Invitational Collaborative Forum
“Working Together for Seniors Care in Alberta”

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Alberta Seniors’ Health Strategic Clinical Network
Presentation to
Alberta College of Family Physicians
Edmonton AB
2014-04-26
Focus Question and Responses

Question:
“What is currently being done by your organization to prepare for and to address the challenges ahead in the care of seniors and more specifically the frail elderly?”

Responses:
– On behalf of Alberta Seniors’ Health SCN
– On behalf of AHS Community Seniors Health
– As a clinician specializing in Geriatric Medicine
Contributions to the Aging Experience
-from a broad Gerontological perspective

- Personality, cultural and cohort variables
- Genetic variables and early development
- Environment, Diet and Exercise, Lifestyle
- Biological age-associated changes
- Acute and Chronic Illness
- Disuse and Deconditioning
- Cognitive and Psychological variables
- Co-morbidity and Frailty
- Social roles, expectations & social supports
10 PRINCIPLES FOR MEDICAL CARE OF OLDER PERSONS

BCMA 1999 and CMA 2000

#3. Particular needs of frail elderly persons
#5. Effective planning for geriatric services

http://www.cmaj.ca/content/162/13/1871.full
Those planning for the health care needs of our growing aging population should:

- urgently respond to the changing demography;
- address access issues created by geographic isolation;
- apply the findings of relevant health care research;
- ensure that older persons and their families are involved in the planning process;
- ensure that caregivers are also involved in the planning process;
- pilot new strategies and evaluate and refine them prior to implementation;
- continuously evaluate to determine optimal methods of service delivery;
- be responsive to linguistic and cultural diversity;
- remain open and flexible to innovation; and
- ensure that adequate human resources are available to provide medical care to older persons.
3. Particular needs of frail elderly persons

- The "frail elderly" are those older persons with multiple interactive, acute or chronic health problems compounded with functional and/or cognitive impairments and the need for supportive care. To achieve optimal health outcomes and quality of life and to minimize inappropriate use of resources, these elderly persons should have rapid access to an integrated range of specialized medical and other health care services.
AHS Community Seniors Health

• Established at origin of AHS
  – Strategic planning portfolio to standardize approach to care across AHS
  – Link between organizational Zones and AH
AHS Community Seniors Health

• Current Major Areas of Work (relevant to topic)
  – Continuing Care Innovation/Redesign
  – Continuing Care Capacity Forecasting/Addition
  – Continuing Care Quality Management Framework
  – Palliative and End of Life Care Framework
Figure 14: Provincial Government Hospital Expenditure by Age, Alberta vs. Canada, 2010

Source: CIHI
Strategic Clinical Networks are provincial, clinically-led teams designed to improve:

- patient outcomes, using evidence & measurement (effectiveness)
- patient satisfaction & experience (accessibility and acceptability)
- clinical practices, including appropriateness of care (effectiveness & appropriateness)
- efficiency and reduction in unjustifiable clinical practice variation (efficiency & effectiveness)
- patient & system safety (safety)
- value for money (efficiency, effectiveness, appropriateness)
- prevention of disease and lessen burdens of illness in AB.
Alberta SCNs – April 2014 2012 - 2014 (under consideration)

1. Diabetes, Obesity and Nutrition
2. Seniors Health
3. Bone & Joint Health
4. Cardiovascular Health and Stroke
5. Cancer
6. Addiction & Mental Health
7. Emergency
8. Critical Care
9. Surgery
10. Respiratory
11. Primary Care & Chronic Disease
12. Maternal, Child, Newborn & Youth Health
13. Kidney
14. Diagnostics (Imaging/Lab Medicine)
15. Gastrointestinal
16. Neuroscience, Vision, ENT
Seniors Health SCN

• Launched June 2012

• Core Committee (40 members)

• 4 Working Groups

• 300+ Community of Practice Members

• 60+ Researcher Network

Seniors Health SCN leadership team
Lynne Mansell, Senior Provincial Director
Duncan Robertson, Senior Medical Director
Heather Hanson, Assistant Scientific Director
Jayna Holroyd Leduc, Scientific Director
Mollie Cole, Manager
Dennis Cleaver, Executive Director
Mission: To make improvements to health care services and practices that enable Alberta’s seniors to optimize their health, well-being, and independence.

Platforms:
- Healthy Aging and Seniors Care
- Aging Brain Care
- Anticipating an Aging Alberta

Pillars:
- Research and Innovation
- Engagement
- Communication
- Quality Improvement and Measurement
Healthy Aging and Seniors

• Preventing, anticipating, optimizing and living with conditions that compromise health and functional abilities in later life.

• Minimize the impact of frailty, illness and disability on independence and quality of life:
  – falls prevention
  – delirium prevention
  – co-morbid depression
  – “elder friendly care” – acute care (e.g. Comfort Rounds)

• Resilience in seniors
Aging Brain Care (ABC)

• preventing, anticipating, and living with conditions common in later life that **result in cognitive changes**

• provincial framework and strategy for dementia
• public education
• dementia care in the community
• assessment of technology

• evidence-informed **care pathway**: health promotion to end of life care
  • evidence based modules
  • guidelines
  • protocols
• for use by caregivers, seniors and health care providers
Dementia Clinical Pathway

- Prevention/maintaining function & wellbeing
- Diagnosis
- Early support
- Goal of Care conversations
- Determining safe Driving
- Adult Day Support program
- “Worried well”
- Antipsychotic use
- End of life care

“modules” on the Dementia Clinical Pathway:
- Evidence-based practice used by clinicians, seniors
Anticipating an Aging Alberta

• Address opportunities and challenges posed by Alberta’s demographic changes

• Influencing and informing health policies developed by:
  – Government of Alberta
  – Alberta Health Services
  – municipalities
  – professional groups
  – community organizations

• Partnering with educational institutions
Seniors Health Strategic Clinical Network

2014-2017 Transformational Roadmap

Seniors Health Strategic Clinical Network
The Seniors Health Strategic Clinical Network (SH SCN) brings together a diverse group of stakeholders – clinicians, researchers, patients, families, and decision makers – to focus on reshaping and improving health care services and practices that enable seniors to optimize their health, wellbeing and independence.

Today, one in nine Albertans are over the age of 65 increasing to one in five over the next two decades. The aging population creates both challenges and opportunities for the healthcare system. The Seniors Health SCN is working on the most effective ways to meet the healthcare needs of Alberta’s seniors based on evidence and best practices within Alberta and around the world.

By addressing the unique needs of seniors within our healthcare system, we will have a positive impact on both the individual’s health outcomes and the efficiency of the healthcare system. As examples of their unique needs, Alberta seniors continue to use emergency departments at twice the rate of non-seniors and are admitted from there to an inpatient unit at five times the rate of non-seniors. Lengths of stay also increase dramatically with age.

Priorities and projects
Over the long term, the three major platforms for the SCN will be: 1) Healthy Aging and Seniors Care; 2) Aging Brain Care; and, 3) Anticipating an Aging Alberta.

A proposed project within the Healthy Aging and Seniors Care platform is the implementation of the best practice of “elder-friendly care” that is emerging in research and practice across Canada. The goal is to improve

http://www.albertahealthservices.ca/7702.asp
Some Principles of SGS

• Target Frailty, Complex Co-morbidity, and Cognition
• Self-referral and screening usually inappropriate but case-finding and anticipatory care is vital
• Real opportunities for prevention exist
• Apply evidence-informed body of knowledge but decision-making often in grey areas
• Address physical, mental, functional, social support in team-based approach.
• Relationship with primary and community care vital
• Build capacity, transfer knowledge and develop skills in all professions/caregivers
Questions to ask yourself at admission of a frail older person

- What was ‘pre-morbid’ level of function & support?
- What impact has recent acute illness had on function?
- Could hospital admission have been avoided by care at home?
- Can we all work toward an Anticipated day of discharge?
- How can nosocomial disability be prevented?
- Could pre-morbid level of function be improved?
- Will post-acute transitional or restorative care be needed to achieve functional recovery?
## How we die

*From Health care use at the end of life in Western Canada. CIHI: (2007).*

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudden Death</td>
<td>Individuals are likely to be in good health prior to the incident that causes death. This could be an accidental death, fall or trauma.</td>
<td>2.9%</td>
</tr>
<tr>
<td>Terminal Illness</td>
<td>These include individuals with a terminal diagnosis including cancer, CKD or HIV related.</td>
<td>28.4%</td>
</tr>
<tr>
<td>Organ Failure</td>
<td>This grouping includes individuals with long term limitations due to CHF/COPD</td>
<td>33.8%</td>
</tr>
<tr>
<td>Frailty</td>
<td>Individuals of advanced age who display a pattern of decline over time including neurological decline. This group also encompasses common causes of death in the elderly</td>
<td>29.3%</td>
</tr>
<tr>
<td>Other</td>
<td>Causes of death that are not included in the other groupings</td>
<td>5.6%</td>
</tr>
</tbody>
</table>
The CSHA Clinical Frailty Scale

A global clinical measure of fitness and frailty in elderly people”, CMAJ 30-Aug-05; 173(5;489-495)

- 1 Very fit – Robust, active, energetic, well motivated and fit; these people commonly exercise regularly and are in the most fit group for their age
- 2 Well – Without active disease, but less fit than people in category 1
- 3 Well, with treated comorbid disease – Disease symptoms are well controlled compared with those in category 4
- 4 Apparently vulnerable – Although not frankly dependent, these people commonly complain of being “slowed up” or have disease symptoms
- 5 Mildly frail – With limited dependence on others for instrumental activities of daily living
- 6 Moderately frail – Help is needed with both instrumental and non-instrumental activities of daily living
- 7 Severely frail – Completely dependent on others for the activities of daily living, or terminally ill
- Later additions
  - 8 Very Severely Frail
  - 9 Palliative/Dying
“FRAILTY SYNDROMES”

- Falls
- Delirium and Dementia
- Polypharmacy
- Incontinence
- Immobility
- End of Life Care
Mission: To make improvements to health care services and practices that enable Alberta’s seniors to optimize their health, well-being, and independence.

Platforms:
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- Aging Brain Care
- Anticipating an Aging Alberta

Pillars:
- Research and Innovation
- Engagement
- Communication
- Quality Improvement and Measurement
Who may access a Care Pathway?

- Wide access to generic components
- Selective access to individual information
  - Individual
  - Circle of care
  - Community Service providers
  - Primary and Secondary Medical Care Practitioners
  - EMS, ED Hospitals, Facility care providers
  - Researchers- with consent
Health Link Alberta, PHP, SCNs, RAAPID, PCNs, PCA, Clinical Pathways

Primary Care
PRE Referral / Procedure / Hospital

- Addiction and Mental Health
- Cancer Care
- Cardiovascular and Stroke
- Bone and Joint Health
- Senior's Health
- Obesity, Diabetes, Nutrition

Primary Care Networks, Primary Care Alliance, Family Medicine, Allied Health Professionals, Pharm, DI, Lab

Strategic Clinical Networks

RAAPID
Supports Clinician referrals & repatriation

Clinician Portal / Clinical Pathway Alliance
(Facilitates Supports Clinical Pathways)
- Creation
- Maintain
- Access
- Promotion
- Evaluation

Public Health, Community Health

Public Facing

Health Link Alberta
Telephone Triage and Advice for the Public (Protocols)

Personal Health Portal
- Creation
- Maintain
- Access
- Promotion
- Evaluation

Clinician Facing

Primary Care
POST Referral / Procedure / Hospital

Primary Care

Opportunities and challenges in elder care

Primary care “medical home” with support from SGS. Team-based care; expanded roles of non-MD practitioners. Home-based care and hospital avoidance. Urban/rural access issues. Widespread application of geriatric and palliative care principles.

Healthy Aging & Resilience. Could they reduce health care costs? What if we had effective Anti-aging Rx -other than diet & exercise?

21st Century Extreme Medical Tourism?
Vivo Bene Resort for Swiss Alzheimer Patients
Opened February 2014 Doi Saket, Chiang Mai. Thailand
Supplementary Slides Follow
Early warning signs of frailty (CSHA Frailty Scale Level 4), Combination of impairments may signal progression toward frailty (CSHA Frailty Scale Levels 5-7):

- weight change
- reduced physical activity levels and endurance
- impaired balance and mobility
- increased number and frequency of falls or first fall if not with cause
- declining functional status
- difficulties due to polypharmacy and psychoactive medications
- impaired vision/hearing
- increased alcohol consumption
- driving competency
- difficulty maintaining continence
- irregular patterns of sleep
- frequent/increased pain
- inappropriate behaviour
- social isolation
- transition in living circumstances
- change in family/caregiver support
- advanced caregiver stress
- irrational fears/concerns
- altered mental health delirium, depression and/or dementia
Development and Implementation of a Care Plan
(from BCMA Guideline and Protocol of Frailty)

- Patient rehabilitation potential
- Appropriate prevention activities for the patient
- Self-management support for the patient and family/caregiver
- Medication Review
- Advance care planning
- Management of health and safety risks (e.g. falls, living alone)
- Management of significant co-morbidities in relation to patient goals
- Expected outcomes
- Names and contact information of other providers involved in the care of the patient (i.e. for case conferencing as required)
- Plans for follow-up
Rationale for Attention to Frailty in Primary care
(Abbreviated from BC Guidelines 2007)

• to assess senior adults based upon level of risk and prioritize unmet needs in collaboration with the patient and caregiver;
• to determine whether older adults require additional care and support interventions in their current environment and
• to identify patients who are frail or at risk for frailty and refer those patients for further comprehensive assessment as needed.
Changes in these areas constitute early warning signs of frailty

- weight change
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- increased number and frequency of falls or first fall if not with cause
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- irregular patterns of sleep
- frequent/increased pain
- inappropriate behaviour
- social isolation
- transition in living circumstances
- change in family/caregiver support
- advanced caregiver stress
- irrational fears/concerns
- altered mental health status,
Having identified a frail older person or one at risk for Frailty
First Step to a Care Plan is Collaborative Goal Setting

• What are the person’s or family/caregiver’s concerns?

• What are the physician’s concerns?

• What are the patient’s priorities for their care when considering both the physician’s concerns and their own?

• What does the patient or family/caregiver hope to achieve from medical or rehabilitative treatment?

• What are their wishes for end of life care?
   (Discuss and document Goals of Care /Advance Care Plan)
Having identified a frail older person or one at risk for Frailty
what next?...

Next Step to a Care Plan – and
for each concern or complaint identify:

• What may be treated
• What may be susceptible to rehabilitation
• Appropriate Preventive interventions
• Information and Health Educational needs
• Self-management supports for the patient and family/caregiver(s)
Generational Trajectory for Boomers

- Baby Boomers”
- “Hippies”
- “Yuppies”
- “Bo-Bos” *
- Frail elders?
- Dead –like all other carbon-based life forms

* Google it!!
For information on Alberta Seniors Health Strategic Clinical Network and access to 2013-2017 Transformational Road Map visit:

http://www.albertahealthservices.ca/7702.asp