INNOVATION PROFILE

SENIORS' COMMUNITY HUB

EDMONTON, ALBERTA

Seniors' COMMUNITY HUB

ADVANCING FRAILTY CARE IN THE COMMUNITY COLLABORATIVE

IMPROVING CARE FOR OLDER PEOPLE WITH FRAILTY AND SUPPORTING THEIR FAMILY/FRIEND CAREGIVERS

A 23-month Quality Improvement Collaborative

Canadian Foundation for Healthcare Improvement
Fondation canadienne pour l'amélioration des services de santé

Canadian Frailty Network | Réseau canadien des soins aux personnes fragilisées

About the Canadian Foundation for Healthcare Improvement

The Canadian Foundation for Healthcare Improvement supports partners to accelerate the identification, spread and scale of proven healthcare innovations. We work shoulder-to-shoulder with you to improve health and care for everyone in Canada. CFHI is a not-for-profit organization funded by Health Canada.

About the Canadian Frailty Network

The Canadian Frailty Network (CFN) improves the care of older adults living with frailty and supports their families and caregivers. CFN does this by increasing recognition and assessment of frailty, increasing evidence for decision making, advancing evidence-based changes to care, educating the next generation of care providers, and by engaging with other adults and caregivers.

The views expressed herein do not necessarily represent the views of Health Canada.

OVERVIEW

The Seniors' Community Hub (SCH) model of care was co-created by a care of the elderly (COE) physician and a primary care physician working in Alberta. The SCH program was implemented in partnership with the Edmonton Oliver Primary Care Network (EOPCN) in July 2016, and originally launched as a pilot program at the Misericordia Family Medicine Centre – one of EOPCN's more than 40 partner physician clinics. Starting in January 2019, the program began to expand to serve patients within EOPCN's larger network.

The overarching goal of the SCH is to transform primary care into a central hub to better meet the health and social needs of older adults and their caregivers. The program:

- Encompasses a structured process for identifying, assessing and managing frailty.
- Develops effective information sharing between patients, care providers and healthcare settings.
- Provides community-based support to patients and their caregivers to help prevent or alleviate caregiver burden.
- Fosters long-term sustainability in the primary care sector.

TARGET GROUP FOR THE INNOVATION

- **Patients 65 years of age and over in the primary care provider's patient roster/panel.**
  - Patient charts are reviewed by the primary care physician and/or the clinic nurse, and patients are invited to participate in the program if they have an Electronic Frailty Index (eFI) score of "mild to moderate" frailty.

TRAINING REQUIRED TO SUPPORT THE PROGRAM

- The eFI is a simple-to-use case finding tool for frailty. It is not currently automatic in the electronic medical records (EMR), but registered nurses, licensed practical nurses and physicians can be easily trained in one short session on frailty using the eFI and Clinical Frailty Scale (CFS). The CFS not only helps clinicians visualize what frailty looks like, but also correlates well with the categories of frailty as defined by the eFI tool.
- To complete the primary care geriatric assessment (called the Seniors' Community Hub Multidomain Assessment, or SCH-MDA), nurses are trained on geriatric syndromes and common interventions, as well as on community resources and supports in their area. SCH has a central team consisting of a geriatric assessment nurse and pharmacist as well as a COE physician or geriatrician who support the program centrally as clinical lead.

APPROACHES TO INTERVENTIONS

Intervention	Approaches
1. Frailty Identification	• Patients 65 and over can join the program by talking to any care provider at their primary care clinic. They might be prompted to do so by a poster or brochure in the clinic that outlines the program. • Patients can be called in for assessment by the care team. • The patient's physician or nurse uses the eFI to identify frailty. They can do this either in advance, by reviewing the patient chart, or at the time of the clinic visit. Those with mild to moderate frailty are moved to the geriatric assessment outlined in approach #2, below. **Time to complete eFI:** Typically less than five minutes, depending on how accurately the patient's medical and functional history is populated in the EMR and how well the clinic nurse or physician knows the patient. **Method of documentation:** The tools are typically completed through an EMR but can be done on paper as well. **Resources:** No additional resources, tools or equipment are needed to complete the assessment. **Licensing:** The eFI is publicly available in English. **Providers Involved:** Nurse, physician or a keen clinical team member.
2. Geriatric Assessment	• The project team created an assessment called the Seniors' Community Hub Multidomain Assessment (SCH-MDA) based on the Comprehensive Geriatric Assessment (CGA). The SCH-MDA is easier than the CGA to use in primary care. • The SCH-MDA helps define the multiple components or domains of frailty in an individual, e.g. physical, functional, cognitive, psychological, social and environmental. It uses screening questions as well as a "deeper dive" of evidence-based assessment tools (such as the Geriatric Depression Screen) when screeners identify that a deeper dive is necessary. It includes reviewing the appropriateness of medications (START/STOPP criteria) and the patient's quality of life using EQ-5D/VAS (a self-rated patient health measurement tool). • Interdisciplinary team members support the nurse, as necessary, to complete these assessments, and the assessments are reviewed by the COE physician. **Time to complete assessment:** One to two hours. **Method of documentation:** The tools are completed through an EMR. **Resources:** The SCH-MDA template is built into the EMR. Trained team members complete the assessment and any necessary tools, e.g. vitals, cognitive testing, portable hearing amplifier.

	2. Geriatric Assessment	**Licensing:** all tools available in English: • Assessment – SCH-MDA • START/STOPP • EQ-5D/VAS, available in English and French – Healthcare teams must have prior written consent of the EuroQol Office to use, reproduce, alter, amend, convert, translate, publish or make available in whatever way (digital, hard-copy) the EQ-5D and related proprietary materials. **Providers Involved:** Nurse, pharmacist, physician
	3. Tailored Intervention	• Patients and families are engaged as partners in their care and co-create their personalized wellness plan (i.e. care and support plan). This includes evidence-informed recommendations and interventions based on their assessment and driven by their goals and priorities. A copy of the plan is given to the patient and another is placed in the patient record. • As part of their primary care network, patients have access to an interdisciplinary team that may include nurses, pharmacists, nutritionists, mental health professionals and other allied health professionals. SCH leveraged these interdisciplinary resources and hired a geriatric assessment nurse to support the education and smooth functioning of the team. The clinic nurse acts as the primary case manager for the patient. **Time to complete:** • Charting the SCH-MDA and summarizing the issues and interventions takes one to two hours, depending on the complexity of the patient. • The care and support plan takes 20 minutes and is automatically generated from the SCH-MDA charting. **Method of documentation:** The tools are completed through an EMR. **Resources:** Access to team members who can support the interventions and are aware of community resources. **Licensing:** The care and support plan is drafted in English and can be made available by the team. **Providers Involved:** Nurse

	4. Person and Family-Centred Care	• The care plan is driven by the patient's and caregiver's goals and priorities. Education and self-management skills are provided. • An active patient and family advisory board provides input on the program and evaluation. • The clinical environment enhances the patient's experience (e.g. a quiet space with ample seating, familiar location or home visit, joint team assessments to reduce assessment fatigue and redundancy). • An objective measurement is taken of the caregiver's burden. SCH uses the caregiver risk screening tool that is also used by home care to build a common language across care settings. • SCH measures satisfaction for the services rendered from multiple perspectives, including the patient, caregiver and provider.

	5. Collaborative Care	• The following tools and processes have been essential to SCH's success:
		  • Curriculum on interprofessional core competencies and principles of geriatric care for the clinical team
		  • Skills session for the clinical team on case finding tools, conducting multi-domain assessment, and care planning
		  • Team meetings to review patient cases
		  • Health information technology as an enabler of a virtual collaborative space (e.g. shared assessment template)

	6. Community Supports	• SCH integrates care with local social and community support services such as SAGE, the seniors association in Alberta that provides social supports; homecare; and caregiver support agencies.
Overarching Principles		Approaches
7. Quality Improvement, Change Management and Evaluation, and System Level Change		• SCH measures patient, provider and health system data. • SCH builds consistency of care processes in primary care clinics to improve the capacity to collect, analyze and use data.

OUTCOMES ACHIEVED

To date, SCH has seen improvement in several areas of its clients' health, including:

✔ Functional status	✔ Frailty score
✔ Walk test score	✔ Quality of life
✔ Self-reported domains of pain, mood, mobility and usual activities (EQ-5D)	✔ Caregiver burden
✔ Appropriateness of medications	

LESSONS LEARNED

The SCH team has noted several recommendations based on its implementation journey:

- Incorporate change management strategies like the ADKAR model (Awareness-Desire-Knowledge-Ability-Reinforcement).
- Recognize you are adding to an already stretched primary care system where providers' "buckets are full." Show them how and why this is worth doing and how they will be supported by the team.
- Build on prior investments – like resources from the Patients Medical Home - Primary Care Networks Program. Also, look at what resources are already in place, and which health care providers are most motivated, so a team can be assembled and redesign can happen!
- Engage multi-level stakeholders, including patients and caregivers, on the design, implementation and evaluation of the program.
- Gain insight from key players to make the necessary adaptations for success. Get information about how things are going from those doing the identification, assessment and management components, as well as those receiving services – the patients, caregivers and care providers.

AVAILABLE RESOURCES, ARTICLES, RESEARCH ON THE INNOVATION:

- Seniors' Community Hub website
- Seniors' Community Hub CFN Award and CFN Story Board