

# Implementation Plan for Local SGS Teams *September 2018*

Addendum to:  
NSM SGS Program Clinical Design Report & Recommendations (2016)

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## Executive Summary

There is a long history in the North Simcoe Muskoka (NSM) region of working to build an integrated regional program for the delivery of health services for seniors. Beginning with the *Vision* (2009) document, the NSM Local Health Integration Network (LHIN) has advanced planning in the region culminating in the *Clinical Design* (2016) document that was embraced broadly by health service providers across the LHIN. This design was informed by an interprofessional team with a multitude of perspectives consisting of stakeholders from across all sub-regions and health sectors. The clinical design model was based upon the concept of a "hub and spoke" service delivery model that was grounded in the fundamental belief that all seniors from across the LHIN have the right to access specialized geriatric services, regardless of where they live. The hub and spoke approach is a practical model designed to ensure access to high quality services regardless of the geography, population density, distance and other socio-economic factors that often impact access.

In January 2018, the regional Specialized Geriatric Services (SGS) leadership team commissioned a report to advance implementation of the local SGS teams in each NSM sub-region (spokes). This report and its recommendations summarize the findings that emerged from a comprehensive review of the work completed to date, key informant interviews, and insights regarding how to advance regional programs/models within the context of the current health care environment. The proposed model builds upon the original hub and spoke concept and articulates the specific functions, roles, responsibilities and accountabilities that are needed to support local SGS team implementation. The document recognizes that although standardization is important to achieve equal access to high quality care, unique and local solutions (including relationships between providers) are a critical success factor that will drive success in adoption of any new local SGS team. As a result, this principle underpins the framework articulated for implementation which will be built on the following components:

- **Local collaboration ("it takes a village"):** providing services for frail seniors in their communities requires a constellation of providers (formal and informal) working together to be most effective.
- **Strong Leadership ("it takes believers"):** building a system of care and service for frail and often marginalized older adults requires the conviction and dedication of a team of leaders who are trusted and respected.
- **Shared accountability ("everyone owns the solution"):** Every part of the system has to work together and own the problem and the solution. No one organization owns the successes or failures – they are owned by all of us.
- **Having the right basic resources ("get the job done well and effectively"):** There must be a dedicated team of the professionals with the right skills and scope of practice to ensure that frail seniors receive the care and service that they deserve.

This report includes an overview of the current state of health service delivery across the region from the SGS lens. It is not intended to be a comprehensive overview of all seniors' health services, nor a commentary on the state of health service delivery across

the region. Rather, the overview provides a 30,000-foot view of access to Comprehensive Geriatric Assessment (CGA) and SGS for the sub-regions within the LHIN. The tremendous strengths are highlighted, as well as the opportunities and gaps in service.

Moving from design to implementation will require tremendous cooperation across the LHIN. There is great passion and ownership for the current service delivery models that exist in a number of communities but also a strong desire and conviction to improve. As such, an oversight structure is recommended to facilitate shared accountability for advancing the model while ensuring that communities have a voice in how the model unfolds in their particular environment. The structure aligns with the NSM LHIN's proposed future governance structure for all regional programs under its mandate. Given that there are also a number of promising practices in seniors' care emerging across the LHIN, the structure allows for the sharing of these practices to inform implementation of a "made in NSM" model built upon leading practices. The new oversight structure provides a solid platform for advocacy to the LHIN to secure new resources and reconfigure existing investments to optimize gains for the region.

Recommendations are included around the health human resource requirements for local SGS teams, starting with recognition of the importance of building off of and redesigning existing resources. As stated in the Clinical Design (2016) document:

*"Sufficient financial resources must be in place to support the implementation of the desired clinical design. First, we must re-design the existing system to capitalize on efficiencies and optimize outcomes. Frail seniors are already in our system accessing services. They are in our hospitals, long-term care homes, communities and primary care settings. At this time many programs are in place that, through system re-design and improved partnerships, could be leveraged to support implementation of some of the clinical design recommendations."*<sup>1</sup>

The document concludes with recommendations around a three-year phased implementation plan that starts with establishment of the oversight structure, including the establishment of local SGS collaboratives and local leads.

## Recommendation Summary

### Local SGS Implementation

#### Roles & Accountabilities

- To advance implementation of the clinical design model, a socialization and discussion process be undertaken with sub-regions in fall 2018 that includes:
  - sharing of the roles and accountabilities for the hub and the local SGS collaboratives;
  - sharing of the criteria for the local lead; and,
  - identification of a process to define local leads in each sub-region.

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<sup>1</sup> Source: Clinical Design p. 49

- The SGS leadership team and the LHIN develop and implement a communication strategy over the next 12-18 months outlining the essential roles of the hub to strengthen and reinforce the capacity of the SGS program to deliver on the value proposition.

### **Oversight & Funding**

- A new oversight structure be established based upon the principles of shared responsibility to guide implementation of local SGS teams. This structure should build upon work underway with NSM sub-region planning; the local lead should be a participant at the local sub-region table as the link to SGS local and system planning.
- The LHIN should continue to advance the concept of an NSM SGS program single funding envelope, where possible and appropriate.
- A means of outlining roles and accountabilities between the LHIN, the SGS program and the local SGS collaboratives (including the local lead) be defined (i.e. project charters; accountability and authority agreements; legal service agreements; development of new/amendments to existing LHIN Service Accountability Agreements).

### **Health Human Resources**

- The health human resource planning directions be accepted for the purpose of beginning planning discussions related to the implementation of local SGS teams, understanding directions may need to be modified to accommodate available resources, local context and available funding.
- Starting with those resources under SGS program control, continue the redesign journey in alignment with clinical design directions.
- The SGS program and local lead work with their local SGS collaborative to map existing resources, identify redesign opportunities and confirm the minimum investment needed after the mapping exercise to create “one” local SGS team in each sub-region. Based on the mapping exercise, align SGS program resources and leverage local resources.
- Surplus funding realized through early reorganization of services and/or regionalization of services and/or any new funding that becomes available through relevant LHIN or Ministry initiatives be allocated to fill the:
  - Identified gaps in clinical care and health human resources across the sub-regions. Optimizing existing administrative and leadership resources will be necessary to mitigate additional investment in non-clinical staff.
  - Gap in physician remuneration until such time the Ministry commits to an Alternate Funding Plan.

### **Implementation Strategy**

- A three-phased approach to implementation be applied, acknowledging the primary focus in year one is establishing the oversight structure and ensuring engagement and shared responsibility for implementation.
- A detailed project charter with associated timelines be developed to guide planning.
- The local lead selection process be initiated as soon as possible.

- The SGS program will continue to leverage the already adopted/developed change management framework and communication strategy.
- A mechanism be put in place to identify successes and lessons learned as part of a quality improvement approach.
- Implementation of a readiness self-assessment be utilized with the local collaboratives to determine which teams are ready to advance the “one team” concept; and, to ensure broad engagement and education regarding the successful components of a collaborative team.

## **Implementation Considerations**

### **General Opportunities**

- The role of primary care and sub-region planning continue to be key considerations in the implementation of local SGS teams.
- The NSM SGS program will complete the development of a Performance Monitoring & Evaluation Program for the program.

### **SGS and The Regional Model**

- The LHIN leverage *Aging with Confidence: Ontario's Action Plan for Seniors (2017)* to develop and implement a broader regional seniors' strategy and communicate that strategy to providers, key stakeholders and the public.
- A communication strategy be developed and implemented by the LHIN and Waypoint that includes a clear statement of the principles and rationale that underpin the work of the regionalization of SGS services.
- Early investments focus on the expansion and redesign of clinical services, streamlining administrative costs where possible.
- The SGS program will continue to take into consideration the balance between central hub and local spoke planning and provides clarity around roles and accountabilities in the implementation of the local SGS teams.

### **SGS and Comprehensive Geriatric Assessment Access**

- In sub-regions where SGS volumes and capacity may be smaller:
  - Local SGS teams develop in-reach capability to support geriatric assessment in sectors as required (i.e. in-patients, the ED, LTC). In-reach teams can ensure continuity of care and serve to support transitions back to the community for seniors with complex needs.
  - Consider service from the central hub or from other sub-region SGS teams to under-serviced sub-regions as capacity develops.
- The SGS program will continue to play a lead regional role in planning and advancing standardization and best practices in specialized geriatric services, including advancing the concept of CGA.
- Surplus funding available through early reorganization of services and/or regionalization of services be allocated, where possible and if permitted, to fill the identified gaps in clinical care across the region. Leveraging existing administrative resources will be necessary to prevent any additional investment in non-clinical staff.

- Advocacy will occur to ensure that funding available through emerging opportunities (i.e., Dementia Strategy, short-term transitional care models) can be directed to fill gaps in services for SGS clinicians.

### **Specific SGS Community Resources**

- A physician remuneration model be developed to optimize funding envelopes while concurrently maximizing partnerships, scope of practice and outcomes.
- In alignment with provincial dementia capacity planning, the LHIN and the SGS program collaborate to develop and implement a coordinated regional strategy and delivery model that encompasses the entire spectrum of needs (from early identification/screening to tertiary assessment and management).
- Opportunities related to the expansion of community-based geriatric psychiatry access be explored.
- Work will continue to build the relationship between geriatric medicine and geriatric psychiatry teams, as appropriate, under the leadership of Waypoint and the SGS program.
- Remaining BSS-partner resources be integrated into the BSS team AND all NSM resources related to responsive behaviours be better aligned to improve communication, the quality of care, and clinical outcomes.
- The Regional Rehabilitation Steering Committee should be leveraged to support development of a:
  - Plan for increasing access to specialized rehabilitation services for the frail senior population.
  - Vision and service delivery model for the continuum of community rehabilitation to determine the role of Home and Community Care (HCC), Seniors Maintaining Active Roles Together (SMART) and Enhanced SMART within that continuum.

## Introduction

In March 2016 the North Simcoe Muskoka (NSM) Local Health Integration Network (LHIN) and Waypoint Centre for Mental Health Care, the lead agency for the NSM Specialized Geriatric Services (SGS) Program, established a Clinical Design Working Group. The mandate of the Working Group was to develop a final report and recommendations related to the clinical design of the new NSM SGS program. On August 19, 2016 the *Clinical Design Report & Recommendations* document was endorsed by the NSM LHIN Seniors Health Project Team.

The *Clinical Design (2016)* document, like the *Strategy for an SGS Program in NSM (2014)* document, was designed as a guiding document. It offers direction to support planning and decision-making recognizing that significant work is still required to support implementation.

Within the document:

- Design standards and benchmarks are identified for consideration.
- Recommendations are made for the sequencing of design implementation.
- The scope of the clinical service is defined in regard to:
  - The relationship between the SGS Program and the broader NSM Seniors Health Program;
  - The Clinical Frailty Scale;
  - Key safety nets for frail seniors within the system; and,
  - Considerations like geographic boundaries, response time, the role of transitions and the relationship with programs like tertiary mental health services and responsive behaviours.
- A governance structure is outlined.
- Clinical service outcomes are identified.
- Recommendations are made around the design of a Central Intake Service.
- Clinical service eligibility is defined based on the need for a Comprehensive Geriatric Assessment (CGA), support with responsive behaviours and/or the need for nurse practitioner support in long-term-care (LTC).
- The hub and spoke model is outlined, including a high-level description of the services to be available in the central hub and local spokes.
- Key enablers are identified.

A key feature of the clinical design is the siting of a single integrated interdisciplinary local SGS team in each of the five NSM LHIN sub-regions (spokes) to provide the first line of care for frail seniors referred to the SGS clinical service. Working in close partnership with primary care, these teams provide consultative support to health service providers in local communities through ambulatory, satellite and out-reach services. Local SGS team resources are also to be located in area hospitals and LTC using an in-reach approach to care. As a consultative service, care is time-limited and targeted with roles including assessment, diagnosis, treatment, transitions, care plan development, caregiver support, case management and capacity building.

Within the clinical design, the specialized resources of the central SGS services (hub) support local SGS teams by providing very targeted, time-limited care to more complex cases. The goal of central SGS services is to build the capacity of the local SGS teams to ensure care is provided as close to home as possible. When specialist consult is required (i.e. geriatrician, geriatric psychiatrist, behaviour technician, etc.) clinicians will, in most cases, travel to the sub-regions to work with the local SGS teams.

In January 2018, the NSM SGS program commissioned a report to provide direction and detail on the implementation of the hub and spoke model, with particular focus on the local SGS teams. Key activities included:

- Reviewing the current state of service delivery and human resource investment across the LHIN with respect to SGS;
- Interviewing key stakeholders and groups to re-engage NSM health service providers in the discussion and to elicit feedback to guide implementation of the regional service delivery model;
- Clarifying key processes and structures required to support implementation of the hub and spoke concept to create a regional service delivery model including leadership/oversight requirements, clarification of roles and responsibilities, and processes to strengthen relationships and accountabilities among local and central partners;
- Reviewing health human resources needs; and,
- Developing an implementation plan confirming specific priorities and timelines for operationalizing the model.

The *Implementation Plan for Local SGS Teams* (2018) continues the NSM SGS program journey by building on key documents and directions while concurrently taking into consideration the changing NSM landscape and emerging LHIN priorities and directions.

## Implementation Considerations

In addition to the *Clinical Design (2016)* document, several key pieces of information were considered in the development of this document including new demographic data, advancements within the SGS program since 2016 and the key informant interviews completed in early 2018 (Appendix A). This information identified further considerations in local SGS team implementation.

### Strengths

- The LHIN is fully committed to the creation of the NSM SGS program.
- Primary care across the LHIN is very well resourced and generally well organized in team-based care practices.
- There are many caring and dedicated professionals with an interest in seniors' care across NSM.
- There are pockets of grassroots collaboration focused on delivering services for seniors in communities across the LHIN.
- There are a variety of services in the region that have resources focused on frail seniors and specialized geriatric services.
- There are promising practices in seniors care in local communities across the LHIN that can be leveraged, where appropriate, to build local SGS teams.
- There is a new dedicated SGS leadership team committed to integrating services through more centralized coordination of services.
- There is a developing collaboration between geriatric medicine and geriatric psychiatry teams under the leadership of the SGS program and Waypoint.

### Gap Analysis

#### General Opportunities

- The population of seniors continues to grow in NSM.
- Alternate Level of Care (ALC) numbers are climbing in hospitals impacted by increasing challenges in access to community care and discharging individuals with responsive behaviours.
- There are long wait times in some sub-regions to see a primary care practitioner as well as a lack of access to after-hours clinics. Primary care is important in an SGS system because it helps support flow and communication continuity.
- Some sub-regions are better organized than others in regard to partnerships and sub-region planning as evidenced in primary care organization and the state of sub-region LHIN-led planning tables. This, along with the variation in SGS resources across sub-regions, will challenge the creation of an organized and supported united position on priorities.
- There is duplication in care coordination that results in redundancy and role confusion.
- There is a lack of performance measurement and outcome analysis for many of the services targeting frail seniors.

### Recommendations: General Opportunities

It is recommended that...

- i) The role of primary care and sub-region planning will continue to be key considerations in the implementation of local SGS teams.
- ii) The NSM SGS program will complete the development of a Performance Monitoring & Evaluation Program for the program.

### Understanding of Specialized Geriatric Services and the Regional Model

- Significant education is required, along with additional clarity, with respect to the vision, direction, and rationale for a broader regional approach to seniors' care, with the SGS program as the first building block.
- There is a lack of understanding of the mandate and purpose of a regional SGS program. While there was excitement and support, there was also fear and skepticism among providers about the difference this program would make.
- There is a lack of appreciation for the value of seniors' specialized geriatric services across sub-regions and providers.
- A prevalent sentiment expressed during interviews was an overarching fear of a sub-region losing the ability to locally customize service delivery to meet community needs. In particular, there was some confusion about regionalization and what this meant vis-à-vis local service delivery and autonomy.

### Recommendations: SGS and the Regional Model

It is recommended that...

- i) The LHIN leverage *Aging with Confidence: Ontario's Action Plan for Seniors (2017)* to develop and implement a broader regional seniors' strategy and communicate that strategy to providers, key stakeholders and the public.
- ii) A communication strategy be developed and implemented by the LHIN and Waypoint that includes a clear statement of the principles and rationale that underpin the work of the regionalization of SGS services, including clarity regarding the benefits for the community and the residents of NSM.
- iii) Early investments focus on the expansion and redesign of clinical services, streamlining administrative costs where possible.
- iv) The SGS program continue to take into consideration the balance between central hub and local spoke planning and provide clarity around roles and accountabilities in the implementation of the local SGS teams.

### Access to Specialized Geriatric Services and Comprehensive Geriatric Assessment

- Access to specialized geriatric services and comprehensive geriatric assessment (CGA) across NSM varies significantly by sub-region and sector. As a result, sub-regions with limited resources may have a greater need for in-reach support from local SGS teams into sectors (as described in the *Clinical Design 2016* document)

and/or there may be a greater need for outreach from central SGS services or from other sub-region SGS teams as capacity develops.

- CGA, which occurs within specialized geriatric services, remains a poorly understood concept. It is important because it provides the opportunity to minimize and/or reverse frailty and improve overall functional independence. In some sub-regions, outpatient/community CGA is advanced due to the organization and leadership of providers and organizations. For example, some of the family health teams (FHTs) and community health centres (CHCs), by way of their mandate, have developed specialized teams and services in clinical areas where there is a clear need and substantive volume.
- In some cases, services are focused on symptom management or wrapping services around the senior, placing emphasis on care and support versus reversibility and improvement. It is the constellation of all these services that comprises an integrated regional program. However, the skeletal infrastructure of any regional program for frail seniors requires ensuring access to services grounded in the principle that frailty can often be prevented or reversed.
- There is a lack of standardization and variations in best practices in specialized geriatric services across sub-regions and sectors.
- To increase understanding of the importance of the SGS program and to continue to improve access to specialized geriatric services across regions, it will be important for early investments to focus on clinical service.

#### **Recommendations: SGS & CGA Access**

It is recommended that...

- i) In sub-regions where SGS volumes and capacity may be smaller:
  - Local SGS teams develop in-reach capability to support geriatric assessment in sectors as required (i.e. in-patients, the ED, LTC). In-reach teams can ensure continuity of care and serve to support transitions back to the community for seniors with complex needs.
  - Consider service from the central hub or from other sub-region SGS teams to under-served sub-regions as capacity develops.
- ii) The SGS program continue to play a lead regional role in planning and in advancing standardization and best practices in specialized geriatric services, including advancing the concept of CGA.
- iii) Surplus funding available through early reorganization of services and/or regionalization of services be allocated, where possible and if permitted, to fill the identified gaps in clinical care across the region. Leveraging existing administrative resources will be necessary to prevent any additional investment in non-clinical staff.
- iv) Advocacy occur to ensure that funding available through emerging opportunities (i.e., Dementia Strategy, short-term transitional care models) can be directed to fill gaps in services for SGS clinicians.

### Access to Specific Specialized Geriatric Service Resources

- While NSM has seen an increase in Care of the Elderly (CoE) physicians and geriatricians, many cannot make sufficient income in the current remuneration model. As such, many are not practicing exclusively in seniors' care.
- With the emergence of family practice-based memory clinics, a positive step to improving access, there is a need to consider these screening clinics within the broader context of the evolving system.
- Access to geriatric mental health support in the community is limited by having only one geriatric psychiatrist doing outreach across the region.
- Although good work has been done to redesign NSM Behaviour Support System (BSS) resources, there is the need for a system-wide approach to planning that leverages the full spectrum of provider resources for individuals with responsive behaviours and clearly articulates the purpose and mandate of each resource.
- There are issues with access to a system of rehabilitation, restorative care and therapy in general; in particular, access for frail seniors and those with cognitive impairment to appropriate levels of geriatric rehabilitation.

#### Recommendations: Specific SGS Community Resources

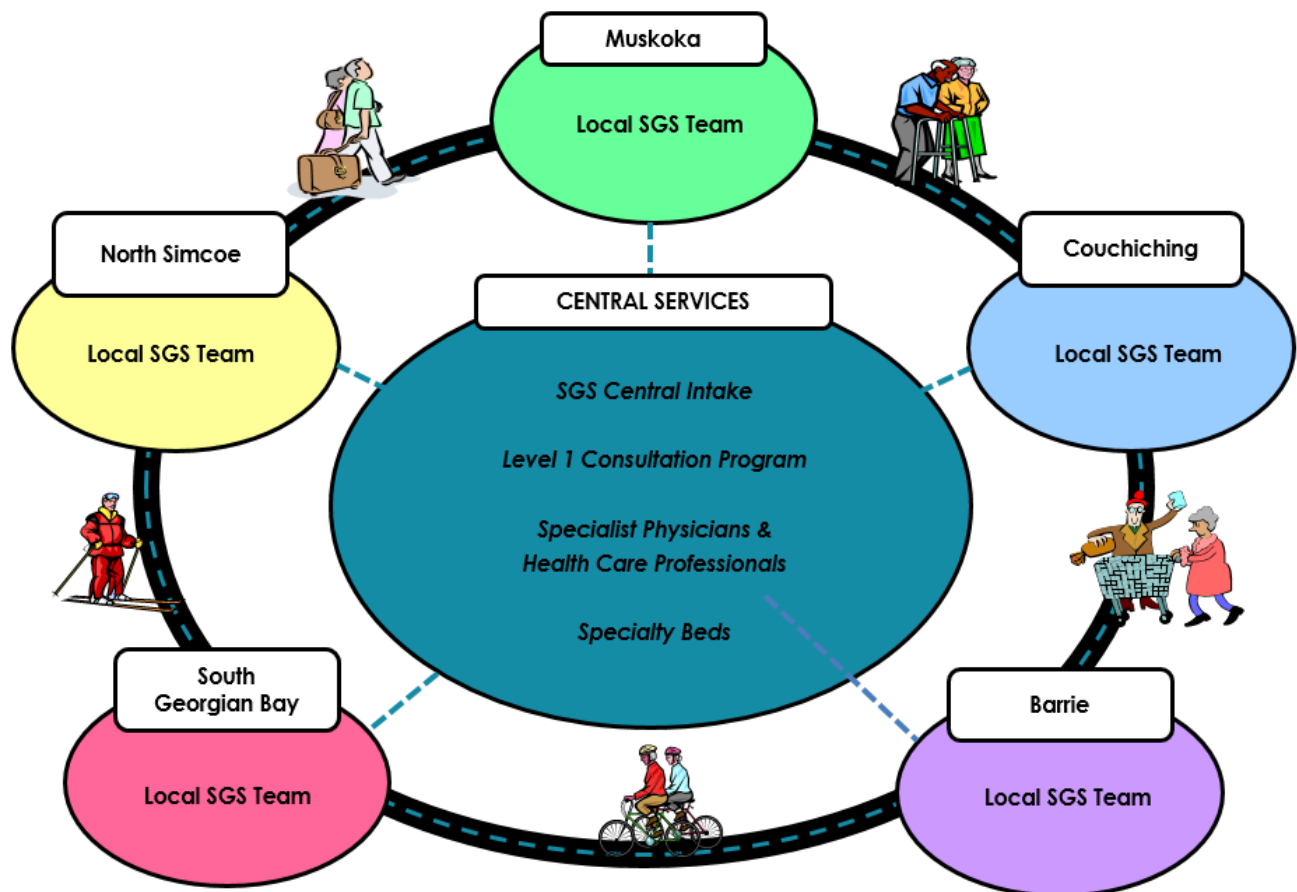
It is recommended that...

- i) A physician remuneration model be developed to optimize funding envelopes while concurrently maximizing partnerships, scope of practice and outcomes.
- ii) In alignment with provincial dementia capacity planning, the LHIN and the SGS program collaborate to develop and implement a coordinated regional strategy and delivery model that encompasses the entire spectrum of needs (from early identification/screening to tertiary assessment and management).
- iii) Opportunities related to the expansion of community-based geriatric psychiatry access be explored.
- iv) Work continue on building the relationship between geriatric medicine and geriatric psychiatry teams, as appropriate, under the leadership of Waypoint and the SGS program.
- v) Remaining BSS-partner resources be integrated into the BSS team AND all NSM resources related to responsive behaviours be better aligned to improve communication, the quality of care, and clinical outcomes.
- vi) The Regional Rehabilitation Steering Committee should be leveraged to support development of a:
  - Plan for increasing access to specialized rehabilitation services for the frail senior population.
  - Vision and service delivery model for the continuum of community rehabilitation to determine the role of Home and Community Care (HCC), Seniors Maintaining Active Roles Together (SMART) and Enhanced SMART within that continuum.

# Hub and Spoke Model

## The Model: Revised

Based on experience within the SGS program since the completion of the *Clinical Design (2016)* document, the following is offered as a revised version of the 2016 hub and spoke model.



Key changes focus on the central hub:

- Explicit inclusion of the SGS Central Intake Service;
- Expansion of "specialist physicians" to include other "health care professionals", recognizing the importance of interprofessional teams and specialists in the provision of regional specialized geriatric services; and,
- Removal of specific types of "specialty beds", recognizing that in addition to beds focused on responsive behaviours and mental health needs, there will be other needs that will arise like geriatric rehabilitation.

## The Model: Clarified

Although planning documents to date have defined SGS program principles, assumptions and the hub and spoke model, it is evident that further clarity is required.

### Principles (... the what)

The following principles have been derived from a number of planning documents and further refined and informed through the key informant interviews. This refinement was necessary to establish the common ground that would garner universal support from key partners across the region. Working from these principles, the vision of a regional model can continue to be operationalized.

- **Build off work to date:** This includes “staying the course” related to NSM SGS program planning to date, aligning with LHIN directions and planning as well as building off existing NSM services and programs through re-design.
- **Equitable access to a comprehensive basket of specialized geriatric services:** When needed, frail seniors across NSM will have access to CGA, treatment and management all aimed at preventing functional decline and frailty and at improving the management of overall health and well-being, regardless of where the senior resides.
- **High-quality services:** Services will be standardized and driven by the best evidence available regarding geriatric syndromes, as well as restoration of health and well-being. SGS providers will be well-educated, and trained in the latest methods, protocols, and techniques related to seniors' care.
- **Efficient delivery of services to create as much capacity as possible:** As stewards of the public health system, funds will be used to help ensure cost-effective delivery of services, so that resource deployment matches need and requirements. Administrative costs will be minimized, duplication (waste) will be eliminated, and clinical care investments will be maximized to ensure that more seniors can continue to receive services over time.
- **Reduce unnecessary redundancy while preserving requisite diversity:** Embracing and appreciating sub-region diversity is essential in the creation of any regional program or system of services. In other words, standardize where necessary and customize where appropriate.
- **Providers will develop expertise in seniors' care:** Seniors are proportionately the highest users of health services. As such, it is incumbent upon all providers to build their knowledge and competencies in caring for seniors and caregivers. It is especially critical for providers to develop the requisite expertise in dementia care, given the projected increase in dementia prevalence in NSM.

- **Shared accountability and joint ownership for service delivery and system performance:** To create a regional program partners must come together to plan for the delivery of services across the region and commit to delivering such services according to the established principles. This shared accountability is based upon an understanding that partners can leverage each other's strengths and support each other in finding solutions to the challenges faced and that they are, together, accountable for system outcomes and performance. Readiness is key to success.
- **Providers mutually benefit from being part of the system and have a commitment to reciprocity:** The various providers and communities, along with the program leadership understand what each other is contributing to the system and what the benefits are to each party. This requires the hub, and each spoke, to explicitly identify what these roles and contributions are, namely collaboration and reciprocity versus competition and myopia.

## Outcomes (... the why)

The following outlines the clinical service outcomes proposed within the *Clinical Design* (2016) document:

| Wellness, Independence and Quality of Life in Aging                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Strategy Vision                                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| To establish an Integrated Regional Program of Specialized Geriatric Services inclusive of geriatric medicine and geriatric psychiatry that improves patient outcomes, builds capacity and fosters system change.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | How we will achieve our Vision (i.e. Strategy Mission, Priorities) |
| Improved Patient Outcomes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Enhanced System Capacity                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | A More Affordable, Sustainable and Accountable System                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Expected results/impact                                            |
| <p><b>Focus:</b> Interprofessional Care; Comprehensive Geriatric Assessment; Geriatric Syndromes.</p> <ul style="list-style-type: none"> <li>▪ Maintained or improved frailty (resulting from, for example, improvements in functional decline, improved cognitive function, etc.)</li> <li>▪ Improved assessment and management of responsive behaviours (resulting from, for example, reduced wait time for behaviour resources, appropriate antipsychotic use, etc.)</li> <li>▪ Reduced caregiver burden (resulting from, for example, increased caregiver support and knowledge, etc.)</li> <li>▪ Increased patient / caregiver satisfaction with services and outcomes (resulting from, for example, improved system navigation, improved transitions, tell story once, meeting cultural needs, etc.)</li> </ul> | <p><b>Focus:</b> Education &amp; Mentorship; Standardization; Implementing Leading Practices.</p> <ul style="list-style-type: none"> <li>▪ Increased shared knowledge and skillsets of health care providers in the care of frail seniors and their caregivers</li> </ul> <p><b>AND</b></p> <ul style="list-style-type: none"> <li>▪ Enhanced self-management abilities of frail seniors and their caregivers</li> </ul> <p>(resulting from, for example, timely and collaborative consultations, relevant communication supporting knowledge transfer, standardized assessment tools, implementation of leading practices in care delivery, increased awareness of resources, etc.)</p> | <p><b>Focus:</b> Optimal Use of Resources; Aging in Place; Partnerships; Prevention/Avoidance</p> <ul style="list-style-type: none"> <li>▪ Increased care of frail seniors and their caregivers in their home settings in each NSM sub-geography (resulting from, for example, increased access to local SGS services, reduced demand on central SGS services, improved partnerships with core services, etc.)</li> <li>▪ Reduced inappropriate use of hospital and LTC resources (resulting from, for example, increased access to timely SGS clinical services, fewer inappropriate ED visits, reduced 30/60 day hospital re-admits, reduced ED visits and ALC LOS attributed to behaviours, delayed or reduced LTCH admissions, reduced # crisis placements, etc.)</li> </ul> | Potential outcomes                                                 |

## Model Assumptions (... the how)

It was clear from key informant interviews, that although there is agreement to the overarching principles, they mean different things to different people. Consequently, in developing the service delivery model, it becomes necessary to create explicit operating assumptions to underpin model development. The following assumptions are consistent with the principles but serve to further specify model attributes required to support a universal understanding going forward.

1. The model for SGS in the NSM LHIN is in fact a “system” of SGS, with services that function both together and separately and form the backbone of an evolving integrated network of services for seniors (e.g., the broader Integrated Regional Seniors Health Program).
2. Central (hub) clinical services will be minimized with the focus on local (spoke) care delivery and coordination. Central clinical services will be limited to those that require highly specialized resources that are scarce and/or will serve a low volume need across the region.
3. The local delivery model for SGS services in each sub-region may look and operate differently to reflect local needs and resources; however, the same tools and approaches will be used to promote equitable access and best practice care delivery. What is most important is that outcomes are the same.
4. Each local SGS team will be a virtual team that includes team members working locally and others who visit and deliver services regionally. Regardless of whom is delivering these services, they will all be part of one team. This requires strong partnerships between SGS providers.
5. A local SGS team will be located in each sub-region to allow for strong partnerships with primary care. This will facilitate early identification (upstream point of contact) to minimize the use of avoidable downstream resources (e.g., ED visits).
6. Success of local SGS teams will be dependent on strong relationships and effective partnerships with local providers. To achieve these ends, local SGS collaboratives will be developed comprised of the SGS program and sub-region partners. Local leads will be established in each collaborative to help coordinate SGS activity between and among providers at the point of care. Local leads must be integrated into the LHIN sub-region planning tables and SGS program.
7. Recognizing the complexities inherent in existing funding envelopes and agreements, the SGS leadership team will partner with the LHIN to leverage current resources, where possible, across the system to advance the model.
8. While it may be difficult to fully implement a single funding envelope for all specialized geriatric services given existing funding parameters and limitations, the SGS leadership team will partner with the LHIN to continue to advance a centralized funding envelope, where feasible.

# Local Specialized Geriatric Services Implementation

To promote success, it is important that all parties understand and are committed to all aspects of the plan, including the SGS program quality framework, the hub and spoke model, the *Clinical Design (2016)* document and the components of this 2018 addendum document. A lack of collective commitment will cause even the best designed system to fail. As identified by Hollander and Prince,<sup>2</sup> commitment to the philosophy as well as “a belief in the benefits of the system” by service providers is a prerequisite to the successful adoption of an organized service delivery model.

## Roles & Accountabilities (... the function)

### The Model

The following provides a graphic overview of the hub and spoke delivery system layered with the key roles and accountabilities for the partners in the evolving system.



### ROLES & ACCOUNTABILITIES

#### Central (Hub):

- System Leadership
- Clinical Leadership & Regional SGS Service Delivery
- System Education & Mentorship
- System Advocacy
- Research & Ethics

#### Local SGS Collaboratives:

- Collaborating with the Hub (NSM SGS Program) to:
  - Coordinate and integrate services;
  - Build local capacity;
  - Support performance monitoring, evaluation and reporting;
  - Integrate leading practices into service delivery;
  - Support the standardization of services across the region; and,
  - Deliver local Specialized Geriatric Services
- Local Lead as liaison with Hub (NSM SGS Program)

<sup>2</sup> Hollander MJ; Prince MJ. “Organizing healthcare delivery systems for persons with ongoing care needs and their families: a best practices framework.” *Health Care Quarterly*, 2008; 11 (1):44-54, 2.

## The Central Hub

The hub can be envisioned as a virtual entity with core roles and other centralized functions that support all providers in the system. As the lead of the hub, the SGS program's essential roles have been well articulated in both the *Strategy (2014)* and *Clinical Design (2016)* documents. These roles become the value proposition for the evolving regional program/system. They are the assets of value and become the reason why providers want to be part of something bigger. They include:

- **System Leadership** – This would include, for example: strategic planning and priority setting; supporting centralized governance; linking to provincial, national and international partners; and, being a key liaison to the NSM LHIN and a key resource to partners regarding frail seniors and seniors' care.
- **Clinical Leadership & Regional SGS Clinical Service Delivery** – This would include, for example: defining core competencies; developing clinical programs, including supporting and integrating service delivery; and, identifying leading practices and disseminating evidence-based tools. The work would also include direct management oversight for regional services (e.g., BSS, Central Intake Service, Level 1 Consultation, etc.).<sup>3</sup>
- **System Education & Mentorship** – This would include, for example, coordinating and providing region-wide education and knowledge mobilization for all providers of seniors' care across the region (capacity building). Work would also include providing a mentorship service for interested professionals and students.
- **System Advocacy** – This would include advocacy for frail seniors and necessary health services, including funding. Advocacy is based upon planning for current and future services required by seniors and caregivers across the region.
- **Research & Ethics** – This would include a translational research function as well as leading quality improvement initiatives and creating, as appropriate, next practices in senior's care delivery.

## Local SGS Teams

Local SGS teams will be comprised of members of the SGS program and sub-region partners. Success will be dependent upon collaboration and cooperation to create "one team" in each sub-region. Each collaborative may have a unique constellation of partners working together to wrap services around frail seniors and their caregivers.

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<sup>3</sup> It is important to understand that although many services lend themselves to central management and staff deployment, other services may need to remain more closely tied to their local community. It is this healthy tension between centralization and local autonomy that will underpin the conversations going forward as the new regional system unfolds.

Members within each collaborative will work together to:

- Coordinate and integrate services in each sub-region;
- Build local capacity;
- Support performance monitoring, evaluation and reporting;
- Integrate leading practices into service delivery;
- Support the standardization of services across the NSM region; and,
- Deliver local SGS services.

### **Local Leads**

A local lead will facilitate each local SGS team and provide local leadership in alignment with the directions of the SGS program. The lead will be pivotal in advancing the model and care at a local level. To achieve these ends, the lead will bring local providers together to implement mechanisms to coordinate care for complex frail seniors and to promote the “one team” philosophy. This includes coordinating local care and regional services, upstream identification in primary care and coordination with local hospitals to pull seniors back into the community. This also includes the lead working in partnership with the SGS program to co-lead the local SGS team.

As the key sub-region liaison with the hub, the lead will work in close collaboration with the SGS program to help build capacity and guide system development and evolution in the spirit of shared governance for the evolving system. The lead will represent the interests and needs of frail seniors in their sub-region at their LHIN sub-region planning table and participate on relevant committees (see Oversight & Funding section).

Choosing a local lead with the right leadership skills and experience to advance the model will be important. In fact, very few organizations may be able to meet the requirements given the complexity associated with implementing the regional program. The lead could be a single organization or two agencies coming together to jointly fulfill the role. Regardless of the organization(s), there needs to be an agreement between the SGS program and the lead that clearly articulates roles and accountabilities.

The following is the proposed criteria for a local lead:

- Currently has specialized staff (geriatricians, Care of the Elderly physicians and NPs) undertaking CGAs (e.g. already has some capacity in service delivery).
- Demonstrated organizational interest and commitment to the care of frail seniors (mission statement, organizational goal, etc.).
- Has made investments in specialized geriatric services and programs without additional funding (e.g. resources invested from the organization's base budget or advocacy efforts has resulted in funding for specialized seniors services).
- Experience with and a solid understanding of SGS requirements; currently delivering some SGS services.

- Capacity to support local coordination activity with administration and back office functions (willing to dedicate resources to take this on with no administrative additions)<sup>4</sup>.
- Viewed as local leaders in the care of frail seniors by other health care partners in the community.
- Demonstrated commitment to collaboration with system partners (examples of initiatives/efforts/structures showing successful inter-organization collaboration).
- Demonstrated commitment to capacity building through education and clinical support for health care practitioners working with seniors.
- Experience with health human resource planning, union negotiation and other labor relations activities.
- Willing to participate in sub-region planning and in the overall oversight model for SGS in the NSM LHIN region to advance services for frail seniors.
- Are a LHIN-funded health service provider or willing to accept LHIN-funded resources and the associated accountability agreements and reporting requirements.

#### Recommendations: Roles & Accountabilities

It is recommended that...

- To advance implementation of the clinical design model, a socialization and discussion process be undertaken with sub-regions in fall 2018 that includes:
  - sharing of the roles and accountabilities for the hub and the local SGS collaboratives;
  - sharing of the criteria for the local lead; and,
  - identification of a process to define local leads in each sub-region.
- The SGS leadership team and the LHIN develop and implement a communication strategy over the next 12-18 months outlining the essential roles of the hub to strengthen and reinforce the capacity of the SGS program to deliver on the value proposition.

## Oversight & Funding (... the form)

In both the *Strategy (2014)* and the *Seniors Health Program Review (2015)* documents, the work of Hollander and Prince regarding best practices for integrated systems was considered. For example, it was recommended within the documents that the SGS program have “*direct management oversight for a comprehensive range of specialized geriatric services*” and responsibility for “*the funding of specialized geriatric services provided by organizations*” within the program. While the concepts resonate, some are difficult to implement to their fullest extent. Single funding envelopes while in theory are ideal, are difficult to achieve in practice because of funding envelopes and

<sup>4</sup> The provision of local coordination will require some administrative support and potentially other administrative functions (such as performance reporting and local coordination activity) as services in the area evolve. It is expected that much of the administrative burden can be absorbed by local resources in order to preserve funds for clinical investment.

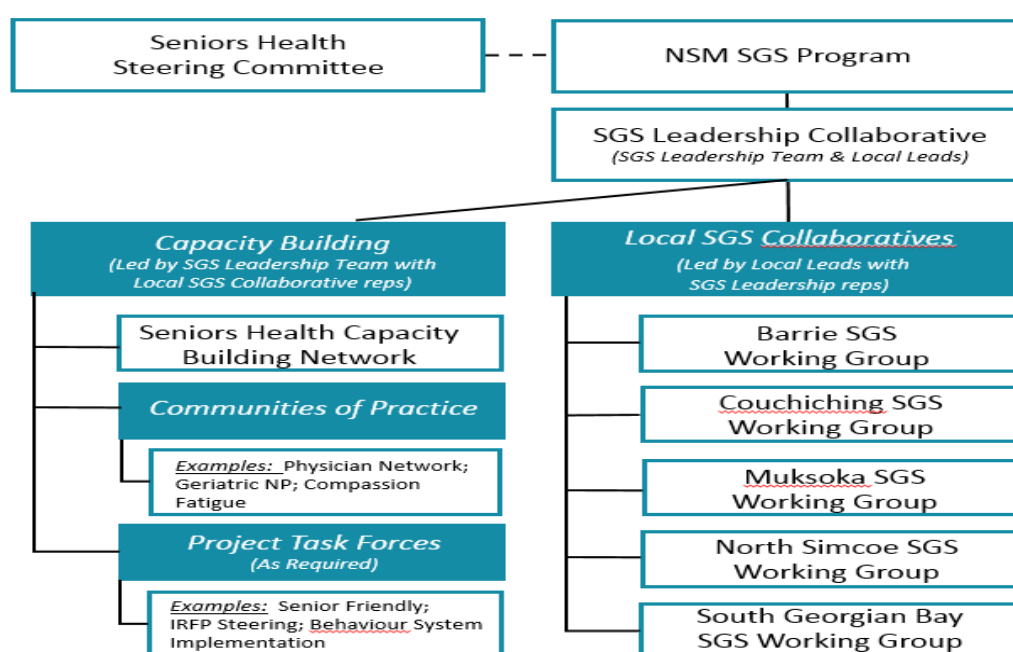
parameters. Many specialized geriatric services currently in place reflect historical investments by government and organizations in seniors' care. Extracting these operating costs from organizations may not be feasible or appropriate, especially when one takes into consideration health human resource implications.

## Oversight

The MOHLTC *SGS and RGP Review (2015)*<sup>5</sup> reinforced the need for central coordination and consistent performance reporting to improve access to a minimum basket of specialized geriatric services. Within the interim report, there was strong recognition of the need for shared decision-making between and among service providers.

The implementation of local SGS teams provides an opportunity to re-examine previous thinking related to oversight as proposed in the *Clinical Design (2016)* document and take into consideration new LHIN governance directions. The concept of central oversight must be balanced with the spirit of building a system where collaboration, cooperation, and reciprocity are critical elements and guiding principles in local SGS team implementation.

The oversight structure proposed below for implementation of local SGS teams encourages shared responsibility in developing and implementing the model, standards, processes and practices as well as in performance monitoring. Participation ensures that each partner understands their responsibility for delivering on the agreed-upon standards. As the lead agency for the SGS program, Waypoint will report on system performance to the LHIN on behalf of all partners.

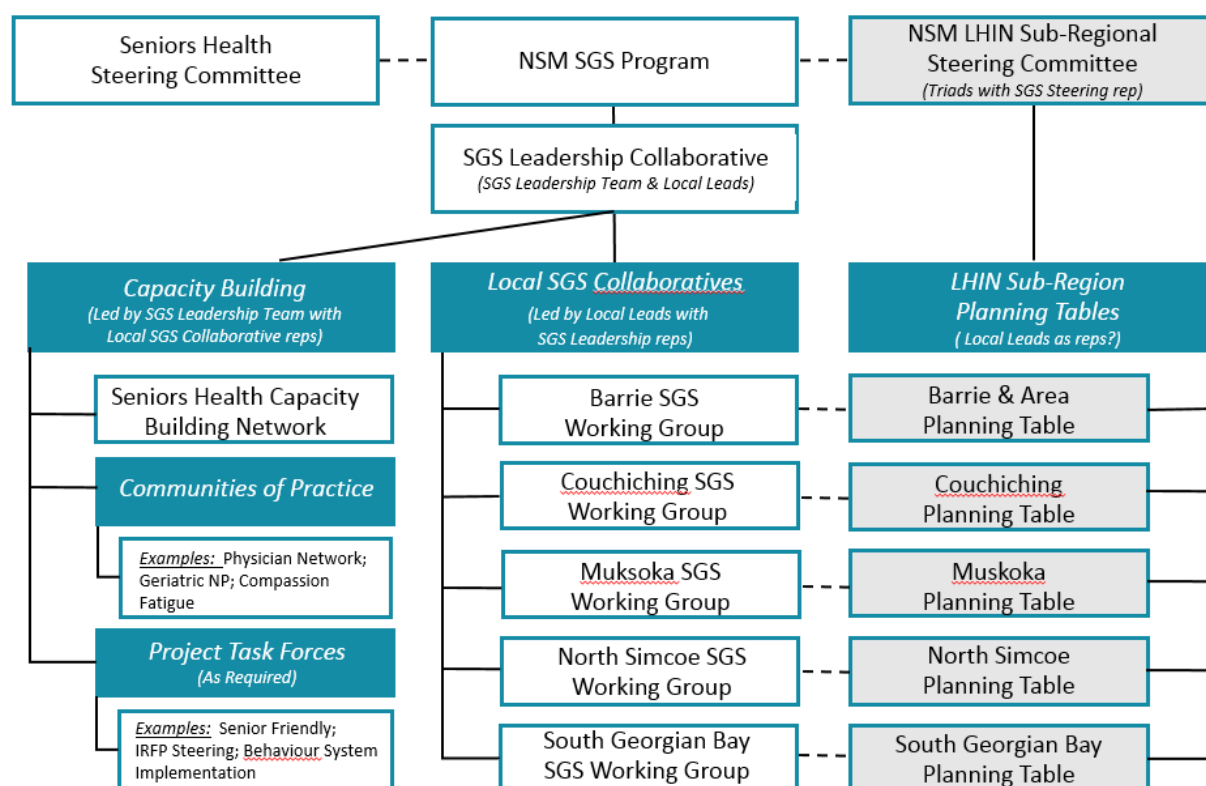


<sup>5</sup> Specialized Geriatric Services and Regional Geriatric Programs: Review and Recommendations (DRAFT Report); June 2015

With recent LHIN activity focused on refreshing regional and local governance structures, there is an opportunity to better align SGS-related work. In doing so, the SGS program can advance strategic directions while concurrently continuing to play a leading role in regional health system planning. To better align with LHIN activity:

- Working groups will be established in each sub-region to support the work within local SGS collaboratives. These working groups will be aligned with LHIN sub-region planning tables to promote planning coordination and facilitate local and system communication.
- The committee structure naming convention will be updated to reflect the changing environment (i.e Project Teams replaced by Steering Committees).

The following graphic shows the interface between the SGS program oversight structure and the new LHIN structure:



## Funding

In general, the SGS program will be responsible for central (hub) resources. As noted in the model assumptions above, these resources would include highly specialized resources that are scarce and/or will serve a low volume need across the region. The SGS program may be responsible for local SGS team resources but so to could the local leads or other partners depending on the conditions of funding and community

readiness. The ultimate goal of funding, in alignment with the Hollander and Prince framework, is to advance the premise of a single funding envelope where possible and appropriate, especially when “new” funding can be leveraged as an incentive.

As stated in the *Clinical Design (2016)*<sup>6</sup> report “...the desired clinical design will take time to implement. In the interim, Waypoint and the LHIN will work with area health service providers to advance implementation planning. Although much of the work will be achieved through collaboration and partnerships there may be a need for the LHIN to amend Service Accountability Agreements with LHIN-funded health service providers to encourage and achieve alignment.” (p.24). Going forward, the preference will be to create new service and funding agreements between the SGS program and partner organizations. As required, there may be a need for the LHIN to create new, or alter existing, Service Accountability Agreements with health service providers to advance the implementation of local SGS teams.

### **Recommendation: Oversight & Funding**

In the spirit of creating a truly regional program, it is recommended that...

- i) A new oversight structure be established based upon the principles of shared responsibility to guide implementation of local SGS teams. This structure should build upon work underway with NSM sub-region planning; the local lead should be a participant at the local sub-region table as the link to SGS local and system planning.
- ii) The LHIN should continue to advance the concept of an NSM SGS program single funding envelope, where possible and appropriate.
- iii) A means of outlining roles and accountabilities between the LHIN, the SGS program and the local SGS collaboratives (including the local lead) be defined (i.e. project charters; accountability and authority agreements; legal service agreements; development of new/ amendments to existing LHIN Service Accountability Agreements).

## **Health Human Resources (... the who)**

As noted in the *Clinical Design (2016)* document, there are no benchmarks for SGS health human resources in the province. However, there is a combination of Regional Geriatric Program (RGP) performance data, literature, and NSM local experience/ context that can be factored into decisions on minimum base resources required in a local SGS team. The *Clinical Design (2016)* document provides a reasonable foundation for planning. Current work within the SGS program related to the redesign the BSS, Integrated Regional Falls Program (IRFP) and Enhanced SMART resources provides good momentum to support continued action.

## Planning Directions

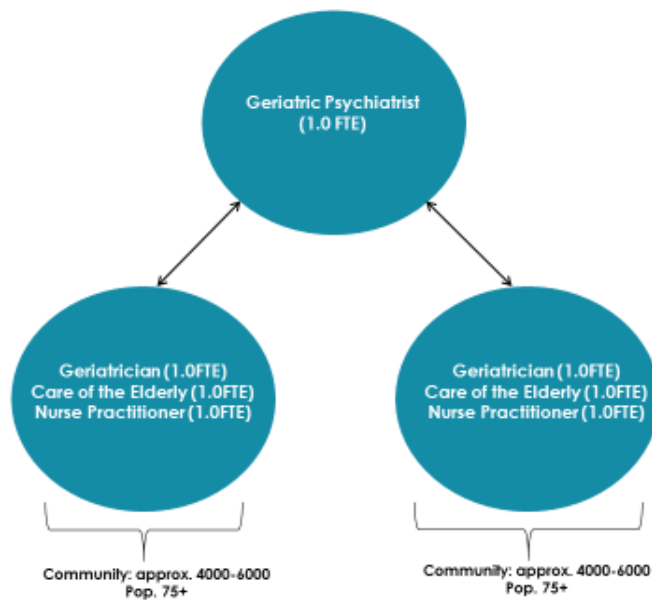
The following are proposed as directions to guide health human resource planning:

- Recommendations from the *Clinical Design (2016)* document regarding health human resources continue to guide planning for the local SGS teams:
  - Ideal ratio of SGS case manager to frail senior = 1: 30-35.
  - Time be built into team member schedules to support staff capacity building and SGS operations (min. 2-3 days/ month per 1.0 FTE).
  - Time be built into team member schedules to support building capacity among patients, caregivers and providers (up to 1 day/week per 1.0 FTE).
  - Coverage for vacation, sick time, education days and extended absences be built into SGS resources (1.0FTE coverage for every 5.0FTEs).
  - Ratio 1 SGS clinician per 100-120 hospital beds for each defined service.
  - Ratio 1 SGS clinician per 120-175 LTC beds for each defined service.
- That specialist physicians:
  - Be members of the SGS program hub.
  - Work in a collaborative practice model as a resource and support to local SGS teams. Support would include, for example, attending team rounds and providing specialized clinics in the sub-regions as well as supporting capacity building within the team and with other health service providers in the sub-region.
  - Remain connected with an acute care facility to support the ongoing development of SGS within the hospital sector in the NSM LHIN. This also ensures access to adequate remuneration opportunities until an alternate funding arrangement is established.
  - Have privileges across NSM hospitals to support sub-specialty expertise that may develop over time and to support coverage.
  - Be regionally aligned based on a ratio of approximately:
    - 1 geriatrician: 4,000 – 6,000 age 75+
    - 1 geriatric psychiatrist: 2 Geriatricians
- A Physician / Nurse Practitioner (NP) triad model be established in each local SGS team based on a ratio of approximately 1 triad: 4,000 – 6,000 age 75+<sup>6</sup>. Triads will be comprised of a Geriatrician, a CoE Physician and a NP. The SGS program model will leverage the triad as the basis of the medical resource requirements in each local SGS team, with the geriatrician functioning as a second level of consultative support. One geriatric psychiatrist will be aligned

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<sup>6</sup> There are no recent published benchmarks for Geriatricians although the Ontario Delphi Consensus Survey (1988)<sup>6</sup> recommended one Geriatrician/3,488 pop.>age 75 which has been supported by the British Geriatrics Society (e.g., 1/4,000 pop.>age 75). Benchmarking related to specialist physicians must factor in practitioners like CoE physicians and NPs, especially those working to full scope.

with every two triads<sup>7</sup>. At this time, this would translate into 1 triad in each sub-region, with two in the Barrie area to support current demographics.



- In alignment with the *Clinical Design (2016)* document, each triad be supported by a broader interprofessional team. The interprofessional team:
  - Would have the fundamental skill set and scope of practice required to undertake CGAs, management and treatment in the community.
  - Evolve toward functioning as a transdisciplinary (vs. multidisciplinary or interdisciplinary) team which will require investment in capacity building and make resource retention critical.
  - Provide service across the continuum of care, as appropriate, to support assessment, diagnosis, care planning and communication and ultimately more effective and timely transitions to the next level of care.
  - Be based upon a minimum resource base to effectively deliver ambulatory, congregate, outreach and in-reach services as required given the population and geography<sup>8</sup>. This includes:
    - At minimum, one nurse and allied health dyad working together (physiotherapy or occupational therapy). Ideally two dyads should

<sup>7</sup> The *Guidelines for Comprehensive Mental Health Services for Older Adults (2011)* by the Mental Health Commission of Canada recommends the benchmark for the physician component of a geriatric mental health outreach team be 1 FTE:10,000 seniors.

<sup>8</sup> Local SGS team resources are contingent upon geography, other available community resources, team maturity and experience, and patient socio-economic factors. Recent experience of the Couchiching community outreach/clinic shows that 3.8 FTEs see ~230 new referrals and complete ~800-1000 follow-up visits/year; excluding Geriatrician visits in the clinic. This equates to 60 new referrals / FTE and between 210-260 follow-up visits. A recent analysis of outreach team activity in a metropolitan area found 1 FTE supported between 116 to 209 visits/year/FTE, serving to validate the Couchiching experience.

be present, one comprised of physiotherapist (PT) and one of an occupational therapist (OT) with resources also support the Enhanced Seniors Maintaining Active Roles together (SMART) program.

- One social worker (SW) providing social services support, family counselling and customized wrap around care.
  - One Intensive Case Manager from HCC to assist with the high-risk patients and facilitate transitions/communication across sectors.
  - Community and LTC-targeted BSS resources.
  - One nurse with expertise in mental health and addictions to support links with the geriatric psychiatrist.
  - Enhanced SMART program (kinesiologist, rehabilitation assistant).
  - One of each for every 100-120 acute care beds to support communication, hospital flow and capacity building<sup>9</sup>:
    - Geriatric Emergency Management Nurse (7-day coverage preferred)
    - Advanced Practice Clinician (Nurse Practitioner preferred)
  - One administrative assistant (initially dependent on the size and activity within the local SGS team).
  - Access to:
    - SGS hub resources including, for example: pharmacy, clinical dietitian, speech language pathology, psychometrist, behaviour technicians, psychogeriatric resource consultants.
    - LTCH NPs (ideally 1:120-175 LTCH long-stay beds)
- Apply a “build it and they will come” and a continuous quality improvement approach to planning given the challenges with benchmarking and the extent to which true needs across the sub-regions are unknown.
  - Leverage existing resources already available as a first step in all sub-region planning. This includes evolving the Integrated Regional Falls Program (IRFP) team to a broader focus on geriatric medicine and having all resources participate in a CGA-approach to assessment and care.

## Approach to Redesign

While the health human resources proposed seem significant, there are resources in the region providing care to frail seniors that can be redesigned and/or re-aligned to form local SGS teams. The journey ahead around implementation will be impacted by the type and magnitude of change required and the limitations imposed by funding types and funding parameters. However, the delivery of effective CGA, management and

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<sup>9</sup> As per the Clinical Design (2016) document, smaller organizations could establish a shared GEM/APN role or an in-reach model from the SGS hub (resource dependent) could be applied.

treatment is contingent upon having staff with the right scope of practice, particularly the medical manpower to diagnose, treat and rehabilitate a very complex population. While there are various approaches that could be used to advance redesign, the focus will be on:

- Improving partnerships;
- Leveraging attrition and vacancies;
- Redesigning roles and scope where feasible;
- Re-assigning staff where possible;
- “Growing our own” through education and mentorship opportunities, including consideration of investing in advanced education/training to fulfill new roles in the system; and
- Encouraging new investments when able and appropriate in alignment with LHIN and ministry directions.

### **Recommendation: Health Human Resources**

It is recommended that...

- i) The health human resource planning directions be accepted for the purpose of beginning planning discussions related to the implementation of local SGS teams, understanding directions may need to be modified to accommodate available resources, local context and available funding.
- ii) Starting with those resources under SGS program control, continue the redesign journey in alignment with clinical design directions.
- iii) The SGS program and local lead work with their local SGS collaborative to map existing resources, identify redesign opportunities and confirm the minimum investment needed after the mapping exercise to create “one” local SGS team in each sub-region. Based on the mapping exercise, align SGS program resources and leverage local resources.
- iv) Surplus funding realized through early reorganization of services and/or regionalization of services and/or any new funding that becomes available through relevant LHIN or Ministry initiatives be allocated to fill the:
  - Identified gaps in clinical care and health human resources across the sub-regions. Optimizing existing administrative and leadership resources will be necessary to prevent additional investment in non-clinical staff.
  - Gap in physician remuneration until such time the Ministry commits to an AFP.

# Implementation Strategy

## Implementation Assumptions

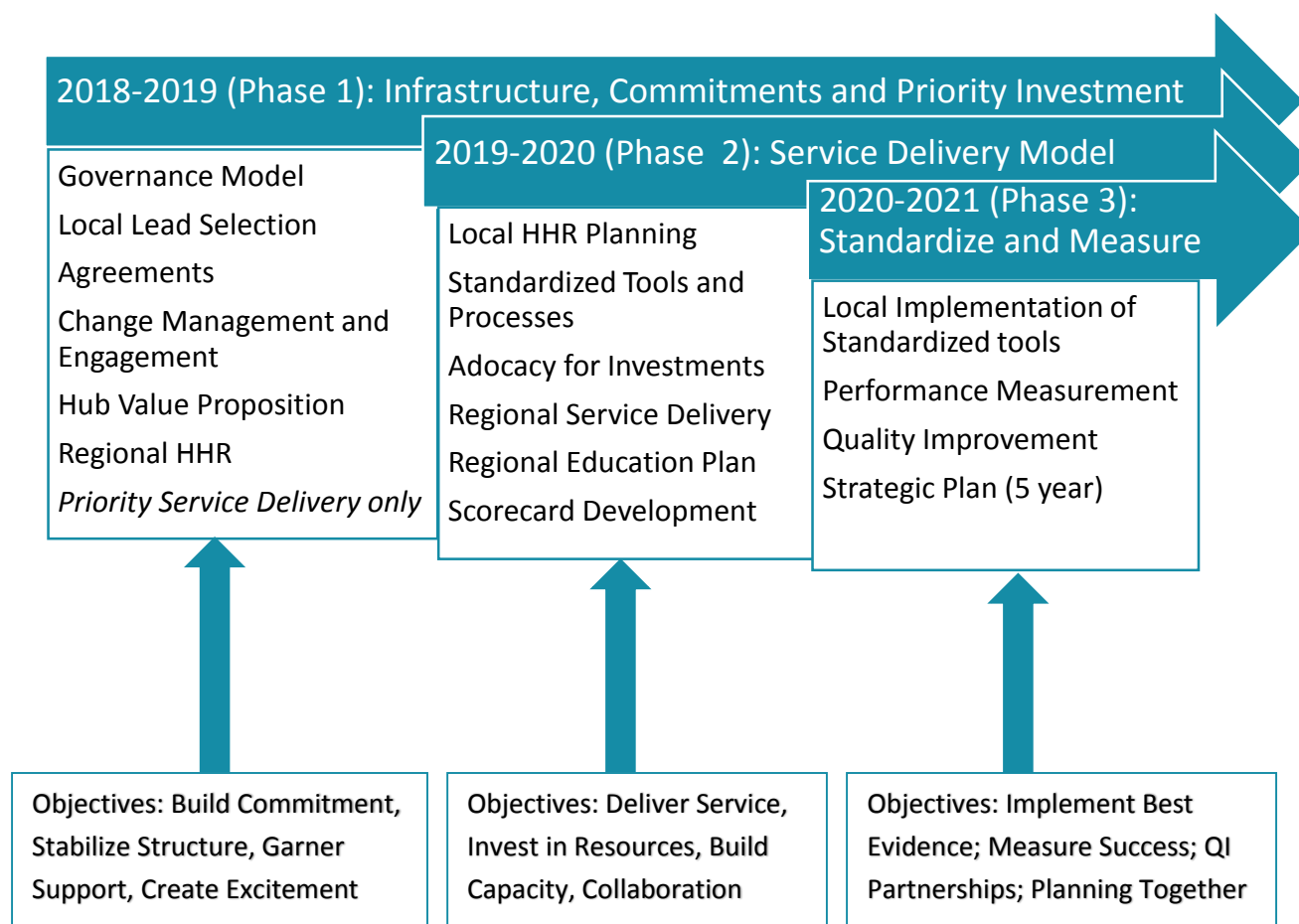
The implementation strategy is built upon the following assumptions:

- Implementation will require a three-year timeframe to be successful.
- Implementation will represent a significant change for health service providers across the region and will require support for change management strategies.
- The oversight structure will be established first to facilitate the engagement and shared responsibility required to advance the model beyond the current SGS leadership team.
- Implementation of local SGS teams should begin once the oversight structure is in place. Consideration will need to be given to the timing of sub-region implementation.
- Some regions may be better prepared than others to develop the local SGS team. Striking a balance between supporting these teams to move forward with some planning, yet preventing local areas from moving forward independently, will be necessary to reduce frustration for those embracing this change early.
- Leveraging existing health human resources to create the local SGS teams will require collaboration between providers. It will be necessary to take the time to establish the cooperation mechanisms locally (including building trust) before advancing the “one team” concept in all regions.
- All partners are committed to, and interested in, advancing the new regional program together. Partners, in fact, want to work together to create a better system and believe that a unified approach will be the most successful.
- As regional and local SGS resources are enhanced/added, all frail seniors in the local area must have equal access to receive care (e.g. not being “rostered” to a particular family practice cannot be a barrier to access).

## Implementation Approach

A three-year approach to implementation will be utilized, beginning with building the infrastructure required, implementing local SGS teams and ultimately measuring and reporting as one system.

A project charter will be developed that will include a detailed implementation plan based upon the three-year phased approach. Although timelines should be ambitious, it will be important to stay focused on the desired state, capture and share successes along the way and ensure partners remain engaged and committed to the project. As with any continuous quality improvement initiative, it will be necessary to evaluate progress and utilize implementation experience to constantly adjust and modify the plans and timelines.



### Recommendation: Implementation Approach

It is recommended that...

- i) A three-phased approach to implementation be applied, acknowledging the primary focus in year one is establishing the oversight structure and ensuring engagement and shared responsibility for implementation.
- ii) A detailed project charter with associated timelines be developed to guide planning.
- iii) The local lead selection process be initiated as soon as possible.
- iv) The SGS program continue to leverage the already adopted/developed change management framework and communication strategy.
- v) A mechanism be put in place to identify successes and lessons learned as part of a quality improvement approach.
- i) Implementation of a readiness self-assessment be utilized with the local collaboratives to determine which teams are ready to advance the "one team" concept; and, to ensure broad engagement and education regarding the successful components of a collaborative team.

## Appendix A

### Implementation Considerations: Background

Changes/Updates Since Completion of the *Clinical Design* (2016) Document

#### Data

#### Demographics

Most recent demographics indicate the NSM LHIN has the third highest proportion of seniors compared to the rest of the province. Seniors comprise 19.6% of the total population with 90,615 over the age of 65.<sup>10</sup> Although Barrie and surrounding area has the lowest proportion of seniors, they have the highest number of seniors in the region with almost one third of all estimated frail seniors living in Barrie and Area.

|                                         | Barrie<br>Area | & Couchiching | Muskoka<br>& Area | North<br>Simcoe | South<br>Georgian<br>Bay | Total   |
|-----------------------------------------|----------------|---------------|-------------------|-----------------|--------------------------|---------|
| <b>Total Population</b>                 | 217,348        | 76,045        | 60,599            | 48,302          | 63,262                   | 464,263 |
| <b>Seniors&gt;age 65</b>                | 30,250         | 16,780        | 15,440            | 11,625          | 16,900                   | 90,615  |
| <b>Proportion</b>                       | 14%            | 22.1%         | 25.5%             | 24.1%           | 26.7%                    | 19.6%   |
| <b>Seniors&gt;age 75</b>                | 12,985         | 7,205         | 6,710             | 4,690           | 6,895                    | 38,350  |
| <b># Potentially Frail<sup>11</sup></b> | 4,540          | 2,517         | 2,316             | 1,743           | 2,535                    | 13,651  |

**Table 1. Proportion and Total Volume of Seniors and Potential Frail Seniors in NSM**

#### ALC Data

NSM hospitals continue to report significant challenges with alternate level of care (ALC) pressures in acute care with a reported rate that is consistently among one of the highest in the province. As of January 2018, NSM had the fifth highest ALC rate in the province (19.9% compared to 15.1% for the provincial average), with an increase of 34% more cases compared to the same time last year<sup>12</sup>.

<sup>10</sup> Source: 2016 Census

<sup>11</sup> Source: 15% of 65+ (RGPO Fact Sheet)

<sup>12</sup> Source: North Simcoe Muskoka LHIN ALC Performance Summary, January 2018, CCO

## NSM SGS Program Planning

Since the completion of the *Clinical Design (2016)* document, additional work has been done to support and advance the SGS program.

### SGS Program Infrastructure

A number of initiatives were aligned and initiated by the new SGS leadership team including establishment of a Physician Network, alignment of the Geriatric Nurse Practitioner (NP) Community of Practice, development of the SGS Health Information Strategy, development of the SGS Education Strategy, and the launch of a new website ([www.nsmmsgs.ca](http://www.nsmmsgs.ca)).

### Renewed SGS Program Strategic Framework

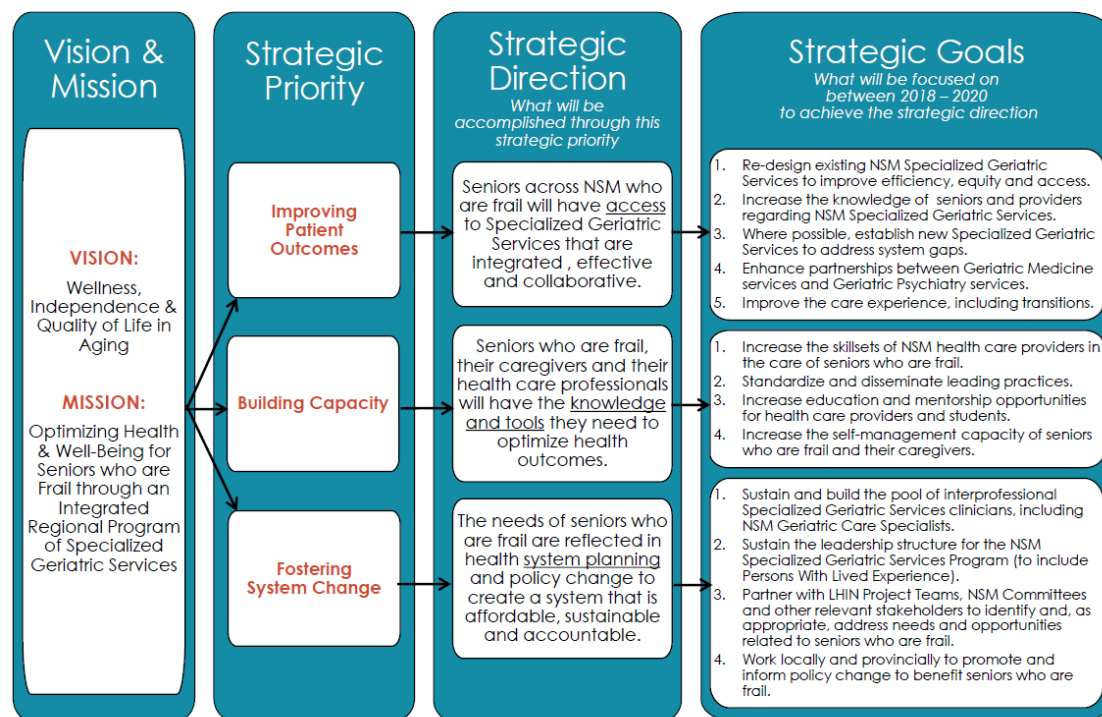
In late 2017, the SGS leadership team refreshed the original quality framework as a guide for action until 2020 maintaining the three original strategic directions:

- Improving patient outcomes
- Building capacity
- Fostering system change.

The SGS strategic directions directly align with the NSM LHIN IHSP (2016-2019) three strategic priorities.



### Quality Framework 2018 - 2020



Final November 17, 2017

## Specialized Geriatric Services Program Redesign

In 2017, and in alignment with the *Seniors Health Program Review (2015)* recommendations, SGS leadership began the process of designing the regional service delivery model for a number of key programs starting with the NSM Behaviour Support System (BSS). April 1, 2018, saw the leadership for both the Integrated Regional Falls Program (IRFP) and the Enhanced SMART program transfer to the SGS program.

### Behaviour Support System

Like many LHINs across the province, NSM is trying to reconcile the following realities:

- Dementia projections and the associated impact;
- Behaviours as the most significant contributor to ALC days;
- Gaps in service and variations in quality of care; and,
- The significant risks providing care in environments that are neither equipped nor suited for individuals with responsive behaviours.

Since June 2017, the SGS leadership team has been implementing redesign changes within the BSS team to increase access to services, improve the standardization of care and enhance the quality of outcomes. NSM has worked within Behaviour Supports Ontario (BSO) funding parameters to redesign existing services and to leverage new base funding to expand programming across the region. One-time BSO funding has supported capacity building activities and key projects like:

- Development of seniors' mental health curriculum to support regional training;
- Completion of an operational plan for a Transitional Behaviour Support Unit;
- Development of a draft BSS Performance Monitoring & Evaluation Framework; and,
- Completion of current and future state mapping to support the establishment of a BSS electronic health record (live effective June 2018).

The redesign work completed to date has been applauded by many key stakeholders.

### Integrated Regional Falls Program

In 2010, Orillia Soldiers' Memorial Hospital (OSMH) was designated the lead agency to host the newly established IRFP, a provincially-funded Aging-at-Home initiative. IRFP is a regional community-based falls prevention program, set in place to reduce the risk of falls and falls related injuries in NSM seniors. Its four key services include:

- support to NSM emergency departments
- community screening clinics
- specialized assessment clinics
- home visiting

In alignment with recommendations from the *Seniors Program Review (2015)* document, OSMH and Waypoint (lead agency for the SGS program) submitted a voluntary integration business case to the NSM LHIN in fall 2017. The business case proposed that

the IRFP lead agency role and responsibilities be transitioned from OSMH to Waypoint. The LHIN Board supported the voluntary integration and Waypoint assumed responsibilities for IRFP, as part of the SGS program, as of April 1, 2018.

### **Enhanced Seniors Maintaining Active Roles Together (Enhanced SMART)**

The SMART program was initiated in 2008 by the Victoria Order of Nurses (VON) and expanded in 2013 with physiotherapy (PT) reform across the province. It is a volunteer-based congregate exercise program led by the VON and offered in communities across NSM. SMART focuses on maintaining and promoting the health and well-being of seniors through regular group exercise and education.

In 2014, the Enhanced SMART program was established. The enhanced program leverages the existing successful SMART program but focuses on *frail* seniors who require more specialized assessment and individualized support. The enhanced program includes a congregate and, for a targeted population, an in-home exercise program. Both are complemented by an education component, the same as that offered through SMART. The program is offered twice a week for a defined period, with the goal to transition participants to a lower level of support such as the regular SMART program.

The NSM LHIN transitioned leadership and responsibilities for Enhanced SMART to Waypoint, as part of the SGS program, as of April 1, 2018.

### **Sub-Region Activity & Key Informant Interviews**

Between January – March 2018, meetings were held with sub-region partners to inform the development of the commissioned report. The following reflects the key findings from that consultation process along with additional information reflecting most recent activity.

#### **Barrie and Area**

Barrie and its surrounding area is home to just over 217,000 permanent residents of which 14% / 30,250 are over the age of 65. Although the Barrie area is comprised of a comparatively younger population, one third of the total population of seniors (~30,000) in the NSM LHIN live in the Barrie area.

The residents in the sub-region are serviced by a large 319 bed regional hospital, Royal Victoria Regional Health Centre (RVH), which is also home to many of the LHIN's regional programs (e.g. Cancer, Cardiac, etc.). Primary care in the sub-region is delivered by a large family health team with ~150,000 patients rostered and 95 family physicians, the Barrie Community Health Centre (BCHC), and the Georgian Nurse Practitioner (NP)-led clinics. There are only nine solo physicians still practicing outside of these organized practice models.

The Barrie and Area sub-region has the largest number of specialized geriatric services, many of which are housed at RVH.

RVH is committed to providing excellence in acute care for frail seniors and has developed a SGS Strategy to guide planning in seniors' care over the coming years. RVH's core specialized geriatric services are delivered by a geriatrician and 2 NPs who provide consultation services to inpatients across the campus and the Emergency Department (ED), as well as participating in the ambulatory clinics that are offered on site. This small team offers an outpatient geriatric clinic operating two days per week (urgent geriatric assessment clinic) and, as part of the IRFP, a falls clinic one day per week with a 0.2 PT involved. The wait time to see the RVH geriatrician is almost one year. There are two geriatric emergency management (GEM) nurses working in the ED who liaise with the consultation team as necessary. In addition to the availability of the consultation services in-house, RVH has designated a 34-bed medical unit as a Seniors Care Unit (Acute Care of the Elderly [ACE] Unit). Originally the unit was a closed unit for acutely ill seniors but is now a general medical unit serving primarily an older population, many of whom have dementia. The unit offers additional support seven days a week from behavioural support workers (therapeutic recreational staff) who assist with care planning. The unit utilizes the geriatrician for consultation with the hospitalists functioning as Most Responsible Physicians (MRPs). RVH has also implemented the Hospital Elder Life Program (HELP) – a program that utilizes trained volunteers who sit with and support older individuals who may be experiencing delirium to prevent further deterioration and negative outcomes such as falls. In summer 2018, RVH recruited a new geriatrician. At this time, it is unclear to what extent he will support inpatient or outpatient specialized geriatric services.

As with many of the acute care hospitals, RVH is experiencing significant ALC issues and is having transition challenges with local long-term care (LTC) homes. Many patients have responsive behaviours that are posing a barrier to discharge. As of December 2017, RVH had the highest percentage of acute care beds occupied by ALC (33.7%) and had opened a 36-bed transitional care unit for ALC patients awaiting either home care, convalescent care, retirement home or LTC.

The Barrie and Community Family Health Team (BCFHT) Aging Well Clinic is part of the chronic disease management program. It is a consultative multidisciplinary comprehensive geriatric assessment (CGA) clinic serving frail seniors (frailty scale 5-6). The team includes nursing, occupational therapy, and a pharmacist, and has access to a Care of the Elderly (CoE) physician twice per month, the geriatric psychiatrist one time a month, and receives some physiotherapy support from the Barrie Community Health Centre (CHC). The team carries approximately 250-300 active patients at any one time and receives about 25-30 referrals/month from the BCFHT physicians or members of the interprofessional team. Although consultative in nature, the team may follow some patients more intensively, such as those with cognitive decline, providing support as the disease process evolves. The goal of the clinic is to support family physicians in managing frail seniors with complex needs in the community through a "shared care" model. In addition to the consultative clinic, the team is actively involved in supporting the hospital through both formal and informal means. The team offers a pre-op optimization program for frail seniors and accepts direct referrals from hospital specialists and hospitalists to support the transition between hospital and community for BCFHT rostered patients. The team also informally liaises with specialized geriatric service

team members at RVH to prevent duplication in services and improve care coordination. The team has identified the need for additional physician support.

The BCHC provides primary care to approximately 3,100 vulnerable individuals in Barrie and the surrounding area, including frail seniors with complex needs. The BCHC functions as a resource to the broader community (including BCFHT patients) offering education and support to the community as part of their core mandate. Using Aging at Home funding, the BCHC grew the North Innisfil Health Services Program (priority program) and now offers comprehensive specialized geriatric primary care to approximately 450 patients across the region. The team consists of 2 NPs and a CoE physician providing CGA, outreach, and primary care for some of the most complex seniors in the area.

### **Couchiching and Area (including Rama First Nation)**

The Couchiching region is home to approximately 76,000 residents with more than 16,000 of those residents over the age of 65 (22%). The region is served by Orillia Soldiers' Memorial Hospital (OSMH), a full-service 160 bed hospital located centrally in the region in the city of Orillia. Primary care in the sub-region is primarily provided by the Couchiching FHT. This practice group includes 47 family physicians who cover the Orillia and surrounding area; there are only two, family physicians practicing outside of the organized practice model. The CFHT has approximately 56,000 patients rostered. There is a full complement of inter-professional team members and a number of physician specialists who visit regularly.

In 2015, OSMH closed their Geriatric Day Hospital. To ensure that the service continued and had a strong integration with primary care, the clinic re-opened as part of the Couchiching FHT under the medical leadership of Dr. Kevin Young (with the model also used to inform the design of the Enhanced SMART program). The clinic subsequently moved to larger space but continues to be connected operationally to the Couchiching FHT. Although the hospital no longer offers any outpatient specialized geriatric services, they continue to develop services targeted to supporting seniors both locally and regionally. Until recently, OSMH led the IRFP and is currently the local provider for the Nurse-Led Outreach Team (NLOT) in 8 LTC homes across NSM. OSMH has 2 geriatricians within their internal medicine team who continue to provide on-call services for the hospital. The geriatricians work with a geriatric resource clinician, who provides consultations for in-patients across acute care. Recently, the hospital implemented a 40-bed integrated rehabilitation unit - a unit that integrates rehabilitation services and acute medicine together. On this unit, the hospital has designated and operates 10 ACE beds. The unit supports early discharge and prevents functional decline by using a restorative care philosophy and senior-friendly best practices, including order sets. Like RVH, OSMH is experiencing unprecedented numbers of ALC patients (with 33.2% of acute beds occupied in December 2017), with a number of these patients presenting with dementia and responsive behaviours. The hospital also implemented the HELP program to support hospitalized seniors.

The Couchiching FHT Specialized Geriatric Assessment Clinic offers CGA through both outreach and clinic visits. The Couchiching FHT Executive Director secured funding for

a dedicated seniors' care inter-professional team through an application to the Ministry of Health and Long-Term Care (MOHLTC) that demonstrated proof of community need. The clinic has been running for approximately 4 years and has 2 geriatricians, 1.8 FTE gerontological nurses, 2 occupational therapists; 1 clinic coordinator (RPN), and administrative support. The outreach team (nurse and OT) complete the initial CGA in either the person's home or the clinic followed by the follow-up visit with the geriatrician in the clinic. The clinic receives approximately 230 referrals per year and clinic staff conduct about 90 initial home visits and 140 initial in-office assessments in addition to approximately 800-1000 follow-up appointments per year. There currently is a 4 month wait for initial assessment by the team. Clinic leadership and the team recognize the potential benefit of augmenting the team by adding physiotherapy and social work to assist with managing and navigating services for some of the complex cases for patients with significant financial and/or other social needs. In addition, a third geriatrician consults monthly with the team and is supported by the Clinical Nurse Specialist from the SGS program. The geriatrician, with a subspecialty in nephrology and chronic pain management (including medical marijuana), travels to the region from Hamilton once/ month. Dr. Young has located all clinic services in one location at Leacock Care Centre along with other community services such as the Enhanced SMART Program and the Alzheimer's Society. More recently agencies such as Helping Hands (for navigation) and Functional Fitness are sharing this space as well. The geriatricians have also committed to providing services regionally, including travel to other NSM sub-regions to deliver education and provide some consultative advice. They see this as their role in community capacity building and to pave the way for the new regional program. Like RVH, an IRFP Specialized Assessment Clinic operates in this space on a regular basis with support from a geriatrician.

### **Muskoka and Area (including WAHTA Mohawks & Moose Deer Point)**

Muskoka and area is home to just over 60,000 permanent residents, with approximately 15,440 (25.5%) 65+ and 6,710 (11.1%) 75+. Of note is the large surge of seasonal residents (estimated to be as high as 85,000) that occurs over the summer months. The Muskoka sub-region has the largest geography accounting for 47% of the total size of the NSM LHIN. The sub-region is serviced by Muskoka Algonquin Healthcare (MAHC), a 96-bed hospital with two campuses located in Bracebridge and Huntsville (note: 16 beds are Complex Continuing Care [CCC]). Primary care is delivered predominantly through two family health teams (Algonquin FHT and Cottage Country FHT) and a NP-led clinic. There are only three family physicians who practice outside of this organized practice model. The sub-region is currently undergoing a significant health system transformation planning exercise intended to reduce duplication and improve integrated delivery – known as the Muskoka Area Health System Transformation (MAHST).

Currently there are a few specialized geriatric services being delivered across Muskoka, most notably geriatric assessment and outreach, and care coordination for complex seniors in the community. In addition, the sub-region utilizes other regional services (geriatrician and geriatric psychiatrists) for education and consultation and is a significant user of the Ontario Telemedicine Network (OTN) network, leveraging this network for both education and clinical consultation. With the implementation of Health Links there was an investment in additional care navigators (2.6 FTE) who support

coordinated care planning for complex patients, including some of the frail seniors seen by other SGS teams in the sub-region.

In 2011, MAHC received funding to establish the Seniors Assessment and Support Outreach Team (SASOT). SASOT was a pilot project and was intended to be the first local SGS team in NSM, in alignment with the *Vision* (2009) document). During design, a focus was placed on addressing ALC challenges, improving flow, and reducing unnecessary ED visits. SASOT is a multi-disciplinary team that spans the community and the hospital, with a focus on coordinating wrap-around services for frail seniors with complex needs. This wrap-around service is an important component of a community SGS team, recognizing that maintaining frail seniors in the community often requires a unique constellation of health and social supports that are customized to the individual's needs. The team serves the south portion of the area (Port Sydney and south) and has a strong presence in the community. They receive referrals from many partners including a number of community agencies like Home and Community Care (HCC), family physicians, and local pharmacies. The team crosses from the hospital to the community providing transition continuity for the patient. The team is recognized as having a "just do it" and person-centered approach to their work. Although the team is not providing CGA, they appreciate that this should be built into their team going forward and have identified the need for physician/NP involvement in the team, as well as access to other health disciplines (e.g., Speech Language Pathology).

The Algonquin FHT is located in north Muskoka and has 21 physicians (many part-time) serving Huntsville and the surrounding area. There are two initiatives targeted at seniors – an education series and a Geriatric Care Team. The 10-week healthy living education program for seniors runs four to five times per year and covers both disease-specific and lifestyle-specific topics with a focus on prevention. The Geriatric Care Team is a consultative community geriatric outreach team consisting of 2 RNs (1.6 FTE), an NP, and an HCC Intensive Case Manager who is involved in complex high-risk cases. The team sees patients in their homes who are declining, completes a CGA, and liaises with the primary care practitioner for follow-up. The team will continue to see the patient for as long as is needed, participating in care navigation and wrap around services as required. One unique feature of the team is the role of the NP who works to full scope and sees patients in both the community and in hospital. The NP visits the hospital every day collaborating with the care teams to assist with diagnosis and care planning, as well as pulling patients back into the community. The NP utilizes OTN to facilitate specialist consults and follows the patient until they are transferred to their destination outside of hospital to ensure a smooth transition and consistent plan of care. The Algonquin FHT has limited access to allied team members.

The Cottage Country FHT is located in south Muskoka and has 19 physicians serving the Bracebridge and surrounding area. The Cottage Country FHT offers a geriatric consultative service for the family physicians with a particular emphasis on memory assessment. The team reviews referrals from family physicians and completes an assessment specific to the referral (e.g., memory issues, polypharmacy, navigation, etc.). With a full-time pharmacist on the team, there is strong emphasis on early identification of drug-related issues, addressing polypharmacy and implementing safe medication use for seniors. The pharmacist also undertakes electronic medical record

screening for patients with high-risk meds, and initiates medication reviews with the family physicians. The memory clinic is operated by a CoE physician and is modeled after the Linda Lee Memory Clinic model. The team (nurse, pharmacist, CoE physician and HCC care coordinator) participate in this multidisciplinary assessment clinic and link with the SASOT team for care navigation in the community as required. Like the Algonquin FHT, the Cottage Country FHT also has limited access to allied team members.

Across the region there are many resources dedicated to navigation and coordination, including resources within HCC, SASOT and Health Links. There has been some discussion in the region around this as overlap and duplication has been identified.

### **North Simcoe (including Christian Island Beausoleil First Nation)**

The North Simcoe area is the smallest region geographically and by population and is home to 48,000 permanent residents with 11,625 being over age 65. Similar to other areas in the LHIN, this sub-region is impacted by significant seasonal growth over the summer months. Local residents are served by the Georgian Bay General Hospital (GBGH), a 115-bed full service hospital located in Midland with ambulatory and administrative services at the Penetanguishene campus. In addition to a very busy ED (47,000 visits per year), the hospital operates 79 acute in-patient beds, 21 complex continuing care beds, and 15 rehabilitation beds. The hospital is under redevelopment with a plan for additional mental health beds (20) and day services. As with many hospitals in the province the in-patient population is primarily seniors, with an average age of 80.

Primary care in North Simcoe is far less organized in contrast to other sub-regions, with only 22 of the 45 family physicians delivering care as part of the North Simcoe FHT (serving approximately 25,000 residents). The remaining 23 physicians work outside of this model in small group practices (family health organizations [FHOs]) or as solo practitioners. This has created challenges in the community as more than 50 per cent of residents do not have access to team-based care. The North Simcoe FHT has submitted a proposal to become a "Family Health Centre" (Health Hub) that will offer the full spectrum of team-based support to local residents, regardless of whether they are rostered with the FHT. There are no plans at this time to direct any of these services to the frail senior population.

The Chigamik CHC has two physicians, several NPs, and a number of other practitioners, including traditional healers, social work, physiotherapy and dietician. Their focus has been primarily the marginalized population in the community, as well as the francophone population and those seeking traditional healers.

Currently, North Simcoe does not have local specialized geriatric services available to its residents and there are no geriatricians or CoE physicians in the area. The North Simcoe FHT does, however, facilitate distance consultation with a geriatrician and a geriatric psychiatrist from Toronto utilizing OTN. A HCC care coordinator participates in these consultation sessions to support care coordination for this population. Although there are no coordinated services for frail seniors in the region, there are lessons that

can be learned from earlier initiatives. A few years ago, an NP-led geriatric assessment clinic was implemented in the region. Initially the clinic was inundated with appropriate referrals to see frail seniors (and often their partners) who required assessment and follow-up. However, due to the lack of available support and infrastructure, the NP found the work overwhelming and left the community, resulting in the discontinuation of the service.

The administration at GBGH is aware of existing gaps in service in hospital and in community, and attributes much of this to a lack of coordination of services across the entire sub-region. The hospital has expressed an interest in building a coordinated geriatric program that spans the hospital and community, and views Phase 2 of their redevelopment as an opportunity to advance planning for seniors' care.

### **South Georgian Bay**

The South Georgian Bay region is home to 63,000 permanent residents and, like Muskoka, experiences a significant influx of seasonal residents. This sub-region has also experienced significant population growth (11.7%) between 2011 and 2016 and has the highest proportion of seniors (26.7% or 16,900) in the NSM LHIN. Many seniors have relocated to the area for their retirement. The local residents in the area are served by the Collingwood General and Marine Hospital (CGMH), a 68 bed general hospital with an active ED that has approximately 35,000 visits per year. There are no complex continuing care, rehabilitation or mental health beds in the region, although community mental health services are available through the CGMH Community Mental Health Service. A Seniors Advisory Council has been established in the hospital to guide the implementation of Senior Friendly Care, and clinical leadership is actively working to establish a sustainable champion model for behavioural support.

Primary care in the region is delivered through the Georgian Bay FHT with 52 physicians participating serving approximately 60,000 patients. The FHT has a shared electronic medical record between all physicians and the 20 allied health staff employed by the FHT. Only two physicians work outside this organized practice model. The Georgian Bay FHT is the lead for the Health Links program in the sub-region. The program is focused on coordinated care planning for complex patients and the dominant population served is seniors. The program involves a coordinator and mental health counsellor who see approximately 175 people/year needing care coordination and wrap around services.

In addition, the South Georgian Bay CHC, located in Wasaga Beach, provides primary care for approximately 1700 residents, as well as programs and services supporting 4000 residents in the area. The primary focus for the CHC has been the marginalized population, primarily middle-aged adults, many of whom have mental health and addictions issues, poverty, and housing issues.

There are currently no specialized geriatric services available at CGMH and some limited services in the community. Distance consultation is provided by a geriatrician at St. Michael's Hospital in Toronto via OTN. In the community, both the FHT and CHC have developed some services focused on frail seniors. The Georgian Bay FHT Healthy Aging Program involves CGA using a registered nurse (RN) and a geriatrician who

consults monthly with the team. The geriatrician, with a subspecialty in nephrology and chronic pain management (including medical marijuana), was recruited into the region by the SGS program in 2017 and travels to the region from Hamilton once/ month. The team is involved in cognitive screening, exercise and balance, and the provision of education related to healthy living. The team sees approximately 350 unique patients a year across all of the services offered (including education). The South Georgian Bay CHC also offers some seniors health promotion services (e.g., 0.5 FTE physiotherapy for balance) as well as other education that is available to all residents in the area.

## **Primary Care Across the NSM LHIN**

The NSM LHIN is relatively well organized from a family practice perspective with very few solo physicians; the majority of physicians are part of an FHT or a CHC. As a result, many of the physicians are comfortable working in a team environment. However, there continues to be a sense of frustration among many physicians across the region who, because of their experience working in the community, view it as being “poorly organized”. Many of their older patients are very complex, and physicians report being challenged and frustrated in navigating and coordinating services to support the needs of their patients. Many older persons do not have a sufficient informal caregiver network making home support even more difficult to coordinate. With respect to their views on regionalization, although there is an appreciation that standardization for the purposes of ensuring evidence-based care is a necessary step forward, there is a keen desire to ensure that care in local communities continues to be customized in the delivery.

## **Primary Care and Physician Engagement**

In 2017, the NSM LHIN began the work of enhancing primary care engagement at the local and regional level through the creation of a primary care leadership structure. The structure includes the selection of a senior leader and central point person at the LHIN for primary care and a network of physician leaders from across the LHIN representing each sub-region planning area. These clinical leads have been selected and are in the very early days of creating the organizational structure that will move the integration and collaboration agenda forward. They work in their respective sub-regions as part of a three-person team that includes a senior LHIN planner and home care lead. The “glue” that will optimize these new teams will be a focus on quality patient outcomes across the region. The newly established Regional Quality Advisory Council has representatives from hospital leadership, Cancer Care Ontario, Health Quality Ontario, LHIN leadership, and other key physician opinion leaders, and will be the mechanism to advance collaboration across the region by focusing on issues that matter to the broader physician stakeholder group. The priority that has been established for their first joint quality initiative is to make improvements in *Transitions in Care*. It is also critical that this new committee and team is “action-oriented” and “results-oriented” so that it can gain some traction and credibility with physicians across the LHIN.

Although many physicians view health care reform as being bureaucratic, they would embrace a regional SGS program for frail seniors *if* they experienced improvements in care coordination and better patient outcomes. If real and tangible benefits are not

experienced early in implementation, the program may not be embraced by primary care. To have success in the implementation of local SGS teams in regard to primary care and physician engagement, there is a need for significant community engagement, a focus on the “why” and clarity on improved outcomes (i.e. quality, access) for patients.

## **Regional Specialized Geriatric Services**

### **Specialist Providers**

There are currently four geriatricians working in the NSM LHIN, with the most recent geriatrician recruited to the Barrie area effective July 2018. There is one geriatrician supporting the region two days/month from Hamilton. There are three geriatric psychiatrists based at Waypoint. One supports the Community Consultation Service and a second supports Horizons. The third was recently recruited and started providing services in July 2018, with some time to be dedicated to BSS. In addition, the NSM LHIN has five Care of the Elderly (CoE) physicians.

The NSM SGS Physician Network was established in 2016 and functions as both a community of practice and discussion forum whereby champions in seniors' care from across the region meet regularly to support integrated care for seniors. One of the significant issues faced in the NSM LHIN with respect to physician recruitment and retention is physician remuneration, specifically related to geriatricians and CoE physicians. Although there is seemingly a significant number of physicians with expertise in caring for seniors within the NSM LHIN, there are ongoing challenges with practicing strictly in seniors' care. In particular, current remuneration models do not meet needs. For example, the FHT payment scheme does not allow for CoE physicians who are part of the FHT to see and bill for another primary care physician's patients. The SGS physician lead, is working with the Physician Network to better understand and quantify the financial impact, billing challenges and revenue required to utilize specialist physicians effectively as part of an evolving SGS system of care.

Under the leadership of the SGS program, technology-based platforms are currently being explored to improve access to specialist physicians. In June 2018 an eConsult pilot was launched with a targeted group of NSM physicians and NPs to evaluate processes and volumes with the hope to expand access to a broader NSM group. Plans are underway (pending funding) to bring GeriMedRisk to the region. GeriMedRisk, an eConsult program started in the Waterloo-Wellington region, provides access to additional geriatric and geriatric psychiatrist support with a specific focus on clinical pharmacology.

In addition to a growing number of specialist physicians, there is a growing number of specialist nurses and allied health providers in the region. Some of these resources, as articulated to date, are part of primary care, acute care, community and LTC teams. Others have developed as part of regional programming and are slowly being aligned with the SGS program. This includes resources within the BSS team as well as those within the IRFP and Enhanced SMART teams.

## Geriatric Mental Health Services

Waypoint is a large specialized mental health care facility located in Penetanguishene which houses 301 beds – 20 acute and 281 specialized mental health beds. The hospital offers a number of ambulatory and outreach community services across a region that encapsulates part of the North East LHIN and Central LHIN as well as the NSM LHIN. The two SGS services include an inpatient psychogeriatric assessment and treatment unit (Horizon unit) and the Community Consultation Service – Geriatric Psychiatry (CCS-GP). As noted above, three geriatric psychiatrists are employed by Waypoint.

The CCS-GP is consultative in nature, offering assessment clinics and outreach in local communities. It is comprised of three RNs and a Geriatric Psychiatrist with access to occupational therapy support from Waypoint's outpatient services. The nursing staff see all referrals in advance for assessment before the psychiatrist consults. The wait time can be three to four months from intake through to seeing the psychiatrist. The CCS-GP team supports serious mental illness, including behavioural and psychiatric symptoms of dementia (BPSD), with referrals primarily for consultation related to BPSD and responsive behaviours. The team is currently not formally aligned with the rest of the BSS team, with both teams continuing to work in isolation. The SGS leadership team is beginning to initiate dialogue to promote collaboration between the CCS-GP and BSS.

Waypoint's inpatient unit is a psychogeriatric unit, supporting both serious mental illness and BPSD. As the only unit in the region, and in the absence of a regional behavior support unit, the majority of admissions are for BPSD with the unit currently experiencing the same ALC issues as acute care partner organizations. The result has been a significant reduction in flow (e.g., ALOS >600 days).

There is a strong sentiment in the community that Waypoint's inpatient and outpatient services are difficult to access. As a result, health service providers do not know where to go for help and feel overwhelmed trying to provide care and service to this complex population, often in environments that are less than ideal.

Overall there is a lack of integrated regional geriatric mental health services in the region, with resources outside Waypoint being limited:

- Under their transitional program, Wendat has five registered practical nurses that provide transition services for individuals with responsive behaviours. There are also currently three social workers providing support across the region to older adults with geriatric mental health issues. These services need to be considered within the context of SGS redesign in regard to geriatric mental health services (inclusive of BSS).
- CGMH Community Mental Health Services has taken some local leadership in seniors' mental health outpatient services in the South Georgian Bay region

The biggest challenge identified by providers across the region is the ability to provide the necessary assessment and support within existing environments in a timely fashion. In addition to gaps in geriatric mental health services (especially ongoing case management services that crosses the continuum of care), providers express frustration

with accessing and navigating existing geriatric mental health services; especially because services are governed by a variety of rules and requirements that make access and navigation difficult and limit eligibility. The biggest challenge faced by members of geriatric mental health teams, including the BSS team, is the varying interest of health service providers (organizations and individuals) to engage in a shared-care model, including collaboration in the implementation of recommendations and in the uptake of best-practices.