North Simcoe Muskoka
Specialized Geriatric Services

A Rehabilitation Strategy to Address Functional Decline Among Older Adults in NSM

FINAL

May 14, 2021

Waypoint
CENTRE for MENTAL HEALTH CARE
CENTRE de SOINS de SANTÉ MENTALE

Advancing Understanding. Improving Lives.

Avancer la compréhension. Améliorer la vie.

Outline

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Key Concepts

- **Frailty**
  "Frailty is a medical condition of reduced function and health in older individuals… Things like inactivity, poor nutrition, and social isolation or loneliness, and multiple medications contribute to frailty… [With frailty, the] body does not have the ability to cope with minor illnesses that would normally have minimal impact if you were healthy. With frailty, these minor stressors may trigger rapid and dramatic deterioration… People who are frail usually have three or more of five symptoms that often travel together. These include unintentional weight loss (10 or more pounds within the past year), muscle loss and weakness, a feeling of fatigue, slow walking speed and low levels of physical activity. *(Canadian Frailty Network. What is Frailty)*

- **Confinement Syndrome**
  Confinement Syndrome reflects the constellation of clinical issues that are occurring among older adults and their caregivers during COVID-19 that can be linked to the confinement resulting from COVID restrictions. *(NSM SGS Program)*

- **Functional Decline**
  Functional decline "is often defined and measured by a reduction in ability to perform self-care activities of daily living because of a decrement in physical or cognitive functioning… Functional decline may be acute, occurring within a week, or sub-acute, developing over many weeks or months. It is associated with social isolation, reduced quality of life, and death. It is also an important predictor of hospitalization, prolonged hospital stay, repeat emergency department visits, and need for home care." *(Abdulaziz, Perry, Taljaard, Émond, Lee, Wilding, Sirois & Brehaut. 2016. National Survey of Geriatricians to Define Functional Decline in Elderly People with Minor Trauma. Canadian geriatrics journal : CGJ, 19(1), 2–8)*

- **Rehabilitation**
  "Rehabilitation is focused on enabling individuals with impairments and disabilities to reach and maintain their optimal physical, sensory, intellectual, psychological and social functional levels and thereby promote health and well-being, re-integration to community living and improve quality of life."
  (Rehab Care Alliance. 2015. Definitions Framework for Community–Based Levels of Rehabilitative Care)

- **Integrated Care**
  Integrated care is "patient care that is coordinated across professionals, facilities, and support systems; continuous over time and between visits; tailored to the patients' (and caregivers] needs and preferences; and based on shared responsibility between patients and caregivers for optimizing health." *(Singer et al, from Masterclass: Implementing Integrated Care iCoach event December 2, 2019)*

- **Specialized Geriatric Services**
  Specialized Geriatric Services (SGS) are 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. *(NSM SGS Program)*

Background

- Older adults have been most significantly impacted by COVID-19. At January 2021, age 60+ in Canada accounted for 21% of COVID cases in Canada, 71% of COVID-related hospitalizations and 96% of COVID-related deaths.

- As a result of COVID and COVID restrictions, older adults have functionally deteriorated over time. Recognizing both the short and long term impact of Confinement Syndrome on both older adults and their caregivers, the NSM SGS program advocated regionally for greater consideration of the rehab needs of older adults.

- NSM LHIN approached the Central OHT for Specialized Populations/ NSM SGS Program to play a leadership role in addressing the concept of rehab in the context of the COVID-19 pandemic.

- During scoping, 3 key rehab issues facing older adults were identified:
  - Ongoing rehab service needs (as existed pre-COVID);
  - COVID-19 disease-specific rehab for those contracting the disease; and,
  - Rehab needs resulting from COVID-19 restrictions.

- Recognizing the impact of COVID on older adults and their caregivers, and considering the OHT focus, the OHT/Seniors Health Working Group agreed to provide oversight to the development and implementation of a NSM-wide rehab strategy focused on preventing and reversing the functional decline experienced by older adults as a result of COVID restrictions.

- With the support of an external consultant and with feedback from key partners, a Rehabilitation Strategy was developed to guide local planning.
  - *Short-Term Goal*:
    To address functional decline in older adults resulting from COVID restrictions, starting with congregate community-based programming.
  - *Longer-Term Goal*:
    To build an integrated regional rehab system of services for an aging population, specifically targeting functional decline.

Rationale

- **The NSM population is aging**
  Older adults account for 19.6% of NSM population *(2016 census)*

- **Frailty negatively impacts both individuals, their caregivers and our health system**
  - The prevalence of frailty rises alongside growth in an aging population
  - The course of frailty is characterized by a decline in functioning across multiple physiological systems
  - Frailty places a person at increased risk of adverse outcomes, including falls, hospitalization, and mortality. Frailty studies have shown a clear pattern of increased health-care costs and use *(Lancet, 2019)*

- **Physical activity among community-dwelling older adults was low prior to COVID**
  Prior to pandemic, only 14% of aged 65-79 were meeting Canadian physical activity guidelines of 150 min of moderate-to-vigorous physical activity per week in bouts of 10 min or more *(sf7 Toolkit: Mobility)*

- **Confinement Syndrome is leading to a deconditioning pandemic**
  As a direct result of COVID and COVID restrictions, older adults are experiencing social isolation and physical/cognitive/emotional decline at a rate and magnitude greater than before the pandemic

- **The current state of rehab services for older adults in NSM is not sufficiently resourced or integrated to support current and post-pandemic needs**
  - As Ontario reopens services, rapid access to rehab care targeting frail older adults will be essential. Rehab services need to maximize functional ability, psychological wellbeing and social integration *(RCA, June 2020)*
  - Prior to COVID, there was an identified lack of sufficient rehab services in NSM for older adults. The services that do exist, often operate in isolation of each other and of seniors health services
  - SMART (VON), CARE (NSM SGS Program) and Building Balance (SGB CHC) are recognized and successful rehab services for older adults within NSM
  - Since the outset of the pandemic, there has been a further eroding of rehab services. Some services have been paused and others have moved to virtual platforms with varying degrees of success

- **Therefore, there is a pressing need to establish a rehab system of services in NSM for older adults and their caregivers that targets the functional decline occurring among older adults as a result of COVID and COVID restrictions**

Scope

- **In-Scope:**
  - Community-based rehab services delivered in the NSM region for older adults that:
    - Focus on preventing or reversing functional decline;
    - Are offered through congregate programming; and, that
    - Consider physical and/or cognitive rehab needs AND recognize the important value of social interaction within rehab programming

- **Out-of-Scope:**
  - Emergent, acute or bedded post-acute rehabilitation care
  - In-home, 1:1 community based services
  - Services for individuals requiring COVID disease-specific rehab
  - Rehab service needs that existed pre-COVID (i.e. neuro, orthopedics, ABI, etc.)

Alignment of Outcomes

By reversing or reducing functional decline, the Rehab Strategy will help support key outcomes, in alignment with the NSM SGS Program's clinical design:

Wellness, Independence and Quality of Life in Aging

Strategy Vision

To establish an Integrated Regional Program of Specialized Geriatric Services inclusive of geriatric medicine and geriatric psychiatry that improves patient outcomes, builds capacity and fosters system change.

How we will achieve our Vision (i.e. Strategy Mission, Priorities)

Improved Patient Outcomes	Enhanced System Capacity	A More Affordable, Sustainable and Accountable System
Focus: Interprofessional Care; Comprehensive Geriatric Assessment; Geriatric Syndromes.	***Focus:*** Education & Mentorship; Standardization; Implementing Leading Practices.	***Focus:*** Optimal Use of Resources; Aging in Place; Partnerships; Prevention/Avoidance
• Maintained or improved frailty *(resulting from, for example, improvements in functional decline, improved cognitive function, etc.)*	• Increased shared knowledge and skillsets of health care providers in the care of frail seniors and their caregivers	• Increased care of frail seniors and their caregivers in their home settings in each NSM sub-geography *(resulting from, for example, increased access to local SGS services, reduced demand on central SGS services, improved partnerships with core services, etc.)*
• ~~Improved assessment and management of responsive behaviours~~ *~~(resulting from for example, reduced wait time for behaviour resources, appropriate antipsychotic use, etc.)~~*	***AND***	• Reduced inappropriate use of hospital and LTC resources *(resulting from, for example, increased access to timely SGS clinical services, fewer inappropriate ED visits, reduced 30/60 day hospital re-admits , reduced ED visits and ALC LOS attributed to behaviours, delayed or reduced LTCH admissions, reduced # crisis placements, etc.)*
• Reduced caregiver burden *(resulting from for example, increased caregiver support and knowledge, etc.)*	• Enhanced self-management abilities of frail seniors and their caregivers	
• Increased patient / caregiver satisfaction with services and outcomes *(resulting from, for example, improved system navigation, improved transitions, tell story once, meeting cultural needs, etc.)*	*(resulting from, for example, timely and collaborative consultations, relevant communication supporting knowledge transfer, standardized assessment tools, implementation of leading practices in care delivery, increased awareness of resources, etc.)*	

Expected results/ impact

Potential outcomes

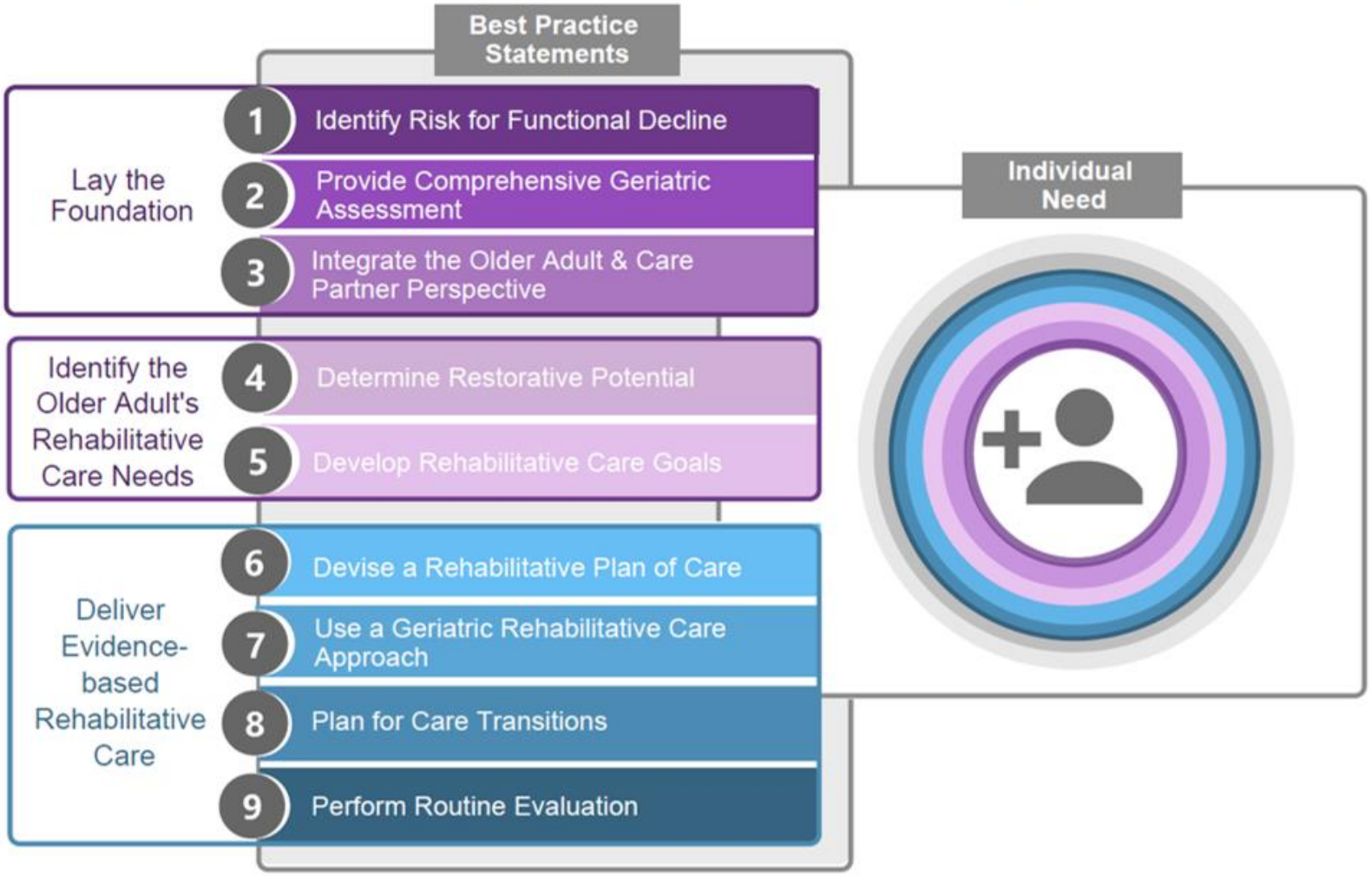
(NSM SGS Program Clinical Design Report & Recommendations, 2016)

Key Design Principles

- Focus on frailty scores 3-6 to prevent and reverse frailty
- Ensure individuals are aligned with services best designed to meet their needs; providing individual care plans where possible and required
- Incorporate:
  - Both progression-focused and maintenance focused rehab
  - An interdisciplinary approach to care (leveraging full scopes of practice)
  - A focus on physical rehab, cognitive rehab and social interaction
  - Education and coaching to promote self-management
  - A senior friendly approach to care, including assessment tools and processes that monitor for key geriatric risk factors and syndromes
  - Specialized classes for target populations, including older adults living with Dementia, Parkinson's Disease and Osteoporosis
  - Both in-person and virtual service options
- Engage and educate informal caregivers to support exercise implementation

- Utilize a hub-spoke approach to clinical design
- Leverage and build on existing NSM programs and services and make optimal use of resources
- Establish links with local and regional:
  - Seniors health programs and services;
  - Rehab programs and services
- Leverage partnerships with local community providers and organizations (i.e. Municipal partners, YMCA)
- Develop an integrated approach to service delivery built on positive relationships, effective communication, timely access and seamless transitions
- Integrate as (a) a rehab system and (b) as part of a broader local and regional health system
- Build capacity in geriatric rehab across NSM providers, services and programs promoting a standardized approach to care and adoption of leading practices
- Build a system to meet both current and future rehab needs of older adults

Rehabilitative Care for Older Adults with Frailty: Best Practices Across All Health Care Settings



(Rehabilitative Care for Older Adults Living with Frailty DRAFT, 2021)

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Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house.** Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

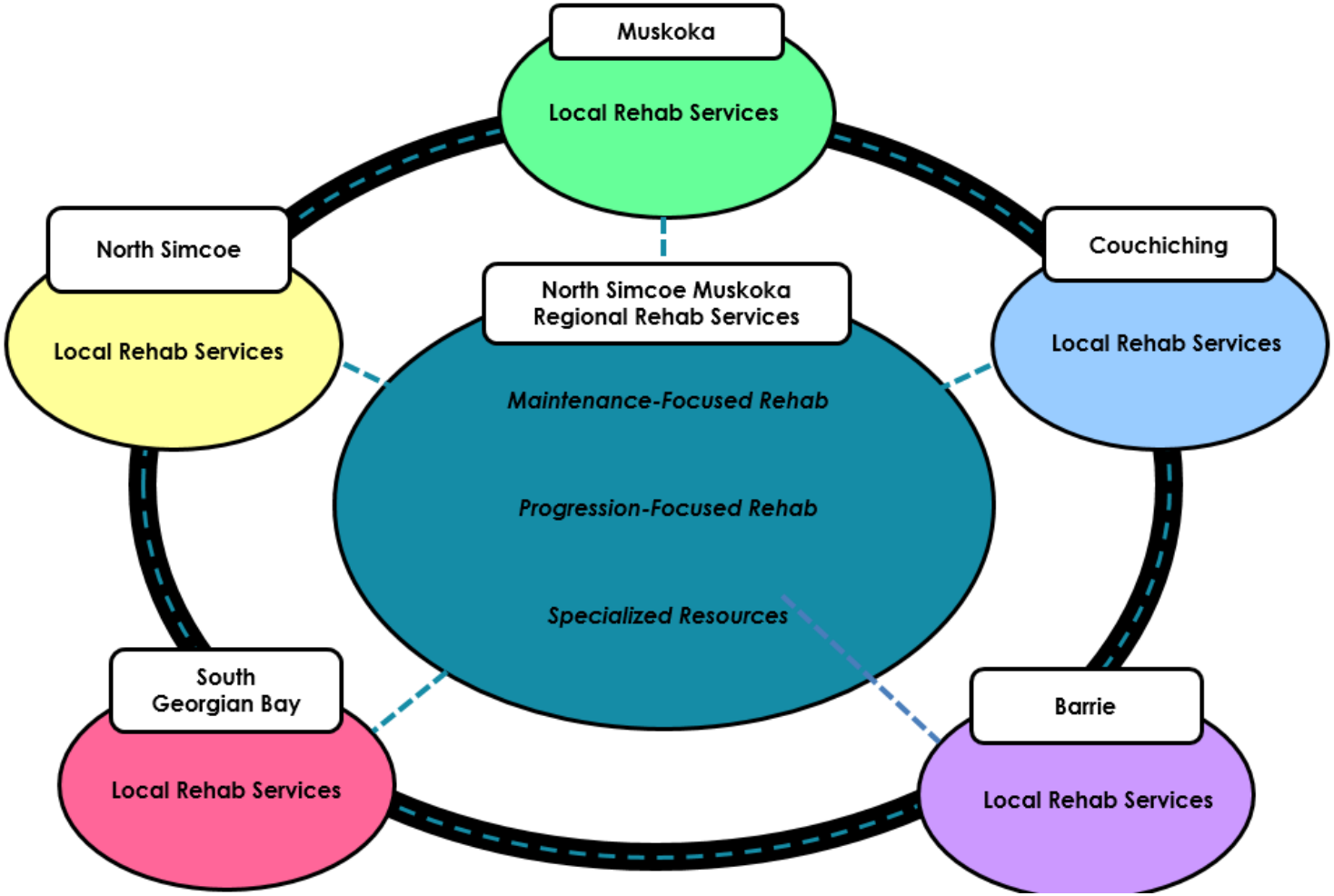
* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

(Kenneth Rockwood, Dalhousie University)

Alignment

- Strategy for an Integrated Regional Seniors Health Program in NSM
  (NSM SGS Program, 2014)
- NSM SGS Program Clinical Design Report & Recommendations
  (NSM SGS Program, 2016)
  - Addendum: Implementation Plan for Local SGS Teams
    (NSM SGS Program, 2018)
- Definitions Framework for Community-Based Levels of Care *(RCA, March 2015)*
- Frail Seniors: Guidance on Best Practice Rehabilitative Care in the Context of COVID-19 *(RCA, June 2020)*
- Rehabilitative Care for Older Adults Living with Frailty DRAFT *(RCA, PGLO, 2021)*
- sfCare Framework *(RGP Toronto)*
- sfCare Senior Friendly 7 Toolkit *(RGP Toronto, 2019)*
- Competency Framework for Interprofessional Comprehensive Geriatric Assessment *(RGPs of Ontario, 2017)*

Model & Recommendations



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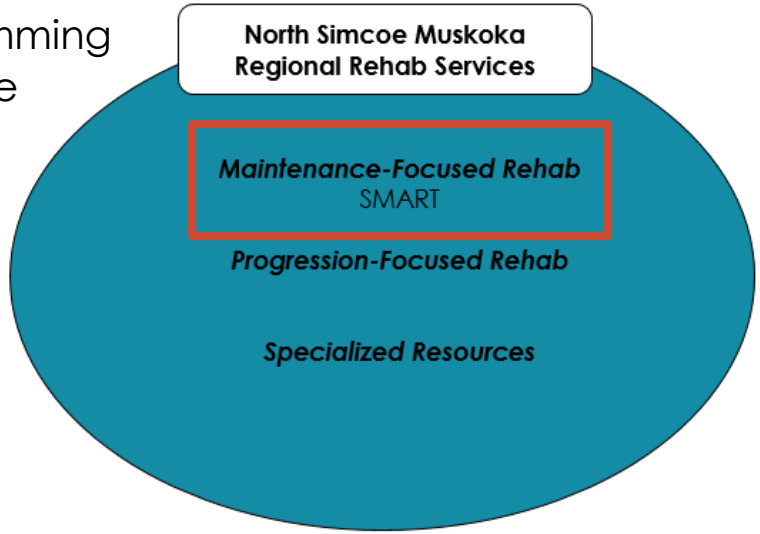
Maintenance-Focused Rehab:

	Existing or New to NSM?	Frailty Level Population Served	Progression or Maintenance Focused	Description
SMART *(VON)*	Existing	2 – 5	Maintenance	Monitored exercise classes to community members 55+ who wish to improve their strength, balance and flexibility, regardless of current physical ability. SMART exercise program is available across NSM in many Retirement Homes and community locations. Some classes intended for specific conditions (i.e. Parkinson's, Osteoporosis, ABI, CVA, Deaf Access) but limited predominantly to Barrie region.

- **Maintain and expand the existing VON SMART program**

  Rationale: Proven NSM program. Expansion would help support more older adults, better support timely transitions from progression-focused rehab services and allow for expansion of programming to targeted populations. During COVID, SMART provided virtual programming (YouTube recorded sessions; internet-based live classes; TV sessions delivered on local cable networks) with plans to continue similar options post-COVID. Post COVID, SMART will be challenged by volunteer availability, smaller class sizes, partner willingness to provide free space.



  Maintenance/Expansion suggestions:

  - Funding for space (while continuing to pursue donated space where available)
  - Funding for additional paid exercise leaders
  - Expand existing specialized programs across all NSM regions (Parkinson's, Osteoporosis, ABI, CVA, Deaf Access)
  - Expand specialized programs to include considerations like balance.

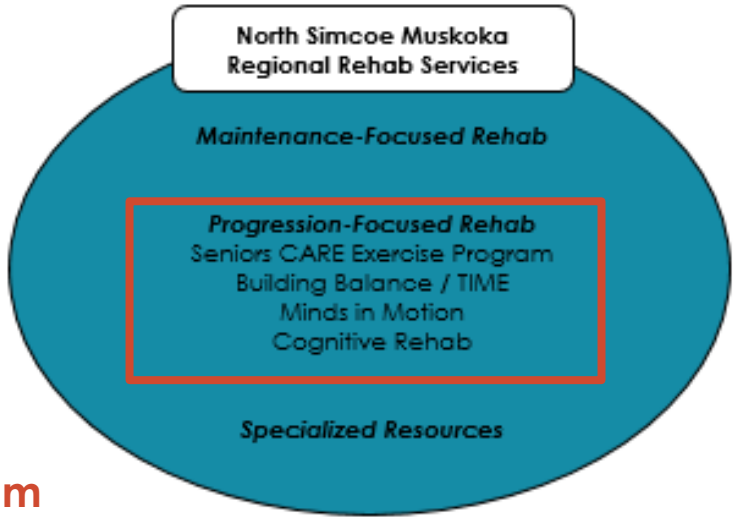
Progression-Focused Rehab:

	Existing or New to NSM?	Frailty Level Population Served	Progression or Maintenance Focused	Description
Seniors CARE Exercise Program *(NSM SGS)*	Existing	4 – 6	Progression **General exercise classes, higher level complexity than SMART*	Group exercise classes 2 times/week for 10 -12 weeks with a focus on balance, coordination, upper and lower extremity strengthening. Each class is 2 hours, with time dedicated to exercise, cognitive stimulation and education. Classes delivered by Registered Kinesiologists with access to a SGS Physiotherapist.
Building Balance *(SGB CHC)* **OR** **TIME** *(UHN)* ** Some history with the Orillia YMCA and was exploring partnership with Barrie YMCA pre-COVID*	Existing New	4 – 6 4 – 6	Progression **Independent standing required, balance focus, circuit training*	8 week program with a higher level of intensity for those with mobility and risk of falls, etc. 8 clients meet 1-2x/ week. Classes are led by a PT and volunteers. Group exercise class developed by PTs for adults who have challenges with balance and mobility. It is run by fitness instructors in community centres. Classes occur 1-2x/wk. for 8-12 wks. and incorporate a mix of aerobic training, balance training, functional strengthening, and functional mobility exercises.

	Existing or New to NSM?	Frailty Level Population Served	Progression or Maintenance Focused	Description
Minds in Motion *(Alzheimer Society)*	Existing	3 – 6	Progression **Early to mid cognitive impairment, physical activity and mental stimulation*	8 week program, led by non regulated staff and volunteers (certification is required through Western U). Program is intended for individuals with early to mid-stage signs of dementia and their caregivers. It combines both physical activity and mental stimulation and provides social activities focused on building personal skills.
Cognitive Rehab	New	4 – 6	Progression **Rehab specifically addressing cognitive impairment*	**To Be Developed** ** Interventions that target cognitive deficits and the associated difficulties with activities of daily living are the subject of ever-growing interest. Cognitive training and cognitive rehabilitation are specific forms of non-pharmacological intervention to address cognitive and non-cognitive outcomes. CFHT Geriatric Outreach Team offering Learning the ROPES for those with Mild Cognitive Impairment (standardized program, purchased workbooks, offered by OT)*

- **Expand the current CARE program resources to 5 days/wk. AND expand programming across all five NSM sub-regions**

  Rationale: Proven NSM program supporting frail older adults with more complex co-morbidities. Two Kinesiologists support each sub-region program, working in a 0.8FTE capacity. This program is currently offered in the Barrie, Couchiching and North Simcoe regions. CARE includes a focus on physical rehab, brain games and education to promote self-management. During COVID, CARE has provided virtual programming.

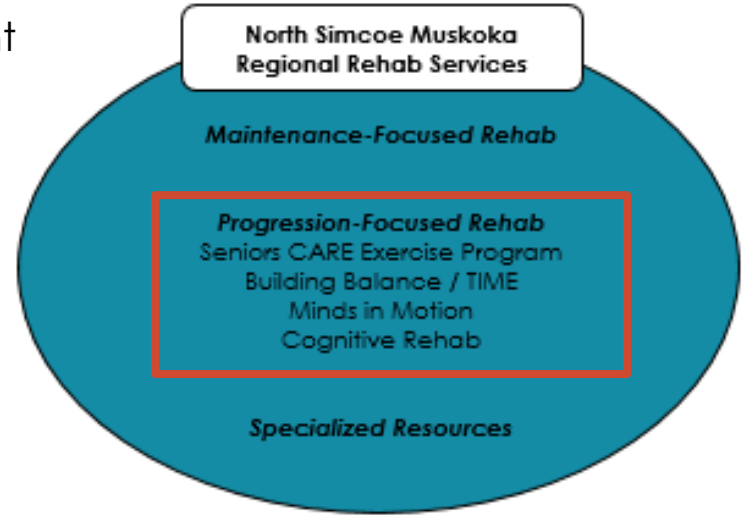


- **Expand the SGB CHC Building Balance program (or implement the TIME program) across all five NSM sub-regions**

  Rationale: The SGB CHC has a proven Building Balance program, similar to the focus of UHN's TIME program. Aligning Building Balance (or TIME) with CARE program resources (HHR, education modules, etc.), would provide an option of rehab services across NSM sub-regions that would better meet the diverse needs of older adults with a specific focus on balance training. Could potentially be supported by CARE team as complimentary program offering.

- **Align Recreation Therapy with the NSM SGS Program and Simcoe Muskoka Alzheimer Societies to support programming**

  Rationale: Recreation Therapy utilizes recreation and other activity-based interventions to address the physical and cognitive rehab needs of older adults, including those with dementia. Augmenting the current complement of resources with the addition of a Recreation Therapy-led, volunteer-supported program will benefit both community services and progression-focused rehab services like Minds in Motion.



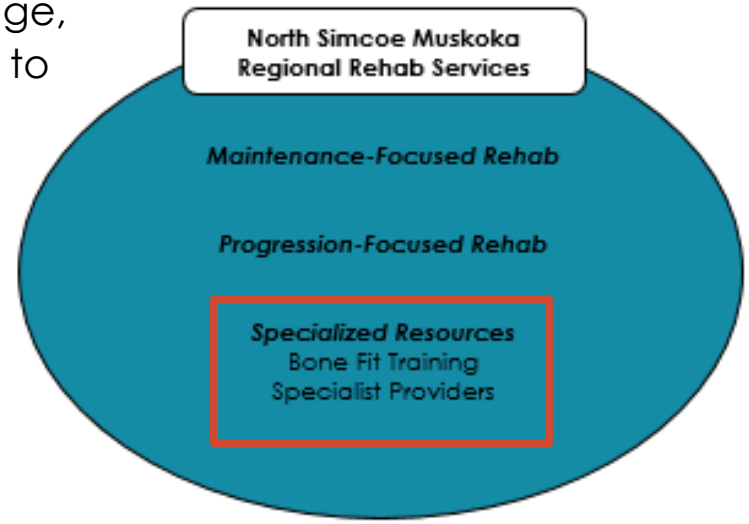
- **Establish a standardized Cognitive Rehab program in all five NSM sub-regions**

  Rationale: With the exception of some programming available through the CFHT, formal cognitive rehab programs do not exist in NSM. Cognition is an important factor in optimizing an older adult's functional abilities. Providing cognitive rehab to optimize cognitive capacity will help reverse/reduce the risk of functional decline. This could be a great partnership opportunity between local SGS services and local Alzheimer chapters.

Specialized Resources:

- **Build Bone-Fit Basic or Bone-Fit Clinical into the orientation and training curriculum of all Rehab Strategy service providers**

  Rationale: Bone-Fit training, offered by Osteoporosis Canada, ensures both exercise and fitness instructors (Basic course) and rehab professionals (Clinical course) have the knowledge, skill and judgement to provide safe clinical care to those living with Osteoporosis.



- **Ensure all five NSM sub-regions have access to dedicated allied professionals with expertise in geriatrics: PTs, OTs, Recreation Therapy, SLP**

  Rationale: Each sub-region requires access to dedicated PT AND OT resources focused on supporting local SGS teams, including maintenance and progression-focused rehab service teams. Across the NSM region there should also be access to Recreation Therapy and Speech Language Pathology. Specialized providers are needed to support evidence-informed assessment and treatment within the clinical services; support the development/ implementation of new clinical services; build capacity among providers, programs and organizations, including establishing local Communities of Practice with allied health partners.

Enablers & Recommendations

Health Human Resources:

A skilled, satisfied and appropriately resourced workforce will be essential to success. 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.

- **Standardize core services and associated practices across the region.** *(i.e. tools, guidelines, pathways, standards of care)*
- **Design roles that encourage staff to work to their full scope of practice.**
- **Develop and implement a regional orientation program for all new staff.**
- **Define core competencies and build programs to support staff to achieve those competencies. Ensure competencies are achieved and maintained over time.**
- **Consider equity with respect to salary/benefits to promote staff retention and program stability.**

Financial Resources:

Sufficient financial resources must be in place to support the implementation of the desired clinical design. Through system re-design and improved partnerships, some existing resources could be leveraged to support implementation of some of the recommendations.

- **Convene a meeting with key regional and sub-region partners to explore the feasibility of leveraging available resources to advance the proposed design.**
- **Meet with Central Ontario Health to detail the required resources to support implementation of the proposed design.**

Technology Resources (Programming):

As a result of COVID, tele-rehabilitation or virtual care has become a more widely-used platform to improve access for those unable to access face-to-face healthcare interventions. When the circumstances are appropriate (i.e. hearing, vision, cognition, security of health information, etc.), virtual care can be used to support patient assessment and diagnosis, treatment, maintenance activities, consultation, education, and training. Access to both in-person and virtual supports will be equally critical components of all future rehab services.

- **Establish a Seniors Health Virtual Care lead in NSM to develop and implement a virtual care strategy for older adults, starting with the Rehab Strategy.**
- **Establish a hybrid model of care across all Rehab Strategy services to ensure older adults have in-person and virtual options to meet their unique needs.**
- **Increase the use of technology options to improve access and quality:**
  - **Expansion of technology platform options to improve access to services.** *(i.e. zoom, OTN, cable, YouTube, etc.)*
  - **Expansion of technology options to improve clinical care.** *(i.e. Google Nest/Alexa; virtual reality to support treatment; technology to support monitoring between visits; available education modules, communication and/or progress tracking tools, etc.)*
- **Explore partnerships with technology and software providers/industry to become a leader in technology innovation across a regional rehab system.**

Technology Resources (Connectivity):

Connectivity is a significant barrier to virtual care for many older adults. Older adults must have access to technology and to reliable internet connections. Finances can be a barrier for many as can comfort with using the technology and associated programs. Many require support to explore and access new platforms and tools. Many organizations have secured resources for older adults to support virtual care but are finding challenges with implementation. Clinicians are spending significant time and energy to support training and problem-solving, often resulting in frustration for the older adult, caregiver and provider.

- **Establish a centralized iPad/alternate loan program that provides oversight to technology maintenance, distribution, configuration, cleaning and loaning. This program should be governed by policies and procedures and accessible to regional rehab services (and local SGS teams) across the five sub-regions.**
  - **Ensure a portion of available equipment have funded internet access for use when required.**
- **Establish a technology support program that provides older adults, caregivers and clinicians with free access to technology expert(s) to support problem-solving and training in the use of technology and platforms to promote success with virtual care.**

Partnerships:

Partnerships and relationships will be critical to the success of regional rehab services. Partnerships will impact how and where services are delivered, the quality of clinical care, the success of transitions and self-management and the effectiveness of communication.

Older Adults and Caregivers as Partners:

- **Engage, educate and support older adults and their caregivers to promote self-management. Leverage available resources and tools to support education, communication and service delivery.**
- **Develop services that meet the unique needs of our diverse population, including cultural and linguistic needs, starting with the francophone and aboriginal communities.**
- **Ensure persons with lived experience are engaged in co-design, supporting planning, implementation and evaluation.**

Care Delivery Partners

- **Develop and communicate clear service-specific referral criteria for referring sources to support referral clarity**
- **Implement collaborative approaches to service delivery among Rehab Strategy service partners to support successful transitions** *(i.e. a bridging program between progression-focused services and SMART where individuals do 1 class a week in each program for a 2-4 wk.. period to promote transition success)*
- **Develop a process/algorithm to support Home & Community Care Support Service NSM to leverage regional rehab congregate and virtual services.**
- **Build relationships with primary care and acute care to understand referral opportunities and explore transition opportunities.**
- **Build relationships with available local rehab services (programs and providers) for older adults to build an integrated system of care that supports seamless transitions and ensures optimal use of all available local resources based on needs, tolerance and abilities.**
- **Ensure local clinical leaders (with expertise in rehab and care of older adults) are engaged in co-design, supporting planning, implementation and evaluation.**

Health System Partners:

- **Explore partnerships within and outside health care to support the co-location of Rehab Strategy services across NSM.**
- **Explore innovative partnerships with technology providers, Georgian College, local libraries to support virtual care service delivery, including public-private partnerships where appropriate and feasible.**
- **Engage local Age-Friendly Committees and municipal partners to promote urban design, recreation programs and local projects that encourage physical, cognitive and social activity among older adults.**
- **Engage NSM transportation partners in discussion to explore available resources and services to support individuals unable to access virtual options or where in-person support is required to achieve desired outcomes AND in cases where a vehicle can not be safely driven to classes or there is no caregiver available to support transport to/from classes on a regular basis.**
- **With all NSM sub-region OHTs having a focus on older adults, collaborate with OHT partners (Central OHT:Local OHT) to support local planning, implementation and evaluation.**

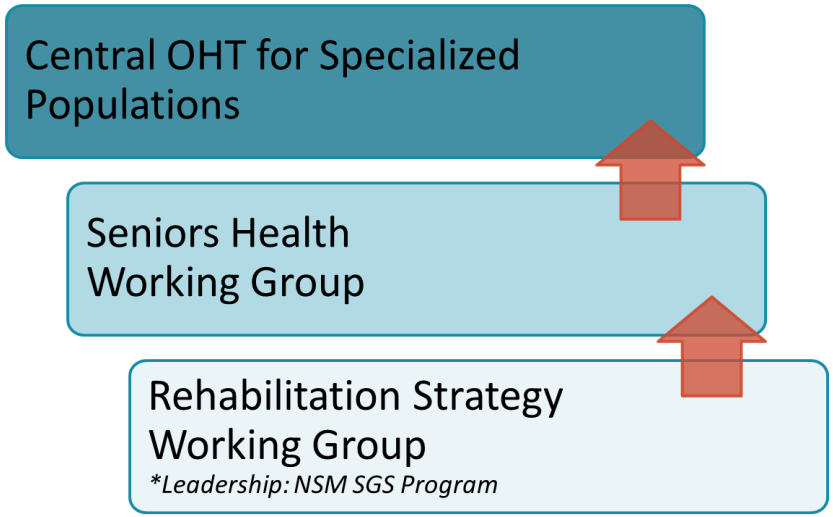
Communications:

Communication is integral to implementation success of the rehab strategy. Four key relationships are important to consider: between Rehab Strategy service teams and clients; between the Rehab Strategy service team and the circle of care; between the various Rehab Strategy service teams; and, between the Rehab Strategy service system and key stakeholders, including the public.

- **Develop communication strategies related to clinical service delivery, team communication and partner/stakeholder communication, including building relationships between members of the Rehab Strategy service teams.**
- **Where appropriate and required:**
  - **Explore circle of care requirements, and develop data sharing agreements to support the flow of relevant communication between providers.**
  - **Leverage available resources to support provider communication (i.e. Connecting Ontario, partner portals like HPG, etc.)**
- **Provide regular updates regarding progress through available means like communiques, newsletters, social media. Leverage OHT communication structures where possible/feasible.**

Leadership & Oversight:

Leadership and ongoing oversight to further planning and implementation of the Rehab Strategy will be critical to success.



- **Establish a Rehab Strategy Working Group under the leadership of the NSM SGS program and the oversight of the Seniors Health Working Group / Central OHT for Specialized Populations to support further planning, implementation, evaluation and communication. The Working Group should be established immediately and be comprised of a combination of leaders, clinicians and Persons with Lived Experience**

Out-of-Scope Considerations

Bedded Levels of Care

While bedded levels of care are outside the scope of this Rehab Strategy, they are important to consider in the context of a rehab system of care for older adults.

- Since the outset of COVID, all 56 Convalescent Care Program (CCP) have been closed in the NSM region. Some of these beds were funded through provincial CCP funding envelopes and others were funded through LHIN funds.
- Complex Continuing Care (CCC) capacity in the region has decreased over time.
- As noted in the NSM SGS Clinical Design (2018), there are no dedicated geriatric rehabilitation beds in the region.

While expansion and integration of community-based congregate programs will help prevent and improve functional decline among older adults in the region, there will always be a need for bedded levels of care for those with increasing complexity and co-morbidity.

Future planning should consider the role of bedded levels of care as part of the regional rehab service continuum, including how CCP and CCC programming and funding is used across the system to meet the requisite needs.

In-Home and 1:1 Care

Community-based congregate programming will meet needs of a targeted population but there will continue to be a large group of individuals requiring in-home support and 1:1 care. As such, in-home and 1:1 care are important to consider in the context of a rehab system of care for older adults.

- Home and Community Care Support Service NSM offer a range of in-home 1:1 services, some of which may be able to be augmented and supported by virtual congregate programming. Waits for some rehab services vary by discipline, need and region.
- Between December 2018 and March 2020, VON implemented a Kinesiology Pilot Program. In this pilot, Kins were used to support in-home care in targeted cases. Initially, the program accepted low acuity community-dwelling clients and, in September 2019, expanded to include some Retirement Home residents. The program was viewed as a success, addressing needs of both clients and the system. It was found to be timely, efficient, and cost effective.

Future planning should include:

- **Discussion with HCC-SS NSM to explore opportunities to reconfigure in-home 1:1 care / resources to optimize resources by leveraging congregate and virtual programming, as appropriate.**
- **Consideration of re-instatement of the VON Kinesiology in-home support program.**

OHT Considerations

OHTs play a key role in building local partnerships, strengthening and integrating service delivery within communities and in improving transitions for both older adults and their caregivers. With all NSM sub-region OHTs focused on older adults, an opportunity exists to help advance local deliverables through this Rehab Strategy. The OHTs can, for example:

- Engage the Seniors' Health Working Group (via the NSM SGS Program) in conversation to better understand the proposed plan and recommendations.
- Bring the Rehab Strategy forward to OHT planning tables to promote local dialogue and engagement and assess how it may help advance local OHT planning.
- Determine how the proposed hub-and-spoke model could be implemented at a local level.
- Ensure representation on the Rehabilitation Strategy Working Group to provide local feedback into system planning, implementation and evaluation; ensure a feedback loop is in place to support the OHT to monitor progress and support implementation.
- Conduct an inventory of resources to determine what is available locally to support implementation of the proposed plan and recommendations.
- Identify key local rehab services and facilitate linkages between local and Rehab Strategy services.
- Use this Rehab Strategy as a first step toward building a continuum of rehab services for older adults in the sub-region.

Next Steps

- Secure endorsement from the Central OHT for Specialized Populations.
- Convene a meeting with Ontario Health (Central Region) to formally submit the report and recommendations.
- Establish the Rehab Strategy Working Group to continue to advance planning and, when/where feasible and appropriate, begin to implement recommendations.

North Simcoe Muskoka
Specialized Geriatric Services