

Strategy for a Specialized Geriatric Services Program in North Simcoe Muskoka

MAY 7, 2014

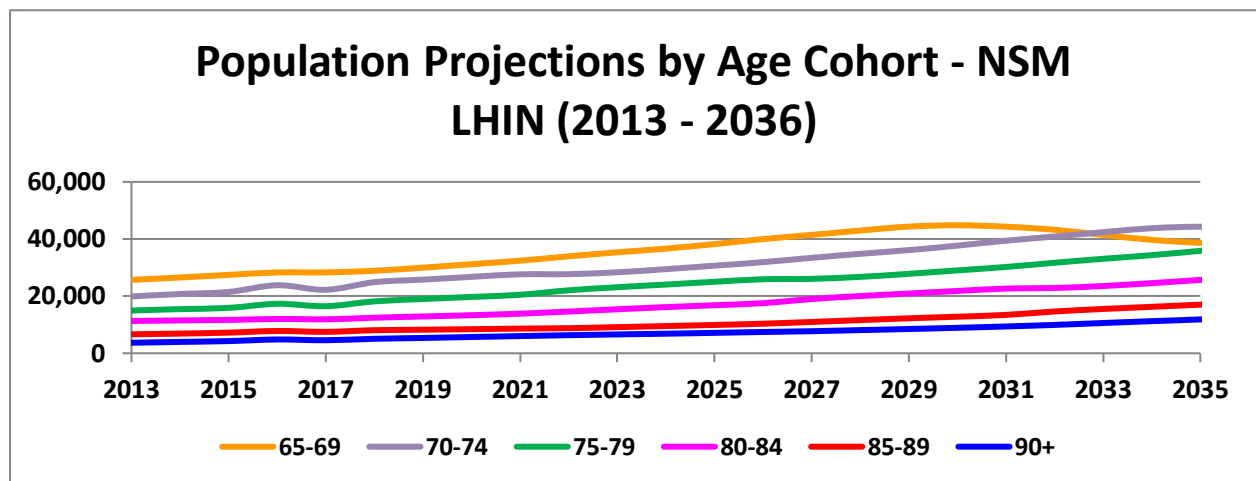
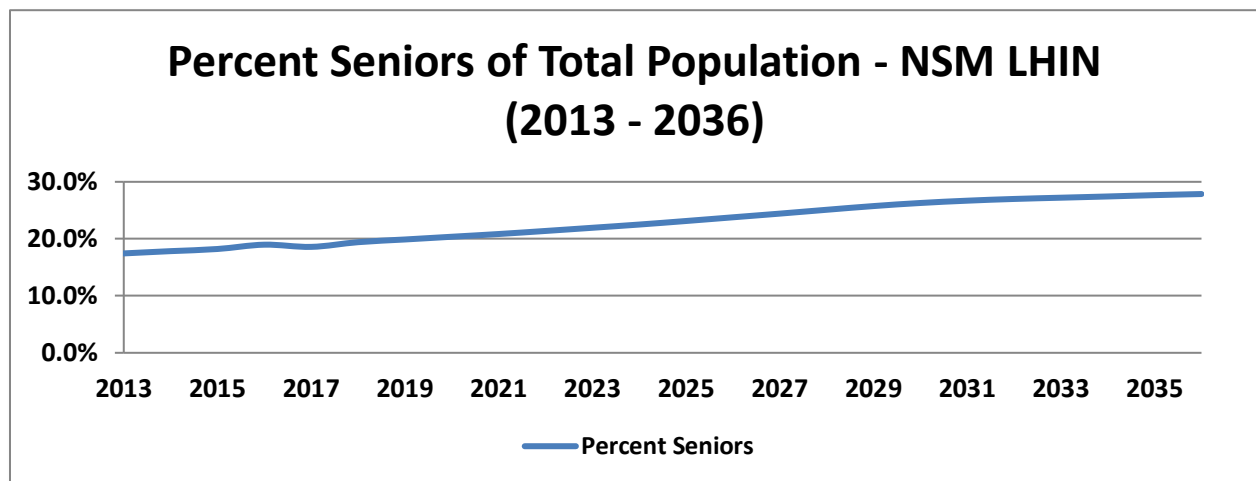
**Prepared by:
Seniors Strategy Task Group**

Appendix Package

APPENDIX A: DATA

Demographics

- Based on 2011 Population Estimates from the Ministry of Finance, approximately 40,665 individuals in NSM are age 65-74 and 33,360 are 75+. In total, approximately 74,025 are age 65+, representing 16.9% of the NSM population (Ont. avg. 14.6%).
- Based on most recent Ministry of Finance Population Projections it was projected that there were 82,200 age 65+ in NSM in 2013 representing 17.4% of the population. This number is expected to more than double over the next 20 years to 176,630 or 27.8% of the population by 2036.

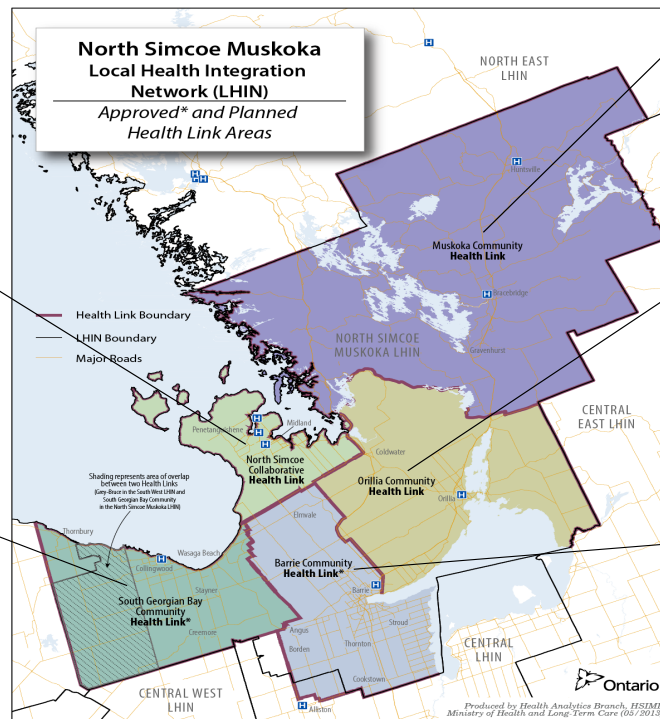


Midland / Penetanguishene & Area

- 5,305 age 65-74
- 4,325 age 75+
- 65+ = 9,630
- **20.4%** of the population is 65+
- 65+ in Midland/ Penetang area = **12.8%** of the NSM 65+ cohort

Collingwood & Area

- 8,015 age 65-74
- 5,940 age 75+
- 65+ = 13,955
- **23.3%** of the population is 65+
- 65+ in Collingwood area = **18.5%** of the NSM 65+ cohort



Source: Census, 2011

Muskoka

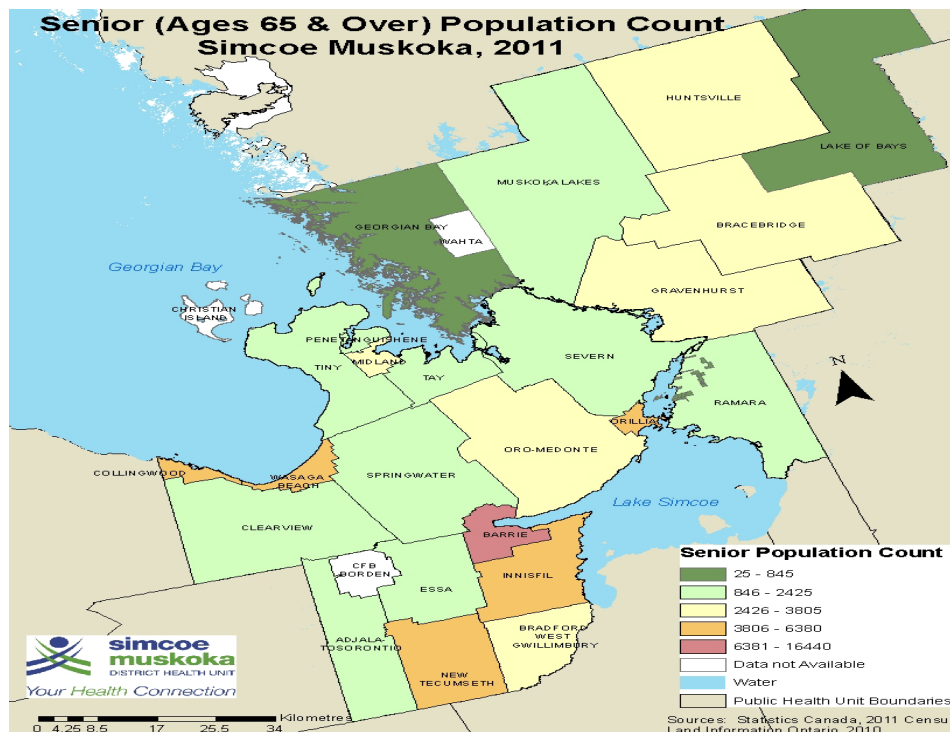
- 6,855 age 65-74
- 5,775 75+
- 65+ = 12,630
- **21.7%** of the population is 65+
- 65+ in Muskoka = **16.8%** of the NSM 65+ cohort

Orillia & Area

- 7,695 age 65-74
- 6,270 age 75+
- 65+ = 13,965
- **19.1%** of the population is 65+
- 65+ in Orillia area = **18.5%** of the NSM 65+ cohort

Barrie & Area

- 13,495 age 65-74
- 11,665 age 75+
- 65+ = 25,160
- **12.3%** of the population is 65+
- 65+ in Barrie area = **33.3%** of the NSM 65+ cohort



Note:

Map source is SMDHU therefore region extends outside usual NSM LHIN boundaries

Francophone Population

- Based on 2006 Census data, 2.8% (11,960) of the total NSM population identify French as their mother tongue (Ont. avg. 4.4%). This is highest in the Midland/Penetanguishene area where 7.4% (3,375) identify French as mother tongue.
- There are 3 major francophone populations in NSM:
 - Tiny, Tay and Midland areas have a long history of francophone families
 - Barrie tends to be home to younger families who have immigrated from northern Ontario and Quebec.
 - The military population, is less bilingual, younger and are usually transferred to the region from Quebec.
- The *2009 Vision* indicated NSM was home, at the time, to approximately 2,000 francophone seniors. The document revealed poor system understanding of francophone needs and little or no data regarding francophone health, French Language Services or French-speaking health professionals. It was noted that the francophone community wanted equitable access to linguistically and culturally respectful service, not just access to interpreters and translators. As one of the two official languages in Canada this right is upheld within Ontario's 1986 French Language Services Act.

Aboriginal Population

- Based on 2006 Census data, 3.3% (13,770) of the total NSM self-identify as aboriginal (Ont. avg. 2.0%). These individuals live on and off-reserve with 4 reserves in the NSM region.
 - Midland/ Penetanguishene region = 11.1% (5,090) self-identify; 4.2% in Orillia, 2.5% in Muskoka.
- Self-identification is an recognized issue as many aboriginal people do not self-identify.
- It is unclear how many aboriginal seniors live in NSM
- In the *2009 Vision* document it was noted that:
 - First Nation seniors have higher rates of disability (58.5% vs. 46.5% non-aboriginal) and a higher incidence of arthritis, respiratory, cardiac and circulatory diseases.
 - 30% of First Nation men and 32% of women live with diabetes (14% and 11% non-aboriginal respectively).
- In November 2013, the Health Council of Canada published, Canada's Most Vulnerable: Improving Health Care for First Nations, Inuit and Metis Seniors. Within that report it indicated that the population of seniors is growing, expected to increase from 5% (2006 Census) nationally to 6.5% of the total aboriginal population by 2017. This report identified many factors contributing to the health complexity inherent in the population (i.e. diet changes, finances, the impact of residential schools, out-migration, etc.) and suggested services for Aboriginal seniors should start at age 55 due to the earlier onset of chronic conditions and shorter life expectancy. Of note, informants to the report stressed that despite challenges, many seniors are resilient and serve as primary caregivers for grandchildren as well as cultural touchstones in their communities. The following were identified as key concerns:

- First Nations seniors on-reserve are not receiving the home care and continuing care support, including long-term care, that they need to stay in their communities.
- The needs of the Métis population are not well understood or addressed with Metis unable to access First Nation programs.

Chronic Disease

- The *2009 Vision* referenced Ontario's Health System intelligence Project (2007) which found that in NSM:
 - 49% of seniors were living with 2 or more of the following conditions (Ont. avg. 46%): Diabetes, Depression, heart disease, Hypertension, Cerebrovascular Accidents (CVA), Chronic Obstructive Pulmonary Disease (COPD) and/or arthritis. In relation to provincial averages:
 - Arthritis/Arthritis-related conditions - fewer visits with a family physician (age 65-74) but a higher rate of Emergency Department visits, hospitalizations and deaths (all age 75 +)
 - Hypertension and Diabetes - fewer visits with a family physician but a higher rate of Emergency Department visits, hospitalizations and deaths
 - Depression - twice as many family physician visits, much fewer Emergency Department visits and hospitalizations but slightly more deaths (age 75+)
 - COPD, CVA, Congestive Heart Failure, Malignant Neoplasms - more family physician visits, Emergency Department visits, hospitalizations and deaths
- According to data currently posted on the Simcoe Muskoka District Health Unit website, the prevalence, rate of hospitalization and risk of death from COPD, Diabetes, Ischemic Heart Disease, Hypertension and CVAs all increase significantly with age. For example:
 - Deaths from COPD at age 75+ were >4x the rate for those 65 to 74 years of age and >50x the rate for those 45 to 64 years of age.
 - Hospitalizations for COPD for those 75+ were >2x the rate for those between 65 and 74 and >10 times higher than those aged 45 to 64.
 - Diabetes-related death for age 75+ was >3x the rate for those 65 to 74 years of age and >18x the rate for those 45 to 64 years of age.
- In a letter from the Alzheimer Society of Ontario to the NSM LHIN CEO in June 2013:
 - In 2012 NSM was home to 7,570 individuals with Dementia. By 2020 this number is expected to grow to 10,340 (37% increase). NSM will have the third highest rate of growth in the province.
 - >90% of those living in the community with dementia have two or more coexisting medical conditions.
 - It was indicated that Dementia lacks a comprehensive disease management strategy. There was a request that the NSM Integrated Health Service Plan (IHSP): specifically acknowledge specialized training in dementia for both

professionals and family caregivers; and provide more explicit plans to address the needs of persons with dementia and caregivers.

SIMCOE MUSKOKA HEALTHY COMMUNITIES PARTNERSHIP
SIMCOE MUSKOKA COMMUNITY PICTURE

Table 4-1: Leading Causes of Death of Residents, by Age Group
Simcoe Muskoka, 2000 to 2005 (Combined)

Age Group	Number of Deaths	Leading Causes of Death (%)
<1 year	115	Perinatal conditions (56%) Congenital anomalies (23%)
1 – 19 years	138	Transport crashes (40%) Cancer of lymph, blood & related (7%) Suicide (6%)
20 – 44 years	814	Transport crashes (13%) Suicide (12%) Ischaemic heart disease (8%)
45 – 74 years	7,443	Ischaemic heart disease (17%) Cancer of lung and bronchus (14%) Cancer of the colon, rectum & anus (5%)
75+ years	12,569	Ischaemic heart disease (21%) Cerebrovascular diseases (9%) Dementia & Alzheimer's disease (7%) Chronic lower respiratory disease (6%)

Data source: Ontario Mortality Data [2000 to 2005], Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: [May 28, 2010].

Emergency Department Utilization

- Between 2010 and present, seniors accounted for 22.4% of all NSM ED visits. 9.7% by ages 65-74 and 12.7% by ages 75+ . At CGMH and MAHC seniors accounted for >25% of ED visits.
 - As acuity increases (lower CTAS value), seniors comprise an increasing proportion of the volumes. In NSM:
 - CTAS 1 volumes - 39.7% were seniors
 - CTAS 2 - 31.0%
 - CTAS 3 - 26.4%
 - CTAS 4 - 16.3%
 - CTAS 5 - 16.6%

**Table 4-3: Leading Causes of Emergency Visits of Residents, by Age Group
Simcoe Muskoka, 2003 to 2009 (Combined)**

Age Group	Number of Emergency Visits	Leading Causes <i>ICD-10 Chapter</i>
<1 year	4,577	Diseases of Respiratory System (34%) Certain Infectious Diseases (12%) Injuries & Poisonings (9%) Diseases of Digestive System (7%)
1 – 9 years	25,699	Diseases of Respiratory System (30%) Injuries & Poisonings (23%) Diseases of the Ear (10%) Certain Infectious Diseases (10%)
10 – 19 years	31,379	Injuries & Poisonings (38%) Diseases of Respiratory System (17%) Certain Infectious Diseases (5%)
20 – 44 years	76,161	Injuries & Poisonings (26%) Diseases of Respiratory System (12%) Diseases of Musculoskeletal System (7%) Diseases of Digestive System (7%)
45 – 64 years	57,090	Injuries & Poisonings (23%) Diseases of Respiratory System (11%) Diseases of Musculoskeletal System (9%) Diseases of Digestive System (7%)
65 – 74 years	19,748	Injuries & Poisonings (18%) Diseases of Respiratory System (11%) Diseases of Circulatory System (10%) Diseases of Musculoskeletal System (8%)
75+ years	26,632	Injuries & Poisonings (17%) Diseases of Circulatory System (13%) Diseases of Respiratory System (10%) Diseases of Digestive System (7%)

Data source: Ambulatory Visits [2003-2009], Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: [December 2010].

Hospital Utilization

- The leading cause groups of acute length of stay days in NSM hospitals between 2010-2013. In many cases there is an annual improvement in volumes over this period (i.e. Acute Myocardial Infarction, Chronic Obstructive Pulmonary Disease and Bronchiectasis) and in other cases there is an annual increase in volumes (i.e. Other Disease of the Urinary System)

Lead Cause Group - NSM LHIN Patients ≥65	2010 Acute L	2011 Acute L	2012 Acute L	2013 Acute L
(054) CHRONIC OBSTRUCTIVE PULMONARY DISEASE AND BRONCHIECTASIS	7,339	7,121	6,876	4,293
(114) OTHER SYMPTOMS, SIGNS AND ABNORMAL CLINICAL AND LABORATORY FINDINGS	5,528	4,856	4,828	4,066
(044) HEART FAILURE	5,302	4,666	4,394	3,969
(045) CEREBROVASCULAR DISEASES	3,939	3,148	3,856	2,525
(040) ACUTE MYOCARDIAL INFARCTION	4,009	3,160	3,523	2,769
(118) FRACTURE OF FEMUR	3,035	3,506	4,032	2,790
(120) OTHER INJURIES	2,960	3,291	3,302	2,221
(015) OTHER MALIGNANT NEOPLASMS	3,421	3,446	2,505	1,979
(050) PNEUMONIA	2,671	2,680	3,613	2,346
(004) SEPTICAEMIA	2,752	2,285	2,879	2,210
(093) OTHER DISEASES OF THE URINARY SYSTEM	1,900	2,554	2,735	2,826
(130) OTHER FACTORS INFLUENCING HEALTH STATUS AND CONTACT WITH HEALTH SERVIC	2,817	2,669	2,120	1,838
(043) CONDUCTION DISORDERS AND CARDIAC ARRHYTHMIAS	2,368	2,732	2,361	1,758
Grand Total - All Acute IP Admissions	98,837	95,448	97,775	76,162
Total Top Leading Causes	48,041	46,114	47,024	35,590
% Total Top Leading Causes	48.6%	48.3%	48.1%	46.7%

- **Mental Health:**
Between 2010-2013 we see increases in the number of admissions for seniors and average shorter lengths of stay:

2010 – 164 admissions, 8003 total days, average LOS 48.8

2011 – 170 9062 53.3

2012 - 179 4959 27.7

2013 - 97 1645 17.0

- **Falls:**
Between 2009-2012 we see increasing number of admissions due to falls:

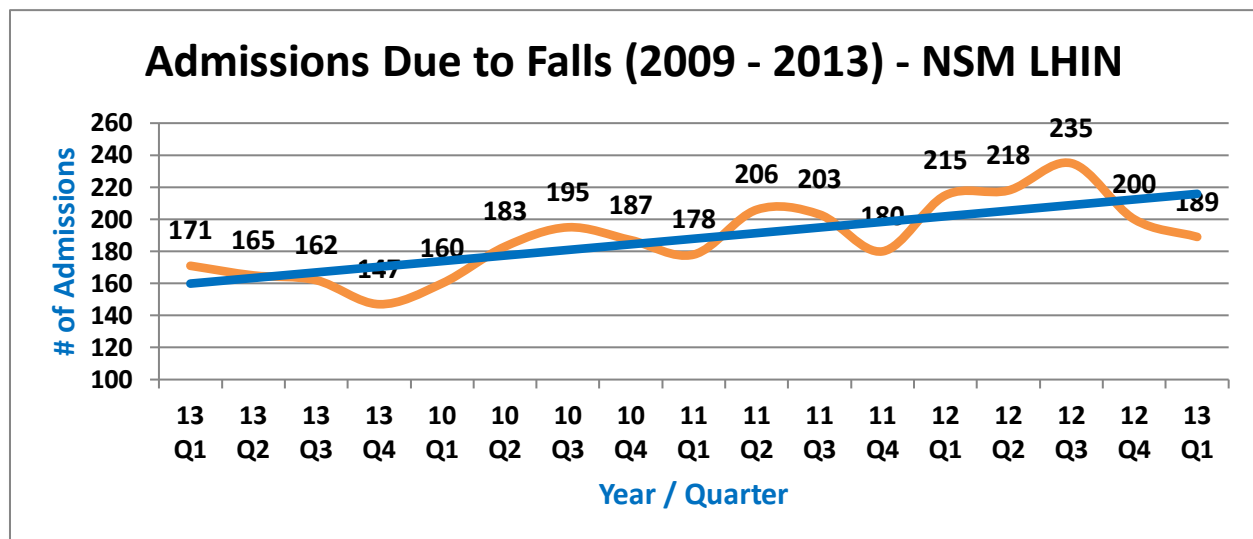
2009 – 645 admissions, 3.6% of provincial total of falls admissions

2010 - 725 3.7%

2011 - 767 3.9%

2012 - 868 4.1%

Of note, according to Osteoporosis Canada, the current one year mortality rate following a hip fracture is 20-24% for women and 34% for men (overall average 25%). The rate is higher in LTCH residents at 39%.



Alternate Level of Care

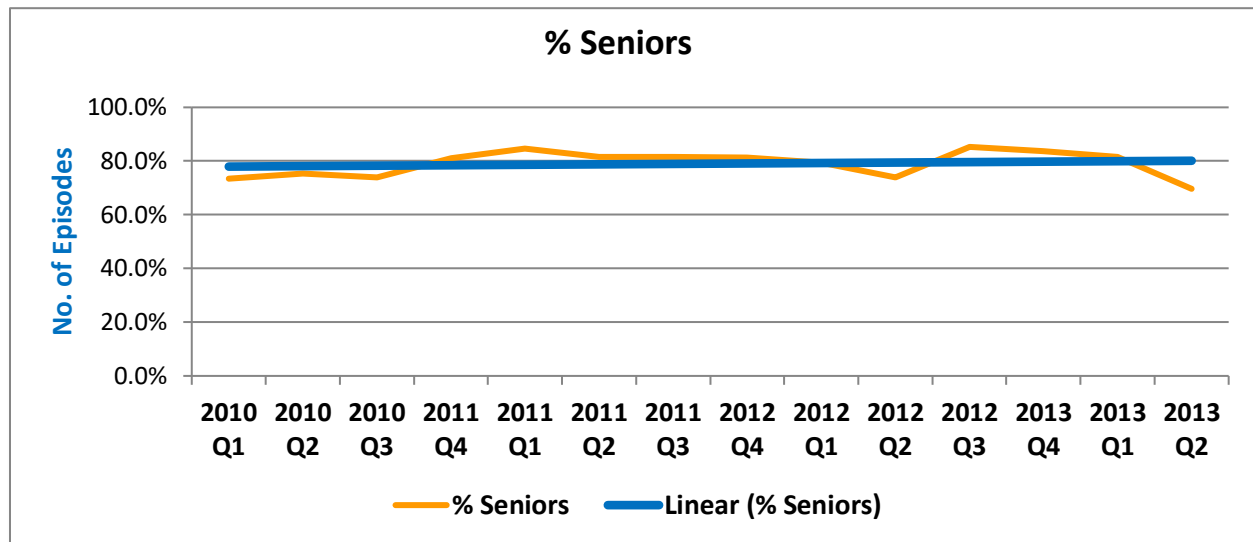
- The leading cause groups of Alternate Level of Care (ALC) length of stay days in NSM hospitals between 2010-2013. Dementia, Alzheimer's Disease, Other Mental and Behavioural Disorders accounted for 20% of all days.

Lead Cause Group - NSM LHIN Patients ≥65	2010 ALC LO	2011 ALC LO	2012 ALC LO	2013 ALC LO
(024) DEMENTIA	3,353	3,964	5,987	3,156
(130) OTHER FACTORS INFLUENCING HEALTH STATUS AND CONTACT WITH HEALTH SERVICE	3,094	3,804	3,647	2,312
(045) CEREBROVASCULAR DISEASES	2,457	1,860	2,684	1,380
(114) OTHER SYMPTOMS, SIGNS AND ABNORMAL CLINICAL AND LABORATORY FINDINGS	2,748	1,323	2,160	1,813
(118) FRACTURE OF FEMUR	1,677	1,470	2,289	1,332
(029) OTHER MENTAL AND BEHAVIOURAL DISORDERS	857	1,304	2,779	1,449
(034) OTHER DISEASES OF THE NERVOUS SYSTEM	753	1,676	1,788	1,819
(120) OTHER INJURIES	1,651	1,401	1,907	1,066
(054) CHRONIC OBSTRUCTIVE PULMONARY DISEASE AND BRONCHIECTASIS	1,143	1,354	1,655	1,206
(030) ALZHEIMERS DISEASE	1,318	840	1,529	1,208
(044) HEART FAILURE	1,526	1,348	934	828
(093) OTHER DISEASES OF THE URINARY SYSTEM	580	669	1,101	1,454
(129) OTHER MEDICAL CARE (INCLUDING RADIOTHERAPY AND CHEMOTHERAPY SESSIONS)	1,002	883	937	807
Grand Total - All Acute IP Admissions	33,255	33,096	43,207	29,029
Total Top Leading Causes	22,159	21,896	29,397	19,830
% Total Top Leading Causes	66.6%	66.2%	68.0%	68.3%

- In 2009, CIHI suggested the top three populations for targeting nationally to reduce ALC days were: the frail elderly, those with cognitive/behavioural problems, and neurology/stroke patients.
- Based on NSM data tied to ALC barriers and needs:
 - We are the highest in the province in identifying needs and barriers tied to behavioural requirements.
 - Other issues in NSM included Mental Health as a barrier and needs related to dialysis and meds/labs/therapy.
- In June 2012 the NSM CCAC partnered with area providers to complete a regional review of 61 ALC long-stay cases (>40 day ALC LOS). Key recommendations included:
 - Home First philosophy to continue to be the basis of all patient interactions and presented prior to any LTC discussions.
 - That CCHNCC explore behavioural needs and develop a strategy to guide future funding investments with the LHIN, specifically focusing on the role of CCC and behavioural units.
 - That education on Mental Health continue to be provided to LTCH.
 - Develop a cross-continuum and cross-sector dual diagnosis management strategy to support effective transitions and ongoing supports to these patients by leveraging existing expertise in the developmental, Mental Health and LTCH sectors as per the Interministerial Dual Diagnosis Guideline (2008).

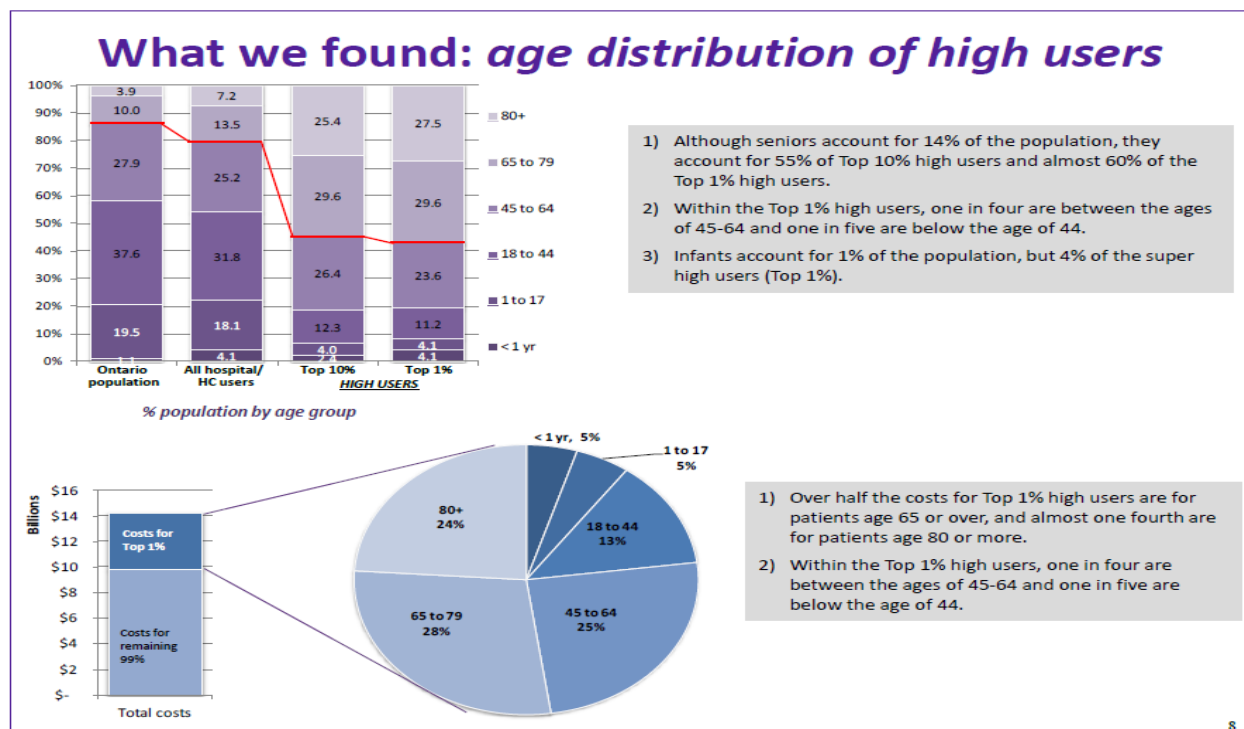
Rehabilitation

- In NSM, 75-80% of rehab episodes are by age 65+ with an increasing trend.



High Users

- The following data is from provincial work related to high users and is based on 2009/10 data analysis. It is important to note that seniors represent only one population of high users.



8

What we found: *conditions in acute care that account for highest spending*

<1 year

Neonates

1-17 yrs

Bone marrow, stem cell transplants
Cancer treatment

18-44 yrs

Extensive burns
Colostomy, enterostomy
Spinal trauma
Brain injuries
Cardiac valve replacement
Other trauma & injuries
Multisystemic/Unspecified site infection

45-64 yrs

Multisystemic/Unspecified site infection
Respiratory failure
Colostomy, enterostomy
Septicemia
Cardiac valve replacement
Liver/Pancreas/Duodenum Transplant
Lung disease

65-79 yrs

Multisystemic/Unspecified site infection
Cardiac valve replacement
Colostomy, enterostomy
Respiratory failure
Septicemia
Stroke
Heart failure

80+ yrs

Respiratory failure
Dementia
Stroke
Cardiac valve replacement
Multisystemic/Unspecified site infection
Heart failure
Colostomy, enterostomy
Hip replacement
Pneumonia

13

Long Term Care

- NSM has 3066 LTCH beds – 1,169 Barrie area, 418 Collingwood area, 421 Midland/Penetanguishene area, 537 Muskoka, 521 Orillia area
- LTCH bed ratio / 1000 seniors age 75+ (Ont. avg. 87.5/1000):
 - NSM – 88.3 /1000
 - Barrie area – 98.1 /1000
 - Collingwood area – 75.2 /1000
 - Midland/Penetanguishene area – 95.9 /1000
 - Muskoka – 89.0 /1000
 - Orillia area – 76.2 beds/1000
- Convalescent Care Program beds – 56 in NSM
Barrie 35 beds, Collingwood 4 beds, Gravenhurst 12 beds (to serve Orillia and Muskoka), Midland 5 beds
- ED visits by residents from Homes for the Aged and LTC homes varies by region and by home. Across the NSM LHIN, RVH receives the majority (32.4%) of LTC home resident visits. One LTC home in the Barrie area has accounted for 22.4% of all the RVH LTC home resident ED visits since 2010.

NSM LHIN Hospital	2010 Visits	2011 Visits	2012 Visits	2013 YTD Visits	Total	Proportion of Visit Volumes
ROYAL VICTORIA REGIONAL HEALTH CENTRE	734	926	700	421	2,781	32.4%
ORILLIA SOLDIERS' MEMORIAL HOSPITAL	577	630	656	240	2,103	24.5%
COLLINGWOOD GENERAL AND MARINE HOSPITAL	353	317	284	159	1,113	13.0%
GEORGIAN BAY GENERAL HOSP-MIDLAND SITE	398	403	329	158	1,288	15.0%
MUSKOKA ALGONQUIN HEALTHCARE-HUNTSVILLE	76	83	97	46	302	3.5%
MUSKOKA ALGONQUIN HEALTHCARE-BRACEBRIDGE	312	298	247	133	990	11.5%
Grand Total	2,450	2,657	2,313	1,157	8,577	

- From 2010 to 2012 the total number of hospital admissions originating from LTC homes was on average 2.4% of total. The top six diagnoses for inpatient acute admissions from Nursing Homes in 2012 were:
 - (01) I. Certain infectious & parasitic diseases (A00-B99)
 - (09) IX. Diseases of circulatory system (I00-I99)
 - (10) X. Diseases of respiratory system (J00-J99)
 - (11) XI. Diseases of digestive system (K00-K93)
 - (14) XIV. Diseases of genitourinary system (N00-N99)
 - (19) XIX. Injury & poisoning & certain other consequences of external causes (S00-T98)
- In November 2013 a LTC Study was completed for the NSM LHIN:
 - Age 85+ represented 52% on wait list and 46% of LTCH residents
 - 40% of all LTCH admissions originated from acute care
 - <10% of wait list clients were categorized as crisis with an average wait time of <200 days, 90% were categorized as low priority
 - 68% of wait list clients scored 'high' to 'very high' on MAPLe (ADLH, Cognitive Performance Scale, wandering and behavioural problems)
 - Hospital wait list clients generally had highest clinical needs (very high MAPLe)
 - Avg. wait time varied between 245 days (CW) and 472 days (Barrie)
 - 2% of all LTCH residents received "Behaviour problem" resources
 - 37% of LTC resident were discharged to an acute care hospital
 - General findings suggest inadequate specialized services to meet needs of specialized populations. For example, residents with dementia ranged from 56% (Midland) to 69% (Muskoka). Only 25% of LTCHs in Midland/Muskoka identified providing specialized dementia care.
 - Recommendations (2 of 3):
 - Consider the availability of care alternatives in the community as well as strategic investments for ensuring the appropriateness of LTCH;
 - Increase availability and equitable access to specialized services (including Mental Health and Behavioural Supports)

ICES Studies

In November 2011, ICES published a provincial report entitled, Health System Use by Frail Ontario Seniors which provided in-depth examination of 4 vulnerable cohorts: older women; community dwelling older adults with physician-diagnosed dementia; medically complex home care clients; older adults newly placed in a LTCH. Using 2007/08 data, findings included:

- NSM was home to 3.9% to the provinces community dwelling older adults with physician-diagnosed dementia:
 - Of the 3,930 people in NSM, 7.4% of them had a hospitalization with ALC in-year following baseline, 4th highest in the province; 20.3% had hospitalization with no ALC, 2nd highest in the province, 72.3% had no hospitalization, 3rd lowest in the province
- Of the medically complex >age 65, 56.1% were d/c to the community with home care, 3rd highest in the province
- NSM contributed 4.2% to the province's newly placed to LTC.
 - 61.2% of NSM admissions came from the community, 2nd highest in the province.

In September 2010, ICES collaborated with the Ontario Home Care Research Network to publish, Aging in Ontario: An ICES Chartbook of Health Service Use by Older Adults. This Chartbook compared health system data over time and across LHINs and explored several population characteristics including frailty. Relevant findings include:

- NSM had the fourth highest % change in seniors aged 65+ between 02/03 and 08/09 in the province
- NSM had the second highest rate of individuals living in rural areas in 08/09
- In 08/09, NSM was one of 3 LHINs having the highest rates of unscheduled ED visits. In each case there was more than one visit per adult over the age of 85. "Northern and remote LHINs" were also identified as having the highest rates for potentially preventable conditions, with this increasing with age.

APPENDIX B: EXAMPLES OF NSM GERIATRIC SERVICES

NSM Geriatric Services Care Continuum									
	Prevention & Health Promotion Programs	Primary Care Programs	Community Service Programs	Long-Term Care Programs	Ambulatory & Outreach Programs	Crisis & Intensive Management Programs	Inpatient Programs	Rehabilitation Programs	End-of-Life/ Palliative Care Programs
Seniors Mental Health & Addictions			Psychogeriatric Program: Transition Service (Wendat)	Geriatric Psychiatry Outreach Team (Waypoint)	Community Mental Health Services (CGMH)	Crisis Program (MPSCMHS)	Horizons: Geriatric Psychiatry Inpatient Program - 28 beds (Waypoint)		
			Psychogeriatric Program: Mobile Social Work Service (Wendat)	Behaviour Intervention Response Team (BIRT)	BSS Mobile Support Team (Waypoint/County)				
				BSS Mobile Support Team (Waypoint/County)					
Seniors Health	Exercise & Falls Classes (VON)	North Innisfil Health Service (BCHC)	First Link: Support Service (Alzheimer Society Simcoe County)	Nurse Practitioner Geriatric Outreach/NLOT (OSMH)	Seniors Assessment & Support Outreach Service (MAHC)	Intensive Case Management (CCAC)	Geriatric Inpatient Unit - 32 beds (RVH)		
		Planned Seniors Days (Cottage Country FHT)	First Link: Learning Series (Alzheimer Society Simcoe County)	Nurse Practitioner LTC Outreach/NLOT (RVH)	Geriatric Day Hospital (OSMH)	Geriatric Emergency Management (RVH)	Healthy Aging Service (RVH)		
		Geriatric Care Team (Algonquin FHT)	Mobile Seating & Mobility Clinic (County/PT Health)		OTN (OSMH)	Urgent Geriatric Clinic (RVH)	Senior Friendly Program (OSMH)		
		Aging at Home (Beausoleil)	Social Work Services (Red Cross)		Integrated Regional Falls Program (OSMH)				

APPENDIX C: CONCURRENT INITIATIVES

LHIN-SPECIFIC INITIATIVES

Care Connections: Second Curve Committee

This Committee is a sub-group of the NSM LHIN Leadership Council. Their task is to refresh the *Care Connections: Partnering for Health Communities* plan to accelerate our future vision and move toward second curve thinking. The plan will address: what programs and services will be delivered in the five subLHIN regions; and, the programs and services that will be delivered locally in each community, at a LHIN level and those that will not be delivered within the LHIN.

PROVINCIAL INITIATIVES

Health Links

Much like the work of the Task Group, Health Links is intended to:

- Bring health service providers in a community together to better and more quickly coordinate local health services and care
- Improve care for seniors and others living with complex conditions
- Work as a team to better coordinate the care for the person across their journey through the health system

Appendix D highlights key content from the business cases of the five NSM Health Links. All NSM Health Links referenced the 2009 Vision in their final business case.

Provincial Regional Geriatric Programs of Ontario review

This review will occur spring 2014. Based on a recommendation in Dr. Sinha's report, the Ministry and LHINs will undertake a review of existing Regional Geriatric Programs to determine how their contributions can be optimized and better aligned with current priorities. Regional Geriatric Programs provide Specialized Geriatric Services.

Senior Friendly Hospital Strategy (SFHS)

The provincial SFHS Strategy has focused on three key areas: functional decline, delirium and transitions. The initial mandate of the Regional Clinical Nurse Specialist, Seniors Health is to evaluate the impact to date of the functional decline initiative and to develop and implement a delirium program across all NSM hospitals. The provincial SFHS Committee is recommending mandatory reporting of indicators related to functional decline and delirium across all Ontario hospitals beginning in 2014. Although the focus of the SFHS Strategy is on hospital environments, programs could be leveraged across the continuum of care.

Rehabilitation / Assess & Restore

The Ministry is examining rehabilitation with several key areas of focus, including frail seniors. A provincial Assess & Restore policy is expected in the coming months with specific emphasis on frail seniors. To begin planning for rehabilitation in NSM a Kaizen event was led by the LHIN in March 2014. Examples of key recommendations stemming from that event were the creation of regional centers of expertise, defining specialty populations, developing care

pathways for patient populations and development of a business case for interdisciplinary ambulatory rehabilitation services.

NSM Behavioural Support System (BSS)

A Specialized Behaviour Support Task Group was established under the NSM BSS Project Steering Committee. A briefing note was brought from BSS Committee to the Complex & Chronic Health Needs Coordinating Council January 2014 with the following recommendation:

That the Behavioural Support System Project Steering Committee support the preparation of a proposal to the LHIN to fund:

- *A Specialized Behaviour Team for Supportive Housing.*
- *A 10-12 bed transitional Behaviour Support Unit in LTC.*
- *In addition the Task Group recommended: complex case review program, ED Diversion protocols/processes and development of a behaviour care pathway.*

The briefing note was approved in principle by the Coordinating Council.

APPENDIX D: NSM HEALTH LINKS BUSINESS CASE INFORMATION

Couchiching Community Health Link

- The initial target population of the CHL is individuals with Chronic Obstructive Pulmonary Disease (COPD). This HL will start with a cohort of 20 individuals. As time progresses they will expand this to an additional cohort of 30 additional high needs patients with complex conditions. Care will focus on communication and education, encouraging self-management, advanced care planning and palliative care and improved access to health care providers
- The CHL will develop and implement service enhancements, care coordination tools and programming. Patient engagement through the patient advisory council will be used to support planning.
- The CHL will build strong relationships between health care providers, working together to create an effective future state that reduces wastes, meets patient's needs, and is cost effective.
- The CHL will build on current Link opportunities, including the Seniors Health Strategy.

North Simcoe Community Health Link

- 64% of high users in the NSHL were over age 65 with clinical conditions mainly related to heart and lung health. On average the top 5% had almost 4 Emergency room visits and 2 admissions over the year. The top 5 % accounted for 76% of inpatient weighted cases.
- In an analysis of Waypoint top 5% inpatient high users (36 individuals), 75% of the had addresses in NSM, 36% were age 65+ with most common diagnoses: Schizophrenia and other psychotic disorders (33%); Delirium, dementia and other cognitive disorders (25%); and Disorder of childhood/adolescence (22%) with latter patients on the Dual Diagnosis unit.
- NSHL is focusing initially on 20 seniors with complex health issues, with special attention to those with cardiac and lung health issues. The initial focus will also include attention to health factors of special significance to aboriginal and francophone seniors with complex health issues. At the end of year one the focus will expand to more formally include mental health.
- NSHL will leverage the experience of those 20 patients and families in phase two and partner with primary care providers and community partners to: develop standardized tools and protocols related to care, communication, decision-making and evaluation; identify opportunities for system change and new partnership strategies (e.g. special clinics, processes); and make recommendations on capacity building, training and education.
- The NSM Seniors Strategy was identified as a support for the work of the NSHL

South Georgian Bay Community Health Link

- High Users:
In this region, 440 high users were between the ages 65-79 and 275 were age 80+. Age 65+ comprised 88.2% of CCAC top 5% high users in this region, with 51.6% of them

being > age 80. Of the final group defined as a focus for the SGBHL (139 individuals), 65% were seniors.

- SGBHL will build upon current collaborations and partnerships, like Home for Life and ePrescribing. There is a focus on using a Collaborative Care Model to improve discharge transitions and assessment of re-admission risk.
- This HL is focused on building upon the capability of Home for Life, establishing a Collaborative Care Model for high users and frail seniors at risk and establishing an Urgent Care Clinic.
- To achieve provincially directed results, some of the SGBHL will include:
- Reducing the time from primary care referral to specialist consult by leveraging OTN to achieve better access to Orthopedics, Geriatrics, Neurology and Adult Psychiatry.
- Leveraging the ED Transitional Care Team in concert with Home for Life, Home First and Rapid Response Nurses to reduce 30 day re-admissions.
- Improving the experience for users by improving their ability to self-manage their care, reduced readmissions and remain safely at home.
- The NSM Seniors Strategy was identified as supporting the work of the SGBHL.

Muskoka Community Health Link

- During MHL planning, several challenges were identified:
 - Muskoka total population is 142,423, with 58% of these considered semi-permanent residents. These residents tend to live in rural areas and increase strain on the NSM health system for approximately six months each year.
 - 31.5% of the permanent residents live in rural areas.
 - Due to the geographical layout of the North East LHIN and the limited access to health care for residents living just North of the Muskoka boundary, approximately half of this population (4,760) is estimated to access care from MAHC sites.
- Age 65+ account for 82.4% of MHL's top 1% users and 73.2% of top 5% high users.
- MHL has chosen three target populations:
 - Senior citizens
 - Marginalized and disabled people
 - Mental health conditions
- MHL's 3 Health Links priorities are to:
 - Reduce ALC Designated Patients
 - Create a Central Intake and System Navigation Process
 - Improve Access to Primary Care and Human Services
- MHL will be looking to: leverage existing modalities (i.e. OTN, web-based portals) and increase technology connectivity; build and expand Nursing Stations to support primary care; better leverage programs like SASOT and the AFHT Geriatric Team; and will consider development of transition housing like Foster Homes for Seniors.
- Central intake will produce streamlined access to all service providers in the area and will leverage existing tools such as the CCAC's CHRIS patient information system,

nshealthline.ca and 211. System Navigation is focused on system navigator roles and the use of volunteers and unregulated providers.

- MHL's 3 priority areas: coordination and communications; program enhancement; and service accessibility



Barrie Community Health Link

- Through a high user analysis of RVH data, they found 74% of high users were age 65+ and 57% were age 75+. 915 high users were identified between the ages of 65-79 and 665 age 80+.
- The Barrie Health Link is focused on developing a Clinic for Medically Complex individuals focused on 1% high users (1,000-1,700 patients), with a specific focus on those age 65 with: chronic diseases, mental health issues, cognitive dysfunction, medication problems, challenges related to social determinants of health (i.e. poverty, justice, education, isolation, housing, wellness, culture etc.)
- This Health Link is looking to build on partnerships, including those with the Cognitive Assessment Clinic and to develop Barrie and Community Protocols / Care Plans.
- This Health Link proposal includes Little Lake planning.

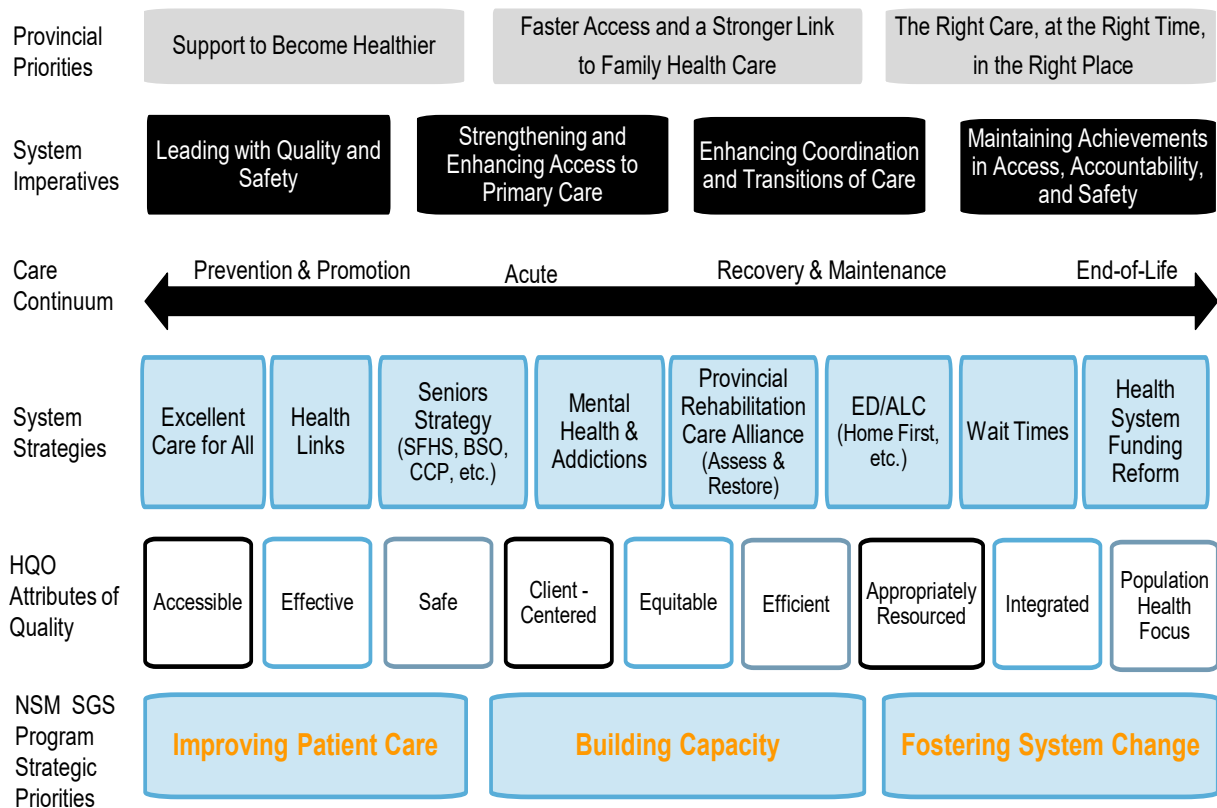
Tree Diagram Worksheet



APPENDIX F: NSM SGS PROGRAM STRATEGIC PRIORITY ALIGNMENT

LHIN Accountability Agreement Logic Model: A Provincial Snapshot of Health System Priorities for Ontario

* adapted from the Provincial Rehabilitation Care Alliance



APPENDIXH: PROJECT STEERING COMMITTEE RECOMMENDATIONS

The current Seniors Strategy Task Group will disband with the completion of this Strategy document. To continue the momentum it is recommended that the In-Home & Community Capacity Coordinating Council move quickly to establish a Project Steering Committee. Based on the experience of the current group, the following are recommended to IHCC for consideration:

- A clear statement of purpose be established through an approved Terms of Reference and Project Charter. Timeframes should be outlined, deliverables clear and in-scope/out-of-scope defined. This should be established prior to a call for membership.
- The group should focused on short term deliverables and long-term vision. Oversight will be required with early work focused on implementation of key aspects of the NSM Specialized Geriatric Services Strategy. Working groups may need to be established to support planning and implementation.
- The Project Steering Committee should be of similar size to the current Seniors Strategy Task Group with the following member composition:
 - Sector and geographic representation;
 - A mix of strategic and clinical leaders, including a minimum three members from the current Seniors Strategy Task Group;
 - Membership from the Physician Lead and the Regional Clinical Nurse Specialist;
 - Person-with-lived-experience should be considered for membership if the right skillset is available. Should a PWLE be identified, barriers to attendance must be addressed at the outset. If no appropriate individual emerges, engage PWLE in planning through ad hoc membership, working groups and/or engagement events.
- A call for membership should be issued in tandem with communication regarding the NSM Specialized Geriatric Services Strategy. Individuals must understand the work to date and be clear on their roles and accountabilities going forward.
- The Project Steering Committee should be established by the end of June 2014 to continue Strategy momentum and to be positioned to support any possible 2014/15 funding opportunities.
- As an early step in defining accountability, the accountability between the Project Steering Committee and the host agency holding Strategy funds should be defined.

APPENDIX I: HEALTH EQUITY IMPACT ASSESSMENT

On April 24, 2014, the ***Strategy for Specialized Geriatric Services In North Simcoe Muskoka*** was reviewed by several NSM representatives¹ using the Health Equity Impact Assessment (HEIA) Template. Using the template as a guide for discussion, the group reviewed a variety of populations which would/could be impacted by the Strategy. The discussion provided a high-level HEIA that will be used as a starting point for NSM SGS Program planning. Discussion acknowledged some key themes and possible mitigation strategies were identified. Overall, there was recognition that completion of all mitigation strategies would be ambitious. As such, the group spoke about the value of partnerships in addressing the themes.

Population	Discussion – Key Themes	Mitigation Strategy
Aboriginal, e.g. First Nations, Métis, Inuit peoples	- Health care challenges compounded by issues faced in regard to social determinants of health and history (i.e. residential schools) 4 reserves with many also living in urban areas - Issues with self-identification - Most providers don't know, understand or appreciate traditional medicine - Many seniors unclear on how to access system, services - Unclear # of Aboriginal seniors – likely approximately 20% of the Aboriginal population – unclear on where they are, what they need - Some reserve areas have limitations re technology (i.e. wifi access)	- Define geographic areas of greatest need as early intervention area - Heighten awareness within SGS team regarding culturally appropriate care (i.e. Clinical Services, education, communication strategies, etc.), creating partnerships where possible and appropriate to support the needs of frail seniors (i.e. CHIGAMIK for traditional healing) - Engage CHIGAMIK, Aboriginal Health Circle, front line providers to Aboriginal population in planning and implementation - Leverage existing seniors programs for Aboriginal population as resource for care across the SGS - Build standardized assessment tools and care plans to attend to the needs of this population (i.e. diet, medication, residential schools, finances, place of residence, etc.)

¹ Attendance: Ligaya Byrch (NSM LHIN), Sandra Easson-Bruno (NSM LHIN), Christine Colcy (SSTG), Deborah Duncan (SSTG), John Kurvink (SSTG), Anita Chevalier (SSTG), Germaine Elliott (Aboriginal Health Circle), Christine Morisson (Entité 4)

Francophone populations, including new immigrant francophones, deaf communities using LSQ/LSF etc.	- Increasing diversity in the francophone population across the province, especially given the increase in the french-speaking African population - Many of the French-speaking African community are facing difficulties accessing services in French so trying to learn English too - Most providers don't know, understand or appreciate that culturally appropriate care is about more than language - Many seniors unclear on how to access system, services – difficulty navigating system when language barrier	- Define geographic areas of greatest need as early intervention area (i.e. higher level of francophone seniors in Tiny, Tay area) - Heighten awareness within SGS team regarding culturally appropriate care (i.e. Clinical Services, education, communication strategies, etc.), creating partnerships where possible and appropriate to support the needs of frail seniors - Engage representatives from local francophone communities in planning and implementation
Ethno-racial, e.g., racial/ racialized or cultural minorities, some immigrants and refugees. Linguistic communities, e.g., people not comfortable receiving care in English or French or whose literacy affects communication	Increasing diversity in NSM population with different primary languages and cultural beliefs, including increasing Asian and afro-caribbean population in the Barrie area	Heighten awareness within SGS team regarding culturally appropriate care (i.e. Clinical Services, education, communication strategies, etc.), creating partnerships where possible and appropriate to support the needs of frail seniors (i.e. BCHC partners with CHIGAMIK, participates on Immigration Partnership Council)
Religious/faith communities	Increasing diversity in NSM population with different religious/faith communities having different approaches to health care (i.e. care by male vs. female, death and dying beliefs across religions, family required to be present, etc.)	Provide education to SGS team regarding culturally appropriate care, creating reference guide which can be accessed as required
Disability, e.g., physical, deaf, deafened or hard of hearing, visual, intellectual/ developmental, learning, mental illness, addictions/substance use	- Dual diagnosis lifespan increasing, with many living as seniors - Many seniors live with hearing and vision impairments, chronic diseases, cognitive impairment	- Establish partnership with Social Service Sector - Have access to tools and equipment to support the varying needs of seniors, including development of partnerships with key agencies (i.e. CNIB)
Rural/remote, inner-urban populations, e.g., geographic isolation, social isolation, under-served areas.	- The eligibility of some services is tied to place of residence. Equity of access requires services be provided to seniors regardless of place of residence. - Rural residents face challenges accessing services	Clinical Services to consider limitations placed on their eligibility criteria (i.e. LTC, Retirement Homes, homeless, penitentiary, etc.) - build policies as

Place of Residence – personal dwelling, Retirement Home, LTC Home; homeless, marginally or under-housed people, etc.	Some residences are not winterized, have no running water	required to support - Include as part of a comprehensive geriatric assessment and take into consideration in building plan of care - Incorporate technology/virtual services in planning including programs like OTN, Telehomecare where possible/ appropriate - Include outreach as a component of Clinical Services (must be built into Program funding)
Socially isolated, limited caregivers	Impacts ability to: remain safe at home, get to/from appointments and tests, etc.	- Volunteer programs, Home for Life - Include as part of a comprehensive geriatric assessment and take into consideration in building plan of care
Low income	- Costs associated with transportation to access programs (i.e. parking, gas, mileage) - Costs tied to social determinants of health to reduce risk of frailty (i.e. housing, nutrition, heat/hydro) - Costs associated with medication and other treatment options to address frailty	- Include as part of a comprehensive geriatric assessment and take into consideration in building plan of care - Partner with agencies addressing social determinants of health - Include outreach as a component of Clinical Services (must be built into Program funding)
Age	Presentations and care needs of seniors aged 65-74, 75-84, 85+ including 100+ differ, support networks vary	Include as part of a comprehensive geriatric assessment and take into consideration in building plan of care
Sex/gender, e.g., women, men, trans, transsexual, transgendered, two-spirit	- Females tend to live longer and live alone longer - Females tend to be caregivers - Females tend to face more challenges tied to transportation as males often drivers	Include as part of a comprehensive geriatric assessment
Sexual orientation, e.g., lesbian, gay, bisexual	- Increasing incidence of HIV and AIDS, Hepatitis C as people live longer, manage chronic diseases - Many still in closet - Challenges in some Retirement Homes, LTC Homes, general senior population where issues of tolerance, acceptance exist	- SGS and key stakeholder education - Include as part of a comprehensive geriatric assessment - Address within broader integrated regional Seniors Health Program

Limited / No access to health care – health cards, primary care	Some don't have any MD, some have left MDs behind in other region	- Intake guidelines in primary care to take in family members of current patients - Consider entry point into NSM SGS Program (i.e. MD referral, etc.) - Work in partnership with Health Links and Health Care Connect
Limited / No access to transportation	Ability to access Clinical Services, local education events, etc.	- Explore transportation options, including volunteer drivers - Incorporate technology/virtual services in planning including programs like OTN, Telehomecare where possible/ appropriate - Majority of care by Locally-Delivered Specialized Geriatric services - Include outreach as a component of Clinical Services (must be built into Program funding)
Health Literacy / Literacy	Varying degrees of health literacy	- Engage stakeholders in development of information and other materials related to the SGS Program - Address health literacy during Clinical Services planning