Coordinating Complex Pediatric Nutrition in the Medical Home Model

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Guelph Family Health Team — Celebrating 10 Years 2007-2017

Where It All Began

The Waterloo-Wellington Local Health Integration Network (WWLHIN), CBI Home Care Registered Dietitian (RD) and Guelph Family Health Team (Guelph FHT) identified the need to support a collaborative approach when transferring stable enterally fed pediatric patients to dietary services within primary care.

The Guelph FHT RD team had not previously provided service to children receiving enteral nutrition and we were committed to making this happen together.

Can We Help?

Building Competency?
- Is this in our scope as primary care RDs?
- What education plan do we need?
- Who can we ask questions to?
- How do we transfer knowledge?
- What do we need to know about the formulas?

Identifying Experts?
- Who currently helps pediatric patients on enteral feeds in Guelph?
- How can we learn from others?
- Is anyone doing this in primary care

Building Capacity?
- How do we operationalize this without new resources (who, what, where, when...)?
- What does our process need to look like?

Documentation and IT Solutions?
- Where do we chart?
- How will we share information?

Physician Relationships?
- Who do we talk to first?
- Can we get to know the pediatricians in Guelph?

Needs of the Patients and Families?
- How do we build awareness of resources and programs (financial, supplies, troubleshooting)?
- How can we make the transition as smooth as possible?

Risk Management?
- What if a child becomes unstable?
- How do we ensure competency in our clinicians?
- Who manages trouble shooting?
- Where do we ask circle of care questions?

People get the care they need when they need it

Ontario — Local Health Integration Network

What's Our Process?

Building Competency
- Confirmed enteral nutrition services are within the scope of a primary care RD
- Education plan: self-study, webinars, conferences and membership with professional organization (ASPEN)
- Joint visits with mentors
- Monthly case studies with RD team
- Meeting with industry representatives

Identifying Experts
- Mentors identified:
  - Guelph General Hospital (GGH)
  - WWLHIN
  - London Health Sciences (LHSC)
  - McMaster Children's Hospital (MCH)
  - Grand River Hospital (GRH)

Building Capacity
- Multiple meetings between Guelph FHT and WWLHIN to map the process
- Definition for stability created
- Estimated 25-30 patients to be transfered per year

Documentation and IT Solutions
- Purchase of an Electronic Medical Record (EMR) server that can provide documentation for patients outside the Guelph FHT
- Referral form created for "Transfer of Care"
- Stamps designed for charting consistency
- Access to ClinicalConnect

Physician Relationships
- Outreach to pediatricians including letters and in-person visits

Needs of Patients and Families
- Became familiar with resources and financial supports

Risk Management
- Process mapping with WWLHIN allowed for patients to be re-referred as stability changed
- Discussions with privacy officer
- Troubleshooting would be addressed by patient with primary or tertiary medical team

Patients feel good about the care we provide

Our Journey

Apr 2015
- First request from WWLHIN for a "Transfer of Care" for a pediatric G-tubepatient to a Guelph FHT RD

Nov 2015 to Now
- Education plan begins
- Ongoing learning and knowledge transfer from formula company representatives
- Case studies presented and discussed

Nov 2015
- Started meeting with WWLHIN and home care RD to begin mapping transition process
- Started shadowing home care RD

Feb 2016
- LHSC observership

Mar to Apr 2016
- Outreach to pediatritions in Guelph

May 2016
- First patient: completed "Transfer of Care"
- Initial consultation process with Waterloo Wellington Pediatric Feeding Map

Jun 2016
- Initially accepting referrals for Guelph FHT physician patients

Jul 2016
- Second patient: began supporting on Blenderized Tube Feeding (BTF)

Nov 2016
- Third patient: "Transfer of Care" not completed due to patient moving away
- Fourth patient: referral for G-tube from family physician

Mar 2017
- Creation of an EMR server to allow patients outside of the Guelph FHT to receive service

Apr 2017
- Fifth patient: "Transfer of Care" for first patient outside the Guelph FHT

Jul 2017
- First meeting of Guelph Community Pediatric Collaborative

CBI HOME HEALTH

We work with our community to build a better health system

Transfer from Home Care to Guelph FHT RD Service

- Home care RD/Care Coordinator has a conversation with patient/family regarding referral and "Transfer of Care" to Guelph FHT RD
- Home care RD makes a referral by calling the FHT RD to notify, complete and send the referral/"Transfer of Care" form via secure fax containing previous assessment notes, history of care provided by home care RD and needs of the child
- FHT RD reviews the transfer request with the primary care physician or pediatrician to confirm eligibility for transfer
- First transfer appointment with the patient is a joint visit with Guelph FHT RD and home care RD to allow a "warm hand-off" of care
- Timeline for appointment(s) is created based on the patient's needs and the RD's schedule

If a patient calls home care RD with nutrition questions after the transfer of care has occurred, they will be redirected to the FHT RD

If a patient does not attend the FHT RD appointment, the FHT RD will contact physician/pediatrician to notify and discuss next steps

If a patient's condition becomes medically or nutritionally unstable and they require home care the physician/pediatrician will refer the patient back to home care RD

If a patient's condition remains stable, the FHT RD provides ongoing/routine check-ups to ensure stability and adjusts accordingly

Navigating New Challenges

Charting Needs
- Needed to access an EMR server to support patients outside of Guelph FHT

Evolving Needs
- Learning new skills (types of feeding, transitioning to oral feeds)

Accessing Additional Health Services
- Needed for support of patients and families

Partnership Needs
- Strengthen partnerships to support patients

Low Patient Numbers
- "Go live" date came and went with only a few referrals
- Created capcity to support patients outside the Guelph FHT

Next Steps

Community Partnerships
- Continue working closely with WWLHIN and home care RD to provide enteral nutrition care to stable children who are ready to be transferred into primary care
- The Guelph pediatric nutrition collaborative has formed and contains RDs from public health, hospital, home care and primary care as well as OTs from KidsAbility and Care Coordinators from the WWLHIN
- Our aim is to continue to streamline the approach to nutrition care for children in Guelph through communication, tools and increasing access to resources

Tools and Capacity
- Continue to support the learning of primary care RDs to increase capacity to manage enteraly fed children in primary care
- ***Feeding Map:*** Map the available pediatric services in Guelph so it is easy to navigate where children can receive nutrition care
- Continue working on communication tools and approaches between organizations

Measurements and Outcomes
- Only 5 referrals to date, but as transfers increase we hope to collect and compile metrics on children that have met their individualized growth targets to sustain this work within primary care

Guelph Family Health Team

We feel good about our work