Aging at Home

Accessing Care for Our Seniors

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Presenter Disclosure

- Presenters-Nancy Campbell and Jenny Lane
- Credit: Burlington Family Health Team for the name Aging at Home
- Relationships with commercial interests
  - Grants/Research Support: none
  - Speakers Bureau/Honoraria: none
  - Consulting Fees: none
  - Other: none

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Disclosure of Commercial Support

- This program has not received financial support
- This program has not received in-kind support

- Potential for conflict(s) of interest:
  - The speakers have not received payments of funding from any organizations
  - No products will be discussed in this program

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Learning Objectives

- Program development
- Identifying the target population
- Program Parameters
- Challenges
- Lessons Learned
- Future Expansion

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- 2014 Population in L&G: 99,000 : 21,500 are over 65 years old
- Approx. 21% in L&G vs. 15.6% in Ontario-2014 Census data
- Patients enrolled in LGCFHT: 8,800
- Multi-site FHT in Leeds and Grenville County
- Mostly rural with small towns and villages
- Largest town: Brockville 22,000

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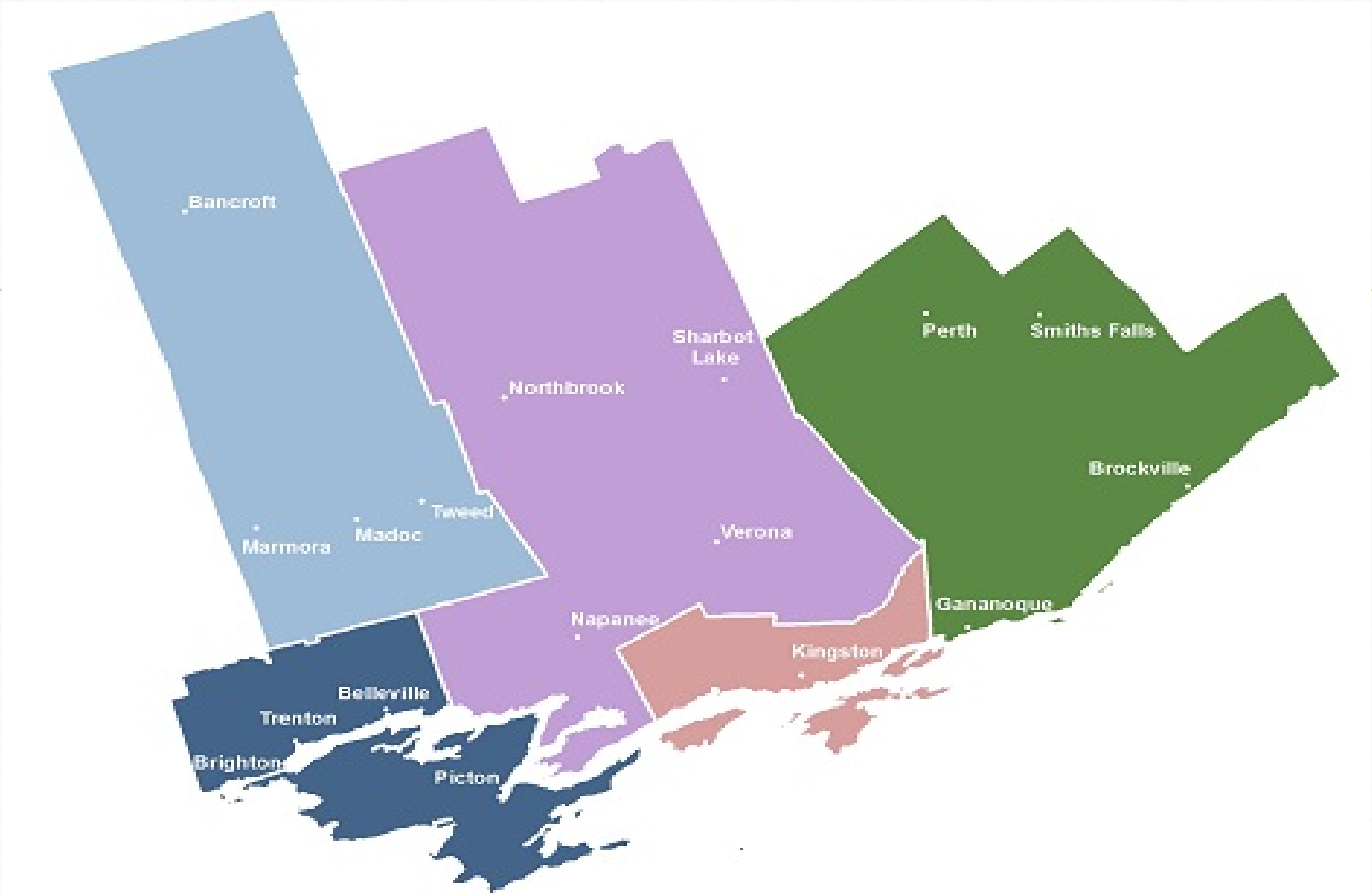
Bancroft
Northbrook
Sharbot Lake
Perth
Smiths Falls
Brockville
Tweed
Madoc
Marmora
Verona
Gananoque
Napanee
Kingston
Belleville
Trenton
Brighton
Picton

Why Aging at Home

- Need identified by Primary Care Providers and Key Stakeholders in Community
- Issues identified were
  - Frail elderly getting to clinic appointments
  - 3 or more chronic diseases per patient-hard to manage in clinic setting
  - Increase use of Emergency Room to care for exacerbations of chronic disease issues
  - End of Life care

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Identifying potential patients

- EMR-PS Solutions
- Reports ran on key identifiers
  - Number of chronic diseases per patient
  - Age-over 65
  - Last seen in clinic/numbers of visits in past 12/6 months
  - Last ER visit or hospital discharge

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Referral Criteria

- Rostered patients 65 years and older* who meet at least **one** of the following criteria
- *patients under 65 who meet the criteria may be referred but acceptance to the program is subject to review by Nurse Practitioner.
- Housebound/social isolation
- Poor support network
- Diagnosis of COPD, CHF, CAD (HTN, PAD, CVA), DM, Dementia and neurological conditions
- Balance and gait impairment
- Fall in the past 3 months
- Recent discharge from acute care
- Recent emergency department visit
- 2 or more admissions to acute care for the same issue within the last 6 months

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Where did we start

- Met with Primary Care Providers
- Presented list of patients identified through EMR
- Gave PCP's opportunity to comment on patients identified or suggest other patients
- Developed/Presented referral form to PCP's and uploaded it in the EMR for ease of use

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Where did we start

- Developed template for initial visit and follow up visits in EMR
- Initial appointments 120 min in length
- Follow up appointments 60 min in length
- Initial visit schedule: 4-6 patients per day

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Typical Aging at Home visit

- Review last visit, new referral notes, new results etc.
- Complete medication reconciliation
- Review chronic diseases
- Physical exam
- Health teaching, prescriptions, lab reqs, referral letters
- Book follow up appointment depending on current presentation

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Equipment Needed

- Lap top
- Cell phone
- VPN key to gain access to EMR remotely
- Portable printer
- Medical Kit-B/P cuffs, Pulse Oximeter, Ophthalmoscope, Stethoscope
- Clerical and technical support

Approximate: $2000

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Challenges

- Management Considerations:
  - HR Allocation
  - Risk Management
    - Safety
    - Policy/Procedures
  - Allocation of Resources
    - Time Management
    - Cost

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Challenges

- Program Considerations:
  - Communication-Reports/Documents/EMR
  - Patients “double dipping”
  - Referrals-appropriate/ongoing
  - Large geographic area
    - Travel time
    - Personal vs. company car
    - Inclement weather

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Challenges

- Follow up-what is too much/too little
- Time for must see urgent patients
- Post Hospital Discharge follow up

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Successes

- Patient goals honoured
- At home End of Life care
- Reduced Emergency room visits due to exacerbations
- Reduced Hospital admission due to exacerbations
- Decreased Family burden and stress
- Increased access to services

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Future Expansion

- Post Hospital Discharge
- Emergency Room follow up
- Registered Staff Support

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Questions?

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