North Simcoe Muskoka
Specialized Geriatric Services

# NSM SGS Program
# Clinical Design Report:
# *Summary*

**September 2016**

Waypoint
CENTRE for MENTAL HEALTH CARE
CENTRE de SOINS de SANTÉ MENTALE
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Ontario
North Simcoe Muskoka Local Health Integration Network
Réseau local d'intégration des services de santé de Simcoe Nord Muskoka

In March 2016 the NSM Local Health Integration Network (LHIN) and Waypoint Centre for Mental Health Care, the lead agency for the NSM Specialized Geriatric Services (SGS) Program, established a Clinical Design Working Group to develop a final report and recommendations related to the clinical design of the new NSM Specialized Geriatric Services Program. Building on the *Strategy for a SGS Program in NSM* document (2014), the Clinical Design report is a guiding document, designed to support planning and decision-making in the years ahead.

## Desired Outcomes

Starting with a logic model approach to planning, the Working Group identified a variety of key outcomes measures to be achieved by the clinical service reflecting:

- Improved patient outcomes (e.g. maintained or improved frailty, improved assessment and management of responsive behaviours, reduced caregiver burden);
- Enhanced system capacity (e.g. increased knowledge and skills of health care providers in the care of frail seniors and enhanced self-management by frail seniors and their caregivers); and,
- A more affordable and sustainable health system (e.g. reduced inappropriate use of Long-Term Care and hospital resources).

The clinical service was designed using these outcomes as a foundation for discussion.

## Target Population

Eligibility for the clinical service is defined in the report as follows:

1. Senior; AND
2. Resides in the NSM region AND is able to receive service in the region; AND
3. Meets any of the following eligibility categories:

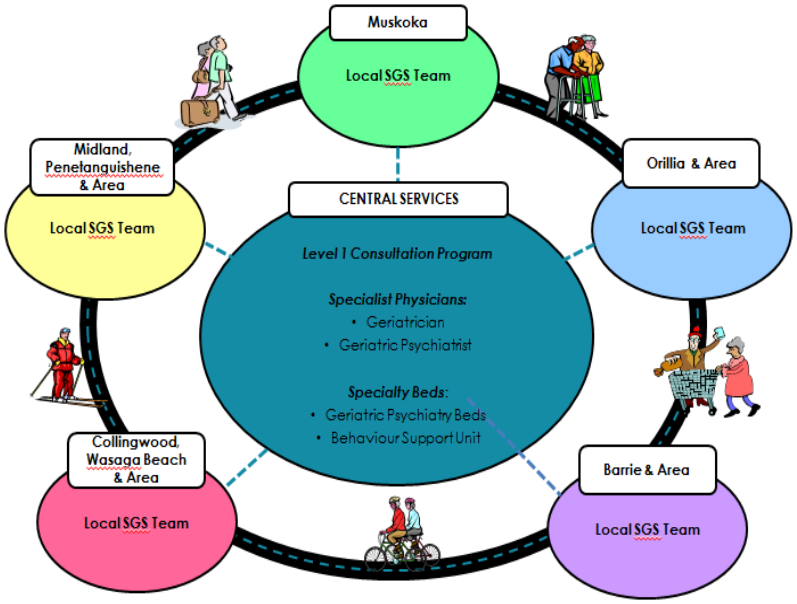
| A. | B. | C. |
|---|---|---|
| **** Comprehensive Geriatric Assessment*** | ****Responsive Behaviours*** | **** Nurse Practitioner Support in LTC*** |
| • Meet the characteristics of stages 4, 5 or 6 on the Clinical Frailty Scale;<br>• Have the potential to improve and/or maintain their current health state;<br>• Require a comprehensive geriatric assessment by two or | • Have cognitive impairment and an associated responsive behaviour(s);<br>• Require a behaviour assessment and/or support in the development of a | • Be a LTC resident;<br>• Have the potential to benefit from the care of a Nurse Practitioner;<br>• Present with one or more of the following:<br>o Geriatric syndromes[10] that require assessment, |

| | | |
|---|---|---|
| more members of the available interdisciplinary team;<br>• Present with multi-morbidity and complexity including:<br>o The presence of geriatric syndromes[1] that require assessment, diagnosis and/or treatment; ***AND***<br>o The loss or high risk for loss of Activities of Daily Living (ADLs)[2] and/or Instrumental Activities of Daily Living (IADLs)[3] | behaviour plan of care;<br>• Present with a change in behavior(s) to a degree that caregivers require support to manage the behaviour(s). | diagnosis and/or treatment; ***OR***<br>o An acute event that could be addressed within the LTC home to avoid an Emergency Department visit or hospital admission; ***OR***<br>o The need for support in the transition from hospital back to the LTC home. |

## Model & Services

In alignment with the *Strategy* document the clinical service will be accessed through a single entry point, the SGS Intake.

The clinical service will be comprised of Local SGS Services & Central SGS Services. Local SGS Services will be located in each NSM sub-geographic region while Central SGS Services will be more specialized resources that serve the entire NSM region.




At the local level, one interdisciplinary team will be located in each NSM sub-geographic region and will provide the first line of care in the majority of clinical service cases. The team will support health service providers in local communities through ambulatory, satellite and out-reach programs. Local SGS Team resources will also be located in area hospitals and Long-Term Care Homes using an in-reach approach to care. Local SGS teams will work in close partnership with primary care, providing consultative support. Care from the Local SGS Teams is time limited and targeted with key roles including

[1] Geriatric Syndromes - Dementia, delirium, depression, falls, polypharmacy, pain, malnutrition, urinary incontinence, constipation, elder abuse, functional decline
[2] ADLs –bathing/ grooming, dressing, transferring, toileting, self-feeding
[3] IADLs – housekeeping, meal preparation, medication management, managing money or finances, shopping, use of telephone or other form of communication, transportation within the community

assessment, diagnosis, treatment, transitions, care plan development, caregiver support, case management and capacity building.

Central SGS Services will be limited and provide support primarily to the Local SGS Teams through very targeted, time-limited care. The goal of the Central SGS Services will be to build the capacity of the Local SGS Teams to ensure care is provided as close to home as possible. The Level 1 Consultation Program will provide access to specialists for "hallway" conversations to expedite interventions, improve clinical outcomes and build local capacity. When specialist consult is required (Geriatrician, Geriatric Psychiatrist) specialists will, in most cases, travel to the sub-geographic regions to work in partnership with the Local SGS Teams to assess and manage complex cases. In cases where admission is required to support the needs of the frail senior the Working Group recommends access to dedicated geriatric psychiatry beds and a Behaviour Support Unit.

## Conclusion

With the clinical design report and recommendations complete, the NSM SGS Program, under the leadership of Waypoint, will work in partnership with the NSM LHIN and area health service providers to begin implementation planning. This will include developing program plans and mapping existing resources against the desired clinical design. As an advisory body to Waypoint and the LHIN, the NSM Seniors Health Project Team will be engaged to inform implementation planning.

***"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*