South East
LOCAL HEALTH INTEGRATION NETWORK

RÉSEAU LOCAL D'INTÉGRATION DES SERVICES DE SANTÉ
du Sud-Est

48 Dundas Street West , Unit 2
Belleville, ON K8P 1A3
Tel: 613-967-0196
Fax: 613-967-1341

48 rue Dundas Ouest, unité 2
Belleville, ON K8P 1A3
Tél : 613-967-0196
Téléc : 613-967-1341

OVERVIEW OF INITIATIVES IN THE SOUTH EAST

...Targeted to a Frail and Elderly Patient Population

The South East LHIN has the highest proportion in the province of residents aged 65 years of age or older. By 2016, it is estimated that one in five residents will be 65 years of age or older. We know that our older residents are high consumers of health care services. Data tells us that seniors in the South East and elsewhere use a disproportionate amount of acute care services relative to their numbers, but more in-depth analysis reveals that it is, in fact, a sub-group of frail and elderly seniors who account for a high proportion of hospital and ER use. Predictors of frailty include the presence of extreme age, visual loss, impaired cognition/mood, limb weakness, abnormalities of gait and balance, sedative use, as well as multiple chronic diseases. We also know that, in its early stages, frailty in the elderly is characterized by being both identifiable and, therefore, potentially reversible.

It is critical that this patient population be identified, and provided with appropriate and flexible care alternatives, other than costly acute care, and that unnecessary institutionalization in long-term care homes be prevented whenever and wherever possible. Consequently, a number of local initiatives are underway. These programs and projects address the health and wellness needs of an older patient population by building on service strengths, addressing service gaps and on remedying system integration-type problems, such as moving patients out of hospital and into their homes, when they no longer need acute care, and bringing in needed services, so they can recuperate in the most appropriate setting. They also see health service providers across the South East working more effectively together – to build a more cohesive, efficient and effective health care system.

Programs

EASIER + (Eldercare Access Strategy in Emergency Room) – Now in place at Quinte Healthcare in Belleville and at the Kingston General Hospital in Kingston, EASIER + is intended to prevent the unnecessary hospitalization of frail elderly seniors who seek care through hospital emergency departments, when care could be better provided to them at home through community support services. It involves having a case manager (known as a geriatric case manager) from the South East Community Care Access Centre on site in the emergency room (ER). This makes it easier to arrange for intensive short-term home care or community support services, without having to admit individuals. A simple questionnaire (i.e., TRST – triage risk screening tool, developed in the United States and tested through the GEM project) is used by the triage nurse to assess high risk elderly persons in the ER, prior to medical treatment. Those who are found to need home care support are referred to the geriatric case manager, who assesses individuals and matches them with appropriate nursing and/or home care and/or social supports. Referrals to other community support services, which would be beneficial to the individual, are also provided.

Frail elderly seniors who are part of EASIER +, are also eligible for up to 30 days of enhanced home care and community support services.

The SMILE Program (Seniors Managing Independent Living Easily) – SMILE is a new long-term functional support program. This initiative is the outcome of recent planning efforts in the South East related to the implementation of the provincial Aging at Home Strategy. SMILE will make it possible for more seniors who are frail and elderly, and most at risk of premature institutionalization, to receive help with activities that are essential to daily living, so they can remain in their homes. In addition to these core services, the program also enables recipients to leverage community support services that are available locally, or variations on these services.

> *"Most of the time, a frail elderly person's trip to the emergency room results from a significant medical condition. Up to 40% are repeat visits. But it's not enough to treat the medical condition and send the person home without putting in place home support and communicating with the family physician. Problems such as difficulties taking medication, risk of falls, or poor nutrition can be identified and avoided if home supports are put into place."*
>
> – **Dr. John Puxty**, Chief of Staff, Providence Care (Kingston), and Lead, Regional Geriatric Assessment Program

Because dignity is a matter of choice, SMILE will offer them options – in managing their care, in selecting services, in choosing who comes into their home and when. The assistance of a care coordinator, if wanted or needed, is also an option.

Implementation of the program is being phased in over three years, and is slated to begin in the spring of 2008. The program is managed regionally by VON Canada – Ontario. Its development was a collaborative effort, led by the South East Local Health Integration Network (LHIN) and involving seniors and local health service providers.

Pilot Projects

Maintaining Function of Elderly Acute Care Patients – This new project is currently being piloted at Quinte Healthcare in Belleville. It involves the provision of physiotherapy and/or reactivation services to prevent the functional decline that occurs in elderly patients as a result of hospitalization. Loss of muscle strength during bed rest has been estimated to be as high as 5% a day. Through one hour of daily therapy, elderly patients who are medically stable, but at risk of extended stay in hospital, can regain strength and be discharged in a more timely fashion, so they can return to their homes and receive home care, if needed.

Transitions Project – Initiated in August 2007 and led by the South East CCAC, this project focuses on tackling the ALC situation in hospitals. In addition to ensuring that community-based Part of the solution lies in working out who should be classified as an ALC patient, how beds can be best utilized, and how discharge to various and appropriate settings can be expedited. It involves:

- mapping the current and future processes related to ALC patients from an acute care setting to a long-term care home in the region;
- identifying and recommending improvements;
- developing an implementation plan for these improvement opportunities; and
- identifying existing enabling IT applications that might assist with addressing the ALC issue.

"I would never move from my home.
I like to be on my own."
– Luella

Activities to date have included:

- Developing a standard definition of ALC
- Standardizing discharge
- Educating, informing and supporting clients and families
- Bed stock utilization
- Performance measurement
- Information technology solutions
- LTCH Flexible Admission Cycle
- System capacity for policy change

Mobile Inter-Professional Coaching Team (MICTs) and the Geriatrics Inter-Professional Inter-Collaborative Coaching (GIIC) – These two intensive and time-limited projects (2008/09) involve primary care providers, i.e., family health teams and community health centres. The objective is to develop best practice inter-professional care solutions that build on existing organizational resources and optimize outcomes. The emphasis is on building knowledge and capacity within primary care.

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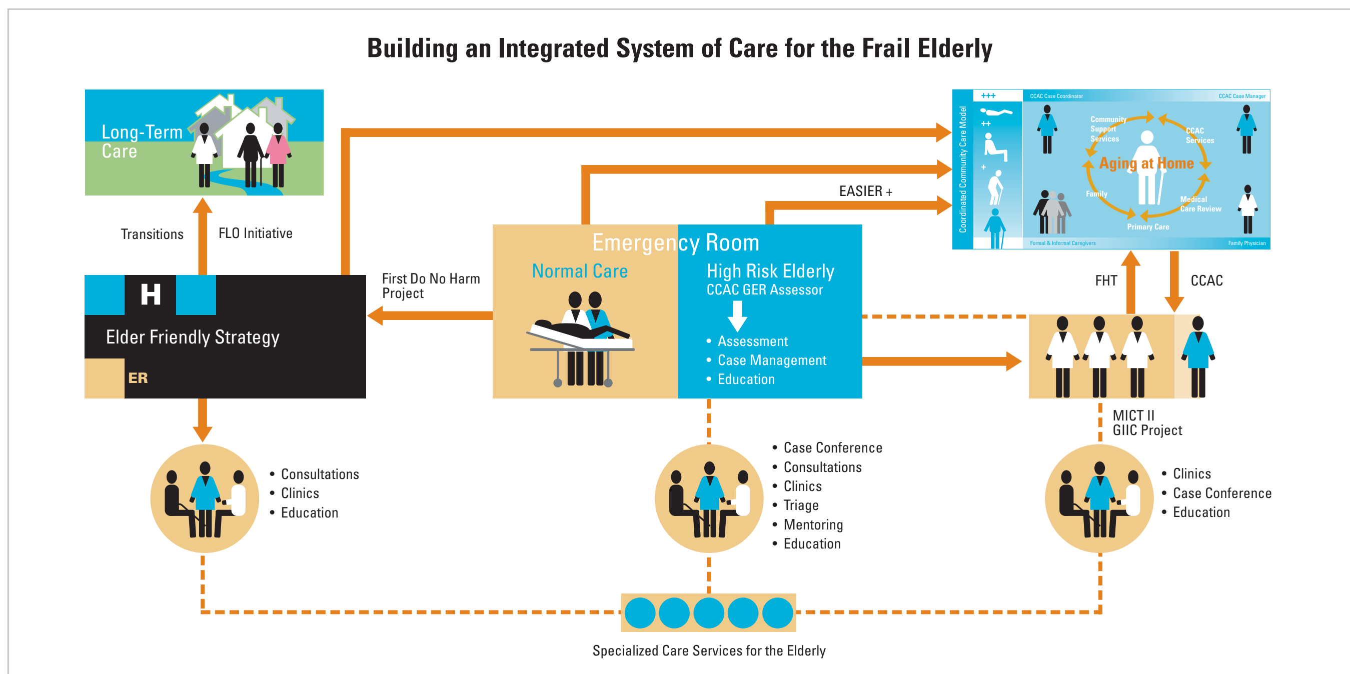
Mobile Inter-Professional Coaching Team

This field-based initiative, led by Providence Care, is built on a foundation of interprofessional care. The team brings together providers from across disciplines (medicine, nursing, social work), organizations (Family Health Teams, Specialty Geriatric Mental Health Outreach, Alzheimer Society: First Link Project) and sectors (primary care, mental health, and community) to benefit older adults with complex, co-morbid and chronic mental and physical health conditions. The initiative also incorporates integral partners from the academic sector (Queen's University Family Medicine, Geriatric Psychiatry, School of Nursing, School of Rehabilitation Therapy) to advance a common vision, language, and approach across the practice and education continuum for this population. The completion of this first phase was instrumental in building relationships, trust and a culture of shared responsibility between participants, as well as a strong foundation for continued collaboration between disciplines, organizations and health care sectors. The second phase will create systems, processes and tools to support sustainable, learner-driven interprofessional collaboration.

The diagram below is a schematic representation of different, but inter-related initiatives. It illustrates how they are contributing to building an integrated system of care for the frail elderly.



Conceptual Diagram by: Dr. John Puxty, Chief of Staff, Providence Care, and Lead for the Regional Geriatric Assessment Program