sfCare Senior Friendly Care

RGP REGIONAL GERIATRIC PROGRAM OF TORONTO

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Practical Pearls

from

GTA Ontario Health Teams Senior friendly Community of Practice

Implement case management as a team function

Scaling case management can be a challenge when the responsibility is reserved for certain team members only. North Toronto OHT is using a process where the primary contact for a client is the team member who is most involved with the client, regardless of professional role. This leaves additional capacity for intensive case managers for clients who need it most. This approach, in combination with regular case conferencing, has allowed team members to learn more about each other's professions and become each other's eyes and ears.

Communication is key when pathways are complex

There may not be clear pathways for complex clients with multiple co-morbidities. Diagnostic clarity and intervention implementation can be enhanced if service provider organizations and clinical care providers have a collaborative mechanism to augment evolving assessments and care planning. This ensures the care for complex patients/clients is individualized and streamlined.

Strategically select the physical location of integrated teams

Finding opportunities to bring care teams closer together may be valuable in providing cohesive care plan execution. For example, bringing in specialized geriatric services to community support service agencies or community health centres can be an effective way to bring specialty frailty assessment and primary intervention services together in one locations.

Integrated care alone does not guarantee senior friendly care

Functional integration at the point of care is a great achievement; however, it does not guarantee that the teams have competency in good geriatric care, or critical team cohesiveness. Interprofessional teams need competency in these three areas: individual disciplines, teamwork, and geriatrics.

Resources to explore

Frailty Population Estimates

Elements of Integrated Care

One Client, One Team Model

Thank you to our guest speaker Kelly Kay, Executive Director of Provincial Geriatrics Leadership Ontario!

Questions? Contact an RGP coach at info@rgptoronto.ca

The Provincial Geriatrics Leadership Office completed a scoping review that identified 13 design elements that underpin quality integrated care for older persons. The table below outlines how each element can be implemented.

Download the full review or visit **rgps.on.ca** for more information on the Provincial Geriatrics Leadership Office

Table 6: Design Element Implementation Continuum

Core Elements	Basic-level Implementation	Mid-level Implementation	High-level Implementation
Multidisciplinary teams	No multidisciplinary team	Traditional health sector professions	Extended non-traditional health and social sector professions
	Fixed team membership	Flexible team membership	Flexible support network
Collaboration	Multidisciplinary	Interdisciplinary	Transdisciplinary
Cross-sector partnership	Non joined-up multidisciplinary team	Joined-up health services	Joined-up health and social services
Comprehensive assessment & care planning	Focus on illness-related issues	Additional focus on functioning and quality of life issues	Additional focus on social and prevention issues
Integrated care at-the-point-of-care	Detached delivery of services at the point-of-care	Co-ordinated delivery of interprofessional care at the point-of-care	Co-delivery of interprofessional care at the point-of-care
Shared responsibility for continuity of care	Individual practitioners assume responsibility for delivering discipline/sector-specific interventions	Team members assume responsibility for co-ordinating discipline/sector-specific interventions	All team members assume shared responsibility for all interventions
Integrated specialized geriatric expertise	Geriatric expertise available via consultation	Geriatric expertise embedded into interprofessional team or SGS as primary provider	SGS team joined-up with one or more interprofessional health and/or social care services
Integrated community & home-based interventions	No formal community & home-based interventions	Community and home-based version of hospital-based care	Innovative community and home-based care interventions
Older person-centred care	Focus on illness-related care goals. Older persons & family/friend caregivers are not invited into care conversations.	Focus on physical, mental and social care goals. Older persons & family/friend caregivers are invited into care conversations	Focus on physical, mental and social care goals. Older persons & family/friend caregivers are invited to give input to planning care interventions
Engaged older persons and family/friend caregivers	Older persons & family/friend caregivers are not invited to play an active role in planning or carrying out interventions	Older persons & family/friend caregivers are invited to play an active role in planning interventions	Older persons & family/friend caregivers are invited to play an active role in carrying out interventions
Self-management support	No formal self-management support provided	Information is provided to older persons and family/friend caregivers	Interventions are designed to actively support older persons and family/friend caregivers to self-manage everyday health concerns
Integrated technologies	No intentional implementation of technology to enhance the integration of care of older persons or to enhance the integration of care processes across programs, organizations, sectors	Intentional implementation of technology to enhance the care of older persons (e.g. health-related smart-phone applications)	Intentional implementation of technology to enhance the care of older persons and to enhance the integration of care processes across programs, organizations, sectors (e.g. shared information data systems)
Multi-tiered evaluation	Micro-level (e.g. frailty, function, perceived sense of well-being) indicators only	Combination of micro and meso-level (e.g. appropriate prescription of medications, community linkages, self-management support) indicators	Combination of micro, meso and macro-level (e.g. healthcare utilization, cost-savings) indicators