Central East **LHIN**

Praxis: The *techne* of Moving from Policy Recommendations to Policy Action

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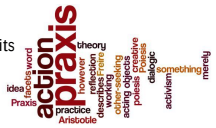
Praxis – The Good. Deliberation. Action.

For Aristotle, three basic activities of human beings each guided by their own *telos* (i.e., the good, the end)

- *Theoria* – The pursuit of truth through contemplation. *Telos* is knowledge for its own sake
- *Poiēsis* – The Art of skilled production. *Telos* is to make an artifact
- ***Praxis* – The art of of practical reasoning. *Telos* is practical wisdom (*phronesis*).**

- *Techne* – is the art of making through the exercise of skill



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Praxis – The Good. Deliberation. Action.

In praxis there can be no prior knowledge of the right means by which we realize the end in a particular situation. For the end itself is only specified in deliberating about the means appropriate to a particular situation (Bernstein 1983: 147).

As we think about what we want to achieve, we alter the way we might achieve that. There is a continual interplay between ends and means. In just the same way there is a continual interplay between thought and action. This process involves interpretation, understanding and application in *'one unified process'* (Gadamer 1979: 275).

Praxis is the basis of the scientific method, which is the heart of quality improvement (e.g, PDSA)

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Praxis = Informed Committed Action

The Good	• People begin with a situation or question which they consider in relation to what they think makes for human flourishing
phronesis	• They are guided by an ethical disposition to act truly and rightly
Praxis	• This enables them to engage in a situation as committed thinkers and actors
Interaction	• The outcome is a process

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Objectives and Approach

Share

- Practical Approaches and Lessons Learned

Through specific examples

- Example 1: Investment simulation for Seniors Services
- Example 2: Seniors Care and ALC

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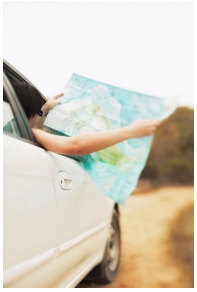
Outline

1. **Starting Thesis**
2. **Policy Questions and Approaches**
   - Adoption of a Policy Design Framework
3. **Creating Better Evidence**
   - Understanding your clients. Options and Analysis
4. **Action to Results**
   - Strategic Aim. Spread Strategy. Execution Strategy. QI and performance Strategy.



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Moving from Policy Recommendations to Policy Action

STARTING THESIS

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Thesis 1: Policy and Practice

- **Good policy (and programs) often fail because of:**
  - Lack of overall system design to set context
  - Incomplete knowledge of target population
  - Poor execution and change management strategies
  - Focus on form over function
  - Insufficient detail to operational mechanisms and constraints.
  - Low tolerance of risk and inclusion of "tests of change"
  - Focus on evaluation at the end of process, rather than a Quality Improvement to guide iterative learning

In other words, there is a breakdown of the unified process of thought and action, in understanding and application.

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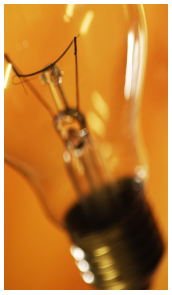
Thesis #2: Health System Realities



1. **Quality & Value must be defined from the patient perspective**
2. Low Value Health System: Generate Low Quality at High Cost
3. More health care does not alone create better care and create health
4. ***How* care – not *what* care – is delivered is a major determinant of outcomes.**
5. Value for Money must be driven by a quality and economic imperative. Financial leaders should be champions of quality improvement.

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Thesis #3: Misalignment of Vision and Production Systems

Vision / Strategy System

Delivery System

Is the current delivery (production) system organized or prepared to deliver on the vision and values system?

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ADOPTION OF A POLICY DESIGN FRAMEWORK

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The Importance of a Policy Design Framework

- Good policy is supported by a design framework to help create focus, support decision making, and support change management
  - Example: Chronic Disease Prevention and Management Model. Behavioural Support Ontario.
- Without a design framework, good policy will lose focus during implementation, and/or not sustain gains
  - Example: No explicit provincial Aging Strategy
- A key success of the Central East LHIN was the adoption of the **Institute for Healthcare Improvement *Triple Aim*** in 2008.

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The Triple Aim

INSTITUTE FOR HEALTHCARE IMPROVEMENT

System-Level Metrics

Health care / Public Health Social Services

System-Level Metrics

PH

The "Triple Aim"

Define "Quality" from the perspective of an individual member of a defined population

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- Patients and Families
- Definition of Primary Care
- Integration
- Per Capita Cost Reduction
- Prevention and Health Promotion

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Sustainable Access for Improved Outcomes

CREATING BETTER EVIDENCE

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Central East LHIN Sustainable Access Report

- Assessment of current and future needs based on a balanced care approach
- The report includes
  - An assessment of the existing complement of health services against the requirements of the frail elderly
  - Forecasts of future health service requirements to determine the anticipated future requirements for health services across the continuum of care in the CE LHIN
  - A set of feasible recommendations toward providing the optimal level and mix of institutional and community health services

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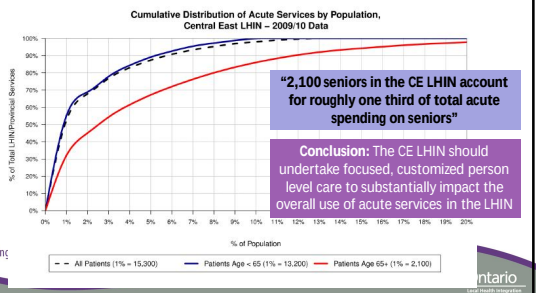
Who is our Frequent Client?

1% accounts for 53 % of total acute services received (~$636M)

1% of the 65+ population accounts for 32 percent of acute services received by all CE LHIN 65+ residents



"2,100 seniors in the CE LHIN account for roughly one third of total acute spending on seniors"

Conclusion: The CE LHIN should undertake focused, customized person level care to substantially impact the overall use of acute services in the LHIN

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Sample: High Use, High Risk Seniors and Hospital ALC in Durham

Lakeridge Health, Oshawa

	High User	Low User
Number of patients	115	829
Average Length of Stay	65 days	11 days
Average Age	76	75
Admitted from ED	83%	81%
From Home without Care	73%	71%
From Retirement Home	7%	5%
Top Diagnosis: Dementia, Stroke		

Rouge Valley, Ajax-Pickering

	High User	Low User
Number of patients	33	260
Average Length of Stay	104 days	13 days
Average Age	79	77
Admitted from ED	91%	88%
From Home without Care	52%	66%
From Retirement Home	12%	6%
Top Diagnosis: Stroke, Cardiac		

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ALC By Diagnostic Group: High and Low Users

Diagnosis Cluster	High Users			Low Users		
	Cases	ALC Days	Relative Frailty Index	Cases	ALC Days	Relative Frailty Index
North East Cluster						
Senility, org. mental disorders, and degen. disorders of NS	43	5929	1.1	84	2181	1.1
Person awaiting admission to adequate facility elsewhere	14	1788	1.2	28	1089	1.1
Palliative Care	12	1179	1.9	91	1532	1.8
Durham Cluster						
Palliative Care	49	3842	1.9	342	4661	1.5
Senility, org. mental disorders, and degen. disorders of NS	26	2086	1.1	72	1330	1.1
Cerebrovascular disease	16	1131	1.7	114	1129	1.3
Scarborough Cluster						
Palliative Care	10	898	2.8	180	2741	1.4
Senility, org. mental disorders, and degen. disorders of NS	9	681	1.4	45	1190	1.1
Cerebrovascular disease	7	693	2.3	65	1071	1.5

The CE LHIN should focus its ALC reduction efforts on the types of long-stay, frail seniors such as hospitalized seniors requiring palliative care

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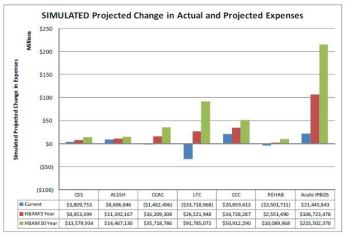
Expense Simulation: Central East - Provincial per Senior Funding



- Applying the Provincial benchmarks, CE LHIN's expenses are forecast to increase faster than under current state:
  - CSS: 42%
  - Assisted Living: 111%

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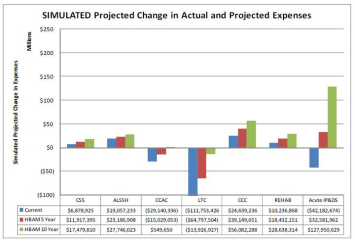
Expense Simulation: Central East - Higher Performing LHIN per Senior Funding



Applying the higher performing LHIN benchmarks, CE LHIN's expenses are forecast to increase faster than under current state:
- CSS: 54%
- Assisted Living: 213%

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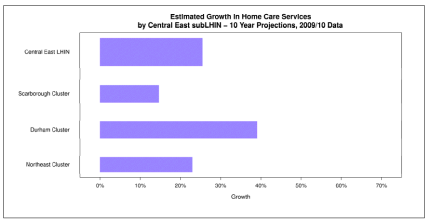
Example #1: Expected Growth in Home Care Sector



- 26% increase in demand for home care services, majority of which provided through the Community Care Access Centre (CCAC)..
- To provide care within expected resources, requires more deliberate shifting of service provision to the CSS sector.

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Example #1: CCAC Predicted Costs

- Through the Sustainable Access Study, the CE LHIN developed an HBAM model for Ontario's CCACs.
- The accuracy of predicted costs can be vastly improved by separately estimating the costs for people who had an acute hospitalization from those that did not.

Age Group	*00-09*	*10-44*	*45-64*	*65-74*	*75-84*	*85+*
Acute	167	230	833	1,163	1,568	2,042
Non-Acute	47	19	35	101	311	882

- *Analysis: ED-ALC requires a priority focus of CCAC service allocation to hospital referrals. While meeting the hospital demand, this has created an inability to address community referrals. Perversely, this results in non-deferral of ED/Hospitalization and subsequently, higher predicted costs per patient.*

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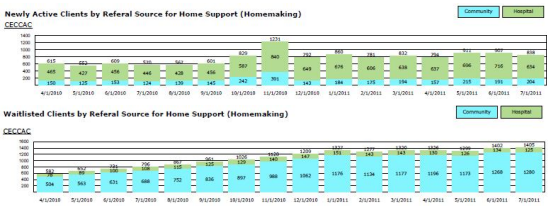
Example #1: Demand on CCAC Home Care – Referral Sources



- These tables depict the source of NEW CCAC homemaking referrals. CCAC active community clients hospitalized who then receive additional services are not NEW clients.
- Table 1 demonstrates a 75/25 distribution of hospital to community NEW referrals.
- Table 2 demonstrates the outcome of a focus on hospitalized clients is creating a growing pressure in the Community waitlist.

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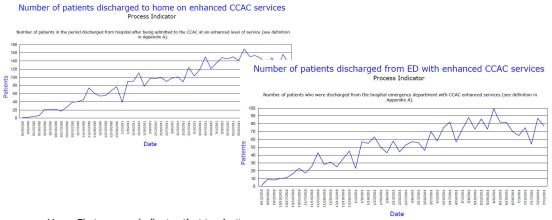
Example #1: Demand on CCACH Home Care – Referral Sources/Home First



- Home First process indicator that tracks the number of patients discharged on enhanced CCAC services from both hospital and the ED (as of July 31, 2011)
  - This would not include persons previously receiving CCAC services who were discharged from the hospital without additional services.
- The graph depicts the increased activity resulting from Home First. It also demonstrates the increasing risk of sustainability.

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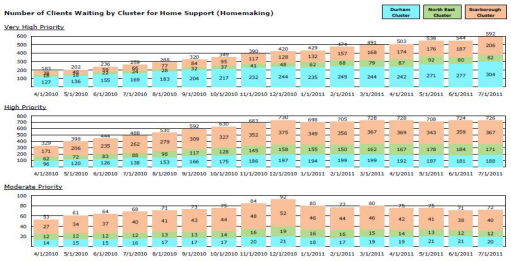
Example #1: Demand on CCAC Home Care - Waitlist



- VH waitlist lower than H, although VH waitlist continues to increase, while H remains stable.
- Variance of distribution of VH – H waitlist across LHIN clusters. Significant VH waitlist in Durham.
- Comparing VH and H waitlist, indicates that HF clients may be of the H cohort, not the VH.

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Example #1: Problem Statement - Summary

- Increased "capture" rate of hospitalized clients as a result of ED Case Management and Home First has had positive results in ED/ALC. However, the result also means:
  - Higher average costs for hospitalized patients
  - Increasing community waitlists
- Greatest waitlist and wait is in Durham Region for Very High and High Clients
- Durham Region has the lowest rate of access to Long-Term Care compared to its CE LHIN cluster counterparts and the provincial average (Sustainable Access Study).

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Example #1: Assisted Living for High Risk Seniors - Defined

- ALSSH to be provided to eligible high risk seniors at all times (24/7) both on a scheduled and unscheduled basis. Services Include:
  - **Personal Support Services**
  - **Homemaking services**
  - **Security checks or reassurance services**
  - **Care Co-ordination**
- Persons receiving assisted living services shall not receive more than a combined maximum of 180 hours of personal support, homemaking and professional services per month.

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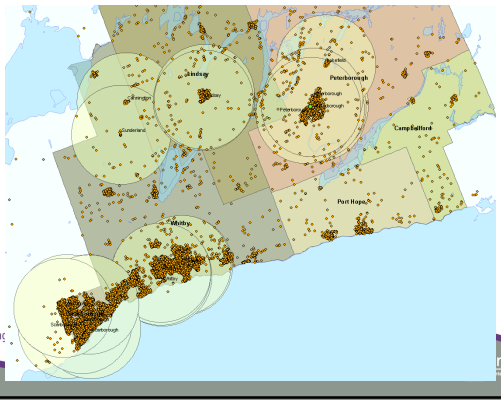
Example #1: Creating an ALSSH Cluster



Summary of Benefits of Good Evidence

- Through the evidence of the Sustainability Access Study, the CE LHIN has:
  - Better defined its target population
  - Already applied spending scenarios to new funding to optimize the mix of senior services
  - Explicitly shifted resources and responsibilities between health care sector
  - Launched a Community Health Services Integration Strategy
  - Pursuing innovations in chronic disease management and a palliative care

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Moving from Policy Recommendations to Policy Action

FROM ACTION TO RESULTS

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STEP #1: Start with the End State in Mind

- More detailed that a vision statement, and AIM statement informs both outcomes and processes:
  - What Do You Want to Achieve?
  - By How Much?
  - For Whom Do you Want to Achieve it?
  - By When?
  - Who will be involved?

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Strategic Aim:
Save 1M Hours of Time Patients Spend in Emergency Departments

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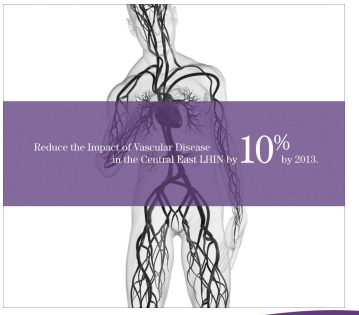
Strategic Aim: Reduce Impact of Vascular Disease by 10% by 2013



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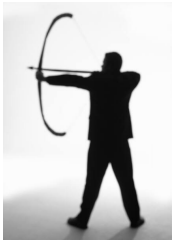
STEP #2: Focus on Execution of Initiatives to Achieve Aims

1. Design of a structure to support improvement
2. Setting of organizational or business/service line goals connected to system measures
3. Developing a rational portfolio of projects to support the aim
4. Deployment of resources to the projects
5. Executing each of the individual projects in the portfolio
6. Oversight, learning, and integration



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How will the ED Aim be Achieved?

- **Improving ED Utilization**
  - ED Visits for 1000/population
- **Improving ED Wait Times**
  - Admitted ED Patients
  - Non-Admitted Non-Complex Patients
  - Non-Admitted Complex Patients
- **Improving Hospital Bed Utilization**
  - Reducing Alternate Level of Care (ALC)
  - Improvements in LOS, access to specialized services, rehab and other transitional services.
- **Improving the Care Experience**
  - Transition Management. Senior-Friendly services. Readmissions.

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ED Wait Times, ALC and Health Enhancement

- While seeking to improve "flow" through the hospital to alternate levels of care (e.g., home care), we needed to address:
  - quality from a patient perspective
  - contributing factors that created risk of continued institutionalization and/or readmission of clients?
  - sustainable solutions that generated value-for-money, better patient experience and health outcomes
- In addition to enhanced home care services, the LHIN equally focused on hospital **geriatric activation** and **senior friendly practices** as central part of the ED/ALC strategy.

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Step 3: Develop Scale and Spread

Often over looked, determine a spread strategy to support step #2.

- **Assess Practice Readiness for Spread**
  - Plan and assess for learning, readiness. Revisit scope, spread and speed
- **Assess Readiness to Receive**
  - Plan for sequencing based on learning. Create monitoring mechanisms and metrics
- **Choose a Spread Approach**
  - Based on findings of previous steps, choose spread approach and required resources
- **Develop a Plan for Spread**
  - Fully describe change practice. Confirm measurement Plan. Determine Infrastructure and Resources. Identify experts who will teach others

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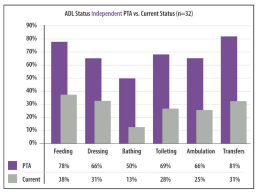
Example #2: ALC Patient Population

- 34-50% of hospitalized elders experience decline in their functional status between hospital admission and discharge and that muscle strength loss of 10% can occur within one week of hospitalization.
- CE LHIN Case Study data showed consistent declines in the ADLs from independent status prior to admission to supervised, assistance required or dependent status in **every area of self-care for the selected patient group since** their admission to hospital.
- For example, of the 78% that could independently feed themselves prior to admission, only 38% were still able to do so.



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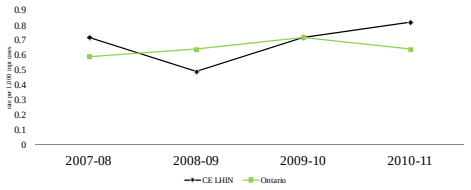
Example #2
In-Hospital Hip Fracture in Elderly (65+) Patients



Definition: This graph measures the rate of in-hospital hip fractures among acute care inpatients aged 65 years and older. This is not an MLPA indicator.

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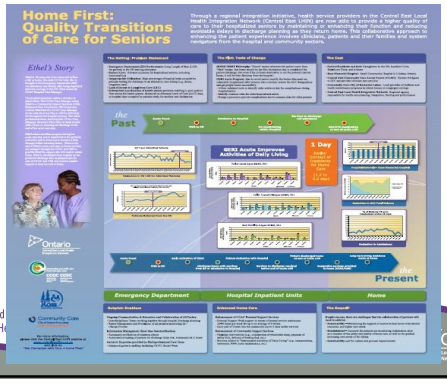
Example #2: Ross Memorial Hospital



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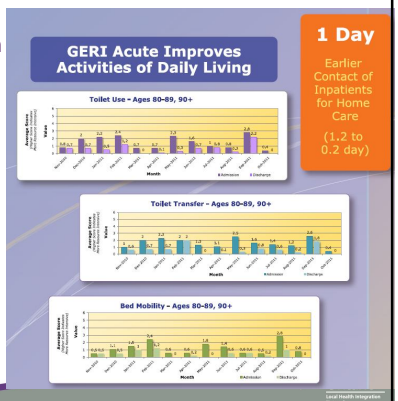
Example #2: Geriatric Activation

- Significant improvement in Activities in Daily Living through early activation of geriatric IP population in medicine units.
- Early engagement of the community care team to support return home goals.



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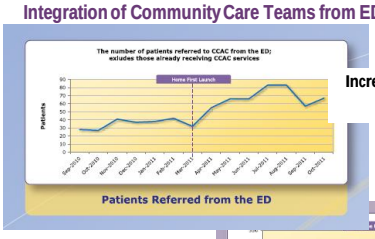
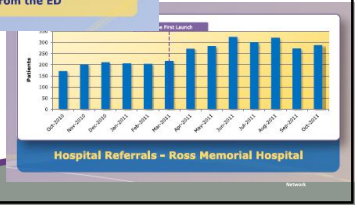
Example #2:
Integration of Community Care Teams from ED to Discharge



Increase referrals for home care out of ED

Increase referrals for home care at discharge



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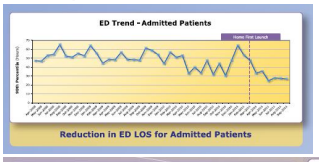
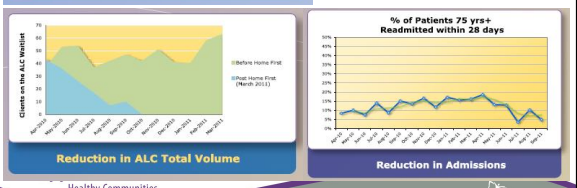
Example #2: Results!



- Dramatic Reductions in ED LOS and ALC Volume
- Decline in Readmissions for Patients 75+yrs



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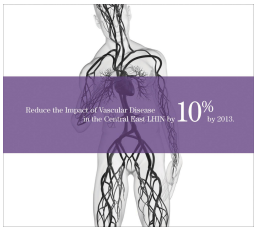
So how are we doing so far?



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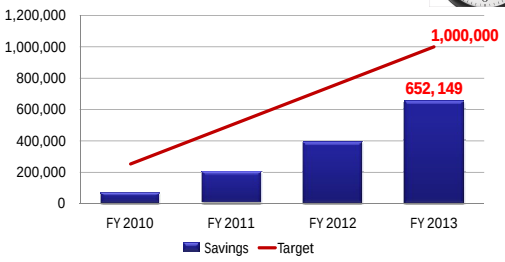
ED Hours – Actual & Projected Hours Saved



Projections assume 2010-11 rate of improvement maintained to FY 2013.

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Vascular Aim – Actual & Projected Days Saved

Projections assume 2010-11 rate of improvement maintained to FY 2013.

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Capability vs. Capacity

"Never be afraid to try something new. Remember that a lone amateur built the Ark. A large group of professionals built the Titanic."

Dave Barry

Opportunity Knocks

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