The Rural Geriatric Glue

Dr Sadhana Prasad, BSc, MD, FRCP(C),
FACP(Geriatrics), Associate Clinical Professor of Medicine
(Geriatrics) McMaster University

Wendy Dunn, NP(Adult)

North Perth Family Health Team
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March 2013

Objectives

- To describe a model for rural geriatric care.

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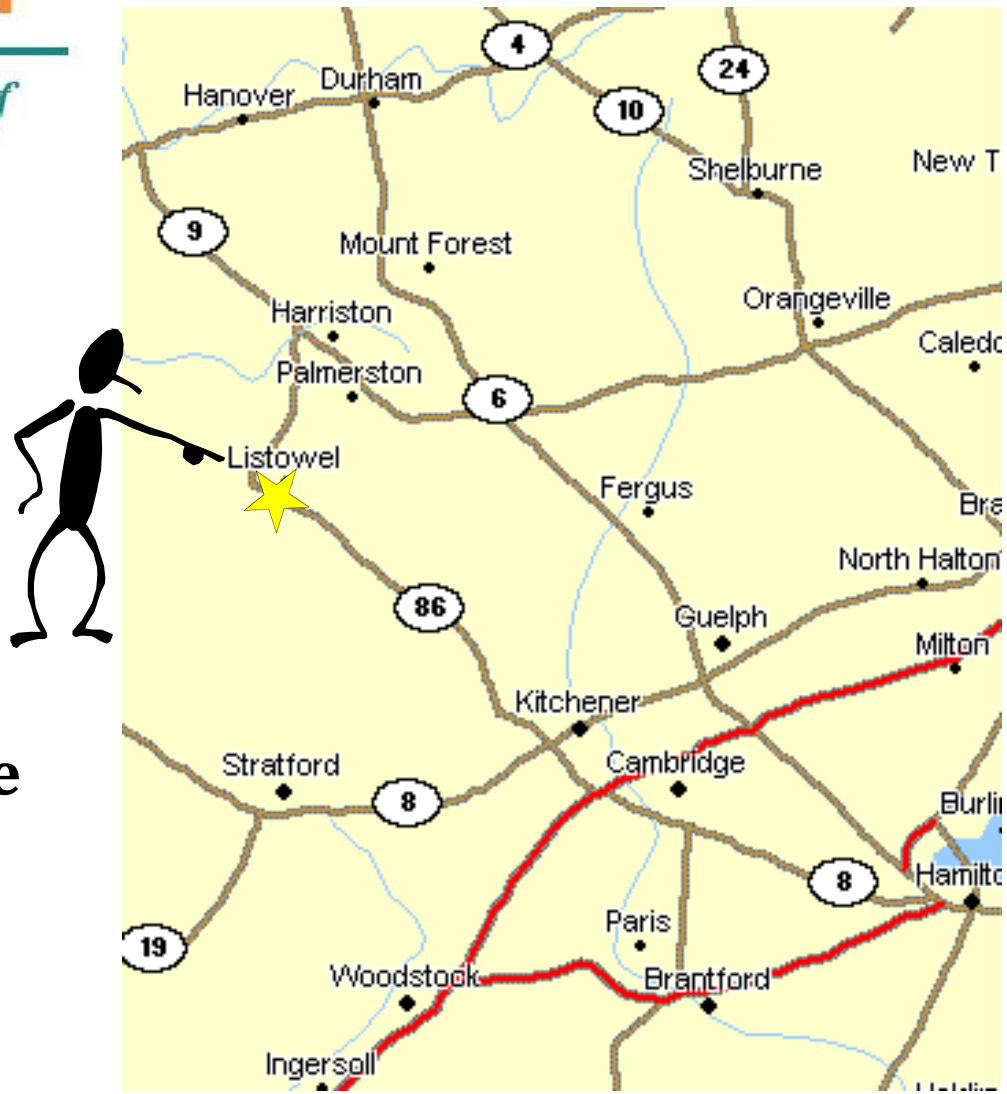

Fisher Family Primary Care Centre
185 Inkerman St. East,
Listowel, ON
N4W 2N1

Organizational Profile

- 10 family physicians
- Rural FHT in operation for 5 years
- Fully integrated EMR system between hospital, laboratory/radiology, clinic, community partner (community rehab clinic)
- Lead organization for Health Links 2013

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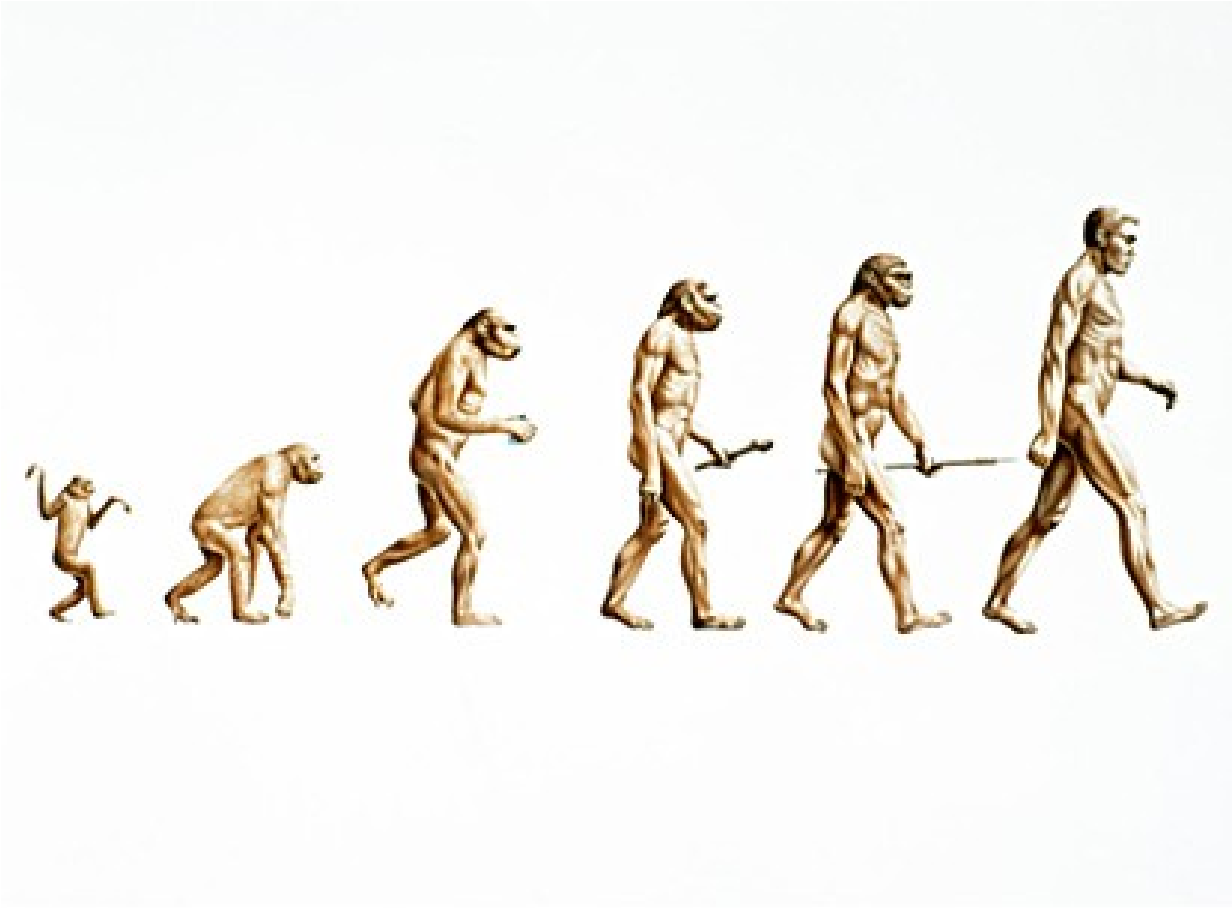
Geriatric services in 2008 when I arrived…

- Family physician assessments
- Seniors Mental Health Program – Geriatric Psychiatrist and nursing/SW support
- CCAC – Geriatric Resource Consultant for Perth County supported by family physician (RGP initiative)
- Geriatrician – out patient and in-patient consults at Listowel Memorial Hospital (LMH)

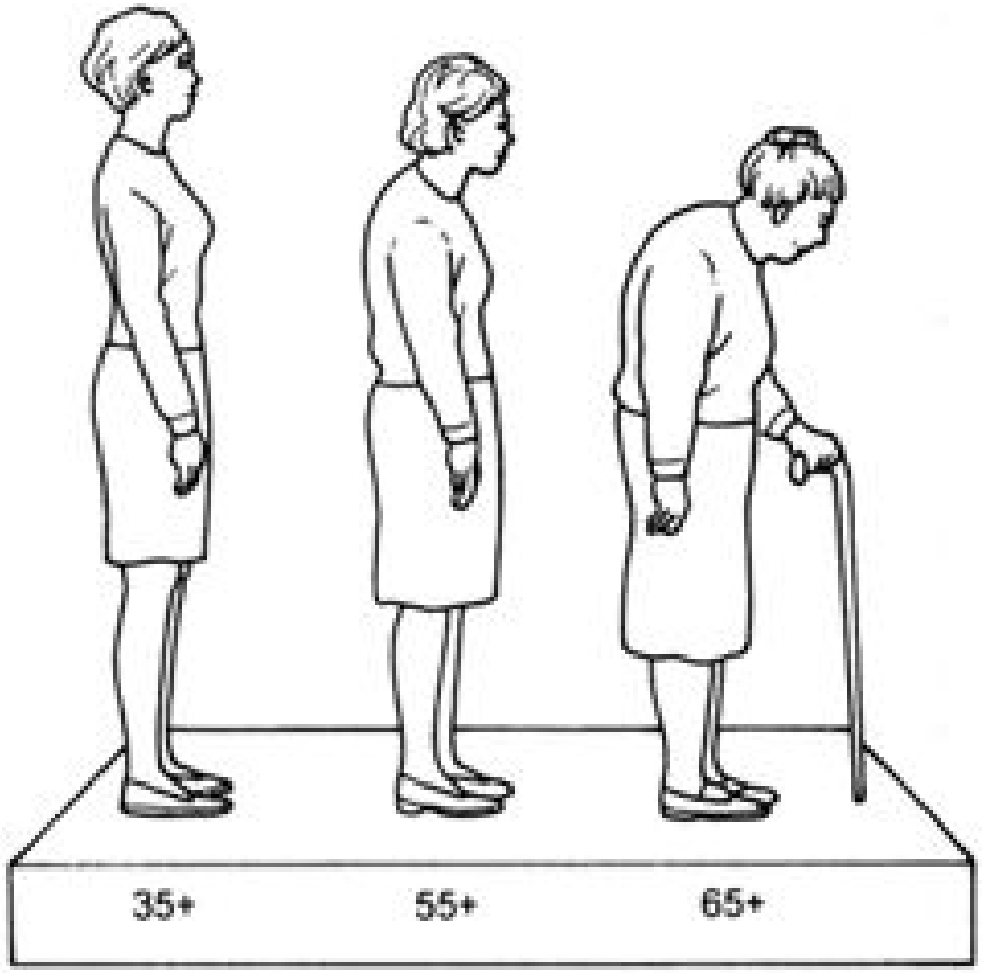
NP Background

- NP Geriatrics at St Mary's General Hospital with Dr Prasad
- Joined FHT in January 2008
- Geriatric experience in LTC, chronic care, community (PSW and RN)
- Developed program plan and role evolved…

Evolution…



OR...



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

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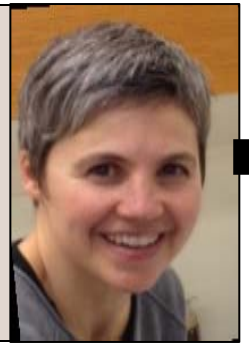
Long Term Care – Retirement Home

Patient At Home

Nurse Practitioner

Note: EMR access at all locations



Geriatrician

Community Resources

Listowel Memorial Hospital

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Care for Seniors program today

- Referrals:
  - Family physician
  - Families/patient
  - Other health care providers within the FHT/FHN
  - External agencies – CCAC, Alzheimer's Society
  - Retirement Homes
  - Listowel Memorial Hospital (LMH)
  - Complex Continuing Care – LMH

*****High risk – seen within 1-3 working days**
Low risk – seen within 10-14 working days

*****Tip: KEEP THE REFERRAL PROCESS SIMPLE!! – verbal referral**

Care for Seniors program today…

- Assessments
  - Functional/social – ADLs, IADLs and social supports
  - 3 D's, incontinence, falls, POA, safety, end of life care, etc.
  - Physical exam and chronic disease management
  - Medication reconciliation
  - Collateral history
  - "Magic wand" question
  - Use of standardized tools – MOCA, GDS, SIGECAPS, PHQ-9, FBI

*****Tip: COMPLETE OVER A NUMBER OF VISITS IN THE MOST APPROPRIATE SETTING.**

Care for Seniors program today…

- Develop plan of care
  - Include all members – patient, social support/family, family physician, community partners
  - Communicate plan
  - Arrange follow-up and referrals – Geriatrician, Geriatric Psychiatrist, CCAC, Alzheimer's Society, Arthritis Society, etc.

*****Tip: BE FLEXIBLE AND CREATIVE – PLAN-DO-STUDY-ACT MODEL.**

Long Term Outcomes

- Improved early detection and intervention
- Improved capacity at a primary care level to manage chronic health conditions in the elderly
- Reduced unnecessary use of health system resources (decreased phone calls/visits to office)
- Enhanced transition across health sectors
- Improved care coordination and integration across the continuum of care
- Enhanced linkages across the continuum of care

Improved capacity, care coordination and transitions (Apr 2011-Mar 2012)

Retirement Home
(117 beds – 717 visits)

Patient At Home
(42 clients– 109 visits)

Geriatrician
(24 new consults – 42 follow up visits

Nurse Practitioner

Note: EMR access at all locations

Community Resources
(Alzheimer's Society : 13 clients in 2007, >100 in 2012

Listowel Memorial Hospital
(25 beds – 550 visits on CCC and 14 assessments on AC)

North Perth Family Health Team
(64 initial visits – 290 follow-up visits)

Retirement Homes

- 4 Retirement Homes – visit each Home every 2 weeks and as needed
- Acute/episodic management
- Chronic disease management
- Connect to external services to enhance care – CCAC, Alzheimer's Society, Arthritis Society
- Build capacity

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Patient at Home

- 2.5 visits/patient/year - Not onerous!!
- 2-3 home visits/week
- Homebound patients – acute/episodic and chronic disease management
- Enhance geriatric assessment by seeing in home
- Joint home visits – CCAC, Geriatrician, Geriatric Psychiatrist
- Grateful family

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Community Resources

- Needed to create enhanced programs in the community to support needs/referrals
- Falls prevention working group
- Dementia networking group

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- Decreased phone calls and visits to the clinic
- Team approach – easy, face-face consultation

"…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

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Listowel Memorial Hospital - CCC

CCC Patients	Apr 08 - Mar 09	Apr 09 – Mar 10	Apr 10 – Mar 11	Apr 11 – Mar 12
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.**

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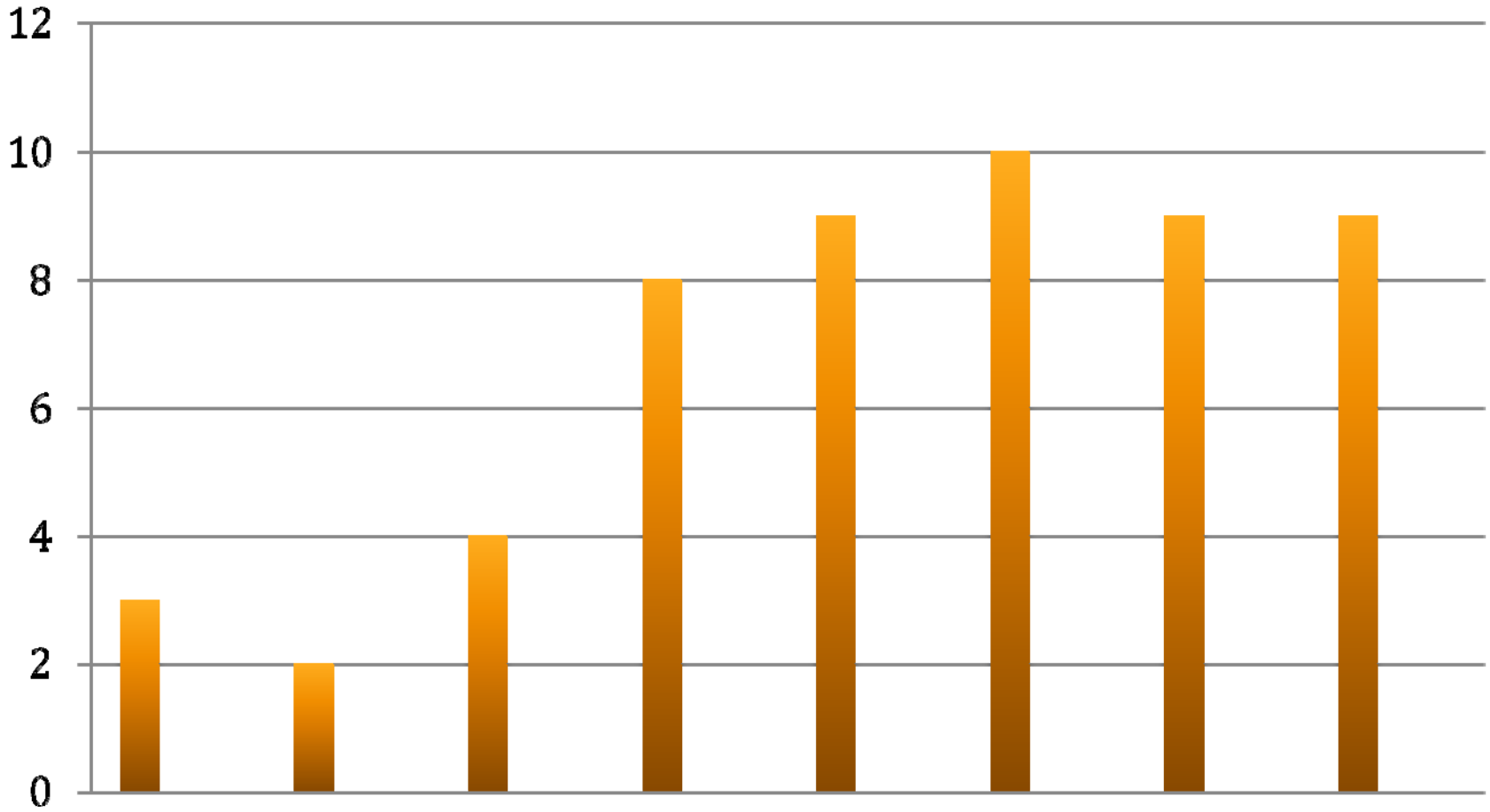
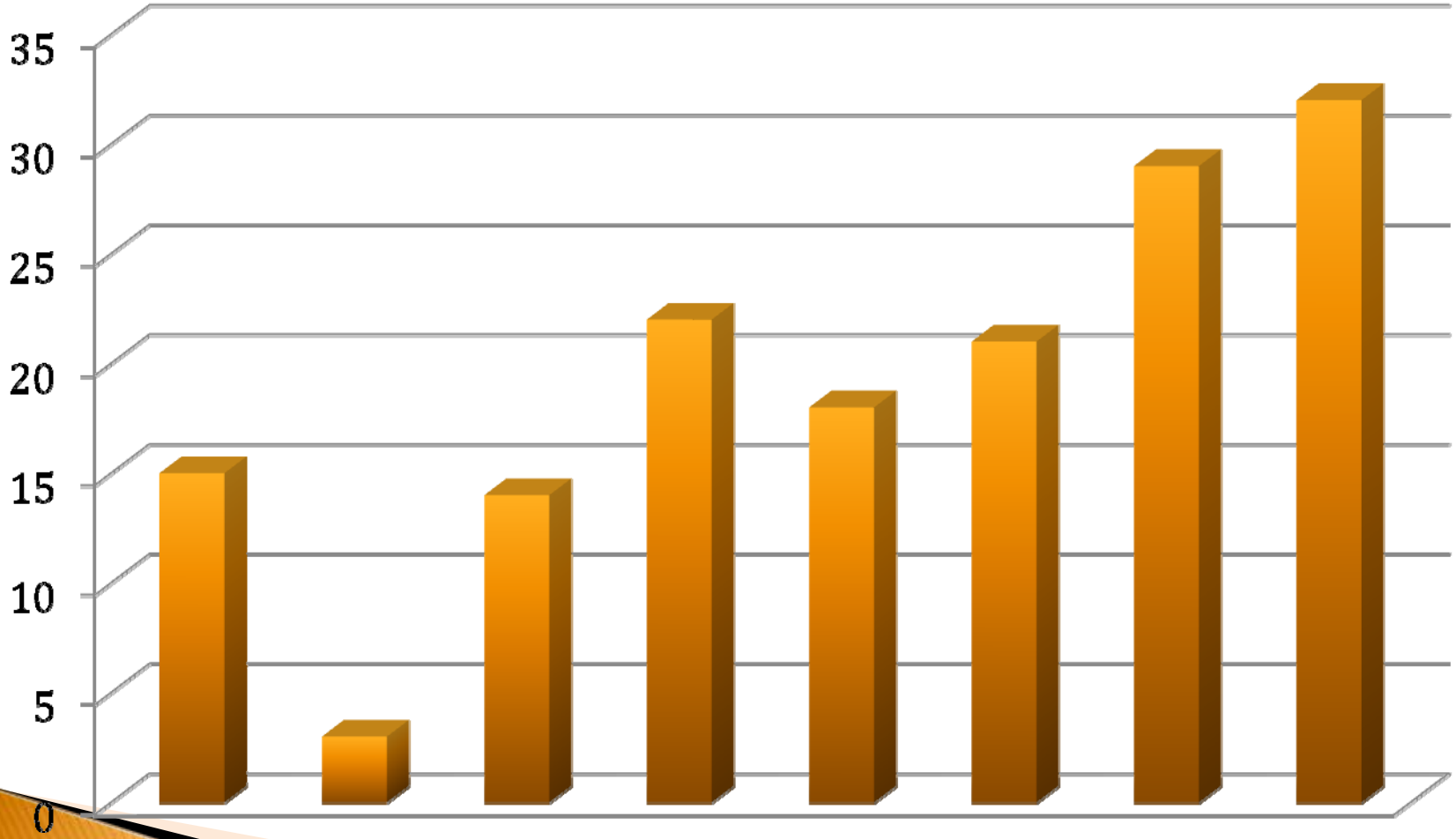
Geriatrician

- The Specialized Geriatric Medicine service was disorganized, chaotic, and inefficient before NP involvement
- The case finding has increased as reflected in numbers; hence earlier intervention

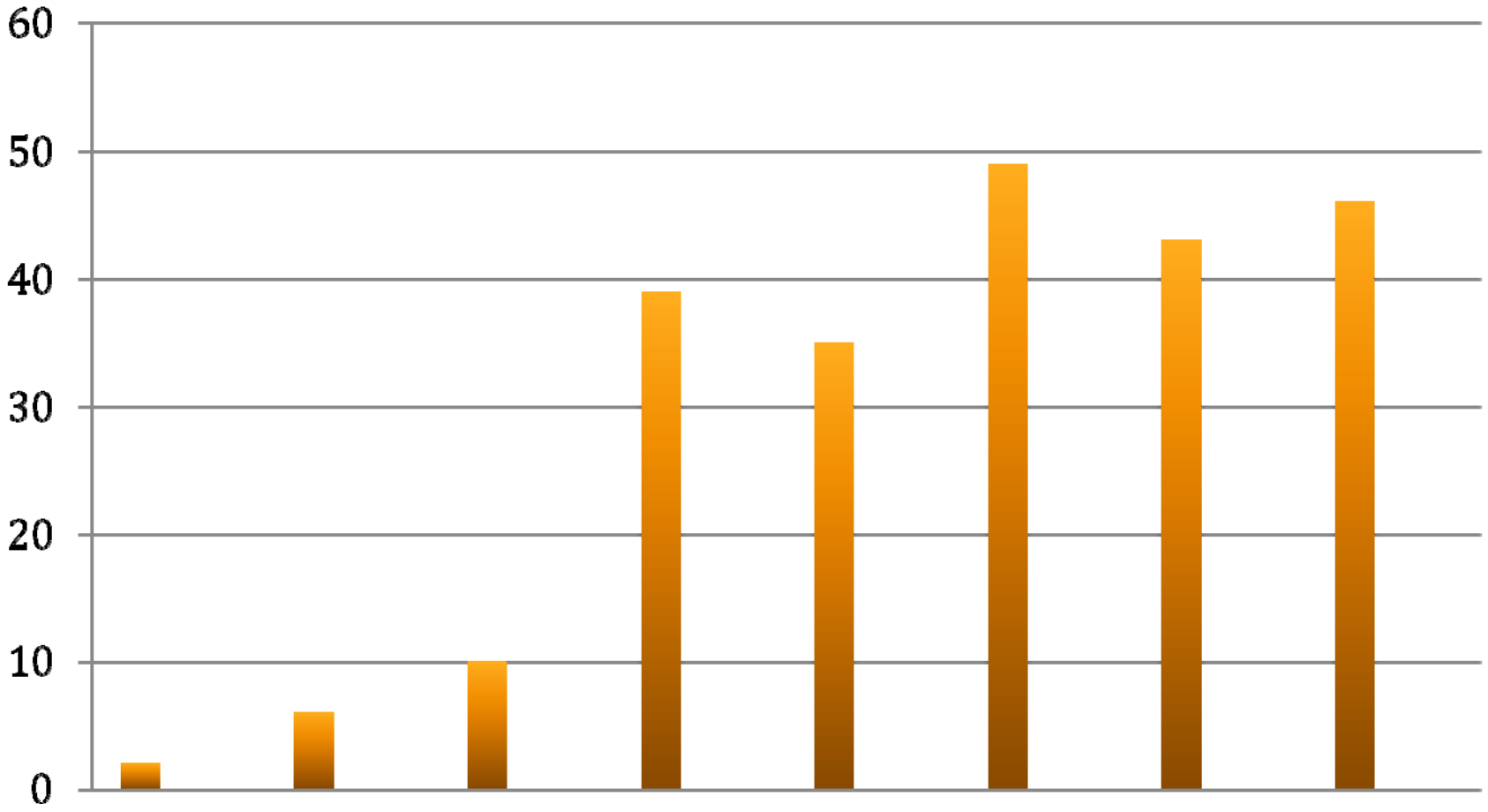
Geriatrician – Frequency of visits to Listowel (2005-2012)



Geriatrician – New Consults (2005-2012)



Geriatrician – Follow-up visits (2005-2012)



Geriatrician data

	2005	2006	2007	2008	2009	2010	2011	2012
NEW	15	3	14	22	18	21	29	32
F/U	2	6	10	39	35	49	43	46
FREQ	3	2	4	8	9	10	9	9

Research

Action research or **participatory action research**

- doing research with and for people, rather than doing research on them
- focuses on working with people to identify problems in practice, implement solutions, monitor the process of change, and assess outcomes
- can influence practice while systematically collecting data

Participatory action research. Canadian Family Physician, Oct 2002. http://www2.cfpc.ca/cfp/2002/Oct/vol48-oct-resources-3.asp

Action Research in Health Care

- appeals to clinicians because it translates into action much faster than traditional research
- flexible in a constantly changing clinical environment
- no need to control the variables, a situation impossible to achieve in clinical practice or in communities

Participatory action research. Canadian Family Physician, Oct 2002. http://www2.cfpc.ca/cfp/2002/Oct/vol48-oct-resources-3.asp

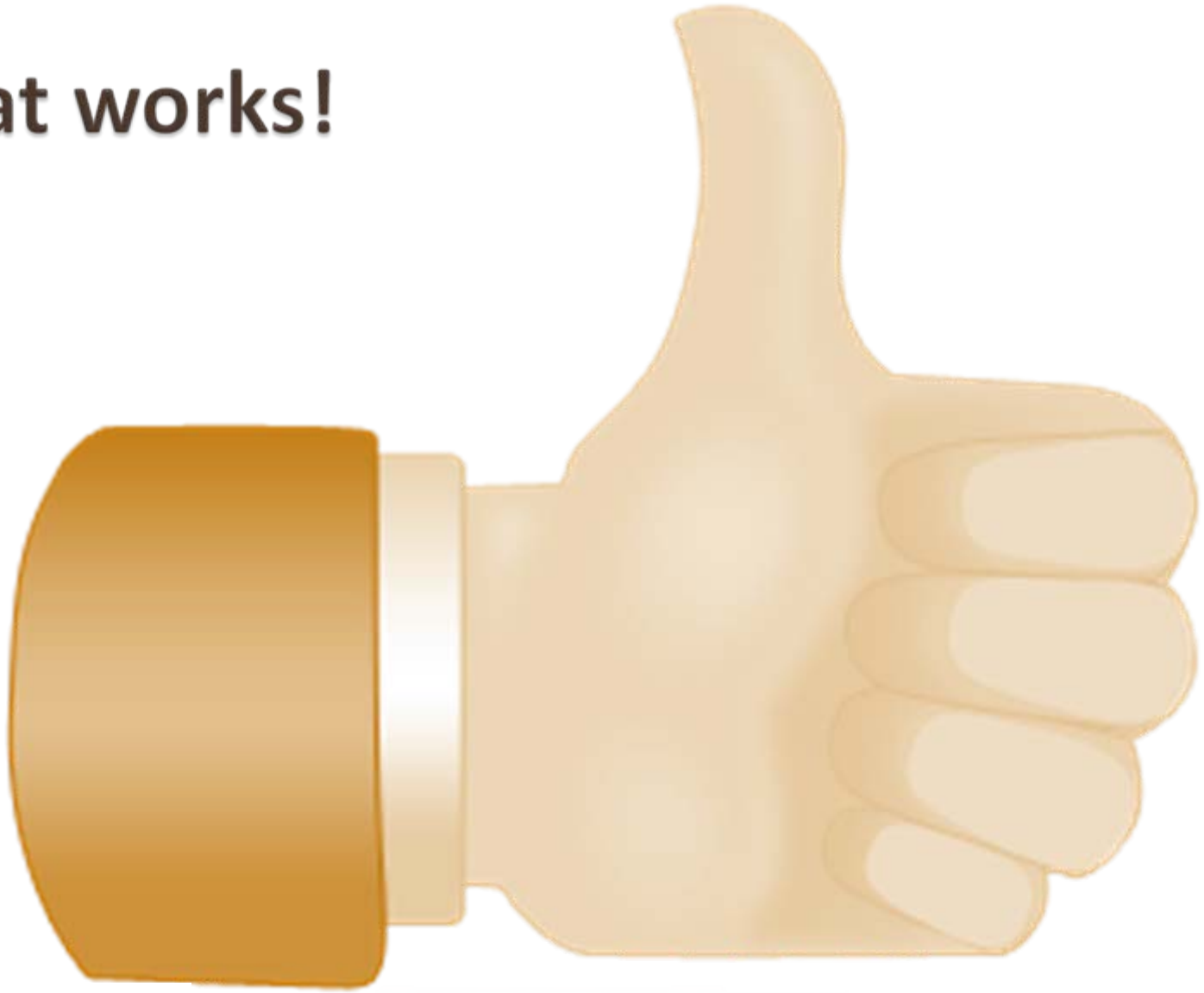
Investigative Methodology

- Action research – Plan-Do-Study-Act
- Mixed methods – qualitative and quantitative
- Ecosystem approach
- Organic...

Discussion

- A retrospective analysis of a model of care
- Process evolved gradually into current approach
- Seeing less patients in the traditional setting
- Seeing more patients in their current environment
- The real “glue” in this model is the Nurse Practitioner developing roles and relationships over time
- The bonus is the ability of the NP to access the patient’s complete Electronic Medical Record (EMR)

What works!



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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
- Building capacity across sectors

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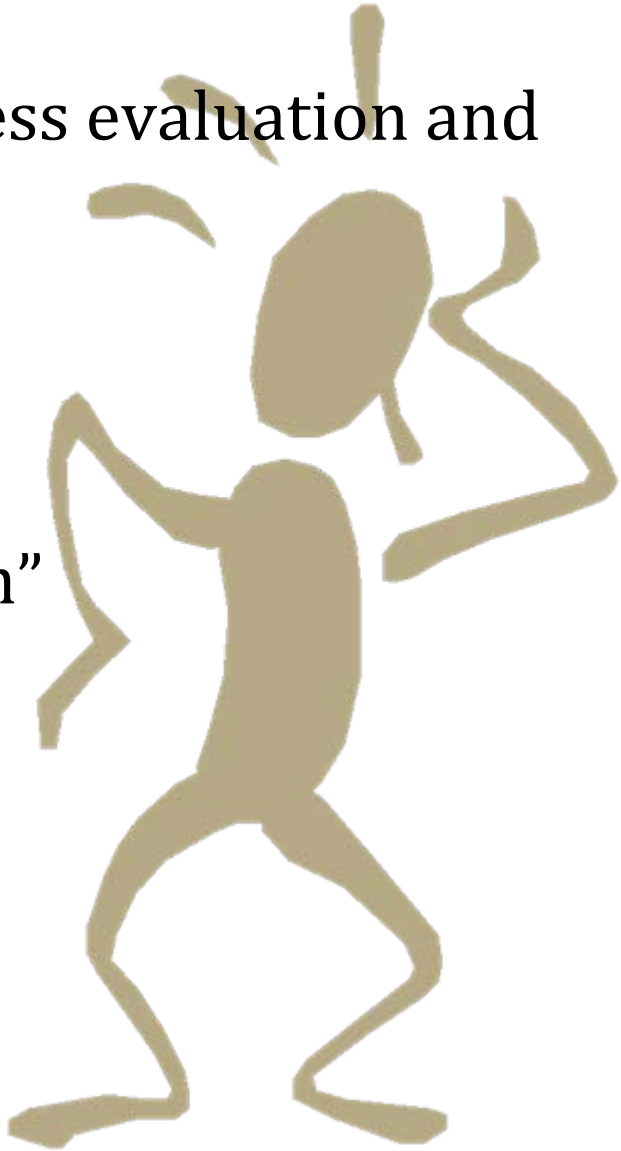
Limitations

- Decision support – cost effectiveness evaluation and resource management
- Retrospective data
- ?? similar models for comparison
- Data collection challenges – ie. ER avoidance/decrease use of “system”



Discussion…

sprasad@smgh.ca

wdunn@npfht.ca

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