# **Persons with Frailty Focus Group – January 20th, 2020**

# ***Table Group Discussion Notes Summary***

# ***for Distribution to Workshop Participants***

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| **Compilation of “Top Three” Gaps in Care Experience For Persons With Frailty** | | | | |
| **Table Rosslyn** | **Table Cathy** | **Table Sarah** | **Table Jennifer** | **Table Trish** |
| Navigation |  | System Navigation | System Navigation/Care Coordination Among Specialists and Providers |  |
| Coordinated Information | Shared & Accessible Patient Information |  |  |  |
| Social Investments In Community Services | Accessibility to Reliable Supports |  |  |  |
|  | Formal & Informal Patient & Care giver Support & Education |  |  |  |
|  |  | Early Identification & Management | Early Identification of Rising Risk Persons |  |
|  |  | Inadequate Capacity Across the System |  | Inadequate Capacity, Integration & Teaming Across the System |
|  |  |  | Inequitable Access to Care Services | Lack of timely & 24/7 Access |
|  |  |  |  | Lack Subsidized & Supportive Housing |

## **Whole Group Workshop Reflection: What strikes you as either commonalities or differences amongst the work of the five table groups?**

**Navigation**

* It’s a complicated system – even we do not know everything
* Needs to start early

**Patients Front Line Needs**

* Don’t lose sight of patient/caregiver’s frontline needs of paper lists on the wall with instructions because different PSW’s come in or that tell how patient can engage in own care

**Capacity Issues**

* Therefore, supported self management is needed and navigation is a key part of this

**Primary Care**

* PC physician is the constant – most important to the individual because this is with who they feel safe

**OHT Development**

* Don’t forget Primary Care clinicians
  + We need change – there is both opportunity and inspiration
  + “we” feel isolated and need to be supported

**Access**

* Bring services to people and/or have one place to go e.g. hubs are people friendly
* Need a culture change so going to the emergency department is not the automatic “go to place” if family physician is not conveniently available

**Rural**

**Lack of Trust & Confidence**

* Between and among providers, hospital, patient, Primary Care (and this is partly because we don’t know where people should go)

**Palliative Approach to People with Frailty**

* Advance care planning

# **Rosslyn’s Table**

## **Top Three Gaps in Care Experience**

**Navigation**

* Starts early – ACP (Advance Care Planning) – with people you trust (peers, consistency, knowledge – not just health), choice, flexible
* At multiple stages across continuum

**Coordinated Information**

* Among providers – digital, client/family focused, accessible, focused on the right information, level of literacy and cultural diversity in mind

**Social Investments in Community Services**

* Day programs, housing options (campus models, subsidized retirement homes, cooperative neighborhoods e.g. field of dreams Elmira) and transport options

# **Details of Discussions**

* Upstream thinking – prevention, promotion
* ACP - was a QIP so already some planning
  + Coach with gatekeepers (Primary care and/or day programs) -RN working in dispatch with 911 services
  + Need follow up once information has been provided
* Access to urgent/crisis @ home
  + Eligibility criteria can be restrictive/slow access
* Home visits (primary care) 24/7 access
* Human Health Resources shortages/changes: both quantity and expertise
* Alternates to LTC i.e. low cost/affordable housing (3 participants mentioned this)
* Increase in social services and increase in community support services
  + Community airways clinic – add SGS (Special Geriatric Services) support
* Early detection – dementia
* Respite – day programs (equals more capacity for early intervention) and at home
* Criteria in Rehab – ø access with memory loss (2 participants mentioned this)
* Transportation options to access service (need to be creative)
* $$ - costs related to access many services especially for people with limited incomes ($19,300 low income cut off is very low) – results in “missed’ persons who can’t/won’t access because of costs
* Navigation supports
  + Understanding very complex system
  + Don’t know options – don’t know what they don’t know
  + Has to be patient centred
  + Primary Care based or linked
  + Across silos, not just health care but including social and community services
  + Has to be tailored for the person
* IGSW – flexible, practical navigation
* Continuum of home/housing “in place” different levels of care in neighborhood campus model
* LTC beds shortage (where needed)
* Access to $$$ for long term care to age at home supports, especially to support clusters of seniors
* Specialist supports to primary care, targeted screening & walk with patients/families
* Idea: geriatrician in community once per month to do clinic
* Communication:
  + Question: digital EMR/minimal data base mobile device available
  + Information accessible across systems
  + Lack of access to patient’s notes in Primary Care pharmacy when in acute cate = basic access needs to be with the patient
* Lack of education to patient/family
* Caregiver “crash” – burn out
* More than one issue needs addressing in Primary Care visit
* Wait list for doc/specialist advice
* Idea: Support Primary Care to action identified clinical and social issues
  + Start with understanding that ageing is normal
* Choice: able to live @risk – autonomy, trust, consistency
  + Depends on relationships – peers and hcps (health care providers)
* CREMS – more proactive with increased funding
  + Some remote monitoring for high risk already available
  + frequency of calling 911= a good indicator of risk
* Rapid Intervention Teams e.g. Niagara Falls EMS 2005 pilots
  + RNs in dispatch centre can triage differently to divert dispatch of ambulance i.e. send social support, screen with a home visit, non-emergency transportation rather than acute blue light response
* High percentage of solo MDs lack supports; in home 24/7 visiting – lack of resources for visits

# **Cathy’s Table**

## **Top Three Gaps in Care Experience**

**Shared and Accessible Patient Information**

* Collaborative communication and EMR

**Formal and Informal Patient and Caregiver Support & Education**

* Person and role centred
* Standard, timely, what to expect, capacity to address?

**Accessibility to Reliable Supports**

* Timely access supports prevention of worse health outcomes
* Idea: Build on innovative models
* Transportation and transitions in care are issues and reliable access is affected by:
* Geography
* Eligibility
* Income
* Knowledge of what is available
* Capacity

# **Details of Discussions**

* Improve front line care – patient/families lack tool kit for direction care I.e. instruction lists
* Expanding role for home care to include/expand direct care
* Communication gaps between home, primary care, providers
* Person and role centred communication tools – language tailored to role
* Unreliable home care
* Include care givers in provision of care communication
* Communication flows across roles
* Multiple people in home – separate roles – lack of connection
* Not one consistent relationship – who do you communicate with?
* Privacy agreements impact ability to communicate
* Decrease in home visits – average family doctor not doing home visits – not feasible
* Families need multiple respite options and options have costs – need to build capacity with people going home – interplay between mental health and co- morbidities
* Transportation options as part of the interaction
  + Specialized transportation increases impact
  + Day to day interactions
* Families burnt out trying to deal with conditions – can’t do it anymore
* Capacity issues across system
  + Providers, caregivers, primary care, care coordination
* Access
  + Gaps across geography
  + Low income?
  + Eligibility/internal process/ 1 route to access – not connected across pathways
* Resources available for in home supports i.e. meals, homemaking
* Support in managing non-urgent conditions
* Health system navigation for patients/family/providers
* Shift in primary care to focus on one issue, minimum questions – does not promote interplay
* Stigma – language e.g. bed blockers, frequent flyers, Tsunami – people internalize
* How do we coordinate multiple contacts especially with frail clients – within context of primary care how do we streamline communication/roles?
* Shared patient record – volume of information if one record – how do you efficiently sort through it
* Coordination among various roles that coordinate care
* Lack of consistency in people supporting care

# **Sarah’s Group**

Three gaps and accompanying areas for improvement in the care of the frail elderly:

1. Early identification and management:
   1. Supporting a “prematurely aged” population who may not meet existing service eligibility criteria
   2. Care planning prior to the crisis
   3. Integrating wellness supports into traditional medicine
   4. Focus on function versus the disease
2. System navigation:
   1. Need to improve digital communication, information sharing and enablers to care
   2. Support to navigate through transitions
   3. Earlier involvement of clinical and community supports, including geriatric medicine, advance care planning, etc.
3. Building capacity… in:
   1. The system- to perform earlier diagnosis, focus on functional medicine, and recognize the impact and provide management of multiple conditions
   2. Assess capacity in bedded levels of care and clinical health human resources to support an increasingly large and aged population
   3. Increased access to specialists- not “sick enough” to refer
   4. Improve communication- to patient and caregiver, and between providers with knowledge transfer, training, instilling choice and resiliency in the patient
   5. Building a caring community- identifying more neighbourhood assets to supplement the paid caregiving system

The identification of various gaps, prior to theming them above

* Transitions in care, especially hospital to home
* Communication across sectors and to patients and caregiver
* Digital enablers to care
* In home supports, including homecare and primary care access
* Early identification and providing support where patients are at
* Providing more supports for the caregivers (respite care, training, education, empowerment, choice)
* Primary care needs more time spent with patient to identify root causes of symptoms, understand and appreciate comorbidities, diagnosis dementia earlier and develop a robust care plan
* Address clinical symptoms and function, alongside the social determinants of health
* Awareness of a hospital in-patient strategy for frail seniors?
* Supports for prematurely aged or those with early onset of disease
* Examine other community assets and ready the community to help
* Examine cross- system capacity and ALC rates (bedded levels of care, support for responsive behaviours, training of clinicians, clinical capacity)
* System-wide prioritization framework for patient need- will help address resource scarcity
* Lack of integration between sectors and organizations
* Need to take a wellness approach to care, including nutrition, exercise, mental health, resiliency training, and proactive case planning

# **Jennifer’s Group**

Some general ideas/concepts ideas that came up in broader discussion

* Concept of physiological frailty (not an adjective but a physiological state)

**Group One (Jennifer F’s Group)**

***Gaps***

1. Individuals and their caregivers who are flying under the radar (those at rising risk)
   * No one is monitoring the situation
   * Often when they get to community and primary care they are in crisis and only option is to refer them to ER
   * Need more integration of preventative services
   * Early referrals are necessary
2. Individuals and their caregivers dealing with multiple co-morbidities
   * They are often referred to multiple specialists which is exhausting/segregated/siloed
   * If someone is dealing with cognitive impairment/dementia one specialist is stressful…compound this by multiple specialists
3. Inequity in access to care: depending upon where you enter the system your access differs e.g., primary care referred to memory clinics but many primary care physicians are unaware of the options / opportunities
   * Need more consistency in approach and access
4. Information sharing/exchange
   * Not able to share information across healthcare providers (shared EMRs) let along community services
5. There are no alternatives to emergency rooms
   * Nothing between primary care and acute care
   * Primary care often has voice mail messages that refer folks to emergency rooms after hours
6. Lack of shared knowledge about what is out there and how to access it (amongst healthcare providers and community service providers as well as patients and caregivers)
7. Individuals on long term care lists who should not be on long term care lists
8. There is no coordination of supports for caregivers

***Ideas/Opportunities***

* We “catch” caregivers and their loved ones where they are (we find them they don’t find us)
* Community Hub (further developed below)
  + Co-location and coordination of services with a focus on combining upstream prevention and escalation of care options (primary care/urgent care etc.)
* Creating a hub of specialists (or a way of linking non-hospital-based physicians)
* Leveraging entire health system to better coalesce around early identification of needs
  + Gatekeeper model similar to Guelph (individuals who are trained to refer to Here 24-7)
  + Social prescribing by family physicians

***Addressing Gap #1 (Patients at low risk and rising risk)***

Community Hub model

* Virtual (coordination of services) AND co-located
* Focus would help support decreasing number of visits across system (gap #2)
* Could be multiple locations (dif combination of services at dif locations)
* Should not duplicate community centres but work with community centres
* Ties to Dementia Friendly Communities

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| --- | --- | --- | --- | --- | --- | --- |
| System navigation/  Care coordination | Preventative Services | | Primary care & other community health | Acute care / Specialists | Hospital | Long Term |
| Day to day necessities | City & Community  Services |
| Centralized intake  24 hour line  System navigators/  Care coordinators  Info hub | Groceries  Social programming  Salon  Library  Coffee shop  Communal dining options  Transportation options | Day programs  Community programs  Exercise programs  Gatekeeper program | PCP office (s)  PC drop-in clinics e.g., dieticians  Memory clinics co-located & close to com services  Pharmacy  Labs & imaging  Joint care teams  Mental health  First aid | Foot care | Satellite?  Acute care option?  Some co-located specialists working with primary care  Part of discharge planning | Information (as part of a spectrum of options) Care coordination |

# **Trish’s Group**

**Frail Elderly Notes- Trish’s group**

Gaps

-Education on what “frail elderly” is. On all ends (docs, providers, caregivers)

- Primary care directs to ED, and it is hard to access PC

-Emerge department becomes the front door for services because you can access them all in one place.

-Incapacity in PC to address ambulatory care sensitive conditions.

-removal of “frail elderly” criteria from programs such as the Rapid Access Nurse.

-The hospital is open 24/7 therefore it is accessed after hours.

-Comprehensive geriatric services are limited in the community.

- No continuity in assessments. Multiple different assessment are done that are not connected to each other.

- Limited services for low income seniors (taxis, meds)

- Lack of community home visits. To observe medications, in home conditions such as pharmacists and nurses.

- divided services within home care. Separate contracted service that don’t speak to one another.

- Lack of home care capacity and consistency. Private care services end up being more effective and are not affordable.

-Lack of geriatricians

-Digital health record doesn’t connect.

- Primary care can’t support 24/7

-Legislative requirements can be barriers ie/ paramedics.

- physician billing leads to barriers to care

-Subsidized retirement home/seniors supportive housing is limited and over subscribed.

**Ideas**

1. Integrated community based geriatric teams ie/ G-FACTT
   1. Comprehensive assessment
   2. Specialists
   3. Pharmacy, labs, respirologists
   4. Better management of ambulatory care sensitive conditions.
   5. Access to EMR/clinical record
   6. Collaborative care plan
   7. Embedded within PC
2. Accessible 24/7 care with rapid response (24-72 hours) for non-affiliated docs (solo) PCP with timely support from medical specialists. (RAC for PCP)
3. Subsidized and supportive housing for seniors.