CHCA Project ECHO
Integrated Seniors Care

All Teach, All Learn

Bridging the Knowledge Gap in
Home and Primary Health Care

Interdisciplinary Collaboration for Seniors with Cognitive Impairment

Teaching Presentation: Dr. Tim Stultz, MD, Family Medicine, Summerside, PEI
Case Study: Amy Garrett, Nurse Practitioner, Provincial Geriatric Program, Summerside, PEI

Host: Jennifer Campagnolo, Canadian Home Care Association
January 22, 2025

Canadian Home Care Association

Land Acknowledgement

Artist Credit: Patrick Hunter

We recognize with humility and gratitude that Canada is located in the traditional, historical and ceded and unceded Lands of First Nation, Inuit and Metis Peoples. On behalf of us all, we acknowledge and pay respect to the Indigenous peoples past, present and future who continue to work, educate and contribute to the strength of this country.

Reminders

- Say “Hello!” and introduce yourself via the chat! Remember to select “Everyone”.
- Use the chat function if you have any comments or are having technical difficulties.
- Captioning is available and can be activated through your Zoom options.
- Microphones are muted. **Please use the Q&A function to ask the panelists questions.** We will be taking time to answer any questions at the end of the presentation.
- This session is being recorded and will be available at **https://cdnhomecare.ca/chca-project-echo-integrated-seniors-care**
- Remember not to disclose any Personal Health Information (PHI) during the session.

Project ECHO ISC

Canadian Home Care Association

Project ECHO

Integrated Seniors Care

Project ECHO Integrated Seniors Care, in partnership with the Canadian Medical Association, will enhance the competencies of home care and primary health care providers to meet the holistic and diverse needs of Canadian seniors with complex chronic conditions in home and community settings.

Project ECHO ISC

Mild Cognitive Impairment, Dementias

Canadian Home Care Association

Project ECHO

Integrated Seniors Care

Integrated Clinical Practice Approach to Educational Content:

- Early Identification and Assessment
- Collaborative Care Planning
- Team-Based Care Delivery
- Shared Decision-Making and Communication
- Engaged Persons, Family and Caregivers
- Holistic Safety and Risk Management

With a focus on the:

SKILLS

KNOWLEDGE

ATTITUDES

needed by primary care

and home care providers

Interdisciplinary Collaboration

Canadian Home Care Association
Project ECHO
Integrated Seniors Care

An Interdisciplinary, collaborative approach ensures:

- Holistic care
- Person-centred care, tailored to a person's unique needs, goals and values
- Coordinated approach to care
- Better communication
- Support for family and caregivers

Introductions

Dr. Tim Stultz, MD
Family Medicine
Summerside, PEI

Amy Garrett, NP
Nurse Practitioner
Provincial Geriatric Program,
Summerside PEI

Unlocking the Power of Interdisciplinary Collaboration: PEI's COACH Program

DR. TIM STULTZ

AMY GARRETT, NP

PROVINCIAL GERIATRIC PROGRAM, PRINCE EDWARD ISLAND

Disclosures

- Dr. Stultz
  - I have no disclosures
- Amy Garrett
  - I have no disclosures

Who Are We? Dr. Tim Stultz

- 1988-Mount Allison University- BSc.
- 1992-Dalhousie University- Medicine
- 1993-Dalhousie University- Internship
- 1993-1998-Family Doctor Albert Co. Hospital
- 1998-2004-Geriatric consultant –The Moncton Hospital
- 2003-2005-Dalhousie University- diploma of Care of the Elderly
- 2004-present-Geriatric consultant PEI, COACH collaborator

Who Are We?

Amy Garrett NP

2007-2011: BScN at the University of Prince Edward Island

2014-2019: Master of Nursing, Nurse Practitioner at Dalhousie University

Current role: Geriatric Nurse Practitioner with the Provincial Geriatric Program, focus on the COACH program across the province.

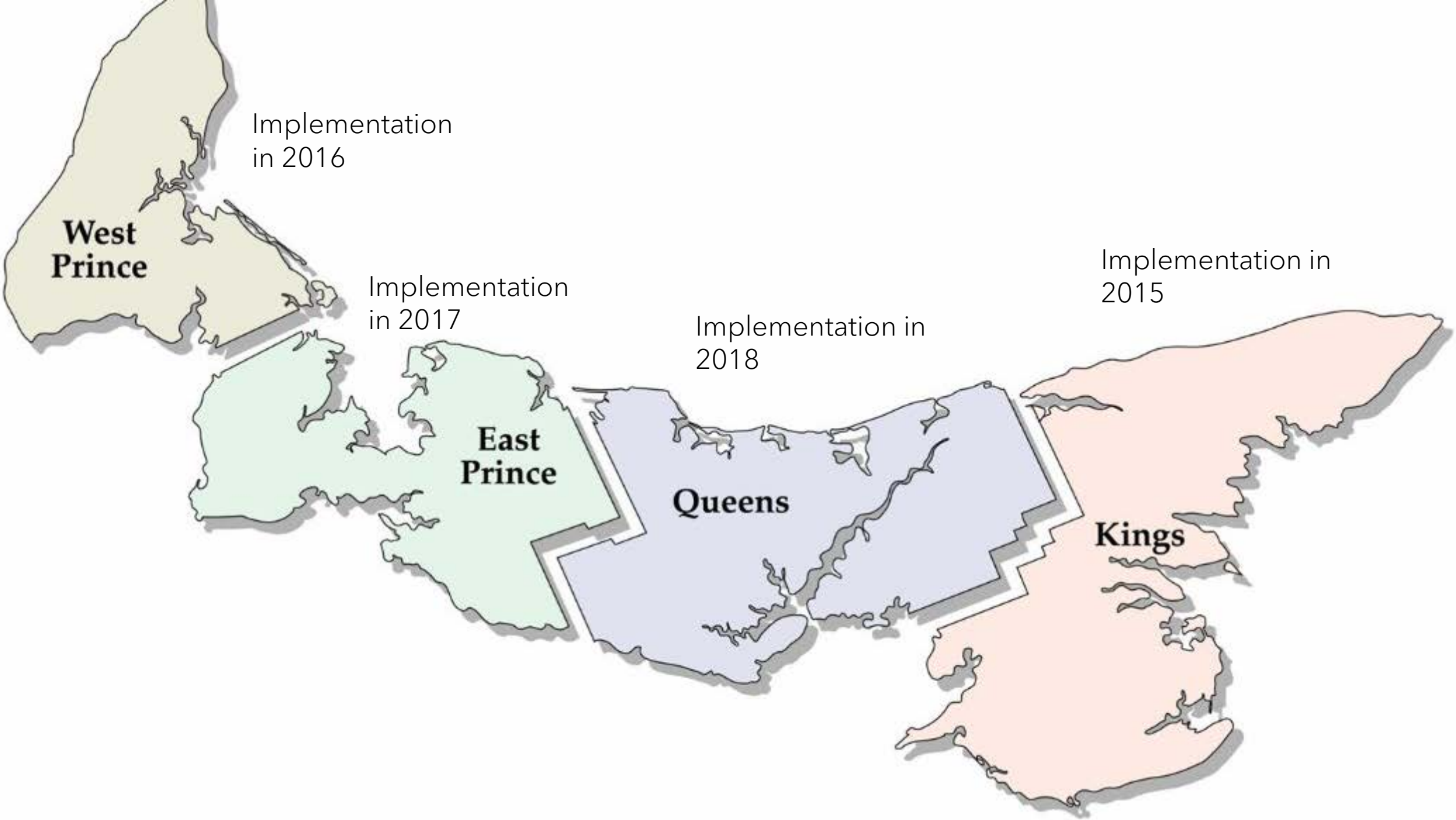
History of the COACH Program

- Reviewed best practice across country

*Reference Prasad S1, Dunn W, Hillier LM, McAiney CA, Warren R, Rutherford P. Rural geriatric glue: a nurse practitioner-led model of care for enhancing primary care for frail older adults within an ecosystem approach. J Am Geriatr Soc. 2014 Sep;62(9):1772-80. doi: 10.1111/jgs.12982.

- Criteria for new approach:
  - Home is Best
  - Person-centered care
  - Integration and coordination
  - Supporting caregivers
  - Quality improvement
  - Nurse Practitioner
  - No new $$

COACH
Caring for Older Adults in Community and at Home


West Prince
Implementation in 2016
East Prince
Implementation in 2017
Queens
Implementation in 2018
Kings
Implementation in 2015

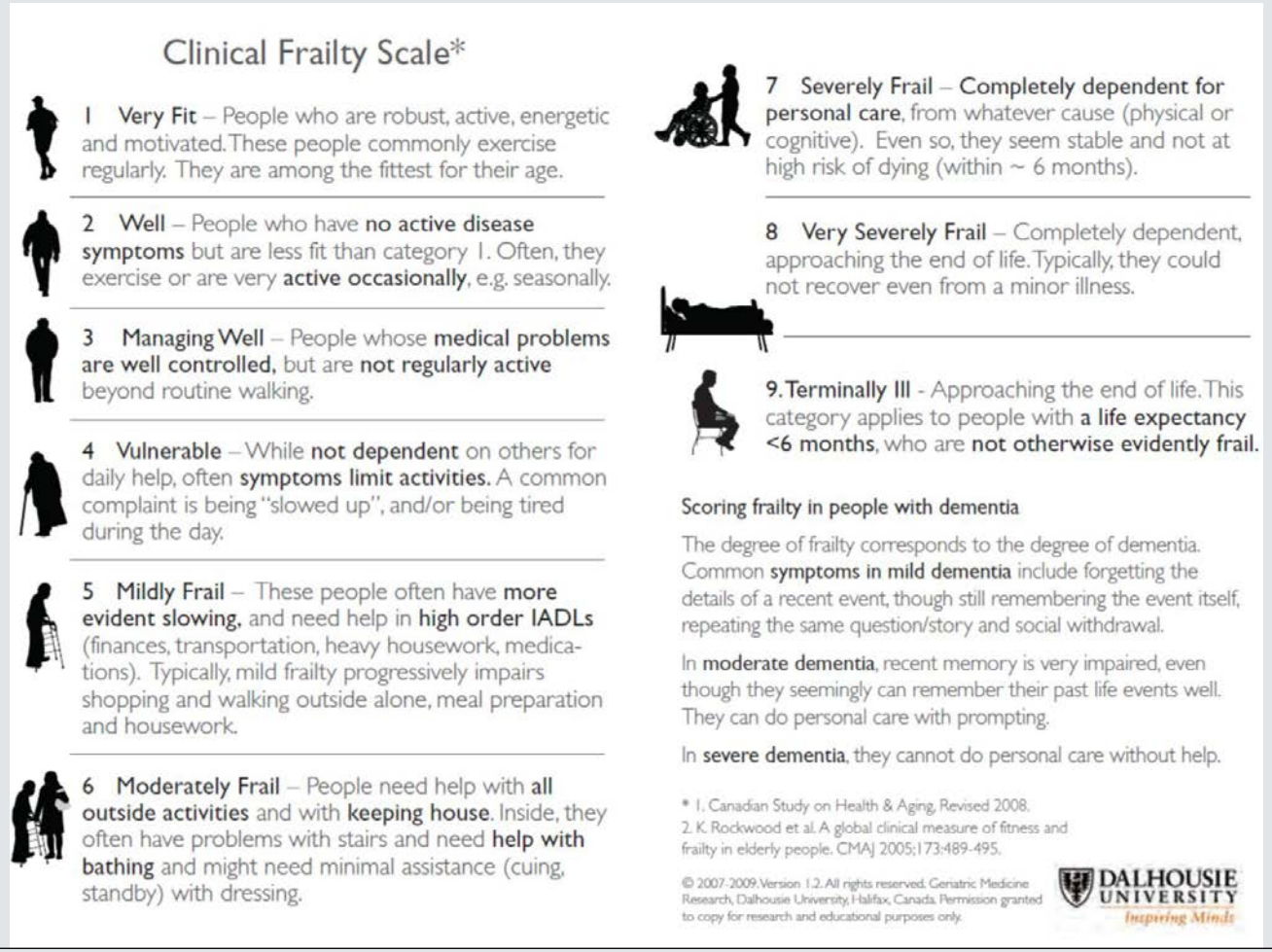
Members of the COACH Team

- Core members:
  - Geriatric Nurse Practitioner
  - Primary Care Provider
  - Home Care RN Care Coordinator (7 in total spread through different regions)
  - The patient and their caregivers
- Other team members are determined by identified patient needs, including Home Care staff, Primary Care staff and Geriatrician

Goals of the COACH program

- To improve access to care for frail seniors with complex needs through collaboration
- Supporting seniors to remain at home longer and/or return home from acute care by optimizing resources
- Reducing duplication and repetition for seniors through the sharing of information between partner programs
- To increase team awareness and expertise of complex geriatric syndromes
- Improving or maintaining quality of life for frail older adults. Adding "life to years".

Target Population



Clinical Frailty Scale*

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.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

DALHOUSIE UNIVERSITY *Inspiring Minds*

- Older adults with complex needs (physical, psychosocial) and geriatric syndromes. Individuals under 65 with geriatric syndromes are eligible on a case-by-case basis
- Rockwood Clinical Frailty Score of 6 or greater

Target Populations

- Living at home or in a community care facility. Primarily home bound due to cognitive or functional limitations
- Experiencing one or more geriatric syndromes (dementia, falls, incontinence, depression, delirium, immobility, sleep disturbance, polypharmacy)
- Because it is a collaborative program, their primary care provider needs to agree to collaborate

- Preference given to patients who:
  - Have increased utilization of the healthcare system (ER visits, hospital admissions)
  - Are at risk of premature long-term care admission
  - Have difficulty accessing care outside of their home
  - Have caregivers/support persons at risk of caregiver burnout
  - Are experiencing behavioral and psychological symptoms of dementia

Functions of the COACH Team

- Comprehensive geriatric assessment
- Focus on in-home interventions and services when possible
- Prevention of acute care admissions, post-discharge follow up if an admission is necessary
- Advanced Care Planning
- Coordinating Home Care resources
- Timely access to geriatric specialist (primarily geriatric NP)
- Collaboration between geriatric NP and Geriatrician
- Teaching and supporting family/support persons to manage complex geriatric syndromes
- Providing support to caregivers, family members, and patients

Services available to COACH patients

- Services available through Home Care
  - Physiotherapy
  - Occupational Therapy
  - Assistance with personal care/bADLS
  - In-home caregiver respite, coordination of in-facility respite at local long-term care facilities
  - Pharmacist
  - Home Care nursing (wound care, injections, health monitoring)
  - Dietician services
  - Mobile Integrated Health (community paramedicine)
  - Day Program
  - NEW medication assistance program to assist with medication monitoring
  - Respiratory Therapy
  - Social work/Adult Protection
  - Collaboration with the Integrated Palliative Care Program (if needed)
  - Long-term Care Coordination (if needed)

Role of the Care Coordinator

- Coordinate services provided through the provincial Home Care program
- Act as a link between the patient/family and the COACH NP
- An initial contact for patients and their supports when they need to access the healthcare system with a concern
- Completes regular home visits with the patient/support person. Monitors for changes in health and response to COACH interventions. Helps to mitigate risks in the home
- Attends bi-weekly COACH team rounds with the larger team (COACH NP, pharmacist, team leaders through Home Care)

Role of the COACH NP

- Provision of care at home when possible
- Act as a link between the patient/family and primary care
- Complete Comprehensive Geriatric Assessments, medication reviews, and medication changes
- Completes regular home visits with the patient/support person, often in collaboration with the care coordinator
- Attends bi-weekly COACH team rounds with the larger team (COACH NP, pharmacist, team leaders through Home Care)

Role of the Primary Care Provider

Maintains the lead on medical care for patients (the COACH NP does not take over primary care needs, but works together to address concerns with the primary care provider to help provide timely access)

Agrees to collaborate with members of the COACH team and to participate in mutual information sharing

Collaboration

- Sunnybrook Framework for Interprofessional Team Collaboration

- A set of six core competencies to support collaboration in four domains: clinical and professional practice and care, education, research, and quality improvement, and leadership

McLaney E, Morassaei S, Hughes L, Davies R, Campbell M, Di Prospero L. A framework for interprofessional team collaboration in a hospital setting: Advancing team competencies and behaviours. Healthcare Management Forum. 2022;35(2):112-117. doi:10.1177/08404704211063584

Collaborative Skills

- Communication: Respectful, timely communication is key. We communicate regularly amongst the core members of the team, and with the larger team during bi-weekly COACH rounds
- Interprofessional conflict resolution: Working together to problem-solve conflicts that can happen among team members
- Shared decision-making: We regularly discuss complex situations as a large team and encourage input from all team members involved in the case
- Reflection: Opportunity to review and discuss (and learn from) challenging situations and ethical dilemmas.
- Role clarification: Each member is aware of their role on the team. We need the expertise of so many of our colleagues to support our complex, frail patients. Opportunity for consultation is important and a key part of making the team flow. A high level of trust in the expertise of teammates is essential.
- Interprofessional values and ethics: Valuing each team member's perspective. Each team member is an expert in his or her area. Creating a safe space for questions or advocacy.

Collaboration is Key

- UPEI Psychology Training Clinic
  - Lead by Dr. Jessica Strong
  - Support with diagnosis via assessment
  - Caregiver supports (via group and individual therapy)
  - Behavioural Support interventions

Dr. Jessica Strong
Certified Clinical Gero psychologist and Assistant professor of Psychology at UPEI

- Alzheimer's Society

-Significant support provided in the community to both patients and their support persons

Société Alzheimer Society
CANADA

Statistics

Decrease in inpatient hospital admissions by 66%

Decrease in ER visits by 33%

Average length of stay in long-term care for COACH patients is approximately 0.65 years compared to an average of 2.6 years for those not part of the COACH program. **Difference is 1.95 years on average for patient at home and in their community…**

Impact of COACH

- "The COACH program has made a significant positive impact on my mother's life and well-being, as well as on our family's ability to care for her. The combination of receiving necessary medical care at home, avoiding the stress of medical appointments and emergency rooms, and providing respite and social engagement is invaluable. The program not only helps my mother, (who has dementia and mobility issues), maintain a good quality of life but also brings moments of joy and stimulation through interactions with different caregivers. COACH enables her to live with her family and enjoy a quality of life that she could never experience otherwise at this stage of her life....and for this we are extremely thankful"

  - Family member of a COACH patient

Impact of COACH

- “Watching mom’s Parkinson’s and dementia get worse, I found myself not knowing what to do or where to turn. The COACH program provided guidance and support in ways I didn’t think we could even get. We wouldn’t be able to care for mom and keep her in her own home surrounded by her family if it wasn’t for them”

  -Family member of a COACH patient

Challenges

- Decreasing access to primary care (no primary care provider and/or difficulty with timely access) has resulted in more involvement of the COACH in medical concerns, particularly with unaffiliated patients.
- Communication challenges related to different methods of documentation (paper chart vs electronic medical records)
- Increased demands on the healthcare system for patients overall. Resources are stretched for those living at home, and there is less access to long-term-care beds.
- Geography – while PEI is small, there is a lot of area to cover. New implementation of virtual care technology is helping to cover the gaps

Case Study – Mr. M

- 92-year-old gentleman with complex medical history :
  - Dementia, renal cell carcinoma, ? lung mass, GERD, BPH
- Retired Air Force veteran.
- Lives in a single level bungalow in an urban area of Western PEI
- Proudly displays many artifacts from his fascinating life and travels. Many hobbies including model boat building, art collecting and collecting military memorabilia.
- His is widowed. He and his wife were married for 62 years. He has children who live in another province but are very supportive.
- Lifelong love of animals (particularly dogs). His senior dog died a few years ago and he still misses her.

Story of Mr. M

- Mr. M required significant supports as his dementia progressed. He expressed a strong desire to age-in-place, which was consistent with his values. He absolutely, 100% did not want to go to a long-term care facility. He also consistently and adamantly declined follow-up and intervention for his renal-cell carcinoma.
- Living at risk – concerns related to kitchen safety and oral intake, wandering, and in the later stages, hallucinations and delusions.
- He was assessed in the community by Dr. Stultz, and once he required more supports, he was enrolled in the COACH program.
- Received assistance from Home Care for personal care (bathing, dressing). The Mobile Integrated Health team (community paramedics) assisted with monitoring of his vitals and medications. Physiotherapy and Occupational Therapy assisted with home-safety concerns.

Story of Mr. M

- Mr. M and his family were able to hire private caregivers (did have funding through VAC) to support his care needs at home and mitigate the risks associated with aging-in-place.
- He developed changes in his health (related to his renal cell carcinoma) but wanted a comfort-based approach without further investigations. His family felt this was consistent with his life-long values.
- Continued to be followed by the COACH team. Developed mood changes associated with his dementia, and medication changes were implemented to support his mood (this required a team-based approach with engagement of his family and caregivers to assess for efficacy and tolerance)
- We were able to engage his caregivers to implement non-pharmacological strategies (pet therapy, distraction)

Story of Mr. M

- Mr. M experienced a decline in his health with increased drowsiness and decreased oral intake. Over time, these symptoms progressed and along with his family, we decided it was time to look at end of life care
- Collaboration with the Integrated Palliative Care Program (through Home Care) to provide the supports needed at end of life. Mr. M's primary care provider was not available for collaboration, so the COACH NP was able to facilitate end-of-life orders at home
- Mr. M died peacefully at home, consistent with his wishes and he absolutely, 100% avoided admission to long-term-care

Story of Mr. M: Challenges

- Reluctance to accept in-home supports
- Challenges with access to primary care
- Gaps in care: lack of access to funded overnight care resulted in need to be creative to mitigate risks (technology such as door alarms and motion cameras)
- Living at risk: comfort level of community, family and care providers
- Understanding of capacity and ability to live at risk, even if capacity is lacking or unclear

In Summary:

- The COACH program has been successful in helping older adults to live at home (even with risks)
- Our data shows that people are staying at home longer, dying at home (when desired) and spending less time in hospital and long-term-care
- Team based approach and collaboration is key to facilitating aging-in-place and adding "life to years'"
- Successful capacity building for caregivers, people living with dementia, and healthcare staff.

COACH
Caring for Older Adults in Community and at Home

From a Recent COACH patient Obituary

"As in every case of Dementia/Alzheimer's, the slow deterioration of a mind is tragic. What becomes more tragic is how often a patient's family members and friends fall away in a time when they are needed most. People feel uncomfortable, don't know what to say, cannot face what is happening, etc. What is not understood is that these patients, while they may not be the same person they once were, can still experience moments of joy by a happy face, by caring touch, by a kind voice, whether recognized or not. These snippets of joy strung together can make a difference to that patient's emotional well-being that can last for a while, even after the visit is forgotten. This is the very least that we owe loved ones when they are stricken. In lieu of flowers, we request that every person reading this who has or will have loved ones with dementia/Alzheimer's, reach beyond their own feelings to make that effort to visit that loved one. They deserve the dignity of not being ignored. They deserve a gentler release from this life"

Thank you!

Discussion / Q&A

Dr. Tim Stultz, MD
Family Medicine
Summerside, PEI

Amy Garrett, NP
Nurse Practitioner
Provincial Geriatric Program,
Summerside PEI

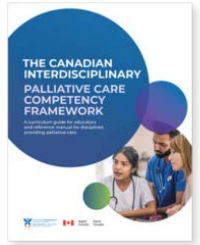
Upcoming TeleECHO Sessions

Canadian Home Care Association | Project ECHO

Integrated Seniors Care

Linking Health and Community: Social Prescribing in Integrated Seniors' Care
February 12 2025, 12 - 1pm ET

New Series Starting this Spring!
Domain 6: Last Days and Hours



March – Preparing for and Managing Emergent Symptoms at Home

June – Holistic Spiritual Care at End of Life

Register: cdnhomecare.ca/chca-project-echo/