The story of 463 Patients
The Nurse Debbie Experience

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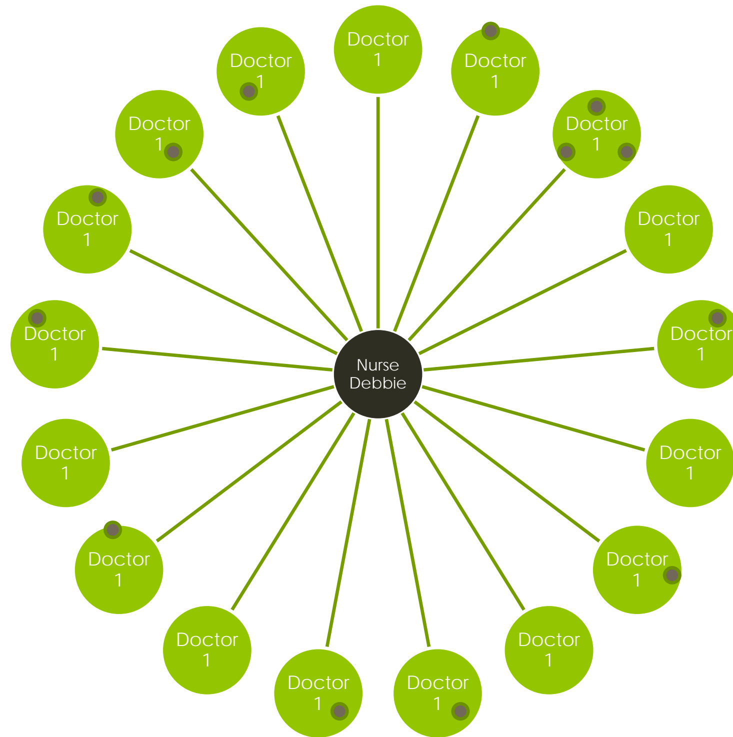
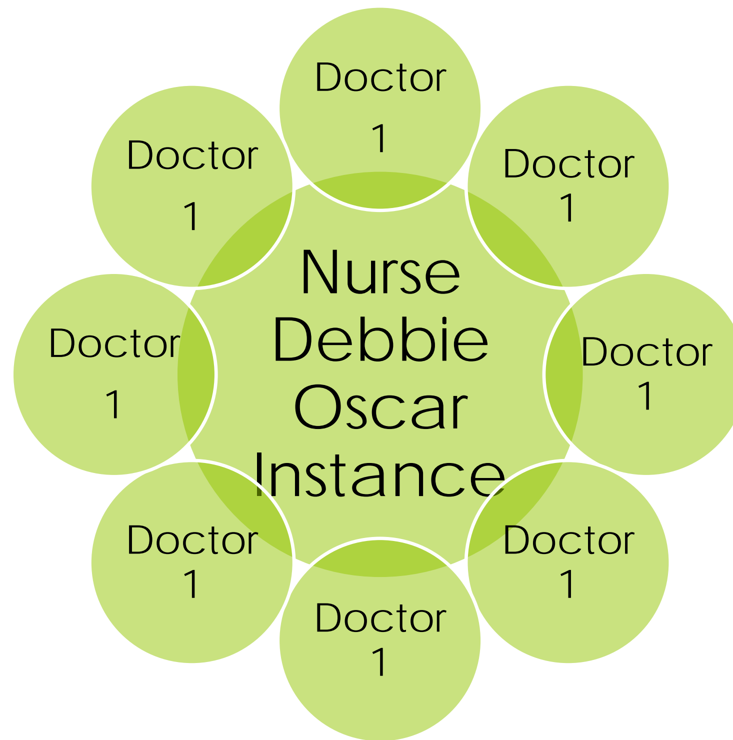
Sunshiners Frail Seniors Project DNW

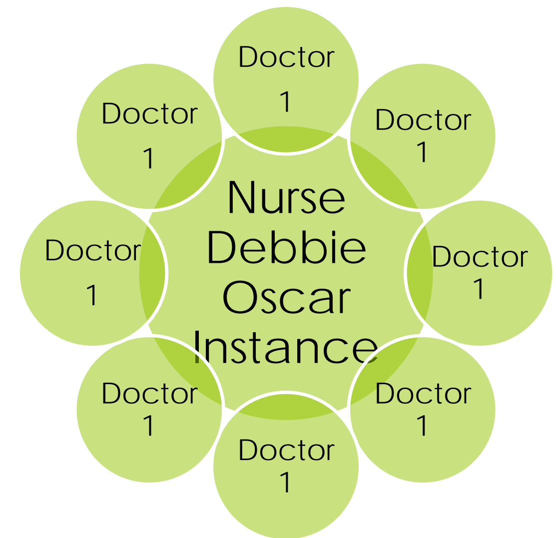


Technology infrastructure



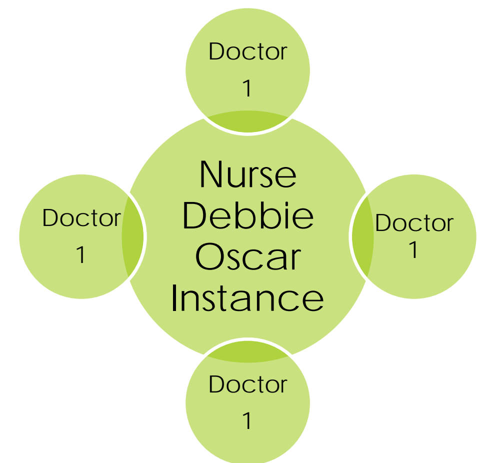
Technology How??

- PIA Completed by Doctors of BC
- Nurse Debbie and Physician team can see charting in real time in their EMR



Who are the patients

- At this time 463 Patients have been enrolled into the sunshiners network
  - They are a combination of homebound or quite frail seniors that needed additional care to remain safely in the community



How has this small change impacted the patients and families

- Patients can safely remain in the community longer
- They can avoid hospital stays that are not necessary
- They can receive services without ED visits
- They can be assessed sooner and emergent care provided
- The physician can have real time access to service provision

How will this model Transform Health Care in the System

- FH has trained nurse debbie in the community case management functions
- Cohorts of patients that would benefit from this type of care will be identified together with the division and replications of this model will be put into place.
- Familiar Faces

How do we know that this works

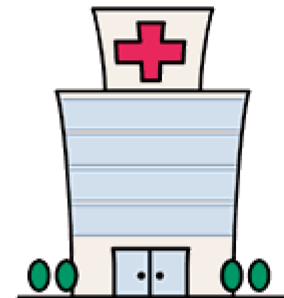
- Administrative data was used to define the pre-Nurse Debbie patient baseline for 365 days
- Post intervention data was collected for the next 365 days

Acute Care Utilization Data

- Year 2 data was astounding

- 500 ED visits averted
- 17000 inpatient days saved

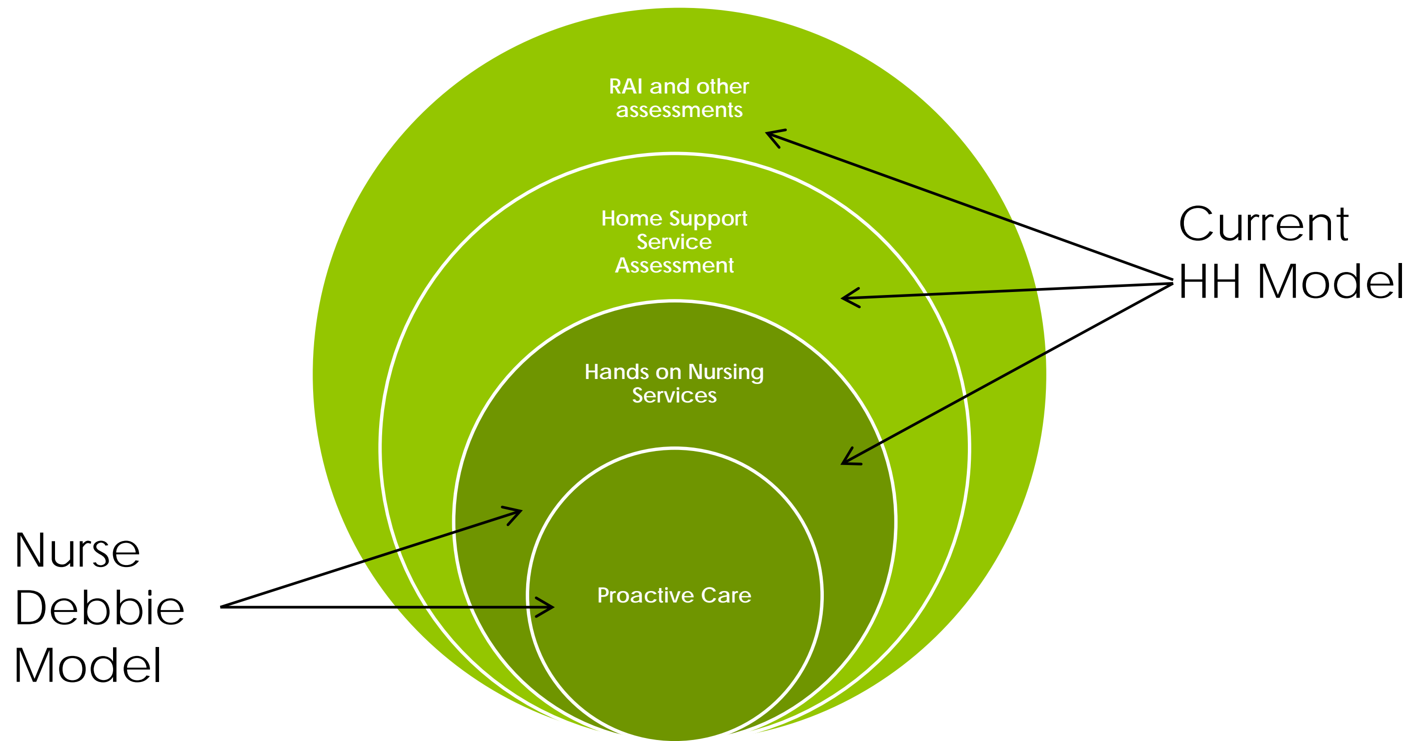
- And that was just 463 patients



So now what

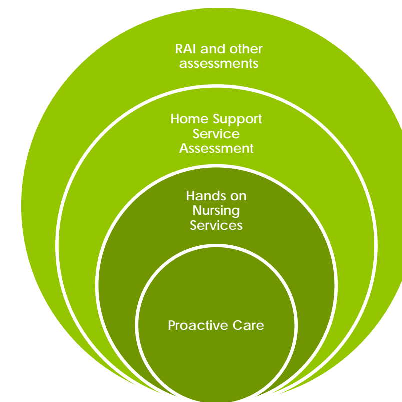
- Now we had to figure out how to change the system to allow for this model of care with the incorporation of all of the other services that needed to be provided in the context of a traditional Home Health Service Model.

What did we need to bundle



Current system of Care

- We examined the current system next.
- Each referral had 68 steps for service provision
- There was no communication with primary care
- Nurses either did assessment or care provision not both
- There were +++ resources in hospital aimed at community care that were disconnected from both the physicians and community teams



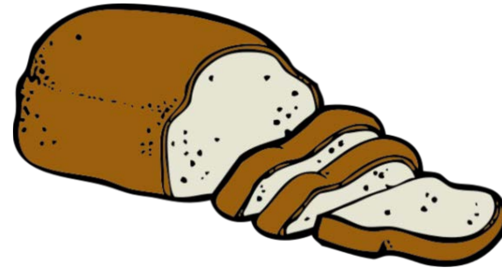
SIMPLIFICATION!!!!

- There were over 100 forms and documents to complete per client
- Over half were to communicate with physicians
- We removed 90% of the paper and process overhead

One Nurse Model

- A new JD for primary care nurses was created to allow for both the assessment and front line care of the patient
- All HH clients were assessed and determined the best site of services
- Half of HH clients were ambulatory so we knew we had to build out ambulatory services
- This showed us capacity that could be freed up in our HH services to support our ADC

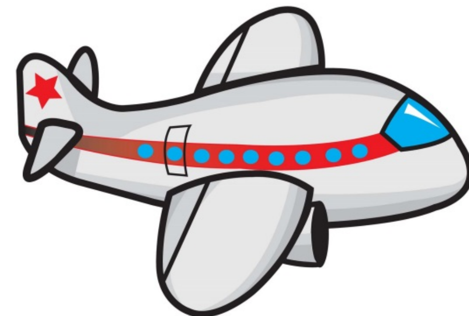
RAI is not Bread



- The RAI assessment needed on clients to assess IADLs and ADLs seemed to take forever!!
- A new role was created for LPNs for the administration of the RAI and clerical support was determined for the collection and validation of financials
- Typing tests mandatory

How do we change a model while in a Model of Care???

- Ok, here comes the tricky Part…
- We have a model in place. There are not extra people floating around or no new dollars
- How do we fly the plane while we are in the process of building a new one???



Community and Hospital Teams

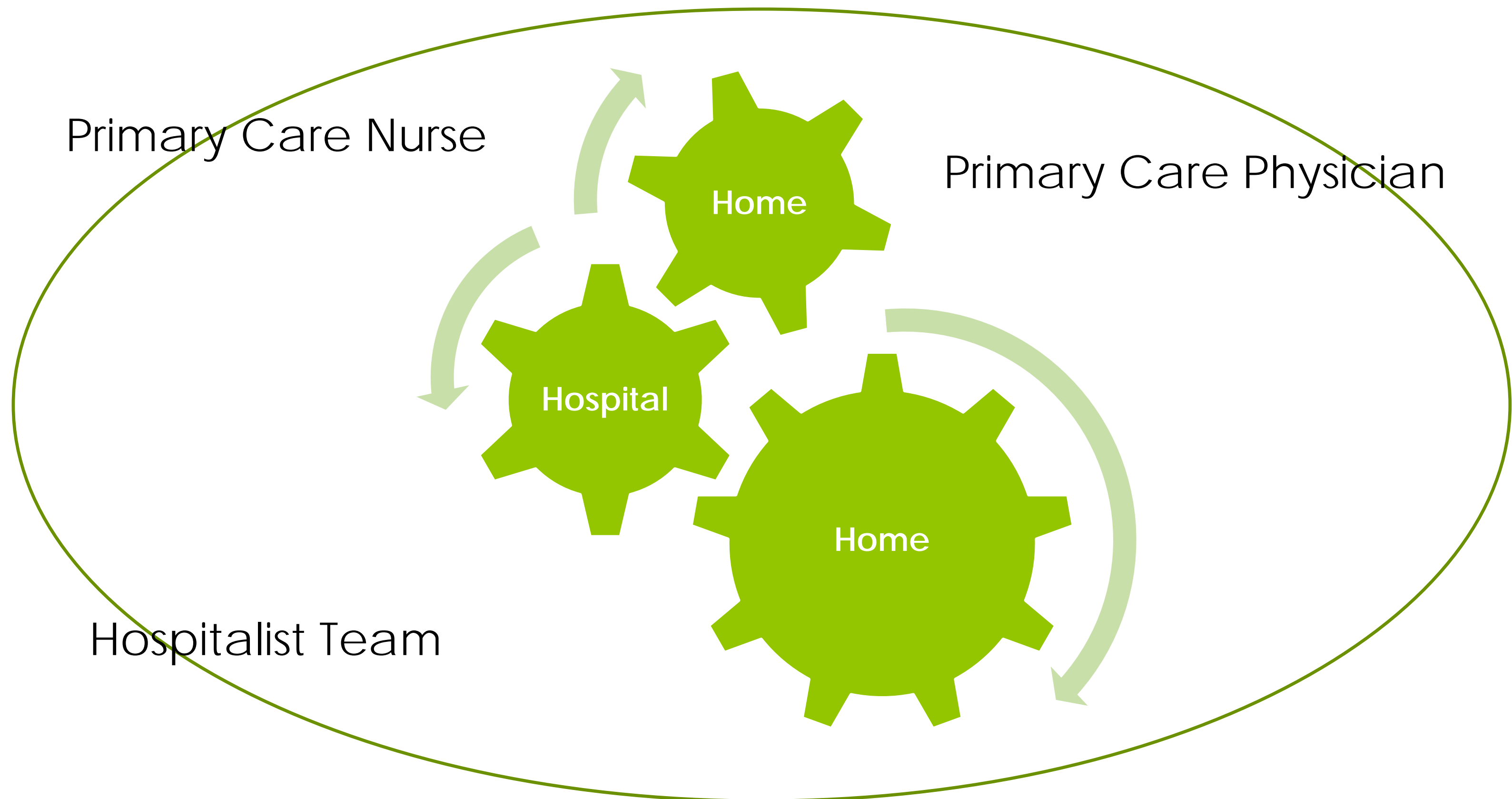
- Having already evaluated the community teams we did the same with the hospital teams
- We realized that the HH teams in hospital had been put in 7 years prior and effectiveness had not been determined
- Results were staggering……
- This addition eroded the DC

Planning process significantly

LIGHTBULB

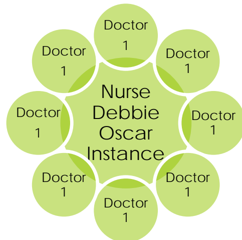
- Given the capacity of the PCC group a decision was made to take ½ of the home health teams out of the hospital
- This required retraining of the PCC group
- Retraining of the Home Health Hospital team
- And reshaping of the system of care transitioning between hospital to community

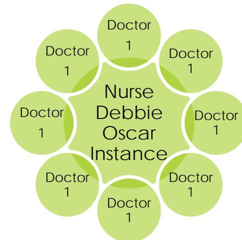
Defining the New Model

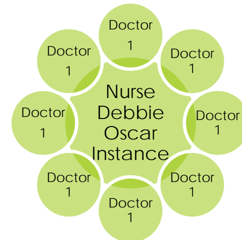


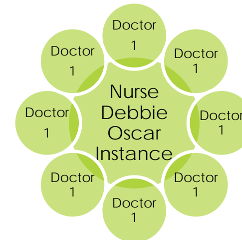
And then there were 8

clerical



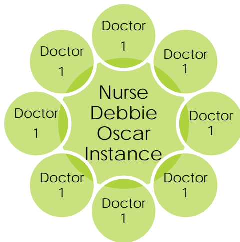


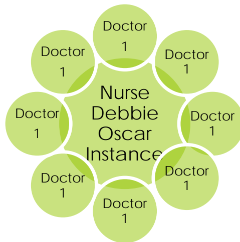


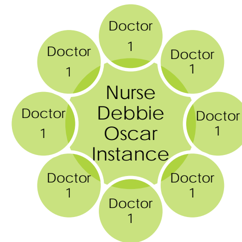


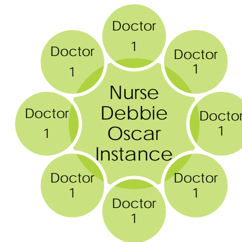
Social Worker

Social Worker









RAI assessor

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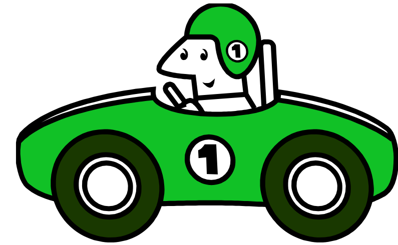
We are on our Way



- Next steps will be populating all case loads of PCNs
- In 3 months we will move over the case management files to the 8 nurses
- At that time we will conduct a baseline evaluation of all caseloads to be re-evaluated in 6 months

QUESTIONS