ERIE ST. CLAIR HEALTH SYSTEM PRIORITIES

Information for partners in our health system

Hospitals across Ontario continuously strive to improve the quality of care they provide to their patients, while balancing their costs against challenging resource constraints. Although local health care professionals value their relationships with existing suppliers, they are always looking for new opportunities to innovate and improve the health system in ways that enhance patient care and increase value. Partnering with the vendor community offers the potential for new and innovative ideas to be adopted by the health system.

The five hospitals within the Erie St. Clair region share common priorities to ensure each patient gets the right care, at the right place, and at the right time. Driven by the Ontario's Patient's First Action Plan for Health Care, TransForm and its hospital partners have identified the following regional priorities:

- **Effective Transitions** – The health care system is composed of various providers that care for patients in different ways. Hospitals want to improve the transition of patients from one level of care to the next. An effective transition means:
  - Patients and families have the right clinical education provided to them before discharge, in a way that they can understand and refer back to.
  - Patients and families know what to expect when they arrive at their next level of care or at home.
  - Patients and families understand when, how and where to return to access follow-up care (i.e. primary care provider (PCP), care in the community, a walk-in clinic, or to the ED).

- **Special Condition Management** – Patients with certain conditions often face unique challenges and can become inadvertent high users of services across the health care system. They include:
  - Chronic Conditions & Rehab – Patients with long-lasting diseases that progress over time, like COPD or heart failure, need special care. This includes patient-friendly education, tools for symptom management, information about exacerbations of their condition, and access to the right care in the community. The hospital must ensure that patients receive quality care during their acute state, and equally important, make the right connections to community partners to continue their recovery and symptom management outside of the hospital.
  - Mental Health – Each hospital is striving to provide the same high quality care to mental health patients. However, the mechanisms of care and how interactions take place with these patients and their families are different. Hospitals are looking for innovative ways to improve care for these patients, such as reducing or predicting the need for restraint and seclusion usage. System navigation and confirmation of next steps in care are also important factors in the effective transitions of mental health patients. Community partners play a pivotal role in the transitions of mental health patients from hospital to home, and together with hospitals, can reduce the chances that patients might return to the hospital.

- **Embedding Patient and Family Feedback** – Quality clinical care involves not only exceptional treatment, but also the assurance that patient and family input is embedded into the care provided at the bedside. Hospitals need timely patient and family feedback to know where to improve, how to escalate a specific patient or family concern, and how to embed this feedback in a timely manner into the ongoing work of quality improvement happening across the hospital system.

- **Medication Reconciliation** – In most cases, when patients present to the hospital for care, a complete and accurate list of their medication types, dosages, routes, and frequency is not available. The care team must compile a Best Possible Medication History (BPMH) quickly and accurately for review by the patient's physician. Accessing this information is time-consuming and normally paper-based. Hospitals are working to complete a BPMH on all admitted patients and repeat this process upon discharge.

- **Home First: Alternative Level of Care** – Depending on the availability of resources across the health care system, as well as a patient's specific clinical condition, socio-economic circumstances and family situations, patients may find themselves needing an Alternative Level of Care (ALC) that they cannot access. Hospitals would benefit from predicting the likelihood of a patient needing an ALC and taking actions early on to remove barriers beforehand. Once a patient experiences a delay, a timely and effective resolution is often resource intensive.

- **Resource Utilization for Appointment Based Services** – In addition to acute or rehab care, hospitals provide appointment-based services. This could include a mental health clinic, rehab follow-up or assessment, or diagnostic imaging services like MRIs or CTs. Last minute cancellations, no-shows, or empty spaces reduce the efficiency of these services and delay treatment for other patients. Hospitals need creative solutions to manage appointments, connect with patients and their families to remind them of scheduled appointment times, and quickly respond to open availability to ensure an effective use of services. Innovative solutions could help patients book their own appointments, self-register when they arrive, or identify those patients that are likely to be a no-show so the right proactive steps can take place.

- **Health System Funding Reform** – Hospitals are now being paid primarily based on the volume and type of patients they treat. Data that is used for funding calculations comes from the systemic recording of key information from the patient's chart. Failure to document relevant clinical information, or failure to find and record such information, affects the amount of payment hospitals receive. Hospitals would benefit from helpful tools to identify such opportunities, ultimately improving funding accuracy.

Other hospital priorities:

- Keeping patients safe from harm, like falls and hospital acquired infections
- Keeping staff safe at work
- Improving staff attendance
- Tracking/improvement of staff engagement, satisfaction and morale
- Timely access to appropriate levels of care by reducing wait times or creating capacity
- Delivering care closer to home
- Virtual care delivery
- Improving access to palliative care
- Process improvement and best practice implementation for patient care areas
- Mobility and in-hospital activation strategies

Examples of projects that provide opportunities for innovation:

- Patient self-registration and reminders
- Patient TVs and in-room communication tools
- Non-urgent patient transportation
- Patient flow visibility and operational management tools
- Patient lifts that improve staff safety and patient mobility
- Staff duress (i.e. personal alarm systems) and safety alerts to increase staff safety in the workplace
- Hospital surveillance and monitoring systems
- Building and facilities projects (i.e. energy management initiatives)

Interested in joining the conversation?

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TransForm
SHARED SERVICE ORGANIZATION
Leading Innovation. Improving Healthcare.

TransForm Shared Service Organization is responsible for supply chain, information technology and project management services to its five member hospitals in the Erie St. Clair region. This document is based on reviews with hospital leaders, hospital strategic plans, capital plans, and quality improvement plans.