Hamilton Health Sciences

Bridging The Gap In Health Disparities For People Living With Frailty

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Introduction

Why did this **initiative** come about?

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The Issue At Hand

- 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.

Frailty & Hospitalization

- Patients, with age-related deficits affecting multiple systems, are at risk for adverse outcomes when hospitalized, such as falls, delirium, drug interactions, functional decline, institutionalization, and death.[1, 2]
- Many older adults admitted to hospital are somewhat frail,[3 - 11] and approximately half experience a decline in their functional abilities in the weeks prior to their admission.[12]
- At discharge, over one third of patients who are frail are still functioning below their pre-decline level, and half either do not recover the lost function, or acquire new disability.[12]
- Many adverse outcomes from acute care hospitalizations are preventable.[13]
- Screening proactively and early for factors contributing to adverse outcomes and their related risks can prevent those outcomes.[13]

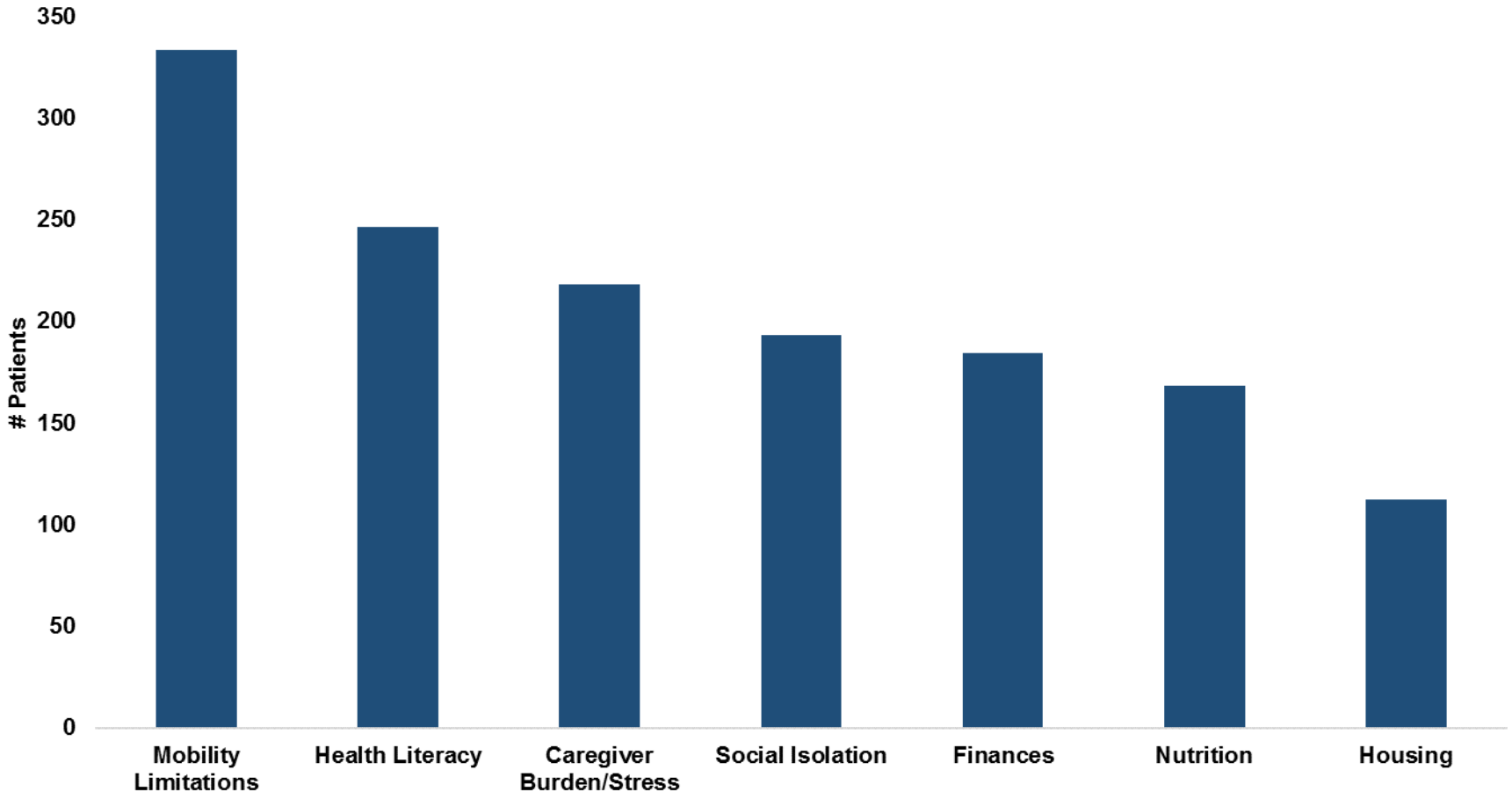
Costa & Hirdes, 2010 [1] ; Sinha et al., 2014 [2] ; Buth et al., 2014 [3] Carlson et al., 2015 [4] ; de Vries et al., 2011 [5] ; Gordon & Oliver, 2015 [6] ; Joosten, et al., 2014 [7] ; Jung et al., 2014 [8] ; Kenig et al., 2015 [9] ; Oliver, 2014 [10] ; Patel et al., 2014 [11] ; Covinsky et al,, 2011 [12] ;Muscedere et al., 2016 [13]

Frailty & Social Determinants of Health

- Canadian studies indicate, lower social position (education and income) is strongly associated with frailty, and social vulnerability correlated moderately with frailty,[14] with both contributing independently to risk of death.[15]
- Frailty is also influenced by low socioeconomic status, having few relatives and neighbours or little contact with them, low participation in community activities, and low social support.[16-19]
- Social determinants of health place even the healthiest seniors at higher risk for cognitive decline and mortality. [20-22]

St. John et al., 2013 [14] ; Andrew et al., 2008 [15] ; Lurie et al., 2014 [16] ; Peek et al., 2012 [17]; Salem et al., 2013 [18] ; Woo et al., 2005 [19] ; Andrew et al., 2008 [20] ; Andrew et al., 2012 [21]; Andrew & Rockwood, 2010 [22]

Social Determinants of Health Impacting HHS Outreach Patients*



*Based on sample of 429 patients

Application Of Best Practice

- Screening for Risk
- Centralized Care & Transition Team
- Hospital Outreach Team

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Identifying Patients At Risk For Frailty At HHS

Early Intervention Screening Tool for Individuals 65+
InterRAI Preliminary Screener © Assessment Urgency Decision Tree

Is the Patient Self-Reliant in their Environment? *Ask*:
Do you need any supervision or help to take a bath or shower? (Includes transferring in and out of tub/shower. Excludes washing of back and hair)
Does someone help you make decisions about daily tasks? (Includes when to get up, have meals, clothing, and activities)
Do you need any supervision or help to dress and undress below the waist? (Includes clothes, underwear, prostheses/orthotics, pants/skirts, belts, shoes)
Do you need any supervision or help to move between locations on the same floor level? (If person is self sufficient using assistive devices, code as NO)
Do you need any supervision or help to manage your personal hygiene? (Includes combing hair, brushing teeth, shaving, make-up, or washing face or hands)

Note: Yes to any of the above questions would prompt a "YES" and movement to the next question box.

NO - Self-reliant

YES - Impaired

Self-rated Health *Ask:*
In general, how would you rate your health?

Excellent or Good

Fair or Poor

Could not (or would not) Respond

Unstable *Ask:*
Do you have any conditions that make your health unstable?
(Includes any disease/condition that causes fluctuating, precarious, or unstable functioning, mood, or behaviour)

NO

YES

1

3

Dyspnea *Ask:*
Do you sometimes feel short of breath when performing daily tasks?
(Includes : Dyspnea at rest or during normal daily activities)

NO

YES

2

3

Family Overwhelmed
ASK FAMILY OR FRIENDS:
In general, do you feel overwhelmed by the person's illness/condition?
Note: Use your best clinical judgement to rate this item if additional info available.

NO

YES

6

No Family or Friends

Self-rated Mood
ASK PERSON ONLY;
In the last 3 days, have you felt sad, depressed or hopeless?

NO

YES

6

Could not (or would not) respond

6

Support in Personal Hygiene ADL
ASK PERSON ONLY;
Do you need any supervision or help to manage your personal hygiene?
(Includes combing hair, brushing teeth, shaving, make-up, and washing face or hands)

NO

YES

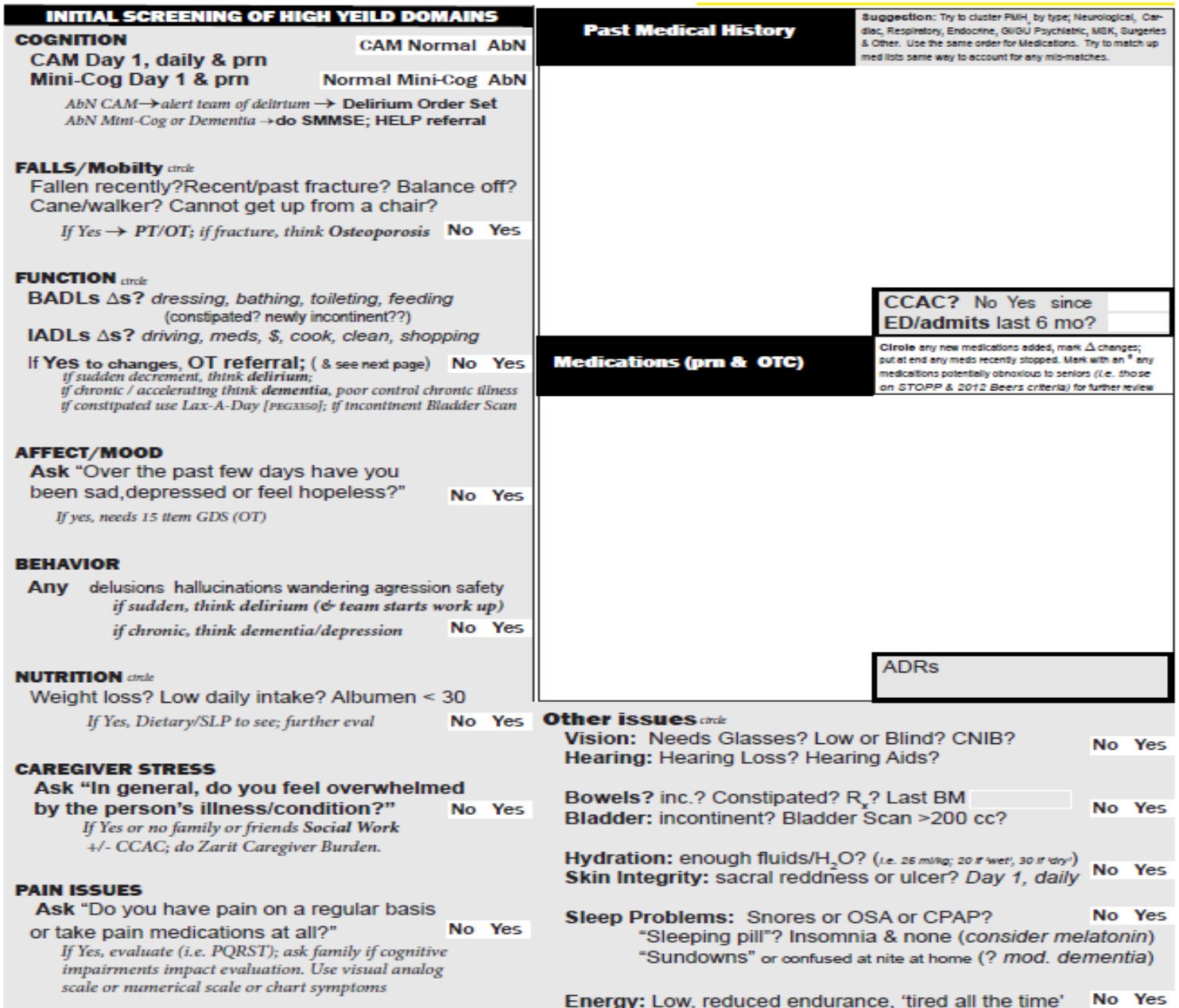
4

5

Centralized Care & Transition Team (CCaTT)

- Interdisciplinary team at the Hamilton General and Juravinski Hospitals
- Early screening (within 24 hours), 7 day-a-week model
- Standardized comprehensive geriatric assessments of patients scoring high-risk for frailty (AUA 5 and 6)
- Apply MOHLTC's Assess & Restore Guideline
- Develop and implement care plans to reduce the risk of adverse outcomes such as delirium or falls
- Make referrals to appropriate health and social services
- Rehabilitative care provided in parallel with acute care

Standardized CCaTT Assessment



INITIAL SCREENING OF HIGH YEILD DOMAINS

COGNITION CAM Normal AbN

CAM Day 1, daily & prn

Mini-Cog Day 1 & prn Normal Mini-Cog AbN

AbN CAM→alert team of delirium → **Delirium Order Set**

AbN Mini-Cog or Dementia → **do SMMSE; HELP referral**

FALLS/Mobilty *circle*

Fallen recently?Recent/past fracture? Balance off? Cane/walker? Cannot get up from a chair?

If Yes → ***PT/OT; if fracture, think Osteoporosis*** No Yes

FUNCTION *circle*

BADLs Δs? *dressing, bathing, toileting, feeding* (constipated? newly incontinent??)

IADLs Δs? *driving, meds, $, cook, clean, shopping*

If **Yes to changes, OT referral;** (& see next page) No Yes

if sudden decrement, think ***delirium****;*

if chronic / accelerating think ***dementia****, poor control chronic illness*

if constipated use Lax-A-Day [PEG3350]; if incontinent Bladder Scan

AFFECT/MOOD

Ask "Over the past few days have you been sad,depressed or feel hopeless?" No Yes

If yes, needs 15 item GDS (OT)

BEHAVIOR

Any delusions hallucinations wandering agression safety

if sudden, think delirium (& team starts work up)

if chronic, think dementia/depression No Yes

NUTRITION *circle*

Weight loss? Low daily intake? Albumen < 30

If Yes, Dietary/SLP to see; further eval No Yes

CAREGIVER STRESS

Ask "In general, do you feel overwhelmed by the person's illness/condition?" No Yes

If Yes or no family or friends ***Social Work***

+/- CCAC; do Zarit Caregiver Burden.

PAIN ISSUES

Ask "Do you have pain on a regular basis or take pain medications at all?" No Yes

If Yes, evaluate (i.e. PQRST); ask family if cognitive impairments impact evaluation. Use visual analog scale or numerical scale or chart symptoms

Past Medical History

Suggestion: Try to cluster PMH by type; Neurological, Cardiac, Respiratory, Endocrine, GI/GU Psychiatric, MSK, Surgeries & Other. Use the same order for Medications. Try to match up med lists same way to account for any mis-matches.

CCAC? No Yes since

ED/admits last 6 mo?

Medications (prn & OTC)

Circle any new medications added, mark Δ changes; put at end any meds recently stopped. Mark with an * any medications potentially obnoxious to seniors (*i.e. those on STOPP & 2012 Beers criteria*) for further review

ADRs

Other issues *circle*

Vision: Needs Glasses? Low or Blind? CNIB? No Yes

Hearing: Hearing Loss? Hearing Aids?

Bowels? inc.? Constipated? R_x? Last BM No Yes

Bladder: incontinent? Bladder Scan >200 cc?

Hydration: enough fluids/H_2O? (*i.e. 25 ml/kg; 20 if 'wet', 30 if 'dry'*) No Yes

Skin Integrity: sacral reddness or ulcer? *Day 1, daily*

Sleep Problems: Snores or OSA or CPAP? No Yes

"Sleeping pill"? Insomnia & none (*consider melatonin*)

"Sundowns" or confused at nite at home (*? mod. dementia*)

Energy: Low, reduced endurance, 'tired all the time' No Yes

Hospital Outreach Team

- Team of regulated healthcare professionals transitioning patients from hospital to home
- Utilize MOHLTC's Health Links Model of Care
- Develop coordinated care plans *with* patients based on, *What is most important to the patient*
- Make referrals to appropriate health and social services
- View patients through a trauma informed care lens
- Use a non-judgmental curiosity through use of motivation communication skills in developing partnerships with patients
- Use standardized validated screening tools to help determine root cause for frequent hospital utilization (i.e. unmet needs, undiagnosed cognitive impairment and depression, health literacy issues)
- True integration of assessing and addressing health and social domains of the patient

Standardized Hospital Outreach Team Assessment

What's Most Important To Me and My Concerns

What is most important to me right now:

What concerns me most about my health care right now:

My Care Team (Include active family/caregivers, providers)

Coordinating lead (notify if patient is hospitalized) | Name: | Phone number:

Name of team member	Role	Organization	Contact information: Primary number	Contact information: Secondary number

Palliative Approach to Care

The person most responsible for my palliative care is:

Physical support plan (pain management, shortness of breath, constipation, nausea and vomiting, fatigue, appetite, drowsiness)

Symptoms	Treatments	Comments

Psychological support plan (emotion, anxiety, depression, autonomy, fear, control, self-esteem)

Symptoms	Treatments	Comments

Social support plan (relationships, family caregiver, volunteers, environment, financial, legal):

Spiritual support plan (values, beliefs, practices, rituals):

Preferred place of death:

Grief and bereavement support:

Other:

More About Me

Topics	Details
Income	
Employment	
Housing	
Transportation	
Food security	
Social network	
Health knowledge	
Newcomer to Canada	
Legal	
Spiritual affiliation	
Caregiver Issues	

My Goals and Action Plan

What I hope to achieve	What we can do to achieve it	Details	Who will be responsible	Date goal identified (YYYY-MMM-DD)

My Medication Coordination (Attach current medication list or complete the medication appendix)

Most reliable source for medication list (primary prescriber/medication manager/family):

Aids I use to take my medications:

If someone helps you with medications, who helps you?

Challenges I have taking my medications (side effects, are you able to afford all your medications?):

Hospital Outreach Team Assessment Includes:

- How do you get to appointments? Does someone go with you? Are transportation costs difficult for you?
- For patients receiving ODSP: Do you have the costs for taxis to your medical appointments covered by ODSP?
- How do you get your medications/your prescriptions filled?
- What would be something you regularly have for breakfast, lunch and supper? Do you have enough food to last you till you get paid again?
- Sometimes we find our patients are not always receiving all the possible income sources they are eligible for, so if you do not mind telling me, how much do you receive every month?
- Do you ever have trouble filling out forms and paperwork?

Evaluation

- Centralized Care & Transition Team
- Hospital Outreach Team

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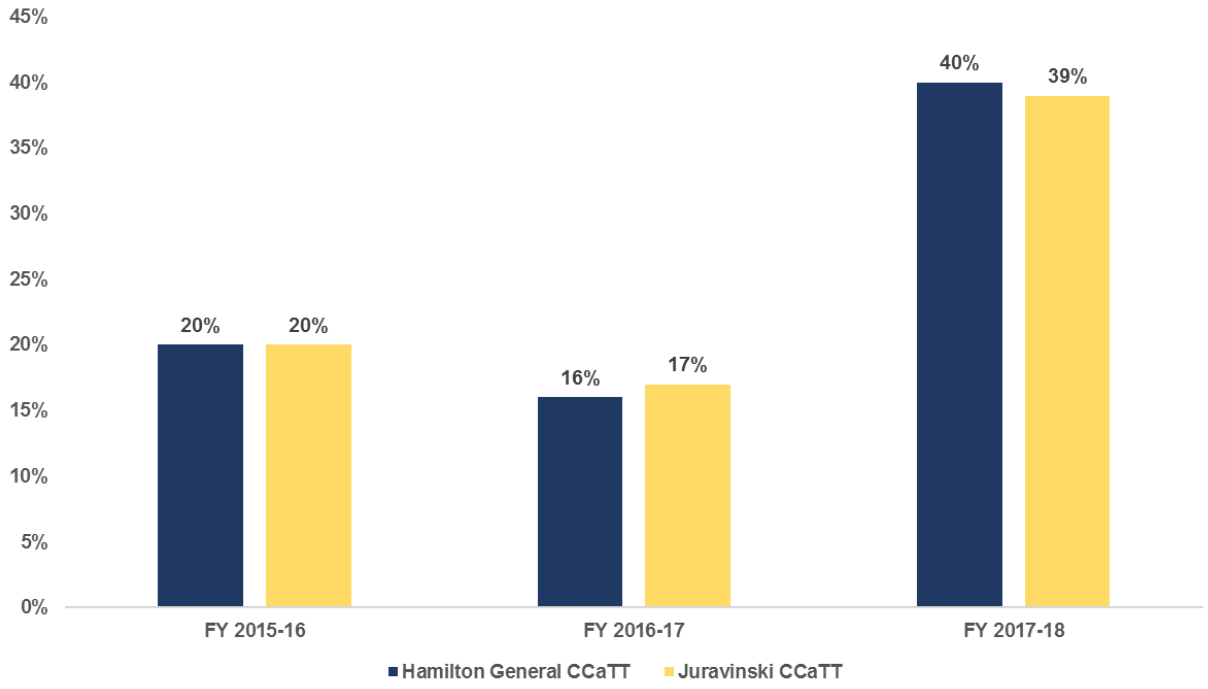
CCaTT Patient Pre-Post Outcome (Barthel Activities of Daily Living Index)

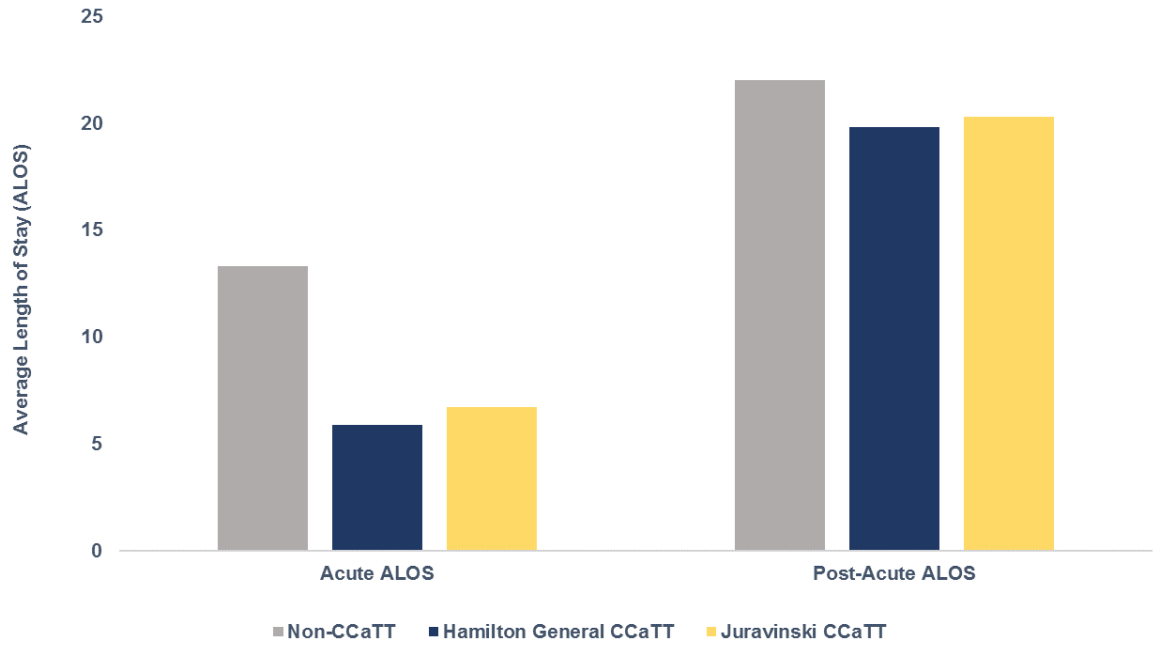
Patients cared for in FY 2017/2018 = 2,553

- Measure: Percent change of patient function from admission to discharge for CCaTT patients discharged
- CCaTT patients' pre-post function improved in each of three years with the greatest improvement seen in 2017-18



CCaTT versus Non-CCaTT Patients

- Patients seen by CCaTT had **lower average lengths of stay (ALOS)** compared to similar patients (i.e. “case mix groupings”) that were not seen by the CCaTT in addition to receiving standard hospital care interventions.
- CCaTT patients at HHS’ Hamilton General site had **56% lower acute ALOS** and **10% lower post-acute ALOS** compared to Non-CCaTT patients.
- CCaTT patients at HHS’ Juravinski site had **50% lower acute ALOS** and **8% lower post-acute ALOS** compared to Non-CCaTT patients.



Hospital Outreach Team

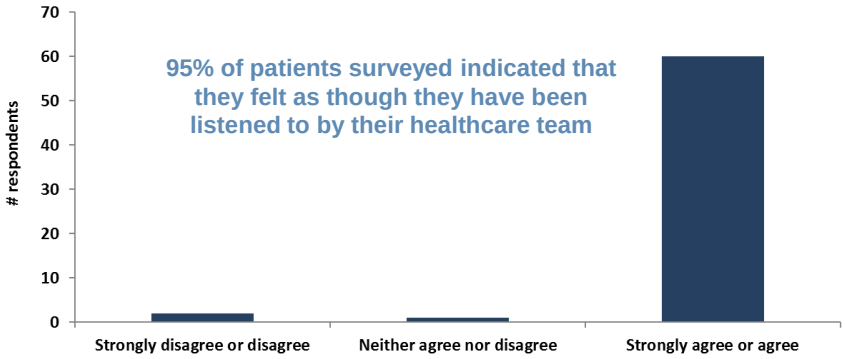
Patients cared for = 1,013

12 months post-initiation of Care Plan:

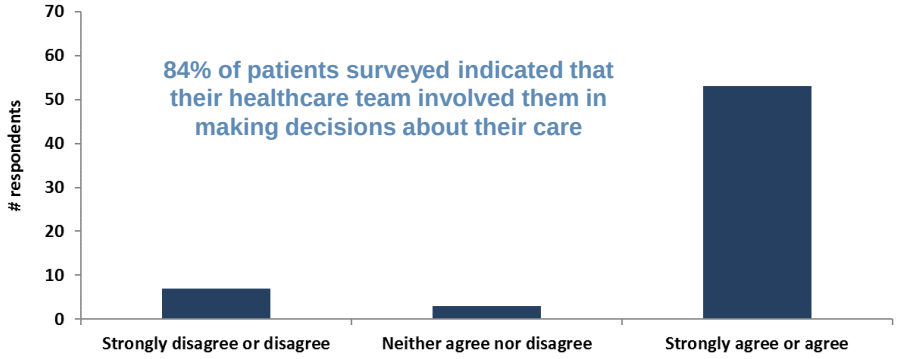
- Fewer ED visits: 40%
- Fewer admissions: 51%
- Fewer 30-day readmits: 58%
- Fewer admissions for ambulatory care sensitive conditions: 35%
- 97% of patients said the team linked them to health services when needed and 88% said their care plan addressed both their health and social needs

Patient Experience

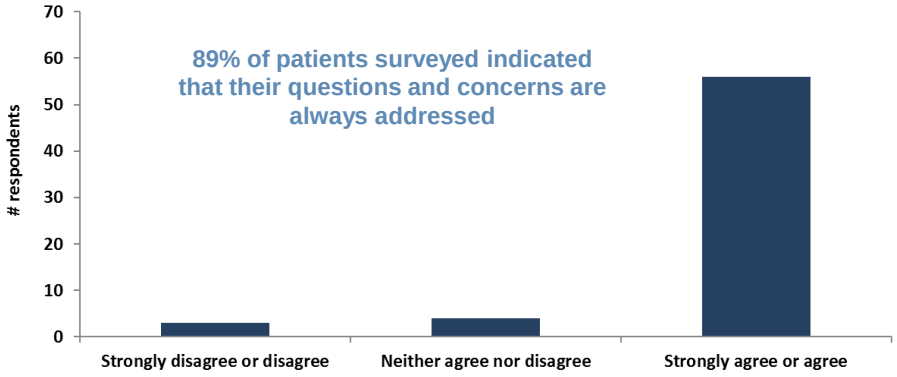
I feel as though I have been listened to by my healthcare team



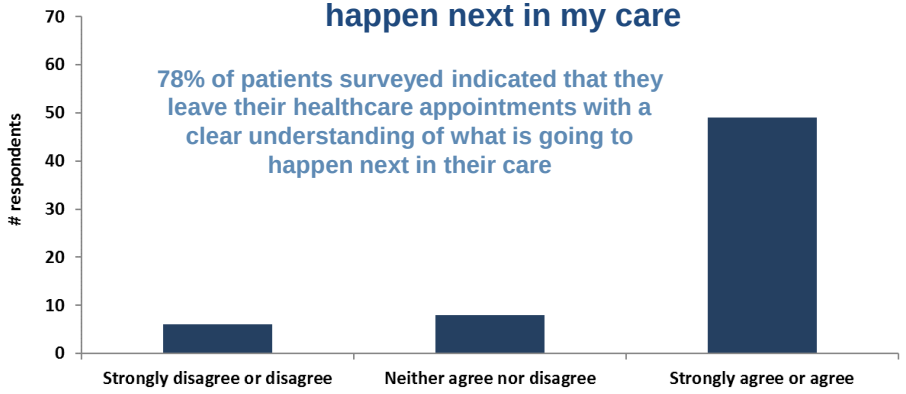
My healthcare team involved me in making decisions about my care



My questions and concerns are always addressed

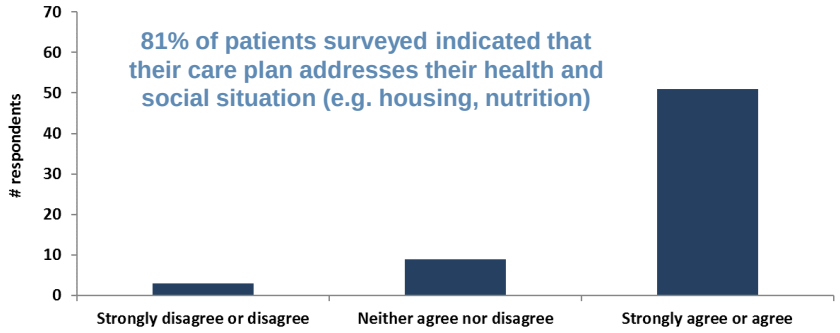


I leave my healthcare appointments with a clear understanding of what is going to happen next in my care

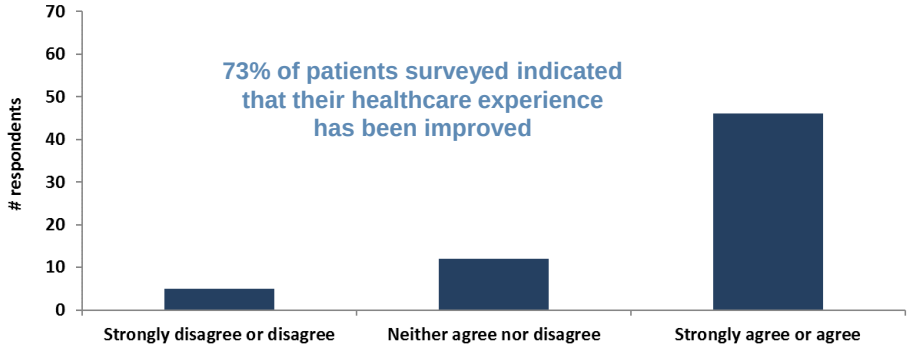


Patient Experience continued

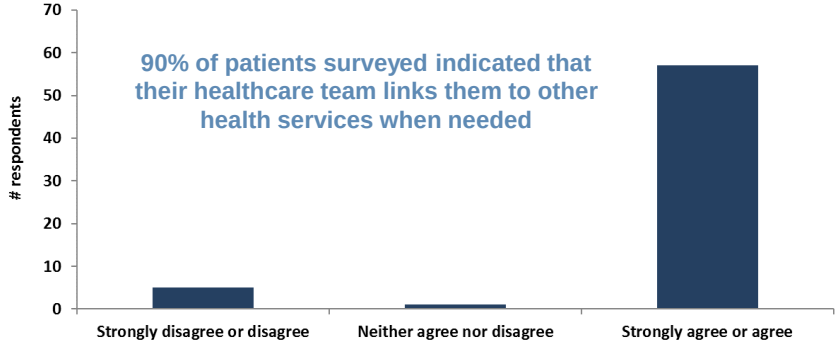
My care plan addresses my health and social situation (e.g. housing, nutrition)



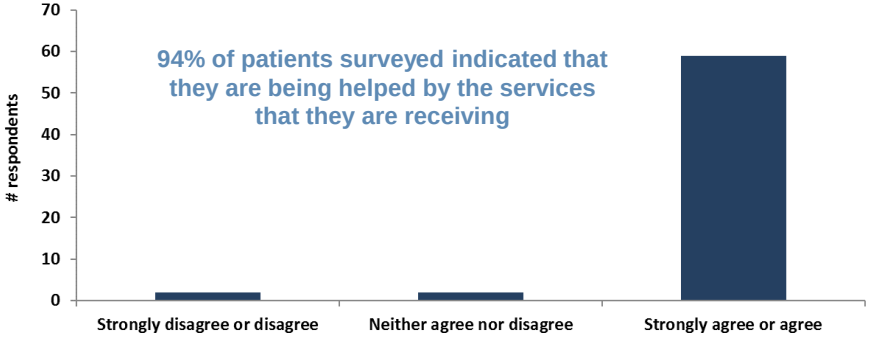
My healthcare experience has been improved



My healthcare team links me to other health services when needed



I am being helped by the services I am receiving



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*

Steve's Story…..

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