EAST TORONTO HEALTH PARTNERS

EVALUATION OF WINTER SURGE INITIATIVES

2018-2019

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EVALUATION TEAM

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The evaluation team wishes to thank the project leads and other staff who took the time to share their experiences and learnings with us.

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EXECUTIVE SUMMARY

1. THE CHALLENGE

Emergency departments (ED) routinely struggle to maintain capacity during the winter flu season. This is exacerbated by health care providers often reducing their hours and services during the holidays. As a result, more people are funneled to EDs, leading to overcrowding, hallway medicine and suboptimal care.

Ontario's health system needs better ways of dealing with winter flu season and the associated surge in demand for services. One approach worth investigating is for hospitals and local health organizations to work collaboratively to more effectively deal with the winter surge. Can community-based approaches help maintain critical capacity and alleviate hallway medicine?

2. MGH WINTER SURGE INITIATIVE

To investigate the potential of this approach, Michael Garron Hospital (MGH) used some of its 2018/19 surge funding to meet with community partners and collaboratively develop a series of surge relief projects. On November 12, 2018, MGH brought together a group of East Toronto health providers for a planning day, to discuss ways to better address winter surge.* Out of this planning day, 12 projects were selected for funding. These projects generally aligned with one of three strategies:

1. Divert people from hospital through proactive supports in the community;
2. Reduce time in ED through increased resources and operational improvements;
3. Transition patients home more efficiently by partnering with providers in the community.

Eight of the projects were "scale-ups" — meaning they expanded upon existing programs or services — while four were new programs being trialed for the first time. Projects lasted 8 to 14 weeks and ran sometime between mid-December and the end of March. Due to the nature of the surge funding, all projects ended by March 31. A list of the funded projects can be found on the next page.

**KPMG System Capacity Design Workshop. Workshop Debrief. November 12, 2018.*

STRATEGY 1: DIVERT FROM HOSPITAL

NAME	PARTNERS	DURATION	SCALE-UP OR NEW?	INVESTMENT
Albany Medical Clinic Extended Walk-In Hours	AMC	Dec. 22-Mar. 1 (10 weeks)	Scale-up	$115,200
Thorncliffe Park After-Hours Clinic	HATP, THCC	Dec. 17-Mar. 8 (12 weeks)	New	$85,000
CHC Supports for Vulnerable Populations	SRCHC	Feb 17-Mar. 31 (6 weeks)	Scale-up	$75,000
Supports and Services for Chronically Homeless People	WoodGreen	Jan. 21-Mar. 31 (10 weeks)	Scale-up	$75,000
NLOT	MGH	Did not run	Scale-up	n/a
RAAM	MGH	Did not run	Scale-up	n/a

STRATEGY 2: REDUCE TIME IN ED

NAME	PARTNERS	DURATION	SCALE-UP OR NEW?	INVESTMENT
MGH Pediatric After-Hours Clinic	MGH	Jan. 21-Mar. 29 (10 weeks)	New	$20,000
Increased Emergency Department Assessment Capacity	MGH	Dec. 22-Mar. 31 (14 weeks)	Scale-up	$115,200
Improving Access and Flow in the Hospital	MGH	Jan. 8-Mar. 31 (12 weeks)	Scale-up	$45,000

STRATEGY 3: TRANSITION HOME MORE EFFICIENTLY

NAME	PARTNERS	DURATION	SCALE-UP OR NEW?	INVESTMENT
Home2Day	MGH, VHA, Woodgreen	Jan 14. Mar. 31 (11 weeks)	New	$67,670
Retirement Home Reactivation Solution	MGH, SE Health, Beach Arms	Feb. 5 - Mar. 31 (8 weeks)	New	$129,555
Enhanced In-Home Supports For High-Needs Neighbourhoods	VHA	Jan. 9 - Mar. 31 (12 weeks)	Scale-up	$48,958

3. IMPACTS

Impacts of the winter surge initiative ares summarized in the following tables, and described in further detail throughout the report.

STRATEGY 1: DIVERT FROM HOSPITAL

The projects under strategy 1 were reasonably successful in diverting patients from the ED. While it is difficult to determine the exact number of patients diverted, each project had evidence that suggested some diversion had occurred.

PROJECT	DIVERSION FROM ED	OTHER IMPACTS
Albany Medical Clinic Extended Walk-In Hours	Patient reported: 26% MD reported: 10-15%	• 845 more patients seen • Early clinic closure avoided on 23 days
Thorncliffe Park After-Hours Clinic	Patient reported: 63% MD reported: 39%	• 562 patients seen • 25 referrals to HATP • Filled vacuum left by fire
CHC Supports for Vulnerable Populations	Likely but hard to quantify	• 206 client visits across 5 homeless shelters • 4 service agreements
Supports and Services for Chronically Homeless People	27 EMS calls avoided 3 clients housed	• 680 meals served • 165 shared care visits • 55 Naloxone kits given

Note: NLOT and RAAM did not run and thus could not be evaluated.

STRATEGY 2: REDUCE TIME IN ED

The projects under strategy 2 aimed to reduce time in the ED. The first project did so, reducing both time to initial physician assessment and total length of stay. The second project reduced time in the ED slightly by adding an additional physician shift. More importantly, the additional physician was seen as essential by other ED physicians. The third project aimed to improve access and flow through a number of related initiatives. These likely had a positive impact, but no hard data was available to support this.

PROJECT	REDUCED TIME IN ED	OTHER IMPACTS
Paediatric After-Hours Clinic	PIA: 2 hours faster LOS: 1 hour less	• 169 patient visits • 100% patient satisfaction
Increased ED Assessment Capacity	6 min faster than 2018 Seen as essential by ED physicians	• 110 shifts staffed • 2090 patients seen by extra shift • Faster lab results
Improving Access and Flow in the Hospital	Time in ED likely reduced, but no hard data to support	

STRATEGY 3: TRANSITION HOME MORE EFFICIENTLY

The projects under strategy 3 had mixed success in transitioning patients home more efficiently. The first project was successful, reducing hospital length of stay by 3.5 days while providing 6.5 days more home support. The second project was unsuccessful, with initial hospital LOS likely reduced but a very high (50%) readmission rate. The third project also likely reduced hospital LOS, but had limited reach and lower volumes than expected.

PROJECT	TRANSITION HOME	OTHER IMPACTS
Home2Day	Hospital LOS: - 3.5 days + 6.5 days home support	• 17 patients enrolled • 238 in-home visits • 30-day readmission same
Retirement Home Reactivation Solution	Hospital LOS likely reduced, but data is unclear 14 days reactivation + up to 14 days home support	• 10 patients enrolled • Avg days in program: 21.9 • 5 patients readmitted
Enhanced In-Home Supports for High-Needs Neighbourhoods	Hospital LOS likely reduced, but data is unclear Weekend discharge, home-making, and extreme cleaning	• 57 clients supported • Positive client feedback

4. LEARNINGS

Summaries for each of the projects, along with key metrics, outcomes, and learnings, can be found in sections 2, 3 and 4 of the evaluation report. At a high level, learnings from the winter surge initiative can be summarized as follows:

1. More time for project start-up

All project leads asked that more time be allocated for project start-up. Getting a project up and running in a matter of weeks was challenging, especially for those projects that were new rather than scale-ups of existing services.

2. Staffing was a challenge

Finding staff for the surge relief projects was challenging. Indeed, two projects (NLOT and RAAM) could not run because qualified staff could not be found. The challenge was exacerbated by the fact that these projects were short-term and temporary, making it hard to attract staff.

3. Communication is essential

Communication both within and between organizations is essential to successful implementation of projects. Particularly where projects involved multiple organizations, good communication was a key element of success. In addition, many project leads said they would have liked to know more about what was happening in the broader initiative (i.e., more communication about other surge relief projects and how they fit together).

4. Relationships are essential

Organizations that had worked together before were more successful at implementing their projects than those that were working together for the first time. The short timeframe of the surge initiative made it difficult to develop robust relationships where none had previously existed – although some project leads did comment on improved relationships as a result of their project.

5. Implementation success varied

Most projects had reasonably successful implementations but a few did not run as planned (or run at all). Generally speaking, scale-up projects were more successful in terms of implementation than new projects. For new projects, it is critical that implementation details be worked out prior to being approved for funding. Those projects that were most successful in terms of implementation had staff who had worked together before and/or had already been thinking about doing a collaborative project for some time.

6. Measures tended to be programmatic, not outcomes-focused

Most projects focused on programmatic measures (e.g., number of patients seen, hours of service provided) rather than outcome measures. While understandable, these measures offer little guidance in terms of evaluating the effectiveness or long-term value of projects. In the future, project measures should be aligned with desired outcomes.

7. Evidence of learning

There was evidence of learning in all projects. Some projects were more thoughtful about encouraging and capturing learning, e.g., by incorporating regular feedback mechanisms such as daily/weekly huddles. Others relied on ad hoc feedback, which generally speaking was less effective.

8. Opportunity to test change

Many projects under the surge initiative can be seen as pilots that offered an opportunity to test change. In other words, the value of the project lay not only in the services delivered but also in the opportunity for organizations to work together for the first time, or for a health provider to try something that they would not otherwise have tried. In some cases (e.g., Albany Medical Clinic), the pilot demonstrated to the provider that a new clinic model was financially viable without additional support – laying the groundwork for future service changes.

4. RECOMMENDATIONS

Outcomes and recommendations for each project are summarized below. Recommendations are based on whether project goals were met, how well projects addressed surge priorities, patient and client experience (where available), cost, and partnership building (if applicable).

In terms of future planning, projects fell into one of four categories:

A. Successful. Continue funding.

- CHC Supports for Vulnerable Populations, Supports and Services for Chronically Homeless People, ED Assessment, Home2Day

B. Successful. Can continue without funding as program is self-sufficient.

- Albany Medical Clinic Extended Walk-In Hours

C. Mixed results. Need to rethink program goals and/or delivery before funding again.

- Thorncliffe Park After-Hours Clinic, MGH Paediatric Clinic, Enhanced Supports for High-Needs Neighbourhoods

D. Unsuccessful. Do not run again without major changes.

- Retirement Home Reactivation

STRATEGY 1: DIVERT FROM HOSPITAL

PROJECT	OUTCOME	RECOMMENDATION
Albany Medical Clinic Extended Walk-In Hours	Successful "test of change" pilot.	Continue. Self-sufficient. Does not require further funding.
Thorncliffe Park After-Hours Clinic	Successful as a short-term solution to community need. Longer term value not clear.	Need to rethink goals and program delivery if it were to run again. Revisit whether to fund again.
CHC Supports for Vulnerable Populations	Successful continuation and expansion of services.	Continue. Requires funding.
Supports and Services for Chronically Homeless People	Successful continuation and expansion of services, with training opportunities.	Continue. Requires funding.

STRATEGY 2: REDUCE TIME IN ED

PROJECT	OUTCOME	RECOMMENDATION
MGH Paediatric After-Hours Clinic	Mixed results. High patient satisfaction but low patient volumes. Long-term sustainability unclear.	Need to rethink program delivery and implementation. Revisit whether to fund again.
Increased ED Assessment Capacity	Helped as expected	Fund every year
Improving Access and Flow in the Hospital	Helped as expected	Continue utilizing technology investment and adjust as needed

STRATEGY 3: TRANSITION HOME MORE EFFICIENTLY

PROJECT	OUTCOME	RECOMMENDATION
Home2Day	Successful pilot.	Continue and scale-up with adjustments. Requires funding.
Retirement Home Reactivation Solution	Unsuccessful clinically. Multiple implementation issues. Did not reach scale.	Need to rethink program and implementation. Do not fund without major changes.
Enhanced In-Home Supports for High-Needs Neighbourhoods	Mixed results. Successful clinically but had limited reach. Needs higher volumes to be sustainable.	Need to rethink program design and implementation. Do not fund without major changes.

1. INTRODUCTION

1.1. BACKGROUND

Michael Garron Hospital (MGH) received $1.05 million to open and operate 14 additional inpatient surge beds from November 2018 to March 2019. In addition, MGH received $1.505 million to maintain critical capacity in the hospital sector, by investing in initiatives developed in collaboration with partner organizations in East Toronto. This report evaluates projects funded through this second set of funding.

- A total of 12 programs were approved
- These programs were intended to help address the annual "winter surge" through a variety of interventions
- Funding was provided by the TC LHIN through a one-time injection of funding
- Programs start dates varied. All programs ended by March 31, 2019
- In addition, other surge-related programs ran concurrently, e.g. mobile flu clinic

At the request of Michael Garron Hospital, an evaluation was conducted.

- The goal of the evaluation was to support learning from each of the surge projects
- Particular focus was placed on the following priority projects*
    - *Home 2 Day COPD Pilot*
    - *Retirement Home Reactivation*
    - Expanded Walk-in Clinic Hours at 3 sites (*Albany, Thorncliffe, MGH*)
- In consultation with MGH, it was decided the evaluation would provide a high-level summary of each project, along with more in-depth analysis of the priority projects

*Priority projects are italicized throughout the report.

1.2. METHODS

Interviews were conducted with project leads at the beginning and end of each project.

- Purpose of start interviews were to review key information about project and help leads think about what data they would need to collect for evaluation
- Purpose of exit interviews were to provide an opportunity reflect upon the project and lessons learned

For priority projects, data collection plans were developed in consultation with project leads to complement and expand on data that project leads planned to collect.

- The additional data was generally qualitative in nature and meant to provide additional context and insight to project
- Methods used to collect this data include patient and provider surveys, interviews with patients and providers, focus groups with providers, and patient journey mapping
- Interviews and focus groups were transcribed and coded thematically
- Consent was obtained whenever collecting data from patients or providers

Where appropriate, information provided by project leads to MGH were shared with the evaluation team.

- Requests for additional information were made where information provided by project leads were insufficient

1.3. SURGE RELIEF PROJECTS

PROJECT	ORGANIZATIONS
Albany Medical Clinic Extended Walk-In Hours	Albany Medical Clinic (AMC)
Thorncliffe Park After-Hours Clinic	Health Access Thorncliffe Park (HATP), Toronto Healthcare Centre (THCC)
MGH Paediatric After-Hours Clinic	Michael Garron Hospital (MGH)
Improving Access and Flow in The Hospital	MGH
Increased Emergency Department Assessment Capacity	MGH
Nurse Led Outreach Teams	MGH
Rapid Access to Addiction Medicine Clinic	MGH
Home2Day	MGH, VHA Home Healthcare, WoodGreen
Retirement Home Reactivation Solution	MGH, SE Health, Beach Arms
CHC Supports for Vulnerable Populations	South Riverdale Community Health Centre (SRCHC)
Enhanced In-Home Supports For High-Needs Neighbourhoods	VHA
Supports and Services for Chronically Homeless People	WoodGreen

Italics indicate priority projects.

Projects generally aligned with one of three strategies:

1. **Divert people from hospital** through proactive supports in the community;
2. **Reduce time in the ED** through increased resources and operational improvements;
3. **Transition patients home more efficiently** by partnering with providers in the community.

2. STRATEGY 1: DIVERT FROM HOSPITAL

The projects in this section focused on attending to patient needs before they reach the hospital. This was done through a variety of strategies including:

- Increasing access to walk-in and after-hour clinics
- Providing supports and services to vulnerable populations, including the chronically homeless
- Expanding capacity of outreach teams and addiction clinic

The goal of these strategies was to improve access to supports and services in the community for individuals seeking non-urgent care. By improving access in the community, patients are more likely to receive timely and proactive care, through community programs and services outside emergency department.

The table below lists the six projects earmarked for funding through the surge relief initiative. Of these, two did not run due to staffing issues. The next table summarizes the main impacts of the four projects that did run. Additional information about each project is presented on the following pages.

TABLE 2.1. STRATEGIES TO DIVERT FROM HOSPITAL

PROJECT	PARTNERS	TYPE	DATES	INVESTMENT
Albany Medical Clinic Extended Walk-In Hours	AMC	Scale-up	Dec 22 - Mar 1 (10 weeks)	$115,200
Thorncliffe Park After-Hours Clinic	HATP, THCC	New	Dec 17 - Mar 8 (12 weeks)	$85,000
CHC Supports for Vulnerable Populations	SRCHC	Scale-up	Feb 17 - Mar 31 (6 weeks)	$75,000
Supports and Services for Chronically Homeless People	WoodGreen	Scale-up	Jan 21 - Mar 31 (10 weeks)	$75,000
NLOT	MGH	Scale-up	Did not run	n/a
RAAM	MGH	Scale-up	Did not run	n/a

TABLE 2.2. STRATEGY 1 OUTCOMES

PROJECT	DIVERSION FROM ED	OTHER IMPACTS
Albany Medical Clinic Extended Walk-In Hours	Patient reported: 26% MD reported: 10-15%	• 845 more patients seen • Early clinic closure avoided on 23 days
Thorncliffe Park After-Hours Clinic	Patient reported: 63% MD reported: 39%	• 562 patients seen • 25 referrals to HATP • Filled vacuum left by fire
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Note: NLOT and RAAM did not run and thus could not be evaluated.

The projects under strategy 1 were reasonably successful in diverting patients from the ED. While it is difficult to determine the exact number of patients diverted, each project had evidence that suggested some diversion had occurred.

2.1. ALBANY MEDICAL CLINIC EXTENDED WALK-IN HOURS

TAKE-AWAYS

- Modest self-reported ED diversion (26% patient reported, 10-15% physician estimated)
- Data supports business case to continue without additional funding
- More clarity needed around rationale for choosing clinics

GOALS

- Divert non-emergent cases from the Emergency Department at MGH
- Expand access to care for non-emergent cases in the Toronto East sub-region during flu surge season
- Pilot a method of faxing notes to primary care providers of patients not rostered at AMC

COSTS

- Investment: $115,200
- Cost per patient: $193.07
  ($115,200/579 patients)

INTERVENTION

- Dec. 22 to Mar. 1
  Weeknights: to 10 p.m. (+2 hrs)
  Weekends: to 6 p.m. (+2 hrs)
  Holidays: to 6 p.m. (+4 hrs)
- 1-2 physicians based on demand
- 2 reception staff, plus a security guard after 8 p.m.
- On-site Rexall Pharmacy extended its hours

ALBANY MEDICAL CLINIC EXTENDED WALK-IN HOURS

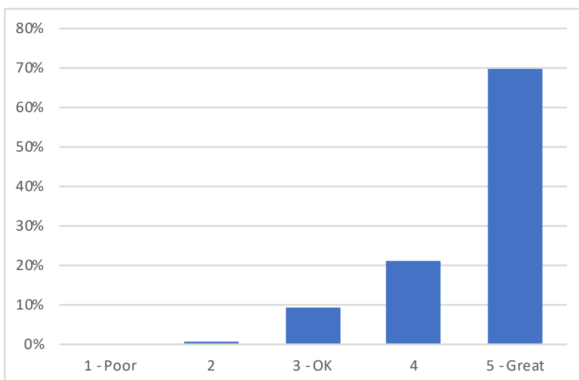
EVALUATION OBJECTIVES

1. Assess impact of extended hours on non-emergent ED visits
2. Understand patient demand and satisfaction for extended hours at AMC
3. Assess impact of faxing notes to physicians of non-AMC patients

OUTCOMES

- 845 additional patients seen by extending hours and avoiding early closure
- Based on this pilot, AMC plans to continue offering extended walk-in hours next surge season

PATIENT SATISFACTION



IMPACT

597 PATIENT VISITS

26% PATIENT-REPORTED ED DIVERSION

90% PATIENT SATISFACTION

140 EXTRA CLINIC HOURS

216 CLINICAL NOTES FAXED

AVOIDING EARLY CLOSURE

- AMC was able to significantly decrease instances of closing early due to reaching capacity for patients who can be seen
- Early closure was avoided on 23 of the project's 70 days
- 248 patients were seen after normal close (in addition to 597 registered during extended hours).

ALBANY MEDICAL CLINIC EXTENDED WALK-IN HOURS

FINDINGS

- 26% of patients reported their visit diverted them from the ED; physicians estimated 10-15% of cases were ED diversions
- 76% of patients reported they came to the clinic because of the after-hours program
- Demand was highest on weekends
- Patients came from a wide geographic area, with no clear pattern of concentration or clustering
- The vast majority of patients were satisfied with the service
- There were concerns from other primary-care physicians about a fee-for-service clinic receiving funding to extend its hours
- The clinic agreed to follow-up notes to non-AMC physicians. This was found to be resource intensive (see box, 'Faxing Notes')

FAXING NOTES

- 62% of patients were not rostered at AMC; 231 of them (38% of the total) identified a family doctor
- No single physician had more than 3 patients visit
- Clinic staff were able to send 216 notes by locating contact information online and building a list
- Follow-up communication with family physicians has been identified as a high priority by primary care
- However, locating physician for walk-in patients was time consuming and deemed unsustainable without further resources (e.g., central database)

"Overall, the clinic was just an extension of what we do in our walk-in, and it worked exceptionally well."

Dr. Brian Adno

RECOMMENDATIONS

1. Future extended hours projects should focus on peak demand times, i.e. weekends and early evenings
2. Increase public awareness of walk-in services, e.g. through advertising, community outreach, etc.
3. Walk-in initiatives should take account of the fact that clinics such as AMC serve a clientele well beyond their immediate neighbourhood
4. A centralized database indicating where patients are rostered would make it easier to send follow-up notes to family physicians
5. More transparency about goals and rationale of clinic selection in future funding decisions

2.2. THORNCLIFFE PARK AFTER-HOURS CLINIC

TAKE-AWAYS

- Modest self-reported ED diversion (63% patient reported, 39% physician estimated)
- Allowed physicians to spend more time with patients than they normally would
- Successful at addressing immediate for clinic space need due to fire

GOALS

1. Expand access to after-hours care in Thorncliffe Park
2. Divert non-emergent cases from the Emergency Department at MGH
3. Build partnerships between physicians and allied health professionals

COSTS

- Investment: $85,000
- Cost per clinic visit: $151.25 ($85,000/562 patients)

INTERVENTION

- A partnership restored after-hours access during surge season after a fire at the East York Town Centre had led to discontinuation of after-hours walk-in services in Thorncliffe Park
- Dec. 17 to Mar. 8
Weeknights: 5 to 9 p.m. (4 clinic hrs.)
Weekends: 10 a.m. to 4 p.m. (6 clinic hrs.)
- 1 physician, supported by receptionist and care navigators
- Salaried funding model; FHOs were not negated when their patients visited
- Information-sharing to familiarize physicians about services available through Health Access Thorncliffe Park
- Translation services available

THORNCLIFFE PARK AFTER-HOURS CLINIC

EVALUATION OBJECTIVES

1. Understand demand for service by collecting data on utilization, demographics, and conditions treated
2. Assess impact on ED diversion
3. Evaluate patient satisfaction and provider experiences
4. Explore relationships and knowledge of primary care practitioners pertaining to local allied health services, in part to inform a future health- and social-service hub

OUTCOMES

- 562 patients were seen in 402 clinic hours
- 63% of patients reported their visit diverted them from the ED; physicians estimated 39% of cases were ED diversions
- The project enabled Health Access Thorncliffe Park (HATP) to familiarize physicians with their clinical space in the East York Town Centre and referral pathways for allied health and social services
- Approximately 25 referrals were made to HATP, mostly for diabetes management and social work
- The extent of referrals and usage of translation services varied considerably between physicians
- 64% of patients lived in Thorncliffe Park (M4C postal forward sortation area)
- Physicians described having more time with patients compared to ordinary walk-in clinics
    - They attributed this to the salaried funding model as well as the relatively low volume of patients

IMPACT

562 PATIENT VISITS

63% PATIENT-REPORTED ED DIVERSION

90% PATIENT SATISFACTION

402 CLINIC HOURS

THORNCLIFFE PARK AFTER-HOURS CLINIC

FINDINGS

- The opportunity to have physicians practice in HATP's space helped to familiarize them with allied health services.
  - However, given that walk-in services at the East York Town Centre have traditionally been provided on the main floor, closer to the entrances and major businesses, the location of this space in the basement likely impacted on patient volumes
- FHO-based physicians reported to project leads that they were eager to refer patients to the clinic because the funding model avoids negation
- Physicians who practised at the clinic were generally enthusiastic about collaborating on a future community hub, and said they became more familiar with HATP through the walk-in initiative

RECOMMENDATIONS

- Location and community awareness should be key considerations for any future initiatives to expand walk-in services in Thorncliffe Park
  - Advertising in languages other than English was identified as particularly important in this community
- The project created an opportunity for collaboration and relationship building between HATP and THCC at an organizational level
  - This may be helpful in planning for future integration through a hub for primary care and allied health and social services in the Thorncliffe Park community
  - A funding model that avoids negation for visits by FHO clients was identified as important to ensuring FHO-based physicians support the clinic and recommend it for after-hours care
- Future collaborations could build on the strong interest in integration and community-focused care expressed by the physicians, allied health professionals, and clinical leaders who participated in the project

2.3. CHC SUPPORTS FOR VULNERABLE POPULATIONS

TAKE-AWAYS

- Investment allowed CHC to attempt scale up of programs and services
- Good value for supporting vulnerable populations outside of hospital
- Strengthened community network

GOALS

1. Engage people who are not accessing preventative health-care opportunities with education and primary care
2. Provide primary care services and health education to people who are homeless or under-housed
3. Reduce utilization of emergency services through preventative health care, education, and attachment to primary care amongst vulnerable populations

COSTS

- Investment: $75,000
- Cost per patient: $364.00 ($75,000/206 patients)

INTERVENTION

- 2 nurse practitioners (NPs) onboarded to provide primary care outreach to residents of 5 homeless shelters
- Hours and capacity for intake through referrals expanded at the community health centre
- Flu prevention through immunization
- Overdose prevention through education and naloxone training and distribution
- Increase attachment to primary care and allied health care, especially for people living with long-term chronic conditions
- Capacity to roster patients at the CHC immediately

CHC SUPPORTS FOR VULNERABLE POPULATIONS

OUTCOMES

- Surge funding enabled South Riverdale CHC to implement standing service agreements with local shelters, which remain in place after the end of funding
- Initial plans for a 3-person outreach team consisting of an NP, harm-reduction worker, and Certified Respiratory Educator were modified to facilitate implementation of NP-based outreach services on a short timeline
- NPs addressed 3 key conditions:
    - Wound care
    - COPD and asthma exacerbations
    - Medication renewals for significant conditions that would likely have ended up in ED if not treated
- In addition to partnerships with 5 shelters, the initiative led to increased coordination between South Riverdale's safe consumption and harm-reduction services, and related services at Michael Garron Hospital such as the Rapid Access to Addiction Medicine (RAAM) Clinic and detoxification
- SRCHC had hoped to retain the NPs recruited through the project using other funds, but they accepted full-time permanent positions elsewhere at the end of the pilot period
- The outreach program ended with the surge funding. However, SRCHC plans to reactivate and sustain it on a long-term basis
- Having received positive feedback from partners and clients, SRCHC is committed to continuing to provide services under the standing service agreements established through the pilot with surge funding

IMPACT

206 CLIENT VISITS

5 CLINIC LOCATIONS

4 SERVICE AGREEMENTS

2.4. SUPPORTS AND SERVICES FOR CHRONICALLY HOMELESS PEOPLE

TAKE-AWAYS

- High impact, low cost
- Allowed continuation and expansion of service offerings
- Continue to invest in community programs to extend and strengthen partner network

GOALS

1. Facilitate preventative health care through outreach and improved access
2. Reduce demand for ED services through preventative primary care activities
3. Address social determinants of health through food security
4. Build community partnerships to support vulnerable persons

COSTS

- Investment: $75,000
- Average per individual service: $86.01 ($75,000/872 service interactions)

INTERVENTION

- Congregate food security using a drop-in model
- Community partnership to enhance supports for vulnerable persons
- Outreach and drop-in services focused on overdose prevention and social determinants of health
- Drop-in Coordinator (1 FTE), Kitchen Staff (1 FTE), Program Assistant (0.7 FTE), Resource Worker (0.5 FTE)
- Riverdale and Leslieville BIA engaged in distributing WoodGreen information

SUPPORTS AND SERVICES FOR CHRONICALLY HOMELESS PEOPLE

OUTCOMES

- Funding for a full-time kitchen worker enabled the drop-in centre to provide more nutritious meals more regularly, as well as involve clients in cooking
- Extra staff and training in crisis prevention and restorative justice led to 27 instances where 911 calls were avoided
- The presence of extra staff was credited with reducing overdoses, near-overdoses and directing people to a safe-use site in the neighbourhood
- The program used a relationship-building model and emphasized life skills development for people who are homeless or chronically housed
- Three long-term drop-in users were housed, at least one of whom is now employed

IMPACT

165 SHARED CARE VISITS

27 ED DIVERSIONS

680 MEALS SERVED

55 NALOXONE KITS DISTRIBUTED

3 CLIENTS HOUSED

RECOMMENDATIONS

- The program demonstrated value for a significant number of chronically homeless people
- Data and staff reports on ED diversions demonstrate the potential for crisis intervention and restorative justice training, as well as enhanced staffing of the drop-in facility
- Given the focus on relationships of this successful, low-cost intervention, the impact of short-term funding models and sustainability issues should be considered

2.5. NURSE-LED OUTREACH TEAMS (NLOT)

TAKE-AWAYS

- Project did not run due to difficulty recruiting staff
- Recruitment challenges exacerbated by short timeframe and need for specialized skills (RNs with outreach experience)
- Consider additional employment models and partnerships to address staffing concerns in future

GOALS

1. ED diversion through providing care to seniors in the community during winter surge season
2. Evaluation of utllization of the NLOT team through data on the number of buildings and homes supported, and visits to the ED

COSTS

- $90,000 was originally budgeted; this was revised to $20,000
- No funds were expended

INTERVENTION

- Additional RN support to long-term care homes and supportive housing in east Toronto to complement services provided by the existing NLOT program
    - Target housing facilities with higher emergency department (ED) utilization
- Project did not run due to difficulty recruiting staff. A number of strategies were tried to overcome this problem, but they were not successful
- Due to difficulties finding RNs, longer-term alternative staffing strategies such as inclusion of RPNS in some aspects of the program are being considered

2.6. RAPID ACCESS TO ADDICTION MEDICINE (RAAM) CLINIC

TAKE-AWAYS

- Project did not run due to difficulty scheduling addiction-medicine specialists
- Engage clinicians earlier to ensure expanded service offerings align with specialist capacity
- Consider additional employment models and partnerships to address staffing concerns in future

GOALS

1. Plan was to expand capacity of the existing RAAM clinic at Michael Garron Hospital
2. Improve access and client experience through reduced wait-times and more convenient hours
3. Expanded education and preventative care could reduce use of the emergency department as well as other intensive emergency services

COSTS

- Original planned investment of $110,000 in surge funding
- No surge funding expended

INTERVENTION

- Project did not run as planned due to difficulty with scheduling addiction-medicine specialists to provide additional capacity with minimal lead-up time
- Focus of plans for the RAAM clinic has shifted to renovations that will better facilitate delivery of the program
- The renovated clinic will free up space in the ED on two half-days per week, and is expected to improve the experience of RAAM clinic clients

3. STRATEGY 2: REDUCE TIME IN ED

Projects in this section focused on making patient encounters in the Emergency Department (ED) more efficient. Strategies employed include:

- Opening a paediatric after-hours clinic
- Adding staff to increase ED capacity
- Improving access and flow throughout the ED

The goal of these strategies was to reduce ED wait times and improve patient flow in the ED. By doing so, patients are likely to spend less time in the ED and have a better hospital experience.

The table below lists three projects earmarked for funding through the surge relief initiative. All of these projects ran. The table on the next page summarizes the main impacts of the projects. Additional information about each project is presented on the following pages.

TABLE 3.1. STRATEGIES TO REDUCE TIME IN ED

PROJECT	PARTNERS	TYPE	DATES	INVESTMENT
Paediatric After-Hours Clinic	MGH	New	Jan 21 - Mar 29 (10 weeks)	$20,000
Increased ED Assessment Capacity	MGH	Scale-up	Dec 22 - Mar 31 (14 weeks)	$115,200
Improving Access and Flow in The Hospital	MGH	Scale-up	Jan 8 - Mar 31 (12 weeks)	$45,000

TABLE 3.2. STRATEGY 2 OUTCOMES

PROJECT	REDUCED TIME IN ED	OTHER IMPACTS
Paediatric After-Hours Clinic	PIA: 2 hours faster LOS: 1 hour less	• 169 patient visits • 100% patient satisfaction
Increased ED Assessment Capacity	6 min faster than 2018 Seen as essential by ED physicians	• 110 shifts staffed • 2090 patients seen by extra shift • Faster lab results
Improving Access and Flow in the Hospital	Time in ED likely reduced, but no hard data to support	

The projects under strategy 2 aimed to reduce time in the ED. The first project did so, reducing both time to initial physician assessment and total length of stay. The second project reduced time in the ED slightly by adding an additional physician shift. More importantly, the additional physician was seen as essential by other ED physicians. The third project aimed to improve access and flow through a number of related initiatives. These likely had a positive impact, but no hard data was available to support this.

3.1. MGH PAEDIATRIC AFTER-HOURS CLINIC

TAKE-AWAYS

- Very positive response from patients
- Low number of users
- Need to redesign and determine right case mix, location, etc. in order to be sustainable

GOALS

1. Divert lower-acuity cases from the Emergency Department at MGH during periods of peak demand
2. Reduce waiting times and improve patient and caregiver satisfaction

COSTS

- Investment: $20,000
- Cost per clinic visit: $118.34 ($20,000/169 patients)

INTERVENTION

- January 21 to March 29 Weeknights, 5 p.m. to 9 p.m. (4 clinic hours)
- Paediatrician on duty
- RN to facilitate assessment, patient flow, and coordination
- Patients go through registration and triage at the Emergency Department and low-acuity cases are diverted to the clinic

PROJECT LEAD: Shelley Darling

MGH PAEDIATRIC AFTER-HOURS CLINIC

EVALUATION OBJECTIVES

1. Assess impact of in-hospital paediatric after-hours clinic on ED flow and waiting times
2. Understand patient demand and satisfaction

OUTCOMES

	2018	2019	2019 Breakdown	
Paeds Visits during clinic hours	8.41 per day	8.51 per day **(+1%)**	Clinic*:	2.9
			ED:	5.6
90th %ile PIA	3:35	**2:16** (-37%)	Clinic:	**0:53** (-75%)
			ED:	**2:54** (-19%)
90th %ile LOS	5:40	**4:47** (-17%)	Clinic:	**4:05** (-28%)
			ED:	**5:00** (-12%)

*Stats exclude 16% of clinic patients who arrived at ED before the clinic's opening time. Stats including those patients:

- 3.4 arrivals per day
- 90th percentile PIA: 1:07
- 90th percentile LOS: 4:59

- Patients diverted to the clinic experienced considerably shorter waiting times than for an average ED visit
- The majority of patients treated were triaged as CTAS-3

IMPACT

169 PATIENT VISITS

100% PATIENT SATISFACTION

70% PATIENTS SEEN WITHIN 30 MINS OF ARRIVAL FROM ED

2/3 PATIENTS DISCHARGED IN UNDER 2 HOURS

3.4 VISITS PER DAY

MGH PAEDIATRIC AFTER-HOURS CLINIC

PROVIDER EXPERIENCE

- A number of advantages were identified, including:
  - Very high patient and caregiver satisfaction
  - Lower waiting times
  - specialist attention, which evidence suggests leads to fewer unnecessary tests
  - availability of diagnostic tests and other hospital-based services when needed
- Direct registration for walk-in and follow-up visits, and capacity to treat higher-acuity patients, were identified as possible strategies to increase the clinic's potential to relieve the ED during surge season

"It's really about providing access to care, in a more efficient and expedited way, with things like access to a paediatrician, some of the diagnostics, the testing that is not available in community settings."

Project Lead

"I also think it's worth it in terms of less investigations, but also the advantage that, if you need investigations, it's actually available."

Paediatrician

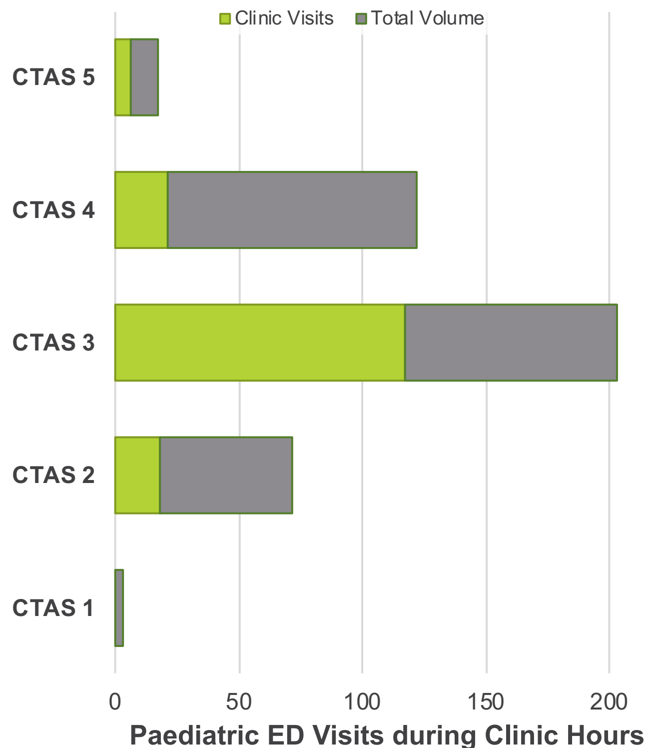
"They always come from Emerg, they have to register at Emerg. So it's not until they get to Triage that I can see them in the system.

Clinic RN

MGH PAEDIATRIC AFTER-HOURS CLINIC

FINDINGS

- Reduction in waiting times for initial physician assessment by more than 2 hours, and length of stay by nearly 1 hour.
- Patients who came to the clinic were higher acuity than expected
- The majority of patients seen at the clinic were CTAS 3s
  - CTAS 4s and 5s were mostly cuts and breaks, which were triaged to the ED yellow zone
- Parents expressed very high satisfaction
- Survey comments indicate that people found the clinic to be fast, efficient, and child-focused
- Survey comments and staff feedback indicate the space and location were ideal



RECOMMENDATIONS

- Starting earlier, e.g. October, would better capture seasonal peaks in ED usage in this population
- Advertising could increase utilization and enable the clinic to augment community based primary care in the evenings, especially given the central location
- A direct intake and registration process could shorten waiting times and relieve the ED further; staff noted that any walk-in model within a hospital should still have capacity to identify serious conditions

> "Prompt, didn't feel rushed, listened to all our questions."
>
> Parent Feedback

3.2. IMPROVING ACCESS AND FLOW IN THE HOSPITAL

TAKE-AWAYS

- Project facilitated a culture shift in the organization towards campus-wide flow
- Clinical leaders report more of a 'pull' vs. 'push' of patients from the ED to the floor
- Positive response from physicians and engagement in supporting flow

GOALS

1. Improve patient flow from the ED to inpatient beds
2. Improve flow across inpatient units
3. Improve flow from hospital to community

COSTS

- Investment: $45,000

INTERVENTION

- Transitioned from individual program-managed flow to corporate flow strategies, in order to:
    - ensure a coordinated approach across the organization
    - maximum utilization of all bed resources across the campus
- Assessment capacity expansion aimed at mid-acuity patients, who often have to wait longest
- ED leadership monitored waiting-times data and explored the impact of additional assessment capacity on other services in order to identify potential bottlenecks
- Invested in new bed board technology to improve bed management, in support of broader access and flow across the hospital

OUTCOMES

- Avoided surgery cancellations during winter surge due to the optimized bed and resource management, enabled by centralized Access and Flow
- Created physician and nursing leadership roles to manage patient flow challenges, to help reduce ED wait times and 'hallway health care', resulting in better bed surge management throughout the winter season

PROJECT LEAD: Dr. Kevin Edmonson

3.3. INCREASED EMERGENCY DEPARTMENT ASSESSMENT CAPACITY

TAKE-AWAYS

- Small improvements in wait times
- Additional shift was seen as essential by emergency department (ED) physicians
- Continue to fund and monitor flow within the ED and look for further opportunities to optimize patient and information flow

GOALS

1. Increase assessment capacity during winter surge season
2. Avoid significant increases in waiting times during periods of peak demand
3. Ensure the ED maintains adequate capacity for assessment and discharge in a timely, organized manner

COSTS

- Investment: $290,000
- Cost per patient seen by extra shift: $139 ($290,000/2,090 patients)

INTERVENTION

- Additional shift from 1 p.m. to 9 p.m. (+8 physician hours daily) targeted at the period of peak demand
- Assessment capacity expansion aimed at mid-acuity patients, who often have to wait longest
- ED leadership monitored waiting-times data and explored the impact of additional assessment capacity on other services in order to identify potential bottlenecks

INCREASED EMERGENCY DEPARTMENT ASSESSMENT CAPACITY

OUTCOMES

- Positive impact on waiting-times (6 minutes fewer compared to last year), despite overall increase in volume compared to previous year
- Physicians reported that the timing of the shift coincided with peak periods of demand on the emergency department
- Physicians also described additional assessment capacity as making the department less hectic and ensuring patient care was not compromised by high volumes during surge season
- Physicians expressed concern about the potential for bottlenecks elsewhere in the emergency medicine process if additional assessment is added
    - While there are a number of potential areas for bottlenecks, data from this year's pilot indicates that the waiting-time for lab results actually decreased significantly more than the overall time emergency-room patients spent at the hospital

RECOMMENDATIONS

- Fund again during surge season
- The hours chosen for the extra shift this year appear to have had an optimal impact
- Continue to monitor bottlenecks and patient flow

IMPACT

110 SHIFTS STAFFED

19 PATIENTS PER SHIFT

6 MINS DECREASE IN PIA

23 MINS DECREASE, TIME FOR LAB RESULTS

4. STRATEGY 3: TRANSITION HOME MORE EFFICIENTLY

The projects in this section focused on getting patients out of hospital quicker and more efficiently. Strategies included two pilot programs and a targeted expansion of existing services:

- Discharging low-risk patients home sooner, with added home support
- Transitioning low-acuity patients to a reactivation centre before going home
- Providing in-home supports for patients with high needs

The goal of these strategies was to improve patient throughput and successfully transition patients home. By providing additional resources and supports after discharge, it was hoped patients would transition home smoothly and be more likely to stay out of hospital.

The table below lists three projects earmarked for funding through the surge relief initiative. All projects ran. The next table summarizes the main impacts of these projects. Additional information about each project is presented on the following pages.

TABLE 4.1. STRATEGIES TO TRANSITION HOME MORE EFFICIENTLY

PROJECT	PARTNERS	TYPE	DATES	INVESTMENT
Home2Day	MGH	New	Jan 14 - Mar 31 (11 weeks)	$67,670
Retirement Home Reactivation Solution	MGH, SE Health, Beach Arms	New	Feb 5 - Mar 31 (8 weeks)	$129,555
Enhanced In-Home Supports for High-Needs Neighbourhoods	VHA	Scale-up	Jan 9 - Mar 31 (12 weeks)	$48,958

TABLE 4.2. STRATEGY 3 OUTCOMES

PROJECT	TRANSITION HOME	OTHER IMPACTS
Home2Day	Hospital LOS: - 3.5 days + 6.5 days home support	• 17 patients enrolled • 238 in-home visits • 30-day readmission same
Retirement Home Reactivation Solution	Hospital LOS likely reduced, but data is unclear 14 days reactivation + up to 14 days home support	• 10 patients enrolled • Avg days in program: 21.9 • 5 patients readmitted
Enhanced In-Home Supports for High-Needs Neighbourhoods	Hospital LOS likely reduced, but data is unclear Weekend discharge, home-making, and extreme cleaning	• 57 clients supported • Positive client feedback

The projects under strategy 3 had mixed success in transitioning patients home more efficiently. The first project was successful, reducing hospital length of stay by 3.5 days while providing 6.5 days more home support. The second project was unsuccessful, with initial hospital LOS likely reduced but a very high (50%) readmission rate. The third project also likely reduced hospital LOS, but had limited reach and lower volumes than expected.

4.1. HOME2DAY

TAKE-AWAYS

- On average, patients transitioned home 4.3 days earlier than control group
- 30-day readmissions same as for comparable non-intervention group
- Continue to invest and scale up given the good value for money, with attention to recommendations

GOALS

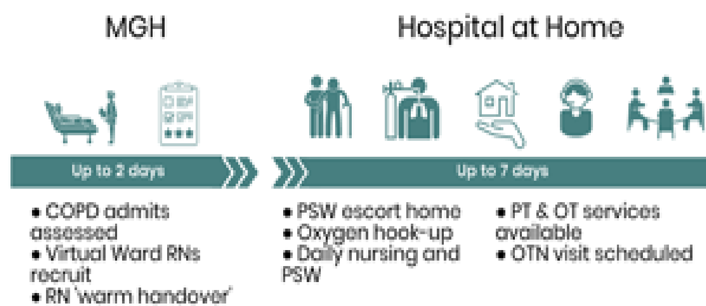
1. Support early discharge and smooth transition to home for low-risk COPD patients
2. Breaking the silo between hospital and home care
3. Reduce hospital length of stay, hospital readmission, emergency department visits, and costs
4. Improved patient satisfaction and self-management competency at home

COSTS

- Investment*: $67,670
  MGH: $20,000
  VHA: $27,780
  WoodGreen: $19,870
- Cost per patient for care at home: $4,229 ($67,670/16 patients)

**Does not include in-kind contribution for start-up and evaluation costs.*

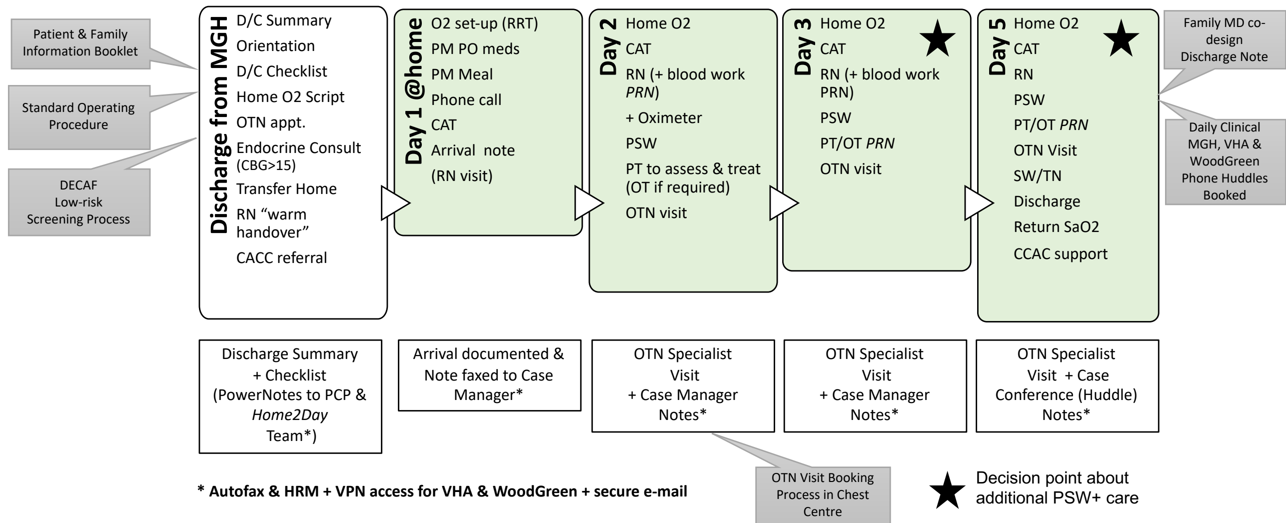
INTERVENTION



- Assess patients in hospital
- Discharge home on Day 2
- Provide support at home (daily RN, PSW, and rehabilitation services)
- Inter-team communication
  - Daily clinical huddle (all partners)
  - Weekly leadership huddle (all partners)
  - Viewing access to MGH patient records
- Evidence-based model supported by dialogue and research capabilities

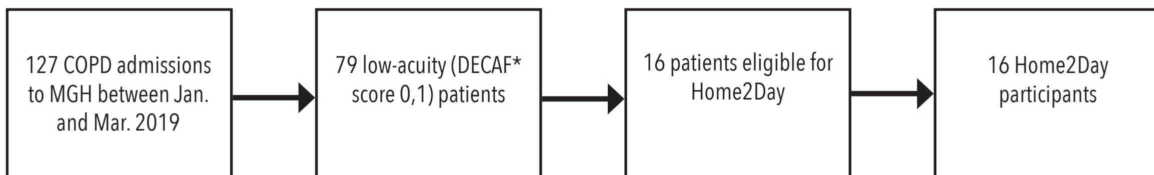
PROJECT LEADS: Ian Fraser (MGH), Courtney Bean (VHA), Annabelle Bryden (WoodGreen)

HOME2DAY PROCESS MAP



POPULATION

TARGET: LOW-RISK COPD PATIENTS



- Low-acuity patients who were not eligible generally needed services and supports beyond those included or had complicating factors that made them unable to participate
- No potential patients declined the program

** DECAF= eMRCD 5a/5b + Eosinopenia + Consolidation on CXR + Acidemia (pH<7.3) + atrial Fibrillation*

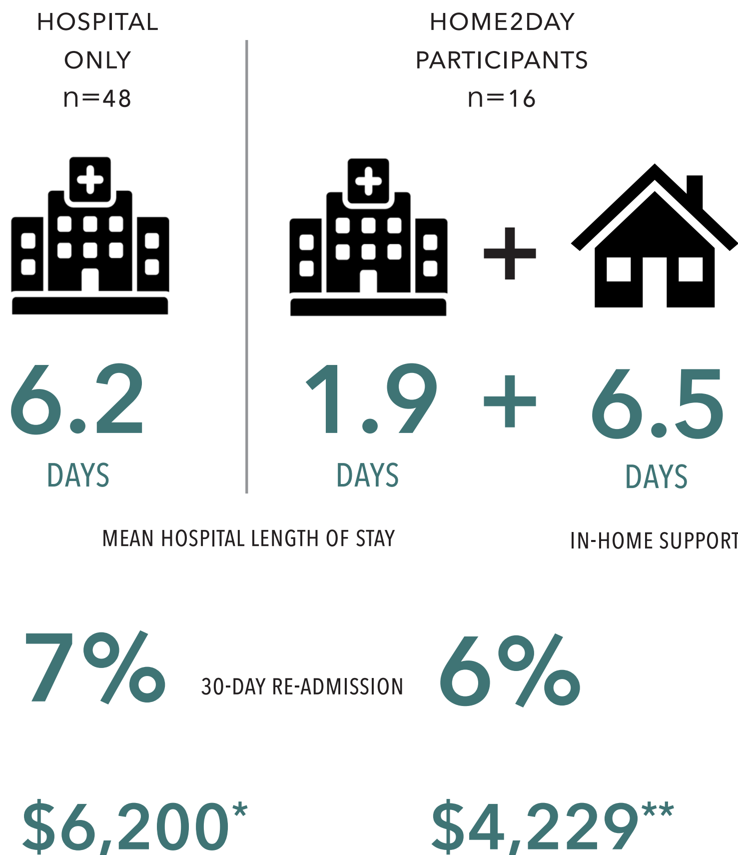
HOME 2DAY

EVALUATION

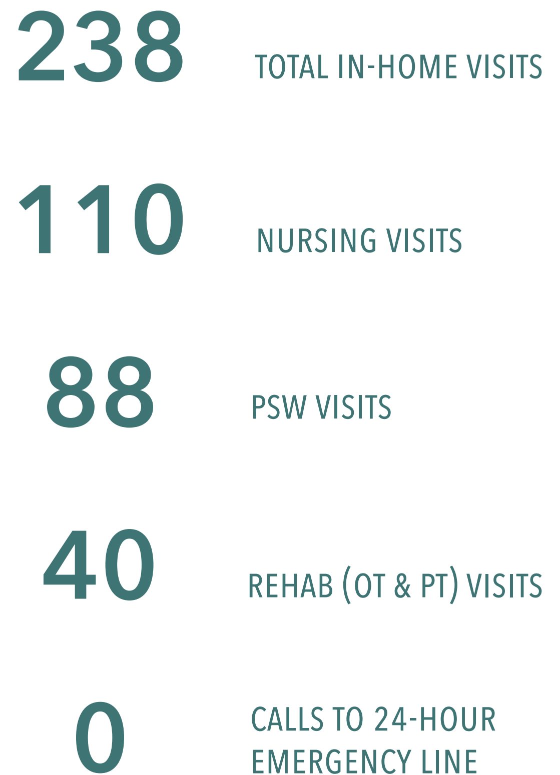
- On average, patients went home 4.3 days sooner
- The average length-of-stay in the program (hospital plus home care) was 1.9 days in hospital and 6.5 days at home
- Re-admissions remained low
- Providers reported that the program helped break down silos between hospital and come care

> “I like short interactions with patients ... I get to see the results and measure the set goals within 7 days.”

OUTCOMES



SUPPORTS



*Based on the average cost of $1,000 per hospital day for this patient population
**Cost of supporting clients in their home for an average of 6.5 days, plus the cost of an average 1.9-day hospital stay.

HOME 2DAY

PATIENT EXPERIENCE

WHAT DID PATIENTS LIKE?

- Early discharge to home

  "I was very happy to go home early ... I was pretty sad and lonely in the hospital."

- Transition back to normal life with support provided at home

  "It [homecare] was wonderful...they helped me settle in."

- Patient education at home

  "Teaching was amazing, especially breathing exercises ... I've learned a lot and taken step to help my mother."

WHAT DID PATIENTS WANT TO IMPROVE?

- Provide more information about the program prior to enrollment

  "We did not know what to expect. [...] We felt that we were rushed into making a decision."

- Day one at home is "overwhelming"

  "It was very early in the morning ... I was very tired coming home from hospital ... This person asked me to get a pen and paper and then spoke for five minutes non-stop ... it was too much."

- Be more flexible and consider individual patients' needs and preferences

  "I was not ready to be discharged ... I was in pain and I was distressed and worried about breathing issues and panic attacks ... but there was no bed available."

  "I did not use the 24/7 phone number...I did not need it."

- OTN set-up needs improvement

  "Even though I had help and he knows all about technology and we spent so much time on it, we could not get it to work."

HOME 2DAY

PROVIDER EXPERIENCE

WHAT ARE THE PROGRAM'S STRENGTHS?

- It benefits the patients

"It decreases patients' exposure to infection ... and they get to go home."

"Having received nursing and PT at their home, patients will be one step ahead in their path to recovery."

"Patients are wrapped really well … daily visit by nurse, PT for seven days, a lot of teaching."

- Teamwork

"It's great to work with the nurse ... I can consult with her ... it is also great that there are different people checking patients' vitals."

"I like working with a team ... direct and regular communication with the team."

"There were some challenges at first…I brought it in the daily huddle…it was resolved quickly…now things [are] running smoothly."

"Nice circle of care ... nice streamlined process ... we all know where we stand ... nobody works in silos ... we are all well connected... everybody seems to be on top of it."

HOME 2DAY

PROVIDER EXPERIENCE

WHAT COULD BE IMPROVED?

- Provide more information about the program prior to enrollment

  “Patients don’t have enough information about the program ... they need to know what to expect ... who we are ... why are we at their homes.”

- Day one at home is “overwhelming”

  “I find patients to be overwhelmed especially on day one with all the services, all the people, and all the scheduling.”

- Be more flexible and consider individual patient’s needs and preferences

  “Most of these patients do not need personal support.”

  “My patients were independent...had family around them...and did not need personal care....or they need it but decline it...but they enjoy companionship.”

- OTN set-up needs improvement

  “Even we are not clear on the process…and our patient population…like they don’t have emails or even wi-fi.”

- No information about the home environment

  “It would be great if we receive, at the very least, a short description about the client like who lives with the patient and if they have pets.”

  “Client had a big dog … and you know not everybody is comfortable with them … I’m not … I had to reschedule the visit.”

RECOMMENDATIONS

1. Revisit the consent process
    - It's not about the amount of information provided to patients
    - It is about how to communicate the information given patients' state of mind and physical health
2. Make program more flexible to accommodate individual patients' needs and preferences
    - Make day 3 discharge possible
    - Not all patients need personal care support
    - Many patients did not need all of the supports provided
3. Have a complaint-handling process in place
    - Follow up with patients and/or family members to let them know how you addressed their complaint
4. Include an environmental assessment to ensure safety and satisfaction of home care team, as well as patient safety
    - Do prior to discharge from hospital

IN THEIR OWN WORDS...

“Brilliant idea … who wants to stay in the hospital when you get to go home … more comfortable and less noisy.”

Patient Feedback

“I have a sister [with COPD] but she lives somewhere with no such program … it's a shame because she would benefit from it.”

Patient Feedback

“Please continue the program.”

Patient Feedback

4.2. RETIREMENT HOME REACTIVATION SOLUTION

TAKE-AWAYS

- On average, patients spent 20 days at Beach Arms and received 6 days of home care However, this was highly variable (range 5-31 days for Beach Arms, 0-14 for home care)
- High readmission rate
- Low numbers and multiple implementation issues suggest major changes needed before trying program again

GOALS

1. Reduce length of stay by moving ALC patients out of hospital
2. Avoid 30-day readmission through retirement home activities and home care
3. Attach patients to community care

COSTS

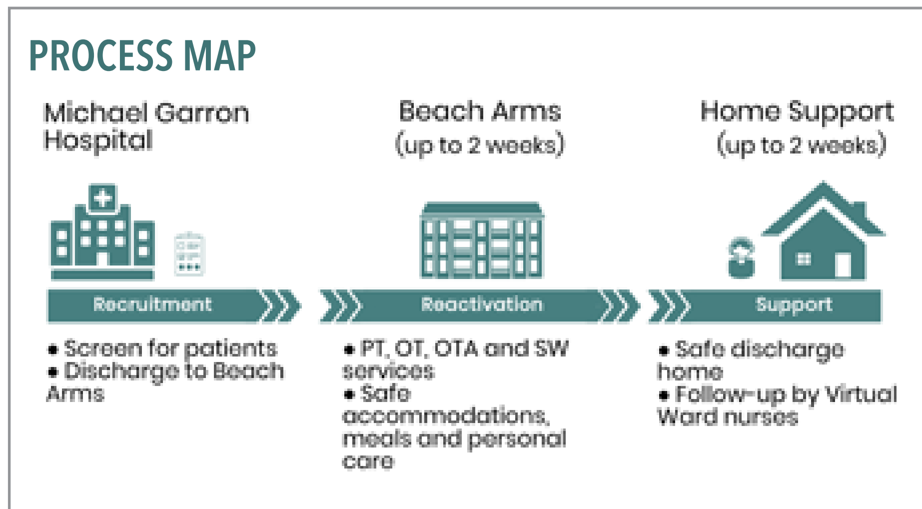
- Investment: $129,555
- Cost per patient: $12,995.50 ($129,555/10 patients)

INTERVENTION

- 2 weeks of reactivation and up to 2 weeks of in-home support with PT, PTA, OT, SW support as needed
- 5 reactivation beds designated at Beach Arms retirement home
- Tailored reactivation focused on:
  - Increasing strength, mobility and endurance
  - Improved self-care
  - Enhanced patient motivation
  - Enhanced confidence in the client's ability (family/caregiver)

BEACH ARMS RETIREMENT RESIDENCE Health

RETIREMENT HOME REACTIVATION SOLUTION



OUTCOMES

- Average length in overall program (Beach Arms plus home care): 21.9 days (range 6-28)
  - Average LOS at Beach Arms was 20.2 days (range 5-31)
  - Average length of home-care service period was 6 days (range 0-14 days)
- 2 of 10 patients returned directly to hospital; 3 more were readmitted after discharge to home, for a total readmission rate of 50%

IMPACT

10 PATIENTS ENROLLED

4 PATIENTS SAID THEY ACHIEVED GOALS OF REACTIVATION*

50% READMISSION

**Based on patient survey administered by SE Health.*

RETIREMENT HOME REACTIVATION SOLUTION

ONE PATIENT'S JOURNEY

Female, 88 year old patient; fairly independent and cognitively very sharp. She was admitted for falls (other conditions: diabetes and CHF); she was identified, agreed to be enrolled, and provided consent for evaluation on March 12th.

The decision to be enrolled in the program was made in consultation with the family; the family and the patient agreed to be part of the program after their request for rehab was rejected.

GOALS IDENTIFIED BY PATIENT	PATIENT'S EXPERIENCE
• Her main goal was to walk without falling and independently	• Patient early discharge prevented her meeting her goals • Additionally, patient was not happy with the amount of exercise she received; she was expecting more and routine exercise
CONCERNS IDENTIFIED BY PATIENT	**PATIENT'S EXPERIENCE**
• She was worried if the home was aware of her diet	• Retirement Home was unaware of no-salt diet. Patient became ill and returned to the ED and was admitted requiring early discharge from the program
• She was unsure about the amount and type of exercises she might receive at the home	• She was told by nurses in the hospital that she will be exercising every day but this did not happen
• She was worried about taking stairs during her stay at the home	• It was resolved after she used the elevators on the first day to go to the dining room
• She was not sure if her medication will be sent to the home • She was not sure if her walker and her belongings will be transferred to the home	• Walker and medication was brought to the home by the family (it was not properly communicated to the patient by the nurses or the family)

RETIREMENT HOME REACTIVATION SOLUTION

PROVIDER FEEDBACK

PERCEPTIONS OF THE PROGRAM'S STRENGTHS

- Potential benefits to patients

> “It's serving an essential need.”

> “Healthy eating which could result in losing weight…and socializations…for example patients have to go to the dining room to eat their meals… are the main advantages of the program.”

> “They [patients] don't have to worry about outside or transport; very convenient for them…they can just focus on getting better.”

- Inter-disciplinary team

> “Before this program, I was only focused on patients' specific needs related to my specialty but working in a team, I get a more complete picture of their needs.”

> “We as a team put together a care plan…we adjust the care plan in consultation with others.”

WHAT CAN BE IMPROVED?

- Patients did not have enough information about the intervention

> “They [patients] thought they were being sent to somewhere like Providence [rehabilitation facility].”

> “Patients were not given enough information about the program…so they had different expectations…they thought BA was a rehab.”

> “Patients were not properly oriented…they were looking for fitness programs.”

RETIREMENT HOME REACTIVATION SOLUTION

DESIGN AND IMPLEMENTATION ISSUES

- Inclusion criteria (who is the “right patient”?)

  “The main challenge is finding the right fit for the program.”

  “We were expecting patient[s] with light level[s] of care but in reality we had to bring LHIN to support patients sent to us.”

  “Suitable patients to them [BA&SE] are those that are ready to go home…if they are ready to go home why do they need to be enrolled to the program?”

  “Too many steps in figuring out who is eligible…patients are being rejected for reasons that we don’t understand.”

- Meetings the patients’ needs

  “BA is a retirement home…it does not have equipment needed for patients; for example, walkers, wheelchairs, bars.”

  “Not enough equipment in the home…no hospital bed and they [patients] can fall off…no grab bars.”

  “Necessary equipment could impact patients’ quality of life.”

  “We need to choose somewhere with additional equipment…maybe a long-term care home.”

- Lack of common understanding among partners

  “I don’t understand the allocation of staff for this program. We need more PSW support, for example…I feel money goes in the wrong direction.”

  “We need to have a clear defined parameters in terms of patients’ needs and how to meet their needs.”

  “We need to ensure that there is a common understanding among partners in terms of patients’ needs and how to meet their needs.”

- Working environment

  “We have to carry out our files; so I feel we are a bit disorganized; no Wi-Fi connection; no privacy for phone calls with clients.”

RETIREMENT HOME REACTIVATION SOLUTION

LEARNINGS

This was a new care program involving partners that had not worked directly together before. As a result, a significant amount of time was spent in the first several weeks becoming familiar with each organization's practices and developing confidence in each other.

- For example, it was not clear from the outset who the "ideal patient" would be

Different expectations (e.g., around level of care) led to disagreements on whom to enroll in the program. This was addressed over time through "communication between partners to better understand the program so the right information can be communicated to the patient and for the nurses to recruit the suitable patient."

- As one partner put it, "regular check-ups with partners to see what their concerns are" led to changes in the inclusion criteria as well as other program changes such as the addition of LHIN services to provide PSW support to patients

Communication is essential.

- Lack of information about the program caused concerns for the patient.

From providers, we heard the main learning was to find positive ways to communicate with all partners to ensure all partners are on the same page and share the same understanding about different aspects of the program:

> "Communication between partners to better understand the program so the right information can be communicated to the patient and for the nurses to recruit the suitable patient."

> "Giving confidence to all partners that we are all in this together and work together…so they all realize that each if use bring different experience and perspective to the table."

> "Regular check-ups with partners to see what their concerns are regularly."

RECOMMENDATIONS

1. Before launching program, ensure all partners have a shared understanding of program goals and delivery
    - Clarify who the "ideal" patient is and how patient will be identified
    - Implementation details need to be worked out ahead of time
2. Provide more information to prospective patients before enrolling in program
    - Adjust consent process to allow time for patient to discuss with caregivers and family
    - Follow up with the patient to ensure they understand what is/is not offered by the program
    - Revisit the patient around discharge time from hospital to answer any concerns
3. Clear communication between and within organizations
    - Ensure patient information and history is properly documented and communicated with all care staff at retirement home
    - Share clinical notes between reactivation team and virtual ward nurses
    - Provide discharge notes whenever patient is moved (i.e., to retirement home, to home, back to hospital)
4. Have shared metrics that all partners collect, to allow for evaluation and quality improvement

4.3. ENHANCED IN-HOME SUPPORTS FOR HIGH-NEEDS NEIGHBOURHOODS

TAKE-AWAYS

- Low referral rates in early weeks of program led to low volumes and low numbers overall. Not sustainable in current form
- Consider reinvestment with improved process and communication plans
- Potential for improved patient flow for frail seniors living alone who need in-home support

GOALS

1. Reduce hospital readmissions and ED use by providing practical supports in the home to allow a safe and comfortable transition home and ongoing services to remain at home
2. Facilitate earlier discharge from the hospital by providing deep cleaning services to return homes to a condition consistent with public health standards
3. Bridge service gaps over the weekends to reduce hospital admissions and facilitate discharges over weekends (transition to LHIN funded services)

COSTS

- Investment: $48,958
- Cost per individual supported: $858.91 ($48,958/57 clients)

INTERVENTIONS

- The service programs address patient flow and ongoing support to minimize hospital admissions & readmission to ED by supporting independence and aging in place
- Weekend Discharge Support: The program provides the services of a personal support worker over the weekend to help people remain at home until more stable services can be arranged. Assistance with ADLs, personal care, caregiver relief, light housekeeping, meal preparation, escort from hospital back home
- Home Making Services: The program provides short-term in-home support to help people transition home from the hospital sooner by providing light housekeeping, laundry service, grocery shopping assistance, meal preparation and advance meal preparation, caregiver support, accompaniment to appointments and other needs
- Extreme Cleaning Services: The program provides support to discard extreme clutter and deep cleaning services to help people regain control of their living space and allow them to transition back home from the hospital

VHA Home HealthCare
Creating More Independence

PROJECT LEADS: Jennifer Blum, Barbara Cawley & Lenore Cabral

ENHANCED IN-HOME SUPPORTS

IMPACT

24 WEEKEND DISCHARGES

25 CLIENTS SUPPORTED WITH HOME-MAKING

8 EXTREME CLEANS

1,396 HOURS OF SUPPORT IN THE COMMUNITY

RECOMMENDATIONS

- Potential improvements to promote awareness of community services
  - A dedicated VHA agency staff to be onsite at MGH to promote and facilitate transitions alongside the hospital staff
  - Check-off menu (post card format) listing VHA services for patients based on their needs to be transitioned home
  - Check-off menu to be disseminated especially in the ED to patients/caregivers. While they are waiting they can familiarize themselves with the 'menu of services' and be more aware/receptive to inquiry about services and/or to speak to the VHA Intake Resource Worker for possible setup

IN THEIR OWN WORDS...

"Meghan is very nice and a pleasure to have in our home. I have hip and knee issues and struggle to keep up with cleaning, laundry, and grocery shopping and having Meghan has been a great source of help."

Client Feedback

"Extreme cleaning service was beautiful and I was so impressed. … Overall, the team was amazing and I am very satisfied with the service."

Client Feedback

5. LEARNINGS

The projects that comprised the winter surge initiative were quite varied. These ranged from single organization projects that were extensions of existing programs to multi-organization projects that attempted something new. This diversity makes it difficult to compare projects directly. Nevertheless, some common themes emerged from our evaluation, which we describe below.

THEME 1: MORE TIME FOR PROJECT START-UP

- All project leads said ramp up time was short
- All said they would have benefited from more time at the beginning to plan and launch their programs
- Length of implementation: by the time projects were up and running, funding was ending

THEME 2: STAFFING WAS A CHALLENGE

- Staffing was an issue for several projects
- 2 projects (NLOT, RAAM) did not run due to inability to find appropriate staff
- Other projects (e.g., Reactivation) had delayed starts, in part due to difficulties in finding staff
- Generally, the more specialized the staff position, the harder it was to fill
- An exacerbating factor was the short-term nature of the positions. It is difficult to attract staff to a temporary, 2 or 3 month position

THEME 3: COMMUNICATION IS ESSENTIAL

- Communication was often mentioned as an area for future improvement
- This applied within projects (e.g. who is ideal patient?), across initiatives (e.g., what else is going on?) and within the community (i.e., awareness of walk-in clinic)
- Communication within an organization can be as challenging as between organizations

THEME 4: RELATIONSHIPS ARE ESSENTIAL

- Building new relationships and learning to work together were frequently mentioned as the most challenging aspects of the surge initiative
- Having established good working relationships was a good predictor of project success

THEME 5: IMPLEMENTATION SUCCESS VARIED

- Project implementation spanned from smooth to significantly challenged
- Projects that were extensions of existing programs were easiest to implement

THEME 6: MEASURES TENDED TO BE PROGRAMMATIC, NOT OUTCOMES-FOCUSED

- Metrics and data collected tended to focus on internal process measures (e.g., staff hired, # of patient visits) rather than outcome measures
- An exception was questions on patient surveys, which typically asked about satisfaction and patient experience

THEME 7: EVIDENCE OF LEARNING

- Generally, there was evidence of learning in all projects, even those that did not run smoothly
- Some project leads were much more open to learning and collaboration than others
- Some projects were designed with built-in feedback mechanisms (e.g., weekly huddles) that supported learning. Most did not

THEME 8: OPPORTUNITY TO TEST CHANGE

- Pilots provided opportunity for providers to try out new programs or models of care
- Surge funding facilitated initiatives that might not have happened otherwise
- Some projects (e.g. AMC) have demonstrated value to their organizations and will run again without surge funding

6. RECOMMENDATIONS

Outcomes and recommendations for each project are summarized below. Recommendations are based on whether project goals were met, how well projects addressed surge priorities, patient and client experience (where available), cost, and partnership building (if applicable).

In terms of future planning, projects fell into one of four categories:

A. Successful. Continue funding.

- CHC Supports for Vulnerable Populations, Supports and Services for Chronically Homeless People, ED Assessment, Home2Day

B. Successful. Can continue without funding as program is self-sufficient.

- Albany Medical Clinic Extended Walk-In Hours

C. Mixed results. Need to rethink program goals and/or delivery before funding again.

- Thorncliffe Park After-Hours Clinic, MGH Paediatric Clinic, Enhanced Supports for High-Needs Neighbourhoods

D. Unsuccessful. Do not run again without major changes.

- Retirement Home Reactivation

TABLE 6.1. STRATEGY 1: DIVERT FROM HOSPITAL

PROJECT	OUTCOME	RECOMMENDATION
Albany Medical Clinic Extended Walk-In Hours	Successful "test of change" pilot.	Continue. Self-sufficient. Does not require further funding.
Thorncliffe Park After-Hours Clinic	Successful as a short-term solution to community need. Longer term value not clear.	Need to rethink goals and program delivery if it were to run again. Revisit whether to fund again.
CHC Supports for Vulnerable Populations	Successful continuation and expansion of services.	Continue. Requires funding.
Supports and Services for Chronically Homeless People	Successful continuation and expansion of services, with training opportunities.	Continue. Requires funding.

RECOMMENDATIONS

TABLE 6.2. STRATEGY 2: REDUCE TIME IN ED

PROJECT	OUTCOME	RECOMMENDATION
MGH Paediatric After-Hours Clinic	Mixed results. High patient satisfaction but low patient volumes. Long-term sustainability unclear.	Need to rethink program delivery and implementation. Revisit whether to fund again.
Increased ED Assessment Capacity	Helped as expected	Fund every year
Improving Access and Flow in the Hospital	Helped as expected	Continue utilizing technology investment and adjust as needed

TABLE 6.3. STRATEGY 3: TRANSITION HOME MORE EFFICIENTLY

PROJECT	OUTCOME	RECOMMENDATION
Home2Day	Successful pilot.	Continue and scale-up with adjustments. Requires funding.
Retirement Home Reactivation Solution	Unsuccessful clinically. Multiple implementation issues. Did not reach scale.	Need to rethink program and implementation. Do not fund without major changes.
Enhanced In-Home Supports for High-Needs Neighbourhoods	Mixed results. Successful clinically but had limited reach. Needs higher volumes to be sustainable.	Need to rethink program design and implementation. Do not fund without major changes.

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evaluation, please contact
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