THE COLLEGE OF FAMILY PHYSICIANS OF CANADA | LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

Foundation for Advancing Family Medicine | Fondation pour l'avancement de la médecine familiale

Co-RIG Project

# Enhancing Support for Frail Adults During COVID-19: A contact and monitoring pathway

**Project lead:** Henry Siu, MD, MSc, CCFP (COE), Associate Professor, Department of Family Medicine, McMaster University Family Health Centre
**Project location:** Hamilton, Ontario

## Summary

Dr. Henry Siu and team developed a contact and monitoring pathway to help family physicians proactively identify older adults with frailty during COVID-19. The pathway supported patient assessment, including COVID-19 risks and overall mental and physical health, and then helped link patients to the appropriate care and supports. Working with the contact monitoring pathway, family physicians were able to improve patient care during the pandemic and enhance patient and provider relationships, while alleviating pressure on hospital and secondary health care systems.

## Faces of COVID-19

### Catching colon cancer early

Mr. Asher, age 70, lives at home with his partner. He had not been seen by his family physician since October 2019. Through the review of the patient roster, Mr. Asher was deemed vulnerable by his family physician. During a telephone appointment, Mr. Asher told his doctor that he had significant bowel problems and some blood but had been putting off a visit because he was worried about bothering his family physician and catching COVID-19.

His doctor was able to reassure him that it was safe to come into the clinic and that it was important to investigate his symptoms. The physician was able to schedule prompt diagnostics that resulted in a diagnosis of stage II colon cancer. Because of this pathway, Mr. Asher was not overlooked and is now receiving care that is in line with his goals and wishes.

## Project detail

During the pivot to virtual care, Dr. Henry Siu and a team from the McMaster Family Health Team noticed that many of their most frail patients were avoiding or delaying seeking care—a scenario that could increase likelihood of negative health outcomes.

With Co-RIG funding, Dr. Siu sought to address this gap in care by creating a contact and longitudinal monitoring pathway. The Ontario-focused innovation serves as a proactive connection with patients. It helps family physicians assess COVID-19 risks and overall physical and mental health, and supports efforts to link patients to resources and follow-up care, including advanced care planning.

The Contact and Longitudinal Pathway uses the Clinical Frailty Scale to identify patients most in need, then the clinic staff reach out to those patients using a plan-do-study-act cycle so that family physicians are able to connect with patients and respond to their needs. This approach was complemented by a longitudinal continuous improvement process that allowed the model to be adapted as new solutions became available across the broader primary care community.

## Impact

- **Enhancing family medicine:** Dr. Siu's proactive contact monitoring pathway helps target care to patients with the greatest need. Use of the pathway helps family physicians with a process to identify risk factors in their older patients with frailty and target responses that will help improve patient outcomes.
- **Building capacity:** The pathway alleviates pressure on the hospital and secondary care systems by addressing minor or routine care before issues become more advanced.
- **Patient-centred approach:** The pathway has important benefits for the patient and provider relationship. For patients, being able to speak to their doctor about things not normally addressed in a typical encounter, such as feelings of loneliness and isolation, has helped deepen their trust.
- **Quality improvement:** By working with health administrators, residents, and infrastructure technologists, family physician leads were able to ensure clinic staff supported the shift to virtual care and that patient privacy was respected.

## Results to date

- In a 30,000-person patient roster, 6,000 were 65 years or older and 2,853 had Clinical Frailty Scale scores documented.
- Of the 680 unique phone encounters conducted, 200 focused on advanced care planning.
- Contact pathway identified several areas of patient concern including anxiety, social isolation and loneliness, mobility concerns, access to medications, and other health care supports. Financial security was not a concern found through chart checks.

- Six "intensive" interventions were generated by the health care team to support patients and a document detailing local resources was shared with older adults and their caregivers to allow them to connect with resources most appropriate for them. Intensive refers to time required to develop, operationalize, and sustain the intervention.

## Methodology

- Use the Clinical Frailty Scale to identify patients most in need of the pathway.
- Implement plan-do-study-act cycles at clinical sites, prioritizing telephone calls for the most frail.
- Analyze data collected from patient telephone conversations including advanced care planning discussions.
- Conduct two focus group sessions with primary health care teams.
- Brainstorm strategies to effectively and efficiently operationalize health care provider ideas for better supporting patients and integrating them into the care pathway.

> "Family medicine and primary care are the foundation of an effective health system. By proactively identifying and reaching out to our frail and at-risk older patients, we are helping them maintain optimal health, and reducing the burden of disease downstream."
>
> – Dr. Henry Siu, project lead


### Project team

**Project lead: Henry Siu,** MD, MSc, CCFP (COE), Department of Family Medicine, McMaster University

**Michelle Howard,** MSc, PhD, Department of Family Medicine, McMaster University

**Jennifer Lawson,** MLIS, Department of Family Medicine, McMaster University

**Dee Mangin,** MBChB, Department of Family Medicine, McMaster University

**Cathy Risdon,** MD, DMan, CCFP, FCFP, Department of Family Medicine, McMaster University


### Partners

**McMaster Family Health Team (MFHT)**

 The COVID-19 Pandemic Response and Impact Grant Program (Co-RIG) was launched by the FAFM in 2020 to support family physicians in their response to the COVID-19 pandemic, and was made possible by a generous $5 million contribution from the CMA Foundation. For more information, go to **https://fafm.cfpc.ca/corig-phaseone**.