Hamilton Health Sciences

# An Inter-professional Approach to Managing the Complex Geriatric Patient in a Hospital Setting

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# Introduction

- JH Medicine Program
- F5 Medicine
- Case Scenario
- Questions

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# JH Medicine Program

Patient requires hospitalization

Arrives at Hospital Triaged, Ax, Tx

Medicine Consulted

Decision to Admit

GIM MD –acute pt. Treated and discharged, or:

Refer to GRU

Refer to SPH

Transfer to F5 if D/C plan not ready

Discharge coordinated with community

- Emergency Department
- Acute Medicine Clinical Teaching Unit
  - E3, F3, B3 at Juravinski Hospital
- Geriatric Rehabilitation Unit *(GRU)*
- St. Peter's Hospital *(Palliative, Complex Care, ALC)*
- F5 Medicine *(Alternate Level of Care)*
- Our Community Partners *(LHIN, TCB, LTC)*

# Volumes
## April – October 2017

| Program | Budgeted Beds | Actual Bed Usage | Occupancy % | Average Acute Length of Stay (LOS) | Average Overall Length of Stay (LOS) |
|---|---|---|---|---|---|
| Medicine | 116 | 159.1 | 118.7% | | |
| E3 | 32 | 33.6 | 104.9% | 6.3 | 7 |
| F3 | 31 | 32.5 | 104.9% | 6.8 | 7.3 |
| B3 | 15 | 14.9 | 99.2% | 6.6 | 7.9 |
| F5 | 38 | 41.1 | 108.3% | - | 27 |
| **Program** | **Average visits/day** | **Visits YTD** | **Admitted** | **% admitted** | |
| Emergency | 117 | 17,906 | 3,702 | 20.7% | |

38% of patients presenting to Juravinski ED are 65 years of age or greater
75% of patients cared for on the Juravinski Medicine units are 65 years of age or greater

# What is Frailty?

State of reduced physiologic fitness and reserve resulting in vulnerability to stressors and leading to poor outcomes.

*Bergman, 2007*

**Frailty is a concurrence of;**

- comorbidities
- age-related physiological changes, including cognitive impairment
- geriatric syndromes (falls, delirium, incontinence, etc.)
- gaps in social support

Frailty is a combination of multiple deficits interacting with one another leading to a progressive erosion of fitness and increased vulnerability.

# F5 Medicine
# ALC – Alternate Level of Care

**What is Alternative Level of Care?**

Ministry of Health and Long Term Care definition**:**

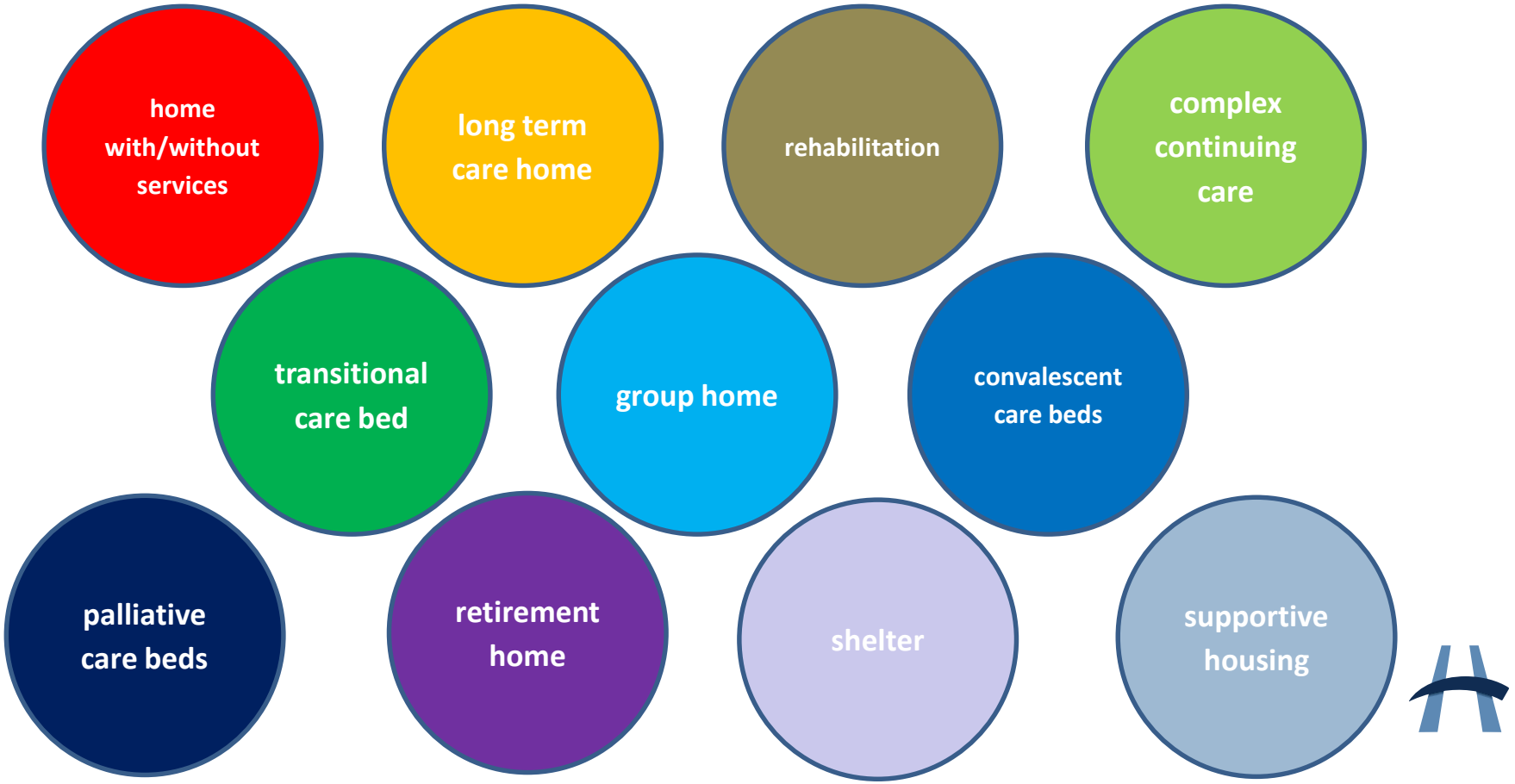
- When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting.
- The patient is designated ALC by the physician and the ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination.

# F5 Medicine
# ALC – Alternate Level of Care

**A patient can be designated ALC when:**

# F5 Medicine

## Discharge/transfer destinations may include:



# F5 Medicine: Our Team

***Who do you need to run a Transitional Medicine Unit?***

- Registered Nurses
- Health Care Aides
- Occupational Therapists
- OTA/PTAs
- Business Clerks
- Environmental Aides
- Registered Practical Nurses
- Social Workers
- Physiotherapists
- Pharmacists
- Physicians
- Nutrition Associates

# Case Study

## The Patient

- Diagnosis of Alzheimer's Dementia
- From Home with Spouse
- Complex care needs – progression of disease, acute changes causing readmission

# Case Study

## 1st admission

- Patient's care needs (nursing, psw, therapy) were able to be managed at home with LHIN and community supports
- Home First Plan

# Case Study

## 2nd admission

- Caregiver Burnout
- Patient's care needs were reviewed and his level of care exceeded a return home
- Patient's care needs (nursing, psw, therapy) required a more supervised setting
- Transitional Care Bed

# Case Study

## 3rd admission

- Change in patient's care needs
- Supportive documentation from the healthcare team (hospitalist, nursing, OT/PT, PSW, SW)
- Patient escalated to wait in hospital since December 2016
- Review of Care Needs – Inter-professional Approach to Discharge Planning on F5

# Analysis

Examining **what can we learn** and how can we apply the knowledge

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# What we have learned

Our patient population is very complex

- Many patients will admit to the hospital multiple times
  - Their illness/co-morbid condition often worsens and changes their care needs
  - Their community environment/support structure may be weakening
  - They may simply be outliving their available support
- What happens during their post-acute time in hospital is critical to their success after discharge.
- ALC/post acute care requires an inter-professional approach to sustain medical stability, emotional and functional capacity.

# What we have learned

## The Inter-professional Care Plan on F5

- If they can get up, they should get up
- OT/PT/Nursing/HCA/Physician communication & collaboration
- Hospital Elder Life Program (HELP)
- Involving the family/caregivers
- Partnering with community providers

# What we have learned

The Inter-professional Care Plan on F5 includes:

- Inter-disciplinary rounds 2 times per week
- Daily Huddles that are not just about safety
- ALC Rounds 3 times per week
- Behaviour Management training (GPA, neurobehavioural)
- LHIN Updates
- Behavioural Support Ontario (BSO)
- Family meetings

# What we have learned

## The Inter-professional Care Plan on F5

- Inter-professional practice places the patient, the person, at the centre of care and progress towards discharge.

- When a team of specialists communicate, and work together towards a goal, we can advance a care plan that will lead to the most sustainable discharge plan.

# What we have learned

## The Inter-professional Care Plan on F5

- With this inter-professional approach, we will still encounter recurring or advancing illness, and repeat hospitalization.  Progressive illnesses will alter care needs as time passes.

- We always aim to optimize the quality of our patients lives with the most appropriate discharge plan, through contributions from all team members, utilizing all available areas of expertise.


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