IMPLEMENTING & EVALUATING THE ASSESSMENT URGENCY ALGORITHM IN PRIMARY CARE AND AN EMERGENCY DEPARTMENT

WATERLOO WELLINGTON LOCAL HEALTH INTEGRATION NETWORK

April 20th, 2016

Submitted by:
Waterloo Wellington Rehabilitative/Complex Continuing Care Council and Waterloo Wellington Frail Elderly Medically Complex Steering Committee

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EXECUTIVE SUMMARY

INTRODUCTION

Screening older adults for ‘risk’ provides an opportunity to offer supportive interventions prior to an adverse outcome. A review conducted by Ovretveit (2011) found that care coordination based on risk identification of individuals led to cost savings and an increase in quality of care. Furthermore, providing these individuals with referrals for community supports and/or self-management strategies promotes opportunities for sustaining the functional independence of older adults.

The lack of consistent screening and assessment tools has led to inefficient assessment processes, confusion in interdisciplinary communication, and limited ability to assess quality and outcomes (Stolee, 2010). One way to resolve this challenge is to adopt standardized screening and assessment tools that support consistent language across assessments, consistent development of care plans, and more efficient communication between care providers (Heckman et al., 2013; Challis et al., 2004; Gray et al., 2009). Standardized approaches have been shown to improve care quality and outcomes (Boorsma et al., 2006). Although standardized approaches have clear benefits, primary care settings have limited time to complete assessments. Therefore, assessment processes must be efficient and identify patients needing referrals to community services or to specialists for more comprehensive assessments.

The purpose of this project was to trial a standardized approach for assessing risk in older (70+) adults and to develop pathways to support referral to appropriate supports based on the results of the risk assessment. To this end, the interRAI Assessment Urgency Algorithm (AUA) was implemented in primary care settings and an emergency department.

The AUA is a risk-stratification screening tool that helps to identify older adults in need of geriatric assessment and who may be at risk of adverse outcomes. The AUA stratifies older adults into six categories (1 – low risk, 6 – high risk). The AUA can be utilized to identify referral needs for older adults and to facilitate subsequent care planning. The AUA score directs primary care staff and patients to a portfolio of care options, ranging from self-managed care (which will be most appropriate for low-risk patients), support for care coordination and system navigation, and access to specialized care (most appropriate for higher-risk patients) and community resources. The screening tool, together with customized referral pathways, helps to prioritize assessments and guide referrals to appropriate services based on risk. The AUA is compatible with other interRAI instruments used across the Waterloo Wellington LHIN.

IMPORTANT FINDINGS

The AUA was implemented in two Family Health Teams, one Community Health Centre and one Emergency Department from January 2015 to March 2016.

Using an implementation framework, the following steps occurred:

i. Consultations were completed with primary care and community care providers to understand current referral processes and communication and engagement practices;

ii. Using information from the consultations, referral pathways were created, aligning with the AUA level of risk;

iii. An online referral mechanism, Caredove¹, was chosen to facilitate referrals. An AUA-specific landing page was added to the Caredove website (http://easycoordinatedaccess.com/aua/);

iv. AUA and Caredove training was provided to primary care and emergency department pilot teams

¹ Caredove (www.caredove.com) is an online database of community services. Caredove facilitates referrals to services across the health care system.
• **560 older adults were screened** across three primary care sites
  - 31 (5%) screened High Risk
  - 144 (26%) screened Moderate Risk
  - 385 (69%) screened Low Risk

• Over a 3 week data collection period, 33 older adults were screened in the emergency department
  - 18 (55%) screened High Risk
  - 5 (15%) screened Moderate Risk
  - 10 (30%) screened Low Risk

• **In total, 60+ referrals** were completed to Community Support Services (CSS), Waterloo Wellington Community Care Access Centre (WW CCAC) and Specialized Geriatric Services (SGS)

Qualitative data (interviews with patients, caregivers and health care providers) demonstrates overall support for the AUA and referral processes.

> “The AUA does flag people, because when you’re going through you’re thinking “oh I think they’re managing”, but that’s actually not the case….so this helps to make sure the patient has the right support” - Health Care Provider

Particularly noteworthy is the high percentage of patients in primary care who scored within a low to moderate risk level (95%) which suggests that this screening tool is well situated within primary care and captures those who may benefit from early intervention. The AUA also assists with identifying individuals who are in urgent need of a more comprehensive assessment or service referrals. Providers using the tool see the value in it, and have said that they identified some patients in the moderate-high risk category who they previously thought were managing well.

The implementation of the AUA allows for timely access to services based on the needs of the individual. Continued support of a broad roll out in primary care will ensure a decision support mechanism which will target resources efficiently, identify those most at risk for functional decline which can lead to increased emergency department visits and unnecessary or early institutionalization.

**NEXT STEPS**

This project provided an opportunity to strengthen the role of primary care within the broader health system, including positioning primary care to identify patients who are in need of services and/or further assessments, and to coordinate care accordingly. Broader adoption of the AUA, with a particular emphasis on non-affiliated physicians and rural communities would further these aims. Broader adoption of the AUA in emergency departments is also needed to support consistent screening across the LHIN. Furthermore, ongoing education, supports for sustainability, capacity building and quality improvement related to the interRAI suite of tools is needed across multiple health sectors.
INTRODUCTION

Primary health care provides and coordinates care for a growing population of older persons with complex health conditions and chronic diseases, but at present would benefit from resources and tools to perform these roles efficiently. Prior research, literature reviews, and extensive stakeholder consultations have identified priorities for improving primary health care for older adults: consistent processes to identify and assess older persons and create individual care plans aligned with risk levels; self-management supports; improved care coordination and system navigation; improved communication and linkages with specialists and community resources; and patient-centred care and engagement.

The lack of consistent screening and assessment processes has led to inefficient assessment processes, confusion in interdisciplinary communication, and limited ability to assess quality and outcomes (Stolee, 2010). Consultations with older adults demonstrate that this population want providers to have consistent referral processes (Manderson et al., 2012). To achieve this, primary care providers require tools to screen for risk in older adults, and then, when needed, to conduct more comprehensive assessment or refer to specialist resources (Heckman et al., 2013; Challis et al., 2004; Schmader et al., 2004).

One way to resolve this challenge is to adopt standardized screening and assessment tools that support consistent language across assessments, consistent development of care plans, and more efficient communication between care providers (Heckman et al., 2013; Challis et al., 2004; Gray et al., 2009). Standardized approaches have been shown to improve care quality and outcomes (Boorsma et al., 2006). Although standardized approaches have clear benefits, primary care settings have limited time to complete assessments. Therefore, assessment processes must be efficient and identify patients needing referrals to community services or to specialists for more comprehensive assessments.

Project Purpose: The interRAI Assessment Urgency Algorithm (AUA) was implemented in primary care settings and an emergency department to trial a standardized approach to risk assessment with subsequent referral to appropriate supports based on the identified level of risk. Referral pathways were developed to begin to standardize referrals based on identified risk. The AUA is compatible with other interRAI instruments used across the Waterloo Wellington LHIN, facilitating coordinated care planning.
STRATEGIC ALIGNMENT WITH PROVINCIAL & LHIN PRIORITIES

ASSESS AND RESTORE

This project directly aligns with the goals of the Ontario Ministry of Health and Long-Term Care (MOHLTC)’s ‘Assess and Restore’ initiative, which are to, “extend the functional independence of community-dwelling frail seniors and other persons for as long as possible; reduce caregiver burden by improving psychosocial and health outcomes for community-dwelling frail seniors and other persons; and facilitate the adoption of evidence-based clinical processes and interventions that have demonstrated efficacy in improving functional independence for community-dwelling seniors and other persons” (MOHLTC, Assess and Restore Guideline 2014, p1-2).

This project addresses the priority of extending the functional independence of community-dwelling frail seniors. Results of this project demonstrate that by screening older adults for ‘risk’, there is opportunity to provide supportive interventions prior to an adverse outcome. Providing these individuals with referrals for community supports and/or self-management strategies promotes opportunities for sustaining the functional independence of older adults. The high percentage of patients in primary care who scored within a low to moderate risk level suggests that this screening tool is well situated within primary care and captures those who may benefit from early intervention.
PATIENT’S FIRST REPORT

The project also aligns with the Ontario Patient’s First Report (2015):

Access: ...people want to take steps to prevent illness; they need to be able to get the right kind of help, whether from a family doctor, nurse-practitioner, pharmacist or a number of different care providers

- This project provides an opportunity to leverage AUA information and build communication between sectors using a common language and a common assessment tool.
- Access to comprehensive, standardized and reliable clinical information will improve efficiency of care and promote inter-professional collaboration through a common assessment language.

Connect: ...Connect services – delivering better coordinated and integrated care in the community, closer to home. The foundation has been laid to enable the home and community care sector to meet the needs of today’s population with an enhanced focus on seniors and chronic disease management.

- There has been ongoing refinement of Caredove throughout the project. Most recently, Caredove has included a field that communicates the AUA score and associated information across Health Care Sectors.
- The incorporation of feedback from patient and provider interviews has guided implementation.

Inform: ...It is about living a healthier life, avoiding getting sick and learning about good ways to manage illness when it happens. Creating a culture of health and wellness will support Ontarians in making educated, informed decisions about their care.

- Patient feedback (see page 24 of this report) highlights patient interest in being informed about their healthcare.

Protect: ...targeting funding on preventing illness and improving results for patients.

- Continued support of a broad roll out in primary care will ensure a decision support mechanism which will target resources efficiently, identify those most at risk for functional decline which can lead to increased emergency department visits and unnecessary or early institutionalization.

Patients’ First: Ontario’s Action Plan for Health Care (MOHLTC, 2015)
**PROJECT OVERVIEW**

**AUA OVERVIEW**

The AUA is a risk-stratification screening tool that helps to identify older adults in need of geriatric assessment and who may be at risk of adverse outcomes. The AUA stratifies older adults (70+) into six categories (1 – low risk, 6 – high risk). The screening tool, together with customized referral maps, helps to prioritize assessments and guide referrals to appropriate services based on risk.

The implementation of the AUA allows for timely access to services based on the needs of the individual. The AUA score directs primary care staff and patients to a portfolio of care options, ranging from self-managed care (which will be most appropriate for low-risk patients), support for care coordination and system navigation, and access to specialized care (most appropriate for higher-risk patients) and community resources.

**ORGANIZATIONAL STRUCTURE & PROJECT TEAM**

![Diagram of organizational structure and project team]

*Frail Elderly Medically Complex (FEMC) Committee:* The FEMC Committee is a sub-committee of the Waterloo Wellington Rehabilitative Care Council and comprises representatives from across the health care system including representation from primary care, community care, acute care, post-acute, long-term care, mental health, specialized geriatric services and the WW Geriatric Services Network. Although this project’s focus was primary care and emergency department settings, the referral pathway development spanned various health
sectors. The FEMC identified the need for consistent screening tools and the implementation of the AUA in primary care and emergency departments became part of their annual work plan. St. Joseph’s Health Centre Guelph as the Lead Organization and the FEMC provided system level oversight to the implementation of the AUA.

*Project Leads:* A part-time project lead and a part-time evaluation lead spearheaded implementation and evaluation within primary care settings and worked collaboratively with a project lead at St. Mary’s emergency department (ED) for ED implementation. Within both settings, project leads conducted stakeholder consultations, developed care pathways, trained providers, and supported implementation and evaluation.

**PILOT SITE DESCRIPTIONS**

**MOUNT FOREST FAMILY HEALTH TEAM**
Mount Forest Family Health Team (MFFHT) in Wellington North (rural), includes: physicians, primary care nurses, nurse practitioners, medical secretaries, a patient care coordinator, pharmacist, nurse clinicians, lab technicians, registered dieticians, health counsellors, and administrative staff.

**NEW VISION FAMILY HEALTH TEAM**
New Vision Family Health Team (NVFHT) in Kitchener (urban), includes 12 family physicians, nurses, nurse practitioners, clinical pharmacist, social workers, registered dieticians, respiratory therapists, and administrative staff.

**WOOLWICH COMMUNITY HEALTH CENTRE (WELLESLEY SITE)**
Woolwich Community Health Centre (WCHC) operates two health centre sites: the main site in St. Jacobs and the satellite site in the village of Wellesley. The Linwood Nurse Practitioner Office (LNPO) is an affiliated access point of the Wellesley site. The WCHC serves the rural townships of Woolwich, Wellesley, and Wilmot, and small areas of Perth County/North Easthope. Among the residents of WCHC’s catchment area, priority for primary health care and program development focuses on populations that may experience greater barriers to health or barriers to accessing health resources. Seniors (60+) and their caregivers are noted as one of the priority populations.

**ST. MARY’S HOSPITAL**
St. Mary’s is the second-largest acute care hospital in the St. Joseph’s Health System and serves the residents of Waterloo, Wellington County, and extending out to Dufferin, Grey-Bruce and beyond. St. Mary’s has nearly 2000 staff, physicians and volunteers. St.Mary’s Hospital is the regional cardiac care and respiratory centre.
CURRENT STATE OF AUA IMPLEMENTATION ACROSS WATERLOO WELLINGTON

The AUA risk screening tool is embedded within the Contact Assessment, which is part of the interRAI suite of assessment and care planning tools. interRAI instruments are currently used across Waterloo Wellington in long-term care facilities, CCAC, community support services and at Grand River Hospital (ED Screener) Emergency Department. The AUA is not currently used within primary care.

This project builds on the work of the Grand River Hospital’s ED Screener implementation, which developed care referral pathways associated with risk levels. Grand River Hospital’s implementation framework has been adapted for use in this project.

The map below illustrates this project’s AUA/ED Screener Implementation across the LHIN.

Mount Forest FHT has 12,500 rostered patients, 20% aged 65+ years and 8% aged 75+ years.

Woolwich CHC implementation was at the Wellesley site which has 2,178 rostered patients, 11% aged 65+ years and 5% aged 75+ years.

New Vision FHT has 24,000 rostered patients, 9.7% aged 65+ years, and 3.7% 75+ years.

St. Mary’s Hospital ED visits: 4400 patients/month Age 65-80: 18.5% 80+: 11%

This map highlights AUA adoption in three primary care sites and one Emergency Department. Based on the percentage of patients rostered 65+ within the primary care sites (7290) and total population of seniors aged 65+ in WWLHIN (109,000), approximately 6% of patients in primary care now have access to this screening option.

http://www.waterloowellingtonlhin.on.ca/aboutus/population_snapshot.aspx
AUA IMPLEMENTATION

IMPLEMENTATION PROCESS

UNDERSTANDING THE CURRENT CONTEXT OF PRIMARY AND COMMUNITY CARE

To gain a better understanding of the current referral processes within primary care sites, communication mechanisms between providers, and information about patient engagement in care planning, focus groups and individual interviews were conducted with primary care and community care providers. Interviews were conducted at three study sites (Mount Forest FHT, New Vision FHT, and Woolwich CHC). Focus groups and individual interviews were 60-90 minutes in length; these were audio-recorded and transcribed verbatim. Collected information was used to validate current referral pathways and address any gaps.

Consultations Completed:

<table>
<thead>
<tr>
<th></th>
<th>Community Care Providers</th>
<th>Primary Care Providers</th>
<th>Patients and Caregivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Focus Groups (n=6-8/group)</td>
<td>3 Focus Groups (n=6-8/group)</td>
<td>1 Focus Group with SHARP² (n=4)</td>
<td></td>
</tr>
<tr>
<td>5 Individual Interviews</td>
<td>3 Individual Interviews</td>
<td>1 Individual Interview</td>
<td></td>
</tr>
</tbody>
</table>

REFERRAL PATHWAY DEVELOPMENT

Based on focus group and interview information, referral pathways were developed to align with the AUA scores. Caredove, an online referral mechanism, was chosen as the referral platform in Waterloo Wellington. Caredove modified their site to enable an ‘AUA’ specific link that prepopulated risk levels with appropriate service options. Additionally, Caredove added an “AUA Score” box to allow primary care providers to input the AUA score for community care providers when submitting a referral.

* See Appendix A for a more detailed description of the implementation process (including consultation process and pathway development).

AUA AND CAREDOVE TRAINING

An interRAI Knowledge Broker (KB) conducted initial 1.5 hour training sessions with MFFHT and NVFHT and the project leads conducted training with the Woolwich CHC (Wellesley site). Training materials were developed by the interRAI KB and AUA Evaluation Lead.

² Seniors Helping as Research Partners (SHARP) is a group of older adults that engage in health system program evaluation with the Geriatric Health System Research Group at the University of Waterloo (www.uwaterloo.ca/ghs/sharp)
To date, the following persons have been trained on, educated or informed about the AUA:

- **AUA Training:** These individuals participated in a 1.5-hour training session that included education about interRAI instruments, the AUA tool and practical application using case scenarios, referral pathways:
  
  - 7 nurses + 1 executive director at MFFHT
  - 8 nurses + 3 Medical Office Assistants at NVFHT
  - 6 frontline providers at WCHC
  - 59 nurses + 2 managers at St. Mary’s Hospital

- **AUA Education:** These individuals received information about implementation of the AUA across Waterloo Wellington, background about the AUA tool and how the score translates into referral pathways:
  
  - 60 providers in Waterloo Wellington
  - 29 people in-person at the Provincial AUA Education Day [including 20 OTN sites with 1-8 individuals at each site (Feb 20th, 2015)]

- **AUA Informing:** Brief overview of the project including the implementation and evaluation process:
  
  - 170 Waterloo Wellington providers informed on primary care project and AUA implementation at the WW Passport Day (Feb 10th, 2015)
  - 25 Waterloo Wellington providers informed on primary care project and AUA implementation at the WW Passport Day (Mar 24th, 2016)
  - 13 physicians and LHIN representatives informed at the LHIN primary care advisory meeting
  - 61 sites logged in for OTN Provincial Presentation (Jan 20th, 2016)

**EVALUATION PROCESS**

**EVALUATING IMPLEMENTATION OF THE AUA AND CAREDOVE IN PRIMARY CARE**

**Health Care Providers:** Individual interviews were conducted with primary care and community care providers to understand experiences using the AUA and Caredove. Individual interviews were conducted face-to-face or by telephone and lasted 60-90 minutes in length. The interviews were audio-recorded and transcribed verbatim.

**Patient and Caregivers:** In-depth, semi-structured, face-to-face interviews were completed with patients and a family caregiver to capture individual perspectives. Interviews were completed at two time points, the first interview took place within a week of the AUA being administered at the clinic, and the second interview took place two months later to assess subsequent experiences. Specific attention was placed on the perceptions of engagement in care decision-making and thoughts around the process of screening and being referred to services.
Interviews Completed:

<table>
<thead>
<tr>
<th></th>
<th>Number of Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Care Providers</td>
<td>4 Individual Interviews</td>
</tr>
<tr>
<td>Primary Care Providers</td>
<td>10 Individual Interviews</td>
</tr>
<tr>
<td>Patients and Caregivers</td>
<td>11 Individual Interviews</td>
</tr>
</tbody>
</table>

**EMERGENCY DEPARTMENT IMPLEMENTATION & EVALUATION – St. Mary’s General Hospital**

The AUA Primary Care Project Leads worked closely with the AUA ED Project Lead to implement and collect initial evaluation data. Monthly meetings took place from July – December 2015 to discuss current work flow, AUA training, internal referral processes and ED letters back to primary care.
PRIMARY CARE EVALUATION RESULTS

SUMMARY OF RESULTS
The numbers of people screened during the evaluation period [June 2015 – December 2016 for NVFHT and MFFHT and February-March 2016 for WCHC] are provided below. Of note, each site has fully embedded the AUA into current practice.

- **560 older adults were screened** across three primary care sites
  - 31 (5%) screened High Risk
  - 144 (26%) screened Moderate Risk
  - 385 (69%) screened Low Risk

- **40+ referrals** were completed to community support services (CSS), CCAC and SGS (Specialized Geriatric Services)
  - 24 referrals were made through Caredove to community support services
  - 11 other referrals were made to internal Family Health Team (FHT) programs
  - 5 other referrals were made using Easy Coordinated Access paper forms
  - Additional referrals were made to CCAC and SGS, however these were not captured in Caredove.

In total, 560 patients were screened and 40 tracked referrals were made to CSS (tracked through Caredove) and FHT programs. Feedback on AUA forms indicated that additional referrals were made to CCAC and SGS. These referrals were unable to be tracked as patients were not referred to these services through Caredove.

There were a number of reasons why referrals were not made (see chart below), including: patient having caregiver support or patient taking information home to think about options. Regardless of the reason, providers discussed the process of making notes in the patient record to discuss referrals at the next appointment.

Overall providers support the AUA screener in primary care with one provider saying:

“The AUA does flag people, because when you’re going through you’re thinking “oh I think they’re managing”, but that’s actually not the case….so this helps to make sure the patient has the right support”

Patients also supported the process; one patient said “I really think this process makes people more aware of the services. This gives patients access to information about so many different services which is helpful”.

DETAILED EVALUATION RESULTS & PATIENT/PROVIDER EXPERIENCES

*New Vision Study Site*
Of the 452 individuals screened at New Vision FHT, 58% were female and 42% were male. The figure below illustrates the proportion of patients in each risk level (ranging from level 1 – 6); the table below displays the percentage of patients stratified into 3 categories -
low, moderate and high. Seventy per cent of individuals were screened at low risk (AUA 1 and 2); 25% were screened at moderate risk (AUA 3 and 4); and 5% were screened at high risk (AUA 5 and 6).

**Proportion of Patients by Risk Level (NVFHT)**

<table>
<thead>
<tr>
<th>AUA Levels of Risk</th>
<th>Percentage of Patients Screened</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUA 1</td>
<td>61%</td>
</tr>
<tr>
<td>AUA 2</td>
<td>9%</td>
</tr>
<tr>
<td>AUA 3</td>
<td>22%</td>
</tr>
<tr>
<td>AUA 4</td>
<td>3%</td>
</tr>
<tr>
<td>AUA 5</td>
<td>1%</td>
</tr>
<tr>
<td>AUA 6</td>
<td>4%</td>
</tr>
</tbody>
</table>

**Percentage of Patients in Each Risk Category**

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Risk (1-2)</td>
<td>70%</td>
</tr>
<tr>
<td>Moderate Risk (3-4)</td>
<td>25%</td>
</tr>
<tr>
<td>High Risk (5-6)</td>
<td>5%</td>
</tr>
</tbody>
</table>

**Mount Forest FHT Site**

Of the 60 individuals screened at Mount Forest FHT, rural study site, 68% were female and 32% were male.

The figure below illustrates the proportion of patients in each risk level (ranging from level 1 – 6); the table below displays the percentage of patients stratified into 3 categories, low, moderate and high. 58% of individuals were screened at low risk (AUA 1 and 2); 32% were screened at moderate risk (AUA 3 and 4); and 10% were screened at high risk (AUA 5 and 6).
Proportion of Patients by Risk Level (MFFHT)

Percentage of Patients in Each Risk Category

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Risk (1-2)</td>
<td>58%</td>
</tr>
<tr>
<td>Moderate Risk (3-4)</td>
<td>32%</td>
</tr>
<tr>
<td>High Risk (5-6)</td>
<td>10%</td>
</tr>
</tbody>
</table>

Woolwich CHC Site

Over an 8 week data collection period, 48 older adults attended the WCHC and 100% of patients were screened using the AUA. 58% of patients screened were female (n=28) and 42% were male (n=20).

The figure below illustrates the proportion of patients in each risk level (ranging from level 1 – 6); the table displays the percentage of patients stratified into 3 categories, low, moderate and high. 71% of individuals were screened at low risk (AUA 1 and 2); 25% were screened at moderate risk (AUA 3 and 4); and 4% were screened at high risk (AUA 5 and 6).
Percentage of Patients in Each Risk Category

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Risk (1-2)</td>
<td>71%</td>
</tr>
<tr>
<td>Moderate Risk (3-4)</td>
<td>25%</td>
</tr>
<tr>
<td>High Risk (5-6)</td>
<td>4%</td>
</tr>
</tbody>
</table>

**Caredove Referrals**

For those individuals screened, referrals were made, when appropriate, to community services using Caredove. In total, 24 referrals were made with many of these referrals (30%) for housekeeping services. The average wait time for an appointment was 12 days, with the shortest wait time being only one day and the longest wait time being 29 days. The 29 day wait time was due to an error on behalf of the community organization who overlooked the referral.

The figures below illustrate the number of referrals made to a variety of community services from MFFHT and NVFHT site, respectively.
Woolwich CHC did not use Caredove as the team is most familiar with referral through paper forms (Easy Coordinated Access) but indicated they would work on using Caredove moving forward. The data indicates that a number of referrals were made for the moderate and high risk individuals. 3 referrals were made to Community Support Services (CSS), 2 referrals were made to CCAC and 2 referrals were made to Specialized Geriatric Services (SGS). There were instances where services were offered to patients, however the patient declined the option of referral at this time.

Mount Forest FHT - External Referrals by Service

![MFFHT SITE: EXTERNAL REFERALS BY SERVICE]

New Vision FHT - External Referrals by Services

![NVFHT SITE: EXTERNAL REFERALS BY SERVICE]
A number of referrals were also made internally to services that were offered by the FHT. These data were only available from New Vision FHT. The figure below illustrates internal referrals.

Internal Referrals in the New Vision FHT

![NVFHT: NUMBER OF INTERNAL REFERRALS BY SERVICE](image)

**Reasons why referrals to services were not completed**

Health care providers provided information on the bottom of the screening form that explained why referrals were not completed. The chart below displays all of the reasons why a referral was not completed across all risk levels. When a referral was not made, providers discussed the process of making notes in the patient record to discuss referrals at the next appointment.

**Table 6.4. Reasons for decisions not to make a referral***

<table>
<thead>
<tr>
<th>Reasoning</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasoning section left blank**</td>
<td>295</td>
</tr>
<tr>
<td>Patient has caregiver support</td>
<td>51</td>
</tr>
<tr>
<td>Reason</td>
<td>Count</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>CSS or CCAC already in place</td>
<td>47</td>
</tr>
<tr>
<td>Managing well in current situation/patient doesn’t want supports</td>
<td>155</td>
</tr>
<tr>
<td>Took information home to consider options</td>
<td>13</td>
</tr>
<tr>
<td>Discussing concerns with the doctors (a referral may have been made but this wasn’t captured)</td>
<td>22</td>
</tr>
</tbody>
</table>

*For some patients, more than one reason may have been captured (e.g. CCAC in place and caregiver support)

**The reasoning section was often left blank when the patient scored AUA 1
PATIENT AND CAREGIVER FEEDBACK

Following the implementation of the AUA risk-screening tool and the referral process using Caredove, interviews were conducted with patients and if available, family caregivers. Initial interviews were conducted with six patients and one caregiver following their doctor’s appointment at the primary care clinic and three month follow-up interviews were completed with four of the participants. The table below describes each participant, AUA score, types of referrals made and whether caregiver support was available. The mean age of participants was 79.2 years old (range 66-88), and participants represented a range of AUA scores. Some participants had a service referral as a result of the AUA score; for others it was felt that they were managing fine and referrals were not necessary.

Table X. Participant Characteristics

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>AUA Score</th>
<th>Referral Made?</th>
<th>Caregiver Support?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbey</td>
<td>80</td>
<td>1</td>
<td>No referral made</td>
<td>Lives with husband</td>
</tr>
<tr>
<td>Kay</td>
<td>66</td>
<td>3</td>
<td>Friendship Circle; Dietitian; Education programs; Physiotherapy</td>
<td>Lives alone; son provides transportation when needed</td>
</tr>
<tr>
<td>Sarah</td>
<td>85</td>
<td>1</td>
<td>In-home exercise</td>
<td>Lives alone; granddaughter lives in community</td>
</tr>
<tr>
<td>Alice</td>
<td>84</td>
<td>2</td>
<td>Housekeeping</td>
<td>Lives alone</td>
</tr>
<tr>
<td>Roger</td>
<td>72</td>
<td>6</td>
<td>Adult Day Program, Alzheimer Society, CCAC</td>
<td>Wife provides a lot of support</td>
</tr>
<tr>
<td>Bob</td>
<td>88</td>
<td>1</td>
<td>No referral made</td>
<td>Lives alone</td>
</tr>
</tbody>
</table>
The findings from these interviews revealed a number of themes related to patient and caregiver experiences with the AUA and Caredove process.

**Table 2. Themes and Subthemes (Patient/Caregiver Experiences)**

<table>
<thead>
<tr>
<th>THEMES</th>
<th>SUBTHEMES</th>
<th>EXAMPLES</th>
</tr>
</thead>
</table>
| 1. **PATIENTS VALUED INFORMATION AND EDUCATION** | • *First time hearing about services*  
• *Lots of services available to them* | o took information home  
o education  
o learning about services |
| 2. **PATIENT ENGAGEMENT IN DECISION-MAKING** | • *Involved in decision-making*  
• *Providers spent adequate time with patients* | o Engagement  
o Decision-making  
o Appointment time  
o Discussing services |
| 3. **PATIENTS SHARING INFORMATION WITH OTHERS** | • *Encouraging friends to attend programs*  
• *Passing information to friends and family* | o Conversations with people in the community  
o Broader education |
| 4. **ACCESSING SERVICES**              | • *Cost of Services*  
• *Waitlist Issues*  
• *Accessing Services* | o Patient still on waitlist  
o Patient cannot afford services |
EXCERPTS FROM THE PATIENTS

Patients valued information and education

Participants valued the information they received during their appointment.

“I was looking at all of this information & I was surprised that there were so many services that I could use” – Patient

Participants recognized the value of learning about the different services should they need to access more services in the future. One participant acknowledged that physicians are not always aware of the community services and appointment times are short so there is limited time to discuss service options,

“I really think this process makes people more aware of the services. This gives patients access to information about so many different services which is helpful because physicians can’t remember all of that information nor do they have time to discuss it with you.” – Patient

Many participants felt this was the first time that this information had been provided to them and overall they felt it was beneficial.

“Have they ever spoken to you about these kinds of services before?”

“No, that was the first time...it is helpful because there are many people in my age that it could benefit.” – Patient

Regardless of whether a referral was actually made on behalf of the patient, participants truly felt that they had gained knowledge about services that were available for them in the community. They also commented that they now had a contact at the clinic, someone to call if they decided they wanted to access a service that they had learned about. Through conversations with the participants, there seemed to be an overall sense of support for this process in primary care. Participants were not necessarily aware that a nurse would be asking them questions when they came into the appointment, but many did not seem to mind and actually appreciated that the providers were taking extra care to ask about their health,

“I’m 88 years old and manage well on my own so I don’t need any services. I think this process is important for us though and now I know who to ask if I need help.” – Patient

“I didn’t know that they were doing this [assessment] at the office, but it is very good for people my age” – Patient
During a follow up interview, one patient wanted to express how thankful she was to have been linked up with services. She was now attending cooking classes, yoga classes, and physiotherapy and education webinars for her chronic disease. This participant shared her thoughts about keeping this program in primary care in the quote below,

*This is a great way to really look after us old people. And it’s now up to...the doctors and the nurses in particular...they have to make sure they refer their patients to the services, you can’t make a horse drink if they don’t want to, but let them know these services are available, because that’s what I hear from people, is “Oh we didn’t know we could go to that, we didn’t know that was available”. So, my only remark would be to make sure that all the doctors, the nurse clinicians, and RPNs or whatever they are, registered practical nurses, that, that they do like mine does, and says this stuff is available, are you interested in going? That’s what [health care provider] did with me and I’m very thankful. – Patient*

**Patient engagement in the decision-making process**

Patients who participated in an interview felt that the provider who completed the risk-screening and referral process spent adequate time walking through different service options and discussing the benefits of the services. Overall patients felt they were engaged in decision-making process about accessing services and enjoyed the conversations they had with providers about their care planning. This is described in quotes below:

*Oh yeah, we spent a lot time and talked them [services] over and how it might help or not help. For instance, she asked about the dietitian referral, and I said it would help because I don’t currently eat well. – Patient*

*Interviewer: Do you feel that all your questions were answered? Did you feel included in the decision-making?*

*Patient: Yes, oh she [provider] was great! I asked my questions and she spent a lot of time walking through the options with me.*

One participant, who was a retired nurse, added this comment about patients being involved in decision-making,

*I think the reason patients are not as involved in making decisions is simply because they don’t know that they can be... - Patient*

Although there were many people who benefited from this process and there was overall support, some participants did experience difficulty when trying to access services (e.g. wait times, cost of services). This is described in the quotes below:
He suggested someone to help me with my house cleaning, and I would have to pay for that... You see, and those are the most, important thing to me, really but it is too expensive... And uh she did give me like a different dietitian option, the different meals on wheels or you know, but again the prices of the different meals are too expensive for me. So I didn’t participate in any – Patient

Patient: Yes, the other lady came, uh, I can’t remember her name, isn’t that awful. Yes, she did come, and, but she said that the waiting list is so long, for people that are interested in the exercises.

Interviewer: Yeah, so, so have you heard anything since then?

Patient: No, no.

Interviewer: They haven’t contacted you, or...?

Patient: No, no, I’d just decided I’d wait and, and hear.

PATIENT PAMPHLET

We heard early on from providers that sometimes patients were overwhelmed with all of the services offered and needed time to think about their options. A patient pamphlet was created in partnership with a group of older adults. The pamphlet is displayed below (and in Appendix B):

PATIENT PAMPHLET

We heard early on from providers that sometimes patients were overwhelmed with all of the services offered and needed time to think about their options. A patient pamphlet was created in partnership with a group of older adults. The pamphlet is displayed below (and in Appendix B):
Following the implementation of the AUA risk-screening tool and the referral process using Caredove, interviews were conducted with health care providers in the primary care clinics. Interviews were completed with nine health care providers from three primary care sites [NVFHT (n=4); MFFHT (n=3); WCHC (n=2)]. Interviews were also completed with care providers who provided community services (n=4) to patients from the primary care clinics.

Information from the interviews resulted in a number of themes to describe the experiences, found in the table below.

<table>
<thead>
<tr>
<th>THEMES</th>
<th>SUBTHEMES</th>
<th>EXAMPLES</th>
</tr>
</thead>
</table>
| **1. INTEGRATION OF PROCESS INTO CURRENT PRACTICE** | - Current Workflow  
- Health Care Provider process for screening | o AUA Process  
- Completing AUA  
- Using Caredove |
| **2. BUILDING RELATIONSHIPS WITH PATIENTS** | - Conversations with patients  
- Engagement in decision-making about services | o Conversation  
- Engagement  
- Relationship building |
| **3. KNOWLEDGE ABOUT SERVICES IN THE COMMUNITY** | - Education  
- Information about services  
- Caredove | o Using Caredove  
- Spending extra time learning about services  
- Service options |
| **4. ASSESSMENT OF PATIENTS** | - AUA Score  
- Assessing older adults | o Age for AUA  
- Asking the AUA questions  
- Physician asking AUA score |
| **5. ISSUES WITH TIME** | - Conversation takes time  
- Appointment time needs to be longer | o Conversation takes time  
- Caredove Fax form |
| **6. ACCESSING SERVICES** | - Waitlist  
- Cost of Services | o Too many options for patients  
- Provider struggling to choose service |
| **7. BROADER SYSTEM ISSUES** | - Communication with community care  
- Information Sharing | o Communication with community services  
- Getting information back  
- Caredove issues |
The following excerpt outlines the process of screening in a primary care setting, as described by the nurse:

> In the morning, we screen the patient list and make a little note beside each patient’s name to do the AUA. Usually we bring our patient in and we take care of what they’re here for first, because we have to get that in case we don’t have time to do the AUA, at least what they’re in for is done first and blood pressure, and then we say to them “we are asking patients some questions that help us better suggest services for you.” Most of them say yes, we’ve had a few people say I’m not interested. If they are in the higher category, it is in the patient chart so the physician can also see it. We show the patient the Caredove site and go through different services that might help them. We either make a referral or give them information. If a referral is made we have to fax a separate form. At the end we print the AUA screening and place it in a folder at the nurses’ station for you to collect. – Health Care Providers

The nurses at the Woolwich CHC site followed a similar process even though they were using paper-based forms. The administrative staffed screened the appointment list the day before and highlighted people over 70 who would need to be screened. An AUA form was placed on a clipboard with the patient chart indicating to the nurse that an AUA would need to be completed. Once completed, the nurse would hand the completed AUA form back to the front desk, who scanned a copy into the EMR and placed the original into the folder for the project leads to collect for analysis.

**Building Relationships with Patients**

Through the interviews with health care providers it was evident that many found the screening and referral process beneficial.

Providers felt the screening/referral process facilitated open and honest conversations with the patient,

> It opens up a lot of discussion and I think it makes people more honest about what their needs are... A lot of our seniors have privacy issues, or “I’m okay” and they don’t want people to worry about them, so I think there’s a couple things happening...we can be more aware of what’s really going on and I don’t know, it just seems like, again, that supportive environment, and I think people are more honest about what they need – Health Care Provider

Sometimes patients say that they are managing well, however when the patient is engaged in a discussion about their activities of daily living and asked to report how they
are feeling, the provider may learn more about the patient. Based on this information, providers felt that they were better able to link the patient with services and support.

*It empowers our staff to make a difference in people’s lives. Especially with the Caredove, taking the time to go on there with the patient, and I think it’s forming connections and relationships, I think it’s nice for those patients down the road if they have a question, they remember that staff member who took the time to do it with them, and ask them questions, or follow up with them. So that’s nice – Health Care Provider*

Providers also felt that they got to know a little bit more about the patients:

*We get to know them [patients] a little bit more because of the questions...most of them kind of talk about their life and that kind of thing, which helps me to figure out what maybe options are for Caredove and that kind of thing. – Health Care Provider*

**Gaining knowledge about services in the community**

Providers were not aware of all the services in the community that could assist their older adult patients. Providers did say they were familiar with the common programs such as CCAC or the Adult Day Program for persons with dementia, however they were not as familiar with the community support service sector or the services for chronic disease management and prevention. This is described by a participant below,

*There was never any kind of community supports really offered before, unless it was like, you go to [Adult Day Program] and then you’re under that umbrella, for a day program and that sort of thing. But there was never a time where we could help them with housekeeping, get private care or... it’s just made us realize how much support there is in the community for these people. – Health Care Provider*

Providers were surprised by the number of services that were available in the local community,

*I have been sitting on the website every once and awhile when I get a few minutes to look at it. I didn’t even realize that they can get a phone call once a week to see how they are doing and all that kind of stuff, which is great for someone who maybe doesn’t want someone to visit but a phone call or something like that, I thought “Oh my god wow, like they even have that!”...so I’ve looked at it just to see what options are out there – Health Care Provider*
Using the AUA in Primary Care

Many providers felt that the screening tool was helpful in identifying individuals who needed extra help. At first, providers were not sure if a tool was necessary because they know some of their patients so well. After using the tool for a while, one provider said,

*I would say it [the AUA] does flag people, because when you’re going through you’re thinking “oh I think they’re managing”, but that’s actually not the case....so this helps to make sure the patient has the right support*” – Health Care Provider (Urban)

Although the use of clinical judgement is the most important, the tool does help to identify individuals who are in urgent need of a more comprehensive assessment or service referrals. Providers who are using the tool see the value in it, and have said that they have identified some patients in the moderate-high risk category who they previously thought were managing well.

Although there was support for the AUA process in primary care, it is important to highlight that even in even in a team-based approach, nurses found it difficult to have conversations with patients ensuing from the AUA due to time limitations, however completing the AUA was not an issue.
Together with the ED team, the project leads assisted with AUA implementation at St. Mary’s Hospital (SMH) Emergency Department.

St. Mary’s Hospital had previously trialed the use of the ED Screener in the Emergency Department, however, full implementation was delayed as the timing of the trial conflicted with other ED priorities and there was further need for buy-in from physicians and staff.

To facilitate a more successful project launch, learnings from Grand River Hospital (GRH) ED implementation were shared. Grand River Hospital’s experience shaped the composition of the St. Mary’s project team, informed referral pathway development, assisted with the creation of patient and physician letters and provided additional staff training content.

Monthly meetings took place at St. Mary’s from July 2015 – December 2015 to plan for implementation. Meetings included the project manager, ED educator, CCAC care coordinator, GEM nurse and an IT manager.

The project leads designed an AUA online training program that was implemented in January 2016 to train all ED frontline nurses. The ED Screener (app on iPads) was chosen for use in the ED and the training program provided additional background information on the use of interRAI tools across the health system. The ED project manager was available for questions after the nurses completed the online training.

Patient and Physician Letters (see Appendix C) were created to provide patients and primary care with information about the screening process and resulting referrals/follow ups. The ED developed a process to ensure that the physician letters were sent to primary care following the completion of the AUA.

March 7th marked the “go live” date at SMH.

During the month of March, the ED saw more than 170 patients/day. Volumes in ED were extremely high (20% above average) during the first 3 weeks of implementation. This had a direct effect on practice change and processes to implement this new assessment.

Over the 3 week period, 33 older adults were screened using the AUA/ED Screener. See Figure below for numbers by level of risk. 18 older adults were screened at high risk and 5 were screened at moderate risk and 10 at low risk. As a result of the screening tool, a number of referrals were made: 10 GEM referrals were completed; 12 referrals were made to CCAC; and 4 community support service referrals were completed. Furthermore, 5 patient letters were sent back to primary care to notify family physicians that their patient had been seen in the ED.
A meeting took place with the ED project manager, ED educator and AUA project leads to discuss the issues that arose during implementation:

**Unplanned Delays**

The original “go live” date was scheduled for January 14th, 2016, however there were a number of setbacks:

- The team was short staffed and therefore they could not backfill for training
- Waiting on technology (purchase of iPads)
- Lost momentum - once training was complete team was still waiting for iPads
- Project manager was injured and off work for a period of time
- CCAC management and staff turnover

**Staff Reaction to AUA**

- The implementation of the AUA required organizational change (IT modification, staff training) which occurred prior to the “go live” date.
- Emergency Department (ED) internal referral processes to GEM were previously guided by clinician assessment, without the use of a standardized tool. Some nurses felt that this was “one more thing they don’t have time for”. Additionally, there was concern that this new process will substantially increase referrals to GEM and be difficult to accommodate.
• Others were supportive that this change in referral processes would enable more upstream thinking.
• Nurses also supported the letters generated back to primary care which provide family physicians with additional information to support patients rather than a return to ED.

The project team at SMH is committed to the implementation of the AUA and following the early data, further implementation is planned for the end of April 2016. The project team will be meeting with GEM nurses and CCAC coordinators to discuss the referral issues.
**SYSTEM LEVEL IMPLICATIONS**

**BROADER WW LHIN SYSTEM ISSUES**

The roll out of the AUA in primary care surfaced a variety of system issues that merit discussion. Although primary care teams were making connections with community care providers through the use of Caredove, these providers were unaware that an AUA had been completed. As a result, community care providers were often conducting a re-assessment that may not have been necessary. Interviews with community care providers identified that this was still an area that needed to be improved,

*When I look at the referrals from the family health team, there is nothing on this booking that says they went through uh, an interRAI screener already* – Community Care Provider

The interviews with community care representatives suggested that they would appreciate knowing that a screener had been completed and that this information would help to speed up their process of putting the patient on appropriate services,

*I do think it should be in primary care as long as the person who’s implementing and putting the information down, puts it down. It’s only, it’s only as good as the tool is, as the person who’s inputting the data. If there’s, if there’s no data it doesn’t help me...The more information the better, and it’s better for the client because I don’t have to ask those questions over, and over, and over again because, they get um, uh, things get very convoluted in the sense of they have so many different people calling them. CCAC, VON, all the different providers, right?* – Community Care Provider

Both community care and primary care providers discussed that *information from community care also needs to be communicated back to primary care, and this was not occurring.*

Primary care providers referred their patients and wanted to know the outcome of the referral. Community care providers recognized this was an area for improvement.

**INTERFACE WITH SYSTEM COORDINATED ACCESS:**

During this project year, regular meetings were held with the System Coordinated Access Group. Given that both projects targeted primary care and utilized Caredove, meetings focused on opportunities to: leverage primary care contacts, incorporate learnings into future project sites, promote integration of both projects in primary care and share evaluation data to inform system design.
It empowers our staff to make a difference in people’s lives. Especially with the Caredove, taking the time to go on there with the patient, and I think it’s forming connections and relationships, I think it’s nice for those patients down the road if they have a question, they remember that staff member who took the time to do it with them, and ask them questions, or follow up with them. So that’s nice – Health Care Provider

Always the time part is important. If there’s some way to get a little bit more time, and I think it’s not really the questionnaire that’s the problem, it’s figuring out the Caredove part if needed. So finding out, just booking those appointments, because they do take that extra time because you have a conversation, then have to fill out everything on the computer and then you have to fill out a fax form and then faxing that off and then making sure it gets sent out. That I find is more time consuming – Health Care Provider

CONCLUSIONS

This project identified a risk screening tool (AUA) that has been implemented within busy primary care practices, and continues to be a priority for implementation in an Emergency Department. The tool was well tolerated by patients and providers. Particularly noteworthy is the high percentage of patients in primary care who scored within a low to moderate risk level (95%) which suggests that this screening tool is well situated within primary care and captures those who may benefit from early intervention.

The rural site had a higher proportion of moderate and high risk individuals which is consistent with data from Statistics Canada (2008) which demonstrates that rural communities have higher proportions of older adults (65+) and the rural population is aging faster than urban populations. Additionally, there are many barriers to accessing health services in rural communities, including transportation difficulties, social isolation and financial constraints (Goins et al., 2005). Feedback from the rural site confirms these findings as providers indicated they have difficulty accessing services that are free of charge for the patient or services that do not require transportation.

Multiple health sectors are familiar with the AUA and it contributes to a common language that facilitates patient care planning and patient engagement. Caredove referrals now communicate the AUA score to Community Support Services, which in time, and with continued oversight, will ensure timely follow up for patients, access to comprehensive assessment and referral to appropriate services.

Of final note is the importance of ongoing education about the AUA within primary care. The implementation of the AUA in 2 EDs, with subsequent letters being returned to primary care after an ED visit, will require that all primary care providers be educated about the AUA and available options for referral and follow up. This project successfully reached about 6% of primary care providers across the WWLHIN. Further implementation of the AUA and education about options for referral can support increased equity of access for patients, ongoing support for primary care providers and efficient care planning options.
POLICY IMPLICATIONS

This work has a number of policy implications for the delivery of primary and community care services to older adults. This project is timely as it aligns with and builds on many current provincial initiatives in Ontario.

- The results from consultations with community and primary care providers highlighted issues with coordinating care for older adults in primary care, including: lack of information sharing; lack of engagement of patients and caregivers in decision-making; confusion around roles; and lack of knowledge of services in the community for older adults. Results from this project indicate an opportunity to strengthen the role of primary care within the broader health system, including positioning primary care to identify patients who are in need of services and/or further assessments, and to coordinate care accordingly.

This is in agreement with three recent reports: Ontario Seniors Strategy: Living Longer, Living Well (Sinha, 2013); the Patient Care Groups: A new model of population-based primary health care for Ontario Report (Price et al., 2015); and the Patients’ First: Ontario’s Action Plan for Health Care (MOHLTC, 2015); and with the Ontario Health Links program (MOHLTC, 2015). These documents call for a shift to occur within the Ontario health care system in which providing coordinated, patient-centred care becomes a greater priority.

- **Ontario Seniors Strategy (2013):** outlined a number of recommendations including strengthening primary care for older persons and enhancing community and home care services to support aging in place. This project identifies concerns such as inefficient referrals to community organizations and lack of communication between care providers across the system.
  - This project further helps to address these concerns by implementing a tool in primary care that stratifies older adults by level of need, and by facilitating connections with community services. This helps to ensure appropriate access to resources by individuals who would be most likely to benefit.

- **Health Links** aims to provide coordinated, efficient care to patients with complex needs (the top 5% of health service users) by encouraging collaboration and coordination among providers through the development of personalized care plans. The Health Links initiative identifies those individuals at high risk (through an unstandardized process) and supports development of appropriate care plans. The roll-out of this project varies across the province in terms of how people are identified as high risk and how care plans are structured.
  - The implementation of the AUA provides an efficient way to identify high-risk patients, but also allows for identification of individuals at moderate risk...
who may need more support from community organizations, and those at low-risk, who may benefit from education or supports for self-management.

- **The Patients’ First report** identifies key objectives for providing better care to Ontarians: a) Access – providing access to the right care; b) Connect – delivering better coordinated and integrated care; c) Inform – provide education and information to make decisions; d) Protect – protect universal health care.

  - This project identified mechanisms to support older adults that align with these provincial objectives. The use of a standardized screening tool helps to ensure older adults are accessing the right care including self-management supports, community services, or specialist care. Through this project, primary care providers are now better linked with the rest of the system through the use standardized assessments and referral mechanisms. Although there are still broader system issues to be addressed, this project has started a mechanism for primary care to be better integrated into the health care system and to become the central coordinating hub for older patients. The AUA process also demonstrates a process in which health care providers are having conversations with patients about services in the community, thus building relationships and educating and informing patients so that they can make decisions that are best for their situation. The AUA and Caredove mechanisms were implemented within current primary care resources, supporting their sustainability and helping to protect universal health care.

### NEXT STEPS: PLAN FOR YEAR 3 – BROADER IMPLEMENTATION AND SUSTAINABILITY

The table below outlines a draft plan for Year 3 funding. Rationale for this plan is based on:

- Broader adoption of the AUA, with a particular emphasis on non-affiliated physicians
- Ongoing education, capacity building and quality improvement related to the interRAl suite of tools across multiple health sectors
- Sustainability of the AUA as a key resource for patient engagement and care planning in primary care

<table>
<thead>
<tr>
<th>DRAFT Plan for Year 3</th>
<th>Risks of Not Moving Forward</th>
<th>LHIN Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adopt AUA in all Wellington FHTs</td>
<td>1 of 4 FHT teams has been trained; the 4 FHTS represent a sub-LHIN geographical region.</td>
<td>Access; Connect</td>
</tr>
<tr>
<td><strong>Upper Grand</strong></td>
<td>East Wellington Team has already indicated interest in moving forward</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>---------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><em>Adoption of AUA in several non-affiliated physician practices</em></td>
<td>The CDPM project is currently working with 3 non-affiliated physicians; this group may be easily leveraged to trial the AUA</td>
<td></td>
</tr>
<tr>
<td>Adoption of AUA in 1-2 practices in Cambridge</td>
<td>There is no adoption in a Cambridge location</td>
<td></td>
</tr>
<tr>
<td>RFP and adoption in 1 additional ED</td>
<td>Cambridge, Guelph, North Wellington have not adopted which presents equity issues across the sub-LHIN geographical areas</td>
<td></td>
</tr>
<tr>
<td>Continued monitoring of existing AUA sites</td>
<td>Competing priorities in ED and primary care would suggest the importance of having a dedicated person to ensure infrastructure, compliance, ongoing training needs are met.</td>
<td></td>
</tr>
<tr>
<td>Engagement with CSS and CCAC to ensure AUA score and referral feedback is being communicated from Primary Care and to Primary Care</td>
<td>As a result of community consultations and discussions with CSS leads, efforts to increase communication between health care sectors have been initiated. Communication of the AUA score between primary care and the CSS sector has been identified as a priority for the patient voice to be heard.</td>
<td></td>
</tr>
<tr>
<td>Sharing AUA Primary Care/ED learnings with broader WW health care system</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Vendor/interRAI data collection and building of EMR</em></td>
<td>Any adoption of AUA in new sites will require vendor and license agreements with interRAI. interRAI shares this information, via CIHI with LHIN for population-based health care planning. AUA data provides a decision-support mechanism to target resources efficiently</td>
<td></td>
</tr>
<tr>
<td>Dissemination of WW AUA learnings to Provincial Working Group through RCA</td>
<td>WW LHIN has self-identified as the RCA lead for Assess and Restore.</td>
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</tbody>
</table>

**Access, Protect**

**Access**

**Access, Connect, Protect**

**Connect, Protect**

**Inform, Protect**
REFERENCES


APPENDIX A: DETAILED IMPLEMENTATION PROCESS

IMPLEMENTATION FRAMEWORK

The following steps were adopted for AUA implementation (See Figure 1):

1. Conducted community and primary care stakeholder consultations to understand local resources, current referral processes, and care team capacity
2. Provided AUA training to primary care teams
3. Using the information from the consultations, develop appropriate referral maps including; self-management supports, community services, and specialist referrals that can be used to make referrals in partnership with the patient/caregiver
4. Collected data for ongoing monitoring and follow-up using appropriate evaluation techniques (observations, interviews, tracking forms, surveys)

Figure 1. Implementation Framework
SITE CONSULTATIONS – PRIMARY CARE AND COMMUNITY CARE

Five focus group interviews were completed with 4-8 participants in each group and a number of health care providers were interviewed individually across the 3 primary care/community care study sites.

Themes emerging from these focus groups are summarized below, with reference to the Patient’s First Report:

<table>
<thead>
<tr>
<th>THEMES</th>
<th>SUBTHEMES</th>
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</table>
| 1) **ENGAGING OLDER ADULTS IN DECISIONS ABOUT THEIR CARE** *(INFORM)* | • Older adults should be more engaged than they are currently  
• Understanding why older adults decline services  
• “Time” is needed for meaningful conversations  
• Caregivers are an important part of the circle of care |
| 2) **WHO IS RESPONSIBLE FOR COORDINATING THE CARE?** *(CONNECT)* | • The role of a coordinator  
• Role clarity needed among patients and providers  
• Primary health care as a hub for coordinating care |
| 3) **INFORMATION SHARING BETWEEN HEALTH CARE PROVIDERS** *(ACCESS)* | • Communication between primary care and community care is fragmented  
• Providers going above and beyond to get information about a client  
• Multiple documentation systems make it hard to access patient information |
| 4) **CURRENT REFERRAL PROCESS: REFERING AN OLDER ADULT TO COMMUNITY SERVICES** *(CONNECT)* | • Types of referrals to community services  
• Issues with referring patients to external services |
| 5) **IDENTIFYING SERVICES IN THE COMMUNITY FOR OLDER ADULTS** *(INFORM)* | • Many organizations offer a variety of services for older complex patients |
| 6) **CARING FOR OLDER ADULTS IN A RURAL COMMUNITIES** *(CONNECT)* | • Cultural boundaries  
• Coordinating care in large geographical location |
**SYSTEM ISSUES IDENTIFIED IN CONSULTATIONS:**

1. **Engaging Older Adults**

Primary and community care providers were asked to discuss how they currently engaged older adults and caregivers in care planning; the following provides some examples of the various responses:

   Yes, we use surveys if that’s what you’re getting at ... there’s really no participatory involvement in the care pathway or planning – Primary Care Provider Urban

   Not as much as they could or should be. I think that many feel powerless – not knowing what is available to them or how to ‘work the system’ - Urban Community Care Provider

A strong and trusting relationship is most important when engaging older adults. Building a trusting relationship takes time and the current health care system is not designed to support the time that this may take.

2. **Care Coordination:**

The role of a system navigator came up in all of the focus group discussions. The groups discussed whether there was a need for a specific designated role and where that person should be located within the system, versus having the system work collaboratively to coordinate care for an individual.

   What I would expect to see is that system navigation is part of a process or function of primary care and the home team. – Community Care Provider (Urban)

   I think that what might be more advantageous is to look at our ways of communicating with each other and the systems of support we have in place for each other, and again, that it might be better done as a partnership. It’s not just that we want to say “oh, you’re responsible okay here you take it”, you know there might be two or three people who are just as responsible for different aspects but they need to be able to work together - Primary Care Provider (Rural)

   I think that people are not knowledgeable about programs and services until they need them, and then they’re in a crisis situation, and then it’s not a good time to be searching for information. So if there was someone they could contact then they’re not taking up primary healthcare time with a physician or NP, over something that could be dealt with by the most
appropriate service provider. The second thing that we run into with our hospice and our caregiving supports is, when the family is living at a distance, they are sometimes not able to respond and help mom or dad figure things out and I think by having a system navigator that person could be followed and the right services put into place to prevent a serious fall or some other situation that people are picking up on – Primary Care Provider (Urban)

It is also important to acknowledge that some patients who have knowledge of the system and feel empowered to take a leadership role in their care may indicate that they want to be their own navigator, as described in this quote below.

*In fact, some say that we would have some consumers that feel that they should be the navigator.*

Having patients engaged in discussions would allow for the best decisions to be made for individual situations.

### 2. Information Sharing between Primary Care and Community Care

As illustrated in the excerpts below, many providers point out that information sharing among providers, within or between organizations, is an area for improvement at a system level.

*We um don’t have a lot of conversation going back and forth between primary care. What does happen sometimes ... we would check on Clinical Connect to try and get more information about it which isn’t always helpful...sometimes they don’t give you all the information. Again, that’s limited too because Clinical Connect – not everybody is connected – Community Care Provider (Urban)*

*I think that’s an area that there’s a lot of room for growth and improvement on. It is, for us, it’s been more individualized, so as an example, if we know, if we’ve had a referral come from primary care locally and we’re working very closely around the care for an individual, there’s some natural systems in place to share and to communicate that back, but it really, really depends, we don’t have a standard, formal process for that, we talk about how that might happen...but it’s a bigger system to try to figure out how we communicate back. – Community Care Provider (Urban)*
So that’s maybe something within the system that is available to be improved I’m not sure. Outside of that it’s much more on a case by case basis I would say, if we receive consent from the person to follow up with an agency or service, we try to make those connections where we can but it’s certainly not a process that is done consistently the same way or with every person. – Community Care Provider (Urban)

I think it’s absolutely an area for, room for improvement. We’re finding, especially over the last few years that the complexity of our consumers are increasing. For example, we’re providing services to somebody 24 hours a day, and it really would be nice to have a better relationship with the physician, we deal with the primary care physician, they say “sure your staff can do that” and then, like “no we can’t do that” and if we could be on the same page it would be more helpful, so that’s a little bit of a challenge. – Community Care Provider (Rural)

3. Current Assessment and Referral in Primary Care

Another major theme that arose during the focus group and individual interview process was the current process of referring patients to community services when appropriate. The interviews revealed that there was no standardized process in primary care for identifying which patients would benefit from additional services.

Interviewer: Do you currently use any standardized assessments on your older adults?

Primary Care Provider (Urban): No, definitely not on every older adult. Sometimes the MoCA or screening for diabetes and hypertension. We go for the most commonly used ones

Interviewer: And what about referral pathways for those patients, would most of your assessments have a referral piece to them as well?

Primary Care Provider (Urban): Not always, no.
AUA/CAREDOVE TRAINING AND IMPLEMENTATION IN PRIMARY CARE

AUA IMPLEMENTATION

For New Vision and Mount Forest Family Health Teams, the AUA screener was built into Practice Solutions for the purposes of this pilot work. A button was created on the PS home screen and a reminder appeared for all patients 70 years of age and older.

AUA – PS Electronic Version
CAREDOVE: PATHWAY DEVELOPMENT & TRAINING

Information gathered from focus group and individual interviews was used to populate the referral pathways. During this iterative process we learned that capturing all of the services would be a large undertaking. We felt it was necessary to look at other existing pathways and potentially build on to what is already available. We looked into both Caredove and HealthLine.ca platforms to integrate our AUA work. A decision was made to move forward with the Caredove platform.

We know, from previous research, that patients with an AUA of 1 or 2 will more likely to benefit from self-management support and education services; for patients with an AUA of 3 or 4, community services will likely be of benefit; and for those with an AUA of 5 or 6, referrals to specialist services will be more beneficial (Eckel, 2015).

During each focus group and individual interview, participants discussed services to which they commonly refer older adults, as well as discussing services that their specific organization offers. The figure below gives an example of what the pathways might look like at each level. We compiled a list of specific organizations that service each FHT.

- **Low Risk (1,2)**
  - **Self-Management Support & Education**
  - Examples:
    - Church groups, Community Centres, Library, Clinic Programs (e.g. nutrition and exercise education programs)

- **Moderate Risk (3,4)**
  - **Community Services**
  - Examples:
    - Meals on Wheels, Transportation Services, House/Lawn Maintenance, Home Care Services

- **High Risk (5,6)**
  - **Specialist Geriatric Referral & Community Services**
  - Examples:
    - Specialized Geriatric Referrals
    - Community Services (see Moderate Risk examples)
We worked with the WW Easy Coordinated Access program to develop pathways associated with each AUA level. We worked with a Caredove developer who embedded an AUA site within the Caredove platform (screenshot of webpage below). The site has been set up in a way that should allow for easy navigation by provider who needs to make a referral based on AUA level (and clinical judgement). For AUA levels 1 and 2, referrals will be made through the CDPM site, for AUA levels 3 and 4, referrals will be made through CSS site, and for AUA 5 and 6, referrals will be made through the SGS site (See pictures below for screenshots of the AUA site).

A Caredove representative provided training to providers at the pilot sites.
**SUMMARY OF AUA IMPLEMENTATION IN PRIMARY CARE**

Following a health services Implementation Framework by Chaudoir and colleagues (2012); the implementation process was assessed using the following components: system level, organization level, program/project level, provider level and patient level.

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>EXAMPLE</th>
<th>SUMMARY OF IMPLEMENTATION PROCESS</th>
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</thead>
<tbody>
<tr>
<td><strong>SYSTEM</strong></td>
<td>Public Policy/Infrastructure</td>
<td>• Multiple EMR systems continue to cause issues with sharing information</td>
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<tr>
<td></td>
<td></td>
<td>• Limited information sharing between community care and primary care</td>
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<tr>
<td><strong>ORGANIZATION</strong></td>
<td>Funding Model; Management Style</td>
<td>• Buy-in is needed from entire primary care team; management support is necessary for implementation</td>
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<td></td>
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<td>• Other providers felt NPs should be involved,</td>
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<td>• Even in a team-based approach; nurses found it difficult to have conversations with patients</td>
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<td>ensuing from the AUA due to time limitations, however completing the AUA was not an issue</td>
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<td></td>
<td></td>
<td>• Primary care teams decided, in partnership with AUA project leads, how to best fit the AUA into</td>
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<tr>
<td></td>
<td></td>
<td>current practice/workflow</td>
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<tr>
<td><strong>PROGRAM</strong></td>
<td>Innovation being implemented</td>
<td>• An ongoing evaluation process was used to obtain feedback on the implementation of AUA and</td>
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<td></td>
<td>Caredove – changes were made overtime including moving from paper form to EMR-based screening tool</td>
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<td></td>
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<td>in the two FHTs (the CHC continues to use the paper-based form as they await plan to EMR changes)</td>
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<tr>
<td><strong>PROVIDER</strong></td>
<td>Attitudes towards program</td>
<td>• Informal feedback and meetings with health care providers were completed to assist with project</td>
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<tr>
<td></td>
<td></td>
<td>rollout</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Development of relationship and support to the team was very important for success of this project</td>
</tr>
<tr>
<td><strong>PATIENT</strong></td>
<td>Characteristics that may influence</td>
<td>• Risk screening tool chosen that identifies patients with varying levels of risk</td>
</tr>
<tr>
<td></td>
<td>program</td>
<td>• Initially the process was reviewed by Seniors Helping as Research Partners (SHARP) group (group of</td>
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<tr>
<td></td>
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<td>older adults); however there was no patient representative on the implementation team (should be</td>
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<td>future consideration for projects)</td>
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APPENDIX B: PATIENT PAMPHLET (FRONT AND BACK)

Your Health Care Plan

Based upon your recent visit we would like to suggest you consider the following steps to maintain your health:

1. **Consider** which areas in your life might benefit from access to more supports.
2. **Review** the program options presented to you (on the back).
3. **Connect** with the program directly and/or your family doctor to book an appointment.

You may wish to consider the following programs in your community:
- **Education Programs**
- **Clinic Health Programs**
- **Community Recreation Programs**
- Other: ____________

Your Health Care Plan

Based upon your recent visit we would like to suggest you consider the following steps to maintain your health:

1. **Consider** which areas in your life might benefit from access to more supports.
2. **Review** the program options presented to you (on the back).
3. **Connect** with the program directly and/or your family doctor to book an appointment.

You may wish to consider the following programs in your community:
- **Community Care Access Centre**
- **Community Support Services**
- **Community Pharmacist**
- Other: ____________

Your Health Care Plan

Based upon your recent visit we would like to suggest you consider the following steps to maintain your health:

1. **Consider** which areas in your life might benefit from access to more supports.
2. **Review** the program options presented to you (on the back).
3. **Connect** with the program directly and/or your family doctor to book an appointment.

You may wish to consider the following programs in your community:
- **Community Care Access Centre**
- **Community Support Services**
- **Primary Care Memory Clinic**
- **Specialized Geriatric Services**
- Other: ____________

Comments

Name of referring healthcare provider: ____________

New Vision Family Health Team

421 Greenbrook Drive Unit #23B
Kitchener, ON N2M 4K1
Phone: (519) -578-3510

For more information about health and wellness resources in your community, please visit www.easycoordinatedaccess.com
APPENDIX C: PATIENT/PHYSICIAN LETTERS FROM ED TO PRIMARY CARE

Letters have been created for each AUA Level of Risk. Below is an example of the AUA 4 letter.

FOR PHYSICIAN: ASSESSMENT URGENCY ALGORITHM (AUA) SCORE: LEVEL 4

Your patient was seen in our Emergency Department on the above date.

In order to ensure that older adults receive the best possible care in our Emergency Department we routinely perform assessments on patient home safety and supports. One assessment completed is called the Assessment Urgency Algorithm (AUA). This risk assessment indicates whether a person is requiring extra help at home, or would benefit from seeing a nurse, therapist or physician who is specialized in older adults’ health.

Your patient was found to have an AUA score of 4, indicating moderate risk for poor outcomes related to geriatric syndromes. Typically, people with an AUA score of 4 can be summarized as dependent for all or part of ADL and IADL function, however mood disturbance and caregiver stress is not reported.

Accordingly, follow up by the Geriatric Emergency Management (GEM) nurse and/or CCAC care coordinator was arranged.

On discharge from St Mary’s General Hospital Emergency Department your patient was encouraged to arrange an appointment with you within 2 weeks of the ED visit. At your discretion please consider the patient’s AUA score when assessing for any further care needs. The patient was also instructed to return to the Emergency Department based on their own needs and/or return of symptoms.

FOR PATIENT: RISK ASSESSMENT IN THE EMERGENCY DEPARTMENT

We want to make sure that older adults receive the best possible care in our Emergency Department. To do this we often ask questions about home safety and supports. Your answers will give us a score on the ED Screener. This score may show if you need extra help at home, or other supports. It can also let you know if you should see a doctor or other health care worker who specializes in older adults’ health.

During your Emergency Department visit you scored in the moderate range. You are able to do most on your own care tasks. However, you may have health issues that are making it harder to cope at home. Because of this score we have asked the Geriatric Emergency Management (GEM) Nurse and/or Home Care (CCAC) Coordinator to speak with you.

☐ I saw the Geriatric Emergency Management (GEM) Nurse and/or CCAC coordinator.

☐ The Geriatric Emergency Management (GEM) Nurse or the CCAC coordinator will call me at home in the next week.

Your Family Doctor will be advised of your recent visit. Please book an appointment to follow up with your Family Doctor in the next 2-3 weeks.