BAFHT: ELDER CARE REGISTERED NURSE SUPPORTING AGING COMPLEXITIES

PRÉSENTÉ PAR / PRESENTED BY: AUDREY LIENHARD, ELDER CARE RN – BRUYERE ACADEMIC FAMILY HEALTH TEAM (BAFHT)
VELA TADIC, DIRECTOR FAMILY HEALTH SERVICES & DR. PAUL CRABTREE, MEDICAL CHIEF FOR FAMILY MEDICINE

Bruyère
#Droitaucoeur #BeMoved

FOCUS

- Population-based approach with cohort of 85+
- Improve health outcomes, quality of life and aging at home, early identification of needs and support for palliative care, care coordination and improved documentation in the EMR.
- Falls prevention program for minority and remote Francophone communities.

SUCCESSES

- Community Linkages/Networking with Partners
- Improved knowledge and awareness in team through education and consultation
- Improved early identification needs and documentation
- Improved patient readiness to discuss care goals through promotion
- Trust through continuity of consultations with patient and primary care provider
- Improved access to patients for these discussions
- Improved support for palliative care, care coordination, and communication

CLINIC OVERVIEW

In July 2006, the Bruyère Academic Family Health Team was formed with two distinct clinic sites: Primrose and Bruyère. We have a tripartite governance agreement with the University of Ottawa, Department of Family Medicine, Bruyère Continuing Care and the Bruyère FHO physicians.
We have 23 physicians, many of whom are part time with a combined of 10 FTE clinical time. We typically also have about 50 family medicine residents as well as other learners (medical students, allied health students, nursing etc).

Patient Demographic and Disease Profile Snapshot 2023

Total #Patients	19,239		**Chronic Disease Profile**	
Ontario Rostered*	13,928		Mental Health	3368
Quebec/Other Province	2,383		Hypertension	2987
			COPD	1090
Male	46%		Asthma	2187
Female	54%		Diabetes	1658
Non-binary**	0.1%		Heart Disease	1115
Spoken language other than French/English at home	3%		Osteoporosis	916

Nurse Practitioners have their own patient roster which is accounted in the difference.

DATA

Feb 2022 to Jul 2023	Numbers
Charts audited	452
Patients who meet criteria to be contacted/seen	410
Internal referrals & Community linkages	181
MoCa completed	42
Advanced care planning & goals of care discussions initiated	98
Do Not Resuscitate formed completed	7
Housecalls	33

STRUCTURE

- Referral based and chart audits
- Individualized visits with clinician to assess needs by performing complete geriatric assessment
- Facilitate linkages with existing community resources.
- Screening and assessments provided
- Generate frailty score as reference and guidance for follow ups
- Early care planning discussions and advocacy.
- Clear and appropriate documentation of patient's goals, values and wishes to help current individualized needs and any future health care decisions

NEXT STEPS

- Continued education to providers, residents, patients and families.
- Continue to use existing resources within our team and collaborating to coordinate care.
- Continue to strengthen community relationships and services
- Continue to improve awareness and accessibility
- Continue to support physician/nurse practitioners
- Establishing a standardized documentation of advance care planning in our EMR
- Promote falls prevention group sessions for our FHT frail elders aged 75+
- Work with Bruyère Research Institute to improve quality improvement plan
- Strategic scheduling to introduce concept to plan for a visit after chronic illness diagnosis, or a hospital discharge to discuss understanding of their illness, trajectory and introduce an initial discussion around advance care planning.

PATIENT STORY

Patient Background:

- 85-year-old multiple chronic conditions. Known mild cognitive impairment. Lives on own in same place x30 yrs. No family, few friends, little community support. No known substitute decision maker
- Very proud, autonomous, active man, making own decisions and wanting to remain independent.
- Pandemic contributed to functional and cognitive decline due to social isolation, changes noted with (I)ADL's.
- When questioned pt always reported to be “doing ok” with no specific need, however, had repeated visits in ER for falls, weakness, and malnutrition

Referred to Elder care program RN:

- Chart audit revealed health trajectory changes showing functional and cognitive decline between Jan 2021-Feb 2023
- Client in need of support, no initial discussion about goals of care and advance care planning

Interventions:

- Since summer 2022 initially met every 4 months with a focus on building trust. Initial contact q4months, with time patient agreed monthly
- Shift to monthly wellness check in and home visits
- Patient education provided, care goals identified, and collaborative care plan developed including internal and external referrals
- Frequent visits and discussions about values and wishes along with changes to own health trajectory has led to acknowledgement of move to a retirement home setting adapted to his needs.
- Currently at the planning stages for the move.