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NOTE: Appendices have been attached as supplemental documents due to large file size.
Executive Summary

With the recent renewal of the hospital’s Mission, Vision and Values and Strategic Plan, The Scarborough Hospital embarked on a journey to create a Clinical Action Plan. This planning process was designed to maintain a unique focus on the patient experience and incorporate the notion of an “ideal patient experience” into every aspect of the plan. To this end, Communities of Practice were created in order to span multiple programs and reflect the bundle of services a typical patient has contact with during the course of their treatment. In this way, traditional silos between programs were broken down and - for the first time at TSH - an interdisciplinary approach to planning was enabled. In order to further focus the Communities of Practice Planning Groups on the patient experience, custom patient scenarios were developed for each group that described the story of several typical patients and these were used as starting points for exploring the ideal future state. The following 12 Communities of Practice were established:

1. Acute Adult Inpatient Care
2. Ambulatory Patient Care
3. Chronic Disease Management
4. Mental Health
5. Elective Surgery
6. Musculoskeletal
7. Cancer
8. Renal Disease
9. Children’s Health
10. Women’s Health
11. Men’s Health
12. The Ideal Patient Experience*

*Note: The Ideal Patient Experience Community of Practice was a ‘virtual’ group with no defined membership due to the cross-cutting nature of the associated objectives. All other CoP planning groups were obliged to build the ‘ideal patient experience’ into their deliberations and recommendations. Any ‘ideal patient experience’ aspects that were applicable to multiple Communities of Practice (as was the case with most) were addressed separately in a dedicated bundle of initiatives focused solely on creating the ideal patient experience (See Appendix 1).

Each CoP was tasked with developing future state recommendations in order to achieve the “ideal patient experience”. Draft recommendations were presented to a broad range of internal and external stakeholders during a Consensus Summit where additional input and preliminary ranking occurred. Based on the outputs of the Consensus Summit, the Clinical Action Plan Steering Committee then selected the following 9 top recommendations to undergo a more fulsome business case development exercise:

- Cancer: Establishment of a comprehensive cancer program at TSH
- Renal Disease: Establish a Centre of Excellence for delivery and management of Chronic Kidney Disease (CKD)
• Chronic Disease Management: Develop a framework to deliver comprehensive care for chronic diseases at TSH
• Acute Adult Inpatient: Development of a comprehensive Hospitalist Model for all of acute adult inpatient units at both TSH sites
• Elective Surgery: Create and develop a “Centre of Excellence” in Breast, Urological, Minimally Invasive GI and Vascular Elective Surgical Procedures
• Acute Adult Inpatient: Provide consistent, timely, reliable and safe services, across both campuses, for inpatients experiencing critical situations and medical emergencies
• Musculoskeletal: Maintain TSH as a Centre of Excellence in Total Joints, Spine and Sports Medicine and enhance the Foot and Ankle Program
• Children’s Health: Improved Paediatric Emergency Care at The Scarborough Hospital
• Musculoskeletal: Development of a Strong Regional Anaesthesia and Acute Pain Program

The Clinical Action Plan Steering Committee received the business cases that included detailed descriptions of the proposed recommendations, outlined key risks and benefits, high-level financial and human resource impacts and implementation considerations. These business cases were also presented at a high level to an audience of Clinical Action Plan Steering Committee members, Community Advisory Panel members and other key stakeholders in order to provide additional clarifications regarding the risks, benefits or financial implications of the proposal.

The process for final decision-making regarding which business cases would be fully implemented involved a final rank ordering of 5 business cases that represented considerably large initiatives. This was done to provide additional focus on priority setting as it would be critical to the success of the plan to avoid overburdening the organization with too many large, complex initiatives. During the final Steering Committee decision making meeting, the rankings of large scale initiatives were reviewed, and a facilitated discussion was held to determine the optimal balance between financial resources, organizational capacity, human resource implications and impact on the patient experience. Based on these discussions, the following 6 recommendations were selected for full implementation:

• Establishment of a comprehensive cancer program at TSH
• Develop a framework to deliver comprehensive care for chronic diseases at TSH
• Develop a comprehensive Hospitalist Model for all acute adult inpatient units at both TSH sites
• Provide consistent, timely, reliable and safe services, across both campuses, for inpatients experiencing critical situations and medical emergencies
• Provide improved paediatric emergency care at TSH
• Develop a strong regional anaesthesia and acute pain program

These 6 areas will be the top clinical priorities over the next 3-5 years. The organization has committed to investment in these areas and is moving forward with implementation planning.

In many ways, the development of the Clinical Action Plan represents a significant achievement for The Scarborough Hospital. This is an important milestone in the organization’s journey toward realizing its corporate strategy. However, as the focus shifts to implementation, the challenging journey toward realizing the benefits of the Clinical Action Plan has now just begun.
As The Scarborough Hospital moves forward with implementation of its clinical priorities, there are several factors that will either enable success or present potential barriers, if not addressed appropriately. It will be important for the organization to be mindful of these seven critical success factors in order to help ensure that the Clinical Action Plan achieves maximum impact.

**Demonstrated Commitment from Leadership**
With any significant project that involves multiple stakeholder groups, new ideas and ways of doing things, unwavering commitment from the Leadership Team is critical. Employees and other stakeholders will look to leadership for direction and support while experiencing the uncertainties and challenges that accompany change.

**Executive Sponsorship**
In addition to the demonstrated commitment of leadership, clear executive sponsorship is also critical. Executive sponsorship not only helps maintain the momentum behind implementation, but also creates an accountability structure to one person who will serve as the primary champion at the executive-level. The implementation of the Clinical Action Plan represents a significant undertaking that will continue to require executive sponsorship to ensure focus is maintained and help address implementation challenges and emerging issues.

**Medical Staff Engagement**
This stakeholder group represents a highly influential and integral group, without which, implementation simply cannot succeed. Medical staff play a role as project champions amongst their own peer group and can help guide and shape the outcomes of the implementation. Early and frequent engagement throughout implementation – similar to the plan development phase – will help keep this group informed and help identify potential issues early, in order to launch more proactive mitigation tactics.

**Community Engagement**
The community has been engaged throughout the Clinical Action Plan and has informed and aided in decision-making quite considerably. During the implementation phase, it will be important to keep the community apprised of progress in order to maintain the high level of trust that has been cultivated through the unique approach to planning thus far. While the input phase is complete, buy-in from the community will help enable a smooth transition for the organization and continue to build TSH’s reputation as a world class community hospital.

**Communications**
As was required during the Clinical Action Plan development phase, a robust and comprehensive communications plan is critical to successful implementation as well. Interlinked with many of the other success factors, a thorough communication plan will help keep stakeholders informed and engaged, help mitigate potential risks, and increase buy-in throughout the organization.

**Early Action**
Recognizing that the Clinical Action Plan involves many long-term and complex initiatives, it will bode well for the implementation teams to produce tangible interim results that demonstrate concrete progress towards execution of the plan. Early progress showcases the organization’s commitment to change, as well as reinforces the priorities that have been set through the process. Many organizations implementing initiatives that involve significant change experience some degree of scepticism and a ‘wait and see’ attitude. These stakeholders can be quickly won over by demonstrating swift action. This enabler is closely tied to a strong communications plan and the stakeholder engagement strategies. Communication around upfront results to all interested groups will continue to build momentum and commitment from all stakeholders.
Alignment of Budgets to Clinical Priorities

An often cited barrier to success of strategy implementation (be it corporate or clinical) is a lack of dedicated resources. With the Clinical Action Plan clearly defining the set of clinical priorities for the organization, these priority initiatives must be supported by the budgetary framework for two main reasons. Firstly, and most simply, a lack of required financial and human resources will immediately stall the implementation of any project. As clinical priorities, resources must be similarly prioritized in order to begin building the future of the organization. Secondly, if the existing budgeting processes produce a set of clinical priorities that differ from those laid out in the Clinical Action Plan, there will be confusion and the process may be discredited. The entire planning process, executive sponsorship, robust communications and engagement efforts could be viewed as ‘all for naught’ if budget allocations do not mirror the clinical priorities in a way that allows implementation to proceed.
Introduction

This section provides an introduction to The Scarborough Hospital’s unique clinical service planning approach. It highlights the organization’s vision for the future, key differentiators of the Clinical Action Plan process and core principles that served as the foundation for the planning work.

Our Unique Approach to Clinical Services Planning

Following a successful process that led to a new Mission, Vision and Values and a Strategic Plan, The Scarborough Hospital (TSH) embarked on a journey to create a Clinical Action Plan. This initiative represented an exciting and challenging opportunity for the organization to integrate a new way of thinking about clinical services planning – an approach that focused on the patient experience.

Why shift the planning process to focus on the patient experience? Quite simply, it is about realizing a vision. The Scarborough Hospital is driven by a vision “to be recognized as Canada’s leader in providing the best healthcare for a global community”. To achieve this vision, the organization recognizes that the paradigm must shift from provider-focused discussions to patient-focused discussions. With the patient as the focus, it challenges the organization to view the hospital just as the patient and the community experiences it. In this way, patient-focused discussions strive to break down traditional program silos and - for the first time at TSH - foster an integrated approach to planning and delivering care in order to create the ideal patient experience. The mission of the organization strongly reflects this commitment to putting the patient first by providing an “outstanding care experience that meets the unique needs of each and every patient.”

Key Differentiators of the Clinical Action Plan Process

In general, the Clinical Action Plan process was based on the following six core principles:

• **Patient-centred approach to planning** – Planning discussions did not start with data; instead early discussions were focused on patient scenarios. These scenarios provided a lens for the participants to begin current state discussions and explore future opportunities.

• **Integrated planning through Communities of Practice** – Planning discussions were not focused on existing Program Service Groups (PSGs). To promote integrated planning, Communities of Practice were created to serve as planning groups for the Clinical Action Plan process. These multi-disciplinary groups were the driving force behind the planning process. Communities of Practice provided a forum for staff and physicians from across multiple PSGs to truly plan together. In some cases, the creation of Communities of Practice actually brought people together for the very first time to think about how to better provide care to their shared patients.

• **Hypothesis thinking** – Planning Groups were challenged to generate a series of possibilities about the clinical future of TSH for each Community of Practice. To assist in this thinking and spark dialogue and debate, groups were provided with a starting point for a possible future vision. By leading with this vision, groups were able to generate many ideas about the future.

• **Evidence and outcomes-based** – Although the Clinical Action Plan process was not a data-driven exercise, it was informed by evidence and outcomes. Along the journey, planning groups had access to resources that
would allow them to incorporate data into their decision-making. For instance, at the outset of the process, a Planning Primer was created to serve as the primary reference tool for data.

- **Highly inclusive of staff, physicians and the community** – The Clinical Action Plan process represented an initiative that was fully committed to meaningful engagement and communication with staff, physicians, and the community. This approach allowed the Clinical Action Plan process to build a sense of ‘ownership’ and, ultimately, generate outcomes that truly represent the collective will and commitment of the organization to change.

- **Clinical stewardship through clinical leadership** – The Clinical Action Plan process was driven by the leaders of the medical staff within the organization. For The Scarborough Hospital, this meant that the process was lead by the executive sponsorship of the Chief of Staff. As well, physicians were actively engaged in the process as both Community of Practice co-leads and participants, providing leadership and demonstrating ownership for the process and outcomes.

**What is the Ideal Patient Experience?**

The concept of the ideal patient experience is one that has been discussed a great deal in healthcare circles in recent years. But what exactly is an ideal patient experience? A literature search reveals that there is no common definition of the “ideal patient experience” – in some instances, it refers to the quality of care, in others it refers to access and the journey through the system, while others suggest it is the sum total of the patients’ experiences – from arriving in the parking lot to leaving after discharge.¹

To further refine the understanding of the “ideal patient experience”, The Scarborough Hospital consulted with patients and those who had experience with the hospital (as friends and family members of patients) to help the organization define the elements that would create an ideal patient experience. This was done through a series of face-to-face meetings, focus groups and an on-line survey. In total, approximately 3,000 people informed this study.

As part of the survey, participants were asked to think about the most important elements of the “ideal patient experience”. Figure 1 below highlights the top elements identified by survey participants.

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¹ *Ideal Patient Experience Study Summary*, 2010, Anne Marie Males
Overall, the top element selected by respondents was friendly, courteous and respectful service, followed by improve or eliminate wait times. For full information on the survey results, refer to Appendix 1.

**Planning Principles**

The following Planning Principles were established for the Clinical Action Planning process:

**Sustainability**

TSH should have enough qualified providers, funding, information, equipment, supplies and facilities to look after patient’s health needs.

**Safe**

Patient’s should not be harmed by the care that is intended to help them.

**Quality**

Patient’s should receive care that is effective and based on the best available scientific information.

**Equitable**

Patient’s should get the same quality of care regardless of whom they are and where they live.

**Access**

Patient’s should be able to get the right care at the right time in the right setting by the right healthcare provider.

**Patient-Centred & Diversity**

Healthcare providers should offer services in a way that is sensitive to an individual’s and families’ needs, preferences, values and beliefs.

**Integrated**

All parts of TSH should be organized, connected and work with one another and its community partners to provide high quality care.
Process Overview

This section describes the specific process that was followed to reach the outcomes and decisions of the Clinical Action Plan. The process was designed in order to be transparent and allow for efficient and informed decision making. Key aspects of the process included an electronic shared workspace to enable continuity and transparency, as well as a staged approach to maximize the number of ideas undergoing formal evaluation and consideration.

Approach and Methodology

The approach that was developed for the TSH Clinical Action Plan process was strongly focused on the patient experience and dedicated to interdisciplinary thinking. Care was also taken throughout the process to ensure transparency and adequate opportunity for consultation and input. These themes were kept front and centre as the planning process unfolded and decisions were made about the future of TSH.

The following six-phase approach was employed. Detailed descriptions of activities conducted in each phase are presented in the following sections.

Phase 1: Set-up & Preparatory Work
Phase 2: Planning Primer Preparation
Phase 3: Communities of Practice Sessions & Recommendations
Phase 4: Consensus Summit & Evaluation
Phase 5: Business Case Development & Final Decision Making
Phase 6: Clinical Action Plan Finalization

Figure 2
Phase 1: Set-up & Preparatory Work

Committee Structure & Project Governance
Phase 1 included the establishment of the various committees and groups that would be responsible for stewarding the Clinical Action Plan Process through to completion. The process had a robust governance structure which involved the establishment of the following groups:

- Clinical Action Plan Steering Committee
- Clinical Advisory Panel
- Community Advisory Council
- Clinical Action Plan Working Group

While ultimate oversight rested with the TSH Board of Directors, ongoing project decision making and approval of all interim deliverables were accomplished via the Clinical Action Plan Steering Committee. Figure 3 illustrates the various committees and their relationships to each other.

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Figure 3
Community Advisory Council
The Community Advisory Council (CAC) was a pre-existing body that was specially engaged by TSH, reflecting the hospital’s focus on the patient experience. As community members with a broad range of personal experiences and knowledge of specific community needs, this group was able to provide valuable insights into how the proposed actions and recommendations would impact patients and the broader Scarborough community.

Clinical Advisory Panel
The Clinical Advisory Panel was established to formalize a comprehensive group of clinical experts that could provide valuable insights to both the process itself, and the outputs generated. In order to ensure there was purposeful and structured feedback opportunities from all clinical areas of the hospital, the Clinical Advisory Panel was comprised of specially selected leaders that would be able to both provide direction and advice to the Steering Committee and Working Group, but also serve as champions of the project when interacting with their colleagues and staff on a day-to-day basis.

Clinical Advisory Panel members were instrumental in validating key process components, selecting Community of Practice members, and evaluating Community of Practice Planning Group recommendations and business cases.

See Appendix 2 for the Clinical Advisory Panel Terms of Reference.

Steering Committee
The Clinical Action Plan Steering Committee was responsible for all formal decision making and determination of the final Clinical Action Plan Recommendations. The Steering Committee was comprised mostly of Senior Administration, Medical Leadership and a representative from the Community Advisory Council.

See Appendix 3 for the Steering Committee Terms of Reference.

Working Group
The Working Group for the Clinical Action Plan was established to provide project management support and coordination of all planning activities. The working group included the following membership:

- Chief of Staff/Project Sponsor, Dr. Steve Jackson
- Vice President, Patient Services, Lindsey Crawford
- Vice President, Patient Experience/Communications, Anne Marie Males
- Project Manager, Jacqueline Phan
- Administrative Support, Yvonne Ragnitz

KPMG team members also formed part of the working group and provided formal weekly status updates and managed the weekly agenda.

Assumptions & Evaluation Criteria

Assumptions
Although TSH was interested in exploring as many new ideas as possible, several planning assumptions were articulated from the outset. The following assumptions were maintained throughout the process and any proposals that would contravene an assumption were not discussed.
• Zero-sum game – ie: no new financial resources available
• One corporation, one leadership, two acute care sites with satellites
• Two 24/7 Emergency rooms

Evaluation Criteria
Throughout the process, future clinical opportunities within the Communities of Practice would need to be evaluated against standardized, objective criteria. This approach ensured that clinical options were assessed and prioritized for optimal impact.

The following table summarizes the Evaluation Criteria that formed the basis for all evaluative discussion throughout the Clinical Action Plan process.

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Fit</td>
<td>The extent to which a health service contributes to advancing the strategic directions of the organization (i.e., “fit” with the organization’s mission, vision, values, and goals/objectives).</td>
</tr>
<tr>
<td>Alignment with External Directives</td>
<td>The extent to which a health service is limited by government mandates (e.g., protected programs) and legislated obligations, and/or contributes to achieving regional or provincial health services objectives.</td>
</tr>
<tr>
<td>Ideal Patient Experience</td>
<td>The degree to which plans move the health service closer to or further from the ideal patient experience, as defined through the community engagement process.</td>
</tr>
<tr>
<td>Clinical Impact</td>
<td>The extent to which health services volumes are sufficient to ensure clinical competency, patient safety and effective care, as well as considerations related to uniqueness of the service in the local/regional areas and to quality of service provided.</td>
</tr>
<tr>
<td>Community Needs</td>
<td>The extent to which health services and volumes are consistent with health needs of a defined community (or catchment area), including present and future demands for service.</td>
</tr>
<tr>
<td>Partnerships (external)</td>
<td>The extent to which a health service works in partnership with other organizations to coordinate delivery of care to defined populations (e.g., to enhance service quality, improve access, optimize resource utilization in the region or local catchment area).</td>
</tr>
<tr>
<td>Interdependencies (internal)</td>
<td>The extent to which a health service coordinates and collaborates with other health services within the organization to enhance quality or optimize resource use.</td>
</tr>
<tr>
<td>Resource Implications</td>
<td>The extent to which the resource context for health services delivery has implications for degrees of freedom in relation to prioritization, including funding source (e.g., base hospital budget, ministry of health volume-based funding, donation, revenue-generating activity), availability of staff (e.g., nurses) and capital resources (e.g., equipment, space), contractual arrangements (e.g., union contracts) and model of service delivery (e.g., efficient verses inefficient).</td>
</tr>
</tbody>
</table>

Table 1
This set of Evaluation Criteria was adapted from criteria used by the Central East LHIN\(^2\) for priority setting and validated through the Clinical Action Plan Steering Committee.

**Phase 2: Planning Primer Preparation**

In order to inform the discussions occurring within the Communities of Practice, a comprehensive data package was prepared and provided to all Community of Practice, Steering Committee and Clinical Advisory Panel members. This reference document included the following elements:

- Demographic/Patient Profiles at LHIN, Scarborough and TSH levels
- Referral Patterns by CoP by FSA
- Market Share by CoP by FSA
- Ambulatory Referral Pattern
- Competitive Analysis
- Policy Analysis

See Appendix 4 for the full Planning Primer document.

**Phase 3: Communities of Practice Sessions & Recommendations**

**Communities of Practice**

As a method to facilitate integrated planning that was focused on the patient experience, Communities of Practice were established. The Communities of Practice were designed to bring together areas of expertise that aligned to the full patient experience, rather than just conventional Program Service Groups (PSGs). By crossing typical service boundaries via these interdisciplinary planning groups, the process was able to have more creative and open-ended discussions around how to best provide services to optimize the patient experience. Based on the work completed in the two initial phases, the following is a list of the 12 Communities of Practice that evolved from the Clinical Action Plan process (see Appendix 5 for the Communities of Practice Terms of Reference and membership):

1. Acute Adult Inpatient Care
2. Ambulatory Patient Care
3. Chronic Disease Management
4. Mental Health
5. Elective Surgery
6. Musculoskeletal
7. Cancer
8. Renal Disease
9. Children’s Health
10. Women’s Health

11. Men’s Health
12. The Ideal Patient Experience*

*Note: The Ideal Patient Experience Community of Practice was a ‘virtual’ group with no defined membership due to the cross-cutting nature of the associated objectives. All other Community of Practice Planning Groups were obliged to build the ‘ideal patient experience’ into their deliberations and recommendations. Any ‘ideal patient experience’ aspects that were applicable to multiple Communities of Practice (as was the case with most) were addressed separately in a dedicated bundle of initiatives focused solely on creating the ideal patient experience (See Appendix 6).

Membership for each Community of Practice was initially established by the Clinical Advisory Panel. Once the Community of Practice areas were finalized, each Clinical Advisory Panel member was encouraged to nominate 1-2 key stakeholders (or specific roles where names were unknown) to participate in the Planning Groups. For the purposes of the Planning Groups, a key stakeholder was defined as: “a representative from the area/service that is vital for planning”. In other words, who is best able to bring the required expertise to the table to enable informed planning discussions? Who is recognized by their peers as a thought leader in this area? Who understands the true complexion of the ideal patient experience?

Examples of key stakeholders included, but were not limited to, some of the following roles:

- Clinician
- Administrator
- Patient/Family member
- Community Partner representative
- Community Association member

These key stakeholders would also carry out an ambassador-like role and liaise between the Community of Practice Planning Group and their peer group or staff. In order to ensure productive planning sessions, the aim was to have 12-18 members on each Planning Group, but these members were encouraged to bring as many ‘voices’ to the table as possible. Between planning sessions, the Planning Group members were also encouraged to solicit thoughts and feedback on the work completed by the Planning Group from their colleagues, staff and external partners.

Over the course of several weeks, the Community of Practice Planning Groups met to hypothesize what the clinical services should look like in order to meet the needs of the patients relevant to their Community. Specific patient scenarios were developed for each CoP that articulated a typical patient of TSH (See Appendix 7 for full patient scenarios). This approach allowed many of the other circumstances surrounding patients, beyond just their clinical diagnoses, to be highlighted and considered during the planning process. Sessions were facilitated by KPMG in order to ensure equal opportunities for participation, and consistent outputs across Planning Groups. The following figure outlines the objectives of each Planning Group session:
Recommendations and Submissions

Following the last facilitated session, the Planning Groups had all the information they required to compile a detailed submission document that would be received by the Steering Committee for evaluation (See Appendix 8 for full Steering Committee submissions). These documents contained the following key elements:

1. Vision and Principles for the Community of Practice
2. Recommended Actions, including:
   - Detailed description of each proposed action
   - Alignment to Evaluation Criteria

Community of Practice submissions were received by the Steering Committee on October 7, 2010 for detailed review prior to the Consensus Summit.

Phase 4: Consensus Summit & Evaluation

Summit Preparation

As a method to obtain wide ranging feedback on all submitted recommendations, a Consensus Summit was designed to feature all Communities of Practice in an open setting. Each Planning Group prepared a summary of their submitted recommended actions to be presented in small groups during the summit. Clinical Advisory Panel, Community Advisory Council and Steering Committee members were provided summary binders with full Community of Practice submissions prior to the Summit. These groups would be required to complete numerical scorings of each Community of Practice recommendation and, therefore, required the extra lead time to familiarize themselves with the submissions.
**Consensus Summit**

During the Consensus Summit, each Community of Practice Planning Group was provided an area to deliver a short presentation that was to highlight the key aspects of their recommendations. Summit participants would have the opportunity to attend 4 Community of Practice sessions that were of specific interest to them. There would be 4 rotations of 20 minutes each allowing for 10 minutes of presentation and 10 minutes of questions/feedback from the participants. The Planning Groups were given guidelines to provide an overview of their descriptions, highlight key benefits and risks and specific impacts on the patient experience of their recommendations. During the ‘question and answer’ period, participants could seek clarifications or point out additional risks and benefits that were important. General Summit participants were provided feedback sheets in order to document feedback and provide a ranking of each Community of Practice recommendation. Clinical Advisory Panel and Community Advisory Council members also had ranking sheets that were uniquely identifiable in order to analyze ranking results by stakeholder group after the session.

**Steering Committee Evaluations**

All feedback submitted from participants was consolidated and circulated to Steering Committee members for their consideration as addenda to the submission summary binders. Based on the rankings from the Community Advisory Council, Clinical Advisory Panel and general participants, Steering Committee members then submitted their own ranking of each Community of Practice recommendation via on-line survey. Results were tabulated in advance of the Steering Committee decision making meeting.

The Steering Committee’s task was then to analyze the outputs of the rankings from all stakeholder groups and select those recommendations that warranted formal Clinical Action Plan Business Case development. Recommendations were sorted in rank order based on the average Steering Committee score and presented in a summary Table (See Figure 5).

For the top and middle third recommendations (shaded green and white) the Steering Committee discussion focused on a decision to move to a “CAP endorsed” business case or move to another process (e.g. current operations, LEAN project, etc.). For the bottom third recommendations (shaded in red), discussion focused on the decision to move to another process only, as these recommendations did not merit a “CAP endorsed” business case based on alignment to evaluation criteria (See Appendix 9 for full ranking and decision rationale). Appendix 9 also includes the alternative mechanisms suggested for those recommendations not selected for formal business case development.
<table>
<thead>
<tr>
<th>CoP</th>
<th>Recommendation</th>
<th>Score (out of 4)</th>
<th>Score (out of 4)</th>
<th>Score (out of 4)</th>
<th>Score (out of 4)</th>
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<tr>
<td>Cancer</td>
<td>Establishment of a comprehensive cancer program at TSH</td>
<td>3.65</td>
<td>3.51</td>
<td>3.50</td>
<td>3.00</td>
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<tr>
<td>Renal Disease</td>
<td>Establish a Centre of Excellence for delivery and management of Chronic Kidney Disease (CKD)</td>
<td>3.46</td>
<td>3.63</td>
<td>3.76</td>
<td>-</td>
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<tr>
<td>CDM</td>
<td>Develop a framework to deliver comprehensive care for chronic diseases at TSH</td>
<td>3.38</td>
<td>3.40</td>
<td>3.64</td>
<td>2.00</td>
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<tr>
<td>Acute Adult Inpatient</td>
<td>Development of a comprehensive Hospitalist Model for all of acute adult inpatient units at both TSH sites</td>
<td>3.36</td>
<td>3.59</td>
<td>3.52</td>
<td>4.00</td>
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<tr>
<td>Acute Adult Inpatient</td>
<td>Creating an Elderly friendly environment</td>
<td>3.30</td>
<td>3.38</td>
<td>3.77</td>
<td>3.00</td>
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<tr>
<td>Elective Surgery</td>
<td>Create and develop a &quot;Centre of Excellence&quot; in Breast, Urological, Minimally Invasive GI and Vascular Elective Surgical Procedures</td>
<td>3.27</td>
<td>3.39</td>
<td>3.62</td>
<td>-</td>
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<td>Acute Adult Inpatient</td>
<td>Provide consistent, timely, reliable and safe services, across both campuses, for inpatients experiencing critical situation and medical emergencies</td>
<td>3.04</td>
<td>3.42</td>
<td>3.84</td>
<td>4.00</td>
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<td>Acute Ambulatory</td>
<td>Improving Access to Support Services in the ED After Hours</td>
<td>2.98</td>
<td>3.21</td>
<td>3.49</td>
<td>3.00</td>
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<td>Mental Health</td>
<td>Divestment of Manse Road</td>
<td>2.97</td>
<td>3.37</td>
<td>3.33</td>
<td>-</td>
</tr>
<tr>
<td>Acute Ambulatory</td>
<td>Ambulatory Program</td>
<td>2.95</td>
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<td>2.93</td>
<td>3.40</td>
<td>3.88</td>
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<td>Apply for psycho-geriatric outreach program with external partners</td>
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<td>MSK</td>
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<td>3.08</td>
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<td>Acute Adult Inpatient</td>
<td>Review the structure and roles of each unit and evaluate the best interprofessional structure for medicine, surgery, critical care and other specialty areas</td>
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<td>3.35</td>
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<td>Women’s Health</td>
<td>Develop a Women’s Health Network; A Mother Baby Drop-in Clinic House For Scarborough</td>
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<td>3.28</td>
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<td>Mental Health</td>
<td>Improvement and expansion of case management program</td>
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<td>Mental Health</td>
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<td>MSK</td>
<td>Sports Medicine Clinic</td>
<td>1.78</td>
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</tr>
</tbody>
</table>

**Figure 5**
Appeals Process

A detailed appeals process was established in order to allow any member of the TSH community to submit an appeal through the Community of Practice Leads (See Appendix 10 for detailed appeals process and Appeals Committee membership). Appeals could be launched based on the following merits:

1. New Information or New Argument:
   - The appeal is based on new information or a new argument that lends strength to the Community of Practice’s submission.

2. Lack of Due Process:
   - The appeal is based on procedural issues (e.g. key stakeholder not given the opportunity to participate in the process) relating to the application of the Clinical Action Plan process.

If an appeal was deemed to be valid based on these criteria, it would be heard by a specially appointed Appeals Committee with interdisciplinary representation and 2 independent co-chairs.

Following the Steering Committee’s decisions on which recommendations to move forward to the business case stage, one appeal was received. However, the issues outlined in the appeal were addressed during preliminary discussions without invoking the formal appeals process and the appeal was withdrawn.

Phase 5: Business Case Development & Final Decision Making

Business Case Development

The following Community of Practice recommendations were selected for full business case development:

- Cancer: Establishment of a comprehensive cancer program at TSH
- Renal Disease: Establish a Centre of Excellence for delivery and management of Chronic Kidney Disease (CKD)
- Chronic Disease Management: Develop a framework to deliver comprehensive care for chronic diseases at TSH
- Acute Adult Inpatient: Development of a comprehensive Hospitalist Model for all of acute adult inpatient units at both TSH sites
- Elective Surgery: Create and develop a “Centre of Excellence” in Breast, Urological, Minimally Invasive GI and Vascular Elective Surgical Procedures
- Acute Adult Inpatient: Provide consistent, timely, reliable and safe services, across both campuses, for inpatients experiencing critical situations and medical emergencies
- Musculoskeletal: Maintain TSH as a Centre of Excellence in Total Joints, Spine and Sports Medicine and enhance the Foot and Ankle Program
- Children’s Health: Improved Paediatric Emergency Care at The Scarborough Hospital
- Musculoskeletal: Development of a Strong Regional Anaesthesia and Acute Pain Program

These groups were provided with a business case template that was developed specifically for the Clinical Action Plan Business Case Teams and based on the current corporate template (See Appendix 11 for final Business Case documents). Key sections of the business case template included the following:

1. Background of Recommendation
2. Proposal Description
Alignment to Evaluation Criteria

Environmental Analysis

Options Analysis

Recommendation

Implementation Strategy

All Business Case Teams were assigned a resource from Decision Support, Finance and the Senior Leadership Team in order to facilitate data gathering and financial analysis.

Business Case Teams also had the opportunity to engage KPMG in additional facilitated sessions in order to help ensure the necessary levels of contribution were possible. While much of the writing of the business cases was done independently, several larger team sessions were required in order to gather all the required information.

Approximately 3 months were provided for completion of the detailed business cases, at which point the business cases were submitted to the Steering Committee for review, in preparation for business case presentations.

Business Case Presentations

Presentations by each Business Case Team were scheduled with the Steering Committee, Clinical Advisory Panel and Community Advisory Council representatives. These presentations were designed to allow the Business Case Teams to actively address any remaining clarifications, or make note of additional areas of importance before the final Steering Committee decision making session.

The Steering Committee was encouraged to review all business cases and submit specific questions for clarification to the Business Case Teams in advance of the presentations. This would allow the Business Case Teams to provide a thorough response to Steering Committee member questions as a priority. Other questions were encouraged from the other participants in reaction to the presentations.

Each Business Case Team was supplied with a brief PowerPoint template to summarize the key points of their business case submission. Major areas of focus included:

- Outline of recommendation
- Proposal details
- Key benefits/impacts
- Financial implications
- Summary

Steering Committee Final Decision Making Session

Prior to the final decision making session, business cases were grouped based on scope and complexity. Large scope, long term business cases (such as ‘Centre of Excellence’ proposals) formed one grouping while shorter term, less capital intensive business cases form the other group. While all 9 business cases were equally considered in terms of viability, it was especially important to ensure the organization would not over commit itself by taking on too many large business cases; any one of which could potentially consume most of the organization’s resources (e.g. financial, people, time, effort, etc.). To this end, the following 5 “large” business cases were identified for a forced ranking exercise against the original evaluation criteria in order to inform a prioritization exercise during the decision making meeting.

- Cancer: Establishment of a comprehensive cancer program at TSH
- Renal Disease: Establish a Centre of Excellence for delivery and management of Chronic Kidney Disease (CKD)
• Chronic Disease Management: Develop a framework to deliver comprehensive care for chronic diseases at TSH
• Elective Surgery: Create and develop a “Centre of Excellence” in Breast, Urological, Minimally Invasive GI and Vascular Elective Surgical Procedures
• Musculoskeletal: Maintain TSH as a Centre of Excellence in Total Joints, Spine and Sports Medicine and enhance the Foot and Ankle Program

The following figure outlines the process used during the March 24th decision making session:

Based on the initial prioritization of the “large” initiatives, and discussion around which other initiatives could be reasonably committed to without putting the organization at risk, the following recommendations were approved for full implementation:

• Cancer: Establishment of a comprehensive cancer program at TSH
• Chronic Disease Management: Develop a framework to deliver comprehensive care for chronic diseases at TSH
• Acute Adult Inpatient: Development of a comprehensive Hospitalist Model for all acute adult inpatient units at both TSH sites
• Acute Adult Inpatient: Provide consistent, timely, reliable and safe services, across both campuses, for inpatients experiencing critical situations and medical emergencies
• Children’s Health: Improved Paediatric Emergency Care at The Scarborough Hospital
• Musculoskeletal: Development of a Strong Regional Anaesthesia and Acute Pain Program

It is important to note that although both the Renal Disease and Musculoskeletal “Centre of Excellence” recommendations did not move forward as clinical priorities, the Clinical Action Plan Steering Committee reinforced the organization’s continued commitment to promoting its strong “brands” – dialysis and joint replacements.

**Phase 6: Clinical Action Plan Finalization**

The final Clinical Action Plan recommendations will go before the TSH Board of Directors on May 10th, 2011 for final approval. All 6 Business Case Teams have been invited to provide a brief overview of their recommendations to the Board in order to inform them of the details of their proposals. The Board will seek to ensure the process undertaken has been sound and appropriate, and that the organization has not exposed itself to any unnecessary risks.

Those business cases not selected for full implementation as “CAP endorsed” priorities may still be implemented if alternative funding and other resource sources can be secured. It has been recognized throughout the process that all the ideas that came forward had significant merit and would undoubtedly improve the patient experience at TSH. The need for the organization to focus its limited resources on only those initiatives that would garner the highest impact and that were most strategic led to only a few initiatives being selected for full commitment. All other recommendations are welcomed by the organization and will be considered in the future as resources allow.
Our Clinical Action Plan

This section describes the outcomes and final decisions of the clinical planning process. Of the 32 original recommendations that came forward from the Planning Groups, 6 were selected as the top priority areas for The Scarborough Hospital over the next 5 years.

Outcomes

The following 6 recommendations represent the top clinical priorities for The Scarborough Hospital over the next 5 years:

• Establishment of a comprehensive cancer program at TSH
• Develop a framework to deliver comprehensive care for chronic diseases at TSH
• Develop a comprehensive Hospitalist Model for all acute adult inpatient units at both TSH sites
• Provide consistent, timely, reliable and safe services, across both campuses, for inpatients experiencing critical situations and medical emergencies
• Provide improved paediatric emergency care at TSH
• Develop a strong regional anaesthesia and acute pain program

Each recommendation is outlined in the following sections which present highlights from the business case documents submitted by the teams.
Comprehensive Cancer Program

VISION & PRINCIPLES:

The Scarborough Hospital is committed to providing an outstanding care experience that meets the unique needs of each and every patient. A comprehensive cancer program sited at TSH will provide this organization the prestigious opportunity to become the leader in cancer care for Scarborough. TSH will be well positioned regionally within the Central East LHIN, and provincially as it will continue to benefit from investment from Cancer Care Ontario.

The TSH Comprehensive Cancer Program will:

- Provide patient and family driven care that is integrated, timely and coordinated at each phase of the cancer care continuum.
- Ensure high quality care is delivered safely, reliably and consistently in a state of the art facility that is welcoming and satisfactory for the patients, their families, and our providers.
- Deliver exemplary outcomes that drive referrals to the Scarborough Cancer Program from both our internal and external partners.

DESCRIPTION:

The development of a comprehensive cancer program for the Scarborough region has significant investment of time and resources. This proposal recommends these four foundational elements required to develop and implement a complete cancer program at TSH.

Proposed Solutions & Recommended Actions

In addition to the gaps previously highlighted, and the strategic importance of aligning with CCO for future growth and development, a clear opportunity exists for TSH to invest in, develop and operate a comprehensive cancer program. This program will attract highly talented physicians, specialists and allied health professionals, and will provide foundational direction for the development of future programs such as elective surgery, women’s health, men’s health, and diagnostics. This high profile program will bring revenue and prestige to the organization and community.

The development of any program is complex and as such, the cancer plan will use the experience of a patient with breast cancer as an initial disease in which a system of services must interface and coordinate to ensure that cancer care is provided in a coordinated and integrated manner.
Once the foundation is in place, the systems and processes used to address the patient’s experience with breast cancer will expand to address a patient’s experience with other cancers - hematological malignancies, colorectal cancer, lung cancer, prostate cancer, and gynecological cancers. By investing in, and implementing the following recommended actions, the TSH Cancer program will follow the patient throughout the continuum of their care with a strong emphasis on integrated, seamless transitions between each phase of the cancer journey.

1. Establish a TSH multidisciplinary Oncology Council to provide dedicated leadership to the program.
2. Establish space, infrastructure, human resources, and other requirements.
3. Implement and operationalize the Breast Assessment Centre by September 2011. See care map in appendices.
4. Integrate role of patient navigator.
5. Implementation of oncology IT/IM system, including an e-chart, a scheduling system and CPOE (computerized physician order entry).
6. Develop and implement a Rapid Response Oncology Assessment clinic – similar to an urgent care clinic – as part of the ambulatory unit for oncology patients with urgent care needs. This clinic may be staffed by a nurse practitioner with support from the medical oncologist. Patients would have access to care for cancer-related problems with the goal of reducing the number of oncology patients presenting in emergency. Critically-ill patients would be referred directly to the emergency department.
7. Work with Diagnostic Imaging and Laboratory services to establish and expand the infrastructure necessary to support cancer services, improve turn-around times, and implement a broader range of interventions to support the cancer patient.
8. Partner with CE RCP and TSH Department of Surgery to support an increase in cancer surgeries and market share through the development and implementation of additional Diagnostic Assessment Units. Breast DAU to be operational mid-2011. Thoracic DAU has been in operation since December 2010.
9. Partner with CE RCP and TSH Department of Surgery to support an increase in cancer surgeries at TSH for Scarborough patients for common cancers; and facilitate transfer to level 1 facilities for highly specialized surgeries; e.g. thoracic surgery.

**BENEFITS:**

Cancer care will be one of the foundational programs at TSH, as it becomes recognized as the Regional Cancer Centre in Scarborough. CCO has committed to supporting programs that will provide high quality cancer care services as close to home whenever possible. The comprehensive cancer program allows for TSH to be the leader in providing cancer services for the Scarborough community and will have the following benefits:

**TSH**

- TSH will be well positioned for future growth and development; as well as investment opportunities from CCO
- TSH will provide an integrated program delivery model utilizing best practice guidelines, partnership agreements and patient navigation throughout the cancer care continuum.
• TSH will provide minimally invasive surgical (MIS) options to appropriate cancer patients
• TSH will provide high quality and safe care in space that is pleasing from the patients and families perspective; as well as for the professionals groups providing the care delivery
• TSH cancer program physician and staff satisfaction will improve by working together toward common goals – including improving work flow and work processes, ongoing opportunities for education, and resources to enable staff to continue to provide high quality and safe care

Our Patients
• TSH patients can expect timely diagnosis and treatment
• TSH patients can expect ongoing health teaching and education, effective and collaborative communication about their disease and care plan
• TSH patients can expect and will benefit from support along all domains – physical, psychosocial, emotional, spiritual; and receive respect and dignity at all times in a greatly improved and comfortable facility.
• TSH patients and families will benefit by working with a patient navigator as they journey through a complex health care system
• TSH patients can expect to receive as much care as possible within the hospital and will be referred where appropriate to regional cancer centres.

Our Providers
• Family physicians will benefit from ready access to specialists for referrals and consultation
• Improved opportunities for communication through access to electronic health record, ensuring that all health professionals have access to pts’ info including emergency department
• TSH providers can expect overall improvements in coordination of care from definitive diagnosis to treatment for their referred patients
Chronic Disease Management

VISION & PRINCIPLES:

Vision
Chronic Disease Management at TSH demonstrates our strength and excellence at integrated and connected care for our patients and community throughout the progression of disease.

Principles
At TSH, any patient with chronic disease will experience care that:

• Treats the patient under a shared care team whose disease is managed throughout the progression of the disease from community to hospital and back to the community with focus on maximizing ability to remain at home.

• Utilizes partnerships to put the patients at the centre of the coordination to enable seamless continuity of care between community care and hospital care and vice versa.

• Strives to provide timely, high quality services to the patient by serving the patient in the most appropriate setting and with seamless access to diagnostics, assessments, interventions, and education

DESCRIPTION:

Given the gaps and the needs required providing comprehensive care for chronic diseases at TSH (as outlined above), this proposal is recommending the following:

1. Improve the system and supports in order to improve the CDM patient’s experience and
2. Develop a Chronic Disease Management Framework for TSH that can be applied to managing all patients with Chronic Diseases.

Recommendation 1 - System Improvement:

A. Develop a mechanism to better define the types of chronic disease patients receiving care at TSH.

• Care delivery is currently provided on a case by case basis making the process and service provision inconsistent.

• There is a need to better define the types of patients receiving chronic disease care at TSH, define which types of patients would best benefit from hospital-based services vs. community based services.

• For patients requiring hospital based care, need to create timely access to needed services and consistency in their care delivery. The process elements to enable the above and direct system improvements are outlined below in Figure 5.
**Figure 5: Process elements that direct system improvements**

![Diagram of process elements]

**Action(s):**

Implement Kaiser Permanente’s risk stratification pyramid (See Figure 6)

Establishing tools, systems, and processes that enable ease of referrals from various referral sources is the first process element that accesses this system. Risk Stratification with level specific service intensity can be established utilizing the Kaiser Permanente’s risk stratification pyramid (See Figure 6) which has been implemented and utilized successfully in California.

This model enables patient assessment and categorization based on their level of risk of being admitted to hospital. Each category of patient risk will have developed interventions and levels of care defined for each level of risk within each chronic disease service. This allows consistency in patients’ care planning, management and care delivery of services. Resource needs can also be better identified and managed; roles, responsibilities, and tasks of each interdisciplinary team members both within the hospital setting and the community can also be well defined.
B. Space Configuration

- System improvements will require space configurations that enable increased efficiencies in clinical operations.

**Action(s)**

Ensure planning efforts associated with the need for the Diabetes Education Centre (DEC) to move out of their current space by Spring of 2011 and the identified need for reconfiguration of space within the Cardiology Heart Function (CHF) Clinics (to improve patient flow and fulfill accessibility requirements), are considered to best support optimal patient flow, operational efficiencies and improvement of the patient experience. See Appendix E for space reconfiguration plans for the DEC and CHF clinics. The forward movement of these activities will also help to establish improvements in patient flow as well as gain efficiencies through improved care delivery design and further development and clarity of human resource roles and responsibilities.

**Recommendation 2 - Chronic Disease Management Framework**

The development of a Chronic Disease Management Framework for TSH will allow three key deliverables: Firstly, defining how TSH will manage patients with chronic disease (how care will be delivered; including development of shared care models with community providers based on degree of illness), secondly, defining TSH’s role in managing Chronic Disease (preventing impact of chronic disease on hospital acute care resources).
A. Managing patients with Chronic Disease

- The development and implementation of the TSH CDM framework would be best achieved by initially focusing on one chronic disease.
- Following the identification of the key components of the framework required to manage the disease, the framework may be applied to other chronic diseases.

Action(s):

- It is proposed that Diabetes be the chronic disease utilized to enable and inform the development and implementation of the TSH CDM framework.

Diabetes is a disease that spans across all chronic diseases and having a framework that encompasses the ability to manage multi-faceted interventions across many chronic disease services both within the hospital and the community, will enable consistent application to all other chronic diseases provided at TSH.

B. Managing Chronic Disease

- The Ontario Chronic Disease Prevention and Management framework provides evidence based, population-based, and client centred approach to chronic disease management. The Ontario CDPM Framework (see Figure 7) recognizes a more responsive approach to chronic disease in that chronic disease:
  - Is ongoing, and therefore warrants pro-active, planned, integrated care within a system that clients can easily navigate
  - Involves clients living indefinitely with the disease and its symptoms, requiring them to be active partners in managing their condition, rather than passive recipients of care,
  - Requires multi-faceted, culturally sensitive care which calls for clinicians and non-clinicians from multiple disciplines to work closely together, to meet the wide range of needs of the chronically ill,
  - Can be prevented and therefore warrants health promotion and disease prevention strategies targeted to the whole population, especially those at high risk for chronic disease. 3

Advantages of the Ontario CDPM Framework:

Patient Centred Care:

- Identifies key components required of TSH to enable patients with chronic conditions to experience a change both in their care and their disease management.
- Directs patients to become equal partners in their own health and full collaborators in managing their conditions.
- Organization and delivery allows expert care to be received when and where needed. The framework
- Patients do not have to struggle through the system on their own and bounce from provider to provider.
- Care is planned and based on the best evidence, and both providers and clients are supported in following through with the plan.

Prevention:

- Prevention includes measures to halt the disease’s progress and to prevent complications and co-morbidities.
- For the health care system, the Framework’s approach to prevention means: expanded prevention and health promotion in health care settings, more pro-activity in preventing disease and promoting the health of clients, and outreach beyond client rosters to catchment area populations and the population as a whole.
- As defined in this framework, prevention includes interventions both to reduce the risk of disease among chronically ill individuals and individuals at high risk of developing disease, as well as broad initiatives to improve health within the population as a whole and prevent new cases from occurring.

Community Partnerships:

- The framework identifies key components of the community that work in tandem with the patient, their families and with health care organizations to manage chronic disease.
- This model clearly defines the elements, roles, requirements and system coordination needed to enable comprehensive management of Chronic Disease. Using this model as means to direct and define TSH’s role within the full continuum of managing Chronic Disease will enable a proactive approach that works to decrease impact on acute hospital resources through proper management of chronic disease.

**Figure 7**

**Ontario’s Chronic Disease Prevention and Management Framework**

**BENEFITS:**

Implementation of this initiative would be expected to bring about the following benefits:

1. A developed CDM framework for TSH that would:
   - Treat the patient under a shared care team where the disease is managed throughout its progression from community to hospital and back to the community with the focus on maximizing the ability to remain at home.
   - Utilize partnerships to put the patients at the centre of the coordination to enable seamless continuity of care between community care and hospital care
   - Provide timely, high quality services to the patient by serving the patient in the most appropriate setting and with seamless access to diagnostics, assessments, interventions, and education
   - Be transferrable and consistently applied across all other chronic disease services offered at TSH
2 Improved and consistent access to care
3 Decreased wait times
4 Formalized screening approach/strategies to identify patients with or at high risk of chronic disease
5 Maintained or improved population health outcomes with a focus on co-morbidity management integration of risk stratification and self-management support.
6 Seamless patient care coordination, communication and integration of healthcare delivery
7 Operational savings through creation of workflow efficiencies and maximization of existing resources.
8 Cost containment or cost avoidance through reduced acute and emergency hospitalization rates
Development of a Comprehensive Hospitalist Model

VISION:
At TSH, Acute Adult Inpatient care will be the leader in providing patient driven care using a hospitalist model for service excellence. The structure, accountabilities and service areas provided through a comprehensive hospitalist model of care is the root of interprofessional patient driven care across all programs. The Hospitalist program will encompass the following principles of patient driven care and service excellence:

PRINCIPLES:
• Provide seamless and coordinated care throughout the course of a patients’ stay across the various transitions
• Utilize a team-based philosophy to provide care to all acute adult inpatient units
• Involve patients and families in decisions – patients will be active leaders in their care using TSH’s expertise to guide this care
• Use the philosophy of the right practitioner for the right patient at the right time
• Ensure meaningful presence of staff at the bedside

DESCRIPTION:
Given the background analysis and system level challenges proposed to you, this business case is recommending not only the key components of a comprehensive hospitalist model but also the integration within this model to impact this system level gap. Embedded in the following recommendations is the vision of acute care services to shift to a patient driven model rather than provider focused which aligns with the priority of hospitalists managing the care of hospitalized patients across the system as a whole.

<table>
<thead>
<tr>
<th>Service Challenges</th>
<th>Recommendations</th>
<th>Rationale</th>
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</thead>
<tbody>
<tr>
<td>ALC care delivery model</td>
<td>Develop a family physician-nurse practitioner hospitalist model for ALC</td>
<td>To align non-acute care needs with appropriate community based resources and care delivery model</td>
</tr>
<tr>
<td>Medicine management for acute inpatients</td>
<td>Develop a sustainable model for medical care for general internal medicine patients as well as other non-medicine inpatients</td>
<td>To provide coordinated care to general internal medicine patients To minimize the patient safety risk for negative outcomes for surgical patients</td>
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<tr>
<td>Segmented care delivery</td>
<td>Develop an integrated hospitalist model to permeate medicine management across programs, campuses and units</td>
<td>To build upon current hospitalist models to break down silos and integrate service delivery across the system</td>
</tr>
</tbody>
</table>
1 **Develop a hospitalist model for ALC patients:**

As ALC patients are non-acute patients that should be reintegrated back into the community, a community based model of care is being proposed for the management of this patient group. Family physicians along with nurse practitioners are the experts in primary care, and therefore the **development of a family physician-nurse practitioner based hospitalist model** is being proposed. This model incorporates a Nurse Practitioner role in partnership with the family physician for daily primary care management of ALC patients. Current regulations outline requirements for a nurse practitioner to provide primary care in an inpatient setting which includes the partnership with a physician for consultation and practice parameters (i.e. Need for medical directives). Therefore, ensuring clear accountabilities for physician participation highly correlates with the success of the nurse practitioner in this inpatient role. While fee for service was considered an option in this realignment of resources, it limits the accountability to the partnership model that is required from both parties. Therefore, a financial investment is required to support the consultation and participation of the physician to this partnership.

Another component to this recommendation is to facilitate the development of an overall ALC program. This would include cohorting ALC patients that are waiting for long term care placement to a geographical inpatient unit to support both operational efficiency from a staff resource perspective but also to foster care plans and care coordination that align with community based long term care model. In turn this will allow limited acute care resources to be appropriately aligned to acute care needs.

2 **Develop an expanded hospitalist model inclusive of care for surgical inpatients, general internal medicine and other non-medicine inpatients**

A **co-management model for care delivery for surgical inpatients** is being recommended whereby the surgeon remains the MRP to manage surgery related care issues, while the hospitalist provides ongoing management of medical co-morbidities. In turn, this opportunity to would improve collaboration between medicine and surgery to meet patient needs.

Early research in the co-management model for surgical patients has demonstrated its value to care coordination by appropriately utilizing resources to optimize patient outcomes. Other organizations have approached this service gap for surgical patients along a continuum of ownership ranging from intermixing surgical and medical patients on “med-surg” units to primary MRP hospitalist model for surgical patients with surgeon consultation (See Appendix B). The proposed co-management model shares the accountability for the patient care through a defined number of surgical cases (approximately 18-20 surgical inpatients) that require daily onsite medical management rather than one time medicine consultation. The model would include clear role expectations, service level agreement in partnership between medicine and surgical programs, and performance objectives.

In addition, volume demands show that an **additional 3 hospitalist units can be introduced across both campuses** with 2 at the Birchmount (3A and 4D) and 1 additional unit at the General campus (T7, T9 and CP1 general medicine patients only) See Appendix C. The consolidation of general internal medicine patients onto 3 additional units requires the realignment of other subspecialty patients such as cardiac and cancer patients. As research shows that other hospitals have branched specific subspecialty areas such as neurology into hospitalist

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units with good success\textsuperscript{5}, we are proposing an expanded model that consolidates general medicine patients with key subspecialty groups into a hospitalist unit with appropriate consultation to the subspecialist. As we have developed a current hospitalist program that we believe factors in the benefits much of what is both known in the literature\textsuperscript{6} and demonstrated at other hospitals, this further consolidation aims to optimize the overall care coordination for medicine patients across both campuses. The Clinical Resource Leader role would continue to be integral to the operation of a hospitalist model as in our current program to foster interprofessional collaboration within the full team as well as improved patient care coordination. This additional hospitalist resource will more appropriately allow for consultation to mental health and obstetrical areas where there is patient need.

The introduction of a \textbf{discharge follow-up clinic} is being proposed to support both patient flow as well as improved patient safety outcomes. Research shows that inpatients that have appropriate follow-up post discharge reduce the incidence of adverse events\textsuperscript{7} and in turn readmission to hospital\textsuperscript{8}. In an effort to impact both the length of stay for medicine patients as well as readmission rates in medicine program, the discharge follow-up clinic would be an added support in the patients’ transition back to their community based medical team. The development and operation of a clinic would also encompass key qualitative factors for improving the ‘patient experience’ as noted in the literature by focusing what patients would value in a follow-up clinic\textsuperscript{9} such as direct communication with the physician and what to expect around future care.

3 \textbf{Develop an integrated hospitalist model to permeate medicine management across programs, campuses and units}

This recommendation for an integrated hospitalist service delivery model will provide the outstanding care needed to meet the unique needs of each and every patient as it changes the way inpatient care is organized. The model will break down silos in care delivery across current service groups and provide care to the patient where they are and at the appropriate level of care. In doing so, the need to realign inpatient care delivery is presented as described in the above recommendations. However, integration really starts with being ready to take a “big picture” approach to care delivery. The goal here is to develop a “big picture model” with system level perspective that supports medical care that permeates across these acute care areas. Therefore this recommendation is inclusive of the need to cohort general internal medicine patients, while establishing the

medical support needed to also meet the demand in surgery, ED and the outpatient discharge follow-up group as a package compliment to this model.

**Critical success factors for a ‘great’ hospitalist model:**

Given that the majority of other acute care hospitals have implemented hospitalist models (See Appendix B), we had the opportunity to integrate the benefits/learnings from those models into our recently introduced hospitalist model which will provide a significant launching pad for these further enhancements to expand upon. The majority of hospitals across the GTA have hospitalist models but there is no cookie cutter approach as each model is customized to the needs of each hospital in delivering service. TSH looks at best components or lessons learned from each model to mould into customized TSH model. These components include:

- Appropriate inclusion of GP model for non acute patients
- Internist-based hospitalist model for inpatient acute patients
- Need for specific and clear deliverables for hospitalists
- Clinical support available to optimize care delivery
- Predictable volumes (i.e. inpatient units) are linked to base stipend
- Fee for service model to offset base stipend in areas where timely attention is required (i.e. ED)
- Designation of geographical area/unit to improve workflow and coordination of care

Furthermore, as noted above, a key factor for success for a hospitalist model is the **inclusion of detailed accountabilities that serve to meet the 4 pillars of service excellence:** Comprehensive care plan development, communication between team and patient/family, access to care, and continuity of care. Therefore, we have considered these factors into the above recommendations so that, in combination, they provide a compliment to one another that leads us to a “great” hospitalist model.

**BENEFITS:**

It is our proposal that a fully implemented comprehensive hospitalist program at TSH will provide the following benefits:

- **Resource utilization**
  - Aligning appropriate resources (hospitalist) to prioritize hospitalized patients. By minimizing the dynamic of competing priorities for medical attention, resources can more efficiently meet patient needs in a timelier manner.

- **Quality of Care**
  - Physician access to enhance communication between the team and to patients and families would directly impact patient satisfaction
  - Care coordination amongst the interprofessional team contributes to appropriate care plans and in turn appropriate length of stay

- **Patient Safety**
• Onsite physician access enhances any needed opportunity to reassess patient’s needs for revised treatment plans to prevent critical interventions

• Follow-up support for the patient’s transition back to community to prevent adverse events and readmission
Critical Care Response Team

**VISION:**

*Acute Adult Inpatient Care is foundational for the Hospital to deliver on mission, vision and values. CCRT is one of its cornerstones.*

The CCRT initiative relates directly to our Mission and Vision statements, while also providing quality of care and patient safety. CCRT brings critical care expertise outside the walls of the Critical Care Centre to the patient’s bedside, and supports quality of care and patient safety. The implementation of a CCRT at Birchmount supports the principle that every patient at TSH will receive “perfect care”.

It is for these reasons that the Planning Group is recommending the development of an RN lead CCRT at the Birchmount Campus. This will ensure equity of access to care at the Birchmount Campus. This recommendation uses the philosophy of the right patient in the right bed at the right time with the right care. The access to timely attention is something our community wants and through the CCRT we can enhance this goal, with particular attention to sudden and significant changes in patients’ status.

**DESCRIPTION:**

**Success Stories**

Many hospitals in the United States are collecting clinical data about outcomes to gauge the impact of the Critical Care Response Team, including number of calls and number of Codes. According to some data collected at McKeesport hospital, they have gone from approximately 8 Codes per month to about 6. Further the survival rate has increased from 40 % to 60%. This data suggests that people are calling Codes sooner. It is also noted that about 50% of the approximately 25% non-Code, early intervention calls the team gets each month result in the patient moving to a higher level of care.

Another example of successful implementation of the CCRT can be Missouri Baptist, Hospital. CCRT was implemented in April 2004 and now averages about 65 calls per month, cardiac arrests dropped by 31 % from the year before.

Tallahassee hospital has experienced a 33% drop in Codes since implementing CCRT in August 2003.

Critical Care Teams have been in the United States for upwards to 10 years. Enough data is now being generated to see reliable positive outcomes. The first CCRT was implemented in Ontario, Canada in 2007. While performance data is being collected and analyzed it is recognized that it takes years of data to draw positive conclusions and show impact. It is important to note however that in our Quarterly comparison reports favourable data is shown on our excellent response times, ICU Length of stay remains consistent, and that our Code Blue numbers are not increasing. This data also demonstrates that ward RN recognition of patient deterioration is improving and that time to CCRT RN notification is decreasing, supporting early effective patient intervention.

Early recognition of warning signs of clinical deterioration and interventions by a CCRT may provide better outcomes for general medical-surgical patients. Buist reported that CCRT resulted in a 50% reduction in the occurrence of cardiac arrest outside the ICU. In another study of CCRT, Bellomo reported that postoperative complications requiring transfer to the ICU were reduced by 58%, and postoperative deaths were reduced by 37%. CCRT may also...

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decrease the number of unnecessary transfers to a higher level of care by a mean of 30% and decrease overall hospital mortality by a mean of 26%\textsuperscript{11}.

It is evident that implementation of CCRT in the hospitals produce positive clinical results and outcomes and benefiting hospitals organizational cultures and staff morale as well.

**Critical Care Response Team at the Birchmount Campus:**

The implementation of an RN lead Critical Care Response Team at the Birchmount Campus will provide outstanding care by bringing the expertise of the Critical Care RN to the bedside. This will allow us to meet the urgent, critical needs of each and every patient by providing rapid response to a patient’s acute change in condition. The early identification of the patient’s condition is critical to patient outcomes.

CCRT would support all units in the Hospital (Birchmount Campus), with the exception of Paediatrics and outpatient clinics. Families, as well as any health care provider, will be empowered to call CCRT. The rapid response ensures timely assessment of the patient, addressing the concern of the individual who initiated the call. Nurses today are more specialized. The Critical Care RN is able to assess patients rapidly and is able to administer different medications that nurses on the units are unable to give. The availability of a cardiac monitor assists in critical assessment of the patient; this would be available on the CCRT cart.

CCRT ensures the patient is in the right bed at the right time. Should the patient require an increased level of care, such as cardiac monitoring, medications, increased nursing care, (patient nurse ratio) this need is identified and the patient moved to the right bed as needed. This addresses comfort and care of the patient so their wants and needs are met.

CCRT takes the critical care expertise outside the walls of the critical care unit thus allowing immediate access to an Internist/Intensivist. As the CCRT RN is directly providing care at the bedside both the patient and the family are continually updated and communicated in regards to the patient’s condition, the assessment and findings, and when the physician is expected at the bedside, and why the patient is being moved. Both the patient and the family therefore, are very involved in the patient plan of care. This direct contact allows for ongoing communication. Care provided is rapid, immediate, proactive, and safe and provides an increased level of expertise to match the immediate need. The CCRT RN has a cart on wheels that consists of a cardiac monitor, medications that the unit will likely not have available as well as equipment. The CCRT RN has all of the necessary tools to provide critical care to the patient at the bedside. Having the expertise of the CCRT RN in the unit also allows for “just-in-time” education and building of capacity of other members of the team.

\textsuperscript{11} http://ccn.aacnjournals.org/content/27/1/20.full
Thus, CCRT has calling criteria that prompt staff once recognized to call. CCRT Calling Criteria are as follows:

Any Acute Change in:

<table>
<thead>
<tr>
<th>Airway</th>
<th>Threatened, Stridor, Excessive secretions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breathing</td>
<td>RR &lt; 8 or &gt; 30, Distressed breathing, O2 Sats. &lt; 90 on 50% O2 or 6L/min</td>
</tr>
<tr>
<td>Circulation</td>
<td>Systolic BP &lt; 90mmHg. Or &gt; 200mmHg. Or decrease &gt; 40mmHg. Heart rate &lt; 40 or &gt; 130</td>
</tr>
<tr>
<td>Disability</td>
<td>Decreased level of consciousness (GCS decrease &lt; 2 points)</td>
</tr>
<tr>
<td>Other</td>
<td>Urine output &lt; 100ml over 4 hrs. (except dialysis patients) Serious concerns about the patient</td>
</tr>
</tbody>
</table>

**BENEFITS:**

The specific benefits that will be realized from this recommendation are the following:

1. Prompt diagnosis and implementation of treatment to prevent multi-organ failure, cardiopulmonary arrest as well as unnecessary deaths
2. Early identification of acute change leading to better patient outcomes
3. Empowered health care providers and families who participate in patients care
4. Ensuring the patient is in the right bed at the right time
5. Support to health care providers
6. Health care provider education
7. Increase in staff satisfaction
8. Increase patient/family satisfaction
9. Physician support
10. 48 hours post Critical Care follow up; ensuring patients are progressing well outside of the Critical Care unit
11. Recruitment and retention of Critical Care Nurses
12. Identification of education needs through the collection of CCRT data.

The MOHLTC recognizes that it may takes years to draw conclusions from all of the data generated, however at this point the following can be said of the CCRT at the General Campus;

1. Readmission rate to Critical Care has remained the same or shows a slight decrease
2. Number of Code Blue calls have remained the same or shown slight decrease
3. End of Life discussions initiated in over 1/3 of CCRT consults seen
4. Mortality rate showing no change to date – but many variables to consider

5. Overall ICU LOS slightly lower

6. Recruitment and retention of Critical Care Nurses is positive.

7. Time lapse between CCRT calling criteria met and when CCRT notified, marked improvement

8. CCRT calls by Call outcome, (disposition, transfer to ICU/higher level of care) numbers remain consistent
Improved Paediatric Emergency Care

VISION:

TSH Children’s Health Program will be recognized for providing high quality, easily accessible, family-centered care for the infants, children and youth of Scarborough’s global community through its advanced specialized programs.

PRINCIPLES:

- Children’s Health services will utilize **evidence-based best practices** and an inter-professional approach to the delivery of care.
- Recognizing that The Scarborough Hospital Emergency Department is one of the busiest in Canada, implementing a model of **specialized paediatric emergency care** will set a new standard for community hospitals.
- The Scarborough Hospital’s Children’s Health Program will **excel in the coordination of care** between healthcare providers.
- Both regional and local community **partnerships will be optimized** to provide superior paediatric care.

DESCRIPTION:

“The result of moving children into their own setting, creating paediatric specific processes and localizing care into a well circumscribed area, likely all contribute to improved throughput time and patient satisfaction.” (Redefining the Community Pediatric Hospitalist, Pediatric Emergency Care, 2007)

“The change in the physical environment in which we treat our paediatric emergencies seemed to enhance the level of satisfaction of our attendees.” (Paediatric Emergency department design: Does it affect staff, patient and community satisfaction?, Emergency Medicine, 2003)

The planning group recommends:

A. Improve Paediatric Care in the ED through training, enhancing Paedlink processes and developing dedicated Paedlink space.

Improved Paediatric Care in the Emergency Department

- Increase the movement of children through the Emergency Department to either an inpatient unit, Paedlink or discharge home in a timely fashion.
- Care to be provided in a “designated” paediatric friendly environment which allows for family involvement.
- Provision of care will be provided by specially trained staff in the field of paediatric medicine and nursing.
- The designated area will also allow for age appropriate care provision with inter-professional support, i.e., Child Life Specialists, Phlebotomists, IV Team and Diagnostic Imaging, RRTs, and Pharmacy.
Enhanced Triage of Paediatric Patients

The triage process in the ED will be enhanced to facilitate rapid movement of children from the waiting room into appropriate care stream:

- Resuscitation
- Paedlink
- Routine ED Care
- After hours clinic

The triage RN in the ED will perform initial assessment and determine if child fits criteria for Paedlink. If clinical criteria are met, child immediately is placed into the Paedlink process with appropriate medical directives and moved from the ED to the designated Paedlink area for further treatment and care.

B. Create an After Hours Clinic at or near the General site

Create an Paediatric After Hours Clinic

- Establish an afterhours clinic, that operates from 4pm to 10pm, Monday to Friday;
- Clinic to be easily accessible for families within the Scarborough boundaries.
- Clinic to be staffed by paediatric trained physician and nursing staff with a paediatric friendly environment.
- Our patient population will encompass children from newborn to 15 years of age.
- Furnishings will be conducive to paediatric age for treatment and exams.
- Accessibility to direct admissions to Paediatric Units and the Emergency Departments for further treatment as required.
- Represents an opportunity to develop partnerships with paediatric staff at other Scarborough Hospitals and community agencies within the CELHIN. (CCAC, TPH, RVHS, Lakeridge, Lactation Support).
- Clinic will also offer the ability for referrals to subspecialties/community consultations. (i.e. speech, plastics, dentistry, orthopaedics, ENT, urology)

Recommendations A and B are imperative to facilitate the following:

- Create opportunity to decrease emergency department wait times within the system
- Decreases volume of inappropriate patient cases coming to the emergency department
- Improves patient satisfaction by cohorting paediatric cases within a specialized care team model
- Links with Paedlink, inpatient services, ambulatory care and after hours clinic
• **Improves paediatric profile** by providing a unique program specific to family needs

• Ensures the **right care is provided by the right people at the right time**...quickly and efficiently

• **Meet Provincial Standards Wait-times**

**BENEFITS:**

A. **Improve Paediatric Care in the ED through training, enhancing Paedlink processes and developing dedicated paediatric space.**

**Benefits Include:**

**Improved patient flow** through timely, accessible and safe care:

- Staff dedicated to paediatrics will increase their clinical skills and level of excellence resulting in improved confidence, better outcomes and reduced adverse events and near misses.
- Decrease door to nurse to doctor time
- Decrease time to treatment
- Decrease need for return visits
- Decrease unnecessary testing and interventions
- Meet identified provincial targets: PIA, LOS, and wait-times.

“**Children may be at particularly increased risk for medical errors because of their inherent variability in size and the need for age-specific and weight-based dosing**” (Emergency department overcrowding and children, Paediatric Emergency Care, 2007)

“The majority of family health care decisions regarding access are made by mothers.” (Public Health Nursing 2001 May-Jun;18(3); 157-68)

“Staff seemed to be more confident when dealing with these patients in a dedicated paediatric area.” (Paediatric Emergency department design: Does it affect staff, patient and community satisfaction?, Emergency Medicine, 2003)

B. **Create an After Hours Clinic at or near the General site**

**Benefits include:**

- Provides alternative to emergency department for after hours support – lower wait times for children and parents.
- Accessibility for children and families in our community
• Paediatric focused care provided by experts in the field of Paediatrics
• Decrease the number of children visiting the Emergency Department
• Contributing to an ideal patient experience
• Decrease Emergency Department wait-times
• Further development of community partnerships, i.e., Rouge Valley Health Care System, CCAC
Development of a Regional Anaesthesia and Acute Pain Program

VISION & PRINCIPLES:

The overarching vision of the MSK Community of Practice is to have TSH recognized as a Centre of Excellence in Musculoskeletal (MSK) Care, with emphasis on total joints, spine, sports medicine and foot and ankle. The key principles are to provide excellent, evidence-based inpatient and outpatient MSK care in a timely, compassionate, fiscally responsible, and safe manner. The development of a Regional Pain Program is integral to the overall realization of this vision.

The Regional Anesthesia and Acute Pain Program would be able to meet the unique needs of each and every patient. We are recommending the development of a strong Regional Anesthesia program to complement the current Acute Pain Service (APS). The APS is an evidence-based model of care that consists of an Advanced Practice Nurse, an Anesthesiologist, and other members of the health care team, in managing pain to achieve best patient outcomes.

This proposal would involve Anesthesia Care Teams with Anesthesia Assistants (AA) in conjunction with a designated block room and the APS. The Regional block program provides best evidence, leading practice in the intraoperative period and the APS provides excellent care in the post-operative period.

This program would be able to offer world-class, patient-centered care, which is in accordance to TSH’s mission statement. In addition, as the business case will highlight, the efficiencies and enhanced flow afforded by a Regional Anesthesia service would enable better access to regional anesthesia for many other surgeries- the initial plan to start with total joints.

DESCRIPTION:

This proposal is aimed at developing a strong Regional Anesthesia Program and enhanced Acute Pain Service. Related to this, the program will:

1. Include a comprehensive clinical care pathway for total joint surgical patients that encompass pre-op, intra-op, post-op and rehab interventions.  
2. Focus on regional anesthesia to provide effective pain control, decrease post-op complications and improve patient satisfaction.
3. Utilize parallel processing of patients to create efficiencies when compared to our current sequential processing of patients.
4. Rely on the Anesthesia Care Team model and the Anesthesia Assistants to allow for parallel processing of patients.
5. Link with existing initiatives (Surgical Safety Checklist, Development of a block room, role expansion of the OR RRTs, and the Acute Pain Service) to create a smooth, seamless patient care pathway.

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12 See document, “Peri-operative Analgesic Pathway for TJR Surgery”
13 See document, “Patient Care Pathway for TJR Surgery”
14 See document, “Regional Block Room policy – Draft”
4. See document “ Canadian Pain Society, 1997”
6. Result in a high efficiency center for total joint surgery that will support TSH vision to be a Centre of Excellence in MSK Care.

7. The regional anesthesia program will include the development and implementation of a strong educational program to develop competence in managing pain and measuring patient outcomes. It is important to note that this program proposes to start with total joint replacements and to start at the Birchmount Campus (BM), as the elements there are more easily aligned and accessible. Also, the General Campus is our high volume site for TJR surgery and we have more to lose if and when the inevitable glitches occur. Processes and procedures can be developed and refined at BM. Our leadership team (medical, nursing and administrative staff), move back and forth between the two sites and we have experience in assimilating processes and procedures between the two sites. The emphasis will be to make sure that we have a smooth, highly functioning process in place that will work at both sites of the Scarborough hospital. The goal is to have the program integrate seamlessly into the practice at the General from the start.

This program exists in other organizations (NYGH, Holland Orthopaedic & Arthritic Centre) with excellent results (see Table I)

<table>
<thead>
<tr>
<th>2004</th>
<th>2007</th>
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<tbody>
<tr>
<td>1500 total joint arthroplasties.</td>
<td>2300 total joint arthroplasties</td>
</tr>
<tr>
<td>100% under general anaesthesia</td>
<td>Neuroaxial anaesthesia in 85%</td>
</tr>
<tr>
<td>Limited use of femoral nerve blocks</td>
<td>Peripheral nerve block used in 90% of TKA</td>
</tr>
<tr>
<td>Post op: nurse managed morphine PCA</td>
<td>Peripheral nerve block catheters used for continuous infusions</td>
</tr>
<tr>
<td>Average LOC 7 days</td>
<td>Average LOS 4 days</td>
</tr>
<tr>
<td>In patient rehab 10 days</td>
<td>67% discharged home (Day 5)</td>
</tr>
<tr>
<td>20% to long term rehab (16 days)</td>
<td>24% short term in patient rehab – 5 days (on day 3)</td>
</tr>
<tr>
<td>Average 16/20 lists per month ran overtime</td>
<td>9% for long in patient rehab</td>
</tr>
<tr>
<td>Average overtime was 30 hours/month</td>
<td>Average overtime dropped to 12 hours/month</td>
</tr>
<tr>
<td>On average 18 cancellations/month</td>
<td>Average cancellations dropped to 5/month</td>
</tr>
<tr>
<td>Reduced PACU stay</td>
<td>Reduced PACU stay</td>
</tr>
<tr>
<td>17% decrease in time for patient in to patient out (of surgical suite) from 2004 to 2007 data- for total knee arthroplasties</td>
<td>18.6% decrease in time required for patient in to patient out for total hip arthroplasties</td>
</tr>
</tbody>
</table>
**BENEFITS:**

<table>
<thead>
<tr>
<th>Clinical Care/ Patient Experience</th>
<th>Being a Community leader/ CELHIN leader</th>
<th>Clinicians- both staff and physicians/ surgeons</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aligns with TSH MVV as it will optimize the patient’s positive anesthesia experience</td>
<td>Part of second largest LHIN, with a significantly ageing and diverse population who will need orthopedic surgery</td>
<td>Utilizing the experienced and well developed clinical staff in the areas of RRT, OT, PT and Nursing</td>
<td>Places the Birchmount Campus as the leader as the program will focus here first</td>
</tr>
<tr>
<td>Regional Blocks decrease intraoperative and immediate post-op nausea &amp; vomiting</td>
<td>We would be the only Regional Block program in the CELHIN</td>
<td>Support the strongly desired full scope of practice for the RRT and the possibility of advanced practice RRT roles</td>
<td>While focused initially on total joint replacement, the development of this program can eventually provide additional support for the Maternal Child program as well as for general pain management in other programs at TSH</td>
</tr>
<tr>
<td>Decrease in post-op sequellae will result in enhanced ability to participate in rehabilitation, decreasing LOS</td>
<td>We would be the largest community hospital to offer this service</td>
<td>Will enhance and highlight the work of the APS- better satisfaction- for those currently providing care in this service</td>
<td>The proposed increased efficiencies and flow of patients will enable better use of OR rooms, less cancellations. Since total joints is a funded program, this may increase volumes significantly so as to provide additional funding</td>
</tr>
<tr>
<td>Superior pain control and decreased opioid use</td>
<td>This would position us well as a community leader, along our path to becoming a Centre of Excellence for MSK Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased DVT/PE and decreased blood loss and transfusion rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4-fold reduction in mortality with regional as compared to GA</td>
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Looking Ahead – Implementing the Plan

This section describes critical success factors that should be considered as part of the implementation of the Clinical Action Plan. These critical success factors represent important enablers to achieving the priorities outlined in the Clinical Action Plan.

Critical Success Factors

In many ways, the development of the Clinical Action Plan represents a significant achievement for The Scarborough Hospital. This is an important milestone in the organization’s journey toward realizing its corporate strategy. However, as the focus shifts to implementation, the challenging journey toward realizing the benefits of the Clinical Action Plan has now just begun.

As The Scarborough Hospital moves forward with implementation of its clinical priorities, there are several factors that will either enable success or present potential barriers, if not addressed appropriately. It will be important for the organization to be mindful of these seven critical success factors in order to help ensure that the Clinical Action Plan achieves maximum impact.

Demonstrated Commitment from Leadership

With any significant project that involves multiple stakeholder groups, new ideas and ways of doing things, unwavering commitment from the Leadership Team is critical. Employees and other stakeholders will look to leadership for direction and support while experiencing the uncertainties and challenges that accompany change.

Executive Sponsorship

In addition to the demonstrated commitment of leadership, clear executive sponsorship is also critical. Executive sponsorship not only helps maintain the momentum behind implementation, but also creates an accountability structure to one person who will serve as the primary champion at the executive-level. The implementation of the Clinical Action Plan represents a significant undertaking that will continue to require executive sponsorship to ensure focus is maintained and help address implementation challenges and emerging issues.

Medical Staff Engagement

This stakeholder group represents a highly influential and integral group, without which, implementation simply cannot succeed. Medical staff play a role as project champions amongst their own peer group and can help guide and shape the outcomes of the implementation. Early and frequent engagement throughout implementation – similar to the plan development phase – will help keep this group informed and help identify potential issues early, in order to launch more proactive mitigation tactics.

Community Engagement

The community has been engaged throughout the Clinical Action Plan and has informed and aided in decision-making quite considerably. During the implementation phase, it will be important to keep the community apprised of progress in order to maintain the high level of trust that has been cultivated through the unique approach to planning thus far. While the input phase is complete, buy-in from the community will help enable a smooth transition for the organization and continue to build TSH’s reputation as a world class community hospital.
Communications
As was required during the Clinical Action Plan development phase, a robust and comprehensive communications plan is critical to successful implementation as well. Interlinked with many of the other success factors, a thorough communication plan will help keep stakeholders informed and engaged, help mitigate potential risks, and increase buy-in throughout the organization.

Early Action
Recognizing that the Clinical Action Plan involves many long-term and complex initiatives, it will bode well for the implementation teams to produce tangible interim results that demonstrate concrete progress towards execution of the plan. Early progress showcases the organization’s commitment to change, as well as reinforces the priorities that have been set through the process. Many organizations implementing initiatives that involve significant change experience some degree of scepticism and a ‘wait and see’ attitude. These stakeholders can be quickly won over by demonstrating swift action. This enabler is closely tied to a strong communications plan and the stakeholder engagement strategies. Communication around upfront results to all interested groups will continue to build momentum and commitment from all stakeholders.

Alignment of Budgets to Clinical Priorities
An often cited barrier to success of strategy implementation (be it corporate or clinical) is a lack of dedicated resources. With the Clinical Action Plan clearly defining the set of clinical priorities for the organization, these priority initiatives must be supported by the budgetary framework for two main reasons. Firstly, and most simply, a lack of required financial and human resources will immediately stall the implementation of any project. As clinical priorities, resources must be similarly prioritized in order to begin building the future of the organization. Secondly, if the existing budgeting processes produce a set of clinical priorities that differ from those laid out in the Clinical Action Plan, there will be confusion and the process may be discredited. The entire planning process, executive sponsorship, robust communications and engagement efforts could be viewed as ‘all for naught’ if budget allocations do not mirror the clinical priorities in a way that allows implementation to proceed.