Breaking Bad....Barriers

CHNC Conference 2018 - Regina

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Alberta Health Services

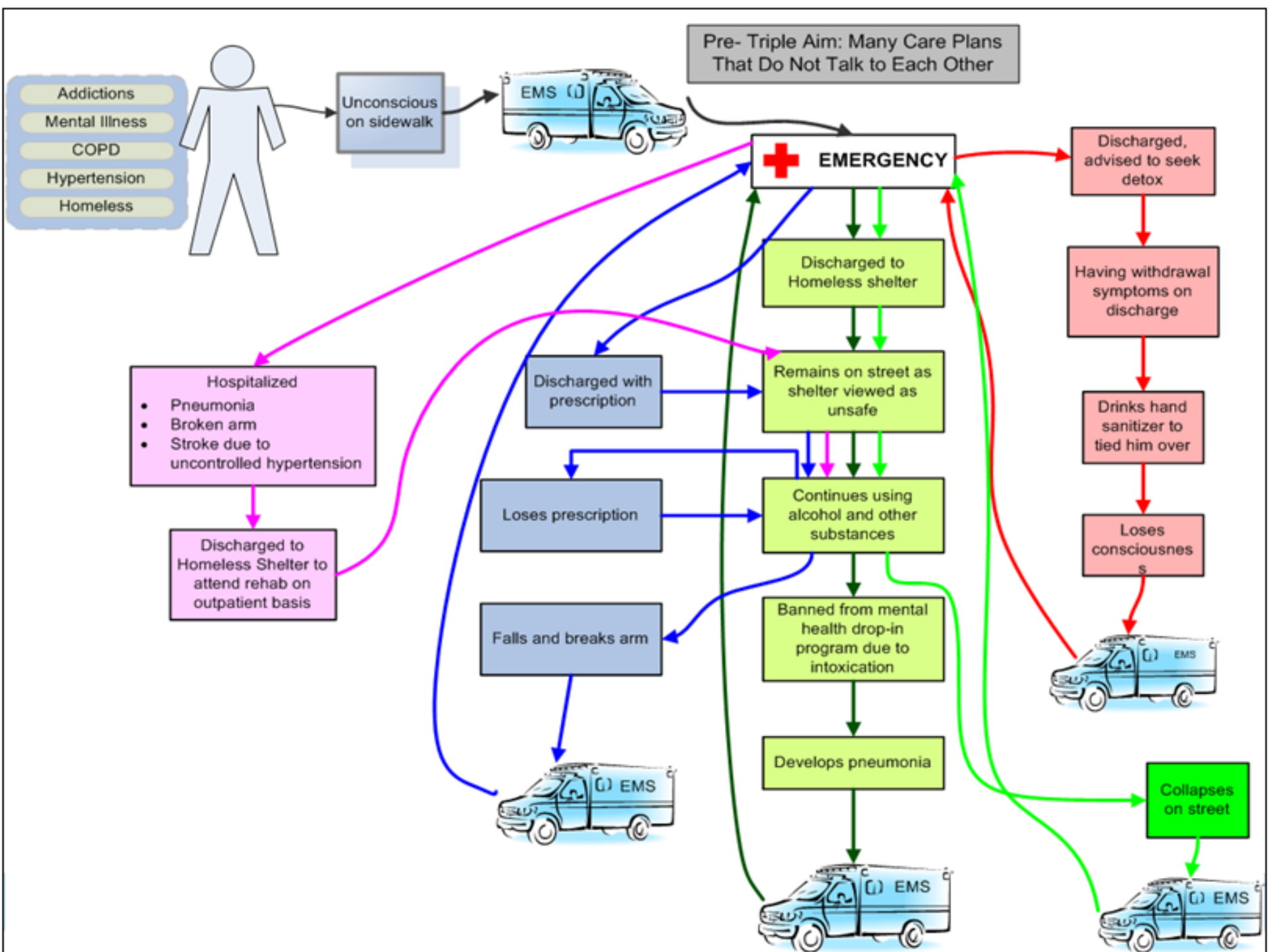
Breaking Bad... Barriers: Leading and Measuring Integrated Approaches for Change with Vulnerable, Complex Clients.

Outline –

- Brief Initiative Overview
- Data Sources and Measures
- Findings
  - What works
  - Barriers
- Collective Impact
- Action on Partnerships
- Q&A

The Triple Aim Initiative 2012-2016

Addictions & Mental Health – Inner City
Home Care
East Edmonton Health Centre – Family Care Centre
Enhanced Services for Women & Addiction
Boyle McCauley Health Centre (CHC)
Emergency Medical Services
Palliative Care (Home Care)


Pre- Triple Aim: Many Care Plans That Do Not Talk to Each Other
Addictions
Mental Illness
COPD
Hypertension
Homeless
Unconscious on sidewalk
EMS
EMERGENCY
Discharged, advised to seek detox
Having withdrawal symptoms on discharge
Drinks hand sanitizer to tied him over
Loses consciousness
Collapses on street
Discharged to Homeless shelter
Remains on street as shelter viewed as unsafe
Continues using alcohol and other substances
Banned from mental health drop-in program due to intoxication
Develops pneumonia
Discharged with prescription
Loses prescription
Falls and breaks arm
Hospitalized
Pneumonia
Broken arm
Stroke due to uncontrolled hypertension
Discharged to Homeless Shelter to attend rehab on outpatient basis

Bill's Story

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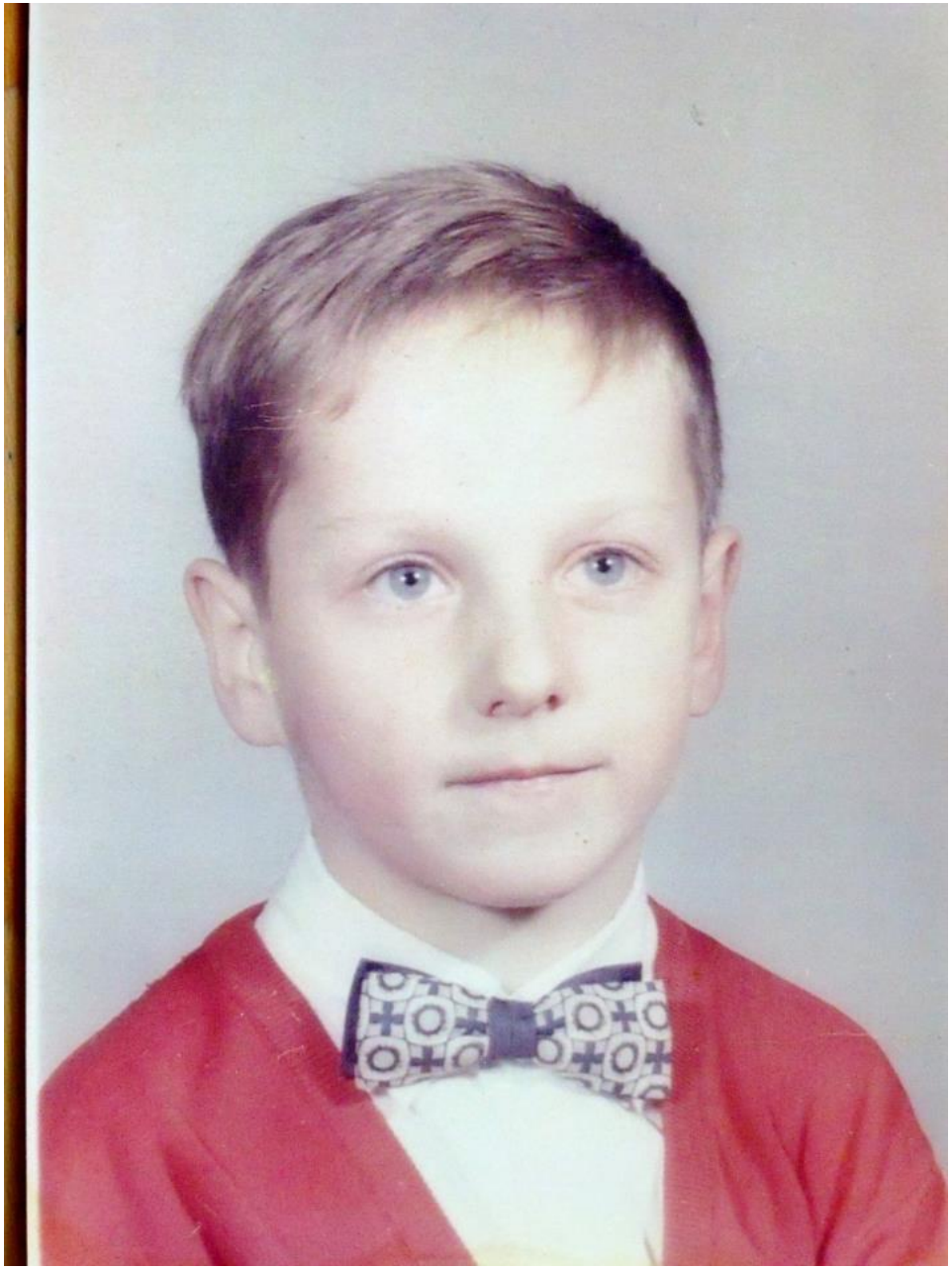


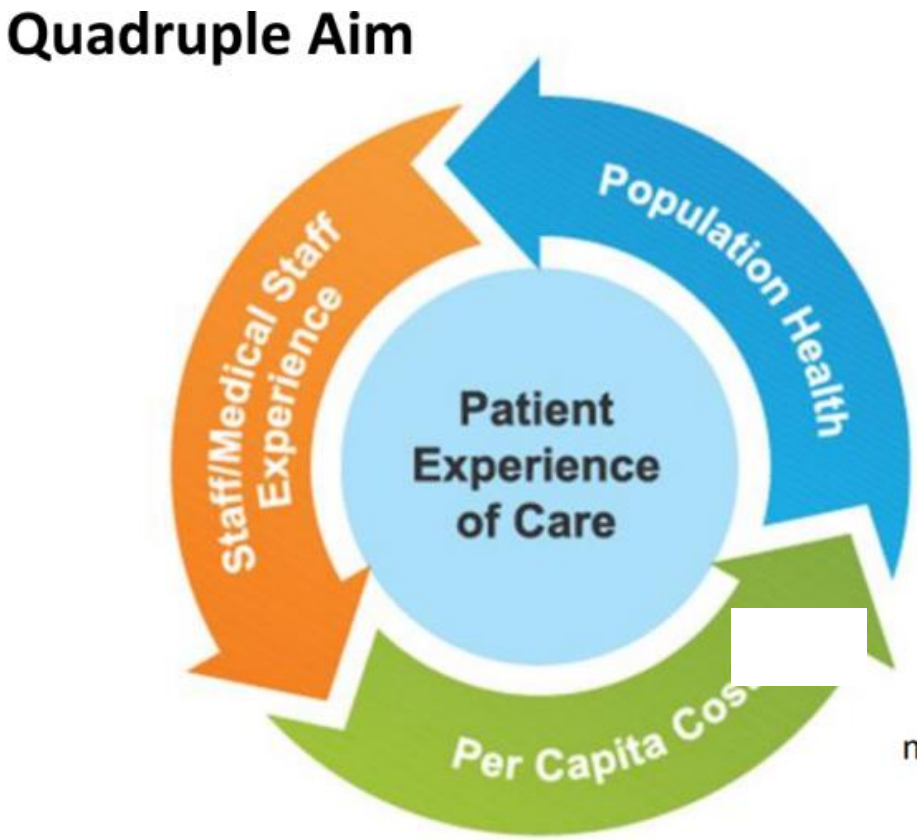

GIANT

Triple Aim for Populations Approach and Care Redesign Guide: Better Health and Lower Costs for People with Complex Needs

http://www.careredesignguide.org/

IHI, 2017

Our Vision – Action and Evaluation*



*Evaluation funding supported by Alberta Innovates and Merck Canada

Evaluation – Measures Used

Quantitative and qualitative data sources:

- Questionnaires (semi-structured interviews) with Clients, Team Staff and the Support Team
- Client Administrative Data (system level data)
- Focus groups with Clients, Team Staff and the Support Team.

System Measures

EXPERIENCE OF CARE

Administrative Data on Ambulatory Care Sensitive Conditions (ACSC)

Family Practice Sensitive Conditions (FPSC)

Usual Provider Continuity (UPC) Index

HEALTH STATUS

Canadian Triage and Acuity Scale (CTAS)

Clinical Risk Group (CRG)

Emergency Department (ED) visit

Urgent Care Centre (UCC) visit

EMS Utilization: call and transport

Inpatient Admission (includes Intensive Care Unit (ICU) if applicable)

System Measures II

COST

ED and Inpatient Cost

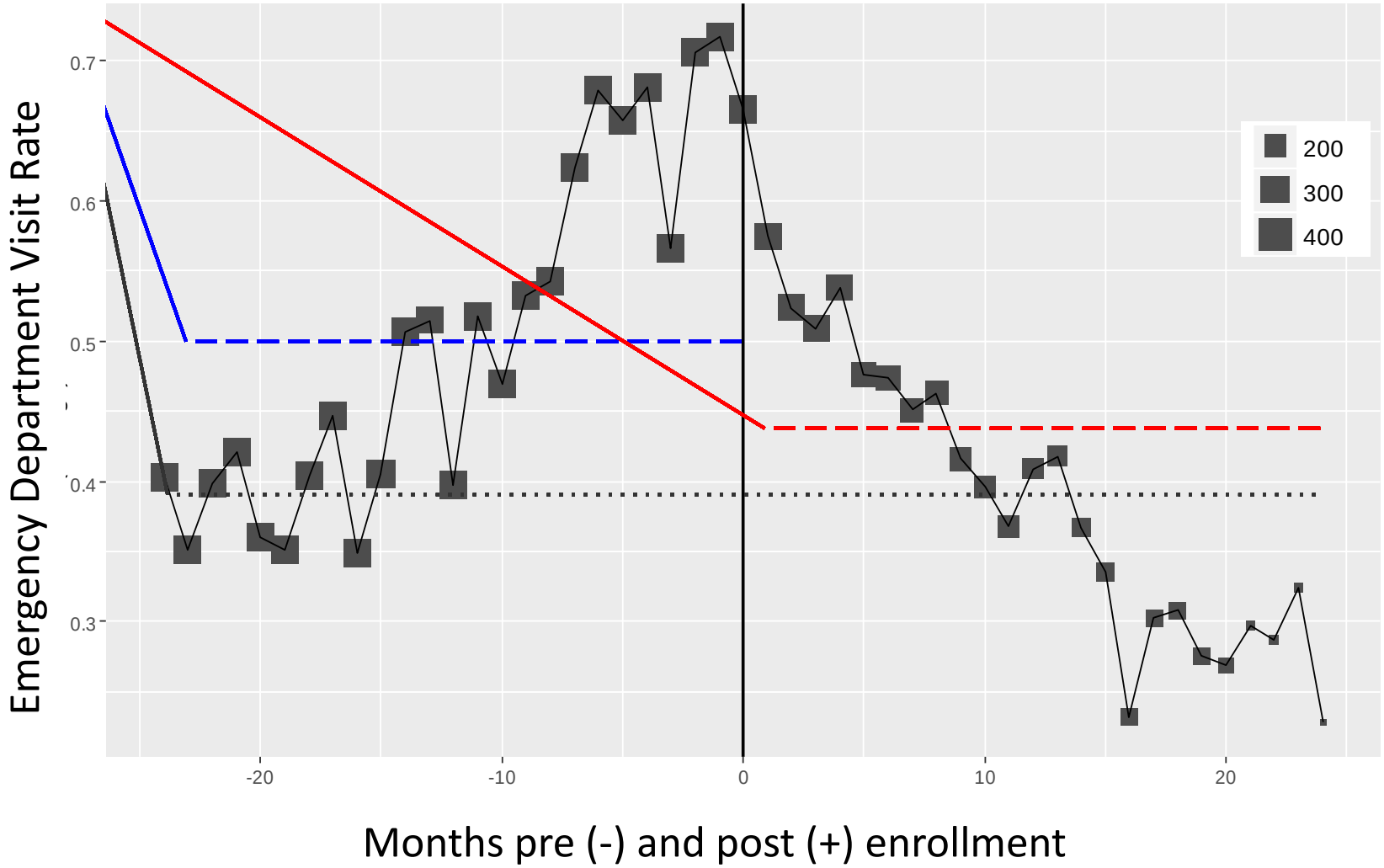
Inpatient Resource Intensity Weight (RIW)

ED Resource Intensity Weight (RIW)

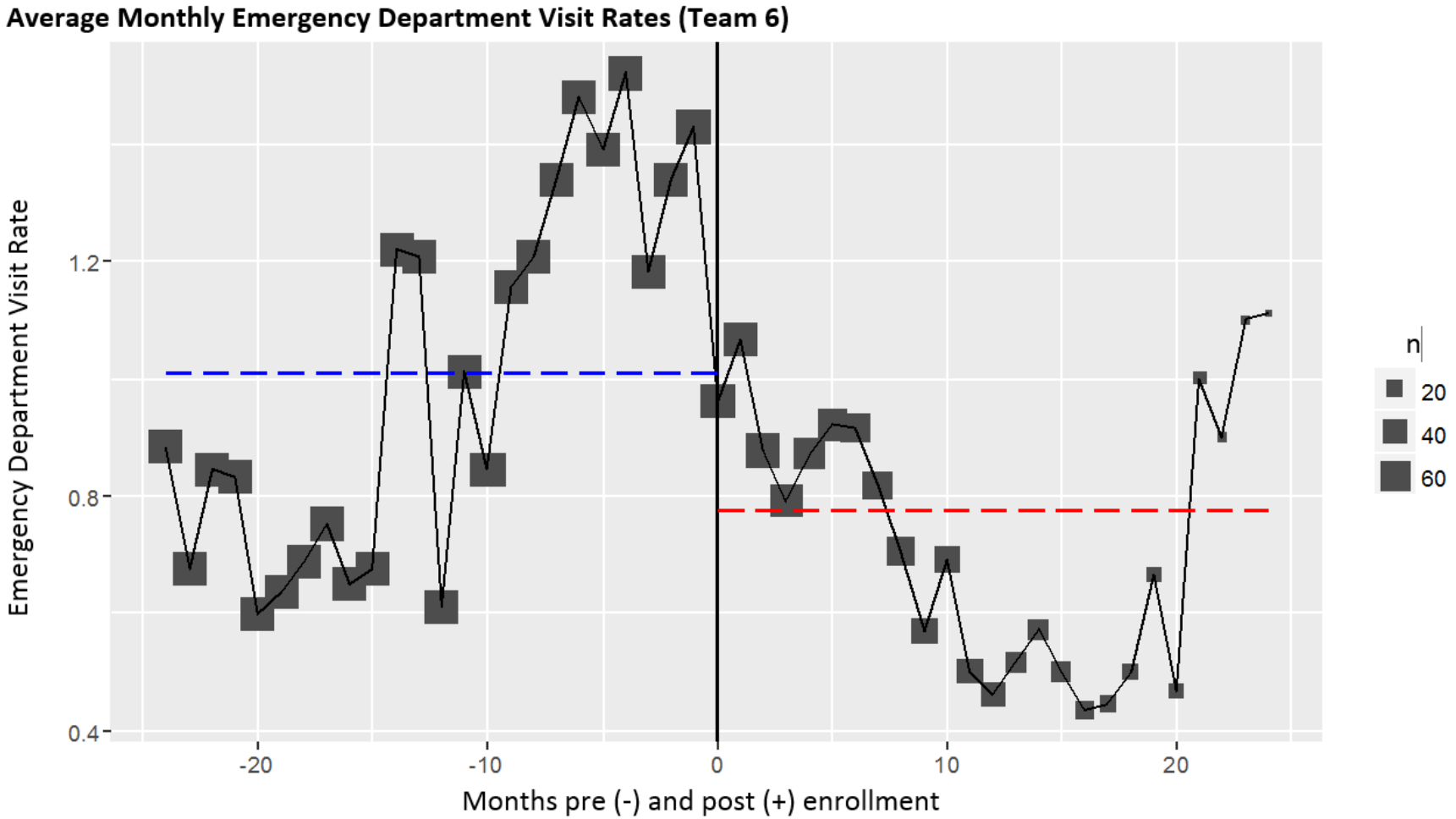
Activity Tracking Sampling

Unable to get average costs for EMS

Average Monthly Emergency Department Visit Rates



Some programs had more success: Cohort: Addiction and Mental Health



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Average Monthly Rates for Emergency Department Visits for CTAS 4s and 5s

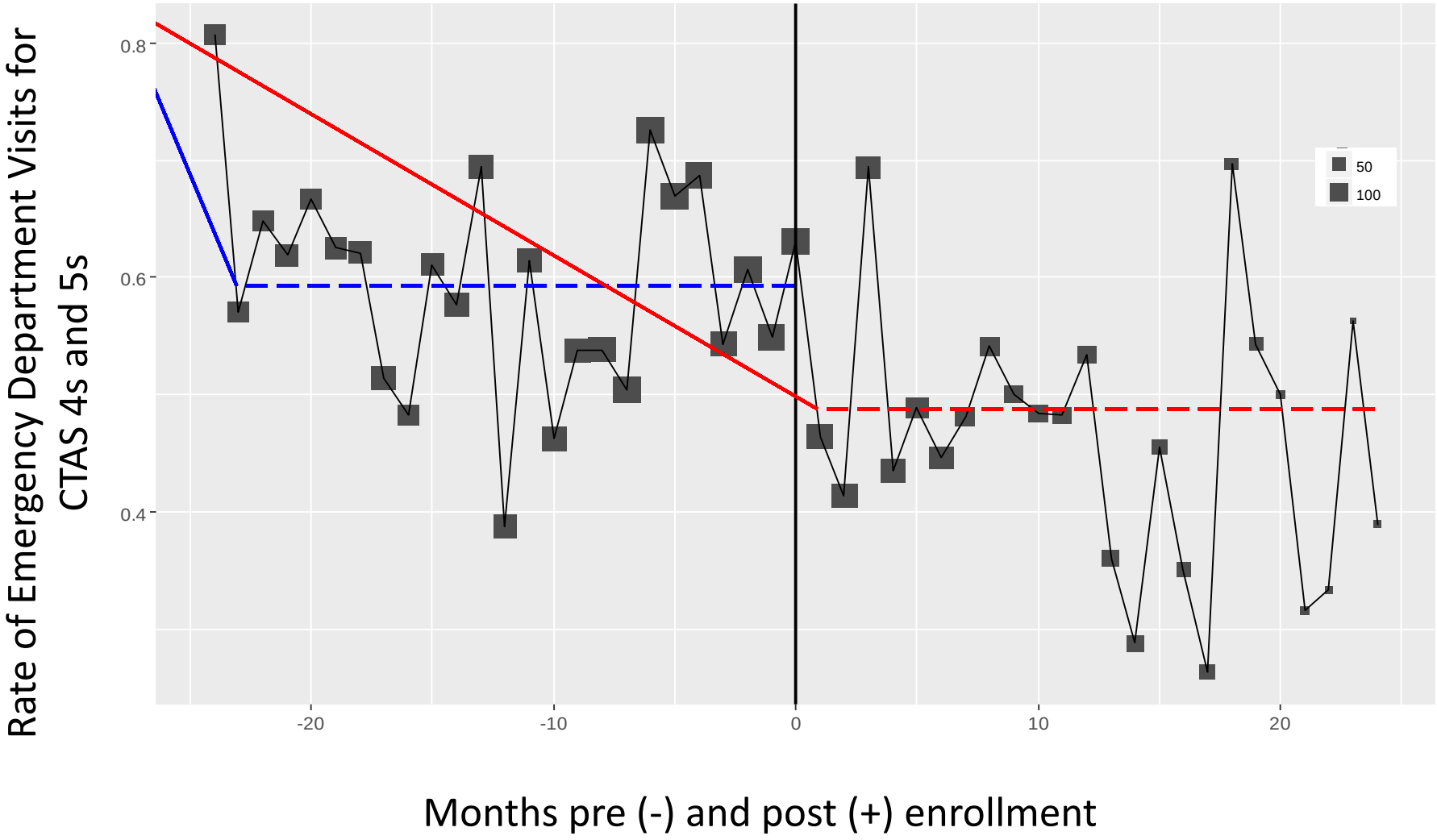


Tableau Example 1 – by Team

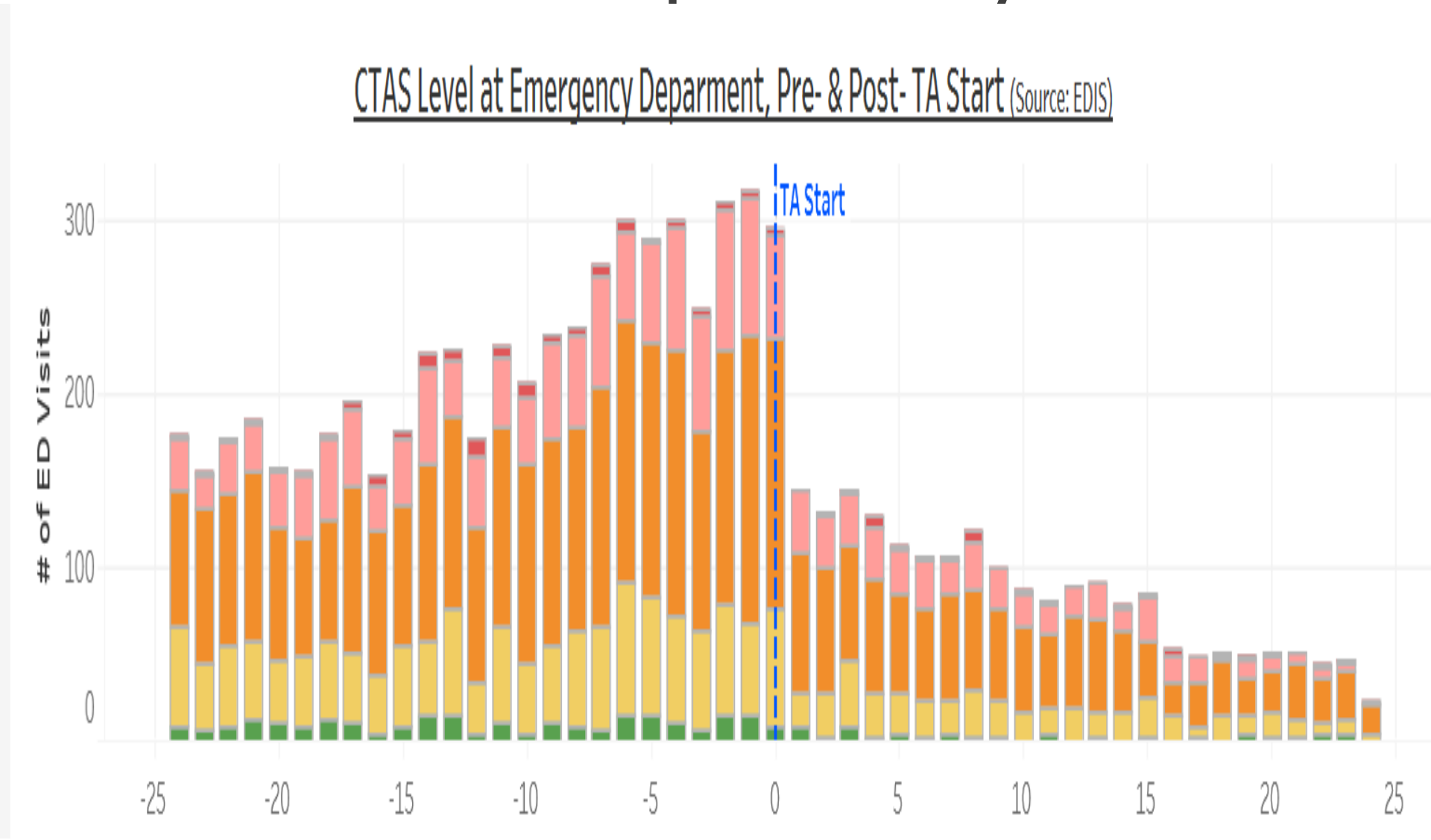


Tableau Example 2 – By Case

01-065	2
01-100	6
01-133	2
01-149	2
01-166	3
01-168	2
01-179	2
01-195	2
02-004	2
02-014	3
02-060	3
02-064	4
02-061	6
02-066	2
02-094	2
02-102	6
02-110	2
02-114	2
06-019	2
06-019	3
06-026	2
06-050	2
06-041	3
06-064	2
06-072	2
06-076	3
06-079	2

(Fiscal ye 201617 :h 31)

Instructions

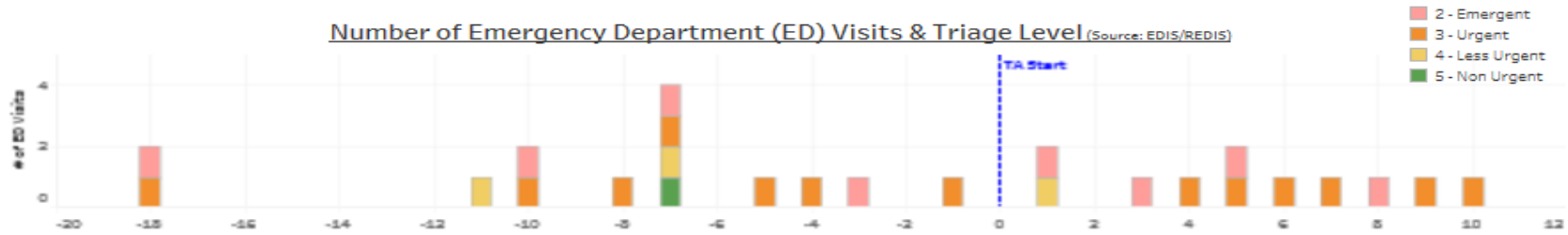
This *section* shows you clients' number of visits before and after the start of Triple Aim. Please select a ID Number below:

06-061

You have selected the following Client:

ID Number	Gender	Age	Team	Current Status
06-061	Male	60	HC	Discharged

Month, Day, Year of Start Date	TA month	Month, Day, Year of Discharge Date	Reasonfor Discharge
February 17, 2016	12	February 6, 2017	Deceased



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Questionnaires/Focus Groups

EXPERIENCE OF CARE/PROVIDING CARE

Provider Interview

Staff Focus Groups

HEALTH STATUS

EQ-5D-5L

Intake, Monthly and Semi-Annual Semi Structured Interviews

Results: Common Patient Barriers

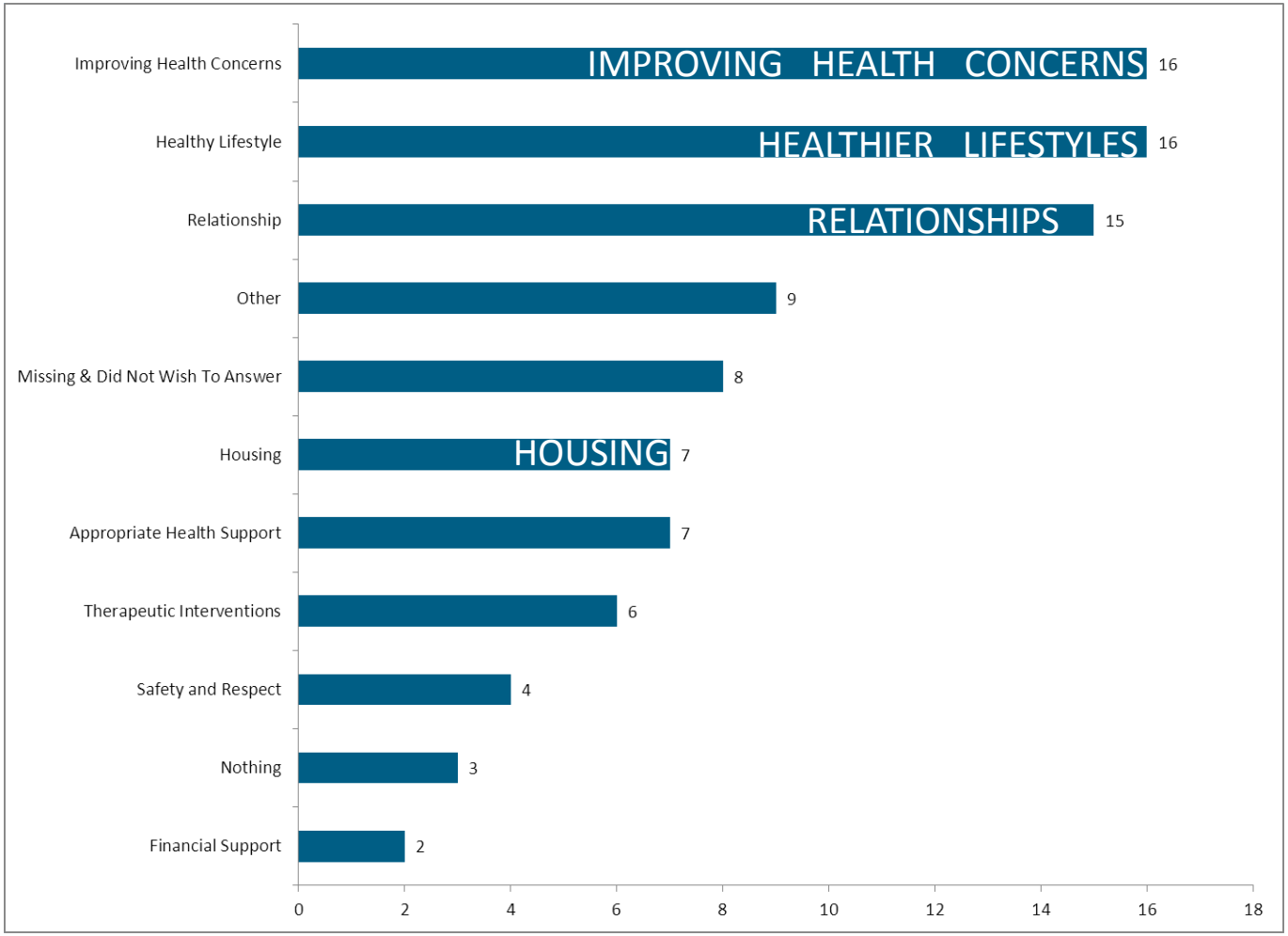
Patient Barrier Themes - Before

- Providers didn’t look at patients’ broader needs
- Providers didn’t know what was available to increase these clients’ success with healthier living and opportunities for improved quality of life
- Providers didn’t talk to each other, or look at each others’ actions with same patient
- Little coordination of care or services
- Some clients experienced stigmatization

What Works: Meet Needs, Relationships and Respect, Coordination

Frequencies of Grouped Client Responses Regarding "*One Thing to Feel Healthier*?"

Themes From Client Responses on What Would Make Clients Feel Healthier



Number of Responses Per Theme

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Some Patient Experience Results (small sample)

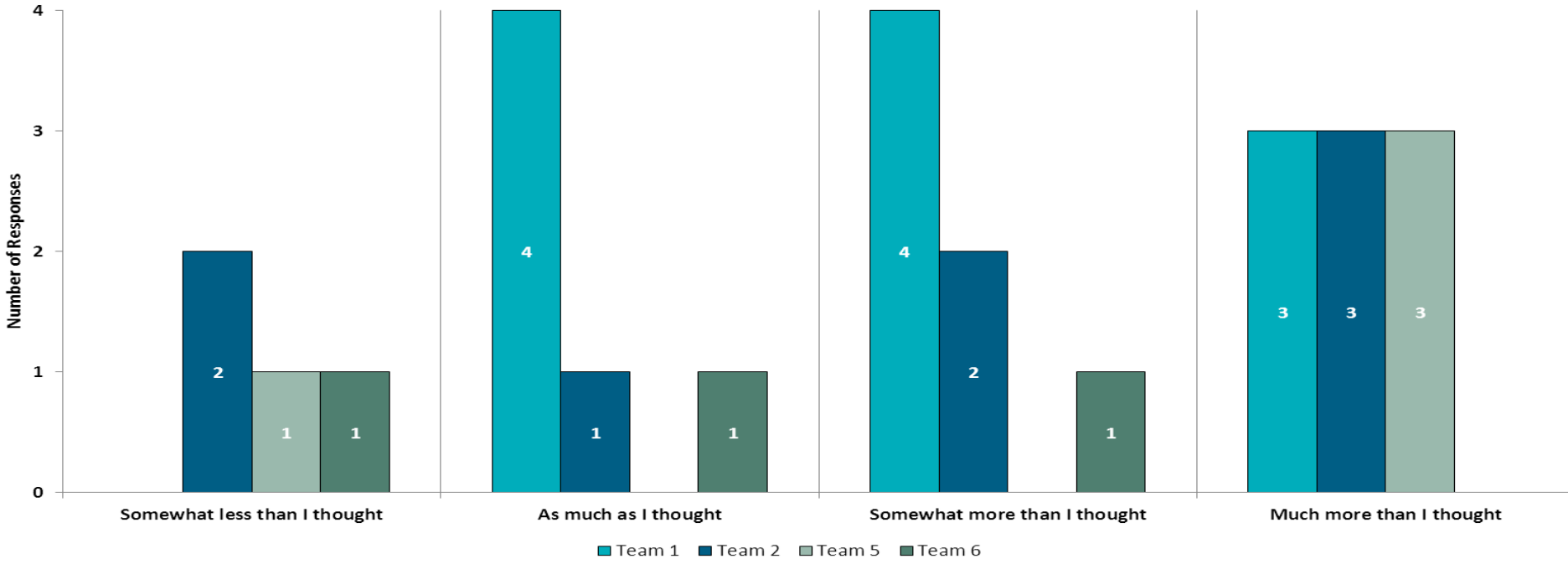
Positive Experience in their Program Area

90% rated care **good or excellent**

93% felt care was **well coordinated**

100% felt **comfortable** talking about issues

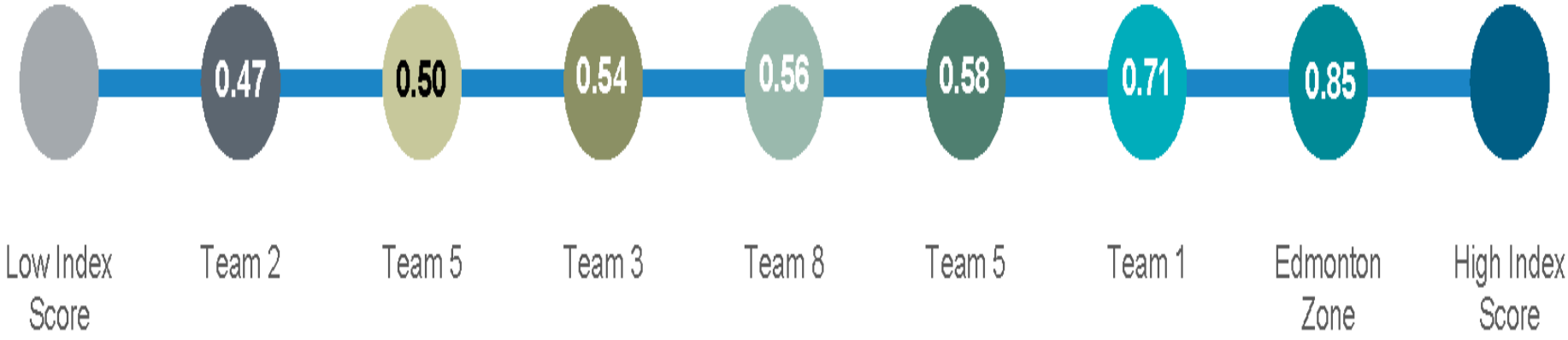
Clients feel respected and supported by their provider. They also experience progress on their self-identified goals



Health Outcomes

We work with clients with poorer health status. Overall improvements in health outcomes were not demonstrated over the evaluation time, and are thought to be partly about systemic barriers

By Teams - EQ5D Index Scores



What works?: Providers Aim to Remove Barriers

Providers - Ways to Reduce CHNP Barriers

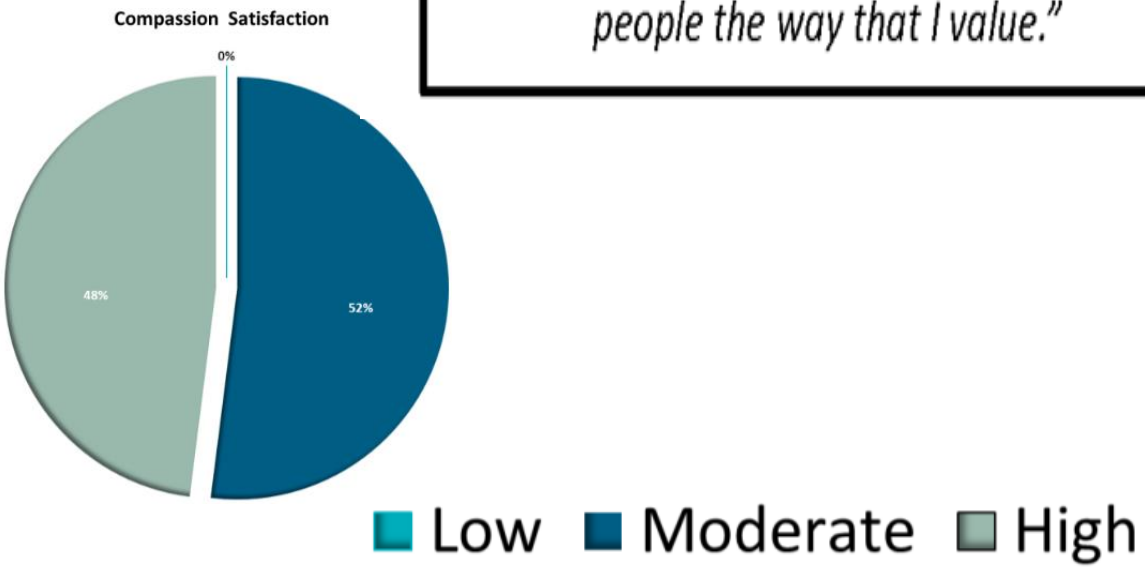
- Focus on Trust & Relationship
- Have Respect & Provide Accommodation
- Be More Accessible
- Help Patients Direct their Own Care (Plans based on patient goals)
- Ensure Service Coordination
- Listen to Patients; Share their Plans
- Learn About and Access Community Services
- Identify and Communicate System Barriers for Patients

Provider Barriers – the Fourth Aim

Providers have high satisfaction building relationships with their patients, focusing care on patient goals

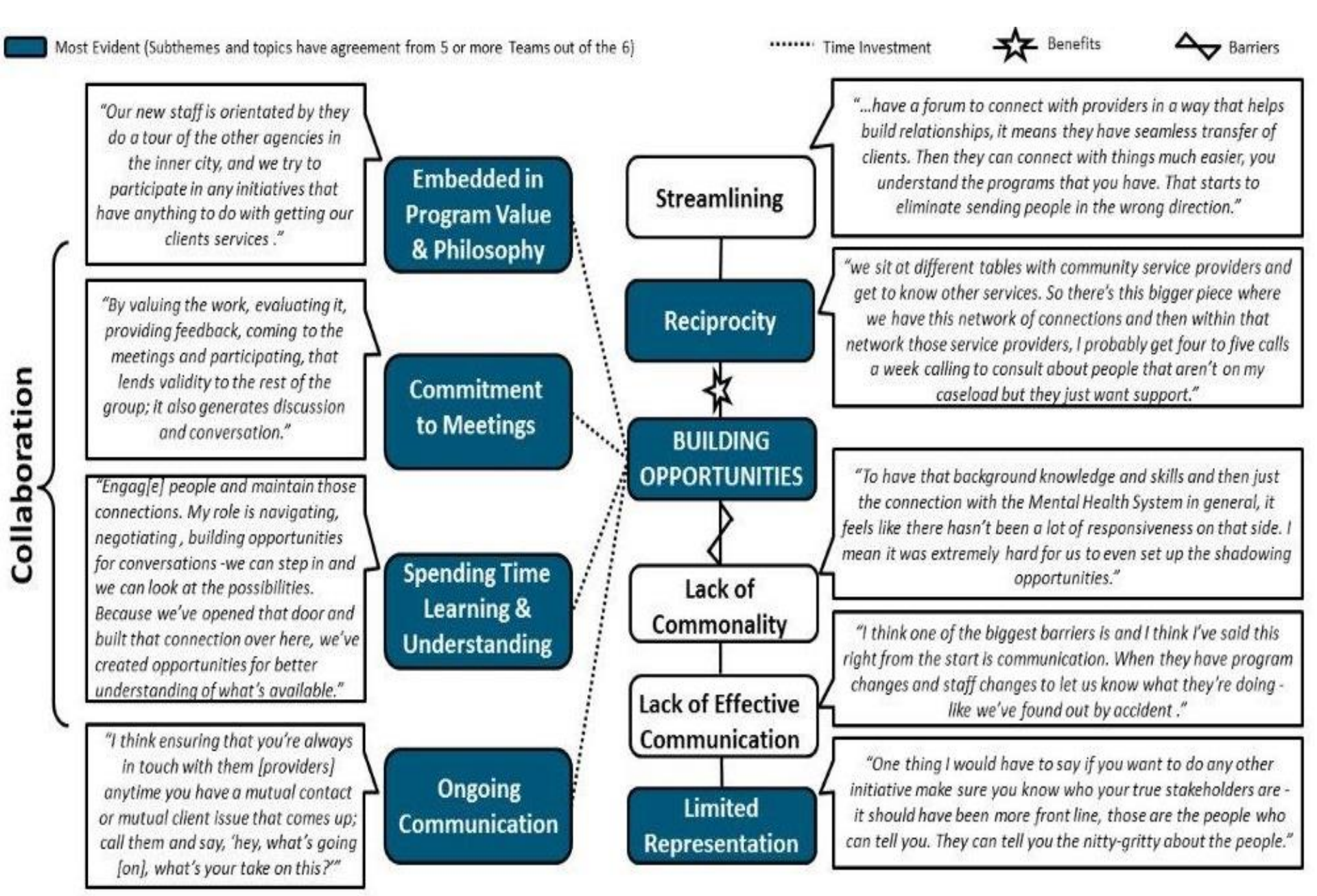
"My experience has been good and there has been a lot of learning based on the things we have accountability for, that we are able to continuously adapt to the needs of those that we support."

"I feel a personal satisfaction with it. I feel comradery amongst my colleagues, like we're on a kind of united quest, trying to support people the way that I value."



Providers are ACCOMMODATING unique needs of individuals

"It might take [time] to get that trust going. I tell them what I do, what my team does, my history of care. Try to open it up that this is the kind of care I've done for people, it could be there for you. I'm not here to judge. I'm here to care for you."


Most Evident (Subthemes and topics have agreement from 5 or more Teams out of the 6)
Time Investment
Benefits
Barriers
Collaboration
"Our new staff is orientated by they do a tour of the other agencies in the inner city, and we try to participate in any initiatives that have anything to do with getting our clients services ."
Embedded in Program Value & Philosophy
"By valuing the work, evaluating it, providing feedback, coming to the meetings and participating, that lends validity to the rest of the group; it also generates discussion and conversation."
Commitment to Meetings
"Engag[e] people and maintain those connections. My role is navigating, negotiating , building opportunities for conversations -we can step in and we can look at the possibilities. Because we've opened that door and built that connection over here, we've created opportunities for better understanding of what's available."
Spending Time Learning & Understanding
"I think ensuring that you're always in touch with them [providers] anytime you have a mutual contact or mutual client issue that comes up; call them and say, 'hey, what's going [on], what's your take on this?'"
Ongoing Communication
BUILDING OPPORTUNITIES
Streamlining
"...have a forum to connect with providers in a way that helps build relationships, it means they have seamless transfer of clients. Then they can connect with things much easier, you understand the programs that you have. That starts to eliminate sending people in the wrong direction."
Reciprocity
"we sit at different tables with community service providers and get to know other services. So there's this bigger piece where we have this network of connections and then within that network those service providers, I probably get four to five calls a week calling to consult about people that aren't on my caseload but they just want support."
Lack of Commonality
"To have that background knowledge and skills and then just the connection with the Mental Health System in general, it feels like there hasn't been a lot of responsiveness on that side. I mean it was extremely hard for us to even set up the shadowing opportunities."
Lack of Effective Communication
"I think one of the biggest barriers is and I think I've said this right from the start is communication. When they have program changes and staff changes to let us know what they're doing - like we've found out by accident ."
Limited Representation
"One thing I would have to say if you want to do any other initiative make sure you know who your true stakeholders are - it should have been more front line, those are the people who can tell you. They can tell you the nitty-gritty about the people."

Making sure “front line” is represented in any initiative – their needs must be heard

- Providers challenged with having priorities with patients directly (high case loads) vs time and resources for participation in collaborative
- Some have concerns about privacy and sharing
- Some agencies not interested in working with CHNPs, ‘philosophy’ is different
- Learning about community services and their varied “eligibility” – efforts to make intake and referrals easier and less difficult for providers

What is working…

- Respondents see the Initiative as an opportunity to discuss and collaborate with other internal and external to AHS
- Some examples included sharing stories and focusing on the day-to-day aspects of their work with Clients
- Teams feel more engaged and have a better understanding of one another's programs and supports

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Improving our work together

- The need for more clearly defined goals for the Initiative
- Frequent, open and transparent communication
- Continue to plan meeting structures and agendas that are more meaningful to participants

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Outcomes can be strengthened by being clear about the aims

- Ensuring clear and communicated vision, goals and objectives
- Leadership clarifying the expectations of the Teams
- Stronger communication and connections through all levels of Zone Leadership
- Clarity on process for defining and acquiring the resources required for scale and spread
- Priority placed on supporting communication and collaboration with Teams not yet involved in the Initiative

Teams of Providers Say That.....

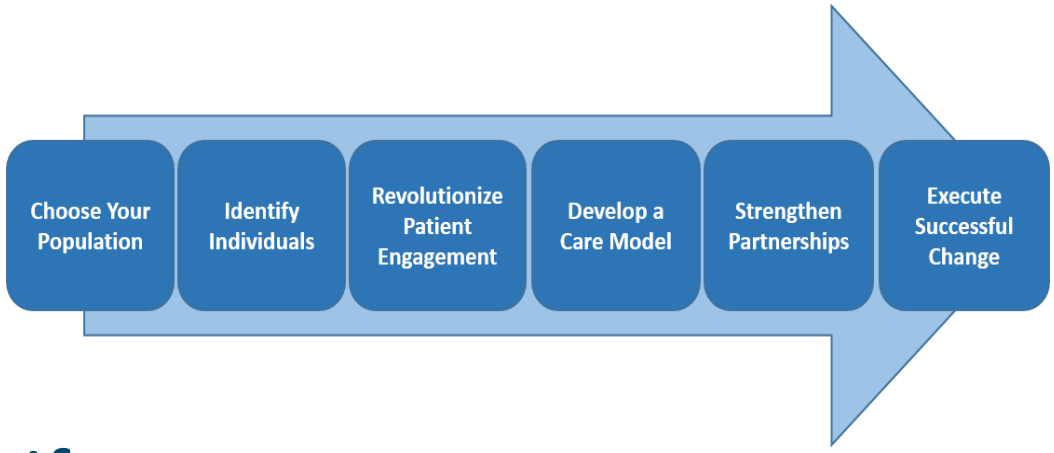
- We are meeting clients where they are at, building relationships, working on client goals and coordinating their care accordingly
- We are collaborating more with each other and other partners in the community

Clients are now getting the care and services they need to start addressing their wellbeing

Improved health outcomes and cost savings are outcomes we need to assess in the longer term

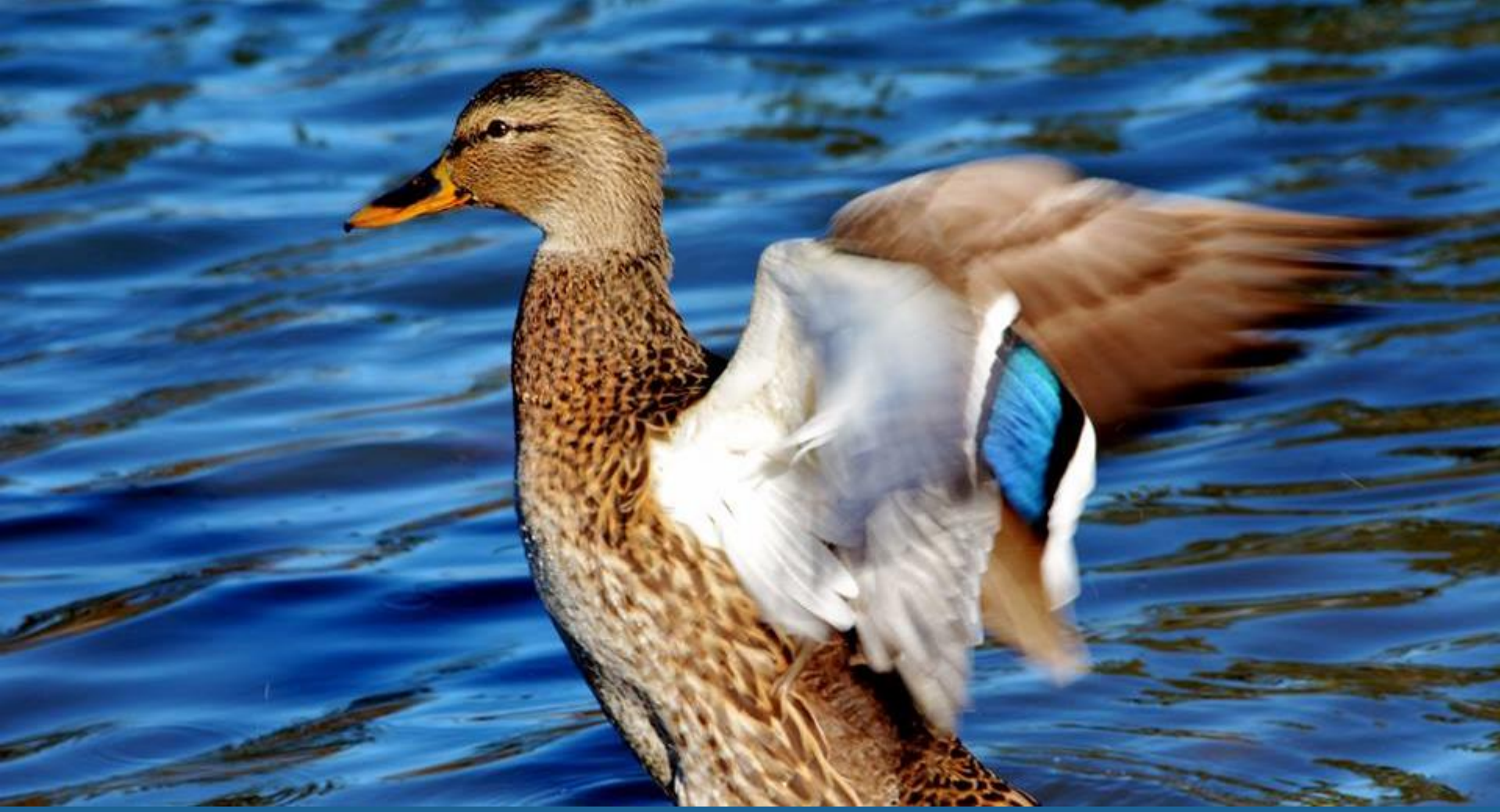
"I think they feel heard. So I think that's important for clients to feel heard and then they feel hopeful. So even though that you're not able to change the trajectory of their health they feel actually supported and heard and I think that is what's important, so their experiences of their health is that the providers are there to support them where they're at."

Most teams describe that the “Triple Aim Approach” is just how they do business now



CHNP Manifesto

- We recognize that our healthcare system does not adequately meet the needs of Complex High Needs Patients
- We strive to serve this population better
- We strive to improve our approaches, including measurement and sharing approaches together
- We strive to improve our healthcare system



What Works: Data that is Meaningful and Current for Each Group

Team Staff overall did not find the data useful during the evaluation period

However, they did identify some measures to continue collecting

System Measures

- ED Visits
- Inpatient Stays
- EMS Interactions

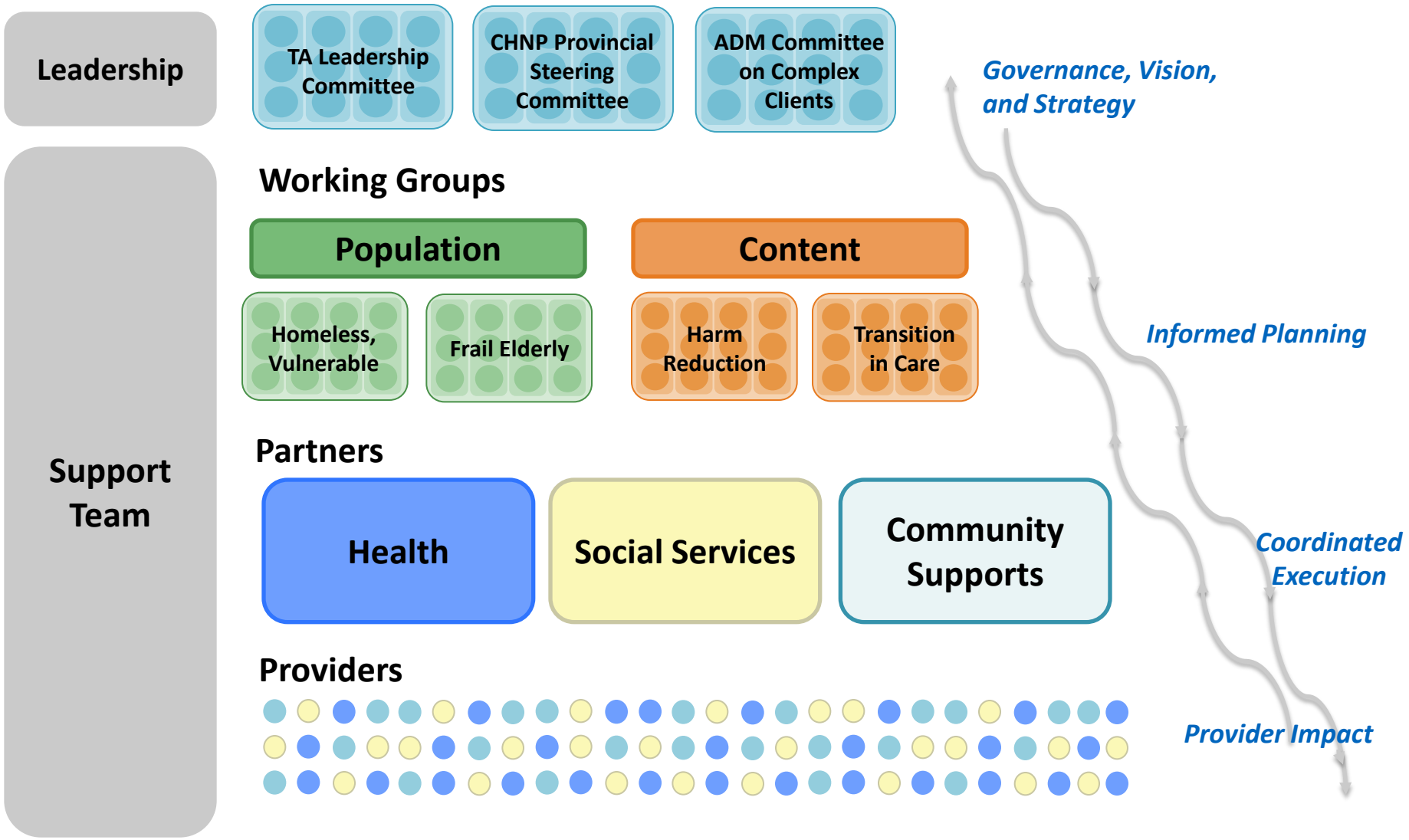
Survey Measures

- Visual client-reported health scale
- Client-reported system-level experience of care

Current Status in Brief

Collective Impact Involves Five Key Elements

FSG REIMAGINING SOCIAL CHANGE


Leadership
TA Leadership Committee
CHNP Provincial Steering Committee
ADM Committee on Complex Clients
Governance, Vision, and Strategy
Support Team
Working Groups
Population
Content
Homeless, Vulnerable
Frail Elderly
Harm Reduction
Transition in Care
Informed Planning
Partners
Health
Social Services
Community Supports
Coordinated Execution
Providers
Provider Impact

Questions?

Thank you

NOTE: Photos by Bill Neis

Thank you to Bill for sharing and for providing so many of your beautiful and powerful images for the slides in this presentation.

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References

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Edmonton Zone Triple Aim Initiative Evaluation Team. (2017). *Edmonton Zone Triple Aim Initiative: External Outcome Evaluation Technical Report.* Edmonton, AB: Alberta Health Services.

Further questions about these data can be directed to Eric VanSpronsen at (780) 735-1069 or Eric.VanSpronsen@ahs.ca.

FSG (June 13, 2013). Webinar presentation on **Collective Impact** *Strategies to Achieve Systemic and Sustainable Health Improvement* to Association for Community Health Improvement.

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