Alberta Health Services

DREAM IT ACHIEVE IT TOGETHER
QUALITY & SAFETY SUMMIT 2017

Quality Summit 2017 Poster Judges

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Carmelle Steinke
Carol Rowntree
Charlene McBrien-Morrison
Chris Mayhew
David Mador
Dawn Hartfield
Deanna Picklyk
Deb Gordon
Donna Ouelette
Hina Laeeque
Hugh Sanders
Jennifer Rees
Jennifer Salt
Joann Beckie
Julie Schellenberg
Karen Horon
Karen Tingley
Katie Wiltshire
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Poster Awards

Transformation through Innovation

Richard Phillips
Presenter

Richard Phillips, Marlies van Dijk, Zahra Sunderji, Maya Pajevic, Lynette Lutes
Authors

What do you think about Patient First? Using Co-Design Events with patients to pick better ways to become person centered in AHS

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PATIENT FIRST STRATEGY

@AlbertaPFCC
Patient.First@AHS.ca

What happens if we scrap the committees and co-design with patients instead?

What is co-design & why is it different?

Co-design goes beyond consultation by building and deepening equal collaboration between people affected by, or attempting to, resolve a particular challenge. Users are experts of their own experience, and become central to the design process.

Co-design combines lived experience with professional expertise to identify and create an outcome, service or product.

Healthcare co-design is founded in the idea that services are created **WITH** patients, instead of **FOR** patients.

THE 3 PHASES OF CO-DESIGN

1 identify & define	2 develop & protoype	3 test & iterate

250 participants: physicians, nurses, clerks, admin, leaders, consultants, patients & families.

INCLUSIVE
RESPECTFUL
PARTICIPATIVE
ITERATIVE
OUTCOMES FOCUSSED

40 patient & family advisors actively co-designing with AHS staff

3 co-design sessions

13 pitches focussed on finding innovative ways to put patients and families at the centre of health care services

1030 engaged partners across the province who continue to learn and share co-design principles

90 days to develop, prototype, test and launch the first co-designed idea for engagement

By building upon the engagement process, a network of changed mindsets and behaviours is organically spread through social democracy

SUCCESSFUL PITCHES

Leader Rounding

Leader Rounding is when administrative leaders get out to the front lines to ask patients and families what matters to them.

Tackled the challenge of provincial scale and spread of a proven practice.

Used a grass-roots approach and one-week campaign to challenge over 85 leaders across the province to participate, including Dr. Yiu.

YELP for Patients

A real-time anonymous feeback tool providing patients and families the opportunity to share care experiences at the point of care; like YELP for patients.

Simple interface allowing easy rating, dashboard access for front line teams, and priority data gathering.

AMPLIFY

What Matters to You?

Rooted in making sure that patient and family voices are not only heard but really listened to.

Instead of asking "what's the matter with you?" staff are encouraged to ask "what matters to you?"

Joined the international #WMTY campaign with 1000 participants from across 30 countries on June 30th, 2017.

Nearly 15000 Twitter impressions for @AlbertaPFCC tweets, with 2 in the international top 10 (#3 and #10 based on number of retweets).

What was it like to co-design solutions with staff, patients and families?

"It was obvious from the beginning of the day that there was a very strong buzz in the room - equally from patients & providers - that the status quo was not good enough. Collectively, we had to make things better."
Phil, Patient

"Asking patients #WMTY2017, I am surprised to see how shocked our patients are that we are asking this question."
Jennifer, Nurse

"It was great fun to work with a cross-section of staff and patients to define storyboards and pitches - and exciting to see the close alignment of priorities, ideas and key messages."
Lona, Patient

"It brought patients and families to the fore front and it made us move forward on initiatives and hear what was important to them."
Lynette, Leader

"I learned that when we listen to patients we design solutions that will truly make a difference in their lives."
Ali, Consultant

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Celina Dolan
Presenter

Celina Dolan
Nicholas Mitchell
Authors

AHS ID Program – Improving Client Access to Much-Needed Services

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AHS ID Program – Improving Client Access

Celina Dolan, BS, MBA; Nicholas Mitchell, MSc, MD, FRCP; Todd Atkinson, BSc, MSc
Provincial Planning and Capacity Management; Community, Seniors and Addiction & Mental Health

Homeless People - Health Profile

- Greater physical and mental illness than the general population[1]
- Five times more likely to be admitted to acute care[2]
- 100 times more likely to be admitted to psychiatric wards than their counterparts in society[2]
- One-third of the homeless population unlikely to receive treatment[3]
- Lack of treatment may be attributed to many barriers, including lack of identification and/or proof of insurance (IDs)[4,5,6,7]
- Lack of IDs impedes ability to access diagnostic services, community health-care and additional services ranging from disease prevention and palliative care[8], causing delays in discharging patients[9]

Impacts to Healthcare System

- Homeless people may be entitled to healthcare, but they are faced with an inability to access it, as they find themselves without a personal health card, or appropriate ID to obtain one.
- Alberta Health Services (AHS) has numerous homeless patients without government-issued photo identification and healthcare cards (IDs).
- Without IDs, discharging patients may be delayed due to the inability to refer clients to more appropriate levels-of-care or follow-up services in the community.

Traditional Process

- The following diagram highlights the conundrum experienced by both clients and their health providers alike; that is, to obtain a birth certificate clients require ID; but to obtain ID, they require a birth certificate.

- In many healthcare environments, social workers traditionally assist clients to obtain IDs by first ordering birth certificates and subsequently IDs once birth certificate is received.
- Depending on province of birth, delays of up to 12 weeks are experienced further delaying discharge. Ordering replacement landing documents for immigrants or refugees can take up to 8 months!

Methodology

- Mixed methods, multi-phased approach incorporating combination of qualitative and quantitative data collection methods. Combination of expert and local knowledge provided by clients and health providers.
- Developed with Alberta Health, Service Alberta, Human Services and Justice and Solicitor General (Adult).

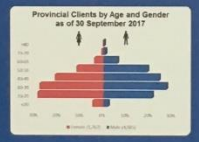
Alternate Means

- Employing "Alternate Means" allows the AHS ID Program to work with its partners, collaborators and other trusted sources, as consented by the patient, to provide confirmation of client's identity.
- This foregoes the need, in the majority of cases, to obtain birth certificates providing clients with the ability to access much-needed services faster.

- Collaborations with Alberta Vital Statistics, Community and Social Services, Immigration, Refugees and Citizenship Canada; Justice and Solicitor General, Veteran Affairs and provincial registry agents.

Program Outcomes

Provincial Clients by Age and Gender



Net-New Clients by Location

- Calgary - 2,820
- Edmonton - 1,673
- Grande Prairie - 287
- Lethbridge - 646
- Medicine Hat - 330

IDs Required by Type

Reasons IDs Required by Type

Benefit to Clients

- Sense of identity and empowerment
- Basic needs: housing, shelter, food banks and hampers
- Health Improvement – follow-up appointments, homecare, prescriptions, lab work, addiction supports, methadone treatment, psychiatrists, etc.
- Community stabilization – reconnect with family, better police interactions

"The ID Program has put me back on my feet and set me up for life". - Larry O. - Client since 2014

"Since I got my ID, I have an identity. I am less stressed". - Leona SD. - Client since 2016

"Now that I have ID, I am not hampered from obtaining services". - Michael D. - Client since 2016

Benefit to System

- $4,192,112 – Cost Avoidance (To Date)
- $1,362,677 – Cost Avoidance (Fiscal 2017)
- $27,483 – Cost Recoveries (To Date)

Learnings

1) Remaining barrier -- clients in care or in corrections unable to leave facility in order to attend a registry to finalize the last requirement to obtain IDs.
2) Vulnerable clients residing in rural/remote areas are unassisted to obtain IDs.
3) Homeless youth are unassisted due to inability to obtain guardian consent.

Next Steps

Program scope widened to include youth 16+

Use of virtual health technology to assist hard-to-reach patients

Digitize IDs for when required to access care.

Acknowledgements

The AHS ID Program would not exist if it were not for AHS leadership who supported its creation and implementation; its partners who were willing to work along side to make it happen and its wonderful team members, who through their dedication, compassion and continued effort together contributed to its success!

Contact: Celina Dolan, Manager, AHS ID Program – (Celina.Dolan@AHS.ca; 587-779-2570)

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Successful Quality Improvement Projects

Susan Witt
Presenter

Susan Witt, Kirby Peterson, Carolyn Whitfield, Vince DiNinno
Authors

We Prefer De-Cath: Optimization of Foley Catheter Utilization at the Medicine Hat Regional Hospital

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We Prefer Decath...

Optimization of Foley Catheter Utilization at the Medicine Hat Regional Hospital

Susan Witt, Kirby Peterson, Carolyn Whitfield, Vince DiNinno, Talal Alphin, Nolan Mastel

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The Problem :

Unnecessary Foley Catheters Harm Patients

Foley Catheters are an important part of the care in critically ill patients or those with bladder obstructions

- **1 in 5** hospitalized patients are catheterized
- **25-50%** are for **inappropriate** indications
- Often left for longer than necessary
- 40% attending physicians unaware of patient catheter status
- Often employed for convenience
- **80%** UTIs in hospital catheter related

The Risks

3 point restraint

- Deconditioning
- Blood clots
- Pressure ulcers
- Pneumonia
- Weakened bladder
- Falls

Urinary infections (daily by 5%)

Sepsis in 4% (mortality 15%)

LOS by 2-4 days

Injury to urinary tract

Pain & Delirium

The Process :

Learning to Think Differently

Research:

Literature search
Specialist Consultation
Indication development
Operations support

Collaboration:

FUN

Conversation & Knowledge Sharing:

Interactive quizzes
Mega-posters
Videos
Workshop
Walk abouts
Patient pamphlet

Measurement & Evaluation:

Real time data
Analyzed monthly
On unit feedback

Process Change:

Daily re-assessment
Physician reminders

REPEAT, REPEAT, REPEAT

Watch our video

www.goo.gl/4uzQBB

The Results :

A Change in Culture

"A New Appreciation For a Different Way"

Looking for Unnecessary Catheters Everyday as a TEAM

Data & Learnings:

- **35%** Reduction in Absolute Catheter Numbers
- **38%** Reduction in Catheter Prevalence

- ⚠ Data was challenging to obtain
- ⚠ Time intensive & lengthy project

- Sustained monitoring & feedback of results
- Monitoring infection rates
- Spreading work through zone

- Physicians, nursing staff and allied health at MHRH who made this work a reality
- Jeanette Barsky, Renee Wenzel-Krein, Tawny Johnson & Chandel Lovig who helped educate
- Leadership at MHRH (Brenda Ashman, Sheila Burkart, Terry Seitz, Racquel Charnetski, Tony Saba) who were instrumental in getting us up and running
- Janice Steinke for all the excellent printing
- Office of the CMO for supporting this project

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Adrienne Feasel
Presenter

Adrienne Feasel, Emma Billington, Gregory Kline
Authors

Empowering Patient Autonomy in Osteoporosis Management: The Self-Consult Program

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Empowering Patient Autonomy in Osteoporosis Management: The Self-Consult Program

Alberta Health Services

Authors: A Lynn Feasel, Emma O Billington, Greg A Kline

UNIVERSITY OF CALGARY

THE OPPORTUNITY

Improve access to osteoporosis care

Expedite access to osteoporosis services

Osteoporosis and fragility fractures impact Albertans

Deliver osteoporosis services in an efficient and timely manner

Provide educational support for both patients and their referring physicians

Yearly, **~3000** Albertans fracture a hip and **>7000** Albertans have a non-hip fragility fracture [1]

clinic wait time **> 16** months

The Idea...

The Self-Consult Program (SCP)

Inspire patient autonomy while working with the patient's primary care physician

Patients make an informed decision about their osteoporosis management

Design a group consultation program for osteoporosis care

THE PROGRAM

Pre-screen
- post menopausal osteoporosis referrals
- up to 20 patients per session

Group Consultation Session
- 2-hour physician-nurse lead group
  - consequences of fracture
  - fracture risk factors/estimation
  - treatment options

Follow-Up
- consult letter completed outlining decision
- discuss/implement treatment plan with their referring physician

Evaluation

from May 2016 to June 2017

78 Patients

15 Self-Consult Programs

100% Female

62.1 Mean age

Patient Experience

'it was very informative'

'able to have my questions answered, learned from others' questions, presented as clear, manageable process'

'liked the group aspect'

'very helpful and feel privileged to have been a part of this group'

'felt good that I was getting most up to date info'

'that I know more closely my osteoporosis risks. I have more knowledge on how to improve my risks/problems with osteoporosis'

THE OUTCOME

47 patients agreed to participate in a qualitative assessment of the SCP

100% felt the information provided at SCP was useful

84% felt they were provided enough information to make their treatment decision

96% reported an overall satisfaction with the SCP

clinic wait time reduced **< 3** months

Consider Savings in...

Each SCP (10 patients/session) = 2.9 MD clinics (3.5 patients/clinic)

Potential MD cost savings with implementation of 10 SCP/year
MD cost of 10 SCP (100 patients) = $2316.00
MD cost for 29 clinics (101 patients) = $26 965.50
Potential savings = $24 649.50/year

Lessons Learned

- For patients with age-associated osteoporosis, the SCP is an alternative option
- SCP is an innovative approach for patients to make an informed decision regarding their osteoporosis care
- Notification to ALL Southern Alberta physicians about the SCP during the initial launch was seen as a potential limitation to access

Next Steps...

Continued collaboration with Primary Care Networks in urban and rural Alberta to expand the delivery of osteoporosis care to a broader population

[1] Majumdar SR, et al. Osteoporos Int. 2017; 28: 1965-1997

Dr. David Hanley Osteoporosis Centre website: http://www.osteoporosiscalgary.com