Barrie and Community Family Health Team

Aging Well

A Team Based Approach to Complex Elder Care

Presenters:
Catherine Jones PHC- NP
Jennifer Handley Pharmacist

Ontario

Presenter Disclosure
AFHTO 2017

Presenter: Catherine Jones

Relationships with commercial interest:

- Barrie & Community Family Health Team employee
- No commercial interests to disclose

Presenter Disclosure
AFHTO 2017

Presenter: Jennifer Handley

Relationships with commercial interest:

- Barrie & Community Family Health Team employee
- Speakers Bureau/Honoraria: Purdue Pharma

(unrelated to this program or the Aging Well Clinic)

Disclosure of Commercial Support

- **This program has not received any financial support from any commercial organizations.**
- **This program has not received in-kind support from any commercial organization.**

- **<u>Potential for conflict(s) of interest</u>: None**

Aging Well Clinic

- Community based specialized geriatric care
- Referral base
  - 90 physicians , 21 Family Medicine Residents & 21 NPs affiliated with Barrie FHT
  - > 40,000 patients aged 65+
- Shared Care model with primary care provider

Geriatric Services

- Consultation & management of:
  - Clinically frail/medically complex (CFS 4-6)
  - Cognitive impairment/dementia
  - Preoperative optimization for major elective surgery
  - Home visits when clinically indicated

The Team

- Family Physician with Focused Practice in Care of the Elderly - 2 days per month
- Nurse Practitioners - 1 FTE (2 x 0.5 FTE)
- Nursing - 1.3 FTE (RN 0.5 FTE & RPN 0.8 FTE)
- Clinical Pharmacist - 0.4 FTE
- Occupational Therapist - 0.4 FTE
- Access to CHC Physiotherapist

Guiding Principles

Patient Centered Care

"Patient - Care Partner Dyad"

Build Capacity within Patient and Care Partners

Maintain/Improve Independence

Optimize Health, Well-Being and Function

Guiding Principles

Facilitate Long-Term and Advanced Planning

Minimize Service Duplication

Streamline System Navigation

Clinic Process Geared Towards Vulnerable Population

Comprehensive Geriatric Assessment

- Includes:
  - Social determinants of health
  - Functional status
  - Mobility/falls
  - Cognition
  - Depression/delirium screen

Comprehensive Geriatric Assessment

- Includes:
  - Alcohol/substance use
  - Nutritional status
  - Medication reconciliation and polypharmacy
  - Chronic medical conditions
  - Clinical Frailty Scale score

Plan of Care

Interdisciplinary Team Approach - targeted interventions based on assessment

Dementia clients followed long term

Medically complex clients are optimized and discharged to primary health care providers

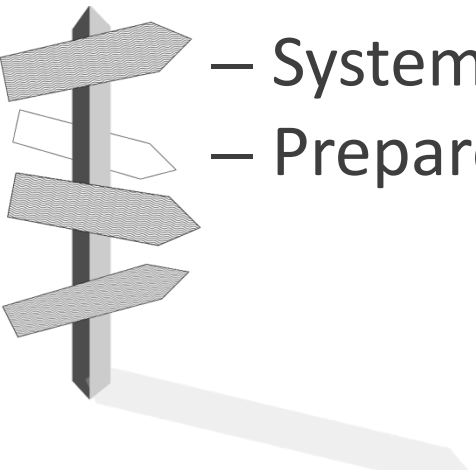
Clinical Assessment Tools

- MMSE & MoCA
- Kingston Functional Activities Questionnaire
- Kingston Caregiver Stress Scale
- Geriatric Depression Scale
- Texas Functional Living Scale (TFLS) by OT
- Driving: Trails A & B, SIMARD MD

- Kingston Standardized Behavioural Assessment
- Frontal Lobe Inventory

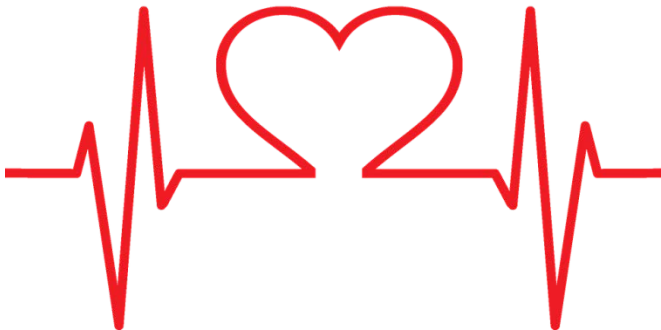
Work Flow & Roles

- Administrative Assistant:
  - Book appointment
  - Triage phone calls
  - Phone support to client/care partner
  - Track referrals into clinic
  - Track referrals to specialists
  - Track appointments for diagnostics, specialists, etc.
  - System navigation
  - Prepare clinical tools



Work Flow & Roles

- Nursing:
  - Triage referrals
  - Chart review & start Intake Form
  - Cognitive testing & client interview
  - System navigation & referral community resources
  - Health teaching & counseling
  - Phone support to client/care partner
  - Driving Assessment (back up for OT)
  - Wt, BP, HR, O2 sat at every visit



Work Flow & Roles

- Nurse Practitioner:
  - Most responsible care provider for majority of clients
  - Family interviews +/- client interview
  - Diagnosis & care planning with team
  - Health teaching & counseling
  - System navigation & referral community resources
  - Internal referrals to clinic's physician
  - Referrals to outside specialists
  - Phone support to client/family
  - Home visits as needed

Work Flow & Roles

- Clinical Pharmacist:
  - Medication review & recommendations
    - Deprescribing, chronic disease management
    - Renal/hepatic impairment
    - Clinician support
  - Phone screens re new medications, dose adjustments
  - Health teaching & counseling esp chronic disease
  - System navigation & referral community resources
  - Home visits as needed

Work Flow & Roles

- OT:
  - Mobility
  - Home safety
  - Mobility Aids
  - Functional Assessments +/- TFLS
  - System navigation & referral community resources
  - Cognitive Testing
  - Driver's Assessments
  - Home visits frequently required

Work Flow & Roles

- Physician:
  - Medical support to team
  - Complex clients
  - Dementia- FTD, LBD, atypical presentation, young age, severe responsive behaviors
  - Pain management
  - Diagnostic clarification
  - System navigation & referral community resources
  - Referrals to tertiary centres (case review with NP)
  - Home visits as needed

Documentation & Tracking

- Accuro EMR
  - Geriatric identifier (Geri-Phone, Geri-Progress)
- EMR Pt messaging/task system to track labs, diagnostics etc (can post date)
- Team developed:
  - Standardized Intake Assessment Form
  - Standardized Dementia Flow Sheet

Community Partnerships

Barrie Community Health Centre

- Physician Support
- Physiotherapy

RVH Royal Victoria Regional Health Centre

- Direct referrals and repatriation
- Pre-Op Program with Arthroplasty Intake Clinic

Waypoint Centre for Mental Health Care / Centre de soins de santé mentale

- Waypoint Geriatric Psychiatric Outreach Team
- Provide clinic space monthly

Community Partnerships

- Dementia education with Alzheimer's Society

- CCAC case conferences monthly

- Retirement Home Rounds

- Outreach - seniors education & advocacy

Program Challenges

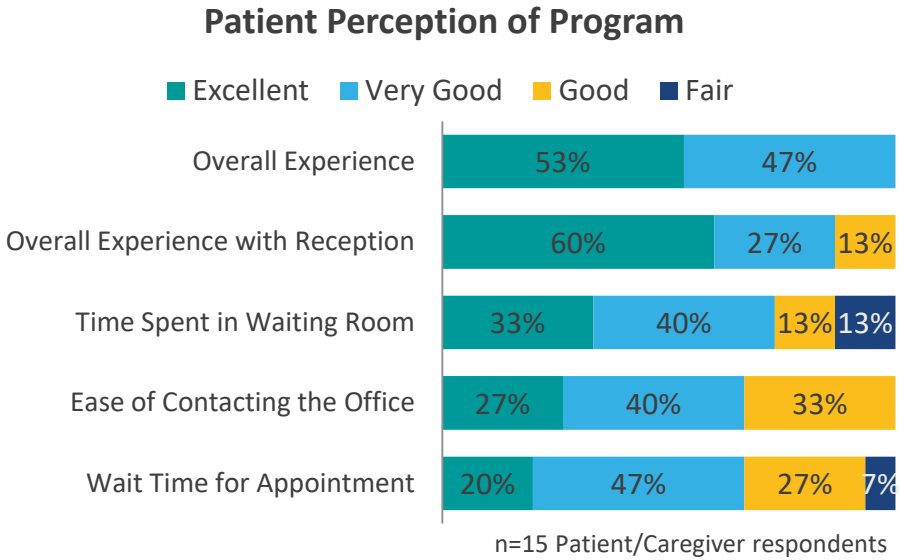
- Driving
- Challenging family dynamics
  - Mismatch between presentation and collateral Hx
  - Family buy-in to care needs
  - Decision making and capacity
- Realistic long-term planning
- EMR not designed for team approach
- Addressing mental health & addictions
- Outcome measurement

Program Successes

- Improved access to care
- Decreased burden for family physicians
- Improved health outcomes (team approach)
- Increased support and education
- Increased community resource utilization
- Increased future & advanced care planning
- Improved road safety
- Enhanced home safety, falls prevention and medication management

Program Evaluation - Patients

- **Patients and Caregivers *always* or *often* feel:**
  - Staff listen carefully
  - Provide clear and easy to understand explanations
  - Provide the right amount of information
  - Provide opportunities to ask questions
  - Involve patients/caregivers as much as they want
  - Spend enough time with patients/caregivers



n=15 Patient/Caregiver respondents

- **Patient and Caregiver Thoughts about the Clinic:**

"Interacting and intervening with our family member and advocating for my mom."

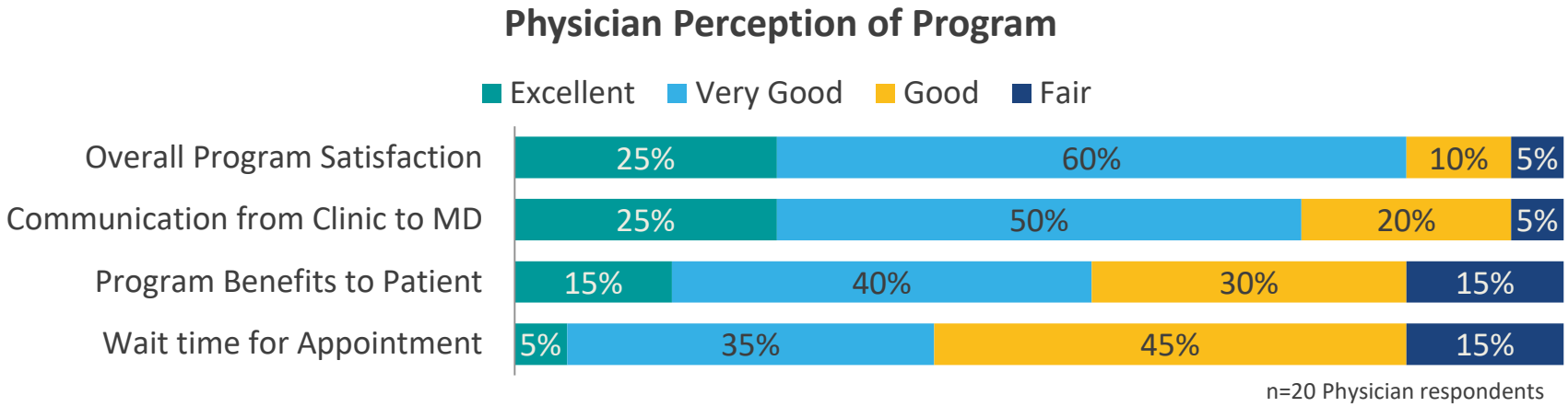
"I am very impressed with everything at the wellness centre."

"Make a person feel very comfortable with them. Can talk easily to them. Very empathetic to ones feelings and fears."

"Very friendly staff, always eager to help."

"I feel completely satisfied with the help provided. They are very thorough and keep you informed."

Program Evaluation - Physician



- **What Physicians like best about the Aging Well Clinic and its services:**

"Just how thorough the assessment is. And that the practitioners will take the initiative to set up patients with social workers, etc."

"Helped support the diagnosis and transition for families over time."

"Support given to patients , families/ caregivers. Advise to assist in management of my patients. Excellent team approach to care."

"Great assessments of function and good follow up."

"Centralized approach with involvement of family members."