Hamilton Health Sciences

Hospital Without Walls: Bridging the Gap in Health Disparities for Seniors Living With Frailty

Transforming Care by Aligning Acute with Outreach Team

The Issue

- In 2017-18, 41,575 visits to Hamilton Health Sciences (HHS) emergency departments (ED) were by seniors aged 65+ years; 10,204 were by those aged 85+ years. Of those aged 65+ years, 29.9% were admitted. Of those aged 85+ years, 39.2% were admitted.
- The Canadian Frailty Network estimates that 25% of people aged 65+ years and 50% of those aged 85+ years are "medically frail" suggesting that HHS cared for over 6,000 "frail" seniors.
- Patients aged 65+ years account for 60% of HHS' highest cost/risk patients. Many of these patients have 4 or more chronic conditions. Most come to hospital from home.
- Patients seen by HHS' Outreach Team typically have few social supports, low health literacy, low mood, functional and/or memory impairment, limited finances, and high hospital visits.

The Innovation

- Patients aged 65+ years screened in ED as highest risk for frailty are referred to the Centralized Care and Transition Team (CCaTT), an interdisciplinary team with geriatric experience. CCaTT assesses mood, memory, function, social supports, medications, and develops evidence-based interventions and recommendations aligned with Ontario's Assess & Restore Guidelines.
- CCaTT refers the most vulnerable patients to HHS' Outreach Team which uses the Ontario's Health Links Model of Care and partners with patients in their homes to identify:
  1. *What is most concerning to them about their health*
  2. *What is most important to them right now*
  3. *What they hope to achieve*
- Goals are developed with patients and the Outreach Team collaborates with partners including primary care, geriatrics, home care, and community service organizations to initiate actions that will help patients achieve their goals.

Patient Testimonials

- "Knowing I have someone to call who will call me back helps me feel less anxious. I suffer from depression but have been feeling much better since having someone to help me when I have questions or need things. I get nervous and don't how to figure these things out on my own."- *Lisa*
- "Thank you for listening to me. I want to keep my mother at home and it is good to talk about how hard it can be sometimes. Thank you for all your help." - *Stephen*
- "You are the only people I have to help me. I have no one else. I now get to all my appointments and when I need anything I know who to call as you always help me. It makes me feel good to have people I trust that check on me and get me the help I need." - *Betty*

Patient Impact – Mr. S.

Mr. S. frequently visited hospital EDs for help and prescriptions to manage multiple health conditions including an acquired brain injury, seizures, discitis, falls, depression and chronic pain. He had no family doctor and few social supports. His only daughter lived out of town. Previously, Mr. S. stayed in local shelters but now resided in a rooming house. Unsafe housing conditions, very low income and restricted mobility all posed barriers for Mr. S.to achieve his health goals:

Mr. S. – I'm most concerned about my pain and my weight loss…I don't want to live with this pain anymore. I want to find a place to live where I feel safe and can get the help I need.

Health Determinant	Coordinated Care Plan - Issues Identified	Patient Action Plan - Outreach Actions / Interventions
Access to health services	• No access to primary care.	• Obtained family doctor. • Screened mood (Geriatric Depression Scale); communicated results to new physician. • Facilitated specialty physician and clinic consults for chronic conditions (gastrointestinal and pain issues).
	• Hospital to home transition.	• Re-connected patient to home care for nursing and occupational therapy (OT) assessments.
	• Advance care planning.	• Advance care plan created with patient & doctor. Shared with patient's daughter.
Cognition & Health Literacy	• Only partial ability to teach back. • Self-reported memory challenges.	• Screened cognition (Mini-Cog/Clock). Shared results with family physician. • Provided reminders and accompaniment for medical appointments when needed.
Income to support health needs	• Limited finances. • No income support.	• Assisted with completion of paper work for Old Age Security, Canadian Pension Plan and Guaranteed Income Supplement. • Arranged free tax preparation through local MPP.
Transportation	• Mobility challenges making use of regular public transit difficult. • Cost a barrier to using taxis.	• Completed application for subsidized accessible transportation with door-to-door service. • Assisted with booking transportation when needed.
Food & Nutrition	• Residents of rooming house residents "stealing" food.	• Food donations delivered on multiple occasions.
Mobility	• Walker "stolen" at shelter. • Falls on rooming house stairs.	• Referral completed to LHIN Home & Community Care to obtain new walker and for OT home environmental safety assessment.
Housing	• Theft (food, belongings), exposed to violent conflict in rooming house environment.	• Assisted patient to apply and move to affordable supportive housing with no stairs. • Donated furniture and household items obtained.

Evaluation

CCaTT (Patients served in 2017-18 = 2,553)	Hospital Outreach Team Hamilton West (HW) & Niagara North West (NNW)
• 40% improvement in function (Barthel Index) • Only 7% required post-acute rehab • 87% discharged to own home • Cost savings based on acute inpatient and post-acute rehab length of stay reductions and admission avoidance estimated to be approximately $3.9M.	• Fewer ED visits: 40% (HW) & 39% (NNW) • Fewer admissions: 51% (HW) & 59% (NNW) • Fewer 30-day readmits: 58% (HW) & 61% (NNW) • Fewer admissions for ambulatory care sensitive conditions: 35% (HW & NNW) • 97% of patients said team linked them to health services when needed & 88% said their care plan addressed both their health and social situation

Potential for Spread

This model of care has **unlimited** capacity for spread. Key elements include:

- **Standardized criteria** to identify highest risk patients
- **Systematic screening, comprehensive geriatric assessment and interventions** using evidence-based, validated tools, best practices and approaches including:
  - interRAI Assessment Urgency Algorithm
  - CCaTT Collaborative Assessment
  - Geriatric Depression Scale
  - Mini-Cog, Montreal Cognitive Assessment (MOCA), Standardized Mini-Mental State Examination (SMMSE), Confusion Assessment Method (CAM)
  - Barthel Index (activities of daily living)
  - Population health management approach including screening for social determinants of health
  - Assess and Restore Guidelines
  - Ministry of Health & Long Term Care Health Links Model of Care and Health Quality Ontario's Coordinated Care Planning Tool
  - Motivational interviewing
  - Change readiness assessment
  - Trauma-informed care
  - Self-management techniques (teach-back, patient action plans in plain language)
- **Decision making algorithms** to support consistent practice amongst team members
- **Education, training and mentorship** for staff/partners involved in delivering the model of care
- **Proactive partnerships** with patients, family/friend caregivers, hospital, primary care, specialists, home care and community services
- **System navigation and advocacy** to help patients access adequate nutrition, housing, medical equipment, supplies and transportation to medical appointments

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