Markham FHT CLINICAL PROGRAM PACKAGE
Evaluation Tool

Review date: November 11 2015 For period: Sept 30 2014- Sept 30 2015

Program	**Eating Disorders Bridge Program**	
Program Lead(s)	[redacted]	
Physician Lead(s)		
Program Members		
Program Synopsis	The goal of the program is to offer support to any patient waiting for treatment at an eating disorders program by 1. Doing no harm 2. Monitoring the health of the patient to prevent further medical instability The program will meet this goal by providing a core resource and care team with a special interest and focus in the treatment of eating disorders, who will assess and follow referred patients until the time they enter a formal eating disorders program.	
Does program align with vision/mission?	Optimizes health? Y	Collaborative approach? Y
	Best practices? Y	Advanced IT? Y
Target Population	Eligible patients must meet the following criteria: 1. Patient **must be** on a wait list for a community ED Program 2. Patient must meet that program's eligibility criteria 3. Patient agrees to transfer to that program once the space becomes available	
Objective 1	Patients of the program will have achieved and/or maintained medical stability (as defined at the end of this table) at the time of discharge from the FHT program (to enter the formal eating disorders program) *Indicator: Of those patients in the program:* ➢ *Weight at discharge from program will be same or increased since entry to program* ➢ *Number (if any) of ER visits or admissions related to the eating disorder should = 0* ➢ *HR > 50 at discharge from program* ➢ *Blood pressure measurement at discharge will be same or improved from entry to program* ➢ *If lab values were abnormal at entry, patient will show stabilization or improvement in values at discharge*	
Objective 2	Program Lead completes an intake assessment, which includes evaluating the patient's medical stability and baseline metrics, and facilitates follow up visits with the Program IHP's; follows as per care plan *Indicator: Tracking code NP269 or ED269*	
Objective 3	RD and SW assess and follow patient according to care plan. *Indicator: Tracking codes: RD269 or SW269*	

Patient Encounters	**11** patients have been seen by the program since Sept 2014. (5 in 2014 review) ➢ 5 remain in EDB program, awaiting acceptance to formal There were **228** visits related to the EDB program (~1h each)	
Resources/Personnel Utilized	Program research and development occurred prior to the review period (see metrics for hour breakdown) [redacted] 3h meeting time for program review (program members + CPM)	
Metrics 1	Of the **5** pt's d/c'd from program: ➢ Weight at discharge from program demonstrated an increase since entry to program for all pts ➢ 1 ER visit related to ED for 1 pt (facilitated by program) ➢ HR remained > 50 ➢ BP remained stable ➢ N labs at entry and d/c Of the **5** pts still in the program ➢ Both remain medically stable as above	Met objectives? Y
Metrics 2	NP 269 – **61** instances and **10** pts	Met objectives? Y
Metrics 3	RD269 – **84** tracking instances for 58.5 hours and **11** pts SW – **83** tracking instances for 74.25 hours and **10** pts	Met objectives? Y
Summary	Objectives met for keeping pts medically stable Education/support group for parents with ED is in Phase 3 (Rhonda and Nancy, SW) ED CON time spent consulting through meetings	
Recommendations	Try to coordinate initial appointment with NP/RD as joint appointment due to overlap of information gathered at these sessions and to reduce the appointment/time burden on patients.	

CCG Recommendations	

Reviewed by:

Medically stable (both of the following)	Medically Unstable (any of the following)
• Avoiding ER visit or admission r/t ED • Maintaining weight	• HR < 50 • Orthostatic hypotension • Arrhythmia • Abnormal labs