Good Samaritan Seniors' Clinic: Providing excellence in seniors care in the community embracing complexity and optimizing wellness

THE GOOD SAMARITAN SOCIETY
A Lutheran Social Service Organization

Primary Care Network
EDMONTON SOUTHSIDE

CONTEXT

The Seniors' Clinic opened in February 2004 following extensive collaborative planning and a community needs assessment.

Community focus groups composed of seniors identified the need for quality care that was accessible and available in their community. The clinic is an innovative, interdisciplinary model located in a community setting providing primary health care and geriatric consult services to seniors with complex medical, functional, psychological, or social needs.

We provide accessible, comprehensive care, interdisciplinary services and care coordination ensuring linkages with community partners to allow the senior population to "age in place". Our goal is supporting seniors to remain at home and thriving in their community for as long as possible.

THE MODEL

Interdisciplinary Clinic Team

- Includes physicians with experience in care of the elderly (4.8 FTE), Nurse Practitioner with specialization in aging (1 FTE), Social Worker (1 FTE), RN (0.8 FTE), 2 LPN (2 FTE), unit clerk (1 FTE) and MOA (1 FTE).

Collaborative Model

- Works in partnership with Edmonton Southside Primary Care Network.
- Links seniors to community resources, for example, home care.
- Involves seniors and their caregivers in the decision-making process.

Community-based Seniors Care

- Provide on-going primary care and consult services for elderly patients with dementia/cognitive impairments and/or complex health, functional and psychosocial care needs both in the office and at home (for those who are homebound).
- Clinic operations tailored to seniors in a senior-friendly space.
- Extended appointment times to allow for regular follow up of multiple chronic conditions.

Increased Accessibility

- Reduced barriers to access accepting referrals from patients, families and health care professionals.
- 24/7 on call services.
- Accommodation for urgent visits to prevent avoidable use of acute care.
- Telephone access to nurses and social worker for patients and families during clinic hours.

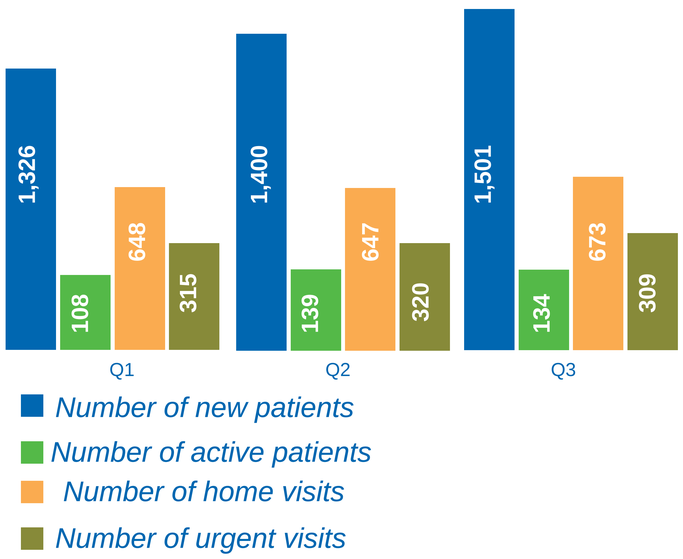
RESULTS

Positive patient outcomes following an evaluation in 2009:

- patient satisfaction was rated high;
- caregiver stress was decreased;
- length of time and ability to stay in community was increased;
- number of emergency visits were decreased; and
- patients identified home visits were critical to remain living in the community.

2015-2016 Quarterly Results

Currently have >1,500 active patients and patient volume continues to increase.



On-going Innovation

- We're working on a project to address personal directives and power of attorney on all of our patients.
- We've developed a process to follow our patients' hospitalizations and are contacting them within 48 - 72 hours post discharge to maintain continuity of care.

CASE STUDY

Mr. and Mrs. M were referred from a social worker in acute care:

- Mrs. M is home bound with complex medical issues including dementia, limited mobility, frequent ER visits and acute care admissions (see table).
- Mr. M is a burned out caregiver, not attached to a family doctor and having his own medical issues and frailty (see table).
- They received an eviction order due to bankruptcy.

Mr. M	Mrs. M
Diabetes 2	Diabetes 2, neuropathy
Depression	Dementia
HTN	Depression
CAD with prior CABG	HTN
Sarcoidosis	CRF on dialysis
COPD	OA
CRF	PVD with prior amputation
OA	GERD
OSA	Restless leg syndrome
Gout	Panytopenia
BPH	Leg edema

Actions

- Within the initial six weeks, 10 home visits by multiple clinic team members were made.
- Within 24 hours, home care assistance for personal care, medications and meals were in place.
- It became apparent Mrs. M was using the incorrect dialysis solution contributing to worsening edema, 20 kg weight gain and immobility.
- Several indirect encounters: Managing issues with the patients, home care, pharmacists, respite care, legal bodies and specialists (Nephrologist and the Home Care Peritoneal Dialysis Program. Switching to the proper dialysis solution led to dramatic improvement in her edema and mobility.)
- Ongoing care, monitoring and frequent follow up, timely response to issues and communication with all partners was imperative to the patients' management.

Outcomes

- Acute care visits decreased.
- Referrals to specialists decreased.
- Mrs. and Mr. M's health and well-being improved and they were able to remain safe in their home.

Conclusion

By working as a team and partnering with community resources, the clinic was able to address the multitude of heath determinants impacting these patients' independence, health, and wellbeing. The interventions and support provided enabled the patients to age in place.