Partners Actively Transforming Healthcare: Redefining patient and provider partnership

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The Change Foundation

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The Change Foundation

- Established in 1995 by the Ontario Hospital Association

- $65 million endowment with charitable status – spend the investment $.

- Mission to improve the patient and family experience as we use the Ontario health care system.

- Spent the last five years working directly with patients and front line staff to look at how the experience could be better and also to understand the best way to engage directly.

- Products of special interest: study on hospital patient and family advisory councils; framework for determining when organizations should pay patients and family advisors, top 15 lessons learned on rules for engagement; policy papers on integrated care and many more.
Who is The Change Foundation?
Background: Health Care in Canada

• Delivered through a publicly funded health care system, with most services provided by private entities

• **Provincially** based Medicare systems; each doctor handles the insurance claim against the provincial insurer.

• Hospital care is delivered by publicly funded hospitals

• The Canada Health Act does not cover prescription drugs, home care or long-term care, prescription glasses or dental care; most Canadians pay out-of-pocket for these services or rely on private insurance

• Limited coverage is provided for mental health care.
Background: Health Care in Province of Ontario

**Local Health Integration Network**
- Hospitals
- Home and Community Care
- Long Term Care Homes

**Ontario Health Insurance Plan**
- Physicians
- Diagnostics

**Private Insurance or Out of Pocket**
- Pharmaceuticals
- Other Treatments
- Long Term Care Homes
Patient-centred Care
An overall philosophy and approach that ensures everything individual providers or health care organizations do clinically or administratively is based on patient needs and preferences.

Patient Engagement
The way in which individual providers or health care organizations solicit patient needs and preferences to ensure they are delivering patient-centered care.

Patient Experience
How patients perceive and experience their care, involving the ability by providers to hear and measure experiences and use this information to change practice, policies, rules.

The Patient Experience in Ontario 2020: What Is Possible?
IAP2 Spectrum of Public Participation

**Inform**
To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.

**Consult**
To obtain public feedback on analysis, alternatives and/or decisions.

**Involve**
To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.

**Collaborate**
To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.

**Empower**
To place final decision-making in the hands of the public.

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**Promise to the public**
- We will keep you informed.
- We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision.
- We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.
- We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.
- We will implement what you decide.

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**Example techniques**
- Fact sheets
- Web sites
- Open houses
- Public comment
- Focus groups
- Surveys
- Public meetings
- Workshops
- Deliberative polling
- Citizen advisory committees
- Consensus-building
- Participatory decision-making
- Citizen juries
- Ballots
- Delegated decision

© 2007 International Association for Public Participation
1. Rounds with family/patient present
2. Expressed needs drive care planning
3. Persons care decisions honoured
4. Visitors no more
5. Patient Advisors/Advisory Councils
6. Patients in employee interviews
7. Capital planning projects
8. Advisory Groups
9. Resource allocation decisions
10. Research priorities
11. Citizens panels
12. Create environment for engagement
13. Engagement is a strategic priority
14. Learn from others

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<thead>
<tr>
<th>To</th>
<th>For</th>
<th>With</th>
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<tbody>
<tr>
<td>Provider makes rules and controls all schedules</td>
<td>Patient/family have some input</td>
<td>Patient/family as source of control</td>
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<tr>
<td>Information not shared with patients</td>
<td>Some transparency, public data</td>
<td>Shared knowledge and decision making</td>
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<td>“I talk-you listen”</td>
<td>“We help you”</td>
<td>“We walk together”</td>
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<td>Compliance focus</td>
<td>Improvement focus</td>
<td>Co-design focus</td>
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<tr>
<td>Unilateral</td>
<td>Benevolent</td>
<td>Partnership</td>
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Audience Discussion:
Where is does your engagement work fit on this spectrum?
The Change Foundation's first health integration report.

Who Is the Puzzle Maker?  2008
Patient and caregiver perspectives on navigating health services in Ontario. The Change Foundation’s first health integration report.

Winning Conditions to Improve Patient Care  2011
In its second integration report, Winning Conditions to Improve Patient care, The Foundation offers its best advice on how Ontario can move closer to an integrated health system and improve patient experience.

Using Patient Experience to Redesign Healthcare Services  2012
Leading UK health policy experts lend wisdom/advice to Ontario’s patient-centred efforts.
Our path to……

• Addresses what we learned from patients and their caregivers in our recent work:
  
  Navigating the system- Is anyone joining the dots?
  
  Getting lost in the transition- Who is the puzzle maker?
  
  Frustration with redundancy, repetition and delay
  
  Communication- Who is listening?
  
  Integrated healthcare is key to improving patient experience

• Links care transitions and health system improvement work under the umbrella of patient centered co-design.

• What we learn in PATH will be used to improve care transitions for everyone in Ontario
Key components/features of PATH

• Patient led experience based co-design

• Seniors with chronic health conditions

• One community partnership
  • -- Patients --Home and community care providers
  • -- Informal caregivers -- Primary care providers
  • -- Social support providers -- Funders and other stakeholders
  • -- Acute care providers -- Mental health care providers

• Care transitions

• Patient experiences
Selecting the PATH Community

1. July 2011  Letter of Intent call was issued; 27 submissions received

2. November 2011  Letters of Intent reviewed; short list of five submissions determined

3. January 2012  Five communities invited to submit full project proposal

4. April 2012  Site visits by Foundation staff to all five sites

5. May 2012  Final determination of PATH community

6. June 5, 2012  $3-million project to improve seniors’ healthcare transitions and use patient input to drive redesign to the Northumberland Community Partnership

7. September 2012  Initial project work began
# What are PATH Goals?

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<tr>
<th>For the Local PATH Community</th>
<th>Measures/Evaluation?</th>
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<td><strong>Experiences</strong> of people served</td>
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<td><strong>Seek and Design</strong> solutions to the real needs of patients and caregivers</td>
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<td><strong>Test</strong> a totally new approach for Ontario – <em>experienced based healthcare co-design</em></td>
<td><strong>Impact of Patient Participation</strong> – experienced based healthcare co-design</td>
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<td><strong>Prompt</strong> system-wide change in Ontario</td>
<td><strong>Value of broad partnerships</strong> for system-wide change</td>
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“Their PATH, Our Journey”
http://www.changefoundation.ca/library/video-path-journey/
PATH Project Overview

**PHASE 1: GATHERING OF STORIES**
- SENIORS & CAREGIVERS
- PARTNER PROVIDERS

- **Phase 1 Completed April 2013**

**PHASE 2: CO-DESIGN PROJECT TEAMS & SMALL TESTS OF CHANGE**
- Patients/Caregivers/Providers Recruited

- **Completed December 2013**

**Project Element 1:** Planning Ahead/Aging Well

**Project Element 2:** My Health Experience

**Project Element 3:** Person Centered Care Provider Model

**Project Element 4:** Transition Coaching and Advocating

**Project Element 5:** Funding Model

**PHASE 3: TESTING PHASE**
- 300 Seniors/Caregivers to test new Products/Processes
- Pilot Group of Providers from each Partner Organization

- **Begins February 2014**
Experience Based Co-Design: A Service Improvement Methodology

- A service *improvement* methodology developed by NHS England specifically for health care
- Starts with a *partnership* between patients, caregivers and staff
- Emphasizes *experience* rather than opinion or attitude
- Uses story telling to identify *touch points in the health care journey*
- Partners work together on *co-designing better processes*
- Systematic *evaluation* of improvements and benefits
PHASE 1: GATHERING OF STORIES

Capture the experience

Understand the experience
What does PATH mean for me as a senior/caregiver?

By participating in PATH, it will allow me to:

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

Present my self-identified health needs.
What are the Improvement Ideas?

- **Planning Ahead and Aging Well**
  - Aging Well Kit, Aging Well Plan
  - Raising awareness in community

- **My Health Experience**
  - Life story/Health Story
  - Monitoring and Tracking

- **Patient Centred Care Provider Model**
  - Building relationships w/ providers
  - Person centred care transitions

- **Transition Coaching**
  - Transition partners trained
  - Matched with patients in transition

- **Funding Model**
  - Explore a patient centered funding design consistent with Excellent Care for All Act
Planning Ahead and Aging Well

PATHway to Aging Well Website

Welcome to the PATHway to Aging Well!
Discover your own personal PATHway to aging well.

Choose an option to begin:
- Aging Well Planning
- Learn about PATH
- PATH Pilot Program Participants

Meet the PATH Partners

Participating in the PATH Pilot Program?
Click Here to access the PATH Pilot Program
Planning Ahead and Aging Well

PATHWAY TO AGING WELL
INFORMATION, PLANNING, RESOURCES.

Northumberland PATH
Partners Advancing Transitions In Healthcare
A first with Ontario Patients

Planning Tools

Aging Well Planning
Information about aging

Seniors Connect

My Dashboard
My personal page

My Notes & Organizer
My notes and virtual wallet

My Life Story
Who I am as a person

My Health Story
My important health detail

My Monitoring
Personal & Clinical Monitoring

My Account
My login and email detail

Planning Information
Community Resources
Family & Caregivers
My Plan
Summary

Healthcare Options

As we age and experience physical, cognitive, emotional, and social changes, we may need additional support and help from others.

Please indicate on the sliding scale below, how important it is for you to know everything about your healthcare?

Not very important Somewhat important Very important

How much control do I want over my healthcare decisions?

Not very important Somewhat important Very important

Please select the following, which best describes your views on contemporary medical interventions

Check one
- No, I do not believe in contemporary medical interventions
- Yes, I believe in contemporary medical interventions but would not use them
- Yes, I believe in contemporary medical interventions and would try them

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Finance, Insurance, Legal
This improvement idea focuses on providing a means for people:

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

### My Health Story

*Includes information pertaining to an individual's health (e.g. personal & family health history, conditions and treatments, decision makers, monitoring,) to share with providers.*

### My Life Story

*Includes important facts about the person (e.g. life experiences, family, personality, daily routines, comforts, goals) to share with providers.*
My Plan

My Values

My values help define who I am. My attitude about myself and aging impacts the decisions I make and how I make choices.

What does having a good quality of life mean to me?

1. Being able to garden every summer
2. Being independent and being able to live on my own

What feelings/experiences come to me when I think about aging?

I've seen some of my friends and family lose their independence as they get older and this frightens me. I want to live my life independently - how I want.
Health Timeline

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

Jan 2012
Stroke
Dr. Ethan McAndrews
Sunnybrook Hospital
Complication: Completely paralyzed on the right side, no speech, frozen face

Jan 2012
Angioplasty
Dr. Sharan Alexander
Sunnybrook Hospital
Complication: Stroke

Mar 1998
Right Medial Meniscus Knee Surgery
Dr. Jacob Diesel (Surgeon)
Toronto General Hospital
Complications: Infection

Apr 1991
Hospitalized with Severe Pneumonia
Dr. William Morgan (Family Physician)
Credit Valley Hospital (Mississauga)

Apr 1982
Tonsillectomy Surgery
Dr. Michelle Huang (Surgeon)
Credit Valley Hospital (Mississauga)
Complications: N/A
The Technology
Self Monitoring and Communicating Self Identified Needs
Self Monitoring and Communicating Self Identified Needs
Real Time Feedback
After Each Healthcare Encounter
Core Principles
Respecting and honouring the beliefs of persons and families
Collaborative engagement and partnership with persons and families
Excellent communication for shared decision making with persons and families
Holistic care with persons and families
Empathetic relationships with persons and families
The Power Of Community Engagement: PATH Volunteer Transition Coaches

• Introduction of **formally trained volunteers** matched with seniors/caregivers
• Coach’s role is to provide support and encouragement during transitions
• Supported through community partnership (CCN & YMCA)
• Formal recruitment and screening process
• Education module
Desired Outcomes:
Meeting the persons self identified needs in the community will:

- **Improve** the quality of life for the person and their caregiver
- **Reduce** unnecessary ER, physician, and hospital visits
- **Support** caregivers and decrease caregiver burden
- **Create** a partnership service delivery model
- **Decrease** overall healthcare costs
# What are PATH

## Goals?

### For the Local PATH Community

- **Improve** healthcare experiences and transitions
- **Seek and Design** solutions to the real needs of patients and caregivers

### For The Change Foundation

- **Test** a totally new approach for Ontario – *experienced based healthcare co-design*
- **Prompt** system-wide change in Ontario

## Measures/Evaluation?

### Experiences of people served
- Person centered care practices in place
- Care experience, anxiety, etc.

### Effectiveness of improved transitions
- Patient Activation Measure
- Patient Assessment of Care for Chronic Conditions
- Readmissions, unplanned ED visits

### Impact of Patient Participation – experienced based healthcare co-design

### Value of broad partnerships for system-wide change
I had all of the services that I needed to meet my needs
Did you feel that you had to repeat your health condition and information unnecessarily?
CollaboRATE Scale

Week 38
The impact of PATH: a patient’s perspective

https://youtu.be/8FoeBOl9y9E
**SPINOFFS OF PATIENT ENGAGEMENT**

- Chaplaincy
- HELP (Hospice Elder Life Program)
- Community of Practice
- Emergency Room
- Acute Care
- Post Acute
- Safe Mobility Committee
- CCAC: Staff and Board
Audience Discussion:
Where COULD your engagement work be this spectrum?
Value & Impact of patient Involvement

✓ Positive, respectful, productive relationships
✓ Increased meaningful engagement in co-creating knowledge and shaping change
✓ Increased capacity of both providers and p/c for partnering in

“The enthusiasm of the caregivers and patient members really helped to fuel and accomplish change of a significant nature. Their stories encouraged ‘thinking outside of the box’ to ensure patient-centered care is adopted”
Value & Impact of Broad Partnerships

☑ Greater use of Experience-Based Knowledge in shaping decisions & solutions
☑ Stronger, more productive relationships & collaborations among partners

→ Shared accountability for transitions
→ Alignment of resources to support ongoing patient involvement
Outcomes for The Change Foundation

✓ Authentic opportunity to engage – patients/caregivers moved from the periphery to the core
✓ Shifting provider thinking and practices to support improved patient experiences
✓ Building capacity for co-design and prototyping new strategies and solutions
✓ Created interest and avenues for change & involvement in the community
✓ Surfaced barriers to inform strategy going forward
Questions?

Thank you!

For more information:

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@TheChangeFdn
LinkedIn