Connecting and Improving the System for the Care of Frail Older Adults
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A Message from Catherine Danbrook, Board Chair, and Kelly Kay, Executive Director, Seniors Care Network

New insights, emerging expertise and connected possibilities have shaped the foundational work that has occurred this fiscal year. Across an area that covers 17,000 square kilometres of mostly rural geography, a seamless network of care is emerging, building on the expertise of dedicated health professionals and a collective focus on providing the best healthcare experience for frail older adults in Central East LHIN.

Together we are creating opportunities to enhance the healthcare experience for frail older adults and their caregivers as well as working to provide care tailored and focused on their needs. This progressive network is person-centred, approachable, empathetic, and collaborative. To better reflect the evolution of specialized geriatrics care, this year we renamed the entity formerly known as Regional Specialized Geriatric Services to Seniors Care Network. This change is but one of many key milestones and achievements that defined the past 12 months for us.

Seniors Care Network reflects agreement amongst those we support that our role is about affecting change and helping health service providers and those in need of frail older adult services to better navigate our system of care. Within the pages of our first Annual Report, we bring examples to life that reflect collaborative leadership, shared expertise, and a recognized need for consistency across our system of care. We are focused on providing seniors with the best health experience through coordinated systems of care, including specialized older adult care and mental health services, tailored to their needs. We hope you will enjoy the success stories that are unfolding.

Sincerely,

Catherine Danbrook        Kelly Kay
Community First – Seniors Aim

Improving health care for seniors is a top priority of the Central East LHIN and Seniors Care Network.

The population of seniors is growing, and this group often has complex health care needs. As a result, there will be increased pressure on caregivers, communities and our health care system.

A focus on seniors will foster improvements in the health care experience of patients and their caregivers, as well as in the overall quality and sustainability of the health care system in the Central East LHIN.

Achieving the Seniors strategic aim requires providing alternatives for home and specialized care that helps seniors stay at home and in their community rather than in a long-term care home. Not only will this aim benefit seniors who wish to stay at home or in the community, it will also benefit those who do require placement in a long-term care facility. By reducing overall demand for long-term care we will also reduce the wait time to access long-term care for those who need it the most.

Seniors Care Network is grateful for the funds it receives from Central East LHIN to create momentum in the system and bring the Seniors Aim to life. Working together with many health care providers and community partners, we are creating a very large circle of care for frail older adults and their caregivers. It’s a circle of care guided by the shared principles of dignity and respect for older people and ensuring the best quality of life for all.

For more information on Central East LHIN’s Seniors Aim go to: www.centraleastlhin.on.ca/goalsandachievements/Seniors.aspx
**Seniors Care Network Strategic Plan Creates a Vision for Best Health Experience for Frail Older Adults**

Seniors Care Network’s three-year strategic plan is focused on providing frail seniors with the best health experience through coordinated systems of care, including specialized older adult care and mental health services tailored to their needs.

Its Mission is to create and maintain a high quality integrated person-centred network that ensures the best quality of life for frail older adults and their families.

Three strategic priorities define Seniors Care Network’s strategic plan and are guiding the delivery of supporting action plans. The plans, programs and initiatives that support the strategic priorities are about working with a system of care to improve the organization, coordination and governance of specialized geriatric services for a growing number of frail older adults in Scarborough, Durham Region, Northumberland County, Peterborough City and County, City of Kawartha Lakes and Haliburton County. The strategic plan is summarized by the following:

### OUR STRATEGIC PRIORITIES, DIRECTIONS AND GOALS

<table>
<thead>
<tr>
<th>STRATEGIC PRIORITY</th>
<th>IMPROVING CARE</th>
<th>FOSTERING EXCELLENCE</th>
<th>INCREASING AWARENESS</th>
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<tbody>
<tr>
<td>STRATEGIC DIRECTION</td>
<td>Patients and families have access to specialized geriatric services with smooth transitions, tailored to individual needs, and found on partnerships with providers</td>
<td>Health care providers will have knowledge and tools to deliver high quality care and effectively and continually monitor and improve their performance</td>
<td>There is increased awareness of the needs of frail seniors and the creation of regional programs to address those needs.</td>
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<tr>
<td>STRATEGIC GOALS</td>
<td>1. Improved access to care</td>
<td>1. Increased adoption of leading practices</td>
<td>1. Increased presence of professionals with a specialization in geriatrics</td>
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<td>2. Increased comprehensiveness of care</td>
<td>2. Improved system monitoring</td>
<td>2. Increased provider participation in screening and assessments</td>
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<td>3. Improved caregiver services</td>
<td>3. Improved system performance</td>
<td>3. Increased enrollment in home-based care and communication programs for our “target” population</td>
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<td>4. Improved care experience</td>
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**Regional Specialized Geriatric Services (SGS)**

SGS are those services focused on frail seniors, older people whose complex health concerns threaten their independence and function. SGS provides greater specialization and uses interprofessional teams, inter-organizational collaboration and standardized approaches in its delivery, increasing customization of care to respond to patient and family needs and improve outcomes.

**Specialized Geriatric Care includes:**
- specialized geriatric assessment and consultation
- short-term treatment rehabilitation and short-term specialty case management
- geriatric medicine and
- geriatric psychiatry

**Risk Factors Impacting Frail Seniors:**
- Mobility level
- Cognition and memory
- Level of Independence
- Physical Health
- Financial and/or housing status
- Social supports
- Increasing number of medications
- Physical and social isolation
- Age and the use of health services
Seniors Care Network Takes Shape

In January, we set out to develop a brand that would most effectively communicate our core promise of value delivered for those we work with and the older adults and caregivers we support. Following a Request for Proposal process, Shikatani Lacroix (SL) was chosen to guide the organization through this “way finding” journey and turn our value proposition into visual language to help us better connect with and define our offering to our stakeholders.

To jump start the process, SL facilitated a Visioning session with Program leaders and others who touch the work of Regional Specialized Geriatric Services (RSGS). A future model for RSGS emerged from this dialogue (pictured below) that suggested a network of care, working in conjunction with RSGS, would feed system information on a constant basis, enabling RSGS to develop stakeholder-informed plans to improve the system where needed.

Following consultation with Board members and Program Leaders on naming options, three possible names were considered: Older Adults Network, Senior Care Network, and Elder Care Network. Six logos were then tested through an on-line survey with 250 Ontario residents across three categories of stakeholders:
- Older Adults: Ontario residents who are an older adult (60+) currently, or in the next two years, receiving long-term health support from a family member or service provider
• Caregivers: Ontario residents who are currently, or in the next two years, are a caregivers of a frail older adult family member
• Health Professionals: Ontario residents who work in a profession related to the care of older adults

In order to ensure that branded elements express the correct message, the following brand attributes (based on the Brand Card) were measured for both naming and logo options:
• Approachable and inclusive
• Empathetic
• Progressive and proactive
• Collaborative
• Representing knowledge, expertise and leadership
• Overall appeal

"Senior Care Network" received the highest overall ratings and was most appealing to older adults receiving care (18% higher score than “Elder Care Network”) and health care professionals (17% higher than Elder Care Network). "Senior Care Network" was rated the most approachable & inclusive, the most empathetic & caring, the most collaborative, and best representing knowledge, expertise, and leadership. Survey feedback also suggested making “Senior” plural to “Seniors.”

Of the six logos considered, feedback also showed a preference for the logo illustrated here and ultimately adopted by the Board. Perhaps best described as a “circle of care that includes the Older Adult as part of the dialogue”, it best expressed the functional personality of being collaborative and knowledgeable, and having expertise and leadership. It was rated highly on emotional characteristics of being approachable, inclusive and empathetic, especially by Older Adults.
At its April meeting, the Board approved the adoption of a new identity – Seniors Care Network – (reflected in the Brand Card below) that:

• Instills a sense of security and confidence amongst our stakeholders, while helping build clarity on what our organization offers;
• Creates a visual identity which is memorable, easy to read at a distance, simple, cost effective and adaptable to the various communication elements it will be used in to promote and build awareness of our programs and initiatives.

“Best health experience can mean different things for different people depending on need. Consider this story shared by an interprofessional team member of a Specialized Geriatrics Program: A patient and his wife attended our clinic – he suffered a stroke six years ago and is aphasic. [He] suffers from moderate dementia and superimposed depression. His wife was very distressed re: behavioural issues and was feeling that she couldn’t care for him at home anymore – she was beside herself over this, as she didn’t want to place him in Long Term Care. After the assessment, we changed some meds, were able to put in some supports at home. Within a month, he improved drastically and has been able to remain at home with a good quality of life.” – (Interprofessional Team Member of an SGS program)
Regional Specialized Geriatric Services’ Report Supports the Need for Community-based Seniors’ Care as Number of Seniors Living in Ontario’s Central East Expected to Double in Next 20 Years

A report commissioned by Seniors Care Network shows that 15% of the Central East Local Health Integration Network’s (Central East LHIN) 1.6 million residents are seniors who consume almost half of the CE LHIN’s health care resources. This population of frail older adults is estimated to grow by 27% over the next 10 years. There are an estimated 96,573 seniors in the Central East LHIN who may be considered frail or at risk for frailty. Frail seniors are at risk for worsening health; frail seniors are less able than others to recover after a health stressor event. Nine per cent of frail seniors reside in long-term care or Complex Continuing Care; the remainder live in the community.

Different approaches are required for rural and urban areas.
The Central East LHIN covers 17,000 square kilometers of mostly rural geography. Only 11% of residents live in rural regions while 80% of residents are concentrated in Scarborough and Durham. Some communities are growing faster than others. Specialized Geriatric Services will need to use different approaches to meet the needs of seniors in rural and dense urban areas. Senior’s preferences and constrained health care budgets will increase the need for community based delivery of senior care. There is potential for Specialized Geriatric Services resources to expand in many settings outside long term care homes and hospitals, including seniors’ own homes, in retirement homes or Assisted Living in Supportive Housing. Early access to these interventions in the community is critical for delaying or avoiding frail seniors’ need for institutional care, according to the report.

Specialized geriatric services in both institutions and the community will need to increase in the future as the population ages. How this is done will affect the whole health care system. Essential components of a system of specialized geriatric care include:

• Providing services to those seniors that would benefit most
• Ensuring coordinated specialized geriatric services are available in the community with the goal to reduce specific health risks such as injuries, muscle weakening, infections and exacerbation of chronic conditions
• Ensuring service is continuously evaluated for quality, access and effectiveness.

The Report notes that case finding is an important tactic to ensure that Specialized Geriatric Service resources are best used. To demonstrate, a segment of high users was created that could be targeted for specialized services – 4,900 high acute use seniors were identified in Central East LHIN. These seniors had high rates of potentially avoidable hospitalizations and their health deteriorated from low to high levels of frailty in the years before their hospitalization and institutionalization.

“Seniors Care Network Capacity and Needs Assessment Report provides a strong platform upon which to build our action plans and health policy input for the foreseeable future to provide the best health experience for frail seniors living in the Central East,” says Kelly Kay, Executive Director, Seniors Care Network.

The Seniors Care Network Capacity and Needs Assessment Report also indicated that almost half (52%) of frail seniors in the community segment had no in-year contact with either hospitals or home care. Therefore, physician offices and other community and outreach services are currently the only potential Specialized Geriatric Services (SGS) contacts for approximately half of the frail seniors in the LHIN.
Health Care Providers and 20 Year Forecast Growth in the Senior Population in the Central East LHIN: Specialized geriatric services will need to grow faster in some clusters.
Senior Friendly Hospital Initiatives Fostering Excellence

As members of Seniors Care Network, nine hospitals in the Central East LHIN are working together to improve the health and well-being, as well as the care experience, of seniors while in the hospital.

Representatives from each of these hospitals, the Central East Seniors Care Network, the Regional Geriatric Program of Toronto and the Central East LHIN are participating on the Central East Senior Friendly Hospital Working Group. Care seniors receive while in a hospital, and the hospital experience itself, can impact their health and well-being. The Working Group is focused on improving seniors' health and well-being by taking steps to reduce the possibility of physical and mental decline while receiving care in hospital.

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), 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 of the Senior Friendly Hospital Working Group include:

- 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

“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,” says Kelly Kay, Executive Director, Seniors Care Network.
Seniors Care Network: A Model of Regional Teamwork

It is 8:00 a.m. and Sarah Gibbens, Geriatric Emergency Management (GEM) Nurse, reviews the chart of 85-year old Albert.* Albert came to the Emergency Department at Northumberland Hills Hospital in Cobourg after a fall in his home in nearby Port Hope. Gibbens learns that Albert was seen several months ago by Geriatric Assessment and Intervention Network (GAIN) team member Andrea Jack, based at Peterborough Regional Health Centre. With his permission, she calls her specialized geriatrics colleagues to discuss his care plan.

Andrea Jack, GAIN Nurse Practitioner, receives Sarah’s call and remembers Albert. She reviews the team’s assessment findings – a comprehensive assessment and detailed recommendations that include her input and that of an occupational therapist, pharmacist, physiotherapist, social worker and a specialist in geriatric medicine. Andrea learns that since Albert was last seen, his wife has passed away and he is now living alone in a two-story house. Sarah’s current geriatric assessment of Albert paints a picture of a person who has become increasingly frail and who is having difficulty managing day-to-day. Andrea and Sarah arrange a conference call with Albert’s family physician in Port Hope to review his care plan and Sarah’s recent assessment findings. The three arrange to speak with Albert and his daughter, who lives in Winnipeg. Together, they determine Albert might benefit from intensive case management, a service available through the GAIN team located in Port Hope.

Sarah and the Emergency Department team clear Albert medically – a close call as falls can signal significant underlying problems and result in considerable consequences for older people. Albert is met at the Emergency Room by a personal support worker from the Port Hope GAIN team who escorts him home and helps him settle in. A GAIN Care Coordinator arrives at Albert’s home the next morning. She consults with the team and reviews all of the assessment information from Sarah, his family doctor, and Andrea’s team and, with this in mind, begins what will be a long-standing relationship with Albert. Albert’s GAIN Care Coordinator will help organize all of the services that will support Albert at home, which may include adult day programming, assisted living services, home care and other supports and she will keep close contact with his family doctor and the rest of the GAIN team.

While Albert is a fictitious patient and this scenario is merely illustrative, his story is all too real to the more than 96,000 older adults living in the Central East LHIN who meet a definition of frailty. These individuals are the focus of Seniors Care Network and the specialized geriatric programs and related services intended to help older adults with complex health concerns that threaten their independence and function.
In addition to those programs described above (e.g. GEM, GAIN), specialized geriatrics includes Behaviour Supports Ontario (BSO), comprised of trained health professionals and programming helping older people with challenging behaviours resulting from dementia, neurological disorders, mental health and addiction related concerns. Rounding out the services available within the Central East LHIN is the Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT) program. The NPSTAT program is a team of Nurse Practitioners who assist residents of Long-term Care facilities experiencing acute health concerns in order to help avoid transfers to hospital, and to support their return home as quickly and as safely as possible.

These Specialized Geriatric programs are part of the Seniors Care Network, working together to improve care and provide the best health experience for older adults and their caregivers. Some of the initiatives underway to draw upon the expertise and collective knowledge of various professionals supporting the Specialized Geriatrics programs are:

• The creation of a Behaviour Supports Ontario Design Team providing leadership, advice, guidance and support to long-term care homes, community service providers, hospitals and key stakeholders in the development, implementation and sustainability of BSO in Long-term Care Homes in Central East LHIN. The team’s membership will ultimately include subject matter experts from organizations across the three LHIN geographic clusters to ensure a balance of perspectives.

• The creation of a BSO Metrics Working Group that meets regularly to review, analyze and revise the existing metrics collected from all the Long-term Care homes throughout the Central East LHIN.

• NPSTAT staff have contributed to a literature review of screening and assessment tools to inform geriatric assessment approaches and provided feedback via the GAIN Design Team process. This information is part of a regional orientation program that will support new health professionals joining one of the Region’s four specialized geriatrics programs and others working with frail older adults to offer the highest quality, age-appropriate care to clients like Albert.

• Creating of a Geriatric Emergency Management work plan that includes a 'refresh' of metrics, monitoring and reporting and review of software for the collection and reporting of GEM metrics.

• The creation of a GAIN Design Team accountable for the design and launch of GAIN community teams in April 2014. Today, GAIN includes ten interprofessional teams within the Central East LHIN, based in hospitals and community organizations. In 2010, GAIN teams were established in The Scarborough Hospital, Rouge Valley Health
System, Lakeridge Health, and Peterborough Regional Health Centre. There are three key components to the GAIN approach:

- **Engagement:** GAIN delivery programs are co-created and continuously improved with community input. Information sharing is encouraged to help identify older adults experiencing challenges with independence and function who might benefit from GAIN, and referrals to GAIN from multiple sources.

- **Assessment:** The intake process identifies client specific needs, gathers background data to avoid duplication of assessments and prioritizes referrals requiring urgent attention. A Comprehensive Geriatric Assessment occurs using validated tools and an interprofessional team approach, covering the domains of cognitive, mobility, mental health and addictions, function, medications, physical health, social – environmental situations and nutrition.

- **Care Planning and Delivery:** A review and summary of assessment findings is completed, followed by development of recommendations with clients and other partners. Implementation and management of recommendations and planned follow-up occurs with partners. The level of care provided may range from intensive case management to supported self-care. Periodic evaluation and adjustment of plans are made. Care planning and delivery is linked to Health Links Integrated Care Planning and Delivery processes.
GAIN Redesign: Bringing Expertise Together to Provide Comprehensive Care for At-Risk Seniors

Pictured here: The GAIN team at Carefirst Seniors and Community Services Association

In October, 2013, the Central East Board of Directors approved the introduction of Geriatric Assessment & Intervention Network (GAIN) Community Teams and the GAIN Redesign Initiative facilitated by Seniors Care Network. Within ambitious timelines – the goal was to have the new GAIN community teams launched by April 1 – the GAIN Redesign team was tasked with:

- Accelerating the realization of the comprehensive GAIN strategy, adapted to current context (e.g., Health Links) to realize a Comprehensive Primary Health Care Model for At-Risk Seniors
- Expanding GAIN Clinics from a “treatment, assessment (and follow-up)” model into a comprehensive managed care model or philosophy supporting Primary Care models within a Health Link.
• Creating GAIN Community Teams that will support patients at-home, in the community.

• Determining the GAIN-enrolled patient population through a shared clinical assessment (including CCAC) and willingness of Primary Care team (NP, Physician) to agree to a “shared care” approach

• Establishing a comprehensive case management/navigation role

The Gain Model of Care Framework is noted here:

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<tr>
<th>ENGAGEMENT</th>
<th>ASSESSMENT</th>
<th>CARE PLANNING &amp; DELIVERY</th>
<th>METRICS, MONITORING &amp; EVALUATION</th>
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<tr>
<td>Community Participation</td>
<td>Intake/ Prioritization</td>
<td>Collaborative Care Planning</td>
<td>Evaluation Framework</td>
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<td>Identification</td>
<td>Assessment Processes</td>
<td>Interventions</td>
<td>Indicators</td>
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<td>Access</td>
<td>Diagnostics/ Problem Identification</td>
<td>Care Coordination</td>
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<td>Partnerships</td>
<td>Reporting</td>
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<td>Client stories</td>
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<td>Follow-up</td>
<td>Date Use/Planning</td>
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ENABLERS: Shared governance, collective leadership and operational oversight, regional planning, evidence informed practice

This was a complex change management undertaking that involved the adoption of standardized approaches, while allowing for local adaptation and customization. More than 50 stakeholders were engaged in the design process, including older adults, family caregivers, and front-line health professionals.
The team was successful in achieving their goal. As of April 1st, six new community-based GAIN teams are now established to complement and build upon the work of existing GAIN teams based in The Scarborough Hospital, Rouge Valley Health System, Lakeridge Health Oshawa and Peterborough Regional Health Centre. The new GAIN teams are located at: Carefirst Seniors and Community Services Association and St. Paul’s L’Amoreaux Centre in Scarborough; Oshawa Community Health Centre in Durham; Community Care City of Kawartha Lakes in Lindsay; Port Hope Community Health Centre; and Peterborough Regional Health Centre.

GAIN teams provide specialized care to support frail older adults living at home or in retirement residences with multiple complex medical 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 will benefit from the services offered by their local GAIN team. Depending on the needs of a particular individual, an interprofessional care team is created to provide the required support to increase the capacity for frail older adults to remain in their home in the community. GAIN teams will draw upon the expertise of nurse practitioners, physiotherapists, occupational therapists, social workers, pharmacists, personal support workers, dedicated GAIN/Community Care Access Centre Coordinators, collaborating Geriatricians and other specialists.

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

In 2013/14 active GAIN teams (e.g. hospital-based teams) completed 3,456 comprehensive geriatric assessments (CGAs), bringing the total number of CGAs to 9,849 since the program began (see Charts that follow). This is an increase of 4% from 2012/13.

In 2013/14 GAIN teams provided 3,658 follow-up appointments to patients and teams have provided 9,327 follow-up appointments since inception (see Charts that follow). This is a decrease of 5%, largely explained by team time required to support the development of new teams.
The Emerging Profile of GAIN Clients

To better understand the needs of clients visiting GAIN, in 2013/14 GAIN teams began to collect information about frailty and dementia staging for the first time. Following the completion of the comprehensive geriatric assessment, GAIN teams utilize the Clinical Frailty Scale, developed by Dr. Ken Rockwood, and the Brief Cognitive Rating Scale (Reisberg & Ferris, 1988) to stage clients in terms of frailty and dementia severity. This information helps to understand the profile of seniors visiting GAIN teams and allows teams to refine intake processes and interventions to target and assist the most frail seniors in the Central East LHIN. See Charts that follow, illustrating the emerging profile of GAIN clients.
The preceding charts paint a picture of a community-dwelling GAIN client population that is generally moderately frail and may be suffering from moderate dementia. This reflects people who need help with all instrumental activities of daily living (IADLs), activities such as banking, paying bills, cooking and driving, and who need at least some help with basic activities of daily living (BADL), such as bathing and dressing. Further, this client profile suggests individuals who have significant memory deficits and are challenged to manage their day to day lives independently.

With the development of new community teams, who have the ability to visit clients in their homes and whose focus will be on providing intensive case management for frail, complex seniors, we anticipate the profile of GAIN clients to shift to increasingly frail individuals, with more severe dementia.

For more information on GAIN, go to: www.centraleastlhin.on.ca/goalsandachievements/Seniors/GAIN.aspx
Behavioural Supports Ontario (BSO) Helping Older People With Challenging Behaviour, While Improving Quality of Life

Sam* loved his local coffee shop. He also experiences developmental delay and dementia. A resident at a local long-term care home, Sam enjoyed going down to the coffee shop all day but would then refuse to return to his home for personal care and meals. Even after the coffee shop was closed and there weren’t any other people around, Sam did not want to return. He would demonstrate responsive behaviours such as refusing care, striking out at staff if they tried to move his wheelchair, verbal complains and calling out. He was at risk of skin breakdown because he refused care and he appeared sad much of the time. A member of the BSO team befriended Sam and earned his trust. They gave him the job of handing out aprons and greeting other residents as they came into the dining room. He wore a “volunteer” name tag with his name on it. He now had reason to return to his unit before meals so he could do his “job.” This idea came from BSO Montessori training, where the “job” was within his abilities. Today, Sam no longer spends his days alone at the coffee shop. He enjoys going to the many activities in the home and is very social. He is smiling more, and feels useful and needed. Sam is also more likely to allow staff to provide care.

BSO exists to enhance services for older people like Sam with responsive behaviours linked to cognitive impairments, people at risk of the same, and their caregivers; providing them with the right care, at the right time and in the right place (at home, in long-term care or elsewhere).

Through development and implementation of new models designed to focus on quality of care and quality of life for this population, a $4-million provincial BSO investment in the Central East LHIN has allowed local health service providers to hire new staff – nurses, personal support workers and other health care providers, and to train them in the specialized skills necessary to provide quality care to these residents in long-term care and clients in the community. The Central East LHIN provides funding to the Central East CCAC for staffing resources to support the BSO project. The project is rooted in client-centered and caregiver-directed care where:

- everyone is treated with respect and accepted “as one is”
- person and caregiver/family/social supports are the driving partners in care decisions
- respect and trust characterize relationships between staff and clients and care providers.
Key program focus areas for 2013/2014 included spreading the program to all 56 Phase 2 long term care homes, continued emphasis on building capacity, metrics analysis and refinement, and development of the BSO Community model. Completing its second year of operation in 2013-14, key achievements included:

- Hiring 50 new front-line staff including 7 new PSWs hired in 5 Phase 2 homes (18 of 69 homes now have BSO funded staff).
- Utilizing an Early Adopter model, 13 Early Adopter homes are charged with knowledge transfer and spreading the BSO program to the 56 Phase 2 homes.
- Increasing in-house behavioural supports in almost all 69 long-term care homes in Central East, with 74% of Phase 2 homes reporting BSO program implementation status as nearing 100% completion. This is an increase from 41% in 2012/2013.
- Increasing the use of the supporting BSO tools with 82% of the homes using a visual communication system and 2389 residents supported with the Behavioural Assessment Tool, reflecting an increase of over 200% year over year.
- Through the BSO framework goal to develop knowledgeable care teams, ensuring 879 front-line staff received specialized training in techniques and approaches applicable to behavioural supports and quality improvement bringing the total staff trained since project implementation (February 2012) to 2309.

Through analysis of the utility of the data collected, the Metrics Working Group tested and refined the metrics from 15 to 12 indicators. Submission of BSO metrics increased from 80% in April 2013 to 92% in March 2014. Early analyses of the quantitative metrics indicate:

- Minimal transfers to the Emergency Department for responsive behaviours (less than 1% of the behavioural population)
- Improved direct access to tertiary care
- Hospital visits avoided through increased utilization of the Integrated Care Team
- Minimal use of physical restraints, Form 1s, police interventions, and High Intensity Needs Funding related to responsive behaviours
Qualitative Feedback from surveys, success stories, spread reporting and Community of Practice events show:

• Reduced responsive behaviours
• Improved resident quality of life
• Increased family engagement and satisfaction
• Coordinated, focused education significantly increased behavioural management skills and increased staff confidence
• Increased utilization of the Integrated Care Team for care planning
• Improved team work and documentation
• Common language provides better collaboration and communication among care teams

For more information on BSO, go to:
www.centraleastlhin.on.ca/goalsandachievements/Seniors/BehaviouralSupportsOntarioProject-CentralEastLHIN.aspx
Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT)
Help To Keep Older Adults at Home and Out of Hospital

The Central East LHIN’s NPSTAT team’s ten nurse practitioners provide care to the LHIN’s long-term care residents for acute and episodic changes in condition to reduce unscheduled transfers to hospital for conditions that might be otherwise treated in the community. In addition, the team supports efforts to reduce hospitalization and length of stay for long-term care residents while enhancing the capacity and competency of long-term care staff in the management of increasingly complex conditions. In keeping with the CELHIN’s 2013-2016 Integrated Health Services Plan, the Ministry of Health’s Excellent Care for All Act, and the Central East Community Care Access Centre’s (CECCAC) 2013-2016 Strategic Plan, NPSTAT focuses on being both an outstanding care partner and system partner in supporting key LHIN program deliverables while delivering the right care in the right place at the right time.

2013-2014 Engagement

Over fiscal 2013-2014, NPSTAT services expanded to include 61 of the 68 CELHIN long-term care homes. NPSTAT directly assessed and cared for 4,231 long-term care residents while providing consultative care on an additional 846 residents, a 26.8% and 17.5% increase over the previous fiscal year. Efforts to directly bypass the emergency department and support for earlier repatriation of residents comprised an additional 39 residents cumulatively. Of all clinical care visits, only 2.5% of resident visits resulted in an unscheduled transfer to hospital, an average consistent with previous fiscal years. This value represents a potential system contribution of 15,316 emergency department hours saved and a potential hospital cost savings of $4,221,835.

In addition, capacity building efforts supporting staff, residents, and families involved more than 600 targeted interventions both at the bedside and in formalized presentations within our engaged long-term care homes covering topics from Hypodermoclysis initiation, acute change of condition assessment and management, and palliative care management in the long-term care environment.
Ministry stocktake values across the province demonstrate consistent disparity between nurse-led outreach team (NLOT) supported homes and those not engaged with NLOT. Trends reflect greater transfers to hospital among NLOT homes for urgent patients (CTAS 1-3) and less for non-urgent patients (CTAS 4-5) comparatively. As well, there are greater admissions for those transfers from NLOT homes. Similar data is reflected in the CELHIN for NPSTAT supported homes where earlier intervention in non-urgent patients results in less need for transfer from worsening acuity and where more urgent transfers support greater hospitalization.

Among the most urgently assessed residents (CTAS 1-2), NPSTAT had a 90.9% transfer to admission rate but only a 52% and 45.4% transfer to admission rate for CTAS 3 and non-urgent patients respectively likely reflective of the need for diagnostics in transfer rather than an underlying need for acute care.

**Strategic Directions:**

New program direction for NPSTAT began in January 2014, with a strategic review of NPSTAT the following month. Four central themes were identified during the review reflecting identified system needs and supporting data collection moving forward. These themes are:

- Direct Clinical Care
- Filling the Gap
- Building Capacity
- Coordinating Service

**Direct Clinical Care:**

Efforts to support LHIN initiatives with respect to the vascular and palliative aims of the current IHSP, sustaining the gains in terms of emergency department savings, and supporting BSO efforts in relation to the integrated care team continue into fiscal 2014-2015. Continuing to track patients by both International Classification of Diseases (ICD) diagnosis and by Complaint Oriented Triage symptom (COTS) will inform these efforts.

As resident acuity increases, reflected in Method for Assigning Priority Levels (MAPLe) scores for new admissions to long-term care of high to very high in 83% of residents, there is a need for timely intervention in supporting acute and episodic decline that the current system does not adequately address. As reflected in literature, potentially ambulatory care sensitive conditions can comprise approximately 25% of all emergency department transfers. As such there is a continued need to intervene earlier in the disease process to prevent unscheduled transfers to hospital. In fiscal 2013-2014, 69.5% of all direct face to face encounters were for these non-urgent visits and the lack of hospital transfer is indicative of team impact on resident care.
Moving forward there is a continued need for quick turnaround and triage of long-term care residents to prevent acute decline. NPSTAT’s one hour triage follow-up appears appropriate given regional size and to support monitoring and evaluation among front-line staff. As well, there is a need to support residents post discharge from hospital to prevent repeat hospitalization and facilitate home-based care particularly in the first seven and thirty days and to link these efforts to work already undertaken by the CELHIN with respect to specialized geriatric services.

Filling the Gap

Acute care settings have the specific goal of stabilization and discharge, a focus that is not consistent with the needs of the long-term care setting and its residents. NPSTAT will continue efforts to support working with existing hospital resources to both enhanced the emergency experience and to avoid the emergency department entirely where possible. This involves engaging hospital partners in the Geriatric Emergency Management (GEM) program which varies regionally sometimes to the complete exclusion of long-term care. As well, there is a need to continue previous efforts around hospital staff engagement to facilitate their understanding of the circle of care, long-term care system realities, and to build transfer processes that ensure relevant information related to care flows to and from hospital.

NPSTAT will continue to follow residents while in hospital and design mechanisms to ensure notification and follow-up on return to home as a support to primary care.

Building Capacity

Long-term care homes and their staff are required by both legislation and by the increasing complexity of the residents under their care to provide better and more complex care. While system design in long-term care is meant to address this requirement and ensure appropriate funding mechanisms to achieve it, the reality is far from adequate. NPSTAT continues to deliver specific educational sessions both in formal events and at the bedside but will track the scope and volume of education moving forward. Satisfaction surveys have and will be more broadly employed to evaluate impact through fiscal 2014-2015 and skills lists again be developed to support discharge planning in hospital.

NPSTAT has worked with our engaged partners to identify learning needs in the home and use collected data to evaluate engagement patterns with respect to diagnosis. Efforts to support policy development and meet corporate and accreditation requirements will also continue so that long-term care staff can provide required support to their residents.
Finally efforts to develop capacity must engage the physician community in long-term care, many of whom are not specific geriatric providers. Facilitating the integration of best evidence into care planning will enhanced resident care and outcomes in the home.

**Coordinating Services**

Communication in long-term care must be integrated among all partners both system-based and patient-centred. NPSTAT has begun reviewing branded material to support resident and family engagement and promote an understanding of program delivery and NP scope of practice. As well, in keeping with LHIN themes, NPSTAT is developing specific palliative program supports that help set expectations and enhance staff capability to provide care.

NPSTAT participates within the home at Professional Advisory Committees providing data not only on the patients NPSTAT has cared for but offering system feedback around home transfers for all patients so that gaps in care can be identified on a home by home basis. NPSTAT will continue this engagement at the corporate and municipal levels to effect broader system change.

NPSTAT will continue to support external groups, BSO, Hospice Palliative Care Network, Central East CCAC, Ontario Long Term Care Physicians, Ontario Association of Non-Profit Homes and Services for Seniors, Ontario Long Term Care Association, and Seniors Care Network in providing information and supporting system design and refinement.

### NPSTAT Direct Clinical Care: Facts and Stats

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
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<tbody>
<tr>
<td>Total Enhanced Patient Flow Activities</td>
<td>3,049</td>
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<tr>
<td>Total Direct Clinical Care (including BSO)</td>
<td>7,280</td>
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<tr>
<td>Total Indirect Clinical Care (including BSO)</td>
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<tr>
<td>Total Nurse Practitioner Encounters</td>
<td>9,024</td>
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<tr>
<td>Total Number of Diverted Transfers by Central East LHIN</td>
<td>4,968</td>
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<td>NP STAT ED Diversion Rate %</td>
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<tr>
<td>Total ED Hours Saved</td>
<td>15,316.26</td>
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<tr>
<td>Total ED $$ Saved</td>
<td>$4.2 Million</td>
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</tbody>
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For more information on NPSTAT go to: www.centraleastlhin.on.ca/Page.aspx?id=17706
Supporting Frail Older Adults in Emergency Departments:
Geriatric Emergency Management (GEM)

Geriatric Emergency Management (GEM) programs provide specialized geriatric emergency management services to frail older adults in the emergency department (ED). GEM programs are located at various hospital locations across the province, and are often led by a GEM nurse. GEM nurses are uniquely positioned within an ED to identify and assess at-risk seniors and connect them with services to better meet their health needs. There are a total of nine GEM nurses working at nine hospitals within the Central East LHIN.

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. Further, GEM nurses strive to build geriatric and senior-friendly capacity within the hospital through knowledge transfer and education opportunities with staff.

“I see now that people can live with dementia and have quality of life, I know that I can do things that help my mom feel more comfortable even when things are stressful for her.” – Family Member seen by GEM Nurse

Frail older adults represent as many as 30% of the patients seen in Emergency Departments, more than any other age group. Illness complexity, hospital admission rates, lengths of stay and risk of functional decline are also highest for seniors. Indeed, emergency department visits are often sentinel events for seniors, threatening loss of independence, health and well-being. By providing specialized frailty friendly services in Emergency Departments, decline and loss of independence can often be prevented or postponed.

Their role within the ED is valued by older adults and their families as indicated by this compliment from a family member: “...the GEM nurse spoke directly to my Dad, while allowing my husband and I to participate with ‘filling in’ the medical history. He’s a man who as fluent in 6 languages (including Latin) and is struggling with the onset of dementia. It was so validating for him to have physicians and nurses speak to him as an ‘adult’ again.”
A key milestone for Fiscal 2013/14 was the establishment of a GEM Metrics Working Group. This team is in the process of developing metrics that would be used by all GEM nurses in the Central East. Potential indicators are currently being put through a decision matrix. This matrix maps each of the potential indicators against Health Quality Ontario’s Attributes of Quality.

In Fiscal 2013/14: 3,877 GEM Assessments, Visits and Follow-up were completed.

For more information on Seniors Care Network, go to:
www.centraleastlhin.on.ca/goalsandachievements/Seniors/Seniors%20Care%20Network.aspx
Summary

Emerging Themes: Building Capacity for Best Health Experience for Frail Older Adults and their Families

System design and expansion, sustained volumes, capacity building and new partnerships were highlights of this year. Throughout 2013/14 this network of care focused on frail older adults continued to provide expert, specialized seniors services across the Central East LHIN.

The coming year will bring further opportunities for collaboration, partnership, and growth. Priorities for 2014/15 will include:

• Standardizing clinical services and simplifying process
• System design based on community development, experience-based co-design principles
• Greater collaboration, linking with Health Links and the broader Community Service Sector and linking with Palliative and End-of-Life initiatives
• Exploring expanded telemedicine/technology use
• Building capacity for gerontological practice and continuing to develop gerontological expertise across the Central East LHIN

For more information on Seniors Care Network, go to:
www.centraleastlhin.on.ca/goalsandachievements/Seniors/Seniors%20Care%20Network.aspx