Community Rapid Response Team (CRRT)

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Community Rapid Response Team (CRRT)

A pilot program in partnership between:

• Department of Health and Community Services
• Regional Health Authorities
  • Home & Community Care
  • HSC & SCMH Emergency Departments (ED)
Community Rapid Response Team (Cont’d)

Based out of emergency departments at four sites:

• Health Sciences Centre (St. John’s)
• St. Clare’s Mercy Hospital (St. John’s)
• Central Newfoundland Regional Health Centre (Grand Falls-Windsor)
• Western Memorial Regional Hospital (Corner Brook)
Why Implement this Pilot Program?

- Seniors comprise 25% of all ED visits
- 44% of discharged seniors will return within six months
- Discharge with no readily available caregiver or support system can lead to early re-admission
- Average length of stay for seniors in hospital is twice that of any other age group
Why Implement this Pilot Program? (Cont’d)

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

• Strong support systems key for seniors to remain at home:
  - Formal
  - Informal

Data Source: CIHI 2010
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
Multiple risk factors which complicate treatment/discharge options:

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

Seniors want to age in place
Why Implement this Pilot Program? (Cont’d)

To facilitate

• recovery at home for a client that may have been previously admitted to hospital
• independence in activities of daily living

Other jurisdictions have success with similar programs including:

• positive client outcomes
• positive impact on emergency and acute care inpatient bed utilization
In 2013/14 fiscal year:

- 22.8% of ED registrations individuals age 65+
- Equates to over 20,000 visits

- 11.8% of ED registrations individuals age 75+
- Equates to over 10,000 visits

(Data Source: Meditech via Cognos reporting)
Alternate Level of Care (ALC)

Acute inpatient days utilized as alternate level of care (ALC) continues to increase

In 2013/2014 fiscal year at HSC & SCMH:

• 21% of inpatient days for inpatients 65+ were ALC days = 53 beds

• 28.6% of inpatient days for inpatients 75+ were ALC days = 38 beds

(Data source: DAD 3M via Cognos reporting)
Eastern Health Data (Cont’d)

Emergency Department Entry Point

Within Canada, 67% of seniors within acute care waiting for alternate level of care entered the hospital via the emergency department

(Data Source: CIHI, 2011)

HSC & SCMH 2013 /2014 Fiscal year:

• 77% of the ALC patients age 65+ were admitted through the ED = 46 beds
• 82.5% of the ALC patients age 75+ were admitted through the ED = 35 beds

(Data source: DAD 3M via Cognos reporting)
Goals of the Program

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

- Positive impact on ED wait times
- Positive impact on acute care utilization / services
- Maintain people in own home / community
Goals of the Program (cont’d)

- To provide enhanced community based services in the short term for a period of up to 30 days

- To develop plans of care that link clients to the appropriate community services necessary to meet their long term needs
Eligibility Criteria

• Adults who present to the ED primarily age 65 years and older who meet eligibility criteria
• Clients under the age of 65 who meet eligibility criteria may be considered
• Present to the ED during daytime hours, after hours or on weekends
• Multiple medical problems
• Prescribed / taking multiple medications
• Presented due to a fall or are at risk of falling
• Acute delirium - stabilized through intervention
Eligibility Criteria (Cont’d)

- Common diagnosis but not limited to UTI, CHF, COPD
- 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

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

• St. John’s
• Torbay, Flatrock, Pouch Cove, Portugal Cove - St. Phillips
• Mount Pearl
• Paradise, Conception Bay South
• Southern Shore – Communities serviced from Witless Bay and Ferryland Community Health offices
CRRT Data to Date
As of September 29, 2015

Referrals Accepted to CRRT Program:
191 Regular hours (since Sept 15 2014)
116 After hours (since Dec 8 2014)
17 Early discharge (since June 15 2015 HSC)
328

Referrals Declined:
203 Regular hours
301 After hours
2 Early discharge (HSC only)
506
Members of the Community Rapid Response Team

2 Teams in St. John’s
• Two full - time Community Health Nurses – one based at the HSC & St. Clare’s ED

Community based staff:
• Two full - time Community Health Nurses
• Two full - time Nurse Practitioners
• One full - time Physiotherapist
• One full - time Occupational Therapist
• One full - time administrative support staff
Other CRRT Services

- Pharmacist Consultation – Medication Review
- Social Worker consultation for Long Term Home Support
- Case Conferences with CRRT Program Collaborating Physician
What about Clients Without a Family Doctor?

- 2 Physician groups in St. John’s willing to accept new patients who do not have a Family Doctor
CRRT Program Details

• 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 are considered during the pilot

- Formal evaluation following 18 months - NLCHI
Evaluation

- Target population – suited to receive service
- Adequacy of service – service provider & client satisfaction
- Impact of program on acute care bed utilization
- Communication between acute care & community
- Successes & challenges
- Utilization of provincial Health Line
Key Insights & Lessons Learned

- Implementation of a new community based program with staff new to community practice
- Demonstrated need for increased community based OT & PT services
- Public unaware of how to access community based / home care services
- Uptake lower than anticipated when program’s initial criteria implemented
- Number of people without family physician lower than expected
- Length of time for home support services available through CRRT inadequate at times
• Engaging stakeholders & providing ongoing education regarding the program prior to & following implementation
• Ongoing education of acute care staff
• Celebrate successes – positive stories
• Address challenges – input from stakeholders
• Draw on resources within the Health Authority to address identified gaps e.g. pharmacist, SW
• Securing home support services & equipment in a timely manner
Questions & Discussion
Thank-You