumberland community

Healthcare Providers
• Northumberland Hills Hospital
• Northumberland Family Health Team
• NHH Community Mental Health Services

Community Providers
• Central East Community Care Access Centre
• Community Care Northumberland
• Golden Plough Lodge Long Term Care Home
• Palisade Gardens Retirement Residence
• YMCA Northumberland

Others
• Central East Local Health Integration Network
• Health System Performance Research Network
• Patients’ Canada
• QoC Health (Technology)
PATH Person Centered Care Model

Core Principles
Respecting and honouring the beliefs of persons and families
Collaborative engagement and partnership with persons and families
Excellent communication for shared decision making with persons and families
Holistic care with persons and families
Empathetic relationships with persons and families
An exciting **new way** of bringing patients, caregivers and healthcare providers together

**Sharing the role of improving care** through the re-design of services

**Use the power of stories** to:
- Capture and understand experiences and the **impact** of those experiences
- Drive quality improvement initiatives
- Engage & mobilize project teams
# Evolution of Patient Experience in Healthcare

**Doing “to” patients**  
Barbara Balik, Common Fire, Meeting of the Minds June 2011

<table>
<thead>
<tr>
<th>To</th>
<th>For</th>
<th>With</th>
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<tbody>
<tr>
<td>Provider makes rules and controls all schedules</td>
<td>Patient/family have some input</td>
<td>Patient/family as source of control</td>
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<tr>
<td>Information not shared with patients</td>
<td>Some transparency, public data</td>
<td>Shared knowledge and decision making</td>
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<tr>
<td>“I talk-you listen”</td>
<td>“We help you”</td>
<td>“We walk together”</td>
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<tr>
<td>Compliance focus</td>
<td>Improvement focus</td>
<td>Co-design focus</td>
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<tr>
<td>Unilateral</td>
<td>Benevolent</td>
<td>Partnership</td>
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Phase 1: Gathering Of Stories

Capture the experience
Understand the experience
“We encountered this a lot when [spouse] was slipping into severe anxiety and depression and we were trying to find effective treatment. We were having trouble seeing our doctor. There was a case where the doctor referred us to the (specific) program. We heard nothing for weeks. When we went back to the doctor she said “Oh, they said [spouse] was too far gone for them to effectively intervene so they bounced it back to me”. Well, nobody told us that. … By the time we actually got an appointment, [spouse] had been to the ER twice (INT EE-FF 31, 31).
Understanding Patient Needs

What We Know:

• Patient’s can identify their own needs
• One size does not fit all – people live with multiple and different types of chronic illnesses
• When needs aren't responded to the needs become greater and there is an adverse impact on the person, the caregiver, and the system

How PATH Can Help:

• Provides a mechanism to ensure that our system truly puts the needs of patients at its centre
• Contributes to a body of knowledge that ensures the system can respond to self-identified needs
“There is no break. I do get out twice a week for half an hour to get groceries. And once a week I go to the bank for 15 minutes. That’s it. There’s no help. ..I wish there was something more they could do for caregivers. I have a sister who just lost her husband a year ago. And she was doing exactly what I am doing. Caregiver for 2 years. She said “Do you ever just all of a sudden stop and cry for no reason? I said “Yeah, buckets” (INT 34).
Understanding Caregiver Needs

What We Know:

• Caregivers are an important and integral part of the healthcare circle but are often excluded from the conversation
• Informal caregivers are the coordinators of care
• Caregiver burnout must be prevented
• Caregiver needs must be attended to and supported

How PATH Can Help:

• PATH puts the caregiver in the centre of care together with the patient
• Provides a mechanism to understand caregiver needs so that the healthcare system can respond
PARTNERS ADVANCING TRANSITIONS IN HEALTHCARE

NEW Innovative Solutions to Enhance Patient Experience Across the Continuum of Care
NEW Innovative Solutions to Drive Enhanced Patient Engagement

Developed Using Experience-Based Co-Design, A new Person-centered Care Model:

- The PATHway to Aging Well Portals and Mobile App
- A Volunteer Transition Coach Model / Service
- A Community Patient / Family Advisor Model

- Patient and Provider Portals, Dashboards, and Mobile Apps
- EMR Integration
- Mobile Health Briefs
- Adaptable Clinical Monitoring
- Personalized Journaling
- Real time Patient Experience Measures
- Needs Tracking
- Planning Tools
- Resources
- Analytics and Reporting

NEW Innovative Solutions to Drive Enhanced Patient Engagement
Powered by QoC and RelayHealth

**Patient Portal**
- Dashboard
- Organizer / Notes
- Aging well
- My life story
- My health story
- Resources
- Summaries
- PHR module
- Messaging module
- Detailed personal health information

**Provider Portal**
- Dashboard
- Reports / Summaries
- Monitoring data
- Resources
- Access to patient health summary
- Messaging module

**Patient Mobile**
- Monitoring
- Summaries
- Health brief
- Share Experience
- Care provider info
- Note taking
- Resources

**HIS Systems**
- Northumberland Hills Hospital
  - Meditech
- Family Health
  - EMR’S
- CCAC
  - CHRIS

Data transformations to health information systems.

Partnering Advancing Transitions in Healthcare
A first with Ontario patients

Powered by QoC and RelayHealth
Planning Ahead and Aging Well

- This project element focuses on building community awareness to empower people to shape how they age, access care, manage their own health, and stay well.

www.pathwaytoagingwell.com
My Health Experience

This project element focuses on providing a means for people:

- To present themselves as a person to the healthcare system
- To build a stronger relationship with their providers
- To shape the narrative of their care
- Accessible online patient/caregiver/provider portal

<table>
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<tr>
<th>My Health Story</th>
<th>My Life Story</th>
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<td><em>Includes information pertaining to an individual's health (e.g. personal &amp; family health history, conditions and treatments, decision makers, monitoring,)</em> to share with providers.</td>
<td><em>Includes important facts about the person (e.g. life experiences, family, personality, daily routines, comforts, goals)</em> to share with providers.</td>
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Health Timeline

This timeline will quickly present the significant health events that I have experienced in my life (e.g. date/year of heart attack, stroke, surgeries) also the date when first diagnosed with my chronic conditions.

Jan 2012

- **Stroke**
  - Dr. Ethan McAndrews
  - Sunnybrook Hospital
  - Complication: Completely paralyzed on the right side, no speech, frozen face

Jan 2012

- **Angioplasty**
  - Dr. Sharan Alexander
  - Sunnybrook Hospital
  - Complication: Stroke

Mar 1998

- **Right Medial Meniscus Knee Surgery**
  - Dr. Jacob Diesel (Surgeon)
  - Toronto General Hospital
  - Complications: Infection

Apr 1991

- **Hospitalized with Severe Pneumonia**
  - Dr. William Morgan (Family Physician)
  - Credit Valley Hospital (Mississauga)

Apr 1982

- **Tonsillectomy Surgery**
  - Dr. Michelle Huang (Surgeon)
  - Credit Valley Hospital (Mississauga)
  - Complications: N/A
Real Time Feedback
After Each Healthcare Encounter
Self Monitoring and Communicating Self Identified Needs
NEW Innovative Solutions to Drive Enhanced Patient Engagement

The PATH e-solutions empower seniors and their caregivers to:

- Self-manage their conditions with their primary care providers
- Engage in their care thereby shifting the locus of control to the patient
- Have access to enhanced care coordination

Case Study:
Over a One Year Period
Visits prior to PATH:
7 Emergency Room and 18 Physician

Visits with PATH:
0 Emergency Room and 8 Physician
New Ways of Learning and Evaluating Data Generation from Older Persons/Caregivers

Needs  Barriers  Experiences  Gerontological Impact
New Ways of Learning and Evaluating
The Power Of Community Engagement
PATH Volunteer Transition Coaches
SUPPORTING SENIORS & CAREGIVERS

What We Know:

- Seniors and caregivers need assistance with healthcare transitions.
- Providers often put more emphasis on the medical perspective rather than the lived day to day experience.
- Seniors and caregivers respond to those who have similar lived experiences.
- Seniors need assistance with new technology.

How Can PATH Help:

- We have learned that we have a huge untapped resource in each of our communities.
- We have implemented a successful Volunteer Transition Coach (VTC) model.
- The PATH VTC can be easily replicated in other communities.
Marilyn and Jim’s Story

Video
What does PATH mean for me as a senior/caregiver?

By participating in PATH, it will allow me to:

- Present my self-identified health needs.
- Experience person-centred care.
- Age well by planning ahead; access resources, information, and planning tools.
- Get assistance from a Transition Coach (if I need one).
- Share real-time feedback on every healthcare encounter I have.
- Communicate with providers my life story and who I am as a person.
- Share my health story with providers. Once.
- Track and monitor my health conditions from home.
QUESTIONS?