Development of a Comprehensive Seniors Care Program for Newfoundland and Labrador

Objectives

To demonstrate how implementation of a comprehensive seniors care program for Newfoundland and Labrador (NL) can occur.

Practice Points

1. The number of persons >65 years of age in NL has more than doubled over the past 30 years and will continue to increase over the next 20 years.
2. Twenty-three percent of the NL population is >65 years of age (over 120,000 people).
3. Over 1/4 of the population in NL aged >65 years is considered frail.
4. Prevalence of frailty in acute care in this province is higher than the national average, with 80% of individuals >65 years who are admitted to hospitals being vulnerable or frail.
5. Frail elderly are the highest users of acute care.
6. Patients who do not require the level of intensity of services provided in an acute care hospital occupy 20% of all acute care beds (300 acute care beds per day).

Data

Health Accord NL provided a blueprint for implementation of a seniors care program focused on frailty. The committee for the aging population wrote this blueprint. The health transformation team in government has communicated with stakeholders to determine alignment of proposals.

Results

- There are several key components required for the creation of a comprehensive seniors care program.

Planning and Quality
A senior's secretariat to support a ministerial committee for seniors, a component of which will include the provincial seniors care program;
A strategic framework for the provincial seniors care program (frail elderly focus) with input from geriatricians and clinical leaders;
Seniors care program in the strategic directions of government (health and community services) for the 2023–2026 strategic planning cycle;
Administrative structure and strategy necessary (e.g., program director, administration, resources, and connections to all clinical areas); and
Clear public outcome/performance reporting on quality of care (using a seniors' lens).

Community Teams
Community-based regional frailty referral networks as community teams are established and practitioners are trained;
Clinical and social navigators;
A person-centered model of care instead of an institutional-based model;
Process for the identification of elderly living with or at risk of frailty;
Resident Assessment Instrument-Home Care (RAI-HC) and other complementary assessments (e.g., the Comprehensive Geriatric Assessment (CGA) utilization);
Standardized care pathways based on comprehensive assessments;
Community level rapid response teams to address early symptoms of frailty; and
Provincial focus to addressing polypharmacy for seniors.

Hospitals

A senior-friendly care framework for all hospitals and centres of excellence on aging that encompass the continuum of care in Western Health (WH), Central Health (CH) and Eastern Health (EH) regions and a program for Labrador Grenfell-Health (LGH).

Provincial tertiary care team and seniors care (frail elderly) unit in St. John's to care for complex frailty cases referred by the regional networks. Seniors care units (frail elderly) in CH and WH, and a similar approach for LGH, with a focus on assessment, rehabilitation, respite care, and restoration inclusive of:

- repurposing beds currently being used by those receiving alternate level of care (ALC);
- rehabilitation and restorative beds for the three regional centres (30 rehabilitation and 35 restorative beds in total), and the additional staffing required to provide appropriate care; and
- restorative care unit at the Miller Centre for patients on a pathway to return to the community.

Certification of all emergency departments as senior-friendly across the province, beginning with the renovation at the Health Sciences Centre.

Dementia Care

Innovative options to support individuals with dementia in other areas of the continuum, as part of broader dementia care action plans and at the provincial and federal level;

Transitioning and broadening of the existing Home Dementia Program;

Specialized dementia care spaces in personal care homes or protective community residences.

Long-Term Care

Comprehensive person-centered, equitable care focused on maximizing function and independence in long-term care (LTC);

A community team model in LTC;

Connections for LTC facilities across the integrated continuum of care;

A well-prepared, empowered, and appropriately compensated work force; and,

LTC facilities that are engaged in the Learning Health and Social System.

Training and Education

Recruitment of 10–12 geriatricians located across the province:

- 1–2 in LGH, WH, and CH; 6–8 in EH over the next 10 years;
- Establishment of a temporary return of service agreement with another university for the education of geriatricians; and,
- Establishment of geriatrician training program at Memorial University with faculty appointments for geriatricians actively involved in clinical training.

Education of 30 Family Physicians (FPs) in Care of the Elderly (CoE) and 60 geriatric-educated Nurse Practitioners (NPs):

- Increased training posts in Memorial University's FP CoE program;
- Utilization of education programs in other jurisdictions (e.g., Nurses Improving Care for Health System Elders program in Nova Scotia)
- Provide Continuing Education.

Senior/geriatric care in the physician, NP, other health professional curriculum.

CoE educated allied health professionals inclusive of social and clinical navigators on community teams or are available regionally.

Sustainable workforce of adequately educated/ compensated home support workers.

Conclusions

1. Planning for the seniors care program has started which will require recruitment of geriatricians over time as they are trained.

2. All community teams should include FPs and NPs with enhanced skills in the care of older persons and other trained providers.

3. A tertiary seniors care team and unit should be provided in St. John's.

4. Location of centres of excellence on aging with development of interdisciplinary teams for geriatrics, stroke care, rehabilitation, and restorative care should evolve over the next five years in Central and Western NL.

5. An appropriate model of care for frail elderly persons in the Labrador-Grenfell region should be developed.

6. An appropriately implemented model will result in:

    - Prevention of frailty and better management of frail elderly persons in their communities;

    - Prevention of hospitalization and emergency room use;

    - A geriatrics informed approach to care in the community with reduced unnecessary use of health interventions;

    - A geriatrics-informed approach to frail elderly patients in hospitals, particularly in prevention of deterioration, decreases length of stay, ALC, and transfers to LTC; and,

    - Strengthened health outcomes and improved health equity for older persons.