South East Toronto

Family Health Team

VIRTUAL WARD PROGRAM

Improving Transitions in Care

In partnership with:

- Toronto East General Hospital (TEGH)
- TC-LHIN Community Care Access Centre (CCAC)
- Ontario Telemedicine Network (OTN)

Ontario

Goals

- Collaborate with Toronto East General Hospital to provide this vulnerable high risk population with improved follow-up care after discharge.

- Identify and assist a growing population of unattached patients who do not have access to primary care and thus, are at increased risk for hospital readmissions.

- Admit these patients to a Virtual Ward in order to assist with the transition back home from hospital (and hopefully reduce the risk of readmissions).

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Key Factors

Key Issue: Focus on PATIENT-Centred Experience

- Current system in Ontario does not center around the patient → acutely ill patient gets discharged from hospital (TEGH) with high intensity of care to very little care back home in the community

- Ontario has passed the Excellent Care for All Act which aims *to foster a culture of continuous quality improvement where the needs of patients come first*

- The Virtual Ward puts the ***Patient*** in the centre of care

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Key Factors –
meeting government priorities

- *Keeping patient out of hospital* - reducing wait times and burden on hospital emergency departments;
- *Family Health Care for all* – providing access to a primary care provider;
- *Ensuring access* to the right provider at the right time - using an Interprofessional team based approach to care;
- Managing the patient with complex needs through *chronic disease prevention and management* and empowering patients to take care of own health at home through *self-management* support;

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Key Factors –
meeting government priorities

- *New technologies* to monitor a patient's health through virtual means (i.e. Telehomecare);
- *Quality improvement* approach to improving patient outcomes; and
- Opening the doors to new health care professionals (*integration of a Physician Assistant in primary care* – less physician intervention needed).

A Virtual Ward within primary care empowers the role primary health care has in bridging the care gap experienced by many patients at the time of hospital discharge.

Expected savings by reducing readmission rates should make this model a sustainable health innovation.

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Key Actors

Physician Assistant (PA)	• Works as the clinical case manager
	• Meets patient the day before discharge at TEGH
	• Will check on patients daily by phone
	• Primary contact for CCAC
	• Identifies patients needing intervention:
	  • Provides home visits if needed
	  • Arranges for FHT visits or with specialists
	  • Communicates with family physician

Supervising Physician	• Reviews patients with PA daily/weekly
Care Navigator	• Arranges CCAC services, transportation, community supports, lab work at home if required
Pharmacist	• Reviews/adjusts medication
Nurse Practitioner	• Provides home visits if required
Mental Health Addictions Counsellor	• Arranges for mental health and addiction supports as required

Key Actors – Our Partners

- Toronto East General Hospital
  - Patients admitted to TEGH are identified by hospital case manager daily/weekly based on LACE score.
  - If patient does not have a family doctor they are seen prior to discharge from hospital by PA/MD for enrolment in SETFHT Virtual Ward
- Toronto Central Community Care Access Centre
  - Automatically notified of Virtual Ward admission and services are arranged for patient by hospital CCAC coordinator
  - SETFHT will soon have access to CCAC portal so will know what home care services our patients are receiving
- Ontario Telemedicine Network
  - Patients may also receive Ontario Telemedicine Network (OTN) Telehomecare equipment for remote monitoring of vital signs

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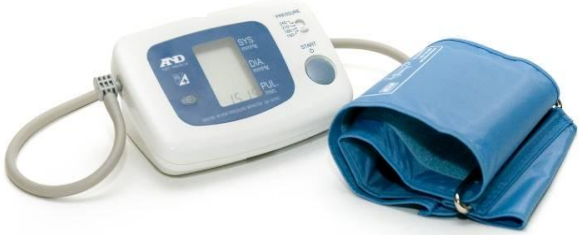

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Change Process Milestones

Organizational Readiness:

- South East Toronto Family Health Team
  - New primary health care organization with visionary leadership, experience in team-based approach to care, telemonitoring of higher risk patients, full electronic medical records
- Toronto East General Hospital
  - Tight budget deficits forced leadership to engage in new innovative projects that can assist in decreasing deficits

Community Care Access Centre

- Major headway made through their engagement in new initiatives such as St Michael's Virtual Ward, as well as new programmatic approach to improving transitions in care

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Change Process Milestones

Steps in the Process:

- Application for pilot grant for full-time primary care Physician Assistant to lead SETFHT Virtual Ward
- Development of electronic data entry on TEGH electronic system (not previously used for direct charting) to allow for common record sharing between primary care and hospital
- Funding of a part-time case manager and physician stipend at the hospital level

How was progress monitored

- Ongoing drive by SETFHT for monthly meetings between the various agencies to push the project forward and ensure ongoing communication
- Development of a process map early on

Change Process Milestones

Key Turning Points/Unexpected Turns:

- Initial distrust across sectors ***slowly*** changed to a more collaborative approach. *Key change* – SETFHT ED request for monthly meeting with TEGH Vice President to discuss primary care concerns one-on-one

- Opportunistic timing – call for grant proposals by HealthForceOntario for Physician Assistant in Primary Care made available when contemplating development of FHT Virtual Ward

- Enthusiastic support for project by OTN based on successful pilot within FHTs in reducing ER visits of COPD/CHF patients (SETFHT was one of six pilot sites)

Lessons Learned

Major Challenges on the way:

- Need for development of communication strategies between the three health care organizations about the *COMMON PATIENT* → electronic Virtual Ward Record created in hospital electronic record all providers can access and update

- Lack of incentives for *COLLABORATION* across various sectors → initial driving force dependent on common vision of key leaders

- Funding the work of the supervising physician:
  - Capitation-based model within FHTs (through physician compensation model of a Family Health Organization) allows for phone management and team discussions but hospital has had difficulty finding funding for physician time spent on supervising a patient remotely at home

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Lessons Learned

How will it evolve/is it sustainable?

- Limited hospital funding for part-time case manager and very limited physician hours (1h/d/wk), limiting case load to top 1% patients at risk (true reduction in readmission might require expansion of model to all discharged high risk patients)

Can this innovation be spread – Why (not)?

- QIIP: general enthusiastic spirit of quality improvement within Family Health Teams in Ontario that serves as a forum for spread
- FHTs provide an Interprofessional team approach to care of the complex patient and there is funding for EMR that facilitates communication about common patients
- Local hospital and FHT needs to be interested in a partnership (engage in the common goal)

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Lessons Learned

Key Success Factors for Spread:

- Readiness by local acute care hospital/community care agency/primary care groups to work together on the common goal to improve the transition from hospital back to the community (and reduce the risk of readmissions)

- Electronic records that can be shared by all care provider

- Availability of team-based approach to patient care has now become available in the community in Ontario to improve care of the patient with complex needs

- Ensure proper funding is in place to collect patient outcomes and develop measures that will encourage quality improvement methodology to develop a program that best meets the needs of the patient

Thank You

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