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Office régional de la  
santé de Winnipeg  
*À l'écoute de notre santé*

# Managing Respiratory Care Across the Service Continuum: Ventilator Community Living Model

## A Case Study in Applied Leadership

# The Winnipeg Health Region

- Full range of health services to citizens of Winnipeg & East and West St. Paul
- Major referral centre for Manitoba, Nunavut & Northwestern Ontario
- Approximately 27,000 staff
- Over 200 health services, facilities and programs including:
  - Four community hospitals
  - Two tertiary (teaching) hospitals
  - Three long term care health centres
  - 39 personal care homes
  - 20 community health offices

# Context for the Case

## Relevant Strategic Planning Priorities

- Emphasis on initiatives that
  - Reduce LOS
  - Improve resource utilization
  - Decrease waiting times
  - Reduce dependence on acute care service delivery
  - Enable Community living & independence
  - Align with the Long Term Care Strategy
  - Improve case coordination between care sectors
  - Use evidence to inform decision-making

# Identifying the Problem

- Increasing number of ventilator-dependent (LTV) clients
  - Adult & pediatric clients
  - Occupying acute & long-term care beds
  - Long transition times (LOS) in acute care
  - Existing LTC spaces fully occupied
  - Limited options to support community living
  - Inability to provide timely access to respite
- Increasing respiratory care educational requirements for community clients and staff
- High turnover in community support staff

# Possible Barriers

- Skepticism in acute care re ability to support complex care in community
  - Need to overcome professional biases
  - Medical model versus Social model of care
- Historically no Respiratory Therapy (RT) resources in community sector
- RT Scope of Practice
  - Perception of RT role being exclusive to acute-care sector
  - No experience with RT in formal case coordination role
- Recruitment challenges and acknowledged shortfall of funding for RTs in acute care
  - Inability to simply transfer acute-care RT resources to community

# Leveraging Opportunities

- EXTRA<sup>1</sup> Fellowships
  - WRHA-sponsored Fellows
  - Specific Intervention Projects
    - Aligned with corporate priorities
    - Evidence-based or evidence-informed decision-making key
    - High level of organizational support to implement projects
    - Keen interest in expanding RT scope of practice and presence in community sector, including case coordination role
- Long Term Care Strategy
  - Independent-living model for technology dependent clients
  - Focus on aging in place

1. More information about the EXTRA (Executive Training for Research Application) program can be found at [www.chsrf.ca/extra](http://www.chsrf.ca/extra)

# Literature and Data Review

- Research Questions:
  - Alternative roles for RTs outside acute care
  - Impact of cross-sector case coordination
  - Systemic barriers to caring for LTV clients outside acute care
  - Models for managing complex respiratory care in other jurisdictions
  - Perspectives of clients & their families or caregivers regarding care in the home
  - Magnitude of the Problem

# Findings

- RTs can assume many roles outside acute care
  - Discharge planning
  - Case management for complex respiratory care
  - Supporting members of the community health care team
- Cross-sector Case management
  - Improves discharge planning & continuity of care
- Clinical support and education for staff and clients
  - Increases confidence and comfort level
  - Decreases dependence on ED visits & hospital admissions
- Ventilator-dependent clients
  - Can be safely managed in community settings
  - Need professional & non-professional healthcare providers to support independent, community living & self-managed care
  - Want input into model development
  - Hope to avoid acute care or LTC admissions

# Findings

- Existing housing and placement options in the WRHA
  - Too few for existing clients & projected growth
  - Placing considerable strain on acute care resources
- Lack of options
  - Compel clients to take inappropriate risks to avoid LTC
- Consistency with WRHA Long Term Care Strategy
  - Creation of housing options to enable individuals with complex care needs to live in the community
  - Increased autonomy for clients with a level of support to maintain quality of life and independence

# Leveraging the Findings

- Data
  - Magnitude of problem recognized
- Clinical Literature
  - Pointed to possible solutions
  - RT presence recognized as integral to success of proposed model
- Change management literature
  - Emphasized importance of alignment with strategic goals
  - Cultural shift
- Corporate priorities
  - Project consistent with mandate for LTC Strategy
  - Enhanced ability to make business case

# Implementation and Measuring Success

- Develop 8 new suites for LTV clients
  - Engage clients through focus groups
  - Clustered suites with enhanced support from 24/7 attendant care
  - Emphasis on independent living, aging in place
- Develop model of care
  - Entrance & exit criteria, transition processes
- Provide community-based RT resources
  - Including RT Case Coordinator
  - Support new model and community health care team
  - Reduce staff turnover
- Decrease LOS in acute care
  - Transition time to LTC or community housing
  - Capacity for acute or respite admissions
  - Improved coordination between sectors

# Implementation Milestones

- Creation of RT role descriptions
  - Case coordination & inter-sector collaboration
  - Discharge planning
  - Consultation, education & resource services
  - Patient assessment
    - point of care diagnostics
    - evaluate and modify therapy
    - develop & review care plans



# Implementation Milestones

- Recruit professional & support staff
- Train support staff
- Relocate existing tenants to allow creation of clustered unit
- Capital renovations
- Select new tenants using entrance & exit criteria

# Implementation Challenges

- Technology issues
  - Ventilator alarm/pager system
- Model disparities
  - Needed to find common ground
- Staffing
  - Addressing competency maintenance issues and professionalism stereotypes
- Cultural shift from medical model to social model of care
  - Overcoming paternalism in favor of independence and autonomy
  - Assessment and acceptance of “risk”
  - Managing expectations of user groups







# What Next?

- Utilization Management (UM) Tool
  - Patient flow and LOS data
  - Oxygen therapy requirements for admitted & discharged patients
    - outcome based oxygen therapy management
    - discharge planning



# What Next?

- Focus RTs on
  - Teaching & continuing competency maintenance for the multidisciplinary team
  - Reviewing complex patients
  - Evaluating clinical practice & referral patterns
  - Prioritizing referrals
- Use UM Tool data to drive practice changes
  - Across disciplines & care sectors
- Making the business case for further investment in RT
  - Quantifying the value-add



# What Next?

- Pediatric ventilator-dependent clients
  - Differing needs compared to typical adult ventilator clients
  - Need for supportive housing alternatives into adulthood
    - aging in place
  - New care team models
    - RN/RT model

# Lessons Learned

- Critical to obtain buy-in from key stakeholders and decision-makers
  - Apply available evidence to resolve key organizational problems
  - Leverage opportunities
- Overcome preconceived ideas about providing complex care in the community
  - Values and perceptions of partners may vary
  - Medical model versus Social Model
    - Independence & client engagement
- Acknowledge efforts of existing staff

# So...what are the key applied leadership skills in this case?

- Alignment with corporate strategy and priorities
  - Be prepared: do your homework and leverage opportunities when they present
- Theory of “Small wins”
  - Make incremental changes to organizational culture & thinking
- Broad consultation with key stakeholders
  - Validate the perspectives and values of partners and user groups
- Managing relationships and “politics”
  - Lead with an open mind, and a collaborative, flexible, inclusive and respectful approach

*“Improvement begins with the belief  
that improvement is possible.”*

*- Donald M. Berwick, MD*



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