

Vision for an Integrated Regional Seniors' Health Program in North Simcoe Muskoka

Submitted by: The North Simcoe Muskoka Seniors' Health Regional Action Group

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INTRODUCTION

According to Statistics Canada (2006), 64,145 residents of North Simcoe Muskoka (NSM) are over age 65 making NSM home to one of the older populations in the province. The NSM population age 75+ is expected to grow by 92.3% between 2008 and 2025. The anticipated regional growth for the same period is 38.8% (NSM LHIN, December 15, 2008). Couple this region's aging population with the fact that seniors are recognized as the biggest consumers of health care resources and one quickly appreciates the urgent need for health system planning for this population. The North Simcoe Muskoka Local Health Integration Network (NSM LHIN) has recognized the importance of seniors in our health care landscape and, since its inception, has taken active steps to support system planning for this cohort. While providing such leadership, the LHIN was faced with two major provincial initiatives – the four year \$1.1 billion Aging at Home Initiative and the Emergency Department/ Alternate Level of Care initiative. These, along with the work of the LHIN around both seniors' health and health system design, provide a great opportunity to change the face of seniors' health as we know it in NSM. However, to move forward there needs to be a vision for the future. This document, a condensed version of a much larger document developed by the NSM Seniors' Health Regional Action Group, proposes a vision. It focuses on leadership, integration and access and is built on the principles of specialized geriatric assessment, early intervention and an appropriate environment of care. It emphasizes the importance of building on existing resources, successes, planning and regional passion. This vision addresses a breadth of issues but is not meant to be all encompassing. Rather, it is meant to provide initial direction. It speaks to possibilities and reflects the collective wisdom of a group of NSM health care leaders who, on a daily basis, attend to the needs of our aging population. This vision is intended to provide guidance within the NSM region so that, together, we can move forward as a united voice in planning and action.

BACKGROUND

Seniors comprise 15.2% of the NSM population and represent a diverse and unique group. The area is home to four groups of seniors – those who have lived in the region and are aging in place; seniors who have second homes in the region and are “seasonal” residents^{1,2}; those moving or retiring into the region following their families; and those moving or retiring into the region leaving family behind. These seniors live across the varied geography of the LHIN's five sub-planning regions. Cultural diversity is limited when compared with other regions of the province, with the larger populations being of francophone and aboriginal descent. Socioeconomic status varies across and within regions with the greatest disparity evident in Muskoka where the affluence of seasonal residents exists in stark contrast to the lower socioeconomic status of many local residents. Each of these differences creates unique challenges and opportunities for health system planning.

In regard to health, seniors can range from healthy active individuals to complex individuals living with multiple disabilities and many life challenges. When compared with younger adults, seniors have a higher incidence and prevalence of chronic diseases, are more likely to be on multiple medications, decondition³ more rapidly, have atypical presentations and suffer excess disability⁴ more frequently. As such, the health of seniors is often likened to a house of cards – remove one card and the whole house can collapse.

Within NSM, the health situation of seniors as well as their actual and potential impact on our health care resources is evident in available statistics:

¹ The term “seasonal” is becoming increasingly misleading. Historic summer and winter “seasonal” trends are now extending across all four seasons.

² The volumes of seasonal residents is not included in census data. As such, seasonal fluctuations further increase the volume of seniors in the region

³ Deconditioning is defined as, “the multiple changes in organ system physiology that are induced by inactivity and reversed by activity” (Siebens, 1990 in Stone, Wyman, & Salisbury, 1999, p.269))

⁴ Disability beyond that directly imposed by the illness

- 49% of seniors are living with 2 or more of the following: diabetes, depression, heart disease, hypertension, cerebrovascular accidents, chronic obstructive pulmonary disease and/or arthritis. The provincial average is 46% (Health Systems Intelligence Project, October 2007).
- Between 2006 and 2016 the projected prevalence of dementia is expected to grow by almost 50%, ranking NSM third highest provincially in terms of rate of growth (Alzheimer Society of Ontario, April 2007).
- At December 2008, 9.5% of seniors were receiving NSM CCAC services with 31.2% of these clients scoring high and very high on a Needs Risk Indicator (NSM CCAC (Val Armstrong), 2009).
- Seniors account for:
 - 19.5% of all area Emergency Department visits and about 40% of acute care admissions
 - 62.6% of all hospital length of stay days (equivalent to over 332 beds)
 - 58.3% of the total acute length of stay and 85.9% of the Alternate Level of Care length of stay (NSM LHIN, December 15, 2008).
- 1% of the population accounts for 43% of the total hospital and home care volumes. About 60% of this population is over age 65 (Preyra & Perez, 2008).
- The forecasted annual growth rate in health services for seniors is 4.0%. The provincial average is 2.4% (Preyra & Perez, 2008).
- In 2004/2005 the rate of Emergency Department visits for seniors who had fallen was the third highest in the province while the rate of admissions was the highest in the province (Ontario Injury Prevention Resource Centre, 2007). Using an average mean length of stay of 10.3 days this would translate into 11,443 total days (equivalent to 31.4 beds). In the same period the rate of seniors hospitalized for a fractured hip was, by far, the highest in the province (CIHI, 2006). Of note, falls cause more than 90% of all hip fractures and 20% of seniors die within a year of a hip fracture (Geriatric Interprofessional Interorganization Collaborative, 2008a).
- At October 2008 1,351 individuals were on the waiting list for a long-term care home with an additional 514 in long-term care homes waiting transfer to their destination of choice. At that time there was a median wait time of 91.3 days to access a bed. The provincial average is 50 days.
- In 2006-2007, long-term care residents accounted for an average of 1.3% of all Emergency Department transfers with 51.5% of those resulting in admission for a total length of stay of 13,817 days (equivalent to 38 beds) (NSM LHIN, December 15, 2008).

There is a slow growing basket of health services for seniors in NSM. Most are relatively new, having been established within the last five years. Most were developed using existing funding and evolved in isolation of the others. All were developed by visionary, passionate leaders who recognized the importance of targeted seniors' health services. The basket of services for seniors in NSM must continue to grow in breadth and depth to meet the needs of seniors and, more important, to reduce health system demands in particular for high-cost services like those provided in Emergency Departments and acute care.

One area of the basket requiring specific attention is Specialized Geriatric Services. Specialized Geriatric Services are based on the principles of specialized geriatric assessment, early intervention and the provision of an appropriate environment of care. "Specialized Geriatric Services are provided on a consultative basis by an interdisciplinary team of health professionals in a variety of home, ambulatory, long-term care homes and in-patient hospital settings. The goal of Specialized Geriatric Services is to reduce the burden of disability by detecting and treating reversible conditions and optimizing management of chronic conditions" (Regional Geriatric Program of Toronto, 2006). "With proper elder-friendly care and community support many seniors

can continue living in their homes, and unnecessary hospitalizations can be avoided. Specialized Geriatric Services are a major factor in meeting these challenges . . . Such services have been shown to decrease length of stay, maintain functional abilities and lead to lower rates of long-term care institutionalization (Stuck, 1993). Specialized Geriatric Services lead to continued independence and improved quality of life, improved patient outcomes and increased clinical efficiencies in the health care system” (Regional Geriatric Program of Toronto, unknown - b).

THE INTEGRATED REGIONAL SENIORS’ HEALTH PROGRAM

Seniors’ health crosses all sectors and most clinical specialty areas making it difficult for any one agency to be fully accountable for all outcomes. As such, the Seniors’ Health Regional Action Group proposes the establishment of a new agency in NSM – the integrated regional **Seniors’ Health Program (SHP)**. The SHP should be a single highly coordinated structure under this broad seniors’ health umbrella. It should provide consultative support to the full breadth of seniors’ health issues but direct clinical and operational leadership to a portion of the seniors’ health umbrella only. The main focus of the SHP should be **Specialized Geriatric Services**. The SHP should be accountable for all services, programs and structures emanating from the SHP or for which this agency has been given responsibility by the LHIN. The target population for the SHP should be, **“adults age 65 and older OR vulnerable populations aged 55 and older with age related conditions⁵ living in the NSM region.”**

The health resources, successes, planning and passion from the region’s existing Specialized Geriatric Services should form the foundation for the SHP. The SHP should integrate additional best practices and innovations in seniors’ health and system integration. It should consider the present but focus on future needs, in particular supporting the shift to community care so that seniors can age in place. It should be part of an integrated health system – on a small scale under the seniors’ health umbrella and on a larger scale integrating with other regional programs and system supports. As such, this document should complement that of the Balance of Care, Severe Behaviours and Regional Transportation initiatives. It should also be tightly connected to the LHIN’s Emergency Department/ Alternate Level of Care Task Force, health system design planning, “e”-strategy, and the province’s 10-year Mental Health & Addictions planning.

Desired Outcomes

Should this vision move forward, the SHP would be one of this LHIN’s early attempts at integrating a regional program. The focus should be on building the best integrated health system for seniors rather than on figuring out how to make seniors’ health fit within the existing system. By focusing on the population the ultimate outcomes for the SHP should be about **improving quality of life and maximizing health potential**. To achieve these ends the SHP should:

- Increase access to Specialized Geriatric Services
- Improve the quality of care provided to seniors and their caregivers
- Increase the self-management capacity of seniors and their caregivers
- And Improve customer satisfaction

These, in turn, should impact the system by **reducing the impact of the aging population on our health care resources**. More specifically the SHP should:

⁵ This would include the aboriginal population, those with developmental disabilities, those with addiction and mental health issues and those living in poverty.

- Reduce the percentage of seniors visiting an Emergency Department.
- Reduce the percentage of seniors requiring acute care admission.
- And reduce the percentage of seniors requiring long-term care home placement.

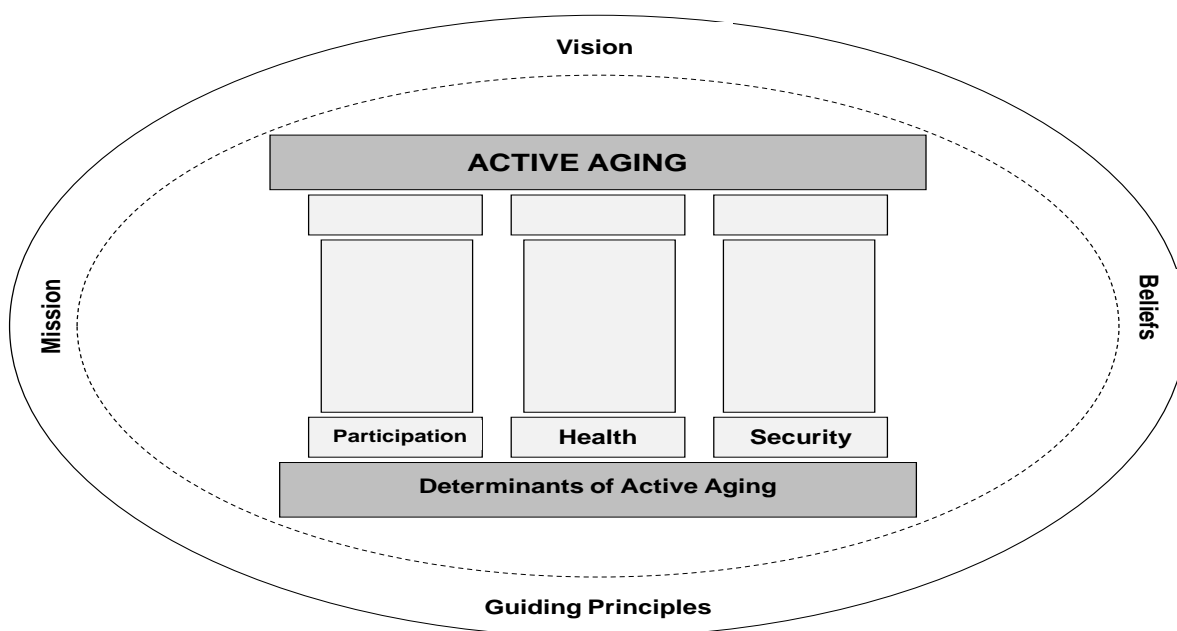
In regard to current system pressures this would translate into reduced Emergency Department wait times as well as reduced acute and alternate level of care lengths of stay.

Conceptual Framework

A slightly modified version of the World Health Organization's (2002) Active Ageing: A Policy Framework could be used to form the conceptual framework for the SHP.

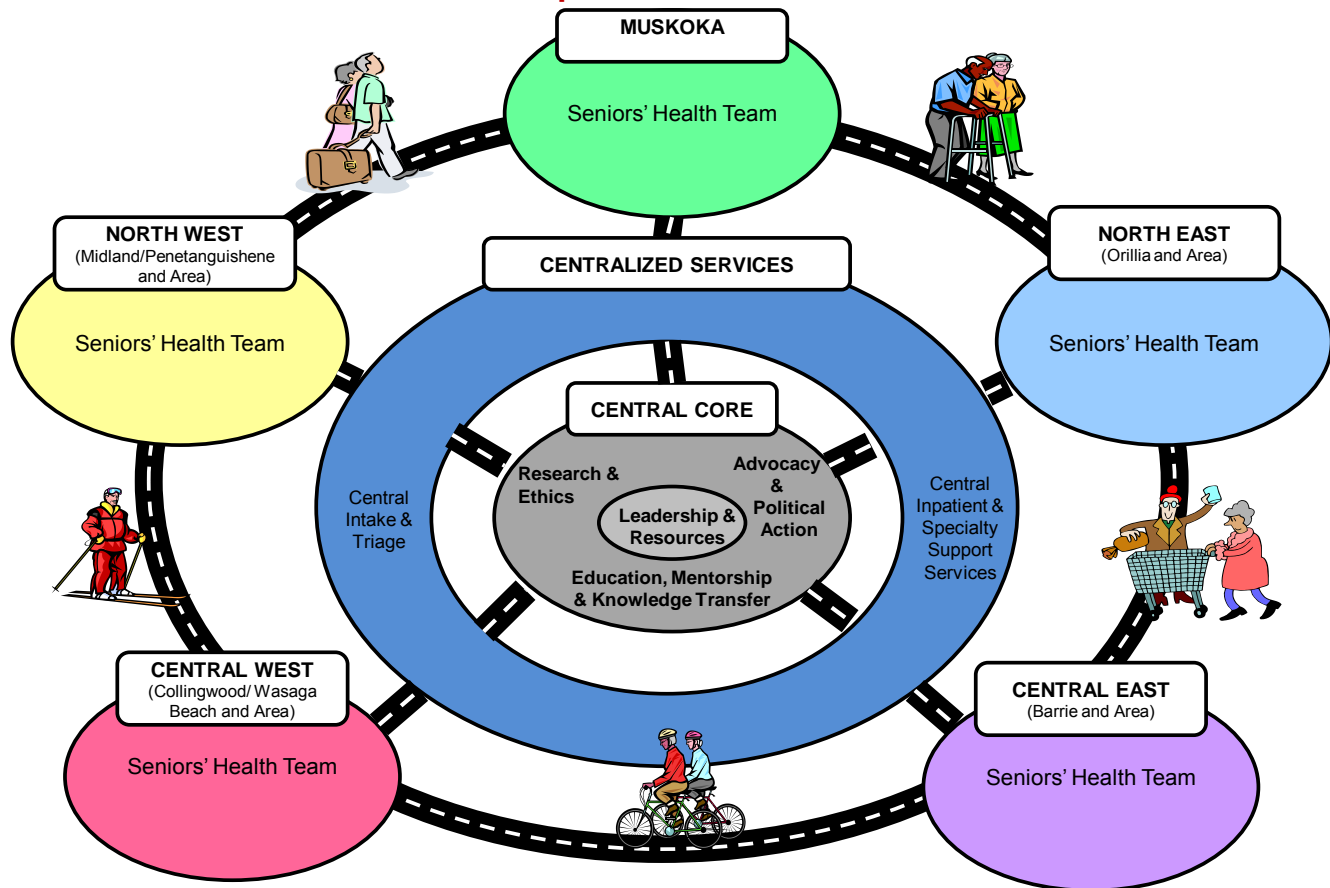
Active Ageing is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age. It . . . allows people to realize their potential for physical, social and mental well-being throughout the life course and to participate in society, while providing them with the adequate protection, security and care where they need . . . Maintaining autonomy and independence for the older people is a key goal in the policy framework for Active Ageing . (World Health Organization, 2002, p. 12)

The Vision for a Conceptual Framework for the NSM SHP



The conceptual framework should contain the SHP's vision, mission, beliefs and guiding principles while concurrently recognizing the impact of the determinants of Active Aging. The proposed Vision of the SHP is, ***“Toward Active Aging. Together”***. The proposed Mission is, ***“To build the best integrated health system for NSM seniors”***.

A Model for Specialized Geriatric Services



The SHP, in providing leadership for Specialized Geriatric Services in NSM, should be comprised of various components. These components should function within the SHP's conceptual framework and should address both the target population and SHP scope as identified above. Each component should play an important role in supporting *Active Aging*. One of the key assumptions of the proposed Model is that clinical services within the SHP should not be 'destinations' – they should be 'supports'. As such, the role of the SHP should not be to take people to their destination but to support those guiding the journey.

In addition to the SHP vision outlined to date, this model highlights other key considerations:

- As part of its **Central Core**, the SHP should:
 - Establish a leadership team responsible for providing operational leadership and, as appropriate, clinical leadership to all components of the new SHP agency. Led by an Executive Director, this structure should include a Physician Director, Medical Director Long-Term Care, advanced practice nurse(s) and others as appropriate to support operational function.
 - Consider incorporation and governance by a Board of Directors.
 - Explore membership with the Regional Geriatric Program of Ontario to promote provincial connectivity.
 - Establish a Seniors Advisory Committee to provide input into SHP planning and direction.

- Establish a Committee structure to support regional planning and integration, including Committees related to Education, Mentorship & Knowledge Transfer and Research & Ethics. It should also incorporate existing individual networks targeting seniors' health issues (i.e. NSM Dementia Network, NSM Elder Abuse Network, Staying Independent Falls Prevention Coalition).
 - Hold and manage the single funding envelope related to SHP services.
 - Collaborate with the LHIN to move forward the agenda of geriatric care physician funding and recruitment (i.e. Geriatricians, Care of the Elderly family physicians, Geriatric Psychiatrists) as geriatric care physicians are integral to the success of the SHP.
 - Collaborate with the LHIN to develop and implement both a health human resource strategy and technology strategy to build system capacity.
 - Coordinate regional Education, Mentorship and Knowledge Transfer related to the SHP. This should include: supporting the professional development of SHP staff, other area health care professionals, health care professional students and the public; centralization existing Geriatric Grand Rounds; establishing an annual conference; and developing a central education fund for SHP staff.
 - Centrally coordinate Research & Ethics as well as Advocacy & Political Action as related to seniors' health.
- As part of its **Centralized Services**, the SHP should:
 - Use the Interim Central Intake & Triage service established in the Regional Falls Program as the foundation for a permanent Central Intake & Triage service. This Specialized Geriatric Service should operate seven days per week, be accessible through a 1-800 number and build on existing resources like 211, CCAC and Telehealth.
 - Establish a Central Inpatient & Specialty Support Service (CISSS) in one centralized location in NSM. CISSS should provide consultative support to the locally-based *Seniors' Health Teams* (see below) for complex seniors requiring **highly** specialized interdisciplinary geriatric assessment, treatment and/or rehabilitation. It should incorporate *ambulatory and outreach services*. For those requiring inpatient assessment and treatment, CISSS should develop an 8-10 bed *Seniors' Assessment Unit* and a 12-16 bed *Seniors' Rehabilitation Unit* for time-limited consultative intervention. Both should be located in single location in NSM and should build on and/or complement existing system services.
 - As part of each **Regional Pod**, the SHP should:
 - Expand and replicate the Algonquin Family Health Team's Geriatric Care Team to establish a high functioning interdisciplinary Seniors' Health Team in each Regional Pod. Each Team should be based in one permanent central location but will travel the region as required. The central location should be shared with other services to encourage 'one-stop shopping'. These consultative Teams should provide *ambulatory services, outreach services, intensive case management, and Geriatric Emergency Management*. These Teams should build on existing regional best practices in Specialized Geriatric Services and complement existing community resources. The SHP should establish Teams in Muskoka and North East in Year 1, followed by Central East (Year 2) and then Central West and North West (Year 3). Where available, existing resources should be used to form the foundation for these new teams. These Teams should be the cornerstones of the SHP.

- The SHP should develop and implement various **programs** relevant to the transformation of regional seniors' health including:
 - General programs like ageism and elder-friendly environments as well as standards of care for seniors' health.
 - Programs related to Geriatric Syndromes with early attention given to falls, medication management and polypharmacy, cognitive function as well as to time intensive high risk issues (i.e. capacity for personal care and finances, elder abuse).
 - Population support programs including both Aboriginal and Francophone Cultural Support programs.

- The SHP should provide **consultative support** to mental health and addictions, specialized behaviours, acute care, rehabilitation, chronic disease management, palliative and end-of-life care, as well as to issues related to shelter, home supports and transportation. The SHP should work with appropriate Regional Action Groups and other stakeholders to support the development of integrated programs that build on existing resources, successes and planning AND ensure the right care is being provided in the right place by the right providers. Other actions should include, for example,:
 - Hiring an advanced practice nurse to consult with acute care regarding opportunities to improve the quality of care and/or generate cost savings.
 - Collaborating with Municipalities to explore supportive housing options and continued involvement in the Balance of Care initiative.
 - And advocating for the establishment of a regional Retirement Home Committee and a regional Long-Term Care Committee.

Recommendations, Timelines & Resource Implications

The vision, as described in the larger version document developed by the Seniors' Health Regional Action Group, contains 16 recommendations to the LHIN around regional programming and health system design (Appendix A). The document also proposes over 100 actions related to the SHP vision (Appendix B).

The following table outlines the timing with which envisioned services are proposed to **start** development from a **system** perspective. The first several years of the SHP would need to focus on internal capacity building and, as such, some of these issues (i.e. cognition, elder abuse) would require internal professional development earlier than noted on the timetable.

ENVISIONED START DATES FOR SHP INFRASTRUCTURE, SERVICES & PROGRAMS

	PHASE 1			PHASE 2	PHASE 3
	Year 1	Year 2	Year 3	Year 4-5	Year 5-10
CENTRAL CORE: LEADERSHIP & RESOURCES	<ul style="list-style-type: none"> • SHP <ul style="list-style-type: none"> ○ Executive Director & Physician Director ○ Incorporation ○ Affiliation with Regional Geriatric Program of Ontario ○ Committee Structure • Geriatric care physicians • HHR Strategy • Technology Strategy • Evaluation 	<ul style="list-style-type: none"> • SHP <ul style="list-style-type: none"> ○ Medical Director, Long Term Care ○ Board of Directors ○ Seniors' Advisory Committee ○ Integration of 3 NSM Networks (Falls, Dementia, Elder Abuse) 			<ul style="list-style-type: none"> • Ombudsman
CENTRAL CORE: DOMAINS OF PRACTICE	<ul style="list-style-type: none"> • Education, Mentorship & Knowledge Transfer: <ul style="list-style-type: none"> ○ E&M&KT Coordinator • Advocacy & Political Action 	<ul style="list-style-type: none"> • Education, Mentorship & Knowledge Transfer: <ul style="list-style-type: none"> ○ E&M&KT Committee 	<ul style="list-style-type: none"> • Education, Mentorship & Knowledge Transfer: <ul style="list-style-type: none"> ○ EMKT Annual Conference • Research & Ethics: <ul style="list-style-type: none"> ○ R&E Committee 		
SPECIALIZED GERIATRIC SERVICES	<ul style="list-style-type: none"> • Central Intake & Triage • Seniors' Health Teams: Muskoka; North East • Central Inpatient & Specialty Support Service: Ambulatory Services 	<ul style="list-style-type: none"> • Seniors' Health Teams: Central East 	<ul style="list-style-type: none"> • Seniors' Health Teams: North West; Central West 	<ul style="list-style-type: none"> • Central Inpatient & Specialty Support Service: Seniors' Rehabilitation Unit 	<ul style="list-style-type: none"> • Central Inpatient & Specialty Support Service: Seniors' Assessment Unit
CLINICAL PROGRAMS	<ul style="list-style-type: none"> • Ageism & Elder Friendly Environments • Standards of Care for Seniors' Health • Medication & Polypharmacy (2yrs) • Aboriginal Cultural Support 	<ul style="list-style-type: none"> • Time Intensive High Risk Issues -Capacity Personal Care & Finances; Elder Abuse & Neglect (2-3 yrs) • Cognitive Function • Francophone Cultural Support 	<ul style="list-style-type: none"> • Driving • Nutrition, Malnutrition & Anorexia (2 yrs) 	<ul style="list-style-type: none"> • Urinary Incontinence 	
CONSULTATIVE SUPPORT	<ul style="list-style-type: none"> • Mental Health & Addictions • Specialized Behaviours • Transportation 	<ul style="list-style-type: none"> • Rehabilitation • Palliative & End-of-Life Care • Shelter • Home Supports 	<ul style="list-style-type: none"> • Acute Care • Chronic Disease Management 		

The scope of the proposed SHP appears extensive as do the resource implications. However, these can not be viewed in isolation of the current NSM state. Seniors already play a significant role in our existing health care landscape. As such, there is great opportunity for resource re-alignment and specialization (i.e. for services like the Seniors' Assessment Unit, Seniors' Rehabilitation Unit, and the Seniors' Health Team in the Muskoka and North East Regional Pods). In other cases there is a clear business case that funding will generate cost savings over and above the initial upfront cost (i.e. pharmacists for Medication Management & Polypharmacy program). In still other cases there may be the potential to share resources for joint programming. The true extent of these possibilities is unclear and requires ongoing dialogue at both the service and system levels as planning for the envisioned SHP progresses.

CONCLUSION

The SHP is a vision for the future built using an upstream approach to care. Timely and appropriate care will take the place of crisis management and patchwork care. Interprofessional and intersectoral collaboration will lend to improved continuity and care planning. Best practices and evidenced based care will provide the outcomes the system is demanding. Existing resources, successes, planning and regional passion will form the basis for the future to ensure we build on what we do well. In essence the SHP vision targets and dismantles the structures that drive seniors' into the high-cost areas of our system and builds new structures to support seniors in moving toward more cost-effective alternatives to care. By increasing access to Specialized Geriatric Services, improving the quality of care, enhancing self-management abilities and building health human resource capacity the SHP should reduce the percentage of seniors requiring care in Emergency Departments, acute care facilities and long-term care homes. This would translate into reduced Emergency Departments wait times as well as reduced acute care and alternate level of care lengths of stay.

Investment in the SHP vision is both daunting and exciting. To effect outcomes in the near and distant future, system change must start today. This is not a leap of faith. The data and research all point toward the proposed SHP as a logical cost-effective solution to the challenges facing our system. A great opportunity exists for change but we must be willing to work together to breathe life into this document, take risks when necessary, be patient and persevere against all odds. Is the vision being proposed better than what exists today? Absolutely. It is better for seniors, their caregivers, health care professionals and for the system as a whole. The time for change has come and the environment is ready.

APPENDIX A: Recommendations to LHIN

- The LHIN provide leadership regarding regional **health system design**. For IRSHP planning purposes direction would be helpful in regard to structure and function, incorporation, the flow of funding and the employment of staff.
- The LHIN provide leadership and support to regional programs in the development of a centralized approach to common **infrastructure supports** (i.e. finance, human resources, occupational health and safety, purchasing, etc.) to reduce service duplication and promote regional integration.
- The LHIN set direction regarding **governance structures** for regional programs. This direction should articulate the interface between the governance structures of the LHIN, regional programs and individual organizations. Accountability needs to be clarified with a clear description of roles, responsibilities and expectations to ensure accountability matches authority (NSM LHIN). IRSHP development could provide an opportunity for model evaluation.
- The LHIN move ahead with plans to establish a **forum to support regional program alignment and collaboration**. This forum would include representatives from each Regional Action Group and would meet regularly to promote communication and collaboration.
- The LHIN set direction and provide necessary **supports to facilitate agency collaboration or integration** (and avoid multiple regional letters of understanding). The process should be supportive and encouraging to maximize resources and promote regional growth, development and good-will.
- The LHIN provide leadership and support to the regional programs in the development of consistent and strong **funding policies, accountability agreements and aligned incentive programs**.
- The LHIN provide leadership through development of a regional **health human resource strategy**. This could include: the development of a regional recruitment and retention plan; the promotion of regional wage parity; recommendations regarding a regional approach to labour relations; and the development of a regional Human Resource Department.
- Continue to move forward with the patient and provider portal strategy on the NSM LHIN **eHealth Strategic Implementation Plan**. Improved communication and coordination across providers and sectors will reduce service duplication, improve patient safety, increase coordination of care, improve consumer satisfaction and, most important, will help seniors and their caregivers be the best they can be for as long as possible.
- The LHIN develop both a **Regional Research Ethics Board** and a **Regional Ethics Committee** that could be used across regional services and programs. The latter should include a bioethicist.
- The LHIN consider contracting the services of a **philosopher** who could support regional planning and development by challenging norms and pushing boundaries of thought into new realms.
- It is suggested that funding from transitional beds be considered for re-allocation to NSM CCAC and the Community Support Sector to further develop **supportive living** options for seniors.
- It is recommended the **regional transportation system** move toward a central access number with 24/7 access to transportation. Access should account for planned and urgent needs. One central agency should coordinate all scheduling OR all should be on a single scheduling system to maximize available resources. Standard fares should be established across the region with provisions to accommodate low income individuals. Eligibility criteria should be standardized and access to eligibility assessment should be easy. The procedure of curb-to-curb, door-to-door or door-through-door should be based on need, not policy. Opportunities for the use of school buses in off-hours should be explored.

- The LHIN continue funding **Aging at Home vans and drivers**. On an annual basis funds should be allocated to replace aging vehicles and enhance the existing fleet to support the growing aging population and access to the increasing basket of IRSHP services.
- The LHIN provide funds to La Cle de la Baie for a van and driver to support the francophone community (as has been done for the aboriginal community).
- The LHIN contract the services of a team with expertise in **evaluation** to support regional programs in: (1) developing a shared understanding of evaluation and evaluation principles; and (2) developing service-specific indicators for short and long-term program evaluation.
- The LHIN provide leadership and guidance to regional programs regarding reasonable and appropriate reporting mechanisms based on current practices. Accountability needs to be clarified with a clear description of roles, responsibilities and expectations.

APPENDIX B: SHP Action Items

CLINICAL & OPERATIONAL LEADERSHIP

- The SHP should be established as a new agency in NSM. It should be a single highly coordinated structure providing consultative support to the full breadth of seniors' health issues in NSM but direct clinical and operational leadership to a portion of the seniors' health umbrella only. The main focus of this new agency should be ***Specialized Geriatric Services***.
- The SHP should be accountable for all services, programs and structures emanating from the SHP or for which this agency is given responsibility by the LHIN.
- The SHP should be led by an Executive Director and a 0.5FTE Physician Director.
- To promote linkages and encourage a systematic provincial approach to planning, the SHP should explore membership with RGP Ontario.
- As per recommendations 12 and 25 of the NSM Specialized Behaviour Committee (Appendix F), the SHP should hire a 0.5FTE Regional Medical Director for long-term care.
- A Seniors Advisory Committee should be established to provide input into SHP planning and direction. This committee should be comprised of seniors from across NSM. Membership criteria should be developed with individuals chosen based on skills, qualifications and interest.
- The SHP should establish a Committee structure to meet the needs of regional planning and integration. Groups should be comprised of clinical and operational leaders. These working groups should be responsible for making recommendations around regional planning, implementation and evaluation.
- The SHP should work with existing local networks targeting seniors' health issues (i.e. NSM Dementia Network, NSM Elder Abuse Network, Staying Independent Falls Prevention Coalition) to establish timelines and develop strategies to promote successful individual integration within the SHP Committee structure.
- The SHP should establish links with appropriate provincial, national and international seniors' health networks and agencies.
- SHP professionals should remain connected through joint activities, events and team meetings.
- As the SHP evolves, consideration should be given to establish an Ombudsman-type role to address concerns from seniors and their caregivers around system care.

GOVERNANCE

- The SHP and LHIN should establish a strong effective working relationship. The SHP should provide direction to the LHIN in matters regarding seniors' health regionally. In turn, the LHIN should provide necessary support and direction to encourage regional collaboration, maximize system outcomes and enforce accountability. As with all health care services, ultimate accountability for seniors' health in the region should remain with the LHIN.
- The SHP should consider incorporation and governance by a Board of Directors. Board membership should have broad representation and include senior-level decision-makers who have the authority and ability to effect and support system change. The Chair of the Seniors' Advisory Committee should be a member of the Board. In the interim, the Seniors' Health Regional Action Group should continue to provide leadership and direction in SHP development. The Seniors' Health Regional Action Group should review its membership to ensure broad sector representation. Particular attention should be given to community mental health, rehabilitation, long-term care, education, and representation from the Staying Independent Falls Prevention Coalition.

FINANCIAL RESOURCES & STRUCTURES

- As an incorporated agency within the LHIN, the SHP should hold and manage the single funding envelope related to specialized geriatric services in NSM. This funding envelope should also include other services for which the SHP is responsible (as designated by the LHIN).
- In cases where funding is flowed to agencies, tight accountability agreements should be established. When there is a need to withdraw or re-allocate funding there should be strong policies in place to support the SHP's ability to shift or withdraw funds.
- The role of the Executive Director should include government relations and funding generation. Responsibilities should include monitoring government directions and funding opportunities as well as developing and tracking collaborative submissions for funding.
- The SHP should explore opportunities for funding linked with local companies and/or corporations as ethically appropriate. With an increasing aging population comes the risk for increased sick and vacation time as individuals strive to meet the needs of loved ones. Working with local employers to reach creative solutions may benefit seniors, the employers and the SHP.

HEALTH HUMAN RESOURCES

- In Year 1, the SHP should designate funding for 2.0FTE Geriatricians. Funding should supplement fee-for-service income and remain in place until the Alternate Funding Plan is complete. Active attempts should be made to recruit at least one additional geriatrician to the region by 2012.
- The Alternate Funding Plan for Care of the Elderly family physicians should be closely monitored. To support initial SHP development, funding for 2.0 FTE Care of the Elderly family physicians should be designated in Year 1. Funding should supplement fee-for-service income and remain in place until the Alternate Funding Plan is complete. Active attempts should be made to recruit at least four additional Care of the Elderly family physicians to the region by 2012.
- The Seniors' Health Regional Action Group should promote system integration by collaborating with the Mental Health Regional Action Group to assess the current capacity for Geriatric Psychiatrists and determine the need for increased resources.
- A model of physician care should be developed within the SHP to maximize the skills of each geriatric care physician. This model should emphasize the clinical roles of these physicians, define their scope of practice related to Specialized Geriatric Services and articulate the relationship between geriatric care physicians themselves and between geriatric care physicians and their physician colleagues.
- Seniors are triaged at higher levels, more likely to present with complex medical conditions, and take longer to recover from health changes than younger populations. As such, geriatric care physicians are integral to the success of the SHP. The SHP should collaborate with the LHIN to move forward the agenda of geriatric care physician funding and recruitment. In the interim, the SHP should collaborate with existing geriatric care physicians and key stakeholders to develop an alternate plan for medical coverage in the event funding and/or recruitment make the ideal model unattainable. This plan could include use of family physicians and/or Nurse Practitioners who would work in collaboration with existing geriatric care physicians.
- Recognizing the need to build regional capacity among current and future area health care professionals and the need to build capacity in the area of Specialized Geriatric Service, education, mentorship and knowledge transfer should be central components of the SHP (see *Education, Mentorship & Knowledge Transfer* below).
- The SHP should develop a health human resource strategy in consultation with the LHIN. This strategy should include:

- Mentorship and training programs for health care professional students (*'grow our own'* philosophy).
- Developing quality workplace environments in the SHP by incorporating characteristics historically associated with *'magnet hospitals'*, where appropriate.
- Working with unions and agencies to provide unique opportunities for health care professionals.
- Incorporating a pool of relief staff within the Central Core to support short and long term vacancies across the SHP and to help build regional capacity.
- Exploring the role of volunteers and volunteer opportunities within the SHP for the purpose of enhancing the care experience and maximizing the roles of existing SHP professionals.

TECHNOLOGY

- A technology expert should be hired to support the SHP.
- Working within NSM's Health "e"-Strategy and leveraging existing resources and platforms (while minimizing duplication), the SHP should explore opportunities within the region to promote safe, timely and effective communication. This could include :
 - A forum for sharing seniors' specific information with consumers and among providers. Public items could include things like weblinks, newsletters and an events calendar while secure space for providers could include discussion boards, minutes from team meetings and working groups, links to education and research materials, a list of all regional staff and their contact information, access to regional referral and assessment tools as well as patient information sheets, the regional policy and procedure manual, etc.
 - An e-collaboration environment for health care professionals to facilitate communication, a standard approach to care and a regional interdisciplinary approach to problem solving.
 - Secure transmission and storage of personal health information.
 - A central registry for all seniors that have entered the NSM seniors' health system.
 - A central scheduling system for all services within the SHP to improve access to services and system coordination.
 - All staff being equipped with portable, always-on devices to promote real-time responses. These devices could contain tools like the Giic toolkit, the Merck Manual and Epocrates.
- The SHP should work with existing systems and providers to better utilize regional technologies to improve quality of care and access to cost-effective services. This could include:
 - Working with OTN to support the use of video conference technology across the region. Consideration should be given to purchasing and deploying OTN equipment across all SHP sites to promote connectivity.
 - Working with the Re-ACT and OTN technologies to explore whether a more targeted population for in-home monitoring would contribute to improved patient and system outcomes.
 - Working with other technology providers as appropriate (i.e. Diagnostic Ultrasound regarding bladder ultrasound machines; Lifeline).

EDUCATION, MENTORSHIP & KNOWLEDGE TRANSFER

- The SHP should establish an Education, Mentorship & Knowledge Transfer Committee with representation from all sectors. This Committee should be responsible for meeting the needs of existing health care professionals, future health care professionals and the public.
- The SHP should hire a 1.0FTE to oversee regional education, mentorship and knowledge transfer. This individual should work closely with the Education, Mentorship & Knowledge Transfer Committee to: coordinate and generate exciting and unique opportunities for existing health care professionals, health care professional students and public education; promote knowledge transfer; support professionals in the

development, delivery and evaluation of education events; develop regional preceptors and mentors across sectors; coordinate an annual regional conference; coordinate education funding; facilitate regional orientation; facilitate the standardization of education products; and support Ontario Telemedicine Network use. This individual should also be responsible for Regional Geriatric Grand Rounds and for establishing a calendar of regional education events.

- Education, mentorship and knowledge transfer within the SHP should emphasize interprofessional and practice and collaboration, cross rural and urban landscapes and cross the continuum of care. A variety of education forums and strategies should be used to encourage attendance and generate excitement. Technology would play a critical enabling role.
- Relationships should be established and nurtured with Georgian College, Rural Ontario Medical Program, the Northern Ontario School of Medicine, the aboriginal teaching center being developed at Rama and the Family Practice Teaching Unit at the Royal Victoria Hospital to develop regional capacity in seniors' health, enhance SHP recruitment and retention opportunities, and to support SHP programming, services, education, policy and research.
- The SHP should pursue opportunities with the Family Practice Teaching Unit at the Royal Victoria Hospital around using available clinic space for some of the SHP's clinical services.
- All professionals employed within the SHP should contribute to regional education, mentorship and knowledge transfer. This should be included in position descriptions and each professional should have dedicated time to develop and provide education to colleagues, students and/or the public.
- All professionals employed within the SHP should have dedicated time for their own professional development. This should be included in position descriptions.
- Year 2 Aging at Home funds allocated to the annual falls education event should be re-allocated to support an annual seniors' health conference which may include a presentation on falls.
- A central education fund should be established for SHP staff to support professional development. Funding allocated to the Regional Falls Program should be shifted into this central fund. Those interested in attending events should apply for funding. Funding allocations should be based on need, applicability, equity and cost and should be governed by the Education, Mentorship & Knowledge Transfer Committee.
- Regional Geriatric Grand Rounds should become centrally based within the SHP effective July 2009.

RESEARCH & ETHICS

- The SHP should establish a Research & Ethics Committee. This committee should be responsible for:
 - Establishing and leading research and ethics rounds to promote evidence based care. These rounds should provide an opportunity for interested providers to come together to review cases, examine research and discuss ethics related to seniors' health.
 - Encouraging the examination of SHP initiatives and programs through a research and/or ethics lens.
 - Making recommendations and supporting the development of research ideas and proposals.
 Until a regional structure is established, the SHP should explore the merits and challenges in linking with an existing Research Ethics Board and Ethics Committee.
- The SHP and all SHP staff should become members of Seniors' Health Research Transfer Network (SHRTN), an on-line knowledge exchange network that includes communities of practice, library services and access to the Ontario Research Coalition/ Centres on Health & Aging.
- The SHP should explore opportunities with Georgian College and the Centre for Education and Research on Aging & Health (CERAH) at Lakehead University regarding joint research opportunities.

- All professionals employed within the SHP should support the SHP research foundation by reviewing research studies, including research in presentations and using research to develop and continuously improve services. As appropriate, professionals should participate in SHP research projects.

ADVOCACY & POLITICAL ACTION

- The SHP should play an active role in regional advocacy and political action starting by examining issues like:
 - The recent fires in area retirement homes and LTC facilities.
 - Increasing prices by pharmacists for medication blister packs.
 - The structural design of new Retirement Homes being built in the region.

CENTRAL INTAKE & TRIAGE

- The SHP should use the Interim Central Intake & Triage service established in the Regional Falls Program as the foundation for a permanent Central Intake & Triage service. It should include:
 - Seven day a week service operating, at minimum, eight hours a day.
 - A single toll-free phone number.
 - Processes and procedures adopted from the interim service.
 - The central scheduling and client registry components of the interim service.
- The SHP should ensure the service builds on, and is integrated with, existing resources like 211, NSM CCAC and Telehealth. Seniors should continue to be directed to existing entry points. However, all NSM seniors should be able to access this service when their needs exceed the knowledge and scope available at existing entry points. Only those meeting specific SHP eligibility criteria should receive assessment and triage support.
- To enhance system accessibility, SHP services should accept referrals from any health care professional and, when appropriate, seniors and caregivers. In cases where eligibility criteria is not met referring sources should be linked with other services where possible and appropriate. In cases where physician involvement is required attempts should be made to acquire appropriate primary care support.

CENTRAL INPATIENT & SPECIALTY SUPPORT SERVICE

- The SHP should establish a Central Inpatient & Specialty Support Service in one centralized location in NSM. The location should have access to: a high functioning interdisciplinary team with expertise in seniors' health; a Geriatrician and Geriatric Psychiatrist; other medical specialists; and to a broad scope of diagnostic testing that supports the assessment of complex seniors.
- CISSS should use the Falls Clinics (to be established in the Regional Falls Program) and the Orillia Soldiers Memorial telemedicine clinic as the foundations for its ambulatory and outreach components. Flexibility and fluidity should underlie the design of these services in order to best meet the needs of seniors and the locally-based Seniors' Health Teams. The design should incorporate technology as a key enabler.
- CISSS should include an 8-10 bed **Seniors' Assessment Unit**. This unit should target complex seniors requiring specialized interdisciplinary assessment and time-limited intervention in an inpatient setting. The unit should provide short stay consultative support to seniors residing across the continuum of care.
- CISSS should include a 12-16 bed **Seniors' Rehabilitation Unit**. The possibility of establishing the unit within an existing Complex Continuing Care Unit in NSM (ideally Orillia Soldiers Memorial Hospital) to serve the slow stream rehabilitation population should be explored.

SENIORS' HEALTH TEAMS

- The SHP should expand and replicate the Algonquin Family Health Team's Geriatric Care Team to establish a high functioning interdisciplinary Seniors' Health Team in each Regional Pod.

- The SHP should hire a 1.0FTE Manager and 1.0FTE Administrative Assistant to manage and coordinate each Team. Team members should include: a Care of the Elderly family physician, 1.0FTE Nurse Practitioner, 2.0FTE RNs; 1.0 FTE Physiotherapist; 1.0FTE Occupational Therapist; 1.0FTE Rehabilitation Assistant; 1.0 SMART Coordinator; 1.0FTE Social Work; 0.4FTE Speech Language Pathologist; 1.4-2.2FTE RNs for Geriatric Emergency Management; and 2.0FTE NSM CCAC Client Care Coordinators to support intensive case management. A 0.4FTE pharmacist and 0.4FTE Clinical Dietitian should be hired for a two year period at which point the positions should be re-evaluated based on regional capacity. Of note, all resources identified should be doubled for Central East.
- The resources from the Orillia Soldiers Memorial Geriatric Day Hospital, the Algonquin Family Health Team's Geriatric Care Team and those from the NSM CCAC Intensive Case Management program should be used to form the first Seniors' Health Teams in Muskoka and North East. The work, successes and experience of these teams should be leveraged to form the foundation of all regional Seniors' Health Teams.
- Resources within the Regional Falls Program (Falls Screening Clinics, Emergency Department Support Service) should be shifted to support the establishment of area Teams.
- The SHP should stagger the development and implementation of the Seniors' Health Teams recognizing the need to build capacity and engage key stakeholders in planning. Development should start with the establishment of Seniors' Health Teams in Muskoka and North East (Year 1), followed by Central East (Year 2) and then Central West and North West (Year 3).
- The SHP should consult with key stakeholders in the North East region to determine whether the site of the current Geriatric Day Hospital at Orillia Soldiers Memorial Hospital is the best location for the area's Seniors' Health Team or whether other options should be explored.
- Each Seniors' Health Team should connect at minimum monthly with an area Geriatrician via the Ontario Telemedicine Network.
- The SHP should open dialogue and collaborate with local agencies regarding the co-location of services. This would include discussion, as appropriate, of shared space and shared programming.
- The SHP should collaborate with Georgian College's Health Sciences Faculty and the Community Support Sector to explore opportunities for seniors' health screening clinics across the region.
- The SHP should explore the status of current screening clinics in the region being funded by corporate agencies. As appropriate, the SHP should approach these agencies regarding service alignment and resource sharing opportunities.
- The SHP should recruit Senior Citizen Counsellors. These could be senior volunteers or could be seniors paid at a nominal fee who could provide several hours of service/wk to support seniors in locating appropriate government supports and in completing associated paperwork. This would not include income tax paperwork. An area accountant or service could be recruited during tax time to support area seniors.
- Depending on the evolution of the Seniors' Health Teams, resources from existing regional 'transition worker' roles could be re-allocated to these Teams.

AGEISM & ELDER-FRIENDLY ENVIRONMENTS

- The SHP should promote senior-friendly health care environments through action and policy. This should be a fundamental mandate of this agency.
- The SHP should provide consultative support to the broad seniors' health umbrella regarding senior-friendly environments and advocate, as appropriate, for system change.

- The SHP should link with existing age-friendly community initiatives around the region and, if no initiatives exist, should advocate for the establishment of such committees.

STANDARDS OF CARE FOR SENIORS' HEALTH

- The SHP should provide consultative support to the broad seniors' health umbrella regarding standards of care and advocate, as appropriate, for system change.
- The SHP should establish standards of care within all SHP Specialized Geriatric Services.
- The SHP should collaborate with the Regional Geriatric Programs of Ontario to promote the Geriatric Interprofessional Interorganizational Collaborative (GiiC) toolkit as a key regional resource.

FALLS

- The SHP should work with the Staying Independent Falls Prevention Coalition to establish timelines and develop strategies to promote successful integration within the SHP Committee structure.
- The NSM Regional Falls Program Planning Committee should continue to plan and develop a Regional Falls Program for seniors in NSM (see Appendix I) (planned implementation fall 2009). In future, resources from this first SHP building block should be shifted to support SHP evolution. For example:
 - The Clinical Nurse Specialist should broaden her scope.
 - The ED Support Service should form the foundation for Geriatric Emergency Management and intensive case management in each Regional Pod.
 - Resources should be shifted centrally to support SHP evolution: \$10,000 annual conference; professional education fund.
 - The Falls Clinics should form the foundation of the NSM Seniors' Health Clinic.

MEDICATION MANAGEMENT & POLYPHARMACY

- Given the impact medication has on seniors and the health system from a safety and cost perspective, the SHP should hire 2.0FTE pharmacists for a 2 year period at which point the role should be re-evaluated. These individuals should play a key role in working with pharmacists in the community, acute care and within family health teams to build regional capacity regarding medication and seniors. As part of their mandate, this group should be responsible for developing and implementing a regional program addressing the use of medications with seniors.

COGNITIVE FUNCTION

- The SHP should work with the Mental Health Regional Action Group and the NSM Dementia Network to develop an integrated regional Cognitive Function Program that builds on existing resources, successes and planning. This will form the second building block of the SHP.
- The SHP should work with the NSM Dementia Network to establish timelines and develop strategies to promote successful integration within the SHP Committee structure.
- Along with falls, cognition should be a core component of the SHP and central to orientation and professional development.

TIME INTENSIVE, HIGH RISK ISSUES

- The SHP should work with the Mental Health Regional Action Group and the NSM Dementia Network to develop an integrated regional approach to the assessment of Capacity for Personal Care & Finances that builds on existing resources, successes and planning. Local lawyers or law societies should be involved as appropriate.
- The SHP should work with the NSM Elder Abuse Network to develop an integrated regional approach to Elder Abuse & Neglect that builds on existing resources, successes and planning.
- Given that capacity and elder abuse are time intensive high risk issues, that there is a need to increase regional knowledge and skills, and that there is interest in developing a standard regional approach to care, the SHP should hire a 1.0FTE for a 2-3 year period to address capacity and elder abuse. This

individual should: build regional capacity through education, mentorship and knowledge transfer; support the work of the SHP and key regional groups by doing the work required to develop and implement a regional approach to both capacity and elder abuse; and provide guidance to SHP staff in cases of capacity and suspected elder abuse and neglect.

- The SHP should work with the NSM Elder Abuse Network to establish timelines and develop strategies to promote successful integration within the SHP Committee structure.
- The SHP will consult with the NSM Elder Abuse Network to clarify the role of the existing Muskoka resource.

DRIVING

- The SHP should open dialogue with Skill Builders to explore the possibility of collaboration to establish a coordinated and standardized regional approach to driving safety in NSM through SHP Occupational Therapists.

NUTRITION, MALNUTRITION & ANOREXIA

- Given the impact nutrition has on seniors and the health system and the presence of dietitians in the community, acute care and family health teams, the SHP should hire 2.0FTE dietitians for a 2 year period at which point the role should be re-evaluated. These individuals should play a key role in working with area dietitians to build regional capacity. As part of their mandate, this group should develop and implement a regional program addressing nutrition, malnutrition and anorexia in seniors. This program should be initiated upon completion of the Medication & Polypharmacy program.

URINARY INCONTINENCE

- Along with falls and cognition, continence should be a core component of the SHP and central to orientation and professional development. Programming around continence should form the third large building block of the SHP.
- The SHP should meet with existing Nurse Continence Advisors to explore integration opportunities.
- Where and when possible the SHP should support SHP Registered Nurses in becoming trained as Nurse Continence Advisors.
- 1 bladder ultrasound machine should be purchased for each Seniors' Health Team for use in the assessment and management of urinary continence.

ABORIGINAL CULTURAL SUPPORT

- The individual currently hired through Aging at Home funding to support the cultural needs of aboriginal seniors should remain located with the Barrie Area Native Advisory Council but become accountable to the SHP. This individual should expand their scope from the community to cross the continuum of care. This individual should support all aspects of the SHP (i.e. services, education, research, political action) to support the provision of culturally sensitive care to NSM seniors and their caregivers.

FRANCOPHONE CULTURAL SUPPORT

- The SHP should hire a 1.0FTE fluently French-speaking RN to be located at La Clé de la Baie in the North West region. Like the Aboriginal Support role, this individual should work with francophone seniors across the NSM region and across the continuum to provide consultative services in French. This individual should not be the sole francophone support within the SHP but a first step toward the provision of more culturally sensitive care. This individual should support all aspects of the SHP (i.e. services, education, research, political action) with responsibilities including, for example, participation in clinics to deliver services in French, providing education and committee membership as required. This position should be accountable to the SHP.

MENTAL HEALTH & ADDICTIONS

- The SHP should work with the Mental Health Regional Action Group to support the development of an integrated regional psychogeriatrics program that builds on existing resources, successes and planning AND ensures the right care is being provided in the right place by the right providers. During planning consideration should be given to: establishing a position to oversee the development of a regional plan for Mental Health that would include psychogeriatrics as a key target population; establishing specialty staff within each existing MH service; developing the psychogeriatric capacity of Emergency Department Crisis Workers as well as SHP staff; promoting an integrated and collaborative approach to care between Mental Health and SHP staff; and establishing a position specifically dedicated to supporting seniors crossing into the criminal system.
- The SHP should work with existing mental health and addiction services to explore opportunities to integrate such services into the Regional Pods.

SPECIALIZED BEHAVIOURS

- The SHP should work with the Mental Health Regional Action Group and the NSM Dementia Network to support the development of an integrated regional Specialized Behavioural Health Supports Program that builds on existing resources, successes and planning.

ACUTE CARE

- The SHP should hire a 1.0FTE Clinical Nurse Specialist, Seniors' Health to provide consultative support to interested hospital teams to support quality of care improvements and generate cost savings. Five populations are at greatest risk and would benefit from focused interventions:
 - Dementia with behaviour problems
 - Delirium
 - Medically complex population – seniors admitted with diagnoses like weakness, falls, Failure to Thrive. These complex diagnoses are often associated with increased morbidity and LOS.
 - Seniors falling between the cracks – seniors admitted with straightforward medical conditions who remain in the system longer than required because they literally 'fall between the cracks'.
 - Falls – falls are commonplace in hospital, so common they are often overlooked as a normal part of aging. Falls are a focus of accreditation and patient safety.

REHABILITATION

- The SHP should work with formal regional networks (i.e. Central East Stroke Network, etc.) and key stakeholders as appropriate to support the development of an integrated regional plan for rehabilitation as well as the prevention and management of deconditioning in seniors that builds on existing resources, successes and planning.
- To extend the success of VON's SMART program's congregate and in-home volunteer-led exercise program, the SHP should increase the existing regional SMART Program Coordinators (from the Regional Falls Program) from 4.0FTEs to 6.0FTEs to align with the Regional Pods.
- As noted above, the SHP should develop a Seniors' Rehabilitation Unit for seniors requiring more intensive inpatient rehabilitation.

CHRONIC DISEASE MANAGEMENT

- The SHP should work with formal regional networks (i.e. Central East Stroke Network, the region's Diabetes Collaborative, etc.) and key stakeholders as appropriate to support the development of integrated regional chronic disease programs that build on existing resources, successes and planning.

PALLIATIVE & END-OF LIFE CARE

- The SHP should work with the NSM Palliative Care Network to increase integration between the two sectors:

- The SHP should support the NSM Palliative Care Network in advocating for the establishment of a Palliative Resource Team in each Sub-Planning region. The SHP should then work with the NSM Palliative Care Network to explore opportunities to integrate these teams into each Regional Pod.
- The SHP should work with the NSM Palliative Care Network to share resources and knowledge to build the capacity of both teams and promote system integration.

SHELTER

- The SHP should collaborate with the Municipalities to explore supportive housing options and lobby for additional resources as appropriate.
- The SHP should continue to be actively involved in the Balance of Care initiative and support recommendations regarding shelter through advocacy and, when appropriate, action.
- The SHP should advocate for the regulation of Retirement Homes in the province to ensure seniors are receiving safe appropriate care.
- The SHP should advocate for the establishment of a regional Retirement Home Committee to promote ongoing improvements in care and standardization across this sector. The SHP could be a member of this Committee to provide consultative support.
- The SHP should advocate for the establishment of a regional Long-Term Care Committee to promote ongoing improvements in care and standardization across this sector. The SHP could be a member of the Committee to provide consultative support.
- The SHP should advocate for the establishment of specialty units in the NSM long-term care network to better meet the needs of specific populations (i.e. under age 60; Specialized Behaviours).

HOME SUPPORTS

- The SHP should work with the Community Support Sector and the NSM CCAC to explore integration opportunities that build on existing resources, successes and planning. Where possible new and innovative approaches to care should be explored and implemented. For example:
 - Shared care models and co-location of services within the Regional pods should be explored.
 - The SHP should work with Aging at Home funded initiatives like Re-ACT, First Link, the Mobile Seating & Mobility Clinic and Home At Last to promote integration into the Regional Pods. Through such opportunities, initiatives like Re-ACT for example may be able to target higher risk seniors and build on the successes this program has seen to date.
 - The SHP should work with key stakeholders including the Community Support Sector and the NSM CCAC to develop, establish and continually improve the Seniors' Health Teams.
 - The SHP should collaborate with the NSM CCAC to replicate and integrate the Intensive Case Management program within each Seniors' Health Team.
- The SHP should support the Community Support Sector and the NSM CCAC in advocating for continued growth in home support funding to enhance the basket of services currently available to NSM seniors and their caregivers. In particular there is a gap in convalescent beds around the region, evening and weekend respite, day programs to support individuals with more complex needs (i.e. quadriplegics, feeding tubes, catheters, etc), in-home counselling, cognitive behaviour therapy, etc.
- The SHP should continue to be actively involved in the Balance of Care initiative and support recommendations regarding home supports through advocacy and, when appropriate, action.
- The SHP should advocate for the establishment of a call-center in each Regional Pod connecting volunteers with targeted seniors. This center could help reduce social isolation, provide reminders regarding key appointments or routine events, and help monitor needs.

TRANSPORTATION

- The SHP should continue to support the LHIN and community support services in the development of an integrated regional transportation system that builds on existing resources, successes and planning.
- The SHP should continue to be actively involved in the Balance of Care initiative and support recommendations regarding transportation through advocacy and, when appropriate, action.

SHP OUTCOMES

- The SHP should hire a consultant with expertise in evaluation and balanced scorecards to support the development of an evaluation framework for the SHP within Year 1.
- The SHP should hire an individual as part of the Central Core to support data analysis, outcome evaluation and ministry reporting.
- The SHP should work with the LHIN to establish reporting mechanisms that would meet any possible SHP accountability requirements.

210 Memorial Avenue
Suites 127-130
Orillia, ON L3V 7V1
Tel: 705 326-7750
Toll Free: 1 866 903-5446
Fax: 705 326-1392
www.nsmhlin.on.ca

210, avenue Memorial
Bureaux 127 à 130
Orillia, ON L3V 7V1
Téléphone : 705 326-7750
Sans frais : 1 866 903-5446
Télécopieur : 705 326-1392
www.nsmhlin.on.ca

Behavioural Support System Project Steering Committee

Draft Final Version August 24, 2011

Terms of Reference

Purpose

To design and implement a comprehensive Behavioural Support System (BSS) for the residents of the NSM LHIN.

General Responsibilities

- Support the development of an integrated BSS that provides person-centred, timely, equitable access, high quality, evidence-based services in an efficient, effective and sustainable manner;
- Identify innovations in the delivery of an integrated BSS across the health system continuum, in alignment with the Ontario BSS Framework for Care (2011);
- Manage change and transformation to enable an integrated BSS that better services the population¹, their families and health service providers;
- Provide direction (short and long-term) for BSS initiatives to ensure alignment with the overall Care Connections integrated implementation roadmap;
- Facilitate continued emphasis on inter-professional collaboration and standardization;
- Recommend the next level of priorities for BSS;
- Plan for future system capacity;
- Ensure communication, coordination and standardization with the Complex and Chronic Health Needs Coordinating Council and other Coordinating Councils and Project Steering Committees as appropriate;
- Work with NSM LHIN to develop measurements to track performance and the achievement of results.

Specific Responsibilities

Oversee and ensure the:

- Implementation of LHIN-wide BSS arising from the recommendations in the 10- year *Care Connections – Partnering for Healthy Communities Project*. Recommendations for years 1-3 of the 10-year plan are:
 - Provide an inpatient care setting and programming to better meet the needs of a specialized population that currently may not receive appropriate care; and
 - Enhance community care services and capacity to support individuals with behavioural needs within the system to care for this population.

- The engagement and creation of opportunities for involvement of people living with behavioural support needs who live within North Simcoe Muskoka, including cultural diverse populations (i.e., Aboriginal People, Francophones, etc.).

Lead Organization and Project Steering Committee Chair

Lead organization for the Project Steering Committee named by the LHIN Board upon recommendation of the LHIN Leadership Council.

Chair: Lead organization Executive Director/CEO or designate.

Role and Responsibility of the Project Steering Committee Chair

- Chair committee meetings;
- Act as liaison between the Project Steering Committee and the Coordinating Council; and
- Facilitate work towards fulfillment of annual committee objectives and project charter.

Role and Responsibility of the Vice Chair

- Jointly prepare agendas;
- Act as Chair in the absence of the chair.

Role and Responsibility of the Project Manager:

- To facilitate the application of project management principles and techniques to committee work;
- To bring agenda items to the vice-chair for inclusion on the agenda to support the application of Project Management; and
- To track and report on progress on committee projects using tools available (i.e., Eclipse).

Role and Responsibility of Committee Members

- Each member will leverage their power, influence, knowledge and authority at whatever level possible to advance the work of the BSS Project Steering Committee. As well each member will contribute their resources where appropriate to advance the work of the BSS Project Steering Committee.

Project Steering Committee Composition

The Project Steering Committee will reflect representation from all LHIN funded and non-LHIN funded health service providers and non-health providers required to provide expertise and diverse perspectives related to the continuum of care for the target population.

The BSS Project Steering Committee will include:

- Lead organization CEO/ED (Chair)
- LHIN Liaison (LHIN staff member; ex-officio; non-voting)
- Representation from:
 - LTC Homes
 - Acute Care
 - Community Support Services (CSS)
 - Primary Care (e.g., FHTs, CHCs, NP-Led Clinics, Allied Health Professionals)

- CCAC
- Specialized Psychogeriatric and Behavioural Support Services
- Community Mental Health - Psychogeriatric Services
- Physician (i.e., family physician and/or specialist)
- Others as determined by the Project Steering Committee.

Members will be expected to bring a broad system level perspective to the table. From time to time there may be a need to involve ad hoc groups or individuals which reflect the target population, the geographic areas of NSM, and affected organizations. Additionally, an individual member may represent multiple constituents.

Accountability

- The Lead Organization Board and CEO/ED will be accountable to the LHIN to ensure the functioning of the Project Steering Committee through a signed Project Charter.
- The Project Steering Committee will report to the CCHNCC through the Project Steering Committee Chair.
- On a schedule determined by the Coordinating Council, the Project Committee will report on progress and outcomes of its work, and as it relates to impacts on established priorities.
- Development and dissemination of a comprehensive communication plan to guide the operationalization of these change initiatives.

Quorum

A quorum for the meeting will be 50% plus one, not including ex-officio, non-voting members.

Confidentiality/Transparency

Members are expected to be open and candid in discussing items before the Project Steering Committee. For this reason, members will agree not to disclose information or views expressed by individuals during meetings, including any confidential information or documentation. Declarations of confidentiality should be announced during the meeting. Members agree to support the decisions of the Project Steering Committee and to speak with one voice outside the meetings.

Conflict of Interest

Individual members of the Project Steering Committee shall identify prior to any discussion any potential, real or perceived conflict of interest. If the Steering Committee deems that there is a real, potential or perceived conflict of interest, that Steering Committee member must remove him/herself from the discussion.

Decision Making Framework (Refer to Tool)

Available to the Project Steering Committee, if required, is the NSM Decision Making Framework that includes the following steps:

- Step 1: Frame the question
- Step 2: Determine decision makers
- Step 3: Screen for strategic fit
- Step 4: Finalize decision criteria
- Step 5: Gather relevant information
- Step 6: Apply decision support tool

- Step 7: Identify and assess risks and controls
DECISION
Step 8: Communicate the decision
Step 9: Evaluation & Continuous quality improvement

Consensus Building

Any disagreement or dispute which might arise between the members will be resolved harmoniously, creatively and constructively through a process of consensus decision making. In the event that an agreement is not forthcoming and the members are at an impasse, the following protocol will be invoked:

- a) An impasse is defined as an unresolved or unmanageable disagreement that has discernable and measurable negative consequences for the committee or the project.
- b) Best efforts will be given to resolving the impasse in a timely manner by openly acknowledging and applying the guiding principles noted above.
- c) If warranted, the Coordinating Council will be consulted, only after all other avenues to resolve the disagreement have been exhausted.

Code of Conduct

Although the Project Steering Committee may establish further guidelines to which members must adhere, the following guidelines will apply:

- Members operate under the Terms of Reference;
- Members will make the Project Steering Committee a priority to attend meetings and complete assigned tasks on time and on budget;
- Members will arrive on time to all meetings, and actively participate throughout the full duration of each meeting;
- Members will be transparent and collaborative in their approach, and support full discussion of ideas during meetings;
- Members will be responsible for completing any preparatory work or information required in advance of task force meetings;
- Membership will strive for consensus building approach to making recommendations; and
- Membership will be responsible for discussing opportunities for change with key stakeholders in their own organizations, to gain stakeholder inputs and build buy-in to key decisions.

Evaluation

The Project Steering Committee shall evaluate the effectiveness annually in meeting their objectives and designated responsibilities, as noted in these terms of reference and Project Charter and/or Project Plan.

Frequency of Meetings

Meetings will be held monthly, with additional meetings held on an as needed basis, as determined by the BSS Project Steering Committee Chair.

BSS Project Steering Committee Chair

CCHNCC Council Chair

Date Approved: _____

Date Revised: _____

DRAFT

ⁱ older people with cognitive impairments due to mental health problems, addictions, dementia, or other neurological conditions often exhibit responsive or challenging behaviours such as aggression, wandering, physical resistance and agitation. **FOOTNOTE (BSO, A Framework for Care, January 2011)

FACTS

Doorways

Strengthening connections between providers and clients

'Doorways' is a client centric Community Mental Health and Addictions eHealth Project being undertaken in partnership with eHealth Ontario and initiated by four of Ontario's LHINs (*North East, North West, North Simcoe Muskoka and Champlain*), which will realize benefits for all of Ontario's 14 LHINs once the pilot has proven the technology value of this important information sharing tool.

This portal technology is an intranet portal that will be an access point for clinical information for a limited number of addictions and mental health care providers, under this pilot. The tool will provide a doorway to information for a complete history that can be used in assessing the right services for this group of clients. Intranet portals have restricted access. Internet portals are open to anyone.

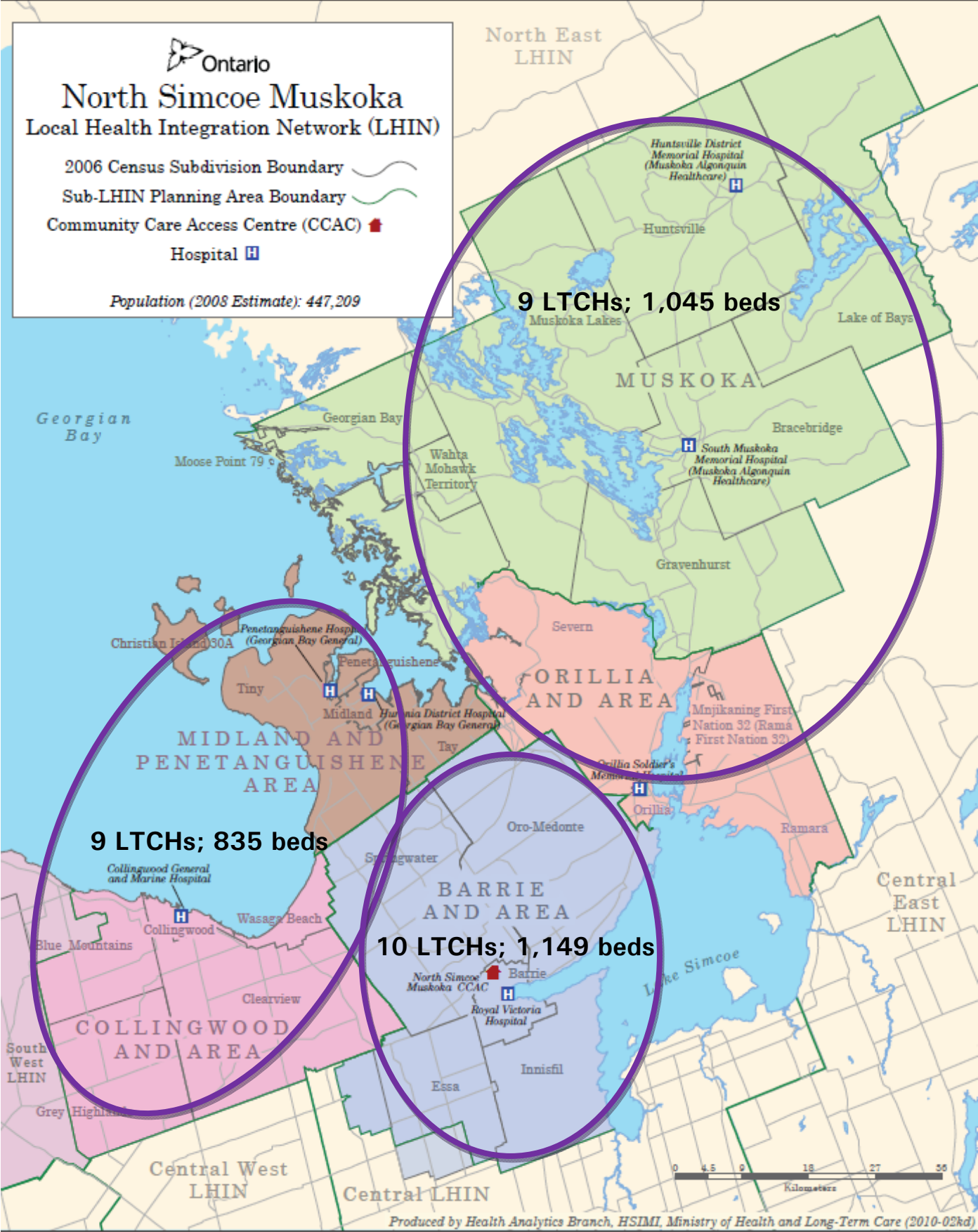
Sault Area Hospital working with North East (NE), North Simcoe Muskoka (NSM), North West (NW), and Champlain LHINs will deliver system-to-system integration via a provider portal across the participating LHINs. The type of information to be shared will be mental health and addictions assessment information (Ontario Common Assessment of Needs – OCAN) along with inpatient and RAI Mental Health (MH) information. During this pilot project, this information will be shared amongst a small group of geographically clustered, authorized users including care and service providers within community mental health and addictions services, hospitals/ERs/in-patient psychiatric services and community physicians.

Pilot participants will access mental health and addictions assessment information for patients across all participating LHINs through a multi-LHIN provider portal hosted by The Ottawa Hospital in accordance with applicable privacy and consent policies. Participants will include a cross-section of clinicians and users from at least one Schedule 1 Hospital and at least 2 community-based settings within each LHIN.

This project is the first step to a larger potential technology system for accessing medical information from a number of different sources all through one 'doorway' or portal. This project will test the value of this portal technology for health care providers and the opportunities for adding information that will broaden the depth of information providers can access in assessing needs of clients. This is being portal pilot is being undertaken with mental health and addictions providers and clients.

For more information on this project, please contact Gary Hurd, Senior Project Manager, PMO & eHealth, North Simcoe Muskoka Local Health Integration Network at (705) 326-7750 ext: 205.












September 2010



PLANNING AREA	#	NSM LHIN LTCH - ORGANIZATION	Location	Type of Operator	Total Number of Beds
MUSKOKA (5)	1	The District Municipality of Muskoka, The Pines Home for the Aged	Bracebridge	Municipal	160
	2	Huntsville District Nursing Home Inc. (Fairvern)	Huntsville	Nursing Home Non-Profit	76
	3	Leisureworld Caregiving Centre – Muskoka	Gravenhurst	Nursing Home For Profit	182
	4	Huntsville Long-Term Care Inc. (Muskoka Landing)	Huntsville	Nursing Home For Profit	94
	5	Muskoka Algonquin Healthcare (MAHC) – South Haven	Huntsville	Hospital –Interim Beds	12
ORILLIA & AREA (4)	6	Revera Long-Term Care Inc. (Oak Terrace)	Orillia	Nursing Home For Profit	94
	7	Trillium Manor Homes for the Aged	Orillia	Municipal	122
	8	Orillia Long-Term Care Centre (Leacock Care Centre)	Orillia	Nursing Home For Profit	145
	9	Leisureworld Caregiving Centre – Orillia Spencer House	Orillia	Nursing Home Non-Profit	160
MIDLAND/ PENETANGUISHENE & AREA (4)	10	Villa Care Centre	Midland	Nursing Home For Profit	114
	11	Georgian Bay General Hospital	Midland	Hospital – Interim Beds	36
	12	Hillcrest Village Care Centre	Midland	Nursing Home For Profit	164
	13	Georgian Manor Home for the Aged	Penetanguishene	Municipal	107
BARRIE & AREA (10)	14	Sara Vista Nursing Centre - Revera Long Term Care Inc.	Elmvale	Nursing Home For Profit	60
	15	Coleman Care Centre	Barrie	Nursing Home For Profit	112
	16	I.O.O.F. Seniors Home Inc.	Barrie	Charitable	162
	17	Woods Park Care Centre	Barrie	Nursing Home For Profit	123
	18	Mill Creek Care Centre	Barrie	Charitable/not for profit Christian	160
	19	Grove Park Home for Senior Citizens	Barrie	Nursing Home Non-Profit	143
	20	Leisureworld Caregiving Centre Barrie	Barrie	Nursing Home For Profit	57
	21	Barrie Long-Term Care Centre Inc. (Roberta Place)	Barrie	Nursing Home For Profit	140
	22	Ontario Long-Term Care Home for the Deaf	Barrie	Nursing Home Non-Profit	64
	23	Victoria Village Manor	Barrie	Nursing Home Non-Profit	128
COLLINGWOOD & AREA (5)	24	Bay Haven Nursing Home Inc.	Collingwood	Nursing Home For Profit	60
	25	Sunset Manor Home for the Aged	Collingwood	Municipal	150
	26	Collingwood Nursing Home Ltd.	Collingwood	Nursing Home For Profit	60
	27	Stayner Nursing Home Ltd.	Stayner	Nursing Home For Profit	49
	28	Leisureworld Caregiving Centre – Creedan Valley	Creemore	Nursing Home For Profit	95

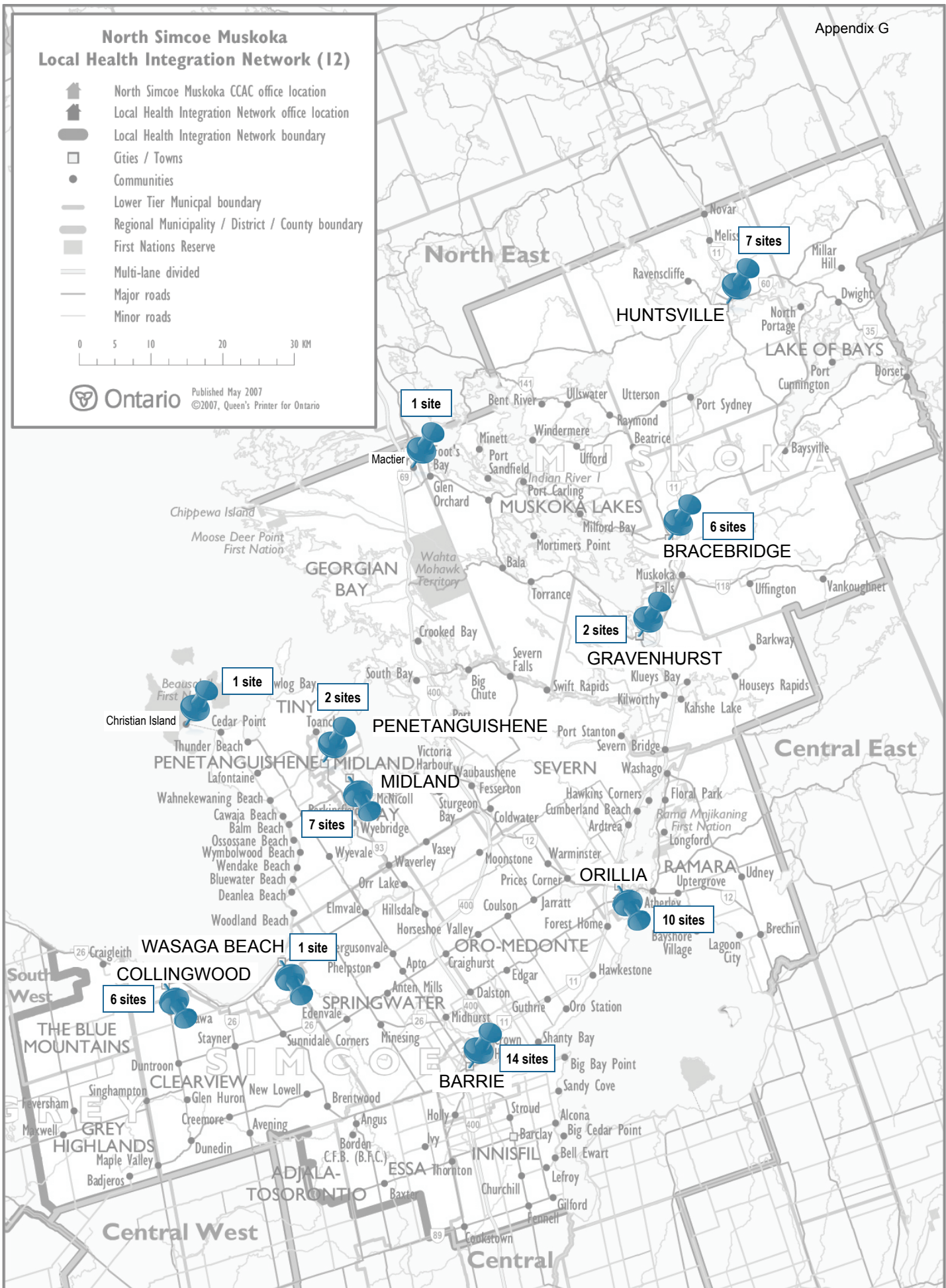
Date	Event	Participant/ Stakeholders
August	Call for member ship and formation for the NSM BSS Local Action Plan Working Group	Post BSO Launch, weekly NSM BSS Working Group meetings (face to face and web conference).
Sept. 5-16 th	NSM LHIN website update, Communication Memo to Local Action Plan Working Group for public/staff, Update at the NSM Dementia Network Steering Committee Meeting, NSM ALC Bullet Rounds, NSM LHIN Internal Staff Education/Communication	
Sept . 20/21 st	Value Stream Mapping with Health Quality Ontario	41 participants including our 2 Buddy LHINs 39 Frontline NSM professionals representing various professions(e.g., PSWs, NPs, Case Managers, Occupational Therapy, RPNs, Pharmacy, Social work, PRCs, Geriatric Nurse Clinicians, Aboriginal Health workers etc.) and Programs/Providers (e.g., NSM CCAC, NP LTCH Outreach Teams, LTCHs, Hospitals, OSMH Geriatric Day Hospital, First Link, Red Cross, VON, Wendat, BIRT, BANAC, Beausoleil Family Health Centre, CHC etc.).
	Physician Forum Sept 20 th – LTCH Medical Directors Meeting - discussed role of primary care physician in the system with the population of focus and areas of need. Feedback incorporated into VSM day 2 dialogue.	2 Physician Leads – Dr. Moser and Dr. Mossman 7 LTCH Medical Director/Physicians
	Sept 21 st Value Stream Mapping Invite to Debrief/Close out and Documents on the LHIN allocation and action plan development	Email communication was sent to: ALC bullet round members (Hospitals, CCAC, CSS) Local NSM BSS Action Plan Working Group All agencies that received an invitation for frontline staff participation (Hospitals, FHTs, FHN, CHCs, CSS, A&MH, 28 LTCH Administrators etc.) Care Connections Operations Council of the NSM LHIN NSM LHIN 5 Local Leadership Councils
Sept. 27 th	Open Stakeholder Webcast and In person presentation & review of the plan with Q&A	32 participants Sector Representation Included: LTCHs, Addictions & Mental Health Agencies (Aboriginal), Psychogeriatric Resource Consultants (PRCs), Specialized Geriatric Services, NSM CCAC, Community Support Service Agencies (CSS), Hospitals, LHIN Buddies and Physicians
	NSM Community Support Services (CSS) Collaborative – presentation of the plan to members for input.	The following is a list of some of the organizations represented in membership with the CSS Collaborative: Aboriginal Health Circle/BANAC; Alzheimer Societies, CHCs, Brain Injury Services of Simcoe County, Breaking Down Barriers, Canadian Mental Health Association, Canadian Paraplegic Association, Canadian Red Cross, Canadian National Institute for the Blind, County of Simcoe Adult Day Programs, Deaf Access, The Friends, Helping Hands, Hospices, Independent Living Services, VON etc.
Sept. 28 th	Presentation to the Complex and Chronic Health Needs Coordinating Council (CCHNCC)	Motion of support from the CCHNCC CEO of Georgian Bay General Hospital/ Chair of the CCHNCC CEO of Orillia Soldiers’ Memorial Hospital/ Chair of the Chronic Disease Prevention & Management (Diabetes) Project Steering Committee CEO of Muskoka Algonquin Healthcare/ Chair of the Complex Continuing Care Project Steering Committee

North Simcoe Muskoka Local Health Integration Network (12)

-  North Simcoe Muskoka CCAC office location
-  Local Health Integration Network office location
-  Local Health Integration Network boundary
-  Cities / Towns
-  Communities
-  Lower Tier Municipal boundary
-  Regional Municipality / District / County boundary
-  First Nations Reserve
-  Multi-lane divided
-  Major roads
-  Minor roads



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North Simcoe Muskoka LHIN

Barrie OTN Sites	
Brain Injury Services Muskoka	
Canadian Mental Health Association	151 Essa Road Suite 202 (705-725-5491)
Canadian Mental Health Association	15 Bradford St. (705-726-5033)
Canadian Red Cross Society	
Children's Treatment Network of Simcoe York	165 Ferris Lane (705-719-4795)
LMC Barrie	5 Quarry Ridge Rd. (705-737-0830)
New Path Youth and Family Services	
North Simcoe Muskoka CCAC	15 Sperling Dr. (705-721-8010)
Ontario Addiction Treatment Centres	20 Owen St. (705-730-0286)
Rajkhowa Medicine Professional Corporation	46 Eugenia St. (705-739-6245)
Royal Victoria Hospital	201 Georgian Dr. (705-728-9090)
Simcoe Community Services - Fraser Court	129 Ferris Lane (705-727-1235)
Simcoe Muskoka District Health Unit	15 Sperling Dr. (705-721-7520)
York Central Hospital BMS York & Simcoe	570 Bryne Drive Unit H (705-728-9143)
Bracebridge OTN Sites	
Community Living South Muskoka	RR 7, 15 Depot Dr. (705-645-5494)
Family, Youth and Child Services of Muskoka	
Hands TheFamilyHelpNetwork	23 Ball's Dr. (705-645-3155)
Muskoka Algonquin Healthcare	75 Ann St. (705-645-4400)
Muskoka Parry Sound Community Mental Health Service	173-202 Manitoba St. (705-645-2262)
Ontario Addiction Treatment Centres	500 Hwy 118 W #5 (705-645-1677)
Christian Island OTN Sites	
KOTM - Beausoleil First Nation Health Centre	82A Katekegwin St. (705-247-2012)
Collingwood OTN Sites	
Children's Treatment Network of Simcoe York	200 Hume St. 705-719-4795
Collingwood General & Marine Hospital	459 Hume St. (705-445-2550)
E3 Community Services Inc.	100 Pretty River Pkwy N. (705-445-6351)
Georgian Bay Family Health Team	186 Erie Street, Suite 100 (705-444-5885)
Rural Ontario Medical Program	459 Hume St. (705-445-7667)
Rural Ontario Medical Program (ROMP)	150 St. Paul St. 705-445-7667
Gravenhurst OTN Sites	
Correctional Service Canada - Fenbrook Institution	2000 Beaver Creek Dr. (705-687-6641)
Simcoe Muskoka District Health Unit	2-5 Pineridge Gate (705-684-9090)

Huntsville OTN Sites	
Christian Horizons - North District	114A Main St E. (705-789-1725)
Dr. Mark Mensour	35 Lake Drive (705 326-7750)
Family, Youth and Child Services of Muskoka	
Muskoka Algonquin Healthcare	100 Frank Miller Dr. (705-789-2311)
Muskoka Parry Sound Community Mental Health Service	67 Main St. Unit 1 (705-746-4264)
North Simcoe Muskoka CCAC	8 Crescent Road, Unit B3 (705-721-8010)
Mactier OTN Site	
Mactier Medical Centre	53 Haig St (705-375-5200)
Midland OTN Sites	
Canadian Mental Health Association	478 Bay St. (705-527-8738)
Children's Treatment Network of Simcoe York	230 Aberdeen Blvd. No phone number on file
Community Living Huronia - Lead Agency	339 Olive St. (705-526-4253)
Community Living Huronia - Childrens Treatment Network	230 Aberdeen Boulevard (705-526-0311)
Georgian Bay General Hospital	1112 Andrew's Dr. (705-526-1300)
Métis Nation of Ontario	9170 Country Rd. 93 Box 50 Unit 301 (705-526-6335)
North Simcoe Family Health Team	240 Penetanguishene Rd, Suite 100 (705-526-7804)
Orillia OTN Sites	
Canadian Mental Health Association - Orillia	76 Nottawasaga St. (705-726-5033)
Children's Treatment Network of Simcoe York - Orillia	1080 Mississauga St. West (705-326-214X)
Couchiching Family Health Team	
Dr. John MacFadyen	216 Colbourne St. W. (705-325-1120)
North Simcoe Muskoka Infection Control Network	80 Victoria St., Unit 7 (705-325-2201)
North Simcoe Muskoka LHIN	210 Memorial Av, Suite 127-130 (705-326-7750)
Orillia Pediatric Teaching Associates - Dunedin St.	17 Dunedin St. (705-327-9188)
Orillia Public Health Laboratory	750 Memorial Ave. (705-325-7449)
Simcoe Community Services - Orillia	35 West St. North (705-726-9082)
Orillia Soldiers' Memorial Hospital	170 Colbourne St W. (705-325-2201)
Wasaga Beach OTN Site	
South Georgian Bay Community Health Centre	14 Ramblewood Dr., Unit 202 (705-422-1888)
Penetanguishene OTN Sites	
Georgian Bay General Hospital	25 Jeffrey St. (705-526-1300)
Mental Health Centre Penetanguishene	500 Church St. (705-549-3181)