The Virtual Ward

An Integrated Care Model for Hospital-to-Home Transitions for Adults with Complex Health Care Needs

A partnership between acute, community and primary care providers
The scale of the problem

- 26,000 adult medical admissions in Toronto Central LHIN each year
  - 30 day readmission rate is 13% = 3,270 readmissions
  - 90 day readmission rate is 21% = 5,440 readmissions

- Average readmission costs ~$11,000 in hospital costs alone

- Total cost of readmissions to hospital within 90 days
  - Approximately $60,000,000 in Toronto Central LHIN alone

- If we could reduce readmissions by 50%
  - Cost savings of $30,000,000 in TC LHIN alone

- If we could reduce readmissions by 25%
  - Cost savings of $15,000,000 in TC LHIN alone
Why focus on care after discharge?

Disease intensity
Care intensity

Time

Hospital
Rehab
Home

Too much care

Hospital
Rehab
Home

Not enough care

Hospital

Long-term care

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The Virtual Ward model

- Interdisciplinary team (including a VW physician)
- Family physician involved throughout
- Daily rounds to discuss patients
- Care coordination
- Shared notes
- Single point of contact with 24/7 physician availability
The Virtual Ward model

Virtual Ward

- Housed at Women’s College
- NP, care coordinator, pharmacist, clerical staff work for CCAC
- Physicians come from U of T Division of General Internal Medicine

Discharge to primary care

Communicate with non-Virtual Ward care providers (family doctor, non-Virtual Ward CCAC staff, social supports, specialists, etc.)

Discharge to primary care will occur quickly if family physician keen to assume care
Chronic care pyramid

Virtual ward focuses on the highest-risk patients
Readmission risk

- Can be predicted at the time of discharge using the LACE index (van Walraven et al, CMAJ 2010)

- 1/3 of TC LHIN discharges have a predicted 90 day readmission of 32%

- Virtual ward will focus on these high-risk patients
Why focus on care after discharge?

- Lots of “low-hanging fruit”
  - Communication could be strengthened
  - Collaboration could be improved
  - Medications could be reconciled
  - Patients could be monitored more closely
  - Social supports could be increased or tailored
  - Patients could be educated about how to manage their health problems
  - Very few places to seek urgent (but not emergent) post-discharge care → patients end up back in ER
Benefits of a Virtual Ward

- Reduced ED use and therefore ED wait times
- Increased ability to “age at home” → reduced LTC use (and fewer ALC days)
- Improved patient outcomes
- Fewer patients “falling through the cracks”
- Increased support for primary care providers
- Platform for interdisciplinary education

- Cost saving → cost of readmissions likely to exceed cost of running a virtual ward

- Opportunity to test a model for integrating multiple sectors/organizations
How will family doctors be involved?

• Discussion with family physician
  – on Day 1 of admission
  – as needed/desired during Virtual Ward admission

• Discharge plan from Virtual Ward created by VW team and family physician
Evaluation

• Researchers from ICES, Li Ka Shing Knowledge Institute and Women’s College Research Institute working collaboratively

• Primary evaluation will focus on readmissions
  – Final results in 2 years

• Additional evaluations will focus on
  – Provider/patient perspectives (qualitative)
  – Process/utilization tracking
  – Quality improvement
  – Economic evaluation
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