

NSM SGS Program Clinical Design Report & Recommendations

Submitted To: LHIN Leadership Council
Submitted By: Seniors Health Project Team
Date: August 29, 2016 (*FINAL*)

ACKNOWLEDGEMENTS

The NSM SGS Program Leadership team would like to acknowledge and thank the membership of the Clinical Design Working Group. The report and recommendations were influenced and informed by their passion, wisdom and experience.

- Sherry Bell, County of Simcoe (Georgian Manor)
- Susan Clark, Orillia Soldiers Memorial Hospital (Nurse-Led Outreach Team)
- Dr. Geoff Daniel, Waypoint Centre for Mental Health Care (NSM SGS Program)
- Dr. Vicki Dechert, Cottage County Family Health Team
- Estelle Duchone, Entite4
- Deborah Duncan-Randal, Waypoint Centre for Mental Health Care (NSM SGS Program)
- Karen Fleming, Muskoka Algonquin Healthcare
- Monica Gabriel, NSM CCAC
- Donna Gordon, Georgian Bay General Hospital
- Eileen Hilson, Couchiching Family Health Team
- Debbie Islam, Alzheimer Society of Simcoe County
- Catherine Jones, Barrie & Community Family Health Team
- Natalie Kidner, Collingwood General & Marine Hospital (Psychogeriatric Resource Consultants)
- Melissa Kilpatrick, Algonquin Family Health Team
- Annalee King, Waypoint Centre for Mental Health Care (NSM SGS Program)
- Heather Klein-Gebbinck, South Georgian Bay Community Health Centre
- Susan Lalonde Rankin, Waypoint Centre for Mental Health Care
- Ameth Lo, Entite4
- Fran Masterson, Rama First Nation
- Susan McCutcheon, CMHA - Simcoe County Branch
- Ryan Miller, Orillia Soldiers Memorial Hospital (Integrated Regional Falls Program)
- Meredith Morrison, County of Simcoe
- Dana Naylor, Royal Victoria Regional Health Centre
- Tamara Nowak-Lennard, Waypoint Centre for Mental Health Care (NSM SGS Program)
- Catherine Petch, Royal Victoria Regional Health Centre
- Ulla Rose, VON Canada - Simcoe County Branch
- Debbie Sloan, NSM Hospice Palliative Care Network
- Nancy Steben, Entite4
- Eric Sutton, Waypoint Centre for Mental Health Care
- Bev Vaillancourt, Community Networks of Specialized Care
- Stephanie Walpole, Jarlette Health Services (Villa Care)
- Kathy Wolfer, NSM CCAC
- Dr. Kevin Young, Waypoint Centre for Mental Health Care (NSM SGS Program)

“The aging population is not a tsunami . . . it’s an iceberg. The only way you get hit by an iceberg is if you don’t get out of the way in time”.

Michael Rachlis

TABLE OF CONTENTS

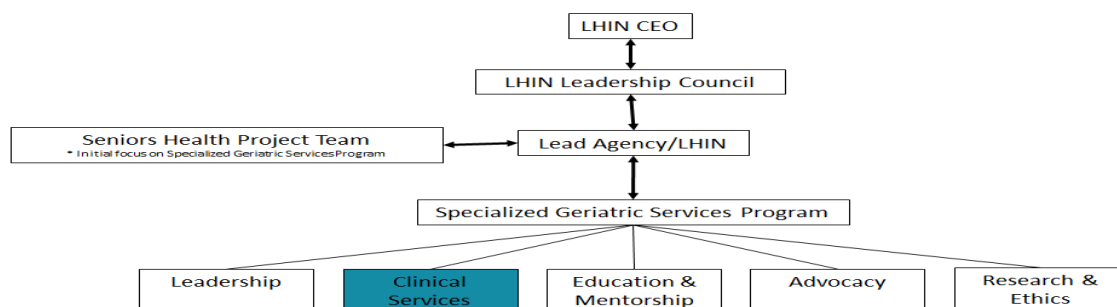
Executive Summary	... 4
Introduction	... 8
Key Concepts	... 10
Planning Considerations	
Key Material	... 10
Data	... 10
NSM Planning	... 12
Provincial Planning	... 14
Standards & Benchmarks	... 14
Sequencing Principles	... 16
Defining Scope	... 16
Where Does the Clinical Service Fit within Seniors Health	... 16
Who Does the Clinical Service Serve	... 17
Target Population	... 17
Eligibility & Discharge Criteria	... 18
Where is the Clinical Service Focused	... 23
Governance, Accountability & Authority	... 24
Outcomes	... 25
The Clinical Service	... 26
The Clinical Service Commitment	... 26
SGS Intake	... 26
Eligibility & Discharge	... 26
Hub & Spoke Model	... 28
Clinical Service Overview	... 29
Local Services: The Local SGS Team	... 30
Central Services	... 39
Level 1 Consultation Program	... 39
Specialist Physicians	... 41
Specialty Beds: Geriatric Psychiatry	... 43
Specialty Beds: Behaviour Support Unit	... 45
Key Enablers	... 48
Health Human Resources	... 48
Financial Resources	... 49
Technology Resources	... 50
Partnerships	... 51
Communication & Community Engagement	... 53
Risks	... 54
Next Steps	... 56
Conclusion	... 57
Recommendation Summary	... 58

EXECUTIVE SUMMARY

In March 2016 the 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 Specialized Geriatric Services Program starting with the *Strategy for a SGS Program in NSM* document (2014). Like the *Strategy*, it is a guiding document. It offers direction to support planning and decision-making recognizing that significant work is required in the years ahead to support implementation.

To support clinical design planning, several key pieces of material were considered by the Working Group including regional demographics, dementia projections, key NSM planning documents and provincial directions. Standards and benchmarks related to the design are identified for consideration and recommendations are made around the sequencing of design implementation. Finally, parameters are outlined to delineate the scope of the clinical service. The scope is defined in relation to: the relationship between the NSM SGS Program and the broader NSM Seniors Health Program; the Clinical Frailty Scale; the building of key safety nets for frail seniors within the system; and, eligibility considerations including geographic boundaries, response time, the importance of transitions and the relationship with key programs like geriatric psychiatry and responsive behaviours.

As Lead Agency for the NSM SGS Program, Waypoint is accountable to the LHIN and LHIN Leadership Council for the clinical service. This includes planning, implementation, performance monitoring and evaluation as well as accountability for all relevant aspects of operations including clinical outcomes. Waypoint will consider recommendations of the Seniors Health Project Team, act in accordance with the Service Accountability Agreement and ensure operations are delivered in alignment with relevant legislation, policy and procedures and available funding.



Starting with a logic model approach to planning, the Working Group identified a variety of key outcomes to be achieved by the clinical service. This includes measures

that will reflect improved patient outcomes (i.e. maintained or improved frailty, improved assessment and management of responsive behaviours, reduced caregiver burden), enhanced system capacity (i.e. increased knowledge and skills of health care providers in the care of frail seniors and enhanced self-management by frail seniors and their caregivers) and a more affordable and sustainable health system (i.e. reduced inappropriate use of Long-Term Care and hospital resources). Using these outcomes as a foundation for discussion, the clinical service design was defined.

In alignment with the *Strategy* document the clinical service will be accessed through a single entry point, the SGS Intake (***Please refer to the SGS Intake Report & Recommendations - Appendix A**). Individuals will be considered eligible for the clinical service if they meet the following criteria:

1. Is a senior; AND
2. Resides in the NSM region AND is able to receive service in the region; AND
3. Meets any of the following eligibility categories:

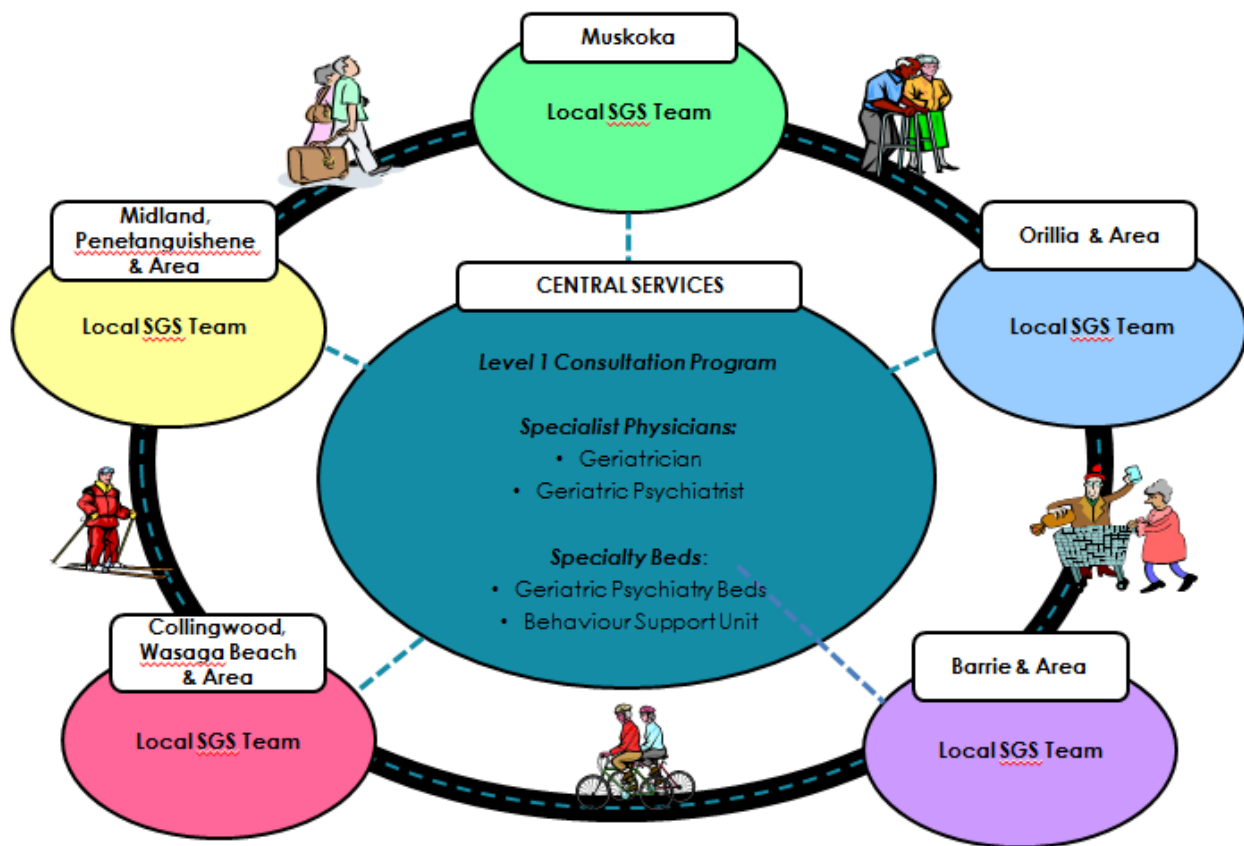
A.	B.	C.
* Comprehensive Geriatric Assessment • Meet the characteristics of stages 4, 5 or 6 on the Clinical Frailty Scale; • Have the potential to improve and/or maintain their current health state; • Require a comprehensive geriatric assessment by two or more members of the available interdisciplinary team; • Present with multi-morbidity and complexity including: ○ The presence of geriatric syndromes¹ that require assessment, diagnosis and/or treatment; AND ○ The loss or high risk for loss of Activities of Daily Living (ADLs)² and/or Instrumental Activities of Daily Living (IADLs)³	*Responsive Behaviours • Have cognitive impairment and an associated responsive behaviour(s); • Require a behaviour assessment and/or support in the development of a behaviour plan of care; • Present with a change in behavior(s) to a degree that caregivers require support to manage the behaviour(s).	* Nurse Practitioner Support in LTC • Be a LTC resident; • Have the potential to benefit from the care of a Nurse Practitioner; • Present with one or more of the following: ○ Geriatric syndromes¹⁰ that require assessment, diagnosis and/or treatment; OR ○ An acute event that could be addressed within the LTC home to avoid an Emergency Department visit or hospital admission; OR ○ The need for support in the transition from hospital back to the LTC home.

¹ Geriatric Syndromes - Dementia, delirium, depression, falls, polypharmacy, pain, malnutrition, urinary incontinence, constipation, elder abuse, functional decline

² ADLs –bathing/ grooming, dressing, transferring, toileting, self-feeding

³ IADLs – housekeeping, meal preparation, medication management, managing money or finances, shopping, use of telephone or other form of communication, transportation within the community

The clinical service will be comprised of Local SGS Services & Central SGS Services. Local SGS Services will be located in each NSM sub-geographic region while Central SGS Services will be more specialized resources that serve the entire NSM region.



At the local level, one interdisciplinary team will be located in each NSM sub-geographic region and will provide the first line of care in the majority of clinical service cases. The team will support health service providers in local communities through ambulatory, satellite and out-reach programs. Local SGS Team resources will also be located in area hospitals and Long-Term Care Homes using an in-reach approach to care. Local SGS teams will work in close partnership with primary care, providing consultative support. Care from the Local SGS Teams is time limited and targeted with key roles including assessment, diagnosis, treatment, transitions, care plan development, caregiver support, case management and capacity building.

Central SGS Services will be limited in scope and function. These specialized resources will provide support primarily to the Local SGS Teams through very targeted, time-limited care. The goal of the Central SGS Services will be to build the capacity of the Local SGS Teams to ensure care is provided as close to home as possible. The Level 1 Consultation Program will provide access to specialists for “hallway” conversations to expedite interventions, improve clinical outcomes and build local capacity. When

specialist consult is required (Geriatrician, Geriatric Psychiatrist) specialists will, in most cases, travel to the sub-geographic regions to work in partnership with the Local SGS Teams to assess and manage complex cases. In cases where admission is required to support the needs of the frail senior the Working Group recommends access to dedicated geriatric psychiatry beds and a Behaviour Support Unit.

Where possible, details are provided to inform clinical design and guide implementation planning. Success will be dependent on key enablers that include:

- Access to a skilled, satisfied and appropriately resourced pool of **health human resources**, including physicians;
- Sufficient **financial resources**, including the re-design of existing resources to optimize efficiencies and outcomes;
- A robust system of **technology resources** to support timely and effective communication and connectivity within and outside the clinical service, including an integrated electronic health record;
- Strong **partnerships** with health service providers within and outside the NSM region, including primary care providers, Long-Term Care Homes, hospitals, paramedic services and the community support sector; and
- A timely and effective **communication and community engagement strategy** that balances the push and pull of information to ensure the voice of frail seniors and their caregivers continues to support clinical service planning.

With the clinical design report and recommendations complete, the NSM SGS Program, under the leadership of Waypoint, will work in partnership with the NSM LHIN and area health service providers to begin implementation planning. This will include developing program plans and mapping existing resources against the desired clinical design. As an advisory body to Waypoint and the LHIN, the Seniors Health Project Team will be engaged to inform implementation planning.

INTRODUCTION

In March 2016 the NSM Local Health Integration Network (LHIN) and Waypoint Centre for Mental Health Care, the lead agency for the NSM Specialized Geriatric Services 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 Specialized Geriatric Services Program starting with the Strategy for a Specialized Geriatric Services Program in North Simcoe Muskoka document (2014). The final report was to include key components and resources required within the basket of services for frail seniors at the local/sub-geographic level and the central/regional level.

Between April 8, 2016 and July 5, 2016 the Clinical Design Working Group provided input into the clinical service design. The direction, ideas and discussion were used to inform this final report and recommendations. This report provides an overview of the desired clinical design. Like the Strategy, it is a guiding document. It offers direction to support planning and decision-making recognizing that significant work is required in the years ahead to support implementation (i.e. development of detailed program plans, operational processes, performance monitoring and evaluation frameworks, etc.). Implementation requires that this desired clinical design be flexible in order to meet the needs of frail seniors and their caregivers in our continuously changing environment.

On August 19, 2016 the Clinical Design Report & Recommendations document was endorsed by the NSM LHIN Seniors Health Project Team.

KEY CONCEPTS

There are several key concepts that permeate this document. It is important to define these concepts at the outset to promote clarity.

“Frail Seniors”

Frail seniors are a distinct subset of the senior population. According to the work of Dalziel (2008)⁴, this population presents with:

- Multiple diseases with multiple drugs = complexity.
- Multiple problem areas = multidimensionality.
- Premorbid function disability = slippery slope.

⁴ Dalziel, B. (2008). Can you Unfrail the Elderly? RGP Toronto Toolkit: Frailty

Seniors can move in and out of frailty and can experience varying degrees of frailty as a result of their physical, mental, emotional and social circumstances. When in the health care system, frail seniors can benefit from an interdisciplinary approach to care inclusive of geriatric medicine and geriatric psychiatry services as well as social services and discharge planning.

Informal caregivers are key resources to frail seniors. Demands on caregivers grow as the degree of frailty increases. For the purpose of this document, the term “frail senior” is inclusive of the frail senior and his/her caregivers.

“Specialized Geriatric Services”

Specialized Geriatric Services (SGS) is defined as a comprehensive, coordinated system of hospital and community-based health and mental health services that assess, diagnose, and treat frail seniors. These services are provided by interdisciplinary teams with expertise in care of the elderly and provided across the continuum of care. SGS is inclusive of both geriatric medicine and geriatric psychiatry services.

“The Clinical Service”

The NSM SGS Program has five key roles: Leadership, Clinical, Education & Mentorship, Advocacy; and, Research & Ethics. The Clinical role encompasses direct care as well as work related to establishing a standardized approach to care across the NSM region (e.g. standards of practice, collaborative care plans and care pathways, etc.).

According to the Strategy document, the clinical service (or direct care component) is comprised of three interdependent components:

- SGS Intake;
- Local SGS Services; and,
- Central SGS Services

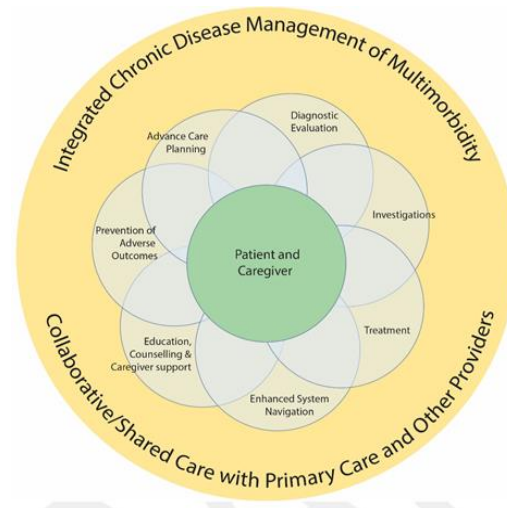
For the purposes of this document, the term “clinical service” is reflective of the Local and Central SGS Services only. A separate report has been developed to address the design of the single entry point (or intake) into the Local and Central SGS services.

*** Please refer to the SGS Intake Report & Recommendations (Appendix A)**

“Comprehensive Geriatric Assessment”

Frail seniors have unique needs that present specific challenges for accurate assessment, diagnosis, and treatment. Comprehensive Geriatric Assessment (CGA) is a multidimensional approach to care that identifies the frail senior's presenting problems, their personal strengths and resources and their service needs in order to develop an individualized patient-centred plan of care to guide treatment, follow-up and support transitions. The CGA is comprised of nine key components:

- Diagnostic Evaluation
- Investigations
- Treatment
- Prevention of Adverse Outcomes
- Enhanced System Navigation
- Patient Education, Counselling, & Caregiver Support
- Advance Care Planning



The CGA is supported by an interdisciplinary team. It is delivered within a collaborative practice model. Teams that provide CGA integrate with primary care, specialists, and other providers to ensure a patient-centred approach. “There is evidence that CGA improves diagnostic accuracy, optimizes care plans, improves patient and system outcomes, and assists clinicians in identifying the need for treatment change”⁵.

PLANNING CONSIDERATIONS

Key Material

In addition to the *Strategy* document, several key pieces of recent material⁶ were considered in the development of the clinical design. This included demographic data as well as information from the local and provincial planning environments.

Data

Demographics

The population of seniors in the NSM region has continued to increase. In 2013, 82,854 individuals over age 65 lived in NSM⁷. In 2015, NSM ranked in the top three LHINs in relative proportion of seniors aged 65+ with seniors representing 18.8% of the NSM population.

When comparing 2013 to 2011 NSM data (source: *Intellihealth*):

- The total volume of seniors increased in all LHIN sub-geographic regions ranging from a low of 4.0% (Orillia region) to a high of 16.6% (Collingwood region).

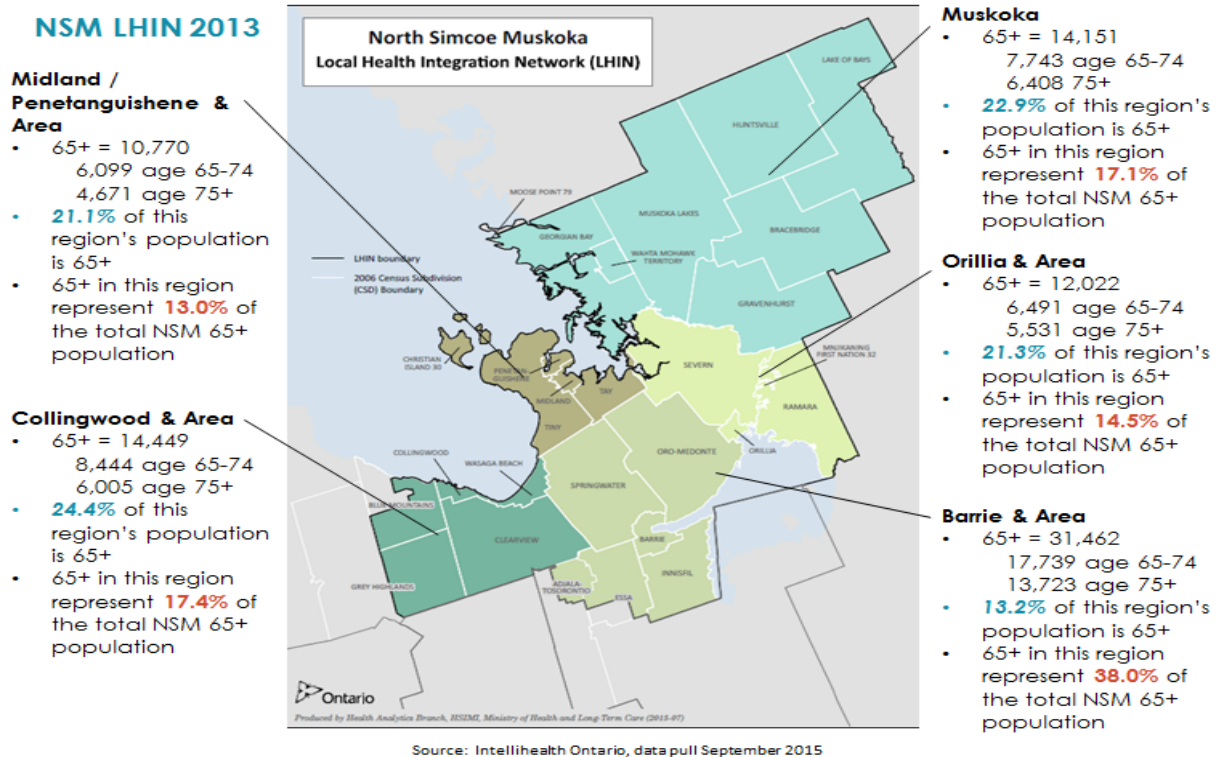
⁵ The RGP of Ontario: Three Frequently Asked Questions.

http://rgps.on.ca/sites/default/files/RGPs%20FAQ%20-%20CGA%20and%20SGS%20Mar%206%202016_0.pdf at July 6/16.

⁶ Material and information gathered and/or newly released within the last two years.

⁷ Of note, this does not include those with second residences in the region or the seasonal population that frequents the region throughout the year.

- When examining the distribution of individuals over age 65 across NSM, only the Collingwood region saw an increase in their market share (i.e. from 16.4% to 17.4% of the NSM 65+ cohort). All other regions either maintained or reduced their market share.



Frail Senior Volumes

According to the Regional Geriatric Programs of Ontario, 15% of the population 65 years of age and older is frail⁸. Using this number as a proxy, the number of frail seniors in each NSM sub-geographic was estimated to inform planning and discussion:

Region	Estimated # of Frail Seniors
Barrie & Area	4,719
Collingwood, Wasaga Beach & Area	2,167
Muskoka	2,123
Orillia & Area	1,803
Midland, Penetanguishene & Area	1,616
NSM LHIN	12,428

Dementia

Between 2012 and 2020 there is a projected increase in the number of cases in NSM from 7,570 to 10,340 (37%), the fourth highest percent increase in the province⁹. In April

⁸ RGPO fact sheet. <http://rgps.on.ca/role-and-value-specialized-geriatric-services> at May 16/16

2016, the Alzheimer Society of Ontario released the first bulletin of the *Ontario Dementia Profile Series*¹⁰ highlighting key provincial and LHIN-level data:

- Prevalence projections together with health administrative data suggest that the proportion of persons without a diagnosis could be as high as 30%.
- In 2013, nearly 3,700 community-dwelling NSM-LHIN residents (40+) were living with a diagnosis of dementia, an increase of 46% since 2007. Of note, 7.9% of these individuals were aged 40-65. Individuals aged 75-84 accounted for the highest proportion of persons with dementia.
- In 2013/14 the following information was gathered regarding community dwelling persons with a diagnosis of dementia:
 - 50.4% had at least one Emergency Department visit.
 - 10.6% had at least one fall-related Emergency Department visit.
 - 24.5% had at least one inpatient hospitalization.
 - 8.3% had at least one inpatient hospitalization with ALC days. The average ALC length of stay was 21.7 days (vs. 10.1 days for persons without dementia).
 - 14.2% were placed in LTC (vs. 1.8% of persons without dementia).
 - 7.6% died.

RECOMMENDATIONS: *Demographics*

- During implementation planning, resource allocation and priority setting:
 - Consider the continued growth in each NSM sub-geographic region, including recognition that: Collingwood, Wasaga Beach & Area is the fastest growing sub-geographic region; and that Barrie & Area has more than double the population of any other sub-geographic region;
 - Consider the impact of geography on service delivery in Muskoka as the region accounts for 46.6% of the total NSM geography; and,
 - Consider the impact of dementia on our health system resources (including ALC days).

NSM Planning

In July 2014, the *Strategy for a Specialized Geriatric Services Program in North Simcoe Muskoka* document was endorsed by the NSM LHIN Leadership Council. The *Strategy* focused on SGS and frail seniors as the first building block in an integrated regional Seniors Health Program. The document provided a framework and guiding principles to

⁹ Alzheimer Society of Ontario. (2015). *Dementia Fact Sheet*.

¹⁰ Alzheimer Society of Ontario. (2016). *Ontario Dementia Profile Series: Bulletin #1: Highlights by LHIN / North Simcoe Muskoka*.

inform NSM direction and decision-making. Within the document the clinical service was identified as the heart of the NSM SGS Program with some preliminary thinking provided regarding the scope, model and characteristics of the clinical service.

Since completion of the Strategy document, additional work has been done to support and advance planning:

- Seniors Program Review - Thirteen targeted seniors programs in NSM were reviewed, both as individual programs and as part of an integrated system. The review identified strengths as well as opportunities for improved efficiencies and outcomes. A variety of recommendations were made. These included general recommendations (e.g. single lead agency, single funding envelope, integrated electronic health information system, central intake process inclusive of responsive behaviours, etc.) and clinical recommendations (e.g. improving case management, integrating services within the current Behaviour Support System, creating interdisciplinary SGS teams similar to the Seniors Assessment Support & Outreach Team model in Muskoka, etc.).
- LHIN Action Plan - The LHIN identified Specialized Geriatric Services, including behaviours as a LHIN priority project until March 31, 2018. The LHIN Action Plan focused on three key goals:
 - Establish the infrastructure for an integrated regional Specialized Geriatric Services Program.
 - Support the development of a LHIN-wide basket of Specialized Geriatric Services through redesign, rational re-allocation and integration.
 - Ensure alignment with, and completion of, key provincial initiatives targeting frail seniors.
- Basket of Services - A one-day planning session was held in April 2015 to begin to discuss the basket of services for frail seniors. The discussion informed the NSM LHIN approach to the provincial Assess & Restore initiative, providing the foundation for the establishment of the VON Enhanced SMART Program in the region.
- Behaviour Concurrent Review - A Behaviour Concurrent Review was completed as part of the NSM LHIN Alternate Level of Care (ALC) Review project. In this review, an Expert Panel was convened to review all NSM ALC patients identified as having responsive behaviours delaying their discharge. A key finding was the variation in practice across hospitals with the review highlighting opportunities related to standardization, resource awareness, medication management and clinical re-design.

Provincial Planning

Although there is significant provincial activity underway related to system transformation, two key pieces of work must be considered in clinical design planning:

- Ontario Dementia Strategy - Action is underway provincially to develop and implement a comprehensive strategy to care for individuals with dementia and their caregivers. This includes the implementation of 25 new primary care Memory Clinics across Ontario and the provision of \$10 million in new funding to support responsive behaviours in LTC Homes across the province.
- Ministry-LHINs Regional Geriatric Programs / SGS Review - The provincial RGP/SGS Review report was drafted and recently presented to the LHIN CEOs. Although the report has not yet been finalized, an early identified goal was to improve access and quality by:
 - Ensuring access to specialized geriatric services through a minimum basket of services in each LHIN (to be defined); and,
 - Ensuring access to the nine components of a comprehensive geriatric assessment for eligible individuals, no matter where they live.

RECOMMENDATIONS: Provincial Planning

- Waypoint will work closely with the LHIN to:
 - Monitor activity and progress related to key provincial initiatives like the Ontario Dementia Strategy and the Ministry-LHINs RGP/SGS Review;
 - Ensure clinical design alignment with provincial initiatives; and,
 - Take necessary action to leverage provincial funding opportunities that may arise.
- Monitor activity regarding the establishment of primary care Memory Clinics in the NSM region in order to: build partnerships; promote a standardized approach to practice; and, ensure clear distinction between the clinical service and the service offered in primary care Memory Clinics.

Standards & Benchmarks

Ideally, all planning related to the allocation of resources within the clinical service should align with existing standards of practice. At this time there are no clear local, provincial or national standards for SGS resource allocation because of the variation across programming. In the absence of standards, the following guiding principles will be used as a starting point to guide planning. It will be important to monitor demand and utilization over time to create benchmarks for future use:

- For every 1,500 frail seniors, we propose:
 - Access to 2 Behaviour Support Unit beds;

- Access to 1 specialty geriatric psychiatry bed; and,
- Access to 1 acute medical bed.

**Please note, additional information is provided later in the document about these beds.*

- All cases will require some degree of SGS case management to achieve outcomes and promote flow through the clinical service. We propose the ratio of SGS case manager to frail senior be 1: 30-35.
- Initially, Geriatricians and Geriatric Psychiatrists will receive many referrals. As capacity builds in the local communities and processes are established, the demand on specialist physicians will become more targeted and appropriate.
- When considering clinical service resources we will take into consideration:
 - Building Capacity within the SGS Team: In addition to ensuring sufficient time for orientation, we propose a minimum 2-3 days/ month be allotted for education, training, project work and staff meetings for each 1.0 FTE.
 - Building Capacity of Health Service Providers: According to Geriatric Emergency Management (GEM) research, GEM staff spends about 20-30% of their time building the capacity of health service providers. Using this proxy, we propose up to 1 day/week is allotted for capacity building for each 1.0 FTE.
 - Coverage for vacation, sick time, education days and extended absences: For every 5.0 FTEs, we propose up to 1.0 FTE be allotted for coverage.
 - Infrastructure Support: Clinical and operational leadership as well as back-office support positions (i.e. communication, decision-support) are integral to the success of the clinical service. We propose these positions be integrated into the clinical design.
- For SGS services offered in:
 - Acute care hospitals: We propose 1 SGS clinician be aligned with every 100-120 hospital beds for each defined service.
 - LTC facilities: We propose 1 SGS clinician be aligned with every 120-175 LTC beds for each defined service.

**Please note, additional information is provided later in the document about these services.*

RECOMMENDATIONS: Standards & Benchmarks

- In the absence of SGS clinical service standards and benchmarks, the principles proposed in this report are recommended as a starting point to support SGS implementation planning, resource allocation and priority setting.

Sequencing Principles

Sequencing and prioritization will be important considerations in the implementation of the clinical design plan. Should sufficient resources not be available in the early stages of implementation it is recommended that decisions be made in favour of preserving the integrity of the clinical design. The Clinical Design Working Group agreed it would be better to start with a fewer number of full teams than create teams weak in skills and resources. Early teams could do outreach to underserved areas to build capacity and support the development and implementation of new teams.

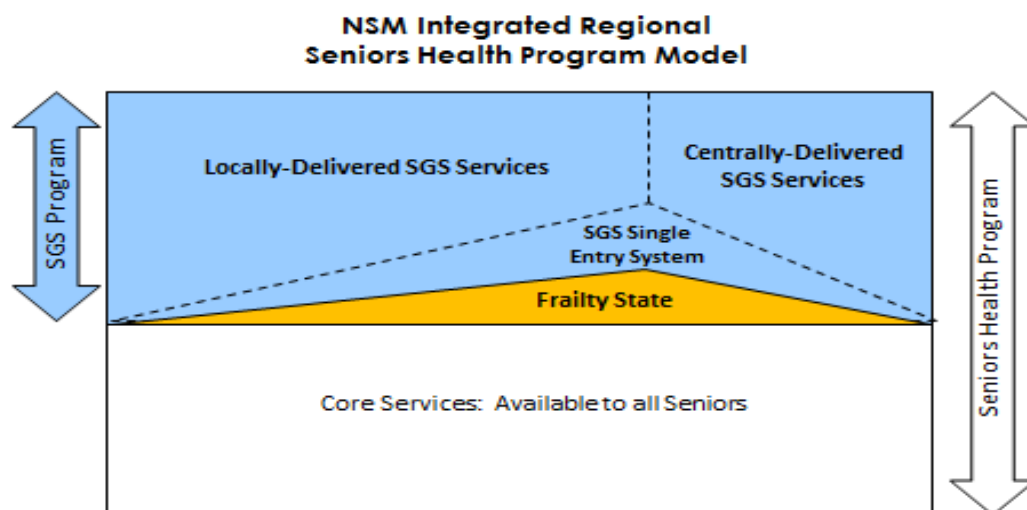
RECOMMENDATIONS: *Sequencing Principles*

- If during implementation planning a decision is required in regard to sequencing, resource allocation and/or priority setting, it is recommended that priority be given to the development of a fewer number of full teams to preserve the integrity of the clinical design.

DEFINING SCOPE

Where Does the Clinical Service Fit within Seniors Health?

In the *Strategy* document, a working model was proposed for an integrated regional Seniors Health Program. Within the model, the NSM SGS Program is depicted as one component (and the first building block) of the broader Seniors Health Program. The model recognizes that many health service providers support seniors, including frail seniors, on a daily basis. It also recognizes that seniors regularly transition between core services and the clinical service as their needs and life circumstances change. As such, the clinical service is one partner in care that will support the senior at various times along their journey.



Core services refer cases to the clinical service when the complexity and intensity of care exceeds the knowledge, skill and judgment of core service providers. Ideally, the clinical service will provide targeted, time-limited care. Through a collaborative care model, the clinical service will work with the core service to develop and implement a plan of care, including a transition plan.

Differentiating Core Services and Specialized Geriatric Services

Core services and Specialized Geriatric Services can be differentiated by the type of care provided. Within SGS, care is typically:

- Consultative in nature;
- Provided to frail seniors with a complex or multi-morbid clinical presentation;
- Includes a focus on geriatric syndromes (i.e. dementia, falls, polypharmacy, etc.) and the functional decline that is often associated with geriatric syndromes;
- Provided by an interdisciplinary team with specialized knowledge and skills in geriatric medicine and/or geriatric psychiatry; and,
- Incorporates a comprehensive geriatric assessment.

Typical Examples of Specialized Geriatric Services	Typical Examples of Core Services
Hospital-Based / Inpatient: • Inpatient Consultation Team • Acute Geriatric Units / Acute Care of the Elderly Units • Geriatric Assessment & Treatment Units / Geriatric Psychiatry Units / Geriatric Rehabilitation Units Community: • Geriatric Outreach Teams (including in-home, outreach) • Outpatient Geriatric Clinics • Geriatric Day Hospitals • Geriatric Emergency Management in Emergency Departments	• Meals on Wheels • Transportation Programs • CCAC Case Management • CCAC Services generally provided to seniors (i.e. Personal Support, Nursing, Physiotherapy, Occupational Therapy, etc.) • Paramedic Services • Adult Day Programs • Assisted Living for High Risk Senior programs or Supportive Housing Programs • Exercise & Falls Prevention Classes • Friendly Visiting Programs • First Link • Hospice & Palliative Care programs • Primary Care • Long-Term Care, including Convalescent Care

Who Does the Clinical Service Serve?

Target Population

Within the NSM SGS Program, the target population is frail seniors. For the purpose of eligibility into the clinical service specifically, the target is seniors in stages four to six on the Clinical Frailty Scale¹¹.

¹¹ Rockwood, Song, MacKnight, Bergman, Hogan, McDowell & Mitnitski. (2005). A global clinical measure of fitness and frailty in elderly people. *CMAJ*. 173(5). pp.489-495.

Box 1: The CSHA Clinical Frailty Scale

1. **Very Fit**—robust, active, energetic, well motivated and fit; these people commonly exercise regularly and are the most fit for their age
2. **Well**—without active disease but less fit than people in category 1
3. **Well, with Treated Co-Morbid Disease**—disease symptoms are well controlled compared to those in category 4
4. **Apparently Vulnerable**—although not frankly dependent, these people commonly complain of being "slowed up" or have disease symptoms
5. **Mildly Frail**—with limited dependence on others for instrumental activities of daily living
6. **Moderately Frail**—help is needed with both instrumental and non-instrumental activities of daily living
7. **Severely Frail**—completely dependent on others for the activities of daily living, or terminally ill

Note: CSHA = Canadian Study of Health & Aging

Eligibility & Discharge Criteria

While it would be ideal to serve all frail seniors, it is important to build a system where the right care is being provided at the right time by the right provider. Partnerships must be established, capacity must be built and transition planning must be a central component of every plan of care. The Clinical Frailty Scale provides a starting framework for eligibility but other factors will be taken into consideration to define eligibility and discharge criteria.

Frailty Prevention & End-of-Life Care

Many existing programs support seniors who fall outside stages four to six on the Clinical Frailty Scale. For example, the Integrated Regional Falls Program has identified 40% of those served as stages one, two or three on the Clinical Frailty Scale. The importance of these existing services to NSM seniors during implementation planning must be considered. In addition to building partnerships, it will be important to build bridging programs while we work toward the desired clinical design. This will require an upfront investment in capacity building within the SGS Program and LHIN consideration of future resource allocations.

RECOMMENDATIONS: *Frailty Prevention & End-of-Life Care*

- Support the shift of frailty prevention, screening and early identification to ensure the right care is being provided at the right time by the right provider:
 - Advocate to the Ministry for sufficient funding and resources to support prevention, screening and early identification within primary care and other core services.
 - Monitor activity regarding the establishment of primary care Memory Clinics in the NSM region in order to: build partnerships; promote a standardized approach to practice; and, ensure clear distinction

between the clinical service and the service offered in the primary care Memory Clinics.

- Ensure family physicians are aware of relevant billing codes.
- Collaborate with primary care and other core services to identify collaborative initiatives that could be targeted (e.g. screening tools, guidelines, standards of practice, etc.).
- Consider supporting primary care and other core services by:
 - Allocating a minimum 1.0 FTE within the clinical service to develop and support implementation of standardized regional prevention, screening and early identification programs and processes.
 - Providing targeted clinical service resources (time-limited with clear deliverables) to support start-up initiatives to help build capacity and build the case for “need”.
- Build a key-partner relationships with the NSM Hospice Palliative Care Network:
 - Build a palliative approach to care within the clinical service;
 - Promote a common language for communication messaging by leveraging research (i.e. research correlating the Clinical Frailty Scale and the Palliative Performance Scale).
 - Recognizing that there will be a sub-set of the population where the Hospice Palliative Care Network of services will become more engaged, implement a collaborative care model in appropriate cases and ensure transition plans are in place.

Geriatric Psychiatry

Geriatric psychiatry is an integral component of the clinical service. However, seniors will require only the services of the geriatric psychiatry team when:

There is a need for the assessment, diagnosis and/or treatment of a serious mental illness (i.e. Psychotic Disorders, Mood and Anxiety Disorders, Substance Dependency) by an interdisciplinary team with specialized geriatric mental health knowledge and skills.

In these cases, care is focused on a serious mental illness and the individual presents with core psychiatric symptoms. If the individual does not meet the eligibility for the clinical service the geriatric psychiatry team is accessed directly through Waypoint Central Intake.

It is important to note that the catchment area for Waypoint does extend outside the NSM LHIN boundaries. As such, there may be cases referred to the geriatric psychiatry team which meet the profile of the clinical service but the cases are not eligible because they reside outside the NSM region.

RECOMMENDATIONS: Geriatric Psychiatry

- Collaborate with Waypoint to develop a clear algorithm for health service providers to guide geriatric psychiatry referrals to the appropriate program (i.e. SGS Program's clinical service vs. Waypoint).

Responsive Behaviours

Currently, services supporting *older adults with cognitive impairment and responsive behaviours* operate as distinct partners under the NSM Behaviour Support System (BSS) umbrella. In alignment with the recommendations of the Seniors Program Review (2015), the current behavior and geriatric psychiatry resources supporting this unique population will be re-designed and aligned under the clinical service to create an integrated regional system. As such, services for older adults with cognitive impairment and responsive behaviours will be included in the eligibility criteria for the clinical services. As part of the clinical service, staff will provide consultative support. Staff will partner with frail seniors and NSM health service providers to develop and implement a plan of care, including a transition plan. Responsive behaviours will fall under the leadership of geriatric psychiatry.

**Please note, additional information is provided later in the document about the responsive behaviour resources.*

RECOMMENDATIONS: Responsive Behaviours

- Re-design and align current BSS resources under the clinical service to create an integrated regional system for older adults with cognitive impairment and responsive behaviours.

Discharge & Transitions

Frailty is a dynamic state. For this reason seniors discharged from the clinical service will have the option to be referred again should their condition change. The purpose of discharge is to ensure the clinical service supports as many frail seniors as possible across the NSM region.

Successful transitions will be integral to the success of the clinical service. Health Quality Ontario¹² published a document entitled Adopting a Common Approach to Transitional Care Planning to promote standardization in transitional care practices for complex Health Link patients. Therein it states that studies have found, “improvements in hospital discharge planning can dramatically improve outcomes for patients as they move to the next level of care. Although discharge planning is a significant part of the overall

¹² Health Quality Ontario (?). Adopting a Common Approach to Transitional Care Planning: Helping Health Links Improve Transitions and Coordination of Care

care plan, there is a surprising lack of consistency in both the process and quality of transitional care planning and documentation across the health care system. In fact, transitional care planning varies from hospital to hospital, across other parts of the care continuum, and often within organizations as well" (p.5). This document will provide a good foundation for transition planning within the clinical service.

RECOMMENDATIONS: *Discharge & Transitions*

- To support the successful transition of clients upon discharge:
 - Leverage the Health Quality Ontario document entitled Adopting a Common Approach to Transitional Care Planning, to support transition planning within the clinical service.
 - Establish a transition protocol for use within the clinical service.
 - Ensure a transition plan is in place for every discharge from the clinical service.

Geographic Boundaries

To provide the best care possible, individuals must be able to access the clinical service and the clinical service must have a partnership with the health service providers involved in the care of the frail senior. For this reason, the primary focus of the clinical service is for residents of the NSM LHIN. The clinical service will only be offered within the NSM LHIN region.

Within the context of this eligibility there are several important considerations:

- It is recognized that the NSM region has several bordering LHIN communities that travel into NSM for health care services. Upon receipt of this type of a referral, cases will be reviewed for exemption taking into consideration several things including the individual's home-LHIN SGS resources and the individual's ability to travel to the clinical service.
- Partnerships with provincial SGS networks and organizations will be critical. Where appropriate, referrals will be re-directed to the most appropriate SGS provider.

RECOMMENDATIONS: *Geographic Boundaries*

- Develop exemption criteria for out-of-region referrals.
- Build partnerships and transition protocols with other SGS networks and providers to re-direct, when appropriate, out-of-region referrals.

Rostered vs. Unrostered

While primary care can be limited in some programs to the care of rostered patients, the clinical service will have no limitations of this kind. With primary care as a key partner to the clinical service this will need to be considered during planning.

RECOMMENDATIONS: *Rostered vs. Unrostered*

- In collaborating with primary care on clinical design implementation, include discussions related to the care of both rostered and un-rostered patients.

Response Time

While it is important to receive the right care at the right time, response time is dependent on available resources. For the purpose of this document:

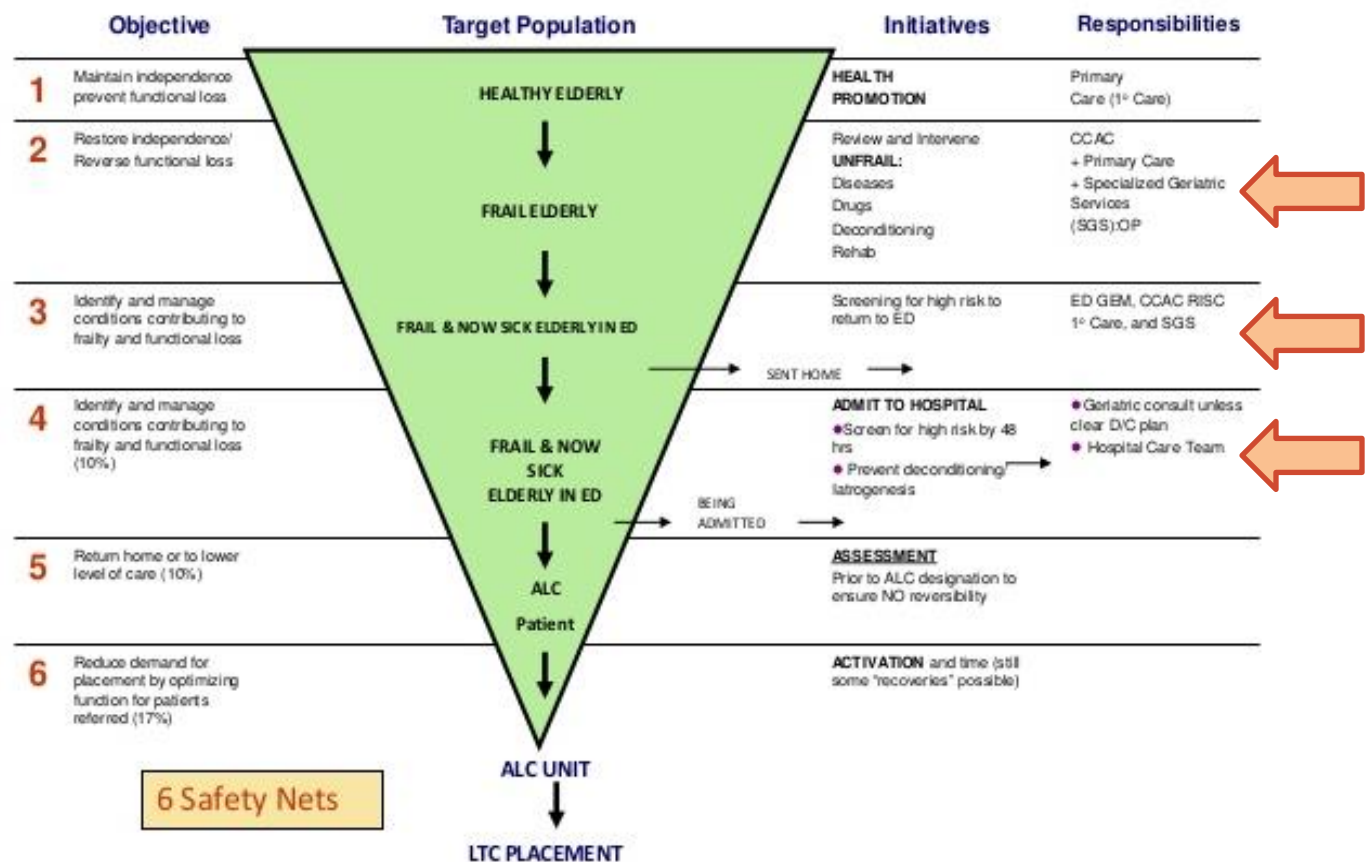
- An **important** referral is one whereby an individual needs to be seen by the clinical service to address one or more non-life-threatening health issue(s).
- An **urgent** referral is one whereby an individual needs to be seen by the clinical service to address one or more non-life-threatening health issues(s). In these cases, there are concurrent factors creating time pressures on the referral.
- A **crisis** (or emergency) referral is one whereby an individual requires immediate attention to address a life-threatening issue. This would include those requiring immediate medical attention and those at immediate risk of serious harm to self or others.

The clinical service will not provide crisis response. Life-threatening situations need to be dealt with in appropriate settings by trained health care professionals. The clinical service will serve important and urgent referrals and strive to provide a timely response. The focus of care is on supporting complexity and intensity, not acuity. Response time will vary by service and will be dependent on available resources and referral volumes.

RECOMMENDATIONS: *Response Time*

- Develop a triage/priority protocol that can be implemented by SGS Intake to support the triage and prioritization of referrals into important and urgent categories.
- During implementation planning, build a Service Accountability Agreement that clarifies definitions and identifies target response times for important and urgent referrals for Local & Central SGS Services.

Where is the Clinical Service Focused?



The above diagram proposes a trajectory from frailty to LTC Home placement¹³. Although a senior's trajectory does not always follow such a linear approach to decline, the diagram does present an interesting opportunity. It highlights the location of six possible system safety nets along the trajectory. With the goal to "start early, target and treat", the clinical service will focus on building three safety nets for the purpose of optimizing outcomes and, where possible, changing the trajectory: within primary care/at the community level (including LTC); within Emergency Departments; and, in area hospitals.

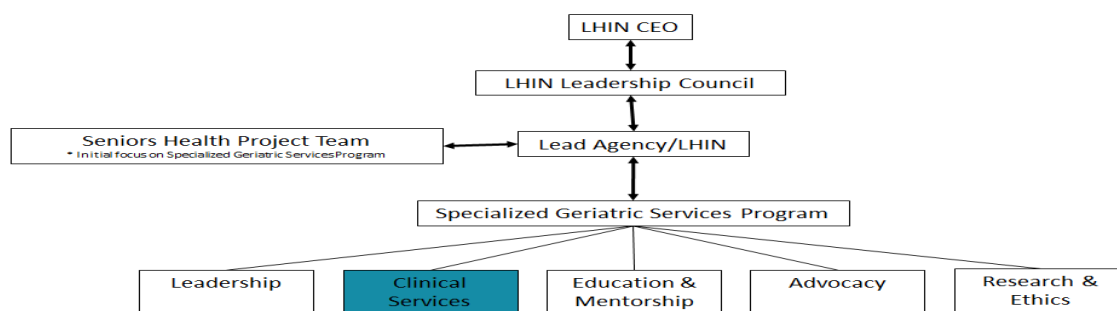
RECOMMENDATIONS: Building Safety Nets

- Support the NSM target of ALC reduction through an upstream approach to care, building safety nets in primary care/ at the community level (including LTC) as well as in area Emergency Departments and hospitals with the goal to reduce the proportion of frail seniors designated ALC.

¹³ Dr. Jo-Anne Clarke. (June 3, 2013). Improving community based seniors care. Data pulled on June 3, 2016 from http://www.slideshare.net/HSN_Sudbury/designing-a-more-seniorsfriendly-health-care-system

GOVERNANCE, ACCOUNTABILITY & AUTHORITY

As Lead Agency for the NSM SGS Program, Waypoint is accountable to the LHIN (through the Service Accountability Agreement) and LHIN Leadership Council (as Co-Chair of the Seniors Health Project Team) for the clinical service¹⁴. This includes planning, implementation, performance monitoring and evaluation as well as accountability for all relevant aspects of operations including clinical outcomes. Waypoint will consider recommendations of the Seniors Health Project Team, act in accordance with the parameters of the Service Accountability Agreement and ensure operations are delivered and conducted in alignment with relevant legislation, policy and procedures and available funding. The SGS Program Director is responsible for the clinical service and works in collaboration with the SGS Program's Leadership Team to achieve targets and complete deliverables.



* Of note, while clinical design implementation is underway there may be programs, services and providers that claim affiliation and membership in the clinical service. Waypoint is accountable for, and has authority over, only those programs, services and providers formally funded by, and associated with, the clinical service.

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 this 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.

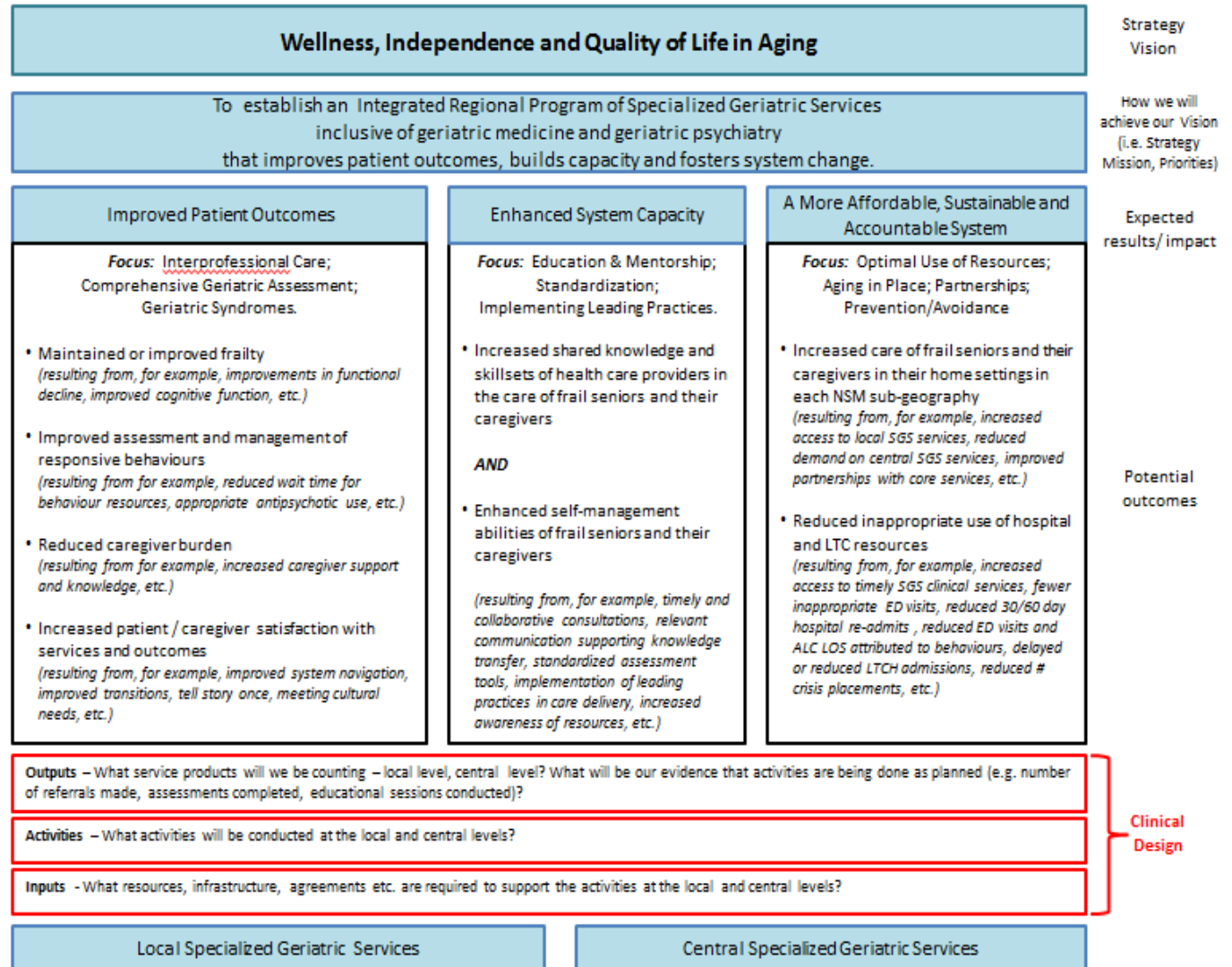
RECOMMENDATIONS: Governance, Accountability & Authority

- As required, the LHIN will amend Service Accountability Agreements with LHIN-funded health service providers to advance the clinical design.

¹⁴ Of note, within the Accountability & Authority Framework between Waypoint and the LHIN, each organization shares 50% accountability for all Program deliverables until December 2016. From January 2017 – March 2018 Waypoint assumes 75% accountability for Program deliverables with LHIN accountability reduced to 25%. The purpose of this shared accountability structure is to promote long-term success of the NSM SGS Program. By April 1, 2018 the goal is to have Waypoint fully accountable for all Program deliverables.

OUTCOMES

A logic model approach to planning was applied, starting with key concepts from the *Strategy* document. The following outcomes will be targeted by the clinical service:



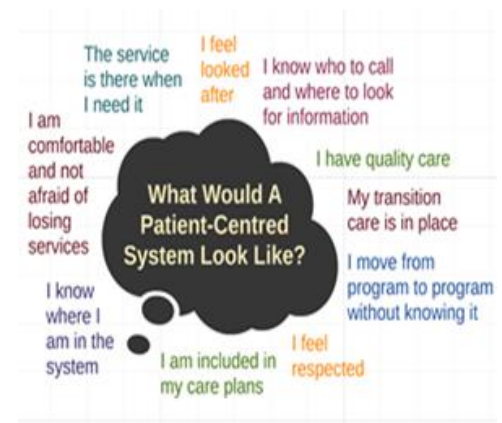
RECOMMENDATIONS: Outcomes

- Develop and finalize a Performance Monitoring & Evaluation Framework for the clinical service that takes into consideration: Accountability Agreements; Health Quality Ontario's Common Quality Agenda; indicators defined by the Regional Geriatric Program of Ontario; and, local frameworks like those developed by the Behaviour Support System and the VON Enhanced SMART Program. Indicators need to be Specific, Measurable, Attainable, Relevant and Trackable (SMART).

THE CLINICAL SERVICE

The Clinical Service Commitment

- The senior is our reason for being; “nothing about us, without us”.
- We care for the senior AND his/her caregivers.
- Our services look similar across each sub-geographic region. This standardized approach to programming and care includes a flexibility which allows us to also meet the unique needs of our frail seniors, our communities, our health service providers and our diverse populations.
- We are one team comprised of geriatric medicine and geriatric psychiatry that can be accessed through a single entry point.
- We support complexity and intensity, not acuity. We are not a crisis service.
- We provide care to a senior in need where they need it (based on criteria).
- We endeavour to help seniors remain in their homes for as long possible.
- We provide care that:
 - is based in evidence and leading practices;
 - values safety;
 - respects the dignity of risk and right to failure;
 - embraces partnerships;
 - welcomes innovation;
 - aligns with required legislation and regulation;
 - is fiscally responsible; and,
 - makes common sense.
- Care is targeted and time-limited. Collaborative care and transitions are important as they allow us to support as many seniors as possible.



SGS Intake

As noted previously, the clinical service is comprised of three interdependent components: the SGS Intake, the Local SGS Services and the Central SGS Services. The SGS Intake serves as the single entry to the Local and Central SGS Services.

*** Please refer to the SGS Intake Report & Recommendations (Appendix A)**

Eligibility & Discharge

To be eligible for the clinical service, the individual must:

1. Be a Senior.

Characterized as presenting with age-related conditions and issues.

A specific “senior” age range is not defined as some individuals will present with age-related conditions and issues before age 65 because of their life circumstances.

2. Reside in the NSM LHIN Region
AND Be Able to Receive Service in the NSM LHIN Region.

In cases where an out-of-region referral is received, a case-by-case review will occur.

AND

3. Meet Any of the Following Eligibility Categories:

A.	B.	C.
* Comprehensive Geriatric Assessment - Meet the characteristics of stages 4, 5 or 6 on the Clinical Frailty Scale; - Have the potential to improve and/or maintain their current health state; - Require a comprehensive geriatric assessment by two or more members of the available interprofessional team; - Present with multi-morbidity and complexity including: - The presence of geriatric syndromes¹⁵ that require assessment, diagnosis and/or treatment; AND - The loss or high risk for loss of Activities of Daily Living (ADLs)¹⁶ and/or Instrumental Activities of Daily Living (IADLs)¹⁷	*Responsive Behaviours - Have cognitive impairment and an associated responsive behaviour(s); - Require a behaviour assessment and/or support in the development of a behaviour plan of care; - Present with a change in behavior(s) to a degree that caregivers require support to manage the behaviour(s).	* Nurse Practitioner Support in LTC - Be a LTC resident; - Have the potential to benefit from the care of a Nurse Practitioner; - Present with one or more of the following: - Geriatric syndromes¹⁰ that require assessment, diagnosis and/or treatment; OR - An acute event that could be addressed within the LTC home to avoid an Emergency Department visit or hospital admission; OR - The need for support in the transition from hospital back to the LTC home.

The clinical service will strive to serve all seniors referred and deemed eligible. For those not eligible, the SGS Intake will, where possible, navigate the individual to another program or service that may be better suited to meet their needs.

Seniors will be discharged from the clinical service when one or more of the following conditions are met:

- The work of the clinical service is complete:
 - The individual is no longer frail;

¹⁵ Geriatric Syndromes - Dementia, delirium, depression, falls, polypharmacy, pain, malnutrition, urinary incontinence, constipation, elder abuse, functional decline

¹⁶ ADLs –bathing/ grooming, dressing, transferring, toileting, self-feeding

¹⁷ IADLs – housekeeping, meal preparation, medication management, managing money or finances, shopping, use of telephone or other form of communication, transportation within the community

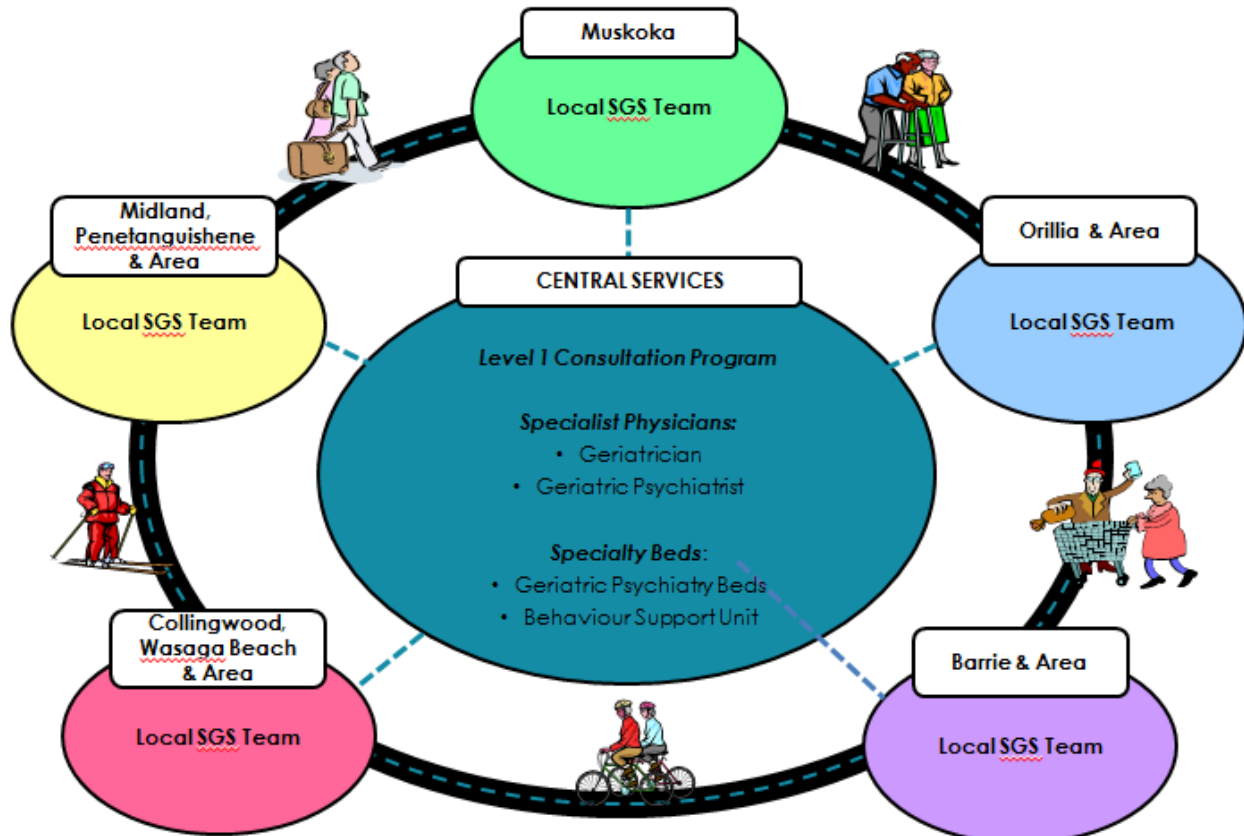
- The degree of frailty has been improved to the extent possible (i.e. the individual is at their new baseline level); and/or
 - The clinical service can offer no new suggestions or treatments to improve the frailty state.
- The senior and/or the substitute decision maker are no longer interested or able to participate in the clinical service assessment and/or treatment plan.

RECOMMENDATIONS: *Eligibility & Discharge*

- Develop a care authorization tool that can be implemented by SGS Intake to support the determination of eligibility and triage.
- Incorporate a system navigation role into the SGS Intake system to ensure way-finding support for individuals found ineligible for the clinical service.

Hub & Spoke Model

The clinical service will be comprised of Local SGS Services & Central SGS Services. Local services will be located in each NSM sub-geographic region while Central Services will be more specialized resources that serve the entire NSM region. The following model reflects the hub and spoke model of the clinical service:



Clinical Service Overview

	Local SGS Services	Central SGS Services
Programs	Local SGS Team	- Level 1 Consultation Program - Geriatric Specialist Physicians - Geriatric Specialty Beds
Description	1 interdisciplinary team in each NSM sub-geographic region that will provide the first line of care in the majority of clinical service cases. The team will support health service providers in local communities through ambulatory, satellite, outreach and in-reach programming.	Specialized LHIN-wide resources that provide support to the Local SGS Teams through targeted, time limited care. These cases require specialist consultation or support.
Target Population	Cases meeting the clinical service eligibility criteria.	Cases meeting the clinical service eligibility criteria AND having a degree of complexity and/or intensity that exceeds the knowledge, skill and judgement of the Local SGS Services.
Referral Source	- Central SGS Services - SGS Intake	- Local SGS Services - SGS Intake
Response Time	Based on triage/priority protocol. Note: This is not a crisis service	Based on triage/priority protocol. Note: This is not a crisis service
Key Roles	- Assessment - Diagnosis - Treatment - Transitions - Care Plan Development - Caregiver Support - Case Management - Capacity building	- Assessment - Diagnosis - Treatment - Transitions - Care Plan development - Capacity building
Length of Stay	Short or medium term as per the discharge criteria.	Short term with timely and appropriate transition to Local SGS Services. The Local SGS Services will implement and provide oversight to the prescribed plan of care.

Local Services: The Local SGS Team

The clinical service will be comprised of 5 "spokes", with each spoke reflective of a single Local SGS Team. Each Local SGS Team will support a specific sub-geographic region. Each Local SGS Team will work as a single entity within the region to support frail seniors across the continuum of care.

For the purpose of this document, the Local SGS Team information will be broken into several descriptors to better articulate the specific intent of some of the distinct in-reach resources.

Local SGS Team	
The Idea in Brief: A single interdisciplinary team comprised of geriatric medicine and geriatric psychiatry (including responsive behaviour) resources that support the assessment and management of frail seniors in the local community and builds local community capacity.	
	• Accepts referrals from the SGS Intake or the Central SGS Services. • Provides the first line of care in the majority of cases referred to the clinical service. The majority of care within the clinical service is provided by this team. In addition to assessment, diagnosis and treatment the team: ○ Supports transitions: ▪ Between Local and Central SGS Services; ▪ For frail seniors admitted to the clinical service and moving across the continuum of care; and ▪ For frail seniors being discharged from service. ○ Works with key partners, including the frail senior, to develop care plans; ○ Provides case management support to all active cases to ensure successful implementation of the plan of care and that the senior flows through the clinical service in a timely fashion; ○ Is comprised of therapy resources to provide targeted and time-limited congregate therapy programs with outreach provided in cases where the senior requires a brief bridge until they are able to attend the congregate program; and, ○ Assists caregivers by providing education and support as well as linking them with community resources. • Works "hand-in-hand" with primary care in a collaborative care model to support frail seniors in the local communities and build primary care capacity through education and mentorship. • Build partnerships and relationships with local services to support the needs of the frail senior, support system navigation and build local capacity. • Wraps services around seniors to support their needs through use of available clinical service resources AND by building a network of supports with partner agencies. • A "one-stop shop" for services for frail seniors meeting the clinical service eligibility criteria.

	• Able to cross the continuum of care to meet the needs of frail seniors where they live. • Supports the work of the Central SGS Services by providing Local SGS Team resources to: ◦ Support assessment and implementation of the Central SGS Services plan of care at the local level, including transitions. ◦ Support satellite clinics and outreach services offered by the Specialist Physicians in the sub-geographic region. ◦ Provide on-site local support for OTN consults and follow-up visits by the Specialist Physicians. • For seniors without a primary care provider, the NP will provide interim support and will work to expedite attachment with a primary care provider. • Responsive Behaviours: ◦ Team comprised of a Behaviour Lead and Behaviour Support Workers. ◦ Behaviour Lead will support initial assessment, the development of the plan of care and provide oversight to the Behaviour Support Workers. This individual will also support the management of complex cases as required. ◦ Behaviour Support Worker will implement and monitor the plan of care, including supporting transitions. • Capacity Building: ◦ Develop and implement leading practices, care pathways and standards of care to promote consistency of practice across the local sub-geographic region and across all local SGS Teams; ◦ Provide education and mentorship to local health service providers; and, ◦ Identify local needs and develop programming, when possible and over time, to meet those needs (i.e. falls program, Parkinson's program, etc.) • Connected under the clinical service by a common leadership team, a single point of entry, a single and shared electronic health record, regular team meetings, standardized tools and practices, etc. • Care is targeted and time-limited with discharge criteria defined. • Service is offered Monday-Friday as this is not a crisis service. <i>*Note: Geriatric Emergency Management (see SGS Local Team: Supports to Hospitals) will have extended hours to facilitate links with the clinical service with the goal to support Emergency Department diversion and admission avoidance (where possible and appropriate).</i>
 Target Pop.	• Frail seniors meeting the clinical service's eligibility criteria. • Seniors, caregivers, local health service providers including primary care and Paramedic Services (capacity building).
 Location	• Ambulatory Clinics: ◦ One central location within each sub-geographic region; ◦ Clinics ideally co-located with other seniors' services in either store front or areas where there is access to a critical mass of frail seniors (one-stop shop). ◦ Space requirements – offices for reception and multiple concurrent assessments, space for congregate treatment programs, space for team

	offices (ideally), space for other seniors programs (ideally). • Outreach into seniors homes or congregate settings (e.g. adult day program sites) for seniors in need (criteria-based). • In-reach into LTC and hospitals (see additional Local SGS Team boxes below) • Satellite Clinics in alternate locations within each sub-geographic region – critical mass required.
	• Care of the Elderly Physician • Nursing: Nurse Practitioner, RN, RPN, Geriatric Mental Health Nurse • Allied Health: PT, OT, PTA/OTA, Kinesiologist, Exercise Leader, Social Work, Pharmacist, Dietitian, Community Mental Health Worker. • Responsive Behaviours: Behaviour Lead, Behaviour Support Worker • Administrative Assistant • Access to (CCAC) Intensive Case Manager; Psychometrist; Speech Language Pathologist • Access to administrative leadership, clinical leadership as well as back-office supports including decision support. <i>* Specific FTE allocation will be defined as part of implementation planning.</i> <i>* Note: Staff funded by the NSM SGS Program will be employees of the Local SGS Team. They will be accountable for achieving the clinical outcomes of the NSM SGS Program.</i>
	• Increased access to SGS resources within each NSM sub-geographic region. • Better integration of care leading to improved communication, improved clinical outcomes, improved coordination of care, improved collaboration and improved transitions. • Access to a single team where referrals are triaged within the team (vs. the health service provider trying to navigate referral options across the community) • Increased local capacity and more targeted use of specialist resources. • Improved utilization of health and mental health resources, including an upstream approach to ALC reduction.
	The proposed benchmarks for seniors' mental health services in Canada¹⁸ suggest 5.5 FTE health professionals/10,000 elderly for Seniors Mental Health / Outreach Teams. These teams are described as providing consultation/liaison service to LTC, collaborative/shared care in the community. Care is time limited and the focus is direct service.

RECOMMENDATIONS: *Local SGS Teams*

- Establish a Local SGS Team in each NSM sub-geographic region, including:
 - Securing necessary resources, including health human resources;
 - Identifying an appropriate location(s) for services;
 - Building a toolkit of standardized resources and tools to support; and,

¹⁸ Mental Health Commission of Canada (October 2011). Guidelines for Comprehensive Mental Health Services for Older Adults in Canada: Executive Summary.

- Developing operational policies and procedures.
- LHIN to complete the review of the Enhanced SMART Program (as part of the provincial Assess & Restore funding initiative) and consider continued funding and expansion of the concept as part of each Local SGS Team. Advocate to the Ministry as required.
- Develop partnerships with primary care and other core service. As appropriate, develop agreements that clearly define, at minimum, accountability and authority, responsibilities, expectations, deliverables, and timelines.
- Establish eligibility for outreach programming to ensure optimal use of clinical service resources. Where possible build partnerships and processes that leverage the information and mandate of existing resources (i.e. Paramedic Services, in-home resources, etc.).
- As per the October 2013 recommendation of the BSS Project Steering Committee, advocate for the establishment of a behavioural interdisciplinary team to support clusters of beds (total = 12 beds) in sites across NSM. Consider and support existing supportive housing environments serving residents with challenging behaviours as part of a “housing first” approach.

Local SGS Team: Supports to Long-Term Care

The Idea in Brief:

Each Local SGS Team will be comprised of dedicated Responsive Behaviour resources and Nurse Practitioner resources that will be available to interested LTC homes (through an in-reach approach) to support the assessment and management of frail seniors in LTC and to build local LTC capacity.



- As above (Local SGS Team), except:
 - Works “hand-in-hand” with LTC, including the Medical Director, in a collaborative care model to support frail seniors in the LTC home and build LTC home capacity through education and mentorship.
 - Does not have access to therapy resources within the Local SGS Team.
 - Hybrid mobile/integrated model where Local SGS Team members will be deployed to interested LTC homes to support residents and staff. Team members will have scheduled days/times on sites AND will also be available to respond to referrals on unscheduled days. Team members will have a dedicated LTC home portfolio and will be aligned with a cluster of homes in the sub-geographic region. Team members can cross the continuum of care as required to support transitions. Team members can engage other clinical service resources as required.
- * Note: These team members are not gatekeepers to the clinical service. They are an available resource to interested LTC homes to support and help navigate frail seniors within the clinical service. As with other members of the Local SGS Team, these resources will be leveraged by the Central SGS Services to support their work.*

	• Responsive Behaviours: ◦ Team comprised of a Behaviour Lead and Behaviour Support Workers. ◦ Behaviour Lead will support initial assessment, the development of the plan of care and provide oversight to the Behaviour Support Workers. This individual will also support the management of complex cases as required. This individual may or may not have a dedicated LTC home portfolio. ◦ Behaviour Support Worker will implement and monitor the plan of care, including supporting transitions. This individual will have a dedicated LTC home portfolio. • Nurse Practitioner: ◦ To support: comprehensive geriatric assessment; assessment, diagnosis and treatment of acute medical needs (including IV therapy, antibiotic management, oxygen administration, etc.); and, palliative care support as appropriate. • OTN to support connectivity.
	• Frail seniors in LTC Homes meeting the clinical service's eligibility criteria (<i>clinical outcomes</i>). • LTC Home residents, staff, physicians and leadership (<i>capacity building</i>).
	• NSM LTC Homes (26 homes).
	• 1.0 FTE NP will be aligned with the Local SGS Team to support every 120-175 LTC home beds. <i>* Note: LTC homes will need access to sufficient funding to support blood work/labs, equipment and medication for the purpose of Emergency Department diversion and admission avoidance.</i> • 1.0FTE Behaviour Support Worker will be aligned with the Local SGS Team to support every 120-175 LTC home beds. <i>* Note: Staff funded by the NSM SGS Program will be employees of the Local SGS Team. They will be accountable for achieving the clinical outcomes of the NSM SGS Program.</i>
	• Improved access to Nurse Practitioner resources in each NSM sub-geographic region. • Better integration of behaviour and Nurse Practitioner resources with each other and with the broader clinical service resulting in improved communication, continuity of care and transitions. • Scheduled on-site access to resources increases in-time care, education and mentoring resulting in reduced Emergency Department visits, hospital admissions and hospital length-of-stay. • Contact with consistent Local SGS Team members helps build SGS-LTC relationships and LTC capacity.

	Benchmarks: - New Ministry funded home-based NPs = 1 FTE per 175 beds. Rationale: - Recently the Ontario Long-Term Care Home Association (OLTCA) evaluated the two models of the Behaviour Support System across the province: mobile; “in-home”/integrated. The evaluation found LTC staff strongly believed the “in-home” model out-performs mobile teams across all key measures related to care planning, provision, collaboration, team building and home-level outcomes¹⁹. Integrated approach also reduces costs associated with travel time and mileage. Recent conversation with NSM Mobile Support Team showed clear consensus on preference for mobile model – “Staffing some homes will be difficult and will become a recruitment and retention issue”; “We like the ability to collaborate within our team and when we go into different homes we can lay a fresh set of eyes on the situation.”. Staff also indicated that within the integrated model there is the risk of being engaged in home tasks and activities falling outside the scope and mandate of the role and, potentially, outside the target of responsive behaviours. The evaluation did not explore options around a hybrid model where the resources are integrated into a clinical (vs. LTC home) team. A hybrid mobile/integrated model would address some aspects of the OLTCA evaluation while concurrently attending to the concerns identified by the NSM team. - Dr. Sinha stated; Nurse-Led Outreach Teams (NLOT) “focus on supporting residents who may develop an acute care issue that can be managed in the LTC Home, or through a focused and facilitated visit to a local hospital. The program has a particular focus on building the capacity of LTC nurses and other front-line staff to successfully manage appropriate acute issues in the LTC and thereby reducing avoidable hospitalizations and ED visits.”²⁰
---	---

RECOMMENDATIONS: *Local SGS Teams – Supports to Long-Term Care*

- Align a 1.0 FTE behaviour resource and a 1.0 FTE NP with each local SGS Team to support every 120-175 LTC beds.
- Develop partnerships with LTC homes, including Directors of Care and Medical Directors. As appropriate, develop agreements that clearly define, at minimum, accountability and authority, scope, responsibilities, expectations, deliverables, and timelines.
- In partnership with the LTC homes, determine the most appropriate physician partner for the Nurse Practitioner.
- LHIN to advocate to the Ministry for sufficient funding for LTC homes to support the on-site assessment and treatment of acute medical events.
- Partner with developmental services and community living to increase Local

¹⁹ Ontario Long-Term Care Home Association (2015). Impacts of BSO Models on Key Aspects of Resident Care: Results of the Ontario Long Term Care Association Member Survey.

²⁰ Sinha (2012). Living Longer, Living Well. p. 124.

SGS Teams skillsets with dual diagnosis population.

- Build a process into the SGS Intake to ensure timely referrals to on-site staff and to avoid delays in service.

Local SGS Team: *Hospital Resources*

The Idea in Brief:

Each Local SGS Team will be comprised of Geriatric Emergency Management (GEM) resources and Nurse Clinician resources dedicated to hospitals (through an in-reach approach) to support the assessment and management of frail seniors in hospital and to build local hospital capacity. Hospital resources would include Local SGS Team access to acute medical beds.



- As above (Local SGS Team), except:
 - Works “hand-in-hand” with *hospital teams*, in a collaborative care model to support frail seniors in the *hospital* and build *hospital* capacity through education and mentorship.
 - Does not have access to therapy resources within the Local SGS Team.
 - Responsive Behaviours will be addressed by the Nurse Clinician and/or the GEM resources as appropriate.
 - Where appropriate, the GEM resources will operate extended hours Monday – Friday (e.g. 12 hr days) and will provide service on Sundays.
- Dedicated on-site supports focused on supporting area hospitals to assess and manage frail seniors meeting clinical service eligibility criteria. Key emphasis on admission diversion, facilitating inpatient flow and reducing ALC volumes and days. Team members can cross the continuum of care as required to support transitions. Team members can engage other clinical service resources as required.

** Note: These team members are not gatekeepers to the clinical service. They are an available resource to interested LTC homes to support and help navigate frail seniors within the clinical service. As with other members of the Local SGS Team, these resources will be leveraged by the Central SGS Resources to support their work.*
- Geriatric Emergency Management:
 - Dedicated resource in every NSM Emergency Department.
 - Where appropriate, will operate extended hours Monday – Friday (e.g. 12 hr days) and will provide service on Sundays.
 - To provide targeted geriatric assessment, including responsive behaviours.
 - Will establish links for the frail senior with other members of the Local SGS Team as appropriate.
 - Focus on Emergency Department diversion and admission avoidance.
- Nurse Clinician:
 - Dedicated resource in every NSM hospital to support inpatient units in the assessment and management of frail seniors, including responsive behaviours.

	- Will also support: - Implementation of an Acute Care of the Elderly (ACE) philosophy of care across each hospital with the goal to improve the quality of care, increase best practice guidelines and standards and build hospital capacity. - Continued implementation of the Senior Friendly Hospital Strategy (SFHS) with a focus on functional decline and delirium. - Direct admissions to acute medical beds for frail seniors admitted to the clinical service. - Local SGS Team access to acute medical beds: - Access when required for direct admissions with the goal to provide a controlled/targeted admission and prevent a crisis in the community. - Hospitals will be consulted when a bed is required to negotiate the admission date and plans. - Plan of care oversight by the Nurse Clinician. - MRP would be negotiated among the partner physicians and Nurse Practitioners in the case. - Beds ideally located in a consistent acute medical unit to build capacity. - OTN to support connectivity.
	- Frail seniors in NSM Emergency Departments or inpatient units meeting the clinical service's eligibility criteria (<i>clinical outcomes</i>). - Acute care hospital patients, staff, physicians and leadership (<i>capacity building</i>).
	- NSM Emergency Departments. - NSM hospital inpatient acute and post-acute units.
	1.0 – 2.0 FTEs GEM staff (additional FTEs to accommodate for extended hours as appropriate) will be aligned with the Emergency Department for every 100-120 hospital beds. 1.0 FTE Nurse Clinician will be aligned with every 100-120 beds in the hospital. - Each hospital site will implement an ACE philosophy of care. Larger sites may choose to have dedicated units and beds based on clinical volumes. - Each hospital will continue to support the work of the SFHS Committee. - Each hospital site will provide access to 1 acute medical bed for every 1,500 frail seniors in their sub-geographic region.
	- Increased access to GEM and inpatient resources across NSM hospitals. - Alignment of hospital resources within the SGS clinical service resulting in improved communication, continuity of care and transitions. - On-site staff increases in-time care, education and mentoring resulting in Emergency Department diversions, reduced hospital admissions, reduced hospital length-of-stay and reduced ALC volumes/days. - Contact with consistent SGS clinical service staff helps build SGS-hospital relationships and hospital capacity. - Implementation of an ACE philosophy of care and continued support of the SFHS work will lend to better quality of care, improved clinical outcomes, fewer

	adverse events and increased hospital capacity. • Access to medical beds by the clinical service will reduce prolonged ED lengths-of-stay, reduce acute events in the community and provide a more targeted and controlled approach to an acute care admission.
	Benchmarks: • Based on a review of GEM nurses by the Regional Geriatric Program of Toronto, they found in their second year of operation they were spending 60-70% of their time in patient care and 20-30% in capacity building and each GEM nurse performed 690 face to face visits or telephone assessments²¹ • Benchmarks for a 7 bed Acute Geriatric Unit: 1770 inpatient days; 123 annual admissions and discharges; average LOS 15 days; LOS range 12-20 days.²² • A review of Geriatric Assessment Units in Quebec revealed a variety of models. In 2003, the ratio was 10.7 beds / 10,000 seniors age 65+ across the 71 units in the province.²³ Rationale: • With implementation of the desired clinical design it is suggested by the Clinical Design Working Group that we could reduce some current pressures. At present, area hospitals are dealing with several senior populations – those that could be re-directed from the Emergency Departments, those that require acute care and those that are defaulting into the hospital because of the lack of area resources (e.g. responsive behaviours, mental health and addictions, ALC). By positioning someone in the Emergency Department and another as a resource to staff across the building the goal is to improve patient flow and health outcomes. • RVH piloted GEM nurses seven days/week and found that volumes were not warranted but there was a need for service on Sundays. • GEM was recognized by Dr. Sinha as “one of the most impactful initiatives”, referencing the positive impact on admissions, return ED visits and on connecting orphan seniors with a primary care provider. He also referenced Acute Care of the Elderly (ACE) Units. “ACE Units operate within a specially designated ward of the hospital that aims to combine geriatric assessments, quality improvement, a specially planned environment, interprofessional team rounds, frequent medical care reviews, and comprehensive discharge planning. ACE Units have been shown to reduce lengths of stay, readmissions, and long-term care placements and help

²¹ Regional Geriatric Program of Toronto. (2012). Building Specialized Geriatric Services in Acute Care Hospitals: the Business Case and Toolkit. Information pulled May 16, 2016 from <http://rgp.toronto.on.ca/sites/default/files/SGS%20business%20case%20toolkit.pdf>

²² Regional Geriatric Program of Toronto. (2012). Building Specialized Geriatric Services in Acute Care Hospitals: the Business Case and Toolkit. Information pulled May 16, 2016 from <http://rgp.toronto.on.ca/sites/default/files/SGS%20business%20case%20toolkit.pdf>

²³ Latour, Lebel, Leclerc, Leduc, Berg, Bolduc & Kergoat. (2010). Short-term geriatric assessment units: 30 years later. BMC Geriatrics. 10:41

	hospitalized older adults maintain functional independence in basic activities of daily living".²⁴ The Ottawa Hospital explored a costing methodology of their GEM+ program and found that in fiscal year 2012/13 the program saved over a thousand bed days, avoided over \$1.9 million in costs and successfully diverted cases from being admitted into hospital or becoming ALC due to the programs 11.5% lower admission rate and 1.3% lower ALC rate.²⁵
--	--

RECOMMENDATIONS: Local SGS Teams – Hospital Resources

- Align 1.0 – 2.0 FTEs GEM staff and a 1.0 FTE Nurse Clinician with every NSM hospital. In smaller hospitals, these positions could be combined.
- Develop partnerships with NSM hospitals. As appropriate, develop agreements that clearly define, at minimum, accountability and authority, scope, responsibilities, expectations, deliverables, and timelines.
- Each hospital site to implement an ACE philosophy of care. Larger sites may choose to have dedicated units and beds based on clinical volumes.
- Each hospital to continue to support the work of the SFHS Committee.
- Each hospital site to provide access to 1 acute medical bed for every 1,500 frail seniors in the region for direct admissions.
* Cases would always be negotiated with the hospital and the beds would only be used when an appropriate need is identified.
- Partner with geriatric psychiatry to increase Local SGS Teams skillsets with serious mental illness.
- Build a process into the SGS Central Intake to ensure timely referrals to on-site staff and to avoid delays in service.

Central SGS Services

Central SGS Services are specialized LHIN-wide resources that provide support to the Local SGS Teams through targeted, time limited care. All cases referred into Central SGS Services require specialist consultation or support.

Level 1 Consultation Program

The Idea in Brief:

To provide targeted health service providers with access to specialists (Clinical Manager/Clinical Nurse Specialist, Behaviour Support System Manager, Geriatrician, Geriatric Psychiatrist) where advice or guidance is needed regarding the care of a frail

²⁴ Sinha. (2012). Living Longer Living Well. p. 117.

²⁵ Regional Geriatric Program of Eastern Ontario. (2015). Geriatric Emergency Management PLUS Program Costing Analysis at the Ottawa Hospital. <http://www.rgepo.com/media/68649/gilsenan%20-%20gem%20plus%20program%20costing%20analysis%20methodology%20-%20tested%20at%20toh.pdf> at May 16, 2016

senior, rather than a referral to the clinical service.	
	• Access through SGS Intake. • The majority of cases requiring information or system navigation will be supported by SGS Intake. When the information required exceed the knowledge, skill and/or judgement of Intake staff a Level 1 Consultation will be scheduled. • Level 1 Consultation Program will provide: ◦ Health service providers, including Local SGS Teams, with access to the Clinical Manager/Clinical Nurse Specialist or the Behaviour Support System Manager to discuss cases where assessment, treatment or navigation advice or guidance is needed. OR ◦ Local SGS Team physicians and NPs with phone or OTN access to a Geriatrician or Geriatric Psychiatrist to discuss frail senior cases where medical advice or guidance is needed. • Where possible, cases will remain anonymous, no identifiers shared. If personal health information is shared consent will be required. • No active care will be provided by the specialists. The intent is to provide health service providers with a sounding board (or “hallway conversation”) to help navigate through cases and care. The goal is to build capacity and avert or delay a referral to the clinical service. • Scheduled blocks of time will be built into the calendars of specialists to support the scheduling of appointments. • Majority of cases can be addressed through phone conversations although OTN will also be available. For the Geriatrician, OHIP billing limits phone consultations to 10 minutes. • Upon consultation specialists may refer cases into the Local SGS Team or the geriatric specialist physicians may request a consultation be generated to them for the frail senior.
	• NSM Health Service Providers, Local SGS Teams (<i>capacity building</i>).
	• Telephone Appointments. • OTN Appointments.
	• Several hours / week of blocked time from the following: ◦ Clinical Manager/Clinical Nurse Specialist ◦ Behaviour Support System Manager ◦ Geriatrician ◦ Geriatric Psychiatrist
	• Reduce or delay admissions to the clinical service thereby optimizing use of available resources. • Builds capacity across health service providers in the assessment and management of frail seniors through education and mentorship.

	Supports health service providers to put actions in place in a more timely fashion, thereby improving flow and clinical outcomes.
	This concept builds on the findings of the NSM Responsive Behaviours Complex Case Resolution pilot project where 4/6 referrals for complex cases were diverted through an initial conversation and discussion of best practices.

RECOMMENDATIONS: *Central SGS Services – Level 1 Consultation Program*

- Leverage the Responsive Behaviour Complex Case Resolution Process processes and tools to pilot a Level 1 Consultation Program across NSM for a six month period. Evaluate outcomes and determine appropriateness and feasibility of continued implementation.
- Explore opportunities related to eConsult and eReferral to streamline processes.

Specialist Physicians

The Idea in Brief:

A short-term targeted consultative service whereby Local SGS Teams can engage the Geriatrician and/or Geriatric Psychiatrist in the assessment, diagnosis and treatment of complex frail seniors.

	- Referrals through the Local SGS Team. <i>* Note: There may be cases where referrals will be sent directly to geriatric specialist physicians from SGS Intake.</i> - Physician referral required. - Components: <u>Combined Geriatrician & Geriatric Psychiatrist Clinic</u> – Located in one central location in the region on scheduled days. Both physicians will be present to support the assessment and diagnosis of complex frail seniors. If volumes are sufficient in future, satellite clinics will be considered. <u>Outreach Services</u> - Specialist physicians will travel to each sub-geographic region on scheduled days throughout the month to support Local SGS Teams in the care of complex frail seniors. Specialist physicians will provide clinics and conduct outreach visits into hospitals, LTC and Retirement Homes. <u>OTN</u> – OTN will be used for scheduled case consultations on complex cases with Local SGS Teams and for follow-up visits with frail seniors, as appropriate. For follow-up visits, a Local SGS Team member will be present to participate and support the visit. - The Specialist Physicians will partner with the Local SGS Team to provide targeted and time-limited support when care exceeds the knowledge, skill and judgement of the Local SGS Team. Assessment will be supported by members of the Local SGS Team. Implementation of recommendations as well as implementation and monitoring of the care plan will rest with the Local
---	--

	SGS Team.
	• Frail seniors meeting the clinical service's eligibility criteria AND having a degree of complexity and/or intensity that exceeds the knowledge, skill and judgement of the Local SGS Team (<i>clinical outcomes</i>). • Local SGS Team (<i>capacity building</i>).
	• Across NSM: ◦ Combined Geriatrician & Geriatric Psychiatrist Clinic in one central location in NSM with option for satellite sites in future if sufficient volumes ◦ Outreach into sub-geographic regions – satellite clinics, outreach into hospitals, LTC and the community. ◦ OTN • Space requirements: – offices for a reception and multiple concurrent assessments for the Combined Clinic; access to the clinic space of the Local SGS Teams for the sub-geographic satellite clinics; access to OTN when required.
	• Geriatric Nurse Clinician(s) to be aligned with every Geriatrician. • Geriatric Mental Health Nurse Clinician(s) to be aligned with every Geriatric Psychiatrist. • Access to Behavioural Neurology and/or Neuropsychology • Administrative Assistant • Access to Local SGS Team resources to support the local assessment and management of referred seniors. <i>* Note: Staff funded by the NSM SGS Program will be employees of the SGS clinical service. They will be accountable for achieving the clinical outcomes of the NSM SGS Program.</i>
	• More targeted utilization of specialist physicians, increased volumes of individuals seen. • Improved access to specialist physicians across the NSM region. • Local delivery of specialist physician services which reduces travel time for seniors and their caregivers. • Increased capacity within the Local SGS Teams as a result of specialist physician engagement and education/mentorship.
	

RECOMMENDATIONS: Central SGS Services – Specialist Physicians

- Establish a Geriatric Physician Specialist service across NSM, including:
 - Securing necessary resources, including health human resources;
 - Identifying an appropriate location(s) for services;
 - Building a toolkit of standardized resources and tools to support; and,
 - Developing operational policies and procedures.
- Build a process or algorithm into the SGS Central Intake to ensure referrals

bypass Local SGS Teams and are sent directly to Geriatric Physician Specialists when appropriate to avoid delays in service. This could include a process whereby Local SGS Team Care of Elderly Physicians review the referral and confirm the bypass.

Specialty Beds: *Geriatric Psychiatry*

The Idea in Brief:

Inpatient mental health beds where a team of geriatric psychiatry specialists, with access to geriatric medicine team specialists, provide comprehensive geriatric assessment with a focus on frail seniors (meeting the clinical service eligibility criteria) with the key presenting problem as a complex mental health issues. This includes the assessment, diagnosis, treatment and stabilization of a psychiatric condition and may include those with underlying addiction, neuropsychiatric disorders or possibly a dementia with or without behaviours but all presenting with core psychiatric symptoms.



- This resource does exist as Waypoint Horizons Program.
- Accepts referrals from the SGS clinical service only.
- Access through Waypoint Central Intake. Geriatric Psychiatrist must approve admission.
- With a portion of geriatric psychiatry as part of the NSM SGS Program, the clinical service will require access to beds when appropriate. As part of the clinical service, the population within Horizons could broaden slightly given the partnership with geriatric medicine team specialists, including Geriatricians. However, the environment will still require patients to be medically stable for admission.
- Primary provider team is geriatric psychiatry with access to geriatric medicine team specialists as required, including a Geriatrician.
- Works "hand-in-hand" with key partners, including the Local SGS Team, in a collaborative care model to support frail seniors and build capacity through education and mentorship.
- In addition to assessment and diagnosis:
 - Treatment includes pharmacological and non-pharmacological approaches to care.
 - Works with key partners, including the frail senior, to develop care plans;
 - Provides case management support to all active cases to ensure successful implementation of the plan of care and that the senior flows through the clinical service in a timely fashion;
 - Is comprised of therapy resources; and,
 - Assists caregivers by providing education and support as well as linking them with community resources.
- Transitions supported by the Local SGS Teams.
- Nurse Clinician will support this program as required.
- Care is targeted and time-limited with discharge criteria defined.

	• Frail seniors meeting the clinical service's eligibility criteria AND presenting with core psychiatric symptoms requiring admission to an inpatient mental health unit (<i>clinical outcomes</i>).
	• Waypoint Centre for Mental Health Care
	Access is required to the following disciplines: • Geriatric Psychiatrist. • Care of the Elderly Physician. • Nursing – including, Nurse Clinician, RN and/or RPN. • Allied Health: PT, OT, PTA/OTA, Social Work/ Discharge Planner, Pharmacist. • Administrative Assistant. • Access to Geriatrician and other members of the geriatric medicine team as required. • Access to (CCAC) Intensive Case Manager, Dietitian, Speech Language Pathologist. • Access to Behavioural Neurology and/or Neuropsychology. <i>* Note: Staff funded by the NSM SGS Program will be employees of the Local SGS Team. They will be accountable for achieving the clinical outcomes of the NSM SGS Program.</i>
	• Improved utilization of geriatric psychiatry inpatient beds. • Increased collaboration between Geriatric Psychiatry and Geriatric Medicine. • Increased ability of Waypoint to deal with individuals with concurrent underlying geriatric syndromes and/or some medical conditions. • Transitions (in/out) supported by Local SGS Teams thereby improving patient flow through the beds, communication and implementation of a defined plan of care. • Increased capacity within the Local SGS Teams as a result of education/mentorship occurring through transitions role.
	• Currently 68% of patients admitted to Horizon beds are ALC, with the bulk facing discharge delays due to responsive behaviours. • The proposed benchmarks for seniors' mental health services in Canada²⁶ suggest 3.3 beds/10,000 elderly for Specialized (Medium Stay) Geriatric Psychiatry Inpatient (Hospital) beds for assessment and active treatment. These beds are described as geriatric psychiatry beds for seniors who required intensive treatment and the expertise of a specialized geriatric team in hospital, with an average length of stay below 90 days. Based on the NSM LHIN population 65+ this would equate to 28 beds which is the current size of the Horizons Program. Of note, Waypoint does serve a region larger than the NSM boundaries. The NSM SGS Program suggests that with the addition of a

²⁶ Mental Health Commission of Canada (October 2011). Guidelines for Comprehensive Mental Health Services for Older Adults in Canada: Executive Summary.

	Behaviour Support Unit in NSM there would be an opportunity for improved utilization of Horizons beds.
--	--

RECOMMENDATIONS: *Central SGS Services – Specialty Beds: Geriatric Psychiatry*

- Upon establishment of a Behaviour Support Unit in NSM, Waypoint to provide access to up to 1 geriatric psychiatry bed for every 1,500 frail seniors in the NSM region. These Horizon beds would target frail seniors in the clinical service with complex mental health issues. Eligibility will exclude older adults with cognitive impairment and responsive behaviours, unless presenting with core psychiatric symptoms.
- Develop partnerships with Waypoint Horizons Program. As appropriate, develop agreements that clearly define, at minimum, accountability and authority, scope, responsibilities, expectations, deliverables, and timelines.
- Build a process to support Horizon Program access to geriatric medicine team specialists including Geriatricians, as appropriate.

Specialty Beds: *Behaviour Support Unit*

The Idea in Brief:

16 bed Behaviour Support Unit (BSU) in LTC where a team of behaviour specialists, under the clinical leadership of geriatric psychiatry and with access to geriatric medicine, provide specialized geriatric assessment and treatment to older adults with cognitive impairment and responsive behaviours.



- The BSU is operated by the LTC home in partnership with the clinical service.
- Accepts referrals from the SGS Clinical Service only.
- Access through existing CCAC LTC eligibility and admission processes. Geriatric Psychiatrist must approve admission.
- Physician referral required.
- Single dedicated 16-bed unit centrally located in NSM with ease of access to geriatric psychiatry resources. Unit would have capacity to support transitional cases and, if required, longer-stay cases. The goal is to build a system within the clinical service that supports transitions. Length of stay is ideally weeks to months.
** It is proposed that beds are dedicated, within reason, recognizing that admission pressures may require an off-service admission to address occupancy requirements.*
- Purpose is to assess, treat and stabilize and monitor behaviours and, when appropriate, reduce risk of harm to self/others.
- Primary provider team is geriatric psychiatry with access to geriatric medicine team specialists as required, including a Geriatrician.
- Works "hand-in-hand" with key partners, including the Local SGS Team, in a collaborative care model to support the older adult with cognitive impairment and responsive behaviours and build capacity through education and

	mentorship. • In addition to assessment and diagnosis: ◦ Treatment includes pharmacological and non-pharmacological approaches to care. ◦ Works with key partners, including the individual or substitute decision maker, to develop care plans; ◦ Provides case management support to all active cases to ensure successful implementation of the plan of care and that the senior flows through the beds in a timely fashion; and, ◦ Assists caregivers by providing education and support as well as linking them with community resources. • Transitions supported by the Local SGS Teams. • Care is targeted and time-limited with discharge criteria defined. • Single site will require a strategic communication strategy explaining the benefits to support admission support from caregivers. Strategy to facilitate communication with loved ones will be imperative. • Specialized Units in LTC require a special license and additional per diem funding to support the unique needs of the population.
	• Frail seniors meeting the clinical service's eligibility criteria AND requiring admission to a Behaviour Support Unit bed (<i>clinical outcomes</i>).
	• A single NSM LTC site with ease of access to geriatric psychiatry.
	• Possible renovations to an existing site. • Sufficient technology to support monitoring and timely intervention to reduce risk of harm to self/others. • Per Diem funding (approximately 125/bed/day) in addition to the basic LTC funding required. Access is required to the following disciplines: • Geriatric Psychiatrist. • Care of the Elderly Physician. • Nursing – including, Nurse Clinician, RN and/or RPN. • Unregulated Care Providers. • Behaviour Support Technicians. • Allied Health: OT, Social Work/ Discharge Planner. • Administrative Assistant. • Access to Geriatrician and other members of the geriatric medicine team as required. • Access to (CCAC) Intensive Case Manager, PT, PTA/OTA, Pharmacist, Dietitian, Speech Language Pathologist. • Access to Behavioural Neurology and/or Neuropsychology. * Note: Staff funded by the NSM SGS Program will be employees of the Local

	SGS Team. They will be accountable for achieving the clinical outcomes of the NSM SGS Program.
	- Improved utilization of hospital beds across NSM, including Waypoint Horizons Program. - Clustering of complex cases allows care by a dedicated team with the knowledge, skills and judgement to support the care needs of the senior. - Transitions (in/out) supported by Local SGS Teams thereby improving patient flow through the beds, communication and implementation of a defined plan of care. - Increased capacity within the Local SGS Teams as a result of education/mentorship.
	Benchmarks: - MH LHIN – Sheridan Villa 19 bed unit = LOS range 44 – 629 days. Average LOS is 330 days, avg. treatment days is 218 days. Staffing ratio = D/E 1RN, 1 RPN, 3 PSWs, N - 1 RPN, 2 PSW; 1.0FTE OT and 1.0 FTE Activation Therapist. The MH LHIN provides an additional \$125/per diem/bed. - Additional Units = 23 bed SBSU Baycrest; 16 bed SBSU Cummer Lodge - The proposed benchmarks for seniors mental health services in Canada²⁷ suggest 7.5 beds/10,000 elderly for Residential Mental Health beds (non-hospital). These beds are described as being used for the longer-term stabilization and treatment for those with severe or persistent behavioural and psychological symptoms of dementia on a specialty designed unit in a LTC facility. This would equate to 62 beds in the NSM region. Rationale: - Since October 2013, the Behavioural Support System Project Steering Committee has been advocating for a 10-12 bed Transitional Behaviour Unit in NSM. - In the Behaviour Concurrent Review, responsive behaviours delaying discharge accounted for 56 cases and, in 41 of those cases, accounted for a cumulative ALC length of stay >10,000 days.

RECOMMENDATIONS: *Central SGS Services – Specialty Beds: Behaviour Support Unit*

- Establish a 16 bed Behaviour Support Unit in a single site in a LTC home in the NSM region for older adults with cognitive impairment and responsive behaviours. Eligibility will exclude those presenting with core psychiatric symptoms. The number of beds will need to be monitored over time regarding utilization and demand. Implementation planning would include:
 - Securing necessary resources, including funding;
 - Securing necessary licensing;
 - Identifying an appropriate location(s) for services;

²⁷ Mental Health Commission of Canada (October 2011). Guidelines for Comprehensive Mental Health Services for Older Adults in Canada: Executive Summary.

- Building a toolkit of standardized resources and tools to support; and,
- Developing operational policies and procedures.
- Once a site is identified, develop partnerships with the LTC home, including the Director of Care and Medical Director. As appropriate, develop agreements that clearly define, at minimum, accountability and authority, scope, responsibilities, expectations, deliverables, and timelines.

KEY ENABLERS

To achieve the desired clinical design, there are several key enablers that must be in place: health human resources; financial resources; technology resources; partnerships; and, communication.

Health Human Resources

A skilled, satisfied and appropriately resourced workforce will be essential to the success of the clinical service. Clinical and operational leadership must be present to set direction, provide oversight, advance programming and to build and lead the team. To develop skillsets, all staff require ongoing training and mentorship including access to a robust orientation program that sets standard expectations and monitors progress over time. Individuals must be encouraged to work to their full scope of practice. Effective recruitment and retention strategies must be put in place to build a sustainable workforce and retain the knowledge investment. Finally, staff must look forward to coming to work and enjoy their job. We must build on their strengths and consider their interests. They must feel good about the care they provide and the outcomes they achieve.

Physician Resources

Although all health human resources are important to the clinical design, Geriatric Specialist Physicians, including Care of the Elderly physicians, are integral to the medical and psychiatric care of frail seniors. Historically, NSM specialist physicians have requested this region focus on addressing five key supports to help with their retention and recruitment:

- Stable funding and a model that supports appropriate remuneration;
- Skilled, dedicated and stable interdisciplinary teams operating within an appropriately designed clinical service;
- A cohort of health service providers passionate about seniors' health interested in increasing their capacity;
- Improved system efficiencies through technology, streamlined processes and standardized approaches to care; and,

- Locally delivered services and programming targeting early intervention.

With many of these issues now being addressed, a Physician Lead now in place and increasing interest from Geriatric Specialist Physicians in re-locating to the NSM region, the focus must now shift to building a model to support appropriate remuneration.

RECOMMENDATIONS: *Health Human Resources*

- Develop a recruitment and retention strategy for all health human resources, including physicians.
- Collaborate with NSM health service agencies, the LHIN, Ministry and the Ontario Medical Association to pursue a model supporting appropriate remuneration for a system of Geriatric Specialist Physicians. This would include exploring stipend opportunities with Family Health Teams.
- Build clinical and operational leadership positions into the clinical service.
- Standardize and advance practice through the development of tools, guidelines, pathways and standards of care.
- Design roles that allow and encourage staff to work to their full scope of practice.
- Develop and implement an orientation program for all new staff within the clinical service.
- Define core competencies and build programs to support staff to achieve those competencies. Ensure competencies are achieved and maintained by staff over time.
- Review the concepts inherent in the magnet hospital literature and incorporate key and relevant concepts into the clinical service.

Financial Resources

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.

In preparation for this work information was gathered regarding existing SGS-type programs and services in the region as well as information regarding programs and services currently available in area Family Health Teams and Community Health Centres. This information will be used to map existing resources against the recommendations in this report. Through this process we will be able to identify the impact of re-design and where net new resources will be required.

RECOMMENDATIONS: *Financial Resources*

- Waypoint and the LHIN to map existing resources against the desired clinical design to identify re-design opportunities. Once existing resources are mapped, gaps in the clinical design can be identified and a list can be generated. This list can become the foundation for requests should any funds become available within the LHIN in future.

Technology Resources

Technology is an important enabler as it supports communication and connectivity. Within the current system, seniors are frustrated with repeating their story and with the lack of communication between providers. Health service providers are frustrated with antiquated referral processes, the lack of timely information and the difficulties in accessing client level data.

Through technology there is as an opportunity to improve information sharing, streamline referral processes, support way-finding and enhance team collaboration and communication. In addition to the communication and information benefits of an electronic health record, technology can also be used to increase access to specialist physician consults and to reduce travel time for frail seniors and health service providers. Technology will be a critical resource in the building of the hub-and-spoke model across the NSM region.

RECOMMENDATIONS: *Technology Resources*

- Establish a Task Group to support the development and implementation of an eHealth/Technology strategy for the clinical service.
- Ensure OTN is accessible at all hub and spoke sites of the clinical service.
- Collaborate with OTN and partner health service provides to optimize the use of OTN equipment across NSM sites (e.g. hospitals, LTC, etc.).
- Explore access to new geriatric specialist physicians and other relevant programs through OTN to support the clinical service and address under-resourced sub-geographic regions.
- Explore opportunities related to eConsult and eReferral to streamline processes.
- Identify opportunities to promote the mobility, connectivity and capacity of the clinical service staff across the region (e.g. remote access, electronic documentation, portals with key resources, eLearning modules, virtual in-home assessment, etc.)
- Explore, develop and implement an EMR solution to support clinical service connectivity across the NSM region. This solution should build on existing work and platforms (e.g. Care Coordination Tool, North East SGS electronic record, etc.)

- Establish a strategy to promote the use of technology by frail seniors and their caregivers in a way that contributes to and advances their role in self-management and promotes communication.
- Develop and leverage a website for the NSM SGS Program, including an electronic referral system to support SGS Central Intake.
- Explore partnerships within the technology and software industry to become a leader in technology innovation across a regional SGS Program.

Partnerships

Over time, programs and services have emerged to advance the health and well-being of NSM seniors. In reviewing these programs, the Clinical Design Working Group, was struck by the opportunities and efficiencies that could be achieved through re-design and partnership. Three different types of partnership were identified for the clinical service:

- Key Partner – These resources would ideally be collaborative care partners and/or co-located with the Local SGS Teams. Engagement with these partners would be frequent. Examples include: NSM CCAC, NSM Hospice Palliative Care Network, the Alzheimer Society, OTN, Community Mental Health Association, etc.
- Regular Partner – These resources would be very important to achieving successful outcomes for frail seniors. Referrals to these partners would occur when appropriate. Examples include: Retirement Homes, adult day programs, SMART, Assisted Living for High Risk Seniors, etc.
- Occasional Partner – Referrals would be made on occasion to these partners. Examples include: Developmental Services Ontario, Community Networks of Specialized Care, Stroke Network, Acquired Brain Injury Association, etc.

In addition to the partners noted to date, several other partnerships were identified by the Clinical Design Working Group as requiring specific attention in the early stages of planning and implementation:

- Health Links
- Transportation
- ALC Steering Committee regarding the medical-legal interface
- Entite 4
- The aboriginal community, including the Aboriginal System Coordinator
- Neighbouring LHINs

In addition to building partnerships, the clinical service must also be conscious of the impact of the service on partner resources. As clinical services expand and as volumes and team knowledge increases, referrals to partners will rise. This increase will impact partners as each operates with finite resources.

Primary Care, LTC and Hospitals

Local and Central SGS Services will be providing in-reach services to LTC homes and NSM hospitals. This will necessitate the development of strong successful partnerships. Possibly more important, is the development of partnerships with primary care.

Within the desired clinical design, the Local SGS Team will work “hand-in-hand” with primary care in a collaborative care model to support frail seniors in the local communities and build primary care capacity through education and mentorship. Primary care is playing an increasingly active role in the assessment and management of frail seniors with many NSM primary care teams developing services and programs over the last several years. Heckman, Hillier, Manderson, McKinnon-Wilson, Santi & Stolee (2013)²⁸ consulted health service providers, patients and caregivers in the Waterloo-Wellington region to identify system strengths, challenges and gaps in providing care to frail seniors. Their research contained three key recommendations related to primary care:

- Multidisciplinary capacity for providing comprehensive Geriatric Assessment in primary care and specialty care should be enhanced.
- Opportunities for greater integration of specialty care with primary care should be pursued, building on existing evidence in the literature and local practice, to more proactively manage frailty and prevent further decline leading to Emergency Department visits, hospitalization, and ultimately premature institutionalization.
- The management of mild frailty should be further integrated through closer collaboration of primary care with other sectors, including Public Health Units, pharmacists, and providers of exercise and physical activity programs in the community.

The authors propose that implementation of these recommendations will lend to both improved system and patient outcomes including: optimal use of limited specialist resources; increased capacity in primary care to manage complex individuals including interdisciplinary clinics like Memory Clinics and Nurse Practitioner-Led Clinics; reduced acute care use and institutionalization rates; and, decreased functional decline and caregiver burden. .

Paramedic Services

In 2015, Simcoe County Paramedic Services serviced over 24,000 calls for seniors, representing 50% of their total call volume. Using the proxy value noted earlier (15% of seniors are frail), it could be estimated that 3,600 of those served in the Simcoe County

²⁸ Developing an integrated system of care for frail seniors. Healthcare Management Forum. Winter 2013. Volume 26. Pp. 200-208.

service were frail seniors. This does not reflect the calls supported by other Emergency Medical Services like fire and police nor does it include Muskoka volumes. The 15% proxy likely also underestimates the volume of frail seniors served by Paramedic Services.

Paramedic Services provide an interesting opportunity for partnership. As first responders who often see the patients in their home setting, they can provide a unique perspective on the environment and the case. They can initiate referrals to the clinical service, gather key information and, in some provincial programs, they provide community follow-up visits. As an example, the Community Paramedicine Program pilot between the Barrie & Community Family Health Team and Simcoe County Paramedic Services resulted in a 55% reduction in 911 calls in a targeted population.

RECOMMENDATIONS: *Partnerships*

- Review, revise (as appropriate) and implement the NSM SGS Program Communication Strategy, including the community engagement recommendations.
- Collaborate with existing resources to build a clinical service that meets the unique needs of our diverse population, including the francophone and aboriginal population. This would include developing programs and services that meet cultural and linguistic needs, including translation services.
- Collaborate with primary care teams to:
 - Build the relationship between primary care and the clinical service;
 - Increase capacity regarding key aspects of frailty, geriatric syndromes responsive behaviours and knowledge of clinical service resources; and,
 - Identify collaborative initiatives that could be targeted to help support assessment and intervention planning (e.g. screening tools, guidelines, standards of practice, etc.).
- Collaborate with Paramedic Services to:
 - Build the relationship between Paramedic Services and the clinical service;
 - Increase capacity regarding key aspects of frailty, geriatric syndromes responsive behaviours and knowledge of clinical service resources; and,
 - Work together to define an education profile for Paramedics to help support assessment and intervention planning (e.g. screening tools, guidelines, standards of practice, etc.).

Communication & Community Engagement

Communication and community engagement are integral to the success of the NSM SGS Program. Strategies will be put in place to address four key relationships:

- Communication between the clinical service and the senior, caregiver;
- Communication between the clinical service and the circle of care;
- Communication within the clinical service; and,
- Communication between the clinical service and key stakeholders (i.e. Project Team, NSM LHIN, health service providers and provider agencies; the public, etc.).

The push of information (communication) will be balanced with the need to pull information (engagement) to ensure the voice of the frail senior and our key partners continue to support planning and implementation of the clinical service. The NSM SGS Program has developed a Communication Strategy to support communication and engagement. With the clinical design now complete, it will be important to review that document and make any necessary revisions.

RECOMMENDATIONS: *Communications & Community Engagement*

- Review, revise (as appropriate) and implement the NSM SGS Program Communication Strategy, including the community engagement recommendations.
- Ensure persons with lived experience are highly visible within the community engagement plan. Early work could include providing an update to the LHIN Patient Advisory Committee regarding this report. Establish communication protocols and tools to support communication between the clinical service, frail seniors and relevant health service providers.
- Work with Waypoint Privacy Officer to establish guidelines and forms to support the sharing of information within the clinical service and across the Circle of Care.

RISKS

Given the magnitude of system change proposed within this report and the associated recommendations, many risks could be identified. The table below outlines six key system risks that must be that considered during implementation planning:

Issues	What is the Risk?	Mitigation Strategy
Target: Clinical Frailty Scale 4-6	▪ Loss of service to individuals in stages 1, 2, 3, and 7 currently receiving services.	▪ Build partnerships to support transitions. ▪ For an interim period, support key partners like primary care by collaborating with them to build

		capacity to support seniors in stages 1-3.
Sequencing of Implementation	▪ A phased approach to implementation will result in sub-geographic inequity.	▪ Implement Communication Strategy.
Re-design	• Program de-stabilization. • De-stabilization of the existing HHR infrastructure. • Provider and public dissatisfaction. • Loss of service to some seniors currently receiving care. • System expectations and desired timelines do not align with the pace of change.	• Implement Communication Strategy. • Establish HHR Task Force. • Work collaboratively with the LHIN upon completion of the report and recommendations to develop a plan for next steps. • Engage provider agencies impacted by re-design as soon as possible to discuss next steps. • Develop and implement a comprehensive transition plan for those impacted by changes: ○ For seniors and their caregivers. ○ For HSPs and health care professionals. • Develop and implement change management strategy.
Geriatric Specialist Physicians	• Retention and recruitment challenges resulting in a lack of sufficient medical support for the management of frail seniors within the clinical service.	• Develop a retention and recruitment strategy for physicians, inclusive of a model that appropriately supports a system of Geriatric Care Specialists.
Funding	• Efficiencies found through re-design will not be sufficient to offset planning needs.	• Complete existing resources mapping project and leverage existing resources. • Develop a phased approach to implementation in partnership with the LHIN prior to any system changes. • Identify and rank priority recommendations. • Build partnerships and share resources to achieve clinical service design. • As appropriate, advocate for net

		new funding.
Partnerships	• Partners may not choose to engage due to competing priorities, poor communication, lack of interest, insufficient resources. • The volume of referrals from the clinical service could overwhelm partner resources.	• Implement Communication Strategy. • Build relationships with partners through site visits, ongoing dialogue and strive for creative solutions. • Share resources as appropriate to achieve clinical design. • Track referral patterns to NSM partners to monitor the impact of the clinical service.

NEXT STEPS

Upon completion of this report and associated recommendations, additional work will be required to operationalize the clinical design plan. This would include developing program plans, identifying health human resource opportunities and defining the authority of the clinical service.

As a first step, the NSM SGS Program Leadership Team will map existing resources against the desired clinical design. In preparation for this work information was gathered regarding existing SGS-type programs and services in the region, including those available in area Family Health Teams and Community Health Centres. Once the mapping is complete, Waypoint and the LHIN will be able to identify the scope of the resources available, where re-design opportunities exist and where net new resources will be required in future. Recognizing the critical work ahead and the importance of building partnerships among NSM health service providers to advance the care of frail seniors in the region, a collaborative approach to planning will be applied. As an advisory body to Waypoint and the LHIN, the Seniors Health Project Team will be engaged to inform implementation planning. Leaders from health service agencies impacted by re-design will be engaged early in the process to explore opportunities and risks as well as to inform planning. When appropriate, communication will be provided to health service partners and the public in alignment with the NSM SGS Program's Communication Strategy.

CONCLUSION

According to Thomas Lee and Harvard economist Michael Porter (2013)²⁹;

“Around the world, every health care system is struggling with rising costs and uneven quality despite the hard work of well-intentioned, well-trained clinicians. Health care leaders and policy makers have tried countless incremental fixes—attacking fraud, reducing errors, enforcing practice guidelines, making patients better “consumers,” implementing electronic medical records—but none have had much impact.

It's time for a fundamentally new strategy.

At its core is maximizing value for patients: that is, achieving the best outcomes at the lowest cost. We must move away from a supply-driven health care system organized around what physicians do and toward a patient-centered system organized around what patients need. We must shift the focus from the volume and profitability of services provided—physician visits, hospitalizations, procedures, and tests—to the patient outcomes achieved. And we must replace today's fragmented system, in which every local provider offers a full range of services, with a system in which services for particular medical conditions are concentrated in health-delivery organizations and in the right locations to deliver high-value care.

Making this transformation is not a single step but an overarching strategy. ... It will require restructuring how health care delivery is organized, measured, and reimbursed. ... The question is which organizations will lead the way ...”

²⁹ The strategy that will fix healthcare. *Harvard Business Review*. October 2013. <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care> at July 7/16.

RECOMMENDATION SUMMARY

Demographics	- During implementation planning, resource allocation and priority setting: - Consider the continued growth in each NSM sub-geographic region, including recognition that: Collingwood, Wasaga Beach & Area is the fastest growing sub-geographic region; and that Barrie & Area has more than double the population of any other sub-geographic region; - Consider the impact of geography on service delivery in Muskoka as the region accounts for 46.6% of the total NSM geography; and, - Consider the impact of dementia on our health system resources (including ALC days).
Provincial Planning	- Waypoint will work closely with the LHIN to: - Monitor activity and progress related to key provincial initiatives like the Ontario Dementia Strategy and the Ministry-LHINs RGP/SGS Review; - Ensure clinical design alignment with provincial initiatives; and, - Take necessary action to leverage provincial funding opportunities that may arise. - Monitor activity regarding the establishment of primary care Memory Clinics in the NSM region in order to: build partnerships; promote a standardized approach to practice; and, ensure clear distinction between the clinical service and the service offered in primary care Memory Clinics.
Standards & Benchmarks	In the absence of SGS clinical service standards and benchmarks, the principles proposed in this report are recommended as a starting point to support SGS implementation planning, resource allocation and priority setting.
Sequencing Principles	If during implementation planning a decision is required in regard to sequencing, resource allocation and/or priority setting, it is recommended that priority be given to the development of a fewer number of full teams to preserve the integrity of the clinical design.

Frailty Prevention & End-of-Life Care	- Support the shift of frailty prevention, screening and early identification to ensure the right care is being provided at the right time by the right provider: - Advocate to the Ministry for sufficient funding and resources to support prevention, screening and early identification within primary care and other core services. - Monitor activity regarding the establishment of primary care Memory Clinics in the NSM region in order to: build partnerships; promote a standardized approach to practice; and, ensure clear distinction between the clinical service and the service offered in the primary care Memory Clinics. - Ensure family physicians are aware of relevant billing codes. - Collaborate with primary care and other core services to identify collaborative initiatives that could be targeted (e.g. screening tools, guidelines, standards of practice, etc.). - Consider supporting primary care and other core services by: - Allocating a minimum 1.0 FTE within the clinical service to develop and support implementation of standardized regional prevention, screening and early identification programs and processes. - Providing targeted clinical service resources (time-limited with clear deliverables) to support start-up initiatives to help build capacity and build the case for “need”. - Build a key-partner relationships with the NSM Hospice Palliative Care Network: - Build a palliative approach to care within the clinical service; - Promote a common language for communication messaging by leveraging research (i.e. research correlating the Clinical Frailty Scale and the Palliative Performance Scale). - Recognizing that there will be a sub-set of the population where the Hospice Palliative Care Network of services will become more engaged, implement a collaborative care model in appropriate cases and ensure transition plans are in place.
Geriatric Psychiatry	Collaborate with Waypoint to develop a clear algorithm for health service providers to guide geriatric psychiatry referrals to the appropriate program (i.e. SGS Program's clinical service vs. Waypoint).
Responsive Behaviours	Re-design and align current BSS resources under the clinical service to create an integrated regional system for older adults with cognitive impairment and responsive behaviours.
Discharge & Transitions	- To support the successful transition of clients upon discharge: - Leverage the Health Quality Ontario document entitled <u>Adopting a Common Approach to Transitional Care Planning</u>, to support transition planning within the clinical service. - Establish a transition protocol for use within the clinical service. - Ensure a transition plan is in place for every discharge from the clinical service.

Geographic Boundaries	• Develop exemption criteria for out-of-region referrals. • Build partnerships and transition protocols with other SGS networks and providers to re-direct, when appropriate, out-of-region referrals.
Rostered vs. Unrostered	• In collaborating with primary care on clinical design implementation, include discussions related to the care of both rostered and un-rostered patients.
Response Time	• Develop a triage/priority protocol that can be implemented by SGS Intake to support the triage and prioritization of referrals into important and urgent categories. • During implementation planning, build a Service Accountability Agreement that clarifies definitions and identifies target response times for important and urgent referrals for Local & Central SGS Services.
Building Safety Nets	• Support the NSM target of ALC reduction through an upstream approach to care, building safety nets in primary care/ at the community level (including LTC) as well as in area Emergency Departments and hospitals with the goal to reduce the proportion of frail seniors designated ALC.
Governance, Accountability & Authority	• As required, the LHIN will amend Service Accountability Agreements with LHIN-funded health service providers to advance the clinical design.
Outcomes	• Develop and finalize a Performance Monitoring & Evaluation Framework for the clinical service that takes into consideration: Accountability Agreements; Health Quality Ontario's Common Quality Agenda; indicators defined by the Regional Geriatric Program of Ontario; and, local frameworks like those developed by the Behaviour Support System and the VON Enhanced SMART Program. Indicators need to be Specific, Measurable, Attainable, Relevant and Trackable (SMART).
Eligibility & Discharge	• Develop a care authorization tool that can be implemented by SGS Intake to support the determination of eligibility and triage. • Incorporate a system navigation role into the SGS Intake system to ensure way-finding support for individuals found ineligible for the clinical service.

Local SGS Teams	- Establish a Local SGS Team in each NSM sub-geographic region, including: - Securing necessary resources, including health human resources; - Identifying an appropriate location(s) for services; - Building a toolkit of standardized resources and tools to support; and, - Developing operational policies and procedures. - LHIN to complete the review of the Enhanced SMART Program (as part of the provincial Assess & Restore funding initiative) and consider continued funding and expansion of the concept as part of each Local SGS Team. Advocate to the Ministry as required. - Develop partnerships with primary care and other core service. As appropriate, develop agreements that clearly define, at minimum, accountability and authority, responsibilities, expectations, deliverables, and timelines. - Establish eligibility for outreach programming to ensure optimal use of clinical service resources. Where possible build partnerships and processes that leverage the information and mandate of existing resources (i.e. Paramedic Services, in-home resources, etc.). - As per the October 2013 recommendation of the BSS Project Steering Committee, advocate for the establishment of a behavioural interdisciplinary team to support clusters of beds (total = 12 beds) in sites across NSM. Consider and support existing supportive housing environments serving residents with challenging behaviours as part of a “housing first” approach.
Local SGS Teams: Supports to LTC	- Align a 1.0 FTE behaviour resource and a 1.0 FTE NP with each local SGS Team to support every 120-175 LTC beds. - Develop partnerships with LTC homes, including Directors of Care and Medical Directors. As appropriate, develop agreements that clearly define, at minimum, accountability and authority, scope, responsibilities, expectations, deliverables, and timelines. - In partnership with the LTC homes, determine the most appropriate physician partner for the Nurse Practitioner. - LHIN to advocate to the Ministry for sufficient funding for LTC homes to support the on-site assessment and treatment of acute medical events. - Partner with developmental services and community living to increase Local SGS Teams skillsets with dual diagnosis population. - Build a process into the SGS Intake to ensure timely referrals to on-site staff and to avoid delays in service. SGS Teams skillsets with dual diagnosis population.
Local SGS Teams: Hospital Resources	- Align 1.0 – 2.0 FTEs GEM staff and a 1.0 FTE Nurse Clinician with every NSM hospital. In smaller hospitals, these positions could be combined. - Develop partnerships with NSM hospitals. As appropriate, develop agreements that clearly define, at minimum, accountability and authority, scope, responsibilities, expectations, deliverables, and timelines. - Each hospital site to implement an ACE philosophy of care. Larger sites may choose to have dedicated units and beds based on clinical volumes. - Each hospital to continue to support the work of the SFHS Committee. - Each hospital site to provide access to 1 acute medical bed for every 1,500 frail seniors in the region for direct admissions. <i>* Cases would always be negotiated with the hospital and the beds would only be used when an appropriate need is identified.</i> - Partner with geriatric psychiatry to increase Local SGS Teams skillsets with serious mental illness. - Build a process into the SGS Central Intake to ensure timely referrals to on-site staff and to avoid delays in service.

Central SGS Services: Level 1 Consultation	• Leverage the Responsive Behaviour Complex Case Resolution Process processes and tools to pilot a Level 1 Consultation Program across NSM for a six month period. Evaluate outcomes and determine appropriateness and feasibility of continued implementation. • Explore opportunities related to eConsult and eReferral to streamline processes.
Central SGS Services: Specialist Physicians	• Establish a Geriatric Physician Specialist service across NSM, including: ◦ Securing necessary resources, including health human resources; ◦ Identifying an appropriate location(s) for services; ◦ Building a toolkit of standardized resources and tools to support; and, ◦ Developing operational policies and procedures. • Build a process or algorithm into the SGS Central Intake to ensure referrals bypass Local SGS Teams and are sent directly to Geriatric Physician Specialists when appropriate to avoid delays in service. This could include a process whereby Local SGS Team Care of Elderly Physicians review the referral and confirm the bypass.
Central SGS Services: Geriatric Psychiatry Beds	• Upon establishment of a Behaviour Support Unit in NSM, Waypoint to provide access to up to 1 geriatric psychiatry bed for every 1,500 frail seniors in the NSM region. These Horizon beds would target frail seniors in the clinical service with complex mental health issues. Eligibility will exclude older adults with cognitive impairment and responsive behaviours, unless presenting with core psychiatric symptoms. • Develop partnerships with Waypoint Horizons Program. As appropriate, develop agreements that clearly define, at minimum, accountability and authority, scope, responsibilities, expectations, deliverables, and timelines. • Build a process to support Horizon Program access to geriatric medicine team specialists including Geriatricians, as appropriate.
Central SGS Services: Behaviour Support Unit	• Establish a 16 bed Behaviour Support Unit in a single site in a LTC home in the NSM region for older adults with cognitive impairment and responsive behaviours. Eligibility will exclude those presenting with core psychiatric symptoms. The number of beds will need to be monitored over time regarding utilization and demand. Implementation planning would include: ◦ Securing necessary resources, including funding; ◦ Securing necessary licensing; ◦ Identifying an appropriate location(s) for services; ◦ Building a toolkit of standardized resources and tools to support; and, ◦ Developing operational policies and procedures. • Once a site is identified, develop partnerships with the LTC home, including the Director of Care and Medical Director. As appropriate, develop agreements that clearly define, at minimum, accountability and authority, scope, responsibilities, expectations, deliverables, and timelines.

Health Human Resources	• Develop a recruitment and retention strategy for all health human resources, including physicians. • Collaborate with NSM health service agencies, the LHIN, Ministry and the Ontario Medical Association to pursue a model supporting appropriate remuneration for a system of Geriatric Specialist Physicians. This would include exploring stipend opportunities with Family Health Teams. • Build clinical and operational leadership positions into the clinical service. • Standardize and advance practice through the development of tools, guidelines, pathways and standards of care. • Design roles that allow and encourage staff to work to their full scope of practice. • Develop and implement an orientation program for all new staff within the clinical service. • Define core competencies and build programs to support staff to achieve those competencies. Ensure competencies are achieved and maintained by staff over time. • Review the concepts inherent in the magnet hospital literature and incorporate key and relevant concepts into the clinical service.
Financial Resources	• Waypoint and the LHIN to map existing resources against the desired clinical design to identify re-design opportunities. Once existing resources are mapped, gaps in the clinical design can be identified and a list can be generated. This list can become the foundation for requests should any funds become available within the LHIN in future.
Technology Resources	• Establish a Task Group to support the development and implementation of an eHealth/Technology strategy for the clinical service. • Ensure OTN is accessible at all hub and spoke sites of the clinical service. • Collaborate with OTN and partner health service providers to optimize the use of OTN equipment across NSM sites (e.g. hospitals, LTC, etc.). • Explore access to new geriatric specialist physicians and other relevant programs through OTN to support the clinical service and address under-resourced sub-geographic regions. • Explore opportunities related to eConsult and eReferral to streamline processes. • Identify opportunities to promote the mobility, connectivity and capacity of the clinical service staff across the region (e.g. remote access, electronic documentation, portals with key resources, eLearning modules, virtual in-home assessment, etc.) • Explore, develop and implement an EMR solution to support clinical service connectivity across the NSM region. This solution should build on existing work and platforms (e.g. Care Coordination Tool, North East SGS electronic record, etc.) • Establish a strategy to promote the use of technology by frail seniors and their caregivers in a way that contributes to and advances their role in self-management and promotes communication. • Develop and leverage a website for the NSM SGS Program, including an electronic referral system to support SGS Central Intake. • Explore partnerships within the technology and software industry to become a leader in technology innovation across a regional SGS Program.

Partnerships	• Review, revise (as appropriate) and implement the NSM SGS Program Communication Strategy, including the community engagement recommendations. • Collaborate with existing resources to build a clinical service that meets the unique needs of our diverse population, including the francophone and aboriginal population. This would include developing programs and services that meet cultural and linguistic needs, including translation services. • Collaborate with primary care teams to: ◦ Build the relationship between primary care and the clinical service; ◦ Increase capacity regarding key aspects of frailty, geriatric syndromes responsive behaviours and knowledge of clinical service resources; and, ◦ Identify collaborative initiatives that could be targeted to help support assessment and intervention planning (e.g. screening tools, guidelines, standards of practice, etc.). • Collaborate with Paramedic Services to: ◦ Build the relationship between Paramedic Services and the clinical service; ◦ Increase capacity regarding key aspects of frailty, geriatric syndromes responsive behaviours and knowledge of clinical service resources; and, • Work together to define an education profile for Paramedics to help support assessment and intervention planning (e.g. screening tools, guidelines, standards of practice, etc.).
Communication & Community Engagement	• Review, revise (as appropriate) and implement the NSM SGS Program Communication Strategy, including the community engagement recommendations. • Ensure persons with lived experience are highly visible within the community engagement plan. Early work could include providing an update to the LHIN Patient Advisory Committee regarding this report. Establish communication protocols and tools to support communication between the clinical service, frail seniors and relevant health service providers. • Work with Waypoint Privacy Officer to establish guidelines and forms to support the sharing of information within the clinical service and across the Circle of Care.