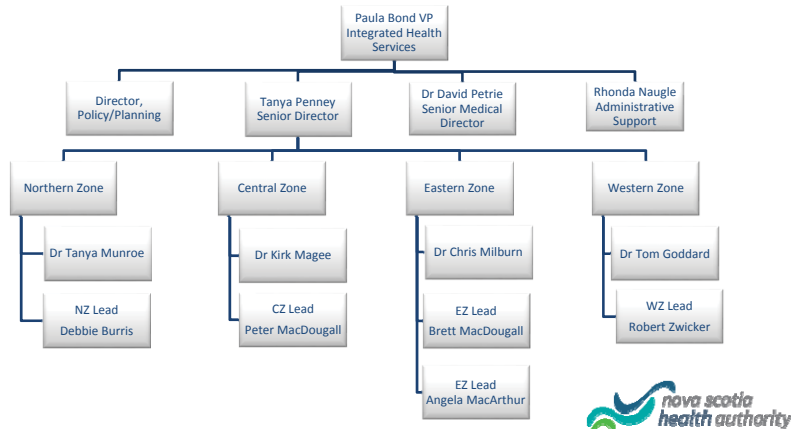


Emergency Program of Care



Emergency Program of Care



We Are EPOC (and Epic!)

Vision and Guiding Principles

Vision


- One responsive, effective and integrated network of emergency health care, with many access points, and a single collective mission

Mission

- To improve patient outcomes by ensuring that all Nova Scotians have timely access to high quality emergency health care

Values

- **Readiness:** robustness, responsiveness, resilience, adaptability, agility
- **Value:** evaluation, patient and population outcomes, cost-effective, stewardship
- **Systems thinking:** integration, inter-dependence, collaborative, inter-professional / trans-disciplinary problem solving



NSHA and IWK Emergency Program of Care Health Services Strategic Plan

Vision	Mission	Values		
One responsive, effective and integrated network of emergency health care; with many access points, and a single collective mission.	To improve patient outcomes by ensuring that all Nova Scotians have timely access to high quality Emergency Health Care	Readiness: robustness, responsiveness, resilience – “anybody/anything/anytime”, adaptability, agility Value (Patient outcomes/costs): evaluation, patient and population outcomes, cost effectiveness, stewardship Systems thinking: integration, inter-dependence, collaborations, inter-professional / trans-disciplinary		
STRATEGIC DIRECTION #1				
Network Integration: Siting, Sizing, Synergizing and optimizing health human resources				
Goal #1	Goal #2	Goal #3	Goal #4	Goal #5
Categorization of EDs and other system access points should be formalized with operational implications, and system accountabilities.	Categorization recommendations should involve hazard analysis methodology in determining proposed levels of care and possible alternative mitigation strategies	Siting, sizing, and synergizing within the Emergency Program of Care requires integrating the strategic plans of EHSNS, as well as with that of the broader Health Services Planning process.	Optimize utilization and integration of all health care professionals as part of the EM patient care team	Establish and implement a systematic approach to providing continuing education, team based care models and improving use of clinical best practices in patient care
Actions	Actions	Actions	Actions	Actions
<ul style="list-style-type: none"> • Definitions should be based on the literature and national guidelines • Collaborate with ICU, Peri-OP and Trauma Programs to establish mutually supportive leveling 	<ul style="list-style-type: none"> • Develop a ‘formula’ to consistently measure the likelihood and magnitude or risk considered in relation to the capability of the ED/facility (vs alternative mitigation strategies) • Distance from the closest hospital will be an over-ride consideration (too far increases level, too close decreases) 	<ul style="list-style-type: none"> • Improved telemedicine links (hub and spoke design with level 3/4s to closest level 2) • Improved planning of patient transitions / interfaces with other Programs of Care 	<ul style="list-style-type: none"> • Physician Resource Plan should recognize board certification in EM (credentialing aligned with national recommendations, definitions, etc) • Creative hub and spoke partnering/supporting for staffing and scheduling • Improve Physician Emergency Medicine competencies / credentialing, as well as their accountabilities, and 	<ul style="list-style-type: none"> • Roles/responsibilities, purpose, and integration; inter-professional team based care • Implement a common platform to support access to best practice guidelines, care directives, clinical order sets, patient education media • Establish a provincial strategy that support

3 Strategic Directions:

1. Design an integrated provincial network with appropriate sizing, siting and synergizing
2. Provide exceptional emergency care through standardization, monitoring and continuous quality improvement
3. Optimize patient flow across the continuum of services to improve care quality and operational efficiency
4. Establish a governance and accountability structure that optimizes the balance between site level operational decision making and improvements and system level coordination and strategic adaptations.

Scope	Problem Statement and Current State	Future State Opportunities
Strategic Direction 1: Network Design and Integration: Siting, Sizing, Synergizing and optimizing health human resources	Currently there are assumptions, but no formal definitions or operational criteria to describe the level of ED response capacity in the system, and therefore rational and evidence based discussions about an integrated network are compromised.	Categorization (siting and sizing) of EDs should be formalized with operational implications, system accountabilities and consideration of other system access points.
	The interface between primary care and the Emergency Department lacks consistency and there are some problems with patient information transitions (in both directions). Home and continuing care requires better system integration.	Better Horizontal integration of “the patient care journey” for the person with an unexpected illness or injury that does not require hospitalization
	There are still some inconsistencies in availability of specialist and subspecialist scheduling on-call coverage for Emergencies (at the site, regional, and provincial level). EHSNS is not always aware of changes in interfacility transports this entails.	Better Vertical integration of “the patient care journey” for the person with an unexpected illness or injury that does require secondary, tertiary, or quaternary care/hospitalization
	Inconsistent education, maintenance of competence, and utilization of paramedics, nurses, physicians and other health care providers skill sets/scopes of practice. The physician resource plan doesn't recognize board certification in Emergency Medicine	Optimize human resource utilization and integration of all health care professionals as part of the Emergency Medicine (EM) patient care team.

OVERVIEW

By Ricardo Martinez and Brendan Carr

Creating Integrated Networks Of Emergency Care: From Vision To Value

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ABSTRACT Emergency care is an essential component of the care delivery system in the United States, but it received little attention during the debates about health care reform. As a result, US emergency care remains outdated and fragmented. We provide an overview of efforts to regionalize emergency care in the United States, and we both identify challenges to change and recommend next steps in five domains: people, quality and processes, technology, finances, and jurisdictional politics. We offer a commonsense approach to increasing the value of emergency care delivery by developing regionalized integrated networks of emergency care that take advantage of emerging changes in the health system and are designed to meet time-sensitive patient needs.

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Strategic Direction 2: Exceptional emergency care through standardization, monitoring, and continuous quality improvement	There currently is not a provincial level forum to regularly discuss, share ideas/successes, and move towards a standardized and coordinated approach to quality improvement and patient safety in EDs across the province	Have a Provincial Emergency Quality and Standards Committee which is integrated with zonal operational structures to establish high quality standardized practices throughout the emergency care system.
	Currently, there is not trans-provincial or standardized reporting of important operational and patient oriented metrics to understand the functioning and quality of care in NS EDs. Patient outcomes / improvement science expertise is lacking.	Quarterly reporting of key process indicators and outcomes (when available) for all sites and zones
	Early start on standardizing EM quality and processes across the province. Some standards from the better care sooner initiative are excellent, some need modification, and some may not add value to the system.	Support the existing provincial ED standards and continue to evolve/modify/improve the standards.
	A challenge of EM systems of care is that the lower the volumes and acuties of ED patients, the more important maintaining skills through other means becomes important (e.g. simulation, distance education, telemedicine support).	Establish a provincial strategy that supports maintenance of competence , and ongoing professional training for front-line providers.

Quality, Standards, and Patient safety: Q+S committee



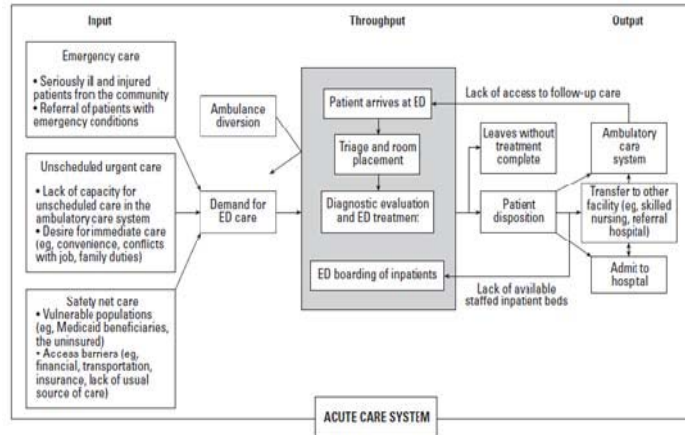
Strategic Direction 3: Hospital and System patient flow and efficiency	<p>The ED length of stay of admitted patients in the adult level 1 ED, and many level 2 EDs far exceeds provincial and national targets. This leads to prolonged wait times, ambulance off-load problems and, increased morbidity and mortality</p> <p>"You can't fix what you can't measure". Ongoing operational efficiencies and quality initiatives require reliable real time data accumulation and analysis - this is only available in a small number of EDs in the province.</p> <p>Same day / same week access to primary care physicians and some specialists is limited which can direct complex (but not acute), ongoing care to the ED as "safety net". ***Unscheduled, but low acuity pts in the ED do not cause ED access block</p> <p>The ED is the default "safety net" for adult protection patients, and many social services crises "placement" situations which can utilize ED beds for days (sometimes weeks) at a time - this is not "the right pt, in the right place, at the right time".</p>	<p>Patient wait times are in the top third of performers of the nationally accepted CAEP benchmarks.</p> <p>An emergency department information system (EDIS) is available in all level 1 and 2 EDs to monitor patient flow and inform planning</p> <p>Work with primary care and specialists to improve same day / urgent access alternatives for appropriate patients</p> <p>Improve non-ED alternatives for the complex comorbidity patient, the frail elderly, and long term care residents who do not have an acute worsening of their medical condition</p>
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Hospital and System flow: ED Information Systems

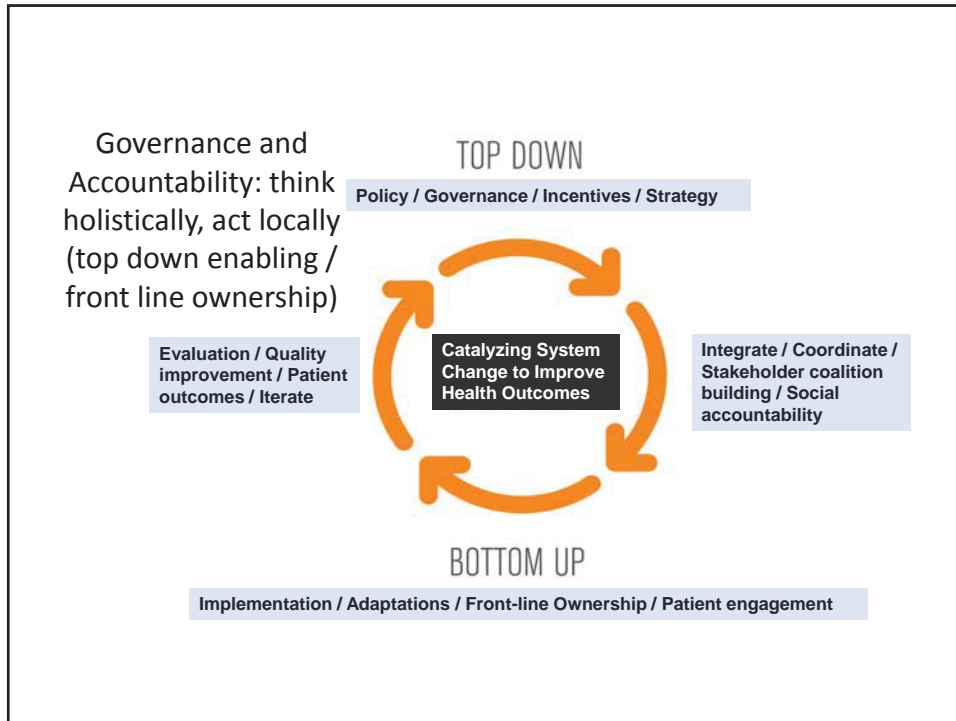


Input, Throughput, Output Model:

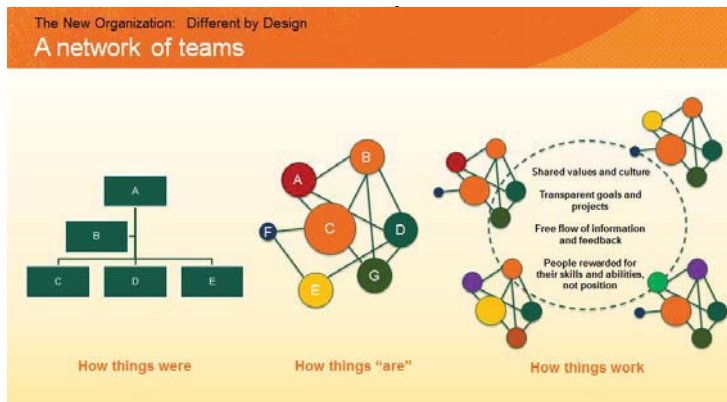


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Strategic Direction 4: Establish a governance and accountability structure that optimizes the balance between site-level operational decision-making & improvements, and system level coordination	Conceptually the ED and EHSNS systems are building towards a more Integrated Networks of Care model, but at this point, the leadership and governance structure has not been formalized, so practically, who makes what decisions is unclear	EM care must be planned as a single Integrated Network , but will respect and enable local management
	.Implementation, coordination, and corrective/innovative iterations of this plan will require a provincial level steering and strategy committee which does not exist at this time	Have a Provincial Steering and Strategy committee overseeing the implementation, evaluation, and iterative improvements of the EPoC strategic plan
	The leadership and accountability framework for the EPoC (and the rest of the NDHA/IWK) is in evolution - role clarity, reporting lines, and influence maps need to be established, and a mechanism to iteratively improve them over time, created.	Have a detailed leadership and accountability structure to support the Emergency Program of Care.
	In some cases, physicians (and other providers) have not been accountable for their responsibilities to support the needs of the system, and likewise the "system" has not met its responsibilities to support the needs of the providers (in service of pts)	Physicians are accountable through performance based service agreements and NSHA/IWK/DHW is accountable to maintain standards and support the necessary infrastructure.



Governance and Accountability: provincial EPoC steering and strategy



Top 5 Successes

1. Collective Vision and Mission with Strategic Plan
2. Engagement → Integration
 1. Internal
 2. External
3. CPG's/Policies
4. Provincial/Zone Site committee structures
5. **First province to have a all inclusive & fulsome report on CAEP benchmarks

The table is titled "NSA and IWK Emergency Program of Care Health Services Strategic Plan". It is organized into three main sections: Vision, Mission, and Values. Below these are three Strategic Directions, each with specific Goals and Actions.

Strategic Direction #1	Strategic Direction #2	Strategic Direction #3
Goal #1: Better horizontal integration of the patient care journey for the patient with an unexpected illness or injury that does not require hospitalization. Goal #2: Better vertical integration of the patient care journey for the patient with an unexpected illness or injury that does require hospitalization, surgery, or specialty care. Goal #3: Optimize human resource utilization and integration of all health care professionals as part of the Emergency Medicine ED patient care team.	Goal #1: Support the existing provincial ED standards and continue to assess needs/improve the standards. Goal #2: Establish a provincial strategy that supports maintenance of competencies, and ongoing professional learning for front-line practice.	Goal #1: Review current standards currently in place and determine which ones are true standards requiring monitoring and accountability, which ones require modification, and which ones are aspirational goals to which accountability is not required. Goal #2: Establish and enforce an accountability framework (including monitoring and reporting) for the ED standards. Goal #3: Publicly report performance.

Top 5 Challenges

1. Boarding / ED → Hospital → Systems Flow
2. EDIS in all Level 2 EDs (you can't fix what you can't measure)
3. Rural ED closures / Categorization (siting, sizing, synergizing)
4. Health Human Resources issues (Recruit/Retain, PRP/residency positions, Maintenance Of Competence, max scopes of practice)
5. Connections, Communication, and IT support



Sorry—we're full! Access block and accountability failure in the health care system

Grant Innes, MD

The Accountability Crisis:

In the face of demand capacity mismatch a program / queue can:

1. Improve efficiency and appropriateness, and lobby for more resources (difficult) or...
2. Block inflow and leave pts in the queue (default response)
3. Solution for one program is a problem for another program
4. Shifts care to downstream programs less capable of providing it
5. Displaces consequences of access failure to remote parts of system
6. Leaders capable of assessing/addressing root causes are protected from having to do so
7. And leaders in impacted areas are incapable of doing (because they have no authority)

Table 4. Quotes that exemplified responses from high-performance, low-performance, and improver hospitals.

Performance accountability	High	Everybody had their part and was expected to report...on what they were going to do, changing their behavior.—Hospital 5, quality director
	Improver	One of the first things we did was give all the individual providers their feedback, individually, on their ED [lengths of stay], their door-to-doc times. And we also showed where they ranked amongst their peers. And we would give this to them every month and then also a quarterly summary. And I would meet with them individually for the outliers to identify issues why they were kind of outlying and not being as efficient as some of the other providers. We could identify hurdles and barriers and try and break those down. So I think that was also a major impact in our ED throughput.—Hospital 9, ED director
	Low	It's one of those things where sometimes you're, like, trying to turn the <i>Queen Mary</i> with a rowboat. Unfortunately...some people view it in terms of dictating their practice. But we get pushback like that.—Hospital 3, nursing supervisor

