Primary Health Care Integrated Geriatric Services Initiative

Key Evaluation Findings 2019

Background

In 2015, work within the Seniors Health Strategic Clinical Network™ (SH SCN™) identified a need to support seniors to age and live well in their communities. As discussions and early work evolved, an opportunity emerged for the SH SCN and the Primary Health Care Integration Network (PHCIN), along with Alberta Health Services (AHS) and community partners such as the Alzheimer Society of Alberta and Northwest Territories (AS AB/NT), to work together with Central Alberta Primary Care Networks (PCNs) to advance integrated care for older adults.

The Primary Health Care Integrated Geriatric Services Initiative (PHC IGSI) was developed to enhance primary health care team capacity to recognize, diagnose and provide care and support in community for a variety of other co-morbidities, including cognitive impairment and dementia. Specific aims of PHC IGSI are to: 1) Develop and adopt an integrated, health and social framework; 2) Develop and implement common educational and mentorship supports to enhance clinical practice related to dementia and aging brain health; and, 3) Inform a sustainable business funding model to support ongoing practice development using the proposed framework.

An integrated 3-level framework was developed to help guide initiative work. These levels include: PHC team members, who are well prepared to recognize, diagnose, manage and support persons living with dementia (level 1); geriatric assessment team with more advanced skills (level 2); and specialized services (level 3).

Five PCNs expressed interest in working with the SH SCN and PHCIN to advance integrated care for older adults. These PCNs included: Big Country, Wolf Creek, Red Deer, Provost and Wainwright.

With support from the PHC IGSI project team, key activities included a series of three workshops, local education sessions in participating communities, website learning resources and level 2 mentoring.

The early adopter phase was January 2017 to June 2018, with Phase 2 planned July 2018 through June 2019.

Evaluation

This evaluation used a mix of qualitative and quantitative methods to assess the experiences of PHC team members, care partners of persons living with dementia (PLWD) and com- munity stakeholders.

The following domains were main are- as of focus: workshops, education and learning; quality improvement; PLWD and care partners; health care providers and clinic teams; community coalitions and integration; referral, assessment and diagnosis; and health care system.

Data collection included surveys, interviews, focus groups, administrative data and AS AB/ NT referral data.

Provincial level oversight of the evaluation was provided by PHC Applied Research and Evaluation Services (ARES), with local evaluation activities supported by evaluators (contracted and internal) and PHC team leads.

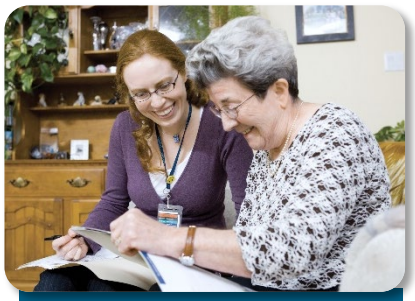
Alberta Health Services | Primary Care Networks | Alzheimer Society Alberta and Northwest Territories

Evaluation Results

The evaluation focused mainly on the experience of primary health care team members, care partners, PLWD and community stakeholders involved in level 1 and 2 of the integrated service framework. To assess impact, interviews, focus groups, and surveys collected information from over 60 care providers on participating clinical teams, 40 care partners of PLWD, 40 PLWD, and over 40 community stakeholders and decision makers. With the support and leadership of the PHC IGSI project team, key activities and inputs to improve clinical practice included 24 community coalition meetings, a series of 3 workshops attended by over 300 stakeholders and an additional 28 local educational sessions/events in participating communities. Clinical teams in four communities (Drumheller, Three Hills, Innisfail, and Red Deer) set goals to enhance care and support for those living in their communities with dementia, frailty and other co-morbidities. Administrative data was used to assess impact on health system utilization.

Evaluation indicators clearly show that this 'ground up' collaborative community-based activity with primary health care teams met and/or exceeded attaining the goals and aims of PHC IGSI. Data collected from participants involved in PHC IGSI indicate that their expectations had been met. Through participation in PHC IGSI, PHC teams identified improvement goals and activities relevant to their own practice setting and community. These PHC teams participated in PHC IGSI activities and accessed project resources (i.e., workshops, within community education events, access to online resources, supports from PHC IGSI project team) in collaboration with diverse stakeholders with common goals to enhance seniors' care in the community. Information collected to assess the impact of PHC IGSI participation shows the following:

- Care partners of PLWD engaged with both level 1 and level 2 teams show high scores for dementia knowledge, caregiving self-efficacy and satisfaction with life.
- Experience reported by care partners of PLWD indicate that they were satisfied with the care and services received from PHC teams and felt they had access to services and supports needed.
- Providers in both level 1 and 2 clinics in all participating communities show high scores for dementia knowledge, self-efficacy in dementia care, and attitudes towards dementia.
- PHC teams revealed the high educational value of the workshops and local education sessions.
- PHC team members felt they were working together well as a team to provide care to PLWD and for most teams results indicate an improved team approach to care.
- PHC IGSI components contributed to practice change in clinics that included use of an innovative care planning tool, improvements in team approach to care and follow-up, and workflow processes (i.e., initiation of a patient flow chart).
- Level 2 care providers highly valued the mentorship program, felt the educational training days enhanced their knowledge of geriatric care, and overall perceived it was an effective approach to developing new skills and enhancement of caregiving capacity.
- Results suggest work has progressed in a positive direction with respect to integration of care.
- Integration of service advanced at the clinic level through improved coordination of care and at the community level through the development of community coalitions (all in their early stages).
- Post-PHC IGSI utilization data show decreasing trends in hospitalizations and ED visits of PLWD and an increase in primary care visits in all participating communities.
- There were only a few patients with specialty visits to psychiatry and/or mental health physicians (identified by physician billing data) and no discernable trends for specialist utilization.



"Well they're working together…they're talking about his issues and my issues and I feel that they are trying to help both of us to manage life as we can."

– Care partner

"I think it definitely improved care. Early recognition. Caregiver support."

– PHC Team member

"I think the community coalition has a big role in helping those services develop honestly because if everybody works in silos they're not aware of what needs are not being met. It's when we get around the table and we talk about where the gaps are in the system - that's where you're going to get a really good integrated service I think."

– PHC Team member

"Overall, really excellent workshop. Very impactful. Looking forward to future workshops and exploring other opportunities for integration.

– Workshop 1 participant

PHC IGSI Strengths

- PHC IGSI workshops
- Shared learnings and resources
- Inclusion of care partner and PLWD perspective
- Building capacity within PHC teams/clinics for improved geriatric assessment, screening and care planning
- Progress toward integrated health and social dementia supports through development of community coalitions with a focus on relationship building, collaboration and awareness of other services and supports
- 'Ground-up' approach and strong PHC IGSI project team leadership

PHC IGSI Challenges

- Resources to sustain activities in clinics and communities (e.g., evaluation, quality improvement work, time intensive
- care planning process with patients)–in particular resources required in rural areas for PHC teams to participate in complex provincial projects
- Challenges at all levels to do 'ground-up', community-based work to enhance integrated geriatric services (e.g., individual care, clinic and community service planning, PCN level, community coalitions and provincial project team)
- Time and support needed to: conduct new assessment, screening and planning processes at the clinic level; achieve system change; and build relationships and community coalitions

Recommendations & Next Steps

Recommendations

Based on a review of evaluation results and consultation between the evaluation team and the PHC IGSI project team, a number of recommendations were created to help advance PHC IGSI Phase 2. Broadly, these recommendations focused on: resources (e.g., local level resources to support PHC IGSI activities, resources for patient level analyses and a re- turn on investment analysis, resources to support development of community coalitions, resources and education to PHC teams to facilitate care planning processes); increased face-to-face opportunities for PHC teams, community members and other stakeholders to enhance initiative 'spread'; development of a health and social dashboard; continued work with SH SCN to identify and track performance indicators; continued support to develop community coalitions through collaboration between PHC, PHCIN and SH SCN; and ensure ageist language is not used in communication and reporting.

Next Steps

Next steps include: PHC IGSI Workshop #4–*Brain Health*; continued support for local primary health care education in communities; new resources and links for the PHC IGSI website; continued development of Information Management Agreements; continued tracking of patient level indicators; seek and confirm opportunities for initiative funding; continued expansion of PHC IGSI work with a North Zone PCN; and broad sharing of findings to inform zone service planning and policy development.

Key Messages from the Evaluation

Relationship Building & Collaboration

Building strong relationships and enhancing collaboration were foundational to moving work forward. Relationship building was essential for PHC teams, PLWD and their care partners, community stakeholders and the PHC IGSI project team.

Time & Resources

Change takes time. Bringing about change at all levels (patient, clinic, community and system) for this complex initiative takes considerable time. Resources and support is required, especially in rural areas, to implement and sustain activities.

Multifaceted Approach

The multifaceted approach to PHC IGSI design and implementation, including work-shops, local education sessions and level 2 mentoring, was a key contributor to success. The multifaceted initiative, tailored to local needs, advanced integrated care.

For more details, see the full PHC IGSI Final Evaluation Report.

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