HSPN HEALTH SYSTEM PERFORMANCE NETWORK

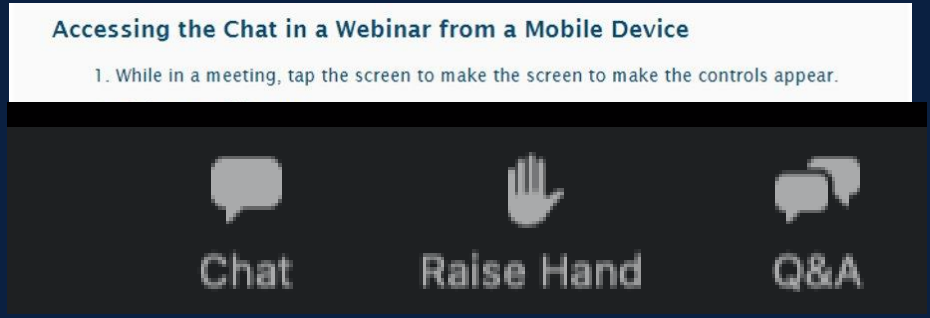
OHT Implementation :

A Focus on Measures for Local Evaluation

HSPN Webinar - November 24, 2020

Welcome & thank you for joining us!

Please let us know who you are by introducing yourself (name & OHT or other org) to all panelists and attendees in the chat box



Poll 1

Have you joined us for an HSPN webinar previously?

- Yes
- No. This is my first event.

Land acknowledgement

We wish to acknowledge this land on which the University of Toronto operates. For thousands of years it has been the traditional land of the Huron-Wendat, the Seneca, and most recently, the Mississaugas of the Credit River. Today, this meeting place is still the home to many Indigenous people from across Turtle Island and we are grateful to have the opportunity to work on this land.

We acknowledge that Canada is home to many diverse First Nations, Inuit and Métis peoples, and that each of you are joining us from one of those many traditional and treaty territories.

Today's event

Host

Dr. Walter Wodchis
Principal Investigator
HSPN

Presenters

Dr. Kaileah McKellar
Evaluation
HSPN

Judy Smith
Patient Family Partner
Southlake

Jennifer Andrachuk
Physiotherapist
Southlake

Margaret Furman
Operations Manager
SE Health

Gayle Seddon
Executive Innovator
Community Partnerships
Southlake

Overview

1. A Focus on Measures for Local Evaluation
    - ❖ *Kaileah McKellar*

2. OHT Implementation
    - ❖ *Judy Smith, Margaret Furman, Gayle Seddon*

3. Discussion

Poll 2

Did you participate in or view the webinar on Logic Models in in February 2020 ?

- Yes
- No

Poll 3

Have you worked on a logic model or measures for your local evaluation ? (Select all that apply)

- I am not involved in measurement work in an OHT initiative
- We are working on a logic model but still need to select measures
- We have selected measures without constructing a logic model
- We have neither a logic model nor measures yet
- We will use primarily measures from the Ministry list (e.g. readmissions)
- We will use primarily measures that we have created locally (e.g. enrolment)

HSPN HEALTH SYSTEM PERFORMANCE NETWORK

A Focus on Measures for Local Evaluation

Kaileah McKellar

Outline

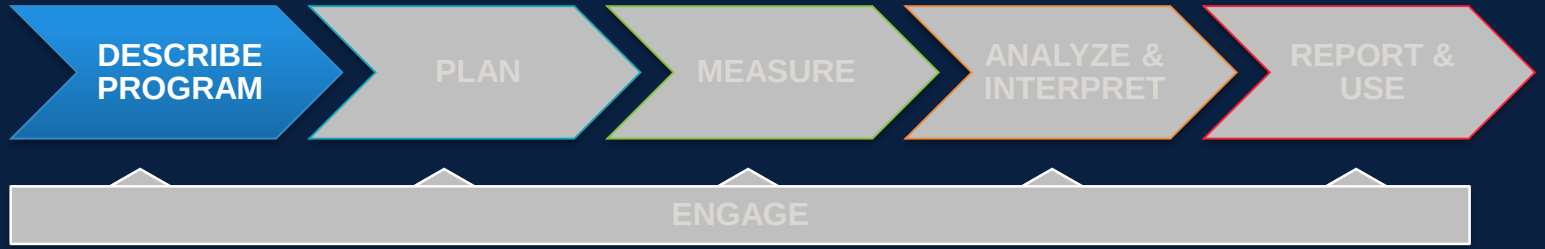
1. Revisiting logic models
2. Developing your evaluation questions
3. Measures to answer your evaluation questions
4. Considerations for design and use of measures

Measurement as part of the Evaluation Process

Evaluation Steps

Measurement as part of the Evaluation Process

Evaluation Steps



What is a Logic Model?

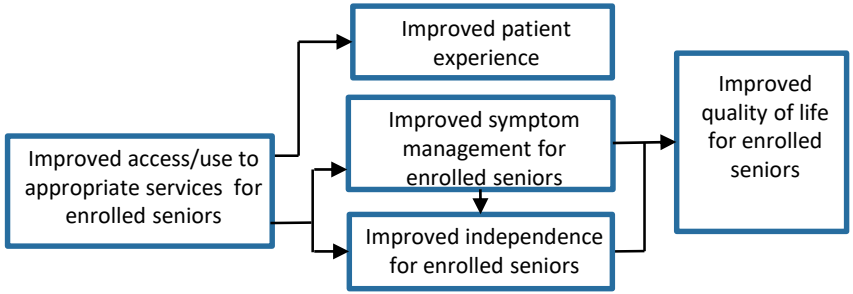
- A graphic depiction of the relationships among the program resources, activities, and the results you hope the program will achieve.

*Goal Statement:*_____

Logic Model for Seniors Coordinated Care Program

Goal: Provide seniors with access to coordinator care to support improved health and quality of life

Resources/ Inputs	Activities	Outputs	Short-term Outcomes	Long-term Outcomes	Impact



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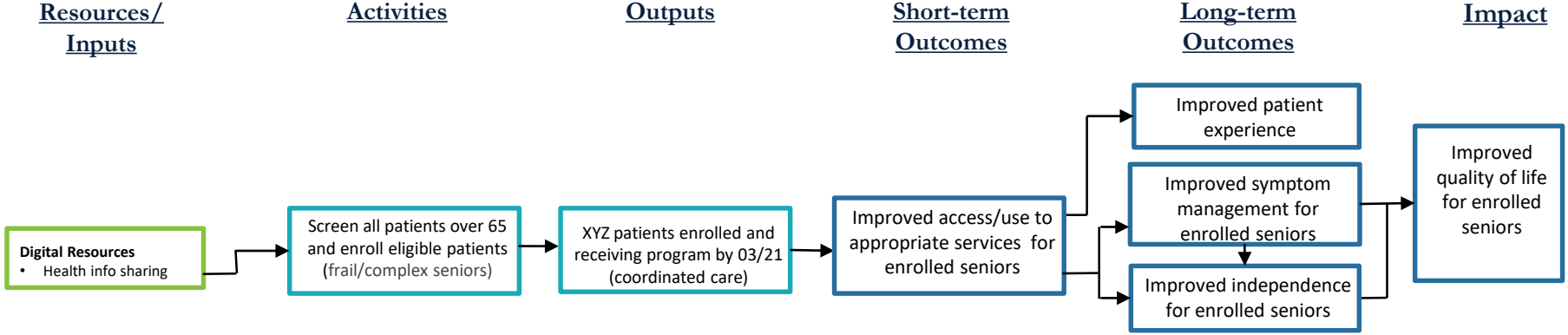

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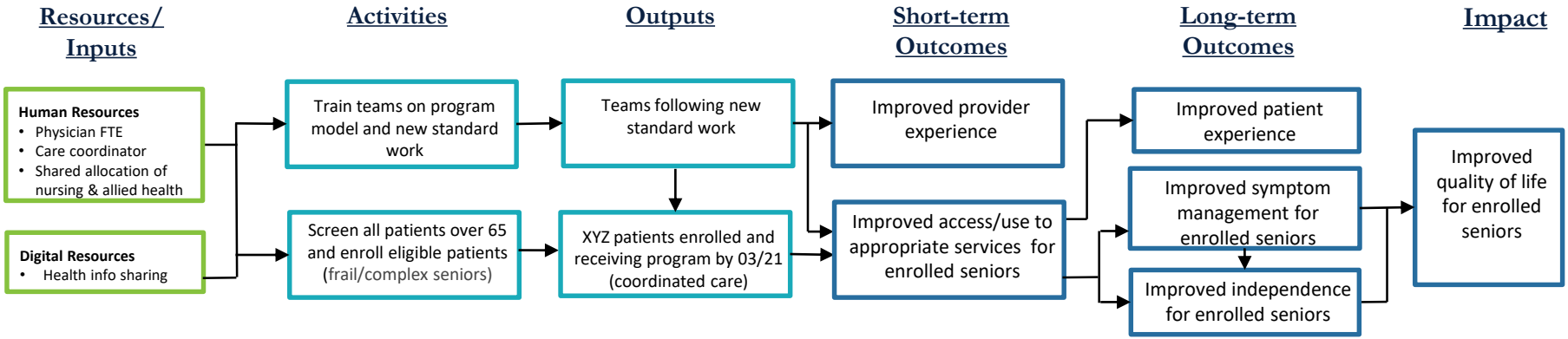
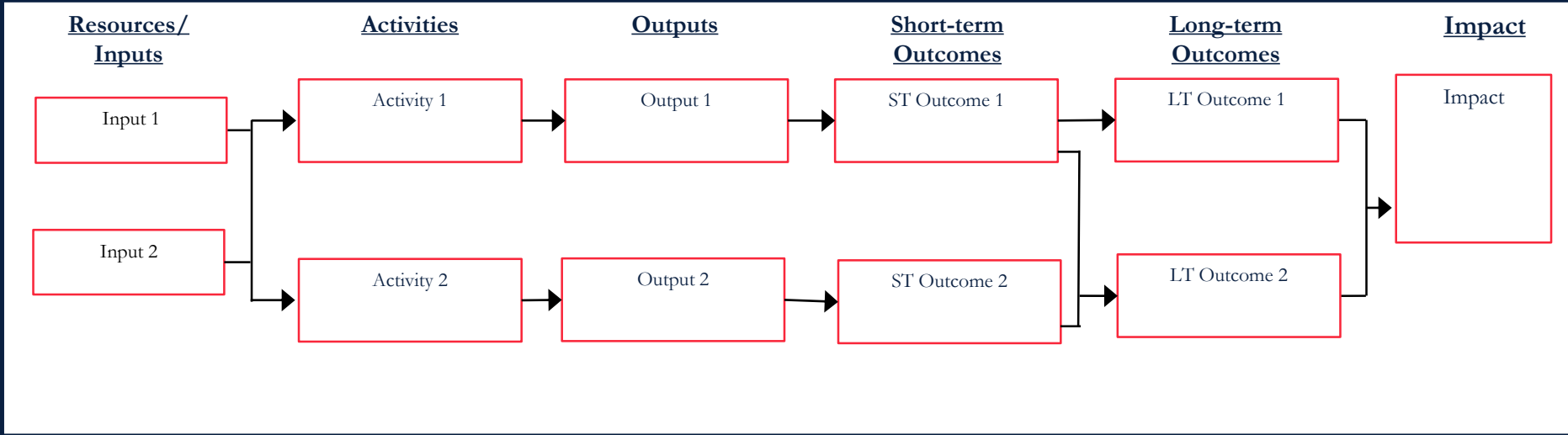


How does a Logic Model Help with Measurement?

1. Identifies processes and outcomes
2. Ensures measures are relevant
3. Timeline of impact
4. Prioritization

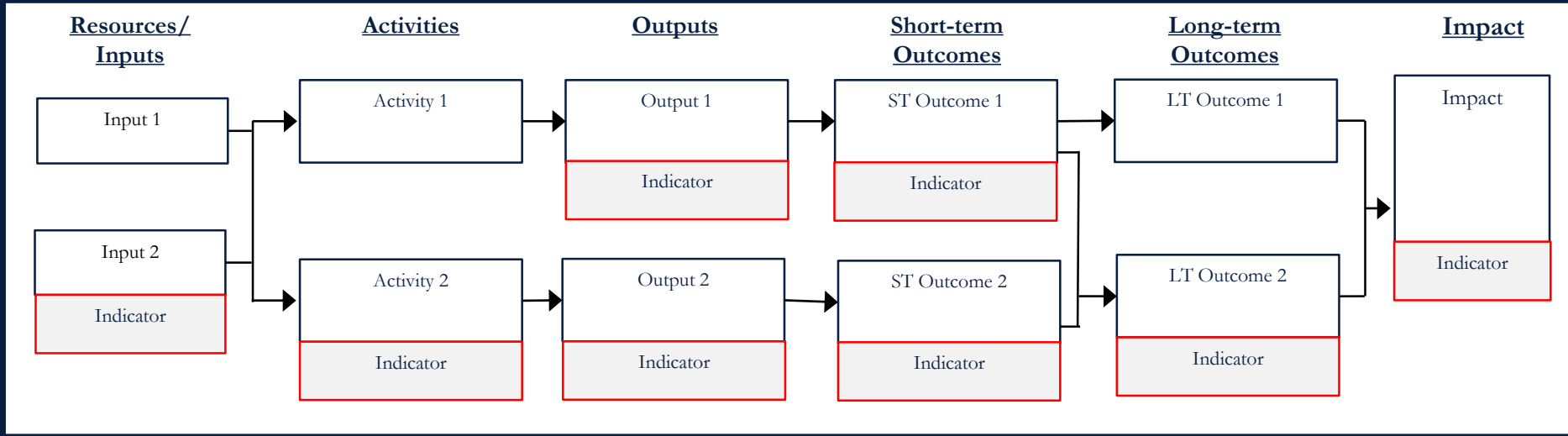
How does a Logic Model Help with Measurement?

1. Identifies the processes and outcomes that should be measured



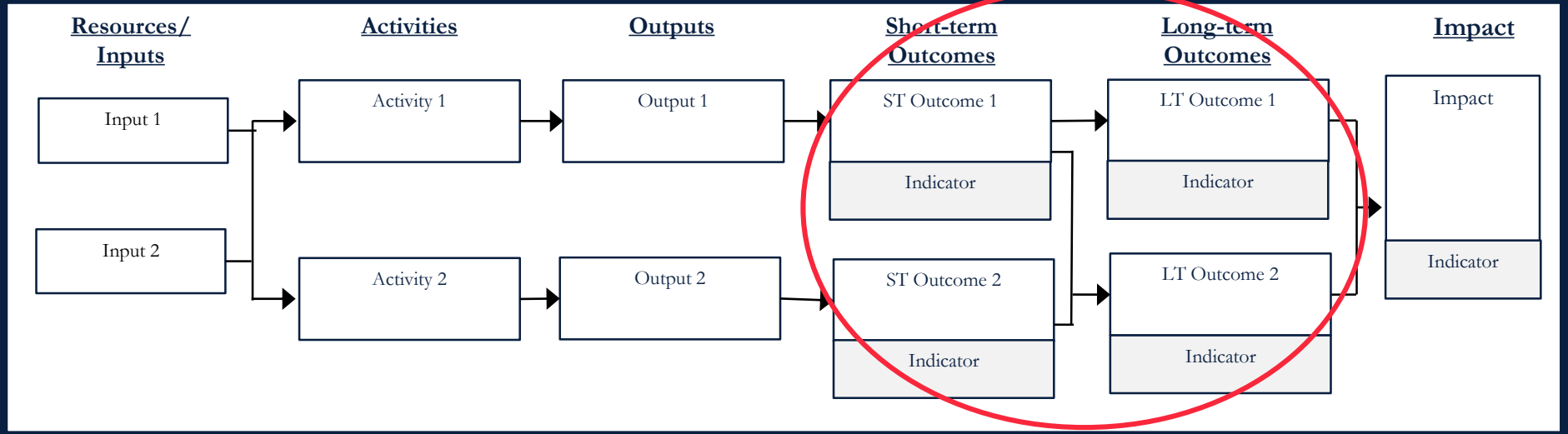
How does a Logic Model Help with Measurement?

2. Ensures measures are relevant to the program



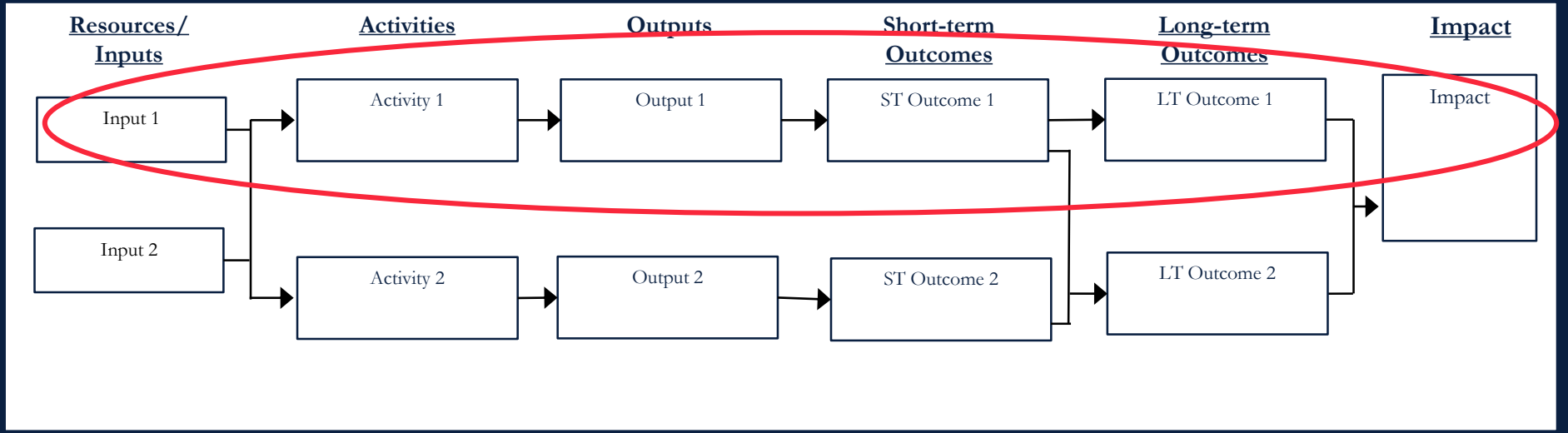
How does a Logic Model Help with Measurement?

3. Help to distinguish short- and long-term outcomes and which are feasible to measure and when



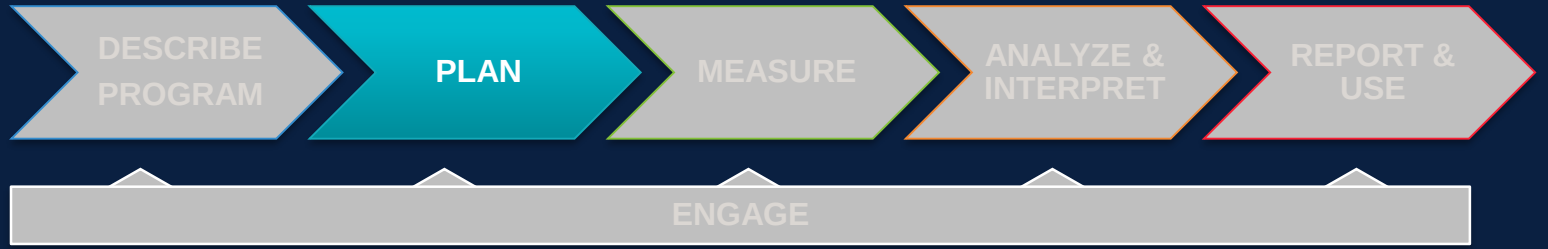
How does a Logic Model Help with Measurement?

4. Support stakeholder discussions and prioritization of measures



Measurement as part of the Evaluation Process

Evaluation Steps



Ways to Prioritize what to Measure

- What is the critical part of your program?
- What do you want to learn?

Evaluation Questions

What do you and your stakeholder want to learn about the program?

Example Process Questions

- To what extent is the program being implemented as planned? Why? Why not?
- Who are we reaching? How does that compare to who we targeted?

Example Outcome Questions

- To what extent was the program successful, in what ways, for whom?
- What unintended outcomes occurred?

Developing Evaluation Questions

1.1
- Involve key stakeholders, including patients, and review your logic model

2
- Brainstorm evaluation questions

3
- Classify your questions
  - Process and outcome; optional other themes

4
- Prioritize evaluation questions
  - Identify primary and secondary questions

Evaluation Question Checklist

- ☑ **Clear, specific, well defined**
- ☑ **High priority and aligned with stakeholders' interests**
- ☑ **Measurable by the evaluation**
- ☑ **Focus on program or program component (aligned with program logic model)**

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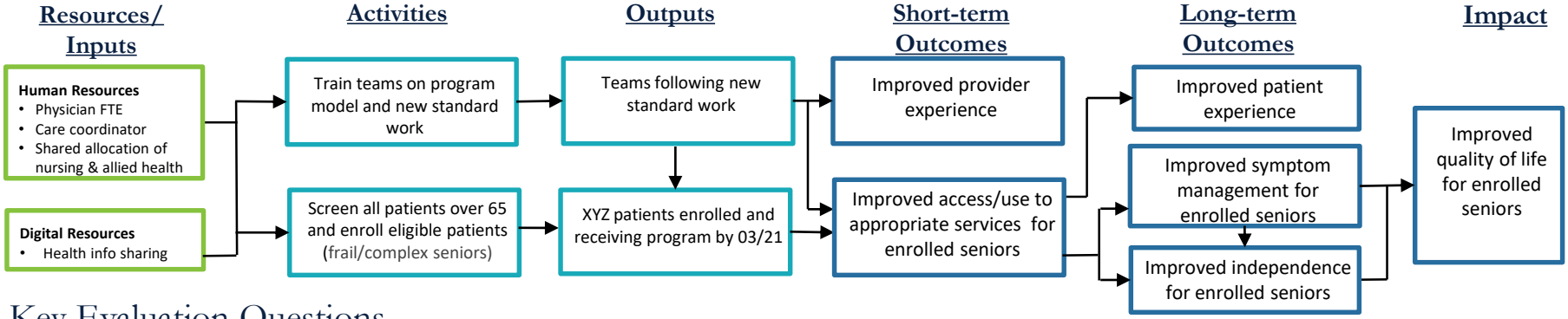

Key Evaluation Questions

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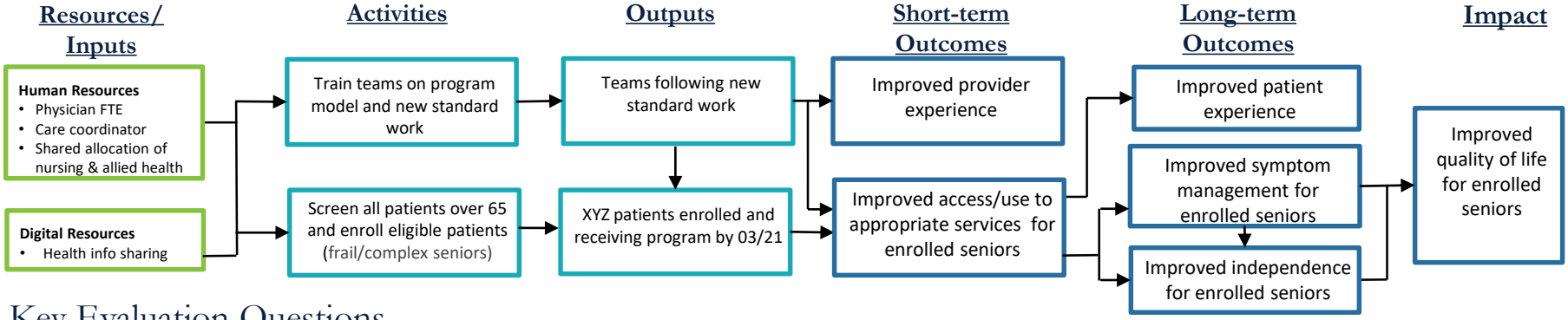

Key Evaluation Questions

Are we providing sufficient training to staff and providers?

Has provider experienced improved?

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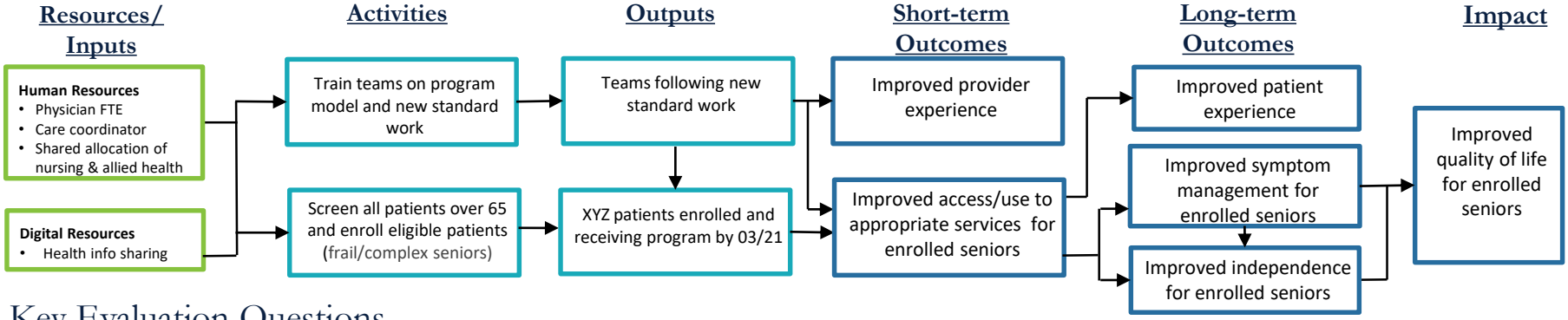

Key Evaluation Questions

Are we providing sufficient training to staff and providers?

Has provider experienced improved?

Are enrolled seniors receiving coordinated care?

Are enrolled seniors benefiting from coordinated care?

What information/data do we need to answer our evaluation questions?

Evaluation Steps

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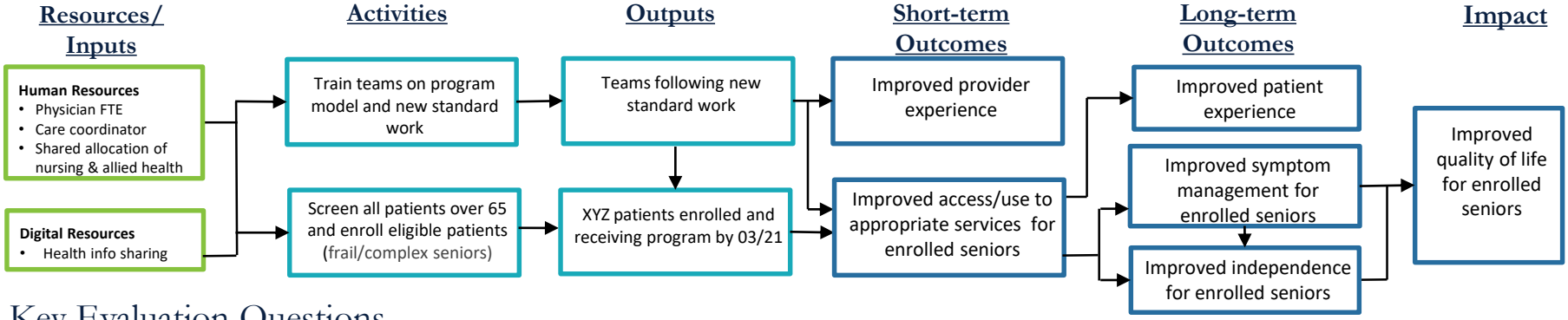

Key Evaluation Questions

- Are we providing sufficient training to staff and providers?
- Has provider experienced improved?
- Are enrolled seniors receiving coordinated care?
- Are enrolled seniors benefiting from coordinated care?

Measures (Indicators)

- # of training session held
- # or training participants
- % providers who felt "program made it easy for me to arrange access for my patients" (strongly agree/agree)

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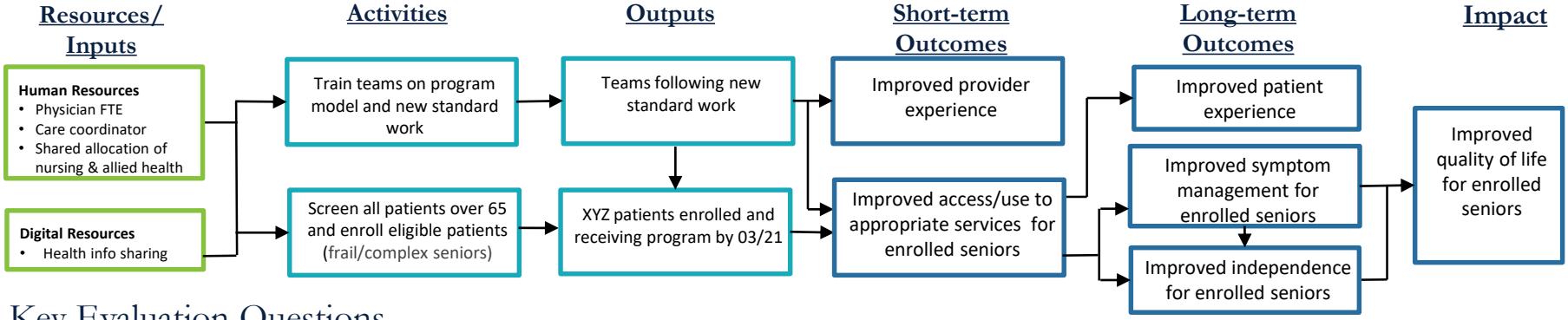

Key Evaluation Questions

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Measures (Indicators)

- # of training session held
- # or training participants
- % providers who felt "program made it easy for me to arrange access for my patients" (strongly agree/agree)
- # of patients in enrolled in the program
- % of enrolled seniors actively attached to a care coordinator
- % of patients with primary care follow-up within 7 days of leaving the hospital for selected conditions
- % of patients felt that their care was well coordinated
- Improved IADL
- Improved EuroQol-5D5l

Getting Detailed about Measures

Level	Inputs/ resources	Activities (Processes)	Outputs	Short-term Outcomes	Long-term Outcomes	Impact
Description of LM component						
Measures (Definition)						
Data source						
Extraction/ Approach to data capture						
Frequency of reporting and audience						

Example Measures

Level	Inputs/ resources	Activities (Processes)	Outputs	Short-term Outcomes	Long-term Outcomes	Impact
Description of LM component				Improved access/use to appropriate services for enrolled seniors	Improved patient experience	Improved quality of life of elderly patients and their caregivers
Measures (Definition)				% of patients with primary care follow-up within 7 days of leaving the hospital for selected conditions	% of patients felt that their care was well coordinated (response strongly agree/agree)	Health related quality of life: Improved EuroQol-5D5l
Data source				EMR, (partners w/ physician network), DAD	Patient survey	EMR
Extraction/ Approach to data capture				Decision support to create new process to pull info	Team analyst to create spreadsheet of responses	Routinely extracted
Frequency of reporting and audience				Monthly, Steering committee	Quarterly, Steering committee	Bi-annually, Steering committee

Considerations: Measures

- Limit number of measures (e.g. 6-12)
  - Aligned with logic model and evaluation question
  - Focus on measures that show if the program is achieving objectives or signal a problem
- Measures should be actionable
- Look at your set of measures as a whole

Considerations: Data Collection

- Leverage existing data sources***
  - E.g. add a flag for patients enrolled in the program
  - E.g. Special projects field (e.g. DAD)
- Build data collection into existing work
- Think about incorporating verification
  - E.g. appointment scheduled: date of appointment vs. checkbox
- Think about frequency (episodic or continuous)
- Think about data extraction
  - Work with IT and decision support

Considerations: Stakeholder Involvement

- Who should be at the table?
  - Patients, families, front-line staff, managers, directors, those who collect data
- Ensure you have general agreement
  - For example, what would indicate:
    - Effective implementation?
    - Quality performance?
    - Success?

Resources Available

- HSPN
  - Logic model webinar (Feb 2020) https://hspn.ca/logic-models-ohts/
  - Logic Model Development Guide
    http://hspn.ca/wp-content/uploads/2020/02/HSPN_OHT_Logic_Model_Development_guide.pdf
  - Current webinar will be available
- RISE (Rapid-Improvement Support and Exchange)
  - RISE brief 8: Data analytics
    https://www.mcmasterforum.org/docs/default-source/rise-docs/rise-briefs/rb8_data-analytics.pdf?sfvrsn=7e7757d5_8
- Other
  - HQO Logic Model Resource Guide
    www.hqontario.ca/portals/0/documents/qi/qi-rg-logic-model-1012-en.pdf

HSPN HEALTH SYSTEM PERFORMANCE NETWORK

OHT Implementation

Judy Smith, Margaret Furman, Gayle Seddon

Webinar Presentation for Measurement

GAYLE SEDDON

DIRECTOR, COMMUNITY PROGRAMS AND PARTNERSHIPS

JUDY SMITH

PATIENT PARTNER

MARGARET FURMAN

OPERATIONS MANAGER, SE HEALTH

JENNIFER ANDRACHUK

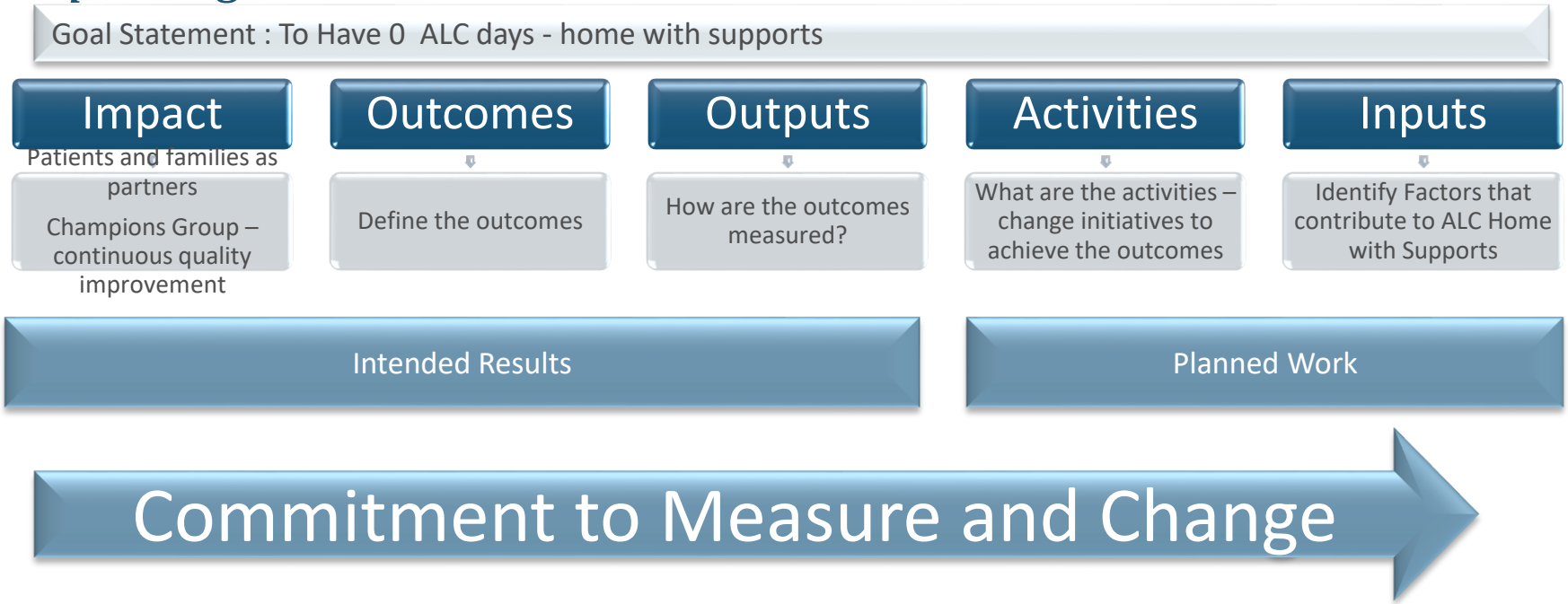
PHYSICAL THERAPIST SRHC

NOVEMBER 24, 2020 |12:00-1:30

SOUTHLAKE
REGIONAL HEALTH CENTRE

Leading edge care. By your side.

Southlake Community OHT: *Our experience using a logic model to drive local measurement and reporting*



SOUTHLAKE REGIONAL HEALTH CENTRE
Leading edge care. By your side.

The Desired Outcome of Southlake@home

In early 2019, Southlake Regional Health Centre launched a unique, integrated home and community care model – the first of its kind in Ontario.

A year later, Southlake@home has helped close to 270 patients transition home successfully and reduced average ALC-to-home days by more than 12 days.

Unlike most hospital-to-home bundled models, Southlake@home took a population-based approach focused on complex populations at highest risk of becoming ALC.

The model **redefines how homecare services are integrated**, and **includes mechanisms to incorporate social, community supports, and primary care**.

OUTCOMES

“We wanted to move quickly to improve. We knew we needed an outcome-focused model that went beyond incremental change – we wanted to fundamentally **REWIRE** how we work together with our partners.

Using human centred design methods helped us **GET STARTED FAST** and kept us focused on what patients actually need.”

SOUTHLAKE
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What would it take to reduce our ALC-to-home days to ZERO?

Southlake@home grew out of a need to get at the root cause of our ALC-to-home pressures. Too many people are spending longer in hospital than they needed.

These patients often decondition and can face an increased risk of hospital-acquired conditions, falls and infections.

We could see from our data that our ALC-to-home patients are mostly medically and socially complex seniors that required significant support through transition; many lived in the same neighbourhoods.

How do we identify what needs to be measured?

To create a clear pathway home for these patients, we knew the program would need to directly address the barriers to transition, through:

- **TRUST** – building patients' confidence in a reliable, dependable home and community care system that provides a safe and supported transition home
- **CUSTOMIZED, HOLISTIC CARE PLANS** – where every care plan starts with understanding a patient's care needs
- **HIGH TOUCH TRANSITIONS** – hands-on integration model that delivers collaboration at the point of care
- **NO ELIGIBILITY CRITERIA** – making it easy for frontline staff and physicians to refer their patients – any patient can be referred that lives within the geographic area
- **HOMECARE TEAMS WORKING AT THEIR FULL SCOPE** – shifting focus from a task-based homecare models to one that allows everyone on the care team to work at their full scope of practice to provide comprehensive care
- **A RELENTLESS FOCUS ON OUTCOMES** – where patient outcomes are measured and accountability is shared among all our partners

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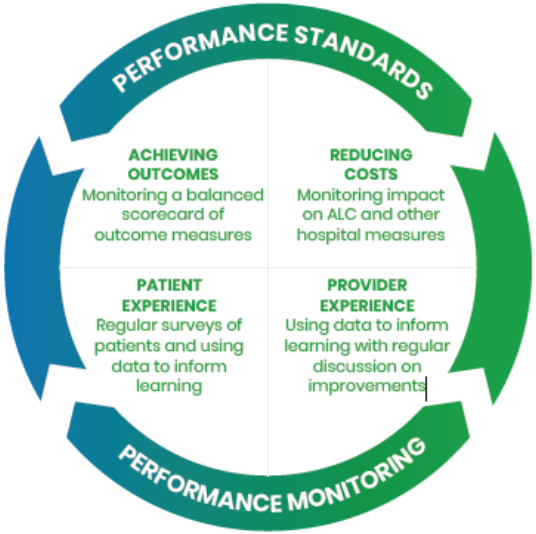
MONITORING PERFORMANCE

GET SERIOUS ABOUT OUTCOMES

Good data strengthens relationships and equips the team with critical feedback to adjust and grow the program. A comprehensive performance framework will help get the most out of available data, and make sure that all the partners have near real-time information to inform their work.

EIGHT TOOLS SOUTHLAKE USES TO KEEP FOCUSED ON OUTCOMES

1. **TRACKING CLINICAL OUTCOMES** – reduced ALC days, ED visits, hospital deconditioning; improved collaboration with primary care
2. **BALANCED SCORECARD** – top-line dashboard to focus leadership on clinical outcomes, patient experience, provider satisfaction, and cost
3. **PROVIDER REPORTING** - minimum data set for provider reporting on core homecare and community care indicators
4. **SERVICE UTILIZATION AND COSTING** - active clients, types of services received, duration of service, monitoring per-patient bundled care costs
5. **POST-TRANSITION PATIENT SURVEY** – a telephone survey to be asked of the patient and or the caregiver within the first 2 weeks post-hospital-to-home transition
6. **DISCHARGE PATIENT SURVEY** – a telephone survey to be asked of the patient and/or the caregiver within the first 1-2 months post-transition from the program
7. **QUALITY AND RISK MANAGEMENT** – monthly provider meetings to narrow in on performance and emerging issues
8. **PROVIDER SURVEY** – regular check ins with provider teams on their experience with the program



ON THE GROUND EXPERIENCE…

For Example:

1. Early example from the project; Patient & Family experience: visit schedule

2. Recent example from the project; Clinical Outcomes: 7-day follow–up with primary care

MEASURING SUCCESS

- Demonstrated improvement on priority hospital indicators (ALC, avoidable ED, readmission)
- Demonstrated improvement on patient experience and activation
- Active oversight of provider outcomes for ongoing quality improvement
- Patient and provider feedback informs program development

THE MEASUREMENT TOOLS

- Comprehensive performance management
- Executive reporting tool/ scorecard
- Homecare monitoring indicators and utilization reporting tools
- Patient and provider survey tools

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Compassion

Patient and Family Advisor: Judy Smith

- Patients and their families are our active partners.
- We didn’t start or end with a process map. We took the time to EMPATHIZE – partnering with patients and families to understand what they’re actually experiencing and plan for the most important touchpoints
- We also took the time to understand what staff experience and what could improve, ultimately creating a better program for patients.
- Measurement: Patient Experience – visit scheduling.

The Champions Group: Measurement

Margaret Furman SE Health
Jennifer Andrachuk SRHC Physical Therapist

What You Need

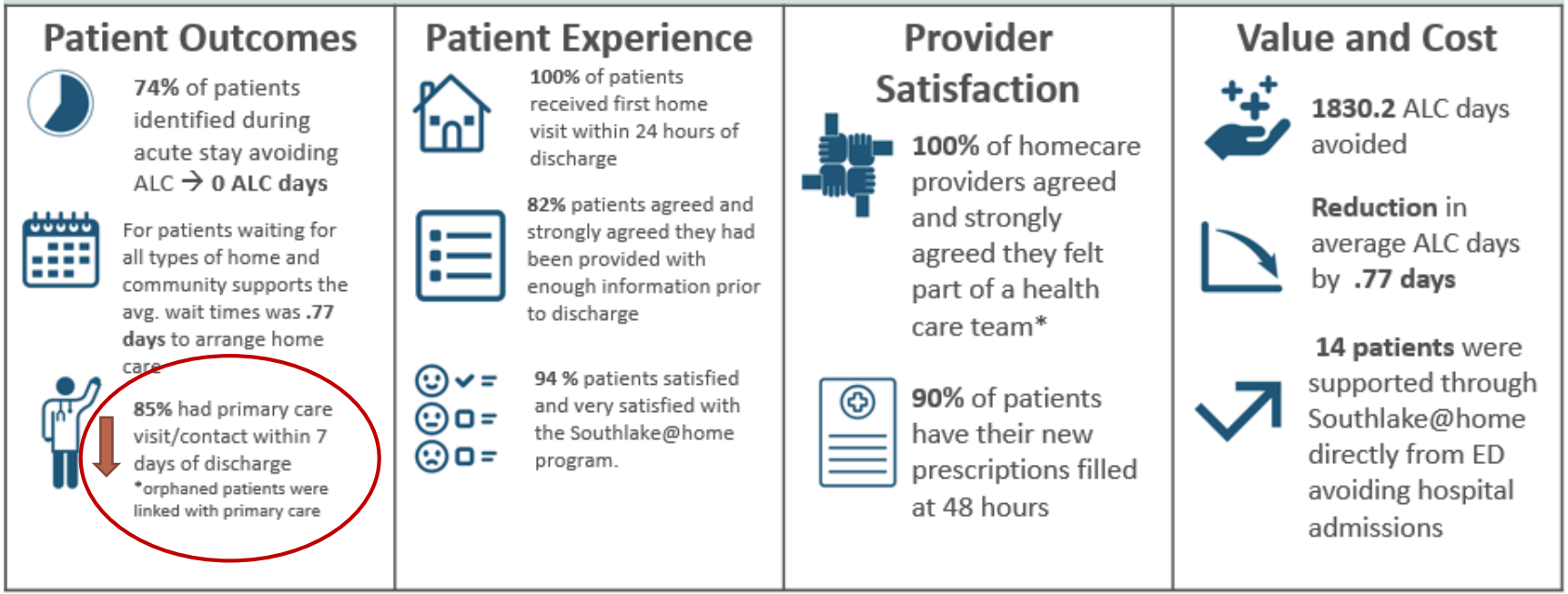
- Feedback from patients and families to guide quality improvement
- Data and feedback from partners to monitor outcomes
- Ongoing checkpoints with partners to share learning and problem solve together
- A team culture that welcomes transparent dialogue about what's working well and could be improved
- PFAC members as full and equal partners

Iterate and Learn

Work with patient, families, caregivers and other partners to continuously learn and refine your program design.

Recent Change in Measurement… Engaging all partners to understand

(Reporting Period: April 1 -October 31, 2020)



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Results to Date

(Reporting Period: April 1 -October 31, 2020)

Patient Outcomes

74% of patients identified during acute stay avoiding ALC → **0 ALC days**

For patients waiting for all types of home and community supports the avg. wait times was **.77 days** to arrange home care

85% had primary care visit/contact within 7 days of discharge

*orphaned patients were linked with primary care

Patient Experience

100% of patients received first home visit within 24 hours of discharge

82% patients agreed and strongly agreed they had been provided with enough information prior to discharge

94 % patients satisfied and very satisfied with the Southlake@home program.

Provider Satisfaction

100% of homecare providers agreed and strongly agreed they felt part of a health care team*

90% of patients have their new prescriptions filled at 48 hours

Value and Cost

1830.2 ALC days avoided

Reduction in average ALC days by **.77 days**

14 patients were supported through Southlake@home directly from ED avoiding hospital admissions

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Questions for speakers?

Use the Chat Box
To all panelists and attendees.

What are your plans for measurement in your OHT ?

Fireside chat with our speakers

Everyone is involved!

Time for discussion and questions

Use the chat-box **<To everyone>** to enter thoughts, reflections and questions

Poll 4

I learned something useful here today that will help me advance our OHT.

- Yes
- No

Up Next:

HSPN Webinar Series

- 4th Tuesday of the Month: 12:00 – 1:30pm

Upcoming Topics:

- ✓ The Generation of Integration: Lessons Learned in Ontario
- ✓ A Focus on Measures for Local Evaluation
- Population Health Management
- HSPN OHT Evaluation Measures

… and more.

Everyone is involved!

Question:

Other suggestions for future webinar topics?

Use the chat-box **<To everyone>**

Key Resources Available

Teams are encouraged to access the **ministry's central program of supports** for resources and assistance to improve their readiness to implement the Ontario Health Team model wherever they are in the readiness assessment process.

Teams can access this central program through the Ministry of Health website: http://health.gov.on.ca/en/pro/programs/connectedcare/oht/default.aspx

Ontario
Ministry of Health
Ministry of Long-Term Care

Key resources include:

- **Ontario Health Teams: Digital Health Playbook** – playbook to help understand how providers can build a digital health plan for OHTs that supports the delivery of integrated care (available at MOH website above).
- **Rapid-Improvement Support and Exchange (RISE)** – an interactive website (www.ohtrise.org) that provides access to resources, experts and assistance for potential Ontario Health Teams. Main rapid learning and supports delivery partner.
- **HSPN – Central OHT Evaluation** – evaluation of the progression of teams in discovery and in development through the readiness path, rapid cycle evaluations of implementation to inform OHT candidate's real-time decisions and adjustments, and a comparative evaluation across OHTs. (www.hspn.ca)

RISE
Rapid-Improvement Support and Exchange

HSPN
Health System Performance Network

Central Evaluation Team

Co-Leads

Dr. Walter Wodchis

Dr. Ruth Hall

Team Members

Dr. Gaya Embuldeniya

Dr. Shannon Sibbald

Dr. Kaileah McKellar

Jennifer Gutberg

Nusrat S. Nessa

Amanda Everall

Everyone is involved!

https://hspn.ca/evaluation/ontario-health-teams/

Follow us: @infohspn

Email: OHT.Evaluation@utoronto.ca

Thank you!