Facilitating Integration from the Community: Intensive Geriatric Service Worker Program

Janice Paul & Heather Higgs
October 21, 2010
Overview

- To describe the integrated service for frail, at-risk seniors in Waterloo Wellington
- To describe the Intensive Geriatric Service Worker program and highlight a success story
- To review interim evaluation findings and highlight lessons learned
What is an integrated system?

- A cohesive, coordinated model of delivering geriatric care
- Strong partnerships with stakeholders
- Evidence of improvement in patient outcome measures
- Capacity building
What does Integration Mean?

- Integrated team approach to complex issues
- Linkages across the continuum of care
- Targeted to high risk seniors
- Presently initiated: ED, ALC, SGS—“ripple effect”—flows across the continuum of care
How did We Get to Where We are Today?

- Health Accord Funding
- RGP Central – Support
- Networks
- Partnerships
- Environmental Scan
- Linkage with Academic Settings
- Evaluations
- Aging at Home Funding
Guiding Principles – High Level

- Senior Centered: services will respond to the need of seniors
- Community Based and Integrated: within broader health system
- Equitable: recognize demographic and geographic challenges
Guiding Principles Continued….

- Cost Effective: best care at optimal cost recognizing benefits of volunteerism and local community responses.

- Results Oriented: results defined and measured
System Accountability

- WWGSN - System of Care for Seniors –
- Accountability Agreements signed by all partners
- Data collection
- Ongoing integrated evaluations
Integrated Services for Seniors

Dr. John Yang

- Community
  - Coordinated Intake and E File
  - Specialized Geriatric Services
    - Common Specialized Assessment
      - Home Assessor CGS
      - Geriatric Assessment Unit
      - Neurobehavioural Unit
      - Clinical Assessor
      - GEM Nurses
        - Geriatric Clinical Nurse Specialist in Acute Care
      - Geriatric Medicine
      - Geriatric Psychiatry
  - Intensive Geriatric Service Worker
    - Supports
      - Community Support Services
      - CCAC Services
      - Addiction Services
      - Primary Care
      - Associations/Societies such as Alzheimer's, Parkinson's, Arthritis, CNIB, Hearing
      - Housing
      - Multi-Faith/Multicultural Communities

Flow of Seniors
Design Principles

1. Process capable of meeting need and demand
2. Process will deliver client value and demonstrate outcomes
3. Robust and Reliable
4. Uses and Improves Existing Infrastructure
5. Clearly defined operations that can be enabled with information technology.
6. Improves flow by minimizing all types of waste and by creating “pull”
7. Has positive impact on system goals
Intensive Geriatric Service Worker (IGSW)
Key Roles: IGSWs

- To implement care plans from GEM Nurses, acute care health team (including hospital CCAC Case Manager), or Specialized Geriatric Services

- To provide timely intensive support, transition and follow-up with primary care, specialty care & community support services

- To support person-centered self-directed care (i.e., coach seniors and caregivers)
IGSW Goals – Healthy, Happy, Safe
Referral Guidelines

- Frequent user of the emergency department
- Recent hospital admission (90 days) and/or ED visit (30 days)
- Complexity of needs (number and/or type of support required)
- Socially isolated
Referral Guidelines (cont’d)

- Resistant to assistance or support
- Ability to access services is limited due to financial reasons
- Language or cultural barrier
- MD or RN concern about ability to follow through with recommendations
- Caregiver burden, lack of caregiver support or long-distance caregiver
Referral Process

Senior in need

Community

ED

Assessment GEM and CCAC

Admit

Home

IGSW required

Assessment & Notes Faxed to IGSW Team

Care plan implemented

Hosp database

CCAC database

CCAC database

Trellis Caseworks Database

Hosp database

Processbook Website

Trellis Caseworks Database

Trellis Caseworks Database

Assessment SGS Geriatric Medicine Geriatric Psychiatry
Secure Web Portal for GEM referrals
Home Visit Appointment Slip

To guide and connect you with supports and services to help you in your home, you have an appointment with an Intensive Geriatric Service Worker:

IGSW Name: Sylvia DeSchiffart
Date: Wednesday, September 22, 2010
Time: 11:00 AM

If you are unable to keep the appointment, or have any questions please call:

(519) 772-8787 x 212 Waterloo - Community Support Connections

Your health information will be shared with your family doctor and other health partners involved in your care. (PHIPA; IPC Brochure Circle of Care: Sharing Personal Health Information for Health-Care Purposes; lpc.on.ca)
IGSW Qualifications

- Recruitment - IGSWs cross-section of academic preparation:
  - Gerontology
  - Rec therapy
  - Sociology
  - Pastoral Care
  - Psychology
  - Social Services

- Geriatric experience within the team:
  - Community support
  - Long-term care
  - Mental Health
  - Community Ministry
  - Retirement Home
  - Day Program
  - Private Home care
  - Acute Care
  - Rehab

- Language, ethnicity, culture
  - German, Italian, Dutch, French, Portuguese, Mennonite
Celebrating Success
Case Review

ED Presentation:

- 87 year old female that a neighbour found wandering in hallway of apartment building.
- The neighbour noticed an increase in confusion and arranged for EMS to take her to the hospital.
- In the ED she admits she was wandering around as she was seeing people in her apartment, including her dead husband. This has been happening for quite some time.
Comprehensive GEM Assessment

Social / Functional:
- Manages bathing / dressing on her own. No trouble toileting.
- Walks with no aid, but has had several falls “more than I can count”.
- Reports difficulty managing medications often forgets if she has taken them or not (this also was evident from her blood work).
- Meals are a gap, her neighbour assists with groceries but she admits she is not eating well. She relies on taxis or her neighbour to get around.
- Is interested in retirement living but does not know how to go about it.

Cognition:
- Admits her memory is poor “My head is all messed up”. MMSE 23/30.
- She was also having ongoing hallucinations.
After the GEM assessment, it was clear that this women would benefit from and do well with IGSW support. A plan for discharge was created and included:

1. Referral to geriatrics (further cognitive assessment and falls assessment)
2. CCAC to assess
3. IGSW to assist arranging meals on wheels, attending appointments, looking at retirement options and medications compliance.
IGSW bridge a huge gap. GEM was able to book an IGSW appointment prior to ED discharge.

- Historically, discharge suggestions are made to patients, followed-up by CCAC and few suggestions are followed through by patients. (forget, don’t see importance, confused)
- Discharge suggestions forwarded to IGSW, ‘Smart Goals’ and for this patient, every recommendation has been met and more
Home in the Community

- Client seen by IGSW in her home less than 24 hours after discharge, joint visit with CCAC Community Case Manager.

- During visit, extra medications cleaned out and returned to pharmacy. ( Entire shopping bag filled including medications over 10 years old that she brought when she moved from Toronto ).

- Client was concerned she missed a pacemaker appointment, called to confirm date of appointment.

- Plans made to accompany client to pacemaker clinic next week.
The hospital has recommend the following for you:

- Book a follow up visit with family doctor
- Appointment with Geriatrician
- Visit and choose retirement home
- Ensure correct medications are taken at the correct time
- Meals on Wheels

I will work with you to arrange the above. I am also happy to go with you to these appointments.

Heather Higgs, IGSW
519-772-8787 x 219
To date

- Arranged for Meals on Wheels
- Arranged for medication to be put in a blister pack
- Accompanied to Pacemaker appointment, drugstore and bank
- Accompanied to Geriatrician
- Accompanied to Family Doctor
To date (cont’d)

- Toured 3 different retirement homes
- Accompanied to the lab for weekly blood work
- Arranged for move to retirement home
- Follow up visit with Geriatrician
- Seen in May – moved to retirement home by end of June.
Currently

- Using walker
- Now settled at retirement home and is happy with the move. She is aware she was not coping at home.
- Now eating better (hadn’t cooked since husband passed away several years ago).
- INR levels regulated
- Memory is improving
- Hallucinations have stopped
- Now socializing regularly – was very isolated before
- Now safe
- Family now visiting weekly. At home family was calling but not visiting.
It Takes a Village

- Meals on Wheels
- CCAC services including Occupational Therapy, PSW and nursing
- Pharmacy Assistant
- Primary Care doctor
- Geriatrician
- Friend/Family
- IGSW
Ongoing involvement:

- Accompanied to follow up Geriatrician appointment
- Geriatrician very pleased with her progress and wrote in client’s file: “Since last being seen she has flourished.”
- Plans to accompany to 2 more appointments
- Client now confident she can attend appointments on her own or arrange through family.
“I couldn’t believe it and everybody was so nice. I wish everybody could have the service I had.”
Waterloo Wellington
Integrated Services for
Seniors - Interim Evaluation

Evaluators
Carrie McAiney, PhD
Loretta Hillier, M.A.
## Referrals

<table>
<thead>
<tr>
<th>Total # of clients referred to IGSWs</th>
<th>Percentage (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Guelph site</td>
<td>42% 351</td>
</tr>
<tr>
<td>Waterloo site</td>
<td>38% 38%</td>
</tr>
<tr>
<td>Cambridge site</td>
<td>20% 38%</td>
</tr>
</tbody>
</table>

| Clients served by IGSWs             | 95% (334)      |
|                                     |                |

<table>
<thead>
<tr>
<th>Reasons clients were not served</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>service was not needed</td>
<td>1.4% (5)</td>
</tr>
<tr>
<td>client refused service</td>
<td>0.3% (1)</td>
</tr>
<tr>
<td>client died before first IGSW visit</td>
<td>0.6% (2)</td>
</tr>
<tr>
<td>clients waiting to be served</td>
<td>2.6% (9)</td>
</tr>
</tbody>
</table>

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## IGSW Activities

<table>
<thead>
<tr>
<th>Activities</th>
<th>Percent (#) of Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Contact</td>
<td></td>
</tr>
<tr>
<td>• <em>face-to-face</em></td>
<td>32%</td>
</tr>
<tr>
<td>• <em>telephone</em></td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>37%</td>
</tr>
<tr>
<td>Collateral services/consultation/collaboration</td>
<td>19%</td>
</tr>
<tr>
<td>Documentation</td>
<td>19%</td>
</tr>
<tr>
<td>Administration</td>
<td>13%</td>
</tr>
<tr>
<td>Travel</td>
<td>12%</td>
</tr>
</tbody>
</table>

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## Discharges

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # of clients discharged</td>
<td>132 (38%)</td>
</tr>
</tbody>
</table>

Among existing clients:
- avg. length of time on service: 89 days
- range: 1 – 248 days

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## Reasons for Referral

<table>
<thead>
<tr>
<th>Activities</th>
<th>Percent (#) of Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD / RN concern; Recommendation f/up</td>
<td>58%</td>
</tr>
<tr>
<td>Social isolation</td>
<td>52%</td>
</tr>
<tr>
<td>Recent hospital or ED visit</td>
<td>50%</td>
</tr>
<tr>
<td>Caregiver burden / lack of support</td>
<td>42%</td>
</tr>
<tr>
<td>Complex needs</td>
<td>40%</td>
</tr>
<tr>
<td>Resistance to service / support</td>
<td>24%</td>
</tr>
<tr>
<td>Service access issues due to finances</td>
<td>10%</td>
</tr>
<tr>
<td>Frequent use of ED</td>
<td>6%</td>
</tr>
<tr>
<td>Cultural / Language barrier</td>
<td>4%</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>1%</td>
</tr>
</tbody>
</table>
## Client Characteristics

<table>
<thead>
<tr>
<th>Age</th>
<th>Mean</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80 years</td>
<td>48 – 95 years</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>36%</td>
<td>64%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Widowed</th>
<th>Married</th>
<th>Divorced / Separated</th>
<th>Single</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>45%</td>
<td>30%</td>
<td>12%</td>
<td>9%</td>
</tr>
</tbody>
</table>

| No family physician | 5% |

| Not involved with CCAC | 16% |

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# IGSW Experience

<table>
<thead>
<tr>
<th></th>
<th>GEM</th>
<th>IGSW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not have to wait long to see…</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Agree</td>
<td>74%</td>
<td>83%</td>
</tr>
<tr>
<td>- Disagree</td>
<td>6%</td>
<td>0</td>
</tr>
<tr>
<td>- Neutral</td>
<td>6%</td>
<td>17%</td>
</tr>
<tr>
<td>Satisfaction with amount of time spent with…</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Agree</td>
<td>99%</td>
<td>97%</td>
</tr>
<tr>
<td>- Disagree</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- Neutral</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Greater understanding of my condition as a result of interaction with…</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Agree</td>
<td>86%</td>
<td>90%</td>
</tr>
<tr>
<td>- Disagree</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- Neutral</td>
<td>11%</td>
<td>10%</td>
</tr>
</tbody>
</table>
IGSW: Other Impacts

<table>
<thead>
<tr>
<th>Impacts as a result of assistance from the IGSW</th>
<th>IGSW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your ability to take care of yourself…</td>
<td></td>
</tr>
<tr>
<td>• Worse now</td>
<td>0</td>
</tr>
<tr>
<td>• About the same</td>
<td>13%</td>
</tr>
<tr>
<td>• Better now</td>
<td>83%</td>
</tr>
<tr>
<td>Your knowledge of who or what organization to call for services you need</td>
<td></td>
</tr>
<tr>
<td>• Worse now</td>
<td>0</td>
</tr>
<tr>
<td>• About the same</td>
<td>27%</td>
</tr>
<tr>
<td>• Better now</td>
<td>67%</td>
</tr>
<tr>
<td>Your ability to meet your goals for better health</td>
<td></td>
</tr>
<tr>
<td>• Worse now</td>
<td>0</td>
</tr>
<tr>
<td>• About the same</td>
<td>0</td>
</tr>
<tr>
<td>• Better now</td>
<td>100%</td>
</tr>
</tbody>
</table>
# IGSW: Other Impacts

<table>
<thead>
<tr>
<th>Impacts as a results of assistance from the IGSW</th>
<th>IGSW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Your health</strong></td>
<td></td>
</tr>
<tr>
<td>- Worse now</td>
<td>0</td>
</tr>
<tr>
<td>- About the same</td>
<td>37%</td>
</tr>
<tr>
<td>- Better now</td>
<td>57%</td>
</tr>
<tr>
<td><strong>Your knowledge about when you need to go to the ED</strong></td>
<td></td>
</tr>
<tr>
<td>- Worse now</td>
<td>0</td>
</tr>
<tr>
<td>- About the same</td>
<td>60%</td>
</tr>
<tr>
<td>- Better now</td>
<td>37%</td>
</tr>
<tr>
<td><strong>Your ability to talk to doctors and other health professionals about your health</strong></td>
<td></td>
</tr>
<tr>
<td>- Worse now</td>
<td>0</td>
</tr>
<tr>
<td>- About the same</td>
<td>73%</td>
</tr>
<tr>
<td>- Better now</td>
<td>27%</td>
</tr>
</tbody>
</table>

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Summary of the Ways in Which the IGSWs were Helpful to Patients/Caregivers

Increased access to community support services (16)
(e.g., system navigation, Meals on Wheels, home help, personal care, grocery shopping service, Lifeline, friendly visiting, adult day programs, Alzheimer Society)

Accompanied client to appointments (14)
(e.g., medical appointments, visit housing options, day programs, pharmacy, errands)

Emotional support (14)
(e.g., someone to talk to at length about concerns, morale support, support to caregivers – understanding and managing dementia related behaviours)

Increased access to information (13)
(e.g., information on illness, symptoms, management strategies, housing options, internet access – improved computer skills)

Increased access to transportation (10)
(e.g., arranged transportation, assisted with application for paratransit/ senior’s service, or bus pass)

Assistance with a variety of tasks (10)
(e.g., correspondence client could not understand, preparation of questions for doctor’s appointment, interpretation of doctor’s recommendations, arranging for income tax form preparation, management of hoarding behaviours, home safety/ fall prevention, smoking cessation)

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Summary of the Ways in Which the IGSWs were Helpful to Patients/Caregivers (cont’d)

Arranged appointments (5)
(e.g., with doctors, dentists, medication review)

Follow-up calls and visits (3)
(e.g., ensures clients are well, questions if they assistance)

Communication with family members (3)
(e.g., provides clients’ children with updates/ information on health status)

Arranged for interventions/ equipment (2)
(e.g., physiotherapy, home equipment such as raised toilet seat, grab bars, walkers)

Ensured compliance with treatment recommendations (2)
(e.g., adherence to medication regime, diet)

Identification of issues within the home (1)
(e.g., issues that can only be identified by home visit such as safety issues)

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IGSW: Other Impacts

Do you think the help you received from the IGSW has helped to keep you out of hospital or from visiting the ED?

Yes: 53%
No: 20%
Not sure: 27%

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Satisfaction with IGSW Service

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“IGSW has gotten me a lot of help. I've had more visitors in the past 2 months then in the past 2 years. I told the nurse that came by the other day that my mood is better and she asked if I'm ever depressed and I said it's been at zero for quite some time now. “

“She has helped us with a lot of things and this has really made us feel more confident about being here at home and staying here a bit longer before we need to move to somewhere when we need more assistance. When she says she going to do something, she does it, and it’s always good to work with someone who's dependable. “

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### Evaluation: Next Steps

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue to collect information on referrals &amp; activities</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Work with LHIN and hospitals to obtain more data on ED and hospital utilization</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Surveys/Interviews with patients and caregivers</td>
<td>Sept/Oct 2010 Jan/Feb 2011</td>
</tr>
<tr>
<td>Survey of health professionals</td>
<td>January 2011</td>
</tr>
<tr>
<td>Stakeholder interviews</td>
<td>January 2011</td>
</tr>
</tbody>
</table>

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Lessons Learned: IGSWs

Facilitating Factors:

- Cross-sector representation in planning role
- Formation of: Implementation & Operational Working Groups
- Hiring all 9 IGSWs at the same time
- IGSWs hosted by a variety of community organizations
- IGSW Lead role
- Strong partnership CCAC
- Good IT support
- Development of SMART goals
Lessons Learned: IGSWs

- Roles belong to the system not one agency
- Collaborative approach with GEM Nurses, SGS and Acute Care – GEM support does not end when senior leaves the hospital
- IGSWs are part of the Circle of Care
- Communication
Lessons Learned: IGSWs

Challenges:
- Differing cultures of the various IGSW host agencies
- Role clarity
- Lack of uniform information system (available to all sectors) for tracking clients in both community & hospital

Service Delivery Issues that Threaten IGSW Effectiveness:
- Keeping up with increasing demands for service
- Maintaining client flow
- Managing unrealistic goals from referral sources
Questions
Contact Information

- Janice Paul – Intensive Geriatric Service Worker Lead: 519-576-2333 x 277, cell 519-400-8176, jipaul@trellis.on.ca
- Heather Higgs – Intensive Geriatric Service Worker hhiggs@trellis.on.ca
- Jane McKinnon Wilson – Waterloo Wellington Geriatric Systems Coordinator: jmckinnon@trellis.on.ca
- Maria Boyes – GEM Clinical Resource Consultant: mboyes@cmh.org
- Carrie McAiney – Lead Evaluator: mcaineyc@mcmaster.ca