Central East **LHIN**

Regional *Specialized Geriatric Services* in the CE LHIN: Coordination, Organization and Governance

May 2011

Engaged Communities.
Healthy Communities.

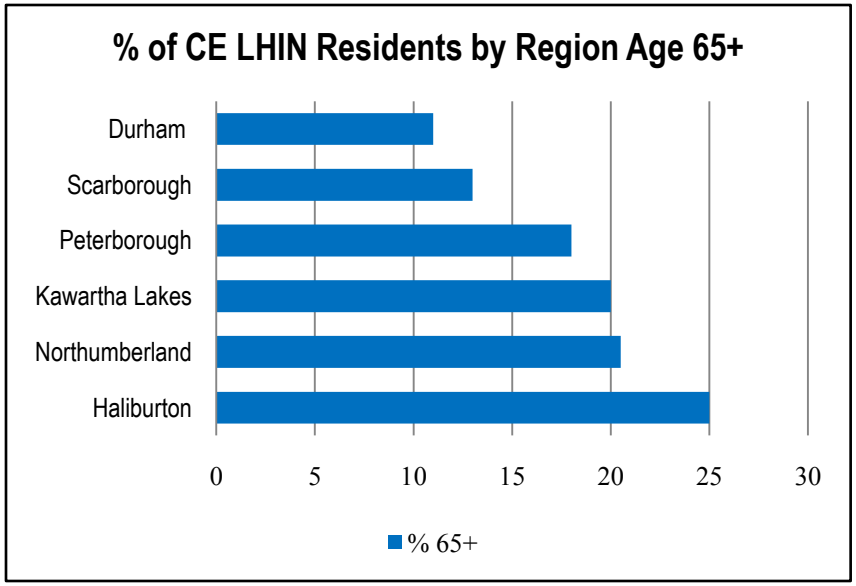
Ontario
Local Health Integration Network

The Need for an Integrated System for Frail Seniors…..

- The current system of health services for frail seniors is *inadequate*:
  - "Frustrating; confusing; duplication; unclear; need assistance to navigate; waiting for services" *(frail senior)*
  - "Little or NO access to SGS; multiple assessments with no action; insufficient expertise" *(service provider)*
  - "Aging clientele putting tremendous strain on the system; unsure how to connect or what is available" *(primary care provider)*
- Frail seniors have the most significant impact on the health system in terms of *utilization* and overall *performance*

The Need for an Integrated System for Frail Seniors…..

- Seniors 65+ in the CELHIN = 13.75%....however, significant regional variation:



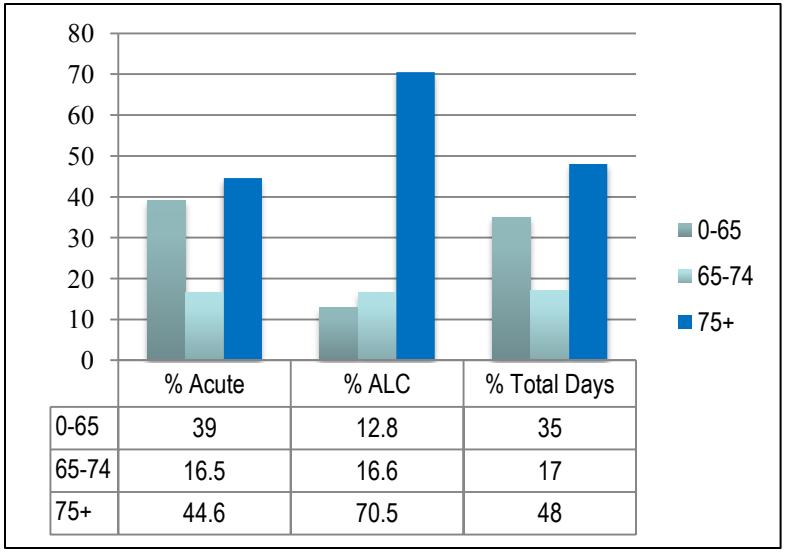
- Growth in seniors by 2019 is 19%; 47% for those >age 85!!

The Need for an Integrated System for Frail Seniors…..

- Aged 75+ in the CE LHIN ….. currently 6.5% of population
- However, utilizes *45% of all acute* hospital days and *70% of all ALC days*
- Seniors 75+ have increasing chance of *frailty*…a major determinant of health service utilization
- CE LHIN ALC days *grew 125%* over the last five years
- ALC continues to impact the *entire population*…limiting access to necessary health services for everyone

The Need for an Integrated System for Frail Seniors…..

- The ALC Issue = a frail senior issue:



	% Acute	% ALC	% Total Days
0-65	39	12.8	35
65-74	16.5	16.6	17
75+	44.6	70.5	48

The Need for an Integrated System for Frail Seniors…..

The situation is compounded by increasing prevalence of *dementia:*

- Affects *1 in 3 adults* over the age of 85…this age group projected to grow by 47% by 2019
- Dementia is the *top CMG* associated with ALC days = 12,199 days!
- Few alternatives for families/caregivers
- Early identification and coordination of preventative and supportive care services is desperately needed

Summary of Key Issues…..

- Current system is *unacceptable to the community*
- Limited coordination/integration of services on any level
- Lack of available services (see inventory gaps)
- Lack of access to services across the region
- Spending precious dollars …wrong place, wrong time
- Organizations are competing for resources …no "system" accountability
- Hospitals do NOT see seniors as their core business
- *The problem is getting worse exponentially!!!*

Project Scope…the Mission

- To examine the current state of affairs regarding the organization and delivery of SGS locally, provincially and beyond in order to recommend to the CE LHIN a starting point that would enable the integration of SGS and delivery of a coordinated system for the community

The Work Undertaken in the Project

- ✓ Creation of an Integration Framework to Guide the Work
- ✓ Development of Vision, Mission, Principles and Values
- ✓ Review of Integration Models (Provincial, National, International)
- ✓ Review of Integration Innovations across the Province
- ✓ Undertake Interviews with Champions from across the Province
- ✓ Determination of Key Components of the CE LHIN SGS Model
- ✓ Recommendation regarding the Governance Model
- ✓ Recommended Next Steps and Quick Wins

Models Reviewed: Integrated Models for Frail Seniors

- Programs of All-Inclusive Care of the Elderly *(PACE)*
- Comprehensive Home Option of Integrated Care for the Elderly *(CHOICE)*
- System of Integrated Care for the Frail Elderly *(SIPA)*
- Integrated Care (Italy)
- Program of Research to Integrate Services for the Maintenance of Autonomy *(PRISMA)*
- Hospital Admission Risk Program *(HARP)* – Australia
- Social Health Maintenance Organization *(S-HMO)*
- *Coordinated, Accessible Community Healthcare for Elders in Toronto (CACHET) – not implemented*
- *All Inclusive Seamless Services for Independence of Seniors for Today and Tomorrow (ASSIST) – not fully implemented*

Models Reviewed: Other Integrated Models

- Regional Geriatric Programs of Ontario *(RGP's)*
- Waterloo Wellington Geriatric Services Network
- North Simcoe Muskoka Seniors Health Program
- Northeastern Geriatric Program (Sudbury) – RGP affiliate
- Cancer Care Ontario
- Child Health Network
- GTA Rehab Network
- Many, many clinical and organizational integration successes

What Did We Learn…

- ✓ *There is an abundance of integration activity for frail seniors across the Province…many models are successful*
- ✓ *There is a strong desire and need for a Provincial Strategy*
- ✓ *Integration projects fail without the sustainable infrastructure that requires and rewards service provider integration*
- ✓ *There is a need for local leadership/championship to gain trust and move stakeholders forward*
- ✓ *The model moving forward must have five key features*

5 Key Features of the Recommended Model: CE Regional Specialized Geriatric Services (CE-RSGS)

1. Umbrella Organization
2. Control Over Funding
3. Service Providers are Organized around the Client
4. Other System Linkages (primary care)
5. System-level Case Management

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Key Features of CE Regional Specialized Geriatric Services: An Umbrella Organization

What?	Why?
• A centralized body for the regulatory and administrative functions of the system to eliminate the piecemeal way that seniors care is currently organized •Guides system planning (both strategic and annual service planning) •Responsible for creating the common vision and principles •Clear and shared accountability for outcomes for a specific population	• Eliminates inter-organizational complexities that impede integration •Streamlines decision-making •Forces accountability at a "systems" level by those with senior responsibility •Signals the importance of planning for the special needs of this population
Recommendation: Shared Governance Model with a Governance Authority/Board	

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Key Features of CE Regional Specialized Geriatric Services: Control Over Funding

What?	Why?
• funding is allocated by the accountable body to service provider organizations based upon activity, targets and the system-wide SGS strategic plan • existing SGS global funds are identified and protected • new funding is centralized and utilized to address regional service gaps, new priorities and leverage new partnerships	• must be able to allocate resources upstream to eliminate the downstream costs • can be used to leverage commitment to the goals and mission and vision *"If not compelled by strong policy or financial controls, providers will hold on to control of their budgets and services and some will simply choose not to participate"(MacAdam, 2008).*

Recommendation:

•The Governance Authority submits the Annual Service Plan to the LHIN and holds service providers accountable to deliver on agreed upon targets and outcomes

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Key Features of CE Regional Specialized Geriatric Services: Service Providers Organized (and client-focused)

What?	Why?
• creation of a formal relationship between SGS service providers in the system with expectations for collaboration and joint planning • a mechanism to streamline decision-making and facilitate joint planning between service provider organizations	• currently providers build services around their own organizations scope of services that they are responsible for...not the client • a mechanism to collaborate formally is required to ensure consistency and standardization across the region • ensures commitment to the vision at different levels in an organization

Recommendation:
Creation of *Service Operations Committee* reporting to the Governance Authority with SGS Service Providers responsible for execution of the system plan

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Key Features of CE Regional Specialized Geriatric Services:
Other System Linkages (e.g. primary care)

What?	Why?
• formal mechanisms to connect the SGS system of care with other parts of the system that it is dependent upon: -primary care -long term care -community support services, and -hospitals	• need to ensure that all health and social services are working together in "lock-step" • can be used to share information, gain trust and spread best practice beyond the service providers directly involved • encourage grass roots collaborations to flourish that are consistent with vision and principles

Recommendation:

Create primary care tactical team (foundational) to determine the most appropriate mechanism to "weave" primary care into the model

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Key Features of CE Regional Specialized Geriatric Services: System Level Case Management

What?	Why?
• a single system-level case management system that transcends organizational boundaries • provides for continuous assessment and re-assessment of client needs • the creation of individualized and dynamic service packages…no matter where the client resides or what services are needed	• the current system of health and social services is too complex for consumers to navigate •the current funding and legislative framework in Ontario does not support integrated case management • frail seniors are inherently vulnerable – early identification and close monitoring is essential

Recommendation:
Immediately undertake a demonstration project of frailty-focussed case management

What is needed from the CE LHIN…

- Take action…stakeholders are ready and we cannot afford to wait!!!
- Approval to proceed immediately with the recommendations outlined in the report with specific emphasis on:
    1. Creation of the *Governance Authority*
    2. Establishment of the *Secretariat* (infrastructure)
    3. Initiate the *Tactical Teams* related to central intake, primary care and case management
    4. Identification of *"host" organization*

What is needed from the CE LHIN…

- The Secretariat:
  - essential *administrative infrastructure* to organize and coordinate the system, projects, tactical teams, etc…
  - advocacy, leadership, "championship", overall *planning and coordination* for the governance authority
  - Executive Director, Medical Lead, Project/Inter-professional Lead, Admin support *(3.4 FTE's)*
  - 420k in 2011… *720k annualized funding* (SPO levy or LHIN sponsored)

Conclusions

- The current “system” of services for frail seniors is *NOT a system*
- This has created issues with poor access, inefficiency and ultimately has affected *quality of life*
- We need to put in place the infrastructure to move ”systems-thinking” forward:
  - WE need to ensure *better health* for frail seniors
  - WE need to ensure *better care* by being client-centered
  - WE need to demonstrate *value-for-money* around the client
  - WE need to act *now*…everyone is ready!

A Special Thank you to the Project Team

Project Leadership: Carol Anderson, LHIN Lead SGS Planning

Regional Geriatric Advisory Committee:

• Kate Reed	LHIN Lead for Implementation and Integration
• Dr. David Ryan	Regional Geriatric Program (RGP) Representative
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• Clara Tsang	GAIN Nurse Practitioner, RVHS
• Laszlo Cifra	Program Director, Aging at Home (CECCAC)
• Nancy Veloso	Director, The Scarborough Hospital (TSH)
• Pat Dingman	Interim Director, Lakeridge Health (LH)
• Sheryl Bernard	Director, Seniors Mental Health (Ontario Shores)
• Dr. Jenny Ingram	Geriatrician, PRHC
• Dr. Jim Park	Physiatrist /Physician with an Interest in the Elderly
• Randy Filinski	CE LHIN Seniors Advocate, Public Member

The Need for an Integrated System for Frail Seniors…..

A Story from Dr. Ingram