Evaluation Focusing: Development of an Evaluation Framework for Specialized Geriatric Services in the Central East Local Health Integration Network

Final Report

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"Health care is a sacred mission ... a moral enterprise and a scientific enterprise but not fundamentally a commercial one. We are not selling a product. We don't have a consumer who understands everything and makes rational choices - and I include myself here. Doctors and nurses are stewards of something precious. Ultimately the secret of quality is love. You have to love your patient, you have to love your profession, you have to love your God. If you have love, you can then work backward to monitor and improve the system.“

From: Ayanian & Markel, New England Journal of Medicine, 2016;375(3):205-207

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Executive Summary

The Seniors Care Network is a progressive, person-centered, collaborative network that provides services and opportunities to frail older adults and their caregivers who live the Central East Local Health Integration Network (LHIN). Working in collaboration with other Central East LHIN healthcare providers and programs, Seniors Care Network programs promote comprehensive care across an older person's healthcare journey.

Programs that operate under the umbrella of the Seniors Care Network include:

- Geriatric Assessment and Intervention Network (GAIN): providing comprehensive geriatric care for at-risk seniors;
- Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT): helping to support seniors in long-term care, and keeping them out of the hospital;
- Behavioural Supports Ontario (BSO): helping seniors with responsive behaviours, while improving quality of life;
- Geriatric Emergency Management (GEM): supporting frail seniors in hospital Emergency Departments; and
- Senior Friendly Care: improving the experience and outcomes of seniors when they are hospitalized by preventing their physical and mental decline.

To date, only the GAIN program has undergone a formal evaluation.

As a strategy to establish the effectiveness of all Seniors Care Network programs and to promote ongoing program evolution and quality, there was an interest in developing and then implementing a comprehensive evaluation framework that would:

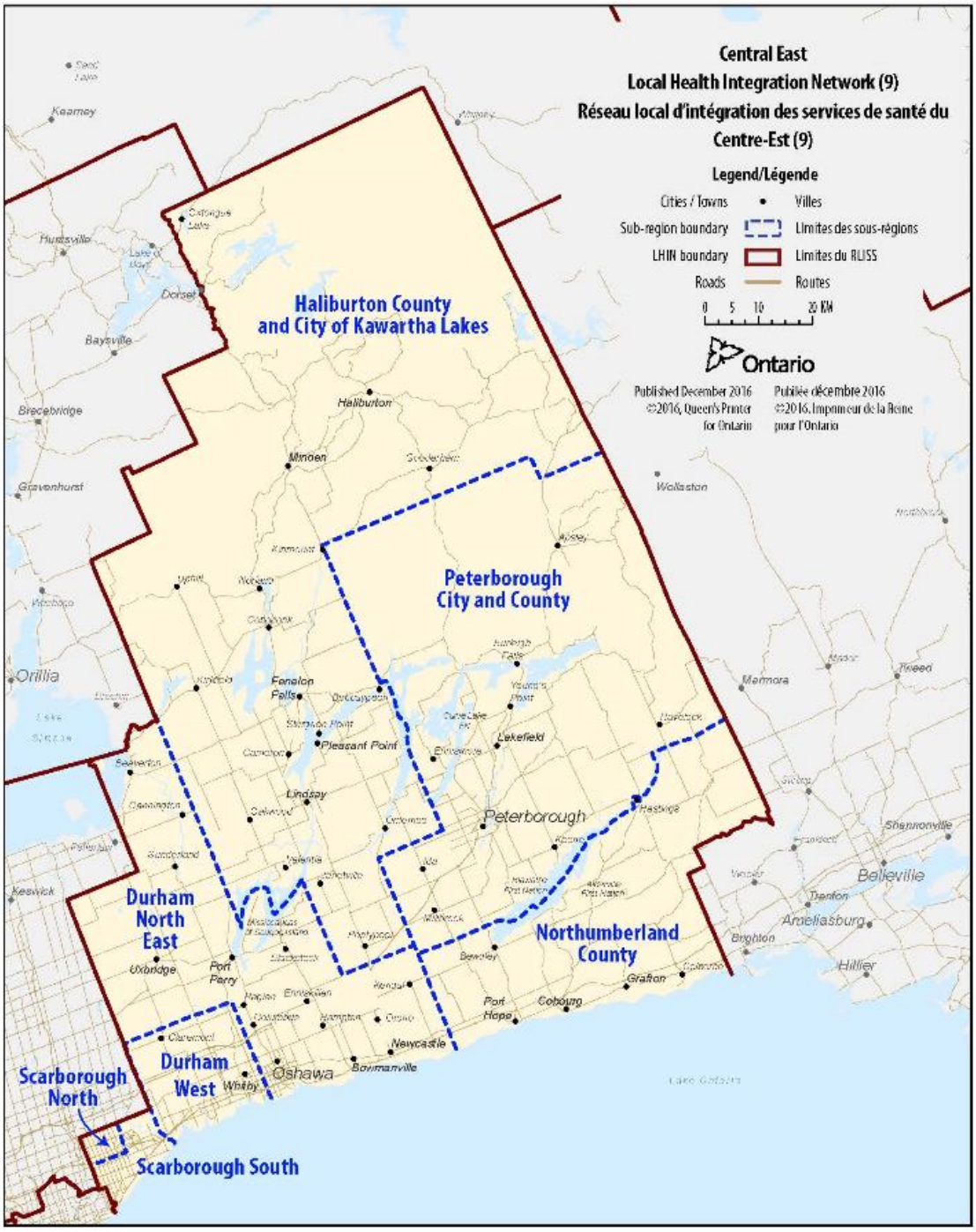
- build capacity for self-evaluation (i.e., internally implemented evaluation);
- support results-based management; and
- inform decision-making regarding program funding, service planning, practice improvement, and policy development.

The proposed evaluation framework, based on the Donabedian Framework[1,2] for evaluating health care services, was developed in stages. First, stakeholder perspectives on elements key to the development of the evaluation framework was obtained through an on-line survey. Next program descriptions and program logic models were developed from existing documents and in consultation with the program leads. Next, based on the program logic model, program leads were asked to identify key evaluation questions, which were fine-tuned through ongoing consultation with the program leads. These questions were then organized according to the Donabedian Framework by objective. The proposed evaluation framework identifies key outcomes, potential outcome indicators, and data sources as well as methods for each evaluation question.

Evaluation is not an end point; rather it is an ongoing, evolving process where questions are answered and new questions are posed. As such, the proposed framework is not so much of a work plan as a catalogue of evaluation possibilities. It is suggested that the framework be considered a living document, one that is meant to be continuously updated and revised depending on the evolving client and healthcare landscape as well as program and/or funding priorities.

[1] Donabedian, A. (1988). The quality of care: How can it be assessed? JAMA, 260(12), 1743–8.
[2] Donabedian, A. (2005). Evaluating the quality of medical care. 1966. The Milbank quarterly. 83(4), 691–729.

Map of Central East LHIN



1.0 Background

The Seniors Care Network is a progressive, person-centered, collaborative network that oversees services and opportunities to frail older adults and their caregivers who live the Central East Local Health Integration Network (LHIN). Serving a diverse geographic region with urban, rural, and remote communities, the programs and initiatives operating under the umbrella of the Seniors Care Network provide individualized, empathetic, collaborative, person-centered care. Funded by the Central East LHIN and comprised of dedicated healthcare professionals who unrelentingly share their expertise and knowledge in an effort to provide the best healthcare experience and expand care provider capacity, Seniors Care Network programs focus on frail seniors or older seniors whose complex health concerns threaten their independence and function.

The following programs are built on enhanced geriatric expertise and reflect the research evidence supporting the benefit of inter-professional teams and organizational collaboration in the care of older adults:

- *Behavioural Supports Ontario (BSO):* provides assistance to older adults living with responsive behaviours resulting from complex and challenging mental health issues, addictions, dementia and/or other neurodegenerative problems; BSO staff support those living in both long-term care and community settings as well as their family members.
- *Geriatric Assessment and Intervention Network (GAIN):* 12 inter-professional teams provide comprehensive geriatric assessments and develop care plans for high risk older adults in collaboration with geriatricians, other specialists and primary care providers with the aim of optimizing function and independence.
- *Geriatric Emergency Management (GEM) Nurses*: based out of hospital Emergency Departments, GEM nurses assess and support older adults with acute health concerns.
- *Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT):* Nurse practitioners who serve older adults in long-term care homes experiencing acute health concerns with the aim of preventing hospitalization and supporting successful transitions from acute care to long-term care.
- *Seniors Friendly (SF) Care:* promotes and provides strategic direction and leadership of senior friendly care within the region.

Working in collaboration with other Central East LHIN healthcare providers and programs (e.g., the Alzheimer Society First Link Program, the Assess and Restore program, and Geriatric and Neuropsychiatry Outpatient Services), Seniors Care Network programs promote comprehensive and seamless care across an older person's healthcare journey.

The overarching goals of the 2016-2019 Central East LHIN Integrated Health Service Plan (IHSP), "Living Healthier at Home: Advancing integrated systems of care to help Central East LHIN residents live healthier at home", lend support for programs and initiatives that promote the ability of older adults to live successfully in their homes with the aim of avoiding the use of acute care services and preventing Alternate Level of Care (ALC) days. While clinicians are clearly aware of client impacts, to date, only the GAIN program has undergone a formative evaluation. As a strategy to establish the effectiveness of all Seniors Care Network programs and to promote ongoing program evolution and quality, there was an interest in developing and then implementing a comprehensive evaluation framework that would:

- build capacity for self-evaluation (i.e., internally implemented evaluation);
- support results-based management; and
- inform decision-making regarding program funding, service planning, practice improvement, and policy development.

Further, the Seniors Care Network was seeking an evaluation plan that would:

- be clearly linked to Program Logic Models;

- help key stakeholders identify important evaluation questions and objectives;
- promote the identification of outcome indictors based on priority evaluation questions;
- help evaluators either identify potential existing data sources or develop new information sources;
- describe potential evaluation approaches/ methods; and
- endeavor to identify common objectives and outcome indicators across the various Seniors Care Network programs, while acknowledging and preserving the uniqueness of each program and the contributions they make to the care of seniors in this region.

This report describes the development of program descriptions, program logic models and an evaluation framework for the programs of the Seniors Care Network.

2.0 Evaluation Framework Development: Methods

2.1 Evaluation Focusing

The program logic models and evaluation framework presented in this report were developed in collaboration with the Seniors Care Network's Joint Service Operations Committee (JSOC), including the following leaders:

- Kelly Kay, Executive Director, Senior's Care Network
- Deb Daly, Regional Clinical Lead, Geriatric Assessment and Intervention Network, TSH/ Seniors Care Network
- Brandi Flowers, Interim Regional Manager, Geriatric Assessment and Intervention Network, Lakeridge Health
- Jeffery Gardner, Director, Clinical Care Program, Central East Local Health Integration Network
- Sarah Gibbens, Geriatric Emergency Management, Clinical Nurse Specialist, Northumberland Hills Hospital
- Stacey Hawkins, Director, System Planning, Implementation & Evaluation, Seniors Care Network
- Karen Lee-Boulton, Senior Manager, Behavioural Supports Ontario, Central East Local Health Integration Network
- Rhonda Schwartz, Director, System Planning, Implementation & Quality, Seniors Care Network

As well, program leads may have vetted their program logic models, program descriptions, and evaluation questions with program staff.

Program logic models (PLMs) that described the activities and anticipated outcomes of each program provided the foundation of the proposed evaluation framework. Specifically, PLMs provide a vehicle for creating a shared understanding of a program, highlighting the activities that need to be accomplished in order to achieve desired goals. PLMs facilitate program development, management, and evaluation.[3,4]

As there was considerable interest in developing an evaluation plan that included outcome indicators, existing PLMs were revised to clearly articulate specific outcomes that were directly linked with program activities and objectives. Based on these revised PLMs, an evaluation framework was developed that describes possible indicators for anticipated short and long-term program outcomes as well as potential methods (potential data sources, data collection tools). Both quantitative and qualitative methods are suggested. Further, existing sources of information (local and provincial databases) are suggested in an effort to decrease program staff time commitments.

[3] Cooksy L.J., Gill, P., & Kelly, A. (2001). The program logic model as an integrative framework for a multimethod evaluation. Evaluation and Program Planning, 24, 119-128.
[4] Julian, D.A. (1997). The utilization of the logic model as a system level planning and evaluation device. Evaluation and Program Planning, 20, 251-257.

The development of the proposed evaluation framework was consistent with the Donebedian conceptual model,[5,6] a commonly used framework for evaluating health care services that focuses on three key dimensions: 1) *structures* (attributes of settings in which care is provided, 2) *processes* (practices involved in delivering care), and 3) *outcomes* (impact of care).

Prior to the development of the evaluation framework, the evaluation consultants met with Kelly Kay, Executive Director, Seniors Care Network, to scope out the project work plan. The following steps were undertaken to develop the evaluation framework:

1. A 'Pre-Work' survey of key stakeholders was completed to identify their perspectives and begin the process of developing consensus on key elements that would be used to inform the development of the evaluation framework. A description of this survey and the results are presented in the following section.

2. An evaluation focusing meeting was held with the members of the Seniors Care Network JSOC on May 15, 2017. The purpose of this meeting was to: share the results of the Pre-Work survey; clarify and interpret the survey findings within the context of program evaluation; and gather more information from JSOC members. Several key questions formed the basis for discussion at this meeting:
    - What is our role, as consultants, in your development of an SGS evaluation framework?
    - Why did we conduct a Pre-Work survey?
    - How do we plan to create an evaluation framework?
    - What is program evaluation? How does it differ from quality improvement and research?
    - What do you want to learn from this/future evaluations?
    - What principles that will guide the evaluation?
    - What components will be included in the framework?
    - What are potential sources of information for the evaluation?
    - What factors will enable the evaluation?
    - How will evaluation results be used?

3. Following the May 15 meeting, the evaluation consultants began the process of developing program descriptions and PLMs from available program documents. Initial drafts of the program descriptions and PLMs were shared with each program lead for review, after which one of the consultants (Dr. Iris Gutmanis) met individually with each program lead via telephone to further refine and revise these documents.

4. The revised PLMs and program descriptions were reviewed with members of the JSOC on June 26, 2017; group discussion informed further revisions. An additional focus of this meeting was to identify key evaluation questions for each program that would then be included in the evaluation framework.

5. Following the June 26 meeting, further revisions were made to the program descriptions and PLMs. The consultants met with each program lead to: confirm the final versions of these documents; further discuss the key evaluation questions that would be included in the evaluation framework; and explore feasible methods for collecting required data. Once these meetings were completed, the consultants began the process of developing the evaluation framework.

6. The framework was presented to the JSOC on September 11, 2017 at which time there was an opportunity to raise questions, discuss key service delivery issues, and propose suggestions for improvements.

[5] Donabedian, A. (1988). The quality of care: How can it be assessed? JAMA, 260(12), 1743–8.
[6] Donabedian, A. (2005). Evaluating the quality of medical care. 1966. The Milbank quarterly. 83(4), 691–729.

7. Following the September 11, 2017 meeting, JSOC members were asked to provide feedback or suggestions for changes on the latest versions of their PLMs, program descriptions, and on the draft evaluation framework.

8. A draft final report was presented to the JSOC on October 3, 2017, for feedback, after which time a final report was prepared for submission.

3.0 Pre-Work Survey

A 'Pre-Work' survey was developed to gather stakeholder's perspectives on elements key to the development of the evaluation framework. The focus of the survey was to obtain an understanding of:

- what stakeholders wanted to learn from the evaluation and why;
- principles that will guide the evaluation;
- components to be included in the framework;
- key potential sources of information;
- potential factors that will enable evaluation;
- potential challenges/ threats to evaluation and strategies to overcome these; and
- how evaluation results will be used.

This survey, administered on-line (www.surveymonkey.com), is presented in Appendix A. Invitations to complete the survey were distributed by the Seniors Care Network to all program leads and members of the Seniors Care Network Board of Directors. Twenty individuals were invited to complete the survey.

Response Rate: In total, 18 surveys were completed, representing a 90% response rate. Half of the surveys (50%; N = 9) were completed by members of the Seniors Care Network Board, eight (44%) by members of the JSOC, one by a representative of the Central East LHIN and one by a Seniors Care Network program staff member.

Survey results are presented in Appendix B. As well, a summary of responses to some of the key survey questions is presented below.

Why evaluate SGS at this time?

- To understand the context of service delivery
  - Resource Allocation
  - Fiscal soundness
  - Alignment within the system
- To understand implementation
  - CQI: identify gaps, opportunities for improvement
  - Celebrate successes! (strengths)
- To demonstrate specific outcomes
  - Client outcomes / program objectives
  - Care coordination/ cross sector collaboration
  - Value for investment
  - Baseline data - benchmarking

What do you wish to learn from an evaluation of SGS programs?

- Program structures
  - How the programs function
  - Infrastructure needs
  - Role/ impact of the Seniors Care Network
  - Cost analysis – health system impacts
  - Staff/ job satisfaction
- Program Implementation

    - What works well, gaps, opportunities for improvement
    - Client perspective – what do they want/ need?
- Program / client outcomes
    - Are programs meeting their objectives related to patient outcomes?

The survey responses aligned well with the Donebedian framework of structure, processes, and outcomes.

How important is evaluating each of these components?
The majority of survey responders indicated that the evaluation of outcomes and processes was *extremely* important; however only 40% of respondents felt that it was *extremely* important to evaluate structures (See Table 1).

Table 1: Ratings of the importance of evaluating structures, processes, and outcomes (components of the Donebedian framework)

	Not at all important	A little bit	Somewhat	Very	Extremely important
Structures (attributes of the settings in which care is provided)	0	0	20.0% (4)	35.0% (7)	40.0% (8)
Processes (practices involved in providing care)	0	0	0	45.0% (9)	50.0% (10)
Outcomes (impact of care)	0	0	0	5.0% (1)	90.0% (18)

How will the evaluation results be used?
- Quality improvement
- Funding accountability
- Support future planning
- Support role of the Seniors Care Network in supporting SGS

What is important to keep in mind as the evaluation framework is developed? (Evaluation principles)
- Include senior/ client perspectives
- Reflect input from all key stakeholders….
- Be sensitive to cultural and geographic (urban vs. rural; sub regions) diversity
- Be transparent - promote ongoing communication
- Be utilization focused – "actionable information"
- Facilitate inquiry/ learning/ excellence- focused organizational cultures
- No new funding will be available; no new long-term care beds
- "More" is not better
- Some people have allergic reactions to "evaluation"
- Leadership – divided attention
- Understand that the aim of geriatric care is not always to make clients "better" but to stop them from getting "worse".
- There should be no penalty for substandard practice[7]

[7] While programs need to assume responsibility (accountability) for their performance, it was suggested that programs should not be penalized for evaluation findings that suggest less than optimal outcomes but should instead use that information to further understand the factors contributing to poor outcomes and to develop concrete strategies to overcome this.

Who will be using the evaluation information?
The majority of survey respondents indicated that policy makers and program/ organizational leaders would likely be the main evaluation users (See Table 2). Other identified key stakeholders included researchers, other sectors and programs serving seniors, professional associations and the general public.

Table 2: Identified evaluation users*

Who?	Will definitely use evaluation information
Local Health Integration Network (LHIN)	100% (18)
Program managers	88.9% (16)
Senior management (e.g., CEOs, ED, etc.)	83.3% (15)
Program staff	77.8% (14)
Funding agencies	77.8% (14)
Ministry of Health and Long-Term Care	77.8% (14)
External partners	66.7% (12)
Clinical staff (physicians, nurses, allied health professionals)	66.7% (10)
Other health sectors (acute care, long-term care, primary care)	44.4% (8)
Program participants (patients, family members)	38.9% (7)
Program volunteers	22.2% (4)
Program planners	5.6% (1)

*Response choices: will not be using evaluation information, maybe, or definitely will be using evaluation information.

What are some potential sources of evaluation information?
- Program records – stats/ metrics, program documents
- Surveys/ interviews with key informants
- Direct observation of practice
- "Big" data sets (NACRs, DAD, CHRIS, CIHI)

What resources are needed to support evaluation efforts?
- Standardized reporting systems
- Awareness of evidence-informed practices in evaluation
- Technology to support data collection
- Dedicated human resources
- Access to "big" data

4.0 Program Descriptions and Program Logic Models

First, the following information was collected from both program leads and existing documents and used to develop program descriptions:

- General service description
- Clinical program partners/ organization(s) involved
- Program start (year)
- Hours of service
- Eligibility criteria for service
- Application/ referral process
- Intake process
- Administrative program partners
- Funding source
- Program governance
- Program coordination
- Data reporting
- Fees for service
- Clinical staff (FTEs)
- Model of care
- Approximate volumes
- Website link and links to other relevant program information.

Existing program logic models were then refreshed. Built on the Seniors Care Network strategic priorities (see Figure 1), the components of each PLM were the three Seniors Care Network strategic priorities: improving care, fostering excellence, and advocacy regarding age-related needs.

Figure 1. Seniors Care Network Vision, Mission, and Strategic Priorities (2016-2019)

Each PLM outlines key program activities (what the programs *do)*, targets (*who* is the target of program activities), anticipated short-term outcomes (*why* the programs do what they do), metrics (*what* data is currently being collected), longer-term outcomes (long-term benefits of the program) and the ultimate program goal(s).

Program descriptions and PLMs can be found in the appendices (BSO – Appendix C; GAIN – Appendix D; GEM – Appendix E; NPSTAT – Appendix F). The initial draft program description and PLM for Senior Friendly Care (based on documents from the Central East LHIN Senior Friendly Care Committee) are provided in Appendix G. However, Senior Friendly Care is considered a 'philosophy' that should be embedded in all programs offered to older adults, rather than a stand alone program. Therefore, the

documents were not revised at this time but instead senior friendly care activities and goals were included in each PLM in this report. The existing committee is focused on hospital care. With the impending release of the provincial Senior Friendly Care Framework, a new structure will be developed and implemented with an expanded focus that will include care across the continuum. As the impact of this change in focus is yet to be determined, the documents included with this report may be revised in the future. It is for the reasons above that Senior Friendly Care is not included in Section 5.2: Evaluation Objectives and Questions.

5.0 Evaluation Framework

5.1 Guiding Principles

A number of underlying principles guided the development of this evaluation framework.

- A number of evaluation questions were identified for each program and for each question there may be one or more potential methodologies. It is not necessary to answer all of the questions at one time or to use multiple methods to answer each question; it is possible that several questions can be answered with the same methodology (e.g., a survey may include questions that could answer more than one evaluation questions).
- The framework is not so much an evaluation "plan" as evaluation "possibilities". The framework is not prescriptive, but suggestive. Various methods were identified to answer the proposed evaluation questions; however, other viable methods may also exist.
- The framework should be considered a "living" document, one that is meant to be continuously updated and revised depending on changes and opportunities within programs as well as changes in the healthcare environment.
- While some of the evaluation questions are applicable across programs, most are program specific. Certainly some of the evaluation questions specified by individual programs could be applicable to other programs; however at this point in time these questions were not articulated but could be considered for future evaluations. As a 'living' framework, additional questions can be added after current evaluation priorities have been completed, building on key lessons learned to date. Evaluation is not an end point, it's an ongoing, evolving process, where questions are answered and new questions are posed.
- As the evaluation is conducted, it may become evident that some data sources are not as robust as initially assumed, so that revisions / adaptations to the evaluation framework may be necessary.
- Although it may be anticipated that participation in Seniors Care Network programs may impact client health outcomes, it is also possible that a number of other intervening factors could impact health outcomes making it difficult to attribute change directly to the program. Understanding client outcomes is nonetheless important and has implications for quality improvement initiatives.
- Sources of information for the evaluation should be inclusive of all key stakeholders including clients, care partners, clinicians, mangers, policy makers and other relevant stakeholder. Key stakeholder input should also be sought regarding overall evaluation plans, including methods.

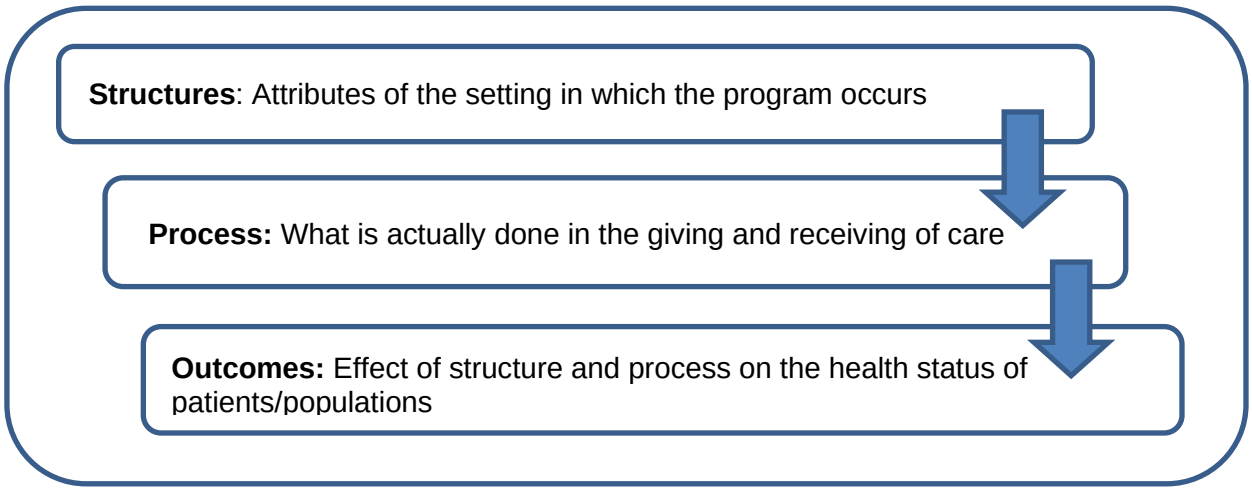
The evaluation framework that was developed for the Seniors Care Network is consistent with the Donebedian framework[8,9,10] for evaluating health care services. This commonly used framework has three basic components:

[8] Donabedian, A. (1966). Evaluating the quality of medical care. The Millbank Quarterly, 44(3), 166-206.
[9] Donabedian, A. (1988). The quality of care: How can it be assessed? JAMA, 260(12), 1743–8.
[10] Donabedian, A. (2005). Evaluating the quality of medical care. 1966. The Milbank quarterly. 83(4), 691–729

1. ***Structures*:** attributes of settings in which care is provided including the physical facility, equipment, governance structures, committees and human resources, as well as organizational characteristics such as staff training;
2. ***Processes*:** practices involved in delivering care; and
3. ***Outcomes*:** impact of care.

Generally speaking, this evaluation model assumes that programs will be unable to achieve anticipated outcomes when they do not have structures in place that are needed to deliver a service or when optimal processes of care delivery are not in place. As such each component is influenced by the other; the components are interrelated. This model is depicted in Figure 2. The Donebedian framework is particularly salient to the evaluation of the Seniors Care Network as it is relevant to the stated goals for the evaluation as identified in the pre-work survey and to the evaluation questions identified by program leads.

Figure 2: The Donebedian Framework for Evaluating Health Care Services



Source: Donabedian, A. (1966). Evaluating the quality of medical care. Millbank Quarterly, 44(3), 166-206.

5.2 Evaluation Objectives and Questions

The development of the evaluation framework was guided by the evaluation questions posed by each program lead who was tasked with identifying the specific information that they wanted generated from an evaluation. The development of the evaluation questions was guided by three key questions related to program activities, target groups, and outcomes:

- Think about which *activities* contribute towards the program's outcomes. Which *activities* are you most concerned about? Think about who the program is designed for. Do you need to know if you are reaching this *target group* and who you are not reaching?
- Think about which outcomes are most crucial. Which *outcomes* are the most important for this program?

Once questions relating to activities, target audience, and outcomes were developed, program leads were asked to consider: what questions need to be answered now by the program staff and/or by other stakeholders; what questions could be answered with currently collected data; and what resources would be needed to answer questions that required additional data collection. They were then asked to prioritize each question (low, medium, high). The consultants then worked with the program leads to fine tune their

final evaluation questions. These final questions were then organized / categorized into key evaluation objectives. While some questions were consistent across all programs, the majority were program specific.

The final evaluation objectives and questions, associated with each element of the proposed framework are as follows:

Structure

Objective 1: **To describe resource allocation and implementation within the context of expectations / program descriptions/ mandate.**

Evaluation Questions

BSO

1. Do BSO staff (both LTCH embedded staff and GAIN-based RPNs) and all staff working in LTCHs as well as healthcare providers working in the community with older adults with behavioural issues have the knowledge and skills needed to comprehensively address the needs of older adults living with dementia, addictions, complex mental health issues, and neurodegenerative diseases that impact cognition?

2. Does the BSO program have the needed infrastructure in each sector (long-term care, community, hospital) to ensure clients receive the right care, in right place, at the right time?

GEM

1. Do program staff have the needed skills and knowledge to implement their roles/ work activities?

Process

Objective 1: To describe the patient population served by each program.

Evaluation Questions

BSO

1. Who are the clients served by BSO?

GEM

1. Who are the clients served by GEM?

GAIN

1. Who are the clients served by GAIN?

NPSTAT

1. Who are the clients served by NPSTAT?

Objective 2: To describe the services provided by each program.

Evaluation Questions

BSO

1. How many seniors are served?
2. What services are delivered (clinical and nonclinical)?

GEM

1. How many seniors are served?
2. What services are delivered (clinical and nonclinical)?

GAIN

1. How many seniors are served?
2. What services are delivered (clinical and nonclinical)?

NPSTAT

1. How many seniors are served?
2. What services are delivered (clinical and nonclinical)?

Objective 3: To describe the provision of care within the context of evidence-informed practices for care of the elderly.

Evaluation Questions

BSO

1. Do BSO-funded staff in both LTCH and the community (BSO-funded GAIN team members) provide value stream mapped/standardized/ evidence-based processes of care?

GEM

1. How does the GEM program support patient transitions (continuity of care) across sectors?

GAIN

1. Which GAIN care model has the greatest impact on client outcomes?
2. Are care plans developed by GAIN teams client-focused and goal-oriented?

NPSTAT

1. What is the role of NPSTAT nurses in supporting palliative care?

Objective 4: To describe the provision of care within the context of other services offered in the CELHIN for seniors.

Evaluation Questions

GEM

1. How is GEM linked with retirement home/ community care providers? What are the goals of these linkages?

NPSTAT

1. Does NPSTAT duplicate what is offered through other funded roles (e.g., does the NP role duplicate that of the LTCH medical director)?
2. Is LTC the "best place" for NPSTAT? Should NPSTAT be increasingly aligned with primary care?

Outcome

Objective 1: To describe the client and care partner-related outcomes associated with Seniors Care Network programs.

Evaluation Questions

BSO

1. What is the client experience with care (process, satisfaction)?

GEM

1. What is the client experience with care (process, satisfaction)?

GAIN

1. What is the client experience with care (process, satisfaction)?
2. How does GAIN impact client outcomes?
3. Does GAIN impact (increase/ improve) the health-related quality of life of older adults?
4. Does GAIN impact (improve/ maintain) client perception of subjective health?
5. Does GAIN impact client functional status? (improve, maintain, prevent decline)
6. Does GAIN impact (increase/ improve) care partner quality of life and (reduce) care partner burden/stress?
7. Does GAIN contribute to reduced ED visits for clients?
8. To what extent does GAIN help clients attain their care goals?

NPSTAT

1. What is the client experience with care (process, satisfaction)?

Objective 2: To describe the health system-related outcomes associated with Seniors Care Network programs.

Evaluation Questions

BSO

1. Do current practices (e.g., policies, standardized clinical pathways/practices, and hiring and orientation practices) ensure successful transitions and successful outcomes across the care continuum?
2. Does adherence to the value stream mapped process of care lead to increased staff/care partner ability to manage responsive behaviours?
3. Does adherence to the value stream mapped process of care lead to increased staff and resident safety?

GEM

1. To what extent has the GEM program increased ED staff knowledge of geriatric syndromes?

NPSTAT

1. Are key stakeholders (LTCH, physicians, staff) satisfied with NPSTAT?
2. Does NPSTAT keep clients out of the hospital? Does NPSTAT reduce potentially avoidable transfers to local EDs/hospitals? Are fewer LTCH residents being admitted to hospital over time?
3. Are LTCH residents getting the "right care" in "the right place" at "the right time"? Are they receiving needed care in the LTCH where they are less likely to pick up nosocomial infections/suffer the side effects of being admitted to hospital/attending an ED?

Objective 3: To describe the organization-related outcomes associated with Seniors Care Network programs.

Evaluation Questions

GAIN

1. Who is best served by GAIN? What are the characteristics of the clients who make the greatest gains with GAIN?

5.3 Evaluation Framework and Potential Methodologies

The evaluation consultants developed an evaluation framework that listed key outcomes, outcome indicators, potential data sources, and methods for each evaluation question. Where possible, existing sources of information (e.g., activity logs, administrative records, charts, intake forms, population databases) were proposed. As well, new data sources and proposed methods, such as prospective data tracking, surveys and interview methods, case studies, and key stakeholder meetings (e.g., Kaizen events), were identified and listed and additional information about these proposed methods was provided. Where possible, multiple methods were suggested and examples of potential data sources (e.g., specific survey and interview questions) were provided. The full evaluation framework is presented in Appendix H.

Further, tools for measuring specific health outcomes were identified. For example, one of the program leads was interesting in determining if the program changed client quality of life. Several health-related quality of life measures were identified and, where possible, online links to these measures were provided.

If new tools are needed to answer a specific question, it is recommended a number of issues be considered including ease of administration, clinician preference, quality (is the tool psychometrically sound), feasibility (will this tool take too long to administer), cost, copyright, ability to provide the sought information, and if relevant, availability in different languages. Piloting different tools using Plan, Do, Study Act (PDSA) cycles with feedback from users/ clients may assist in the selection process. Such an

approach to quality improvement has been used in a variety of settings for a variety of health issues[11,12] and has been endorsed by the Ontario Ministry of Health for quality improvement initiatives.[13] (Quality Improvement Innovation Partnership, 2009). In addition, Health Quality Ontario provides information on quality improvement strategies such as Quality Standards for various health issues (e.g., depression, behavioural symptoms of dementia, and dementia care in the community), including clinical guides, recommendations for adoption, outcome indicators, and supporting resources (www.hqontario.ca).

For several questions, case study methodology was recommended. A qualitative case study approach can be used to describe service provision to clients (including processes, service partners and care providers involved) attending healthcare programs and to explore the impacts associated with the program. This approach facilitates a holistic exploration and understanding of a phenomenon within its context focusing on a variety of data sources and perspectives.[14] In particular, this methodology is useful when describing an intervention in the real life context in which it occurs and when exploring potential outcomes associated with an intervention.[15] Case studies are a useful tool for generating hypotheses,[16] in this case, regarding potential benefits and impacts associated with Seniors Care Network programs.

6.0 Evaluation Implementation

6.1 Determining Readiness for Evaluation

The evaluation framework presented in this report represents the first comprehensive attempt at evaluating the activities of the previously described Seniors Care Network programs. It is anticipated that evaluation will be an evolving process for many reasons including: access to new sources of data/information; opportunities to collect data in conjunction with other evaluation efforts; and increased capacity for evaluation (e.g., experience). It is also anticipated that this evaluation will provide opportunities to highlight regional differences in activities aimed at achieving the Seniors Care Network mission.

Acknowledging that additional resources are almost always required for evaluation (e.g., time, manpower), it may not be feasible for all of the proposed evaluation questions to be addressed at one time. It may be advantageous to start the evaluation by strategically selecting evaluation questions. Readiness for evaluation is a critical first step in planning in an evaluation. There are a number of reasons why organizations or programs may not be ready for evaluation, including lack of management or frontline staff support, lack of resources (e.g., funding, staff), or lack of expertise. There is a need to be realistic about what can and cannot be evaluated.

A number of tools are available to assist organizations to determine their readiness for evaluation, some of which are presented below.

Evaluation Capacity Framework: This framework assesses six key dimensions of evaluation capacity: human resources, organizational resources, evaluation planning and activities, evaluation literacy,

[11] Brodsky KL, Baron RJ. (2000). A "best practices" strategy to improve quality in Medicaid managed care plans. Journal of Urban Health, 77(4), 592-602.
[12] Tanabe P, Hafner JW, Martinovich Z, Artz N. (2012). Adult emergency department patients with sickle cell pain crisis: results from a quality improvement learning collaborative model to improve analgesic management. Academic Emergency Medicine, 19, 430–438.
[13] Institute for Healthcare Improvement (IHI). Breakthrough Series Collaborative model. Available at: www.ihi.org
[14] Baxter, P., & Jack, S. (2008). Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers. The Qualitative Report, 123(4), 544-559.
[15] Yin, R.K. (2003). Case study research: Design and methods (3rd ed.). Thousand Oaks, C.A.: Sage.
[16] Flyvbjerg, B. (2006). Five misunderstandings about case-study research. Qualitative Inquiry, 12(2), 219-245.

organizational decision making, and learning benefits. Each of these dimensions is broken down into sub-dimensions. More information about this tool is available in:

Bourgeois, I., & Cousins, J.B. (2013). Understanding dimensions of organizational evaluation capacity. American Journal of Evaluation, 34(3), 299-319

Bourgeois, I., Toews, E., Whynot, J., & Lamarche, M.K. (2013). Measuring organizational evaluation capacity in the Canadian Federal Government. Canadian Journal of Program Evaluation, 28(2), 1 – 19. Available at: https://evaluationcanada.ca/secure/28-2-001.pdf

Bourgeois, I. (2016). Performance measurement as precursor to organizational evaluation capacity building. Evaluation of Journal of Australasia, 16(1) 11-18. Available at: http://www.enap.ca/cerberus/files/nouvelles/documents/La_recherche/Article_IBourgeois_EJA_16_1_FINAL_2.pdf

Readiness for Organizational Learning and Evaluation Instrument (ROLE): This 76-item questionnaire assesses organizational culture, leadership, systems and structures, communication of information, teams, and evaluation capacity. A scoring template and interpretation guide is provided. This tool is available at:
http://dmm.cci.fsu.edu/IADMM/iowaDmm/materials/ImplementationTeams/Survey/ROLESurvey.pdf
http://www.fsg.org/tools-and-resources/readiness-organizational-learning-and-evaluation-instrument-role

Evaluation Capacity Assessment: This tool was developed by Ontario Public Health Units and considers human resources, organizational resources, evaluation planning and literacy, organizational decision-making and learning benefits. More information on this tool is available in:

Hotte, N., & the Building Evaluation Capacity in Ontario's Public Health Units LDCP Workgroup. (2015). *Evaluation Capacity Assessment Instrument*. Cornwall, Ontario, Canada. Available at: http://www.publichealthontario.ca/en/eRepository/Building_Evaluation_Capacity_Final_LDCP_2015.pdf

Evaluation Capacity Assessment Instrument (ECAI): This 68-item tool is designed to assess evaluation capacity among staff of nonprofit organizations. More information about this tool is available in:

Taylor-Ritzler, T., Surarez-Balcazar, Y., Garcia-Iriarte, E. et al. (2013). Understanding and Measuring Evaluation Capacity. A Model and Instrument Validation Study. American Journal of Evaluation, 34(2), 190-206.

Additional information on building evaluation capacity is available at:
https://www.acf.hhs.gov/sites/default/files/cb/building_evaluation_capacity.pdf

6.2 Potential Facilitating Factors and Barriers to Evaluation

In any evaluation, a number of factors facilitate the evaluation process including: 1) management and frontline staff support ("buy in") for evaluation (objectives, data collection, use of results); 2) willingness of partners to share existing data sources, resources (staff, time, tools) to collect data that is beyond what is collected as part of standard service delivery; 3) access to technology required to collect and share information (e.g., electronic referrals, databases, records); and 4) development of a standardized data collection process that uses consistent definitions and terminology to ensure data integrity.

Similarly, many factors, such as limited resources and time, can act as barriers to evaluation efforts. As well, limited information/data collection systems or limited access to existing information systems may make comparisons across programs difficult. Further, limited ability to collect evaluation data that is beyond what is collected as part of standard service delivery, as well as limited IT support and technology (computer systems, databases, software) may hamper data collection efforts.

A number of evaluation enablers and potential barriers were identified in the pre-survey (See Appendix B) and are summarized below.

What strengths currently exist to complete evaluation efforts?

- Manpower and evaluation expertise
- Availability of data / metrics
- Strong leadership: willingness and commitment
- Buy-in / interest at all levels

What potential challenges may be encountered?

- Time/ workload/ competing priorities
- Potential for bias
- Inability to make causal links between interventions and outcomes
- Using client stories to develop meaningful metrics
- Limited infrastructure to support evaluation (e.g., common electronic medical record)
- Lack of clarity regarding what is SGS

While controlling all of these barriers may be beyond the scope of those evaluating Seniors Care Network programs, barriers that could impact evaluation implementation, data collection, and possibly bias the interpretation of the evaluation findings should be acknowledged. Further discussions may be necessary to identify strategies to overcome these barriers. Survey respondents identified a number of potential strategies to overcome such barriers.

What are some potential strategies to overcome threats to evaluation?

- Transparency – ongoing communication
- Engagement of key stakeholders
- Use of volunteers to collect data
- Prioritization of evaluation needs
- Consider third party evaluation/ centralized reporting
- Embed evaluation metrics into reporting requirements

6.3 Internal vs. External Evaluation

Internal evaluations are those that are conducted by employees of an organization to evaluate the organization's own program activities. External evaluations are those that are conducted by an evaluator who is not an employee of the organization that has ownership of the programs being evaluated. The major distinction between internal and external evaluations is the objectivity of the evaluator – not being an employee of the organization may make external evaluator more objective and free from conflict of interest. Participants of evaluations conducted by external evaluators are sometimes more comfortable providing feedback to someone outside of their organization without fear of reprisal. There are advantages and disadvantages to both internal and external evaluations. Internal evaluations can be done with minimal cost, but add to program staff workload and may introduce errors if not conducted properly. External evaluators may have the expertise to conduct the evaluation, but without established relationships within an organization, they may have limited access to critical sources of information (e.g., people, or databases). As well, evaluations can be conducted jointly with both internal and external resources – an external evaluator can lend credibility and internal resources can facilitate the implementation of the evaluation plan. A summary of criteria for use of internal and external evaluation resources[17] is presented in Table 3.

Table 3: Criteria for Use of Internal and External Evaluation Resources

[17] Conley-Tyler, M. (2005). A fundamental choice: internal or external evaluation? Evaluation Journal of Australasia, 4(1-2), 3-11.

Use internal evaluators when….	Use external evaluators when….
human resources are available within the organization to conduct the evaluation there are limited resources for evaluation capacity exists to design and analyze the evaluation there is perceived credibility and objectivity within the organization there is an organizational culture that supports continuous learning and quality improvement	human resources within an organization (to do an evaluation) are limited funding resources are available complex evaluation plans are employed that require specialized expertise for design, implementation and analysis credibility and objectivity are critical reliability and validity of measures are critical transparency and documentation are critical

6.4 Resources to Support Evaluation Implementation

Excellent resources that support evaluation implementation are readily available. In fact, many are available for free on-line. Some of these resources are listed below, and, where available, links to on-line sources of information are provided.

Worksheets

Of particular relevance are the worksheets developed by Public Health Ontario for their program evaluation tool kit. These worksheets can assist in the development of a work plan for methods that will be used for data collection (Methods Worksheet) and in planning the logistics of the evaluation, in terms of human and financial resources (Logistics Worksheet). Blank worksheets are provided in Appendix I. https://www.publichealthontario.ca/en/LearningAndDevelopment/PHREDArchives/Program%20Evaluation%20Tool%20Kit[1].pdf).

Case Study Development

Baxter, P., & Jack, S. (2008). Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers. The Qualitative Report, 123(4), 544-559. Available at: http://nsuworks.nova.edu/cgi/viewcontent.cgi?article=1573&context=tqr

Yin, R. (nd). A (very) brief refresher on the case study method. Available at: https://www.sagepub.com/sites/default/files/upm-binaries/41407_1.pdf.

University of Texas. (nd). The Case Study as a Research Method. Available at: https://www.ischool.utexas.edu/~ssoy/usesusers/l391d1b.htm)

Client Feedback

Brown, H. (2009). A guide to capturing and using patient, public and service user feedback effectively. University of Birmingham, Health Services Management Centre. Available at: http://pure-oai.bham.ac.uk/ws/files/10495118/A_guide_to_capturing_and_using_patient_.pdf

Health Quality Ontario (2016). Ontario Patient Experience Measurement Strategy. Available at: http://www.hqontario.ca/Portals/0/documents/system-performance/patient-experience-measurement-strategy-1608-en.pdf

Institute for Innovation and Improvement. Experience Based Design. Using patient and staff experience to design better healthcare services. Guide Book and Tools. Available at: https://www.slideshare.net/NHSIQlegacy/experience-based-design-guide

Wong, S.T. & Haggerty, J. (2013). Measuring patient experiences in primary health care. A review and classification of items and scales used in publicly-available questionnaires. UBC Centre for Health Services and Policy Research. Available at: https://open.library.ubc.ca/cIRcle/collections/facultyresearchandpublications/52383/items/1.0048528

Existing Sources of Healthcare Information/ Data Sets

Continuing Care Reporting System (CCRS): this data file has both the complex continuing care data and the LTCH data as collected with RAI tools. Available at:
https://www.cihi.ca/en/continuing-care-metadata
https://secure.cihi.ca/estore/productSeries.htm?pc=PCC126
https://secure.cihi.ca/estore/productSeries.htm?pc=PCC570

Statistics Canada:
Central East LHIN demographic profiles
Based on the 2011 census:
http://www12.statcan.gc.ca/census-recensement/2011/dppd/prof/index.cfm?Lang=E

Based on the 2016 census:
http://www12.statcan.gc.ca/census-recensement/2016/dppd/prof/index.cfm?Lang=E

Central East LHIN health profiles
http://www.statcan.gc.ca/pub/82-221-x/2013001/tbl-eng.htm

Canadian Institute for Health Information
Health profiles
https://yourhealthsystem.cihi.ca/hsp/indepth?lang=en#/

Ontario Ministry of Finance
Demographic information
http://www.fin.gov.on.ca/en/economy/demographics/

Cancer Care Ontario
Health risk profiles
https://www.cancercare.on.ca/cms/one.aspx?pageId=16716

As well, many reports that include LHIN-level information can be found at the following sites:

Institute for Clinical and Evaluative Sciences
https://www.ices.on.ca/

Ontario Long-term Care Home Association
http://www.oltca.com/oltca/OLTCA/ReportsPublications/OLTCA/Public/ReportsPublications/Main.aspx?hkey=d54389e1-07aa-4e25-a11f-cfe9d7ba1657

Health Quality Ontario: Long-Term Care Indicators
http://www.hqontario.ca/System-Performance/Long-Term-Care-Home-Performance

Differentiation of Quality Improvement and Research

Alberta Research Ethics Community Consensus Initiative (ARECCI). Ethics Guideline and Screening Tools. Available at: http://www.aihealthsolutions.ca/initiatives-partnerships/arecci-a-project-ethics-community-consensus-initiative/tools-and-resources/

Guidelines for differentiating among Research, Program Evaluation and Quality Improvement https://cdn.dal.ca/content/dam/dalhousie/doc/research-services/Guidelines%20research%20PE%20QI%20(28%20Nov%202013).pdf

Kring, DL. (2008) Research and Quality Improvement: Different Processes, Different Evidence. MEDSURG Nursing. 17(3), 162-169.

Newhouse, R. (2007). Diffusing Confusion between Evidence Based Practice, Quality Improvement and Research. Journal of Nursing Administration. 37(10), 432-435. Available at: http://www.marianjoylibrary.net/EBM/documents/Newhouse_10_2007.pdf

Reinhardt, A, and Ray, L. (2003). Differentiating Quality Improvement from Research. Applied Nursing Research. 16 (1), 2-8.

Rozalis, ML. (2003). Evaluation and Research: Differences and Similarities. The Canadian Journal of Program Evaluation. 18(2), 1-31. Available at: https://evaluationcanada.ca/secure/18-2-001.pdf

Evaluation Planning and Implementation

Agency for Healthcare Research and Quality (2007). Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Available at: https://www.ahrq.gov/downloads/pub/evidence/pdf/caregap/caregap.pdf

Alberta Health Services. Evaluation Plan and Evaluation Framework. Available at: http://www.albertahealthservices.ca/assets/info/res/mhr/if-res-mhr-eval-resources-plan-framework.pdf

Bialek, R., Moran, J., & Kirshy, M. (2015) Using a population health driver diagram to support health care and public health collaboration. National Institute of Medicine. Available at: https://nam.edu/wp-content/uploads/2015/06/DriverDiagramCollaboration1.pdf

Centers for Disease Control and Prevention [CDC]. (1999). *Framework for Program* Evaluation in Public Health. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm

Health Communication Unit (2007). *Evaluating Health Promotion Programs Version 3.4*. Health Communication Unit, Centre for Health Promotion, University of Toronto. Available at: http://www.thcu.ca/infoandresources/publications/EVALMaster.Workbook.v3.6.08.15.07.pdf

Health Quality Ontario Indicator Development Methodology (2017). How Indicators are Selected to Measure Ontario's Health System Performance. Available at: http://www.hqontario.ca/System-Performance/Measuring-System-Performance/How-Indicators-are-Selected.

Kahan, B. (2008). Excerpts from Review of Evaluation Frameworks. Available at: http://idmbestpractices.ca/pdf/evaluation-frameworks-review.pdf

W.K. Kellogg Foundation. (2004). *Logic Model Development Guide*. Retrieved from http://www.wkkf.org/~/media/20B6036478FA46C580577970AFC3600C.ashx

KU Work Group for Community Health and Development. (2011). Chapter 36, Section 5: Developing an Evaluation Plan. Hampton, C: University of Kansas. Retrieved from the Community Tool Box: http://ctb.ku.edu/en/tablecontents/sub_section_main_1352.aspx

Public Health Ontario. (nd). A program evaluation tool kit. Available at: https://www.publichealthontario.ca/en/LearningAndDevelopment/PHREDArchives/Program%20Evaluation%20Tool%20Kit[1].pdf

Interview Methods

McLeod, S. A. (2014). The Interview Method. Available at: www.simplypsychology.org/interviews.html

Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Methods of data collection in qualitative research: interviews and focus groups. British Dental Journal, 204(6) 291-295. Available at: http://www.nature.com/bdj/journal/v204/n6/pdf/bdj.2008.192.pdf

Holm-Hansen, C. (nd). Conducting interviews. Tips for conducting program evaluation. Available at: https://www.wilder.org/Wilder-Research/Publications/Studies/Program%20Evaluation%20and%20Research%20Tips/Conducting%20Interviews%20-%20Tips%20for%20Conducting%20Program%20Evaluation%20Issue%2011,%20Fact%20Sheet.pdf

Krueger, R.A. (2002). Designing and Conducting Focus Group Interviews. Available at: http://www.eiu.edu/ihec/Krueger-FocusGroupInterviews.pdf

McNamara, C. (2006). Field guide to consulting and organizational development. Guidelines for Conducting Interviews. Available at: http://www.managementhelp.org/evaluatn/intrview.htm

Kaizen Events

EMS Consulting Group. What is a Kaizen Event? Available at: https://www.youtube.com/watch?v=ZhRGSVquFBQ

Farris, J.A., Van Aken, E.M., Doolen, T.L., Worley, J. (2009). Critical Success factors for human resource outcomes in Kaizen events: An empirical study. International Journal of Production Economics, 117, 42-65. Available at: https://s3.amazonaws.com/academia.edu.documents/35547653/Critical_success_factors_for..._-_artigo_-_2009.pdf?AWSAccessKeyId=AKIAIWOWYYGZ2Y53UL3A&Expires=1505421046&Signature=b4yxCSv4CiEU0Z7SjQYuDF81L2o%3D&response-content-disposition=inline%3B%20filename%3DCritical_success_factors_for_human_resou.pdf

Manos, A. (2007). The benefits of Kaizen and Kaizen events. Quality Progress; Milwaukee 40.2 : 47-48.

Survey Development

Statistics Canada. (nd). Survey Methods and Practices
Available at: http://www.statcan.gc.ca/pub/12-587-x/12-587-x2003001-eng.pdf

Castle, N.G. & Engberg, J. (2004). Response formats and satisfaction surveys for elders. Gerontologist, 44(3), 358-367. Available online.

Harvard University Program on Survey Research. (nd). Tip sheet on question wording. Available at: https://psr.iq.harvard.edu/files/psr/files/PSRQuestionnaireTipSheet_0.pdf

Office of Quality Improvement, University of Madison-Wisconsin. (2010). Survey fundamentals. A guide to designing and implementing surveys. Available at: https://oqi.wisc.edu/resourcelibrary/uploads/resources/Survey_Guide.pdf

Glasow, P.A. (2005). Fundamentals of Survey Research Methodology. Available at: https://www.mitre.org/sites/default/files/pdf/05_0638.pdf

Please note: Appendices H and I are on legal size paper.

List of Appendices

Appendix A	Pre-Work Survey
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Appendix H	Evaluation Framework
Appendix I	Evaluation Planning and Implementation Worksheets

Please note: Appendices H and I are on legal size paper.

Appendix A

Pre-Work Survey

Thank you for taking the time to complete this survey. This survey aims to collect information important to the development of a framework for ongoing evaluation of Specialized Geriatric Services (SGS).

In responding to the questions please reflect on the needs and issues of the specific program with which you are associated, but also on SGS as a whole ('system' of care for older adults) in your region.

Online Instructions: To proceed forward in the survey, click on the "next" button. If you would like to go back and review or change your answer to a question, click on the "back" button to go back. If you would like to quit the survey without submitting your responses, simply click on "Exit this survey" located in the top right hand corner. To submit your responses at the end of the survey, simply click "submit". Survey completion is anonymous; you will not be asked to identify yourself.

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1. No program is evaluated just for the sake of being evaluated. Why do you think it is important to evaluate SGS at this time?

2. What do you want to learn from an evaluation of specific programs and SGS as a whole? What questions do you have about these services that would you like answered by an evaluation? Your question(s) can be broad (e.g., Does this program work? Is this program worth continuing?) or they can be specific (e.g., Did the program reach the intended target group? Were activities implement as planned?

3. Thinking about how you answered the question above, how will the information gained from this evaluation be used? How could others use the information?

4. Who will be using the information gathered from this evaluation? Who is the intended audience of this evaluation?

	Will not be using evaluation information	**Maybe**	**Will definitely be using evaluation information**
Program managers	☐	☐	☐
Program staff	☐	☐	☐
Program planners	☐	☐	☐
Clinical staff (physicians, nurses, allied health professionals)	☐	☐	☐
Senior management (e.g., organization's CEOs, Executive Directors, etc.)	☐	☐	☐
Partners in service planning or delivery of services external to specialized geriatric services (e.g., other	☐	☐	☐

	Will not be using evaluation information	Maybe	Will definitely be using evaluation information
community services)			
Other health sectors (acute care, long-term care, primary care)	☐	☐	☐
Funding agencies	☐	☐	☐
Local Health Integration Network (LHIN)	☐	☐	☐
Ministry of Health and Long-Term Care	☐	☐	☐
Program participants (patients, family members)	☐	☐	☐
Program volunteers	☐	☐	☐

5. Is there anyone else, not listed above, who would use the information gathered from an evaluation of SGS?

6. A commonly used framework for evaluating health services is the Donebedian conceptual model, which focuses on *structures* (attributes of settings in which care is provided including the physical facility, equipment, governance structures, committees and human resources, as well as organizational characteristics such as staff training), *processes* (practices involved in delivering care), and *outcomes* (impact of care).

   Please rate the extent to which you think evaluating each of these components is important to and evaluation of Specialized Geriatric Services?

	Not at all important	A little bit	Somewhat	Very	Extremely important
Structures (attributes of the settings in which care is provided)	☐	☐	☐	☐	☐
Processes (practices involved in providing care)	☐	☐	☐	☐	☐
Outcomes (impact of care)	☐	☐	☐	☐	☐

7. What do you think is important to keep in mind as the framework is developed? What are the values or principles that should guide this process? An example of a guiding principle could be the need for evaluation to support continuous quality improvement.

8. What assumptions should be kept in mind? An example of an assumption is that there will be no additional funding to accommodate any programmatic changes.

9. Information can be communicated to multiple audiences in many ways. Which are the following communication strategies do you think should be used to communicate the results of an SGS evaluation? Check all that apply.

    - ☐ One page written summary
    - ☐ Formal, detailed evaluation report
    - ☐ Group presentation
    - ☐ Website-posted summary
    - ☐ Other, please specify

10. What would you like to see included in an evaluation framework (i.e., how would you like it to 'look'?). Please rate the extent to which you think each of the following components are important to include in an evaluation framework developed for Specialized Geriatric Services.

	Not at all important	**A little bit**	**Somewhat**	**Very**	**Extremely important**
Clearly articulated evaluation questions / program objectives	☐	☐	☐	☐	☐
Outcome indicators (what will be measured / what information will be collected)	☐	☐	☐	☐	☐
Expected short- and long-term outcomes	☐	☐	☐	☐	☐
Identified sources of information (e.g.,, data sources/ what information is collected from who)	☐	☐	☐	☐	☐
Identification of who is responsible for collecting the information	☐	☐	☐	☐	☐
Description of how the data will be collected (e.g., description of specific methods such as surveys, interviews)	☐	☐	☐	☐	☐
Timelines (e.g., when will the information be collected; when will it be collated; how frequently it will be shared)	☐	☐	☐	☐	☐

11. Is there any other information that you would like to see included in the evaluation framework?

We would now like to know a little more about each of the programs.

12. Have the key activities as outlined in your program logic models been implemented as planned?

	Don't know	**Few**	**Some**	**Most**	**All**
Behavioural Supports Ontario	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

	Don't know	Few	Some	Most	All
GAIN					
GEM	☐	☐	☐	☐	☐
NPSTAT	☐	☐	☐	☐	☐
Senior Friendly Care	☐	☐	☐	☐	☐

13. To what extent have the short-term outcomes that were identified in the program logic model been achieved?

	Don't know	A little	Somewhat	Mostly	completely
Behavioural Supports Ontario	☐	☐	☐	☐	☐
GAIN	☐	☐	☐	☐	☐
GEM	☐	☐	☐	☐	☐
NPSTAT	☐	☐	☐	☐	☐
Senior Friendly	☐	☐	☐	☐	☐

14. Have there been any unintended outcomes? If yes, please describe.

	Don't know	No	Yes	Describe
Behavioural Supports Ontario	☐	☐	☐	
GAIN	☐	☐	☐	
GEM	☐	☐	☐	
NPSTAT	☐	☐	☐	
Senior Friendly	☐	☐	☐	

15. Are there any programs gaps, i.e., any areas in which there are gaps in care? If yes, please describe.

	Don't know	No	Yes	Describe
Behavioural Supports Ontario	☐	☐	☐	
GAIN	☐	☐	☐	
	☐	☐	☐	

	Don't know	No	Yes	Describe
GEM				
NPSTAT	☐	☐	☐	
Senior Friendly	☐	☐	☐	

16. Thinking about what you would like to learn from an evaluation of Specialized Geriatric Services, what do you envision would be key potential sources of information that could easily be accessed for evaluation purposes?

17. What strengths do you think currently exist to complete evaluation efforts? What factors exist that you think will enable evaluation? Are there any existing resources or supports that could be engaged for evaluation?

18. What do you think are potential challenges that will be encountered when conducting an evaluation of Specialized Geriatric Services? Are there things that could pose a threat to completing an evaluation?

19. Thinking of the challenges/ threats you identified above, what suggestions do you have for overcoming these?

20. Are there any resources or supports that do not currently exist that you think would be necessary to build capacity to conduct an evaluation of Specialized Geriatric Services?

21. Do you have any additional or final comments to make about an evaluation framework for Specialized Geriatric Services or regarding the process to develop or implement this framework?

22. Do you have any evaluation related questions that you would like the evaluation consultants to address when we meet together on May 15th?

Tell us about yourself!

I'm a member of:

	No	Yes	If yes, I've been a member for:
The Joint service operations committee	☐	☐	_____ years
Seniors Care Network Board	☐	☐	_____ years
Other, please specify			

With which program are you primarily associated with?

☐ Behavioural Supports Ontario	☐ NPSTAT
☐ GAIN	☐ Senior Friendly
☐ GEM	☐ Other, please specify:

Appendix B

Pre-Work Survey Results

Central East LHIN Specialized Geriatric Services Evaluation Framework Survey Results

No program is evaluated just for the sake of being evaluated. Why do you think it is important to evaluate SGS at this time?

- *SGS should be evaluated regularly to determine if targets set are meeting the current needs of the customer group served.*
- *To understand the impact that the initiation of SGS has had on our frail senior population over the last 6 years. I would like us to demonstrate that coordination of the major programs focused on seniors care has improved the ability of clinicians and teams to meet the needs of our population. Identification of research projects that have the potential to enhance seniors care in Central East LHIN Demonstrate the value provided for the investment that has been made in seniors care identify program gaps, and improve the effectiveness of SGS programs*
- *It is important to evaluate SGS programs to ensure that they are aligned to the LHIN (regional) and Ministry (provincial) strategic aims to ensure value for money and relevant patient outcomes. In addition, at this time it is critical to ensure that they are re-examined in light of the system transformation as a result of the Patient First Act. Lessons learned from an SGS evaluation may support broader system transformation consistent with the Patients First goals of care.*
- *It is important to evaluate at this time for: - continuous quality improvement of existing services - to identify potential gaps in services - to assess*
    - *to demonstrate impact of specialized geriatric services, organized and delivered as we do, to the people we serve - to compare our programs to other successful approaches - to assess if changes are needed to our programs to improve them - to identify opportunities for innovation - to celebrate and highlight what is working well*
- *Understand strengths and opportunities for improvement*
- *To provide objective information to: • determine the extent to which the programs are achieving goals/objectives • determine if programs are making a difference to the patients/residents, understand impact of programs on patient/resident base, meeting the needs of the specific population • determine if the programs have the appropriate inputs, processes, outputs and outcomes • move away from relying on individual's 'gut and passion' as to the success of the programs • gain feedback and course correct as necessary • identify gaps, remove waste • establish equitable access and the same services no matter where patient enters the system • improve efficiency • compare similar programs - identify strengths, areas for development, identify minimum expectations*
- *evaluate client outcomes*
    - *evaluation should drive best practice - evaluation should show value and need - evaluation may also show us a need to do things differently - evaluation may show the need for more*
- *To determine effectiveness of the program, whether it is meeting its objectives, whether it is having an impact (and what that impact is) on the care and outcomes of seniors.*
- *To provide objective information to: • determine the extent to which the programs are achieving goals/objectives • determine if programs are making a difference to the patients/residents, understand impact of programs on patient/resident base, meeting the needs of the specific population • determine if the programs have the appropriate inputs, processes, outputs and outcomes. • move away from relying on individual's 'gut and passion' as to the success of the programs • gain feedback and course correct as necessary • identify gaps, remove waste • establish equitable access and the same services no matter where patient enters the system • improve efficiency • compare similar programs - identify strengths, areas for development, identify minimum expectations*

- *GAIN is 5 years mature and grew rather quickly since initial inception. It is important that we evaluate where we are today as a foundation so we can continue to evolve and grow and be able to easily be able to evaluate each team and the impact that they are having on the lives of the frail seniors that we are serving*
- *Two reasons: 1) Overall it is important to know whether a program targeting a specific group of people is worth having in the first place, i.e. is it doing any good that could not be achieved otherwise (through other established programs) and are the benefits worth the expense. 2) It is worthwhile to know what type of problems exist, if any, and whether such problems exist in all geographic areas or only in some. If they exist in only some, what is causing the problem (system or staff).*
- *As new directions in primary care in particular are receiving support, it is important that SGS contributions are evaluated and outcomes documented. Best practices, in particular regarding systems collaboration need to be advanced at a more rapid pace. Evaluative outcomes to support decision making would be helpful.*
- *SGS should be evaluated regularly to determine if targets set are meeting the current needs of the customer group served.*
- *Evaluation is a vital component of all public sector services, programs, and systems. It is important to understand whether: (a) the processes and structures that support a program are working efficiently; (b) whether a program is meeting their outlined objectives; and (c) what impact(s) is that program having in a larger system context. Evaluation supports system accountability, future research, as well as ongoing quality improvement.*
- *Identify if the program is delivering what it is intended to deliver - Confirm program goals are still relevant - Determine impact on patient care - Identify what is working and what needs improvement - Inform future planning - Surface program interrelationships/integration opportunities - To learn from strengths of all programs - Use to benchmark against similar programs across the province - Ensure return on financial investment*
- *to ensure meeting the community needs, fiscally sound and in line with Seniors Care Network and CELHIN strategic directions*
    - *To see if the Senior Care Network has any impact on the improvement of the SGS across the different regions of CE LHIN. - To see if SGS across the different regions of CE LHIN are functioning well and identify areas of improvement. - To identify gaps of SGS for expansion in alignment of the Patient First Acts and new Ontario Budget.*
- *It has grown it is now a major participant in care of frail elderly and we need the data to support their prowess administratively as well as clinically*

What do you want to learn from an evaluation of specific programs and SGS as a whole? What questions do you have about these services that would you like answered by an evaluation? Your question(s) can be broad (e.g.,: Does this program work? Is this program worth continuing?) or they can be specific (e.g., Did the program reach the intended target group? Were activities implement as planned?

- *I would like to learn more about the GAP program on how it identify frail seniors and the planning process on a specific program designed to prevent decline in overall functional abilities. b. Does this program identify Residents admitted to hospital from LTCH or RHRA? If so how? What is or would be the discharge plan for these Residents/Patients?*
- *All of the above, plus: What is needed to enable the growth and enhance service delivery of each program? I would specifically like to understand this for the GEM program. Are the programs (GAIN specifically) resourced appropriately? Should some of the HR allocations be adjusted? Is the effectiveness Seniors Care Network optimized under the current structure (i.e.: management of a "virtual" budget rather than actually having the ability to manage all SGS program funding?). Does Seniors Care Network have enough "teeth" to help move the LHIN and Provincial Seniors Strategy forward? Is the accountability structure of host organizations to the LHIN, and SGS designed to be optimally effective and financially accountable? Does each program focus on the appropriate goals/functions? Where is there room for improvement?*

Which aspects of each program work well, and which need to be adjusted or eliminated? Are the services we are providing congruent with program goals?

- *It is important to ensure that all of the stakeholders have a shared understanding of terminology and details of the performance metrics that are being used to measure the success of various initiatives and/or programs. We believe the evaluation should answer questions like: - What is this program intended to achieve? - Is the program achieving that intent? - What gaps have been identified that the program can evolve to meet? - Have gaps been filled that were inconsistent with the original program expectations? - Does the program have impact on metrics/service for other system partners? - Is the program integrated to support access and transitions for patients?*
- *What is working well within existing programs and what needs fine tuning/improvement in order to meet client needs? - What needs to happen to ensure programs can meet the needs of the growing target population as a result of the growth in the older adult population? - What portion of those who could benefit from the programs have access to them? - For those who could benefit and don't access the programs what is the reason? - What additional needs are there that the programs do currently address? - How senior friendly are the programs? - are we actively engaging older adults living with frailty and their family caregivers in the system evaluation, including hearing their stories of their healthcare experiences? - What are we doing to clearly understand the needs of older adults living with frailty and the current gaps and challenges they encounter? - How do we know that the program this program truly meets the care and support needs of older adults living with frailty and their family caregivers? - are our programs truly patient-centred? - How are our programs adding value or service to older adults living with frailty? - do our program designs demonstrate empathy for older adults living with frailty?*
- *Have we organized SGS programs in the best possible way? Are there better ways to deliver on the goals of the programs? Are the goals of the programs the right goals? Are we making a difference?*
- *Would like to see more outcome indicators - able to measure true impact of the program*
- *To what extent are the programs achieving goals/objectives? • Are the programs making a difference in the lives of the patients/residents they serve? • Are the programs meeting the needs of the patients/residents they serve? • What is the impact of the programs on the lives of the patients/residents they serve? • Are the programs assisting in patients being able to remain in the community? • Do the programs have the appropriate inputs, processes, outputs and outcomes? • Does a patient/resident receive the same care no matter where they live in the region? • Are there any unintended outcomes/consequences or negative effects? • Are the various sites of a program being administered in a consistent manner? • What is the impact of regional variation to the programs?*
- *Decisions taken and processes used by funders to allocate or reallocate resources to improve client outcome*
- *What are the metrics that actually measure the program correctly - is this program building capacity in others? - can this program reach more of the target population - can this program use technology in different ways to collaborate and/or reach the target population - what are the most valued components of the program*
- *I think it is important to have a range of evaluation metrics, including those that look at process and those that look at outcomes. In addition to the examples in the question, I would suggest: *is the program meeting its objectives? *Is the intended target group benefiting from the program (e.g., are positive outcomes being experienced as a result of the program)? *How do persons receiving the program's services rate their experience with the program? (What could be improved?) *How do persons providing services in the program rate their experience (e.g., how satisfied are they with the work they are doing, support they are receiving, etc.) *Are there others who could benefit from this program beyond the intended target group? *How aware are people about this program? Are referral processes working? *How integrated is this program with the overall health system? What are opportunities for further integration?*
- *To what extent are the programs achieving goals/objectives? • Are the programs making a difference in the lives of the patients/residents they serve? • Are the programs meeting the needs*

of the patients/residents they serve? • What is the impact of the programs on the lives of the patients/residents they serve? • Are the programs assisting in patients being able to remain in the community? • Do the programs have the appropriate inputs, processes, outputs and outcomes? • Does a patient/resident receive the same care no matter where they live in the region? • Are there any unintended outcomes/consequences or negative effects? • Are the various sites of a program being administered in a consistent manner with some regional/local variation as planned?

- *Is this program operating as it was intended? Is GAIN having a positive impact on the patients and their families that we are serving? What is the cost of this program and the financial impact to the rest of the health care system Are the staff of GAIN satisfied with their current jobs? Are the patients and their families that GAIN has served seeing an impact on their Quality of life, functional ability and their ability to remain in their own home?*
- *1) Is there a good match between what patients/caregivers have identified as their need and the service that was provided? 2) What needs of patients/caregivers are not met by the current system. 3) What are the problems identified by the service providers 4) what are the problems identified by the patients/caregivers 5) how do points 3 and 4 relate to each other. It is very important to get input from both sides separately to get a true picture of what reduces the effectiveness of the program. Patients/caregivers have to be assured of anonymity because of fear of retaliation (power imbalance). 6) Do any problems exist over all geographic areas or only in some? If so, why? Are there any indicators that point to a specific problem, either systemic or staff related? 7) Conversely it is also good to know what works well for both sides, and why. Does it work well across all geographic areas?*
- *Which model of SGS service provision is most patient/family centred enabling seamless care delivery? How citizen engagement is most meaningfully accomplished? How can nurses be best utilized at their full scope of practice providing for frail older adults living in their home? What best practices of collaboration exists across usual silos, such as primary care, public health, long term care, palliative care, home care and community services (transportation)? What systems approaches instituted are support efficient collaboration?*
- *1. I would like to learn more about the GAP program on how it identify frail seniors and the planning process on a specific program designed to prevent decline in overall functional abilities. 2. Does this program identify Residents admitted to hospital from LTCH or RHRA? If so how? What is or would be the discharge plan for these Residents/Patients?*
- *All of these questions are important. I believe an evaluation should answer several questions that examine processes and outcomes. In the context of SGS, programs must not be considered in isolation; it's also important to consider the systems/network elements. Cost analysis - although not always addressed - is an important evaluative element in the context of health systems, and particularly in geriatrics where our services (as a clinical sub-specialty) are expensive to fund. Policy makers are always interested in the long-term impacts of our services on cost-savings. Also, outcomes for our patients/clients are always difficult to conceptualize for non-geriatric audiences, namely because 'success' of our clinical services are not always a simple as 'people got better,' rather 'people didn't get worse.'*
- *Learn - Identify opportunities to strengthen accountability agreements - Identify if providers are meeting accountabilities - Identify gaps/opportunities to strengthen program delivery/ relationships - Determine program infrastructure needs (i.e. automation of reports) Questions - How did the concept of leveraging existing resources work? What works? What are barriers exist? - How does having a program office/secretariat add program value to patient care, provider care? - Are the right measures in place? - Does the program delivery model work?*
- *Is the program meeting primary and secondary objectives - formative/process evaluation - impact analysis - outcomes evaluation - economic evaluation use quantitative, and qualitative data performance indicators*
- *To see if the Senior Care Network has any impact on the improvement of the SGS across the different regions of CE LHIN. - To see if SGS across the different regions of CE LHIN are functioning well and identify areas of improvement. - To identify existing best practices of SGS for spreading across the CE LHIN.*

- *Can data accrued by SHS service providers be evaluated and used to compare with CCAC data or MIN OF HEALTH data how much overlap in patients care is noted from SGS TO CCAC WHAT gaps are identified? How can SGS serviced allow or promote integration with Primary care and geriatric psychiatry? What impact does medical availability have on service delivery (geriatric med/ geriatric psych/ primary care)?*

Thinking about how you answered the question above, how will the information gained from this evaluation be used? How could others use the information?

- *a. Information gained can be used to improve quality of service and measurement. b. Others should be able to use this information to analyze the existing programs and/or make adjustments or expand on their services as a quality improvement and delivery*
- *Hosting institutions would benefit from being obligated to understand the important role they play in not only supporting their SGS teams, but also in moving the Seniors Strategy forward. Hopefully the Central East LHIN will acknowledge and support an increased administrative role for Seniors Care Network, so that they are able to actively support teams and SGS, effectively manage resources and explore creative ways to use the existing resources (human and physical) across the entire region. Individual programs will understand where they have strengths and opportunities to improve the care they provide, and processes under which they guide their work. Host organizations can account for the funding they receive, and be held accountable for using the funding only for its intended purpose We can all use this information to help us develop additional creative ways for disparate organizations (from varying ministries and areas of specialty) to collaborate, access the same information and provide seamless care to a vulnerable population.*
- *The information will be useful to: - Identify gaps and duplication between programs/initiatives - For program refinement for the evaluated partner - resourcing, service direction - Program refinement for other system partners - resourcing, service direction - Identifying integration opportunities with hospitals: supporting ALC pressures and transitioning care to places other than hospital -To support Long-Term Care/CCC/Community care planning and identify needs for supportive care to facilitate transition and care in place, and - For information purposes for Primary Care Providers to understand interventional models of care for patients, and refer to appropriate services for consistent expectations of care.*
- *My hope is that the information will be used: - for fine tuning/improvement of existing programs - for identifying which additional programs are needed, or where there might be geographic gaps in programs or the need to expand a program to handle more clients. - To benchmark current programs against best in class programs on other jurisdictions (ours might turn out to be among the best in class). - For sharing of our program successes with other organizations delivering specialized geriatric services.*
- *To demonstrate effective approaches - to make improvements - to rationalize requests for expansion - to look for opportunities/elements to partner and spread*
- *Outcomes can impact the need for other services*
- *• to identify strengths, gaps, opportunities • for decision making e.g., program modifications • to identify potential unintended consequences or negative effects • to identify opportunities to decrease silos or formalize collaboration between programs and/or partners • to identify recommendation and lessons learned to improve programs • to identify learning opportunities • to establish accountability • to highlight effectiveness to funders*
- *n/a*
- *I'd also like to use evaluation to articulate what the program does, despite popular belief of managers/directors outside of gerontology but may have influence on the utilization of the role. When collaborating with host organizations, this may easily assist in communication about the program, expectations, and also who should hold the financial package for the program. It may also assist those who hold the funding to understand what they are using the funding for as opposed to making assumptions that they can manipulate the role/program to meet the needs of*

ED flow, priorities, etc. Others may use the information to show need and value, and others may be able to use the information to build a program of their own.

- *This information would help inform decisions about the future of the program, and any changes that may need to be made to improve its effectiveness. It could also be used to build the case for additional resources, program expansion, etc.*
- *To identify strengths, gaps, opportunities • for decision making e.g., program modifications • identify potential unintended consequences or negative effects • identify opportunities to decrease silos or formalize collaboration between programs • identify recommendation and lessons learned to improve programs • tool to identify learning opportunities, establish accountability, collaborative participatory tool • highlight effectiveness to funders*
- *Will be used for quality and process improvement, establishing a baseline and articulating to the LHIN and host organizations the impact that this program can make on an individual's life and the system as a whole*
- *1) The information should be used to improve the current system, as identified. 2) It would be useful for other provinces that may consider a similar program. 3) Currently planned and future programs could use the information to better support patients/caregivers. 4) Upcoming technologies could incorporate the findings in their development (Telemedicine, Artificial Intelligence, robots).*
- *Improved evidence to inform decisions to improve access to and support from community based programs to enable older adults and their caregivers to stay in their homes, particularly in rural areas. Improved coordination of care among service providers, particularly specialists. Advancing a common electronic medical record.*
- *1. Information gained can be used to improve quality of service and measurement. 2. Others should be able to use this information to analyze the existing programs and/or make adjustments or expand on their services as a quality improvement and delivery.*
- *I think any evaluation should contain information that is applicable to a variety of stakeholders, and could be used for a variety of purposes, including future research, quality improvement, service planning, restructuring, and so forth.*
- *Funding planning - Service planning - Policy development - Roles & Responsibility development - Identify integration opportunities - Reduce service duplication/system waste - Streamline reporting and analysis*
- *use to determine continuation/changing the programs from delivery to target fiscally determine if this is the right service, right time, right person can be a model for developing other programs across the province*
- *Is Senior Care Network functioning effectively to support the development of SGS in CE LHIN? - What support SGS providers deem helpful from Senior Care Network? - To identify existing best practices of SGS for spreading across the CE LHIN, especially in the areas of integrated care for older adults with complex needs, dementia care, and caregiver support services.*
- *To promote planning and funding in a patient centered way*

Who will be using the information gathered from this evaluation? Who is the intended audience of this evaluation?

	Will not be using evaluation information	Maybe	Will definitely be using evaluation information
Program managers	0	10.0% (2)	85.0% (17)
Program staff	0	20.0% (4)	80.0% (16)
Program planners	0	90.0% (18)	5.0% (1)

	Will not be using evaluation information	Maybe	Will definitely be using evaluation information
Clinical staff (physicians, nurses, allied health professionals)	0	45.0% (9)	55.0% (11)
Senior management (e.g., organization's CEOs, Executive Directors, etc.)	0	15.0% (3)	85.0% (17)
Partners in service planning or delivery of services external to specialized geriatric services (e.g., other community services)	0	40.0% (8)	60.0% (12)
Other health sectors (acute care, long-term care, primary care)	5.0% (1)	50.0% (10)	40.0% (8)
Funding agencies	0	20.0% (4)	70.0% (14)
Local Health Integration Network (LHIN)	0	0	100% (20)
Ministry of Health and Long-Term Care	5.0% (1)	25.0% (5)	70.0% (14)
Program participants (patients, family members)	5.0% (1)	50.0% (10)	40.0% (8)
Program volunteers	20.0% (4)	55.0% (11)	20.0% (4)

Is there anyone else, not listed above, who would use the information gathered from an evaluation of SGS?

- *Community governments, for planning for Senior Friendly Communities*
- *Ensure specific sector partner leadership are included: hospital, primary care, long-term care.*
- *As a community member my expectation is that all of the above audience will use the evaluation information. In addition, I believe that the general population, including older adults living with frailty and their family caregivers, could benefit from having a synopsis of this information.*
- *CCAC, Community Support Services, Retirement homes, CARP*
- *OMA, Public Health, RNAO, other professional bodies, Municipalities, Private Sector, Researchers,*
- *Potentially the RGPs of Ontario, researchers, and other providers/planners outside of the Central East LHIN.*
- *Provincial Program Committees*
- *private business/service providers*
- *HFO is searching for a way to quantify community based care and needs of seniors They have poor data available perhaps this may guide them in future Recruitment people*

A commonly used framework for evaluating health services is the Donebedian conceptual model, which focuses on *structures* (attributes of settings in which care is provided including the physical facility, equipment, governance structures, committees and human resources, as well as organizational characteristics such as staff training), *processes* (practices involved in delivering care), and *outcomes* (impact of care).

Please rate the extent to which you think evaluating each of these components is important to and evaluation of Specialized Geriatric Services?

	Not at all important	A little bit	Somewhat	Very	Extremely important
Structures (attributes of the settings in which care is provided)	0	0	20.0% (4)	35.0% (7)	40.0% (8)
Processes (practices involved in providing care)	0	0	0	45.0% (9)	50.0% (10)
Outcomes (impact of care)	0	0	0	5.0% (1)	90.0% (18)

What do you think is important to keep in mind as the framework is developed? What are the values or principles that should guide this process? An example of a guiding principle could be the need for evaluation to support continuous quality improvement.

- *Input from the population to be served - Evaluation cycles - Transparency*
- *This process should be patient and family centered -- collaborative -- transparent -- should focus on building a positive, forward-moving culture within the region -- encourage questioning (of processes, content knowledge) -- should produce realistic, actionable recommendations and information -- involve stakeholders of all stripes - patients/families, administrators, clinicians, volunteers, community partners -- should clearly articulate an expectation of excellence -- in care, service, accountability, fiscal responsibility*
- *Need to ensure that the evaluation assesses whether the program is truly patient centred and supports patients' needs - is there evidence that patients are receiving affordable, appropriate care that emphasizes patient need (and considers patient wants vs. needs), and isn't based on historical practices of the provider and what works for them Need to ensure that the evaluation assesses that the program policies and processes facilitate equitable access. There are existing issues for example, for the primary care memory clinics whereby the clinics only see the physicians' own patients and don't currently meet the needs of the general population.*
- *The Donebedian conceptual model's focuses on structures, processes and outcomes strikes me as being quite clinical. I'd like to see patient-centred care included as one of the guiding principles .... Do the individual programs revolve around the needs of older adults living with frailty within the CE LHIN and their family caregivers rather than the needs of the healthcare providers, fiscal pressures or space/geographic restrictions? ... Are providers working with frail older adults and their family caregivers to determine health goals that are realistic and achievable? Is the older adult living with frailty and their family caregiver at the centre of their own health care within individual programs? ... Are older adults living with frailty and their family caregivers engaged as members of the healthcare team when making care decisions within a program?*
- *Principles - Optimizing patient/resident/citizen experience - Supporting programs to be clinician led, administrator supported (not the reverse) - Fostering flexible program design that is responsive to new evidence and ideas, new approaches - Embracing a network philosophy - minimizes place and organizations, maximizes partnering and integration - Inclusion of complexity theory and systems thinking in design - Enhancing a learning culture*
- *Client and family centered CQI - plan, do, study, act cycle Understand impact to system*
- *Support continuous quality improvement • be a learning process • utilize data • share the findings with various audiences as appropriate • respect for those involved in the process • all voices are important • collaborative process*
- *Client focused feedback and responsiveness population based planning*

- *I think that time is very important, and that things should not be rushed. QI methodology should be utilized, absolutely. Patients/caregivers should have input from the grass roots.*
- *The evaluation should be well-rounded and reflective of multiple aspects of the program, and should include input/feedback from all stakeholders (e.g., recipients of service, providers of service, supporters of service, those who refer to the service, etc.), and should include process, outcome, and balancing metrics (e.g., is the program having any unintended impacts on other parts of the system - either positive or negative).*
- *Support continuous quality improvement • be a learning process • utilize data • share the findings with various audiences as appropriate • respect for those involved in the process • all voices are important • collaborative process*
- *1) The guiding principle for the evaluation should be to get a true, unbiased picture of the way things are at present. What to do with its findings is someone else's job. There should be no preconceptions. 2) Have a separate evaluation of service providers and a separate evaluation of patients/caregivers (their views might not always agree)*
- *Citizen engagement principles Patient/family centred principles Partnership & Collaborative Leadership Transparency*
- *Input from the population to be served - Evaluation cycles - Transparency*
- *The need for accountability in service delivery. The need to identify applied research activities.*
- *Continuous Quality Improvement must be the foundation to guide this process to ensure the elements of time, cost & quality are considered. Evaluation results either positive or negative will provide opportunities for remediation or recognition and also identify emerging "great' practices.*
- *critical look at what is currently being evaluated and how spread across all programs in a consistent application meaningful data ability of front line staff to have data that directly impacts their abilities to make changes as needed*
- *To support and feedback to providers for continuous quality improvement - To identify exemplary practices for spreading (copy and learn) - To support community of practices (what works and what doesn't work)*
- *Complexity Coordination. Equity Cultural availability Client driven care not politically expedient care*

What assumptions should be kept in mind? An example of an assumption is that there will be no additional funding to accommodate any programmatic changes.

- *Restate/delete/change some of the objectives set - Slow acceptance*
- *All funding designated to the program should be used for that program ONLY -- the expectation will be placed on all SGS participants that they will actively engage in supporting recommended changes in delivery, services, etc. -- everyone will act in good faith (and not undermine the evaluation process or any recommended changes)*
- *No additional funding without clear return on investment and documented business case that is reviewed and approved by all stakeholders that are impacted - Flexibility in service delivery to meet patient and system need - Alignment with Patients First Ac*
- *I'd like to see the following approach: - Step 1. Identification of all enhancements of current programs & new program introductions required to address the needs of older adults living with frailty in the CE LHIN assuming an ideal world of funding being available to meet all needs. - Step 2: Prioritization of the above based on need and the greatest benefit to older adults living with frailty within the CE LHIN.*
- *No additional funding - partnership and integration can aid change - highly talented and committed provider pool - divided leadership attention (SGS may be managed off the side of some desks) - host organizations may not be champions of SGS - need to get there - very complex frail service population*
- *Increasing need due to demographics Program will need to take into consideration the geography within which it is implemented - will not be the same in rural versus urban setting Will need to be supported by leaders*
- *No additional funding • query if budget neutral staffing changes could be a reality*

- *n/a*
- *I think one assumption is that we already have answers about certain programs and how they could be "better". I think those assumptions should be matched to data and to the comments of those who work in the program. Another assumption is that just because there may be funding doesn't mean we already know what to do with it (ex. just expand gem time) - we may want to consider the role and expansion of the role in different ways - maybe not just "more of the same". another assumption is that everything is working well - we may want to consider innovation*
- *No additional funding • query if budget neutral staffing changes could be a reality*
- *How are additional funding and program evaluation connected? Insufficient funding may be a conclusion of an evaluation but not the evaluation itself unless you want to evaluate how current funding supports/hinders health care services. If you make assumptions up front, how can you get an unbiased, accurate picture?*
- *Acknowledgement of asymmetric reciprocity, power and cultural differences*
- *Restate/delete/change some of the objectives set - Slow acceptance*
- *No additional funding for hospital-based services. CCAC is being restructured under the LHIN. Host-organization differences (e.g. hospitals, for-profit organizations, non-profit community agencies, etc.), and the impact of those organization's priorities on SGS services. Geriatrics does not fit a typical 'diagnose and treat' model of care; our patients/clients are complex and don't always work well with general health service delivery models (i.e. service models designed to treat the general population). Some people have an 'allergic reaction' to the word "evaluation," and feel that quality improvement approaches address evaluation in a more efficient way. I completely disagree, but it's something I've noticed. There seems to be a fundamental misunderstanding over the function(s) of evaluation, and evaluation methodologies. How do you know that quality improvement is needed if you haven't effectively evaluated the thing that you are trying to improve? Is the program you are trying to improve worth improving?*
- *Funding in place will continue and will meet the needs of providers to sustain program delivery - Frail elderly population growth projections are reasonably accurate -*
- *ability to collect data within existing resources minimum data sets meaningful data for majority of stakeholders generate a meaningful report that speaks to clients and families committed to making changes based on meaningful data*
- *No penalty for sub-standard practice or programs not working - Uphold principle of CQI*
- *No new LTC beds No coordi ratio of community based care No overall integration of municipal and provincial focus People want to be at home even when sick and frail. Palliative care does not address chronic disease management at end of life last 2 years Most health care does dementia poorly and dementia is still an unspoken diagnosis of shame.*

Information can be communicated to multiple audiences in many ways. Which are the following communication strategies do you think should be used to communicate the results of an SGS evaluation? Check all that apply.

One page written summary	5.0% (1)
Formal, detailed evaluation report	15.0% (3)
Group presentation	5.0% (1)
Website-posted summary	5.0% (1)
All of the above	70.0% (14)

NOTE: CHECK ALL THAT APPLY OPTION WAS NOT FUNCTIONAL; the following are “other” responses

- *I believe all of the above will make the best impact*
- *I think we will need multiple methods to communicate the results of the evaluation: the SGS, LHIN and individual programs will need a detailed evaluation report. Patients/families/community collaborators etc. may just want to see a one pager, which of course, should be posted on the Seniors Care Network website.*

- *The survey doesn't allow selecting more than one option. A detailed formal evaluation report that is circulated as appropriate is critical. In an effort to be transparent and ensure that there aren't erroneous assumptions in the analysis, it would be helpful to include raw data in the appendices. A group presentation or presentations would be helpful in sharing the information, and getting feedback and creating a plan to move forward using the insights gained in the evaluation.*
- *All of the above for health care and to the general public.*
- *A and B - the rest can be developed as we go along*
- *I was unable to check more than one. I believe all of the above communication strategies should be utilized to communicate the results of an SGS evaluation.*
- *I tried to click all that applied but the survey wouldn't let me. I would consider all of the above based on the purpose and the audience.*
- *All of the above (survey tool didn't allow selection of multiple options). A detailed report is necessary, and should be accompanied by an exec summary. A presentation would be great - or a series of presentations (travelling road show??).*
- *Would only allow me to click one. I think all are necessary to the various audiences*
- *The program allow you to click only one circle. All are good depending on the audience.*
- *The survey response does not allow all that apply. Citizen groups and decision makers are different knowledge users, however both need clear plain language information. A one page summary on a web site can also have supporting links to detailed reports and metrics. A video or infographic is helpful as well.*
- *I believe all of the above will make the best impact*
- *Check boxes won't let me check all of the options, but I would say that all could be appropriate, depending on the audience you are trying to communicate to, and what you are trying to communicate.*
- *all of the above, plus webinar or conference workshop*
- *all of the above*
- *Won't let me check more than 1 but all are good*

What would you like to see included in an evaluation framework (i.e., how would you like it to 'look'?). Please rate the extent to which you think each of the following components are important to include in an evaluation framework developed for Specialized Geriatric Services.

	Not at all important	A little bit	Somewhat	Very	Extremely important
Clearly articulated evaluation questions / program objectives	0	0	0	40.0% (8)	60.0% (12)
Outcome indicators (what will be measured / what information will be collected)	0	0	0	20.0% (4)	80.0% (16)
Expected short- and long-term outcomes	0	0	15.0% (3)	35.0% (7)	45.0% (9)
Identified sources of information (e.g.,, data sources/ what information is collected from who)	0	5.0% (1)	15.0% (3)	25.0% (5)	55.0% (11)
Identification of who is responsible for collecting the information	0	5.0% (1)	25.0% (5)	25.0% (5)	40.0% (8)
	5.0% (1)	0	20.0% (4)	40.0% (8)	35.0% (7)

	Not at all important	A little bit	Somewhat	Very	Extremely important
Description of how the data will be collected (e.g., description of specific methods such as surveys, interviews)					
Timelines (e.g., when will the information be collected; when will it be collated; how frequently it will be shared)	0	0	20.0% (4)	50.0% (10)	30.0% (6)

Is there any other information that you would like to see included in the evaluation framework?

- *Not at this time*
- *Elements where program objectives overlap for identification of duplicate roles.*
- *Background about the agreed-upon principles and theoretical framework -Detailed methods to assist a future evaluation team to implement the evaluation tasks*
- *Any consent processes where applicable.*
- *I am wondering about "Expected short and long term outcomes" in question 10 above. How do expectations relate to evaluation? Do you want to compare what people expected with what actually happened?*
- *Stakeholder engagement, particularly those more challenging to engage, both frail older adults and specialists such as cardiologists/ nephrologists, even primary care to an extent.*
- *Not at this time*
- *Results segmented by sector and provider funding levels*
- *Measurement of patient experience*

We would now like to know a little more about each of the programs.

Have the key activities as outlined in your program logic models been implemented as planned?

	Don't know	Few	Some	Most	All
Behavioural Supports Ontario	30.0% (6)	0	15.0% (3)	25.0% (5)	10.0% (2)
GAIN	25.0% (5)	5.0% (1)	20.0% (4)	25.0% (5)	10.0% (2)
GEM	20.0% (4)	10.0% (2)	20.0% (4)	15.0% (3)	5.0% (1)
NPSTAT	30.0% (6)	0	20.0% (4)	20.0% (4)	10.0% (2)
Senior Friendly Care	25.0% (2)	10.0% (2)	15.0% (3)	20.0% (4)	0

To what extent have the short-term outcomes that were identified in the program logic model been achieved?

	Don't know	A little	Somewhat	Mostly	Completely
Behavioural Supports Ontario	45.0% (9)	0	15.0% (3)	20.0% (4)	0
GAIN	35.0% (7)	0	30.0% (6)	15.0% (3)	0
GEM	35.0% (7)	10.0% (2)	10.0% (2)	15.0% (3)	0
NPSTAT	40.0% (8)	0	10.0% (2)	30.0% (6)	0
Senior Friendly	35.0% (7)	10.0% (2)	15.0% (3)	10.0% (2)	0

Have there been any unintended outcomes? If yes, please describe.

Program	Don't know	No	Yes	Describe
Behavioural Supports Ontario	65.0% (13)	5.0% (1)	15.0% (3)	*Travel costs for organizations to send staff for training.* *inconsistency with model development across the community, working to create a standardized model* *comprehensive professional development strategy* *Increased data collection with limited funding. Example DOS monitoring with new or identified behavioral.*
GAIN	60.0% (12)	15.0% (3)	15.0% (3)	*Synergy with other programs (Assess and Restore)* *Variations in referral patterns across clusters, variations to the "acceptable" patients for different teams each team has evolved their own models. The GAIN operating manual was just approved and circulated with expectations for each team. It will be interesting to see the adherence to the standards* *demand is clearly apparent, particularly for community teams*
GEM	65.0% (13)	0	15.0% (3)	*As per above* *invaluable resource on senior friendly hospitals and age-friendly initiatives* *Hospitals feel they own this and the money disappears*
NPSTAT	60.0% (12)	5.0% (1)	10.0% (2)	*Likely as a result of the capability and expertise of the NPs in the NPSTAT program - the following unintended outcomes are being seen: increase in NP usage for skill-specific intervention that should be supported by LTC partners; use of NPs for facilitation of Medical Assistance in Dying; and NP engagement by hospital to address hard to place patients not yet admitted to home (ALC to LTC)* *Decreasing pressure on ED*
Senior Friendly	65.0% (13)	0	10.0% (2)	*Synergy with age-friendly initiatives becoming apparent* *Hospitals are answering that they are senior friendly when they are way behind*

Are there any programs gaps, i.e., any areas in which there are gaps in care? If yes, please describe.

Program	Don't know	No	Yes	Describe
Behavioural Supports Ontario	35.0% (7)	0	45.0% (9)	*Limited/lack of BSU beds15. - Wait times for BSU beds - Delayed supplementary funds yes. NPs should be available on late evenings and weekends. As the percentage of ER transfers will be greatly reduced* *Lack of a robust presence in the community* *More work required to full develop a community component of BSO - need to continue to push beyond training to solidify practice change* *Funding discrepancies among LTC facilities - LTCs functioning at different levels - not sure if all community teams have access to BSO to the same levels - variation in how integrated care teams function* *Funding discrepancies among LTC facilities - LTCs functioning at different levels - not sure if all community teams have access to BSO to the same levels - variation in how integrated care teams function* *Acute Care* *There are many barriers to universal access.* *Limited/lack of BSU beds - Wait times for BSU beds Delayed supplementary funds* *Community-based BSO - there needs to be more training/skills development for informal caregivers. They provide the majority of care, so why aren't we supporting them with skills that could assist them with provision of that care?* *Acute Care Sector Implementation of BSO philosophy of care - There are opportunities to further strengthen BSO Community support services - through GAIN, ADP, CCAC etc. - Inequity and variation of delivery geriatric mental support services to LTC across the LHIN region - Services for patients under 65 can be challenging - Geriatric Mental Health support services for community patients* *Lots of homes have none and community has little help and get psych is almost bill*
GAIN	20.0% (4)	5.0% (1)	60.0% (12)	*A plethora. Some clinicians practicing below standard; institutions/organizations not being accountable for supporting teams, some teams appear to be practicing in a model that we did not intend (keeping patients on caseload too long, or not long enough). I feel like some of the key program principles are misunderstood.* *Wait lists resulting in delays for those in need in accessing care.* *Further standardization of clinical approaches (e.g. depth of assessment capacity, breadth of interventions) required* *Teams function differently - not all teams provide intervention to the same extent - access not coordinated* *underestimate of demand* *GAIN still functions somewhat as a silo when it comes to working with hospitals, particularly with patients in*

Program	Don't know	No	Yes	Describe
				ALC beds (hospital staff trying to access GAIN services for these patients sometimes encounter roadblocks). • *Teams function differently - not all teams provide intervention to the same extent - access not coordinated* • *Capacity* • *Direct access to BSO services for appropriately assessed patients* • *Intervention for clients who are cross LHIN residents - leverage collaboration with existing home and community programs, e.g. GAIN to collaborate with Assisted Living* • *No medical involvement in many poorer equity care in those*
GEM	30.0% (6)	0	45.0% (9)	• *Standardization of role required* • *Would like to see all funding allocated to this program utilized for the program and if not spent, given to other organizations that have the program up and running well.* • *Not available at all hospitals - only available usual work hours Monday - Friday - GEM utilized differently in different organizations* • *Not available in all hospitals.* • *Not available at all hospitals - only available usual work hours Monday - Friday - GEM utilized differently in different organizations* • *When there is the desire for older adults to return to their homes in the community and there are not adequate community services that can be funded to enable that.* • *Not all Emergency Departments in the LHIN have GEM Nurses. Although we know there is no anticipated funding for hospitals, I would challenge that concerted efforts to make EDs more senior friendly could assist in this.* • *Hours of coverage* • *Not well structured overall yet administratively and clinically*
NPSTAT	50.0% (10)	5.0% (1)	15.0% (3)	• *Inability to support patients in community outside of long-term care, particularly retirement homes - Lack of awareness of LTC patients transferred to hospital without engaging the program first* • *Past gap in not being able to prescribe narcotics for palliative patients which I understand is being addressed by new provincial legislation.* • *Clinical guidelines to support NP practice in these roles* • *Not available in all LTC homes.* • *Yes. NPs should be available on late evenings and weekends. As the percentage of ER transfers will be greatly reduced.*
Senior Friendly	40.0% (8)	30.0% (6)	5.0% (1)	• *Is the need to roll out this approach to the community?* - *continuing work needed to embed SFc in the fabric*

Program	Don't know	No	Yes	Describe
				of organizations - *has been focused on only hospitals to date, this will change once provincial senior friendly care framework is developed and released - not all hospitals have embraced senior friendly care to the same extent - no accountability structure between Central East LHIN, hospitals and committee* *Has been focused on only hospitals to date, this will change once provincial senior friendly care framework is developed and released - not all hospitals have embraced senior friendly care to the same extent - no accountability structure between Central East LHIN, hospitals and committee* *Too many to count. There needs to be more explicit mechanisms in place to ensure organizations are striving to be senior-friendly. The good-will of one keen individual from an organization is not going to move an organization forward (particularly at multi-site organizations). There needs to be a more concerted effort by senior-management, including reconsidering the processes of care.* *Too huge to describe gaps awful Many hospitals tying people up missing diagnosis etc.*

Thinking about what you would like to learn from an evaluation of Specialized Geriatric Services, what do you envision would be key potential sources of information that could easily be accessed for evaluation purposes?

- *Monthly stats from each program financials clinician/staff surveys direct observation of practice*
- *Process Measures: unique patients, face to face vs. telephone - Patient descriptors: disease profile, frailty, geriatric syndromes present, primary care engagement, home care engagement - Outcome Measures: use of hospital in last quarter, death at home, transfers to hospital, admissions to hospital, cost of care/visits - Balancing Measures: death at hospital by choice, transfers to hospital by patient choice, cost of baseline primary care with similar engagement - Sources: CCRS, NACRS, DAD, HAB, CHRIS - Utilization of data*
- *Not sure*
- *Program managers - program staff - service recipients - charts - policies - program manuals*
- *Program logic models • Program indicators/metrics/data • Program operating guidelines • Annual reports • Other relevant reports - e.g., Need for Specialized Geriatric Services in the Central East LHIN (October 2013), previous evaluations, LHIN and provincial reports • Individuals involved in the operations of SGS - e.g., staff, physicians, patients/caregivers • Individuals that are recipients of the programs - e.g., patients, caregivers, family members • Partner organizations/programs • Funding agencies*
- *n/a*
- *key potential sources of information: - SGS staff data - SGS staff feedback - patient caregiver feedback - host organization feedback*
- *Program logic models • Program indicators/metrics/data • Program operating guidelines • Annual reports • Other relevant reports - e.g., Need for Specialized Geriatric Services in the Central East LHIN (October 2013), previous evaluations, LHIN and provincial reports • Individuals involved in the operations of SGS - e.g., staff, physicians, patients/caregivers • Individuals that are recipients of the programs - e.g., patients, caregivers, family members • Partner organizations/programs • Funding agencies*

- *Current metrics 16/17 financials patient satisfaction staff satisfaction process audit*
- *The first source should always be the patients/caregivers as they are the ones living with the disease and having to cope with the situation. They should be assured of anonymity so they do not have to be afraid of retaliation. It would be best if surveys are done by third parties.*
- *Existing metrics for the programs Preyra Report Previous evaluation reports*
- *Program descriptions, metrics, logic models, funding letters, Service Accountability Agreements, Roles & responsibilities, position descriptions, competencies, Seniors Care Network framework*
- *Programs ministry communities CELHIN hospitals partner agencies CCAC*
- *Surveys/Interview of service providers - Surveys of service users - survey other stakeholders*

What strengths do you think currently exist to complete evaluation efforts? What factors exist that you think will enable evaluation? Are there any existing resources or supports that could be engaged for evaluation?

- *Manpower and expertise to complete the evaluations.*
- *There is a willingness to do so, and a curiosity on the part of clinicians to understand where their individual teams, clusters and the region stands in regard to meeting program objectives. Good will between organizations Strong emphasis on program evaluation in the current work culture It's an expectation of the government that we do so Each organization engages in CQI -- they will benefit from the SGS evaluation Resources: leadership within Seniors Care Network; potential assistance from host organizations?*
- *CHRIS system reporting - provincial and regional - Availability of provincial and regional RAI data*
- *Very strong leadership team both at Seniors Care Network level and program level.*
- *Some central office staff that could support the process - advanced scheduling and a realistic work plan could enable evaluation efforts - might be able to invite participation from and partner with other RGPs*
- *Commitment of Seniors Care Network • staff of Seniors Care Network and specialized geriatric services programs*
- *n/a*
- *Strengths and enablers?: strong and determined team, technology,*
- *Commitment of Seniors Care Network - staff of Seniors Care Network and specialized geriatric services programs -*
- *Teams are currently craving a program evaluation. Teams feels at this time there is not enough evidence to "show their worth".*
- *Staff understanding of metrics and existing partnerships LHIN wide are definite assets. Emerging primary care leads show promise and potential to leverage the change as part of changes of CCAC*
- *Manpower and expertise to complete the evaluations.*
- *Because the programs have just completed their program logic models, evaluation is fresh in peoples' minds.*
- *Strengths: There is a wealth of excellent program documentation and metrics available. Existing resources or supports that could be engaged for evaluation: Working groups & committees Providers Integrated Care team partners Provincial partners Metrics & reports*
- *have a strong base that needs some centralization there are multiple sources for collecting data that already exist*
- *Use of Health Links forums*
- *Too hard to answer*

What do you think are potential challenges that will be encountered when conducting an evaluation of Specialized Geriatric Services? Are there things that could pose a threat to completing an evaluation?

- *Knowledge/understanding of the project/program topic and the evaluation process*

- *Time and workload*
- *Self-evaluation poses potential conflict of interests - Multiple provider practices for data collection at front level - Limited engagement with back-end data as part of routine business practice - 2 quarter gap in CIHI systems reporting - Causal links between provider intervention and patient outcomes*
- *Challenges in securing voice of frail older adults and their caregivers.*
- *Host organizations will need to facilitate access to charts, policies - "closeness" to topic, internal people will need to think about how they contribute to evaluation process - competing priorities, authority to require evaluation is unclear*
- *Age and cognitive ability of the client may impact ability to complete an evaluation*
- *no*
- *Evaluations and data need to be able to be articulated with context behind them. The questions we ask may restrict or diminish the complexity of gerontology, we may just fall into the system like always, as opposed to being innovative, different and outside the box! - technology may be limited, and manual labour can be difficult for busy SGS staff*
- *Very difficult to quantify the qualitative data that would be required to truly tell the story of how SGS impacts the lives of frail seniors*
- *If only service providers are included in the evaluation, the results would be flawed.*
- *The obstacle of the lack of a province wide EMR platform as a source of data collection and communication will continue to be a barrier. The usual lack of resources dedicated to personnel to coordinate this kind of work, both in data collection and analysis is a challenge.*
- *Knowledge/understanding of the project/program topic and the evaluation process*
- *Our data is not linked - which could be a challenge when considering the relationships between these programs.*
- *Available time of CCAC program leads during LHIN transition may be an issue. New funding announcement work may compete for time to engage in the evaluation work.*
- *What will be the impact on current systems of evaluation and will it be perceived as more work? If a player decides not to participate does Seniors Care Network have any authority?*
- *People, including service providers, do not really know what exactly are SGS - Difficult to go back to interview service users for feedback as some of those SGS are short-term crisis intervention*
- *Everyone wants to talk about what they do well.*

Thinking of the challenges/ threats you identified above, what suggestions do you have for overcoming these?

- *Be transparent - keep people/participants informed - regular and complete updates.*
- *Consider prioritizing work. When developing the framework and actual evaluation, perhaps we can focus on the priority information we need to garner. If we can make this a relatively straightforward process, that isn't overly onerous, has a higher likelihood of being completed How thorough do we need to be? Do we need to evaluate everything? We can leverage technology*
- *Consider a third party evaluation process - Clear criteria and standardized processes for data collection - Centralized reporting hub for data collection/presentation - Routine refresher re: data collection expectations*
- *See Seniors Care Network engagement strategy document.*
- *Consultation with LHIN and host organization to seek buy-in (report to Seniors Care Network Board)*
- *Use of volunteers to collect data*
- *no comment*
- *Considering tech alternatives - considering step wise data collection - consider longer time for return of data - consider the questions being asked as a group and how they will be used to show value of the role*

- *Make sure the receivers of care, i.e. patients and their caregivers, are included in any evaluation of services provided.*
- *Salaried multidisciplinary primary care teams and salaried specialists. Province wide secure health information systems.*
- *Be transparent - keep people/participants informed - regular and complete updates.*
- *Not sure*
- *Ensure LHIN/CCAC leadership are aware & supportive of the evaluation work required.*
- *Engage players at the earliest possible stages*
- *Embed the evaluation as part of reporting*
- *Outcomes. It opinions need to be used*

Are there any resources or supports that do not currently exist that you think would be necessary to build capacity to conduct an evaluation of Specialized Geriatric Services?

- *no*
- *Consistent, standardized reporting of provider activities across SGS programs - Robust centralized data collection*
- *Not sure*
- *Practice - may have to build in an "inter-rater" component while we learn to conduct evaluation effectively*
- *yes*
- *Consider ways of measuring the impact on community, and capacity building - all activities measured using technology/or application*
- *Health information systems discussed above and dedicated human resources for supporting the activities.*
- *Access to 'big data' (i.e. Health Administrative Data).*
- *No*
- *not aware*
- *Standardized performance indicators (tools? how?)*
- *EMR and same EMR across LHIN*

Do you have any additional or final comments to make about an evaluation framework for Specialized Geriatric Services or regarding the process to develop or implement this framework?

- *Building capacity for personnel/staff*
- *I am not an expert in program evaluation, but am happy to support, learn and help.*
- *Timeframe for immediate vs. long-term results - Clarify intended targets of LHIN/Ministry*
- *Need to make sure to include gap analysis related to unmet needs within target population.*
- *As mentioned several times before, you will only get a true picture of whether provided services are of value if you hear it from the horse's mouth, i.e. from the patients/caregivers themselves.*
- *Building capacity for personnel/staff*
- *Great work!*

Do you have any evaluation related questions that you would like the evaluation consultants to address when we meet together on May 15th?

- *I've asked as I've moved through this survey.*
- *Expectations of provider agencies in data collection - Timelines for one-time and recurrent completion*
- *What is the strategy for hearing the patient/caregiver voice in this initiative?*
- *Still unclear about how we will go about not only collecting evaluation data, but making sense of it, given there are still rather limited metrics associated with SGS programs.*

- *Financial resources, including surplus funding - we know it exists, but reporting on financials has been a challenge.*
- *Can the evaluation be segmented by program elements? Example: - Leadership program/ infrastructure - Funded providers- by sector - Non-funded providers - Existing resources leveraged to support the program*
- *none*
- *nil*

Tell us about yourself!

I'm a member of:	No	Yes	If yes, I've been a member for:
The Joint service operations committee	30.0% (6)	45.0% (9)	Since inception - N = 5
Seniors Care Network Board	45.0% (9)	50.0% (10)	Since inception - N = 2 1-2 years – N = 2 >3 years – N = 1
Other, please specify: *CE LHIN PFAC* *Seniors Care Network Staff*	0	10.0% (2)	< 1 year – 4 years

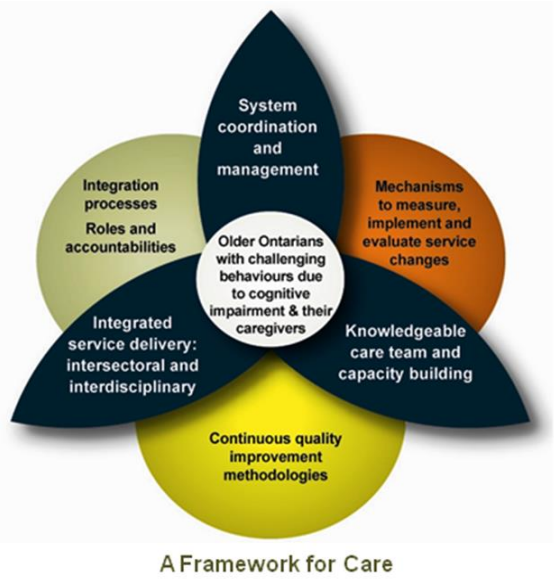
With which program are you primarily associated with?

10.0% (2)	Behavioural Supports Ontario
20.0% (4)	GAIN
15.0% (3)	GEM
0	NPSTAT
15.0% (3)	Senior Friendly
30.0% (6)	Other, please specify: *All (1)* *More than one; combinations of BSO, GAIN, NPSTAT (3)* *Home at Last/ Home First (1)* *Seniors Care Network Board (2)*

Appendix C

Program Description and Logic Model: Behavioural Supports Ontario

Program Description

	Behavioural Supports Ontario (BSO)
Service Description: General **Figure 1: Provincial BSO Framework**  A Framework for Care	Focused on helping older people living with responsive behaviours associated with cognitive impairments due to complex mental health, addictions, dementia, or other neurological conditions and their caregivers, BSO enhances services for older adults providing them with the right care, at the right time, and in the right place (at home, in long-term care or elsewhere). **Program Goals**: To: - reduce behaviour-related resident transfers from Long-Term Care Homes (LTCHs) to acute or specialized units - delay need for more intensive services, reducing acute care admissions and risk of Alternate Level of Care (ALC) - reduce length of stay for person in hospital who can be discharged to LTCHs with enhanced behavioural resources - develop and implement new models of care that focus on quality of care and quality of life - promote new ways to manage behaviours and provide standardized, consistent

	levels of care • apply continuous quality improvement methodology to test and learn what works best • build a consistent, standard care process as a foundation for improvement though a phased approach and a series of improvements • share lessons learned across the Central East LHIN and across Ontario

Clinical Program Partners/ Organization involved	***Long-Term Care***
	Embedded BSO
	• embedded staff in 45of 68 LTCHs serve 67% of long-term care residents in Central East LHIN
	Integrated Care Team
	• Integrated Care Teams:
	  • serve all 68 LTCHs
	  • members: local Psychogeriatric Resource Consultants (PRCs), Geriatric Mental Health Outreach Teams (GMHOT), and Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT)
	NPSTAT: each NP covers 8-12 homes
	GMHOT: Each LTCH is assigned to a Geriatric Mental Health Outreach team member; each team covers from 5 to 11 homes; hosted at various Health Service Providers (HSPs)/hubbed out of 4 locations
	PRC: Each LTCH is assigned a PRC; each PRC serves 9-27 homes; hosted at various

	health services providers ***Community*** (includes retirement homes, personal residences) • **GAIN:** 12 teams located at 11 sites, in three clusters*; 4 teams: hospital-based (in bold); 8 teams: community based **NE Cluster** • Community Care City of Kawartha Lakes • **Peterborough Regional Health Centre** (Community team and hospital-based team) • Trent Hills Community Team • Haliburton Highlands Health Services • Port Hope Community Health Centre **Scarborough Cluster** • Carefirst Seniors • Community Services Association and Senior Persons Living Connected • **The Scarborough and Rouge Hospital: General & Centenary sites** **Durham Cluster** • Carea Community Health Centre • **Lakeridge Health Oshawa** All 12 GAIN teams will do home visits for BSO clients
Program Start Date	2011

Hours	***Long-Term Care*** *Embedded staff:* Hours vary by LTCH *Integrated Care Team* **NPSTAT:** Monday through Friday, 10 am to 6 pm.; currently no weekend hours, but will be developing/pilot testing weekend hours this fiscal year **GMHOT:** Monday through Friday; 8 am to 5 pm **PRC:** Monday through Friday; 8 am to 5 pm ***Community*** **GAIN:** Teams provide a range of hours with most offering Monday-Saturday service, as well as various evening and Sunday coverage
Eligibility	Older adults who are living with responsive behaviours resulting from cognitive impairments due to complex mental health, addictions, dementia, or other neurological conditions and their caregivers.
Application/Referral	***Long-Term Care*** *Embedded staff:* Referrals accepted from all LTCH staff *Integrated Care Team* **NPSTAT:** Referrals accepted directly from BSO embedded staff, LTCH staff, and residents' families; by phone or email **GMHOT:** Referrals accepted directly from designated LTCH staff by phone, fax or email **PRC:** Referrals accepted directly from designated LTCH staff by phone, fax or email

	Community **GAIN:** Referrals accepted from Emergency Department staff; Family Physicians or Nurse Practitioners in the community; Inpatient hospital units for follow-up after discharge from hospital; Individuals/family members; Community organizations
Intake	***Long-Term Care*** *Embedded staff:* each home has its own intake process *Integrated Care Team* **NPSTAT:** once a LTCH resident's needs are identified (by anyone working in the LTCH or a family member), concerns are shared with the home's charge nurse; the charge nurse contacts the family physician serving the LTCH; if no response in 1 hour, or if family physician indicates that NPSTAT should be consulted, the NPSTAT nurse who provides service to that home is contacted by phone; all referral sources are contacted by NPSTAT within 1 hour of request for service. **GMHOT:** individualized by team **PRC:** referrals by email or phone ***Community*** **GAIN:** each of the 12 GAIN teams do their own intake and triage; all new referrals are reviewed and prepared for clinical triage within 3 business days; teams have a maximum of 5 business days to complete clinical triage and provide the patient with an appointment/visit date
Program Partners: Administrative	Central East LHIN as well as the Seniors Care Network Board and Seniors Care

	Network
Funded by	The Ontario Ministry of Health and Long-Term Care through the Central East LHIN
Program Governance	• Long-Term Care Embedded staff: report to the home's designated leadership • Community BSO Clinicians: report to GAIN Team Managers • System Planning by Design Team, Education Committee, and regional Implementation Tables • BSO Program Lead: reports to LHIN Lead, Director of Home & Community Care, Patient Services
Program Coordination	**BSO Program Office** • Linkages with NPSTAT, GEM, and GAIN facilitated by Program Lead's participation in Seniors Care Network • Program Lead (Seniors Care Network member) provides administrative oversight, and represents the Program at: (1) Seniors Care Network Board; and (2) Joint Services and Operations Committee • Program Lead connects bi-monthly with provincial BSO Coordinating Office ***Long-Term Care*** *Embedded staff* • Homes grouped into 3 geographic clusters/7 sub-regions*; clusters meet 4-6 times/year *Integrated Care Team* **NPSTAT:** program staff report to the NPSTAT Program Administrative Lead

	GMHOT: Linkages facilitated by participation in cluster based Implementation Table and email **PRC:** Linkages facilitated by participation in cluster based Implementation Tables, BSO Education Committee and email ***Community*** **GAIN:** program staff report to the GAIN team manger who reports to the host organization; GAIN team managers meet monthly with GAIN Program Lead
Data Sent to	• Long-Term Care Home embedded staff: metrics and program implementation statistics reported to BSO program admin monthly • Quarterly data reports and annual reports are submitted to Seniors Care Network Board via Seniors Care Network Executive Director Report • Quarterly Activity & Annual Reports are submitted to the BSO Provincial Coordinating Office
Fees	No fees for clinical services patient costs covered through program operating budget
Clinical Staff (FTEs per discipline)	***Long-Term Care*** *Embedded staff:* 3.1 FTE registered nurses; 38.6 FTE registered practical nurses; 31 FTE personal support workers *Integrated Care Team* **NPSTAT:** Nurse Practitioners: 9 FTEs; Administrative lead: 0.5 FTE **GMHOT**: Scarborough 2.5 for 22 homes , Durham 2 for 26 homes, North East approx. 3 for 20 homes

	PRC: Scarborough 2 for 22 homes , Durham 2 for 19 homes, North East approx. 1.5 for 27 ho**mes** ***Community*** **GAIN:** 12 BSO RPNs **Primary Care Collaborative Memory Services**: 2 BSO RPNs; hosted by and report to Durham Alzheimer Society
Operational Staff (FTEs)	• Program Lead (Seniors Care Network member): 1.0 FTE • Quality Improvement Facilitators: 2 FTE • Administrative Assistant: 1 FTE • Project Manager: 1 FTE (currently vacant)
Model of Care	***Long-Term Care*** *Embedded staff:* assessment, implementation of care strategy, monitoring/evaluation of impact, follow-up: individualized/ dependent on client needs *Integrated Care Team* • NPSTAT, GMHOT, PRC staff provide support and care continuum coordination; ongoing care as required ***Community*** **GAIN** • Time-limited; often intensive case management: often 3 visits/client; patients can also receive moderate case management or light case management **Capacity Building**

	• education provided to care providers across the care continuum • shared learning promoted • Communities of Practice meet 3x/year • "buddy" LTCHs promote spread and sustainability of BSO philosophy and approach to care
Approximate Volumes	Quarterly: Approximately 3,100 long-term care residents; approximately 170 community-dwelling clients
Website	http://centraleast.behaviouralsupportsontario.ca/ http://seniorscarenetwork.ca/programs-initiatives/programs/behavioural-support-ontario-bso/
Other	http://www.centraleastlhin.on.ca/goalsandachievements/Seniors/BehaviouralSupportsOntarioProject-CentralEastLHIN.aspx

*: Clusters:

1. Scarborough: has 2 LHIN sub-regions
2. Durham: 2 LHIN sub-regions
3. North East: 3 LHIN sub-regions

Program Logic Model: Behavioural Supports Ontario (BSO)

COMPONENTS	Advocacy for Age-Related Needs	Improving Care: intake, assessment, follow-up, care coordination	Fostering Excellence: Capacity Development & Networking

ACTIVITIES (What do we do?)	• Promote BSO program at conferences/meetings
	• Foster SGS program linkages
	• Enhance partnerships with other providers (MH, addiction services, DSO)
	• Encourage organizational support of Senior Friendly principles of care
	• Encourage organizational support of Dementia Friendly care
	• Develop a process for obtaining lived experience input
	• Develop a comprehensive communications strategy that engages and informs key stakeholders
	  • Develop e-newsletter on BSO mini-site
		• Encourage the application of Senior Friendly Care principles in BSO-related processes of care
		• Work with GAIN to develop and implement a practice model for community Behavioural Supports Ontario
		• Spread and sustain use of Behavioural Assessment Tool (BAT):
		• develop electronic LTC BAT on PCC/POC;
		• pilot project with LHO re hospital use of BAT
		• Realign partner (GAIN team) LTCH assignments
		• Develop process for LTCHs to identify and recommend benefits of other health professional roles (e.g., DSW, SSW)
		• Compile BSO program manual
		• Standardize LTCH engagement & referral processes
		• Identify opportunities to reduce variation with GMHOT process steps
		• Collaborate to refine and implement streamlined Ontario Shores admissions for LTCH residents and those living in the community
		• Examine care transitions:
		  • Develop transitions process with CE LHIN acute care hospitals
		  • Conduct Kaizen events to identify, implement, and test strategies that support transitions
		  • Refine the LTCH value stream process to further support patient transitions
		• Develop and implement a complex case resolution process and determine alignment with Health Link Coordinated Care Plan
		• Develop & implement strategy to increase LTCH primary care physician/NP engagement
		• Investigate the need for a Transitional Behavioural Support Unit (TBSU) in CE LHIN:
		  • Complete chart review of CE patients waiting for an out of region BTSU
		  • Prepare briefing note with recommendation
			• Encourage long-term care home (LTCH) uptake of Senior Friendly Care knowledge and practices
			• Develop annual work plan and obtain approval
			• Collect and analyze BSO program data
			• Generate and submit quarterly/ annual reports reflecting program performance (e.g. provider performance, LTCH refusal data)
			• Identify strategies to improve data quality (e.g. methods to reduce manual data collection, refine operational definitions of key metrics)
			• Identify key program evaluation question(s) & conduct evaluation
			• Lead and foster leadership in QI initiatives
			• Review current roles & responsibilities of BSO funded staff
			• Develop & implement Mental Health Education curriculum
			• Implement a knowledge translation strategy
			• Develop capacity in Retirement Homes to manage responsive behaviours
			• Investigate possibility of incorporating required performance expectations into service contracts (e.g., L-SAAs)
			• Contribute to Home and Community Care's Provincial Behavioural Assessment Working Group for education and improvement opportunities

TARGETS (Who are we targeting with each activity?)	• CE LHIN • CE Home and Community Care • Ministry of Health and Long-Term Care • Older adults living in CE LHIN with responsive behaviours and their family • SGS program staff • Seniors Care Network • Care continuum (specialty care, home and community care, primary care) • BSO patients/family • CE LHIN community • BSO staff	• Older adults living with responsive behaviors and their family/informal care providers • BSO referral sources • Care continuum (specialty care, home and community care, primary care) • CE LHIN community • BSO program staff • BSO partners: Integrated Care Team members and host organizations; GAIN team	• Older adults living with responsive behaviours and their family/informal care providers • Care continuum (specialty care, home and community care, primary care) • BSO program staff • Seniors Care Network • CE LHIN • CE LHIN community

SHORT-TERM Outcomes (Why are we doing this?)	• Process through which consumer voice will be heard developed • Senior Friendly/dementia friendly care principles are embedded in BSO-involved organizations • Increased community and healthcare provider awareness of BSO Program • Increased linkages among SGS programs • Improved communication among SGS program providers	• BSO patient transitions to other services supported • Funding allocations reflect data, program experience and service demand/need • Program expanded through optimization of current resources • Fewer barriers to successful care transitions/improved patient transitions from LTCH to ED/acute care and back • Equitable services levels at all LTCHs • Complex case are successfully reviewed • Increased physician/NP engagement and understanding of BSO program in LTCHs • Increased understanding of need for BTSU	• Knowledgeable BSO staff • Improved data collection processes/improved data quality and analysis • BSO evaluation framework developed • Program data collected and used to identify QI opportunities • Staffing and roles aligned with BSO program needs • Fewer LTCHs refusing to take people with responsive behaviours • Increased capacity in retirement homes to care for those with responsive behaviours • Increased understanding of BSO program among health care providers across the care continuum • Better health care provider/system understanding of LTCH behaviour-related concerns • Up to date work plans
METRICS (What data are being/could be collected?)	**Milestones** • Process for obtaining input from persons with lived experience developed • e-newsletter on BSO mini-site developed **Structure Measures** **Process Measures** • # presentations re BSO to community and healthcare providers **Outcomes** • increased awareness of BSO Program	**Milestones** • Practice model for community BSO implemented • Complex case resolution process implemented **Structure measures** • # of vacant BSO positions • % of LTCH staff who understand the role of BSO **Process Measures** • # LTCH residents with responsive behaviours • # of initiated BATs for residents with new or worsened behaviours • # of people on BSO program • # of residents with a new or worsened responsive behaviour who received a change in treatment for a medical or physiological condition that likely triggered the behaviour • # of residents with responsive behaviours being actively managed with a BAT who require support from the Integrated Care Team but remain in their LTCH • # incidents related to responsive behaviours • % of staff time spent on direct care • % of staff time spent on indirect care **Outcome Measures** • % of transitions to other services that are supported by BSO staff • # LTCH resident transfers to the ED for responsive behaviours • # LTCH residents referred for the purpose of admission to tertiary care due to responsive behaviours • # residents admitted to tertiary care due to responsive behaviours • # police interventions initiated by LTCH relating to responsive behaviours	**Milestone** • BSO staff role profiles generated **Structure Measures** • % of BSO embedded LTCH RPNs working to scope of practice **Process Measures** • # BSO staff who attended Community of Practice events • # education sessions provided/coordinated by BSO program staff **Outcome Measures** • Fewer LTCH applications and admission refusals among people presenting with responsive behaviours

LONG-TERM Outcomes
(What are the long-term benefits of the program?)

- BSO Program Office staff/LTCH embedded staff/12 BSO-GAIN staff are satisfied with the program
- LTCH staff are satisfied with the program
- Program clients and family are satisfied with the program/improved client experience
- Coordinated care/smooth transitions
- Sustainable, effective, and efficient system planning
- BSO program appropriately resourced
- LTCH staff can anticipate and manage responsive behaviours
- Delayed need for more intensive services
  - Reduced number of behaviour-related LTCH resident transfers to acute care or specialized units
  - Reduced number of acute care admissions for older adults with responsive behaviours
- Reduced number of behaviour-related Alternate Level of Care days among older adults
- Reduced in-hospital length of stay for person who could be discharged to LTCHs with enhanced behavioural resources
- Models of care are focused on quality of care (evidence-based care) and quality of life
- Standardized, consistent levels of care for older adults living with responsive behaviours
- Continuous quality improvement approaches/methodology embedded in all BSO-related work plans

METRICS
(What data are being/could be collected?)

Milestone
- Patient experience survey tool & process developed
- Process mapped transitional care pathways

Structures
- # BSO staff by educational training (% with GPA training, % of U-First!; % with P.I.E.C.E.S.)

Process
- # of LTCH residents living with responsive behaviours
- # of LTCH residents living with new or worsened behaviours

Outcomes
- # & % of BSO staff who are satisfied with the program
- # & % of people living with responsive behaviours/family members who are satisfied with the program
- # & % of supported transitions
- Fewer LTCH residents who are transferred to the ED/acute care/specialized units whose primary reason for transfer is a behavioural issue
- # of ALC days among older adults with behavioural issues
- Decreased length of stay for older adults admitted for behavioural issues who could be discharged to LTCHs

OVERALL PROGRAM GOALS

- Better healthcare for older adults living with responsive behaviours and their care partners
- Better system of care for older adults living with responsive behaviours and their care partners

Potential Evaluation Questions (BSO)

ACTIVITIES

Think about which activities contribute towards the program's outcomes. Which activities are you most concerned about?

Activity	**H=High priority; M=moderate priority; L=Low priority**
Spread use of BAT	H
BSO promotion at key conferences/meeting	L
Process for obtaining lived experience voice developed for patients, care partners & care providers	H
BSO community processes standardized	H
Examination of care transitions	H
Examination of BSO metrics and accountabilities	M
BSO staff role profiles updated	M

TARGET GROUPS

Think about who the program is designed for. Do you need to know if you are reaching this group and who you are not reaching?

Target Group	**H=High priority; M=moderate priority; L=Low priority**
Older adults living with responsive behaviours and their caregivers in the CE LHIN	H
BSO referral sources	H
General population in CE LHIN	L
BSO staff	H

OUTCOMES

Think about which outcomes are most crucial. Which outcomes are the most important for this program?

Outcome	**H=High priority; M=moderate priority; L=Low priority**
BSO clients have a good care experience	H
BSO staffing and roles aligned with BSO program needs	H
Increased capacity to support persons living with responsive behaviours in all settings	M
BSO client successfully transitioned back to LTCH from hospital	M

Outcome	**H=High priority; M=moderate priority; L=Low priority**
Lived experience voice heard	H
BSO staff knowledge of mental health issues	H

Appendix D

Program Description and Logic Model: Geriatric Assessment and Intervention Network

Program Description

	Geriatric Assessment and Intervention Network: GAIN
Service Description: General	GAIN is a network of 12 hospital- and community-based health professional teams providing comprehensive assessments and creating care plans with patients to optimize function and independence and keep older people living at home. GAIN focuses on the: (1) Reduction of distress to the person and the family; (2) Improvement and/or maintenance of function; (3) Optimization of the individual's capacity for autonomous living; and (4) Maximization and maintenance of the highest possible level of independence. GAIN teams provides both clinic and home-based (in private homes or retirement homes) clinical services to older adults with frailty issues and who are living with multiple, complex medical problems including one or more geriatric syndromes (e.g., cognitive impairment, decreased function, falls or risk of falls, impaired mobility, incontinence; multiple medications). GAIN teams provide service to older adults who are experiencing changes in their support needs, who have safety concerns, or psychosocial and mental health concerns or who are frequent health service users. Overall program goal: to assist older adults to remain in their homes for as long as possible.
Clinical Program Partners/	12 teams located at 11 sites, in three clusters*; 4 teams: hospital-based (in bold); 8 teams:

Organization(s) involved	community based **NE Cluster** • Community Care City of Kawartha Lakes • **Peterborough Regional Health Centre** (Community team and hospital-based team) • Trent Hills Community Team • Haliburton Highlands Health Services • Port Hope Community Health Centre **Scarborough Cluster** • Carefirst Seniors • Community Services Association and Senior Persons Living Connected • **The Scarborough and Rouge Hospital: General & Centenary sites** **Durham Cluster** • Carea Community Health Centre • **Lakeridge Health Oshawa** BSO embedded in all 12 teams; all GAIN teams will do home visits for BSO clients GAIN Regional Office located at Lakeridge Health (Oshawa)
Program Start Date	2010
Hours	• All GAIN teams are expected to provide extended hours of service to patients and their families • 12 teams provide a range of hours with most offering Monday -Saturday service, as well as varied evening services

Eligibility	GAIN provides services to frail older adults living at home (NOT in a long-term care home) usually aged 65+ (age in the context of other presenting conditions) whose health, dignity and independence are at risk due to: (1) multiple complex chronic medical and psycho-social problems; (2) a decline in health and/or level of function; and (3) loss of capacity for independent living.
Application/Referral	Referrals directly from: (1) primary care providers; (2) hospitals (in-patient and emergency departments upon discharge; (3) community organizations; and (4) individuals and their caregivers. Referral form: www.seniorscarenetwork.ca
Intake	Referrals, once completed, can be faxed or scanned to any of the GAIN teams. A consultation request letter can also be completed and faxed or scanned to a GAIN Team. Within 3 business days, all new referrals are reviewed and prepared for clinical triage by each team's clerical staff At least 3 attempts are made to contact the patient; appointment date is communicated to both the patient/family and the referral source GAIN Teams have a maximum of 5 business days to complete clinical triage and provide the patient with an appointment date. Patients are triaged as urgent, semi-urgent, not-urgent or inappropriate (see GAIN Operating Guidelines for more detail). Application for funding a model of coordinated access office submitted; central office will send the referral to the most appropriate GAIN team or community partner
Program Partners:	Central East LHIN through the Seniors Care Network Board and Seniors Care Network Team

Administrative	
Funded by	Ontario Ministry of Health and Long-Term Care through the Central East LHIN
Program Governance	GAIN program staff report to a local GAIN team manager; all recruitment and retention efforts remain the accountability of the host organization. All team members have an accountability to their host organization, in addition to an interprofessional collaborative practice approach within the Network GAIN Regional Manager and GAIN NP Clinical Lead report to Lakeridge Health leaders; specifically, the GAIN Regional Manager reports to the Director of the PASS Program at Lakeridge Health
Program Coordination	GAIN Regional Office: hosted by Lakeridge Health, the Regional office houses the GAIN Regional Manager, the GAIN NP Clinical lead, and GAIN Program administrative support responsible for receiving, collating, rending, and analysis of compliments, complaints and incident data coordinates and schedules Care Review Rounds, Regional Rounds and the annual Knowledge Exchange; collects statistical, narrative and financial data from all GAIN teams identifies trends and coordinates QI/program evaluation across the network GAIN Regional Manager: leads the planning, coordination, implementation, and evaluation of the GAIN program meets with the 12 GAIN team managers monthly

	GAIN Regional Manager (Seniors Care Network member) represents the program at: (1) Seniors Care Network Board; (2) Joint Services and Operations Committee; (3) Clinical Performance Committee; (4) Behavior Supports Ontario (BSO) design team GAIN NP Clinical lead: member of leadership team of the Regional Program Office for GAIN; provides clinical leadership and expert consultation services across the GAIN program. GAIN Operations Committee: provides leadership, planning and evaluation for the GAIN teams; co-chaired by the GAIN Program Lead and GAIN NP Clinical lead GAIN Strategic Management Team (SMT) provides leadership to GAIN by exploring operational efficiencies, financial accountabilities and by removing barriers identified by the Operations committee Cluster Working groups: GAIN team members from that geographic cluster plus other local partners; goal: to coordinate GAIN planning, service design and implementation across the Cluster, aligning with policy and program directions and guidelines from the GAIN Operations Committee and the Seniors Care Network Profession-Specific Communities of Practice: enable each profession in GAIN to connect to regional colleagues for CPD
Data	sent to Seniors Care Network Board monthly; each quarter one report focuses on each of finances, program metrics, and qualitative outcome data Annual reports sent to Seniors Care Network Board via Seniors Care Network Executive Director Report

<table>
<tr><td>Fees</td><td>No fees for clinical services patient costs covered through program operating budget</td></tr>
<tr><td>Clinical Staff (FTEs per discipline)</td><td>Not included: collaborating geriatricians and other specialists;

Clinical Staff paid through GAIN dollars:
<table>
<tr><th>Profession</th><th>FTEs</th></tr>
<tr><td>NP</td><td>16.9</td></tr>
<tr><td>PT</td><td>4</td></tr>
<tr><td>OT</td><td>11.73</td></tr>
<tr><td>SW</td><td>10.23</td></tr>
<tr><td>Pharmacists</td><td>8.44</td></tr>
<tr><td>CSW/PSW</td><td>9.57</td></tr>
<tr><td>SLP</td><td>0.6</td></tr>
<tr><td>RD</td><td>0.9</td></tr>
<tr><td>BSO</td><td>12.0</td></tr>
<tr><td>RN/RPN</td><td>3.1</td></tr>
<tr><td>Care Coordinator</td><td>8.0</td></tr>
<tr><td>GAIN Nurse Care Coordinator</td><td>14.0</td></tr>
<tr><td>Regional office</td><td>2.0 (manager and admin)</td></tr>
<tr><td>Total Clinical</td><td>101.47</td></tr>
</table></td></tr>
<tr><td>Operational/Administrative Staff (FTEs)</td><td>Administrative staff: GAIN Regional Office: 1 FTE; supporting the 12 GAIN teams: 16.15 FTE Clerical
GAIN Program lead: 1 FTE; NP Clinical Lead: 0.5 FTE</td></tr>
<tr><td>Model of Care</td><td>Clinical
 Following a comprehensive geriatric assessment (GCA) (inter-professional data, physical</td></tr>
</table>

	assessment findings, analysis and synthesis of the clinical picture and development of a collaborative plan of care and follow-up). Goal-based care planning (the ongoing process through which patients and health care providers work together to collaboratively set goals, establish priorities and develop strategies to achieve positive and meaningful outcome) is used. GAIN teams use a Case Management continuum; patients are identified as needing intensive or moderate or light case management and are then discharged from the program. • Hospital-based teams: a more consultative model, often see people once, conduct a CGA and develop recommendation that are shared with the client and primary care • Community-based teams: mostly intensive case management; 3 visits. • GAIN strives for a collaborative, shared care approach with Primary Care Providers and all care partners. **Capacity Building** • Senior Friendly care principles applied to all assessments and care planning • Dementia Friendly care principles applied to assessment and care planning for persons with dementia • Education provided to care providers across the care conium • Shared learning promoted
Approximate volumes	• GAIN teams see approximately 1160 patients each month, and provides almost 29,000 visits annually
Website	http://seniorscarenetwork.ca/programs-initiatives/programs/geriatric-assessment-and-

	intervention-network-gain/
Brochure	http://www.prhc.on.ca/Assets/Uploaded-CMS-Files/prhc%20GAIN%20brochure%20July%207%202015-7fbc312a-2306-49a1-a6f5-c37c701673ba.pdf
Other	http://www.centraleastlhin.on.ca/goalsandachievements/Seniors/GAIN.aspx http://www.centraleasthealthline.ca/listServices.aspx?id=10275

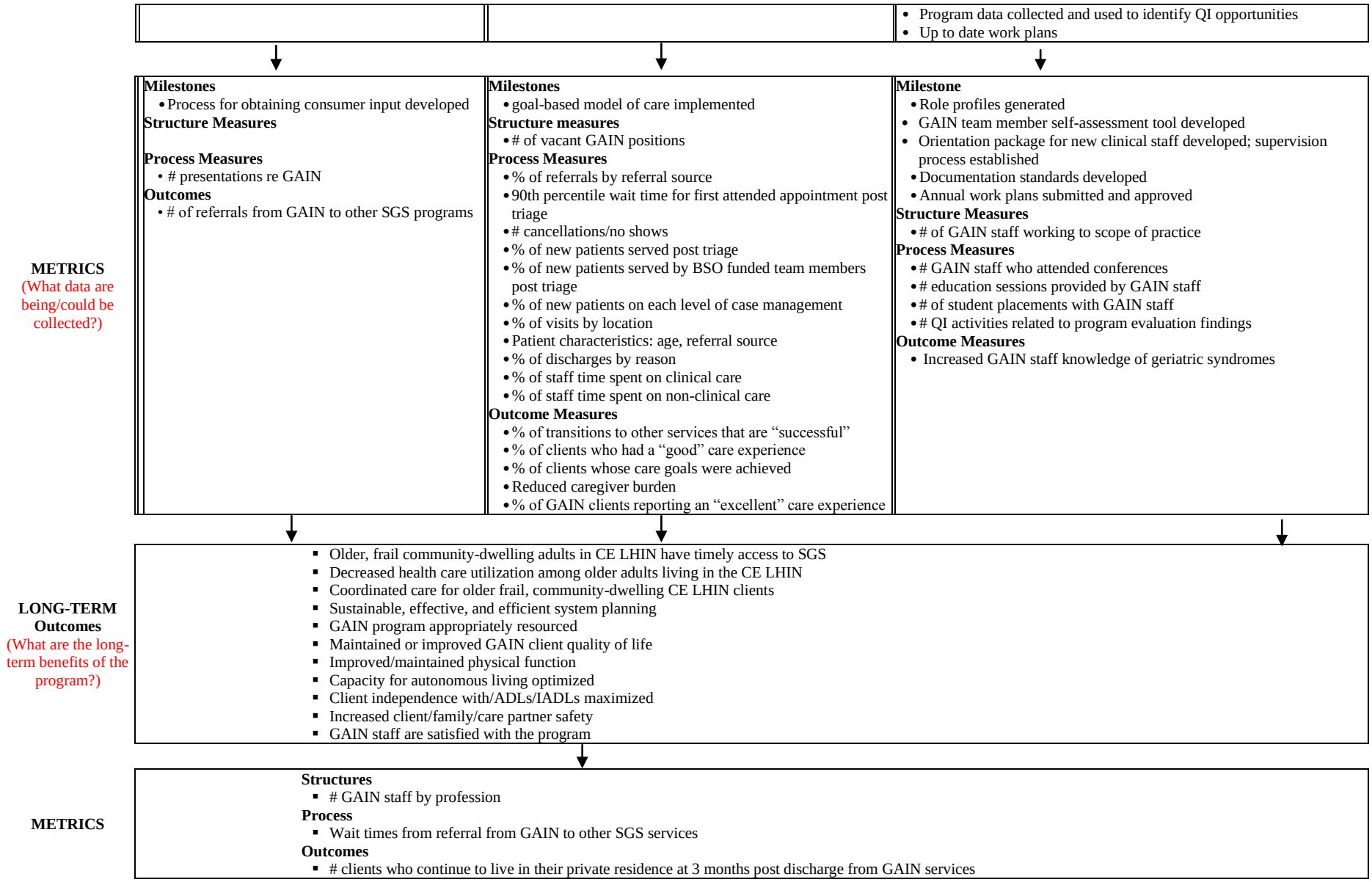
*: Clusters:

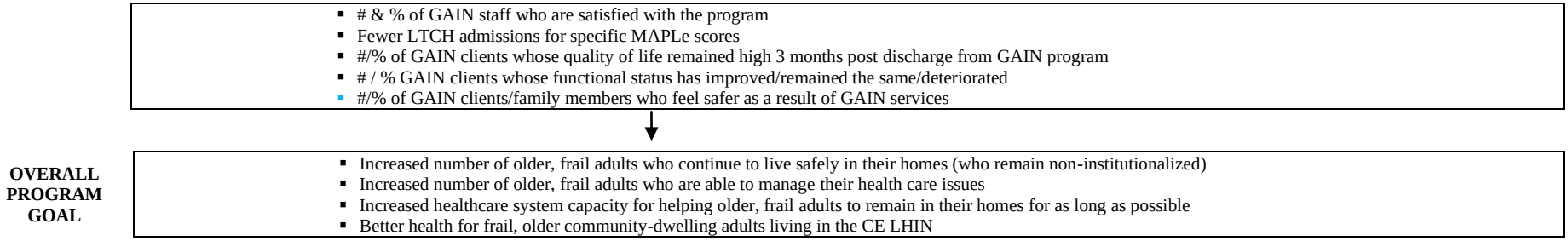
1. Scarborough: has 2 LHIN sub-regions
2. Durham: 2 LHIN sub-regions
3. North East: 3 LHIN sub-regions

Program Logic Model: Geriatric Assessment and Intervention Network (GAIN)

COMPONENTS	Advocacy for Age-Related Needs	Improving Care: intake, assessment, follow-up, care coordination	Fostering Excellence: Capacity Development & Networking
ACTIVITIES (What do we do?)	• Promote GAIN program at conferences/meetings • Foster/promote SGS program linkages • Encourage the participation of GAIN patients and families in Seniors Care Network's engagement activities • Continue to contribute to Health Links planning tables and report on experiences related to coordinated care planning • Encourage organizational support of Senior Friendly principles of care • Encourage organizational support of Dementia Friendly care	• Encourage the application of Senior Friendly Care principles in GAIN-related processes of care • Participate in development of model for coordinated SGS access • Develop, implement and evaluate a model of case management for frail community-dwelling seniors • Develop and implement a process to identify the most appropriate location and approach for care delivery (e.g., home visits vs. cohorted visits) • Develop and implement a model and process for goal-based care planning • Implement and evaluate GAIN operating guidelines • Revise and implement a Seniors' Experience Survey	• Encourage organizational uptake of Senior Friendly Care knowledge and practices • Create a GAIN inter-professional practice framework, including documentation norms • Clearly articulate clinical leadership roles within teams • Formalize role descriptions for all roles within GAIN • Develop and implement a process for clinical orientation and supervision • Develop and implement a clinical self-assessment process to evaluate clinical knowledge against required geriatric competencies and support learning plan development • Participate in knowledge transfer activities (e.g., promote student GAIN placements, presentations at evidence-based conferences) • Evaluate the GAIN model including clinical activities and administrative processes • Develop a GAIN evaluation framework • Collect program data (including feedback from older adults and families) and generate annual reports • Develop annual work plan and obtain approval • Identify quality improvement opportunities/implement QI strategies
TARGETS (Who are we targeting with each activity?)	• CE LHIN • CE LHIN community • Ministry of Health and Long-Term Care • Older frail adults living in CE LHIN and their family • SGS program staff • Care continuum (specialty care, home and community care, primary care) • GAIN patients/family members • Seniors Care Network • GAIN program staff	• Older frail adults and their family/informal care providers • GAIN referral sources • Care continuum (specialty care, home and community care, primary care) • CE LHIN community • GAIN program staff • Seniors Care Network • CE LHIN • SGS program staff	• Older frail adults and their family/informal care providers • Care continuum (specialty care, home and community care) • GAIN program staff • CE LHIN community • CE LHIN
SHORT-TERM Outcomes (Why are we doing this?)	• Process through which consumer voice developed • Senior Friendly/dementia friendly care principles supported/embedded in GAIN-involved organizational practices • Increased community and healthcare provider awareness of GAIN Program • Increased linkages across SGS programs	• Successful transitions from GAIN to other services • Model of case management evaluated • Goal-based care planning implemented • Client/family care experience evaluated • Clients receive care in most appropriate location • Reduced caregiver burden • Improved or maintained client function • Reduced service wait times	• Knowledgeable GAIN staff • Increased awareness of student placement opportunity • GAIN staff comfortable in presenting programmatic information • Standardized documentation • New staff receive standardized clinical orientation • GAIN evaluation framework developed • Increased understanding of GAIN program activities, staff roles, and administrative processes among GAIN staff

Gutmanis, I., & Hillier, L.M.
October 19, 2017


• Program data collected and used to identify QI opportunities
• Up to date work plans
Milestones
• Process for obtaining consumer input developed
Structure Measures
Process Measures
• # presentations re GAIN
Outcomes
• # of referrals from GAIN to other SGS programs
Milestones
• goal-based model of care implemented
Structure measures
• # of vacant GAIN positions
Process Measures
• % of referrals by referral source
• 90th percentile wait time for first attended appointment post triage
• # cancellations/no shows
• % of new patients served post triage
• % of new patients served by BSO funded team members post triage
• % of new patients on each level of case management
• % of visits by location
• Patient characteristics: age, referral source
• % of discharges by reason
• % of staff time spent on clinical care
• % of staff time spent on non-clinical care
Outcome Measures
• % of transitions to other services that are "successful"
• % of clients who had a "good" care experience
• % of clients whose care goals were achieved
• Reduced caregiver burden
• % of GAIN clients reporting an "excellent" care experience
Milestone
• Role profiles generated
• GAIN team member self-assessment tool developed
• Orientation package for new clinical staff developed; supervision process established
• Documentation standards developed
• Annual work plans submitted and approved
Structure Measures
• # of GAIN staff working to scope of practice
Process Measures
• # GAIN staff who attended conferences
• # education sessions provided by GAIN staff
• # of student placements with GAIN staff
• # QI activities related to program evaluation findings
Outcome Measures
• Increased GAIN staff knowledge of geriatric syndromes
METRICS
(What data are being/could be collected?)
▪ Older, frail community-dwelling adults in CE LHIN have timely access to SGS
▪ Decreased health care utilization among older adults living in the CE LHIN
▪ Coordinated care for older frail, community-dwelling CE LHIN clients
▪ Sustainable, effective, and efficient system planning
▪ GAIN program appropriately resourced
▪ Maintained or improved GAIN client quality of life
▪ Improved/maintained physical function
▪ Capacity for autonomous living optimized
▪ Client independence with/ADLs/IADLs maximized
▪ Increased client/family/care partner safety
▪ GAIN staff are satisfied with the program
LONG-TERM Outcomes
(What are the long-term benefits of the program?)
Structures
▪ # GAIN staff by profession
Process
▪ Wait times from referral from GAIN to other SGS services
Outcomes
▪ # clients who continue to live in their private residence at 3 months post discharge from GAIN services
METRICS


▪ # & % of GAIN staff who are satisfied with the program
▪ Fewer LTCH admissions for specific MAPLe scores
▪ #/% of GAIN clients whose quality of life remained high 3 months post discharge from GAIN program
▪ # / % GAIN clients whose functional status has improved/remained the same/deteriorated
▪ #/% of GAIN clients/family members who feel safer as a result of GAIN services
OVERALL PROGRAM GOAL
▪ Increased number of older, frail adults who continue to live safely in their homes (who remain non-institutionalized)
▪ Increased number of older, frail adults who are able to manage their health care issues
▪ Increased healthcare system capacity for helping older, frail adults to remain in their homes for as long as possible
▪ Better health for frail, older community-dwelling adults living in the CE LHIN

Potential Evaluation Questions (GAIN)

ACTIVITIES

Think about which activities contribute towards the program's outcomes. Which activities are you most concerned about?

Activity	**H=High priority; M=moderate priority; L=Low priority**
Coordinated access model implemented	
GAIN promotion at key conferences/meeting	
Process for obtaining consumer voice developed	
Goals-based care planning implemented	
Senior Friendly strategies implemented	
GAIN inter-professional practice framework developed	
Governance model reviewed	
GAIN staff role profiles developed	

TARGET GROUPS

Think about who the program is designed for. Do you need to know if you are reaching this group and who you are not reaching?

Target Group	**H=High priority; M=moderate priority; L=Low priority**
Older adults living with frailty in the CE LHIN	
Primary Care	
General population in CE LHIN	
GAIN staff	

OUTCOMES

Think about which outcomes are most crucial. Which outcomes are the most important for this program?

Outcome	**H=High priority; M=moderate priority; L=Low priority**
GAIN clients have a good care experience	
Care continuum finds referral process easy to use	
Client care goals achieved	
Client successfully transition to community-based programs/services	

Consumer voice heard	
GAIN staff knowledge of geriatric syndromes	
Client experience with GAIN	

Appendix E

Program Description and Logic Model: Geriatric Emergency Management

Program Description

	Geriatric Emergency Management (GEM) Program

Program Description: General	• The GEM program provides specialized geriatric emergency management services to frail, older adults attending a Central East LHIN hospital's Emergency Departments (ED)
	• Goals:
	  ◦ to deliver targeted, emergency comprehensive geriatric assessment to frail older adults in the ED, and to help seniors access appropriate services and/or resources that will enhance functional status, independence, and quality of life;
	  ◦ to build an ED team and community capacity in the assessment and care of frail older adults; and
	  ◦ to collaborate with host organizations, community care providers and specialized geriatric services (SGS) in the provision of comprehensive care to frail older adults.

GEM Nurse Role Description	Responsibilities include: utilizing and demonstrating a comprehensive theoretical knowledge base and advanced level of clinical competence in the assessment and care of older patients; acting as a resource; and serving as a consultant to individuals and groups within the healthcare professional community. Role and responsibilities are aligned with the scope of practice associated with a Master's

	prepared nurse (i.e. Clinical Nurse Specialist [CNS], or Nurse Practitioner [NP])

Clinical Program Partners/Organization(s) involved	There are currently 9.0 full-time equivalent (FTE) GEM nurse positions at nine hospital locations within the Central East LHIN, including:
	• Peterborough Regional Health Centre, Peterborough (since 2009)
	• Ross Memorial Hospital, Lindsay (since 2009)
	• Northumberland Hills Hospital, Cobourg (since 2009)
	• Lakeridge Health:
	  ◦ Ajax-Pickering Campus, Ajax (since 2009)
	  ◦ Bowmanville Campus (since 2009)
	  ◦ Oshawa Campus (since 2009)
	• The Scarborough and Rouge Hospital:
	  ◦ Birchmount Campus, Scarborough (since 2009)
	  ◦ Centenary Campus, Toronto (since 2003)
	  ◦ General Campus, Scarborough (since 2009)

Hours	Hours vary by location; usually Monday through Friday, 8 am to 4 pm (hours match those of agencies/services available to older adults; hours maximize GEM nurse ability to effectively communicate and coordinate care as clients transition to their discharge destination)
Eligibility	Frail older adults, aged 65 and older, attending the ED at the above mentioned hospitals
Application/Referrals	Referrals directly from all ED staff; however, in some cases referrals are made by community members, NPSTAT, and long-term care (LTC) staff. GEM nurses also receive requests for service from community services (e.g. police, EMS, GAIN Teams, Home and Community

	Care) for help and advice regarding issues specific to older adults, such as elder abuse and availability of community services.
Intake	Referrals are sent directly to the GEM nurse by the ED team in a number of ways: • electronically via triage risk tool done by ED triage RN that automatically generates a referral to GEM (only in some organizations); • electronically/in person to GEM at any time during ED stay; • by phone from team members internal and external to the organization; and • by Home and Community Care Coordinator for individuals receiving home care who are flagged electronically using the Common Client Alert Rarely, patient/families may request GEM services (e.g. patients who have seen the GEM before).
Program Partners: Administrative	• Central East LHIN through the Seniors Care Network Board and Seniors Care Network Team • 1.0 FTE position at the Scarborough and Rouge Hospital Centenary has administrative oversight through the Regional Geriatric Program (RGP) of Toronto on behalf of the Ministry of Health and Long-Term Care. • Host organization provides a direct report (in some cases this is a manager role and in some organizations this is a director role).
Funded by	Ontario Ministry of Health and Long-Term Care through: • the Central East LHIN (funding for 8.0 FTE GEM Positions made available through Year 2 of the Aging at Home Strategy); and

	the RGP of Toronto (1.0 FTE Position) The GEM budget is handled differently in each hospital, but GEM funding often falls within the ED budget.
Program Governance	• Each GEM nurse reports to administration at the host hospital For 1.0 FTE Ministry-funded position, administrative oversight provided through the RGP of Toronto
Program Coordination	Central East LHIN GEM Network Group (comprised of all GEM Nurses) meets 4 times a year Regional GEM spokesperson: nominated by members of the GEM Network Group represents point of care GEMs across CE LHIN, and provides administrative oversight and clinical support as a Seniors Care Network member, represents the Program at: (1) Seniors Care Network Board; (2) Joint Services and Operations Committee; and (3) Clinical Performance Committee Seniors Care Network Offices
Data sent to:	Data reports are sent quarterly to Seniors Care Network Board, and the Central East LHIN Board (via Executive Director Report) Data from the GEM nurse funded by the RGP of Toronto are sent quarterly to the RGP of Toronto Data are sent to the host organizations quarterly

Fees	No fees for clinical services; patient costs covered through program operating budget
Clinical Staff (FTEs per discipline)	9.0 FTEs, 1.0 FTE per site
Operational Staff (FTEs)	Administrative support provided by the local hospital

Model of Care	**Clinical**
	• Depending on client needs/goals: targeted or comprehensive geriatric assessment and consultation to older adults in the ED setting (primarily)
	• Assistance with in-patient geriatric consultation offered at some host organizations
	• Assessment leads to recommendations for:
	  • appropriate care during ED stay,
	  • hospital admission with clear goals/plan,
	  • safe discharge home linking older adult to:
	  • needed community services;
	  • specialized geriatric services;
	  • other specialized services;
	  • primary care; and/or
	  • Home and Community Care.
	Capacity Building
	• Senior Friendly care principles are applied to all assessments and care planning
	• Dementia Friendly care principles are applied to assessment and care planning for persons with dementia

	• ED and other hospital staff capacity development in gerontological knowledge, assessment, and best practices • Community collaboration and partnerships with surrounding academic centers • Provides education internal and external to the organization on local, regional, provincial, and national levels • Annual meetings with GEM nurses from across the province (provincial GEM Network)
Approximate volume	2-6 people per clinical day at each site Average is typically 4 assessments per day (with inclusion of other capacity building activities)
Website	http://seniorscarenetwork.ca/programs-initiatives/programs/geriatric-emergency-management-nurses-gem/
Other	http://www.centraleastlhin.on.ca/goalsandachievements/Seniors.aspx http://gem.rgp.toronto.on.ca/

Program Logic Model: Geriatric Emergency Management (GEM) Program

COMPONENTS	Advocacy for Age-Related Needs	Improving Care	Fostering Excellence: Capacity Development & Networking

ACTIVITIES (What do we do?)	• Promote GEM program at conferences/meetings
	• Foster SGS program linkages
	• Encourage ED/hospital/community healthcare leadership/organizational support of Senior Friendly (SF) Care principles and initiatives
	• Encourage ED/hospital/community healthcare leadership/organizational support of Dementia Friendly care
		• Encourage the application of Senior Friendly Care principles in GEM-related processes of care
		• Conduct targeted geriatric assessment in the ED for frail seniors
		• Conduct goal-based care planning and intervention
		• Provide proactive follow-up with patients/caregivers
		• Develop standardized CE LHIN GEM program model
		• Define and develop standardized GEM role profile
		• Evaluate current GEM care planning practices for frail seniors
		• Pilot and evaluate the use of delirium order sets for the ED at one GEM site
		• Encourage the application of Senior Friendly Care principles in ED processes of care
			• Encourage ED staff uptake of Senior Friendly Care knowledge and practices
			• Collect and analyze program data & generate annual reports
			• Develop an annual work plan and obtain approval
			• Identify program evaluation question(s) & conduct evaluation
			• Participate in QI initiatives both internal and external to the host organization/hospital
			• Provide formal/informal learning: "just in time" and more formal teaching provided to ED staff, hospital staff, community partners and community members
			• Increase knowledge translation: GEM nurses attend appropriate conferences/rounds; present scholarly posters and/or oral presentations at key meetings
			• Share best practices with community partners
			• Supervise students
			• Determine appropriate model of clinical leadership for CE LHIN GEM program
			• Develop annual continuing professional development plans
			• Develop appropriate tools:
			  • Gerontological needs assessment framework for the ED;
			  • GEM-Professional Development Plan template

TARGETS (Who are we targeting with each activity?)	• Older frail adults living in CE LHIN • ED staff • GEM nurses • Care continuum (specialty care, home and community care, primary care) • Seniors Care Network • Ontario GEM Network • CE LHIN hospitals/EDs • SGS program staff • CE LHIN community • CE LHIN • GEM patients • Ministry of Health and Long-Term Care	• Older frail adults living in CE LHIN • CE LHIN • Joint Services and Operations Committee • SGS program staff • Senior Care Network • CE LHIN hospitals/EDs • GEM program operations committee • Care continuum (specialty care, home and community care, primary care)	• CE LHIN older frail adults & their caregivers • ED staff • Care continuum (specialty care, home and community care, primary care) • GEM nurses • CE LHIN community • GEM program operations committee • University students • First responders (EMS, police) • CE LHIN Hospital organizations • CE LHIN • RGPs of Ontario • Ontario GEM network

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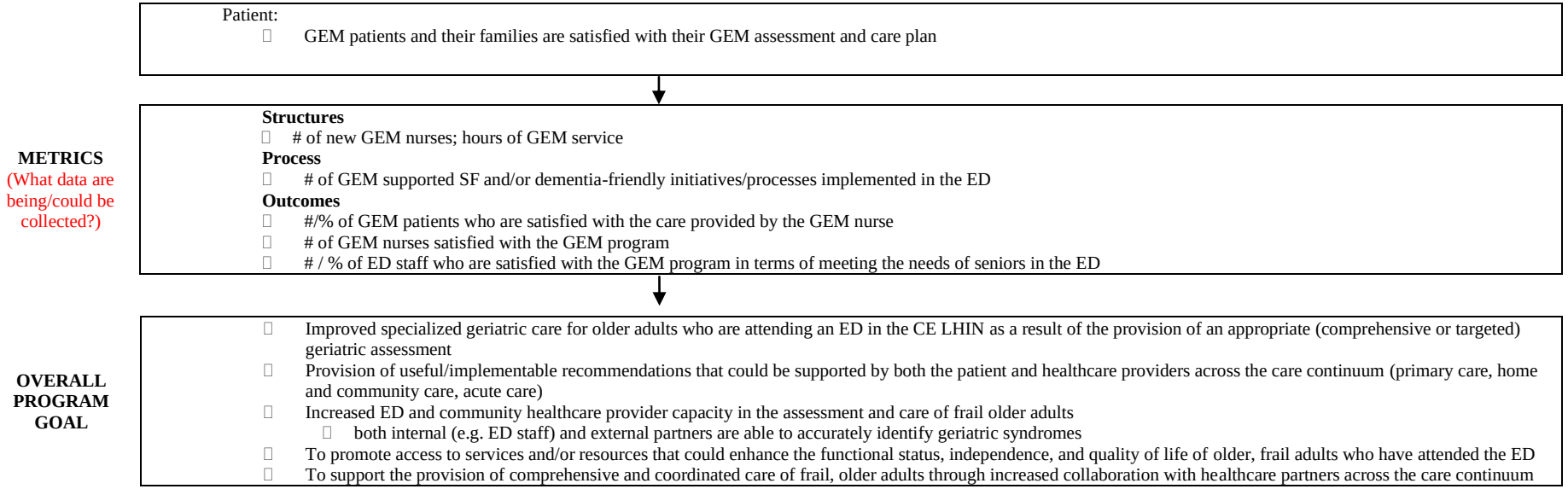
SHORT-TERM Outcomes (Why are we doing this?)	• Consumer voice heard and needs of seniors are assessed as per best practice in the ED setting • EDs, hospitals and community healthcare settings have moved towards the implementation of SF care and dementia friendly care principles due to the influence of GEM activities and projects • Increased awareness of GEM across the healthcare continuum • Best care practices for older frail adults are integrated into ED policies and procedures • Increased linkages across SGS programs	• Patients receive an appropriate geriatric assessment • Seniors attending the ED receive safe, coordinated care • Assessment information is incorporated/shared with appropriate care providers during care transitions • Goal-based planning facilitates patient–focused care, post-transition • Patients and family have effective health management strategies • Frail seniors are discharged home from the ED with a plan and connection to community services • GEM identifies HealthLink candidates in ED	• Knowledgeable GEM staff who integrate geriatric principles into patient care and provide high quality, evidence-informed care • Increased # of ED staff/community partners who understand the principles underpinning safe and effective geriatric care • Increased university student awareness of GEM program and knowledge of geriatric care • Up-to-date work plans
METRICS (What data are being/could be collected?)	**Milestones** **Structure** **Process** • # presentations re GEM • # of attendances at SF or age-friendly community initiatives **Outcome** • # EDs that have moved towards the implementation of SF care principles due to the influence of GEM activities and projects	**Milestones** • Standardized GEM Role Profile developed **Structure** • # of vacant GEM nurse positions **Process** • # & % new patients seen by GEM • # & % visits by type (initial/follow-up) • # & % of referrals to services by type (BSO, GAIN, NPSTAT, Home and Community Care, other) • # sites with standardized GEM model • # sites adopting standardized GEM role • # of piloted delirium order sets • # of linkages with external partners • % of staff time spent on direct care • % of staff time spent on indirect care • **Outcomes** • # of patient who feel they have been connected to needed community services	**Milestones** • Model of clinical leadership for CE LHIN GEM program developed • GEM-Professional Development Plan template developed • Site escalation policies/practices re disagreement with plan of care developed **Structure** • # GEM sites reporting GEM financials **Process** • # capacity building sessions provided by GEM nurses • # of students hosted • # GEM sites reporting GEM metrics • # of GEM nurses participating in CPD activities related to geriatrics **Outcome** • Increased ED and hospital staff knowledge re best practices in geriatrics • Increased community awareness about specialized geriatric services available
LONG-TERM Outcomes (What are the long-term benefits of the program?)	System: • EDs have appropriate number of GEM nurses to meet patient needs • Safe, coordinated geriatric care for frail seniors who are seen by a GEM in an ED in the CE LHIN • CE LHIN GEM program is seen as a champion of Senior Friendly Care and dementia-friendly care in the hospital and the community because of strong leadership, change management, and advocacy • Increased awareness of senior friendly principles/philosophies/approaches in the ED and host organizations • Primary care is aware of GEM recommendations Hospital/Site/ED: • GEM nurses are satisfied with the GEM program • ED staff are satisfied with the GEM program in terms of meeting the needs of seniors in the ED • Increased capacity amongst ED health care providers in the provision of a targeted geriatric assessment regardless of patient discharge disposition		


Patient:
GEM patients and their families are satisfied with their GEM assessment and care plan
METRICS
(What data are being/could be collected?)
Structures
# of new GEM nurses; hours of GEM service
Process
# of GEM supported SF and/or dementia-friendly initiatives/processes implemented in the ED
Outcomes
#/% of GEM patients who are satisfied with the care provided by the GEM nurse
# of GEM nurses satisfied with the GEM program
/ % of ED staff who are satisfied with the GEM program in terms of meeting the needs of seniors in the ED
OVERALL PROGRAM GOAL
Improved specialized geriatric care for older adults who are attending an ED in the CE LHIN as a result of the provision of an appropriate (comprehensive or targeted) geriatric assessment
Provision of useful/implementable recommendations that could be supported by both the patient and healthcare providers across the care continuum (primary care, home and community care, acute care)
Increased ED and community healthcare provider capacity in the assessment and care of frail older adults
both internal (e.g. ED staff) and external partners are able to accurately identify geriatric syndromes
To promote access to services and/or resources that could enhance the functional status, independence, and quality of life of older, frail adults who have attended the ED
To support the provision of comprehensive and coordinated care of frail, older adults through increased collaboration with healthcare partners across the care continuum

Potential Evaluation Questions (GEM)

ACTIVITIES

Think about which activities contribute towards the program's outcomes. Which activities are you most concerned about?

Activity	**H=High priority; M=moderate priority; L=Low priority**
Development and implementation of delirium order sets in the ED	L
Linkages with retirement home/community care partners	H
Development of annual continuing professional development plans	M
Strategic planning process for the CE LHIN GEM program	H
Determination of appropriate model of clinical leadership for CE LHIN GEM program	H
Development of an electronic GEM resource Toolbox	L

TARGET GROUPS

Think about who the program is designed for. Do you need to know if you are reaching this group and who you are not reaching?

Target Group	**H=High priority; M=moderate priority; L=Low priority**
Older adults living with frailty in the CE LHIN	H
ED physicians	H
General population in CE LHIN	L
GEM nurses	H

OUTCOMES

Think about which outcomes are most crucial. Which outcomes are the most important for this program?

Outcome	**H=High priority; M=moderate priority; L=Low priority**
GEM-Professional Development Plan template developed	M
Increased ED staff knowledge of key geriatric syndromes	H
GEM patients have been referred to appropriate community services	H
Site escalation policies/practices re disagreement with plan of care developed and implemented	L

Additional evaluation questions posed by Program Lead

Are GEM nurses being utilized in common way? Are GEM nurses fulfilling their mandate?
What happens to people after being seen by GEM? What is their outcome?

Appendix F

Program Description and Logic Model: Nurse Practitioners Supporting Teams Averting Transfers

Program Description

Program	Nurse Practitioners Supporting Teams Averting Transfers
Service Description: General	• Program builds system capacity to care for long-term care home (LTCH) residents while providing acute and episodic medical care to frail, complex LTCH residents so that they can remain in their home for management of their acute care needs, medical complexity, and palliative care goals. • NPSTAT Nurse Practitioners (NPs) work with LTCH caregivers to support the sharing of geriatric expertise and to increase formal and informal caregiver ability to support the increasingly complex clinical needs of LTCH residents. • Goal: to reduce transfers to the emergency department (ED) and unscheduled transfers to a hospital and to facilitate LTCH resident transfers back to their home following either an acute care admission or an ED admission; to improve patient flow within the ED • New program expansion to function as attending NP to long-term care residents in 4 homes providing all legislated assessments and primary care management.
Clinical Program Partners/Organization(s) Involved	• NPSTAT provides outreach service to all of the 68 LTCHs in the Central East LHIN • Administrative Lead is housed within the Central East LHIN, Home and Community Care • NPSTAT NPs work from their personal home
Program Start date	2010

Hours	• Monday through Friday, 10 am to 6 pm. • Currently no weekend hours, but will be developing/pilot testing weekend hours this fiscal year
Eligibility	Frail older adults living in Central East LHIN LTCHs
Application/Referral	Referrals directly from all LTCH staff and residents' families
Intake	• Once a LTCH resident's problems are identified (by anyone working in the LTCH or a family member), concerns are shared with the home's charge nurse; the charge nurse contacts the family physician serving the LTCH; if no response in 1 hour, or if family physician indicates that NPSTAT should be consulted, the NPSTAT nurse who provides service to that home is contacted by phone; all referral sources are contacted by NPSTAT within 1 hour of request for service. • Each NP has own phone and deals with all calls
Program Partners: Administrative	Central East LHIN as well as the Seniors Care Network Board and Seniors Care Network Team
Funded by	The Ontario Ministry of Health and Long-Term Care through the Central East LHIN
Program Governance	• NPSTAT program staff report to the NPSTAT clinical program lead (LHIN Director, Home and Community Care, Clinical Care Programs) • NPSTAT clinical program lead reports to the LHIN Vice President, Home & Community Care and Central East LHIN's Seniors Portfolio lead.

Program Coordination	• NPSTAT Program lead:
	  • represents point of care NPSTAT NPs across CE LHIN, and provides administrative oversight and clinical support
	  • as a Seniors Care Network member, represents the Program at: (1) Seniors Care Network

	Board; (2) Joint Services and Operations Committee; and (3) Clinical Performance Committee
Data sent to	• Quarterly metrics sent to Seniors Care Network Board, the Central East LHIN, Home and Community Care, and the Central East LHIN Board (via the Seniors Care Network Executive Director Report)
Fees	No fees for clinical services; patient costs covered through program operating budget
Clinical Staff (FTEs per discipline)	• Nurse Practitioners: 9 FTE • Clinical lead: 0.5 FTE • each NP covers 8-12 homes
Operational Staff (FTEs)	Administrative support: 1.0 FTE through Central East LHIN Home and Community Care Administrative lead: 0.5 FTE through Central East LHIN Home and Community Care
Model of Care	**Clinical** • intensive case management model; usually 1 assessment visit and 1-2 follow-up visits • same day access to assessments • specialized clinical services including: antibiotics for infections, IV therapies, suturing lacerations, hypodermoclysis, post-fall assessments, G/J-Tube re-insertions • repatriation engagement with assessment and care plan review in hospital for timely discharge and admission to LTC. **Capacity Building** • Senior Friendly care principles applied to all assessments and care planning • Dementia Friendly care principles applied to assessment and care planning for persons with

	dementia • Education provided to care providers across the care continuum
Approximate Volumes	NPSTAT nurses see approximately 61 unique patients each month per NP
Website	http://seniorscarenetwork.ca/programs-initiatives/programs/nurse-practitioners-supporting-teams-averting-transfers/
Other	http://www.centraleastlhin.on.ca/Page.aspx?id=17706 http://www.centraleastlhin.on.ca/newsandevents/TellaStory_f/ExcitementstirringaroundprovincesLTCnursepractitionerannouncement.aspx http://www.centraleastlhin.on.ca/newsandevents/TellaStory_f/NPSTATsLong-TermCareOutreachNursePractitionersprovideend-of-lifecareatthebedside.aspx http://www.centraleastlhin.on.ca/goalsandachievements/Seniors.aspx

Program Logic Model: Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT)

COMPONENTS	Advocacy for Age-Related Needs	Improving Care: Intake, Assessment, Follow-up	Improving Care: Hospital Repatriation	Fostering Excellence: Capacity Development & Networking
ACTIVITIES (What do we do?)	• Promote NPSTAT program at conferences/meetings • Provide access to a clinical ethicist or ethics consultation • Foster SGS program linkages • Develop a process for obtaining consumer input • Encourage organizational support of Senior Friendly principles of care • Encourage organizational support of Dementia Friendly care	• Encourage the application of Senior Friendly Care principles in NPSTAT-related processes of care • Provide acute and episodic medical care in CE LHIN LTCHs • Conduct geriatric assessments as appropriate (targeted or comprehensive, by telephone/OTN/in person) • Develop and document individualized care strategies • Conduct primary care review and develop recommendations • Provide integrated care support for palliation and BSO strategies • Integrate with OTN eConsult • Maintain full NP complement • Provide needed clinical services (e.g., antibiotics for infections, IV therapies, suturing lacerations, hypodermoclysis, post-fall assessments, G/J-Tube re-insertions • Identify/implement palliative care needs • Ongoing participation in LTC medication prescribing project	• Ensure care plans developed in ED/acute care are supported in LTCHs • Facilitate care transitions from ED to LTC • Identify resident transition needs • Ensure good information flow re individualized care strategies from LTCH to acute care and back	• Encourage organizational uptake of Senior Friendly Care knowledge and practices • Provide formal/informal learning: "just in time" and more formal teaching to ED/hospital/LTCH staff • Share best practices with other healthcare providers: NPSTAT nurses attend appropriate conferences/rounds • NPSTAT NPs complete Controlled Drugs & Substances CNO requirement • Align NPSTAT professional development plans with university continued skills competencies • Ensure data sharing agreements with HAB are in place • Collect and analyze program data & generate needed reports • Identify possible program evaluation questions • Develop an annual work plan and obtain work plan approval
TARGETS (Who are we targeting with each activity?)	• CE LHIN • Ministry of Health and Long-Term Care • Older frail adults living in CE LHIN LTCHs and their family • SGS program staff • Care continuum (specialty care, home and community care, primary care) • Seniors Care Network • CE LHIN community • NPSTAT patients/family • NPSTAT nurses	• Older frail adults living in CE LHIN LTCHs and their family • LTCH family physicians/staff • SGS program staff	• Older frail adults living in CE LHIN and their family • LTCH family physicians • CE LHIN acute care hospitals • SGS program staff	• Care continuum (specialty care, home and community care, primary care) • NPSTAT nurses • LTCH family physicians • Seniors Care Network • Central East LHIN • NPSTAT Operations Committee • Ministry of Health and Long-Term Care: HAB • CE LHIN community

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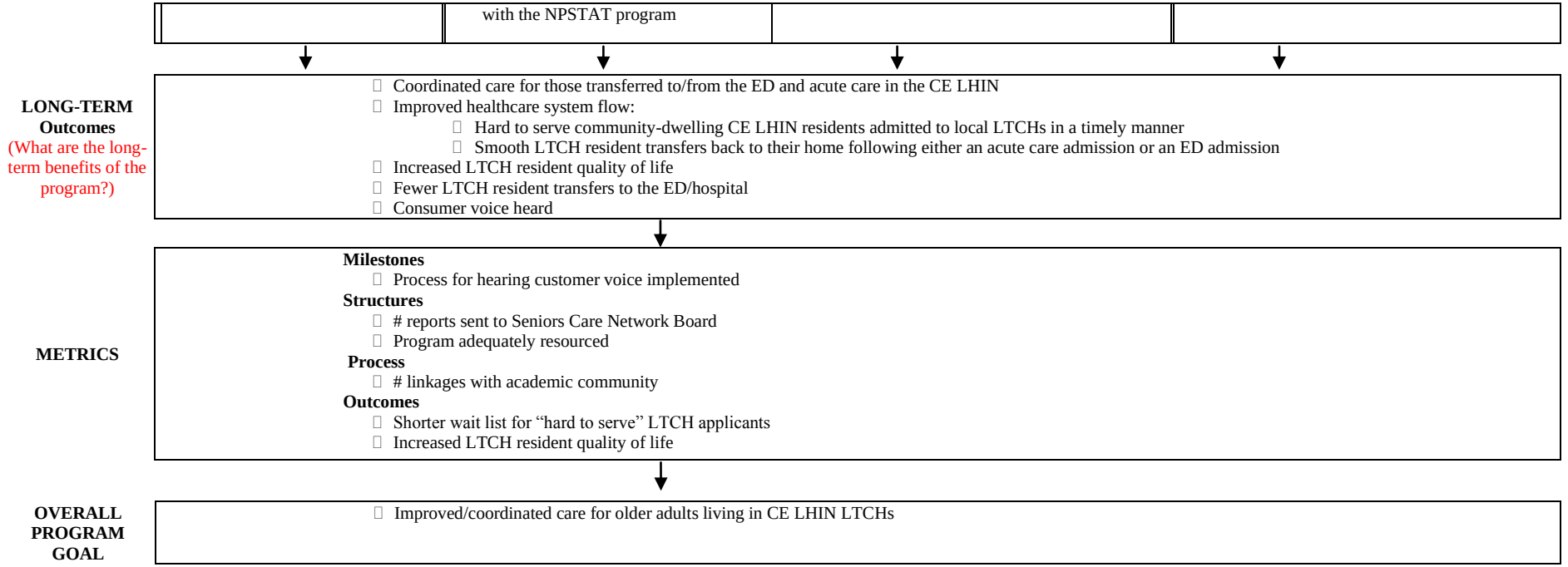
SHORT-TERM Outcomes (Why are we doing this?)	• Process through which consumer voice will be heard developed • Increased awareness of Senior Friendly care principles in all LTCHs • Increased community and healthcare provider awareness of NPSTAT	• Stronger links to other system partners (GEM, BSO) • Care plans supported by LTCH staff • Improved used of technology to access broader physician community • Improved prescribing in LTC • Clients receive an appropriate assessment • Fewer potentially avoidable transfers to local ED/hospital • NPSTAT nurses are satisfied with program • LTCH staff are satisfied with program • Clients are satisfied with program	• "Successful" transitions from LTCH to ED/acute care and back • Improved patient flow in ED • Hospital (ED/acute care) staff are satisfied with the NPSTAT program	• Knowledgeable NPSTAT nurses • LTCH staff are better able to support clinical complexity • Increased acute care awareness of LTCH care delivery capacity • Effective evidence-based care provided at all encounters • Up to date work plans
METRICS (What data are being/could be collected?)	**Milestone** • Process for hearing consumer voice developed • Clinical ethicist made available **Structure** **Process** • # presentations re NPSTAT **Outcomes** • # referrals to other SGS programs	**Milestones** • NPs aligned with each hospital site **Structure** • # of vacant NP positions • % of LTCH staff who understand the role of NPSTAT **Process** • # of initial visits by location (LTCH, acute care, etc.) • # follow-up visits by location (LTCH, acute care, etc.) • # of assessments by type (telephone, OTN, in person comprehensive assessment, in person targeted assessment) • % of staff time spent on direct care • % of staff time spent on indirect care • Evidence of integration with OTN eConsult **Outcomes** • Appropriate antipsychotic use/medication prescribing • # and % of all LTCH residents assessed by NPSTAT who were NOT transferred to ED/acute care due to NPSTAT intervention by CTAS level • % of NPSTAT nurses who are satisfied with the program • % of LTCH staff who are satisfied with the NPSTAT program • % of LTCH residents who are satisfied	**Milestones** **Structure** **Process** • # of care plans developed in acute care that were implemented in the LTCH **Outcomes** • # and % of assessments that resulted in NP-initiated hospital admissions • % of ED/acute care staff who are satisfied with program	**Milestone** **Structure** • # evidence-informed practice/care protocols developed • # NPs with completed Controlled Drugs & Substances CNO requirement • % of NPs working to scope of practice **Process** • # of education sessions provided **Outcomes** • Increased # of LTCH staff who are knowledge about geriatric syndromes • Increased # of LTCH staff who are able to manage clinical complexity


with the NPSTAT program
LONG-TERM Outcomes
(What are the long-term benefits of the program?)
Coordinated care for those transferred to/from the ED and acute care in the CE LHIN
Improved healthcare system flow:
Hard to serve community-dwelling CE LHIN residents admitted to local LTCHs in a timely manner
Smooth LTCH resident transfers back to their home following either an acute care admission or an ED admission
Increased LTCH resident quality of life
Fewer LTCH resident transfers to the ED/hospital
Consumer voice heard
METRICS
Milestones
Process for hearing customer voice implemented
Structures
reports sent to Seniors Care Network Board
Program adequately resourced
Process
linkages with academic community
Outcomes
Shorter wait list for "hard to serve" LTCH applicants
Increased LTCH resident quality of life
OVERALL PROGRAM GOAL
Improved/coordinated care for older adults living in CE LHIN LTCHs

Potential Evaluation Questions (NPSTAT)

ACTIVITIES

Think about which activities contribute towards the program's outcomes. Which activities are you most concerned about?

Activity	**H=High priority; M=moderate priority; L=Low priority**
Resident received an appropriate assessment	
Needed program data collected	
Individualized care strategies identified and documented	
Senior Friendly strategies implemented	
Best practices identified and shared	
NP work aligned with the LTC medication prescribing project	
Integration with OTN eConsult	

TARGET GROUPS

Think about who the program is designed for. Do you need to know if you are reaching this group and who you are not reaching?

Target Group	**H=High priority; M=moderate priority; L=Low priority**
Older adults living with frailty in CE LHIN LTCHs	
LTCH family physicians	
LTCH staff and administrators	
General population in CE LHIN	
NPSTAT nurses	

OUTCOMES

Think about which outcomes are most crucial. Which outcomes are the most important for this program?

Outcome	**H=High priority; M=moderate priority; L=Low priority**
Improved use of technology to connect teams and coordinate care	
Increased knowledge of geriatric syndromes across the health care continuum	
Successful repatriation from ED/acute care to LTCH	
Consumer voice heard	

NPSTAT nurses using evidence-based assessment tools/resources	
Improved medication prescribing in CE LTCHs	
LTCH administrators/physicians/staff satisfied with NPSTAT program	H
Fewer potentially avoidable transfers to ED	H

Appendix G

DRAFT Program Description and Logic Model: Senior Friendly

Program Description

Program	**Senior Friendly Care**

Service Description: General	• A Senior Friendly healthcare provider provides an environment, organizational culture, and ways of care-giving that accommodate and respond to seniors' physical and cognitive needs, promote good health (e.g. nutrition and functional activity), maximize safety (e.g. preventing adverse events like a fall in the hospital), and involves patients, along with families and caregivers, to be full participants in their care.
	• This initiative asks healthcare providers to:
	  ◦ Ensure the physical environment minimizes the vulnerabilities of frail patients;
	  ◦ Address unique ethical situations in seniors care and research as they arise;
	  ◦ Deliver care and service in a way that is free of ageism and respects the unique needs of patients and their caregivers;
	  ◦ Provide care based on best practices for seniors care so their independence is preserved; and
	  ◦ Make senior friendly care an organizational priority
	• Goal: to enable seniors to maintain optimal health while they receive care so that they can return home or transition to the next level of care that best meets their needs.

Organization(s) involved	• Central East CCAC, Central East LHIN, the 8 hospitals in the CE LHIN, Seniors Care

	Network, Regional Geriatric Program of Toronto
Initiative Partners	Central East Senior Friendly Care Working Group members include representatives from: • Central East CCAC • Central East LHIN • The 8 hospitals in the CE LHIN • Seniors Care Network • Regional Geriatric Program of Toronto
Program Administration	Central East LHIN through the Seniors Care Network Board and Seniors Care Network Team
Funded by	The Ontario Ministry of Health and Long-Term Care through the Central East LHIN
Program Governance	Seniors Care Network Board and the Central East LHIN Board
Program Coordination	• Program Lead (Seniors Care Network member) provides administrative oversight, and represents the Program at: (1) Seniors Care Network Board; (2) Joint Services and Operations Committee; and (3) Clinical Practice Committee
Staff (FTEs)	Program Lead: approximately 0.4 FTE

Program Details	• Promotion of Senior Friendly care principles to all care planning
	• Provides a basic philosophy of care as provided by the other Seniors Care Network programs: GAIN, GEM, NPSTAT, BSO
	• Initiative activities align with the following five SFH domains:
	  • organizational support;
	  • processes of care;
	  • emotional and behavioral environment;

	ethics in clinical care and research; and physical environment.
Website	http://seniorscarenetwork.ca/programs-initiatives/programs/senior-friendly-hospital/
Other	http://seniorfriendlyhospitals.ca/

DRAFT Program Logic Model: Senior Friendly

COMPONENTS	Advocacy for Age-Related Needs	Improving Care	Fostering Excellence: Capacity Development & Networking
ACTIVITIES (What do we do?)	• Promote SF "walkabouts" in CE LHIN hospitals • Promote the incorporation of SF initiatives into hospital annual corporate plans, goals, objectives and QIPs • Help hospitals create an environment that is conducive to SF care, that is to say an environment that allows hospital-based services to incorporate environmental changes as suggested in the document Code Plus* • Complete ageism literature review • Support hospital leadership endorsement of SF philosophy, values, and principles • Promote strategies that empower hospital staff to develop/make changes to HR-related processes (e.g., orientation), hospital policies & procedures, and physical spaces so that care is provided in a SF manner • Develop an elder abuse communication/ awareness strategy for staff	• Develop a process through which hospitals can identify functional decline/deconditioning and then implement a remediation program • Assist local hospitals in implementing inter-professional delirium screening, prevention and management protocols • Help hospitals implement an ethics framework that promotes SF care • Identify key elements of care plans for older adults that ensure successful transitions between long-term care homes and hospitals • Support other programs targeting older adults, including those offered through the Seniors Care Network (GAIN, GEM, BSO, NPSTAT) and help them incorporate SF principles into their care strategies • Adapt the Behavioural Assessment Tool (BAT) for the hospital setting and trial it in at least 2 organizations	• Implement a gerontological education program for seniors care to support broader capacity for SF care based on SF philosophy, values, principles and practices • Provide training/education to support individuals presenting with responsive behaviors • Develop a learning module that focuses on common geriatric syndromes/health issues • Develop a SF orientation presentation that hospitals can use for new staff
TARGETS (Who are we targeting with each activity?)	• Older frail adults living in CELHIN • Care providers across the care continuum (specialty care, home and community care, primary care) • Seniors Care Network programs • CE LHIN hospital board members, staff and leadership • Community support agencies that focus on older, frail adults	• Older frail adults living in CE LHIN • Seniors Care Network • Care providers across the care continuum (specialty care, home and community care, primary care)	• Older frail adults living in CE LHIN • Care providers across the care continuum (specialty care, home and community care, primary care)
SHORT-TERM Outcomes (Why are we doing this?)	• Hospital leadership is committed to providing SF care • Hospital staff are empowered to develop/make changes to HR-related processes (e.g., orientation), hospital policies & procedures, and physical spaces so that care is provided in a manner that is sensitive to the needs of older, frail patients • Hospital physical environments are more senior friendly	• Decreased functional decline among hospitalized older, frail patients who live in the CE LHIN • Care & services are provided in a manner that maximizes satisfaction & the quality of the hospital experience • Hospital care is delivered in a manner that is free of ageism and respects the unique needs of older patients & their caregivers • Care strategies promote safety, independence	• Increased community and healthcare provider awareness of SF principles and common geriatric syndromes/health issues • Increased hospital staff knowledge of SF principles of care • Increased hospital staff awareness of how to support individuals with responsive behaviours • Hospital staff orientation includes a presentation on SF care

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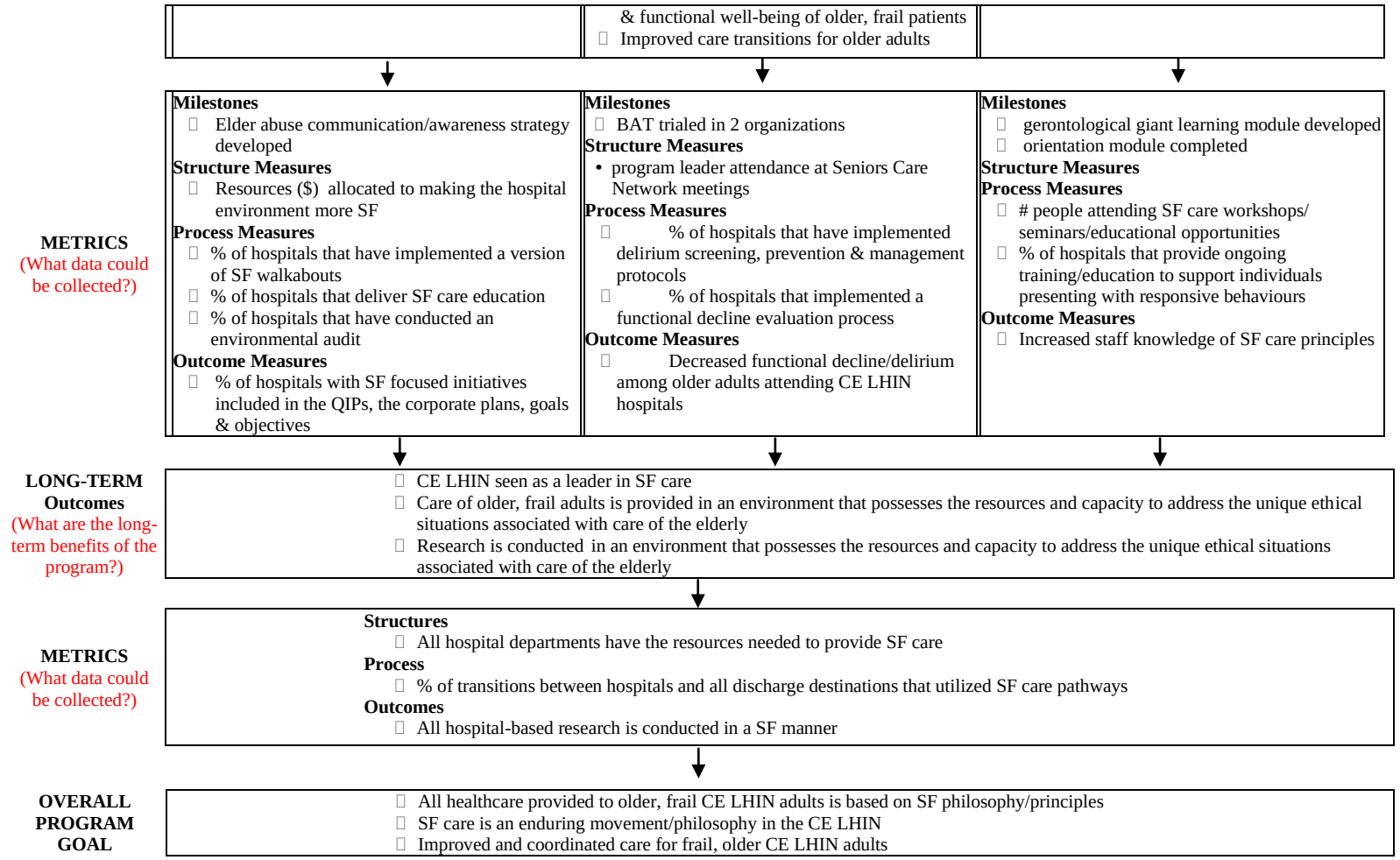

Code Plus*: see https://www.fraserhealth.ca/media/CodePlus%20-%20Physical%20Design%20Components%20for%20an%20Elder%20Friendly%20Hospital.pdf

Note: The Senior Friendly Care mandate is changing and expanding. Further details to be developed in October 2017

Potential Evaluation Questions (Senior Friendly)

ACTIVITIES

Think about which activities contribute towards the program's outcomes. Which activities are you most concerned about?

Activity	**H=High priority; M=moderate priority; L=Low priority**
Hospital audits/walkabouts	
Development and implementation of inter-professional SF Care protocols across hospital departments	
SF Care design principles are applied to any hospital environmental/infrastructure changes	
Hospital staff learning needs identified	
Recruit/train geriatrics champions	

TARGET GROUPS

Think about who the program is designed for. Do you need to know if you are reaching this group and who you are not reaching?

Target Group	**H=High priority; M=moderate priority; L=Low priority**
Hospital Executives/Hospital Board members	
Older adults attending CE LHIN hospitals	
Health care providers involved with programs targeting older adults (NPSTAT, GEM, GAIN, BSO)	

OUTCOMES

Think about which outcomes are most crucial. Which outcomes are the most important for this program?

Outcome	**H=High priority; M=moderate priority; L=Low priority**
# of hospital staff trained in the principles of SF Care	
# people attending SF Care workshops/seminars/educational opportunities	
Decreased functional decline/delirium among older adults in CE LHIN hospitals	

Appendix H

Evaluation Framework

STRUCTURE

EVALUATION OBJECTIVE: Describe resource allocation and implementation within the context of expectations/ program descriptions/ mandate.

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
BSO				
"Do BSO staff (both LTCH embedded staff and GAIN-based RPNs) and all staff working in LTCHs as well as healthcare providers working in the community with older adults with behavioural issues have the knowledge and skills needed to comprehensively address the needs of older adults living with dementia, addictions, complex mental health issues, and neurodegenerative diseases that impact cognition?"	Staff skills and knowledge consistent with program expectations	# (%) of staff whose academic preparation and skills (work experience, specialized expertise) match program criteria # Job descriptions reflect BSO core competencies # (%) of BSO staff participating in continuing education initiatives related to BSO core competencies # (%) of staff with GPA training # (%) of staff with P.I.E.C.E.S™ Training # (%) of staff with U-First™ Training # (%) of staff with Dementiabilty Training # (%) of staff involved in training	Program records	Process review of program criteria: # mapping staff academic preparation and skills to program criteria # mapping of BSO core competencies to job descriptions Tracking of staff participation in continuing education initiatives that relate to BSO core competencies
	All staff understand that behaviours have meaning	# Staff awareness and knowledge # Care plan recommendations that reflect an understanding that behaviours have meaning # (%) of BSO staff participating in continuing education initiatives related to BSO core competencies # (%) of staff with GPA training # (%) of staff with P.I.E.C.E.S™ Training # (%) of staff with U-First™ Training # (%) of staff with Dementiabilty Training # (%) of staff involved in training	BSO staff Program records	Annual performance appraisals/reviews: Review of staff knowledge and skills; informal assessment of staff understanding of responsive behaviours and review of work performance (care plan recommendations) that reflects an understanding of responsive behaviours. Checklists/ appraisal templates can be created to ensure staff knowledge and performance is consistent with program expectations. Tracking of staff participation in continuing education initiatives that relate to BSO core competencies
	All staff understand their	# Staff awareness and knowledge # Care plan recommendations that reflect staff	BSO staff Program records	Annual performance appraisals/reviews: Review of staff knowledge and skills; informal assessment of staff understanding of their role in influencing the

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
	role in influencing the expression of responsive behaviour	understanding of their role in influencing the expression of responsive behaviours • # (%) of staff participating in continuing education initiatives related to BSO core competencies • # (%) of staff with GPA training • # (%) of staff with P.I.E.C.E.S™ Training • # (%) of staff with U-First™ Training • # (%) of staff with Dementiabilty Training • # (%) of staff involved in training		expression of responsive behaviours and review of work performance (care plan recommendations) that reflects an understanding of their role in influencing expression of responsive behaviours. Checklists/ appraisal templates can be created to ensure staff knowledge and performance is consistent with program expectations. Tracking of staff participation in continuing education initiatives that relate to BSO core competencies
Does the BSO program have the needed infrastructure in each sector (long-term care, community, hospital) to ensure clients receive the right care, in right place, at the right time?	Appropriate BSO-specific resources, policies, hiring, and orientation practices currently in place in each sector	• Identification of BSO-specific resources, policies, hiring, and orientation practices currently in place in each sector (LTC, Community, acute care) • Accountability definitions are included in funding agreements	Program records	Review/collect descriptions of BSO-specific resources, policies, hiring, and orientation practices used in each sector and map to BSO core competencies/ job descriptions, current and future needs.
			Key stakeholders (BSO Staff, Directors of Care, team/ program leads across sectors),	Key stakeholder meeting (e.g., Kaizen events) with discussion of processes that will be used to map current staffing practices to core competencies/job descriptions, population needs, and current strengths, weaknesses, opportunities for improvement, and threats as related to ensuring clients receive right care, in the right place, at the right time.
	Appropriate BSO-specific clinical pathways/ standardized clinical practices currently in place in each sector	• # (%) of BSO teams (LTC, community, acute care) with BSO-specific clinical pathways/ standardized clinical practices currently in place	Program records	Process review of BSO-specific clinical pathways/ standardized clinical practices in place
			Client health records	Case Study: A case study approach can be used to describe the impact of clinical pathways and standardized clinical practices on clients' receipt of the right care, in the right place, at the right time. Each team (or sector) could provide one or two case studies (either randomly selected, or selected with specific criteria). A list of questions should be provided to guide the development of the case study. Each case study should provide information describing: • Client characteristics (age, sex, living situation, diagnosis, living situation, current issues, services currently involved) • Issues prompting BSO referral • Referral and triage/ intake process • BSO assessment (use of clinical pathway/ standardized clinical

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
				practices) - Outcomes related to access to services, changes in responsive behaviours - Assessment of whether client received the most appropriate service/ care, in the most appropriate sector/ service, at the right time.
GEM				
Do GEM program staff have the needed skills and knowledge to implement their roles/ work activities?	Staff skills and knowledge consistent with GEM program expectations	- Professional development plan created and completed for each GEM nurse.	Program records	Training Needs Assessment (TNA) of practice competencies as outlined in the Competency Framework for Inter-professional Comprehensive Geriatric Assessment (CGA) Tracking of the creation and completion of professional development plans for each GEM nurse
	Academic preparation consistent with GEM program expectations (Master's prepared/ Advanced Practice Nurse)	- # (%) of GEM Nurses with Master's degrees in Nursing - # (%) of GEM Nurses with Advanced Nursing Practice certification (i.e. Clinical Nurse Specialist [CNS], or Nurse Practitioner [NP]) - # (%) of GEM nurses that are Canadian Nursing Association certified in Gerontological Nursing (GNC(C) certified)	Program records	Review of GEM nurse qualifications. Development of a consistently used job description that outlines the scope of practice and core competencies. Examples can be found at: https://www.lakeridgehealth.on.ca/en/aboutus/ClinicalNurseSpecialistGEM.asp http://gem.rgp.toronto.on.ca/gem-management (note: the RGPs have developed role profiles for both urban and rural areas

PROCESS

EVALUATION OBJECTIVE #1: Describe the client population served by each program

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
BSO				
Who are the clients served by BSO?	Clear description of BSO target population Description of clients served • Demographic information • Level of complexity	• Age: age at the time of assessment/ first contact • Gender: # (%) males; # (%) female • Living location: # (%) living in own home; # (%) retirement home in community; # (%) in LTC; # (%) other • # (%) awaiting LTC placement (GAIN teams) • Living situation: # (%) living alone; # (%) with an available formal care providers/home care services; # (%) with informal (family) care partners (GAIN teams) • # (%) new LTCH residents with a with a Home and Community Care Behavioural Assessment referred to BSO on admission to LTC; # (%) not referred to BSO on admission • Diagnosis: # (%) with each diagnosis related to responsive behaviours (e.g., dementia, mental health issue, addictions) • # (%) with one or more geriatric syndromes: # (%) with each syndrome (e.g., cognitive impairment, decreased function, falls or risk of falls, impaired mobility, incontinence, multiple medications (GAIN teams) • # (%) triaged as urgent, semi-urgent, not urgent or inappropriate (GAIN teams) • Average scores and range of scores on standardized measures that are used (e.g., cognitive scores, functional scores, activities of daily living) (GAIN teams) • Average scores and range of scores on standardized measures used to assess behaviours (e.g., assessment tools contained in Behavioural Assessment Tool and RAI) • # (%) LTC residents with a new or worsened responsive behaviour who received a change in treatment for a medical or physiological condition that likely triggered the behaviour • # (%) BSO clients with incidents related to responsive	Prospective tracking by each BSO-funded LTC staff member and each BSO-funded GAIN team member	Development of a tool (paper template, excel spreadsheet, online reporting form implemented using survey software). Timeline: Prospective tracking for a specified period of time (e.g., one quarter or more, randomly or seasonally selected months). Note: Retrospective chart audit is an alternative to prospective tracking, however it is more labour intensive and time consuming, which would likely result in a lower sample size of clients and introduce greater chance of error, and thus is not recommended
			Home and Community Care	For those clients receiving services from Home and Community Care some of these data elements are available in the MDS-RAI Home Care dataset (CHRIS)
			BSO Program Records	Some of the indicators listed are currently being collected by the program (these will likely be available aggregated at a program level, not individual client level)

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
		behaviours - # (%) BSO clients with police interventions initiated by the LTCH relating to responsive behaviours		
GEM				

Who are the clients served by the GEM program?	Description of clients served
	- Demographic information
	- Level of frailty/complexity
	  - # people with specific geriatric syndromes by level of impact
	  - # clients with existing Home and Community Care services
	  - # clients with a primary care provider
		- Age: age at the time of assessment/ first contact
		- Gender: # (%) males; # (%) female
		- Living location: # (%) living in own home/retirement home in community; # (%) living in LTC; # (%) other
		- # (%) with a primary care provider (family physician, NP)
		- # (%) with specific geriatric syndromes
		- # (%) with existing Home and Community Care services
		- Living situation: # (%) living alone; # (%) with an available caregiver
		- Clinical Frailty Scale scores: # (%) by level
		- # (%) clients seen who had been discharged from hospital in the previous 7 days
		- # (%) clients seen who had an ED visit in previous 30 days; total # ED visits in the previous 30 days among older clients
		- # (%) clients seen who had a hospital admission in the previous 90 days; total # of hospital admissions among older clients
		- # (%) clients positive for each TRST subscale (or overall, High Risk Discharge) or alternative tool [18]
		- Discharge disposition: # (%) discharged home/ LTC/ other non-hospital destination; # (%) hospital admission
			Individual GEM nurse tracking
			
			Hospital Decision Support
				Development of a tool (paper template, excel spreadsheet, online reporting form implemented using survey software).
				
				Timeline: Prospective tracking for a specified period of time (e.g., one quarter or more, randomly or seasonally selected months). Note: Retrospective chart audit is an alternative to prospective tracking, however it is more labour intensive and time consuming, which would likely result in a lower sample size of clients and introduce greater chance of error, and thus is not recommended.

GAIN				

[18] Triage Risk Screening Tool (TRST): The TRST identifies baseline functional impairment in older adults (>75 years). The TRST is deemed positive when there is the presence or suspicion of 2 or more of 5 risk factors: cognitive impairment, five or more medications, difficulty walking/ transferring or recent falls, ED use in the last 30 days or hospitalization in the last 3 months, and ED staff concerns about the presence of common geriatric issues (depression, incontinence, neglect/ abuse, etc.). In EDs using the TRST, those positive on the TRST are flagged in their chart as a High Risk Discharge (HRD). Some EDs use different risk triage tools, such as the Identification of Seniors at Risk (ISAR) tool, which is a 6-item risk tool covering the common and most frequently observed problems in seniors in the ED department: functional loss, cognitive impairment, polypharmacy, visual impairment and frequent hospitalizations; scores of two or more identify clients at increased risk.

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
Who are the clients served by GAIN?	Clear description of GAIN target population Description of clients served • Demographic information • Level of complexity • Rehabilitative/restorative potential	• Age: age at the time of assessment/ first contact • Gender: # (%) males; # (%) female • Living location: # (%) living in own home; # (%) retirement home in community; # (%) other • # (%) with a primary care provider (family physician, NP) • # (%) awaiting LTC placement • Living situation: # (%) living alone; # (%) with an available caregiver • # (%) clients with one or more geriatric syndromes: # (%) with each syndrome (cognitive impairment, decreased function, falls or risk of falls, impaired mobility, incontinence, multiple medications • # (%) clients with decline in health and/ or level of function as a presenting problem • # (%) clients with loss of capacity for independent living as a presenting problem • # (%) clients with safety concerns • # (%) triaged as urgent, semi-urgent, not urgent or inappropriate • Average scores and range of scores on standardized measures that are used (e.g., cognitive scores, frailty scores, MAPLE scores) • # (%) with rehabilitative/restorative potential	Prospective tracking by each GAIN team	Development of a tool (paper template, excel spreadsheet, online reporting form implemented using survey software). Timeline: Prospective tracking for a specified period of time (e.g., one quarter or more, randomly or seasonally selected months). *Note*: Retrospective chart audit is an alternative to prospective tracking, however it is more labour intensive and time consuming, which would likely result in a lower sample size of clients and introduce greater chance of error, and thus is not recommended.
			Home and Community Care	For those clients receiving services from Home and Community Care some of these data elements are available in the MDS-RAI Home Care dataset (CHRIS)
			Potentially: RGP Comprehensive Geriatric Assessment (CGA) Tool	The RGP CGA Tool, currently in development, may provide a potential data source related to the assessment of decline in health and/ or level of function. Rehabilitative Potential: The information currently collected within this framework can be used to define rehabilitative potential. For further information on potential assessment measures/ tools and how define restorative potential see: http\\\;//www.rehabcarealliance.ca/fsmc-compendium (see information specific to Community-based rehabilitative care and in-home rehabilitative care). Analysis: Data collected should be summarized by GAIN team, by region, and by care model

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
				(Consultative, Intensive Case Management) for comparative purposes.
NPSTAT				
Who are the clients served by NPSTAT?	Description of clients served - Demographic information - Diagnosis (ICD-10 codes) - Procedures (e.g., IV, G/J tube reinsertion, suturing, etc.)	- Age: age at the time of assessment/ first contact - Sex: # (%) male; # (%) female - # (%) clients seen by CTAS level - Reason for interaction (ALC/hospital support, consultation, ED bypass) - # (%) clients seen by diagnosis - # (%) clients seen by procedure	NPSTAT nurse tracking	Review of existing data tracked by NPs.

EVALUATION OBJECTIVE #2: Describe the services provided by each program

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
BSO				
How many seniors are served?	Description of BSO program capacity (Each team and across all teams)	# (%) LTCH residents referred to BSO team # (%) new referrals # (%) ongoing clients # (%) referrals assessed # (%) referrals not assessed (Reasons why not) # (%) assessed from each referral sources (LTCH: LTCH staff, NPSTAT, GMHOT, PRC; GAIN teams: primary care, in-client units, ED, community organizations, other SGS programs, individuals, care partners)	Prospective tracking by BSO staff (LTCH embedded staff, Integrated Care Team members, BSO-funded GAIN team members) Program records	Development of a tool (paper template, excel spreadsheet, online reporting form implemented using survey software). Capacity: Should include information on number of clients served considering the number that the program is able to serve; need to develop criteria for measuring this, e.g., number of clients, appointment slots (an indicator that will describe the extent to which resources allocation is addressing client needs). Timeline: Prospective tracking for a specified period of time (e.g., one quarter or more, randomly or seasonally selected months). Note: Retrospective chart audit is an alternative to prospective tracking, however it is more labour intensive and time consuming, which would likely result in a lower sample size of clients and introduce greater chance of error, and thus is not recommended. Analysis: data can be summarized by location (LTCH, community, sub-region) and totaled across all teams/locations.

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
What services are delivered?	Description of BSO services (clinical activities)	# (%) clients served by LTCH embedded staff # (%) clients served by GAIN BSO-funded RPNs # (%) clients served by Primary Care Collaborative Memory Services Average wait time for service (difference between date of referral and date of first contact, days), overall and by urgency status (urgent, semi-urgent, non-urgent) # (%) clients seen for one or more visits (average # of visits per client) by location (LTCH, community); by urgency status (urgent, semi-urgent, not urgent); by model of care (Consultative, Intensive Case Management) # (%) BSO clients with responsive behaviours being actively managed with a BAT who require support from the Integrated Care Team but remain in their LTCH # (%) referred to other SGS services (GEM, NPSTAT) # (%) BSO clients referred for the purpose of admission to tertiary care due to responsive behaviours # (%) BSO clients admitted to tertiary care due to responsive behaviours	Prospective tracking by BSO staff (LTCH embedded staff, Integrated Care Team members, BSO-funded GAIN team members) Program records	Development of a tool (paper template, excel spreadsheet, online reporting form implemented using survey software) Timeline: Prospective tracking for a specified period of time (e.g., one quarter or more, randomly or seasonally selected months) Analysis: data can be summarized by sector (LTCH, community), teams (LTCH, Integrated Care teams, GAIN), geography (urban, rural) and totaled across all teams
	Description of non-clinical activities	Time spent traveling in minutes: 15 minute increments Time spent consulting with other programs/ services, clinicians on client-related issues: 15 minute increments # of internal program meetings Time spent in internal meetings in minutes: 15 minute increments # of external program-related meetings (e.g., Community of Practice meetings)	Individual clinician tracking (prospective)	Development of a tool (paper template, excel spreadsheet, online reporting form implemented using survey software) Tracking of meeting/ committee name, date, time commitment Tracking of education sessions: date, topic, target audience, number in attendance, length (time).

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
		Time spent in external program-related meetings in minutes: 15 minute increments # of formal BSO-related education sessions provided by sector Time spent providing formal education sessions in minutes: 15 minute increments # of conference presentations # of student placements per clinician; Time spent with students in minutes: 15 minute increments		Timeline: Tracking for a specified period of time (e.g., one quarter or more, randomly or seasonally selected months) Analysis: data can be summarized by sector (LTCH, community), teams (LTCH, Integrated Care teams, GAIN), geography (rural, urban) and totaled across all teams
GEM				
How many seniors are served?	Description of GEM program capacity	# (%) clients referred by various referral sources (ED staff; internal and external team members (e.g., Home and Community Care Coordinator, LTC, EMS, police, clients/ family) # (%) clients assessed # (%) clients referred to GEM but not assessed (reasons why not assessed) How client was identified: # (%) ED referral; # (%) case-finding; # (%) consultation[19]	Individual GEM nurse tracking (prospective)	Development of a tool (paper template, excel spreadsheet, online reporting form implemented using survey software). Capacity: Should include information on number of clients served considering the number that the program is able to serve; need to develop criteria for measuring this, e.g., number of clients, appointment slots (an indicator that will describe the extent to which resources allocation is addressing client needs). Timeline: Tracking for a specified period of time (e.g., one quarter or more, randomly or seasonally selected months). Note: Retrospective chart audit is an alternative to prospective tracking, however it is more labour intensive and time consuming, which would likely result in a lower sample size of clients and introduce greater chance of error, and thus is not recommended.
What services are delivered (clinical and nonclinical)?	Description of GEM CLINICAL services	# (%) clients referred to other SGS programs (NPSTAT, BSO, GAIN) # (%) clients referred to other health care	Prospective GEM nurse tracking	Development of a tool (paper template, excel spreadsheet, online reporting form implemented using survey software)

[19] Client was formally referred to GEM nurse by ED staff; GEM nurse identified a potential client without a formal referral from staff; GEM nurse was asked to consult on a case without formally assessing the client.

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
		services (clinics, specialists) - # (%) clients referred to Home and Community Care: new referrals, change in existing services - # (%) referrals to other community services (identify services)		Timeline: Tracking for a specified period of time (e.g., one quarter or more, randomly or seasonally selected months). Note: Retrospective chart audit is an alternative to prospective tracking, however it is more labour intensive and time consuming, which would likely result in a lower sample size of clients and introduce greater chance of error, and thus is not recommended.
	Description of GEM NON-CLINICAL activities	- # of GEM nurse meetings: internal program meetings - Time spent in GEM nurse meetings in minutes: 15 minute increments - # of in-hospital committee meetings - Time spent in in-hospital committee meetings in minutes: 15 minute increments - # of external committee meetings - Time spent in external committee meetings in minutes: 15 minute increments - # of formal GEM-related education sessions provided in-hospital and externally - Time spent providing formal education sessions in minutes: 15 minute increments - # of conference presentations	Individual GEM nurse tracking (prospective)	Development of a tool (paper template, excel spreadsheet, online reporting form implemented using survey software) Tracking of meeting/ committee name, date, time commitment Tracking of education sessions: date, topic, target audience, number in attendance, length (time). Timeline: Tracking for a specified period of time (e.g., one quarter or more, randomly or seasonally selected months)
GAIN				
How many seniors are served?	Description of GAIN program capacity (Each team and across all teams)	- # (%) assessed from each referral source (primary care, in-client units, ED, community organizations, other SGS programs, individuals, care partners - # (%) clients assessed - # (%) clients referred to GAIN but not assessed (reasons why not assessed) - Assessment Capacity: # assessments completed/ # anticipated completed assessments	Prospective tracking by each GAIN team Program records	Development of a tool (paper template, excel spreadsheet, online reporting form implemented using survey software) Capacity: Should include information on number of clients served considering the number that the program is able to serve; need to develop criteria for measuring this, e.g., number of clients, appointment slots (an indicator that will describe the extent to

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
		Follow-up Capacity: # follow-up visits completed/ # anticipated follow-up visits		which resources allocation is addressing client needs). Timeline: Prospective tracking for a specified period of time (e.g., one quarter or more, randomly or seasonally selected months). Note: Retrospective chart audit is an alternative to prospective tracking, however it is more labour intensive and time consuming, which would likely result in a lower sample size of clients and introduce greater chance of error, and thus is not recommended. Analysis: data can be summarized for each team and totaled across all teams and summarized by model of care (Case management, consultative), discipline, and region.
What services are delivered?	Description of GAIN CLINICAL services	Average wait time for service (difference between date of referral and date of first contact, days; date of assessment, months), overall, by urgency status (urgent, non-semi-urgent) Location: # (%) assessed in home; # (%) assess in clinic/ hospital # (%) clients seen for assessment only # (%) clients seen for one or more follow-up visits (average # of follow-up visits per client) # (%) clients with goal-based care planning # (%) clients identified as needing intensive, moderate and light case management # disciplines involved in client care # (%) clients referred to other SGS programs (GEM) # (%) clients discharged per reason Length of time on service: Average and range of length of time on service (days or months) Clinicians: Time spent on direct client care: 15 minute increments	Prospective tracking by each GAIN team Program records	Development of a tool (paper template, excel spreadsheet, online reporting form implemented using survey software). Timeline: Prospective tracking for a specified period of time (e.g., one quarter or more, randomly or seasonally selected months). Retrospective chart audit is an alternative to prospective tracking, however it is more labour intensive and time consuming, which would likely result in a lower sample size of clients and introduce greater chance of error, and thus is not recommended. Analysis: data can be summarized for each team and totaled across all teams, and by model of care (case management, consultative), discipline, and region.

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
	Description of GAIN NON-CLINICAL activities	Time spent traveling in minutes: 15 minute increments Time spent consulting with other programs/ services, clinicians on client-related issues: 15 minute increments # internal program meetings Time spent in internal meetings in minutes: 15 minute increments # of external program-related meetings Time spent in external program-related meetings in minutes: 15 minute increments # of formal GAIN-related education sessions provided by sector Time spent providing formal education sessions in minutes: 15 minute increments # of conference presentations # of student placements per clinician Time spent with students in minutes: 15 minute increments	Individual clinician tracking	Development of a tool (paper template, excel spreadsheet, online reporting form implemented using survey software) Tracking of meeting/ committee name, date, time commitment Tracking of education sessions: date, topic, target audience, number in attendance, length (time). Timeline: Tracking for a specified period of time (e.g., one quarter or more, randomly or seasonally selected months) Analysis: Data can be summarized for each team and totaled across all teams by model of care (Case management, consultative), region, and discipline.
NPSTAT				
How many seniors are served?	Description of NPSTAT program capacity	# (%) clients referred to NPSTAT by various referral sources (ED staff; internal and external team members, Home and Community) # (%) referred clients who were assessed # (%) referred clients who were not assessed by reason why (e.g., not an appropriate client due to age) # (%) clients seen in LTCH; # (%) seen in acute care	NPSTAT nurse tracking	Review of data currently collected by NPs Review of data collection tools (paper template, excel spreadsheet, online reporting form implemented using survey software) Capacity: Should include information on number of clients served considering the number that the program is able to serve; need to develop criteria for measuring this, e.g., number of clients, appointment slots (an indicator that will describe the extent to which resources allocation is addressing client needs).

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
				Timeline: Tracking for a specified period of time (e.g., one quarter or more, randomly or seasonally selected months). Note: Retrospective chart audit is an alternative to prospective tracking, however it is more labour intensive and time consuming, which would likely result in a lower sample size of clients and introduce greater chance of error, and thus is not recommended.
What services are delivered?	Description of NPSTAT CLINICAL services	Average wait time for service (difference between date of referral and date of first contact, days), overall, by CTAS[20] score # (%) procedures by type (e.g., IV, G/J tube reinsertion, suturing, etc.) # (%) clients referred to other SGS services (BSO, GEM) # (%) clients referred to other clinical services by type (e.g., Home and Community Care, ADP, meals on wheels)	NPSTAT nurse tracking	Review of data collection tools (paper template, excel spreadsheet, online reporting form implemented using survey software) Timeline: Tracking for a specified period of time (e.g., one quarter or more, randomly or seasonally selected months). Note: Retrospective chart audit is an alternative to prospective tracking, however it is more labour intensive and time consuming, which would likely result in a lower sample size of clients and introduce greater chance of error, and thus is not recommended. Additional services elements could be tracked such as: # (%) clients with newly prescribed medications; # (%) clients with changes to existing medications (increase, decrease)
	Description of NPSTAT NON-CLINICAL services	Time spent travelling to LTC # of NPSTAT nurse meetings: internal program meetings Time spent in NPSTAT nurse meetings in minutes: 15 minute increments # of in-hospital committee meetings Time spent in in-hospital committee meetings in	NPSTAT nurse tracking (prospective)	Review of data collection tools (paper template, excel spreadsheet, online reporting form implemented using survey software) Timeline: Tracking for a specified period of time (e.g., one quarter or more, randomly or seasonally selected months). Note: Retrospective chart audit is an

[20] Canadian Triage Acuity Scale (CTAS): All clients admitted to the ED are assigned a CTAS score at the time of admission based on their acuity level: CTAS = Resuscitation; CTAS 2 = Emergent; CTAS 3 = Urgent; CTAS 4 = Less-Urgent (Semi-urgent); CTAS 5 = Non-urgent

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
		minutes: 15 minute increments - # of external committee meetings - Time spent in external committee meetings in minutes: 15 minute increments - # of formal NPSTAT-related education sessions provided to in-hospital staff/external sources - Time spent providing formal education sessions in minutes: 15 minute increments - # of NPSTAT-related formal presentations at conferences		alternative to prospective tracking, however it is more labour intensive and time consuming, which would likely result in a lower sample size of clients and introduce greater chance of error, and thus is not recommended.

EVALUATION OBJECTIVE #3: Describe the provision of care within the context of evidence-informed practices for care of the elderly

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
BSO				

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
Do BSO-funded staff in both LTCH and the community (BSO-funded GAIN team members) provide value stream mapped/standardized/ evidence-based processes of care?[21]	Existence of completed value stream mapping/ standardized/ evidence-based processes of care	• Documentation and description of value stream mapping • # (%) BSO teams in LTCH that have completed value stream mapping • # (%) GAIN BSO teams that have completed value stream mapping • Description of standardized processes of care • # (%) BSO-funded LTCH-based staff who have documented their use of standardized processes of care • # (%) BSO-funded GAIN team members who have documented their use standardized processes of care	Program records	Review of documentation on value stream mapping and standardized processes of care *Interpretation of results:* determine the extent to which care processes provided by each of the BSO-funded GAIN team members are standardized and how much inter-team variability exists
			Chart audit	Review of staff documentation re use of standardized processes of care. Potentially select 5-10 charts per home to review; need to determine who the best person/ role is to conduct this review considering time constraints, potential for bias, and various sensitivities. Review would include collecting information on: • Documentation of presenting issue, assessment efforts, and care plan • Evidence of care plan implementation • Evidence of evaluation of the effectiveness of the care plan
GEM				
How does the GEM program support client transitions (continuity of care) across sectors?	Continuity of care across sectors (acute, LTC, community)	• # (%) clients referred to other SGS programs (NPSTAT, BSO, GAIN) • # (%) clients referred to other health care services (clinics, specialists) • # (%) clients referred to Home and Community Care: new referrals, change in existing services • # (%) referrals to other community services (identify services) • # (%) clients with follow-up contacts with referral sources and other health care providers (pre or post-client discharge from ED) • # (%) clients with contacts with retirement homes and community care providers (pre or post-client discharge from ED)	Individual GEM nurse tracking	Development of a tool (paper template, excel spreadsheet, online reporting form implemented using survey software). Timeline: Tracking for a specified period of time (e.g., one quarter or more, randomly or seasonally selected months). Note: Retrospective chart audit is an alternative to prospective tracking, however it is more labour intensive and time consuming, which would likely result in a lower sample size of clients and introduce greater chance of error, and thus is not recommended.

[21] Value stream mapping is complete for long-term care and in progress for GAIN

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
		# of follow-up contacts with clients post ED discharge		
			Key stakeholders: GEM nurses (CELHIN, other LHINs), GEM program managers/ leads (in CELHIN, other LHINs), ED Medical Directors/ Nursing Managers, other relevant stakeholders (geriatricians, community program service providers, provincial GEM program leads/ experts)	Survey or interview methods; could potentially be integrated into other evaluation efforts with the same target groups. *Potential survey question:* Given your understanding of the GEM nurse program, to what extent to does the GEM program contribute to continuity of care once clients are discharged from the ED? 5-point scale: not at all; a little bit; somewhat; very much; completely *Potential interview questions:* Given your understanding of the GEM nurse role, in what ways does the GEM nurse program promote successful client transitions across sectors, that is, how do they contribute to continuity of care? Based on your experience with GEM, what possible barriers could impede GEM nurse ability to support client transitions across sectors? What suggestions do you have for how GEM nurses could better support client transition across sectors?
			Client health records – GEM nurse generated	Case Study: A case study approach can be used to describe service provision related to care transitions across sectors, including a description of processes, and other care providers involved and to explore the impacts associated with GEM involvement. Each GEM nurse could provide two case studies, one illustrating a successful or optimal transition and one illustrating a less than optimal transition. A list of questions should be provided to guide the development of the case study. Each case study should provide information describing: Client characteristics (age, sex, living situation, health status, issues, services currently involved) Issue prompting GEM referral (who referred) GEM nurse response to the referral (how was the referral received, what assessment was conducted, with who) How was care planned (who was involved) What was the plan (care strategies, referrals to other services) What were some of the key successes and challenges

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
				associated with this case (enabling factors, challenges, strategies attempted to overcome challenges, suggestions for service improvements) • How was the care plan/strategy evaluated? • Was it effective? What were the outcomes? • Were there any unique features to this case that illustrate the effectiveness/ ineffectiveness of GEM nurse involvement in care transitions?
GAIN				
Which GAIN care model has the greatest impact on client outcomes?	Identification of clients with greatest gains made in specified outcomes by specific care model.	• Identified outcome measures of interest[22]: ○ health quality of life ○ subjective health ○ caregiver burden ○ ED visits ○ goal attainment ○ functional status ○ frailty	Client health records	Chart audit: Potentially select 5-10 charts per team to review. Review assessment and discharge data for each outcome. Charts can be picked randomly or selected with specified criteria (e.g., specific diagnoses, level of risk, etc.). Create a data collection form that included the outcome measures of interest. Analysis: Calculate change scores and stratify client outcomes by model of care (i.e., summarize client results for each outcome for each model of care).
			Client health records – GAIN team clinician generated	Case Study: A case study approach can be used to describe client outcomes for each GAIN care team, including a description of care planning and services provided and to explore the impacts associated with different care models. Each GAIN team could prepare at least one case study, selected based on pre-determine criteria (e.g., age, complexity, number of services involved, urgency, length of time on service) in order to provide some consistency for comparative purposes. A list of questions should be provided to guide the development of the case study. Each case study should provide information describing: • Client characteristics (age, sex, living situation, health status, issues, services currently involved) • Issue prompting GAIN referral (who referred) • GAIN assessment and outcomes

[22] These outcomes are described in more detail within the Outcomes Evaluation Framework

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
				• Care plan developed (description of care strategies and goals) • Status (outcomes) at discharge. • What were some of the key successes and challenges associated with this case (enabling factors, challenges, strategies attempted to overcome challenges, suggestions for service improvements) • Were there any unique features to this case that illustrate the effectiveness/ ineffectiveness of GAN involvement? For case studies prepared by teams using a consultative model, follow-up with primary care may be necessary to understand client outcomes. Alternatively, cases in which clients were re-referred to GAIN (within a specified time period) could be used.
Are care plans developed by GAIN teams client-focused and goal-oriented?	Documentation of client-specific goals and care plans	• Identification and documentation of client-focused and goal-oriented care plans	Client health records/ documentation	Chart Review – Select a specified number of charts to review from each team; charts can be picked randomly or selected with specified criteria (e.g., specific diagnoses, level of risk, etc.). Review should include: • How goals were determined / if recorded. • Description of whether and how goals were reflected in the care plan and discharge plan. • Indication of whether goals were reviewed with clients at discharge. • Indication of whether goals not met were attended to in some other way (e.g., referral to other services).
			Client health records- GAIN team clinician generated	A case study approach can be used to describe care planning in terms of process and goal attainment. Each GAIN team could provide one or two case studies. A list of questions should be provided to guide the development of the case study. Each case study should provide information describing: • Client characteristics (age, sex, living situation, health status, issues, services currently involved) • Issue prompting GAIN referral • GAIN assessment and outcomes • Care plan developed (description of care strategies and goals, how it was developed, client and caregiver involvement) • How did the GAIN team goals for care differ from client and

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
				caregiver goals? How were any discrepancies managed? • How was the care plan/goals evaluated? • What were the outcomes? • What were some of the key successes and challenges associated with this case (enabling factors, challenges, strategies attempted to overcome challenges, suggestions for service improvements) • Were there any unique features to this case that illustrate the effectiveness/ ineffectiveness of creating client-focused and goal-oriented care plans?
	Client experience with care	• # (%) clients reporting their goals for care were incorporated in the care plan • # (%) clients reporting their goals for care were met • # (%) clients satisfied with goal attainment	Clients/ care partners	Client/ care partner satisfaction/ experience of care survey" Questions can be asked about whether clients perceived that their goals/ needs for care were attended to and met, whether their care plan included goals that they felt were useful and the extent to which they were satisfied with goal attainment. WatLX© Outclient Rehabilitative Care Client Experience questionnaire: "I achieved my treatment goals" (7-point scale: Entirely disagree to entirely agree). For more information see: http://rehabcarealliance.ca/uploads/File/Initiatives_and_Toolkits/Outclient_Ambulatory/WatLX_Customer_Survey_10Q-Blur.pdf
NPSTAT				
What is the role of NPSTAT nurses in supporting palliative care?	Standardized role description developed for support of palliative care clients Secondary outcome: • role description approved and applied to future job	• Description of NPSTAT nurse role with supporting palliative care	Interviews with NPSTAT nurses, LTCH nursing staff, LTCH DOCs	Focus groups/one-on-one interviews *Potential interview question:* How do you support LTCH residents who require palliative care?

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
	advertisements/ work situations			
			Document review	Review all sources of information that may identify roles or activities related to palliative care (e.g., formal job descriptive, funding documents)
			Resident health records	Review of charts of resident who have died; potentially select 10 charts of the most recently deceased residents for review. Review (within 3-months prior to death) to include: • Frequency of consult requests to NPSTAT program • Reason for consult request • Description of NPSTAT involvement Interpretation of results with consideration of NP scope of practice.

EVALUATION OBJECTIVE #4: Describe the provision of care within the context of other services offered in the CELHIN for seniors

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
GEM				

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
How is GEM linked with retirement home/ community care providers? What are the goals of these linkages?	Description of GEM linkages with retirement home/ community care providers (type, goals).	# of clients assessed living in retirement homes # of contacts with retirement homes (pre or post-client discharge from ED) # of contacts with community care providers (pre or post-client discharge from ED	Individual GEM nurse tracking	Tracking described above
			Key stakeholders: GEM nurses (CELHIN, other LHINs), GEM program managers/ leads (CELHIN, other LHINs), stakeholders representing retirement homes and community care services (Home and Community Care)	Interview methods; could potentially be integrated into other evaluation efforts with the same target groups. Retirement home/ community – select those who have experience with GEM program – perhaps based on # clients referred to GEM program *Potential interview questions:* For GEM Nurses: In what ways have you been involved with retirement homes and community care providers? What do you think are the specific goals of building your relationship with retirement homes and community care providers? What would be the specific activities, benefits and outcomes associated with this relationship? What threats or barriers to fulfilling this role do you anticipate? What are some potential strategies to overcome these threats? Do you have any suggestions for engaging and fostering relationships with these groups? Are there any specific resources or supports that you require to be successful in this endeavor? For key stakeholders: In what ways have you interacted, or been involved with GEM nurses as related to the clients you serve? In what ways do you see the GEM nurses having a role to play in the care of the clients you serve? What do you think are the specific activities and goals of this relationship with the GEM program? What threats or barriers to fulfilling this role do you anticipate? What are some potential strategies to overcome these threats? Do you have any suggestions for engaging and fostering relationships with these groups? Are there any specific resources or supports that are required for this relationship to be successful?

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
NPSTAT				
Does NPSTAT duplicate what is offered through other funded roles (e.g., does the NP role duplicate that of the LTCH medical director)?	Clear understanding of role & function of NPSTAT nurse with regards to; • clinical assessment • clinical care (including writing of prescriptions) and how this differs from the role/function of LTCH physicians, LTCH RNs, others	• Description of NPSTAT role	Document review	Review all sources of information that may identify roles or key NP activities (e.g., review of key qualifications in recent job advertisements, LTCH legislation, criteria for NPSTAT consultation, flow charts/ process maps)
			Resident health records	Chart audit; select 10 residents randomly from current caseload; abstract information on the following:: • Description of sample (age, sex) • Reason for consult (presenting problem) • Comorbidity/ complexity • Description of NPSTAT involvement (medical and nursing recommendations) (e.g., what are NPSTAT nurses recommending/ordering) Comparison sample; select 10 residents matched by unit/ floor not seen by NPSTAT to review charts: • description of sample (age, sex) • Reason for consult (presenting problem) • Comorbidity/ complexity • Description of physician involvement (medical and nursing recommendations) (e.g., what are physicians nurses recommending/ordering) *Interpretation of results:* Consider differing roles of NPs and physicians based on case mix (comorbidity/ complexity) of residents and different approaches to care.
			Key stakeholders (NPs, physicians, DOCs, senior nurses)	Interview methods: could potentially be integrated into other evaluation efforts with the same target group. *Potential interview questions:* Describe the types of issues referred to NPSTAT? For which issues do you typically call physicians? (NPSTAT/ Physicians: Describe the types of issues typically referred to you; How easy is it for you to access NPSTAT? LTCH physicians?

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
				What criteria do you use for making referrals to NPSTAT? To physicians?
Is LTC the “best place” for NPSTAT? Should NPSTAT be increasingly aligned with primary care?	Better understanding of NPSTAT role in managing urgent/ critical cases, and preventing secondary complications/issues	In what proportion of cases do NPSTAT nurses deal with preventative issues? In what proportion of cases do NPSTAT nurses deal with critical/urgent cases?	Resident health records	Chart audit; randomly select charts of 5 residents of each NP (total 50 charts) for review: Description of sample (age, sex) Reason for consult (presenting problem) Comorbidity/ complexity Description of NPSTAT involvement (medical and nursing recommendations) (e.g., what are NPSTAT nurses recommending/ordering; what procedures are completed) Interpretation of results should consider type of activities and consideration of whether activities are based on need vs. current practice.
			Key stakeholders (NPs, physicians, DOC, senior nurses, representation from resident and family council)	Interview methods: could potentially be integrated into other evaluation efforts with the same target group. *Potential interview questions:* To what extent do you see the NPSTAT program as a preventative model/ approach to care? To what extent do you see the NPSTAT program as a reactive model/ problem-driven approach to care? In your opinion which model (preventative or reactive model) do you think is best approach to serving LTCH resident needs? Is LTC the best place for NPSTAT or should it be aligned with primary care? What impact would withdrawal of the NPSTAT program have in LTC?
			Literature review	Review of literature on optimal use of NP resources – what evidence exists on outcomes (cost effectiveness/ cost benefits) associated with different NP models of care.

OUTCOMES

EVALUATION OBJECTIVE #1: Describe the client and care partner-related outcomes associated with SGS programs.

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
All Programs				
What is the client experience with care (process, satisfaction)?	Description of client care experience and/or their satisfaction with care	RGP measure currently under development[23]	Survey	Survey tool distributed either directly to the client/ their care partner at or following discharge visit. Client asked to complete tool and mail it back in the return envelope. Example of questions: How would you evaluate the way your therapist listened to you during the visit? Response options: Very good / Good / Fair / Poor / Very poor
GAIN				
How does GAIN impact client outcomes?	Understanding of impact of GAIN services on selected client outcomes	Outcome measures of interest: ○ health quality of life ○ subjective health ○ caregiver burden ○ ED visits/acute care admissions ○ goal attainment ○ functional status ○ frailty	Client health records – GAIN clinician generated	Case Study: A case study approach can be used to describe GAIN impact on client outcomes. Each GAIN team could provide two case studies, one illustrating a successful client outcome(s) and one illustrating a less than optimal client outcome(s). Cases could be selected based on predetermined criteria (e.g., age, diagnosis, complexity etc.). A list of questions should be provided to guide the development of the case study. Each case study should provide information describing: Client characteristics (age, sex, living situation, health status, issues, services currently involved) Issue prompting GAIN referral (who referred) What was the plan (care strategies, referrals to other services)? What were some of the key successes and challenges associated with this case (enabling factors, challenges, strategies attempted to overcome challenges, suggestions for service improvements)? How was the care plan/strategy evaluated? What were the client outcomes? Were there any unique features to this case that illustrate the effectiveness/ ineffectiveness of

[23] Based on "Measuring Patient Experiences in Primary Health Care" by Wong & Haggarty; Available at: https://open.library.ubc.ca/cIRcle/collections/facultyresearchandpublications/52383/items/1.0048528; Current dimensions: Access; Interpersonal communication; Continuity and coordination; Comprehensiveness of services; Trust; Patient-reported impacts of care; Examples of patient experience surveys at: https://www.cihi.ca/en/patient-experience

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
				GAIN involvement?
Does GAIN impact (increase/ improve) the health-related quality of life of older adults?	Health-related quality of life (HRQOL)	Change in a standardized measure of health-related quality of life	Client health records	There are several HRQOL measures available; selection should be based on ease of administration, clinician preference, quality (sound psychometric properties), feasibility, ability to provide the information sought, and if relevant, availability in different languages. Piloting different measures using a PDSA cycles with feedback from users/ clients can assist in the selection process. Timeline for Intensive Case Management: Administer at assessment and prior to discharge; for all clients or a specific subset (consecutive assessments for a specified period of time). Analysis and interpretation is at group level. Timeline for Consultative Models: administer at assessment; analysis and interpretation is at a group level. Criteria/ Cut Offs – each tool has specified cut offs for defining health-related quality of life; check manual/ literature to ensure correct cut offs are used. Analysis: Test of significant differences between admission and discharge scores; calculation of a mean change in scores. ***Centres for Disease Control and Prevention HRQOL Measures:*** CDC HRQOL–14 "Healthy Days Measure" consisting of three subscales: Healthy Days, Activity Limitations, Healthy Days Symptoms (14 questions total). Available at: https://www.cdc.gov/hrqol/hrqol14_measure.htm ***Quality Of Life Questionnaire (15D©):*** 15 questions describing health status. Available at: http://www.15d-instrument.net/15d/ ***EQ-5D:*** standardised measure of health status developed by the EuroQoL Group; consists of 7 questions covering multiple dimensions (e.g., pain, mobility, self-care, depression/ anxiety). Available at: https://euroqol.org/wp-content/uploads/2016/09/EQ-5D-5L_UserGuide_2015.pdf ***SF12 Health Status Questionnaire:*** Shortened version of the SF-36 measure consisting of 8 subscales related to health functioning. Available at: https://www.hss.edu/physician-files/huang/SF12-RCH.pdf ***World Health Organization QOL-BREF Measure:*** 26 questions covering physical health, psychology, social relationships, and environment.

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
				Available at: http://www.who.int/mental_health/media/en/76.pdf\ **Dementia Specific Tools:** There are a number of QOL measures for use with clients with dementia [Activity and Affect Indicators of QOL; Alzheimer Disease Related Quality of Life (ADRQL); The Cornell-Brown Scale for Quality of Life in Dementia (CBS); Dementia Care Mapping (DCM); Dementia Quality of Life Instrument (DQoL); Psychological Well-Being in Cognitively Impaired Persons (PWB-CIP); The Quality of Life in Late-Stage Dementia (QUALID) Scale; Quality of Life-Alzheimer's Disease (QOL-AD); Quality of Life Assessment Schedule (QOLAS)]. These measures vary in how they define quality of life, length, administration and psychometric properties; a good review of these tools can be found at: https://www.springermedizin.de/quality-of-life-measures-for-dementia/9558366 and https://repositori.upf.edu/bitstream/handle/10230/23490/perales_intpsycho.pdf?sequence=1
Does GAIN impact (improve/ maintain) client perception of subjective health?	Subjective perceptions of health status	Change in subjective health status	Client health records	Single, validated question:[24] Compared to others your age, how would you rate your health? Poor, fair, good, very good, excellent Analysis: Test of significant differences between admission and discharge scores; calculation of a mean change in scores. Timeline for Intensive Case Management: Administer twice, at assessment and prior to discharge; for all clients or a specific subset (consecutive assessments for a specified period of time). Analysis and interpretation is at group level. Timeline for Consultative Models: administer at assessment; analysis and interpretation is at a group level. For clients re-referred to the service, change in scores at first and second assessment can be calculated to provide client-level change scores.
Does GAIN impact client functional status? (improve, maintain, prevent decline)	Client functional status	Change in functional assessment score (as assessed with a standardized tool) Frailty scale score (note frailty	Client health records	Functional Status: There are several potential functional assessment measures that could be used; selection should be based on ease of administration, clinician preference, quality (sound psychometric properties), feasibility, and ability to provide the information sought. Piloting different measures using a PDSA cycles with feedback from users/ clients can assist in the selection process. Analysis: Test of significant differences between admission and discharge scores; calculation of a

[24] Wu S, Wang R, Zhao Y, et al. The relationship between self-rated health and objective health status: a population-based study. BMC Public Health, 2013; 13:320. Available at: https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-320

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
		scores provide an indication of functional status but may not necessarily change with intervention)		mean change in scores. Possible psychometrically sound functional assessment tools: Barthel Index (http://camapcanada.ca/Barthel.pdf), RAI-Home Care (http://www.interrai.org/home-care.html); Lawton Instrumental Activities of Daily Living Scale (http://micmrc.org/system/files/IADL.pdf); Timed up and Go Test (https://www.cdc.gov/steadi/pdf/tug_test-a.pdf); Functional Independence Measure (FIM™) (http://www.rehabmeasures.org/lists/rehabmeasures/dispform.aspx?id=889) Frailty as a measure of functional status: The Canadian Study on Health and Aging Clinical Frailty Scale is a validated scale for measuring level of frailty. Available at: http://camapcanada.ca/Frailtyscale.pdf. However, while frailty scores calculated with this tool may provide an indication of functional status, this tool is primarily a discriminative tool and not an evaluative measure. While other frailty measures exist (e.g., Fried Frailty Criteria[25]) assessment requirements (e.g. measuring gait speed and grip strength) are not feasible in some clinical settings. Timeline for Intensive Case Management: Administer at assessment and prior to discharge; for all clients or a specific subset (consecutive assessments for a specified period of time). Analysis and interpretation is at group level. Timeline for Consultative Models: administer at assessment; analysis and interpretation is at a group level. For clients re-referred to the service, change in scores at first and second assessment can be calculated to provide client-level change scores.
Does GAIN impact (increase/ improve) care partner quality of life and (reduce) care partner burden/ stress?	Care partner Stress/Burden	Change in standardized measure of care partner stress burden	Primary care partners of GAIN clients	GAIN is currently in the process of pilot testing two measures: Caregiver Strain Index (http://www.npcrc.org/files/news/caregiver_strain_index.pdf) (modified) and the Zarit Burden Inventory (http://dementiapathways.ie/_filecache/edd/c3c/89-zarit_burden_interview.pdf). There are several caregiver quality of life tools. Selection should be based on ease of administration, clinician preference, quality (sound psychometric properties), feasibility and ability to provide the information sought. Piloting different measures using a PDSA cycles with feedback from users/ clients can assist in the selection process. List of caregiver assessment tools at: https://www.caregiver.org/sites/caregiver.org/files/pdfs/SelCGAssmtMeas_ResInv_FINAL_12.10.12.pdf

[25] Fried, L. P., Tangen, C. M., Walston, J., et al. Frailty in older adults: evidence for a phenotype. *The Journals of Gerontology.Series A, Biological Sciences and Medical sciences,* 2001; 56A: M146-M156.

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
				Analysis: Test of significant differences between admission and discharge scores; calculation of a mean change in scores. Timeline for Intensive Case Management: Administer at assessment and prior to discharge; for all clients or a specific subset (consecutive assessments for a specified period of time). Analysis and interpretation is at group level. Timeline for Consultative Models: administer at assessment; analysis and interpretation is at a group level. For clients re-referred to the service, change in scores at first and second assessment can be calculated to provide client-level change scores.
Does GAIN contribute to reduced ED visits/acute care admissions for clients?	Number of ED visits Number of acute care admissions	# of ED visits/acute care admissions among older community-dwelling CE LHIN clients in 2012 and 2013 by fiscal quarter (prior to GAIN) and by sub region vs. number of ED visits/acute care admissions among older community-dwelling CE LHIN clients in 2017 by fiscal quarter and by sub region	CIHI / CE LHIN	Data pulled by CE LHIN data analyst and graphed and examined for time trends. Interpretation: Number of ED visits/acute care admissions will likely increase overtime due to the increasing number of older adults in the community. Interpretation of these data should be considered within the context of the overall number of older adults (both community dwelling and institutionalized) in the CELHIN region, perhaps a rate per 10,000 CE LHIN-based older adults.
	Healthcare provider subjective assessment re ED diversion	Client contacts resulting in ED diversion	GAIN team members	Prospective tracking (can be incorporated into evaluation tracking tools): For each client contact (in-person, via telephone), team members answer the question: “Did this client contact divert/prevent an ED visit.” (yes, no, not sure) For one week each fiscal year quarter, at the end of each day GAIN team members respond to: “Would any of today’s clients have likely gone to the ED if there had not been a GAIN visit?” The proportion of all visits that likely resulted in ED diversion are tracked quarterly to examine time trends.
To what extent does GAIN help clients attain their care goals?	Attainment of client-related goals	Documentation of client goals Goal attainment	Client health records Clients	There are several potential methods for measuring goal attainment; selection should be based on ease of administration, clinician preference, quality (sound psychometric properties), feasibility and ability to provide the information sought. Piloting different measures using a PDSA cycles with feedback from users/ clients can assist in the selection process.

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
				Goal Attainment Scaling (GAS)[26]: A process for establishing and scoring the extent to which goals have been attained. More information about GAS scoring to assess change is available at: https://www.kcl.ac.uk/lsm/research/divisions/cicelysaunders/attachments/Tools-GAS-Practical-Guide.pdf ***Canadian Occupational Performance Measure (COPM):*** client-centred tool that identifies and prioritizes everyday issues that restrict or impact client performance in everyday living. As part of the assessment process clients are asked to self-rate performance and satisfaction for the problems addressed; these are rated again at discharge to calculate the performance and satisfaction change scores. More information (including illustrative videos) about COPM is available at: http://www.thecopm.ca/learn/ The measure is available at: http://www.neuroreha.cz/sites/default/files/materialy/COPM.pdf Timeline: Assess client goals at assessment; assess attainment prior to discharge.
			Clients and clinicians	Discharge Debrief; At the time of discharge include client and health care provider assessment of what enabled and challenged goal attainment: What do you think helped you/ your client achieve their care goals? Why do you think you/ your client was unable to achieve their care goals? What challenges did you/ your client experience?

[26] Rockwood K, Howlett S, et al. Responsiveness of goal attainment scaling in a randomized controlled trial of comprehensive geriatric assessment. Journal of Clinical Epidemiology, 2003; 56(8): 736-743.
Stolee P, Zaza C, et al. Clinical Experience with Goal Attainment Scaling in Geriatric Care." Journal of Aging and Health, 1999; 11(6): 96-124.
Turner-Stokes, L. Goal attainment scaling (GAS) in rehabilitation: a practical guide. Clinical Rehabilitation, 2009; 23(4): 362-370.

EVALUATION OBJECTIVE #2: Describe the health system-related outcomes associated with SGS programs.

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
BSO				
Do current practices (e.g., policies, standardized clinical pathways/practices, and hiring and orientation practices) ensure successful transitions and successful outcomes across the care continuum?[27]	Delay in the need for more intensive service	**Community-based:** • # of clients who received community-based BSO services (GAIN) who were still living at home 6 months post discharge/# of clients who received community-based BSO services **LTCH-based:** • # (%) LTCH residents who received LTCH-based BSO services referred to Behavioural Support Unit (BSU)/ acute care/ tertiary care within 1 month of discharge from BSO services	Client health records	Names/unique identifiers of all community-based BSO service recipients who were discharged in the last 3 months are provided to Home and Community Care who then determine client discharge disposition (death, admission to LTC, other) Analysis: Data can be summarized by sector (community, LTC), GAIN model of care (Consultative, Intensive Case Management), sub-region, and geography (urban, rural) Retrospective and/ or prospective tracking of those who received BSO services, specifically tracking the provision of 1:1 supervision in the month following discharge from BSO services. Track this number over time. One suggestion would be to start with an early adopter LTCH.
			Home and Community Care	For those clients receiving services from Home and Community Care some of these data elements are available in the MDS-RAI Home Care dataset (CHRIS).
	Reduced number of acute care admissions for behavioural issues	**Community-based** # of acute care admissions for older community-dwelling CE LHIN residents for responsive behaviours (selected ICD-10 codes) in 2010 vs. number of acute care admissions for older community-dwelling CE LHIN residents for responsive behaviours in 2017, 2018, etc.	CIHI / CE LHIN /Health Analytics Branch, Ontario Ministry of Health and Long-Term Care	Data pulled by CE LHIN data analyst, graphed, and examined for time trends. Interpretation: Historical comparisons reflect clients served at that time based on criteria that may differ from those currently used.

[27] Acknowledging that *causal* attributions will be difficult to make.

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
		LTCH-based # of acute care admissions for CE LHIN LTCH residents for responsive behaviours (selected ICD-10 codes) in 2010 vs. number of acute care admissions for CE LHIN LTCH residents for responsive behaviours in 2017, 2018, etc.		
	Reduced number of ALC days	# of ALC days for those who are ALC due to responsive behaviours/mental health issues by fiscal year quarter	Wait Time Information System (WTIS) database; CE LHIN / Health Analytics Branch, Ontario Ministry of Health and Long-Term Care	Data pulled by CE LHIN data analyst, graphed, and examined for time trends.
	Increased healthcare provider understanding of the system of care (cross sector navigation)	# (%) successful* return visits from ED to LTC supported by NPSTAT or GEM / total # of transitions back to LTC from ED # (%) successful return visits from acute care to LTC that were supported by NPSTAT / total number of transitions back to LTC from acute care *Successful: no unplanned ED visits/hospital admissions within 7 days of returning to LTCH	Client health records	Chart review: Identify LTCH residents transferred to the ED in the last month. Identify the number of residents with an unplanned return visit to the ED/have a hospital admission within 7 days of returning from ED/acute care. These data could also be tracked prospectively. Analysis: Data collected should be summarized by sector (community, LTC) and sub region.
	Successful transitions	# (%) successful* return visits from ED to LTC / total # of transitions back to LTC from ED # (%) successful* return visits from ED to LTC where clinical pathways were used / total number of transitions back to LTC from ED	Client health records	Chart review: Identify LTCH residents transferred to the ED in the last month. Identify the number of residents with an unplanned return visit to the ED/have a hospital admission within 7 days of returning from ED/acute care. These data could also be tracked prospectively. Analysis: Data collected should be summarized by sector (community, LTC) and sub region.

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
		# (%) successful* return visits from acute care to LTC / total number of transitions back to LTC from acute care # (%) successful* return visits from acute care to LTC where clinical pathways were used / total number of transitions back to LTC from ED *Successful: no unplanned ED visits/hospital admissions within 7 days of returning to LTCH		.
	All outcomes listed above: Delay in need for more intensive service Acute care admissions ALC days Increased health care provider understanding of cross system navigation Successful transitions	Key stakeholder perception of the impact of current practices (e.g., policies, standardized clinical pathways/practices, and hiring and orientation practices) on successful transitions and successful outcomes across the care continuum	Key stakeholders (BSO, GAIN, NPSTAT program staff)	Survey or interview methods; could potentially be integrated into other evaluation efforts with the same target groups. *Possible interview/survey questions*: How could current BSO-related resources, policies, standardized clinical pathways/practices, and hiring and orientation practices impact successful transitions of older adults living with responsive behaviours from LTC to acute care? From acute care back to LTC? From LTC to the ED? Ask similar questions related to impacts related to other indicators. What current BSO practices support these outcomes? What BSO practices need to change to improve outcomes? What factors contribute to these outcomes?
			Client health records	Case Study: A case study approach can be used to describe BSO practices impact on selected outcomes. Cases could be selected to reflect successful and less than optimal outcomes; criteria will need to be developed to define the outcomes (e.g., to describe those clients who should be transferred to acute care). Cases could be selected based on predetermined criteria (e.g., age, diagnosis, complexity etc.). A list of questions should be provided to guide the development of the case study. Each case study should provide information describing: Client characteristics (age, sex, living situation, health status, issues, services currently involved) Client diagnosis and issues

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
				• Assessment process and outcomes • What was the plan (care strategies, referrals to other services)? • How was the care plan/strategy evaluated? • What were the client outcomes? • Was (and how was) the need for more intensives services delayed/ acute care admission avoided? • What contributed to the need for acute care transfer/ ALC designation? • At what points were care transitions successful/ less than optimal? What factors contributed to this? • What were some of the key successes and challenges associated with this case (enabling factors, challenges, strategies attempted to overcome challenges, suggestions for service improvements)? • Were there any unique features to this case that illustrate the effectiveness/ ineffectiveness of BSO practices?
Does adherence to the value stream mapped process of care lead to increased staff/care partner ability to manage responsive behaviours?[28,29]	Documented adherence to value stream mapped process of care Documented adherence to value stream mapped process of care and documented client outcomes	**Community-based:** • # of clients who received community-based BSO services based on the value stream mapped process of care/ # of community-based residents who received BSO services • # of clients who both received community-based BSO services (GAIN) and whose care adhered to the value stream mapped process of care who were still living at home 6 months post discharge/# of clients who received community-based BSO services **LTCH-based:** • # of LTCH residents who	Client health records	Name/unique identifier of all community-based BSO clients who were discharged in the last 3 months provided to Home and Community Care who then review the client chart to see if client was discharged from services due to: death, admission to LTC, other.
			Home and Community Care	For those clients receiving services from Home and Community Care some of these data elements are available in the MDS-RAI Home Care dataset (CHRIS).
			Resident health records	Review charts of those who received BSO services in last month to see if they received care as described in the value stream mapped process of care and if they required 1:1 supervision in the month following discharge from BSO services. Track this number over time.
			Staff interviews/survey/ focus group	*Possible survey/focus group questions*: Are you aware of the value stream mapped process of care for BSO? How frequently do you adhere to the value stream mapped process of care? What are some of the challenges

[28] Acknowledging that *causal* attributions will be difficult to make
[29] Value stream mapping is complete for long-term care and in progress for GAIN

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
		received LTCH-based BSO services based on the value stream mapped process of care/ # of LTCH residents who received BSO services - # of LTCH residents who received LTCH-based BSO services based on the value stream mapped process of care who required 1:1 supervision within 1 month of discharge from BSO services - # of LTCH residents who received LTCH-based BSO services but services were NOT based on the value stream mapped process of care who required 1:1 supervision within 1 month of discharge from BSO services Staff perceived ability to manage responsive behaviours.		in applying this process of care? What do you think are the benefits of complying with this process? What are some of the results associated with this process of care? For example, as a result of this process, have you noticed fewer transfers to the ED for responsive behaviours?
Does adherence to the value stream mapped process of care lead to increased staff and resident safety?[30],[31]	Increased family member perception of safety	**Community-based** - Perceived family member safety.	Family member exit interview/survey	Survey or interview methods; at discharge visit, family members are given a survey/are interviewed and asked: Do you now feel safer when interacting with/taking care of your family member? Analysis by use of the value stream mapped process of care

[30] Acknowledging that causal attributions will be difficult to make
[31] Value stream mapping is complete for long-term care and in progress for GAIN

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
	Fewer LTCH staff injuries due to interactions with residents with responsive behaviours	**LTCH-based** • # of LTC staff WSIB claims due to injuries received during an interaction with a resident with responsive behaviours who has received BSO services as per the value stream mapped process of care	WSIB claims	# of claims by month tracked over time and graphed.
		• LTCH staff perception of safety.	Staff interviews/ survey/focus group	*Possible survey/focus group questions*: What factors impact your sense of safety when interacting with residents with responsive behaviours? Do you feel safer when interacting with residents who have responsive behaviours when you are using the value stream mapped BSO process of care?
	Fewer resident injuries associated with interactions with LTC residents with responsive behaviours	• # of resident injuries associated with interactions with LTC residents with responsive behaviours.	Long-Term Care Home Critical Incident Reports; LTCH inspection reports	Review of all incident reports in the last 3 months (for information on the Critical Incident System (CIS) see: https://www.ltchomes.net/CIS/doc/CIS%20Manual%20Home.pdf). Review of long-term care home inspection reports in last 3 months to identify number of critical incidents related to behaviours. (http://publicreporting.ltchomes.net/en-ca/Search_Selection.aspx)
GEM				
To what extent has the GEM program increased ED staff knowledge of geriatric syndromes?	Increased ED staff knowledge of geriatric syndromes	• ED staff perceptions of GEM nurse impact on their knowledge (self-perceived knowledge)	ED staff (physicians, nurses, social workers, discharge planners, Home and Community Care Coordinators and other relevant ED staff.	Survey or interview methods; could potentially be integrated into other evaluation efforts with the same target groups or expanded to include other outcomes related to overall ED staff satisfaction with the GEM program. *Potential survey questions:* • Have you participated in any formal education, information, or in-service sessions conducted by the GEM Nurse? [Yes, No, Not sure; if yes - How helpful were these sessions? (5-point scale: 1 = not at all helpful; 5 = extremely helpful.)] • Have you had any opportunities to informally (in the moment, at the bedside, in conversation) learn new information about geriatrics (care of the elderly) or available community supports for older adults from

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
				the GEM Nurse? [Yes, No, Not sure; if yes - How helpful were these sessions? (5-point scale: 1 = not at all helpful; 5 = extremely helpful.)] • How would you rate your current level of knowledge of geriatrics (care of the elderly)? (5-point scale: 1 = not at all knowledgeable; 5 = extremely knowledgeable) • How does this compare with your level of knowledge prior to the involvement of the GEM Nurse in your Emergency Department? (5-point scale: Much less knowledgeable now, less knowledgeable now, about the same, more knowledgeable now, much more knowledgeable now. • Similar questions can be asked substituting knowledge with: ability to assess common geriatric issues (within scope of practice); ability to manage common geriatric issues (within scope of practice); knowledge of available community support services and resources for seniors; use of (referral to) available community support services and resources for seniors. *Potential interview questions:* What role does GEM play in your ED? What impact do you think the GEM nurse role has had on healthcare providers working in the ED? What specific impact have they had on capacity building for geriatric care (add specific prompts for impacts on knowledge of geriatric issues, ability to assess and manage common geriatric issues, knowledge of available community services for seniors, referral patterns to available community services for seniors.) The evaluation of GEM nurse impact on ED staff knowledge of geriatric syndromes could be expanded to include other outcomes such as: • perceptions of the GEM Nurse model of care • experience/satisfaction with GEM assessments and resulting treatment recommendations • strengths, challenges, threats, opportunities associated with the GEM nurse role • suggestions for improvements/ further development of the GEM nurse role • potential impacts of the GEM nurse on: ○ confidence and comfort with discharging older adults to

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
				the community (hospital avoidance) ○ clients/ care partners ○ health system utilization (admissions to hospital, revisits to ED) Surveys, focus groups, or interviews with specific subgroups of ED healthcare providers could be used.
NPSTAT				
Are key stakeholders (LTCH physicians and staff) satisfied with the NPSTAT program?	High key stakeholder satisfaction	% (#) stakeholders who are either "very" or "completely' satisfied with NPSTAT services offered at their place of employment	Key stakeholders (LTC nursing staff, directors of care, LTC medical directors) survey/focus group	Survey method; could potentially be integrated into other evaluation efforts with the same target group. Create a sampling frame of NPSTAT stakeholders with contact information Potential survey questions: Considering your involvement with the NPSTAT program in last 6 months, how satisfied are you with the NPSTAT program? (Very dissatisfied/ satisfied/ neutral/ satisfied/ very satisfied). This could be stratified into various dimensions of care (level of satisfaction with access to care, wait time, intake process, communication, care continuity and coordination, comprehensiveness of services, client outcomes, capacity building efforts). Two stars and a wish![32] Identify two things that you really like about the NPSTAT service and a wish (vision, dream, or idea) that you have for this program

[32] For further information on obtaining peer feedback see: http://www.assessmentforlearning.edu.au/professional_learning/peer_feedback/peer_strategies_enhance.html

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
Does NPSTAT keep clients out of the hospital? • Does NPSTAT reduce potentially avoidable transfers to local ED/hospital? • Are fewer # of residents admitted to hospital over time?[33]	Fewer potentially avoidable transfers from LTC to the ED due to NPSTAT services Fewer potentially avoidable transfers from LTC to acute care due to NPSTAT services	• # (%) LTCH residents with health issues that could be managed within the LTCH who were NOT transferred to the ED • # (%) LTCH residents with health issues that could be managed within the LTCH who **were transferred** to the ED • # (%) LTCH residents with health issues that could be managed within the LTCH who were NOT admitted to hospital	Client health records	Chart audit: 1) Create criteria: what issues should be managed within the LTCH vs. what issues should be sent to the ED; 2) conduct audit Potential sampling could be: • For one week every quarter, each NPSTAT nurse reviews charts of residents transferred to ED • Select charts of residents who were transferred to the ED more than 3 times in a one year period (or locally relevant number) Analysis: unit to be "transfers" not residents, as some residents may have more than on transfer in the time period.
	Fewer resident transfers to the ED	• # (%) LTCH residents who are transferred to the ED	Billing for ambulance services/ LTCH records	Review of billing information/ LTCH records to identify # of ED transfers Timeline: Collect information annually for the last 5 years; collect prospectively. Analysis: Graph the numbers by sub-region by year.
Are LTCH residents getting the "right care" in "the right place" at "the right time"? (Are they receiving needed care in the LTCH where they are less likely to pick up nosocomial infections/suffer the side effects of being admitted to hospital/attending an ED?)	Fewer residents with health issues that require medical intervention that can be managed by an NP are seen in the ED/hospital.	• # (%) LTCH residents with health issues requiring medical intervention that can be managed on site by an NP who are sent to ED/hospital for the issue • # (%) LTCH residents with health issues that can be managed on site by an PM who NOT are sent to the ED/hospital for the issue	Client health records	Chart audit; 1) Create criteria: what issues can be managed within the LTCH by the NP vs. what issues should be sent to the ED; 2) conduct audit Potential sampling could be: • For one week every quarter, each NPSTAT nurse reviews charts of residents transferred to ED
	Fewer people returning to their LTCH with hospital-acquired	• # (%) residents returning from acute/specialty care with pneumonia	Client health records	Chart audit; integrated into audit described above; review: • Resident characteristics (age, sex, diagnosis, reason for transfer) • Identify residents returning with or being diagnosed with the

[33] Acknowledging that *causal* attributions will be difficult to make.

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
	pneumonia/delirium/ Methicillin-resistant Staphylococcus aureus (MRSA), C. difficile	# (%) residents diagnosed with pneumonia within 7 days of returning from acute/ specialty care # (%) residents returning from acute/specialty care with MRSA/C. Difficile # (%) residents diagnosed with MRSA/ C. Difficile within 7 days of returning from acute/ specialty care # (%) residents returning from acute/specialty care with pressure ulcer # (%) residents diagnosed with pressure ulcer within 7 days of returning from acute/ specialty care # (%) residents returning from acute/specialty care with delirium # (%) residents diagnosed with delirium within 7 days[34] of returning from acute/ specialty care		following conditions upon return from acute/ specialty care: Pneumonia MRSA/ C. Difficile Pressure ulcers Delirium Identify hospital length of stay Identify those residents seen by NPSTAT while in acute/ specialty care or involved in post-discharge planning Analysis: Compare # (%)'s of conditions (listed above) and hospital LOS for residents for which NPSTAT was involved with those for which NPSTAT was not involved
	Decreased acute-care length of stay (LOS)	Decreased LOS over time (comparing LOS of those transitioned with NPSTAT vs those not), and by reason for admission	CIHI / CE LHIN /Health Analytics Branch, Ontario Ministry of Health and Long-Term Care	Data pulled by CE LHIN data analyst, graphed, and examined for time trends. Interpretation: Historical comparisons reflect clients served at that time based on criteria that may differ from those currently used.

[34] 7-days is recommended here, but clinical opinion/ expertise should be sought to verify an appropriate time frame.

EVALUATION OBJECTIVE #3: Describe the organization-related outcomes associated with SGS programs.

Evaluation Question	Outcomes	Indicator & Definition	Data Source	METHODS: Design/measurement/ timeline
GAIN				
Who is best served by GAIN? What are the characteristics of the clients who make the greatest gains with GAIN?	Identification of client characteristics associated with greatest gains made in specified outcomes.	Individualized client outcome measures of interest[35] ○ health quality of life ○ subjective health ○ caregiver burden ○ ED visits/acute care admissions ○ goal attainment ○ functional status ○ frailty	Client records	Chart Review: Work with clinical group to define "greatest gains" – criteria for determining and defining gains/ improvement (e.g., low, moderate, high) and to identify client characteristics most likely to discriminate gains/ improvement. Select cases to review based on predetermined criteria (e.g., age, diagnosis, complexity, GAIN team). Review: Client characteristics (e.g., age, sex, diagnosis, living situation, caregiver availability) Identify scores on outcomes measures of interest Categorize level of gain attainment (low, moderate, high) Optional: examine potential factors contributing to client ability to make gains (e.g., social determinants of health, such as education, income). Analysis: Compare the client characteristics of those at low, moderate, high levels of gains; test for statistically significant differences between these groups. Link with existing resources to identify their criteria (e.g., rehab potential, client agreement to terms of care plan)

[35] These outcomes are described in more detail as related to client-related outcomes

Appendix I

Evaluation Planning and Implementation Worksheets

Methods Worksheet
Logistics Worksheet – Questionnaires
Logistics Worksheet – Interviews
Tool Worksheet

More information, with examples of completed worksheets, about these can found in: Public Health Ontario. (nd). A program evaluation tool kit. Available at: https://www.publichealthontario.ca/en/LearningAndDevelopment/PHREDArchives/Program%20Evaluation%20Tool%20Kit[1].pdf

Methods Worksheet

Evaluation Questions	Expectations of the Program	Data Collection Plan							Logistics
	"I expect to have…"	Does the Data Exist?	Type of Tool	Who Could Provide the Data? (Source)	Who Can Gather the Data? (Collection)	Design	How Many?	Timeframe	Is this Feasible?
		☐ Yes ☐ No							☐ Yes ☐ No
		☐ Yes ☐ No							☐ Yes ☐ No
		☐ Yes ☐ No							☐ Yes ☐ No
		☐ Yes ☐ No							☐ Yes ☐ No
		☐ Yes ☐ No							☐ Yes ☐ No
		☐ Yes ☐ No							☐ Yes ☐ No
		☐ Yes ☐ No							☐ Yes ☐ No
		☐ Yes ☐ No							☐ Yes ☐ No
		☐ Yes ☐ No							☐ Yes ☐ No
		☐ Yes ☐ No							☐ Yes ☐ No
		☐ Yes ☐ No							☐ Yes ☐ No

Logistics Worksheet – Questionnaires

Tasks	Resources Required													Is It Feasible?
	Human Resources							Other Expenses			Time			
	In-House			*External*										
	Who Could Do It? Name(s)	How Long Will It Take?	Do They Have Time?	Who Could Do It? Name(s)	How Long Will It Take?	How Much Will It Cost?	Are The Funds Available?	Equipment, Supplies, & Administration	How Much Will It Cost?	Are The Funds Available?	Date Required	Can It Be Done In Time?	
☐ Determine if Research Ethics Board approval is needed														☐ Yes ☐ No
☐ Check for existing measures or tools, then develop a new tool or modify an existing one														☐ Yes ☐ No
☐ Assess quality of tool														☐ Yes ☐ No
☐ Determine type of survey (paper, on-line)														☐ Yes ☐ No
☐ Prepare instructions for people handing out the tool/ online completion														☐ Yes ☐ No
☐ Train people administering the tool and provide														☐ Yes ☐ No

Logistics Worksheet – Questionnaires													
	Resources Required												
	Human Resources							Other Expenses			Time		
	In-House			*External*									
Tasks	**Who Could Do It?** Name(s)	**How Long Will It Take?**	**Do They Have Time?**	**Who Could Do It?** Name(s)	**How Long Will It Take?**	**How Much Will It Cost?**	**Are The Funds Available?**	**Equipment, Supplies, & Administration**	**How Much Will It Cost?**	**Are The Funds Available?**	**Date Required**	**Can It Be Done In Time?**	**Is It Feasible?**
instructions													
☐ Pre-test and revise if necessary													☐ Yes ☐ No
☐ Reproduce tool (paper)													☐ Yes ☐ No
☐ Distribute tool (paper, online)													☐ Yes ☐ No
☐ Gather completed tools													☐ Yes ☐ No
☐ Enter/ download, analyze data													☐ Yes ☐ No
☐ Interpret the results													☐ Yes ☐ No
☐ Decide how to disseminate findings													☐ Yes ☐ No
☐ Prepare and disseminate findings													☐ Yes ☐ No

Logistics Worksheet – Questionnaires

Tasks	Resources Required												Is It Feasible?
	Human Resources							Other Expenses			Time		
	In-House			*External*									
	Who Could Do It? Name(s)	How Long Will It Take?	Do They Have Time?	Who Could Do It? Name(s)	How Long Will It Take?	How Much Will It Cost?	Are The Funds Available?	Equipment, Supplies, & Administration	How Much Will It Cost?	Are The Funds Available?	Date Required	Can It Be Done In Time?	
☐ Determine if Research Ethics Board approval is needed													☐ Yes ☐ No
☐ Check for existing measures or tools, then develop a new tool or modify an existing one													☐ Yes ☐ No
☐ Assess quality of tool													☐ Yes ☐ No
☐ Determine type of survey (paper, on-line)													☐ Yes ☐ No
☐ Prepare instructions for people handing out the tool/ online completion													☐ Yes ☐ No
☐ Train people administering the tool and provide													☐ Yes ☐ No

Logistics Worksheet – Questionnaires													
	Resources Required												
	Human Resources							Other Expenses			Time		
	In-House			*External*									
Tasks	**Who Could Do It?** Name(s)	**How Long Will It Take?**	**Do They Have Time?**	**Who Could Do It?** Name(s)	**How Long Will It Take?**	**How Much Will It Cost?**	**Are The Funds Available?**	**Equipment, Supplies, & Administration**	**How Much Will It Cost?**	**Are The Funds Available?**	**Date Required**	**Can It Be Done In Time?**	**Is It Feasible?**
instructions													
☐ Pre-test and revise if necessary													☐ Yes ☐ No
☐ Reproduce tool (paper)													☐ Yes ☐ No
☐ Distribute tool (paper, online)													☐ Yes ☐ No
☐ Gather completed tools													☐ Yes ☐ No
☐ Enter/ download, analyze data													☐ Yes ☐ No
☐ Interpret the results													☐ Yes ☐ No
☐ Decide how to disseminate findings													☐ Yes ☐ No
☐ Prepare and disseminate findings													☐ Yes ☐ No

Tool Worksheet			
Type of Tool:			
Expectation of the Program (From Methods Worksheet)	**Individual Question on Tool**	**Type of Response** (open or closed)	**Pre-Set Response Choices**