Partners in Care: Navigating Resources for Frail Seniors

Case Study 1 Patient Journey Map (3-6 months) - Early to Moderate Frailty

MARCH 2024

Meet Herman

- 80 years old
- Lives alone
- Daughter is caregiver with limited time
- Isolated & lonely
- Chronic conditions: COPD, CHF, T2DM

Herman's daughter brings him to his Primary Care Provider for a medication refill. He is having difficulty doing his daily walks and he often forgets to eat. He is staying in and sleeping more. He is feeling hopeless.

Primary Care Provider speaks to Herman about PCN IPT and how they can help. Herman agrees to getting help and Provider sends a referral requesting CC and OT support

IPT Intake Clinician reaches out to Herman to discuss needs and goals and speaks to Herman's daughter (with permission). CC & OT support confirmed, and appointments are booked.

CC works with Herman on low mood and feelings of hopelessness. Sessions take place over 3 months. Modalities used would be based on the fundamental reasons for low mood.

OT & CC work collaboratively to develop behavioral activation strategies. OT further explores and assesses Herman's sleep, ADLs, iADLs. Help develop smart goals around sleep hygiene and daily activity schedule.

Internal referral to SW to support social connection. SW will identify community resources based on Herman's needs, values & interests. SW works with Herman around Advance Care Planning based on Herman's values & willingness to engage.

CC & OT assess that Herman may benefit from RD to explore calorie and nutrient dense foods. Low energy is restricting meal prep & exercise.

CP can support by reviewing meds to see if they are contributing to his mood, sleep or energy challenges. Could then speak with Herman and/or Provider about any recommended changes to meds.

OT – Occupational Therapist
CC – Clinical Counsellor
SW – Social Worker
RD – Registered Dietitian
CP – Clinical Pharmacist
ADL – Activities of Daily Living
iADL – Instrumental Activities of Daily Living

AT DISCHARGE: Herman has clear post-IPT plan which includes community resources, mood/ energy/sleep improvement, ongoing structures to ensure he can maintain gains. Thorough and clear discharge summary sent to provider.

ACCESSING COMMUNITY SUPPORTS

- Family Caregivers of BC – can provide support to Herman's daughter
- 211 BC - Help with resource and service navigation
- Nidus Registry – Advance Care Plan ensures Herman's healthcare wishes are upheld should he no longer been able to speak for hims elf

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Case Study 2 Patient Journey Map – Moderate to Severe Frailty

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Herman's Journey

- 85 years old
- Still living alone
- Two recent falls
- Admitted to hospital 2X in the last year due to exacerbation of CHF
- Daughter experiencing caregiver burnout

5 years later, Herman's daughter brings him to his Primary Care Provider following hospitalization. He is not taking his medication regularly, isn't safe cooking or bathing on his own. He is losing weight and sleeping most of the day. He is having mobility issues and more homebound.

Primary Care Provider assesses and refers to Home Health Services for case management assessment, fall & home safety assessment and possible initiation of home support services.

Home Health Clinicians can support goals of care conver-sations to ensure care plans are reflective of personal values & decision making.

Explore interest in Adult Day Program. Clients typically attend 2 or more days/week.
Services offered:

- Therapeutic social and recreational activities
- Special events & seasonal celebrations
- Falls prevention education and movement classes
- Health status monitoring (weight, blood pressure and nutrition)
- Dementia support and pain management
- Caregiver support including respite

Additional community supports such as Meals on Wheels or volunteer visitors could be explored

ACCESSING COMMUNITY SUPPORTS

- Family Caregivers of BC – support daughter with caregiver burnout
- 211 BC Help with resource and service navigation
- Nidus Registry – Advance Care Plan (ACP) ensures Herman's healthcare wishes are upheld should he no longer be able to speak for himself

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Case Study 3 Patient Journey Map – Onset of Dementia

MARCH 2024

Meet Lena

- 78 years old
- Lives in family home with 80-year-old husband
- Recent hospital discharge – urosepsis, protracted delirium
- Diagnosis of major neurocognitive disorder (vascular)
- Chronic Conditions: hypertension, atrial fibrillation, T2DM

Lena's husband is struggling to accept the diagnosis. He has noticed a significant change in her memory and behavior. She is often agitated, anxious and can be aggressive. She is up at night, so he is not sleeping. He has stopped driving due to an accident. They have no surviving family.

Primary Care Provider previously referred to Home Health Services. Lena is connected to a case manager, receives home support for bathing assistance and attends an ADP two times per week.

Over the past several months, Lena has become incidentally more physically responsive to other participants at the ADP and refuses personal care from community health workers.

Primary Care Provider has completed an assessment and ruled out potential medical causes for Lena's worsening mood and behavior. A SSRI has been started as a first line approach to addressing mood and responsive behavior.

After a 6-week trial of a SSRI, Lena continues to present with sleep disturbance and agitation. Home Health has ceased home support as she and her husband refuse the service. Referral is made to the OA MHSU Program for assessment & treatment of dementia symptom, care planning and caregiver support.

After 6 months, further complications have arisen including a 3kg weight loss and frequent falls. Lena's husband's health is failing. A referral is made to the Short-Term Assessment and Treatment Inpatient Unit for a comprehensive geriatric medical and psychiatric assessment & treatment.

ACCESSING COMMUNITY SUPPORTS

- Family Caregivers of BC – support Lena's husband with caregiver resources
- 211 BC Help with resource and service navigation
- Nidus Registry – Advance Care Plan ensures Lena's healthcare wishes are upheld should she no longer be able to speak for herself
- Public Guardian & Trustee – available to support if needed (no ACP and substitute decision maker)