Edmonton West Primary Care Network Frail Elderly Outreach Program

Primary Care Network EDMONTON WEST

Lesley MacGregor: BNSc, MN, NP ~ Lesley.MacGregor@edmontonwestpcn.com
Brenda Lamoureux: BSc Pharm, BCACP, CGP ~ Brenda.Lamoureux@edmontonwestpcn.com
Sharon Nelson: RN, Primary Care Program Manager ~ Sharon.Nelson@edmontonwestpcn.com

Introduction

There is a cohort of the frail elderly that are invisible to the health care system until they require emergency care or hospitalization. This population of frail elderly have complex social and medical problems that make them among the most vulnerable and marginalized patient population as well as the most difficult to manage medically. The EWPCN has developed an outreach program that will address this gap in the provision of health care to an aging population.

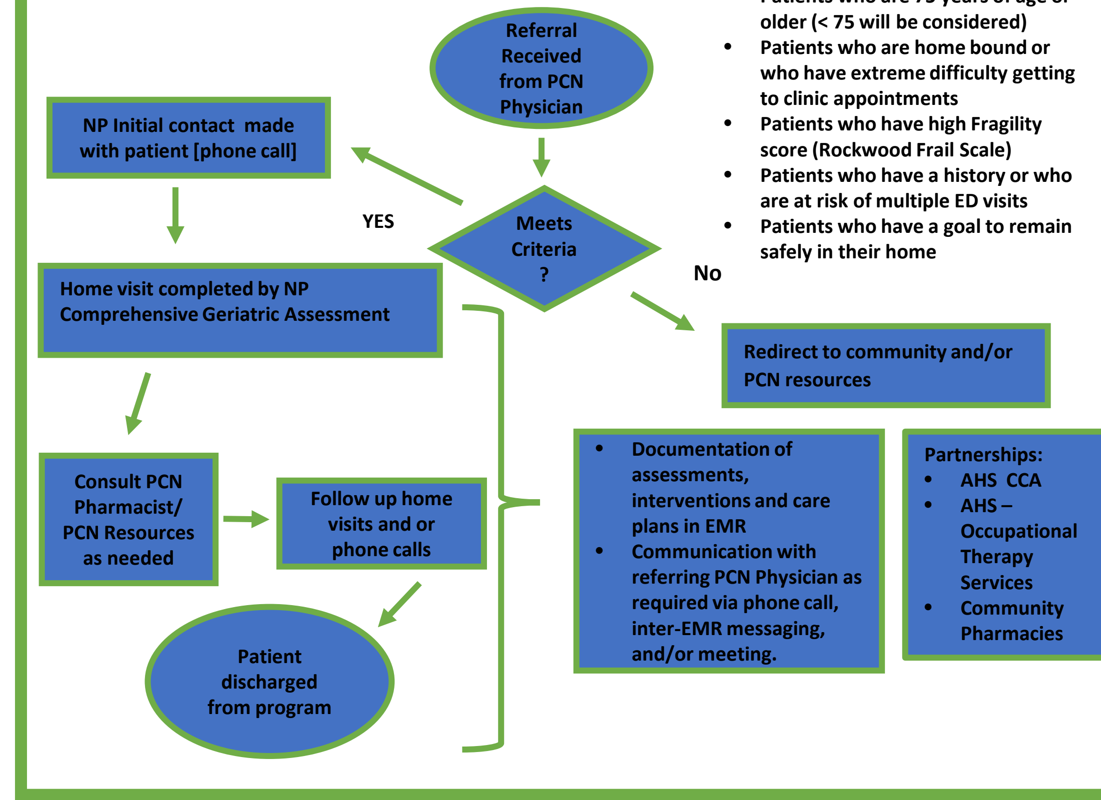
Needs Assessment

Prioritization Exercise:

- Geriatric support services identified as top 3 priority by 14 of 47 physicians
- Second most important top three priority by the physician group
- 13 clinics selected it as a priority for additional services from the PCN
- Frail elderly was ranked 5th in funding allocation by the physician group.

Program Goals

- Sustain an innovative/forward thinking program
- Identification of at risk Seniors in the community
- Utilization of a Nurse Practitioner to provide outreach Geriatric Assessments and Primary Care in the home
- Maximize patient function, maintain independence
- Reduce risk of hospitalization and Long Term Care Admissions



Comprehensive Geriatric Assessment

- Geriatric syndromes
- Medication review/optimization
- Advanced care planning
- Functional assessment
- Cognitive assessment
- Neuro-behavioral assessment
- Physical assessment

Assessment Tools/Best Practice

- Clinical Frailty Scale [Rockwood et all, 2008]
- Nurse Practitioner referral triage [Adapted from AHS Home Living-Edmonton Zone]
- Homebound Status Assessment [Adapted from AHS 2006]
- SF-12 Quality of Life Assessment
- Caregiver Survey ZBI-12
- Geriatric Depression Scale
- TUG Test [Fall Prevention Initiative-Calgary Zone 2009]
- Falls Risk for Older People assessment tool-Community Setting [FROP-Com]
- MOCA – version 7.1

Progress to Date

- 50 + referrals with an average age of 89 years
- Completion of Geriatric Assessments in the home
- Provision of Primary Care in the Home by Nurse Practitioner (Management of Complex Comorbidities)
- Development of Care Plans
- Coordination of care in Supportive Living
- Assessment/interventions re: Caregiver stress
- Completion of Capacity Assessments
- Successful referrals to In Patient Specialty Services
- Successful referrals to Community Partners for assistance with Function/Mobility in the home
- Successful working relationships with PCN Physicians