Transforming primary care for older Canadians living with frailty

Canadian Home Care Association 2018 Home Care Summits

Alison Kernoghan, University of Waterloo

Canadian Frailty Network | Réseau canadien des soins aux personnes fragilisées

The Federal Network of Centres of Excellence Program

ghs Geriatric Health Systems Research Group

University of Waterloo

Outline

- Previous research from the Geriatric Health Systems Research Group
- Ontario pilot study in primary care
- CFN Transformative Grant, “Transforming primary care for older Canadians living with frailty”

Past health system research

- Our past research projects and workshops have included consultations with over **800** older adults and health care providers from across the health care system
- Through this work, there was recognition that primary care should be the hub of care coordination for older adults
- There is value in a well-integrated system that strongly links primary care and home care

Why Primary Care?

- Primary care is seen as “gatekeeper”, helping patients navigate the system and coordinate their care
  - For many, it is the entry point into the health care system

- An opportunity for broad impact - reaching the greatest proportion of patients, at the earliest point, facilitating relevant referrals based on assessed need and patient preference.

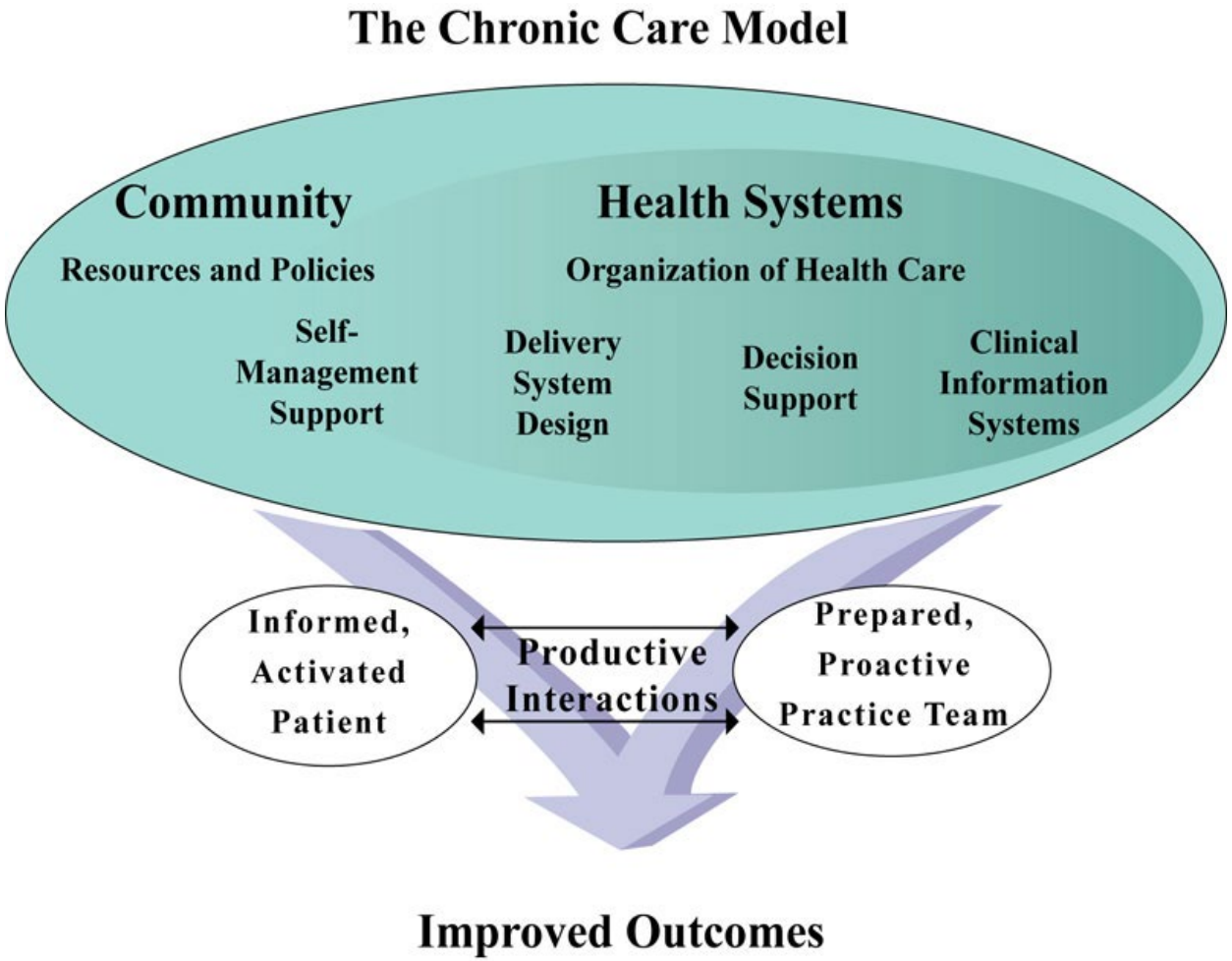
Health system challenges

- Older Canadians are high users of health care services, but the health care system is not well-designed to meet the needs of those who use it most (Schoenman, J. A., 2012).

- Many older adults are challenged by chronic illness, and often with multiple conditions. Identified shortcomings in the management of chronic conditions:
  - Rushed office visits with practitioners
  - Lack of care planning and care coordination
  - Patients who are not trained or informed adequately to manage their care.

- Patients may have health problems that are not properly assessed, managed or treated leading to poorer health, as well as preventable and expensive emergency department visits and hospital stays.

The Chronic Care Model



Pilot work in Ontario

- We worked with 2 primary care sites (Family Health Teams) in Ontario to:
  - **Understand the current context:** referral processes between primary care and community care organizations, services offered by community organizations and facilitators/barriers to care coordination
  - **Develop and implement** a screening and referral process to improve care coordination

Pilot work: Interview results

The current context in primary care:

- ❑ "We don't have a lot of conversation going back and forth between primary care and community care."

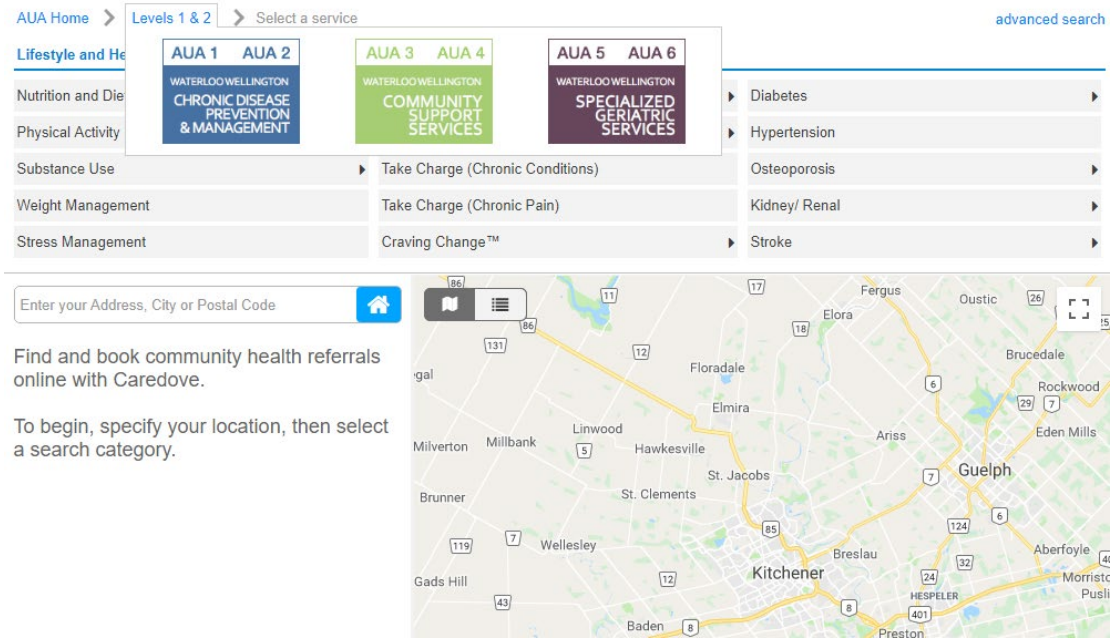
- ❑ "Patients and caregivers are not engaged in decision-making as much as they could or should be. Many feel powerless – not knowing what is available to them or how to **work the system."**

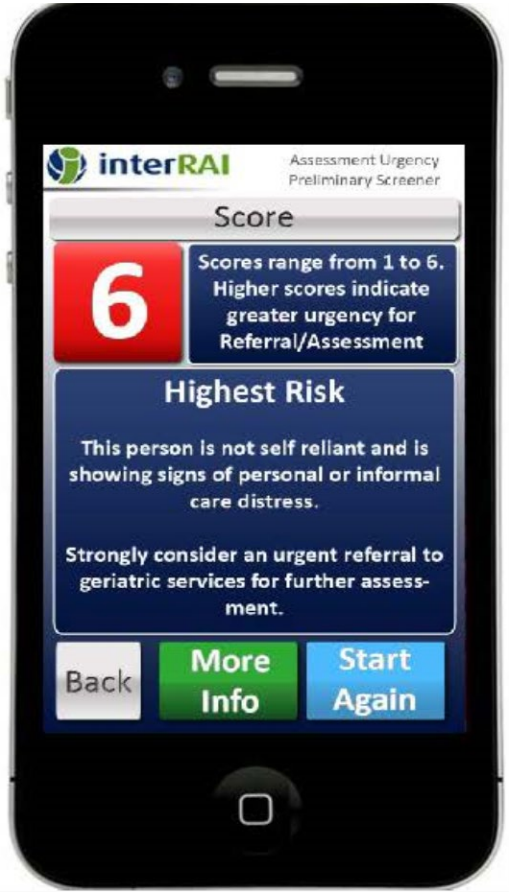
- ❑ **"Getting people to accept services sooner is a big piece,** we are getting people way too late. If they had called us much sooner we could have been a lot more helpful and supportive to the client and to their families …I think helping to **pick up those earlier cues** to make those connections sooner…in the long run I think it would really save healthcare dollars by using services appropriately."

Pilot work: Implementing screening & referral

Following the consultations, primary care sites implemented:

- The interRAI preliminary screener
- Caredove, an online referral platform





Some conclusions from pilot work

- Older patients are often not very involved in decision-making around their care
- Family caregivers both have and need knowledge, but often have a limited role in care planning and decision-making
- Limited use of technology
- Coordination and communication between providers and services is often inadequate
- Primary care could play a key role in identifying at-risk older persons and coordinating their care, but needs support for this role

Canadian Frailty Network (CFN)

- CFN is Canada's network for older adults living with frailty; they are funded by the Government of Canada's Networks of Centres of Excellence program
  - They provide funding for large transformative research projects

- We saw this grant as an opportunity to test our pilot work further in multiple settings/provinces and add additional components that contribute to a high functioning primary care team:
  - Engagement of patients and caregivers in decision-making
  - Support from enabling technology (McCarthy et al, 2015; Aggarwal & Hutchison, 2012; Aggarwal & O'Shaughnessy, 2014)

CFN Transformative Grant

Research Question

Compared to usual care in primary care settings, does our proposed model improve health, social and economic outcomes for frail and at-risk older Canadians, aged 70+?

CFN Transformative Grant

Proposed research initiative/model addresses priorities informed by prior research, consultations and literature review:

1. Consistent screening and assessment of frailty
    - interRAI preliminary screener
2. Care coordination and system navigation
    - Caredove
3. Patient/caregiver engagement & shared decision-making
    - Decision boxes
4. Enabling technology support
    - MyCareMapp

Research team

UNIVERSITY OF WATERLOO

McMaster University

Alberta Health Services

DALHOUSIE UNIVERSITY

LAURIER
Inspiring Lives.

UNIVERSITY OF TORONTO

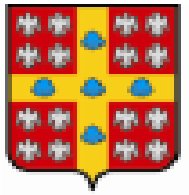
UNIVERSITY OF CALGARY

THE UNIVERSITY OF BRITISH COLUMBIA

CONESTOGA
Connect Life and Learning

UNIVERSITY OF ALBERTA

Centre intégré universitaire de santé et de services sociaux de la Capitale-Nationale
Québec
Centre d'excellence sur le vieillissement de Québec



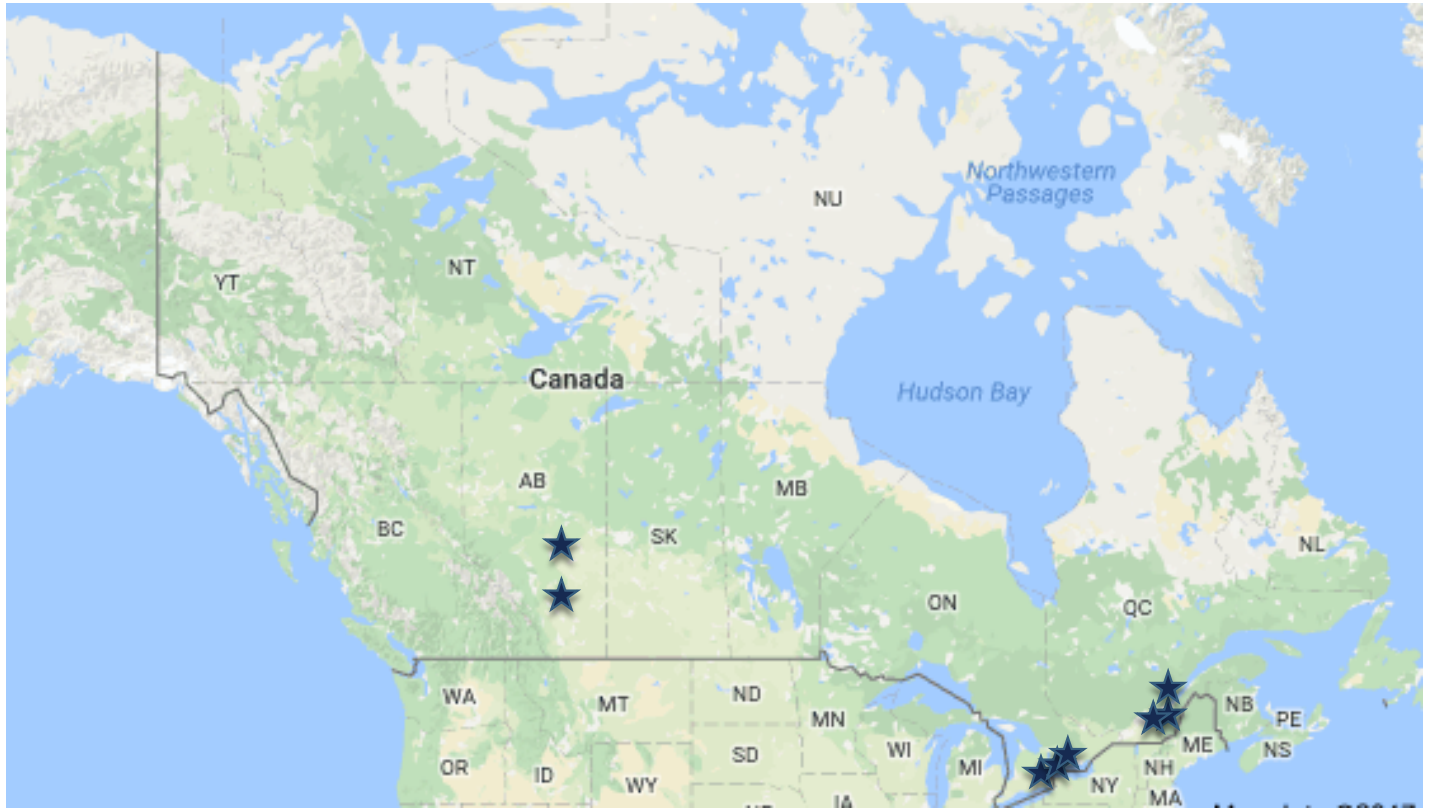
UNIVERSITÉ LAVAL

Partner Organizations - > $3M

Centre d'excellence sur le vieillissement de Québec

Study sites across Canada

- Eight primary care sites across Alberta (n=2), Ontario (n=3) and Quebec (n=3), both urban and rural



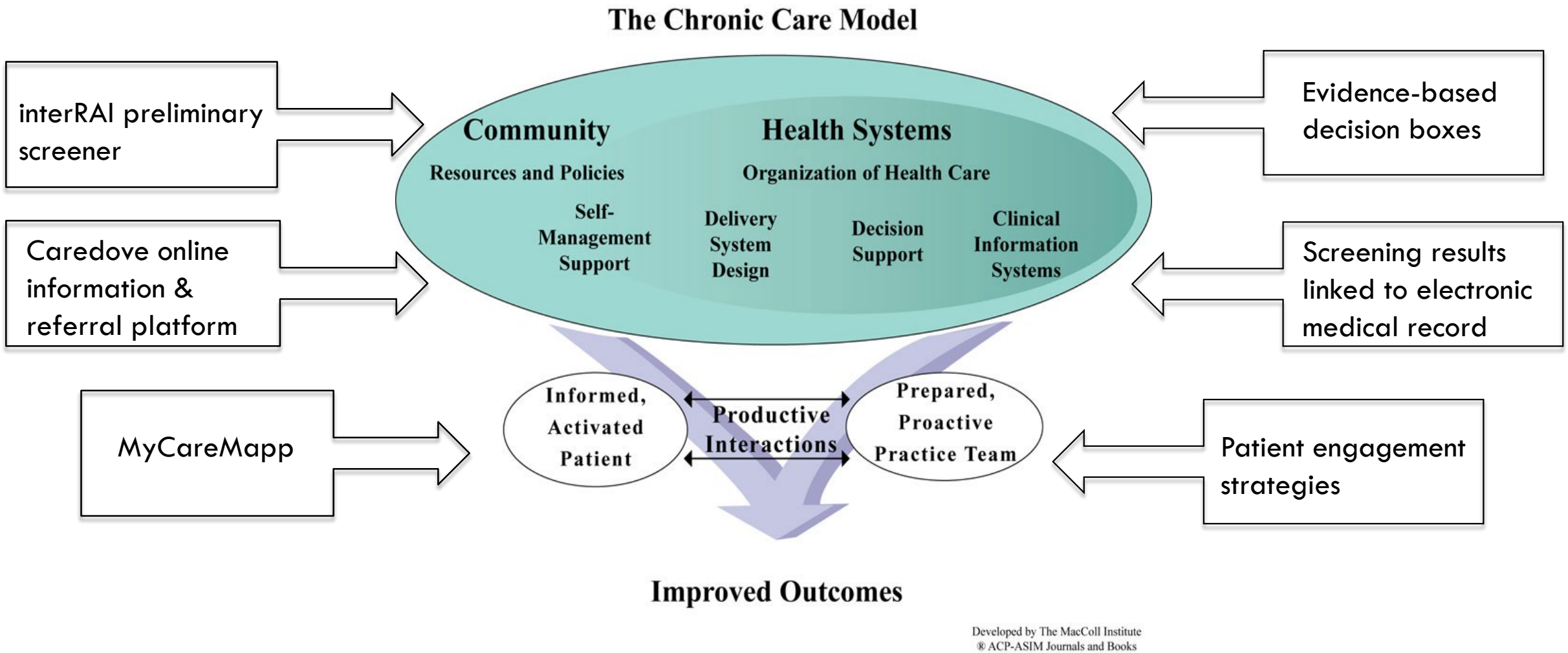
Current project progress

- We are collecting baseline data from older adults and health care providers in 8 sites across three provinces
- Over the winter of 2018/2019 we are implementing our intervention
- A number of sub-projects, led by participating co-investigators, are also being completed
  - e.g. we are exploring options for providers, such as pharmacists or home care coordinators, to assist with screening older adults

Anticipated Impacts

- An effective, feasible and sustainable model of primary care for older adults living with frailty
- A system that can screen and assess older adults at earlier stages of risk and frailty, and coordinate appropriate care plans
- An enhanced role for primary care that is more closely integrated with other parts of the healthcare system such as home care
- Stronger patient and family caregiver partnerships at both the clinical level (in our intervention) and in research (SHARP)

The Chronic Care Model: Improving outcomes



References

- Aggarwal, M., & Hutchison, B. (2012). Towards a Primary Care Strategy for Canada. Ottawa: Canadian Foundation for Healthcare Improvement. Retrieved from http://www.cfhi-fcass.ca/Libraries/Reports/Primary-Care-Strategy-EN.sflb.ashxli
- Aggarwal, M., & O'Shaughnessy, T. G. (2014). Harnessing an innovation agenda for primary care transformation. Toronto: KPMG. Retrieved from https://www.kpmg.com/Ca/en/IssuesAndInsights/ArticlesPublications/Documents/WebPDf-KPMG-Harnessing-an-Innovation-Agenda-for-Primary-Care-Transformation.pdf
- McCarthy, D., Ryan, J., & Klein, S. (2015). Models of care for high-need, high-cost patients: An evidence synthesis. Commonwealth Fund Publications, 31. Retrieved from http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/oct/1843_mccarthy_models_care_high_need_high_cost_patients_ib.pdf
- Schoenman, J. A. (2012). The Concentration of health care spending: NIHCM foundation data brief. Washington, D.C.: National Institute for Health Care Management Research and Educational Foundation. Retrieved from http://www.nihcm.org/pdf/DataBrief3%20Final.pdf

To learn more…

The Geriatric Health Systems Research Group
www.uwaterloo.ca/ghs

Canadian Frailty Network
http://www.cfn-nce.ca/

Alison Kernoghan
alison.kernoghan@uwaterloo.ca