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Developing an Integrated Clinical Services Plan for Frail Seniors in the WW LHIN: Guiding principles

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A. ***The primary objective of any plan to integrate clinical services for geriatric care is to manage Frailty and prevent its complications.***

Simply put, frailty is an increased state of vulnerability to adverse health outcomes as a result of the accumulation of age-associated deficits that reduce physiologic reserve across multiple systems. Important characteristics of frailty to consider include:

1. *Frailty does not equal disability*

While most disabled persons are frail, not all frail persons are disabled. While some seemingly independent seniors may tolerate an acute illness relatively unscathed, others are at risk of complications. We should aim to prevent adverse health outcomes in all frail seniors, including those who have not yet suffered from its complications.

2. *Frailty is usually associated with chronic disease*

Not all persons with chronic disease are frail. However, most frail persons have one or more chronic diseases. Some of these diseases are clinically manifest, whereas others are subclinical. The risk of frailty increases with the number of chronic diseases. Optimal management of frailty requires that these chronic diseases be optimally managed as well.

3. *Exercise is a key component of managing all stages of frailty*

Exercise is beneficial at almost any stage of frailty, except perhaps end-stage frailty. It should be available to those who wish or need to participate.

4. *Healthy aging requires consideration of all aspects of wellness*

Optimal biological and psychological health requires a healthy environment, proper nutrition, and attention to community supports and connections. Socially connected and active seniors are healthier. Poor social support contributes to frailty, and in some may tip the balance from relative independence to institutionalization.

B. ***Frailty can be optimally managed under the Chronic Disease Management model***

Chronic Disease Management (CDM) refers to a system of care that supports the adoption by individuals with chronic illness of behaviours intended to maintain their health and reduce the need to access health care. A core feature is the empowerment and training of patients and

caregivers to assume greater control and responsibility over healthcare. Under the CDM approach, evidence-based care is provided by multidisciplinary teams. The intensity of the care provided to patients is tailored to their risk of an adverse outcome. Care coordination among providers as well as clinical information and decision support systems are essential. CDM has been shown effective for diabetes, cardiac disease, COPD and mental health, among others.

A substantial body of literature exists demonstrating that comprehensive geriatric assessment and care has been shown effective at improving health and reducing health service utilization. A number of implications arise from adopting the CDM as the preferred approach to geriatric care.

1. ***Frail patients are ubiquitous***. The bulk of care can and should be delivered at the primary care level. In addition, effective care for frail seniors can and should also be provided by other front-line providers, including hospitalists, emergency rooms, long-term care facilities, or any other service or care provider, inpatient or otherwise.

2. ***Targeting care***
    a. Most (75%) patients will do well with low-intensity CDM, usually delivered by one or two providers, who usually include the primary care physician or nurse practitioner.
    b. Mid-intensity (15-20%) patients will require multidisciplinary team involvement, and possibly access to specialist support, either directly or through capacity building initiatives within primary care.
    c. Approximately 5-10% of patients will require high-intensity CDM, with case-coordination and management and close coordination of primary care and specialists.

3. ***The role of specialists*** is to provide direct clinical services to high-intensity patients as well as to selected mid-intensity patients, and to provide capacity-building / indirect support at least at the mid-intensity levels. Furthermore, developing strategies for optimal deployment of geriatricians will require consideration of the recent OMA agreement to provide Alternative Funding Plans for geriatricians working in multidisciplinary teams, as well as the provision by the MOH LTC of enhanced specialist billings codes and sessional fees for work with Family Health Teams.

C. Education and evaluation

In order for an integrated clinical services plan for frail seniors to function and be sustainable, continuing educational opportunities aimed at new and established learners, and at all levels of health services personnel, whether directly involved in clinical work or not, must be built into the model from its inception.

Similarly, it is imperative to ensure that all aspects of the plan resulting from this exercise be evaluated using appropriate and clinically relevant outcome measures in order to ensure that optimal care is delivered, to identify ongoing deficiencies in care provision, and to inform remedial measures to correct these deficiencies.

Proposed methodology and timelines

1. Semi-structured interview of all interested stakeholders. A list of stakeholders and an interview guide are attached (winter / spring 2010);
2. Use of qualitative methods to identify themes and priorities emerging from the interviews. Dr. Carrie McAiney (McMaster University) has agreed to assist in the analysis of this data (spring / summer 2010). Local assistance will also be sought from the University of Waterloo.
3. Develop a list of key clinical strategies and initiatives based on the results of the interview analyses. Using a Delphi methodology, these strategies and initiatives will be ranked by the Stakeholders in terms of priority. Using the results, a clinical services plan will be developed (early fall 2010);
4. A ½ - 1 day forum will be held to review the results of the survey, to present the clinical services plan, and to solicit direct feedback (late fall 2010). Relevant performance indicators will be identified. The WWLHIN will assist with the planning and logistics for this session.
5. The feedback will be incorporated into the final clinical services plan, which will be submitted to the WWLHIN (December 2010).

Oversight for the Project

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