


SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

Coordinated Care Planning – Prevention of MH Readmissions

Oct 31st, 2017

iCare

Integrity • Compassion • Collaboration & Partnership •
• Accountability • Respect • Excellence

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Introduction – Who are we?

Eva Torresan – Registered Nurse certified in psychiatric/mental health nursing with 14 years experience. Currently working in outpatient mental health at SAH. Trained as a Guided Care Nurse through John Hopkins University.

Tara Farkas – Registered Nurse certified in psychiatric/mental health nursing with 14 years experience. Currently working on inpatient mental health at SAH as the discharge planner. Trained as a Guided Care Nurse through John Hopkins University.

What is Health Link?

The health link model is a care delivery model that was developed as a strategic priority to make care more effective, efficient, and ultimately to strengthen the sustainability of the health system. It establishes one point of contact for care plan development, care team and patient to: eliminate duplicate work, improve inter-professional communication and improve trust and consistency though a point person.

The early focus of health link centers on the complex populations, with a plan to broaden its focus over time. The goal is to support a growing and increasingly complex patient population to live with independence close to home, with strong communication between providers.

The Health Link Target Population

Focuses on the top 5% of Ontario's complex patients. The target population served by Health Link includes patients with 4 or more comorbid conditions and complex system utilization.

Often, these patients fall into one of the following categories:

a) Frail elderly

b) Mental health and addictions

c) Palliative

Health Link SSM goals

1. Improving the patient experience by meeting people's needs as they define them
2. Supporting providers to deliver services that are effective and reflective of best practices
3. Promoting inter-professional teamwork to enable integration of care
4. Simplifying care coordination for medically complex patients
5. Creating care plans for medically complex patients

SSM Health link goals Cont'd

6. Establishing one point of contact for care plan development, care team and patient to:

a. Eliminate duplicate work

b. Improve inter-professional communication

c. Improve trust and consistency through a point person who serves as a 'quarterback'

7. Proactively monitoring patients to:

    a. Assess whether goals of care are being advanced

    b. Continue links and communication with health and social service providers

    c. Identify any emerging health issues

8. As a result, building an efficient system that we can afford now and in the future

The Guided Care Model

The Health Link SSM adopted the John Hopkin's proven model of Guided Care.

A number of Registered Nurses were trained in this model. So far the focus has been on more of a medical model and it has shown measures of success.

Our goal is to build it into our Mental Health and Addictions model of patient centered care.

8 Core Responsibilities of Guided Care Nurses

1. Assessing the patient
2. Creating a CCP
3. Monitoring patient proactively
4. Empowering the patient; encouraging self-management
5. Coordinating providers of care
6. Smoothing the patient's transitions into and out of the hospital or other facility
7. Educating and supporting caregivers
8. Accessing community resources

What is a Guided Care Nurse Trained to Do?

A Guided Care Nurse is trained to:

- Coordinate patient care
- Monitor patient
- Teach patients and families self management skills including early identification of worsening symptoms that can be addressed before presentation to emergency or admission to hospital

Responsibilities of Patient and Caregiver

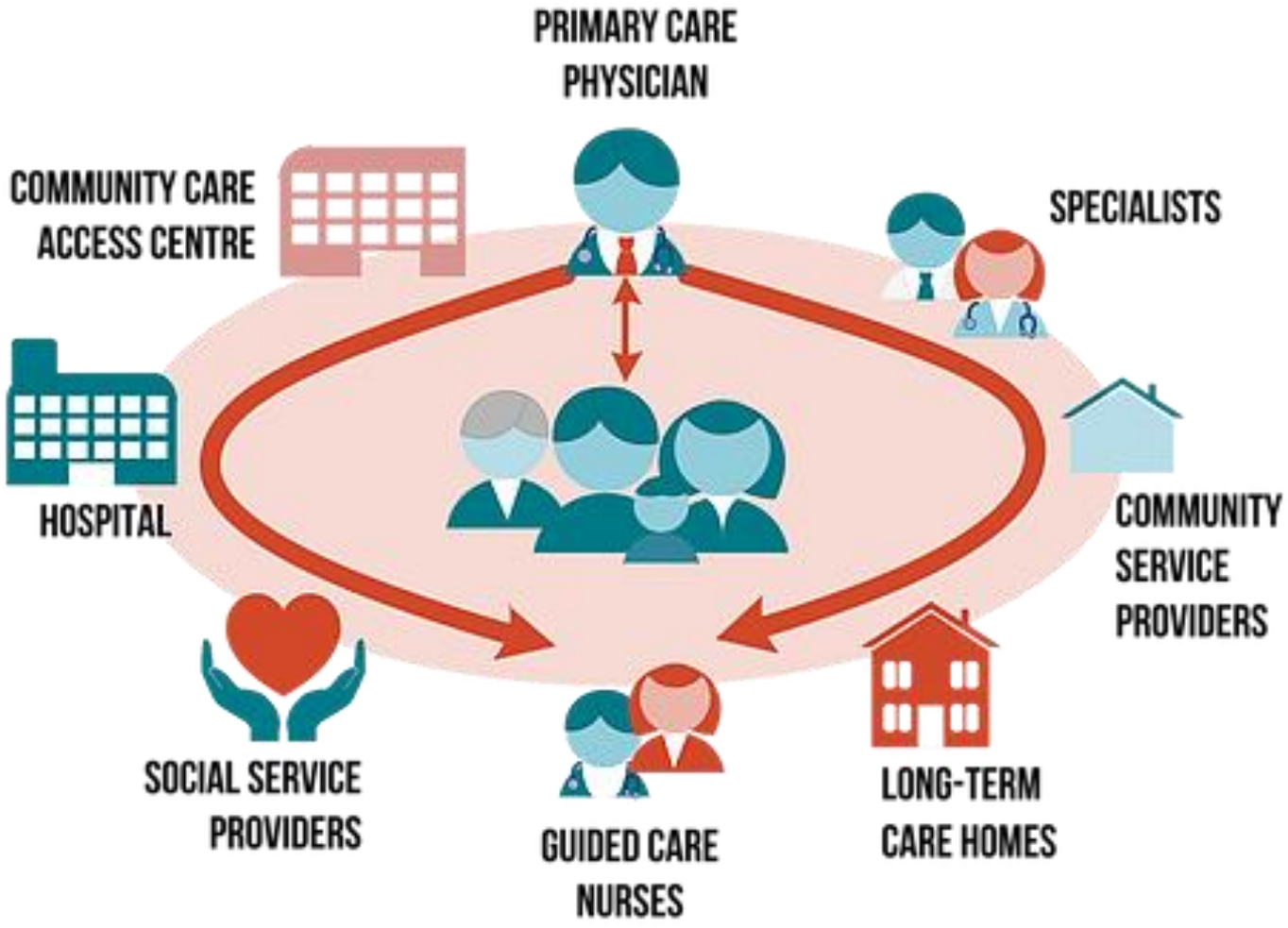
- Consent to participate in Guided Care
- Completion of a Coordinated Care Plan
- Identify who is currently involved in their care
- Share their health care and lived experience
- Engage in exploring their goals and needs
- Participate in Coordinated Care Conference(s) with GCN and PCP (others as indicated)

- Work towards achieving their goals and needs as per the Coordinated Care Plan
- Refer to their Current Care Guide with condition targets, red flags and actions, notify GCN if any red flags persist despite actions taken
- Adhere to the communication and follow up strategy as determined by Coordinated Care Plan and conference(s)
- Inform all Providers that they have a Coordinated Care Plan

Guided Care Plans

https://www.healthlinkssm.com/healthcare-providers

A Collaborative Approach



Patient Experience with Guided Care Nursing

https://www.healthlinkssm.com/human-connection

Guided Care Nurse Results (non-mental health)

The first 50 patients with Guided Care Plans attended the emergency department 276 times prior to initiating their plans.

Within 6 months these presentations decreased to 204 and after one year decreased to 72 emergency visits.

With the initiation of the Mental Health Guided Care Plans, we anticipate the same results.

Target Population to Trial

MH&A Complex Care Needs as identified by 4+ readmissions to hospital within 30 days

(April 1/16-December 31/16)

- 74 individuals were readmitted to the adult inpatient unit within 30 days of discharge, accounting for 154 admissions in total.

Of those 74 individuals:

- 11 were readmitted on 4+ (4-18) occasions, accounting for 67 admissions or 44% of total readmissions within 30 days

Of those 11 individuals:

- 9 of the 11 (or 82%) have concurrent mental and substance use disorders
- 4 of the 11 (or 36%) have no primary care provider and have been referred to a range of 4-18 different services
- 7 of the 11 (or 64%) are followed primarily by their psychiatrist and are not actively engaged in other MH&A support services

What We Expect to See

We would expect to see:

- Improved partnership with the patient and their caregivers
- Identification of realistic expectations of the individual and/or their caregivers to manage their health at home
- Fewer medication errors
- Providers no longer incorrectly believing that a person understands their health care needs, care plan, and post-discharge instructions

How can this help to prevent readmissions:

Discontinuous and poorly coordinated care transitions result in poor quality of care, compromised patient safety and create unfavourable experiences of care.

Present State with the Mental Health Care Plans:

At present there are 2 high needs mental health clients that have readily agreed to be a part of this program. The 2 care plans have been initiated and are being rolled into the electronic documentation system at SAH.

Challenges:

- Homelessness
- No contact number
- Poor attendance to outpatient appointments
- Not attached to Primary Care or Psychiatrist
- Workload limitations
- Lack of dedicated family and social supports
- Compliance with treatment

With our experience in the mental health field we have been able to establish connections with other mental health and social service agencies which allow us to be creative in where we meet with our clients.

There are some clients that we know we are unlikely to reach by phone and in the near future will be trying more to ‘meet the client where they are at’. This may mean service agencies in the downtown area. By meeting the client in the community we will be able to make stronger connections with their care circle will only improve the communication and wrap around care.