Enhancing Primary Care Collaboration for Frail Seniors Living in the Community

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Faculty/Presenter Disclosure

• **Faculty:** Bobbi Junior  
  Marjan Abbasi  
  Sheny Khera

• **Relationships that may introduce potential bias and/or conflict of interest:**  
  • No relationships to declare.
Grandpa
Credentials – Story teller and Caregiver
Shortness of breath?
You’re 72 years old. What do you expect?
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Disclosure of Commercial Support

• This program has received NO COMMERCIAL financial support.
• This program has received NO COMMERCIAL in-kind support.
What was the issue we were addressing?
By 2036, one quarter of the Canadian population will be 65 years of age and older (Statistics Canada, 2014).

Age alone is not the driver! Higher rates of health utilization are from multiple chronic diseases and complexity often associated with ageing (CIHI, 2011; Lee, 2012).

It is estimated that 75% of seniors have at least one chronic health disease, and over 40% suffer from three or more chronic diseases (CIHI, 2011).
• Old age itself does not define frailty

• Most definitions describe frailty as loss of function, strength, physiologic reserve, with increased vulnerability to morbidity and mortality.

• Wide variation in prevalence of frailty in the community depending on the definition used;
  - 9.9% when defined on the basis of physical findings; 13.6% when psychosocial aspects were included;

• Frailty prevalence increases with age, up to 30% by age 90.

• Multiple frailty screening tools have been developed to identify older adults at highest risk for adverse health outcome. No standard of practice in this area.
Impact of Frailty

• On Patient
  • Increased adverse outcomes
  • Falls
  • Increased Dependency and functional decline
  • Increased mortality/morbidity

• On Health Care System
  • Increased Hospitalization/Length of Stay
  • ER Visits
  • Institutionalization

• On Health Care Professional
  • Lack of best practices on recognition, Evaluating and management of frailty
What you see as presenting illness is the tip of the iceberg.

Traditional Medical Model do not recognize the complexity and heterogeneity of presenting illness in frail elderly.
Four Alternative Models

- Synergistic Morbidity Model
- Attribution Model
- Causal Chain Model
- Unmasking Event Model

Diagram:
- Physical and mental health
- Environment and Social circumstances
- Functional Capacity
Now

- “The frail elderly”
- Presentation late and in crisis
- Hospital based

Future

- “An older person living with frailty”
- Early identification, preventative and proactive care; supported by self management and personalized coordinated care plan
- Community based
What did we want to achieve?
INTEGRATED GERIATRIC CARE MODEL FOR FRAILTY

- PROACTIVE IDENTIFICATION
- TEAM BASED ASSESSMENT
- PERSON CENTERED COORDINATED CARE & SUPPORT PLAN

[Diagram]

- Higher risk cases
- 70-80% of people with long-term conditions
- Complex cases with co-morbidities
- High proportion of professional care
- Equally shared care
- High proportion of shared care

NHS Report
How did we go about addressing the issue to reach our goal?
Frailty is a complex and growing issue:

Frailty can be mitigated if identified early & planned interventions

“Care by design not by default”

No standard of practice in primary care for this process

Many guidelines: British Geriatric Society Guidelines
6 essential qualities for services for frailty:
- effective recognition, diagnosis and referral for frailty;
- a person-centred ethos and practice;
- integration of care in multiple settings;
- expertise of staff;
- practice underpinned by comprehensive geriatric assessment and care planning; and
- use of tools to assist case-finding.
PCN Snapshot:

Physicians: 152; 32 Clinics
170,000 patients

- Registered Nurses
- Licensed Practical Nurses
- Social Workers
- Dietitians
- Pharmacists
- Psychologists
- Kinesiologists
- Referral Coordinators
- Screening Coordinators
• EOPCN patient panel is older and at a higher risk than the zone or provincial panels
• EOPCN supports a patient medical home (PMH)
• Team based approach; integrated CDM nurse and allied health providers familiar with the patients, right in the PMH
• Electronic medical record (EMR)
• Focused on quality improvement

• HQCA data 2013-2014 fiscal year, using Clinical Risk Grouper (CRG) to assess and classify individual patients according to the severity of illness and the projected costs to the healthcare system. Measure of chronic and acute conditions ranked on severity (1healthy-9catastrophic)
• 65+ patients: mean CRG 5.0 EOPCN cf. 2.9 Zone cf. 2.8 Provincial panel
• Mean CRG scores: 3.2 EOPCN cf. 2.9 Zone cf. 2.8 Provincial panel
The Seniors’ Community Hub

Funded by Network of Excellence in Seniors’ Health and Wellness, Covenant Health
• Inclusion: ≥65 community dwelling seniors, active patients of the Misericoridia Family Medicine Centre

• Created Structured Process of Care for Frailty
  • Case finding for frailty levels 4-6 in primary care setting
  • Proactive team based approach to assessment and management
  • Create person centered Care & Support Plans
  • Include identification of caregiver burden and support as well

• Workshops to Educate on Frailty & Training sessions on tools

• Understand/Enhance Interprofessional Collaboration and Integration
1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4 Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being “slowed up”, and/or being tired during the day.

5 Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In severe dementia, they cannot do personal care without help.
Process of Care

**IDENTIFICATION**
- CASE FINDING – 4 METER GAIT SPEED; PRISMA 7; electronic FRAILTY INDEX (eFI)
- RISK STRATIFICATION – FRAILTY AND CARE PLANNING ASSESSMENT TOOL (FACT)

**ASSESSMENT**
- COMPREHENSIVE MULTIDOMAIN, INTERPROFESSIONAL GERIATRIC ASSESSMENT
- IDENTIFY POTENTIAL REVERSIBLE AND MODIFIABLE RISK FACTORS

**CARE AND SUPPORT PLANNING**
- CREATING AN INDIVIDUALIZED, PATIENT CENTERED CARE AND SUPPORT PLAN
- CDM NURSE CASE MANAGER/NAVIGATOR
Patients who are ≥65 yo enter the SCH via multiple routes of entry:
- Self-referral
- Pharmacy Discharge
- PMH team referral
- Panel review

Recruitment process and inclusion criteria

Inclusion criteria:
- Patients: community-dwelling seniors (≥65yo), active patients (seen by the clinical staff in last 3 years), give consent, [PRISMA ≥3 OR 4m walk test ≥5s OR eFl ≥0.13 OR 4m wt ≥5s], FACT 4-6
- Caregivers: ≥ 18 yo, consent

Legend:
Roles and responsibilities (boxes and arrows) are colour-coded.
- Chronic disease management (CDM) nurse

** Levels of frailty according to the FACT: 1 – thriving; 2&3 – normal aging; 4 – vulnerable; 5 – mild; 6 – moderate; 7 – severe; 8 – very severe.
<table>
<thead>
<tr>
<th>Baseline Mobility</th>
<th>Social</th>
<th>Function</th>
<th>Cognition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Thriving</td>
<td>○ Fit, exercises regularly (among fittest for age)</td>
<td>○ In charge of organizing social events</td>
<td>○ Still working at job or high level hobby</td>
</tr>
<tr>
<td>2+3. Normal Aging</td>
<td>○ Active/exercises occasionally</td>
<td>○ Socializes weekly &amp; would have a caregiver if needed</td>
<td>○ Subjective impairment (i.e. Does everything on own but finds things more difficult)</td>
</tr>
<tr>
<td>4. Vulnerable</td>
<td>○ Starting to slow down and often tired during the day</td>
<td>○ Socializes less than weekly OR might not have a caregiver if needed</td>
<td>○ Not dependent on others but symptoms often limit activities</td>
</tr>
<tr>
<td>5. Mild</td>
<td>○ Walking slower and regularly uses (or should use) a cane or walker</td>
<td>○ Socializes rarely</td>
<td>○ Needs help with some instrumental activities of daily living (IADLS) (e.g. housework, banking or medications)</td>
</tr>
<tr>
<td>6. Moderate</td>
<td>○ Needs help of another person when using stairs, walking on uneven ground, or getting in/out of bath OR Has fallen more than once in the past 6 months, excluding slip on ice</td>
<td>○ Mostly house-bound</td>
<td>○ Needs assistance or dependent for IADLS and cueing with basic activities of daily living (BADLS) (e.g. help choosing what to wear or requires reminders to bathe)</td>
</tr>
<tr>
<td>7. Severe</td>
<td>○ Always needs someone’s help or supervision when walking OR Unable to propel self in manual wheelchair</td>
<td>○ House-bound and isolated OR caregiver stress/or no available caregiver to meet care needs</td>
<td>○ Needs hands on help with BADLS (bathing, toileting, dressing)</td>
</tr>
<tr>
<td>8. Very Severe</td>
<td>○ Bed bound, unable to participate in transfers</td>
<td>○ Unable to participate in any social exchange, even when visited</td>
<td>○ Dependent for all aspects of daily life</td>
</tr>
<tr>
<td>9. Terminal</td>
<td>○ Terminally ill with a life expectancy ≤ 6 months regardless of function, cognition or mobility status</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Signature _______________________________ Date __________________________
“Intervention” of the SCH CARE & SUPPORT PLANNING

- COMPREHENSIVE MULTIDOMAIN, INTERPROFESSIONAL GERIATRIC ASSESSMENT
  - INFORMATION GATHERING
  - DRIVEN BY ACTIVE PATIENT & CAREGIVER INVOLVEMENT GOALS AND PRIORITIES
  - CDM NURSE WITH GAN MENTORSHIP

- CASE CONFERENCE
  - PCN inter-professional team, GAN, CDM nurse and MD
  - SHARE/CONTRIBUITE AND DELIVER CSP ROLES & RESPONSIBITILITES
  - IN PERSON VS VIRTUAL COLLABORATIVE SPACE

- CDM NURSE CASE MANAGER/NAVIGATOR
  - CSP COMMUNICATION WHAT & HOW
  - Follow up
Outcomes

Quasi-experimental one group pre-post- study design.

• Description of the characteristics of the patients served in terms of demographics, level of frailty, and interventions and services provided

• Measurement of the impact of the SCH on hospital admission rates, emergency department visits, patient-caregiver satisfaction, interprofessional collaboration

• Explore the experiences of the SCH
Baseline measurements (“Pre”)

**Patients:**
- Quality of Life (EQ-5D)
- Functional status (SMAF)
- Frailty score (FACT)
- Utilization of health services (length of stay in a hospital, # of ER visits, etc.)
- Timed gait test (4 meter walk test time), PRISMA 7, eFI

**Caregivers:**
- Risk to caregiver’s physical or mental well-being (Caregiver Risk Screening Tool)

**Healthcare providers:**
- Healthcare team members’ perception of working collaboratively (Collaborative Practice Assessment Tool)

*Health utilization data is obtained from AHS administrative data at time points 12 months prior, at baseline, 12 and 18 months post-intervention.*
Patients:
• Quality of Life (EQ-5D)
• Functional status (SMAF)
• Frailty score (FACT)
• Utilization of health services (length of stay in a hospital, # of ER visits, etc.)
• Satisfaction survey

Caregivers:
• Risk to caregiver’s physical or mental well-being (Caregiver Risk Screening Tool)
• Satisfaction survey

Healthcare providers:
• Healthcare team members’ perception of working collaboratively (Collaborative Practice Assessment Tool)

6 and 12 month measurements (“Post”)

Add in future qualitative research component to explore the experiences with the SCH by patients, caregivers, healthcare providers
Our first patients
SCH patients flow

N=46 pts approached/screened
- N=24 Consented to be in the study and screened using eFl, 4m walk test, PRISMA7
- N=2 Declined participation in the study
- N=17 Enrolled in the study (FACT 4-6)
- N=11 CGA completed by the geriatric assessment nurse
- N=20 Screened using eFl, pending consent and further assessment
- N=2 FACT is pending
- N=2 CGA is pending
- N=5 Excluded (4-FACT 7&8 or 1-unable to obtain collateral report)
- N=4 CGA is not required (followed at the Senior’s Clinic or by other clinicians)
Characteristics of patients approached/screened (n=44)

- Age: M=79.30 (SD=7.92)
- Sex: 30 (68.2%) females
- Route of referral to the SCH: 30 (61.4%) panel review
- eFl: M=0.22 (SD=0.1. range 0.03 – 0.5)
Demographic characteristics of the SCH sample (n=17, by Nov 23, 2016)

- Average age 83.7 (SD=6.243; range 74 – 96)
- Sex: 8 males, 9 females

**ROUTE OF REFERRAL (N=17)**

- Panel review: 23%
- PMH team referral: 77%

**REASON FOR REFERRAL (N=17)**

- Cognitive impairment/dementia
- Falls and decreased mobility
- Depression
- Medication review or polypharmacy
- Other (gastroenterology issues)
- Caregiver burden
- Chronic pain
- Home support
- Medically complex
Results of the screening for frailty

12 (70%) patients scored 3 and more on PRISMA7.

17 (100%) scored 0.13 and more on eFI.

9 (53%) spent 5 seconds and more on walking 4 meter distance at their usual pace.
Frailty Assessment for Care Planning Tool (FACT):

Among 46 patients, FACT assessment was done for 22 patients. 5 patients were excluded from the study due to: FACT>6 and/or unable to obtain collateral report.

FACT scores:
- 4 – vulnerable
- 5 – mild
- 6 – moderate
- 7 – severe
- 8 – severely frail

LEVEL OF FRAILITY ACCORDING TO FACT (N=17)

- vulnerable (4), 2
- mild (5), 1
- moderate (6), 14
Number of chronic conditions and active medications (n=17)

- Number of active medications (n=17): M=8.5, SD=3.7.
- The average number of chronic conditions (n=17): M=4.6, SD=1.5.
- All 17 patients whose charts were reviewed had 3 and more chronic conditions.
- 14 out of 17 had 5 and more active medications.
- 24 CGs approached
- 20 CGs gave consent to be in the study
- 17 were included in the study. 13 completed the Caregiver Risk Screening Tool (9 females and 4 males). Duration of care provided ranged from 0 (no care is needed since a senior is living independently) to 12 years.

2 caregivers scored more than 17 (high and very high risk) on Caregiver Risk Screen.
What did we learn?
Key Elements of the Seniors’ Community Hub program

Seniors’ Community Hub

Patient engagement

- Patients and families are engaged as partners in designing and evaluating delivery of care to improve health outcomes

Team-based care/collaborative practice

- Health care professionals provide patient-centred care by collaborating with each other, patients, families and caregivers
  - Partnership with external agencies and associations

Education/Building capacity

- Interprofessional education
  - Training CDM nurses in Comprehensive Geriatric Assessment (CGA)
  - Training for screening and assessment of frailty

Process of care

- Case finding frailty in primary care (FACT 4-6)
  - CGA
  - Medication review
  - Case conferencing
  - Case management
  - Patient Education & Self Management
  - Personalized care & support planning

Caregiver support

- Screening caregivers for the risk to their emotional and/or physical wellbeing
- Linkages to community support services

Health Information Technology

- Enhancing the EMR with screening and assessment tools
- Using EMR data to calculate electronic frailty index
- Embedding Clinical best practices/Care pathways
- Creating a virtual collaborative space
Relationships with health care professionals can make a difference

People in stable well-functioning relationships develop a larger meaning and purpose in life and are more motivated to protect themselves against disease/illness/injury (Sullivan, 1997).
The Seniors’ Community Hub helps each senior define what ‘quality of life’ means for them, and then they work together to maintain that.
Who might they be to others?

NANCY  Age 91

RENNIE  Age 90