CHCA Project ECHO
Integrated Seniors Care

All Teach, All Learn

Bridging the Knowledge Gap in
Home and Primary Health Care

Building Competencies in Integrated Care: Lessons from Vancouver’s Home ViVE Program

Teaching Presentation: Dr. Judith Hammond, Family Physician, Vancouver, BC
Case Study: Dr. Conrad Rusnak, Family Physician, original member Home ViVE Program
Joti Bagri, Registered Nurse, Home ViVE Program

Host: Jennifer Campagnolo, Canadian Home Care Association
December 4, 2024

Land Acknowledgement

Artist Credit: Patrick Hunter

We recognize with humility and gratitude that Canada is located in the traditional, historical and ceded and unceded Lands of First Nation, Inuit and Metis Peoples. On behalf of us all, we acknowledge and pay respect to the Indigenous peoples past, present and future who continue to work, educate and contribute to the strength of this country.

Project ECHO ISC

- Project ECHO Integrated Seniors Care (ISC), in partnership with the Canadian Medical Association, will enhance the competencies of home care and primary health care providers to meet the holistic and diverse needs of Canadian seniors with complex chronic conditions in home and community settings.

Project ECHO ISC

Year 1 Theme: Mild Cognitive Impairment, Dementia

- According to the Public Health Agency of Canada, approximately **597,000** Canadians were living with dementia (2020)
- **25%** of those aged 85+ are diagnosed with dementia
- Each year, about **76,000** new cases of dementia are diagnosed in Canada, with the risk increasing significantly with age

Sources

Public Health Agency of Canada (PHAC). "Dementia in Canada, including Alzheimer's disease." Government of Canada, 2020.

Alzheimer Society of Canada. "Latest Stats on Dementia." Alzheimer.ca, 2022.

Canadian Institute for Health Information (CIHI). "Dementia in Canada." CIHI.ca, 2021.

Project ECHO ISC

Mild Cognitive Impairment, Dementias

Integrated Clinical Practice Approach to Educational Content:

- Early Identification and Assessment
- Collaborative Care Planning
- Team-Based Care Delivery
- Shared Decision-Making and Communication
- Engaged Persons, Family and Caregivers
- Holistic Safety and Risk Management

With a focus on the:

SKILLS

KNOWLEDGE

ATTITUDES

needed by primary care and home care providers

Learning Objectives:

Through today's session, participants will be able to:

Recognize
The impact of collaborative care through enhanced patient care and healthcare navigation.

Consider
Local opportunities to improve integration among providers, home care services and population needs

Reflect
On the attitudes necessary to implement integrated team models and approaches

Introductions

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Founding member,
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Joti Bagri
Registered Nurse
Home ViVE Program
Vancouver, BC

Home ViVE

Home Visits to Vancouver’s Elders

ECHO Integrated Seniors Care, December 4, 202

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Disclosures

- No financial or other conflicts of interest

Objectives

1. Home ViVE’s:
   1. Mandate
   2. Patient population
   3. Team composition
   4. Model of care
2. System Challenges
3. Case for discussion

Mandate

- Provide comprehensive quality care to frail elderly patients in their homes (as an alternative to long term care)
- Respect patient / family wishes regarding the direction and goals of their health care

Goals

- Maintain or improve function, independence, symptom management and safety*
- Manage chronic diseases appropriately
- Support patient and caregivers and help them navigate a complex and fragmented health care system
- Avoid or delay hospitalization for acute issues
- Avoid or delay long term care admissions
- Provide good palliative care at end-of-life, support home death as possible

*Balancing safety and autonomy is a frequent part of the job

Patient population

- Age over 80 (with exceptions)
- Homebound, unable to get out consistently for care
- Moderately or severely frail (Clinical Frailty Scale 6+, dependent for iADL and ADLs)
- Medical and/or psychiatric impairment
- Often at high risk for decompensation, hospitalization
- Care needs exceed what can be provided through usual community supports
- Geographically limited to Vancouver

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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Who would be on your home visiting dream team?

Team composition
high degree of collaboration within team

- 9 part-time family physicians (currently paid fee-for-service through provincial Medical Services Plan)

The rest of the team are employed by Vancouver Coastal Health (based out of shared office):

  - 2 FTE Nurse Practitioners
  - 3 FTE registered nurses
  - 1.5 occupational therapist - currently have 1 FTE
  - 1.5 physiotherapists - positions not currently filled
  - 2 rehab assistants - positions not currently filled
  - 1 community liaison worker
  - Part-time clinical pharmacist
  - 1 administrative assistant

Additional collaboration with other care providers:

- Community health units (6 geographically defined units in Vancouver): RNs, including specialized nurses (eg NSWOC- nurse specialized in wound/ostomy/continence); CMs (nurses or social workers), PT
- Mental health teams: geriatric psychiatrists and mental health case managers (also do home visits)
- Lifelabs mobile lab
- Occasionally with paramedics
- Hospitalists and other providers in ED and hospital to facilitate assessment and discharge
- Specialists: Geriatricians and wide range of other specialists providing either longitudinal support or episodic consultation (often by phone)
- Other (private and not for profit): Foot care; PT; Mobile optometry; Mobile dental hygienists, dentists, denturists; Mobile Audiology; Massage; Meals on Wheels, neighbourhood houses

Model of care

- Low volume, high intensity:
  - Medical and/or psychiatric complexity (with frequent crises / exacerbations)
  - Language barriers (frequent use of Provincial Language Services interpreters)
  - Hearing impairment that slows communication
  - Social / family dynamic complexities
  - Palliative care at end of life
- Longitudinal care with one primary care provider (NP or GP), highly collaborative with team members and other care providers
- Routine monitoring in addition to flexible visits and responsiveness in crises
- One physician always on call overnight/weekends/holidays (phone or home visits)
- Exclusively home-based

Model of care

Referrals

- In-flow based on MD/NP capacity - currently about 6 month wait time
- Referral sources: Community CM’s, RN’s, MH teams, GP’s, Specialists, Hospitalists etc.
- Referrals are screened by HV nurses for appropriateness (age, frailty, lack of existing primary care)
- For medical-legal reasons patients aren’t considered part of the practice until the MD/NP has done first visit (Private vs HA practice)

Model of care

New patient intake assessment

- Initial assessment completed by primary care provider (+/- by allied health team members) is often time-consuming, involving reviewing previous medical records, sometimes phone calls for collateral information, and often about two 30-45 minute home visits within the first month.
- Complex geriatric assessment: Medical history, social history, functional assessment, medication review (on paper and in reality), physical exam
- Identification of substitute decision maker
- Assessment of unmet needs re: medical management, symptom management, patient and caregiver support, home equipment, etc

Model of care

Initial intake meetings and ongoing

- Education of patients and families about frailty

- Respect patients’ wishes and their autonomy. Understand their risk tolerance. Understand their need for diagnostic clarity. Understand their preferences re: medical care.

- Goals of care conversations

- [Medical Order for Scope of Treatment (MOST) form is kept on patient’s fridge and in their EMR, includes 24/7 ph number for Home ViVE]

Model of care

Ongoing care

- Routine visits: often about once a month; some patients require more or less frequent
- Timely assessment and intervention for urgent medical issue or functional decline: medical care as well as increasing care / functional support as needed.
- Reviewing of goals of care as situation changes (progression of frailty and underlying medical conditions)
- Palliative care at home and/or transition planning, if appropriate, to long term care or hospice.

Model of care

Palliative care at home

- 40% of our patients die at home, and more receive much of their palliative care at home (avoiding admission to long term care or hospice and with less time spent in hospital)
- Anticipatory guidance
- Enlisting and educating family caregivers- may help with sc medication administration
- Nursing support may include daily visits at end of life or, sometimes, shift-care nursing (up to 24/7 for 5-7 days).

Strengths of Home ViVE

- Relatively low staff turnover
- High degree of team cohesion with efficient, timely communication
- Experienced, skilled team members
- Attitude: caring, creative, responsive, flexible, patient-centred, mutually supportive
- Shared, portable electronic medical record

Some numbers

- Patient roster: about 400 patients at any given time, but about 550 over the course of a year, with about 150 new patients/ year, 100 deaths/year and 50 LTC placement/year
- Home deaths: 60 - 70%
- High intensity / low volume: 5 to 7 home visits and 3 to 5 phone calls with patients per day, in addition to collaboration with allied health, acute care, specialists, pharmacy, etc.

What is the need?

- Population size City of Vancouver ~ 680,000
- How many do you think are > 65?
  How many are > 85?
- What percent of seniors do you think are frail with CFS 6+?
- What percent do you think live in long term care?
- How many seniors in Vancouver would benefit from home-based primary care?

What is the need?

We don't know exactly, but we're pretty certain we're not meeting it

- Population size City of Vancouver ~ 680,000
- How many do you think are > 65? About 17%, ~115,000
  How many are > 85? About 2.2%, ~14,960
- What % of seniors do you think are frail with CFS 6+? *We don't know*
- What % of seniors do you think live in long term care? ~3% ~3,450
  According to Vancouver Coastal Health, in 2025 there will be a shortage of 300 LTC and 90 AL beds in Vancouver.
- How many seniors in Vancouver would benefit from home-based primary care? *Probably many more than we're currently serving*

System challenges

1. Limits to support available to current Home ViVE patients
    - High staff turnover in Community Health Units (CHUs)
    - Limited availability of public OT, PT and rehab
    - No social worker position in Home ViVE, limited SW service in CHUs
    - Home support (community health workers): limited availability, limitations of what staff are allowed to do, inconsistency in staff and timing
    - Communication during transitions of care with ED and hospital
    - Medical information systems: improving, but still limitations in information availability and accuracy

System challenges

2. Challenge in scaling up to expand access to home-based care for more frail, elderly Vancouverites
    - Availability of people for all roles: nursing, physiotherapy, occupational therapy, rehab, family physicians, nurse practitioners, and incentive structures favouring other types of work (eg private practice)
    - For family physicians in particular: burden of 24/7 call (unremunerated),

Sophia

Sophia

- Dementia- late stage
- Mobility
- Comorbidity
- Supports
- Goals

HomeVIVE referral criteria met

- Lives in Vancouver
- Over 80
- Rockwood Frailty score 7
- Housebound
- Not getting primary care (walk in clinic)

Clinical Frailty Scale

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team visits

clinical course

success

Longitudinal care

24/7 coverage

Shared EMR

Timely visits

Close relationship with nursing

Tapping into community resources

Discussion

CMAJ front cover, May 2021

Discussion / Q&A

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Upcoming TeleECHO Sessions

CHCA Project ECHO Integrated Seniors Care

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Bridging the Knowledge Gap in Home and Primary Health Care

Interdisciplinary Collaboration for Seniors with Cognitive Impairment
January 22 2025, 12 - 1pm ET

Linking Health and Community: Social Prescribing in Integrated Seniors' Care
February 12 2025, 12 - 1pm ET

CHCA Project ECHO Rural Connections

All Teach, All Learn

Bridging the Knowledge Gap in Isolated Communities

Bridging Gaps in Diabetic Foot Ulcer Management: Care Strategies
December 11, 2024, 11:00 – 12:00 pm ET

Register: cdnhomecare.ca/chca-project-echo/