Template #1: Strengths and Challenges within the Current System in Addressing Population Needs

Integration of specialty geriatric medicine services within primary care	PAG Facilitator: Dr. A. Moore, Dr. D. Cowan
Strengths	Challenges
Strengths within the primary care system to facilitate this project include: The target group of this proposal is frail older adults living in the community who are at risk of functional decline, hospitalization, and institutionalization in long term care homes. This project proposes collaboration between specialized geriatric services (SGS) and primary care. The initial phase proposes a shared care model with family health teams. Subsequent stages will extend to community health centres, non FHT group and solo practices with the ultimate goal of integrating SGS in primary care across the LIHN. A comprehensive and accessible primary care network in the HNHB LHIN. More than 95% of residents over 65 years of age have family doctors (significantly higher than the Ontario Average). Concentrated core of FHT's with multidisciplinary teams poised to provide appropriate care for the complex needs of community dwelling frail elderly (about 25% of family doctors work in family health teams). Minimal wait times to see Family Doctors vs specialized geriatric services Family doctors provide the majority of care for the aged. Relationship between geriatric medicine specialists and family doctors is an opportunity for capacity building.	**Challenges within the primary care system to facilitate this project include:** Volume 200,000 seniors, fastest growing age group, largest number of seniors in all 14 LIHN populations in Ontario. Complexity Seniors living with more than one chronic condition is increasing. 55% of Ontarians suffer from two or more chronic conditions Primary care challenges Primary care practitioners provide the majority of care for elderly living in the community. Family physicians have identified inadequate training, lack of confidence and resources to manage complex frail elderly. The traditional organization of primary care which emphasizes triage and patient flow, focuses on acute problems that are managed in short (average 7 minutes) unprepared visits without consistent after care. This practice is incongruent with the needs of frail elderly. Advanced care planning is minimally addressed in primary care and represents the ideal opportunity for these discussions. Wide variety of primary care models (family health teams, community health centres, family health groups, fee for service, solo and group practices).

<table>
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<td>Highly dedicated staff

Patient satisfaction

Academic affiliations (some providers)

Opportunity for early intervention, health promotion, disease prevention, risk reduction (eg vitamin D, exercise program, prevention of falls and social isolation – risk of depression, medication management, driving and home safety assessment) potentially leading to decreased emergency department visits, alternate level of care placement and increased average age at admission to long term care.

Opportunities for advanced planning (health, shelter, finances)

Early experience with shared care model integration of specialized geriatric medicine in primary care (collaboration project between the Department of Family Medicine, McMaster University, Hamilton Family Health Team, Alzheimer's Society, Community Care Access Centre).</td>
<td>Delayed <u>access to consultant</u> services (geriatric medicine, rehabilitation services, orthopedics, internal medicine).

Access to MRIs

Communication delays and gaps with specialists – Lack of shared health electronic record

Access to marginalized immigrant, aboriginal, socially isolated and disadvantaged seniors</td>
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<tr>
<td>Strengths within specialized Geriatric Medicine system to facilitate this project include:

Highly dedicated staff
Academic affiliations (education and training health care professionals)
History of relationships with Family doctors
Hospital based services – <u>full scope of medical</u> programs available
Existence of partnerships; i.e., (HHSC, SJH, etc…)
Linkages and collaboration with community resources (CCAC, DVA, AS)</td>
<td>Challenges within the specialized geriatric medicine system to facilitate this project include:

Inconsistent access to specialized geriatric medicine services
Largely hospital based, urban centred
Prolonged wait times to access specialized geriatric medicine services (up to 6 months)
High ALC rates
Lack of access to alternatives to hospital admission
Delayed access to consultant services (geriatric medicine, rehabilitation services, orthopedics, internal medicine)
Access to MRIs
Communication delays and gaps – Lack of shared health electronic record</td>
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Template #2: Factors Most Likely to Increase or Decrease the Future Demand for Health Care:

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As of 2006, the HNHB LHIN was home to over 200,000 seniors aged 65 years and older; the largest number of seniors of all LHINs. In 2006, seniors 65 years of age and older represented 15.8% of the total HNHB LHIN population, compared to 13.6% for all of Ontario. • Twenty-nine percent (29%) of seniors aged 65+ live alone in HNHB communities, higher than the provincial average of 27%. Within HNHB the highest proportions of seniors living alone are found in St. Catharines (33%) and Brantford (33%) and the lowest proportion in Wainfleet (19%). • Seniors living alone may be at greater risk of social isolation. The lack of social support among the elderly contributes to poor health status and the need for formal and institutional care. Approximately 27.7% of seniors in the HNHB LHIN live alone (See Table 2). Seniors living alone may be at greater risk of social isolation. The lack of social support among the elderly contributes to poor health status and the need for formal and institutional care. [i] A recent Statistics Canada study[ii] demonstrated that the vast majority of seniors remain in the community as their health care needs increase. Between 1981-2001 the proportion of Canadians aged 65+ living in health care institutions remained at about 7%; in 2001, approximately one-third of Canadians age 85+ lived in an institutional care setting. Among seniors living in the broader community, the Ministry of Health and Long-Term Care estimates that relatives, friends and volunteers provide about 80% of support to seniors with needs. The majority of seniors that live in the HNHB LHIN live within Hamilton and Niagara (See Figure 1). In terms of absolute numbers, Hamilton and Niagara are each home to over 74,000 seniors 65 years of age and older, and together represent 72% of the total HNHB LHIN population over 65 years of age. Population aging presents significant challenges to the health care system in Ontario. Not the least of these is the fact that 82% of seniors have one or more chronic health condition and 43% have three or more chronic conditions. This latter group is at risk of becoming frail. Frailty, characterized by complex bio-psycho-social and functional problems, is associated with increased health system usage and puts seniors at risk of loss of the capacity for independent living and lowered quality of life (Wolff et al, 2002). Within the aging demographic, frailty may be the fastest growing issue across the province and particularly in northern regions and	Significant impact on future demand for health care

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outside high-density urban areas (Manuel & Schultz, 2001).

The ageing of the Baby Boomers will be the main driver of the increased number of people who are 65 years and over. These numbers will increase by 50% over the next 10-15 years. Improved life expectancy will also see the numbers of people aged 80 years and over double during the next two decades. As we live longer we are likely to see an increasing proportion of people with age related medical disorders such as neurodegenerative disorders, depression and mental health problems (Hopkins & Hopkins, 2005).

A key contributor to the increase in severe disability experienced by those over 80 is growth of neurological conditions, which result in disorders of memory, cognition, behaviour, motor and sensory functioning, mobility and balance. These neurodegenerative diseases are often slowly progressive and they have not, so far, been amenable to prevention or delayed onset, as have other disorders such as heart attacks and stroke. While there is no strong evidence that the incidence of these diseases is changing, their prevalence is rising rapidly as more people are living longer. We can expect the systemic disorders to be overtaken by neurodegenerative diseases as the major cause of death in older people during the coming decades and also the major cause of severe disability.

People will come out of hospital with the capacity to get better and it will be important that the health system has a strong focus on *restorative and preventative measures*. The demand for rehabilitation and other services following these acute events will certainly increase. In response to these trends we may benefit from a hospital sector that plays a greater role in preventing acute admissions to hospitals and delivers more services in the community.

The Dementia Epidemic:

In Ontario, dementia is the leading cause of disability for those over 60 years of age causing more years lived with disability than stroke, cardiovascular disease and all forms of cancer (Alzheimer Society of Ontario, 2007). It is expected that by 2010, 175,000 Ontarians will be living with dementia; this will increase by almost 127% by 2020 (Hopkins & Hopkins, 2005). Table 1 presents the estimated incidence of dementia in the HNHB LHIN for 2006.

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Table 1: Estimated Incidence of Dementia in the HNHB LHIN, by County and Age Group, 2006.

Geography	Age Group						
	60-64	65-69	70-74	75-79	80-84	85+	Total (60+)
Brant	31	50	93	173	291	533	1,171
Burlington	45	73	134	238	391	667	1,548
Haldimand-Norfolk	31	48	86	148	242	438	994
Hamilton	125	207	386	742	1,242	1,968	4,670
Niagara	121	204	378	704	1,201	1,997	4,605
HNHB LHIN	353	583	1,077	2,005	3,367	5,603	12,988
Ontario	2,984	4,872	8,578	15,146	24,486	42,003	98,069

Source: Statistics Canada, 2006 Census; Dementia Age Relative risk: 60 1%; 65 2%; 70 4%; 75 8%; 80 16%; 85+ 32%. Source:

Ageing demographics will have a significant *impact on human resource planning* and development in all professions working in many health care contexts across the circle of care (McKnight et al. 2003). Providing care to this expanding population of frail seniors requires both an increase in the numbers of care providers, capacity building across various health care sectors, and restructuring of how and where we deliver care. Our skill sets require expertise in three broad competencies - geriatrics, inter-professional practice and inter-organizational collaboration.

Competence in geriatrics is required because the clinical presentations of frail seniors are unique and include the 'geriatric giants' of dementia, delirium, falls, continence and poly-pharmacy. These often co-exist in complex ways. Competence in inter-professional practice is required because the complexities of these clinical presentations are such that optimal care requires an interdisciplinary team. Inter-professional teamwork, as outlined in the recently published Health Force Ontario, Inter-professional Care: Blueprint for Action (Oandasan & Closson, 2007), is the care delivery method of choice in caring for frail seniors (Geriatrics Interdisciplinary Advisory Group, 2006). Finally, competence in inter-organizational collaboration is required because the management of frail seniors requires the sharing of care across many organizational boundaries from primary and community based care to emergency and hospital-based services.

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Advancement in technology and how we communicate with each other Based on this aging population and HR challenges we need to develop e – health strategies such as video conferencing, maximize electronic record sharing such as clinical connect, standardize all documentation processes to facilitate data collection, evaluation and reduce redundant assessment practices that are a further burden on staff and patients and families. Common forms and tools will create more effective practice and help different teams start communicating AS ONE. Common documentation will facilitate rapid and improved transfer of information. Capacity building will be much easier and bench marking will be attainable. Patients/clients need to assume more responsibility for their care. Work has been done using patient passports and best practice needs to be implemented using principles from the chronic disease model, e.g., flag prevention measures, telephone follow up to reinforce messages etc. Video conferencing is now being tested by geriatricians and office space has been secured. Geriatricians will be among a very small group in the province of Ontario to actually use video conferencing for clinical purposes. We are just beginning to understand the full ramifications of this technology. How services are offered As frail seniors decondition rapidly in hospitals e.g., loosing muscle mass, delirium, infections etc., it is imperative that services are designed that prevent admission and re-admission and help people live longer in their homes with a good quality of life. The specialty of geriatrics can not tackle this problem single handedly. Using a collaborative model, we propose developing a shared care model with family health teams and community health centres. Building expertise in geriatrics across the continuum with targeted specialist support will help multi-disciplinary groups identify seniors at risk. We need to equip primary care settings to be responsive to seniors at risk so they can provide time sensitive support to hospital discharges or seniors presenting in emergency who can return home with expedited clinical support. Having a flexible team that can provide outpatient and at home outreach services is critical. Many seniors in our LHIN live in isolated situations and are at risk. Best practice We know that targeted care to frail seniors makes a difference in health outcomes. Evidence indicates that interdisciplinary teams on an inpatient and outpatient basis is important. Comprehensive Geriatric Assessment targeted at frail seniors responds to	

Integration of specialty geriatric medicine services within primary care	
immediate issues and prevents other medical conditions from worsening. Home visits will improve overall functioning and help seniors live more independently. Teaching seniors more about their health and how to manage their care more proactively is a integral part of the care process. Already, we have positive results in the Transitional Care program through Dr. G. Heckman that shows teaching frail seniors is effective and helps them stay out of hospital. Using communication strategies like providing patients a copy of their treatment plan, having them bring their patient passport to all health care appointments is an important health information tool. This will introduce evidence based practice for meeting the needs of aging population	

What factors are expected to influence the demand for health care beyond 2013?

Practice of geriatric care is clustered in urban centres, primarily Hamilton

Rapidly growing older adult population with shortage of geriatric specialty trained health care professionals across all sectors of health care including primary care and community.

Movement of older adults to retirement communities, often smaller towns with poorly established geriatric health services and limited family and transportation

Finite number of Long Term Care beds

Template #3: Components of an Ideal Service Delivery Model

PAG Name Integration of specialty geriatric medicine services within primary care		PAG Facilitator	
Component of service delivery model	Services associated with this component of the model	Clinical and non-clinical interdependencies (e.g., DI, lab, other programs/services, other PAGs)	Linkages to community services
Health Promotion/Disease Prevention	- Patient and family educational materials • Collaboration with case manager at CCAC regarded self efficacy for client in the home. Capacity building-Educational events for the Family Health Teams • Patient Passport • Public Education • Professional Continuing Education - Resource specialists/CCAC case managers on site - Needs assessment from clients and families related to gaps in knowledge	- Referrals from outpatient and Home visits assessments to specialists, organizations and CCAC - Case finding – Referrals from Health Team to specialists, continence advisors, bone density testing - University Education	- Links to community groups e.g. Alzheimer Society – First Link program, counseling and education, respite care, CCAC, legal services, seniors Drop-In centres
Primary Care / Pre-hospital Care	- This program provides service in the persons local community (FD office, CHC or home) care is locally accessible in a familiar setting. - Supports self care and independent living at home as long as possible by treating medical social, psychological and functional needs - Efficiency is maximized by working	- Similar to out patient visit	- Links to current community services, back to the referrer and to new community support organizations - e.g. other consultants, Alzheimer Society

PAG Name Integration of specialty geriatric medicine services within primary care		PAG Facilitator	
Component of service delivery model	Services associated with this component of the model	Clinical and non-clinical interdependencies (e.g., DI, lab, other programs/services, other PAGs)	Linkages to community services
	with local resource network (CCAC, Alzheimer Society, DVA, meals on wheels) no duplication of services, engagement of appropriate services. - Given comprehensiveness of assessment this responds to diverse needs and individual client characteristics. - Specialized Geriatric Services (e.g., newly proposed atHome Program's geriatric outreach team to assist with diversion from hospital, ER admission) response to primary care request for clinic or home visit - Referrers are family physicians, CCAC, etc. - Add mechanism to deal with patients who do not have a family physician - Consult note has an educational component and is shared with patient and family • Tele health is starting in some areas and will be expanded • Local geriatric clinics • Case management model so clients have a primary worker who is accountable for overall coordination of care		CCAC (home care, day care, LTC)

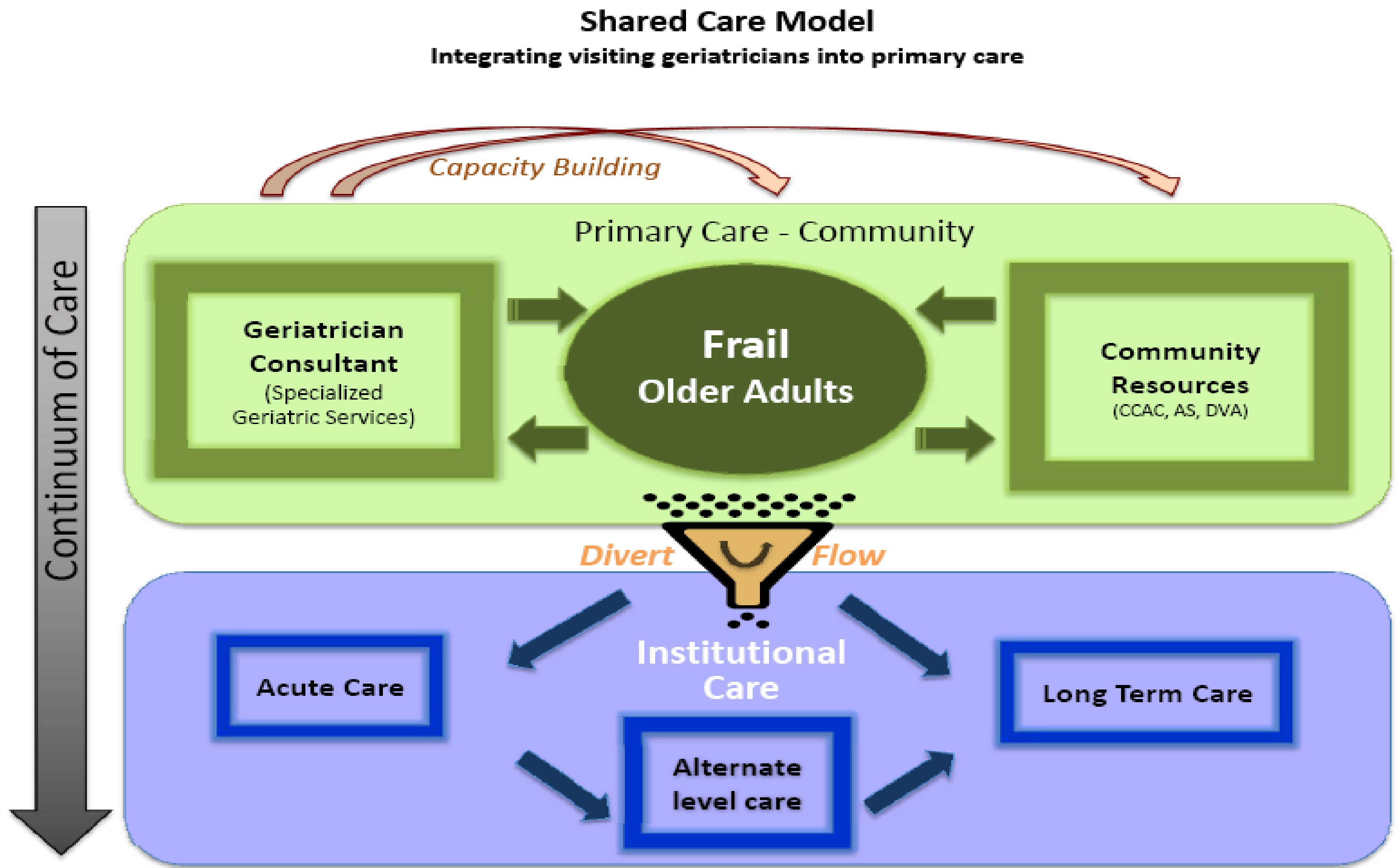
PAG Name Integration of specialty geriatric medicine services within primary care		PAG Facilitator	
Component of service delivery model	Services associated with this component of the model	Clinical and non-clinical interdependencies (e.g., DI, lab, other programs/services, other PAGs)	Linkages to community services
	• Visiting specialists - Eventual incorporation of physician assistants		
Acute Hospital Care	- Prevent admission to acute hospital care by increasing resources in the community - Link with Transitional Care and proposed atHome geriatric outreach program to prevent readmission. Handoff from the transitional program to primary care will be very important - Increase access to Specialized Geriatric Services via multiple clinic settings across the LHIN - Referral to appropriate geriatric inpatient services such as rehabilitation as required. • Pre operative Comprehensive Geriatric Assessment eg elective hip will help reduce LOS to acute hospital care. If surgery is required hospital admission can be delayed by increasing resources in the community - Improved two-way communication – automatic notification of	- Similar to out patient visit	- Link with CCAC or other CHC services - Link to RGPc network of geriatric service providers - Link to proposal/atHome geriatric outreach program

PAG Name Integration of specialty geriatric medicine services within primary care		PAG Facilitator	
Component of service delivery model	Services associated with this component of the model	Clinical and non-clinical interdependencies (e.g., DI, lab, other programs/services, other PAGs)	Linkages to community services
	admission to hospital to family health team, pharmacist etc -		
Non-acute Hospital Care	- Increase referrals to CCAC and community support programs to help people manage at home - Hospital admission to rehab, geriatric assessment unit, day hospital, OT, PT, SLP, physiatrist	- Similar to out patient visit	- Discharge planning - Need for expedited follow up on frail seniors - Linkage with outreach/outpt programs/day hospitals
Post-Hospital Care	- Support for “precarious discharge” patients (e.g. transitional care). - Shared care model will offer a variety of clinical settings. High risk patients will be seen promptly. This will help reduce hospital and LTC admissions. This will also provide a discharge location as hospital teams will have more confidence that referrals will be picked up quickly for frail clients. - Having multiple teams in various primary care settings is an enhancement of the current		- CCAC - Community support services - Transitional care - Primary care

PAG Name Integration of specialty geriatric medicine services within primary care		PAG Facilitator	
Component of service delivery model	Services associated with this component of the model	Clinical and non-clinical interdependencies (e.g., DI, lab, other programs/services, other PAGs)	Linkages to community services
	outreach program		
Community-based Acute Care / Community-based Non-Acute Care	• Patient Passport • Transitional care coach • Reintroduce links between family health team and CCAC case management • Enhanced community rehabilitation services Inpatient assessment to identify patients who need rapid follow-up assessment		- CCAC and community support services

Diagram of Ideal Service Delivery Model:

Integrated Specialty Geriatric Services Within Primary Care



Template #4. Assess and Describe the PAG service delivery model using the HNHB LHIN Criteria

PAG Name – Integration of specialty geriatric medicine services within primary care		
Domain	Criteria	Assessment Description
Strategic Fit	Alignment with LHIN priorities for health improvement in response to the demographic imperative	- Decrease readmissions to hospital and visits to Emergency Departments - Improve Aging in Place - Improve access to services - Aligned with Chronic Disease Management model (self efficacy, self care, education) - Health promotion and prevention – target specific interventions such as memory loss, depression, falls risk, confusion re: polypharmacy
	Alignment with trends in health care needs and system transformation	- System of services, standard assessment forms and common care path approaches - Connecting individuals to services and improving collaboration amongst service providers - Will build on Best Practice - Use of shared care models - Access to other team resources
Population Health	Health status (clinical outcomes & QOL)	- Improved health and quality of life
	Prevalence	- targeting of frail older adults eg 25% of over 80's
	Health promotion & disease prevention	- Will target those at risk of falls, declining functional status, memory loss etc. Will build in strategies to help people learn more about their health so they take on more responsibility -

PAG Name – Integration of specialty geriatric medicine services within primary care		
Domain	Criteria	Assessment Description
System Values	Client-focus	- Yes, bringing service to the client at home. Link with "aging at home" services - Use of circle of care approach, drawing in extended family, church and significant others - Will reach those who are marginalized due to physical disability or lack of transportation - Will have improved access to staff who speak different languages and will promote cultural sensitivity based on client population characteristics
	Partnerships	- Pts, families and informal supporters - Multiple partnerships; - Community organizations – e.g. formal (CCAC) and informal (Alzheimer Society) - Sectors (primary care, acute care, community care) - Professions (OT, PT, SLP)
	Community Engagement	- Will be responsive to diverse needs and in corporate approaches to care and education that is appropriate - Will improve proximity to care as lack of transportation will not exclude people from expert care - Teams in rural areas may need to be made up of a different mix of disciplines compared to urban/academic centres. Rural areas will collaborate with a smaller set of organizations. We will be sensitive to the needs and strengths nested in each "community" area - Resources will be more efficient if a "shared care" approach is used. Tremendous capacity building - Ongoing focus groups will be required with senior citizens to help develop age friendly

PAG Name – Integration of specialty geriatric medicine services within primary care		
Domain	**Criteria**	**Assessment Description**
		health promotion and prevention strategies and a review of how each "communities" constellation of services are working together. Care issues will be addressed through this ongoing feedback loop from consumers. The Hamilton Council on Aging (HCOA) is very diverse and has agreed to help develop this form of engagement with consumers of health care. The HCOA will help us link with other seniors groups in other areas of the LHIN
	Innovation	- Enhancement of current service with outreach workers using a shared care model - This service will be responsive using different interventions such as telephone reminders, assessing priority visits for those screened at high risk, assessing self efficacy skills etc
	Equity	- Reach frail seniors who cannot travel to current service sites - Address travel/transit challenges (particularly in rural regions of the LHIN)
	Efficiency (operational)	- Yes – shared care models - Screening by trained staff will allow specialists to see those at high risk while other patient referrals may be managed by team members or referred to other community programs. This model will ensure those most at need will be seen by the specialist. This will also allow the specialist to see more patients at clinics when team members have already completed a battery of tests with a preliminary assessment in place
System Performance	Access	- improved access through multiple clinic sites and home visits
	Quality	- Quality assurance component - Patient and family satisfaction

PAG Name – Integration of specialty geriatric medicine services within primary care		
Domain	Criteria	Assessment Description
	Sustainability	- This model can be implemented very quickly. All that is required is clinic space, access to appropriate staff and basic infrastructure needs
	Integration	- This outreach model will promote more consistency of care with common approaches, common assessment documentation and linkage with transitional care and primary care settings. Continuity of care is known to improve overall patient care

Template #5: Description of Pre-requisites, Enablers and Challenges to Implementation:

Category	Pre-requisites	Enablers	Challenges
Policy/legislation	Policy will address access variation to specialized geriatric services LHIN wide Agreements accountability, locus of care Criteria for intake Model evaluation, definition of outcome measures Standardized assessment tools to allow evaluation/audit LHIN wide	Developed –Hamilton Family Health care mental health policy agreements in alignment with current legislation (Seniors health initiative in family health team) Large resource of evidence based quality indicators (some tools developed locally)	Adaptation to models of primary care delivery across LHIN
Resources (e.g., human, fiscal, capital, etc.)	Distribution of specialized geriatric team based expertise from hospital (urban) to community (urban and rural) Recruitment / Training physician and allied health. Financial and human resources Interprofessional communication Inter-organizational communication	Well established hospital based multidisciplinary geriatric teams Highly skilled providers Expertise in collaboration CCAC FHTs Hospitals Co-located team based care facilitates communication enhances continuity of care between specialist, and community providers (family doctors, allied	Experience community based geriatric multidisciplinary medicine teams (role definition, scope of practice, communication, electronic medical records, remuneration)
Community readiness	Ongoing communication will be required with all stakeholders patients, family, care givers, primary care providers, specialized geriatric medicine providers, community resource organizations, community partners (Hamilton	Recognition of need has been identified, preliminary experience Familiarity with shared care model (mental health shared care model HFHT) History of collaboration between	Widely variable models of primary care delivery across the LHIN (variation in resources of space, human, remuneration) development of patient health

	Family Health Team),	stakeholdes; patients, primary care, specialized geriatric providers, community organizations and partners) Current initiatives: Shared care model with specialized geriatric medicine in primary care (Collaboration between Hamilton Family Health Team, Department of Family Medicine, McMaster University, AS, CCAC) Patient health passport	passport
Services	Survey and identify process for linkages between services (eg.acute care, LTC primary care, community resources, transitional care, 'at home' program,	Clinical services with established efficacy	Under utilization, duplication of services, variable awareness of resources and services Coordination of services will require communication, accountability.
Partnerships/linkages	Engage, communicate build on current linkages among stekeholders/partners (CCAC AS DVA CNIB meals on wheels etc), survey needs and identify strategies to maximize resources and linkages to avoid under utilization and duplication of resources and services	Well established relationships collaborative partnerships among stakeholders (patients family, care givers, primary care providers specialized geriatric providers, community partners)	