PGLO

Ideas for Enhancing Delivery of Integrated Care to Older Adults with High Intensity Needs

1. **Expansion of Geriatric Emergency Management (GEM) (Plus) Program**
   Increase the number of Registered Nurses/Nurse Practitioners, Rehabilitation professionals (Occupational/Physiotherapy) and Social Workers who collaborate to complete targeted geriatric assessments and facilitate navigation to community supports from the Emergency Department (ED), with the capacity to purchase service/space in community programs as needed, to avert hospital admission. Expansion may include adding positions to organizations without current GEM capacity (e.g. rural hospitals) and increasing the number of GEM nurses, and rehabilitation and social work supports in the ED, to cover more hours (24/7). Prior evaluation data has demonstrated this program results in approximately 60% diversion rate and shortened Length of Stay (LOS) for the patients who do require a hospital admission. This recommendation is also consistent with the latest version of the Alternative Level of Care Leading Practices Guide (in revision), that recommends comprehensive geriatric assessment occur in the ED to avoid inappropriate admission.

2. **Expand Transitional Bed Capacity and Increase Attachment of Specialized Geriatric Services (SGS) Supports**
   Building on the success of North East Specialized Geriatric Centre and a recent collaborative proposal from LOFT and North Simcoe Muskoka SGS, provide additional supports (e.g. PSW, Seniors Mental Health and SGS) to new bedded space procured in retirement homes or other locations to enable those individuals with moderate needs who would otherwise be designated Alternate Level of Care (ALC) to be supported outside an acute care environment.

3. **Expand Behavioural Supports Ontario (BSO) services within Acute Care & Community.**
   Increase the number of BSO Clinicians who support acute care (e.g. Registered Nurses, Registered Practical Nurses, Occupational Therapists, and Social Workers). These Clinicians are specifically focused on providing behavioural assessment, interventions and care planning, for patients presenting with responsive behaviours in acute care settings that are posing barriers for discharge. Early evaluation data has identified these resources are contributing to a reduction in overall length of stay (ALC Days), helping to divert unnecessary transitions, reducing restraint use, and helping to build capacity in acute care.

   Increase the number of BSO Clinicians who support people in the community, including those in private dwellings, retirement homes, assisted living, etc. Demands for behavioural support in community settings have increased prior to and during COVID-19. In addition to providing direct support to individuals and building capacity with their care partners in order to help the individual remain at home and avoid hospital admissions, BSO Community Clinicians facilitate specialized transitional support across sectors, including into LTC.

4. **Augment/Develop In-Patient Geriatric Medicine/Geriatric Psychiatry Consultation Liaison Services in All Acute Care Facilities**
   Increase the number of expert interprofessional teams who can evaluate and unpack multimorbidity to inform care planning and interventions in the acute and sub-acute care

environment. This includes a post-discharge follow-up component to support transition home after an acute care stay. Experiences in a number of regions (e.g. Champlain, Central East) and evidence suggest that a team-based approach to the care of admitted older adults can function effectively as a co-management model of care that has been shown to reduce mortality, complications from surgery, delirium, and rehospitalization in those on a surgical service[1]. Other meta-analyses have shown that team-based geriatrics reduces the likelihood of requiring discharge to a higher level of care (i.e. Long-term care)[2]. This recommendation is also consistent with the latest version of the Alternative Level of Care Leading Practices Guide (in revision), that recommends comprehensive geriatric assessment occur in the acute and post-acute environment to prevent avoidable harm such as delirium and functional decline while treating and providing rehabilitation from acute illness, and to transition patients to their next best care location promptly.

5. **Leverage Existing Underutilized Care of The Elderly Physician Practice by Creating Alternate Funding Plans or Salaried Positions in the Acute and Community Setting**
Of the 143 Care of the Elderly physicians identified in 2018, only 46 were practicing with a specific focus on older adult care[3]. This is a currently available and underutilized expert clinician group that could be leveraged to lead initiatives and provide direct clinical service relevant to the care of older adults living with complex health concerns. There are opportunities to build on successful practice arrangements (e.g. William Osler Health System) that optimize Care of the Elderly Primary Care Physician contributions.

6. **Expand Community Paramedicine Attachment to Community Specialized Geriatrics Teams**
Building on SGS examples in East and North Regions (Haliburton Highlands and Sudbury), increase the number of community paramedics attached to Community SGS teams and Geriatric Outreach teams. This increases screening capacity for both geriatric and COVID related concerns, alerts geriatric specialist teams of the need for support, fosters liaison with primary care and supports care delivery in-home for older adults.

7. **Expand Post COVID Screening Follow-up for Presenting Older Adults**
Building on the success of North East Specialized Geriatric Centre and North Simcoe Muskoka SGS and Couchiching FHT, for older adults who are seen in a COVID screening centre or report COVID symptoms, commit resources to proactively follow-up to determine ongoing health status and need for additional community supports or in-home medical intervention.

8. **Expand attachments to Geriatric/Seniors Mental Health Outreach or Community SGS Teams to include Personal Support Workers and Therapeutic Recreationists**
Building on experiences in Waterloo Wellington, Central East and North Simcoe Muskoka, add PSW/Unregulated Health Care Providers and Therapeutic Recreation staff to SGS teams to build relationships with local community programs and provide recreation and leisure assessments and interventions for targeted older adults/caregivers living in community. Current experiences have demonstrated that attachment to an interprofessional team results in very low turn-over

[1] Van Grootven B V., Flamaing J, De Casterlé BD, et al. (2017). Effectiveness of in-hospital geriatric co-management: A systematic review and meta-analysis. *Age Ageing*, *46*(6):903-910. doi:10.1093/ageing/afx051
[2] Matarese, M. & Palombi, M. (2019). Comprehensive geriatric assessment for older people admitted to a surgical service. *Int J Nurs Pract*, *25*(5). doi:10.1111/ijn.12746
[3] Borrie, M., Cooper, T., Basu, M., Kay, K., Prorok, J., & Seitz, D. (2020). Ontario geriatric specialist physician resources 2018. *Canadian Geriatrics Journal, 23*(3). Doi:10.5770/cgj.23.448

for PSWs/UCPs and provides continuity of care and support for the implementation of geriatric, seniors mental health and behavioural interventions in the home.

9. Attach a Geriatric Assessor to Proposed HCC-Led HISHP Initiatives

Organize or repurpose existing community interprofessional teams to including nursing, rehabilitative care health professionals and dedicated care coordination, and include attachment to local a geriatric assessor who can also leverage SGS including specialist geriatric physician support.

10. Increase/Develop Rapid Access (RA) Outpatient Geriatric Assessment

Build on emerging models of rapid access geriatric assessment where patients are being seen in collaborative Nurse Practitioner/Geriatric Physician Specialist models, receive a focused assessment reflective of the patient/family chief medical complaint, and then follow one of three pathways to care plan development and case management, if necessary. The three pathways include: 1) RA and follow up by Primary Care, 2) RA and focused follow up by NP/Geriatrician/Care of the Elderly, and 3) RA, followed up by an interprofessional CGA, development of a patient centered care plan and ongoing case management.

11. Expand Promising Community Based Models of Integrated Care for Older Adults Living with Complex Health Concerns

There are a number of existing models of integrated community-based care that can be leveraged or expanded to address the needs of the population of focus and to enhance functional status and reduce longer term reliance on higher levels of supportive care. The following are only a few examples:

Geriatric Assessment and Intervention Network (GAIN)
Home Independence Program
Seniors Mobile Assess and Restore Teams (SMART)
Seniors Managing Independent Life Easily (SMILE)