

Centre for Health Services and Policy Research
22nd Annual Conference
March 30 – 31, 2010

**Critical HHR-Related
Success Factors Underlying
Effective System Change I –
System-level (macro) Success Stores**

Dr. Brian Postl



Joint Operating Division

Supporting Development of
Manitoba's Academic Health
Sciences Network



Joint Operating Division

Winnipeg Regional Health Authority and University of Manitoba

- approximately 1500 medical staff
- independent contractor relationship with the WRHA
- separate employment relationship (or volunteer) with the University



Joint Operating Division

Shared vision of an Academic Health Sciences Network within a regional context:

- Functional integration of patient-centred clinical service, health sciences education, research and administration
- Pooling of Resources between Region and faculty
- Single job description and accountabilities for all of clinical, education, and research responsibilities



Joint Operating Division

Joint administrative structure:

- Recruitment and retention of medical staff and faculty
- Coordination of educational programs and projects
- Coordination of research programs and projects



Joint Operating Division

- JOD created in fall of 2008
- Executive Director and WRHA Chief Medical Office/Associate Dean Clinical Affairs in place – January 2009



Joint Operating Division

JOD \Rightarrow AFP \Rightarrow AHS Network



Joint Operating Division

Coordination of Education Programs and Projects

- Terms of Reference for an Education Advisory Council established
- Clinical Learning Simulation Facility operational



Joint Operating Division

Coordination of Research Programs and Projects

- Terms of Reference for Research Advisory Council established
- Centre for Healthcare Innovation established
- Neurobiology Program under development



Nurse Practitioner in Long Term Care

Outcome of NP as Primary Care Provider:

- Decreased drug cost/bed/day from \$3.50 to \$2.51
- Polypharmacy rate reduced by 55%
- Antipsychotic medication use decreased by 63%
- Transfers to emergency reduced by 20%
- Family satisfaction with the quality of health care provided increased 24%



Nurse Practitioner in Emergency Departments – Minor Treatment

Outcomes:

- Left Not Seen reduced by approximately 11% - 7.9% in first 6 months
- Reduced Length of Stay for ALL patients by 30 – 40 minutes
- Reduced Length of Stay for CTAs 4 & 5



Addressing an anesthesiology shortage in WRHA/UM system

- **1990s/early 2000s: Anesthesia shortage**
- **Multiple solutions**
 - New leadership
 - Enhanced recruitment of faculty
 - Fellowship training
 - Improved OR efficiencies



Alternate Provider Models

Ophthalmic Sedation Practitioners (OSP)

Impetus:

- Shortage of anesthesiologists, OR cancellations

Solution:

- Less-complex ophthalmic cases, freeing up anesthesiologists for challenging slates
 - RTs/RNs/IMGs (**1-month course, OR-based, tailored content**)

Success Factors:

- Strong Leadership
- Similar models had demonstrated success elsewhere
- Convincing anesthesiologists/surgeons/hospital



Ophthalmic Sedation Providers (OSPs)

Outcomes: Rare situation where all are winners

- Improved use of anesthesiologists
 - Anesthesiologist:OR ratio (1:1 → 1:3, soon to be 1:4)
 - Central monitoring allows MD to troubleshoot/oversee while OSPs maintain workflow
- Redeploy anesthesiologists to other sites
 - ↓ cancellations



Ophthalmic Sedation Providers (OSPs)

- FFS redirected to stipend anesthesiologist, OSP salaries
- *Significant FFS excess redirected to*
 - Hire academic anesthesiologists with changing allegiances
 - Departmental capital/research/educational/administration
- Created new practice opportunities for RTs/RNs/IMGs



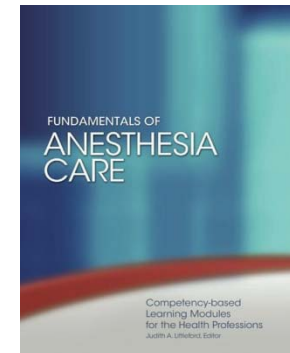
Ophthalmic Sedation Providers (OSPs)

- Surgeon/hospital satisfaction high
 - 100% slate delivery, maintained volumes, no safety issues in > 5000 cases
- Patient satisfaction high, unchanged



Anesthesia Clinical Assistants (ACA)

- Advanced **1-year** course for RTs, nurse, IMG, others
- Deliver anesthesia care under *direct supervision* of Anesthesiologist, governed by CPSM



Anesthesia Clinical Assistants (ACA)

Success Factors

- Leadership
- “Slippery slope to nurse anesthesia”
- Anesthesia shortage/over-work
 - Would improve quality of work-life, enhance safety/efficiency



Patient Transport Program

- Since 2000, Inter-facility Patient Transport Team staffed with Advanced Practice Respiratory Therapists (RTs)
- Collaboration with Winnipeg Fire Paramedic Service
 - Single communication centre staff
 - Primary Care Paramedic crews staff ambulances
 - Transfer ambulances or roaming supervisory units rapidly transport RTs to any WRHA site for unstable/critical patients



Patient Transport Program

- Delegation of function from physician



Patient Transport Program

- Full scope of RT clinical practice
 - Advanced life support, including intubation, defibrillation, medications, pacing, etc.
 - Administer medications as required, including vasopressors, inotropes, antiarrhythmics, sedatives, narcotics, etc



Patient Transport Program

- Scheduled time for ongoing competency maintenance
 - Simulation lab and clinical time for low volume/high risk skills built into rotation



Patient Transport Program

Benefits of Model:

- Staffing efficiencies
 - Nursing
 - Advanced Care Paramedics on emergency ambulances remain available to respond to 911 calls
- Enhanced safety and consistency for patients moving between WRHA sites
- RTs also accept patients from paramedic crews during offloading delays in Emergency Departments



Patient Transport Program

Benefits of Model:

- High job satisfaction for RTs who are empowered to work to full scope of practice

