Strategic Clinical Networks™

Primary Health Care Integrated Geriatric Services Initiative

Final Evaluation Report

January 17, 2019

Alberta Health Services

Primary Care Networks

Alzheimer Society
ALBERTA AND NORTHWEST TERRITORIES

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Alberta Health Services, Applied Research and Evaluation Services. 2019. *Primary Health Care Integrated Geriatric Services Initiative: Final Evaluation Report.* Edmonton, Alberta, Canada.

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PHC IGSI evaluation team and stakeholders: Applied Research and Evaluation Services (AHS), Seniors Health Strategic Clinical Network (AHS), Primary Health Care Integration Network (PHCIN), Alberta Primary Care Networks, Academics in Public Health, Department of Family Medicine, Alzheimer's Society of Alberta and North West Territories, Leaders in community service organizations related to dementia and care partner supports.

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Note: This report has been reformatted to comply with AHS branding requirements. The table of contents and cross-references has been revised to reflect current pagination and embedded documents have been removed and replaced within the PDF file. The content of the report is otherwise unchanged.

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Acknowledgements

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List of Acronyms

ADSAP	Alberta Dementia Strategy and Action Plan
AH	Alberta Health
AHS	Alberta Health Services
AS AB/NT	Alzheimer Society of Alberta and Northwest Territories
CRG	Clinical Risk Grouper
DAD	Discharge Abstract Database
ECAC	Elder Care Assessment Clinic
FCSS	Family and Child Social Services
ED	Emergency Department
IMA	Information Management Agreement
PCN	Primary Care Network
PHC	Primary Health Care
PHC ARES	Primary Health Care Applied Research and Evaluation Services
PHC IGSI	Primary Health Care Integrated Geriatric Services Initiative
PHCIN	Primary Health Care Integration Network
PLWD	Person Living with Dementia
SH SCN™	Seniors Health Strategic Clinical Network™

Executive Summary

Dementia is a progressive and degenerative condition that involves impairments in memory and other cognitive functions such as mood, speech, behaviour and ability to carry out activities of daily living (Standing Senate Committee on Social Affairs, Science and Technology, 2016). The number of Albertans living with dementia is expected to more than double, and by 2038 about one in ten Albertans over the age of 65, and nearly half (47.5%) over age 90 are expected to be living with dementia (Population Estimates of Dementia in Alberta [PEDA], Alberta Health, 2015). This will increase health care use and deteriorate the health status of Albertans (Muscedere, 2016). If not proactively addressed there is a clear potential for avoidable health system use.

The Seniors Health Strategic Clinical Network (SH SCN™) and the Primary Health Care Integration Network (PHC IN™) along with Alberta Health Services (AHS) and community partners worked with Central Alberta Primary Care Networks (PCNs) to address this issue. The Primary Health Care Integrated Geriatric Service Initiative (PHC IGSI) was developed to enhance primary health care team capacity to recognize, diagnose and provide care and support in community to 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. The framework is built on three levels.

Level 1: All primary health care team members are equipped to recognize and assess seniors regarding frailty and changes in brain health. This level must have ready access to a level 2 team.

Level 2: Embedded, integrated, geriatric assessment team (GAT) with more advanced skills in dementia and frailty care that provides dementia support and works to continue building capacity of the primary health care team in level 1. Where necessary, this team will access level 3 specialized supports.

Level 3: Specialized supports (e.g. Geriatrician, Geriatric Psychologist, etc.) for the most complex, complicated challenges related to dementia diagnosis and management.

PHC IGSI is focused on a primary health care approach. Throughout this report terminology used is primary health care (PHC)–not primary care (PC). Although the terms PC and PHC are often used interchangeably, primary care refers to “first line” services at the clinic level, while PHC includes a focus on illness management and also involves a holistic approach of contributing health factors, an emphasis on health promotion and prevention, engagement of patients as partners in their care, and an establishment of relationships with community organizations to facilitate access and referral (Canadian Nurses Association, 2005).

The evaluation focused mainly on the experience of primary health care team members, care partners of persons living with dementia (PLWD) and community stakeholders involved in level 1 and 2 of the integrated service framework. To assess impact of PHC IGSI, 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 within participating communities.Clinical teams in four key 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. The emphasis on local community work was an important element of successful implementation as the focus on locally tailored work has support from a recent article on system integration finds three speakers (Chris Ham, Geoff Huggins and Helen Bevan) advising a focus on “local solutions as success will come from letting front-line workers develop new ways to care for the people and communities they know, not from centralized planning” (Fooks et al., 2018, p. 18).

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 within 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 overall 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.
- Results suggest that PHC IGSI components contributed to practice change within clinics which 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 that 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 ED visits and hospitalizations of PLWD as well as an increase in primary care visits within 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.

Strengths

- PHC IGSI workshops.
- Shared learnings and resources.
- Inclusion of care partner and PLWD perspective.
- Building capacity within PHC teams and clinics for improved geriatric assessment, screening and care planning (e.g., Geriatric 5Ms©).
- Progress toward integrated health and social dementia care services and 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 leadership of the PHC IGSI Project Team.

Challenges

- Resources to sustain activities such as clinic level evaluation and quality improvement (QI) activities and time intensive care planning for patients.
- Challenges at all levels to do 'ground-up', community-based work to enhance integrated geriatric services and supports (e.g., individual care, clinic and community level service planning as well as PCN, community coalition and provincial project team).
- Time needed to conduct new assessment, screening, and planning processes at the clinic level.
- Time and support needed to achieve system change.
- Time and support needed to build relationships and coalitions at the community level.
- The process of care planning has been implemented in clinics by PHC teams, however very few care partners understood the concept of a care plan, and in most cases the PLWD did not have one. As such, the integrated care planning objective outlined by PHC IGSI is still in the early stage of development.
- Resources in rural areas that provide an enabling environment for the rural PHC teams to participate in complex provincial projects.

A review of evaluation results and the activities and experiences of PHC teams/communities participating in PHC IGSI reveals differences in the availability of resources (e.g., ability to resource evaluation and QI work, staffing, support from AS AB/NT etc.) between smaller rural communities and an urban centre. Concern regarding availability and equitability of resources (services, supports, AS AB/NT) in rural communities emerged in the results. Challenges faced by rural PHC teams/communities/PCNs participating in the initiative are important and should be considered as evaluation results are reviewed.

Overall, PHC team members perceived they have increased confidence in their ability to recognize, diagnose, assess and/or create care plans for older adults. Team members also felt they were more aware of cognitive assessments available, and of local services and supports available. It was perceived they improved their ability to support their patients both in the clinic and in the community as their patients' dementia progressed. For some, they learned how to better support care partners and involve them more in patient care planning. Additionally, many team members realized the importance of connecting to their patients on a personal level and determining what is most important to them in terms of their care – more individualized approach to care than before.

As one PHC team member noted: ***"I think it definitely improved care. Early recognition. Caregiver support."***

Overall, care partners and PLWD figured prominently within PHC IGSI. Care partners expressed they had good access to services, were connected to community supports and were satisfied with care from their PHC teams.

A care partner noted: ***"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."***

Recommendations

Recommendations for future PHC IGSI work are presented below:

- As new communities join PHC IGSI, ensuring understanding and securing of local resources to support PHC IGSI activities is key at the onset, for example, local leads, evaluation support, access to practitioners with advanced knowledge.
- Enhancing resources at the local level for action planning at both the PCN clinic level and at the community level in order to build capacity around the health and social needs of seniors.
- Discussion of evaluation results among PHC IGSI team members affirmed support for a shift in culture ensuring ageist language is not used in communication and reporting.
- Clarify perceptions and provide education/resources to PHC teams on the Health Information Act (HIA) and Freedom of Information and Protection (FOIP) to PHC teams. Some providers noted their lack of understanding regarding cross sector sharing of care plans; therefore, provision of education on sharing care plans beyond the clinic would be beneficial to PHC teams.
- Increase face-to-face opportunities that focus on sharing: locally generated tools, learnings and processes (i.e., flow map) and networking with other clinic team members, PCNs, community organizations and partners. Clear indicators show in person sharing opportunities is an effective project 'spread' mechanism.
- Continue resources to support development and recommendations generated by community coalitions. There are indications that through shared goal development, coalitions will reduce duplication and enhance integrated care through improved informational and management continuity.
- Develop health and social dashboard (see page 93 for 'The Case for an Interactive, Decision Support Tool: A Balanced Scorecard or Dashboard Approach') to track prevalence, incidence and health utilization of dementia cases provincially and assess PHC IGSI spread to other communities within the province.
- Identify resources to conduct a patient level analyses with those PLWD directly experiencing care from PHC teams to demonstrate direct impacts of PHC IGSI.
- Identify resources to conduct a return on investment (ROI) analysis resulting from a reduction in numbers of unplanned emergency department (ED) visits and hospitalizations.

- Continue to work with Tammie Nahas, PHC, Alberta Health Services and Alberta Health grant on community coalition work (tool development).
- Explore with PHCIN and SH SCN™ development of community coalitions to enhance care in community.
- As teams continue to work on care planning bring in resources and socialize the PaCT care planning process from the PaCT initiative.
- Continue to identify and track performance indicators with SH SCN™.

Next Steps

Next steps for PHC IGSI are identified below:

- Plan and conduct PHC IGSI Workshop #4–*Brain Health* on June 14, 2019.
- Continued support for local primary health care education in communities (March-April 2019).
- Provide new resources and links to community websites on the PHC IGSI website.
- Continued development of an Information Management Agreement (IMA) for Wolf Creek PCN and Big Country PCN.
- Continue to track patient level indicators until 2020.
- Seek and confirm opportunities for initiative funding.
- Continue to expand PHC IGSI work with a North Zone PCN (one community).
- Share findings more broadly to inform Zone service planning and policy development and Alberta Health/AHS.

PHC IGSI Context & Background

Dementia is a progressive and degenerative condition that involves impairments in memory and other cognitive functions such as mood, speech, behaviour and ability to carry out activities of daily living (Standing Senate Committee on Social Affairs, Science and Technology, 2016). People living with dementia represent a vulnerable portion of our population and as such, dementia has a profound impact on individual Albertans, families, communities, and the health care system. Over the next quarter century the number of Albertans living with some form of dementia is expected to more than double as the baby boom generation moves into older age. This means that by 2038 about one in ten Albertans over the age of 65, and nearly half (47.5%) over age 90 are expected to be living with dementia. (Population Estimates of Dementia in Alberta [PEDA], Alberta Health, 2015). Diagnosis of dementia is included within the newly termed major neurocognitive disorder in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (American Psychiatric Association, 2013). In this report, the term dementia will be used and considered equivalent to major neurocognitive disorder (see Appendix A for a definition of major neurocognitive disorder and other key terms).

In addition, frailty is a major determinant of hospitalization, dependency, and health care costs for Alberta seniors (Lewanczuk, 2016). Frailty is a driver of higher health care use and a decline in health status (Muscedere, 2016). The challenge is that frailty may not be recognized, which means appropriate health and community resources are not proactively engaged, and the potential for unplanned hospital admissions increases.

Supporting seniors to age and live well in their communities is a key priority for Alberta Health Services, the SH SCN^{TM} and PHCIN. This priority aligns with the government of Alberta's vision to develop supports for individuals to age in their communities supported by integrated care and social support services that aim to optimize independence, quality of life and wellbeing of seniors (Alberta Health Services, 2016; Alberta Dementia Strategy and Action Plan, 2017).

PHC IGSI Background

Following a 2015 scan of Alberta's 42 Primary Care Networks (PCNs) by the Seniors Health Strategic Clinical Network™ (SH SCN™), it was found that approximately one dozen had included various elements of a geriatric consult team. There was a significant need and an emerging opportunity for the SH SCN^{TM} and PHCIN to work with PHC teams to enhance their capacity to recognize, diagnose and manage a variety of co-morbidities, including cognitive impairment and dementia.

Funding for the PHC IGSI was provided by Alberta Health (AH), and is in alignment to the vision set forth in the Alberta Dementia Strategy and Action Plan (ADSAP, December 2017). The ADSAP articulates four key foundational outcomes for Albertans, which include:

Outcome 1 - Albertans understand the impact of dementia and actively work towards optimal brain health

Outcome 2 - Albertans living with dementia and their caregivers are supported in communities

Outcome 3 - Albertans living with dementia and their caregivers receive timely recognition, diagnosis and clinical management through primary health care, supported by specialized services
Outcome 4 - Albertans living with dementia and their caregivers experience timely, accessible, integrated and high quality care and services.

As an integrated community approach is integral to achieving impact within all four of the outcome areas, a key activity for the communities who are action planning is the development of a local community coalition. Community coalitions are comprised of members from the public, social and health sectors at the local level, that form in order to identify how together they can proceed in an integrated fashion in order to support PLWD, care partners and their communities.

The SH SCN™ hosted a workshop on February 26th, 2016 in Red Deer, Alberta with a public forum event held the evening prior. The workshop aimed to: 1) Showcase current primary health care practices established to meet the needs of older Albertans, and 2) Begin to establish a collaborative process by engaging interested primary care and community teams to make changes designed to enhance their ability to diagnose and provide ongoing care and support for people living in the community with dementia in an inclusive primary health care approach.

Stakeholder consultation also occurred between the SH SCN™ and Central Zone PCNs. Following these consultations, five PCNs in the Central Zone expressed readiness to enhance their ability to recognize, diagnose and provide ongoing care and support for PLWD in the community, and began collaboratively planning with the SH SCN™ and PHCIN. Those five PCNs included: Big Country, Provost, Red Deer, Wolf Creek, and Wainwright.

Following this workshop, meetings occurred with participating PCN executive directors, physician leads, PCN registered nurses, AHS community programs and the Alzheimer Society of Alberta and Northwest Territories (AS AB/NT) with the intent to develop an early adopter initiative focusing on recognition, diagnosis and ongoing care and support for those living in the community with dementia, frailty and delirium. The early adopter phase for PHC IGSI occurred January 2017 – June 2018, with Phase 2 planned from July 2018 through June 2019.

Overview of PHC IGSI

PHC IGSI aims to develop and assess a service model where seniors in Alberta have access to an integrated PHC team equipped to deliver excellence in dementia care and support. PHC teams will be able to provide timely and accurate diagnosis, and offer a coordinated, pro-active approach to the ongoing care and support needs for seniors to live well with dementia in community.

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 required to support practice excellence relating to dementia and aging brain health
3) Articulate a sustainable business funding model to support ongoing practice development within the proposed framework

The PHC IGSI project team aims to enhance, support, develop, implement and evaluate areas within Central Zone served by participating PCN communities:

- An integrated 3-level PHC framework (see Figure 1), that is:
    - Multidisciplinary
    - Representative of key stakeholders from various community health and social programs
- Common educational curriculum and tools for level 1 and level 2, focused on frailty, dementia and delirium in the senior population

The initiative is grounded in the development of a geriatric service framework that is built on three levels (see below for description of levels).

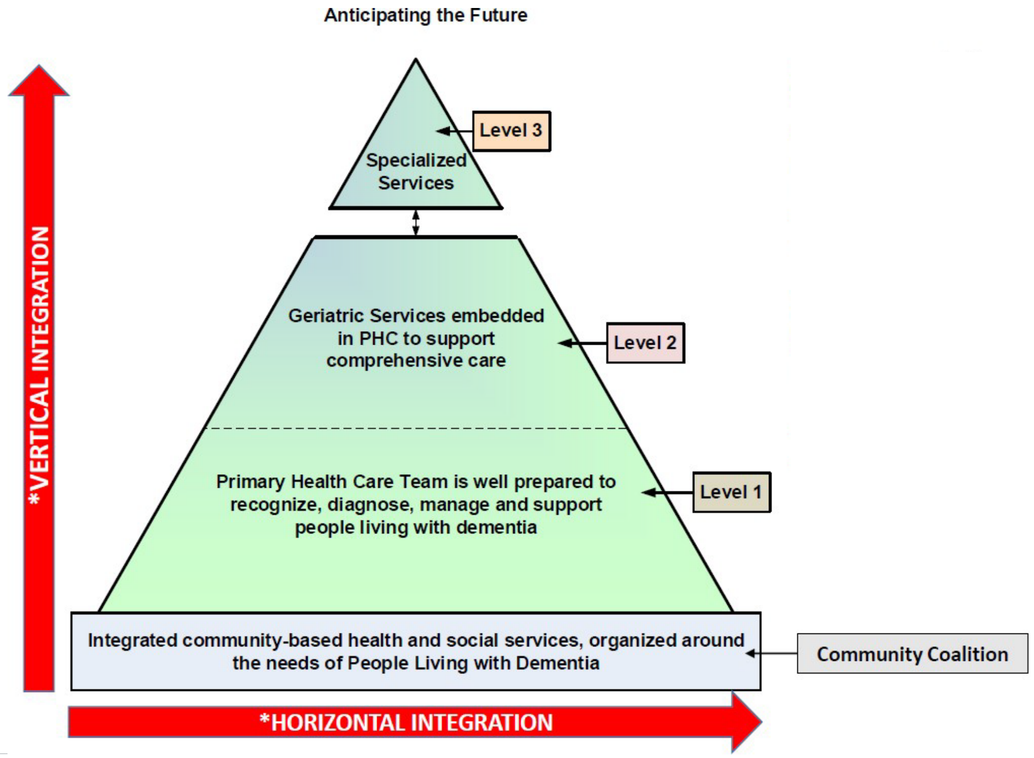
- Community Coalition (integration): Development of an inclusive group of local health, social and community partners who come together to understand the needs of local seniors and work together to identify priorities to meet locally identified needs.

Level 1: All primary health care team members are equipped to recognize and assess seniors regarding frailty and changes in brain health. This level must have ready access to a level 2 team.

Level 2: Embedded, integrated, geriatric assessment team (GAT) with more advanced skills in dementia and frailty care that provides dementia support and works to continue building capacity of the primary health care team in level 1. Where necessary, this team will continue to access level 3 specialized supports.

Level 3: Specialized supports for the most complex, complicated challenges related to dementia diagnosis and management.

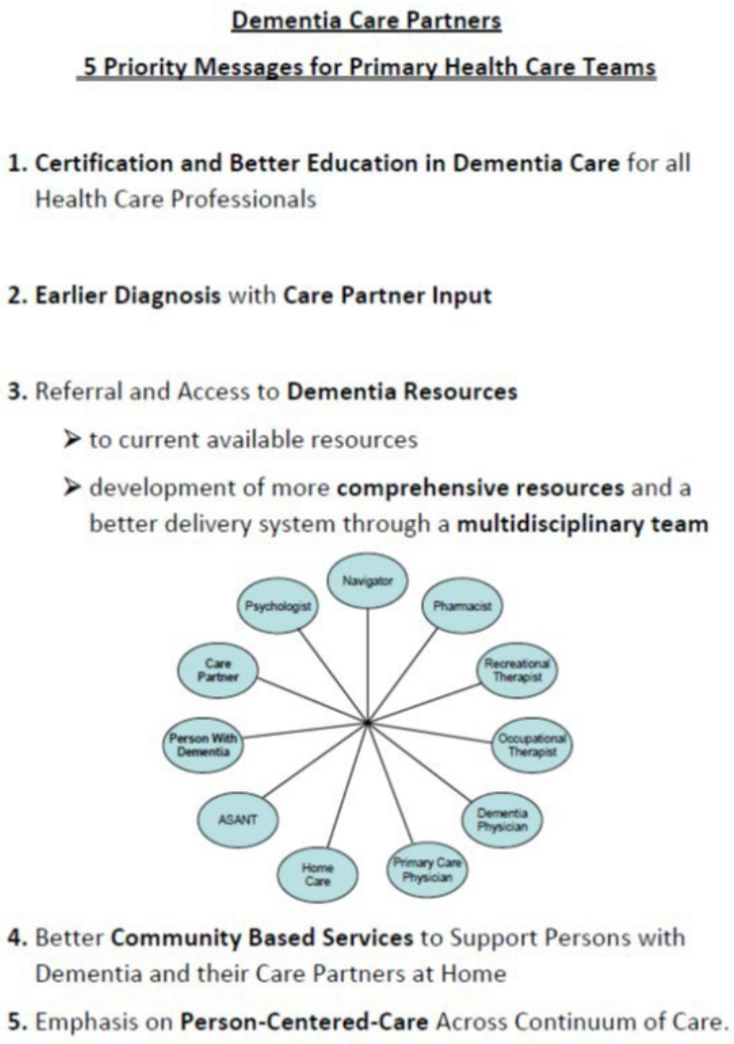
Figure 1. PHC IGSI 3 Level Model–Anticipating the Future of Community Based Geriatric Services



Priority Messages for Primary Health Care Teams

Development, planning and implementation of PHC IGSI has been guided by a set of priority messages for PHC teams. These priority messages were developed by approximately 20 care partners from Central Alberta for the Advancing Dementia Diagnosis and Management in Alberta (ADDMA) workshop that was held in February, 2016. These messages were priorities the care partners wanted to communicate to PHC clinicians and leaders regarding what they felt needed to change in the system in order for PLWD and their care partners to be supported well in the community. The voice of care partners is evident in these five priority messages and they are foundational to planning and actions of this initiative. The priority messages are: certification and better education in dementia care for all health care professionals; earlier diagnosis with care partner input; referral and access to dementia resources; better community based services to support persons with dementia and their care partners at home; and emphasis on person-centred care across the continuum of care (see below for the visual storyboard developed at the ADDMA workshop):

Figure 2. Visual Storyboard of Dementia Care Partners 5 Priority Messages for Primary Health Care



Dementia Care Partners

5 Priority Messages for Primary Health Care Teams

1. **Certification and Better Education in Dementia Care** for all Health Care Professionals
2. **Earlier Diagnosis** with **Care Partner Input**
3. Referral and Access to **Dementia Resources**
   - to current available resources
   - development of more **comprehensive resources** and a better delivery system through a **multidisciplinary team**

4. Better **Community Based Services** to Support Persons with Dementia and their Care Partners at Home
5. Emphasis on **Person-Centered-Care** Across Continuum of Care.

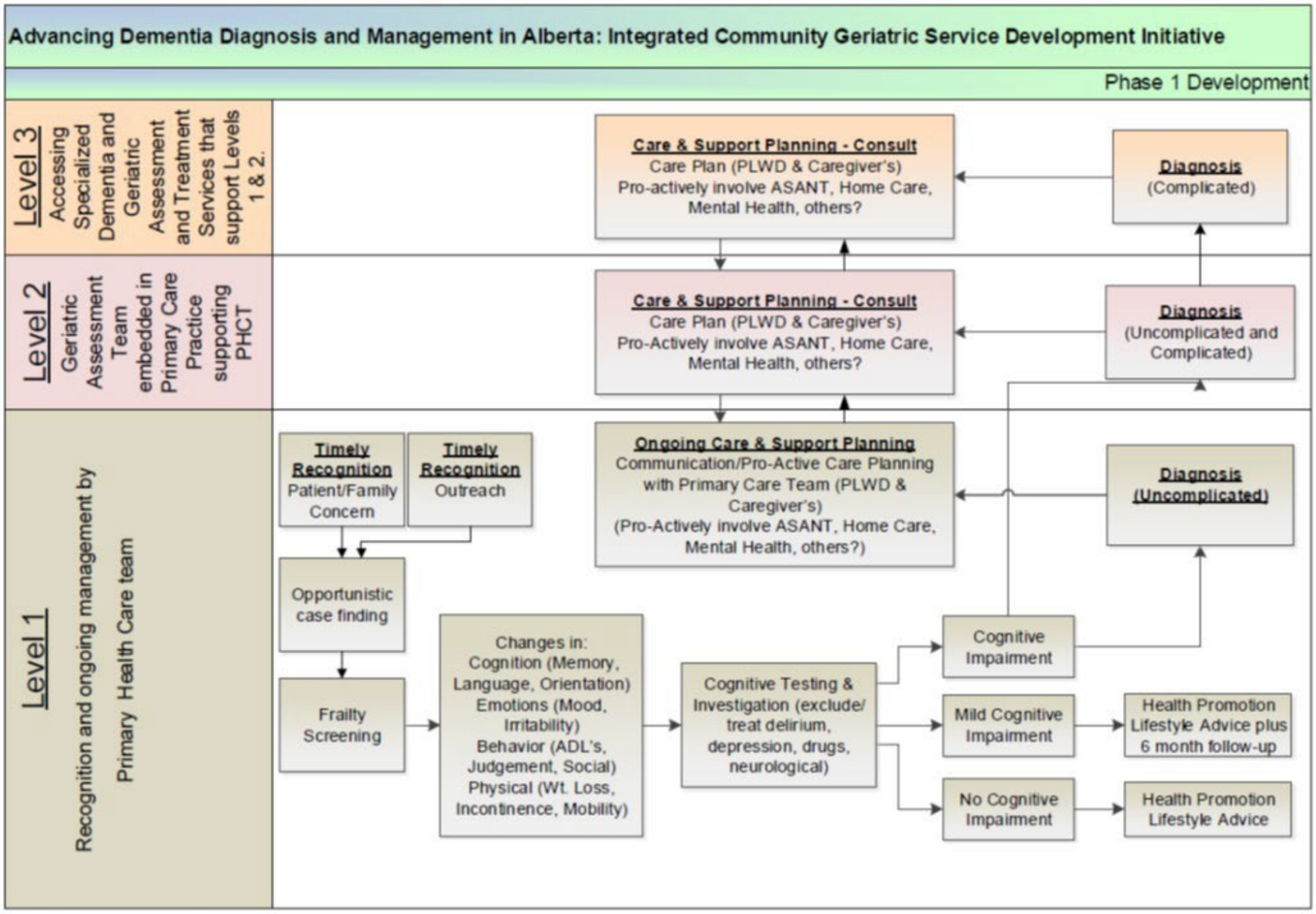
PHC IGSI Goals and Activities

PHC IGSI aims to enhance care provider capacity to recognize, diagnose and provide ongoing care and support for those living in the community with dementia, frailty and multi-complexity. The three overarching goals of the initiative are to:

1) Provide timely and accurate dementia diagnosis
2) Create a coordinated, pro-active approach to ongoing care and support of PLWD so they can live well in the community
3) Increase capacity in community to recognize, diagnose and develop integrated care and support plans for people living with dementia and/or other co-morbidities

A clinical workflow diagram (see Figure 3 below) highlights key activities in each level of the framework in relation to recognition, diagnosis and ongoing care and support of those living in the community with dementia, delirium and frailty. Activities reflect the needs of both the PLWD and their care partners. The Expert Advisory Working Group has developed common educational and mentorship tools to support activities outlined in levels 1 and 2 of the workflow diagram.

Figure 3. Integrated Geriatric Teams Clinical Workflow Diagram



Description of Workshops, Learning Resource Supports and Level 2 Mentoring

Workshops

Education, evidence-based resources and tools, and level 2 mentoring are key initiative components. The initiative involves provision of education to primary health care partners which include clinicians as well as community partners from the health and social sectors of participating community teams. Through a 3-part educational workshop series, as well as level 2 mentoring, the focus has been on increasing capacity across sectors to provide ongoing care and support for PLWD in the community. The workshops have been designed to provide education across the continuum from timely recognition and diagnosis of dementia, to care at the end of life. Three workshops were developed and delivered in the early adopter phase.

- Level 1 Education Workshop #1 held June 16, 2017 in Red Deer, Alberta

  Focus: Recognition and pro-active post diagnostic care and support for people affected by dementia
- Level 1 Education Workshop #2 held December 8, 2017 in Red Deer, Alberta

  Focus: Strategies on how to support people living in community with dementia, delirium and frailty to manage in more difficult times
- Level 1 Education Workshop #3 held May 25, 2018 in Lacombe, Alberta

  Focus: Utilizing a personalized, proactive, palliative approach to end of the life dementia care

Learning Resource Supports

The PHC IGSI Workshop Resources publically available website (https://www.albertahealthservices.ca/scns/Page13527.aspx) launched on June 18, 2018. The website hosts resources on dementia care for health care providers and members of the public. The website includes the following resources: recorded workshop presentations, practitioner specific resources and evidence-based tools, and resources focused on the Geriatric 5Ms© Framework–Mind, Mobility, Medication, Multi-complexity, and Matters Most.

Level 2 Mentoring

Level 2 mentoring and modelling of an advanced level 2 team initiated in the Red Deer PCN in June, 2017 and was in conjunction with the launch of the Elder Care Assessment Clinic (ECAC). The ECAC involves geriatric services embedded in PHC to support comprehensive care for patients. This Level 2 team works closely with their Level 1 colleagues to increase capacity within PHC to provide care and support to PLWD and their care partners.

The ECAC team was mentored by Dr. Duncan Robertson, Geriatric Specialist, and Karen Horsley, Geriatric Nurse Specialist, both of whom developed and worked in specialized geriatric service in the Red Deer Regional Hospital Centre (RDRHC) for a number of years. The mentoring process involved working directly with the level 2 team as they learned to identify, assess, diagnose and provide recommendations for the care and support of patients living with dementia, frailty, multi-complexity and/or other co-morbidities. In addition, teams were guided through how to work in a team situation which in many ways differed dramatically from other work they were involved in. Duncan and Karen made themselves available to the team a minimum of 2 days a week, and often communicated with team members on a daily basis in order to support establishing the clinic and its processes, as well as communicate with PCN Leadership. Four full day local training sessions were held for ECAC team members, which included lecture-type education components as well as an opportunity to work through numerous case studies as a team. In addition, other staff from the Red Deer PCN also attended some sessions.

Resources available within the Red Deer PCN and the extensive support provided to the PCN by the mentoring team to establish a multi-disciplinary team to train for ECAC work was highly beneficial for establishment of the clinic. It is important to note the size, structure and resources of the Red Deer PCN in comparison to some other PCNs and communities were considerable, and other PCNs/communities planning to establish a level 2 clinic may face challenges replicating the ECAC model without sufficient supports in place. For more information on the ECAC clinic refer to the Red Deer PCN section on page 63.

PHC IGSI Timeline

Key initiative milestones are documented in the timeline (2015–2020) below.

2015-2016	Jan. 2016-May 2017	June 2017-Nov. 2018	December 2018	Jan. 2019-Dec. 2020
Pre-PHC IGSI	Initiative and evaluation planning	Implementation of PHC IGSI	Final PHC IGSI evaluation report	Post final reporting of PHC IGSI
Preliminary discussions within SH SCN™ and with established PHC geriatric teams across Alberta regarding initiation of the PHC IGSI	Initiative • SH SCN™ hosts engagement workshop in Red Deer • Stakeholder consultation with 5 Central Zone PCNs • Planning meetings with SH SCN™, PCNs, AHS & AS AB/NT • 5 PCNs express interest in initiative participation • PHC PCHIN becomes involved as a partner in the initiative Evaluation • Evaluation working group formed • Logic model, data matrix and evaluation framework created • University of Calgary student research project with RD PCN planned • Evaluation tools and resources developed	Initiative • Content for PHC IGSI Workshops #1, #2 & #3 developed and delivered • Website of dementia care resources launched • PHC IGSI team collaboration with participating communities to implement action plans Evaluation • Data collection and analyses initiated (surveys, focus groups, interviews, document review & administrative data) • Interim evaluation report including preliminary provincial level and local level results	Evaluation • Interim evaluation report on PHC IGSI results written (May, 2018) • Interim evaluation–a compilation of provincial level evaluation results and local results • Results of student research project at the RD PCN • Final evaluation report completed (Dec 2018)	Initiative • Collaboration and action planning between SH SCN™ and participating communities continues • PHC IGSI Workshop #4 and #5 planned for 2019 • Website of PHC and public dementia care resources launched • Launch of Phase 2 Evaluation • Ongoing data collection and analysis at provincial and local level • Administrative data pulls and analysis as needed

Methods

Evaluation Approach

The evaluation uses a descriptive design, with a utilization-focused approach to help ensure results are meaningful and useful to stakeholders. The evaluation approach is also developmental in nature as it aims to capture findings that evolve from emergent, complex processes within PHC IGSI. During implementation of PHC IGSI and its evaluation plan, there is an assumption that the starting point for each community varies. The intent is to start small, learn from each PCN, share learnings across participating PCNs, and consider scale and spread options as PHC IGSI is implemented across the province. This means that each participating PHC team has distinct evaluation and performance goals. However, throughout the early adopter phase, it is envisioned that a common key set of performance indicators will emerge. For example, clinic teams focusing on level 2 of the model will have different improvement goals, evaluation questions and performance indicators than those teams focusing more on enhancing level 1 capacity. These diverse improvement goals, questions and measures have been incorporated into the evaluation plan in a developmental fashion. Developmental evaluation "tracks and attempts to make sense of what emerges under conditions of complexity, documenting and interpreting the dynamics, interactions and interdependencies that occur as innovations unfold" (Patton, 2011, pg. 7). Conditions of complexity are evident in PHC IGSI with respect to multiple partners with varied levels of support and with varied internal and external influencing factors on processes and outcomes (see Appendix C for complexity graphic).

In an effort to implement an evaluation structured to mirror the complexity of the initiative, this multi-method evaluation has been initiated at two levels: provincial and local. At the provincial level, oversight of implementation of the evaluation has been a major focus with PHC Applied Research and Evaluation Services (ARES) staff contributing to evaluation co-ordination, data collection and analyses, tool development, and administrative data analysis and reporting. Locally, the PHC teams/communities have initiated evaluation activities using approaches that make sense for them given their starting point, resources, support and capacity for evaluation. Therefore, evaluation activities varied depending on PHC teams, communities, their goals and availability of resources. Evaluation support for each community varies considerably, with one site supported by a full time, internal evaluator, three sites were supported by evaluation consultants, and one site with no designated evaluation support.

Development of a logic model (Appendix D) involved an iterative process to ensure it incorporated multiple and diverse perspectives informed by representatives from the PCNs, SH SCN™, PHCIN, AHS, community stakeholders, care partners as well as relevant academic literature. Generally, inputs include: Alberta Health Grant Funding, SH SCN™ (Co-lead and Project Coordinator), PHC Integration Network (Co-Lead and Senior Planner), Expert Advisory Working Group, PCN Resources, AS AB/NT resources, and a collaborative core project team/ Evaluation & Measurement Working Group. The main deliverables of the Evaluation & Measurement Working Group were to create the framework, data matrix and implementation plan. The ARES team, along with identified PCN evaluation supports, implemented evaluation activities.

Evaluation Questions

Key stakeholders were involved in development and planning of the PHC IGSI evaluation. Formal community coalition meetings with stakeholders were initiated in a few of the local communities. Community and diverse stakeholder perspectives of current health service supports, barriers and gaps were discussed in addition to their thoughts on measurement and evaluation. At each stakeholder meeting, participants were asked two questions:

1) What does success look like?
2) How will we know when we get there?

General themes were identified as key areas of success, and subsequently evaluation work for this project was guided by these themes. The following evaluation domains were identified: workshop, education and learning; quality improvement; PLWD and care partners; health care providers and clinic teams; community coalition, inter-organizational and service integration; referral, assessment and diagnosis; and health care system. These provided the areas of focus for an evaluation framework (Appendix E) which outlines 37 key evaluation questions. Evaluation questions and associated data sources can be found in this framework. For a list of the initial evaluation questions developed see Appendix F. The degree to which these questions could be addressed in this evaluation varied depending on domain and available information (i.e., evaluation resources available to individual PCN teams; validity of administrative data to address any given question). Inclusion of a developmental approach to evaluating this complex initiative meant some evaluation questions emerged as a higher priority than others as the initiative was implemented.

Data Collection

PCNs, participating clinics, teams and community partners were involved in collecting data and reporting progress toward forming inter-organizational teams that created a shared vision, improvement goals and outcomes. The Provincial PHC ARES team supported data collection and analysis where resources were available (i.e., honors project aligned with data collection at Red Deer PCN ECAC; PHC IGSI funding to transcribe and theme interviews and focus groups), workshop participants completed paper-based or on-line surveys, PLWD surveys and interviews were completed post clinic visit, care partner surveys and interviews were conducted pre-post clinic visit, care provider surveys and interviews were completed at varied times depending on the implementation phase of any particular PCN, clinic/community team, and key stakeholder interviews were also conducted. Table 1 presents key evaluation participants, activities and data collection methods used in the evaluation.

Table 1. Evaluation Participants/Activity, Areas of Assessment and Data Collection Methods

Evaluation Participants/Activity	Main Areas of Assessment for PHC IGSI Evaluation	Data Collection Method
Workshops	Quality of content, applicability to practice, motivation to change, goal achievement to enhance dementia care and diagnosis	Surveys
Educational resources	Number of physicians and providers accessing resources	On-line activity counts for the PHC IGSI website
Persons living with dementia	Satisfaction and experience, perceived benefits of service, support, quality of life, integration	Surveys and interviews
Care partners	Dementia knowledge, skills, self-efficacy, satisfaction and experience, care planning, personal support, access to community support, information needs, stress and anxiety, and integration	Surveys and interviews
Care providers	Dementia knowledge, skills, self-efficacy, strengths and gaps, care planning, resources and tools, integration and mentoring experience	Surveys and interviews
Clinic/community teams	Characteristics of clinic/community teams and narratives of the teams' journeys since implementation of PHC IGSI including successes, challenges, action and activities, and integration	Document review, focus groups, interviews and action planning meetings
Project leads, ECAC geriatric nurse mentor, PCN EDs	Initiative expectations, quality improvement, community coalition development, care plans, resources and tools, integration, and strengths, weaknesses, opportunities, threats (SWOT)	Focus groups and interviews
Health care system	Dementia cases explore age and sex, clinical risk group, social and material vulnerability, continuity of care, hospitalization and prescribed medication	Administrative data
Alzheimer Society of AB/NT	Inter-organizational collaboration (integration) outcomes/efforts, First Link® referrals, volunteer led support groups supported by AS AB/NT, quality improvement activities	Focus group, AS AB/NT database

Resources to collect and analyze information for the evaluation depended on the PHC team/community and its goals and resources to do so. Resources included the following:

- University of Calgary Honours student in psychology worked with an applied research team to assess the Red Deer ECAC
- Part-time contract with a Red Deer College (RDC) Health Research Collaborative Research Technician supported transcription, initial theming and validation of interviews and focus groups
- Red Deer PCN internal evaluator coordinated activities at the ECAC and provided support for the student research project
- Big Country PCN and Wolf Creek PCN evaluation supports helped to collect information in participating PCN communities which was shared with the collaborative evaluation team for analysis
- In other communities evaluation team members provided provincial staff to collect information
- Other information was collected at PHC IGSI workshops
- Other data was collected from secondary data sources that provide indicators of baseline activity that may be used to assess PHC IGSI impact
- AS AB/NT data collection on First Link® referrals

Survey Outcome Measures

Survey outcome measures presented in this report are listed in Table 2 below.

Table 2. Evaluation Measures Reported in PHC IGSI Evaluation

Outcome	Group	Measure*
Dementia knowledge	- Level 1 Care Partners & Care Providers - Level 2 Care Partners & Care Providers	- Alzheimer's Disease Knowledge Scale (ADKS) (Carpenter, Balsis, Otilingam, Hanson, & Gatz, 2009). - ADKS is a 30 item scale that asks participants to indicate whether statements regarding dementia are true or false.
Dementia attitudes	- Level 1 Care Partners & Care Providers - Level 2 Care Partners - & Care Providers	- Dementia Attitudes Scale (DAS) (O'Connor & McFadden, 2010). - DAS is a 20 item scale that asks participants to indicate using a Likert scale from 1 to 7, with 1 = strongly disagree and 7 = strongly agree, the extent to which they agree with each statement.
Perceived self-efficacy in dementia care	- Level 1 Care Providers - Level 2 Care Providers	- Perceived Self-Efficacy in Dementia Care survey (Cheng, 2008). - Scale consists of 25 items that ask participants to rate the extent to which they agree with each of the statements presented using a Likert scale ranging from 1 to 5, where 1 = "disagree very much" and 5 = "agree very much
Self-efficacy for caregiving	- Level 1 Care Partners - Level 2 Care Partners	- Revised Scale for Caregiving Self-Efficacy (Steffen, McKibbin, Zeiss,Gallagher-Thompson, & Bandura, 2002) includes 15 items dividedinto 3 domains: self-efficacy for obtaining respite, self-efficacy for responding to disruptive patient behaviors, and self-efficacy for controlling upsetting thoughts. - Participants rate their degree of confidence for each of the questions using a 10 point Likert scale ranging from 0 to 100, with 0 = cannot do and 100 = certain can do
Satisfaction with life	- Level 1 Care Partners - Level 2 Care Partners	- Satisfaction with Life Scale (SLS)(Diener, Emmons, Larsen, & Griffins, 1985). - SLS is a 5 item scale that assesses a participant's subjective satisfaction with life by asking respondents to indicate the degree to which they agree with each statement provided
Knowledge and attitude toward mentoring	- Level 2 Care Providers	- Category 1 Mentoring Interest Survey for Prospective Participants (n.d.) - Public domain survey consisting of 8 items asking participants for their opinions, knowledge, and experience with mentoring. Both multiple choice and true/false questions are presented

*Description of measures from Hastings (2018)

Data Analysis

Survey data has been collected and analyzed using Statistical Package for the Social Sciences (SPSS) software (see Appendix G for statistical tests used). Frequencies have been calculated for Likert scale response categories, and mean scores were calculated for rating scale responses. All interviews and focus groups were digitally recorded. Audio recordings of interviews and focus groups were uploaded onto a secure server and pre-transcribed using the Dragon Naturally Speaking Software 13.0 automatic transcription feature. The automatic transcripts were uploaded into NVivo 11. Using a VLC media player, the transcripts were replayed several times while a research technician edited the script to match the recording verbatim. Transcripts were coded by the research technician using NVivo 11 software. Coded nodes were read and reread to identify patterns and themes within the data.Themes were validated by a second, and sometimes third, independent reviewer.

Findings

Initial expressions of interest in PHC IGSI included five Central Zone PCNs: Big Country, Wolf Creek, Red Deer, Provost and Wainwright. Of these five PCNs, Big Country, Wolf Creek and Red Deer had communities that were actively action planning with the PHC IGSI team; therefore, evaluation results from these PCNs and their associated communities will be the primary focus of this report. Staff from the Provost PCN and Wainwright PCN have participated, as able, in workshops but for a variety of reasons, did not actively action plan. Additionally, PHC IGSI work in the community of Lacombe (Wolf Creek PCN) has begun. As available, information from the communities of Provost, Wainwright and Lacombe have been included. An overview of clinic and PHC team structure of the four main participating communities (Drumheller, Three Hills, Innisfail, and Red Deer) is presented below (Figure 4).

This report presents results in the following areas: workshops, education, mentoring and learning resources website; quality improvement; care partners' knowledge, skills, self-efficacy and experience; care providers/clinic teams' knowledge, skills, self-efficacy and experience; community coalitions and service integration; referral, assessment and diagnosis; and health care system utilization.

*Figure 4. Clinic and Team Structure of the Main Participating PCNs/Communities in PHC IGSI**

Level	PCN	Community	Clinic	PHC Team/Community Members
Level 1	Big Country	Drumheller	Rural health care clinic	PCN Team – RNs, wellness coordinator, navigator Physicians Health care team – Home Care, AHS Community counselor, Alberta Healthy Living Program, Seniors Outreach Community partners – Town Seniors Coordinator, Pioneer Trail Society, Badlands Elder Care, Helping Hands, Family & Community Support Services (FCSS)
		Three Hills	Rural health care clinic	PCN Team–RNs, wellness coordinator and navigator, physicians, Home Care, AHS community counsellor and Seniors Outreach
	Wolf Creek	Innisfail	Rural health care clinic	Medical home/PCN Team Town council representative FCSS Palliative care resource nurse ▯ Home care ▯ Family advisors ▯ Alzheimer Society ▯ Seniors mental health
Level 2	Red Deer	Red Deer	Elder Care Assessment Clinic (ECAC)	Community partners: Specialized Geriatric Services, Alzheimer Society of Alberta and Northwest Territories, Family Services of Central Alberta, Home Care, persons living with dementia and their care-partners ECAC: 4 PCN physicians, registered nurses, nurse practitioner, mental health counsellors, pharmacists, social workers

* Provost, Wainwright and Lacombe have participated in PHC IGSI as able and to varying degrees. Drumheller, Three Hills, Innisfail and Red Deer have participated extensively in the initiative and therefore are highlighted in this report as complete case narratives.

Workshops, Local Education, Mentoring & Website Learning Resources

The following section provides detailed results for PHC IGSI workshops, local education sessions and website learning resources. Workshop data was gathered with paper-based and on-line surveys post workshop. Data on local education came from PHC team focus groups, tracking forms and email communication. AHS Community Engagement and Communication provided data on the number of website visitors and page views.

PHC IGSI Workshops

A key objective of PHC IGSI is to "develop a common educational and mentorship curriculum to support practice excellence in community regarding dementia care". A series of workshops held for PHC teams and community coalition partners are key activities which contribute significantly to the outcome of PHC IGSI which includes "improve the recognition and diagnosis and to develop an integrated care and support plan for those living with dementia and frailty in the community." In this reporting period, PHC IGSI developed and held three workshops in this educational series:

- Level 1 Education Workshop #1 held June 16, 2017 in Red Deer, Alberta. (92 participants)
- Level 1 Education Workshop #2 held December 8, 2017 in Red Deer, Alberta. (102 participants)
- Level 1 Education Workshop #3 held May 25, 2018 in Lacombe, Alberta. (119 participants)

Collaborative Action Planning

Collaborative action planning for community teams was a core component of Workshop #1 and #2. Workshop #3 did not include an action planning component as it was the wrap up event of the implementation phase. Action planning worksheets and activities were developed and advanced during the workshops by the two PHC IGSI project leads. Time was dedicated (approximately 75 minutes) to community action planning at each workshop. The purpose of the collaborative activity at the first workshop in June, 2017 was to create an opportunity for teams to discuss planning and next steps in a context most appropriate for their team. Additionally, worksheets completed by teams were shared with PHC IGSI project leads to help the leads better understand each teams' improvement goals and the amount and type of support each team wanted, as well as identify a local lead as a contact person. At Workshop #1, teams from eight Central Zone communities (Sylvan Lake, Innisfail, Three Hills, Rimbey, Red Deer, Drumheller, Ponoka and Provost) participated in collaborative action planning. Out of these eight teams, five identified improvement goals to increase dementia care and support in their community.

The purpose of collaborative action planning at Workshop #2 was to provide teams with an opportunity to plan next steps, identify supports needed from the PHC IGSI project team and confirm the name and contact information for each teams' local lead. Teams from eight communities (Sylvan Lake, Innisfail, Three Hills, Rimbey, Red Deer, Lacombe, Ponoka and Westlock) participated in the action planning activity at this workshop, but not all communities continued on with action planning.

An integral component of PHC IGSI has been the collaborative action planning among teams that is supported by PHC IGSI project leads. From the implementation stage of the initiative at Workshop #1, project leads have supported local teams to advance work in their communities. In worksheets provided during collaborative planning, teams were asked if they wanted to have regular 'touch base' meetings with the PHC IGSI project team to support them as they implemented changes. Teams that provided contact information on their collaborative planning worksheets were contacted by project leads who initiated follow-up meetings for those who indicated they wanted this support.

Formative Evaluation Statement

Participants' "perspectives" from Workshop #1 through #3 indicate increasing quality of content and learning environment. Free format responses from participants examined greatest impact on learning, areas for improvement, and content ideas for future workshops. The Expert Advisory Working Group, PHC IGSI implementation team and partners (AS AB/NT) were responsive to this feedback which helped to shape the content and format of the second and third workshop. This formative approach contributed significantly to the excellent feedback received.

Workshop #1 - *Supported Well, Living Well*: focused on recognition and pro-active, post diagnostic care and support for people affected by dementia. In addition to exploring Provost PCN's established approach to supporting seniors in the community, providing the care partner experience, and collaborative planning to participate in PHC IGSI, sessions targeted the following:

> **"Overall, really excellent workshop. Very impactful. Looking forward to future workshops and exploring other opportunities for integration."**
>
> – Workshop 1 Participant

- Pre-diagnosis: Recognition of dementia, delirium, depression and frailty in community
- Supported well, living well: Proactive post-diagnosis care and support
    - Assessment and personal outcomes focused approach to intervention
    - Assisting those with dementia to better understand and live well with their condition
    - Supporting care partners to manage – AS AB/NT

Workshop #2 - *Managing in More Difficult Times*: focused on the Geriatric 5Ms© approach to assessment and management of mind, mobility, medications, multi-complexity and what matters most for people affected by dementia and their care partners. In addition, each of the four teams that were action planning was able to outline their local work, discuss lessons learned and challenges, and discuss next steps. Sessions targeted the following:

- *Mind*: Decision-Making Capacity.
- *Medications*: The complexity of polypharmacy and knowing when less is more for the person with dementia

- *Mobility*: Learn about assessment, interventions, and resources for mobility in elderly patients including driving assessment in the context of dementia.

> ***"I attended Mobility- great information regarding driving & assessment for frailty."***
> –Workshop 2 Participant

- *Multi-Complexity:* Cognitive decline in old age, frailty and multiple co-morbid conditions often coexist. Definitions, epidemiology, screening for frailty and the need for caution in applying Clinical Practice Guidelines designed for single chronic conditions in care older persons with multi-complexity is examined.
- *Matters Most:* each individuals own meaningful outcomes, goals and care preferences.

Workshop #3 - *"Compassionate Communities: Personalized, Proactive, Palliative Approaches to Care"*: focused on communication and care planning during the latter stages of a dementia diagnosis. In addition to exploring a palliative approach to late life dementia care, offering a care partner experience, hosting an *Ask me Anything* forum, and showing videos of community team progress to date, workshop sessions targeted the following:

- Communicating with families in late life dementia.
- Understanding pain in older adults:
- assessment and management of pain in geriatrics.
- It takes a village.
- Communicating through the creative arts.

> ***"Booths at the back of room. Videos of PCN PHC IGSI - great to see how far they (PCN's) have come in this journey.***
> **Involvement of caregivers in the agenda and as conference participants.**
> **Conversation breaks facilitating opportunities to network."**
> – Workshop 3 Participant

Detailed evaluation results for Workshop #1, #2, and #3 can be found in Appendix H.

Participants

Workshop attendees were recruited by participating PCN delegates who involved partners in their community they were partnering with, and or felt would benefit. Other attendees were based on expression of interest (i.e. PCN staff from other areas who reached out to the PHC IGSI project team). Participants at workshops included individuals from nine PCNs (Big Country, Provost, Red Deer, Wolf Creek, Wainwright, Camrose, Aspen, McLeod River and Calgary Foothills), AHS (SH SCN™, Provincial Primary Health Care), care partners, City of Red Deer, Maskwacis Health Services, Alberta Health, AB AS/NT and other community professionals.

Workshop #1 was attended by 92 participants; Workshop #2 by 102 participants, and Workshop #3 by 119 participants. Based on Workshop #1 survey data, participants consisted primarily of: primary care physicians (approximately 25%), nurses (approximately 25%), allied health team members (approximately 15%) and other community based primary health care service stakeholders (approximately 35%). Participants that attended the first workshop were predominantly the same as those participating in the second. In the third workshop, participants were approximately 5% physicians, 35% nurses, 20% allied health team members and 40% other community based primary health care service stakeholders. 74% of Workshop #1 attendees attended Workshop #2 and/or Workshop #3.

Impact

Workshop evaluation response rates were very good at 54%, 60%, and 56%, respectively. Overall, participants “agreed” or “strongly agreed” that workshop activities were collaborative, appropriate and would transfer to practice in a manner that will have impact on community based services and PLWD (see Table 3).

Table 3. Presentation of Key Survey Items from PHC IGSI Workshop #1, #2 and #3

Survey Items	Workshop #1	Workshop #2	Workshop #3
This workshop was timely and relevant to my current work	94%	97%	97%
The information presented was valuable	98%	98%	100%
Inter-organization connections were enhanced through shared goal setting	80%	93%	89%
I expect my clinical work to improve as a result of attending this event	79%	87%	90%
I am motivated to change our team’s practice	89%	88%	83%
This workshop will help us achieve our goal to enhance recognition, diagnosis and provide integrated care and support for people affected by dementia	94%	100%	N/A

- ✓ Recruitment was effective; participation was at maximum capacity for all three workshops
- ✓ Participant return rates were high and an indicator that content was of value and the format provided a supportive and engaging environment for diverse learners
- ✓ Workshop performance indicators increased significantly
- ✓ Significant improvement in participants’ rating of “enhanced knowledge of how to recognize, diagnose and provide an integrated care plan and support for people affected by dementia ” (94 to 100%)

- ✓ Significant improvement in participants' rating of "inter-organization connections were enhanced" (80% at Workshop #1 to 89% at Workshop #3)
- ✓ Motivation "to change our team's practice" was the only survey item that showed a decrease across the workshops with a slight decline from 89% at workshop #1 to 83% at Workshop #3

Qualitative Feedback on Workshops from PHC teams and Key Stakeholders

Results from a qualitative analysis of interview and focus group data gathered from PHC teams and key stakeholders supported the positive survey results. Overall, team members and executive directors felt the workshops were educational, created awareness of activities in other communities and provided an opportunity for individuals to network and share ideas. It was felt that the material presented at workshops was up-to-date information on dementia care that was useful and informative. Creating awareness of activities in other communicates was considered to be beneficial, as individuals could see what had been created and implemented elsewhere and could be used in their communities.

Local Education

A variety of local education sessions have been presented at PCN clinics for health care providers, physicians and other team members by individuals from the PHC IGSI Expert Advisory Working Group. Education topics varied depending on the needs of the local community, and included topics such as falls and bone health, driving and dementia, healthy brain aging, and depression in older adults. Local education events for both clinic and community members occurred in Innisfail, Drumheller, Three Hills and Red Deer. The number of education sessions presented in each community varied from one to five events. Local education events occurred both within clinics and in communities with attendees including PHC team members, other health care providers and members from community organizations. For a complete list of local education topics presented in communities see Appendix I.

Level 1 PHC teams noted in focus groups that local education had been offered in their communities. One PHC team focus group noted that education had been provided to a community group and also at an in-service with acute care and home care staff. A PHC team from another community described two workshops that had been held for healthcare providers from the local hospital, home care staff, clinic staff and community members. These workshops aimed to increase knowledge about Alzheimer's disease and included education from PHC IGSI project staff, Dr. Robertson and AS AB/NT. PHC team members from a third community noted that experts had been invited to their clinic to present education. They highlighted their appreciation for the education provided, and noted positive feedback from home care nurses.

> ***"Overall, I was just going to say on the education piece, I've heard from the home care nurses that they've picked up some really great information from attending the education that you've been helping bring out. So, yeah, definitely that's been a positive for the nurses."***
>
> -- PHC team member

Level 2 local education was provided by Dr. Robertson, Geriatric Specialist, and Karen Horsley, Geriatric Nurse. Four full day training sessions were held for the ECAC team and also included other professionals from the PCN. The sessions involved working through case studies, reviewing research articles, reviewing guidelines and best practices, and educational presentations.

Level 2 Mentoring

Level 2 mentoring and modelling of an advanced level 2 team was initiated in the Red Deer PCN. The level 2 team worked with their level 1 colleagues to increase capacity within PHC to provide ongoing care and support to people living with dementia and their care partners in community through mentoring from Dr. Robertson and Karen Horsley.

Focus groups and interviews with the ECAC team found that every provider directly or indirectly referred to the importance of the clinic mentors to their experience with the clinic. The geriatrician and geriatric nurse were a central source of knowledge and support as the program developed. Care providers appreciated the educational training days that were hosted by the mentors as they enhanced their knowledge of geriatric care, and allowed the team to work cooperatively to analyze case studies with mentor assistance. Overall, the mentorship was perceived as an effective approach to developing new skills and enhancing caregiving capacity by all members of the clinic team. One team member reported: “That full day of the education with the doctors, with everyone in the team, that was very helpful.”

Learning Resource Supports

In support of the objective to “develop common educational and mentorship curriculum to support practice excellence in community regarding dementia care” PHC IGSI has developed a learning resource website (https://www.albertahealthservices.ca/scns/Page13526.aspx). The content aligns with and supports the learning objectives of each workshop and is available publically to health care professionals and members of the public.

All workshops have been recorded and are available asynchronously online for future access. The site organizes information and resources by stages that a person living with dementia will encounter along their journey. It also has practitioner specific resources. Evidence-based resources for each of the following categories have been identified and focus on the Geriatric 5M’s© (Mind, Mobility, Medication, Multi-complexity, and Matters Most)

- Geriatric 5Ms© Framework – Mind, Mobility, Medication, Multi-Complexity, Matters Most
- End of Life Care
- Guidelines for Primary Healthcare Providers
    - Physicians and Nurses – National Institute for Health and Care Excellence (NICE) Guidelines, primary care tools
    - Pharmacists - Drug interactions
- Continuing Education - Webinars, journals, and elder care courses

AHS Community Engagement and Communication compiled a list of the number of pageviews for the Advancing Dementia Care & Support in Alberta: Dementia Resources Toolkit for Health Professionals. Results of pageviews from January 1, 2017 - October 31, 2018 are presented in Table 4 below. The number of visitors to the main page was 3,609 with 5,157 pageviews. Two out of three individuals who visited the PHC IGSI page also explored the workshop resources, while only a few (5-15%) looked into PHC IGSI related resources.

Table 4. Dementia Website Number of Pageviews and Visitors January 2017-October 2018

Page Title	Website Link	Number of Visitors*	Number of Page views**
Advancing Dementia Care & Support in Alberta: Dementia Resources Toolkit for Health Professionals	https://www.albertahealthservices.ca/scns/Page13343.aspx	3,609	5,157
Primary Health Care Integrated Geriatric Services Initiative PHC IGSI Seniors Health SCN	https://www.albertahealthservices.ca/scns/Page13526.aspx	276	493
PHC IGSI Workshop Resources	https://www.albertahealthservices.ca/scns/Page13527.aspx	186	307
PHC IGSI Related Resources	https://www.albertahealthservices.ca/scns/Page13538.aspx	15	35

* Visitor is a single user who visits a site within a half hour period.

** Pageview is how many times a visitor has accessed a page within the half hour time period

Quality Improvement

Quality improvement (QI) activities have been implemented in varied ways in all four communities (Drumheller, Three Hills, Innisfail and Red Deer) that have been actively engaged in PHC IGSI. Changes in clinic practice for all communities include development of patient flow maps, utilization of the Geriatric 5Ms© format (including incorporation into clinic electronic medical record (EMR) system), and development and utilization of work/action plans. Other QI activities included PLWD and care partner satisfaction and experience surveys and a chart review.

Data analyzed from level 1 PHC team focus groups suggests that no level 1 teams had identified improvement goals or performance measures to monitor progress. Two PHC teams referred to the early stage of the initiative and their QI work, with one noting they were fairly new so they had not yet done a lot of QI work, while another reported they were just starting to do QI activities. Teams expressed an interest in engaging future QI measurement work (e.g., quality of life, ED visits and acute admissions). One team noted it was challenging to develop measures because it is such a new initiative, and another team shared that they did not realize they had to do their own measurements.

> ***"I think it's really hard to put measurements in place when the program hasn't even been around for one year."***
>
> \- Level 1 PHC Team Member

Although specific QI goals and/or performance measurements were not identified in retrospective level 1 focus group discussions, as described previously, all level 1 PHC clinic teams have implemented QI activities within their clinics. As more data becomes available, teams plan to advance local QI work. QI work at the level 2 clinic in Red Deer included development of indicators, collection of care partner and PLWD satisfaction surveys and a chart review assessment of referrals. It is important to note the disparity in evaluation supports between communities – in particular, the availability of in house, PCN evaluation.

A model of PHC IGSI activities (including QI) by community is presented below (Figure 5). All communities had representation at three workshops, have developed patient flow maps, have utilized the Geriatric 5Ms© in clinic practice and hosted local education sessions. All communities have started the process of community coalition development, and are at varied stages of formation. A detailed list of key output measures, including level 1 and level 2 activities, community coalition indicators, and quality improvement measures for Drumheller, Three Hills, Innisfail and Red Deer can be found in Appendix J.

Figure 5. Model of PHC IGSI Activities by Community

Community	Workshop 1	Workshop 2	Workshop 3	Community Coalition	Patient Flow Map	Geriatric 5Ms©	Local Education	Mentoring Level 2
Drumheller	■	■	■	▨	■	▨	▨	□
Three Hills	■	■	■	▨	■	▨	▨	□
Innisfail	■	■	■	▨	■	▨	▨	□
Red Deer	■	■	■	▨	■	▨	▨	■

Code: ■ Completed
▨ In development/ongoing
□ Not applicable

Care Partners of Persons Living with Dementia

> ***"…[I] didn't understand you know the process of the digression... So yeah I understand more about what...what is happening because I didn't know anything before and at least someone is giving me some informed input.."***
>
> – Care partner from a community focused on level 1

Paper-based surveys and semi-structured interviews (telephone and face-to-face) were conducted with care partners of PLWD that received care from both level 1 (n=9) clinics and the level 2 clinic (n=7) to assess their knowledge of dementia, attitudes towards PLWD, perceived self-efficacy in dementia care, quality of life, and satisfaction and experience with care. Information was also gathered on care planning utilization and processes, perceptions of availability and access to community supports and services, and care partner stress.

Care Partners’ Dementia Knowledge, Attitudes, Self-Efficacy and Satisfaction/Experience

Care partners of patients accessing services at level 1 PCN clinics in rural communities and at the level 2 ECAC in Red Deer completed surveys. Care partner and care provider results for the level 2 ECAC have been gathered through a research project on the ECAC (Hastings, 2018). Of note, some level 2 providers had been involved with the ECAC and education longer than others. Additionally, the sample size for level 2 was larger than other clinics and results may be skewed by these smaller sample sizes. Survey results for both level 1 and 2 are provided below, followed by a qualitative assessment of data.

Level 1 care partner participants were recruited from Innisfail, Three Hills, Lacombe, and Drumheller. The experience of partners in each of these communities differs as each community clinic has implemented PHC IGSI activities most appropriate to the capacity and resources available in their communities. The experiences and circumstances of each care partner also varies, as they are working with different clinic teams and clinic processes in each of the communities involved.

PHC IGSI clinic leads in each of these rural communities provided names and numbers for care partners. Care partners were then contacted and asked to provide feedback about their care experiences, supports received, and changes to care that have taken place since the PHC IGSI initiative was implemented.

Level 2 care partners were asked to take a survey containing the following scales both prior to and 6 to 8 weeks after accompanying someone they are responsible for (including PLWD) to an appointment with the level 2 ECAC in Red Deer. These participants were included in a comprehensive care planning process involving the Geriatric 5Ms© care planning tool and they were referred to community supports when needed.

Care Partners’ Dementia Knowledge

Dementia Knowledge Scale

Knowledge of dementia was assessed using the 30 item true/false Alzheimer’s Disease Knowledge Scale (ADKS) designed for use among students, health care professionals, and the general public (Carpenter, Balsis, Otilingam, Hanson, & Gatz, 2009). The ADKS questions assess knowledge in the following 7 dementia domains: factors, assessment and diagnosis, symptoms, course, life impact, caregiving, and treatment and management. Level 1 and level 2 care partners obtained very similar scores on the dementia knowledge scale. No significant differences were found between level 1 and level 2 care partners (see Table 5). Both level 1 (M=24.4) and level 2 (M=23.6) care partner scores were higher on the dementia knowledge scale than a comparable group of dementia caregivers (M = 22.7; Carpenter et al., 2009).

Level 1 Care Partner Interview Data on Knowledge

Care partners accessing services from level 1 PHC teams were asked in interviews if their knowledge of dementia had recently changed as a result of working with the clinic team; analysis of results found that more than half (n=5) of those interviewed felt their knowledge of dementia had increased as a result of the PHC team. One care partner reported knowing “very little” while another noted she/he was “completely uninformed about dementia” before working with her/his clinic team. Among those who noted an increase in their knowledge, some shared that they learned about the stages of dementia and progression of the syndrome, and one care partner reported that she/he learned how to deal with things better.

Table 5. Level 1 & Level 2 Care Partner Survey Results

Scale Used	Level 1	Level 2	*p*-value
Dementia Knowledge Scale	*M*= 24.4 *SD*= 4.54 *N*= 7	*M*= 23.6 *SD= 4.13* *N= 9*	*p* =.70
Dementia Attitudes Scale	*M*= 90.6 *SD*= 22.1 *N*= 7	*M*= 109 *SD*= 12.5 *N*= 10	*p* =.04
Satisfaction with Life	*M*= 27.4 *SD*= 6.90 *N*=7	*M*= 27.0 *SD*= 6.43 *N= 10*	*p* =.90
Revised Scale for Caregiving Self-Efficacy			
• SE-Respite	*M*= 70.4 *SD*= 34.4 *N*= 5	*M= 61.0* *SD= 37.6* *N= 10*	*p* =.65
• SE-Behaviour	*M*= 77.7 *SD*= 14.9 *N*= 5	*M= 76.7* *SD= 26.2* *N= 10*	*p* =.97
• SE-Thoughts	*M*= 78.0 *SD*= 15.7 *N*= 6	*M= 78.2* *SD= 13.1* *N= 10*	*p* =.98

* Non-responses on the dementia attitudes scale and the SE scale were scored as zero. Missing data points on the Dementia Attitudes scale were replaced with the respondents scale mean.

**p-value ≤ .05 indicates significance difference between pre- and post-survey results

Care Partners' Dementia Attitudes

Dementia Attitudes Scale

Care partner attitudes towards dementia was measured using O'Connor & McFadden's (2010) 20 item Dementia Attitudes Scale (DAS) which asks participants to indicate on a seven-point Likert scale the extent to which they agree with statements presented (1=strongly disagree and 7= strongly agree). A significant difference was observed between level 1 (M=90.6) and level 2 (M=109) care partners, with level 2 care partners expressing more positive attitudes. Although the sample sizes of these groups were low, perhaps this is related to the involvement of level 2 care partners in the Geriatric 5Ms© assessment as well as the development of the Personal Integrated & Support Plan (PICS) at the ECAC. For comparison (a comparison to care partners of PLWD was not available in the literature), level 1 care partners scored slightly lower on the Dementia Attitudes Scale than a group of American undergraduate students (M = 98.6) sampled and tested by the scale's authors. Level 2 care partners scored higher than this group of students (O'Connor & McFadden, 2010).

Care Partners' Self-Efficacy

Revised Scale for Caregiving Self-Efficacy

Care partner self-efficacy was evaluated using the 15 item Revised Scale for Caregiving Self-Efficacy (Steffen, McKibbin, Zeiss, Gallagher-Thompson, & Bandura, 2002) which asks participants to rate their confidence for each situation presented along a 10 point Likert scale (0 = certain cannot do, 100 = certain can do). Items and scores are divided into three domains: self-efficacy for obtaining respite, self-efficacy for responding to disruptive patient behaviors, and self-efficacy for controlling upsetting thoughts. Self-efficacy scores collected from level 1 and level 2 care partners remained comparable across all 3 self-efficacy domains and no significant differences were found. Both level 1 and level 2 care partners scored higher on this self-efficacy scale than a comparable sample of 145 men and women who cared for a relative or close friend diagnosed with Alzheimer's or another form of dementia across all three self-efficacy domains (SE-Respite M = 56.8, SE-Behaviour M = 71.6, SE-Thoughts M = 69.4) (Steffen et al., 2002).

Level 1 Care Partner Interview Data on Caregiving Self-Efficacy

Most of the care partners who responded to a question (five out of seven responses) asking about changes in caregiving confidence felt their caregiving confidence had changed since the PHC team became involved in the care of the PLWD. Generally, they felt their confidence in the caregiving role had increased. Reasons for increased confidence varied; one care partner noted more confidence because of the help provided by the team, and another felt the physician was aware of the PLWD's issues and for major problems she would be referred. He/she noted: "I feel now that when she goes to see the doctor they are aware of her issues and it just makes me feel more relaxed. I know that if she goes to her doctor and there's something major that she is going to get referred to whatever she needs." Although most responded that their confidence had changed, one reported "not really" and another indicated that her/his confidence had changed but not only because of the program/clinic care, but also because of research that she/he had conducted: "It has changed but I can't say it's because of that. I have done a lot of courses, I've done a lot of research, and yeah. It was complementary, it wasn't like "whoa this changed at all for me." But it was good to know that other people know what we're talking about now."

Care Partners' Satisfaction and Experience with Providers/PHC Teams

Satisfaction with Life Scale

Subjective satisfaction with life was measured using the five item Satisfaction with Life Scale (SLS) (Diener, Emmons, Larsen, & Griffins, 1985) that asks participants to rate on a 7 point Likert scale the extent to which they agree with each statement presented (1 = strongly disagree, 7 = strongly agree). Satisfaction with Life scores obtained from level 1 and level 2 care partners were almost identical.

Level 1 Care Partners' Overall Satisfaction with PHC Teams' Care and Services

When asked about their satisfaction with the level 1 PHC team/clinic, all care partners responding to the question (n=7) expressed satisfaction with the care and services received from PHC teams. Broadly, they felt their PLWD had received the care and help they needed from the team. One care partner felt the PLWD was "well looked into and looked after". Describing the clinic team, one care partner volunteered that they were: "Super professional. Super individual, patient-centered, highly conscientious".

The main themes found in the care partner satisfaction responses included communication, supportive PHC team and easy accessibility. Clear communication from PHC team members was valued by care partners. Care partners appreciated the explanations that were given about the PLWD and their syndrome. One care partner noted that he/she felt “listened to”. Another reported that the nurse encouraged questions and answers.

> ***“…now they're actually doing assessments to see if they should be giving medications, what things they should be promoting for them to be safer and to keep them in their homes… I think it's been a good thing in just promoting their health and it's getting more people involved so that they actually aren't getting left behind I think.”***
>
> – Care partner from a community focused on level 1

Some care partners felt supported by the PHC team in their role as caregiver to their PLWD. Care partners felt they had team members they could go to for help and support to manage their PLWD’s care. For one care partner, she felt the clinic team was helping her cope better with her caregiving role. She noted: “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.” Four care partners were satisfied with access to the PHC team as they felt they were able to call and “get in” to see providers as needed.

Care partners’ perceptions of change in care

Although the care partners interviewed were overwhelmingly satisfied and appreciative of the care and services provided by level 1 PHC teams, when they were asked to describe how their healthcare experience had changed, some care partners reported that there had been no change in their healthcare experience since the team became involved in the initiative. For three of these care partners, it was felt that nothing needed to be improved. Two care partners noted there had been no change, but added the PLWD now received follow-up, and that they now had a team member they could talk to. One care partner shared that the care of the PLWD had changed a lot, specifically noting that assessments had been done for medication and home safety.

Care planning

Care partners were asked if the PLWD they care for currently had a care plan. Out of nine care partners, only two reported that the PLWD had a care plan. Out of these two, only one reported having a paper copy of the plan in their possession. Five care partners revealed that the person they provide care for did not have a plan, while two did not know. A review of interview responses revealed that almost half of the care partners appeared uncertain with what was meant by the term care plan. Four care partners felt that having a care plan would be a good idea, while one did not want to have a care plan and felt “…I can just go day by day and see how things go”.

> ***“They did that assessment but he doesn't really have a care plan because at this point we're.. He's providing most of his stuff in ..him and my mom and me are doing it all."***
>
> – Care partner from a community focused on level 1

Level 1 Care Partners' Information Needs and Feedback on Supports/Services

Information Needs

Care partners were asked about sources of information on dementia that they have access to; three main themes emerged from their responses: the PHC team, the Internet, and handouts/books/pamphlets. Some noted they had received dementia information from PHC team members, including nurses and physicians. For some, the Internet was a strong source of information, with one care partner sharing she/he was efficient on the computer, and another reporting she/he did research on the Internet. Paper-based information was also an important source, as care partners identified handouts about dementia, pamphlets and books. For two care partners, community organizations provided information, notably AS AB/NT and FCSS.

Personal and Community Supports/Services

Care Partners' Perceptions of Change in Access to Supports/Services

When care partners were asked about changes in access to supports in the last year most care partners (n=8) felt that access to supports and services had improved. Access to home care was mentioned by three care partners. One reported high satisfaction with home care and another shared that they had started getting home care after seeing the clinic team. One care partner had been referred to community paramedics and expressed high satisfaction with this service, and another referenced a support group. Three care partners reported increased access over the past year but did not mention access to any specific services. Only one noted that increased access to support had not occurred, indicating that the PLWD goes only to their physician.

Care Partners Felt They Have Adequate Personal and Community-Based Support

Generally, care partners felt they had an adequate amount of personal support. For some, they felt that either they were personally capable of caring for the PLWD, or that the PLWD they were caring for was currently functioning adequately and there was no need for additional support. One care partner reported he/she was "still mobile" and could drive and did not need a lot of support. For another, the care partner noted the PLWD could still perform personal activities such as showering and getting dressed so there was currently no need for additional support. Although care partners felt they had adequate support, two provided additional information that implied support may not be adequate. Initially, one care partner shared that she had adequate support to be successful, but later reported during the interview that her daughter lived out of province and with a child in another city experiencing health difficulties she felt like she was "drowning", suggesting her personal support may not have been adequate. Another referred to financial challenges. Furthermore, one care partner noted she had adequate support but "could use more". She noted she already attended a care group who meets monthly and talks to people from FCSS and Seniors Outreach.

Sources of Support for Care Partners

The main source of personal support for care partners was family and friends. Most care partners volunteered that they had family and/or friends that helped them care for the PLWD. Some noted support with "respite" care. Others reported that family/friends provided encouragement.

Additional supports reported by care partners were a physician, Alzheimer's group, home care, Provincial Seniors Benefits and financial support.

Suggestions for Support Improvements and Additional Support/Services
Care partners were asked if there were other supports they would like to see in their community or that they wished they had access to. Responses included: offer community seniors programs in smaller communities (e.g., get active, interactive, exercise, coffee time, games), additional home care hours, snow shoveling in winter, respite care to allow care partner time away, adult day program, support group, ability to call someone to come and visit with PLWD, financial support for respite care, ability to hire a family member to help care for PLWD because this person would be familiar, more community awareness of people with dementia, and advertising and promotion of available services.

Level 1 Care Partners' Stress

Care partners' responses to a question asking them to describe their current level of stress experienced due to their caregiving role elicited a wide range of responses. Three care partners reported little stress, one felt his/her stress was mild to medium and two reported high stress.

The main causes of stress found in an analysis of their responses were behavioral problems in the PLWD, emotional loss, and dementia diagnosis and placement. A variety of behavioural concerns were reported by five care partners. Three noted eating behaviours in the PLWD (lack of nutritional routine, loss of weight, PLWD will eat if care partner cooks food but otherwise will not warm up food), as one commented: “And eating - this really worries me too. Since going up there she has lost 30, 40 pounds and she has only been there 2 months.” Other behavioural stressors included: not taking medication; incontinence; concern with PLWD as he/she does not remember to turn off the stove after cooking; hiding objects throughout the house; PLWD has memory challenges and is confused; PLWD is argumentative and repetitive; and PLWD is depressed and has become reclusive.

Emotional difficulties were noted by four care partners. For two care partners, the emotional loss of support from the PLWD was profound. One care partner reported that her husband was no longer interested in the things they used to do together. She shared that for years she and her husband had danced together, but now he did not want to go dancing with her and as a result, she felt an emotional loss as “some things that we always shared and I always thought would always be there”. Another reported that “my emotional support of a husband is gone”.

> ***“My emotional support of a husband is gone. Like I don't have any emotional support. Sometimes I'll come home and “guess what I did!” And then I realized I can't tell him that. It'll just upset him. So that is… That's probably the most difficult thing is that, you know, my friend, my companion, and my husband is no longer.”***
>
> – Care partner from a community focused on level 1

For two care partners, diagnosis and placement of the PLWD was notably stressful. One care partner described difficulties waiting for a home placement closer to where the care partner lived. Another care partner shared her frustrations with a long wait from the initial assessment for the PLWD to when a problem was found: “…they had done some assessments. But what I found was they said, ‘oh no, he’s within normal range.’ And I’m going ‘no. This is not normal. What he’s doing is not normal.’ And it took three years before I got them to say, ‘oh yeah, maybe there is a problem.’

Health Care Providers and PHC Teams

Surveys, focus groups and interviews were conducted with PHC team members to assess their knowledge of dementia, attitudes towards PLWD, perceived self-efficacy in dementia care and knowledge and attitudes toward mentoring (level 2 ECAC clinic). Disciplines and organizational representation included: nurses, physicians, panel manager, social worker, medical student, executive director, scheduler, home care manager, and representation from AS AB/NT and FCSS. Representation from organizations and disciplines varied (i.e., not all disciplines and representatives participated in each community). Information gathered from PHC teams through focus groups and interviews also aimed to assess provider knowledge and skill to co-develop care plans for PLWD and their care partners. Additionally, data was analyzed to assess change in clinical or community team composition as a result of PHC IGSI.

Care Providers’/Clinic Teams’ Dementia Knowledge, Self-Efficacy & Mentoring

Level 1 care providers from Drumheller, Innisfail, Three Hills and Lacombe were assessed using the Alzheimer’s Disease Knowledge Scale, the Dementia Attitudes Scale, and the Perceived Self-Efficacy in Dementia Care survey scales after the PHC IGSI educational workshop series was complete. Of 27 level 1 providers, at least 11 attended one or more of the PHC IGSI workshops.

Level 2 care providers from the Red Deer ECAC were assessed on the same survey scales at two time points using a pre-test post-test design. For the purpose of comparing, the following level 2 results represent survey scores collected from level 2 providers after attending 2 of 3 PHC IGSI educational workshops and receiving dementia education locally within their clinic.

Dementia Knowledge

Alzheimer’s Disease Knowledge Scale
Knowledge of dementia was assessed using the 30 item true/false Alzheimer’s Disease Knowledge Scale (ADKS) designed for use among students, health care professionals, and the general public (Carpenter, Balsis, Otilingam, Hanson, & Gatz, 2009). The ADKS questions assess the following seven dementia domains: factors, assessment and diagnosis, symptoms, course, life impact, caregiving, and treatment and management. All community/clinic samples from Innisfail, Three Hills, Drumheller, and Lacombe scored similarly on the ADKS and all of their scores were quite high. No significant differences were found on the ADKS between the four rural community samples and knowledge scores gathered from the level 2 PHC IGSI clinic team (see Table 6).

Level 1 Care Provider Focus Group/Interview Data on Dementia Knowledge
Analysis of level 1 and level 2 focus group and interview data found that overall PHC teams in communities reported adequate knowledge of dementia. This finding is in alignment with high dementia knowledge scores for providers found in survey data. Some noted their knowledge of dementia because of previous work related experience or personal experience caring for a PLWD. Other providers reported increased knowledge due to PHC IGSI activities; specifically, a

level 1 PHC team reported that workshop information provided a better understanding of what to screen for and brought the team updated knowledge. One team member reported: “My skills and knowledge have been tremendously enhanced and improved just in regards to geriatric medicine. I’ve worked with geriatric clients before in acute care but didn’t really get so much in depth with the assessment and the care piece. So yeah, I would say mine has tremendously improved for sure”.

Dementia Attitudes

Attitudes towards dementia was measured using O’Connor & McFadden’s (2010) 20 item Dementia Attitudes Scale (DAS) which asks participants to indicate on a 7-point Likert scale the extent to which they agree with the statements presented (1=strongly disagree and 7= strongly agree). Table 6 shows that care provider participants from all five communities scored very similarly on the DAS and mean scores from each clinic were very high (ranging from 119 to 129 out of a possible 140). No significant differences were found between level 1 and level 2 care providers.

Table 6. Providers’ Dementia Knowledge, Attitudes and Self-Efficacy in Care

Scale/Domain	Community ‘A’ (N= 6)	Community ‘B’ (N= 2)	Community ‘C’ (N=9)	Community ‘D’ (N=11)	Red Deer Level 2 (N=11)	Central Zone Providers (N= 39)
Dementia Knowledge	M= 27.3 SD= 1.97	M= 28.0 SD= 1.41	M= 26.6 SD= 1.74	M= 27.1 SD= 1.81	M= 27.2 SD= 1.34	M= 27.0 SD= 1.63
Dementia Attitudes	M= 128 SD= 10.7	M= 129 SD= 7.07	M= 123 SD= 6.47	M= 119 SD= 9.43	M= 127 SD= 9.90	M= 124 SD= 9.33
Self-Efficacy in Dementia	M= 97.8 SD= 11.9	M= 111 SD= 6.11	M= 99.3 SD= 6.11	M= 94.2 SD= 9.40	M= 101 SD= 10.5	M= 98.5 SD= 10.3

*Note: a non-response on the Dementia Knowledge Scale or the Perceived Self-Efficacy in Dementia Care scale were scored as zero. Missing data points on the Dementia Attitudes scale were replaced with the respondents scale mean.

Perceived Self-Efficacy in Dementia Care

Care provider self-efficacy was measured using the 25 item Perceived Self-Efficacy in Dementia Care survey (Cheng, 2008) which asks participants to rate the extent to which they agree with the statements presented on a five point Likert scale (1 = disagree very much - 5 = agree very much). Although more variation among clinic/community scores was observed on this scale than the ADKS or the DAS, there were no significant differences found between any of the more rural level 1 clinics sampled and the level 2 ECAC care providers.

Analysis of Level 1 Care Provider Focus Group/Interview Data on Confidence in Dementia Care

Overall, PHC teams in communities reported some level of increased confidence in dementia care. PHC teams in two communities specifically reported increased confidence diagnosing dementia, screening and assessing PLWD and having discussions with families. Although most teams noted increased confidence, some team members stated they were early on in the work with one level 1 member reporting she “was not so very confident”.

Knowledge and Attitude Towards Mentoring (Level 2 Red Deer ECAC Only)

Results from Category 1 of the mentoring scale revealed that at both pre- and post-measurement, 100% of care provider participants reported a positive to very positive general attitude toward mentoring and a belief that mentoring is an effective method for developing potential.

PHC Team Composition and Team Approach to PLWD Care

Overall, level 1 PHC teams reported that team composition had not changed (i.e. no addition of disciplines added to PHC teams caring for PLWD) since they became involved in initiative work, but some current roles had been expanded to accommodate current care needs of patients. For one clinic, timing of initiative start-up coincided with the hiring of a geriatric nurse and a panel manger, and in another community a geriatric nurse felt the creation of her position was “in part due to the PHC IGSI initiative” as the PCN wanted to improve geriatric services.

In three clinics, a lead nurse role had been created. Analysis of level 1 focus group and interview data suggests these teams have become increasingly reliant on lead nurses to care for PLWD. In one clinic, as PHC IGSI work has progressed, the lead nurse’s workload with seniors has changed from initially working with a small number of seniors to having a case load almost completely comprised of seniors. This has led to a high demand in services for the lead nurse and a wait list for her services. As one co-worker noted: “Your schedule is very full and people are having trouble getting in”. In another clinic, nurses appeared to be taking a lead role as the PHC team described their clinic involvement in the initiative as “quite nurse led as well”. In the third clinic, with a lead nurse in place, a physician refers patients to the nurse for assessment and follow-up. In three communities, results suggests physicians have started to refer more of their senior patients to the lead nurse for assessment.

Although results suggest that lead nurses in some clinics have assumed increasing responsibility for seniors, focus group and interview data reveals that generally it was felt that PHC members were working together as a team to provide care to PLWD. In one clinic, PHC team members noted they recognized they needed a team to provide care for individuals and appreciated the opportunity to have others to “bounce ideas off of”. Two other PHC teams also noted their team approach during focus groups, with one reporting that they worked well as a team to ensure the support and safety of patients. Another described the strong team support in their clinic. For one clinic, a team approach to care was not highlighted, with results suggesting this may have been in part due to low physician involvement in the initiative.

Practice Change in Clinics

Practice changes in all level 1 clinics were self-reported by PHC team members during focus groups/interviews. Analysis of data regarding clinical practice changes found care planning and patient care, specifically improved follow-up with patients and changes in workflow planning/approach were three major themes. Since PHC IGSI began, care planning for PLWD has changed in all clinics actively involved in the initiative. Level 1 PHC teams and the level 2 ECAC team have begun utilizing the Geriatric 5Ms© care planning tool in clinic practice and have incorporated it into their clinic EMR. Teams reported more care plans have been created for patients as a result of the initiative. The extent of utilization of the Geriatric 5Ms© care plan, and the care planning process differs throughout PHC teams. In two level 1 communities, PHC teams have developed care plans with a small number of PLWD. At the level 2 ECAC, care plans have been developed for every PLWD that has been assessed in the clinic.

Analysis of data from level 1 PHC team focus groups/interviews found that in most clinics, PLWD, care partners and PHC team members have been involved in development of the care plan. PHC team members involved in care plan development included nurses and physicians. Physician involvement in the care planning process varied, as one PHC team noted a team effort between the nurse and physician to collaborate on care plan development, while members of another team reported that the nurse lead and another clinic nurse had completed most of the care plans and that although physicians had seen the template there was uncertainty regarding the extent of utilization among clinic physicians. Focus group participants from another clinic noted only one physician was using the care plan template and that the nurses were not involved in the care planning process.

Use of care planning tools in clinics also varied as PHC team members in one clinic noted that the Geriatric 5Ms© care plan had been used as more of a "visit template" than a care plan that is printed for PLWD. In another clinic, the Geriatric 5Ms© care plan template had been combined with another care plan template from the Patients Collaborating with Team (PaCT) initiative.

> ***"Yes and team meetings generally with [nurse] and the physician and the patient and the family to help put that care plan together. It's not just a standardized care plan that somebody is filling in on their own. It's a meeting setting your goals and priorities ..giving them the resources that they can access as well as what is available here."***
>
> – Level 1 PHC Team Member

In two level 1 clinics, it was reported that paper copies of the Geriatric 5Ms© care plan are printed and given to PLWD and their care partners to keep in their Green Sleeves which includes goals of care information. Providers from one clinic noted it was suggested to PLWD to keep their care plan in their Green Sleeve to show to other healthcare providers in the event that they may need to go to the hospital ED.

Teams in three communities reported follow-up with patients had been enhanced. Specifically, one team noted extra follow-up visits for patients with the nurse or physician. Another team reported follow-up for patients after a clinic appointment and perceived that at follow-up patients were connected to resources and supports in a timelier manner. Additionally, a third team described a process of improved follow-up for patients because of the way the physician now practices with the nurse.

Three teams cited a change in workflow planning and approach overall due to their involvement in the initiative. For two teams this involved an exploration of the current workflow with an aim to improve it. One team noted that they looked at clinic processes and then planned "a proper workflow to ensure that all the care gets done", while another described how they looked at the process flow to assess how it was currently working before expanding. With respect to change in clinic processes, one PHC team reported that they had "a much more structured approach to these patients" with the addition of a new nurse.

Increased screening of patients was reported by two PHC teams. Another shared that in addition to opportunistic screening they had explored clinic processes and had been doing additional screening of patients.

Community Coalitions and Service Integration

Community Case Narratives

A primary objective of PHC IGSI is to work with Central Zone PCNs, and their associated communities to develop and adopt an integrated health and social geriatric framework/model. Implementation of this multi-level framework in participating communities has been guided by the underlying assumption that the starting point for each PCN and their community varies, with an identified intention to start small, learn from each community, share learnings across participating teams and consider scale and spread options to other PCNs and communities across Alberta.

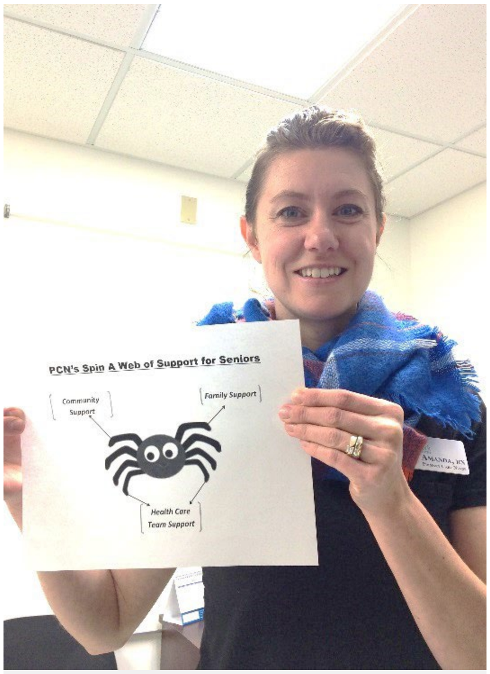
As this initiative evolved, it became evident to PHC IGSI project leads that the focus on action planning and initiative work for some teams was focused at the community level rather than at the PCN level. For example, the communities of Drumheller and Three Hills, both with the Big Country PCN, have evolved in PHC IGSI in different ways even though they are part of the same PCN. Given the community level focus for initiative involvement and planning, reporting of PHC IGSI activities and progress will be captured in this section of the report through presentation of narrative case study profiles for communities which have been highly involved in initiative work. These communities include: Drumheller, Three Hills, Innisfail, and Red Deer.

These case study profiles present unique stories of the involvement of communities in the initiative. They aim to tell the story of each communities' journey toward service integration for PLWD and their care partners. Local context is varied and reflect the distinct starting points and journeys for each community. PHC teams involved in the initiative also vary with respect to size and involvement in initiative activities. The case studies profiled in this report provide insight into planning, development and implementation of PHC IGSI in Central Alberta communities.

A standard case study format was used to capture the local story. Data to inform reporting have been gathered from several sources, but there is variability between communities depending on the local context and sources available: program documents (work/action plans, evaluation frameworks, patient flow maps, PowerPoint presentations, collaborative planning worksheets), PHC IGSI Workshop #1, #2 and #3 data, PHC team focus group/interviews, care partner interviews, Skype action planning meetings, communication with PHC team members and administrative data. Draft case narratives were emailed to key project members (team leads, PCN executive directors, and evaluation staff) in each community to be member checked. Representative members from all communities validated narrative content.

Drumheller

‘Providing a web of support for seniors’



Big Country PCN & Drumheller Clinics

Big Country PCN (BC PCN) which has been operational since 2008, includes the communities of Castor, Consort, Coronation, Drumheller, Hanna, Stettler, Three Hills and Trochu. It is estimated that PCN provides services to approximately 36,000 patients. There are 41 physicians within the PCN practicing across nine clinics.

Multidisciplinary teams within the PCN deliver primary care services within the office setting and are involved in complex care, chronic disease, public health, obstetrics and education (http://bigcountrypcn.com/About/Pages/default.aspx). Currently, 10,907 patients are panelled to PCN physicians.
There are two physician clinics in Drumheller. Within these two clinics there are currently 13 general practitioner (GP) physicians. All GP physicians are involved in the PCN (the PCN does not include specialists).

Improvement Goals & Expectations

Three improvement goals have been developed by the Drumheller team. These goals, identified in the PHC IGSI Workshop #2 “Report Out”, included the following:

1. More timely and accurate diagnosis
    - Framework
    - Education
    - Patient flow map
2. Access–health and social service providers
    - Team visits and referrals
    - Updated local resources list
3. Coordinated, pro-active approach

PHC team goals were also discussed during an interview with a Drumheller team member in 2017. The long term goal of the project was to keep seniors living well at home (out of hospital), and through the care process to refer them to health and community resources sooner to enhance their quality of life and ability to live well at home.

Expectations of the initiative described by the Drumheller PHC team member in 2017 were to screen at risk patients earlier, and to provide better support for patients to live well at home and out of the hospital setting. It was also hoped that patients would experience referral to health and community resources in a timely way. Data analyzed from a retrospective PHC team focus group in August, 2018 found that members came to initiative work with varied expectations. One team member noted in the focus group that they did not have “solid expectations” and that “we’ve created our own path because there wasn’t a path to follow per se”.

Since summer 2017, the PHC team in Drumheller has been using an integrated approach to support patients through a network of health and community services.

PHC team members have attended workshops, developed and hosted local education events and implemented a number of practice changes within the clinic including utilization of Geriatric 5Ms© Framework for care planning with PLWD. A community coalition has been developed with work in the early stages of development.

Using a community-driven approach tailored to local context the team has made considerable progress in advancing senior care in the community of Drumheller.

Action and Activities

Education

Team members attended PHC IGSI Workshop #1 (n=1), Workshop #2 (n=2) and Workshop #3 (n=4). Physician and interdisciplinary team members attended local education events. Workshop information and other resources has been shared with physicians and PCN registered nurses that did not attend the workshops.

The Drumheller PHC team has developed and hosted events in their community to increase awareness and knowledge of dementia, and to increase community awareness of services for seniors. A seniors fair was held in 2017, with another planned for fall 2018. Two presentations have been conducted at the Pioneer Trail Society. Local education for hospital acute care staff and home care staff has also been provided. A complete list of local education events (n=10) offered in Drumheller is provided below:

- Annual Seniors Fair- Oct 2017:
  - Spider Presentation regarding the PHC IGSI, PCN supports available, connecting in the community and early screening for dementia, resources such as the Alzheimer's Society.
- Three Hills Seniors Wellness Day - Nov 2017: (Three Hills Education)
  - Spider Presentation again as above
- Pioneer Trail Center Info Session - Jan 2018:
  - Specifically talking to seniors about dementia, screening, support and resources
- Seniors Pancake Breakfast - June 2018:
  - Seniors Week event- serving seniors breakfast and casual conversations about PHC IGSI, PCN support and community support/connections
- Radio interview on local station - Feb 2018:
  - Information on PHC IGSI and seniors supports in the community
- News article on local Drumheller Online:
  - Same as radio interview above
- BC PCN Website- Creation of Seniors Info Page:
  - Resources for Seniors: Dementia, frailty, community supports
- In-services at the clinic (x 2) for Physicians, PCN RNs
  - Discuss PHC IGSI, dementia screening, patient flow map, visit templates (5M's©), resources
- Workshop Information sent out to the physicians and PCN RNs
  - 2 RNs attended workshop #2 (PCN)
  - 4 RNs attended workshop #3 (PCN and acute care)
- Mental Health First Aid November 2018 - Booth during coffee breaks with information on PHC IGSI, Community Connections, and Screening and Resources on Dementia

Practice Change

A number of practice changes in the Drumheller clinic have occurred since PHC IGSI began:

- ***Utilization of the Geriatric 5Ms© Framework for care planning with PLWD***

  The Drumheller PHC team reported during the retrospective focus group that there are more care plans completed for patients than before the initiative began. It was noted that care plan development involves a meeting with the patient, their care partner, a physician, and the nurse lead. The care plan is individualized and community oriented as it focuses more on the priorities the patient and their family identify, and connects them to resources in the community as required. PHC team members explained that the Geriatric 5Ms© Framework offers a more comprehensive plan of care, and covers aspects previously missing from patient care plans. The nurse lead has helped patients update and/or put together their green sleeves.

- ***Tools and resources created for use in the clinic setting***

  The PHC team developed resources and tools to help improve care for seniors within their clinic and in the community. A work/action plan has been developed to help guide local action planning. To improve patient navigation within their clinic, the team created a patient flow map (see Appendix K). A community resources list has also been created to help clinic staff and community members become more aware of resources and services available for seniors in their community.

- ***Patient referrals to the nurse lead and referrals to the Seniors Outreach Nurse***
  Physicians and the clinic navigator have increasingly referred patients to the nurse lead when additional time and resources need to be dedicated to the care of senior patients. As a result of increased referrals to the nurse lead, it was noted during the focus group that the lead's workload is comprised of more senior patients than prior to the initiative.
- ***Team approach to caring for seniors***
  Focus group data suggests that the PHC team feels they are utilizing more of a team approach to caring for senior patients than they were prior to their involvement in PHC IGSI. Generally it was felt that collaboration among team members had improved over the past year. It was noted that Seniors Outreach and the nurse lead have worked collaboratively to deal effectively with difficult cases and they reported that they have witnessed great success together.

Resources Shared

Through the initiative, the PHC team in Drumheller received resources and tools to help improve their capacity to care for seniors. The Geriatric 5Ms© Framework shared by the PHC IGSI support team was identified during the focus group as being the most commonly used and helpful tool provided to the team. Other resources and information received included: support from the PHC IGSI support team, an online resource list, connections to the AS AB/NT, information regarding how other PCNs are conducting driver's medicals, and information and awareness of what other communities have been doing.

The PHC team in Drumheller shared some of their developed resources within the larger PHC IGSI. It was reported during the focus group that the nurse lead had received inquiries from individuals in other communities to share what had been done in Drumheller to improve care. The patient flow map was shared with other PCNs and thought to be used as a template in other clinics to create individualized flow maps. One PHC team member reported "The patient flow map for sure I know other communities have looked at that and mimicked that".

Community Coalition Building

Since the start of PHC IGSI, the PHC team has worked to create a community coalition and strengthen networks within Drumheller. The Drumheller community coalition has had nine meetings and involves the following seven participants/partners: AHS Home Care RN, AHS Seniors Outreach Nurse (SON), town of Drumheller Seniors' Coordinator, Pioneer Trail representative, one patient living with dementia, and two care partners. A review of PHC team focus group data revealed that development of the community coalition was described as being reasonably successful. The coalition has met numerous times in the last year to plan community events and create community resources related to senior care. One PHC team member described how the initiative has provided additional opportunity to connect with the services in their community, while others explained how the initiative had increased their awareness of services and supports available to both seniors and care partners in their community.

Strengths & Challenges

Strengths

Strong clinic lead Analysis of focus group data revealed the strong PHC team lead had been integral to advancing initiative work within the clinic and the community. The team lead has been highly involved in all aspects of initiative work. With support from others on the team, the lead has created a work plan, coordinated educational community events, developed clinic documents, and attended all PHC IGSI workshops.

Education and resources

PHC team members overall felt that the education and resources shared was a strength of the initiative. Overall, the PHC IGSI workshop series was reported by members to have improved understanding about the signs and symptoms of dementia, which some members reported improved their ability to diagnose dementia. One member reported: "Yes probably just the information in the workshops certainly helped to give me a better understanding of what to screen for or questions to ask or how you approach those more sensitive patients."

Challenges

High service demand for clinic lead - A major strength of the initiative in Drumheller is the clinic lead. However, demand for seniors' care has increased for the lead resulting in a full schedule and a wait list for patients.

Lack of time for PHC team to complete care plans - During the PHC team focus group, the challenge of a lack of time for physicians and other care providers in the Drumheller clinic to provide patients with comprehensive assessments and care plans was noted. This time challenge to assessment and care planning was noted as one reason for physician referrals to the nurse lead.

Information Management Agreement Lack of an Information Management Agreement between the Drumheller physicians and the PCN was also reported as a challenge during the focus group. It was felt that having an agreement in place would assist the PCN in creating quality improvement goals and measures.

Perceived Impact of PHC IGSI on Patient Care and Service Integration

Drumheller PHC focus group results reveal that the team perceived the initiative to have improved the level of care received by their patients and care partners in multiple ways. One team member noted: "I think it is generally better care". The team perceived the supports for care partners of their patients improved as they were more aware of resources, could offer more resources than before (e.g., information support) and could involve other healthcare and community organizations as needed. The nurse lead also provides patients and partners with additional support. Moreover, the clinic team has encouraged their patients and care partners to complete their Green Sleeves and personal directives to not only alleviate some of the stress experienced by care partners in times of crisis, but to also allow patients to have an input in their care.

> **"I think the family feels more supported because it's more of a team approach... Because it gives them more resources."**
>
> – Level 1 PHC team member

Generally, PHC team members perceived their participation in PHC IGSI to have a positive impact on service integration. One team member felt collaboration had improved within the clinic, out in the community, and between the two, resulting in an ability to provide more comprehensive care. Service integration was also perceived as improved and it was felt that as a result, patients and members of the community now have a better understanding of what the PCN is and what they offer, as well what services are available in the community.

Care Partners' Satisfaction and Experience with Care

A review of data from semi-structured interviews conducted with two care partners of PLWD from Drumheller revealed that overall the care partners were satisfied with care. One care partner noted that the PLWD was "well looked into and looked after". Accessibility was a theme with both care partners noting they can "get in" to see care providers. One care partner noted they were treated well and listened to, while the other reported they now have help and someone they can go to and ask questions.

> **"I'll speak for me and my mom, I think that we actually don't feel like we're kind of all in this alone. That there is somebody that we can ask questions to."**
>
> – Care partner

Evaluation & Impact

Evaluation work related to PHC IGSI in Drumheller has been guided by a work/action plan that identified local goals, objectives and measurements. Early evaluation activities in Drumheller were carried out by the team lead with support, as needed, from the PCNs evaluation consultant and the PHC ARES team. Evaluation resources were vetted through the Big Country PCN executive director. A role change resulted in reduced local evaluation consultant support for the latter part of 2018, resulting in the PHC ARES team playing a larger role in completing evaluation activities for final reporting.

The PHC team in Drumheller tracked a number of key outputs throughout initiative work (e.g. number of team visits with patients, number of patients referred to the seniors outreach nurse). No QI goals or performance measurements were identified in focus group data, however, improvement goals were set at the beginning of the initiative and some QI work has been initiated (e.g., patient experience surveys and clinic process changes). Evaluation and QI work is ongoing. A summary of evaluation activities is presented in Table 7.

Table 7. Summary of Evaluation Activities in Drumheller

Domain	Evaluation Activity	Description of Activity	Status Update
Patient	• Patient satisfaction surveys (paper-based)	• Patient satisfaction surveys post visit	• 2 completed to date
	• Health-related quality of life (EQ-5D)	• Administer EQ-5D to appropriate patients	• 11 completed to date
Care partner	• Surveys (paper-based)	• 1 care partner survey mailed	• N/A
Care provider	• Surveys (on-line) • Surveys (paper-based)	• 1 care provider emailed link to on-line survey • Surveys were provided to clinic/community • team during focus group –12 attendees	• 1 completed • 8 completed
Administrative data	• EMR data	• Referrals to Seniors Outreach Nurse requiring follow-up • Days (N) to complete assessment • Visits (N) with PHC team	• 68 • N/A • 33
	• Administrative data from Alberta Practitioner Claims, Discharge Abstract Database and Pharmaceutical • Information Network	• Analysis of administrative data for Big Country PCN found 730 cases of dementia and for these cases explored: age and sex, clinical risk grouper, social and material vulnerability, continuity of care, hospitalization and prescribed medication	• Completed
Clinic/community team	• Interview • Focus group	• 1 face-to-face interview with a team member • Group interview with 12 clinic/community team members	• 1 Completed • 1 Completed

A review of data from a focus group conducted in late summer 2018 with Drumheller PHC team members perceived that overall work had advanced with success. One member noted they were hoping to achieve a “more collaborative approach of the dementia client and I think we've started down that path and it's been very successful”. Generally, the initiative was described in the focus group as meeting or exceeding expectations. PHC team members came to the initiative with varied expectations. Members were surprised and gratified with the level of teamwork and collaboration that was fostered through initiative activities. It was broadly felt that all components of the initiative helped to increase capacity to provide and support senior care to some degree. The bottom-up approach that gave clinics the freedom to implement initiative activities appropriate to their communities was also appreciated.

Using a community-driven approach tailored to local context, and guided by a strong clinical lead, the PHC team has collaborated with individuals and organizations in Drumheller and completed foundational PHC IGSI work. Practice change within the PHC team/clinic is evident. This change, coupled with education via the three PHC IGSI workshops, local education, and the availability of shared resources suggests capacity has been built to provide better care for PLWD. Challenges exist with an increased workload for the clinical nurse lead, time for care planning and lack of an IMA. Community coalition work is still in the early stage of development. Overall, evaluation results suggest the work done since initiative start-up has firmly established the PHC team to advance work with community partners.

Goals set by the PHC team in Three Hills at initiative start-up were to increase awareness of dementia, identify service gaps, improve early diagnosis and management of PLWD, and increase collaboration with community organizations.

An important first step was taken through development and delivery of a survey to better understand the health and social needs of community members.

Evaluation results reveal the PHC team in Three Hills has made practice changes to clinic care. Team members have participated in all three PHC IGSI workshops, and have offered local education at the clinic for health professionals and community members. A community coalition has been started, as well as an Alzheimer caregiver support group. Through their work, the PHC team in Three Hills has made meaningful progress advancing PHC IGSI in their community.

Three Hills

'A journey towards improved dementia care'

Big Country PCN & Three Hills Clinic

Big Country PCN (BC PCN) which has been operational since 2008, includes the communities of Castor, Consort, Coronation, Drumheller, Hanna, Stettler, Three Hills and Trochu. It is estimated that PCN provides services to approximately 36,000 patients. There are 41 physicians within the PCN practicing across nine clinics. Multidisciplinary teams within the PCN deliver primary care services within the office setting and are involved in complex care, chronic disease, public health, obstetrics and education (http://bigcountrypcn.com/About/Pages/default.aspx). Currently, 10,907 patients are panelled to PCN physicians.

There is one clinic in the town of Three Hills. The clinic was built by the County of Kneehill and serves about 10,000 people. There are 8 physicians working in the clinic that are all part of the PCN.

Current Challenges with Dementia Care in Three Hills

Current gaps in dementia care in Three Hills identified by the clinical team in a community action planning document are lack of a day program, lack of respite care in the community and challenges with communication processes between the PHC team and Home Care. It was recognized by the Three Hills clinical team that they would have to also understand the gaps identified in dementia care by community members in order to prioritize action goals. In order to identify local public opinion regarding gaps in community care for PLWD and care partners, a survey was developed to solicit public opinion.

Improvement Goals & Expectations

Improvement goals identified in the Three Hills Dementia Action Plan include the following:

1. Increase awareness of dementia in Knee Hill area
2. Identify community awareness of services and service gaps
3. Improve early diagnosis and management of dementia patients
4. Increase collaboration with other agencies and service providers in the Knee Hill area

Analysis of data from a retrospective Three Hills PHC team focus group/interview (August, 2018) found all team members wanted to become more knowledgeable about dementia and how to manage and care for patients once they have been diagnosed with dementia. Team members hoped to learn best steps for providing dementia care, how to identify dementia earlier, and what types of supports are available to help patients and their care partners cope with a dementia diagnosis. It was a priority for most members to improve support for patients, care partners, and other vulnerable seniors through earlier diagnosis and increasing awareness of services and supports.

Action & Activities

Education

PHC team members from Three Hills attended all PHC IGSI Workshops. Other than the workshops, team members reported they received education regarding dementia and dementia care by consulting with other providers, reading articles, mentoring and through conferences.

Local education events offered in the Three Hills area included:

- Knee Hill Medical Clinic education day held on November 18, 2017 – included a community presentation by AS AB/NT, and a presentation to PCN clinic staff and other PHC providers on dementia by the PHC IGSI project team including Dr. Robertson, Karen Horsley and Charlene Knudsen.
- Elnora community presentation in conjunction with Seniors Outreach (provided information about the PHC IGSI, what has been done and what is offered in Three Hills and area).

> **"I think the education sessions have been very helpful and probably having those...almost on …fairly regular basis rather than one time things would be helpful. Because it's also good to refresh the memory about or certainly about latest research or things like that."**
>
> – Level 1 PHC team member

Practice Change

A number of practice changes in the Three Hills clinic have occurred since PHC IGSI began:

- ***Increased screening to identify patients with dementia***
  A review of focus group/interview data revealed the PHC team reported they are doing more dementia screening. One member noted: "We're doing a ton more screening and hoping to catch those patients falling through the cracks"… One member noted there was an opportunity for earlier recognition as they went back through some charts and pulled names of patients whose screening had shown concern but they had not been followed-up with. It was noted by one provider that generally it is episodic identification of patients rather than systematically going through all patients to assess risk, but they are trying to identify more patients that present opportunistically.
- ***Utilization of the Geriatric 5Ms© Framework for care planning with PLWD***
  During the focus group/interview members reported a slight increase in the number of care plans being created for patients at the clinic. To date several plans have been created. The biggest difference for the PHC team is that current care planning uses the Geriatric 5Ms© Framework, and care plans are created at an earlier stage in patients' progression of dementia. Both patients and their care partners are now involved in creating their care plan, and patients are provided with a printed copy. The team perceived that the care plans are being created in a way that is more meaningful to the patients than before.
- ***Tools and resources used in the clinic***
  A work/action plan has been developed by the team to guide local planning. A Knee Hill Medical Clinic flow map (see Appendix L) for cognitive or behaviour concerns which considers Toward Optimized Practice guidelines, has been created by the PHC team. The algorithm presents different steps to be considered throughout the process of dementia diagnosis, and was considered to be a useful guide for providers. It was reported during the focus group/interview that the initiative promoted the team to look closely at their clinic processes and how they could be improved. Another tool that was reported to be used in the clinic more often was the Trails B to assess for driver safety.
- ***Team approach to caring for seniors***
  A review of focus group/interview revealed some providers felt the initiative had prompted them to think about how to work better as a team to ensure patients get the care they need. It was reported that one physician now asks the nurses or wellness coordinator to be more involved in helping to support an assessment of the patient and family.

Community Coalition Building

Building of a community coalition has started in Three Hills. The nurse lead for the Three Hills PHC team is leading this work. The community coalition includes: three RNs, three physicians, home care, AHS community counsellor, Seniors Mental Health and Seniors Outreach. To date, two meetings have been held. The coalition has also worked together to develop and facilitate community education.

Creation of an Alzh eimer Caregiver Support Group

A local education presentation by AS AB/NT and subsequent connection and collaboration of community members prompted the creation of an Alzheimer caregiver support group in Linden with once per month meetings held. Virtual support is provided from the AS AB/NT and a community volunteer facilitator. To date, several meetings have been held. The team also spoke of the possible development of another support group in Trochu. In general, members felt the initiative had encouraged them to begin having conversations and collaborating with Seniors Outreach and other community partners involved in senior care.

Strengths & Challenges

Strengths

Workshop education - Overall, team members felt the workshops were a valuable educational opportunity. It was felt the workshops were informative and helpful as they provided up-to-date information on dementia care. For two members, the workshops were the most impactful component of the initiative, while another wished for them to continue on a regular basis. One member noted that the “workshops were awesome” and another reported: “I think the education sessions have been very helpful and probably having those...almost on …fairly regular basis rather than one time things would be helpful. Because it’s also good to refresh the memory about or certainly about latest research or things like that.”

PHC IGSI Project Team - A review of focus group/interview data showed generally members appreciated the support and encouragement received from the PHC IGSI project team. They were described as a great resource for ideas, feedback, information regarding activities in other communities, and connecting the team with professionals to provide education and program implementation support.

Shared learning and resources - The PHC team found it beneficial to learn about the activities and initiatives taking place in other communities involved in PHC IGSI. It provided them with ideas for their own clinic and community, it was a valuable way to share what has/has not worked for other clinics, and it was felt that it increased their awareness of some of the programs being offered in other communities

‘Starting a Conversation’ - The initiative was appreciated for ‘starting a conversation’ about the need for better senior care and for increasing momentum to improve and better support dementia care throughout Central Zone communities.

Challenges

Physician involvement and awareness of PHC IGSI - With one physician currently involved in the initiative, the PHC team members expressed a concern regarding lack of physician involvement and awareness of the initiative. Although physician involvement was a concern, it was acknowledged that physicians have little time and competing demands. All team members expressed their desire to have more physicians involved and for one, increasing physician awareness of the initiative needs to be “one of the next steps”.

Resourcing - Challenges with time was noted in the focus group/interview data. Time needed to attend community coalition meetings and the length of time required to complete the Geriatric 5Ms© Framework was also noted. Funding was noted as a challenge by one member. Another member identified the challenges faced by rural communities as there are not as many services and supports available in rural communities, and people have to travel to access them, which can be very difficult for someone living with dementia.

Communication of care plan with others

Due to FOIP, the PHC team felt there were some barriers to communicating the care needs of their patients to other services or organizations in the community. It was also unclear to the team who they could share the care plans they had created without violating FOIP guidelines.

> **"And then sharing this care plan you know I am just... I'm really unsure about that like I don't know what the FOIP rules all are and we're going to have to work that out of… once that 5M care plan is done. Who gets to see it? Does the family agree?"**
>
> – Level 1 PHC team member

Perceived Impact of PHC IGSI on Care Providers, Patient Care and Service Integration

Overall, PHC team focus group/interview data showed members perceived they increased their confidence in their ability to recognize, diagnose, assess and/or create care plans for their senior patients. Members also felt they were more aware of cognitive assessments, services, and supports available. It was perceived they improved their ability to identify dementia earlier in their patients, and better support them both in the clinic and in the community as their dementia progressed. For some, they learned how to better support care partners and involve them more in patient care planning. Additionally, many members realized the importance of connecting to their patients on a personal level and determining what is most important to them in terms of their care – more individualized approach to care than before. As one member noted: "I think definitely improved care. Early recognition. Caregiver support."

A review of data revealed that team members felt some action had been taken to improve integrated care. It was perceived that referrals to AS AB/NT (First Link) happen more quickly than before, and providers noted they have started referring patients to more external services. They perceived there had been improved follow-up and communication between services, and more collaboration with Seniors Outreach, PCNs, and other community services.

Care Partners' Satisfaction and Experience with Care

A review of data from semi-structured interviews conducted with two care partners of PLWD from Three Hills found that overall the care partners were satisfied with the team providing care. One care partner felt the team had been very helpful, supportive and he/she felt it was possible to call and talk to staff at any time. The other care partner was satisfied with their interactions with the clinic team and felt they knew "what they are talking about".

> **"I don't really have an awful lot to say except that I'm quite happy with how things are going and that they're… they have been there for me when I need some help."**
>
> – **Care partner**

Evaluation & Impact

Early evaluation activities carried out in Three Hills were supported, as needed, by the Big Country PCN evaluation consultant. Evaluation resources were vetted through the Big Country PCN executive director. A role change resulted in reduced local evaluation consultant support for the latter part of 2018, resulting in PHC ARES team completing some evaluation activities (see Table 8 for a summary of evaluation activities) for final reporting.

In the community of Three Hills, a survey was developed and distributed to assist the PHC team and community partners to better understand the health and social needs of community members. 41 respondents completed the on- line and paper-based survey. Two reports compiling survey responses were completed: one provided a complete list of all open-ended survey responses and the other was a summary of qualitative theming. Although focus group/interview results did not reveal specific QI goals or performance measurements for PHC IGSI, overall improvement goals were set at the beginning of the initiative and QI work has involved process changes at the clinic level.

Table 8. Summary of Evaluation Activities in Three Hills

Domain	Evaluation Activity	Description of Activity	Status Update
Care provider	• Surveys (on-line) • Survey (paper-based)	• 4 care providers emailed link to on-line survey • 3 surveys distributed to providers during focus group	• 3 completed • 3 completed
Community	• Community Survey	• Survey distributed post Education Day November 2017, by community organizations and open access on the Big Country PCN website	• 41 collected
Administrative data	• Administrative data from Alberta Practitioner Claims, Discharge Abstract Database and Pharmaceutical Information Network	• Analysis of administrative data for the Kneehill Medical Clinic found 91 cases of dementia and for these cases explored: age and sex, clinical risk grouper, social and material vulnerability, continuity of care, hospitalization and prescribed medication	• Completed
Clinic/community team	• Interview • Focus group	• Individual interview with PCH team member • Focus group with PHC team members (n=3)	• 1 completed • 1 completed

Overall, retrospective focus group/interview data revealed that the team felt the initiative had been valuable. They felt it had changed the way they work with patients in their office and their community and that they have already seen success. In general, there was consensus among PHC team members that their expectations had been met by the initiative. One team member reported: “My expectations for this initiative…was yeah just to basically learn more about dementia and where do we go now basically when someone gets a diagnosis helping support the patients. And I think that was one of the goals… of the team and I said for our patients…And I said yes the initiative met the expectation.”

The PHC team in Three Hills has made practice changes to clinic care, including increased screening to identify patients with dementia, utilization of the Geriatric 5Ms© Framework for care planning with PLWD, development and utilization of a work/action plan and clinic flow map for patients with cognitive or behavior concerns, and increased patient referrals within the clinic. PHC team members have participated in all three PHC IGSI workshops, and have offered local education at their clinic for health professionals and community members.

Work in the community to advance care integration has begun. An important step was taken with distribution of the community survey to better understand the health and social needs of community members. A community coalition has been started, as well as an Alzheimer caregiver support group in Linden. Initiative work at the community level continues to develop. Challenges in Three Hills area included resourcing, physician involvement and concerns with sharing the care plans. One next step for the group is to increase physician awareness of PHC IGSI. The local PHC team has made meaningful progress to improve early diagnosis and management of dementia through clinic practice change, participation in educational opportunities (PHC IGSI workshops and local education), and through resource sharing.

In 2017, the PHC team in Innisfail began PHC IGSI work with an aim to: conduct proactive case finding; establish a community coalition; provide ongoing education, mentoring and capacity building; and provide patient-centred care.

Retrospective focus group data revealed team members felt the initiative had "started the conversation", and overall, it was felt by members that they had "come a long way in a very short time".

Areas of focus identified during the 2017 focus group were care plans and follow-up visits with PLWD. Results reveal the PHC team has made progress in both these areas as the Geriatric 5Ms© Framework is now part of clinical practice and members felt follow-up with patients was being done. Community coalition development is in the early stages as members continue to identify partners and complete structures for the group. Overall, the team has made strong progress in advancing dementia care in the community of Innisfail.

Innisfail

'Creating circles of integrated care'

Wolf Creek PCN & Innisfail Clinics

Wolf Creek PCN, operating since 2008, provides services to patients in the communities of Innisfail, Lacombe, Ponoka, Rimbey and Sylvan Lake. In this PCN there are 64 physicians and a variety of health care professionals that work in 12 clinics. Wolf Creek PCN uses a collaborative approach to care provision. Health care providers, along with physicians, assist patients with extra counselling, guidance, and education throughout their health care journey (https://wcpcn.pcnpmo.ca/Pages/default.aspx).

There are two medical clinics in Innisfail. In 2016, the Innisfail Medical Clinic and the Innisfail Associate Clinic joined the Wolf Creek PCN. The Innisfail Medical Clinic has 11 physicians and the Innisfail Associate Clinic has 4 physicians.

In an ongoing effort to improve care for seniors, the primary care team identified the need for a proactive, person centred care model with a single point of access to comprehensive, integrated care. To achieve this, the Innisfail clinic joined the Wolf Creek PCN and worked to establish a geriatrics program. A geriatric nurse was hired to help improve care of Innisfail's senior population.

Current Challenges with Dementia Care in Innisfail

An analysis of data gathered in a 2017 focus group with PHC team members found that one of the main challenges impacting dementia care in the community of Innisfail is fragmented care. Themed analysis of data found that fragmented care for patients in the community is influenced by the following three contributing factors: communication gaps between services; inadequate integration of available services; and rigid procedures or systems preventing timely responses to care.

Inadequate communication channels among health care service providers that interrupt continuity of care for patients was highlighted by one team member during the focus group. Communication of information was also recognized as a barrier to dementia care by the PHC team during a collaborative planning activity at PHC IGSI Workshop #1. Specifically, communication of information, including poor access to the AHS system, and duplication of work and assessments as a result of poor bridging of communication were communication barriers identified during the activity.

Other barriers to dementia care identified by the PHC team during collaborative planning at the workshop were as follows: reactive instead of proactive pathway for care; Home Care is not located in-house with physicians (poor liaison); volunteer access; lack of knowledge of service availability; lack of advance planning in population; broad rural population with general attitude of self-sufficiency; challenging to establish follow-up in deep rural areas; lack of training for frontline workers to deal with delirium and agitation; and level 2 geriatric service is lacking within the community.

Improvement Goals & Expectations

Four PHC IGSI improvement goals have been developed by the Innisfail PHC team. These goals, reported in program documents and presentations, include the following:

1. Proactive case finding for patients at risk of cognitive decline in order to assess, provide education (patient and family), develop patient centred care plan and plan follow-up visits
2. Establish a community coalition with the following members: PCN geriatric nurse, AHS Home Care, AS AB/NT AHS palliative care nurse, Family and Community Support Services (FCSS), physician, PCN social work, AHS Seniors Mental Health, members of the public
3. Ongoing education, mentoring and capacity building
4. Provide patient-centred care

Goals of the geriatric program were also discussed during the 2017 PHC team focus group. Analysis of focus group data revealed broad overall program goals, to be achieved through community coalition building and development of a geriatric program, are to improve continuity of care and quality of life for patients. Proposed areas of focus to achieve change include improved service integration, streamlined inter-professional and interdisciplinary communication, and building public and professional capacity through education and collaboration with community stakeholders.

PHC team members discussed their expectations of the initiative during a focus group held in late 2017. An analysis of data found fragmented care and utilization of care plans were priority areas, in addition to identification, increased awareness and integration of community resources and services. When asked about expectations of the project by the facilitator, one PHC team member noted: "The main thing is to stop some of our fragmented care and to have actual care plans and follow-up and follow some of these individuals with dementia." Additionally, one team member noted they wanted to work from the bottom-up noting "We were looking at the bottom up approach and we really wanted to start at the ground level so that if people are really interested they would approach their managers and say you know this is happening and I want to be part of it, can we be part of it?"

During a retrospective focus group held with the PHC team in August 2018, initiative expectations were similar to those discussed the previous year. Generally, there was a hope of integrated care for patients and increased awareness of community services outside the medical home which would include an adult day support program.

> **"Creating circles of care right, just around the person that's more holistic right. Outside the medical home involving the community and then themselves."**
>
> – Level 1 PHC team member

Action & Activities

Education

Team members have participated in a variety of educational opportunities since the initiative began. Education for Level 1 PHC team members has involved participation in PHC IGSI Workshop #1 (n=9), Workshop #2 (n=9) and Workshop #3 (n=10). A review of data from a retrospective interview with the clinic team, conducted in August 2018, in which individuals reflected back on all 3 workshops indicated that level 1 PHC team members found the workshops to be informative, educational, and a great opportunity to network and connect with experts in the field. Education for level 1 PHC team members has also been achieved through locally held presentations on dementia and senior care. To date, the Innisfail PHC team has hosted the following local education sessions:

- Dr. Darrel Rolfson - "Frailty in Primary Care" (Sept. 6, 2018)
- Dr. Karenn Chan - "Dementia: Diagnosis, Treatment, and What Else Matters" (Dec. 7, 2017)
- Dr. Justin Okeke - "Falls and Bone Health" (Apr. 18, 2018)

- Dr. Jasneet Parmar - "Capacity Assessment" (May 3, 2018)
- Dr. Karenn Chan - "Driving and Dementia: Practical Tips and Approach to assessing Fitness to Drive" (May 24, 2018)
- Dr. Robert Warren/Palliative Resource Nurse" Palliative Program" Moose & Squirrel Medical Clinic Sundre (Dec 14, 2017)
- Advance Care Planning "Conversation Matters" AHS South Zone (Feb. 26. 2018)
- Dr. Neil Nedley "Mental health and lifestyle medicine – optimize your brain (July 17, 2018)

Practice Change

A number of practice changes have occurred in Innisfail clinics since PHC IGSI began:

- ***Clinical staff changes & Flowmap Development***

  Although changes to clinic practice had been planned and instigated before the initiative rolled-out, it was stated in the retrospective focus group by a team member that as a result of the initiative, the geriatric program developed likely focused more on assisting patients with dementia.

  Staffing changes that occurred at the clinic during initiative start-up included the addition of the team lead geriatric nurse role, and a change in the role of panel managers. The addition of the geriatric nurse role was also mentioned during the 2017 PHC team focus group. One team member felt the experience of the newly hired geriatric nurse provided a strong foundation to build capacity within the program, through education and training, to enable other staff members to learn to conduct geriatric patient assessments. The PCN Team decided to develop a flowmap based on a logic model approach to bridge the health and Social System Gap based on cognitive, physical and social frailty.

> **"…It was good timing for the PHC IGSI for us because we were just getting going with the PCN and we were planning on having some kind of program for geriatrics. I think it maybe focused us on dementia a bit more and then the frailty part of it, but we've kind of evolved at the same time – the PCN and bringing in the PHC IGSI initiative at the same time, so I've noticed a lot of changes. I think some of it would have changed whether we were involved with PHC IGSI or not, but I think it's kind of focused us a little bit more"**
>
> – Level 1 PHC team member

- ***Utilization of the Geriatric 5Ms© Framework for care planning with PLWD***

  During the 2017 focus group, team members reported they were aware of the Geriatric 5Ms© Framework, but were not at a point of using it. Analysis of 2018 retrospective focus group data found that the PHC team reported they now use the Geriatric 5Ms© Framework to create a care plan for all patients showing physical, social and cognitive frailty – not just those diagnosed with or suspected as having dementia. Care plans are created by a team that includes the patient, their family, the geriatric nurse, and a family physician. Patients are provided with a paper copy of their plan. The component of their new care planning process that the team has found most useful but also most challenging is individualizing the care plan so it captures what is most important to a patient and their family. Focus group data suggests the team makes an effort to ensure patients receive adequate follow-up, and referral to programs and services that will best support them in their community.

- ***Team approach to caring for patients***

  Analysis of retrospective focus group data reveals members appreciated the new team approach used in the clinic to assess their dementia patients. By working as a team, and bouncing ideas and suggestions off one another some members reported their confidence for diagnosing and creating care plans had increased. It was felt the team members support one another. For some members, it was felt working as a team allowed them to refer patients and their families to the geriatric nurse to help alleviate demand on physicians who are often restricted for time. Additionally, through their experience with the initiative, some of the members learned a team approach is essential to providing patients with comprehensive, quality care.

- ***Screening to identify patients with dementia and frailty***
  Involvement in the initiative encouraged the team to review clinic processes which resulted in increased screening for dementia and frailty. Originally, using proactive case finding, 30 patients were initially identified on three physician panels for geriatric assessment. Since the development of the geriatric program flowmap patients are identified by using the frailty screen criteria identified in the flowmap. A team member noted that in addition to opportunistic screening, more intentional screening was being done in the clinic. As noted by one member: "We've kind of looked at our processes in that we actually now do some screening as well as opportunistic".
- ***Tools and resources used by the PHC team***
  A flow map for geriatric patients has been developed to help guide the team in assessment and care of geriatric patients (See Appendix M). An initiative work/action plan has also been created with activities, action items and status level for initiative planning. All action items are completed and the team will develop a 2019 action plan by December 31, 2018.
- ***Follow-up for patients***
  In the retrospective focus group, one member noted a change in process has been follow-up for patients. After an assessment there is a follow-up with patients based on multiple indicators. The team member perceived that "we connect to them quicker".

Community Coalition Building

Innisfail has started building their community coalition. The coalition has membership representation from Family and Community Support Services, Home Care, Dementia Support Group, palliative care, AS AB/NT, Seniors Outreach, physicians, social work, allied health, and pharmacy. The coalition held its first meeting in February 2018, and to date has met twice.

Retrospective focus group results reveal PHC team members felt there has been some early success creating new partnerships which have increased collaboration with community services. Members thought these collaborative partnerships had also helped to address program funding challenges and gaps in community care. It was felt that through the coalition, members have been able to clarify and increase awareness of the unique services they provide to their community seniors, which they perceive has helped reduce service duplication and improved the appropriateness of care provider referrals. Progress has been made, but as one member noted "We've only had two meetings so it's really, really early". The Town performed a seniors needs assessment in 2016 and at this time have an Elder friendly community committee looking at the assessment to develop an action plan regarding that assessment. At this time the community coalition is temporarily inactive pending the outcomes based on the town's community development approach. However, the team continues to focus on tasks related to the creation of a new collaborative structure with AHS. There has been a financial commitment from AHS Home Care and Allied Health in supporting an adult day support program in Innisfail. The team continues to collaborate with FCSS to address social frailty and care partner fatigue with programs such as Art from the Heart and Alberta caregiver COMPASS program for mental health support.

Strengths & Challenges

Strengths

PHC IGSI Workshops - Overall, team members felt the PHC IGSI workshops were a significant strength h of the initiative for the education they provided and the opportunities for networking. Most of the retrospective focus group team members had been attending the workshops since they started and generally they found them to be educational.

Members also appreciated the workshops for the networking opportunities they provided, and the way they catalyzed into education in their own community.

Shared Learning and Resources - Another initiative strength that emerged from the data was the shared learnings and resources that occurred as a result of the initiative. The PHC IGSI project team distributed the Geriatric 5Ms© Framework that the clinic team now uses to create patient care plans, and the clinic team developed the patient flow map to raise the profile of frailty in the medical home. Pathways were tailored for their needs in the context to the degree of frailty and identifying the less frail who may benefit from a more preventative approach. Peer support, assessment tools, and information about other community initiatives, were also received by the clinic team through the initiative.

PHC IGSI Project Team - An additional strength reported during the focus group was support received from the PHC IGSI Project Team. Providers felt that the PHC IGSI Project Team was able to provide them with any support they asked for, including supports they did not know were available to them. Support for evaluation from the PHC ARES team was also noted.

Challenges

A wide variety of challenges were noted by members in the retrospective focus group:

- Communication of patient care/care plans between different services and supports in the community. Currently it is not possible for patient information to be shared between services or support which leaves communication dependent upon patients and their Green Sleeves.
- PHC Team challenges to reflect on objective measures of success as they are still collecting early stage data to assess the impact of their clinic on patient care.
- Improving care for seniors and PLWD will require a system-level change, and that takes time.
- Some organizations or agencies can be challenging to work with as they also experience change and people move to new roles.
- Funding for programs needed in the community. Care plans are created in the medical home and although community capacity building and partnership are made, advancement depends on resources outside the clinic.

Perceived Impact of PHC IGSI on Care Providers, Patient Care and Service Integration

Some PHC team members heavily involved in diagnosing patients felt confident in their ability to refer patients for assessment. They felt they have been successful in establishing their assessment processes.

Generally, it was felt by the team that service integration had started but was at the preliminary stage. The theme of collaboration was found in the retrospective focus group data. Some members reported the newly developed partnerships had increased collaboration with other community services, and have helped to address program funding challenges and other gaps in community care. In doing so, it was felt everyone had become more aware of each other's needs and they had been able to work together to address them. The PHC team communicated with the Oliver PCN in Edmonton to learn more about the initiative at the Seniors Hub in frailty identification and how other PCNs are using their own resources to address some of the same service gaps. Also, collaboration has also facilitated goal alignment. It was perceived that FCSS and other community services are now more aware of the goals of the PCN, and the PCN and community services/organizations are more aware of larger provincial goals for this project. The team expressed trying to work together to support each other to meet all of the larger initiative and programming goals.

Care Partners’ Satisfaction and Experience with Care

A review of interview data gathered from Innisfail care partners (n=4) of PLWD found that care partners were satisfied with the level of care provided by the PHC team. One care partner reported having “more piece of mind” knowing the PLWD is being watched, and another felt the PLWD was getting the best care possible. Communication was a theme across the interviews, with care partners reporting that team members were following up and making contact. It was also noted by a care partner that she/he, along with the PLWD, talk to PHC team members and that the team is good at explaining things. Two care partners reported the team provided them with support. One care partner noted support from the nurse and another reported moral support from a physician. This care partner felt the team was helping her to cope and that she was able to go to members that are knowledgeable. Additionally, she perceived that staff were working together, talking about the PLWD’s and the care partner’s issues and were trying to help them manage.

> **“Well she is very, I’d say very thorough and certainly encourages questions and give answers. I know that my son and daughter-in-law were very… I’ll use the word impressed. Impressed with her and how she answered questions and the follow-up she gave.”**
>
> –Care Partner of PLWD

Evaluation & Impact

Early evaluation work in Innisfail was facilitated and implemented by an external, evaluation consultant, along with the lead geriatric nurse and PCN Social worker/improvement facilitator. A Wolf Creek PCN evaluation plan for PHC IGSI Innisfail described processes and outcomes using a mixed methods approach with a variety of data sources to evaluate the initiative. As the initiative progressed, external evaluation with support from the consultant was no longer available which resulted in PHC ARES completing some evaluation activities (see Table 9 for a summary of evaluation activities) for final reporting.

Table 9. Summary of PHC IGSI Evaluation Activities in Innisfail

Domain	Evaluation Activity	Description of Activity	Status Update
Patient	• Interview	• 1 patient interview	• Completed
Care partner	• Surveys (paper-based)	• 11 care partner surveys mailed	• 2 returned
Care provider	• Surveys (on-line) • Surveys (paper-based)	• 26 care providers emailed link to on-line survey • 8 surveys distributed to care providers during focus group	• 6 returned • 5 returned
Administrative data	• EMR data	• 30 patients identified for geriatric assessment from 3 physician panels • Measures tracked for these 30 patients	• Ongoing • Ongoing
	• Administrative data from Alberta Practitioner Claims, Discharge Abstract Database and Pharmaceutical • Information Network	• Analysis of administrative data for Innisfail Medical Clinic found 191 cases of dementia and for these cases explored: age, sex, clinical risk group, social and material vulnerability, continuity of care, hospitalization and prescribed medication	• Completed
Clinic/community team	• Focus group • Focus group	• 1 focus group with 4 team members • 1 focus group with 8 team members (August 2018)	• Completed • Completed

The Innisfail PHC team has collected quality improvement measures, primarily in the form of qualitative patient and care partner surveys. The surveys were designed to assess patients and care partners' satisfaction with the Geriatric 5Ms© Framework. A review of retrospective focus group data did not reveal specific QI goals or performance measurements, however improvement goals were set early on in the initiative and QI work implemented by the PHC team at the clinic included the following:

- Collection of PLWD and care partner surveys that will measure the confidence in the program with indicators of care needs and communication between physician and patient/care partner.
- All screening done for the program is based on a chart review and a panel screening for a 7 set criteria that are evidenced for frailty.
- All patients that have moved through the program to the comprehensive geriatric assessment has had a care plan written for them and explained to them.
- ED admissions and visitations have been an indicator of performance since the inception of the program.

ED visits were a performance indicator chosen by the PHC team and both this and the qualitative surveys are in the early stage of baseline collection. Future evaluation of quantitative administrative data is planned with PHC ARES, and an IMA is now in place to provide data linkage and analytical support.

Retrospective focus group data reveals team members felt the initiative had "started the conversation"– people have started talking to each other about what could be done in the community. Members overall were pleasantly surprised with their community coalition development, and their ability to gather to work towards a collaborative goal. There are now more people 'at the table' talking to one another than there was before. Overall it was felt by members that "we've come a long way in a very short space of time", and there is a lot of potential for improvement.

Care plans and follow-up with PLWD were areas of focus identified during the 2017 focus group. Retrospective focus group results a year later reveal the PHC team has made progress in both these areas as the Geriatric 5Ms© Framework is now part of clinical practice, and members felt follow-up was occurring. Care partner interview data also supported the team member perception of follow-up for PLWD. Overall, evaluation results suggest the PHC team in Innisfail has meaningfully advanced PHC IGSI work in the community. Community coalition development is in the early stages as members continue to gather to identify partners and structures for the group. Team members continue to work on a variety of activities identified in their detailed work plan to reach initiative goals. PHC team members have worked to advance care for PLWD and results suggest that education, clinic practice change and development of a community coalition have set a strong foundation for work to improve seniors care in the community of Innisfail.

The main priority in Red Deer was establishment of a Level 2 clinic at the Red Deer PCN. This goal was achieved as the ECAC began receiving referred patients in June, 2017.

The ECAC team has been mentored by Dr. Robertson, Geriatric Specialist, and Karen Horsley, Geriatric Nurse. Mentoring included 9 months of support and involved working directly with teams as they learned to identify, assess, diagnose and provide recommendations for the care and support of patients living with dementia, frailty or other geriatric syndromes. To date, 177 patients have been referred to the ECAC.

ECAC team members have attended workshops, held training and education sessions and are in the early stages of developing a community coalition.

Evaluation of ECAC has been extensive with patient and care partner surveys and interviews, physician surveys, a chart review, a team effectiveness survey and various QI activities. A research project found care providers and care partners serve to benefit from ECAC.

Red Deer

'Building an Elder Care Assessment Clinic'

Red Deer PCN & Elder Care Assessment Clinic

Red Deer PCN (RD PCN) is the eighth largest PCN in Alberta and has been operating since 2006 offering a variety of complex care and mental health services and programs to a patient population of 128,000. Thirty health care professionals, including family nurses, support nurses (panel managers), and mental health counsellors are co-located in physician clinics to provide team care within the clinic medical homes. Kinesiologists, pharmacists, pregnancy and baby nurses, and a recreation therapist work from a central location, all to support the 82 physicians (21 clinics) within the PCN. These professionals are also involved in planning and offering nine group programs that address high need areas within mental health and lifestyle change. A total of 24 programs and services are available through the RD PCN through physician or self-referral. A Street Clinic operated by a Nurse Practitioner, and the Police and Crisis Team (Psychiatric Nurses and Police Officers) serve the vulnerable populations of the RD PCN.

It was determined early on in the initiative that the priority focus of the RD PCN would be to establish a level 2 clinic. This clinic, called the *Elder Care Assessment Clinic* (ECAC), is for individuals 75 years of age and older who's primary care physician is from the Red Deer PCN, and who has unexplained changes in memory and thinking, behaviour and/or function. Patients are referred by their primary care physician, and come to an ECAC clinic day along with their care partner and/or other personal support members, to be assessed by a team of health professionals who work with them to co-design a patient centred care and support plan. A copy of this care and support plan is given to the patient and shared with the patient's primary care provider. Once assessed by the ECAC team, patients have a follow up appointment with their family doctor to review the plan, and together decide on any changes to care.

Current Challenges / Needs for Dementia Care in Red Deer

Needs recognized by community partners for Red Deer, as noted in the PHC IGSI Workshop #2 "Report out" presentation, include the need for:

- Collaboration and effective communication between service providers
- A multi-disciplinary team assessment
- Increased awareness of community supports/services available
- Increased understanding of how to access existing resources
- Proactive follow-up care versus crisis response
- Importance of planning for the future
    - Enduring power of attorney (EPOA)
    - Personal directives (PD)
    - Goals of care (GOC)

Improvement Goals & Expectations

The primary goal of the RD PCN is to establish a level 2 Clinic. Specific objectives identified to achieve this goal include:

1. Create a process to identify patients for level 2 clinic assessments
2. Refine the multi-disciplinary approach for clinic visits
3. Model and mentor the team to:
   - Recognize and provide timely diagnosis of dementia
   - Co-develop a patient centred care plan
4. Create awareness of the clinic across the PCN

Action & Activities

The primary goal of establishing a level 2 clinic in Red Deer has been achieved. A variety of activities implemented by the RD PCN and involving community partners, contributed to the establishment of this clinic. Key actions that occurred in early 2017 included hiring a geriatric care consultant, and organization of a community coalition meeting (March, 2017). Development of the level 2 clinic began in spring 2017 and involved clinic set-up, gathering of patient resources, creation of geriatric team educational binders, staff meetings, and development of a selection and referral process. The ECAC began accepting referred patients in late June, 2017 for patients who were on the panel of the physicians who expressed an interest in joining the level 2 team. Referrals by any RD PCN level 1 physician began in October, 2017 with the first patients from these referrals being seen at the beginning of November, 2017. To date, 177 patients have been referred to the clinic and 150 patients have been seen by the ECAC team.

The ECAC team was mentored by Dr. Robertson, Geriatric Specialist, and Karen Horsley, Geriatric Nurse, both of whom developed and worked in the specialized geriatric service in the Red Deer Regional Hospital Centre for a number of years. The mentoring process involved working directly with the teams as they learned to identify, assess, diagnose and provide recommendations for the care and support of patients living with dementia, frailty or other geriatric syndromes. Five, full day training sessions have been held since June, 2017. Attendees included all clinic MDs, RNs, mental health professionals and pharmacists. These educational sessions involved working through case studies, reviewing research articles, review of guidelines and best practices, educational presentations and perspectives from PLWD. The team case-based discussions (case histories designed to foster team collaboration and clinical information designed to promote discussion about questions to be addressed in face-to-face encounters with patients and caregivers). Each education/training day was designed around expressed needs of attendees at previous days. In addition to the ECAC clinic team, other interested family physicians and clinic nurses have been invited to participate, and in the next session (planned for February, 2019) ECAC clinic team staff will act as mentors to new attendees.

Mentoring included nine months of active and hands on support from the geriatric specialist and geriatric nurse and included participation in the following activities: review of referrals four times per month; participation in patient assessments, team huddles and conferences; and patient/care partner interviews (geriatric nurse specialist on-site and the geriatrician on-site or available by phone). Also included was mentoring on how to work differently as a team, assistance to develop roles and responsibilities for each team member, development of the case studies, content development and reaching out to subject matter expert connections to deliver content, as well as working with the team to develop a sustainability plan for the clinic to help ensure its sustainability over the long term without the hands on support from the geriatric specialist and the geriatric nurse.

Establishment of the ECAC in Red Deer also involved numerous brainstorming, planning and follow-up meetings to determine team roles, clinic set-up and clinic process with the geriatric nurse specialist and geriatrician when on-site. Promoting awareness of the ECAC to level 1 clinics involved six ECAC clinic roll-outs to level 1 clinics which used Lunch and Learn sessions with the geriatric nurse specialist and the ECAC physician lead. The support provided will not only serve to increase this team's capacity to provide ongoing care and support for those living in the community with dementia or other geriatric syndromes, but also includes modelling behaviours and skills that will facilitate working together as a cohesive, multi-disciplinary team. The team will also be positioned to be the "in-house" specialists of this population and be an ongoing resource to the care of this population.

In addition to creation of ECAC, Red Deer has made progress toward building a community coalition. An initial community coalition meeting held in early 2017, was attended by the following partners: Family Services of Central Alberta, AHS (PHC and SH SCN; Mental Health and Addictions; Home Care; Specialized Geriatric Services), AS AB/NT and two care-partners of persons living with dementia. Four community coalition meetings have been held in 2018. In April, 2018 the coalition chose to “start small” and downsized their team to a core group of key Red Deer senior service representatives. In attendance at July's meeting: 1 member from AS AB/NT, 1 person from Family Services of Central Alberta, 1 member from Alberta Health Services Specialized Geriatric Services, and the remaining attendees were employed within the RD PCN. At the April and July, 2018 meeting the coalition team began creating their Terms of Reference. The last community coalition meeting was held in November, 2018 with approximately 30 people in attendance from across the health system and community. A steering committee of staff from RD PCN, AHS- Specialized Geriatric Services, Family Services of Central Alberta, AS AB/NT and a care partner (involvement of care partner since October) have met approximately four times prior to the November 2018 meeting. The next meeting is planned for January, 2019.

Strengths/Successes and Challenges

Successes reported by the team during their “Report Out” at PHC IGSI Workshop #2 were as follows: education sessions delivered to ECAC team members and RD PCN physicians, referral process established, and clinic operating four days per month. Two additional physicians will be joining the clinic in the new fiscal year. Strengths identified in the care provider interviews included: multidisciplinary team approach, mentoring education, efficiency in assessing patients and providing care plans.

Challenges identified in the “Report Out” include the following: scheduling, role definition and identifying appropriate patients. Team meetings involved ongoing process improvements, including flow of information so all have appropriate access, to upgrading referral forms for level 1 physicians for better assessment of appropriateness of referrals. Challenges identified in the care provider interviews include the following: ensuring proper referrals, scheduling, role definitions, collecting comprehensive collateral information, and role conflicts.

Further challenges identified at the January training day included the need for future information on healthy brain aging and the role that lifestyle change plays (particularly for level 1 teams), understanding effective ways to obtain feedback from level 1 physicians on recommendations from the ECAC team, sustainability and future RD PCN physician involvement in the ECAC. Progress has been made on these issues. The ECAC team created a “Duties and responsibilities of the ECAC team members” document that helped provide clarity to members, and have also developed a sustainability plan.

Evaluation & Impact

Evaluation Activities

Evaluation activities at the ECAC are coordinated and implemented by a full time, internal RD PCN evaluator. To date, evaluation has been extensive with work the PCN evaluator has conducted, and an applied research project completed by a University of Calgary student (Hastings, 2018). Red Deer College (RDC) and Alberta Health Services (AHS) are partners in a Health Research Collaborative (HRC), an applied research initiative between the two organizations. The HRC establishes and supports project teams of health professionals and decision makers, multi-disciplinary faculty, students, consultants, and community stakeholders to develop and support evidence-based initiatives that address the health issues they face across Alberta. The Red Deer PCN partnered with the HRC to assess the ECAC within the PHC IGSI. A logic model for the ECAC clinic has been developed. A detailed evaluation framework has been created with numerous evaluation questions, indicators and methods. Methods include:

- Patient and care partner satisfaction surveys.
- Care partner interviews.
- Patient interviews.
- Tracking of process indicators (referral numbers, patients seen).
- Level 1 survey on dementia knowledge at a physician Town Hall in October 2017.

- Broader spread to level 1 team members assessing knowledge, attitudes and self-efficacy.
- Two physicians volunteered to provide confirmed patient panels for a data matching trial conducted by the AHS PHC ARES team to identify patients with dementia to validate a provincial administrative data definition that can be used to link and examine PLWD’s utilization of health services.
- RD PCN received a 1 year SPARK grant from Baycrest Centre for Aging and Brain Health Innovation to fund the Elder Care Case Coordinator position (Nurse Practitioner who does follow up on the visit with patients, care partners and physicians). A part-time Nurse Practitioner was hired which allowed time to do follow-up two days per week. Evaluation of this grant includes qualitative interviews with patients, care partners and physicians in regards to the effectiveness of this position to support implementation of recommendations from the ECAC.
- A Health Team Effectiveness Survey was completed by the ECAC staff in the spring of 2018 that assisted them in better understanding changes they could make as a team.

Quality Improvement

Quality improvement processes initiated in the level 2 ECAC include development and utilization of an individualized care and support plan and an ECAC Referral Algorithm (Appendix N). As part of their assessment with patients, clinicians use a My Personal Integrated Care and Support (My PICS) Plan which includes the Geriatric 5Ms$^{©}$ Framework. Additionally, the Red Deer PCN has collected patient and care partner satisfaction surveys. The ECAC evaluation framework identifies numerous quality improvement measures such as staff satisfaction, evidence of process improvement (team meetings, processes and tools for review) and patient referrals.

ECAC Chart Review - In summer 2018, a QI project was initiated at the ECAC. A chart review was conducted to assess how well patients and their family physicians had been addressing recommendations made by the ECAC team. With this review the PHC team hoped to identify barriers that may be preventing patients, care partners, or physicians from moving forward with the 5Ms care plan, as well as which recommendations are being consistently met across patients.

ECAC Patient Charts

26 patient charts initiated by the ECAC team between November, 2017 and March, 2018 have been reviewed. Information recorded from these charts includes:

- Date of original ECAC referral and appointment
- Diagnosis received (if any)
- Recommendations and/or referrals made by the ECAC team or family physician and outcome (when available)
- Care partner referrals and recommendations
- Evidence of integration
- Patient attitudes

Results

- Initial review of earlier files and specifically the 5M care plan indicated time to determine recommendations, referrals and follow up could pose a barrier to follow up for patients. Early care plans often simply summarized the patient’s current condition rather than include specific steps the patient or referring physician could take to address noted concerns. Over time the 5M care plan recommendations became more specific not only noting concerns, but also providing provider and/or service recommendations to address the issues faced by patients and/or their care partners.
- Growth in documented evidence of integration between the ECAC and care providers coincided with the change in 5M care plan recommendations as previous patient history from the referring physician and referral forms for services like the First Link® program and Home Care (etc.) began to appear in later files.
- Initial time to determine follow up and time between referral and follow up appointments also appeared to be another possible barrier to case management in earlier files. The introduction of the Referral Flow Sheet (RFS) in later files however rectified much of this issue, and provides evidence of increased efficiency and integration of care among providers over time.

Follow-up Summaries

22 patient follow-up summaries completed between early April, 2018 and July 3rd, 2019 have been reviewed. Information recorded from these follow ups include:

- Date of ECAC appointment
- Date of Follow-up
- Recommendations made by the ECAC team
- Recommendations and/or referrals made by the ECAC team or family physician and outcome (when available). Preliminary impressions:
- Patient and care partner resistance to some suggested changes were a recurring reason why ECAC recommendations had not been met.
- Recommendations for medication changes were often carried out, while it appeared patients and their partners were much less likely to respond to suggestions regarding counselling, RD PCN group programs, or the use of other services.

Comparison summary:

- Of the 22 patient follow up summaries reviewed only 10 of these follow ups were done with the ECAC patient files reviewed between November, 2017 and March, 2018. As such, comprehensive assessment of follow up and identification of successful referral techniques and barriers to follow up on the majority of these files is difficult to determine without review of family physician charts.

Patient & Care Partner Satisfaction Survey Results - High satisfaction ratings have been demonstrated in survey data completed by both patients and care partners: 77% of patients and 92% of care partners rated the visit 9 or 10 (best) on a 10 point scale. 95% of patients and care partners “strongly agreed” or “agreed” they felt involved in their care decision. An ECAC patient noted the following: “Outstanding consultation. Staff made me feel they really cared about my concerns and well-being”. Qualitative data from a care partner satisfaction survey included the following quote: “This program is excellent. Very informative and eases family stress if done earlier in stages of aging. Thank you for the support. Awesome program.”

Patient Interview - An interview conducted with an ECAC patient found overall the patient appeared satisfied with her care at the clinic. Although she did not state any expectations for her visit, she did note some of her pills were reduced and “They did help me out.” She felt comfortable talking to clinicians and stated that her care plan included seeing a family nurse for smoking cessation, and attending the Alberta Anxiety to Calm program at the RD PCN.

Town Hall Physician Survey - Level 1 knowledge of dementia and geriatric syndromes survey at an October, 2017 town hall (33% of RDPCN physicians participating) found:

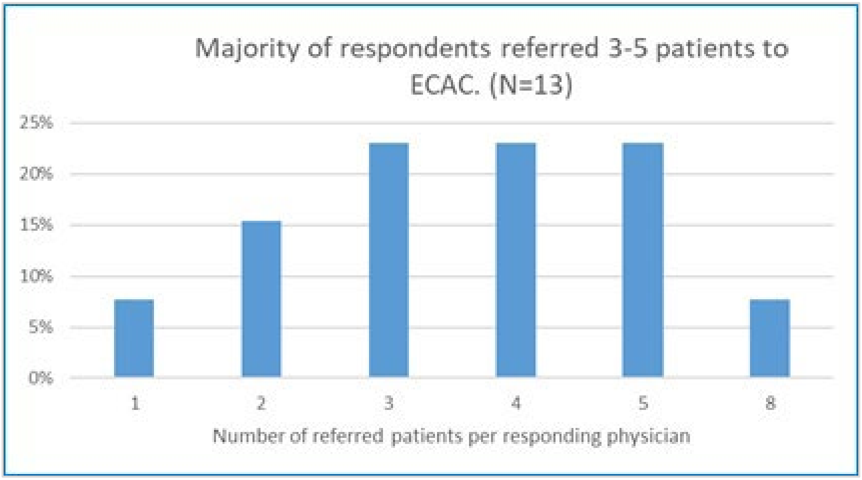
- Knowledge of dementia: Mean = 7/10
- Knowledge of geriatric syndrome : Mean = 6.6/10
- Confidence in ability to provide care: Mean = 6.5/10

Survey results showed information or training physicians noted as most important to them in the area of geriatrics. These included:

- Treatment
- Community resources
- Management of dementia related behaviour
- Expectations for physician management of dementia in primary care
- Palliative care of dementia patients
- Support of care partners
- Role of the family physician in diagnosis – differential diagnosis

Town Hall with Dr. Adzich – A Town Hall for RDPCN physicians was held on October 24, 2018 with Dr. Adzich providing a presentation on *A Palliative Approach to Late Life Dementia.* Approximately 35 physicians attended. Physicians were asked to participate in a survey to provide feedback on the ECAC report and recommendations they receive regarding their patients' visits. 13 physicians completed surveys. Results included:

- 100% indicated the report included all the information that was needed for follow up care with the patient.
- 1 physician suggested the report may be too long.
- 92% indicated they were able to carry out most of the recommendations.
- Respondents identified areas they liked about the report they received including because it was comprehensive, a good template for care, broke down issues into related areas, and team approach.
- Self-reported physician referrals to the ECAC are presented in the graph below



Red Deer College Student Research Project: Potential Benefits of the Integrated Geriatric Services Initiative for Professional Care Providers and Family Care Partners of PLWD (Hastings, 2018) - A unique component of evaluation at the ECAC was a Red Deer College/University of Calgary collaborative psychology student applied research project. The purpose of the research was to evaluate the potential benefits of the ECAC mentoring program by analyzing care partner and care provider questionnaires and interview responses.

A summary of results from the Hastings (2018) manuscript suggest both care providers and care partners serve to benefit from participating in the ECAC. Although pre and post-initiative quantitative survey results did not change significantly, valuable, useful, and impactful feedback was collected using interviews conducted with care providers and care partners. Both caregiving groups found the ECAC to be a positive and valuable experience that was not only effective at educating and developing the caregiving capacity of care providers, but it also improved the quality and comprehensiveness of care received by patients and their care partners. The clinic's team approach and the mentoring model of occupational development were deemed to be most significant to the clinic's success. Both caregiving groups spoke to aspects of the program that could benefit from future improvement. From the perspective of the care providers, resolving inefficiencies in the clinic process was a priority, and something that was continuing to evolve and improve with time to enhance patient and partner care. Interview responses also indicate care partners continue to experience difficulty fulfilling their clinic recommendations as adequate integration across additional primary care and community services external to the clinic has not yet been achieved. More detailed care provider and care partner survey results as well as interview themes and supporting quotes from Hasting's (2018) report are available in Appendix O.

A summary table of evaluation activities in Red Deer is presented below.

Table 10. Summary of Evaluation Activities in Red Deer

Domain	Evaluation Activity	Description of Activity	Status Update
Patient	• Interview • Satisfaction surveys	• 1 patient interview • Post clinic visit surveys	• Completed • 37 completed
Care partner	• Satisfaction surveys • Surveys (on-line and paper- based) • Interviews	• Post clinic visit surveys • 28 pre and 17 post surveys were distributed. These surveys measured: knowledge of dementia, attitudes towards dementia, caregiving self-efficacy, and satisfaction with life • Individual care partner interviews explored: ECAC expectations, ECAC strengths and gaps, caregiving self-efficacy, care planning, support, access to support, knowledge of dementia, information needs, stress and anxiety, and perceptions of integrated care	• 64 completed • 22 pre-surveys and 10 post-surveys completed • 7 completed
Care provider	• Surveys (on-line and paper- based) • Interviews	• 15 surveys distributed and measured: knowledge of dementia, attitudes towards dementia, self-efficacy, and attitudes towards mentoring • Individual interviews with care providers explored: mentoring experience, ECAC strengths and gaps, self-efficacy for assessing dementia, care planning, resources and tools, knowledge and skill development, and perceptions of integrated care	• 11 completed • 9 completed
Administrative data	• Administrative data from Alberta Practitioner Claims, Discharge Abstract Database and Pharmaceutical • Information Network	• Analysis of Red Deer PCN administrative data found 1190 cases of dementia and for these cases explored: age and sex, clinical risk grouper, social and material vulnerability, continuity of care, hospitalization and prescribed medication	• Completed
ECAC physicians	• Focus groups	• Pre-focus group interview conducted with 4 ECAC team physicians • Post-focus group interview conducted with 2 ECAC team physicians	• 1 completed • 1 completed

Partnerships, Collaboration & Service Integration

An Exploration of the Meaning of Integrated Care

Building community partnerships and collaboratively working to improve dementia care in communities by improving integration and coordination of dementia care between PHC teams/clinics and community based programs and services is a goal of teams. An exploration of what integration of care means for patients, providers and other key stakeholders is part of this evaluation. PHC teams and other stakeholders have been asked "What does good, integrated care (integrated with other health and community services) for these patients look like from your perspective?", and care partners were asked "What does integrated care (with other health and community services) look like from your perspective"?

Level 1 Care Partners - Care partners (n=9) of PLWD were interviewed in summer 2018 to assess their feelings of 'good integrated care'. Analysis of interview data indicated that care partners varied in terms of how they defined integrated care. Results found one did not respond and three care partners may have had difficulties understanding the question. Many participants asked that the question be repeated or explained further, indicating a lack of understanding for the question. For three others, responses focused on professionals from the health care sector (e.g., nurses, physicians, home care). It was noted that integrated care was seamless and integrated service was from a variety of specializations that was patient-centred, and involved the availability of physicians or nurses. Two care partners noted community services; one identified the community organization FCSS, while another mentioned the importance of community involvement and the creation of opportunities for people to introduce each other (e.g., a suggestion to have nursing homes 'open their doors' to people in the community living with dementia and have them visit), and to have greater community awareness of dementia.

> **".. From my perspective its nurses and doctors and everybody working together right. And for the outcome of the patient and trying to keep people in their homes rather than in the system and I think you need to have integrated care. You have to have those systems but I'm not sure they've done a great job until now of getting some of these programs going because the resources for home care seem like there is enough of them out there and stuff like that so...I think that that means that everybody has to come together between home care, nursing, doctors' clinics, that's what I foresee - everybody has come together for patient care"**
>
> – Care partner from a community focused on level 1

Level 2 Care Partners Care partners (n=5) of referred patients were interviewed 6 to 8 weeks after their appointments at the ECAC. Themed data to assess the meaning of 'good integrated care' for this group found that a multidisciplinary and collaborative approach to care was noted as key to improving patient care by enhancing communication across care providers and services. Two of five care partners interviewed felt that good integrated care should reduce the amount of burden and caregiving responsibility they experience as part of their caregiving role.

Level 1 PHC Team - An analysis of retrospective focus group data of level 1 PHC teams found the most common element across teams was care coordination and services across the PHC team and community-based services. Coordinated care involved links to community services, referrals and an awareness of available services. It was also felt that coordination of care across the continuum was needed; this involved care within the PHC team, and outside the medical home with inclusion of community based supports and services. The definition includes an awareness of where patients are at in the process as they move through the system, starting from their physicians' care forward, without gaps and stops along the journey.

Important components of care were identified by teams. These included: shared care plans, community coalitions and a team approach to care. Patient-centred care was also identified by teams. Two team members reported that communication was important, specifically open communication with all involved in the care of a patient and good communication across the PHC team.

Level 2 PHC Team - Interview and focus group data collected pre and post-measurement from level 2 ECAC care providers was thematically analyzed to capture their perceptions of 'good integrated care.' Level 2 providers' emphasized components of integration required at different levels of the healthcare system. Integrated care within the ECAC was defined as utilizing a multidisciplinary team to assess, diagnose, and create a comprehensive and individualized 5Ms© care plan involving PLWD and their care partners.

To integrate care between the clinic and the community, the level 2 PHC team emphasized the importance of the ECAC teams' awareness of supports and services available in the community to refer and connect patients to necessary and appropriate care supports (e.g., AS AB/NT, home care, occupational therapy, counselling, etc.). Integration of care back to the community also involved transfer of information and care planning to family physicians, ECAC follow-up with community supports and physicians, and transfer of knowledge to level 1 PHC providers.

Overall, 'good integrated care' in general was defined by the following: sharing of information to keep everyone "on the same page," collaboration and de-compartmentalization, follow-up, tailored plan of care, ease of access through the healthcare system, keeping PLWD independent in their communities as long as possible, and 'team' support of patients.

Key Stakeholders (PHC IGSI Project team members, PCN Executive directors, one PCN project team and AS AB/NT) - As with the level 1 and 2 PHC team results, data from other stakeholders on the meaning of "good integrated care" also revealed a focus on coordination of care. It was thought that good coordinated care would mean the social sector and health care services have an awareness of each other's services and there would be a willingness to work together collaboratively to support PLWD. Patient-centred care was also noted by some with support provided through diagnosis to end of life. One key stakeholder felt integrated care would mean easier navigation through the system, with improved information sharing and having everyone know the story of the patient.

> ***"A hopeful interaction with the health and social sector supporting me. And that to me would be integration."***
>
> – Key Stakeholder

Integrated Care in Level 1 Communities

Perception of progress to integrate care in communities - Retrospective focus group data from level 1 PHC teams on perceptions of integrated care found overall that teams felt some progress had been made to integrate care in communities, but work was in the early stages. Teams used phrases such as "some action" and "a work in progress" to describe integrated care in their communities.

Collaboration and partnerships - Results reveal that overall it was felt by members that collaboration had improved within the PHC team, among community members and between the clinic and community. Integrated care partnerships involving the PHC team, community services (e.g. AS AB/NT First Link®) and other health care services (e.g. home care) had been made. It was noted by one team that the impact of PHC IGSI on the community had brought partners together. Another team spoke of improved collaboration between the PHC team and the seniors outreach nurse, and their work together on difficult cases.

Communication - It was generally felt across teams that communication within clinic teams and among community members had improved. PHC teams have started to reach out and have conversations with supports and services in the community they did not work closely with before. In general, results suggest communication had improved between members of three of the four clinic teams as they have moved towards a team approach to care (physicians, nurses, panel managers, etc. all communicating more). One team reported communication had improved with Seniors Outreach and within the PCN (among different offices), another mentioned better communication overall, and a third team reported they had communicated with other PCNs.

Community coalition building - Community coalition building has begun in all the main participating communities (Innisfail, Drumheller, Three Hills and Red Deer), in addition to a newly engaged community – Lacombe. The number of community coalition meetings held in communities to date varies, ranging from one to eleven meetings. Community coalition members vary with diverse representation of membership including AS AB/NT, FCSS, home care, AHS and a variety of other groups depending on the community. Generally, analysis of focus group data reveals that development of community coalitions is in the early stage as groups work to determine membership partners and formalize procedures such as completion of a terms of reference.

> ***"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."***
>
> - Level 1 PHC team member

Care plans - Utilization of the Geriatric 5Ms® was reported to be used in four communities. Two teams mentioned care plans could be kept in the patients' Green Sleeve, with one noting that if the patient was to visit the ED it could be shown to other healthcare providers. During the retrospective focus group one team felt integration would "come in" with patients with the 'matters most' part of the care plan as it is individualized with more than medical information. For most teams, the care plan was not shared with others outside the PHC team; however, one team noted that the care plan is shared outside the team "if the patient chooses to share".

Support Groups - For one community, a new Alzheimer's support group had recently been organized and there was discussion of another being created. One PHC team reported they hoped to create a support group for care partners.

Strengths, Weaknesses, Opportunities, Threats (SWOT) Analysis

Retrospective focus groups/interviews conducted with PHC level 1 team members gathered data on the strengths and challenges of participation in PHC IGSI. Additionally, a question guide for key stakeholders included SWOT analysis questions to gather feedback on initiative strengths, weaknesses, opportunities and threats. Broadly, the findings that emerged are presented in Table 11.

Table 11. SWOT Analysis of PHC IGSI

Strengths	• Workshops • Shared learning and resources • PHC IGSI Project Team support and leadership • PHC IGSI catalyst for starting conversations around better senior care • Bottom-up approach to implementation that is tailored to local context
Weaknesses/Challenges	• Resources (time, financial, staff) • Evaluation and QI • Collaboration and relationships • Care planning • System level change and support
Opportunities	• Clinic processes – clinic flow/process, follow-up • Collaboration with community, and between PCN and physicians • Increased awareness of PHC IGSI activities in other communities • Opportunity for PHC teams to do pilot project work where they see gaps
Threats	• Financial support to sustain services and initiative overall • Lack of time to do initiative work well • Clinic nurses receive larger proportion of geriatric appointments related to dementia creates a large workload • Culture change without proper supports at local and provincial level

Strengths

The strongest theme found in the data on strengths was PHC IGSI workshops. Generally, it was felt the workshops were valuable, helpful and provided up-to-date information on dementia. In addition to the educational value of the workshops, results show the networking opportunities they offered were valuable, as was the ability to see work other communities were engaged in.

Another significant strength was shared learning and resources. PHC teams and key stakeholders found it beneficial to learn about activities taking place in other communities, learnings from other PCNs regarding what was working/not working, and seeing what communities of a similar size, as well as larger communities were doing. Education and training was also noted. Shared resources identified in focus groups/interviews were:

- Geriatric 5Ms© Framework
- Patient/clinic flow maps
- Assessment tools such as the Frailty Scale, Trails B, and the Comprehensive Geriatric Assessment tool

For some, the PHC IGSI Project Team was noted as an initiative strength. PHC teams appreciated their support and encouragement. They were considered to be a valuable resource for ideas, feedback, information regarding activities in other communities, and connecting the team with professionals to provide education and program implementation support. For one key stakeholder, the strong leadership of the team leads was reported as important to provide a foundation for work moving forward.

The initiative as a ‘conversation starter’, and a bottom-up approach were also considered strengths by some. It was felt the initiative was a catalyst to starting conversations in communities to improve dementia care and to encourage people to take steps to look at ways to enhance care in communities. The grassroots approach taken was also thought to be a strength as it was a tailored with an individualized approach aimed to meet people where they were at in terms of community goals.

Weaknesses/Challenges

Resources was a very strong theme that emerged from data analysis on initiative weaknesses/challenges. Funding was a primary challenge, with funding for community programs and payment structures for supporting different organizations specifically noted as concerns.

A concern about the availability and equitability of resources (services, supports, AS AB/NT) in rural communities was also a theme. One participant noted there are not as many services and supports available in rural communities, and that people have to travel to access them which can be very difficult for those with dementia. Another noted they were part of a small PCN so they did not have a lot of clerical or administrative staff which meant that PHC IGSI activities and/or QI “all falls on the nursing staff”.

Staffing and time were two additional resource themes. Staffing concerns were noted by two key stakeholders. One concern was having adequate staffing to meet increased demand for AS AB/NT services. Another described a staff role change during early involvement in the initiative - this coupled with lack of physician availability to participate, resulted in tangible challenges for the PHC team to actively participate in PHC IGSI. One final theme, time, was found in the data as one PHC team noted concerns with the time needed to attend community coalition meetings, and the time required to complete the Geriatric 5Ms© Framework. Another stakeholder identified a concern with having enough time to dedicate to the initiative.

Ability to conduct evaluation and QI were weaknesses identified. The following items were identified in focus groups/interviews: lack of an Information Management Agreement; the need to create quality improvement goals and measures; PHC teams ability to reflect on objective measures of success was limited as measures have not yet been collected to assess the impact on patient care; even PCNs who contracted an external part-time evaluator found evaluation difficult; lack of evaluation work completed – with one member noting that they “haven’t done very much evaluation because there’s no support in that area for us”.

For some, collaboration and relationships were described as a weakness. Working with organizations can be difficult because of time, restrictions and policies associated with large organizations such as AHS, change within organizations generally and people changing roles, and some resistance from professionals to work collaboratively with community agencies.

Care plan challenges were highlighted by three PHC teams: FOIP concerns and barriers related to communicating the care needs of patients to other services or organizations in the community who could help support their patients and their partners, specifically a lack of clarity if created care plans can be shared without violating FOIP guidelines; lack of time for the PHC team to complete comprehensive assessments and care plans; and sharing patient information between services/support sectors is not possible which leaves communication dependent on patients and their Green Sleeves.

System level change and support was briefly noted. One PHC team felt improving care for seniors and PLWD will require a system level change which takes time. A key stakeholder weakness was that integration requires system level support.

Opportunities

Opportunities noted by key stakeholders included: clinic processes (e.g., clinic flow/process, follow-up); collaboration between the PCN and the community and the PCN and physicians; increased awareness of PHC IGSI activities in other communities; and opportunities for PHC teams to do pilot project work where they see gaps.

Threats

Threats to the initiative identified were: financial support to sustain services and initiative overall; lack of time to do initiative work well; clinic nurse receives larger proportion of geriatric appointments related to dementia which creates a large workload; culture change without proper supports at the local and provincial level.

Most Valuable PHC IGSI Resources/Supports

When key stakeholders (PCN EDs and a PCN project team) were asked which resources/ supports they found most valuable, and if there were any additional supports/resources they wished they had received from the PHC IGSI Project team to help them implement initiative activities, the most valuable supports identified were: leadership from the PHC IGSI Project team to help get the initiative “off the ground”; educational training, “it was all valuable, new learning for everyone; and workshops. One key stakeholder noted that help in the area of community coalitions and creating community awareness beyond the PCN was an additional resource they wished they had received from the PHC IGSI Project Team.

Essential Elements for Implementation of PHC IGSI and Next Steps

PCN EDs and a PCN Project team shared their key recommendations for implementation of the initiative in other PCNs/communities. Their suggestions included:

- Community support – more information that could be given to community partners to encourage them to participate in and understand what is trying to be accomplished
- Leadership within the team – someone taking a proactive role
- Continued leadership from the PHC IGSI Project team
- Education is essential
- Community coalitions

- Buy-in from interested individuals who want to participate and make a change–including a passionate lead person

Next Steps

Important next steps for PHC IGSI identified by key stakeholders (PCN EDs and a PCN Project Team):

- More dedicated time to the initiative for the nurses to keep advancing work
- Continued communication on PHC IGSI to PCNs/communities (e.g., final report, recommendation, follow- up on work)
- Ensure resources allotted are equal for all PCNs regardless of size

Referral, Assessment and Dementia Diagnosis

Referral

PHC IGSI has been developed and implemented by AHS SH SCN™ and PHCIN in partnership with AS AB/NT. This partnership has provided a unique opportunity for AHS to work collaboratively with AS AB/NT to improve dementia care in Central Alberta communities.

Data gathered from the internal AS AB/NT information system for First Link® referrals was shared for inclusion in this report. A table summarizing the information is presented below. A comparison of referrals 18 months previous to PHC IGSI implementation (for the purpose of this table PHC IGSI Workshop #1 is considered the start of the initiative), to 16 months after implementation shows an increase in the total number of referrals for all communities combined. However, Table 12 shows most of the increase can be accounted for by referrals coming from mostly Red Deer and a few from Innisfail, Three Hills and Sylvan Lake.

Table 12. Referral to AS AB/NT First Link® Program by Central Zone Community.

	2015	2016		2017		2018		
Community	**Feb-Jul***	**Jan-Jun**	**Jul-Dec**	**Jan-Jun**	**Jul-Dec**	**Jan-Jun**	**Jul-Oct**	**Total**
Drumheller	1	0	0	0	0	0	0	**1**
Innisfail	0	0	0	0	1	5	4	**10**
Ponoka	1	0	0	0	0	0	0	**1**
Provost	0	0	0	0	1	0	0	**1**
Red Deer	7	0	11	6	25	10	18	**77**
Red Deer County	0	0	0	1	1	2	2	**7**
Sylvan Lake	0	0	1	1	3	0	1	**6**
Three Hills	0	0	0	1	0	1	4	**6**
Rimbey	0	0	0	0	0	0	1	**1**

It is interesting to note that the total number of First Link referrals from PCNs in the Central region in 2018 was 92, as compared to 62 from referring PCNs in the Edmonton region. Although anecdotal, this may indicate that the PHCIGSI project has made a difference in referrals following diagnosis for support services and education.

Referral data to community mental health services and home care services was not available from administrative data. Also, as most of the referrals are sent through the family physician and therefore are not available from clinic EMRs for this evaluation.

Assessments

Without clinic level data from EMR relevant to assessment or primary data collected within clinics (which did not occur), no information on assessment was available to inform the evaluation. In addition, there was no access to administrative data relevant to assessment (i.e. Resident Assessment Instrument – Home Care [RAI-HC] data).

Dementia Diagnosis

More time is needed to examine the notion that PHC IGSI has had an impact on earlier diagnosis of dementia. Standardized administrative data definitions for dementia were used and validated using two physician panels in this study. Analyses that can assess the ongoing prevalence (existing cases) and incidence (newly emerging cases) of dementia and determine PHC IGSI impact on early diagnosis requires at least two years of post-initiative administrative data which won't mature until December of 2020. However, recommendations regarding the use of these indicators to monitor health system performance using so-called "dashboards" are discussed in this report.

Using Administrative Data to Evaluate Outcomes of PHC IGSI

This section highlights findings from the pre and post-PHC IGSI implementation data analyses to inform the evaluation of changes in patient healthcare utilization, specifically ED and hospital use of PLWD identified using a validated administrative data definition or who have been referred to PHC IGSI clinics but not necessarily diagnosed. The pre-initiative time period used was from October 1, 2016 to September 30, 2017. The post- initiative implementation period was October 1, 2017 to September 30, 2018. Time from the first PHC IGSI workshop in June of 2017 to October, 2017 is considered as a 'washout' period, which allows for implementation of learning from the workshop and patient enrollment. The tables presented here have anonymized specific clinics within communities participating in PHC IGSI to prevent the possibility of identifying patients.

The first few tables use a standardized definition to identify possible cases of dementia using administrative data. It uses claims data submitted by physicians in these clinics to identify patients 40 years of age and over, and then identifies those possible cases of PLWD using the validated definition. The tables then present basic demographics and health system utilization information for these patients and then compares their pre and post- initiative ED and hospital use to assess health system impact of PHC IGSI.

Table 13. Identified cases of dementia by community clinics participating in the PHC IGSI

	Patients >= 40 years	*Identified cases*
Clinic A	3713	141
Clinic B	2159	45
Clinic C	6207	154
Clinic D	4936	57
Clinic E	2861	31
Clinic F	34,904	87

**Includes patients identified using administrative data methodology or who have been referred to PHC IGSI clinics but not necessarily diagnosed.*

Individuals with primary care visits during April 1, 2017 to March 31, 2018 to clinics associated with those participating in the PHC IGSI were identified using Alberta Health Practitioner Claims database. Individuals were assigned to a clinic that had the maximum number of primary care visits during the one year period. A case of dementia was identified using at least three physician visits one month apart in Alberta Practitioner Claims data, one hospitalization in Discharge Abstract Database (DAD), and dispensation event for dementia drugs in Pharmaceutical Information Network (PIN) data during April 1, 2007-March 31, 2018. Specific ICD9 and ICD10 codes were used to identify visits in Practitioner Claims data and DAD, while specific Drug Identification Number (DIN) were used to identify drugs in PIN data. Table 13 shows the number of identified cases of dementia for six community clinics participating in PHC IGSI. It is important to note that a case of dementia does not equate to a clinical diagnosis of dementia, and the methodology might underestimate the number of true prevalent cases.

Table 14 shows identified cases of dementia were more likely to be females, except for Clinic B which had equal proportion of both sexes. Most PLWD tend to be older as was the case for Clinic A, B, C and D, however more than half of identified cases were less than 80 years of age for Clinic E and Clinic F. Furthermore, it was seen that most cases (more than 90%) from all clinics had one or more comorbidities along with dementia. Material deprivation status was identified using the Pampalon Index which categorizes patients into deprivation quintiles based on area of residence. Most patients from Clinic A, C and F belonged to the low-moderate (Q1-Q3) material deprivation quintile, while most patients from Clinic B, D and E belonged to the high deprivation (Q4-Q5) quintile. Additionally, longitudinal continuity was measured using the Usual Provider Continuity (UPC) index, and it was seen that most patients from all clinics had moderate to high physician level continuity. Also, most patients had better clinic level continuity as compared to physician level continuity.

Table 14: Distribution of demographic, health status, deprivation status and longitudinal continuity data for identified cases of dementia.

	Clinic A	*Clinic B*	*Clinic C*	*Clinic D*	*Clinic E*	*Clinic F*
	N=141	N=45	N=154	N=57	N=31	N=87
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Sex						
Female	84 (59.6)	22 (48.9)	97 (63)	31 (54.4)	22 (71)	56 (64.4)
Male	57 (40.4)	23 (51.1)	57 (37)	26 (45.6)	9 (29)	31 (35.6)
Age Group						
40-64	7 (5)	4 (8.9)	17 (11)	0 (0)	3 (9.7)	0 (0)
65-69	10 (7.1)	5 (11.1)	10 (6.5)	0 (0)	4 (12.9)	16 (18.4)
70-74	10 (7.1)	6 (13.3)	16 (10.4)	9 (15.8)	7 (22.6)	24 (27.6)
75-79	22 (15.6)	7 (15.6)	20 (13)	14 (24.6)	6 (19.4)	14 (16.1)
80-84	31 (22)	9 (20)	35 (22.7)	25 (43.9)	4 (12.9)	25 (28.7)
85+	61 (43.3)	14 (31.1)	56 (36.4)	9 (15.8)	7 (22.6)	8 (9.2)
Clinical Risk Groupers (CRG)*						
Healthy/Sig.Acute/Minor Chronic	3 (2.1)	1 (2.2)	9 (5.8)	4 (7)	2 (6.5)	7 (8)
Chronic Disease in one or two organ systems	103 (73)	24 (53.3)	95 (61.7)	45 (79)	22 (71)	62 (71.3)
Chronic Disease in three or more organ systems-Catastrophic conditions	27 (19.1)	20 (44.4)	40 (26)	7 (12.3)	7 (22.6)	14 (16.1)
Dominant & metastatic malignancies	8 (5.7)	0 (0)	10 (6.5)	1 (1.8)	0 (0)	3 (3.4)
Material Deprivation (Pampalon Index)*						
1-Least Deprived	62 (44)	2 (4.4)	1 (0.6)	0 (0)	2 (6.5)	4 (4.6)
2	1 (0.7)	4 (8.9)	24 (15.6)	4 (7)	6 (19.4)	18 (20.7)
3	6 (4.3)	3 (6.7)	86 (55.8)	8 (14)	5 (16.1)	22 (25.3)
4	13 (9.2)	16 (35.6)	3 (1.9)	29 (50.9)	11 (35.5)	21 (24.1)
5-Most Deprived	40 (28.4)	10 (22.2)	15 (9.7)	12 (21.1)	6 (19.4)	11 (12.6)
N/A	19 (13.5)	10 (22.2)	25 (16.2)	4 (7)	1 (3.2)	11 (12.6)
Continuity Index - Physician level						
Low	19 (13.5)	1 (2.2)	15 (9.7)	3 (5.3)	3 (9.7)	8 (9.2)
Moderate	82 (58.2)	34 (75.6)	109 (70.8)	21 (36.8)	23 (74.2)	47 (54)
High	40 (28.4)	10 (22.2)	30 (19.5)	33 (57.9)	5 (16.1)	32 (36.8)
Continuity Index - Clinic level						
Low	9 (6.4)	5 (11.1)	4 (2.6)	1 (1.8)	5 (16.1)	5 (5.7)
Moderate	84 (59.6)	25 (55.6)	59 (38.3)	38 (66.7)	24 (77.4)	35 (40.2)
High	48 (34)	15 (33.3)	91 (59.1)	18 (31.6)	2 (6.5)	47 (54)

**CRG utilizes historical healthcare utilization and demographic data during a defined time period to assign individuals to a single mutually exclusive risk group*

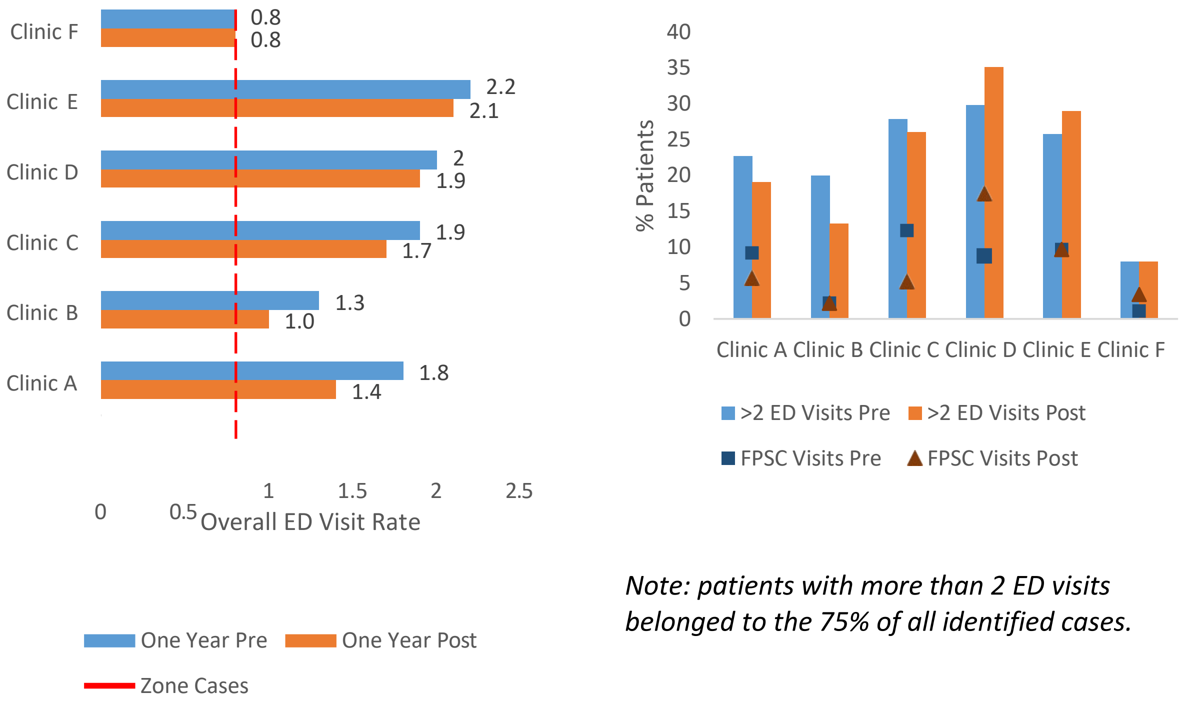
***Pampalon Index was calculated using factor analysis with 2011 National Household Survey data at dissemination area level and the Material Deprivation component used three variables: 1) The proportion of people aged 15 years and older with no high school diploma, 2) The average income of people aged 15 years and older, 3) The employment/population ratio of people aged 15 years and older*

Table 15. Identifying differences in Emergency Department (ED) and Inpatient Hospitalization (IP) use one year before (Oct 1, 2016-Sep 30, 2017) and one year after (Oct 1, 2017-Sep 30, 2018) implementation of PHC IGSI.

		Emergency Department				*Inpatient Hospitalization*			
		N	Mean	Median	p-value	N	Mean	Median	p-value
Clinic A (n=141)	*Pre*	81	1.77	1	0.2505	41	0.44	0	0.987
	Post	67	1.44	0		37	0.40	0	
Clinic B (n=45)	*Pre*	24	1.33	1	0.3669	14	0.76	0	0.7665
	Post	23	0.96	1		19	0.82	0	
Clinic C (n=154)	*Pre*	96	1.94	1	0.6809	55	0.67	0	0.7278
	Post	93	1.73	1		60	0.62	0	
Clinic D (n=57)	*Pre*	40	2.0	1	0.9674	8	0.23	0	0.1067
	Post	39	1.9	1		17	0.40	0	
Clinic E (n=31)	*Pre*	19	2.16	1	0.7691	11	0.52	0	0.4299
	Post	18	2.10	1		12	0.68	0	
Clinic F (n=87)	*Pre*	39	0.83	0	0.7472	14	0.22	0	0.8918
	Post	35	0.76	0		17	0.22	0	

Emergency Department (ED) and Inpatient Hospitalization (IP) was identified using National Ambulatory Care Reporting System (NACRS) and Discharge Abstract Database (DAD) respectively, one year before (Oct 1, 2016 to Sep 30, 2017) and one year after (Oct 1, 2017 to Sep 30, 2018) PHC IGSI implementation. Time from June, 2017 until October 2017 can be considered as a washout period for the intervention. Non-parametric sign rank test was used to determine the differences in average ED visits and hospitalizations (Urgent/unplanned) one year before and after implementation, and the results are presented in Table 15. For ED use, it was seen that there were no statistically significant differences in average ED visits for any clinics. However, Figure 6 shows the number of patients visiting ED more than twice in a year either decreased or stayed the same for all clinics except Clinics D and E. Similarly, the trend for Family Practice Sensitive Conditions (FPSC) - potentially avoidable ED visits if addressed in primary care - also showed the number of patients visiting ED for FPSC either decreased or stayed same for all clinics except for Clinic D and F (see graphs below). It is important to note he ED rate before PHC IGSI implementation for Clinics A-E was noticeably higher as compared to Central Zone ED rate for identified cases (0.8 visits/case), which might be an indication of patients using ED setting for primary care services.

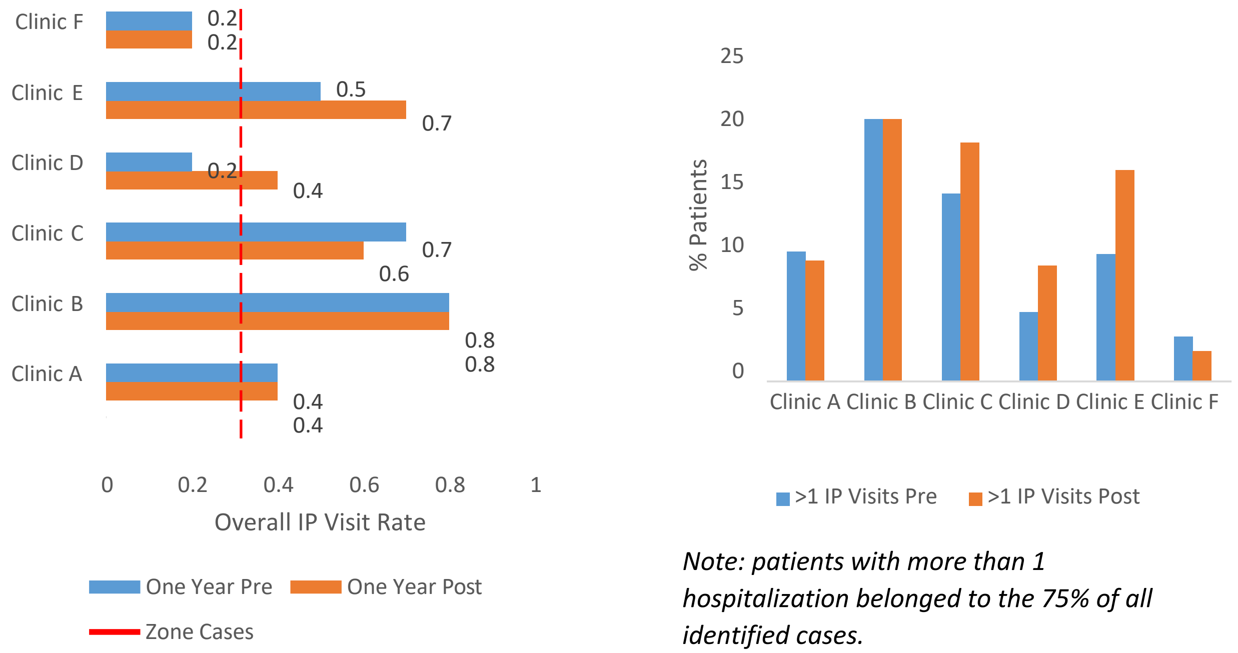
Figure 6. Emergency Department (ED) use one year before (Oct 1, 2016-Sep 30, 2017) and one year after (Oct 1, 2017-Sep 30, 2018) implementation of PHC IGSI.



Note: patients with more than 2 ED visits belonged to the 75% of all identified cases.

Similarly, there were no statistically significant differences in average number of hospitalizations before and after IGSI implementation. Figure 7 shows the overall hospitalization rate and the number of patients being hospitalized two or more times in a year either decreased or stayed the same for Clinics A, B and E, while Clinics D and E saw an increase in case of both indicators. Moreover, only a few patients were hospitalized for Ambulatory Care Sensitive Conditions (potentially avoidable hospitalizations if addressed in primary care) in both time periods. Furthermore, primary care visits were identified 30 days following urgent/unplanned hospitalizations, and it was seen that all patients had at least one primary care visit after discharge in both time periods pre and post.

Figure 7. Inpatient Hospitalization (IP) use one year before (Oct 1, 2016-Sep 30, 2017) and one year after (Oct 1, 2017-Sep 30, 2018) implementation of PHC IGSI.



Note: patients with more than 1 hospitalization belonged to the 75% of all identified cases.

Both emergency department and inpatient hospitalization are system level indicators and are expected to take longer than one year to demonstrate statistically significant change. Primary diagnosis for emergency department and hospitalizations can be examined in the clinic level reports provided to each participating clinic and allow them to check for changes in dementia related ED visits/hospitalizations, which can help understand clinically important changes in acute care use.

Table 16. Differences in average primary care visits one year before (April 1, 2016-March 30, 2017) and one year after (April 1, 2017-March 30, 2018) PHC IGSI implementation.

		N	*Mean*	*Median*	*p-value*
Clinic A	Pre	140	19.1	13	**0.0479**
	Post	141	21.4	19	
Clinic B	Pre	44	18.7	19	**0.0079**
	Post	45	24.5	25	
Clinic C	Pre	153	12.7	13	**0.0006**
	Post	154	15.7	16	
Clinic D	Pre	40	2.0	1	0.4889
	Post	39	1.9	1	
Clinic E	Pre	31	13.4	10	0.0644
	Post	31	17.1	11	
Clinic F	Pre	86	10.0	9	**0.0306**
	Post	87	12.0	9	

Primary care utilization was identified using Alberta Practitioner Claims data one year before (April 1, 2016 to March 30, 2017) and one year after (April 1, 2017 to March 30, 2018) PHC IGSI implementation (see Table 16). Paired t-test was used to determine the differences in average primary care visits one year before and after, and it was seen there was a statistically significant increase in primary care visits in the post period for all clinics except Clinic D and Clinic E. However, as most patients have other comorbidities it is not clear if this increase is due to patient need or PHC IGSI.

Specialist visits for Psychiatry-Specialty and Specialists Mental Health Physicians were identified, and it was seen there were only few (1-8) patients from each clinic with specialist visits in the pre and post period, and there was no discernable trend for these visits. Chart reviews revealed a growing number of specific recommendations for referral to community services, however without specific review of actual follow up on these recommendations we cannot determine whether or not these patients have received these referrals from their physician.

Longitudinal continuity pre and post intervention was not examined due to unavailability of practitioner claims data. Continuity examined during April 1, 2015 until March 31, 2018 showed most patients had moderate to high continuity with primary care providers, and is not expected to change.

Discussion & Conclusion

The number of Albertans living with dementia is expected to more than double where by 2038 about one in ten Albertans over the age of 65, and nearly half (47.5%) over age 90 are expected to be living with dementia (Population Estimates of Dementia in Alberta [PEDA], Alberta Health, 2015). With funding from Alberta Health and guided by the Alberta Dementia Strategy and Action Plan, the Seniors Health Strategic Clinical Network and the Primary Health Care Integration Network along with AHS and community partners worked with Central Alberta Primary Care Networks to proactively address this issue. The Primary Health Care Integrated Geriatric Service Initiative (PHC IGSI) was developed to enhance primary health care teams' capacity to recognize, diagnose and provide ongoing care and support for a variety of co-morbidities, including cognitive impairment, dementia, frailty and delirium. 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 required to support practice excellence relating to dementia and aging brain health;
3) Articulate a sustainable business funding model to support ongoing practice development within the proposed framework.

PHC IGSI is grounded in the development of a multi-level geriatric service framework built on three levels.

Level 1: All primary health care team members are equipped to recognize and assess seniors regarding frailty and changes in brain health. This level must have ready access to a level 2 team.

Level 2: Embedded, integrated, geriatric assessment team (GAT) with more advanced skills in dementia and frailty care that provides dementia support and works to continue building capacity of the primary health care team in level 1. Where necessary, this team will continue to access Level 3 specialized supports.

Level 3: Specialized supports for the most complex, complicated challenges related to dementia diagnosis and management.

The evaluation here reports primarily on the experience of primary care team members, care partners and PHC IGSI stakeholders involved in level 1 and 2 of the service framework as well as the integration of health and social with community coalition work.

To assess the impact of PHC IGSI, an evaluation was developed with care partners of persons living with dementia (PLWD), community stakeholder and primary care provider engagement. The diverse mixed methods evaluation used interviews, focus groups, and surveys which collected information from over 60 care providers on participating teams, 40 care partners, 40 PLWD/patients, and over 40 community stakeholders and decision makers. With the support and leadership of the PHC IGSI project team, other key activities included 24 community coalition meetings, a series of 3 workshops attended by over 300 key stakeholders and an additional 28 educational sessions/events within participating communities. 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 care teams met, and in most cases exceeded attaining the goals and aims of PHC IGSI, as well as expectations of participants.

Including the Views and Voices of Care Partners

Care partners have been involved in PHC IGSI in a variety of ways. First, development and implementation of the initiative has been guided by a set of five priority messages for PHC teams that were developed by approximately 20 care partners at Advancing Dementia Diagnosis and Management in Alberta (ADDMA). Second, care partners have been actively involved in PHC IGSI workshops. Approximately 10 care partners attended workshops, the care partner team helped plan, and participated in an interactive break-out session at Workshop 2, and a family of care partners presented at Workshop 3 – ‘A Care Partner’s Story’. Finally, through active involvement in evaluation the voice of care partners has been heard. Evaluation results found overall the care partners scored higher on dementia knowledge and caregiving self-efficacy than a comparable group of dementia caregivers.

Generally, care partners were satisfied with the care and services received from PHC teams. Also, care partners felt they had access to services and supports needed, and provided suggestions for support improvements.

Additionally, PHC teams shared they have started to utilize the Geriatric 5Ms© care planning tool and involve the PLWD and their care partner in the planning process.

The engagement activities with care partners highlighted above are in alignment with AHS' Patient First Strategy (Yiu et al.) which aims to strengthen AHS' culture and practices to fully embrace patient and family centred care. Ensuring the care partner voice has been incorporated into planning and design from the beginning, has been important as "the emphasis on patient involvement and improved outcomes and experiences needs to be at the heart of any integration initiative" (Shaw & Levenson, 2011, p. 26).

Enhancing Provider/PHC Team/Clinic Capacity for Dementia Care

PHC IGSI aimed to develop and assess a service model where seniors in Alberta have access to an integrated PHC team equipped to deliver excellence in dementia care. Initiative activities which aimed to enhance capacity included three learning workshops, creation and launch of a learning resources website, local education sessions and level 2 mentoring for the ECAC team. Evaluation results suggest the education curriculum may have been helpful to care providers' dementia knowledge, confidence and attitudes and, additionally helped with clinical practice change.

Knowledge, confidence and attitudes for Level 1 and Level 2 providers

Survey results highlighted high scores in dementia knowledge, self-efficacy in dementia care and dementia attitudes in both level 1 and level 2 providers across participating communities. Qualitative feedback from teams reflected the high educational value of the workshops and local education sessions. Of note, high scores for knowledge, confidence and attitudes may also be connected to past work experience with PLWD and/or personal experience caring for PLWD, and other education (external to PHC IGSI) received by providers.
Results do not reveal why providers scored so high on knowledge, self-efficacy, and the dementia attitudes scale, but it is possible their high scores may be associated with the amount or type of dementia training received from participating in PHC IGSI. Qualitative knowledge and self-efficacy gains support survey findings, as well as strong post workshop survey responses. Survey results from PHC IGSI workshops 1 and workshop 2 found respondents provided strong agreement that the workshop "will help achieve our goal to enhance recognition, diagnosis and provide integrated care and support for PLWD". Additionally, there was high participation at workshops from care providers. At least 12/28 level 1 care providers assessed, and all 11 of the level 2 care providers attended one or more PHC IGSI workshops.

Practice change in clinics

Results suggest the initiative components may have contributed to practice change within clinics. Although follow-up with survey respondents to assess application of knowledge to practice change was not part of the evaluation, retrospective PHC Team focus groups found a number of identified practice changes. Identified changes since involvement in the initiative were: 1) utilization of the Geriatric 5Ms© care plan and perceived improvements in 2) team approach to care 3) follow-up, and 4) workflow with the initiation of a patient flow chart. The high knowledge and confidence, in addition to learnings gained from workshops and other local education may have contributed to practice change. This finding is supported by the large majority of workshop participants who agreed that they expected their clinical work to improve and were motivated to change their teams' practice.

ECAC in Red Deer

In spring 2017 set-up for a new level 2 ECAC began at the Red Deer PCN. Patient referrals were accepted starting in late June 2017. The ECAC team was mentored by a geriatric specialist and a geriatric nurse and involved case study training, reviewing research articles, guidelines and best practices, and education presentations. Level 2 care providers highly valued the ECAC 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. Through education and support of the mentorship specialists, and high knowledge and confidence, it is likely that initiative education components helped improve overall capacity for dementia care in Red Deer.

It is challenging to attribute training/education/workshops/mentoring to enhanced dementia knowledge, confidence and practice change, but the high survey scores, along with positive qualitative findings indicate these activities may have helped with knowledge, confidence and application of clinical practice change which overall, may have improved capacity for dementia care at the individual and clinic level. In their systematic review on the effectiveness of capacity building interventions in public health practice DeCorby-Watson et al. (2018) found evidence which supported training and workshops achieved gains in knowledge, skill, confidence, change in practices and policies and behavior. Lee et al. (2018) studied the impact of a three-hour workshop on changes in knowledge, confidence and ability to assess and manage memory problems and on self-reported application of learning to clinical practice, and found it was effective in improving participants' confidence in assessing and managing patients with cognitive impairment and self-reported a number of practice changes. Although evaluation results suggest that PHC IGSI educational components may have helped with knowledge, attitudes and confidence, and practice change, it is important to note the workshops were valued by participants for both their educational benefits and for networking opportunities. Shared resources and tools were also important activities. With some participants engaging in a variety of PHC IGSI activities, it may be that no single factor helped contribute to outcomes, but some combination.

Creating a Strong Foundation for Integrated Care

There are many definitions on integration of care. With such an array of definitions, this evaluation explored the meaning of integrated care to better understand care partners and PHC teams' perceptions of integrated care. Care partners descriptions of the meaning of 'good integrated care' tended to focus more on health care experiences, particularly involvement of providers and the notion of care that is seamless. Level 1 providers and key stakeholders had a strong emphasis on clinical integration and coordination of care, but also spoke about service integration beyond the clinic to include community based supports and services. The focus of coordination found in this evaluation aligns with that of Shaw et al. (2011) as they define integrated care as "an organizing principle for care delivery with the aim of achieving improved patient care through better coordination of services provided" (p. 7).

PHC IGSI uses an approach to integrated care that is described as horizontal and vertical (see model). Curry and Ham (2010) describe horizontal integration as occurring when “two or more organisations or services delivering care at a similar level come together” and vertical integrations as occurring when two or more organisations or services delivering care at different levels come together” (p. 4). This initiative aims to improve both facets of care.

It is beyond the scope of this evaluation to measure the extent of integrated care in communities and assess system change with respect to integration as work is still in the early stages and measures of integration have yet to be defined. However, evaluation results suggest that although it is early, work has progressed in a positive direction. Namely, integration work has advanced at the clinic level through improved coordination of care, and at the community level with the development of community coalitions.

With respect to care coordination and clinic processes, each PHC team has evolved and adapted their own personalized system for providing care to PLWD given staffing, levels of provider and physician engagement and resources available. Reviewing a list from the Agency for Healthcare Research and Quality on coordination activities and approaches presented in Bynum and Ross (2012), evaluation results suggest gains have been made with communication, follow-up and care planning. Qualitative findings revealed perceptions by some care providers/PHC teams of improved collaboration, follow-up and communication. Additionally, the Geriatric 5Ms© Framework was reported to be utilized in clinics. However, only two care partners interviewed reported they had a care plan and only one of the two reported they had a paper copy. Also, there was little support in the data for sharing completed care plans beyond the team. A ‘gold standard’ of care planning and care plans (Burt et al., 2014) describes use of both a collaborative care planning process with a patient, and of a written document that records the outcome of the process. As one of the overarching goals of the initiative is increased capacity in the community to develop integrated care plans for PLWD, results suggest more work is needed in this area.

Community coalition development has started in communities; however, work is in the early stages as PHC teams and community organizations work together to determine membership, complete terms of reference, and set shared goals. Membership is diverse, with AS AB/NT commonly indicated as a partner in community work. The focus on coalition building for this initiative is reasonable as a strategy to improve dementia care as there is evidence in the literature to suggest that linkages with community services improves dementia care (Venohr et al., 2001). Lee, Hillier and Harvey (2014) found partnerships between the Alzheimer’s Society (AS) and primary care-based memory clinic resulted in a significant increase in the number of referrals to AS, ensuring that PLWD had immediate access to information and community supports.

Referrals were assessed in the chart review at the ECAC in Red Deer. Results found some contained tangible evidence of referrals made (one home care referral and several First Link Referral® Forms), and the majority of the ECAC care plans contained recommendations for referrals for the patient’s family physician to follow up on. Follow-up with patients will be needed to assess if recommendations for referrals have been carried out. An assessment of referral data from AS AB/NT found a comparison of referrals 18 months previous to PHC IGSI implementation to 16 months after implementation showed an increase in the total number of referrals for all communities combined. Generally, there was an increase post PHC IGSI workshops, but numbers in most participating rural communities are low. Of note, there is limited availability of AB AS/NT representation in rural communities, and with an increased number of referrals to AB AS/NT (as stated above) there has been additional demand placed on this organization.

Overall, evaluation findings suggest there is a lot of work to be done in coalition building to advance integrated care for PLWD and their care partners, but some foundational work is in place. Community coalition building takes time so it is not surprising work is still in the early stages. Butterfoss and Francisco (2004) note that coalition building is a “long-term investment of time and resources” (p. 108); therefore, coalition building in communities may take considerable time as members work to put structures in place to benefit PLWD and frailty in communities.

A Tailored Local Context ‘Bottom-up’ Approach Supported by PHC IGSI Leadership

Evaluation results suggest strengths of the initiative, among others, included both PHC IGSI Project team support and leadership, as well as the ‘bottom-up’ approach to planning and implementation that was tailored to local context. The benefits of a top-down approach with bottom-up buy-in has been noted by Ham (2014), and Wodchis et al. (2015) found that all seven programs in their cross-case synthesis of seven integrated care programs were bottom up and driven by local needs.

This initiative has been implemented with a ‘bottom-up’ approach guided with leadership as the PHC IGSI Project Team has centrally coordinated and initiated activities while local teams engaged and advanced work based on their starting points and individual goals. The initiative has balanced central leadership, and a grassroots approach that allowed PHC teams/communities to plan and make change in ways that were tailored to local context with local clinic leads implementing initiative activities.

PHC teams and some key stakeholders emphasized the need for project team leadership, and voiced appreciation for the opportunity to work as they wanted. Local ownership of the project was important, as was the central leadership. PHC teams and key stakeholders described the PHC IGSI project team as being very supportive, and helpful in sharing learning across the communities. The focus on locally tailored work has support as a recent article on system integration finds three speakers (Chris Ham, Geoff Huggins and Helen Bevan) advising a focus on “local solutions as success will come from letting front-line workers develop new ways to care for the people and communities they know, not from centralized planning” (Fooks et al., 2018, p. 18).

Complex Initiative Mirrored by Evaluation Complexity

Creating change within the healthcare system is challenging. Healthcare is a “complex adaptive system” (Braithwaite, 2018, p. 1). Additionally, this initiative involved work with community-based organizations and PCNs. The structures and resources available in PCNs and the associated communities who implemented PHC IGSI were complex, crossing multiple levels with a variety of providers involved. Leadership within PHC teams varied, as did staffing and other resources. These factors added to the complexity.

Several challenges/weaknesses with the initiative emerged from an analysis of the data. Resources was a major theme across PHC teams, PCNs and key stakeholders including the PHC IGSI Project team, and AS AB/NT. There was a concern regarding funding, availability and equitability of resources in rural communities, staffing and time. At the PCN/clinic level, evaluation results revealed difficulties for some teams when staff members changed roles. Loss of a key staff member/clinic lead created challenges for two teams as these staffing changes made it difficult for the teams to actively engage in the work. Also noted was a concern with a clinic nurse receiving a larger proportion of geriatric appointments related to dementia creating a large workload. Physician involvement and buy-in was also a concern for some. For AS AB/NT a concern with having capacity to meet demand for services was noted.

Evaluation and QI work is ongoing for PHC teams, with concern for some regarding IMAs to support access to AHS administrative data. Improvement goals were set by teams early on the initiative. Although results suggest PHC teams did not identify QI goals and performance measures during focus groups, teams have been working to improve quality of care and additional QI work is planned as the initiative advances and more data is available for analysis. The focus on teams and process-management tools in PHC IGSI is clear, and this is illustrated in an operational description of QI that identified the three elements of utilization of teams to identify and solve problems, use of scientific methods and statistical tools for monitoring and analyzing work processes, and use of process-management tools (Weiner et al., 2006).

Evaluation of PHC IGSI was complex, drawing on multiple methods with various data sources and varied levels of local evaluation support. Provincial led evaluation and local evaluation work needed to be coordinated as activities were carried out in communities with support from both internal and external evaluators. As the initiative evolved, PHC ARES provided additional support to complete evaluation activities. As noted above, capacity to conduct local evaluation and QI were also concerns for a few level 1 PHC teams. In the absence of IMAs, it was not possible to link patient data to administrative data sets to assess impact. Evaluation resources for rural PCNs is a concern, as evaluation and QI efforts will be needed to assess progress and impact of the initiative. These are substantial challenges to be addressed at both the clinic and system level as the initiative moves into Phase 2. It should be noted that a process to establish IMAs with participating PCNs began early in the initiative and succeeded in creating only one at the PCN level, and a second at the individual clinic level in October, 2018 (post implementation phase). Although beyond the scope of this evaluation, a lack of trust and understanding data sharing among health information custodians within Alberta are key issues that need to be resolved.

Impact of PHC IGSI on Health System Utilization

Administrative data of patients identified as being diagnosed with dementia and visiting clinics in communities participating in PHC IGSI was used to examine the use of emergency departments (ED) and inpatient hospitalizations (IP). A validated definition was used to identify patients likely to have a diagnosis of dementia that visited participating clinics in the time period that of PHC IGSI implementation. Cases of dementia identified were more likely to be females over the age of 80 years with several comorbidities in addition to dementia. Most of the patients identified were experiencing low to moderate material deprivation and had relatively good to high relational continuity with their primary care provider and clinic.

The analysis examined health system utilization and compared ED visits and hospitalizations in these patients one year pre and post-PHC IGSI. Although not statistically significant, trends indicate a reduction in both ED visits and hospitalizations post PHC IGSI workshops. Furthermore, this acute care use might not be inappropriate, as literature has shown that the elderly population (especially those 65 years and older) with a high prevalence of chronic diseases are susceptible to frequent exacerbations that might result in an ED visit or an unplanned hospital admission (Roberts et al., 2008). In addition, physician visits increased significantly post PHC IGSI in these patients, which can benefit patients as studies indicate that regular primary care use and access to systematic geriatric programs can reduce the need for ED visits (Turrell et al., 1999; Finucane et al., 1999). It should be noted that not all these patients would have been directly involved in care influenced by PHC IGSI and as such it is difficult to attribute these trends directly to PHC IGSI impact. Analysis comparing the prevalence and incidence of dementia using longer intervals of time would need to be examined to further assess impact on health system utilization. It is recommended that AHS continue to track these indicators.

Similarly, there were no statistically significant differences in average number of hospitalizations before and after IGSI implementation. Figure 7 shows that the overall hospitalization rate and the number of patients being hospitalized two or more times in a year either decreased or stayed the same for most clinics. Moreover, only a few patients were hospitalized for Ambulatory Care Sensitive Conditions (potentially avoidable hospitalizations if addressed in primary care) in both time periods. A systematic review examining effects of geriatric interventions showed that most studies did not use urgent hospitalizations and ACSCs as outcome indicators, and therefore more research is required to understand these outcomes (McCusker et al., 2006). Furthermore, primary care visits were identified 7 and 30 days following urgent/unplanned hospitalizations, and it was seen that all patients had at least one primary care visit after discharge in both time periods pre and post.

Both emergency department and inpatient hospitalization are system level indicators and might take longer than one year to demonstrate significant change. Primary diagnosis for emergency department and hospitalizations can be examined in the clinic level reports provided to each participating clinical team to check for changes in dementia related ED visits/hospitalizations, which may help them to understand clinically important changes in acute care use.
The PHC IGSI evaluation also attempted to examine referrals using administrative data of specialist visits to Psychiatry-Specialty and Specialists Mental Health Physicians. It was seen that there were only a few (1-8) patients from each of these clinics with specialist visits in the pre and post period, and there was no discernable trend.

LIMITATIONS

Generally, an overarching limitation is the emphasis on self-reported data (e.g., information collected through interviews and focus groups) without other validated measures of activity.

Limitations identified related to the mixed methods evaluation approach include the following for information analyzed from care partners:

- Care partner survey sample sizes were small.
- Lack of pre- post-PHC IGSI comparison design to assess data collected from level 1 care partners.

- Variations in the clinic/care experience received by care partners due to diverse communities and activities likely result in a lack of rigour and standardized ‘intervention’ at each participating site.

Limitations to the survey scale results obtained from care providers include:
- Small sample sizes from each community.
- Difficult to assess the impact of the initiative on survey outcomes without pre-PHC IGSI data for comparison.
- Ceiling effects observed on all scales (i.e., high initial assessments of knowledge, attitudes and self- efficacy.

Recommendations

Recommendations for future PHC IGSI work are presented below:

- As new communities join PHC IGSI, ensuring understanding and securing of local resources to support PHC IGSI activities is key at the onset, for example, local leads, evaluation support, access to practitioners with advanced knowledge.
- Enhancing resources at the local level for action planning at both the PCN clinic level and at the community level in order to build capacity around the health and social needs of seniors.
- Discussion of evaluation results among PHC IGSI team members affirmed support for a shift in culture ensuring ageist language is not used in communication and reporting.
- Clarify perceptions and provide education/resources to PHC teams on the Health Information Act (HIA) and Freedom of Information and Protection (FOIP) to PHC teams. Some providers noted their lack of understanding regarding cross sector sharing of care plans; therefore, provision of education on sharing care plans beyond the clinic would be beneficial to PHC teams.
- Increase face-to-face opportunities that focus on sharing: locally generated tools, learnings and processes (i.e., flow map) and networking with other clinic team members, PCNs, community organizations and partners. Clear indicators show in person sharing opportunities is an effective project 'spread' mechanism.
- Continue resources to support development and recommendations generated by community coalitions. There are indications that through shared goal development, coalitions will reduce duplication and enhance integrated care through improved informational and management continuity.
- Develop health and social dashboard (see page 93 for 'The Case for an Interactive, Decision Support Tool: A Balanced Scorecard or Dashboard Approach') to track prevalence, incidence and health utilization of dementia cases provincially and assess PHC IGSI spread to other communities within the province.
- Identify resources to conduct a patient level analyses with those PLWD directly experiencing care from PHC teams to demonstrate direct impacts of PHC IGSI.
- Identify resources to conduct an return on investment (ROI) resulting from a reduction in numbers of unplanned emergency department (ED) visits and hospitalizations.
- Continue to work with Tammie Nahas, PHC, Alberta Health Services and Alberta Health grant on community coalition work (tool development).
- Explore with PHC IN™ and SH SCN™ development of community coalitions to enhance care in the community.
- As teams continue to work on care planning bring in resources and socialize the PaCT care planning process from the PaCT initiative.
- Continue to identify and track indicators with SH SCN™.

The Case for an Interactive, Decision Support Tool: A Balanced Scorecard or Dashboard Approach

Given the breadth and richness of the knowledge generated from Phase 1 of the PHC IGSI evaluation, there is a strong push for a simplistic, yet comprehensive way to present the most important information relevant to the initiative to the patients, care partners, providers, healthcare teams and project stakeholders. One potential recommendation for Phase 2 of PHC IGSI, is the development of a balanced scorecard or dashboard approach/conceptualization.

The concept of "balanced scorecards," developed by Robert Kaplan and David Norton (1996), represents an attempt to enhance the value of information and to exploit the capability of information (i.e., data specific to the initiative) to deliver true value to decision-makers and users. Balanced scorecards simply state that reporting should be available on those key attributes that really affect performance or progress of a project. Data are of little value if they do not provide information that can be used to improve the organization's performance. The scorecard system connects the dots between big picture strategy elements such as mission (our purpose), vision (what we aspire for), core values (what we believe in), strategic focus areas (themes, results and/or goals) and the more operational elements such as objectives (continuous improvement activities), measures or key performance indicators (which track strategic performance), targets (our desired level of performance), and initiatives (projects that help you reach your targets).

A brief example is highlighted on the following page, including several examples of the types of information and measures that could be incorporated into a PHC IGSI scorecard based on results of the evaluation.

Strategic Objectives are continuous improvement activities that we have to implement for success…

Strategy maps visualize strategy

High Level Strategy Elements provide high level context

Measures are used to track clinic and organizational performance

Targets are the desired level of each performance for each measure

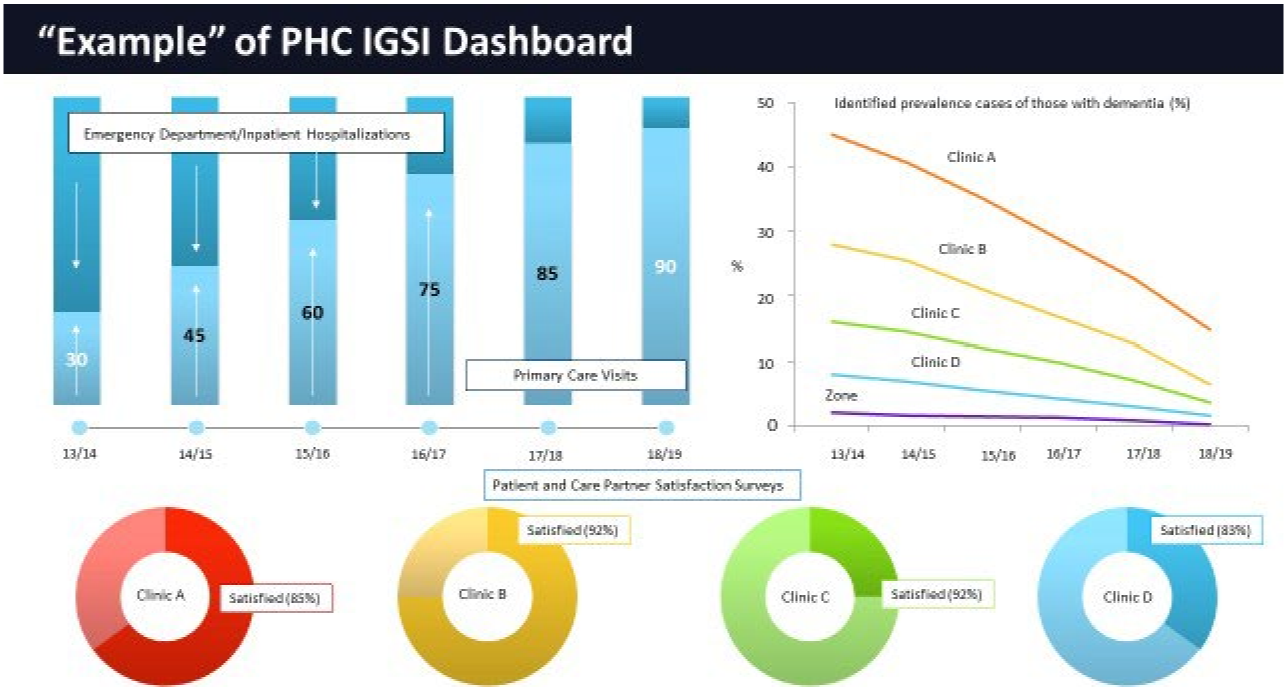
Strategic Initiatives are projects or elements that help you reach your targets

MISSION / VISION / VALUES / STRATEGIC THEMES

STRATEGY MAP/OBJECTIVES	MEASURES	TARGETS	INITIATIVES
Healthcare Teams Level 1, Level 2, Level 3	• Formative Evaluation Statements • Workshop Satisfaction Survey	• TBD	• Educational Workshops • Post-Workshop Survey
Patient/Family/Care Giver	• Patient and Care Giver Satisfaction Rates	• TBD	• Surveys and Interviews
Process	• ED/Inpatient Hospitalization • Prevalence Rates • Referral Rates	• TBD	• Tracking of process and outcome indicators
Organizational Capacity	• Inter-organizational collaboration (integration) outcomes/efforts, First Link referrals, volunteer led support groups supported by AS AB/NT, quality improvement activities	• TBD	• Focus group, AS AB/NT database

* This does not represent an all-inclusive list of potential measures, it would be up to the discretion of the project team and partners to decide what would be of most value to include in the scorecard.

Similarly, a dashboard is a form of reporting, and a natural subset of balanced scorecards and is being increasingly used in healthcare to keep clinicians, stakeholders and decision-makers focused on critical areas that affect overall performance of the project and/or organization. “*A dashboard is a visual display of the most important information needed to achieve one or more objectives; consolidated and arranged on a single screen so the information can be monitored at a glance.” (Kaplan and Norton, 1996).* A brief example is highlighted below, including several examples of the types of information and measures that could be incorporated into a PHC IGSI dashboard based on results of the evaluation. There are many different types of dashboards (i.e., visual displays and designs) that one could use for their own purposes, the one below is a “simplified version” of a dashboard available in excel format.


“Example” of PHC IGSI Dashboard

Indicators focused on the referral, assessment and dementia diagnosis should be incorporated into the dashboard, the clinical measures related to these broad performance indicators could include the following:

- Measures that assess the ongoing prevalence (existing cases) and incidence (newly emerging cases) by clinic
- Measures of distribution of demographic, health status, deprivation status and longitudinal continuity data for identified cases of dementia
- Measures of emergency department (ED) and inpatient hospitalization (IP) visits pre/post implementation of PHC IGSI
- Measure of the differences in average primary care visits pre/post implementation of PHC IGSI
- Measures of patient, family and care giver satisfaction
- Measure of providers’ dementia knowledge, attitudes and self-efficacy in care

As it was not one of the primary goals of the PHC IGSI to determine new or incident cases of dementia, it is a recommendation of this evaluation, that this be a high priority on the “next steps” in Phase 2. Identifying both new cases and the “risk-markers” for developing dementia will provide clinicians and teams with the necessary information and support to start proactively managing patients who may be showing symptoms related to cognitive decline, confusion and memory loss. This is a key step in moving from management of PLWD to actively treating dementia prior to a patients confirmed diagnosis.

This dementia dashboard can be used by both providers, patients, care partners and project leaders to look at practices and patterns related to the project and treatment. Level 1, 2 and 3 care providers can review the extent of the problems encountered by dementia patients. Project Leads are also able to use the dashboards to improve the quality of information on practicing clinics, resulting in better planning towards future progress of the PHC IGSI. There are many key aspects to building a good scorecard or dashboard. The following five features are critical if the decision is made to follow a balanced scorecard or dashboard approach (Kaplan and Norton, 1996).

- **Be easily accessible.** These types of tools should be easily accessible to each user who will need to tap into its insights. If the report isn’t easily accessible, they are unlikely to reference the report when making decisions.
- **Display reliable data.** Users need reliable, trustworthy data; if they don’t trust it, they won’t use it. Including those who use the data in the build and validation process can significantly help with team buy-in. Consider leveraging already existing data repositories such as Alberta Health Services Data and Analytics.
- **Contain relevant data.** A good scorecard or dashboard should only contain the information users need. If the dashboard can report on 50 metrics, but the user only needs five, the extra 45 metrics just clutter up the user’s abilities to focus on what’s important. Figure out what are the key data points and information needed to inform the users.
- **Use timely data.** A decision-support tool needs to contain near real-time data (dashboard) or real-time reporting, so users can address challenges promptly. If the provider or department can see near real-time information about a patient’s episode of care, it’s easier to intervene while the circumstances are still fresh in the team’s memory.
- **Include trends, if benchmarking is too aggressive.** Trends show users where they’ve been and where they are going. If improvement efforts don’t move the needle on cost or quality, users need to know so they can change their actions or project strategy to adjust for the desired process/outcome. This keeps them engaged and motivated.

As a final thought, any data or information that is included in the dashboard should be clearly linked back to the project’s strategic objectives and initiatives, this is the reason why many will link both a scorecard and dashboard approach. It allows the user to connect the dots between big picture strategy elements and the more operational elements such as objectives (continuous improvement activities) and measures or key performance indicators.

The final section of this report, will focus on future recommendations for PHC IGSI.

Next Steps for PHC IGSI

Next steps for PHC IGSI are identified below:

- Plan and conduct PHC IGSI Workshop #4–*Brain Health* on June 14, 2019.
- Continued support for local primary health care education in communities (March-April 2019).
- Provide new resources and links to community websites on the PHC IGSI website.
- Continued development of an Information Management Agreement (IMA[1]) for Wolf Creek PCN and Big Country PCN.
- Continue to track patient level indicators until 2020.
- Seek and confirm opportunities for initiative funding.
- Continue to expand PHC IGSI work with a North Zone PCN (one community).
- Share findings more broadly to inform Zone service planning and policy development and Alberta Health/AHS.

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Appendices

Appendix A: Key Terms

Care partner: A care partner is most commonly a spouse or an adult child (Brodaty & Donkin, 2009; Fortinsky, Unson, & Garcia, 2002), the vast majority of whom tend to be female (Jennings et al., 2015), but the title refers to anyone who assumes the daily responsibility of caring for a PLWD that can no longer live autonomously (Zacharopoulou, Zacharopoulou, & Lazakidou, 2015).

Care provider: Care providers are paid healthcare workers who provide formal care for PLWD.

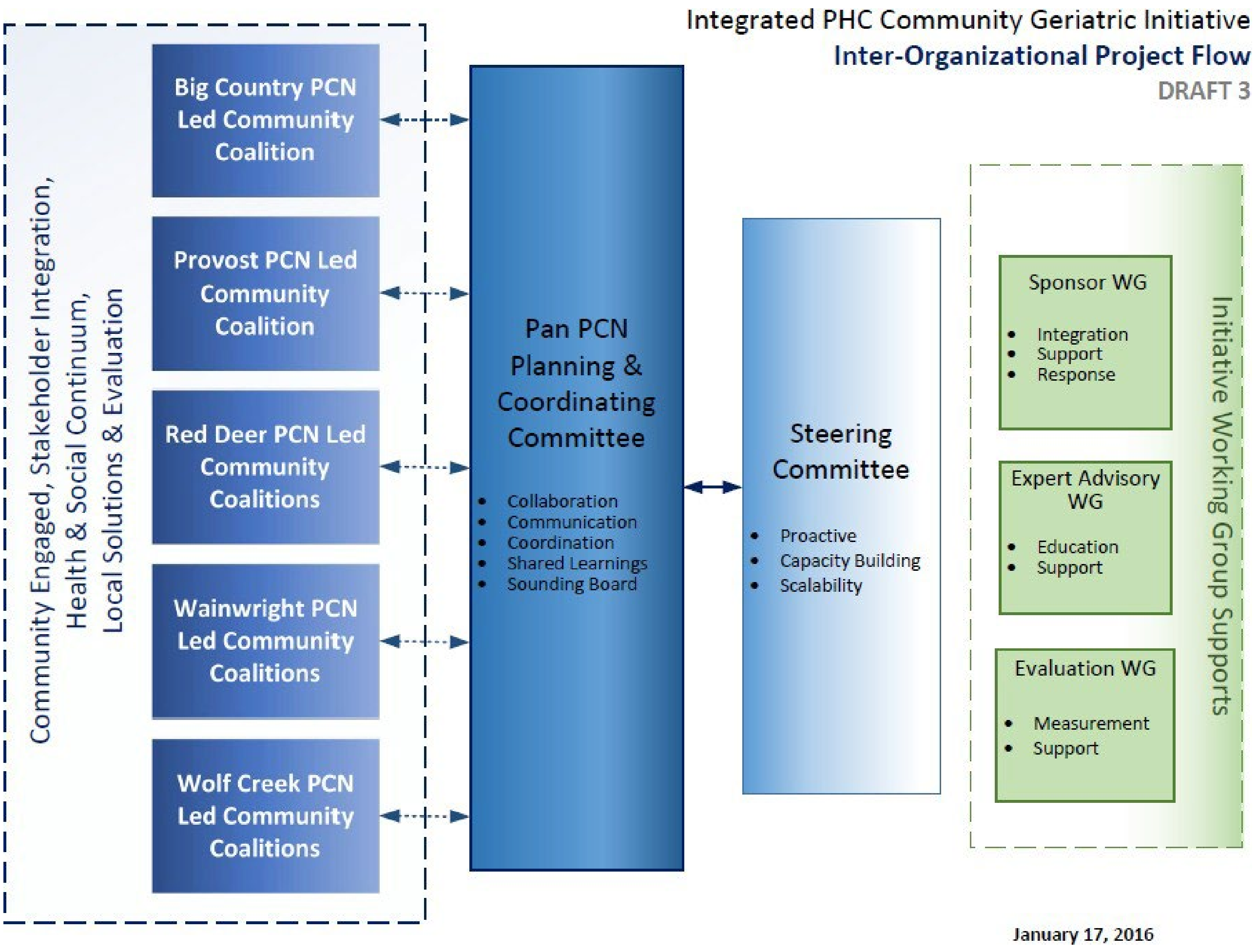
Information Management Agreement: or "IMA" between a custodian of health information and an information manager (i.e., AHS, PCN) entered into pursuant to section 66 of the HIA, that governs the terms under which the Information Manager, among other responsibilities prescribed by the HIA, processes, stores, retrieves or disposes of health information; strips, encodes or otherwise transforms individually identifying health information, or provides information management or information technology services.

Alberta Health Services. "Information Management Agreements." Alberta Health Services, 2018, www.albertahealthservices.ca/info/Page3957.aspx.

Major Neurocognitive disorder (DSM-V) Diagnostic Criteria: A. Evidence of significant cognitive decline from a previous level of performance in one or more area of cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor or social cognition) based on : 1. Concern of the individual , a knowledgeable informant or the clinician that there has been a significant decline in cognitive function; and 2. substantial impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence , another quantified clinical assessment. B. The cognitive deficits interfere with independence in everyday activities. C. The cognitive deficits do not occur exclusively in the context of a delirium. D. The cognitive deficits are not better explained by another mental disorder (e.g., major depressive disorder, schizophrenia). https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm17

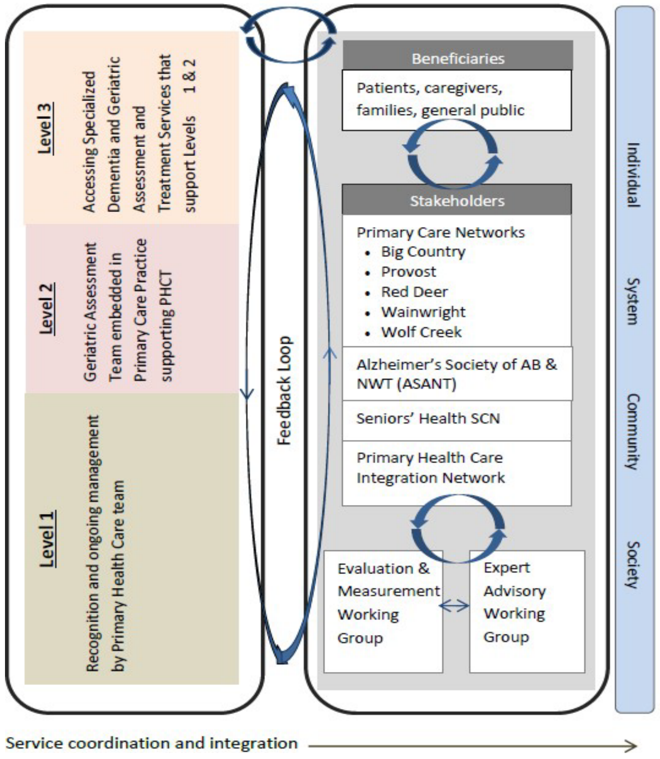
Pampalon Deprivation Index: a small area–based composite index that uses census data at the Dissemination Area (DA) level to present socioeconomic disparities among the population (Pampalon, Hamel & Gamache, 2009).

Appendix B: PHC IGSI Inter-Organizational Project Flow Diagram



Appendix C: Tracking and Monitoring Complexity within PHC IGSI

Integrated Community Geriatric Service Development Initiative: Complexity Considerations and Challenges



Integrated Geriatric Service Development Initiative complexity issues include:

Multiple Partners with Varied Levels of Support

The initiative is being implemented in five Central Zone PCNs with potentially varied levels of organizational support and resources and with multiple community partners operating at different levels. Varied levels of support and resources within PCNs may impact the iterative, interactive process of this developmental evaluation approach. In developmental evaluation timeliness of reporting on data is critical[1]. PCN capacity to report on, and integrate timely learnings from emerging data in an uncertain environment of innovation with rapid change may, in some ways, be challenging.

Stakeholder Internal and External Factors Influence Processes & Outcomes

Multiple internal and external factors within PCNs and other participating stakeholder organizations may influence the effectiveness of the initiative in varied ways, thereby creating challenges in assessing what contributing factors are resulting in desired changes at the individual, system, community and societal level.

Feedback Loops

Many complex interventions are dependent on activation of a "virtuous circle" whereby an initial success creates conditions for future success–this requires evaluation to gather early evidence of these small changes and track the changes throughout implementation of the initiative[2]. Evaluation for complex initiatives requires on-going rapid feedback for those involved in implmentation[3]. This initiative requires considerable set up of monitoring and feedback systems to incorporate continuous real-time feedback into an evaluation cycle that is able to effectively track change throughout initiative implementation.

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1 Gamble, J. A Developmental Evaluation Primer. http://www.mcconnellfoundation.ca/de/resources/publication/a-developmental-evaluation-primer

2. Rogers, P. (2008). Using program theory to evaluate complicated and complex aspects of interventions. *Evaluation*, 14(1),29-48DOI:10.1177/1356389007084674

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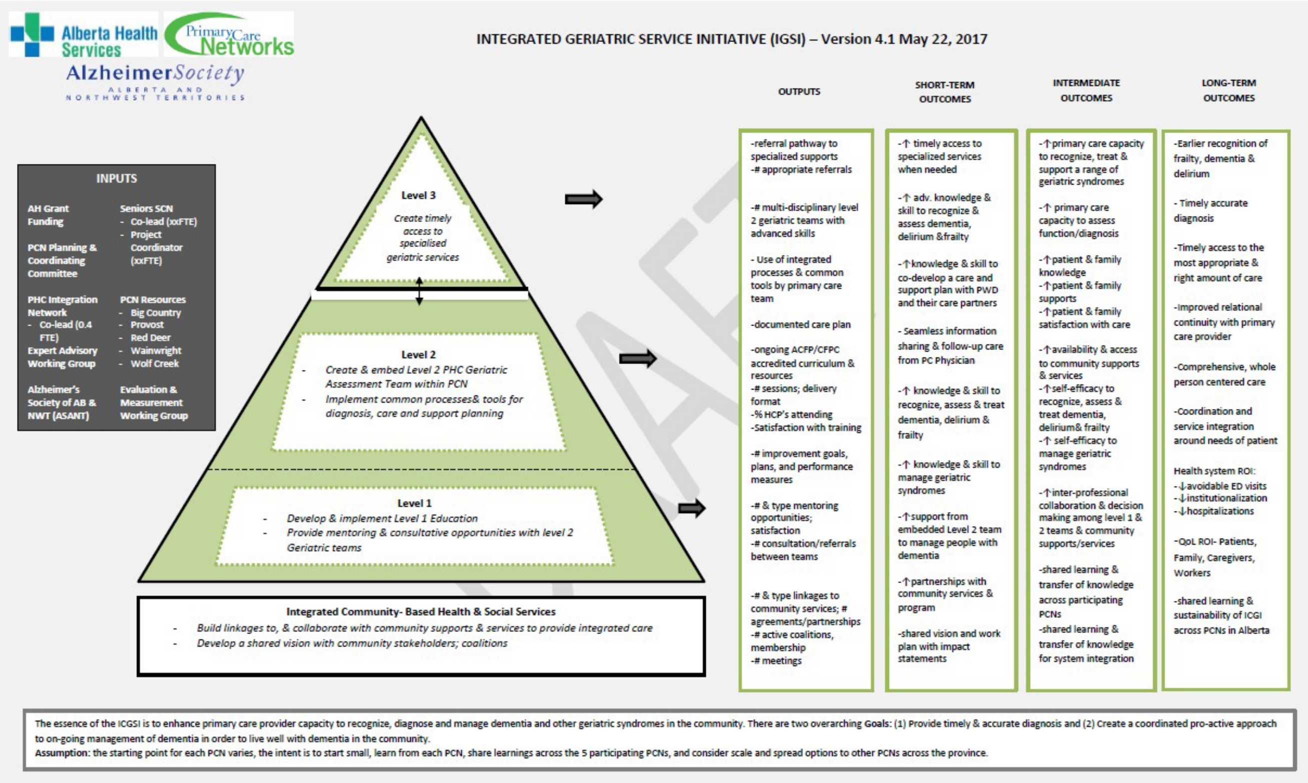
Appendix D: PHC IGSI Logic Model



INTEGRATED GERIATRIC SERVICE INITIATIVE (IGSI) – Version 4.1 May 22, 2017

INPUTS

AH Grant Funding

PCN Planning & Coordinating Committee

PHC Integration Network
- Co-lead (0.4 FTE)

Expert Advisory Working Group

Alzheimer's Society of AB & NWT (ASANT)

Seniors SCN
- Co-lead (xxFTE)
- Project Coordinator (xxFTE)

PCN Resources
- Big Country
- Provost
- Red Deer
- Wainwright
- Wolf Creek

Evaluation & Measurement Working Group

Level 3

Create timely access to specialised geriatric services

Level 2
- *Create & embed Level 2 PHC Geriatric Assessment Team within PCN*
- *Implement common processes& tools for diagnosis, care and support planning*

Level 1
- *Develop & implement Level 1 Education*
- *Provide mentoring & consultative opportunities with level 2 Geriatric teams*

Integrated Community- Based Health & Social Services
- *Build linkages to, & collaborate with community supports & services to provide integrated care*
- *Develop a shared vision with community stakeholders; coalitions*

OUTPUTS

-referral pathway to specialized supports
-# appropriate referrals

-# multi-disciplinary level 2 geriatric teams with advanced skills

- Use of integrated processes & common tools by primary care team

-documented care plan

-ongoing ACFP/CFPC accredited curriculum & resources
-# sessions; delivery format
-% HCP's attending
-Satisfaction with training

-# improvement goals, plans, and performance measures

-# & type mentoring opportunities; satisfaction
-# consultation/referrals between teams

-# & type linkages to community services; # agreements/partnerships
-# active coalitions, membership
-# meetings

SHORT-TERM OUTCOMES

-↑ timely access to specialized services when needed

-↑ adv. knowledge & skill to recognize & assess dementia, delirium &frailty

-↑knowledge & skill to co-develop a care and support plan with PWD and their care partners

- Seamless information sharing & follow-up care from PC Physician

-↑ knowledge & skill to recognize, assess & treat dementia, delirium & frailty

-↑ knowledge & skill to manage geriatric syndromes

-↑support from embedded Level 2 team to manage people with dementia

-↑partnerships with community services & program

-shared vision and work plan with impact statements

INTERMEDIATE OUTCOMES

-↑primary care capacity to recognize, treat & support a range of geriatric syndromes

-↑ primary care capacity to assess function/diagnosis

-↑patient & family knowledge
-↑patient & family supports
-↑patient & family satisfaction with care

-↑availability & access to community supports & services
-↑self-efficacy to recognize, assess & treat dementia, delirium& frailty
-↑ self-efficacy to manage geriatric syndromes

-↑inter-professional collaboration & decision making among level 1 & 2 teams & community supports/services

-shared learning & transfer of knowledge across participating PCNs
-shared learning & transfer of knowledge for system integration

LONG-TERM OUTCOMES

-Earlier recognition of frailty, dementia & delirium

- Timely accurate diagnosis

-Timely access to the most appropriate & right amount of care

-Improved relational continuity with primary care provider

-Comprehensive, whole person centered care

-Coordination and service integration around needs of patient

Health system ROI:
-↓avoidable ED visits
-↓institutionalization
-↓hospitalizations

-QoL ROI- Patients, Family, Caregivers, Workers

-shared learning & sustainability of ICGI across PCNs in Alberta

The essence of the ICGSI is to enhance primary care provider capacity to recognize, diagnose and manage dementia and other geriatric syndromes in the community. There are two overarching **Goals:** (1) Provide timely & accurate diagnosis and (2) Create a coordinated pro-active approach to on-going management of dementia in order to live well with dementia in the community.
Assumption: the starting point for each PCN varies, the intent is to start small, learn from each PCN, share learnings across the 5 participating PCNs, and consider scale and spread options to other PCNs across the province.

Appendix E: PHC IGSI Evaluation Framework

PRIMARY HEALTH CARE -

INTEGRATED GERIATRIC SERVICES INITIATIVE EVALUATION AND PERFORMANCE MEASUREMENT FRAMEWORK

Document created by: Scott Oddie and the IGSI Evaluation Working Group

Document reviewed by: IGSI Pan PCN Planning & Coordinating and Expert Advisory Committees

Version #: v03-2

Last updated: October 19, 2017

Table of Contents

ACKNOWLEDGEMENTS

We would like to acknowledge the contributions of the ICGI Evaluation and Working Group and others who contributed in significant ways to the creation of this evaluation framework.

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Renee Martin	AHS – Evaluation Support Lead
Scott Oddie	AHS – ARES Director
Tanmay Patil	AHS – ARES Senior Analyst
Margo Schmitt-Boshnick	Red Deer PCN Evaluator

IGSI SUMMARY

BACKGROUND

An opportunity exists in Alberta to work with Primary Care Networks (PCNs) to:

1. Develop and adopt an integrated, health and social framework/model for care and support of seniors;
2. Develop and implement common educational and mentorship supports required to support practice excellence in primary care relating to the care and support of seniors and those living in the community with dementia and other geriatric syndromes;
3. Articulate a sustainable business funding model to support ongoing practice development within the proposed framework.

The Central Zone PCNs participating in this initiative are Big Country, Provost, Red Deer, Wainwright, and Wolf Creek.

The focus of this document is on setting evaluation and performance measurement plans and priorities to inform the implementation of this integrated service model in diverse settings; the assessment of its impact; and decisions to scale and sustain the framework/model.

The IGSI will develop and assess a service model where seniors in Alberta have access to an integrated Primary Health Care (PHC) team equipped to deliver excellence in dementia care. PHC teams will be able to provide a timely and accurate diagnosis and a coordinated pro-active approach to the on-going management of dementia in order for seniors to live well with dementia in community.

The development of a multi-level geriatric service framework ensures that at:

Level 1: All primary care team members are equipped to recognize and assess seniors regarding frailty and changes in brain health. These individuals can then access in a timely fashion,

Level 2: an embedded integrated, geriatric assessment team (GAT) with more advanced skills in dementia care that provide dementia support and builds capacity of the PHC team, who in turn can access,

Level 3: specialized supports for the most complex, complicated challenges related to dementia diagnosis and management.

The Benefits

Better Outcomes

- ✓ Alberta seniors will experience a coordinated approach to service provision and support.
- ✓ Increase knowledge and capacity within health and social teams regarding dementia, delirium and frailty.
- ✓ Increase role, clinician satisfaction regarding serving the senior population in Alberta.

Better Quality

- ✓ Assure people living with dementia and their caregivers are supported by evidence informed practices.
- ✓ Provide consistent services to Alberta seniors across geographical boundaries.
- ✓ Provide access to the most appropriate health and social service provider(s) in a timely fashion.

Better Value

- ✓ Gain cost effectiveness in developing common Alberta College of Family Physicians (ACFP) accredited educational and mentorship curriculum/tools.
- ✓ Leverage expertise by forming health and social partnerships in order to integrate knowledge and process within and across communities.
- ✓ Provide access to specialized support when needed.

Need/Justification for IGSI

People living with dementia represent a vulnerable portion of our population, and dementia has a profound impact on Alberta's families, communities and the health care system. Over the next quarter century, the number of Albertans living with some form of dementia is expected to more than double as the baby boom generation moves into older age. This means that by 2038, about one in ten Albertans over the age of 65 and nearly half (47.5%) over age 90 are expected to be living with dementia. (Population Estimates of Dementia in Alberta [PEDA], Alberta Health, 2015).

Supporting seniors to age and live well in their communities is a key priority for Alberta Health Services Seniors' Health Strategic Clinical Network (SH SCN) and Primary Health Care (PHC) Innovation Network, and is in alignment with the Alberta Government's vision to develop supports so individuals can age in their communities, supported by enhanced integrated care and social support services that optimize independence, quality of life and wellbeing.

IGSI Goal and Objectives

The essence of the IGSI is to enhance primary care provider capacity to recognize, diagnose and provide ongoing care and support to those living in the community with dementia or other geriatric syndromes. There are ***two overarching goals***:

- ✓ Provide timely & accurate diagnosis and,
- ✓ Create a coordinated pro-active approach to on-going care and support of dementia in order to live well with dementia in the community.

Through IGSI implementation, PHC teams will be prepared to recognize, diagnose, provide ongoing care and support to people living with dementia. Services are embedded in communities to support comprehensive care. Specific ***IGSI objectives include***:

1. Develop and adopt a common, integrated health and social service framework in the five participating PCNs.
2. Develop a sustainable business funding model to support ongoing practice development within the framework.
3. Develop common educational and mentorship curriculum to support practice excellence in community regarding dementia care.

This will be achieved through the delivery of Educational Workshops/Learning Collaboratives that deliver education and mentorship curriculum to PHC staff through structural changes made within PCNs that ensure access to advanced embedded geriatric teams and through local community coalition efforts that support integration of services for seniors.

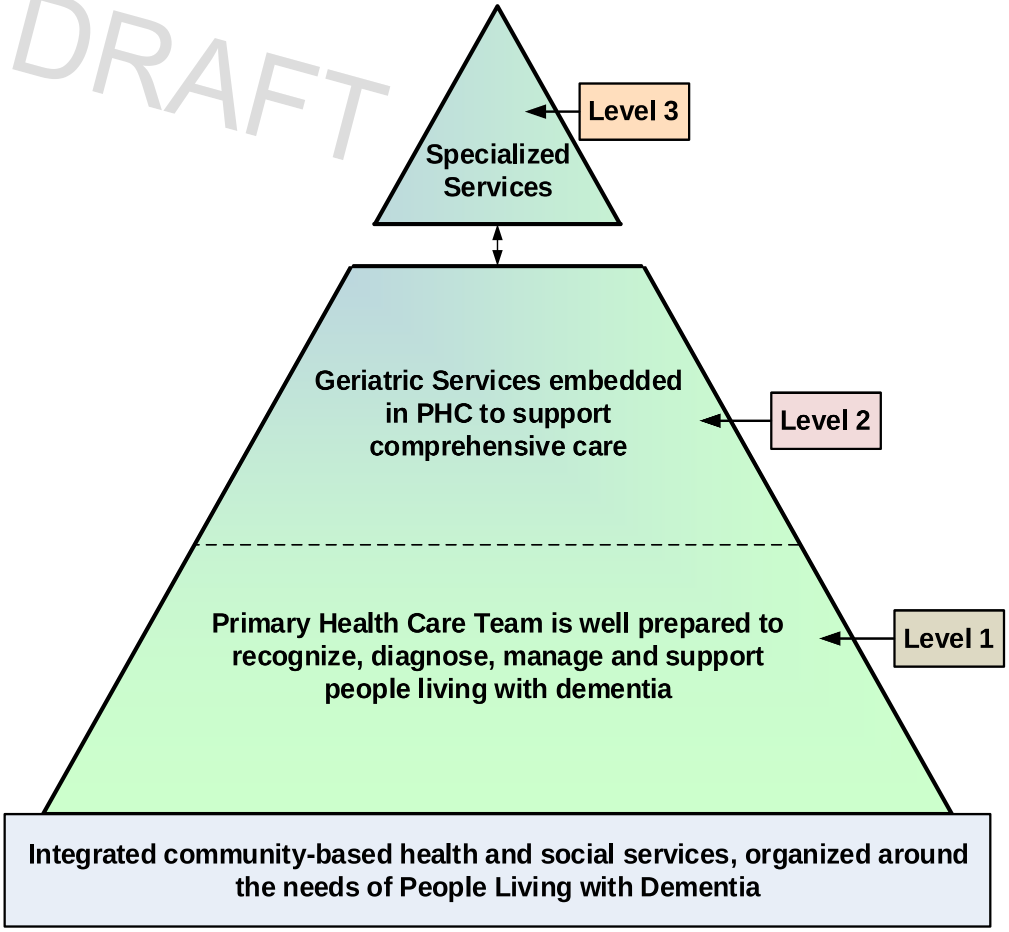
A collaboratively resourced evaluation for the initiative will also be developed which is presented in this document.

The Framework

By March 2018, IGSI will enhance, support development of, implement and evaluate in the geographical areas within the Central Zone served by the participating PCNs. An integrated 3-Level PHC framework is presented below that is:

- ✓ Multidisciplinary
- ✓ Representative of key stakeholders from various community health and social programs
- ✓ Standardized in the use of educational curriculum and tools and is focused initially on frailty, dementia and delirium in the senior population.

Anticipating the Future..Integrated Community Geriatric Service Development Initiative



EVALUATION AND PERFORMANCE MEASUREMENT

EVALUATION & PERFORMANCE MEASUREMENT CONTEXT

The purpose of this document is to provide a guide for designing and conducting effective performance monitoring, evaluation, and assessment of the IGSI, and to outline key factors that are critical in determining success and sustainability. A more detailed review of literature for evaluation and performance measurement can be found in Appendix A. See Appendix B for framework terminology.

EVALUATION GOALS & OBJECTIVES

This evaluation framework encourages an approach that is integrated with clinical operations, as data collection typically occurs within an EMR-based clinical setting. However, to access information to address evaluation objectives, information from diverse sources is needed and will also integrate AHS data sources supported by the development of information management agreements with PCNs and physicians. The emphasis is on practical, ongoing strategies that involve all stakeholders, not just evaluation experts. The information produced from a formative evaluation can be used to describe IGSI processes and activities; to establish the standards and performance measures that must be reached for the IGSI to be considered successful; to improve operation of IGSI activities; and to fine-tune the overall evaluation implementation strategy (including education/training, knowledge transfer, data collection processes, and resource allocation).

Evaluation results will aid in:

- Validating results, including how and why they were/were not achieved
- Comparing planned versus unintended outcome achievement
- Focusing on how and why outputs and strategies contributed to the achievement of outcomes
- Focusing on questions of effectiveness, sustainability and change
- Evaluating achievement of outcomes by comparing pre-post implementation indicators (i.e. review of baseline data versus indicator results)

Evaluation Goals	Objectives
To make recommendations for quality improvements	➢ Update IGSI goals and objectives as reports on progress become available – use results to drive future objectives and re-adjust current objectives that are not being met based on certain circumstances ➢ Use results to show overall IGSI successes and failures, as well as resource deficiencies and areas where additional support, changes or improvements may be required ➢ Support PCNs, participating clinic- and inter-organizations teams to develop local quality improvement plans based on PDSA and evaluation results (the evaluation strategy can help drive quality improvement plans/activities)
To ensure accountability to the system, PCNs and providers	➢ Provide reports on aggregated statistics regarding IGSI activity participation, noting variances ➢ Report successes and failures to stakeholders to ensure accountability

Evaluation Goals	Objectives
	➢ Use reporting structure to enable PCNs and participating clinics to demonstrate accountability to the goals/objectives of IGSI
To ensure clinician engagement and satisfaction with IGSI	➢ Make use of trend analysis reports to participating teams that sustain their engagement and motivation to attain quality improvement goals ➢ Use results to highlight areas of success and determine areas where participating clinics need additional support or resources ➢ *[If appropriate resources are provided – i.e. Data Analyst and additional Evaluation & Quality Consultants*] Implement a clinician engagement survey to ensure clinicians are engaged and satisfied with IGSI
To ensure IGSI is having an impact on outcomes	➢ Review evaluation results to portray the successes of the project to all stakeholders ➢ Ensure outcomes are being achieved in the allotted time and that progress is on track toward achieving longer-term outcomes
To ensure IGSI serves to enhance and sustain partnerships with community services and programs	➢ Assessments will examine that partners shared vision and expectations of roles and functions are transparent and achieved ➢ Use evaluation results to demonstrate that IGSI is an effective and efficient integrated service model that can be sustained

Assumptions

1. Appropriate human resources will be dedicated to data collection, aggregation and analysis at patient, care-partner, provider, team, clinic, PCN, community and system levels
2. Each practice/participating clinic has a functioning information technology (EMR, database) and management agreements in place to collect, share and match patient level data to monitor progress
3. Proposed outcomes will reflect the goals and objectives of IGSI
4. Common definitions will be used for evaluation terminology and data terms (see Appendix B) – each participating clinic collects data using the same definitions (and where possible, use the same fields in common EMRs or databases), and receives the same progress reports
5. Clinicians, PCN staff, clinic staff, AHS and community support organization staff will actively participate in data collection activities in a timely manner
6. Participating clinics and community organizations will provide information to the PCN, and PCNs will make available anonymous information to the IGSI team
7. Data collected is confidential and the provisions of the Health Information Act will be observed
8. Timelines are realistic, manageable and will be adjusted as necessary due to unforeseen events
9. The results will be acted upon in a culture of continued improvement driven by the findings
10. The evaluation will be beneficial to all stakeholders, particularly users of the PHC system

Evaluation Project Risks

Risks	Steps suggested to mitigate risk
Resources must be adequate to implement all activities outlined in this framework (i.e. collecting, analyzing and interpreting data, while supporting PCNs to gather data). The strategy of IGSI and partner organizations is to provide supportive services and training to PCNs so PCNs can better support participating clinics to participate in measurement and evaluation activities. However, resources are currently insufficient to assist all PCNs with this level of support. The success of IGSI is reliant on making use of additional human resources such as Data Analysts and Evaluation Consultants (either hiring additional team members or having dedicated resources from partner organizations). If resources are not available, IGSI will be unable to accomplish everything outlined in this strategy. The evaluation of IGSI will only be successful if a collaborative approach to resource and collect the information needed to monitor performance and assess impact.	*[note: these are recommended steps that would require additional funding or support]* ➢ Fund additional data support and evaluation positions ➢ Develop partnerships with other organizations to share human resources (dedicated to IGSI activities) ➢ Host Evaluation workshops and pan-PCN meetings to discuss topics around data collection and aggregation (this would require resources to host in-person sessions, as these have better results than webinars)
PCNs need the resources and capacity to support participating clinics, and require the capacity to collect and report data at the PCN level. The IGSI team will assist PCNs to build capacity to participate in measurement and evaluation activities. However, as resources vary greatly between PCNs, alternative resources may need to be provided to support many PCNs. IGSI does not have the ability to address resource requirements such as staffing, funding or EMR development (e.g. adding or modifying templates or fields). Should participating clinics and PCNs not have the capacity and resources required to collect and report data, the evaluation team alone will be unable to report on activities and outcomes outlined in this framework.	➢ Make use of EMR Super Users to assist with EMR development – would require additional resources to dedicate Super User time ➢ Fund zone-based data coordinators that can assist PCNs across the zone with data collection issues ➢ Seek support from EMR vendors to provide updates to data fields and reports
Data collection requires EMRs and databases to be in place at all participating clinics, and these resources are currently not being used within all clinics or PCNs. Additional resources and support to embed and ensure maximum utilization of EMRs within all clinics will be required to ensure successful measurement of IGSI progress.	➢ Provide funding alternatives to PCNs to encourage participation in EMRs ➢ Provide IT infrastructure support to PCNs to enable database development or design
This evaluation framework, particularly the indicators, would benefit most from consultation from a representative group of PCN leaders, physicians, evaluators, clinic staff and community support representatives prior to approval. Should this approval not be sought, there is the risk of lack of engagement on the part of PCNs or participating clinics. To mitigate the risk, it is suggested that a focus group be developed to provide input and feedback on the recommended indicators and the feasibility of collecting data geared toward indicator progress. This process needs to happen rapidly and in an efficient manner or additional project risk may be created.	➢ Lead focus groups to provide feedback on the framework and indicators

IGSI KEY ENABLERS

Leadership

Change management literature acknowledges that strong and consistent commitment from leadership over a prolonged period is crucial for organisational change to be sustained (Creasey & Hiatt, 2012). This can be demonstrated by PCN and AHS leaders developing an ongoing measurement and evaluation review committee that monitors implementation of evaluation and data collection plans (see below). Once in place, clinic leadership is instrumental in ensuring data is collected locally and that sufficient resources are in place to participate in evaluation activities.

Resources

Evaluation tools (e.g. surveys) need to be evidence-based and be in a format that minimizes the added workload to staff, while data collection tools (e.g. EMR) need to be developed to capture the appropriate data. Reliable, valid information is necessary for decision-making at all levels, and the best source of quality information is often found in electronic medical records and other health service databases. The Collaborative IGSI Evaluation Working Group will develop or select evaluation tools, and the PCNs collectively can assist clinics in collecting information. Training for all tools needs to be available to PCN and clinic staff, and the evaluation plan will have a strategy to ensure staff has the opportunity to learn tools, practice using tools, and review the evidence base around the proposed tools.

Culture

The existence of an evaluation plan is meaningless if the organizational culture and collaborating community does not support its implementation (Ravasi & Schultz, 2006). Successful measurement and evaluation requires a supportive organization, and a culture that emphasises quality, adaptability, teamwork, continued learning, involvement, communication and patient-centredness. Encouraging staff to be involved in measurement and data capture is a positive step in the direction of ensuring care is meeting the needs of staff and patients alike. In addition, setting a culture where results are provided to PCN and clinic staff is essential to ensuring IGSI sustainability and involvement.

Stakeholder Engagement

It is essential that key stakeholders are involved in the development of an evaluation and performance measurement strategy. These health issues are complex and the diverse patient, care-partner, PHC team and community stakeholders' perspectives must be taken into account. The broadest interpretation must be used to define stakeholders if multi-level practitioner, team, clinic, PCN and system change is expected to implement and integrate a new service planning model. Here we have adopted and inclusive definition of stakeholders as *individuals, groups, or organizations that can affect or are affected by an evaluation process and/or its findings* (Bryson, Patton, & Bowman, 2011, pg. 1). For IGSI, identification regarding which key community stakeholders were regarding dementia care in community was determined in planning meetings. Formal Community Coalition meetings with stakeholders are initiated in a few of the local PCN's community. Diverse stakeholder perspectives of current health service supports, barriers and gaps were discussed in addition to their thoughts on measurement and evaluation. Each stakeholder meeting participant was asked two questions: 1) What does success look like; and 2) How will we know when we get there? General themes that were identified as key areas of success, and subsequently performance measurement and evaluation included:

- ✓ coordinated and integrated services
- ✓ care partner support and respite
- ✓ ability to establish performance measures
- ✓ education and mentoring
- ✓ care planning
- ✓ appropriate referral

Appendix C provides a detailed example of comments and themes gathered from stakeholders. This information was used as a guide to develop evaluation questions and methods. Appendix D lists references consulted to create this evaluation framework.

Information to Catalyze Quality Improvement

Key information will be needed for teams participating in workshops/learning collaboratives to develop improvement goals and "plan, do, study, act" (PDSA) cycles. Participating clinics and teams with PCN-AHS Information Management Agreements (IMA) will receive an EQUiP (Evaluation and Quality Improvement Panel) Assessment that provides information on their patients to help them refine improvement goals, better identify potential areas of impact, and monitor their progress in PDSA cycles. Ultimately, this information will also be included within the evaluation framework to assess the effectiveness of the IGSI. Appendix E provides an example of an EQUiP Assessment and Appendix F presents a sample indicator definition table.

EVALUATION IMPLEMENTATION STRATEGY

INTENT OF THE EVALUATION

During implementation of the IGSI and its evaluation plan, there is an assumption that the starting point for each PCN varies. The intent is to start small, learn from each PCN, share learnings across the participating PCNs, and consider scale and spread options as IGSI is implemented across the province. This means that each participating PCN team will have distinct evaluation and performance goals. However, throughout the early adopter phase, it is envisioned that common key performance indicators will emerge. For example, some PCN teams may have already developed practice skills at level 2 of the model and their improvement goals, evaluation questions and performance indicators will be different from another PCN team focused on enhancing level 1 capacity. These diverse improvement goals, questions and measures will be incorporated into the evaluation framework in a developmental fashion. Developmental evaluation "tracks and attempts to make sense of what emerges under conditions of complexity, documenting and interpreting the dynamics, interactions and interdependencies that occur as innovations unfold" (Patton, 2011, pg. 7)."

Regardless of a PCNs initial starting point, IGSI stakeholders will be able to use evaluation results to:

- Review progress of a PCNs dementia services within the adopted framework
- Assess PCN involvement in IGSI activities over time
- Explore relevant outcomes and highlight successes through knowledge transfer
- Participating clinics can link and use their own local data, as well as AHS data, to participate in learning collaboratives that support quality improvement (Plan, Do, Study, Act cycles) and monitor progress and performance
- Develop continuous quality improvement strategies and change management plans
- Identify areas of the IGSI that may need changes or updates
- Identify areas of concern and satisfaction among PCNs, participating clinics, patients and care-partners, and community partners

Evaluation Questions

Evaluation questions are presented, by domain, in the table below.

Domain	Evaluation Questions
Workshop, Education & Learning	1. Do workshops provide an engaging learning environment for participants? 2. Have communities hosted local Education Days for team members that did not attend workshops?
Quality Improvement	3. To what extent do communities/teams engage in quality improvement and the identification and collection of performance measures to monitor progress? 4. Do the educational, learning and planning activities conducted at workshops transfer to practice improvements? 5. What quality improvement measures and goals have been set by teams?
Persons Living with Dementia (PLWD) & Care Partner	6. Is there an increase in care partner knowledge of dementia, care plans and options? 7. Is there an increase in care partners' self-efficacy to care for persons with dementia? 8. What are the PLWD and care partners' level of satisfaction and experiences with providers/teams providing care? 9. Is the self-reported quality of life of PLWD and care-partners improved? 10. Do care partners and PLWD have a care plan that connects them to the right services at the right time? 11. Are home care referrals consistent, timely and ensure that all families who need assistance can access it? 12. Is availability and access to community supports and services enhanced? 13. Is coordination and service integration around the needs of patients and care partners enhanced?
Health Care Providers & Clinic Teams	14. Is there an increase in knowledge and skill among team members (self-efficacy) to better recognize (earlier and more effective), assess and treat dementia, delirium & frailty; to co-develop a care and support plan for PLWD and their care partners; and to better manage geriatric syndromes? 15. Is there a change in clinical or community team composition? 16. What are the experiences of providers with education, workshop and mentoring activities? 17. Is there increased referral and support from embedded Level 2 teams to manage PLWD? 18. Was information provided to teams about patients on their panel of value (i.e., informed diagnoses, care planning, identify areas of QI and impact)?
Community coalition, Inter-organizational & Service Integration	19. How has the journey from initiative start-up to collaboration and service integration unfolded across time? 20. Has there been a reduction in duplication or competition of services? 21. Are partnerships with community services and programs enhanced and integrated in care planning? 22. Are inter-organization connections enhanced through shared goal setting and planning (i.e., Home Care, Mental Health, and clinic with the PCN)? 23. Is there increased primary care capacity to assess function/diagnosis? 24. Is there an increase in inter-professional collaboration and decision making among level 1 & 2 teams & community supports/services? 25. Is there shared learning & transfer of knowledge across participating PCNs enhancing system integration? 26. Can shared learning and integrated service models be scaled up across additional PCNs?
Referral, Assessment & Diagnosis	27. Is there more timely and accurate diagnosis of dementia, delirium and frailty by teams within primary health care? 28. Are there more appropriate referrals for PLWD where less referrals to specialized services and more and/or earlier referrals to other programs such as home care and community mental health may be expected? 29. What is the number of referrals made to specialists for PLWD?

Domain	Evaluation Questions
	30. For PLWD, does the proportion with cognitive assessment reviewed within a 12-month period increase? 31. Is there timely referral and access to specialized services?
Health Care System	32. Has information continuity and other aspects of team effectiveness increased? 33. Are more PLWD seen in primary care within 30 days after discharge from a non-elective hospital stay for dementia or related geriatric syndrome? 34. Does the relational continuity that persons living with dementia (PLWD) have with primary care providers and medical homes increase? 35. Are unplanned hospitalizations of PLWD decreased? 36. Among PLWD, is there a decrease in admissions to acute care that have not been assessed for alternate level of care while at home? 37. Among PLWD, are avoidable ED visits reduced? 38. What number/types of medications were patients with dementia prescribed?

Framework Timeline and Approach

Workshops to deliver education and establish PCN team improvement goals and plans occur June 16, 2017, Fall of 2017 and March of 2018. The process for developing the Evaluation Framework will include:

- Continued updating of the Evaluation Framework to reflect progress, ongoing changes and new opportunities incorporated into action plans;
- Indicator review by an expert group composed of PCN Leads, physicians, and evaluators: September 2017; and,
- Expected completion of the IGSI workshops: March 2018.
- Completion of the short and mid-term evaluation outcomes and performance monitoring: March 2018.
- Completion of long term outcomes and monitoring: March 2020.

Note: an Evaluation Framework is not a static document, and will require additional input and revision over the course of the initiative. It is expected that updates will be made at least annually, and more frequently as the IGSI itself evolves over time.

Guiding Principles

Key principles were identified to guide the performance measurement and evaluation activity. These are as follows:

- ✓ Engagement of partners in the development of the framework is necessary and will sustain the grass roots approach taken to date (i.e., avoid “top-down”)
- ✓ Individual PCN context is important and measurement needs to be flexible and support variability in implementation that meets local needs
- ✓ A developmental evaluation approach will be used to capture “lessons learned” in diverse and complex contexts and share them effectively to change or enhance
- ✓ Measurement needs to reflect effective integrated care across the continuum:
    - More timely and accurate diagnostics;

    - Creation and management of care plans that coordinates care across the health and social continuum; and,
    - Avoidable hospitalization and duration of hospital stay.
- ✓ Measurement and evaluation planning should support a “scope & scale” approach. That is, measures should be scalable and relevant beyond the immediate scope of a “pilot” project.
- ✓ Return on investment should be considered in framework, but is not a prevailing driver.

LOGIC MODEL

The IGSI logic model, process workflow diagram and complexity map can be seen in Appendix G. The development of the logic model involved an iterative process to ensure that it incorporated multiple and diverse perspectives, informed by representatives from the PCNs, Seniors SCN, AHS, Community stakeholders, care-partners as well as relevant academic literature. Generally, inputs include: Alberta Health Grant Funding, PCN Planning & Coordinating Committee, Seniors SCN (Co-lead and Project Coordinator), PHC Integration Network (Co-Lead and Senior Planner), Expert Advisory Working Group, PCN Resources, Alzheimer’s Society of AB & NWT (ASANT) Resources, and a collaborative Evaluation & Measurement Working Group. The target group of this input activity is participating PCNs within the Central Zone, related AHS and community support service organizations and staff. The data matrix which evolves from this logic model outlines the methods and tools to monitor expected outputs and outcomes as well as address the IGSI evaluation questions.

Monitoring Complexity and Developmental Evaluation

Appendix G also presents an Integrated Geriatric Teams Clinical Workflow diagram. Participating teams start small at differing locations in the diagram, learn through their unique workshop and inter-workshop activities, and share learnings across participating PCNs. This allows IGSI to monitor success and then scale and spread strategies as the initiative is further implemented. Each participating PCN team will have distinct and likely different evaluation and performance goals which will need to be incorporated into the evaluation framework in a developmental “like” fashion. This will allow IGSI to monitor learnings that result from complex processes and direct information back into the evaluation framework which will evolve and accommodate changing goals, questions and performance measure as well as serendipitous outcomes.

To provide this developmental aspect to the evaluation, members of the organizational infrastructure (also see Appendix G) will receive education and tools (to be constructed) that provide a process to capture and monitoring this ongoing complexity and feedback.

The areas of complexity that will be monitored regularly to obtain developmental feedback and their association to the evaluation logic model are presented in Appendix G. Feedback loops will be created to monitor IGSI complexity and support a developmental evaluation approach.

As is shown, complexity and variability within IGSI occurs at several levels:

1) Multiple Partners with Varied Levels of Support – there is likely varied levels of organizational support and resources among multiple community partners operating at different levels.
2) Stakeholder Internal and External Factors Influence Processes & Outcomes - Multiple internal and external factors within PCNs and other participating stakeholder organizations may influence the effectiveness of the initiative in varied ways, thereby creating challenges in assessing what contributing factors are resulting in desired changes at the individual, system, community and societal level.

Evaluation for complex initiatives requires ongoing rapid feedback for those involved in implementation (Hummelbrunner, 2011). Many complex interventions are dependent on activation of a “virtuous circle” whereby an initial success creates conditions for future success. This requires evaluation to gather early evidence of these small changes and track the changes throughout implementation of the initiative (Rogers, 2008). In developmental evaluation timeliness of reporting on data is critical (Gamble, 2006). PCN capacity to report on, and integrate timely learnings from emerging data in an uncertain environment of innovation with rapid change may, in some ways, be challenging.

Feedback loops must be established within IGSI committees, working groups and improvement teams. This feedback would likely be in the form of structured reflection and reporting of activity outputs and outcomes with a goal to provide “real-time” feedback to the measurement and evaluation review committee who are then able to effectively track change by monitoring IGSI implementation.

EVALUATION METHODOLOGY

Sampling Procedures

All PCNs, participating clinics, teams and community partners will be involved in collecting data and reporting progress toward forming inter-organizational teams that create a shared vision, improvement goals and outcomes. In order for results to be validated and where applicable (e.g., patient experience survey), a calculation for sampling will be provided to data collectors. *The sampling strategy will be provided in a future update of this framework.* Evaluation & Quality Consultants can assist participants in determining the sample size.

Data Analysis

Descriptive statistics will be used to provide a snapshot of a set of performance indicators [TBD]. SPSS will be used for statistical data analysis, with factor analysis summarizing correlations in the data. Regression analysis may be used to identify trends in performance measures and the critical variables for success [TBD]. Thematic analysis will also be used in analyzing emerging themes where qualitative data is collected (e.g., interviews and focus groups with persons with dementia, care partners, physicians and inter-organizational teams, staff and community stakeholders). To perform analyses outlined for these methods, the aforementioned patient panel assessments for QI, performance measurement reports to teams, and primary data collection needed to answer priority evaluation questions, dedicated collaborative resources will be required.

Evaluation Design

A non-experimental, descriptive design, utilization-focused approach will be undertaken for the evaluation and monitoring of evaluation measures and performance indicators. Non-experimental (including descriptive designs) are most often used to evaluate health care initiatives (Linden & Adams, 2006). Control will not be used as all clinics are encouraged to participate in data collection and monitoring, however, comparative data may be available for some secondary data source indicators and performance measures. Data analysis will comprise of comparative, correlation, trend analysis, descriptive statistics, and thematic as appropriate. In addition, as mentioned above a “developmental-like” approach will capture findings that evolve from complex processes within IGSI.

Limitations of the Design

This design hinges upon the majority of participating PCN clinics and teams reporting accurate data in a timely manner, meaning that analysis can only take place once all results are provided.

The intent of the design is to consider feasibility of ongoing performance monitoring and reporting where resources become available to sustain efficient and effective aspects of the IGSI model. This would allow for the continued improvement at PCN, clinic and integrated team levels.

DATA COLLECTION PLANNING

Data Collection and Storage

A reporting template for data collection is recommended for evaluation of IGSI activities, measures and indicators, and needs to be resourced in order to be successfully implemented. In terms of the report structure, key items could be added to a Report Template circulated at critical intervals; if this is not possible, a separate reporting mechanism will need to be established. Participating PCN clinics will need to be held accountable to provide the information. An interactive PDF or online report template is preferable, and can be developed and maintained by an Evaluation and Measurement Review Committee. Decisions will need to be made regarding the best means of collecting project-related information from PCNs, clinics, inter-organizational teams and community partners. Until that time, this section will be "under construction".

Note: sustaining these ongoing measurement activities are contingent upon receiving analytical and reporting support from AHS and PCN partner organizations.

Data will be stored in a secure portal and will be disseminated only in an appropriate manner as outlined in information management and applied research agreements to stakeholders with a vested interest in the project. Privacy and confidentiality of data will be maintained and the Health Information Act will be respected.

Data Collection Plan

Data collection templates will need to be created by the Evaluation and Measurement Working Group, with decisions made on the best means of collecting data at multiple initiative levels and times. This template will be completed once final decisions are made on the reports/template used to report data back to and collect measures and indicators from IGSI teams. An example is provided here.

Indicator	Data collection tool/report	Data collection responsibility	Frequency of data collection	Required resources	Report frequency

Proposed Continuous Quality Improvement (CQI) and Communication

Plans for continuous quality improvement (CQI) and communication are proposed here and can be found in Appendix H. These plans and tools would require review, approval and resource supports by senior initiative leadership prior to implementation.

Work Plan

A tentative work plan for the evaluation is presented in the table below.

Activity	Proposed Timelines
Evaluation Project Initiation	
Communicate plan and objectives to IGSI Steering Committee	June 2017
Finalize Patient Assessment Report format to catalyze QI and deliver information to workshop participants	June 2017
Workshop #1 Evaluation	June 16, 2017
Approve Evaluation and Performance Measurement Framework	July 2017
Draft IGSI Measurement and Evaluation Review Committee composition and terms of reference to outline evaluation and monitoring activities and timelines (work plan)	August – Sept. 2017
Interorganizational project infrastructure evaluation training to monitor learning, progress and serendipity	August 2017
Workshop #2 Evaluation	Fall 2017
Develop data collection report/tool/mechanism for PCNs to report aggregated results	Aug. – Sept. 2017
Workshop #3 Evaluation	March 2018
Develop Implementation Strategy	
Finalize Data Collection Plan	June - July 2017
Finalize Communication Plan	Sept. – Oct.2017
Finalize Continuous Quality Improvement Plan	March 2018
Complete Evaluation and Monitoring Components	
TBD	
Reporting	
Draft reports	TBD
Submission of final reports for review to IGSI Steering Committee	
Approval of report	
Dissemination of report to appropriate stakeholders	

[Note: To be updated with final timelines once participating PCN team improvement goals, plans and measures are determined and incorporated into the overall project plan at the steering committee level. More activities will need to be added to this plan]

APPENDIX A: PERFORMANCE MEASUREMENT AND EVALUATION

For this initiative, measurement is developed to answer both evaluation questions and as indicators established by PCN provider teams to monitor quality improvement goal performance. Evaluation and performance measurement are interconnected approaches that will focus on the assessment of IGSI in a way that provides direction about making improvements in integrated service function, effectiveness, delivery, resource allocation, policy, etc. It is common to use evaluation and performance measurement together to assess multiple aspects of an initiative and overall effectiveness, as they are complementary approaches (McDavid, Huse & Hawthorn, 2013). It is not used in a judgmental or punitive manner, but to guide and inform.

Current State of Measurement & Evaluation

Information and Communications Technology (ICT) has a critical role to play in ensuring that information to drive quality and safety in health and social care settings is available when and where it is required. However, in Alberta there is no common ICT strategy or data collection method (EMR/database) for all clinics and PCNs to use in monitoring IGSI activities and progress. The available resources and technical skills in each participating PCN are varied and some may be at a disadvantage in their ability to collect and report data. This evaluation framework aims to develop and implement a collaboratively resourced evaluation through the development of 1) information management agreements with each participating PCN and AHS, 2) appropriate indicators of performance pulled from AHS data sources, and 3) clinic and PCN data sources. This will serve to reduce the measurement burden on participating clinics and PCNs as well as standardize measures across these diverse PCN clinic settings.

Performance Measurement

Performance measurement is the “process of ongoing monitoring and reporting of program accomplishments, particularly progress toward established goals”, and is tracked through the identification of performance indicators (U.S. Government Accountability Office, 2011). Performance measurement informs how well a project is performing relative to targets; focuses on the products or services provided by the project team (outputs); and is used to reveal changes based on the delivery of these products or services (outcomes). A performance indicator measures an important component of an initiative, tying resources and activities to results and providing a means of ensuring accountability (Austin, 2013). Indicators are renewed on an ongoing basis and are time-based achievements. Performance indicators are viewed widely in best practice literature as part of the process to systematically monitor, evaluate and continuously improve the quality of care provided through healthcare organizations (Health Information and Quality Authority, 2012; Smith, Mossialos & Papanicolas, 2008; U.S. Government Accountability Office, 2011).

Performance measurement alone does not address the strengths and weaknesses of an initiative’s design or the variables affecting program performance, and thus needs to be coupled with evaluation (Treasury Board of Canada Secretariat, 2009; Upadhaya, Munir & Blount, 2014).

Evaluation

Evaluation can be defined as "the systematic collection of information about the activities, characteristics, and results of programs to make judgments about the program, improve or further develop program effectiveness, inform decisions about future programming, and/or increase understanding" (Patton, 2008, p. 37). Evaluation can be used to assess project results and identify new ways to improve or enhance the performance and/or effectiveness of a project (Wholey, Hatry & Newcomer, 1994). Evaluation entails the collection of multiple sources of information or evidence, which can be used to improve project implementation and to attribute observed outcomes to the project. Evaluation requires additional data sources and methodologies to answer key questions, always seeking to address the 'how' and 'why' of activities and outcomes. Evaluation is guided by key Evaluation Standards that include:

- utility standards, which ensure an evaluation will serve the information needs of intended users;
- feasibility standards, which ensure an evaluation will be realistic, prudent, diplomatic, and frugal;
- propriety standards, which ensure an evaluation will be conducted legally, ethically, and with due regard for the welfare of those involved or those affected by its results; and
- accuracy standard, which ensure an evaluation will reveal and convey technically adequate information about the features that determine worth or merit of the program being evaluated[1]

Some of the main uses of evaluation include (Wholey, Hatry & Newcomer, 1994):

- Analysis of the efficiency and effectiveness of the project and project components
- Establishment of accountability by monitoring ongoing progress of project results
- Identification of project strengths and weaknesses
- Provision of information needed to maintain and/or improve quality
- Assessment of the overall project impact
- Determination of which project components (activities, deliverables, outputs) produced the best results, and the conditions under which the results were optimally achieved
- Identification of where additional resources may need to be devoted

> *Evaluation and performance measurement activities do not improve quality just by virtue of being completed; however, they act as alerts to identify good practice; provide comparability within and between services or organizations; highlight opportunities for improvement; and indicate where a more detailed investigation is warranted (Health Information and Quality Authority, 2012).*

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[1] For a detailed description of the Evaluation Standards, see the Canadian Evaluation Society (2014).

APPENDIX B: TERMINOLOGY

Activities

Activities are the tasks, operations or work processes a project team completes with available resources (inputs). Activities can include processes, tools, assessments, events, and actions that are an intentional part of the program or project implementation. Activities are used to bring about the intended program changes or results (W.K. Kellogg Foundation, 2004).

Denominator

The denominator is the set of specifications that describe the sampling, inclusion, and exclusion criteria determining the eligibility of data for measurement (Health Information & Quality Authority, 2012).

Developmental Evaluation

Developmental evaluation “tracks and attempts to make sense of what emerges under conditions of complexity, documenting and interpreting the dynamics, interactions and interdependencies that occur as innovations unfold” (Patton, 2011, pg. 7).

Evaluation

Evaluation refers to the systematic collection of information about the activities, characteristics, and results of programs to make judgments about the program, improve or further develop program effectiveness, inform decisions about future programming, and/or increase understanding (Patton, 2008).

Evaluation Standards

The Canadian Evaluation Society National Council set standards for effective Canadian evaluation practice. There are 30 Evaluation Standards and these can be described by four categories (Canadian Evaluation Society, 2014):

1) Utility standards are intended to ensure that an evaluation will serve the information needs of intended users.

2) Feasibility standards are intended to ensure that an evaluation will be realistic, prudent, diplomatic, and frugal.

3) Propriety standards are intended to ensure that an evaluation will be conducted legally, ethically, and with due regard for the welfare of those involved in the evaluation, as well as those affected by its results.

4) Accuracy standards are intended to ensure that an evaluation will reveal and convey technically adequate information about the features that determine worth or merit of the program being evaluated.

Formative Evaluation

Formative evaluations strengthen or improve the object being evaluated - they help form it by examining the delivery of the program or technology, the quality of its implementation, and the assessment of the organizational context, personnel, procedures, inputs, and so on (Trochim, 2006).

Indicator (also known as Key Performance Indicator)

Indicators are the measures selected as markers of project or activity success (W.K. Kellogg Foundation, 2004). Indicators are quantitative measures of structures, process or outcomes that: provide a simple and reliable means to measure achievement and assess quality; reflect the changes related to project implementation; or help assess the performance of stakeholders or participants (Health Information & Quality Authority, 2012; OECD, 2010).

Inputs

Inputs are the resources required to accomplish intended outcomes, and include the human, financial, organizational, and community resources a project/organization has available to direct toward doing the work (producing outputs and accomplishing outcomes). Examples of inputs include: funds, personnel, equipment, supplies, partnerships, research, best practices, etc. (OECD, 2010; W.K. Kellogg Foundation, 2004).

Logic Model

A logic model is an achievable and practical description of how a program is intended to work (program theory), that outlines the sequence of causes (inputs, activities, outputs) that produce the effects (outcomes) sought by a program (McLaughlin and Jordan, 1999). The logic model is a systematic and visual way to present and share the relationships among the available resources to operate a project, the planned activities, and the anticipated changes or results, by linking outcomes to program activities and the theoretical assumptions/principles of the project (W.K. Kellogg Foundation, 2004).

Numerator

The numerator is the set of specifications that define the subset of data items in the denominator that meet the indicator criteria (Health Information & Quality Authority, 2012).

Outcomes

Outcomes are the specific changes in attitudes, behaviours, knowledge, skills, status, or level of functioning that participants will experiences as a result of participation in project activities (W.K. Kellogg Foundation, 2004). They are the results or goals of a program, or the changes or benefits resulting from activities and outputs. Short-term outcomes outline the changes or benefits most closely associated with or 'caused' by the outputs; intermediate outcomes outline the changes that result from an application of the short-term outcomes; while long-term outcomes follow from the benefits accrued through the intermediate outcomes (McLaughlin & Jordan, 1999).

Outputs

Outputs are the counts of events, services, activities products that are planned to be generated by direct project activities. They include the products, procedures, deliverables, capital goods, and services that result from project implementation, and may also include changes resulting from the intervention that are relevant to the achievement of outcomes (OECD, 2010; W.K. Kellogg Foundation, 2004).

Summative Evaluation

Summative evaluations examine the effects or outcomes of a project - they summarize it by describing what happens subsequent to delivery of the project; assessing whether the activities can be said to have caused the outcome; determining the overall impact of the causal factor beyond only the immediate target outcomes; and, estimating the relative costs associated with the object (Trochim, 2006).

Target Group

The target group includes a specific group of individuals or organizations (participants) at which the project and activities are aimed (OECD, 2010).

APPENDIX C: THEMES FROM STAKEHOLDER FEEDBACK

Red Deer PCN Community Coalition Stakeholder Meeting Feedback		
Theme	**Stakeholder comments**	**N**
Question 1: What does success look like?		
Coordination & service integration	• Navigating the system with families – early intervention and a TEAM approach to care (more family wellness nurses to help navigate) • Better, more comprehensive assessment of the patient (taking into account possible behavioral issues) prior to going into care to ensure that they are placed in an appropriate facility. • The care giver and person with dementia would have a supportive team, a clear pathway and care plan that connects them to the right services at the right time. • Not duplicating services or competing with each other to serve families • Navigating the system with families – early intervention and a TEAM approach to care (more family wellness nurses to help navigate) • Knowledge of private care options for families waiting for placement – a better relationship with the private sector • Full not partial funding for FSCA Day Support Program through AHS • Consistent and timely referrals through home care to ensure all families who need assistance can access it • Memory care clinic functional and with all needed services coordinated • Inter disciplinary teams of professionals in place who work together to support the patient and care partner, the end result being the patient is kept at home as long as possible. • Better, more comprehensive assessment of the patient (taking into account possible behavioral issues) prior to going into care to ensure that they are placed in an appropriate facility. • Placement that is prioritized by the best possible match of patient to facility, rather than what is first available, thereby avoiding a transfer when the best match is available. • Easy access to services through one access point • All persons living with dementia/frailty and their care partners will have access to care that is proactive, bio-psychosocial and integrated (primary, secondary and community services) • All persons living with dementia/frailty and their care partners will have access to a person-centred care approach to care where all practitioners liaise together seamlessly and appropriate processes are in place for relevant information sharing between agencies • When people with dementia and their care givers are able to see their family doctor and get quickly connected for assessment and care planning. • The care giver and person with dementia would have a supportive team, a clear pathway and care plan that connects them to the right services at the right time. • Develop great communication with community supports. • Gain timely access to services needed- capacity will have to change from its current state. • Extended subsidized programs for respite (currently available for 3 hours, 3 days a week) • All persons living with dementia/frailty and their care partners will have access to a person-centred care approach to care where all practitioners liaise together seamlessly and appropriate processes are in place for relevant information sharing between agencies • Identifying and locating families that are in need of help, that none of us have met yet	22

Caregiver support & respite	• Supports in place for caregivers. • Prevention- preventing caregiver burnout is so important, preventative care as opposed to reactive care makes the most sense to • Care partners feeling supported early on in their journey • Accessible crisis beds with less stringent rules around them • Home care trying to create consistency and peace of mind when providing respite to Dementia families • Professional, accessible, and affordable, evening and weekend respite care options • Give respite care before they start feeling burnt out would be the best case scenario in my view. I see those beds that are utilized at certain times of the year and open at others being a on a pre booked schedule… Either that or more availability at Adult day program. • Maybe more of a rotation to allow for better access- its sounds like some people use it all the time leading to less availability for other families. • Accessible crisis beds with less stringent rules around them • Home care trying to create consistency and peace of mind when providing respite to Dementia families • Professional, accessible, and affordable, evening and weekend respite care options • Extended subsidized programs for respite (currently available for 3 hours, 3 days a week) • Of course that our site would be running at a full capacity to meet the needs of the caregivers. • Give respite care before they start feeling burnt out would be the best case scenario in my view. I see those beds that are utilized at certain times of the year and open at others being a on a pre booked schedule… Either that or more availability at Adult day program. • Maybe more of a rotation to allow for better access- its sounds like some people use it all the time leading to less availability for other families.	15
Performance measurement	• # of people see an assessed by the PCN that have personal directives and POA drawn up • # of people seen by the PCN that have documented discussions regarding advanced care planning and Goals of Care • # of people with the diagnosis of dementia that are seen by the family nurse through the PCN, seniors mental health, Home Care, ACE team. • # of people with dementia currently placed within the continuing care stream that are satisfied with their experience with the health care system from diagnosis to placement • # of people admitted to acute care with dementia as a diagnosis that have not been assessed for alternate level of care while at home • # of people admitted to acute care with dementia that accessed maximum Home care supports prior to admission, that have a Personal Directive and POA in place, that had contact with ASANT • # of people see an assessed by the PCN that have personal directives and POA drawn up • # of people within the PCN that are currently screened for dementia • # of people seen by the PCN that have documented discussions regarding advanced care planning and Goals of Care • # of people with the diagnosis of dementia that are seen by the family nurse through the PCN, seniors mental health, Home Care, ACE team. • # of patients within the PCN that have a diagnosis of dementia that have been referred for further support. • # of people with dementia currently placed within the continuing care stream that are satisfied with their experience with the health care system from diagnosis to placement • # of people admitted to acute care with dementia as a diagnosis that have not been assessed for alternate level of care while at home • # of people admitted to acute care with dementia that accessed maximum Home care supports prior to admission, that have a Personal Directive and POA in place, that had contact with ASANT	14

Education	• Access to trained and knowledgeable social workers • A provincial training program that is affordable and accessible for front line workers and care partners • All doctors in Red Deer knowledgeable and aware of community resources for families facing Dementia • Program workers better educated in dementia. Most programs available are not tailored to the dementia patient (consistency is key). • Case workers better educated in dementia. In our experience, some case workers did not have the skillset to interview a dementia patient. • Are better educated in dementia • An education program or marketing campaign that works towards educating families so when they come to a that point that they need support or know someone does they know where to go. • Education at all levels of care- if health care professionals know how to manage dementia/ Alzheimer's patients, the patients and the family will feel more supported and cared for. • Educating the general public on signs to watch for and steps to take • Dementia training for HCA's (partner with local institutions) to have a module specifically to Dementia in their diploma	10
Care plan	• Early diagnosis planning and where to go for assistance • Listen to the family, they know the patient best and are able to give relevant information • All persons living with dementia/frailty and their care partners will have access to a care plan that focuses on patient and family determined outcomes and is built on strengths versus needs • Those with memory loss concerns would feel like they have been supported and cared for all along their journey. I would like better than anything, not to have to hear stories like we heard last night…. Where people felt lost, not supported and very frustrated.	4
Appropriate referrals	• Refer patients to First Link (or alternatively our new inter disciplinary teams) • Automatic screening for dementia when people reach a certain age, possibly 70?	2
'Other'	• Working with one EMR for the province • Serving rural residents as a priority • Ending the transportation barrier	3
Question 2: How will we know when we get there?		
Patient & caregiver support	• Caregivers will feel supported, with tools and training to care for Dementia • Amount of people with dementia that are receiving maximum support at home through home care increases. • You'll know you're there when caregivers do their chosen job without suffering burnout. • # of caregivers that state that they feel supported in the caregiver role increases • # of community services and supports for people with dementia and their caregivers increases • As well as support their caregivers, which would be determined by increased level of satisfaction of staff, families and clients.	6
Coordination & service integration	• Patients that go through the program will be connected to the community agencies that support the caregiver and the person with dementia. • And it needs to be coordinated to decrease duplication of services and to streamline these services throughout • I think there are currently too many referrals that are going to Seniors Mental Health and the ACE team for things that should have been identified and addressed early in the diagnosis. • I think various models of care already exist that we could model after to help streamline the system that currently exists. • Local placement options	5
Performance measurement	• I also would like to see increased collaboration between Home Care and the PCN somehow measured – perhaps number of joint visits or something like that. • Number of people screened for dementia has increased • Number of people seen by the PCN that have documented discussions regarding advanced care planning and Goals of Care increased • I would like to see tracking of all referrals to secondary and tertiary services for dementia diagnosis or care to see if over time we can reduce the tertiary services to just the most appropriate referrals, and use primary care and secondary services more appropriately • Number of people with a PD and POA increased	5

Healthcare system utilization	• Less Dementia patients at the ER and Centennial Centre • # of people admitted to acute care R/T dementia not assessed at home decreases • # of ER visits with diagnosis of failure to cope/thrive would decrease • # of ER visits from a Supportive Living facility due to behaviours would decrease.	4
Timely diagnosis of dementia	• When we get there, we will be seeing individuals for the initial diagnosis of dementia. • Identified Red Deer "special team" to help diagnose early • Early diagnosis and intervention is key to be able to support clients and families with this diagnosis	3
Appropriate referrals	• Duplication of referrals decreases because of early intervention and screening • # of people diagnosed with dementia that have been referred for further support increases	2
Satisfaction	• Satisfaction of clients and families increases • No Home care complaints	2
Education	• More doctors in RD who feel comfortable with the diagnosis process • Educational supports and training for all staff within the continuum of care increases to be able to assess and manage the care needs and behaviours of people with dementia	2
Increased accessibility	• The wait time for placement moves from years to weeks • I'm hoping at a systems level we will see better navigation and access to services.	2
'Other'	• All Red Deer residents will be knowledgeable and aware of the signs and symptoms of Dementia – and know where to start • No families will have the story of Anne Baltimore, again • Less Elder abuse statistics in Central Zone • Facilities that offer specialized Dementia care have the equipment and proper facilities to provide safe and dignified care	4

APPENDIX D: REFERENCES

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APPENDIX E: PANEL ASSESSMENT FOR QI

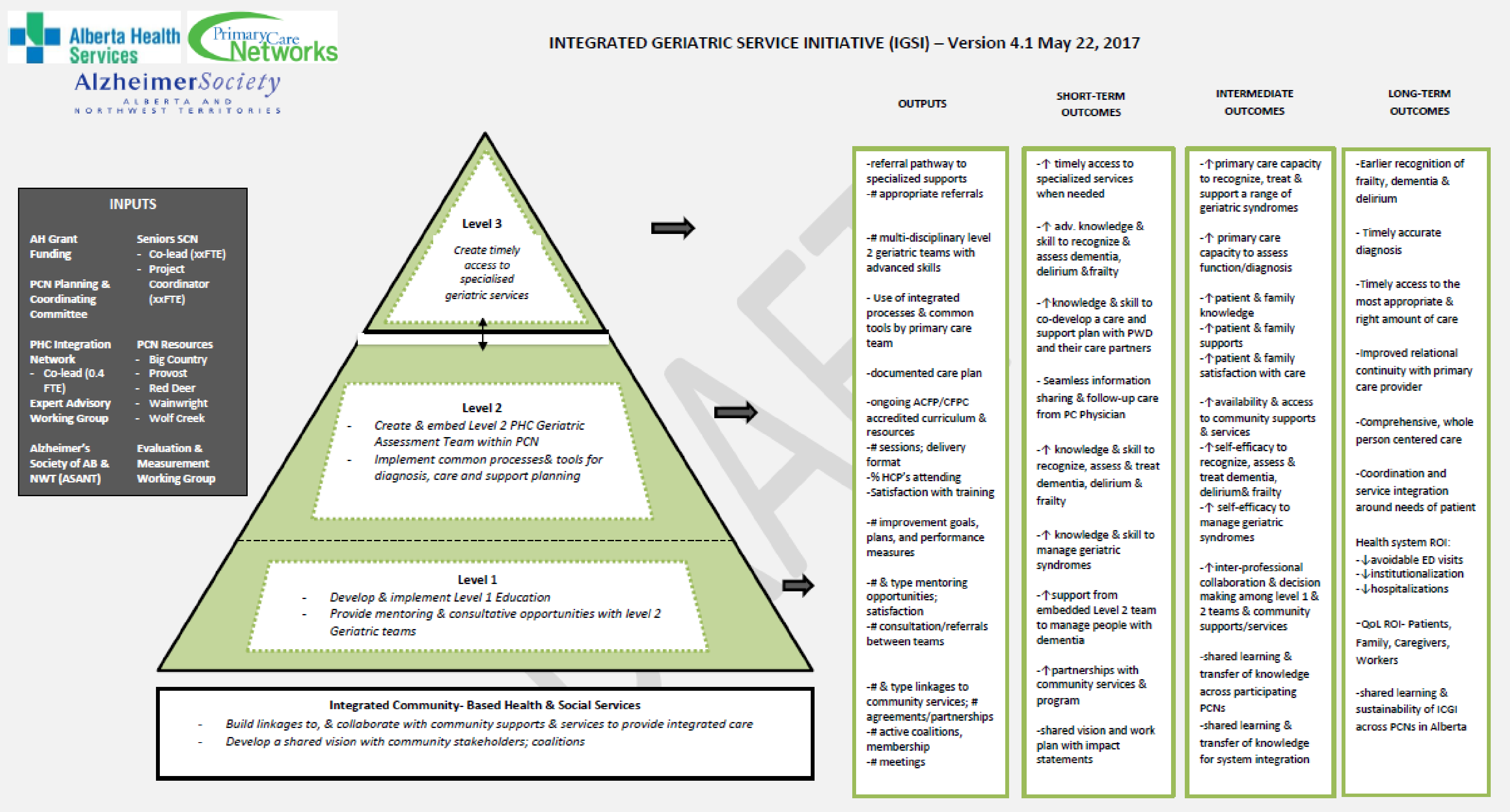
Mock report not available

APPENDIX F: INDICATOR DEFINITIONS

Indicator			
Definition			
Numerator			
Denominator			
Baseline			
Target	2017	2018	2019 (and beyond)

APPENDIX G: LOGIC, CLINIC WORKFLOW, IGSI & COMPLEXITY MAPS

IGSI LOGIC MODEL



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

INTEGRATED GERIATRIC SERVICE INITIATIVE (IGSI) – Version 4.1 May 22, 2017

INPUTS

AH Grant Funding

PCN Planning & Coordinating Committee

PHC Integration Network
- Co-lead (0.4 FTE)

Expert Advisory Working Group

Alzheimer's Society of AB & NWT (ASANT)

Seniors SCN
- Co-lead (xxFTE)
- Project Coordinator (xxFTE)

PCN Resources
- Big Country
- Provost
- Red Deer
- Wainwright
- Wolf Creek

Evaluation & Measurement Working Group

Level 3

Create timely access to specialised geriatric services

Level 2
- *Create & embed Level 2 PHC Geriatric Assessment Team within PCN*
- *Implement common processes& tools for diagnosis, care and support planning*

Level 1
- *Develop & implement Level 1 Education*
- *Provide mentoring & consultative opportunities with level 2 Geriatric teams*

Integrated Community- Based Health & Social Services
- *Build linkages to, & collaborate with community supports & services to provide integrated care*
- *Develop a shared vision with community stakeholders; coalitions*

OUTPUTS

-referral pathway to specialized supports
-# appropriate referrals

-# multi-disciplinary level 2 geriatric teams with advanced skills

- Use of integrated processes & common tools by primary care team

-documented care plan

-ongoing ACFP/CFPC accredited curriculum & resources
-# sessions; delivery format
-% HCP's attending
-Satisfaction with training

-# improvement goals, plans, and performance measures

-# & type mentoring opportunities; satisfaction
-# consultation/referrals between teams

-# & type linkages to community services; # agreements/partnerships
-# active coalitions, membership
-# meetings

SHORT-TERM OUTCOMES

-↑ timely access to specialized services when needed

-↑ adv. knowledge & skill to recognize & assess dementia, delirium &frailty

-↑knowledge & skill to co-develop a care and support plan with PWD and their care partners

- Seamless information sharing & follow-up care from PC Physician

-↑ knowledge & skill to recognize, assess & treat dementia, delirium & frailty

-↑ knowledge & skill to manage geriatric syndromes

-↑support from embedded Level 2 team to manage people with dementia

-↑partnerships with community services & program

-shared vision and work plan with impact statements

INTERMEDIATE OUTCOMES

-↑primary care capacity to recognize, treat & support a range of geriatric syndromes

-↑ primary care capacity to assess function/diagnosis

-↑patient & family knowledge
-↑patient & family supports
-↑patient & family satisfaction with care

-↑availability & access to community supports & services
-↑self-efficacy to recognize, assess & treat dementia, delirium& frailty
-↑ self-efficacy to manage geriatric syndromes

-↑inter-professional collaboration & decision making among level 1 & 2 teams & community supports/services

-shared learning & transfer of knowledge across participating PCNs
-shared learning & transfer of knowledge for system integration

LONG-TERM OUTCOMES

-Earlier recognition of frailty, dementia & delirium

- Timely accurate diagnosis

-Timely access to the most appropriate & right amount of care

-Improved relational continuity with primary care provider

-Comprehensive, whole person centered care

-Coordination and service integration around needs of patient

Health system ROI:
-↓avoidable ED visits
-↓institutionalization
-↓hospitalizations

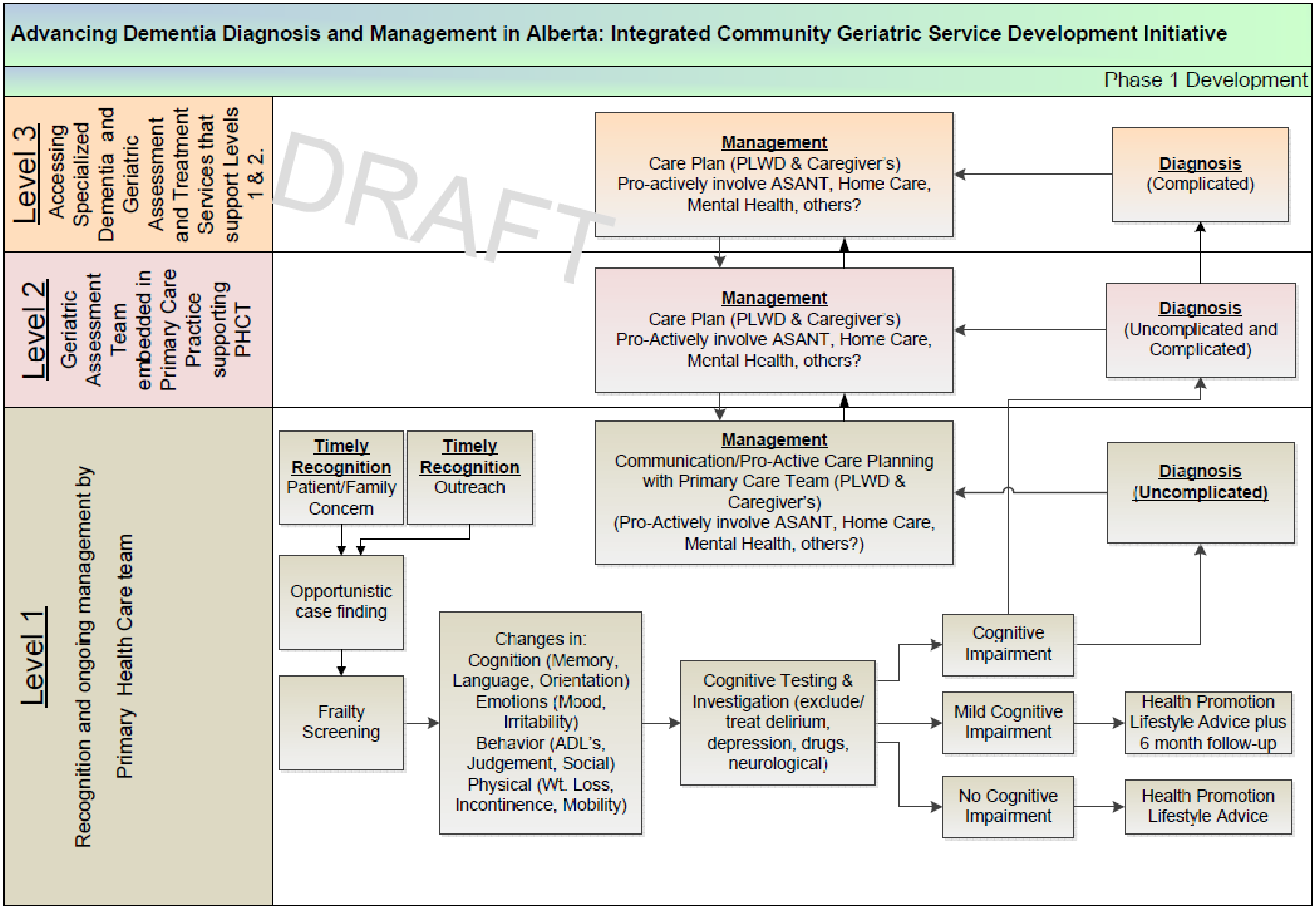
-QoL ROI- Patients, Family, Caregivers, Workers

-shared learning & sustainability of ICGI across PCNs in Alberta

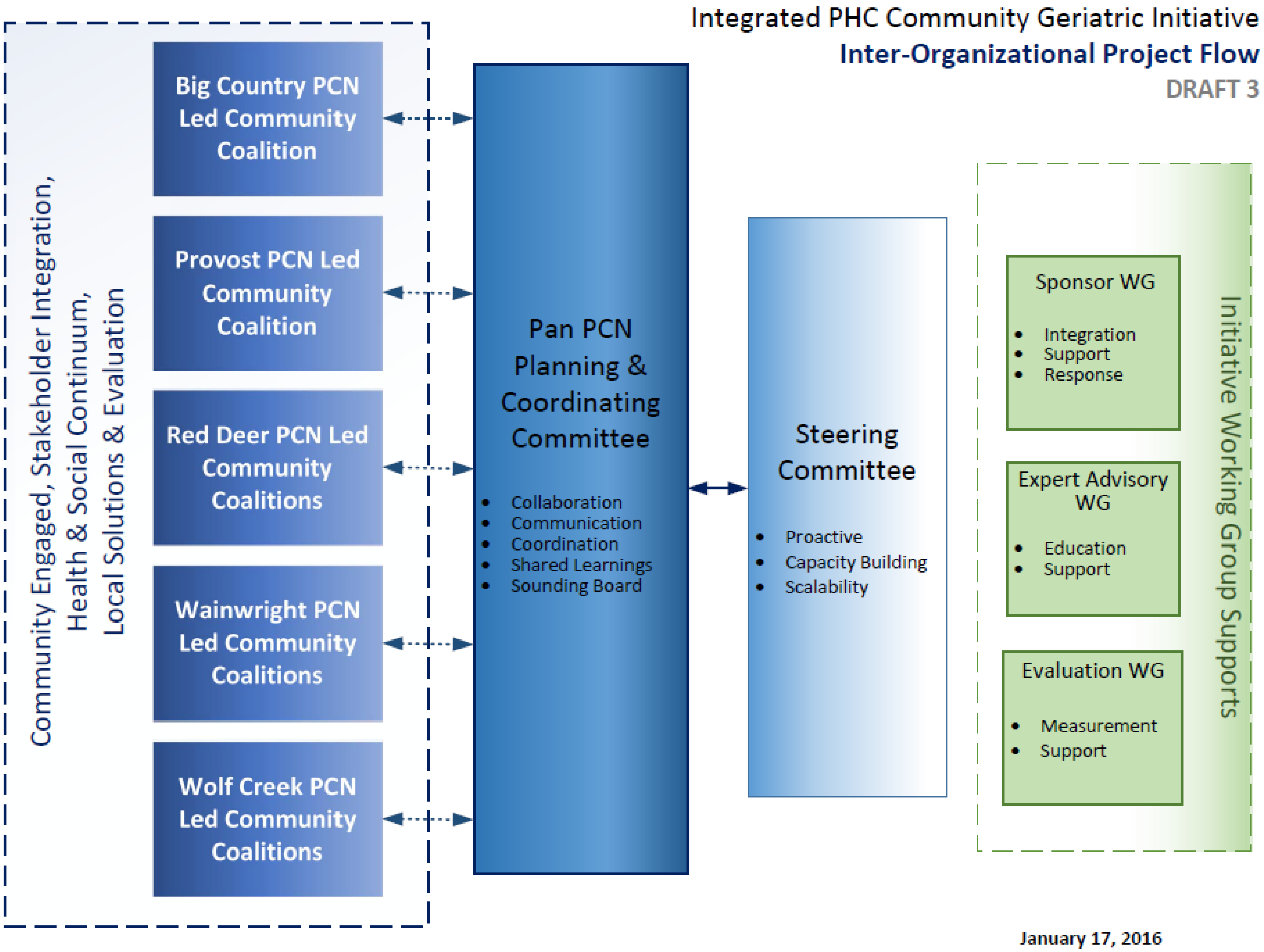
The essence of the ICGSI is to enhance primary care provider capacity to recognize, diagnose and manage dementia and other geriatric syndromes in the community. There are two overarching Goals: (1) Provide timely & accurate diagnosis and (2) Create a coordinated pro-active approach to on-going management of dementia in order to live well with dementia in the community.

Assumption: the starting point for each PCN varies, the intent is to start small, learn from each PCN, share learnings across the 5 participating PCNs, and consider scale and spread options to other PCNs across the province.

INTEGRATED GERIATRIC TEAMS CLINICAL WORKFLOW DIAGRAM



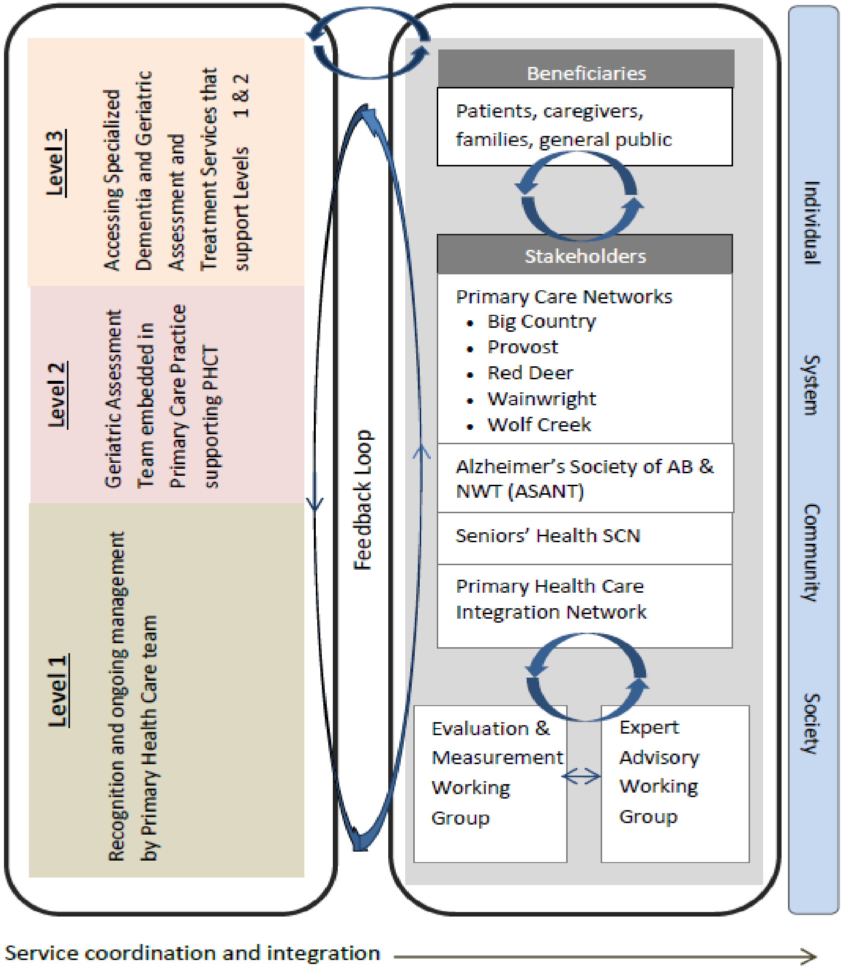
INTER-ORGANIZATIONAL IGSI INFRASTRUCTURE


Integrated PHC Community Geriatric Initiative
Inter-Organizational Project Flow
DRAFT 3

January 17, 2016

TRACKING AND MONITORING COMPLEXITY WITHIN THE IGSI

Integrated Community Geriatric Service Development Initiative: Complexity Considerations and Challenges



Integrated Geriatric Service Development Initiative complexity issues include:

Multiple Partners with Varied Levels of Support
The initiative is being implemented in five Central Zone PCNs with potentially varied levels of organizational support and resources and with multiple community partners operating at different levels. Varied levels of support and resources within PCNs may impact the iterative, interactive process of this developmental evaluation approach. In developmental evaluation timeliness of reporting on data is critical[1]. PCN capacity to report on, and integrate timely learnings from emerging data in an uncertain environment of innovation with rapid change may, in some ways, be challenging.

Stakeholder Internal and External Factors Influence Processes & Outcomes
Multiple internal and external factors within PCNs and other participating stakeholder organizations may influence the effectiveness of the initiative in varied ways, thereby creating challenges in assessing what contributing factors are resulting in desired changes at the individual, system, community and societal level.

Feedback Loops
Many complex interventions are dependent on activation of a "virtuous circle" whereby an initial success creates conditions for future success–this requires evaluation to gather early evidence of these small changes and track the changes throughout implementation of the initiative[2]. Evaluation for complex initiatives requires on-going rapid feedback for those involved in implmentation[3]. This initiative requires considerable set up of monitoring and feedback systems to incorporate continuous real-time feedback into an evaluation cycle that is able to effectively track change throughout initiative implementation.

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1 Gamble, J. A Developmental Evaluation Primer. http://www.mcconnellfoundation.ca/de/resources/publication/a-developmental-evaluation-primer

2. Rogers, P. (2008). Using program theory to evaluate complicated and complex aspects of interventions. *Evaluation*, 14(1),29-48DOI:10.1177/1356389007084674

3. Hummelbrunner, R. (2011). Systems thinking and evaluation. *Evaluation*. 17(4)395-403 DOI:10.1177/1356389011421935

APPENDIX H: CONTINUOUS QUALITY IMPROVEMENT & COMMUNICATION PLAN

Continuous Quality Improvement (CQI) Plan

Review of IGSI progress will take place on a quarterly basis. Some evaluation questions and performance measures will require more or less frequent review (e.g., assessing learning collaboratives; clinician satisfaction; health team effectiveness and self-efficacy) and these methods will be outlined in the evaluation data matrix. Working groups will review evaluation data to see if the results match those anticipated, and where there may have been issues or successes in implementation. The evaluation and measurement review committee will also monitor the developmental feedback monitoring complex initiative processes. For each evaluation and performance measure indicator, the template below can be completed to help in determining where and how to make changes to project goals or outcomes (as required), and where outcomes were successfully met.

The results in this table will be included in summary reports of findings for the indicators, and participants can make use of the template to refine and design their own additional quality improvement plans. An outline for a detailed continuous quality improvement plan will be developed once the inter-organizational teams participating in workshops, learning collaboratives and PDSAs has established their improvement goals and performance measures. The purpose of integrating the template below into the evaluation framework is to highlight the importance of reviewing evaluation data to make recommendations for changes, enhancements or modifications to current activities, projects, programs or services.

Indicator findings	Anticipated results	Decision for change	Timeframe	Responsibility	Resources required

Communication plan

The likelihood that evaluation findings are used is improved when evaluation findings are communicated directly with intended users of the evaluation (e.g. executive directors, team members, clinic managers, decision-makers, community partners in integrated care planning). In order to communicate the results, a communication plan needs to be designed to ensure that results are communicated in a timely and appropriate manner to the appropriate audience[2].

The frequency and outline for following types of communication/reports will need to be developed:

- Evaluation reports – these reports communicate the overall findings of the evaluation process and should be completed quarterly

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[2] A communications plan will need to be developed further once it is determined what types of data collection templates/reports will be used to gather data; what types of information summary reports of findings should be included for each audience (i.e. what to report to the steering committee versus partners); the required reporting frequency to meet the steering committee's needs; and the resources dedicated to reporting and disseminating results to all stakeholders.

- Trend analysis reports – these reports detail the ongoing findings from performance indicators, highlighting trends in results over time
- Presentation of results to PCNs and community stakeholders – define how and when results should be best communicated, via different methods (e.g. annually via email; updates at conferences/workshops, etc.)
- Presentation of results to internal IGSI team members

The communications plan may need to accommodate for primary intended users who are internal and external to the collaborating organizations. The following needs to be considered when developing the plan:

- What types of findings would be relevant to each audience
- Who is best suited to deliver the message to each audience
- The best means of delivering the message to each audience
- The expected impact or intended use of the message (e.g. will the results be used for quality improvement, employee recognition, etc.)

The level of detail and presentation style of the information will likely need to be adapted to meet the needs of different audiences. For example, some audiences may prefer an executive summary that describes the bottom line, while other audiences will need full details of all activities, outputs and outcomes.

Report Dissemination Strategy

Report type	Timeline for completion	Stakeholder groups	Means of dissemination (by stakeholder)

Appendix F: PHC IGSI Evaluation Questions

Domain	Evaluation Questions
Workshop, Education & Learning	1. Do workshops provide an engaging learning environment for participants? 2. Have communities hosted local Education Days for team members that did not attend workshops?
Quality Improvement	3. To what extent do communities/teams engage in quality improvement and the identification and collection of performance measures to monitor progress? 4. Do the educational, learning and planning activities conducted at workshops transfer to practice improvements? 5. What quality improvement measures and goals have been set by teams?
Persons Living with Dementia (PLWD) & Care Partner	6. Is there an increase in care partner knowledge of dementia, care plans and options? 7. Is there an increase in care partners' self-efficacy to care for persons with dementia? 8. What are the PLWD and care partners' level of satisfaction and experiences with providers/teams providing care? 9. Is the self-reported quality of life of PLWD and care-partners improved? 10. Do care partners and PLWD have a care plan that connects them to the right services at the right time? 11. Are home care referrals consistent, timely and ensure that all families who need assistance can access it? 12. Is availability and access to community supports and services enhanced? 13. Is coordination and service integration around the needs of patients and care partners enhanced?
Health Care Providers & Clinic Teams	14. Is there an increase in knowledge and skill among team members (self-efficacy) to better recognize (earlier and more effective), assess and treat dementia, delirium & frailty; to co-develop a care and support plan for PLWD and their care partners; and to better manage geriatric syndromes? 15. Is there a change in clinical or community team composition? 16. What are the experiences of providers with education, workshop and mentoring activities? 17. Is there increased referral and support from embedded level 2 teams to manage PLWD? 18. Was information provided to teams about patients on their panel of value (i.e., informed diagnoses, care planning, identify areas of QI and impact)?
Community coalition, Inter-organizational & Service Integration	19. How has the journey from initiative start-up to collaboration and service integration unfolded across time? 20. Has there been a reduction in duplication or competition of services? 21. Are partnerships with community services and programs enhanced and integrated in care planning? 22. Are inter-organization connections enhanced through shared goal setting and planning (i.e., Home Care, Mental Health, and clinic with the PCN)? 23. Is there increased primary care capacity to assess function/diagnosis?

Domain	Evaluation Questions
	24. Is there an increase in inter-professional collaboration and decision making among level 1 & 2 teams & community supports/services? 25. Is there shared learning & transfer of knowledge across participating PCNs enhancing system integration? 26. Can shared learning and integrated service models be scaled up across additional PCNs?
Referral, Assessment & Diagnosis	27. Is there more timely and accurate diagnosis of dementia, delirium and frailty by teams within primary health care? 28. Are there more appropriate referrals for PLWD where less referrals to specialized services and more and/or earlier referrals to other programs such as home care and community mental health may be expected? 29. What is the number of referrals made to specialists for PLWD? 30. For PLWD, does the proportion with cognitive assessment reviewed within a 12-month period increase? 31. Is there timely referral and access to specialized services?
Health Care System	32. Has information continuity and other aspects of team effectiveness increased? 33. Are more PLWD seen in primary care within 30 days after discharge from a non-elective hospital stay for dementia or related geriatric syndrome? 34. Does the relational continuity that persons living with dementia (PLWD) have with primary care providers and medical homes increase? 35. Are unplanned hospitalizations of PLWD decreased? 36. Among PLWD, is there a decrease in admissions to acute care that have not been assessed for alternate level of care while at home? 37. Among PLWD, are avoidable ED visits reduced? 38. What number/types of medications were patients with dementia prescribed?

Appendix G: Statistical Tests for Data Analysis

Collected data were statistically analyzed using SPSS.

Measure	Statistical Test/Analysis
Dementia Knowledge Scale	• Independent samples t-test pre-post ECAC involvement
Dementia Attitudes Scale	• Independent samples t-test pre-post ECAC involvement
Perceived Self-Efficacy in Dementia Care	• Independent samples t-test pre-post ECAC involvement
Satisfaction with Life	• Independent samples t-test pre-post ECAC involvement
Revised Scale for Caregiving Self-Efficacy	• Independent samples t-test pre-post ECAC involvement

Appendix H: Survey Results of PHC IGSI Level 1 Workshop #1, #2 & #3

PHC IGSI Workshop #1 Evaluation

We have a total of 49 participants that responded to this evaluation survey from an estimated 90 participants that attended the workshop, which gives us a response rate of 54%.

Section A: About you.

1. What organization are you representing at this session today?

Respondents: 34/49 = 69%

Organization	(N) participants	Percentage
Big Country PCN	2	6%
Provost PCN	2	6%
Red Deer PCN	10	29%
Wolf Creek PCN	13	38%
Other ○ PCN ○ Seniors Health SCN ○ Primary care/ homecare RN ○ Family Services of Central Alberta ○ AHS	7 (2) (1) (1) (1) (2)	21% (6%) (3%) (3%) (3%) (6%)

2. Please indicate your profession and / or role on the team:

Respondents: 46/49 = 94%

Role on Team	(N)	Percentage	
Family Physician	11	23.91%	
Pharmacist	2	4.35%	
Nurse Practitioner	1	2.17%	
Dietitian	0	0.00%	
Family Practice Nurse / Clinic Nurse	12	26.09%	
Physiotherapist	0	0.00%	

Public Health Nurse	0	0.00%	
Occupational Therapist	0	0.00%	
Mental Health Nurse	1	2.17%	
Office Manager	1	2.17%	
Social Worker	1	2.17%	
Clerical / Reception Staff	0	0.00%	
Psychiatrist	0	0.00%	
Psychologist	2	4.35%	
Other:	16	34.78%	

#	Other:
1	Mollie Cole
2	Health care programs co-ordinator
3	Home Care RN
4	Managing HCA's @ Adult Day Support Program
5	RN Manager of Specialty Clinics
6	Alberta Health rep
7	Clinical Nurse Educator
8	Seniors outreach nurse program
9	Home Care Case Coordinator
10	RN- Homecare
11	LPN, panel manager
12	Primary Care RN
13	Policy Analyst
14	Alzheimers Society
15	FCSS
16	Indigenous Health Program Coordinator-WHCC

Section B: Overall experience.

1. This workshop was timely and relevant to my current work.

Respondents: 49/49 = 100%

Choice	Percentage	Count	
Strongly agree	55.10%	27	🟦
Agree	38.78%	19	🟩
Disagree	0.00%	0	
Strongly disagree	2.04%	1	🟥
N/A or don't know	4.08%	2	🟪

Additional comments: Unsure where this will lead.

2. The information presented was valuable.

Respondents: 48/49 = 98%

Choice	Percentage	Count	
Strongly agree	62.50%	30	🟦
Agree	35.42%	17	🟩
Disagree	2.08%	1	🟧
Strongly disagree	0.00%	0	
N/A or don't know	0.00%	0	

3. I am satisfied with the organization of this workshop.

Respondents: 48/49 = 98%

Choice	Percentage	Count	
Strongly agree	70.83%	34	🟦
Agree	27.08%	13	🟩
Disagree	0.00%	0	
Strongly disagree	2.08%	1	🟥
N/A or don't know	0.00%	0	

4. Inter-organization connections were enhanced through shared goal setting

Respondents: 47/49 = 96%

Choice	Percentage	Count	
Strongly agree	44.68%	21	🟦
Agree	40.43%	19	🟩
Disagree	8.51%	4	🟨
Strongly disagree	2.13%	1	🟥
N/A or don't know	4.26%	2	🟪

Additional comments: Obvious no one knows what other disciplines are doing.

5. I expect my clinical work to improve as a result of attending this event.

Respondents: 48/49 = 98%

Choice	Percentage	Count	
Strongly agree	31.25%	15	🟦
Agree	47.92%	23	🟩
Disagree	4.17%	2	🟨
Strongly disagree	0.00%	0	
N/A or don't know	16.67%	8	🟪

Additional comments: On a personal level with existing clients.

6. I am motivated to change our team’s practice.

Respondents: 47/49 = 96%

Choice	Percentage	Count	
Strongly agree	51.06%	24	🟦
Agree	38.30%	18	🟩
Disagree	0.00%	0	
Strongly disagree	0.00%	0	
N/A or don't know	10.64%	5	🟪

Additional comments: Know our PCN director is highly motivated to establish programs in our communities. Think for her, she must have realized she'd spent a lot of $'s on what turned out to be repetition for those of us who have been attending meetings

Section C: Workshop Objectives and PHC IGSI Goal

7. Provide information regarding timely recognition of dementia in a primary care setting.

Respondents: 48/49 = 98%

Choice	Percentage	Count
Strongly agree	45.83%	22
Agree	50.00%	24
Disagree	0.00%	0
Strongly disagree	2.08%	1
N/A or don't know	2.08%	1

8. Provide information on dementia assessment in order to accurately capture changes over time, in order to develop a pro-active plan of care and support.

Respondents: 48/49 = 98%

Choice	Percentage	Count
Strongly agree	37.50%	18
Agree	60.42%	29
Disagree	0.00%	0
Strongly disagree	2.08%	1
N/A or don't know	0.00%	0

9. Inform primary health care (PHC) providers how they can help people with dementia understand their illness, support community connections and pro-actively plan for future decision making and care.

Respondents: 48/49 = 98%

Choice	Percentage	Count
Strongly agree	52.08%	25
Agree	43.75%	21
Disagree	0.00%	0
Strongly disagree	2.08%	1

N/A or don't know	2.08%	1

10. Equip PHC providers to assist care partners to understand dementia, manage in their care partner role, support community connections, and plan pro-actively for future decision making and care.

Respondents: 47/49 = 96%

Choice	Percentage	Count
Strongly agree	38.30%	18
Agree	57.45%	27
Disagree	0.00%	0
Strongly disagree	2.13%	1
N/A or don't know	2.13%	1

11. Gain an increased understanding of the health and support needs of people living with dementia.

Respondents: 49/49 = 100%

Choice	Percentage	Count
Strongly agree	44.90%	22
Agree	53.06%	26
Disagree	0.00%	0
Strongly disagree	2.04%	1
N/A or don't know	0.00%	0

12. Initiate planning in order to measure and monitor practice changes based on chosen goals.

Respondents: 46/49 = 94%

Choice	Percentage	Count
Strongly agree	39.13%	18
Agree	56.52%	26
Disagree	0.00%	0

Strongly disagree	2.17%	1	
N/A or don't know	2.17%	1	

13. This workshop will help us achieve our goal to enhance recognition, diagnosis and provide integrated care and support for people affected by dementia.

Respondents: 48/49 = 98%

Choice	Percentage	Count	
Strongly agree	50.00%	24	
Agree	43.75%	21	
Disagree	0.00%	0	
Strongly disagree	2.08%	1	
N/A or don't know	4.17%	2	

Appendix A

Suggestions made for future workshops by themes

Satisfaction with Workshop

- Great w/s. No suggestions to improve. Efficient, organized, and relevant.
- Very well organized.
- Enjoyed format/ good timeline/ interesting topics and essential to initiatives.
- Overall, really excellent workshop. Very impactful. Looking forward to future workshops and exploring other opportunities for integration.

Improvements

Technical

- Improve audio. Speakers working on only 1/2 room
- Sound. Couldn't always hear participants

Workshop

- Not a good use of my time. All this is basic knowledge. This info would be good for teaching nursing students or general public looking to understand dementia. Not physicians and professionals. Lost an opportunity to re-envision and redesign system. Missed opportunity. Do not think people will come to another session.
- Please encourage presenters to stay on time. More access to staff working in AHS and PCN-education
- Include community-based agencies who serve those older adults NOT connected to medical interventions. Golden Circle- Monica Morrison. Grassroots community based programs are needed! And after 5PM most definitely!
- Concentrate more on how to [realign] AHS and Primary Care Networks to better care for older patients.
- Would be helpful to have access to the attendee list to know who was present at the event and how to connect with them.
- Groups/ PCN's are at different stages of development. Might be useful to know what those further ahead are doing that might help other groups get up to speed.

Future Workshop Planning

- More involvement of the registrants
- Maybe more time to collaborate as teams (likely as today was a lot of information sharing as prep)
- More group activities
- More breaks/ exercise/ stretch activity
- Nothing I can think of to improve the workshops but have MORE workshops.
- Less didactic lecture, more team collaboration/planning. Stand-up tables in the back, so I can still write notes but not have to sit all day
- More networking time would be helpful
- More emphasis on planning services.

Appendix B

The areas of the workshop participants asked for additional knowledge based by PCN.

Big Country PCN	
• How best to implement this in a distributed fashion across a large geography with limited resources.	
Wolf Creek PCN	
• Respite for caregivers	
Sylvan Lake	Resources available/ where to find them
Rimbey	I'd like to know more about the steps required to get a diagnosis of dementia.
Ponoka	How the PCN can help the ER flow better
Innisfail	Successes and measurement of improvement trends Integration of systems. Ex. H.C. with physicians with PCN with stakeholders
Provost PCN	
Drug-related dementia's. How are they being supported?	
No PCN Mentioned	
• How the community coalitions are linked to other similar community groups that are addressing chronic disease prevention and management, if at all. • As a homecare nurse, we can be a vital 1st link. Try to convince our Home Care supervisor that we ARE the 1st link and allow us to case manage individuals with dementia, allow us to be nurse navigators. • Accountability for cognitive testing. What should practitioners do when the get a low Mme? • Time to simply make the admin changes needed in our healthcare system to meet patient needs. • Planning and implementing Dementia care in a timely and effective way- methods, ideas • Know who to call • I need to know more about everything. I am relatively new to the enterprise.	
Other Organizations/ Community Partners	
Alberta Health Services	
• How home care is involved/ informed of all these initiatives	
Family Services of Central Alberta	
• Why home care can't send consistent home care workers into Dementia homes. Respite needs to be trusted. They need Dementia training!	

Appendix C

The areas of the workshop participants felt the greatest personal impact

General Impact
Excitement for potential of great care for our clients with dementia.
Start early with support!
All the connections and information about what is happening to advance dementia care in the central zone.
Very in-depth day on Alzheimers vs addressing the next step of program implementation. Obvious at the end that the "left hand doesn't know what the right hand is doing"
Networking is key. AHS hardly offer courses/ seminars in large groups with other health professionals. Being able to meet with other individuals allows us to learn more!
Activity-Provost Primary Care Network Geriatric Services: A Team Approach
Stories, teamwork approach.
Activity- Care Partner Experience
Mark's story
Mark's presentation
Caregiver presentation
Care partner story- compassion of ca diagnosis support vs. dementia
The experience Mark provided as a care partner. From a policy, planning perspective, this provided a very sobering view of need to realize and support the shift to person-centered care. Learning in-depth about the role and programs that the Alzheimer Association has to offer.
Mark's story
Care partner story, ASANT, bringing in how important the role of the care partner is in the presentations, how important collaboration/ partnerships are to advance this work!
So thankful for being invited. Caregiver discussion- a great example of our gaps. Talk to those who know the gaps. Read ALL complaints and change the system accordingly.
Mark Johnson's story: very eye-opening. Helped paint a more in-depth picture of the care-giver experience
Activity- Recognition of Dementia, Delirium, Depression and Frailty in the Community
Learning how to recognize the signs
Duncan's presentation and the Alzheimer’s Society presentation
Dr. Duncan Robertson's presentation on Dementia, Delirium, Depression and Frailty: Informative and applicable.
How to screen for dementia to get the full picture (collateral information)!

Activity- The Dementia Experience and a Proactive Approach to Care
The Alzheimer Society. What they can do for the caregivers and clients. Support from the workshop as well.
I was a bit tardy, but I really found "The Dementia and a Proactive Approach to Care" most impactful
Family presentation
Learning about IGSI, and "thought model" that Alzheimer's Society uses to educate patients/family
Learning in-depth about the role and programs that the Alzheimer Association has to offer.

Activity-Collaborative Planning Activity & Team Planning Session
Networking and collaboration
The team action planning session and hearing the other team’s plans. Gave more ideas! Collaboration and communication is so key!
Breakout action planning
Collaboration with others about community needs/ gaps
Group-team/ brainstorm
Hearing what all the various PCN's are doing. Where they see their gaps and strengths
Final workshop of the day
Planning phase
Discussing actual cases
Group discussion about PCN Geriatric service provision
Being able to connect with physicians and try to form an action plan to work together better.
Team/ community discussions

If you have any questions regarding the evaluation of the PHC IGSI, please contact Dr. Scott Oddie, the Director of Measurement and Knowledge Integration on the Applied Research and Evaluation Services team by email: Scott.Oddie@albertahealthservices.ca

PHC IGSI Workshop #2 Evaluation

We have a total of 62 participants that responded to this evaluation survey from an estimated 100 participants that attended the workshop, which gives us a response rate of 62%.

Section A: About you.

1. What organization are you representing at this session today?

Respondents: 53/100 = 53%

Organization	(N) participants	Percentage
Aspen Heights PCN	2	4%
Big Country PCN	7	13%
Red Deer PCN	12	23%
Wolf Creek PCN	10	19%
Other	22	42%
○ AHS	(3)	(6%)
○ AHS Home Care	(1)	(2%)
○ AHS Senior’s Mental Health	(1)	(2%)
○ AHS Specialized Geriatrics – Home Care	(1)	(2%)
○ Alzheimer’s Society of Alberta & Northwest Territories	(4)	(8%)
○ Community Care Transition Services	(1)	(2%)
○ Family & Community Support Services	(2)	(4%)
○ Golden Circle Resource Center	(1)	(2%)
○ Long Term Care	(1)	(2%)
○ PCN	(2)	(4%)
○ No Specific Organization	(5)	(9%)

2. Please indicate your profession and / or role on your team:

Respondents: 60/100 = 60%

Choice	Percentage	Count
Family Physician	23.33%	14
Pharmacist	1.67%	1

Nurse Practitioner	1.67%	1
Dietitian	0.00%	0
Family Practice Nurse / Clinic Nurse	28.33%	17
Physiotherapist	0.00%	0
Home Care Staff Member	1.67%	1
Occupational Therapist	0.00%	0
Mental Health Nurse	3.33%	2
Office Manager	3.33%	2
Social Worker	3.33%	2
Clerical / Reception Staff	0.00%	0
Psychiatrist	0.00%	0
Psychologist	1.67%	1
Other:	33.33%	20

#	Other:
1	Evaluator
2	Community Support Services Outreach
3	Discharge Planning RDRHC
4	Improvement Facilitator
5	Patient Advisor SCN Seniors Health
6	PCN RN
7	Care Partner
8	Family
9	Chronic Disease Nurse
10	Chaplain
11	Provincial Client Service Lead Assant
12	Clinical Nurse Educator
13	Director

14	Manager
15	LPN- Chronic Disease Management
16	Care Partner
17	Staff nurse
18	One on one support : FCSS
19	FCSS
20	FCSS Director

Section B: OVERALL EXPERIENCE.

1. This workshop was timely and relevant to my current work.

Respondents: 62/100 = 62%

Choice	Percentage	Count
Strongly agree	67.74%	42
Agree	29.03%	18
Disagree	0.00%	0
Strongly disagree	1.61%	1
N/A or don't know	1.61%	1

2. The information presented was valuable.

Respondents: 62/100= 62%

Choice	Percentage	Count
Strongly agree	74.19%	46
Agree	24.19%	15
Disagree	0.00%	0
Strongly disagree	1.61%	1
N/A or don't know	0.00%	0

3. I am satisfied with the organization of this workshop.

Respondents: 62/100=62%

Choice	Percentage	Count
Strongly agree	70.97%	44
Agree	27.42%	17
Disagree	0.00%	0
Strongly disagree	1.61%	1
N/A or don't know	0.00%	0

4. Inter-organization connections were enhanced through shared goal setting.

Respondents: 62/100 = 62%

Choice	Percentage	Count
Strongly agree	53.23%	33
Agree	40.32%	25
Disagree	0.00%	0
Strongly disagree	1.61%	1
N/A or don't know	4.84%	3

5. I expect my clinical work to improve as a result of attending this event.

Respondents: 61/100=61%

Choice	Percentage	Count	Score
Strongly agree	37.70%	23	
Agree	49.18%	30	
Disagree	0.00%	0	
Strongly disagree	0.00%	0	
N/A or don't know	13.11%	8	

6. I am motivated to change our team’s practice.

Respondents: 61/100=62%

Choice	Percentage	Count
Strongly agree	54.10%	33

Agree	34.43%	21
Disagree	0.00%	0
Strongly disagree	1.64%	1
N/A or don't know	9.84%	6

Section C: WORKSHOP OBJECTIVES & PHC IGSI GOAL

7. Introduce the 5Ms approach as a framework to assist planning care and support for those living in the community with dementia.

Respondents: 61/100=61%

Choice	Percentage	Count
Strongly agree	63.93%	39
Agree	36.07%	22
Disagree	0.00%	0
Strongly disagree	0.00%	0
N/A or don't know	0.00%	0

8. Based on the 5Ms approach to geriatric care - provide information on Mind, Mobility, Medications, Multi-complexity and what Matters most.

Respondents: 61/100=61%

Choice	Percentage	Count
Strongly agree	65.57%	40
Agree	31.15%	19
Disagree	1.64%	1
Strongly disagree	0.00%	0
N/A or don't know	1.64%	1

9. To learn what actions teams have taken to improve care and support for those living in their communities with dementia.

Respondents: 60/100=60%

Choice	Percentage	Count

Strongly agree	55.00%	33	
Agree	45.00%	27	
Disagree	0.00%	0	
Strongly disagree	0.00%	0	
N/A or don't know	0.00%	0	

10. This workshop enhanced my knowledge of how to recognize, diagnose and develop an integrated care plan for those living with dementia with dementia and frailty in the community.

Respondents: 61/100=61%

Choice	Percentage	Count	
Strongly agree	52.46%	32	
Agree	47.54%	29	
Disagree	0.00%	0	
Strongly disagree	0.00%	0	
N/A or don't know	0.00%	0	

Section D - OTHER THOUGHTS WE'D LIKE YOU TO SHARE:

11. What part of the workshop had the greatest impact on your learning experiences?

Respondents: 56/100=56%

11. What part of the workshop had the greatest impact on your learning experiences?
The segment on capacity assessing.
Understanding what was happening across central zone. Care partner stories. Session on Mind and assessing capacity.
Networking
Development of personalized integrated care & support plan RD PCN ECAC Team
Clinic experiences
Mind-session
The case studies Decision Making PIC's Plan/Capacity
5M's

Clinical info shared in break out sessions that I can apply to my work i.e.: Falls Ax
Learning about the systems that are already started and their success & challenges
Break out sessions discussions throughout
Mobility & Multicomplexaty
5M's - Plan
The 5M's - the importance of community networking/partners
Understanding the universality of challenges throughout the province
Capacity Accessing& Mobility - Driving Excellent Info :&Presenters
Dr. Robinson multi-complexity session : As a diabetes educator I feel as though I'm a contributor to the polypharmacy as I endeavour to improve/lengthen young people's lives. Light bulb moments
Dr. Robertson’s workshop . Very informative and interesting
Other community initiatives and development Break out sessions
So many people working/striving to improve how services delivered in communities
The breakout session with Jasmeet Parmar was most beneficial in my learning in decision making with capacity assessment
Mind break out session
Capacity assessment
Frailty - multi complexity Capacity assessment
5M's
Meds break out
All Dr. Robertsons info! Understanding capacity assessment process Hearing what other groups are trying
Break out sessions & report outs by 4 communities
Multi-complexity break out session
break out sessions
Capacity Assessment
Capacity talk
Capacity
The definition of capacity

5M's team presentation
Multi-complexity
Attempting to improve the patient experience +/o this experience
Dr. Chan's presentation mobility assessment & driving
I attended Mobility- great information regarding driving & assessment for fraility
Excellent Dr.Robertson's initial talk/ full session/ Dr.Parmar v. - Good also
Break out- medicine, mobility
Dr. Robertsons talk on frailty Frame work of 5M's
(not legible)
Hearing what other places are doing
The break out sessions on mobility and multi complexity were very interesting
Meeting with our community and seeing the 5M's in practice at the start of the day
Matters Moore / Tremendous organization & communications before Multi Complexity / & during
Talk on capacity
The increase in (not legible) we going to see
Presentations from experts in their fields
Capacity decision making
Multi complexity and the role of prevention/intervention especially as it relates to protection of brain health
Information from other groups about how they see our services interacting. Ideas sharing was fabulous - interesting to see the common ideas that are shared by many.
Capacity assessment Dr. Robertson
Polypharmacy
Frailty info was great -mind & multi complexity sessions -more info on PCN Directives

Appendix A

Suggestions made for future workshops by themes

Satisfaction with Workshop
• Well organized: Excellent content • Content, time allotments & break up of activities flowed well • I thought the workshop went well today & looking forward to the next workshop • It was great • Thoroughly enjoyed it • Thought it was an excellent format • Extremely well organized and executed workshop • Excellent & well organized! Well done • I thought two formal sessions with interactive exercises were a nice balance • I have a few gems from each speaker today that I will bring back to my PCN

Improvements
Technical
• Larger space required. • Should have a microphone • Hard to see front display • Better signs indicating how to get to room • No small group work in room: to small to handle (noise, lack of space etc)
Workshop
• Start at 9…easier for those 1-2 hours away to get here • Allow more time for questions • Invite/involve health care workers not associated with PCN. These individuals need to know about PCN programs. Education offered by PCN's is current and useful. • Provide slides prior to presentation to facilitate note taking • A bit more time for discussion with our partners because we are such a large group • Healthier food • More break -out sessions made a little shorter so you can see more • More time for break-out sessions • As we move past initial development it would be good to have specific program ideas to try • Slightly more in-depth

- 2 breakout sessions were great. Wish I could do all 4. less interested in AHS lab
- Continue please to invite care partners
- Extra time at end of day for Q&A?
- Make it 2 days
- I would have liked to go to all of the talks today - somehow ensure time to hear all speakers.
- start discussions on how to build community capacity to support people suffering dementia and vulnerable in their community (informal support)
- Keep practical
- Share all of the info discussed with the group
- Less clinical- more social services focused - what agencies can do for patients
- Induce some community care approaches for the ones that aren't here from PCN or a physician
- How to start organizing as we are at the beginning
- Break-out session with same one as dementia (mild - mod)
- Break-out session from a care provider Dementia village in rural setting
- Complaints: that we were not able to attend all break-out sessions

13. Are there any topics you'd like to know more about?

Respondents: 26

13. Are there any topics you'd like to know more about?
Capacity assessment
End of life care
Long term care - it has a lot of the same issues but also issues specific to that environment
Workforce education & training
Medications: multi-complexity
Mobility Driving issues
Caregiver supports
There was talks in breakout sessions that I missed i.e.: multicompletxity - wished that I was able to hear all the topics instead of 2
How and where the stigma regarding dementia has been successfully broken down
Behavior management / individual care planning
Tips on filling out the 5M care plan. Screening tool use

Cognitive Screening
Palliative care End of life in dementia
Vulnerability in seniors - Building resiliency
Collaboration
What matters most to people with dementia and their care providers
Tools of flags to identify diagnosis of dementia and MCI
Prevention/Early intervention

14. As your work and learning on improving care for those with dementia progresses, how might the PHC-IGSI Team (Sharon, Charlene, and Karen) support you and your team?

Respondents: 34

14. As your work and learning on improving care for those with dementia progresses, how might the PHC-IGSI Team (Sharon, Charlene, and Karen) support you and your team?
Continue to be available
Further education for community and level 1
To have some community support stakeholders @ the table that are able to support care partners in the journey
Collaboration and sharing with other health care providers not PCN connected. e.g.. AHS acute care -Provincially shared EMR, accessible by PCN & AHS sites -Duplication of services thereby confusion of clients accessing programs & services
Updates on all clinics successes & team focuses
Keep up the present directions
As our community is in preliminary stages additional supports & guidance to achieve goals. Promotion of community collaboration
Come talk to our doctors and our staff
Communication & Education
Action planning, connections networking. Education
Continuing Educational support
Continue to do what you do -do follow up sessions with care partners as discussed
Stay connected
Would be excellent support & Help

Being a phone call or email away.
Resource integration
Continued follow up
Acknowledge individual PCN priorities for dementia and support the same financially.
Keep including the Alzheimer Society so we can support you to
A presentation to RMH pCN?HOme Care/ Acute Care
Continued contact for resources (speakers, evaluators, referrals to 'key expertise').
Continued check ins with our team to keep the momentum going (Amanda - Drumheller)
Continued support
Continue network building and information sharing
Share inputs from each workshop
Come to our region & meet with doctors & PCN staff - Thank You
Will look forward to more involvement and input for care partner volunteer/education & practical mentoring
Share all the info discussed with the group
Help with a conversation with the "team" in our communities
Come to Lacombe
In clinic information session
Keep doing what you are doing
Education opportunities for communities

PHC IGSI Workshop #3 Evaluation

We have a total of 67 participants that responded to this evaluation survey from an estimated 119 participants that attended the workshop, which gives us a response rate of 56%.

Section A: About you.

1. What organization are you representing at this session today?

Respondents: 67/119 = 56%

Organization	(N) participants	Percentage
Aspen Heights PCN	1	1.5%
Big Country PCN	2	3%
Red Deer PCN	9	13%
Wolf Creek PCN	6	9%
Other	53	79%
○ **AHS**	(5)	(7%)
○ **AHS Central Zone Palliative Care Team**	(1)	(1.5%)
○ **AHS Home Care**	(1)	(1.5%)
○ **AHS Transition Services**	(1)	(1.5%)
○ **AHS Specialized Geriatric Services**	(3)	(4%)
○ **Alzheimer's Society of Alberta & Northwest Territories**	(1)	(1.5%)
○ **Brenda Stafford Foundation**	(1)	(1.5%)
○ **Big Country Community Practice**	(1)	(1.5%)
○ **Family & Community Support Services**	(2)	(3%)
○ **PCN**	(4)	(6%)
○ **RDRH**	(2)	(3%)
○ **WestView Health Centre**	(1)	(1.5%)
○ **No Specific Organization**	(30)	(45%)

2. Please indicate your profession and / or role on your team:

Respondents: 67/119 = 56%

Choice	Percentage	Count	
Family Physician	4.48%	3	▌

Pharmacist	2.99%	2	
Nurse Practitioner	1.49%	1	
Dietitian	0.00%	0	
Family Practice Nurse / Clinic Nurse	37.31%	25	
Physiotherapist	0.00%	0	
Home Care Staff Member	5.97%	4	
Occupational Therapist	1.49%	1	
Mental Health Nurse	4.48%	3	
Office Manager	1.49%	1	
Social Worker	2.99%	2	
Clerical / Reception Staff	0.00%	0	
Psychiatrist	0.00%	0	
Psychologist	1.49%	1	
Other:	41.79%	28	

#	Other:
1	SH SCN
2	Health Care Program Coordinator
3	Transition Service RN
4	SCN Seniors Health
5	Palliative Nurse Consultant
6	Primary Care Nurse
7	Sr Consultant
8	Program Coordinator
9	RN
10	Lawyer
11	Spiritual Health
12	PCN ED
13	Medical Student
14	Registered nurse (in hospital setting)

15	Primary Care
16	Care Partner
17	FCSS Community and Social Development Coordinator
18	Registered Nurse
19	Panel Manager
20	Specialty Program Manager
21	Caregiver
22	Nurse - Long term care supportive living
23	Health Care Aide
24	RN - Community Health Promotion Coordinator and Complex Care
25	Project Coordinator
26	PC Resource Nurse
27	RN
28	RN, Family Nurse

Section B: OVERALL EXPERIENCE.

1. This workshop was timely and relevant to my current work.

Respondents: 66/119 = 55%

Choice	Percentage	Count
Strongly agree	56.06%	37
Agree	40.91%	27
Disagree	0.00%	0
Strongly disagree	0.00%	0
N/A or don't know	3.03%	2

2. The information presented was valuable.

Respondents: 66/119 = 55%

Choice	Percentage	Count
Strongly agree	69.70%	46

Agree	30.30%	20
Disagree	0.00%	0
Strongly disagree	0.00%	0
N/A or don't know	0.00%	0
Total	100%	66

3. I am satisfied with the organization of this workshop.

Respondents: 67/119 = 56%

Choice	Percentage	Count
Strongly agree	62.69%	42
Agree	37.31%	25
Disagree	0.00%	0
Strongly disagree	0.00%	0
N/A or don't know	0.00%	0

4. Inter-organization connections were enhanced through shared goal setting.

Respondents: 65/119 = 55%

Choice	Percentage	Count
Strongly agree	50.77%	33
Agree	38.46%	25
Disagree	3.08%	2
Strongly disagree	0.00%	0
N/A or don't know	7.69%	5

5. I expect my clinical work to improve as a result of attending this event.

Respondents: 67/119 = 56%

Choice	Percentage	Count
Strongly agree	59.70%	40
Agree	29.85%	20
Disagree	1.49%	1

Strongly disagree	0.00%	0
N/A or don't know	8.96%	6

6. I am motivated to change our team’s practice.

Respondents: 65/119 = 55%

Choice	Percentage	Count
Strongly agree	46.15%	30
Agree	36.92%	24
Disagree	0.00%	0
Strongly disagree	0.00%	0
N/A or don't know	16.92%	11

Section C: WORKSHOP OBJECTIVES & PHC IGSI GOAL

7. Explore how a personalized, palliative approach applies to providing late life dementia care and support in community.

Respondents: 65/119 = 55%

Choice	Percentage	Count
Strongly agree	67.69%	44
Agree	29.23%	19
Disagree	3.08%	2
Strongly disagree	0.00%	0
N/A or don't know	0.00%	0

8. Provide practical information and tools to support communication in late life dementia.

Respondents: 64/119 = 54%

Choice	Percentage	Count
Strongly agree	60.94%	39
Agree	35.94%	23
Disagree	3.13%	2
Strongly disagree	0.00%	0

N/A or don't know	0.00%	0	

9. To learn about, and celebrate what teams have achieved to improve care and support for those living in their communities with dementia.

Respondents: 65/119 = 55%

Choice	Percentage	Count	
Strongly agree	56.92%	37	
Agree	38.46%	25	
Disagree	1.54%	1	
Strongly disagree	0.00%	0	
N/A or don't know	3.08%	2	

10. To highlight the importance of a community approach to providing ongoing care and support in the community for people living with late life dementia and frailty.

Respondents: 65/119 = 55%

Choice	Percentage	Count	
Strongly agree	66.15%	43	
Agree	30.77%	20	
Disagree	1.54%	1	
Strongly disagree	0.00%	0	
N/A or don't know	1.54%	1	

11. Provide clinical information on important late life dementia topics such as communication, symptom management, and holistic care and support.

Respondents: 64/119 = 54%

Choice	Percentage	Count	
Strongly agree	60.94%	39	
Agree	37.50%	24	
Disagree	0.00%	0	
Strongly disagree	0.00%	0	

N/A or don't know	1.56%	1	

Section D - OTHER THOUGHTS WE'D LIKE YOU TO SHARE:

12. What part of the workshop had the greatest impact on your learning experiences?

Respondents: 58/119 = 49%

11. What part of the workshop had the greatest impact on your learning experiences?
all
The music - how it brought the gentleman to life. He was happy and alive. It was incredible
The link between palliative care and dementia talk early. Individualize care plan
the keynote speakers (Kim and Karenn)
sharing ideas, collaboration, and resources.
Presentations from experts and chance to network with people who have common goals.
partner stories
Palliative care communication
Palliative Approach to late life dementia
Pain management.
Networking
Least impact on learning experience - I was hoping for more specifics and information from Dr. Taiwo.
I enjoyed the family story which provide the foundation for day's topic
How to approach the palliative care discussion
Family stories, update on pain, Palliative content videos
Enjoyed listening to Dr Kim although palliative care doesn't apply as much to my work in PCN.
Dr. Kim's Address and the OMA presentation.
Dr. Kim Adzich presentation about palliative care with Dementia
Dr. Kim A's talks were incredible
Break-out sessions
Dr. Adzich's 1st lecture - (NB - ?) to get Palliative Care approach involved early
Dr. Adzich's

Booths @ the back of room Videos of PCN PHC IGSI - great to see how far they (PCN's) have come in this journey. Involvement of caregivers in the agenda and as conference participants Conversation breaks facilitating opportunities to network
all info very informative
Dr Adzich's presentation and Forum
Communicating with Families in Late Life Dementia Care
Change in perspective.
Chance to network and hearing the way other communities are getting the conversations about dementia.
Dementia is a terminal illness Communication techniques for palliative care approach and transition techniques crucial conversations and real life experiences and valuable resources.
Ask my anything, (illegible) families
All of it
Wonderful networking opportunities. Learned about new programs. Seeing the collaboration in the regions was wonderful.
Dr. Adzich
Keynote, workshop on communications, and ask me anything forum.
Networking always and brainstorming solutions
Dr. Adzich's presentation and the breakout session about communication with families.
Seminars
Dr Kim Adzich presentation
Palliative approach to late life dementia care
Dr. Adzich's thoughtful and powerful perspective on late life care.
I loved the videos. Quick way to learn about all the great work being done in the province.
Learning about the 5 PCN's involved and what they have been doing in their communities. Dr. Taiwo's, Dr. Adzich, and Dr. Chan's presentations were great!!
Learning tips on how to initiate early conversations about palliative care, overcome barriers to effective [illegible] and planning
Tools and successful initiatives working for other PCN's. - Review/communication is the "Bridge."
Dr Adzich was amazing and gave me another way to look at end of life care . . . its really just care of life. "you matter"
All good
Dr. Adzich's keynote speech.
Dr. Kim's Presentation
The importance of involving the family in early discussion/planning in preparing for what is to come

Dr. Kim Adzich - keynote
The path of palliative care and dementia is an excellent step forward.
The keynote speaker was very inspiring, because he was inspired. The care partner talk was so practical and we will share his story [illegible] and partners
Excellent knowledge shared. Great speakers and break out sessions. Listening to all the advice to assist in taking my practice to the next level.
Pain management Tools to utilize
Presentation by Central Zone Palliative Care + what communities are doing
The Fabulous talk From Dr. Adzich
So excited to see many aspects of communities connecting. Education about connections between dementia and pall. needs
Enjoyed Dr. Adzichs compassionate/caring interest in palliative care. Was reassuring

13. What suggestions do you have to improve potential future workshops for this initiative?

Respondents: 28/119 = 24%

Suggestions made for future workshops by themes

Satisfaction with Workshop

- Great day.
- It was GREAT, no improvements. Would love to see slides and contact information of attendees.
- N/A
- none
- none - great already
- Nothing I can think of now.

Improvements

Technical

- Instruct speakers on importance and how to use P.A. system. Also get volume a little higher.
- To turn down the AC – Brrr
- Took quite a bit of persistence to get info about the day and what it was to include, who would benefit or even it made sense for me. Glad I persisted.
- Offer decaf coffee please! Thanks! :)
- Main room was VERY cold - quite uncomfortable. Would have liked to have the agenda sent out earlier.

Workshop

- Encourage more interactive discussion to generate more real life challenges and potential situations
- family-centred care, HAI/FOIP, etc. (privacy).
- fan out the info (tips) to family members and community "It takes a Village"
- I think more conversation on how to bring info into the general public, and experience on this.
- Incorporating many different aspects and areas on the same subject works really well and just expanding on that. (Having multiple knowledgeable speakers, etc.)
- increase Networking time
- invite "acute care" AHS employees
- More break out session's
- Longer workshop time. Need extra time for questions and the end of presentations.
- more info on incontinence in the elderly how to engage family in care
- more moving, less sitting
- More time for lunch and to move between sessions.
- Reducing [illegible] to front line workers
- The pain in dementia session was not the best; presenter was disorganized and less engaging
- Was too drawn out
- continual learning
- Please be sure to send out info to all of us in the hospital about upcoming events.

14. Are there any topics you'd like to know more about?

Respondents: 29

13. Are there any topics you'd like to know more about?
Access to Dementia care
Alzheimer's Society programs.
Capacity Assessments
cognition therapy
How the community comes together on social aspects of living with dementia
Medical management and regards to end of life sx
Plans for sustainability. Knowledge dissemination to larger scale (HCAs, family and LTC nurses)
no
Strategies to overcome obstacles faced by small communities.
cannabis for palliative pain management research. How to advocate palliative approach to other professional staff.
Love to learn

Nothing I can think of at the moment a lot to process yet! amazing day!
Community Coalitions
Driving Assessment
If preventative initiatives are starting? Alternative therapies and new research on treatment and prevention.
use of cannabis in elder care
How PCNs can help drive community programs and how we can work PHC-IGSI during our dementia friendly community project. Would love to partner.
Early stage dementia (resources) Use of CBS/medical marijuana for seniors
Communicating with the Non-Verbal
Best ways to engage community create an effective coalition for improved dementia support.
considering where we are headed . . . a professional who understands CBD oil and such in treating pain etc...
No
marijuana in the elderly
Cognitive Assessments.
Please have more workshops on care of the dementia pt and family How we could develop a dementia friendly community in Red Deer => how did other communities start theirs?
Preventative Care of a range of conditions vs waiting until people are in crisis to intervene or plan.
no.
anxiety in pain management (physical/medical/emotional pain)
Lots of questions about how and when to introduce Pall. care - especially given to general all long trajectory that is common.

15. As your work and learning on improving care for those with dementia progresses, how might the PHC-IGSI Team (Sharon, Charlene, and Karen) support you and your team?

Respondents: 32

14. As your work and learning on improving care for those with dementia progresses, how might the PHC-IGSI Team (Sharon, Charlene, and Karen) support you and your team?
Continue supporting smaller communities to implement geriatric framework
Follow up
Great work! amazing to see how much has been accomplished since Workshop #1

continue to allow education/ updates/ pt stories as we move forward with our initiatives
help with planning next steps
Keep up the good work!!
Potentially as the (our) project moves forward.
resources made available
There is so much great work being done and I am much impressed by all of it.
We need to engage more front line AHS staff to attend such as home care and LTC
Provide community-specific directions.
Emensely.
More workshops for front line :) Tnx so much!! Awesome day
Continue to be available for consults and new ideas.
continue to have excellent workshops.
N/A
Lacombe was a terrific site to host inservice
I'm new to my team, so i'm unsure at this time.
Helping us build capacity to meet our goals
Would love to build a community of practice with the dementia friendly communities project. Could we collaborate with PHC-IGSI to do this.
Keep communicating with all organizations within or without AHS.
Offer more education sessions beyond #3. 4, 5, 6...
Dementia = terminal illness "Deprofessionalize dying"
Will learn more through our RD Alz. Society Thanks for connection Charlene, Sharon and Karen. An absolutely wonderful (whole) day!!! Thank you.
Its pretty good already
Help us get started!
always great to know resources available in the region.
More education conferences like this one. Thank you for everything you do.
We are just beginning. The ball is just rolling. please repeat some more of the education, it will help momentum. Continue to share what other communities are doing. This will become standard of care!

If we could get some direction and support in making "PHC-IGSI" a self sustaining local initiative and how to develop Dementia Friendly Community in Red Deer and how I can be part of that (Kathy Sayyad) Red Deer PCN.
Keep open communication with the whole team on progress, updates, etc.
Keep more of these workshops coming! Loved it!

Appendix I: Local Education Topics

Presentation topics delivered at Innisfail:

- Dementia, Diagnosis and What Else Matters
- Falls and Bone Health
- Driving and Dementia
- Capacity Assessment
- Depression/Anxiety recovery
- Frailty in Primary Care

Presentation topics delivered at Three Hills/Kneehill Country

- Case studies also developed to help inform presentations
- 10 facts to know about dementia
- Primary Health Care's role in dementia care
- Signs of dementia, delirium and depression
- Diagnosing dementia
- Troublesome medications
- Driving
- Healthy brain aging

Presentation topics delivered at Drumheller

- Annual Seniors Fair- Oct 2017:
  - Spider Presentation regarding the PHC IGSI, PCN supports available, connecting in the community and early screening for dementia, resources such as the Alzheimer's Society.
- Three Hills Seniors Wellness Day - Nov 2017: (Three Hills Education)
  - Spider Presentation again as above
- Pioneer Trail Center Info Session - Jan 2018:
  - Specifically talking to seniors about dementia, screening, support and resources
- Seniors Pancake Breakfast - June 2018:
  - Seniors Week event- serving seniors breakfast and casual conversations about PHC IGSI, PCN support and community support/connections
- Radio interview on local station - Feb 2018:
  - Information on PHC IGSI and seniors supports in the community
- News article on local Drumheller Online:
  - Same as radio interview above
- BC PCN Website- Creation of Seniors Info Page:
  - Resources for Seniors: Dementia, frailty, community supports
- In-services at the clinic (x 2) for Physicians, PCN RNs

    - Discuss PHC IGSI, dementia screening, patient flow map, visit templates (5M's©), resources
- Workshop Information sent out to the physicians and PCN RNs
    - 2 RNs attended workshop #2 (PCN)
    - 4 RNs attended workshop #3 (PCN and acute care)
- Mental Health First Aid November 2018 - Booth during coffee breaks with information on PHC IGSI, Community Connections, and Screening and Resources on Dementia

Presentation topics delivered at Red Deer PCN

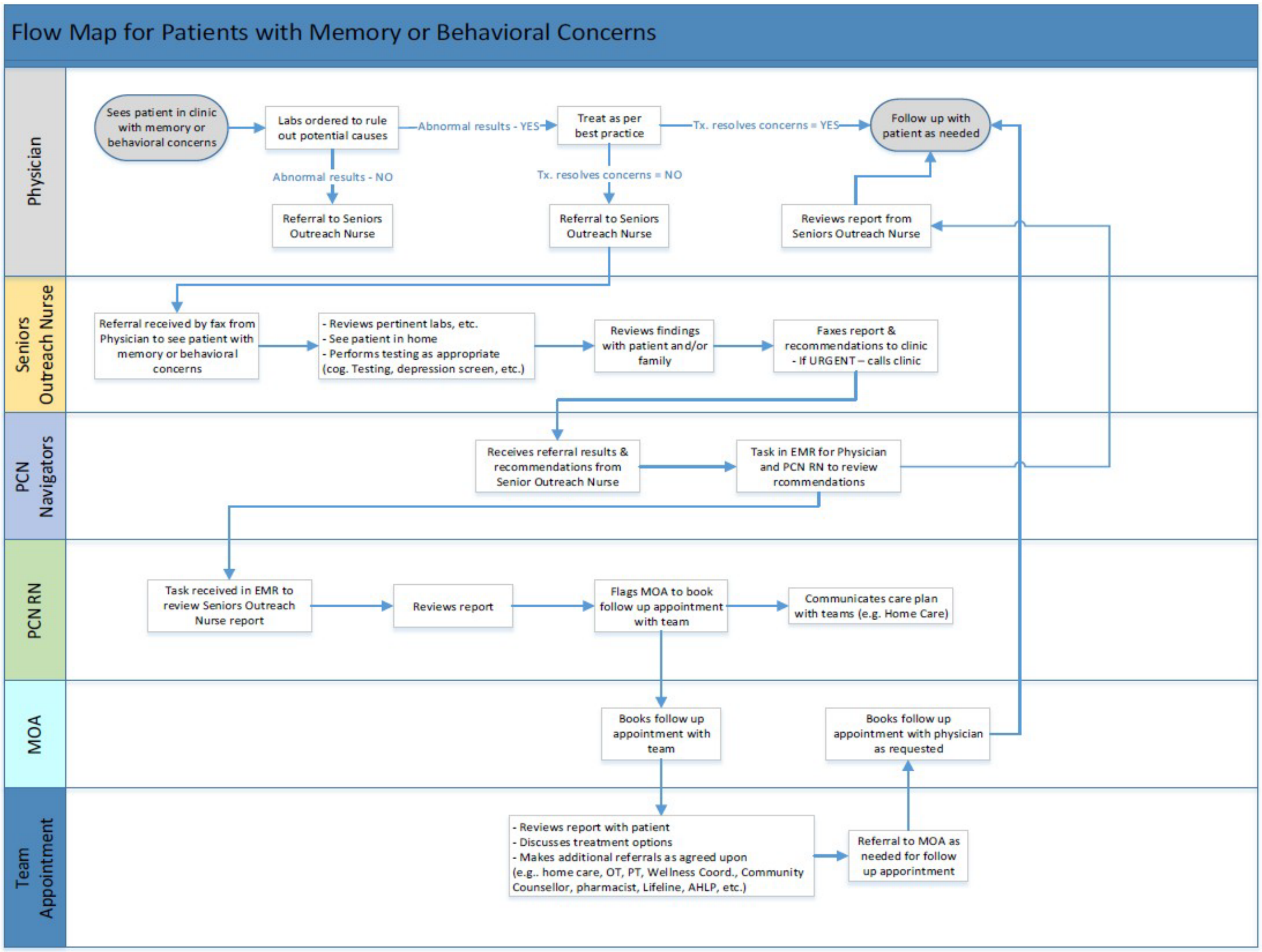
- Numerous case studies have been developed to use to inform discussion/augment presentations
- Recognition and Diagnosis of Dementia and Frailty in Primary Health Care - an overview. Preparing Primary Health Care teams to meet the challenges of an aging population
- Dementia (MNCD) Diagnosis ……in greater depth……… Recognition and Diagnosis of Dementia and Frailty in Primary Health Care - an Overview.
- Frailty….in greater depth
- Driving
- Healthy Brain Aging
- Falls and Fall-related injuries: Prevention, Assessment and Management
- Complex Comorbidities, Dementia and Frailty
- De-prescribing
- Pain and Dementia
- Differential Diagnoses of Dementia - Discussion and Handouts
- Insomnia
- Fall Prevention: What Works?
- Depression in the Elderly
- Examining the Frail Elderly Patient
- Multimorbidity & Therapeutic Conflict
- Hypertension in the Elderly
- Cholinesterase Inhibitors and Older Adults
- Statins in the Frail Older Adult
- Importance of the Psychosocial Assessment/Role of ECAC Mental Health/ASANT
- ECAC Nurse Practitioner and Pharmacist Roles
- Capacity
- Appropriate Use of Antipsychotics

Appendix J: Key PHC IGSI Output Measures by Community

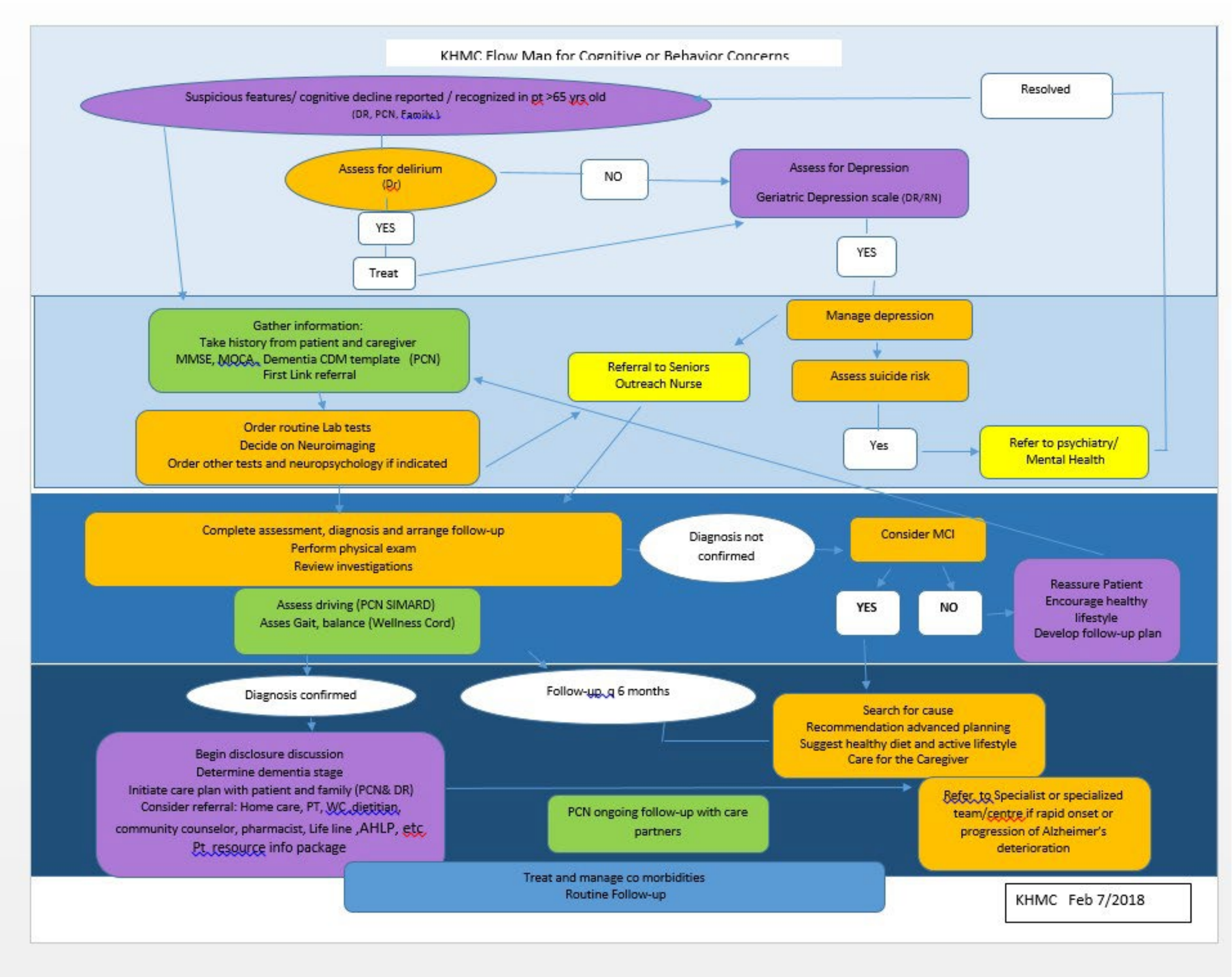
Activities	Description	Drumheller	Three Hills	Innisfail	Red Deer
Level 1					
Workshop 1	# of participants	1	2	9	32
Workshop 2	# of participants	2	5	9	25
Workshop 3	# of participants	4	3	12	25
Education Day/local	# of education days for level 1 care providers	5	1	5	N/A
Level 2					
Patients referred to ECAC	# of patients referred to ECAC (May 2017-Nov. 2018)	N/A	N/A	N/A	177
Patients seen at ECAC	# of patients seen at ECAC	N/A	N/A	N/A	150
Education day/local	# of education days	N/A	N/A	N/A	3
ECAC team training	# of training sessions	N/A	N/A	N/A	5
ECAC Providers	# of providers mentored	N/A	N/A	N/A	9
ECAC physicians	# of physicians mentored	N/A	N/A	N/A	4
ECAC Clinic roll-outs (Lunch & Learn)	# of clinic roll-outs to level 1 clinics by geriatric nurse & ECAC physician lead	N/A	N/A	N/A	6
Integration					
Community coalition	# of meetings	11	2	2	5
Community coalition	# of participants	7	8	12	31
Community coalition	# of partners	7	4	12	19
QI–Project Tools Implemented					
Patient flow map	# developed and used	1	1	1	1
Work/action plan	# developed and used	1	1	1	1
Geriatric 5Ms©	# patients Geriatric 5Ms© has been discussed with	46	3	20	150
Personal Integrated & Support Plan (PICS)	# of patients with a PICS care plan	N/A	N/A	N/A	150
QI–Local Interoganizational care planning					
Patients referred to SON	# of patients referred from PHC team to SON	68	N/A	N/A	N/A
Patients followed-up by PCN	# of patients referred to the SON followed-up by PCN	58	N/A	N/A	N/A
Patients with team visits (level 1)	# of patients with team visits with physician, PCN, family & Home Care	33	N/A	N/A	N/A
QI–Local Active Case Finding					
Case identification	# of patients identified for level 1 geriatric assessment	N/A	N/A	32	N/A
Local leadership					
Local project lead	# of project leads	1	1	2	1
Physician lead	# of physician leads	0	1	2	4

N/A Not applicable

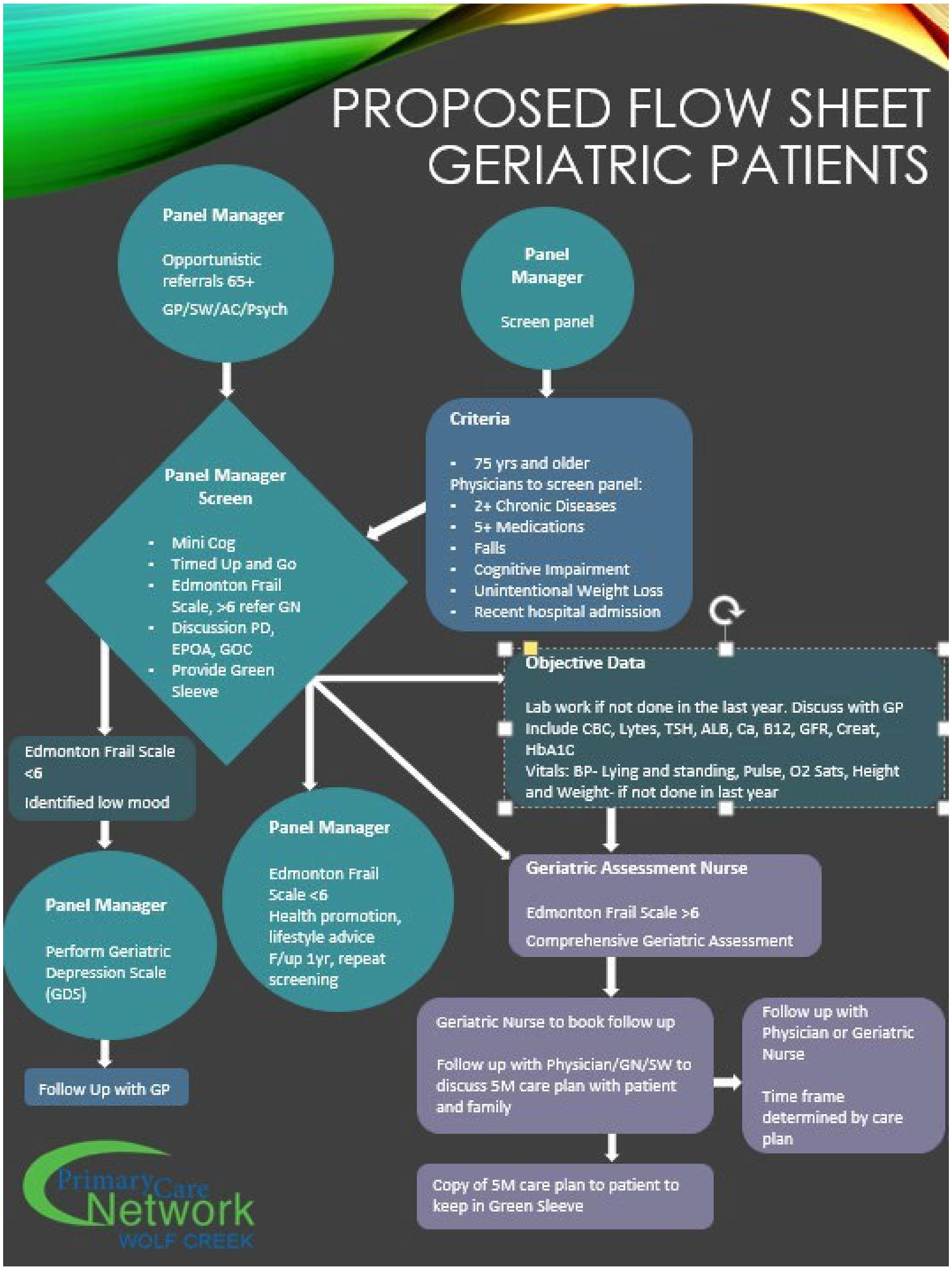
Appendix K: Drumheller Flow Map for Patients with Memory or Behavioural Concerns



Appendix L: Three Hills KHMC Flow Map for Cognitive or Behaviour Concerns



Appendix M: Innisfail Flow Map for Geriatric Patients



PROPOSED FLOW SHEET
GERIATRIC PATIENTS

Panel Manager

Opportunistic referrals 65+

GP/SW/AC/Psych

Panel Manager

Screen panel

Criteria

- 75 yrs and older

Physicians to screen panel:

- 2+ Chronic Diseases
- 5+ Medications
- Falls
- Cognitive Impairment
- Unintentional Weight Loss
- Recent hospital admission

Panel Manager Screen

- Mini Cog
- Timed Up and Go
- Edmonton Frail Scale, >6 refer GN
- Discussion PD, EPOA, GOC
- Provide Green Sleeve

Objective Data

Lab work if not done in the last year. Discuss with GP Include CBC, Lytes, TSH, ALB, Ca, B12, GFR, Creat, HbA1C

Vitals: BP- Lying and standing, Pulse, O2 Sats, Height and Weight- if not done in last year

Edmonton Frail Scale <6

Identified low mood

Panel Manager

Perform Geriatric Depression Scale (GDS)

Follow Up with GP

Panel Manager

Edmonton Frail Scale <6

Health promotion, lifestyle advice

F/up 1yr, repeat screening

Geriatric Assessment Nurse

Edmonton Frail Scale >6

Comprehensive Geriatric Assessment

Geriatric Nurse to book follow up

Follow up with Physician/GN/SW to discuss 5M care plan with patient and family

Follow up with Physician or Geriatric Nurse

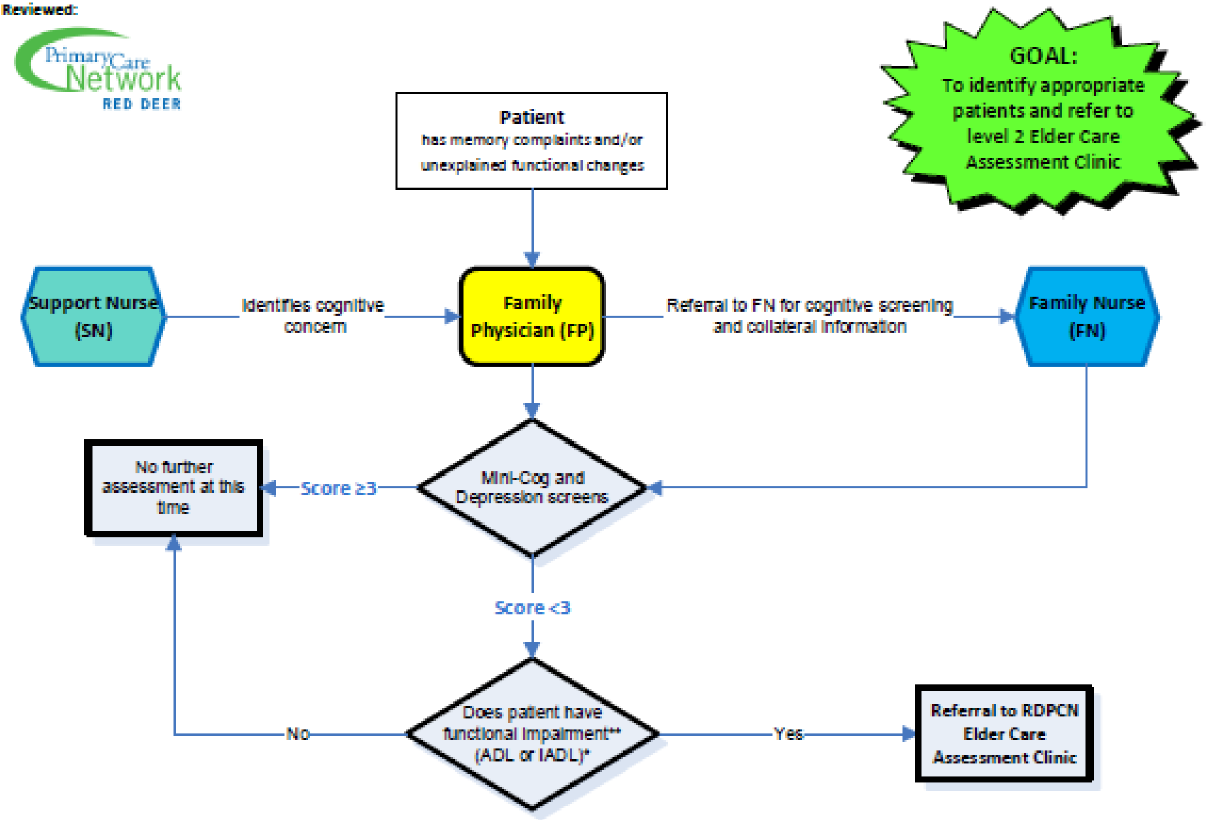
Time frame determined by care plan

Copy of 5M care plan to patient to keep in Green Sleeve

Appendix N: ECAC Referral Algorithm

Created: August 2017
Revised: September 2017
Approved:
Reviewed:

Elder Care Assessment Clinic (ECAC)



FN **Family Nurse Role:**

- May identify cognitive concern – refer back to Family Physician for assessment
- Complete cognitive assessment as requested by FP or at FN discretion
- Report results to Family Physician and refer patient back to Family Physician
- If not being referred to level 2 ECAC follow the RDPCN Cognitive Assessment Algorithm

SN **Support Nurse Role:**

- May identify cognitive concern – discuss possible referral to ECAC with FP
- Refer to FN for cognitive assessment if FP agrees

FP **Family Physician Role:**

- Medical management: see TOP Cognitive Impairment CPG's
- Complete ECAC referral form if indicated or refer to FN to complete (Mini Cog, 4 Question GDS, and Functional Activities Questionnaire)
- Implement recommendations from ECAC after received
- Refer to Seniors MH Team, Seniors Geriatric Services or neurology as appropriate

*ADL = activities of daily living (bathing dressing etc)
IADL = instrumental activities of daily living (cooking, medication administration, finances etc)
**If results are suggestive of cognitive impairment, support with collateral information (Functional Activities Questionnaire) when possible.

Appendix O: Eldercare Assessment Clinic Results

Staci Hastings, 2018

Care Provider Survey Results

*For care provider survey results please refer to the table below

Knowledge of Dementia
No significant differences were found between scores collected from 11 care providers pre- and –post measurement using the Alzheimer's Disease Knowledge Scale (Carpenter, Balsis, Otilingam, Hanson, & Gatz, 2009). At both time points, care providers involved in the Elder Care Assessment Clinic scored higher on this knowledge scale than a comparative sample of 75 healthcare professionals (M = 22.70, SD = 1.89) involved in dementia research and service provisions.

Dementia Attitudes
Significant differences were not found between pre- and post-measurement scores on the Dementia Attitudes Scale created by O'Connor and McFadden (2010). With ECAC care providers scoring a mean score of 120 at the beginning of their ECAC involvement, and a mean score of 127 at post-measurement, ECAC care providers scored much higher than the sample of 157 undergraduate psychology students (M = 98.64, SD = 12.82) used by the scale's authors to validate this tool.

Self-Efficacy
No significant difference was found between care provider self-efficacy scores gathered at the beginning and end of their ECAC mentoring. At pre-measurement, the 11 ECAC care providers from the current study (*M* = 88.2 , *SD*= 19.3) scored comparably on the Perceived Self-Efficacy in Dementia Care scale (Cheng, 2008) to a group of 45 nurse caregivers who worked with dementia patients and were assessed prior to receiving training in a dementia education program (*M* = 85.64, *SD* = 12.53). Similar to the nurses used in Cheng's (2008) study who's self-efficacy for providing dementia care increased after their dementia education (*M*= 92.6, *SD* = 10.1), ECAC care provider self-efficacy scores increased after 5 months of mentoring and working in the clinic setting.

A main limitation of the statistical analyses were the small sample sizes obtained for the study which could not be increased due to the total team's size.

Care Provider Survey Results (n = 11)

	Pre-Group		Post-Group			
Scale	*M*	*SD*	*M*	*SD*	*t*	*p*
Alzheimer's Disease Knowledge Scale	27.6	1.50	27.2	1.33	.75	.46
Dementia Attitudes Scale	120	10.2	127	9.90	-1.65	.11
Perceived Self-Efficacy in Dementia Care	88.2	19.3	101	10.5	-1.90	.073

Care Partner Surveys Results

Knowledge of Dementia

Significant differences were not found between knowledge scores collected from care partners both before and after their ECAC appointment visits, although scores did increase slightly in the direction anticipated. At both pre and post-clinic visit measurement, care partners in the current study scored slightly higher than a comparable sample of 54 dementia caregivers (*M* = 22.70, *SD* = 4.27) tested by the authors of the Alzheimer's Disease Knowledge Scale (Carpenter, Balsis, Otilingam, Hanson, & Gatz, 2009). The dementia knowledge scores from the ECAC care partner sample were more similar to results obtained from a group of 89 community dwelling, non- caregiving older adults (*M* = 24.10, *SD* = 2.95).

Dementia Attitudes

Dementia Attitude Scale (O'Connor & McFadden, 2010) scores received from ECAC care partners prior too, and again after their clinic appointments, did not significantly differ from one another as they remained identical. At both pre and most-measurement, care partners in the current study scored higher, indicating more positive attitudes towards dementia, compared to a sample of 157 undergraduate psychology students used to validate the Dementia Attitudes Scale (O'Connor & McFadden, 2010).

Self-Efficacy

Care partner results on the Revised Scale for Caregiving Self-Efficacy (Steffen, McKibbin, Zeiss, Gallagher- Thompson, & Bandura, 2002) scale are broken down into three self-efficacy domains: Se for controlling upsetting thoughts, SE for responding to disruptive behaviour, and SE for obtaining respite. In the current study, no significant differences in pre- and post-clinic scores were found on any of the self-efficacy domains. Compared to a sample of 145 people providing care for a relative or close friend with Alzhiemer's disease involved in a study conducted by Steffen, McKibbin, Zeiss, Gallagher-Thompson, and Bandura in 2002, the care partners in the current study scored higher on ever self-efficacy domain. In Steffen et al.'s (2002) study, caregivers mean scores were as follows: SE for obtaining respite (M = 56.8, SD = 29.1); SE for controlling upsetting thoughts (M = 69.4, SD= 19.7), and SE for responding to disruptive behaviours (M= 71.6, SD = 19.5).

Care Partner Survey Results	Pre -Group			Post-Group				
Scale	*n*	*M*	*SD*	*n*	*M*	*SD*	*t*	*p*
Alzheimer's Disease Knowledge Scale	20	23.8	3.45	8	24.6	2.77	-.61	.55
Dementia Attitudes Scale	22	109	13.4	10	109	12.5	-.08	.94
Satisfaction with Life	22	27.6	5.57	10	27.0	6.43	.27	.80
Revised Scale for Caregiving Self-Efficacy								
SE-Respite	21	70.7	24.1	10	61.0	37.6	.87	.39
SE-Behaviour	21	77.5	20.5	10	76.7	26.2	.10	.92
SE-Thoughts	21	71.9	20.9	10	78.2	13.1	-.87	.39

Life Satisfaction

Scores on the Satisfaction of Life Scale (Vitaliano, Russo, Young, Becker, & Maiuro, 1991) were much higher among care partners involved in the Elder Care Assessment Clinic both pre- and post-clinic visit than a comparable sample of 79 elderly dementia caregivers providing care for their spouses in the early stages of dementia ($M = 21.2$, $SD = 7.7$). Again, no significant differences were observed between satisfaction with life scores obtained before and after care partners went with patients to the ECAC.

Care Provider Interview Results – Initial Themes

Interviews conducted with 13 care providers at the beginning of their involvement with the Elder Care Assessment Clinic resulted in the following themes:

Concern for Patient and Partner Care

It was clear from care provider interview responses that everyone involved in the ECAC program was sincerely concerned with improving the lives of both patients and care partners. Many providers joined the ECAC team expecting the program to improve their caregiving capacity while alleviating gaps in care that currently exist in Red Deer. Care providers also emphasized the importance of improving support for care partners of PLWD, increasing awareness of supports and resources available in the community, and reducing appointments and diagnosis times for patients.

- *“I hope to meet more people in the community that are falling through the cracks, that are not getting assessed, that are struggling at home, and hopefully to be able to provide them the resources and support so they can stay at home longer.”*
- *“And when you think of the time for the patient and the caregiver, if they had to go to five or six of those different modalities to get opinions and results back from things, the cost of that would be phenomenal compared to having it together as a team that’s quite compact.”*

Optimism for the Program

All care provider participants expressed optimism for the potential of the ECAC program to increase their knowledge of dementia and capacity to provide geriatric care. ECAC providers were also enthusiastic about the hands-on learning they could gain from the program and how they expected it to have a great impact their confidence and skill development.

- *“There is a tremendous opportunity for learning here, in terms of not only learning about the process itself, but what kinds of supports are important to the caregiver and certainly how dementia manifests itself, things to look for and all of that.”*
- *“I would agree that as we do more and more clinics, we’re developing more confidence.”*

Team Approach Highly Valued

Across all participant interviews, care providers expressed their satisfaction and appreciation for the integrated team approach employed in the Elder Care Assessment Clinic. The multidisciplinary team was consistently deemed a major strength to improving the level of care and comprehensiveness of the care plans offered to patients and their partners. The integrated approach allowed multiple healthcare workers to simultaneously assess patients and care partners, thereby reducing clinic appointments, and all participants reported greater assessment and care planning confidence when done in conjunction with other members of the clinic team.

- *"[H]aving a team of physicians, nurses, pharmacy, mental health, the ASANT Alzheimer Society. Having everyone involved in assessing the patient, in developing the care plan, collaborating, and working together, I think it just gives such a well-rounded and thorough plan of care to the patient and caregiver."*

- *"I feel like I've had guidance and because no one thing rests on my shoulders, I feel confident because I'm part of a team that is competent and that builds my confidence."*

Mentors as a Valuable Resource

Every provider directly or indirectly referred to the importance of the clinic mentors to their experience with the clinic. The geriatrician and geriatric nurse were a central source of knowledge and support as the program developed. Care providers appreciated the educational training days that were hosted by the mentors as they enhances their knowledge of geriatric care and allowed the team to work cooperatively to analyze case studies with mentor assistance. Overall, the mentorship was perceived as an effective approach to developing new skills and enhancing caregiving capacity by all members of the clinic team.

- *"I think Dr. Robertson has forgotten more about dementia then I'm ever likely to know. So it's pretty useful having him."*

- *That full day of the education with the doctors, with everyone in the team, that was very helpful."*

- *"So far, the strengths of the programs is how I think the mentoring between Dr. Roberts[on] and Karen to the team that's going to be doing it is a huge advantage."*

Program Improvements Needed to Meet Ultimate Clinic Goals

Although the clinic was reported by all participants to be a beneficial and valuable program, with the ECAC being newly developed, care providers also identified aspects of the program that needed further improvement to fully achieve their care goals. Many gaps identified pertained to the clinic process. Limitations included: ensuring proper clinic referrals, collecting adequate collateral information from patients, organization, and clinic role definition. Communication within the clinic team itself, as well as with external community services, was also reported as needing improvement.

- *"However, there are still shortcomings and miscommunications and things that [need] to be weeded out that will happen with time."*

- *"Ensuring proper referrals are coming in. Even just the overlapping of referrals to the senior geriatrics program at the hospital. Just sometimes missed information just not being completely pulled out of the charts appropriately. Not getting all the data from the doctor's offices. Things like that."*

In summary, the initial interviews conducted with care partners revealed that participants were already benefitting from the Eldercare Assessment Clinic early on in its implementation and that, like most new programs, some aspects of the clinic process needed improving. The initial perceptions of the clinic were very positive and all care providers anticipated that their competency in geriatric care would improve to provide PLWD and their care partners with better care.

Themes from 5 Month Follow-Up Interviews

Improved Quality of Care for Patients and Partners

ECAC care providers felt that 5 months of clinic participation, mentorship, and training substantially improved the quality of care they provided to both patients and care partners. By enhancing their knowledge of geriatric syndromes, care providers reported being better able to recognize, diagnose, assess, and create care plans for elderly patients and their care partners. Quality of care for patients and care partners improved by enhancing care provider awareness of support available in the Red Deer community, increasing clinic time with patients, and using the 5 M care planning tool to create individualized, comprehensive care plans.

- *"[L]earned bank loads more about the whole process of dementia, how it effects people, how people kind of struggle with it, some of the supports they need, [and] some of the supports that are available."*

- *"I guess it's mostly made me a better provider within the clinic and that is because you can be much more thorough and do things better, you have more time right. And you have the additional help of the rest of the team, which makes a huge difference."*

Valuable Educational Approach and Experience

Not only did care provider participants perceive the mentoring approach of development to be effective at enhancing their caregiving capacity, but they also found the experience enjoyable and rewarding. Expectations for the ECAC were met for all but one of the care providers interviewed as the mentors enhanced participants' knowledge of eldercare, awareness of community resources, care confidence, skill, and ability to identify and manage dementia through education days, resource distribution, support, and modelling.

- *"[T]he way that it [the team] has developed with the mentorship from Dr. Robertson and Karen. That they've kind of held our hand and walked us through it until we got to the point of gaining confidence and gaining more expertise."*

- *"My expectations were met, and probably exceeded."*

Continuing Program Evolution

While many gaps identified in the initial ECAC program interviews had been addressed in the 5 months between provider interviews, clinic processes were still evolving and improving at post-interview. Many care providers described the process as a continual evolution of learning and improving over time with experience to continue improving the level of care the clinic offers to patients and care partners.

- *"I think it's not gaps, it's just a continuous learning for everybody so it improve every, you know, every time we do it."*
- *"[O]ur role is changing like as of right now . . . So I think that, sort of how we're able to contribute now will be more accurate and more specific to the patient."*

In general, care providers continued striving to offer the best care they could to the patients and partners referred to the Eldercare Assessment Clinic. It was clear from the interview feedback received that both care provider caregiving capacity and the clinic process had been improved or strengthened since the initial interviews.

Care Partner Interview Results

Individual Interviews were conducted with care partners 6 to 8 weeks after their clinic appointments to inquire about their experiences with the clinic team and as a caregiver. The following themes were identified from interviews completed with 7 care partners who accompanied patients to the ECAC:

Positive Clinic Experience

All but one care partner interviewed expressed satisfaction when recounting the overall experience they had with the ECAC. Care partners felt the integrated team approach improved the quality of the care they and the person they provide care for received in a number of ways: they were given sufficient personal attention; the team was supportive, knowledgeable, and invested in the care process; and the team provided a more comprehensive and individualized care plan than patients could receive at an appointment with their physician. Care partners also left the appointment with a greater sense of certainty and direction for their caregiving roles.

- *"I liked the team approach. I certainly liked that. I like that they seemed to be very engaged. I was very impressed with the doctor in terms of how he came in."*
- *"One of the main things was the Green Sleeve was offered to us, the D.N.R. was offered… information about setting up wills was reminded to me. Those are very important. I felt that I had put them on the back burner and they brought them to light and that was good."*
- *"[P]robably there are quite a few people that would benefit from it."*

Support from Family and Friends

It was apparent in care partner interviews how critical family was to the care process. For care partners responsible for providing someone's care, family and friends served as a primary source of personal support and information. Care partners also played a significant role in the care that PLWD and other loved ones received by being proactive in the care process. Some care partners were highly knowledgeable about dementia as they educated themselves about dementia and how to care for a PLWD before attending the ECAC appointment. In some instances, they were also responsible for patient referrals to the clinic. It was also implied that individuals living with dementia were unlikely to receive the level of care they required without the support of their care partners.

- *"[M]y biggest go-to would be my wife and my brother."*
- *"I had a lot of information before I ever went because that's how I know how to get there. Wasn't the doctor. This is a big problem. Some of these doctors now are not the ones saying, "I think we should refer you to the Personal [sic] Healthcare Network." No, it was me."*

Patient reliance on family also contributed to the stress and burden experienced by some care partners.

- *"[I]t's hard to work full time, I got my mom in a nursing home, I have my dad not doing well at home independently, and then I have my children and my grandchildren and yeah, it often feels like there's not enough hours."*

Integration and Continuity of Care

Although integration within the ECAC team itself was valued by care partners, perceived integration between certain services and care processes was reported as needing improvement. Interview responses indicate that integration was strong between the ECAC and the Alzheimer's Society. Integration and continuity of care back to family physicians and some other primary care services was lacking for some, but perceived as adequate satisfactory by others. Some partners also expressed a desire for the ECAC team to expand or increase their capacity to address more healthcare concerns and further reduce appointments. Furthermore, it was clear from care pare partner interviews that some participants did not have a full understanding of what the term integration meant, or how integration could look outside of the ECAC clinic team, as some responses did not fully or directly address the question being asked.

- *"It's a really big relief knowing that I have the Alzheimer's Society, knowing that I've got other people supporting it, you know, I think that's good."*
- *"Like this was good, the team, the multifunctional team, but what I felt was a lack of communication back to his GP."*
- *"I thought that they would've been able to place her on a waiting list and they said no. That either goes through occupational health or through the Alzheimer Society. So I think that they need to be able to access that because they have a social worker, they have the nurses. I don't understand why they can't get her on the placement list."*

Difficulty Following Through with Clinic Recommendations

For most of the interviewed care partners, following through with the recommendations and suggestions made by the ECAC team proved difficult. Facing resistance directly from the person being cared for was a common barrier to fully implementing the care plan created by the patients, partners, and team at the Eldercare clinic. At a primary care level, a few partners were also limited in their ability to achieve care plan goals as they felt unsupported by their family physicians.

- *"I do get frustrated very much, you know, repeating, repeating, repeating. Thinking I have him on board and then the next day he changes his mind and we have to start all over again, right."*
- *"[T]he GP kind of made me feel like I was stupid."*

Education and Awareness

In their interviews, almost all care partners spoke about improving education and awareness to some extent. Although most partners felt they received an adequate amount of information to be successful caregivers, some expressed leaving their appointments with a lack of information and a desire to learn more. Although much variation was observed between care partner expectations for the ECAC, almost all care partners came to their ECAC appointment with the expectation that they themselves would become more knowledgeable about dementia and more aware of support services and strategies available to caregivers of PLWD.

- *"I need some hard information about what I can do to help, from a medical provider or someone that knows what dementia is all about or something."*
- *"I was hoping to understand what his problem was."*

Three care partner participants also came to the appointment with the expectation or hope that the clinic team would help the person they provide care for come to terms with the status of their health and cognitive capacity, while others came without any clear expectations and a lack of prior knowledge for that the ECAC provides – emphasizing the need to educate and build awareness for the clinic.

- *"[F]or him to realize that yes, he does have this condition and, you know, there are things that he can do to help."*
- *"I didn't know what to expect. It was all new to me."*

Overall, interview responses indicate care partners found the ECAC to be a valuable service to themselves and others who are caring for people living with dementia and other geriatric syndromes. With the ECAC being a newly developed program, care partners also made suggestions for future improvements. Adding additional care services and personnel to the ECAC team, and cultivating greater awareness and support among primary care physicians were the two most salient improvements recommended to enrich the care and convenience of the ECAC service moving forward. Care partners also emphasized the importance of continuing to educate and build awareness within the ECAC to improve their ability to provide care.

Summary

The findings from this study suggest that both care providers and care partners serve to benefit from participating in the Eldercare Assessment Clinic. Although quantitative survey results were not statistically significant, a lot of valuable, useful, and impactful feedback materialized from qualitative interviews conducted with care providers and care partners. Both caregiving groups found the ECAC to be a positive and valuable experience that was not only effective at educating and developing the caregiving capacity of care providers, but it also improved the quality and comprehensiveness of care received by patients and their care partners. The clinic's team approach and the mentoring model of occupational development were deemed to be most significant to the clinic's success. Both caregiving groups also spoke to aspects of the program that could benefit from future improvement. From the perspective of the care providers, resolving inefficiencies in the clinic process was a priority and something that was continuing to evolve and improve with time to enhance patient and partner care. Interview responses also indicate that care partners continue to experience difficulty fulfilling their clinic recommendations as adequate integration across additional primary care and community services external to the Eldercare clinic has not yet been achieved.