Fostering Excellence in the Care of Frail Older Adults
Annual Report 2014-2015

seniors care
network

VISION

Best healthcare experience for frail older adults in the Central East LHIN

MISSION

To create and maintain a high quality, integrated, person-centred system of care that supports the best quality of life for frail older adults and their families

VALUE STATEMENT

Connecting and improving the system of care for frail older adults

PILLARS

Leadership – Expertise - Consistency

Leadership Message from the Board Chair & Executive Director

Throughout the past year, we have worked collectively to build a strong network of specialized geriatric services focused on providing the best health experience for frail seniors in the Central East Local Health Integration Network. Now, almost 150 health care providers strong, the care we provided through the year touched the lives of over 10,000 older people and aimed to keep people experiencing frailty living in the location they call home.

Together with patients and providers, we are designing a responsive, networked health system that keeps the needs of older people with complex health concerns front and centre. We have enhanced our use of quality improvement methodologies and rigorously evaluated regional education and training needs for geriatric and gerontology based programming.

We have strengthened and expanded existing programs, such as the *Geriatric Assessment and Intervention Network,* and addressed identified system gaps and the challenges faced at end-of-life by people diagnosed with Dementia, through collaborative regional initiatives such as our *IDEAS* project. Our programs, such as *Behavioural Supports Ontario* and *Senior Friendly Care*, have been recognized for their leading practices and called upon to teach others both within and outside our region. Our *Geriatric Emergency Management* and *Nurse Practitioners Supporting Teams Averting Transfer* clinicians continue to optimize the way older people use acute care services and ensure that older people who do require acute care are treated appropriately.

We have many people to thank for the successes of the past year including the many wonderful patients and families who invited us into their lives and the dedicated clinicians who go to great lengths to support older people to achieve their health goals. We also want to thank Staff and Board members alike, as well as our Central East LHIN for their vision and leadership and for helping to forge the strong partnerships that are enabling us deliver on the promise of truly transformative health care for older people experiencing frailty.

Catherine Danbrook, Board Chair and Kelly Kay, Executive Director

In This Report

Governing Directors

Organizational Partners and Hosts

Ballycliffe Lodge
Altamont Care Community
Bay Ridges Long Term Care Center
Bendale Acres
Bon Air Residence
Burnbrae Gardens
Campbellford Memorial Hospital
Carefirst Seniors and Community Association
Caressant Care Mary Street
Caressant Care McLaughlin
Case Manor Care Community
Centennial Place Millbrook
Central East Community Care Access Centre
Central East LHIN
Community Care City of Kawartha Lakes
Craiglee Nursing Home
Ehatare Retirement & Nursing Home
Extendicare Cobourg
Extendicare Guildwood
Extendicare Haliburton
Extendicare Kawartha Lakes
Extendicare Lakefield
Extendicare Oshawa
Extendicare Peterborough
Extendicare Port Hope
Extendicare Rouge Valley
Extendicare Scarborough
Fairhaven
Fairview Lodge
Fenelon Court
Fieldstone Commons Care Community
Fosterbrooke Long Term Care Home
Frost Manor
Glen Hill Terrace Strathaven
Golden Plough Lodge
Haliburton Highlands Health Services
Hellenic Home for the Aged Inc.
Highland Wood
Hillsdale Estates
Hillsdale Terraces
Hope St. Terrace (CNH Port Hope)
Hyland Crest Senior Citizens Home
Ina Grafton Gage Home
Kennedy Lodge
Lakeridge Health
Lakeview Manor
Marnwood Lifecare Centre & Retirement Home
Midland Gardens Care Community
Mon Sheong Scarborough LTC Centre
Northumberland Hills Hospital
Ontario Shores Centre for Mental Health Sciences
Orchard Villa (CNH Pickering)
Oshawa Community Health Centre
Peterborough Regional Health Centre
Pinecrest Nursing Home
Pleasant Meadow Manor
Port Hope Community Health Centre
Port Perry Place (CNH Port Perry)
ReachView Village
Regency Manor Retirement and Nursing Home
Riverview Manor
Rockcliffe Care Community
Ross Memorial Hospital
Rouge Valley Health System
Seven Oaks
Shepherd Village - Shepherd Lodge
Springdale Country Manor
St Paul's L'Amoreaux Centre
St. Joseph's at Fleming
Streamway Villa
Sunnycrest Nursing Home
Tendercare Living Centre
The Scarborough Hospital
The Village of Taunton Mills
The Wexford Residence
The Wynfield LTC
ThorntonView LTCH
Tony Stacey Centre for Veterans Care
Trilogy LTC
Victoria Manor Home for the Aged
Warkworth Place (CNH Warkworth)
Winbourne Park
Yee Hong Centre for Geriatric Care - Finch
Yee Hong Centre for Geriatric Care - McNicoll

Specialized Geriatric Services in the Central East LHIN

The Regional Geriatric Programs of Ontario define Specialized Geriatric Services (SGS) as "a spectrum of hospital and community-based health care services that deliver comprehensive geriatric assessments. [This means] they diagnose, treat, and rehabilitate frail older persons with complex medical, functional, and psychosocial problems. SGS are delivered by interprofessional teams of geriatric and geriatric mental health care providers specifically trained to recognize and treat frail seniors with multiple and complex needs. Teams may compromise the following: physician, *nurse practitioner*[1], nurse, social worker, physiotherapist, occupational therapist, dietitian, pharmacist, and other health professions".

> "The target population for SGS is frail seniors whose health, dignity and independence are at risk due to:
>
> - Multiple complex medical and psycho-social problems
> - A recent unexplained decline in health and/or level of function
> - Loss of capacity for independent living"
>
> *RGPS of Ontario*

Seniors Care Network coordinates regional SGS services funded by the Central East LHIN. These include five core programs, briefly described below.

Behavioural Supports Ontario (BSO): Trained health professionals and programming helping older people with challenging behaviours resulting from complex and challenging mental health, addictions, dementia or other neurodegenerative issues.

Geriatric Assessment and Intervention Network (GAIN): Twelve interprofessional geriatric teams located throughout the Central East LHIN, collaborating with geriatricians and other specialists, providing comprehensive assessments and creating care plans with seniors and families which include a wide range of interventions to optimize function and independence and keep older people living at home.

Geriatric Emergency Management (GEM) Nurses: Nurses working in the emergency department who conduct assessments and provide support to older people experiencing acute health concerns, with a focus on trying to reduce unnecessary hospital admissions.

Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT): Nurse practitioners responding to residents of Long-Term Care facilities experiencing acute health concerns, helping to avoid transfers to hospital.

Seniors Friendly (SF) Care: Overseen by a working group comprised of representatives from all area hospitals and the RGP of Toronto collaborating to promote and provide strategic direction and leadership for Senior Friendly Hospital (SFH) care within the Central East Local Health Integration Network (CE LHIN).

[1] Added by Seniors Care Network, where NPs in the Central East LHIN provide clinical leadership in many SGS services

Overview of Seniors Care Network

Seniors Care Network engages in…

- Planning
- Standardization
- Coordination
- Monitoring & Evaluation
- Quality Improvement
- Communication
- Integration
- Environmental Scanning

Seniors Care Network was established in 2012 by the Central East LHIN to improve the organization, coordination and governance of specialized geriatric services (SGS) for frail seniors in the Central East LHIN. The work of Seniors Care Network is focused on three strategic priorities, which are:

Improving Care: Patients and families have access to specialized geriatric services with smooth transitions, tailored to individual needs, and founded on partnerships with providers.

Fostering Excellence: Health care providers will have knowledge and tools to deliver high quality care and effectively and continually monitor and improve their performance.

Increasing Awareness: There is increased awareness of the needs of frail seniors and the creation of regional programs to address those needs.

Although not independently incorporated, Seniors Care Network is governed by 12 governors who act in the capacity similar to that of a Board of Directors. Seniors Care Network is accountable to the Central East LHIN for the deliverables outlined in its annual service plan.

Fast Facts: SGS Programs and Services of Seniors Care Network:

- More than $19M invested by the Central East LHIN across regional SGS clinical programs
- Approximately 180 funded health care providers and others collaborating to deliver specialized services to the most vulnerable older adults in the region
- More than 27,000 direct encounters across all clinical programs in 2014/15
- Consistently high patient satisfaction ratings
- Emerging impact of SGS showing emergency room diversion, change in treatment plans, appropriateness of admissions
- Increasing synergy between SGS programs due to joint planning
- Emerging collaborations with Health Links, Primary Care and SGS
- Growing role on provincial landscape (e.g. Senior Friendly approaches, interprofessional geriatric competency development)
- Increasing inquiries from health professionals seeking to work in SGS services in the Central East LHIN – demonstrating positive recruitment impacts
- New web presence: www.seniorscarenetwork.ca

Improving Care

Easing Transitions at End of Life for Clients With Dementia
An Improving & Driving Excellence Across Sectors (IDEAS) Project

Project Overview

In the region of the CE LHIN it has been acknowledged that approaches for identifying older adults presenting with dementia who are nearing end of life is not well established. As a result, many clients with late-stage dementia are not identified as palliative and are unable to access appropriate palliative supports. This may result in the pursuit of futile treatments and interventions and missed opportunities to promote comfort and reduce suffering for clients and families.

Seniors Care Network convened a project group and submitted a successful application to the Improving & Driving Excellence Across Sectors (IDEAS) competition. IDEAS is a new, province-wide learning initiative to advance Ontario's health system priorities by building capacity in quality improvement, leadership and change management across all health care sectors. A key component of the IDEAS program is an applied learning project.

The project, titled "Easing transitions at end of life for clients with dementia", addresses the current service gap by improving the identification of significant frailty associated with late-stage dementia and fostering timely linkages to palliative services. Campbellford Memorial Hospital (CMH) is the site of this pilot project.

The core team (a representative from Campbellford Memorial Hospital, Northumberland Hills Hospital, Rouge Valley Health System and Seniors Care Network and) participated in the 9 day IDEAS Advanced Learning Program from September 2014 to February 2015. The larger 22 member project team is comprised of the core team and representatives from CMH (nursing, physicians, pharmacy, health records, discharge planning, recreational therapy, quality, CCAC), CE CCAC (palliative & community), Community Care Northumberland (visiting hospice) and the Bridge Hospice (residential hospice). The overall aims of the project were:

Big Dot Aim: By December 31, 2015, 80% of inpatients at Campbellford Memorial Hospital (CMH) with a diagnosis of dementia, who were screened and whose Frailty Assessment for Care-planning Tool (FACT) score was 8 or above, will be referred to palliative services.

Jack was admitted to the hospital with weakness and dementia. His family members were his decision makers and requested that if his heart and lungs were to stop that they wanted the staff to do everything they had to, to save his life. Over the next few days, Jack's health status deteriorated. This led to a conversation with his family members regarding what they felt Jack's end of life wishes would be. They indicated that he would want to die with dignity and requested that his last days be spent at a more home like setting, a residential hospice. The hospital arranged transfer to the residential hospice where Jack stayed 2 days before passing.

Prior to the project, this type of patient may not have been considered palliative and therefore, their final days would not have been in the location of their choice.

Project Aim: By March 1, 2015, 90% of inpatients with a diagnosis of dementia at CMH will be screened to determine if they meet the criteria for referral to palliative services

Staff were involved in every aspect of the project and reported the following:

"Not afraid to try new things"

"Not as difficult as it first appears"

"It's not failing, it's evolving"

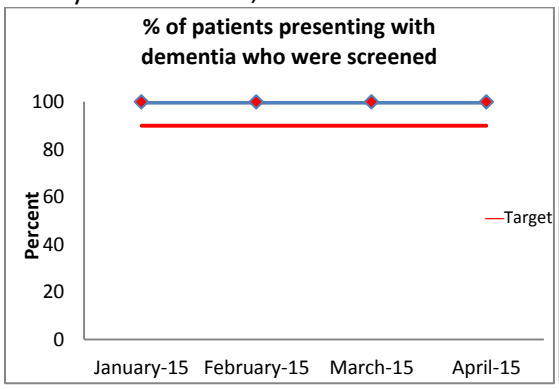
"We're all in this together" - collaborative effort

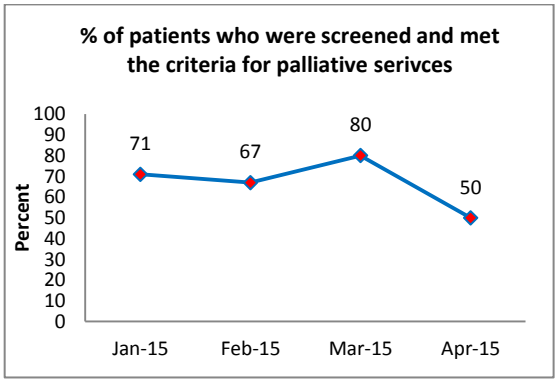
"Try and then adapt as needed"

"Simplify rather than over think"

Achievements

The project aim has been achieved and the team continues to work towards achieving the big dot aim by December 31, 2015.





Impacts

Clinical Outcomes

- Earlier identification
- Implementation of standardized screening tool
- Common language

Patient Experience

- Right care: care is provided with a palliative focus
- Right time: earlier access to care and supports
- Right place: patients now have a choice of where they would like to receive their palliative care (home, hospital, hospice)

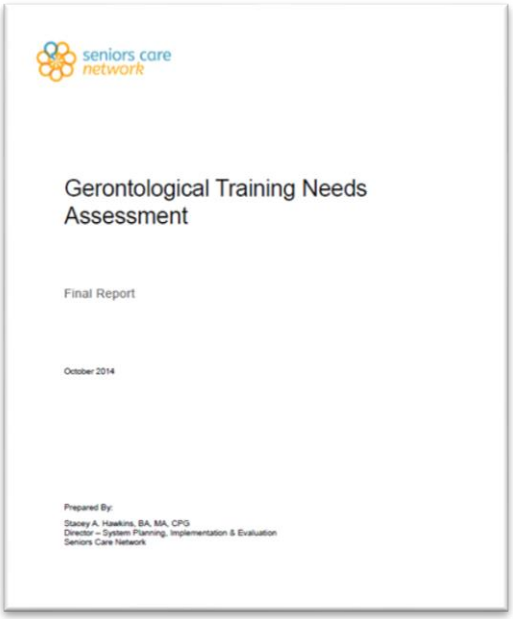
Efficiency, Productivity, Effectiveness

- Interdisciplinary team rounds now standardized with a focus on dementia and frailty
- Created improved patient flow
- Improved collaboration amongst stakeholders

Fostering Excellence

Regional Training Needs Assessment (TNA) – Building Capacity With a Skill-based Approach to Specialized Clinical Practice

A gerontological training needs assessment (TNA) was conducted by Seniors Care Network in 2013 and 2014, and included a survey of perceived gaps in education/skills/abilities among specialized geriatric service (SGS) providers in the Central East LHIN. Findings and recommendations were summarized in a 2014 report, and this has guided a number of capacity building and system planning activities since its release. Further, the TNA methodology and findings presented in the report, has generated provincial interest from a number of organizations and colleagues.



Achievements and Impacts

- Led to development work to create competency frameworks for each of the four Seniors Care Network programs
- Inclusion of findings in a provincial meta-analysis of geriatric training needs assessments by SIM-one Ontario Simulation Network
- Invited presentation on geriatric TNA methodology at the Rehabilitative Care Alliance provincial webinar (June 15, 2015)

Data Highlights

Analysis of data revealed that the majority of our SGS providers felt their core professional training/education had not prepared them to work with older adults, and 87.9% indicated that there were clear gaps in this education/training. The majority rated their current level of knowledge/expertise as just above average.

The overwhelming majority of respondents stated they currently felt least prepared to deal with (based on knowledge/training/skills) the management, treatment, and identification of dementia, mental health, and/or behavioural issues (including a-/typologies, symptomologies, and etc.). These perceived gaps in their own practice were also gaps they observed/perceived among non-SGS providers who currently work with older adults.

The findings from the TNA have identified key areas where Seniors Care Network should focus capacity building efforts with existing SGS providers, including SGS-specific knowledge transfer (KT) initiatives, and greater opportunities for regional educational/training that are relevant to specialized clinical practice.

A copy of the full report is available at

http://seniorscarenetwork.ca/wp-content/uploads/2015/03/3.1.4Seniors-Care-Network-Training-Needs-Asessment-Report-FINAL-2014.pdf

Increasing Awareness

Community Paramedicine – In-home Health and Wellness Checks for Seniors

Seniors Care Network supported a successful community paramedicine application and program development project with Haliburton County Paramedic Services Chief, Craig Jones during this fiscal year. The $85,000 development grant – funded by the Ministry of Health and Long Term Care (MoHLTC) – was awarded to the County of Haliburton in the early Fall of 2014.

Planning work led by Haliburton Paramedics and Seniors Care Network began immediately following the announcement, in conjunction with geriatrician, Dr. Amer Jilani, The Halliburton Highlands Family Health Team, Haliburton Highlands Health Services, Geriatric Assessment and Intervention Network, and the Community Care Access Centre.

Paramedics are uniquely positioned, trusted health professionals working in the community, who:

- are used to working and providing care to persons within home environments
- are able to quickly establish trusting relationships with patients
- are able to identify older adults who are at risk for adverse health outcomes
- often interact with at-risk persons, long before other care providers

Community Paramedicine is a non-emergency, community-based service that focuses on health monitoring, health promotion, system navigation, and injury prevention. Community Paramedics apply their clinical training and skills beyond the traditional role of emergency response, and operate through scheduled, home-based visits. This evidence-supported model is particularly useful in rural and remote communities. Visits may involve ongoing medical monitoring and home-safety assessments.

> "It's an opportunity to see the patient in a way they might never get to see…I think a lot of things were noticed in the house that wouldn't have been caught at a doctor's office."
>
> *Paramedic on joint telemedicine facilitated visits between home-based patient with EMS support and the office-based family physician*

The Haliburton Community Paramedicine program supports primary care physicians working in the Family Health Team, by providing scheduled, in-home health and wellness checks to frail seniors on a referral basis. These scheduled visits may include the use of Ontario Telemedicine Network (OTN) personal computer video conferencing (PCVC) technology to facilitate concurrent visits between the EMS team and the patient in the home, and other clinical professionals (e.g. family physician, GAIN team, geriatrician, and etc.) off-site.

Key accomplishments of this project include:

- extensive regional collaboration between SGS providers, health services, and community service providers in the development of the project
- cross-sectoral collaboration between County and Health services
- development of community paramedic, home-based simulation modules

- development of a Community Paramedicine Wellness Checklist for home safety and well-being assessments
- development of a community paramedicine competency framework and geriatric training curriculum
- training of all four platoons of Haliburton County Paramedics in Community Referrals from EMS (CREMS), and the Community Paramedicine training curriculum
- purchase and installation of wireless hotspot and OTN-PCVC technology to facilitate in-home collaborative assessments

The process, competency framework, and curriculum will be finalized in 2015 as a part of a community paramedicine development toolkit. This toolkit will be made publicly available on the Seniors Care Network website in order to assist other paramedic services interested in developing similar community paramedicine initiatives for community-dwelling seniors.

The Community Paramedicine program is scheduled to begin seeing clients on May 21, 2015.

> "I feel better prepared to assess certain elder issues (e.g. cognitive issues, falls assessments, and etc.)."
>
> *Paramedic following completion of community paramedicine curriculum.*

Other Highlights

- Seniors Care Network led the Geriatric Assessment and Intervention Network (GAIN) Design initiative in collaboration with existing and new GAIN teams and partners. Design work included:
  - Developing assessment and referral mechanisms
  - Creation of an intensive case management model (in collaboration with CECCAC)
  - Defining practical gerontological service excellence for the CE-LHIN population
  - Testing of tools and clinical processes to identify urgency and opportunities for rapid response
  - Forging linkages with primary care
  - Development of a GAIN clinical model
- Defining core metrics for SGS Programs – development of Data Dictionaries for SGS Metrics
- Participation in relevant forums (e.g. Rehabilitative Care Alliance, RGPs of Ontario) to gather information and influence system planning
- Developing linkages with community sector service providers to optimize service options for frail seniors
- Studying the use of technology in the care of frail seniors in the Central East LHIN

Program Reports

The programs within the embrace of Seniors Care Network are focused on older adults whose complex health concerns threaten their independence and function. We are proud of the progress we are making in the following programs. They reflect the use of enhanced geriatric expertise, interprofessional teams, and organizational collaboration. Together, we are sharing this expertise and the ways to deliver care that is responsive to our client, patient and family needs. Ultimately, it is all about providing the best health experience for seniors.

Below is a report on the progress this year in our current Specialized Geriatric Services and Programs:

Behavioural Supports Ontario (BSO): *Helping Seniors with Responsive Behaviours While Improving Quality of Life*

Program Overview

BSO provides trained health professionals and programming to help older people with challenging behaviours resulting from complex and challenging mental health, addictions, dementia or other neurodegenerative issues. Utilizing an Early Adopter strategy, thirteen Early Adopter Long-Term Care Homes (LTCH) are engaged to:

- Enhance care
- Participate in quality improvement activities
- Transfer knowledge to staff
- Share lessons learned with 55 Phase 2 homes.

The model is supported by the Integrated Care Team, consisting of existing external resources - Psychogeriatric Resource Consultants (PRC), Nurse Practitioners Supporting Teams Avoiding Transfers (NPSTAT) and Geriatric Mental Health Outreach Teams (GMHOT). The Integrated Care Team provides support and care coordination across the continuum.

Achievements and Impacts

As the BSO program continued to mature, 2014/2015 initiatives were guided by attention to continuous quality improvement, stakeholder engagement, capacity building and strengthening program measurement. Key accomplishments for 2014/2015 include:

Continuous Quality Improvement

- Through stakeholder engagement Kaizen workshops, consolidation of lessons learned resulted in a streamlined, user-friendly Behavioural Assessment Tool (1059 LTCH residents supported)
- Behavioural Assessment Tool spread to Community sector and shared with Senior Friendly Hospital Working Group
- Hosted Student Practicum to study and identify quality improvement opportunities for BSO patient transitions from Alternate Level of Care to LTCH

Program Measurement and Evaluation

- Provided in-depth metric analysis to Early Adopter and Phase 2 LTCHs to enhance quality of metrics collected
- 67 of 68 homes submitted monthly metrics, with commitment for remaining LTCH to submit in 2015/2016
- Developed program scorecard and summary reports
- Coordinated Provincial BSO Data Sharing Forum
- Conducted Phase 2 Satisfaction Survey (Masters of Public Health (MPH) Student Practicum) (66% LTCH participation)

Capacity Building and Stakeholder Engagement

- Designed and delivered "BSO Energize Your Team" course to support in-house BSO team development (84% of LTCHs attended)
- Facilitated ten Community of Practice learning and collaboration events (402 participants)
- Coordinated Music and Memory training pilot in Durham Cluster (8 Facilities participated)
- Provided BSO Education backfill funding to increase clinical skill development (72 registered staff participated in P.I.E.C.E.S. training)
- Organized BSO core curriculum training (697 participants trained, bringing the total trained since program inception to over 3000)

Community BSO

Community roll-out commenced with seven RPN positions located in GAIN teams. Most were hired in Fall 2014 and these providers achieved:

- 1024 visits in first 7 months of operation, served 404 clients in total
- Significant focus on caregiver support and education
- Important role in fostering linkages and acceptance of other services
- Full integrated into GAIN teams
- Ongoing clinical development with support of Psychogeriatric Resource Consultants

Data Highlights

To better understand the BSO population and program impact, data is collected manually for 12 key metrics.

Prevalence of residents with responsive behaviours is increasing, however residents with new or worsened behaviours has seen a slight decrease. This is likely due to increased staff capacity to understand and manage behaviours. Forty per cent of residents with a new or worsened behaviour have a Behavioural Assessment Tool in progress to identify behaviour triggers in order to implement appropriate intervention strategies.

There are very few transfers from LTC to the Emergency Department for the primary reason of responsive behaviours. There is a gap between referrals for admissions and actual admissions to tertiary care that is expected due to bed flow. Data will be further analyzed to better understand if all referrals for admission are accepted and to identify improvement opportunities, as measuring referrals for admission is a new metric that will need to be evaluated as more points of data are available. Incidents remained steady, however, there has been an increase in Quarter 4, which may correlate to the prevalence increase. Further evaluation is required in 2015/2016. Police interventions with long term care home residents demonstrating responsive behaviours remains very low throughout Central East.

The BSO Experience – Everyone Has a Role

Despite the busy atmosphere a dietitian holds the hand of a nonverbal resident as she completes her work. The resident displays calmness and appears to enjoy the companionship sitting with the staff member.

Two residents are paired up together at a dining room table; regardless of a language barrier they provide each other with companionship through touch and facial expression.

A PSW notices the agitation increasing as a resident looks for something to do. She encourages the resident to help make the beds, which provides him with a sense of purpose and accesses his procedural memory.

Several women pace the halls looking to "go home" and "what to do". A basket of towels is given to these women who sit together and fold the laundry while conversing. These women now feel useful and a "togetherness" as they fold the laundry.

A housekeeper notices a bored elderly man and provides him with a cloth to dry the tables as she washes them. This simple act of kindness provided the man with a purposeful activity that decreased his agitation and boredom.

Dining room volunteer role provides purpose and belonging to an exit seeking resident with a history of being a community activist.

Restless/agitated resident that calls out frequently resulting from fear from vision and hearing loss is settled by music therapy from an MP3 player containing music from his past.

When given meaningful tasks such as gardening, cutting the grass, trimming the trees and “renovation” type activities a resident who exit seeks and becomes verbally and physically aggressive, feels that he is needed, which fills his time and decreases responsive behaviours.

BSO Exemplar:
Streamway Villa

Mr. M is an RCAF veteran who worked as a mechanical engineer. This husband and father of three children moved to Streamway Villa Long-Term Care Home (LTCH) after living with his wife in a retirement home. Upon admission, Mr. M. was documented to wander halls and rooms, resist care and become physically aggressive. Staff used various assessment approaches to better understand Mr. M, patterns in his behaviours, his interests and needs. The team identified meaningful Montessori-based interventions for Mr. M. such as folding laundry, playing solitaire, music therapy, building cabins out of blocks, cleaning tables and sweeping. Ensuring an afternoon rest period and a proactive toileting plan helped Mr. M. to decrease responsive behaviours. The team continues to work diligently with Mr. M to eliminate as needed (PRN) antipsychotic use. Mr. M is now visibly happier and more engaged in activities and there are fewer incidents. Mr. M’s daughter recently expressed how much she loves Streamway Villa and all that has been done to support her Father. She enjoys watching Mr. M smile and clap along to the music when participating in music therapy.

As Mr. M. is now moving to Golden Plough to be with his wife, the Streamway Villa BSO team will ensure a smooth transition by sharing successful intervention strategies.

Geriatric Assessment and Intervention Network (GAIN): *Providing Comprehensive Geriatric Care for At-Risk Seniors*

Program Overview

GAIN is a regional network of health professional teams that provide comprehensive geriatric assessments (CGA), conduct diagnostic testing, create care plans and implement interventions with seniors and families that strive to optimize function and independence and keep seniors living at home.

GAIN teams provide specialized geriatric care to support frail seniors living at home or in retirement residences, who have multiple complex medical and social problems including:

- Cognitive impairment
- Decreased function
- Falls or risk of falls
- Impaired mobility
- Incontinence and/or
- Multiple medications.

Frail older adults experiencing changes in support needs, safety concerns, psychosocial and mental health concerns or frequent health service usage may also benefit from the services offered by their local GAIN team. Depending on the needs of a particular individual, an interprofessional care team provides the required support to increase the capacity for frail older adults to remain in their home in the community.

GAIN teams draw upon the expertise of nurse practitioners, physiotherapists, occupational therapists, social workers, pharmacists, personal support workers, dedicated Community Care Access Centre Coordinators, collaborating Geriatricians and other specialists.

Referrals to GAIN are accepted from primary care providers, hospitals, community organizations, seniors and caregivers.

Achievements and Impacts

While serving a growing community of patients, the GAIN Regional Program is pursuing region-wide program standardization of clinical and administrative processes, policies and procedures. These activities are expected to strengthen the program's foundation and support continued growth, including the integration of new teams at Haliburton Highlands Health Services and Campbellford serving Trent Hills. Other activities in 2014-15 included:

- A Knowledge Exchange Day was held on October 30, 2014. This brought together 144 GAIN team members from across the Region to share innovations and contribute to ongoing program development.
- An orientation program was initiated for new GAIN team members ensuring supports will be in place for new clinicians.

- A scoping exercise was conducted to review barriers to extended hours of operation for GAIN teams, to include evenings, weekends and on-call.
- The Comprehensive Geriatric Assessment (CGA) task group was developed to address clinical standardization and best practice. This expert group of clinicians has developed a draft competency framework for interprofessional comprehensive geriatric assessment, along with draft guidelines for clinical supervision and clinical support. These tools will support capacity development across GAIN.

Data Highlights

- Increase from 4 to 12 teams teams in fiscal 2014/15
- 716 new clients seen in GAIN community teams in 2014/15, 3602 new clients in total seen across GAIN
- Over 14,500 client visits in 2014/15
- Completion of program metrics development and creation of a program data dictionary
- A new model of Intensive Case Management (ICM) was introduced, supporting more vulnerable seniors in the community. This model of case management combines expert geriatric evaluation with ongoing team-based treatment plan support to older adults who are at risk for loss of independence or institutionalization. ICM model development continues in collaboration with Central East Community Care Access Centre. More than 235 patients received ICM in 2014/15. The ICM model connects to local HealthLinks activity through the use of Coordinated Care Plans.

Geriatric Emergency Management: *Supporting Frail Seniors in Hospital Emergency Rooms*

Program Overview

"As a GEM nurse, I am feeling a sense of accomplishment, pride and satisfaction in knowing that I am contributing to ensure that our most vulnerable seniors are receiving the best possible, proper and safe disposition from our ED." – *Edgardo Valles (The Scarborough Hospital)*

The Geriatric Emergency Management (GEM) program provides specialized geriatric emergency management services to frail older adults in the emergency department (ED). The goal of the GEM program is to deliver targeted geriatric assessment to high-risk seniors in the ED, and to help seniors' access appropriate services and/or resources that will enhance functional status, independence and quality of life. The CE LHIN GEM program is comprised of nine GEM nurses who strive to build geriatric and senior-friendly capacity within the hospital through knowledge transfer and education opportunities with staff. They are uniquely positioned within nine CE LHIN EDs to identify and assess at-risk seniors and connect them with services to better meet their health needs. A GEM nurses is either a Registered Nurse or Nurse Practitioner with geriatric training.

Achievements and Impacts

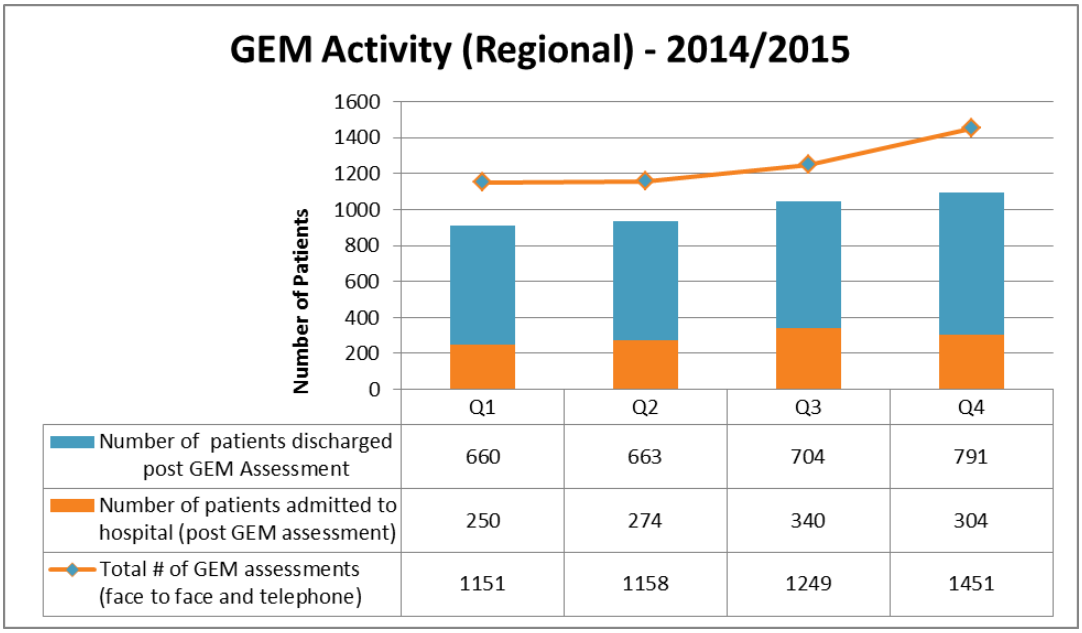
During the 2014/2015 fiscal year, GEM nurses in the Central East LHIN identified many professional accomplishments, including:

- leading the development of ED-specific and hospital-wide policies and procedures to guide practice related to elder abuse and falls prevention
- facilitating and developing patient care initiatives including: Move On, Hospital Elder Life Programs (HELP), Assess and Restore Mobile (ARM) teams, Music Therapy, Montessori Methods, Purposeful Rounding
- participating in simulations, including disaster preparedness procedures including Mock Code Orange (CBRNE)
- developing and leading hospital and community education and outreach events including Safe and Secure Aging, Seniors Fairs, World of Gerontology sessions, annual Geriatrics Days, and creation of GEM pages on hospital websites
- participating various scholarly activities and knowledge sharing work, including: oral and poster presentations at the Ontario Gerontology Conference, Regional Geriatrics Program (RGP) Education Day, and the Canadian Gerontological Nursing Association (CGNA)

"The GEM nurse program has been a tremendous asset to our team, our patients and our community. [Our] patients benefit from a comprehensive assessment [that] the ER nurses and doctors are not able to provide. Our elderly, frail patients need all the advocates they can get, and the GEM nurse clearly advocates for great outcomes and service." – *Emergency Room Nurse*

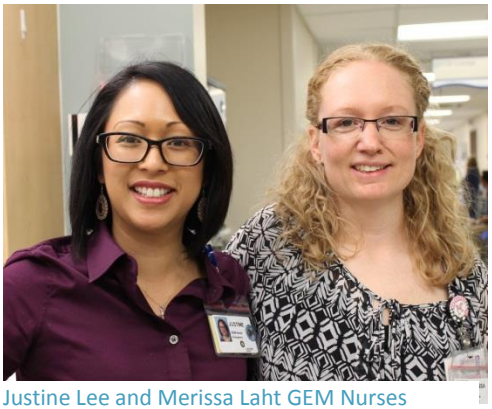
- providing geriatric nursing mentorship and hosting clinical placements for Masters and Bachelor of Nursing Students
- initiating daily and 'in-the-moment' geriatric teaching with ED staff and health partners (e.g. geriatric assessment, communication strategies, and etc.)
- participating in continuing professional development (CPD), including formal education associated with Clinical Nursing Specialist (CNS; Gerontology), and Nurse Practitioner (NP) certifications

Data Highlights



	Q1	Q2	Q3	Q4
Number of patients discharged post GEM Assessment	660	663	704	791
Number of patients admitted to hospital (post GEM assessment)	250	274	340	304
Total # of GEM assessments (face to face and telephone)	1151	1158	1249	1451

The GEM Experience – The Importance of Collaboration and Relationships



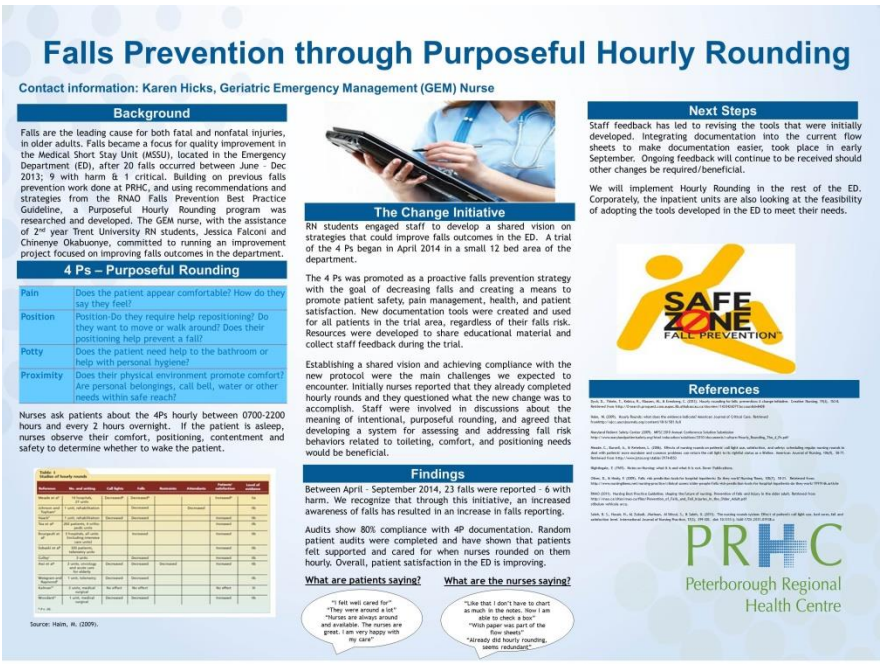
Justine Lee and Merissa Laht GEM Nurses
At Lakeridge Health, Bowmanville and Oshawa Sites

GEM nurses build and establish significant relationships in the community, and many times it is through this collaboration that answers can be found and meaningful outcomes can be achieved for our patients. Here is an example shared by a GEM nurse in Central East LHIN:

"Each GEM case requires critical thinking and expertise. For many individuals, the Emergency Department is a place where one 'thing' needs fixing. In GEM – there is no such thing. For example, I was asked to assess an elderly woman when my colleagues were stumped. Her

situation was described to me as ‘a very confusing case that required a GEM nurse.’ From my assessment, I was able to identify that the clinical picture of this woman was not making sense; there seemed to be information missing that might explain her physical state For GEM nurses, we rely on our assessment findings and how they ‘sit’ with us from a gerontological perspective. GEMs know this as the “gut feeling” or the “GEM intuition”. This kicks into overdrive after years of geriatric experience; your perspective of a situation – as a whole – shifts and you know exactly which questions to ask, and where to go for answers. Like a forensic detective, we look for clues and take time to dig into a case.

In this particular case, this senior informed me that she was being emotionally, physically and financially abused by her son. I decided to inquire with the Police in order to brainstorm on how this woman could be supported while trying to find out more about her family/social situation. Upon phoning the police, I learned this case was under review for potential elder abuse and a missing persons case. The police were minutes away from sending out a search party as her son had reported her missing the previous day. The police were just about to make a public announcement about a missing woman – the same woman I had just assessed in the ED . Learning about this woman’s complex situation provided new, clinically-relevant information to help complete my assessment, and target a meaningful approach to her care. My discussions with the police also helped them to not only to identify a missing person, but it also aided in their investigation on alleged elder abuse”.



Conference poster on Purposeful Rounding presented by Karen Hicks (PRHC) at the annual Ontario Gerontology Conference (OGA) in Toronto in 2015.

Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT):
Helping to Support Seniors in Long-term Care With Home-based Support

Program Overview

Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT) is the Central East LHIN's nurse-led outreach team to long-term care, hosted by the Central East CCAC. Tasked with reducing potentially preventable hospitalizations for long-term care patients, NPSTAT provides support to 61 of the 68 long-term care homes in the Central East LHIN and their almost 9000 patients.

The 9.5 FTE Nurse Practitioners (NPs) work to their full scope of practice, providing episodic, on-call intervention to long-term care patients experiencing acute changes of condition that might otherwise result in an emergency transfer to hospital. In addition, NPs work collaboratively with long-term care homes and hospital partners to both reduce length of stay while in hospital and to build the capacity of long-term care home staff to manage an increasingly complex, medically frail population. This includes direct intervention for the management of responsive behaviours and the provision of palliative care supports to long-term care residents.

Achievements and Impacts

The following examples illustrate the impact NPSTAT's NPs are having system-wide:

- An NP repairs a patient's arm laceration following a fall in the dining room, preventing a trip to hospital.
- A family stands around the bed of their dying grandmother while an NPSTAT NP explains what comes next in managing her death at home.
- An NP demonstrates the correct practice for changing a gastric tube at the patient's bedside and evaluating placement and integrity of the tube site.
- An NP participates in hospital rounds to evaluate a long-term care patient's readiness to return to his long-term care home.
- An NP reviews the Quality Improvement Plan for antipsychotic reduction in the home with the Director of Care and the Medical Director of Care.

NPSTAT: Keeping Care at Home

Sarah was called to see Mary, a long-term care resident with increasing rectal pain and frank and dark blood in her stool. Mary reported feeling lethargic with moderate abdominal pain but stated she did not want to be transferred to hospital for assessment. She wanted to stay in her home. Sarah reviewed Mary's medication and discussed the risk and benefits of care options with her. A treatment plan based on her expressed goals and wishes was developed which included holding Mary's anticoagulation medication, starting a proton pump inhibitor and consulting with her primary physician to adjust pain medication for adequate pain control. Bloodwork to monitor her blood cell count and referral to a GI specialist completed the plan. Over the next few days Mary was monitored for her vital signs and level of bleeding and within a week, significant improvement was noted. While her specialist appointment was pending, Mary could remain home supported by NPSTAT, something that Mary is happy about.

- A patient's abscess is drained at the bedside under local anaesthetic by the NPSTAT NP.
- A resident returns from hospital with mild shortness of breath and the home's registered nurse contacts the NPSTAT NP to review her concerns in developing a care plan for his management.
- NPSTAT is called for a resident's ongoing responsive behaviours and works with the home and the PRC to rule out delirium as a cause and to implement Dementia Observation System (DOS) monitoring and behavioural vital signs.
- NPSTAT NPs assess evacuated residents from the Fairview Lodge fire and direct staff on monitoring techniques to evaluate acute deterioration.

Data Highlights

NPSTAT NPs directly assessed 4380 patients in their long-term care homes and provided telephone consultation and support to 1720 more. Only 1.9% of these patients were transferred to hospital potentially saving more than 15,000 hours of time across LHIN hospitals and $4.9 million in patient care costs. Consistent with expectation most intervention occurred early in the disease process with 70.9% of patients ranked at low acuity using the Canadian Triage and Acuity Scale 4 and 5 scoring levels. Across all acuity, the top diagnostic needs for NPSTAT NPs focused on management for decubitus ulcers, dementia, urinary tract infections, pneumonia and upper respiratory symptoms. In all direct clinical encounters, 42% of patient encounters were for potentially preventable diagnoses. Palliative care and Behaviour Supports Ontario (BSO) engagement was 19.7% and 8.0%, respectively.

NPSTAT further facilitated early repatriation for 79 hospitalized patients with varying lengths of stay. This was complemented by clinical capacity building efforts with long-term care staff, with NPs offering more than 300 educational sessions, with the majority of sessions focused on bedside teaching to three or more staff at a time. While educational topics varied, top themes included assessment for acute change of condition, palliative care, falls assessment, gastric tube management and wound care assessment and stabilization.

Throughout fiscal 2014/2015 NPSTAT was instrumental in events regionally and at the LHIN level. NPSTAT provided direct clinical care to the residents of the Fairview Lodge fire both on site during the evacuation and subsequently on designation in their new homes, reducing hospitalization and helping to stabilize the patient population. During the influenza surge that saw reclassification of the long-term care population in hospital, NPSTAT provided direct patient assessment in hospital for assessment of risk and timeliness of repatriation. And on a case by case basis in the community, NPSTAT has provided local support for individual long-term care homes in the development of their Quality Improvement Plans particularly around the reduction of ED transfers and appropriate antipsychotic usage.

NPSTAT service was summarized in an end-of-year satisfaction survey with responses from half of our engaged homes demonstrating 94.1% program satisfaction across respondents.

Senior Friendly Care

Program Overview

The vision of the provincial Senior Friendly Hospital Strategy is to improve the experience and outcomes of seniors when they are hospitalized by preventing their physical and mental decline.

To operationalize this vision in the Central East Local Health Integration Network (Central East LHIN), Seniors Care Network established the Central East Senior Friendly Hospital Working Group to advance the goal of Senior Friendly Care. The membership includes representatives from each of the nine hospitals, Seniors Care Network, the Regional Geriatric Program of Toronto and the Central East LHIN. The purpose of the Senior Friendly Hospital Working Group is to provide the strategic direction and leadership for Senior Friendly Hospital care within the Central East LHIN. The Working Group fosters a culture where senior friendly care is woven into the fabric of the hospital.

What is A Senior Friendly Hospital?

Care seniors receive while in a hospital, and the hospital experience itself, can impact their health and well-being. A Senior Friendly Hospital is one in which the environment, organizational culture, and ways of care-giving 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 involve patients – along with families and caregivers – to be full participants in their care. The aim is to enable seniors to maintain optimal health while they are hospitalized so that they can return home or transition to the next level of care that best meets their needs.

Shared Goals

- Having hospital leadership and support in place to make senior friendly care an organizational priority
- Providing care based on best practices for seniors care so their independence is preserved
- Delivering care and service in a way that is free of ageism and respects the unique needs of patients and their caregivers
- Addressing unique ethical situations in seniors care and research as they arise
- Ensuring the hospital's physical environment minimizes the vulnerabilities of frail patients

Achievements and Impacts

Seniors Care Network continues to support the regional Senior Friendly Hospital (SFH) Work group through the implementation of its work plan. Highlights include:

"The overall vision of the Senior Friendly Hospital Strategy is to enable seniors to maintain optimal health and function while they are hospitalized so that they can transition successfully home or to the next appropriate level of care. The Senior Friendly Hospital Working Group embodies the collective desire for a regional approach to senior friendly hospital care and the need for an 'enduring' movement that makes a senior friendly approach simply the way we provide care in our Region"

Kelly Kay, Executive Director, Seniors Care Network

- SFH Working Group continues to meet on a monthly basis
- 2014/15 SFH Scorecard was finalized and forwarded to members
- 2014/15 CE SFH Initiatives Summary was updated
- 2015/16 work plan and scorecard were developed in alignment with the Seniors Care Network strategic directions and the SFH Provincial domains
- SFH Gerontological Foundation Task Group completed the final draft of the *Senior Friendly Philosophy, Values, Principles and Practices* document
- Senior Friendly Walkabout Framework was developed and distributed for use
- Ageism Task Group initiated a literature review regarding communication/awareness strategies for staff surrounding ageism - development of a manuscript as an output of this systemic review is under consideration.
- SFH Health System Improvement Pre-Proposal (HSIP) was submitted to the Central East LHIN requesting minor (non-capital) equipment and training to support senior friendly initiatives aligned with the SFH workplan – funding was approved for the provision of evidence-supported responsive behaviour training/education for staff and the requisite tools/equipment to facilitate the transition of knowledge to practice
- SFH Capacity Grant Steering Committee and Advisory Committee continue to develop the curriculum for the SFH Advanced Leadership Training Program
- Provincial *Senior Friendly Hospital Indicators Evaluation of Feasibility and Clinical Value Report and Recommendations of the Senior Friendly Hospital Indicators Evaluation Working Group* (September 2014) was released and distributed to all working group members
- In February, 2015, the RGP of Toronto released a series of reports on the status of SFH Care by hospital, LHIN and province - Central East LHIN demonstrated significant improvement across all domains, and while there is still work to do, the SFH Working Group, led by Rhonda Schwartz, Director, System Planning, Implementation & Quality, Seniors Care Network, was recognized as a model of coordination of SFH activity
- Seniors Care Network staff presented "From Siloed Initiatives to a Philosophical Movement: Weaving a Fabric of Gerontological-Focused Senior Friendly Hospital Care in the Central East LHIN" at the 43rd Annual Scientific and Educational Meeting of the Canadian Association on Gerontology on October 18, 2014
- Seniors Care Network was invited to present on the CE SFH Working Group in the upcoming fiscal year at the:
  - Provincial SFH *Action* Program (April 2015)
  - South West Senior Friendly Hospital Networking Day (May 2015)

"We have a high percentage of seniors [in our practices] and we need all the help we can get. Thank you – Keep up the good work"

From Central East LHIN Primary Care Providers

A Look Forward: 2015/16 Service Plan Highlights

Building on successes of 2014/2015, efforts in 2015/2016 will focus on continued spread and sustainability of all SGS programs. This will be accomplished through continuous quality improvement initiatives, building capacity, monitoring progress and enhancing stakeholder engagement to standardize processes to support patients wherever they are served by SGS programs. The following table summarizes planned activities for 2015/16

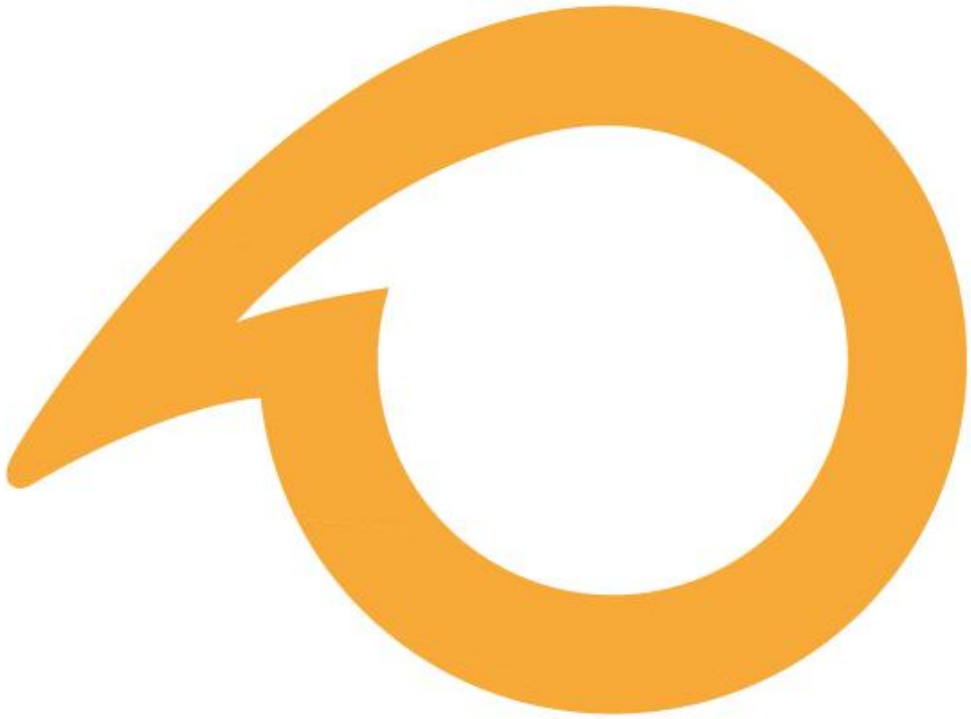
Strategic Direction	Goals	Objectives	Actions/Activities
Improving Care	• Patients and families have access to individualized specialized geriatric services (SGS) that are designed to enhance transitions	• There is timely access to SGS services across all programs • SGS are integrated across SGS and other services to coordinate care for frail seniors • There are sufficient resources (human and financial) to support the provision of SG services in the Central East LHIN	1. Develop and implement a model for common SGS intake. 2. Develop and implement SGS Partnership Agreements with all agencies hosting SGS. 3. Support the development of a SGS funding and accountability framework to facilitate decision-making regarding resource allocation to SGS programs. 4. Establish program human resource models.
Fostering Excellence	• Health care providers have knowledge and tools to deliver high quality care to frail seniors effectively and continually monitor and improve provider performance.	• Evidence supported gerontological practices are developed, standardized and adopted region-wide • Health professional have the required competencies for SGS practice • SGS in the Central East LHIN is supported by robust Quality & Risk Frameworks • SGS system indicators are identified and monitored	5. Evaluate health professional learning needs. 6. Develop competency profiles for all SGS programs. 7. Develop and implement a standardized approach to interprofessional comprehensive geriatric assessment. 8. Develop and implement SGS Quality & Risk Frameworks. 9. Support the development of core SGS program and system-level metrics.

Strategic Direction	Goals	Objectives	Actions/Activities
Increasing Awareness of Age Related Needs	• There is increased awareness of the needs of frail seniors and the creation of regional programs that build on their experiences and input through meaningful partnerships between seniors and providers.	• Senor friendly approaches are woven into the fabric of organizations providing care to older adults in the Central East LHIN • Models for seniors' health service design and service delivery are researched and developed • Linkages with Primary Care are strengthened	10. Lead the implementation of Senior Friendly Hospital strategies and support the expansion of this work to other settings. 11. Initiate comprehensive planning and develop SGS policy to inform emerging initiatives (e.g. Age-Friendly Communities, Assess & Restore/Rehabilitation Initiatives, Health Links). 12. Review, evaluate and synthesize emerging gerontological literature, models & policy. 13. Communicate the work of Seniors Care Network broadly. 14. Develop a Primary Care involvement plan

In the 2015/2016 fiscal year, Seniors Care Network will continue to support the Central East LHIN goals as the new Integrated Health Services Plan is developed.

"I just wish this kind of care was more openly available. In other words it should be part of every senior's care. Everything is covered and I didn't once hear the words "you are getting old and these things happen. Thank you."

Patient of an SGS service



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