The TEGH Virtual Ward: A Novel Transition Model for Vulnerable Patients

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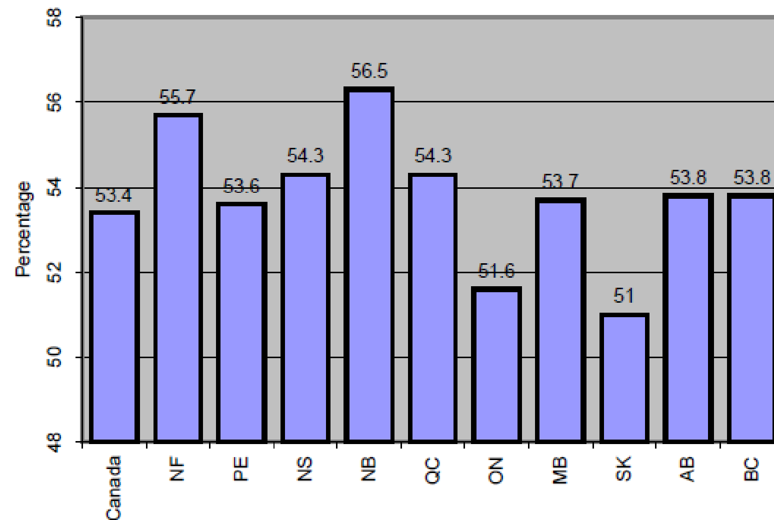
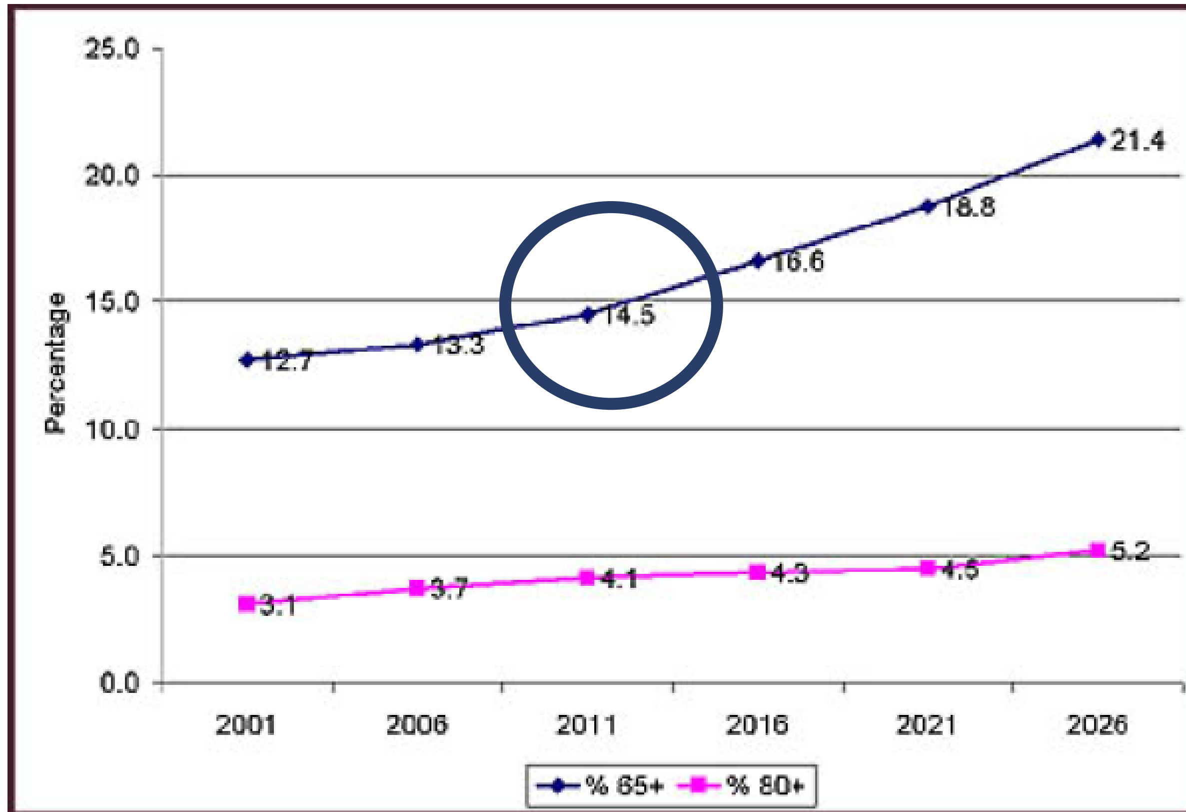
The Cost of Chronic Disease to Total Economic Burden of Illness in Canada

- 70% of all deaths in Canada (2002)
- >50% of all medical care, premature death & disability costs
- 66% of all productivity losses & cost Canada more than $93 billion annually in direct health care costs and indirect productivity losses



The Aging of Canadians

Figure 35. Projected Percentage of Canadians 65+, 80+, 2001-2026, (%)



Source: Statistics Canada, "Population Projections … to 2026"; available at http://www.statcan.ca/english/Pgdb/demo23c.htm.

Some Data...

- A recent study found that 19.6% of Medicare patients discharged from hospitals between October and December 2003 were readmitted within 30 days, 34% within 90 days, and 56.1% were readmitted within 1 year of hospital discharge. **(Jencks et al. 2010)**
- Research indicates that those with multiple chronic conditions cost up to 7 times those patients with only one (**Integrated Client Care Project (ICCP) for Seniors with Complex Needs, Communication 2011)**
- A recent Ontario review estimated that 0.3% of patients account for approximately 10% of hospital discharges and 40% of bed days (Colin Preyra)

What Are We Doing Now?

- Home First
- ALC reduction strategies
  - Long term ALC
  - 2 day ALC
  - Crisis/Convalescence
- Integrated Care for Complex Populations
- Discharge Planning (Balancing Rights and Responsibilities)
- TC LHIN Senior Friendly Hospital Report and Actions

"We have been too much consumed with the supply side of the health care equation and too little concerned with the demand side. The best way to reduce costs and improve health at the same time…is not just to control the services provided but to also reduce the need and demand for care… "

Fries, Koop, Sokolov, Beatle and Wright 1998

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What is the TEGH Virtual Ward?

A transition model bridging the service gap from hospital to home to family doctor for people with the most complex medical and social needs.

- Create new alliances between
  - hospital and primary care physicians
  - hospital and CCAC
- Forge new pathways
- Reduce readmission burden

Not new to the world…new to Canada

Goals of TEGH Virtual Ward

To provide post-discharge support for patients identified as high risk for readmission in order to:

- Enable patients to remain healthy within their home environment
- Reduce the frequency & duration of unscheduled hospital re-admissions
- Increase patient satisfaction scores by improving the quality and effectiveness of TEGH follow-up care services
- Improve post-discharge health related quality of life scores

Virtual Ward Process

ENROLLMENT

- Screening
- Consent
- Consults
- CCAC
- Physicians

AT HOME

Case Manager Phone Calls

Daily Reports

DISCHARGE from VIRTUAL WARD

Weekly Rounds

Discharge Criteria

Virtual Ward Nurse Documentation

Preferred Phone Number

Perferred Time of Day

Alternate Contact Name

Alternate Contact Number

Call Start **-***-**** Call End **-***-****

General Observations

Speech

- [ ] Normal
- [ ] Slurred
- [ ] Language barrier
- [ ] Other:

Fever

Weight kg

General Observation Intervention

- [ ] Family/SDM notified
- [ ] CCAC - Case Coordinator
- [ ] Dietitian
- [ ] Family MD notified
- [ ] Virtual Ward MD notified
- [ ] Not applicable
- [ ] Other:

Coping and Support

Identify CCAC and Family Involvement in Care

- [ ] Spouse/Partner
- [ ] Daughter
- [ ] Son
- [ ] Niece
- [ ] Nephew
- [ ] Grandchild
- [ ] Sister
- [ ] Brother
- [ ] Friend
- [ ] Personal Support Worker
- [ ] Nursing
- [ ] Social Worker
- [ ] Physiotherapy
- [ ] Occupational Therapy
- [ ] Case Management
- [ ] Other:

Patient's Assessment of Well Being

- [ ] I am not improving or getting better
- [ ] I am not able to do my usual activities
- [ ] I am not sleeping through the night
- [ ] I feel anxious/afraid
- [ ] I am able to do my usual activities
- [ ] I feel rested after sleeping
- [ ] I am getting better
- [ ] Other:

Coping and Support Intervention

- [ ] Family/SDM notified
- [ ] CCAC - Case Coordinator
- [ ] Dietitian
- [ ] Family MD notified
- [ ] Virtual Ward MD notified
- [ ] Education
- [ ] Virtual Ward Clinic
- [ ] Not applicable
- [ ] Other:

Level of Activity

Patient's Assessment of Activity

- [ ] Climbs stairs on own
- [ ] Able to walk usual distance
- [ ] Bathes self
- [ ] Climbs stairs with assistance
- [ ] Walking shorter distances
- [ ] Needs assistance walking

Assistive Devices

- [ ] Cane
- [ ] Walker
- [ ] Wheelchair
- [ ] Motorized chair/scooter
- [ ] Other:

Falls

Number of Falls

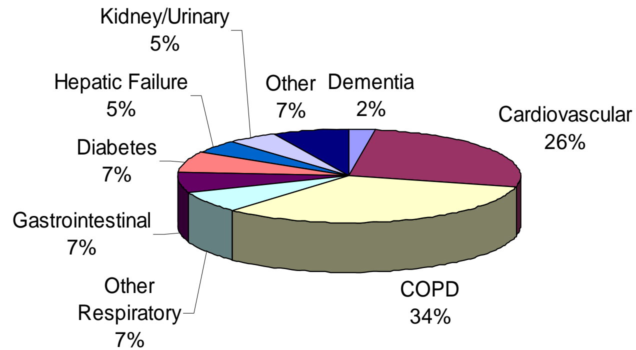
Injury from Fall

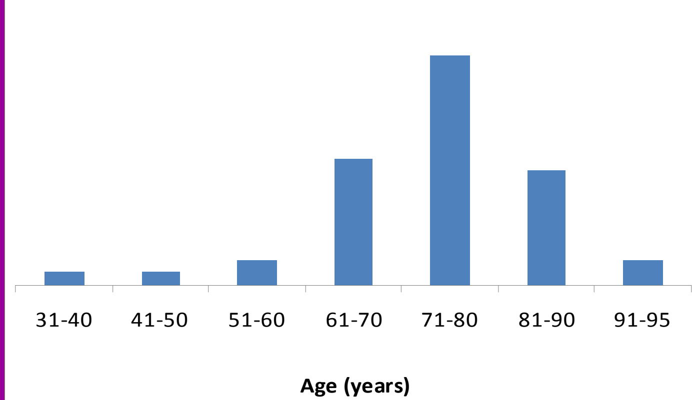
Date of Fall **-***-****

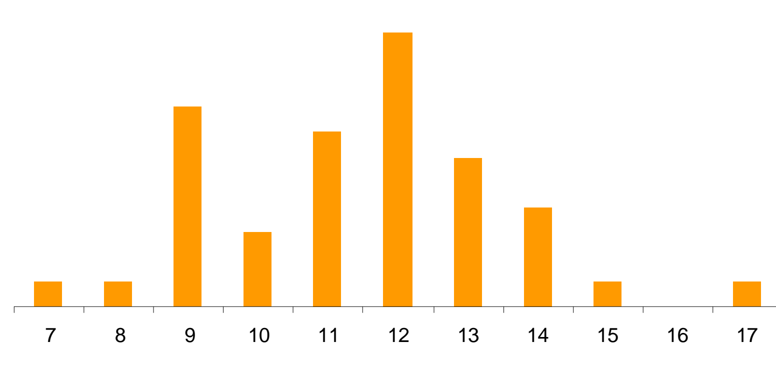
CASE STORY

Mr. A……

Demographics







How Are We Doing?

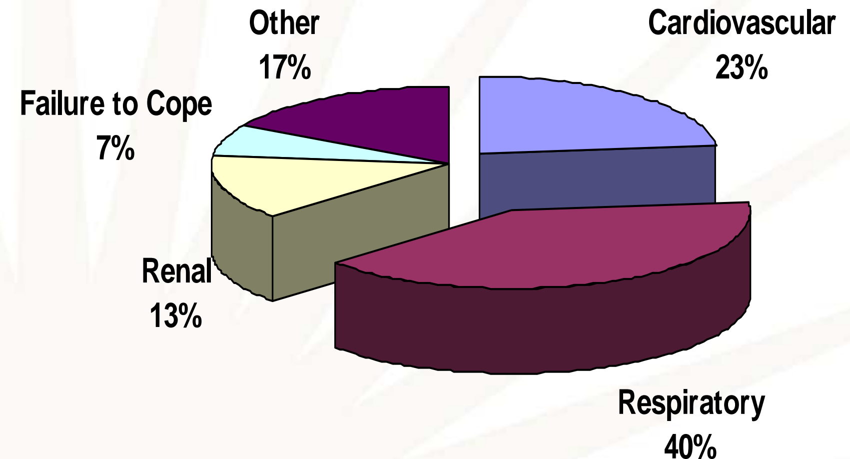
September 7. 2010 to February 1, 2011

No. of Patients	43
Median Length of Stay	52

Outcomes

Patients Readmitted	19
Readmission Events	30 (30%)
Deaths	7 (16.3%)
Transitioned to LTC	4 (9.3%)

Reasons for Readmission



Patient Satisfaction

LESSONS LEARNED

- Complex patients have more than just medical needs
- Health care is more than illness care
- Chronic disease management frameworks should acknowledge end of life care as a component

Next Steps

Program Evaluation

Evaluation of Electronic Documentation

Palliative Care Arm

Work Towards Sustainability

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T E G H

Above all,
we care.