 **Project Plan Frail Seniors**

1. **Summary**

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| **Project Title** | Frail Seniors | **Last Revision Date** | Jan. 17, 2014 | **Projected Completion** | 2015 |
| **Problem Statement** | Coordination between SP/FP’s, and between SP/FP’s and health services are inconsistent and create coordination gaps for frail seniors living in community which can negatively impact their ability to remain at home and may lead to admission into acute or residential care services. Key elements of the problem identified in scoping include:   * Mismatch between family expectation of the system and what the scope / role of the system is * Inconsistent communications between acute services (ER), family physicians and community services to “catch” changing conditions, new patients for service * Complex care requirements of frail seniors demand ongoing clear information sharing between family physicians, specialists and community care providers whenever changes occur in patients’ condition and /or care plans are modified. There is a need for a consistent communications between primary care, acute and community services to minimize gaps.   Discharge planning for frail seniors addressing the transition from hospital to home may result in re-admission and/or longer than necessary length of stays. Key elements of the problem identified in scoping include:   * Tension between hospital wanting quick discharge and limited resources in the community to manage the increasing level of frailty * Speed of discharge doesn’t allow for appropriate assessment , as senior still in acute phase of recovery with not enough time for the community to respond to changed needs | | | | |
| **Improvement Goal** | 1. Develop / improve communications pathways using a case conferencing model approach for patients in community transitioning between services (home health or allied health), family physicians, geriatric psychiatrists, internists and acute care:  * timeline: 12 months * regular meetings are happening with the following key stakeholders: family physicians, Home Health nursing, mental health, family supports and specialists as needed * mutually understood process for multidisciplinary care team communications and case conferencing documented and ratified * patients and their families included in the change process * region-wide adoption, customized to the unique needs of each community (Nelson (North Kootenay and Arrow Lakes); Boundary; Castlegar; Trail)   Creating a seamless continuum of care between acute, community services, family physicians and specialists as a team providing care for frail seniors is critical. Many aspects of care for frail seniors are focal to work being undertaken provincially, and in other regions (Central Okanagan, Thomson Divisions of Family Practice). Through our involvement of IH acute care providers as well as community services at the advisory committee and working groups, the Kootenay Boundary Frail Seniors team is well informed and co-ordinating with pilot projects underway (48 / 6; Home First) as well as being linked to other regional initiatives through Shared Care relationships. Awareness of other project work enables our team to start working in an area not currently being addressed in other areas, share our learnings with other groups, and leverage best practices to further our work in new areas.   1. Analyze and identify opportunities for improving ER / specialist (if consulted in ER) communications pathways with community supports (Home Health, FPs, allied health, pharmacy) to optimize the management of changing conditions for complex care patients:    * Timeline: 12 months    * Formal communications process between ER and community supports (Home Health, FPs, allied health, pharmacy) flagging patients whose condition has changed or patients who need to receive care services (work with Central Okanagan, Thomson Divisions project staff to leverage work already underway)    * Region-wide adoption of process, customized to the unique needs of each hospital setting (Kootenay Boundary Regional Hospital, Boundary District Hospital, Kootenay Lake Hospital, Castlegar Emergency, Nakusp Emergency)    * Patients and their families are included in change process 2. Align work done in case conferencing and ER communications (above) with ALC reduction and discharge planning improvement goal processes currently underway through the KB Area Care Partnership Committee (ACPC). Ensure GP & SP voice is active and present in ACPC process:  * concurrent with above work - 12 months * discharge processes developed are aligned with community case conferencing (e.g. protocol in place for patient transitions) * patients and their families included in the change process | | | | |
| **Outcomes & Indicators** | 1. Improved patient outcomes:    1. Teams report improved patient outcomes for frail seniors care as a result of responsive care teams    2. Patient experiences reflect confidence in their continuity of care between family doctors, acute and community services    3. Patient and / or family members report increased empowerment through process    4. Reduced (re)admissions to acute services    5. ALC patient length of stays are reduced 2. Strengthened relationships between professionals working with frail seniors:    1. Physicians, specialists, clinicians, families and other health care providers supporting frail elderly in community report improved collegial communications, respect & appreciation.    2. Physicians report confidence in care teams to bridge patients into community from acute services with reduced length of stay in hospital 3. Patients are included in change process:    1. Patients and Providers report evidence that the process benefitted from patient’s involvement with the process and contributed to the design of the identified outcomes.    2. Key patient concerns identified in patient surveys (to be completed under this project) are included in outcomes once identified. | | | | |

1. **Context**

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| **Background** | In the Fall of 2011, the KB CSC identified frail seniors as a priority area. It was decided that an initial scoping meeting should be held with key informants from IHA and the KB Division of Family Practice. A workshop was held in Castlegar that Winter, and involved five GPs and ten front line practitioners from IHA. During the session practitioners identified the strengths and gaps in the system, and made suggestions where opportunities for collaboration might lie.  Highlights from the workshop report include:   * The population is aging: the proportion of people aged 65+ in the KB HSDA is projected to rise from its current level of 17.9% to 24.1% over the next ten years (Kootenay Boundary HSDA Health Services Profile, June 2011); * The use of health care resources by this population is increasing, which puts pressure on the community and acute care sectors, and the interaction between them; * The healthcare workforce itself is aging; * IHA is mandated under its Memorandum of Understanding with the Ministry of Health to focus on priority populations, one of which is frail seniors   Prioritized areas for future work to support frail seniors, identified in the report were:   1. Improving / increasing access to convalescence beds as an intermediate return to home service from acute services 2. Upstream promotion and prevention with a responsive multi-disciplinary team in community 3. Education on the roles and resources available for seniors in community along with improved caregiver supports 4. Making ER’s more senior friendly and improve communications to care teams 5. Improve discharge processes to ensure success on return to community.   The report was provided to the CSC for consideration on next steps / action in the spring of 2012. It was agreed in the spring of 2013 to form a working group to move forward with addressing issues raised by the report’s findings.  We are aware that we are not alone in prioritizing this patient group, with various aspects of care for frail seniors being focal to work undertaken provincially, and in other local communities. Through the involvement of IH Acute and Community staff at this project’s advisory committee and working groups, we are integrating our project with pilot projects and initiatives already underway (48/6; Home First; ALC initiative). Through Division, IH Interdivisional Strategic Council and Shared Care provincial tables, we are linked to other local initiatives hosted by Divisions (Central Okanagan, Thomson). Awareness of other project work has enabled our team to narrow our focus to Improvement Goals not currently being addressed in KB, share our learnings with other groups, and leverage best practices to further our work. |
| **Accomplishments to Date** | * CSC approved a working group in the spring of 2013 to start to move work in the area of Frail Seniors forward. * Working group has met to flush out first key focus areas and identify key participants for the project. * Some process mapping has started to identify a model for a responsive multi-disciplinary community team. * Smaller working groups have been created to develop case conferencing model in each community. |
| **Future Possible Improvement Goals** | Addressing other areas for improvement from the 2011 Focus Group report listed above. |

1. **Workplan**

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| **Change Concepts** | 1. Patient consultation has not been a part of work completed to date. In order to ensure baseline data leading to the success of both project improvement goals and to gain a better understanding of the issues from the patient perspective, some form of survey or mapping is needed to gather patient input. In addition a patient or family advocate can be recruited to participate in the committee’s work on an ongoing basis. 2. Consensus exists at the Frail Seniors Working Group that implementation of formal case conferencing model for frail seniors will achieve Project Outcomes. The initial vision for case conferencing came from a family physician who identified the need to solidify community supports so that transitions between hospital to home for patients could be smooth. Communications between community care providers has been done inconsistently and often in multiple settings (geriatric assessment team meetings with psychiatrists, family meetings, physician & case managers). Moving to a model in which one meeting inclusive of family physicians, specialists, and other care providers improves care planning for complex patients. Determining the most effective way to implement this process and to ensure sustainability and traction on a community-by-community basis is the key focus for the committee.   Our plan is to approach Case Conferencing using rapid PDSA cycles. Using the PDSA approach, we will start piloting the model in one community with a very small number of patients. From this learning we will expand to more patients within the pilot community, and then expand the Model to communities throughout the region. The following key questions need to be resolved throughout early iterations of the PDSA cycle:   * + - Identity team members     - How does case conferencing occur? Who initiates call? How can we ensure accessibility for team members?     - Frequency / types of case conferencing     - Appropriate Training and Team building in place.  1. Develop / improve a formal communications process between ER / specialists consulted / family physicians / community supports (Home Health, allied health, pharmacy) flagging patients whose condition has changed or patients who need to receive care services (work with Central Okanagan, Thomson Divisions project staff to leverage work already underway).    * Scope issue / need for communications pathways improvement / development in each community (Nelson, Trail, Castlegar, Boundary)    * Map processes in each acute centre    * Identify key areas for improvement – set strategic goals    * Identify strategies to target goals 2. Interior Health has identified patient flow and access as a priority area for improvement. A project specifically targeting ALC patients has been initiated under the Area Care Partnership Committee (ACPC) involving acute, community, residential and allied health services. KB Division, via the CSC, has recently joined this table. Under this focus, initiatives will be developed to address improving length of stay for ALC patients in particular as well as standardizing discharge processes.   Frail Seniors are a large part of the population that these initiatives will target. Working within this ACPC process, and ensuring a physician voice is engaged fully within it, the Frail Seniors Working Group can align the case conferencing model with discharge planning initiatives build relations between all stakeholders working on the issue. |
| **Activities** | |  |  |  | | --- | --- | --- | | **Activity Milestone** | **Description** | **Target completion date** | | **30 day readmission survey of acute patients**  **(based on IHI survey)** | * Form working group to oversee survey development / implementation * Design survey / process to identify patients / identify person to conduct survey * Gather patients identification through chart review and Meditech – get permissions to contact for survey * Conduct surveys * Data collection * Analyze and report on data | April 2014 | | **Recruitment of family caregiver / patient onto committee** | * Regional doctors to recommend potential patient participants (or caregiver advocates) * Contact Patient Voices Network for potential participants * Organize a vetting process to choose up to two patients / advocates | March 2014 | |  |  |  |  |  |  |  | | --- | --- | --- | | **Process map case conferencing model including identifying areas for improvements** | Working group reviews map and advises on implementation possibilities | March 2014 | | **Implement new model in one community**   * 1. **Identify community and have team meet to discuss model and expectations** |  | April 2014 | | **Monitor / evaluate model and adjust as needed** | PDSA cycles:   * + 1. first case conferencing session to be limited to one hour – 4 patients     2. provide feedback forms to team     3. review feedback prior to next meeting date     4. advise team on changes to format suggested by feedback     5. second case conferencing session held – up to two hours as needed depending on case load   Collect feedback and repeat cycles | April – June 2014 | | **Implement model in other regional locations** | * Local community working groups developed to identify community specific differences in model * PDSA cycles:   + 1. first case conferencing session to be limited to one hour – 4 patients     2. provide feedback forms to team     3. review feedback prior to next meeting date     4. advise team on changes to format suggested by feedback     5. second case conferencing session held – up to two hours as needed depending on case load * Collect feedback and repeat cycles | July 2014 | | **Ensure liaison between ACPC (ALC and discharge planning) committee and share learnings between committees** | * Evaluate input from patients (survey above) and provide reports to Acute Services for their use in informing their process change activities * Ensure GP and SP participation in change process * Project staff to be familiar with work underway and assist in aligning other project work with initiatives in acute services | Ongoing | | **Scope issue / need for ER / GP / SP / community communications pathways improvement / development in each community (Nelson, Trail, Castlegar, Boundary)** | * Initial meetings with doctors / ER / IH acute team to identify if there are areas for improvement in each acute facility: Nelson, Castlegar, Grand Forks, Trail | June 2014 | | **Map processes in each acute centre identified for improvement goal** | * Work closely with acute care staff to do process map for communications between doctors / ER / IH acute * Provide report including recommendations to committee | September 2014 | | **Identify key areas for improvement – set strategic goals** | * Committee has facilitated discussion on report / recommendations * Identifies strategic goals for ER communications pathways | September 2014 | | **Identify strategies to target goals** | * Implementation plan developed for target outcomes to be identified by committee | November 2014 | |
| **Risks** | |  |  |  |  | | --- | --- | --- | --- | | **Risk** | **Probability** | **Impact** | **Mitigation Strategy** | | Low levels of engagement of key participants from key stakeholders, esp. IH CIHS Team & local GPs, given transition currently in process in Home Health | Low | Moderate | * Keep work flow at a pace that keeps people engaged but allows space for other change occurring for teams * Ensure messaging to participants on the importance of their participation * If individual participants are unable to meet regularly, communicate with group participants on progress / successes to date * Provide training / team building support if appropriate | | Lack of access to acute patients for survey | Low | Low | * Identify alternate methods of data collection | | Complexity of discharge planning creates barrier to project goals | Medium | Moderate | * Key relationships in place to prevent barriers from emerging (IH / project staff) | | Scope creep, esp. re facilitative leadership of ACPC process | High | Moderate | * Work closely between project staff – Shared Care project manager and IPCC facilitator to keep working group focused | |

1. **Resources**

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| **Project Governance & Reporting** | |  |  |  | | --- | --- | --- | | Shared Care Steering Committee: | Quarterly | Full report | | Division Board: | Quarterly | ED reports | | CSC project working group | Monthly | Minutes / monthly reports | | Shared Care provincial Committee | Monthly | Monthly reports | | Collaborative Services Committee | Monthly | Monthly reports, Staff presentation / updates | |
| **Key Partners & HR Resources** | **Shared Care Steering Committee Members:** Dr. Ellen Smart, Dr. Martha Wilson, Dr. Sam Segal, Dr. Sharman Naicker, Aman Hundal, Andrew Earnshaw  **Project Physician Lead:** Dr. Keith Merritt  **Advisory Committee Members:** Dr. Keith Merritt, Dr. Libby McCoid, Dr. Leslie Paul, Dr. Bob Lewis, Barb Nielsen (NP), Cheryl Whittleton (CIHS Director) Denise Gamble (CIHS), Shannon Jennings (CIHS), Cydney Higgins (CIHS), Trish Hallstrom (CIHS), IH-acute representatives: Ingrid Hampf, Jane Cusden and Cindy Crane; Cindy Kozak-Campbell IH Director Residential Care  Specialist Consultants: Dr Richard Magee, Dr Brendan Tuvel, Dr Sam Segal, Dr. Cletus Okonkwo  **Project Manager**: Mona Mattei  **IPCC Facilitator**: Jo-Ann Tisserand  **Admin Support**: Erin Perkins |
| **Budget Summary** | See Excel Detailed Project Budget |

1. **Communications**

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| **Objectives** | * Engage buy-in of key stakeholders/partners in the project and process (physicians, patients, families, community care, specialists, hospitalists, residential, acute care practitioners, etc.) * Enable leadership to be champions of the initiative * Provide communication to the project team to support overall effectiveness * Create alignment with change management requirements – considerations of people and systems impacts (impact on training, resourcing, policy, procedures, processes, etc.); * Manage expectations and reinforce scope of project * Build trust, transparency and relationships through open communication and collaboration amongst all stakeholders |
| **Key Messages** | * Key messages include:   + This initiative is designed to improve patient experience as the patient transitions from acute to home/residential, as well as improve patient outcomes   + It will improve effectiveness and efficiency in patient discharge practices and enhance treatment planning   + It will result in reduced in patient days and improved discharge efficiency   + It will provide increased effectiveness of patient placement and reduce GP response time   + It will improve appropriate utilization of home and community services and improve appropriate utilization of family practice services   + It will enhance communication and information transfer between specialists, hospitalists, family physicians (with & without privileges) in hospital and community services allied professionals, patients and families |
| **Audience** | Key partners in project work:   * + Collaborative Services Committee   + Project Working Group   + Shared Care/Transitions in Care   + The Board of Directors, Kootenay Boundary Division of Family Practice   + Medical Community   + Interior Health Authority Leadership forums     - Area Care Partnership Committee     - Community Integrated Health Services     - Various Hospitals     - Others   + Ministry of Health   + Hospice   + External partners including community and residential Pharmacists, Patient Voices Network, agencies such as United Way, etc. |
| **Activities** | |  |  |  | | --- | --- | --- | | **Communication Milestone** | **Description** | **Timing** | | Monthly / quarterly reports | Inform and provide regularly updates to all partners | Monthly | | Report cards – short timely updates celebrating successes | Inform partners, committees and interested doctors, IH staff, etc. | Three time throughout project: March 2014; June 2014; completion | | Staff and team meetings  Leadership meetings (e.g. Board, CSC, CIHS, IHA)  Presentations (e.g. LMACs, Divisional meetings, IH staff gatherings as appropriate, MOH/Shared Care/TIC) | Keep medical community aware of the activities in the area of frail seniors to encourage participation / uptake on change | Shared Care Christmas; KB Division AGM; quarterly LMAC meetings | |

1. **Evaluation**

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| **Person(s) Responsible** | Stephen Riechart and Associates |
| **Evaluation Measures** | Key evaluation measures and indicators will be developed as part of the development of a full Evaluation Framework which will be designed and implemented at the start of the project and run concurrent to project activities through to the project’s completion in March 2015. Generally:  1. To what extent has the project been implemented as planned?   * Has the project been able to successfully carry out all of its planned activities? * Were new activities identified as part of the project’s development?   2. To what extent has the project been able to successfully identify and engage stakeholders?   * How were stakeholders engaged in the process? * How were they recruited? * What were their respective roles and responsibilities? * What does their involvement mean? To the project? To the stakeholders? * To what extent is the project achieving its planned results?   3. What are the key outcomes of the project?   * Has the project resulted in better communication between GP’s and Specialists supporting perinatal care in KB? * To what extent do stakeholders identify improved care, access and referrals for patients?   4. How effective is the project in sharing what is learned?   * How has the project been able to document what was learned before, during and after the CME event? * How has it been able to share resources, learnings and best practices? * What learnings does the project provide that could be transferable to other regions? Specialties? Divisions? |
| **Informants** | Project Manager, Steering Committee Members, GP’s, SP’s attached to the project, Community Care Providers, PVN Members, other stakeholders identified through the evaluation process. |
| **Activities** | |  |  |  | | --- | --- | --- | | **Evaluation Milestone** | **Description** | **Target Completion Date** | | Framework development | Development of an evaluation framework that includes an approach that is aligned with the Triple Aim. The framework will include a detailed description of the evaluation’s goals and objectives as well as the methodological approach, questions, indicators, stakeholders, methods, timelines and evaluation matrix. | Within 30 days of funding approval and prior to project operations. | | Data Tool Development | On-going and aligned with significant project milestones and activities. | On-going to the project’s end | | Data collection | Administration of data collection tools as various times throughout the project’s timeline and specifically aligned again with project milestones and activities. | On-going to the project’s end | | Review of data and report back to project key findings | Interim reports and briefs will be developed and designed to provide key evaluation information back to the project as collected – in this respect these reports will be designed to be a resource and project management tool for the project manager and staff. | Estimated to be at 4 -6 month intervals throughout the cycle of the project | | Creation of Final Evaluation Report | A final report will be created that analyses and summarises all data collected throughout the reporting cycle of the project and include lessons learned as well as a SWOT analysis. | March 2015 | |

1. **Appendices & Attachments**
2. Detailed Project Budget