October 9, 2007

Proposal for

North Eastern Ontario Specialized Geriatric Services
(Phase 1)

and a

Future Northern Regional Geriatric Program
(Phase 2)

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For The City of Greater Sudbury
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I. EXECUTIVE SUMMARY

A unique opportunity exists to capitalize on several converging factors that can enable both the recruitment of a Geriatrician to Sudbury, and the development of a Northern Regional Geriatric Program

Critical is the knowledge that these factors are occurring simultaneously and that this opportunity is time limited.

This document outlines the growing need for Specialized Geriatric Services in the North. It describes the network of Regional Geriatric Programs within Ontario with a mandate of clinical services delivery, education, research and evaluation. It outlines existing opportunities that can facilitate the creation of a new northern regional geriatric program, including recently announced "Aging at Home" strategy funds, and a "soon to graduate" Geriatrician who would be willing to move back to her home town of Sudbury.

One of the key elements of specialized geriatric services is utilizing inter-professional teams, clinically led by a geriatrician. One geriatrician can support 3 or 4 skilled interdisciplinary teams, thereby maximizing the impact of service delivery.

This document outlines the rationale for a Regional Geriatric Program, a description of the interdisciplinary teams that a Geriatrician could support, and a timeline for proceeding to ensure that the opportunities are not missed.

There is a narrow window of opportunity to attract the Geriatrician and to get a contract signed. There is also a narrow window of opportunity to develop a proposal to capitalize on the " Aging at Home" strategy, which could fund a program director and clinical teams that will work with the Geriatrician.

If these elements can be brought together, they will establish the nucleus for the clinical services, which will be part of a Northern Regional Geriatric Program. In turn, they will provide a clinical setting for students in the Medical school and other health sciences, and enable the fulfillment of the mandate of education and research and evaluation.

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II. Phase 1

North Eastern Ontario Specialized Geriatrics Services Proposal

1. Rationale for recruiting a geriatrician to Northeastern Ontario

1.1 Area and Demographics

With an area of over 400,000 sq. km., almost 42% of Ontario's landmass[1], geographical challenges will exist in providing accessible Specialized Geriatric Services (SGS) throughout the North East Local Integrated Health Network (NE LHIN). Some existing models already promote accessibility, including teleconferencing via Ontario Telemedicine Network (OTN) and limited outreach services. Building on these existing structures as well as creating new and innovative services will be necessary to ensure effective delivery of SGS outside of the Greater Sudbury area. Establishing SGS in Sudbury with outreach to larger centres, expanding the videoconferencing reach, while remaining sensitive to intra-regional differences will be an important goal.

Almost 30% of the population of the NE LHIN is concentrated in the Greater Sudbury area (population of approximately 158,260). Sault Ste. Marie (80,100 – 14.6%), and North Bay (63, 425 – 11.6%) are the next most populous areas respectively. Together the 3 centers make up just over 50% of the population[2]. The remainder of the North East is made up of communities ranging in size from 100 people to approximately 43,700 (Timmins)[3]. Adding to the uniqueness of Northeastern Ontario is the fact that considerably more residents report French as their first language compared to Ontario as a whole (24% vs. 4%). Furthermore, Aboriginal and First Nation communities make up 8% (just over 41,000) of the NE.[4]

In 2006, the Canadian Census found that the 65-and-over population made up 13.7% of the total population of Canada, a new record for this age group. The proportion of people aged 65 and over in the Greater Sudbury area increased from 2001 to 2006 by 9.2% (to 23,505) and is above both the national and

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[1] North East Local Health Integration Network: About out LHIN. Accessed September 16, 2007 at: http://www.nelhin.on.ca/aboutourlhin.aspx?ekmensel=e2f22c9a_72_184_btnlink

[2] Statistics Canada. 2007. *Age and Sex, 2006 counts for both sexes, for Canada and census metropolitan areas and census agglomerations - 100% data* (table). 2006 Census. Statistics Canada Catalogue no. 97-551-XWE2006002. Ottawa. Released July 17, 2007. http://www12.statcan.ca/english/census06/data/highlights/agesex/index.cfm?Lang=E (accessed August 30, 2007).

[3] Population Health Profile, NE LHIN. Accessed August 30, 2007 http://www.health.gov.on.ca/transformation/providers/information/resources/profiles/profile_northeast.pdf

[4] North East Local Health Integration Networks: Integrated Health Service Plan. Sociodemographic Profile, December 2006. Accessed September 5, 2007.09.05 http://www.nelhin.on.ca/uploadedFiles/Home_Page/Integrated_Health_Service_Plan/Sociodemographic.pdf

provincial averages at 14.9%.[5] The percentage of people over the age of 80 increased in 2006 by 30.1%, to a total 5,720, or 3.6% of the Greater Sudbury population.

1.2 Geriatric Medicine Human Resource Planning

In 1992, Ontario specialists in geriatric medicine published a Delphi consensus survey of experts in health response planning. To fill clinical, academic, and administrative positions, they estimated a need of **1.25 full time geriatric specialists per 10,000 people ≥ 65 years.**[6] In the Greater Sudbury area alone, there are 23, 505 people over the age of 65, suggesting a present need for 2.5 FT geriatricians. [7] Currently, there is no full time specialist in geriatric medicine in Northeastern Ontario, where there are over 81,640 people over the age of 65.[8]

The City of Greater Sudbury's vision is to create a Seniors' Campus Model of Care, to provide a living environment and facility that will represent a centre for excellence in geriatric care. The goal of this campus is to combine long-term care accommodations with medical services focusing on senior's issues, specialized geriatric programs geared towards the needs of the elderly and geriatric research and training opportunities[9]. Key components of realizing this strategy are the recruitment of a geriatrician and the development of specialized geriatric services.

1.3 North East LHIN Integrated Health Service Plan/Integrated Geriatric Services

The NE LHIN IHSP has identified both Alternated Level of Care and Chronic Disease Prevention and Management as priority areas. One of the components of a comprehensive geriatric assessment (CGA) is disease management and medical optimization, as well as health prevention. CGA has been shown in the literature to increase the odds of living at home, and CGA programs which link geriatric evaluation with long-term management can improve survival and

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[5] Statistics Canada. 2007. *Age and Sex, 2006 counts for both sexes, for Canada and census metropolitan areas and census agglomerations - 100% data* (table). 2006 Census. Statistics Canada Catalogue no. 97-551-XWE2006002. Ottawa. Released July 17, 2007. http://www12.statcan.ca/english/census06/data/highlights/agesex/index.cfm?Lang=E (accessed August 30, 2007).

[6] Patterson C, Dalziel WB, Goldlist BJ et al. Geriatric medicine in Ontario: Manpower predictions based on a Delphi consensus survey. Ann RCPSC 1992; 25:99–102.

[7] Statistics Canada. 2007. *Age and Sex, 2006 counts for both sexes, for Canada and census metropolitan areas and census agglomerations - 100% data* (table). 2006 Census. Statistics Canada Catalogue no. 97-551-XWE2006002. Ottawa. Released July 17, 2007. http://www12.statcan.ca/english/census06/data/highlights/agesex/index.cfm?Lang=E (accessed August 30, 2007).

[8] NE LHIN: Integrated Health Service Plan, Sociodemographic Profile. Dec 2006. Statistics Canada 2001Census data. http://nelhin.on.ca/download/Sociodemographic.pdf (accessed August 30, 2007)

[9] Establishment of a Seniors Campus. City of Greater Sudbury: Analysis of Opportunities for Vacated Space. Submitted by KPMG, May 20, 2004.

function in older individuals[10].

Currently in our health care system, there are a wide range of publicly funded health and social services for the frail elderly. However, these services are often delivered through a fragmented delivery network. Programs of integrated geriatric services care for vulnerable community dwelling elderly use comprehensive geriatric assessment, case management and interdisciplinary team members to link these medical and social services[11]. Various models currently exist in Canada, and have been evaluated. The System of Integrated Care for Older Persons (SIPA) in Montreal has been shown to decrease ALC times by up to 50%[12]. Other models of integrated and/or coordinated geriatric services exist throughout North America (the Program of All Inclusive Care in the USA[13], the Comprehensive Home Option of Integrated Care for the Elderly in Edmonton[14], the Resource Integration for Seniors in the Community in Ottawa[15], and the Comprehensive Community Care program in Calgary). These programs have been shown to improve individual patient outcomes, decrease ALC stays, decrease readmission rates to acute care, and decrease rate of referral to LTC. While these programs are large undertakings, a single geriatrician in the NE could support a number of interdisciplinary teams that form the core of coordinated geriatric services, thereby helping to address the LHIN priorities.

See Population Distribution Map Appendix I.

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[10] Stuck AE, Siu AL, Wieland GD et al. Comprehensive geriatric assessment: a meta-analysis of controlled trials. Lancet 1993;342:1032-36.

[11] Johri M, Beland F, Bergman H. International experiments in integrated care for the elderly: a synthesis of the evidence. Int J geriatr Psychiatry 2003;18:222-235.

[12] Beland F, Bergman H, Lebel P etal. A system of Integrated Care for Older Persons with Disabilities in Canada: Results From a Randomized Controlled Trial. J Gerontol: Med Sciences. 2006;61A:367-73.

[13] Eng C, et al. Program of All-inclusive Care for the Elderly (PACE): An Innovative Model of Integrated Geriatric Care and Financing. JAGS 1997;45:223-232.

[14] Pinnell Beaulne Associates Ltd (1998). CHOICE Evaluation project. Evaluation summary. Final report; November 26, 1998; and http://www.capitalhealth.ca/NewsAndEvents/Features/2006/choice. Accessed Online October 8, 2007.

[15] Dalziel WB, Amos S, Martel C et al. Resource integration for Seniors in the Community. Presented to Ontario Hospital Association, November 1, 2005. Accessed Online October 8, 2007 at: http://rgps.on.ca/presentations

2. Opportunity for linkages in Sudbury – Existing Senior-Friendly Community Services and Programs

2.1 Northeastern Ontario Dementia Assessment and Consultation (NODAC) Service

NODAC provides access to geriatrician assessment through the use of videoconferencing for people who have changes in memory. NODAC accepts referrals for consultation from communities in the following districts: Sudbury/Manitoulin, Algoma, Nipissing/North Bay, Cochrane/Timmins, Temiskaming, Muskoka/Parry Sound. Patients are referred to the service by their family physician, nurse practitioner or psychiatrist. This may on occasion be facilitated by other community service groups, such as the Alzheimer's society. The referral is received through a centralized intake centre, at Pioneer Manor by Kim Pelkman, the NODAC Clinical Manager. Ms Pelkman ensures all the appropriate referral forms, cognitive screening tools, and investigations are completed (either by herself if the patient is in the Sudbury area, or by the referring centre if outside of the region). The patient is then further assessed via videoconference, by Dr Trevor Bon, a geriatrician in Thunder Bay. He provides recommendations to the family physician via a consultation letter. Up to July 2007, there had been 135 new assessments referred to the NODAC service since it's inception in 2003.

> *Opportunity: A geriatrician in Sudbury could support the NODAC service with videoconferencing to the North East region. In addition, patients in the Sudbury area with memory loss would benefit from an in person CGA, allowing for a direct physical/neurological exam in clinic or home. This could remove limitations that can exist in video-conferencing, such as hearing impairment.*

2.2 Société Alzheimer Society Sudbury – Manitoulin

Located within Pioneer Manor, the Société Alzheimer Society Sudbury – Manitoulin (SASSM) staff offer a range of services for patients with dementia and their families and caregivers, including:

- Three nurses (2 FTE) who provide an assessment (in home or on site), as well as counseling and case management. The nurses do not make a diagnosis of dementia as this is outside their scope of practice.
- Ten support groups for those with dementia and their caregivers, which are led by professionally trained volunteer facilitators
- Educational initiatives which occur via public information sessions, customized training workshops and presentations for families and caregivers
- A Day Program which involves structured daily activities, exercise, cooking and gardening programs for people with dementia.
- A Respite Program which provides home care for help with Activities of Daily Living (ADL's), personal care, and relief and support to caregivers.

- A library with a variety of resources available for clients and their families.

The SASSM has also been designated a First Link test site in Ontario. First Link is a program that connects the individual and family affected by dementia to resources in the local community for education, services, and support. Any health care provider may refer clients directly to First Link, and they will then receive a phone call within 4 weeks by a First Link coordinator. First Link then provides one on one support to families, information on dementia and the Alzheimer Society, and connects them with the appropriate community supports.

> *Opportunity: The SASSM's location in Pioneer Manor is an optimal site for the creation of a partnership between the SASSM and a Memory Clinic, also at Pioneer Manor. Patients referred for diagnosis in the clinic who are diagnosed with mild cognitive impairment (MCI) or one of several dementias (e.g. Alzheimer Disease, vascular dementia, Lewy body dementia, Parkinson dementia, Pick's Disease, Frontal Temporal Dementia, mixed dementia) could be linked directly to the SASSM by nurse participation, in a case manager role, or via education displays. Likewise, people with a diagnosis of dementia referred by the family doctor to the SASSM could also be followed annually, or as required through the memory clinic for ongoing management of their dementia while they live at home. Geriatrician talks on the medical aspects of dementia to the caregiver group information services and during Alzheimer Awareness Month could be an important complementary education resource to the SASSM. In addition to the prescription and monitoring of approved cognitive enhancing medications to patients followed in the memory clinic, participation in clinical trials of new compounds could be offered.*

2.3 Sudbury and District Health Unit

The Sudbury and District Health Unit has made a commitment to senior's health and, in particular, falls prevention has been identified as a priority. In the 2004/2005 fiscal year, there were a total of 86,820 emergency hospital visits and 24,647 hospitalizations due to a fall among those 65 years or older in Ontario. Among seniors, falls accounted for 59% of all visits for an injury to the emergency department and 80% of all injury related hospitalizations. Among seniors who were hospitalized, 38% were discharged home, 25% were transferred to another facility, and 26% were transferred to long-term care. Overall injury rates for emergency department visits and hospitalizations among seniors are higher in the North East LHIN than the remainder of the provincial LHINs, at 11,444/100,000 visits and 2,359/100,000 hospitalizations respectively.[16]

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[16] Ontario Injury Prevention Resource Centre. Injuries Among Seniors in Ontario. A Descriptive Analysis of Emergency Department and Hospitalization Data. Toronto: Ontario Injury Prevention Resource Centre, 2007.

The Sudbury and District Health Unit has responded by instituting a multi-strategy approach to falls prevention called the Stay on Your Feet Program. Several components have been created for this prevention goal, including the Medicine Clean Out Campaign, the Fall Busters Volunteer Program, as well as educational seminars. The Fall Busters Program is a home visiting program led by trained volunteers targeting seniors who are living at home in the City of Greater Sudbury who are at risk of falls. Peer volunteers are trained to provide home visiting support to the senior and education. Education includes risk factors for falls, home hazards, physical activity, and information on community resources. The Health Unit is also looking at innovative ways to improve recruitment and adherence to their program, including hospital referrals, and through the use of physician "prescription".

Opportunity: These falls prevention educational initiatives could be linked to an interdisciplinary falls clinic and management program for seniors who are experiencing falls. A fall is a strong predictor of further falls. Such a clinic, led by a geriatrician, would complement current population education initiatives, and provide a strategy to further reduce the risk of falls in a LHIN that has the highest provincial rates of injury from falls. The falls management teams could include an individual's comprehensive assessment of reversible factors. There is substantial evidence in the literature that multi-component interventions such as medication adjustment, strengthening exercises, balance/gait retraining, and provision of appropriate mobility aids are effective strategies to reduce the risk of falls[17].

2.4 Research and Evaluation

The Public Health Research, Education and Development (PHRED) Program at the Sudbury & District Health Unit is one of five Ontario sites and the only one in the North. The program is part of the health unit's Resources, Research, Education and Development (RRED) Division. The PHRED Program is the "research and development" arm of public health. This multidisciplinary team is affiliated with Laurentian University and conducts applied research and program evaluations that lead to effective and innovative public health programs and services. PHRED also promotes educational opportunities for future public health professionals.[18]

Opportunity: There would be an opportunity to create partnerships to evaluate the effectiveness of programs developed in partnership with the health unit and geriatric outpatient services. In particular, the evaluation of a falls assessment and management program would be important to

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[17] Gillespie LD, Gillespie WJ, Robertson MC et al. Interventions for preventing falls in elderly people. Cochrane Database Syst Rev. 2003, 4.

[18] From Sudbury and District Health Unit Home. Accessed August 31, 2007 http://www.sdhu.com/content/resources/folder.asp?folder=16&lang=0

assess its impact on seniors who fall, supportive services, and the acute care hospital.

2.5 Psychogeriatric Resource Consultants

There are three psychogeriatric resource consultants (PRC's) in northeastern Ontario funded through the Alzheimer Ontario Initiative. These consultants have education, consultation, and network building as their focus, and formal care providers as their targets (i.e. Long-term Care facilities, CCAC, and other Ministry of Heath and Long-term Care funded agencies). The 3 PRC's are based in Sault Ste. Marie (Arlene Gear), Sudbury (Monica Bretzlaff) and North Bay (Robert Spicer).

Opportunity: A geriatrician could act as a further resource to the PRC's, and participate in formal and informal education and consultation initiatives. The geriatrician and geriatric assessment team members could offer a comprehensive geriatric assessment (CGA) for older adults with complex cognitive/mental health needs and multiple medical illnesses in long-term care or at home as part of regional outreach clinics and/or videoconference as an expansion of NODAC. Furthermore, the geriatrician could serve as a valuable external resource to Dementia Networks. within L.H.I.N. # 13

2.6 Senior's Mental Health Outreach Program of the Hôpital régional de Sudbury Regional Hospital.

The Senior's Mental Health Outreach Program is available to assist individuals 60 years of age and over residing in the City of Greater Sudbury who are experiencing a late onset mental illness such as depression, anxiety, responsive behaviours, feelings of social isolation, substance misuse, dementia or delirium. The program offers a comprehensive assessment by a team member, consultation with a psychiatrist as needed, education, support, referral to other health care agencies and services. Outreach services are provided in the home when possible. The program is accessed through a centralized intake service. It is currently staffed by two nurses, two social workers, one occupational therapist and a part-time consultant psychiatrist.

Opportunity: A geriatrician and geriatric assessment team could support this team, acting in a consultation when patients could benefit from a comprehensive geriatric medical assessment. In a reciprocal manner, this team and the psychiatrist could act as a resource for the geriatrician and the geriatric outreach team, allowing the integration of geriatric medical and mental health services to avoid duplication of service. The creation of a common geriatric intake service would facilitate this integration.

2.7 The North East Community Care Access Centre (NECCAC)

NECCAC is the access point for home health services, school health services, and information/referral to community support services for all of Northeastern Ontario. Services available through NECCAC include nursing, personal support, caregiver respite, physiotherapy, occupational therapy, speech therapy, dietary, social work, access to long-term care, access to complex continuing care at Sudbury Regional Hospital, and information about and referral to community based services.

> *Opportunity: Traditionally, a partnership between SGS and CCAC is complementary and supports seniors to remain in their homes. CCAC provides allied health services and other services to maintain a senior's independence in the home, as well as case management, and eventual planning for long-term care, if it becomes inevitable. SGS provide seniors comprehensive geriatric assessment for their multiple medical conditions, multiple medications, and to identify reversible disability. The NECCAC has expressed interest in exploring partnerships and innovations with the new proposed SGS with the goal of further enhancement of seniors' ability to age independently in their homes for as long as possible and prevent crisis admissions to acute care.*

2.8 *Northern Ontario School of Medicine (NOSM)*

A new medical school for the whole of Northern Ontario, the Northern Ontario School of Medicine is a joint initiative of Laurentian University, Sudbury and Lakehead University, Thunder Bay. With main campuses in Thunder Bay and Sudbury, the School has multiple teaching and research sites distributed across Northern Ontario, in large and small communities.

The 4-year undergraduate program uses student learning in small groups, much of the time in distributed community-based learning sites supported by broadband communication information technology. The community based medical education program has students learning not only in larger hospitals but also in smaller hospitals, health services, family practices and community settings.[19]

> *Opportunity: There are currently lectures and small group sessions which cross the lifespan, one of which is end of life care and geriatrics. There are many points of opportunity for care of the elderly, geriatric medicine and geriatric psychiatry to be introduced into the curriculum including lectures, small group sessions, elective and clinical opportunities at the undergraduate and postgraduate level. The challenge will be to decide what are the short and long-term geriatric education goals for the North East and where can one geriatrician and geriatric assessment team can*

[19] Northern Ontario School of Medicine website. Accessed August 31, 2007. http://www.normed.ca/about_us/glance.htm

have a sustainable educational influence. Offering 1st and 2nd year trainees a clinical experience may influence a few to consider a career in Geriatric Medicine or Care of the Elderly. Those that are partial to geriatric electives in 4th year and during Internal Medicine or Family Medicine, may consider these career directions. A 3rd year Family Medicine Care of the Elderly six month or one year training program may attract family physicians in training to develop an interest in geriatrics and/or long-term care patient management. In the next 10-15 years, training physicians in the North with an interest in the care of the elderly will be essential to ensure carry over from the present existing long-term care physicians.

2.9 LTC Provider Group/Family Physicians

There are currently nine family physicians who provide care for over 1300 Long-Term Care beds in the Greater Sudbury Area. These physicians continue to run part-time to full-time family practices, and also share the responsibility for transitional care beds and complex continuing care beds, currently located at HRSRH.

Opportunity: Input from this group into the development of integrated SGS will be essential, as they are currently very involved in the care of the elderly in both the primary care and acute care environment. A close partnership, between SGS with geriatrician support and this physician group could provide for additional resources that they might refer to when caring for their older adults. Additionally, a geriatrician could provide consultation to this group, in both a formal (i.e. LTC, CCC), and informal (lunch and learn) settings. There could also be an opportunity to work in consultation with this group and other NOSM faculty from the Department of Family Medicine to develop a 3rd year Care of the Elderly training program in Family Medicine.

2.10 Proposed City of Lakes Family Health Team (FHT): Pioneer Manor Site

FHT provide comprehensive primary health care through an interdisciplinary team of doctors, nurses, nurse practitioners and other healthcare professionals. They provide integration with other parts of the health care system, emphasize health promotion, and are unique from community to community, in order to adapt to individual gaps and needs. Pioneer Manor is one of the anticipated sites for 1 of 4 FHT proposed for the City of Greater Sudbury (the others being located in Walden, Chelmsford, and Val Caron).

Opportunity: As older patients will likely represent a significant portion of practice visits, a geriatrician and specialized geriatric services could be available to the FHTs in a consultative basis. The family health teams could be one of the training sites for future care of the elderly trainees.

2.11 Other linkages

There are certainly other existing services and groups involved in geriatric care in the City of Greater Sudbury and throughout the North East where opportunities for partnerships will exist. Identifying, contacting and planning with these services will be integral to the development of SGS across the North East. This is one function that could be fulfilled by a program director (see 3.6).

3. Proposed new Specialized Geriatric Services

One geriatrician can support several highly specialized interdisciplinary teams. As a starting point, one Geriatrician could support:

a) one interdisciplinary team that provides assessment and intervention for patients in **an ambulatory setting**,
b) one team that provides **outreach consultation to the region**, and
c) one team that provides comprehensive consultation in **acute care**.

3.1 Ambulatory setting

In an ambulatory setting, a single geriatrician is limited by the time required to perform a comprehensive geriatric assessment (CGA) (1 ½ to 2 hours). Inter-disciplinary team members trained in CGA could complete most of this assessment (including history, collateral history, cognitive and depression screening, and limited physical examination) in the community, prior to the patient coming to clinic. The team member could then review this information at the clinic in consultation with the geriatrician. Information, in advance, allows for efficient use of the geriatrician's time, and increases the number of patients that can be assessed. This approach also facilitates comprehensive case management and follow up by the team member. Outpatient clinics could be a mix of specialized clinics (memory, falls, osteoporosis) and general geriatric medicine clinics. Each specialized clinic would require different support services and clinician expertise. The falls clinic in particular would rely on expertise from all team members.

Proposed Team:
1 Nurse Practitioner (1 FTE)
1 Occupational Therapist (0.5 FTE)
1 Physiotherapist (0.5 FTE)
1 Social Worker (0.5 FTE)
1 Secretarial Support (1 FTE)

3.2 Outreach

This would include a team that provides outreach services to the region. These interdisciplinary teams provide CGA and link with other geriatric services, local resources, and treatment options in or near the client's home. Individual team members would perform the initial assessment and then case conference or review their assessment directly with the geriatrician either in the home or in the ambulatory clinic setting (in person or by teleconference or video). The target group would be seniors, 65 years and over, living in the community with complex, multiple health problems, experiencing difficulty coping on their own, or recently hospitalized and agreeable to a referral by a physician.

Proposed team:
1 Nurse Practitioner (1 FTE)
1 Occupational Therapist (0.5 FTE)
1 Physiotherapist (0.5 FTE)
1 Social Worker (0.5 FTE)
1 Secretarial Support (1 FTE)

3.3 Hôpital régional de Sudbury Regional Hospital (HRSRH) – Acute Care Model

A single geriatrician in the community could be available to acute care to provide consultative services in a model similar to that which currently exists in the other regional geriatric programs. In London, a Consultation Liaison (CL) Team, run by 2 nurse practitioners (NPs), provides consultation to the medical and surgical services in the hospital. The target population is inpatients 65 years or over with complex medical issues that require geriatric assessment and intervention (i.e. the assessment and management of delirium, polypharmacy, depression, responsive behaviours). The NPs receive the consultations and then performs a comprehensive geriatric assessment (CGA) (history, collateral history, a physical examination, cognitive testing, functional and psycho/social assessment). The geriatrician, available on a limited basis, reviews the findings and provides additional recommendations. The NPs are then responsible for follow up care, with ongoing support from the geriatrician as needed.

This could be modeled at HRSRH beginning with one NP. A Nurse Practitioner would perform a CGA on referred patients and review these with the geriatrician. The geriatrician could complete the consultations two half days per week (i.e. Tuesday mornings, and Thursday afternoons). The Nurse Practitioner would follow-up assessed patients for implementation of the recommendations and review outcomes.

Proposed Team:
1 Nurse Practitioner (1FTE) – funded by HRSRH

3.4 Research and Program Evaluation

Research is integral to the delivery of evidence-based care. Through the generation of new knowledge and then translation of this new knowledge to practice, patients can be assured of the best quality of care. In addition, all services and programs should be evaluated to demonstrate accountability to the funders and ensure that clients are receiving what was intended (process evaluation) and that the expected outcomes are achieved (outcome evaluation). Thus, it is recommended that the infrastructure supporting these new programs also include an evaluator with the training and skills to conduct health services research and program evaluation with the necessary funding for this activity.

Proposed Team:
1 Evaluator (0.5 to 1 FTE)

3.5 Centralized Intake/Report Typing/Support Staff

The above model of specialized geriatric services will require both infrastructure support and secretarial/support staff. These would likely include 4 secretaries (one aligned with the geriatrician, one with the outreach team, one with the outpatient clinics and day program/falls clinic, and one for the program director (see phase II). The staff with the two teams would perform the centralized intake services (for community, LTC and acute care referrals) type reports for team members and send out the referrals to the community agencies. NPs in the acute care hospital would use the hospital centralized system for their reports.

3.6 Program Director/Administrative Lead

Roles

1. To establish collaborative partnerships with existing geriatric services, and evaluate how existing and new services can be functionally integrated to form specialized geriatric services for the City of Greater Sudbury and the North East.

2. To develop processes needed to support the new clinical programs (ie. centralized intake, health records, referral processes, budget processes, ongoing management of risk issues, equipment needs, facility space, hiring requirements, HR issues). These elements will need to be in place before the geriatrician arrives.

3. To establish representative SGS steering committee for the North East.

4. To establish an evaluation process for the new services and how they integrate with existing services.

5. To participate in future planning that encompasses the North West for the Northern RGP proposal.

3.7 Overall Local Model of Care – Proposed Geriatrician schedule

	Monday	Tuesday	Wednesday	Thursday	Friday*
AM	Program Development	Hospital Consults	Clinic	Program Development	Clinic/case conferencing
PM	LTC Consults/ Case Conferencing	Clinic (falls/general)	Clinic	Hospital Consults	Program Development

- Fridays could alternate with Outreach to other communities and/or NODAC assessments to balance the needs in Sudbury and the region
- Falls clinic/Day Program: could run Tuesdays and Thursday by the interdisciplinary team, with physician support for CGA and follow up on Tuesdays.
- LTC – long-term care consults alternating with case conferencing to the outreach teams.
- Program development would include both administrative, networking, educational, and evaluation roles, in partnership with the program director.

III. Phase 2

4. Rationale for a Regional Geriatric Program for a Northern (NE and NW) Regional Geriatric Program

4.1. Background

The Ministry of Health (MOH) established guidelines in 1987 for the creation of Regional Geriatric Programs (RGP's). The RGP's were established in the 5 existing Ontario Medical School/Academic Health Sciences Centres between 1988 and 1992.

The 4 mandates for the RGP's were:

1. Clinical services: assessment/diagnosis, evaluation (for placement), initiation of rehabilitation and post-discharge follow-up.
2. Teaching/Education: institutional and community health care workers, volunteers, the elderly and their families
3. Clinical Research/Evaluation: in healthcare delivery and medical delivery and medical problems of old age
4. Consultation: to physicians, hospitals, healthcare and community agencies

Each RGP (Hamilton, Kingston, London, Ottawa, Toronto) implemented the 4 mandates. However, the RGP spectrum of services that were funded by the MOH (Institutional Branch) reflected the needs of the region and were complementary to the existing network of services funded through other sources, such as hospital global budgets.

In each region, the host organizations varied and included the lead organization(s) already providing geriatric services to the city/region, the acute care hospital(s) and the medical school/university Division of Geriatric Medicine.

The primary goal of the RGP is to enable elderly people to live independently within their own communities through the provision of expert medical, functional and psychosocial assessment. Working in partnership and with family practitioners, community agencies and support services, the RGP and its network seeks to ensure appropriate treatment of those seniors with multiple problems, thereby avoiding inappropriate placement.

In addition to comprehensive clinical consultation services, the RGP's include an extensive needs-based education component oriented to staff, institutions and agencies, clients and their families. As well, research and evaluation personnel, with interdisciplinary team members participation, evaluate new and innovative partnerships that improve the care of the elderly throughout the region.

The intent is to provide equitable access to appropriate and timely services for the elderly, regardless of where a person lives. Within each RGP, the traditional core clinical services include:

- General geriatric or specialty outpatient clinics
- Outreach services within the city – home visits and long-term care consultation
- Outreach visits/clinics within the region
- Day hospital(s)
- Geriatric rehabilitation units
- Acute care hospital consultation/liaison team(s)
- Geriatric assessment unit(s)

The extent of each of these services and the development of the new services depend on the funding and resources/people available (geriatricians, Care of the Elderly physicians, nurse practitioners, physiotherapists, occupational therapists, social workers, nutritionists etc.).

Recent RGP innovations include:

- Geriatric emergency management (GEM) nurses
- Acute Care for the Elderly (ACE) unit/team
- Networks of local county teams that link to the central Specialized Geriatric Services (SGS) for consultation on complex patients and for continuing education
- Specialty outpatient clinics:
    - Memory disorders/Dementia and Mild Cognitive Impairment
    - Continence
    - Falls
    - Movement disorders
    - Osteoporosis
    - Polypharmacy

4.2 Partnerships

Partners common to each RGP include the CCAC(s), Alzheimer Society (as part of a dementia network), long-term care facilities, Family Health Teams (FHT's – a new development), nurse practitioners attached to long-term care, CCAC or acute care, and acute care hospitals.

The RGP's of Ontario is the network organization that links the leadership from each RGP (geriatrician/leader, program director, and research/evaluation director), through monthly teleconference calls to advance issues and programs common to the RGP's. The Chair of the RGP's is selected in rotation from the member RGP's with some administrative support funds provided from each member RGP.

The RGP's of Ontario host an annual workshop at the Ontario Hospital Association meeting and partners with the Ontario Gerontology Association to cosponsor the OGA Annual Scientific meeting. At this meeting, the RGP's have one educational development day for sharing new and innovative approaches between team members attending from each of the RGP's.

4.3 Mentorship

RGP mentorship to Northern Ontario has been provided on various fronts. Dr. William Dalziel (Ottawa RGP) has provided consultation, education and mentorship for over 21 years to Timmins and consultation and planning to Sudbury for the last six years. In the role of Physician Education Mentor for the Ontario Alzheimer Strategy in the North, he has provided education on dementia management to family physicians.

Outreach consultation and education to Manitoulin Island has occurred from Drs Irene Turpie and Christopher Patterson with the Hamilton RGP, and to Sudbury from Dr William Molloy with the Hamilton RGP and Dr Albert Kirshen from the Toronto RGP.

Training and ongoing mentorship has been provided to physicians in the North including, but not limited to:

- Dr Trevor Bon, Geriatrician in Thunder Bay, with Toronto RGP
- Dr Grant McKercher, Care of the Elderly Physician in North Bay, with London RGP
- Dr Julie Auger, Care of the Elderly Physician in TImmins, with Ottawa RGP
- Dr Edward Smith, Care of the Elderly Physician in Timmins, with the Ottawa RGP

As a strong advocate for the development of services for the elderly in under serviced areas in Ontario, the RGP's of Ontario recognizes that, with the creation of the Northern School of Medicine (NOSM), it is timely to advocate for a Northern RGP. As well, with Dr. Jo-Anne Clarke originally from the Sudbury area, a geriatrician training in London with the University of Western Ontario Division of Geriatric Medicine, there is an opportunity to recruit a leader to develop SGS in Sudbury. In May of 2005, the City of Greater Sudbury hosted two representatives from the RGP's of Ontario - Chair of the RGP's, Dr. Michael Borrie, and Ottawa Program Director, Mr. Cal Martell – to present to representatives from the City, hospital and NOSM on the benefits of a geriatrician and, eventually, a fully-funded Northern RGP, for Northern Ontario.

Brief facts about RGP's that were emphasized are attached as Appendix 1.

4.4 Developing a Northern RGP Proposal

To develop a comprehensive RGP proposal for Northern Ontario will require a representative task force of planners, administrators, clinicians/healthcare providers with representation from:

- Both Local Health Integration Networks (LHINs)
- Specialized Geriatric Services (SGS) Program Directors or equivalent from the NE and NW
- Geriatricians, Care of the Elderly, Long-term Care Physicians and Geriatric Psychiatrists in the north
- Northern Ontario School of Medicine (NOSM)
- Regional hospitals
- CCAC's
- Alzheimer Societies
- Host organizations of geriatric services
- Input from consumer focus groups

A necessary step will be to identify the existing clinical and educational resources and the present gaps in services. The needed future services that best suit the North can be described in the RGP Plan.

4.5 RGP Proposal – Appropriate Funding Model for Physicians

Development of new clinical services will depend on identifying funding for trained physicians and allied healthcare professionals to implement and staff the services. An Alternative Funding Plan (AFP) that funds academic and community-based geriatricians, geriatric psychiatrists (if not funded by Regional or North East Mental Health) and care of the elderly physicians will be needed to ensure the existing services are sustained and new services developed according to the predictable seniors growth over the next 30 years.

Approval of funded vacant recruitment positions for geriatricians, care of the elderly and geriatric psychiatrists will be the necessary incentive to attract new recruits, some of whom may be locally trained at NOSM.

The small numbers of geriatricians, geriatric psychiatrists and care of the elderly physicians linked to NOSM represent the core expertise to integrate geriatric content to under-graduate, post-graduate training and CME events. Negotiation for an appropriately and competitively funded AFP for this group could occur within a NOSM faculty-wide AFP or through an RGP AFP. Later it could be rolled into a faculty-wide AFP.

4.6 Training Opportunities of Physicians and Allied Health Professionals in the North

The RGP's of Ontario can offer subspecialty training in each of the 3 specialty areas to northern trainees to gain additional training experience. The RGP's of Ontario can also offer training of other healthcare professionals from Northern Ontario. For example, in Southwestern Ontario, Specialized Geriatric Services has provided clinical mentorship to several nurses who have obtained RNAO fellowships for 3 months training with the RGP outreach team.

5. Developing an Operational Plan

5.1 The key elements for success are almost in its place

- The City of Greater Sudbury is willing to provide upfront funding to establish a contract with a geriatrician until an alternate payment plan (APP) can be negotiated and implemented.

- Newly announced Aging at Home Strategy funds could fund the new clinical teams (supported by 1 geriatrician) that form the nucleus of Specialized Geriatric Services as outlined in this proposal, as well as a program director to lead this initiative).

- A proposal has been submitted for capital funds to renovate a 4000 sq ft area for outpatient clinics, falls program/day program, and office space for the geriatrician, SGS team members, office support for program director for SGS at Pioneer Manor in Sudbury.

- Funding support is needed from the Acute Care Hospital for a Nurse Practitioner which could be supported by the Geriatrician to form the nucleus of an acute care consultation/liaison team.

- Securing a geriatrician will ensure ongoing mentorship and consultation from the provincial RGP network.

5.2 Proposed Timeline

1. The highest priority, before any programs can be developed, is to secure a Geriatrician.
   Timeline: *By November 2007*

2. Submit Proposal to LHINs to fund a Program Director
   Timeline: *Hire by April 2008*

3. Submit a Phase I proposal to the LHINs to coincide with decisions on the recently announced "Aging in the Home" Strategy funds. These funds could be used to fund the clinical teams that would form the basis of Core Specialized Geriatric Services in Northeastern Ontario.

4. Establish a Task Force of key constituents. (This report can be used as a discussion document for this Task Force/Steering Committee). Project management support may be required for the planning process, and to develop a report for the LHINs.

5. In collaboration with a North West planning group, write a Phase II proposal to establish a Northern Regional Geriatric Program.

5.3 What are the roles of the Program Director?

1. To establish collaborative partnerships with existing geriatric services, and evaluate how existing and new services can be functionally integrated to form specialized geriatric services for the City of Greater Sudbury and the North East.

2. To develop processes needed to support the new clinical programs (ie. centralized intake, health records, referral processes, budget processes, ongoing management of risk issues, equipment needs, facility space, hiring requirements, HR issues). These elements will need to be in place before the geriatrician arrives.

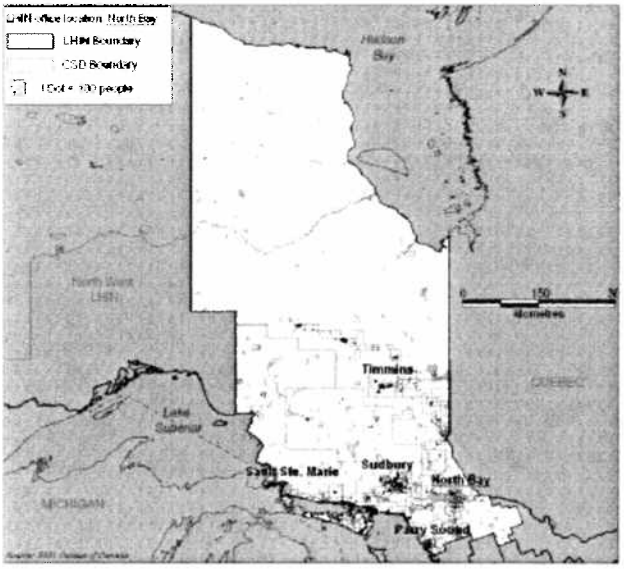
3. To establish representative SGS steering committee for the NE.

4. To establish an evaluation process for the new services and how they integrate with existing services.

5. To participate in future planning that encompasses the North West for the Northern RGP proposal.

IV. APPENDIX I

Map 1: Population distribution in North East



RGPs OF ONTARIO

V. APPENDIX II

Fact Sheet:

The Role and Value of Specialized Geriatric Services

Purpose:

- A system of health care services that optimizes the health, independence and quality of life of seniors with complex health problems.

The Need:

- Demographics and Dollars: the needs of an aging population will be the single most significant challenge facing our health system.
- a major factor in health system re-structuring.
- Challenges in Assessment and Treatment: The fundamental premise is that much of the disease, disability and dependency in old age is preventable, treatable, or manageable.
- Seniors with complex health problems have unique needs and present specific challenges for accurate diagnosis and assessment.
- Inaccurate diagnoses may result in inappropriate treatment, with further losses of health and independence, premature placement and long lengths of stay in acute care.

Who Benefits:

- Seniors, 75 years of age or more, with complex, multiple health problems, dependent, in activities of daily living.
- 15% of the population 65 years of age or more, "the frail elderly"
- Family caregivers, through education and linkages to community services.
- Society, through the reduction of unnecessary human and financial costs

What We Provide:

- A comprehensive range of specialized geriatric assessment, short term treatment and rehabilitation services provided by interdisciplinary teams with expertise in care of the elderly, across the continuum of care.

Inpatient	**Outpatient**
Geriatric Assessment Units	Geriatric Clinics
Geriatric Rehabilitation Units	Geriatric Day Hospitals
Geriatric Consultation Teams	Geriatric Outreach Services

- Consultation and advice on the management of complex health problems
- Integration of consultation, education, research and community development to extend the ***geriatric capability*** of primary and continuing care
- Research to promote evidence-based, high quality, effective care of the elderly.

When to Refer

- ❒ Major Geriatric Problems: Recent onset of unexplained changes in physical, mental or functional status
- ❒ *falls, incontinence, confusion, impaired mobility, and polypharmacy*
- ❒ Interaction of multiple and complex medical problems.
- ❒ Increased use of health care services
- ❒ Major change in support needs.

The Benefits;

- ❒ Increased independence and quality of life for seniors and their caregivers.
- ❒ Improved patient outcomes:
  - ➨ Reduce functional decline associated with hospitalization
  - ➨ Increased likelihood of discharges home / reduced institutionalization.
  - ➨ Reduced mortality
- ❒ Increased clinical efficiencies in acute care
  - ➨ Reduced lengths of stay and readmission rates
  - ➨ Decreased ALC days
- ❒ Enhanced capacity of physicians and other care providers to assess and treat health problems of the elderly.

VI. APPENDIX III

DRAFT HIGH LEVEL BUDGET – PHASE 1
North Eastern Specialized Geriatric Services
October 2007

There are 4 areas of funding:

1. The City of Greater Sudbury will fund the Geriatrician as a start up initiative until an Alternate Payment Plan is negotiated. This will require a 5 year commitment to "top up OHIP receipts" to a negotiated salary level, as per contract negotiated between Dr. Clarke and the City of Greater Sudbury.

2. LHIN Funding through the "Aging at Home Strategy" funds will be required to fund the interdisciplinary community teams, as outlined in a proposal submitted to the North East LHIN. The staffing complement for the combined outreach/ambulatory teams will be 2 FTE RN's (nurse practitioners) and 3 FTE allied health, 1 FTE evaluator/research associate, 1 FTE Program Director, and 4 FTE secretaries (1 for each of the two teams, 1 for the program director, 1 for the geriatrician) 150K. Total community team staffing budget – 680 K. Additional operating expense and travel budget – 150K.
   Total LHIN funding – 980K (ongoing annual)

3. Money to renovate space, and purchase "start up" capital equipment at Pioneer Manor has been applied for through the "Heritage Fund" – Renovations 800K and Capital Equipment 180K.
   Total Start up – 980K (one time funding)

4. An Acute Care Consultation Liaison Team would be funded within the Global budget of the Acute Care Hospital and would consist of 1 FTE Nurse Practitioner, 0.5 FTE clerical support. The team would require office space and an office expense budget. Assuming 1 NP –
   Approximate Acute Care Total – 140K (ongoing annual)