Development of the G-Care Team, Canadian Mental Health Association Lambton

April 29th, 2010

RGP's of Ontario

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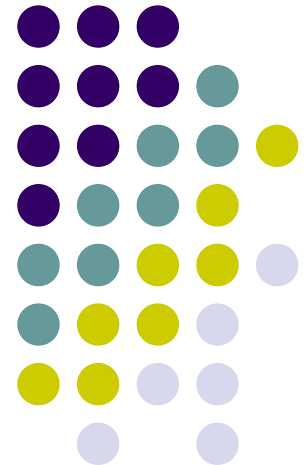
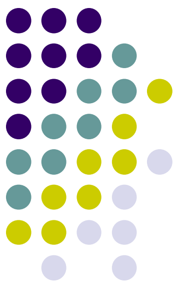
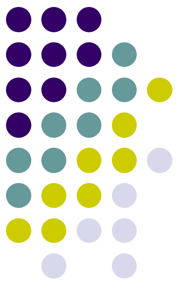


Background



- Demand for services exceeded the capacity, gap identified for geriatric and geriatric mental health services for Sarnia-Lambton
- Reduction in resources with the elimination of 2 PRC roles in 2009, leaving 1 geriatric assessor to support a growing geriatric population (14,180)
- Crisis situation – 4-6 month wait for assessment, no geriatric MH treatment services for seniors living in their homes or LTC
- 10 LTC homes, no GEM nurses at Bluewater Hospital

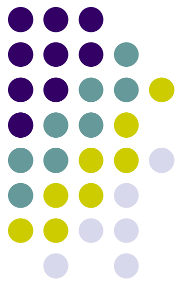
Quick Facts - LHIN 1



The Erie St. Clair LHIN

- Chatham-Kent, Sarnia/Lambton and Windsor/Essex, an area with a population of approximately 650,000 people

Quick Facts - Sarnia Lambton

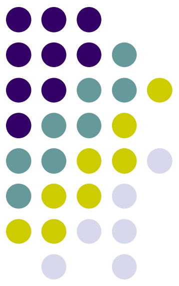


- Sarnia/Lambton population 132,000

Population Profile *(Based on 2006 Census Data)*

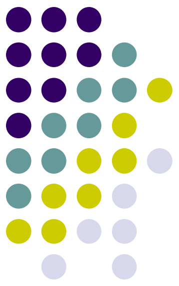
Erie St. Clair LHIN	2006 % population 65=	2010 % Population 65+	2016 % Population 65+
Sarnia/Lambton	16.3	17.8	21.2
Chatham/Kent	15.3	16.0	18.4
Windsor/Essex	12.5	12.9	14.4

LHIN Mental Health Working Committee



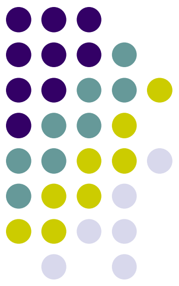
- Erie St. Clair LHIN formed the Sarnia/Lambton Geriatric Mental Health Working Committee
- Mandate – to develop a business case to provide enhancements for specialized geriatric mental health services for Sarnia-Lambton
- LHIN Specific goals -proposal had to…
  - reduce avoidable ED visits by providing interventions in the home/LTC
  - provide seniors MH services
  - leverage existing resources, partnerships, collaborations

LHIN Mental Health Working Committee

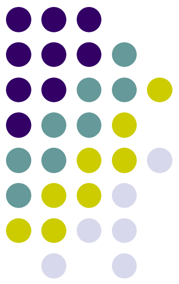


- Business case developed requesting funds to develop a geriatric mental health outreach team
- Year 1 – Focus on LTC
- Goal to improve early identification of residents with mental health and behavioural issues, and provide specialized geriatric mental health assessment, treatment, care planning, and follow-up
- Year 2 -expand into community

Aging at Home –Funding received



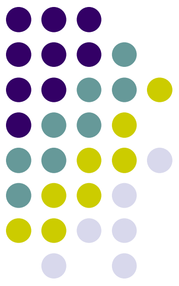
- Aging at Home funding received in the Fall of 2009
- Canadian Mental Health Association Lambton Branch host agency
- LHIN decided to continue the MH Advisory committee to support the LHIN in Sarnia/Lambton



Implementation of the Geriatric Care Team

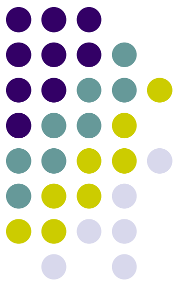
Using a Phased approach

CMHA Lambton’s Specialized Geriatric Mental Health Team



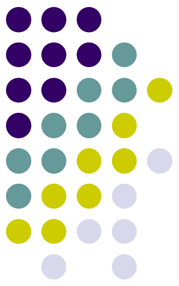
- Shortened name to Geriatric CARE Team for ease of use
- **C** – Compassionate
- **A** – Accessible
- **R** – Recognize uniqueness of every client
- **E** – exemplary care

Target Population



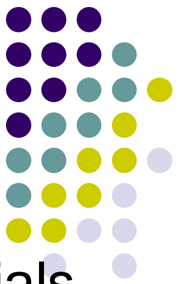
- Older adults with emotional or behavioural problems related to conditions such as:
- Dementia, delirium, mental illness
- Criteria for referrals: attention seeking behaviour, wandering, challenging behaviours (screaming, yelling, swearing), changes in behaviour (physical/verbal aggression, sleep disturbance, poor appetite, loss of interest), delirium, increased confusion, paranoia, hallucinations or delusions , depression, resistance to care, disinhibited behaviours

Program Goals



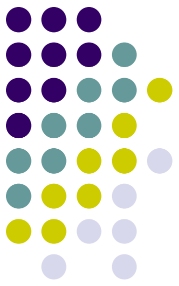
- Enhance the quality of life of older age adults in a long term care setting
- Provide support and education to families, caregivers and staff
- Promote early intervention
- Reduce emergency room visits and psychiatric admissions

Program Time Line



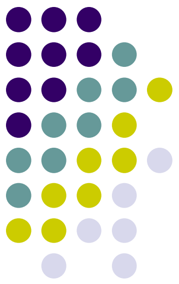
- November and December 2009 – program development - focused on recruiting the team, reviewing best practice materials, identifying assessment process and tools – started to pilot program with a few clients
- January 2010 – official launch of program – provided information to each of 10 LTC homes in Lambton County through meetings with Directors of Resident Care and staff – provided program brochures, posters and referral forms – further program development including intake process, assessment documentation, staff education – received several referrals
- February 2010 – OT started with the team, connected with community partners, developing the PRC role
- March 2010 – connecting with community partners (meeting with SWOGAN, presentation to Alzheimer's Society)
- April 2010 – started program evaluation process, staff education, on target for referral numbers

Geriatric CARE Team Members



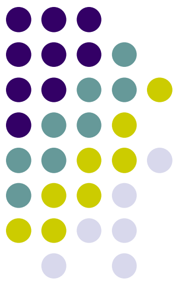
- Under the leadership of the agency Nursing Program Lead, outreach services are provided by a multidisciplinary team
- Initially a Team Psychiatrist was recruited
- 3 RNs were hired with a background in geriatrics and mental health , one RN is the PRC but carries a small caseload
- Then OT was recruited – this role provided 10 hours per week of support to the team completing supplementary assessments for clients involved with the program

Referral Process



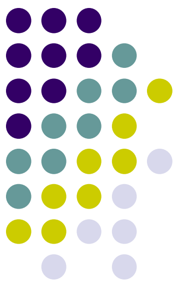
- Referrals must be initiated by the Physician providing care to the resident of the LTC home
- One page referral form is completed and sent to CMHA
- Referrals are reviewed weekly by the team and a Nurse is assigned
- The LTC home staff are contacted with an update regarding the plan for follow up

The Assessment Process

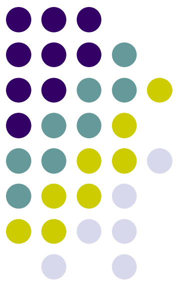


- The Nurse attends the LTC home within a few days of receiving the referral to start the assessment
- The Nurse shares information with the Geriatric CARE team at weekly rounds meetings to identify recommendations (both non-pharmacological and pharmacological)
- Recommendations along with a comprehensive assessment are provided to the LTC home in writing
- During the assessment phase visits from the team may be weekly then as the situation improves visits are spread out every two weeks and near discharge may be monthly – this allows the LTC staff time to implement the recommendations and the team time to monitor for any changes – if the client's status deteriorates meeting frequency is increased based on need
- Team members work closely with LTC staff exchanging information and providing teaching/support
- Team Geriatric Psychiatrist meets with every client
- As the client is discharged from the service, a written discharge summary is provided to the LTC home
- The resident may be referred back in future if concerns arise

Program Indicators



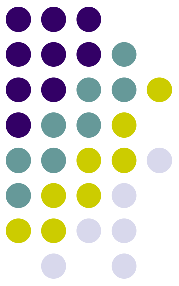
- Monitored and recorded on monthly basis starting in Jan/10 (the 3 RNs track this information for each of their clients)
- # Psychiatry contacts with clients
- # of resident contacts
- # of clients admitted for psychiatric hospitalization
- # of Geriatric CARE staff consults with team Psychiatrist
- # of consults with LTC staff



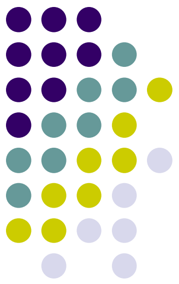
Success to Date

- Have received referrals from all 10 LTC homes in Lambton County
- Nursing staff have been given remote access to database at one home and more homes are interested – this is on a read only basis
- Psychiatric hospital admissions have declined
- LTC staff are implementing strategies and recommendations
- Linkages with community partners are strengthening

Next Steps Moving Forward



- Further program development (polices/procedures)
- Continued education for team members
- Program evaluation expanding to clients, families, front line staff
- Strengthening partnerships
- In future moving into community



QUESTIONS?