Shared Care Final Project Report

Project Title	A Multipronged Approach to Coordinating Care for Older Adults
Physician leads	Dr. Kathy Kiani, Family Physician Lead Dr. Simon Woo, Geriatric Psychiatrist, Specialist Lead
Project lead	Sanjam Laura
Date of Submission	August 28, 2023

EXECUTIVE SUMMARY

Background / overview

The Fraser Northwest Division of Family Practice (FNW DoFP) launched the Older Adult Shared Care Initiative to improve care coordination and planning for older adults with complex health concerns in the Fraser Northwest community. The project aimed to enhance access to patient and family community supports, increase awareness of allied health support, provide dementia education for Family Physicians (FPs), develop a comprehensive referral algorithm and coordinated care plans, and address polypharmacy risk. The target population included older adults aged 65+, families, and caregivers in the community. By fostering collaboration among stakeholders and utilizing data-driven strategies, the initiative sought to enhance the overall support and outcomes for older adults in the region.

Project Objectives

The FNW Older Adult Shared Care Initiative aimed to achieve several key objectives. First, it sought to enhance access to patient and family community supports by increasing FPs' awareness of available community resources for older adults with complex health concerns. Collaborative efforts with partners like the Alzheimer's Society and SHARE Family and Community Services provided rapid access to family counseling, education, and support. Additionally, the initiative compiled essential community services to streamline referrals, ensuring improved patient access to necessary care and advance care planning.

Secondly, the project aimed to improve awareness of allied health support among FPs. This involved increasing their understanding of allied health services, such as the PCN social worker, PCCRN, and Registered Nurse in Practice. These insights were incorporated into coordinated care plans for older adult patients. Collaborating with the Specialized Community Service Program further strengthened efforts to align resources and enhance access to vital allied health services for older adults in the community.

Project Outcomes

The FNW Older Adult Shared Care Initiative has yielded valuable outcomes, reflecting positive advancements in several areas. FPs have demonstrated increased awareness of available community resources and services for older adults, leading to improved confidence in managing and treating various health conditions in this patient demographic. The project's focus on patient care has shown measurable differences in knowledge and confidence among FPs, yet limitations persist in addressing shortened wait times for patients.

The patient feedback survey identified ongoing gaps in patient care, particularly concerning accessibility to healthcare services. Despite efforts to provide role clarity between Geriatric Psychiatry and Geriatric Medicine, there are still gaps in understanding. However, the project facilitated process streamlining, such as improved referral practices to geriatric psychiatry, and increased awareness of the challenges related to long wait times.

Educational events have had a positive impact on physician understanding of available resources. However, challenges remain in addressing existing referral wait times and measuring physician burnout. Overall, the project has made notable progress in enhancing care coordination and knowledge, with opportunities for further improvement in specific areas.

INTRODUCTION

The Fraser Northwest Division of Family Practice (FNW DoFP) encompasses FPs in New Westminster, Coquitlam, Port Coquitlam, Port Moody, Anmore and Belcarra representing the traditional catchment area of the Royal Columbian and Eagle Ridge Hospitals. Together, members and division staff work to improve patient access to local primary care, increase local physicians' influence on health care delivery and policy, and provide professional support for physicians.

The inception of the Older Adult Shared Care Initiative in the Fraser Northwest was the result of insightful discussions among physicians providing care to complex older adult patients in our communities. It became evident that by joining forces with multiple providers, we could significantly improve the coordination of care for this population.

Problem statement:	**Aim Statement:**
Recognizing that older adult patients with multiple comorbidities often require the involvement of multiple specialist physicians and community services, the challenge for providers is to effectively coordinate care for a seamless patient and provider experience.	To improve care coordination and planning for older adults with complex health concerns by supporting increased FP and specialist understanding of what resources and services are available to them and their patients in the Fraser Northwest community.

With the objectives in mind, the Older Adult Shared Care Initiative seeks to strengthen partnerships, facilitate access to essential services, and foster a collaborative environment where providers can collectively work towards enhancing the care experience for our older adult population.

PROJECT OBJECTIVES

The objectives of the FNW Older Adult Shared Care Initiative are:

1. Enhance Access to Patient/Family Community Supports:
    a. Increase awareness among FPs of available community resources to support older adults with complex health concerns.
    b. Collaborate with partners like the Alzheimer's Society and SHARE Family and Community Services to provide rapid access to family counseling, education, and support.
    c. Compile essential community services to streamline referrals and improve patient access to necessary care and advance care planning.
2. Improve Awareness of Allied Health Support:
    a. Increase FPs' awareness of allied health support services, such as the PCN social worker, PCCRN, and Registered Nurse in Practice, to enhance coordinated care plans for older adult patients.
    b. Collaborate with the Specialized Community Service Program to align efforts with the Older Adult Shared Care project.
3. Increase Access to Geriatric Care:
    a. Facilitate group medical visits in partnership with a geriatrician either in the office or community settings to improve accessibility to care for older adult patients.
        i. *Note: Instead of facilitating group medical visits as initially planned, the project successfully implemented the Geriatric Round Series. The Geriatric Round Series provided opportunities for open dialogue and addressed challenges within the community. This*

adaptation demonstrated the project's flexibility and ability to find effective alternatives to achieve its objectives.

4. Enhance Dementia Education for FPs:
    a. Collaborate with the Practice Support Program (PSP) to administer the dementia module to meet the expressed need for increased dementia education among FPs.
5. Develop a Referral Algorithm and Coordinated Care Plans to improve the coordination of care for older adult patients:
    a. Create a comprehensive referral algorithm that outlines when and how to refer to specialized services, including the Specialized Seniors Clinic, Rapid Access Clinic, Geriatric RACE line for tele-consultation, Clinical Pharmacy, PCCRN, Home health, Alzheimer's Society and First Link, Geriatric Psychiatry, and SHARE Mental Health Counseling.
6. Address Polypharmacy Risk:
    a. Collaborate with the PCN Clinical Pharmacist to enhance referrals to the Medication Management Program. This program conducts home visits for meaningful medication reviews to reduce polypharmacy risk among older adults.

These project objectives aim to implement a multipronged approach to improve care coordination and planning for older adults with complex health concerns, leading to enhanced patient outcomes and better overall support within the community.

TARGET POPULATION

The target population includes older adults aged 65+, families, and caregivers in the Fraser Northwest community.

ENGAGEMENT STRATEGY

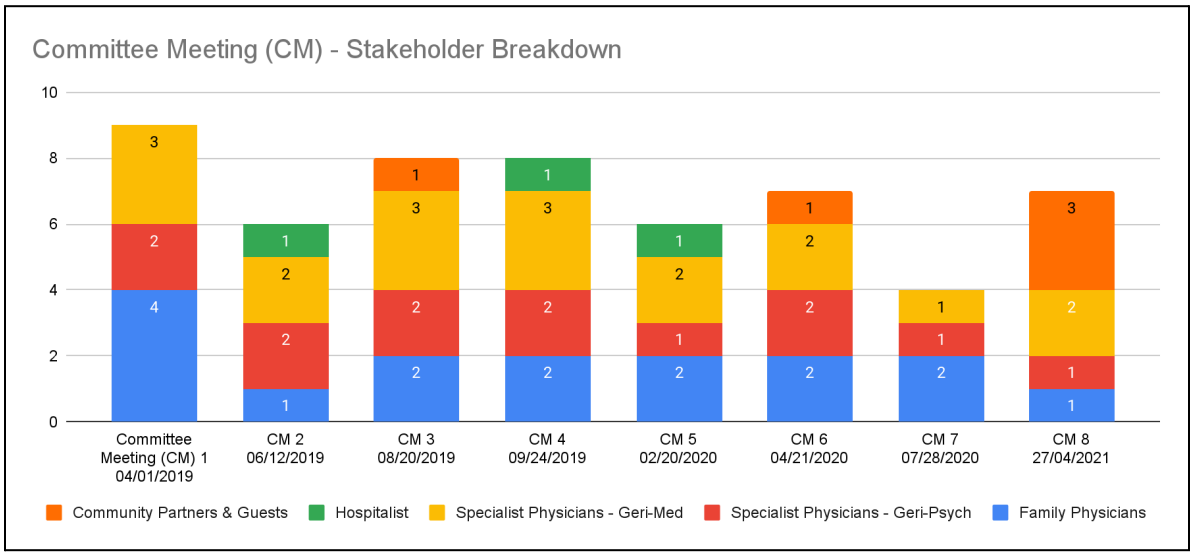
In the planning phase of the Older Adult project, the FNW Division engaged various stakeholders involved in older adult care, including FPs, specialists, including geriatricians and geriatric psychiatrists, patient care coordinators, community organizations, allied health teams, and partners who showed a keen interest in enhancing care coordination for older adults.

The active engagement of diverse stakeholders played a pivotal role in shaping and driving the success of the Older Adult Shared Care Initiative. With representation from family physicians, geriatric psychiatrists, geriatricians, PCN pharmacists, PCN nurses, and community organizations, the committee provided valuable insights and perspectives from various specialties and healthcare settings. Their input helped identify areas for improvement in older adult care coordination and facilitated the development of strategies to address these challenges. The table below shows Physicians and Non- Physician stakeholders who showed an interest in participating and driving this project making up the committee for this project.

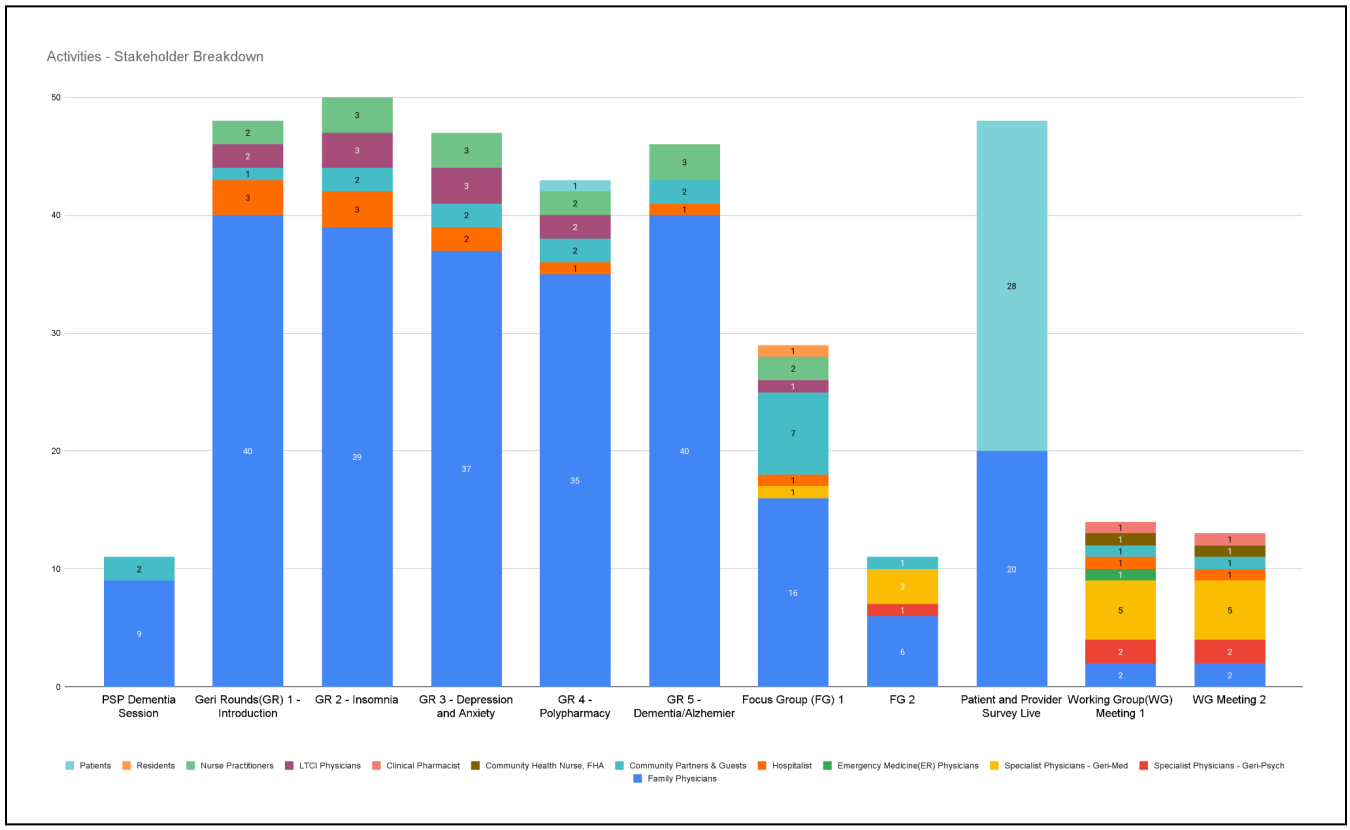
NAME	ROLE	PRIMARY PRACTICE LOCATION
PHYSICIAN ENGAGEMENT		
Dr. Kathy Kiani	FP Lead	Coquitlam
Dr. Simon Woo	Geriatric Psychiatrist, Specialist Lead	Royal Columbia Hospital (RCH), New Westminster

Dr. Funmi Okunola	Family Physician	Vancouver
Dr. Hem Phaterpekar	Geriatric Psychiatrist	RCH, New Westminster
Dr. Peter O'Connor	Geriatrician	Seniors Specialized Clinic (SSC), New Westminster
Dr. Wendy Lin	Geriatrician	SSC, New Westminster
Dr. Mamta Mian	Geriatrician	SSC, New Westminster
Dr. Nishi Varshney	Geriatrician	SSC, New Westminster
Dr Belinda Rodis	Geriatrician	SSC, New Westminster
Dr. Liliana Cioata	Hospitalist	RCH, New Westminster
NON-PHYSICIAN ENGAGEMENT		
Susan Prosser	Support and Education Coordinator, First Link and Alzhemier's Society	Burnaby
Peggy Dang	Clinical Pharmacist	Fraser Health Authority
Debbie Shields	Community Health Nurse	Fraser Health Authority

The following graphs present a comprehensive breakdown of stakeholder engagement and involvement in committee meetings and project activities. This graph illustrates the timeline of Committee Meetings (CM) conducted between April 2019 and April 2021. The 8 committee meetings allowed Physicians, Specialists and other allied health members to collaborate to develop a patient centered, coordinated model of care as patients move between healthcare providers and settings. The meetings served as essential milestones for the project, fostering collaboration and decision-making among the participants to meet project objectives.



This graph caption highlights the engagement and involvement of stakeholders in key activities of the older adult project. The project encompassed several activities, including PSP Dementia session, educational Geri Rounds on topics like insomnia, depression, anxiety, and polypharmacy. Additionally, there were specialized sessions on dementia and Alzheimer's. The project also featured interactive Focus Groups and surveys involving patients and healthcare providers. Working Group meetings played a role in shaping the project's direction and success. Together, these initiatives formed a comprehensive approach to enhance the quality of care for older adults by providing support for increased understanding of what resources are available to the FP and Specialists in the FNW Community to improve care coordination and planning for older adults with complex health concerns.



DATA COLLECTION ACTIVITIES

The evaluation approach was conducted through a mixed-methods design (i.e. collection of both qualitative and quantitative data). Quantitative data was collected from FHA analytic data and program administrative records. Qualitative data was collected from surveys and interviews with physicians, specialists, stakeholders, patients, and program administrators will be collected and collated. The data collected has a developmental lens that focuses on continuous quality improvement and links back to the overall Shared Care goals.

During the Older Adult Shared Care Initiative, spanning from June 2018 to August 2023, a diverse range of data collection activities were undertaken to gather valuable insights and feedback from stakeholders, shaping the project's objectives and ensuring its effectiveness in enhancing care coordination for older adults with complex

health concerns. The project kick-started with eight committee meetings, commencing in April 2019, providing a platform for FPs, specialists, partners, and stakeholders to align their vision and goals. These sessions fostered a shared understanding of the project's purpose while addressing key areas of concern related to older adult care within the FNW community.

To better understand older adults' experiences in accessing healthcare services, a comprehensive patient survey *(appendix 1)* was conducted at the end of 2019. The survey identified areas for improvement and opportunities for enhanced care delivery. Concurrently, a providers' survey *(appendix 2)* sought insights from healthcare providers within the circle of care to assess the state of older adult care and identify potential opportunities for enhancement. Additionally, in 2023, a follow-up patient survey *(appendix 3)* was conducted to assess the impact of the Older Adult Shared Care Initiative on older adults' experiences with healthcare services.

Throughout the project, an ongoing member feedback survey *(appendix 4)* collected continuous input from FPs in the community, facilitating adjustments and improvements to project strategies based on their valuable insights. Additionally, feedback from attendees of six project-related events was gathered, enabling the project team to evaluate the effectiveness of these events and glean valuable insights from members and partners. In addition to surveys and feedback mechanisms, program-level data was collected at various stages, allowing the evaluation of specific initiatives within the Older Adult Shared Care project. This data-driven evaluation process informed ongoing improvements and adaptations to ensure the project's success.

The data collection activities enriched the project's outcomes and enabled the Older Adult Shared Care Initiative to address the needs of older adults with complex health concerns in the FNW community effectively.

RESULTS / DATA MATRIX

The purpose of this evaluation is to align and support the overall Shared Care goal which is to provide coordinated, continuous and comprehensive patient care in a way that fits the local context and community needs specific to the FNW. The evaluation objectives and questions link directly back to the overall FNW project aim statement noted in the previous section. Implementing evaluation measures throughout this initiative supports real-time data collection and clear identification of when progress markers have been attained or when adjustments need to be made to existing measures. The evaluation program’s main purpose is to support the cyclical quality improvement processes focusing on the PDSA cycle which supports the implementation, identifies opportunities for improvement, and allows for ongoing feedback between and amongst PCN stakeholders.

The work of this project and its subsequent evaluation are to focus and improve the following key attributes:

- Shared Care project goals
- PMH Attributes
- PCN Attributes
- Quadruple Aim

The evaluation has two main objectives and their subsequent evaluation questions below:

1. **To evaluate the effectiveness of the Older Adult Shared Care Initiative in the Fraser Northwest community**
    a. To what extent does the program contribute to FPs' increased understanding of what resources are available to their older adult patients in the FNW?

b. To what extent does the program contribute to increased coordination of care between FPs and specialist physicians?
c. To what extent does the program contribute to improved patient care?
d. To what extent did the program contribute to a change in health care utilization and what effect did it have on system costs?

2. To identify areas for quality improvement and document lessons learned for the PCN

a. What were the unanticipated outcomes of the proposed strategies?

PROJECT ACTIVITIES & DELIVERABLES

As part of the Older Adult Shared Care Initiative, several activities and deliverables were undertaken to address key challenges and achieve project goals. These activities played a crucial role in enhancing care coordination and improving support for older adults with complex health concerns.

One of the initial activities that played a pivotal role in launching the Older Adult Shared Care Initiative was the Resource Kick-off Event (*appendix 5*), which took place in November 2019. The event was designed as a dynamic panel-style presentation, featuring insights from key stakeholders representing various specialties involved in coordinating care for the older adult population. The panelists, comprising experts from Family Medicine, Geriatric Medicine, Geriatric Psychiatry, the Alzheimer's Society, Primary and Community Care RN (PCCRN), Clinical Pharmacy, Emergency Medicine, and Hospital Medicine, provided valuable perspectives on their roles and the challenges they encountered. During the event, attendees had the opportunity to hear from these eight specialties, with each presentation reflecting the patient's journey throughout the healthcare system. This structured approach allowed for an understanding of the care continuum, highlighting the areas where coordination is essential for older adults with complex health needs.

To further engage participants, the event included small group table discussions (*appendix 6*), fostering an interactive and collaborative environment. Each table was equipped with discussion prompts, encouraging attendees to share their ideas and suggestions for enhancing care coordination for medically complex older adults. The insights gathered during these discussions provided diverse perspectives from a wide range of healthcare professionals, community organizations, and stakeholders. By addressing the lack of awareness surrounding available resources for older adults, the Resource Kick-off Event sought to empower attendees with knowledge about community support and allied health services. The primary goal was to increase access to these resources, ensuring that older adults receive the comprehensive care they require. As a result of the event's successful execution, it laid the foundation for collaborative efforts among healthcare providers, ultimately benefiting the well-being of the older adult population within the FNW community.

Another significant initiative was the Geriatric Round Series, conducted on multiple dates from July 16, 2020 to May 25, 2021. This series aimed to clarify roles among various providers caring for older adults while building partnerships with geriatricians and geriatric psychiatrists. The first session, held on July 16, 2020, provided a General Overview of geriatric care, focusing on the unique challenges and complexities that older adults may encounter in their healthcare journeys. This foundational session set the stage for the subsequent discussions, ensuring a shared understanding among attendees from different specialties and healthcare settings. The Geriatric Rounds Series included the following sessions:

- July 16, 2020 – General Overview (*appendix 7*)
- September 29, 2020 – Insomnia in the Older Adult (*appendix 8*)
- January 26, 2021 - Mental Health & Geriatric Psychiatry (*appendix 9*)

- March 30, 2021 – Polypharmacy (*appendix 10*)
- May 25, 2021 – Dementia / Alzheimer's Diagnosis and Medical Interventions (*appendix 11*)

To increase access to community supports and resources, Pathways learning was integrated into the Geriatric Rounds Series throughout the project duration. This step aimed to address the challenge of limited awareness surrounding available resources.

Another key partnership formed during the initiative was with the Alzheimer's Society. This collaboration aimed to increase awareness of available community support for older adults, fostering a supportive network to address their unique needs effectively.

The Older Adult Shared Care Initiative proactively aimed to bridge the gap between Geriatric Medicine and Geriatric Psychiatry, two crucial disciplines in older adult care. Throughout the project, efforts to clarify differences and similarities between these areas were integrated into various aspects, including the Resource Kick-Off Event, communication strategies, Geriatric Round series, and focus group sessions. The initiative emphasized the importance of collaboration and communication between geriatricians and geriatric psychiatrists, encouraging a unified approach to care.

Recognizing the need for accessible community resources for older adults, the Wallet-sized Resource Card *(appendix 12)* for Seniors was developed in April 2020. This practical resource aimed to connect patients with community support services. Furthermore, to address FPs' discomfort with dementia management, the initiative organized the PSP Dementia Session on January 30, 2020. This session provided increased opportunities for dementia education among FPs, enhancing their ability to provide better care for patients with dementia-related concerns.

An essential ongoing collaboration was established with the Specialized Community Service Programs (SCSP) since April 2021. This collaboration sought to clarify referral pathways, navigation, and coordinated care plans, increasing access to community supports and allied health services for older adults. The SCSP integration into the FNW Home Health Focus Group meetings further strengthened the support network *(appendix 13).*

Moreover, building relationships with the FHA Specialized Seniors Clinic was a significant aspect of the initiative. Two focus groups (*appendix 14)* were conducted in October 2022 and April 2023, providing a platform for open dialogue to address frustrations and challenges faced by providers and older adults. Additionally, the Delirium Summit on November 30th, 2022, and the Geriatric Continuing Education Series (GCES) in 2022 and 2023 contributed to building partnerships with geriatricians, geriatric psychiatrists, and the health authority.

In conclusion, the Older Adult Shared Care Initiative's various activities and deliverables have enriched care coordination,

addressed key challenges, and ultimately enhanced support for older adults with complex health concerns within the FNW community. The ongoing commitment and collaboration among stakeholders have paved the way for improved outcomes and better care for this vulnerable population.

LESSONS LEARNED

Throughout the Older Adult Shared Care Initiative, numerous successes and milestones were achieved, fostering trust and building stronger relationships within the community. One significant achievement was bringing together stakeholders to understand and share available resources, resulting in increased awareness of support services like the Alzheimer's Society. The initiative emphasized collaboration, leading to better partnerships between FPs and specialists. Collaborative events and platforms, like focus groups and panel presentations, provided opportunities for open dialogue and addressing challenges within the community. The restructuring of Specialized Community Service Programs (SCSP) and Home Health, while yielding positive effects on provider satisfaction and relationships, required ongoing support and collaboration to ensure continuation of services. Day-to-day relationships improved, enhancing comfort levels for FPs to reach out to their specialist colleagues and seek advice, bridging the gap that formal documents couldn't achieve. Reflecting on their involvement, physician leads expressed pride in tackling a challenging task systematically and building a strong foundation. Building trust and repairing historically challenging relationships brought significant achievements and momentum to the initiative. The project's success was marked by increased communication and understanding between providers, laying the groundwork for more collaboration in the future.

However, the initiative also faced some challenges and areas for improvement.

- Unnecessary administrative burdens on FPs, particularly concerning referral rejection and redirection, have persistently posed challenges within various areas of the health system, requiring ongoing attention and resolution.
- The development of a wallet-sized resource card revealed the need to prioritize existing allied health support and community navigators (e.g., BC 211) to ensure sustainable content and maintenance.
- Managing the project scope's complexity proved challenging, with instances of scope creep leading to the necessity of integrating new activities and objectives into the project while staying aligned with the overall vision.
- Physician time constraints posed considerable challenges for scheduling, as clinicians faced ever-increasing workloads, leading to delays in project activities and requiring greater flexibility in coordinating future engagements.
- The COVID-19 pandemic introduced unforeseen challenges and disruptions, causing further timeline delays and underscoring the need for adaptable planning and robust mitigation strategies to ensure continuity in future initiatives.
- The COVID-19 pandemic had a notable impact on opportunities for face-to-face engagement, presenting a significant barrier to in-person interactions and collaboration, requiring the implementation of innovative virtual engagement methods.
- The project's success heavily relied on the strong commitment from partners throughout its duration, underscoring the importance of fostering and maintaining collaborative relationships to drive continued progress and success.
- Despite best efforts, providers still feel unclear about the differences between Geriatric Medicine and Geriatric Psychiatry, which can be attributed to the complexity of the mental health system in terms of access and navigation. This challenge highlighted the need for continued educational initiatives and

enhanced clarity on the roles and services offered by each specialty to improve overall care coordination for older adults.

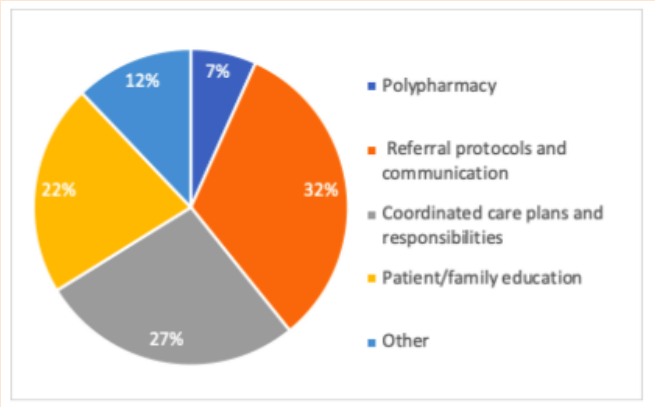
- Involvement of allied health support, such as RNs in practice, CHNs, and MOAs, played a crucial role in encouraging team-based models of care and promoting more comprehensive and coordinated healthcare delivery for older adults with complex health concerns. However, challenges in reaching out to certain participants for focus group participation underscored the need to explore alternative strategies for effective stakeholder engagement in future initiatives.

NEXT STEPS

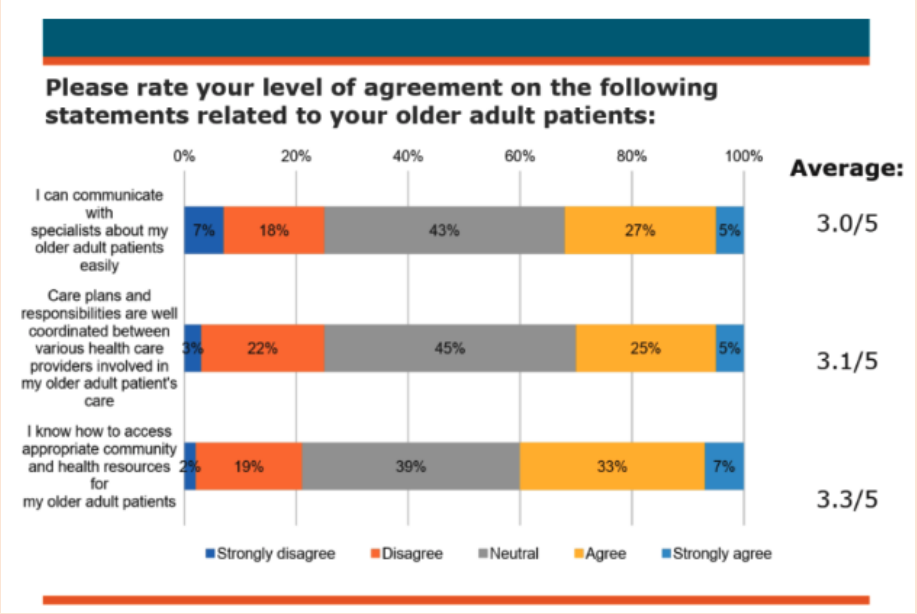
To ensure the sustainability and spread of this impactful work, key strategies were identified. Consistent and scheduled educational series, reminders about available resources, and regular check-ins with FPs and specialists are essential to maintain engagement. Webinars and educational aspects should continue to spread knowledge, while fostering new relationships with incoming members ensures continuity. However, it is important to note that the Wallet-sized Resource Card for Seniors, developed in April 2020, will not be sustained. The development of this card revealed the need to prioritize existing allied health support and community navigators (e.g., BC 211) to ensure sustainable content and maintenance.

In conclusion, the Older Adult Shared Care Initiative showcased collaboration and communication in enhancing care coordination for older adults with complex health concerns. By valuing relationships and fostering trust, the project created an impact on the community's healthcare landscape. The valuable lessons learned from this experience serve as valuable advice for other groups undertaking similar work, emphasizing the significance of relationships, education, and ongoing engagement to achieve meaningful and sustainable change.

EVALUATION FRAMEWORK & DATA MATRIX

IHI Modified Triple Aim	Anticipated Outcome	Data Source(s)	Results
Provider Experience: To what extent does the program contribute to family physicians' increased understanding of what resources are available to their older adult patients in the FNW?	Increased physician understanding of community resources Increased understanding of specialists' scope of practice Shortened wait times Improved patient outcomes due to seamless communication	Program documentation FHA referral program data Community resource to access key services (i.e. Specialized Seniors Clinic, Alzhemiers clinic, clinical pharmacy, Geriatric RACE line)	This project emerged out of the need for improving coordination of care for older adult patients with complex health concerns. In order to do so, this project aimed to streamline the process by supporting Family Physicians (FP's) and specialists around the available resources and services within the community for this patient demographic. In 2019, the FNW organized a Resource Kickoff for FP's to increase their knowledge surrounding the current landscape of available resources for older adults. While members gained an 88% better understanding of the gaps and challenges pertaining to the coordination of care for older adults, there continues to be 5 main challenges which impact coordination of care for medically complex older adults: 

In 2020, members provided their feedback through our ongoing bi-monthly member feedback survey as it pertained to communication and coordination of care for older adults; more specifically when providing patients care alongside specialists and other healthcare providers. As a result, 60% of FP's noted satisfactory communication with specialists, 62% reported care plans are well coordinated across involved care providers and 66% of FP's noted that they know how to access appropriate community and health resources for their older adult patients.



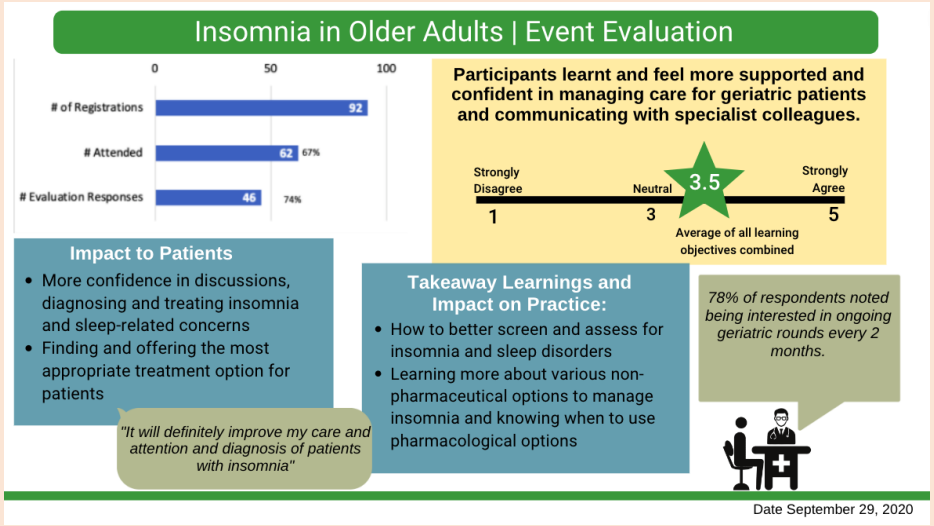
Throughout the duration of this project, a total of 5 Geriatric rounds transpired between 2020 to 2021, which addressed the following topic areas through Ask the Expert (ATE) series :

1) General Overview (2020)
2) Insomnia in the Older Adult (2020)
3) ATE: Mental Health & Geriatric Psychiatry (2021)
4) ATE: Polypharmacy (2021)
5) ATE: Dementia/Alzeimer's Diagnosis and Medical Interventions (2021)

The goal of these sessions were to provide role clarity for the various clinician and healthcare providers involved in patient care, while simultaneously providing FP's the opportunity to develop partnerships and establish relationships with geriatricians and geriatric psychiatrists.

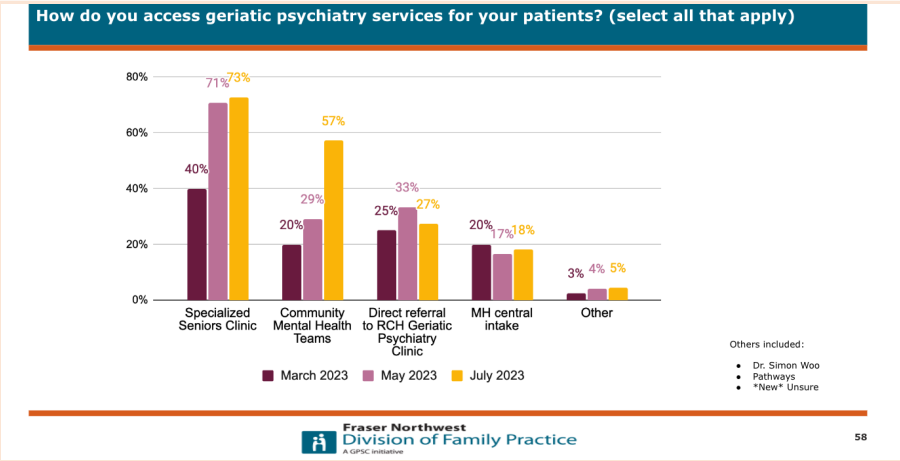
During the General Overview Geriatric round, there were multiple key takeaways members noted, including the following concerns which continue to worry them regarding their geriatric patients:

- Having timely access to specialists, services and supports
- Limited access to public funded community supports
- Managing patients quality of life with multiple comorbidities and polypharmacy
- Isolation, losing independence and decision making, lack of support from family members
- Dealing with family member expectations and values



70% providers who attended the Insomnia in Older Adults event, expressed that they were more confident in managing the care for their geriatric patients. Similarly, 70% of providers noted that they felt they could easily communicate with specialists about their geriatric patients.

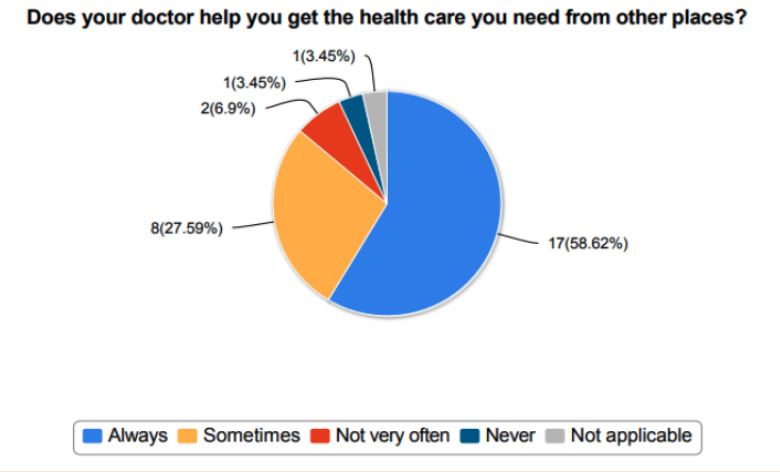
In our ongoing FNW bi-monthly member survey, providers noted which of the following services they access for their patients. It was identified that 40% of providers utilize the Specialized Seniors Clinic and 25% directly refer to Royal Columbia Hospital (RCH) Geriatric Psychiatry Clinic.

			 It is evident, collectively through these project activities, FP's have gained an increased awareness of the available community resources and services for older adults. As well, notable increases in confidence with managing the care and treating the older adult patient demographic various health conditions. It is also important to mention, while measurable differences in knowledge and confidence were shown pertaining to patient care, there remain limitations addressing shortened wait times.
Patient Experience: To what extent does the program contribute to improved patient care?	Increased physician understanding of what resources are available Increased understanding of complex medical diagnoses for patients	Patient satisfaction Average wait times # of community resources available Physician satisfaction	In 2019, a patient survey was disseminated to better understand how patients accessed care, in addition to their overall satisfaction of care received. Patients noted the following obstacles as barriers when accessing care in their respective communities:

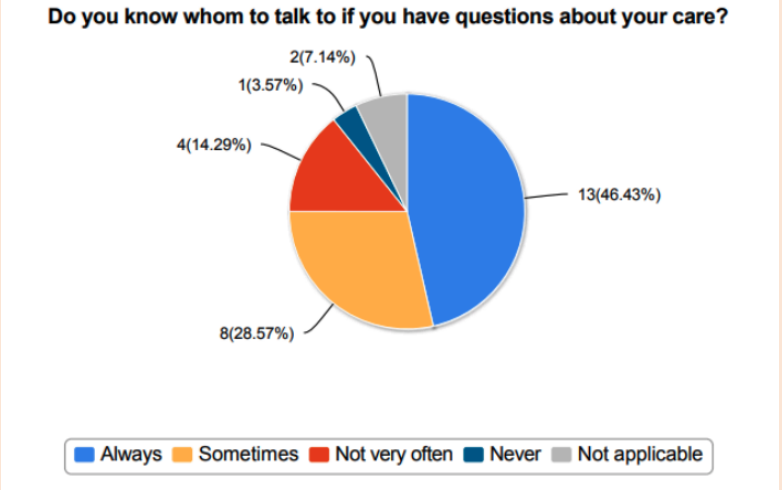
	Increased satisfaction for patients Decreased referral wait times	# of engagement sessions for physicians and specialists	

Answer	Count	Percent
Difficulty getting a referral	5	9.26%
Difficulty getting an appointment	4	7.41%
Waited too long between booking appointment and visit	11	20.37%
Waited too long to see the doctor (i.e. in-office waiting)	7	12.96%
Service not available in the area	2	3.70%
Service not available at time required	1	1.85%
Transportation problems	4	7.41%
Unable to leave the house because of health problem	1	1.85%
General deterioration of health	5	9.26%
Other	2	3.70%
None Of The Above	12	22.22%

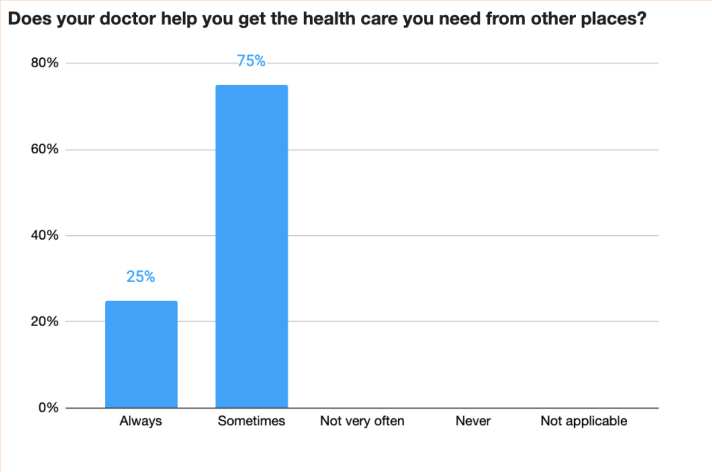
Similarly, 38% of patients indicated that their healthcare provider either '*sometimes, not very often or never'* provides help when seeking care from other places.



As well, 46% of patients noted they either *'sometimes, infrequently or never'* know who to speak to when questions arise about their health and care overall.

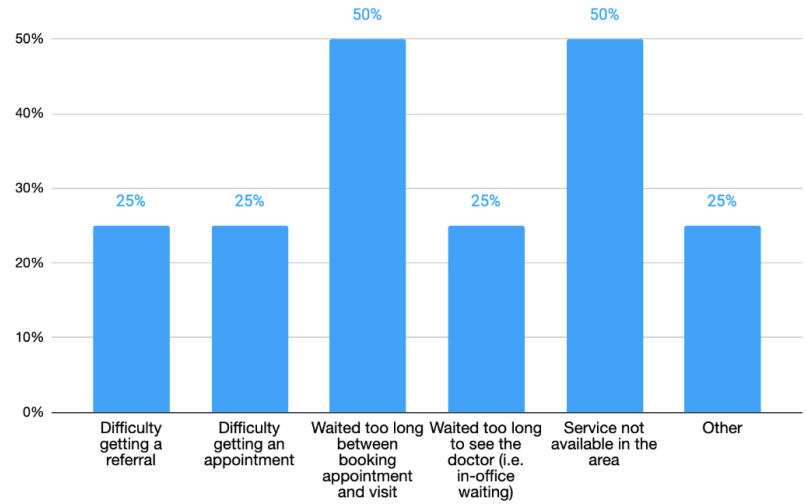


In 2023, this patient survey was relaunched in order to understand the current climate of patient care and identify any changes that transpired over the course of the project. As seen below, 75% of patients noted that their doctor 'sometimes' assists them when accessing care from other providers or community health services.



When addressing accessibility to care, common obstacles highlighted by patients included:

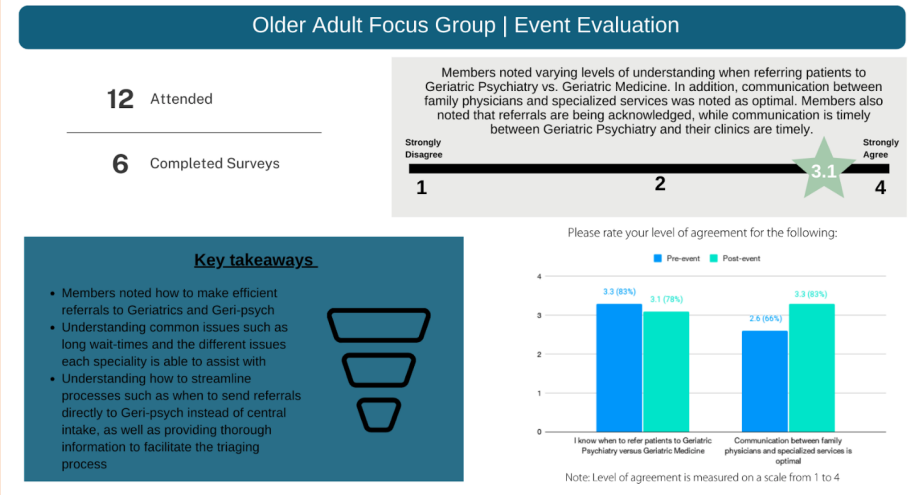
If you experienced obstacles in getting the care that you need, please select which apply. What types of difficulties did you experience?



It is evident that there continues to be long wait times between booking an appointment and having the first point of contact with a physician (50%) for older adults seeking care. It was also noted that services of interest were also not available in the area (50%).

Collectively through this patient feedback survey, it is apparent that there continue to be gaps in patient care as it relates to accessibility of patient care. As a result, patient satisfaction has been shown to be impacted as a result. It is also important to note, a limitation of this project includes the limited data collected on the ongoing average wait times for referral services within the community.

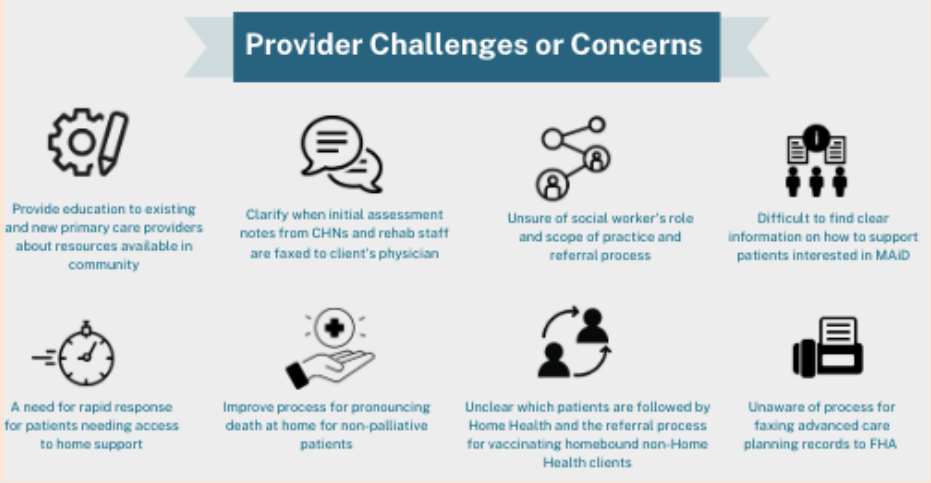
			As noted above, the FNW hosted a series of events aimed at increasing provider knowledge. In 2020, the first geriatric round took place and provided FP's a general overview of geriatric care. It was identified that 78% felt more confident managing the care for their geriatric patients and 76% of providers felt they could easily communicate with specialists about their geriatric patients. Members noted the following major themes they took away from this geriatric round: 1) A better understanding of how to perform capacity assessments and how to facilitate conversations with patients 2) How to manage insomnia and sleep disorders with CBT 3) A better understanding on how to prescribe and manage donepezil and calcium supplements for patients.

Provider experience: To what extent does the program contribute to increased coordination of care between family physicians and specialist physicians.	Increased physician understanding of community resources Increased understanding of specialists' scope of practice Improved provider satisfaction due to reduce physician burnout - patients are being seen when they need to be - preventative care	FNW Member Event FHA specialist program data Specialist Satisfaction Physician satisfaction interview/survey	It's important to note, throughout the duration of the project and through implemented feedback mechanisms, program staff identified FP's were experiencing trouble understanding the roles geriatric medicine and geriatric psychiatry did within patient care. In 2023, the FNW launched an Older Adult Focus Group, where 78% FP's indicated that they knew when to refer patients to Geriatric Psychiatry versus when to refer to Geriatric Medicine. Similarly, 83% of FP's noted communication between Psychiatry and their respective clinics were timely.  While efforts have been in place to provide role clarity between Geriatric psychiatry versus Geriatric medicine, there continues to be gaps in understanding among physicians as noted above. However, members noted how to streamline processes (i.e. when to send referrals to Geri-psych instead

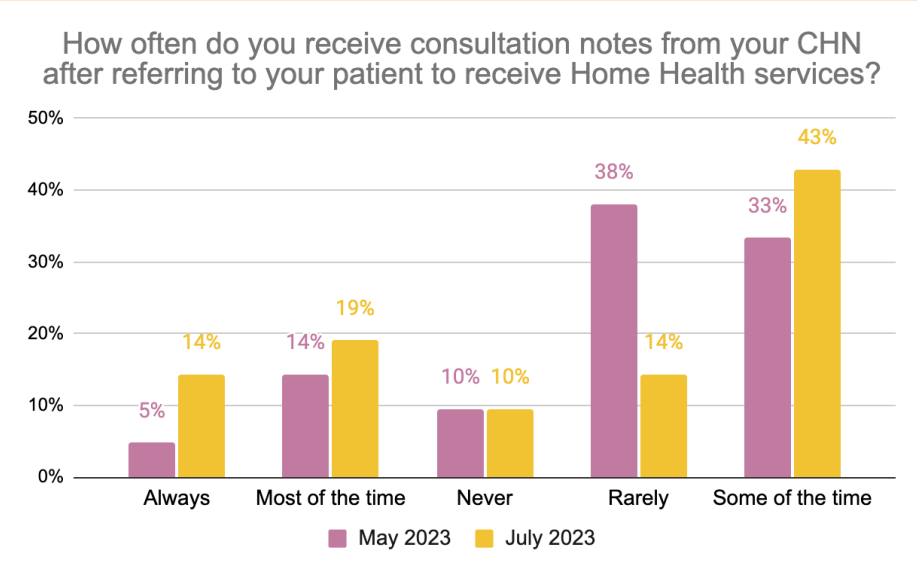
of central intake), along with having a better understanding of the ongoing concerns surrounding long wait times.

Overall, educational events have impacted physician understanding of available resources. However, there continues to be a limitation with the existing referral wait times, as well as measuring physician burnout.

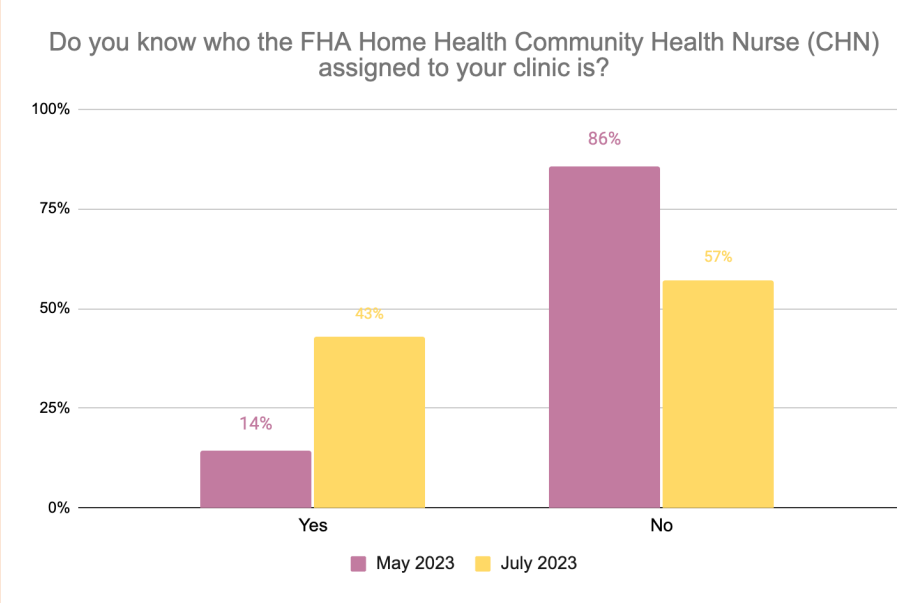
Between 2021 to 2022, A community year in review was administered to collect ongoing provider feedback from Home Health and Community physicians. Some of the common challenges providers noted include the following:



Through our ongoing FNW bi-monthly member survey (May 2023 to July 2023), we collected feedback from our members pertaining to the consultation notes received from the Community Health Nurse following a referral made to Home Health:



In the most recent member survey, 57% of providers noted that they do not know who their FHA Home Health CHN is for their assigned clinic.

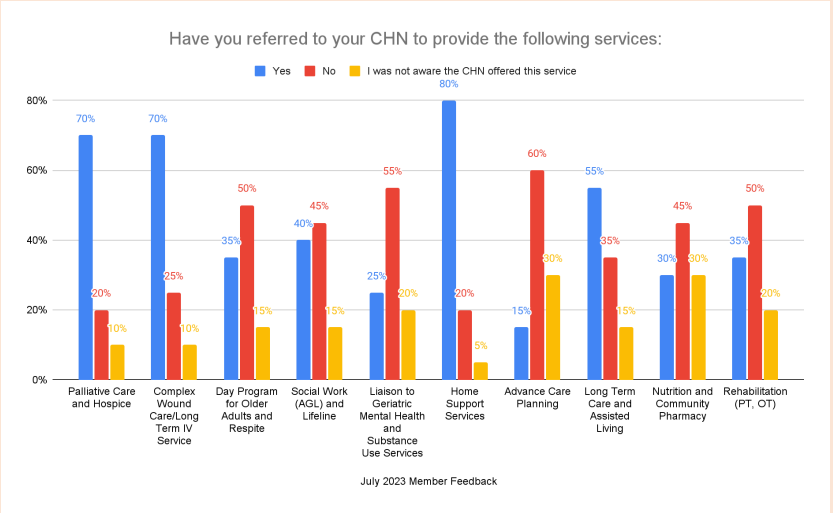


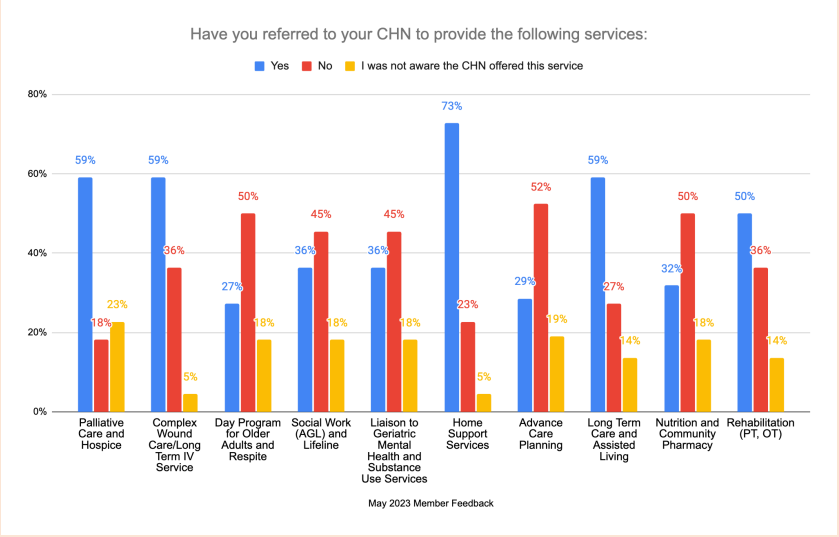
Similarly, when asked which of the following community resources have providers utilized most, they indicated the following in both the May 2023 and July 2023 member survey:

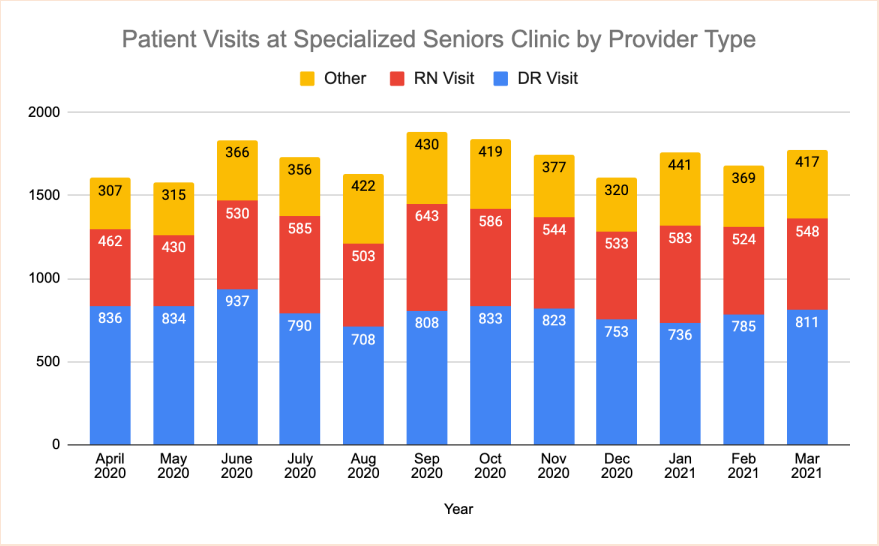
1) Home Support Services
2) Palliative Care and Hospice
3) Complex Wound Care/Long Term IV Service

TEMPLATES AND FORMS

SharedCare
Partners for Patients



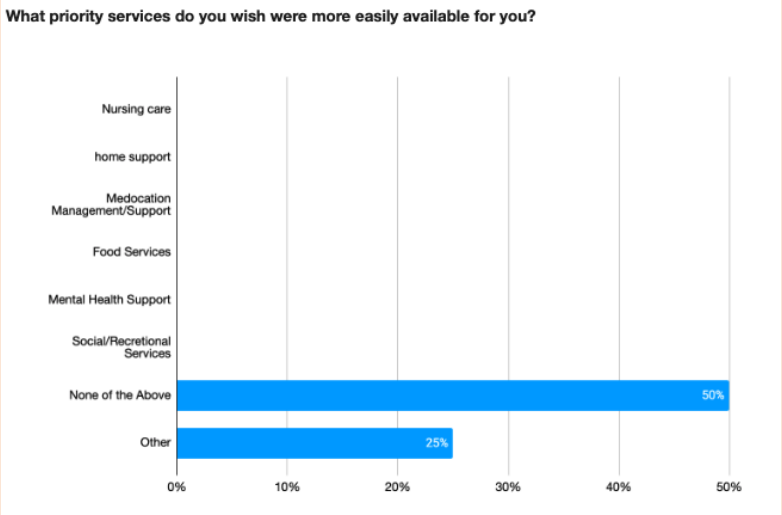


			Collectively, this data shows that providers are well versed and relatively knowledgeable of the available community resources. However, there are some gaps in provider knowledge as it pertains to services provided by the Community Health Nurse.
Health outcomes: To what extent did the program contribute to a change in health care utilization and what effect did it have on system costs?	Decrease in the number of ER visits, admissions and repeat visits Increase in patient/family satisfaction Decrease in ER/admission costs	Program documentation # of ER visits # of ER admissions # of referrals to specialist services (i.e. geriatrician AL/HH, Specialized Seniors Clinic) # of referrals to community resource services	It is important to address the limited data collected on health outcomes, throughout this project, namely the number of ER visits and ER admission rates for older adults. However, it is important to report the number of patient visits at the Specialized Seniors Clinic and the top reasons for the associated visits. 

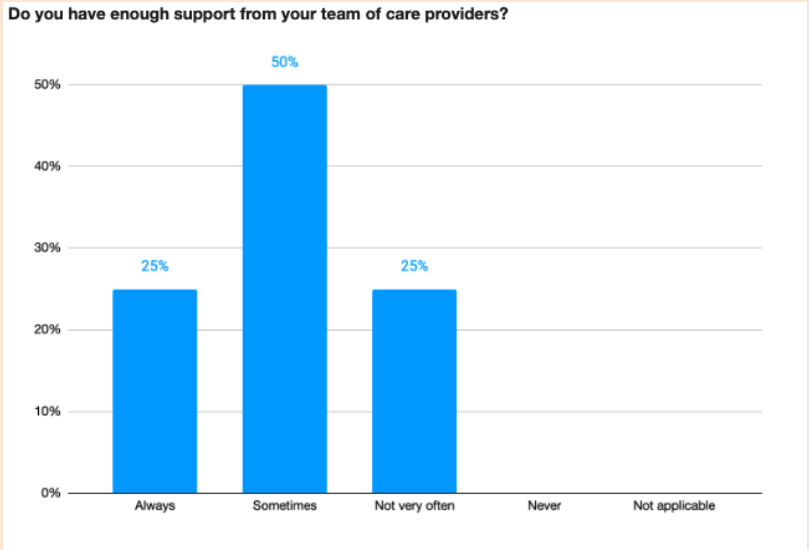
Top reasons for visits	Number of Visits between April 2020 to March 2021
1. Televisit - RN	4651
2. Televisit - DR	1127
3. Televisit - SW	958
4. Follow up - DR (60 MIN)	873
5. Televisit - OT	836
6. Follow up - DR	755
7. Follow up, DR (45 MIN)	626
8. Follow up, DR (30 MIN)	614
9. Initial DR + RN	518
10. Televisit - Pharmacist	507
11. Others - consists of 146 other visit types	9199

It is important to highlight patients feedback as it pertains to health outcomes, such as through a patient survey. A patient noted that wished for easier accessibility, alongside areas of improvements to care with respect to

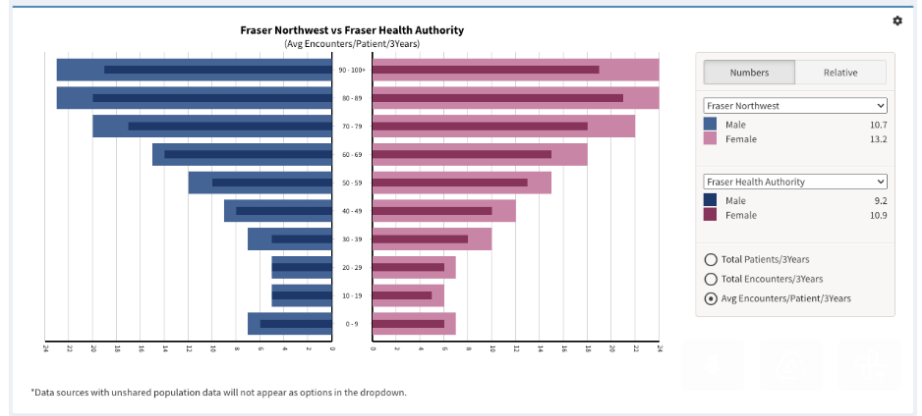
GP, ER, specialist and pharmacare. However, 50% of patients indicated that none of the listed priorities were more accessible.



As seen below, 50% of patients noted that they 'sometimes' receive enough support from their team of care providers, while 25% indicated 'not very often'.



While there is limited pertaining to the immediate and long-term impacts on healthcare outcomes, it is important to address the volume of older adults who are accessing healthcare services within the FNW. As seen below, data from the Health Data Coalition (HDC) shows a large influx of the average number of patient encounters among male and female patients over the age of 60 years in the last 3 years. It is also important to note that this continues to be the largest population group to utilize healthcare services both within the FNW and FHA region.

			
Sustainability & Spread: What are the unanticipated outcomes of the proposed strategies?	Sustainability of program	Program documentation Survey/interview feedback Engagement satisfaction	As part of the close out activities for this project, the team conducted an interview with the lead physicians to capture the key learnings, successes, remaining gaps and sustainability of this project. Below are the reported findings: **<u>Successes</u>** • *"The biggest thing is bringing everyone together to better understand resources that could be helpful to patients (Alzheimer Society), Understanding issues better"* • *"Bringing everyone together, understanding each others perspectives"* • *"Building partnerships with alzheimer's society, allows for collaboration"* • *"Day to day relationships that are built that piece of paper might not be able to do"*

- *"Connection with FPs and specialists to understand challenges and best way to approach and reach our goals."*

Challenges

- *"There are still some people that do not know the difference between the specialties. Through the best efforts, there are still gaps in knowing the difference between Geriatric Medicine and Geriatric Psychiatry. The mental health system is difficult to navigate"*
- *"Low Attendance rates of FP - noticed that there are FPs who don't show up in any of this event but send referrals (either lack of time/low interest). See more names in referrals than see at meetings. How do we engage with these family physicians?"*
- *"How many active members we have so that we know and to understand better why there might be a low attendance rate."*

Sustainability

- *"Regular scheduled engagement/ education series - reminders on how to use resources/ Engagement sessions"*
- *"Follow up directly with GPs- to see what challenges they have, to see if there are any specific cases."*
- *"Continue webinars/educational aspects."*
- *"New specialist and new GP with old members- maybe around late fall together. To introduce new members to old, to know what resources are available"*

Similarly, the FNW team collected additional feedback from our Older Adult Committee. 100% of the committee members expressed that the stated objectives and intended outcomes were met and noted the following reasons:

			• *"Improved communication, provided education, and clarified roles."* • *"The objective and intention is to improve care for frail seniors. We were able to achieve this by providing education to GPs."* Some of the highlighted **successes** are highlighted below: • *"bringing specialists and GPs together to look at systemic issues and find potential solutions"* • *"Increased knowledge of resources and management options for all parties involved"* • *"To encourage involvement from GPs in older adult care."* **Sustainability of program** • *"Continued liaison with every specialists"* • *"Further regular interaction"* • *"Ongoing education session to keep GPs engaged"* Overall, the key lessons learned from this project include the importance of ongoing education and knowledge sharing between all healthcare providers involved in patient care. This is crucial as multiple providers, specialists and stakeholders are involved in the delivery of patient care. In addition to ongoing education for providers, active involvement and collaboration with community stakeholders is equally important for the coordination of care between community providers and may better equip physicians.

*__Shared Measures__ were not implemented at the time of this project creation/implementation

APPENDICES

- Appendices of relevant documents that would be helpful for the audience.Hi
- Provider testimonials, patient impact stories, and quotations including the Physician Lead End of Project Survey
- Include PDF copies and links to all resources created during the project.

1. Patient Survey 2019
2. Provider Survey 2019
3. Patient Survey 2023
4. Member Feedback Survey 2020 (May/Sept)
5. Older Adult & Medically Complex Resource Launch Evaluation – November 26, 2019
6. Resource Kick-Off Event Table Discussion
7. Geriatric Rounds Evaluation – July 16, 2020
8. Geriatric Virtual Rounds: Insomnia in Older Adults - September 29, 2020 Analysis
9. Geriatric Virtual Rounds: Mental Health & Geriatric Psychiatry Management, Tools, and Supports - Jan 26, 2021
10. Geriatric Virtual Rounds: Polypharmacy -How to Prescribe and Deprescribe - March 30, 2021
11. Geriatric Virtual Rounds: Dementia/Alzheimer's - May 25, 2021
12. Older Adult - Pocket Resource - updated 2021_02_04
13. Home Health Visual
14. Focus Group 2
15. Shared Care Physician Lead Close Out Survey