Capacity Planning for Older Adult Care: A Regional Approach

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Health Sciences North
Horizon Santé-Nord

Capacity Planning Discussion

- Regional Context
- The Opportunity
- Putting it into Practice

Context: The System of Older Adult Care in Ontario

Provincial Leadership

Provincial Geriatrics Leadership Ontario

Coordinates the provincial infrastructure for geriatric care:

- Planning & capacity building
- Clinical model and knowledge creation & evidence dissemination
- Performance measurement & evaluation
- Policy development

Regional Infrastructure

North East	North East Specialized Geriatric Centre Centre gériatrique spécialisé du Nord-Est
North West	St. Joseph's Care Group
Central	North Simcoe Muskoka Specialized Geriatric Services
West	St Joseph's Health Care London Waterloo Wellington Older Adult Strategy RGP Central
East	Regional Geriatric Program of Eastern Ontario seniors care network Centre for Studies in Aging & Health, Providence Care
Toronto	RGP Regional Geriatric Program of Toronto

Local Impact

Providing direct care to Individuals & Family/ Friend Caregivers

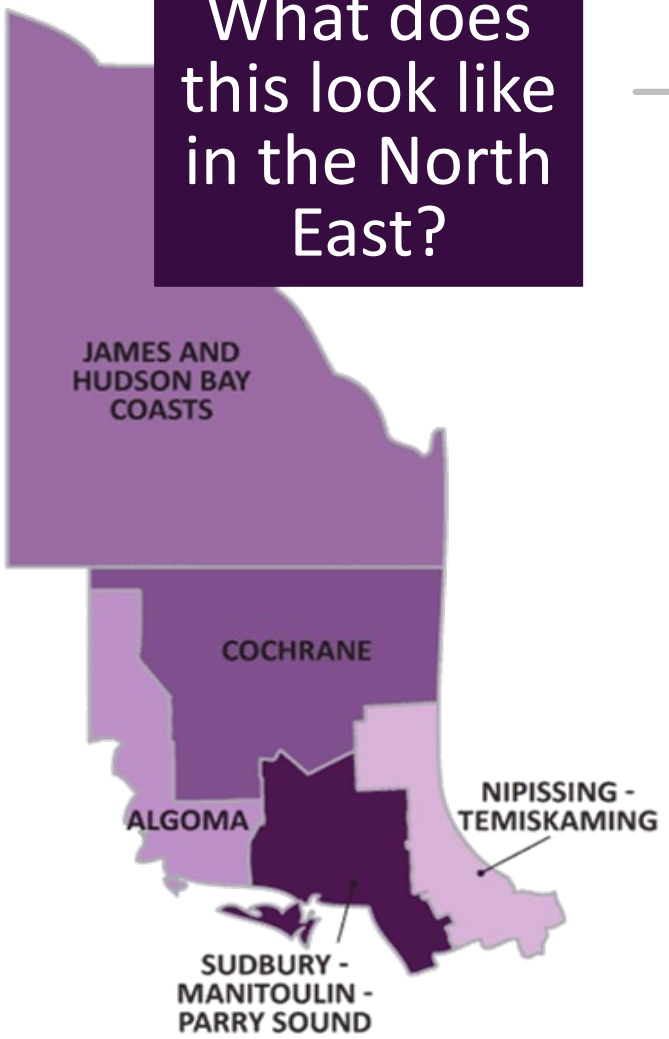
Working with Primary Care

Supporting the work of Local Ontario Health Teams

PGLO - Regional Programs

The North East Regional Geriatric Program

What does this look like in the North East?



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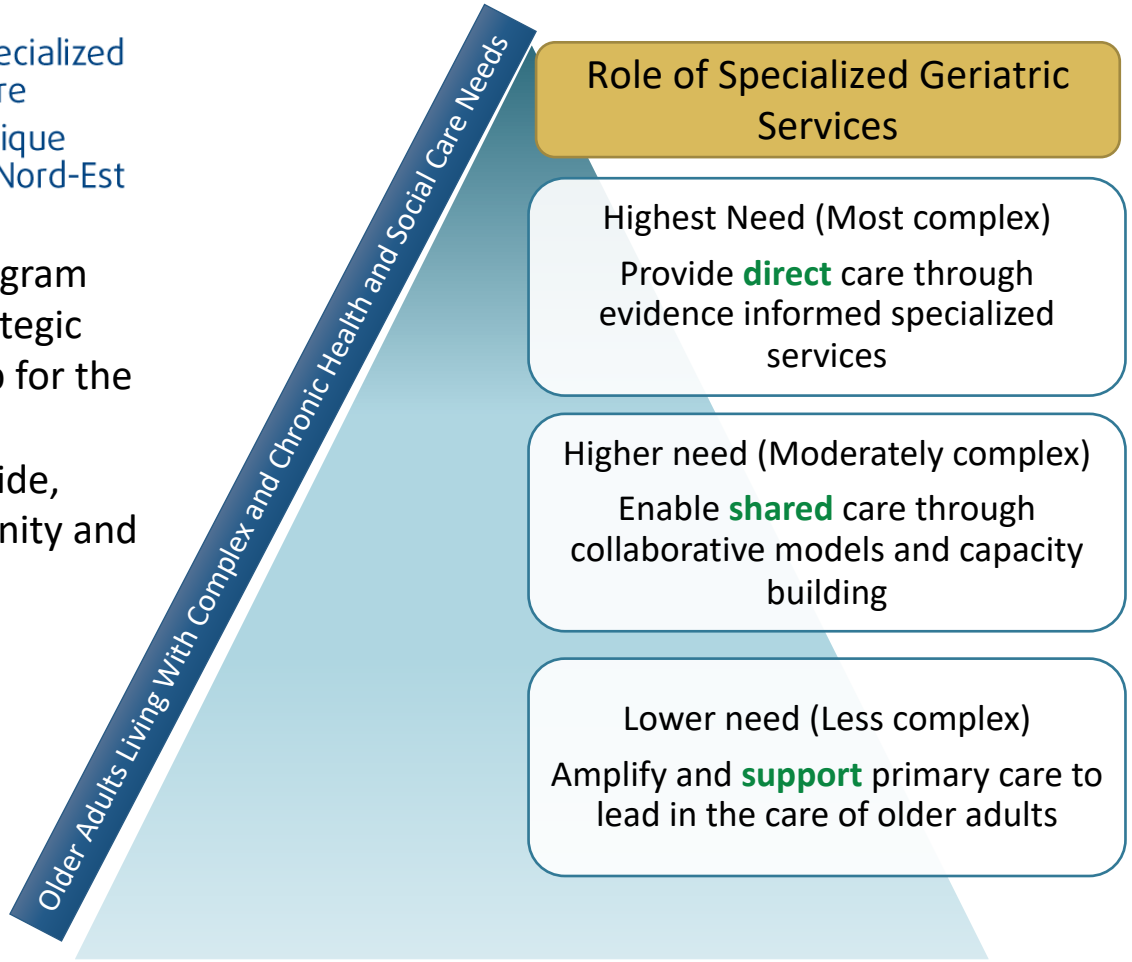
As a Regional Geriatric Program (RGP) NESGC provides strategic and operational leadership for the implementation of clinical geriatric services region-wide, working with local community and health partners across the continuum of care.

PGLO - Regional Programs



PGLO - Regional Programs

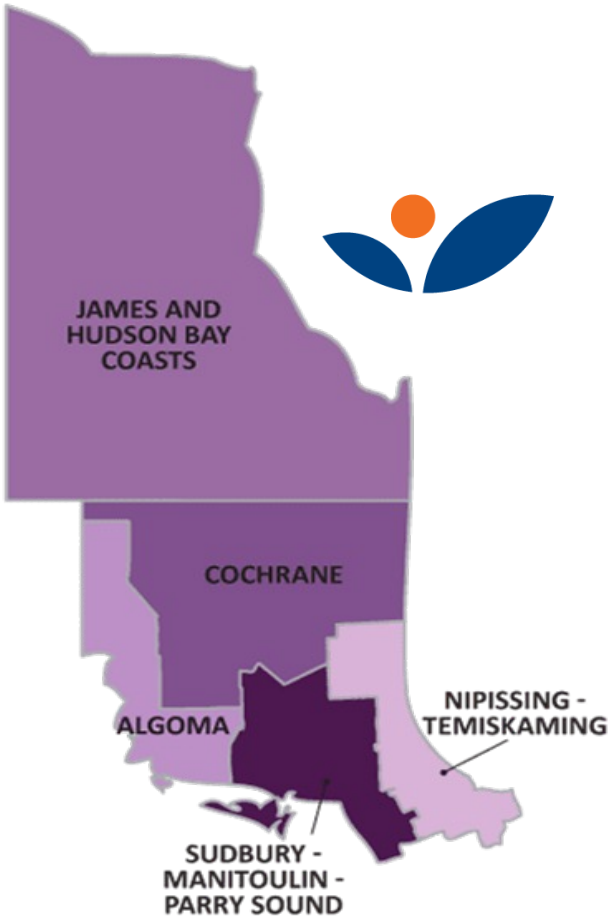
PGLO - SGS Asset Mapping Report

Capacity Planning - Regional Application

Provincial (Macro) Contribution

Care for older adults living with frailty

- Population
- Care needs
- Clinical services
- Current state assessment
- Planning Considerations
- Future state capacity plans



Regional (Meso) Application

What's the Opportunity?

Alternate Level of Care (ALC)

- Provincial priority focus
- ALC improvement must extend the continuum of care – not just a hospital problem
- Immediate reduction in ALC requires a system approach
- Impacts EVERYONE and requires working in partnership – patients, caregivers, providers, system

ALC Initiatives:

	Capacity Maximization
	Admission Diversion
	Discharge Supports
	Additional Local Strategies

Ontario Health North East

ALC Initiative Investments

Informed by regional SGS capacity planning efforts

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1. Population

What we know…

Who is becoming ALC?
Who is most at-risk?

- Majority are over the age of 65, with increasing risk noted over the age of 75
- In Ontario **80%** Age 65+
  64% Age 75+

Common Characteristics

- An admitting diagnosis that includes general medical illness (e.g. infections), falls and dementia;
- Presence of functional or cognitive impairments, & multiple comorbidities;
- Experience of adverse events during admission – functional decline, delirium, falls, social isolation;
- Caregiver stress

ALC Leading Practices Guide 2021

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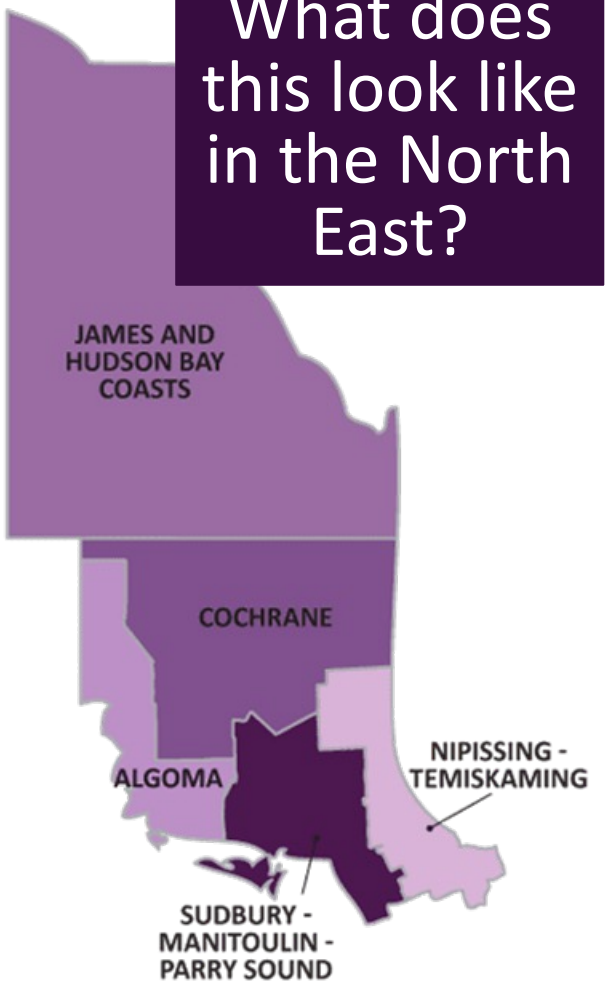
Age Cohort

What data is required to understand the population designated ALC and 'at-risk' for ALC?

What does this look like in the North East?



Batch 1 Priority Locations

ALC Cases by Age Cohort 2021-22	Age 65+	Age 75+
ALL NORTH EAST	**85%**	**65%**
Greater Sudbury	84%	65%
Parry Sound	88%	68%
Sault Ste. Marie	83%	63%
North Bay	85%	66%
Timmins	84%	59%
New Liskeard	92%	72%

Source: IntelliHEALTH

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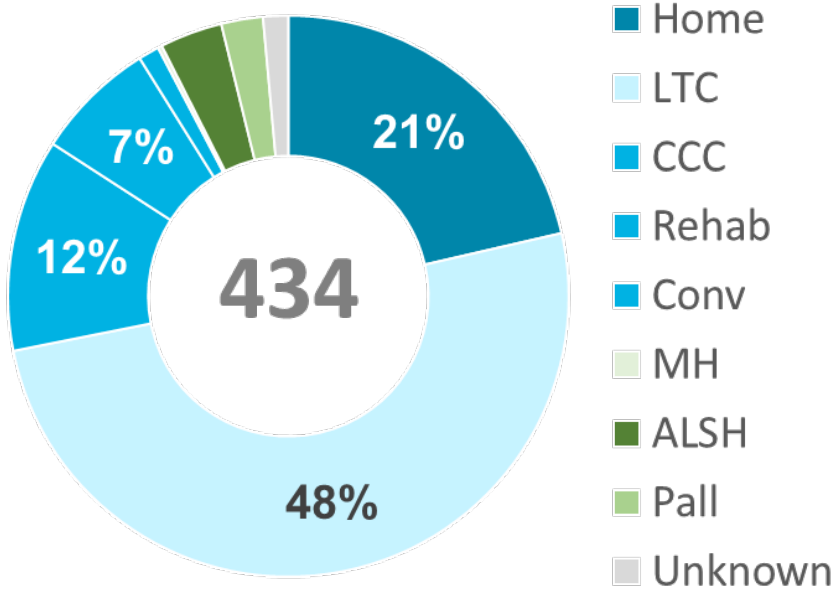
ALC Open Cases

What care are people waiting for?

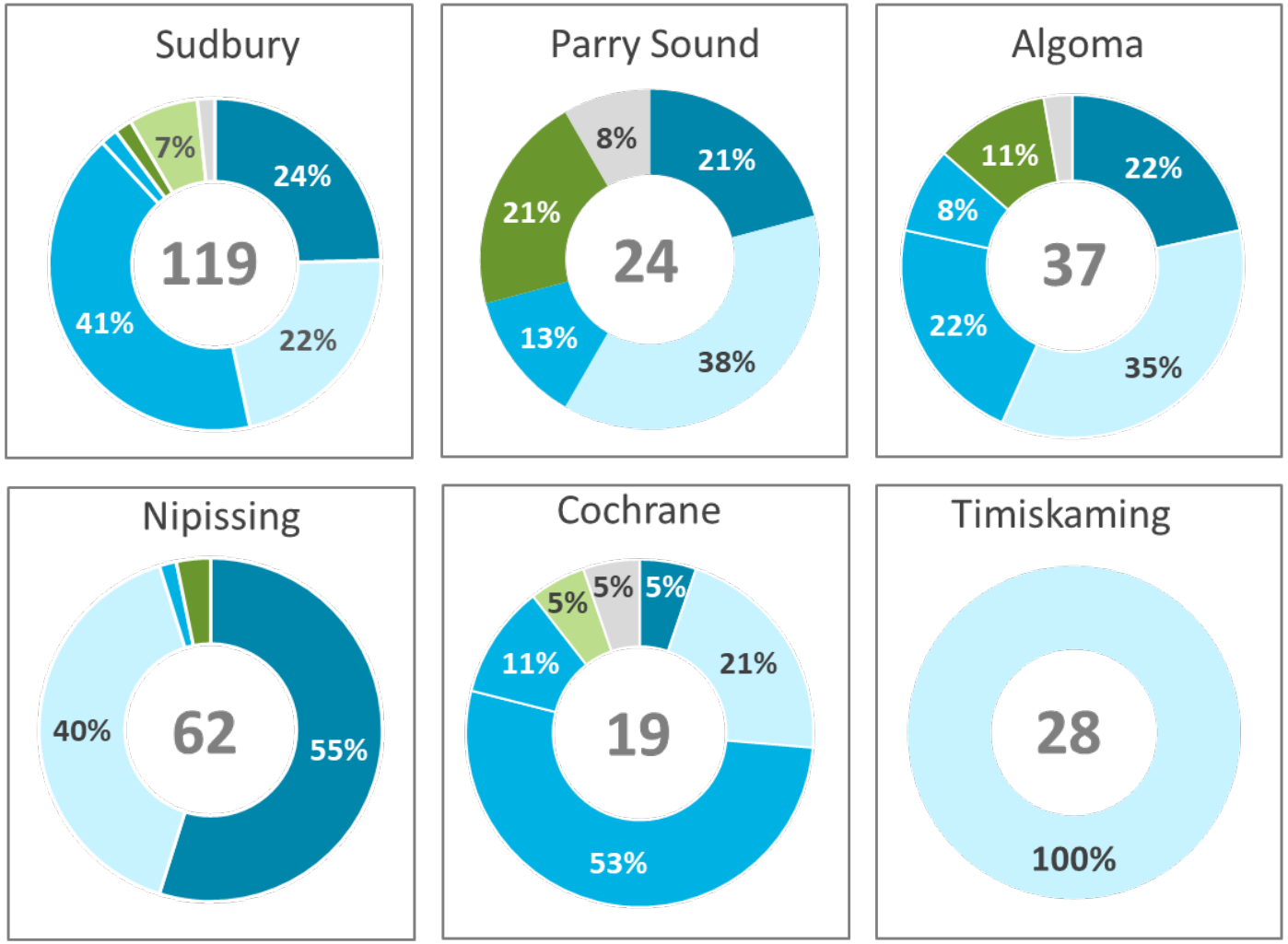
January 12th, 2023:

Ontario Health North East



Aggregate of NE Hospitals
(n=25)

Batch 1 Priority Locations



Source: OH North BI Tool January 12th, 2023

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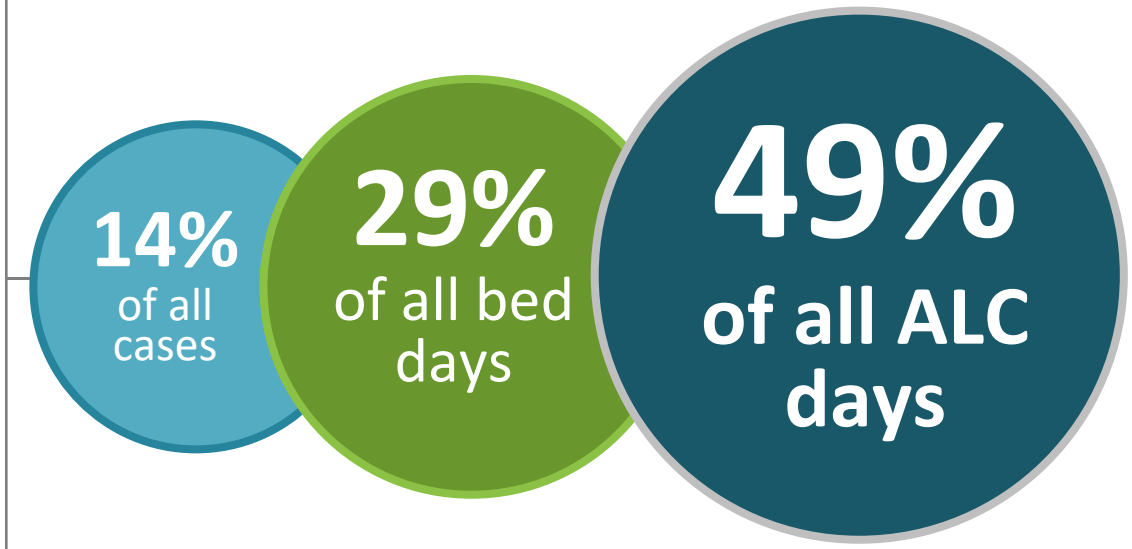
ALC Case Mix Groups (CMGs)

Ontario Health North East

Top 10 CMG's by ALC Cases – FY 2021-22

- Dementia
- 'Falls, Weakness, Frailty'
- Hip Fracture
- Delirium
- CHF
- Stroke
- Palliative Care
- COPD
- Hip Replace. w/ Trauma
- Lower UTI



The top 10 CMGs vary at a sub-region & local level.

However…

Dementia, **'Falls, Weakness, Frailty'** & **Delirium** are consistent across locations

Source: IntelliHealth

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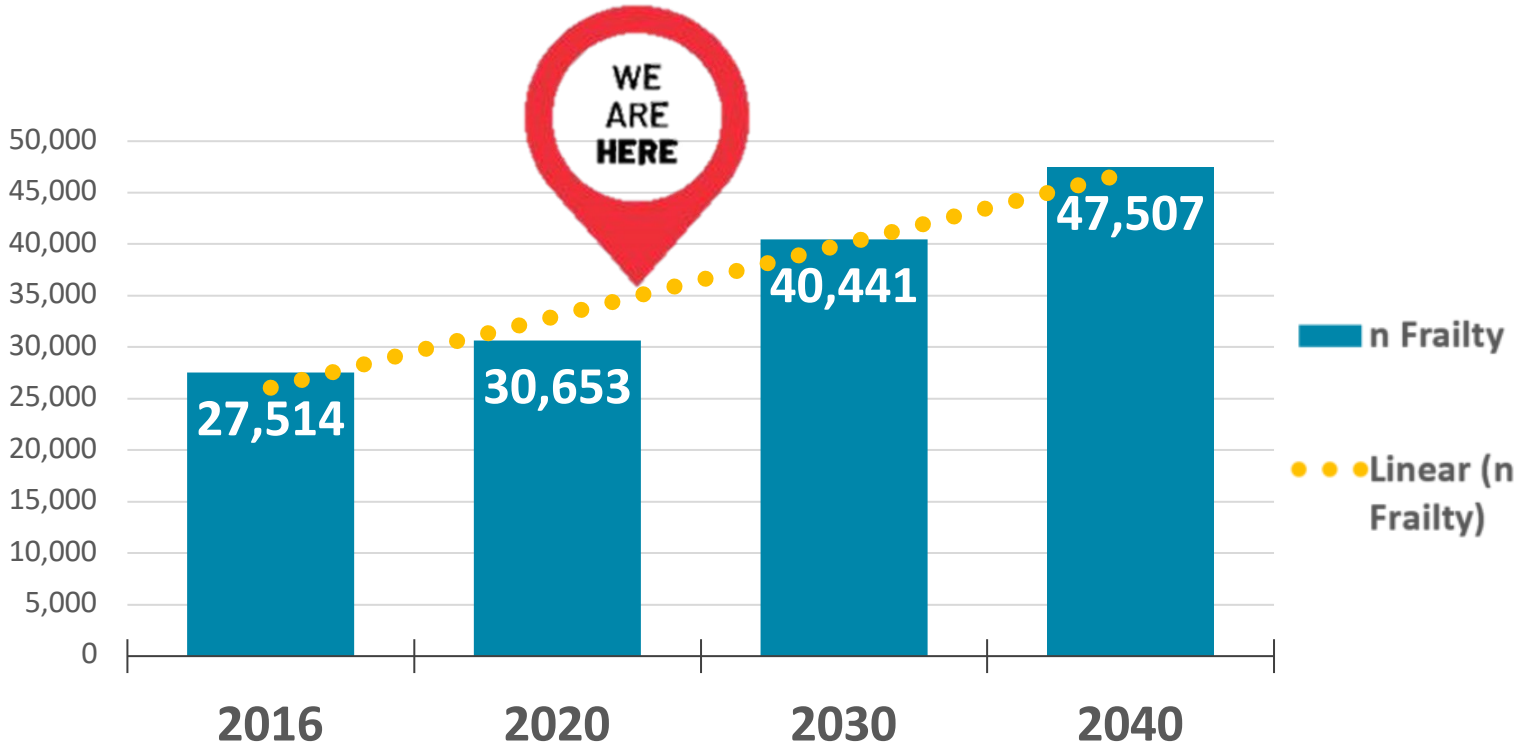
Frailty Projections

While most older adults live healthy and active lives, a small portion become frail and are at risk of avoidable hospitalization and avoidable or premature institutionalization.

North East Population Projections for Older Adults with Frailty



Sudbury-Manitoulin-Parry Sound	57%
	70%
Nipissing	54%
Algoma	48%
Cochrane	56%
Timiskaming	44%

Projected increase in Frailty between 2020 - 2040

PGLO - FAQ CGA 2016
PGLO - Frailty Estimates by Census Division

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2. Care Needs

- Older adults require a holistic approach to care and services that incorporates an individual's physical, mental and cognitive health to prevent disease, optimize health and enable function.
- These requirements necessitate a comprehensive and integrated approach to care

Provincial Clinical Guidelines

- ✓ sfCare™
- ✓ Interprofessional CGA Competency Framework
- ✓ Rehabilitative Care Best Practice for Older Adults Living With/At-Risk of Frailty
- ✓ Post-Fall Rehabilitative Care Pathway
- ✓ Direct Access Priority Process
- ✓ Quality Standards:
  Dementia; Behavioural Symptoms of Dementia; Delirium; Transitions from Hospital to Home; Hip Fracture; Palliative Care
- ✓ The Alternate Level of Care (ALC) Leading Practices Guide
- ✓ PIECES of my Personhood & Supporting Transitions

Provincial Geriatrics Leadership Ontario · RGP Regional Geriatric Program of Toronto · Rehabilitative Care Alliance · Ontario Health · Behavioural Supports Ontario

Standard of Care for Older Adults Living with Complexity and Frailty (1-12)			
Core Components			
Core Elements of Care	Older Person & Care Partner Engagement		
	Equitable & Culturally Appropriate Care		
	Interprofessional Teams		
	Specialized Geriatric Expertise		
	Comprehensive Geriatric Assessment (CGA)		
	Evaluation		
Processes of Care	Early Identification		
	Comprehensive Assessment		
	Care Planning (includes Advanced Care Planning)		
	Intervention		
	Transitions		
Domains of Care	Cognition	Polypharmacy	Continence
	Social Engagement	Nutrition & Hydration	Pain
	Mobility & Falls	Delirium	Mood & Mental Health
	Skin Integrity	Function	Sleep

PGLO - Priorities 2022-23

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3. Clinical Services

Provincial

Provincial Geriatrics Leadership Ontario

Regional

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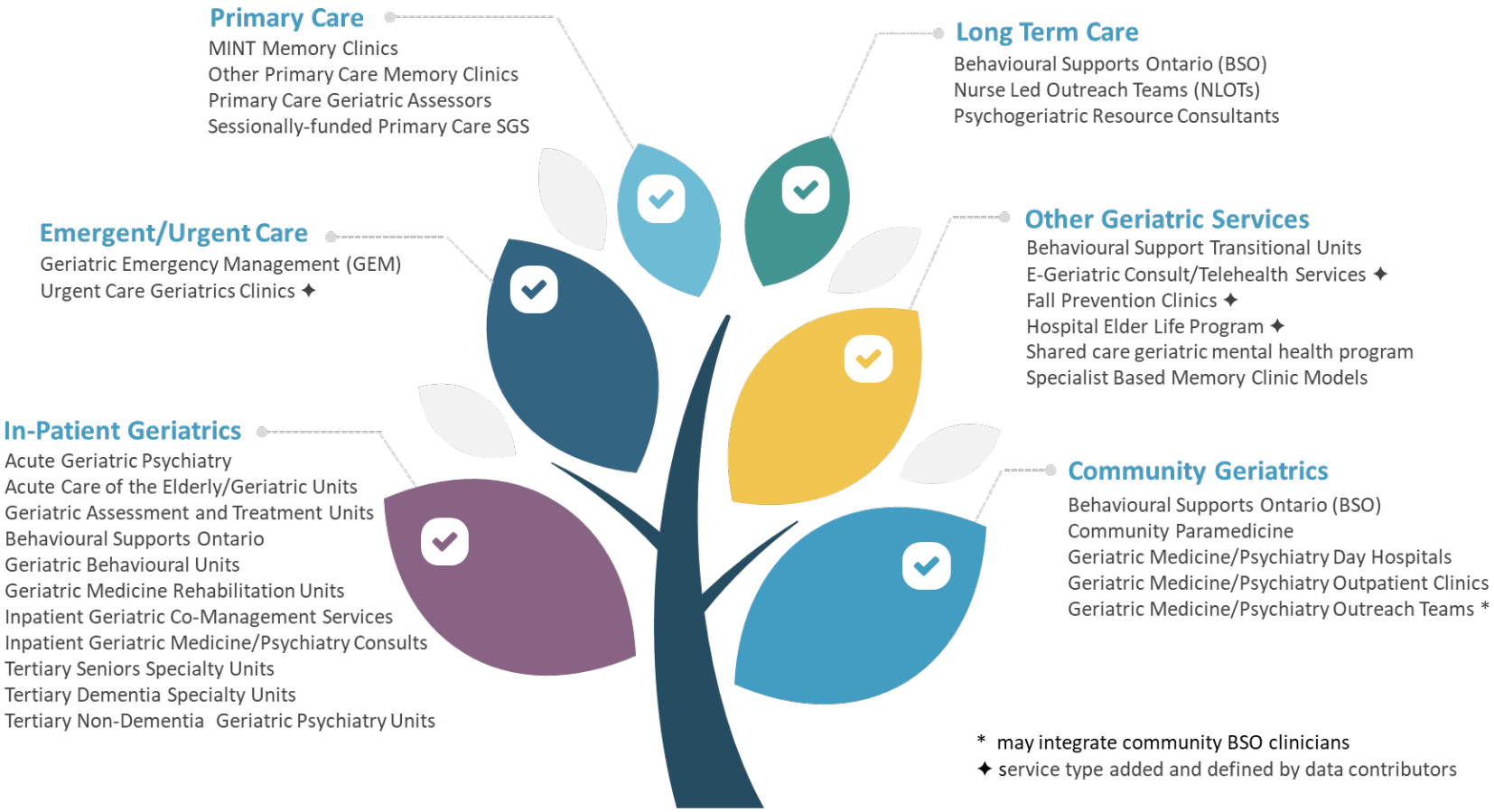
Local

Health Service Providers across the continuum of care



Primary Care
MINT Memory Clinics
Other Primary Care Memory Clinics
Primary Care Geriatric Assessors
Sessionally-funded Primary Care SGS

Long Term Care
Behavioural Supports Ontario (BSO)
Nurse Led Outreach Teams (NLOTs)
Psychogeriatric Resource Consultants

Emergent/Urgent Care
Geriatric Emergency Management (GEM)
Urgent Care Geriatrics Clinics ✦

Other Geriatric Services
Behavioural Support Transitional Units
E-Geriatric Consult/Telehealth Services ✦
Fall Prevention Clinics ✦
Hospital Elder Life Program ✦
Shared care geriatric mental health program
Specialist Based Memory Clinic Models

In-Patient Geriatrics
Acute Geriatric Psychiatry
Acute Care of the Elderly/Geriatric Units
Geriatric Assessment and Treatment Units
Behavioural Supports Ontario
Geriatric Behavioural Units
Geriatric Medicine Rehabilitation Units
Inpatient Geriatric Co-Management Services
Inpatient Geriatric Medicine/Psychiatry Consults
Tertiary Seniors Specialty Units
Tertiary Dementia Specialty Units
Tertiary Non-Dementia Geriatric Psychiatry Units

Community Geriatrics
Behavioural Supports Ontario (BSO)
Community Paramedicine
Geriatric Medicine/Psychiatry Day Hospitals
Geriatric Medicine/Psychiatry Outpatient Clinics
Geriatric Medicine/Psychiatry Outreach Teams *

* may integrate community BSO clinicians
✦ service type added and defined by data contributors

PGLO - SGS Asset Mapping Report

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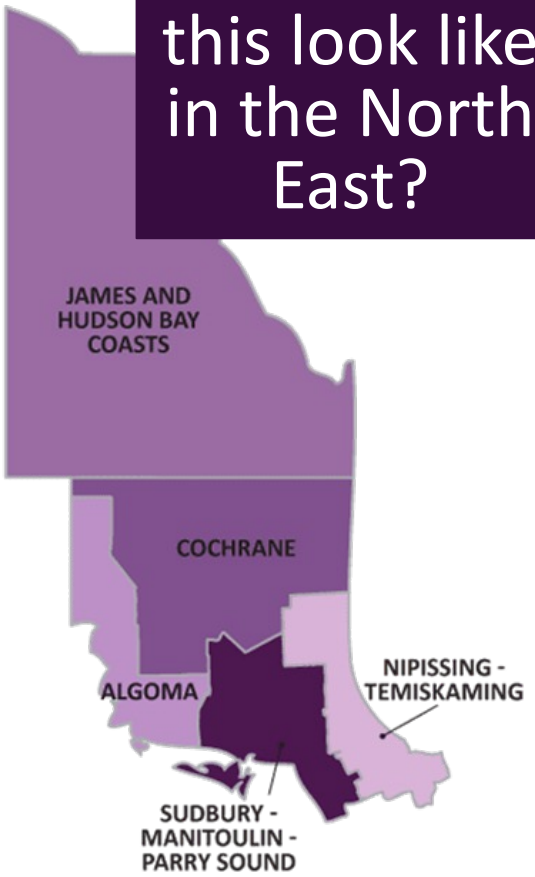
4. Current State Capacity

What does this look like in the North East?



Batch 1 Priority Locations

		Sudbury-Manitoulin-Parry Sound					Nipissing			Cochrane			Timiskaming			Algoma			James Bay Coast
COMMUNITY	Regional Outpatient Geriatric Medicine – Clinic	■								■			■			■			
	Regional Outpatient Geriatric Medicine – Outreach		■			■	■				■	■		■	■		■		■
	Geriatric Outpatient Rehab Service	■																	
	Seniors Mental Health	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
	BSO	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
ACUTE & POST-ACUTE	GEM	■	■				■									■			
	Geriatric Transitional Care																		
	Acute Care for the Elderly (ACE) Unit																		
	Geriatric Inpatient Consult Team	■																	
	Hospital Elder Life Program (HELP)						■												
	Bedded Transitional Care Capacity	■					■			■									
	Inpatient Geriatric Rehab																		
	Regional Tertiary Geriatric Psychiatry Beds						■												

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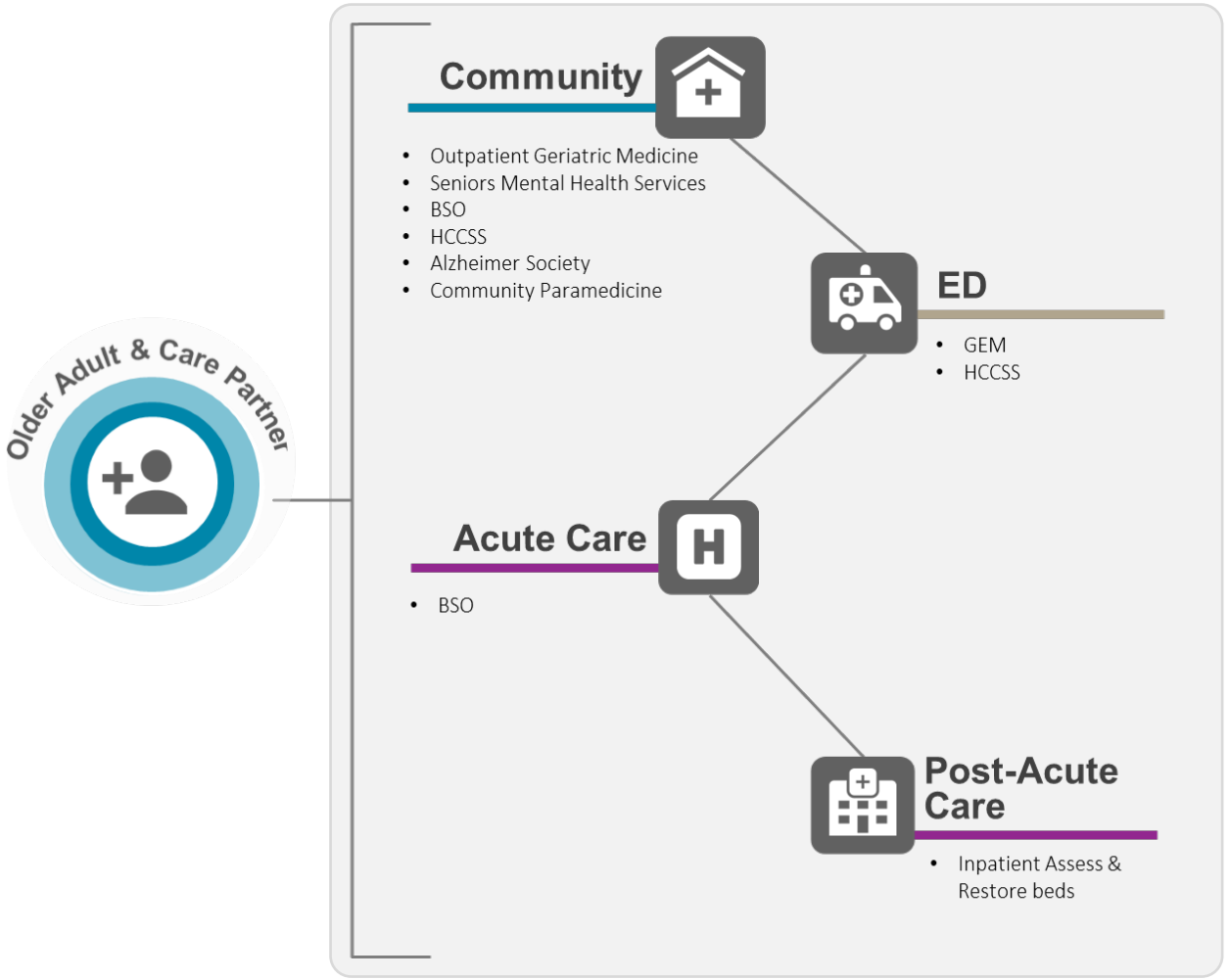
5. Planning Considerations

How does this all go together across the continuum to create a care pathway for older adults?

Current State Care Pathway

- What is the current scope/goal of each service?
- Who is part of your team?
- How are patients identified for each service?
- How does each service's assessment support identification of patient needs?
- What interventions are provided by each service?
- How do teams collaborate to provide optimal care to this population?
- How do patients transition between services and throughout the continuum?



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6. Future State Capacity Planning

What will this look like in the North East?

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COMMUNITY	Regional Outpatient Geriatric Medicine (Clinic)		■			■	■				■	■	■				■	■	
	Regional Outpatient Geriatric Medicine (Outreach)													■	■				■
	Geriatric Outpatient Rehab Service	■														■			
	Seniors Mental Health	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
	BSO	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
ACUTE & POST- ACUTE	GEM	■	■			■	■	■	■	■			■	■	■	■	■		
	Geriatric Transitional Care	■																	
	Acute Care for the Elderly (ACE) Unit																		
	Geriatric Inpatient Consult Team	■	■			■	■			■			■			■	■		
	Hospital Elder Life Program (HELP)	■					■												
	Bedded Transitional Care Capacity	■					■			■						■			
	Inpatient Geriatric Rehab	■																	
	Regional Tertiary Geriatric Psychiatry Beds						■												

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Building Forward

Enabling Future State Integration:

Community

- **Outpatient Geriatric Medicine**
- Seniors Mental Health Services
- BSO
- HCCSS
- Alzheimer Society
- Community Paramedicine
- **Outpatient Geriatric Rehab**

ED

- **GEM**
- HCCSS

Acute Care

- BSO
- **Geriatric Inpatient Consult Team**

Post-Acute Care

- **Inpatient Geriatric Rehab**

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