Informing an Ontario Seniors Strategy

Submission from the Regional Geriatric Programs of Ontario

July 19, 2019

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Introduction

In June 2019, the Ministry of Seniors and Accessibility (MSAA) launched public consultations and a survey to inform the development of an Ontario's Seniors Strategy.

The Regional Geriatric Programs (RGP) of Ontario reviewed the MSAA survey and applauds its focus on age-friendly supports, housing options, social connections, transportation, personal support worker services, safety, workforce participation, information needs, and diversity. Individual RGPs encouraged participation in the MSAA consultation among older adults and their caregivers, and with the more than 2,500 clinicians working in Specialized Geriatric Services (SGS) across the province.

At the same time, we recognized that Ontario's seniors are a large and diverse group, ranging in age from 65 (or 55 for some programs and services) to well over 100. It is estimated that nearly 560,000[1] older Ontarians are currently living with multiple, complex, and often interacting medical conditions, mental health problems and/or lack of social supports. This includes older people living with dementia, chronic diseases, mental health and addictions concerns or, often, a combination of several complex conditions. This constellation of complex conditions is sometimes called frailty. Older individuals living with frailty make up a significant cohort within the 5% of Ontarians that spend over 60% of the health budget. By 2029, we estimate that over 900,000 of the nearly 3.7 million Ontarians over age 65 will be living with frailty. For these individuals and their caregivers, including both family and professional caregivers, their experiences and needs are diverse, necessitating specific consultative approaches. Traditional consultative approaches may not meaningfully engage this particular audience.

In May 2019, in anticipation of the MSAA's consultation, the Regional Geriatric Programs of Ontario canvassed clinical leaders from across the field of geriatrics. The purpose was to gather expert insights pertinent to the needs of seniors living with frailty, in order to inform the anticipated Ontario Seniors Strategy. This report summarizes the input received from 65 clinical experts from across Ontario, whose daily work focuses on the unique needs of older people living with frailty, and their caregivers.

Themes emerging in this report are consistent with the guiding principles and domains of the provincial Senior Friendly Care (sfCare) Framework[2], and the more recent themes of integration, innovation, efficiency and alignment, and capacity identified in the second report from the Premier's Council on Improving Health Care and Ending Hallway Medicine[3]. Where possible, these alignments are noted, and opportunities for continued collaboration between the Government of Ontario, its Ministries, and the RGPs of Ontario, are highlighted.

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[1] https://www.rgps.on.ca/wp-content/uploads/2019/05/Planning-for-Health-Services-for-Older-Adults-Living-with-Frailty-SGS-Asset-Mapping-Report-FINAL.pdf p. 9.

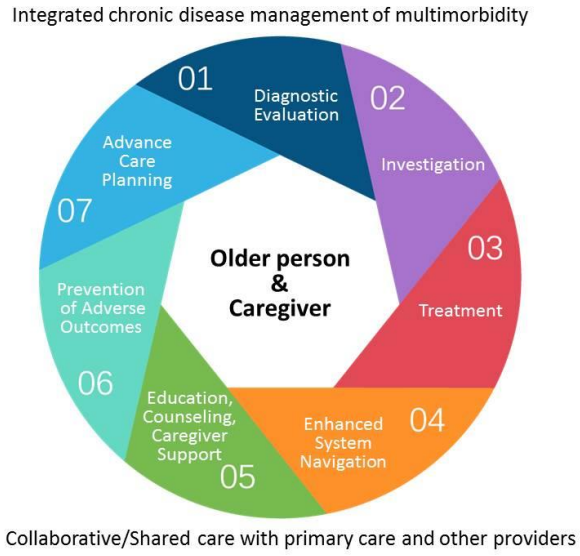
[2] https://www.rgptoronto.ca/wp-content/uploads/2018/04/sfCare-Framework-and-10-Recommendations.pdf

[3] https://www.ontario.ca/document/healthy-ontario-building-sustainable-health-care-system?_ga=2.71989139.1491090077.1563528511-257759617.1559390070

How the RGPs of Ontario Meet the Needs of Frail Older Adults

The RGPs of Ontario, and more generally Specialized Geriatric Services (SGS), provide clinical leadership to the approximately 440 programs and teams that make up SGS. This work focuses on ensuring optimal care for older adults living with frailty in Ontario, and includes direct clinical care, program support, education and knowledge transfer (via a of range approaches designed for health care providers, individuals, and caregivers). We work in collaboration with general primary care, hospitals, home care, community service agencies, and the long term care sector.

Figure 1: The Clinical Model of Geriatric Care: Comprehensive Geriatric Assessment & Intervention



SGS teams consist of interprofessional staff, including Care of the Elderly Physicians (Primary Care), Geriatric Medicine and Geriatric Psychiatry Specialists, and many other health disciplines who are experts in designing and delivering health services for older people living with frailty. SGS promote effective and efficient use of services and resources to enable older adults living with frailty to receive the appropriate, timely care, as close to home as possible. SGS teams prevent unnecessary treatment, minimize medication use, and help to avoid acute episodes for many older adults. Our services match the needs of individuals with the right frequency and intensity of services needed to prevent deleterious outcomes, and ultimately, prevent hallway medicine.

Our Consultation

To ensure the unique care needs of older adults living with frailty could inform an Ontario Seniors Strategy, a short survey was distributed in-person to clinical leaders and shared electronically with stakeholders across the province. Our survey complements the MSAA's survey, and asked respondents to consider:

- Principles critical for a provincial Seniors Strategy;
- Priorities for a provincial health system focus; and
- Specific actions that should be taken to achieve these priorities.

A total of 65 survey responses were received that included 422 specific statements.

What Clinical Leaders Told Us

Analysis[4] of the survey responses identified principles, priorities, and actions that were predominately consistent with the following domains of sfCare Framework[5] (prioritized in order of response frequency)(see Figure 2):

1) Processes of Care
2) Organizational Support

Appendix 1 includes the complete sfCare Framework and associated definitions.

Additional responses were categorized as 'Other' (see Figure 3) and broken down into nine sub-categories (see Appendix 2). The top five action areas identified were (prioritized in order of response frequency):

1) Access
2) Policy Reform/Alternative Models of Care
3) Responsiveness to the Community Needs/Population Demands
4) Geriatric Workforce/Knowledge Enhancement
5) Information and Communications Technology (ICT)

[4] Preliminary analysis was independently conducted by two reviewers from Seniors Care Network (a member organization of the RGPs of Ontario). A joint secondary review of the classified responses was completed to ensure agreement and consistency.

[5] The goal of *The sfCare Framework(2017)* is to achieve the best possible outcome for older adults. It provides the foundation for achieving this goal through guiding principles and defining statements that are intended to foster improvements in care across the system and inspire collaboration between older adults and their caregiver, care providers, and organizations." The sfCare Framework was developed by the RGP of Toronto in consultation with provincial stakeholders.

Figure 2: Alignment of Survey Responses with sfCare Framework Domains

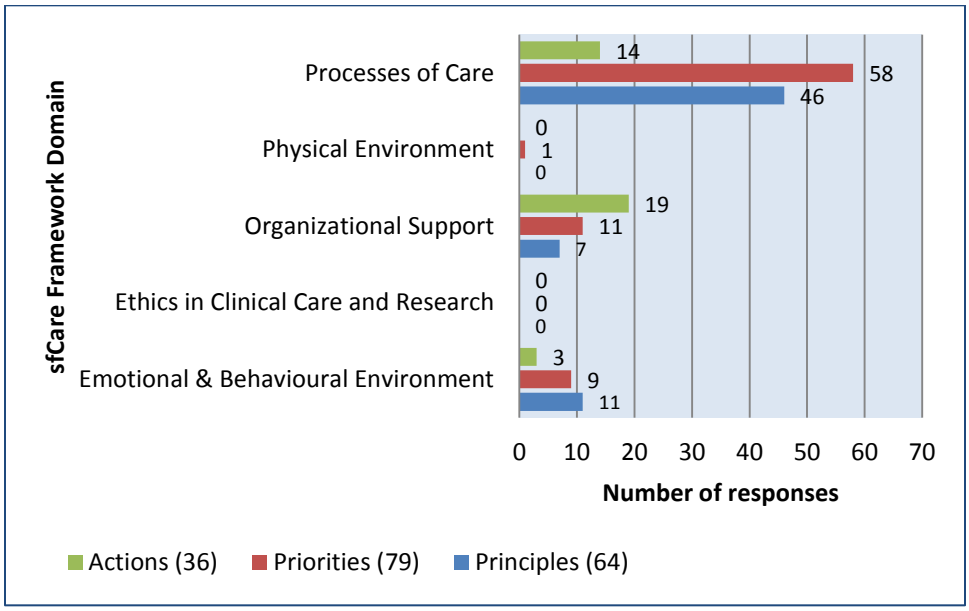
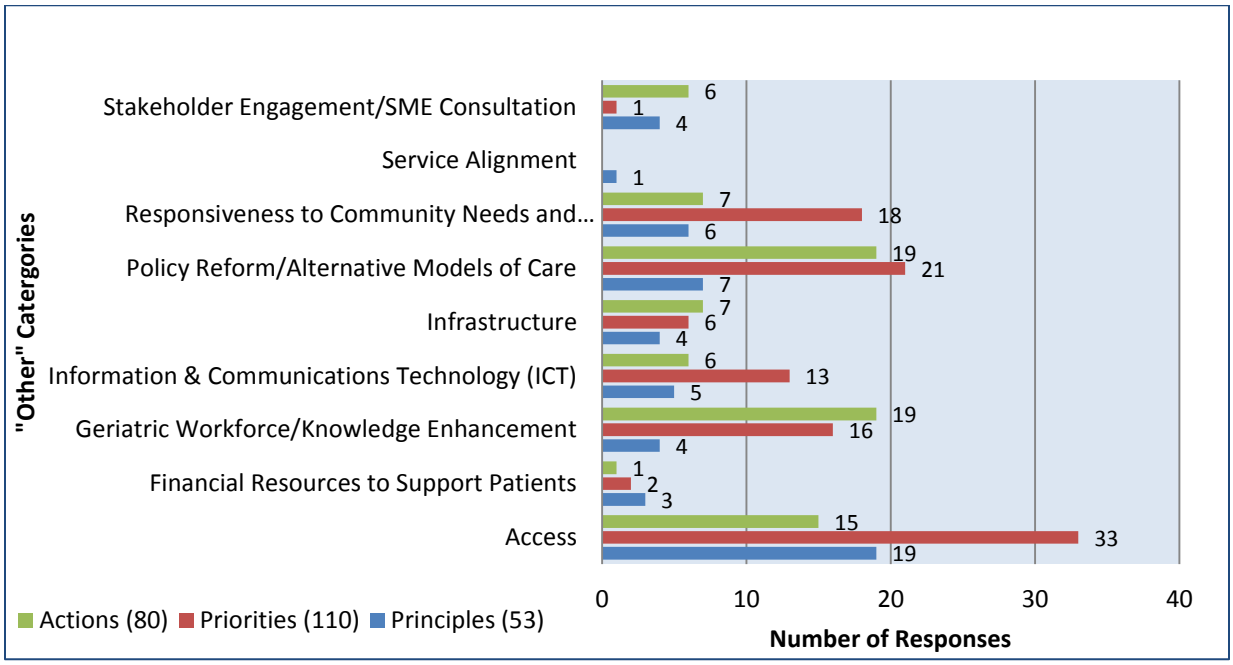


Figure 3: Breakdown of Other Subcategories



The following table summarizes the principles and priorities for action for each of the eight areas of focus.

Table 1: Areas of Focus, Principles and Priorities for Action

Area of Focus	Principles	Priorities for Action
Processes of Care	▪ Person centred care ▪ Integration of SGS	▪ Integrate existing SGS with other services ▪ Improve transitions ▪ Implement evidence-informed practices for dementia care, medication management, maintenance of function upon admission to hospital ▪ Ensure the development of and provision of care by interprofessional teams ▪ Increased support (including funding) for programs that ensure smooth transition from hospital to home (or other settings)
Organizational Support	▪ Coordination/collaboration among various health care organizations	▪ Increase/improve performance measurement (e.g. use of reliable, senior specific, high-quality data to measure system efficiency, report patient outcomes, and to inform clinical strategic planning) ▪ Improve provincial measurement of age-stratified outcomes.
Access[6]	▪ Coordinated access/single point of entry	▪ Improve access to SGS (including dementia care, geriatric medicine, geriatric psychiatry and mental health), ▪ Improve access to community services ▪ Improve access specifically in rural and remote areas of the province, such as communities with higher rurality indices and across Northern Ontario
Policy Reform/ Alternative Models of Care	▪ Transformed processes of managing and/or delivering home and community care	▪ Coordinate home care at physician offices, as opposed to through a separate agency ▪ Compensate Personal Support Workers (PSW) appropriately and enable their provision of a greater variety of in-home services, beyond the scope of personal care ▪ Authorize involved Health Care Providers (HCPs) to direct home care and Long Term Care (LTC) processes related to their care plans
Responsiveness to the Community Needs/ Population Demands	▪ Frailty specific capacity planning	▪ Prioritize community needs and population demands specific to seniors living with frailty during strategic, capacity and other planning activities
Geriatric Workforce/ Knowledge Enhancement	▪ Province-wide access to both community and hospital-based geriatric-trained clinicians	▪ Increase the number and skills of HCPs involved in the care of frail seniors ▪ Incorporate gerontological content in all healthcare related disciplines/practice programs ▪ Improve access to educational material on specific topics, like dementia ▪ Increased resource allocations for capacity-building and the development of geriatric interprofessional teams ▪ Focus on training and skills development for HCPs to improve communication and collaboration with caregivers
Information & Communication Technology (ICT)	▪ ICT enabled care and system integration	▪ Enhance information sharing and communication among multiple HCPs across the system (e.g. access to Connecting GTA for all, shared cross-sector electronic health records)

[6] Refers to access to health care services and the required resources

Summary

We are a provincial network of highly trained individuals with extensive experience in, and understanding of, the unique needs of older adults living with frailty. The insights we have gathered from clinicians and clinician leaders working directly with older adults living with frailty suggest priorities for health system transformation for a part of the population that requires and uses enhanced support. This feedback is aligned with the guiding principles and domains of the provincial sfCare Framework and other major themes arising across the health care system.

The RGPs of Ontario are already leading numerous activities across the province that inform an Ontario Seniors Strategy and address the recommendations of Premier's Council on Improving Healthcare and Ending Hallway Medicine (see Appendix 3). The priorities identified in this report are additional opportunities for the RGPs of Ontario to collaborate with Ministries to develop and implement activities important to seniors and policy-makers, alike.

We are grateful for our ongoing collaboration with the MSAA and are engaged across the province in numerous localized efforts to develop Ontario Health Teams (OHTs). We are willing to serve regionally and provincially as a resource and an innovative model of care for older adults living with frailty as the Ontario Seniors Strategy and OHT development work enters its next phase.

Lastly, we want to assert our commitment to co-design with older adults and their caregiving partners, as well as those on the front lines delivering programs and services. Our provincial work co-developing the Senior Friendly Care Framework as well as educational resources for healthcare professionals, older adults, and caregivers demonstrate this strong track record. There are also numerous regional examples of clinical leadership and excellence in this area.

With our combined expertise, our perspectives arising from various clinical backgrounds, and our direct connection to the lives of older people and their caregivers, we have much to contribute to the development of an Ontario Seniors Strategy. As such, we request to be included as active partners in all decision-making forums relevant to the care of older adults living with frailty. We are willing and able to assist in the achievement of successful health system transformation.

Submitted on behalf of the Regional Geriatric Programs and Specialized Geriatric Services across Ontario[7]*.*

[7] https://www.rgps.on.ca/regional-programs/

Contacts

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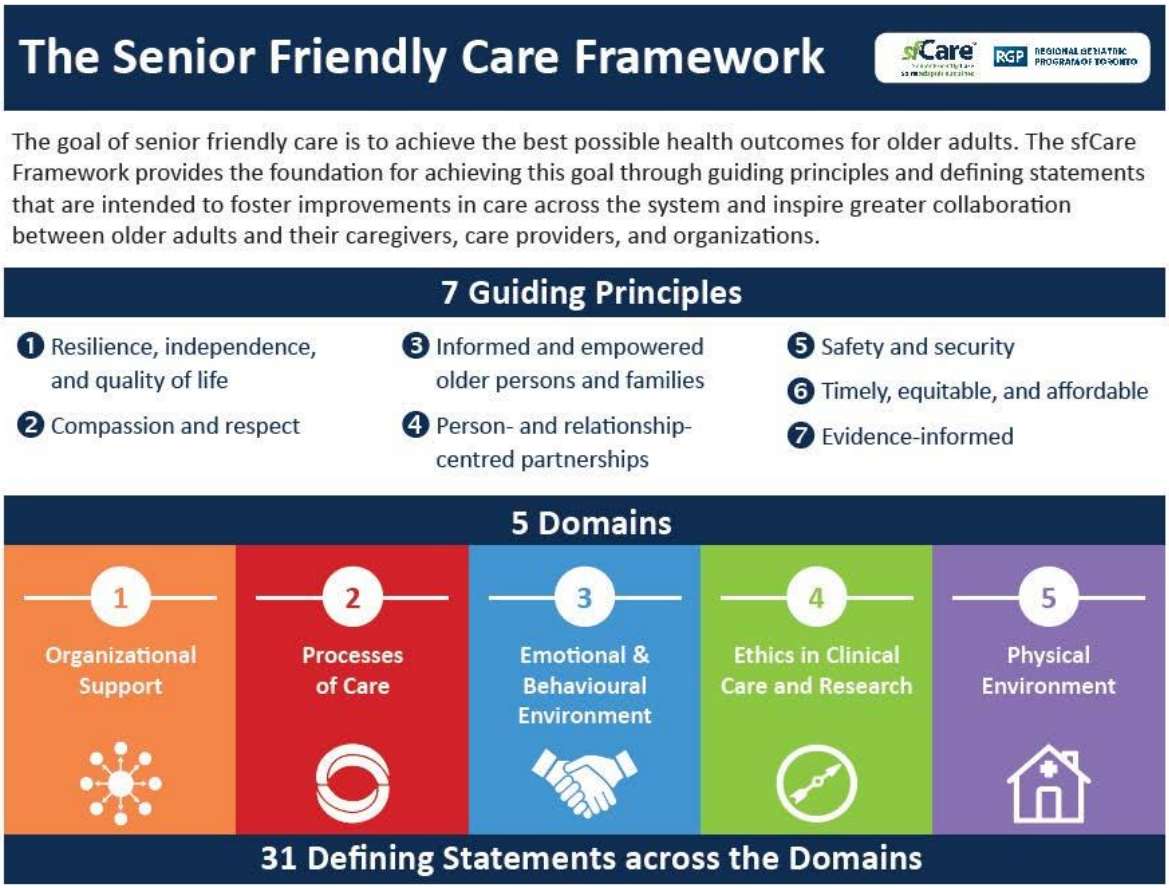
Other Key Contacts

Appendix 1: Senior Friendly Care Framework

https://www.rgptoronto.ca/wp-content/uploads/2018/04/sfCare-Framework-and-10-Recommendations.pdf



31 Defining Statements across the Domains

Organizational Support

1. Senior friendly care is an organizational priority
2. At least one leader in the organization is responsible for senior friendly care
3. There is organizational commitment to recruit and develop human resources with the knowledge, skills, and attitude needed to care for older adults
4. The values and principles of senior friendly care are evident in all relevant organizational policies and procedures
5. The organization has a senior friendly policy that values and promotes older adults' health, dignity and participation in care
6. The organization demonstrates commitment to all domains of the Senior Friendly Care Framework - organizational support, processes of care, emotional and behavioural environment, ethics in clinical care and research, and the physical environment
7. The organization collaborates with system partners to meet the needs of older adults
8. The organization implements standards and monitors indicators relevant to the care of older adults

Processes of Care

9. Assessment is holistic and identifies opportunities to optimize the physical, psychological, functional, and social abilities of older adults
10. Care addresses the physical, psychological, functional, and social needs of older adults
11. Care is guided by evidence-informed practice
12. An interprofessional model of care is preferred especially when older adults are frail
13. Care is integrated and provides continuity especially during transitions
14. Goals of care may include recovery from illness, maintenance of functional ability and preservation of the highest quality of life as defined by the individual
15. Older adults are partners with the care team
16. Care is flexible and aligned with an individual's preferences
17. Communications and clinical and administrative processes are adapted to meet the needs of older adults
18. Older adults are provided information in a way that makes it easy to understand so that they can make informed decisions

Emotional & Behavioural Environment 	19. The care provided is free of ageism and respectful of the unique needs of older adults 20. Care providers are able to identify and address issues of elder abuse and older adults' safety 21. The care of older adults is planned and delivered in alignment with their personal goals 22. Care providers demonstrate competency providing care to an older population with diversity in all its many forms 23. Care providers respect each individuals' breadth of lived experience, relationships, unique values, preferences and capabilities 24. Care is provided in a way that enables the older adult to feel confident in their care providers 25. Care is compassionate and sensitive to the needs of older adults 26. Family and other caregivers are valued and supported as care partners 27. Social connections are recognized as an important contributor to the health and wellbeing of older adults
Ethics in Clinical Care and Research 	28. Autonomy, choice and dignity of older adults are protected in care processes and research 29. Care is delivered in a way that protects the rights of older adults especially those who are vulnerable 30. An older adult will not be denied access to care or the opportunity to participate in research based solely on their age
Physical Environment 	31. The structures, spaces, equipment, and furnishings provide an environment that minimizes the vulnerabilities of older adults and promotes safety, comfort, functional independence, and well-being

10 Recommendations

These recommendations are comprehensive, action-based statements, which create the foundation for the sfCare Self-Assessment Tool and the Implementation Resources in the sfCare Getting Started Toolkit.

1. Commitments to the sfCare Framework are included in the organization's strategic plan, operating plan, and/or corporate goals and objectives.
2. Guiding documents (such as polices, standards, procedures, guidelines, care pathways etc.) reflect senior friendly values and principles; promote older adult's health, autonomy, dignity and participation in care; and ensure that an older adult will not be denied access to care or the opportunity to participate in research based solely on their age.
3. Education and/or training is provided to all staff on senior friendly topics.
4. Care delivery partners from all sectors have been identified, and collaborative processes exist to ensure information sharing and seamless transitions for older adults across the healthcare continuum.
5. Interprofessional assessment and care is guided by evidence-informed practice to optimize the physical, psychological, functional, and social abilities of older adults.
6. The older adult/caregivers are provided with information to let them know what to expect in their care, help them make decisions, and better self-manage their conditions.
7. The care plan, goals, and expected results of care are developed in collaboration with all members of the care team and the older adult/caregivers and aligned with the older adult's preferences.
8. A system is in place to measure the experience and outcomes of older adults and make improvements based on the results.
9. An approach is in place to support care providers and the older adult/caregivers in challenging ethical situations.
10. Structures, spaces, equipment, and furnishings provide an environment that minimizes the vulnerabilities of older adults and promotes safety, comfort, functional independence and well-being.

Note: Coloured numbers correspond with the sfCare Framework domains.

Supported by:

Ontario
Toronto Central Local Health Integration Network

Appendix 2: Reference Document - Other-Subcategories

#	Others- subcategory	Explanation
1	Information & Communications Technology (ICT)-enabled Integration & Care	Implementation of ICT-based solutions to improve health service delivery, management and planning: Example survey responses: ▪ *"Access to Connecting GTA for all"* ▪ *"Improved access to medical records/info cross the sector"*
2	Geriatric Workforce/Knowledge Enhancement	Strategies to increase the geriatric workforce and their skillset to better meet the needs of frail seniors; capacity building at a systemic/provincial level. Example survey responses: ▪ *"Increase geriatrician enrolment"* ▪ *"Health care disciplines need to incorporate adequate gerontology content in entry to practice programs"*
3	Financial Resources to support patients (and caregivers)	Provision of financial resources to patients and their caregivers to improve affordability of prescribed treatments and other medical necessities; alleviation of financial barriers. Example survey responses: ▪ *"Subsidized transportation with accompaniment"* ▪ *"…social/financial access to needed medication, medical supplies (diabetes, colostomy etc.) and mobility equipment)"*
4	Policy Reform/Alternative Models of Care	Responses suggesting: a) Significant changes to the existing health service delivery and management related processes through policy change; b) Introduction/implementation of alternative model(s) of care Example survey responses: ▪ *"…make PSW's public employees not privatized so they have decent wage……designate money to wages vs money going to pay private agency administration"* ▪ *"A review of the LTC Act to address the models of care"*

#	Others- subcategory	Explanation
		▪ *"Less fee-for-service driven care"*
5	Responsiveness to the Community Needs/Population Demands	Prioritizing community needs and population demands during strategic planning activities. Example survey responses: ▪ *"Understanding of current senior trends/care"* ▪ *"Blending the needs of early onset dementia clients into the Seniors Care Strategy"*
6	Infrastructure	The basic physical structures and facilities required for improved health service delivery and utilization. Example survey responses: ▪ *"increased LTC beds"* ▪ *"House - safe affordable ……. hard to find supports and houses for this group"*
7	Stakeholder Engagement/Subject Matter Expert (SME) Consultation	Strategic and planning activities are informed by inputs from patients, caregivers, community & system stakeholders, and subject matter experts. Example survey responses: ▪ *"Meaningful engagement with stakeholders in development of strategy"* ▪ *"That it is (Older Adult Strategy) informed and influenced by Regional Geriatric Programs/experts"* ▪ *"Authentic engagement with clients/patients, families and informal caregivers"*
8	Service Alignment	Alignment with Provincial policy direction
9	Access (to resources/services)	Responses suggesting equitable access to existing resources and health services; alleviation of barriers. Example survey responses: ▪ *"main central intake per city/region"* ▪ *"access to resources"* ▪ *"timely access"*

Appendix 3: Alignment of RGP/SGS Activity with the Premier's Council Recommendations (July 2019)

Premiers Council Recommendations[8]	**Regional Geriatric Programs and Specialized Geriatric Services (SGS) Related Activities and Opportunities**		
Theme	**Activity Name**	**Description**	**Links**
Integration			
1. Put patients at the centre of their health care. Patients should be well-supported and treated with dignity and respect throughout all interactions with the health care system.	Clinical Models: Person Centred Care	Our clinical work is modelled around the patient and their caregiver(s) as central (Figure 1). Across all specialized geriatric services, our approach to older person's care is consistent with international gold standard approaches and is supported locally by a provincial competency framework and related workforce training supports, developed by the RGPs of Ontario.	https://www.rgps.on.ca/wp-content/uploads/2019/04/CGA-RGP-ON-May-23-2018-without-pictures.pdf https://www.rgps.on.ca/initiatives/cga/
	Caregiver Education Resources	Funded by the Ontario Ministry of Health and Long-Term Care and working in collaboration with caregivers across Ontario, the project team is currently developing the *Caregiving Strategies Handbook: Providing Care and Support for a Senior Living with Frailty* and an online course to support the diverse needs of caregivers of seniors living with frailty. These are expected to be available for caregivers in the Fall of 2019.	https://www.rgps.on.ca/initiatives/cetp/
2. Improve patients' and providers' ability to navigate the health care system, simplify the process of accessing and providing care in the community, and improve digital access to personal health information.	Asset Mapping of Specialized Geriatric Resources	There are more than 440 SGS programs across Ontario, which reflect approaches to interprofessional geriatric team practice. Of these, roughly ½ identify as community based programs.	https://www.rgps.on.ca/wp-content/uploads/2019/05/Planning-for-Health-Services-for-Older-Adults-Living-with-Frailty-SGS-Asset-Mapping-Report-FINAL.pdf
	Models of Integrated Care	Among SGS programs are models of highly integrated care, inclusive of system navigation/embedded care coordination that provide a blueprint for community based	http://seniorscarenetwork.ca/wp-content/uploads/2019/05/2019-May-13-Geriatric-Assessment-and-Intervention-Network-GAIN-vFINAL.pdf

[8] Ibid

		health service design for older people. A fully integrated SGS system would enhance integration among specialized geriatric services, including Geriatric Medicine, Geriatric Psychiatry/Geriatric Mental Health and Addictions, Care of the Elderly Primary Care Physicians, and Interprofessional Geriatric Teams, and with primary care. In an integrated system, care coordination would focus on navigation that supports ▪ Procurement of and access to services ▪ Direct follow-up and follow-through support to assist individuals and care providers to take up recommended services and supports ▪ Monitoring of effect/impact of supports and reporting back to the clinical team	https://healthstandards.org/leading-practice/geriatric-emergency-management-plus-gem-plus/
	SGS Focused Coordinated Access	Many RGPs and SGS providers are working to create mechanisms for coordinating access to specialty services that will support faster access to services and more integrated, coordinated care. The RGPs of Ontario welcome the opportunity to expand successful models.	http://systemcoordinatedaccess.ca/wp-content/uploads/2016/08/SCA-BR-case-SGS.pdf
3. Support patients and providers at every step of a health care journey by ensuring effective primary care is the foundation of an integrated health care system.	Clinical Models	Many SGS models are fully integrated with primary care through mechanisms such as: ▪ Onsite co-location ▪ Shared EMR ▪ Collaborative care planning ▪ Embedded Geriatric Assessors (trained interprofessional team members)	https://www.rgps.on.ca/wp-content/uploads/2019/05/Planning-for-Health-Services-for-Older-Adults-Living-with-Frailty-SGS-Asset-Mapping-Report-FINAL.pdf
	Primary Care Collaborative Memory Clinics	In other cases, specialty services directly support primary care led efforts, such as Memory Clinics.	https://www.hqontario.ca/Quality-Improvement/Quality-Improvement-in-Action/ARTIC/ARTIC-Projects/Primary-Care-Memory-Clinics

Innovation			
4. Improve options for health care delivery, including increasing the availability and use of a variety of virtual care options.	Virtual Clinical Models: Geri-Med Risk e-Geriatric consults/OTN	GeriMedRisk is an interdisciplinary telemedicine consultation and education service for doctors, nurse practitioners and pharmacists in Ontario. Using telephone and eConsult, clinicians receive a coordinated response to questions regarding optimizing medications, mental health and comorbidities in older adult patients from a team of geriatric specialists and pharmacists. GeriMedRisk is a not-for-profit service for clinicians. SGS is experienced with virtual delivery of care through OTN and e-consult mechanisms. We have also tested the conduct of assessments through home based OTN connections. The RGPs of Ontario has also identified the need for an integrated and interoperable electronic health record and welcomes the opportunity to collaborate with Government to achieve this vision.	https://www.gerimedrisk.com/
5. Modernize the home care sector and provide better alternatives in the community for patients who require a flexible mix of health care and other supports.	Clinical Models – new and emerging	Many SGS programs report enhanced support for care plan implementation through attachment/embedding of home care supports (e.g. PSWs, care coordinators) to specialized geriatric service teams (e.g. GAIN). There are additional opportunities to adapt successful national and international models to the Ontario context. The RGPs of Ontario is willing to work closely with Government to transform/modify the existing	https://alzheimer.ca/sites/default/files/files/ab/ab_2019%2002%2028%20first%20link%20final%20evaluation%20report%20final.pdf http://www.advantageja.eu/images/WP7-Models-of-Care-a-Systematic-Review.pdf

		processes of managing and/or delivering home and community care to better integrate with clinical delivery infrastructure.	
Efficiency & Alignment			
6. Data should be strategically designed, open and transparent, and actively used throughout the health care system to drive greater accountability and to improve health outcomes.	Older adult specific data sets and standards Older Adult experience survey	The RGPs of Ontario is working to develop a provincial core set of patient experience measurement items targeting older adults living with frailty and other aspects of older person's care (see links) Consistent with the quadruple aim, the RGPs of Ontario have developed an evidenced-based patient experience survey that measures the patient experience accessing SGS in Ontario. The patient experience survey provides a set of standardized questions that will support common reporting and system wide evaluation that includes all RGPs in Ontario.	https://www.ichom.org/portfolio/older-person/ https://www.ichom.org/portfolio/dementia/ To be released summer 2019
7. Ensure Ontarians receive coordinated support by strengthening partnerships between health and social services, which are known to impact determinants of health.	Embedded clinical SGS models	Hosting of clinical SGS models in Community and Social Service Agencies has demonstrated enhanced access to community services, improved transitions and better coordination across services addressing the broader determinants of health (e.g. GAIN, geriatric outreach teams)	
8. As the health care system transforms, design financial incentives to promote improved health outcomes for patients, population health for communities and increased value for taxpayers.	Alternate Funding Plans Linked funding to ensure outcomes	AFP models will enable the practice of Care of the Elderly Primary Care Physicians. This is an underutilized resource, with less than half (47 of 143) of those trained and holding a certificate of added competence practicing in this specialty area due to challenges with viability of fee for service models for this group. Funding approaches whereby resources to implement care plans are held by the programs	https://www.rgps.on.ca/wp-content/uploads/2019/05/Specialized-Geriatric-Services-in-Ontario-RGPO-Final-Report_Apr1.pdf https://www.colleaga.org/case-study/champlain-geriatric-emergency-management-plus-gem-program-

		assessing the need for particular interventions are impacting length of stay. For example, in the GEM+ program, 21% of the program budget is for Geriatric Emergency Management Nurses and 79% is reserved for Adult Day program seats, so that patients referred by GEM to ADP can be guaranteed a space. Cost avoidance of the GEM+ Program at The Ottawa Hospital has been calculated as $1.9 million and a savings of 1,310 bed days for fiscal year 2012/13 (see link).	improves-outcomes-reduces
Capacity			
9. Address short- and long-term capacity pressures including wait times for specialist and community care by maximizing existing assets and skills and making strategic new investments. Build the appropriate health care system for the future.	sfCare Learning Series	Co-developed with geriatric clinical experts from Ontario, on behalf of the Regional Geriatric Programs of Ontario, the sfCare Learning Series comprises introductory educational modules for clinicians, along with supporting posters and patient handouts on 7 key clinical topics: delirium, mobility, polypharmacy, pain, loneliness, nutrition, and urinary incontinence. This initiative can support the Government's efforts to increase the number of HCPs and the skillsets of HCPs involved in the care of frail seniors	https://www.rgptoronto.ca/resources/search/?key=sfCare%20Learning%20Series
	Enhance capacity existing through proven SGS models.	The RGPs of Ontario have identified that expert clinical care is proven to best respond to important challenges to providing care for older people living with frailty which include: an increased number of co-existing chronic conditions, contact with an increased number of health care providers and addressing needs beyond health care[9]. We welcome the opportunity to collaborate with Government to expand access to these services,	https://www.rgps.on.ca/wp-content/uploads/2019/05/SGS-Position-Statement-on-the-Need-for-Expert-Clinical-Care-of-Older-People-Living-with-Complex-Health-Conditions-v2019-May-7-FINAL.pdf

[9] https://www.ices.on.ca/~/media/Files/Atlases-Reports/2011/Health-system-use-by-frail-Ontario-seniors/Full%20report.ashx

		particularly in rural and remote communities, by building on current capacity planning efforts. This would include developing and deploying interprofessional teams skilled in evidence informed frail senior care (including dementia care) across the province in proportion to population estimates of frailty by location. The RGPs of Ontario welcomes opportunities to collaborate with government to address the shortfall in physician human resources in geriatric specialties by right sizing residency positions to match demand and improving the attractiveness of geriatric specialties.	https://www.rgps.on.ca/wp-content/uploads/2019/05/Specialized-Geriatric-Services-in-Ontario-RGPO-Final-Report_Apr1.pdf
10. Champion collaborative and interprofessional leadership development focused on system modernization capabilities.	Interprofessional Clinical Leadership Infrastructure	The RGPs of Ontario Provincial Geriatrics Leadership Office has defined a provincial leadership stricture that engages clinical leadership and caregiver representatives from across the province in system redesign. We welcome the opportunity to collaborate directly with government on issues of common interest in the care of older people living with complex health concerns (e.g. dementia, frailty, mental health and addictions)	