Achieving Excellence Together 2017

Hospital 2 Home (H2H) Integration at the Point of Care

Thursday, June 15\textsuperscript{th}, 2017 (3:45PM - 4:45PM)
Background: Integrated Funding Model

• Hospital 2 Home (H2H): The Central West Integrated Care Model

• Selected as one of six (out of 50) in Ontario to implement innovative approaches to integrate funding over a patient’s episode of care

• Joint initiative of the (former) Central West CCAC, Headwaters Health Care Centre (HHCC) and William Osler Health System (WOHS), working with the Ontario Telemedicine Network (OTN) and supported by the Central West Local Health Integrated Network (CW LHIN)

• Focus on Cellulitis and Urinary Tract Infection (UTI) patients
Key Features of the Program

• **Patient Centred Care:** model was built with patient input at every step

• **24/7 Access to Care:** Phone lines are available 24/7 with a central phone number for patients and caregivers in the community

• **Virtual Care:** will be using OTN virtual technology to strengthen quality of care and overall communication amongst providers

• **Shared Electronic Health Record:** Real-time patient records are available to all members of the team

• **Home Care Model:** Central West LHIN’s Home and Community Care staff provide nursing visits - no third party Service Provider Organization (SPO) involved in this model
Advantages

• **Improved communication** and more seamless discharges from acute care to the community

• **Integrated** interdisciplinary acute and community care teams

• **Direct access** to other community support services (i.e. PT, OT)

• **Model supported and leveraged by non-clinical integrated support services** (i.e. decision support, human resources, finance, etc.) and joint planning initiatives (e.g. quality improvement plans) already in place
Integrated Clinical Pathway

**Inclusion criteria:**
- Diagnosis – Cellulitis or UTI
- Requires short-term community nursing services (less than 60 days)
- 18 years of age or older
- Referral source from Brampton Civic Hospital, Etobicoke General Hospital, Headwaters Health Care Centre

**Exclusion criteria:**
- Active Home and Community Care patient receiving third party nursing at time of referral
- Treatment address is outside of Central West LHIN boundaries
- Patient is ambulatory and can receive treatment in a Central West LHIN Home and Community Care clinic
Critical Components of the Pathway

- Medical Referral
- Intake Assessment and H2H Assignment
- Care Plan and Coordination in Community
- Medications, Supplies & Equipment
- Treatment Completion and Discharge

The H2H team can transition care face to face and/or virtually with patients and families as they are discharged from hospital back into the community.
How did we design our pathway?

• Clinical Working Group

• Non-Clinical Working Groups

• Patient Advisors

• Steering Committee
Patient Involvement

A Patient Advisor was part of our clinical working group and helped co-design the following:

• Model Design
• Pathways
• Pamphlets and Welcome Package
• Home Chart
Patient Enrollment Volumes
(as of April 2017)

→ Total admissions to date: 1075
→ Total in-home visits to date: 10439

Total patients with Cellulitis-414
Total patients with UTI-87
Other diagnosis-574
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<tr>
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<tbody>
<tr>
<td>Average Acute Length of Stay (LOS): hospital admission only</td>
<td>9.1</td>
<td>6.1</td>
<td>3.6</td>
</tr>
<tr>
<td>Average LOS for community care</td>
<td>21.3</td>
<td>12.8</td>
<td>11.6</td>
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<tr>
<td>5 Day Wait time for Nursing for Patients on H2H Program</td>
<td></td>
<td>[Cellulitis: 96.6% UTI: 96.6%]</td>
<td>[99% 100%]</td>
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<td>Proportion of patients whose index event was a hospital admission</td>
<td>21.4%</td>
<td>13.6%</td>
<td>13.2</td>
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<td>Hospital 60 day readmissions</td>
<td>11.5%</td>
<td>10.0%</td>
<td>11.0%</td>
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<td>Average Visits Per Patient During the Episode of Care</td>
<td>13 visits</td>
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<td>8.9</td>
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Quality Improvement Capacity in a Cross-sectoral Environment

- Memorandum of Understanding
- Back-office integration
- Specialized working group(s)
- Leadership Job Shadowing
- Performance dashboard and ongoing reporting
Sustaining Performance

• Weekly Leadership huddles

• Weekly performance dashboard and monitoring

• Clear governance and reporting structures
H2H Video
Patient Experience

H2H is leading the way with patient satisfaction results

Sharing what some H2H patients had to say:

• “I received outstanding care!”

• “My experience was fantastic. Each nurse was extremely knowledgeable and they arrived in the timeframe as promised.”

• “I really appreciate this program. You took the time to talk with my wife and comfort her when I did not know what to say to make her feel better.”

• “You hired the best nurses for the job. They have all been wonderful!”
H2H Leadership

• Clinical Oversight
• Support for staff experience
• Policies & Procedures
• Scheduling
• Supervision & Home visits
• Skills, clinical competencies and scope of practice
• Supplies
• Resource Allocation
• Performance Indicators monitoring
• Risk assessment and quality improvement
Virtual Care

H2H is beginning to utilize OTN to increase effective collaboration, improve access to care and enhance care delivery

• Providers can arrange eVisits with one another and their patients
• Real-time video visits can be conducted on a personal computer, or mobile device
• Work continues to further expand the use of OTN virtual technology within H2H

Anticipated Results:

• Nurses can more easily connect with newly enrolled patients
• Improved care management with convenient and more efficient communications
• Providers have greater access to information, knowledge and mentorship
• Increased patient satisfaction with earlier access to their H2H team
• Increased connection with primary care
Integrated Funding

- **2015/2016** - Bundled carve-out complete; carve out from Home and Community Care resources
- **2016/2017** - Carve-out for bundled payment submitted
- **2017/2018** - Budget for carve-out to be determined
- Back-Office Integration (*e.g.* finance) between (former) CW CCAC, HHCC, WOHS already in place which supports all processes related to bundled payments and risk sharing

**Carve-out submission from partners (CW CCAC, HHCC, Osler) to CW LHIN**

**Funding Letter from CW LHIN to Administrator (Osler)**

**Administrator provides bundled payment to H2H**
Achievements to Date

• Improved key performance metrics

• Direct access to other community support services (i.e. PT, OT)

• Improved communication to Primary Care Providers

• H2H staff has seamless access to patients’ electronic records
Potential for Spread

• Integrated and directly hired staff

• Single point person for care

• One number - 24/7 model of care

• Integrated back office
Questions