# Program Logic Model for a Seniors Care System

**Vision** Better health outcomes for seniors living with or at risk for frailty* across a defined geography and/or Ontario Health Team(s)

**Mission** Working as a coordinated network of senior friendly, high quality systems of health care that address complexity and optimize quality of life

| Components | A single system (one program) of integrated, interprofessional, cross sectoral clinical geriatric and care supports | | | | | | |
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| Activities | Embedded Primary Care Geriatric/Dementia Supports | Community Based Emergent Response | Community Based Interprofessional Specialized (Geriatric/Geriatric Mental Health) Teams | In-Patient Consultation Liaison Services/Bedded Care | Specialist Supports | Community-based participant and caregiver support for education, daily living, socialization and quality of life | Supported Self Care |
| Description | Direct, embedded geriatric/dementia clinical supports in primary care offices | Clinical geriatric experts who can respond to emergent conditions in patient homes (including private homes, retirement home, LTC) to avert transfer to hospital, or receive patients in the ED as needed | Expert teams who can evaluate and unpack multimorbidity to inform care planning and interventions in the community | Expert teams who can evaluate and unpack multimorbidity to inform care planning and interventions in the acute care environment | Physicians from a variety of specialties who provide clinical leadership and direct patient care across the Senior Care System | Staff who provide flexible daily living supports that are essential to maintaining individuals at home with high quality of life | Credible co-designed resources and information to enable effective self care or caregiver supported care |
| Core Functions | Coordinated access<br>Hands on care for geriatric patients (including patients with dementia) and their caregivers (including preventive, restorative and palliative care)<br>Prevention and mitigation of frailty<br>Interprofessional and Interdisciplinary Comprehensive Assessment (e.g. CGA)<br>Collaborative care planning<br>Ongoing staff, participant and family education<br>Prevention and Support for responsive behaviours (BSO)<br>Geriatric rehabilitation (Assess & Restore)<br>Geriatric and dementia informed resource/support finding, procurement and coordination to assist older people to action their plans of care (care coordination/navigation)<br>Direct support for follow-up and follow-through of ongoing treatments, interventions and support<br>Proactively partnering with others to advocate on behalf of frail seniors<br>Engagement of the community to prepare and respond to the age related needs of frail seniors<br>Participation in the development and implementation of evidence informed practices<br>Delivery of a range of flexible supports, informed by therapeutic recreation, rehabilitation, dementia and elder care best practices for community living | | | | | | |
| Examples of programs and services to be part of the integrated seniors care system | Geriatric and Dementia Resource RNs (GNC & BSO trained)*<br>Geriatric and dementia informed general primary care<br>PCCMS<br>ICP Teams | GEM+<br>NPs in LTC<br>Community Paramedicine (Avert/Divert models)<br>Rapid response nurses | GAIN<br>Geriatric Psychiatry/MH Teams<br>Behavioural Supports Ontario | Geriatric Consultation Liaison Service | Geriatric Medicine<br>Geriatric Psychiatry<br>Care of the Elderly and Focused Practice Primary Care<br>Neurology<br>Behavioural Psychology | Adult Day Programs<br>CSS Services<br>Family Support Programs<br>Dementia Navigation<br>First Link<br>Friendly Visiting<br>Transportation<br>Meals on Wheels<br>Nursing and Therapy services<br>Personal Support Services<br>Congregate Housing<br>Assisted Living Programs | Self care management programs<br>Caregiver Education and Training<br>Powerful Tools for Caregivers<br>sfCare Learning Series |
| Short term outcomes | Participants receive a complete interprofessional CGA and interventions, participants are utilizing clinical and community support services, caregivers are utilizing community support services, increased number of geriatric assessors, reduced variation in access (wait times across the region), programs and people have tools to deliver high quality evidence informed care and support<br>Leading practices in elder care policy and services are disseminated | | | | | | |
| Short term indicators | % of participants receiving a completed interprofessional CGA,<br>% of participants where a care plan was developed<br>% of participants receiving/utilizing appropriate treatments, interventions and support<br>reduced wait times for services across the region<br>% of providers reporting satification with collaborative intersectoral teamwork<br>% of participants and caregivers reporting satification with services/supports received | | | | | | |
| Targets - TBD | | | | | | | |
| Long term outcomes (impacts) | Knowledgeable workforce (geriatric assessors), improved staff experience, improved quality of life and health outcomes for older adults, improved quality of life and health outcomes for caregivers, improved quality of care, improved health outcomes, integration/coordination metric (reduced duplication), improved geriatric assessment capacity (system wide), improved community supports (length of stay in the community), improved patient experience, improved caregiver experience, decreased wait times for CGA, improved equity of services, improved access to age appropriate care, dementia educated community | | | | | | |
| Long term indicators | HR vacancy rate,<br>HR retention rate,<br>% LTC eligible patients who remain in the community,<br>% of patients who attend the ED for an ambulatory sensitive conditions (e.g., delirium, falls, polypharmacy) | | | | | | |
| Targets - TBD | | | | | | | |
| Enablers | Common digital platform<br>Digital health/virtual care<br>Mechanism for data collection/performance tracking across partnerships<br>Pooled funding resource to enable flexibility/responsiveness across areas of needs<br>Client engagement<br>Shared leadership structure<br>Supportive, open, senior and dementia friendly, collaborative culture<br>Citizenship focused (model)<br>Affordable housing options | | | | | | |
| Resources | FTEs (TBD)<br>Physician payment models (AFPs, EGGs)<br>Clinical/collaborative space<br>Administrative supports<br>Decision support<br>Other (TBD) | | | | | | |

* This includes older people living with dementia, chronic diseases, mental health and addictions concerns or, often, a combination of several complex conditions and social challenges that make them vulnerable to needing more resources or being unable to stay at home. This constellation of complex conditions is sometimes called frailty.