APPENDIX A: SUMMARY OF INTEGRATED MODELS OF CARE (Building on a document created by the Mississauga Halton LHIN)

Building Blocks	Coordinated, Accessible Community Healthcare for Elders in Toronto (CACHET)
Level of Integration	Fully integrated
Vision, Principles, Goals	Vision: A health system for seniors supports the independence and autonomy of individuals through integrated services which are universally available and provided in an equitable, accessible and affordable manner. In all settings, services for seniors will focus on optimizing each person's independence, health, functioning and quality of life.
Population	65 +
Size of Population (Catchment vs. resident)	Defined geographic catchment area
Points of Access/Entry	Model is based on a single entity (the CACHET "agency") having sole responsibility for providing all five functions. The entity could be an individual organization, a strategic partnership between organizations or a network of organizations.
Scope of services provided	The agency provides or brokers the following services or programs: - community support services - primary health care - in-home professional services - intensive case management - supportive and supported housing - emergency response services - social and recreational programs - prevention and health promotion - specialized geriatric services - ethno-cultural specific services
Approach to Assessment	Individual has first contact with a trained intake worker who will use a common assessment tool as appropriate to the individual's circumstances. The assessment is graduated, becoming more detailed as the individual's care/service needs increase. The tool is standardized across Toronto and includes an evaluation of the individual's health status as well as medical, cognitive, psychological, social, recreational, financial, social and spiritual needs. The tool identifies if the individual is eligible for LTC admission and at what level. It allows the grouping of individuals according to their care and resource needs and is used to determine the needs in the catchment area. Updates are on an as-needed basis if the individual's status changes.
Consistency of Care Classification	N/A - No detailed information available in the literature
Linkages to and Fit within the Continuum	N/A - No detailed information available in the literature

Building Blocks	Coordinated, Accessible Community Healthcare for Elders in Toronto (CACHET)
Information Requirements and Flow	With an individual's consent, this info is shared with the appropriate care providers. Creation of a single, shared database.
Accountability	Rests solely with the CACHET agency for intake; assessment; information and referral; case management coordination / care coordination services. CACHET agencies are accountable to the MOHLTC through the regional office; who is responsible for issuing CACHET agency designations; agencies financially accountable to MOHLTC for both capitated and global budgets.
Performance Management	IF there is insufficient capacity to provide the minimum basket of services the CACHET agency is required to prepare a business case to the MOHLTC Potential outcome indicators could include: - hospitalization rates; functional status; ER visits
Coordination	Informally through meetings of the Executive Directors or an association. Infrastructure to ensure proper coordination will be required for example: - info sharing protocols; - coordinated / harmonized policies; - single, shared database
Other Features	Drew on lessons learned from PACE, On Lok (US), CHOICE (Alberta), SIPA (Quebec). - Funding – agency gets global funding for their core services that include the 5 functions as well as administrative costs such as IT, TQM, and volunteer coordination. - Recommends the option of capitation to cover both government funded services and fee-for-service programs.

Building Blocks	Comprehensive Home Option of Integrated Care for the Elderly (CHOICE)
Level of Integration	Fully integrated
Vision, Principles, Goals	Vision: health promotion through nutrition, exercise and social contact. Goals: - Maintain participants in their own homes and communities as long as possible; - Reduce participants' use of facility-based inpatient and ambulatory care services; - Improve patients' health status and quality of life
Population Definition	Clients are selected according to relatively strict inclusion (degree of disability compatible with admission to a nursing home) and exclusion (e.g., behavioural problems) criteria. These systems usually function in parallel with the socio-health structures in place. Serves the elderly who are eligible for placement in a nursing home, but can be provided service in their own homes. - unable to be managed with home care and other community resources/services - commitment by family and candidate to live at home and attend CHOICE program - chronic medical conditions that require ongoing medical monitoring and treatment - heavy users of health care services - > 60 years (some exceptions based on need) Currently 39% functionally frail; 18% dementia; 31% medically frail; 12% chronic mental illness Avg age: 78.4 yrs
Size of Population (Catchment vs. resident)	Resident within the region
Points of Access/Entry	Single point of entry through Capital Health Authority facilitates access to one of 5 CHOICE programs throughout Edmonton. Through day health centre, health clinic, home support, sub-acute care beds, respite beds in the facility. Also includes transportation and emergency response.
Scope of services provided	24-hour care including: - Day centre - health clinic - home services - transportation - short term care beds - 24 hour response - Medical monitoring and treatment by CHOICE physicians, psychiatrists and nurses - Foot care, dental and eye care screening - Physical, occupational and recreation therapy - Personal care - Social work, spiritual care - Health education - Assistance with meals and nutrition - Support and encouragement of participant and families - Opportunities to take part in social activities - Home care - Loan of equipment such as walkers and railings - Transportation to and from the CHOICE Programs - Short-term stay while they receive treatment for illness - Respite care
Approach to Assessment	Common assessment by an interdisciplinary team includes: physician; advanced practice nurses; RN; LPN; PT; OT; pharmacist: home support coordinator; RT; SW; dietitian; geriatric psychiatry consultation team; personal care attendants; unit clerk; transportation coordinator
Consistency of Care Classification	N/A - No detailed information available in the literature

Building Blocks	Comprehensive Home Option of Integrated Care for the Elderly (CHOICE)
Linkages to and Fit within the Continuum	N/A - No detailed information available in the literature
Information Requirements and Flow	N/A - No detailed information available in the literature
Accountability	15 member boards oversees health services for the greater Edmonton area. Capital Health role includes - Develop program standards - "single point of entry" to all CHOICE sites - Receive referrals and conduct assessments - On-call nursing coverage - Monitor and evaluate programs - Maintain region-wide database
Performance Management	N/A - No detailed information available in the literature
Coordination	-Integrated team with case management approach including client and caregivers - Primary care physicians are team members - Take a preventative and early-intervention approach - All program staff are CHOICE employees
Other Features	Born in Edmonton, designed out of PACE. Proven to promote improvements in: - early detection - continuous management of chronic illness - rehabilitation - maximization of self care potential - risk management Cost/Day - $68.74 ER use by the elderly in the Capital Region has decreased by 63 percent, and the use of outpatient services has dropped by 31 percent. The challenge for CHOICE has been to provide a comprehensive menu of services from a very limited funding base. Other limitations: - optimal services for a limited number - rising medication costs - need to client to come to the program - not all-inclusive (like PACE program)
Evaluation	Evaluation results (Tell, 2002): – inpatient utilization reduced by 52% (annualized cost reduction of $1.2M) – ambulatory services utilization reduced by 25% (annualized cost reduction of $40,000) – ambulance claims reduced by 11% (annualized cost reduction of $7,000) – pharmaceutical claims reduced by 86% (annualized cost reduction of $313,000) McAdam, 2000 (Quasi-experimental; pre-post study design): Data from independent program evaluation: – clients and family were satisfied with program – improved quality of life – decreased use of ambulatory care services, inpatient services, ambulance and medication – participants were able to remain in the community at less cost than if they were not in the program.

Building Blocks	**Expert Geriatric Services Project (EPS)**
Level of Integration	Fully integrated
Vision, Principles, Goals	Vision: To improve the access to expert geriatric resources in their community by creating an integrated service and team that includes specialist physicians, non-physician geriatric assessors and access to other disciplines. Goals: - Increasing the number of clients/patients that can be seen; - Decreasing the length of time to service; - Reducing the need for hospitalization for the elderly with complex needs; - Improving the quality of life for the elderly with complex needs and their families; and - Providing better support for physicians including the geriatrician, geriatric psychiatrist and primary care physicians.
Population Definition	Primary target group is: - 65+ - Resident in Wellington-Dufferin counties; and - With complex medical and/or psychiatric needs
Size of Population (Catchment vs. resident)	Residents of Wellington and Dufferin counties (approx. 30K in 2006)
Points of Access/Entry	A single point of access to all Expert Geriatric Services followed by triaging and assignment to the appropriate 'arm' - geriatric medicine or the geriatric psychiatry (mental Health)
Scope of services provided	Services defined as: - a range of health care services, which diagnose, treat and rehabilitate frail elders with complex and multiple medical, functional and psychosocial problems; provided on a consultative basis by interdisciplinary team of professionals in a variety of home, ambulatory, long-term care facility and in-patient hospital settings; and whose goal is to reduce the burden of disability by detecting and treating reversible conditions and recommending optimal management of chronic conditions
Approach to Assessment	Assessed in their home or facility by a skilled geriatric assessor (non physician) using a standardized assessment tool. Prior to carrying out the assessment, all available information relating to the client/patient and their needs will be gathered from formal and informal care providers. The information gathered through the assessment process is utilized by the geriatrician or geriatric psychiatrist as the starting point for their assessment. The report is then shared, with consent, with the primary care provider, the client/patient and their family and other service providers as appropriate.
Consistency of Care Classification	N/A - No detailed information available in the literature

Building Blocks	**Expert Geriatric Services Project (EPS)**
Linkages to and Fit within the Continuum	EPS acts as a resource and support to the ongoing care system – primary care; hospital care; community care; LTC; and other specialty services, but doesn't replace these components of the health system.
Information Requirements and Flow	The work of the WCHN's Information Technology (IT) Working Group has flagged the importance of an electronic health record and the development of the appropriate network connectivity infrastructure that would support the timely transfer of client/patient information. In addition, the IT Working Group has recognized the value of enhancing videoconferencing capability across the WCHN to facilitate shared educational opportunities. Linkages across sites through technology can also support clinical assessment and consultation to the more rural parts of Wellington-Dufferin and allow for effective deployment of scarce resources such as geriatric specialists.
Accountability	Joint Management Team is responsible for program oversight, development, monitoring and evaluation, system level service planning and capacity building.
Performance Management	Areas for inclusion in an evaluation are: pre-post evaluation of the impact of training for the CMHC Seniors team; evaluation of satisfaction with and impact of service partner training initiatives; and evaluation of client/patient outcomes. The development of a database for the integrated service prior to implementing the service will provide the foundation for future evaluation and monitoring of the service.
Coordination	By EGS Joint Committee – includes Shared EGS Program oversight; development; monitoring and evaluation plus System-Level Service Planning and Capacity Building.
Other Features	N/A
Evaluation	N/A

Building Blocks	Evercare
Level of Integration	Fully integrated
Vision, Principles, Goals	Principles: - Apply an individualized, whole-person approach to care of older persons with all interventions focused on promoting maximal function, independence, comfort, and quality of life. - Use primary care as the central organizing force for health care across the continuum. - Provide care in the least invasive manner, in the least intensive setting. - Avoid adverse effects of medications and polypharmacy. - Use data to strengthen decision-making. Goals: - Look at the entire system from a patient's point of view and correcting the most serious gaps or duplications in the care pathway. - Assure care is delivered in the least intensive setting consistent with patient needs in order to use resources to benefit the broadest group of patients. - Reallocate existing resources to new purposes rather than assigning new resources.
Population	65+ (also see points of access/entry below)
Size of Population (Catchment vs. resident)	Residents in 9 NHS counties
Points of Access/Entry	- Hospital data used to identify individuals 65+ with 2+ unplanned hospital admissions within the last 12 months; or - Patients nominated by GPs to be at high-risk for hospitalization.
Scope of services provided	Varies with community but examples include the following: - A case manager who will work with doctors and providers to manage the enrollee's health care needs - Coordination of Medicaid and Medicare benefits - Access to a large network of contracted doctors, nursing homes, assisted living facilities and pharmacies - Coordinating access to a range of services including: - Adult day health care - Attendant care - Emergency alert systems - Home health services - Home delivered meals or meal preparation assistance - Home modifications - Housekeeping - Nursing - Personal Care -physician and hospital services; -home health aide services; -respite care; -adult day care; -housekeeping and chore services; -escort services to medically necessary appointments; -prescription drugs from our contracted pharmacies; -and, medical supplies and equipment.
Approach to Assessment	(US approach): Assessment within thirty days of joining an HMO. UHG uses Medicare claims data to identify individuals whose history matches them (e.g. diabetes at high risk of further complications and need for treatment). The presence of four chronic conditions is the normal trigger for a nurse visit to the nursing home to assess the patient first hand. The Clinical Risk Assessment tool provides a methodology for the APN to place the patient in an appropriate risk category.
Consistency of Care Classification	N/A - No detailed information available in the literature

Building Blocks	Evercare
Linkages to and Fit within the Continuum	N/A - No detailed information available in the literature
Information Requirements and Flow	Certain Evercare sites were able to link PCT data with NHS trust discharge data and data held on general practice systems. Similarly, the EPIC project depended on data management and IT skills, and integrated data sharing between primary and secondary care.
Accountability	Nothing specific – in the US the United Health Group (owners of Evercare) are organizationally accountable to ensure the funds are spent efficiently.
Performance Management	The project established several indicators linked to their principles to determine if the model had an impact including: - # of unplanned hospitalizations to the hospital in the past year; - nomination by a general practitioner (e.g., bereaved; falls; medical complications; presence of psychosocial issues) - Risk for future hospitalization (high/med/low) - patient and family/carer surveys - # nurse encounters with patient and/or carer - the use of surveys, interviews and focus groups of key NHS staff members involved in the Evercare programme.
Coordination	Specialist nurses known as "advanced primary nurses" (APN) have a case load of patients whom they contact on a regular basis. The advanced primary nurses co-ordinate the care that the patient is receiving and monitor the patient and educate family and carers, particularly to spot changes in the patient's condition.
Other Features	
Evaluation	

Building Blocks	**Program of All-Inclusive Care for the Elderly (PACE)**
Level of Integration	Fully integrated
Vision, Principles, Goals	Vision: to continually lead the movement to improve care for the elderly. Goal: - Helping seniors live at home and in the community for as long as possible by providing healthcare, housing and intergenerational programs that meet the needs of seniors.
Population Definition	Voluntary, and limited exclusively to disabled older persons age 55 and over, certified by their state to need nursing home care, able to live safely in the community at the time of enrollment and live in a PACE service area.
Size of Population	Resident, as certified by their state (resident vs. catchment)
Points of Access/Entry	Care provided in the following venues: the PACE centre; the home or inpatient facilities. An adult day health center typically becomes the focal point of service delivery and most services are often provided directly in the day center setting.
Scope of services provided	PACE provides full, 365-day, in-depth coverage for all services, including long term care in the home, community, and institutional settings. Services provided include the following: - Interdisciplinary assessment and care planning - - - PACE Center services - Primary and specialty medical care - Nursing home (sub-acute to long- term residence) - Home care and home health, Home care aides - Nursing, Physical, occupational and speech therapies - Social services - In-patient and out-patient hospital - Diagnostic services including lab and x-ray - Emergency and non-emergency transportation - Prescription and non-prescription drugs - Speech-language pathology services - Nutrition services and Home-delivered meals - Podiatry - Optometry and eye glasses - Audiology and hearing aids - Dental care - Medical equipment and supplies - Orthotics and prosthetics - Personal emergency response system - Social and environmental supports
Approach to Assessment	High level of interface between the team and family/caregiver occurs in the continuous process of assessment/ reassessment.
Consistency of Care Classification	The needs of PACE participants are reviewed regularly by an interdisciplinary team, so presumably all of them share a common classification lexicon.
Linkages to and Fit within the Continuum	When a patients' status changes and one venue no longer fits his/her needs, the multidisciplinary team will reassess the patient and move them to the most appropriate care setting. The principal care management mechanism in PACE is the interdisciplinary team which directly provides and coordinates all services for the individual. Considerable staff time is devoted by team members to formal and informal idea and information exchange; formal meetings account for approximately 8-hours weekly per participant.

Building Blocks	Program of All-Inclusive Care for the Elderly (PACE)
Information Requirements and Flow	PACE uses a comprehensive set of assessment tools. This is part of an automated data system (DataPACE), which was designed specifically for the program and is used across all sites. This battery of discipline-specific instruments enable physicians, nurses and social workers to independently collect information on all aspects of patient health status and functioning. This patient profile forms the basis of the care plan, which is periodically updated. The care plan is used to "order" services, and serves as the bridge to both internal and external resources.
Accountability	PACE programs may contract for services, but the interdisciplinary team maintains full control of the treatment plans and retains responsibility for the provision of all services.
Performance Management	Small changes are monitored by all members of the interdisciplinary team. PACE has been found to have positive outcomes in terms of shorter lengths of hospital stay, improved health status and quality of life, lower mortality rates, increased choice in how time is spent, greater confidence in dealing with life's problems.
Coordination	PACE provides and coordinates all levels of care for the participant. Integration allows for focused, longitudinal care management which spans time, setting and health care professions. Chronic care trajectory can be controlled and necessary services accessed immediately.
Other Features	SIPA, CHOICE are programs based on the PACE model. Financial support based on capitation base with Medicare and Medicaid.Limitations: - implementation takes time and financial commitment before the benefits are realized - patients and health care providers need to be educated on the benefits of the program - Catchment areas need to be established so as to limit the travel time of frail patients to the centre. **Factors Critical to PACE Success:** *General* - Manage care to control variable costs (e.g. home care, ADHC attendance, pharmacy, inpatient utilization) - Manage risks for acute and long-term care services - Working collaboratively with families or other informal social networks to achieve effective outcomes *Communication* - High level of communication ensures changes in participant social, health and functional abilities are identified - Ensures all services are managed consistently and appropriately - May require reducing services if necessary Collaboration - Removing barriers between professions creates care management that is greater than the sum of its parts - Holistic care for the participant achieves outcomes not found in other models
Evaluation	Eng et al., 1997 (Quasi-experimental – nonrandomized design): In comparison to patients who qualified but chose not to enroll, those in PACE had: • Greater use of specialist physician care • More appropriate use of prescription drugs • Comparable acute bed days to general Medicare population, despite much sicker clientele Shannon & Van Reenen, 1998: Data from the National Pace Association: PACE has reduced use of hospital and nursing home care. Although all enrollees are eligible for nursing home care, only 7.2% of participants are in nursing homes.

Building Blocks	System of Integrated Care for the Frail Elderly (SIPA)
Level of Integration	Fully integrated
Vision, Principles, Goals	Principles: - be a community system based on primary care, which is responsible for the full range of health and social services; - be responsible for the care of a defined population; - provide case management, with clinical responsibility for the entire range of services provided; - be funded on a prepayment basis - be publicly managed Goals: - increase community care to decrease hospital and nursing home utilization; - maintain overall health outcomes - increase client satisfaction - increase quality of care - maintain out-of-pocket costs to the client - do not change per capita costs
Population Definition	75 + Includes elderly people eligible for nursing home entry as well as frail elderly with disabilities who need help to remain in the community and who may benefit from proactive intervention, prevention and rehabilitation. SIPA would serve as a single entry point for all frail elderly, who are deemed eligible if they have severe disability in 1 of the following areas, or mild to moderate disability in 2: activities of daily living, instrumental activities of daily living (such as financial management or meal preparation), mobility, mental status or continence.
Size of Population (Catchment vs. resident)	Resident – CLSC driven (regional authorities); but could be defined according to existing communities or catchment areas in other provinces.
Points of Access/Entry	Recruitment by the clinical personnel working for the CLSC home support services department, for an evaluation of their functional ability using the SMAF instrument.
Scope of services provided	All primary and secondary medical and social services; - Prevention, - Rehabilitation; - medication - technical aids; - LTC - 24-hour nursing hotline
Approach to Assessment	The primary care physician plays a key role in the SIPA model, to ensure continuity of care. With the ability to mobilize community resources quickly and flexibly, including co-management with the SIPA physician when necessary, the SIPA model facilitates the work of the family physician. Other features: - Multi-disciplinary teams worked together; - Case managers participated in planning hospital discharges; - Care protocols were implemented into clinical practice
Consistency of Care Classification	N/A - No detailed information available in the literature
Linkages to and Fit within the Continuum	Consolidated model of case management by organizing and providing most community services. For contracted services, including those obtained in an acute care hospital or LTC institution, SIPA maintains its financial responsibility for costs incurred and shares the clinical responsibility.

Building Blocks	System of Integrated Care for the Frail Elderly (SIPA)
Information Requirements and Flow	N/A -no detailed information was available in the literature
Accountability	CLSC has organizational responsibility. Depending on the jurisdiction, this responsibility might be given to a consortium of public institutions, including acute care hospitals and long-term care institutions, physicians and other professionals, and community organizations.
Performance Management	The evaluation of quality would be an essential component of this system. The SIPA model proposes ongoing evaluation of clinical care and administrative and financial activities based on an information system that is monitored not only internally but also by independent external groups. Some research evaluation studies have been conducted, looking at the change in configuration of costs, reduction in inappropriate hospital institutional care and an overall increase in community intervention without an overall increase of costs.
Coordination	The primary care physician would play a key role in the SIPA model and the elderly would be encouraged to remain with their primary care physician. SIPA would facilitate the work of the family physician. SIPA would also be responsible for physician payment.
Other Features	Interdisciplinary team comprising health and social services professionals using a consolidated model of case management provided care. Services that are contracted by the team are paid for through SIPA and the interdisciplinary team remained integral in the treatment of enrollees. Implementation Challenges: - shortage of certain categories of professionals - intensification of home care services was less than expected - Case managers' duties evolved over time; caseloads reduced and they maintained clinical responsibilities related to their original professions - Physician's availability was below expectations and varied considerably - Case managers were unable to integrate physicians into their practices Successes: - reduction of patients in hospital while awaiting placement; shorter ER stays; fewer admissions from ER; improved access to community physicians, home care services (nurses, homecare workers, social workers, OT, PT); higher patient satisfaction; lower costs of institutionalization and ER services; higher home care costs for RN, OT, PT.
Evaluation	Interim evaluation report – RCT Results (Johri, Beland, & Bergman, 2003): – Significant increase in influenza and pneumoncoccus vaccination rate – Greater use of community services and technical aids – No statistically significant difference in use of hospital emergency services, but a trend toward lower use. – Trend toward lower emergency physician costs (23% less)

Building Blocks	Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA)
Level of Integration	Coordination
Vision, Principles, Goals	Goals: -create a coordination (i.e., not full integration) model, including public, private and voluntary organizations, that may be more appropriate for a publicly funded health system • Include mechanisms and tools designed to improve continuity of care
Population Definition	65+ Moderate-to-severe disabilities (e.g., SMAF score ≥ 15/87, or other measure of functional autonomy Good potential for staying at home Requires two or more health care or social services
Size of Population (Catchment vs. resident)	Resident
Points of Access/Entry	The single-entry point is the mechanism for accessing the services of all health care institutions and community organizations in the area. Resources are accessed by patients, family members and professionals through written referral or telephone. A link with the Health Info Line is available to patients 24/7. Clients are referred after a brief screening (using a standard screening instrument – PRISMA-7) to
Scope of services provided	N/A - No data could be found in the literature
Approach to Assessment	Case management process; single assessment instrument based on clients' functional autonomy. The case manager is responsible for thoroughly evaluating the clients' needs, planning the required services arranging to admit clients to these services. See chart below. A single assessment instrument SMAF is a 29-item scale developed according to the WHO classification of disabilities. It covers five areas: Activities of Daily Living; mobility; communications; mental function and instrumental activities of daily living
Consistency of Care Classification	Uses a case-mix classification system based on functional autonomy.
Linkages to and Fit within the Continuum	Integrates and links with both the ongoing care systems and other specialty services utilized by the elderly with complex needs. The service functions as a support and resource to the ongoing care system. The close and continued involvement of the client/patient's primary care physician or provider is essential to the provision of the Expert Geriatric Service.

Building Blocks	Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA)
Information Requirements and Flow	N/A -no detailed information was available in the literature
Accountability	EGS will utilize referral to specialized services such as rehabilitation as part of the treatment recommendations arising from the assessment. Other specialty services such as ER services and hospital acute care services may also utilize the EGS as part of their provision of services. EGS will utilize referral to specialized services such as rehabilitation as part of the treatment recommendations arising from the assessment.
Performance Management	[BV] No data could be found in the literature, regarding performance management of the system. There is a research article on the evaluation of the system, but nothing about internal controls.
Coordination	- Service Coordination Committee - multidisciplinary team of care providers (led by the case manager) - Coordination exists between decision makers and managers of different organizations and services
Other Features	Comparative analysis: In contrast to other models, PRISMA allows individual organizations and services to continue to function independently, while providing the necessary integrated assessment and continuity of care. Evaluation: In a recent cohort study, fewer people who had moderate-to-severe disability at entry experienced a functional decline. Desire to be institutionalized was positively and significantly lower by the study group at 12 and 24 months; use of acute hospitals was similar; risk of a return ER visit was significantly reduced; risk of being institutionalized was lower.
Evaluation	Hebert et al., 2003 In comparison with a usual care cohort: – Reduced incidence of functional decline – Reduced burden on caregivers – Lower proportion of elders wanting to be institutionalized – Reduced use of acute care hospitals – Reduced risk of returning to Emergency department after discharge.

Building Blocks	**All-inclusive Seamless Services for Independence of Seniors for Today and Tomorrow (ASSIST)**
Level of Integration	Fully integrated.
Vision, Principles, Goals	**Vision:** Working together for seniors' good health. **Mission:** Maximizing health and independence in seniors through an integrated and comprehensive continuum of care. **Principles:** Dignified, Evidence-based practices, Choice, Continuum of Care, Interdisciplinary, Easy access, Joint accountability, Sustainable, Passionate. **Goal:** To design and successfully implement an integrated service delivery model for the seniors of the Mississauga Halton LHIN that fully embraces the guiding principles, and pushes the boundaries by innovatively applying the best available evidence-based practices.
Population Definition	55 or older; targeted to a younger population for proactive health promotion, disease prevention and wellness interventions that may delay or prevent onset of disease in the future.
Size of Population (Catchment vs. resident)	Residents within the Mississauga Halton LHIN.
Points of Access/Entry	Access to services through any provider or a Central Call-in number.
Scope of services provided	**Local Level** – Emphasis on preventative, supportive and primary care. Examples include, but not limited to: Seniors Health & Wellness Centres; FHT and Primary Care Doctors; Health Promotion and Disease prevention; Community Services & Agencies; Adult Day Programs; Supportive Housing **Sub-LHIN Geographic Area Level** – Focus on health conditions that require more specialized and intensive health resources: Long Term Care; Emergency Room/Urgent Care; Hospital based care such as access to sub-specialists such as orthopedics, ophthalmology, specialists of Internal medicine, geriatric assessment. **LHIN-wide Level** – Focus on highly complex specialty care and resources for geriatric populations: Psycho geriatric Behaviour Units/Outreach Teams; Geriatric Assessment Units (These specialized units to operate effectively require a critical mass of patients to justify the presence of a specialized geriatrician). **Inter-LHIN and Provincial Level -** Access to quaternary services, academic health sciences and the flexibility to utilize inter-LHIN referral patterns: Academic Teaching Centres; Regional Geriatric Program; Highly complex quaternary services.
Approach to Assessment	**Standardized Screening, Triage, Assessment and Follow-up Process** - approach to assessment is standardized, graduated and automated. Model for this process to be developed.

Building Blocks	**All-inclusive Seamless Services for Independence of Seniors for Today and Tomorrow (ASSIST)**
Consistency of Care Classification	Care Coordinators linked to primary care physicians/FHT through the Seniors Health and Wellness Centres and are integral to system navigation and care delivery.
Linkages to and Fit within the Continuum	Coordinator of Integrated Services for Seniors to oversee and manage transformation to the integrated model. This role is responsible for the overall management of a highly complex project with multiple sub-projects working simultaneously with significant interdependencies.
Information Requirements and Flow	Detailed data collected is required to determine the array of services available in each of the geographic regions and then to select the most critical detailed planning and action teams, the detailed data collection is required: an assessment of the current and future numbers and distribution of seniors will need to be conducted, including an assessment of transportation needs and a proposal put forth; quantitative (e.g., MOHLTC Information Management Service Centre, the regional planning departments, Public Health, etc.) and qualitative information (e.g., Mississauga Halton Community Engagement Framework that will be focused on seniors and their circle of support to gain valuable insights on their needs, what is working and what is not working in the current system.
Accountability	Two levels of accountability is proposed – first the *Coordinating Council* at the macro level that will approve and commit resources and the other the *Project Steering Committee* at the project level to provide guidance and support for the implementation planning.
Performance Management	Evaluation will include the following areas: Detailed understanding of the problems, challenges and issues facing seniors, care givers and the circle of support; Detailed needs assessment; Detailed analysis of current services that enables the leveraging of service excellence (e.g. Adult Day Services within Halton and Peel); Detailed gap analysis per geographic region; and Review of existing programs and services to identify duplication and opportunities for improved efficiencies and effectiveness.
Coordination	**Care Coordinator:** Care coordinator moves with the patient across the entire continuum. This role will focus exclusively on seniors and exhibit passion and depth of knowledge in complex needs and system navigation. Care coordinators are linked to primary care physicians to ensure proactive case finding for high risk individuals.
Other Features	Other initiatives: Traveling Patient Record as a precursor to the Electronic Patient Record; Falls Prevention Initiative; Pharmacy 'Watch Dog' and Technology Solution (pharmacists involved in the promotion, prevention and pro-active case finding by developing approaches to monitor drug interactions across drugs and across providers; Collaborative development of a plan to enhance long-term care homes; implementation of linkage strategies between long-term care homes and other sectors; enhancing resources in long-term care homes (e.g. addition of nurse practitioners; introduction of special behavioural units; Build on the End-of-Life Strategy to develop a comprehensive approach for Palliative Care.

Building Blocks	Tiered Model of Psychogeriatric Service Delivery
Level of Integration	Coordination
Vision, Principles, Goals	Qualities that define a good service: Comprehensive assessment and management, accessible, responsive, individualized, transdisciplinary, accountable, and systemic.
Population Definition	Older persons
Size of Population (Catchment vs. resident)	Catchment
Points of Access/Entry	The single-entry point is the mechanism for accessing the services of all health care institutions and community organizations in the area. Resources are accessed by patients, family members and professionals through written referral or telephone. A link with the Health Info Line is available to patients 24/7. Clients are referred after a brief screening (using a standard screening instrument – PRISMA-7) to
Scope of services provided	Model depicts tiers in ascending order of severity and decreasing levels of prevalence (Tier one: No mental disorder, universal prevention; Tier 7: Extreme mental disorders, intensive specialist psychogeriatric unit, prevalence rare). Aim is prevent individuals from moving up tiers. Services also include: selective prevention, management through caregiver, staff, general practitioner education in liaison with psychogeriatric services, psychogeriatric consultation, case management by multidisciplinary psychogeriatric outreach teams, management in psychogeriatric or neurobehavioral units or dementia specific units.
Approach to Assessment	Not described.
Consistency of Care Classification	Based on severity of mental disorder; prevention strategies are targeted at known risk factors.
Linkages to and Fit within the Continuum	Integrates and links with other services in the tiered system – Individuals with mild- moderate mental disorders (in the middle tiers) are treated in primary care, often in collaboration with specialized mental health services for older people (psychogeriatric consultation/ outreach teams). Individuals in the top tiers, with severe mental disorders, usually require institutional care.

Building Blocks	Tiered Model of Psychogeriatric Service Delivery
Information Requirements and Flow	Not available
Accountability	Tiered model provides a rationale basis for planning comprehensive service delivery across the full range of disorders, based on population health statistics (prevalence). Targeting funding to lower levels may reduce the demand for higher level services.
Performance Management	Not available
Coordination	By primary care at lower levels; at higher levels: case management.
Evaluation	Evidence-based: Tier 1 and 2 (prevention) interventions are based on evidence of risk factors for mental disorders and essentially promote healthy lifestyles. There is good quality evidence supporting the effectiveness of the interventions outlined in later tiers (multidisciplinary case management team approach); less evidence available on cost-effectiveness.

APPENDIX B: CONTINUUM OF HEALTH AND LONG-TERM CARE SERVICES FOR SENIORS WITH MENTAL HEALTH NEEDS AND THEIR CARERS/CAREGIVERS