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Limited Optimized Resources Lead To Unlimited Positive Patient Impact

Presenter Disclosure

- **Presenters: Jane Derbyshire RN**
  Interim Executive Director
  Heather Aben RN
  Discharge Patient Program
- **Relationships with commercial interests:**
  - **Grants/Research Support:** None to disclose
  - **Speakers Bureau/Honoraria:** None to disclose
  - **Consulting Fees:** None to disclose
  - **Other:** None to disclose

Disclosure of Commercial Support

- **This program has received financial support from no one .**
- **This program has received in-kind support from no one.**

- **Potential for conflict(s) of interest:**
  - Neither Jane Derbyshire nor Heather Aben have received any payment/funding from any organization. [payment/funding, etc.] AND/OR any organization whose product(s) are being discussed in this program].
  - There are no supporting organizations that [developed/licenses/distributes/benefits from the sale of, etc.] a product that will be discussed in this program: no products discussed.

Mitigating Potential Bias

- There are no potential sources of bias identified in either slide 1 or 2.

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Muskoka

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Incredible Beauty

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A place to ‘fall’ in love with

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It’s home for us

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When you think of Muskoka what do you see?

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Probably not a shelter for homeless men.

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Is this what you see when you think of Muskoka?

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You may not even consider addiction when you think of Muskoka

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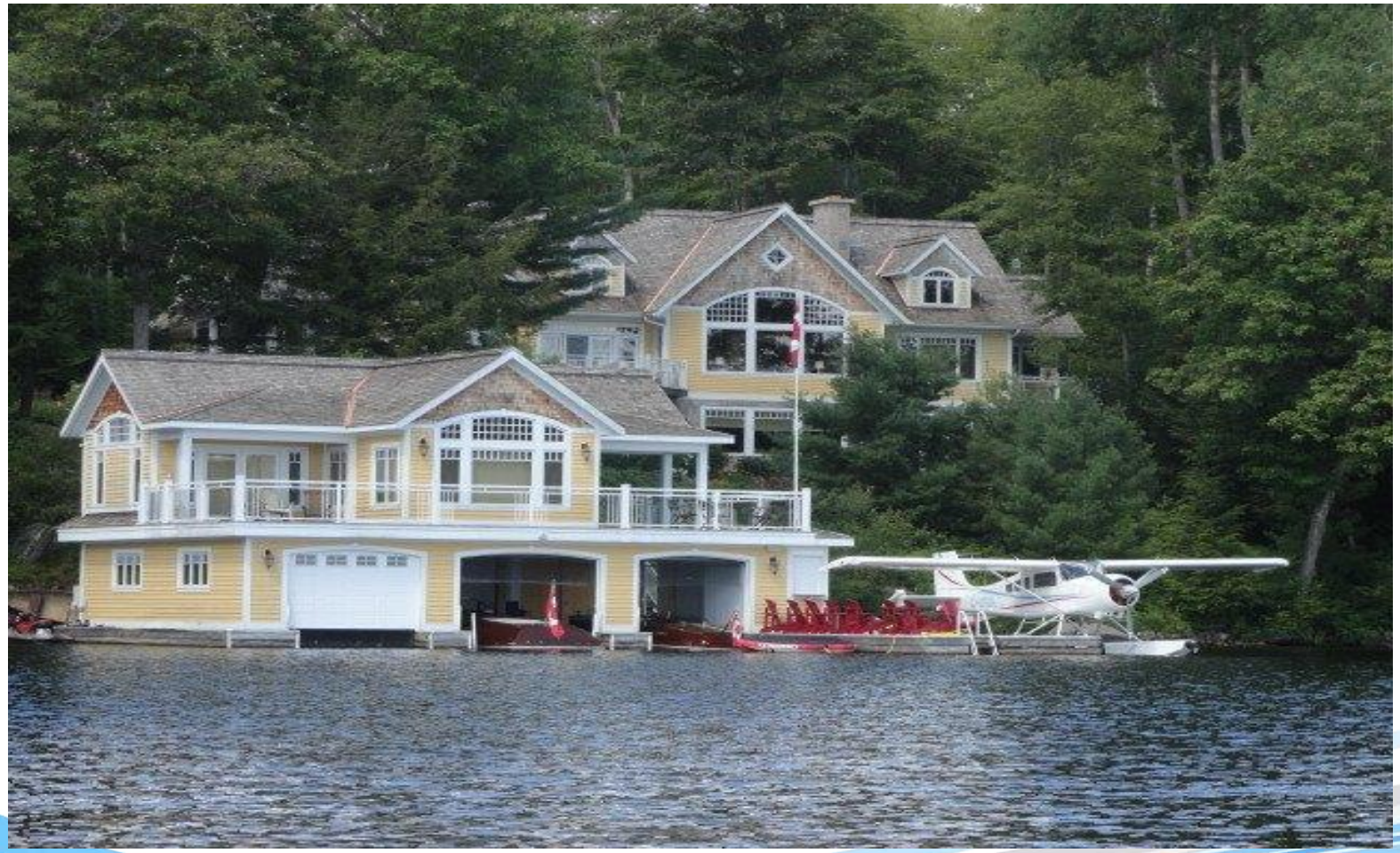
Likely when you think of Muskoka this is what you imagine.



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This is probably not the Muskoka you imagined.

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Nor is this your idea of a Muskoka home.

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Seniors in Muskoka
Carefree, Healthy and Active?

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More likely you will see Seniors living with frailty.

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Huntsville

- Huntsville District Memorial Hospital is our general hospital offering acute care services to 30,000 residents in Huntsville and the surrounding areas. The next acute care centre north of Huntsville is 125 kms away. In the summer months, Huntsville's population can triple.
- Algonquin FHT has 24 Primary Care Physicians and 31 staff members: RNs, NPs, Dietitian, Respiratory Therapist, Mental Health Therapists.

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Huntsville
we call it home.

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Presentation Goals

- Share the specialized nursing skills necessary to implement a successful holistic telephone-based Discharge Patient Program.
- Demonstrate how our primary care team, through our Discharge Patient Program, supports our patient's safe discharge home and reduces re-admission to acute care/ED.
- Share the positive effects of our Discharge Patient Program for the patient, the Physician and the Nurse by optimizing our limited (0.4 FTE) nursing resource.

Focus of our Discharge Patient Program

To proactively identify and address these risks that can lead to readmission to acute care.

1. Medication errors
2. Symptom management
3. Safety at Home
4. Community and AFHT referrals
5. Post-discharge follow-up appointments

Algonquin FHT
Discharge Patient Program

- Heather Aben RN is our Discharge Patient Program facilitator.
- 2 days a week: Monday afternoon, all day Wednesday and Thursday afternoon
- Program objective: timely and holistic nursing assessment of patients discharged from acute care. Phone calls are made within 48-72 hours of discharge. Proactive nursing interventions decrease re-admission and ED visits.

Algonquin FHT
Optimized Nursing Skills

Heather brings a wealth of nursing experience to her role.

- Primary Care Nurse x 5 years
- Senior Assessment and Support Outreach x 2 years
- Community Care Case Manager x 5 years
- Palliative Care Team Nurse x 1 year
- Regional Falls Program Nurse x 1 year
- Acute Care: Emergency and Med/Surg. x 5 years
- Long Term Care x 1 year

Process to successful implementation

- Through a collaborative effort, Heather was granted access to our local hospital's EMR
- This access allows Heather:
  1. To run hospital discharge summaries. These reports provide the information she needs to identify discharged AFHT patients.
  2. Full access to inpatient charts including: discharge summaries, reconciled medication lists, procedures, referrals, physician notes, nursing notes.

Building a Complete Patient History

- Gathering pertinent information starts with the hospital's EMR
- Utilizing AFHT's EMR to build a complete patient history and identifying the risks for readmission prior to placing a proactive phone call to the patient.
- Optimized Nursing Skills: Within minutes of initiating a phone call, Heather establishes a therapeutic nursing relationship.

And Heather listens

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Patient's Stories

Hank

Elderly man discharged from acute care with diagnosis of Congestive Heart Failure and Hypokalemia

- Heather reviewed Hank's symptoms since his discharge. Hank said his shortness of breath and leg edema were much improved, however, he noticed that since yesterday, he is experiencing some shortness of breath again. He also mentioned that he still is not sleeping well.
- Heather reviewed his medications with him and she noted several discrepancies.

Hank

- Hank was taking Lasix once daily. It was ordered twice daily. Slow K ordered 2 tabs twice daily, and he was taking 1 tab twice daily.
- Discharge summary included Digoxin and Imovane which Hank was not aware of and did not have prescriptions for either medication.
- Heather contacted his Pharmacist to clarify his medications. Pharmacist did not have prescriptions for Digoxin or Imovane.

Hank

- Using the EMR, Heather contacted his Family Physician for missing prescriptions and the Doctor faxed the prescriptions to Hank's Pharmacy.
- Patient advised of correct medication regime. Advised that his prescriptions were available at the Pharmacy for pick-up. Hank was not able to pick up his medications and Heather arranged to have the Pharmacy deliver them.

Heather's proactive medication reconciliation helped prevent an acute care readmission within 30 days for Hank, an elderly patient living with CHF.

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Medication Reconciliation

Optimized Nursing Skills:
1. Review medication list from acute care discharge summary. Compare with medication list in patient's primary care EMR. Note changes to discuss with patient.
2. Review medications with patient/caregiver over the phone. Clarify any medication concerns/discrepancies with patient.
Heather listened to Hank's story.
3. Contact local Pharmacists: confirm new prescriptions, did the patient pick up their prescriptions, arrange/adjust blister packs to reflect discharge summary, medication clarification. Ask Pharmacists to set aside over the counter medications for patient to pick-up i.e. stool softeners.
4. If necessary, clarify medications with Physician. Notify Physician if medications are not being taken as prescribed. Provide details of incorrect/missed doses in the EMR.

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Charlie

Elderly man discharged with multiple co-morbidities: compression fractures/pain management/failure to cope.

- Prior to contacting patient, Heather consulted with his Family Physician to clarify changes made in hospital for pain management.
- Spoke with Charlie's elderly spouse/caregiver and heard that he still was living with a lot of pain.
- Heather felt one of the reasons for Charlie's admission for failure to cope was that his pain was not managed well at home.

Charlie

- Health teaching done with caregiver. Heather discussed the role of long-acting morphine, role of break through analgesics and how to objectively assess Charlie's pain using a pain scale.
- Charlie's spouse was hesitant to use break through analgesics but she felt more confident to giving them after she hearing about using the pain scale to access Charlie's needs.
- Heather asked permission to follow-up with caregiver later in the week. Caregiver provided consent.

Charlie

- Heather contacted caregiver again two days later.
- Charlie's pain was better managed, especially at night. Caregiver is using the pain scale and is tracking his need for break through medications. Heather advised her to bring her notes to Charlie's follow-up appointment so that the Doctor can adjust his long-acting morphine if needed.
- Caregiver feels more confident taking care of her husband now and managing Charlie's pain symptoms at home.

Heather's health teaching in symptom management, helped a family cope at home and prevented an acute care readmission within 30 days for Charlie, an elderly man living with pain.

Symptom review and management

Optimized Nursing Skills:

1. Review acute care discharge summary and patient's primary care records in EMR. Identify diagnosis at discharge: is this a new diagnosis, how long has the patient been living with current diagnosis. Review symptoms experienced by patient that led to their admission.
2. During phone call, ask patient what symptoms led to their seeking medical attention. Assess and identify patient's current symptoms.

Heather listened to Charlie's caregiver.

3. Provide patient education for self-management:

- Review normal symptoms
- Health teaching re: symptoms that would require the patient to take action
- Teach symptom management.

  Most common symptoms encountered:

  Exacerbations (CHF, COPD, DM), constipation, pain management, wound care

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Robert

Elderly man discharged from acute care with diagnosis of CVA

- Heather contacted patient's caregiver.
- Robert was having mobility issues with left leg weakness and difficulty with stair climbing.
- A neighbour gave Robert a walker but he was reluctant to use it as he felt it wasn't the right size.
- He was not assessed by Home and Community Care while in acute care as he was discharged early over the weekend.

Robert

- Heather identified the need for: Physiotherapy, Occupational Therapy and the need to connect with the District Stroke Nurse.
- She contacted Family Physician and faxed a referral form for the Doctor to fill out that would provide Robert with OHIP coverage for Physiotherapy.
- A referral was initiated to Home and Community Care for a home safety assessment by Occupational Therapy.
- She also referred Robert to the District Stroke Nurse.

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Robert

Heather's identification of Robert's need for supports to stay safely at home helped prevent a readmission by reducing Robert's risk of a fall and injury post CVA.

Arranging Physio and OT supports maximized Robert's safe rehabilitation post CVA.

Assess for Safety at Home

Optimized Nursing Skills:
1. Ask the patient: How do you feel being back home after your hospital stay? What do you need to feel safe at home?
Heather listened to Robert's story.
2. Assess: Falls and Risk Assessment Medication: side effects, available in the home, affordable Awareness of driving restrictions: post MI, post stroke, post seizure Need for assistive devices Need for Lifeline Auto Alert Fall Detection System Assess Home and Community Care resources

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Ben

Senior male discharged from acute care with diagnosis of Palliative Metastatic Melanoma

- Spoke with spouse/caregiver
- Ben's appetite is poor. He is using a walker in the home and tires easily. His caregiver is providing his personal care,
- Pain is well managed using both long and short-acting morphine. Constipation managed with Senokot.
- Ben is to have staples removed tomorrow by Home and Community Care. He is 13 days post-surgical decompression and stabilization of T 11 spinal cord compression.

Ben

- Caregiver advised by Home and Community Care that Ben would have to travel to their ambulatory care clinic for staple removal.
- Caregiver upset as she felt Ben did not have the energy to make the trip into the clinic.
- His spouse hired a private nurse to come into their home to remove Ben's staples.
- Heather discussed role of AFHT's Palliative Care Team and consent was received for a referral to our PCT.

Ben

- Heather spoke with Palliative Care Team Lead and Team Lead was willing to go to Ben's home and remove his staples.
- Caregiver was advised that the Palliative Nurse would do a home visit the next day to remove his staples. She cancelled the private nurse.
- Caregiver was very thankful. She said that she finally felt their story had been heard.

By initiating a referral to AFHT's Palliative Care Team, Heather was able to reduce the stress that Ben and his family were experiencing.

Heather listened.

Identify referral needs to Community Agency/AFHT

Optimized Nursing Skills:

1. Obtain patient consent to make referral to Algonquin FHT programs:

Geriatric Care Team	Healthy Heart Cardiac Rehab
Palliative Care Team	Breath of Muskoka: COPD/Asthma/smoking cessation
Dietitian	Diabetes Prevention Program
CHF Clinic	Mental Health Therapy

2. Obtain patient consent to make referral to Home and Community Care:
   - Discuss/advocate patient care with Care Coordinator
   - Referral for OT assessment
   - Advocate for HCC services that patient declined while in hospital

Listen to their story

3. Obtain patient consent to make referral to other outside agencies:

Lifeline Auto Alert Fall Detection System	Meals on Wheels
Muskoka Seniors: Transportation and frozen meal program	
First Link-Dementia Network	Community Respiratory Services

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Betty

Elderly woman discharged from acute care with diagnosis of Pneumonia

- Heather spoke with Betty who lives with COPD and Diabetes and also lives alone.
- Betty's symptoms include: productive cough, open draining sores in her mouth, decreased intake due to mouth sores, low blood sugar and she recently quit smoking.
- Betty's blood sugar had been low in the morning and she took her Novo Rapid insulin.

Betty

- Heather advised her not to take Novo Rapid when her blood sugars were low. Using the EMR, she alerted Betty's Doctor and suggested that Betty might need a change in insulin dosing or a sliding scale.
- She rebooked Betty's post-discharge appointment to an urgent appointment the next day.
- Heather contacted the Diabetic Education Centre and booked appointment for Betty to meet with the Diabetic Educator. As well, the Educator was advised of Betty's low blood sugars.

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Betty

Because of Heather's note in the EMR, Betty's Doctor called Betty at home that evening to adjust her insulin.

Heather acted on Betty's need for urgent appointments with both her Family Doctor and Diabetic Educator.

These proactive interventions reduced Betty's risk of experiencing a hypoglycemic episode that would require emergency care.

Post-Discharge Follow-up Appointments

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Optimized Nursing Skills:

1. Assess for a post-discharge follow-up appointment.
   If follow-up appointment not booked, with patient's consent, contact Physician's office to book appointment within 7-14 days of acute care discharge.

Listen to their story

2. Based on a holistic nursing assessment determine the patient's need for an urgent appointment or a home visit. If the patient has worsening symptoms or signs and symptoms of a secondary infection. Examples include: UTI, pneumonia, post-op wound infection, poorly controlled blood sugars, caregiver burnout. With patient's consent contact Physician's office to book urgent appointment or home visit. Advocate for a home visit based on patient needs: mobility issues, palliative.

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Data

Data
Potential to readmit

	2016 Q1-Q4	2017 Q1
Patients contacted	290	73
Percent of AFHT discharged patients	80%	85%
Medication reconciliation	100%	100%
Actual and potential medication errors- potential to readmit	17%	16.5%

Data
Potential to readmit

	2016 Q1-Q4	2017 Q1
Symptom management teaching required- potential to readmit	38%	42%
At risk to readmit from home due safety issues	28.5%	36%
Referral needs resolved	8%	7%

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Post Discharge Appointments

Appointments booked	2016 Q1-Q4	2017 Q1
Total % patient appointments booked within 7 -14 days of discharge by Heather	**28%**	**29%**
Urgent appointments or home visits booked based on assessment	**8%**	**3%**

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Readmit Rates

	Readmit Rates 2016-17 Q1-Q4	Readmit Rates 2017-18 Q1
Huntsville District Memorial Hospital	13%	9.5%
Algonquin Family Health Team Discharge Patient Program	9%	5.5%

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Positive Impacts

From our Patients and their families

- Heather, you've been so helpful. We can't thank-you enough.
- I don't know what I would have done today if you hadn't called me.
- What a wonderful program. You have put my mind at ease.
- Heather, thanks for listening.

From our Physicians and NPs

- Thank-you Heather for all the great work that you do.
- What a terrific program.
- I saw my patient today and they told me how much they appreciated your phone call.
- Thank-you for your help.

From Heather

- This program gives me great job satisfaction.
  - I am able to really help people feel more comfortable and safe at home after a hospitalization.
  - I might help by finding a medication error, health teaching, referrals to a community service or just giving them support and reassurance.
  - I find this job very rewarding.

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Time to Wrap ‘er Up

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Questions??

Contact information:

heather.aben@mahc.ca

jane.derbyshire@mahc.ca