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Conference Abstract

Partners Advancing Transitions in Healthcare (PATH)

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Abstract

Introduction: (comprising context and problem statement) Partners Advancing Transitions in Healthcare (PATH), funded by The Change Foundation, is a community partnership of patients, family caregivers, health and community care providers, and a technology company, making local process changes to improve healthcare transition experiences. Care transition miscues result in poor patient experiences, sub-optimal outcomes and inefficient use of health resources. PATH partners collectively identified four issues contributing to miscues: 1) care transitions are provider-, not person-, centered, 2) critical health and personal information often does not transition with patients, 3) seniors are not intrinsically valued, not provided opportunities for having their needs addressed, 4) community and providers lack knowledge about the aging process and available supports. The partners collectively designed interventions for these issues.

Experience based co-design (EBCD) and person centered care (PCC) are embedded into all PATH processes. PATH's goal is to make measurable improvement in care transition experiences. The improvements are driven by patients' needs and experiences, powered by a unique partnership, and grounded in EBCD.

Description of practice change implemented: Phase 1: Analyze patients', caregivers', and providers' stories to understand care transition challenges and use stories to inform co-design team work.

Phase 2: Teams of patients, caregivers and providers co-design process changes:1) internet portal with resources and information allowing creation of personal "Aging Well" plans.
2) mobile technology, allowing a person to: present their unique health/life story and needs to care providers, exchange messages with providers, perform self-monitoring, and maintain electronic record of health history and information.
Phase 3: Pilot Phase 2 changes: 250 patients and 95 health care providers test the mobile technology at each health care encounter. Measures include experiences, outcomes, and impact.

Aim and theory of change: Demonstrate to stakeholders, leaders, policy makers that improvement work in a community coalition, with patients and caregivers as equal partners, will improve care transition experiences.

Targeted population and stakeholders: Seniors (over 65) with > 1 chronic health condition in Northumberland, Ontario, population 60,000.

Timeline:
Start up: 8/2012-11/2012
Phase 1: 11/2012-4/2013
Phase 2: 4/2013-4/2014
Phase 3: 4/2014–3/2015

Highlights (innovation, impact and outcomes)
- Mobile technology, co-designed by seniors and health system providers, is a valuable tool to plan, inform and improve care transitions;
- Care delivery is now focused on individual needs of people receiving services;
- Local patients and caregivers worked as equal partners with health and community service providers to collectively re-design care transitions;
- Internet based Aging Well Planning and community resources for seniors;
- Established community norm of patient and caregivers engaging as equal partners in improvement projects outside of PATH;
- Demonstrated the impact of seniors and caregivers as equal partners in all phases of PATH;
- Value of cross-sector improvement initiatives demonstrated.

Conclusions (comprising key findings)
- People over 65 embrace mobile technology, particularly as a way to present themselves to the health care system.
- Providers embrace solutions that facilitate understanding of and focusing on an individual - Focusing on patient needs, and providing an accessible communication solution, leads to improved experiences and improved health outcomes.
- Cross sector improvement initiatives, focused on patients' needs, is a valid method to achieve system improvement.
- Partnering with patients and caregivers creates a patient centered culture and leads to sustainable improvement.

Discussions: The PATH partnership, with patients and caregivers as equal partners, is unique in Ontario and has impact beyond the PATH community. PATH led to the creation of Health Links, a Ministry of Health sponsored cross-sector improvement initiative and accelerated patient engagement across Ontario.
PATH partners will sustain and expand PATH improvements through grant funding, Ministry of Health support, PATH partner contributions, and local health region funding.
PATH's interventions are unique to this community, however, cross sector partnership, engaging patients and caregivers as partners, mobile technology solutions, and Aging Well Plans are transferable, with locally informed modifications.

Lessons learned: Launch/Set-up:
Site visits to potential applicants were crucial in selecting the PATH community from among 27 applicants.
Well-defined project governance structure was important for making course corrections.
Phase 1: Story Gathering. Planning and attention to recruitment, and personal contact with patients and caregivers, resulted in a high retention rate. Gathering 20-30 stories will elucidate key themes for improvement work. Important to prepare health care providers to hear from patients about the personal impact of system miscues.

Phase 2: Co-design. Strong project management to organize, facilitate and capture input is critical to maintaining progress. Technology partner being embedded in all team work is crucial.

Phase 3: Pilot. TBD

Keywords

transitions; patient experience; co-design; partnership

PowerPoint presentation

http://integratedcarefoundation.org/resource/icic15-presentations