



Guelph Family Health Team

In-Home Primary Care Program for Frail Seniors: A Guelph Family Health Team Aging at Home Initiative

by Aging At Home Nurses

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System Leadership

Organizational Capacity

System Navigation

Sustainability

Purpose

Today's presentation:

- Why frail seniors as a 'target population'?
- The three key components of our service delivery model
- What our 'customers' have told us
- Future direction

Background

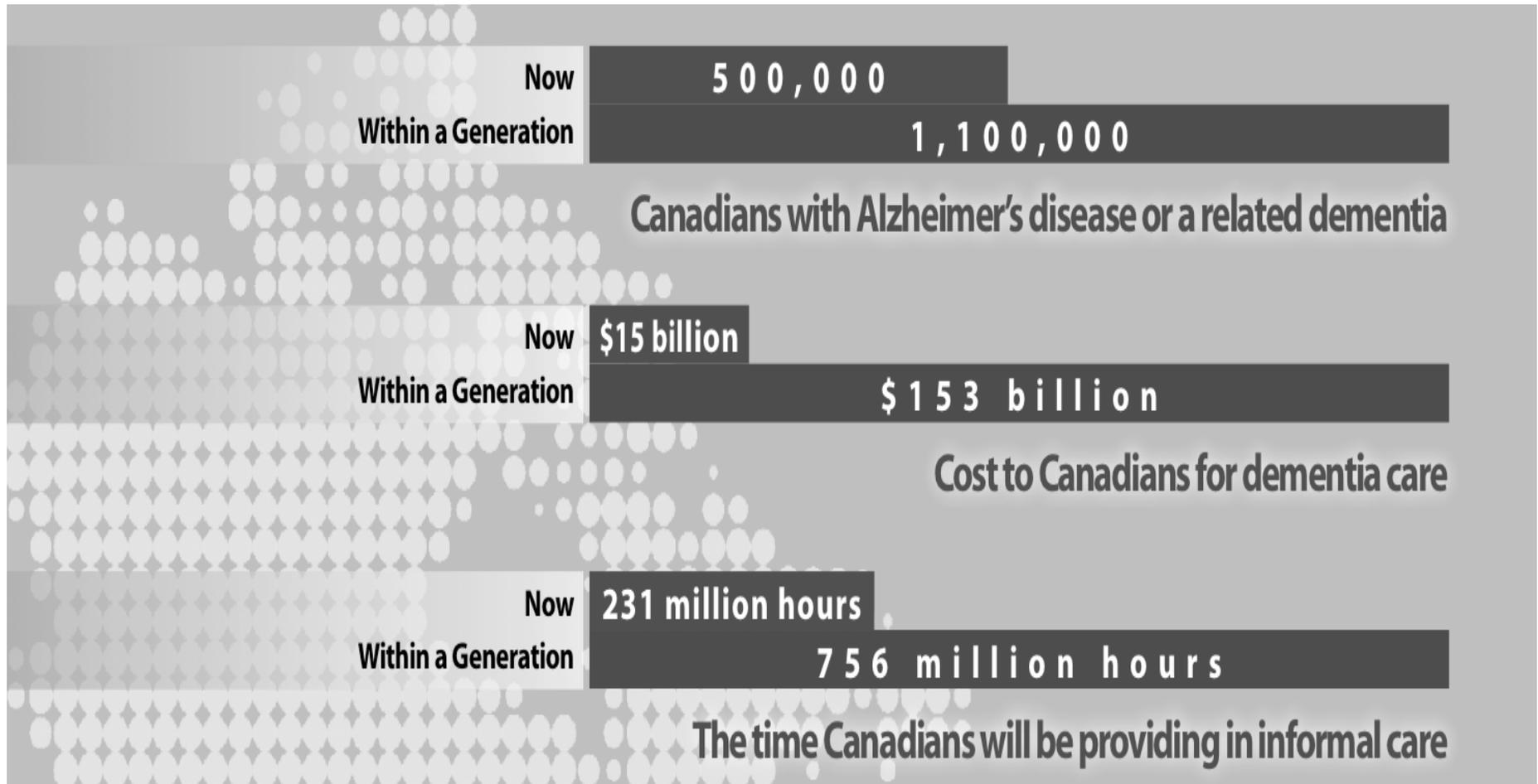
A review of literature on best practice for frail seniors tell us that:

“Improving access to primary care to frail elderly can effectively and efficiently address their health outcomes and reduce health care costs.”

(Heckman, 2011 Vol. 11 No. 1); Leff, Reider, & Frick, 2009 Vol 15 No 8);
(McCusker, Roberge, &Vandenboncoeur, 1009).

Background

The Rising Tide – Executive Summary www.alzheimer.ca



Purpose

Program goal was to build capacity for:

- Proactive identification of seniors at risk for frailty in primary care
- Understanding individual and or caregiver stressor (s) that create barriers to sustained self-management
- System navigation to facilitate timely access to services and resources

Background

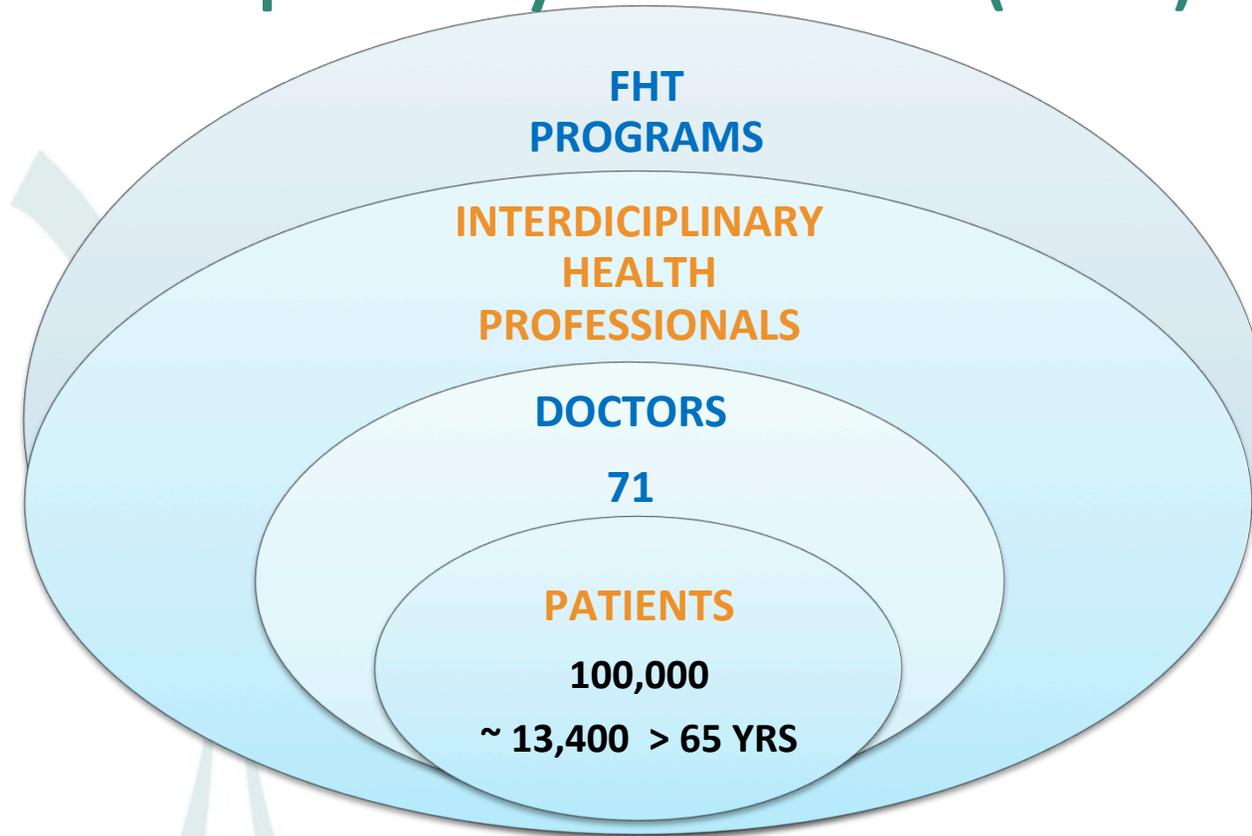
Foundational concepts and models

- Integrated model of care that aligns primary and acute care services with a network of foundational community support services
- Ontario chronic disease prevention and management
 - Focus on targeted populations and patient /provider interactions resulting in prepared, proactive practice teams; informed and actively engaged patients

www.alzheimer.ca

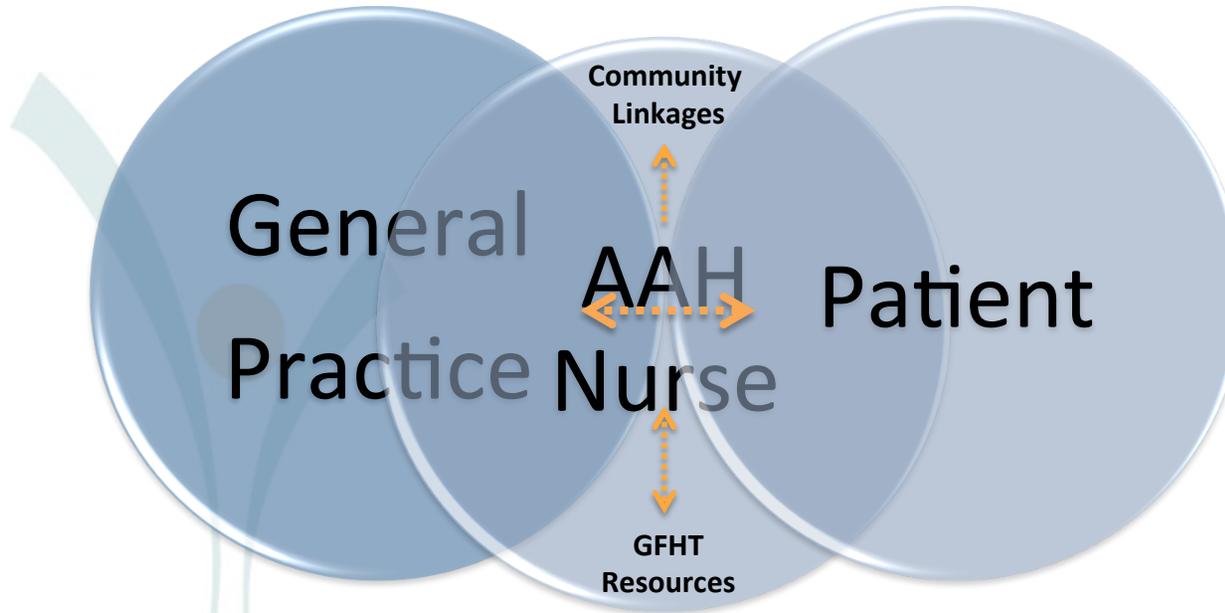
Background

Guelph Family Health Team (GFHT)



Background

Care Delivery Model - Overview



PRIMARY CARE –FRAIL SENIORS-CENTERED MODEL OF CARE

Background

Distinct features of the model

1. An inter-professional team approach to care
2. In-home comprehensive clinical assessment by qualified RNs (physician extender role)
3. Remote/secure access to shared electronic health records through wireless technology to facilitate real time communication with the primary provider

Process

Eligibility Criteria

- ‘ \geq 65 years’
- Reduced capacity to access primary care services
- Primary provider /caregiver report “uneasy feeling” about coping capacity in current environment
- Frequent flyer or observed changes in known health seeking patterns/behaviours
- Evidence of poor management of chronic disease

Process

AAH RN Engagement

- Referrals by primary provider (physician/NP)
- Prioritize in-home visit by individual patient and case load
- Provides Primary care focused in-home visit:
 - Comprehensive and holistic clinical assessments using evidenced based tools (PIECES Framework) to focus on risk identification and management
 - Chronic disease monitoring and preventative care support that include:
 - med compliance and post hospital discharge follow up
 - Episodic event monitoring and management support
 - Collaborates, consults and or triages care to appropriate provider, skill, and team based on patient/ caregiver clinical presentation and timelines
 - Point of care updates to primary provider/care team (EHR, blackberry& or fax)
 - Systems navigation to build capacity and ongoing sustainability
- Negotiates joint /shared visits to facilitate transition between care providers

Process

A Systems Navigator Role

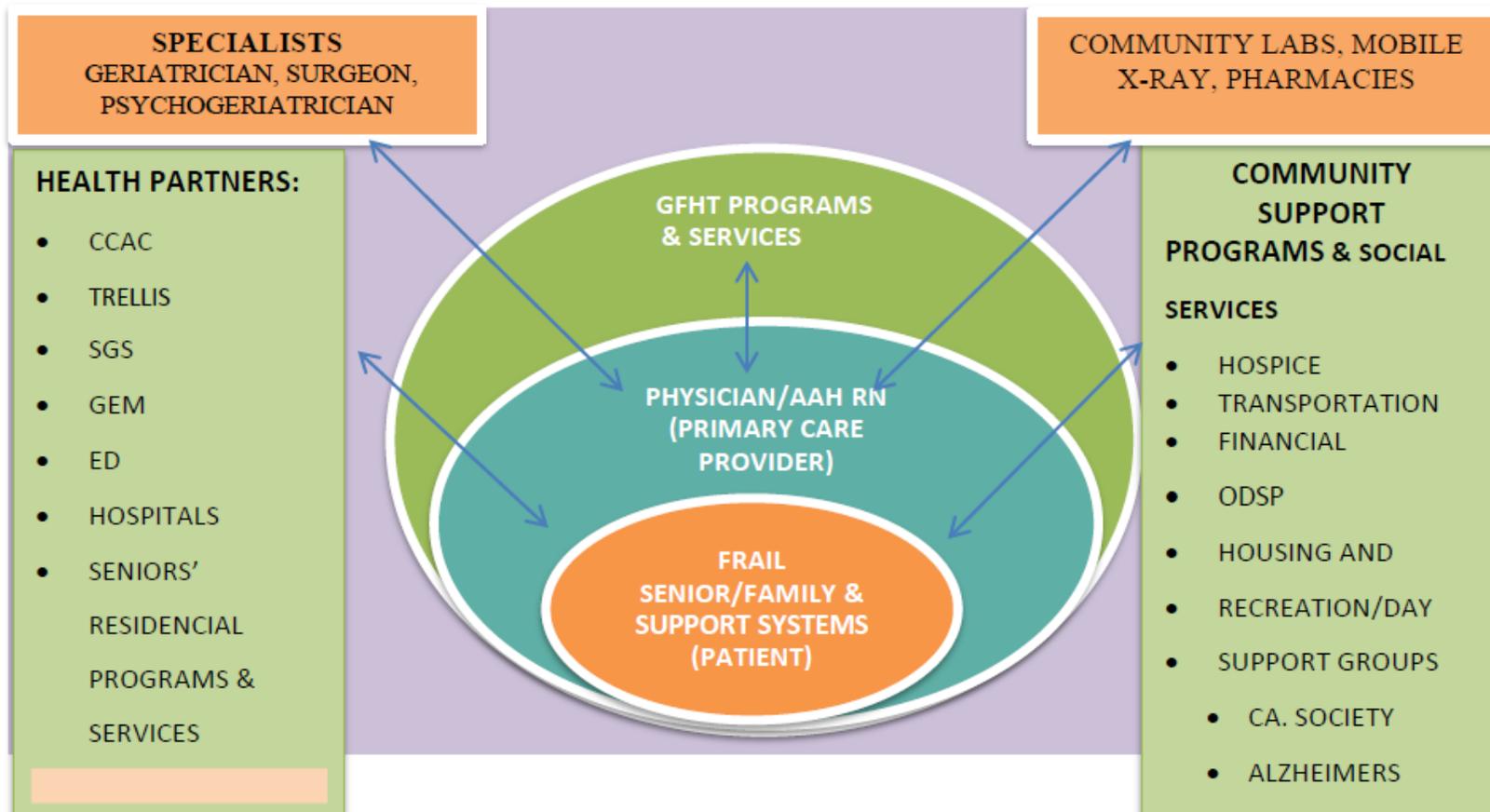


Diagram 1: AAH Nurses as the extension of the Primary care physician and the patient as well as the health care and social systems navigator and advocate.

Process

Case Example 1– “the typical patient”

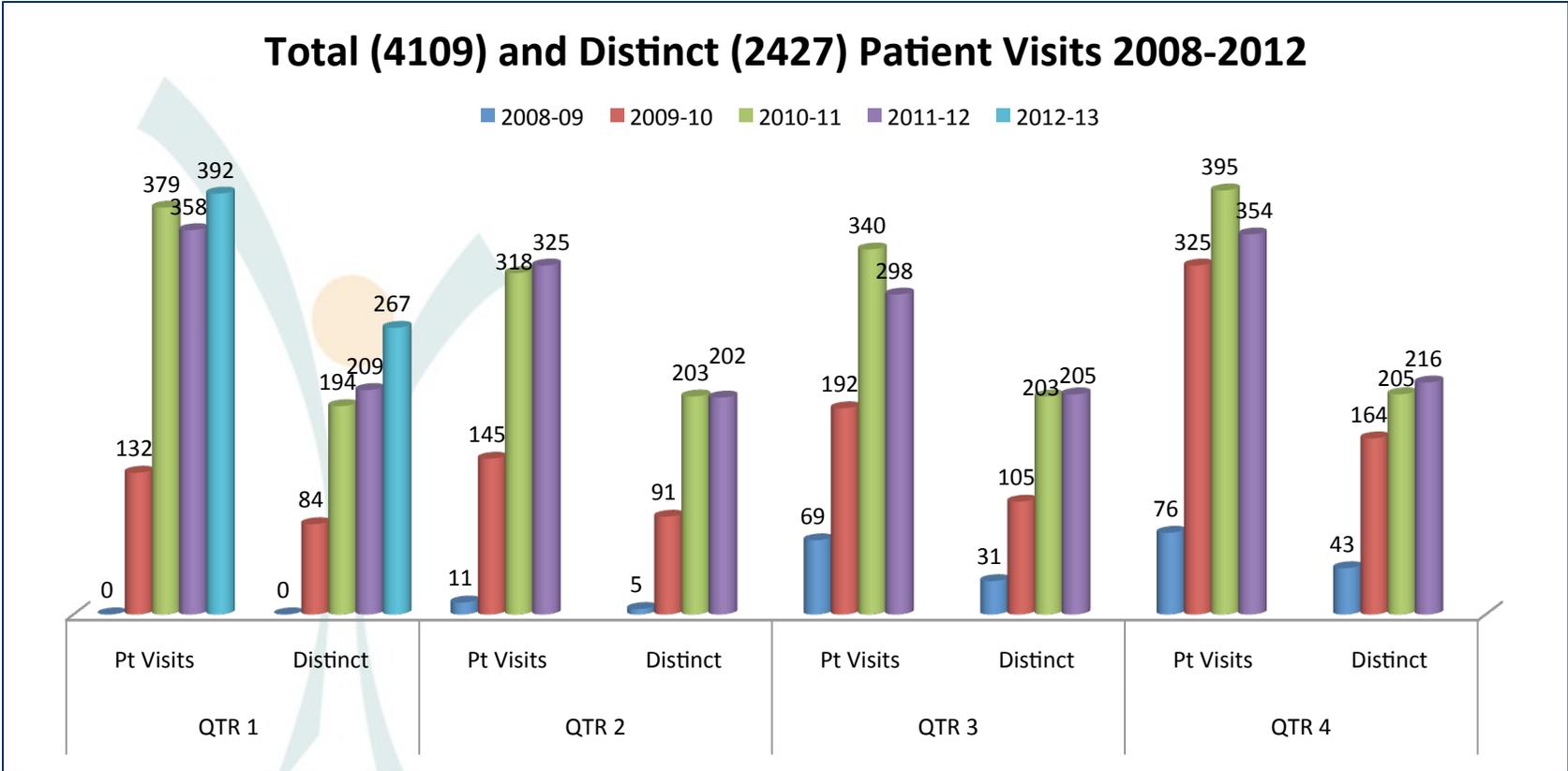
- 90 year old female who lives alone
- Questionable medication compliance
- Missed several physician appointments
- “gut feeling” from family physician that something is not right

Process

Case Example 2 – “the atypical patient”

- 58 year old female
- Referred to AAH program by Mental Health Worker
- Rotting teeth, poor pain management, depression, no community support, medication compliance?

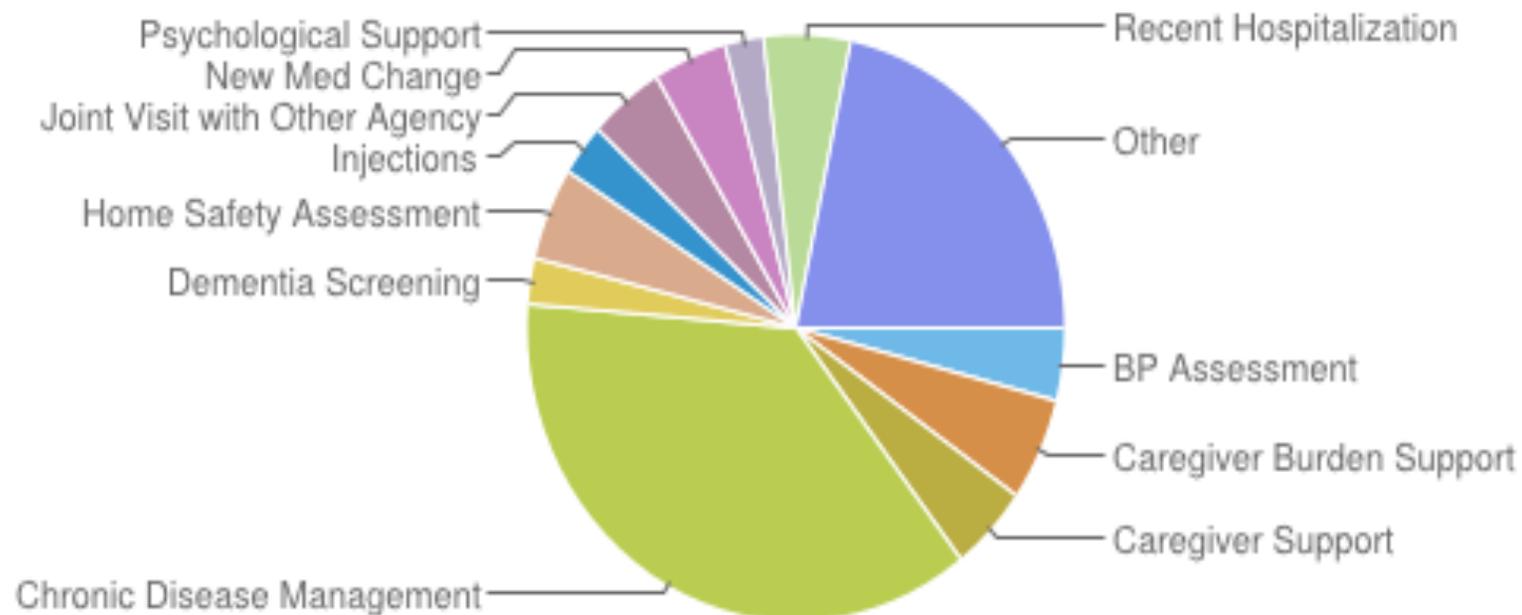
Outcomes



Outcomes

August 2011-2012

Number of Patients by Presenting Problem - Overall
(Aging At Home)



Source: Guelph Family Health Team, IMS Data downloaded July 30, 2012; In-Home Primary Care, Aging At Home Program

Outcomes

Program Evaluation 2011

- Patient /provider telephone survey
 - 15 patients or their caregivers
- Physician questionnaire (survey monkey)
 - participants: n = 47
 - 21 responded (45% response rate)

Outcomes

What our doctors said

- 32% of Physician said AAH reduced ED visits
- 26% of Physicians reported deferred hospital admission
- 100% Physicians used AAH for cognition assessment
- 85% Physicians used AAH for CDM

Outcomes

What our patients said

- 70% of survey participant identified assistance with medication reconciliation, caregiver stress, changes in health status, transition out of hospital.
- Patient told us that:
 - *The service provided a connection to their doctor*
 - *decreased wait times to see a primary care provider*
 - *“The Nurse is marvelous – house calls are great when you’re elderly”*
 - *“The best thing since sliced bread”*

Opportunities

- Lack of resources for special populations
 - the patient and caregiver with hoarding type behaviours
 - The emotionally frail “younger older adult”
 - Hx of Chronic Mental Health
 - Dementia patients with existing chronic conditions
- Coordinating communication amongst all players
- Access to community social work services
- Lack of comparable or baseline data to evaluate impact on ED visit or hospital use

Future Direction

- Base funding for in-home seniors care
- Planning role for frail seniors care by primary care
- Spread model of care across all primary care
- Establish consistent outcome measures to demonstrate impact across health care systems

Questions





Guelph Family Health Team

Thank You

www.guelphfamilyheathteam.com