Seniors Health Program Review

North Simcoe Muskoka LHIN Final Report

April 2015

Ontario

Local Health Integration
Network

Réseau local d'intégration
des services de santé

Contents

EXECUTIVE SUMMARY

In 2009, the NSM LHIN articulated a clear *Vision of an Integrated Regional Seniors Health Program* that was grounded in the recognition that Specialized Geriatric Services, provided on a consultative basis by an interdisciplinary team of health professionals in a variety of settings, could help address demographic and fiscal realities by:

- Maintaining functional abilities and allowing continued independence, thereby leading to lower rates of long-term care institutionalization;
- Reducing ED utilization, acute admissions, acute days and ALC days; and
- Improving quality of life and patient outcomes.

There is LHIN-wide recognition of the need to consider opportunities for system redesign including, where appropriate, the reallocation of existing funding.   In light of the 2014 *Strategy for a Specialized Geriatric Services Program* (SGS Strategy), the LHIN sought to ensure that existing resources are being used effectively.

Through a competitive process, a third party was engaged to:

- Define a framework for the Evaluation of Seniors Health Programs;
- Develop and implement a process to conduct program evaluations in the LHIN;
- Conduct an evaluation of 13 programs; and
- Make recommendations for system redesign.

The NSM Seniors Program Evaluations project was initiated in August 2014 and was guided by a Steering Committee comprised of LHIN membership. The project concluded in March 2015.

Thirteen Seniors Programs were selected by the LHIN for evaluation. These programs included:
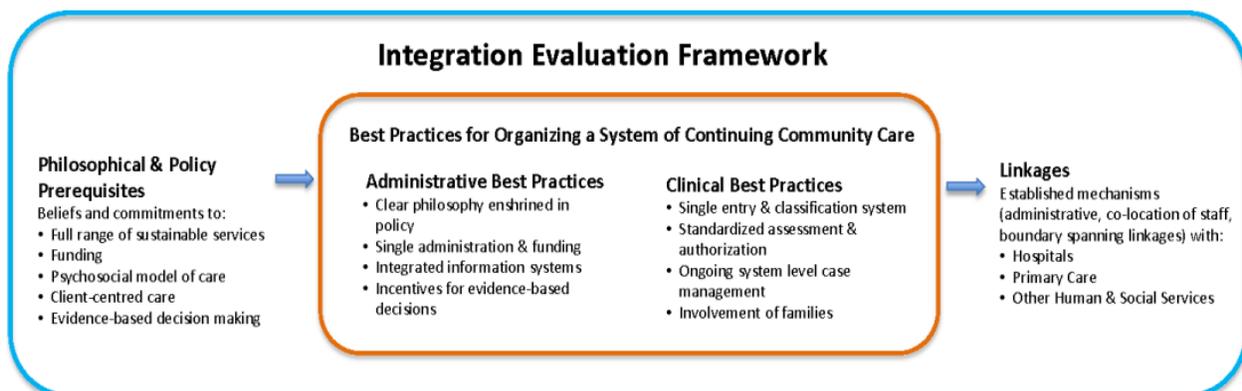
1. Psychogeriatric Resource Consultation (PRC)

2. Behaviour Intervention Response Team (BIRT)

3. Behaviour Support System (BSS) Mobile Support Teams

4. Transitions Service

5. Geriatric Psychiatry Outreach Team (GPOT)

6. Integrated Regional Falls Program (IRFP)

7. Seniors Maintaining Active Roles Together (SMART)

8. Mobile Seating and Mobility Clinics (MSMC)

9. Nurse Practitioner Led Outreach (NLOT) – Orillia

10. Nurse Practitioner Led Outreach (NLOT) – Barrie

11. Seniors Assessment and Support Outreach Team (SASOT)

12. Primary Care Geriatric Outreach

13. Re-ACT Program

A program evaluation framework was used to organize program and health system documents and data provided by the LHIN into a discussion document for each program. These program discussion documents provided a framework for consultation with program management and other stakeholders across the continuum of care.

- The consultants shared key findings with the LHIN and the Steering Committee throughout the process
- Selected key findings were also shared and discussed with senior agency leadership in the region to inform the implementation of recommendations.

A framework[1] for best administrative and clinical practices in the organization of integrated care delivery systems was used to integrate findings and develop recommendations for system redesign.

Integration Evaluation Framework

Philosophical & Policy Prerequisites
Beliefs and commitments to:
- Full range of sustainable services
- Funding
- Psychosocial model of care
- Client-centred care
- Evidence-based decision making

Best Practices for Organizing a System of Continuing Community Care

Administrative Best Practices
- Clear philosophy enshrined in policy
- Single administration & funding
- Integrated information systems
- Incentives for evidence-based decisions

Clinical Best Practices
- Single entry & classification system
- Standardized assessment & authorization
- Ongoing system level case management
- Involvement of families

Linkages
Established mechanisms (administrative, co-location of staff, boundary spanning linkages) with:
- Hospitals
- Primary Care
- Other Human & Social Services

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[1] Hollander and Prince. *Organizing Healthcare Delivery for Persons with Ongoing Care Needs and Their Families: A Best Practice Framework*

Healthcare Quarterly Vol. 11 No. 1 2008.

As per the framework for best practices, the key findings and recommendations are organized around:

- Philosophical and Policy Prerequisites;
- Administrative Best Practices;
- Clinical Best Practices; and
- Linkages.

Key Findings (KF) for System Redesign

Philosophical and Policy Prerequisites

KF1.   Philosophical and policy environment supports an integrated system of care for seniors.

KF2.   The NSM LHIN has clearly articulated its philosophy and vision.

Administrative Best Practices

KF3.   The 13 programs evaluated have many administrators, funders and funding envelopes.

KF4.   Responsibilities and accountabilities are unclear for some paymaster arrangements.

KF5.   Multiple funder and envelope funding systems are bureaucratic and ineffective.

KF6.   BSS multi-agency governance and administration is ineffective and inefficient.

KF7.   BSS does not have a system manager to make needed system improvements.

KF8.   Programs not required to report tend to stop measuring.

KF9.   Some programs do not operate as initially intended or funded.

KF10.   There are no incentives or rewards for evidence-based management or program outcomes.

KF11.   Few programs measure program outcomes in a credible way.

KF12.   The 13 programs reviewed do not share an integrated electronic information system.

Clinical Best Practices

KF13.   The majority of programs reviewed (9 of 13) have isolated intake systems.

KF14.   BSS Central Intake does not effectively match needs with resources in a timely fashion.

KF15.   System level assessment and authorization is a core service of the CCAC.

KF16.   Ongoing system level case management is not available for the 13 programs evaluated.

KF17.   The programs reviewed demonstrated a commitment to engaging and supporting clients and their families.

Recommendations (R) for System Redesign

Administrative Best Practices

R1. The NSM LHIN to identify a Lead Agency for an Integrated Regional Seniors Health Program (IRSHP).

R2. The NSM LHIN to provide the IRSHP with a single envelope of funding.

R3. The NSM LHIN to identify a senior leader to manage the implementation of the recommendations of this report.

R4. IRSHP, CCAC, Hospitals and all IRSHP funded community organizations to be participants in the development of a Regional Decision Support to support IRSHP program evaluation and the development and implementation of incentives to reward program performance.

R5. The NSM LHIN, IRSHP and CCAC establish an Integrated Electronic Health Information System, integrated with the Community Health Resource Information System (CHRIS).

Clinical Best Practices

R6. IRSHP to be provided with the mandate to establish a central intake process for Specialized Geriatric Services that is inclusive of Behavioural Support System programs.

R7. IRSHP to establish admission criteria for all IRSHP regional programs in consultation with program managers, clinicians and program customers.

R8. IRSHP and CCAC partner to ensure the IRSHP benefits from CCAC system level assessment and care authorization infrastructure.

R9. IRSHP consider system level client classification with interRAI.

R10. IRSHP and CCAC to partner to ensure optimal case management for IRSHP clients.

Linkages

R11. IRSHP develop and implement a strategy for linking IRSHP with other health, social and human services.

Integrated Recommendations from the Individual Program Evaluations

Recommendations related to strategically aligned programs were guided by the vision and goals expressed in key LHIN policy documents, including:

- The Vision for an Integrated Specialized Seniors Health Program (2009);
- The Strategy for a Specialized Geriatric Services Program in North Simcoe Muskoka (2014);
- The original BSS Action Plan goals of developing an integrated behavioural support system that provides person-centred, timely, equitable access, high quality, evidence based services in an efficient, effective and sustainable manner; and
- The falls prevention strategy goal to reduce the incidence of falls, risk and falls related injuries among seniors.

The following are recommended to support the strategic alignment of programs and services:

1. It is recommended that the resources and responsibilities for 11 of the 13 programs[2] evaluated be integrated within the mandate of the IRSHP.
2. *An Integrated Capacity Building Program* that provides capacity building services to caregivers in LTC homes and is inclusive of all psychogeriatric and geriatric capacity building and educational services currently provided by PRCs, NLOT Nurse Practitioners, and Nurses/PSWs in the MSTs.
3. *An Integrated Behavioural Support Team* that is seamless and delivered by a single interdisciplinary team whose members:
   - Share standard assessment tools and an integrated information system;
   - Are within the same circle of care; and
   - Are able to seamlessly support and, where necessary, follow clients across the continuum of care.
4. *A better integrated and more comprehensive set of falls strategy programs* that seek to:
   - Minimize duplication of services and, in particular, assessments and home visits;
   - Develop a single central intake function that is efficient and effective and linked to an EHR that is accessible to IRFP, MSMC and SMART program staff for all clients;
   - Broaden the composition of the multidisciplinary team and integrate the patient's primary care and other care providers into the care plan to increase the clinical value of recommendations;
   - Ensure timely access to specialized services in each region of the LHIN;
   - Ensure that the most frail, and in particular those that are home-bound, are not lost in overall service targets, but are prioritized when resources are constrained;
   - Maximize the use of effective technologies to enhance communication and streamline the delivery of care in outreach settings; and

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[2] Exclusions: Re-ACT; Primary Care Geriatric Outreach

- Measure integrated performance and report on access, quality, efficiency and the outcomes of service delivery in each region.

5. *Exploration of the opportunity to replicate the success of SASOT across the LHIN* in local hubs of specialized geriatric services delivered by an expanded multi-disciplinary team.

VISION AND STRATEGY FOR AN INTEGRATED REGIONAL SENIORS HEALTH PROGRAM IN NORTH SIMCOE MUSKOKA

In 2009, the NSM LHIN articulated a clear Vision of an Integrated Regional Seniors Health Program that was grounded in the recognition that Specialized Geriatric Services (SGS) provided on a consultative basis by an interdisciplinary team of health professionals in a variety of settings, could help address demographic and fiscal realities by:

- Maintaining functional abilities and allowing continued independence, thereby leading to lower rates of long-term care institutionalization
- Reducing ED utilization, acute admissions, acute days and ALC days
- Improving quality of life and patient outcomes

In 2013, the NSM LHlN Board of Directors approved a plan to develop an Integrated Regional Seniors Health Program (IRSHP). Using the NSM LHIN's 2009 *Vision for an Integrated Regional Seniors Health Program* as a starting point, a Seniors Strategy Task Group developed and published a *Strategy for a Specialized Geriatric Services (SGS) Program in North Simcoe Muskoka (May 2014)*.

The SGS Strategy focuses on the target population of frail seniors as the first building block of the NSM Integrated Regional Seniors Health Program.

The Task Group characterized Specialized Geriatric Services as:

- A comprehensive, coordinated system of hospital and community-based health and mental health services that diagnose, treat and rehabilitate frail seniors
- Interdisciplinary teams with expertise in the care of the elderly and provided across the continuum of care
- Inclusive of both Geriatric Medicine services and Geriatric Psychiatry services
- Either locally delivered (secondary) or centrally de livered (tertiary)
- Locally delivered Specialized Geriatric Services (Secondary Level) responsible for managing the majority of cases close to home l inked with centrally delivered SGS teams
- Centrally delivered Specialized Geriatric Services (Tertiary Level) responsible for high acuity, high complexity cases that cannot be managed close to home.

PROGRAM REVIEW

Seniors services in NSM have evolved in a variety of ways:

➢ *By design* - through the development of strategic plans for the LHIN that describes how multiple programs and organizations will operate as part of an integrated system of care;
➢ *Independently* - through the efforts of passionate leaders;
➢ *Reactively* - to compensate for historical issues with access to specific services; and
➢ *Incrementally* - through the addition of incremental funding to "build on existing resources".

There is LHIN-wide recognition of the need to consider opportunities for system redesign including, where appropriate, the reallocation of existing funding. In light of the 2014 *Strategy for a Specialized Geriatric Services System (SGS Strategy)*, the LHlN sought to ensure that existing resources are being used effectively.

Through a competitive process, a third party was engaged to:

➢ Define a framework for the evaluation of seniors health programs;
➢ Develop and implement a process to conduct program evaluations in the LHIN;
➢ Conduct an evaluation of 13 programs; and
➢ Make recommendations for system redesign.

In total, thirteen seniors programs were selected by the NSM LHIN for evaluation.

Five core programs of the NSM LHIN *Behavioural Support System Action Plan (2011*) were selected for evaluation. These programs provide a range of specialized secondary and tertiary behavioural and mental health services to clients and their caregivers across the continuum of care, and in the transitions of clients between settings in this continuum. All of the programs have a regional mandate and provide service across the LHIN. These core programs included:

- Psychogeriatric Resource Consultants (PRCs) -Operated by Collingwood General and Marine Hospital (CGMH) providing capacity building and education primarily to LTCHs, but also caregivers in the community.
- Transitions Service (WTS) - A specialized service provided by Wendat Community Programs supporting the transitions of clients with behavioural needs from acute care to long-term care homes. Recently, WTS began expanding to support the transitions of clients across the continuum of care.
- Mobile Support Teams (MST) - A mobile support service, funded through Waypoint Centre for Mental Health Care (Waypoint) and the County of Simcoe, and delivered by Georgian Manor, Care Partners, and Alzheimer's Society of Simcoe, that provides behavioural support to long-term care homes and to caregivers in the community.
- Behavioural Intervention Response Team (BIRT) - A mobile support service operated by Waypoint that provides behavioural support to long-term care homes.

- Geriatric Psychiatry Outreach Team (GPOT)- A geriatric psychiatry outreach service operated by Waypoint that provides consultative support to physicians across the continuum of care.

Three seniors programs selected for evaluation were regional programs that advance the NSM Falls Strategy:

- Integrated Regional Falls Program (IRFP) - led by Orillia Soldiers' Memorial Hospital (OSMH), delivered at OSMH and Royal Victoria Regional Health Centre that provides geriatric assessment, home assessments and service coordination.
- Seniors Maintaining Active Roles Together (SMART) program operated by the Victorian Order of Nurses (VON) that provides both congregate exercise programs for seniors as well as in- home exercise programming for homebound seniors.
- Mobile Seating and Mobility Clinic (MSMC) operated by Bayshore Healthcare and funded through the County of Simcoe that provides Mobility Assessments in a clinic setting.

Two similar programs providing Nurse Practitioner Outreach (NLOT) to long-term care homes were included in the program review. These teams serve the Barrie and Orillia regions, with one operating out of the Royal Victoria Regional Health Centre and the other from the Orillia Soldiers' Memorial Hospital.

The remaining three programs selected for review each provide innovative and unique approaches to care in NSM, offering insight into system re-design opportunities:

- Seniors Outreach and Assessment (SASOT) - led by Muskoka Algonquin Healthcare (MAHC) and based out of the Bracebridge site, this program provides specialized interdisciplinary support to seniors in the local hospital community.
- Primary Care Geriatric Outreach (PCGO) –led by Barrie Community Health Centre (BCHC) and a care of the elderly physician that provides services to a roster of seniors in the North Innisfil region.
- Re-ACT -led by We Care and funded through the NSM CCAC, this LHIN-wide program provides remote monitoring of vital signs for seniors with specific conditions.

These thirteen programs represented a diverse range of specialized seniors programs that include:

- Programs funded through LHIN base funding, LHIN project funding and global budgets
- Programs delivered by hospitals, the community support sector, the NSM CCAC and a long-term care home agency
- Programs that work within individual sectors and some that span sectors
- Programs that share a central intake process and programs that are accessed directly
- Programs that provide service to local LHIN communities and those that have a LHIN-wide mandate
- Programs that require a physician referral and those that do not
- Programs that provide consultative support, short-term support and intervention or support

over a long period of time
- Programs that provide services across the continuum of care and in the transitions between settings within the continuum
- Programs that are focused on behavioural and mental health services and programs that provide geriatric medicine services.

The program review process initiated in August 2014 and was guided by a LHIN-staffed Steering Committee. In September, the Steering Committee received and approved the program evaluation frameworks.

- The program and health system evaluation frameworks were used to organize program and health system documents and data provided by the LHIN into a discussion document for each program that included specific questions and requests for additional data.
- These program discussion documents provided a framework for consultation with program management and other stakeholders across the continuum of care from September 2014 to February 2015.
- The consultation conducted by the consultants, involved senior administrators, physicians, clinical staff, support workers, and other stakeholders. To support evaluation, the consultant included one or more expert clinical advisors in the consultation process. These expert advisors represented:
  - o A geriatrician and the Executive Director of a large regional geriatric program
  - o A geriatric nurse practitioner with expertise in geriatric outreach
  - o A psychologist with expertise in psychogeriatric resource consultation and nursing outreach with knowledge to practice responsibilities for a large regional geriatric program.

The consultants were further supported by two senior advisors each with broad executive level experience within organizations across the continuum of care and with Ministry of Health and Long-Term Care policy. These individuals supported the team in the review of findings and in the development and framing of recommendations for system redesign.

The consultants shared key findings with the NSM LHIN and the Steering Committee throughout the process. Selected key findings were also shared and discussed with senior agency leadership in the region to inform the implementation of recommendations for system redesign.

FRAMEWORKS FOR INTEGRATED PROGRAM EVALUATION

The frameworks approved by the Steering Committee included:

1. A program evaluation framework that was used to provide consistency in the organization of quantitative and qualitative information collected for each program.
2. A health system evaluation framework used to assess opportunities for system redesign by

contrasting the collective analysis of the seniors programs with best practices for the organization of integrated health systems.
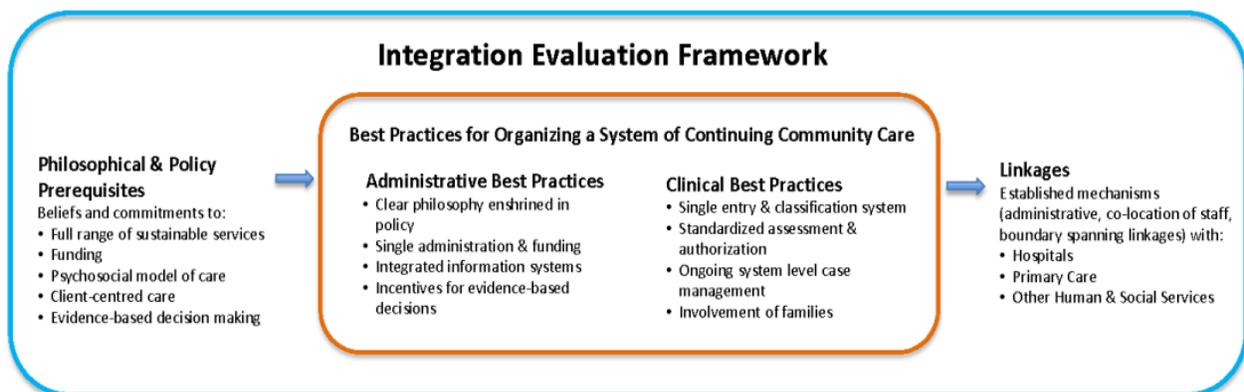
Program Evaluation Framework

The program evaluation framework was based on the University of Wisconsin iteration of the traditional program logic model and included:

- Context - What is the historical context for the program and what are the program goals?
- Program logic and assumptions- How does the program achieve its goals?
- Program inputs- What resources and other assets are invested in the program?
- Outputs- What services are rendered to program participants and those targeted by the program and what is their engagement experience?
- Outcomes- What results have been achieved?
- External Factors - Are there factors beyond program control that influence program success?

Health System Evaluation Framework

To support the analysis of the overall system of seniors programs, a framework for administrative and clinical practices in the organization of integrated delivery systems[3] was used to analyze findings and develop recommendations for system re-design based on:

- Philosophical and policy pre-requisites
- Administrative best practices
- Clinical best practices and,
- Linkages

Integration Evaluation Framework

Philosophical & Policy Prerequisites
Beliefs and commitments to:
- Full range of sustainable services
- Funding
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- Evidence-based decision making

Best Practices for Organizing a System of Continuing Community Care

Administrative Best Practices
- Clear philosophy enshrined in policy
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Clinical Best Practices
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- Involvement of families

Linkages
Established mechanisms (administrative, co-location of staff, boundary spanning linkages) with:
- Hospitals
- Primary Care
- Other Human & Social Services

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[3] Hollander and Prince. (2008). *Organizing Healthcare Delivery for Persons with Ongoing Care Needs and Their Families: A Best Practice Framework.* Healthcare Quarterly Vol. I I   No. I.

THE POLICY ENVIRONMENT

Key Finding 1: Philosophical and policy environment supports an integrated system of care for seniors

The philosophical and policy environment is very supportive of the creation of an integrated system of care for seniors in North Simcoe Muskoka.

- Within the NSM LHIN there is clear commitment to:
  - The benefits of an integrated system of care for seniors
  - Client-centered services delivery models that provide seamless care across the continuum
  - Non-medical services
  - Supports and enablement of clients and their families that allow people to function as much as possible and for as long as possible in their own environments.

The argument for the integration of seniors' services remains as compelling today as it was in 2009 when the LHIN published a *Vision for a Regional Seniors Health Program*. Consultations with stakeholders across the continuum of care verify that benefits of integration are well understood by North Simcoe Muskoka agency administrators, physicians, clinical program leaders and front line staff across the continuum of care.

SYSTEM LEVEL ADMINISTRATIVE BEST PRACTICES AND RECOMMENDATIONS FOR SYSTEM REDESIGN

Administrative best practices for organizing integrated systems of care for people with ongoing care needs include a(n):

- Clear statement of philosophy enshrined in policy;
- Single administration and single funding envelope;
- Rewards and incentives; and
- Integrated electronic information systems.

Recommendations for administrative system redesign are intended to address identified gaps between these best practices and the current state. Specific examples from the program evaluations are provided, where appropriate, to illustrate gaps and/or strengths.

Clear Statement of Philosophy Enshrined in Policy

As is considered a best administrative practice, the NSM LHIN has clearly articulated its philosophy and vision in the following key documents:

- The 2009 NSM Vision for an Integrated Regional Geriatric Program
- The 2009 NSM Integrated Regional Falls Program Document
- The 20II NSM Behavioural Support System Action Plan
- The 2014 NSM Strategy for a Specialized Geriatric Services Program.

Key Finding 2: The LHIN has clearly articulated its philosophy and vision

Single Administration and Funding Envelope

A single administrative structure with a single envelope of funding is considered a best practice for organizing an integrated system of care for frail seniors.

- *Single administration systems* are more efficient, mitigate the negative impact of silos for different components of care, and provide clearer accountability for program and system results. By contrast, multiple administration systems are less efficient and result in silos for different components of care and a diffusion of responsibility making system accountabilities unclear.
- *Single funding envelopes* are critical to maximizing efficiency, effectiveness and quality of care provided allowing for resource transfers between system components.

Key Finding 3: The 13 Programs evaluated have many administrators, funders and funding envelopes

In total, $8.04M in funding supports the 13 seniors health programs evaluated. The programs have many administrators, funders and envelopes of funding: there are 15 funded organizations, 5 funding sources, and 31 distinct envelopes of funding. A number of these funding envelopes are for single Full Time Equivalents (FTEs) or are for small amounts of money.

Key Finding 4: Responsibilities and accountabilities are unclear for some paymaster arrangements

There are situations in which it is effective to have one agency distribute funds to other organizations that are partners in the delivery of an integrated program. For example, Orillia Soldiers' Memorial Hospital (OSMH) is the paymaster for Integrated Regional Falls Program (IRFP) staff in hospitals across the LHIN. Because roles are clear and Memorandums of Understanding (MOUs) are current and consistent, the OSMH-based program administrator can provide adequate administrative oversight and be held accountable for program performance.

It is less effective to have paymaster arrangements set up for administrative convenience. In particular, it makes less sense to have a paymaster agency distribute small amounts of funding to organizations for programs and services in which the paymaster is not a delivery partner. For example, NSM CCAC provides funding to We Care for the Re-ACT program and the County of Simcoe funds the Mobile Seating and Mobility Clinic (MSMC) through Bayshore Health. In both cases there was a lack of clarity between the funding organization and the funded agencies regarding who was responsible for funding monitoring and performance accountability. It was clear that neither the LHIN nor the finding agency was regularly and actively involved in monitoring performance.

Key Finding 5: Multiple funder and envelope funding systems are bureaucratic and ineffective

The use of many funders and funding envelopes is less efficient and effective than a single envelope-funding model. The current state with multiple funding envelopes across sectors and organizations is complicated and leads to bureaucratic outcomes. Within the Behavioural Support System (BSS) program in 2013-2014, the County of Simcoe (Mobile Support Teams in long-term care) experienced a large surplus due to vacancies. In the same period, the Alzheimer's Society of Simcoe County (Mobile Support Teams in community) experienced a deficit that had to be covered by community fundraising efforts.

Multiple funding envelopes risk inequitable distribution of funds. The OSMH NLOT was funded S250K for 3FTEs of Nursing and Nurse Practitioners under Ontario's Emergency Room (ER) and Alternate Level of Care Strategy. The funding was limited to salaries and benefits only with no additional funding provided to support operations. The RVH NLOT was funded S329K for 2FTE Nurse Practitioners through the Aging at Home Strategy. OSMH is required to subsidize all operating costs associated with the program while RVH has had, and maintains, a surplus of funds that have and will be recovered.

Key Finding 6: BSS multi-agency governance and administration is ineffective and inefficient

The *NSM BSS Action Plan* envisioned involving all the major stakeholders within the system in the formalization of activities across sectors and organizations creating:

- An integrated network of autonomous services held accountable under one governing mechanism
- Service and funding agreements for provider members that clearly articulate accountabilities and service delivery requirements for their organization.

The *NSM BSS Sustainability Plan* included the following structure, reporting to the Project Steering Committee:

- BSS Governance Committee chaired by Waypoint Centre for Mental Health Care, with representation from each NSM health service provider host supporting BSS-related FTE positions for community and long term care (Mobile Support Teams).
- BSS Operations Committee chaired by the BSS System Coordinator.

- BSS Quality Improvement Sub-Committee chaired by Trillium Manor Long-Term Care Home on behalf of the County of Simcoe.

The current BSS governance and accountability mechanisms fall short of the vision articulated in the BSS Action and Sustainability Plans. The BSS Governance Committee is:

- Operating with outdated terms of reference that describe the committee accountable to a now disbanded BSS Project Steering Committee;
- Comprised of membership from organizations funded through BSO with no representation from other elements of the BSS such as BIRT or GPOT; and
- Focused exclusively on the Behavioural Supports Ontario (BSO)-funded elements of the BSS, and in particular, the Mobile Support Teams and the matters of funding and service agreements.

As a key example of multi-agency governance in the NSM LHIN, the BSS provides insight into opportunities for system design. Stakeholders involved in the administration and delivery of BSO-funded services are able to articulate the challenges of a multi-administration and multi-funding envelope system of care.

- The administration of the BSS Mobile Support Teams (MST) and BSO funding is cumbersome since MST funding is allocated to three distinct organizations separately for labour and non-labour (mobilization) expenses so that there are six funding agreements for this one "integrated team". In some cases, the funding agreements administered by Waypoint are for 1 FTE or less. For example:
  - o Waypoint provides BSO funding for 1 FTE for the Psychogeriatric Resource Consultants at Collingwood General and Marine Hospital; and
  - o Waypoint provides BSO funding for 1 FTE for the Transition Services at Wendat.
- The process for developing funding and service Memorandums of Understanding (MOU)was described by representatives of three different organizations as a:
  - o "Monumental task" requiring significant administrative time, effort and legal expenses to get consistent language acceptable to the legal councils of all of the organizations.
  - o A "nightmare" requiring "nine months the first time and seven months the next and we are still not finished".
  - o A "lot of work" for the administrator and board volunteers of an agency that cannot afford legal counsel for each and every revision.

As a result of the time taken to develop a MOU, the current agreement now in place is outdated. As a result, organizations are operating the Mobile Support Teams without a current MOU. At present the MOU is pending legal counsel, with some partners unclear of the changes being proposed.

In July 2014, as the evaluation of 13 programs was about to begin, Terms of Reference for a Behavioural Support System Advisory Committee were approved "in principle." The purpose of the Committee is to provide guidance by "promoting dialogue and collaboration to improve the system-wide care for the BSS

target population". In terms of accountability:

- The members will be accountable to their agency or governing body
- The Committee will forward recommendations to the North Simcoe Muskoka *Care Connections* In Home & Community Capacity Coordinating Council.

It is unlikely that critical improvements to the Behavioural Support System and appropriate oversight will be achieved through dialogue and collaboration alone. Given the current diffusion of responsibility across many "autonomous services" it is impossible to effectively manage the BSS without a single administrative structure that includes a dedicated program executive.

Key Finding 7: BSS does not have a system manager to make needed system improvements

Different leadership models exist across programs with varying degrees of success.

Within BSS it was envisioned that a System Coordinator would assume the administrative leadership role for coordinating and integrating BSS services. However, the current role has been primarily focused on the Mobile Support Teams without the mandate, authority or resources to manage a large multi-sector, multi-agency system. No BSS staff directly report to the System Coordinator. Mobile Support Team staff who deliver care to complex clients receive no supervision or performance evaluation and express feelings of "isolation" from the system.

In another example, all Integrated Regional Falls Program (IRFP) staff report to the IRFP Program Manager. The Program Manager has the mandate, authority and resources to support all IRFP work with responsibilities including IRFP policy development, financial oversight and performance monitoring. The IRFP Program Manager reports to the Orillia Soldiers' Memorial Hospital Vice-President who acts as the Chair of the IRFP Steering Committee comprised of key stakeholders from across North Simcoe Muskoka.

Key Finding 8: Programs not required to report tend to stop measuring

Programs that were initially funded through Aging at Home and had developed balance performance measurement frameworks often, but not always, stopped collecting routine management information (client and staff activity, cost, outcomes) once the LHIN stopped asking for such.

Key Finding 9: Some programs do not operate as initially intended or funded

It is further noted that a number of programs do not operate as they were initially intended when funding was approved.

Recommendation 1: The NSM LHIN to identify a Lead Agency for an Integrated Regional Seniors Health Program

It is recommended that the LHIN identify a lead agency for an integrated Regional Seniors Health Program (IRSHP) that is focused on the needs of a defined target population of seniors. Accountable to the LHlN, the IRSHP will be responsible for:

- Management oversight for a comprehensive range of defined specialized geriatric services
- The delivery of specialized geriatric services that are based upon best clinical practices for the care of the elderly
- The funding of specialized geriatric services that are provided by organizations, selected by IRSHP, that:
    - Are effective and efficient
    - Have formal service, funding and accountability agreements with the IRSHP.
- Funded organizations will be required to:
    - Report financial and statistical administrative data that is compliant with the minimum reporting standards in the Ontario Healthcare Reporting Standards
    - Report clinical quality and outcome data as determined by the IRSHP
    - Share an integrated electronic health record with all IRSHP organizations and be included in the singular circle of care of IRSHP clients.
- The comprehensive range of specialized geriatric services will :
    - Integrate Geriatric Psychiatry and Geriatric Medicine
    - Be delivered by multi-disciplinary teams that include physicians, nurses, allied health and personal support workers with specialized geriatric knowledge
    - Be delivered across the continuum of care
    - Include services that are delivered centrally and those that are delivered across the LHIN

Recommendation 2: The NSM LHIN to provide the IRSHP with a single envelope of funding

The single envelope of funding should be derived, as necessary, by reallocating existing funding for specialized seniors services that fall within the Integrated Regional Seniors Health Program (IRSHP) mandate provided by LHIN.

Recommendation 3: The NSM LHIN to identify a senior leader to manage the implementation of the recommendations of this report

The transformation work that needs to be done should be protected and not "put on the shelf ' if and when other priorities appear more acute. Therefore, the position should:

- Report directly to the CEO
- Be strictly dedicated to developing an implementation plan and managing the 2-3 year implementation of the recommendations of this report.

Rewards and Incentives

Administrative best practices for an integrated system of care include providing incentives and rewards for evidence-based management.

The 13 programs reviewed are funded in a variety of ways including base funding and special program funding for labour and or other expenditures.   Funding for these programs is typically based on the inputs (FTEs) and in some cases there are targets set for program outputs (Unit-of-Service, Clients Served).

Key Finding 10: There are no incentives or rewards for evidence-based management or program outcomes

The SMART Program illustrates how funding targets can clearly influence behavior. The program provides:

- Exercise programming in the homes of homebound frail elderly
- Exercise programming in congregate settings for higher functioning seniors
- Fall prevention classes

Recently the program received substantial new funding and associated targets. The new targets for "clients" and "units of service" are combined across the three services listed above. Since congregate settings result in more clients and units of service, focus has been on these activities. Not by design or policy, but through unintended consequence, the incentive has resulted in a reduction of service and an increase in wait times for frail homebound elderly. Currently:

- There are 232 seniors waiting for in-home SMART program service
- The average wait time for in-home exercise classes is 7 months

A funding model that sets separate targets for homebound seniors and congregate exercise classes would remove the current disincentive to dedicate limited volunteer resources to the home-visit program. With separate targets there would no longer be an incentive to focus on congregate classes

that generate more clients and units-of-service, but there would still be no incentive or rewards for effective service. Best administrative practices include providing incentives to reward performance.

For example, the SMART program might be rewarded for in-home client outcomes including:

- Improvements in clinical outcomes such as Timed Up and Go (TUG) and/or
- Homebound clients graduating to the congregate exercise class program.

Rewarding the achievement of program goals requires developing valid and reliable indicators of performance. The majority of the programs evaluated include an explicit goal of reducing ED visits and inpatient admissions, very few programs track their performance relative to these goals with credible data.

Key Finding 11: Few programs measure program outcomes in a credible way

Some programs measure outcomes in a credible way and some attempt to measure clinical outcomes. Examples include:

- Seniors Outreach and Assessment Team (SASOT) measures Emergency Department (ED) visit and admission rates through linkage of program client information with hospital inpatient and ED administrative records
- Orillia Soldiers' Memorial Hospital Nurse Led Outreach Team (OSMH NLOT) measures the rate of avoidable ED visits and hospital admissions through ED for their Orillia long-term care home clients using data from Canadian Institute of Health Information (CIHI), which in turn is derived from inpatient and ED administrative records of the hospital
- Mobile Support Teams (MSTs) measure satisfaction with ability to manage in long-term care and community, and for a restricted sample of long-term care homes, the percentage of residents with behaviours affecting others and the percentage of residents whose behaviour symptoms worsened.

In other areas, data challenges were identified. For example:

- Integrated Regional Falls Program (IRFP) does not track ED visit or inpatient admission rates for clients. The LHIN has directed IRFP to collect self-reported hospital utilization data from clients (frail elderly) 90 days after the provision of a single home visit. The value and credibility of self-reported health service utilization collected in this manner for this client population is uncertain.
- Royal Victoria Regional Health Centre (RVH) NLOT program does not currently evaluate outcomes using available hospital administrative data for inpatient admissions and ED visits. As a measure of whether they have averted an ED visit, the Royal Victoria Regional Health Centre (RVH) NLOT program works under the assumption that a nurse practitioner visit equates with an avoided emergency visit. This is a difficult outcome measure to track and the underlying assumption may not be the most appropriate.

Recommendation 4: IRSHP, CCAC, Hospitals and IRSHP funded health service community organizations to be participants in the development of a Regional Decision Support System to support IRSHP program evaluation and the development and implementation of incentives to reward program performance

The need to link clinical information over time, across organizations and across sectors to support program evaluation and planning has already been identified and some progress has been made. On behalf of the In-Home and Community Capacity Coordinating Council the NSM CCAC has created an integrated data store using de-identified data from participating health service providers. The next phase of this project, the development of a Regional Home and Community Care Decision Support System, is expected to add additional community health services to the integrated data store to create a broader understanding of the patient's journey across the continuum of care. The CCAC has conducted a conceptual privacy impact assessment to:

- Identify privacy risks in such a system
- Set forth recommendations to address those risks.

To leverage existing roles, core competencies, and the investments that have already been made, it is clear that the IRSHP and IRSHP funded organizations should be participants in the evolution and use of this potentially valuable NSM LHIN resource.

Integrated Electronic Information Systems

Integrated electronic information systems are an essential component of an integrated system of care. They enable seamless client-centred care across multiple services and eliminate duplication and waste. Integrated information systems are best practice because they:

- Eliminate the need for:
  - o Each service to conduct similar assessments of clients
  - o Families to tell their stories repeatedly
  - o Programs to collect client reported health utilization data to gauge success.

- Enable sophisticated administrative and clinical research and analysis to support:
  - o Quality improvement initiatives
  - o Clinical reviews of the efficiency of current practices
  - o Regular reporting about the nature and scope of services provided in a geographic area

Key Finding 12: The 13 programs reviewed do not share an integrated electronic information system

The 13 programs reviewed do not share an integrated electronic information system. In many cases the programs do not have an electronic information system at all and rely on traditional paper records and filing systems.

There are a few important examples that offer insight into opportunities:

- The *Behavioural Support System (BSS) Action Plan* included implementation of a "central computerized Client Registry with an integrated client health record containing client and family history, diagnosis, existing services and supports (formal and informal), prior assessments, and current treatment status re complex healthcare and behavioural needs".   The BSS vision has not yet been realized as providers across organizations have been hampered by issues related to interpretation of privacy, circle of care and consent. As a result, each referral to BSS "starts from scratch" as BSS programs are not yet able to seamlessly share access to client information requiring additional work and noted frustration by referring providers such as physicians and long-term care homes.
- As a single program, with a single lead organization, electronic records are accessible within the Integrated Regional Falls Program (IRFP) from IRFP laptops regardless of geographic location. The staff takes their computers with them to clinics, education sessions, home visits etc.so they can do the documentation in as close to real time as possible. The electronic record:
  - Contains all documentation and information collected on a client
  - Is accessible to all staff allowing for real time communication etc.
  - Collects workload for MIS reporting through the Ontario Hospital Reporting System
  - Enables reporting statistical information from the program - number of visits, age of clients etc.

More importantly, the 13 programs do not have seamless access to information contained in the CCAC Client Health Related Information System (CHRIS). CHRIS is a web-based client management system with four key components:

- Case management
- Service provisioning
- Reporting
- Financial management.

Client Health Related Information System (CHRIS) was designed to combine resource planning and client management, alleviating the previous challenge of multiple data entries, the need to fax important client information, and multiple referrals.

CHRIS includes:

- Direct link to assessments, where CHRIS and the RAI-HC function as one seamless application, allowing automated entry of information and availability of a quick summary of results
- Automated file transfer for providers and organizations, allowing important information to flow between case managers, organizations, and providers
- Geographic coding and mapping for referrals to case managers and providers
- Seamless integration within the CCAC's Document Management System, setting the foundation for better automation of document workflow, within and outside of CCACs

The CHRIS system is an integrated electronic health record, but it is not integrated with or accessible to staff in the programs reviewed. Such integration or access would be beneficial since the CCAC is the largest referral source for some of these programs. An inability to access key CCAC information is a source of frustration for clinicians and leads to inefficiencies and duplication of effort.

"Having access to CHRIS would be a tremendous asset to our program (IRFP). Knowing exactly the services a client receives etc. would be incredibly beneficial. Currently the staff is required to call into the CCAC and try and locate this information."

Recommendation 5: The LHIN, IRSHP and CCAC establish an Integrated Electronic Health Information System for IRSHP that is integrated with Community Health Resource Information System (CHRIS)

The NSM CCAC has already begun the process of building a system that can, in the future, be used for regional decision support including patient referrals and collaborative care planning.

SYSTEM LEVEL CLINICAL BEST PRACTICES AND RECOMMENDATIONS FOR SYSTEM REDESIGN

Clinical best practices for organizing integrated systems of care include:

- Single or coordinated entry systems;
- Standardized system level assessment and care authorization;
- System level client classification;
- Ongoing system level case management; and
- Involvement of clients and families.

Recommendations for clinical system redesign are intended to address identified gaps between these best practices and the current state. Specific examples from the program evaluations are provided, where appropriate, to illustrate gaps and/or strengths.

Single or Coordinated Entry Systems

A single-entry system is optimal for an integrated system of care since it:

- Provides for a consistent screening mechanism that ensures that those with appropriate needs are provided services;
- Provides a focal point in local communities; and
- Is user-friendlier as individuals do not have to speak with multiple sources to find out what services are available and how they are obtained.

Where single-entry systems are not possible, a coordinated entry system is preferred, where a limited set of care providers is authorized to conduct standardized assessments and go through the appropriate procedures to register a new or recurring client into the system of care.

Key Finding 13: The majority of programs reviewed (9 of 13) have isolated intake systems

Key Finding 14: BSS Central Intake does not effectively match needs with resources in a timely fashion

The BSS represents the only multi-program single entry system among the 13 programs reviewed. BSS, with the exception of Wendat Transitions Service (WTS), utilizes Waypoint Centre for Mental Health Care's Central Intake Office for single entry to:

- Mobile Support Teams (MSTs);
- Behaviour Intervention Response Team (BIRT); and
- Geriatric Psychiatry Outreach Team (GPOT).

The office also provides intake for all of Waypoint's programs, and has developed criteria for program admission in collaboration with the programs.

Within the current system, issues were identified regarding the ability of Central Intake to match needs with resources. At this time services are utilized in a sequential manner. Some services must be employed without success (MST) before others (GPOT, BIRT) are considered for involvement.

In an attempt to create an efficient use of resources, this process has inadvertently led to delays in access to geriatric psychiatry and in inappropriate referrals as teams are faced with cases where the clients' needs exceed a team's scope of practice. Both unintended results increase risk for clients, caregivers, organizations and, in some cases, other residents of a LTC home.

Recommendation 6: IRSHP to be provided with the mandate to establish a central intake process for Specialized Geriatric Services that is inclusive of Behavioural Support System programs

Recommendation 7: IRSHP to establish admission criteria for all IRSHP regional programs in consultation with program managers, clinicians and program customers

Standardized System Level Assessment and Care Authorization

Clinical best practices for an integrated system of care include coordinated system level assessment and care authorization to determine client needs and ensure that an initial care plan is developed that is closely suited to the needs of the client and uses the full range of services available in the system of care.

- Care plans describe the range and quantity of services to be delivered by one or more types of service providers
- Clients are provided access to care in any of the components or sets of components of the service delivery system across the continuum of care
- System level assessment using standardized assessment tool tested for validity and reliability that provides the information case managers or care coordinators need to develop the best possible system-level care plan.

System level assessment and care authorization provide efficiencies by maximizing the probability that the most appropriate level of care is provided based on the needs of the client.

Key Finding 15: System level assessment and authorization is a core service of the CCAC

Given that this is part of the core business of the CCAC, investing resources in identical infrastructure would be a duplication of efforts. Rather, the IRSHP should leverage existing infrastructure for standardized system level assessment and care authorization.

Recommendation 8: IRSHP and CCAC partner to ensure that the IRSHP benefits from CCAC system level assessment and care authorization infrastructure

System Level Client Classification

System level client classification systems that are used consistently across all sites of care allow for the analysis of clients across service delivery components by level of care. The interRAI client assessments are the gold standard for system level classification and are used worldwide. The family of instruments covers the continuum of care and includes:

- Mental health
- Community mental health

- Intellectual disability
- Home care
- Long-term care homes
- Complex continuing care hospitals
- Acute care hospitals
- Palliative care
- Post-acute care-rehabilitation.

The interRAI is an integrated system that includes common:

- Language and terminology across instruments
- Conceptual basis
- Clinical emphasis on functional assessment rather than diagnosis
- Data collection methods
- Core elements (e.g. Activities of Daily Living, Cognition)
- Care planning protocols for sectors serving similar populations.

The interRAI is compatible across settings and in the management of transitions between settings.

The interRAI is used in Ontario long-term care homes and in the community. It has already been noted there is a direct link to assessments, where CHRIS and the RAI-HC operate as one seamless application, allowing automated entry of information and availability of a quick summary of results. InterRAI is therefore the logical choice for system level client classification in the NSM IRSHP.

Recommendation 9: IRSHP consider system level client classification with interRAI

Ongoing System Level Case Management

Integrated systems of care respond to changes in client needs by revising care plans to ensure that there is a continuing match between the needs of clients and the range of services provided. This is efficient since it prevents clients from deteriorating to the point that more costly services such as emergency visits and inpatient admission are required. By definition, case management is not a short-term service delivered by an individual program, but a feature of an integrated system. System level case management is best accomplished by providing the same case manager or care coordinator over time and across all components of the integrated system of care.

In Ontario, ongoing system level case management is provided by CCACs. It was not within the scope of this engagement to review satisfaction with or the adequacy of NSM LHIN case management. That being said, the senior's health system would benefit from an enhanced case management focus.

Key Finding 16: Ongoing system level case management is not available for the 13 programs evaluated

Case management is not provided, used loosely as a term, and is sometimes misunderstood across the 13 programs reviewed. The IRFP uses the term loosely to describe its service that includes one home visit and a follow up phone call 90 days later. SASOT provides elements of case management on a time-limited basis. Clients, caregivers and providers would benefit from case management within and across programs to promote continuity of care and support transitions.

Recommendation 10: IRSHP and CCAC to partner to ensure optimal case management for IRSHP clients

Involvement of Clients and Families

The importance of effective engagement of clients and families cannot be understated.

Key Finding 17: The programs reviewed demonstrated a commitment to engaging and supporting clients and their families

While this review did not include interviews with clients or their families, it does conclude that the programs evaluated share the view that an essential part of care planning is the involvement clients and their families. The programs also recognized the need to effectively engage clients and families in planning and evaluation efforts. There are a number of ways that clients and their families are assisted in navigating the system and accessing information about available resources:

- The County 211 number is an example of such resource at the system level
- Individual programs also offer navigational support as part of their service.

At the level of the programs evaluated, many seek client input by conducting client satisfaction surveys. Some programs collect detailed client satisfaction on a regular basis. At the level of system governance, the *Care Connections* structure includes clients and family members.

LINKAGES

The evaluation of the 13 Seniors Health Programs did not focus on all seniors programs, nor did it include a comprehensive review of existing mechanisms for linking existing health programs with hospitals, primary care or other social and human services. It is recognized, however, that linkages between system care components are vital to ensuring the best possible care response to meet client needs.

Clients served by the lRSHP will require care coordination within the IRSHP and between the IRSHP and other health, social and human services.

Recommendation 11: lRSHP develop and implement a strategy for linking lRSHP with other health, social and human services

Linkage mechanisms may include:

- Boundary-spanning linkage mechanisms
- Co-location of staff
- High-level cross-sector committees.

SUMMARY OF SYSTEM FINDINGS AND RECOMMENDATIONS

Key Findings (KF) for System Redesign

Philosophical and Policy Prerequisites

KF1.   Philosophical and policy environment supports an integrated system of care for seniors.

KF2.   The NSM LHIN has clearly articulated its philosophy and vision.

Administrative Best Practices

KF3.   The 13 programs evaluated have many administrators, funders and funding envelopes.

KF4.   Responsibilities and accountabilities are unclear for some paymaster arrangements.

KF5.   Multiple funder and envelope funding systems are bureaucratic and ineffective.

KF6.   BSS multi-agency governance and administration is ineffective and inefficient.

KF7.   BSS does not have a system manager to make needed system improvements.

KF8.   Programs not required to report tend to stop measuring.

KF9.   Some programs do not operate as initially intended or funded.

KF10.   There are no incentives or rewards for evidence-based management or program outcomes.

KF11.   Few programs measure program outcomes in a credible way.

KF12.   The 13 programs reviewed do not share an integrated electronic information system.

Clinical Best Practices

KF13.   The majority of programs reviewed (9 of 13) have isolated intake systems.

KF14.   BSS Central Intake does not effectively match needs with resources in a timely fashion.

KF15.   System level assessment and authorization is a core service of the CCAC.

KF16.   Ongoing system level case management is not available for the 13 programs evaluated.

KF17.   The programs reviewed demonstrated a commitment to engaging and supporting clients and their families.

Recommendations (R) for System Redesign

Administrative Best Practices

R1.   The NSM LHIN to identify a Lead Agency for an Integrated Regional Seniors Health Program (IRSHP).

R2.   The NSM LHIN to provide the IRSHP with a single envelope of funding.

R3.   The NSM LHIN to identify a senior leader to manage the implementation of the recommendations of this report.

R4.   IRSHP, CCAC, Hospitals and all IRSHP funded community organizations to be participants in the development of a Regional Decision Support to support IRSHP program evaluation and the development and implementation of incentives to reward program performance.

R5.   The NSM LHIN, IRSHP and CCAC establish an integrated Electronic Health Information System, integrated with the Community Health Resource Information System (CHRIS).

Clinical Best Practices

R6.   IRSHP to be provided with the mandate to establish a central intake process for Specialized Geriatric Services that is inclusive of Behavioural Support System programs.

R7.   IRSHP to establish admission criteria for all IRSHP regional programs in consultation with program managers, clinicians and program customers.

R8.   IRSHP and CCAC partner to ensure the IRSHP benefits from CCAC system level assessment and care authorization Infrastructure.

R9.   IRSHP consider system level client classification with InterRAI.

R10.   IRSHP and CCAC to partner to ensure optimal case management for IRSHP clients.

Linkages

R11.   IRSHP develop and implement a strategy for linking IRSHP with other health, social and human services.