HEALTH INNOVATIONS

NAME OF PRACTICE: Hospital Home Team (Virtual Ward)

JURISDICTION: Manitoba

HEALTH THEME: Access and Wait Times; Alternate Levels of Care, Capacity Building; Patient and Family Centred Care; Team Based Models of Care; Quality Improvement and Patient Safety

HEALTH SECTOR: Home and Community care, Acute care, Cancer care, Long-Term care, Primary care, Rehabilitation

IMPLEMENTATION DATE: 2011

SNAPSHOT: This innovative practice aims to reduce frequencies of emergency department visits, hospital admissions, re-admissions and duration of stay through the provision of accessible, comprehensive health care services. Established in 2011 out of Access River East, a Health and Social Services Centre in North East (NE) Winnipeg, this team managed an original caseload of ten select patients with complex health care needs and has since continued to expand patient intake.

PRACTICE DESCRIPTION:

A common consequence of poor access to primary care services is the overreliance on emergency departments to provide frontline care. Often times, patient needs would be more appropriately met in other settings; however, the structure of the system is not designed to provide such care, particularly after hours and on weekends. The Hospital Home Team was initiated on a pilot project basis from 2011-2012 to improve access, continuity of care and quality of life by enabling patients to safely and happily stay at home. This pilot was funded by Manitoba Health through the Manitoba Patient Access Network. This pilot used a predictive risk model to identify individuals most likely to benefit from the program. The identified individuals included in the first cohort were all existing clients of Home and Primary Care at Access River East and due to their complex health care needs, were frequent visitors to hospital emergency units. The initial interprofessional health care team included a physician, a home care case coordinator (social worker) and a registered nurse. The current expanded team has other community and hospital staff that includes other existing medical, allied health, nursing and support staff. As the model continues to expand, there is intention to include mental health professionals and pharmacists. The team does weekly rounds; patient documentation occurs via the Electronic Medical Record and the Resident Assessment Instrument (RAI), Home Care, Minimum Data Set (MDS). Patients are contacted by telephone to arrange appropriate timing of home visits. The team is notified when patients use
emergency services and the emergency staff have access to MDS. An evolving characteristic of this model is the availability of the on call primary care team during evenings and weekends.

IMPACT:

An assessment was conducted pre- and post-implementation of the pilot virtual ward model. The initial ten patients had sought care in the emergency department a total of 27 times over the 12-month period in 2011 which was compared to 64 times in the 12 months previous in 2010. Length of hospital stay for these patients was also compared at 138 in 2011 to 319 in 2010. Qualitative feedback from the families identified that they felt supported in caring for their loved ones in the community and appreciated the timely response of the team. For patients living on their own, they reported greater confidence living independently despite having complex health needs. From the palliative care coordinator, they reported patients and families expressing satisfaction with the care received and from the palliative care physician, they considered the team approach to be vital to keeping patients in their home communities. The original pilot used existing staff and potential cost reduction for inpatient bed days alone were approximately $140,000 based on a bed cost of $800/day. These savings are not extractable but represent an ability to care for more patients within the original budget allocation.

APPLICABILITY/TRANSFERABILITY:

The concept of the virtual ward is linked to development in the United Kingdom in the early 2000’s. A Canadian-led research team has since developed the ‘LACE’ index (L—length of stay; A—acuity of admission; C—Charlson Comorbidity Index; E—number of emergency room visits in the last six months) to predict otherwise unplanned readmission within 30 days post hospital discharge and provides a transferrable algorithm for calculated appropriate case management for this type of care model.

The successes of the Hospital Home Team in Winnipeg are related to the well-established relationships between the NE Winnipeg staff and leadership across community and acute care and the health and social services programs of the Winnipeg Regional Health Authority and Government of Manitoba, Family Services.

The Hospital Home Team expansion will increase patient capacities to 100 over the next few years and include Access Transcona, a second Health and Social Services site in NE Winnipeg. In addition a second team has been established in West Winnipeg with another planned for South Winnipeg. Additionally, there are three other virtual wards at various stages of development in Canada:

Toronto Central Community Care Access Centre (and in some hospitals associated with the University of Toronto).

South East Toronto Family Health Team (for patients being discharged from Toronto East General Hospital)

http://www.cfhi-fcass.ca/Libraries/Picking_up_the_pace_files/Kavita_Mehta.sflb.ashx;

St Mary’s Hospital in Quebec (which focuses on patients with mental illness)

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