Canadian Home Care Association

High Impact Practices

www.cdnhomecare.ca

Partnering for Patients

A partnership that brings care closer to home

About High Impact Practices

The Canadian Home Care Association (CHCA), as a national voice, promotes excellence in home care through leadership, awareness and knowledge to shape strategic directions. The Association is committed to facilitating continuous learning and development throughout the home care sector to support and promote innovative and effective practices across Canada.

During the CHCA's annual Home Care Summit, health care leaders from across Canada and abroad share new and emerging approaches to home care and engage in dialogue about their experiences so that leading practices from across the country and, around the world, can be examined and adopted. Every year there are initiatives that stand out – those that clearly will impact the health care system. The potential of these practices is such that home care stakeholders want to hear more and are eager to explore the applicability within their respective jurisdictions. Building on the momentum of the Home Care Summits and recognizing the potential "ripple effect" of expanding the dissemination beyond the Summit participants, the CHCA has undertaken to document and publicize a selection of these innovative practices from across the country as High Impact Practices.

EACH OF THE HIGH IMPACT PRACTICES:

- **Promotes** home care that provides evidence-informed service delivery directed toward the achievement of health outcomes in the settings that best support the individual, and family
- **Enhances** the effectiveness of home care
- **Raises the awareness** of the ways that home care contributes to an effective health care system
- **Mitigates** rising health care costs and accentuates existing resources and expertise
- **Enables sharing** and transferring of knowledge, expertise and experience through networking and peer-to-peer learning.

Thank-you to our High Impact Practices Partner…

The Canadian Home Care Association gratefully acknowledges the funding from Health Canada which enabled the execution and completion of this High Impact Practice. Health Canada is the Federal department responsible for helping Canadians maintain and improve their health, while respecting individual choices and circumstances.

The views expressed herein do not necessarily represent the views of Health Canada.

Health Canada Santé Canada

Partnering for Patients

Summary

Presented by representatives from the David Thompson Health Region (DTHR) Home Care Program and the Red Deer Regional Hospital Emergency Department in Alberta[1], this pilot project demonstrated the value of a strengthened relationship between home care and the emergency department.

The goal of the *Partnering for Patients* program was to enhance the integration of care between the community and the acute care sector in order to avoid unnecessary emergency department visits, repeat visits and hospital admissions. Admission to hospital can lead to numerous secondary health effects, especially for the elderly. The home care and emergency staff recognized that many patients presenting in the department could be best served in the community and that with an intensive effort to educate staff and patients, the burden of inappropriate demand on the emergency department could be ameliorated.

The *Partnering for Patients* pilot project involved the placement of a home care case coordinator from the David Thompson Health Region home care program in the Red Deer Regional Hospital emergency department in order to facilitate seamless coordination between the two organizations. Within four weeks the benefits of a home care case coordinator in the emergency department were evident. Through this project, home care was able to safely discharge 46% of the patients they assessed, including some who were admitted in the ER; potential admissions and general patients.

Emergency staff acquired a better understanding of the capacity of the home care team and conversely home care clients became aware of the need to not use the Emergency Department as their first option for problem solving (the need to contact a case coordinator or family physician before proceeding to the emergency was affirmed). Most importantly, patients benefited from a team approach to determining the most appropriate setting of care to address their needs.

David Thompson Health Region

David Thompson Health Region (DTHR) is one of nine health regions in Alberta. The third largest health region by population, the DTHR serves nearly 300,000 residents, covers 60 thousand sq. km of territory and employs over 8,000 staff.

Home care services are a component of the Region's Community Care Program which serves clients of all ages who require assistance to meet their health care needs, to maintain their health and independence, or to make the transition between hospital and community. Services are based on an assessment by a registered nurse. The nurse coordinates the care and makes referrals to other services such as counseling and rehabilitation. Services may include short-term treatment for clients with acute needs, long-term assistance for individuals with ongoing needs and palliative care for individuals requiring end-of-life care. Most clients have services provided in their homes but service may be provided in supportive housing locations, schools, hospitals, continuing care centres or clinics.

Each hospital in the DTHR provides or has access to 24-hour emergency care, ambulances, inpatient and outpatient surgery, general medicine, obstetrics, pediatrics, palliative care, rehabilitation services, radiology, laboratory and diagnostics.

For more information on DTHR, visit: **http://www.dthr.ab.ca/index.htm**

Special thanks to the following individuals who provided advice, answered our questions and reviewed this paper:

Gwen Doran, RN, Home Care Case Coordinator, David Thompson Health Region
Valerie Potts, RN, BN, Case Manager Emergency Department, Clinical Resource Management, Department of the Vice President of Medicine, Red Deer Regional Hospital, David Thompson Health Region

Project Background

Emergency department overcrowding has been defined as "a situation in which the demand for emergency services exceeds the ability of an (emergency) department to provide quality care within acceptable time frames".[2] Emergency department overcrowding is a national concern and reflects system-wide problems that require system-wide solutions. The main overarching causes of over-crowding are twofold: a lack of bed availability, and a lack of integration between community and hospital healthcare resources.[3] A well resourced home and community care system for patients, particularly those with chronic diseases, helps to avoid unnecessary emergency room visits and hospital admissions and helps to keep discharged patients from returning to hospital. In this manner, inpatient resources can be used more efficiently and patients can receive appropriate quality care.[4]

Red Deer Regional Hospital ED averages:

- 60,000 visits yearly
- 165 visits per day
- 21.3 patients are admitted per day through the ED and of these patients, approximately 58% are medical admissions[5]

(2004)

As in many hospitals across the country, Red Deer Regional Hospital Emergency Department (ED) needed to address overcrowding and excessive wait times for inpatient beds. Improving the integration with the community system was one strategy that was undertaken as it was identified that patients could be cared for at home rather than be admitted to emergency. On average more than 65% of the medical admissions processed through the ED are over the age of 65 years making it imperative to provide the necessary services and supports to keep these patients at home and avoid the potential for adverse outcomes (e.g. infection, declining mobility, impaired quality of life, readmission, death) that often occurs when older adults are hospitalized.

It was believed that home care could play an important role in averting patient trips to the ED, avoiding hospital admissions, and expediting discharge from the in-patient units. In so doing in-patient beds could be reserved for those with the greatest need - ultimately securing the right service for the right person at the right time; and alleviating the pressure in the ED.

Within the DTHR, the hospital and home care sectors had worked well together serving a common patient population, but, as in many jurisdictions across Canada, had essentially functioned as separate entities. Communication and collaboration needed to be enhanced and the partners recognized the need to work together to improve delivery of heathcare. Assigning a home care case manager (case coordinator) to the emergency department would provide patients with case management support to access home and community care services and ensure follow-up with their primary care team. The home care case coordinator would facilitate discharge to the appropriate setting in the community and would ensure that community care providers are given all the necessary information about the patient in an accurate and timely manner.

The concept of case management is integral to the home care system. 'Case managers' (also known as community care coordinators) are the individuals who are primarily responsible for the case management function within the home care sector. By drawing on clinical reasoning and mutual understanding of client needs and available resources, the home care case manager in partnership with emergency department staff can effectively assist patients to determine the most appropriate intervention and guide them to the ED only when an emergency exists that cannot be resolved by the primary care resources in the community.

The CHCA defines case management as "a collaborative client-driven strategy for the provision of quality health and support services through the effective and efficient use of resources in order to support the client's achievement of goals."

(CHCA, 2005)

Expanding the approach to case management beyond the functions of an individual job and viewing case management as a strategy for health systems integration enables health care sectors to realize the true value of this important function.

Implementation

The DTHR home care program assigned a case coordinator to the Red Deer ED five days per week from 0800 to 1630. This schedule aligned with the availability of the Region's community resources and allowed the care coordinator to assess those patients held in ED overnight (some patients were held overnight to see the home care nurse others were admitted but no inpatient beds available so home care was able to see those patients too). The assignment was a six week trial from end of February to early April 2004.

"The Home Care Nurse was very resourceful and knew exactly what she could tap into to help support patient and family at home."

~ *Emergency Staff*

The home care coordinator worked with the ED team evaluating service needs for patients pending admission and for the general patient population in the emergency. The coordinator conducted home care assessments using an abbreviated assessment tool that incorporated components of the CAAT[6] and the Regina Risk Indicator Tool (RRIT).[7] The abbreviated tool facilitated the case coordinator's ability to quickly determine the best disposition for the patient – admission to the hospital; home with home care services; placement in a long-term care facility - either for short term care or for permanent residency.

DTHR Home Care Program

Provides

- support to remain independent
- services at home
- services in the community
- communication that will support the client's care needs
- information and right to make own care decisions

Promotes

- well-being, dignity and independence
- quality of life

The home care case coordinator discussed a plan of care for those patients identified as candidates for home care with the ED physician, staff, patient and family and determined whether it was safe to discharge to the community. Those identified for home care services were referred to the appropriate community based program in the region and, as the Red Deer home care program staff is aligned with family physicians, the primary team received timely communication regarding the trip to the emergency.

The case coordinator also visited with general patients in the ED using the opportunity to educate about home care in general and identifying for the ED team where home care could be effective.

Key Success Factors

- Experienced home care case coordinator with knowledge and accessibility to all available home care services in the community
- Professional autonomy allowing the case coordinator the ability to make placement recommendations
- Flexibility to increase service on a short term basis in order to avoid hospital admission
- Openness and receptivity of the ED staff to the case coordinator in the department
- Effective communication amongst the entire health care team
- Adequate front line staff to provide care for patients at home on short notice

Evaluation

Although the timeframe for the pilot was short, it was clear that the integration of home care services with the emergency department yielded benefits – for the ED, the staff and the patient and the home care program. A number of admissions were avoided and both emergency staff and home care personnel strengthened their working relationships. By focusing on that which is "best for the patient" the partners were able to immediately begin exploring how best to use their respective expertise.

"Not only were patients able to avoid admission but could leave the ER knowing that better plans and resources were in place for them."

~ *Emergency Staff*

Findings

Over the six weeks of the pilot 268 patients were assessed in the ED by the case coordinator. Almost half (46 percent or 124 individuals) of these patients

avoided admission to the acute care facility and were placed onto the home care program. Discharge was achieved for patients "admitted" to the ED; for "potential admissions" and for general patients in the department.

Of the 268 patients assessed by the home care case coordinator, 115 were classified as ED admissions awaiting an acute care bed. Home care services were arranged for 38 of these patients thereby canceling the admission plan. 93 patients (of the 268) were considered "potential admissions" and subsequent to a home care assessment and consultation with the ED team, 32 were discharged to home care. 60 general emergency patients were assessed, with 54 of them being discharged home on home care services, many of them on 'short term home care' for intravenous therapy, or wound care.

	Total Seen by Home Care	Discharged to Home Care after Case Coordinator Assessment
Admitted to ED	115	38
Potential for Admission	93	32
General ED Patients	60	54
Total	268	124

The DTHR home care program saw an increase in its general patient population as a result of the emergency team's increased awareness. While able to accommodate the increased demand through the pilot, the project participants recognized a need to plan for an expanded home care program with the continuation of the pilot. Since the completion of the *Partnering for Patients* pilot project, referrals to the home care program from the ED have remained higher demonstrating the effectiveness of the model and the integrating approach to health care in the DTHR.

Outcomes

The presence of the home care coordinator in the ED heightened the staff's awareness and understanding of home care services as an effective care option for patients. This is reflected in more appropriate referrals to home care and better utilization of limited ED resources. Stronger linkages and increased communication between the home care and acute care sectors has enabled staff to proactively respond to patient needs and optimize health care services.

Current planning is to have a full time home care case coordinator assigned to the Red Deer Regional Hospital Emergency Department. There are plans to conduct a comprehensive evaluation of outcomes; develop tools that support consistent and predictable approaches to patients; and process mapping in order to identify and enhance the efficiency of service delivery by the ED/home care team. It is predicted that improved outcomes and increased demand for home care will necessitate increased coverage in the ED and greater access to home care.[8]

Conclusion

The results of the *Partnering for Patients* pilot project demonstrate that the case coordinator plays a critical role in facilitating discharges into the community by finding the appropriate setting (home or an alternate level of care facility) and ensuring that community care providers are given all the necessary information about the patient in an accurate and timely manner. Consequently, home and community services and emergency department services are utilized more effectively and appropriately.

"Having an experienced home-care nurse in the ER allowed us to access resources in the community and avoid admissions."

~ *Emergency Department Physician*

Home care programs need to expand their role and scope across system boundaries to provide the knowledge and services required for patients to minimize emergency visits for non-urgent care. The *Partnering for Patients* participants believe that by integrating home care services with emergency departments throughout the DTHR, there could be a significant impact on the utilization of the emergency departments and patient satisfaction.

Home care has a significant role to play in reducing emergency department overcrowding and enhancing patient access to care through: increased hospital avoidance by patients; increased timely discharge of patients; and increased community provision of certain health care services which do not require admission to hospital. More importantly, the involvement of home care staff with the health care team stimulates communication and collaboration and helps to ensure the effective integration of care across the many facets of the health care system.

It is important to measure the degree of hospital diversion resulting from an enhanced home care program. Indicators such as the number of home care referrals from inpatient units, as well as the ED, and the ED return rate are instructive. However, integration of care will be truly reflected by the extent to which the team is collaborating in order to enable consistent and sustained care management across the continuum and achieve utilization of the most appropriate service at the right time.

For more information on the CHCA's High Impact Practices and other initiatives, visit **www.cdnhomecare.ca**

The CHCA defines home care as an array of services, provided in the home and community setting, that encompass health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration and support for the informal (family) caregiver.

End Notes:

[1] Presentation at the CHCA 2006 Home Care Summit by Gwen Doran, RN Home Care Case Coordinator, David Thompson Health Region; Valerie Potts, RN, BN, Case Manager Emergency Department, Clinical Resource Management, Department of the Vice President of Medicine, Red Deer Regional Hospital, David Thompson Health Region

[2] Canadian Association of Emergency Physicians and National Emergency Nurses Affiliation, Joint Position Statement. Access to acute care in the setting of emergency department overcrowding. Can J Emerg Med 2003; 5(2): 81-6.

[3] Report of the Physician Hospital Care Committee, a Tripartite Committee of the Ontario Hospital Association, the Ontario Medical Association and the Ontario Ministry of Health and Long-Term Care. Improving Access to Emergency Care: Addressing System Issues, August 2006

[4] Ibid

[5] Data from the Red Deer Regional Hospital Emergency Department statistics in the period immediately preceding the pilot.

[6] CAAT - – Community Assessment Access Tool – an assessment tool used by some home care programs

[7] An assessment tool used by home care programs to gather demographic and health information on patients

[8] The home care program is open for new admissions Monday to Friday 0800-1700 hrs. Evening access is for existing patients and/or those on home parenteral therapy.

Canadian Home Care Association
canadienne de soins et services à domicile

© The Canadian Home Care Association, August 2007.
www.cdnhomecare.ca

The use of any part of this publication reproduced, stored in a retrieval system, or transmitted in any other form or by any means, electronic, mechanical, photocopying, recording or otherwise, without proper written permission of the publisher and editors is an infringement of the copyright law.