

BENEFITS REALIZATION: CLINICAL INTAKE FOR GERIATRIC MEDICINE SERVICES



System Coordinated Access

The System Coordinated Access (SCA) program is working to create a seamless experience for patients and providers moving between different parts of our complex health care system, by leveraging existing infrastructure and an innovative technology solution to connect referral sources to providers in a timely, barrier-free manner. The end goal of these system planning efforts is to create a model that will support faster access to services and more integrated, coordinated care for our residents.

In 2016, the SCA program transitioned to the eHealth Centre of Excellence (eCE), a division of the Centre for Family Medicine Family Health Team (CFFM FHT).

 *The Centre for Family Medicine*

Family Health Team

Benefits realization (BR) is a key component of the projects supported through the eCE. The BR team has adopted an approach to evaluation that is linked with the change management and adoption process. The purpose is to identify the processes that produce organizational and clinical value in health workflows and how the use of different e-tools can yield increased value. The BR team examines academic research and documented best practice guidelines to understand the clinical value propositions that should motivate specific clinical workflows to adopt change.

This BR case is part of a series of case studies which describe the clinical value of adopting a new referral process within the Waterloo Wellington Local Health Integration Network (WWLHIN). The work of the eCE BR program is ongoing as the SCA program evolves. Many of the BR cases raise questions which invite further investigation, and clinicians are encouraged to participate in that dialogue in order to develop the answers.

Value Statement

The introduction of a centralized referral process and clinical intake for specialized geriatric services (SGS) is enabling WWLHIN residents to access geriatric psychiatry and geriatric medicine in a more timely fashion, benefiting both patients and their caregivers.

Prevalence and Consequences of Caregiver Burden

The number of individuals providing care to a family member is on the rise. In 2012, 8 million Canadians — or 28% of the population — aged 15 or older provided care for family members or friends with a long-term health condition, disability, or problems associated with aging [1]. According to Health Quality Ontario, as many as 97% of individuals receiving home care report having an informal caregiver, either a family member, friend or neighbour. The burden of caregiving can have negative consequences on the health and finances of the caregiver; it has been reported that feelings of distress, anger and depression among caregivers in Ontario is increasing [2]. Caregiver burden can be impacted by the lack of care coordination, and/or access to appropriate resources for the patient. According to the American Psychological Association, critical supports to reduce caregiver burden include developing a support plan and making appropriate referrals [3].

Using Central Intake and Clinical Triage for all Geriatrician Referrals

Waterloo Wellington's SGS provides support for geriatric patients and their caregivers by conducting assessments, referring to community services, and helping the resident to access geriatric psychiatry or geriatric medicine. Several

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years ago, recognizing the inefficiencies and duplication of services that was happening due to lack of a standardized and organized referral process, the SGS decided to create a clinical intake for SGS referrals. The new intake process – which involved the creation of a common form, a central referral process, and a clinical triage that reviews each referral for completeness and navigates it to the appropriate services – has proven to be a very successful initiative.

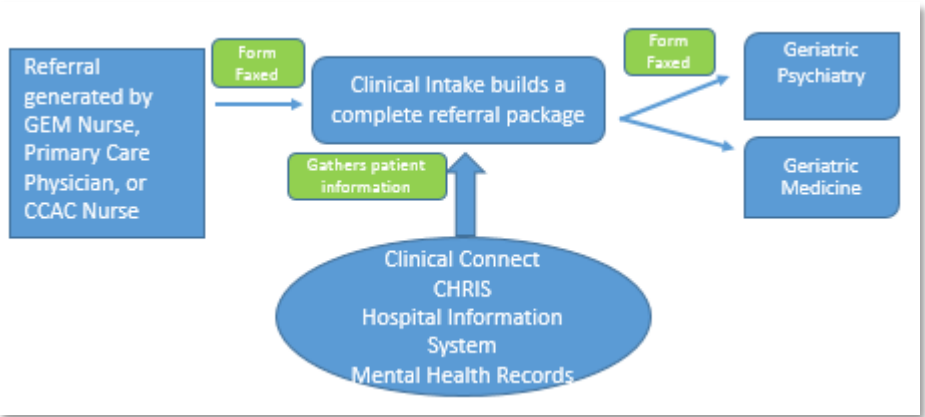


Figure 1: SGS Referral Process Map

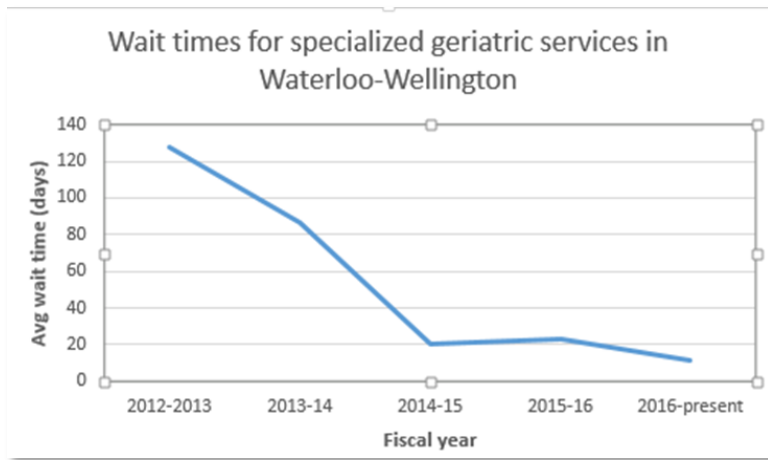


Figure 2: SGS Wait Times

Wait Times Reduced Due to Referral Process Change

The new referral process improvements, including a central intake and clinical triage, have enabled more timely access to specialized geriatric services. Prior to the implementation of the clinical triage, patients were waiting several months to be seen by a geriatrician who would conduct assessments and develop a care plan. The wait time creates stress for the caregivers who are unsure of available services and supports, and what the next steps are in the care for their loved one. Currently, the wait time to see a geriatrician is approximately 3 weeks.

Testimonial

“Centralized Intake and Clinical Triage has reduced the amount of my time required to ensure that consultations have been directed appropriately with essential background information. The entire process occurs in the background and improves the timeliness of assessments.”

- Dr. John Yang, Geriatric Medicine Specialist, Cambridge Memorial Hospital

For questions, comments, or to participate in eCE’s BR program, please contact:
Lori-Anne Huebner, BR Practice Lead, eCE at lori-anne.huebner@ehealthce.ca

References

1. Turcotte, M., *Family caregiving: What are the consequences?* Stats Canada, 2013.
2. *Health Quality Ontario. Measuring Up 2015: A yearly report on how Ontario’s health system is performing.* Toronto: Queen’s Printer for Ontario, 2015.
3. *Family Caregiving.* American Psychological Association: www.apa.org/about/gr/issues/cyf/caregiving-facts.aspx