

The Geriatric Glue

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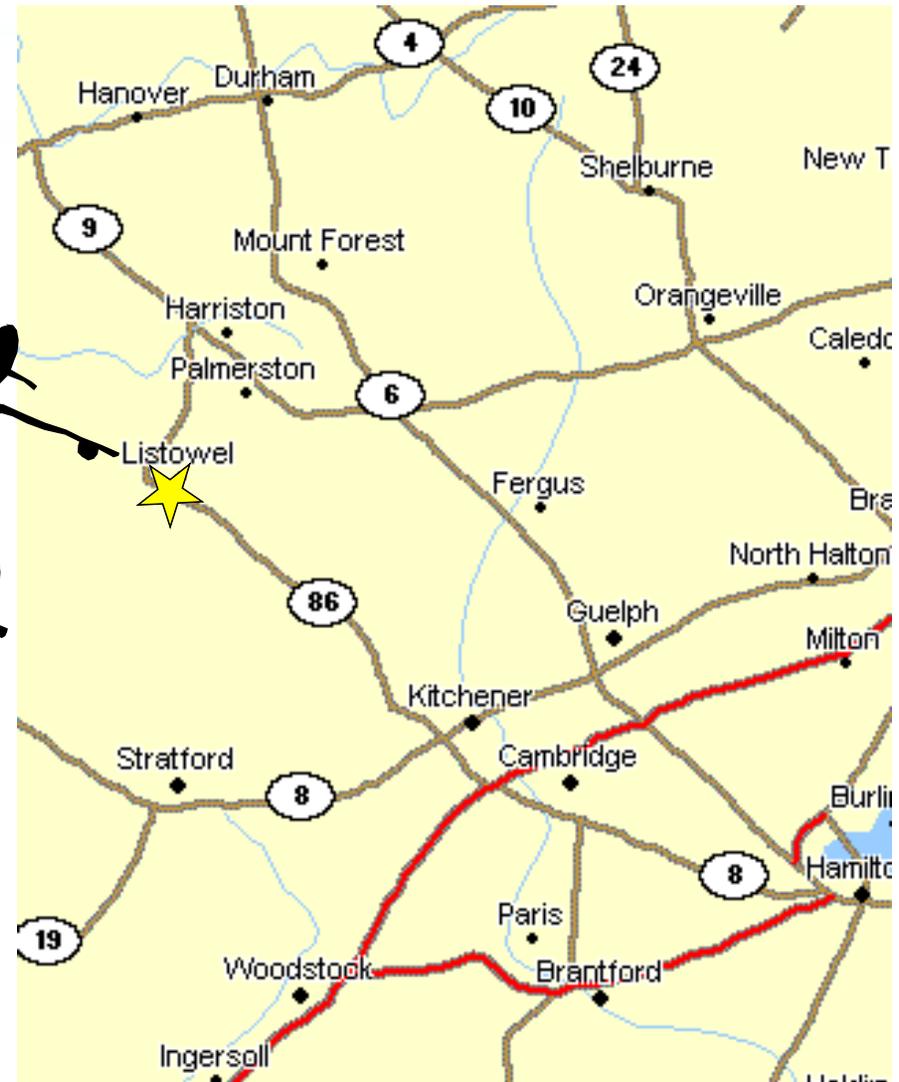
**AFHTO Conference
October 2012**

Objectives

- ▶ Background
- ▶ Describe model
- ▶ What works!
- ▶ Where are we going from here...



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**Fisher Family Primary Care
Centre
185 Inkerman St. East,
Listowel, ON
N4W 2N1**

Organizational Profile

- ▶ 10 physicians practicing
- ▶ Rural health – family physicians managing busy family practice as well as providing obstetrical care, 24 hour emergency department coverage and management of acute/chronic care hospital
- ▶ FHT in operation for 5 years – fully staffed for the past 3-4 years
- ▶ Fully integrated EMR system (Purkinje) between hospital, laboratory/radiology, clinic setting and community partners

NP Background

- ▶ Past experience and education
- ▶ Joined FHT in January 2008
- ▶ Developed program plan and role evolved...



Geriatric services in 2008 when I arrived...

- ▶ Seniors Mental Health Program
- ▶ CCAC – Geriatric Resource Consultant
- ▶ Geriatrician – out patient and in-patient consults at Listowel Memorial Hospital



Program Plan/Goal

“To enable older adults with complex medical conditions to live to their fullest quality of life in an environment that is acceptable to them, safe and that best supports their needs by collaborating with their caregivers (family and health care providers), providing timely assessments in the most appropriate location and partnering with appropriate community supports.”

- August 2008



Program Objectives

Objectives

▶ Short-term

- Build strong working relationships with community partners.
- Provide comprehensive health assessments for older adults including accurate diagnosis, appropriate treatment, support from family physician, timely assessment with any change in condition and access to specialists as needed (geriatrician and geriatric psychiatrist)

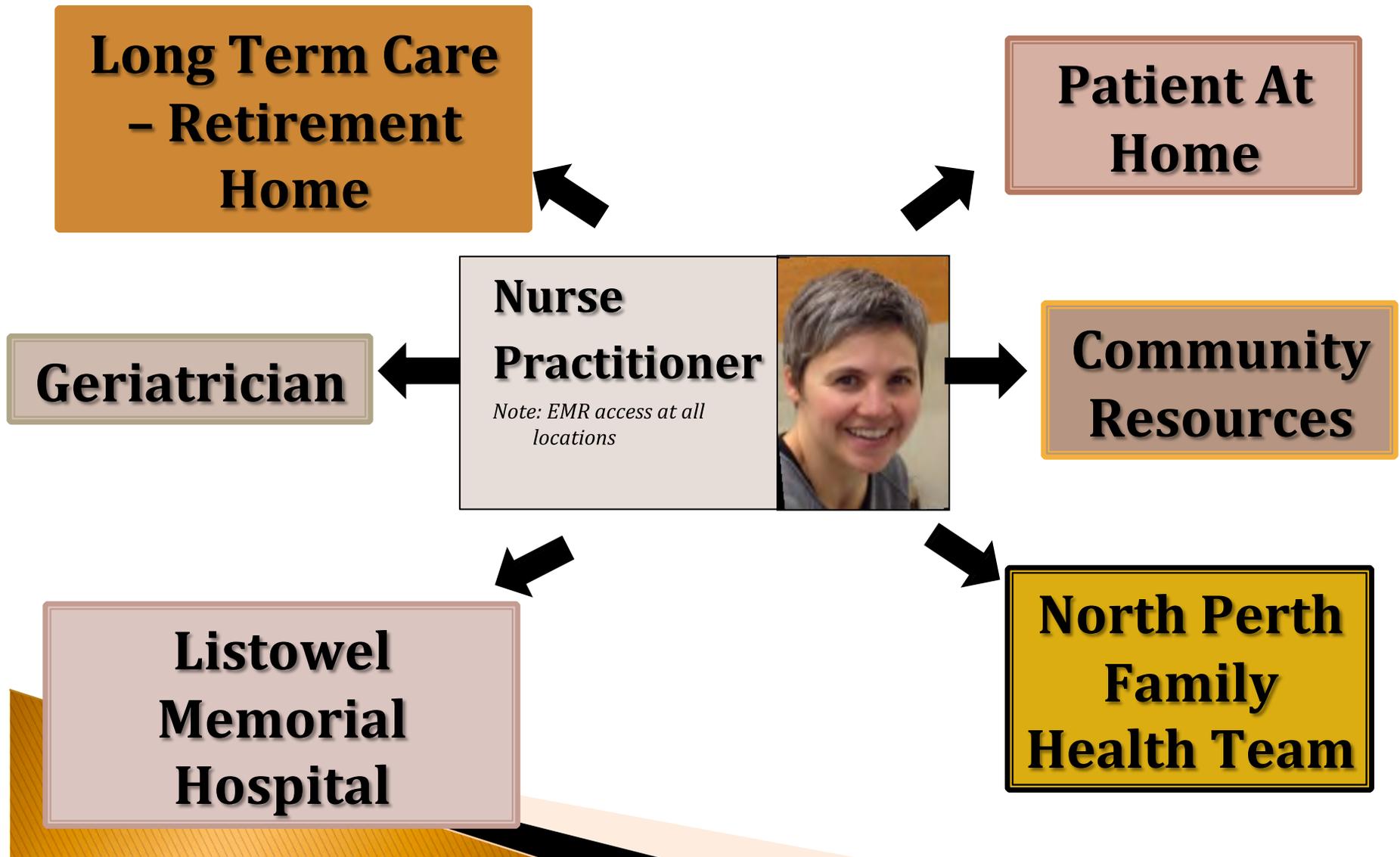
▶ Long-term

- Develop health promotion/proactive/safety awareness programs to minimize risk for seniors (i.e. dementia screening and management, depression screening and management, falls risk assessment, elder abuse awareness, incontinence prevention/management, foot care).

▪ August 2008



The Rural Geriatric Glue



Long Term Care – Retirement Home

“Routine visits from the NP improves the residents’ well-being tremendously – both emotionally and physically. Residents and families feel reassured that they are able to talk to someone who interacts with their family physician on a regular basis and look forward to her visits.”

Number of beds in RH’s in Listowel = 117

	2010/2011	2011/2012	Apr 2012 – Sept 2012
# of visits	585	717	339



North Perth Family Health Team

“There have been a significant decrease in the number of phone calls to the clinic from the RH/hospital and the patients and families feel comfortable that time will be spent on their concerns.”

Sylvia Gibson, Charge Nurse, NPFHT

“...the opportunity to hire a geriatric nurse practitioner, has absolutely transformed the care of the elderly in our community, offering a seamless constancy....”

Dr Barbara Matthews, Family Physician

	2010/2011	2011/2012	Apr 2012 – Sept 2012
# of visits	321	290	134
# of initial assessments	84	64	27

Geriatrician

“...this model of care should be replicated elsewhere. There has been a visceral change in the way I have been able to provide care to the Complex Geriatric Patient since her arrival.” **Dr Sadhana Prasad, Geriatrician**



	2010/2011	2011/2012	Apr 2012 - Sept 2012
# of clinic visits	83	80	34
# of new consults	26	24	11

Listowel Memorial Hospital

“...her expertise in Geriatrics allows us to make appropriate adjustments to treatment modalities....successfully reduced the length of stay on the unit and have successfully returned a significant percentage of our patients to their homes.”

Angela Stanley, VP of Clinical Services/CNE, Listowel Memorial Hospital

	2010/2011	2011/2012	Apr 2012 - Sept 2012
# of visits on acute care	12	14	13
# of visits on complex continuing care	375	550	224

Listowel Memorial Hospital



CCC Patients	Apr 08 - Mar 09	Apr 09 - Mar 10	Apr 10 - Mar 11	Apr 11 - Mar 11
Transferred to LTC	24	26	31	48
Discharged Home	8	42	51	34
Died	11	24	24	24
Transferred to other Acute	0	1	4	5
Admitted	43	94	110	111
Average Length of Stay	277	103.8	82.8	81.57

*** NP weekly rounds and multidisciplinary team discharge meetings began in January 2010.**

Patient At Home

“...without this care she would not have been able to remain in her home. As you know, remaining in her own home is her very determined wish.”

Family



	2010/2011	2011/2012	Apr 2012 – Sept 2012
# of home visits	89	109	41
# of clients supporting at home	32	42	27

Community Resources

“With the significant increase in referrals we are looking to hire another half time support person... and with the automatic referral to us, the pressure is off the client to contact us and they are seen and supported earlier in the disease.” Nancy Martin, Alzheimer’s Society

Alzheimer’s Society North Perth

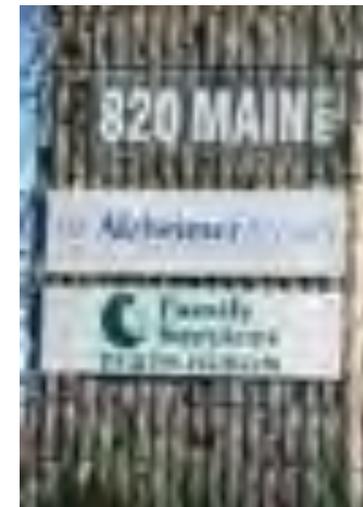
2007 – total clients = 13

2008 – total clients = 28

2012 – total clients = >100

Formal connections with:

- Alzheimer Society
- CCAC
- Canadian Hearing Society
- Arthritis Society
- VON Wellness Program
- Seniors Mental Health



What works!



What works!

- ▶ Assessments over time and across sectors
- ▶ Consistency of care
- ▶ Holistic assessment and connection with caregivers
- ▶ Connecting formally with community resources
- ▶ Working together with the family physician and the specialists
- ▶ Access to EMR at all points in care

Edgar

- ▶ 88 yr old gentleman – living in RH with wife
- ▶ PMHx:
 - severe Chronic Obstructive Pulmonary Disease
 - Atrial Fibrillation
 - History of Transient Ischemic Attacks
 - Osteoporosis
 - severe Aortic Stenosis

Edgar

- ▶ Started visiting RH Jan 2011 – met Edgar and his wife!
- ▶ Emergency room visits
 - 3Dec2010 – LLL pneumonia – admitted
 - 2Feb2011 – persistent pneumonia
 - 6Feb2011 – COPD – admitted
 - 1Apr2011 – COPD – admitted
 - 9May2011 – COPD/pneumonia – admitted
 - 3June2011 – compression fracture
 - 20Apr2011 – muscle strain



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- ▶ Connected with:
 - Respirologist (1 visit in Kitchener)
 - COPD program (NP completed HV with me)
 - Compliance with medication and inhaler technique
 - O2 company
 - Rheumatologist (without him driving to London) – new diagnosis of inflammatory arthritis
 - Multiple discussions with family physician
 - Bi-weekly visits in his home to support both him and wife



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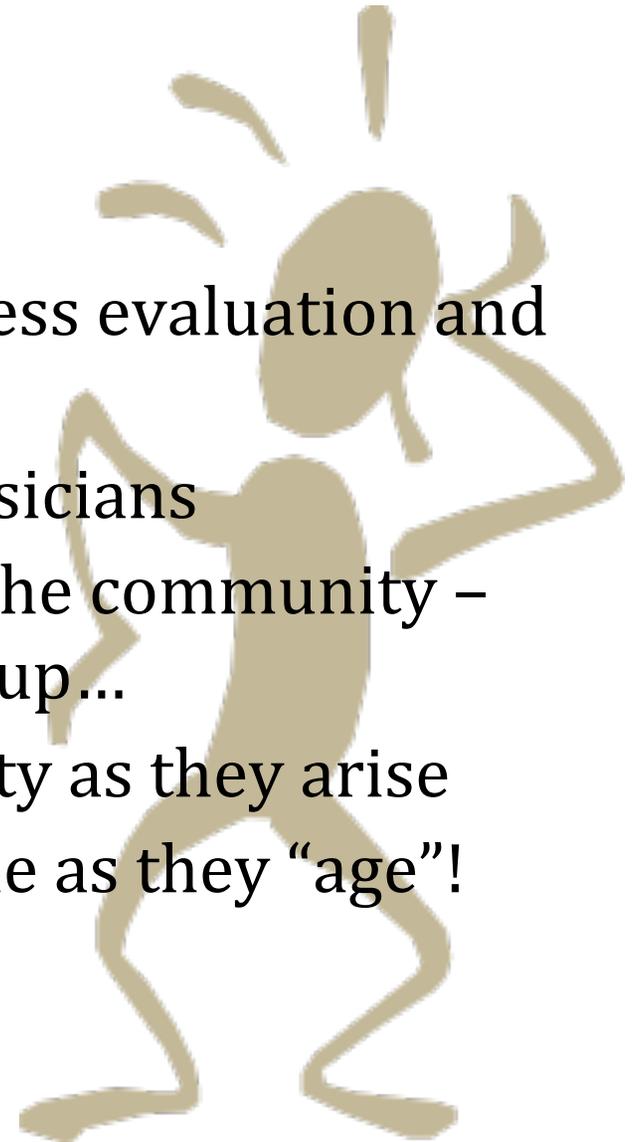
Resulting in

- no trips to emergency department or hospitalization since June 2011!!
- Stable and happy at home!!



Where do we go from here...

- ▶ Sustainability...
- ▶ Further capacity building
- ▶ Decision support – cost effectiveness evaluation and resource management
- ▶ Ongoing partnership with the physicians
- ▶ Continue to develop programs in the community – falls group, dementia network group...
- ▶ Respond to needs in the community as they arise
- ▶ Continue to see and support people as they “age”!



Discussion...

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