High Risk Profiling at points of transitions in care

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Background

- 63% of all inpatient days in Ontario are accounted for by seniors
- 27.2% of inpatient days for seniors in the South East LHIN are considered Alternate Level of Care (ALC)
- 70% of ALC days are associated with individual over 75 years of age
- Significant differences exist between service delivery models for restorative care in South East LHIN and Ontario

SE Ontario Restorative Care Strategy

- The SE Ontario Restorative Care Strategy was developed through broad community and stakeholder consultations through 2010-11.
- The clinical lead for project was Dr John Puxty in association with Joanne Billing, South East CCAC.

Activities undertaken

- In depth review of literature and models in other communities
- Survey of stakeholders re formal and other restorative programs and elements of “senior-friendliness”
- Brain-storming day with facilitated decision-support
- Identification of key areas for focus and task groups

Issues identified through environmental scan

- Evidence of high-risk sub-group who were high-users of services with potentially remedial unmet needs
- Many clients waiting in hospital do not have access to restorative services (includes both formal and informal)
- Current hospital environment and models of care promote avoidable functional decline (30%)
- Services in silos and have stringent admission criteria because of limited resources and concerns regarding flow of "high-risk individuals"
- Lack of repatriation agreements and low priority for access to discharge destinations

Issues identified through environmental scan

- Although likely adequate general rehab beds in region there are inequities and gaps in key personnel and ambulatory components
- Limited access to Geriatrics
- Use of CCC as holding area for ALC is wasted opportunity and adds to problem
- Access to convalescent beds problematic
- Care providers often unaware of available options and difficult to navigate
- Lack of information communicated between institutions

Responses to CSR Community Survey (231)

- 48.5% felt SEO healthcare not senior friendly (vs 22% who felt it was)
- Changes needed included:
  - Improved staff awareness of seniors needs (67%)
  - Access to Parking (58%)
  - Signage and Navigation (41%)
  - Accessibility (38%)
  - Safe entrances (18%)
  - Seating (11%)

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- In Spring 2013 the 7 hospitals, CCAC, LHIN and Queen's signed off on the project with its associated 3 year implementation plan.

Restorative Care Definition

"A program which provides specialized restorative care focused on returning individuals to their highest level of independence in the community. Includes both hospital and community based programs (i.e. CCC, Rehab, Geriatrics, Transitional or Convalescent Care)"

- Source: Ontario's Transitions Care Program Framework

9

Components of CSR for Restorative Care

1. Development of a common high risk identification process across the continuum of care
2. Development of hospital systems that optimize function including senior friendly principles
3. Development of a regional standard for Formal restorative care including geriatrics and rehabilitation
4. Development of a regional standard for other components including ALC units, CCC, LTC, Community
5. Importance of communications & linkages: hospital, community, primary care, & LTC

Development of a common high risk identification process across the continuum of care

- Repeat visits to ER accounted for 43% of all visits within the same period (56% within first month)
- Higher risk for repeat visits are individuals over 75 years of age (relative to 65-74 year olds)
  - 10-15% of all seniors or 30% 75 or older using ER
- Potential flagging tools in ER
  - TRST
  - ISAR
  - AUA
- Actions
  - Linked to structured secondary assessment
  - Customized care plans
  - Flexible integrated community case management
  - Targeted referral to specialized services

Local experience with TRST in ER

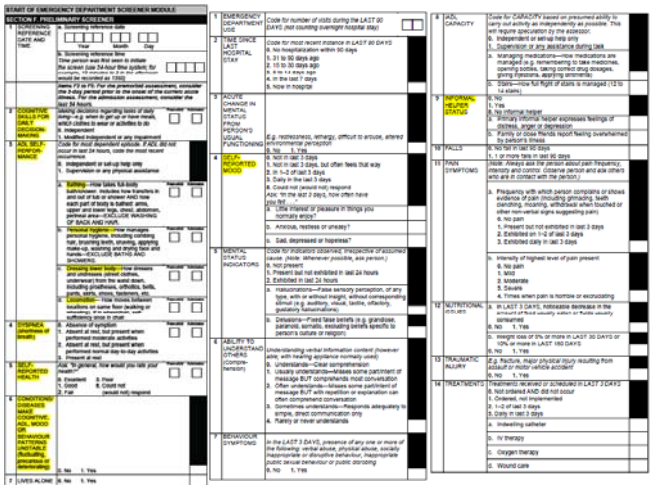
- Piloted at 2 sites (QHC/KGH):EASIER+
- Linked to access 30 days enhanced CSS services
- 50-65% of 75 and overs screened were identified as positive
- Caseload high for CCAC case manager
- Inconsistent use of structured secondary assessment (interRAI ED Screener)
- Improved use of CSS services

Domain	ISAR	TRST	AUA
Vision/Hearing	Do you see well		
Cognition	Serious problems with memory	History of cognitive impairment	Cognitive skills for ADL performance
Mood			Self reported Mood
Ambulation		Difficulty recent falls/walking/transferring	Locomotion
ADL's			Bathing, Dressing lower body and Personal hygiene
Transportation use		Able to get out	
Caregivers	Before or after the illness or injury need someone to help on a regular basis	Lives alone or no available caregivers	Informal caregiver stress
Medications	3 or more	5 or more	
ED or Hospital Use	Hospitalized last 6 months	ED last 30 days or Hospital last 90 days	
Other			Unstable / Fluctuating SOB Self reported Helath

Assessment Urgency Algorithm Background

- Developed in Waterloo
- Responding to need to improve identification of high risk elderly in ER to better target use of GEM and CCAC resources
- Collected data all 75 years olds attending ER using assessment based on 20 categories of information (6 initial screen and 14 clinical evaluation) and outcomes at 90 days

InterRAI Emergency Dept: Canadian Pilot



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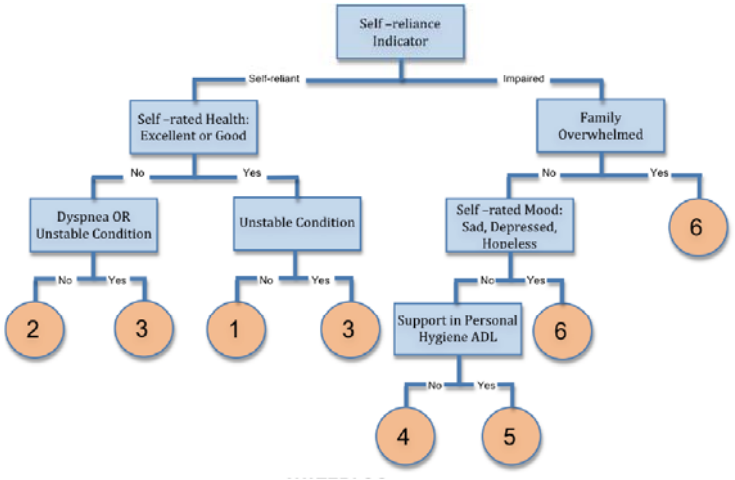
- Collected data all 75 years olds attending ER using assessment based on 20 categories of information (6 initial screen and 14 clinical evaluation) and outcomes at 90 days
- Developed Assessment Urgency Algorithm (AUA) based on 7 of 20 categories
- Subsequently validated in Hamilton and a number of other Canadian and International sites

Assessment Urgency Algorithm (AUA)



Merits of AUA as high-risk screening tool

- Ontario derived tool validated nationally and internationally
- Predicts risk of 30 day ER re-attendance, 90 day re-admission, increased LOS and ALC likelihood
- Reduced false positives relative TRST/ISAR
- Implicit link to CCAC CA Form
- Paper and electronic format (PDA) versions are available

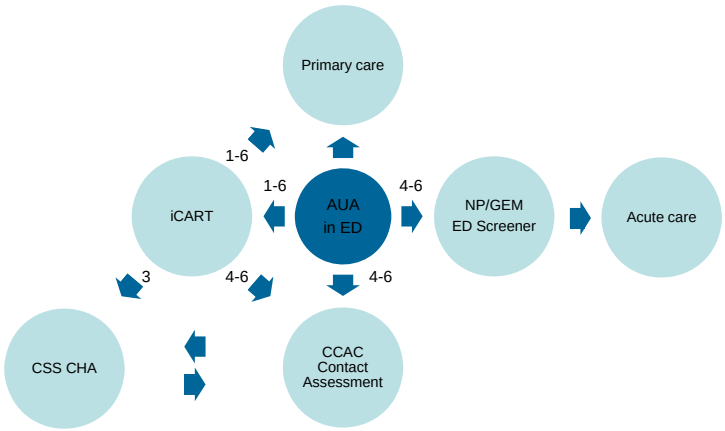
Components of SE Ontario Restorative Care Strategy

- Development of a common high risk identification process across the continuum of care (AUA): Implementation in pilot by April 2013
- Operationalization of senior friendly hospital principles. Implementation in pilot communities October 2013 with wider implementation April 2014-March 2015
- Development of a regional standard for formal restorative care (geriatrics and rehabilitation). Detailed planning April 2013- March 2014
- Development of a regional standard for other components including ALC units, CCC, LTC, and Community. Detailed planning April-Sept 2013. Implementation in pilot communities October 2013 with wider implementation April 2014-March 2015
- Creation of new communication/navigation support resource for health care providers (iCART). Implementation in pilot communities by April 2013

Implementing AUA and iCART

- The AUA and iCART process will be piloted at the Brockville General Hospital and Lennox & Addington Hospital sites from April 2013.
- An automatic AUA carried out in ER for all 75 and over with CTAS 3-5.

ED AUA and Information/Assessment Flow



Implementing AUA and iCART

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- An automatic AUA carried out in ER for all 75 and over with CTAS 3-5.
- If discharged from ER the results of AUA will be sent to iCART (integrated community assessment referral team) who will contact FP within 3 working dates.
  - A score on AUA of 4-6 will result in CCAC referral either through CCAC ER Case manager or via iCART post ER
  - A score on AUA of 3 will result in referral to CSS via iCART. If indicated on completion of interRAI CHA CSS will refer to CCAC.

Work outstanding

- Link to primary care (BWQFHT Fall 2013)
- Inpatient validation of AUA with "secondary assessment tool" (InterRAI ED Screener vs. Blaylock)
- Link to care plans to modify risk factors and reduce barriers to community discharge

That's All Folks!