Xtend Care

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A service presentation by Planned Care

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Development of Role of CHN in Chronic Care: Model of Care

2015 -Long waiting list for Cardiac Chronic follow up, post hospital discharge and readmission rates were 30% within 28 days. Julie Finch, Program Manager Chronic and Complex Care.

Proposed post hospital discharge follow up with the following aims:

- Improve wellbeing, compliance with medication, exercise plans, healthy eating
- Increase GP/specialist follow ups attended by clients.
- Integrate acute, community and primary care for optimal discharge process.
- Specialised sub acute care/Post discharge support within 5 days of discharge
- Train and utilise AIN's to extend reach of cardiac chronic care team with CNC supervising)
- Reduce readmission rates and improve health outcomes
- support of client to manage health post discharge

Goals

REDUCE	INCREASE	IMPROVE
Unplanned and avoidable hospital admissions by	Client access to primary healthcare/GP and attendance at medical follow up appointments	Integration of care between health professionals and teams
The progression and complications of chronic disease and impacts of psychosocial vulnerabilities	Client education and health coaching and support for vulnerable clients with complex presentation	Quality of life for people with chronic disease and psychosocial issues impacting on health outcomes and wellbeing
Duplication of services and unnecessary interventions	Care navigation for clients and families	The Health systems capacity to respond to the needs of people with complex needs

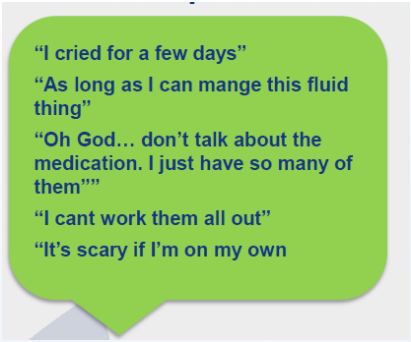
Outcomes of Post Hospital Follow up

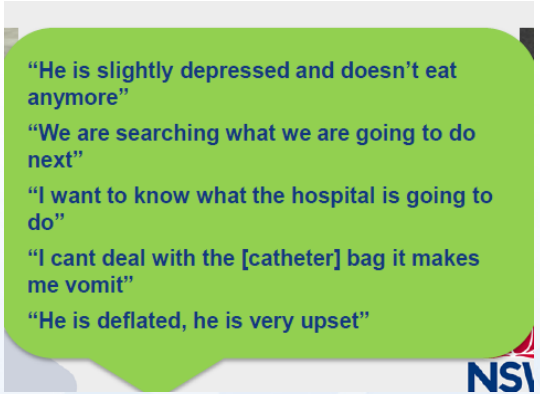
- Reduced readmissions by 10% in 12 months.
- Medication reconciliation and link to follow up apts and GP follow up.
- Language impacted on readmission rate
- Decreased waiting times for Cardiac Chronic care services.
- Education module developed for AIN's
- 2018 grant application for extension to more clients and extended to aged and chronic care clients 2016 in conjunction with existing Chronic Care services in place.

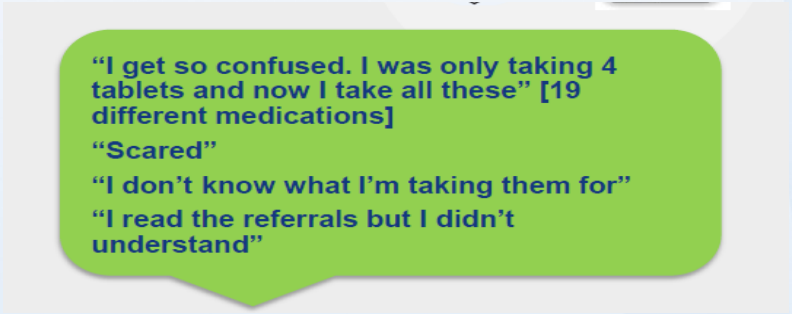
Aims of Xtend remain same as previous and also include:

- Follow up within 48 hours of discharge from hospital
- Reinforcing the inpatient discharge plan
- Escalate needs more quickly
- Develop patient self-management strategies
- Increase patient engagement with their GP in a timely manner and awareness of the discharge plan
- Encouraging the GP as being central to the patient's continuing care
- Reduce 28 days readmission rate

Client Comments before follow up







Review of Xtend 2019

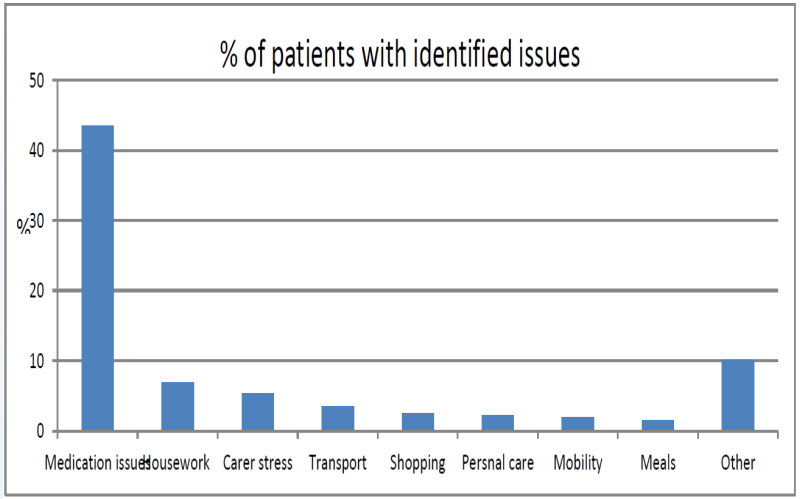


Figure 1: Issues identified by CHW (% of patients)

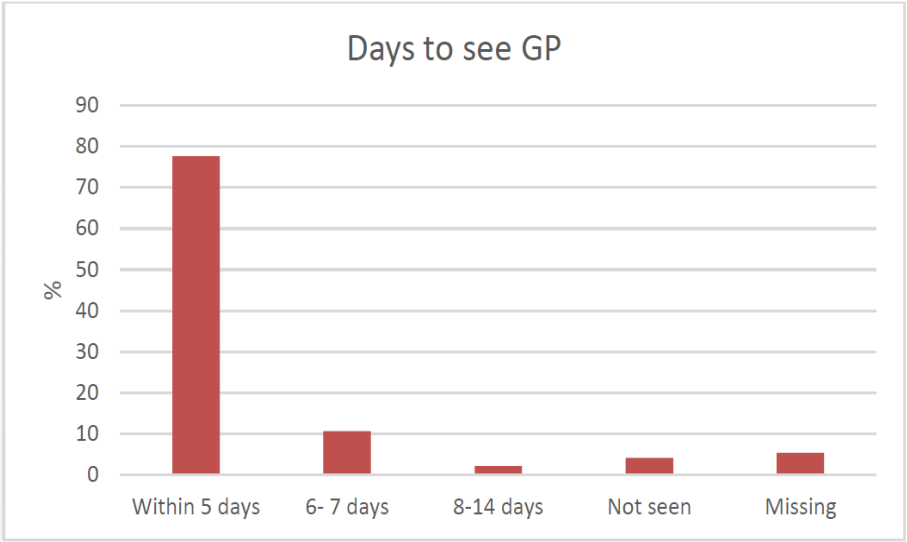
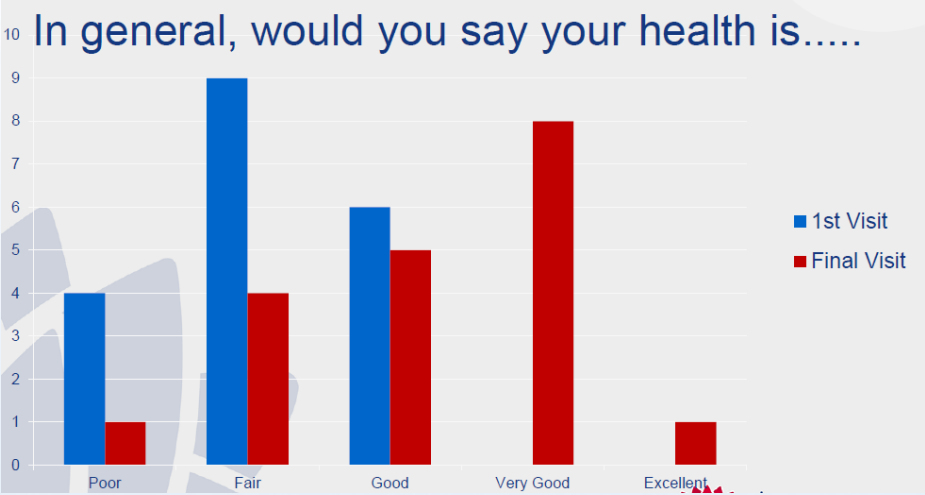
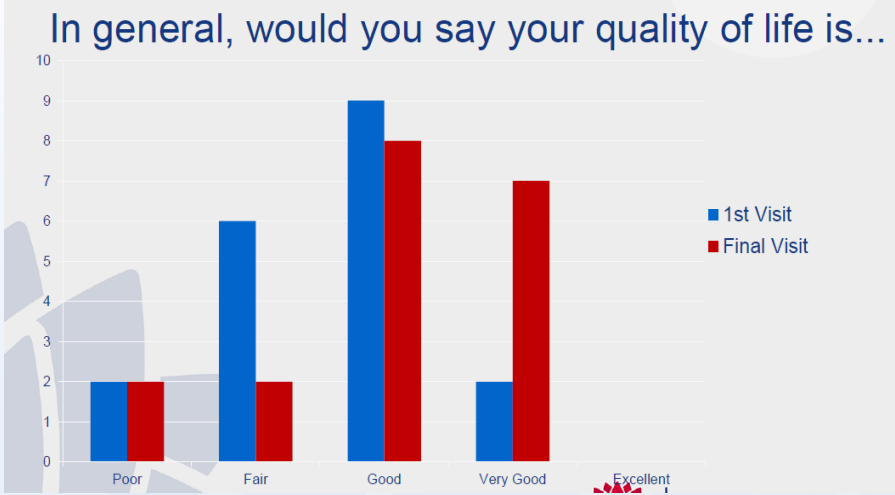


Figure 2: Time (days) until seen by GP (% of patients)

Client reported outcome following CHW input





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Client presentation

- Wait until desperate to get help
- Can find it difficult to ask for help
- Feel better, so don't think need to follow up with GP/specialist
- Don't know how to access services/know services available
- Don't follow discharge plan/medication regime
- Stress, cognition, insight limits management at home
- Home environment and relationships may impact recovery/function.

Importance of early follow up

- Medications confirmed, and limit likelihood of taking incorrect/prev meds
- May not have information/remember/understand what to do when home
- Not sure how to manage or understand condition or warning signs
- Not sure when have to be reviewed or by whom
- Feel better, and think it may not apply now at home
- Someone to ask or remind them when in hospital, no one to ask at home
- Insight to difficulty is not in line with difficulties experienced
- Overwhelmed or motivation barriers identified
- Improve continuity of care
- Predictions of how manage are based on hospital ax not home ax with all t environmental/relationship and support factors related to home.

Assessment

Comprehensive assessment is completed on initial meeting and done preferably face to face in the patient's home. Comprehensive Assessment includes:

Screening and consent: Home Risk Assessment, COVID screening, CcOPS and HOPE

Rapport building

Identifying client motivation and insigh

Contacts: check details and (GP), other Specialists/Teams involved, social contacts
Social background/situation: Childhood/Family/social history/family dynamics, education level, occupation/work/retired, owned/rent//public housing/boarding house, respite/carer stress, finances (self-funded/pension/POA/Financial guardian), home/carer support, services in place/aged Care Approvals referrals indicates, decision making/capacity, cultural background in order to tailor links to suit client situation

Discharge summary review: reason for hospital admission, ability to accessing appointments and possible planning to access appointment, Medication and medication compliance (self-administers/requires prompting/needs Webster pack)

Plan of care: Intervention.

Planned Care Intervention

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Care Coordination and navigation: Referring and assisting with ACAT/RAS/NDIS/Ability First etc.

Health Coaching and Education: Diabetes, CCF, HTN, Epilepsy, Dementia (BPSD), Renal failure, CKD, Asthma, COPD, chronic pain, cancer, heart disease, stroke etc.

Assistance of complex issues: Housing, safety, guardianship, DV etc.

Specialist linkage: Linking with GP, specialists and other allied health staff

Care Planning: Individualised, client centred goals for client to manage health mana

Service linkage: Referral and linking to services where services are available

Connecting with services: Liaison with all care providers including acute, primary, community, services, carers

Individualised Care

Benefit of CHN in Health Based setting

- Access to notes to see d/c plan
- Link to health services for follow up
- Integrated care with other health and community team
- Documentation in medical records and communication available for ongoing medical teams
- Identification of concerns and link to follow up if complex to clinician
- Structure of education and supervision and part of team
- Support from Nurses, SW, TL,
- structure that ensures growth development and access and learning
- Resource links both health and non health support options.
- Geriatrician and Medical case conferences
- Integrated Care measure CCoPS
- Established and standardised PREMS and PROMS using HOPE platform
- Health resources and framework, such as diversity hub, interpreters, cultural awareness programs, supervision, peer support, safety huddles, collaboration, feedback to change processes to improve outcomes, competencies

Intervention scenarios

- identified that the patient was not taking the new medications outlined in the discharge summary and had returned to his pre-hospitalisation Webster Pack. This was escalated to the nurse who liaised with the GP/pharmacist to update his Webster Pack

- identified that the patient had been without glasses and unable to read his medications and discharge instructions. He did not have the means to address the issue or access an Optometrist. The CHW investigated ways to get a new pair of glasses for the patient through discussions with Centrelink and after assisting the patient with the appropriate documentation the patient was able to access glasses free of charge.

- identified that the patient was taking Furosemide 40mg instead of 80mg. The CHW completed a GP Medication list and notified the supervising RN. The patient visited their GP to update the medications and the CHW confirmed with the patient and the family that all the medication issues had been rectified. No further issues were identified at follow up visits.

Intervention scenarios

- identified the situation where a son had filled his mother's dosette box with medications but had unknowingly mixed it up. Instead of antibiotics 3x a day and aspirin every 2nd day the patient was taking aspirin 3x a day and antibiotic every 2 day. The son was able to correct this and the correct medication was then taken.

- identified a heart failure patient on a 1.2 litre fluid restriction who had been given instructions to drink the 3 litres of fluid in preparation for a colonoscopy. This was escalated to the Cardiac nurse to prevent fluid overload and a possible readmission

- identified patients who had difficulty with the cost of medication and the number of different medications. This was listed on the GP Question List to prompt discussion with the GP and consideration of a medication review

- tactfully discussed the patient's strong odour and identified inflamed and infected skin in this obese man's stomach folds. Accepted assistance with showering and personal care through his HCP

Next steps

- Link with UNSW to research the impact of CHN's on client wellbeing
- 3 CHN's employed
- Starting in Nov
- 60 days intervention
- Based on Xtend model