Leading in the Care of Older Adults Series

From Systems to Services
Capacity Planning for Older Adult Care in Ontario

Determining current and future health service requirements and planning for an aging population

January 24, 2023

Welcome

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Land Acknowledgement

Quilt by K. Kay, 2021

Session Objectives

- Identify approaches to capacity planning contextualized for older adults living with complex health conditions (including frailty and dementia)
- Identify sources of information and examples to inform the development of capacity plans for those working to determine current and future health service requirements for an aging population

Three Viewpoints of Capacity Planning

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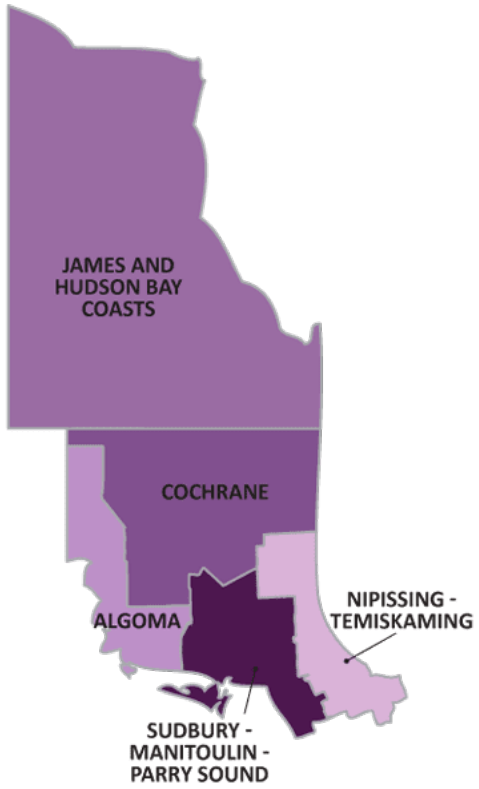
Provincial



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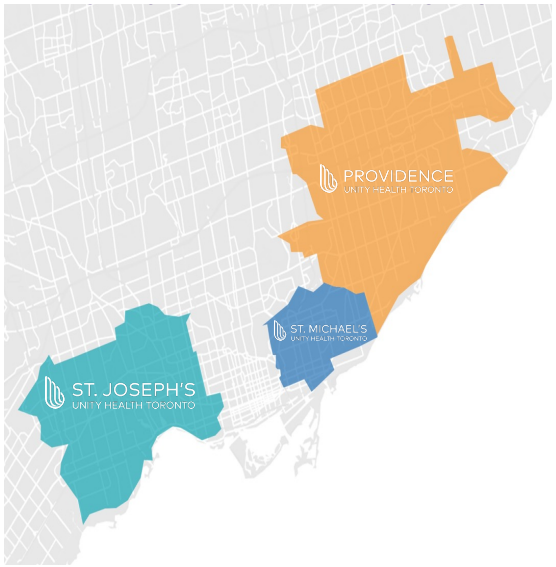
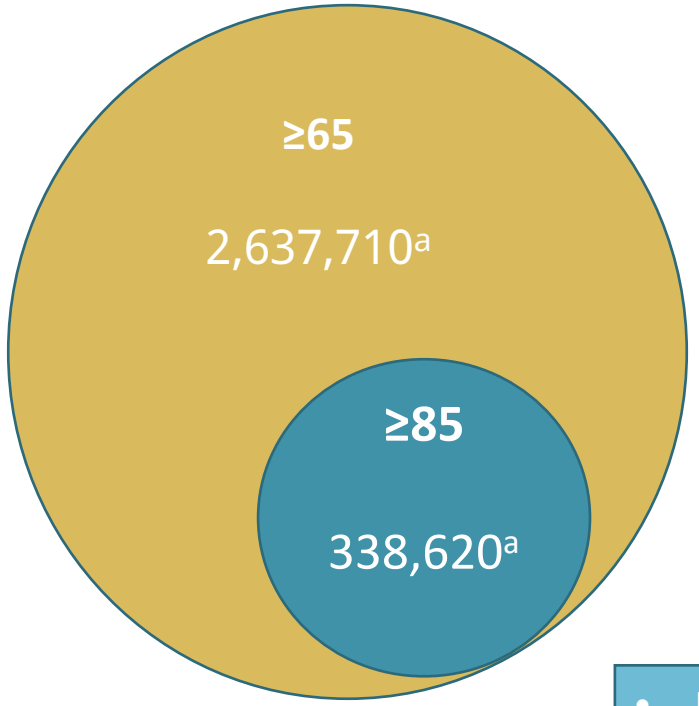


Organizational

The Case for a Focus on Older Adults

Ontario Population aged 65 and older



Opportunities for prevention of frailty

Ontario Population aged 65 and older living with frailty (estimated)

Specific requirements to mitigate the personal and system effects of frailty

- High risk for all chronic disease
- Higher risk of long hospital stays

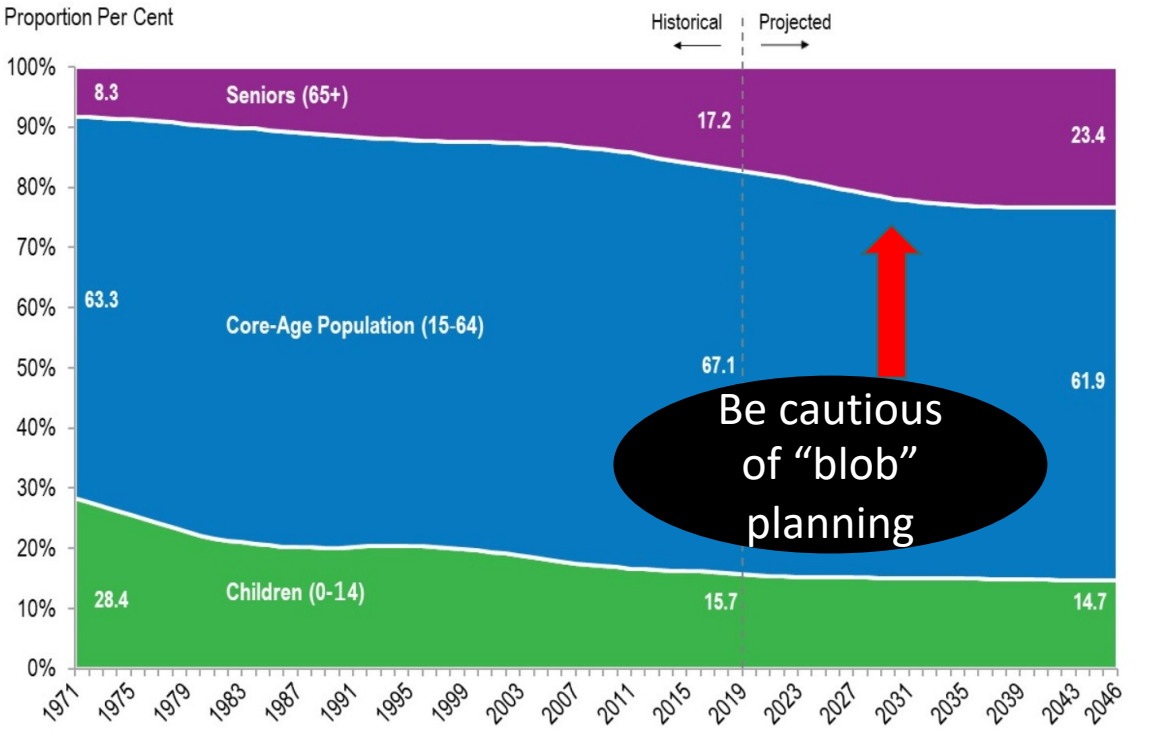
(Rockwood, K., 2022)

a. Statistics Canada. (2021). Census of Population, Ontario

a. PGLO. (2022). Frailty estimates using Hoover et al.

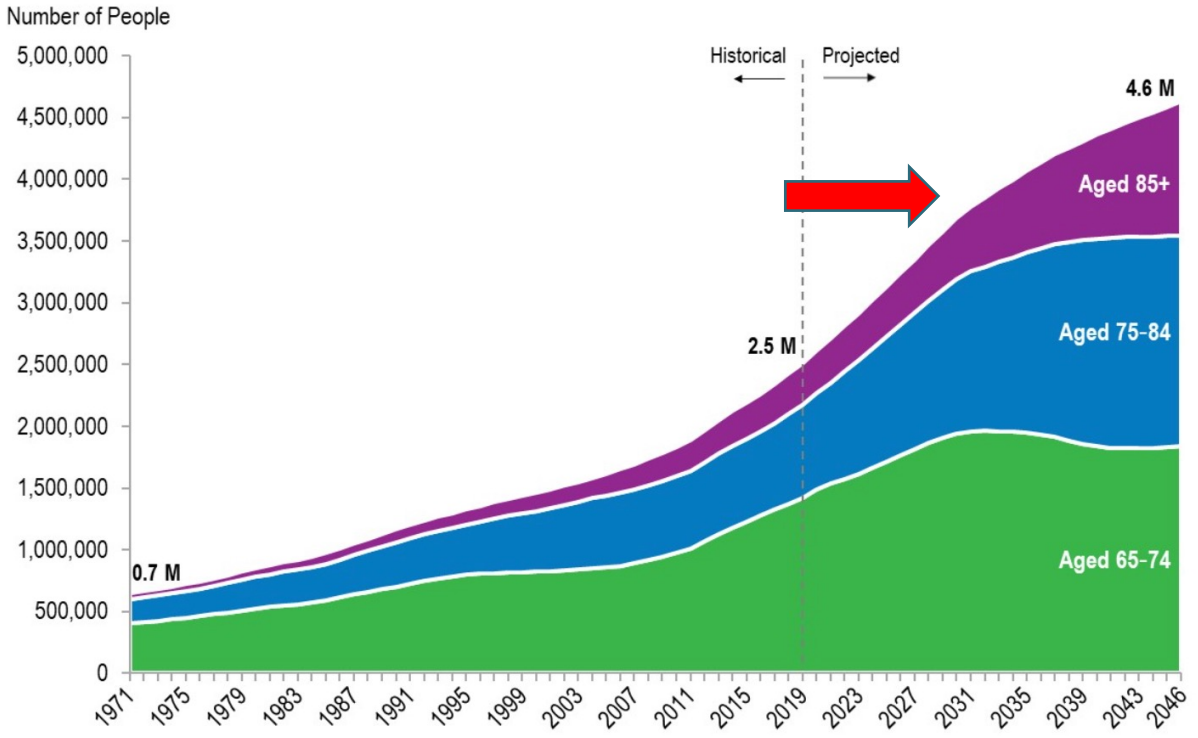
“Slowed Growth” is Not the Same as “No Growth”

Age Composition of Ontario’s Population, 1971 to 2046



Sources: Statistics Canada for 1971–2019 and Ontario Ministry of Finance projections.

Distribution of the Population of Seniors in Ontario, 1971 to 2046



Sources: Statistics Canada for 1971–2019 and Ontario Ministry of Finance projections.

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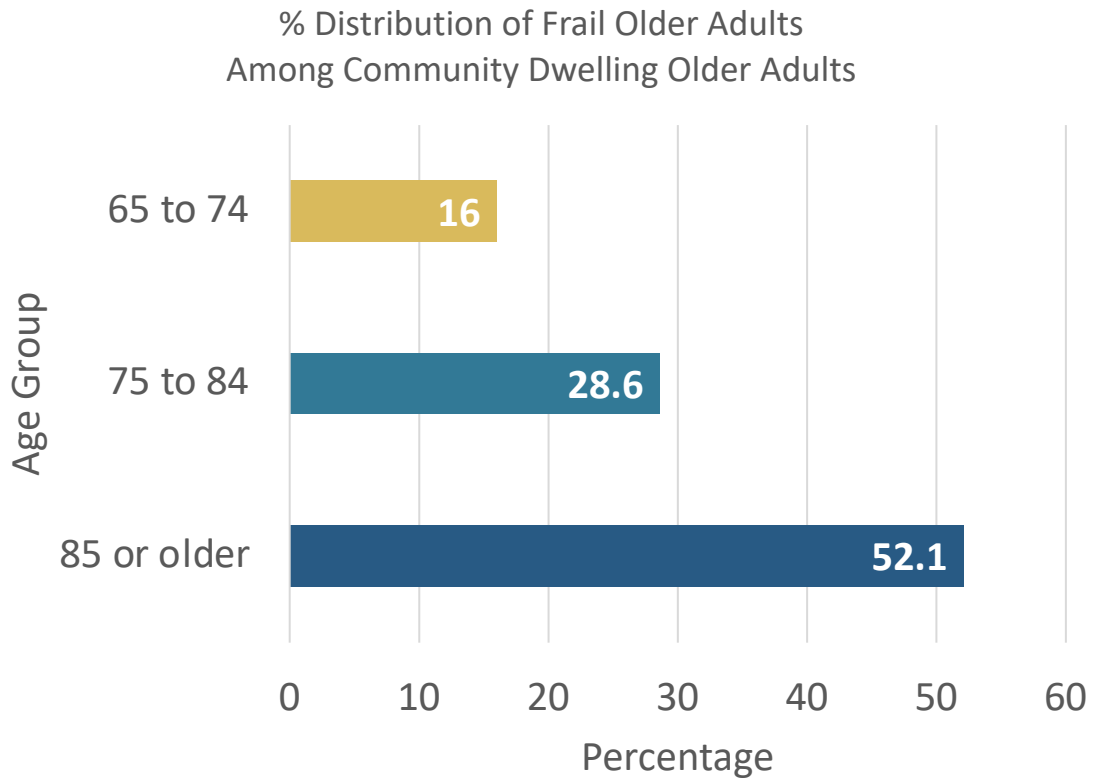
The need to recognize and respond to the health requirements of older adults is not going away

https://www.ontario.ca/document/ontarios-long-term-report-economy/chapter-1-demographic-trends-and-projections

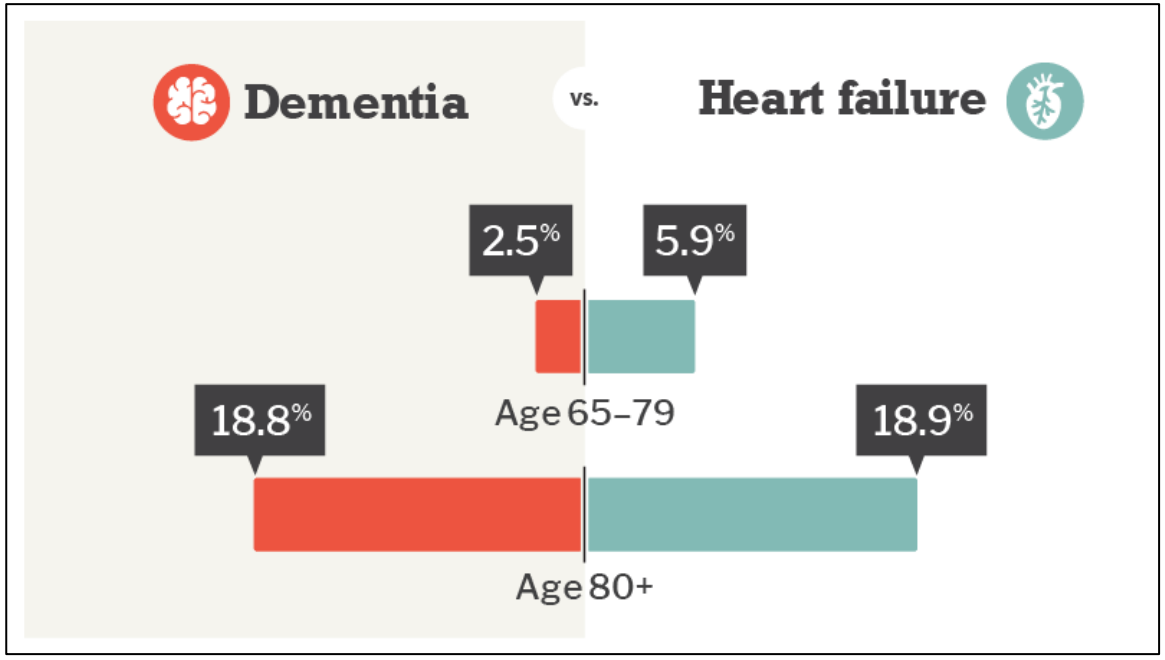
"Higher frailty associated with higher odds of dementia" (Rockwood, K., 2022)

Being Better Prepared: Prevalence

Frailty and Age



Dementia vs. Heart Failure



2013-2014

Hoover, M., Roterman, M., Sanmartin, C., & Bernier, J. (2013). Validation of an index to estimate the prevalence of frailty among community-dwelling seniors. Health Reports, 24 (9), 10-17 https://www150.statcan.gc.ca/n1/en/pub/82-003-x/2013009/article/11864-eng.pdf?st=OvvKzg6_

Canadian Institute for Health Information. How dementia impacts Canadians [report]. Accessed January 19, 2023.

Falls

- In older adults, falls are often a signal of other problems.
- The health system cost of falls among seniors could help fund the programming needed for proactive older person focused care!

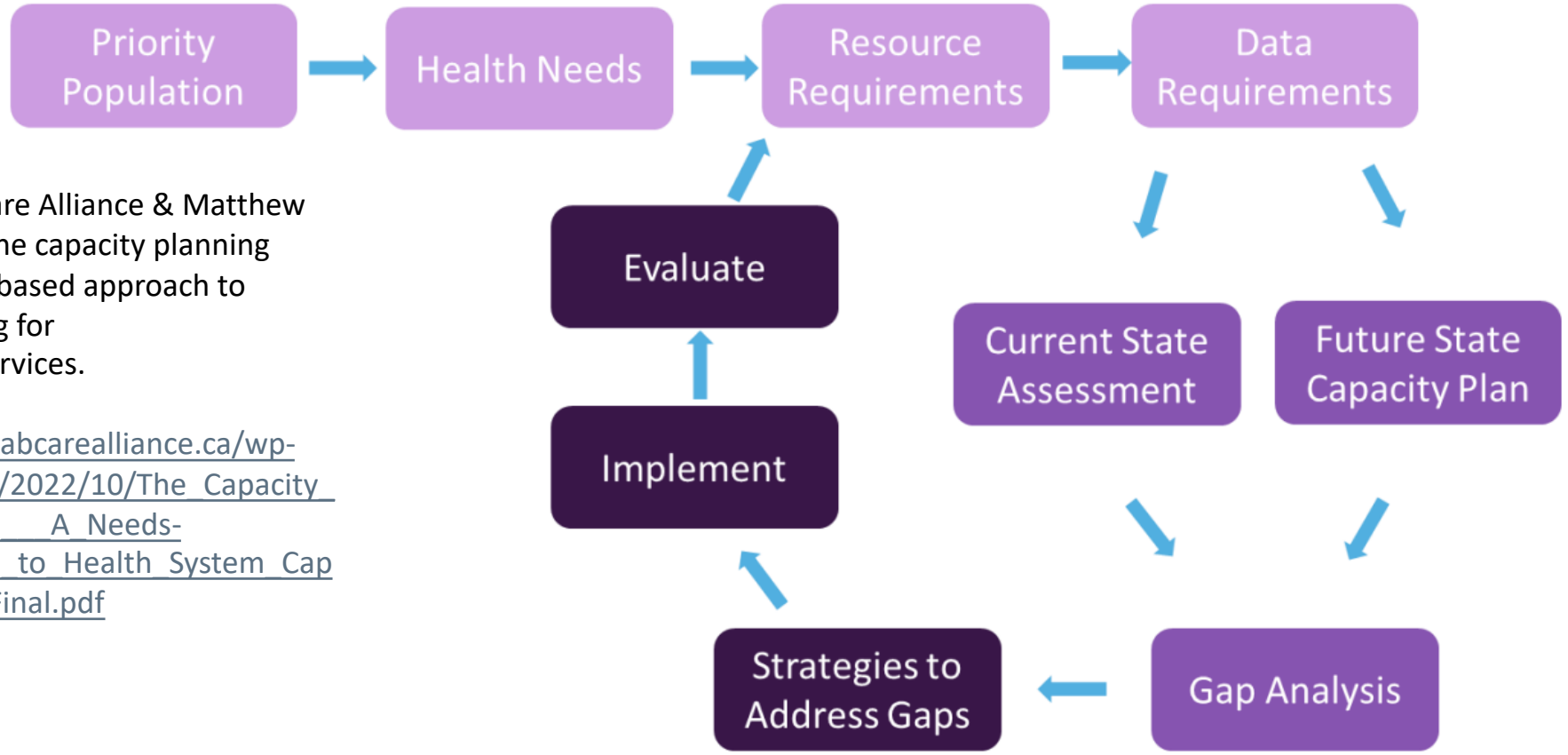
Capacity Planning and Older Adults Care

Capacity Planning Defined

"Capacity planning is a process for determining **current and future health service requirements** and for making the necessary preparations to meet those requirements. Put simply, it is planning to ensure that the system is the correct size and structured in a way that **appropriately meets** the **population's health care needs**" (OHA, 2018).

https://www.oha.com/Bulletins/Capacity%20Planning%20Snapshot.pdf

Capacity Planning: Knowledge to Action Cycle



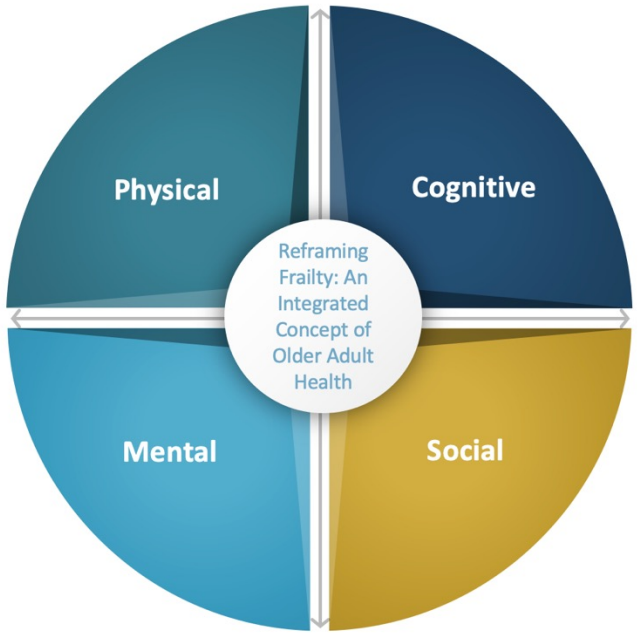
Rehabilitation Care Alliance & Matthew Meyer. (2019). The capacity planning canvas: A needs based approach to capacity planning for Rehabilitation services.

https://www.rehabcarealliance.ca/wp-content/uploads/2022/10/The_Capacity_Planning_Canvas___A_Needs-Based_Approach_to_Health_System_Capacity_Planning_Final.pdf

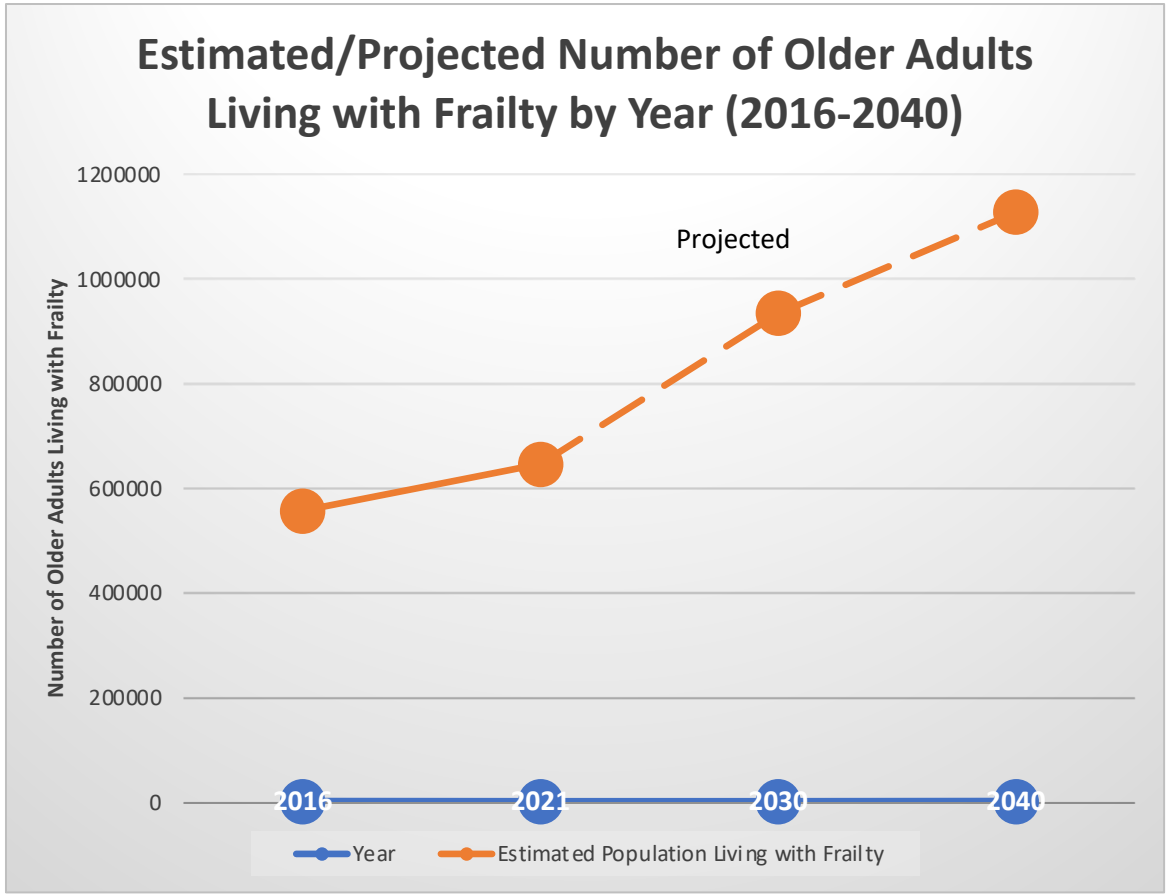
The View from Here: Provincial (Macro) Contribution

- Defining and estimating the priority population
- Describing, broadly, the health needs of older adults living with frailty
- Identify resource requirements (e.g. appropriate clinical services)
- Contributing to data requirements AND planning considerations
- Contributing to current state assessment and future state capacity plans
- Supporting the role of other levels of system planning
- Developing common resources

Defining and estimating the priority population



https://rgps.on.ca/resources/consensus-statement-care-for-the-older-adult-with-complex-health-conditions-reframing-frailty-in-an-ontario-context/



https://rgps.on.ca/resources/frailty-estimates-by-census-division-and-ontario-health-region/

Health Conditions Seen in Older Adults

Older Adults Pre-Pandemic Seitz, D. (2019)

- Diabetes mellitus (29.6%)
- Anxiety disorders (27.7%)
- Chronic obstructive lung disease (19.7%)
- Stroke (18.9%)
- Cancer (17.1%)
- Cardiac Arrythmia (15.3%)
- Congestive heart failure (9.1%)
- Mood Disorders (7.7%)
- Dementia (7.6%)
- Ischemic heart disease (5.0%)
- Substance related disorders (4.0%)
- Falls (3.6%)
- Parkinson's Disease (0.9%)
- Schizophrenia/Psychotic disorders (0.9%)
- Approximately 3% living in Long Term Care

Older Adults Since Pandemic

- Impacts of increased anxiety, increased depression, increased sleep disorders Richter & Heidinger, 2021; Tyler et al., 2021)
- Impacts of decreased physical activity Hoffman (2021)
- Persistent symptoms among older adults who have been hospitalized for COVID-19 Tosato et al. (2021) and potential impact of persistent fatigue on ADLs
- Impacts of trauma and grief (prolonged grief disorder) Goveas & Shear (2020)
- Increased morbidity due to delayed or foregone care Schuster et al. (2021)
- Increased psychosis (anecdotal reports)
- Other emerging requirements

Resource Requirements

Rehabilitative Care

Focus: Function focused reactivation, rehabilitation and adaptation, delivered according to goals of care and provincial guidelines.

Community Management

Focus: Frailty prevention, early identification, screening and assessment, treatment, ongoing support, advance care planning and palliation.

Older Adult Acute Care

Focus: Senior friendly care (incl. investigations, diagnosis, interventions, treatments etc.) to address acute decline or injury and support transition to appropriate destinations.

Urgent/Emergent Response

Focus: Rapid geriatric assessment and facilitated admission diversion (e.g. referral to community resources, care in place) or admission support with a senior friendly care plan and expressed goals of care.

Resource Requirements

Rehabilitative Care

Focus: Function focused reactivation, rehabilitation and adaptation, delivered according to goals of care and provincial guidelines.

Examples/Partners: Rehabilitative models of emergency department, hospital inpatient and community care

Older Adult Acute Care

Focus: Senior friendly care (incl. investigations, diagnosis, interventions, treatments etc.) to address acute decline or injury and support transition to appropriate destinations.

Examples/Partners: Consultation Liaison Teams, acute care of the older adult programs.

Community Management

Focus: Frailty prevention, early identification, screening and assessment, treatment, ongoing support, advance care planning and palliation.

Examples/Partners: Ontario Health Teams (incl. primary care), Integrated Community Geriatrics Teams, Home and Community Care Support Services, Respite Care, etc.).

Urgent/Emergent Response

Focus: Rapid geriatric assessment and facilitated admission diversion (e.g. referral to community resources, care in place) or admission support with a senior friendly care plan and expressed goals of care.

Examples/Partners: Geriatric Emergency Management program, Nurse-Led Outreach Teams.

Supporting Data Requirements

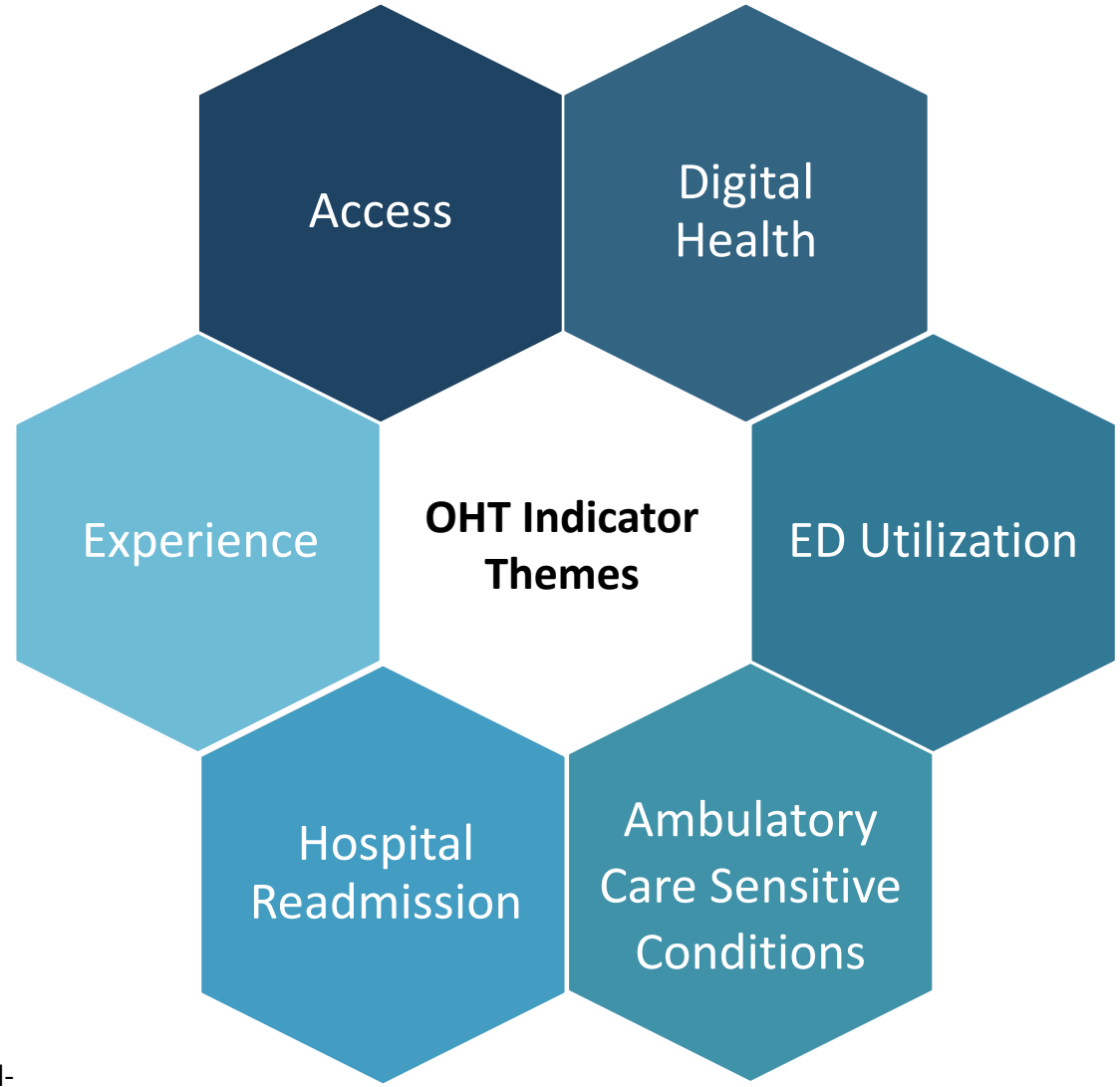
Specialized Geriatric Services in Ontario
Number of Programs/Services by Type

SGS Type Name	Health Region / Fiscal: Central 2021-22	East 2021-22	North East 2021-22	North West 2021-22	Toronto 2021-22	West 2021-22
Acute Geriatric psychiatry units						1
Acute Geriatric Units/Acute Care of the Elderly Units	4	2			3	1
Care of the Elderly Physicians	1				2	
Community Paramedicine	2					1
Falls/Falls Prevention Clinic/Program		1			3	1
Geriatric Assessment and Treatment Units		1				
Geriatric Emergency Management (Nurses)	4	22			5	8
Geriatric Medicine Day Hospitals	1	5	1		4	
Geriatric Medicine Rehabilitation Units		2	1		4	1
Geriatric Outpatient Clinics	9	2	4		7	9
Geriatric Outreach Teams	6	13	3		4	4
Geriatric Psychiatrists		1		2	1	
Geriatric Psychiatry Outpatient Clinics		1			4	1
Geriatric Psychiatry Outreach Teams	2	2	2	2	5	5
Geriatric Telemedicine/Telepsychiatry Service	1			1	1	
Geriatricians	1				2	5
Hospital Elder Life Program (HELP)	1				1	1
In-patient Geriatric Co-Management Services	1				2	
Inpatient Geriatric Consultation/Virtual Ward		3	1	1	10	2
Nurse Led Outreach Teams (NLOTS)	5	1			2	1
Other (Enter Service Type)	6	10	2			
Other Primary Care Memory Clinic						3
Population Health Focused Program (Older Adults)						3
Primary Care Collaborative Memory Clinics (includes MINT clinics)	3	5			1	6
Psychogeriatric Resource Consultants	4	2				1
Shared care geriatric mental health program			1		2	
Specialist Based Memory Clinic Models	1	2			2	
Tertiary Dementia Specialty Units		2			1	
Tertiary Non-Dementia Geriatric Psychiatry Units						1

Provincial Specialized and Focused Geriatric Services Asset Inventory (Map)

Informing Data Requirements

- Thematic analysis of 122 indicators from 42 Ontario Health Teams (initial cQIP indicator set Sept 2021)
- Grouped into six (6) themes
- Mined consensus indicator set for related indicators
- Adjusted wording following expert panel review (June 2022)
- Included new fall related indicators published by PHO[a] (Nov 2022)



[a]https://www.publichealthontario.ca/-/media/Documents/P/2022/prioritization-older-adult-fall-prevention-indicators-ontario.pdf?rev=e415b96bfa5245659f87af3787d59115&sc_lang=en

OHT Domains	Suggested OHT Indicators
Access	• Median number of days that older adults (≥65) waited from referral to first service, by service
	• % of older adults (≥65) who were eligible for home and community care services who did not receive all of their allocated hours of service
Digital Health	• % of older adults (≥65) who have access to their digital health record. (access) • % of older adults (≥65) who utilize their own digital health record. (digital health literacy)
Experience	• % of sites collecting data pertaining to the older adult experience • % of sites collecting data pertaining to the caregiver experience
ED Utilization	• % of older adults (≥65) experiencing 2+ ED visits in the past 30 days and 12 months by reason • FALLS: % of 2+ emergency department visits for falls in the past 30 days and 12 months for older adults (≥65) • FALLS: % of hospitalization for older adults (≥65) due to a fall
	• % of older adults (≥65) discharged from hospital emergency department to home who visit the emergency department within 7 days and 30 days after discharge - by reason
Ambulatory Care Sensitive Conditions	• % of hospitalizations among older adults (≥65) for ambulatory care sensitive conditions
Hospital Readmission	• % of older adults (≥65) discharged from hospital to home who were readmitted to hospital by time frame (24 hours, 7 days, 30 days) and by reason

Data Requirements

Planning Considerations – The Older Adult Context

- **Do not call older adults "frail"**; they may live with or experience frailty and it may be reversible
  - And let's not call our parents, grandparents and future selves "ALCs" or "Beds" either!
- **Plan for proactive care**
  - Treat multi-morbidity at least as proactively as accepted clinical standards for single chronic diseases (e.g. quarterly diabetes care visits).
- **Recognize and respond to "waiting"**; collect broad service wait time data
  - Older adults may be referred to multiple services and wait for all of them.
- **Assess for palliative care needs**
  - Older adults living with frailty may require palliative approaches to care

Data Requirements

Planning Considerations - Continued

- **Question the data**
  - What is excluded? Sites serving people living with complexity (e.g. CHCs, NPs)? Admitting co-morbid diagnoses?
  - How is “ambulatory sensitive” being conceptualized? (e.g. use of Frailty modifiers). Note: Frailty is characterized by the body’s inability to cope with minor illnesses that would normally have minimal impact if one is healthy.
- **Avoid the “frail”/ “non-frail” binary** (see “blob” planning)
  - Degree of frailty provokes different tailored responses

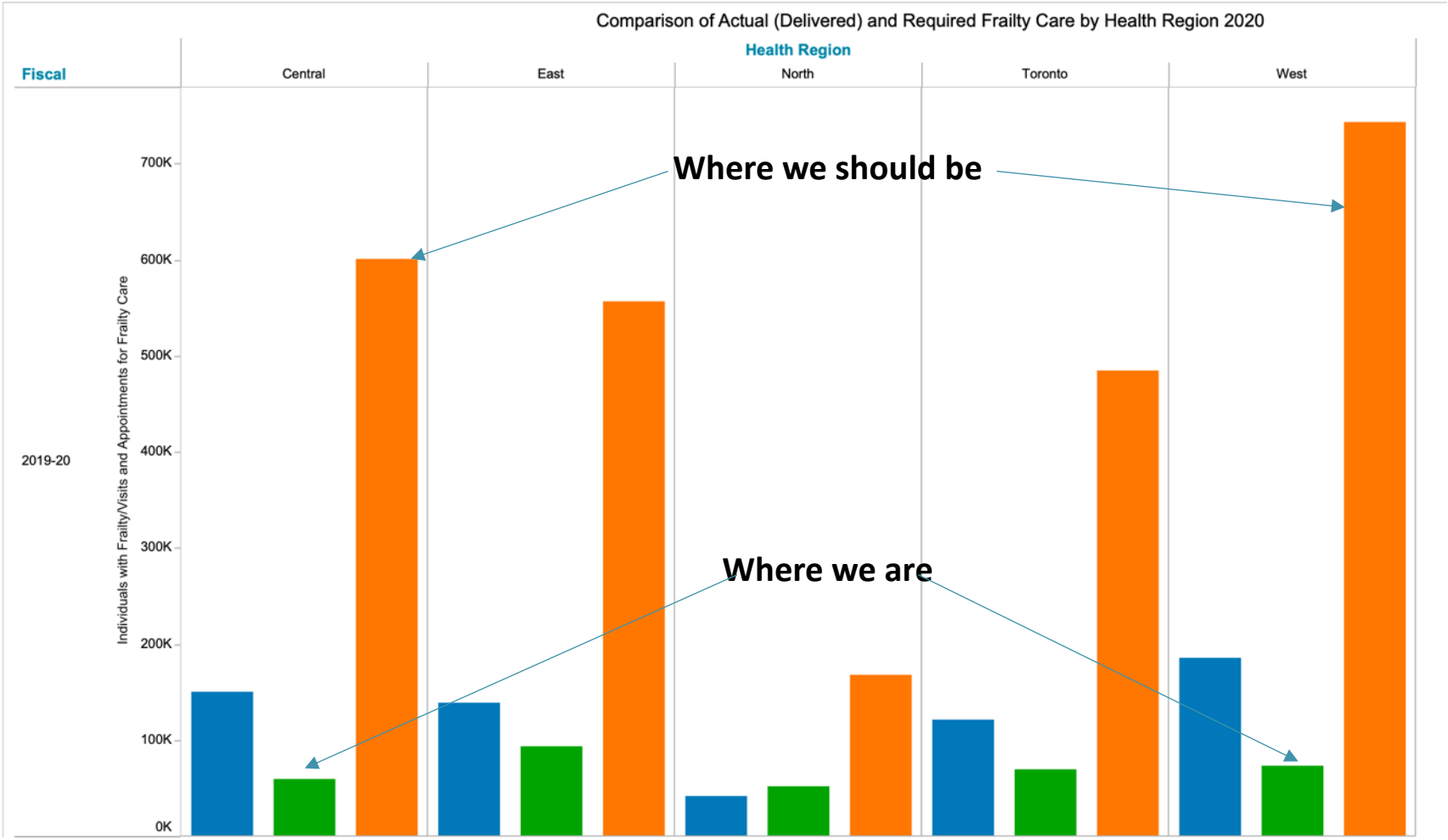
  see https://rgps.on.ca/resources/holistic-approach-to-frailty-for-ontario-health-teams
- **Generally, Alternative Level of Care (ALC) = Frailty**
  - For clinicians, frailty may be a more helpful planning construct because it guides appropriate clinical service design and clinician response.

Current State Assessment

Estimated Number of Older Adults Living with Frailty[1]

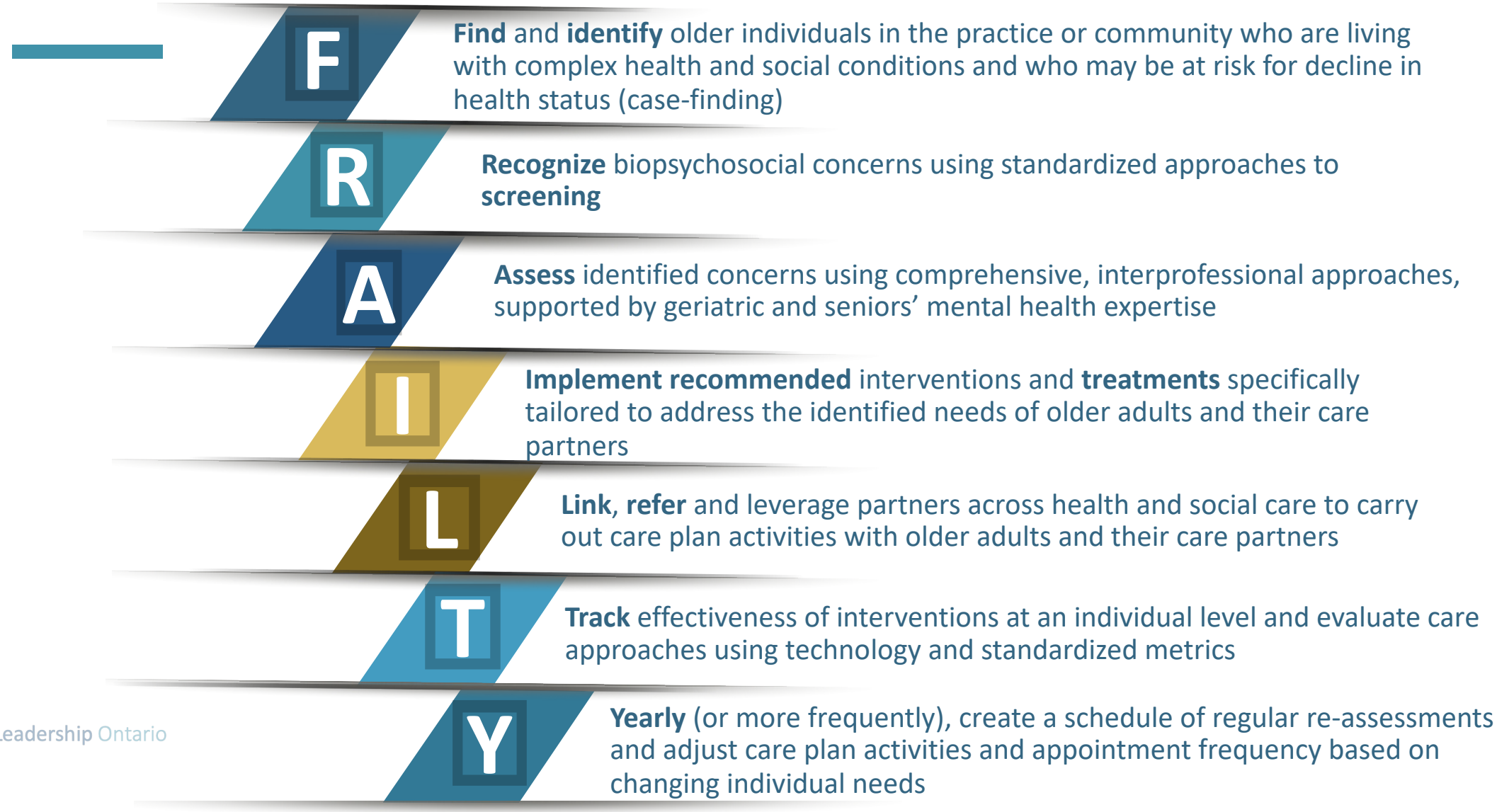
Actual Number of Frailty Focused Visits Annually by SGS

Estimated number of Frailty-Focused Appointments Required[2]



1. PGLO Frailty Estimates ; 2. Assumes minimum four (4) frailty-focused assessment, care planning and intervention appointments annually (based on comparable chronic disease management standards)

Future State: Frailty Informed Clinical Pathways



Provincial Geriatrics Leadership Ontario

Coordinating Clinical Geriatric Services in Ontario

Clinical Service Design
Implementation Rubric for Integrated Older Adult Care

Future State Capacity Plan

Design Elements	Basic-level Implementation	Mid-level Implementation	High-level Implementation	Score (assessed level)
Multi-disciplinary teams	Representation from multiple traditional health sectors.	Representation from multiple traditional health sectors.	Extended non-traditional health and social sector professions.	
	Fixed team membership .	Flexible team membership (may involve representation across organizations).	Flexible support network (involves representation across multiple organizations/supports)	
Collaboration	Multi-disciplinary approach to team-based care (representation of knowledge and practice from different disciplines).	Inter-disciplinary approach to team-based care (synthesizing knowledge and practice across different disciplines).	Trans-disciplinary approach to team-based care (blurring of professional knowledge and practice).	
Cross-sector partnership	Joined-up health services (across traditional organizations operating at same layer of support).	Joined-up health services (across traditional organizations operating at same and different layers of support).	Joined-up health and social services (across traditional and non-traditional organizations operating at same and different layers of support).	
Comprehensive assessment & care planning	Focus of assessment & care planning is on illness-related issues.	Focus of assessment & care planning is on illness-related issues, *and* functioning and QoL issues.	Focus of assessment & care planning is on illness-related issues, functioning , QoL issues *and* social and prevention issues.	
Integrated care at-the-point-of-care	Coordinated delivery of multi-disciplinary supports (provided by different healthcare organizations) at the point-of-care.	Coordinated delivery of multi-disciplinary supports and intentional knowledge exchange (provided by different health care organizations) at the point-of-care.	*Co-delivery* of multi-disciplinary supports and concurrent knowledge exchange (involving representation from different health care organizations) at the point-of-care.	
Shared responsibility for continuity of care	Individual practitioners assume responsibility for delivering discipline/organization-specific interventions.	Individual practitioners assume responsibility for co-ordinating discipline/organization-specific interventions with other members of the team (both within and across organizations).	Individual practitioners assume shared responsibility for all interventions performed by the team (regardless of discipline/organization affiliation).	
Integrated specialized geriatric expertise	Geriatric expertise available via consultation.	Geriatric expertise is embedded into an integrated care team (either a stand alone SGS team or an SGS provider embedded as a member of an integrated team with representation across multiple organizations).	SGS team joined-up with one or more interprofessional health and/or social care services (forming an integrated support network).	
Integrated community & home-based interventions	Community & home-based version of traditional hospital-based care.	Community and home-based version of hospital-based care (representation from multiple health and social care disciplines/organizations in the design process).	Innovative community and home-based care interventions (representation from multiple health and social care disciplines/organizations *and* older persons and care partners in the design process).	
Older person-centred care	Primary focus on illness-related care goals. Older persons are invited to attend care conversations.	Focus is on illness-related issues *and* functioning and QoL issues. Older persons & care partners are invited to contribute to care conversations.	Focus is on illness-related issues, functioning , QoL issues *and* social and prevention issues. Older persons & care partners are invited to play an active role in guiding care conversations.	
Engaged older persons & family/friend caregivers	Older persons & care partners are invited to attend conversations regarding the development of care goals.	Older persons & care partners are invited to play an active role in developing care goals and making suggestions regarding care interventions.	Older persons & care partners are invited to play an active role in designing and implementing care interventions.	
Self-management support	Illness-related information is provided to older persons and care partners to inform them about symptoms and potential treatment interventions.	Illness-related information is provided to older persons and care partners to inform them about symptoms and potential treatment interventions. Information is also provided regarding extended service and support options, along with tips for managing related day-to-day health concerns.	Self-management Interventions are designed (with input from older persons and care partners) to actively support older persons and care partners to self-manage everyday health concerns These interventions are monitored with the intention of tracking ongoing progress.	
Integrated technologies (e-health)	Intentional design/ implementation of e-technology to enable a comprehensive health and care profile of older persons (e.g. EMR with contributions from practitioners across multiple health-related organizations).	Intentional design/ implementation of e-technology to enable to enable a comprehensive and accessible health and care profile of older persons (e.g. EMR with contributions from practitioners across multiple health-related organizations. EMR can be accessed by practitioners across multiple organizations).	Intentional design/ implementation of e-technology to enable to enable a comprehensive and universally accessible health and care profile of older persons (e.g. EMR with contributions from practitioners across multiple health and social care organizations. EMR can be accessed by practitioners across multiple organizations, and older persons and care partners).	
Integrated technologies (m-health	Intentional implementation of m-technology to enhance the care of older persons (e.g. health-related smart phone applications).	Intentional, consistent and systematic implementation of m-technology to enhance the care of older persons (e.g. health-related smart phone applications).	Intentional, consistent and systematic implementation of m-technology to enhance the care of older persons *and* linked services to extend the reach/breadth of support (e.g. health practitioners whose job it is to communicate directly with patients based on symptom reporting via m-technology devices).	
Multi-tiered evaluation	Intentional evaluation of integrated care process and outcomes using relevant macro, meso and micro-level indicators	Intentional evaluation of integrated care process and outcomes using relevant macro, meso and micro-level indicators. Intentional and embedded, systematic continuous learning process is applied to inform ongoing program development.	Intentional evaluation of integrated care process and outcomes using relevant macro, meso and micro-level indicators. Intentional and embedded, systematic continuous learning process is applied to inform ongoing program development. Efforts are made to connect data collection/analysis across organizations/sectors.	
Score (# of design elements/level)				

Three Viewpoints of Capacity Planning

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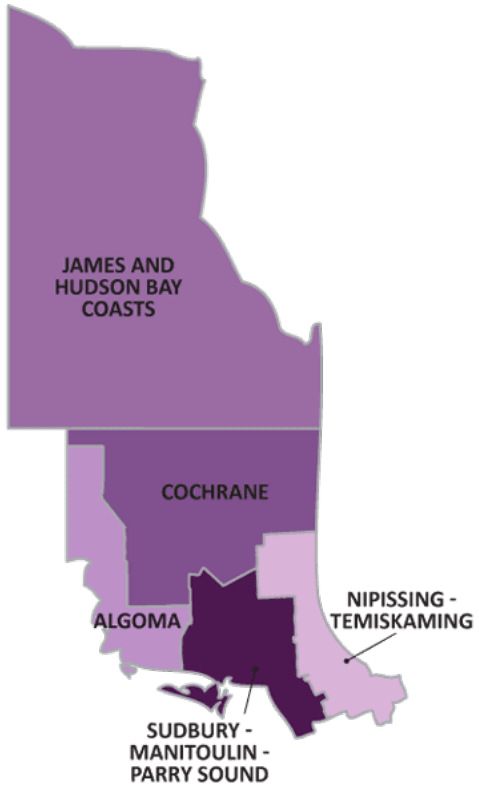

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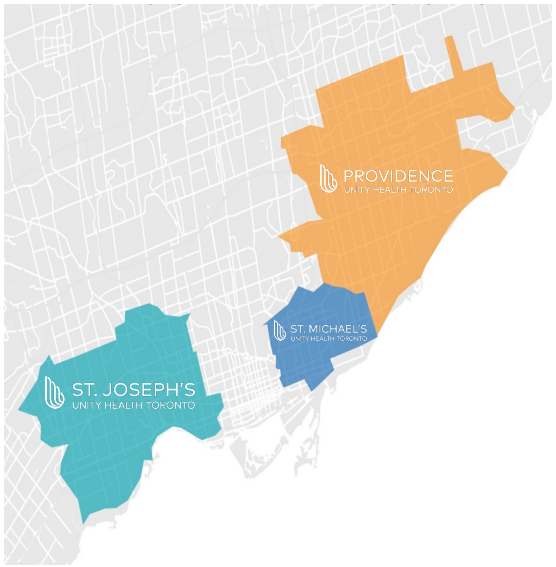

Organizational

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c. Tyler et al. (2021). A Study of Older Adults' Mental Health across 33 Countries during the COVID-19 Pandemic, Int. J. Environ. Res. Public Health 2021, 18, 5090. https://doi.org/10.3390/ijerph18105090

d. Hoffman, G. (2021). Physical functioning and falls during the COVID-19 pandemic. https://www.healthyagingpoll.org/reports-more/report/physical-functioning-and-falls-during-covid-19-pandemic

e. Tosato M et al. (2021). Prevalence and Predictors of Persistence of COVID-19 Symptoms in Older Adults: A Single-Center Study. J Am Med Dir Assoc. 22(9):1840-1844. doi: 10.1016/j.jamda.2021.07.003.

f. Goveas, J. S., & Shear, M. K. (2020). Grief and the COVID-19 Pandemic in Older Adults. The American journal of geriatric psychiatry : official journal of the American Association for Geriatric Psychiatry, 28(10), 1119–1125. https://doi.org/10.1016/j.jagp.2020.06.021

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