Ontario Seniors’ Health Strategy: Implications for Geriatric Day Hospitals

Presentation to the Regional Geriatric Day Hospital Forum

November 28, 2014
Objective

Provide overview of provincial and regional policies related to seniors’ health to inform your discussions on the role of Geriatric Day Hospitals in Champlain.
Outline

- Policy Environment
- Strategic Alignment of Specialised Geriatric Services
- Champlain LHIN Resource Allocation Framework
- Key Initiatives:
  - Review of Regional Geriatric Programs
  - Health Links
  - Assess & Restore Programs
- The Opportunity
The Champlain LHIN

- Easternmost region
- 18,000 square kilometers
- 1.2 M people
- 168,000 seniors
- 3% seniors are frail
- 18,400 people with dementia
- 176 accountability agreements for health services.
Our Visions

Ministry of Health and Long-Term Care:

*Make Ontario the healthiest place in North America to grow up and grow old*

Champlain LHIN:

*Healthy people and healthy communities, supported by a quality, accessible health system.*
Health system transformation is about **redesigning the system** to allow for more **flexible delivery models** which promote access, **quality** and allows for services to be provided in a **fiscally sustainable** manner.

Transformation will be guided by **evidence** and **co-designed** with the sector.

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### 4 Pillars of Transformation

- **Wellness & Prevention**
  - Empowering people to make healthier choices and improving health outcomes for children

- **Funding Reform**
  - Paying for health care services based on the needs of the patient and on performance to drive quality, efficiency and effectiveness

- **Right Care, Right Place, Right Time**
  - Maximizing investments by shifting services to more appropriate and cost effective settings and optimizing existing resources

- **Integration & Execution**
  - Strengthening coordinated care to improve access to health care services and maximizing quality and value

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A focus on **standardization, appropriateness, productivity and safety, innovation** implemented at scale is essential.
Ontario LHIN Senior Director Work Plan: 2014/15

- Review of Specialised Geriatric Services

- Senior Friendly Hospital Strategy
  - Indicator development
  - Hospital (re) survey
  - Leadership Training

- Review Models of Capacity Planning for Seniors Services
Change is Necessary to Our Environment

Ontario’s health care system is facing significant challenges over the next few years

Fiscal Challenge

- Historic levels of investment growth are not seen to be sustainable

Demographic Challenge

- The cost of care for a senior is 3x higher than for the average person
- Changing demographics will result in a higher cost to the system

Complex Health Challenge

- A small number of patients use a disproportionate amount of resources
- Making better use of our health care resources so people get the most appropriate care

Unhealthy Lifestyle Challenge

- Unhealthy eating, lack of activity and smoking levels may lead to increased chronic disease
The 2014 Action Plan will focus on four dimensions that are accountable & transparent.

They will aim to place the person at the centre of every health care decision.

- Modernize Home and Community Care
- Improve System Integration, Accessibility
- Ensure Sustainability and Quality
- Increase the Health and Wellness of Ontarians

Accountable, Transparent & Evidence-Informed
Emerging Priorities

- Redesign of Home & Community Care
- Integrated, coordinated, Patient-centred care
  - Health Links
  - Quality, coordinated care
  - Capacity planning
  - End of life care
  - Integrated Dementia Services
- Health Promotion & Wellness
- Open data / transparency
<table>
<thead>
<tr>
<th>Ontario’s Seniors Strategy</th>
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<td><strong>Healthy Seniors</strong></td>
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<td>- Improved falls prevention programs</td>
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<td>- <strong>Improved access to “Assess &amp; Restore” services</strong></td>
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<td>- Enhanced long-term care</td>
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<td>- Improved access to primary and community care</td>
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<td>- Senior Friendly Hospitals</td>
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<td>- Addressing specialised care needs of older persons</td>
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<td>- Addressing the unique needs of older Aboriginal Peoples</td>
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<td>- Caring for caregivers</td>
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<td>- Health Links</td>
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<td><strong>Senior Friendly Communities</strong></td>
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<td>- Elderly Persons Centres</td>
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<td>- Better access to government programs</td>
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<td>- Improved housing choices</td>
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<td><strong>Safety &amp; Security</strong></td>
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<td>- Elder abuse prevention &amp; intervention</td>
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<td>- Wandering prevention</td>
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Role and Value of Specialised Geriatric Programs

- Teaching and Education
- Community Service Agencies
- Research and Evaluation
- Primary Care
- LTC Homes
- Consultation
- CCAC
- Hospital
- Specialized Clinical Care

Seniors and their Caregivers

Outcome Benefits:
- Independence & Quality of Life
  - Increased Likelihood of Living at Home
  - Improved Physical & Mental Health
  - Improved Continuity of Care
- Patient Outcomes
  - Improved Diagnoses
  - Reduced Loss of Function in Hospital
  - Improved Patient Satisfaction
Champlain Resource Allocation Framework (Seniors)

1) Tenuous Coping
   - Increase capacity for self-care
   - Falls Prevention
   - Dementia Screening

2) Crisis
   - Prevent further deterioration
   - Emergency respite
   - Community crisis intervention

3) Recovery
   - Restore Health
   - In-home & geriatric rehabilitation

4) Stabilization
   - Maintain Stability
   - Home care
   - Community Supports
   - Homemaking

5) De-stabilization
   - Re-stabilize
   - Family, friends
   - Respite care

6) Decline
   - Control deterioration rate
   - Family, friends
   - Palliative / Hospice care
   - Counselling

Adapted from “A Potential Model for Health Care for Ontario’s Elderly”, Mary Lou Kelley, March 1999
More on

1) Tenuous Coping
Managing with Difficulty

Goals

• Improve capacity for self-care
• Increase environmental supports to address unmet needs
• Stabilize and prevent future crises.

Resources

• Falls Prevention
• Dementia Screening
• Info & Referral
• Specialized info & support (Alzheimer Society, stroke recovery)
• Community Support
• Supportive Housing.
More on

2) Crisis

Emergency or Turning Point

Goals

Prevent further deterioration of:
- Senior, or
- Primary caregiver.

Resources

- Senior Friendly Hospitals
- GEM
- Emergency respite
- Community crisis intervention
- Intensive multidisciplinary home care (Quick Response Team)
- Family, friends
More on
3) Recovery

Goals

- Improve physical / mental health
- Improve caregivers physical & mental health & caregiving capacity
- Strengthen environmental supports

Resources

- In-home, geriatric rehabilitation
- Geriatric Day Hospitals
- Convalescent Care
More on
4) Stabilization

Balancing care needs & available resources: week to week stability

Goal

- Maintain stability for individual and caregivers.

Resources

- Home care
- Community supports
- Homemaking
- Respite care
- Assistive devices
More on

5) De-stabilization

*Balancing breaks down between care needs & available resources: situation is out of control*

**Goal**

- Re-stabilize situation through reducing care needs and /or increasing support.

**Resources**

- Family, friends
- Respite care
More on 6) Decline

Slow or rapid deterioration (dementia, terminal illness, caregiver burnout)

Goals

- Control rate and extent of deterioration through care and treatment
- Allocate new supports.

Resources

- Family, Friends
- Hospice or palliative care
- Respite
- Homemaking / home support
- Counseling for individuals & caregivers.
Review of Regional Geriatric Programs
Objective

- To develop solutions on how to support an integrated, effective, patient-centred Specialized Geriatric Service (SGS) delivery system, while ensuring alignment with Ministry and LHIN priorities.

- Provincial Survey
- Regional Consultations
- Report & Findings
Transforming Health Care in Ontario
Health Links at a Glance

**Designed at Patient Level**
- High- or complex-needs patients identified
- Care plan is developed, based on patient’s needs, goals, with family input
- Care is wrapped around patient and coordinated with all the providers.

**Impacting at System Level**
- Improving collaboration across sectors
- Providers adopting more patient-centric and system perspectives (locally)
- Growing emphasis on patient and family goals
- Improvement on key performance indicators
- Anticipated better care at lower cost.

*Patient is at the centre*
Champlain Definition: Patients with High-Needs

- **Champlain residents (1,230,655)**
- **Champlain patients (1,060,528)**
- **Top 10% (106,053)**
- **Multiple Service Needs (28,853)**
- **High Needs Patients (26,744)**
Assess & Restore Guidelines
We have only just begun…
The Challenge.....

• Creating sustainable impact at scale
  • High quality evidence-based care
  • Demonstrating clinical effectiveness and efficiency
  • Continuing to build geriatric models of practice & capability
Questions