Canadian Home Care Association

High Impact Practices

www.cdnhomecare.ca

Supporting Frail Seniors to Stay Safely at Home

Using a coordinated and integrated quality improvement approach to enhance care and maximize independence for frail seniors.

About High Impact Practices

The Canadian Home Care Association (CHCA), as a national voice, promotes excellence in home care through leadership, awareness and knowledge to shape strategic directions. The Association is committed to facilitating continuous learning and development throughout the home care sector to support and promote innovative and effective practices across Canada.

During the CHCA's annual Home Care Summit, health care leaders from across Canada and abroad share new and emerging approaches to home care and engage in dialogue about their experiences so that leading practices from across the country and, around the world, can be examined and adopted. Every year there are initiatives that stand out – those that clearly will impact the health care system. The potential of these practices is such that home care stakeholders want to hear more and are eager to explore the applicability within their respective jurisdictions. Building on the momentum of the Home Care Summits and recognizing the potential "ripple effect" of expanding the dissemination beyond the Summit participants, the CHCA has undertaken to document and publicize a selection of these innovative practices from across the country as High Impact Practices.

EACH OF THE HIGH IMPACT PRACTICES:

- **Promotes** home care that provides evidence-informed service delivery directed toward the achievement of health outcomes in the settings that best support the individual, and family
- **Enhances** the effectiveness of home care
- **Raises the awareness** of the ways that home care contributes to an effective health care system
- **Mitigates** rising health care costs and accentuates existing resources and expertise
- **Enables sharing** and transferring of knowledge, expertise and experience through networking and peer-to-peer learning.

Thank-you to our High Impact Practices Partner…

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Supporting Frail Seniors to Stay Safely at Home

Summary

Presented by representatives from British Columbia's Northern Health and Interior Health communities[1], this project demonstrated the value of proactive home-based care for frail seniors, and of collaboration across jurisdictions in order to develop effective responses to this population's needs.

The goal of the *Supporting Frail Seniors to Stay Safely at Home Initiative* is to improve care provided to frail seniors living in the community through the introduction of a coordinated, multidisciplinary planned care approach, which includes planning and implementing client-centred care and providing clinical responsibility 24x7, as far as possible, to enable individuals to remain in the home of their choice. The outcomes that are sought include: 1) increased independence and quality of life for seniors and their caregivers, and; 2) improved utilization of health services.

The effort required by clinicians to transform the health system and change the care delivery approach to support frail seniors to stay at home is significant. The focus needs to shift from a "rescue and repair" perspective for acute episodic health care to one that integrates biological and non-biological factors and is tailored to individual needs.[2] The change was achieved through team collaboration using the Model for Improvement[3] and as a result of support of the health care community, local community leaders, the British Columbia Ministry of Health, the BC Medical Association and leadership in the two Health Authorities. All parties undertook to share experiences and collaborate on improvements achieved in order to advance this important agenda within British Columbia.

Northern Health & Interior Health

Northern Health & Interior Health are two of six health authorities in British Columbia responsible for ensuring the provision of publicly funded health services. Northern Health covers almost two-thirds of British Columbia's landscape and is divided into three operational areas called Health Service Delivery Areas (HSDAs): the Northeast, the Northern Interior, and the Northwest. Northern Health is responsible for a growing population of about 300,000 people. The region has the highest projected growth rate of seniors in BC, with a 48 percent projected increase by 2010.

Interior Health is the second largest health authority in British Columbia covering almost 200,000 square kilometers. Interior Health is divided into four HSDAs. Interior Health provides a full range of health services to approximately 714,000. 18 percent of the population was 65 years or older in 2007, higher than the provincial average of 14 percent. This higher-than-province-average trend will continue in the next 24 years, making IHA one of the two oldest health authorities in the province, along with Vancouver Island Health Authority.

For more information on Northern Health:
www.northernhealth.ca
And for Interior Health:
www.interiorhealth.ca

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Morag Reid, Facilitator, Trail Seniors-at-Risk Initiative

Rod Schellenberg, Project Manager, Northern Health

Project Background

The Health Council of Canada refers to primary health care and home care as the foundations of the health care system.[4] A primary care approach is vital to address the needs of an aging population, which typically experiences multiple chronic and co-morbid conditions.

In British Columbia, the number of seniors is projected to grow by 100% over the next 25 years and the prevalence of chronic conditions is expected to increase 58%, significantly increasing health care costs.[5] A strategy to address the health of its population and contribute to the sustainability of the health care system was developed by British Columbia's Ministry of Health in collaboration with a broad stakeholder group. Known as the Primary Health Care Charter, the document outlines the multi-faceted strategy required to achieve system-wide improvements in order to better serve specific populations including the frail elderly and people at risk of developing, or living with chronic conditions.

The frail elderly are a population group with significant needs and typically a desire to remain at home. The care goals for the frail elderly are not usually related to cure but rather to maintaining function and quality of life, including symptom control. However, in a system that is disease and treatment oriented, the elderly can end up in hospital which, even during a decline in health, can have significant adverse effects on frail seniors. Furthermore, this population with its multiple co-morbid conditions will often be prescribed several care plans which are not coordinated and may in fact have conflicting outcomes.

Coordinated patient-centred care planning is the preferred approach to serving the frail elderly and integrating the approach within primary care, as opposed to creating a specialty program, ensures its sustainability. To make the approach effective and ensure comprehensive care, providers need to work in teams optimizing each individual's expertise and providing preventive and supportive measures that will help to keep patients independent at home for as long as possible. Patients need to be able to access care 24x7 (although with good planning and anticipatory care, this can become less of an issue). Integrating home care into the primary health care team, as was demonstrated through the Canadian Home Care Association's National Partnership Project[6], is an essential component of comprehensive care for seniors, and was in part, the impetus behind this initiative.

The *Supporting Frail Seniors to Stay Safely at Home Initiative* has its roots in the Seniors At-Risk Initiative (SARI) which began in Trail, BC in June 2006. In Northern Health, the initiative arose from the Frail Elderly Collaborative which came together in November 2006. The Initiative has evolved and continues to develop through the application of the principles of the Model for Improvement. Teams use the Model's "three questions" (1.What are we trying to accomplish? 2. How will we know that change will be an improvement? 3. What changes can we make that will result in an improvement?) and the Plan, Do, Study, Act (PDSA) cycle in order to make small tests of change and continuously improve their care for frail seniors. These tests of change are applied to all aspects of care including clinical care, administrative tasks and team building.

Implementation

The target population is seniors scoring 5 and 6 on the Clinical Frailty Scale. Frailty is defined as a state of vulnerability to experiencing adverse outcomes and includes crises of function. The premise of the initiative is that the home setting is often the best place for these crises to be handled rationally and with compassion. The care of frail people must, at a minimum, have comfort as its priority and be fully responsible, multidisciplinary, collaborative and available 24/7, where possible.

Supporting Frail Seniors to Stay Safely at Home involves the primary care team which includes the family physician; home care case managers, therapists, nurses and home support; family nurse practitioner; community pharmacists; geriatric assessment team; and volunteers.

Clinical Frailty Scale[7]:

1. Very Fit
2. Well
3. Well, with treated co-morbid disease
4. Apparently vulnerable
5. Mildly frail – limited dependence on others for instrumental activities of daily living (IADLs)
6. Moderately frail – help needed with instrumental and non-instrumental ADLs
7. Severely frail

~ Canadian Study on Health and Aging (CSHA)

Once patients are identified as being at risk for frailty (level 4 in CHSA scale) or frail (levels 5-7 in CHSA scale), they are asked for their consent to take part in

the initiative. Their own priorities and concerns are identified and incorporated into assessments undertaken by members of the primary care team, to ensure that a comprehensive understanding of the individual's needs and plan of care can be established. For example, if community case managers have completed their comprehensive initial assessment using the InterRAI-HC[8], a list of identified problem areas generated by that assessment helps to further inform the physician assessment and care plan.

"The primary health care team was in the same sandbox before, but now we're working together to build the same sandcastle!"

~ *Family Physician*

The development and implementation of individual coordinated care plans based on each senior's own expressed priorities and involving the input of the primary care team, is central to the initiative. The care plan is individually developed and addresses modifiable biologic factors (e.g. muscle weakness) and non-biologic factors (e.g. psychosocial) while integrating individual disease factors that impede the health goals of patients. The recommended approach to care incorporates patient-centered preferences and tolerance for intervention and support. The approach is grounded in the philosophy that while frailty may not be preventable, crises of function can be anticipated and delayed, and that patients can improve their function and quality of life through rehabilitation.

The care plan, together with the senior's problem list, medications list, urgent response plan, and advance care directives is given to the patient so they can share it with other health team members, such as the emergency department or in-patient units, as required. The involvement of seniors in their care planning has proven very popular with seniors and their families.

Providing clinical responsibility in the community is essential to keeping seniors safe in the home of their choice. A number of strategies have been established to ensure that the frail senior is well supported at home. These include:

- A Family Nurse Practitioner who is able to diagnose, treat, prescribe drugs for and follow up with patients in their own home.
- A Quick Response Nurse who is available in the community from 1pm – 9pm seven days a week in order to provide clinical support when the family doctor, nurse practitioner and case manager are not available. The nurse can provide advice over the phone or in person, depending on the circumstances.
- Preparing for a health crisis by ensuring that during the case manager's first home visit, crisis management strategies are reviewed with the patient and their caregiver. The urgent response plan, identifying the name, phone number and availability of members of the health care team is established. The case manager also reinforces the importance of proactively seeking help as opposed to waiting until needs have escalated and /or until a time that the only service available is the emergency department.
- Making the most of existing resources by maintaining and making available a Seniors Guide, listing community resources to support independent living.
- Encouraging the use of Personal Emergency Response units, as evidence from four communities in BC has demonstrated a significant impact on emergency room visits, hospital admissions and lengths of stay.[9]

"…I know I will be looked after at home."

~ *Frail Senior*

Falls and problems with medications account for a considerable burden of morbidity and acute care usage. Preventing these is addressed by the Supporting Frail Seniors to Stay Safely at Home Initiative.

Referrals to community physiotherapy enable family physicians to screen for and deal with other causes of falls (for example medications problems), thus making the community physiotherapist's response more efficient. Balance classes have been provided in three communities and have had a significant impact on seniors' balance, mobility and agility and have also provided an opportunity for socializing.

Regular medication reviews with a community pharmacist have been implemented using the list of drugs identified during the InterRAI-HC assessment and the physician's own notes. The pharmacist reviews the patient's profile, identifies any drug-related problems and sends the physician any comments and recommendations. Some pharmacists have undertaken home visits themselves.

Respecting the expressed desire of seniors to discuss end-of-life issues, information and support to prepare an advance care plan is provided during the case manager's home visit. The patient and their family/caregiver then have time to consider what they would like to do and confirm this during their visit with their doctor after the care planning meeting.

Key Success Factors

There are a number of factors believed to contribute to the success of the Supporting Frail Seniors to Stay Safely at Home Initiative.

- Establishment of a broad-based steering committee in order to engage the broader health care community, seniors and local civic leaders.
- Practitioners simply getting to know and trust each other.
- Effective communication & information sharing amongst the team and with secondary and tertiary care when needed.
- An approach to care that is multidisciplinary, proactive, long-term where the patient and their family are active members of the care team.
- Jointly developed and tested approaches and tools, and the application of the Model for Improvement.
- New fee codes recently introduced in BC which compensate family physicians for time spent conferencing with patients and other health care professionals in the development of a care plan.
- Alignment of home care case managers (and other community services) to the family physician's office (not always possible in jurisdictions where patients are broadly dispersed).
- Electronic medical records to enable a patient registry and the use of measurement to inform improvement efforts.

"The team approach allows us to amalgamate our talents for the benefit of the patient"

~ Home Care Case Manager

Outcomes

There have been a number of lessons learned through this initiative:

- Developing a multi-disciplinary primary care team that communicates and shares information effectively, shares in the development and implementation of coordinated care plans and responds to the needs of frail seniors is good practice.
- The Family Nurse Practitioner has prevented many emergency department visits and admissions.
- Family physician engagement has been positive and consistent, with feedback suggesting the initiative provides a framework for doctors to do their work effectively.
- Working with the broader team process requires additional clinical time from the family doctor, though this can be marginal.
- The role of the Case Manager is pivotal.
- The community-based balance classes have received very positive feedback from seniors and the healthcare providers. Functionality scores have improved and seniors described feeling more confident and less dependent on walking aids.
- There has been active support and participation by the community pharmacies.
- There is a lot of interest from seniors, their families and care team in advance care planning.
- The approach and work has gained community support. In one community the seniors became involved in promoting the balance classes and then in the development of community-led sessions.

Evaluation

The Initiative is undergoing independent evaluation at the Trail BC site and results are pending. Patients and providers are enthusiastic and know that emergency department visits have been circumvented and that care has been enhanced, avoiding crises and a reactive approach.

The teams continue to seek ways to strengthen the care of frail seniors in the community. In most of the communities, participating physician practices are expanding their registries so that the whole population of frail seniors is served. Steps to institute electronic sharing of information and updating of the care plan are being explored; community-led programs for seniors are being developed and opportunities for home care case managers to provide group based information are being investigated. The Emergency Medical Service and Emergency Department are becoming more involved with the team, resulting in better communication and coordination.

"There is a real sense of community caring for Dad and I know he is much happier to be able to stay at home."

~ Client's Daughter

Preliminary Findings from Trail BC:

Clients:
- are satisfied with how much say they have in their health care
- know who to call in a health crisis
- are living where they want

Family physicians and case managers:
- find sharing information useful

Family Physicians:
- find identifying seniors' own priorities very useful

Conclusion

The *Supporting Frail Seniors to Stay at Home Initiative* demonstrates the potential of our health system to support an aging population effectively and appropriately. Tools and processes have been developed and tested to provide an integrated person-centred health system that is sustainable and able to meet the needs of the older population. The expectation in BC is that system level change will continue and this new service delivery model will be expanded.

For more information on the CHCA's High Impact Practices or other initiatives, contact **www.cdnhomecare.ca**

The CHCA defines home care as an array of services, provided in the home and community setting, that encompass health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration and support for the informal (family) caregiver.

End Notes:

[1] Presentation at the CHCA 2007 Home Care Summit by Rod Schellenberg, Project Manager, Northern Health; Dr Marnie Jacobsen, GP and Chair, Trail Seniors-at-Risk Initiative, Barb Neilsen, Family Nurse Practitioner, Trail

[2] Tinetti, Mary, Fried, Terri. (2004) The End of the Disease Era. The American Journal of Medicine. 2004; 116: 179-185.

[3] Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. (1996) The Improvement Guide: A Practical Approach to Enhancing Organizational Performance

[4] Health Council of Canada. (2008) Fixing the Foundation: An Update on Primary Health Care and Home Care Renewal in Canada

[5] British Columbia Ministry of Health. (2007) Primary Health Care Charter, p9

[6] Canadian Home Care Association. (2006) Partnership in Practice, www.cdnhomecare.ca

[7] Rockwood K, Song X, MacKnight C, Bergman H, Hogan DB, McDowell I, Mitnitski A. A global clinical measure of fitness and frailty in elderly people. Canadian Medical Association Journal. 2005;173(5): 489-495.

[8] Information about the RAI Home Care can be found at http://www.interrai.org/section/view/?fnode=15

[9] Robert E Roush, Robert E., Teasdale, Thomas A.,Tex, Houston, Murphy, Jane, Kirk Stella. 'Impact of LifeLine System on Hospital Utilization by Seniors in the Community: A snapshot of four BC communities, 1992 – 2000' The Impact of a Personal Emergency Response System on Hospital Utilization by Community-Residing Elders, British Columbia

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