Fraser Northwest
Division of Family Practice
An FPSC initiative

SharedCare
Partners for Patients

A MULTI-PRONGED APPROACH TO COORDINATING CARE FOR OLDER ADULTS

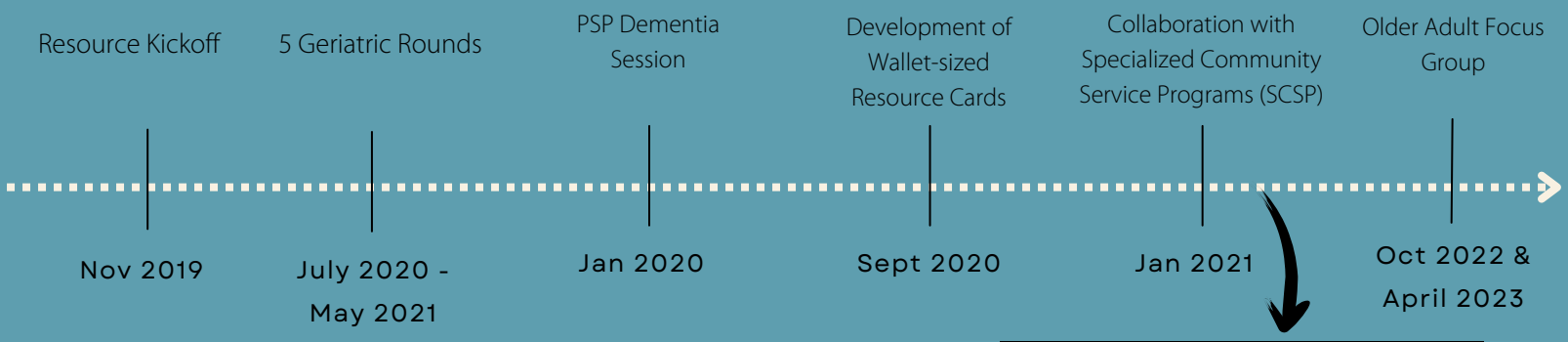
Shared Care Project

Project Overview

Project Aim: Enhance care coordination and planning for older adults with complex health concerns in the FNW, by strengthening partnerships, improving access to essential services and fostering collaboration among healthcare providers

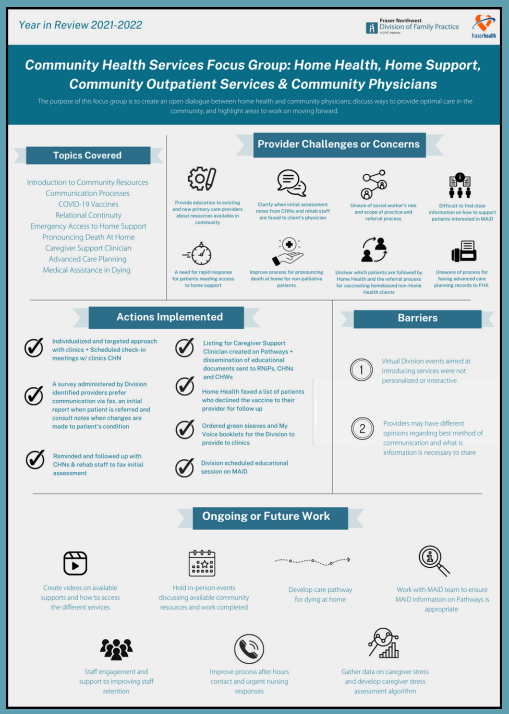
Project Leads: Dr. Kathy Kiana (FP lead), Dr. Simon Woo (Specialist lead)

Project Activities



GERIATRIC ROUNDS TOPICS:

1. General Overview
2. Insomnia in Older Adult
3. Mental Health & Geriatric Psychiatry
4. Polypharmacy
5. Dementia/Alzheimer's Diagnosis and Medical Interventions


Year in Review 2021-2022

Community Health Services Focus Group: Home Health, Home Support, Community Outpatient Services & Community Physicians

The purpose of this focus group is to create an open dialogue between home health and community physicians, discuss ways to provide optimal care in the community, and highlight areas to work on moving forward.

Topics Covered

Introduction to Community Resources
Communication Processes
COVID-19 Vaccines
Relational Continuity
Emergency Access to Home Support
Pronouncing Death At Home
Caregiver Support Clinician
Advanced Care Planning
Medical Assistance in Dying

Provider Challenges or Concerns

Provide education to existing and new primary care providers about resources available in community

Clarify when initial assessment notes from CHNs and rehab staff are faxed to client's physician

Unsure of social worker's role and scope of practice and referral process

Difficult to find clear information on how to support patients interested in MAID

A need for rapid response for patients needing access to home support

Improve process for pronouncing death at home for non-palliative patients

Unclear which patients are followed by Home Health and the referral process for vaccinating homebound non-Home Health clients

Unaware of process for having advanced care planning records to FHA

Actions Implemented

Individualized and targeted approach with clinics + Scheduled check-in meetings w/ clinics CHN

A survey administered by Division identified providers prefer communication via fax, an initial report when patient is referred and consult notes when changes are made to patient's condition

Reminded and followed up with CHNs & rehab staff to fax initial assessment

Listing for Caregiver Support Clinician created on Pathways + dissemination of educational documents sent to RNPs, CHNs and CHWs

Home Health faxed a list of patients who declined the vaccine to their provider for follow up

Ordered green sleeves and My Voice booklets for the Division to provide to clinics

Division scheduled educational session on MAID

Barriers

1. Virtual Division events aimed at introducing services were not personalized or interactive
2. Providers may have different opinions regarding best method of communication and what is information is necessary to share

Ongoing or Future Work

Create videos on available supports and how to access the different services

Hold in-person events discussing available community resources and work completed

Develop care pathway for dying at home

Work with MAID team to ensure MAID information on Pathways is appropriate

Staff engagement and support to improving staff retention

Improve process after hours contact and urgent nursing responses

Gather data on caregiver stress and develop caregiver stress assessment algorithm

Click here for a full resolution of the visual

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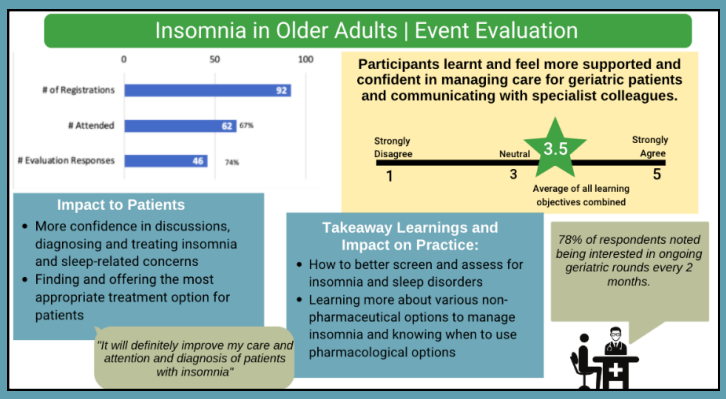
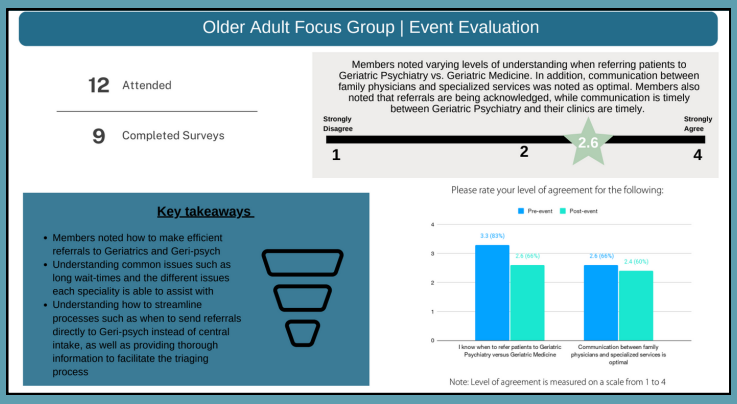
Project Activities: Overview





Lessons Learned: What worked well?

Collaboration among stakeholders resulting in better understanding of available resources and increase awareness of support services (i.e. Alzheimer's Society)

Collaborative platforms and events (i.e. focus groups) led to open dialogue and addressed community challenges

Relationships improved between FP's and specialists, resulting in ongoing support, collaboration, bridging gaps that formal documentation couldn't achieve and continuation of services

Increased communication and understanding between providers, resulting in increased opportunities for future collaboration

Challenges & Gaps

- **Administrative burden on FP's (i.e. referral rejection and redirection)**
- **Prioritizing existing allied health support and community navigators (i.e. BC 211) for maintenance of wallet sized cards and the delivery of comprehensive and coordinated healthcare**
- **FP scheduling time constraints, resulting in high workloads and delays with project activities**
- **Pandemic constraints resulted in delays in timeline, in addition to reduced in-person interactions and collaboration, resulting in robust mitigation strategies to ensure continuity of future initiatives**

Next Steps

- **Ensuring sustainability and spread of key strategies (i.e. education series, available resources and check-ins with FP's and specialists) and continued collaboration with older adult services in the FNW**
- **Implementing webinars and educational events to foster ongoing knowledge and new relationships for incoming members**
- **Wallet-size resource cards for seniors will not be sustained due to ongoing maintenance and sustainability of materials from allied health and community navigators**

Click here for the full Older Adult Shared Care report