Institute for Healthcare Improvement

Scale Up Grids

Examples from IHI BHLC Collaborative Teams

Health PEI

KCA	Individuals 5	25	125	625
Patient Identification	• Familiar faces who presented in one Primary Care Network for an intervention on hypertension, anxiety and/or diabetes. • Patients identified from familiar faces data, then physicians approached to get buy-in/support	• Patients identified as familiar faces through family physicians first	• Familiar faces in one Primary Care Network (~20% of the Island population) referred by a family physician/nurse practitioner, hospital discharger or primary care network clinician and meet the criteria for admission	• Develop strategy based on learnings from previous scale up
Care Model	• Designated case coordinator in a distributed model • Total FTE = 0.5	• Recruitment has changed, care model has not • Added 0.5 FTE, Total FTE = 1.0	• Begin to standardize processes • Increased connection with external orgs • Added 1.0 FTE, Total FTE = 2.0	• Projecting additional case coordinators • Explore opportunities with existing case coordinators in the broader health system • Add 2.0 FTE, Total FTE = 4.0
Community Partnerships	• Case coordinator begins to make connections with community organizations/agencies	• Beginning to build strategic relationships with community organizations/agencies. Health PEI Team (inc. care coordinator) met with Provincial Income Support team.	• Continue to build strategic relationships with community organizations/agencies. Health PEI Team (inc. care coordinator) met with PEI Council of People with Disabilities; Provincial Housing and Income Support teams.	• Continue to build strategic relationships with community organizations/agencies based on learnings from previous scale up
Data	• Identified sub-population & patients from utilization and cost data specific to cluster of 3 chronic diseases.	• Realized that we were not accessing highest users in the area. Referral sources broadened • Patient level data to coordinators – weekly status updates re hospitalizations & ED visits (manual) • Population level data to program administrators - quarterly	• Identifying means to share electronically (automated) • Patient level data to coordinators – daily status updates re hospitalizations & ED visits • Population level data to program administrators - monthly	
Oversight	• Health PEI Team consists of reps from public community-based health services – administration, primary care (inc. case coordinators & management), provincial diabetes, mental health & addictions, health information	• Health PEI Team – added acute care rep (manual)	• Health PEI Team – considering adding home care rep	

Alberta Health Services- Calgary

Key Change Area	Individuals 5	25	125	625
Patient Identification	≥ 6 Emergency Department visits in previous 12 month period	Continue with ≥ 6 ED visits and add recruitment from two inpatient units at large urban acute care site	Invite partners to bring the top 25 clients who “keep them up at night” – Home Care, Addiction & Mental Health, East Calgary Family Care Clinic, Mosaic Primary Care Network	Will need to learn what we can from scaling to 125, but anticipate continuing all strategies to date and inviting more clients from the partners
Care Model	Primary Care Wrap Around	Primary Care Wrap Around within a Case Management Framework – supported by 2 organizations	Primary Care Wrap Around within Case Management Framework – supported by 6 organizations	Less clear right now
Community Partnerships	• Acute Care (Peter Lougheed Centre) • Complex Primary Care Clinic (East Calgary Family Care Clinic) • Network of Family Physicians and interprofessional providers (Mosaic Primary Care Network)	Expansion of initial partners to now include social serving agency (Drop In Centre) and other AHS services (Addiction and Mental Health); currently in conversation with AHS EMS and AHS Home Care	Will involve more social serving agencies in addition to the partners currently involved and will formalize Home Care and EMS in as partners	Will continue to include partners listed and others may emerge through the scaling to 125
Financing	Work is done within existing resources – no new funding	Working Group and Case Management team members conduct work within existing roles	Will be exploring work done in the Edmonton Zone regarding economic impact analysis	Unsure at this point
Data	Measurement Lead has super user access to internal AHS data bases	Beginning to formalize data collection: have identified data points and working with Case Managers to enter data	Storage and data sharing with partners needs to be sorted. Difficult to get these issues easily addressed	
Oversight	Executive Sponsors and Oversight Steering Committee	Organizational Chart for project developed to include reporting	Incorporating partner representatives into reporting structure	