Rapid Response Nursing Program: Supporting Chronic Disease Management through Transitions in Care

Geriatric Day Hospitals Institute
Sunnybrook Health Science Centre
November 25, 2013

Liana Sikharulidze, Manager Rapid Response Nursing and Telehomecare
Anne Stephens, Clinical Nurse Specialist
Learning Goals:

• Discuss the role of the CCAC Rapid Response Nursing Program (RRNP) in promoting safe health system transitions

• Explore opportunities for collaboration between the RRNP and Geriatric Day Hospitals
TC-CCAC Population Based Model for Long Stay Clients

Intensive Case Management + Integrated Team Based Care

Care Coordination + Self Management

Linkage to Community Supports + supporting independence

Modified Independence

Complex or Chronic Conditions

Risk

Frail/ High Need

Intensity of Need

2007 Kaiser Permanente
## RRN Allocation by LHIN

<table>
<thead>
<tr>
<th>LHIN/CCAC</th>
<th>RRN</th>
<th>(Minimum # for Care of Complex Children)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erie St. Clair</td>
<td>8</td>
<td>(1)</td>
</tr>
<tr>
<td>Southwest</td>
<td>13</td>
<td>(3)</td>
</tr>
<tr>
<td>Waterloo-Wellington</td>
<td>6</td>
<td>(1)</td>
</tr>
<tr>
<td>Hamilton Niagara</td>
<td>14</td>
<td>(2)</td>
</tr>
<tr>
<td>Haldimand Brant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central West</td>
<td>6</td>
<td>(1)</td>
</tr>
<tr>
<td>Mississauga Halton</td>
<td>7</td>
<td>(1)</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>10</td>
<td>(2)</td>
</tr>
<tr>
<td>Central</td>
<td>10</td>
<td>(2)</td>
</tr>
<tr>
<td>Central East</td>
<td>11</td>
<td>(2)</td>
</tr>
<tr>
<td>South East</td>
<td>7</td>
<td>(1)</td>
</tr>
<tr>
<td>Champlain</td>
<td>11</td>
<td>(2)</td>
</tr>
<tr>
<td>North Simcoe Muskoka</td>
<td>5</td>
<td>(1)</td>
</tr>
<tr>
<td>North East</td>
<td>13</td>
<td>(3)</td>
</tr>
<tr>
<td>North West</td>
<td>5</td>
<td>(1)</td>
</tr>
<tr>
<td></td>
<td>126</td>
<td></td>
</tr>
</tbody>
</table>
Background

- Effective transitions between hospital and home are recognized as critical to achieving good client outcomes and avoiding rehospitalisation.

- Many clients have sub-optimal experiences in care transition between hospital and home/community care. Problems include:
  - Medication discrepancies
  - Confusion about post discharge care plans

- Risk of readmission is significantly lower when:
  - 1st home care visit takes place within 24 hours of discharge
  - Primary care visit occurs within 7 days of discharge

Nurses in CCACs: Providing Care and Creating Connections Across Sectors, P. 4
Common Reasons for Re-admissions

Lack of Social Support
- Poor d/c instructions; key therapies not initiated in the hospital

Medication errors; adverse drug events; non-adherence

Poor out-patient symptom management; patient confusion about self-care instructions

No follow-up appointment; too far away; lack of adherence to treatment plan

Program Goal

To reduce re-hospitalization and avoidable emergency department visits by improving the quality of transition from acute care to home care for two population groups:
### Target Population

<table>
<thead>
<tr>
<th>Chronic - Medically Stable/Palliative</th>
<th>Complex - Medically Complex</th>
</tr>
</thead>
<tbody>
<tr>
<td>• One or more health/chronic conditions with complicating factors;</td>
<td>• One or more health/chronic conditions with complicating factors;</td>
</tr>
<tr>
<td>• Direct care needs are stable and predictable;</td>
<td>• Direct care needs are unstable &amp; unpredictable;</td>
</tr>
<tr>
<td>• The individual is self-reliant and/or can achieve stability with the right support network;</td>
<td>• Care requirements from medical and/or physiological conditions require ongoing, frequent or time consuming caregiver intervention;</td>
</tr>
<tr>
<td>• Care requirement from medical and/or physiological conditions require ongoing, frequent or time consuming caregiver intervention;</td>
<td></td>
</tr>
<tr>
<td>• Patient or caregiver is self-reliant and/or can achieve stability with the right support network.</td>
<td>• Patient or support network is not self-reliant with high risks in more than 1 area.</td>
</tr>
<tr>
<td>OR</td>
<td></td>
</tr>
<tr>
<td>• A child who is not imminently dying. However does have a life limiting illness or condition.</td>
<td></td>
</tr>
</tbody>
</table>
Client Eligibility Criteria

Inclusion Criteria

- New or existing CCAC clients
- Medically complex adults/Frail seniors
- Ambulatory Care Sensitive Conditions/other
- At risk for readmission to ED or Hospital
- Assessed to have a brittle or poor support network
- Late stage CHF/COPD

Exclusion Criteria

- Primary psychiatric diagnosis
- Palliative /Oncology
Referral Source

Emergency Dept.

Hospital

Care Coordinators

Intake by Hospital CC

- Case finding
- Screening for eligibility
- Identify RRN involvement
- Pre D/C
- Collection of D/C information
- Overall Service Planning
- Service Ordering of RRN

24 Hours

RRN Visit

- Consent for Tx
- Problem-based assessment using common tool
- Teach back approach to education
- Medication Reconciliation
- Confirm medical tests
- Update In-Home Health Record
- Linking with PCP

Follow-up Care

- Ongoing problem-based assessment to ensure client stable & safe
- Address ongoing medication issues
- Linking with PCP
- Contribute to Service Planning
- Joint visit/phone with CC and SP to transition care

7 Days

Discharge from Hospital

Integrated Care

Transitioning from Hospital to PCP/Community Providers

RRN Program Guide, June 2013
RRN Role

**Rapid Response**

- Health assessment
- Primary Care Provider
- Discharge plan
- In-home post-discharge visit within 24 to 48 hours
- Symptom management using teach back
- Medication Reconciliation
Using “Teach Back” and health literacy principles is supported by research

Asking that patients recall and re-state what they have been told is one of the top 11 patient safety practices based on the strength of scientific evidence.

AHRQ, 2001 Report, Making Healthcare Safer
### Every Day:
- Weigh yourself in the morning, after going to the bathroom and before breakfast. Write down the date and your weight.
- Take your medicine as prescribed
- Check for swelling in your feet, ankles, and legs
- Eat foods prepared with low salt (low sodium). Don’t add salt at the table. Avoid prepared, processed and packaged food.
- Balance activity with rest
- Keep walking or join a cardiac rehabilitation program

Which Heart Failure Zone are you today? **GREEN** **YELLOW** or **RED**

### Green Zone
**ALL CLEAR: This zone is your goal**
- No increase in shortness of breath
- No weight gain (your weight remains the same)
- No swelling of your feet, ankles, or legs
- No chest pain
- No unusual feelings of fatigue, dizziness, or confusion

*Ask your doctor or nurse about getting an annual flu shot*

### Yellow Zone
**CAUTION: This zone is a warning.**
**Call your doctor or nurse if you have ANY of the following:**
- Weight gain of 2 pounds in 2 days
- Shortness of breath that is worse than usual
- Swelling (edema) becomes worse in your legs, ankles, or legs
- New fatigue, or increased fatigue which is not relieved by rest
- Fever of 38 degrees Celsius (100.4 degrees Fahrenheit) or above
- New or increased difficulty breathing when lying down
- Any dizziness or lightheadedness
- Wheezing that is worse than usual

### Red Zone
**EMERGENCY**
**Go to the EMERGENCY DEPARTMENT or CALL 911 if you have any of the following:**
- New chest pain, or chest pain that is much worse than usual
- Shortness of breath that is much worse than usual
- Confusion, not able to think clearly
"TAKE WITH MEALS? NO PROBLEM!
I EAT ALL THE TIME!"
Care transitions

A set of actions designed to ensure the safe and effective coordination and continuity of care as clients experience a change in health status, care needs, providers or location.

Adapted from American Geriatric Society, 2003
Transitions…..

It’s the seams that count!
How does it work?

• **Internal** referrals within CCAC
• **External** referrals to community partners and programs
• Role of the Community Care Coordinator (CC) as a system navigator
Benefits and Expected Outcomes

✔ Deliver seamless transitions from hospital to community
✔ Expected to significantly improve the value of the health care system by reducing hospital readmission
✔ Sustain ongoing integrated home care and partnership with service providers and community partners

Risk of readmission is significantly lower when:
• 1st home visit take place within 24 hour post-hospital discharge
• Medication reconciliation
• Primary care visit arranged within 7 days from discharge
CCAC - Telehomecare

Transforming Chronic Disease Prevention and Management
Program Goals and Objectives

To support clients living with Complex Chronic Disease to self manage their care in their own homes with the assistance of a Telehomecare Nurse Coordinator who remotely monitors them using technology.

Objectives:
Reduce the impact of complex chronic disease on clients and on the health care system
Build an integrated system of technology-enabled care
Improve hospital-to-home transitions with daily vital signs monitoring, response and communication with primary care provider
Encourage client self-management for complex chronic diseases
Enhance the quality of life for clients and their caregivers
Reduce caregiver burden and anxiety, knowing there is a health professional monitoring their loved one

THC SPONSORS
Co-funded by Ministry of Health and Long-Term Care and Canada Health Infoway

Led by LHINs - Implemented in North East, Central West and Toronto Central LHINs; NW and Central LHIN implementing Fall 2013; goal of all LHINS by 2015

Telehomecare nursing is provided through CCAC

Program development and technology managed by OTN (Ontario Telemedicine Network)
Expected Client Outcomes

• Improved or stabilized health status
• Significant reduction in ED visits and hospitalizations
• Empowered clients and caregivers with enhanced skills and confidence
• Increased quality of life
• Collaboration with primary care

65% reduction in hospitalization in OTN’s 2007-09 pilot with 813 COPD and Heart Failure patients
Telehomecare Equipment

- Weekly health coaching
- Submits vitals/health responses

**Weekday feeds and alerts**

**Software & Integration RFP**

- Desktop computer
- Monitor

**Patient Device RFP (VoR)**

- Tablet
- BP cuff
- Pulse oximeter
- Scale
THC Nurse’s Role: Monitoring and Coaching

Client Enrolment
- Care plan duration is approximately six months or longer, depending on client needs
- Telehomecare Nurse establishes a care plan based on client goals, PCP data, home assessment and medication

Telehomecare Nurse Monitoring Role
- Contact clients if biometric data or answers to health questions fall out of the range when the care plan was developed
- Work with Most Responsible Provider, Pharmacist and others to decide on appropriate next steps
- Provides regular reports to Most Responsible Provider

Client Care Delivery
- Each weekday, client sends in their biometric data and answers a series of health questions
- Telehomecare Nurse monitors vitals; responds to alerts; teaches and coaches based on client data, expressed goals and needs
- Link clients to community resources, based on their needs
- Ongoing collaboration with client’s primary care providers, to adjust care plan when needed

Telehomecare Nurse Coaching Role
- Telehomecare Nurse works with clients in a series of planned telephone visits, as well as calls the client when data monitoring prompts alerts
- Client is guided to set their own goals and the nurse works to motivate and educate them so that the client applies self management skills

Client Discharge
- Ongoing support from primary care providers and circle of care
- Link clients with community resources related to their condition
Supporting Better Client Outcomes

FOR NURSES
- Facilitate speedier assessment
- Follow up call for additional investigation, Preventative change in management
- Proactive intervention to save client from an unexpected outcome
- Unnecessary visit to hospital and, moreover, improve quality of client’s life, who can be either homebound or complex.

FOR CLINICIANS
- Valuable information for a doctor or NP
- Being more informed in client decision-making
- Facilities the client to be a participant in their own care
- Alerts clinicians to unforeseen needs for treatment interventions and to enable collaborative client-clinician planning for long-term disease management and health maintenance efforts that take place where the client wants to be — at home.
- Enhanced client compliance and more resourceful outreach case management.

FOR CLIENTS
Clients become partners in their own care - right in their own home
- Valuable tools for enhancing care quality in chronic disease management.
- Fewer hospitalizations and emergency visits
- Reduced travel time and cost
- Reduced client primary care utilization,, long-term care home admissions and client morbidity
- Allows clients, families or their support system to increase knowledge on their own condition and become more involved in their own care.
Referral from community
Toronto Central CCAC website

Click “Partners”

Then click “Physicians”

Telehomecare Main Line: 416-217-3841
Opportunities for Collaboration
RRN, THC with GDH Programs

Table Discussion
In what ways can Geriatric Day Hospitals collaborate with RRNP and Telehomecare programs to improve client outcomes and transitions in care?
Questions

Liana Sikharulidze
Liana.Sikharulidze@toronto.ccac-ont.ca

Anne Stephens
anne.stephens@toronto.ccac-ont.ca