Optimizing Primary Care for Chronic Homebound Patients Using a Collaborative Nurse Practitioner Team Based Model of Care A North York Family Health Team Pilot Program

Jessica Lau, MN, NP-PHC & Cassandra Kwok, MN, NP-PHC

Introduction

The North York Family Health Team (NYFHT) nurse practitioner (NP) chronic homebound program provides vital healthcare services to individuals unable to access traditional primary care due to various challenges. NYFHT currently has 94 physicians practicing in 21 locations with 91 348 patients that received team based care between the years of 2023-2024. This NP program services patients who have not been able to see their primary care physician (PCP) indefinitely as they are facing health deterioration, increased frailty, ambulation restrictions, and challenges accessing transportation, thus rendering them homebound.

Through proactive home visits, the NPs deliver comprehensive primary care services collaboratively with their PCPs tailored to each patient's unique needs. These services encompass regular health assessments, medication management, preventive screenings, and chronic disease management, ensuring holistic and personalized care from the comfort of patients' homes.

Aims & Objectives

1. How to provide increased access to the frail elderly population who are chronically homebound within a large, multi-site, urban Family Health Team
2. Facilitate a NP led team-based approach program to provide continuity of care in the comfort of the patient's home.
3. Overcome barriers in seeking appropriate health care services for chronically homebound individuals.
4. Decrease hospital admissions to Emergency Department (ED) and hospital readmission, which in return reduces cost in health care services utilization.

Methods:

- Support from NYFHT executive leadership, primary care physicians & allied health professionals
- Staffing Requirement: 2 NPs dedicated 0.5 FTE each, 1 shared admin
- Accessibility to vehicle to travel within the boundaries of North York Region
- Remote access to EMRs (PSS/Accuro) and virtual care (video/phone)

Community partners:

We collaborate closely with internal interdisciplinary teams, as well as external agencies including home and community care services, to address social determinants of health and optimize patients' overall quality of life, promote dignity, independence, and improved health outcomes.

Ontario Health atHome · RGP Regional Geriatric Program of Toronto · North York General · Sinai Health · Temmy Latner Centre for Palliative Care · SCOPE

NYFHT

NORTH YORK FAMILY HEALTH TEAM

Participants

Enrollment criteria

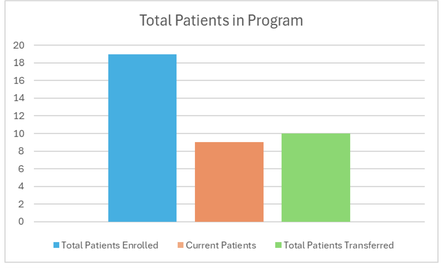
- Patients within the NYFHT who are bedbound or homebound and unable to access their PCPs indefinitely
- Patients living within the geographical boundaries of North York Region
- NPs will triage all referrals from PCPs within the NYFHT

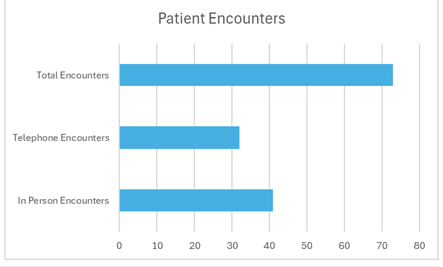
Transition of care criteria

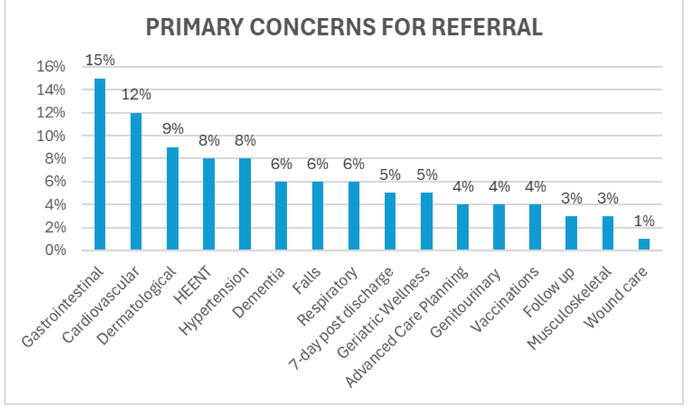
- Transfer of care (Long term care facility, palliative care team)
- Deceased
- Ability to return to PCP's office or health care clinic

Statistics

86% of in home visits prevented hospitalization within 30 days







Evaluation - *From an NP perspective for long term sustainability of the program*

Enablers:

- Supportive executive leadership, IHP team, and administration team
- Initial NP episodic homebound program expanded into chronic homebound program to address needs of patients who were not able to see their PCPs indefinitely
- Collaborative team based approach with NPs and PCPs
- Utilization of community partners

Challenges:

- Staying up to date with resources in community (ex: programs that are put on hold, changes in referral criteria, lack of funding, etc.)
- Part-time program for both NPs
- Accessing multiple EMRs (PSS/Accuro) to communicate with PCPs

Patient Satisfaction Survey Results

Overall positive experience with the program.

Surveys indicated that follow up, connecting to resources, communication, regular review of health status, and suggestions on ways to manage health issues was done well. All were satisfied in their care while enrolled in the Chronic Homebound Program.

Evaluation

Most patients and family members were offered to respond to the qualitative patient satisfaction survey after 1 year of the program initiation. However, there was a low response rate (2 surveys completed) and we were unable to obtain trends.

Qualitative feedback from NYFHT PCPs

- This program is great, it prevented our patient from going to the hospital because the NP was able to assess patient in their home
- Wonderful collaborative team approach to providing care in our patients that are homebound
- The NPs provided seamless care from initiating home care services and coordinating with community partners
- Amazing and comprehensive care for my homebound patient
- Provides opportunity to discuss advanced care planning with patient and their family in the comforts of their home

Conclusion

The Chronic Care Homebound Program enhances patient care by providing primary healthcare services directly to individuals facing mobility or transportation challenges. Through proactive home visits, it ensures timely assessments (quarterly visits), medication management, and preventative screenings, thus optimizing health outcomes. Acute and chronic medical conditions are addressed without delays. By fostering strong therapeutic relationships and collaborating with interdisciplinary teams, it addresses holistic patients needs, including social determinants of health. This personalized, patient-centered approach not only improves health outcomes but also reduces hospital visits, easing strain on the healthcare system while promoting dignity and independence for homebound patients.