



Caring for Older Adults in the Community and At Home (COACH)

Presenters:

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Caring for Older Adults in the Community and At Home (COACH)

- VIDEO



COACH...new
thinking and
an innovative
approach to
frailty

Development of COACH

- Reviewed best practice across country
- Criteria for new approach:
 - ▶ Home is Best
 - ▶ Person-centered care
 - ▶ Integration and coordination
 - ▶ Supporting caregivers
 - ▶ Quality improvement
 - ▶ Nurse Practitioner
 - ▶ No new \$\$



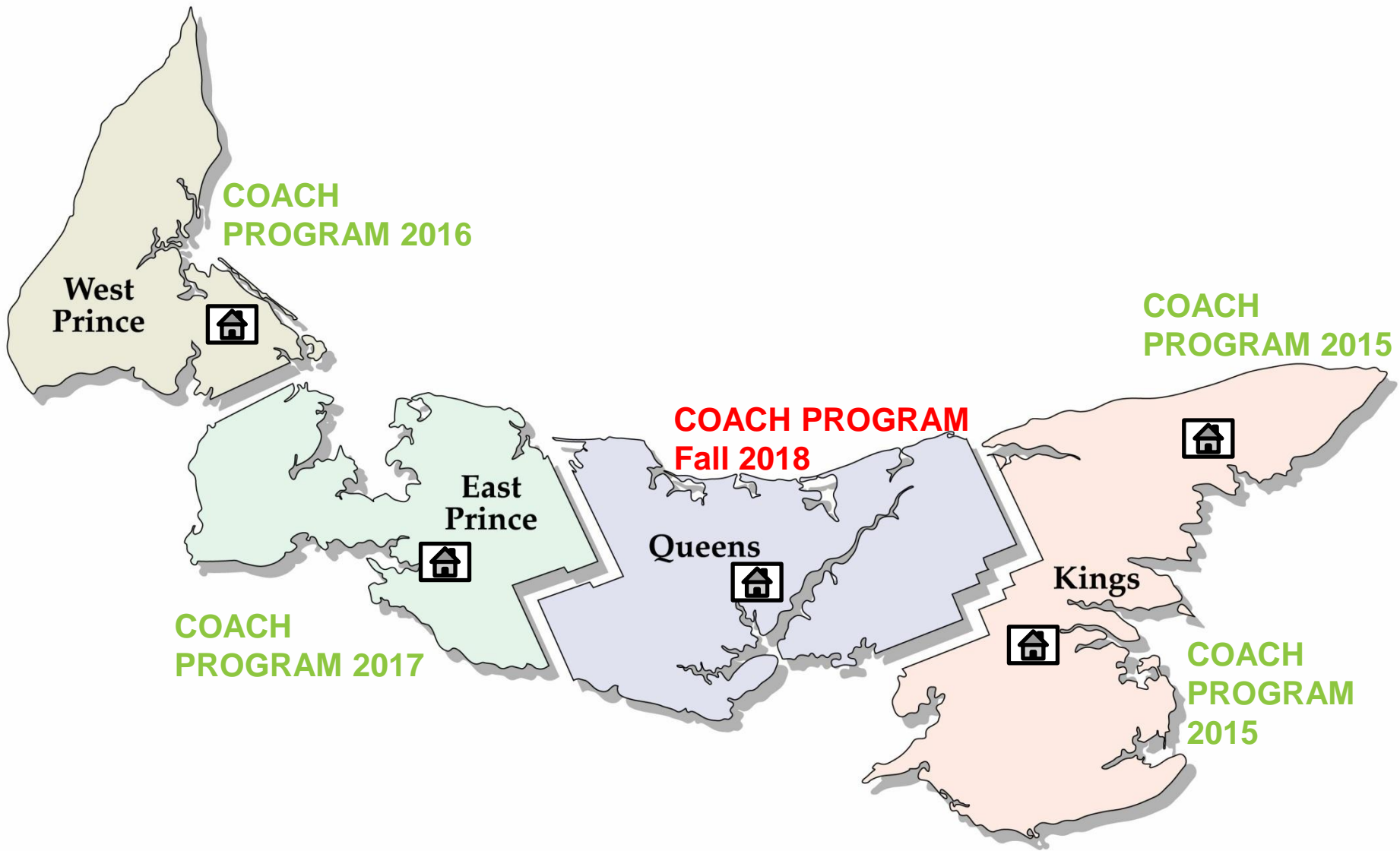
**What do Islanders want?
We asked & Islanders
responded....**

CARE

- In their **COMMUNITY**
- In their home
- ... aging in place

What is COACH?

- Integrated, interdisciplinary expert team with the frail senior at the center
- Leverages Nurse Practitioner expertise
- Building capacity within existing staff/programs



COACH Team Members

- Core members:
 - ▶ Geriatric Nurse Practitioner
 - ▶ Primary Care Provider
 - ▶ Home Care - Care Coordinator

Other team members are determined by identified client needs, including Home Care staff, Primary Care staff and Geriatrician





Health PEI

One Island Health System

The COACH Program improves access to care for Frail Seniors with complex needs...

- CGA with collaboration
 - ▶ Home visits
 - ▶ Hospital
- Priority access to Home Care & Geriatric Program
 - ▶ Teaching/support to family and caregivers on complex geriatric syndromes
 - ▶ Sharing of information for smooth transitions
 - ▶ Facilitating collaborative care planning and advanced care planning



"Everybody has been so good. Every night I say a little prayer for everyone who helps me".

What the numbers said...

- Inpatient admissions decreased by 66%
- Visits to the Emergency Department decreased 33%
- Primary Care Visits decreased by 50% (average appointments/month)

What the people said....

- “The quality of care increased dramatically because of the changes in medications”
- Family Member
- “Personally, my family would not have had the time they did with my father at home, if not for the Home Care, COACH and the Geriatric Programs. These programs apply a priceless positive effect on families they service and the majority of this impact is due directly from the staff which represent each program.” - Family Member

Staff Satisfaction

- I feel very supported by the other team members and, in turn, am able to support our frail patients. I have learned so much from working closely with the Geriatric Nurse Practitioner and the Geriatricians that I feel I am better able to fill my role as a Care Coordinator. Assisting someone to stay in their own home is extremely gratifying.
- - Danita McInnis, COACH Care Coordinator

Recent Data

- Average LOS of stay in LTC for COACH clients who transition to LTC is .65 years
- Average LOS stay in LTC in PEI is 2.6 years

Difference is 1.95 years on average for client at home and in their community...

Benefits for System: Savings of \$1.41 m/13 clients

Benefits for clients/families: *“Their positive impact has been **priceless** and I would suspect their fiscal benefits to the yearly budget, versus the alternative of full care, are a price well worth the investment.”* son of COACH client

Next Steps

- Provincial roll out to final site – Fall 2018
- Continue to demonstrate need- ongoing development of indicators
- Partnerships
 - ▶ Mobile Integrated Health Services
 - ▶ Acute care
 - ▶ Palliative care
- Development of COACH Program materials in both official languages
- Formalize real-time notification for proactive management

Donepezil-

\$40/month

Rollator Walker-

\$300

Having COACH come to your HOME -

PRICELESS!!

Questions...

