



# Innovative Model of Interprofessional Geriatric Consultation: Specialized Seniors Clinics

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## Abstract

As the Canadian population ages, healthcare systems have become increasingly interested in exploring new ways to deliver services to frail older adults, and in particular older adults with dementia. The Specialized Seniors Clinics (SSCs) are an innovative integrated network of six outpatient clinics in BC's Fraser Health Authority that utilize interprofessional teams to provide comprehensive geriatric assessments and care planning for frail older adults. The SSCs provided approximately 19,000 appointments in the past fiscal year, and clients and primary care physicians are highly satisfied with the model. This article describes the SSC model and provides reflection on the model development, implementation and standardization processes.

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## Introduction

As the Canadian population ages, the health of older adults is becoming an increasingly important focus for healthcare systems.

Frailty is generally used to describe vulnerable older adults who have limited health reserves and are at increased risk for adverse health outcomes (Hamerman 1999).

Dementia shares a complex relationship with frailty and they are often found together as comorbid conditions (Sampson 2012).

Dementia is currently a major concern for healthcare systems, and by 2038, it has been estimated that more than 1 million Canadians will have some form of dementia (Smetanin et al. 2009). For dementia, early diagnosis, treatment and follow-up are key to providing effective care (Leifer 2003); however, challenges in managing and diagnosing dementia may be encountered such as needing appointments of longer duration and difficulty accessing specialists (Hinton et al. 2007).

Fraser Health Authority has developed a Specialized Seniors Clinic (SSC) model, which is a secondary outpatient healthcare delivery model. The SSC model has been developed to support primary care and meet the needs of frail older adults who have dementia or multiple/complex healthcare needs. There are three key components to the SSC model: integrated care, interprofessional teams and comprehensive geriatric assessment and care planning. The development of the SSC model was unique in that it involved taking six already existing clinics providing similar services and standardizing them into an integrated network. Important enabling factors for this process included having strong leadership, capitalizing on windows of opportunity for change and the use of information technology. Challenges that were encountered included resistance to change and differing care philosophies, competition for resources and the equity of resources among clinics (e.g., differences in

staffing). The purpose of this article is to share the SSC model and provide reflection on the development of the model.

## Setting and Policy Context

Fraser Health Authority is responsible for providing healthcare services to more than 1.6 million people living in the province of British Columbia (BC), of which approximately 16.1% (249,250) are aged 65 and over (Health & Business Analytics, Fraser Health Authority 2012). The age-specific prevalence rate for dementia in Fraser Health in 2008/2009 was estimated at 6.1%, amounting to approximately 17,000 people (Decision Support Services 2010).

For 2014-2017 Fraser Health has identified ten priority actions to guide organizational improvements, including capacity and patient centeredness (Fraser Health 2014). The SSCs are one way that Fraser Health is working towards meeting these strategic priorities, and these goals fit within the wider provincial objective of the BC Ministry of Health for dementia care and increased integration of primary and community care.

## Conceptual Background

Increasingly, in recent years, healthcare systems have been turning to the concept of integrated care to improve their delivery of services through strategies aimed at increasing the continuity and collaboration between services/care providers. For older adults with dementia, Callahan et al. (2009) have recommended the use of integrated care for a number of reasons including existence of comorbid conditions and requirement of large amounts of healthcare resources. The SSC model combines a number of the strategies of integrated care, most notably of which are the use of interprofessional teams and comprehensive geriatric assessments.

Interprofessional collaboration “involves the continuous interaction of two or more

professionals or disciplines, organized into a common effort to solve or explore common issues, with the best possible participation of the patient” (Barrett et al. 2007: 1). The American Geriatrics Society has recommended the use of interdisciplinary care for older adults with complex needs (Geriatrics Interdisciplinary Advisory Group 2006).

Comprehensive geriatric assessments are useful for older adults because they often have complex, multi-system conditions that require a range of biopsychosocial interventions (Stuck and Iliffe 2011). Comprehensive geriatric assessments have been found to produce a number of benefits for older adults, including increased likelihood of remaining in the home, decreased functional decline and improved cognition (Ellis et al. 2011).

### **SSC Model**

The SSCs are secondary outpatient services that provide interprofessional consultation services for frail older adults. The focus of SSC services includes early diagnosis of dementia, assessment of complex medical and comorbidities, and development of an interprofessional Health Improvement Plan (HIP). Currently there are six SSCs operated by Fraser Health (Abbotsford, Delta, Mission, New Westminster, Surrey and White Rock). All of the SSCs are co-located with, or have a close working relationship with, a nearby acute care hospital. The Older Adult Program within Fraser Health is responsible for overseeing the management and operation of the SSCs, and four SSC managers are responsible for the clinics. The clinics vary in size, resources and the composition of their interprofessional teams, but they all share the same principles and goals, and operate under the same service delivery model. The SSC model is based on four principles of care: (1) client-centred care, (2) evidence-based clinical practice, (3) integrated care and (4) elder-friendly environment.

### **Target Population**

The target population for SSC services are frail older adults with undiagnosed cognitive impairments or other complex medical conditions. The majority of referrals to SSCs come from primary care physicians (PCPs) who require specialized geriatric expertise for their clients. The primary reason for client referral to the SSCs is memory/cognitive changes, accounting for more than 60% of referrals.

### **Interprofessional Teams**

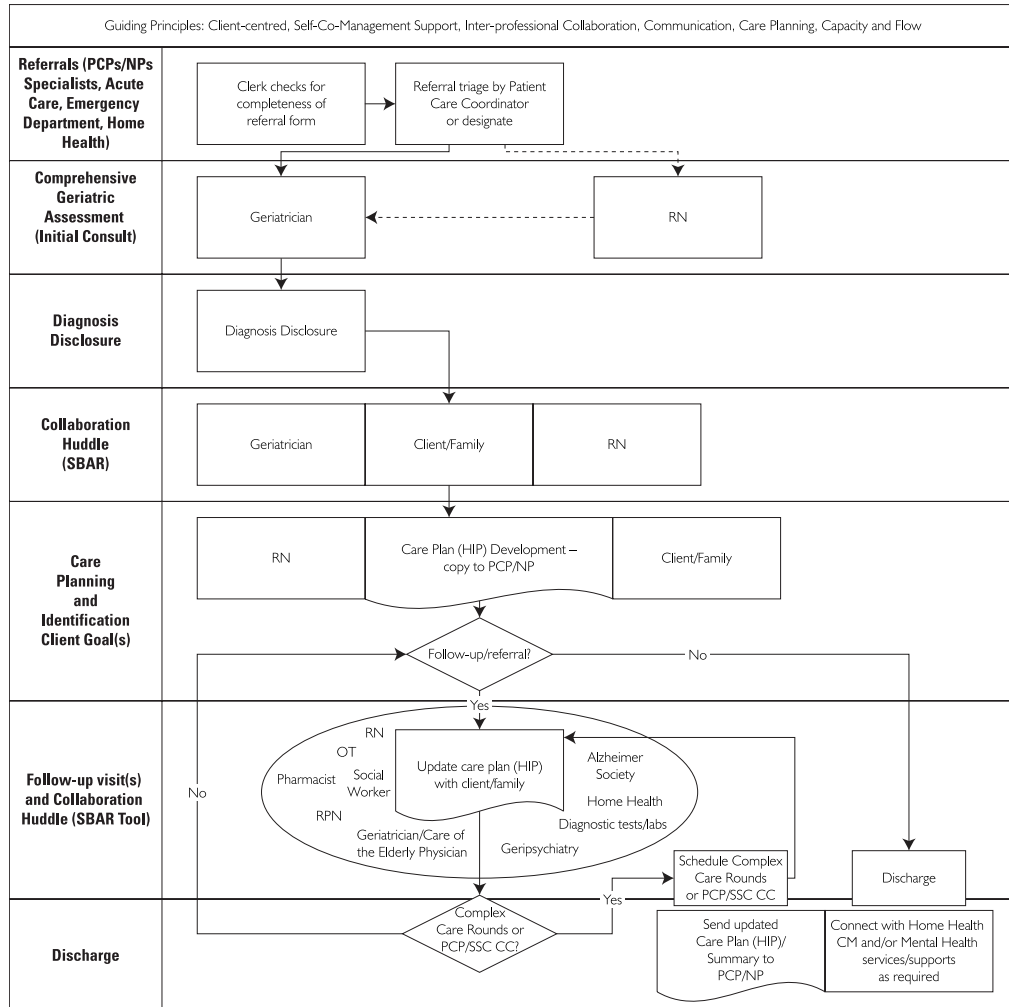
The core members of the teams are a geriatrician/care of the elderly physician, patient care coordinator, registered nurse and clerk. Composition of the SSC interprofessional teams varies by location, and additional team members may include geriatric psychiatrist, occupational therapist, physiotherapist, social worker, pharmacist and dietician. The patient care coordinator is responsible for organizing the interprofessional team and managing day-to-day operations of the SSC. The patient care coordinator is also responsible for screening and triaging the clients who are referred to the clinic. New clients undergo a comprehensive geriatric assessment and a HIP is then developed. Follow-up visits will be provided if required; however, during the period that the older adult is an SSC client regular, primary care is still delivered by their PCP. Figure 1 provides an overview of the SSC service delivery model.

### **Special Features of SSC Model**

#### **Capacity to Serve a Large Volume of Clients**

The larger SSCs are open Monday through Friday, from 8:30 am to 4:30 pm (excluding statutory holidays). The smaller satellite clinics are open one to two days a week. For the fiscal year 2012–2013, the total number of attended appointments was approximately 19,000.

**Figure 1. Care delivery model – Specialized Seniors Clinics**



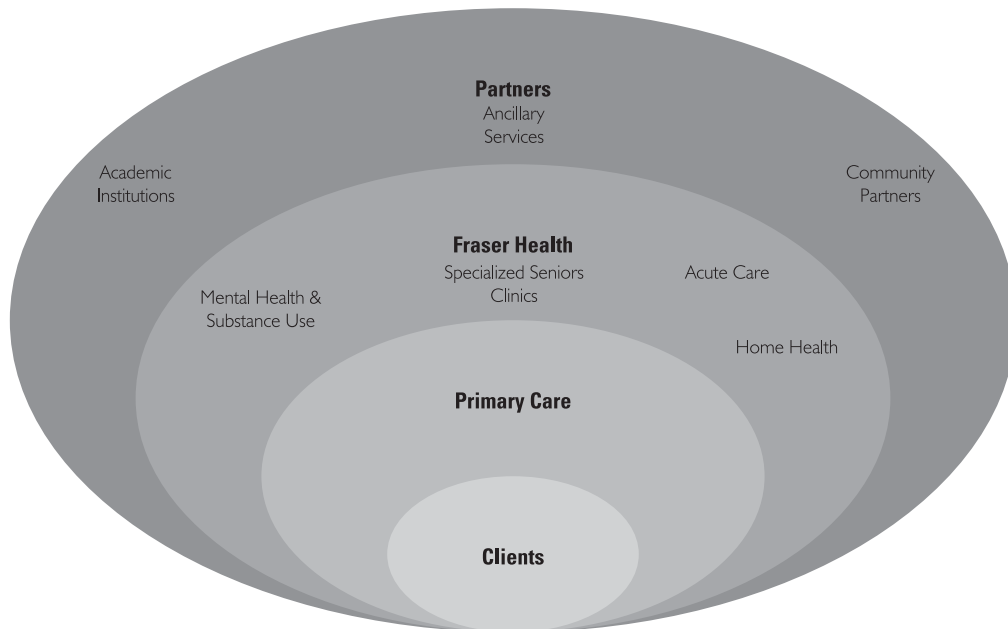
October 2014  
 Abbreviations: RN (Registered Nurse), SBAR (Situation, Background, Assessment, Recommendation), HIP (Health Improvement Plan), OT (Occupational Therapist), RPN (Registered Psychiatric Nurse), CM (Case Manager), PCP (Primary Care Physician/NP), CC (Case Conferencing), NP (Nurse Practitioner)

**Integrated Network of Services**

The six SSCs currently operate together as part of an integrated network of services designed to support primary care. Extensive work has been undertaken to standardize operations within the clinics so they all currently operate under the same service delivery model. This has enabled the SSCs to maximize efficiencies by allowing staff to be floated between sites and also the co-location of positions. All of the clinics share the same electronic medical record system (Meditech), and clients can potentially

receive services at any clinic. The integrated network also allows the different SSC locations to collaborate with each other, and members of the different professions meet one or two times a month to discuss topics related to their practice.

The SSCs are also integrated within the wider healthcare system in Fraser Health. The SSC network has formed relationships with acute care, other Fraser Health programs, primary care and Divisions of Family Practice, external partners (e.g., community organizations, academic

**Figure 2. SSC model**

institutions, etc.) and ancillary services (e.g., laboratories, medical imaging, etc.; Figure 2). For example, a partnership is currently being developed between the SSCs and the Mental Health and Substance Use Program community geriatric mental health services at some locations to enable enhanced integration and communication on shared clients.

#### Client-Centred Care

The SSCs are committed to providing client-centred services by focusing on the needs of both clients and their families. Clients and their families play an important role in the development of the HIPs at the SSCs. In addition, the SSCs have recently introduced a client-focused screening questionnaire, and work is being done to develop chronic disease self/co-management programs to increase the involvement of clients in their care.

#### Educational Opportunities

The SSCs provide educational opportunities for their interprofessional team members

and other health professionals. For the SSC teams, a regional clinical nurse educator provides educational training, orientations and information on clinical decision support tools and organizes workshops.

Interprofessional team members also have opportunities to collaborate with and learn from each other, for example, through participation in complex care rounds. The SSCs serve as educational sites for the University of British Columbia Faculty of Medicine. Lectures, rotations for residents and fellows and clinical placements for other health professionals are offered at some SSC sites.

#### Model Development, Implementation and Standardization

##### Model Development

The catalyst for the development of the SSC model was the introduction of Program Management to Fraser Health, which occurred over the fall 2009/winter 2010 period. This led the six clinics, which had previously been separately managed and

unlinked, to fall under the management of the Older Adult Program. The decision was made to standardize the clinic models and give them the name Specialized Seniors Clinics, with the vision of creating an integrated network of services. The SSC model was grounded in evidence, and was based on resources such as the BC Expanded Chronic Care Model (Ministry of Health 2013) and consultations with the SSC teams. The SSC model cemented the SSCs as specialized secondary care providers, and strengthened the care planning and evaluative components of the service.

### **Model Implementation**

Within the Older Adult Program, there was support from the Program Executive Director, Program Directors and Medical Director from the beginning, and leadership teams were established at various levels within the Older Adult Program to assist with the visioning and implementation process. It was also necessary to ensure that the physicians and interprofessional teams already working within the clinics supported the vision and had input in the planning. The Program Medical Director engaged with the physicians to ensure they were aware of the developments and provided feedback on the model development (later on a Regional SSC Physician and Clinical Leadership Committee was established). In the clinics, the interprofessional teams were consulted, and during the implementation phase, a clinical nurse specialist and clinical nurse educator spent a large amount of time working in the clinics to provide mentoring and ensure that the processes were working. Instituting change can be a difficult process, and while there was some resistance to change at first, this was overcome primarily through explanation and demonstration of the proposed changes. In addition, there was also a need to be flexible and allow for minor variations in the model, as the clinics had different resources in terms of space, staffing and technology.

### **Model Standardization**

Standardization of the clinics was a key step for implementing the SSC model. A Frontline Leaders Group (consisting of the SSC managers, the clinical nurse specialist, the clinical nurse educator and the patient care coordinators) played a key role in this process. The first step for the clinics was to standardize their communication and referral processes. The movement of the Surrey SSC to the Jim Pattison Outpatient Care and Surgery Centre (JPOCSC) in the summer of 2011 was an important enabler for the standardization and introduction of new information technology to the SSCs. Resources were available in Fraser Health at this time to facilitate the opening of the new centre. At JPOCSC there were plans to introduce information technology such as community-wide scheduling and Meditech charting, which made it possible to introduce these at all the SSCs. When standardizing forms and information technology systems, it was necessary to at the same time be planning ahead for future data collection and evaluation needs, and forms had to be customized to collect specific evaluation data. From the summer of 2011 to the end of 2012, the staggered implementation of the SSC service delivery model took place. The SSC model has now been successfully implemented in all six of the SSCs, though there still remains some minor standardization work to be done.

### **Ongoing Operational Evaluations**

Ongoing operational evaluations are currently being conducted at the SSCs. For example, continuous monitoring of the number of client appointments is occurring and targets are being set for yearly increases. In addition, the Plan-Do-Study-Act cycle is being used to guide the development of quality improvement initiatives. Implementation of the SSC model and standardization of the clinics was only completed recently, so system-level utilization impacts are not yet being measured for

clients, but collection of these data will be the next priority for the clinics. Examples of system-level impacts that have been previously explored in the literature on dementia patients and may be used to evaluate the SSCs include physician and specialist visits, hospitalizations, emergency department visits and use of community services and supports (Weber et al. 2011).

However, as many SSC clients are in the early stages of dementia, having a diagnosis and the appropriate supports provided may be the main benefits of SSC services. For these clients, system-level impacts may not be measurable until later stages of the dementia disease trajectory. The other benefits that may be derived from early dementia diagnosis and care planning include earlier initiation of acetylcholinesterase inhibitors therapy, providing clients with the opportunity to participate in planning for their future care, referral to community support services and exercise programs, relieving feelings of anxiety and uncertainty, allowing for future safety risks to be anticipated and mitigated and educating and preparing caregivers for their role (Leifer 2003). An important priority for the SSCs is to provide positive client experiences and client-centred care, and ongoing work is being done to measure the impacts of the SSCs at the client level. Recently, both client and PCP surveys were conducted and showed high levels of satisfaction with the SSCs.

In February 2013, 234 client satisfaction surveys were distributed to clients/family over a 12-day period, and 215 were returned. More than 90% of the clients were mostly satisfied or very satisfied that their care team listened to and understood their needs, were skilled and knowledgeable and involved the client and their family in decisions about their care. Being provided with a diagnosis and the tools and resources needed to manage their condition made clients feel more confident about managing their health.

One client commented “My concerns and questions were answered. I left the appointment feeling positive, informed and knowing my next steps.” Currently a client-focused screening questionnaire is also being trialed in the SSCs with the purpose of better addressing clients’ health concerns, and these questionnaires will be linked with quality-of-life evaluations.

The PCP surveys were distributed to PCPs in Fraser Health through the SSCs. A total of 450 surveys were distributed and 172 were returned over the period of May 1 to July 10, 2013. In the surveys, 91% of PCPs who had used the SSCs were very satisfied or satisfied with the service, and generally, PCPs found the SSCs to be a valuable resource.

## Conclusion

The SSC model is built upon three key components that are strongly supported in the literature as crucial components for healthcare services for frail older adults: integrated care, interprofessional teams and comprehensive geriatric assessment and care planning. Now that the SSC model has been fully implemented, focus for SSC model development has primarily moved past standardization and towards sustainability, evaluating the model and finding opportunities for quality improvement. Three new innovations that are currently being trialed in the SSCs are: a partnership with the Mental Health and Substance Use program, development of chronic disease self/co-management programs and a trial of the client-focused screening questionnaire. In addition, clinics are developing slots for urgent referrals which would reduce acute congestion by pulling clients from emergency and/or allowing early discharge. In the future with aging populations, healthcare systems will be looking for innovative ways to provide services to frail older adults with dementia or other complex conditions. The SSC model is an example of



a successful way to support primary care and provide positive client outcomes by providing interprofessional geriatric consultation for frail older adults.

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