

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*



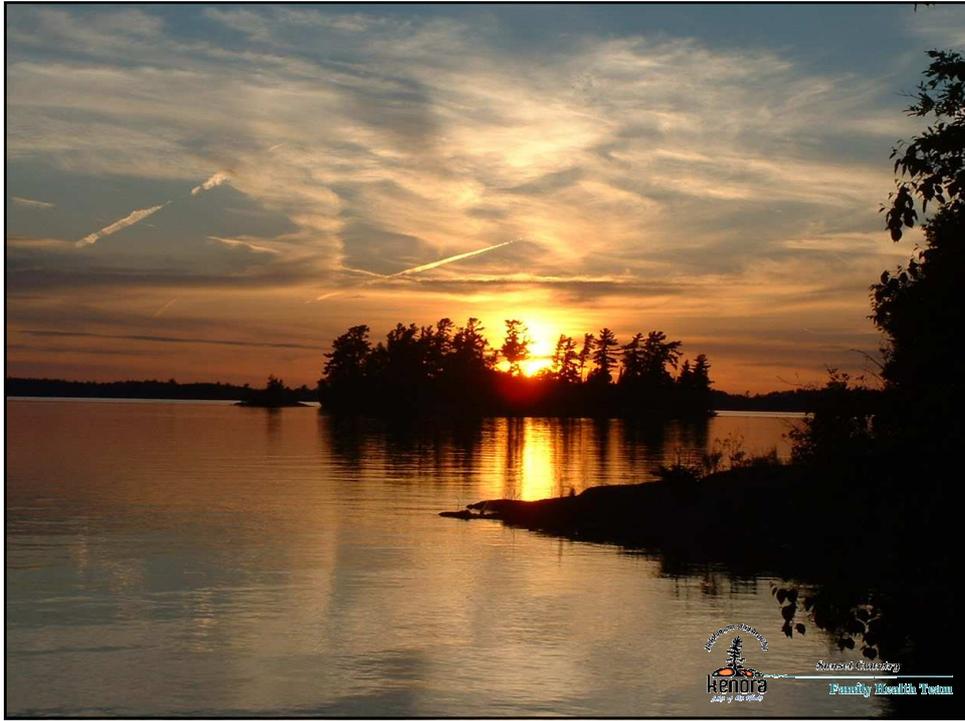
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Where is Kenora?



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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
- Chiropracist – 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



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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



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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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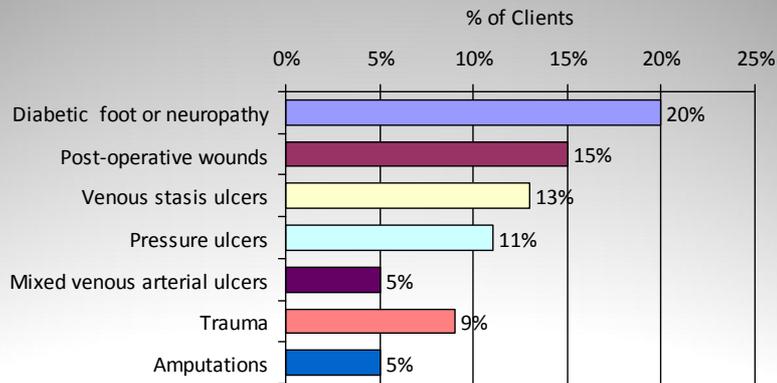
Wound Assessment Team

- 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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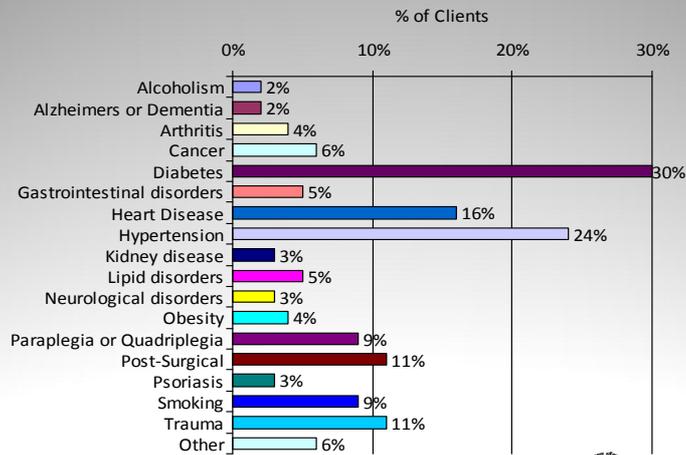
Conditions Assessed (Summary)

- 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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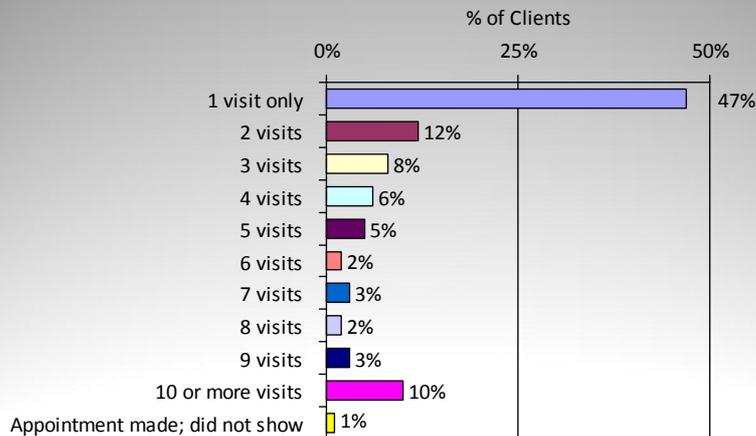
Underlying Health (Summary)

- 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, Chiropracist)



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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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"Treat the whole patient – not the hole in the patient!" The Success of the Kenora Wound Care Pilot Project

Bruce Moore, Mary Ellen Hill, Grace Bandak, Jose Pajo, Serenity Perry, Megan Tiernan, Randy Belair, Colleen Snyder, Lynn Hennebeck
 (Centre for Rural and Northern Health Research, Lakehead University; Sunset Country Family Health Team; Lake of the Woods District Hospital)

IMPLEMENTATION

Prior to Pilot

- No ambulatory wound care in Kenora, a small town of 15,000 residents in North-western Ontario
- Client feedback, in surrounding rural areas and the Nation, felt they "had nowhere else to go but to Emergency" for wound care services

Development

- Program developed by Sunset Country Family Health Team, in partnership with Lake of the Woods District Hospital and the Northwest Community Care Access Centre
- Healthcare professionals of diverse education, part-time staff, hospital care specialist, nurse educator, home care nurses, clinical staff and supplies, other professional services retained as an in-kind basis by partner organizations

Services Provided

- Wound Assessment Team: Clinic of 1000 program, wound nurses, chiropodists, dietitians, physiotherapists, occupational therapists, pharmacists
- Sunset Country Family Health Team: Family physicians, RNs and RPNs
- Northwest Community Care Access Centre (by phone only)

Evaluation

- Centre for Rural and Northern Health Research commissioned to assess program implementation and evidence on program success and challenges
- Evidence required provided: effects on provider confidence in wound care abilities and outcomes, including client service, education and support, as well as potential transferability of the program to other interdisciplinary care teams
- Expanded administrative data accommodations with 22 interventions (13 administrative and nine best health care practices, 9 diets and caregivers)



Best Practices:

- No new clinics, instead in existing services was necessary
- One team – it is important to all team members (clinical and supporting staff) understand the goal of care and utilize the resources, which are part of the program

BEST PRACTICES

Wound Care Competencies

- Educational presentation by internationally recognized Canadian expert on independent wound care
- Locally-developed workshops on wound care best practices, open to all area health care providers

Care Guidelines

- Distribution of information on use of Best-practice Assessment Tool and current Canadian Association of Wound Care Guidelines
- Condition-specific media provided (diabetic, foot, arterial and venous ulcers)
- Client education pamphlets developed (services, ulcer prevention, skin and foot care, medication, nutrition)

Care Coordination

- Specialized interdisciplinary practice (common multi-agency medical referral form)
- Individualized care plans given at initial visit (goals, self-care, follow-up)
- Easier access to care (assessment team clinic every week, family health team appointments 1 hour a week)

Integrated Care:

- Strongly support the goal of meeting the patient holistically in a whole person rather than just treating the wound – it makes the patient feel more supported and less like they are just a "hole in the wall" or "hole in the system"

UTILIZATION

Weekly Wound Assessment Clinic

- 3 1/2 hours assessment open – October 2009, 99 clients seen
- More than 70% had chronic conditions and required complex care. It also had 48 home care
- 80% of clients seen were likely large part of the previously existing 67 visits

Family Health Teams

- 484 visits provided by wound care teams at Family Health Team over 6 months
- "One stop" appointments for assessment, treatment, education and referral
- Challenging for staff to deliver increasing number of wound care clients with other duties (1-120 visits during 6th month)

Transferability

- Agreement collaborative care model was transferable to other small town and rural settings, if funding available
- There needed to build organizational partnerships and interdisciplinary teams
- Implementation would be easier if common client data were available (needs, ongoing tracking)



Success Story:

- On the 10th day of the pilot, a client with a non-healing wound had a wound dressing applied by the interdisciplinary team. Because of the team's efforts, the wound healed in 10 days.



OUTCOMES

Enhanced Competencies

- Widespread use of care guidelines
- Increased number of RNs and RPNs, with skills, significant innovation in using WPA
- More timely care, higher quality care evidenced by fewer complications

Success Stories

- Increased confidence among staff, clients and family in quality of wound care
- Easier access to care, shorter wait times, enhanced patient satisfaction with services
- Individualized care plans and client education key contributors to improved outcomes

Challenges of Sustaining Model

- Weekly clinic continue, supported by donations of staff time from partner agencies
- Integrated wound care made in its entirety could not be sustained without funding
- Application currently pending for operational funding in support of family health team wound care services

For additional information contact:
 Dr. Mary Ellen Hill, Senior Researcher
 Centre for Rural and Northern Health Research,
 Lakehead University
 Kenora, ON P3Y 7R5, Canada
 Tel: 807.468.4810
 Fax: 807.468.4811
 Email: mhill@kenorahealth.com



Thank You!

If you have any questions, please contact SCFHT

Randy Belair, Executive Director
 807-468-4810

rbelair@kenorahealth.com



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