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   10. Video and Online Learning Tools
   11. Sample Learning Objectives Outline
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Introduction

“Into whatsoever houses I enter, I will enter to help the sick…”

- Hippocrates
Introduction

Historically, physicians solely, routinely, and indiscriminately delivered medical care to sick patients in their own homes. Indeed, house calls still accounted for the vast majority of doctor-patient encounters at the turn of the previous century. However, as physicians developed an increasing reliance on technology and payment models began to prioritize volumes and efficiency, the provision of health care shifted to hospitals and office-based settings. Today, the delivery of primary care is largely done in office-based settings, with responsibilities spread across an array of providers.

With fewer primary care providers delivering house calls, medical trainees are less likely to even learn how to perform house calls. Furthermore, medical trainees report a lack of role models as a barrier to ever performing a house call in their future practices.

Increasing evidence is coming to demonstrate the clear benefits associated with delivering home-base primary care to frail homebound elders. While the provision of house calls appears to be on the decline nationally, the provision of house calls has been gaining the increasing interest and attention of Canadian policy makers as one effective way to meet the increasingly complex health and social care needs of our aging populations.
While considered an old-fashioned solution to an emerging problem, modern home-based primary care models must be distinguished from the traditional house call:

*Home-based primary care (HBPC) specifically targets individuals with complex chronic disabling disease, with the goal of maximizing the independence of the patient and reducing preventable emergency room visits and hospitalizations. HBPC programs provide comprehensive longitudinal primary care by an interdisciplinary team in the homes of patients with complex chronic disease, who are not effectively managed by routine clinic-based care. HBPC is very different from and complementary to standard skilled home care services, in population, processes and outcomes. HBPC targets persons with advanced chronic disease, rather than remediable conditions. HBPC provides comprehensive care of multiple co-morbidities, rather than problem-focused care. HBPC is delivered by an interdisciplinary team, rather than one or two independent providers.*

- *Veteran’s Affairs Home Based Primary Care, 2009*

This handbook has been developed for those with an interest in providing home-based primary care to their patients. It is not intended to be a compendium of detailed operating procedures, or clinical practice guidelines as we appreciate that the operational context within which a primary care provider may want to deliver home-based primary care will vary significantly, and that current clinical practice guidelines rarely if ever focus on the needs of the homebound.

Nevertheless, we do think readers will find the ideas and practices outlined in this handbook useful especially to those starting to explore providing this type of care for their patients, and more experienced providers looking to further evolve their existing practices.

Wherever possible, we cite the evidence that exists to support what is contained in this handbook, otherwise, the rest of what is here is based on the consensus best practice experience of this handbook’s authors who are committed providers of home-based primary and specialty care.

For a detailed review of the current status of home-based primary care in Canada, see References.
Chapter 1: Why Provide Primary Home-Based Care?

“Some of us believe that we did it because we recognized there was a great need for this type of care. Some of us believed … we were desperate for something to do that would reinvigorate our practice and make it fun to be a doctor, despite all the pressures of 21st century medicine. A lot of doctors are struggling with the same things that patients struggle with. On both sides of the divide we are desperate for some kind of meaningful relationship.”

- Dr. David Muller, Co-Founder of Mount Sinai Visiting Doctors Program & Dean of Medical Education, Mount Sinai Hospital New York
Why Provide Home-Based Primary Care?

Older Adults Benefit From Primary Care

Adults over age 65 drive the care demands in Canada through their complex and interrelated health and social care needs. Older adults are those struggling with the majority of the chronic disease and associated functional burdens of our population, and as such, are amongst the most vulnerable patient groups. Primary care is the most appropriate first-line means to address the health needs of this population. Primary health care providers also help patients navigate the health care continuum, providing direction and coordination of care.

... But Older Adults Often Can’t Access Office-Based Primary Care

The population of older Canadians (over age 65) is expected to double over the next two decades, while the population over 85 years old is expected to quadruple. This alone will impair accessibility for the much slower growing population of providers. It is currently estimated that there are over 100,000 frail and housebound Canadians. Of those who “have a family doctor”, many cannot actually get to the doctor’s office due to medical, cognitive, functional or social barriers.

For These Patients, Health Outcomes Often Suffer

For frail older patients with growing functional limitations, these challenges only increase as their conditions worsen and typically continue to do so until they are forced into finding an alternative to office-based primary care. These alternatives, such as one-off visiting physician programs, 911 paramedic care, emergency departments (ED), and inpatient hospital admissions, do not offer the continuity of care to prevent future medical escalations. ED and hospital admissions lead to rapid functional decline and a loss of capacity for independent living in older adults.
Caregivers Burnout

Informal caregiver support is key to enabling frail and homebound older adults to remain at home safely and independently as they age. The responsibilities of informal caregivers often extend around the clock, and this can be extremely stressful at an emotional and physical level for the caregiver. Without access to high quality primary care to help support an older adult at home, caregivers often see their own health deteriorate. This understandably can precipitate the likelihood of a hospitalization or institutionalization of the frail older adult they care for.

**CASE STUDY 1**

Maria is a 78 year old patient of yours for the past 6 years. She has diabetes, asthma, high blood pressure and cholesterol. She lives at home with her husband. She has two adult daughters who bring her to the office and help her organize her medications.

Maria had a small stroke last year. She can’t transfer on her own anymore. Her daughters struggle to get her into a wheelchair and down the steps of her home to bring her to your office when she has run out of pills, especially in winter.

Her family notices she hasn’t been eating well for a week, but they hope it will get better.

One morning, they find her semi-conscious. They call 911. The emergency doctor tells her she had a bladder infection and it has spread to her kidneys. She stays in hospital for 12 days.

Her family worries about her declining health. Now, every time Maria isn’t eating well or seems tired, they call 911 because they are afraid an infection might spread again. They don’t know what else to do.

Maria goes to the emergency department six times this year, and is admitted with a diagnosis of urosepsis four times.

You get notices each time Maria has been discharged from hospital. You try to make appointments but it’s just too difficult to get her to your office at all, let alone on short notice when she’s sick. You think of a few patients in your practice with similar patterns.
System Costs Escalate

Of all of the components of our health care system, hospitals currently receive the greatest share (37.3%) of Canada’s health care dollars. Older adults use a disproportionate amount of hospital services, for reasons that include limited access to primary care. They are held longer in the ED, stay longer in hospital, and are heavier users of resources once admitted to an inpatient unit. All of this contributes—in part unnecessarily—to skyrocketing health care expenditures in Canada.

Providers, Patients, and Caregivers Are Less Satisfied

Given these circumstances, patients and their caregivers often feel the care they receive is sub-optimal in fully meeting their needs. As health care providers derive professional satisfaction in knowing they are delivering high-quality care with the best outcomes for patients, self-evaluation reflecting sub-optimal performance leads to loss of work-life balance, lower job satisfaction and burnout.

Emerging evidence shows that participating in the delivery of integrated home-based primary care, providers and their supporting organizations can:

• Maintain patients in the community by meeting their health needs
• Deliver humane care that respects older adults’ choice to live at home
• Support families and caregivers
• Improve quality of patient care
• Reduce system health care costs including decreased ED visits, hospitalization rates, and long-term care admissions
• Increase patient, caregiver and health care provider satisfaction through the above
• Develop better relationships across the health care spectrum, and open up opportunities to advocate for social justice issues collectively
• Educate trainee providers and enrich their future professions

… Together, the purpose is to be a part of creating a health system within which we would all be proud to grow old.
Chapter 2: Who Should Receive Home-Based Primary Care?
Who Should Receive Home-Based Care?

The “Homebound”

Most currently accepted U.S. medical definitions of homebound patients use simple physical criteria which might fail to encompass the complex interplay of medical, cognitive, and social issues that leave a patient unable to access the care they need.

Considering the purpose of what home-based primary care is meant to address, as outlined in the previous chapter, Canadian providers may wish to focus on patients who would most benefit from it and are at the greatest risk for ED use or hospitalization due to social, cognitive, medical and functional barriers impeding access to care.
This “perfect storm” patient may have a variety of chronic disease burden levels as well as social frailty as depicted in this visual snapshot tool:

Betty is 71 years old with CHF, arthritis and impaired mobility reliant on a walker. She has mild dementia, which causes her to forget appointments. Her husband is physically well but also suffers from dementia.

Luisa is 69 years old, with mild Alzheimer’s dementia and a long history of depression. She is widowed and has no children. She doesn’t take medications, and takes walks when feeling sad. She forgets to eat.

Elizabeth is 89 years old with diabetes, CHF, arthritis and impaired mobility reliant on a walker. She is cognitively sharp and relies on her husband to bring her to appointments and for assistance with some of her IADLS.

Fernando is 76 years old with mild Alzheimer’s dementia and a long history of depression. His three daughters and a neighbour take turns checking on him at home, and work together to bring him to his appointments.

Choy is 81 years old with CHF and heart disease. He lives with his eldest daughter who is a single mother. Last year he had a stroke that left him with significant unilateral deficits and dependent for most of his ADLs.

George is 74 years old and wheelchair-bound with diabetes, hearing loss and atrial fibrillation. He takes warfarin. He says he can’t afford to move from his apartment at the top of a steep staircase. His is estranged from his only son.

Maria is 78 years old with diabetes and a previous stroke amongst other chronic conditions. She cannot get down the front steps of her house unless carried. She has two adult daughters who call 911 to take her to the ED regularly.

By leaving the definition of homebound patients open to simply “those who - for medical, social or cognitive reasons - cannot access office-based primary care”, a provider will be able to capture not only the obvious bed-bound, completely dependent frail adults, but also those who may be highly appropriate for home-based care for a combination of other reasons. Another way to look at a reasonable definition is to identify those patients for whom house calls are a necessity, not a mere convenience, ensuring their access to quality primary care.
Subpopulations to Consider

Assuming care for these and other subpopulations will be at the discretion of providers, although special consideration must be given to a provider’s practice setting, capacity, and supporting organizations within the community to determine the patient populations they are able to serve.

Temporarily or Seasonally Homebound – i.e. post-acute care discharge; post-rehabilitation stay; during winter months only; during mental health relapses only

Terminally Ill/Palliative – i.e. likely to die within next 12 months; thought to be within last 30-90 days of life; terminal cancer diagnosis

Functionally Homebound – i.e. due to functional issues experiences limited access to caregiving and other supports (e.g., transportation), the patient is unable to leave their home to seek health care

Dr. L., who provides home-based care to 4 patients, also looks after the spouses of his patients.

One of the couples is able to walk to the office in the summer months. He provides his cell phone number to patients he is palliating at home.

Dr. S. and Dr. A. in a team of 12 MDs find the demand for home-based care services very high.

They have to keep a wait list. As such, they do not accept the spouses of caregivers unless they meet identified criteria.

A group of primary care organizations providing home-based care decide to exclude terminal patients, as there is a robust system of home palliative care medicine operating in their city.

They work collaboratively with this program.
Referral Sources

The following groups may be considered as potential referral sources to a home-based primary care program. Home-based care providers may thus institute systems of regular contact and capacity building communication with these referring providers:

- Family Physicians within the home-based care practice (“internal”)
- Family Physicians outside of the core home-based care practice (“external”)
- Inpatient Hospital Wards (i.e. General Medicine, Specialty Medicine, Geriatrics)
- Outpatient Hospital Clinics (i.e. Geriatrics, Falls or Seniors Wellness Clinics, Geriatric Psychiatry, General Medicine)
- Emergency Departments
- Palliative Care Teams
- Home Care Agencies
- Community Support/Social Service Agencies
- Families
- Individuals
- Patients (Self-Referral)

Patient referral processes will be reviewed in Chapter 4: Processes.

Workload

A successfully manageable full-time equivalent (FTE) caseload varies from 100-225 homebound elders. In Ontario, the Ministry of Health and Long-Term Care has set a 1.0 FTE as a caseload of 120 frail elderly patients (1,600 visits annually) for eligibility for the Care of the Elderly Alternative Funding Plan. The caseload may be shared across any combination of staff as described in the section on “Providers”; however, published studies reviewed for this handbook involved at least two professionals (i.e., Physician (MD) and Nurse Practitioner, MD and Registered Nurse, MD and Social Worker) with administrative support.
Geography

As a provider, the geographic location of the patients served by home-based care is of utmost importance. Urban, suburban, rural, and remote practice areas each provide unique challenges and advantages, which may contribute to a provider’s catchment area for home-based care.

Options may include but are not limited to:

- Patients living close to the office
- Patients living close to the primary care provider’s home
- Patients living in a particular seniors’ apartment or assisted living unit
- Established catchment area of primary care provider’s practice organization
- Defined catchment area of identified street intersections or postal code zones

Further consideration should be given when there are other organizations providing home-based primary care in proximity. Collaborative systems of divided geographic responsibility for home-based patients are an ideal step towards a robust and comprehensive system of care for all Canadians.

---

Dr. L. practices in an office with one other MD and one nurse. He has been in practice for 17 years. He provides home-based care to 4 patients who live conveniently on his route between home and office.

Dr. S. and Dr. A. practice in a team of 12 MDs. There are nursing staff services available and one NP. They provide home-based care to 50 patients living within their defined clinic catchment area in a suburban city.

A group of neighbouring primary care organizations decides to provide home-based care. The leading providers look at a map of the city and divide responsibility by postal code zone boundaries.
Chapter 3:
Who Should Be Involved In Providing Home-Based Primary Care?
Who Should Be Involved in Providing Home-Based Care?

Adaptation is central to the core principles of primary care, so it follows that the purpose of home-based primary care and the particular needs of a specific population of frail housebound older adults should drive the numbers and composition of staff delivering health services for them.

Promotion and expansion of home-based primary care within and across Canadian jurisdictions with a single-design approach to staffing would be impossible, as impossible as implementing a single system of health care across the nation. Rather, flexible provider models based on local considerations will allow home-based primary care to be effectively delivered across the many currently existing primary care structures.

Developing A Core Team

In order to be efficient and effective, one needs at minimum an associated MD and NP/PA/RN who are supported as a core team administratively, as well as a links to home care and community support agencies.
Integrated Providers

Listed below are potential providers with key roles and responsibilities in a home-based primary care team. While assigned duties should be clear, as in any operational context, responsibilities may be quite fluid and dynamic, allowing for role blurring and flexible working to occur to promote a high functioning, well integrated team. When more than one provider is available to participate in this model of care, effective teams will recognize each team member’s unique skill set, to offer care by the right provider, at the right time, and in the right place.

All home-based care providers, especially those in smaller clinical practice settings with fewer providers available, should look outside their core organization for collaborative opportunities with affiliated organizations, in order to construct a well-balanced team. Partnering human resources available in a geographic practice area can increase the scope of services that a provider group can offer, without directly hiring providers to the organization.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Roles &amp; Responsibilities</th>
</tr>
</thead>
</table>
| Administrative Assistant     | • Coordinate clinician home visit schedules  
                              | • Triage and manage patient referrals  
                              | • Initial contact point for patient phone calls before clinical triage  
                              | • Liaise with supporting agencies outside core team                                                                                               |
| Care Coordinator             | • Intensive case management  
                              | • System navigation to support patient across transitions  
                              | • Communication and follow-up across the system  
                              | • Access to community services                                                                                                                      |
| Consultant Specialist        | • Geriatricians, Internists, Psychiatrists and other MDs may provide consultations (formal or informal) via team meetings, e-mail, telephone and/or home visits |
| Family Physician (FP)        | • Most Responsible MD  
                              | • Oversee medical and clinical care plan for patients  
                              | • Available for acute complex care collaboration with other clinical providers                                                                    |
| Nurse Practitioner (NP)      | • Plan medical and clinical care plan for patients  
                              | • Chronic disease management  
                              | • Illness prevention and health promotion  
<pre><code>                          | • Acute episodic care                                                                                                                            |
</code></pre>
<table>
<thead>
<tr>
<th>Team A</th>
<th>Team B</th>
<th>Team C</th>
</tr>
</thead>
</table>
| **Occupational Therapist (OT)** | • Cognitive assessment and support  
• Environmental assessment and support  
• In-home functional assessment and support |  |
| **Pharmacist (Rx)** | • Medication reconciliation  
• Patient education and medication management |  |
| **Physical Therapist (PT)** | • Mobility assessment and support  
• Patient and family education  
• Assistive device arrangements |  |
| **Physician Assistant (PA)** | • Support medical and clinical care plans, chronic disease management, and acute episodic care as directed by NP/MD |  |
| **Registered Nurse (RN)** | • Triage patient and family clinical issues  
• Organize laboratory, imaging and prescriptions with MD/NP  
• Clinical wound care and patient/family education  
• Acute episodic procedures (IV, catheters, phlebotomy) |  |
| **Social Worker (SW)** | • Liaise and organize community social, mental health and other support services for patients and families  
• Advanced care planning  
• Psychosocial support for caregivers, socially complex patients |  |
| **Trainees (Medical, Nursing, Other)** | • Support their supervising provider in clinical or other duties |  |

**Home-Based Care Team A**  
MD – 0.1 Full-Time Equivalent (FTE); RN – 0.1 FTE; Administration – 0.1 FTE  
Team A relies on the local community service agency for PT, OT, RN and SW services as needed. They collaborate with a community Rx who sees the home-based patients at home for their medication reconciliations.

**Home-Based Care Team B**  
MD – 0.5 FTE; RN – 0.5 FTE; Administration – 0.3 FTE; NP 0.5 FTE; Medical Students  
Team B works with the central community access centre for PT and OT services. Several specialists, a SW, and an Rx who work in the same medical building collaborate on their services for home-based patients.

**Home-Based Care Team C**  
MD – 1.0 FTE; RN – 1.0 FTE; Administration – 1.0 FTE; NP 1.0 FTE; SW 1.0 FTE; OT 1.0 FTE; PT 0.5 FTE; Care Coordinator 1.0 FTE; Specialist Consultant 0.1 FTE; Medical Students, Residents  
Team C collaborates regularly with community services (i.e. dentistry; chiropody) to offer full-spectrum care.
## Roles, Responsibilities and Accountabilities

The provision process of home-based primary care is a team activity often shared by a variety of providers. As such, a process overview document may help recognize key relationships within the team, and clarify roles, responsibilities and accountabilities within the context of team integration. See Chapter 4: Processes.

<table>
<thead>
<tr>
<th>roles, responsibilities and accountabilities</th>
<th>Team Coordinator</th>
<th>Physician</th>
<th>Nurse Practitioner / Resident/ RN</th>
<th>CCAC Care Coordinator</th>
<th>Allied Health (SW, Pharmacist) &amp; Community Support Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.0 Intake</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Eligibility Screening (See referral form)</td>
<td>Initial review of eligibility criteria</td>
<td>Final screen (clinical) conducted at weekly rounds</td>
<td>Final screen for home care services</td>
<td>Final screen for related services</td>
<td></td>
</tr>
<tr>
<td>1.2 Scheduling</td>
<td>Schedule all visits</td>
<td>Review schedule and update as necessary</td>
<td>Review schedule and update as necessary</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2.0 Interdisciplinary care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 Initial and ongoing care planning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2 Consent</td>
<td>Implied</td>
<td>Implied</td>
<td>Implied</td>
<td>Verbal, documented</td>
<td>Verbal, documented</td>
</tr>
<tr>
<td>2.3 First to visit client</td>
<td>Schedule first visit</td>
<td>First to visit if available or urgent need, perform assessment</td>
<td>First to visit if available, perform assessment</td>
<td>First to visit if available or urgent need, perform RAI assessment</td>
<td>First to visit if available, perform assessment</td>
</tr>
<tr>
<td>2.4 Care planning for new clients</td>
<td>Pull necessary documentation</td>
<td>Leads, clinical care planning</td>
<td>Support as required</td>
<td>Leads, care planning and coordination of CCAC services</td>
<td>Leads, identifying appropriate supporting services</td>
</tr>
<tr>
<td>2.5 Primary Care</td>
<td>Field calls from clients</td>
<td>MRP Provide hands on medical care for all HC clients including medical and medication mgt, leads development of community-based emergency/ contingency plan</td>
<td>Hands on medical care as appropriate, joint visits with MD as necessary</td>
<td>Arrange CCAC based supporting services</td>
<td>Arrange for supporting services</td>
</tr>
<tr>
<td>2.6 CCAC Based Services</td>
<td>Fields calls from clients, notify Care Coordinator</td>
<td>Collaborative team care, team members consulted, notified as required, joint visit or case conferences as necessary</td>
<td></td>
<td>Lead, care coordination and intensive case management of CCAC services</td>
<td>Collaborative team care, joint visits as necessary</td>
</tr>
<tr>
<td>2.7 Allied Health Services / Community Support Services</td>
<td>Fields calls from clients, notify CSS contact</td>
<td>Collaborative Team care, team members notified as required, joint visits or case conferences as necessary</td>
<td></td>
<td>Lead, Coordination and management of supporting services, joint visits as necessary</td>
<td></td>
</tr>
<tr>
<td>2.8 Specialist Care</td>
<td>Facilitates referrals</td>
<td>Consultations with specialist for added value, joint visit as required</td>
<td>Request consultation, supporting information, joint visit</td>
<td>Request consultation, provide supporting information, may lead as appropriate, joint visit as required</td>
<td>Request consultation, provide supporting information may lead as appropriate, joint visit as required</td>
</tr>
<tr>
<td>2.9 Weekly team rounds (see weekly rounds worksheet)</td>
<td>Prepare list of new patients, relevant documentation for existing clients</td>
<td></td>
<td>Review client status, communication of any changes, flagging and notification of urgent service requests</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3.0 Program Administration</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1 Charting and other patient documentation</td>
<td>Open new patient charts and update existing charts</td>
<td></td>
<td>Review and document at the end of each visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2 Program data collection and reporting (see Research Data Collection template)</td>
<td></td>
<td></td>
<td>Complete Research Data Tracking Template</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Figure 1: Home-Based Primary Care Provider Roles & Responsibilities outlined in a sample Process Overview chart*
Competencies Essential to Delivering Home-Based Primary Care

Whether working in a team of two or ten, the delivery of home-based primary care requires providers to develop new and more advanced skills in:

- Clinical and environmental observation
- Assessing and managing chronic illness within a patient’s home environment
- Telephone triage and follow-up
- Applying a palliative approach to treatment
- Discussion of advanced care directives and goals of care
- Incorporating the psychosocial and socioeconomic determinants of health into patient care plans
- Teamwork
- Care coordination

Building Community Alliances and System Integration

Successful patients’ experiences of seamless and integrated home-based medical programs depend on active collaboration occurring between family physicians and other primary care providers, home care providers, community support services agencies, and local hospitals and specialists.

For Ontarian providers, including the CCAC care coordinator in your team provides an opportunity to provide holistic comprehensive care to the client. A group of local care coordinators may provide case management and system navigation functions. This includes referrals and the inclusion of community support services and non-traditional support services in the care team.

The care coordinator and primary care providers work together to do joint home visits and joint care planning, thus building a shared care model for the homebound clients where real time communication is the norm.
It is incumbent upon the leadership of a home-based care practice to establish strong partnerships with CCAC and other relevant local providers across the various sectors that are involved in keeping homebound patients safe in the community. A suggested but not exhaustive list includes:

- Home Care Agencies
- Community Care Access Centres
- Community Social Service Agencies
- Community Health Centres
- Emergency Medical/Ambulance Services
- Mental Health Service Agencies
- Friendly Visiting Services
- Meal Services
- Podiatry and Chiropody Services
- Vision Services
- Dentistry Services
- Adult Protective Services
- Home-Delivering Pharmacies
- Public Health Agencies
- Housing Authorities

While staff positions may vary across models of home-based primary care, key principles of team and system integration are critical to the success of managing a group of frail elderly patients. Patient care coordination and case management are functions that may be assigned primarily to one particular staff person, or can be shared in a dynamic process by a few key team members.

Ensuring the advanced competency of all staff in team integration principles will contribute to more effective care delivery. The importance of team building to care coordination, and the relevance of regular team meetings will be reviewed in Chapter 4: Processes.
Chapter 4: Five Core Areas Related to Providing Home-Based Primary Care
Five Core Areas Related to Providing Home-Based Primary Care

In many ways, home-based primary care is just that - primary care delivered to the patient at home. The following five core patient care processes ensure that this care specifically meets the needs of frail elders who cannot access office-based medicine. The core processes in a home-based program are transformed into a functional health system by numerous support processes that ensure the delivery of safe, comprehensive, high-quality, and timely patient care.

STEP 1: Admission Screening And Enrollment

Referrals may come from a wide variety of sources (see Chapter 3: People, section “Referral Sources”), and before admission, it is essential to work closely with patients and families to determine if home-based primary care will best meet their needs. Once a provider group has been established, creation of a referral process, admission criteria and an admission algorithm will assist with clarity for both the team and referring sources.
Referral Processes

No matter the size of the program, a formalized referral process including a program information handout, referral form, and established wait-list management strategies will contribute to practice organization and ameliorate future program growth should expansion be necessary.

The Toronto Western Family Health Team
Home-Based Care Program:
A Primary Care Program for Frail Older Adults

The Toronto Western Family Health Team is proud to be working with the Toronto Western Hospital and Toronto Central – Community Care Access Centre (CCAC) to provide frail older adults whose needs are not served by traditional office-based medicine with access to an integrated interprofessional home-based primary care program.

The Toronto Western HCBP includes a Family Physician, Nurse Practitioner, Registered Nurses, Team Administrative Co-Coordinator, Team Community Case Manager, Resident Physicians, and is supported by a Social Worker, Pharmacist and General Internal Medicine Specialist. For these patients, receiving home visits by their health care team is necessary, not a convenience.

Access to the health care team is available during HCBP hours of operation: Monday to Friday, 9:00 a.m. to 4:30 p.m. Please note that the Program cannot guarantee availability of urgent care home visits with all providers. The Program currently offers home visits by medical professionals on Tuesdays, Wednesdays, and Fridays. Hours may vary. A home visit by a health care professional can usually be arranged within 24-48 business hours of notice.

This Program is unique in its focus providing comprehensive ongoing primary care integrated with community care services in the home.

Do you think you have a potential HBCP patient to refer?

HCBP Patient Selection Criteria:

- Patients must meet at least one of the following criteria:
  - Age 85+
  - Live in the Solicitous Area with the corresponding Postal Codes:
    - M5V, M6G, M6H, M6J, M6K
  - Health care needs are not adequately served by traditional office-based primary care due to physical, cognitive or social barriers
  - Must be willing to transfer their primary care from their current family doctor to the HCBP team
  - Consent to participating in this Program, or decide to transfer their primary care from their current family doctor to the HCBP team

Patients meeting the following criteria will be given high priority on our waiting list:

- Acute Care Hospitalization within the past 6 months
- 2+ Emergency Department visits within the past 12 months

Patient Referral Process:

All referrals must be made by a physician via the attached HBCP Referral Form. Please ensure you have the following information from your patient:

- Referring Physician Name and Contact Information
- First and Last Name
- Address and Date of Birth
- Health Card Number (OHIP)
- Current Family Physician Name and Contact Information
- Established Power of Attorney/Substitute Decision Maker Name and Contact Information

Submit referral information to:

Toronto Western HBCP Program
Afton Meredith, Administrative Coordinator
Phone: 416-603-5814
Fax: 416-603-5812

Additional information may be required and/or requested in order to better assess patient suitability. Please see the Home-Based Care Program referral form for further details, or contact Afton Meredith for up-to-date information regarding waiting list times.

Eligible Clients must meet the following criteria:

1. Patient is 65 years or older
2. Patient lives within postal codes M5V, M6G, M6H, M6J, M6K
3. Patient has been identified as requiring home-based primary care by a physician

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When possible, meeting with potential referral sources in person to build capacity and clarify the home-based team admission criteria is helpful in minimizing inappropriate referrals and can often lead to further collaborative practice opportunities.

Eligibility Screening & Intake

Once a referral has been sent in, home-based care staff must establish a process for further assessing eligibility for program admission.

Figure 2: Sample Home-Based Care Program Information & Referral Form
This may be a multi-step process involving administrative assistants reviewing the referral and phoning patients and caregivers, clinical staff reviewing referral information, and/or an “eligibility visit” by a home-based care team member. The “eligibility visit” or “intake visit” is as much an opportunity for the team to screen patient appropriateness and clearly outline program parameters, as it is for the patient and/or caregiver to assess whether home-based primary care is right for them.

### STEP 2: Comprehensive Geriatric Assessment and Advance Care Planning

After being accepted into a home-based practice, a plan of care should be developed based on findings from a multidisciplinary (whenever possible) comprehensive geriatric assessment with input from patients, family members, involved professionals, previous records, and information from the referral source.

#### Initial Visit

The first formal visit will require at least 1-2 hours. A checklist for preparing for a successful initial home visit may include the following items, most of which may be most appropriately reviewed by an administrative assistant:

- A copy of patient address including buzzer code, special instructions (i.e. entry through back door) etc.
- Clear travel directions (GPS, Google Map)
• Preparation of a patient/caregiver information handout package including the contact phone number, list of staff members, visit policies, affiliations, care availability/hours of operation, refill policies, etc.
• Confirmation that primary caregiver/Power of Attorney (POA)/family members will be present for duration of visit
• Request that caregiver/POA/family member have Power of Attorney or Substitute Decision Maker paperwork copy available for provider

The goal of an initial visit is to obtain a cumulative patient profile, with special attention to features essential to the provision of comprehensive geriatric care. In addition to medical, family, social, allergy, medication and immunization histories, providers may wish to incorporate some of the following aspects in initial assessment visits:

• Current symptoms and illnesses and their functional impact
• Recent life changes
• Current functional status (ADL and IADL)
• Current and future living environment and its appropriateness to function and prognosis
• Family situation and availability
• Current caregiver network including deficiencies and potentials
• Cognitive status
• Mobility and balance
• Emotional health
• Nutritional status and needs
• Bowel and bladder health
• Vision and hearing assessment
• Services required and received

The home-based primary care provider can use their clinical discretion in initiating high-yield portions of a geriatric assessment on the first visit; in reality, multiple staff from the available interprofessional team will perform the complete assessment over many encounters. The importance of a care coordination/case management role becomes apparent when efforts are made to provide one common and robust assessment by a team. For a sample Comprehensive Geriatric Assessment template, please see Appendix 1.
A home-based care team may wish to consider patient-driven assessment instruments (popular amongst geriatricians) in order to have completed questionnaires ready before the initial visit. This may save time and provide insight into what issues to prioritize over others, along with the patient and caregiver’s awareness and insight around the management of their own medical issues. Limitations in the chronic complex frail elderly will often include patient functional inability to complete the assessment and other barriers such as language and literacy. For a sample template, please see Appendix 2.

**Standards of Practice**

A complete review of geriatric medicine is beyond the scope of this handbook. Suggested materials for clinical practice guidelines relevant to geriatric primary care are outlined in References.

Guidelines and protocols for home visits contribute to the successful operation of any home-based primary care organization. Having a formal document for reference outlining the initial visit preparation checklist, home visit processes, practical tips for a successful home visit with a frail elder, and pitfalls/safety considerations will assist all staff – especially new providers and trainees – integrate seamlessly into the culture of home-based care, quality, and safety.
Care Conferences/Team Meetings/Team Round

The value of regular team meetings (also referred to as “rounds” or “care conferences”) for a home-based primary care provider group cannot be underemphasized. Elements of opportunity during regular meetings that contribute to optimized team functioning include:

- Face-to-face communication regarding all process elements including direct patient care issues
- Dedicated time to recognize key relationships and links between interprofessional team members
- Care coordination organizational opportunity
- Review new patients and make enrollment decisions
- Scheduling for home visits, diagnostic testing, prescription refills, consultant referrals
- Review quality indicators and plan for improvement strategies (i.e., flu vaccination rates $\Rightarrow$ plan for dedicated flu vaccination visits)
- Discuss coverage for staff absences
- Forum for initial discussions regarding program growth, changes, improvement, etc.

The length and frequency of team meetings will depend on the size of a home-based care practice, volume of intakes/turnover, and provider availability among other local considerations.

<table>
<thead>
<tr>
<th>Home-Based Care Team A</th>
<th>Home-Based Care Team B</th>
<th>Home-Based Care Team C</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD – 0.1 Full-Time Equivalent (FTE); RN – 0.1 FTE; Administration – 0.1 FTE</td>
<td>MD – 0.5 FTE; RN – 0.5 FTE; Administration – 0.3 FTE; NP 0.5 FTE; Medical Students</td>
<td>MD – 1.0 FTE; RN – 1.0 FTE; Administration – 1.0 FTE; NP 1.0 FTE; SW 1.0 FTE; OT 1.0 FTE; PT 0.5 FTE; Care Coordinator 1.0 FTE; Specialist Consultant 0.1 FTE; Medical Students, Residents</td>
</tr>
<tr>
<td>Once a month at lunchtime in the clinic kitchen, the team meets to review 4-10 home-based care patients. The administrator will schedule routine follow-up visits after this meeting. The RN will bring forward Rx renewals for signing.</td>
<td>Tuesdays 0800-0900, the team meets and reports on patient encounters, including phone calls and visits from the week. Visits are scheduled with space left available for urgent calls that may come in. The NP and MDs at the end of rounds review new referrals.</td>
<td>The team reviews 5-10 new referrals each week on Wednesday mornings in the boardroom. Active patient issues are discussed and visits are scheduled.</td>
</tr>
</tbody>
</table>
STEP 3: Follow-Up Visits to Implement and Update Care Plans

At the conclusion of the initial visit, a provider may wish to leave open ended the question of a return visit since confirmation of enrollment acceptance may still be pending team review, depending on the program protocol. In general, leaving scheduling details closer to the date of follow-up visits helps create flexibility in seeing patients according to their condition, helps the provider coordinate visits geographically, ensures the next visit will fit into the caregiver’s schedule, and avoids overextension of the provider.

Follow-up visit times range from 30 minutes to 1 hour, allowing for 3-5 visits per half day depending on patient complexity, use of information technology, concurrent teaching duties, and assistance from support staff. Administrative assistants can schedule days so that the most efficient routes are used, minimizing traveling time between patients. Focusing on neighbourhoods or regions of the community during particular days or half-days will allow for predictability within a provider’s schedule.

Ongoing Care Planning

As discussed in the above section “Initial Visit”, follow-up visits will play an important role in ongoing development of a comprehensive geriatric assessment and the clinical care plans that follow from such findings. Time should be set-aside at each visit to address caregiver concerns, clarify questions, and provide support.

Post-Discharge Visits

Specific elements of a post-discharge (ED, inpatient hospital, rehab unit, other short-stay unit) home-based care visit must be highlighted. Timely arrangement of a post-discharge visit (2-14 days) will contribute to effective transitional care. A medication reconciliation visit performed by any qualified clinical provider is essential as soon as possible post-discharge.

There is a high risk of medication discrepancies after hospital discharge, which if not intercepted particularly in the frail complex elder, will lead to medication errors, drug therapy problems, and adverse drug events. These place patients at high risk of hospitalization and subsequent poor morbidity and mortality outcomes, all of which are avoidable through expedient review by a clinician familiar with the patient’s home setting.
The post-discharge visit is also a key opportunity for an environmental review by occupational therapy or physiotherapy colleagues, given that a patient’s physical and cognitive functional status may have changed over the course of their hospital stay. Intensive care coordination for the post-discharge patient will ensure that all of these and other support elements are in place for a patient returning home.

**Urgent Visits**

Part of a home-based care program operations protocol should include policy regarding the provision of urgent care. The ability for a provider to perform an urgent visit (same day or within 24-48 hours) will depend on several factors including available supports, provider schedules, and patient geography. Advance planning for common urgent complaints will contribute to the ease with which a home-base care provider can respond to these needs. Examples include:

- **Suspected urinary tract infections** → System for same-day urinalysis and antibiotic prescription if appropriate. Providers may leave urine collection containers with high-risk patients, or carry appropriate catheterization equipment in their home visits bag.

- **Dehydration** → Arrangements with local home care agency to respond same-day to home-based care team calls for IV fluids. Providers may also carry equipment for IV starts to avoid rapid decline while awaiting home fluids.

- **Worsening congestive heart failure** → Intimate knowledge of individual patient symptoms with decompensation and comprehensive patient/caregiver education may allow for phone management of diuresis while awaiting home visit for a more detailed assessment.

- **COPD exacerbation** → Knowledge of patient baseline can allow quick assessment and management (potentially over the phone) including prescription of antibiotics and steroids as needed.
Equipment & Supplies

The tasks of home-based primary care are more readily performed if proper instruments and forms have been brought to the home. An ideal home visit bag should be lightweight and capable of carrying 5-15 lbs. Durability, waterproofing, and multiple pockets, including a laptop-padded pocket, are all helpful features. Fishing tackle, photography, messenger or even old-fashioned doctor’s bags are ideal for all of these reasons.

Compact equipment can be purchased from medical supply stores or online at discounted prices. The choice of equipment carried by a home-based care provider will be tailored to individual practice and populations served. Various providers within a home-based care team may wish to carry different skill-specific supplies (i.e., Nurse X to carry phlebotomy equipment, NP Y to carry wound care supplies).

Creating a laminated inventory sheet and placing it in the home visits kit will allow for quick orientation for new users, easy supply monitoring and easy restocking. Some items for consideration include:

- Stethoscope
- Blood pressure cuffs: Regular, Large, Pediatric
- Digital Thermometer
- Otoscope/ophthalmoscope
- Pulse Oximeter
- Glucometer
- Gloves in various sizes
- Lubricant
- Hemoccult slides
- Bandage Scissors
- Toenail Clippers
- Sterile Scissors, Forceps, Disposable Scalpel
- Sterile 4x4 gauze
- Medical tape
- Antiseptic solution
- Urine collection containers
- Standard urinary catheters + drainage bags
- IV fluid start supplies
- Phlebotomy supplies
- Hand-held EKG Machine
- Hand-held i-STAT

Figure 3: Sample Home Visit Kit; Available at Crumpler stores as model Dry Red No. 10 (~$200)
Paper or electronic medical records (EMR) and charting will be reviewed in the section below entitled “Communication”; however, several paper-based forms may be useful to carry regardless of EMR availability. These include:

- Prescription pads
- Progress note paper – for patient instructions, etc.
- Advance Directive forms
- Release of Information forms
- Informed Consent forms
- “Do Not Resuscitate” directive forms
- Death certificates

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**Home-Based Care Team A**

Dr. L carries a small backpack in his car for home visits. It contains a blood pressure cuff, stethoscope and otoscope.

Because his office does not have an electronic medical record, he has a folder containing blank prescriptions and progress note paper amongst other forms.

**Home-Based Care Team B**

Dr. S, Dr. A and NP C share 2 home visit kits stored in small rolling travel bags.

They both contain instruments to measure vital signs, stethoscopes, wound care equipment, urine containers and catheters. NP C also carries a supply of phlebotomy tubes, butterfly needles, tourniquets etc.

**Home-Based Care Team C**

Members of the clinical team carry their own unique home visits kit in a bag of their choice.

The team has one iSTAT machine, which is kept in the office and signed out by providers as needed for lab work. All providers have a laptop computer for charting during home-based care visits.
Safety

Many major personal safety considerations for home-based care providers are the same as those encountered in office-based practice (i.e., caution with known aggressive patients, removal from sensed dangerous situations, having exit strategies from an area, appropriate dress, etc). Those considerations unique to the mobile nature of home visits fall under a few categories:

- **Car**: Keep items out of sight (i.e., in trunk), check back seat of car, emergency kit in car, parking safety. Providers may want to weigh the utility of a dashboard sign i.e. “DOCTOR ON HOUSE CALL” for parking purposes with safety risks of privacy and personal identification.

- **Cell Phones**: Should be used by all mobile providers for emergency use, and office contact while on the road. Another provider or administrator should know each mobile provider’s daily plans for home visits and their phone numbers.

- **Neighbourhood**: Identify safe areas (i.e., restaurants, stores, police stations); be aware of local risks.

- **Pets**: Inquire about pets before initial visits; consider asking family/patient to secure all pets in another room or cages before a visit.

- **Universal Precautions**: Use antiseptic hand gel before, during, and after visits; use kitchens for handwashing; use pumped soap (not bars) and paper towel as needed.

- **Household Hazards**: Do not remove shoes in home (consider carrying disposable booties); be wary of surfaces to sit upon (consider carrying disposable towel pads); do not bring unnecessary personal items into the home (i.e., purse)

- **Transmissible Pests**: If bed bugs, scabies, or other transmissible pests are a worry, exercise precautions. See Appendix 3 for a reference guide on transmissible pests.
Safety policies for trainees should align with academic institutional guidelines (i.e., local association for residents, university or faculty policy). Considerations unique to the area of practice should dictate further safety precautions as indicated i.e., high-density urban area with known crime rates; isolated rural homes with limited emergency or communication access.

<table>
<thead>
<tr>
<th>Home-Based Care Team A</th>
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<th>Home-Based Care Team C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. L knows his few elderly patients very well. He has no concerns of violence or aggressive behaviour with any of them or their spouses. One of the couples lives on farming property, and their two large Doberman dogs are always locked into their kennels when Dr. L. visits.</td>
<td>Team B has a program policy to travel in pairs for new visits. They often have the referring provider (i.e. a community nurse or case manager) meet them at the home. They do not accept patients living in the male-only shelter in town due to previous safety concerns from that institution.</td>
<td>Team C has a program policy that a minimum of two members of the team see new patients together. Trainees are always accompanied by another provider. Because bed bugs are a concern in some buildings in the city, providers wear scrubs on visits and exercise bed bug precautions regularly.</td>
</tr>
</tbody>
</table>

Financial Considerations

While financial feasibility for providers is essential to the viability of any home-based primary care program, the route to fiscal and practice performance optimization will vary enormously depending on local existing fee models. Published literature on practical billing and reimbursement issues derives from the U.S. Medicare system - largely inapplicable to the Canadian context - and within our national system exist a myriad of mixed-method payment models that vary within and across provinces.

See Appendix 4 for a brief summary table of known primary care codes and alternative funding plans related to home visits or frail elder care in Ontario. These codes and plans are intended be used as a starting point for individual home-based care providers to incorporate into to their existing practice structures with tailored guidance from their respective provincial billing guidelines.
Time Management

Considerations for efficiency through time management will be useful to any home-based primary care provider regardless of their financial model of practice:

- Geographic clustering of patients
- Visit length/pace
- Utilization of community-based agencies
- Charting templates
- Billing services
- Support staff
- Electronic record keeping
- Laptop computers
- Smartphone usage

Communications

Perhaps the most important efficiency factor in designating a home-based primary care practice is the area of communications. See the section below entitled “Interprofessional Collaboration - Communications” for details.

Overhead & Capital Needs

The addition of home-based care to a primary care practice entails minimum additional overhead expenses. Current overhead costs for solo office-based providers may be mitigated on home visit days/half-days by minimizing providers left back at the office (i.e., administrative assistant only), and/or using providers on those days to handle the paperwork related to home-based care (i.e., medication renewals, long-term care applications, patient phone follow-up calls).

- A complete durable home visiting kit can be put together for $100-$500
- Mileage, automobile, or transportation expenses will be deductible for physicians; transportation costs for nursing and allied health professionals can range widely depending on frequency of visits and practice setting
- Purchase of daytime cellular phone minutes will be deductible for physicians; a team pay-as-you-go cell phone may be a reasonable expense for groups with multiple providers for $50-75/month
Legal Considerations

No additional physician malpractice insurance is required for providing home-based primary care from the Canadian Medical Protective Association (CMPA). Medico-legal pitfalls in home-based primary care are identical to those in office-based primary care of frail elder patients with chronic complex disease. All standards of practice should be as meticulously adhered to in–home as is done in-office.

Home-based primary care practices embedded within hospitals, universities, community health centres, or other organized institutions need to ensure that their employees are covered by the Workplace Safety and Insurance Board (WSIB; or equivalent insurance) while traveling on the job.

The College of Physicians and Surgeons of Ontario has been involved with the Colleges of Nurses of Ontario and the Ontario College of Pharmacists in publishing a paper entitled, Transferring Clients Safely: Know your Client and Know your Team, (available at: http://www.cpso.on.ca/uploadedfiles/members/resources/TransferringClientsSafelyApr_09.pdf), but no updated position statement has been published yet on Standards of Practice when working with team members of different institutions with different lines of accountabilities.

The CMPA has only now in 2013 published an article on healthcare integration, and members need to be aware of risk management considerations within interdisciplinary teams. The article, New Approaches: Healthcare Integration, can be found at: http://www.cmpa-acpm.ca/cmpapd04/docs/resource_files/perspective/2013/02/com_p1302_3-e.cfm.

Practice Management

The successful management of a group of frail patients at home requires that staff have the capacity to handle some unique additional responsibilities. As with office-based medicine, the skillful execution of duties by administrative assistants and other interprofessional staff are central to the effective practice of clinician-led primary care.
Staff Scheduling & Workload

See section above “Time Management” for tips on maximizing efficiency for home visits. A particularly high-yield strategy involves the clustering of visits geographically to reduce travel time. Administrative assistants may schedule half-days to optimize provider geographic focus, occasionally at the expense of planned visits which can be rescheduled.

See Chapter 2, section “Workload” for a discussion on patient population size in a home-based primary care practice. See Chapter 3, sections “Initial Visit” and “Follow-Up Visits” for a review of time for home visits. See Appendix 5 for a sample home-based care program scheduling and responsibilities outline document.

Additional dedicated, scheduled time may be required to complete the extra tasks outside the home visit arising from this required model of care:

- Administrative assistance and/or clinical provider time to review new patient referrals and eligibility
- Administrative assistance flex time to triage patient phone calls for urgent issues; clinical provider flex time to further triage
- Clinical provider time to phone patients for follow-up
- Clinical provider time for prescription renewals, various forms, other paperwork
Coverage

On-call, after-hours, and emergency coverage processes should be detailed at start-up of any home-based primary care program. The ability to respond after-hours may range from no capacity, to limited phone triage, to full availability of home visit assessments, depending on team composition, staffing, and organizational structure.

The option to link home-based on-call and after-hours demands to existing services within a primary care group can be explored, i.e., home-based care patients making use of provincial Telehealth services. The importance of having clear coverage processes cannot be underscored; communication of these coverage protocols to patients and their caregivers will avoid potential medico-legal pitfalls, delays in care attention, and inflated service expectations.

<table>
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<th>Home-Based Care Team C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. L does not offer after-</td>
<td>All primary care patients in this practice have access to a Telehealth nurse after hours, and home-based care patients are encouraged to call should they need after hours attention. The MDs provide their cell phone numbers for palliative patients actively dying at home.</td>
<td>One of the family medicine residents is on-call for the entire practice every night. They triage phone calls from home-based patients and provide advice as needed. There is a staff MD on call as well, and they may decide to do an after-hours home visit together if appropriate.</td>
</tr>
<tr>
<td>hours care to his home-based patients and they are made aware of this on the first home visit. He has on occasion provided his home number to patients who are dying at home so that he can go in to pronounce the death to save the caregiver from having to call the coroner.</td>
<td></td>
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</table>
Patient Care Coordination

Chapter 2: People, section “Team Integration” introduces the concept that patient care coordination/case management are functions that may be assigned primarily to a particular staff person, or may be shared in a dynamic process by multiple providers. The aim of a robust care coordination strategy within a health care system is to help primary care practices deliver coordinated, accessible, comprehensive, and patient-centered care. Care coordination duties should be outlined in a home-base care team practice management protocol, and may include:

- Communication between providers, patient, and services – see below section “Coordination of Care and Community Resources” for details of these processes
- Sounding board for patient and family needs and concerns
- Handling of test results
- Handling of episodic, urgent requests for home visits
- Communication between providers
- Timely review of forms, referrals, and other paperwork
- Tracking of quality indicators
- Coordination of transitions (i.e. hospital, rehabilitation)

A full review of the potential role of a patient care manager/coordinator is beyond the scope of this handbook.

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**Dr. L. relies on his clinic secretary for care coordination.** She phones and receives calls for home-based patients from families, pharmacies and labs. She triages patient issues and books appointments. She keeps track of home-based patients flu and other vaccine due dates.

**Dr. S. and Dr. A. work with NP C for care coordination.** She sees new patients first, triages patient calls and coordinates with the secretaries to book visits. She visits patients in hospital and helps with transition. Drs. S and A. keep track of quality indicators and NP C audits them periodically.

**A group of primary care organizations hire dedicated community care-coordinators for their home-based care teams.** They visit patients regularly and work in an integrated fashion with other team members to contribute to effective patient care management.
Record Keeping

As with any care records for complex, co-morbid, frail high-needs older adults, home visit records demand meticulous care, accurate documentation, and frequent review. Attention to documentation requirements for billing codes is important as well (i.e., time spent on visits, time spent on phone). Telephone communications, which are often more numerous in the home-based population, should be documented and entered in the chart.

The use of templates within either a paper-based or Electronic Medical Records (EMR) may assist with seamless record keeping; please see Appendix 6 for a sample template. Templates may be customized for a variety of visit types.

Paper Records

Privacy and medico-legal issues associated with mobile paper records (i.e., patient charts in the back of a car; carried around in a bag) are self-evident and warrant careful strategies around transportation, storage, and access. Home-based primary care practices embedded within hospitals, universities, community health centres, or other institutional organizations must investigate local legal implications of patient information handling. Challenges with chart sharing with paper-based records across members of the interprofessional team will also require creative solutions tailored to individual teams.

Electronic Medical Records

A complete discussion of EMR solutions for primary care is beyond the scope of this handbook. For those primary care practices using EMR software, remote access is a generally accessible feature that can be discussed with individual EMR vendors for set-up.

Purchase of mobile internet USB “sticks” through a major Canadian mobile network carrier ranges from $40-70/month, and these, along with a mobile device such as laptop or tablet, will allow access to patient charts in the home.
Technology

Extension of the routine technologies used in primary care into the home often requires creative coordination of resources. Without ready access within an office or hospital, patients and providers may often change goals of care and health management to minimize the need for diagnostic interventions.

Diagnostic Imaging

In the authors’ experience, diagnostic imaging must almost always be referred to an existing equipped clinic or hospital. The use of x-rays will likely be too infrequent to justify the purchase of portable x-ray equipment for a primary care team. There are portable x-ray options available in communities in Ontario; however, sometimes the quality of these films may still require a clinician to send the patient to a clinic or hospital to obtain a more detailed or refined image. When deciding between options to image at home, outside the home, or not to image, providers must determine the need, quality required, and how options fit in with the patient’s stated philosophy of care. While a bedside ultrasound would be helpful in a variety of clinical situations, the need for provider training and expense may again deter a home-based primary care team from purchasing a portable unit.

Laboratory Testing

Strategies for obtaining labs for home-based care patients include:

- Arranging for patient to attend an outpatient laboratory through transportation assistance, personal support accompaniment, etc., if possible

- Home phlebotomy arranged through third party via local community support agency, community care access centre, or local laboratory directly; may have an associated cost to patient of $25-50

Figure 4: Sample Safe Sharps/Hazardous Waste Container available through various online retailers from $5-20 CDN
• Phlebotomy drawn at home by member of home-based primary care team; specimens transported to local laboratory with whom care providers have made arrangements to accept specimen draws from home-bound patients
  
  • Further considerations must include phlebotomy kit including safe sharp and hazardous waste disposal, cooler for specimen transportation, labeling and patient identification processes

• In-home laboratory processing through point-of-care handheld blood analyzers; examples include the i-STAT system; cost approximation $7,000/analyzer and ongoing cost for cartridges; see Appendix 7 for references providing pricing estimates in Canada

Telehealth Home Monitoring

Development and support of telemedicine solutions to improve access and quality of care has gained increasing popularity in various sectors in recent years. For homebound patients, telemedicine offers unique opportunities to maximize both access and efficiency in healthcare provision. Vital sign monitors including O2 saturation monitors allow for objective findings, that can be correlated with patients’ symptoms when they call in for urgent concerns, thereby guiding a change in medication, the activation of a patient self-management plan, or the need for an urgent home visit by a clinician.

More recent advances in telemedicine will enable providers to securely talk and visualize patients using computer screen monitors, thereby allowing homebound patients a different way of accessing their primary care team. With this new advancement, specialists might become more accessible by participating in telemedicine consultations with homebound patients. Please see Appendix 8 for a discussion of current Canadian resources in telemedicine.

**STEP 4: Interprofessional Collaboration**

Central to the process of high-quality home-based care delivery is the concept of continuity of care, maintained through interprofessional collaboration.
**Communication**

Communication may perhaps be the most important efficiency factor in a home-based care practice; it is also the glue that holds the practice together, and the weakest link in the chain of quality care. A communications plan or algorithm may be designed to account for this key team element, and may address communication protocols in the office, on the road, and in the patient’s home. Please see the sections above “Record Keeping,” “Care Conferences/Team Meetings/Rounds,” and “Patient Care Coordination” for a review of those critical elements of effective team-based communication.

Please see Chapter 2, section “Building Community Alliances and System Integration” for a review of the importance of communication with fellow system players in team-building and operation. Please see Chapter 3, sections “Team Integration” and “Competencies” for a review of provider skills essential to foster in a home-based primary care system. Please see section below “Coordination of Care and Community Resources” for a review of specific communication elements between primary, specialty and community care providers.

<table>
<thead>
<tr>
<th>Home-Based Care Team A</th>
<th>Home-Based Care Team B</th>
<th>Home-Based Care Team C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. L often does home visits after office hours. As such, his team knows to check their messages by 0800 the next morning in case he has urgent instructions for the patient he saw at home. Home-based patients are given a direct extension to call with their clinical needs, and instructions to go to the ED if they need after-hours care.</td>
<td>Dr. S, Dr. A and NP C communicate regularly throughout the day via text messaging on their cell phones. Their team administrative assistant is also able to reach providers this way to notify them of urgent issues while they are on the road. The MDs provide their cell numbers to families when a patient is expected to die at home.</td>
<td>The clinical team has designed a Communications Plan with which all team members are familiar. Interprofessional providers use text messaging and cell phone communication in addition to instant and regular messaging through their shared EMR. Patients have one phone line to call to arrange visits and access the on-call after-hours provider.</td>
</tr>
</tbody>
</table>
STEP 5: Coordination of Care and Community Resources

Coordination of care, system integration, and community resources have been outlined in the sections above as a key to ensuring the delivery of integrated, safe, comprehensive, high-quality, and timely patient care. Care coordination is a very important function that may be assigned primarily to one particular staff person, or can also successfully be shared in a dynamic process by a few key providers. Please see Chapter 2: People, section “Community Building and System Integration”; Chapter 4: Processes, sections “Patient Care Coordination” and “Communications” for details.

Below is a selection of potential patient and community services that a home-based care team may harness and integrate into their primary care system:

Specialists

- Involvement of specialists (i.e., geriatricians, psychiatrists, internists) may range from routine consultation support via phone or email, to the actual participation in home-visits and/or integration within a home-based care team. In Ontario, both the primary and specialist provider can bill for telephone and email consultation. The key in establishing a specialist connection is being explicit on what each party needs of the other, what volumes and demands can look like, and what expectations around consultations and follow-up support is needed.

- Some specialists who are involved in the provision of home visits may find it beneficial to have the team organize a list of patients for them to see on a given half-day. Sending patient charts and referral requests in advance will also help specialists understand what may be needed of them, and may allow them to ask further questions in advance, request additional testing, or bring supplementary equipment.

- Specialist home visits that are conducted in collaboration with one of the primary care team members can allow richer discussions to occur, combining the expertise of the specialist with that of the primary care team member who is also familiar with the patient context and history.
Therapists

- Teams may choose to initiate services from external agencies for physio-, occupational, speech-language, and other therapies.

Pharmacists

- Affiliations and collaboration with community pharmacists for medication reconciliation, blister packing, and support may augment patient care.

Mental Health Support

- Most communities have a number of agency-based mental health support services that may function in isolation from primary and community care spheres; outreach to such programs and building of collaborative bridges will help to alleviate the burden of mental health care issues prevalent in older frail adults.

Wound Care

- Teams may choose to initiate wound care services from external agencies should there be a paucity of expertise on the topic within the core team.

Patient and Family Education

- External agencies that specialize in patient and family education for Alzheimer’s Disease, Parkinson’s Disease, general dementia, physical disabilities, arthritis and other common ailments of the frail homebound population can augment and support the work of the home-based primary care team.

- One of the most high-demand services in these authors’ experience include family support and education for behavioural components of dementia; services such as community behavioural support outreach teams and advance practice nursing are invaluable in supporting these patients and families.
Interpreters
• Diversity in language services will be a major consideration in current areas of high ethno-cultural diversity; demand for these services continues to grow across Canada.

Meal Services
• Meals-On-Wheels, grocery delivery, food bank services, and other nutritional supports.

Transportation

Adult Protective Services
Chapter 5: Teaching and Evaluating Home-Based Primary Care
Teaching and Evaluating Home-Based Primary Care

Outcomes such as effectiveness, resource utilization, program finances, satisfaction, and educational competencies all influence the quality of patient care and work life for providers.

Research

There is a paucity of literature measuring not only quality of home-based primary care delivery systems (see below section “Quality Improvement”), but also the impact of these systems on health outcomes and health system performance. The dearth of evidence is a barrier to program expansion and uptake, and a solution calls for stronger evidence demonstrating home-based primary care program effectiveness. A comprehensive discussion of potential rigorous evaluative methods studying home-based primary care is beyond the scope of this handbook; for a detailed review see References.
To plan for local demand, studies are needed to characterize the size and geographic distribution of the population of homebound older adults. Rigorous research must evaluate quality of home-based care; challenges to quality study include the complexity and heterogeneity of home-based care systems. Exploration of reflective ethics and older adults’ and caregivers’ experiences with home-based primary care will help to personalize encounters with the health care system and contribute to literature on program effectiveness.

Research is also needed to determine program outcomes, including structures and processes of care that support elders’ choices to live at home and improve their quality of life, symptom management, and end-of-life care. Examining interprofessional team dynamics, the mix of care providers, clinical and system outcomes such as changes to hospitalization and emergency visit rates, program costs, and satisfaction will inform future decision making about home-based care program design and reimbursement.

Understanding caregiver risks and burnout are also critical to support home-based care systems, which continue to rely heavily on informal caregiving. Safety and efficiencies may be improved through study of how to leverage information technology to manage care and resources. For an executive summary of a current Toronto-based study undertaking some of these research endeavours, see Appendix 9.
Teaching Home-Based Primary Care

Home-based care is an opportunity to enrich professional education across medical, nursing, and allied health trainees. The first step in teaching home-based primary care has already been accomplished when senior providers engage in this model of care; for simple exposure and role modeling is of paramount importance for junior trainees’ achievement of learning competencies. Although a formal review of primary care teaching and evaluation methods is beyond the scope of this handbook, below are presented some teaching pearls structured in the old adage of health care teaching to “see one, do one, then teach one”:

See One

Exposure to home visits may be primed by asking trainees to review a handbook for home-based primary care such as this. Assessment of their previous participation in formal medical home visits or personal experiences with a home-based family member will help set the stage for learning about home care basics. A variety of outstanding video learning tools are available (see Appendix 10), and may provide a practical visualization of what trainees can expect when participating in a house call. Other priming tools before embarking upon their first home visit may include literature reviews on the comprehensive geriatric assessment, interprofessional care, and the value of home care medicine in the geriatric population (see References).

An experienced home-based care provider should accompany trainees on their first home visit. Most trainee safety policies will require that students be accompanied during home visits. The supervisor should act as a reference for home care processes, and as a reflective sounding board for observations and learnings unique to a house call that happen in real time at the point of care. A sample probe and follow-up could proceed as follows:

[Before visit] Supervisor: “Home visits provide an opportunity to learn about determinants of health unique to your patient’s life situation that may not be evident when they are in a doctor’s office or in the hospital. I want you to observe the environment carefully and tell me afterwards what you think.”

.........
[After visit] Supervisor: “Please share your reflections on the patient’s home environment and what it could mean for her health.”

Student: “The first thing I noticed was that the house was very clean, and her bedroom was organized for her care. Her family seems to help her a lot. I also noticed a lot of Catholic effigies. Religion must be important to her…”

**Do One**

The expectations for home-based practice will depend on the individual home-based care program’s capacity to support learners in this type of intensive, integrated, interprofessional care. Expectations for trainees should be clearly outlined, including expected competencies, methods of evaluation, clinical duties, and administrative responsibilities. See Appendix 11 for a sample learning objective outline handout for trainees.

**Teach One**

As trainees become experienced in home-based primary care, they can serve as new role models for junior students (i.e., a senior resident may teach a medical student about home-based care; a NP student may ask a visiting RN student to accompany him on a home-visit). Assessing the trainee’s readiness to teach before assigning responsibility is crucial, and will help further the propagation of high-quality teaching in home care medicine.
Quality Improvement

Applying accepted principles of Quality Improvement (QI) to home based primary care, various patient outcome measures as well as common process measures are proposed here, which will allow home-based primary care providers to measure and improve continuously. Collecting patient and caregiver experiences and satisfaction scores will allow clinical providers to gather more political support for their much-needed work. Other outcome measures to be considered might be avoidance of emergency room visits, delay of admission to long-term care homes, or avoidable readmissions after hospitalization.

Common process measures that might be considered are: vaccination rates for influenza, pneumonia vaccine, follow-up visit after hospitalization within seven days, documentation of advance care directives, documentation of medication reconciliation at least once a year and after hospitalization.
Appendix 1: Sample Comprehensive Geriatric Assessment

Patient Identifier

GDS
To score the GDS (items 1-4) circle yes or no.
1. Do you feel that your life is empty? YES/NO
2. Do you feel happy most of the time? YES/NO
3. Do you often feel helpless? YES/NO
4. Do you feel pretty worthless the way you are now? YES/NO

ADL
To score the ADL (items 5-7) check which level of assistance applies.
5. Bathing (Sponge bath, tub bath or shower)
   - [ ] Receive no assistance (gets into and out of tub by self if tub is the usual means of bathing)
   - [ ] Receives assistance in bathing only one part of the body (such as the back or a leg)
   - [ ] Receives assistance in bathing more than one part of the body (or not bathed)
6. Transfer
   - [ ] Moves into and out of bed as well as into and out of chair without assistance (May use object such as cane or walker for support).
   - [ ] Moves into or out of bed or chair with assistance.
   - [ ] Doesn’t get out of bed.
7. Continence
   - [ ] Controls urination and bowel movement completely by self.
   - [ ] Has occasional accidents
   - [ ] Supervision helps keep control of urination or bowel movement or catheter is used or is incontinence.

IADL
To score the IADL (items 8-11) circle the number which reflects the ability.
8. Can you go shopping for groceries?
9. Can you prepare your own meals?

Without help 3
With some help 2
Are you completely unable to prepare any meals? 1

10. Can you do your own housework?

Without help 3
With some help 2
Are you completely unable to do any housework? 1

11. Can you do your own laundry?

Without help 3
With some help 2
Are you completely unable to do any laundry at all? 1

**MMSE**

**Score as indicated on each item.**

12. Attention and Calculation

Begin with 100 and count backward by 7 (stop after 5 answers): 93, 86, 79, 72, 65. Score one point for each correct answer. If the patient will not perform this task, ask the person to spell "WORLD" backwards (DLROW). Record the patient’s spelling ________________.

Score one point for each correctly placed letter.  
SCORE ______

13. Reading: Read and obey the following: Close your eyes (Show the patient the item on the attached paper).

CIRCLE THE SCORE 1 0

14. Writing: Write a sentence (on the attached paper).

CIRCLE THE SCORE 1 0

15. Copying: Copy the design of the intersecting pentagons.

CIRCLE THE SCORE 1 0

**CLOSE YOUR EYES**

**WRITE A SENTENCE**

**COPY DESIGN**
New Patient Questionnaire

The following questionnaire has been designed to provide us with the information needed to better assess your health. Please take your time in answering each question and provide as much information as possible.

Your Information

Name: ______________________ Date of Birth: ______________________

Name of Person completing this Form: ______________________ Today’s Date: Nov/05/2014

What are your current biggest concerns regarding your health? ______________________

Tell Us About Yourself

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>How long have you been living in Toronto?</td>
<td></td>
</tr>
<tr>
<td>How far did you study in school?</td>
<td></td>
</tr>
<tr>
<td>What faith (if any) do you follow?</td>
<td></td>
</tr>
<tr>
<td>What sort of work have you done?</td>
<td></td>
</tr>
<tr>
<td>What are your current activities?</td>
<td></td>
</tr>
<tr>
<td>Are you currently married or have a partner?</td>
<td></td>
</tr>
<tr>
<td>Do you have any children? If so, how many and where are they located?</td>
<td></td>
</tr>
<tr>
<td>What type of residence do you live in?</td>
<td></td>
</tr>
<tr>
<td>Do you live with anyone else?</td>
<td></td>
</tr>
<tr>
<td>Have any of your friends or relatives died recently?</td>
<td></td>
</tr>
<tr>
<td>Are you having any financial difficulties?</td>
<td></td>
</tr>
</tbody>
</table>

Please describe any CCAC (Home Care) or other community support services (i.e. meals on wheels, etc) you may be currently receiving.

Appendix 2: Sample Patient-Driven Assessment Instrument
### Planning For The Future

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you appointed a durable power of attorney for healthcare or financial decisions?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>If you were unable to make your own healthcare or financial decisions, who would you trust to make these decisions on your behalf?</td>
<td></td>
<td></td>
<td>Name of Person: ___________________________</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Relationship: _____________________________</td>
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<td></td>
<td></td>
<td></td>
<td>Address: ________________________________</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Telephone: ______________________________</td>
</tr>
<tr>
<td>Have you established any advance directives with regards to cardiac resuscitation, mechanical ventilation, feeding tubes, or other medical interventions that your doctor should know about?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

### Your Medical History

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>☐</td>
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<tr>
<td>High Blood Pressure</td>
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<tr>
<td>High Cholesterol</td>
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<tr>
<td>Heart Disease</td>
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<tr>
<td>Stroke</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Memory Problems</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD) or Asthma</td>
<td>☐</td>
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<tr>
<td>Kidney Disease</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Arthritis</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Osteoporosis/Broken Bones</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Cancer</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Eye Diseases (Glaucoma, Macular Degeneration or Cataracts)</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Other (please list)</td>
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</table>
List Any Surgeries You Have Ever Had

<table>
<thead>
<tr>
<th>Type</th>
<th>Date</th>
<th>Hospital</th>
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Do You Have A History of Any Psychiatric or Mental Health Issues?

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<tr>
<th>Type</th>
<th>Comments</th>
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List All Hospitalizations You Have Had Within The Last 5 Years

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<thead>
<tr>
<th>Type</th>
<th>Date</th>
<th>Hospital</th>
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List your Primary Care/Family Doctor and other Specialists You See

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact number</th>
<th>Address</th>
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</table>
### My Medications

(Please list all current medications, over the counter drugs and vitamins/supplements you take)

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>When Taken</th>
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<tbody>
<tr>
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</tbody>
</table>

*Please bring all bottles and blister packs of current medications, over the counter drugs and vitamins to your visit.

### Allergies

(Please list any medication allergies you have)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Reaction</th>
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<tbody>
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</table>
## Geriatric Medicine Clinic

### New Patient Questionnaire

**Patient Name:** ____________________________

### Health Maintenance

<table>
<thead>
<tr>
<th>Question</th>
<th>Date</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has your cholesterol been checked?</td>
<td></td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Has your bone mineral density been measured?</td>
<td></td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Have you had a sigmoidoscopy or colonoscopy?</td>
<td></td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Has your stool been checked for blood?</td>
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<td>☐</td>
<td>☐</td>
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</table>

### Vaccinations

<table>
<thead>
<tr>
<th>Question</th>
<th>Date</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you take the annual flu shot?</td>
<td></td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Have you received the pneumonia vaccine?</td>
<td></td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>When was your last tetanus shot?</td>
<td></td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Have you been received the shingles/zoster vaccine?</td>
<td></td>
<td>☐</td>
<td>☐</td>
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</table>

### Personal Habits

<table>
<thead>
<tr>
<th>Question</th>
<th>Date</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you engage in any exercise?</td>
<td></td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Do you follow a special diet?</td>
<td></td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Do you drink any alcohol?</td>
<td></td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Do you smoke?</td>
<td></td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Did you ever smoke?</td>
<td></td>
<td>☐</td>
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</tbody>
</table>

### For Women

<table>
<thead>
<tr>
<th>Question</th>
<th>Date</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>When was your last mammogram/breast examination?</td>
<td></td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>When was your last pelvic exam/pap smear?</td>
<td></td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Have you ever taken hormones (i.e. estrogen)?</td>
<td></td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

### For Men

<table>
<thead>
<tr>
<th>Question</th>
<th>Date</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>When was your last prostate exam?</td>
<td></td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>
Patient Name: __________________________

### Functional Assessment

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you recently had an eye exam?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you wear glasses?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you recently had a dental exam?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you wear dentures?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you recently had your hearing checked?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you use hearing aids?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Do You Have Problems With Any of the Following Activities?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting out of bed or a chair</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incontinence (leakage of urine or feces)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathing yourself</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing yourself</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeding yourself</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doing your own cooking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doing your own cleaning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking your medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using the telephone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Driving a car</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using public transportation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doing your own shopping</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Managing your own finances</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Family History

(Please list any major medical conditions that run in your family)

---

**Geriatric Medicine Clinic**  
New Patient Questionnaire  
Page 6 of 7
Do You Have Any of the Following Concerns?

<table>
<thead>
<tr>
<th>Concern</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>A recent change in weight?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any episodes of falling?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems with dizziness?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling sad or depressed?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any trouble sleeping?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems with your hearing?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems with your vision?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems with teeth/dentures?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic cough?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest pain, discomfort or heaviness?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shortness of breath?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constipation, diarrhea or change in bowel habits?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any problems with passing urine, leakage, or trouble starting your stream?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any problems with sexual function?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have any other symptoms or health concerns, which have not been mentioned on this form?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Thank you for completing this form. The information you have provided will assist in your assessment.

Please fax the completed form to Stephanie Silva, Clinic Administrator, at 416-586-3168.

If you do not have access to a fax, please bring these documents with you to your first appointment.

Your first appointment has been scheduled on ________________________.

If there are any questions or concerns, please call Stephanie at 416-586-4800 ext. 8563.
March 2008

Bed Bugs

What are bed bugs?
Bed bugs are insects that, as adults, have oval-shaped bodies with no wings. Prior to feeding, they are about 1/4 inch long and flat as paper. After feeding, they turn dark red and become bloated. Eggs are whitish, pear-shaped and about the size of a pinhead. Clusters of 10-50 eggs can be found in cracks and crevices. Bed bugs have a one-year life span during which time a female can lay 200-400 eggs depending on food supply and temperature. Eggs hatch in about 10 days.

What do bed bugs feed on?
Bed bugs prefer to feed on human blood, but will also bite mammals and birds. Bed bugs bite at night, and will bite all over a human body, especially around the face, neck, upper torso, arms and hands. Bed bugs can survive up to six months without feeding. Both male and female bed bugs bite.

Can I get sick from bed bugs?
There are no known cases of infectious disease transmitted by bed bug bites. Most people are not aware that they have been bitten but some people are more sensitive to the bite and may have a localized reaction. Scratching the bitten areas can lead to infection.

How do bed bugs get into my home?
Bed bugs are often carried into a home on objects such as furniture and clothing. If you think you have a bed bug problem, check for live bed bugs or shells in the following areas:
- Seams, creases, tufts and folds of mattresses and box springs
- Cracks in the bed frame and head board
- Under chairs, couches, beds, dust covers
- Between the cushions of couches and chairs
- Under area rugs and the edges of carpets
- Between the folds of curtains
- In drawers
- Behind baseboards, and around window and door casings
- Behind electrical plates and under loose wallpaper, paintings and posters
- In cracks in plaster
- In telephones, radios, and clocks

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Bed bugs can also travel from apartment to apartment along pipes, electrical wiring and other openings. If the infestation is heavy, a sweet smell may be noticed in the room.

**What can I do if I have bed bugs in my home?**

The best method to deal with bed bugs is Integrated Pest Management (IPM), which combines a variety of techniques and products that pose the least risk to human health and the environment.

1. Consult with your local health department or a professional Pest Control operator to confirm that you have bed bugs.
2. Inspect your mattress and bed frame, particularly the folds, crevices and the underside, and other locations where bed bugs like to hide.
3. Use a nozzle attachment on the vacuum to capture the bed bugs and their eggs. Vacuum all crevices on your mattress, bed frame, baseboards and any objects close to the bed. It is essential to vacuum daily and empty the vacuum immediately.
4. Wash all your linens in the hottest water possible and place them in a hot dryer for 20 minutes. Consider covering your pillows and mattress with a plastic cover.
5. Remove all unnecessary clutter.
6. Seal cracks and crevices between baseboards, on wood bed frames, floors and walls with caulk. Repair or remove peeling wallpaper, tighten loose light switch covers, and seal any openings where pipes, wires or other utilities come into your home (pay special attention to walls that are shared between apartments).
7. Monitor daily by setting out glue boards or sticky tape (carpet tape works well) to catch the bed bugs. Closely examine any items that you are bringing into your home.
8. Consult professional pest control services and discuss options that pose the least risk to humans and the environment.

If you choose to treat the infestation with an insecticide, call a Professional Pest Control Service for more information. Use the least toxic product available and follow all manufacturers' instructions.

Whether you choose Integrated Pest Management or insecticides, you may continue to see some living bed bugs for up to ten days. This is normal. If you continue to see a large number of bed bugs after two weeks, contact a professional pest control service.

**What do bed bug bites look like?**

When bed bugs bite people, they inject their saliva into the biting area, causing the skin to become irritated and inflamed. Individual responses to bed bug bites will vary. The skin lesion from bed bug bites may go unnoticed, or be mistaken for flea or mosquito bites or other skin conditions.

Four types of skin rashes have been described in the literature:

1. The most common rash is made up of localized red and itchy flat lesions. The classical bed bug bites could be presented in a linear fashion in a group of three, which is called "breakfast, lunch, and dinner".
2. Small raised red swelling lesions are also common.
3. In rare cases, people may develop large raised, often itchy, red welts.

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4. In people with high sensitivity to bed bug saliva, people may develop a lump filled with blood or fluid.

Bed bug bites most commonly occur on exposed areas of the body, including face, neck, hands, arms, lower legs or all over the body.

**How do I treat bed bug bites?**

Most bed bug bites go away by themselves and don’t need treatment. Keep the skin clean and try not to scratch. If the bites are very itchy, your doctor may prescribe cream or antihistamines to relieve the itchiness. Oral antibiotics may be prescribed for any secondary skin infection from excessive scratching.

**How do I prevent bed bugs from entering my home?**

- Although even the cleanest homes and hotels can have bed bugs, regular house cleaning, including vacuuming your mattress, can help to prevent an infestation. Clean up clutter to help reduce the number of places bed bugs can hide.
- Be careful when buying used furniture or clothes. Make sure to inspect the used item, and feel free to ask the retailer if the items were checked for bed bugs.
- Use caution when bringing home used furniture or clothes from the curb side. These items may be infested with bed bugs.
- When travelling take the following precautions:
  - **Inspect the room and furniture**: inspect all cracks and crevices of the mattress and box spring, and look for blood spots or live insects. Request a different room if you find evidence of bed bugs.
  - **Protect your luggage**: keep all belongings in your luggage and wrap your luggage in plastic to help prevent bed bugs from entering your luggage. Keep luggage on the shelf or away from the floor.
  - **Protect the bed**: move the bed away from the wall, tuck in all bed sheets and keep blankets from touching the floor.
  - **Upon returning home**: keep your luggage in an isolated area of your home, such as the garage. Inspect the luggage. Wash all your clothes in the hottest water possible and put them in a hot dryer for 20 minutes.

**For more information:**
- Toronto Public Health – [www.toronto.ca/health](http://www.toronto.ca/health) or 416-338-7600
CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

House call assessment
A house call assessment is a primary care service rendered in a patient’s home that satisfies, at a minimum, all of the requirements of an intermediate assessment.

A901 House call assessment ................................................................. 45.15

Payment rules:
A house call assessment is only eligible for payment for the first person seen during a single visit to the same location.

[Commentary:
Services rendered to additional patients seen during the same visit are payable at a lesser fee from the General Listings.]

Complex house call assessment
A complex house call assessment is a primary care service rendered in a patient’s home to a patient that is considered either a frail elderly patient or a housebound patient. The service provided must satisfy, at a minimum, all of the requirements of an intermediate assessment.

A900 Complex house call assessment ................................................... 45.15

Payment rules:
A complex house call assessment is only eligible for payment for the first person seen during a single visit to the same location.

[Commentary:
1. A frail elderly patient is defined as:
   a. 65 years or older with one or more of the following age-related illness(es), condition(s) or presentation(s):
      i. Complex medical management needs;
      ii. Polypharmacy;
      iii. Cognitive impairment (e.g. dementia or delirium);
      iv. Age-related reduced mobility or falls; and/or
      v. Unexplained functional decline not otherwise specified.
   and
   b. resides in a home that includes:
      i. The patient’s home; or
      ii. Assisted living or retirement residence (but does not include a long-term care home).

2. A housebound patient is defined as:
   a. A person will be considered homebound where all the following criteria are met:
      i. The person has difficulty in accessing office-based primary health care services because of medical, physical, cognitive, or psychosocial needs/conditions;
      ii. Transportation and other strategies to remedy the access difficulties have been considered but are not available or not appropriate in the person’s circumstances; and
      iii. The person’s care and support requirements can be effectively and appropriately delivered at home.]

Medical record requirements:
Complex house call assessment is not payable if the medical record does not:
1. Demonstrate that an intermediate assessment was rendered; and
2. Demonstrate that the patient was a frail elderly or housebound patient.

House call assessment - Pronouncement of death in the home
A house call assessment - Pronouncement of death in the home is the service rendered when a physician pronounces a patient dead in a home. This service includes completion of the death certificate and counselling of any relatives which may be rendered during the same visit.

A902 House call assessment - Pronouncement of death in the home......................... 45.15

Claims submission instructions:
Submit the claim using the diagnostic code for the underlying cause of death as recorded on the death certificate.

Note:
For special visit premiums, please see pages GP44 to GP52 of the General Preamble.
GENERAL PREAMBLE

SPECIAL VISIT PREMIUMS

A special visit premium is payable in respect of a special visit rendered to an insured person, subject to the conditions and limitations set out below. All special visit premiums are subject to the maximums, limitations and conditions set out in the "Special Visit Premium Table" applicable in the circumstances.

Payment rules:
1. Special visit premiums are only eligible for payment when rendered with certain services listed under "Consultations and Visits" sections of this Schedule.
2. Regardless of the time of day at which the service is rendered, special visit premiums are not eligible for payment in the following circumstances:
   a. for patients seen during rounds at a hospital or long-term care institution (including a nursing home or home for the aged);
   b. in conjunction with admission assessments of patients who have been admitted to hospital on an elective basis;
   c. for non-referred or transferred obstetrical patients except, in the case of transferred obstetrical patients for a special visit for obstetrical delivery with sacrifice of office hours for the first patient seen (C969);
   d. for services rendered in a place, other than a hospital or long-term care facility, that is scheduled to be open for the purpose of diagnosing or treating patients;
   e. for a visit for which critical care team fees are payable under this Schedule;
   f. in conjunction with any sleep study service listed in the sleep studies section of this Schedule; or
   g. for services rendered to patients who present to an office without an appointment while the physician is there, or for patients seen immediately before, during or immediately after routine or ordinary office hours even if held at night or on weekends or holidays.
3. Special visit premiums are not eligible for payment with services described by emergency department "H" prefix fee codes. [Commentary: For elective home visits rendered during daytime, evenings, nights or weekends, submit claim(s) using fee codes found under the column titled "Elective Home Visit" of Special Visit Premium Table VI listed on page GP50.]

Sacrifice of office hours means an insured service rendered when the demands of the patient and/or the patient’s condition are such that the physician makes a previously unscheduled non-elective visit to the patient at a time when the physician had an office visit booked with one or more patients but, because of the previously unscheduled non-elective visit, any such office visit was delayed or cancelled.

SPECIAL VISIT PREMIUMS

PREMIUMS

[Commentary: Special visit premiums are in respect of either or both: a "travel premium" and a "patient seen" premium (i.e. "first person seen premium" or "an additional person seen premium").]

A. Travel Premium

Definition/required elements of service:
A travel premium is only eligible for payment for travel from one location to another location ("the destination") subject to the payment rules below.

A travel premium is not eligible for payment when a physician is required to travel from one location to another within the same long-term care facility, hospital complex or within buildings situated on the same hospital campus. [Commentary: 1. A first person seen premium may be eligible for payment in this circumstance. 2. Only one travel premium is eligible for payment for each separate trip to a destination regardless of the number of patients seen in association with each trip.]

B. First person seen premium

A first person seen premium is eligible for payment for the first person seen at the destination under one of the following circumstances ("the eligible times"): 1. if the insured service is commenced evenings (17:00 hr-24:00 hr) Monday to Friday; daytime or evenings on Saturdays, Sundays, and Holidays; or nights (24:00 hr-07:00 hr); 2. if rendered requiring sacrifice of office hours; or 3. if rendered during daytime hours (07:00 - 17:00 hrs Monday through Friday) in circumstances in which a travel premium is eligible for payment.

C. Additional person premium

An additional person premium is only eligible for payment for services rendered at the destination to additional patients seen in emergency departments, outpatient departments, long-term care institutions or to hospital inpatients, provided that each additional patient service is commenced during the eligible times. [Commentary: Special visit premiums are not eligible for payment for elective services rendered at a long-term care institution, including a nursing home or home for the aged, even when the long-term care institution is the "home" of the patient. Submit claims for routine elective visits in these locations as subsequent visits. For example, if the physician is called to a nursing home to see a patient for a non-elective problem at 8AM, and subsequently sees his/her routine patients on rounds, those additional patients do not qualify for the additional person premium.]
GENERAL PREAMBLE

Medical record requirements:
Special Visit Premiums are only eligible for payment if the following requirements are met:

1. For fee codes listed in Tables I, II, III, IV, VI, VII, VIII, IX and X the time at which the special visit takes place must be documented on the medical record.

2. For fee codes listed in Table V:
   a. the time of the request to attend in the emergency department must be documented on the medical record; and
   b. The specific situation requiring the physician's attendance must be documented on the medical record.

[Commentary: When a special visit service occurs in a hospital, emergency department or long-term care institution where common medical records are maintained, the time when the visit takes place may be documented anywhere in the common medical record.]

Claims submission instructions:
Submit claims using the appropriate A-prefix assessment fee from the “General Listings” for an assessment rendered in conjunction with a special visit premium.

SPECIAL VISIT PREMIUM TABLE VI

<table>
<thead>
<tr>
<th>Special Visits to Patient's Home (other than Long-Term Care Institution)</th>
<th>Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours Non-elective</th>
<th>Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours Non-elective</th>
<th>Evenings (17:00-24:00) Monday through Friday Non-elective</th>
<th>Sat., Sun. and Holidays (07:00-24:00) Non-elective</th>
<th>Nights (00:00-07:00) Non-elective</th>
<th>Elective home visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Travel Premium</td>
<td>$36.40</td>
<td>$36.40</td>
<td>$36.40</td>
<td>$36.40</td>
<td>$36.40</td>
<td>$36.40</td>
</tr>
<tr>
<td>First person seen</td>
<td>$27.50</td>
<td>$44.00</td>
<td>$66.00</td>
<td>$82.50</td>
<td>$110.00</td>
<td>$27.50</td>
</tr>
<tr>
<td>B960</td>
<td>B961</td>
<td>B992</td>
<td>B994</td>
<td>B939</td>
<td>B996</td>
<td>B990</td>
</tr>
<tr>
<td>Maximums (per time period)</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>unlimited</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Travel premiums</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First person seen</td>
<td>10</td>
<td>10</td>
<td>20</td>
<td>unlimited</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

Note:
1. The maximum number of services per physician per day for B960 is 2, for any combination of non-elective and elective visits.
2. The maximum number of services per physician per day for B990 is 10, for any combination of non-elective and elective visits.
3. Special visit to patient’s home premiums are only eligible for payment for first patient seen, regardless of number of patients seen during one visit to a home or to one or more living units in a multiple resident dwelling. A multiple resident dwelling is a single location that shares a common external building entrance or lobby e.g. apartment block, rest or retirement home, commercial hotel, motel or boarding house, university or boarding school residence, hostel, correctional facility or group home.
## Appendix 5: Scheduling and Responsibilities Outline

### Toronto Western Family Health Team

**Home-based Primary Care Program (HBPC)**

<table>
<thead>
<tr>
<th></th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a.m.</strong></td>
<td></td>
<td>MD administrative</td>
<td></td>
<td></td>
<td>NP visits</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>* RN visits +/-</td>
</tr>
<tr>
<td><strong>lunch</strong></td>
<td>12:45 p.m. – 1:30 p.m.: HBPC Rounds, North Conference Room</td>
<td></td>
<td></td>
<td></td>
<td>Resident MD</td>
</tr>
<tr>
<td><strong>p.m.</strong></td>
<td>MD visits +/-</td>
<td>MD visits +/- Resident MD</td>
<td>NP visits</td>
<td>MD visits +/-</td>
<td>MD administrative</td>
</tr>
<tr>
<td></td>
<td>Resident MD</td>
<td>MD/NP administrative</td>
<td></td>
<td>Resident MD</td>
<td></td>
</tr>
</tbody>
</table>

*RN flexible to master RN schedule & availability*

**MD Administrative Duties:**

1. **Co-Lead HBPC Rounds with NP** *(45 min/week)*
   a. Review each patient (~30) every Tuesday; updates from team
   b. Engage with team in care plans
   c. Liaise with involved professionals re: care plans; delegate
   d. Review new referrals for appropriateness; schedule visits

2. **Sign-off labs and other investigations in my mailbox; order follow-up investigations as needed** *(30 min/week)*

3. **Renew prescriptions by fax request in my mailbox** *(15 min/week)*

4. **Update CPP and Sign-Out Tools as needed**

5. **Engage with NP q 2 weeks on Tuesday afternoon re: program updates, clinical housekeeping**

**MD Clinical Patient Care Duties:**

1. **Orient resident to HBPC competencies, administration, expectations etc.** *(45 min/month)*
2. Week 1 of resident rotation, perform 1-2 joint home visit(s) with resident to new or follow-up patient(s) (usually Friday p.m. **1-2 hours/month**)

3. Week 2-5 of resident rotation, perform 1-3 home visits on TUESDAY or FRIDAY afternoons based on patient needs elucidated at rounds Tuesday lunch time
   a. Note: New patient visits done jointly with CCAC coordinator OR other available FHT staff
   b. All new patients met on 1st – 3rd visit by MD
   c. Actual number of home visits in a week ranges from 1-4 **(~2-5 hours/week)**

4. Available during weekdays either in-person or on cell phone for issues with HBCP patients (i.e. nursing, NP, resident, CCAC concerns that require MD review, **1 hour/week**)

---

**Toronto Western Family Health Team**

**Home-based Primary Care Program (HBPC)**

<table>
<thead>
<tr>
<th></th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
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<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a.m.</strong></td>
<td></td>
<td>MD</td>
<td></td>
<td></td>
<td>NP visits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>administrative</td>
<td></td>
<td></td>
<td>* RN visits +/- Resident MD</td>
</tr>
<tr>
<td><strong>lunch</strong></td>
<td></td>
<td>12:45 p.m. – 1:30 p.m.: HBPC Rounds, North Conference Room</td>
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<td></td>
</tr>
<tr>
<td><strong>p.m.</strong></td>
<td>MD visits +/- Resident MD</td>
<td>MD visits +/- Resident MD</td>
<td>NP visits</td>
<td>MD visits +/- Resident MD</td>
<td>MD administrative</td>
</tr>
<tr>
<td></td>
<td>MD/NP administrative</td>
<td>MD/NP administrative</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*RN flexible to master RN schedule & availability*

**MD Administrative Duties:**

6. Co-Lead HBPC Rounds with NP **(45 min/week)**
   a. Review each patient (~30) every Tuesday; updates from team
   b. Engage with team in care plans
   c. Liaise with involved professionals re: care plans; delegate
d. Review new referrals for appropriateness; schedule visits

7. Sign-off labs and other investigations in my mailbox; order follow-up investigations as needed (30 min/week)

8. Renew prescriptions by fax request in my mailbox (15 min/week)

9. Update CPP and Sign-Out Tools as needed

10. Engage with NP q 2 weeks on Tuesday afternoon re: program updates, clinical housekeeping

MD Clinical Patient Care Duties:

5. Orient resident to HBPC competencies, administration, expectations etc. (45 min/month)

6. Week 1 of resident rotation, perform 1-2 joint home visit(s) with resident to new or follow-up patient(s) (usually Friday p.m.; 1-2 hours/month)

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   b. All new patients met on 1st – 3rd visit by MD
   c. Actual number of home visits in a week ranges from 1-4 (~2-5 hours/week)

8. Available during weekdays either in-person or on cell phone for issues with HBCP patients (i.e. nursing, NP, resident, CCAC concerns that require MD review, 1 hour/week)

RN Administrative Duties:

1. Attend HBCP (45 min/week)
   a. Review each patient, updates from team.
   b. Discuss plan-of-care for each patient and be assigned to follow-up on a certain number of patients.

2. Call patients and/or family members to discuss plan of care, telephone triaging, call-in Rx to pharmacy, order BW, and communicate with CCAC (1-2 hours/week).

3. Update PSS and sign-out tools as needed.

RN Clinical Patient Care Duties:
1. Week 1-4, perform 1-2 home visits with a resident to new or follow-up patient (2-4 hours/week).
2. Orient resident to administration, HBCP supply bag, and preparation needed for a house visit (address, Hx, CCAC coordinator contact info, taxi chits, etc) – (15-20 min)
3. Perform home visits individually for ear syringing, vitals, wound assessment/dressing change, and to do blood work (1-2 visits per month - ~ 2 hours/month).

Toronto Western Family Health Team

Home-based Primary Care Program (HBPC)

<table>
<thead>
<tr>
<th></th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.m.</td>
<td>MD administrative</td>
<td></td>
<td></td>
<td></td>
<td>NP visits</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>* RN visits +/- Resident MD</td>
</tr>
<tr>
<td>lunch</td>
<td>12:45 p.m. – 1:30 p.m.: HBPC Rounds, North Conference Room</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>p.m.</td>
<td>Working Group 1:45-2:45 monthly MD visits +/- Resident MD</td>
<td>NP visits</td>
<td></td>
<td>MD visits +/- Resident MD</td>
<td>MD administrative</td>
</tr>
<tr>
<td></td>
<td>MD/NP administrative</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*RN flexible to master RN schedule & availability

NP Administrative Duties:
11. Co-Lead HBPC Rounds with MD (90 min/week)
   a. Review each patient (~30) every Tuesday; updates from team
   b. Engage with team in care plans
c. Liaise with involved professionals re: care plans; delegate
d. Review new referrals for appropriateness; schedule visits

12. Sign-off labs and other investigations in my mailbox; order follow-up
ingvestigations as needed (30 min/week)

13. Renew prescriptions by fax request in my mailbox (15 min/week)

14. Chart reviews, update CPP and Sign-Out Tools as needed (90 min/week)

15. Phone calls from patient families, CCAC, care providers (90 min/week)

16. Engage with MD q 2 weeks on Tuesday afternoon re: program updates, clinical
housekeeping (60 min/biweekly)

17. Engage with Executive Director monthly re: program updates, working group
updates and admin details (60 minutes/monthly)

18. Prepare working group agendas, minutes, maintain supplies, restock bags,
trouble shoot computer and logistic issues (60 min/week)

19. Email and telephone consults with consulting physicians, interprofessional care
providers regarding patient care plans (90 min/week)

NP Clinical Patient Care Duties:

9. In MD co-lead absence, orient resident to HBPC competencies, administration,
effects etc. (30 min/month)

10. Primary clinical liaison for HBPC patients providing continuity of care to bridge
resident transitions and MD absences

11. On as needed basis, perform 1-2 joint home visit(s) with resident to new or
follow-up patient(s) (1-2 hours/month)

12. Weekly homevisits to new and established patients based on day to day triage
and/or patient needs
   a. Note: New patient visits done jointly with CCAC coordinator OR other
      available FHT staff
   b. All new patients met on 1st – 3rd visit by NP
   c. # home visits in a week ranges from 3-8
      (~3-8 hours/week)

13. Available during weekdays either in-person or on cell phone for issues with HBCP
patients (i.e. nursing, resident, CCAC concerns (60 min/week)
### Facesheet Template

**Thursday, September 10, 2009**

**9:30 AM**

#### Demographics

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Contact Tel</th>
<th>D.O.B. (d/m)</th>
<th>OHIP &amp; V.Code</th>
<th>Gender</th>
<th>Marital Status</th>
<th>Languages</th>
<th>Comments (housing, financial, social):</th>
<th>Caregiver (As defined by SPRINT): Y/N</th>
<th>Relationship</th>
<th>Age Range</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Caregiver Breakdown?</th>
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</thead>
<tbody>
<tr>
<td>Name &amp; relationship:</td>
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</table>

<table>
<thead>
<tr>
<th>Power of Attorney</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name &amp; relationship:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Personal Care:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name &amp; relationship:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Property:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Infestation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicable Disease (MRSA, VRE, C-Dif, etc.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pets</th>
</tr>
</thead>
</table>

#### Referral, First Visit, & Ongoing Issues:

<table>
<thead>
<tr>
<th>Source</th>
<th>Hospital Emerg.</th>
<th>Hospital Inpatient</th>
<th>Supp. Housing</th>
<th>CCAC</th>
<th>CSS Agency</th>
<th>Other</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Identify:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date First Seen:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>First Seen By:</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Consent to Info Collection and Sharing? (Y/N)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Consent to Service? (Y/N)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Applied to LTC?</th>
<th>Date, comment:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Admitted to LTC?</th>
<th>Date, comment:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>ED Visits / Admissions</th>
<th>Date, Length of Stay</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>911 Calls</th>
<th>Date, Length of Stay</th>
</tr>
</thead>
</table>

#### Primary Care:

<table>
<thead>
<tr>
<th>Current Dx:</th>
</tr>
</thead>
</table>
### Past Medical Hx:

Vaccinations:
- Tetanus:
- Influenza:
- Other:

Pneumonia:

### Support Services in Place

<table>
<thead>
<tr>
<th>Organization Name</th>
<th>Support Type</th>
<th>Contact Person</th>
<th>Tel</th>
</tr>
</thead>
</table>

### Social Work and Occupational Therapy

### Mobility Issues:

Equipment/Assistive Devices:
(owned, rented, loaned?)
## Appendix 7: Technology Pricing Information

From Amazon.ca & Starkman’s Medical Supplies, Toronto

<table>
<thead>
<tr>
<th>Item</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stethoscope</td>
<td>$15-100</td>
</tr>
<tr>
<td>Blood pressure cuffs: regular, large, pediatric</td>
<td>$25-100</td>
</tr>
<tr>
<td>Digital thermometer</td>
<td>$10</td>
</tr>
<tr>
<td>Otoscope/ophthalmoscope</td>
<td>$200.00</td>
</tr>
<tr>
<td>Pulse oximeter</td>
<td>$75-150</td>
</tr>
<tr>
<td>Glucometer</td>
<td>$50-150</td>
</tr>
<tr>
<td>Gloves in various sizes</td>
<td>$15-25</td>
</tr>
<tr>
<td>Lubricant</td>
<td>$15</td>
</tr>
<tr>
<td>Hemoccult slides</td>
<td>$1.00/slide</td>
</tr>
<tr>
<td>Bandage scissors</td>
<td>$5</td>
</tr>
<tr>
<td>Toenail clippers</td>
<td>$10</td>
</tr>
<tr>
<td>Sterile scissors, forceps, disposable scalpel</td>
<td>$5-25</td>
</tr>
<tr>
<td>Sterile 4x4 gauze</td>
<td>$10/pack</td>
</tr>
<tr>
<td>Medical tape</td>
<td>$30/pack of rolls</td>
</tr>
<tr>
<td>Antiseptic solution</td>
<td>$30 CASE</td>
</tr>
<tr>
<td>Urine collection containers</td>
<td>$1.00/container</td>
</tr>
<tr>
<td>Standard urinary catheters + drainage bags</td>
<td>$10</td>
</tr>
<tr>
<td>Hand-held EKG Machine</td>
<td>$400.00</td>
</tr>
<tr>
<td>Hand-held i-STAT</td>
<td>$1500</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$2848.30</strong></td>
</tr>
</tbody>
</table>
Telemedicine utilizes video-conferencing technology to connect patients to health practitioners across the province. This technology provides for a convenient, private and confidential means to delivering health care.

There are many benefits of the Telemedicine program, which include;

- It reduces patient’s wait time and travel costs;
- It allows for patients to access specialized services, without having to leave their community;
- The patient does not have to be a CCAC patient to utilize the Telemedicine service

What is a Telemedicine Appointment?
A telemedicine appointment uses state-of-the-art video technology and is similar to a traditional face-to-face appointment. The patient can see, hear and interact directly with their health care provider remotely.

Telemedicine provides you with an easy way to have an appointment with your health care provider by using videoconferencing technology. This means you will be able "visit" your health care practitioner without having to leave your community. You will have the opportunity to see, hear and speak with a care provider and discuss your plan of care via a two-way television.

This service is free and only requires a valid health card number. If you are interested in the telemedicine program, or if you are a care provider and may have a patient that you feel would benefit from this great service please contact the Telemedicine Nurse at 416 217-3820 x 4107 who will be happy to assist you with the referral process.

BACKGROUND FROM THE TELEMEDICINE PROPOSAL:
Frail homebound older adults, who often have complex, inter-related health and social care issues, are among the most vulnerable and marginalized patient populations in the Toronto Central Local Health Integration Network (TC-LHIN). More often than not these older adults who are homebound are challenged to access office-based medical care from primary or specialist care providers and thus often end up accessing medical care in crisis situations through EDs and Hospitals.

Not a new concept, home-based primary care is referred to as “an old fashioned solution to an emerging problem”. To meet this challenge, an integrated team-based model of care bringing hospitals and specialists together with primary and community care providers to improve patient, caregiver, and system outcomes was established in the TC-LHIN. Known as the Integrated Home-Based Primary Care (IHBPC) initiative, this model has brought together 6 Family Heath Teams, a CSS-based Primary Care Team (House Calls), Mount Sinai Hospital and the CCAC to develop a standard model of care that can deliver comprehensive and ongoing integrated home-based care to over 450+ homebound TC-LHIN patients each year.
While many of the Family Health Teams and the CSS-based House Calls Program have a consultant internist and/or psychiatrist attending team rounds with their respective IHBPC teams to discuss these often complex patients, the consultant specialists often are not able to provide direct home visits to homebound patients, which is a barrier for providing in some cases the most optimal care. In those programs like House Calls where the affiliated Geriatrician and Geriatric Psychiatrist routinely offer home-based consultations and follow-ups with primary care team members, the need to schedule these visits a few days or weeks ahead of time doesn’t always allow the flexibility for the patients, the primary or specialty care providers that could improve the efficient access to and use of specialty expertise. Also when consultants often see patients for office-based consultations, it often does not occur with the participation of the patient and their family in their own home or with any primary care team members in attendance.

Telemedicine allows health care professionals to evaluate, diagnose and treat patients in remote locations using telecommunications technology. It is an efficient and cost-effective way of accessing specialty care and expertise without travel by either the patients or providers. Using the Ontario Telemedicine Network (OTN) to support and expand telemedicine usage, the Ministry of Health and Long-Term Care (MOHLTC) has funded each LHIN with a complement of new nurses to support the growth and usage of telemedicine technology as part of the Government’s commitment to hire 9,000 new nurses.

Traditionally, telemedicine usage in the TC-LHIN has enabled patients in remote locations outside of the TC-LHIN (sender sites) to access specialized expertise predominantly located in hospitals (receiving site) in the TC-LHIN. Through the use of these new resources from the MOHLTC the TC-LHIN is supporting Urban Telemedicine initiatives that focus on models of care where both the sender(s) and receiver(s) are located in the TC-LHIN.
Integrated Home Based Primary Care (IHBPC)

Mission

The Integrated Home-Based Primary Care (IHBPC) Program is a model of care that provides access to home-based primary care seamlessly integrated with improved home and community care services for frail and house-bound older adults whose needs are not otherwise met by traditional office-based primary care.

Model

The IHBPC model of care is designed is integrate care by delivering home-based primary care services to homebound patients in partnership with the Community Care Access Centre (CCAC) and Community Support Services (CSS) agencies in the Toronto Central Local Health Integration Network (LHIN).

The IHBPC Program Patient Enrolment Criteria targets high risk patients who are:

1. 65 years or older;
2. Homebound – i.e. have great difficulty in accessing a family physician due to physical/cognitive and/or psychiatric disabilities;
3. Live in the catchment area indicated by the corresponding postal codes: M4 – G, N, P, R, S, T, V, W;
4. X, Y; M5 – B, G, M, N, P, R, S, T; M6 – C;
5. Must be willing to transfer their primary care from their current family doctor (if they have one) to
6. the IHBPC Primary Care Team;
7. Consent to participating in the program;
8. Patients cannot be actively dying at the time of enrolment;
9. Patients cannot be living in a retirement or nursing home.

The IHBPC program encompasses two primary care team models, the House Calls Program and the Family Health Team (FHT) home-based primary care programs (please see below). Patients referred to an IHBPC program are first assessed for eligibility to the program (see above criteria). The first home visit is conducted by the physician (independently or jointly with another member of the team) to develop a shared care plan for the team to provide on-going care for the patient.

Thorough assessments are conducted by the CCAC on each IHBPC patient using the Resident Assessment Instrument – Home Care (RAI-HC), and are updated every six months to assist with care planning.
House Calls Program

Initially established in 2007 as a pilot-project embedded in a Community Support Agency, House Calls became a fully-funded TC-LHIN Program in September 2009 through the MOHLTC’s Aging at Home Strategy. It is currently the largest community-based, team-delivered program in Ontario providing exclusively integrated and inter-professional home-based care for frail homebound elders. The goal of the program is to support patients and their caregivers to remain safely in the community for as long as possible while simultaneously delivering better overall patient and system outcomes that include avoidable hospitalizations and ED visits and the ability to die at home. House Calls is a product of its wide-ranging health and community care sector partnerships including Community Support Services, Hospitals, Geriatric and Psychogeriatric Outreach Teams and TC-CCAC. House Calls contains the largest formal training program for medical and allied health professionals wishing to learn home-based primary care in Ontario.

FHT Home-Based Programs

Under the Ontario wide FHT model, home-based primary care is provided by a physician-led inter-professional team encompassing a variety of inter-professional health care providers, including nurse practitioners, social workers, dieticians, pharmacists, occupational therapists, physiotherapists, pharmacists, and/or specialty care providers including internists and psychiatrists. The CCAC care coordinator is directly integrated into each FHT team and links home care and community supporting services for each shared patient, and provides case management to support patients’ transitions to long-term or palliative care. All IHBPC FHT teams are involved in training University of Toronto family medicine residents and the teams have developed resident competencies in providing homebased primary care.

The FHT model is currently operational at the following sites:

- Toronto Western FHT
- South East Toronto FHT
- Taddle Creek FHT
- Mount Sinai FHT
- St. Michael’s Hospital FHT
- Sunnybrook Hospital FHT

The Team

Co-Principal Investigators of the IHBPC model are:

- Dr. Sabrina Akhtar
- Dr. Samir Sinha
- Dr. Thuy-Nga (Tia) Pham
- Dr. Mark Nowaczynski
- Dr. Tracy Smith-Carrier

The Co-Investigators of the IHBPC model are:

- Dipti Purboo (Toronto Central CCAC)
- Jodeme Goldhar (Toronto Central CCAC)
- Gayle Seddon (Toronto Central CCAC)
- Stacy Landau (Senior Peoples’ Resources in North Toronto [SPRINT])
- Dr. Jocelyn Charles (Sunnybrook FHT)
- Dr. Pauline Pariser (Taddle Creek FHT)
- Dr. Michelle Naimer (Mount Sinai Academic FHT)
- Dr. Amy Freedman (St. Michael’s Hospital Academic FHT)
Project/Research Associates

- Selma Chaudhry
- Kera Salvi

Lead Partners

- VHA Home Healthcare and Mount Sinai Hospital
- Toronto Central CCAC

Supporting Partners

- The Applied Health Research Centre (AHRC) of the Li Ka Shing Knowledge Institute

Evaluation

The IHBPC model is being evaluated using a retrospective matched cohort study using a repeated measures evaluation design.

The primary outcome is the number of ED visits and hospitalizations within twelve months following the index enrolment date. The following secondary outcomes will also be examined:

- Actual vs. preferred locations of patients’ deaths
- Percentage of Patients With Advance Directives in Place Within 3 Months of Intervention
- Changes in team culture based on the Dimensions of Teamwork Survey.
- Number of all-cause ED visits within one and three months following the index date
- Number of hospital days within one, three and twelve months following the index date
- Number of hospitalizations within one and three months following the index date
- Percentage of avoidable hospitalizations
- Percentage of avoidable ED visits

A qualitative evaluation of the IHBPC model was also conducted. This evaluation focused on the experience of patients, their caregivers, and the interdisciplinary care team within the IHBPC model of care. An economic evaluation will examine the cost effectiveness of the model.

Status

The IHBPC study is ongoing and enrolling patients to reach the desired target sample size of consented patients. Qualitative interviews have been completed and are being analyzed. ICES data analysis for this study will be completed in 2015, and publications to follow subsequently.

An economic evaluation is being conducted by the IHBPC research team in conjunction with the health economist at AHRC. This evaluation will consider the costs associated with IHBPC service delivery vis-a-vis usual care in Ontario for homebound elderly. The findings of this analysis will be used to determine the cost savings of this model of care as compared to status quo care delivery.
Appendix 10: Video And Online Learning Tools

**House Calls**

A film by Ian McLeod  
List Price: $79.95  
[ADD TO CART](#)

House Calls – Available through National Film Board of Canada  
A Gemini-award winning documentary on three typical house calls patients – runs 56 minutes  
Dr. Mark Nowaczynski, physician and photographer, works to serve these frail elders while raising awareness of the dearth of home visiting programs in Toronto, Ontario

**Doctor In The House**

Available through Talking Eyes Media  
12-minute overview on the largest academic home-based primary care program in the USA  
Excellent contextual primer for trainees embarking on first home visits
PGY-1 HOME-BASED CARE PROGRAM (HBCP)

Family Enriched Block
Toronto Western Hospital
Department of Family & Community Medicine

Contact Faculty:  Dr. Sabrina Akhtar (sabrina.akhtar@uhn.on.ca)
                 Stephanie Van Rooy (stephanie.vanrooy@uhn.on.ca)

Contact Administration: Afton Meredith (afton.meredith@uhn.on.ca)

At the end of completion of the one-month rotation, residents will develop an approach to physician-lead interprofessional primary care of the elderly at home with community support.

1. Discuss the roles of family physicians in the care of the elderly at home
2. Collaborate with interprofessional care providers in the care of the elderly at home
3. Demonstrate proficiency in a primary care comprehensive geriatric assessment, including appropriately thorough histories and physical examinations for elderly patients in a timely manner in the home setting
4. Describe available home resources and acute care supports
5. Demonstrate an effective approach to the presentation of common conditions, undifferentiated illness, and chronic disease in the elderly
6. Demonstrate an effective approach to the elderly patient presenting with confusion or cognitive impairment
7. Demonstrate medication management and reconciliation skills for elderly patients in the home
8. Discuss the role of the family physician in end of life/palliative care
9. Describe the impact of non-medical patient and family characteristics on health and well-being
10. Describe the impact of culture on health and well-being
11. Describe current health care system supports for home-based care and future directions for Canadian/Ontarian policy

Methods:

- Mentored one-on-one home visits with program faculty (Week 1)
- Scheduled and Same-Day house calls accompanies by RN and supervised by faculty over phone and in the office on return (Week 2-4)
- Participation in weekly HBCP rounds (Tuesdays 12:30 p.m. – 1:30 p.m.)
- 1-2 Homebound patients accepted into resident’s longitudinal practice
- Pharmacy Home Medication Reconciliation Session

Evaluation:

- Direct observation of resident at patients’ bedsides in their homes