Title: Complex Geriatric Patients: Priority Setting and Interprofessional Collaboration

Presentation: Ontario FHT Pharmacist Networking Day (10/11/09)
WHO WE ARE…

McMaster University
Department of Family Medicine
McMaster Family Health Team
Stonechurch Family Health Centre
Seniors Collaborative Care Program
The Stonechurch Team: Clinicians

- **Team A**: 10 MDs, 3 NPs, 2 RNs
- **Team B**: 4 MDs, 1 NP, 1 RN
- **Team C**: 2 MDs, 1 RN

**Shared Providers**: 3 SWs, 2 RDs, 1 LC, 1 pharm
Senior’s Collaborative Care Team

- Rachelle Gervais, RPN
- Shelly House, RPh
- Ainsley Moore, CCFP
- Christopher Patterson, FRCP
- Joy White, RN EC
Overview

- Program Description
- Priorities of care for the complex senior
- Interprofessional collaboration
- Program sustainability / justification
Program Description: History

- Wish list (November 2007)
  - Better care for our community dwelling seniors (care processes)
  - Better care providers (capacity)
  - Build on each other’s strengths (collaborate)
  - Strengthen relationships community partners
Program Description: History

Funding pilot study DFM McMaster
April, 2008
Program Description: History

Development:
1) Office based tools for evaluating seniors
2) Model for maximizing multidisciplinary input
3) Incorporated CCAC, AS (first link)
Program Description: History

Two main tools developed:

1) Algorithm for assessment of falls (ACOVE III, Health Canada, Cochrane)

2) Algorithm for assessment of cognitive impairment (ADEPT, CMAJ 2007)
Program Description: History

Model for optimizing multidisciplinary provider input
Model – Care Path

Intake: (telephone screen or referral) → Initial Visit RPN (GDS, Levy, Nutrition Score) → Evaluation by MD or NP for CI or Falls

Referral to SW RD Pharm → Team Based Case Review (MD NP RPN SW RD Pharm Geriatrician) → Referral Community (AS CCAC)
Priorities of Patient Care

- Identification of complex senior

- Complex issues interacting:
  - Diseases, syndromes, medications, social, financial, cultural, family dynamics, transportation
Priorities of Care For The Complex Senior

- Patient centred (preferences, lifestyle considerations)
- Shifting goals of care (prognosis, lifespan)
- Hybrid (preventive, curative, palliative)
- Focus on maintaining function
Priorities of Patient Care

- One stop shop (familiar, accessible, continuity, appropriate mix of providers)
- Planned chart review
- Maximize community resources
- Medication Review
- Case based multidisciplinary review
Priorities of Patient Care

Medication Review:

- Transitions (hospital, primary care, hospice, LTC)
- Multiple Prescribers
- Declining health and functional status (cognition, vision, renal)
- Changing Goals of Care
Priorities of Patient Care

Medication Review

- Fragility: adverse drug events (dehydration, falls, cognitive impairment, delerium)

- Sensitivity: small change big impact
Priorities of Patient Care

Medication Review

- QOL impact:
  - Monitoring requirements, visits to FD, pharm, lab
  - Multiple doses, multiple meds
  - Adherence
Interprofessional Collaboration

- Team building:
  - Respect
  - Comfort with vulnerability
  - Confidence with professional identity
  - Comfort with overlap (knowledge, skills)
  - Continual open feedback communication
  - Flexibility
Interprofessional Collaboration

- Capacity building:
  - Team based case reviews
  - On site geriatrician
  - Discussions, planning together, shared knowledge and learning
  - Spring board for topical learning, geriatric principles
Interprofessional Collaboration

- Capacity building:
  - Open to all team members (providers and residents)
  - Team house calls
  - Closing the loop (feedback to referrer and MRP)
Interprofessional Collaboration

- **Sustainability:**
  - Personal interest
  - Commitment to geriatrics and each other
  - Flexibility
  - Fun 😊
  - Support from other team members
Interprofessional Collaboration

- Sustainability:
  - Geriatrician support issues
  - Institutional support (requires justification of service)
Interprofessional Collaboration

- Justification of Service
- Patient Outcome Measures:
  - Timely access to specialized service
  - Satisfaction with service (PSQ)
  - Improved case management
  - Caregiver burden reduction
Interprofessional Collaboration

- Justification of Service
- Provider Outcome Measures:
  - Improved capacity, confidence
  - Satisfaction with service
  - Interprofessional experience
  - Quality of work life
Interprofessional Collaboration

- Justification of Service
- System Outcome Measures:
  - Reduced FP visits
  - Reduced ED visits
  - Reduced hospital admission
  - Delayed admission to LTC
Conclusions

Priorities: Patient Care, Interprofessional Experience, Evaluation