Resource Integration for Seniors in the Community (RISC)

Quality Improvement Within Existing Systems

Functional Integration

RISC – Key Elements

- Targeting – set of Inclusion/Exclusion criteria
- Comprehensive assessment
- Intensive case management
- Coordinated Primary care
- Rapid access to specialized geriatrics and community service bundle
- Care teams and joint care planning

Target Population

- 75+
- Frail & failing
- Difficulty with ADL/IADL
- Requiring support multiple agencies
- High users health care resources
- Inadequate or failing caregiver support
- Likely to benefit from RISC intervention

RISC - Benefit

System Benefit (ED and hospital avoidance)	$202,480
Additional Case Management Cost	$43,776 ($1,250/ client)
Total Benefit	$158,704
Total Benefit per client	$4,534

Lessons Learned

- Possible to use existing resources in new ways
- Case finding approach used was difficult to sustain
- Intensive case management a significant enabler of good client outcomes – clients need to be willing and able to participate
- High levels of client satisfaction

Regional Geriatric Program of Eastern Ontario

Programme gériatrique régional de l'Est de l'Ontario

Champlain Local Health Integration Network - Geriatric and Community Intervention Program

Aging at Home:
Connecting the Dots in Ontario and Beyond

June 22nd, 2009

Program Objectives

- Target high risk seniors presenting to, and discharged home from, nine Champlain region emergency departments (ED)
- Improve the quality and durability of ED discharges, in turn reducing return visits and admissions to hospital
- Integrate specialized geriatric services, community and primary care

- 67% repeat visits

57,868 Visits 75+

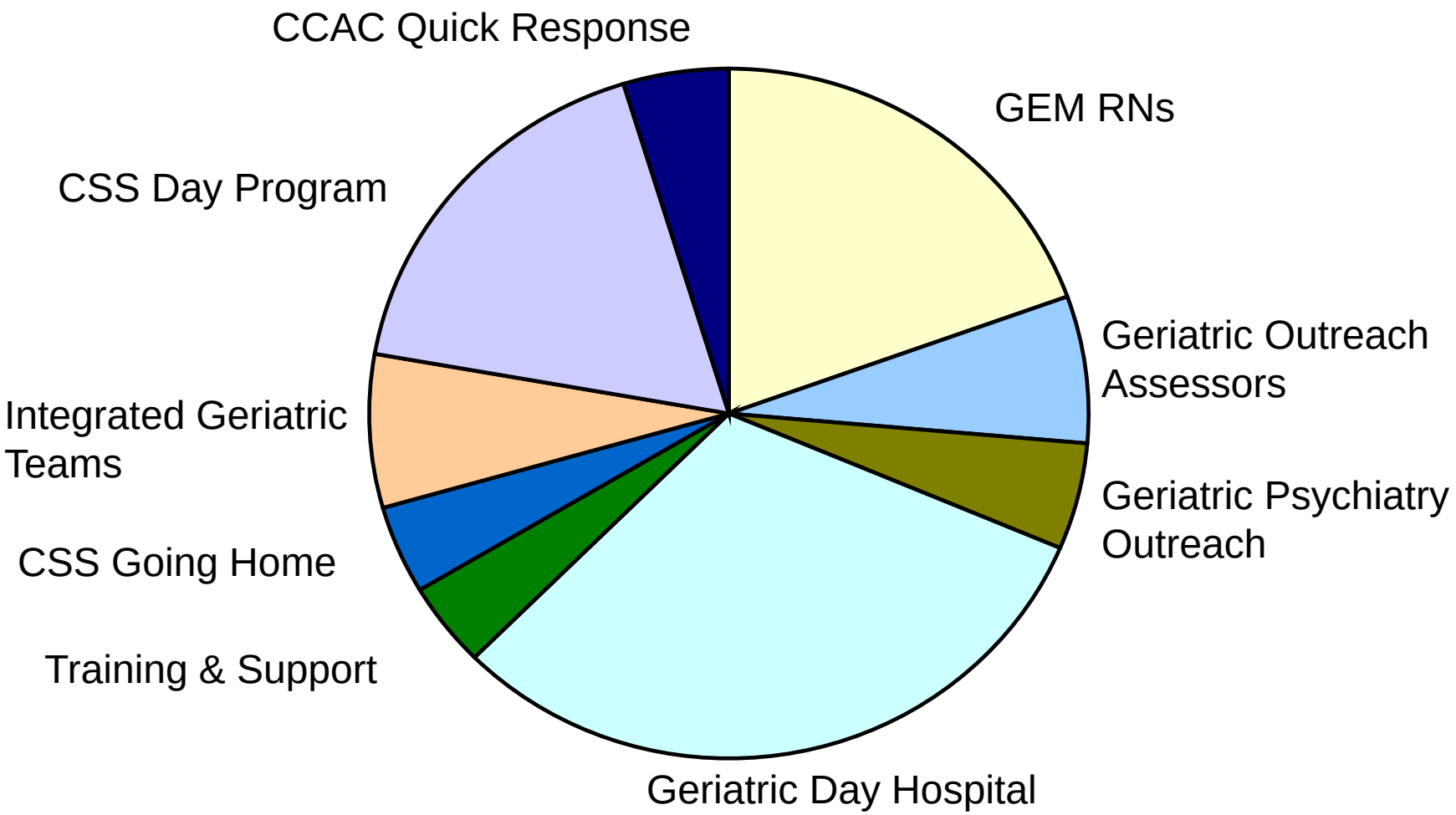
24,000 Screening Assessments

6,000 ISAR GEM Assessments & Referrals

Program Overview

- Geriatric Emergency Management (GEM)
  - Nurses at 9 sites across the region
  - Use a consistent evidence-based model for risk screening
- Geriatric and community service capacity in place for GEM support:
  - Expanded capacity in existing Geriatric Day Hospitals
  - New Geriatric Day Hospitals
  - Expanded capacity in Geriatric Day Programs

Integrated Follow up



Applying an Integrated Service Delivery Model

a. Clearly identified target population
b. Pooled resources: 8 hospitals and 28 community agencies linked with service level agreements
c. Shared governance structure: A project leadership team with nominated representatives from all sectors of the continuum of care
d. Coordinated access to a comprehensive range of geriatric and community services from hospital to home
e. Adherence to the geriatric principles of care: Detect and prevent in order to restore or maintain function and prevent excess disability

Results

- ED Utilization Data (Oct 2007 – March 2008)
  - 563 patients
  - Return visits to the ED within 30 days:

    15% lower than average
  - Subsequent inpatient admission within 30 days from ED visit:

    65% lower than average
  - Seen in the community by Specialized Geriatrics Service:

    30% within 7 days

    65% within 14 days
- No change to the median ED length of stay

Seniors' Impressions

- *" It was great that this service was available for us right here in the emergency "*
- *" I was impressed with how thorough they were. They really think of everything "*
- " I *walked into the ED with a bruised conscience, I walked out with hope and a smile "*

AGING IN PLACE

An Aging at Home Initiative

The Aging in Place Project

- Supported Housing initiative in Ottawa that integrates Champlain CCAC, Community Support Services and Ottawa Community Housing as lead partners
- Integrates client care partnerships with Public Health, Community Health Centres, RGP, primary care and other community agencies in the geographic areas

Target Population

- At-risk seniors living in social housing
- Seniors facing access barriers to health care
- Seniors at high risk for hospitalization
- Seniors at high risk of visiting the emergency room

Program Goals

- Clients have easy access to coordinated program services delivered on-site at no cost
- That these services are delivered as a seamless integrated bundle by CCAC, CSS and other partners
- Clients are linked to other community resources for ongoing needs
- To meet language of service needs - English, French, Mandarin and Cantonese
- To ensure that services support decreased emergency room visits and hospital stays

Program Components

- Outreach and Intervention
  - CM and CSOW on site in “store-front” offices in bldg
- Health promotion / health education
  - Public health sessions, individual interventions
  - Coordinated provision of CSS: transportation, meals, footcare etc
- Targeted enhanced services by NP,PSW, OT, PT, Nursing
- Targeted rapid response
  - NP, CM, allied health, CSOW
- Needs assessment – population health
- Partnership development / System integration

Outcomes

- Reduction in ER visits by 25% from baseline of original 5 buildings
  - Recent addition of NP and upcoming CCAC-ER notification expected to have a significant impact on ER-ALC indicator for this coming year.
- Client satisfaction survey: 100% high satisfaction, 85% stated AIP helped them remain in their homes

- Many anecdotal stories where the project made a difference to hospital discharge or diversion of admission