Addressing the Needs of Older Adults Living with Frailty

Activity Report 2016-2017

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

In This Report

Governing Directors

Leadership Message from the Board Chair and Executive Director

It is the smiles like this one that tell the real story.

The work of specialized geriatric services (SGS) impacts the lives of older people living with frailty throughout the Central East LHIN. Whether it is in Long Term Care Homes, Emergency Departments or even in private homes and retirement residences, thousands of patients and their families come into contact with SGS programs and their dedicated staff every year.

Throughout the year, we have been working hard to help health professionals and others improve the way older people are treated when they seek health care services. Through numerous training activities, the development of the Central East Action Plan for Dementia, in collaboration with partners, and our efforts to advance the uptake of the Provincial Senior Friendly Hospital Framework, Seniors Care Network strives to improve care and foster excellence at every turn.

This year, we also engaged in several research efforts, including a provincial study of an evidence informed mechanism to collect data related to seniors experience with SGS. We have also provided expert input into two quality standards related to dementia care, part of our ongoing work to advocate for the age-related needs of older adults. Along with our many partnerships, we are continuing to deliver on the promise of truly transformative health care for older people experiencing frailty. More importantly, we are proud to bring smiles to the faces of older people living with frailty in our communities.

Dr. Jenny Ingram, Board Chair and Kelly Kay, Executive Director

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 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
Senior Persons Living Connected
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

Overview of Seniors Care Network
Specialized Geriatric Services in the Central East LHIN

Seniors Care Network was established in 2012 by the Central East Local Health Integration Network (LHIN) to improve the organization, coordination and governance of specialized geriatric services (SGS) for seniors living with frailty across the LHIN. Seniors Care Network coordinates regional SGS services funded by the Central East LHIN. These include five core programs, briefly described below.

> "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*

Behavioural Supports Ontario (BSO): 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.

Geriatric Assessment and Intervention Network (GAIN): Twelve interprofessional geriatric teams located throughout the Central East LHIN, collaborating with geriatricians and other specialists, providing comprehensive geriatric assessments, diagnosis, treatments and interventions with seniors and families to optimize function and independence and keep older people living at home.

Geriatric Emergency Management (GEM) Nurses: Nurses providing specialized, geriatric emergency management services to frail, older adults attending a hospital emergency department (ED), by delivering targeted, emergency comprehensive geriatric assessments, and helping seniors access appropriate services and/or resources that will enhance functional status, independence, and quality of life.

Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT): Nurse practitioners responding to residents of all Long Term Care (LTC) facilities, providing acute and episodic medical care to frail, complex residents so that they can remain in their home for management of their acute care needs, medical complexity, and palliative care goals.

Seniors Friendly (SF) Care: Overseen by a working group comprised of representatives from all area hospitals and the RGP of Toronto who collaborate to promote and provide strategic direction and leadership for Senior Friendly (SF) Care within 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 SGS delivered through collaborative partnerships. Patients partner with SGS providers to develop their care goals. SGS services reduce the burden of disability for seniors living with frailty

Fostering Excellence: Our programs and people have knowledge and tools to deliver high quality evidence informed care. We develop and disseminate leading practices in SGS policy and services.

Increasing Awareness: We proactively partner with others to advocate on behalf of frail seniors and engage the community to prepare and respond to age related needs.

seniors care network

Connecting and Improving the System of Care for Older People Living With Frailty in Central East LHIN

One LHIN Seniors Aim → Three Seniors Care Network Strategic Directions → Five Regional Programs

Supporting the Central East LHIN 2016/17 Annual Business Plan

- Coordination of specialized geriatric services through Seniors Care Network programs and services
- Initiation of and support for Physician Lead for Seniors role
- Initiation of & ongoing clinical support for Primary Care Collaborative Memory Services interprofessional team, hosted by Alzheimer Society Durham Region
- Through clinical programs and planning efforts, linkage with other key Seniors' Aim initiatives such as Assess and Restore, adult day programming, assisted living, exercise and falls prevention classes etc.

96,000 Older People Who May Live with Frailty

Key Service Plan Achievements for 2016/17

- Co-led the development of the Central East Action Plan for Dementia
- Leading provincial standardization of comprehensive geriatric assessment in interprofessional geriatrics teams
- Led the Regional Geriatric Programs of Ontario response to the MOHLTC Levels of Care Framework
- Developed a Citizen Engagement Framework and have launched the development of a proposal for training to support caregivers of older people living with frailty
- Delivered the second annual Geriatric Education Initiative, providing grants to more than 62 participants undertaking gerontological training
- Developed a Knowledge Translation strategy for specialized geriatric services in the Central East LHIN
- Developed program logic models with all regional programs, to guide evaluation
- Engaged in one (1) national, two (2) provincial and several local research efforts, including a provincial study of an evidence informed mechanism to collect seniors experience data
- Expert input into two (2) HQO Quality Standards related to Dementia Care
- Numerous local and provincial initiatives to share experiences and advance **Senior Friendly Care (SFC)** with 7 of 8 of the hospitals in the Central East LHIN now identifying SFC strategic or organizational goals
- Developing a model of case management for older people living with frailty
- Developing an approach to enhance goal based care planning among clinicians working with older adults

At-A-Glance – Clinical Program Accomplishments –2016/17

BSO

- **3753** LTC residents supported per quarter (average)
- **2187** BSO patients served in the community, and **830** caregivers supported
- **1689** staff trained in BSO approaches

GAIN

- **13,931** patients served, including 4844 unique individuals
- **28,896** visits
- **2597** new patients receiving case management support
- **800+** people served with moderate to severe dementia
- **1300+** people served with advanced frailty

GEM

- **4367** patients seen
- Majority of patients seen over age 85
- **4052** referrals to alternate sources of care, identified through targeted assessment
- Strategic Planning for GEM

NPSTAT

- **5611** patients seen
- ED transfer rate remains below **1.7%**
- **196** capacity building activities provided
- **35** facilitated repatriations to LTC
- LTC homes below provincial average for ED transfers

Improving Care • Fostering Excellence • Advocacy Regarding Age Related Needs

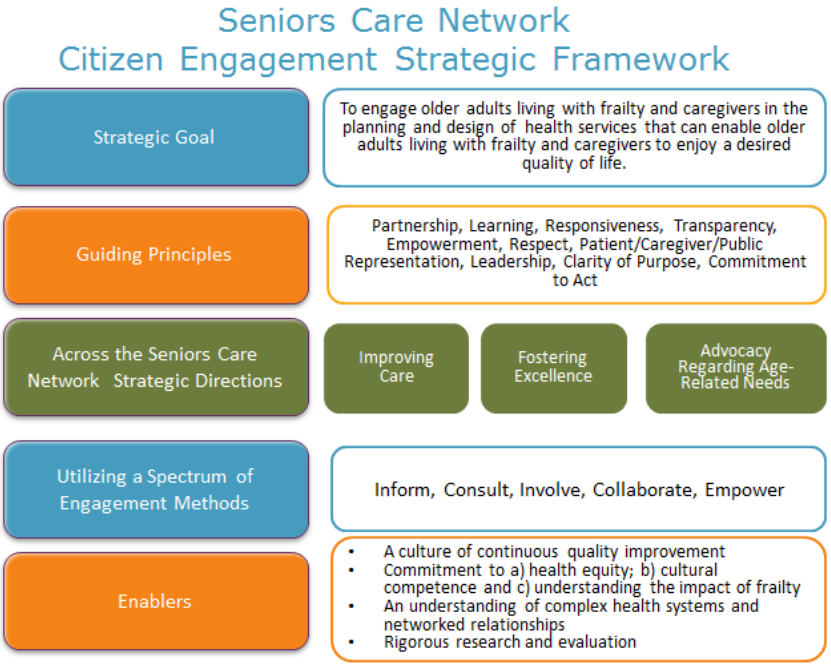
Achieving Our Strategic Directions

Advocacy Regarding Age-Related Needs

Seniors Care Network works with its partners to create regional models and programs that provide geriatric care reflective of the unique experiences of older adults living with frailty and their care givers. Program development occurs through meaningful partnerships between seniors and providers, and proactive communication strategies that raise the profile of age-related concerns among programs, the network and the broader community to enable appropriate responses.

In carrying out its advocacy role, Seniors Care Network adopts a systems approach to the design and integration of services for frail older adults across across the region's communities. This includes proactive collaboration with others to identify and address the broader scope of seniors and age-friendly care.

During the 2016/2017 fiscal year, Seniors Care Network actively participated in Age-Friendly Community projects in Haliburton, Peterborough, and Durham. This work included engaging with municipalities and local partners to conduct environmental scans and community consultations, from which actions were identified to shape local age-friendly plans. Also in 2016/2017, Seniors Care Network staff researched and prepared a strategic framework for citizen engagement, which was unanimously endorsed by the Board. This framework builds on the work of Health Quality Ontario and will guide engagement activities at the program and network level.



SGS Program Staff continue working to enhance partnerships across the system. In keeping with the Central East Action Plan for Dementia recommendations, a plan that was co-developed by Seniors Care Network, the Alzheimer Society Durham Region and Ontario Shores Centre for Mental Health Sciences, Seniors Care Network supported the development of the new Primary Care Collaborative Memory Services (PCCMS). These new primary care-based interprofessional teams support early diagnosis, treatment and linkages to services for people experiencing memory concerns.

Throughout the year, work continued on the development of various communication materials to promote the sharing of senior friendly approaches. New resources include BSO Healthline and a Central East-specific BSO mini-website and Intervention Tool Kit, available at www.centraleast.behaviouralsupportsontario.ca

As a result of the work of the Central East Senior Friendly Care (SFC) Committee, seven of eight of the hospitals in the Central East LHIN requested and received presentations or information about Senior Friendly Care at their senior team and board level from Seniors Care Network staff. Several organizations have also included senior friendly care in their strategic plans, and/or organizational goals and objectives. Seniors Care Network staff also received requests from two other Local Health Integration Networks to share information about the work of the Central East Senior Friendly Care Committee, as well as senior friendly care materials that have been developed.

Network and program staff continue to share knowledge about frailty-specific approaches and age-related needs by participating in Pan-LHIN forums related to BSO, dementia care, and Senior Friendly Care.

Improving Care

Along with its programs and partners, Seniors Care Network collaborates to provide patients and families with timely access to individualized specialized geriatric services (SGS) that are delivered in an integrated manner using a systems approach. Clinical and policy efforts are aimed at reducing the burden of disability, detecting and treating reversible conditions, recommending optimal care approaches, and supporting patients to manage frailty.

In 2016/2017, several creative regional initiatives were undertaken to advance these goals. One initiative was the creation of a $15,000 one-time Studentship through a new partnership with the Trent Centre for Aging and Society. The purpose of this initiative was to better understand how SGS providers in the BSO, GAIN, GEM, NPSTAT and PCCMS programs conduct goal-based care planning. This project will help to guide the development of new patient-centred approaches to care planning with older adults living with frailty.

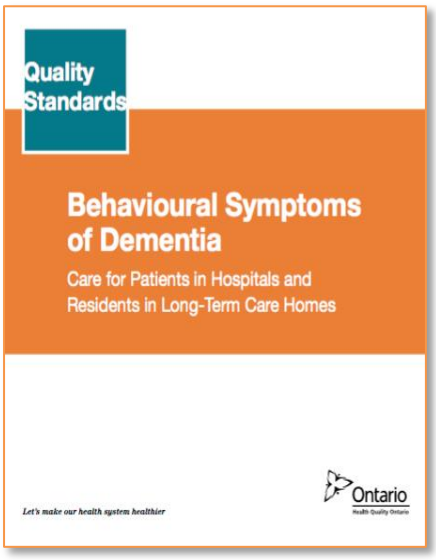
Throughout the year, Seniors Care Network continued to collaborate with the North East Specialized Geriatric Centre, the Regional Geriatric Program of Toronto, and the Regional Geriatric Programs of Ontario, to lead the development of a Competency Framework for Interprofessional Comprehensive Geriatric Assessment (CGA). The purpose of this project is to reach consensus among experts in geriatrics on the required competencies of all members of geriatric teams to complete the CGA. A CGA is the standard of practice for assessment in geriatrics.

Seniors Care Network also funded the second annual Geriatric Education Initiative, a $40,000 grant program that provides grants of up to $1500.00 to local health professionals seeking education consistent with the Competency Framework for Interprofessional Geriatric Assessment. The 2016/2017 Geriatric Education Initiative enabled Seniors Care Network to support 62 health professionals from a variety of disciplines to undertake continuing professional development aimed at improving geriatric/gerontological knowledge and skills, expanding capacity region-wide to deliver evidence informed, senior friendly care.

In July 2016, the Ministry of Health and Long Term Care committed to fund the Central East LHIN an additional $811,828 to support the hiring of new Behavioural Support (BSO) specialized staffing resources, and $78,334 to support the stabilization of previous investments. BSO Regional staff worked with LHIN staff to allocate the funding to support an additional 9.5 Full Time Equivalent (FTE) staff positions across ten Long Term Care (LTC) Homes, and 2.0 FTEs in GAIN Community Teams. This new funding has increased BSO staff coverage to 62.2 FTEs across 28 LTC homes and all 12 GAIN Teams.

Throughout 2016/2017, the BSO Regional Office delivered 66 training sessions through which 1689 individuals received training in behavioural care approaches.

The Senior Friendly Care Committee, in collaboration with the BSO Regional Office staff completed an environmental scan of all Central East hospitals, evaluating organizational readiness against the new Health Quality Ontario (HQO) Quality Standards for Behavioural Symptoms of Dementia. This information will be used as a basis upon which to launch quality improvement initiatives to spread BSO-informed approaches to care in acute and tertiary care centres.



Following extensive research and consultation, Seniors Care Network, in collaboration with GAIN, partners from geriatric mental health services and primary care collaborative memory services, developed a model for Coordinated Access to SGS programs. This model describes the approach determined to be most appropriate to coordinate access to geriatric medicine, geriatric mental health and primary care collaborative memory services across the Central East LHIN. Coordinated access in SGS is distinguished from existing intake models because the population served is undiagnosed and lives with multiple, complex co-morbid conditions. This necessitates an approach to access that includes a robust clinical triage component, in addition to clerical intake functions.

Throughout 2016/2017, NPSTAT continued to support Central East LHIN LTC homes. This included helping to influence a significantly lower transfer rate to hospital during the annual flu season, compared to February 2016. The top needs for which the services of NPSTAT's nine nurse practitioners were sought included management for pressure ulcers, dementia, and minor procedures. NPSTAT was also frequently contacted to resolve respiratory and urinary tract infections and to address problems experienced by residents with Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD). NPSTAT also provided support for palliative care and residents with behavioural concerns, accounting for 7.9% and 5.0% of direct clinical care engagement respectively.

This year, NPSTAT began joint discharge planning for LTC residents at three Central East Hospitals. This process is expected to result in successful early repatriation for LTC residents returning home from hospital. Only 1.7% of 5611 patients seen in 2016/2017 by NPSTAT were transferred to hospital. By Q4 2016/2017 and for the first time in Central East LHIN program history LTC homes were, on average, below the provincial threshold for potentially avoidable emergency department visits.

Fostering Excellence

Seniors Care Network supports health care providers with the knowledge and tools to deliver high quality, evidence-informed care. Included in this work is the monitoring and evaluation of quality across all SGS programs and advancing an applied research agenda that contributes to geriatric knowledge translation in collaboration with other system partners.

In 2016/2017, BSO delivered five regional Community of Practice events, all of which were well-received. The October 2016 Community of Practice event attracted 334 participants from across multiple partners, including the Lovesick Lake Native Women's Association, all SGS programs, representatives from all health sectors and 62 of 68 LTC homes (91%).

In March 2017, the BSO team organized a Leadership Summit for LTC corporate and leadership teams to present current initiatives and elicit input for future planning. The BSO program also hosted two student practicums and collaborated with the Central East Community Care Access Centre to create an e-training module for Care Coordinators on the Behavioural Assessment Tool.

GAIN hosted two medical residents and students from a variety of health disciplines throughout the year. This provided early exposure for learners to interprofessional geriatric practice. The program also developed and implemented a new orientation checklist to improve onboarding of new GAIN team members. Thirteen GAIN team members, along with several GEM nurses and nurse practitioners (NPs) from the NPSTAT program, participated in Primary Care Collaborative Memory Services training to enhance understanding between services and create opportunities for collaboration and shared care. GAIN continues to work with the University of Ontario Institute of Technology (UOIT) Faculty of Health Sciences (Nursing program), to develop interprofessional learning objectives to meet the needs of 3rd year BScN students commencing community placement. Seniors Care Network also hosted two 3rd Year UOIT Community Placement students, who researched and developed two self-care guides.

SGS program staff presented at a variety of conferences over the year. Highlights include NPSTAT's poster at the Ontario Long Term Care Clinician's conference (October 2016) on diagnostic intervention and poster presentations by Seniors Care Network staff at the Canadian Geriatrics Society and Canadian Frailty Network national conferences. The Seniors Care Network team delivered a key note address at the South West Assess and Restore Event (February 2017) in Stratford, on the development of interprofessional competencies and practice in specialized geriatrics teams, and a guest lecture to 3rd year nursing students at UOIT (March 2017) on the topic of dementia, sensory impairments, and geriatrics.

Seniors Care Network staff and GAIN Regional staff also successfully completed the Gentle Persuasive Approaches (GPA) Coach training, which will support the delivery of GPA Training to SGS program staff. The Seniors Care Network team was also invited by local LTC Home family councils and municipal staff of several municipalities to discuss SGS and Senior Friendly Care.

What Success Means to Patients and Their Families

The Wynfield LTC Home had a major breakthrough with the use of baby doll therapy. A female resident struggled with personal care and would become verbally and physically aggressive towards front line staff during bathing. During one of the home's weekly BSO huddles, short meetings conducted on each unit with front line staff for behavioural care planning for residents with responsive behaviours, front line staff noted this resident responded well to the baby doll program during leisure and recreation programming. The team decided to try using a baby doll during bathing with this resident, with great success. The resident now happily gets into the tub when staff bring the baby doll in and ask her to assist with the baby's care. She will undress the baby doll with great care and the two get into the tub.

Provided with a wash cloth, the resident lovingly washes the baby while staff provide personal care to her. With the resident's attention on the bathing of the baby, staff are able complete personal care for the resident.

After the bath, the resident allows staff to dry the baby doll while she gets dressed. She then she focuses her attention on diapering and dressing the baby doll, all while expressing a real sense of purpose and joy.

Big Smiles!

Mrs. T. is 80 years old. Her son was increasingly concerned about her multiple complex health problems, risk of falls, and functional and cognitive decline. Mrs. T. wanted to improve her mobility, and her son wanted her to improve her mobility and increase her independence and safety.

According to her son, Mrs. T. had 10-12 ED visits in the last 6 months. Her husband had severe dementia and was refusing home care. The son was exhausted caring for both parents. When Mr. T. transitioned to Long Term Care, Mrs. T. came to visit the Carefirst GAIN team.

Mrs. T. was grappling with a number of health concerns including Parkinson's Disease (and PD related dementia), depression, and recently had surgery for a right hip fracture following a fall. She also had pressure ulcers on her hips. She was attending an adult day program one day a week, received Meals on Wheels, and used a personal alarm, and accessible transit. According to her son, she was falling frequently and stayed home most days of the week, spending a lot of her time "falling asleep while eating". Her son was contemplating crisis placement in Long Term Care.

GAIN completed a comprehensive geriatric assessment and added Mrs. T. to their case management list. They initiated wound care, in collaboration with home care services, and monitored her pressure sores, which soon healed. GAIN provided education about dementia and medication management to the son and patient's sister, and the team organized increased supervision for medications. Mrs. T.'s medications were assessed and her unnecessary medications were stopped. The team's social worker provided support for the son and assisted the family to develop an advance care plan.

Mrs. T. has had no further hospitalizations. She has improved her mobility and was recently able to travel to the West Indies to see family over the holidays. She has enjoyed increased socialization by attending more days at the adult day program and her falls have decreased. Her son reports a decrease in his own feelings of exhaustion and he has been attending the Carefirst Caregiver Support Group. Most importantly, Mrs. T. has been able to stay at home, where she wants to be.

A Look Forward: 2017/18 Service Plan Highlights

Building on successes of 2016/2017, efforts in 2017/2018 will focus on the following activities:

1. Implement Coordinated Access
2. Engage the Central East LHIN to co-lead the development of an Accountability Framework of SGS programs/providers
3. Develop and implement regional Performance Management systems
4. Participate in the development of provincial SGS Performance Management systems
5. Continue to partner in the development of primary care based initiatives
6. Implement a Knowledge Translation Strategy
7. Finalize and implement the competency framework for interprofessional comprehensive geriatric assessment
8. Advance the Dementia Action Plan
9. Develop and implement an SGS research agenda
10. Develop a SGS evaluation framework
11. Support gerontology/geriatric related continuing professional development across the network
12. Implement the Citizen Engagement framework
13. Advance the adoption of Senior Friendly Care across the Central East LHIN
14. Develop a communication framework for SGS

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