



**Specialized Geriatric Services  
Expansion and Strengthened Access  
Mechanisms for At Risk Seniors in  
the Mississauga Halton LHIN**

April 29, 2010  
RGP of Ontario Conference  
Dr. Barbara Clive and Raymond Applebaum

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**Presentation Objectives**

- To provide an update on the Regional Geriatric Program Model in MH LHIN, and the SGS Task Force Activities supporting the expansion of specialized geriatric services across the LHIN

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**Presentation Objectives**

- To share the development of the ASSIST Access, Information and Referral and Intake Project – which is strengthening the risk identification and access mechanisms for community dwelling seniors and caregivers to the range of healthcare services, including Specialized Geriatric Services

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## Outline



- Context: Ontario's Aging at Home Strategy
- Update on Specialized Geriatric Services in the MH LHIN
- Update on the ASSIST Access, Information, Referral and Intake Project
- ASSIST Project - Test Phase Measurement Plan
  - Preliminary Results – First 60 days of Test Phase
- Observations and Next Steps - ASSIST
- Questions and Answers

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## Context: Ontario's "Aging at Home Strategy"



### Overall Objectives:

- Increase community support services capacity for seniors
  - Support frail seniors' to remain safely at home
  - Promote seniors' health and wellness
  - Provide alternatives to LTC placement
- Reduce acute care pressures through reduced ALC days
- Reduce unnecessary ER visits by seniors

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## SGS -Definition:



- Specialized Geriatric Services (SGS) are defined as interdisciplinary services which diagnose, treat and rehabilitate frail elders with complex and multiple medical, functional and psychosocial problems (LeBlanc, 2005).

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# MH LHIN - SGS Task Force Members



Dr. Barbara Clive, Geriatric Medicine Lead, MH LHIN  
 Priti Patel, Senior Lead, Health Systems, MH LHIN  
 Kim Kohlberger, SGS Project Lead, HHS  
 Susan Bisallion, Director ER & Medical Health Systems, THC  
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 Eileen Bourret, APN, Seniors Health Team, THC  
 Dr. Richard Shulman, Medical Director, Seniors Mental Health Services, THC  
 Nicole Rodney, Mental Health Systems, THC

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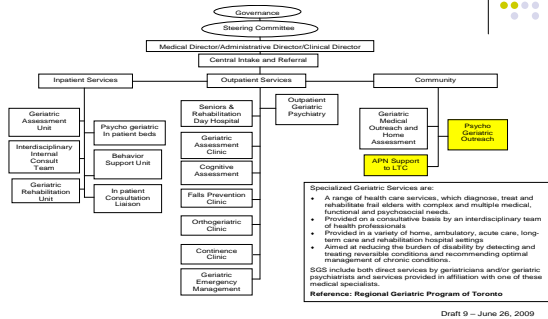
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## SGS - Aging at Home Year 1




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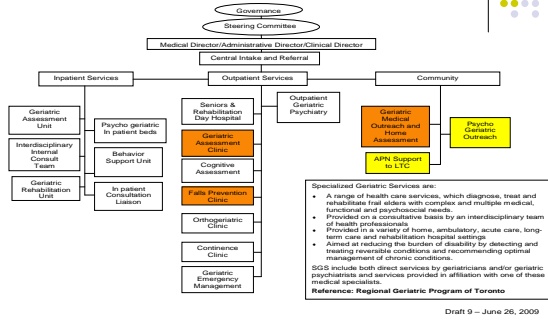
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## SGS - MH LHIN Aging at Home Year 2




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## ASSIST Access, Information, Referral and Intake Project – Overview of Model



The ASSIST project sets a new benchmark for the improved performance of access, information, referral and intake practices across the 16 participating organizations in the Mississauga Halton LHIN area

Key features of the ASSIST Access, Information, Referral and Intake model include :

- Common Referral Processes and Protocols
- Common Intake and Referral Tool
- Common Risk Screening Tool (within Intake and Referral Form)
- Common User Friendly Service Definitions
- Common Communications Methods and Tools (CSP, Family MD Follow-ups, etc)

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## The Opportunities



### Collaboration from the Start

- The All-Inclusive Seamless Services for Independence of Seniors' Today and Tomorrow (ASSIST) is a broad service delivery conceptual model for seniors and their caregivers
- ASSIST Conceptual Model was collaboratively planned from the outset – led by the Seniors Health and Wellness Advisory Committee
- The ASSIST Access, Information, Referral and Intake Project is one component of the broad conceptual service delivery model.

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## ASSIST - Value Stream Analysis: Current State (as of Feb 2009) of Intake Referral Process



- The ASSIST Access, Information, Referral and Intake project, was launched by a group of 24 front-line and management staff using a Value Stream Analysis (VSA) *Lean Quality Improvement* Planning Session held in February 17-20, 2009. This direct input has carried through all of the planning leading to, and during the Test Phase.



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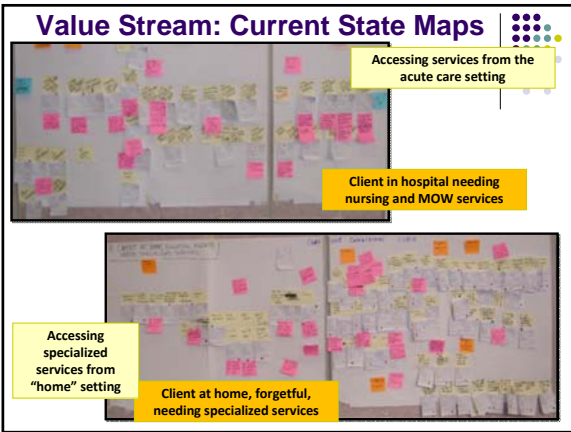
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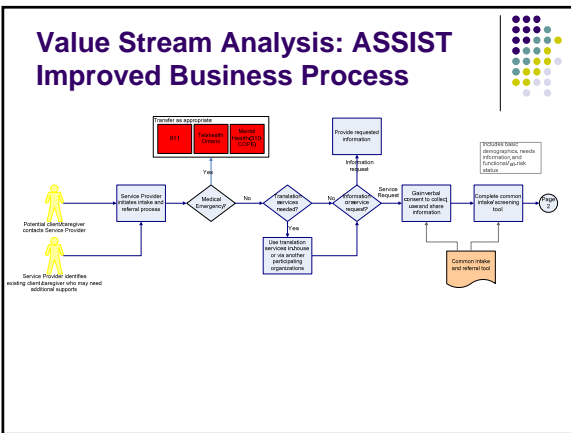
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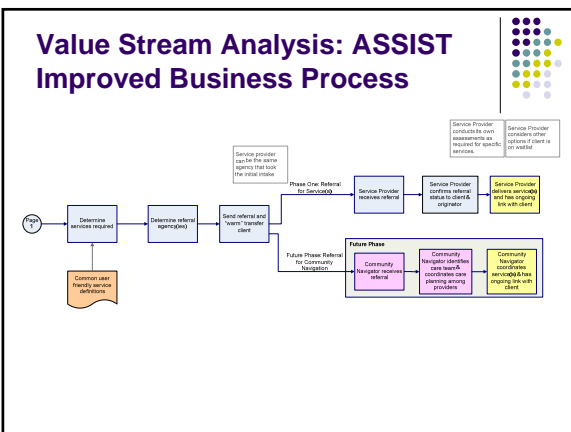
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## ASSIST Access, Information, Referral and Intake: Project Drivers



### The client benefits:

- Clients/caregivers improved access to services of all organizations through any door
- Minimize duplication of similar information requests via the introduction of shared/common intake and referral tool
- Clients/caregivers know who is helping them next with their service referral
- Timely and smooth transitions across the health system for clients/caregivers

### The value to staff is heightened knowledge and skills for:

- Informed and accurate referrals
- Collaborative and consultative referral practices and relationships
- Innovative new tools such as the Community Support Provider (CSP) Portal

### The health system benefits are:

- Smooth and reliable flow of client referrals among providers
- Identification of at risk seniors in the community and referral response
- Accurate consistent approaches for access, information, referral and intake practices

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## Overview: 16 Organizations Participating in ASSIST Test Phase



Alzheimer Society of Peel	India Rainbow Community Services of Peel
Canadian Mental Health Association – Halton Region Branch	Mississauga Halton Community Care Access Centre
Canadian Red Cross – Mississauga Halton	The Peel Addiction Assessment and Referral Centre (PAARC)
The Credit Valley Hospital	Peel Halton Acquired Brain Injury Services (PHABIS)
Forum Italia Community Services - MICBA	Peel Senior Link
Halton Healthcare Services Corporation	Seniors Life Enhancement Centres
Heart House Hospice	St. Joseph's Healthcare (Ham), Halton Geriatric Mental Health Outreach Program
Independent Living Halton	Trillium Health Centre – Seniors' Health

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## Overview: Community Service Provider (CSP) Portal Implementation



- CSP Portal "Live Date" is planned for May 2010
- Registration, content uploads and staff training have been carried out for the CSP Portal during March 2010 The dedicated funding for ASSIST Test Phase organizations will be available for a 6-week period once portal is "live"
- Dr. David Ryan has agreed to include a measurement of the integration levels prior to use of portal, and then again after 2 months of the CSP "go live" date

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## Overview: ASSIST Model Improves Practices



Based on the early evaluation results, the ASSIST model is successfully achieving a higher benchmark of performance for achieving improved access, information, referral and intake practices across participating organizations.

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## The Difference ASSIST Model Makes



Three areas of focus for the test phase performance measurement plan:

1. Impact of the ASSIST initiative on clients and or caregivers
2. Impact of ASSIST initiative in integrating access, information, referral and intake practices of staff and organizations
3. Effectiveness of the ASSIST processes and tools

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## ASSIST Test Phase Measurement: Key Indicators



Impacts	Domain	Key Indicators
Impact of the ASSIST initiative on clients and or caregivers	Efficiency	% 2 days or less: time between client contact or referral request and referral receipt confirmation
	Quality	% accurate referrals % of clients identified at risk who were referred for services % of clients at risk who were referred for further assessment % referrals ranked "urgent" for referral response ranking
	Client Satisfaction	% clients clear about what will happen next in terms of getting the services needed % clients given enough information about the services needed
Impact of ASSIST initiative in integrating access, information, referral and intake practices of staff and organizations	System Quality: Cross-organizational awareness, communication and collaborative practice	% increase in the perceived scope of integration across organizations % increase in perceived depth of integration across organizations

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## Preliminary Results



- The following slides present preliminary measurement results, based on the first 60 days of the ASSIST Test Phase Implementation (February 1 – March 31, 2010)

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## Preliminary Results: Referral Volumes



- Total referrals: 340
  - Note: the original target volume for the two-month test phase was 320 referrals
- Total clients: 168

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## Preliminary Results: Clients and Caregivers



- Average age: 80 years old
- Age Range: 52 to 103 years old
- Person initiating the referral
  - 25% self referrals
  - 49% caregiver referrals
  - 26% other (professionals, non-caregivers)
- 31% require caregiver support

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## Preliminary Results: Types of Referrals



- Inter organization referrals: 54%
  - Test phase participants: 58%
  - Non-participants: 36%
  - Unknown: 6%
- Internal referrals: 33%
- CCAC eligibility referrals for Adult Day Programs: 13%

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## Preliminary Results: ASSIST Process



### Key Efficiency Indicator (n=87):

- 70% with 2 days or less: time between client contact or referral request and referral receipt confirmation

### Key Quality Indicator (n=92):

- 91% accurate referrals

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## Preliminary Results: Client Satisfaction



### Key Client Satisfaction Indicators (n=122, as 46 clients were not asked these questions):

- 99% clients clear about what will happen next in terms of getting the services needed
- 97% clients given enough information about the services needed

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## Preliminary Results: Risk Screening



- 83% (139 of total 168 clients) had a risk screening completed
  - Original target for risk screenings was 75%
- There are a total of 12 Risk Factors in the “Risk Screener” part of the Common Referral/Intake Tool
- Average risk factors per client for whom a risk screening was completed = 4.86 out of 12
- One of the 12 Risk Factors occurred 0% of the time (client has no family doctor)

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## Preliminary Results: Risk Screening



### Key Quality Indicators:

- 94% of clients (130 clients) identified “at risk” and were referred for services
- 60% of clients (83 clients) identified “at risk” were referred for assessment
- 52% (72 clients) of “at risk” clients were referred for both service and assessment
- 16% of service referrals (55 referrals) were ranked “urgent” for response timing (2 days or less)

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## Preliminary Results: Risk Screening



### Types of Assessment Referrals

Assessment Type	Totals
CCAC Eligibility:	
- ADP	25
- LTC Placement	5
CCAC Services:	
- General Assessment	22
- OT Home Assessment	11
- Medications	2
- Physiotherapy	1
Supports for Daily Living:	
- Peel Senior Link RAI-CHA	6
- Centralized Intake	5
Substance Use/Addictions	3
Mental Health	3

Assessment Type	Total
Links2Care	3
CNIB	2
Crisis	1
Specialized Geriatric Services	1
Pain and Palliative	1
Cognitive Assessment	1
Not Specified	6

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## Preliminary Results: Non-Participant Organizations That Received Referrals



Total Referrals  
Received by Non-  
Participants = 66

Links2Care - 20  
Nucleus SDL Centralized Intake - 13  
Etobicoke Services for Seniors - 6  
Recharge Program - 5  
Central West CCAC - 2  
CNIB Halton Peel - 2

The following organizations received 1 referral each:

- Acclaim
- CANES Brampton
- Coast Peel
- Copper County
- Dixie Dundas Health Centre
- Flowertown Older Adult Centre
- Hospital
- Just For You Counselling
- Lifeline
- Life Ring (AA Program)
- Meals on Wheels
- PACE Peel
- Peel Living
- S.E.N.A.C.A.
- Stonehenge T.C.
- Transhelp
- VON Home Support Exercise Program
- Women For Sobriety

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## NEW! Physician Communication and Follow-up using ASSIST Common Intake and Referral Form



- A new and common communication process with MDs has been developed and can be further enhanced (particularly given that all the clients screened for risks have a family doctor)
- In some cases, the completed ASSIST Intake Form and a standardized cover fax cover memo is now being sent to the family physicians to inform them of key risks identified within the risk screener, with a recommendation that the MD:
  - follow-up with a review of client health status, and/or
  - request possible referrals to SGS services (names of services and referral fax numbers included).
- If family MDs become more aware and engaged with this process, it may be a key to mitigating identified risks (seniors/caregivers) in the community and diverting ED visits

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## Preliminary Results: Referral Network Integration Survey



### Key Indicator: System Quality

Ranking Scores were measured by Dr. David Ryan

- Staff were surveyed prior to Test Phase Initiation
- Staff ranked the difference in perceived integration as of Feb 2009 Value Stream Session, and then again as of January 2010 at the end of the Design Stage, prior to Test Phase implementation
- Perceived Integration ranking by staff of intake and referral practices increased from **1.69 to 1.90 out of 4.0** between Feb 2009 and January 2010
- This rating falls within the "moderate" indicator range of integration (between 1.5 and 1.99). There are 8 ranges - and moderate is the 4<sup>th</sup> (in the middle)

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## Preliminary Results: Referral Network Integration Survey



- The following two sets of drawings provide snapshots of ASSIST network integration at the two points in time prior to the start of the Test Phase:
  - a retrospective rating of the early design stage of the ASSIST initiative in *April 2009*
  - a current rating as of *January, 2010* at the start of Test Phase
- Each set of drawings includes a strength of ties analysis and a reciprocity of ties analyses.
- By comparing the drawings at the two points in time you will find:
  - an **increase in the overall level of network integration from "moderate" at project start-up to fractionally below "good"** integration in January 2010 using the Browne et al metric.
  - an **increase in reciprocal ties** is noted in the reciprocity drawings.

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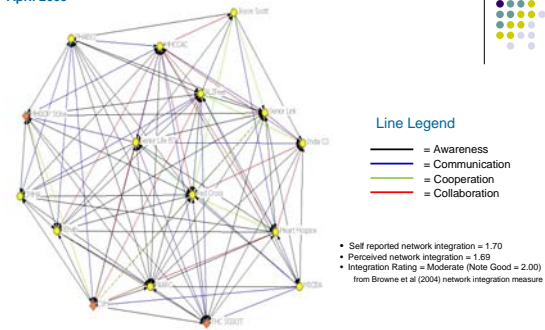
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A Network Analytic Diagram of Ties Between ASSIST Network Members  
April 2009




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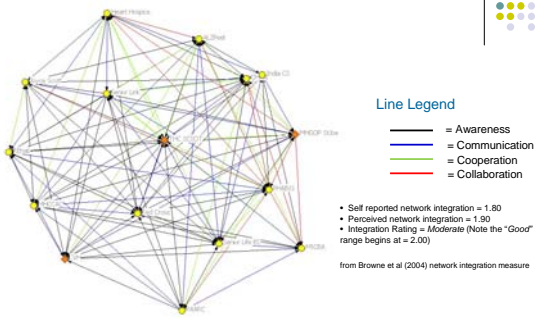
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A Network Analytic Diagram of Ties Between ASSIST Network Members  
January 2010




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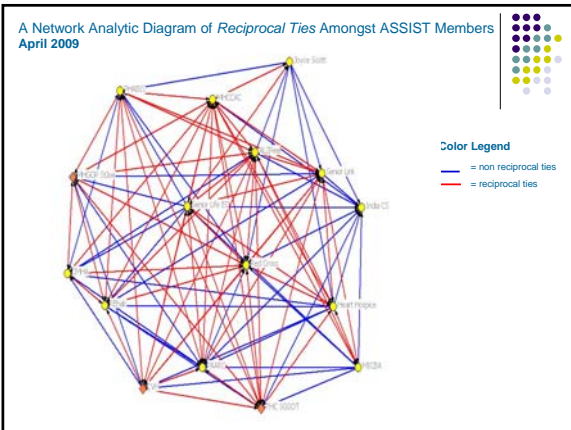
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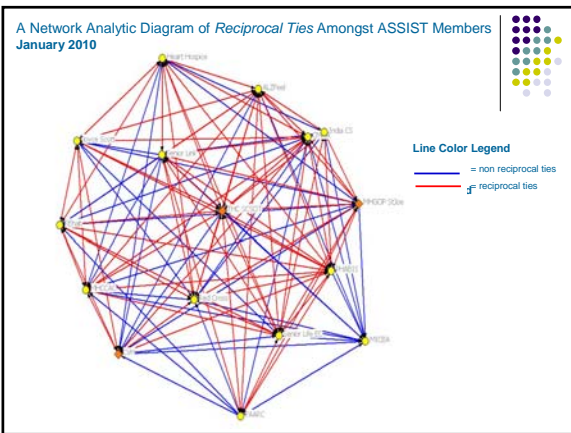
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### Preliminary Results: Anecdotal Data from Staff (Point Persons)

- "Front-end Loading" Concept
  - The in-depth referral information gathered via Common Intake Form takes more staff time up front, but enables more accurate referrals and allows that staff at receiving organization to more efficiently carry through on the intake
- Investment of Time for Accuracy
  - Staff now are recognizing that the time they are taking as professionals to "resource match" would take clients and caregivers *even longer*, given their lack of knowledge
- The Risk Screening Questions
  - Staff remark that they are able to capture more information and see a more holistic picture of the client's needs and risks, which they would have previously missed.

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### Preliminary Results: Anecdotal Data from Staff (Point Persons)



- Point Person contact and teleconferences is a key forum for referral and clinical staff. It enables collaborative learning, case troubleshooting, issues and resolutions, clarifications, process refinements (e.g. physician communication)

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### Observations



- The ASSIST project is successfully moving the organizations from using multiple intake and referral forms to ONE form/dataset used for MANY purposes including:
  - Inter-organizational referrals
  - Internal Intake
  - CCAC Eligibility Requests/Referrals
  - Notification of Risk Results to Physicians for Follow-up
  - Early notification to SGS providers re: potential referral

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### Observations



- There are clear signs of overall performance improvement value from the ASSIST Tools and Processes from the client's perspective
  - high client satisfaction rates and their clarity about who will help them next (99%)
  - high referral accuracy rate (91%) and timeliness (70%)

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## Observations



- Of all of the clients/caregivers that have been through the ASSIST process, 83% have had a risk screening completed and there is a very high rate of follow-up action for these clients including:
  - Referrals to Service – 94%
  - Referrals for Assessment – 60%

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## Observations



- Risk Screening data is a key part of the common intake form, and could be more fully utilized to route referrals and match clients or caregivers to appropriate services (e.g. substance or alcohol abuse to PAARC)
- Referral Staff report on the value of the resource tools (in paper format currently) that aid information about the service offerings of other organizations (e.g. high level service chart identifying “who offers what” and also the detailed service records - both according to new common definitions)

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## Observations



- The ASSIST Project is helping staff know what they can expect from one another during intake and referral, via the common language, process, information via the Intake Form and the relationships they have formed
- There are opportunities to build upon the ASSIST processes including:
  - formalize the linkages between community and primary care practitioners to support seniors/caregivers with navigation and monitoring of health status
  - formalize the referral processes for the intake and referrals across the SGS services

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## Questions and Discussion



- Questions and Discussion

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## Further Information



### Contacts:

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