INNOVATION PROFILE

CARING FOR OLDER ADULTS IN THE COMMUNITY AND AT HOME (COACH)

HEALTH PEI

ADVANCING FRAILTY CARE IN THE COMMUNITY COLLABORATIVE

IMPROVING CARE FOR OLDER PEOPLE WITH FRAILTY AND SUPPORTING THEIR FAMILY/FRIEND CAREGIVERS

A 23-month Quality Improvement Collaborative

Canadian Foundation for Healthcare Improvement
Fondation canadienne pour l'amélioration des services de santé

Canadian Frailty Network | Réseau canadien des soins aux personnes fragilisées

This document was created by the Canadian Foundation for Healthcare Improvement which has now amalgamated with the Canadian Patient Safety Institute to become Healthcare Excellence Canada. There may still be references to the former organizations as well as their logos and visual identities.

About the Canadian Foundation for Healthcare Improvement

The Canadian Foundation for Healthcare Improvement supports partners to accelerate the identification, spread and scale of proven healthcare innovations. We work shoulder-to-shoulder with you to improve health and care for everyone in Canada. CFHI is a not-for-profit organization funded by Health Canada.

About the Canadian Frailty Network

The Canadian Frailty Network (CFN) improves the care of older adults living with frailty and supports their families and caregivers. CFN does this by increasing recognition and assessment of frailty, increasing evidence for decision making, advancing evidence-based changes to care, educating the next generation of care providers, and by engaging with other adults and caregivers.

The views expressed herein do not necessarily represent the views of Health Canada.

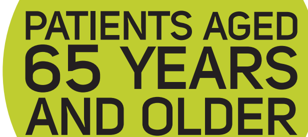
OVERVIEW

Caring for Older Adults in the Community and at Home (COACH) is a province-wide program in Prince Edward Island that improves access and quality of care for frail older adults, and their families and caregivers. COACH is a partnership between Health PEI's Home Care, Primary Care and Geriatric Programs that supports older adults to remain at home longer and return home from hospital sooner.

At the centre of the COACH program is a team of interdisciplinary, specialized healthcare professionals that includes a geriatric nurse practitioner, a primary care provider (physician or nurse practitioner) and home care care coordinator. The COACH team provides direct client care at home to predict, prevent or proactively manage health crises – and decrease the need for emergency services or admission to hospital. The team does this by encouraging advance care planning and access to community support. The COACH program increases awareness and expertise about complex geriatric syndromes for all clinicians who provide care to seniors, and teaches caregivers how to continue to care for and support their family members at home.

A pilot of the COACH program began in January 2015 in Montague, PEI. Since then, COACH has rolled out across the province.

TARGET GROUP FOR THE INNOVATION



COACH program participants are required to meet specific criteria, although outliers are assessed on an individual basis. COACH participants must:

- Be 65 years and older, with complex needs, including physical and psycho-social needs
- Have had a clinical frailty assessment that indicates the need for support (Rockwood Clinical Frailty Scale score of 6 or greater)
- Be primarily home bound due to cognitive or functional limitations
- Be experiencing one or more geriatric syndromes
- Have support from their primary care provider (physician or nurse practitioner) to receive care from the COACH team, and the physician/nurse practitioner must be willing to collaborate
- Be in a position to benefit from care coordination support on an ongoing basis
- Agree to receive care from the COACH team
- Live at home or in a community care facility (long-term care residents are not eligible)

TRAINING REQUIRED TO SUPPORT THE PROGRAM

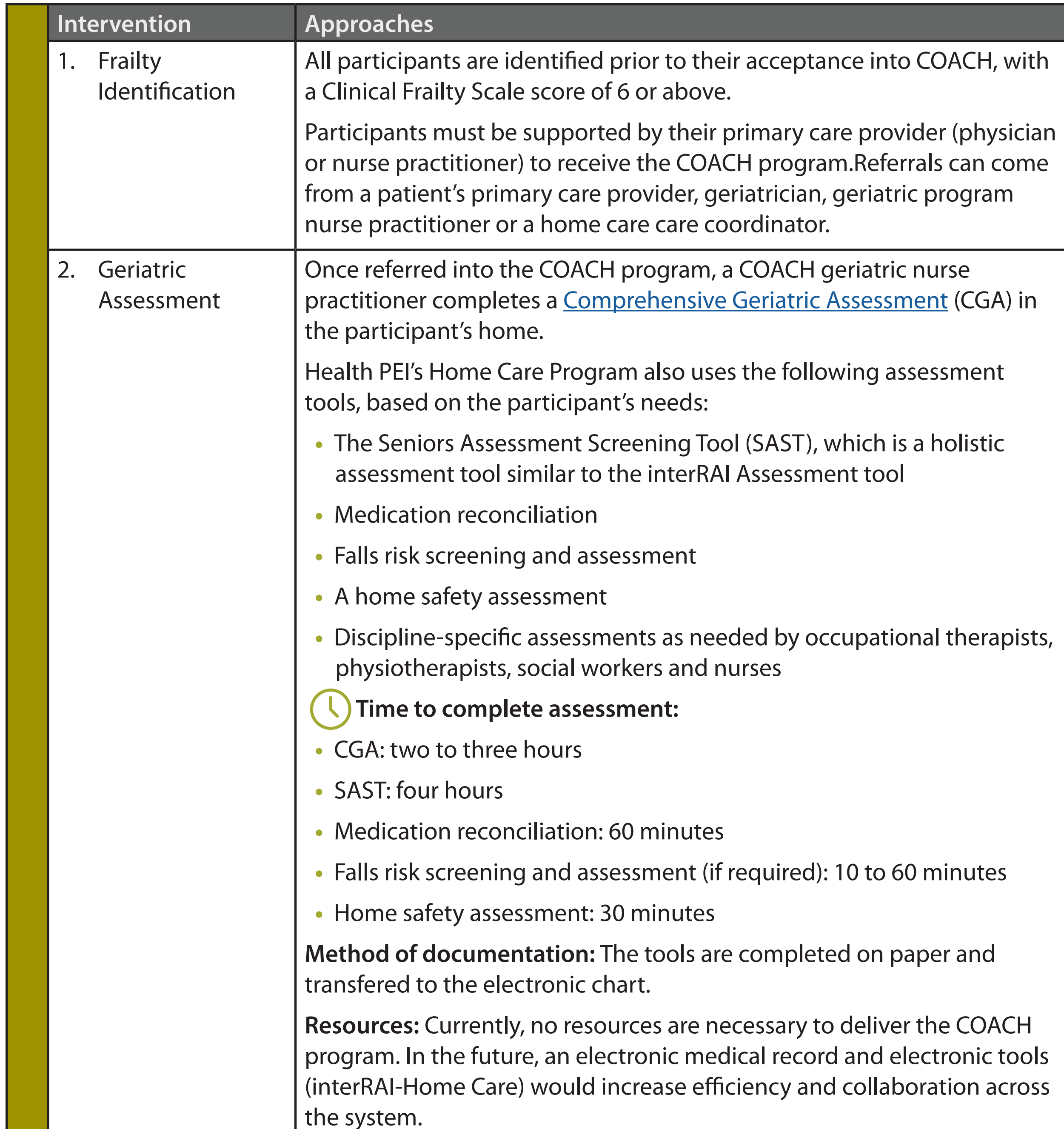
Health PEI's COACH program pilot increased awareness and educated front-line staff about geriatric syndromes. The focus was on increasing staff's awareness of what is appropriate in aging, and on managing chronic diseases with age-appropriate targets. Trust and accountability were built by mentoring staff as they learned new practices, and by working through the care of each client.

Weekly COACH rounds were also seen as a learning opportunity for all team members. By educating home care staff, the COACH pilot increased their capacity and supported their roles in patient care.

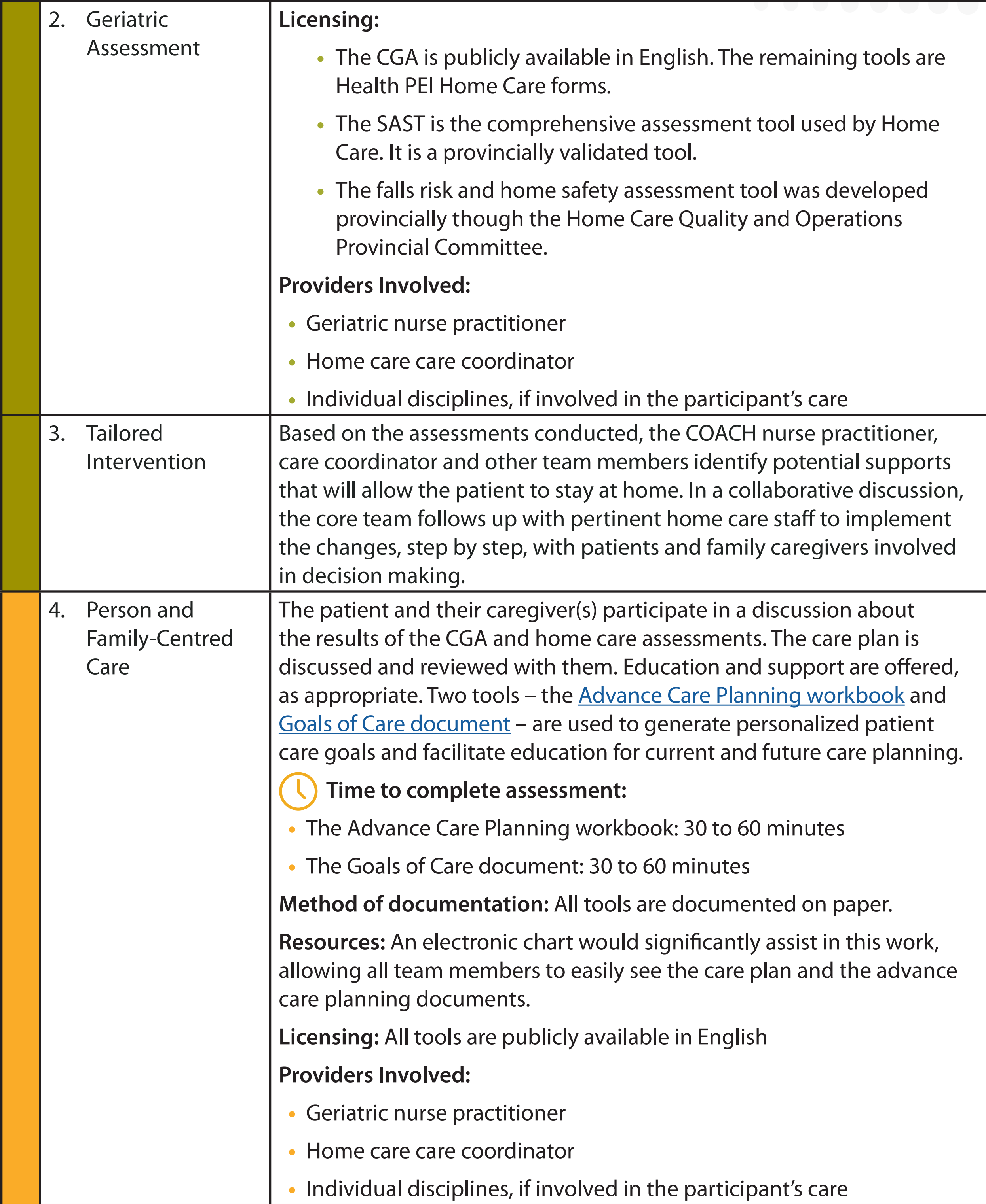
To educate staff, a geriatric team provided in-service learning sessions on geriatric syndromes, medications and other topics. These were seen as particularly helpful, and learnings have been

transferred to other home care clients. Primary care providers noted positive learning outcomes that included education related to medication reviews and adjustments, dementia versus delirium, and assessing home situations. COACH continues to work on identifying staff education needs. For example, a needs assessment was completed in spring 2019, and plans are underway to deliver staff education sessions provincially in response to the 2019 survey results.

APPROACHES TO INTERVENTIONS



Intervention	Approaches
1. Frailty Identification	All participants are identified prior to their acceptance into COACH, with a Clinical Frailty Scale score of 6 or above. Participants must be supported by their primary care provider (physician or nurse practitioner) to receive the COACH program.Referrals can come from a patient's primary care provider, geriatrician, geriatric program nurse practitioner or a home care care coordinator.
2. Geriatric Assessment	Once referred into the COACH program, a COACH geriatric nurse practitioner completes a Comprehensive Geriatric Assessment (CGA) in the participant's home. Health PEI's Home Care Program also uses the following assessment tools, based on the participant's needs: • The Seniors Assessment Screening Tool (SAST), which is a holistic assessment tool similar to the interRAI Assessment tool • Medication reconciliation • Falls risk screening and assessment • A home safety assessment • Discipline-specific assessments as needed by occupational therapists, physiotherapists, social workers and nurses **Time to complete assessment:** • CGA: two to three hours • SAST: four hours • Medication reconciliation: 60 minutes • Falls risk screening and assessment (if required): 10 to 60 minutes • Home safety assessment: 30 minutes **Method of documentation:** The tools are completed on paper and transfered to the electronic chart. **Resources:** Currently, no resources are necessary to deliver the COACH program. In the future, an electronic medical record and electronic tools (interRAI-Home Care) would increase efficiency and collaboration across the system.



2. Geriatric Assessment	**Licensing:** • The CGA is publicly available in English. The remaining tools are Health PEI Home Care forms. • The SAST is the comprehensive assessment tool used by Home Care. It is a provincially validated tool. • The falls risk and home safety assessment tool was developed provincially though the Home Care Quality and Operations Provincial Committee. **Providers Involved:** • Geriatric nurse practitioner • Home care care coordinator • Individual disciplines, if involved in the participant's care
3. Tailored Intervention	Based on the assessments conducted, the COACH nurse practitioner, care coordinator and other team members identify potential supports that will allow the patient to stay at home. In a collaborative discussion, the core team follows up with pertinent home care staff to implement the changes, step by step, with patients and family caregivers involved in decision making.
4. Person and Family-Centred Care	The patient and their caregiver(s) participate in a discussion about the results of the CGA and home care assessments. The care plan is discussed and reviewed with them. Education and support are offered, as appropriate. Two tools – the Advance Care Planning workbook and Goals of Care document – are used to generate personalized patient care goals and facilitate education for current and future care planning. **Time to complete assessment:** • The Advance Care Planning workbook: 30 to 60 minutes • The Goals of Care document: 30 to 60 minutes **Method of documentation:** All tools are documented on paper. **Resources:** An electronic chart would significantly assist in this work, allowing all team members to easily see the care plan and the advance care planning documents. **Licensing:** All tools are publicly available in English **Providers Involved:** • Geriatric nurse practitioner • Home care care coordinator • Individual disciplines, if involved in the participant's care

	5. Collaborative Care	The COACH team includes the geriatric program nurse practitioner, the primary care provider/nurse practitioner and a home care care coordinator. Other team members are determined based on needs and can include other home care staff, primary care staff and a geriatrician. Additional home care staff include home support, nursing, social work, occupational therapy and physiotherapy support in the home, as needed. The geriatric program nurse practitioner and home care care coordinator play a key role on the team, interconnecting between various areas of the health care system. Co-location of team members is seen as beneficial, particularly if an electronic medical record is not present.
	6. Community Supports	Depending on the individual needs of the patient, family and caregivers, connections are made with community supports – e.g. day program, music therapy, meals on wheels, self-help, dementia support.
Overarching Principles		Approaches
7. Quality Improvement, Change Management and Evaluation, and System Level Change		**Measurement** Key indicators include the following: • Hospital admissions, emergency department visits and primary care appointments • Advance care planning, measuring medical directives and goals of care completion • Length of stay of COACH clients who move to long-term care compared to average lengths of stay for individuals 65 years and older in long-term care Data is collected manually, from clinicians. The COACH program is currently exploring best approaches for assessing and measuring caregiver burden and stress.

OUTCOMES ACHIEVED

System utilization data from the COACH pilot (January to October 2015) demonstrated the following:

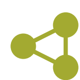
✓ Inpatient admissions decreased by 66 percent	✓ Visits to the emergency department decreased by 33 percent
✓ Primary care visits (average appointments per month) decreased by 50 percent	✓ Benefits for the system included savings of $1.41 million from 13 clients and families
✓ For the COACH clients who had advanced to long-term care (13 clients) and had passed away, the average length of stay in long-term care was .65 years, whereas the average lengths of stay in long-term care in PEI was 2.6 years	✓ Improved staff satisfaction was a major outcome. COACH clients are better able to self-manage and make informed decisions that positively impact their quality of life at home and, when necessary, support smoother transitions to and from acute care or long-term care

LESSONS LEARNED

The strong and effective collaborative partnerships among Health PEI's Home Care, Primary Care and Geriatric Programs was a key factor for the planning and implementation successes of the COACH program.

The implementation and spread of the program require adequate resources, such as geriatric nurse practitioners and care coordinators, as well as additional home care support, nursing, social work, occupational therapy and physiotherapy support in the home. These costs of care are lower and the benefit higher compared to current practices and resource utilization.

Also of significant note, documentation and communication would be better supported with an electronic medical record, which would allow for communication across systems



AVAILABLE RESOURCES, ARTICLES, RESEARCH ON THE INNOVATION:

- PEI COACH Program website
- PEI COACH Program CFN Award and story board