Rural Seniors' Care

OBJECTIVES – EXPECTATIONS

1. **This is a "working workshop" (a CONSULTATION) – the goal is to get your perspectives, opinions and guidance regarding how Rural Seniors' Care should be organized in the future – to guide the ongoing work of the Champlain Regional Geriatric Advisory Committee (RGAC) Rural Subcommittee.**

2. **This is NOT really a teaching / education session. If you are looking for more of an education experience please consider moving over to Dr. Cara Tannenbaum's session on decreasing benzodiazepine use in the community (Dr. Molnar will fully understand and will not be offended in any way as the purpose of this session may not have been clear).**

SPEAKER-FACILITATOR / OBJECTIVES

Dr. Frank Molnar

Medical Director, Regional Geriatric Program

- Geriatric Assessment Outreach Teams (GAOT)

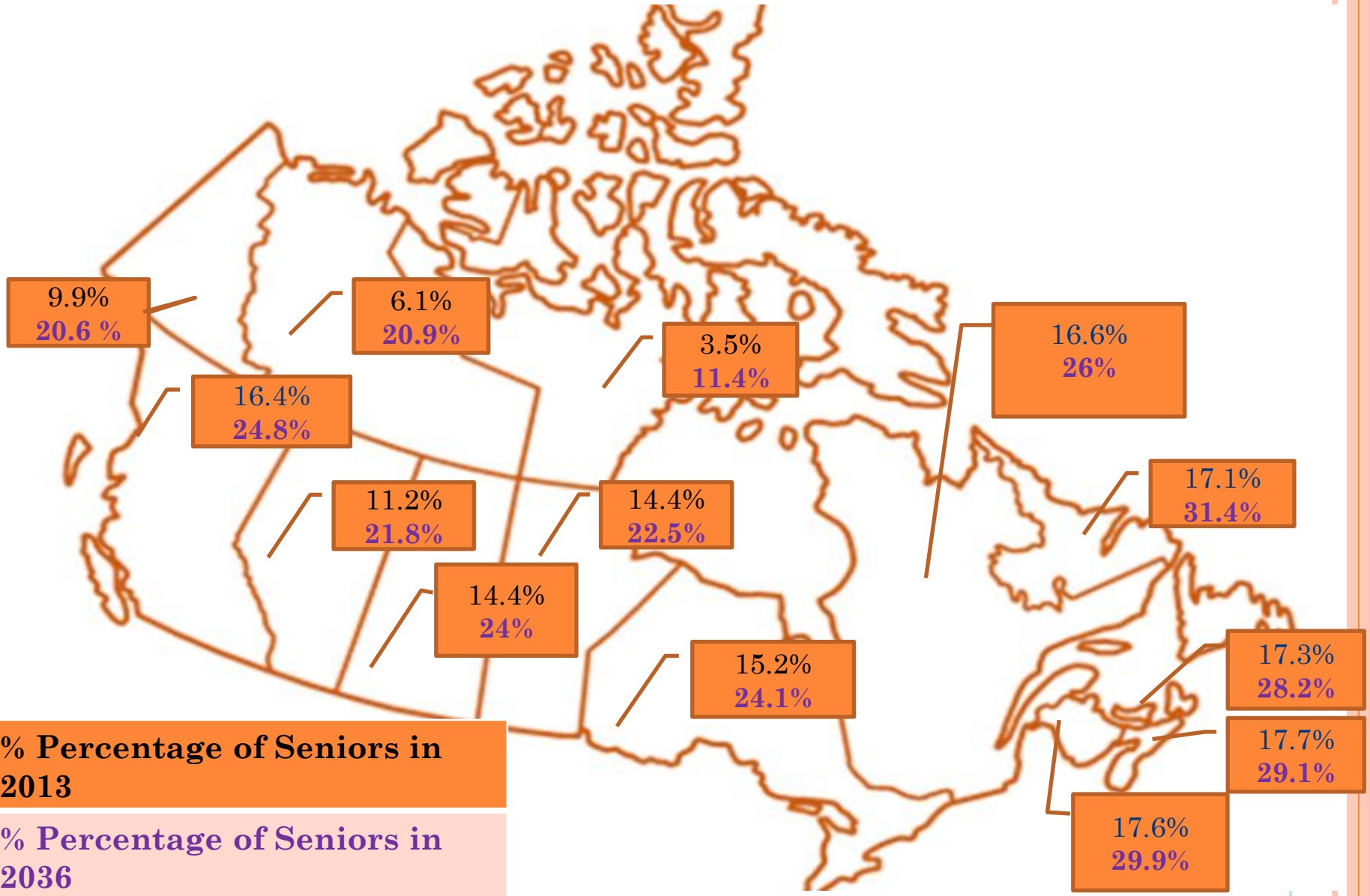
- Geriatric Emergency Management (GEM)

Co-chair, Regional Geriatric Advisory Committee (RGAC)

- Co-chair of the RGAC Rural subcommittee

1. **To describe emerging realities of Seniors Care**
2. **To describe current state of regionalization of seniors care in the Champlain LHIN region**
3. **To obtain your guidance regarding future directions that should be considered**
4. **To explore options to re-engineer existing resources and services**

Emerging realities of Seniors Care



Key Demographics

- The number of seniors are doubling
  - The number of seniors > 85y/o will QUADRUPLE
    - 33% have dementia
    - Many have multiple chronic diseases (medical system not designed to care for people with multiple chronic diseases especially when they have Dementia, Mental Health Issues or Social Determinants (Social Frailty)

What does this mean for the health care system?

1. Rates of hospitalization will increase

Congestive heart failure:

- 387 per 100,000 population for those age 65 to 74;
- 2,240 per 100,000 population for those age 85 and older;

2. Costs will increase - Per person spending for seniors increases with age:

- $6,368 for those age 65 to 69;
- $8,545 for those 70 to 74;
- $11,692 for those 75 to 79;
- $21,054 for those 80 and older.

(CIHI Health Expenditures, 2012)

Our health care system has NOT adapted to the successful aging of Canadians

- Hospital centric system with inadequate home care and no real community care system
  - Hospitals have become the default setting for care.
  - Hospitals are also the most expensive places to provide care:
    - Hospital: $1,000.00 per day
    - Long-term care: $ 130.00 per day
    - Home care: $ 55.00 per day
- Food for thought – can hospitals be restructured so that they become a community hub
  - Will such a model work better in rural or urban areas

How does this affect Canadians in real time?

- Alternative Level of Care (ALC) crisis:
  - 15% of hospital beds are ALC
  - 3 million ALC bed days per year cost $2.6 billion (wasted)
  - Hospital bed gridlock
    - Impacts on access to care and wait times for Canadian of all ages

Better seniors care means better care for everyone

- Seniors care accounts for almost 50% of health care budgets
  - In great part because too much care is provided in hospitals
- This impacts funding available to other areas of health care
  - This will impact access to health care for Canadians of all ages
  - This will impact persons in the workforce who also have to provide care
  - 37% of the work force is taking care of a relative (Stats Can)

Better seniors care means better care for everyone

- Basic math tells us our current model is not sustainable.
- If we want to save universal health care we have to change the way we provide care to seniors:
  - more coordinated;
  - less wasteful;
  - less costly settings;
  - A more **community centered health care system**;
  - built around the needs of seniors not around the needs of institutions.

Early Conclusions

- We are in the right business to make a real difference

- We are also central to the Champlain LHIN's strategy to deal with its major challenges. The Champlain LHIN has;
  - The highest rate of Dementia of any LHIN
  - Falls – highest rates of all LHINs
    - 9/14 ED visits (9th worst) of any LHIN
    - 14/14 Hospital admissions (worst)

  - Wisely strategically invested in regional Dementia and Falls initiatives

BUT

- It is unrealistic to expect large scale new investment in the current fiscal environment

- Those services that demonstrate they are doing everything possible to do more with what they have (to maximize 'bang for the buck' or to maximize Return on Investment) are more likely to be trusted with new investments

Where do opportunities to increase value for money lie?

- Our areas of regional weakness
  - System is too complex for patients and families to navigate
  - Multiple intake points
  - Silo behavior
    - No sharing of waiting lists even if one service has a 2 week wait and another has a 8 month wait (we are service centered not patient centered – *silo funding drives silo behavior*)
    - Limited real collaboration between Day Hospitals, Clinics (Geriatric, Memory Disorder)
  - Inflexible approaches to care
    - Every patient admitted for same fixed length of time rather than flexible patient centered approaches
  - Minimal resources for Specialized Geriatric Services (SGS) – bare bones – lack of nimbleness to shift resources the meet needs (surge capacity and re-engineering limited)

What can we change if we really want Network rather than Silo approaches?

- One stop shopping
  - Central intake with system navigation and triage + ability to track patients and ensure timely communication
- Greater use of electronic extenders
  - OTN
  - eConsult
- Wait list management
  - GAOT and the QCH day Hospital both have success stories to share
  - We need to set maximal acceptable wait times (especially for seniors at risk due to cognitive impairment and/or falls)
    - When exceeding wait times we need surge mechanisms
      - Sharing of staff
      - Sharing of wait lists

Rural Seniors Care – Regional Consultation

Champlain Rural Geriatric Leadership Retreat

- March 30, 2015
- Brought together 30 leaders in health care
- Generated a report that has guided / informed:
  - LHIN investment
  - Regional Geriatric Advisory Committee (RGAC) Strategic Planning
    - Creation of an RGAC Rural Subcommittee
    - Consideration of Rural aspect in the work of other RGAC Subcommittees
      - Dementia
      - Falls
      - Senior Friendly Hospitals
      - Primary Care

how the 3 year vision will be realized

	1	2	3	4
Goals	**Ensure sustainable capacity by building rural geriatrics needs into regional plans**	**Develop an interdependent, strategically aligned inter-organizational network**	**Provide timely coordinated access to services**	**Ensure quality care for high risk seniors**
Objectives	• *Embed rural geriatric focus to the LHIN Integrated Health Services Plan* • *Embed evidence-based practice in all strategic initiatives* • *Identify gaps in in SGS delivery of core services* • *Ensure the resources are allocated in an optimized fashion* • *Build and support Physician Champion*	• *Develop stakeholder engagement and commitment* • *Increase coordination and integration of care delivery* • *Agree on sharing information and common processes*	• *Achieve early detection of high risk* • *Provide single point of access* • *Provide effective navigation services*	• *Develop effective response to clients' needs* • *Define and measure health outcomes including the empowerment of patients and their care givers* • *Understand the allocation of resources to client and their families and align this allocation of resources to prioritized needs* • *Put in place coordinated care plans*
Initiatives	• *Build collective impact by aligning and streamlining strategic directives (regional level) for provision of care for seniors.* • *Involve patients and care givers.* • *Re-engineer traditional roles and models of service delivery to fit the needs of rural geriatrics* • *HR Plan for each rural area* • *Identify Physician Champions in each sub-region & connect to regional body* • *Find a way to provide adequate support for these champions* • *Increase the Health Literacy of families and care providers for high risk seniors*	• *Develop a regional strategy for rural geriatrics which is adopted by all Boards under LHIN direction* • *Create the group a Rural Geriatric Network* • *Develop shared governance and accountability with organizational commitment.* • *Get agreement from all key players, including hospitals on strategic directions (buy-in from boards).* • *Put in place participation agreement.* • *Develop a framework to define the roles of the different stakeholders including accountability agreements with hospitals/partners* • *Ensure all stakeholders are fully aware/committed to their roles and responsibilities in meeting the needs of high risk seniors* • *Develop processes and define primary navigation role* • *Develop an agreement on how stakeholders will be working together to co-manage transitions* • *Service providers communicate and share information effectively within clients' "health community"*	• *Identify providers for early detection (e.g., family, community pharmacies, paramedics)* • *Bringing various touch points in health care delivery to be able to detect high risk seniors and work with them in a systematically holistic manner.* • *Provide common detection processes and tools assessment of urgency and complexity and redirect referrals* • *Ask Health Links for their High Risk Markers and adapt for SGS (promotes and links with an existing initiative)* • *Link high risk seniors to Health Link* • *Identify single entity as well as entry points and protocols attached* • *Communicate eligibility criteria to guide prioritization process* • *Create system navigation function – skill set / network* • *Create a electronically accessible pathways for patients looking at a variety of predictive trajectories.* • *Build on PaTH (Palliative and Therapeutic Harmonization)* • *Create ability to see all "wait lists"*	• *Measure and report patient experience and process/clinical outcomes* • *Review different models (Peds, CCO, CDN, etc.)* • *Put in place the processes required to ensure that all available capacity across providers is utilized to meet the needs of individual patients* • *Ensure access to EMR* • *Explore use of information systems to deliver quality, value, transparency and accountability of SGS for our patients and their families*

The RGAC Rural Subcommittee

- Launched subsequent to Retreat (TOR – August)
- Consolidation of members of the Eastern Counties and Renfrew County Specialized Geriatric Services Networks
- Reports to the Regional Geriatric Advisory Committee (RGAC)
  - Some RGAC Subcommittees (e.g. Dementia, Falls) receive LHIN funding
  - Majority of RGAC activity is volunteer based
- Rural Subcommittee is not funded – volunteer based
- Work plan – THE CONSULTATION
  - To be incorporated into upcoming RGAC Strategic Plan
  - Q? Is this a realistic plan for an unfunded volunteer group?
  - Q? what else should be considered for incorporation

Develop and implement a Champlain LHIN rural specialized geriatric services strategy that builds and sustains capacity to meet the needs to seniors.

Deliverable 1ai.
The LHIN's IHSP will identify rural SGS as a strategic priority over the next three years.

Deliverable 1aii.
A current inventory of SGS that includes a preservation of the historical context of rural geriatric services within Champlain. As part of this inventory, review and monitor that services are utilizing an evidence-informed practice.

Deliverable 1aiii.
Continue evolving the newly established Geriatric Assessor/Care Coordinator role through the GA Working Group.

Deliverable 1aiv.
Identify geriatric champions and teams through promoting education and training in geriatrics and elder care.

Develop and implement a Champlain LHIN rural specialized geriatric services strategy that builds and sustains capacity to meet the needs to seniors.

Deliverable 1bi.
Integrate rural geriatrics within key Champlain LHIN networks, strategies and committees such as the Champlain Dementia Network, Rehab Network of Champlain, and other RGAC sub-committees.

Deliverable 1bii.
Identify the metrics that are part of a rural geriatric balanced scorecard that supports collaborative planning.

Deliverable 1biii.
Explore processes to support shared governance such as accountability agreements and communication to key stakeholders (includes services providers and seniors/families/caregivers).

Develop a process to ensure patient centered, quality care for high risk seniors.

Deliverable 2ai.
Incorporate patients, families, and stakeholders by holding focus groups and lean exercises.

Deliverable 2aii.
Monitor and review the coordinated care planning that integrates initiatives such as rural geriatric services, Health Links and primary care.

Context – Challenges / Barriers

- RGAC Rural Subcommittee
  - Unfunded – volunteer based (sweat equity)
  - Needs enhanced membership
  - Needs more rural champions

- Ministry funding is siloed in Ottawa – not movable (MOH funding blocks regionalization)
  - Regional Geriatric Program
    - MOH has moved funding to base hospitals
    - Geriatric Assessment Outreach Teams – funding locked into 2 base hospital
  - Geriatric Medicine APP and Care of the Elderly AFP
    - Locked into specific Ottawa Hospitals

Context: Champlain LHIN Priorities

- Accessibility
- Integration
- Sustainability

The above can serve as a framework for the RGAC Rural Subcommittee's work

Context: Patients First

- Seniors Care barely mentioned
- Goals – Access, Connect, Inform, Protect

1. More effective integration of services and greater equity
    1. Smaller sub-regions
    2. Franco-Ontarians
2. Timely access to Primary Care, and seamless links between Primary Care and other services
3. More consistent and accessible Home and Community Care
4. Stronger links between Public Health and other health services

YOUR IDEAS – THE CONSULTATION

- What opportunities have we missed vis-à-vis
  - LHIN priorities
  - Patients First Priorities
  - Other areas that are important to pursue even if they do not fit into LHIN or Patients First priorities
- Can these be achieved without funding?
- How can we find Rural Champions to further these priorities?
- Do we need regional rural governance?
- What is happening in Rural Seniors Care elsewhere in Ontario or Canada that we can learn from or link to?