LUNCH WITH THE PROFESSORS

COMPLEX CASE CONFERENCE WITH A HOUSE CALLS PHYSICIAN

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NOVEMBER 1 & 2, 2019

HouseCalls

Interdisciplinary healthcare for homebound seniors

OBJECTIVES

- Practical tips: how to get the most out of a home visit with a frail elderly patient
- Learn an approach to managing geriatric issues in the homecare setting
- Address & explore your homecare questions and complex home-visit cases

CONFLICTS OF INTEREST

- Dr, Elizabeth Niedra – None
- Dr. Christa Sinclair Mills – None

HOME VISITS

PROVINCIAL SENIORS STRATEGY: OBJECTIVE OF INCREASING ACCESS TO IN-HOME HEALTH CARE, TO "HELP SENIORS STAY HEALTHY IN THE COMFORT OF THEIR OWN HOMES" (ONTARIO'S ACTION PLAN FOR SENIORS, 2019).

INCREASED HOME VISITING CAPACITY AS A PRIORITY OF THE ONTARIO HEALTH TEAMS SYSTEM

CFPC FAMILY MEDICINE PROGRAM STANDARDS MANDATE TEACHING COMPREHENSIVE CARE OF THE ELDERLY IN DIVERSE SETTINGS, INCLUDING IN THE HOME

HOMEBOUND PATIENTS – WHO ARE THEY?

As of 2013, 93% of Canadian adults age 65 and older live at home, and 87% of these prefer to stay at home as long as possible.

Compared to the overall elderly population, homebound patients have:

Higher rates of metabolic, cardiovascular, cerebrovascular, and musculoskeletal diseases

Higher chronic medication use

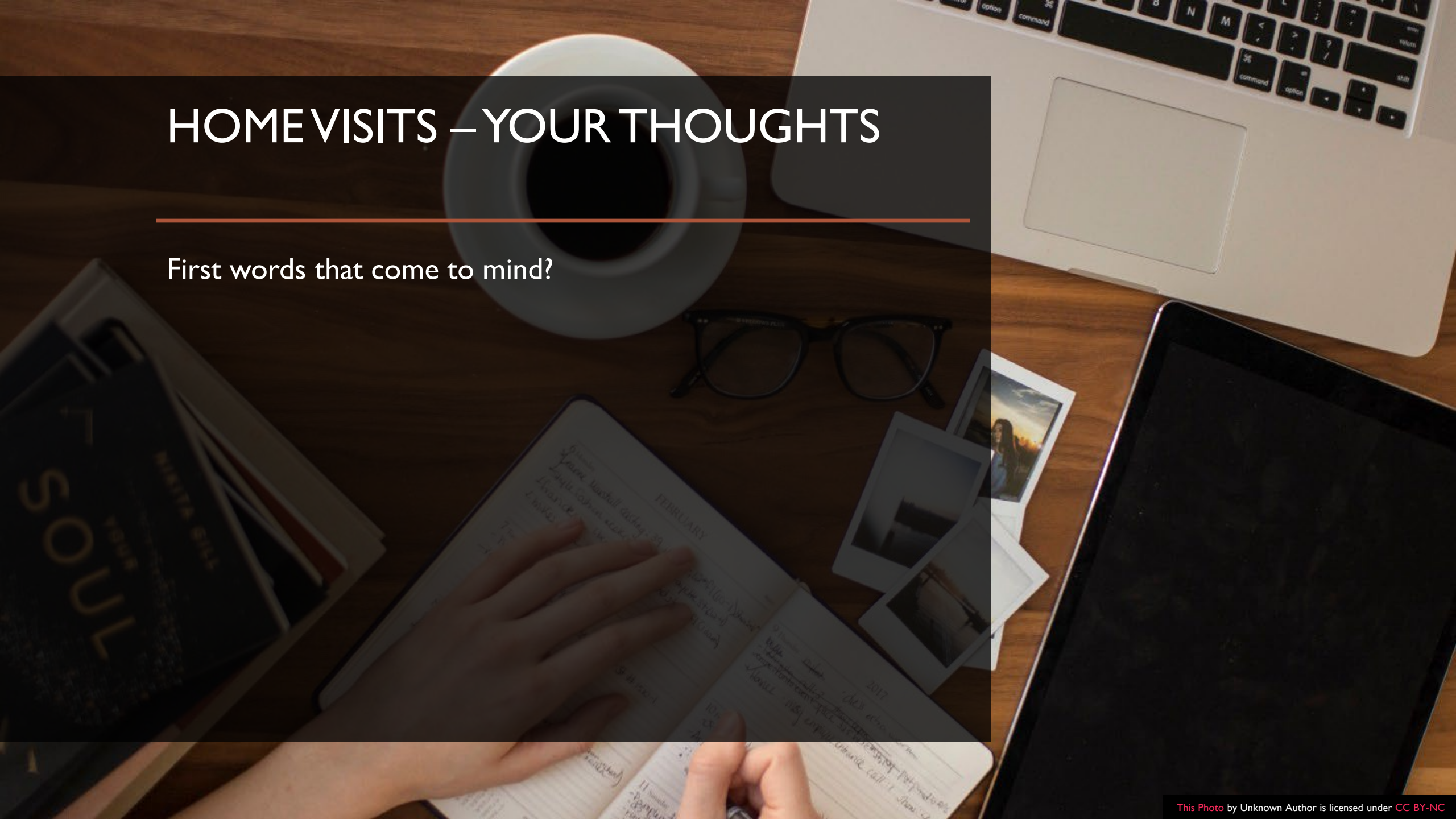
Higher incidence of cognitive impairment, depression and dementia

Higher ED use, and twice the rate of annual hospitalizations

Stall et al, 2013

HOME VISITS – YOUR THOUGHTS

First words that come to mind?



HOME VISITS – YOUR THOUGHTS

First words that come to mind?

Challenges?

HOME VISITS – YOUR THOUGHTS

First words that come to mind?

Challenges?

Rewards?

HOME VISITS – YOUR THOUGHTS

What are your questions and cases?

HOME VISIT SURVIVAL GUIDE

HOME VISIT SURVIVAL GUIDE

- Be prepared
- Manage your time
- Learn from environment
- Know your resources, and use your team
- Have fun!

HOME VISIT SURVIVAL GUIDE

- Be prepared:
  - BP cuff, stethoscope, pulse oximeter, gloves, and internet (or printed paper chart)
  - Give time to find parking!
  - Don't sit on the soft furniture, carry hand sanitizer, always zip your bag
  - If you are going somewhere unsafe, go in pairs; if you don't feel safe, go home!

HOME VISIT SURVIVAL GUIDE

- Manage your time
  - There is a lot of ground to cover, and a *lot* going on in the home – don't let yourself get distracted
  - Do what you can, defer what you must – take advantage of primary care follow-up

HOME VISIT SURVIVAL GUIDE

- Learn from your environment!
- Keep your eyes and ears open, and enjoy the ride

WHAT'S SO SPECIAL ABOUT A HOME VISIT ANYWAY?

- Home visit is a unique opportunity to see the patient in THEIR CONTEXT
- In office, patients are often in their "Sunday Best" – inaccurate representation of home situation, medication compliance, etc.


abulous
Davenport reigns in Oz

TEN THINGS TO NOTE FOR A GOOD HOME VISIT

TEN THINGS TO NOTE FOR A GOOD HOME VISIT

1. Accessibility of Home
2. Appearance
3. Gait
4. Clutter
5. Infestations
6. Equipment
7. Medication
8. Smells
9. Food security
10. General home safety

HOME ACCESSIBILITY

- The visit begins when you arrive!
- Whether a home/apartment/condo has accessible entrance can make a huge difference to the options available to the patient
  - i.e. wheelchair bound in a 3rd floor walkup is different than being wheelchair bound in a fully accessible 8th floor condo
- Make note of stairs, elevators, ramps, unlocked doors, lock boxes and uneven flooring

GAIT

- Note any gait aids, footwear, furniture walking
- Were they able to unlock the door for you?
- Can they get up from a chair?
- Do they have an automatic door opener or a lock box? These modifications can be markers of reduced mobility, and can make a difference in accessibility when implemented

CLUTTER

- Can be a significant falls hazard
- Impedes use of gait equipment and accessibility for emergency personnel
- Increases risk of harm in case of fire or other environmental threats
- Can be suggestive of lack of social supports, mental health issues and/or functional ability

INFESTATIONS

- You might spot lots and lots of critters - cockroaches, bed bugs, you will see it all!
- Hot spots: kitchen, couches, beds.
- If suspicious, avoid sitting on the soft furniture, keep bags zipped and off the floor, and bring bed bug booties.

EQUIPMENT

- What is already in place?
- Ask to check bedroom and bathroom
- Note lifts, bath chairs, raised toilet seats, grab bars etc.
- Ask where they got them – if inherited or installed by family, there may be safety risks

MEDICATION

- Where is the medication?
- Is it in bottles or blister packs?
- Do a pill count and check dispensation dates
- ALWAYS check for other meds or places where pills are stored
  - 6 months worth of warfarin in the bathroom cupboard
  - A teacup full of pills next to the sink

APPEARANCE

- Use your eyes and nose! Self-care points to mental and physical function, and presence of appropriate supports.
  - How are they dressed? Clean and appropriate clothes?
  - Are they washed? Hair clean?
  - Check finger and toenail care
  - Do they have glasses, hearing aids or home O2? Are they *using* them?

SMELLS

Keep using your nose a little more…

Urine?

Stool?

Rotten foods?

FRIDGE

- Fridge biopsy – an incredibly useful bit of detective work
- Food security is a serious issue for many frail elderly patients
- Is there food? Is it expired? How much preparation does it require?
- If prep is needed, does the stove/microwave/kettle work? Are they safe to use?
- Do they access Meals on Wheels?

BIOPSY RESULTS: DIAGNOSIS, NOT INDEPENDENT FOR MEALS

A MEAL DELIVERED IS NOT A MEAL CONSUMED

SAFETY

- Smoking/EtOH/Drugs, loose rugs, loose steps, dim lighting, oxygen tubing, evidence of broken appliances or burned stoves, threatening family members or neighbors
- Again… If something feels unsafe, LEAVE and go home
  - Going back with a team member, or arrange to meet somewhere outside the home; ex. a building common room

HOME VISIT SURVIVAL GUIDE

- Know your resources, and use your team
  - A lot more can be done at home than you think; but it takes knowing where to find what you need, and how to make it happen in real time

WHAT KINDS OF SERVICES ARE AVAILABLE AT HOME?

Hopefully, more thank you think!

WHAT KINDS OF SERVICES ARE AVAILABLE AT HOME?

WHAT KINDS OF SERVICES ARE AVAILABLE AT HOME?

CASE MGR

PSW

WHAT KINDS OF SERVICES ARE AVAILABLE AT HOME?

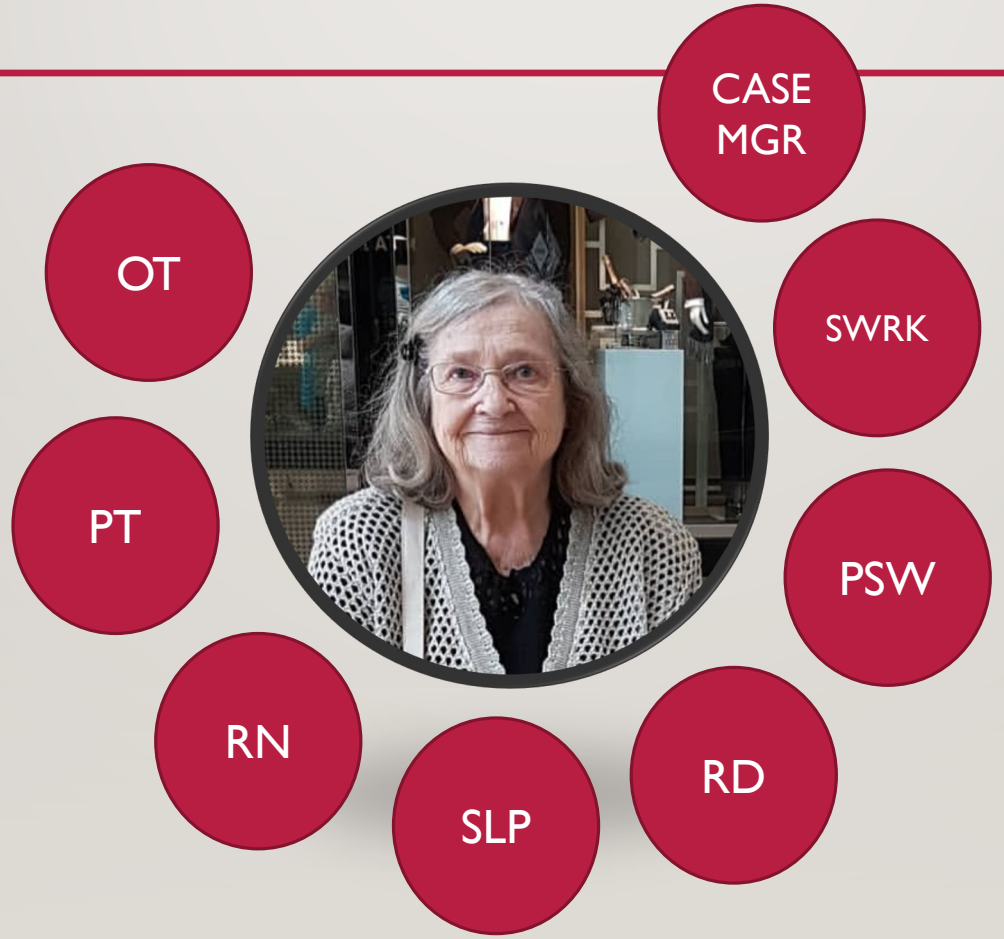
CASE MGR

OT

PT

PSW

WHAT KINDS OF SERVICES ARE AVAILABLE AT HOME?



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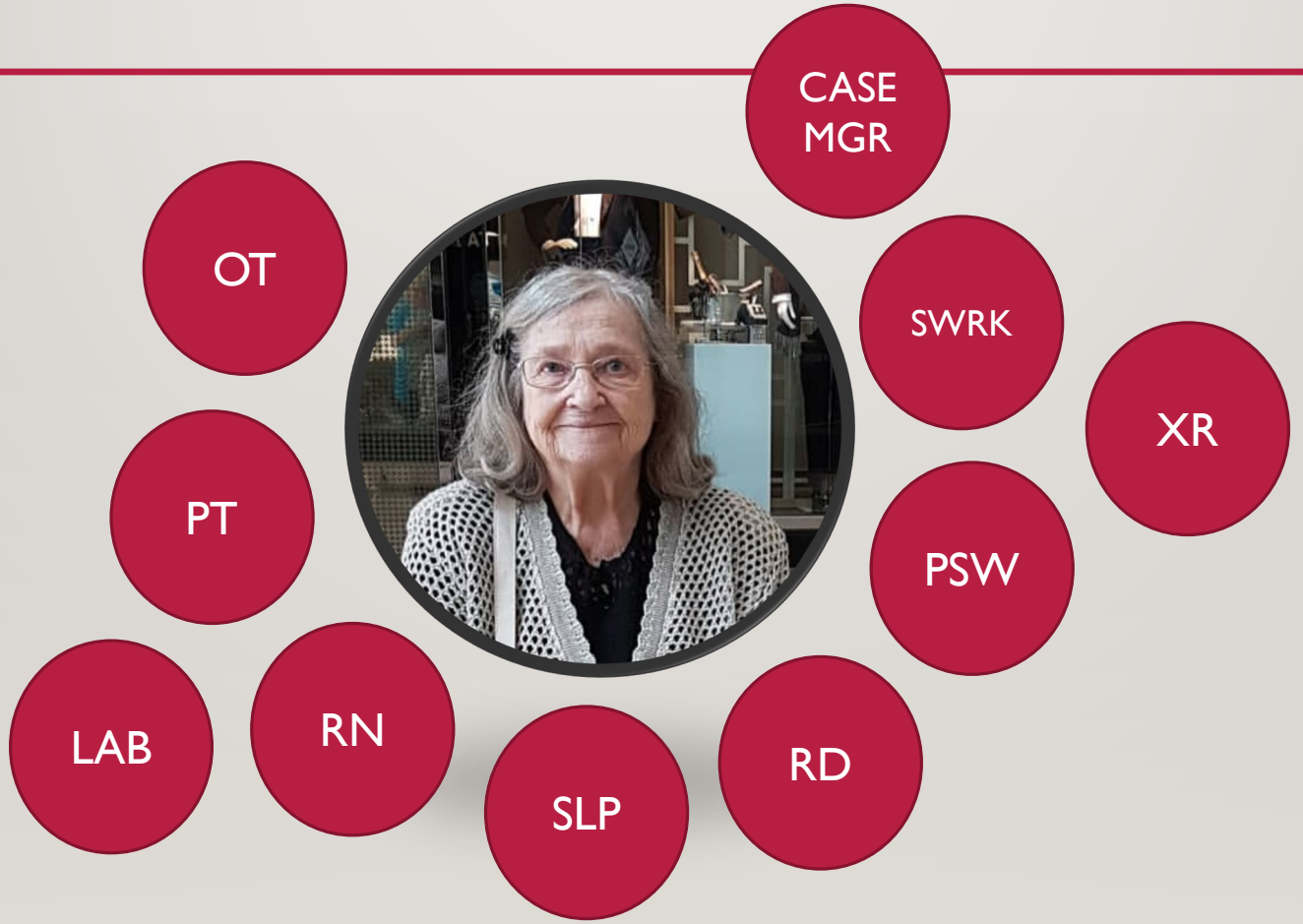

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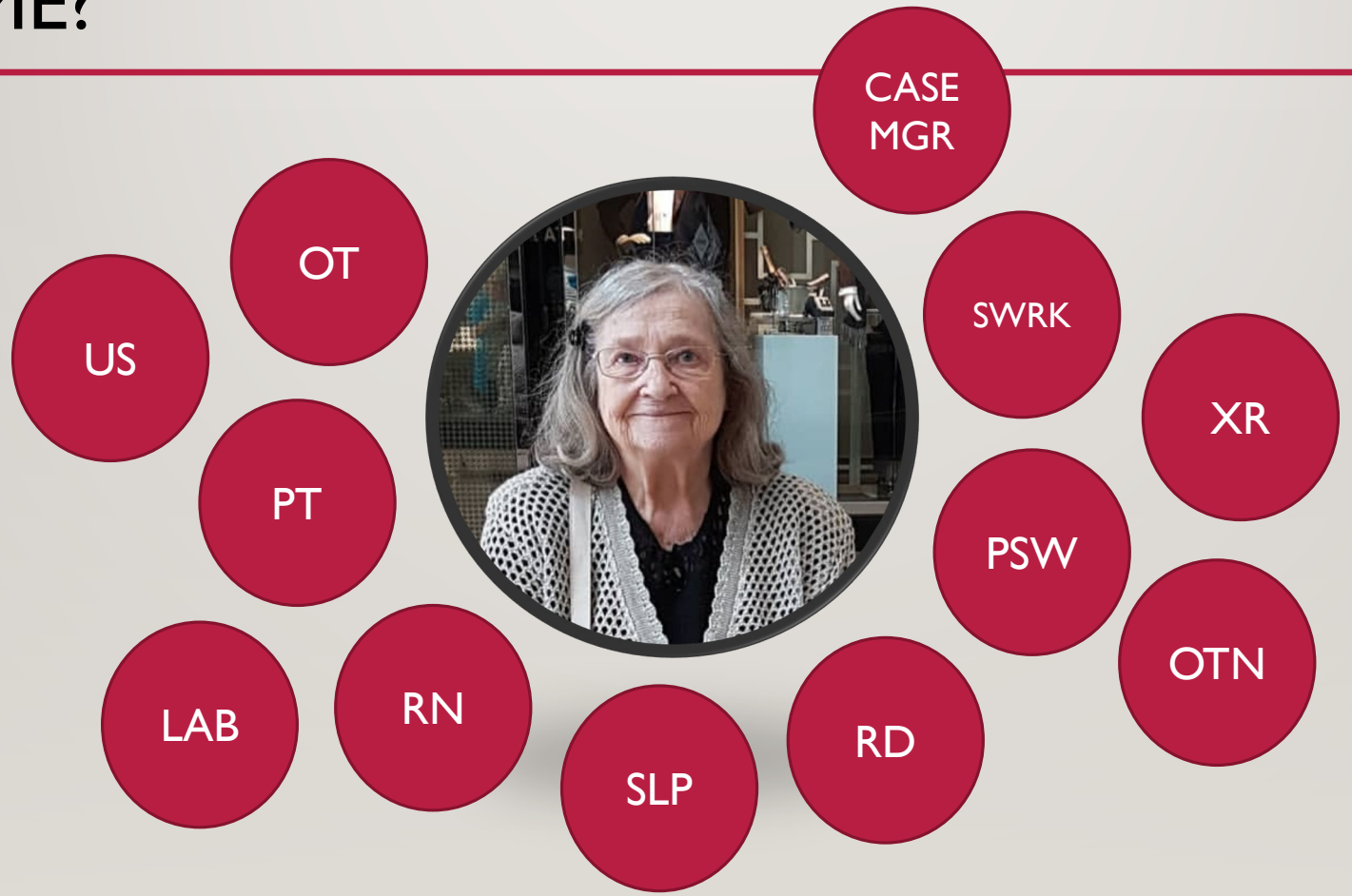
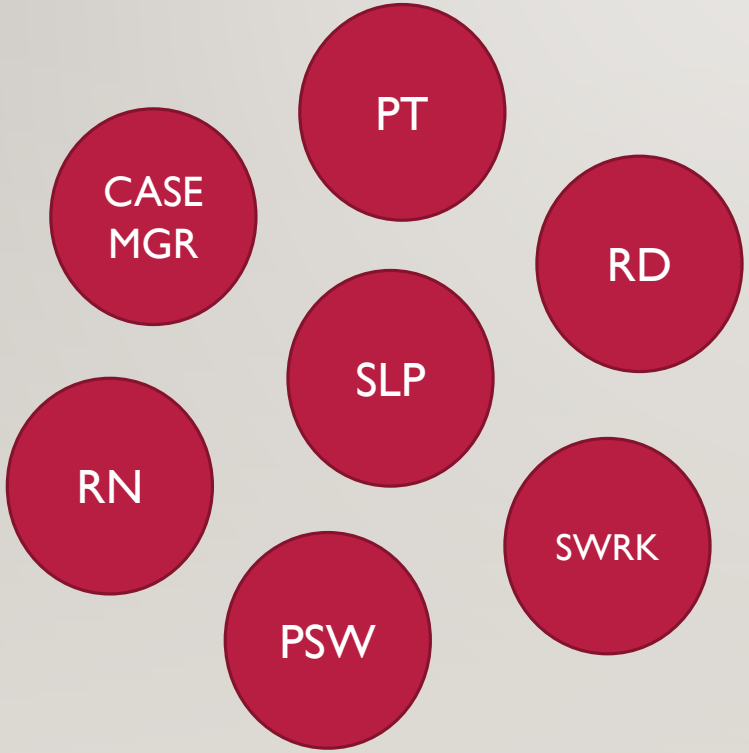
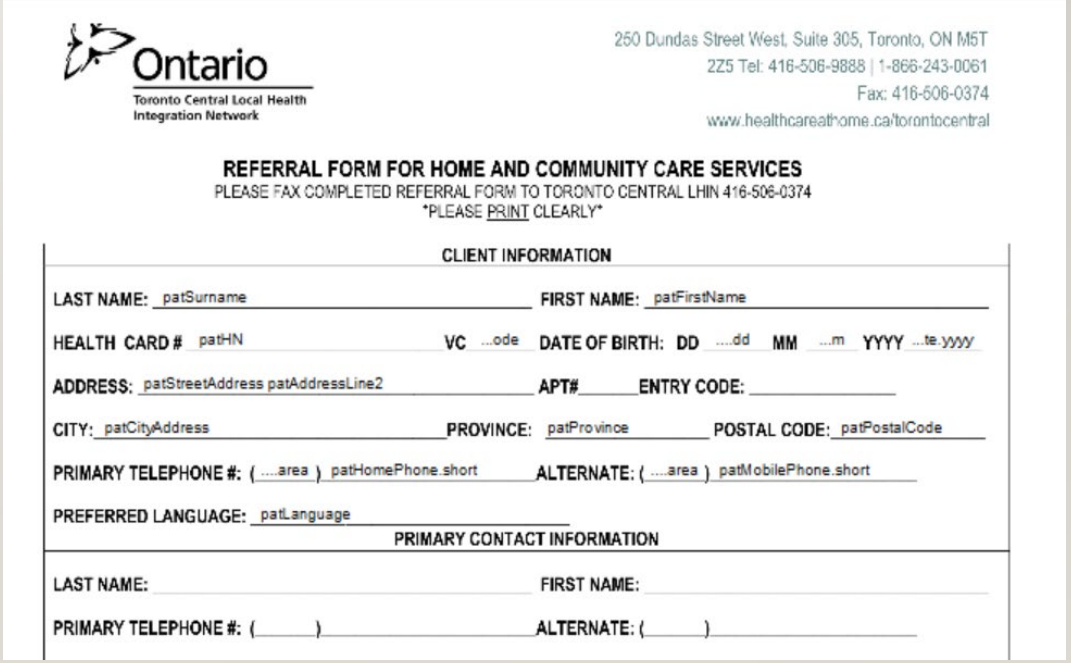


THE LHIN REFERRAL MOTHERSHIP





Ontario
Toronto Central Local Health Integration Network

250 Dundas Street West, Suite 305, Toronto, ON M5T 2Z5 Tel: 416-506-9888 | 1-866-243-0061
Fax: 416-506-0374
www.healthcareathome.ca/torontocentral

REFERRAL FORM FOR HOME AND COMMUNITY CARE SERVICES

PLEASE FAX COMPLETED REFERRAL FORM TO TORONTO CENTRAL LHIN 416-506-0374
PLEASE PRINT CLEARLY

CLIENT INFORMATION

LAST NAME: patSurname FIRST NAME: patFirstName

HEALTH CARD # patHN VC ...ode DATE OF BIRTH: DD ....dd MM ...m YYYY ...te.yyyy

ADDRESS: patStreetAddress patAddressLine2 APT# ENTRY CODE:

CITY: patCityAddress PROVINCE: patProvince POSTAL CODE: patPostalCode

PRIMARY TELEPHONE #: (....area) patHomePhone.short ALTERNATE: (....area) patMobilePhone.short

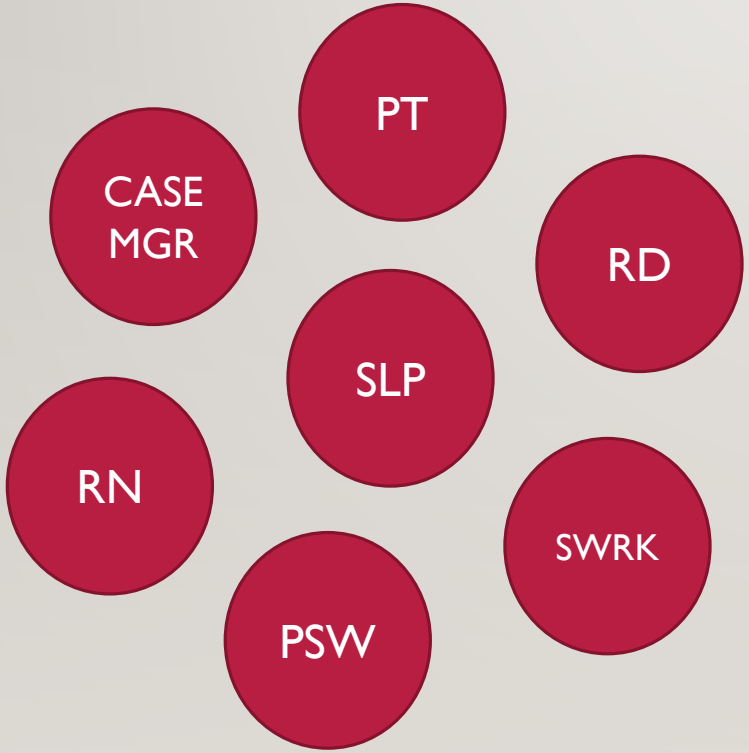
PREFERRED LANGUAGE: patLanguage

PRIMARY CONTACT INFORMATION

LAST NAME: FIRST NAME:

PRIMARY TELEPHONE #: ( ) ALTERNATE: ( )

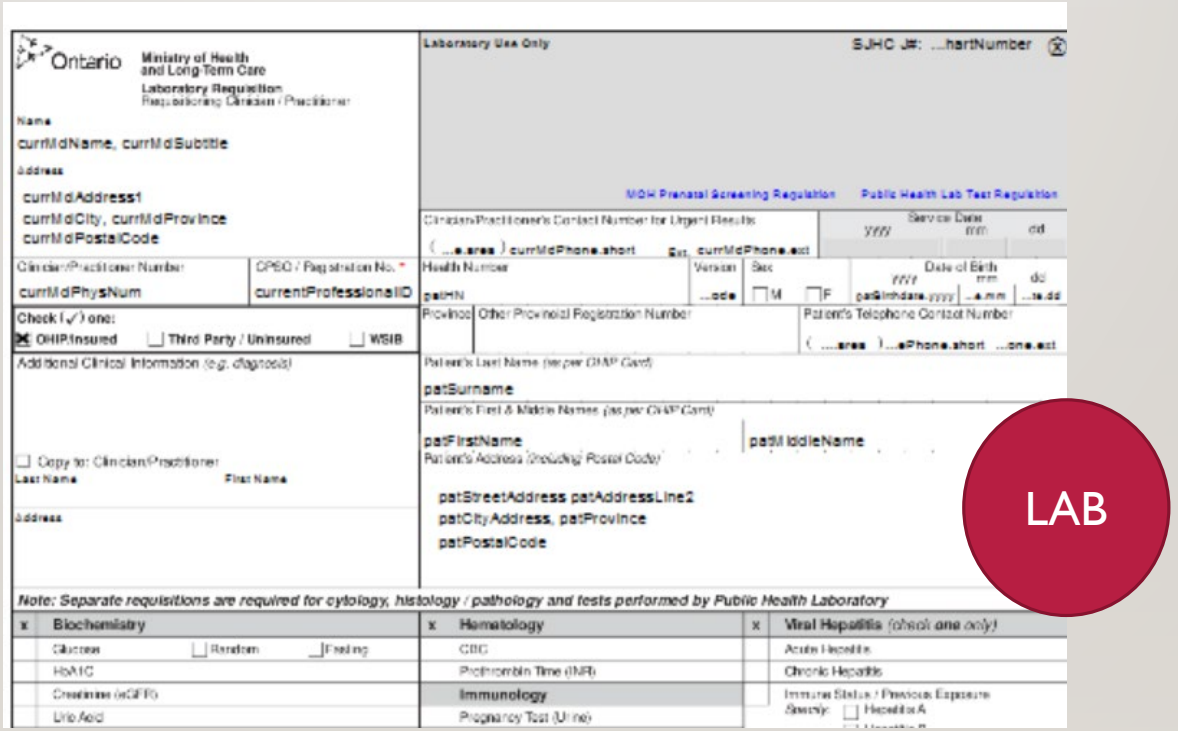
THE LHIN REFERRAL MOTHERSHIP



	Other:
MOBILITY	Ambulatory: ☐ Yes ☐ No Client uses: ☐ Wheelchair ☐ Walker ☐ Cane ☐ Scooter Other:
SERVICES REQUESTED	**PRESENTING ISSUES** *(*important*- identify reason/need for each service checked)*
☐ Case Management ☐ Occupational Therapy ☐ Personal Care (bathing/dressing) ☐ Community Linking (i.e. homemaking) ☐ Physiotherapy ☐ Speech Language Pathology ☐ Social Work ☐ Dietitian/Nutrition ☐ LTCH Assessment ☐ Nursing: Wound Care ☐ Nursing: Other	*(for Nursing service, provide Treatment Orders and Start Date)*
☐ Telehomecare	☐ CHF ☐ COPD ☐ Chronic Bronchitis ☐ Emphysema
PHYSICIAN/NP SIGNATURE:	**DATE:**

CONFIDENTIAL WHEN COMPLETED. IF YOU HAVE RECEIVED THIS FORM IN ERROR PLEASE DO NOT COPY OR DISPOSE OF. CONTACT 416-506-9888 AND WE WILL MAKE ARRANGEMENTS TO COLLECT IT.

HOME LAB SERVICES



Ontario
Ministry of Health and Long-Term Care
Laboratory Requisition
Requisitioning Clinician / Practitioner

Name
currMdName, currMdSubtitle

Address
currMdAddress1
currMdCity, currMdProvince
currMdPostalCode

Clinician/Practitioner Number: currMdPhysNum
CPSO / Registration No.: currentProfessionalID

Check (✓) one:
☒ OHIP Insured ☐ Third Party / Uninsured ☐ WSIB

Additional Clinical Information (e.g. diagnosis)

☐ Copy to: Clinician/Practitioner
Last Name First Name
Address

Laboratory Use Only
SJHC #: ...hartNumber

MOH Prenatal Screening Regulation Public Health Lab Test Regulation

Clinician/Practitioner's Contact Number for Urgent Results
(...a.area) currMdPhone.short Ext. currMdPhone.ext

Service Date yyyy mm dd

Health Number: patHN
Version Code
Sex ☐ M ☐ F
Date of Birth yyyy mm dd: patBirthdate.yyyy ...a.mm ...te.dd

Province
Other Provincial Registration Number
Patient's Telephone Contact Number
(...area) ...aPhone.short ...one.ext

Patient's Last Name (as per OHIP Card)
patSurname

Patient's First & Middle Names (as per OHIP Card)
patFirstName patMiddleName

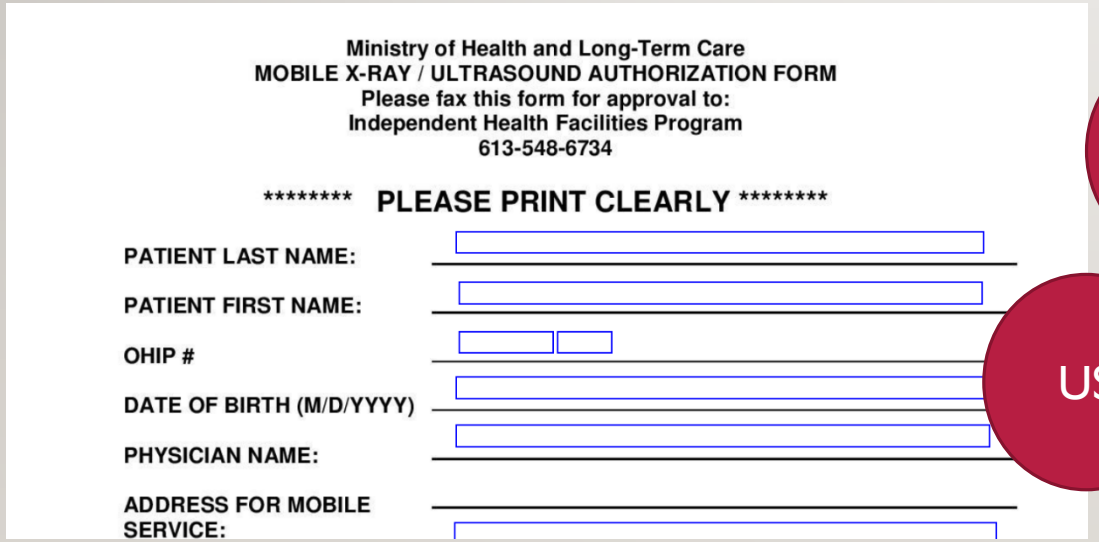
Patient's Address (including Postal Code)
patStreetAddress patAddressLine2
patCityAddress, patProvince
patPostalCode

LAB

Note: Separate requisitions are required for cytology, histology / pathology and tests performed by Public Health Laboratory

x	Biochemistry	x	Hematology	x	Viral Hepatitis (check one only)
	Glucose ☐ Random ☐ Fasting		CBC		Acute Hepatitis
	HbA1C		Prothrombin Time (INR)		Chronic Hepatitis
	Creatinine (eGFR)		Immunology		Immune Status / Previous Exposure
	Uric Acid		Pregnancy Test (Urine)		Specify: ☐ Hepatitis A

MOBILE US AND X-RAY



Ministry of Health and Long-Term Care
MOBILE X-RAY / ULTRASOUND AUTHORIZATION FORM
Please fax this form for approval to:
Independent Health Facilities Program
613-548-6734

******** PLEASE PRINT CLEARLY ********

PATIENT LAST NAME:

PATIENT FIRST NAME:

OHIP #

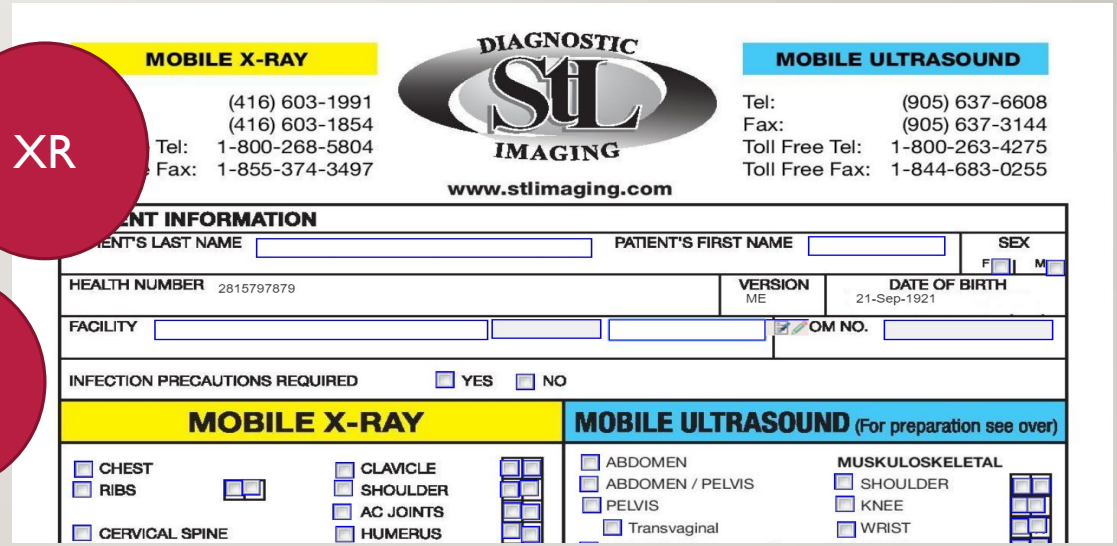
DATE OF BIRTH (M/D/YYYY)

PHYSICIAN NAME:

ADDRESS FOR MOBILE SERVICE:

XR

US



MOBILE X-RAY

(416) 603-1991
(416) 603-1854
Tel: 1-800-268-5804
Fax: 1-855-374-3497

DIAGNOSTIC STL IMAGING
www.stlimaging.com

MOBILE ULTRASOUND

Tel: (905) 637-6608
Fax: (905) 637-3144
Toll Free Tel: 1-800-263-4275
Toll Free Fax: 1-844-683-0255

ENT INFORMATION

ENT'S LAST NAME | PATIENT'S FIRST NAME | SEX F M

HEALTH NUMBER 2815797879 | VERSION ME | DATE OF BIRTH 21-Sep-1921

FACILITY | OM NO.

INFECTION PRECAUTIONS REQUIRED YES NO

MOBILE X-RAY

CHEST
RIBS
CERVICAL SPINE
CLAVICLE
SHOULDER
AC JOINTS
HUMERUS

MOBILE ULTRASOUND (For preparation see over)

ABDOMEN
ABDOMEN / PELVIS
PELVIS
Transvaginal

MUSKULOSKELETAL
SHOULDER
KNEE
WRIST

A NOTE ON OTN

- Make telemedicine work for you!
  - OTN e-consults
  - Geriatric telemedicine at SJHC
  - SJHC internal e-consults – try your specialist by email
- When to consider outpatient visits:
  - Hands-on assessments, ex. Rheumatology for injections, Dermatology for excision/biopsy
  - Specialist not available by OTN, or in-person visit recommended by e-consult
  - Patient preference/relationship to specialist

CASES


I'M PRESCRIBING YOU A NEW MEDICINE.
THE GUINEA PIG JUST EXPLODED.
LET'S STICK WITH THE OLD MEDICINE.

CASE 1

88YO HOMEBOUND MALE PATIENT, LHIN RN CALLING FOR SUPPORT; "COUGHING MORE THAN USUAL"

CASE 1

88YO HOMEBOUND MALE PATIENT, LHIN RN CALLING FOR SUPPORT; "COUGHING MORE THAN USUAL"

Deep breath, and back to basics – review EMR.

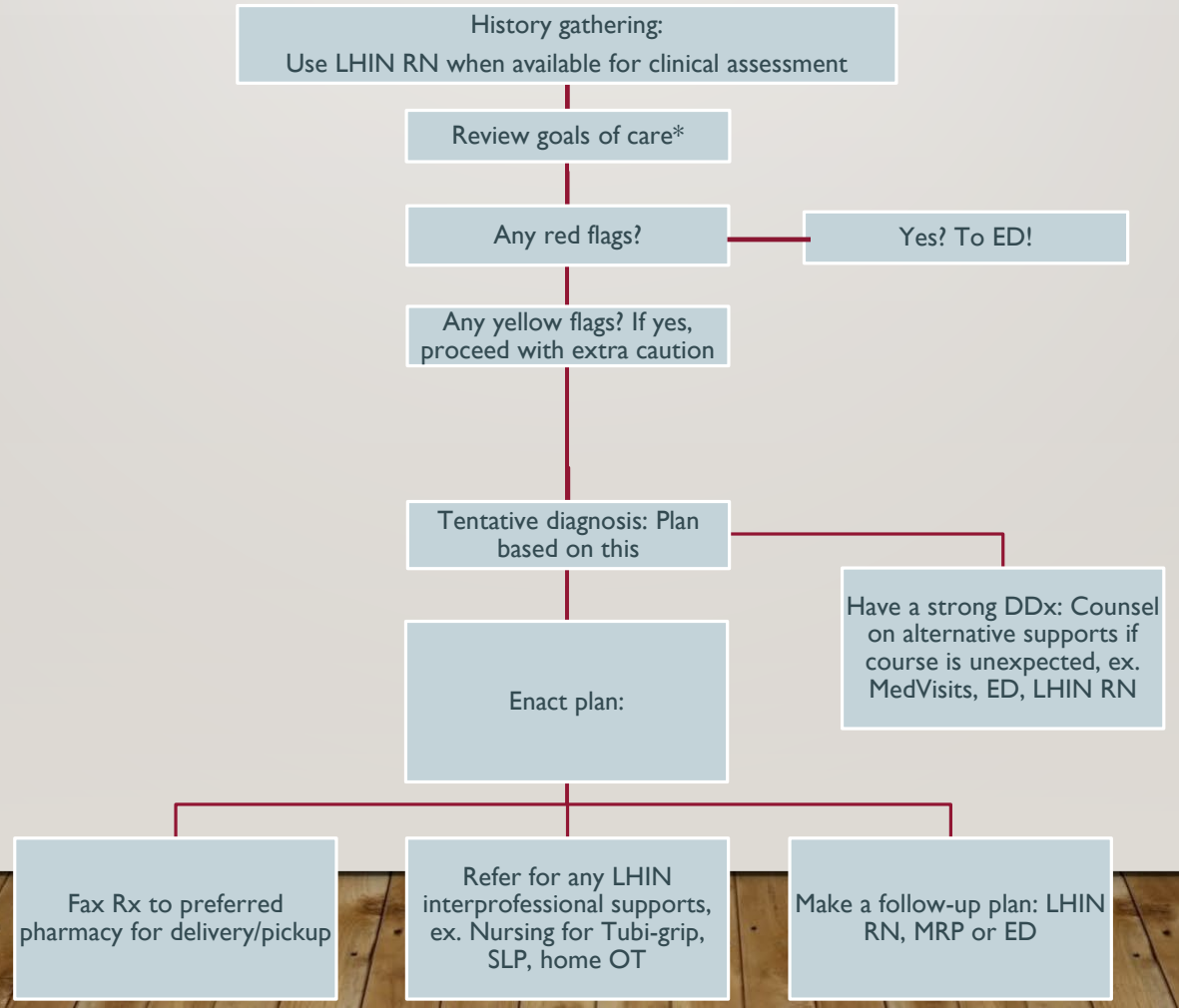
CASE 1

- 88yo homebound male patient, LHIN RN calling for support; "coughing more than usual"
- Deep breath, and back to basics – review EMR.
  - PMHx: COPD, CHF, HTN, mild cognitive impairment.
  - Functional Hx: Mostly wheelchair-bound due to CHF, baseline exercise intolerance. Assist for all ADLs, wife manages IADLs.
  - Rx: Symbicort BID, Ventolin 1-2 puffs Q4H PRN among other Rx
  - No allergies

CASE 1

- 88yo homebound male patient, LHIN RN calling for support; "coughing more than usual"
- Per history from LHIN RN, patient has chronic cough, increased production since 3 days with purulence. No worsened exercise intolerance, no rest dyspnea or CP, no other red flags. GOC are to avoid ED if possible, but patient is Full Code. Has been taking Ventolin TID, Symbicort PRN for severe symptoms of cough.
- Patient comfortable and at baseline, AVSS.

ALGORITHMIC APPROACH TO HV TRIAGE AND MANAGEMENT



Yellow flags:
Frailty features that may impair a patient's agency, i.e.. ability to follow-up or seek emergent care if needed. Examples:

- Social isolation
- Language barrier
- Cognitive impairment
- No current link with LHIN RN or PSW supports

ALGORITHMIC APPROACH TO HV TRIAGE AND MANAGEMENT

- When in doubt, DO send to ED – the goal of robust homecare is to prevent *unnecessary* ED visits, not all ED visits! Home visits can be complex, and patient safety comes first.
  - Send a referral letter once destination ED is known
  - Follow-up any ED referrals; learn from what was done in ED

CASE 1 - ALGORITHM

- History-gathering, diagnosis – likely mild to moderate COPD exacerbation
- Review red flags – to ED if present. no red or yellow flags
- Review goals of care – Full code, wishing to avoid going to ED
- Tentative diagnosis and DDx - COPD exacerbation; DDx is more severe COPDe, CAP, CHF, dysphagia
  - Plan on the tentative diagnosis
  - Counsel on alternative management if trajectory is unexpected
  - Review secondary supports that are always available ex. ED, Med Visits, LHIN RN – Call LHIN RN or Med Visits after-hours if no improvement in symptoms, review red flags to trigger ED
- Enact plan:
  - Fax any Rx to patient's preferred pharmacy – Prednisone 50mg PO daily x 5 days, consider amox-clav, review appropriate puffer use
  - Refer for any interprofessional supports via LHIN, ex. nursing for Tubi-grip, SLP, home OT – LHIN RN to follow-up in 2-3 days, notify team with concerns
  - Make a follow-up plan: LHIN RN, MRP or ED – MRP in 1 week; if no soon appointment available, continue LHIN RN follow-up, counsel to use MedVisits if needed

CASE II

- 94yo homebound female patient, daughter calling for support; "coughing more than usual"

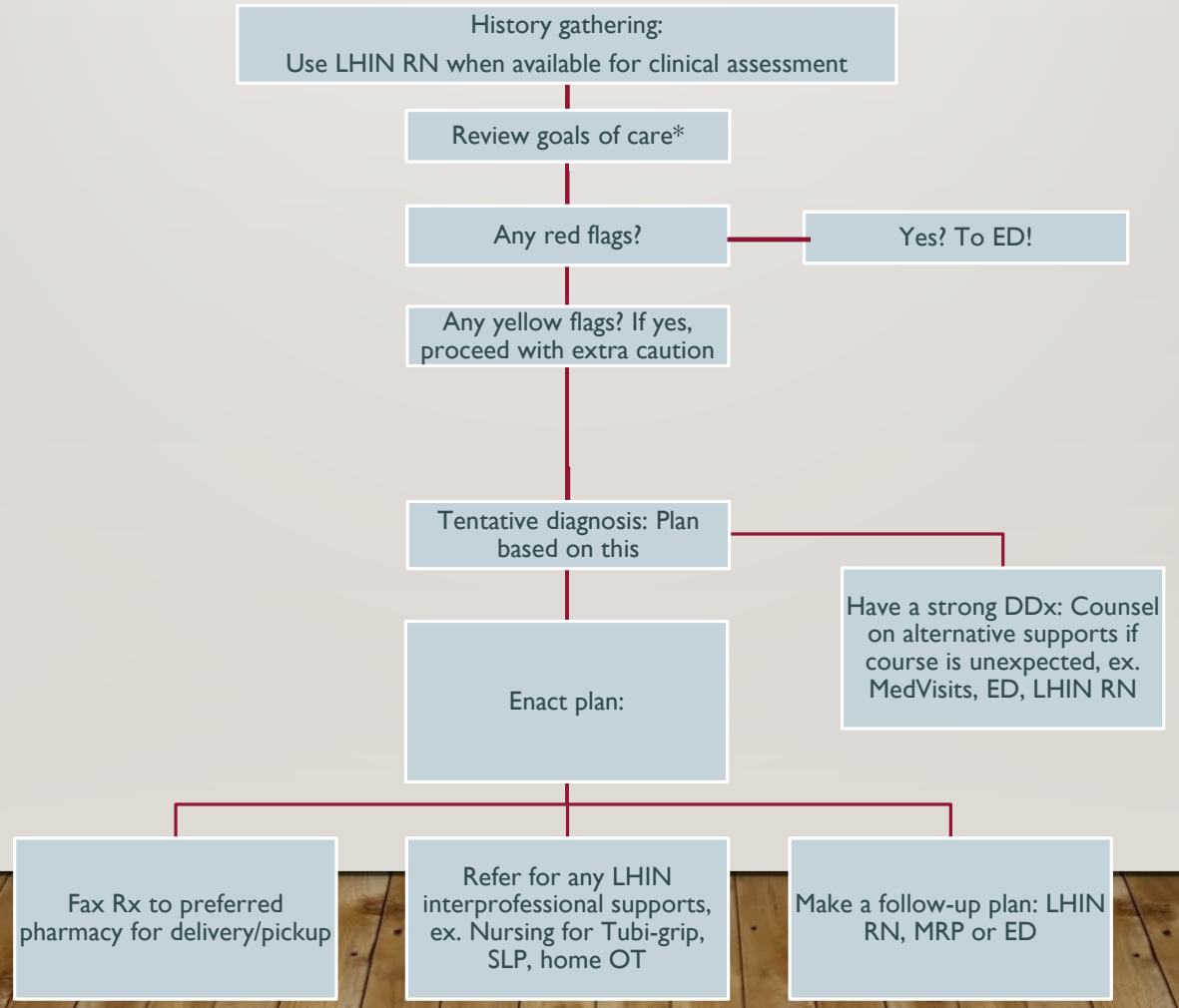
CASE II

- 94yo homebound female patient, daughter calling for support; "coughing more than usual"
- Review EMR:
  - New patient to FHT; only initial visit done to-date.
  - PMHx: Alzheimer's dementia, BPSD.
  - Functional Hx: Dependent for all IADLs, assist for most ADLs including feeding; walks with 2-person assist short distances. Lives on second floor of two-storey home; granddaughter lives in downstairs apartment. PSW support 14h/week. 2 daughters working full time.
  - Rx: Quetiapine 25mg PO QHS, vitamin D 1000 units PO daily, trazodone 50mg PO qAM, melatonin 3mg PO QHS.

CASE II

- 94yo homebound female patient, daughter calling for support; "coughing more than usual"
- Daughter has noted worsening unproductive, wet-sounding cough since 1 week, but coughing with meals and fluids since 1 month. Low-grade fever 1d ago. No noted dyspnea. Decreased PO intake since 1 week, now minimal sips; she is also more confused, sleeping most of the day and night. Daughter feels her briefs need changing much less frequently for urinary voids. No prior SLP assessment. Other ROS negative.
- GOC: Family has not yet discussed this. Per an initial discussion today, you gather they wish for DNR and would consider palliative care at home, but are feeling "overwhelmed" by the decision-making and her care needs.

ALGORITHMIC APPROACH TO HV TRIAGE AND MANAGEMENT



Yellow flags:
Frailty features that may impair a patient's agency, i.e.. ability to follow-up or seek emergent care if needed. Examples:

- Social isolation
- Language barrier
- Cognitive impairment
- No current link with LHIN RN or PSW supports

CASE II - ALGORITHM

- History-gathering, diagnosis – likely delirium with aspiration PNA, 2/2 advanced dementia, dysphagia
- Review goals of care – Unclear! But you gather - DNR is certain, family wishing for supported environment, discussion of different treatment options and are overwhelmed at home
- Review red flags – to ED if present. Yes! Poor PO intake, poor output, altered LOC
- Review yellow flags – Social supports "overwhelmed", difficulty coping at home. No current equipment or LHIN supports
- Tentative diagnosis and DDx –
  - Plan on the tentative diagnosis –
  - Counsel on alternative management if trajectory is unexpected
  - Review secondary supports that are always available ex. ED, Med Visits, LHIN RN –
- Enact plan:
  - Fax any Rx to patient's preferred pharmacy –Refer for any interprofessional supports via LHIN, ex. nursing for Tubi-grip, SLP, home OT –
  - Make a follow-up plan: LHIN RN, MRP or ED –

CASE III - ALGORITHM

- History-gathering, diagnosis – likely delirium with aspiration PNA, 2/2 advanced dementia, dysphagia
- Review goals of care – Unclear! But you gather - DNR is certain, family wishing for supported environment and comfort as a priority of care
- Review red flags – to ED if present. Yes! Poor PO intake, poor output, altered LOC; PPS 20% at most
- Review yellow flags – Social supports "overwhelmed", difficulty coping at home
- Tentative diagnosis and DDx –
  - Plan on the te
  - Counsel on a
  - Review secondary supports that are always available ex. ED, Med Visits, LHIN RN –
- Enact plan:
  - Fax any Rx to patient's preferred pharmacy –Refer for any interprofessional supports via LHIN, ex. nursing for Tubi-grip, SLP, home OT –
  - Make a follow-up plan: LHIN RN, MRP or ED –

Done! This patient should go to the ED

HOME VISITING SERVICES – TAKE-HOME MESSAGE

- Home visits are important in meeting the needs of complex seniors, and optimizing their healthcare utilization
- A practical approach to care and attention to environment are key to a good home visit
- Know your clinic and community resources, and don't be afraid to engage help when available
- Home visits can be challenging, but very rewarding! Challenge your site to ask, how can we help provide better homecare

ALGORITHMIC APPROACH TO HV TRIAGE AND MANAGEMENT

- History-gathering, diagnosis; use LHIN RN when available for clinical assessment
- Review red flags – to ED if present.
- Review yellow flags – frailty features which may impair follow-up or emergent care if needed
  - Ex. Social isolation, language barrier, cognitive impairment, no current link with LHIN RN
- REVIEW GOALS OF CARE.
- Tentative diagnosis and DDx
  - Plan on the tentative diagnosis
  - Counsel on alternative management if trajectory is unexpected
  - Review secondary supports that are always available ex. ED, Med Visits, LHIN RN
- Enact plan:
  - Fax any Rx to patient's preferred pharmacy for delivery/pick-up
  - Refer for any interprofessional supports via LHIN, ex. nursing for Tubi-grip, SLP, home OT
  - Make a follow-up plan: LHIN RN, MRP or ED