PHYSICIAN ASSISTANTS: IMPROVING ACCESS TO CARE FOR CANADA’S SENIORS
LEARNING OBJECTIVES

• Develop a clear understanding of the PA role in a homecare program

• Increase knowledge of how PAs can positively impact a homecare program

• Develop an appreciation of how PAs can provide increased access to quality care in an affordable manner for the aging population
INTRODUCTION

• PA at Taddle Creek Family Health Team (FHT) since January 2012
• Initially funded by HFO on 2 year new graduate contract
• Executive Director got approval for permanent funding October 2013
PA ROLE AT TADDLE CREEK FHT

• PrimaryCare@Home Program Coordinator
• PrimaryCare@Home PA
• Primary Care Clinical PA
• Certified Respiratory Educator
http://taddlecreekfht.ca/programs/primary-care-home/
Patients are identified as truly homebound if they meet at least one criteria from two separate categories.
PC@HOME PRACTITIONER

- Facilitating/updating coordinated care plans (CCPs), advanced care planning
- Providing primary care, both acute management of inter-current illness and chronic disease management that reflects a palliative and therapeutic harmonization (PATH) approach
PC@HOME PRACTITIONER

- Chronic disease visits
- Urgent calls/visits
- Telederm consults

- Procedures in the home
  - Phlebotomy
  - Joint injections
  - Ear flush
  - POC INR for patients on blood thinners
  - Immunization
CASE #1
PC@HOME COORDINATOR

• Primary contact for patients and caregivers
• Maintain active roster
• Quarterly program stats
• Collaborate with FHT/community allied HCPs
• Liaising with community services and agencies
• Coordinating team meetings every 3 weeks
• Management of referrals
• Updating coordinated care plans
TYPICAL SCHEDULE
<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td># Visits population</td>
<td>1000 visits</td>
<td>1048</td>
</tr>
<tr>
<td>Note: broadly defined to include face-to-face, phone calls and emails</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Population with coordinated care plans</td>
<td>70%</td>
<td>78%</td>
</tr>
<tr>
<td>% Population with flu immunization</td>
<td>70%</td>
<td>73%</td>
</tr>
<tr>
<td>% Population with other immunizations</td>
<td>75%</td>
<td>100%</td>
</tr>
<tr>
<td>% Population having had a medication reconciliation</td>
<td>80%</td>
<td>99%</td>
</tr>
<tr>
<td>% Emergency Department visits diverted (person/family-reported)</td>
<td>10%</td>
<td>9% (17 people/families self reported)</td>
</tr>
<tr>
<td>% Population who had a CCAC Home Safety Assessment</td>
<td>50%</td>
<td>70%</td>
</tr>
<tr>
<td>% Population with follow-up home visit within 2 weeks of hosp. discharge</td>
<td>80%</td>
<td>100% (16 people)</td>
</tr>
<tr>
<td>% Population where advanced care planning discussed</td>
<td>80%</td>
<td>93%</td>
</tr>
</tbody>
</table>
“We would like to thank you very much for all your assistance and we know that without your help a lot that has been done for my parents may not have been possible. You and Dr. McMurren are a god send to us. We truly appreciate all your efforts.” 31 May 2017

“Kety, Andrea, and Dr. McMurren, I can't thank you and the rest of the team enough for all of your time, help, support, patience, and wisdom in your dealings with my parents. You are all truly remarkable individuals. We will be forever in your debt. Thank you.” 5 July 2017

“Regular visits enable the healthcare provider to be more proactive in possible health issues” 1 July 2015

“Dr McMurren and Andrea Filip have been a great help to my entire family. We have avoided quite a few trips to the hospital due to Dr McMurren and Andrea Filip’s care. I’m extremely glad for their service” 13 April 2015
I have discovered how the physician assistant role can uniquely improve person- and-family-centered care in its ability to encompass a vast scope of responsibilities, from coordinating complicated logistics to performing joint injections.

Chase Everett McMurren  Physician Lead, PrimaryCare@Home Program, Taddle Creek FHT Medical Director and Psychotherapist, Al and Malka Green Artists' Health Centre, Toronto Western Hospital Lecturer, Department of Family and Community Medicine, University of Toronto Investigating Coroner, Toronto West, Province of Ontario 23 February 2016
Without the presence of this skilled PA we would not be able to offer our homecare program as none of our physicians has the time to make housecalls or to monitor high needs patients so closely. This is the best use of the right care at the right time mobilizing a health care professional who can augment the medical doctors’ reach into the community. We now have a robust program because of her involvement.

Pauline Pariser, MASc MD CCFP FCFP
Co-Lead Physician, Taddle Creek FHT
Associate Medical Director, Primary Care Lead, University Health Network
27 August 2012
CLINICAL PHYSICIAN ASSISTANT

• Advanced Care Plans/Coordinated Care Plans
• Cognitive Assessments (MOCA’s)
• Geriatric preventative care visits
THE VALUE OF PA’S IN FHT’S

Integration
(Part A – 2.0)
✓ Patient First Act
✓ TC LHIN

Access
(Part A -1.0)
✓ For non Enrolled Patients
✓ Inter-professional consultations
✓ Home Visits

System Navigation
(Part A – 2.2)
✓ Partner with other providers/ organization

PAs

S.Kennedy, Executive Director, TCFHT.on.ca AFHTO Teleconference 5/24/2017
HOW PA’S IMPROVE CARE

• Smoother transitions i.e. post discharge planning
• Reduced hospitalizations due to chronic disease exacerbation with closer management
• Easier collaboration amongst care providers with PA as the coordinator
• Reliable access point and timely interactions with caregivers reducing their stress
• Coverage when MD is away or has other obligations
• PA usually able to do urgent visits the same day/next day
ADVANCING PA’S IN SENIOR CARE

• Advocate for our ability to extend medical services to the underserved/vulnerable/isolated/invisible members in the community

• Talk to Executive Directors of CHCs and FHTs about how PAs can improve access to care and request they submit a proposal for a PA position at their clinic for this population in their next fiscal budget

• Explain to other HCPs that our broad generalist knowledge base puts us in an excellent position to do clinical geriatric assessments
REWARDS OF A PA IN HOMECARE

- Flexibility
- Autonomy
- Continuous improvement processes/evolution of role and skillset
- Room for curiosity/creativity in treatment plans
- Privilege see patients in their natural environments and at their most vulnerable
- Regular follow up allows us to see impact of treatment changes
SUMMARY

PAs can positively impact health care delivery for the aging population by

• improving patient outcomes through increased and timely access to healthcare providers
• applying a team approach to management of chronic diseases
• extending care into the community enabling high risk patients to remain safe and comfortable in familiar settings, while receiving high quality medical care
PEARLS FOR PRACTICE

1 Clinical Frailty Scale

Clinical Frailty Scale*

1. Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2. Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g., seasonally.

3. Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4. Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.

5. Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6. Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7. Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).

8. Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill - Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In severe dementia, they cannot do personal care without help.


http://geriatricresearch.medicine.dal.ca/clinical_frailty_scale.htm
2 THE SURPRISE QUESTION

• Would you be surprised if this patient were to die in the next 6-12 months?
• It’s an intuitive question encompassing co-morbidity, social and other factors.
• If you would not be surprised, then what measures might be taken to improve their quality of life now and in preparation for the dying stage?

(Pattison M, Romer AL, 2001)
3 SPEAK UP

http://www.advancecareplanning.ca
QUESTIONS?
REFERENCES


PC@HOME SPECIAL NOTE

PrimaryCare@Home Coordinated Care Plan Summary, updated (date: •  )

Clinical Frailty Scale: • (date: •  )

(http://geriatricresearch.medicine.dal.ca/pdf/Clinical%20Faily%20Scale.pdf)

Primary LHIN coordinator: •

Phone: • Fax: • E-mail: •

Other team members:

Rehab therapists (eg. OT, PT): •

Other physicians: •

Community programs:

Meals-on-Wheels: «discussed •

Faith-based (eg. monthly Eucharist at home): «discussed •»

Day program: «discussed •»
PC@HOME SPECIAL NOTE (CONTINUED)

Goals of care:
Last ACP discussion: •
  What is most important to me right now?
  •
  What concerns me most about my health right now?
  •
  What things make life worth living?
  •

DNR/AND (allow natural death): •
Location of form: •
«When my heart/breathing stops, if someone is close by, I would want them to: •»
«If my condition(s) get worse and it looks like I might not survive, I would like to: •»

SDM/POA Personal Care: •
  Relationship: •
POA Finance: •
  Relationship: •
POA forms signed? «YES» «NO»
Key caregivers at home: ●
Last caregiver burnout discussion: ●
Last fall: ●
Lifeline? «YES» «NO»

Cognition:
Concerns raised? «YES» «NO»
Documented testing: MMSE: ● (date: ● )
MOCA: ● (date: ● )
Alzheimer Society connection made: «YES» «NO»
Day programs reviewed: «YES» «NO»

Last hospitalization: ●
PC@HOME SPECIAL NOTE (CONTINUED)

Medication optimization:
Last medication review: •
Pharmacy: •  Phone: •  Fax: •
Adherence issues? «YES» «NO»
Blister pack?  «YES» «NO»
Last creatinine clearance: •
Pneumovax up-to-date? «YES» «NO»

Financial optimization:
Taxes filed?  «YES» «NO»  Year: •
CPP/Old Age/GIS optimized?  «YES» «NO»  Year: •
Disability/caregiver credits discussed?  «YES» «NO»  Date: •
(Disability Tax Credit is only beneficial if line 420 on the tax return (i.e. Net Federal Tax) has an amount. If the amount is 0, the credit won’t help. If the caregiver has an amount, the credit can be transferred to them)
Canadian Revenue Agency contact number: 1-800-959-8281

Key Practitioner Contact Information:
TCLHIN PHYSICIAN LINE

416-217-3935
HOME VISITS

Paddle Creek
Family Service's
Primary Care Team
Home Program

Notice for ________ to go on visit on ________

1. Daily question: “What can I do TODAY to make my day better?”

My next visit is booked for: ________________________

If I need help sooner, I can call 416-260-1315
I will press O when the recording is heard to get help.

If I am worried and need help as soon as possible, I will say to the person who answers the call: URGENT!
Otherwise, whatever the team will call me when it’s safe.

To get nursing advice overnight and at the weekend, I can call 1-866-997-0006

Your IncomeCrunch Team includes: Dr. Richard Grant, Shuhua Zhou, Melissa Villanueva. We can be reached at: 416-260-1315

Office hours are Monday to Friday, 9:00 AM to 5:00 PM. For weekends, please call 416-332-3214.

Our website is www.icecrunch.com/home-care-website.

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