Burlington
Family Health Team

Aging at Home: Inter-professional care to keep seniors at home and out of hospital

Burlington Family Health Team

Presented by Shawna Cronin (OT), Theresa Hubley (NP), Emilia Wojenska (NP), & Caitlin Grzeslo (Program Coordinator)

Learning Objectives

Share our knowledge in the following areas:

* Program development
* Benefits of utilization of community partners
* Embedding quality improvement into a program

Presenter Disclosure

AFHTO 2015 Conference

* **Presenters:** Caitlin Grzeslo, Theresa Hubley, Emilia Wojenska, Shawna Cronin

* **Relationships with commercial interests:**
  * **Grants/Research Support:** none
  * **Speakers Bureau/Honoraria:** none
  * **Consulting Fees:** none
  * **Other:** none

Disclosure of Commercial Support

AFHTO 2015 Conference

* **This program has not received financial support.**
* **This program has not received in-kind support.**

* **Potential for conflict(s) of interest:**
  * Speakers as listed above have not received payments or funding from any organizations.
  * No products will be discussed in this program.

Mitigating Potential Bias

* No potential sources of bias were identified.

Outline

* Overview of Burlington and Burlington FHT
* Initial Program
* What we do
* Participation in IDEAS
* Changes Implemented
* Sustainability & Spread
* Challenges & Barriers
* Facilitators & Successes
* Moving Forward
* Take Home Messages
* Questions

Mrs. Smith

* 99yo female; lives with daughter & son-in-law; not driving
* Poor mobility; uses cane/walker and occasionally wc
* PMHx: CHF, Temporal arteritis, angina, macular degeneration, PPM for bradycardia; ex-smoker
* Admitted to hospital for stroke Dec. 2014 x 2; HF x 1
* Referred to OT and NP December 2014
* NP visit x 6; OT visit x 5 over 3 months
* No repeat ED visit since, and has been D/C'd from program due to stability of symptoms

Burlington, Ontario at a Glance

* 2011 Population: 175, 779
* In 2011, there were 29,720 seniors 65 years of age and older living in Burlington, making up 16.9 per cent of the population versus 14.6 per cent in the province.
* 30 per cent of seniors 65 + living alone
* Halton Niagara Haldimand Brant LHIN Aging at Home Strategy

2011 Census, Statistics Canada; CIHI 2011

Burlington Family Health Team

* Total roster - 8200 patients (5 practices)
* 1381 rostered patients 65 years and older… 17% (Aug. 2015)
* Original program consisted of home visits by previous NP
* Program put on hold - staffing and recruitment issues
* When OT and NP positions were filled, formal program development was initiated

Initial Aging at Home Program

* Staffing
  * NP 0.4
  * OT 0.6
  * Pharmacist involvement as needed, consultative role
* Referrals generated from EMR data, physicians reviewed and identified candidates
* NP generated caseload from paper emergency department reports
* Cold called patients who were identified as candidates
* Tracked caseload on paper

Program Overview

* Referrals generated by BFHT physicians, residents, allied health staff, and outside agencies (i.e. CCAC case managers)

* Screen referrals to the program based on defined criteria and can also create referrals from patients recently seen in the JBH ED:
  * ED visits are logged at JBH and the list of patients sent to the BFHT program coordinator
  * The program coordinator distributes this list weekly to the NP and OT
  * Eligible patients are flagged as potential candidates to the program and the MRP is notified and asked if the patients should be referred to the program

* Home visits are scheduled at the discretion of the NP/OT

Referral Criteria

Rostered patients 65 years or older who meet at least **one** of the following criteria:

* Housebound/social isolation
* Poor support network
* Diagnosis of COPD, CHF, HTN, Diabetes or Dementia
* Balance and gait impairment
* Fall in the last 6 months
* Recent discharge from hospital
* Recent Emergency Department visit
* 2 or more admissions to hospital for the same issue within the last 6 months
* Family can self-refer

What we do

Provide care to seniors who are residing in the community to maximize their functions through the provision of comprehensive geriatric assessments or focused assessment and appropriate recommendations/ treatment

* Mental Health assessment/ cognitive assessment
* Refer to community partners e.g. CCAC, First Link, Health Links
* Manage program patients independently or in conjunction with the family physician and/or specialist as needed
* Pain management

Nurse Practitioner Role

* Full physical or focused assessment of the patient, practicing to his/her full scope
* Monitor and treat for both episodic and chronic conditions
* Palliative care visits, symptom assessment, and management

Nurse Practitioner Role

* Patient/family teaching regarding medications, devices, and chronic conditions, as well as general health teaching
* Complete medication reconciliation
* Wound assessment and dressing changes, urinalysis, glucometer testing, and form completion as required
* Nutrition screen
* Coordinate lab testing and mobile imaging

Occupational Therapy Role

* Home safety assessment
* Functional mobility
* ADL/IADL assessment
* Community navigation
* Collaboration with nurse practitioner, physician, and community partners as indicated

IDEAS – Improving & Driving Excellence Across Sectors

* "The IDEAS Advanced Learning Program is designed to equip individuals working in health care with the knowledge, skills and tools to lead quality improvement initiatives."

* Attended by OT, NP, & Program Coordinator

* Key take-aways:
  * Tools and Methods
  * Spread of Quality Improvement
  * Team Dynamics and Collaboration/Support
  * Integrated role of Program Coordinator into Program

IDEAS Impact on our program

* Weekly meetings
  * Provided structure, timelines, accountability
  * Ensuring program a priority

* Aim statement changes
  * SMART – specific, measurable, attainable, realistic, timely
  * Final AIM statement: **By March 31, 2015 we aim to reduce the number of preventable emergency department visits by 20% for patients enrolled in the Aging at Home program.**

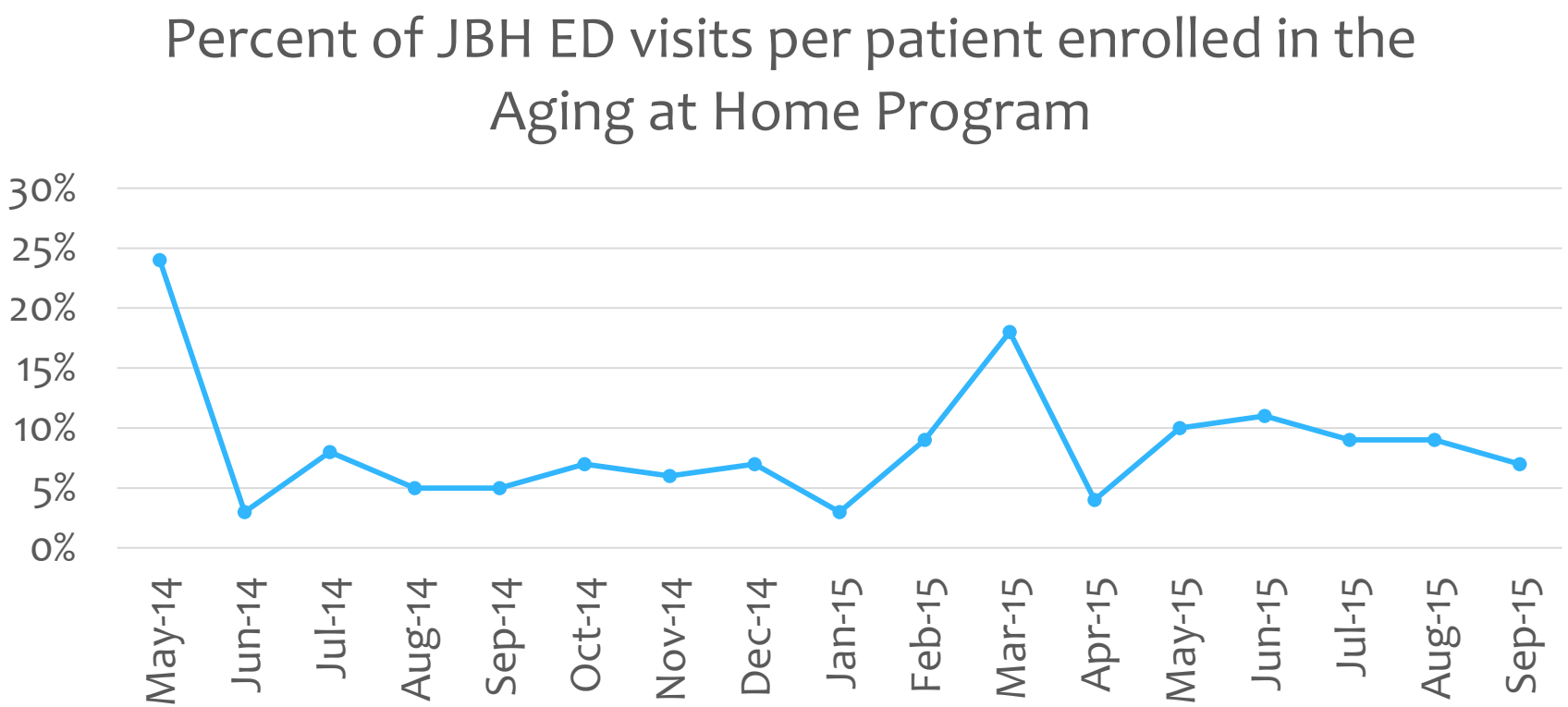
* Change Ideas and PDSA's
  * COLLABORATION!!!

IDEAS Impact on program

* Productivity & Efficiency
  * Team meetings to review caseload
  * Data collection from JBH

* Data Analysis Methods
  * Understanding and displaying data correctly
  * Use of Excel and other statistical programs to create control charts
  * Learned to review control charts, identify when changes created a positive difference
  * Process and balancing measures

IDEAS Impact on program

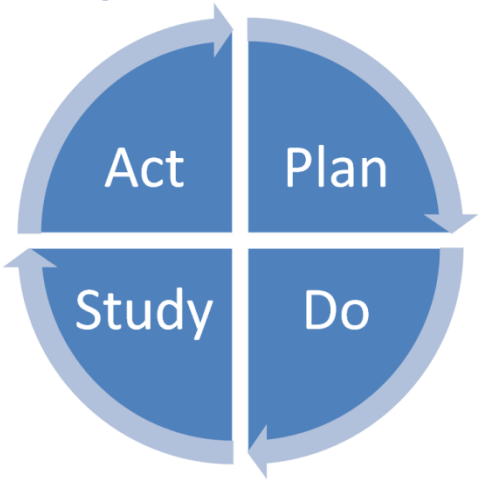


Changes Implemented

* New change ideas
  * Brainstorming session
  * Identified which had “high impact” and which required the most effort

* **P**lan **D**o **S**tudy **A**ct
  * Monitored changes implemented, adopted successful changes.

* Major changes implemented
  * Community partnerships
  * Interdisciplinary team rounds
  * Team education about program



Following IDEAS

* Ongoing measurement
  * Coordination with JBH to receive a list of BFHT patients who have been to the ED within the last 7 days
  * NP and OT independently keep caseload in Excel files and combine reports monthly for distribution prior to rounds
  * Now tracking caseload in OSCAR

* Continuing rounds
  * Have added the CCAC CM to monthly rounds
  * Distribute caseload lists to team prior to meetings
  * Addition of a template in OSCAR for standardized electronic documentation of meeting by NP or OT

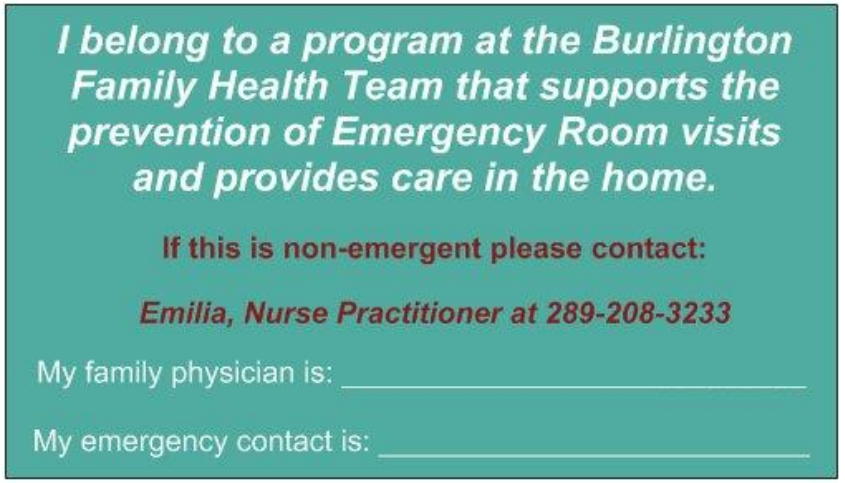
Sustainability

* **Program structure as it stands now**
  * Joining the BFHT as new staff
  * Currently: we have one NP and one OT who do majority of home visits for those enrolled, physicians also make home visits; NP and physician may alternate
  * Weekly visits; NP has 1 day specifically per week for home visits plus 2 half days blocked for programming/ urgent visits
  * Able to see patients anywhere from same day to 10 days; varies weekly/monthly depending on caseload

Sustainability & Spread

* **Capability of program**
  * Current caseload➔ approx 70-80 patients
  * Referrals are generated mostly from BFHT physicians , NP/OT, nursing staff
  * Continue to promote program
  * Discharging patients who are stable/ not actively needing resources
  * Long term maintenance lists
  * Identifying patients enrolled in the program

Aging at Home ID card



Sustainability & Spread

* Collaboration
  * Health Links, Joseph Brant Hospital, CCAC, AD Society
* External referrals
  * Created and disseminated referral form
  * Now receiving referrals from Joseph Brant Hospital, Halton Geriatric Mental Health Outreach Program, CCAC
  * Family self- referral
* Burlington Family Health Team allied health professionals
  * Dietician
  * Pharmacist (ongoing involvement)
  * Social Work

Challenges and Barriers

* Coordination of rounds to access all physicians
* Staff transitioning: NP Mat leave and OT leaving role
* Referral process; hallway consult vs. EMR, external referrals
* Notification of patients discharged from hospital
* Funding – start up costs
* Patient/family resistance to change

Facilitators and Successes!

* Written resources that outline the program
* Program co-ordinator (meetings, measurements, resources)
* Weekly/monthly meetings and team communication
* Supportive team/ environment
* Physician/staff buy-in
* Patient satisfaction
* Addition of CCAC in monthly rounds
* Reduction in ‘preventable’ ED visits

Moving forward

* Addition of allied health professionals and admin support
* Engaging other partners in the community e.g. EMS, other hospitals that are near by (Hamilton, Oakville)
* Collaboration with community partners more closely
* Evaluate capacity of the program with current staffing model
* Continued reduction in preventable ED visits
* Formal feedback

Take Home…

* Take initiative to understand quality improvement
* Outcomes should be realistic and measurable
* Track measures monthly
* Follow up on new changes
* Meetings
  * Make a meeting schedule
  * Meet regularly (more often in the early stages)
* Teamwork – ongoing communication and one common goal
* Celebrate the quality improvement successes!

Thank you!

* Questions?!?!