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

Structured Process of Care

<table>
<thead>
<tr>
<th>STEP 1</th>
<th>STEP 2</th>
<th>STEP 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>FRAILTY IDENTIFICATION</td>
<td>Case finding and risk stratification</td>
<td>FRAILTY ASSESSMENT</td>
</tr>
</tbody>
</table>

Education of Healthcare Workforce

- Curriculum on interprofessional core competencies and principles of geriatric care;
- Skills session on case finding tools, conducting multi-domain assessment, and care planning.

Patient & Caregiver Empowerment

- Patients and families engaged as partners in design, delivery, and evaluation of care:
  - Patient & Family Advisory Board;
  - Clinic environment to enhance patient experience.

- Integrating care with social and community support services:
- Health Information Technology (e.g. clinical support triggers in EMR);
- Increasing efficiency through collaboration.

Partnership in Care

- 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.

MEASURE SUCCESS

<table>
<thead>
<tr>
<th>Patient-Oriented</th>
<th>Provider</th>
<th>System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional status using SMAF</td>
<td>Perceptions on collaborative practice</td>
<td>Number of ER visits</td>
</tr>
<tr>
<td>Level of frailty (change in index)</td>
<td>Satisfaction with care provided</td>
<td>Hospital admission days</td>
</tr>
<tr>
<td>Appropriateness of meds (START/STOPP)</td>
<td>Quality of life using EQ-5D/VAS</td>
<td>Long-term care admission</td>
</tr>
<tr>
<td>Quality of life using EQ-5D/VAS</td>
<td>Carer burden (Caregiver risk screening tool)</td>
<td>Death</td>
</tr>
</tbody>
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RESULTS

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

Schematic of SCH results using the framework from ICHOM.org [http://www.ichom.org/medical-conditions/older-person/]
Seniors’ Community Hub

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

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.”

“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.”

Provider Feedback

“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

“The Hub or Similar model allows 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

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

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“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.”

“…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

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

In partnership with: