Regional Specialized Geriatric Services in the Central East LHIN:

Options for Coordinated Delivery, Organization and Governance

Prepared by

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&

The Regional Geriatric Advisory Committee Expert Panel

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PREFACE: A CONSUMER POINT OF VIEW

(Commentary from a Pickering Resident and Consumer Advocate for Seniors)

This model, hereafter referred to as the *Central East Regional Specialized Geriatric Services (CE-RSGS)*, is the work of an expert panel of health professionals, lead by Carol Anderson, and is focused on improving services targeted at frail, elderly seniors in the Central East LHIN (CE-LHIN).

It is important to remind ourselves that the model is about ***seniors' quality of life*****,** and is based on an assessment of the current environment in which we live. Thus, as you evaluate the model, I would encourage you to be mindful of your own families, friends and neighbours.

Over the years, it has become easier to dismiss client stories as "anecdotal", and of relatively low priority. Nonetheless, I would urge you to include a consumer point of view — from clients and caregivers — as you evaluate the model. To assist you in doing so, I would like to provide some stories that are representative of literally thousands in the current service system:

- *Mr. Smith, age 85, was admitted to hospital after being found unresponsive on the floor of his home. After spending two days in emergency, he was admitted in a de-conditioned state. After his blood sugar had been stabilized, he was discharged, but had nowhere to go and was designated as ALC. The family did not have the ability to care for him, and with LTC as the recommended plan, he was moved to the next town and away from his family (ALC Task Force, June, 2008).*

- *Mrs H, age 90, was found in a confused state in the lobby of her condo. She was taken to emergency and diagnosed with a TIA; she was admitted overnight for further tests. Since the ER was busy, she waited 36 hours in the hallway and became de-conditioned. After being moved to a floor, she fell and broke her hip in the middle of the night. This required surgery, but that was delayed for 48 hours due to other priorities. During her eventual surgery, there were complications, and after four days in the ICU and recovery, she passed away (Scarborough, 2010).*

- *Mrs. Grant, age 79, lived alone and had three children who lived out of town. She had diabetes and was becoming increasingly confused and disoriented, eventually slipping and falling on an icy surface while walking. On admission, she was found to have broken her hip and wrist. Her son flew in to develop a care plan with the staff: LTC was recommended, but there was no facility available and the CCAC could only commit to limited support. She was discharged home, where the family struggled unsuccessfully to support her, with the result that she ended up in LTC (TDHC Report, April, 2004).*

- *"Million-Dollar Murray" was a homeless senior who had mental health and addiction issues, as well as various other chronic conditions. In the course of a year, he would visit or be taken to the Emergency department at least once a week, and was discharged after each episode had been treated. He gained his nickname from the Emergency staff, who estimated that after Murray passed away, they had spent over $1M on his visits (Malcolm Gladwell, What the Dog Saw, 2010).*

- *Moira MacDonald, a caregiver for her elderly father, penned an article called "A Better Way of Death-Our Health Care System is Failing the Dying and Missing the Big Picture". In it she described the confusing, fragmented and un-coordinated communication she experienced in supporting her father until his eventual death at home, especially emphasizing home care after his acute care discharge. She concluded that: "Our parents' deaths make us face up to the reality of death. This country has to figure out a better way to manage the health care of aging people up to and including their deaths" (Toronto Sun, July, 2006).*

The expert panel of health professionals, who understands geriatrics and ultimately produced the following CE-RSGS report, has done an outstanding job of identifying the issues, understanding past and present models of success, and performing a current environmental scan for the CE-LHIN. The panel recommends the adoption of the CE-RSGS model with a full implementation plan.

In the panel's view, the model represents a strong framework for ***improving the quality of life for patients and their care-givers, while significantly reducing the expenditures spent on clients, by employing a proactive, early and complete assessment of their needs.*** The panel's report also recommends an effective "branding" initiative to clearly inform consumers, so that they can more easily understand and more efficiently access the services recommended in the model.

Once again, as you evaluate this model, I encourage you to reflect on your own experiences and expectations as a potential or actual consumer. The model is not a panacea for all seniors' services, but I believe that it does provide a succinct starting point upon which to build a more client-focused and caring future.

What about Mrs. Smith, Mrs. H, Mrs. Grant, Murray, and Moira's father? I am convinced that if this model is implemented, and others like them were to become clients in the CE-LHIN, the outcomes would be very different. I leave it to your imagination to picture the more positive endings that are possible and achievable.

The time to act is now!

Acknowledgements

It would be remiss not to acknowledge the specific contributions of the following individuals and teams, since without their insights this journey and outcome would not have been nearly as rich or fruitful:

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The *Champions and Key Informants* (see Appendix B) who took the time to share their projects, insights and progress on integration activities for frail seniors in Ontario.

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Carol Anderson

EXECUTIVE SUMMARY

There will be a 19% increase in the number of seniors aged 65+ in the CE-LHIN by 2019, and a 47% increase in the number of seniors aged 85 and older. This growth will include 42,449 frail seniors with significant health care needs – an increase of 36%. The impact of these demographic trends will be profound. For example, the current population of seniors in the CE-LHIN aged 75+ is 6.5%, yet they utilize 45% of all acute hospital days and 70% of all Alternate Level of Care (ALC) days. The latter already represents a 128% increase over the last five years. It is critical that the CE-LHIN build a network of services to meet the needs of our rapidly-growing population of seniors. The recommendations contained in this report provide a comprehensive strategy on which to build better health outcomes and ensure excellent care for all frail CE-LHIN seniors.

This report recommends that the CE-LHIN ***adopt and embrace*** the model to develop its network of Specialized Geriatric Services (SGS). Evidence is clear that SGS can identify and prevent frailty, reverse it when it has occurred, support primary care, optimize a senior's independence, and assist in achieving system goals, such as reducing emergency department (ED) wait times, hospital admissions and ALC days. This will require an investment in service development, as the current state of Specialized Geriatric Services in the CE-LHIN is insufficient to meet the needs of today's frail seniors, let alone the growth that is anticipated. In fact, the current system is described as:

> *"...frustrating; confusing/difficult to sort out; unclear who can help to navigate; duplication of information; waiting for assessments and services" (Frail Senior and Family Member).*
>
> *"...little or no access to SGS unless you are in the hospital; multiple assessments with no outcomes/treatment; lack of access to primary care for frail seniors; insufficient expertise in geriatrics; confusing and frustrating to access with long wait times" (Service Provider).*
>
> *"...an aging clientele is putting tremendous strain on primary care; little or no access to geriatric specialists; unsure how to connect into the system; unsure of what is available for frail senior clients" (Primary Care Provider).*

The report will argue that its recommendations are based upon a comprehensive understanding of local, national and international knowledge, which confirms that the CE-LHIN requires a model of services with the following components:

- ✓ An ***umbrella organization*** that has the sole mandate to improve health services for frail seniors that is embedded in the system, as opposed to running parallel to it,
- ✓ An umbrella organization that ***controls funding*** as a mechanism to leverage system-wide change and integration,
- ✓ A mechanism to ***organize service providers*** that ensures accountability to a common philosophy and commitment through joint planning, budgeting and service delivery,
- ✓ Integration and ***linkage with primary care*** and other sectors, recognizing the need to coordinate multiple health and social services to maintain frail seniors in their homes and,
- ✓ The provision of ***system-wide case management*** for high-risk frail seniors that coordinates and navigates the entire system of services needed.

To achieve these goals the *CE-LHIN Regional Geriatric Advisory Committee Expert Panel* recommends that the CE-LHIN proceed immediately to ***endorse*** the model described, to ***fund*** the human resources required to champion the report's components and to ***execute*** the following recommendations:

- The CE-RSGS will be based on a ***Shared Governance Model***, in order to build a sense of shared accountability, an adherence to a common philosophy and a commitment to the vision, mission and goals of the system of services for frail seniors across the CE-LHIN.
- The CE-RSGS will be governed by a new entity, the ***Governance Authority/Board***, bound by a *Memorandum of Understanding* that will guide system-wide strategic planning and share accountability for the overall organization and coordination of Specialized Geriatric Services across the CE-LHIN.
- The CE-RSGS will provide direction to the CE-LHIN regarding funding and performance for all SGS service providers through a ***CE-RSGS Annual Service Plan***.
- The CE-RSGS will require dedicated resources through the creation of a "***Secretariat"*** (administrative and clinical system leadership) that will be funded either by the LHIN directly or through the levy of a mandatory service provider membership fee.
- The CE-RSGS will adopt the principle of standardization, beginning with the creation of a consumer-friendly, identifiable ***"common brand"*** (e.g. "Geriatric Services") that will be recognized and utilized across the entire CE-LHIN. The franchise- type concept would be utilized to brand the services and ensure that, regardless of where the client enters the system, the "brand" is exactly the same (e.g. "store within a store" concept).
- The CE-RSGS will apply to the Regional Geriatric Programs (RGPs) of Ontario to become an ***affiliate member of the RGPs of Ontario***. This will ensure a broader connection to provincial activity and evidence-based practice regarding frail seniors' care.
- The CE-RSGS will initiate a demonstration project of a stratified ***system-wide case management model*** for the high-risk and frail senior population.
- The CE-RSGS will initiate two tactical teams to complete early integration work as identified by stakeholders from across the CE-LHIN: a) ***standardization*** of nomenclature/language and tools, and, b) implementation of ***early identification***, ***centralized screening and referral*** processes.

The creation of the CE-RSGS will provide the necessary ***governance and accountability infrastructure*** to enable: a) the integration of existing SGS (e.g. central intake and screening), b) effective expansion of services to ensure equitable access for all high-risk and frail seniors in the CE-LHIN and, c) the creation of a broader seniors' strategy that encompasses the entire continuum of services for seniors in the CE-LHIN.

It is clear that providers, consumers and other stakeholders are ready to move forward - it is time to move from strategy to action and to implementation!

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SECTION A: CONTEXT AND CURRENT STATE

1. Purpose, Scope and Project Methodology

1.1 Why a Regional Model for Geriatric Services?

The implementation of a regional model for the organization, coordination and governance of specialized geriatric services will provide a platform and structure to facilitate clinical and service delivery integration activity and to build ***better health outcomes for frail seniors*** across the CE-LHIN. A system that provides shared accountability and joint planning, as opposed to competition, will also:

- Provide a mechanism to ensure that services are ***consistently delivered*** across the region according to common principles established for specialized geriatric services,
- Create a system that is ***better understood and more transparent*** to consumers and caregivers, reducing the stress and frustration caused by navigating a complex health system,
- Ensure ***seamless equitable access to*** high-quality and outcomes-focused specialized geriatric services for all residents within the CE-LHIN, regardless of where they live,
- Provide support for the ongoing development of inter-professional teams in geriatrics/gerontology that will facilitate the region-wide development of the expertise required to care for frail seniors – building a sustainable ***human resource infrastructure*** for the CE-LHIN ,
- Enable ongoing ***development and investment*** in Specialized Geriatric Services by leveraging existing resources and capitalizing on the inherent efficiencies gained (improve coordination and reduce redundancy/duplication),
- ***Improve communication*** across all sectors and organizations and,
- ***Preserve the diversity*** of the communities within the CE-LHIN with respect to health service delivery while developing expertise in geriatrics through ***building local capacity.***

It is also recognized that orchestrating this level of inter-organizational integration is challenging within the existing health system in the Province because:

- there are systemic barriers to the development of integrated care models,
- the layers of politics complicate ownership of innovation,
- regional inequalities in the distribution of resources, organizational intensity and economies of scale can compromise collaboration processes,
- inherent inequities can create a sense of fear and perceived loss ("your integration is my disintegration"), causing organizations to ***cling to*** resources and information and,
- integrated networks/models of care require sustained commitment to shared accountability at a senior management level in health service organizations in order for the spirit of cooperation to percolate throughout the system.

The following two statements might be said to underpin the work of health service integration for frail seniors in the CE-LHIN and characterize the spirit within which the recommendations in this report ought to be considered:

Goal: *"Reduce unnecessary redundancy whilst preserving requisite diversity" (Dr. D. Ryan, 2011).*

Behaviour: *"It is amazing what can be accomplished when nobody cares about who gets the credit" (Bob Yates, NASCAR driver).*

1.2 Background and CE-LHIN Context

The CE-LHIN Specialized Geriatric Services (SGS) landscape reflects a number of local services that have evolved over many years in response to the changing demographics of an aging population and the local commitment to deliver specialized services for frail seniors. Health service providers in the CE-LHIN have long recognized the value of planning and delivering services collaboratively; hence, it may safely be assumed that the need to bring together the system of services designed to meet the needs of high-risk and frail seniors living in the community is a common goal.

In fact, there have been many successes in bringing health service partners together on issues related to frail seniors, ranging from collaborative education forums and interest groups (e.g. The Regional Geriatric Interest Group of Durham and the Frail Elderly Alliance of Durham) to numerous joint service delivery planning activities (Home First, PASE, First Link, etc.). With the LHIN now acting as an enabler for regional planning, activity has a broader geographic scope and for the first time is focused on service implementation collaboration (e.g. Geriatric Emergency Management) and service delivery integration (e.g. the Geriatric Assessment and Intervention Network Urgent/Emergent Clinics).

Through the Provincial *Aging at Home* strategy (AAH), the CE-LHIN has been strategically investing in both SGS, CCAC and other community support services targeted at enhancing care for high-risk and frail seniors. These significant investments, however, now require regional coordination. The CE-LHIN and its health service partners recognize that in order to advance the planning and implementation of a network of specialized services across the LHIN, inter-organizational collaboration and overall system coordination is now more critical than ever.

Through the creation of an organized system and common infrastructure, partners can leverage their existing investments in SGS, potentially extending service delivery beyond what is currently possible while providing the capacity to respond to emerging opportunities. This level of integration requires careful orchestration and full collaboration across and between sectors in order to ensure that a truly seamless model evolves – a model that moves Central East closer to a truly "regional" geriatric program.

1.3 Scope of the Current Project

The scope of this work includes determining and recommending to the CE-LHIN Executive Team a regional model that provides a mechanism to organize, coordinate, govern and grow ***Specialized Geriatric Services*** in the CE-LHIN. The proposed model must be principles-driven and built on the requirement for solid commitments from health service organizations. Joint ownership and accountability for outcomes will enable the region to achieve the vision for the delivery of services to high-risk and frail seniors. The project deliverables and associated recommendations include consideration of:

- existing models for system organization and governance, a preferred model for a Regional Specialized Geriatric Services Program in the CE-LHIN, implementation timelines and the associated recommendations,
- existing CE-LHIN investments, services, linkages and relationships as well as leveraging existing LHIN investments in SGS (including GEM, NPSTAT and GAIN) in order to ensure enhanced coordination and organization of these services and,

- the system of Psychogeriatric Services under development in the region to ensure collaboration and synergies in overall approach between these overlapping populations.

Although it is recognized that designing a ***fully-integrated model*** that includes both health and social services is preferable for frail and vulnerable seniors, the report does not include the entire spectrum of services. Why not? It is acknowledged that there are many other care providers, local community services and the primary care network – all of whom are critical to support frail seniors in the community. These partners would be integrated into the model during subsequent rounds of system planning. In addition, this report is NOT intended to articulate a complete Service Delivery Model for SGS in the CE-LHIN. This report outlines the initial work required to improve the organization, coordination and governance of a system of region-wide SGS, thereby providing a solid platform for service delivery integration initiatives.

Hence, the report does not include:

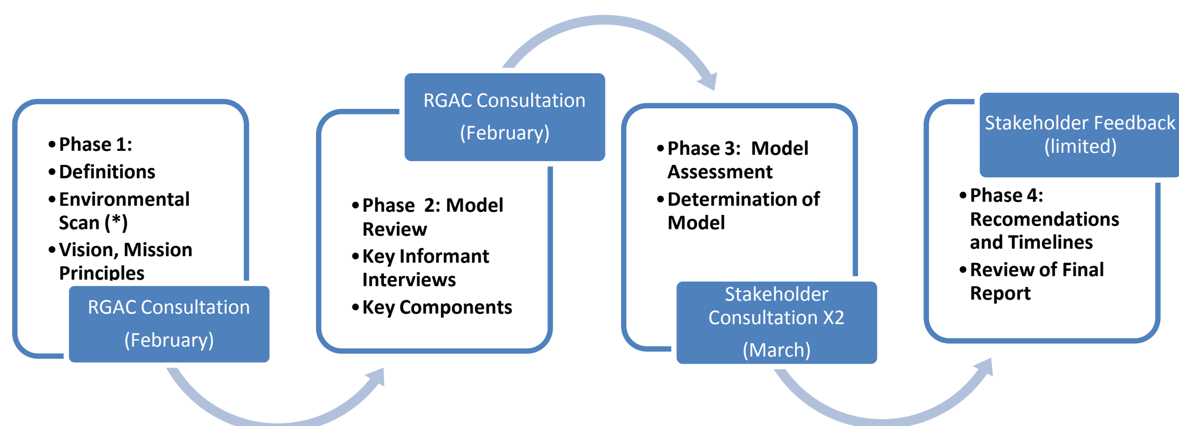
- An assessment of current capacity of SGS or recommendations for investments in current service delivery components,
- A detailed assessment of current SGS utilization and performance (this work is being detailed in a parallel report: *Specialized Geriatric and Pyschogeriatric Services in the CE LHIN: An Environmental Scan, 2011)*.
- Any services for seniors/older persons that are not defined as SGS (e.g. housing, long term care home beds, foot care services, CCAC in-home support, restorative care, etc.), and
- Psycho-geriatric services that are not typically delivered by specialized mental health and geriatric teams.

1.4 Project Methodology:

1.4.1 Work Flow and Consultation

In January 2011, the CELHIN recruited the Project Lead to spearhead the work. The Project Lead, in consultation with SGS providers in the region, brought together an expert panel to assist with providing consultation and direction throughout the project (see Appendix A). The *CE-LHIN Regional Geriatric Advisory Committee Expert Panel* met as a group five times from February through April, 2011; in addition, individual Committee members provided ongoing *ad hoc* advice during the project. The process followed to complete the deliverables (final report) is outlined in Figure 1.

Figure 1. Overview of Project Flow



**Note: Environmental Scan completed by consultant and available under separate cover.*

Phase 1: Determine scope of the project and definitions to guide the environmental scan; review vision, mission and principles from other models for CE-LHIN synergies.

Phase 2: Review of relevant literature related to frameworks for integrated health systems; review of existing models of integrated health services for frail seniors; review of Ontario landscape and some of the progressive models under development utilizing key informants, champions and references (see Appendix B for List of Key Informants).

Phase 3: Complete an assessment of models and model components and obtain evidence to support model components; determine the recommended model components for integrating SGS in the CE-LHIN; deliberate over potential options.

Stakeholder Consultation: Hold two stakeholder consultation sessions; one in the East area of the LHIN (Peterborough) and one in the West (Ajax) (see Appendix C for attendees); Purpose: to share information and received feedback on the inventory to date and the proposed model components.

Phase 4: Determine final recommendations and timelines; review final report and recommendations with Expert Panel and select stakeholders.

1.4.2 Establishing the Vision, Mission and Principles for an Integrated Regional Geriatric Program in the CE-LHIN

The *CE-LHIN Regional Geriatric Advisory Committee Expert Panel* created a vision, mission, principles and values for a regionally-integrated program in the CE-LHIN that would underpin the further development of a model in the region (see Appendix D). The preliminary vision document was used to keep the planning and the discussion grounded in shared values and goals. In addition, the work was positioned from the client or consumer perspective to ensure that discussions and decisions integrated the consumer vantage point (e.g. What is the issue from the seniors' perspective? What would make the most sense from a consumer perspective?).

The vision statement adopted by the team was:

> ***"Better Health Outcomes for Frail Seniors in the CE-LHIN"***

1.4.3 Development of a Planning Framework for Integration

Due to the complexity inherent in planning integrated systems, a framework was designed and utilized to ensure an understanding of the levels and relationships between features of an integrated system. The framework in Appendix E includes the five domains of integration activity (funding, administrative, organizational, service delivery and clinical) within the health system (Kodner and Spreeuwenberg, 2006), and includes consideration of the foundational pieces (shared philosophy and policy prerequisites) that support successful integration activity in any of these domains (Hollander and Prince, 2008). The framework was used to ensure that the project team remained focused on the components and necessary infrastructure for an integrated model, versus a focus on specific service delivery and clinical integration components.

2. Relevant Definitions to Guide Planning Work

2.1 What is "Frailty"?

Frailty generally includes the concept of vulnerability and is based upon a loss of function, medical complexity and advanced age (Markle-Reid and Browne, 2003). It is estimated that approximately 15% of older adults over the age of 65 are frail. Rockwood *et al.* (2005) developed a seven-item Frailty Index from the Canadian Study of Health and Aging (CHSA), which was a cumulative count of 70 clinical deficits, including disease severity, functional deficits and neurological signs of frailty. Fried *et al.* (2001) described frailty from a primarily functional perspective that requires individuals to have three of the five frailty criteria: unintentional weight loss, self- reported exhaustion, weak grip strength, slow walking speed and low physical activity.

For purposes of this report, frailty is defined as ***a multidimensional syndrome of loss of reserves (energy, physical ability, cognition, health) that gives rise to vulnerability*** (Rockwood *et al*., 2005). Regardless of definition, it is widely accepted today that frailty is a syndrome or condition that in many instances can be halted, if not reversed (Wilson, 2004). As such, the focus of Specialized Geriatric Services in recent years has shifted upstream to the identification of those at risk of frailty in order to change the frailty trajectory.

2.2 What is a Senior- friendly Hospital?

A senior-friendly hospital (SFH) refers to an organization that recognizes that older individuals have unique needs, requiring a change in approach in order to ensure a safe hospital stay and healthy outcomes. In 2010, the Regional Geriatric Program of Toronto led the SFH provincial assessment to determine how hospitals are measuring up with respect to care for seniors in five domains:

- *Organizational Support*: reflects how the organization shows support for being a SFH,
- *Processes of Care*: reflects how current the processes of care and treatment for seniors are (e.g. extent of best practice implementation),

- *Emotional and Behavioural Environment*: reflects the organizational culture for seniors,
- *Ethics in Clinical Care*: reflects how fully ethical issues are addressed and,
- *Physical Environment*: reflects whether the physical space is sensitive to the needs of seniors.

2.3 What are Specialized Geriatric Services?

Specialized Geriatric Services (SGS) provide a range of services to support older individuals who are frail. It includes specialized geriatric assessment, consultation, short-term treatment, rehabilitation, and short-term specialty case management. SGS uses inter-professional teams with expertise in the care of the elderly, including geriatric medicine and geriatric psychiatry services, and have specialty physicians (geriatricians or geriatric psychiatrists) as part of the team. SGS relies on other services (e.g. community support services) to be effective, and delivered in a variety of home, ambulatory, long-term care facilities and in-patient hospital settings. SGS can significantly contribute to a frail senior's ability to remain in their home (cf: HNHB Brief Report, 2008).

"The fundamental premise of these services is that much of the disease, disability, and dependence associated with aging are ***preventable, treatable or manageable****. Such services have been shown to decrease the 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. Through consultation and education, specialized geriatric services serve an important role in influencing and sensitizing providers in the health care system to the needs of frail seniors" (RGP Website).

SGS includes both established and emerging service components. These include geriatric emergency management, geriatric rehabilitation, geriatric day hospital, geriatric outreach, geriatric specialty clinics, inpatient geriatric consultation, inpatient geriatric assessment and treatment, acute care of the elderly units, urgent-emergent care clinics and nurse-led outreach to long-term care. The RGP of Toronto is currently undertaking a review of new and emerging SGS.

Many of the following definitions have been adapted from the *"RGP Business Case Template for Specialized Geriatric Services in Acute Care Hospitals" (Draft; December 2010)*. These working definitions traditionally define the scope of SGS. In addition, any new and emerging SGS in Central East will be described in the Environmental Scan. Additional definitions for specific SGS services can be found in Appendix F.

2.4 What is Psychogeriatrics?

Geriatric Psychiatry or Psychogeriatrics refers to that branch of psychiatry concerned with the mental health of older people. The specialty deals with the full range of mental illnesses and their consequences, particularly mood and anxiety disorders, the dementias, the psychoses of old age and substance abuse. In addition, the specialty deals with seniors who developed chronic mental illness at a younger age. Psychiatric morbidity in old age frequently coexists with physical illness and is likely to be more complicated by social problems. Seniors may also have more than one psychiatric diagnosis. Many mental illnesses in old age can be treated successfully. Some, particularly the dementias, are chronic and/or progressive (International Psychogeriatric Association: www.ipa-online.net).

2.5 What is the relationship between SGS and Psychogeriatrics?

There is significant overlap between the current service delivery of psychogeriatric services and Specialized Geriatric Services. The assessment and management of mental state and cognition is routinely part of a Comprehensive Geriatric Assessment (CGA) completed by a SGS Inter-professional team. However, when a vulnerable client presents with significant mental health/cognitive issues AND physical frailty, the need to integrate care and develop a comprehensive and holistic plan is essential. The client-centred principles (see Appendix D) that underpin the development of a regional geriatric model in the CE-LHIN require that service integration be driven from the client, rather than from a service delivery, perspective. Ideally, the interface between these services will remain invisible to the frail, vulnerable consumer and, as such, will not be defined as separate entities in the planning process.

3. Brief Overview of the Environmental Scan – Central East

3.1 Demographic Distribution of Seniors and Frail Seniors in the CE-LHIN

In 2009 the general population of the CE-LHIN was just over 1.5 million residents, 13.75% (200,000) of whom were seniors (65+). This proportion is comparable to other regions of Ontario. However, as evidenced in Figure 2, the distribution of seniors by region or community is dramatically different across the CE- LHIN, with the highest *proportion* of seniors living in the northern and rural communities of Haliburton Highlands, Northumberland and Kawartha Lakes. This unique geography will need to be considered in the creation of a service delivery model that both ensures access to services and is delivered efficiently and cost-effectively.

Figure 2. Percentage of CE-LHIN Residents Aged 65+ by Region

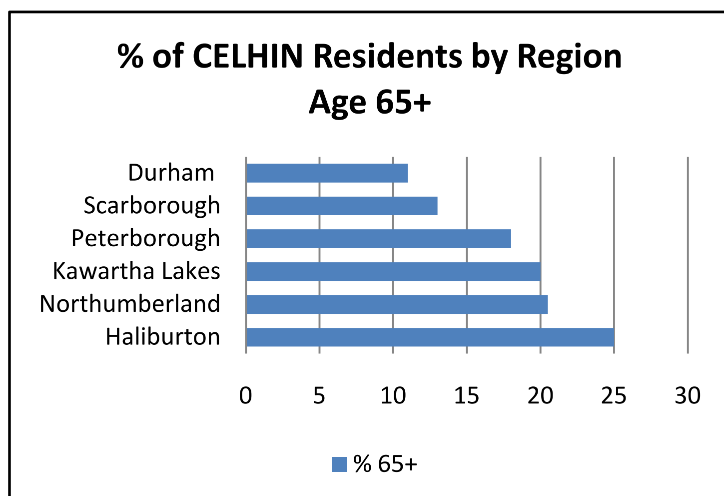
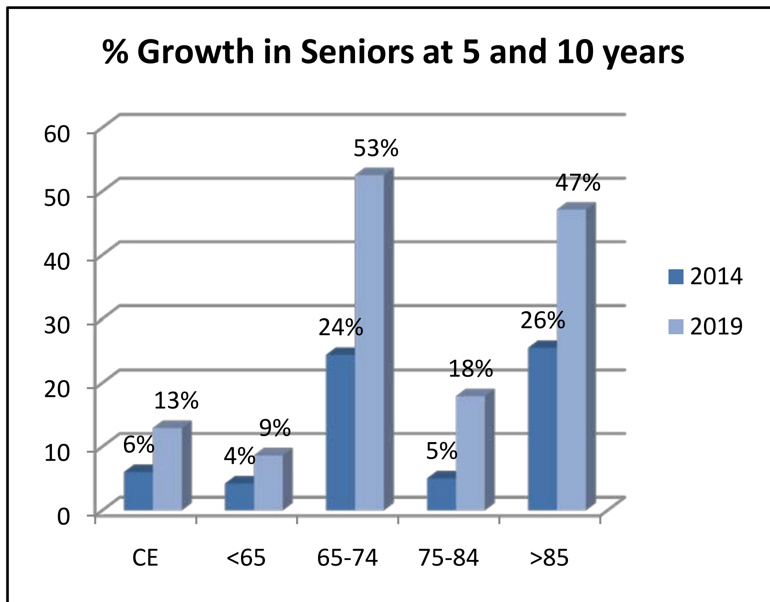


Figure 3. Projected Percentage in Growth of Seniors Populations over the Next 10 Years



The projected growth in the general population in the CE-LHIN is 13% over the next 10 years, also comparable to the rest of the Province. The growth in Durham Region is slightly higher at 19%. There is a disproportionate growth in the population of seniors. Seniors aged 65-74 and those aged 85+ are expected to grow by 52.5% and 47.1% respectively, with the total proportion of seniors in the CE-LHIN reaching 19% by 2019. This has significant implications for health service utilization.

For planning purposes, the proportion of the population deemed to be "frail" can be estimated using the general rule of 15% of those over the age 65. However, more recent research suggests that the estimates of the presence of frailty in the seniors` population can be stratified based upon age categories, as it is generally accepted that the presence of frailty increases with advanced age (Rockwood *et al*., 2004). A more accurate prevalence rate can be attained using the following stratified percentages: 7% of those aged 65-74 years, 17.5 % of those aged 75-85 years, and 36.6% of those 85 years and older. As outlined in Figure 4, the significant growth in the "old-old" seniors' population dramatically shifts the estimated number of frail seniors to 42,449 by 2019.

Figure 4. Estimated Number of Frail Seniors in the CE-LHIN

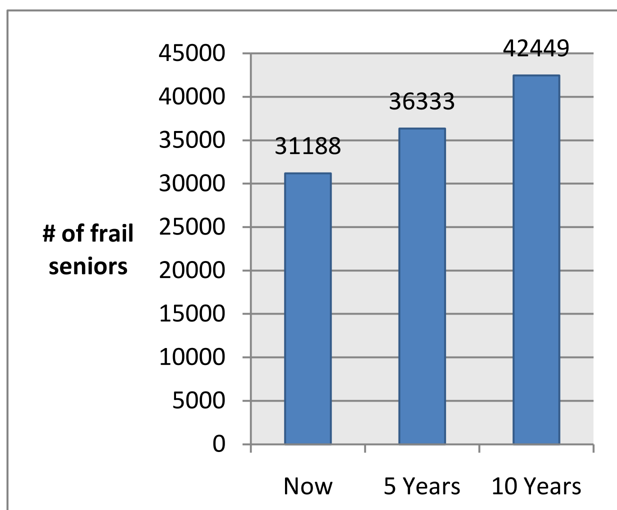
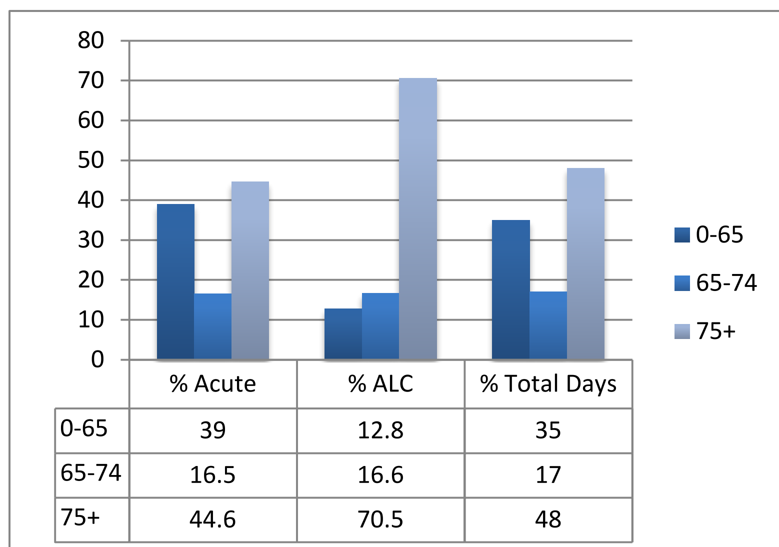


Figure 5. Utilization of Hospital Days by Seniors across the CE-LHIN



	% Acute	% ALC	% Total Days
0-65	39	12.8	35
65-74	16.5	16.6	17
75+	44.6	70.5	48

Currently seniors aged 65+ account for approximately 60% of all acute inpatient days and 86% of all ALC days across the CE-LHIN. However, it is clearly the seniors aged 75+ who account for the majority of these days. Figure 5 demonstrates the utilization of acute hospital resources by age group. It is evident that seniors aged 75+, who presently account for approximately 6.5% of the general population, are utilizing 45% of acute hospital days and 70% of all ALC days across the CE-LHIN.

3.2 Impact of Growth in Numbers of Frail Seniors on the Health Care System

The proportion of seniors aged 75+ in the CE-LHIN, although small, utilizes a significant amount of health care services. This is a matter of concern, as this segment of the population is expected to grow significantly over the next 10 years. In addition, dementia affects 1 in 3 adults over the age of 85 (http://www.alzheimerbc.org) and was the top CMG associated with ALC days in the CE-LHIN (12,199 ALC days or 12%) (Dr. C. Preyra: *Sustainable Access to Community Services in the CE LHIN, 2011).* Over the coming 10 years the CE-LHIN will need to ensure that there are adequate services available throughout the LHIN, especially by building capacity across the system. Not only will it be essential to create capacity within communities (through specialized outreach, community education and day programs), but also for hospitals to adopt specific strategies to prevent deterioration and decline when these individuals are admitted for an acute episode. In the absence of a comprehensive strategy, the ALC situation will undoubtedly escalate.

In 2009, seniors aged 75+ represented 6.5% of the general population, yet they constituted 12.7% of all CE-LHIN ED visits, 45% of all acute inpatient bed days and 70% of all ALC days. The increase in total ALC days for the CE-LHIN from 2005 was 128%, with a 45% increase in ALC LOS. This trend was mirrored across the Province, where the time to placement in Long Term Care for ALC patients increased significantly (median: 45 days to 103 days, a 129% increase) (Institute of Clinical and Evaluative Studies, 2011). It will therefore be important for the CE-LHIN to focus investments in SGS on upstream substitution (services directed at early identification of risk and prevention of frailty) to reduce the overall impact on the health system and improve the quality of life for frail seniors.

3.3 Service Inventory of SGS and Psychogeriatrics in the CE-LHIN

For the most part, the SGS and psychogeriatric landscape reflects local services that have been developed in and around the larger acute care hospitals in response to the changing demographics of an aging population and the commitment from the health service organization. There are both SGS that have evolved from an organization's existing operating funds, as well as new regional SGS investments that have been enabled by recent AAH funding. The services are to some extent integrated internally within each centre (vertical integration), although there are some examples of partnerships and integration between the hospital and community or several organizations working together.

Table 1 reflects current service delivery by sub-LHIN region. It is evident that there are significant gaps in service across the CE-LHIN. In addition, although some services such as Geriatric Emergency Management and Psychogeriatric Outreach appear to be "available" across the LHIN, these services are either NOT available 24/7 in hospital, or the service is only partially available and not substantive enough to meet current community needs. In addition to the lack of access to most services in the northern and more rural communities, there is a significant issue across the entire LHIN with access to the following services:

- Specialized geriatric community outreach
- Specialized inpatient assessment and rehabilitation,
- Inpatient consultation by geriatric experts and geriatric mental health teams,
- Specialized ambulatory services (including clinics) for assessment and rehabilitation and,
- Psychogeriatric community outreach (although present in each community, extensive wait lists exist).

During the stakeholder sessions held in the CE-LHIN, lack of access to services was identified as a key issue. Not only were stakeholders unaware of what services were available, but also there were significant concerns about the absence of services in many communities across the CE-LHIN. Given the growth in the numbers of seniors, the increase in adults with frailty and the paucity of upstream services available to keep seniors healthy and independent in their communities, it will be a priority for the CE-LHIN to invest new monies or leverage existing funds, to fill the gaps in service.

Table 1. Availability of SGS and Psychogeriatric Services across the CE-LHIN

	Kawartha Lakes	Northumberland	Haliburton Highlands	Peterborough	Durham West	Durham East	Scarborough
Inpatient:							
Regional Estimate of Frail Seniors - 2009	2230	2522	517	3905	9679		12335
Acute Care of the Elderly Unit				PRHC		LH	TSH
Geriatric Emergency Management	*RMH	*NHH		*PRHC	*RVHS	*LH	*TSH/ RVHS
Assessment and Treatment Unit					LH	LH	RVHS/ Providence
Geriatric Rehabilitation Unit					LH	LH	Providence
Psychogeriatric Unit	OS	OS	OS	OS	OS	OS	TSH/OS
Consultation Team							
Outpatient:							
Geriatric Day Hospital							
Geriatric Assessment Clinic				PRHC	RVHS	LH	RVHS/TSH
Geriatric Outreach - LTC		NPSTAT (CCAC)	NPSTAT (CCAC)	NPSTAT (CCAC)	NPSTAT (VTM)	NPSTAT (VTM)	NPSTAT (TSH)
**Geriatric Outreach – Community					NPSTAT (VTM)	NPSTAT (VTM)	
**Psychogeriatric Outreach	OS	PRHC/OS	PRHC/OS	PRHC/OS	OS	CCD/OS	TSH/OS
**Psychogeriatric Clinic	PRHC	PRHC	PRHC	PRHC	OS	OS	TSH/RVHS

(OS = Ontario Shores; RMH = Ross Memorial Hospital; PRHC = Peterborough Regional Health Centre; LH = Lakeridge Health; RVHS = Rouge Valley Health System; TSH = The Scarborough Hospital; VTM = The Village of Taunton Mills; CCAC = Community Care Access Centre; NHH = Northumberland Hills Hospital)
* = only available Monday to Friday; ** = partial implementation in most communities

3.4 CE-LHIN Investments in SGS

3.4.1 The Seamless Care for Seniors Health Interest Network

Prior to the Provincial establishment of LHINs in 2006, the MOHLTC invited health service providers in Central East to discuss health services and engage the community in determining priorities and solutions. This "Session at the Barn in Markham" identified the need for "*a comprehensive and seamless system of care for seniors"* as a top priority. Soon after the establishment of the LHIN infrastructure, the CE-LHIN created several health interest networks, including the *Seamless Care for Seniors Health Interest Network*, to advise the LHIN on seniors' issues. The network consisted of a broad distribution of service providers, other stakeholders and consumers (100+ members) who were represented at the LHIN by a

Steering Committee. Over the first few years the Steering Committee participated in shaping the first Integrated Health Services Plan (IHSP 2007-2010) by identifying key priorities and areas of focus for the network and the LHIN. However, in 2007, with the announcement of the AAH strategy, much of the work of the Committee was re-focused on developing processes and tools for the allocation of the 3-year funding envelope. In 2010, with the creation of a new IHSP, the Network structure at the LHIN was disbanded and replaced by expert panels focussed on the new LHIN priorities.

3.4.2 The Aging at Home Strategy

In 2007 the Ontario government announced a multiyear investment targeted at assisting seniors to live in their homes with dignity and independence. Each LHIN developed a strategy for investment that was consistent with their local needs and resource gaps. Over a 3-year period the CE-LHIN invested over $12m in support available to seniors in their communities. In year 3 of the AAH strategy, the LHINs were required to invest in projects that were aligned with the new MOHLTC priorities that "demonstrate quantifiable contributions to reducing time spent in emergency departments and optimizing (hospital) inpatient capacity by reducing Alternate Level of Care days". This provided the CE-LHIN with the opportunity to further invest in addressing the significant gaps in SGS. In total, the CE-LHIN AAH investment strategy resulted in the following expenditures:

- $857K in community support services such as meals on wheels (235K), transportation (322K), and Home at Last (500K)
- $423K in community palliative care
- $3.5M in additional supportive housing and assisted living spaces
- $1.5M in caregiver support and adult day programs
- $6.7M in Specialized Geriatric Services, including Geriatric Emergency Management ($1.3M), Nurse Practitioner Outreach into Long Term Care Homes – NPSTAT ($600K), and The Geriatric Assessment and Intervention Network – GAIN ($4.8 m).

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The CE-LHIN has begun strategic investment in additional specialized geriatric services; this has brought the region closer to having a full spectrum of services available in *some* jurisdictions. It is now essential to look at access for *all* frail seniors across the CE-LHIN.

3.4.3 Geriatric Emergency Management

The idea of having expert geriatric nurses working in the emergency departments of acute hospitals was first envisioned by the Regional Geriatric Program of Toronto. The purpose was to support the ED care teams by screening for high-risk, frail seniors upon their arrival in the ED. Following the initial screening and assessment, the GEM Nurse would either divert the admission through establishing community and primary care linkages/supports for the client, or provide support for the client's admission and transition to an acute inpatient bed.

The first multi-centre project was carried out in 2005-2006, with eight (8) GEM nurses from acute care hospitals in Toronto. This project demonstrated the following benefits: a) increases in primary care visits by frail seniors, b) reduced hospital length of stay for subsequent visits, c) reduction in hospital admissions and, d) a higher admission diversion rate than non-GEM hospitals. A similar study in British Columbia found that Geriatric Emergency Intervention saved 1,170 inpatient days in hospital over four months.

Subsequent to this successful start, the concept has flourished across the Province. The GEM Network, supported by the RGP of Toronto, now has over 95 nurses working across 40 Emergency Departments. Through the AAH investments, the CE-LHIN was able to add an additional nine (9) GEM Nurses to Emergency Departments in the LHIN. This initiative laid the foundation for important hospital infrastructure to support frail seniors. However, it was evident that additional upstream early identification and prevention activity was necessary to truly reduce the inappropriate use of emergency departments and the acute hospital system.

3.4.4 NPSTAT "Nurse Practitioners Supporting Teams Averting Transfers"

The Central East LHIN, working with the Ministry of Health and Long-Term Care, has invested in three Nurse Practitioner (NP) LTC outreach teams – in Scarborough, Durham and the North East cluster, which includes Peterborough, Northumberland, Kawartha Lakes and Haliburton.

In the Central East LHIN, the NP-led LTC outreach teams are collectively referred to as NPSTAT: - *"Nurse Practitioners Supporting Teams Averting Transfers".*

The NPSTAT program was developed to address the health risks of transferring frail seniors to emergency departments for visits which could be avoided if treated in the long-term care home. Reducing avoidable hospital visits and admissions has improved the health profile and health care experience of long-term care home residents, while maintaining or reducing the cost of providing appropriate care in the appropriate setting.

The Nurse Practitioners travel to the LTC homes to provide residents with timely, same-day access to clinical assessments, diagnoses and treatments for acute and episodic conditions and injuries (e.g., IV or oral antibiotics for infections, suturing lacerations, hypodermoclysis, post-fall assessments, G-Tube re-insertions, pain, etc.)

When LTCH residents are hospitalized, NPSTAT helps to facilitate earlier discharges back to the LTCHs which can decrease hospital length of stay and ALC days, enhances continuity of care and communication between acute and LTC sectors, and acts as resources to LTCH staff . NPSTAT supports the changing role of LTC homes and nursing staff by helping to build capacity and skills to help manage more acutely-ill residents.

The service provided by a team of 8 NPs is available to 50% of the CE LHIN's 70 LTCHs. Coverage for NP services has expanded to include evenings and Saturdays in the Peterborough, Lindsay and Bobcaygeon region. The NPSTAT team has an average ED diversion rate of 97%.

3.4.5 The Geriatric Assessment and Intervention Network (GAIN)

GAIN was originally conceived as a community-based model that would build geriatric assessment capacity across the CE-LHIN. The proposal, submitted by CE-LHIN stakeholders, was a joint submission for Year 3 AAH funding consideration. The model recommended the use of local geriatric practitioners in individual communities throughout Central East who were linked to several Specialized Geriatric Teams/Clinics. The model supports the chronic disease prevention and management (CDPM) framework

by facilitating community capacity-building, including support for self-management, and by ensuring appropriate primary care for seniors (see Appendix G for GAIN Logic Model).

Although endorsed by the CE-LHIN, the group was required to re-focus as a result of urgent MOHLTC priorities related to Emergency Department Length of Stay (ED LOS) and Alternate Level of Care. As a result, one of the downstream components (Urgent, Emergent Clinics in the ED) was prioritized for early investment. In the fall of 2010, four of the largest EDs in Central East began the implementation of the clinics, utilizing one of the hospitals (Lakeridge Health) as the transfer payment agency.

The GAIN Urgent-Emergent Clinics are in the early phase of implementation. The Lakeridge Health Clinic is fully operational and has provided more than 400 comprehensive assessments, with approximately 50% of referrals coming from the ED and the remainder from the community or post-discharge from hospital. However, continued implementation of additional system components, including spread and access across the region, will require a system-wide planning approach with the ability to leverage the investment already made. Individual organizations currently participating must not start down the path of ownership of funds, but rather of shared ownership for outcomes and goals in order to continue with the implementation of the model.

3.5 Summary of CELHIN Senior Friendly Hospital Review

As evidenced in Table 2, hospitals across the CE-LHIN are ***reporting*** a significant interest in, and commitment to, senior-friendly Care. In fact, most CE-LHIN hospitals are reporting, a) an *explicit* senior friendly goal/priority as part of the organization's strategic plan, b) an *explicit Board commitment* to becoming a SFH and, c) identified *geriatric champions* within the facility. Although some organizations are reporting the presence of geriatric clinical protocols, it is unclear whether these are practice protocols, assessment or screening tools, or staff education materials. Only two hospitals in the CE-LHIN report having a committee with a specific focus on the care of seniors. It is also evident that all hospitals are reporting a similar impact with respect to acute hospital and ALC days. However, Campbellford reports a much higher percentage of acute days utilized by those aged 75+ (71%) and both Campbellford and Northumberland Hills report a very high proportion of ALC days used by the aged 75+ cohort (82.6%).

It is apparent that there is a general lack of understanding regarding what constitutes SGS, resulting in inconsistencies in the reporting of the operation of SGS at each facility. In addition, key indicators of an organization's attention and commitment to the needs of frail seniors through the implementation of *care protocols* and a *senior-specific committee* are absent from most organizations in the CE-LHIN. However, all hospitals report innovative initiatives/projects underway that support frail seniors, including discharge practices and ED protocols. According to these results, CE-LHIN hospitals are moving in the direction of creating an environment conducive to senior-friendly care. Many have transformed this priority into a strategic thrust that is evident in the strategic plan and supported by board endorsement. Although the presence of a full complement of SGS is not be expected at every facility due to critical mass, it will be important to ensure that all communities (and hospitals) have access to these services, regardless of where they are located.

It is important to recognize that the information reported in Table 2 reflects the perception of individual organizations with respect to their own "senior-friendliness" – this information has not been validated and in many instances appears to be incorrect. However, a full analysis is underway through the Regional Geriatric Program of Toronto and will be available in mid-May, 2011.

Table 2. Summary of SELF REPORTED Senior Friendly Hospital (SFH) Audit 2010/11

Senior- friendly Component	**LH**	**RVHS**	**PRHC**	**TSH**	**NHH**	**CMH**	**RMH**	**OS**	**HH**
2009 ***% acute*** hospital days for the 75+	44	31	46	44	45	71	55	N/A	36
2009 ***% ALC days*** for 75+	68	68	69	71	83	82	72	N/A	62
2009 ***% of readmissions*** within 28 days that are 75+	3	19	43	7	46	63	45	N/A	16
2009 ***fall rate***/1000 patient days	6	7	5	6	7	0.5	9	3	N/A
Specific SFH goal in the organization's ***strategic plan***	√	√	√	√	√	√	√	√	√
Board commitment to Senior -friendly Hospital	√	√	√	X	√	√	√	√	√
Specific Hospital ***committee*** for Seniors' Issues	X	X	X	√	X	X	X	√	X
Care ***protocols*** for geriatric giants in acute care	P	P	P	√	P	P	P	√	P
Existence of ***SGS Services***	√	√	√	√	√	X	√	√	√
Projects or initiatives targeted at frail seniors	√	√	√	√	√	√	√	√	√
Initiatives specific to the ***ED*** for frail seniors	√	√	√	√	√	√	√	N/A	√
Audit completed of senior - friendly ***environment***	X	X	X	√	√	X	√	√	X
Goal for improving senior - friendly care over 3 years	√	√	√	√	√	√	√	√	√

P= partial compliance X = not present √ = present

SECTION B: MODELS FOR INTEGRATION OF GERIATRIC SERVICES

Appendix H provides a brief overview on health service integration and the perspectives of experts in the field. It is evident through the review of models that, in the creation of an integrated model for frail seniors, integration can involve different levels, types and directions, depending upon the overall objective. For purposes of this document, integration will be defined as “a coherent set of methods, and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between cure and care sectors” (Kodner, 2002). This broad definition will allow for flexibility in implementing integration activities across the CE-LHIN that will achieve the desired goal of: “***Better Health Outcomes for Frail Seniors”.***

Although the recommendations regarding the desired model may need to be prescriptive on some levels (funding and administrative), this definition acknowledges the evidence that stakeholders can (and do) drive important and clinically-relevant integration activity in an effort to improve the system for high-risk and frail seniors. However, true system change can only be achieved when the decision-makers and key leaders are connected and driven by a common philosophy and belief system.

4. Models of Integrated Care for Frail Seniors

There are many examples of models and systems for improving the integration of health and social services for seniors that have been implemented internationally and even locally (see Appendix M and N), ranging from full integration models (PACE, SIPA) to coordination models (PRISMA) to those that are primarily linkage level or informal collaborations (Regional Geriatric Programs). However, only a few have been evaluated rigorously in relation to improved client outcomes and system-wide performance. There are also many new models and innovations in service delivery integration activity that are in the process of implementation (ICCP), that have emerged from existing informal collaborations (Waterloo-Wellington, ASSIST) or have developed as a result of the LHIN integration agenda (CE GAIN). Although there are some common features (case management and facilitated access to a wide range of services), there are also significant differences in the organization of service providers, governance, funding/payment systems and the level of clinical and service delivery integration activity. It is evident that successful models have evolved in response to both the needs of clients and to the local context and service organization readiness for inter-organizational collaboration.

4.1 The Regional Geriatric Programs of Ontario

“Regional Geriatric Programs (RGPs) provide a comprehensive network of specialized geriatric services which assess and treat functional, medical, and psychosocial aspects of illness and disability in older adults who have multiple and complex needs. Working in collaboration with primary care physicians, community health professionals, and others, (RGPs) seek to meet the needs of the most frail and vulnerable seniors” (RGPs of Ontario; www.rgps.on.ca).

The RGPs of Ontario originated in the mid-1980’s as a key initiative in the provincial government’s strategic plan (also known as the “The New AGEnda”) to create a comprehensive system of health service for seniors. The intent was to leverage the expertise housed in the Academic Health Science

Centres to improve the quality of health services provided to seniors in hospitals across Ontario. In 1986, the RGPs were established at the Academic Health Sciences Centres in Hamilton, Kingston, London, Ottawa and Toronto, and together they form the Ontario Provincial Network of Regional Geriatric Programs.

In its original guidelines for the "Establishment of Regional Geriatric Programs in Teaching Hospitals", the MOHLTC defined a regional geriatric program as "a comprehensive, coordinated system of health services for the elderly within a region", with the objective of "assisting the elderly to live independently in their own communities thereby preventing unnecessary and inappropriate institutionalization." (*www.rgps.on.ca*). In keeping with the original mandate, the five RGPs developed four key areas of focus: a) Service Delivery (originally specialized hospital-based programs), b) Education and/or teaching activity (related to their academic role), c) Research and, d) Advocacy.

During the last decade, each program has adapted its own priorities, in relation to the needs of the residents they serve, to the ever-changing planning landscape, and to additional funding opportunities. Although it was understood that additional Ministry funding would flow to the education mandate and expansion of service delivery into other areas in Ontario, this in fact did not happen. New initiatives and programs did, however, evolve as individual RGP's have been successful in attracting funding from different Ministry priority funding streams (e.g. Emergency Department Access Fund, AAH, etc.). As well, instances are emerging in which regions without RGPs have developed sufficient sets of SGS that their coordination into a regional program becomes possible (e.g. CE-LHIN, NE-LHIN)

Although the original mandate of the RGPs in Ontario did not include integration as one of the pillars, there are significant integration efforts underway in many regions as a result of the RGP infrastructure. In many instances, the RGPs established a strong foundation for integration through informal linkages and more formal inter-organizational collaborations that evolved over time. Recent government attention, including funding, targeted at the issues associated with an aging population is likely a key factor in the increase of integration activity occurring across the Province. Appendix I includes an overview of the five RGPs and one affiliate RGP with respect to the current state of SGS and integration work for frail seniors.

4.2 Other Models for Integrating Services for High-Risk Seniors

There are many successful models for integrating care for high-risk seniors that have been well-documented and cited in relevant integration work occurring across the Province. Appendix M provides an overview of these frequently- cited models and the common features or elements that have been implemented. The majority of models have been successful, however, in jurisdictions with significant differences in the funding and organization of health and social services. For example, capitation funding supports integrated health service delivery and enables the creation of care models built around individual client needs (e.g. PACE, S-HMO). In Canada, provinces with regional funding models (RHAs and SOCs), although somewhat more restricted in terms of the services included, also provide a ready infrastructure to support integration of health services (e.g. SIPA, CHOICE, PRISMA). In Ontario, the funding mechanisms neither readily enable integration, nor incent organizations to work together; they are primarily individual organization-based, with the rules and incentives different across sectors.

4.3 Other Provincial Models for Integrating and Coordinating Services for High- Risk Populations

Therefore, it was also important to look across Ontario and examine other successful models of integrated care that have been designed for high-risk populations. Three models were considered relevant to this planning exercise: the Cancer Care Ontario Model, the Child Health Network and the GTA Rehabilitation Network.

4.3.1 Cancer Care Ontario Model

Cancer Care Ontario (CCO) is the Ontario government's cancer advisor and the Provincial agency responsible for continually improving cancer services. It is an umbrella organization that steers and coordinates Ontario's cancer services and prevention efforts and is governed by The Cancer Act. As an operational service agency of government, CCO is accountable directly to the Minister of Health and Long-Term Care and the details of this relationship are explicitly laid out in a formal Memorandum of Understanding (MOU). The CCO Board directs over $600-million in public health care funding for cancer prevention, detection and care. CCO also operates screening and prevention programs, collects, monitors and reports information about cancer and cancer system performance; develops evidence-based standards and guidelines for health care providers, and works with regional providers to plan and improve cancer care.

In 2005, CCO established integrated Regional Cancer Programs as partnerships between regional cancer care providers, including hospitals, CCACs, public health and primary care, with the shared goal of improving local cancer services and ensuring equitable, quality cancer care across the Province. CCO works ***directly*** with the Regional Cancer Programs (RCPs) in each of the Province's 14 LHINs. Each RCP is led by a CCO-appointed Regional Vice President, who also leads the regional cancer centre (RCC) located at a "host hospital" in the LHIN. The Regional VP has a matrix reporting relationship to both the host hospital and CCO. The host hospital receives the annual operating funds for the RCC and, in turn, is accountable for the day-to-day operation of the Cancer Centre in accordance with the terms of the agreement with CCO. However, all other aspects of the RCP (e.g. satellite clinics, prevention programs) are funded directly by CCO and, in turn, the Regional VP is accountable directly to CCO for this broader regional work.

The decision to maintain centralized provincial reporting and accountability for the regional program is largely based upon the need to promote regional expansion and delivery of services outside of the host hospital arrangement. This mechanism, despite adding a level of organizational complexity, facilitates unbiased negotiations with regional partners and as such improves inter-organizational collaboration and prevents any possible influence from the host hospital on funding decisions and arrangements.

The quality of cancer services and cancer care across Ontario has dramatically improved over the last decade. This is attributed directly to the creation of a provincial strategy, with CCO providing the mechanism to ensure standardization and regional delivery of services. As an umbrella organization, CCO maintains direct control over incremental funding of cancer services and leverages this to ensure the delivery of the highest standard of cancer care to all clients. Outcomes of this successful integration model include:

- Cancer care is now ***holistic*** and considers the entire journey for the client, from screening through to palliation (versus an intervention-based chemotherapy and radiation therapy service),
- Cancer care is now standardized and ***consistent*** across the Province (best practice protocols),
- ***Quality*** and other outcomes are measured and RCPs are reimbursed according to performance and,
- An improvement in wait times for cancer services across the Province (improved ***access***).

4.3.2 Child Health Network for the GTA

Established in 1999, the Child Health Network for the Greater Toronto Area (CHN) was a unique collaboration of hospital and community providers committed to establishing a more coordinated system of health care delivery for mothers, newborns, children and youth. The impetus for developing and implementing the concept of a virtual network to improve coordination and integration of services emerged from providers themselves, as a result of system issues and pressures. These included a) the excessive number of maternal/newborn transfers sent out of the region, b) demand on tertiary obstetrical beds and concerns regarding the appropriateness of use of these beds, c) fragmentation of services, d) lack of a coordinated approach to planning and developing services, e) human resource shortages and, f) inconsistent care standards across the region.

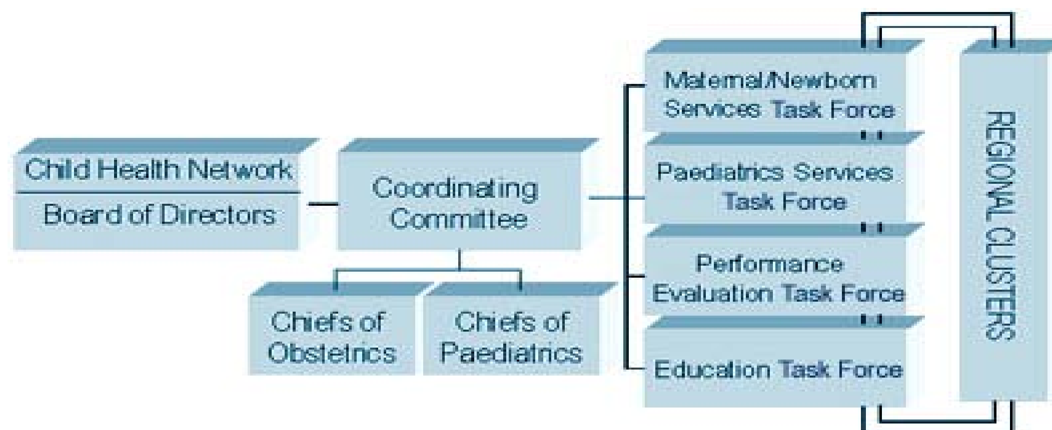
Over its 12 years, the CHN facilitated and supported the development of a regional maternal/newborn and children's health services system. As outlined in Figure 6, the CHN's organizational structure was based on a model of shared governance. The CHN had three main components to its organizational structure: the Council, Board of Directors, and a Coordinating Committee.

The Council was responsible for setting the direction and leading CHN toward fulfillment of its vision. Membership of Council included a representative of the Board of Governors and the CEOs from each member organization. The Board of Directors was responsible for overseeing the work of CHN, and for developing and monitoring the implementation of CHN's annual operating plan. The Board was made-up of members of Council appointed through an open nomination process. The Coordinating Committee was responsible for coordinating the work of the Council's task forces and clusters to ensure that it was consistent with the Council's strategic directions and annual operating plans.

Member organizations paid an annual membership fee (~$50k) to support the integration work, including the salaries of the administrative staff supporting network activity (Administrative Director, Project Leadership and Support Staff). A host hospital was responsible for housing the staff and providing back-office support functions. In addition, there were agreements between member organizations and a clear conflict-of-interest policy to ensure protection of the public interest.

Figure 6. Governance Committee Structure for the Child Health Network

(from: www.childhealthnetwork.com)



In 2010, the CHN ceased operations, in anticipation of the transition to the new Provincial Network for Child, Youth and Maternal Health. During its 12 years of operation, CHN was responsible for significant success related to bringing about the standardization of maternal newborn care and the dissemination of best practices across member organizations. In addition to the development of a shared family-centred care philosophy, the network was responsible for spearheading a surveillance system, developing standardized system-wide performance indicators, developing best practices for most aspects of care, creation of an economic model for planning efficient, effective services, and hosting joint educational opportunities to share knowledge and emerging practices.

4.3.3 The Greater Toronto Area (GTA) Rehab Network

The GTA Rehab Network was formed in 1999 at the direction of the Health Services Restructuring Commission (HSRC), in order to bring about system-wide improvements and standardization across rehabilitation providers in the GTA. The Network serves as a coordinating and advisory body and does not provide direct service to clients. The GTA Rehab Network is made up of publicly-funded hospital and community-based organizations from across the GTA that are involved in the planning and provision of rehabilitation services. Currently members include 13 community hospitals, five CCACs, four teaching hospitals, nine specialty rehab and CCC hospitals, and three *ex-officio* members (Regional Geriatric Program of Toronto, Toronto Acquired Brain Injury Network and the University of Toronto). The GTA Rehab Network is governed by a 15-member Coordinating Council, representing the breadth of the Network's membership. In 2010, the Council was restructured in order to enhance its strategic focus and accountability. Council members now must hold the position of CEO at their respective organizations. The work of the Network is carried out by a small Secretariat, together with task groups and committees comprised of staff from member organizations.

A host hospital (Toronto Rehabilitation Institute) provides the GTA Rehab Network with support services, such as human resources, finance and IT, and the GTA Network rents office space from the hospital. Member organizations pay an annual membership fee that supports network activities and pays the salaries of the Secretariat staff.

The GTA Rehab Network's Mission states that, "together as partners, we strengthen the organization and delivery of rehabilitation services through all healthcare sectors by promoting innovation and best practices, developing tools, guidelines and measures for performance improvement, and leading system integration." (www.gtarehabnetwork.ca). The Network's focus is system-wide and system-level. It identifies issues, develops collaborative solutions with its members, the LHINs and other partners, and facilitates implementation of those solutions. The Network has been successful in bringing about several significant system improvements such as:

- Standardized referral forms and referral processes,
- Standardized discharge planning guidelines,
- *Rehab Finder* – a comprehensive searchable database that helps health care providers access rehabilitation services for their patients,
- Standardized, evidence-based definitions and standards for rehabilitation services,
- Dissemination of best practices and,
- Knowledge exchange opportunities.

4.4 Other Provincial Activity Integrating Services for Seniors

Much of this vigorous activity received its "kick start" as a result of the significant infusion of AAH funds into the health system, and some examples of models that emerged for integrating seniors' care within a geographic area are included in Appendix N. The Mississauga-Halton (MH-LHIN) activity has received noteworthy attention as a result of its proposed comprehensive seniors' strategy, the organized AAH investment and the successful implementation of centralized intake, screening and referral (ASSIST). A cautionary note: although the MH-LHIN adopted a strategy/framework, they have not implemented the strategy beyond several targeted initiatives. They recognized early the need for a targeted approach and instead of attempting to "boil the ocean", they invested in filling many of the service gaps through AAH, developed an organized structure for coordinating SGS and only then implemented centralized intake and referral.

Appendix N also highlights numerous innovative integration projects occurring in many jurisdictions, ranging from capacity-building work (GiiC, London Responsive Behaviours Project) to demonstration projects for new case management models (ICCP and the IGSW) to projects that seek to streamline access to information for frail seniors (SGS On-Line and Doorways to Care).

5. Summary of Themes for Integrating Care for High-Risk Frail Seniors

The insights gained from interviews with key champions, stakeholder consultation sessions and the review of integration models and innovations can be summarized under several key themes. The primary themes uncovered are supported by current integration thinking and resonate within integrated systems that have been successful in other jurisdictions. The abundance of integration activity for seniors care is a very positive sign that there is a wide-spread acknowledgement and recognition of the impact of an aging population on the health system. However, in the absence of a Provincial strategy and clear provincial authority, there is a significant risk that individual jurisdictions will develop and pilot integration activities in isolation. The absence of a centralized repository of best practices and expert opinion has resulted in duplication of efforts and a highly-fragmented system for seniors across the Province.

5.1 Organizational Authority, Commitment and Governance

The majority of successful models and those under development involve the creation of some form of ***umbrella organization or authority*** that is accountable to advance the seniors' agenda and advocate across the system. This takes on many forms, such as system-wide linkage level Advisory Committees (Hamilton GAIN, Ottawa RGAC, NSM Seniors Health Regional Action Group, The GTA Rehab Network), shared governance structures (GTA Child Health Network, PRISMA), and stand-alone separate health organizations (RGP Toronto).

It is clear that the structures that are loosely organized, without clear authority, depend upon service provider good will and intention to participate in integration activity. In these instances the existence of funding is a motivator to participate but, in general, organizations are interested in how much funding "they" will receive, versus working together to ensure an equitable distribution of service.

Given the autonomous nature of health organizations in the Province and persistent lack of a health system focus, many successful models involve having some ***control over funding***, which control is then utilized to leverage integration activity. There are historical challenges with the transfer of funds to an organization's global budget and the subsequent ability to manage the return on investment. Such was the case with the Ottawa RGP, whereby the host hospital made decisions without consideration of the impact or perspective of the RGP. This situation is a current challenge for the Regional Cancer Centres and is prompting a review of the existing host hospital MOU. This is in sharp contrast to the Toronto RGP, which has maintained a paymaster role for participating hospitals and, as such, has service and funding agreements in place that clearly articulate accountabilities and service delivery requirements. During the interviews several key informants commented on their recent deliberations regarding incorporation and creating an arms-length organization in order to better support and advocate for client needs across the entire system.

5.1.1 Considerations in Creating a Separate (Incorporated) Umbrella Organization

There has been significant discussion and dialogue among current service providers (Regional Geriatric Programs) and champions for newly-emerging programs/models related to creating a separate publically-funded organization. It is likely that in the absence of a clear Provincial strategy or recognized authority (such as CCO), providers are seeking to create such an organization that will move the integration agenda forward. However, as outlined in Table 5, incorporation and the requirement to create a public board have significant pitfalls as well as benefits.

Table 5. Considerations for Creating a Separately Incorporated Umbrella Organization

Benefits	Risks
Advocacy: Ability to advocate, plan and execute on system integration for frail seniors without any inherent conflict from competing organizational mandates	**Resource Requirements**: Significant investment of time for paid staff goes into incorporation requirements and other obligations such as HSAA negotiation, financial and legal matters
Autonomy: Arms length from service provider organizations allows autonomy to direct the organizations investments in the system in the best interests of everyone (e.g. upstream)	**Distraction**: Initial time commitment to supporting the development of the Board (bylaws, policy, retreats, appointments, etc...) can shift focus away from system development for frail seniors
Influence and Credibility: Board members are well-connected and influential citizens and can bring credibility to the cause and a stronger profile to frail seniors health issues	**Other Fixed Costs**: increase in costs beyond "back office" to include insurance, legal fees, auditing, etc...
Community Support: Board members can advocate in the community bringing a strong community focus and support to the work	**Managing the Board**: Board members can get involved in "operations" without fully understanding the issues resulting in challenges moving the agenda forward

5.2 Local Leaders and Champions

As evidenced from the interviews and stakeholder sessions, strong leadership from local champions is a necessary prerequisite to building trust among partners and moving from "inter-organizational collaborations" to truly integrating seniors' services between organizations. In the absence of a single organization with a clear mandate and control over all funding, such as PACE, SIPA, S-HMO, CHOICE, CCO, stakeholders must come together with a clear ***desire*** to improve the status quo and implicit ***trust*** that the client will be better served.

There are numerous examples across the Province of service delivery (or organizational) integrations that have been successful. The ASSIST Model, Waterloo-Wellington IGSW Project, NSM Integrated Falls Program, CE-LHIN GAIN Clinics and the London Responsive Behaviours Project are all examples of organizational integrations that were facilitated by trusted strong local leadership/championship and the followership that results.

Many initiatives across the Province have benefitted long term from a ***physician champion*** in a lead role. The work in both Mississauga Halton and Sudbury are testaments to the power of physician leadership to make and sustain health system change. In fact, within the CCO environment, the Integrated Cancer Programs are primarily led by Physician Champions who are also credible practitioners in the field of cancer care. Models with strong leadership from physicians who are also practitioners in the system are more likely to advance changes quickly by facilitating credible buy-in.

5.3 Embedding the Model in the System with Primary Care as Central

It is now well-recognized that the focus of health service integration for frail seniors must be embedded in the local communities and intimately linked to or affiliated with ***primary care***. The most successful model (PACE) not only has physicians within the system but also has strong relationships with primary care. The PRISMA model is a model that is embedded within the existing system of primary care as a resource/support, as opposed to a parallel system of services.

Current research related to the reversibility of frailty and need to improve on the prevention and management of chronic conditions speaks to the need to move service delivery for frail seniors upstream. The SWOGAN Model (London, Ontario) has been in existence for over ten years and is an excellent example of knitting together geriatric expertise, mental health expertise and primary care within local communities across a significant territory. The original GAIN concept in the CE-LHIN was premised on the notion that early identification of those at risk for frailty was the key to reducing the downstream system impact of an aging population. The North Simcoe Muskoka Senior Health Teams project was also based upon a similar infrastructure and the current thinking related to the Mississauga Halton expansion of the ASSIST model will also involve penetration into primary care. At the stakeholder consultation sessions it was identified that there is tremendous capacity in primary care and that this needs to be leveraged to support frail seniors in their communities.

5.4 Clinical and Service Delivery Integration

In some regions (e.g. Kingston RGP), the system of ***psychogeriatric and geriatric services*** evolved independently of each other .This is related to both the historical separation between the physician disciplines and to differing approaches and philosophy of care. This has resulted in significant issues from both the client and service provider perspectives, such as duplication of information. A significant percentage of frail seniors have co-morbid cognitive and/or mental health issues and would benefit from geriatric psychiatry. Indeed, many of the service delivery integration initiatives underway, including central intake, screening and referral, involve partnerships between geriatric medicine and geriatric psychiatry.

Stakeholder sessions in the CE-LHIN (see Appendix O) demonstrated that providers are ready for service delivery integration and are keen to participate in inter-organizational initiatives that bring about improved ***coordination of care.*** In fact, the primary recommendations from these sessions included:

- LHIN-wide implementation of common intake, screening, information and referral,
- Use of standardized, consumer-friendly language,
- System-wide case management that extends beyond the current services coordinated by the CCAC
- Addressing service gaps such as geriatric and psychogeriatric outreach into communities and creating clear linkages between practitioner assessments, intervention and follow-up,
- An upstream, needs-based model versus a reactive downstream model and,
- Shared values, vision and principles between and within organizations.

5.5 System-wide Case Coordination or Case Management

There is substantive evidence from the strongest models of integrated care for frail seniors (e.g. PACE, CHOICE, SIPA, HARP) that system-wide, targeted case management for high-risk and frail seniors is essential to any integrated model. The need to coordinate a wide variety of health and social services across sectors -traditional and non-traditional- is critical in order to enable consumers to navigate a complex system and to ensure frequent assessment of needs and proper medical management for chronic illnesses.

New and innovative local models in Ontario, including the Integrated Geriatric Services Worker (IGSW) and Integrated Client Care Project (ICCP) for seniors with complex needs are excellent examples of flexible, client-centred approaches to stratified case management, whereby the level and extent of coordination is dependent upon an individual client's needs and resources.

In its work on the integration of care for frail seniors in the CE-LHIN, the Expert Panel reviewed the literature, thoroughly examined all of the models (Appendices I, M and N), past and present practices and, in conjunction with the integration framework, developed a model that can be expeditiously implemented.

Section C: Towards an Integrated Model in the CE-LHIN

In 2008, Margaret MacAdam, on behalf of the Canadian Policy Research Networks and supported by a grant from MOHLTC, completed a systematic review of models and frameworks of integrated care for seniors. She identified the four optimal features of an integrated system that have been supported by rigorous evaluation:

- ► ***Umbrella organization***
- ► ***System-wide case management***
- ► ***Organized provider networks***
- ► ***Financial incentives***

She also concludes, however, that “no single element of integrated models of care has been shown to be effective in and of itself”. She comments that the common features of models of integrated care should, at a minimum, use multidisciplinary care/case management for seniors at risk for poor outcomes, have access to coordinating a range of health and social services, and utilize decision tools, common assessment and care planning instruments and integrated data systems.

Furthermore, the strongest models included active ***involvement of physicians.*** In a comparative study in the United States, Kane *et al.* (2006) concluded that in a model where clients continued to use their own family physicians, the results were not as significant as when the model used physicians who were part of the intervention team. They concluded that it is very difficult to change the practice of physicians with seniors when their practice is diverse and they see a lower volume of seniors. It is important to understand and appreciate this context in planning an integration model in the CE-LHIN.

Although Hollander and Prince (2008) support these necessary integration elements identified in MacAdam’s work, they add a significant emphasis on the need for ***philosophical and policy prerequisites*** that create the necessary infrastructure for successful integration efforts. In addition, they conclude that ***strong linkages*** with other sectors (if not part of the umbrella organization) are critical. These linkages include:

- Linkage mechanisms with other population groups
- Linkages with hospitals (e.g. “in-reach”, outreach consultations, a mandate for coordination)
- Linkages with primary care (e.g. co-location of staff) and,
- Linkages with other social and human services.

Appendix P provides a detailed overview of these key essential features of an integrated system for frail seniors that will be required in the CE-LHIN.

6. Components of Regional Specialized Geriatric Services for the Central East LHIN

The findings from the assessment of models and innovations outlined in this report resonate with the conclusions of Kodner (2002), Hollander and Prince (2008) and MacAdam (2008). In addition, the recommendations regarding the key aspects of an integrated system were substantiated during the interviews held with champions, key informants and experts from across the Province. Different types of integration (linkage, coordination or full) can and do exist at different levels within an integrated model.

For example, a system that has a ***coordination-type*** integrating mechanism for the administration of the system (e.g. joint committee), may have a ***fully-integrated*** service delivery component, such as common intake, that is integral to the system. This diversity of integration mechanisms within the system is reflective of priorities, local needs, resources available and, most importantly, the ability and willingness of those individuals working within the system to collaborate and embrace shared ownership for outcomes.

Table 6 provides an overview of the presence of these essential components in the models reviewed and those under consideration (shaded in blue) in jurisdictions across the Province. Note the presence of common tools (screening, assessment and referral) across all models and systems (also the most frequent suggestion voiced at the CE-LHIN stakeholder sessions). It is important that this clinical integration activity move forward quickly to address the frustrations associated with duplication and to facilitate buy-in from clinicians across the region.

Table 6. Presence of Essential Components in Models of Integrated Care for Frail Seniors

Model/Features	Umbrella Organization	Central Control over Funds	Organized Providers	System Linkages	Case Management	Physician Involved	Central Intake, screening	Common Tools
PACE	√	√ (full)	NA	√ (primary)	√	√ (PACE MDs)	√	√
SIPA	√	√	√	√	√	√	√	√
CHOICE	RHA	√	√	√		√	√	√
PRISMA	√ (board)		√ (board)	√	√	√	√	√
CCO	√	√	√	√		√	√	√
S-HMO	√	√	NA		√		√	√
GTA CHN	√ (committee)		√			√		√
RGP Sudbury (affiliate)	√ (municipal)	√	√	√		√		√
RGP - Toronto	√ (incorp.)	√ (partial)	√ (network)	√		√	√	√
CACHET (proposed)	√	√ (full)		√	√		√	√
Miss. Halton Model (proposed)	√ (committee)		√ committee	√	√	√	√	√
Waterloo Well. Model (proposed)	√	√	√			√	√	√
NSM Model (proposed)	√ (incorp.)	√	√ (SAC)			√	√	√

6.1 Assessment of Options

The work completed by the Advisory Group on the *Vision, Principles and Values* (Appendix D) was utilized as the litmus test for determining the viability of different options for each model component in the CE-LHIN. In addition, consideration of *local context, acceptance* and *readiness* was necessary in order to ensure that the model would quickly gain traction across the LHIN. The recent investments in SGS (GEM, NPSTAT and GAIN) can be utilized to leverage the evolution of the model to bring about "early wins", such as standardization of tools. Table 7 provides an overview of each essential component, some of the options deliberated and the final recommendation for the CE-RSGS Model.

Table 7. Options for Each of the System Components and Recommendations

Component 1: Umbrella Organization	
Discussed Options	***Recommendation***
1) A linkage level Advisory Committee to guide system planning and integration activities 2) A formal coordination level Shared Governance Model to ensure service provider ownership for system planning and implementation of shared vision/philosophy 3) Creation of a new incorporated health organization with an explicit mandate for system planning and execution for frail seniors	Implement Shared Governance Model with a ***Governance Authority/Board*** that will function as the Umbrella Organization for SGS that: * is bound by a Memorandum of Understanding with clear commitment to joint vision, mission and principles, * is directly accountable to the LHIN for recommendations regarding the allocation of funds to RSGS service providers and * consists of decision-makers (CEO-level), RGS system leadership and ***consumer*** representation (see Appendix O for Terms of Reference)
Component 2: Control over Funding	
Discussed Options	***Recommendation***
1) Encourage and support each organization in retaining their investments in SGS and make recommendations to the LHIN re: the distribution of any new funds to support expansion and access across the CE-LHIN 2) Centralize all service provider SGS funding and distribute annually, based upon agreements and commitments for performance (build in Pay for Performance criteria based upon activity and quality outcomes) 3) Maintain existing SGS global funding investments within each organization's base budget AND centralize all new funding to leverage expansion, innovation and enhanced access to services across the CE-LHIN	Continue with 2 funding streams: a) ***Organization Global Funding***: maintain and encourage individual organization investments and vertical integration efforts by protecting current SGS funds allocated within the global budget b) ***Regional Components***: Recent AAH investments and other new funding streams for SGS regional ambulatory services (GAIN, NPSTAT, GEM, etc) should be leveraged as a means to facilitate the spread of innovation and to ensure improved access to SGS services across the region.

Component 3: Organized Service Provider Networks	
Discussed Options	***Recommendation***
1) SGS service providers organized around specific services (e.g. GEM) or sectors (hospital, CSS, etc.) to provide both just-in-time advice to umbrella organization AND deliver on integration initiatives 2) A Standing Committee that reports to the umbrella organization and is accountable for coordinating service provider activity and for the execution of strategic priorities 3) SGS Services are horizontally integrated through a joint management structure, with RGS Management reporting through the umbrella organization.	Creation of a ***Service Operations Committee*** made up of service provider organizations and their partners. The committee is accountable to the Governing Committee for execution of the tactical plan and oversight of the annual service plan development and submission Service delivery integration activity (horizontal) would be facilitated through this group, including the early activity related to creation of the "common brand" and to other priorities identified in the stakeholder sessions

Component 4: System Linkages	
Discussed Options	***Recommendation***
1) Subcommittees form the mechanism for a formal linkage to the umbrella organization - could be by "sector" or by community. Primary care needs to be considered. 2) Encourage the formation of community cooperatives or "naturally" occurring community clusters to form around individual areas/communities. Formalize communication through local information sessions and quarterly forums. 3) Utilize the LHIN sub-planning zones or clusters to create formal linkages with the umbrella organization in an advisory capacity	a) Create an initial tactical team to determine the most appropriate mechanism to "weave" primary care into the model. There should be a significant presence of Primary care representation on the Governance Committee b) Ensure that broad community consultation and the spread of innovation related to frail seniors is facilitated through each organizations community consultation processes

Component 5: System-wide Integrated Health Career Care Coordination	
Discussed Options	***Recommendation***
1) Develop transition management approaches that minimize disruption and facilitate the sharing of information as clients transition from one service to another. 2) Expand the current role of the CCAC to include the full range of services within the context of the individual client's community and care team. 3) Develop a frail seniors' case management model that is parallel to the existing system and supports the client across all services and supports.	a) Host a **demonstration project** that brings together the learnings from different case management experiences related to managing frail seniors with different levels of need and complexity (moderate to high risk). b) Examine the feasibility of a blended model that incorporates the principles inherent in the IGSW Project (Waterloo Wellington) and the outcomes from the ICCP project (Toronto).

6.2 Proposed Model for Organizational Authority, Coordination and Governance

The model proposed for the governance, organization and coordination of SGS in the CE-LHIN is a ***Shared Governance Model*** that incorporates the five essential components of a successfully-integrated system: umbrella organization, control over funding, organized service providers, linkages with the system, including Primary Care, and system-level case management or care coordination. Table 8 provides a visual overview of the shared governance model committee structure and the associated accountabilities for the entities within the model. It is suggested that the new regional program be referred to as ***Central East Regional Specialized Geriatric Services (CE-RSGS).***

6.2.1 Governance Authority/Board

The Governance Authority/Board ***is the umbrella organization*** that is ultimately accountable for the development and delivery of an integrated regional system of SGS for frail seniors. Similar to other governing committees or boards accountable for system-wide planning (Child Health Network, GTA Rehab Network, RGP Toronto Board of Trustees), it is suggested that service provider organizations be represented by their respective CEOs (see Appendix Q for Draft Governance Terms of Reference). In addition to ensuring an organization's attention and commitment to seniors at the highest level, there is a need to ensure that hospitals in particular pay increasing attention to the care received by seniors.

It is now widely recognized that failure to attend to the needs of frail seniors has a negative impact on a hospital's ability to function efficiently and effectively. Given the sheer numbers and their impact on health service utilization, seniors must be viewed as the ***core business*** of all hospitals and most health service organizations. *This shift in focus and philosophy can be facilitated by having the CEOs connected to the issue, messaging consistently within their respective organizations and ultimately sharing accountability for system-wide solutions, including investment in upstream prevention.* Table 8 outlines the accountabilities of the Authority to the public, to service providers, and to the CE-LHIN.

6.2.2 Control over Funding

The Governance Authority/Board as the umbrella organization can neither hold nor receive funds directly from the CE-LHIN. In order to ensure control over how SGS funding is utilized, the Authority will have a Memorandum of Understanding articulating the role of the Authority, CE-LHIN and SGS service providers with respect to the flow of funds. The Authority will be required to create and submit to the CE-LHIN a ***CE-RSGS Annual Service Plan*** based upon the agreements between the Authority and SGS service providers.

The Annual Service Plan will include the types and levels of SGS services to be provided across the CE-LHIN in the upcoming year as well as a report on the deliverables for service expansion and access, as identified in the CE-RSGS Strategic Plan. As applicable, the LHIN would embed these performance expectations within each organization's accountability agreement. In addition, the Authority will be responsible for coordinating H-SIP submissions to the CE-LHIN for new and expanded regional SGS. Should new monies become available, the Authority would bring providers together to create an organized funding submission consistent with the identified strategic priorities and investments.

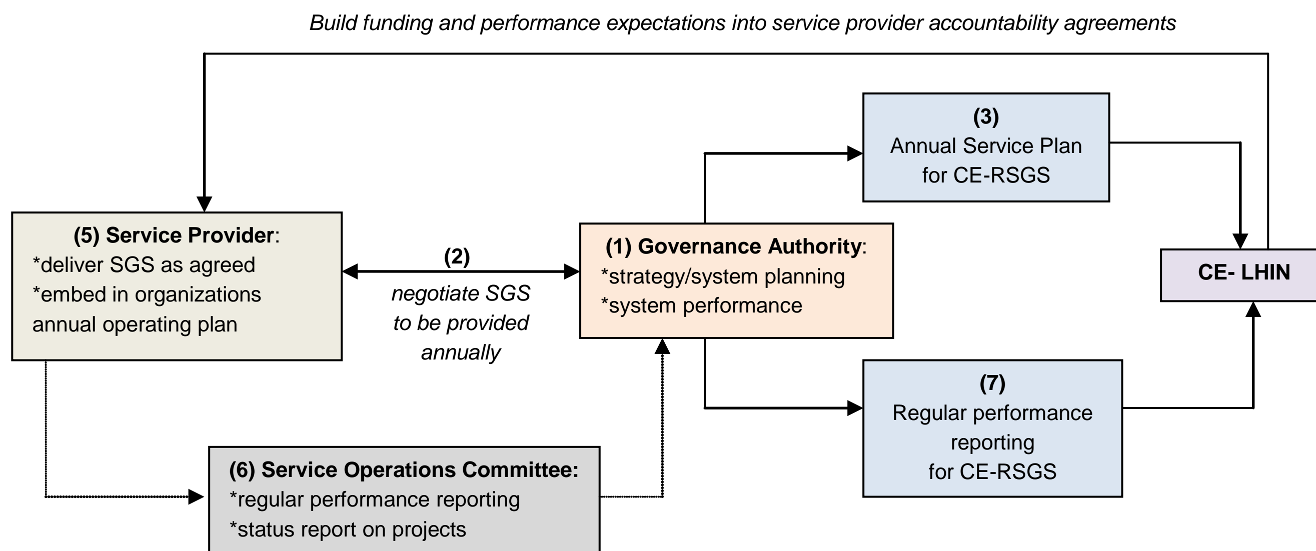
[Table 8. Governance Authority Accountabilities]

Key Roles and Functions	*Accountable to:*	*Accountable for:*
Overall leadership for the development of a regional geriatric system that achieves the vision, mission and principles	Residents of the CE-LHIN	The senior leadership of each service provider organization is ***accountable and committed*** to ensuring that there is alignment within and between service provider organizations, founded on the principles of *equitable access, seamless care, timeliness and responsiveness, collaboration and respect, innovation, creativity and best practice.* The Governance Authority supports and facilitates this commitment, advocates for the needs of frail seniors and ensures "shared accountability" across the system for improvements in system performance and quality
Overall accountability for creation of the strategic plan, development of system priorities and execution of the tactical plans required to bring about system integration	Service provider organizations	As delegated, the ***Service Coordination or Operations Committee*** will work with service providers to translate strategy into action. Through tactical teams and subcommittees, they will support organizations in their work by providing the forum for joint planning, support and direction, tools, education, etc., to move forward the implementation of identified regional priorities
Advisory role to the CE-LHIN for system funding and performance of SGS service providers	CE-LHIN	Providing recommendations regarding annual funding allocations and performance for SGS service provider organizations in the CE-LHIN; coordinate HSIP and other submissions for new funding , consistent with the priorities identified in the strategic plan

Figure 7 provides an overview of the flow of information related to funding and performance within the shared governance model:

(1) The Governance Authority establishes overall direction and annual priorities based upon the CE-RSGS Strategic Plan.
(2) On an annual basis, the Governance Authority (delegated to the Secretariat staff) negotiates the volume and type of SGS to be provided by each service provider organization. This includes integrated services, regional services and new expansions.
(3) The Governance Authority submits to the CE-LHIN the CE-RSGS Annual Service Plan. This plan includes the types and volumes of SGS, budget, performance standards (volume and quality), and the impact on the host organization (required base budget). In essence, the CE-LHIN becomes the recipient of a well-constructed regional service plan that service provider organizations have committed to in advance.
(4) The CE-LHIN embeds these funding and performance expectations into each service provider's Accountability Agreement.
(5) Service provider organizations include SGS within their own Annual Operating Plan and ensure appropriate internal monitoring of performance standards.
(6) The Service Operations Committee (committee of the Authority) coordinates the collection and submission of regular reporting to the Governance Authority.
(7) The Governance Authority provides regular updates and reporting to the CE-LHIN as required.

Figure 7. Flow of Information Related to Funding and Performance for the CE-RSGS



6.2.3 Host Organization: Role and Responsibilities

A host organization will be identified that would receive an overhead fee for provision of i) back-office support that includes functions such as payroll, human resources, financial reporting, legal advice, etc..., and ii) physical office space for administrative personnel that includes furnishings, computers, telephones and all of the infrastructure to support these functions. The benefits of a host organization include:

- The desire to minimize the additional infrastructure related costs for the new RSGS umbrella organization,
- The ability to provide a recognized institution in order for RSGS to apply for new funding streams and opportunities, and
- The need to have an identifiable location or home base for RSGS to carry out operations that is accessible and central in the CELHIN.

It is important that the host organization does not hold any additional authority over the governance of the system. They would be an equal partner in a shared governance model as opposed to a funding agency that would be required to hold other partners accountable for individual performance. Relationships between providers, the host organization and the Governance Authority will be articulated in the *CE-RSGS Shared Governance Memorandum of Understanding.* The RGAC identified the following criteria to assist with the identification of a host organization:

- Must be an approved health service provider of the CE-LHIN
- Must have the physical space available to house Secretariat staff with potential for expansion (minimum three private offices, one shared office and meeting space) ≈ 1600-2000 sq. ft.
- Must be easily accessible for stakeholders within the CE-LHIN
- Must have substantial existing financial and administrative infrastructure in order to provide the support functions of the Secretariat, including human resources support (including

payroll), financial and accounting oversight and support, IT/telecom support, legal and risk management, etc.)
- Must be willing to accept an annual stipend that supports the provision of all "back office and other hotel services" needed by the Secretariat
- Must be willing to create a cost centre for the Secretariat functions, receive annual funding to support these functions and provide regular cost centre reporting (Note: only salaries and consumables are included in the annual budget transfer to the Host Organization)
- Must be flexible and capable of delivering competitive compensation packages for the Secretariat staff in order to eliminate compensation barriers that could impact recruitment
- Must be willing to function as a "bank" (or transfer payment agency) for new initiative funding or strategies that require centralized financial management
- Should be a strategic fit between the CE-RSGS and the organization in terms of senior - friendly care, including a demonstrated history of leading or participating in innovative projects for frail seniors
- Should be prepared to provide advocacy and support for the Secretariat staff and CE-RSGS within and outside of the organization

6.2.4 Service Operations Committee

The Service Operations Committee (SOC) membership consists of the leadership from service provider organizations who are primarily responsible for the delivery of geriatric services within their organizations (Vice Presidents or Directors). The two current SGS regional managers (GAIN and NPSTAT) would also participate on the Committee. In addition, stakeholder representatives from community support services, the long-term care sector and other relevant health and social service providers would be eligible to participate. The SOC is ultimately responsible for coordinating the delivery of the CE-RSGS Annual Service Plan that includes the strategic initiatives and priorities established by the Board.

The SOC works primarily at the coordination level; the bulk of the integration work will occur through both standing subcommittees and tactical teams (task forces with specific deliverables) which are created and dissolved as projects are completed. Integration work will primarily be focused on the integration of processes versus the integration of organizational functions and/or people. However, it is likely that, as work proceeds, recommendations will be brought forward regarding the integration of management positions and some specific functions (such as central intake, screening and referral). Any significant changes in roles or functions between organizations would require approval of the CE-RSGS Governance Committee, with a recommendation to the CE-LHIN if a voluntary integration is recommended.

The SOC may recommend to the Governance Authority when horizontal integration beyond service provider coordination is advantageous. The Committee would of course be mindful of recommending any inter-organizational integration that would negatively impact on an existing organization and its inherent efficiencies and internal dependencies. For instance, there are examples of vertically integrated systems of SGS within existing organizations (e.g. Lakeridge Health) where clients flow between services and providers move across the system to support clinically-integrated care processes. Such nimbleness allows for internal efficiencies and improvements in quality and flow. However, in some instances, centralized reporting/management, centralized services or even mergers may be recommended to create improvements that facilitate access to SGS services.

6.2.5 Tactical Teams and Subcommittees

Several stakeholder-proposed service delivery integration initiatives will be resource-intensive and others will require a longer-term strategy. It is suggested, therefore, that at an early stage, two standing ***subcommittees*** be formed:

1. *The Standardization Subcommittee:* A group with strong clinical representation and leadership that examines and recommends common language and nomenclature for existing SGS services that is consumer-friendly, that creates common tools for screening and assessment, and that coordinates the new RGS brand across the CE-LHIN.
2. *The Performance and Agreements Subcommittee:* A group with strong clinical, financial and decision support representation that supports the development of Service Agreements and MOUs where needed and determines the RGS Scorecard and Performance measures that will be required for regular reporting on system performance

In addition, the first ***tactical teams*** (or time-limited working groups) should be directed at addressing the issues of system-wide care coordination and integration with primary care. Both of these issues were raised consistently at the stakeholder sessions and, prior to this, during consultation sessions held by the CE-LHIN Seamless Care for Seniors Committee.

6.2.6 The Secretariat: Administrative Staff and Support for CE-RSGS

The CE-RSGS, although it will be embedded in the existing health system, will require significant attention to formulate the structure and maintain momentum. As with structures such as the RGPs of Ontario, the Child Health Network and the GTA Rehab Network, there will be a need for both leadership and administrative support. It is NOT possible to create an integrated model and sustain the momentum using existing executive resources/administrators doing the work “off the side of their desk”.

Creating the system, advocating for frail seniors, and sustaining the infrastructure will require an investment of resources. Organizations could be asked to pay a nominal annual fee from their operating dollars in order to sustain the Secretariat. Alternatively, the CE-LHIN could fund the Secretariat from existing funding received under AHA Year 2 and 3 (e.g. GAIN Administration). Several positions will need to be created in order to facilitate and resource the work and provide the much-needed local leadership and credibility that the system will require. The key positions include:

- Full -time Executive Director
- Part-time Medical Lead
- Full-time Project Lead
- Full- time administrative support

► *Executive Director (full time)*:
This key administrative role is hands-on and will be pivotal in creating the initial infrastructure and facilitating the evolution of the model over time. Key tasks:

i. Creation of Terms of Reference for Governance Authority and shared governance committees,
ii. Creation of Annual Service Plan tools, templates and processes,

iii. Support for the Board, including required policies (such as conflict of interest), preparation for meetings and follow-up,
iv. Creation of Memorandums of Understanding between Governance, the LHIN and other service providers,
v. Engaging the community and service providers in establishing the necessary committee structure and the associated accountabilities
vi. Chairing the Service Coordination Committee,
vii. Facilitation of vision, mission and principles (philosophical prerequisites) for the new system in order to create the common platform for the Board,
viii. Facilitation of strategic planning and subsequent development of the multiyear service plan,
ix. Marketing and championing the new system and engaging communities
x. Advocating and acting as spokesperson for the CE-RSGS
xi. Development and execution of the Communications Plan
xii. Establishing the process for engaging the community, including CE-LHIN-wide information-sharing and dialogue related to the needs of high-risk and frail seniors.

► *Medical Lead (part-time):*

This key champion and advocate will be pivotal in gaining support from the physicians and other community stakeholders and ensuring that the Authority remains grounded and educated in the needs of frail seniors across the region. This will be accomplished by:

i. Participating in the Governance Authority as an expert practitioner and advocate for the needs of frail seniors
ii. Functioning in a liaison role for broader provincial strategies and inter-LHIN initiatives related to frail seniors and SGS
iii. Participating in the development of the CE-RSGS Annual Service Plan and any new funding H-SIP submissions to the CE-LHIN
iv. Working collaboratively with the Executive Director on all aspects of the development of the Shared Governance Model, including leadership for the development of primary care linkage mechanisms
v. Providing advice and direction regarding system-wide performance metrics and senior-sensitive indicators
vi. Advocating and acting as spokesperson for the CE-RSGS
vii. Developing a region-wide human resource strategy for physician support (geriatricians and family physicians with an interest in seniors) in the CE-LHIN
viii. Working collaboratively with the OMA and MOHLTC on the creation of geriatrician and NP-led teams and clinics to facilitate capacity-building for frail seniors' care in the CE-LHIN

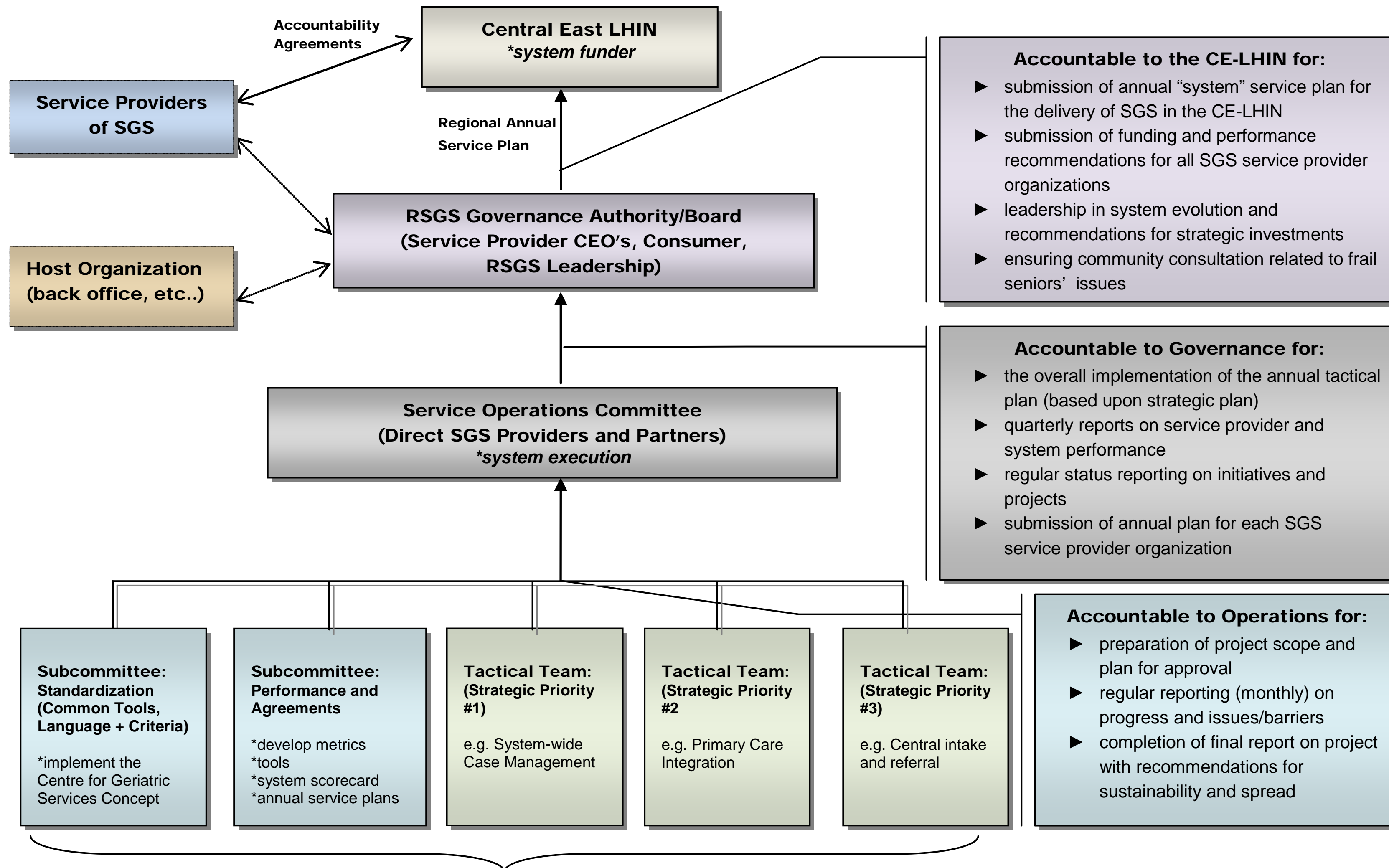
► *Project Leadership (full time):*

Given the volume of early work related to integration activity, it is recommended that the Project Lead position be incorporated into the Secretariat. This individual would work with the subcommittee leads and tactical teams, utilizing a project management approach to ensure that the work is scoped and subsequently delivered according to timelines. This support person would also be instrumental in facilitating the preparation of joint/collaborative H-SIP's and other funding submissions for new funding streams.

► Administrative Support Person (full time):

An administrative support person will be required to support the Medical Lead and Executive Director. In addition, this individual will be required to support the Governance Authority and related committee structure by such tasks as recording minutes, coordinating meetings and supporting correspondence with service providers and the CE-LHIN.

Figure 8. Shared Governance Committee Structure for the Organization and Coordination of Central East Regional Specialized Geriatric Services (CE-RSGS)



"Service delivery integration activity is based upon the integration and standardization of processes versus people and organizations"

7. Recommendations, Implementation Plan and Timelines

7.1 Recommendations

<u>**Umbrella Organization, Governance and Funding;**</u>

1) That the CE-LHIN endorse the ***Shared Governance Model*** in order to build a sense of shared accountability, a commitment to a common philosophy and a commitment to the vision, mission and goals of the system of services for frail seniors across the CE-LHIN.

2) That the CE-LHIN endorse the creation of a ***Governance Authority/Board***, bound by a Memorandum of Understanding, that will lead the system-wide strategic planning, organization and coordination of Specialized Geriatric Services across the CE-LHIN.

3) That the CE-LHIN support the accountabilities of the Governance Authority with respect to their advisory role in recommending to the CE-LHIN the annual distribution of funds to service providers who are delivering SGS services (brokerage system) based upon strategic priorities and written funding agreements embedded in the ***CE-RSGS Annual Service Plan***.

4) That the CE-LHIN support the implementation of the CE-RSGS Service Plan and associated processes for the ***2012/13 fiscal year***.

5) That the CE-LHIN support a process to ensure the protection of current service provider SGS investments through ***Memorandums of Understanding*** and the ability to leverage new monies (both AAH and new funding streams). The two components of SGS funding would include:

> ►*Organization Global Funding*: many organizations already provide SGS from within their global budget allocation and many of these services are vertically integrated for efficiencies. This would be expected and encouraged, not changed. As such, the requirement to retain these services would be articulated in the Memorandum of Understanding and other applicable accountability agreements between the CE-LHIN and service providers.
>
> ►*AAH Regional Services and New Funding*: there are several new AAH funding streams (GAIN, NPSTAT, GEM, etc.) that are intended for the delivery of regional SGS services but which may be located at a service provider organization. These funds and any new funds should be distributed annually as a leverage mechanism to ensure that service delivery gaps and access issues are being considered.

6) That the CE-LHIN establish a process for the identification of a ***host organization*** utilizing the criteria established by the *CE-LHIN Regional Geriatric Advisory Committee Expert Panel*. The role of the host organization will be articulated in a Memorandum of Understanding and, in the spirit of shared accountability, will be limited to the scope articulated in this document.

7) That the CE-LHIN support the expectation that the Governance Committee is responsible for the development of a ***region-wide strategic plan in Year 1*** for Specialized Geriatric Services. This strategic plan must:

- ✓ ensure the development of the philosophical and policy prerequisites that will create the platform for shared governance,

- ✓ take into consideration the feedback from stakeholders on the top priorities for service delivery improvements,
- ✓ include the consideration of an application to become an affiliate of the RGPs of Ontario,
- ✓ include an examination of all existing SGS services and create a system-plan for filling the gaps,
- ✓ include consideration of the role of CE-RSGS as the agent of social change in addressing system-wide “ageism” and the social stigma associated with frailty and dependency in the elderly population and,
- ✓ include an examination of the current roles and reporting relationships of the existing SGS regional management staff (NPSTAT and GAIN) within the context of a regional delivery model.

8) That the CE-LHIN support the creation of a ***Secretariat*** that is either funded by the CE-LHIN or through the levy of a mandatory service provider Membership Fee.

Service Delivery Integration:

1) That the CE-LHIN support and endorse the ***Service Operations Committee*** as the primary mechanism for integration activity related to frail seniors. The Committee will utilize subcommittees and tactical teams to deliver on the priorities as directed by the Governance Committee

2) That the CE-LHIN support the initiation of ***early stakeholder-driven integration activity*** related to two service delivery priorities: a) central intake and screening and, b) common language and tools, and that health service providers’ interest and desire to move forward as fast as possible be leveraged as a “quick win” while governance is being established.

3) That the CE-LHIN support the initiation of a ***demonstration project*** for a stratified, system-wide case management system as articulated in this report and in consideration of current legislation enabling the change in the role of CCACs.

4) That the CE-LHIN support the creation of a ***“common brand”*** (e.g. “Geriatric Services”) based upon feedback from stakeholders and the need to provide recognition and standardization across the system. The franchise-type concept would be utilized to “brand” the services and ensure that, regardless of where the client enters the system, the “brand” is exactly the same (e.g. “store within a store”). This would also be a necessary step in the larger goal of stakeholder-friendly standardization of nomenclature.

System Linkage Mechanisms and Community Integration:

1) That the CE-LHIN support the Governance Authority, through the Operations Committee, to initiate a tactical team with a focus on connecting the frail seniors’ system with the system of ***primary care.***

2) That the CE-LHIN articulate clear expectations for all service provider organizations to lead ***community consultation*** activity relative ***to high-risk and frail seniors*** in the creation of their annual service plan. These regular consultations will enable the spread of best practices and a mechanism to leverage existing local capacity in system planning.

7.2 Recommended Implementation Timelines

The suggested high- level milestones would enable the full operation of the CE-RSGS by April, 2012. To deliver the first strategic plan and 2012/13 CE-RSGS Annual Service Plan it is necessary for approvals from the CE-LHIN to occur in the spring of 2011, with necessary recruitment occurring over the summer months. The Governance Authority would be established in the fall of 2011.

High-Level Milestones	Target Completion Dates
***Approvals and Establishing Supports*:**	**May – August, 2011**
Presentation to the CE-LHIN Board	♦ *May 19, 2011*
Presentation to Other Key Stakeholders	♦ May/June 2011
LHIN confirmation of overall strategy and approval of SGS Shared Governance Model and Committee Structure	♦ June 2011
Communication Plan and Strategy	♦ June/July 2011
Identification of Host Organization	♦ July/August 2011
Recruitment of Executive Director, Medical Leadership and support roles	♦ July/August 2011
Selection Process for Governance Authority Undertaken	♦ July/August 2011
Complete Foundational Work:	**Sept-Nov, 2011**
Governance Authority established	♦ September 2011
Development of Policies (conflict of interest) and Memorandums of Understanding	♦ October 2011
Shared Governance Committee Structure formalized	♦ October 2011
Develop Principles and Vision for regional program	♦ Nov, 2011
SGS Strategic Planning initiated	♦ Nov, 2011
Initiate Work Plans, Tactical Teams and Budget Preparation	**Sept-March, 2011**
Governance to Confirm First Integration Priorities	♦ October, 2011
Initiate Regional Tactical Team for "ASSIST" Implementation (Centralized Intake, Screening)	♦ October, 2011

High-Level Milestones	Target Completion Dates
Initiate Regional Tactical Team for System-wide Case Management	♦ October, 2011
Subcommittee Initiated: Standardization , Nomenclature and Branding	♦ Nov/Dec, 2011
Subcommittee Initiated: Performance and Reporting	♦ Dec/11-Jan/12
Development of Framework for Annual Service Plan	♦ Dec/11-Jan/12
Preparation of 2012/13 System Plan, Goals and Objectives	♦ Dec/11-Feb/12
Negotiation of Annual Service Plan with SGS Service Providers	♦ Jan-March, 2012
Preparation of First Annual Report to the CE-LHIN	♦ March, 2012

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