

Strategy for a Specialized Geriatric Services Program in North Simcoe Muskoka

MAY 7, 2014

**Prepared by:
Seniors Strategy Task Group**

***“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

Acknowledgements

The In-Home & Community Capacity Coordinating Council and the North Simcoe Muskoka Local Health Integration Network would like to extend thanks to all individuals who helped inform the work of the Seniors Strategy Task Group. Thank you to the seniors and caregivers who attended community events and completed the on-line survey. Your insight and experience helped to ground Task Group discussion. Thank you to area physicians, health care professionals, system leaders, community partners and municipal representatives for your contributions. Your knowledge of system needs and opportunities guided Task Group direction.

The In-Home & Community Capacity Coordinating Council and the North Simcoe Muskoka Local Health Integration Network would also like to thank the Seniors Strategy Task Group for leadership in the development of the ***Strategy for a Specialized Geriatric Services Program in North Simcoe Muskoka***. This Task Group completed the work within a culture of collaboration. The Strategy was influenced and informed by their passion, dedication, wisdom and experience:

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Executive Summary

In January 2013, the Ontario Ministry of Health & Long-Term Care released an action plan for seniors entitled *Independence, Activity & Good Health*. Within the plan, seniors were identified as a core element of the Ministry's transformation agenda. In October 2013, in alignment with provincial directions, the North Simcoe Muskoka Local Health Integration Network (NSM LHIN) Board of Directors approved a plan to develop an integrated regional Seniors Health Program. Under the sponsorship of the In-Home & Community Capacity Coordinating Council, the Seniors Strategy Task Group was struck to provide initial leadership to this project.

Using the NSM LHIN's 2009 *Vision for an Integrated Regional Seniors Health Program* as a starting point for discussion, the Task Group came together in a culture of collaboration to develop a ***Strategy for a Specialized Geriatric Services Program in North Simcoe Muskoka***. The Strategy focuses on Specialized Geriatric Services and frail seniors as the first building block in an integrated regional Seniors Health Program. It is intended to be a living document, providing strategic direction while allowing flexibility to accommodate our continuously changing environment. It provides a framework and guiding principles to inform NSM direction and decision-making. The Strategy provides a long-term vision and a short-term strategy for action.

CURRENT STATE

Based on 2011 population estimates, approximately 74,025 people in NSM are age 65+, representing 16.9% of the NSM population (Ontario average 14.6%). In the period 2010-2012, seniors accounted for 22.4% of all NSM Emergency Department visits. In 2013, Dementia, Mental Health and Behavior Conditions accounted for 20% of all NSM Alternate Level of Care (ALC) length of stay days¹. According to the Simcoe Muskoka District Health Unit, the prevalence, rate of hospitalization and risk of death from Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Ischemic Heart Disease, High Blood Pressure and Stroke increase significantly with age. Over the last several years, increasing numbers of seniors are being admitted to hospital with mental health conditions and due to falls. Based on a review of 2009/10 data, the Ministry found seniors accounted for 55% of the top 10% of high users in the province.

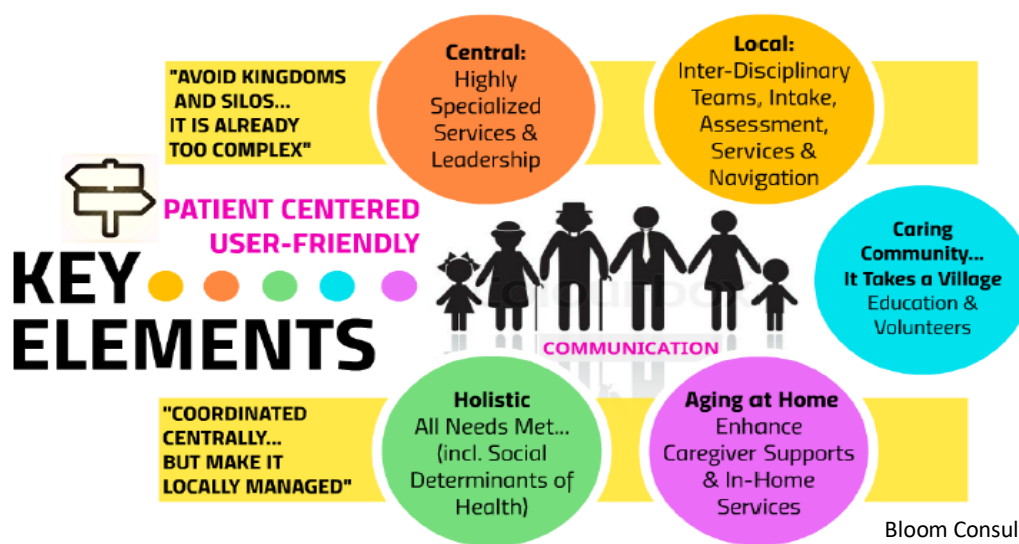
Many programs and services have developed for seniors in NSM over the last ten years. Within the context of this growth there are opportunities for system re-design. Some programs include leading practices and innovative approaches to care that could be leveraged within the region. With many programs developing in isolation, there appears to be opportunities for improved communication and program efficiencies. Collaboration and partnerships could be improved, eligibility criteria could be standardized, standards of practice could be developed and evaluation could be improved through the use of standardized indicators. There is a need to increase the number of health care professionals with expertise in care of the elderly. There is also a need to increase the skill sets of health care professionals in regard to care of the elderly. The most urgent threat to our system is the retention of our remaining Geriatric Care Specialists². In the last two years NSM has lost fifty percent of our Geriatricians and Care of the Elderly Physicians.

¹ Excludes Waypoint Centre for Mental Health Care data

² For the purpose of this Strategy document, "Geriatric Care Specialists" refers to Geriatricians, Geriatric Psychiatrists and Care of the Elderly physicians.

During engagement events, NSM providers and the public advocated for change. To improve the patient experience they described the need for:

- A patient-first approach to care and planning;
- Building capacity across the care continuum;
- Improved and equitable access to services;
- Services that are timely, seamless and community-based with one-stop shopping as well as outreach support for the frail and isolated;
- Support with system navigation;
- A system with simple, uncomplicated structures and processes;
- Better support for caregivers, advanced care planning, oral health and seniors living with dementia;
- A holistic approach to care that addresses medical and non-medical needs including social determinants of health; and
- A focus on prevention.



Bloom Consulting, March 2014

THE NORTH SIMCOE MUSKOKA SPECIALIZED GERIATRIC SERVICES PROGRAM

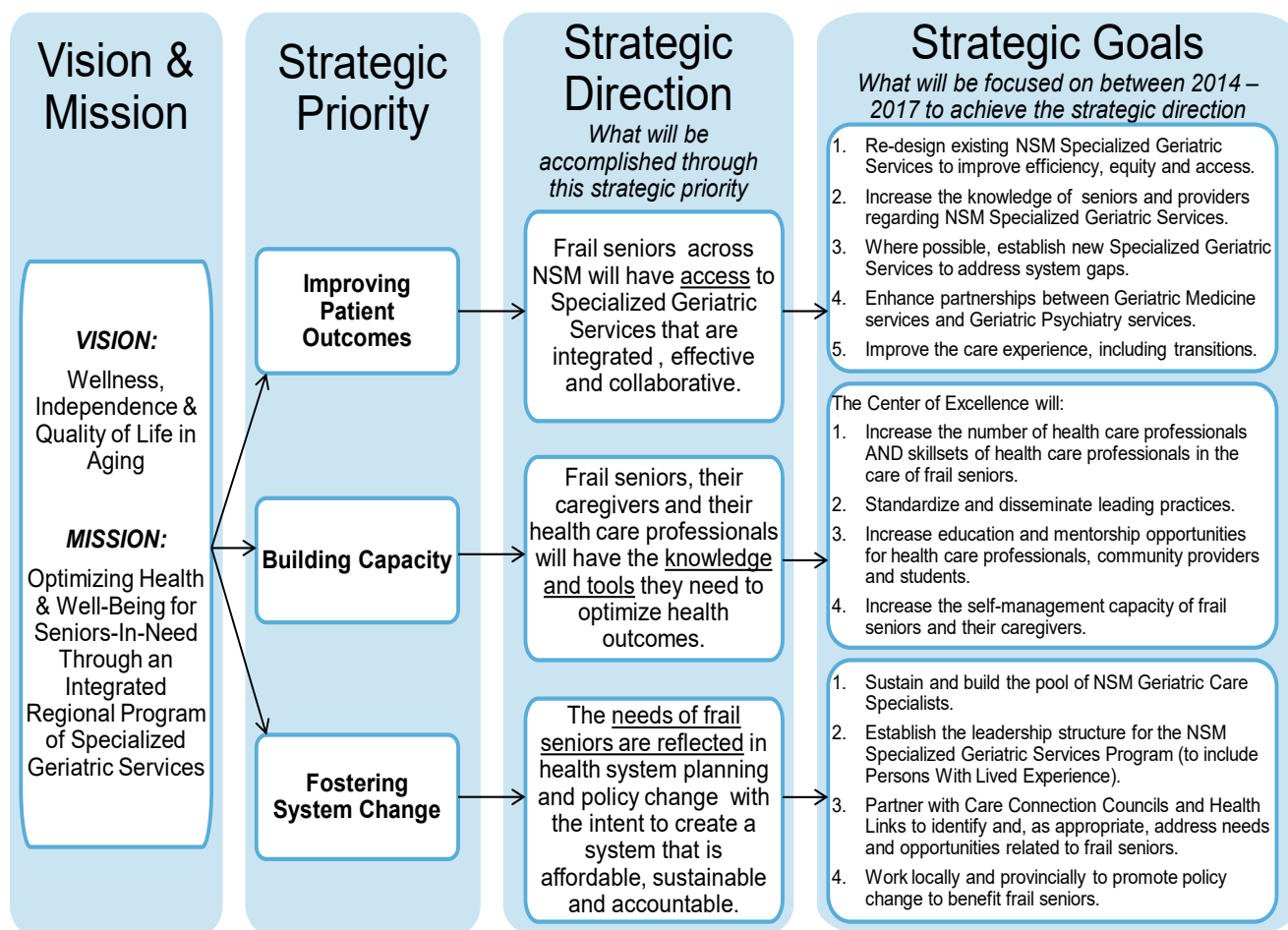
As the first building block of an integrated regional Seniors Health Program, a Specialized Geriatric Services Program (SGS Program) will be established in NSM:

- Specialized Geriatric Services are **defined** as a comprehensive, coordinated system of hospital and community-based health and mental health services that diagnose, treat and rehabilitate frail seniors. These services are provided by interdisciplinary teams with expertise in care of the elderly and provided across the continuum of care. Specialized Geriatric Services are inclusive of both Geriatric Medicine services and Geriatric Psychiatry services.
- The **target population** of the NSM SGS Program will be frail seniors. The Clinical Frailty Scale will be used to conceptualize frailty. Within the Program, Clinical Services will target seniors in stages four to six on the Clinical Frailty Scale who have the potential to improve.

The Task Group proposes the NSM SGS Program be supported by three **key pillars** related to quality, delivery system and leadership:

- The Quality Framework provides strategic direction to the Program. Three strategic priorities are identified: Improving Patient Outcomes; Building Capacity; Fostering System Change.

North Simcoe Muskoka Specialized Geriatric Services Program Quality Framework 2014 - 2017

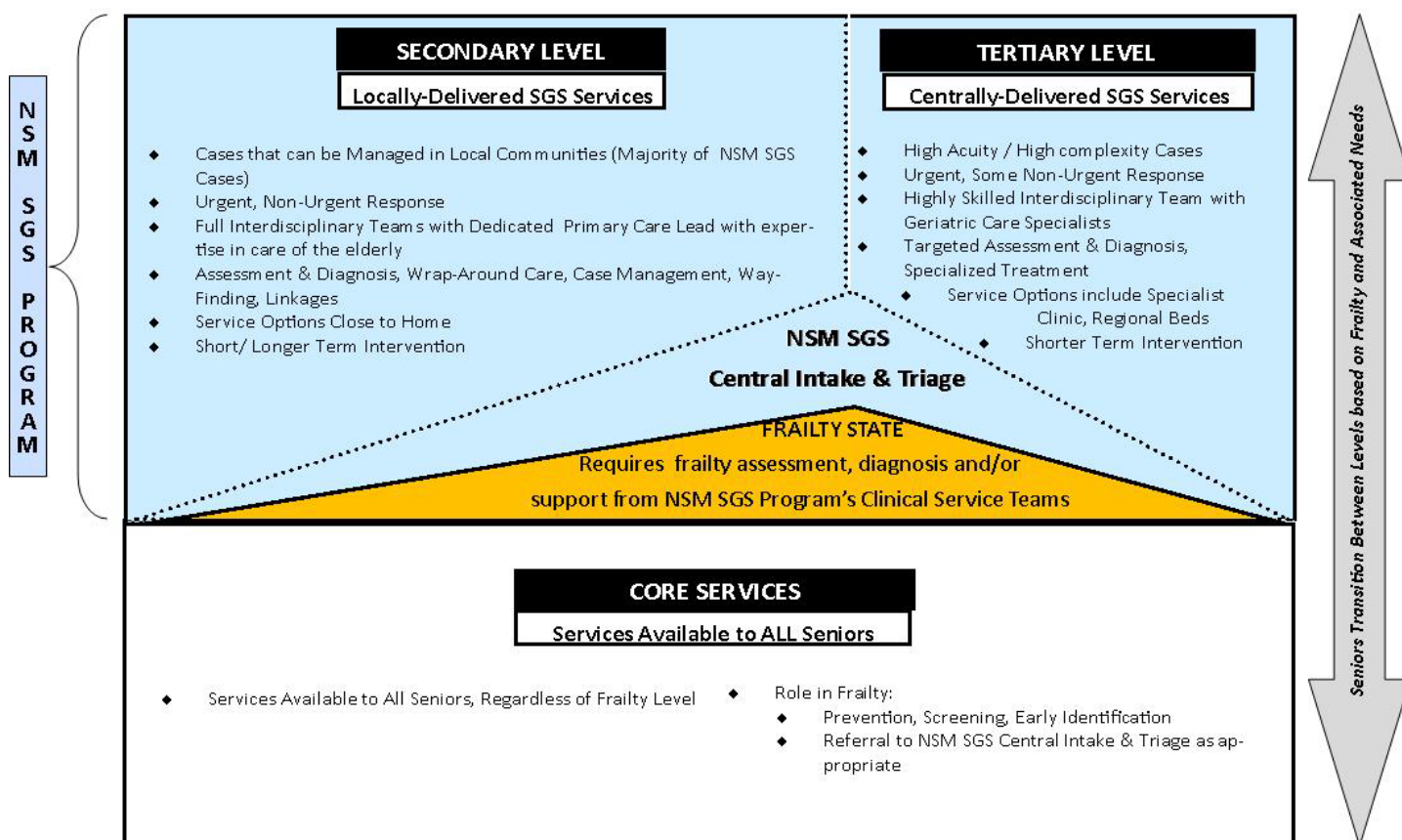


- The Delivery System Framework (refer to page 14) promotes a seamless, integrated model of care delivery. The Task Group recommends the Hollander & Prince (2008) Framework as a starting point for discussion. This best practices framework outlines: philosophical and policy prerequisites supporting integrated systems of care; best practices for organizing service delivery; and boundary-spanning mechanisms for coordination and linkages.
- The Leadership Framework (refer to page 15) supports the building of the Program. An oversight body and dedicated leadership team will be important to Strategy implementation and Program direction. This Framework should be further informed by the work of the *Care Connections: Second Curve Committee*.

The Task Group identified five **key roles** for the NSM SGS Program: Leadership, Clinical, Education & Mentorship, Advocacy and Research & Ethics. Leadership will support system planning while Education & Mentorship will be critical to building regional capacity. The Clinical role will include the development of standards of practice, collaborative pathways, Communities of Practice as well as Clinical Services.

At present, health service providers support seniors on a daily basis across the continuum of care. Many of these seniors are frail. As such, the NSM SGS Program will be only one component of a broader integrated regional Seniors Health Program. The NSM SGS Program will be a partner in care and designed to promote collaborative behavior and teamwork. The Task Group offers the following **working model** for the broader integrated regional Seniors Health Program, one component of which is the NSM SGS Program.

NSM Integrated Regional *Seniors Health Program Model*



When there is a need for support from specialized SGS teams, Core Services will transition frail seniors into the NSM SGS Program's **Clinical Services**. Clinical Services will be comprised of:

- a Central Intake & Triage service;
- Locally-Delivered Specialized Geriatric Services (Secondary Level) responsible for managing the majority of cases close to home and linked with Centrally-Delivered SGS teams; and,
- Centrally-Delivered Specialized Geriatric Services (Tertiary Level) responsible for high acuity, high complexity cases that cannot be managed close to home. These services will include Geriatric Care Specialists.

Four **key enablers** are critical to the success of the NSM SGS Program in the early years of development and implementation: retention and recruitment of Geriatric Care Specialists; leveraging existing resources; technology; and, communication.

TIME FOR ACTION

The Strategy provides a framework and guiding principles to inform NSM direction and decision-making. The Task Group was united in the belief that the system must be re-designed to better support frail seniors and that the time for action is now. Task Group momentum must continue and Strategy recommendations must be operationalized. The following are identified as priority recommendations:

Priority Ranking	Action	Lead	Timelines
1	Retain and recruit Geriatric Care Specialists: - Finalize recruitment of the Physician Lead, Seniors Health and base the contract on stable funding. - Partner with key stakeholders, including the Integrated Health Human Resource Coordinating Council, the Ontario Medical Association and existing Geriatric Care Specialists, to develop and implement a plan to retain and recruit Geriatric Care Specialists, including stabilizing funding and building Clinical Services.	Lead TBD NSM LHIN	May 2014 Oct. 2014
2	Develop and implement a communication strategy related to this <u>Strategy for a Specialized Geriatric Services Program in NSM</u> document, with implementation to commence upon endorsement of the Strategy by the In-Home & Community Capacity Coordinating Council.	NSM LHIN	May 2014
3	Establish a Project Steering Committee under the In-Home & Community Capacity Coordinating Council.	IHCC/ NSM LHIN	June 2014
4	Adopt the key components of the NSM SGS Program as identified within the Strategy document.	IHCC	June 2014
5	To leverage existing resources: - Complete a comprehensive review of targeted seniors programs to inform system re-design opportunities. - Complete a comprehensive SGS inventory of NSM programs and services.	NSM LHIN Project Steering Committee	Sept. 2014 Oct. 2014
6	Establish the Leadership Team for the NSM SGS Program (Regional Seniors Health Program Lead; Regional Clinical Nurse Specialist, Seniors Health; Physician Lead, Seniors Health; Administrative Assistant).	Project Steering Committee	October 2014

Future work must build on the collaborative approach established by the Seniors Strategy Task Group. We must move toward a second curve healthcare system. The need for change is evident, the environment is ready and the timing is right. We must leverage the successful structures, processes, and programs already in place. We must join to mobilize efforts and make difficult decisions when required in order to champion the care of our frail seniors.

Introduction

In January 2013, the Ontario Ministry of Health & Long-Term Care released an action plan for seniors entitled *Independence, Activity & Good Health*. Within the plan, seniors were identified as a core element of the Ministry's transformation agenda. The plan included three goals - Healthy Seniors, Senior Friendly Communities and Safety & Security. 'Healthy Seniors' aligned with the 2013 report released by Dr. Samir Sinha. Within his *Living Longer, Living Well* report, Dr. Sinha made 166 recommendations regarding seniors health ranging from wellness and housing to specialized geriatric services and end-of-life care.

In October 2013, in alignment with provincial directions, the North Simcoe Muskoka Local Health Integration Network (NSM LHIN) Board of Directors approved a plan to develop an integrated regional Seniors Health Program in NSM. To provide initial leadership to this project the Seniors Strategy Task Group was struck under the sponsorship of the In-Home & Community Capacity Coordinating Council.

The ***Strategy for a Specialized Geriatric Services Program in North Simcoe Muskoka*** is the product of the Task Group's collaboration. The Strategy focuses on Specialized Geriatric Services and frail seniors as the first building block in an integrated regional Seniors Health Program. **It is intended to be a living document, providing strategic direction while allowing flexibility to accommodate our continuously changing environment. It provides a framework and guiding principles to inform NSM direction and decision-making. The Strategy provides a long-term vision and a short-term strategy for action.**

Background

In 2009, the NSM Seniors Health Regional Action Group developed a *Vision for an Integrated Regional Seniors Health Program* to the NSM LHIN. The 2009 Vision was completed over an eight-month period by leaders in seniors' health from across the NSM region. The document was grounded in literature, best practices and innovations, broad community consultation and available data. Specifically focused on Specialized Geriatric Services (SGS), the document described a hub and spoke model of care, centrally coordinated and locally delivered. The Vision addressed the role of a SGS Program in system-wide leadership; clinical service delivery; program development and standardization of practice; education, mentorship and knowledge transfer; research and ethics; and, advocacy. It also provided detailed recommendations regarding programming and services, health human resources, outcome measures, budget and timelines. Upon completion, the 2009 Vision was endorsed by the NSM LHIN and has remained a guiding document for regional seniors health planning. The Integrated Regional Falls Program (IRFP) at Orillia Soldier's Memorial Hospital and the Seniors Assessment Support & Outreach Team (SASOT) at Muskoka Algonquin Healthcare originated in concept from the Vision document.

The NSM environment has changed significantly since the completion of the 2009 Vision. New programs have emerged while others have ceased operation. Provincial initiatives like Nurse-Led Outreach Teams (NLOT) and Behavioural Supports Ontario (BSO) have changed the landscape of care for frail seniors. Family Health Teams have developed programming for frail seniors. Campus-based approaches to care have emerged in models like Georgian Village and in the proposed Little Lake project. Specialized Geriatric Services at Orillia Soldiers' Memorial Hospital, Royal Victoria Regional Health Centre and

Waypoint Centre for Mental Health Care have continued to change to meet the growing pressures and demands of their communities. The NSM LHIN has expanded convalescent care capacity and Assisted Living programs for high-risk seniors, increased funding for the NSM CCAC and completed a study to better understand the opportunities within our region's long-term-care sector.

All parts of the system have evolved to better meet the needs of frail seniors. Across the region there is recognition of the need for change, interest in collaboration and a true desire to improve the patient experience. There is also recognition of potential opportunities inherent in system re-design. Many programs for frail seniors developed independent of others in the region. Some programs emerged because of new funding envelopes like Aging at Home where partnership was encouraged and program parameters were defined. There are many leading practices in the region and innovative approaches to care that could benefit a larger community than currently served. Overall, there is the potential to promote collaboration, improve efficiencies, reduce duplication, address some gaps and create a more standardized approach to programming and service delivery.

This current state, coupled with the release of Dr. Sinha's report and the rollout of Health Links across NSM, provides opportunity for health system transformation. In October 2013 the NSM LHIN Board of Directors approved a plan with two key areas of focus: (1) development of an integrated regional Seniors Health Program, to start with a re-refresh of the 2009 Vision document; and, (2) stabilization of the NSM Geriatric Care Specialists³ (Geriatricians, Geriatric Psychiatrists, Care of the Elderly Physicians). Under the sponsorship of the In-Home & Community Capacity Coordinating Council, and with leadership from the NSM LHIN, a Seniors Strategy Task Group was struck in December 2013. The mandate of the Task Group was to provide strategic direction to the NSM LHIN, using the 2009 Vision document as a starting point for discussion⁴. The Task Group was comprised of senior leaders and strategic thinkers representing NSM's continuum of care and subLHIN regions. These leaders came together as stewards of the health system. Through a culture of collaboration, the Task Group reached consensus on Strategy content and recommendations, intentionally designed to improve the patient experience.

Current State

DATA⁵

Based on 2011 population estimates from the Ministry of Finance, there are approximately 74,025 individuals age 65+ living in NSM. Those aged 65+ represent 16.9% of the NSM population (Ontario average 14.6%). Within this population, the most pressing need for linguistically and culturally respectful health services rests with our Francophone and Aboriginal populations.

NSM seniors can be broken into four groups based on mobility patterns: (1) lived in the region for a long period of time and are aging in place; (2) second homes in the region and are "seasonal" residents; (3)

³ For the purpose of this Strategy document, "Geriatric Care Specialists" refers to Geriatricians, Geriatric Psychiatrists and Care of the Elderly physicians.

⁴ The 2009 Vision document was used as a starting point for Task Group discussions. The Task Group focused on the strategic directions and concepts within the Vision but did not review the Vision in detail. As such, the Task Group is unable to endorse specific recommendations in the 2009 Vision document.

⁵ Appendix A = data gathered to inform Task Group discussion.

moved or retired into the region to follow their families; and, (4) moved or retired into the region leaving family behind. Each group presents unique challenges to health care delivery.

Chronic disease plays a significant role in the health status of NSM seniors. According to the Simcoe Muskoka District Health Unit, as individuals age the prevalence, rate of hospitalization and risk of death from chronic diseases like diabetes, heart disease and high blood pressure increases. For example, deaths from Chronic Obstructive Pulmonary Disease (COPD) at age 75+ are fifty times greater than the rate for those age 45 to 64 years. Based on data provided by the Alzheimer Society of Ontario, NSM was home to 7,570 individuals with dementia in 2012. The Society projects this number will grow by 37% in NSM by 2020 (third highest rate of growth in the province).

Between 2010 and 2012, seniors accounted for approximately 22.4% of all NSM Emergency Department visits. According to the 2010 ICES Chartbook, NSM was one of three LHINs having the highest rate of unscheduled Emergency Department visits in 2008-2009. In 2013, the top leading causes of acute length of stay days included COPD and Bronchiectasis, Heart Failure, Disease of the Urinary System, Fractured Femurs and Acute Myocardial Infarctions. Dementia, Mental Health and Behavior Conditions accounted for 20% of NSM's Alternate Level of Care (ALC) length of stay days in 2013⁶. In recent years, the number of admissions for seniors with mental health issues has increased while length of stay has decreased. There are increasing numbers of admissions due to falls and fall-related injuries. In recent years, seniors age 65+ have accounted for 75-80% of rehabilitation episodes, with an increasing trend noted.

In 2012, the province began to explore the health care consumption and costs of high users. Using 2009-2010 data, Ministry research found seniors accounted for 55% of the top 10% high users and almost 60% of the top 1% high users. Respiratory failure, stroke and heart failure were conditions accounting for the highest spending in acute care in both the age 65-79 and 80+ cohorts.

There are 3,066 LTC home beds in NSM, including 56 convalescent care beds. Overall, NSM rests slightly above the provincial ratio of beds/1000 age 75+, with Collingwood and Orillia regions resting below the provincial average. According to the NSM LTC Study (November 2013), the average wait time for a LTC home bed ranged between 245 days in Collingwood to 472 days in Barrie. The study found 40% of all LTC admissions originated from acute care and 37% of LTC residents were discharged to acute care.

RESOURCES

Programs & Services

Frail seniors represent a large proportion of individuals served by Long-Term Care homes, the Community Support Services Sector, the NSM CCAC and area hospitals. However, not all programs are Specialized Geriatric Services. To begin to create a current state SGS inventory for the region, the NSM LHIN collected data from area health service providers in March 2014. Data limitations included tight timelines and confusion around the definition of "Specialized Geriatric Services". Recognizing data limitations, a rough inventory of programs was created (Appendix B) and data analysis occurred.⁷ Based

⁶ Excludes Waypoint Centre for Mental Health Care data

⁷ Inventory inclusion was based on consideration of SGS definition (refer to page 11) and whether assessment, diagnosis and/or treatment of geriatric syndromes (i.e. dementia, delirium, depression, falls, polypharmacy, elder abuse, etc.) appeared to be a component of service delivery.

on the data presented the Task Group identified some high-level system re-design opportunities, including the need to:

- Increase clarity regarding the definition of “Specialized Geriatric Services”;
- Create more equitable access to programs across NSM subLHIN regions;
- Improve consistency in eligibility criteria, standardizing where possible;
- Increase collaboration and partnerships across programs and disciplines;
- Leverage promising practices;
- Reduce duplication in service (i.e. intake, system navigation, caregiver support, etc.), where possible;
- Right size health human resources, where possible; and,
- Improve program evaluation through standardized indicators, where appropriate.

Health Human Resources

The SGS health human resource capacity in NSM remains inadequate. There is a need to build capacity by increasing the number of professionals with expertise in care of the elderly AND by increasing the skill sets of these individuals. The most urgent health human resource threat is the retention and recruitment of Geriatric Care Specialists, an essential SGS Program resource.

At present, NSM has two Geriatricians (total 1.0FTE), four Geriatric Psychiatrists (2.3FTEs) and two Care of the Elderly physicians with focused practices in North Innisfil and in the inpatient beds at Waypoint. In the last two years, fifty percent of NSM Geriatricians and Care of the Elderly physicians have resigned their positions citing lack of appropriate infrastructure and compensation mechanisms. Geriatric Care Specialists are looking for service sustainability and to be enabled to provide optimal care to patients.

Retention is especially important given the challenges faced in recruitment. According to recent statistics, there are only 119 Geriatricians in the province. Most Geriatricians are tied to academic centers and linked with Regional Geriatric Programs. The average age of Geriatricians is increasing with many nearing retirement and only a few graduating across the country annually. In Ontario there are:

- 7.5 Paediatricians/10,000 children (provincial population 2.2M)
- 0.65 Geriatricians and Care of the Elderly physicians/10,000 seniors (provincial population 2M)

Concurrent Initiatives

Initiatives are underway locally and provincially that will influence the direction and recommendations of this Strategy document. Six initiatives, in particular, require monitoring (Appendix C):

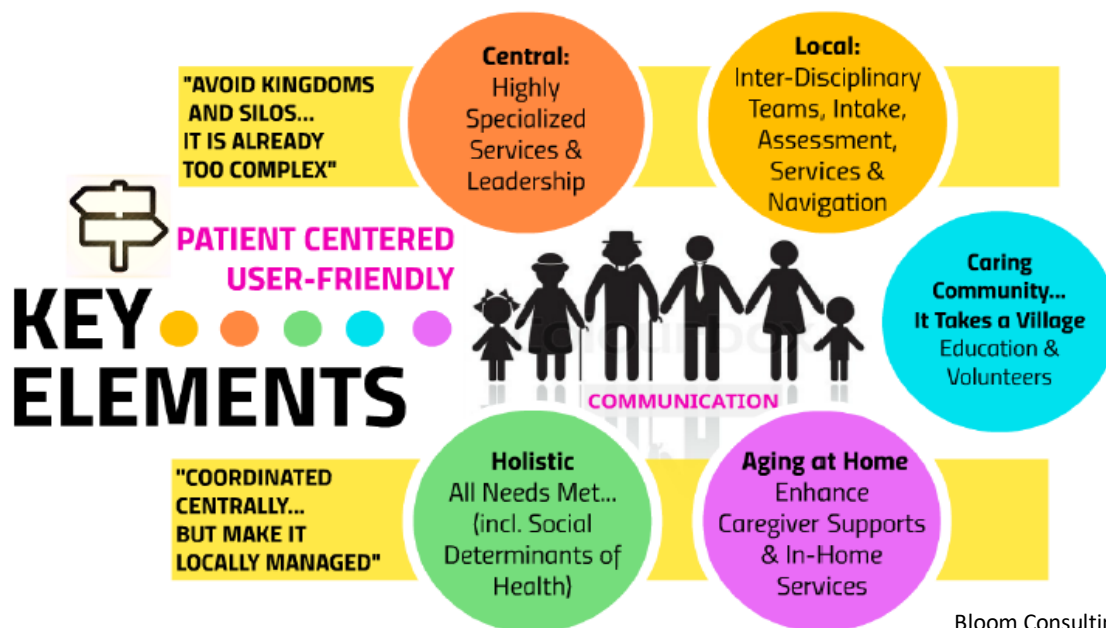
- *Care Connections: Second Curve Committee*
- Health Links
- Provincial Regional Geriatric Programs of Ontario review
- Senior Friendly Hospital Strategy
- Rehabilitation / Assess & Restore
- NSM Behavioural Support System (BSS)

COMMUNITY ENGAGEMENT⁸

A community engagement strategy was implemented to inform Task Group discussion. The purpose was to confirm and re-fresh the seniors health priorities identified in the 2009 Vision⁹. Through the community engagement strategy, over three-hundred individuals were engaged representing over eighty agencies. Recognizing that “frailty” and “Specialized Geriatric Services” would be difficult concepts for many to address, engagement explored seniors’ health more broadly with some targeted questions related to these key concepts. It is important to note that many participants expressed concern with the timelines for community engagement.

Priorities identified in 2014 were similar to those identified in the 2009 Vision, including the need for:

- A patient-first approach to care and planning;
- Building capacity across the care continuum;
- Improved and equitable access to services;
- Services that are timely, seamless and community-based with one-stop shopping as well as outreach support for the frail and isolated;
- Support with system navigation;
- A system with simple, uncomplicated structures and processes;
- Better support for caregivers, advanced care planning, oral health and seniors living with dementia;
- A holistic approach to care that addresses medical and non-medical needs including social determinants of health; and
- A focus on prevention.



Bloom Consulting, March 2014

⁸ Appendix E = Community Engagement report.

⁹ Broad community consultation occurred in 2009 to inform the Vision with over 50 groups consulted. In 2007, the NSM LHIN completed a Frail Elderly Survey, which included 31 one-on-one interviews with NSM seniors, frail elders and caregivers (three were members of the Askennonia Seniors Centre). This study also informed the Vision.

To reach an ideal state, participants described the need to be responsive and flexible to meet changing needs and keep up with system trends. They identified the importance of shifting attitudes and resources toward collaboration and creating trust relationships. Leadership was acknowledged as important with participants describing a structure to provide oversight, advocacy and central coordination. The opportunity to create a Center of Excellence was also identified.

Although feedback was broad and reflected needs related to the broader integrated regional Seniors Health Program, the themes were relevant to Specialized Geriatric Services and helped inform Task Group discussion.

NSM SGS Program: Core Concepts

As the first building block of an integrated regional Seniors Health Program, a Specialized Geriatric Services Program (SGS Program) will be established in NSM.

Definition

“Specialized Geriatric Services” are defined as a comprehensive, coordinated system of hospital and community-based health and mental health services that diagnose, treat and rehabilitate 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 services and Geriatric Psychiatry services.

Target Population

Within the NSM SGS Program, the target population will be ***frail seniors***.

There are several important points regarding frailty:

- Seniors can move in and out of frailty;
- Seniors can experience varying degrees of frailty depending on their health status, the state of their social and support network and their social determinants of health;
- Many health care professionals can identify frail seniors upon presentation but are often challenged to define “frailty”.

Dr. Dalziel (2008)¹⁰, an Ontario Geriatrician and recognized knowledge leader in the topic of frailty, describes frail seniors as different because:

- They present with:
 - Multiple diseases with multiple drugs = complexity.
 - Multiple problem areas = multidimensionality.
 - Premorbid function disability = slippery slope.
- They can require a Medical/Psychiatric interface;
- There is an increased importance in a social network for this cohort; and,
- There is a need for a complex combination of medical and social services requiring discharge-planning support.

¹⁰ Dalziel, B. (2008). Can you Unfrail the Elderly? RGP Toronto Toolkit: Frailty

Within the NSM SGS Program, the Clinical Frailty Scale¹¹ (Box 1) will be used to conceptualize frailty. Within the Program, Clinical Services will target seniors in stages four to six who have the potential to improve.

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

Vision

Wellness, independence and quality of life in aging.

Mission

Optimizing health and well-being for seniors-in-need through an integrated regional program of Specialized Geriatric Services.

Principles & Value Statements

- The frail senior is the reason for being; “*nothing about us, without us*”.
- The term ‘frail senior’ is inclusive of caregivers. It is impossible to support one without supporting the other.
- Geriatric Medicine services and Geriatric Psychiatry services are partners within Specialized Geriatric Services.
- Specialized Geriatric Services focus on meeting needs and, as such, are not limited by catchment area or postal code.
- Although standardization is important so too is attending to the unique needs of individuals, communities, health care providers, organizations and diverse populations.
- Specialized Geriatric Services are delivered through the lenses of evidence, safety and common sense.
- Creative solutions, innovative practices and strong, effective partnerships are critical to success and sustainability.
- There is a need to live within our means and strive for sustainability.
- All parts of the NSM SGS Program are integrated and inter-dependent.

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.

- The SGS Program is one component of a broader integrated regional Seniors Health Program in NSM.

RECOMMENDATION:

- Adopt the NSM SGS Program *core concepts*.

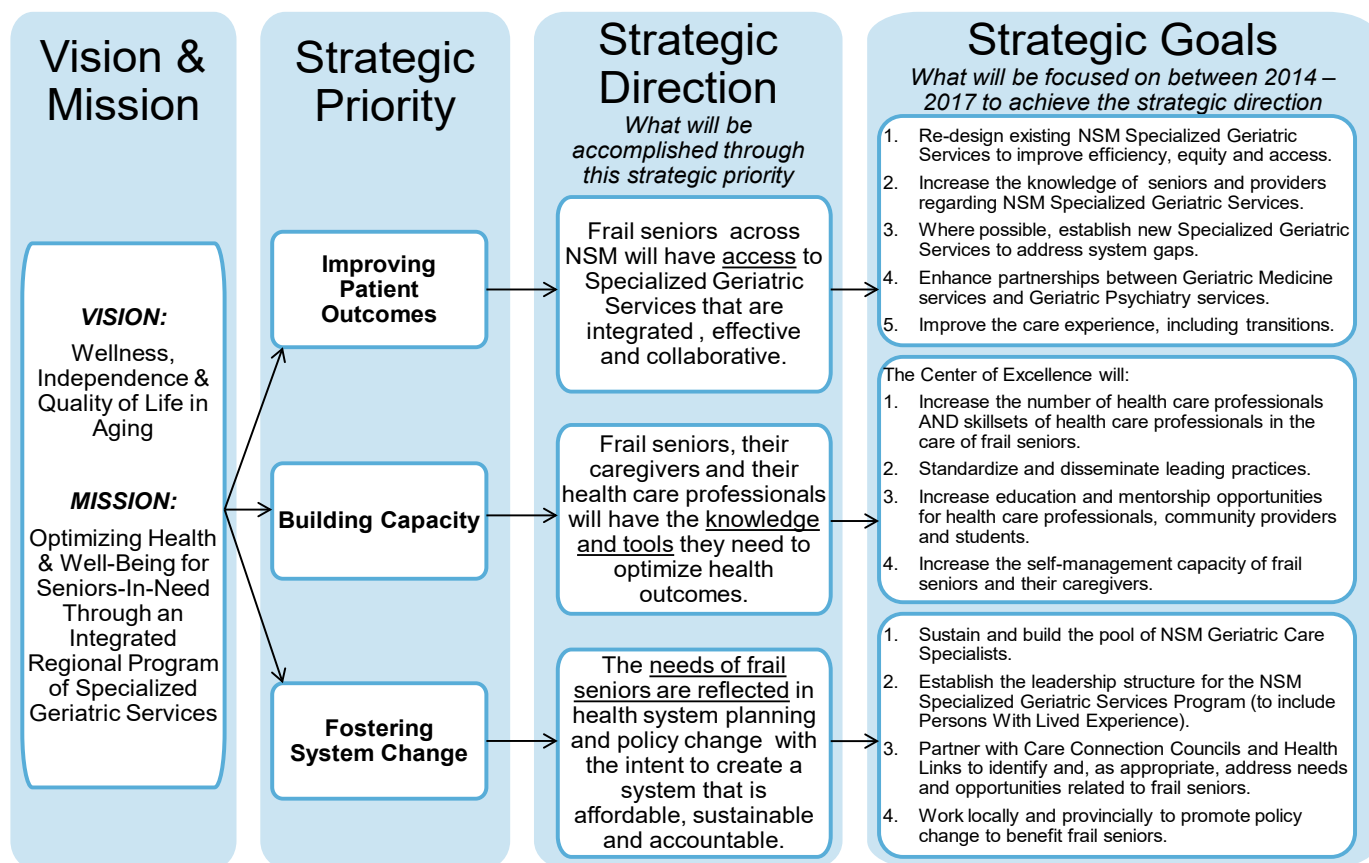
NSM SGS Program: Key Pillars

The Task Group proposes the NSM SGS Program be supported by three key pillars: quality, delivery system and leadership.

QUALITY FRAMEWORK

The Quality Framework provides strategic direction to the NSM SGS Program. Within the Quality Framework, three strategic priorities are identified that align with provincial directions and priorities (Appendix F): Improving Patient Outcomes; Building Capacity; and, Fostering System Change.

North Simcoe Muskoka Specialized Geriatric Services Program Quality Framework 2014 - 2017



The strategic goals align with the nine attributes of quality defined by Health Quality Ontario. The Task Group recommends continued work on the Quality Framework to identify evaluation metrics that can be consistently implemented across the NSM SGS Program. Indicators should:

- Be framed from a patient perspective, using information gathered through the community engagement strategy as a springboard for discussion;
- Be realistic and measurable;
- Include both process and outcome measures;
- Leverage existing and available indicators where appropriate (i.e. Health Quality Ontario's Quality Agenda, Health Links, Senior Friendly Hospital Strategy, etc.); and,
- Capture whether the Program's direct clinical services are serving frail seniors and where they are making a difference within that population.



Through a PDSA cycle, indicators will be evaluated and revised as necessary.

RECOMMENDATIONS:

- Adopt the NSM SGS Program **Quality Framework**.
- Develop standardized **evaluation metrics and outcome measures** in alignment with the NSM SGS Program Quality Framework that reflect the patient perspective.

DELIVERY SYSTEM FRAMEWORK

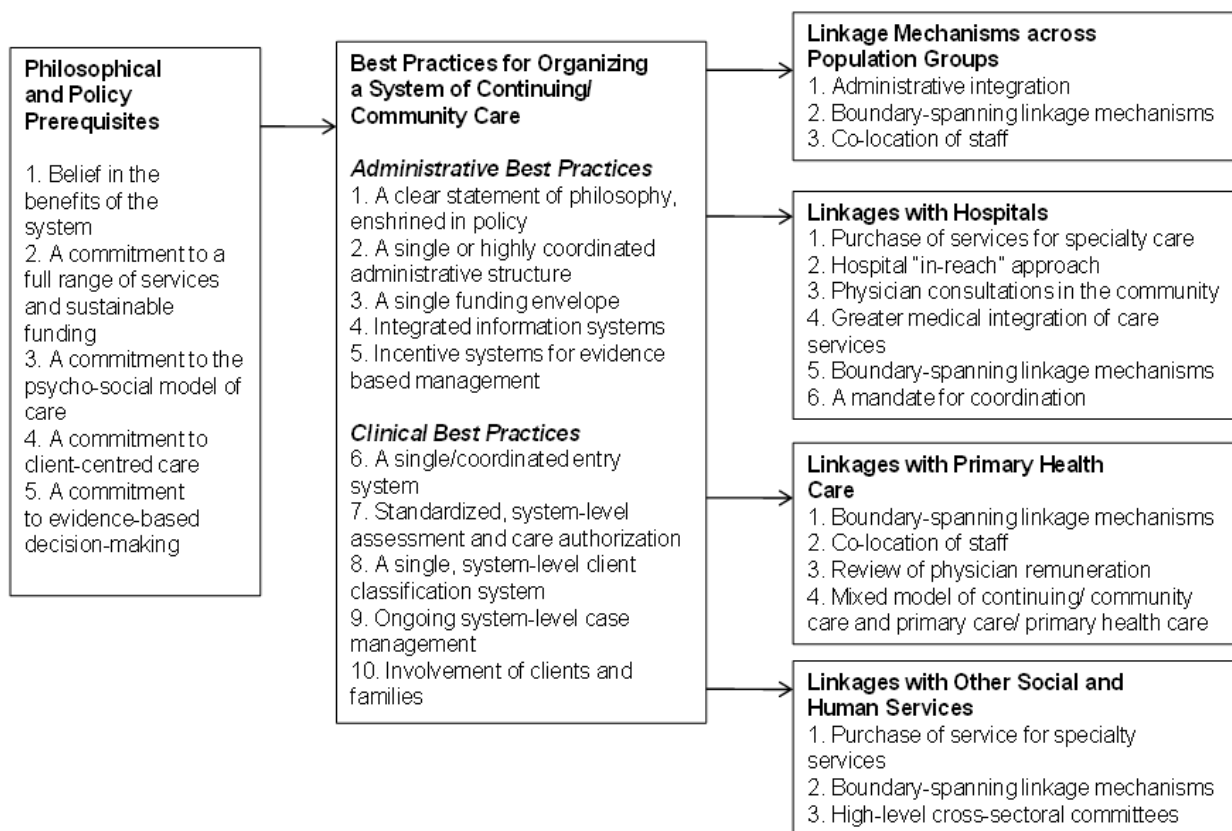
Hollander & Prince (2008)¹² developed a best practices framework for organizing systems of continuing/community services for people with ongoing care needs and their families. One of their four populations of focus was seniors.

Their framework was based on a review of the literature and data from Canadian jurisdictions. The best practices component of the framework was informed by two-hundred and fifty interviews with provincial policy-makers and service providers in Canada. The framework addresses key challenges noted by respondents in organizing seamless, integrated models of care delivery and is comprised of three parts: philosophical and policy prerequisites that underlie ongoing support for integrated systems of care; best practices for organizing service delivery; and boundary-spanning mechanisms for coordination and linkages. This framework was included in the 2009 Vision.

Although the Task Group did not discuss framework details, the framework overall resonated. There was consensus that this would be a good platform for beginning to discuss system characteristics, recognizing not all details may be relevant or appropriate.

¹² Hollander & Prince (2008). Organizing Healthcare Delivery System for Persons with Ongoing Care Needs and their Families. *Healthcare Quarterly*. 11(1). pp.44-54

Hollander and Prince Framework



RECOMMENDATION:

- Leverage the Hollander & Prince (2008) Framework as a starting point for discussions related to the NSM SGS Program **Delivery System Framework**.

LEADERSHIP FRAMEWORK

To build the NSM SGS, dedicated leadership is required. Leadership is required in the form of an oversight body and a leadership team:

Oversight Body

An oversight body will be required to support the implementation of this Strategy. This governance structure should be informed by initiatives like the *Care Connections: Second Curve Committee* and the provincial review of the Regional Geriatric Programs of Ontario. The Task Group discussed principles of shared governance but felt poorly positioned to make recommendations given this concurrent work. In the interim, the Task Group recommends a Project Steering Committee be established under the In-Home & Community Capacity Coordinating Council to advance the Strategy. A Project Steering Committee aligns with the current *Care Connections: Partnering for Health Communities* structure. Project Steering Committee recommendations for IHCC consideration are included in Appendix G. Until LHIN-wide direction is defined, governance models like those developed by the NSM BSS and the NSM Integrated Regional Falls Program could provide insight into initial options for the NSM SGS Program.

NSM SGS Program Leadership Team

Although leadership capacity must be built across the NSM SGS Program, the Program should have a clearly defined, dedicated and sufficiently resourced Leadership Team accountable for Program coordination and oversight. This Team could evolve over time to support the broader integrated regional Seniors Health Program but initial work will focus on the first building block, the NSM SGS Program. As learned from past experience, dedicated leadership is important to success (i.e. with no leadership for the 2009 Vision, the Vision did not move forward as no one was accountable). The work of the Leadership Team will be focused; recognizing the priority for resources must rest in Clinical Services. The initial Leadership Team will consist of the following permanent positions¹³:

- **Regional Seniors Health Program Lead**¹⁴ – this transformational position is key to system integration. Working in partnership with the oversight body, the Program Lead will be responsible for the leadership and operation of the NSM SGS Program with specific responsibilities including: system planning; relationship building; developing and implementing workplans; managing the financial, human and physical resources of the Program; monitoring performance outcomes; and supporting Program communications.
- **Regional Clinical Nurse Specialist, Seniors Health** – this advanced practice nurse will be responsible for clinical programming within the NSM SGS Program, including program planning, implementation and evaluation; development of standards of practice and collaborative pathways; education and mentorship; and development of Communities of Practice.
- **Regional Physician Lead, Seniors Health** – this Geriatric Care Specialist will be responsible for key physician initiatives, including those aimed at physician retention and recruitment as well as the development, implementation and evaluation of physician standards of practice;
- An **Administrative Assistant** – this individual will provide administrative support to the Project Steering Committee as well as the NSM SGS Program Leadership Team; and,
- **Back Office Support** (i.e. Human Resources, Finance, Decision Support, and Information Technology).

“Central leadership must not become a machine itself but empower local SGS service providers.”

RECOMMENDATIONS:

- The In-Home & Community Capacity Coordinating Council will establish a **Project Steering Committee** by the end of June 2014.
- Establish the **Leadership Team** for the NSM SGS Program by fall 2014.

¹³ At the time of Strategy completion, the Regional Clinical Nurse Specialist is in place and recruitment continues for the Physician Lead. Funding for a Physician Lead, Clinical Nurse Specialist, Administrative Assistant and some back office support was included in the 2013/14 NSM SGS Program funding envelope.

¹⁴ This position is currently not budgeted within the 2013/14 NSM SGS Program funding envelope. Funding will be required although it may be possible to find funds through system re-design.

NSM SGS Program: Roles & Function

ROLES

The Task Group identified five key roles of the NSM SGS Program. All the strategic goals within the SGS Program's Quality Framework align with one or more of these roles.

- **Leadership**

System leadership should support strategic planning and priority setting, system coordination, performance monitoring, communication and relationship building. The NSM SGS Program should be a key resource to the NSM LHIN on issues related to frail seniors.

- **Clinical**

Direct clinical service should be the heart of the NSM SGS Program (see below). The clinical function should also include work related to standards of practice, collaborative care plans and care pathways, clinical programming (i.e. dementia, delirium, falls, functional decline, etc.), etc.

- **Education & Mentorship**

The NSM SGS Program should provide education and mentorship to frail seniors and their caregivers, health care professionals, community providers and students. It could be provided through classroom lectures, on-line resources, virtual presentations and one-to-one mentorship and/or teaching opportunities. Development of Communities of Practice will be important to capacity building.

- **Advocacy**

Advocacy should occur daily to foster system change. It could be as straightforward as advocating for a change in medication or as complex as developing proposals and business cases for Program funding.

- **Research & Ethics**

Research should be used to build capacity, inform decision-making, design programs and services and improve outcomes. Ethical situations arise on a regular basis when providing care to frail seniors and should be supported within the NSM SGS Program.

RECOMMENDATIONS:

- Build the NSM SGS Program based on five **key roles**: Leadership, Clinical Service, Education & Mentorship, Advocacy and Research & Ethics.

CLINICAL SERVICE

Clinical Services, or direct patient care, will be the heart of the NSM SGS Program. This Strategy describes Clinical Service based on scope, model and service characteristics.

Scope of the Clinical Services

The NSM SGS Program will support all aspects of frailty however, the Program's Clinical Services will target frail seniors in the four to six range on the Clinical Frailty Scale with the potential for improvement.

	Frailty Continuum	Program Role	Role Description
Pre-Frailty	<i>Prevention</i> <i>Screening & Early Identification</i>	Indirect	Capacity building to promote prevention, reduce risk and support way-finding.
Frailty	<i>Assessment & Diagnosis</i> <i>Treatment (acute, chronic; includes rehabilitation)</i>	Direct & Indirect	- Assessment, diagnosis and treatment. - Capacity building to support assessment, diagnosis, treatment and way-finding.
Frailty Resolved / Unresolvable	<i>Maintenance</i> <i>End-of-Life & Palliative Care</i>	Direct (short-term) & Indirect	- Successfully transition to appropriate team through information sharing and short term follow-up - Capacity building to support geriatric syndromes (i.e. delirium, falls, behaviours, etc.)

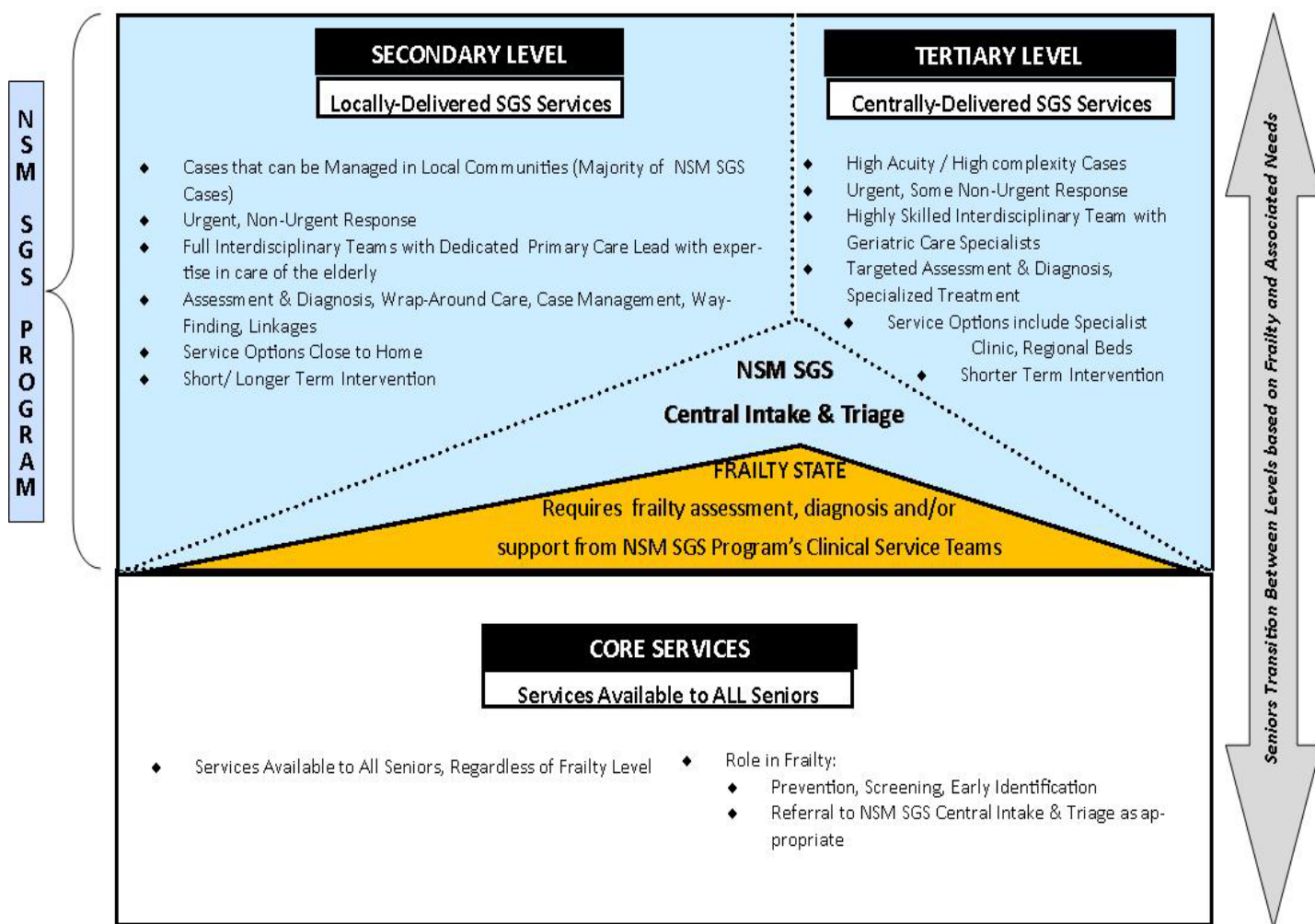
Clinical Service Model

Recognizing that Specialized Geriatric Services are only one of many needs of NSM seniors, the Task Group offers a **working model** for an integrated regional Seniors Health Program, one component of which is the NSM SGS Program. A working model recognizes changes will be required as planning and implementation progresses. It provides structure by outlining services, human resource considerations and key roles while encouraging design flexibility to meet the needs of local communities.

The Model recognizes:

- That the NSM SGS Program's Clinical Services are only one component of a broader integrated regional Seniors Health Program. It recognizes that all seniors need access to support, regardless of frailty. Health service providers support seniors, including frail seniors, on a daily basis within primary care, in Long-Term Care homes, in hospitals and in the community with support from agencies like the NSM CCAC and the NSM Community Support Services Sector.
- That seniors, based on frailty and associated needs, will regularly transition throughout the whole integrated regional Seniors Health Program. The NSM SGS Program's Clinical Services are one partner in care, with the SGS Program design intended to promote collaborative behavior and teamwork.

NSM Integrated Regional *Seniors Health Program* Model



Core Services

Care is provided to seniors on a daily basis by health service providers. Many of these seniors are frail. Services can include Adult Day Programs, in-home supports, respite care and acute care. Care can extend from wellness to end-of-life care and include rehabilitation, way-finding and chronic disease management. Core Services play a key role in addressing the social determinants of health. If not adequately addressed, these factors often contribute to increased frailty amongst seniors. In alignment with second-curve thinking, primary care is the hub of the system. In regard to frailty, Core Services will play a key role in prevention, screening and early identification of frailty.

Frailty State

Most cases of frailty will continue to be assessed and managed at the Core Services level. As a partner in care, the NSM SGS Program can support the Core through capacity building. When there is a need for support from specialized SGS teams, Core Services will transition frail seniors into the NSM SGS Program's Clinical Services. As a partner in care, the SGS teams will work in collaboration with the Core Services to develop and implement a plan of care and transition the senior back to the Core Services when the frailty state has been improved to the extent possible. Transfers are soft, recognizing seniors may need additional support as their frailty and associated needs evolve.

NSM SGS Program's Clinical Services

The NSM SGS Program's Clinical Services will be comprised of three interdependent components:

▪ **Central Intake & Triage**

Central Intake & Triage will support entry into the Secondary and Tertiary Level SGS Services. It will should support way-finding, reduce duplication in data collection, promote information sharing and improve triage by getting the right person to the right place at the right time. Based on a review of existing practices (Appendix H), the following will be key considerations in Central Intake & Triage design:

- A centralized intake model with a single point of entry to all NSM SGS Program Clinical Services;
- A clinical (vs. administrative) intake model led by skilled and knowledgeable clinicians;
- A centralized intake definition inclusive of the following roles: information, referral, screening, intake, decision and scheduling/ registration as appropriate;
- Standardized forms and processes that include consideration of privacy standards and consent requirements.

"A widely advertised number people can call to talk to a live human being. It is frustrating to wait and wait while a voice tells you that your call is important"

The NSM LHIN's System Navigation Coordinating Council will be engaged and, where possible, partnerships will be leveraged (i.e. Health Links, NSM CCAC, Waypoint, existing SGS programs).

▪ **Secondary & Tertiary Levels**

	Secondary Level	Tertiary Level
Also known as...	<i>Locally-Delivered SGS Services</i>	<i>Centrally-Delivered SGS Services</i>
Description	Locally-Delivered SGS Services will reduce the burden of travel on frail seniors. These teams will be the first line of defense in the majority of cases referred by the Core Services. They will support capacity building within local communities and create strong successful partnerships with area providers.	Centrally-Delivered SGS Services will provide support to cases that cannot be managed by Locally-Delivered SGS Services. This team will work in close partnership with Locally-Delivered SGS Services.
Target Population	Cases that can be managed using the resources and skills available within the Local SGS Teams	High acuity, high complexity cases requiring Geriatric Care Specialist involvement
Response Time	Urgent, non-urgent response available including support for Emergency Departments and Long-Term Care homes, with consideration for EMS.	Urgent, some non-urgent response available

	Secondary Level	Tertiary Level
Team Composition & Partnerships	- Teams will be resourced to meet the needs of the local community. Team members will include, but not be limited to: - Nurses and allied health professionals; - Dedicated Primary Care Lead with expertise in care of the elderly; - Mental Health & Addictions; - NSM CCAC - Partnership with Centrally-Delivered SGS Services Team - Strong partnership with Primary Care (shared care model) - Strong partnership with Core Services including social determinants of health - Access to Francophone, Aboriginal resources and others as required to support culturally and linguistically sensitive care - Expedited access to programs including: - NSM CCAC - First Link - Falls & Exercise Programs - BSS Mobile Support Teams	- Highly Skilled Interdisciplinary Team, including: - Nurses and allied health professionals; - Geriatric Care Specialists; - Mental Health & Addictions; - NSM CCAC - Partnership with Locally-Delivered SGS Service Teams - Strong partnership with Primary Care (shared care model) - Strong partnership with Core Services including social determinants of health - Access to Francophone, Aboriginal resources and others as required to support culturally and linguistically sensitive care - Expedited access to programs including: - NSM CCAC - First Link - Falls & Exercise Programs - BSS Mobile Support Teams - Behaviour Intervention Response Team (BIRT)
Services	- Service options close to home: - Ambulatory program – one stop shopping where possible in partnerships with local medical and non-medical providers - Outreach across the continuum - Virtual where possible - Emergency Department - Clustered dedicated local inpatient beds (existing vs. net new) focused on seniors' health.	- Regionally coordinated programs: - Regional SGS Clinic - Regional SGS Beds, including inpatient Geriatric Psychiatry and Geriatric Assessment & Treatment Unit (GATU) - Support for Locally-Delivered SGS Service Teams, including: - Virtual support - Regularly scheduled visits to local communities to support ambulatory programs and outreach as appropriate
Roles	- Assessment and diagnosis - Treatment – wrap-around care, linkages, way-finding, case management - Capacity building	- Targeted assessment and diagnosis - Specialized Treatment - Capacity Building
Length of Stay	Short term and longer term as required to complete plan of care	Short term with timely transition to Locally-Delivered SGS Service Teams

Characteristics of the Clinical Service

- “nothing about me, without me”
- Care is provided by interdisciplinary teams with expertise in care of the elderly.
- Primary care is a key partner in every case (shared care model).
- To optimize resources, services are negotiated to have a beginning and end however transfers are soft, recognizing seniors may need additional support as frailty and associated needs evolve.
- Comprehensive geriatric assessment provides the foundation for care planning and treatment, as does timely communication and quality care.
- Care is supported by standardized eligibility criteria, processes, policies, care pathways and programs. Flexibility exists to ensure the needs of frail seniors are met.
- Way-finding is a key component of clinical services, as is supporting successful transitions and building self-management capacity.
- Care includes creating linkages and striving to address social determinants of health.
- Appropriate technology connects programs and providers.
- Timely response is available for urgent and non-urgent cases.
- Care is focused on need and is not dependent on catchment area or postal code.
- Business hours meet the majority of patient needs.

RECOMMENDATIONS:

- Adopt the *scope, Model and characteristics* of the NSM SGS Program.

Key Enablers

GERIATRIC CARE SPECIALISTS

Geriatric Care Specialists are integral to the medical and psychiatric care of frail seniors. The most urgent threat currently facing the NSM SGS Program is the retention and recruitment of Geriatric Care Specialists.

NSM Geriatric Care Specialists describe a system with inadequate Specialist resources and limited access to skilled interdisciplinary teams. They note increasing caseloads and case complexity. They also note that frail seniors are having increasing difficulty accessing primary care for follow-up. As a result, they describe a crisis management approach to care with cases defaulting into area Emergency Departments, often resulting in avoidable hospital admissions and ALC stays. Compounding the situation is a provincial funding model that is both inadequate and inflexible in meeting the needs of these Specialists.

With the population of seniors continuing to grow, retention and recruitment of Geriatric Care Specialist is the highest priority of this Strategy. Specialists identify five key actions of support:

1. **Stabilize funding.** Advocacy with the Ontario Medical Association, changes to funding models and targeted funding is required. Funding provided from host organizations must also be stable. This urgent threat to Specialists must be addressed by October 2014.
2. Establish skilled, dedicated and stable interdisciplinary **teams** within an appropriately designed NSM SGS Program.

3. **Build capacity** in a cohort of individuals passionate about seniors' health (i.e. primary care physicians, nurses, allied health professionals, students, etc.). Appropriate remuneration must be provided to support Specialists to play a leading role in education and mentorship.
4. Create **system efficiencies** through opportunities inherent in technology, streamlined processes and standardized approaches to care.
5. Develop locally-delivered services and programming that targets **early intervention**.

To support retention, the NSM SGS Program will be built at a pace that is manageable by the Specialists and considers their interests and strengths. Consideration will be given to workload (volume and complexity), building partnerships and leveraging resources where possible. Planning will be sensitive to other physician partners as shifts in Specialist function will affect their care, workload and funding.

RECOMMENDATIONS:

- The NSM LHIN partner with key stakeholders, including the Integrated Health Human Resource Coordinating Council, the Ontario Medical Association and existing Geriatric Care Specialists, to develop and implement a **plan to retain and recruit** Geriatric Care Specialists.
- Finalize recruitment of the **Physician Lead, Seniors Health**, with a contract based on stable funding.

LEVERAGING EXISTING RESOURCES

As noted in the Current State, the NSM LHIN collected information in March 2014 to create a current state SGS inventory for the region. In reviewing this information, the Task Group identified some high-level system re-design opportunities (i.e. leveraging promising practices, standardizing care, reduction in service duplication, etc.).

To support next steps, the Task Group requests a comprehensive SGS inventory be completed as well as a fulsome review of targeted SGS programs and services to identify and understand:

- The original mandate and current performance of existing SGS programs and services;
- Possible system overlap, duplication and gaps;
- Current service delivery models, including re-design barriers and opportunities;
- Funding sources and opportunities for re-design within the various funding envelopes;
- Leading practices; and,
- Program effectiveness, including the patient's experience of the program as a component of the broader health system.

Work related to this review must be clearly articulated, sufficiently resourced and transparent. The process for data collection and analysis must be robust. Timelines must balance the need for results with the time required by providers to gather data.

RECOMMENDATIONS:

- Complete a comprehensive SGS inventory of NSM programs and services.
- Complete a comprehensive review of targeted seniors programs by September 2014 to inform system re-design opportunities.
- Explore and address early/quick-win system re-design opportunities (i.e. leveraging leading practices; building partnerships/collaborations; new standards/ processes)

TECHNOLOGY

Technology is an important enabler as it supports communication and connectivity. Within the current system, seniors are frustrated with repeating information and with the lack of communication between providers. Providers blame ineffective communication on avoidable Emergency Department visits and are frustrated with antiquated referral processes and the lack of timely information.

Through technology there is as an opportunity to improve information sharing, streamline referral processes, support way-finding and enhance team collaboration. In addition to the benefits of an electronic health record, the Task Group discussed the use of technology in producing reports, automatically generating referrals, and creating alerts when seniors from the NSM SGS Program's Clinical Services enter the system. With programs like the Ontario Telemedicine Network (OTN) and Telehomecare, and the emergence of new initiatives like personal videoconferencing, the ability to support frail seniors to remain at home is increasing. During planning, existing programs will be explored and leveraged and new opportunities will be identified (i.e. 211 and nsmhealthline.ca to support way-finding; Home for Life program).

"To tell and re-tell our information over and over again is terrible ... and we are always afraid we might miss something"

RECOMMENDATIONS:

- Develop partnerships to leverage existing and emerging technology AND identify new opportunities, including work underway across NSM Health Links related to an electronic health record.
- Consider the role of technology in all aspects of planning, including the human resource and equipment components required to support start-up and ongoing operation.

COMMUNICATION

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:

- Between the NSM SGS Program and the frail senior;
- Between the NSM SGS Program and the frail senior's circle of care;
- Between the NSM SGS Program and key stakeholders (i.e. Project Steering Committee, NSM LHIN, health service providers and provider agencies; the public, etc.)
- Within the NSM SGS Program team, including physicians.

Communication will be timely and will be designed to meet the needs of the target population. The push of information (communication) will be balanced with the need to pull information (engagement) to ensure the voice of the customer drives planning. Consideration will be given to leveraging features of the experience based co-design methodology as currently being investigated and developed by the Change Foundation.

“...continue these conversations with seniors and caregivers to help give them a voice in changing their circumstances ... and exchange information at the same time”

In addition to communication and community engagement related to the NSM SGS Program, consideration will also be given to a communication strategy related to this **Strategy for a Specialized Geriatric Services Program in North Simcoe Muskoka** document.

RECOMMENDATIONS:

- Develop a robust communication and community engagement strategy for the NSM SGS Program.
- The NSM LHIN develop and implement a communication strategy related to this **Strategy for a Specialized Geriatric Services Program in NSM** document, with implementation to commence upon endorsement of the Strategy by the In-Home & Community Capacity Coordinating Council.

Risks & Mitigation Strategies

Risk	Impact	Mitigation Strategy
Retention & Recruitment of Geriatric Care Specialists	▪ An inability to retain current Specialists and recruit additional physicians would significantly undermine NSM SGS Program development and implementation.	▪ Develop and implement a plan to retain and recruit Geriatric Care Specialists.
Multiple Initiatives & Competing Priorities	▪ With many initiatives underway locally and provincially it may be difficult to focus time and attention on one project. Individuals are becoming increasingly stretched with system priorities competing against organization priorities. ▪ Progress in some initiatives may influence Strategy recommendations and directions.	▪ Remain abreast of current initiatives and competing priorities. ▪ Engage partners in defining priorities and directions. ▪ Balance the need for progress with the undue stress placed on partners – quick wins, phased-in approach.
Concurrent LHIN & Provincial Initiatives	▪ As outlined in Appendix C, there are many LHIN and provincial initiatives that will impact Strategy recommendations, including:	▪ Remain abreast of initiative progress. ▪ Where possible, engage in initiative work (i.e. Health Link Community of Practice,

	○ Health Links ○ <i>Care Connections: Second Curve Committee</i> ○ Provincial Regional Geriatric Programs review	RGP review, etc.) ▪ Establish Project Steering Committee as soon as possible.
Expectations & Access	• With the demand being so high and the need so great, there will be a need to manage expectations regarding the NSM SGS Program. • Inappropriately timed implementation could result in frustrated consumers and NSM SGS Program team members, including Geriatric Care Specialists	• Develop and implement a communication and engagement strategy. • Apply a phased-in approach to planning, achieving success before expansion.
Culture & System Change	• New approaches to care and care delivery, changes in processes, adoption of new standards and components of system re-design can cause stress. Increased stress can create frustration and challenge progress.	• Leverage change management strategies. • Develop and implement a communication and engagement strategy. • Apply a phased-in approach to planning, achieving success before expansion.
Health Human Resources	• NSM SGS Program implementation will require access to a pool of skilled clinicians. This pool currently does not exist. It will take time to build regional capacity.	• Regional CNS to develop orientation program. • Early development and implementation of a regional education and mentorship strategy within the NSM SGS Program. • Engage the Integrated Health Human Resource Coordinating Council in development of a HHR strategy.
Funding	• Funding is a core requirement of NSM SGS Program success. Insufficient and unstable funding will compromise planning and implementation. • The NSM SGS Program must live within its means and strive for sustainability to ensure ongoing success.	• Leverage existing resources. • Advocate for net new funding as appropriate. • Advocate for protected and stable funding and flexible compensation mechanisms.

Interdependence within the broader Integrated Regional Seniors Health Program	The NSM SGS Program is just one component of the broader NSM Integrated Regional Seniors Health Program. This Seniors Health Program is interdependent meaning that changes in one area will have a ripple impact on others. Likewise, gaps in service in one area will impact the function and outcomes of the other.	- Consider impact on Core Level of Seniors Health Model as NSM SGS Program planning progresses. - Advocate for the development of a broader integrated regional Seniors Health Program for NSM.
Action & Momentum	Upon completion of the Strategy there will be a need to continue the momentum of the Task Group and begin to address recommendations. With the Project Steering Committee not likely in place until June and the NSM SGS Program Leadership Team not expected to be in place until fall, there will be a gap in activity. This gap could de-stabilize the project given the current threats.	The NSM LHIN to continue to provide leadership and advance planning and implementation until the oversight body and Leadership Team are in place.
Health Equity Impact Assessment	In the development of programs there are intended and unintended consequences of program planning and implementation on vulnerable or marginalized groups. A high level Health Equity Impact Assessment (HEIA) was completed April 2014 related to this Strategy (Appendix I) .	- Address issues identified during the HEIA during planning. - Review the HEIA on an annual basis and revise as appropriate.

RECOMMENDATIONS:

- Adopt NSM SGS Program *risks and mitigation* strategies.

Directional Recommendations

The *Strategy for a Specialized Geriatric Services Program in North Simcoe Muskoka* provides a long-term vision and a short-term strategy for action. As part of the short-term strategy for action, the Seniors Strategy Task Group makes the following directional recommendations:

Priority Ranking	Action	Lead	Timelines
Within the First 6 Months (May 2014 – October 2014)			
1	Retain and recruit Geriatric Care Specialists : - Finalize recruitment of the Physician Lead, Seniors Health and base the contract on stable funding. - Partner with key stakeholders, including the Integrated Health Human Resource Coordinating Council, the Ontario Medical Association and existing Geriatric Care Specialists, to develop and implement a plan to retain and recruit Geriatric Care Specialists, including stabilizing funding and building Clinical Services.	Lead TBD NSM LHIN	May 2014 Oct. 2014
2	Develop and implement a communication strategy related to this <i>Strategy for a Specialized Geriatric Services Program in NSM</i> document, with implementation to commence upon endorsement of the Strategy by the In-Home & Community Capacity Coordinating Council.	NSM LHIN	May 2014
3	Establish a Project Steering Committee under the In-Home & Community Capacity Coordinating Council.	IHCC/ NSM LHIN	June 2014
4	Adopt the key initial components of the NSM SGS Program as identified within the Strategy document: - Adopt the NSM SGS Program core concepts. - Adopt the NSM SGS Program Quality Framework. - Leverage the Hollander & Prince (2008) Framework as a starting point for discussions related to the NSM SGS Program Delivery System Framework. - Adopt the scope, model and characteristics of the NSM SGS Program. - Build the NSM SGS Program based on five key roles : Leadership, Clinical Service, Education & Mentorship, Advocacy and Research & Ethics. - Adopt risks and mitigation strategies. - Begin to develop a robust communication and community engagement strategy	IHCC	June 2014
5	To leverage existing resources : - Complete a comprehensive review of targeted seniors programs to inform system re-design opportunities. - Complete a comprehensive SGS inventory of NSM programs and services.	NSM LHIN Project Steering	Sept. 2014 Oct. 2014

		Committee	
6	Establish the Leadership Team for the NSM SGS Program (Regional Seniors Health Program Lead; Regional Clinical Nurse Specialist, Seniors Health; Physician Lead, Seniors Health; Administrative Assistant).	Project Steering Committee	October 2014
Within 6 – 12 Months (November 2014 – April 2015)			
	Develop standardized evaluation metrics and outcome measures in alignment with the NSM SGS Program Quality Framework that reflect the patient perspective.	Project Steering Committee	January 2015
	Develop a two year workplan for the NSM SGS Program	Project Steering Committee	January 2015
Ongoing			
	Begin to explore and address early/quick-win system re-design opportunities (i.e. leveraging leading practices; building partnerships/collaborations; new standards/processes)	Leadership Team, Project Steering Committee	ASAP and Ongoing
	In regard to technology : ▪ Develop partnerships to leverage existing and emerging technology AND identify new opportunities, including work underway across NSM Health Links related to an electronic health record. ▪ Consider the role of technology in all aspects of planning, including the human resource component required to support start-up and ongoing operation.	Leadership Team, Project Steering Committee	Ongoing

Conclusion

The ***Strategy for a Specialized Geriatric Services Program in North Simcoe Muskoka*** evolved within a culture of collaboration. As senior leaders and strategic thinkers, the Task Group came together with the intent to improve the patient experience. The Task Group was united in the belief that the system must be re-designed to better support frail seniors. There was also consensus that the time for action is now.

To improve the patient experience, three key recommendations underpin this Strategy:

- NSM will take immediate action to retain and recruit Geriatric Care Specialists.
- An integrated regional SGS Program will be established in NSM targeting frail seniors and focused on improving patient outcomes, building capacity and fostering system change (the first building block of a broader integrated regional Seniors Health Program).
- NSM will work to develop a broader integrated regional Seniors Health Program, of which the NSM SGS Program will be one component.

The work of the Task Group is a first step toward action. The NSM LHIN is at a critical juncture with future success hinging on immediate action. The next six months are critical. The momentum of the Task Group must continue and Strategy recommendations must be operationalized. The greatest risk is that planning becomes the enemy of action.

Future work must build on the collaborative approach established by the Seniors Strategy Task Group. We must move toward a second curve healthcare system. The need for change is evident, the environment is ready and the timing is right. We must leverage the successful structures, processes, and programs already in place. We must join to mobilize efforts and make difficult decisions when required in order to champion the care of our frail seniors.