Rural Assess and Restore Community Program – Pilot Project

Senior Friendly Hospital & Rehabilitation Network Symposium
February 25, 2016
Overview of Pilot Project

• Develop and test a proof of concept for an assess and restore delivery model for high risk seniors that identifies service components appropriate to a rural setting

• Collaborative project co-lead by Carleton Place & District Memorial Hospital and the Regional Geriatric Program of Eastern Ontario

• Oversight provided by the Rehabilitation Network of Champlain (RNOC)

• Steering committee comprised of regional partners meeting regularly to provide guidance and support throughout system level planning and implementation
Objectives of Pilot

- Combine a Geriatric Emergency Management (Gem) Nurse and a Community Geriatric Assessor role in a rural community to identify and assess high risk seniors.

- Improve access to Specialized Geriatric Services and Community Support Services

- Test the effectiveness of the Assessment Urgency Algorithm (AUA) ED Screener as a screening tool to identify seniors at risk.
Combined GEM & Geriatric Assessor Role

**Geriatric Emergency Management (GEM):**

- A program aimed at identifying *seniors at risk* who will be discharged home from the ED, in order to initiate *early referral* to Specialized Geriatric Services and Community Support Services

**Geriatric Assessor:**

- Provides a multidimensional screening home assessment to clients ≥ 65 who live in their home or Retirement Home
- Receives referrals through inpatient discharges or GEM
- Supports Care of the Elderly physician in the clinic
Combined GEM & Geriatric Assessor Role

- Time is divided between GEM nurse and Geriatric Assessor roles
  - Building capacity

**Keys To Success:**
- Candidate right fit
- Collaboration with community partners
- Education
- Communication
- Link with Physician (ACE)
## Pilot Results to Date

### Assess & Restore Rural Pilot Project Statistics: September 14 - December 31, 2015

<table>
<thead>
<tr>
<th>Service</th>
<th>GEM Statistics</th>
<th>Outreach Statistics</th>
<th>Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessments</td>
<td>85</td>
<td>9</td>
<td>94</td>
</tr>
<tr>
<td>Almonte Day Hospital Referrals</td>
<td>12</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Geriatric Clinic Referrals</td>
<td>8</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>CCAC Referrals</td>
<td>20</td>
<td>2</td>
<td>22</td>
</tr>
<tr>
<td>Going Home Program Referrals</td>
<td>22</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td>Lanark County Mental Health Referrals</td>
<td>7</td>
<td>0</td>
<td>7</td>
</tr>
</tbody>
</table>
Case Study

- 84 year old female
- Presented to Emergency Department (ED) at CPDMH
- Complaints of pain, and personal care issues. Patient has a humerus fracture from a fall last month.
- Geriatric assessment done in the ED by GEM.
- Recommendations were implemented based on findings from the GEM assessment
Issues identified through Geriatric Assessment in ED

Mood
- Sad, depressed
- Mourning lost family member
- Estranged from other family
- Anxious about finances

Mobility / Falls
- No mobility aids
- Fracture left humerus after feeling dizzy and falling 1 month ago
- Unable to elevate left arm
- Pain in left arm

Function
- Independent with most ADLs
- Needs some help with cooking
- Does not drive, transportation is difficult
Recommendations Implemented

- **Primary Care Outreach**
  - Support at home

- **Lanark County Mental Health**
  - Assessment of moods, assist with grieving process and depression

- **Almonte Day Hospital**
  - Assess and provide treatment for mobility and pain

- **Community Support/Going Home Program**
  - Provide transportation from hospital, meals on wheels and light housekeeping
Discussion and Questions

Rachel de Kemp, CPDMH – rdekemp@cpdmh.ca
Ann Marie Dimillo, TOH - adimillo@toh.on.ca
Mark Gormley, CPDMH – mgormley@cpdmh.ca