Sunset Country Family Health Team

Kenora Wound Care Pilot Project

October 1, 2008 – September 31, 2009

AFHTO Conference October 6, 2010

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Project Sponsor

HealthForceOntario 2008-09 Optimizing Use of Health Providers' Competencies Fund

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Where is Kenora?

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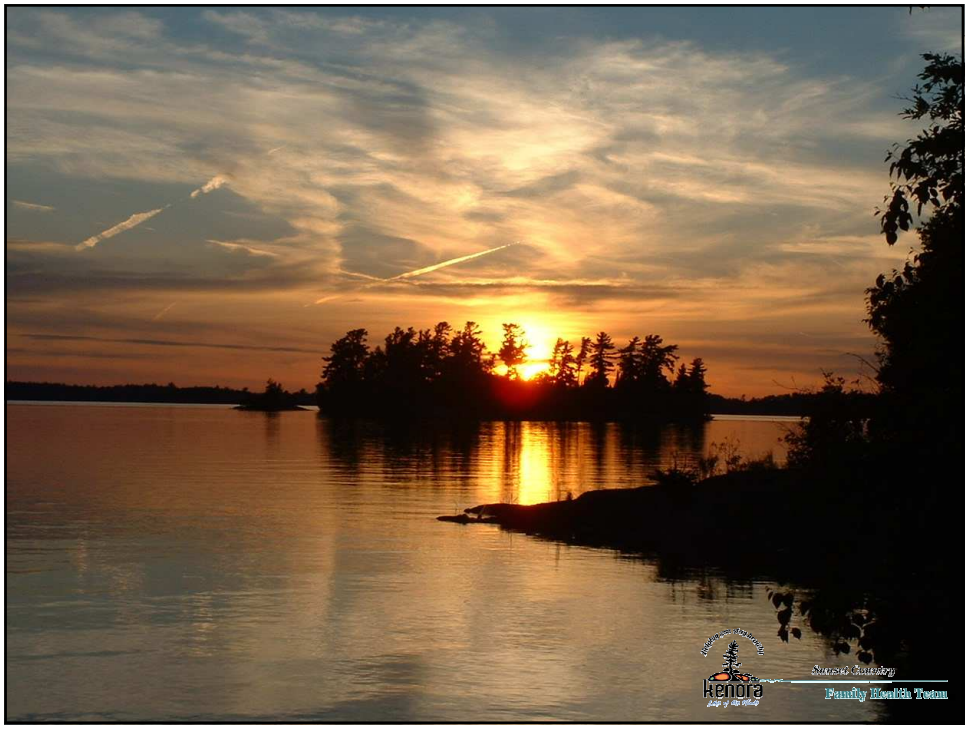
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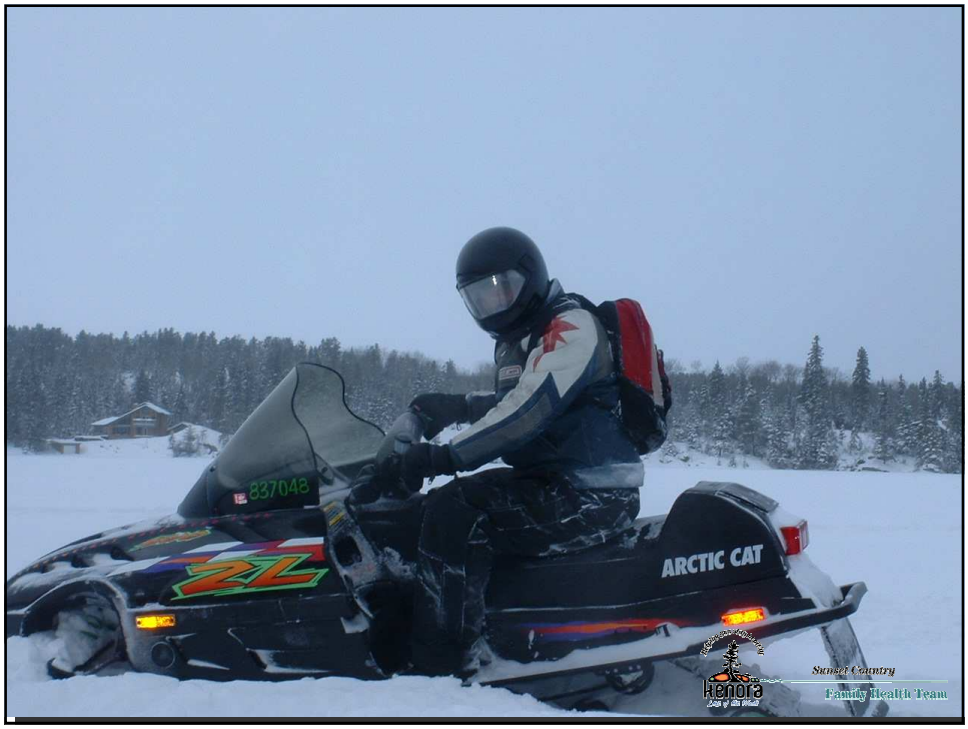
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Who is Sunset Country FHT?

- Began operations in June 2007 (Wave 3 FHT)
- 18 FP Physicians
- 3 sites
  - Paterson Medical Centre (14)
  - Keewatin Medical Clinic (3)
  - Dr. Daly Clinic (2)

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Who is Sunset Country FHT?

- 15.5 FTEs
- Executive Director
- Program Assistant
- Clerical Support
- Nurse Practitioner - 3
- RN Program Coordinators – 2
- RN Diabetes -1
- Dietitian Diabetes - 1
- RPN – 3
- Dietician – 1
- Pharmacist - .5 FTE
- Chiropodist – 1

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Resident Health Status (Kenora)

5 major chronic disease areas identified:

- **Ischemic Heart Disease**
- **Stroke**
- **COLD**
- **Diabetes**
- **Hypertension**
- **+ highest rates of smoking, alcohol, obesity**

Northwestern Health Unit report on Resident Health Status 2004

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Service Gaps in our Community

- **Diabetes services** (disconnect)
- **Lack of affordable foot care**
- **Lack of wound care services** (chronic disease patients)
- Hypertension management
- COPD – lack of symptom management programs
- CHF – ongoing symptom management
- Well women/men clinics
- Healthy lifestyle services – **nutrition, smoking cessation,** exercise programs

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SCFHT Programs

- Hypertension Management Program
- Chiropody (Comprehensive foot care)
- INR Program (Point of Care Testing)
- Nutrition Counseling (+ Healthy You; Heart Healthy Eating)
- Diabetes Education Services
- Medication Counseling
- Drug Information
- CHAP (Cardiovascular Health Awareness Program)
- Smoking Cessation
- COPD + Spirometry (in development)
- Psychiatry/Mental Health Share Care Model (in development)
- Wound Care (Pilot Project)

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Wound Project Background

- June 2008 – call for proposals HFO
- Optimizing Use of Health Providers' Competencies Fund
- September 2008 funding for the Kenora Wound Care Project approved
- 12 month "pilot" project

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Project Summary

- To increase health providers' competencies in wound assessment and treatment
- To develop a comprehensive collaborative community wound care program that involved wound assessment and treatment based on evidenced based best practice

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Project Objectives

- Establish a collaborative model of wound care centered on a multidisciplinary team
- Expedite access to care from any point in the health care system
- Improve continuity of care by fostering partnerships between organizations
- Improve provider and client competencies through education

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Prior to Project Implementation

- Most patients requiring wound care went to the Emergency Department – Lake of the Woods District Hospital
- Only exceptions were CCAC clients eligible for in-home care
- A few clients requiring wound care went to family physicians
- Referrals were problematic
- Client frustrations with delays in care and difficulties accessing appropriate care

Kenora Lake of the Woods
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- Discontinuities in care, people getting "lost in the shuffle"
- Perception that delays in care were leading to poorer outcomes, more serious complications
- Each organization kept independent system of charting, tracking patients and visits
- Definite gaps in the system

Kenora Lake of the Woods
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Project "Partners"

- Lake of the Woods District Hospital Ambulatory Day Clinic (interim funding through the NWLHIN to relieve congestion in ER)
- SCFHT daily Wound Care Clinic for patients of FHN physicians
- Interprofessional Wound Assessment Team that provided wound assessment, treatment and education for difficult or non-healing wounds
- CCAC to provide wound care to home bound patients
- CRaNHR (Centre for Rural and Northern Health Research Lakehead University) "Evaluation of the Kenora Wound Care Pilot Project"

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Project Implementation

Several successful and well attended educational sessions for a variety of health care providers which included a mentorship clinical experience, a common referral tool, common assessment and charting tools , quick desk reference guides, and a collection of patient teaching pamphlets

…….all based on best practice guidelines

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Utilization of Wound Care Services in the Pilot Project

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Wound Assessment Team

- Weekly clinics in Physiotherapy Dept. LWDH
- Multidisciplinary team – surgeon, chiropodist, RN, physiotherapist, occupational therapist, dietitian
- 578 visits (April – October 2009)
- 99 clients receiving care
- Average age 59 (youngest 15, oldest 96)
- Both acute & chronic wounds assessed

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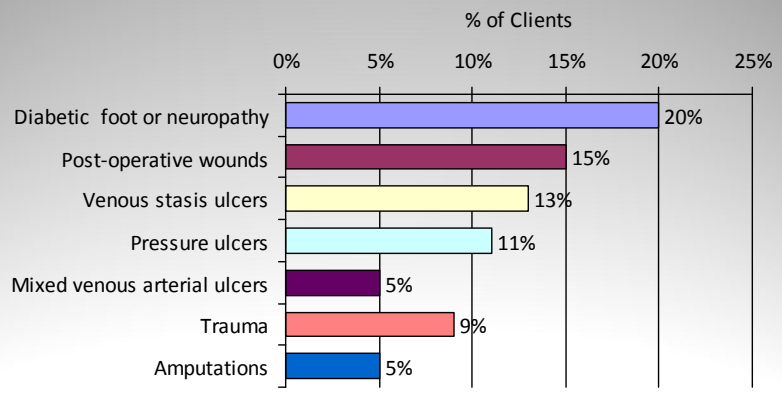
Conditions Assessed



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Conditions Assessed (Summary)

- 1/3 - ulcers (arterial, venous, pressure, mixed)
- 1/5 - diabetes complications (diabetic foot or neuropathy)
- 1/6 - post-op complications (variety of conditions)
- 1/7 - trauma or amputations

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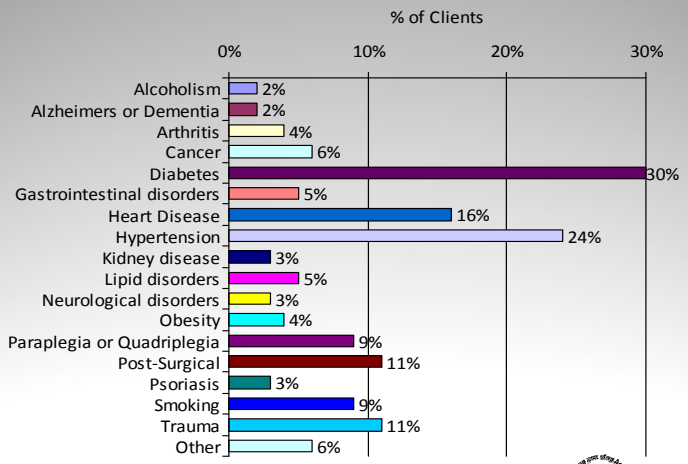
Underlying Health Problems



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Underlying Health (Summary)

- More than 70% of clients had one or more chronic conditions and required complex wound care
- Diabetes in 1/3 clients; hypertension in 1/4 clients
- Additional risk factors that contribute to poor wound healing, such as smoking and obesity, also identified

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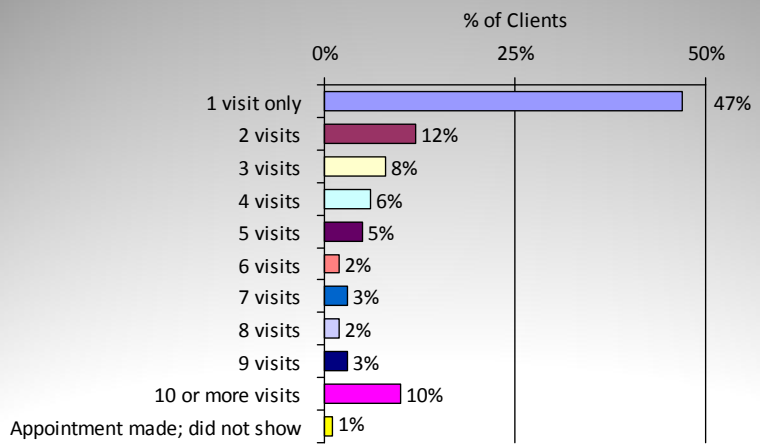
of visits per client



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CCAC (April-October 2009)

- 31 clients visited weekly Wound Assessment Team Clinic
- 24 returned more than once
- 5 clients required more than 10 visits
- CCAC clients received variety of in–home wound care services including dressings and IV therapy
- Clients only eligible for in-home services if non-ambulatory and would experience extreme hardship to go outside home for treatment

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SCFHT (April-October 2009)

- 688 visits for wound care
- Services included: assessments (148), suture removal (157), staple removal (18), simple dry dressings (190), complex dressings (311)
- Patient and family education (70)
- Referrals to other providers (101)
- Care provided by SCFHT RPNs

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LWDH Emergency Department

- Data for 3 month period (June-Aug) for 2007, 2008 and 2009, shows reduction of 24% in volume of visits during pilot
- Reasonable to suggest that patients seen in the Wound Care Assessment Team Clinic and SCFHT Wound Care Clinic were a large part of the previously existing ER traffic

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LWDH Ambulatory Day Clinic

- Established April '09 with NWLHIN interim funding
- Staffed 4 hours per day with 2 RNs
- Provided OP IV therapy, wound care for orphan patients, after hours and weekend wound care
- April 1, 2009-December 31, 2009*
  - 800 visits for dressing changes
  - 300 visits for IV therapy

* SCFHT program ended September 30, 2009

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Effects – Human Resources

- Capacity of project increased significantly as organizations donated staffing support to make it succeed
- Challenging to accommodate increasing number of clients
- Difficult for front-line providers to balance wound care workload with other duties

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Effects – Coordination of Care

- Development of standardized referral process, flowcharts, significantly improved care coordination
- Enhanced referral process, more timely referrals, shorter wait times for appointments
- Improved communication with clients, enhanced patient satisfaction

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Effects - Education

- Provider education, dissemination of best practice guidelines and workshops
- Front-line providers confirmed that education and training increased confidence in delivery of care
- Client education materials improved understanding of wound care and better self-management of wounds

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Successes - Partnerships

- Project showed that partnerships and collaborative care model can produce better care
- Communications was seen as key in developing partnerships and fostering trust between organizations
- Improved providers knowledge of services and programs available

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Successes - Access

- Providers perceived fewer repeat visits for wound care
- Better healing and control over wounds that were previously challenging
- Fewer serious complications seen
- Improved access to care clients who did not have family physicians
- Keeps patients out of ER & Hospital

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Successes - Collaboration

- Communication and collaboration as key factors in success
- Enhanced confidence in team-based care, ability to get feedback, consultation
- "One-stop shopping" approach gave clients easier access to care, more timely treatment and referrals

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Successes – Best Practices

- Adoption of Bates Jenson Assessment Tools and CAWC guidelines were key in ensuring best practices
- Organizations made sure that providers had easy access to guidelines, treatment algorithms, information about wound care products

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Successes - Competencies

- Educational initiatives, workshops and dissemination of best practice guidelines, seen as very successful
- Consensus that wound care competencies were enhanced across the continuum of care
- Increased number of providers with wound care training and skills (RNs, RPNs, Chiropodist)

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Successes – Client Outcomes

- Many success stories around the decrease in the severity of wounds and frequency of complications
- Individualized care plans and client education was also seen as contributing to improved outcomes
- Increased confidence among clients and family caregivers around care provided

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Challenges - Volumes

- Difficulties in accommodating the increasing volume of wound care clients
- Additional staff, more time devoted to wound care, additional administrative supports, would have helped
- Some challenges around eligibility for services, clients moved to where they could access care

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Challenges - Sustainability

- Concerns around sustaining the collaborative care model, in its entirety, once pilot project ended
- Some organizations unable to find resources for specialized staffing, education, supplies and administrative supports
- **Seamless system of care no longer exists** (funding for pilot project ended September 30, 2009)

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Transferability

- Agreement that collaborative care model could be transferred to other settings, provided supports were in place
- Partnerships, consultation between organizations, education essential
- Data on clients requiring care, common mechanism for collecting client data, ongoing client tracking important

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Summary

- Widely viewed as a success, by health care providers and clients alike
- Enhanced provider wound care competencies across spectrum of care
- Improved clients' access to wide range of services and supports
- More timely care, higher quality care and fewer complications evident

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After the Pilot Project

- SCFHT has applied in both budget years for funding for a community based Comprehensive Wound Care Program (No response from MOHLTC)
- Wound Assessment Team continues 1 afternoon per week (SCFHT in-kind contribution Chiropodist)
- Ambulatory Day Clinic funding extended to June 2011

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After the Pilot Project?

- Provider education, competencies and best practices?
- Client education, services and supports?
- Organizational collaboration and communication?
- Interdisciplinary approaches, multidisciplinary team care?

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Thank You!

If you have any questions, please contact SCFHT

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