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

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>System Benefit (ED and hospital avoidance)</td>
<td>$202,480</td>
</tr>
<tr>
<td>Additional Case Management Cost</td>
<td>$43,776 ($1,250/ client)</td>
</tr>
<tr>
<td>Total Benefit</td>
<td>$158,704</td>
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<tr>
<td>Total Benefit per client</td>
<td>$4,534</td>
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</tbody>
</table>
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
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

- CCAC Quick Response
- GEM RNs
- Geriatric Outreach Assessors
- Geriatric Psychiatry Outreach
- Geriatric Day Hospital
- CSS Day Program
- Integrated Geriatric Teams
- CSS Going Home
- Training & Support
Applying an Integrated Service Delivery Model

- Clearly identified target population
- Pooled resources: 8 hospitals and 28 community agencies linked with service level agreements
- Shared governance structure: A project leadership team with nominated representatives from all sectors of the continuum of care
- Coordinated access to a comprehensive range of geriatric and community services from hospital to home
- 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