Compendium of Innovation Posters

2024 Aging Care in Ontario Summit: From Alternate Level of Care (ALC) to Collectively Leveraged Action (CLA)

February 21, 2024

Compendium of Innovation Posters

The Behavioural Supports Ontario Provincial Coordinating Office and Provincial Geriatrics Leadership Ontario co-hosted a powerful event on February 21st in Toronto. The 2024 Aging Care in Ontario Summit: From Alternate Level of Care (ALC) to Collectively Leveraged Action (CLA) brought together those with lived experience, leaders, administrators, researchers, clinicians, and government partners from across Ontario to imagine a health and social care system we all want to age in.

Central to the event was the active participation of individuals highlighting their wealth of expertise and the many novel strategies already underway for mitigating hospital ALC rates through the implementation of new initiatives and cross-sector collaborations. To identify effective existing solutions, participants were invited to submit local, regional, or provincial innovations that have demonstrated efficacy in addressing ALC rates and could be scaled and spread. A total of 40 posters, illustrating a variety of innovative approaches, were submitted and subsequently categorized into three principal themes: (1) system design, (2) care delivery, and (3) capacity building.

This compendium includes each innovation poster hyperlinked from the table of contents below, allowing easy access to each poster. As you peruse the posters, we encourage thoughtful reflection upon the innovative strategies and interventions they depict. These posters serve not only to showcase successful initiatives but also present valuable opportunities for learning and collaboration, sparking renewed commitment to building a better system for generations to come.

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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Behavioural Supports Ontario's Provincial Collaboratives

Organization(s): BSO Provincial Coordinating Office & brainXchange

Description (*2-3 sentences*)**:**

Since 2016, BSO PCO & brainXchange have developed and led provincial communities of practices, (called Collaboratives) that centre around the care of older adults with, or at risk of, responsive behaviours/personal expressions associated with dementia, complex mental health, substance use and/or other neurological conditions. Each collaborative brings together healthcare professionals, leaders and individuals with lived experience to promote and spread best/emerging practices focused on specific themes. Themes include: transitions, acute care, Behavioural Support Transition Units (BSTUs), substance use, and knowledge to practice work.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☒ Comprehensive assessment & care planning
- ☒ Integrated care at the point of care
- ☒ Shared responsibility for continuity of care
- ☒ Integrated specialized geriatric expertise
- ☒ Integrated community & home-based interventions
- ☒ Older person-centred care
- ☒ Engaged older persons & family/friend caregivers
- ☒ Self-management support
- ☒ Integrated technologies
- ☒ Multi-tiered evaluation

Outcome(s):

Based on identified priorities of the Collaborative membership and their collaborative work, the Collaboratives have developed, disseminated and evaluated various clinical tools, reports, and educational resources including, but not limited to: My Transitional Care Plan©; Guiding Checklist: Supporting Transitions from Acute/Community into LTC; Behavioural Supports in Acute Care Capacity Building Package; Environmental Scan of Ontario's BSTUs; Providing Person & Family Centred Care within BSTUs: the Critical Elements; Behavioural Supports in Acute Care: Current Practices & Opportunities for Growth: Survey Results & Key Recommendations; Cannabis and Older Adults: Know the Facts. All publicly available at www.brainxchange.ca/BSO

Key Ingredients of Success:

- Collective efforts from representatives from across Ontario, who come from various roles/disciplines and inclusive of those with lived experience.
- Organizational leadership participation and championing of collaborative products and implementation of products.
- Leadership, facilitation, and support provided by provincial resources.

Lessons Learned:

- Implementation of new tools and sharing of resources is facilitated by the involvement of those most likely to benefit from the tools/resources in their creation.
- There is a desire among cross-sector healthcare providers to adopt new tools that will improve their provision of person-centred care, facilitate collaboration among sectors, and boost efficiency and efficacy across and within the system.

Add your organization's logo here:

Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario
Provincial Coordinating Office, North Bay Regional Health Centre
Bureau de coordination provincial, Centre régional de santé de North Bay

Contact Information (*name, phone number*):
Monica Bretzlaff, 705-675-9193 x8905

Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Behavioural Support Transition Units (BSTU) - Environmental Scan

Organization(s): BSO Provincial Coordinating Office & brainXchange (NBRHC)

Description (*2-3 sentences*)**:**

The objective of the BSTU environmental scan is to offer an overview of the current state of BSTUs in Ontario. The information gathered through this scan enhances the collective understanding of the BSTU landscape, identifies quality improvement activities, and informs future planning for BSTUs in Ontario.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
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- ☐ Self-management support
- ☐ Integrated technologies
- ☐ Multi-tiered evaluation

Outcome(s):

The environmental scan contributed to a deeper understanding of BSTUs, highlighted areas for improvement, informed quality improvement efforts, and provided valuable insights for future planning and policy development within the context of the greater healthcare system. The environmental scan has been especially useful in supporting planning for units that are currently operational, as well as the new BSTUs the MLTC announced in 2023-24; in addition the environmental scan will help inform the BSTU Provincial Evaluation that will commence this fiscal year (2024-26). The results of the environmental scan speak to the role that BSTUs play in reducing ALC LOS in hospital as all of them accept direct admissions from hospitals.

Key Ingredients of Success:

- Development of environmental scan questions in collaboration with cross-sector system partners & healthcare providers working in BSTUs across the province
- Support and endorsement from BSTU representatives as to the value of the environmental scan resulted in a 100% response rate from the BSTUs that were operational at the time of the survey.

Lessons Learned:

- As the MLTC continues to invest in the development of BSTUs in LTCHs across the province, there is tremendous value in uniting BSTU representatives from across the province on a regular basis.
- Despite differences in the size, location, design and admission criteria for BSTUs, there is a desire among BSTU representatives to collaborate on opportunities for quality improvement and evaluation.

Add your organization's logo here:

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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Collaborative Transition Planning Creating a Pathway for Adults Living

Organization(s): Parkwood Institute Mental Health -St Joseph's Health Care London

Description (*2-3 sentences*)**:**

PURPOSE: Provide adults with Serious Mental Illness (SMI) additional supports to successfully transition to Long Term Care (LTC)
Adult mental health (AMH) inpatient applications to LTC frequently denied organizational recognition of LTC home applications being declined, delayed, & failed discharges when transferring care from AMH inpatient services to LTC
Identification of knowledge gaps and varying communication processes between AMH clinicians, geriatric program, & LTC providers
Acknowledgement of Geriatric Psychiatry Programs commitment in collaborating with LTC, shared expertise, & development of liaison and clinical knowledge for mutual

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
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- ☐ Multi-tiered evaluation

Outcome(s):

Since 2021 38 Successful AMH patient transitions to LTC using the referral process with a clinical lead identified from the geriatric and adult programs for each
Developed behavioural transition care plan templates and care pathways
Identified patients that needed to be prioritized to the geriatric program for ongoing monitoring
Improved understanding of the needs of mental health patients requiring LTC & better understanding of patient needs within PIMH services
Joint disposition meetings with LTC, hospital, and care coordinator prior to discharge

Key Ingredients of Success:

Project has focused on three main aspects
Improving collaborative care-planning processes
Increased knowledge-sharing between healthcare teams
Continual process improvement & adaptation
Project has increased joint care planning across inpatient, outpatient, & geriatric programs with improved role clarity and liaison support to LTC homes
Next steps- outpatient partners such as ACT team, Forensics, & external partners and seeking feedback from project partners

Lessons Learned:

Adults with severe and persistent mental illness frequently requiring ongoing psychiatric monitoring post-discharge from hospital and also experience multiple health comorbidities, coexisting cognitive disorders, & functional decline. Stigma towards patients who have mental health diagnoses.
Alternate Level of Care (ALC) designation when ready for transfer from hospital associated with limited social supports , inadequate training for mental health care in LTC, low cross-system collaboration & communication resulting in unclear staff roles

Add your organization's logo here:

St Joseph's Health Care London

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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Direct Access Priority Process (DAPP) Update

Organization(s): Rehabilitative Care Alliance

Description (*2-3 sentences*)**:**

The ALC Leading Practices Guide (2021) outlines that processes should be in place to transition directly to the next level of care, including DAPP. Regional implementation of DAPP, as one component of the ALC leading practices, is therefore recommended. It supports early identification of individuals with restorative potential who require inpatient and/or community-based rehabilitative care and facilitates referrals directly from the community or ED. This streamlined process helps individuals receive timely access to rehabilitation by providing health practitioners with a direct pathway to rehab services and removing acute care as the sole point of access to rehab beds.

Integrated Care Design Elements Included (*please check all that apply*)**:**

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Outcome(s):

Since the DAPP was originally developed in 2015, several key guidelines and frameworks were developed, guiding rehab care for older adults, including RCA-PGLO Rehabilitative Care for Older Adults Living With/At Risk of Frailty: From Frailty to Resilience. With consideration for this new work, a working group consisting of subject matter experts from RCA Older Adults Living with Frailty Task Group updated the DAPP. New entry points were added to span the continuum of care. Determining restorative potential begins with assessing the older adult's baseline function, using at minimum the Clinical Frailty Scale & Barthel Index. Based upon this preliminary evaluation, referrals are made to the appropriate level of rehabilitative care.

Key Ingredients of Success:

The original DAPP was implemented through Assess & Restore. Common themes reported from organizations that implemented the DAPP were:
-Need for an interprofessional team with geriatric expertise
-Early identification & comprehensive assessment
-Care planning that included the patient & care partner
-Consistent referral processes & follow up

Lessons Learned:

The RCA is currently recruiting organizations to be early adopters of the updated DAPP. Convened a DAPP Implementation Working Group, including interested organizations and subject matter experts from across the continuum of care. Exploring barriers & facilitators to implementation. Developing an evaluation framework.
Learnings and data from this implementation will be shared in future.

Add your organization's logo here:

Rehabilitative Care Alliance

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Behavioural Supports Ontario
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Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Geriatric 5Ms: A framework for explaining what geriatrics does

Organization(s): University of Ottawa, Yale University, RGPEO

Description (*2-3 sentences*)**:**

The Geriatric 5Ms framework is:
Mind - mentation, dementia, delirium, depression
Mobility - impaired gait & balance, falls and injury prevention
Medications - optimal and rational prescribing, deprescribing
Multicomplexity - multi-morbidity, complex bio-psycho-social situations
Matters Most - each individual's own meaningful health outcome goals and care preferences

Integrated Care Design Elements Included (*please check all that apply*)**:**

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Outcome(s):

Worldwide dissemination has been enabled by the Canadian, American and British Geriatrics Societies, Societe Quebecoise de Geriatrie, International Association of Gerontology & Geriatrics. Google search yielded 33 websites that refer to the Geriatric 5Ms, representing Canada, United States, United Kingdom, Australia, New Zealand, Costa Rica and Kenya. The American Geriatrics Society recently published a Quick Guide aimed at all primary care providers.

Key Ingredients of Success:

Simple messaging, using the hand and digits to represent the framework, improves understanding of a complex specialty. The understanding is worldwide.

Lessons Learned:

Uncertain how to explain what geriatrics does?
Try using the words: Mind, Mobility, Medications, Multi-complexity and what Matters most !

Add your organization's logo here:

Regional Geriatric Program of Eastern Ontario · uOttawa · Yale University

Contact Information (*name, phone number*):
Allen Huang, 613-761-5122

Behavioural Supports Ontario
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Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Indicator Refresh

Organization(s): South-West Behavioural Supports Ontario Operations Team

Description (*2-3 sentences*)**:**

The quarterly data points (indicators) used for submission to the Behavioural Supports Ontario Provincial Co-ordinating Office (PCO) were re-written and expanded. The original indicators for the PCO report were aligned to an expanded array of indicators accompanied with a re-wording of each indicator definition for clarity. Additional descriptions of each indicator were also written and are now provided at the time of submission.

Integrated Care Design Elements Included (*please check all that apply*)**:**

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Outcome(s):

Alongside the indicator refresh, a new tool; the SWBSO website was developed to deliver a platform for data submission. The new indicators are provided on the website for electronic submission with the extra descriptions optional for those who may have questions about a specific indicator. As a result, there is a broader array of data delivered alongside the mandatory data for each Quarterly report. Additionally, data submissions from all partners in the SW Ontario region have been submitted, ahead of schedule for the PCO report since July 1, 2023.

Key Ingredients of Success:

The key points of success for this work come from a stream of innovative upgrades to electronic data submission in the region. The final product; the website, is an improved version of a previously used electronic submission where weak points where able to be identified and improved upon. The extra work invested into development and improvement of existing tools over time is the real ingredient to this kind of success.

Lessons Learned:

Solutions of improvements to existing problems/weak points are not always achieved on the first try. However, significant success is the result of many smaller projects completed over time and allowed to compound.

Add your organization's logo here:

St. Joseph's Health Care London

Contact Information (*name, phone number*):
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Behavioural Supports Ontario
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Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Integrated Geriatric Mental Health Service

Organization(s): North Simcoe Muskoka Specialized Geriatric Services (NSM SGS)

Description (*2-3 sentences*)**:**

Since our inception in 2016, the NSM SGS program, has advanced the vision of a single, integrated system of geriatric mental health services in the region. Over time, we successfully integrated BSO community and LTC resources in the region, PRCs, and geriatric psychiatry outreach services. We created a single central intake service. We established critical partnerships with Wendat Community Programs, GeriMedRisk, our tertiary mental health unit, regional BSTU and LOFT. Through this work, we expanded the scope and breadth of specialized mental health services, provided by an interdisciplinary team, to better meet the needs of older adults and their care partners.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
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- ☒ Integrated technologies
- ☐ Multi-tiered evaluation

Outcome(s):

-Holistic, person-centred care provided by an interdisciplinary team
-Improved patient access, volumes served, clinical outcomes
-One referral form; reduced the need for the patient to repeat "their story", improved satisfaction for referring sources
-Increased system access and equity to psychiatry consultation
-Enhanced communication and collaboration between interdisciplinary team members and with regional / provincial partners
-Professional growth and development and increased team satisfaction

Key Ingredients of Success:

- Clear vision (hub-and-spoke model); developed in collaboration with area partners
- Clear program purpose and objectives (our why); full team commitment to improving care of older adults and their care partners
- Dedicated leadership and regional commitment to implementation
- Strong partnerships, relationships and collaborations across sectors
- Regular communication with leaders, partners, team
- Proven outcomes, proof-of-concept

Lessons Learned:

- Early buy-in and endorsement from leaders across sectors supported successful planning, implementation
- Clarity in vision and purpose (our why) from the outset helped us stay on our path
- Organizational structures and HHR influenced readiness to change
- Communication plan for stakeholders using multiple methods
- Relationships, trust, credibility and a willingness to collaborate critical to success

Add your organization's logo here:

North Simcoe Muskoka Specialized Geriatric Services

Contact Information (*name, phone number*):
Nancy Hooper
705-715-5811

Behavioural Supports Ontario
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Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: PATH4HIP

Organization(s): A partnership of Bruyère Continuing Care and The Ottawa Hospital

Description (*2-3 sentences*)**:**

The clinical teams across The Ottawa Hospital and Bruyère worked together to facilitate timely transfer to Bruyere's Geriatric Rehabilitation Service, aligned to Quality Standard for Fragility Hip Fractures, from The Ottawa Hospital. Co-design of a collaborative pathway resulted in lower patient LOS in acute care (6 days or less), access to high intensity rehabilitation in the GRS to optimize recovery and transitions home, and additional acute care capacity to admit patients with hip fractures. Leadership for the initiative is provided by Dr. Anne Harley, Chantal Backman, and Dr. Steven Papp, together with their teams.

Integrated Care Design Elements Included (*please check all that apply*)**:**

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Outcome(s):

1. Ortho (TOH) and GRS (Bruyère) Clinical Teams have worked together to coordinate key elements of the overall patient care plan to meet all elements of the Quality Standard for Fragility Hip Fractures. 2. Teams work together to ensure that patients with fragility hip fractures can access geriatric rehabilitation not only to maximize their functional recovery but also to ultimately support a sustainable discharge back to the community. 3.Broader improvement in the weekly Interprofessional Team Rounds process and documentation for all GRS patients. 4.The auto-accept component of the pathway has already led to more consistent flow through surge periods. The next step is a "hard-wiring" of the trigger in the post-operative order set.

Key Ingredients of Success:

• Workshops for clinical teams in both organizations facilitated feedback
• Interviews conducted with all stakeholders (patients, families, clinical teams, transition and flow groups, organizational leaders) to understand barriers and enablers
• Key interventions aimed behavior changes identified (prompt/cues, feedback on behavior, social and environmental consequences)
• Collection of process and outcome measures at each step
• Monthly Steering Committee meetings for collaborative discussion and data review

Lessons Learned:

• More incentives needed to promote inter-organizational collaboration are needed: collaboration is not explicitly measured or required as part of organizational QIPs. • Front-line clinicians will respond to a call to improve patient care and be energized by coming up with creative solutions. • Functional flow through the system is a by-product of good patient care. • Pressure focused solely on increasing flow through can cause clinician disengagement and moral distress, the leading cause of burnout in HCW.

Add your organization's logo here:

Bruyère

Contact Information (*name, phone number*):
Dr. Véronique French Merkley

Behavioural Supports Ontario
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Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: SW BSO Website User Account Functionality

Organization(s): South-West Behavioural Supports Ontario Operations Team

Description (*2-3 sentences*)**:**

The South-West Behavioural Supports Ontario Operations Team recently implemented a website-based quarterly data submission tool. Data submission on the website requires employees at each site to register an account linked to their site to submit. This user account functionality currently provides rapid access to all contact emails for those submitting data, and an existing platform from which a more expansive organization of user profiles and messaging will be developed.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
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Outcome(s):

The user account functionality of the website is just one of recent innovations that have led to on-time reports provided to the Provincial Co-coordinating Office (PCO) with 100% submission from partners for 3 quarters in a row. This specific functionality provides the operations team a streamlined process to providing reminder emails for deadlines to the necessary recipients, and targeted reminder emails for those who haven't submitted as deadlines approach. This streamlined process has reduced the workload of email reminders from a process that required multiple days of work from multiple team members every quarter, to a few hours of effort from a single team member for each email delivery.

Key Ingredients of Success:

This success is a the result of consistent effort from the operations team to improve on previously existing tools. Continual evaluation of the performance of tools and their efficiency or lack thereof provides structure to the mapping of future improvements. This user account functionality was developed as one step to our development of the quarterly data submission process.

Lessons Learned:

Currently existing processes may provide a final usable deliverable and changes to these may be time intensive or costly, but sometimes the final product can provide very clear time and cost savings. In this specific case the goal was to simplify and standardize the submission process through the website, but the user account functionality required along the way provided the largest increase in time-efficiency.

Add your organization's logo here:

St Joseph's Health Care London

Contact Information (*name, phone number*):
Biju Mathai, Co-ordinator Regional Initiatives, 519 685 4292 x 42095

Behavioural Supports Ontario
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Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Waterloo Wellington Delirium Collaborative

Organization(s): Waterloo Wellington Older Adult Strategy, KW4 OHT Frail ElderlyWG

Description (*2-3 sentences*)**:**

This collaborative provides opportunities to work as a system of care to address delirium early on and recognize it as a medical emergency that is treatable. The collaborative leveraged existing evidence informed information about delirium and developed a work plan that focuses on knowledge transfer specific to the following target groups:clinicians across the continuum, older adults, family/caregivers. The delirium collaborative is an outcome of the work plan for the KW 4 Ontario Health Team in partnership with the Waterloo Wellington Older Adult Strategy.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
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Outcome(s):

Development of a Delirium Toolkit, for acute care sites,paramedics, and community SGS partners containing: education pamphlets developed for older adults, family friends; educational poster,(pre-existing). Focused on knowledge transfer for frontline clinical teams: T-shirts "Ask me about delirium" (adapted from NSM-SGS)social media information to align with World Delirium Awareness Day and Webinar:TAKE ACTION! Continued alignment and integration with larger health system quality improvement initiatives focused on delirium prevention, recognition and management.

Key Ingredients of Success:

Engagement with key stakeholders including; Geriatric Emergency Management (GEM) Network, Hospital Elder Life Program, Regional Geriatric Program Toronto-Senior Friendly Care(sfCare) Framework, Regional Geriatric Program Central,PGLO,Niagara SGS, Guelph Wellington Patient &Family Advisory WW OHT Directors; WW Older Adult Strategy Steering Committee,North Simcoe Muskoka SGS, WWOAS Older Adult Network, WW Acute Care CNE/VP; Emergency Council; Community Paramedics;Canadian Coalition for Seniors Mental Health.

Lessons Learned:

Ongoing delirium education is required across the continuum. Older adults/families are very interested in being informed about delirium. A standardized approach is required to foster cohesion/consistency amongst dynamic teams. A system approach to knowledge transfer proves successful and develops rewarding partnerships. The delirium collaborative provides opportunities to work as a system of care to address delirium early on and recognize it as a medical emergency that is treatable.

Add your organization's logo here:

Canadian Mental Health Association Waterloo Wellington | Association canadienne pour la santé mentale Waterloo Wellington | Waterloo Wellington Older Adult Strategy Follow on Twitter @WWOlderAdults

Contact Information (*name, phone number*):

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Behavioural Supports Ontario
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Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Website based Indicator submission

Organization(s): South-West Behavioural Supports Ontario Operations Team

Description (*2-3 sentences*)**:**

The submission of data points (Indicators) for quarterly data reports to the Behavioural Supports Ontario Provincial Co-ordinating Office (PCO) was recently upgraded to a website format. An upgrade from a previous electronic submission platform, Healthchat the new website provides a smoother submission process and built-in validation to standardize the submission process for an expanded list of indicators. This website provides the Operations Team with an organized sheet of data for every indicator provided each quarter.

Integrated Care Design Elements Included (*please check all that apply*)**:**

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- ☐ Multi-tiered evaluation

Outcome(s):

The time commitment for the process of assembling the PCO report and processing the raw data every quarter has been significantly reduced. Once every site has completed their submission, the quantitative component of the PCO report can be generated in moments. Qualitative submissions are also included, and the website allows an instant export for the Operations Team to review and summarize. Primarily, the outcome of this innovation is greatly increased time efficiency in the generation of the PCO report every quarter.

Key Ingredients of Success:

This success is a the result of consistent effort from the Operations Team to improve on previously existing tools. Continual evaluation of the performance of tools and their efficiency or lack thereof provides structure to the mapping of future improvements. The website submission of data is the most recent result of this continual process of evaluation and improvement.

Lessons Learned:

Currently existing processes may provide a final usable deliverable and changes to these may be time intensive or costly, but sometimes the final product can provide very clear time and cost savings.

Add your organization's logo here:

St Joseph's Health Care London

Contact Information (*name, phone number*):
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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: A Comprehensive Approach to Behavioural Support In Actute Care

Organization(s): Alzheimer Society Peel/Trillium Health Partners/Halton Health Care

Description (*2-3 sentences*)**:**

The MH BSO Acute Care Transition (ACT) team was established to support the staff in the hospital sector who are responsible for taking care of patients with responive behaviours that are unmanaged and are deemed as a barrier to being able to provide care and directly contribute to an extended length of stay within the acute care setting.

The behaviours may be associated with Alzheimer's disease and related dementias.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☒ Comprehensive assessment & care planning
- ☒ Integrated care at the point of care
- ☒ Shared responsibility for continuity of care
- ☒ Integrated specialized geriatric expertise
- ☐ Integrated community & home-based interventions
- ☒ Older person-centred care
- ☒ Engaged older persons & family/friend caregivers
- ☐ Self-management support
- ☒ Integrated technologies
- ☐ Multi-tiered evaluation

Outcome(s):

Well-informed and skilled staff resulting in more effective and person-centred care Collaboratively developed individualized care plans taking into consideration the various healthcare disciplines to address the unique behavioural needs of patients to support a succcessful transition to the appropriate care setting.

Improved client/patient experience, increased staff confindence/competency in behaviour mananagement, reduced LOS, increased acceptance to LTCH

# of Supported Transitions from acute care: FY2019/20 - 1004 FY2020-21 - 1031 FY 2021-22 - 1200 FY 2022/23 - 1185 FY 2023/24 - 998 *ytd

Key Ingredients of Success:

Collaborative leadership across organizations - Interdisciplinary team collaboration - Patient-Centered Care Standardized protocols - Seamless sharing of patient information – Regular assessment using standardized tools – Staff Training & Education - Clear and concise documentation - Family/Informal Caregiver involvement

Lessons Learned:

The importance of: Assessment and Evaluation, Flexibility and Adaptability, Regular Reviews and Updates, Communication and Documentation, Interdisciplinary Collaboration, Patient and Family Involvement, Goal Setting, Person-Centred Interventions, Education and Training for all members of the care team which includes formal and informal members.

Add your organization's logo here:

Alzheimer Society PEEL

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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: An Initiative to Support the Social Participation of Older Adults

Organization(s): NSM SGS, VON, County of Simcoe, Bradford Greenhouses

Description (*2-3 sentences*)**:**

Recognizing the importance of social interaction/activity and the benefit in bridging health and social care services, NSM SGS partnered with Bradford Greenhouses Garden Gallery and Adult Day Programs (ADP) across the region to provide in-person gardening workshops throughout the year to ADP participants. Funding for this project was through a New Horizon for Seniors Program Grant. This initiative is being formally studied to (a) better understand the concept of health system integration; and (b) describe and understand the impact of this joint inter-organizational health, social and community partnership on the broader system supporting older adults in the region.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☐ Comprehensive assessment & care planning
- ☐ Integrated care at the point of care
- ☐ Shared responsibility for continuity of care
- ☒ Integrated specialized geriatric expertise
- ☒ Integrated community & home-based interventions
- ☒ Older person-centred care
- ☒ Engaged older persons & family/friend caregivers
- ☐ Self-management support
- ☐ Integrated technologies
- ☒ Multi-tiered evaluation

Outcome(s):

- Approximately 100 ADP participants so far (with one workshop remaining)
- On a scale rating various aspects of satisfaction from 1-5 (5 being the most satisfied), 100% of participants rated their experience a 4/5 or 5/5.
- Participants responses to qualitative interviews suggest that the workshops are a source of recreation, provide enjoyment, help people feel a sense of accomplishment, establish a feeling of community and deliver a desirable amount of support.

Key Ingredients of Success:

- Relationships built between health and social care partners over time
- An organizational commitment to having a person centered approach and to integration
- Regular communication and collaboration for continuous quality improvement
- Commitment of community organizations to learn about Senior Friendly environments through education opportunities

Lessons Learned:

- Early engagement of partners across sectors in the planning stages is vital
- Consider engaging older adults earlier in the planning process
- Importance in flexibility in evaluation strategies based on participants' needs
- Be willing to think outside the box; explore new and innovative partnerships

Add your organization's logo here:

North Simcoe Muskoka Specialized Geriatric Services

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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Behaviour Success Agents (BSA)

Organization(s): North Simcoe Muskoka Specialized Geriatric Services (NSM SGS)

Description (*2-3 sentences*)**:**

In 2022, the NSM SGS program received one-time funding to establish BSAs in each NSM acute care site to improve the care of older adults with cognitive impairment and responsive behaviour. The BSA program is a regional approach to standardized assessment and practice. While delivering care in their hospital, the BSA receives training, support and mentoring from the NSM SGS team and their partner BSAs in the region. Goals: improve quality of care, build hospital clinician capacity, improve hospital flow, reduce ALC days, and enhance system partnerships.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☒ Comprehensive assessment & care planning
- ☒ Integrated care at the point of care
- ☒ Shared responsibility for continuity of care
- ☒ Integrated specialized geriatric expertise
- ☐ Integrated community & home-based interventions
- ☒ Older person-centred care
- ☒ Engaged older persons & family/friend caregivers
- ☒ Self-management support
- ☐ Integrated technologies
- ☐ Multi-tiered evaluation

Outcome(s):

- Increased knowledge, skill and confidence among BSAs
- 548 referrals to BSAs across 6 sites (April 2023 to January 2024)
- In 32% of cases, signs of delirium were newly identifed by BSAs
- In patients with prn restraint use, 83% reduction in use
- In patients with prn medication use, 74% reduction in use
- 412 Group education sessions by BSAs with >2000 participants
- Implementation of BSO toolkit
- Relationships built within health care system to decrease siloed care, inclusive of knowledge translation related to patient centered care

Key Ingredients of Success:

- BSA model aligns with NSM SGS hub-and-spoke model (centrally planned, implemented, supported, evaluated and locally delivered in collaboration with NSM partners).
- Dedicated NSM SGS clinician to coach and mentor each BSA at their hospital site
- Creation of BSA Community of Practice to evolve role, share resources, learnings
- Regular communication with partner leaders, BSA team
- Proven success with BSA model in past pilot

Lessons Learned:

- Early buy-in and endorsement from leaders across hospital sites and region supported successful planning, implementation, evaluation
- Importance of relationships between hospital and community partners at points of admission/discharge/transfer to or from hospital/LTC/RH/Community. This has resulted in increased communication and improved patient outcomes
- Partner relationships, trust, credibility, willingness to collaborate critical to success

Add your organization's logo here:

North Simcoe Muskoka Specialized Geriatric Services

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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Behavioural Supports Hospital Navigator

Organization(s): Bluewater Health and Alzheimer Society Chatham Kent

Description (*2-3 sentences*)**:**

Supports with behavioural mapping and implementing of BSO recommendations via modelling, observation and capacity building with staff. Assists with discharge planning and often takes a lead role in transitional support linking with other supports. Facilitates warm handoff to reduce re-admission to ED and/or hospital, via BSO System Navigator for increased Care partner support and initiate referrals in community and LTC. BSO Partners with Geriatric Mental Health, CMHA, ABI and other

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☐ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☒ Comprehensive assessment & care planning
- ☒ Integrated care at the point of care
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- ☒ Older person-centred care
- ☒ Engaged older persons & family/friend caregivers
- ☐ Self-management support
- ☒ Integrated technologies
- ☐ Multi-tiered evaluation

Outcome(s):

Facilitates discharge discussion before the patient can become ALC.
Provides comprehensive BSO Assessments at bedside. Capacity building in the form of huddles to share knowledge and outcomes with floor staff. Person centred care thus alleviating Responsive Behaviours by supporting identifying the unmet need. Education for staff with support to limit the use of Restraints (chemical, physical), use best practice guidelines (RNAO Best Practices). Reduction of poly pharmacy with non pharm approaches. BSO Team to support transitions to home (LTC& Community) maintaining a therapeutic relationship with patient and care partner.

Key Ingredients of Success:

BSO Toolkit to support Assessments and Education for increase capacity building.
Connecting all healthcare sectors with Person Centred Language, reducing labeling and stigma for persons living with Dementia/ Cognitive Decline.
Able to support on all areas of Hospital

Lessons Learned:

Underestimating the need for more than one resource in Hospital especially with multiple sites.
The importance of being "eyes on" and not just responding to charting
Engaging all BSO external members and Partners proactively
participate in huddles in all areas of hospital and also partner support huddles

Add your organization's logo here:

Contact Information (*name, phone number*):
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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Behavioural Supports: Integrated Care at North York General Hospital

Organization(s): North York General Hospital and LOFT Community Services

Description (*2-3 sentences*)**:**

In 2022, North York General Hospital opened their new Reactivation Care Center and partnered with LOFT to fully integrate behavioural support services into the multidisciplinary team. This coordinated approach to care, through a formal cross-sector partnership, brings together those who specialize in behavioural supports (as part of Behavioural Supports Ontario) to better meet the needs of the patients, their families and the NYGH staff by promoting best practices in person and family-centered behaviour support care inclusive of transition support to the next care destination.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☒ Comprehensive assessment & care planning
- ☒ Integrated care at the point of care
- ☒ Shared responsibility for continuity of care
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- ☐ Integrated community & home-based interventions
- ☒ Older person-centred care
- ☒ Engaged older persons & family/friend caregivers
- ☐ Self-management support
- ☐ Integrated technologies
- ☐ Multi-tiered evaluation

Outcome(s):

-99 patients supported with evidence-based, person centered behaviour support assessments and behaviour support plans
-49 patients provided transition support to long term care
-6 patients provided transition support to Retirement Home:
-1 patient provided transition support back to their own home
Reduction in workplace incidents related to capacity building and knowledgable care teams
Increased acceptance rates to long term care

Key Ingredients of Success:

Formal partnership contract that provides for dedicated behaviour support staff, employed through LOFT (1 Behaviour Support Specialist and 2 Behaviour Support Workers) as a fully integrated team member
Provincial BSO Practice Standards integrated into acute care with processes and pathways developed to support the integration
Transition support utilizing Best Practice Guidelines and inclusive of hands-on pragmatic support on day of transition and post discharge follow up

Lessons Learned:

1. Defining roles/responsibilities of the Behaviour support staff within the interdisciplinary team is imperative
2. Capacity building: understanding of BSO and Standards of Practice to the acute care team needs to take place to support full coordination of care
3. Non hospital staff documenting in hospital based EMR needs to be determined and if such is not allowed, other procedures put into place

Add your organization's logo here:

LOFT

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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: BSO Community Nursing and Carepartner Optimization

Organization(s): Home and Community Care Support Services Central West

Description (*2-3 sentences*)**:**

The BSO Community Resource Nurses support vulnerable patients at risk of hospitalization and destabilization in the community. They utilize a standardized PIECES assessment tool and "Positive Approaches to Care" with the team. Community partners are leveraged including community para-medicine, community pharmacists, palliative nurse practitioners and pain management consultants. This cross sector engagement with care coordination supports collaborative care plans and capacity building opportunities with primary care for a culturally diverse population.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☒ Comprehensive assessment & care planning
- ☒ Integrated care at the point of care
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- ☒ Engaged older persons & family/friend caregivers
- ☒ Self-management support
- ☐ Integrated technologies
- ☐ Multi-tiered evaluation

Outcome(s):

- Sector engagement with network meetings and local Alzheimer organizations
- Education and promotion of neurocognitive disease awareness
- High risk identification and crisis mitigation
- Leveraging acute resources after exhausting community supports
- Improving communication with cross sector partners
- Initiating transitional care pathways and promoting shared accountabilities
- Co-create an older person centered care plan in collaboration with care partners to optimize self-care and caregiver navigation
- Liaise with specialized geriatric services promoting sustainable and clinical outcomes

Key Ingredients of Success:

- Centralized triage for community patients and families
- Standardized assessments leveraging the RAI-HC
- Collaboration in care planning with Home Care Coordination team
- Comprehensive behavioral plans for transitions and implementation with extended BSO Network staff
- Focus on warm hand-offs promoting communication with family members and cross sector members of the patient care team

Lessons Learned:

- Develop robust alignment with Home Care Coordination
- Nurture open dialogue with community partners to co-collaborate and build comprehensive transitional care plans
- Align to specialized geriatric resources to support timely and appropriate clinical investigation and hospital admissions
- Continue to build capacity and link partners to psycho-geriatric care resources

Add your organization's logo here:

HOME AND COMMUNITY CARE SUPPORT SERVICES

Contact Information (*name, phone number*):

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Behavioural Supports Ontario
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Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Estimated Health System Costs Avoided by VBM

Organization(s): Baycrest Hospital

Description (*2-3 sentences*)**:**

Virtual Behavioural Medicine (VBM) is a virtual inpatient neurobehavioural unit without geographical borders which provides services to hospital patients, long-term care (LTC) residents and community members without requiring travel or transfer to a clinical facility. VBM is an important support to patient flow across settings, for this complex patient population for which the default is often the emergency department, resulting in long inpatient ALC stays. The health system costs avoided through improved patient flow are estimated at over $33 Million in from April 1 2022, to March 31, 2023.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☒ Comprehensive assessment & care planning
- ☒ Integrated care at the point of care
- ☒ Shared responsibility for continuity of care
- ☐ Integrated specialized geriatric expertise
- ☒ Integrated community & home-based interventions
- ☒ Older person-centred care
- ☐ Engaged older persons & family/friend caregivers
- ☐ Self-management support
- ☒ Integrated technologies
- ☒ Multi-tiered evaluation

Outcome(s):

VBM supports patient flow by optimizing outcomes for people experiencing responsive behaviours, avoiding unnecessary hospital admissions, supporting transitions, and contributing to the reduction of Alternative Level of Care (ALC) days.
In fiscal year 2022/23 VBM helped 193 patients from the community and from LTC avoid admissions to specialized neurobehavioural beds. In addition, 15 patients were supported to move out of hospital. When patients who receive VBM either no longer require transitions to Hospital, or move out of hospital-based Alternative Level of Care (ALC) to a Long Term Care Home, the health system avoids costs. We estimate the value of the beds that these 193 VBM patients would have taken up to be $33,893,000

Key Ingredients of Success:

Baycrest compared relative costs of different forms of behavioural treatment. We compare cost-per-case of VBM to expected, but avoided, costs of treatment through inpatient behavioural care on our inpatient Behavioural Neurology Unit and on our hospital ALC unit. In a separate analysis we found patients with responsive behaviours in Ontario had an average ALC length of stay of 257 days compared to 130-day ALC length of stay for patients without responsive behaviours. We assume 127 ALC days avoided for each of the 15 patients VBM supported to move out of hospital.

Lessons Learned:

Hospital costs per-bed-per-day are assumed at $1,000 for neurobehavioural unit care and $600 for ALC care. We seek to improve our methodology to estimate cost savings and cost effectiveness. We have partnered with the Institute for Clinical Evaluative Sciences to leverage province-wide administrative to better characterize the VBM client population.

Add your organization's logo here:

Baycrest

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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Frailty Identification and Transition: Accessing Restorative Care

Organization(s): St. Joseph's Care Group/Thunder Bay Reg. Health Sciences Centre

Description (*2-3 sentences*)**:**

An ALC Reduction Strategy. Frailty Identification and Transition (FIT) supports early identification of frailty in the Thunder Bay Regional Health Sciences Centre's ED with intent of transitioning older adults to restorative/rehabilitative care to prevent functional decline; support independence; and decrease hospital admissions and future ED visits Assess & Restore funding utilized placing SJCG SGS OT/PT directly in the ED to screen, assess and identify frailty syndromes and restorative potential in older adults and initiate a "pull" strategy directly to inpatient and outpatient Rehabilitative Care. Model aligns directly with OH Business Plan and ALC LP.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☐ Cross-sector partnership
- ☒ Comprehensive assessment & care planning
- ☐ Integrated care at the point of care
- ☒ Shared responsibility for continuity of care
- ☒ Integrated specialized geriatric expertise
- ☐ Integrated community & home-based interventions
- ☒ Older person-centred care
- ☐ Engaged older persons & family/friend caregivers
- ☐ Self-management support
- ☐ Integrated technologies
- ☐ Multi-tiered evaluation

Outcome(s):

Pilot Evaluation: ED SGS OT/PT increased patient flow; supported quicker discharge. SGS OT/PT in ED utilizing Best Practices increased opportunity to identify and minimize the risk of hospital-induced delirium, and support continence, nutrition and mobility. Stronger
Focused on a Direct Access Priority Process (DAPP) or "pull strategy"
Pilot Data: 169 Assessments. 74% Clients recommended for rehab; 30% discharged home or admitted to Geriatric Assessment & Rehabilitative Care (GARC); 38% admitted directly to inpatient Rehab Care; 90% GARC clients d/c home; only 3% d/c LTC - 4% reduction from previous year.

Key Ingredients of Success:

Geriatric Trained OT/PT in the Emergency Department key to supporting early identification and transition of older adults to rehabilitative care.
Strong partnership between Acute Care (TBRHSC) and Rehabilitative Care Hospital (SJ Hospital) with focus on patient care. Alignment with other related initiatives such as RCA Post-Falls Pathway, DAPP, Remote Care Management, PGLO Provincial Common Orientation have significantly enhanced the program.

Lessons Learned:

Absence of Geriatric Emergency Management Program (GEM) barrier to timely geriatric assessment.
Frailty pathways required for older adults; current no distinct pathway for frailty.
Frailty identification in ED for a fall or risk of fall is a strong indication of frailty syndromes and requirement for referral to Specialized Geriatric Services.
OT/PT in ED supports "pull strategy" for IGARC & timely referral to Outpatient SGS.

Add your organization's logo here:

St. Joseph's Care Group

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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: GeriMedRisk Interdiscplinary Consultation & Education Service

Organization(s): GeriMedRisk

Description (*2-3 sentences*)**:**

GeriMedRisk (GMR) is a non-profit virtual clinical and education service that connects Ontario physicians, nurse practitioners, and allied health professionals with geriatric specialists to optimize medications and support physical and mental health conditions in older adults. Our interdisciplinary team of specialists from geriatric psychiatry, geriatric medicine, clinical pharmacology, and geriatric pharmacy work collaboratively to answer clinicians' questions via telephone, fax and eConsult. GMR also offers monthly accredited geriatric clinical pharmacology and psychiatry rounds on topics related to safe prescribing for older adults.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☒ Comprehensive assessment & care planning
- ☐ Integrated care at the point of care
- ☐ Shared responsibility for continuity of care
- ☒ Integrated specialized geriatric expertise
- ☐ Integrated community & home-based interventions
- ☒ Older person-centred care
- ☒ Engaged older persons & family/friend caregivers
- ☒ Self-management support
- ☒ Integrated technologies
- ☒ Multi-tiered evaluation

Outcome(s):

- 88% hospital diversion (2018);
- $2.14 saved for every dollar invested (2019: Phillips ROI);
- 96% of clinicians felt supported through GMR's consultation (2022);
- 88% of clinicians felt that GMR's consultation improved patient experience (2022);
- Rapid access to multiple geriatric specialties (i.e. patient specific consultations and relevant educational materials typically provided within five business days);
- More than 150 trainees supported through GMR's training hub since 2017; and
- Improved clinician capacity, with more than 400 attendees at monthly geriatric clinical pharmacology and psychiatry rounds.

Key Ingredients of Success:

GMR's success is predicated on:
- Timely access to specialists, where patients may otherwise wait for months for an appointment;
- Close bonds between specialized providers, who work together to address multiple and sometimes conflicting medication and treatment challenges; and
- A centralized approach to providing clinical expertise directly to providers requiring support, in a virtual setting.

Lessons Learned:

- An integrated digital solution can meet some of the needs of complex older adults with physical and mental health comorbidities;
- Provider satisfaction is high with timely responses to complex questions which can be managed within the medical home with support from GMR; and
- A multidisciplinary team in a shared care model can reduce harm and produce better health outcomes by addressing multiple patient needs in one consultation.

Add your organization's logo here:

GERIMEDRISK

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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: High Intensity Needs Transitional Support Pilot

Organization(s): North East BSO, Alzheimer's Society

Description (*2-3 sentences*)**:**

During Q4 of 2021, North East BSO and the Alzheimer's Society with the leadership and support of the OH North had the wonderful opportunity to roll out a High Intensity Needs Transitional Support Pilot across the North East region to enhance supports for patients and care teams with a priority focus on acute to long term care focused on 14-day isolation period. A key part of this transitional support was the coordination and translation of knowledge between care teams, but also engaging the patient in 1:1 meaningful activation during the isolation period to minimize risk of social isolation and enhance adherence to the isolation precautions.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☒ Comprehensive assessment & care planning
- ☒ Integrated care at the point of care
- ☒ Shared responsibility for continuity of care
- ☒ Integrated specialized geriatric expertise
- ☐ Integrated community & home-based interventions
- ☒ Older person-centred care
- ☐ Engaged older persons & family/friend caregivers
- ☐ Self-management support
- ☐ Integrated technologies
- ☐ Multi-tiered evaluation

Outcome(s):

From a systems flow impact, some comments from our acute care partners included… 'We have not seen this level of successful patient flow from hospital, specifically with our patients deemed ALC and requiring complex supports, in quite sometime or if ever and with no one returning back to hospital!' Upon completion of the pilot a quadruple aimed evaluation was completed targeting seven domains with engagement from patient/family care partners, BSO LTC embedded and BSO mobile team members. Over 50 complex transitions were supported, across our region, mainly from acute to LTC in a very rapid time frame with an average of 89% (agree/highly agree) Likert scale experience-based satisfaction rating and zero recidivism.

Key Ingredients of Success:

Team collaboration across sectors & acknowledgment of everyone's key role to enhance transitional supports
Flexibility to shift priorities and quickly engage to meet transitional needs as they arise
Use of Knowledge Translation Tools (My Transitional Care Plan, Pre/post transition huddles)
Engagement of the patient, family care partners

Lessons Learned:

Initiative embraced as a BSO standard of practice
Based on the success from the pilot project, we have since been successful in leveraging and securing base funding to continue to build upon those key successes and further spread the enhanced transitional support across the region.

Add your organization's logo here:

Contact Information (*name, phone number*):
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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: High Risk Geriatric Remote Care Monitoring Post Discharge Program

Organization(s): St.Joseph's Care Group (Geriatric Assessment & Rehab Unit)

Description (*2-3 sentences*)**:**

RCM program supports older adults considered at-risk for ED visits or re-admission discharged from Inpatient GARC for 30 days post-discharge. Clients health data is monitored by a Geriatric-trained Nurse after transition home and in the event that they require additional support/intervention/escalation clients and their care partners are supported through an escalation pathway which includes HCCSS; Primary Care and Community Paramedicine in addition to SJCG SGS Services. This program is strongly aligned with supporting transitions in care from hospital to home.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☒ Comprehensive assessment & care planning
- ☐ Integrated care at the point of care
- ☒ Shared responsibility for continuity of care
- ☒ Integrated specialized geriatric expertise
- ☒ Integrated community & home-based interventions
- ☒ Older person-centred care
- ☒ Engaged older persons & family/friend caregivers
- ☒ Self-management support
- ☒ Integrated technologies
- ☐ Multi-tiered evaluation

Outcome(s):

2023/2024 to date: Over 90% of clients d/d home enrolled in the program.
276 Clients enrolled; 35% required escalation to additional support; 10% Community Paramedicine; 41% HCCSS; 24% Primary Care; 25% Emergency Department with <40% requiring an Acute Care admission (3.2% of clients followed by RCM post discharge were admitted to Acute Care; 75% of clients requiring escalation avoided ED and Acute Care Admission. PREM data (22/23): 72% satisfied with RCM; 65% less need to visit their family doctor; 88% less need to visit ED; 91% less need for 911.

Key Ingredients of Success:

The willingness of Older Adult Clients and their care partners to "try" this solution.
Geriatric Trained Nurse in role of Client Transition Coordinator
Collaboration with Acute Care Partners
Strong escalation pathway including Community Paramedicine and HCCSS
Enrolling clients during their inpatient stay

Lessons Learned:

Older Adults can engage with this type of technology and appreciate the support it provide. Vivify since December 2022 has been a barrier to growth, expansion and increasing enrollments. Eagerly await NEW Provincially endorsed solution.
Partnerships are key to success! working alongside St. Joseph's Continuing Care Centre (Cornwall) with their Geriatric pathway was a key to our success.
We anticipate growing this service supporting older adults using technology at home.

Add your organization's logo here:

St. Joseph's Care Group

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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Implementation of Acute Care BSO Recreational Therapist

Organization(s): North East BSO, Alzheimer's Society

Description (*2-3 sentences*)**:**

Contribute to strengthening BSO's integrated system of care through specialized clinical and recreational based assessments and implementation of purposeful individualized therapeutic recreation based interventions founded on interest, need and ability. Based in hospital, the BSO RT will work collaboratively with the CBRS, acute care partners, and caregivers to enhance the positive impact and spread of BSO (1:1 and group) therapeutic modalities to address and prevent responsive behaviours, while adapting to individual changing needs. Will embody compassion, person-family focused values aligned with BSO's guiding philosophies and frameworks.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☐ Cross-sector partnership
- ☒ Comprehensive assessment & care planning
- ☒ Integrated care at the point of care
- ☐ Shared responsibility for continuity of care
- ☐ Integrated specialized geriatric expertise
- ☐ Integrated community & home-based interventions
- ☒ Older person-centred care
- ☒ Engaged older persons & family/friend caregivers
- ☐ Self-management support
- ☐ Integrated technologies
- ☐ Multi-tiered evaluation

Outcome(s):

There is potential for patients to become withdrawn and loose sense of purpose in their day throughout their hospital admission. Therefore, engagement of an acute care Recreational Therapist has been very influential in improving the patients mood and mental health, improving motivation and reducing potential for behaviours with gaining further understanding of their personhood and finding meaningful engagement within their current environment. Activation can also include increasing mobility to reduce risk of deconditioning. Frequent visits provides opportunity to observe any changes that can be relayed appropriately. Documentation of interactions and improvements is especially beneficial when a patient is applying or awaiting placement to LTC.

Key Ingredients of Success:

Understanding the patients personhood with completing a My Personhood Summary to support implementing meaningful activation that is person centered. Being adaptable/creative in every aspect such as the resources used and space available. Continued advocacy for improvements/alterations that will benefit not only the patient being supported through the acute care RT support yet also other patients within the shared environment. Collaborative approach to access the best possible care with continued focus on making a meaningful difference in people's lives everyday.

Lessons Learned:

Once positive outcomes observed by the multidisciplinary team and the role better understood; there is much appreciation voiced for the efforts and activation planning. "I have always been very passionate about the importance and benefits of recreational therapy, in addition to the BSO foundations. Standing behind those foundations, continuing to educate staff and show first hand how both BSO interventions and RT can drastically improve the health care system especially in the acute care setting".

Add your organization's logo here:

Contact Information (*name, phone number*):
Courtney Tremblay

Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Implementation of Primary Care & ED Post-Fall Pathways

Organization(s): Rehabilitative Care Alliance & North West Seniors Care Program

Description (*2-3 sentences*)**:**

To reduce functional decline and improve patient outcomes, it is essential to integrate rehabilitative care services into secondary fall prevention pathways for older adults with frailty who present to the emergency department (ED) or primary care with a fall. These pathways were developed based on a comprehensive literature review and extensive input from subject matter experts and stakeholders across Ontario, Canada and the United States and piloted in three regions across Ontario. This poster explores the outcomes of the pilot in Thunder Bay, Ontario with Thunder Bay Regional Emergency Department & their Nurse-Led Outreach Team (NLOT).

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☒ Comprehensive assessment & care planning
- ☒ Integrated care at the point of care
- ☒ Shared responsibility for continuity of care
- ☒ Integrated specialized geriatric expertise
- ☒ Integrated community & home-based interventions
- ☒ Older person-centred care
- ☒ Engaged older persons & family/friend caregivers
- ☐ Self-management support
- ☐ Integrated technologies
- ☒ Multi-tiered evaluation

Outcome(s):

Improvements were noted in a more comprehensive preliminary evaluation of frailty, function, gait & balance, fall risk factors and root cause analysis from baseline to end of pilot. Overall, clinicians reported the post-fall pathways to be effective. On the patient reported outcome measure (EQ-5D-5L), the majority (82.4%) had an improvement in at least one dimension (mobility, self-care, usual activities, pain/discomfort & anxiety/depression) and a mean change of 9.7 on Health-Related Quality of Life (MID 7-10). The average overall rating on the patient experience question: I am likely to recommend this service to friends and family if they need the same care was 6.2 on a 7 point Likert Scale.

Key Ingredients of Success:

Having the North West Regional Seniors Care Manager leading the implementation locally! Collaboration with SGS and rehabilitative care partners to ensure smooth referral processes and reciprocal communication between the ED & NLOT clinicians and the rehabilitative care partners. Use of a quality improvement approach to implementation where the pathway was implemented and data collected for a 3 month PDSA cycle. Regional collaborative meetings with all partners were facilitated at the end of each PDSA cycle and action plans were created and implemented.

Lessons Learned:

Enablers to implementation included: partnership with SGS required for geriatric capacity building of clinicians; regional collaboration to adapt and implement the pathways locally; referral processes must be easy and direct; improved awareness of referral options for rehab programs. Barriers that need to be overcome include transportation to services, clinician time restrictions (such as weekend and evening hours) and patient refusal.

Add your organization's logo here:

Rehabilitative Care Alliance

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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Incorportion of a Dementia Resource in the Emergency Rooms

Organization(s): Alzheimer Society of ChathamKent and Chatham Kent Health Alliance

Description (*2-3 sentences*)**:**

A Dementia Resource Consultant, that is specifically trained to provide Dementia care to patients presenting in the Emergency Room, that would benefit from specialized care.
Frontline staff are educated in Alzheimer's Disease and related Dementias, and how to de-escalate patient's that present with an unmet need.
Care partners and patients are provided with resources available through their local Alzheimer Society that would best support them, for a more positive hospital experience and health outcome.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☒ Comprehensive assessment & care planning
- ☒ Integrated care at the point of care
- ☒ Shared responsibility for continuity of care
- ☒ Integrated specialized geriatric expertise
- ☒ Integrated community & home-based interventions
- ☐ Older person-centred care
- ☐ Engaged older persons & family/friend caregivers
- ☐ Self-management support
- ☒ Integrated technologies
- ☐ Multi-tiered evaluation

Outcome(s):

Increase Education for Patients and Care Partners
Navigating supports for In-Home Respite care, Day away programs, Social Groups
Interdisciplinary and multisectoral approach- for better patient outcomes with wrap around care upon discharge
Continuity of care decreases readmission rates, and raises awareness of community resources available
By having bedside BSO tools and resources available- better health experiences are noted by patient and front tline staff.
By reducing avoidable hospitalizations, ALC numbers are decreased, saving a substancial amount on Healthcare.

Key Ingredients of Success:

Integration and colocation between CSS and Acute Care to aid discharges home with support
Continuity of Care - Maintaining a consistent appropriate respite staff - using resource matching to support the individual post discharge.
Best Practice P.I.E.C.E.S assesment with each patient, reduces care partner burden, with reduction of story re-telling, supports staff in a person-centred approach reducing reduncency, and possible behaviours.

Lessons Learned:

Lack of knowledge or stigma surrounding Alzheimer's and Dementia between staff and patients alike.
Gaps noted in service initiation and availability of Home Care supports, often leaving patient/ caregiver's without needed support upon discharge.
Access to support is often restricted due to population served and limitations.
Awareness and advocacy are key to successful community living.
Need to conduct Pre and Post Evaluation

Add your organization's logo here:

Contact Information (*name, phone number*):
Hope Mugridge, Dementia Resource
226-229-2450,hope@justasck.ca

Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: KW4 OHT Integrated Care Team for Older Adults

Organization(s): New Vision FHT & Others (see key ingredients of success

Description (*2-3 sentences*)**:**

The KW4 OHT Integrated Care Team for Older Adults (ICT) is a multidisciplinary team that supports older adults living with frailty. Hosted at New Vision FHT, this nurse practitioner-led primary care model leverages SGS expertise along with local health and social care providers in the screening, assessment, diagnosis, treatment, care planning, and case management of older adults who require a comprehensive approach to chronic disease management. ICT uses the interRAI Check-up as a standardized assessment tool that helps ensure interventions are based on the patient's goals of care, leveraging a palliative approach to care for older adults.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☒ Comprehensive assessment & care planning
- ☒ Integrated care at the point of care
- ☒ Shared responsibility for continuity of care
- ☒ Integrated specialized geriatric expertise
- ☒ Integrated community & home-based interventions
- ☒ Older person-centred care
- ☒ Engaged older persons & family/friend caregivers
- ☒ Self-management support
- ☒ Integrated technologies
- ☒ Multi-tiered evaluation

Outcome(s):

- 100% patient, care partner, team member, and physician satisfaction;
- 82% of patients are confident to self-manage their chronic conditions;
- Reduction in primary care (50%) and specialist appointments;
- Reduced emergency department visits and hospital admissions;
- Maintenance of primary care relationship between patient and provider;
- Reduced care partner stress for coordinating multiple appointments; and
- Evidence of decreased wait times for SGS programs in the region.

We conservatively estimate that the ICT produces a $5.27 return on investment for every dollar spent on the model.

Key Ingredients of Success:

ICT's success depends on tailored care planning and case management, developed by a multidisciplinary team of providers from organizations, including: Alzheimer Society, Behavioural Supports Ontario, CMHA, Community Paramedicine, Community Ward, GeriMedRisk, Home and Community Care Support Services, Hospice Waterloo Region, the Intensive Geriatric Service Worker Program, and New Vision FHT. Geriatricians and geriatric psychiatrists provide consultation and in-person appointments for patients, ensuring our interventions are holistic and coordinated.

Lessons Learned:

- A shared care model produces improved health outcomes, efficiencies in care provision, and a supportive environment for team members to practice to full scope;
- Charting in the family physician's EMR maintains connection to the medical home;
- A standardized, self-reported assessment tool allows for common clinical language;
- Provider satisfaction is high when they work collaboratively across programs; and
- Strong partnerships are the key to providing integrated care for older adults.

Add your organization's logo here:

KW4 ONTARIO HEALTH TEAM

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Adam Morrison 647-521-1624

Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: My Personhood Summary©

Organization(s): Behavioural Supports Ontario Provincial Coordinating Office

Description (*2-3 sentences*)**:**

My Personhood Summary© surfaces a person's life experiences, important relationships, personal preferences, and other psychosocial and environmental factors that influence individual's daily lives. It is a foundational tool that is intended for use with people living with dementia as well as older adults living with complex mental health, substance use, and/or other neurological conditions; however, other populations may also benefit from its use. My Personhood Summary© can be used by all members of BSO teams as well as other healthcare providers and partners.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☒ Comprehensive assessment & care planning
- ☒ Integrated care at the point of care
- ☒ Shared responsibility for continuity of care
- ☐ Integrated specialized geriatric expertise
- ☒ Integrated community & home-based interventions
- ☒ Older person-centred care
- ☒ Engaged older persons & family/friend caregivers
- ☐ Self-management support
- ☐ Integrated technologies
- ☐ Multi-tiered evaluation

Outcome(s):

Team Members Outcomes: (1) foster supportive relationships, (2) recommend meaningful activities, (3) identify ways to promote abilities, (4) maintain social connections, (5) develop tailored approaches and strategies to care, and (6) inform person-centred behavioural support plans. It acts as a tool for sharing information effectively between caregivers, doctors, and family members involved in the person's care enhancing transitional care.
Resident/Patient & Care Partner Outcomes: (1) promotes individual's autonomy and preferences, (2) ensures care is delivered in a manner that aligns with their values and choices, (3) increased quality of life by engaging in activities that are meaningful, (4) builds strong rapport with team members, and (5) improved transition experiences.

Key Ingredients of Success:

-Written in first-person to elicit a focus on the person, instead of on their illness (es)/condition(s).
-Collaborating with the individual and/or their family to obtain current up-to-date information.
-Completing the summary in multiple sessions to give the opportunity to build rapport prior to engaging in conversation about sensitive topics to enhance the provision of person-centred care.

Lessons Learned:

- The information for each section should be collected via natural conversation and does not need to follow the presented order.
-Some fields may be left blank if information is unknown.
-Posting the completed tool in a space that is visible by others assits with the continuity of care.
-The document should be updated when new information becomes known, a significant change in health status, or upon a transition to another setting.

Add your organization's logo here:

Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario
Provincial Coordinating Office, North Bay Regional Health Centre
Bureau de coordination provincial, Centre régional de santé de North Bay

Contact Information (*name, phone number*):
Courtney Stasiuk
705-675-9193 ext. 8914

Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: My Transitional Care Plan©

Organization(s): Behavioural Supports Integrated Team Collaborative

Description (*2-3 sentences*)**:**

My Transitional Care Plan© (MTCP) presents a synopsis of essential information for sharing between members of a person's care team from both their existing and new location. MTCP is intended for temporary use, to prepare and facilitate a move, following which information may be extracted from it to populate a formal care plan. All members of Behavioural Supports Ontario teams as well as other healthcare providers and partners who have assessment and/or care planning in their scope of practice can use MTCP.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☒ Comprehensive assessment & care planning
- ☒ Integrated care at the point of care
- ☒ Shared responsibility for continuity of care
- ☒ Integrated specialized geriatric expertise
- ☒ Integrated community & home-based interventions
- ☒ Older person-centred care
- ☒ Engaged older persons & family/friend caregivers
- ☐ Self-management support
- ☐ Integrated technologies
- ☐ Multi-tiered evaluation

Outcome(s):

1. Enhanced Communication: MTCP serves as a centralized platform for sharing essential information among care team members, fostering improved collaboration.
2. Continuity of Care: By consolidating vital health information, MTCP ensures seamless transitions, minimizing errors in care provision and ensuring person-centred care remains central to the care provided
3. Efficient Assessment and Planning: Healthcare providers can efficiently conduct assessments and develop personalized care plans using MTCP, streamlining the process and enabling prompt identification of individual needs.
4. Improved Transition Experience: MTCP provides individuals and families with structured plans and access to pertinent information; this tool empowers individuals and families to actively participate in care decisions during and immediately after

Key Ingredients of Success:

-Gathering comprehensive information ensures that all relevant details are collected.
-Implementing a standardized clinical tool ensures consistency among care teams and settings.
-Creating an easily accessible and portable resource allows for timely access to information from any location.
-Collaborating within the healthcare team ensures alignment with the individual's care goals, promoting a patient-centered approach to transitional care.

Lessons Learned:

Through qualitative data, providers are stating: 1) Although filling our MTCP take up more upfront work, the benefits far outweigh the time spent. 2) MTCP provides a concise document to communicate immediate concerns and needs in one spot. 3) Most of the information from MTCP is transferable to permanent care plan- saving even more time on the receiving end. 4) MTCP communicated an effective snapshot for physicians about the person's current state baseline at the time of the transition.

Add your organization's logo here:

Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario
Provincial Coordinating Office, North Bay Regional Health Centre
Bureau de coordination provincial, Centre régional de santé de North Bay

Contact Information (*name, phone number*):
Courtney Stasiuk
705-675-9193 ext. 8914

Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Paramedic Post-Fall Pathway Pilot

Organization(s): Rehabilitative Care Alliance

Description (*2-3 sentences*)**:**

A Lift Assist is defined as an event when a patient calls paramedic services and requests assistance to get up or mobilize, where the patient receives no treatment on scene, and refuses transport to the emergency department for further medical attention. To reduce functional decline and improve patient outcomes, it is essential to integrate rehabilitative care services into secondary fall prevention pathways for older adults with frailty who require a Lift Assist. In collaboration with Community Paramedicine Services and PGLO, the ED Post-Fall Pathway was therefore adapted for use by paramedics and a pilot of this pathway is currently underway.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☒ Comprehensive assessment & care planning
- ☒ Integrated care at the point of care
- ☒ Shared responsibility for continuity of care
- ☒ Integrated specialized geriatric expertise
- ☒ Integrated community & home-based interventions
- ☒ Older person-centred care
- ☒ Engaged older persons & family/friend caregivers
- ☒ Self-management support
- ☒ Integrated technologies
- ☒ Multi-tiered evaluation

Outcome(s):

Current state was assessed using a baseline paramedic survey completed by 4 regions and baseline chart reviews completed by 5 regions (to date). It was noted that fall assessment & history taking practices are not standardized, including inconsistent use of fall assessment tools and fall risk factor assessment. Paramedic assessment is shared only with community paramedicine and with the ED if the patient is transported. Referrals are mostly via Community Referral - EMS (CREMs) to Home & Community Care Support Services or to Community Paramedicine. The pilot has been launched in one region: Thunder Bay. There are 5 regions who are completing the preparation phase of the pilot and 3 regions who are considering implementation to date.

Key Ingredients of Success:

Collaboration with all partners, including paramedics, primary care, SGS and rehabilitative care to adapt the pathway to the local context, ensure smooth referral processes and reciprocal communication. Some rehab & SGS services require physician/NP, therefore close collaboration with primary care and a process for unattached patients are needed. Ease of use is key, therefore currently working with partners and vendors to embed the pathway into paramedic EMRs.

Lessons Learned:

Current state analysis confirmed the need to improve paramedic processes of care for older adults who require a lift assist. Partnership with SGS is key for geriatric capacity building of front line paramedics. Using lessons learned and quality improvement approach developed from the Primary Care & ED pathway pilot to improve upon implementation from a paramedic entry point.

Add your organization's logo here:

Rehabilitative Care Alliance

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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: 'Recipe for Success': Co-Designing strategies to enhance transitions

Organization(s): St. Joseph's Health Care London

Description (*2-3 sentences*)**:**

There is growing recognition of the importance and benefits of patient-and caregiver-centred care approaches for older adults and individuals with complex medical needs during points of care transitions. In partnership with providers, patients and caregivers, St. Joseph's Health Care London aimed to improve the quality of care and patient and caregiver experience during transitions, through the implementation of transition strategies. The strategies included: i) patient orientated discharge summary; ii) teach-back education processes; iii) post discharge follow-up phone calls; iv) caregivers as partners in care; and v) a care resource binder.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☒ Comprehensive assessment & care planning
- ☒ Integrated care at the point of care
- ☐ Shared responsibility for continuity of care
- ☒ Integrated specialized geriatric expertise
- ☐ Integrated community & home-based interventions
- ☒ Older person-centred care
- ☒ Engaged older persons & family/friend caregivers
- ☒ Self-management support
- ☐ Integrated technologies
- ☒ Multi-tiered evaluation

Outcome(s):

In Summer 2022, a working group assembled to develop a campaign to generate awareness of the transition strategies, and get frontline staff excited for the work to come. The team developed a campaign, 'Recipe for Success', which highlights a recipe card with a description of the 'ingredients' (transition strategies) needed for a successful transition. Virtual sessions, co-presented with patient/caregiver partners, were held to raise awareness and provide foundational knowledge on the tools and strategies. Over 100 participants attended the webinar sessions to learn more about the work. Tools have been implemented into practice across inpatient programs at Parkwood Institute. Early findings indicate an improvement in care experience.

Key Ingredients of Success:

Successful care transitions are supported by:
- patient orientated discharge summaries with lay language discharge instructions
- teach-back education processes to support patient/caregiver education and training
- implementation of post discharge follow-up phone calls
- engaging with caregivers as part of the care team
- utilizing a care resource binder to support communication between staff and patients and caregivers

Lessons Learned:

A number of key learning have been identified: Input from patients, caregivers and providers – from the beginning is critical; clear communication plan for staff and leaders; a strong work plan, and, multiple training sessions for frontline staff were critical for the success of the initiative.

Add your organization's logo here:

St JOSEPH'S HEALTH CARE LONDON

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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Virtual Behavioural Medicine Program (VBM)

Organization(s): Baycrest Hospital, University of Toronto Neurology, BSO

Description (*2-3 sentences*)**:**

Caregivers and care partners face the challenge of navigating complicated healthcare systems while managing and supporting individuals with complex neuropsychiatric symptoms (NPS).
It is essential to keep individuals in their environment to reduce unnecessary transitions.
Virtual Behavioural Medicine (VBM) is an innovative care escalation option for patients with NPS of dementia.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☒ Comprehensive assessment & care planning
- ☒ Integrated care at the point of care
- ☒ Shared responsibility for continuity of care
- ☐ Integrated specialized geriatric expertise
- ☒ Integrated community & home-based interventions
- ☐ Older person-centred care
- ☐ Engaged older persons & family/friend caregivers
- ☐ Self-management support
- ☒ Integrated technologies
- ☒ Multi-tiered evaluation

Outcome(s):

Avoids the Need for In-Patient Admission to the Behavioural Neurology Unit (BNU).
In our study published in the Journal of Alzheimer's Disease, we found that a substantial majority (60%) of individuals awaiting in-patient admission to the BNU were effectively treated through the VBM program (Freedman et al., 2022).
Reduced Caseload and Waitlist for the BNU. Only patients with the most intractable illnesses require admission.

Key Ingredients of Success:

Collaboration across the continuum: VBM is accessible across diverse care settings including Long-Term Care, Acute Care, Specialty Behavioural Units, Assisted Living and the community; Behaviour Supports Ontario introduces non-pharmacological supports before escalating to VBM; BNU specialized 20-bed locked unit designed for patients with severe NPS who cannot be safely managed in their existing environment.

Lessons Learned:

VBM is a novel virtual neurobehavioural inpatient unit where individuals are treated in their current settings; Reduces emergency visits and acute care hospital admissions when an individual is treated in their current setting; This integrated care model addresses critical systemic issues within the existing care framework and enhances the efficiency and effectiveness of care delivery for individuals with NPS.

Add your organization's logo here:

Baycrest

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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Wellness Calendar

Organization(s): WWOAS, Mapleton Senior Centre for Excellence, KW4OHT FE WG

Description (*2-3 sentences*)**:**

A wellness calendar was developed at the time of COVID 19 to support isolated older adults living in the community including a tool to monitor daily overall physical and mental health. This tool has proved to be very successful as community paramedic teams and older adults requested it to be continued. The distribution has grown from 2,000 calendars (2020-21) to a distribution in 2023 to 22,000. The calendar also provides cognitive and physical exercises and tips to assist with overall health.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☐ Comprehensive assessment & care planning
- ☒ Integrated care at the point of care
- ☐ Shared responsibility for continuity of care
- ☐ Integrated specialized geriatric expertise
- ☒ Integrated community & home-based interventions
- ☒ Older person-centred care
- ☒ Engaged older persons & family/friend caregivers
- ☒ Self-management support
- ☐ Integrated technologies
- ☐ Multi-tiered evaluation

Outcome(s):

Older adults took a proactive approach to maintain their overall health with the help of the daily check in section, which allowed them to track their level of overall health daily. If they recognized a concerning pattern they were encouraged to connect with talk a member of their health team and/or a trusted family member or friend to assist with determining next steps. The tool is used for preventative care and monitoring. Older adults appreciated tips and practical suggestions for maintaining cognitive and physical health and safety. An unexpected outcome of the tool was the valuable data it provided to in-home supports such as community paramedicine, HCCSS, SGS, and caregivers in identifying concerning trends before they became emergent.

Key Ingredients of Success:

Engagement of older adults was imperative. Older adults were outstanding leaders in the co-design, including development of the daily check in section to track their overall health; submitting their art work to be portrayed on main page of each month; sharing content and seeking out tips and practical suggestions to support healthy living. Engage community partners and OHTs to support funding and distribution of calendar: access to grants; initially United Way GWD provided support; most recently New Horizons with a focus on wellness and preventing fraud and elder abuse.

Lessons Learned:

Make it simple; In general, how would you rate your health today?
I feel excellent: I feel good:I feel average: I feel poor/bad
Distribution of calendars is a collaborative approach that goes beyond health providers; examples; legions; churches, community lunches;libraries. Older adults appreciate printed materials, large font with practical empowering/self-directed care

Add your organization's logo here:

Canadian Mental Health Association Waterloo Wellington | Association canadienne pour la santé mentale Waterloo Wellington | Waterloo Wellington Older Adult Strategy Follow on Twitter @WWOlderAdults

Contact Information (*name, phone number*):
Jane McKinnon Wilson 519-823-6994

Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Behavioural Support Capacity Building in Hospitals

Organization(s): St. Joseph's Care Group

Description (*2-3 sentences*)**:**

A Behavioural Education Lead through funding allocated to ALC was created to support Acute and Post-Acute Care hospitals in Thunder Bay in relation to behavioural supports. This position is working collaboratively with health teams to address knowledge gaps, explore opportunities for growth, provide solutions, implement best practices and build capacity.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☐ Multidisciplinary teams
- ☒ Collaboration
- ☐ Cross-sector partnership
- ☐ Comprehensive assessment & care planning
- ☐ Integrated care at the point of care
- ☐ Shared responsibility for continuity of care
- ☐ Integrated specialized geriatric expertise
- ☐ Integrated community & home-based interventions
- ☐ Older person-centred care
- ☐ Engaged older persons & family/friend caregivers
- ☐ Self-management support
- ☐ Integrated technologies
- ☐ Multi-tiered evaluation

Outcome(s):

This initiative is expected to increase the health care team's knowledge, understanding, confidence and self-efficacy in caring for people living with, or at risk of, responsive behaviours, and support staff satisfaction and retention. It is also expected to help reduce ALC and Length of Stay (LOS) rates while increasing the number of clients discharged to most appropriate setting in a timely manner, decrease use of physical restraints, and increase patient/care partner satisfaction

Key Ingredients of Success:

An environmental scan and self assessments conducted by the care team was important during the development phase. It was also important to be innovative in the delivery of education and ensure various modes are available. Ultimately, building relationships with the care teams was the most important element to ensure success.

Lessons Learned:

Hospitals continue to require additional resources to support ALC as it relates to clients with responsive behaviours.T here continues to be challenges to support education needs (i.e. backfilling), however, it's important to be creative in the delivery. It was also observed that new graduates were lacking foundational knowledge in supporting older adults with responsive behaviours, therefore, education was provided to local Nursing and PSW classes with the hopes to continue in the future.

Add your organization's logo here:

Contact Information (*name, phone number*):
Lisa Petersen (807) 343-4364

Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Behavioural Supports in Acute Care Capacity Building Package

Organization(s): BSO Provincial Acute Care Collaborative

Description (*2-3 sentences*)**:**

The development and dissemination of knowledge transfer/translation tools to be used by educators within acute care. The package was designed to reinforce foundational knowledge within acute care teams in providing quality care to older adults with, or at risk of, responsive behaviours/ personal expressions associated with dementia, mental health, substance use and/or other neurological conditions. The package contains three posters and three slide decks for short education sessions regarding key themes: 1) the importance of personhood, 2) all behaviour has meaning, and 3) your approach matters.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☒ Comprehensive assessment & care planning
- ☒ Integrated care at the point of care
- ☒ Shared responsibility for continuity of care
- ☒ Integrated specialized geriatric expertise
- ☐ Integrated community & home-based interventions
- ☒ Older person-centred care
- ☒ Engaged older persons & family/friend caregivers
- ☐ Self-management support
- ☒ Integrated technologies
- ☐ Multi-tiered evaluation

Outcome(s):

Feedback surveys were completed regarding the posters and the mini education sessions. Posters surveys (n=76): on a 5 point Likert scale (1= No, not useful to 5= Yes, very useful), the mean rating of the usefulness of the information was 4.3; and overall rating of poster was 4.4 out of 5. Education session surveys (n=95): on the same 5 point Likert scale, the mean rating of the usefulness of the information was 4.5; and overall rating of mini education session was 4.6 out of 5. Qualitative responses demonstrated planned application of knowledge gained with specific planned modification of approach (e.g. verbal and non-verbal communication), gaining more understanding of the person and identification of reason(s) for the behaviour.

Key Ingredients of Success:

- Collaboration of acute care leaders, clinicians and educators from across Ontario.
- Creation of knowledge transfer/translation tools that are tailored to the acute care environment (e.g. education sessions 15-30 minutes in length).
- Educational tools that are readily/publicly available and easy to use.
- Use of a fictional patient and artwork that elicit empathy through a human story.
- Use of reflective and planned application educational strategies.

Lessons Learned:

Importance of: 1) aligning with other hospital quality improvement initiatives, 2) engaging key collaborators (e.g. clinical educators) in the planning, implementing and evaluation, 3) targeting one program/unit at a time and 4) gauging team readiness and consider competing priorities and barriers (e.g. staff shortages).

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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario
Provincial Coordinating Office, North Bay Regional Health Centre
Bureau de coordination provincial, Centre régional de santé de North Bay

Contact Information (*name, phone number*):
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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Caring for Indigenous Older Adults in Waterloo Wellington E-Module

Organization(s): Waterloo Wellington Older Adult Strategy

Description (*2-3 sentences*)**:**

A one hour e-module co-designed with local Indigenous Elders, knowledge keepers, older adults, Indigenous led health services, local health and community partners to enhance the care of Indigenous older adults. The module includes local history, an examination of determinants of health and focuses on providing practical approaches towards developing successful healthcare partnerships with Indigenous older adults and their communities. Additionally, the emodule provides guidance for organizational planning and developing ongoing relationships with Indigenous communities and organizations. https://geriatricessentialselearning.ca/login/

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☐ Comprehensive assessment & care planning
- ☐ Integrated care at the point of care
- ☒ Shared responsibility for continuity of care
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- ☐ Self-management support
- ☐ Integrated technologies
- ☐ Multi-tiered evaluation

Outcome(s):

* * Through the co-design of this module, healthcare and community support leaders and front-line teams have developed important relationships with local Indigenous older adults, Elders, knowledge keepers and organizations that will serve as the foundation for continued engagement and enhancement of care.
** The e-module is accessible and presents positive opportunities for developing an ongoing collaborative understanding and continued learning with Indigenous partners front-line teams and leaders.* * Feedback from participants: the emodule provides practical guidance and enhances knowledge through the case studies, Indigenous voice recordings and quotes. The information can be easily shared across regions.

Key Ingredients of Success:

**Working through established, collaborative partnerships of the WWOAS with the voice of the older adult at the forefront ensures that this can be a regional success and create opportunities for systems-wide transformation
**Valuing Indigenous knowledge systems and approaches enabled us to work in relationship with Indigenous partners to co-design an effective training
**Recognizing that this is one piece of ongoing work towards our obligations to fulfill Truth and Reconciliation (especially 21 and 22 on healthcare)

Lessons Learned:

**Caring for Indigenous older adults requires a community-centred approach
**We can learn from Indigenous approaches to care to enhance our system for all older adults
**The voice of older adults continues to be paramount in creating any tool about their care, and that certain factors enable optimal levels of input (how you meet, where, when, how to share materials, etc. in a sensitive manner).

Add your organization's logo here:

Canadian Mental Health Association Waterloo Wellington | Association canadienne pour la santé mentale Waterloo Wellington | Waterloo Wellington Older Adult Strategy Follow on Twitter @WWOlderAdults

Contact Information (*name, phone number*):

Christine Platt, 519-829-8342

Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Making the Most of Your Medical Appointments Workshop

Organization(s): Waterloo Wellington Older Adult Strategy

Description (*2-3 sentences*)**:**

The Waterloo Wellington Older Adult Strategy inclusive of older adults and health service providers in the region, co-designed a workshop and handouts with a focus on strategies (ACTIVE and SPEAK) for older adults to enhance their conversations with healthcare partners. Using a self-advocacy approach, the tool provides tangible guidance to assist older adults prepare for conversations, request accommodations, effectively explain what their goal(s) are with enhanced clarity in their meeting with the health service provider, with a focus on understanding a comprehensive plan with articulated next steps. These strategies can be applied in any healthcare conversation.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☐ Comprehensive assessment & care planning
- ☒ Integrated care at the point of care
- ☒ Shared responsibility for continuity of care
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- ☒ Engaged older persons & family/friend caregivers
- ☒ Self-management support
- ☐ Integrated technologies
- ☐ Multi-tiered evaluation

Outcome(s):

** The workshop has reached over 200 older adults and caregivers in the region. The tool is hosted on the YourCare+ website https://www.yourcareplus.ca/
Workshop training of the tool is provided using a train the trainer approach and shared with partners inclusive of healthcare, community support services and older adults. ** Participant surveys provide positive feedback validating the tool is practical, easy to complete and provides successful engaging and goal-oriented meetings with healthcare partners. **The materials empower older adults and caregivers to achieve enhanced results from their healthcare conversations that are person centered. The tool helps with improved continuity of care in a complex healthcare system.

Key Ingredients of Success:

**Co-design provides positive practical outcomes and supports self-directed care.
**Accessibility of materials (free, tailored in length and presentation style, full facilitator notes in the deck) and existing systems partnerships provides easy spread of information in a timely manner.
**Practical easy to access tools that focus on outcomes allows for older adults' priorities to be centre to the conversation with a collaborative planning approach that can enhance confidence and an understanding of next steps for the older adult/family.

Lessons Learned:

**Co-design processes provide practical outcomes while continually enhancing systems transformation.
**Older adults and caregivers welcome ongoing education about how to improve their healthcare interactions: navigation of the health and community support system of care is an ongoing priority for older adults, families and caregivers.
**Tangible tools positive experiences for the older adult and their healthcare team.

Add your organization's logo here:

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Contact Information (*name, phone number*):
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Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Palliative Approach to Care

Organization(s): Waterloo Wellington Older Adult Strategy and CMHAWW

Description (*2-3 sentences*)**:**

The Waterloo Wellington Annual Knowledge Exchange in Geriatrics Collaborative and Working Group developed a knowledge transfer event with a focus on Palliative Approach to Care: Having Important Conversations Early in Your Healthcare Journey. The event focused on the importance of health providers engaging in conversations about palliative approaches to care as an important scope of practice for teams across the continuum of care. Older adults shared they would have conversations with team members they are most comfortable with: e.g. nurse who visits regularly; social worker at the Alzheimer society; and how it is important for teams to have this information

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☐ Comprehensive assessment & care planning
- ☒ Integrated care at the point of care
- ☒ Shared responsibility for continuity of care
- ☒ Integrated specialized geriatric expertise
- ☒ Integrated community & home-based interventions
- ☒ Older person-centred care
- ☒ Engaged older persons & family/friend caregivers
- ☒ Self-management support
- ☐ Integrated technologies
- ☐ Multi-tiered evaluation

Outcome(s):

150 registrants for one day, virtual event: additionally, recorded event shared across 50+ organizations: Leaders in the field of palliative approaches to care: Dr. Seow and Dr. Winemaker, co-hosts of the podcast ‘The Waiting RoomRevolution’, and co-authors of ‘Hope for the Best, Plan for the Rest: 7 Keys for Navigating a Life-Changing Diagnosis" provided a key note that proved foundational for front line clinicians to enter into a dialogue with older adults and families. Event Presentations: Goals of Care and Serious Illness Conversations: Journey of Dementia;I’m Ready to Die;Facilitating Caring Conversations at End of Life. Feedback: Excellent wide breadth of topics, engaging and practical tools. Inspired further learnings/events.

Key Ingredients of Success:

Collaboration through a co-design model inclusive of perspectives from:Hospice Palliative Care, Older Adults, Specialized Geriatric Services, Community Support Services, Community Paramedics, Primary Care, Acute Care,Long Term Care. Planning and working group focus with a Terms of Reference: planning is approximately 10 months. Evaluation immediately after the event provides 30% feedback.

Lessons Learned:

Palliative approaches to care require early dialogues; Clarity is required about the importance of introducing upstream,palliative approaches to care across the system of care. Older adults have an interest in understanding medical assistance in dying MAiD Early on determined two knowledge exchanges required: 1) Palliative Approach to Care: 2) MAiD knowledge exchange event (hosted 3 weeks after the Annual Knowledge Exchange in Geriatrics,200 plus registrants; positive feedback)

Add your organization’s logo here:

Canadian Mental Health Association Waterloo Wellington | Association canadienne pour la santé mentale Waterloo Wellington | Waterloo Wellington Older Adult Strategy Follow on Twitter @WWOlderAdults

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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Person-Centred Language Initiative

Organization(s): Behavioural Supports Ontario PCO & CLRI-RIA

Description (*2-3 sentences*)**:**

Person-Centred Language (PCL) ensures that language choices are appropriate, respectful, life-affirming and inclusive when interacting with and referring to individuals who communicate via responsive behaviours/personal expressions associated with dementia, complex mental health, substance use and/or other neurological conditions, including their family care partners. PCL prioritizes the individuality, dignity, and humanity of people. It puts the person before any condition or label; emphasizing their identity, rather than defining them solely by their circumstances. By using person-centred language, we honour, respect and dignify people in our society by being thoughtful and building up strengths and abilities.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☒ Comprehensive assessment & care planning
- ☒ Integrated care at the point of care
- ☒ Shared responsibility for continuity of care
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- ☐ Self-management support
- ☐ Integrated technologies
- ☒ Multi-tiered evaluation

Outcome(s):

1) Respect and Dignity: Recognizing people's worth beyond their circumstances.
2) Empowerment: Focusing on abilities, strengths, and inherent value to combat stereotypes.
3) Reduced Stigmatization: Avoiding defining individuals by their conditions or by using labels.
4) Improved Communication: Promoting understanding and empathy for better relationships.
5) Increased Inclusivity: Creating welcoming environments for all.
6) Cultural Awareness/Sensitivity: Ensuring respectful communication for those who identify as having distinctive racial, national, religious, linguistic, or cultural heritage.

Key Ingredients of Success:

1) See the person first in a wholistic manner; considering their physical, emotional, social and spiritual wellbeing. 2) Acknowledge, validate and show compassion for each person's unique experiences and perspectives. 3) Build and establish trusting relationships by honouring and respecting what matters to the person. 4) Consider both verbal and non-verbal forms of communication. 5) Advocate for Person-Centred Language within all groups, organizations and sectors. 6) Describe responsive behaviours/person expressions; avoid labeling the person or behaviour.

Lessons Learned:

- Changing language is an evolving process that requires patience, effort and time
- Person-centred language requires commitment to long-term, life-long practice. - The use of Person-Centred language in charting / documentation helps healthcare providers gain a clear understanding of the individual's health needs.
- PCL is more readily adopted among team members, if there is an encouraging environment where successful PCL is celebrated and modelled, among all levels of an organization.

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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Prevention & Reduction of Restraint Use in Acute Care

Organization(s): BSO Provincial Acute Care Collaborative

Description (*2-3 sentences*)**:**

Collectively develop a plan to prevent and reduce the use of physical restraints with older adults in acute care hospitals across Ontario using a quality improvement lens. The problem being addressed: Physical restraints are being misused (e.g. applied for reasons that are not evidenced based such as falls prevention, delirium management and responsive behaviours) and overused (i.e. not as a last resort) with older adults in acute care which leads to new and/or escalated responsive behaviours, as well as other poor outcomes (e.g. functional decline, delayed discharge, risk of injury and death).

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
- ☒ Collaboration
- ☒ Cross-sector partnership
- ☒ Comprehensive assessment & care planning
- ☒ Integrated care at the point of care
- ☒ Shared responsibility for continuity of care
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- ☐ Self-management support
- ☒ Integrated technologies
- ☒ Multi-tiered evaluation

Outcome(s):

Project to date has included the surfacing of root causes of restraint use, a review of the literature and an identified multi-prong approach that will involve the creation of a Restraint Reduction Toolkit. The Toolkit will include resources aimed at acute care organizational leadership, clinical leaders and point-of-care team members and will be designed to address modifiable root causes.

Evaluation plan and the product development in progress.

Key Ingredients of Success:

- Collaboration of acute care leaders, clinicians and educators from across Ontario all passionate and motivated to reduce restraint use.
- Use of a quality improvement tools with a project as multifaceted and complex as restraint use.
- Synergy of clinical experience and the literature identifying root causes and informing solutions.

Lessons Learned:

TBD

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Provincial Coordinating Office, North Bay Regional Health Centre
Bureau de coordination provincial, Centre régional de santé de North Bay

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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Provincial Geriatrics Leadership Ontario

Innovations in Care for Older Adults

Initiative Title: Regional Education Strategy

Organization(s): North Simcoe Muskoka Specialized Geriatric Services (NSM SGS)

Description (*2-3 sentences*)**:**

The NSM SGS program is a single, integrated regional program serving complex/frail older adults and their care partners. To build capacity and support interprofessional learning, we implemented a multi-pronged regional education strategy. Partners from across health sectors access our core curricula (PIECES, U-First, GPA, Positive Approach to Care, Seniors Mental Health, sfCare Learning series), monthly practice shorts, annual conferences and special education events. In addition to these in-person and virtual offerings, team members (including PRCs and LTC RN Team Leads) provide on-site group and 1:1 education, coaching and mentoring to partners.

Integrated Care Design Elements Included (*please check all that apply*)**:**

- ☒ Multidisciplinary teams
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- ☐ Cross-sector partnership
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- ☐ Integrated technologies
- ☐ Multi-tiered evaluation

Outcome(s):

-The NSM SGS education webpage (www.nsmsgs.ca/education) is accessible to all and provides a point of contact. The website describes the courses offered, has a calendar of upcoming events, allows for online registration, and houses archived recordings providing an ongoing resource to learners.
- Standardized topic specific handouts and facilitator guides were created to ensure content is evidence-informed, current and consistent.
- Evaluation data collected is consistently positive. Feedback is used to improve future sessions.
- NSMSGS is a leader for the regional dissemination of best practice information regarding the care of older adults living with complexity/frailty.

Key Ingredients of Success:

- NSM SGS is a trusted, collaborative, regional knowledge broker and partner.
- Events are marketed through our website, social media (X, LinkedIn), flyers, and distributed via email and other networks.
- There is a protected budget to support education events and team education. Events are offered at no or low cost, with targeted sponsorship of particular teams/curricula.
- Educators are regulated health professionals with knowledge of adult education and clinical expertise in the care of older adults living with complexity/frailty.

Lessons Learned:

A regional education strategy builds capacity across health sectors. A centralized webpage and targeted approach enhances marketing. Skilled facilitators with clinical expertise and standardized educational resources promote the adoption of leading practices. Combining virtual and in-person offerings addresses individual preferences and promotes participation across a large geography. Curating offerings by other partners allows for broader reach and breadth of information.

Add your organization's logo here:

North Simcoe Muskoka Specialized Geriatric Services

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