
Edmonton Southside Primary Care Network: A New Step in Dementia Care

The Alberta Medical Association, Alberta Health and Wellness and Alberta's regional health authorities (now Alberta Health Services) came together and created a primary-care network, the first of which was established in Edmonton, with one of its programs geared towards geriatric care, nearly four years ago. The addition of nurses specializing in geriatrics in participating family physicians offices, as well as the specialty program More Time for Care (MTFC), have proven to alleviate the dementia patient's transition from home to hospital, ensure protection for elderly patients with little or no family, and provide comprehensive care for elderly patients' complex and chronic care needs.

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In 2003, the Alberta Medical Association (AMA), Alberta Health and Wellness (AHW) and Alberta's regional health authorities (now Alberta Health Services [AHS]) came together to determine how Alberta's share of federal government seed money, promoting primary care for Canadians, would be used to develop and define primary health initiatives for Albertans.

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To receive this funding, which was separate and above the amount Alberta doctors would still be allowed to bill on a fee-for-service basis, doctors were encouraged to form an associated group or Primary Care Network (PCN) based on historical, geographical, and natural associations, which led to Alberta's Primary Care Initiative (PCI). Table 1 outlines the PCI's key objectives.

The three partners who controlled PCI funding (AMA, AHW, AHS) did not dictate how the programs should be developed or run. Thus, the PCNs were free to decide these aspects of the programs based on the community's grass-roots needs, as long as the general principles mentioned above were addressed.

Another unique component of the PCNs is the arrangement between the family physicians and AHS. The PCN is composed of a board of directors with representation from AHS who can hire or contract services to improve access to, and better coordinate, healthcare for the patients of said family physicians. This flexibility allows the development of local solutions to local health issues, and makes each PCN unique and better able to address the needs of the local patient population.

The Edmonton Southside Primary Care Network

The Edmonton Southside Primary Care Network (ESSPCN) was the first network established in Alberta,

Table 1

Primary Care Initiative (PCI) Key Objectives

- Increase the availability of primary-care services for Albertans
- Provide access to appropriate 24/7 primary-care services
- Help community-based physicians and their offices with an emphasis on:
 - care of patients with chronic diseases and medically complex problems
 - health-promotion strategies
 - disease and injury prevention
- Improve coordination of primary healthcare services with other service providers, such as hospitals, long-term care facilities and specialty care services
- Help establish a team approach to provide primary healthcare at the level of the family physicians' community-based practice

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and began offering its services to the city's residents in 2005.

Geriatrics, a key element of the ESSPCN, was one of the first programs established. It was well recognized by the family physicians that the needs of their geriatric patients required much more time than they were able to deliver on a consistent basis. The group of physicians felt that if the proper resources and services were available, not only would their senior population benefit, but their practice may also reduce some of the burden of caring for the elderly and their unique complex chronic-care needs. This was particularly true as evidenced by a needs assessment completed by participating family physicians in the PCN's infancy.¹

The assessment was conducted to discover the greatest barriers facing GPs who were providing comprehensive geriatric care, as well as the most challenging issues managing this care.

The physicians identified the limited amount of time spent with their patient as the greatest barrier, which hindered their ability to conduct a traditional history in areas of function, cognition and social history. They also noted a lack of knowledge of existing community resources available to these patients as a hindrance in elderly patient care. The most challenging issues identified were concerns with the identification and management of cognitive impairment and dementia, competency assessments, as well as

addressing caregiver and behavior concerns.

Nurses who could assist GPs in their offices, provide home visits and surveillance support, and assist in identifying at-risk frail patients was felt to be the most useful aid. After examining collapsed utilization data from the past four years, dementia and its various aspects of care requirements is the number one reason for referral to the More Time for Care (MTFC) program (described later in this article).¹

PCN Staff and Training/Education

One of the PCN's first hired staff members was a geriatric nurse specialist. Together with the physician lead in geriatrics and the guidance of the PCN's board of directors, it was determined that the ESSPCN would develop a program to educate all employed staff and physicians in the specialty needs of complex elderly patients. Thus began the program of decentralizing geriatric assessments and intervention to the level of the individual physician offices in the community.

Nurses were hired to support the physicians at a ratio of one nurse to three physicians for geriatric care, as well as complex and chronic disease management. Those who were placed in a physician's clinic received education to address geriatric care concerns. This education was designed to increase their awareness, knowledge and skill in geriatric assessment and management with a focus on dementia (Table 2).

Supporting Physicians: Nurses

Nurses are mentored by the geriatric nurse specialist and her team within their clinic settings where they are expected to initiate the dementia screening and cognitive assessments, such as the Standardized Mini-Mental State Exam (SMMSE), the Clock Drawing Test, the Global Deterioration Scale (GDS), the Frontal Assessment Battery (FAB) and the Montreal Cognitive Assessment (MoCA), to assist the physician in the diagnosis of dementia.

However, these screens are also implemented by the nurse as part of the annual physical exam, follow-up of diabetic clients aged 70 years or older, or upon request of the patient, family members or others. With these cognitive screens, nurses are also collecting data on basic and instrumental activities of daily living (ADL), information about services used, current medication lists, including over the counter (OTC) and herbal medication, and the status of personal directives or enduring power of attorney (EPOA).

Specialty Geriatric

Team: MTFC

If the patient is unwilling or unable to come to the clinic, or more complex issues prevent the patient from attending their appointment (*i.e.*, social, environmental, financial, psychological issues or physical abuse), a referral to the specialty geriatric team, MTFC, is made by the PCN nurse or physician. The MTFC team consists of one

Table 2

Nurse Training for Geriatric Patient Care

- Geriatric assessment:
 - screening tools for cognition (*i.e.*, SMMSE, GDS, Clock Drawing Test, FAB, and MoCA)
 - basic and instrumental functional assessment
 - social/financial/safety issues
 - medications used (prescribed, herbal, OTC)
 - support services (family, agency)
- Geriatric lectures (*i.e.*, dementia, delirium, adverse events, frailty, falls and medical legal issues)
- Personal directives and enduring power of attorney
- Dementia medications
- Senior abuse
- Medically at-risk drivers
- Community resources
- The Alzheimer Society of Canada
- Dementia Consensus Guidelines

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clinical nurse specialist (who is also program leader), three nurses and a social worker. Associated occupational therapists (OTs) and a physician lead the support clinic (physicians and PCN nurses) in delivering geriatric care.

The specialty team member then becomes an additional team member to support the physician/nurse dyad in patient care. The most frequent request for help from the physician and/or nurse is in the assessment and management of dementia, and secondly, in providing support to caregivers who

have a family member diagnosed with dementia.

The MTFC team can coordinate the referrals to the geriatrician for the patient’s assessment, facilitate access to acute-care services at the local community hospital and provide ongoing frail-elderly home-visit support, especially for clients with dementia who have no known family. This specialized team can also help the group of community-based physicians and PCN nurses do comprehensive geriatric assessments, initiate treatments, including rehabil-

itation, and provide help in emergency situations, which has been shown to help alter the pattern of emergency-room use and facilitate access to acute-care hospital beds when needed. When decisions are required about whether to enact personal directives or EPOA, or gather information to complete application for Public Guardian or Trusteeship, the MTFC team can spend the time necessary to conduct assessments for the physician or regional program geriatrician.

Clients and their families are also aided in developing personal

initial assessment time in a hospital-based out-patient geriatric clinic was saved by having the PCN nurse or MTFC team member complete much of the geriatric history work-up prior to the patient being seen, especially for dementia assessment and care.

The amount of information gathered on each patient has helped create a smoother transition for patients requiring admission from home to hospital through the emergency room by having the MTFC staff navigate the patient and their information through the ER. This

Discussions between the PCN geriatric physician lead and geriatricians in 2007 estimated that approximately 25 minutes of the initial assessment time in a hospital-based out-patient geriatric clinic was saved by having the PCN nurse or MTFC team member complete much of the geriatric history work-up prior to the patient being seen, especially for dementia assessment and care.

directives or EPOA when newly diagnosed with dementia, and are introduced to support groups such as the Alzheimer Society and other community agencies.

Patients and families may need time and encouragement to use these available resources, and in a busy family practice, the information can be provided. However, readying for their acceptance is a process that takes time, an element more available to the clinic PCN nurse or MTFC member.

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significantly reduces the amount of time gathering information usually devoted to an elderly patient by ER staff. Also, concerned family members appear to be reassured when they are aware of the plan regarding their relative's care.

The MTFC team conducted a survey, which had a 35% response rate, of participating physicians to assess the circumstances of influence that impact a physician's decision to make a referral to the MTFC team. The physicians confirmed that they would first turn to the PCN nurse in the clinic to assist them, and then would call for help from the MTFC team except if in

crisis, where the physician would turn first to the MTFC.²

Case Study: Mrs. H

As a family physician, consider how you would feel and what you would do given the following case scenario.

A solo family physician received a three page letter from a patient's friend, specifically expressing concerns for what she thought was Mrs. H's mental-health decline which included:

- forgetting that she had fallen recently;
- repeating the same questions "four times between 63rd Avenue and 34th Avenue" as they were driving to go shopping;
- recalling stories from when she was a child, but not remembering recent events;
- supposedly losing her purse at her friend's home, and later finding it in her friend's bathroom drawer; and
- paying her income tax twice the previous year, and feeling she needed to send in another payment when she received a reimbursement check from Revenue Canada.

The family physician arranged for the patient to visit the clinic within a week of receiving the letter of concern, but the patient missed her appointment. She also did not return calls to the clinic when messages were left for her to do so.

Does this case seem familiar? Are family physicians prepared and poised to respond to concerns related to cognition as illustrated by

this? Would you be concerned about the amount of time needed to facilitate a resolution to the above problem? As a solo practitioner with a busy practice and one receptionist, how much time could you afford in solving the issues potentially arising?

When Mrs. H failed to contact her physician, the MTFC team received a referral. An MTFC team member then made multiple calls and home visits to the patient and was unable to gain entrance to her apartment. Finally, contact was made with the apartment manager, who let the nurse gain entrance through the main door of the building. Mrs. H allowed a visit by the nurse who noted that the apartment was tidy and the fridge stocked with a variety of foods (current expiry dates). The patient denied use of any medications (prescriptions had expired). However, Mrs. H was not aware that the TV program she was

watching was a security camera image of the front lobby.

With the coordinated efforts of the MTFC team, Mrs. H's friend, her physician and the PCN nurse, Mrs. H was seen by her physician for the first time in many months. It was determined by her physician that guardianship and trustee applications would be required for his patient following the diagnosis of dementia. The MTFC team then started to gather the necessary data for the applications.

During these visits, Mrs. H became very paranoid, barricaded herself in her apartment and refused to eat. She also paid her rent three times in one month. The MTFC team member advised the landlord to stop cashing the checks. It was determined at the last appointment with her physician that Mrs. H had lost about 12 pounds in four weeks, and arrangements were made to admit Mrs. H

to the geriatric unit. Information about the patient's care was provided to the ER staff and geriatric team that would admit her to their service.

Conclusion

The addition of well-educated nurses in the area of geriatric medicine who are mentored in the physicians' offices provides the necessary support to patients and their caregivers dealing with dementia. Furthermore, the additional support of the MTFC team has expanded the physician's care into the community for patients who are unable or unwilling to come to the office for care.

References:

1. DeBruin J, Zirk H, Daly S. Edmonton Southside PCN Geriatrics Needs Assessment Study. Presented at Geriatric Grand Rounds, 2006 Edmonton.
2. Southside PCN More Time for Care Results of Physician Referral Survey 2008, unpublished.