Community Rapid Response Team (CRRT)

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Learning Objectives

Participants will :

- Understand the relationship between various enhanced home based interventions to support seniors to “age in place”

- Recognize the impact of a community based inter-professional team to enable seniors and other clients with complex needs to remain safely in their own home

- Identify successes & challenges associated with the development & implementation of an inter-professional Community Rapid Response Team pilot project

Community Rapid Response Team (CRRT)

A pilot program in partnership with Department of Health and Community Services & Eastern Health:

- Home & Community Care
- St. John's adult emergency departments

Why Implement this Pilot Program?

Seniors compromise 25% of ED visits

44% will return to ED within 6 months

Average length of stay for seniors in hospital is twice that of any other age group

Functional ability is critical to the ability of seniors to remain in their own home and community

Why Implement this Pilot Program?

- Findings suggest that seniors are able to be cared for at home, with the right supports in place (Data source CIHI, 2012)

- Assisting appropriate individuals in returning home upon presentation to ED avoids unnecessary hospital admissions

Why Implement this Pilot Program?

Multiple risk factors which complicate treatment/discharge options:

- multiple medications
- mobility issues
- cognitive impairment
- lack of supports

Seniors want to age in place

Goal of the Program

Eastern Health

To provide quality, cost effective care primarily to seniors in their own home as an alternative to acute or long term care.

Eligibility Criteria

- Adults who present to the ED primarily age 65 years and older who meet eligibility criteria
- Multiple medical problems
- Taking multiple medications
- Presented due to a fall or are at risk of falling
- Acute delirium - stabilized through intervention
- Common diagnosis but not limited to UTI, CHF, COPD

Eligibility Criteria

- Presents due to caregiver burnout /failure to cope at home
- Risk of hospital admission / re-presentation to ED
- Unplanned hospital admission in last 30 days
- Acute care admission-potential early discharge to community
- Live within a defined geographical boundary

- Acute Care – Alternate level of Care (ALC) – assess for discharge to community

CRRT Data to Date

As of April 30, 2016:

Total of 1408 Referrals to CRRT program since Sept 15, 2014 from both EDs.

459 clients accepted to program:

242 presented to the ED during daytime hours Mon to Fri

163 presented after hours or on weekend

54 early discharge from acute care

CRRT Data to Date

As of April 30, 2016:

949 declined service:

455 presented to the ED during daytime hours Mon to Fri

473 presented after hours or on weekend

21 early discharge from acute care

Reasons for declined service:

- Eligibility criteria not met
- Outside geographical boundary
- Adequate community supports already in place
- Client / family did not want service

Members of the Community Rapid Response Team

2 Teams in St. John's (I permanent & 1 Temporary)

- Two full - time Community Health Nurses – one based at the HSC & St. Clare's ED

Community based staff:

- One full - time Community Health Nurse (as of Dec 2015)
- One full-time Social Worker (as of Dec 2015)
- One full - time Nurse Practitioner
- One full - time Physiotherapist
- One full - time Occupational Therapist
- One full - time administrative support staff

Role of the Emergency Department Physician

- Medically assess potential CRRT clients
- Refer potential clients to the CRRT Community Health Nurse for assessment
- Develop the client's treatment plan for discharge in collaboration with the CRRT Community Health Nurse

Role of Emergency Department Nurse

- Assess clients upon presentation to the ED with consideration of CRRT eligibility criteria
- Liaise with the ED physician and CRRT Community Health Nurse based in the emergency department
- Identify/refer potential clients to the CRRT Community Health Nurse for assessment

Role of CRRT Community Health Nurse in Emergency Department

- Receive the referral for CRRT assessment from the ED Team & assess for eligibility
- Assess clients' needs utilizing the comprehensive Geriatric Assessment Tool
- Engage the client and family in the development of a care plan

Role of CRRT Community Health Nurse in Emergency Department

Refer / arrange:

- assessment by other Community Rapid Response Team members in the home
- emergency home supports without financial assessment
- required equipment / supplies
- Educate acute care and community based staff & physicians regarding the CRRT program

Role of CRRT Occupational and Physical Therapy

- Assess, plan and evaluate interventions that support clients in improving functional performance to maintain independence

- Collaborate with members of the client's health care team, formal and informal supports with a goal to achieve optimal client outcomes

- Refer client to appropriate follow-up services, as required, upon discharge form CRRT

Role of the CRRT Community Health Nurse

- Assess and plan interventions utilizing the comprehensive Geriatric Assessment Tool if not completed in the ED & refer to appropriate team members for service
- Monitor progress to assist clients in achieving their optimal level of health and wellness
- Refer client/family to appropriate services for follow-up, as required, following discharge from CRRT
- Educate acute care and community based staff and physicians regarding the CRRT program

Role of the CRRT Social Worker

- On going assessment of home support needs following hospital or ED discharge onto the CRRT
- Assess long term home support needs following the initial 2 weeks of CRRT service
- Liaise with Community Supports program staff & FAOs regarding short / long term home supports if eligible for service
- Assess and implement long term care application for Personal Care Home or Nursing Home as required
- Address & evaluate adult protection concerns as required

Role of CRRT Nurse Practitioner in Community

- Provide primary care services in the home within NP scope of practice
- Collaborate with the client's family physician and other members of the health care team to support the client in the community
- Liaise with other formal and informal client supports

Role of CRRT Administrative Support

- Provide administrative support for the clinical team
- Collect data for monitoring and evaluation
- Provide notification of CRRT service to the client's family doctor and other Eastern Health services providers involved in client's care
- Receive calls from staff, clients and families who need to access the team

Role of the Family Doctor

- Work in consultation with the members of the CRRT
- Participate in decisions regarding the plan of care
- May provide home visits

Other CRRT Services

- Pharmacist Consultation – medication review
- Case Conferences with CRRT collaborating Physician
- 2 Physician groups in St. John’s willing to accept new patients who do not have a Family Doctor

CRRT Program Summary

- Comprehensive Geriatric Assessment Tool completed on all clients
- Access to an NP, CHN, OT and/or PT services as indicated by assessment for up to 30 days
- Access to home support, without financial assessment, for a period of up to 14 days
- Access to equipment / supplies for up to 30 days
- Link to Eastern Health home care services or other community based services to maintain client at home following Community Rapid Response Team involvement

Evaluation

- PDSA Model Quality Improvement Opportunities for revisions were considered during the pilot

- Formal evaluation following pilot to be completed - NLCHI

Key Insights & Lessons Learned

- Uptake lower than anticipated when program's initial criteria implemented
- Implementation of a new community based program with staff new to community practice can be a challenge
- Comprehensive orientation and team building are required
- Engaging stakeholders & providing ongoing education regarding the program prior to & following implementation

Key Insights & Lessons Learned

- Ongoing education / coaching of acute care staff
- Address challenges – input /collaboration with internal stakeholders
- A need for additional services identified:
  - Social Worker
  - Increased community based OT & PT
- Public unaware of how to access community based services

Key Insights & Lessons Learned

- Client average age ~ 80 years
- Falls - most common presenting problem
- Majority of clients have a family physician willing to make house calls
- Number of people without family physician lower than expected
- Length of time for home support services available through CRRT inadequate at times
- Securing home support services & equipment in a timely manner can be a challenge

Thank-You

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Questions & Discussion