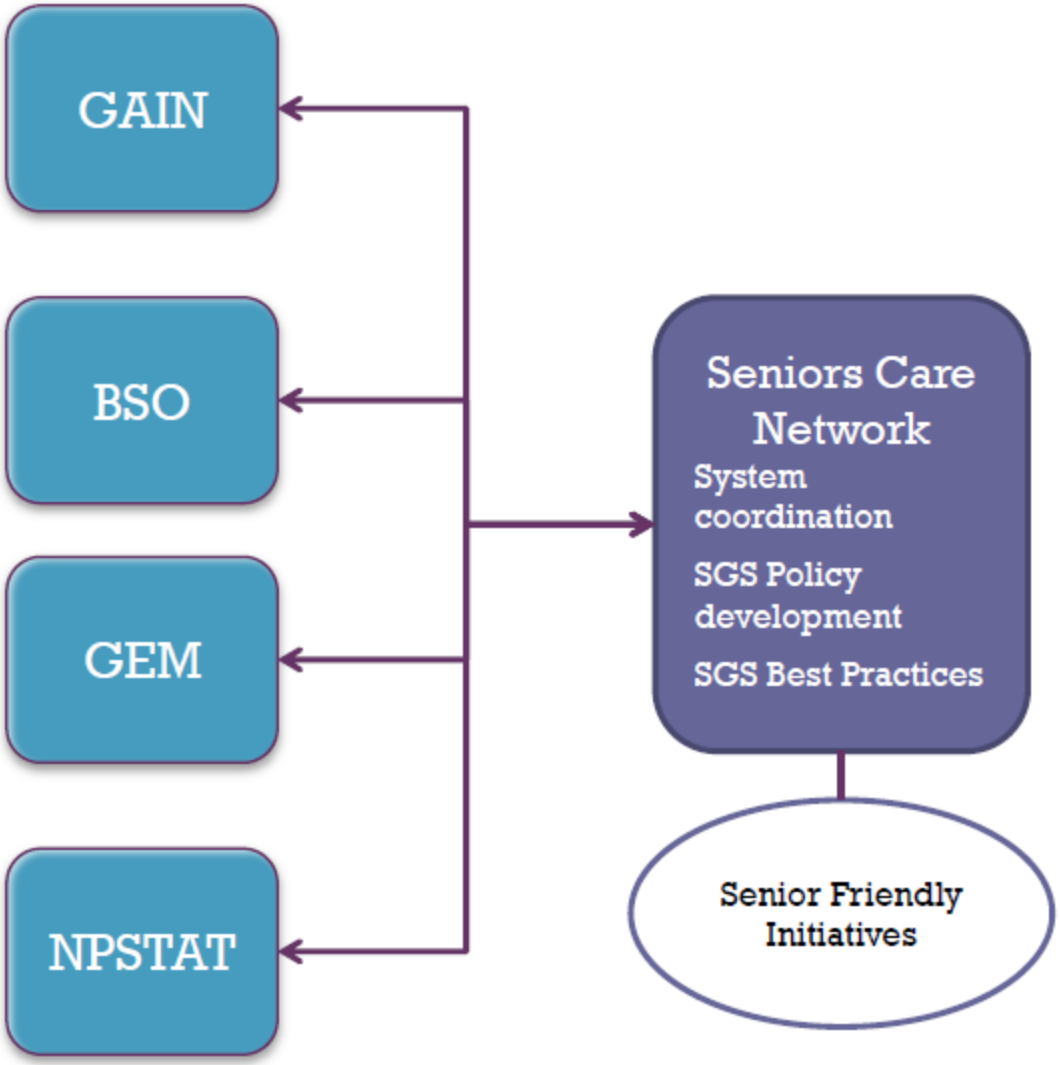
Strengthening Support & Capacity For Frail Older Adults Living At Home

A program of the Central East Regional Specialized Geriatric Services

Specialized Geriatric Services In the CELHIN



Introduction

- The Geriatric Assessment and Intervention Network is a network of coordinated health care services and partners working together to strengthen the supports and capacity for frail older adults - those older people whose health concerns threaten their function and independence - to live at home.

- GAIN includes hospital and community-based teams, hosted by a variety of organizations.

GAIN Goals Summarized

1. Reduce unnecessary emergency department visits, hospital admissions and institutionalization
2. Increase capacity for frail older adults to remain in the community
3. Provide comprehensive interprofessional geriatric/gerontological care
4. Provide Senior Friendly care and services to GAIN clients
5. Improve integration of services between primary care, home/community care, and acute care

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Who is The Population Served by GAIN?

- GAIN clients are frail older adults living at home or in retirement residences with multiple complex medical problems including one or more geriatric syndromes such as:
  - Cognitive impairment
  - Decreased function
  - Falls or risk of falls
  - Impaired mobility
  - Incontinence
  - Multiple medications/polypharmacy

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What Happens in GAIN - The GAIN Model

Engagement

- Co-created and continuously improved with community input
- Information sharing to help identify older adults experiencing challenges with independence and function who might benefit from GAIN
- Referral to GAIN – using your form or ours!

Assessment

- An intake process that identifies client specific needs, gathers background data to avoid duplicating assessments and prioritizes referrals requiring urgent attention
- Comprehensive Geriatric Assessment using validated tools and an interprofessional team approach, covering the domains of cognition, mobility, mental health & addictions, function, medications, physical health, social –environmental situations and nutrition

Care Planning & Delivery

- A review and summary of assessment findings and development of recommendations with clients and other partners
- Implementation and management of recommendations with partners and planned follow-up. This may range from intensive care management to supported self-care.
- Periodic evaluation and adjustment of plans
- Linkage with Health Links integrated care planning and care delivery processes

Intensiveness

Complexity

- leads to development of diverse care strategies and interventions

Frailty

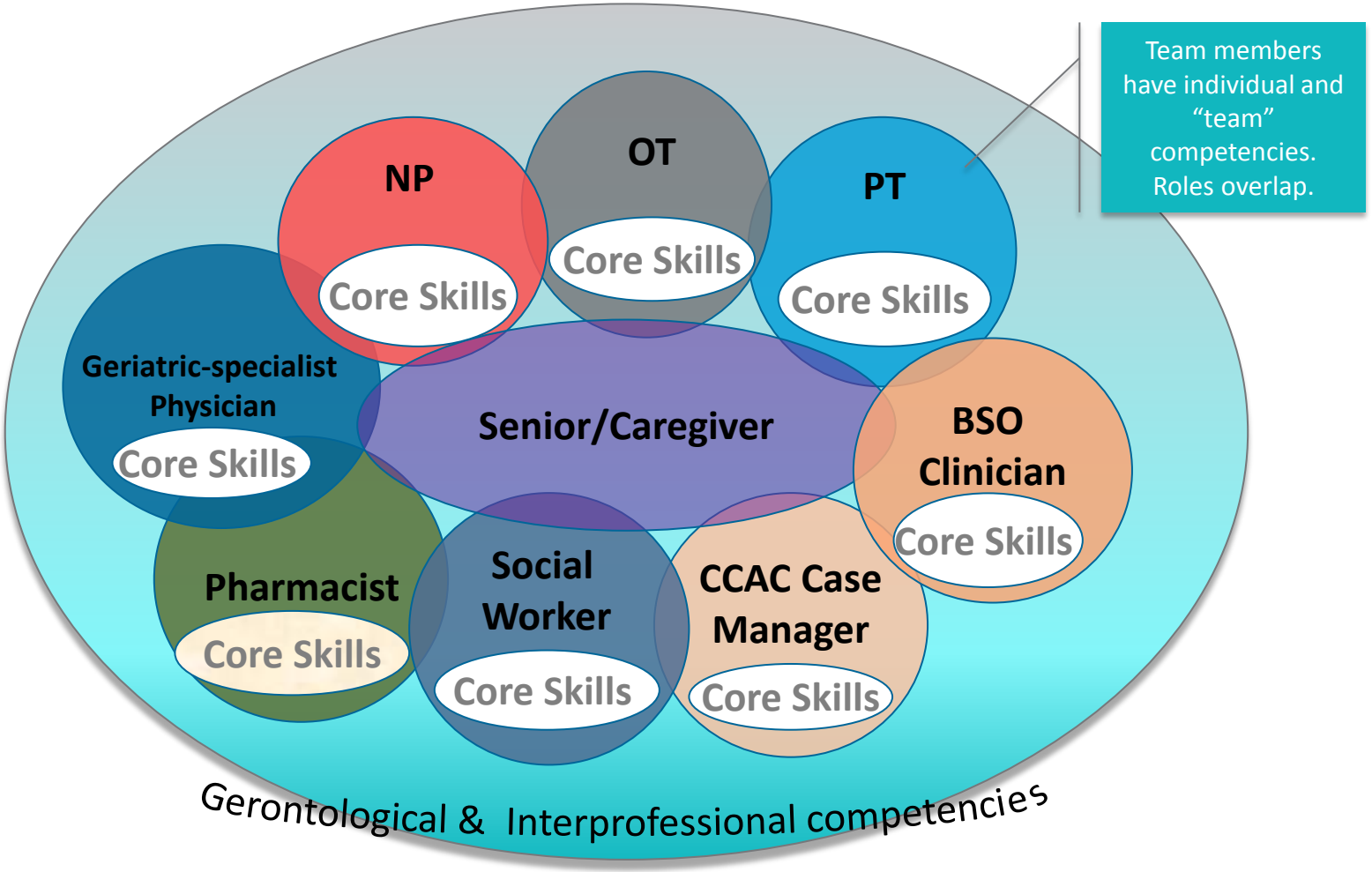
- leads to frequent check ins to manage high risk

Uncertainty

- leads to continuous re-assessment, planned follow-up
- trial and evaluation of innovative ideas, trouble shooting

Dynamic Interprofessional Team

A team is convened around the needs of a particular patient



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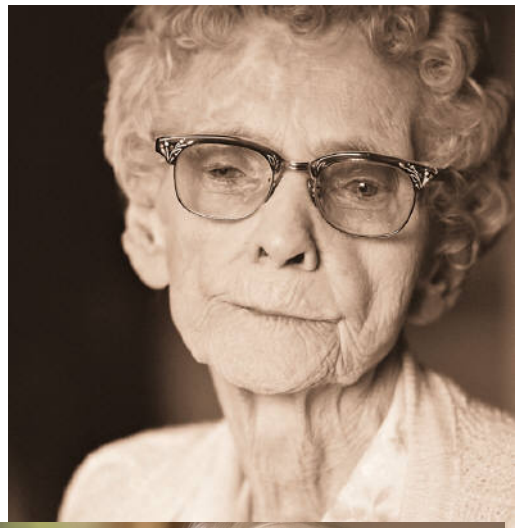
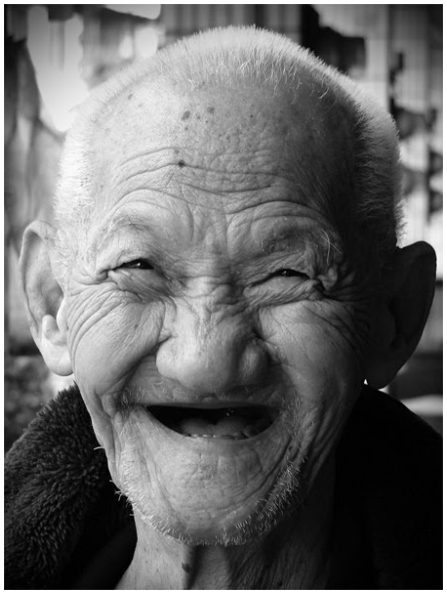
Who is a GAIN Patient?





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Mrs. S.

- 82 year old Greek speaking woman, widowed and has 4 children.
- Lives alone in a condo. Her children live nearby, and are quite involved in her life.
- She reports fatigue, difficulty sleeping, persistent back pain that radiates across her lower back and shoots down her left leg.
- Her daughter is worried because Mrs S has a poor appetite, has lost weight, and gets out of breath while walking with her to the corner shop.
- Has fallen at least 5 times in the last 6 months, becoming confused and irritable at times. The family is concerned that she might be depressed.

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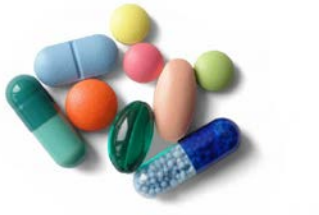

Mrs. S, continued

- She independently takes 12 medications and supplements; has an “emergency supply” of extra meds in her kitchen cupboard
- Has “lost interest” in cooking; receives Meals on Wheels ~ family recently found stacks of meals in the back of the freezer
- Family discovered that she had forgotten to pay her phone bill after the phone service was disconnected
- She used to be a really ‘sharp’ dresser, but lately is paying less attention to personal care

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What Do We DO?

- Patient is asked to have person who knows them best available to provide their perspective
- A regulated health professional acts as primary assessor, gathering data from patient and collateral to be able to “tell the patient’s story”
- The team completes Comprehensive **G**eriatric **A**ssessment, and **IN**tervenes as appropriate.
- Interprofessional Case Review & Recommendations
- Can take place at home if needed, or at clinic
- Comprehensive, collaborative care plan provided in writing

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Sample GAIN Recommendations

Category	Example Recommendations
Medications	• Specific dose adjustments/new Rx (e.g. cognitive enhancers) • Advice for primary care providers • Scheduling of medications and usage of compliance tools i.e., dose planners
Disability/mobility/falls	• Use of assistive devices • Falls prevention strategies
Social/community supports	• Referral to community agencies, transportation services, Adult Day programming • Communication strategies
Medical issues	• Assessment, diagnosis and management/treatment • Nutrition & swallowing related recommendations
Safety	• Home assessment & Safety tools (e.g. Lifeline with Auto Alert, Medic Alert Safely Home)
Cognition	• Brain health strategies • Development of memory aides i.e., Montessori approach with signage
Caregiver support	• Adult Day programming and Respite support • Management of agitation and responsive behaviors (BSO Clinicians) • Supportive Counselling
Future planning	• Housing, living arrangements and advanced care planning
Psychiatric	• Interventions for thought/mood/anxiety disorders (i.e., CBT, relaxation strategy, develop crisis prevention plan)

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12 Teams to Serve Frail Seniors

- **The Scarborough Hospital**
- ***St Paul's L'Amoreaux Centre***
- ***Carefirst Seniors & Community Services Assn.***
- **Rouge Valley Health**
- **Lakeridge Health Oshawa**
- ***Oshawa Community Health Centre***
- ***Peterborough Regional Health Centre***
- ***Port Hope Community Health Centre***
- ***Community Care City of Kawartha Lakes***
- **Campbellford Memorial Hospital**
- **Haliburton Highlands Health Services**

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Referring To GAIN

Origin of Referrals:

- Hospital: ER/GEM/inpatient units
- Community: Primary Care, Community Service Agencies, Alzheimer Society, EMS
- Self Referral: client/caregivers

anyone can refer to GAIN

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Referrals

To refer, you can fax a consultation form or request letter to any GAIN Team. Typically patients will be directed to closest agency

We need:

- ❑ Client details (name, age, gender, contact information, family contact, physician name, primary language etc.)
- ❑ **Problem statement/reason for referral & urgency**
- ❑ Past medical history (CCP) and copies of relevant tests (e.g. bloodwork, EEG, ECG, MRI, CT-scan results etc.)
- ❑ GAIN teams will assist individuals and families to obtain this information
- ❑ Complete medication list

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Referral to GAIN

- You can download our referral form: http://www.centraleasthealthline.ca/pdfs/GAIN%20Referral%20form%20FINAL%20-%20Apr%2014%202014.pdf

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Thank You!

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