Nurses in CCACs: Providing Care and Creating Connections Across Sectors

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Outstanding care – every person, every day
Objective
Learn about the new opportunities for CCACs to address care needs for our most vulnerable patients through the new direct care nursing initiatives.

Agenda
1. Provide background for the new Direct Care Nursing initiatives
2. Explore each Direct Care Nursing initiative – Mental Health and Addictions Nursing (MHAN), Rapid Response Nursing (RRN) and Hospice Palliative Care (HPC) Nurse Practitioners (NP)
3. Review preliminary results
4. Consider Lessons Learned and Next Steps
Recognizing the increasingly complex health-care needs of their patients, Ontario’s 14 CCACs will hire 341 nurses as part of the MOHLTC Action Plan for Health - 9,000 Nurses Commitment

The three programs include:

1. Mental Health and Addiction Nurses in District School Boards
   - 145 Nurses (13 Nurse Leaders, 132 Registered Nurses and Registered Practical Nurses)

2. Rapid Response Nurses
   - 126 Registered Nurses

3. Hospice Palliative Nurse Practitioner
   - 70 Nurse Practitioners
Client Care Model (CCM)

- Focus on monitoring outcomes and enhancing system navigation
- Optimize resources available within the Health Care System - to support system sustainability

Outcome-Based Care

Standards of Care

- Frail Seniors • Palliative Care • COPD • Heart Failure • Stroke
- Primary Care Integration
- Health Links

- Well
- Short-Stay
- Community Independence
- Chronic
- Complex

Focused understanding of care populations and their needs
- Match level of care need with appropriate level of care to optimize outcomes
- Deliver quality care

Rapid Response Nursing

Mental Health & Addiction Nursing

Palliative Nurse Practitioners

Resource and Care Coordination Intensity

Information & Referral

Wound Care • Joint Replacement
Governance Structure

CCAC CEO Council

Ministry Reference Group

Provincial Client Services Committee

Provincial MHAN Working Group

Provincial RRN Working Group

Provincial HPC NP Working Group
Mental Health & Addiction Nurses in District School Boards Program
• Approximately 1 in 5 children and youth in Ontario has a mental health challenge (about 500,000)
• Schools are on the front lines of dealing with mental health and addictions problems among children and youth

Early Identification and Intervention would lead to:
• Improved school achievement
• Better health outcomes
• Cost-savings to the health care & social service systems
• 70% of mental health issues have their onset in childhood and adolescence – can lead to conflicts with family, trouble in school, feelings of isolation

¹Nurses in CCACs: Providing Care and Creating Connections Across Sectors, P. 19
## MHAN Allocation by LHIN

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MHAN - The Journey Ahead

**Provincial MHAN Working Group Initiated**
- April 2012

**Early Communication Tools**
- Provincial and Local Education initiated, collaboration with RNAO
- Documentation Processes Set
- October 2012

**Training for provincial assessment tool: interRAI ChYMH initiated**
- December 2012

**June 2012**
- Reconciliation between MHAN role and other roles from other agencies
- Target Pop/Eligibility Clarified
- Recruitment Process Occurring

**November 2012**
- First CCACs Go LIVE

**April 2013**
- MHAN Go LIVE

**TBD**
- Funding Accountabilities Capabilities
  Measurement & Reporting Processes Confirmed
- BTS in Place

**Ongoing Refinement of MHAN Model**
- June 2013 & Onward
MHAN Program

Provincial Goals

• Identify & Intervene in children and youth mental health needs early
• Increase the amount of professionals able to identify and respond

MHAN Program Goals

• Improve relationships through collaboration with local MH&A partners
• Provide consistent access and coordination of children’s MH&A services

Key Measures for Success

• Decrease inpatient admission rates
• Increased school attendance
• Increased graduation rates
MHAN Role

- **Provides direct clinical care** to students in schools with mental health and addiction issues
- Establishes **effective working relationships through formal partnerships** with District School Boards and Hospitals, Primary Care and other stakeholders to help **build capacity** and **seamlessly transition students back to school**
- Help students and their families/caregivers with **system navigation**; accessing and augmenting appropriate mental health and addiction services where waitlists or gaps are identified
Key Messages

Guiding principles for MHAN implementation:

• Work related to the this collaboration will be linked to and build on local system development work to date

• Where possible, existing structures/forums will be used for planning and implementation

• Stakeholder engagement will be a key element of this initiative

• Planning and implementation will be coordinated and responsive to representatives stakeholder groups

• Each area of work will be informed by the expertise and intelligence inherent in the existing system leadership
Rapid Response Nurse Program

Smoothing Transitions
• Effective transitions between hospital and home are recognized as critical to achieving better patient outcomes and avoiding rehospitalisation.

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

• Hospital readmission rates for COPD / HF ~30%

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

¹Nurses in CCACs: Providing Care and Creating Connections Across Sectors, P. 4
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RRNP - The Journey Ahead

Provincial RRNP Working Group Initiated
October 2012
- RRNP Role Defined
- Scheduling Model Set
- Relationships Clarified
- Common Equipment Determined
- Intake/Screening Processes Defined
- Stakeholder Engagement Planned

Goal & Objectives Refined
RRNP Model Developed
Target Pop/Eligibility Clarified
Recruitment Process Occurring
Work Streams Established
November 2012

Communication Plan Confirmed
Policy/Procedures Gaps Addressed
Documentation Processes Set
Training/Orientation Plan
January 2013

Clinical Supervision Processes Set
Alignment with CCM Determined
February 2012

RRNP Go LIVE
March 2013

Ongoing Refinement of RRNP Model
June 2013 & Onward
- Funding Accountabilities Capabilities
- Measurement & Reporting Processes Confirmed
- BTS in Place

TBD
RRN Program

Provincial RRN Goal

• Reduce rehospitalisation and avoidable emergency department visits by smoothing and improving the quality of transitions from acute care to home care for patients with complex clinical needs.

Provincial RRN Target Population

• Frail adults and seniors who are medically complex or have chronic diseases that tend towards frequent hospitalization, unstable health and costly treatments
• Medically complex/vulnerable children, and their families

Key Performance Measures for Success

• Reduce rehospitalisation and avoidable emergency department visits
• Provide in-home visits within 24 hours of hospital discharge
• Improve primary care provider contacts and first appointments for patients within one week of hospital discharge
Target Population - Complex and Chronic Using CCM:
* Medically complex/vulnerable children, and their families
* Frail adults and seniors that are medically complex or have chronic diseases that tend towards frequent hospitalization, unstable health and costly treatments, including: CHF, COPD, Diabetes, Other Ambulatory Sensitive Conditions
First visit within 24 hours at a time when caregiver available

Conduct clinical problem-based assessment

Use “teach back” approach to provide education about care plan, treatment, symptom management, and when/who to ask for help

Perform medication reconciliation

Confirm and arrange for follow-up tests

Follow-up visit/phone call to provide further assessment or address ongoing medication issues

Arrange follow-up appointment within 7 days of hospital discharge
Hospice Palliative Care Nurse Practitioner Program
Hospice Palliative Care (HPC) is a philosophy of care that aims to relieve suffering and improve the quality of living and dying.

Only 10% of people die suddenly while the remaining 90% will require assistance and support at some point in their lives. Recent polls suggest that 70-80% of people would prefer to die at home, yet 66% of Ontarians die in hospitals.

Interdisciplinary care is the identified standard of HPC. There are a variety of models, one common element is the importance of a direct link between the home care team and the PCP.

Benefits of in-home HPC services include decreased use of acute care services, improved patient care, and lower costs.

1Nurses in CCACs: Providing Care and Creating Connections Across Sectors, P. 4
## HPC NP Allocation by LHIN

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HPC NP Program
High Level Work Plan (Phase 1)

- Target Pop/Eligibility Clarified
- NP Roles & Responsibilities Defined
- Role Clarification Defined
- HPC NP Model of Care Designed
  - Program Phasing Defined

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<td>Common Program Elements Identified</td>
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HPC NP Program

Provincial HPC NP Goal

• Working within an inter-professional Team, the NP will act as a bridge to support hospice palliative care (HPC) patients who have life-limiting illness by:
  • Enhancing quality of HPC
  • Reduce hospitalization and avoidable emergency department visits
  • Supporting patients in dying in their place of choice
  • Strengthening capacity of Primary Care Providers to provide HPC

Provincial HPC NP Target Population

• Adults and Children with hospice palliative care needs who can be identified using 3 triggers:
  • The Surprise Question
  • Choice Need – patient makes a choice for comfort care only
  • Clinical Indicators – patient with cancer, organ failure, elderly with frailty, stroke, dementia

Key Performance Measures for Success

• Improved pain and symptom management
• Reduced rehospitalisation and avoidable emergency department visits
• Dying in place of choice
• Improved Patient/caregiver experience
HPC NP Model of Care

Referral Sources
- Hospital
- PCP/Specialist Physicians
- HPC Teams

Intake & Referral

Service Planning & System Navigation
- Most Responsible PCP/Specialist Physician
- Patient/Caregiver Support to Die in their Place of Choice
- Acute/Specialized HPC Teams
- HPC Community Teams

Hospice Palliative Care (HPC) Integrated Team

HPC NP Role
- Collaborates in service planning
- Provides Direct Clinical Care
- Contributes to the local response to urgent patient situations
- Supports Care with the Most Responsible PCP/specialist physician
- Develops effective partnerships/shared care models with PCP
- Coordinates access to specialized HPC/acute care
- Ensures coordinated exchange of clinical information

Target Population – Complex and Chronic - Adults, Seniors and Children with HPC needs who can be identified using 3 triggers:
- The Surprise Question: Not ‘surprised’ if patient dies within 6-12 months?
- Choice/Need:
  1) Patient makes a choice for comfort care only;
  2) Possible need with advanced illness and unmanaged symptoms not yet diagnosed
- Clinical Indicators – cancer, organ failure, elderly with frailty, stroke, dementia
• **Collaborates** with the CCAC Care Coordinator in service planning

• **Provides** **Direct Clinical Care**
  - Advanced comprehensive and problem focused assessment
  - Order appropriate screening and diagnostic investigations
  - Provide health care management and therapeutic intervention
  - Applies knowledge of pharmacology in selecting, prescribing, monitoring and dispensing drugs
  - Initiate interventions to stabilize patients in urgent or emergent situations as part of an integrated HPC team
  - Provides where necessary, advance care planning;
  - Facilitates direct admissions to hospital or hospice when it is the choice of the patient;
  - Facilitate a plan of care for expected death that may include signing the Certificate of Death.
NP Role – Hospice Palliative Care

• **Supports continuity of care** with the Most Responsible Primary Care Provider

• Establishes **effective working relationships through formal partnerships or shared care arrangements** with a broad range of primary care providers

• **Builds capacity** within the primary care sector in best practice HPC using knowledge transfer approaches, research, and leadership opportunities

• Works with the primary care providers and the HPC Integrated Team to **coordinate access to specialized HPC and, when needed, acute care services.**

• Ensures the **coordinated exchange of information** across primary care, acute care, and specialized care providers with other members of the individual’s integrated healthcare team
Preliminary Provincial Data
Mental Health & Addictions Program **LIVE** in all 14 CCACs as of March 2013

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Rapid Response Nursing Program **LIVE** in all 14 CCACs as of April 2013

RRNs Hired as of May 2013 - **114 of 126 RRNs** (Still Hiring for Pediatric Positions)

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<td>Average # of RRN Visits per Patient</td>
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Implementation Lessons
Key Lessons

• **Strategic governance is essential** and requires Senior Director leadership and broad engagement of CCACs

• **Investment in resources** for planning will result in effective and timely implementation

• **Meaningful connections** through Face to Face meetings early in the process foster working group cohesiveness to build consistency across programs

• **Early stakeholder engagement is key** – LHINs, hospitals, primary care providers, pharmacists, CSS, district school boards

• **Effective Communication Plan** is necessary to support consistent community messaging about new programs

• **Education/networking opportunities are important** for consistent role development and knowledge translation

• **Technology opportunities need to be leveraged** to promote efficiencies and performance measurement
Next Steps

- Continue to **refine direct care nursing initiative program designs** using quality improvement approaches
  - RRN phase 2 and phase 3 to be completed by September and November 2013 respectively
  - HPC NP initiative to go LIVE in July 2013
- Finalize **performance measurement and monitoring processes**
- Continue with the **development of appropriate policies and procedures** to support practice
- **Consider Professional Practice Framework** for Direct Clinical Programs
  - Clinical Supervision
  - Clinical Practice
  - Education plan
Outstanding care – every person, every day