Presentation Overview

- About the South West LHIN
- South West LHIN’s Home and Community Care Team
- Connecting Care to Home (CC2H)
- What are patients and providers saying?
- Questions / Comments
About the South West LHIN
Geography and Communities

• The South West LHIN covers a large portion of south western Ontario from Lake Erie to the Bruce Peninsula an area of 21,639 square kilometers. This includes Bruce, Elgin, Grey*, Huron, Middlesex, Norfolk*, Oxford and Perth counties.

*The South West LHIN only covers portions of these counties.

Population:

London – largest urban centre – population 383,822 from 2016 census
You might be interested to learn…

The South West LHIN home and community care team gets more than 60,000 people the care they need per year… that is one in every 17 people.

Home and community care provides more than 2.8 million in-home visits each year.

Each month, the home and community care team:

• helps more than 3,200 patients get from hospital to home
• helps more than 280 patients find a place in a long-term care home
• supports 2,000 children
• provides services to more than 25,000 patients
Home and Community Care:

Care delivery team of the South West LHIN
Accessing home and community care services

- Self referral by patient
- Anyone can make a referral with patient consent
  - Family member or friend
  - Doctor
  - Hospital
- Depending on needs, a Care Coordinator will assess care needs:
  - in the home
  - in the hospital room
  - by telephone
What is a Care Coordinator?

• Care Coordinators are regulated health professionals

• Through personal visits and regular check-ins, they help patients get the right care and support for their needs.

• Care Coordinators will work with a patient and their family to determine what care will best meet a patient's health care needs and personal goals.

• They will also coordinate with a patient’s health care team, which may include family doctors, the hospital, medical specialists, therapists and service providers.
Connecting Care to Home:
Integrated care enabled by technology
Every once in a while, a new technology, an old problem, and a big idea turn into an innovation.

Dean Kamen
The current health care system – not a system

- A patchwork of uncoordinated services...
- Fragmented exchange between patients and families, providers, hospitals and community services
  - Often several providers agencies involved – silos confusing for families
  - Lack of integration within and between hospital, community and primary care (decreased communication)
  - Long Length of Stay/ High Readmission Rates
  - Lack of standards with variations in care
  - Variation in quality and responsiveness
The Case for Change

Health System largely structured to respond

- 70% of Ontario’s seniors have 2 or more chronic conditions
  - Often cycle through Emergency Departments
  - receive care from 5 or more physicians
  - fill prescriptions from 3 or more pharmacies

High Cost less about patient acuity, more about episodic way the health system interacts with these patients

2016 Census:
3.2 Million Ontario Seniors

IN THE NEXT TWO DECADES, THE NUMBER OF ONTARIANS 65 YEARS AND OLDER IS EXPECTED TO DOUBLE,

THE NUMBER OF CENTENARIANS WILL TRIPLE

THE NUMBER OF ADULTS AGED 85 AND OLDER WILL QUADRUPLE.
The Case for Change


Health Links CCP

High

Rising Risk Patients

Low Risk Patients

5% Use 66% of expenditures

18% Escalate Annually

30%

65%

Source: Edington, D. “Lost Productivity – the High Cost of Doing Nothing”, University of Michigan
Clinical Care Team – Collaboration Across Care Settings

**In-Patient:**
- Care Team

**In-Home Team:**
- Directing RN
- Care Technician
- Physiotherapist
- Occupational Therapist
- Respiratory Therapist
- Primary Care Physician

**Bridging Team:**
- Navigator
- Clinical Care Coordinator (RN)
- Patient Care Facilitators (PCF)
  
  *or*
  
  - Nurse Case Managers (NCM)
Connecting Care to Home: COPD

- **Acute**
  - Hospital
  - LOS: 5 Days
  - MRP: Hospital Physician

- **Home**
  - eHomecare
    - Technology Enabled Intervention
    - 24/7 LIVE Answer

- **Self Management**
  - Supported Self Management
  - Case Management
    - 24/7 LIVE Answer
    - TeleHomecare
    - Ambulatory Clinics

- **MRP: Primary Care Physician**
CC2H: A new ‘system approach’

- Shared accountability as patient transitions across care settings
- Integrated care team across hospital, primary care and home care
  - Continuous Physician support/warm handoff of MRP
  - Hospital Navigator and community Clinical Care Coordinator (RN)
  - Sole home care provider
  - Technology enabled intervention model (eShift/eClinic)
- Integrated care pathway for across hospital, home care and patient self-management
- Consistent Education
- Ensure every member of the care team participates – teach, support, reinforce and uses the same material
- 24/7 LIVE answer by Directing RN
CC2H: A new ‘system approach’

- Coordinate and connect providers and services to work together, instead of apart
- Focus on population health *not just episodic care*
- Evidence based – outcome focused
- Shift from responding to exacerbations, to effective monitoring to anticipate and preempt exacerbations
  - Patient Focus: **Chronic Disease: Moderate** with potential to affect trajectory: return to self-management: Starting with COPD, then CHF and expanding to multiple comorbidities
  - In hospital and in home 60 day care plan: ‘Norman’ baseline patient, PDSA approach (started by over-servicing to build system confidence) and Post 60 days: Supported self-management with Tele-Home care and/or ambulatory clinic
- Patient experience and evaluation
Coordinated Care plans are created with direct input from the patient

Pre-discharge telephone conference - ensures communication of patient’s needs and expectations are clear with all members of the patient’s health team

Post-discharge video conference done via OTN
Physician is able to consult with patient through video
All members of CC2H team are present at video conference to discuss patient’s progress and care needs
Virtual Integration across care settings

Hospital Team
- Daily review of dashboard/access to CHRIS
- Video conferences w/patient in the home for warm hand off to PCP

Homecare Technician

Real-time ‘Dashboard’ on demand

Directing RN (remote)

Monitoring & directing by DRN

Care Coordinator

Primary Care enabled to monitor and engage as appropriate.

Primary Care
Real time community bedside data/dashboard

- Real-time, web-based, on-demand
- Quantifiable data measures change in patient status
- Visual history/clinical trends enable ‘predictive’ planning
- Intervention before exacerbation/avoid ED
- Caregiver experience
### 24/7 LIVE Answer Support

**Answered by Directing RN: primary nurse with access to real-time patient record**

- On-demand support for patients and their families
- Directing RN (eHomecare Nurse)
  - Immediate access to specific patient record (avoids collecting information)
  - Knowledge/participation is specific patient’s care
  - Ability to support/reinforce/action self-management strategies
  - Ability to dispatch provider if needed
  - Ability to communicate with physician if needed
- Avoids ED use

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<tr>
<th>Version</th>
<th>Total Calls</th>
<th>Calls Preventing ED Visit</th>
<th>% of Calls Avoiding ED</th>
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<tr>
<td>Norman 2.0</td>
<td>157</td>
<td>28</td>
<td>18%</td>
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<tr>
<td>Norman 3.0</td>
<td>68</td>
<td>10</td>
<td>15%</td>
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<td>Norman 3.1</td>
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<td>10</td>
<td>17%</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>286</strong></td>
<td><strong>48</strong></td>
<td><strong>16.8%</strong></td>
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Physician remote support (Telemedicine)

“Ensure the reliability, quality and timeliness of the patient information obtained via telemedicine is sufficient, and the patient is accurately identified.”

College of Physicians and Surgeons of Ontario Telemedicine Policy #3-14

When a physician can directly access clinical data, knowing the nurse ceases to be the decision point to provide telemedicine.
## Performance Outcomes

<table>
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<tr>
<th></th>
<th>Norman Baseline</th>
<th>Norman 3.1</th>
<th>% Change to baseline</th>
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<tbody>
<tr>
<td>Hospital LOS</td>
<td>8.1 days</td>
<td>3.9 days</td>
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<td>LHIN LOS</td>
<td>150 days</td>
<td>34 days</td>
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<td>30 day Readmission</td>
<td>22.4%</td>
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<td>30 day ED Use CTAS 1</td>
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<td>2.4%</td>
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<td>4%</td>
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<td>-100%</td>
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<td>Hospital Cost (in patient + readmit + ED)</td>
<td>$12,002</td>
<td>$5,048</td>
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<td>LHIN Care Path Cost</td>
<td>$3,275</td>
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<td><strong>TOTAL COST</strong></td>
<td>$15,277</td>
<td>$7,100</td>
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Testimonials from Patients and providers
Providers and patients say…

“It’s great because it really gives the patient that wrap around care. These are typically high needs patients and CC2H helps fill the gaps and makes everyone involved feel supported.”

— London Health Sciences Centre Resident

“Its great being able to see the patient at home. Usually we’re cut off once they’re discharged, but now I can actually see that they’re doing well at home.”

— London Health Sciences Centre Resident

“I have had COPD for 15 years, always nervous when coming home from hospital, this time was so different. My wife and I feel so supported we can relax.”

— Patient
Hugh’s story – after Connecting Care to Home

- Has been smoke free since October 2015
- Respiratory clinical indicators improved from 30% to 42% as of April 2016, and 98% from previous of 75%
- Has been exacerbation free since October 2015
- Going on vacation to visit family. He says, “first time in ages I have been able to feel well enough to get away.”
- Continues to complete his breathing exercises daily. He says, “I don’t even have to think about it anymore, I just do them.”
Critical Success Factors

- Physician participation
  - Continuous MRP (Hospital to Primary Care)
  - Hospital specialist MRP seven days post discharge
  - Virtual rounds using dashboard (dashboard is patient’s proxy)
  - Shift from responding after crisis to anticipate and pre-plan
  - Warm hand-off to primary care on day eight

- Integrated care path and care teams

- Coordinated and integrated patient education

- eHomecare approach
  - Real-time in-home patient data/dashboard (eShift)

- 24/7 LIVE answer support for patient and caregivers
Next Steps

• Analysis of integrated funding model

• Expansion of congestive heart failure within current acute site

• Evaluation of the model after expansion of congestive heart failure

• Expanding to multiple comorbidities, the possibilities are endless, huge mental health challenges and is this a model that can support this population

• Continue to use patient experience to enable model changes

• Enhancing physician’s engagement at all levels
CC2H is the 3M National Quality Team Award Winner 2017