North Simcoe Muskoka
Specialized Geriatric Services

NSM SGS Program Education Strategy 2017 – 2019

Submitted To: Seniors Health Project Team

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Waypoint
CENTRE for MENTAL HEALTH CARE
CENTRE de SOINS de SANTÉ MENTALE
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"The aging population is not a tsunami . . . it's an iceberg. The only way you get hit by an iceberg is if you don't get out of the way in time".

Michael Rachlis

INTRODUCTION

The North Simcoe Muskoka (NSM) Specialized Geriatric Services (SGS) Program was established in 2015 to improve the quality of care provided to frail seniors and their caregivers. Within the *Strategy for a SGS Program in NSM* document (2014) there are five key roles identified for the program: leadership, clinical, education and mentorship, advocacy, and research and ethics.

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

In alignment with this mandate, a key strategic priority of the SGS Program (Appendix A) is to develop health system capacity; specifically, ***"frail seniors, their caregivers and their health care professionals will have the knowledge and tools they need to optimize health outcomes"***. To achieve these ends, the following strategic goals are identified:

- Increase the number of health care professionals AND skillsets of health care providers in the care of frail seniors;
- Increase education and mentorship opportunities for health care professionals, community providers and students;
- Standardize and disseminate leading practices; and,
- Increase the self-management capacity of frail seniors and their caregivers.

The purpose of this Education Strategy is to outline the directions and plans required to accomplish the strategic priority of capacity building. Like the *Strategy*, it is a guiding document. It offers direction to support planning and decision-making recognizing that significant work is required in the years ahead to support implementation. Implementation requires that this strategy be flexible and nimble in order to meet the needs of frail seniors and their caregivers in our continuously changing environment.

KEY CONCEPTS

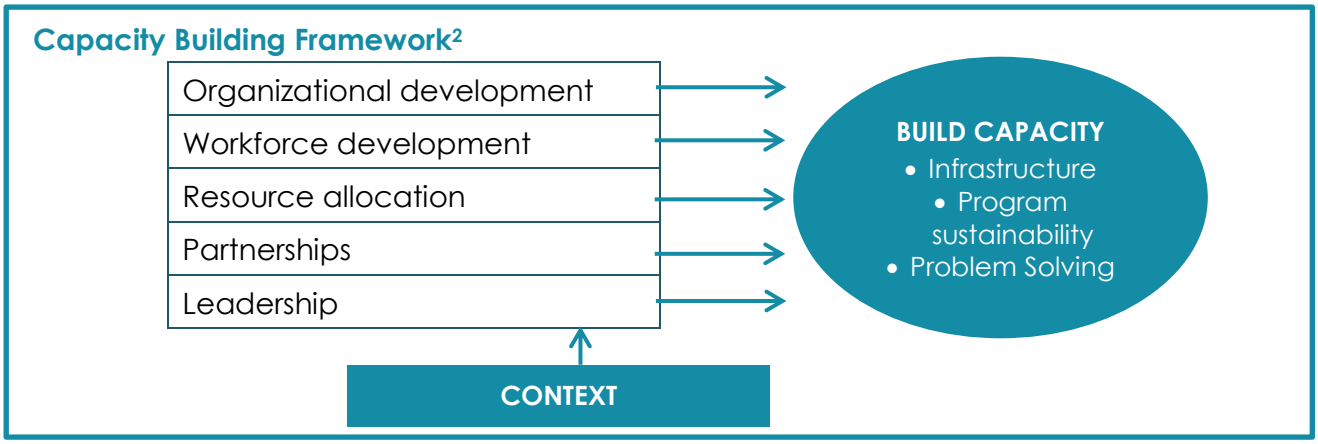
There are several key concepts that permeate this document. It is important to define these concepts at the outset to promote clarity.

"Capacity Building"

"Capacity building is a process by which individuals, groups, institutions, organizations and societies enhance their abilities to identify and meet development challenges in a

sustainable manner" (CIDA, 1996)[1]. Capacity building leads to a greater ability of people, organizations and communities to promote health outcomes.

The Capacity Building Framework below identifies that capacity building occurs within key action areas; organizational development, workforce development, resource allocation, partnerships and leadership. This framework helps one to recognize that learner support, organizational support and leader acknowledgement are integral and that it may be difficult to specifically separate education when looking at the entire concept of capacity building. All five (5) key action areas have been addressed within the goals of this education strategy to the extent possible within the scope of the SGS Program.



"Education"

Within this strategy, the term "education" is used in its broadest sense. It includes the concepts of teaching/training as well as coaching and mentoring; recognizing that *each* plays an important role in building health system capacity. For the purpose of this document, these terms are defined as follows [3]:

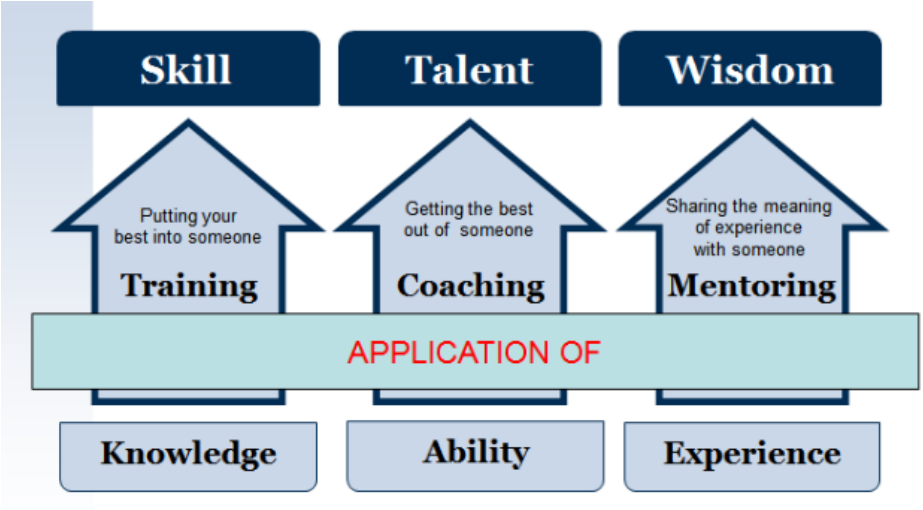
- ***Teaching/Training*** refers to instructing and imparting information, knowledge and wisdom. The teacher/student relationship implies that the teacher has the information, knowledge or wisdom that needs to be transferred to the student.
- ***Coaching*** focuses on the repetitive practicing of skills until mastery is attained. Coaches break down skill sets into distinct, learnable segments that can be practiced until they become second nature. The coach may be teaching valuable information but the onus is upon the student to learn this new skill.

[1] Charles Lusthaus, Marie-Hélène Adrien, Mark Perstinger. Capacity Development: Definitions, Issues and Implications for Planning, Monitoring and Evaluation, Universalia Occasional Paper No. 35, September 1999. http://andewal.com/archive/capacity_development_explored.pdf at Oct 2016

[3] http://www.cio.com/article/2443810/training/should-you-teach--coach-or-mentor-.html Jan 20 2017

- ***Mentoring*** enables a person to tap into one's internal resources to mature and develop as a human being. A mentor/protege relationship is the most complex, generally containing elements of both teaching and coaching. More than skill acquisition and knowledge transfer, mentoring denotes cultivating the whole person—one's values, passions and goals.

The following graphic can be used to depict this relationship [4]:



"Frail Seniors"

Frail seniors are a distinct subset of the senior population. According to the work of Dalziel (2008)[5], this population presents with:

- Multiple diseases with multiple drugs = complexity.
- Multiple problem areas = multidimensionality.
- Premorbid function disability = slippery slope.

Seniors can move in and out of frailty and can experience varying degrees of frailty as a result of their physical, mental, emotional and social circumstances. When in the health care system, frail seniors can benefit from an interdisciplinary approach to care inclusive of geriatric medicine and geriatric psychiatry services as well as social services and discharge planning.

Informal caregivers are key resources to frail seniors. Demands on caregivers grow as the degree of frailty increases. For the purpose of this document, the term "frail senior" is inclusive of the frail senior and his/her caregivers.

[4] https://www.td.org/Publications/Blogs/Sales-Enablement-Blog/2014/08/Training-Mentoring-or-Coaching Jan 20 2017
[5] Dalziel, B. (2008). Can you Unfrail the Elderly? RGP Toronto Toolkit: Frailty

"Specialized Geriatric Services"

Specialized Geriatric Services (SGS) is defined as a comprehensive, coordinated system of hospital and community-based health and mental health services that assess, diagnose, and treat frail seniors. These services are provided by interdisciplinary teams with expertise in care of the elderly and provided across the continuum of care. SGS is inclusive of both geriatric medicine and geriatric psychiatry services.

GUIDING PRINCIPLES

- Patients and their caregivers are at the heart of everything we do.
- Patient-focused care requires competent, caring and capable health care professionals. As such, education is a critical component in staff development.
- Education is based in evidence and best practice.
- Education is available to providers across the health care continuum and across all NSM sub-geographic regions.
- Available funding and resources are optimized to support education.
- Innovations and technology are essential to a sustainable education strategy.
- Education is an important component of team-building and helps build collaborative relationships with internal and external partners.

TARGET POPULATION *(WHO)*

In alignment with the strategic priority of the NSM SGS Program regarding capacity building, there are 4 key populations targeted by this strategy:

SGS Program Staff	Staff employed and/or affiliated with the NSM SGS Program's clinical services. This would include those staff employed within the SGS Program and those associated with the local and central through partnership agreements.
Health Care Professionals and Care Providers	Health care professionals and care providers who provide care and support to frail seniors.
Students	Students from health care profession and care provider programs. ** The intent is to build the capacity of students in the care of frail seniors through partnership and collaborative approaches to learning. The intent is not to be sole provider of that student education.*
Frail Seniors	Frail seniors and the informal caregivers that provide and/or participate in their care.

AREAS OF FOCUS *(WHAT)*

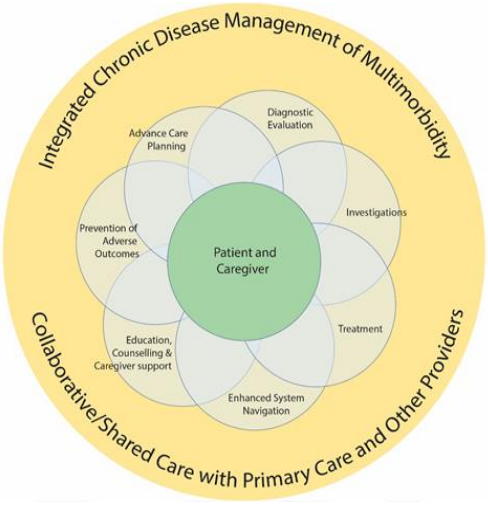
To build health system capacity the focus of education within the NSM SGS Program is on three key areas of focus:

- Comprehensive Geriatric Assessment;
- Geriatric syndromes; and,
- Enabling approaches to care.

Comprehensive Geriatric Assessment

Frail seniors have unique needs that present specific challenges for accurate assessment, diagnosis, and treatment. Comprehensive Geriatric Assessment (CGA) is a multidimensional approach to care that identifies the frail senior's presenting problems, their personal strengths and resources and their service needs in order to develop an individualized patient-centred plan of care to guide treatment, follow-up and support transitions. The CGA is comprised of nine key components:

- Diagnostic Evaluation
- Investigations
- Treatment
- Prevention of Adverse Outcomes
- Enhanced System Navigation
- Patient Education, Counselling, & Caregiver Support
- Advance Care Planning



The CGA is supported by an interdisciplinary team. It is delivered within a collaborative practice model. Teams that provide CGA integrate with primary care, specialists, and other providers to ensure a patient-centred approach. "There is evidence that CGA improves diagnostic accuracy, optimizes care plans, improves patient and system outcomes, and assists clinicians in identifying the need for treatment change"[6].

Geriatric Syndromes

Building capacity in regard to the assessment and management of geriatric syndromes is a central focus of the SGS Program. The term "geriatric syndrome" is used to capture those clinical conditions in older persons that do not fit into discrete disease categories. They can be defined as "multifactorial health conditions that occur when the accumulated effects of impairments in multiple systems render [an older] person

[6] The RGPs of Ontario: Three Frequently Asked Questions. http://rgps.on.ca/sites/default/files/RGPs%20FAQ%20-%20CGA%20and%20SGS%20Mar%206%202016_0.pdf at July 6/16.

vulnerable to situational challenges"[7]. Specialists in geriatric care are often consulted to manage these highly prevalent syndromes due to the complexity and associated poor outcomes on quality of life, disability and morbidity.

There is no standard list or overarching structure to identify geriatric syndromes. In 2015, the Rehabilitation Care Alliance of Ontario issued the *Compendium of Evidence-Based Assessments and Interventions to Support the Management of the Geriatric Syndromes* [8]. This compendium identifies 11 geriatric syndromes and aligns evidence-based practices with various health care sectors (e.g. acute care, bedded rehab, primary care). Within the literature, geriatric syndromes can include:

- Dementia
- Delirium
- Depression
- Polypharmacy
- Falls & Fear of Falling
- Urinary Incontinence
- Constipation
- Malnutrition & Anorexia
- Sleep Disturbances & Insomnia
- Pain
- Pressure Ulcers
- Elder Abuse

Enabling Approaches to Care

To best meet the needs of frail seniors, education must also focus on enabling approaches to care. In other words, we need to support SGS providers to provide care in different ways within the new SGS Program. With a focus on frail seniors, and in recognition of the changing health system within the SGS Program, this strategy focuses on building capacity in the following areas: interprofessional practice and care; change management; compassion fatigue; transitions; and self-management.

Interprofessional Practice & Care

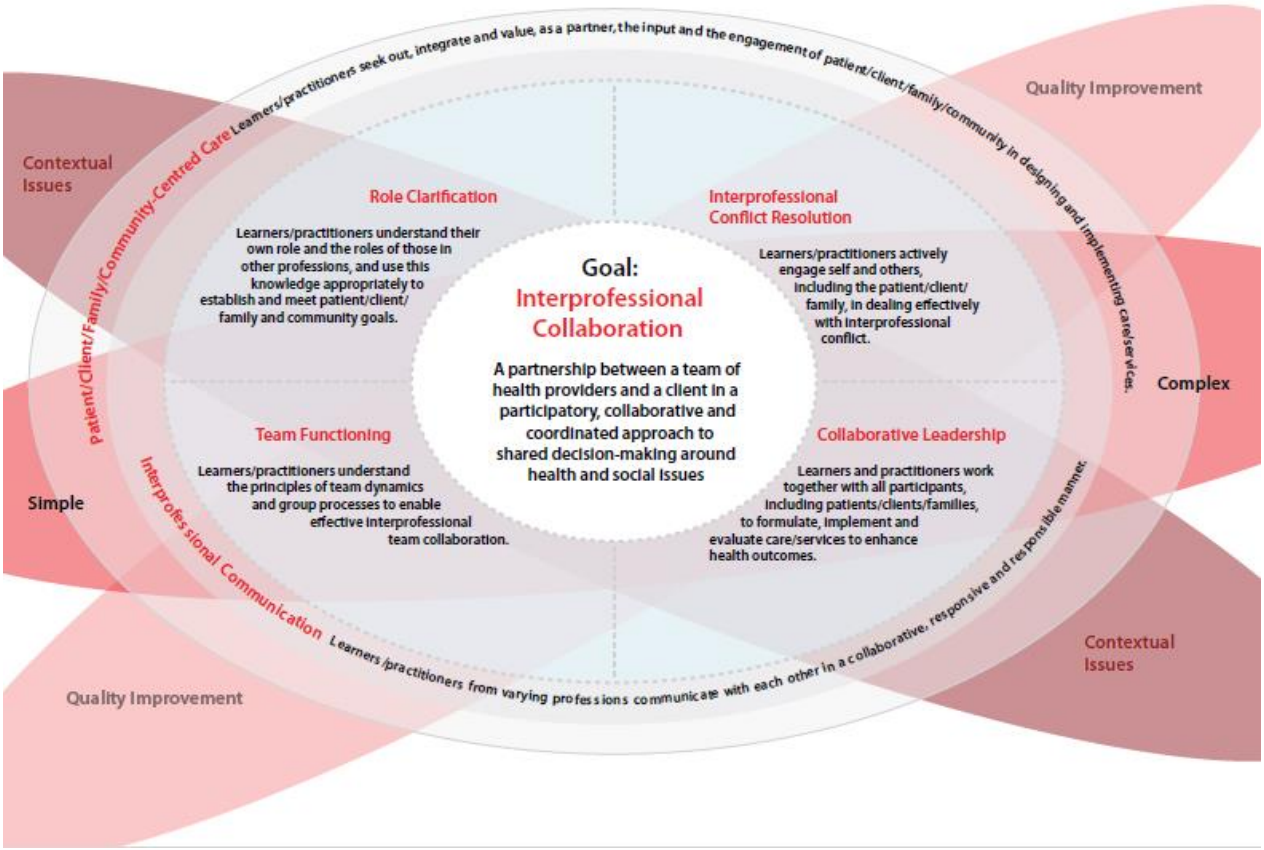
There is substantial literature on the concepts of interprofessional practice and interprofessional care. Using the work of the Canadian Interprofessional Health Collaborative and Health Force Ontario, Ontario Shores offers the following definitions [9]:

[7] Inouye, S. K., Studenski, S., Tinetti, M. E., & Kuchel, G. A. (2007). Geriatric Syndromes: Clinical, Reseach and Policy Implications of a Core Geriatric Concept, J Am Geriatric Society, May, 55(5), 780-791. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2409147/ at Feb 2, 2017.
[8] http://www.rehabcarealliance.ca/fsmc-compendium Feb 2, 2017
[9] http://www.ontarioshores.ca/about_us/our_approach/interprofessional/ Feb 7, 2017

- ***Interprofessional Practice*** is a collaborative practice which occurs when healthcare providers work with people from within their own profession, with people outside their profession and with patients and their families.
- ***Interprofessional Care*** is the provision of comprehensive health services to patients by multiple caregivers who work collaboratively to deliver quality care within and across settings.

Interprofessional practice and interprofessional care are both critical to the success of the SGS Program and key enablers of care. An interprofessional approach to practice and care should lend to higher quality care and better outcomes for frail seniors and should also contribute to improved job satisfaction within the SGS team.

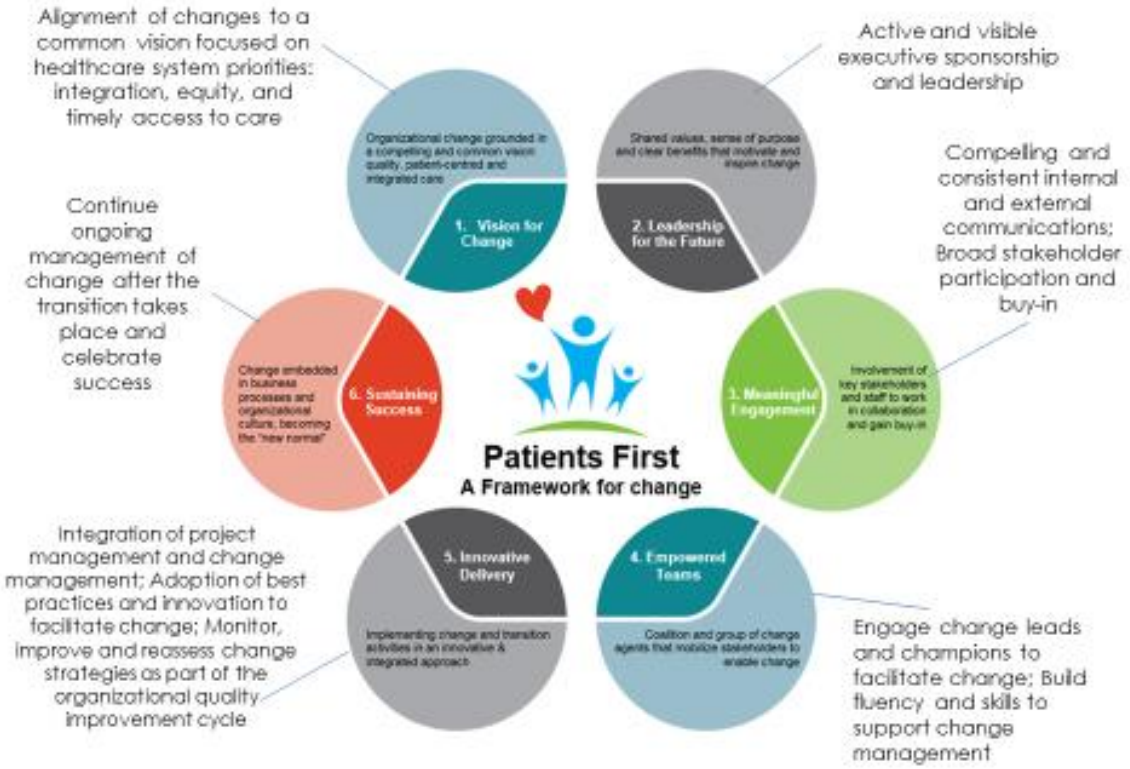
In February 2010, the Canadian Interprofessional Health Collaborative published the *National Interprofessional Competency Framework*.[10] This framework outlines six key competency domains required for effective interprofessional collaboration: interprofessional communication; patient/client/family /community-centred care; role clarification; team functioning; collaborative leadership; and interprofessional conflict resolution.



[10] Canadian Interprofessional Health Collaborative. February 2010. A National Interprofessional Competency Framework. http://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf February 7, 2017

Change Management

As the NSM SGS Clinical Design and other LHIN and ministry initiatives are implemented, we must provide our SGS providers with the necessary tools and support to adapt to change. A key resource will be the NSM LHIN – NSM CCAC Change Management Framework (2016). Developed using change management theory and evidence, this framework embodies Kotter's Eight-Step Model (focused on the people impacted by change) and the UK's National Health Service (NHS) Model (focused on system change, including the impact on structures and processes).



Compassion Fatigue

Within recent years, the concept of compassion fatigue among both formal and informal caregivers has been identified. Within the frail senior population, the emotional and physical burden assumed in caring for seniors with cognitive impairment and responsive behaviours has risen to the forefront as an important theme for health care providers. An opportunity to address this issue has been provided through the recent Ministry of Health and Long Term Care Enhanced BSO Funding. This funding has supported the training of 20 individuals to become certified in the coaching and education of compassion fatigue. To support the sustainability of this investment the SGS Program will endeavor to provide ongoing leadership in the development and maintenance of a regional

structure and process for continuing education of compassion fatigue to health care providers of frail seniors within the LHIN.

Transitions

Under the SGS priority of improved patient outcomes, a key strategic goal is to improve the care experience including transitions. A recent literature review of transition best practices was completed for the Behaviour Service Implementation Steering Committee. Health Quality Ontario and the Change Foundation have also produced literature on the concept of transitions. "A care transition describes the transfer of a patient between different settings and health care providers during the course of an acute or chronic illness."[11] HQO, in relation to their work on Health Links, indicates that a standardized approach to transitional care planning can promote quality care and improve safety, facilitate collaboration among care partners including patients and families, and optimize the appropriate use of health resources. Education for all SGS providers focused on transition best practices will support improved patient and system outcomes.

Self-Management

Under the SGS priority of capacity building, a key strategic goal is to increase the self-management capacity of frail seniors. Through improved self-management, individuals are better able to manage their health needs on a day-to-day basis. Improving self-management support for individuals with chronic conditions is a key component of Ontario's Chronic Disease Prevention and Management Strategy. The Ministry of Health and Long-Term Care (MOHLTC) funds 14 regional self-management programs across Ontario which oversee the coordinated delivery of self-management workshops and supports for both health care providers and people living with chronic conditions. The North Simcoe Muskoka Self-Management Programs, coordinated by the South Georgian Bay Community Health Centre, will be an important resource to the SGS Program. Understanding concepts like motivation, open-ended inquiry, reflective listening and the conviction and confidence models, will help SGS providers better support frail seniors.

EDUCATION AS A LIFELONG JOURNEY *(WHEN & HOW)*

Learning and skill acquisition is a lifelong process. Patricia Benner describes how a clinician, specifically nurses, acquire skills and move in proficiency from novice to expert. Benner's theory is based on the clinician obtaining a proper educational background coupled with a multitude of experiences.[12]

[11] HQO (2012). bestPATH - A support for Health Links: Transitions of Care

[12] http://www.nursing-theory.org/theories-and-models/from-novice-to-expert.php at Feb 7 2017

Orientation & Core Competencies

New SGS providers will require an orientation program to support their entry into the NSM clinical practice. Consideration should also be given to incorporating education regarding frail seniors into other relevant orientation programs. Some of this work is being done in acute care as part of the Senior Friendly Hospital Strategy and should extend into other sectors as part of a broader Senior Friendly Care initiative.

Like orientation, the development of core competencies for both SGS providers and other health care providers is an important foundation to the provision of care for frail seniors across NSM. At present, there are some resources available which the SGS Program can leverage to support the establishment of geriatric care core competencies. The Canadian Gerontological Nursing Association have nursing competencies and practice standards for care of seniors that can become a starting point for basic geriatric care competencies[13]. These standards are broad in nature and do not specify specific nursing skills and as such may be sufficient as a baseline all health care providers. SGS providers, as "experts", require core competencies that exceed these basic considerations. In 2012, Behavioural Supports Ontario developed a capacity building roadmap which identifies core competencies[14] for staff working with individuals with responsive behaviours and cognitive impairment. Many of these competencies can be adapted for SGS providers. More recently, the RGPs of Ontario is collaborating to identify the specific skills and knowledge required to provide specialized geriatric services. This document will be instrumental in planning and developing SGS staff orientation and continuing education initiatives.

Continuing Education

Ongoing education is important to continue to improve the quality of care provided to frail seniors in the NSM region. The Capacity Building Framework above identifies organization development as a key context for building capacity. The NSM SGS Program can directly influence organization development in capacity building by ensuring individual health care professionals and teams are formally supported in attaining the personal qualities required (i.e. engagement, professional development, leadership, continuous improvement for efficiency and effectiveness). Communities of practice, journal clubs, reflective processes in performance appraisals, clear role descriptions that support full scope of practice and shared governance through staff councils are a few of the processes and practices that can enhance qualities that promote flexibility and creativity within the workforce – supporting program sustainability and problem solving and thereby building capacity.

[13] http://www.cgna.net/Standards_of_Practice.html at Feb 7 2017
[14] http://brainxchange.ca/Public/Files/BSO/BSO-capacity-building-roadmap.aspx at Feb 7 2017

KEY CONSIDERATIONS

Leveraging Current Resources

Several programs are available to health care organizations that focus on building capacity and/or care of seniors. Within each program are frameworks and/or resources to increase capacity at both an individual and organizational level. Examples include: NICHE - Nurses Improving Care for Healthsystem Elders (NYR Rory Meyers College of Nursing), the MAGNET Hospital Program (American Nurses Credentialing Centre), Health Quality Ontario's Quality Standards, Registered Nurses Association of Ontario Best Practice Guideline Program, Collaboration for Homecare Advances in Management and Practice (Centre for Home Care Policy & Research, Visiting Nurse Service of New York) and the Ontario Senior Friendly Hospital Strategy. Also available through various web-sites and OTN are individual based education resources, programs and courses inclusive of e-learning modules like the Waterloo-Wellington eFrailty Learning Modules.

This Education Strategy is not meant to duplicate these resources. However, collectively they represent considerable knowledge and information that can be used to guide and support planning and implementation. The SGS Program will endeavor to build upon existing international, national, provincial and regional resources.

Adult Learning Theory

Malcolm Knowles[15] in the 1980's proposed a theory of adult learning that includes assumptions and principles that differentiate adult and child learners.

5 Assumptions of Adult Learning	4 Principles of Adult Learning
1. Self-concept	1. Adults need to be involved in the planning and evaluation of their instruction
2. Adult Learner Experience	2. Experience (including mistakes) provides the basis for the learning activities.
3. Readiness to Learn	3. Adults are most interested in learning subjects that have immediate relevance and impact to their job or personal life.
4. Orientation to Learning	4. Adult learning in problem-centered rather than content-oriented.
5. Motivation to Learn	

In 1996, Jack Mezirow proposed a theory of learning that is uniquely adult, abstract, idealized, and grounded in the nature of human communication.[16] Transformative learning theory suggests that "learning is understood as the process of using a prior interpretation to construe a new or revised interpretation of the meaning of one's

[15] Knowles, Malcolm: The Adult Learning Theory – Andragogy https://elearningindustry.com/the-adult-learning-theory-andragogy-of-malcolm-knowles at Sept 2016

[16] Transformative Learning Theory – An Overview. Available On-line at: http://www.calpro-online.org/eric/docs/taylor/taylor_02.pdf at Sept 2016

experience in order to guide future action". Mezirow's theory has three common themes: centrality of experience, critical reflection and rational discourse.[17]

Both Knowles and Mezirow highlight the importance of self, experience and the need for contemplation by an adult in the learning process. When developing plans for implementing practice change and how education programs assist in sustainability, it will be useful to incorporate elements of both theorists.

Education across Generations

The needs of generations are an important aspect to consider in the development and implementation of the education strategy. These needs must be considered for both SGS staff, other health care professionals, the seniors and their caregivers. Information and expectations of these groups may change with generational changes and the SGS Program must be adaptable. The following summarizes key considerations[18]:

	Traditionalists	Baby Boomers	Generation X	Millennials / Generation Y
Key Descriptor	Informational Learning	Transformational Leaning	Self-Directed Learning	Informal Learning
Birth Year	1925-1945	1946-1964	1965-1980	1981-2000
Learning Needs	• Informational learning style • Traditional classroom setting utilizing mostly lectures • Excellent Mentors • Excellent source of institutional knowledge and experience • Receptive to one on one coaching • Task specific	• Transformational learning style • Traditional classroom learning extended to learning through participation, critical reflection, and feedback	• Self-Directed or Self-Paced • Highly receptive to e-learning series of structured lectures • Requires integration of technology and media in learning. • Make it easy to access the information and industry	• Informal, incidental learning. • Short attention span • Requires integration of technology and media in learning (webinars, social networking sites, Avatars) • Personalized self-directed learning through customized environment • Need access to info when they need/want it

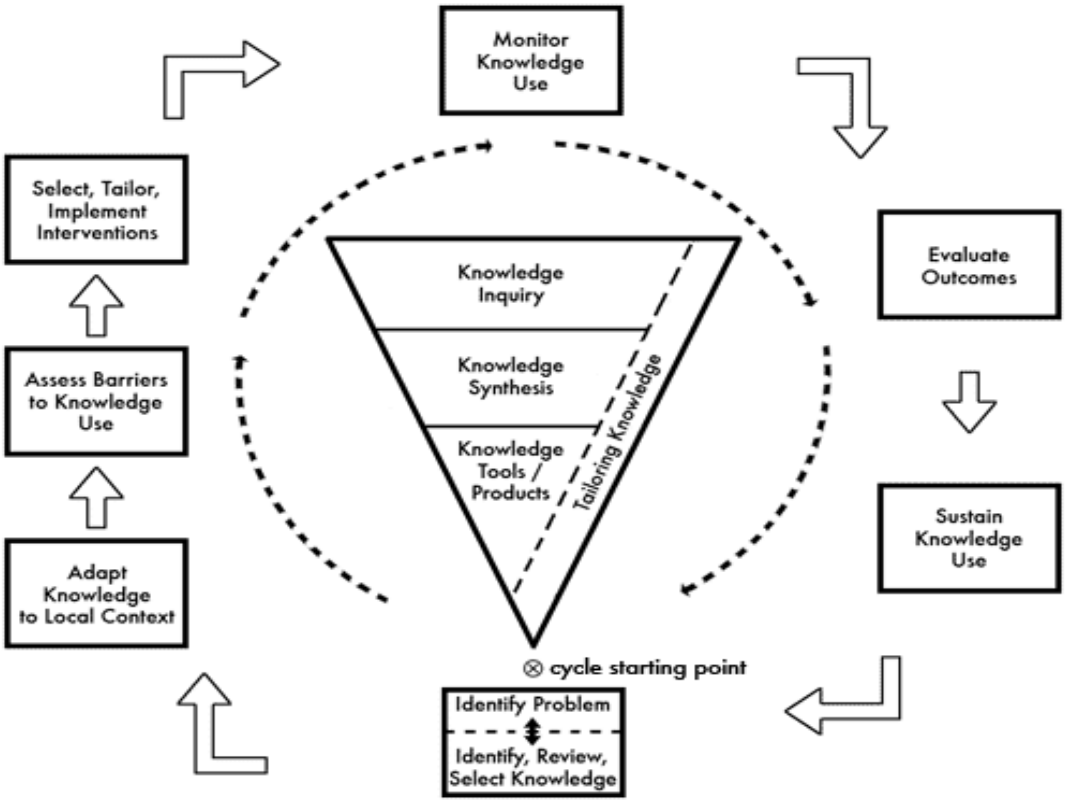
[17] Mezirow, J. (1997). Transformative Learning: Theory to Practice, *New Directions for Adult and Continuing Education*, no. 74, p. 5-12.

[18] United Nations Joint Staff Pension Plan. Overcoming Generational Gap in the Workplace http://aspringer.weebly.com/uploads/1/3/6/4/1364481/designing_recruitment_selection__talent_management_model_tailored_to_meet_unjspfs_business_development_nee.pdf January 20 2017

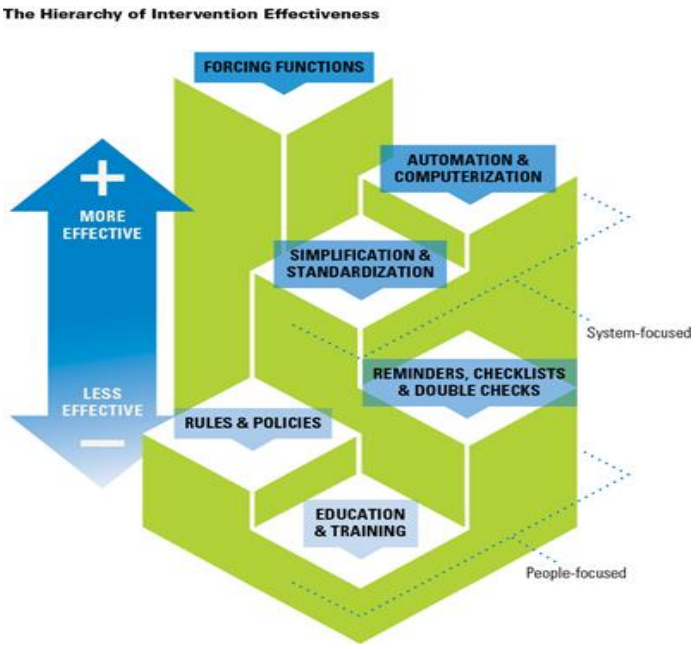
Knowledge Translation into Practice

Changing established behaviour of any kind is difficult. The literature indicates that it can take up to two decades before the findings of original research becomes part of routine clinical practice[19]; a clinical guideline can take up to 3 years to be fully implemented in an organization[20]. Just informing or training health care professionals on evidence-based practice is not sufficient to ensure that the knowledge provided is then consistently used or translated into practice.

The Canadian Instituted of Health Research (CIHR) defines knowledge translation as "a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically-sound application of knowledge to improve the health of Canadians, provide more effective health services and products, and strengthen the health care system."[21]. The Knowledge-To-Action Cycle[22] developed through CIHR identifies milestones that are necessary in bridging the knowledge-to-action gap.



[19] https://archive.ahrq.gov/research/findings/factsheets/translating/tripfac/trip2fac.html at Feb 9, 2017
[20] https://www.nice.org.uk/Media/Default/About/what-we-do/Into-practice/Support-for-service-improvement-and-audit/How-to-change-practice-barriers-to-change.pdf at Feb 9, 2017
[21] http://ktclearinghouse.ca/knowledgebase at Feb 9, 2017
[22] http://ktclearinghouse.ca/knowledgebase/knowledgetoaction at Feb 9, 2017



In 1999, the Institute of Medication Safety[23] developed the Hierarchy of Intervention Effectiveness. This graphic depicts types of interventions and ranks them in order of effectiveness in creating sustainable practice change. The graphic also illustrates that interventions which are more system-focused rather than people-focused are more effective in creating sustainability. The purpose of this graphic is not to dismiss the value of education and training but that one must consider additional interventions when planning for sustainable change.

KEY ENABLERS

Health Human Resources

As described above, education and capacity building are multi-factorial concepts that may require significant planning and organization, especially when considering sustainability of practice and service model delivery change. Positions exist within the NSM SGS Program Leadership Team to address education and capacity building but need could quickly overwhelm current resources. The SGS Program should look to partnerships with other networks and service providers to align and when possible, amalgamate personnel resources focused on education.

Capacity building should not be an isolated role within our personnel. As the SGS Program Clinical Design is implemented, key importance will be to maximize the scope of SGS Program staff. This means that everyone has some role to play in capacity building whether that be through coaching, providing topic specific education and train the trainer initiatives. Key leaders within the SGS Program should be identified to assist and support staff with knowledge transfer to other health care professionals and care providers.

As the NSM SGS Program implements its clinical service design, recognition of the connection between workforce and organizational development in capacity building must be considered. Implementing multiple new teams simultaneously may stretch health human resources and harm potential sustainability of the project.

[23] http://www.longwoods.com/content/22845 at Feb 9, 2017

Financial Resources

Education and training may at times seem to be cost prohibitive. For this reason the SGS Program has set aside funds to specifically address capacity building. The SGS Program capacity building funds will need to have policies and procedures related to accessing the funds for all LHIN health care professionals. Priority topic specific areas need to be identified and funds need to be equitably distributed among the LHIN sub-geographies and health care sectors. Funds should be used for not only registration to conferences, courses and certifications but also for the organization and planning of locally developed events.

Alternative funding sources should also be used whenever possible. Grants, scholarships and one-time funding should be accessed to supplement current funds.

Technology Resources

Technology is an important enabler as it supports both communication of, and access to, educational activities.

Technology in Communication

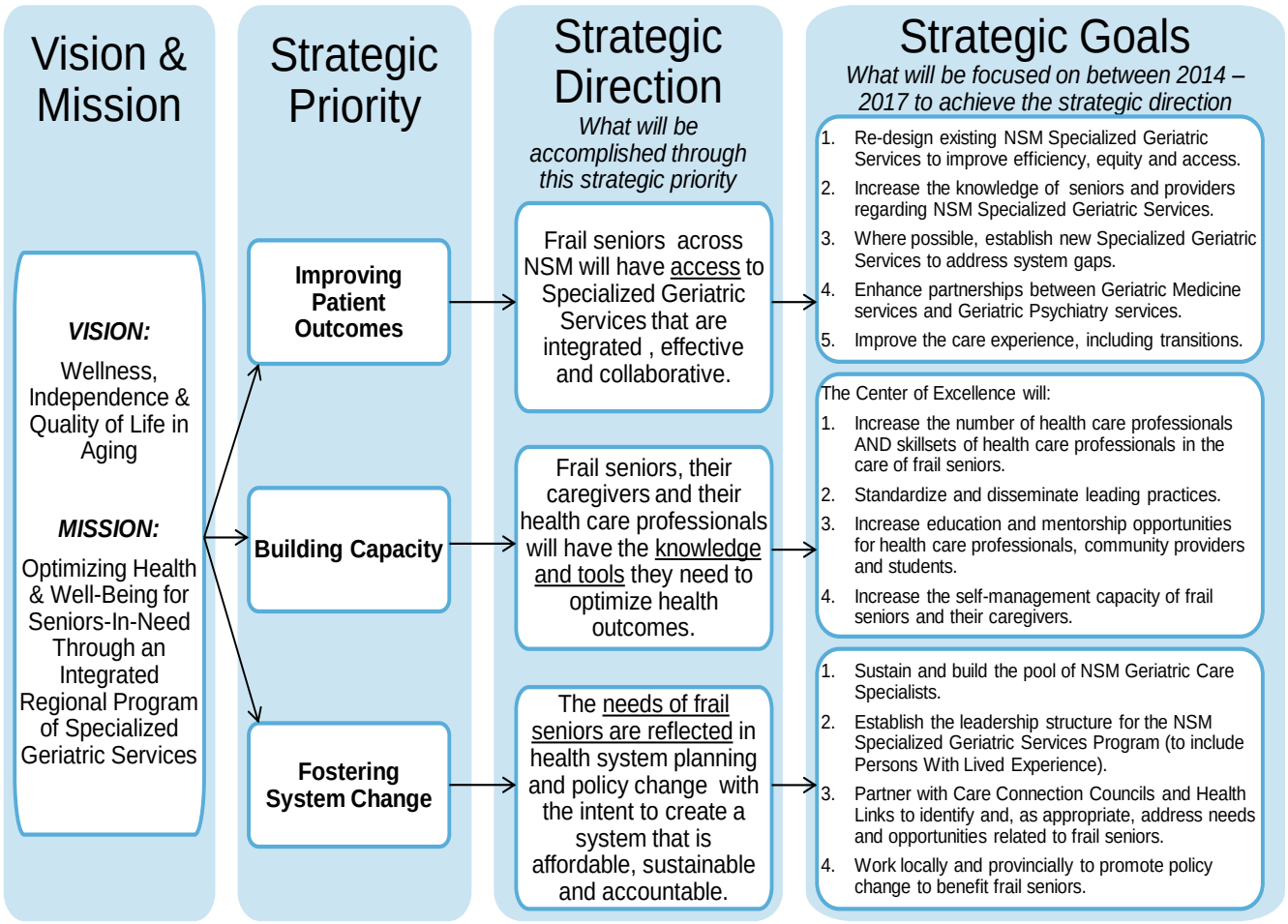
Currently there is no "one" place to source educational events for health care professionals in our LHIN. Communication tools such as websites, intra-nets, and email distribution lists are used by various organizations and networks. As a health care practitioner, one must be aware of where and what to look for when searching for professional development activities. Similar to the clinical service design, the one-stop shopping concept for educational activities will need to be incorporated in future SGS Program technology development (i.e. web-site).

Technology in the Provision of Education

Limited funding to support staff education, conflicting practice priorities and the advent of an IT friendly generation of staff have combined to solidify the importance and development of technology mediums such as OTN, webinars and on-line learning. While these mediums are useful to reaching a geography diverse population there are limitations to the type of information and learning that can be provided. Technology such as on-line registration and post-evaluation surveys will need to be explored for face-to-face workshops and conferences.

Appendix A

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



Appendix B

NSM SGS EDUCATION ACTION PLAN 2017-2018

Strategic Goal	Objectives	Action Item	Target Completion
Increase the number of health care professionals AND skillsets of health care providers in the care of frail seniors. **** Focus: SGS Staff***	Establish core competencies for SGS staff. *Workforce Development*	Establish core competencies for SGS staff.	2017
		Define parameters for Comprehensive Geriatric Assessments (CGA).	2017
		Develop and implement an orientation program for SGS staff.	2017
	Identify, prioritize and address ongoing education needs of SGS staff. *Organizational Development* *Workforce Development* *Resource Allocation*	Develop and implement a staff learning needs assessment tool ** to be completed: on hire; on biennial basis within the program*	2017
		Establish an annual calendar of education events for SGS staff leveraging on-line learning and other technology	2017
		Establish annualized capacity building funds for staff use AND an associated policy/process for fund allocation.	2017
		Establish a monthly journal club for SGS staff	2017
		Provide coaching/mentorship training	2018
	Support the development of enabling approaches to care among SGS providers *Organizational Development* *Workforce Development*	Within SGS Program infrastructure, processes and education, attend to the key concepts of interprofessional collaboration as outlined in the CIHC framework: interprofessional communication, patient/client/family/community-centred care, role clarification, team functioning, collaborative leadership and interprofessional conflict resolution	2019
		Provide change management education to SGS providers.	2017
Increase training, coaching and mentorship opportunities for health care professionals, community providers and students. **** Focus: non-SGS Staff***	Increase awareness of educational opportunities available in the region regarding care of frail seniors. *Workforce Development*	Develop and promote a "shared calendar" of education events related to care of the frail senior.	2017
		Establish an email distribution list of interested health service providers to inform them of SGS program activities and events.	2017
	Provide ongoing education opportunities for health service providers to ensure	Dedicate a section of the NSM SGS webpage to health service providers that would include key resources and links as well as a calendar of events.	2017
		Establish monthly SGS Program rounds via OTN.	2017

Strategic Goal	Objectives	Action Item	Target Completion
	continued delivery of high quality patient focused care. *Workforce Development Resource Allocation*	Establish a BSS Community of Practice and a SGS Community of Practice.	2018
		Incorporate "coach" training in the SGS orientation program.	2018
		Establish and implement a mentoring program and roster of SGS staff mentors for health service providers and students.	2018
		Establish annualized capacity building funds for use by NSM health service providers AND an associated policy/process for fund allocation inclusive of physicians.	2017
		Establish a clinical theme or area of focus annually.	2017
		Establish annual Regional SGS Program Conference and/or Workshops	2018
	Build partnerships with academic programs and centres to support student education and recruitment opportunities. *Partnerships*	Identify and begin to build relationships with key academic programs and centres within and outside the region supporting targeted health care provider training.	2018
Standardize and disseminate leading practices.	Establish basic standards of practice for health care provider agencies. *Workforce Development*	Establish basic core competencies for health care providers in the NSM region regarding the care of frail seniors.	2019
		Establish and promote standardized education programs for use within appropriate health care provider orientation and continuing education programs inclusive of physicians.	2019
		Leverage on-line learning and other technologies to disseminate standardized education programs	2019
	Provide leadership to a regional structure for the continued education and coaching of health care professionals for compassion fatigue developed in the care of frail seniors. *Workforce Development Leadership*	Provide leadership in establishing a Community of Practice for trainers in Compassion Fatigue Community of Practice to: • determine process for health care agencies to access trainers in Compassion Fatigue • establish a process for ongoing train the trainer education as required	2017

Strategic Goal	Objectives	Action Item	Target Completion
	Increase SGS provider capacity in the management of transition best practices *Workforce Development*	Review key literature, develop a plan and provide education to SGS providers regarding transitional care best practices.	2017
Increase the self-management capacity of frail seniors and their caregivers.	Increase SGS provider capacity in self-management best practices *Workforce Development*	Engage the NSM Self-Management Program to provide education to SGS providers regarding self-management best practices.	2019
	Increase awareness of SGS program, area resources and geriatric syndromes among frail seniors and their caregivers. *Leadership Partnerships*	Build a public-friendly NSM SGS website that includes key information regarding the SGS program, area resources and information regarding geriatric syndromes.	2018
		Develop brochures and poster displays regarding the SGS program.	2017
		Participate in local/municipal/MPP senior's days and other partner events as appropriate.	2018