Regional Geriatric Program of Eastern Ontario
Programme gériatrique régional de l'Est de l'Ontario

A Vision to improve UPSTREAM Community-based Care of Seniors

- Helping our acute care hospitals by promoting <u>Aging at Home</u> and ALC <u>PREVENTION</u>

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Understanding FLOW in the Health Care System

The key is …

1. **Balancing investment** in the Portfolio of ED/ALC basket of services

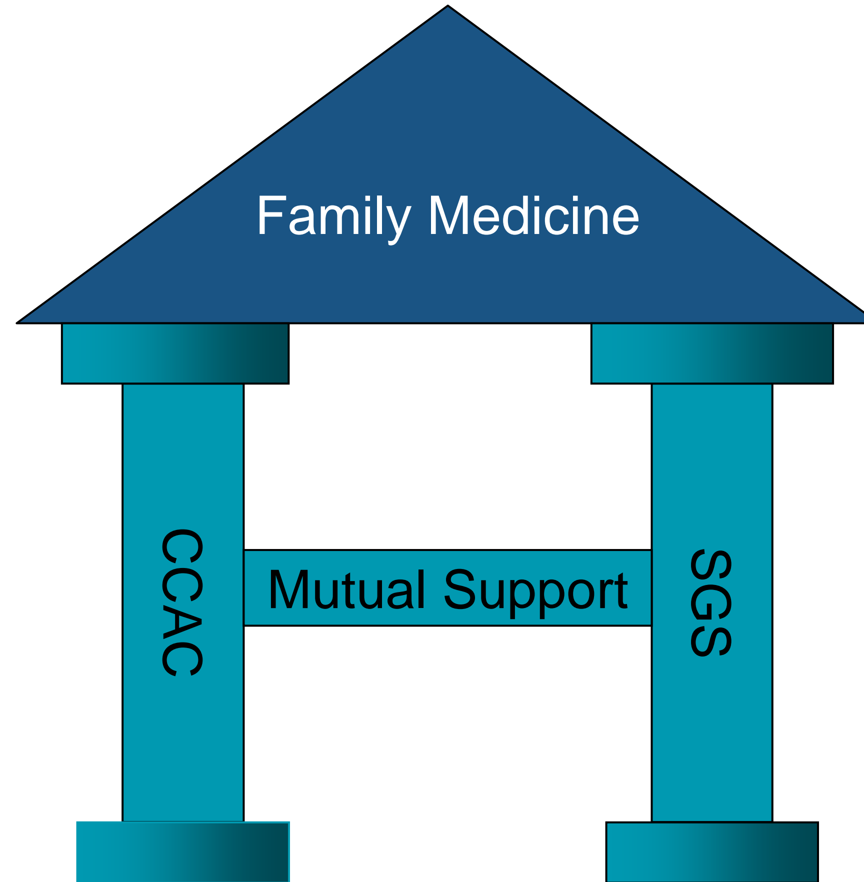
   Do not only focus on downstream issues of what to do **AFTER** someone is designated ALC (Post-ALC measures) but also look upstream to determine what services would have **PREVENTED** most common ED / ALC issues (PRE-ALC Measures)

   (Close the barn door before the horse gets out)

Upstream Community-based ED / ALC Prevention strategies (e.g.. Aging at Home; Home First …)

- THE VISION:
  - Move CCAC to the centre of the Health Care System .
  - Strengthen the Relationship (reciprocal supports) between CCAC and Specialized Geriatric Services
  - Organize Family Medicine into a unified network to permit widespread support
  - PREVENT ED / ALC and enhance AGING at HOME by supporting Family Medicine via the interconnected pillars of CCAC and Specialized Geriatric Services (SGS);
    - Knowledge Resources
    - Service Resources

The IDEAL Structure / system



A partial list of pillar programs that can support each other

CCAC Programs

- Aging in Place programs
- Complex Seniors Case Managers
  - Specialization in Dementia Care
- Home First programs
- Hospital to Home
- Services to support seniors in their homes including therapeutics

Specialized Geriatric Services

- RGP
    - GEM
    - GAOT
      - QCH
      - Bruyere
- Bruyere Continuing Care
  - Geriatric Day Hospital
  - Geriatric Rehab
  - Geriatric Psychiatry
- Acute Hospitals Geriatric and Care of the Elderly programs
  - TOH, QCH, Montfort, Cornwall ….
- ROH Geriatric Psychiatry
- etc

The Current Situation < Silos >
Limited Collaboration and Integration

FHN

FHT

Individual FMD

Community Health Centres

CCAC

RGP – GEM / GAOT

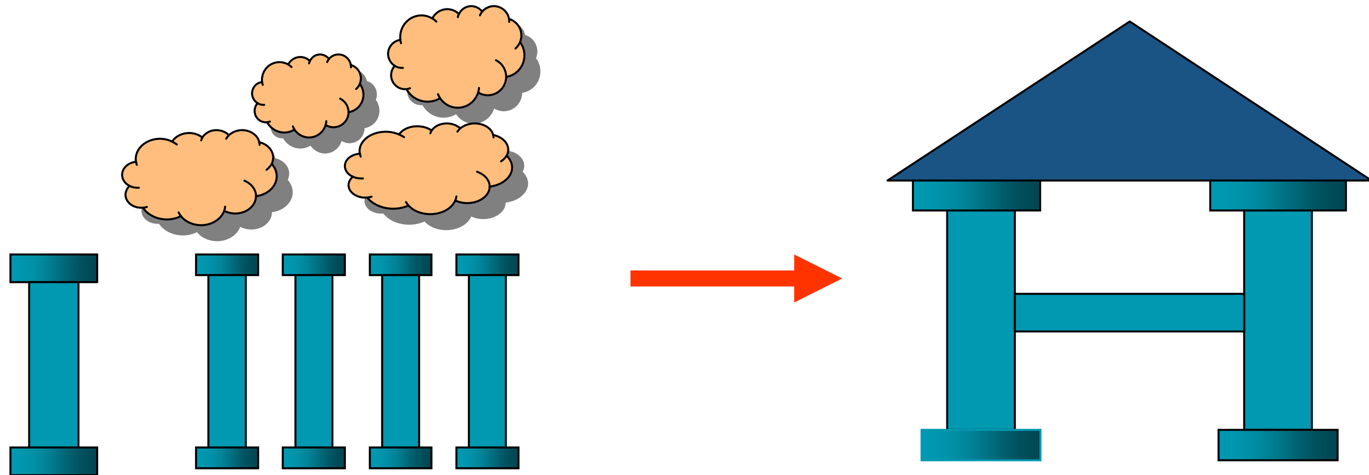
Geriatric Medicine

Care of the Elderly

Hospitals

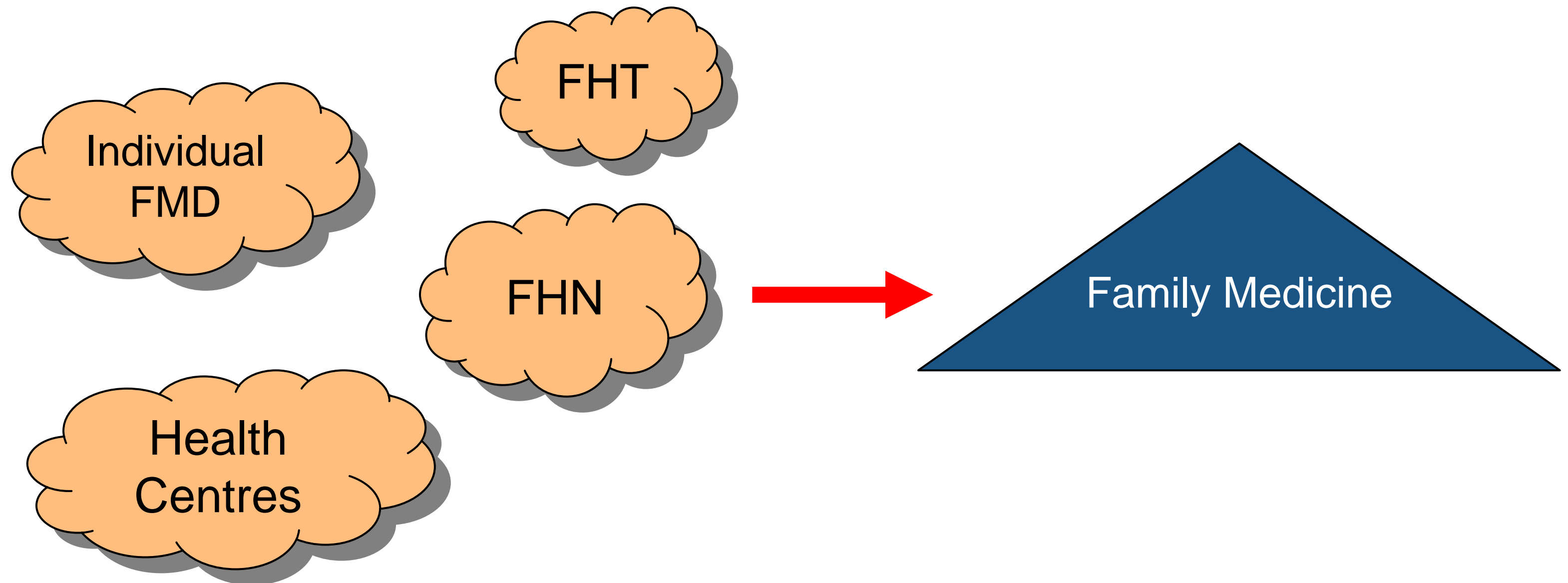
Geriatric Psychiatry

How can we develop the ideal system?



LHIN (Primary Care Table?)

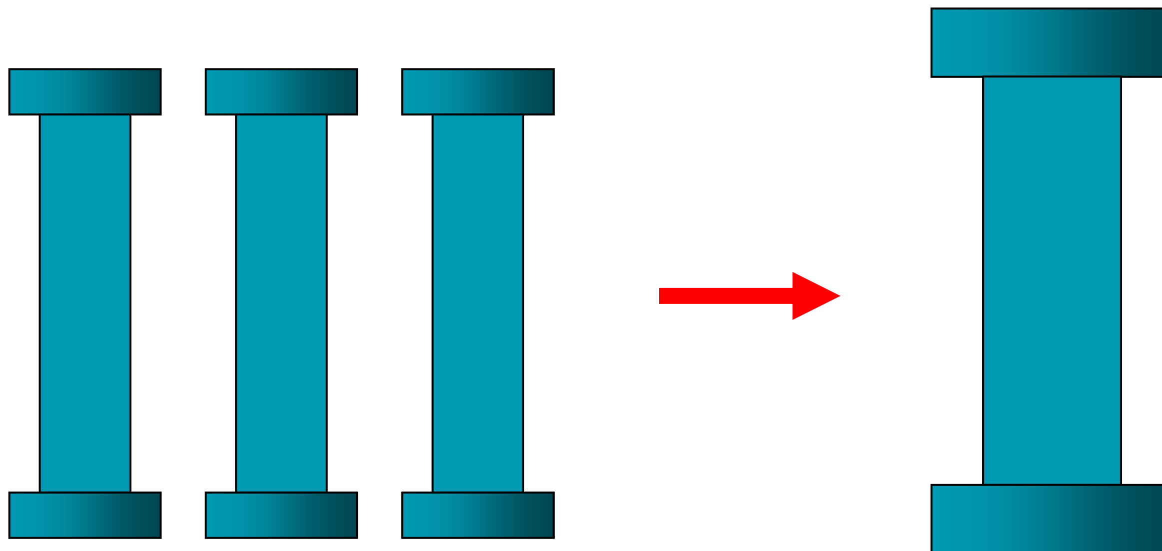
Organize Family Medicine into a unitary organization



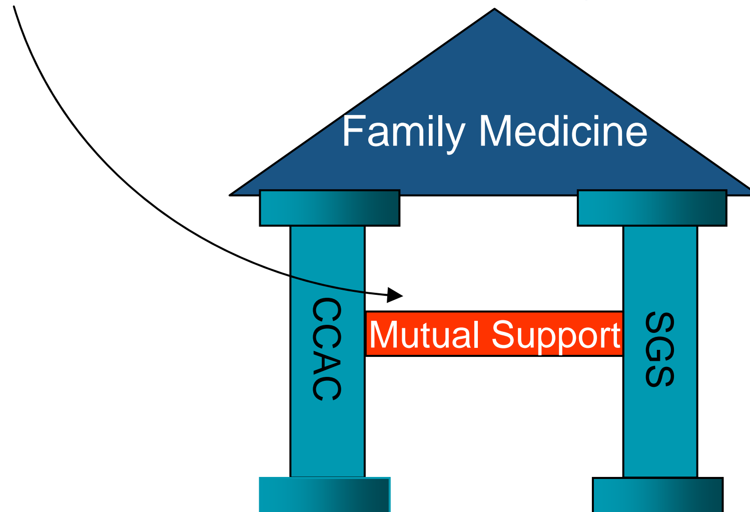
Regional Geriatric Program

Improve collaboration between Specialized Geriatric Services

(Day Hospital Directors' group with GAOT and GEM, Joint educational initiatives between different SGS groups, RGAC)



CCAC / RGP Partnership to buttress system and support Family MD's



Examples of CCAC / RGP Partnership

Dementia Focus of Complex Seniors caseload

- Develop Model
- Work on Triggers and Actions
- Attend SGS Family Conferences

Resources and Education for:

- CCAC Case Managers
- Family Physicians

Changing Perspective (*WHAT to WHY*)

- CCAC, Specialized Geriatric Services, Family Medicine need to stop working in relative isolation – **we need to stop working in silos and develop a system**
- We need to impress upon Health Care planners, the need to continue to invest in UPSTREAM ED / ALC PREVENTION rather than just reacting to ALC after it has occurred.
- To do this we need to focus on seniors who are at highest risk of ED / ALC and need to bundle services around them to promote Aging at HOME
  - The ‘SERVICES’ must include better integration between Family Physicians and Specialists in order to support CCAC efforts
    - All three groups need to focus on WHY deterioration is happening, what can be done to slow or reverse it rather than only on WHAT Services are need

CONCLUSIONS – Where we need to go

Short-term:

- We need to provide better medical (MD, RN, SGS) support for CCAC case managers and Family MDs to **prevent** ED/ALC and allow Aging at Home

Medium-term

- We need the MOHLTC to develop a BLUEPRINT for upstream community-based seniors' care that coordinates community resources in a manner that can truly prevent ED / ALC and can thereby promote Aging at Home. Without such a high level plan our hospitals will continue to suffer as they are overwhelmed by the aging of our population.

Long-Term ????