Waterloo Wellington LHIN

CPRPM / THC+
A True
Integrated Care Model

October 2019

Ontario
Local Health Integration Network

Guelph Wellington Overview

City of Guelph

- Urban area with 135,000+ residents
- Served by 1 hospital, 2 FHTs
- Large majority of Primary Care Physicians (PCP) provide services via FHT set up
- Limited Walk-In Clinic access

County of Wellington

- Rural area with 91,000 residents
- Served by 3 hospitals within borders, 2 hospitals outside borders, and 4 FHTs
- Large majority of Primary Care Physicians provide access via FHT set up, and staff local EDs
- Very limited Walk-In Clinic access

Region of Waterloo
Community Paramedicine Program

- 556,000 population of urban & rural mix
  (2016 census)
- Includes Cambridge, Kitchener and Waterloo plus 5 townships
- 3 acute care hospitals with St. Mary's Hospital as the Regional Cardiac Centre
- THC^{+} Intake from RRN, CP and Paramedic Referrals

Success Stories

Story 1

- *80 y/o M develops chest pain @ 4am. Takes multiple vital signs.*
- *CP reviews alerts at 8am with immediate phone call to patient and RRN that HR was mid 30s (abnormal for this patient).*
- *Patient refuses 911 multiple times, chest pains resolved. PCP notified.*
- *CP arrives at patient's home by 9am, assessment completed including 12 leads – determines HR now in mid-20s, without symptoms. Further consult with RRN and PCP.*
- *By 10am 911 is activated by CP. Transferred to local, then regional hospital for pacemaker implantation.*

Success Stories

Story 2

- *80y/o F presents to CP@Clinic with c/o SOBOE, increased phlegm, lethargy, and weakness. SpO2 lower than normal, but still within range*
- *Mobility already an issue, lives in a rural area*
- *Patient also on THC+. RRN contacted for assessment and intervention*
- *Main RRN on holidays, back up RRN contacted and responded*
- *RRN visited, identifies possible COPD exacerbation or infection*
- *PCP makes prescription adjustments based on RRN and CP findings*

Success Story → THC 50 81 y/o

- Palpations with exertion; not captured on ECG
- Non-compliant with medications
- CP Home Visit captured uncontrolled A-Fib
- High HR alert sent to CP phone while CP nearby and found in uncontrolled A-Fib >140 bpm
- Transported to ED via PSV, cardioverted and discharged home
- Now managing well with medication changes & compliance

Success Story → THC 25 73 y/o

- +++ endurance issues, impaired respiratory status, extensive fluid retention, pitting edema to both lower extremities (foot to abdomen)
- Comorbidities of cardiac, renal impairment and arthritis
- RRN/CP provided focus & encouragement to comply with medications and incremental physical activity
- Exacerbations were kept controlled through phone and home visit monitoring
- Significant weight decrease and fluid maintenance
- Daily physical activity and improved independence

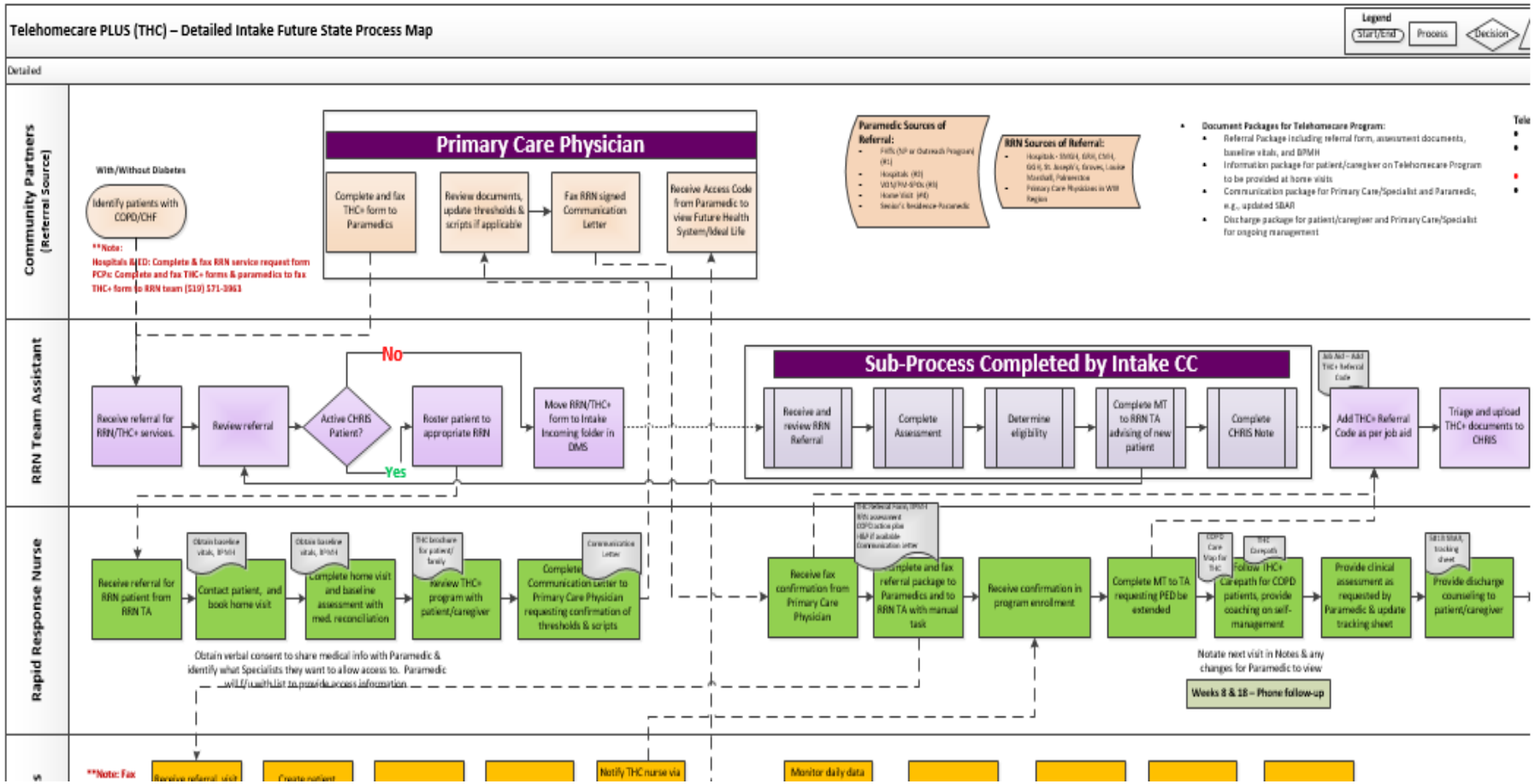
Opportunities

- Further education on chronic disease management
- Integration with discharge planning
- Enhanced communication between agencies
- Streamlined documentation processes
- Scale and capacity
- Enhanced Primary Care participation
- Length of stay
- Funding
- Virtual Care enhancements

Wrap Around Model

- Teamed CPRPM with 6 Rapid Response Nurses (RRN) have teamed with CPRPM team to:
  - Also identify patients for program through hospital or Home care or Primary Care
  - Include the coaching of disease management and additional 3 visits over the 6 month program by the nurse
  - Regular chronic rounds of combined team to support each other, prioritize limited onboarding, solve patient issues
  - Include additional services (primary care attachment, home care services, community services)
  - Build the collaboration as an integrated team

Integrated Chronic Care Process



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Components of Telehomecare Carepath

Telehomecare Carepath: Once enrolled into Telehomecare PLUS, each patient will receive a total of 5* planned home assessments and 2 planned phone assessments. The first* home visit is a face-to-face full assessment completed by the Telehomecare (THC) nurse who provides information on the THC program including brochures, obtains consent from patient/caregiver and faxes completed THC referral package to Paramedics. The Telehomecare Carepath is initiated after patient enrolment to the THC program including set up of devices. The THC nurse is identified as the primary contact for communication between the THC partners. Paramedics will complete equipment set up and IdealLife profile. Prior to each planned home visit, the THC nurse is responsible to review patient data and notes added in CHRIS and IdealLife. Any unplanned visits or phone calls outside of the carepath are as determined by THC nurse and Paramedics based on clinical review of data and alert generated.

Note: If patient's clinical needs require extension of THC program beyond 24 weeks, it is recommended that the nurse, in partnership with Paramedics, will coordinate home/phone assessments at every 4-week interval based on patient's needs.

Designated Telehomecare Nurse Carepath						
*Baseline Home Visit	Week 1 (Home Visit)	Week 4 (Home Visit)	Week 8 (Phone Call)	Weeks 12 (Home Visit)	Week 18 (Phone Call)	Week 24 (Home Visit)
	Post Equipment Set-up	Interim				Transition / Pre-Discharge
Interventions	• Assess and identify patient-specific CHF risk factors (e.g. medication compliance/smoking history/alcohol consumption), assess readiness for patient change & engage in self-management techniques. See Caremap • Respond to patient data reading notifications on an as-needed basis providing technical or clinical response if required. • As per the patient status needs, initiate weekly or more frequent data and notes review Ideal Life and CHRIS Systems. • Provide patient/caregiver with education utilizing best practice, i.e., teach back to support planning to minimize risk and manage crises	• Review weekly patient data and notes to identify trends; • Ensure information sharing of patient's overall status and care needs with circle of care • Provide patient/caregiver with education utilizing best practice, i.e., teach back to support self-management of chronic disease and manage crises • Re-assess and evaluate overall patient care plan (CHF action plan) • Follow up on any identified caregiver issues • Provide clinical response through home visits/telephone call to investigate notifications • Facilitate referrals to community supports/resources &	• Assess and identify patient-specific CHF risk factors • Continue to review patient data weekly to identify trends/patterns • Continue to provide patient/caregiver with education to support self-management of chronic disease and manage crises • Schedule Week 12 home visit	• Continue to review patient data weekly to identify trends/patterns • Continue to provide patient/caregiver with education to support self-management of chronic disease and manage crises • Provide clinical response through home visits/telephone call to investigate notifications • Update patient overall care plan in accordance with notifications and education needs • Initiate community referral(s), as appropriate. - ongoing • Schedule week 18 phone call with patient/caregiver • Assess client's willingness to continue with program if compliance issues	• Assess and identify patient-specific CHF risk factors • Continue to review patient data weekly to identify trends/patterns • Continue to provide patient/caregiver with education to support self-management of chronic disease and manage crises • Schedule discharge home visit	• Investigate patient progress and review data trends • Evaluate and facilitate need for ongoing telehomecare monitoring beyond carepath • Update patient overall care plan as needed • Establish discharge/ transition plan in coordination with patient, family and primary care • Follow up on any outstanding referral(s), as appropriate o Other community supports • Discharge from THC program • If patient is actively receiving WWLHIN services, notify Community Care Coordinator – TA's • Evaluate and facilitate need for ongoing

Next Steps

- Review and inclusion of Patient Experience and Outcome measures (PREM / PROM) to hear the patient voice
- Transition of chronic patients to a Palliative Approach to Care with Palliative Team and workflow process
- Sustainable funding and expansion – there is a wait list
- Identified by OHTs to use as solution for chronic disease management and inclusion of Diabetes patients