

EXECUTIVE SUMMARY

Integration Priority Specialised Services for Frail Seniors

Strategy: A Geriatric Access and Integration Network

What is the problem being addressed?

Elderly persons are the most frequent users of the health system. Frail elderly comprise approximately 10% of persons age 65 years and over and are at risk for adverse conditions because of uncoordinated and inappropriate care. Their health conditions are characterised by multiple co morbidities, they need intensive case management and coordinated and flexible care to meet their needs effectively and efficiently.¹

What is the impact of not addressing the problem?

The Hamilton Niagara Haldimand Brant LHIN has the largest cohort of seniors among all Ontario LHINs. Persons age 65 years and older will comprise approximately xx% (265,643 persons) in 2016. Optimal quality of life for frail elderly persons is at risk in communities where the health system that does not organize and align its resources for client centered care, population health initiatives, chronic disease management, shared client information for planning and decision making, and knowledge transfer.

The need for health care services and supports increases with the onset of chronic disease, increased activity limitation, social isolation and complexity of condition. From client and family perspectives, specialized geriatric services (e.g. geriatrician and psycho-geriatrician services) are instrumental in helping people manage complex medical conditions, preventing premature deterioration of health and avoiding unnecessary hospitalization and/or inappropriate use of resources. However, specialized geriatric services are sometimes difficult to find and access, services are not always available close to home, care options are not tailored to clients' and carers' needs, and comprehensive care options are not organized around changing, co-morbid conditions. Among providers, the range of available services and supports may not be known, the increasing complexity of client and patient conditions requires ongoing skills' enhancement and interdisciplinary case relationships, and, tools to support coordinated and timely access to services e.g. patient information systems, are not in place.

The advent of the LHIN is an opportunity to renew and develop practices and ways of work among providers and patients, and others, that will make a difference to frail seniors' health outcomes, enhance effective program performance, efficiently align LHIN resources, and influence a provincial agenda for seniors' health.

What is the solution?

The Geriatric Access and Integration Network (GAIN) will be strategic and purposeful collaborative among stakeholders and will propose and coordinate LHIN wide strategies to optimize the quality of life for frail seniors. Stakeholders include those who use and will use specialized geriatric services, and providers, educators, funders, policy makers

¹ Baycrest. July 2006. Responding to the Health Needs of the Elderly: A Synthesis with Policy Recommendations for Ontario. Page 3

and researchers. The goal of the collaboration is an interconnected network of specialized geriatric health care services to promote:

- Strategies for optimal care and support for frail elder health in the LHIN
- Equitable access to specialised geriatric services in hospitals and in the community
- Enhanced connectedness among services to make it easier for people to get the right service at the right time consistent with their preferences, and easier for providers to organize and deliver best practice care
- Allocation of resources consistent with need and desired outcomes

Related requirements to support deliberations for future action include assessments of:

- the level of support and commitment for a collaborative network
- the resources available to support frail seniors' health: a report card on the basket of services, access points and protocols, care path planning and assessment, provider connectedness, performance measures, evidence of best practice, among others
- improvement opportunities
- best practices in integrated service delivery models for frail seniors

How will this make a difference?

Collaboration for an informed, connected and evidence based system of care and support for frail seniors will result in informed choices and care plans among clients, patients and carers, timely access to services, fewer inappropriate admissions to any service including hospitals, and, healthier frail seniors with more confidence in the health system. Providers will benefit from purposeful relationships and initiatives for planning, knowledge transfer and peer support.

Why is this the right solution?

The LHIN signals shared responsibility and accountability for health outcomes and health system performance. The GAIN stakeholders and early discussants recognize the need for an integrated delivery model – one that promotes better connectedness and efficient and effective resource allocation for client centered approaches.

The GAIN initiative is an opportunity to influence primary care reform initiatives in the LHIN e.g. family health teams' chronic disease management strategies, implementation of electronic information systems and Provincial strategies for frail elder care and support.

GAIN is focused initially on specialised services for frail elderly, and in subsequent phases can expand its foci on the appropriate service basket to support independent and less frail seniors. At this early stage of its development, the GAIN initiative also presents the broader LHIN community with an opportunity to explore and pilot the ways and means of effective collaboratives. The outcomes will help frame the approaches to enhance the capacity of other collaboratives to achieve community health outcomes.

What is the level of readiness/commitment to action this solution?

The Geriatric Access and Integration Network (GAIN) was first among all priorities at a November 2004 LHIN wide session. In June 2006, 40+ representatives from among service providers met to begin the dialogue on the role and function of GAIN and committed to cooperation and collaboration. Many groups and networks focused on seniors' health care are seeking ways to reduce duplicative efforts, ensure they are

working on the right issues with the right people to improve frail seniors' health outcomes, and leverage limited resources. The GAIN project raised some \$20,000.00 among key LHIN stakeholders to launch planning and relationship building.

While the GAIN is in its infancy, this does not preclude planning and implementation of strategies that, with adequate resources, will help improve system capacity, coordination and integration. As evidenced by examples of current strategies:

- The Dementia Education Program for Family Physicians, a LHIN-wide physician capacity building strategy for enhancing family physician knowledge of geriatric issues. It includes training in screening, assessment and symptom management for psycho-geriatric patients.
- Partnerships among key leaders in the provision of specialized geriatric services within Hamilton Niagara Haldimand Brant LHIN to:
 - Improve the coordination and availability of gerontology educational materials for best practice geriatric care across the continuum of service providers, particularly for the long-term care sector
 - Improve the quality of care for residents and employee safety in long-term homes through staff training in best practice approaches to the management of challenging behaviour associated with dementia.
- Implementation of the Geriatric Emergency Management (GEM) program, whereby Clinical Nurse Specialists are placed in emergency departments to inform and assist other health professionals regarding the unique care needs of seniors.
- Further promotion and coordination of efforts to continue to integrate advance directives into health care facilities as standard best practice.
- Further implementation of Hospital Elder Life Program across the LHIN. This program utilizes volunteers to enhance in-hospital care for seniors.

What resources can be leveraged to implement the solution?

Describe the process used to develop this health improvement solution:

In June 2006, a leadership team facilitated a GAIN workshop session at which 40+ participants from among HNHB LHIN service providers developed a vision, mission, and guiding principles, and proposed goals for the network.

Next steps include a forum in Fall 2006 co sponsored by GAIN and the Hamilton Niagara Haldimand Brant LHIN for specialised care services and affiliated stakeholders networks to begin the process of examining and developing the approaches and tools that enable collaboratives to work effectively. Following this, LHIN wide discussions will continue on the scope and opportunity of the collaborative to optimize frail senior's health, the range and role(s) of collaborative participants, and confirmation of shared aspirations for change.

Requirements for finalising the Executive Summary

1. How does this strategy differ from the role of RGPc?
2. What resources can be leveraged to implement the strategy (other than the Network forum?)
3. What are the implications if any for MOHLTC \$\$ over the next 12 months?