The ElderCare Project: Primary Health Care for Community Living Old Elderly

Co-Investigators

- Sharon Buehler - Epidemiologist
- Bob Miller – Family Medicine
- Wanda Parsons – Family Medicine
- Karen Parsons-Suhl – Nursing
- Vereesh Gadag – Biostatistician
- Anne Sclater - Geriatrician

Project Details

- CIHR Funded
  - Institute of Aging - $371,932
- Duration of 3.5 years
- Nurse-based program of home delivered care to people aged 80 and older

ElderCare Team

- Marshall Godwin – Principal Investigator
    - Family Doctor and Researcher
- Farah McCrate – Research Associate and Project Coordinator
- Andrea Pike – Research Assistant – in charge of recruitment, enrollment and follow-up of outcome measures
- Charlene Lomholt-Mortensen – ElderCare Nurse who will carry out assessments and develop/implement ElderCare Plans

Rationale

- The physician is not always the most appropriate health professional to deal with the types of problems encountered by the ‘old elderly’
- However, these needs cannot be dealt with by a resource limited community-health system
- We propose that another venue of care may prove more cost and time effective

The ElderCare Project

- Does not involve setting up a new system of health care
- Case management will occur to the extent that a single person will work to coordinate interactions between the patient and primary care physician, community services and tertiary care
- Successful implementation will require awareness and support from family physicians, other health professionals and agencies that the patient accesses

Project Objectives

- To improve quality of life
- Improve symptom management
- Better utilize community-based resources
- More efficiently utilize medical care services (primary care, hospitalizations, ER visits)

Stage 1 – Physician Recruitment

- 32 family physicians will be recruited from the St. John's area
- Half will be assigned to the ElderCare program (intervention) and half will be assigned to the control group (usual care)
- Physicians will later be cluster-randomized along with all of their patients to one of the two groups

Stage 2 – Patient Recruitment

- A list of patients aged 80 and over will be developed by clinic staff at each practice
- Patients must be:
  - Aged 80 or over; Be living at home or in a personal care home (Level I or II)
- Patients will be excluded if:
  - They are living in a nursing home, not able to give informed consent, have moderate to severe dementia, have profound communication difficulties

Patient Recruitment Cont'd

- Patient will be sent a letter about the study – given a phone number to call
- The RA will contact patients to further discuss study and to confirm potential eligibility
- If a patient agrees to participate the RA will arrange to visit them at home to complete the MMSE and if appropriate, enrollment

Stage 3 Enrollment / Baseline Date Collection

- Study enrollment – demographic information, co-morbid status, community service utilization frequency
- Baseline Data – SF-36, CASP-19, Comorbidity Symptom Scale, Patient Satisfaction Questionnaire, SLIQ
- Patients will be informed of group assignation in 2-3 weeks

Stage 4 – The Intervention

- Time 1 – Each intervention patient will receive an initial visit from the ElderCare nurse to undergo an assessment
- Chart review and enrollment data collection reviewed prior to visit
- First visit usually takes 2 – 2.5 hours

Assessment Components

- Assessment Includes:
- Medication Review, Nutrition, Safety, ADLs and IADLs, Symptomatology and co-morbid conditions review, Use of community resources, Social Isolation, Coping Abilities, Finances, Pain & Discomfort, Sleep, Comprehensive Geriatric Assessment
- Very extensive

Intervention Cont'd

- The nurse will identify needs/gaps and areas that could be improved for each individual and develop an **ElderCare Plan**
- Goal Attainment Scaling will be used to structure goals
- Done in conjunction with the patient and the family physician

Follow-Up

- The remainder of the year-long intervention involves working towards goals that have been set for intervention group
- The RA will see all patients, intervention or control at 6 & 12 months post enrollment to administer the questionnaires again
- All control group participants will be offered an assessment and development of an ElderCare plan at the end of the year

Outcomes

- Improved quality of life, symptomatology, and patient satisfaction (as evidenced by the questionnaires) in those who receive the intervention
- We also hope to see improved utilization of community-based resources and decreased utilization of medical care services
- A physician focus group will be run at the end of the project

Where We Are Now

- 9 Physicians Recruited
- 35 Patients Enrolled
- 26 intervention / 9 control
- 13/26 have had their first visit
- 4/26 have had their second visit