Out of the hospital

From her third floor office at Trenton Memorial Hospital, Mary Thurgood meticulously prepares a series of medical supplies and physician referral documents crucial to the discharge of a patient on Tuesday.

Inside the elaborate package is a detailed outline informing the patient how he will be cared for from home by a plethora of healthcare providers and support staff like Thurgood, a care co-ordinator with the South East Community Care Access Centre (CCAC).

The planned one-on-one meeting with the recovering patient, awaiting her visit in a surgery room downstairs, is described by Thurgood as a crucial link in ongoing efforts to move less ill patients out of a clogged hospital system and into a home care setting.

“I've prepared notes so I'm ready to complete the assessment with the client,” she said, about the man who had a benign prostate removed. “I've also gathered all the supplies I know he might need.”

There are roughly 70 care co-ordinators working in the Hastings and Prince Edward area. Part of tracking the patients path to recovery includes Thurgood ensuring the home is barrier free for his return and setting up services suited to his needs.

“I will be setting up whatever services are appropriate for him,” she said. “His referral is calling for a nursing visit the following day.”

For various reasons — including a shortage of long-term care spaces — those patients end up waiting in hospital longer than they should, clogging the system, creating capacity problems in inpatient units and longer waits in the emergency. It's estimated supporting less ill patients at home saves the health care system $384 per patient each day.

Some complex clients requires more detailed review and preparation, covering numerous meetings with staff such as physicians, physiotherapist, before home supported or long term care home release is complete.

Patients receive written confirmation of their care plan and contacts, also shared with family doctors and a legion of mobile care co-ordinators, based solely in the community to perform frequent checkups once patients arrive home.

“Depending on where they're being released to ... it could include talking with the family, the client (or the) retirement home about the supports they need,” said Thurgood, a registered nurse.

Community care providers, including physiotherapists, are required to respond within 40 minutes declaring if they will be able to facilitate patients tagged for release. If need be, CCAC will seek assistance from one of the other contracted agencies.

Care co-ordinators are becoming the glue in a system that's gradually shifting from widespread instances of working in silos, said Karen Brown, manager for 11 care co-ordinators at QHC's four sites. Her staff diverted 22 people away from an emergency room admission last week alone.

“The care co-ordinator is a system navigator,” she said. “Our role is to ensure patients are discharged safely to whatever discharge destination to free up those hospital beds.”

Reducing gaps in communication when patients are readmitted is one of the rough patches requiring improvement, Brown said. Electronic notification at QHC — tagging clients as CCAC patients — is a proposed resolution the CCAC is currently piloting.

“The only way we would know is if the care co-ordinator in the community informed us,” she said. There are also weekly ALC meetings held at QHC sites to mitigate those woes. Other discharge-related challenges include, “lots of pressure to move people quickly.” Climbing patient health complexity is another hurdle. Patients with dementia are becoming more difficult to manage at home.

“We've gone from assisting frail elderly to getting in and out of bath tub to managing clients who are bedridden and require significant support,” Brown said. “We live in an unpredictable environment.”

The brief snap shot captured from Thurgood's work day at TMH, encapsulates a transforming Ontario health care picture, where an increasing amount of funding is being diverted away from bursting at the seams networks like Quinte Health Care and into managing certain patients at home, like the one visit by Thurgood.

Sites like Trenton are already reaping benefits, said Kim Fletcher, manager of the 31 bed in-patient wing at Trenton Memorial.

“Over the last six months we've certainly done a better job at supporting patients,” she said.

Moving patients out of hospital beds sooner is touted by local and Ontario health officials as the catalyst in averting the threat of health care swallowing an estimated 80 per cent of the provincial budget by 2030. Healthcare currently eats more than 40 per cent of the budget.

Story and photo by Jason Miller originally ran in May 29 Belleville Intelligencer. Printed with permission of the Belleville Intelligencer.