Senior Friendly Care in Champlain LHIN Hospitals

Hawkesbury General Hospital

Progress Report 2015: Improving Transitions in a Rural Community

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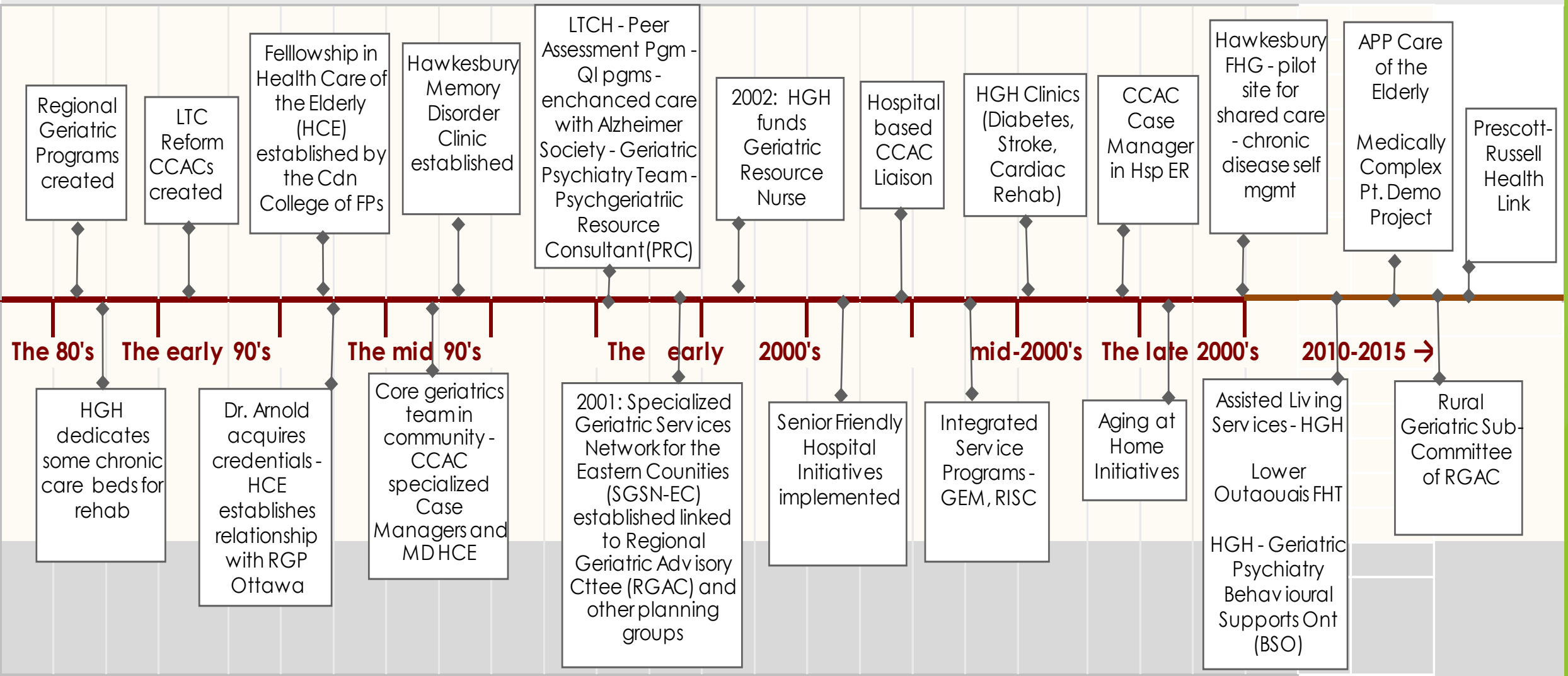
Milestones in Building Geriatrics Speciality in the Hawkesbury Rural Model



KEY HGH STATISTICS FOR AGE 65+ (2013-14)

DISCHARGES:	
Discharges age 65+	1,439
% age 65+ of total discharges	**45%**
LENGTHS OF STAY:	
Patient Days age 65+	18,881
% age 65+ of total patients days	**64%**
READMISSIONS:	
Readmissions within 28 days age 65+	155
% age 65+ of all readmissions within 28 days	**60%**

EMERGENCY:	
ED visits age 65+	8,292
% age 65+ of total ED visits	**21%**
Admissions from ED for age 65+	1,253
% age 65+ of total ED admitted	**63%**
ALTERNATE LEVEL OF CARE:	
ALC patients age 65+	67
% of total ALC patients age 65+	**89%**
ALC days for age 65+	633
% age 65+of total ALC days	**79%**

SENIOR FRIENDLY HOSPITAL DOMAINS

PROCESS OF CARE

3 PRIORITIES:

- DELIRIUM
- FUNCTIONAL DECLINE
- **TRANSITIONAL CARE**
  - **Supporting transitions in care by implementing practices and developing partnerships that promote inter-organizational collaboration with the community**

Projet pilote visant à améliorer les soins aux patients ayant des besoins médicaux complexes

Pour la région de Maillon santé Prescott-Russell – RLISS CHAMPLAIN
2014-2015

Medically Complex Patients - Demonstration Project

For the Prescott-Russell Health Link Area – CHAMPLAIN LHIN
2014-2015

Patient Story

PATIENT STORY:

- Mr. B. is 68 years old and lives in a residential home in Alfred
- LACE = 16 with 4 admissions and 8 ED visits in past 6 months
- COPD O_2 dependent, liver cirrhosis, CAD & HF, chronic pain, diabetes and skin wounds
- 21 medications – financial issues
- Individualized Coordinated Plan – Patient's Goal: get the care he needed and improve symptoms
- Interventions: increase home care, arrange LTC of his choice, reduced # of medications (21→17)
- Patient very happy – no admissions or ED visits – LTC move 2 months later

What is the Medically Complex Patients - Demonstration Project (MCP-DP)?

- The MOHLTC and the OMA are working collaboratively on demonstration projects to improve the care of medically complex patients.
- *A MCP-DP outlines how a physician or a physician group will provide ongoing management of care to medically complex patients*
  - to prevent avoidable admissions to hospitals
  - and/or to provide follow up care after they have been discharged from a hospital to prevent re-admission.
- We also included these goals:
  - Decrease the length of stay in the hospital
  - Decrease the time to appointment with PCP and specialists
  - Decrease ED visits
  - Improve patient, family and provider experience

Project Overview

- MCP-DP is a first step to piloting a model of care for our PR Health Link Area focusing on the transition from hospital-to-home - working with tools, processes and communications used in other HLs.
- Goal is to improve the transition from hospital-to-home for medically complex patients.
- Based on a collaborative partnership with MCP Team, Hawkesbury General Hospital, Champlain CCAC, primary care groups and a pharmacy network.
- Using Health Quality Ontario's Best Practices approach to transitional care planning at three key points: (1) Pre-transition/admission; (2) During Stay; and (3) Post Discharge.

MCP-DP PRHL: THE PROCESS FLOW MAP (abbreviated version)

PRE-TRANSITION IN HOSPITAL

- SCREENING - RISK PREDICTOR TOOL - LACE
- INFORMATION GATHERING (ONGOING) - HOSPITAL TEAM ROUNDS & CHART
- HEALTH LITERACY - CAREGIVER ASSESSMENT - HOME ASSESSMENT
- INFORMATION SHARING - PROGRAM BROCHURE
- PATIENT CONSENT TO PROGRAM
- ENROLLMENT - COMMUNICATION WITH PRIMARY CARE PROVIDER

TRANSITION HOSPITAL TO COMMUNITY

- COMPREHENSIVE ASSESSMENT - COORDINATED CARE PLAN
- ENGAGEMENT OF PATIENT IN ACTIVE TREATMENT & EDUCATION - TEACH BACK (ONGOING)
- MEDICATION REC
- DISCHARGE PLANNING FROM DAY 1

POST TRANSITION IN COMMUNITY

- HOME VISIT FROM MCP TEAM MEMBER
- CONTINUITY OF CARE - TEACH BACK
- COMPLETION OF FOLLOW THROUGH ACTIVITIES
- PRIMARY CARE PROVIDER VISIT WITHIN 7 DAYS POST HOSPITAL DISCHARGE
- SPECIALIST ACCESS WITHIN 30 DAYS
- MED REC IN COMMUNITY
- LINKING WITH CSS
- ONGOING SUPPORT
- PREVENTION OF AVOIDABLE ED VISITS AND HOSPITAL ADMISSIONS
- DISCHARGE WHEN SAFE
- PATIENT EXPERIENCE / EVALUATION

Definition of Medically Complex Patients

- People with conditions that:
  - Are life threatening, cause serious disability, significant pain, and major commitment of time and effort from caregivers.
  - Require frequent monitoring, are associated with severe consequences or whose treatment carries a risk of serious complications.
  - Affect multi-organs and require management and coordination from multiple specialties.
  - Are often terminal requiring discussion of end-of-life care.
- Complexity is a multifaceted attribute referring to growing effects of multiple chronic conditions bringing a challenging blend of medical and personal care needs, specialized care, and high medical acuity.

Our population	
Total[1]	38
Age (average)	78 years
Gender	23 males, 15 females
LACE score (average)[2]	15.5
# of co-morbidities (average)[3]	4 64% COPD, 50% CVD, 93% frail (cannot live alone)
Mortality	9 (24%)
# Medications (average and range)	16 (8-24)

1- Including 3 re-admissions in the MCP-DP
2- A minimum score of 10 is required for eligibility
3- Main diagnoses: Frailty, COPD, CVD, DM

Core Team

- Family Physician, APP Consultant COE
- Transition Navigator, CCAC based
- Nurse Practitioner, FHT based
- Pharmacist, Pharmacy Network
- Project Manager

- This Team is a supportive team that links with the primary care provider. The MRP remains the hospitalist in the hospital and the family doctor in the community.
- The Team will work with medically complex patients and their families to smooth the transition from hospital back to the community over approx. 30 days post discharge, linking them with specialists, CCAC services as well as community support services.

Main Activities

Mrs C., 70 year old widow living alone at home with COPD O2 dependent, lung cancer chronic pain, CAD, anxiety.
Before enrollment with MCP-DP had an average of 7.5 days/month in hospital, compared to 3.7 days/month when followed by MCP team.

- **Identification of MCP in hospital** – LACE, Team Rounds
- **Comprehensive Assessment and individualized Care Planning** begins in hospital
- **CCAC collaboration**
- NP **primary care visit within 7 days post hospital discharge**
- **eConsult** with **specialist**
- Community Pharmacist **MedsCheck** within **14 days of request**
- **On-call telephone service** for patients and family caregivers for support
- **Team case conference prn**
- **Case conferencing with PCP** and information sharing while keeping care plan up to date
- **Discharge** from program when goals attained (or patient transitioned to lower intensity service, or moved to LTC facility or outside area, or deceased)
- Ongoing **measurement** and PDSA to improve our service
- Patient Feedback Surveys at two points in program (after first home visit and at discharge from program)

OPTIMIZING MEDICATION USE IN MCP

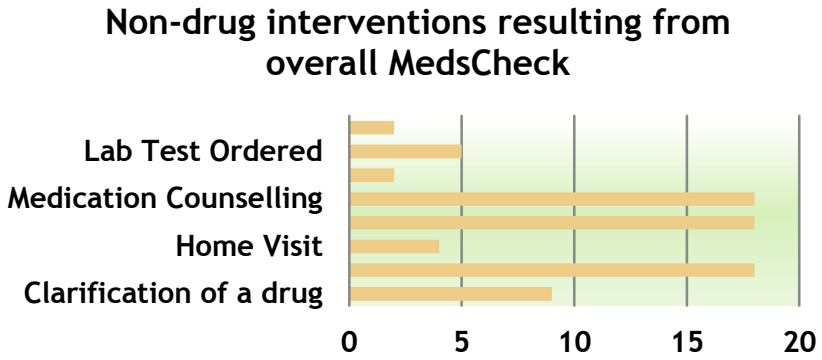
FACT:

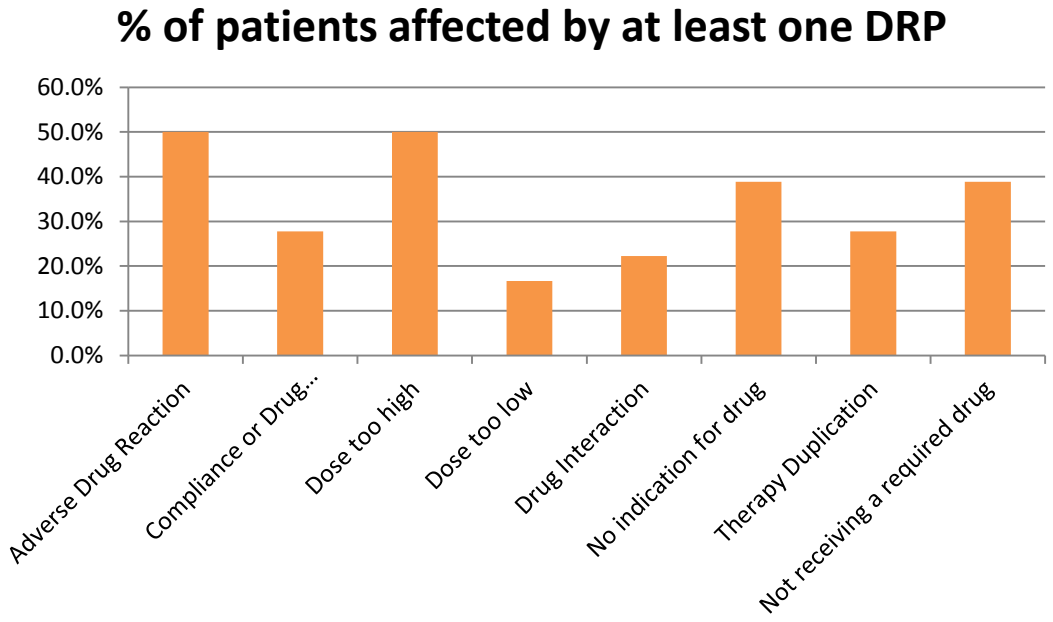
Up to 25% of all hospital admissions and emergency department visits are drug related and we know that medically complex patients are at greater risk of ADRs due to polypharmacy.

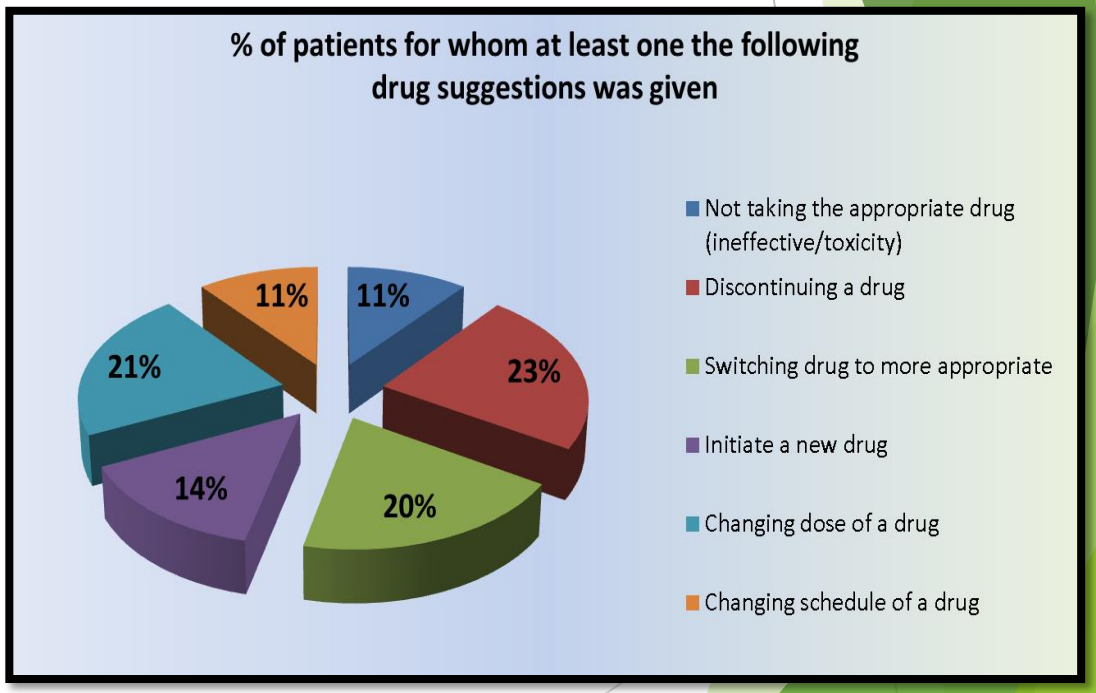
Partnership with Community Pharmacies

- 12 pharmacies participating in network including hospital pharmacist
- MedsCheck are requested for all MCPs (when appropriate)
- Work with CCAC Rapid Response Nurse
- Highlights to date:
  - Prevented adverse outcomes
    - Insulin prescriptions
    - Patient medication system
  - De-prescribing with improved health
  - Education sessions with speakers
  - Communication of issues with physician groups
  - Reports provided to PRHL, which approved their Terms of Reference
  - The pharmacies want to continue the network beyond the project

Medication Management
Clinical Processes & Patient Outcomes







Results and Lessons Learned

- Official start date: **September 1st, 2014.**
- Care coordination at patient level easier than care coordination at system level.
- We needed to focus on what is most important to patients – focus on psychosocial as well as end-of-life care needs and not only health care needs.
- We formed a core team with processes and tools that could assist the future Health Link.
- Patients and families are appreciative.
- MCP-DP provided a opportunity to make significant culture change in our HCS to focus on high needs patients and getting our act together for their benefit.

Our Intervention	
# Patients with a Discharge Folder	38 (100%)
# of Coordinated Care Plans	38 (100%)
Average # days of f/u post hospital discharge[1]	42
Average # of days in hospital/month **before** MCP-DP[2]	5.6
Average # of days in hospital/month **after** MCP-DP[2]	1.8
Average # of services/pt/NP	13
Money saved ($/day)	

1- Excluding the active patients
2- Excluding the patients who died

MERCI!!!
THANK YOU!!!