# THE RURAL HOSPITAL@HOME (H@H) PILOT PROJECT

AFHTO Presentation
October 15, 2014

# AGENDA

1. Welcome – Stephanie MacLaren, ED, PEFHT
2. Prince Edward County – Stephanie MacLaren, ED, PEFHT
3. H@H – the history – Geri Claxton, RN, Team Lead
4. What is H@H? – Geri Claxton, RN, Team Lead
5. How does H@H work? – Brad Gunn, NP
6. South East CCAC experience in H@H – Carol Ravnaas, Senior Director
7. Patient/caregiver experience with H@H– video
8. Queen's Evaluation – what have we learned so far – Carol Ravnaas, Senior Director
9. Successes and Challenges – Geri Claxton, RN, Team Lead
10. The Future – Brad Gunn, NP
11. Questions.

# In Collaboration with:

Saint Elizabeth
*Well beyond health care*

South East
CCAC CASC
Community Care Access Centre
Centre d'accès aux soins communautaires du Sud-Est

QHC
Quinte Health Care

CSPC

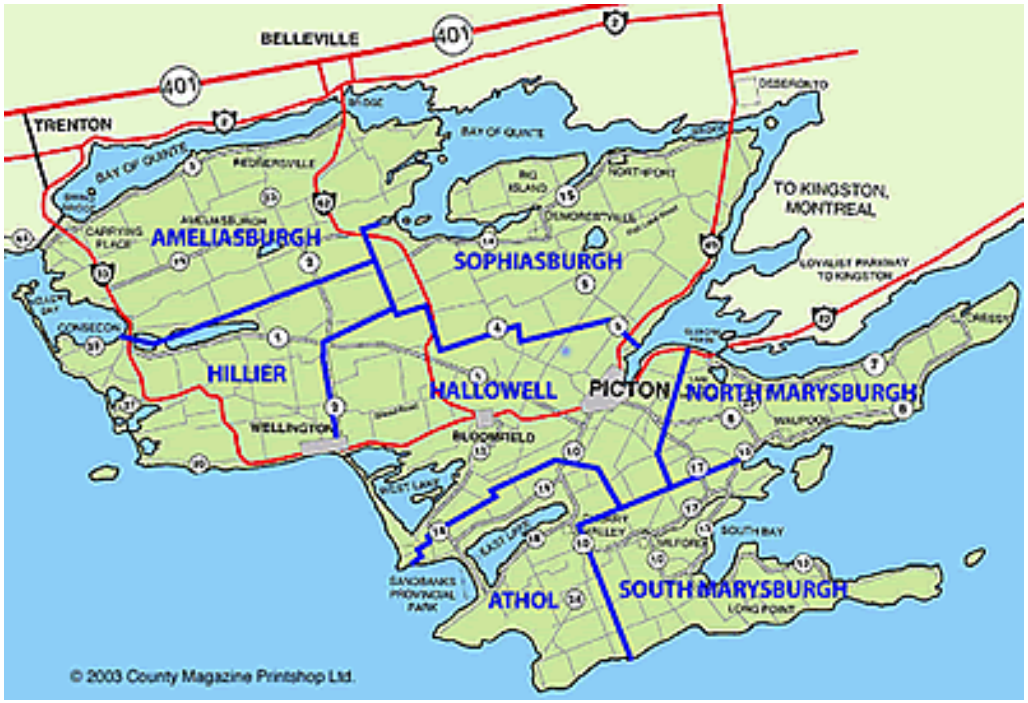
# Presenter Disclosure

## AFHTO 2014 Conference

Presenters: Stephanie MacLaren, Carol Ravnaas, Geri Claxton, Brad Gunn

- Relationships with commercial interests: N/A
- Disclosure of Commercial Support: N/A
  This program has not received financial or in-kind support in any form.
- Mitigating Potential Bias: N/A

# Map of Prince Edward County



# Prince Edward County Demographics

- Population – 25, 258 (2011 – Stats Can)
- Population change of -0.9% since 2006.
- The national average shows a population growth rate of 5.9%.
- Population (age 15-64) 62.6%
- Population (>age 65) 25.2%
- National average (>age 65) 14.8%
- Prince Edward County – mean age 51.6 yrs.
- Ontario – mean age 40.4 yrs.

# The History:

- Ministry of Health priority = find alternatives to hospitalization
- Prince Edward County = perfect place to try:
  - All Family Docs willing to engage / house-calls
  - PEFHT willing to dedicate significant resources
  - CCAC Care Coordinators work closely with MDs
  - Strong community care programs (Community Services Sector, Hospice)
  - Queen's (Centre for Studies Primary Care) nearby and knows PEC

# The History

- Queen's conducted background research
- Reviewed similar projects around the world
- The hospital: standard venue for treating serious illness, but has risks
- Evidence: hospital level of care can be done at home & many patients do better

# What is H@H?

- Innovative program to provide hospital level of care to patients in their own home
- Physician led – care in home supervised and led by the Family Doctor, just like in hospital
- Interdisciplinary team: PEFHT (MD's, NP's, pharm, SW), CCAC, St. Elizabeth Health Care (RN's, PSW's, OT & PT), Community Care for Seniors, Hospice
- Pilot project – 2 years – to see how it works

# What is H@H?

- MD “admits” patients to H@H from office, home, ER or hospital
- Daily, closely supervised care: timely, appropriate, inclusive and collaborative
- Daily home visit from NP and/or MD in addition to RNs, PSWs, …. together decide on daily care plan
- Care plan is patient centred
- Promote healthy behaviours, facilitate patient education and learning

# Why H@H?

- Prince Edward County needs alternative to hospital beds
- Improve quality of life (patient and caregivers)
- Improve access to community resources
- Improve patient and caregiver confidence in their own ability to manage at home
- Improve healthcare providers' satisfaction with the quality of care that they deliver
- Improve cost effectiveness of healthcare system

# How the H@H program works…

- Admitted for up to 7 days (or more)
- Daily NP/MD assessment
- Daily RN assessment (up to 3/day)
- Daily PSW visits (up to 3/day)
- Daily discussion by team (teleconference)
- Pharmacist – medication reconciliation for all H@H patients
- Social worker – assist with access to community services
- Priority access to PEFHT services

# Admission Criteria:

- Elderly, palliative care (for acute symptom management) and complex care patients
- Require hospital admission
- Have local Family Doctor/PCP
- Clear primary diagnosis
- Consent to participate in program
- Live in Prince Edward County
- Home environment safe for patient and team

# The Interdisciplinary Team:

- Family Doctor
- Nurse Practitioner
- Team Leader
- Community Care Coordinator (South East CCAC)
- RN(s)
- PSW(s)
- Physiotherapist
- Occupational therapist
- Pharmacist
- Social Worker
- Others: diabetic educator, clinical nutritionist, Heart Function RN, Palliative Care Coordinator, wound care, etc

# What have we done so far?

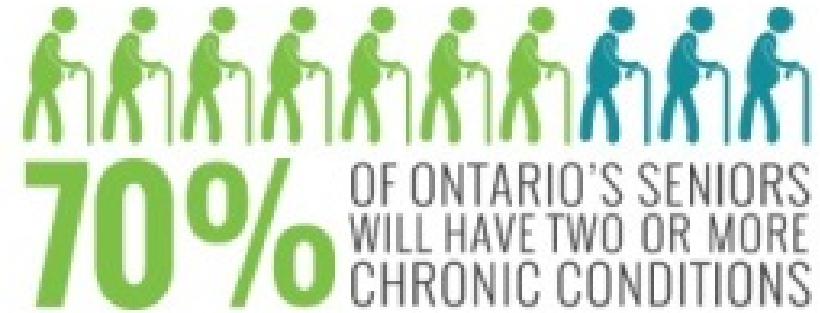
## UP TO September 1, 2014

| | |
|---|---|
| Total patient admissions | 82 (incl. 10 readmissions) |
| Total program days | 781 |
| Admitted from inpatient bed | 66 |
| Admitted from other | 16 |
| Male admissions | 45 |
| Female admissions | 37 |
| Average age | 76.3 |
| Primary Caregiver in home | 57 |
| Lives alone | 25 |

# The common diagnoses:

- Congestive Heart Failure
- Cancer
- Diabetes
- COPD

- Cellulitis
- Pneumonia
- Urosepsis/Sepsis
- Chronic pain
- Parkinson's Disease



# EXPERIENCES IN HOSPITAL@HOME

## Many benefits!

For patients:

- Feel more confident and comfortable leaving the hospital
- Have access to primary care (Nurse Practitioner) daily
- Feel their care is wrapped around them

For the health care team:

- More integrated in care delivery
- Very focused on patient well being and able to respond quickly
- Very collaborative environment
- Feel the access to a pharmacist and daily Nurse Practitioner visits are making a huge impact

# PATIENT/CAREGIVER EXPERIENCE

Hospital@Home - Testimonials-HD.mp4

Video Link – Testimonial

# The Evaluation
# Queen's University (CSPC)

- Why evaluate:
  - Assess program itself – does it work?, how does it work?
  - Can H@H be created elsewhere?

- What to evaluate:
  - Decrease hospital length of stay, number of admissions and re-admissions
  - Reduce the number of ER visits
  - Cost comparison hospital versus H@H
  - Increase satisfaction, quality of life and confidence of patients and their family, in the health care received
  - Improve patient experience at points of transition of care

# Patients and Caregivers

**Patients and Caregivers**

- Highly satisfied with H@H experience
  - 89% of patients were completely satisfied with the quality of care received
- Felt H@H allowed them to be discharged earlier from hospital
- Perceived H@H prevented long term care or nursing home placement

**Healthcare Providers**

- Satisfied with their role in patient care and team functioning.
- Noted that direct access to Primary Care and PEFHT's team facilitated efficient provision of the most appropriate care

# Program Costs

| Total Program Cost (H@H + SECCAC) | |
|---|---|
| Average per patient per stay in Hospital | $4 061.78 |
| Standard deviation | $2 283.00 |
| Median | $3 164.22 |
| Range | $1 220.74-$10 909.86 |
| Average per patient per day admitted to H@H | $418.72 |
| Standard deviation | $41.46 |
| Median | $414.59 |
| Range | $342.05-$519.52 |

# Limitations

- Patients and caregivers found the first day on H@H to be overwhelming and confusing
- Gaps in transfer of information during transition to regular homecare were noted
- The program does significantly impact the workload of some healthcare providers

# SUCCESSES AND CHALLENGES

- Communication
- Team Leader (coordinator) role
- Capacity (skills, experience)
- Partnership/trust
- Consistency of team (core team)
- Close interactions (team with MD's, CCAC)
- Pharmacist
- Social worker

- MD billing/ cost issues
- H@H order set
- Connections with tertiary hospitals
- Clinical pathway – CCP (coordinated care plan)

# The Future

- Expand the admission criteria
- Increase the continuity of care
- Increase confidence
- Increase expertise
- Increase capacity
- 24/7 coverage

- QUESTIONS?

Contact:
Hospital@Home Program
Prince Edward Family Health Team
Geri Claxton, RN Team Leader
613-476-2181, X4718