



Seniors' Community Hub

Advancing Health of Older Adults in Primary Care
 Partnership with Edmonton Oliver Primary Care Network

THE ISSUE

- Late presentation of frailty to acute care services
- Fragmentation of care & unmet needs
- Difficulty navigating the system
- Caregiver burnout
- Rising number & complexity of older adults
- Polypharmacy
- Long wait times for referrals
- Underutilized Primary Care Network resources
- No standards of practice for frailty identification & management in primary care

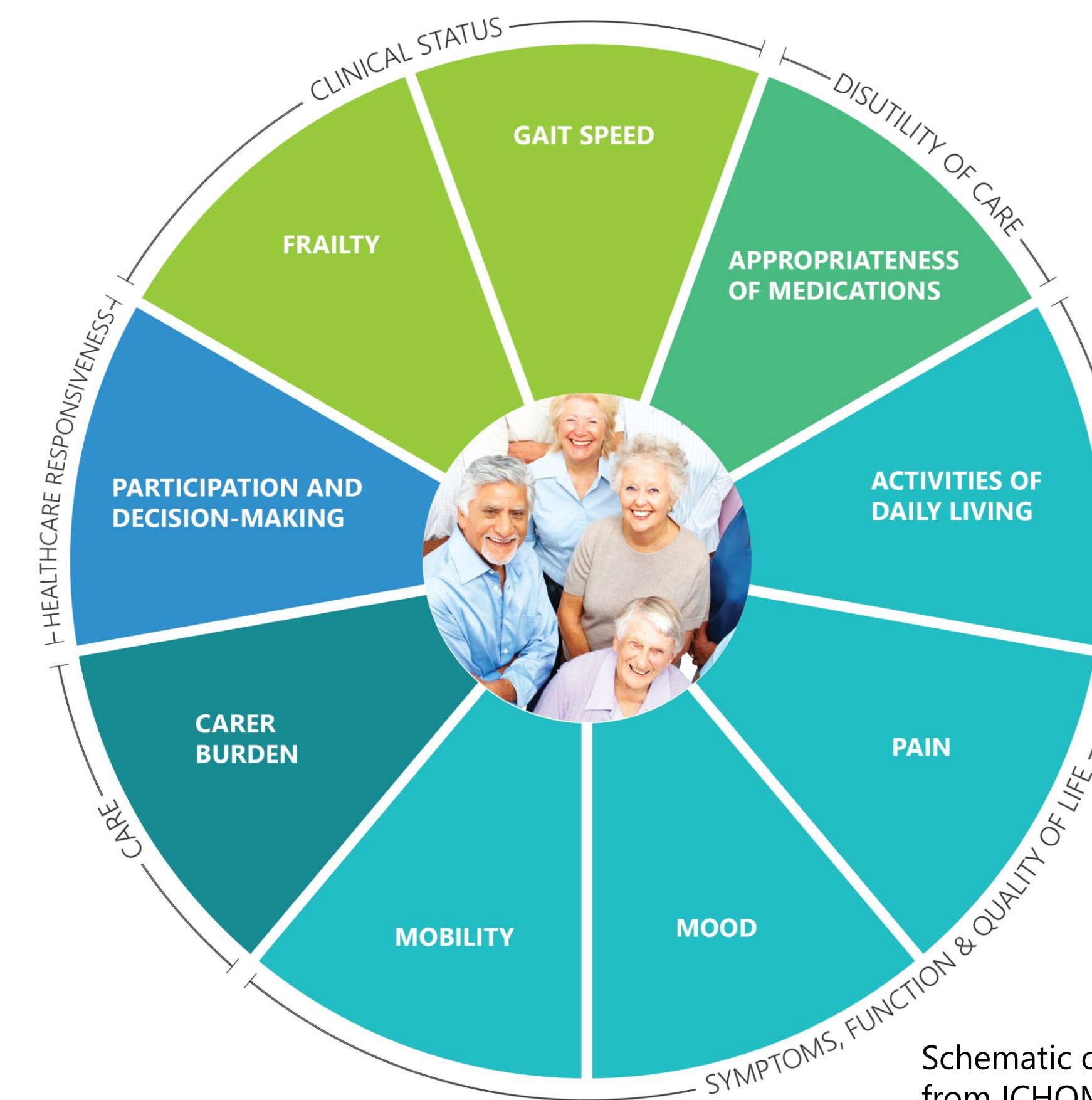
THE INNOVATION

	Structured Process of Care	Education of Healthcare Workforce	Patient & Caregiver Empowerment	Partnership in Care	Metrics
STEP 1	FRAILTY IDENTIFICATION Case finding and risk stratification	<ul style="list-style-type: none"> • Curriculum on interprofessional core competencies and principles of geriatric care; • Skills session on case finding tools, conducting multi-domain assessment, and care planning. 	<ul style="list-style-type: none"> • Patients and families engaged as partners in design, delivery, and evaluation of care; • Patient & Family Advisory Board; • Clinic environment to enhance patient experience. 	<ul style="list-style-type: none"> • Integrating care with social and community support services; • Health Information Technology (e.g. clinical support triggers in EMR); • Increasing efficiency through collaboration. 	<ul style="list-style-type: none"> • Measuring patient/provider /health system level data; • Building consistency of care processes in primary care clinics to improve capacity to collect, analyze and use data.
STEP 2	FRAILTY ASSESSMENT Multi-domain assessment to define components of frailty				
STEP 3	FRAILTY MANAGEMENT Addressing components of frailty				

MEASURE SUCCESS

RESULTS

Patient-Oriented	Provider	System
<ul style="list-style-type: none"> • Functional status using SMAF • Level of frailty (change in index) • Appropriateness of meds (START/STOPP) • Quality of life using EQ-5D/VAS • Carer burden (Caregiver risk screening tool) • Satisfaction of services provided 	<ul style="list-style-type: none"> • Perceptions on collaborative practice • Satisfaction with care provided 	<ul style="list-style-type: none"> • Number of ER visits • Hospital admission days • Long-term care admission • Death



Improvement in:

- Functional status
- Frailty score
- Walk test speed
- Quality of life
- Self reported domains of pain, mood, mobility and usual activities (EQ-5D)
- Caregiver burden
- Appropriateness of medications



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IMPACT

Patient & Caregiver Feedback

"The Seniors' Community Hub has really helped me with my diabetes... I am really happy with my care, it is helpful for planning and has given me better knowledge."

"My relationships with healthcare providers are very important... building up long term rapport is important."

"I am very happy, and I feel listened to."

"One thing about this Hub is that we were able to talk to the pharmacist directly... the pharmacist took his medications and made adjustments. This is one of those things where somebody needs to sit down with the patient and that was what was needed... but it's not normally done."

"... professionals who have time and expertise to help you."

"If it wasn't for that appointment with the Hub, my dad would be in long-term care ... doing nothing with his life."

Provider Feedback

"Helps to make workload of managing frail seniors much easier – helps things get done more quickly and efficiently and reduce duplicated work."

"I have become more aware of team roles and have gradually learned to utilize their expertise."

"HUB makes me feel more confident about how I can deliver elderly care"

"We have helped patients and their caregivers in a variety of ways from providing emotional support, assisting physicians with obtaining diagnoses, linking to community programs such as home care, reducing medications and finding suitable housing."

Org Culture Change & Unexpected Results

"identification of additional reasons for health issues... SCH team noticing wine bottles...during a home visit. I would not have otherwise expected alcohol to be a contributing factor given the history provided by the patient and the collateral from her family." – doctor

"Patients attended the HUB seem to have decreased doctor visits or clinic time as they have more help"-team member

"I also know that my patients are supported when I may not be available. I have had a patient's husband comment "you were away on vacation, but it was fine, because we contacted our HUB team, and they answered our question". - doctor

"Rather than trying to make the patient population fit into their program, they are continuously flexing their initial plan, as they learn more about their patients and their needs..." –citizen advisor

"...integration of the HUB into family practice (with access to the same EMR with visit notes) ensures that there is not a delay in communication."

"[SCH] ...now become an entry point...bringing other community initiatives and programs (...) into a comprehensive, integrated and holistic model for our vulnerable citizens." - citizen advisor

"aware of the value that everyone in every position is providing now... from reception to the nursing, to how the EMR is working, to the doctors, everything.. work end-to-end a little bit better in this model."

"...allowed me to provide more follow-up with patients whether directly or indirectly: more direct follow-up because they can be shorter visits and more indirect follow-up from the updates I get from the team."-doctor

POTENTIAL TO SPREAD

CHALLENGES:

- Adding more to primary care "My bucket is full"
- Culture

RECOMMENDATIONS:

- Incorporate practice change management – *ADKAR* model [Awareness-Desire-Knowledge-Ability-Reinforcement](#)
- Build on prior investments – Patient medical home, Primary Care Network resources
- Engage multilevel stakeholders, including patient and caregivers, on design, implementation and evaluation
- Apply facilitative leadership strategies

Presented through the Canadian Frailty Network Innovation Showcase. Views expressed are those of the authors and do not necessarily represent the views of CFN, CFHI or CIHR-IA.

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