Serving Frail Seniors in Ontario

Through Planning & Care, Education, Evaluation & Research, Advocacy

December 2014

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Contents

Background

It is estimated that the number of Canadians who are 75 years of age or older will almost double over the course of the next 20 years. While most seniors live healthy and active lives, a small portion become frail and are at risk of institutionalization. Frail seniors with complex health problems have unique needs and present specific challenges for accurate diagnosis and assessment. A targeted approach is therefore required for the proportion of seniors with complex and/or multiple chronic conditions. It is this subset of seniors who are at risk of further losses of health and independence and higher use of health care resources, which specialized geriatric services (SGS) are intended to serve. The goal of SGS is to reduce the burden of disability by detecting and treating reversible conditions and recommending optimal management of chronic conditions. Benefits of specialized geriatric services include:

- Increased independence, functional ability and quality of life for seniors and their caregivers
- Prevention of frailty and its complications
- Improved clinical efficiencies in acute care
- Improved patient outcomes
- Enhanced capacity of health care providers to assess and treat frail seniors

Introduction to Regional Geriatric Programs

Regional Geriatric Programs (RGPs) provide a comprehensive network of specialized geriatric services which assess and treat functional, medical, and psychosocial aspects of illness and disability in older adults who have multiple and complex needs. They are provided in a variety of settings by inter-professional teams with expertise in care of frail seniors. Working in collaboration with primary care physicians, community health professionals, and others RGPs seek to meet the needs of the most frail and vulnerable seniors.

In 1986, RGPs were established at Academic Health Sciences Centres in Hamilton, Kingston, London, Ottawa, and Toronto and together form the provincial network, the Regional Geriatric Programs of Ontario (www.rgps.on.ca). This network focuses on education, research and standards of practice and is now a key resource to the provincial healthcare system as it evolves to better meet the needs of Ontario's aging population.

Since the formation of the provincial network, every region of the province has been assisted by an RGP to develop their geriatric services. In two LHINs, this has resulted in the formation of regional programs, which are now part of the RGPs of Ontario Network - Seniors Care Network in the Central East LHIN and the North East Specialized Geriatric Services in the North East LHIN. Each RGP has developed and evolved to respond to its local context and needs.

RGPs of Ontario:

RGP Central (Hamilton)

Specialized Geriatrics Services (South East Ontario)

Specialized Geriatrics Services (South West Ontario)

RGAP Eastern Ontario (Ottawa)

RGP of Toronto

North East Specialized Geriatric Services (Sudbury)

Seniors Care Network (Central East LHIN)

The RGPs of Ontario have been working collaboratively to achieve a vision of better health outcomes for frail seniors. This brief report provides a summary of some of the RGPs' collaborative initiatives in the areas of:

1) service planning and care for seniors

2) early identification and management of seniors at risk

3) building primary care and community care capacity

4) evaluation

5) promoting awareness and disseminating best practices

6) advocacy for frail seniors.

Service Planning and Care for Seniors

GEM Provincial Network

Guided by the RGPs, the GEM nursing network presently comprises approximately 100 nurses in Emergency Departments (ED) across the Province. The network provides GEM assessment services to an estimated 80,000 frail seniors annually. The service is focused on identifying seniors at risk, assessing their needs, linking them to services and when possible diverting them from hospital admissions and/or repeat ED visits. The Ottawa and Toronto RGPs also provide GEM training institutes in response to the needs of new GEM staff. The RGPs have also been instrumental in developing and coordinating a 'sister' program, Emergency Mobile Nursing Services (Nurse Led Outreach to LTCHs - NLOT) in several LHINs and coordinates training institutes to meet the needs of staff in these services. The NLOTs work in partnership with hospital EDs and LTC homes to optimize health outcomes of seniors in LTC homes and reduce the likelihood of transfers to the ED. NLOTs work with hospital flow managers and GEM nurses to facilitate efficient repatriation of LTC home residents for whom an ED transport proves essential.

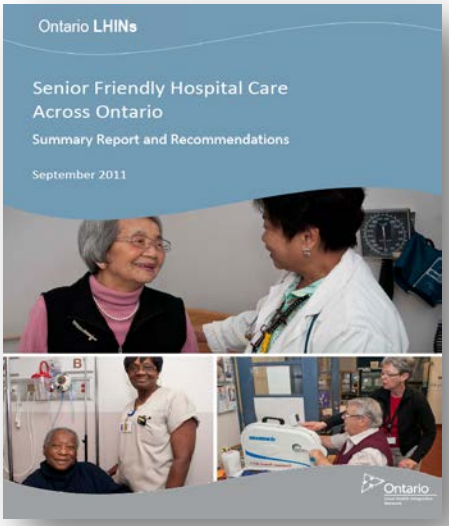
Publications and presentations in this area include:

- *Ryan, D, Liu, B, Awad M & Wong K (2011) Improving the older patient's experience in the emergency room: towards the senior friendly emergency room. Aging Health 7(6) 901-909*
- *Ryan, D (2011) Keeping LTC Patients out of the ER, 2nd Annual Care of the Elderly Conference, Hamilton, June.*
- *Pulfer, T. & Wilding, L. (2010) The Regional Geriatric & Community Intervention Program: A model for enhancing emergency department discharges for high risk seniors. National Gerontological Nursing Association 25th Annual Meeting.*

Senior Friendly Hospital Initiative

The vision of the Ontario Senior Friendly Hospitals (SFH) Strategy is to optimize the health and wellness of older adults while hospitalized to support safe and timely transitions to independent or supported living in the community. The RGPs of Ontario endorse an evidence-informed SFH framework which guides hospitals in an organization-wide approach to quality improvement in the care of frail and at-risk seniors. The SFH framework provided a blueprint for the LHIN-led Ontario SFH Strategy. Highlights of the accomplishment of this pan-LHIN strategy to date include:

1) SFH self-assessments were completed by all adult hospitals across Ontario (March 2011)
2) LHIN-level SFH summary reports and individual feedback letters were provided to all hospitals (June 2011)
3) A provincial summary report, 'Senior Friendly Hospital Care Across Ontario' was released with key priority recommendations: **quality improvement in hospital-acquired delirium and functional decline** (October 2011)



4) SFH Promising Practices Toolkit Working Group – resources on delirium and functional decline were appraised by clinical experts and compiled on a web-based toolkit to provide supporting resources for hospitals (May 2012, available at www.seniorfriendlyhospitals.ca)
5) SFH Indicators Working Group – accountability indicators for hospital-acquired delirium and functional decline were identified through a collaborative, multi-disciplinary process (November 2012, the full report is available at http://seniorfriendlyhospitals.ca/files/SFH%20Delirium%20and%20Functional%20Decline%20Indicators%20Report.pdf)

The RGP of Toronto continues to chair a working group guiding feasibility testing of the SFH indicators, occurring in 44 hospitals across 10 LHINs. Participation in this collaborative has made complex clinical quality improvement a shared experience, with large and small hospitals supporting and learning from one another.

The RGPs continue to convene an SFH provincial leadership/steering committee every two months with the fourteen LHINs, Health Quality Ontario, and the Registered Nurses' Association of Ontario. Progress in the indicator implementation is shared, along with a discussion of LHIN- and province-wide health care priorities. There is a high degree of support for continued provincial collaboration, regional networks (LHIN-wide or involving clusters of LHINs), and a provincial standardization of clinical SFH practice.

This work is evolving into a provincial steering committee and a clinical collaborative for SFH care. We expect that the knowledge-to-practice improvements achieved through this collaborative will be transferable to other health system initiatives whose outcomes depend on competency in frailty, clinical complexity, inter-professional practice, and inter-organizational collaboration.

RGPs of Ontario contribution to service planning in other regions of the province

Seniors Care Network (formerly the Central East Regional Specialized Geriatric Services) was created by the Central East LHIN in 2012 to coordinate the planning, design, implementation and evaluation of clinical service delivery approaches intended to improve health outcomes for frail seniors in the region. Similar to RGPs, Seniors Care Network is focused on strategic directions that include improving care, fostering excellence and increasing awareness of age-related needs. The RGPs have provided critical support to the development of Seniors Care Network, through direct consultation, sharing of models and resources and ongoing participation of RGP of Toronto leadership in the Seniors Care Network Board and Senior Friendly Hospital Working Group. This support has advanced the start-up and leadership

development of Seniors Care Network at a pace not otherwise possible. As a result, Seniors Care Network is now leading a major expansion of geriatric assessment and intervention services across the Central East LHIN.

As the City of Greater Sudbury began to develop services for older adults in the North East, the RGPs of Ontario were able to provide support, advice, guidance and clinic practices that would contribute to the development of North East Specialized Geriatric Services. Through the leadership of the Southwestern Ontario and Ottawa RGPs, the framework for developing a specialized geriatric program was shared and local providers were coached in the implementation. Ongoing mentorship continues to be an added-value benefit of collaboration in the RGPs of Ontario. To sustain the North East Specialized Geriatric Services during a leave of absence by the geriatrician, locums were recruited by the RGPs of Ontario. This support ensured that our patient population continued to receive quality services.

Human Resources planning – Enhanced Geriatric and Geriatrician Services (EGGS) Working Group

A working group was established in 2009 to discuss and implement the Ministry of Health & Long Term Care and Ontario Medical Association 2008 Physician Services Agreement, specifically sections 8.1, 8.2 & 8.3. By late 2010, a new funding arrangement for community-and academic-based geriatricians in Ontario was established and implemented. One geriatrician from the Southwestern Ontario RGP represented the academic-based geriatricians and RGPs, and a Toronto geriatrician represented the community-based geriatricians.

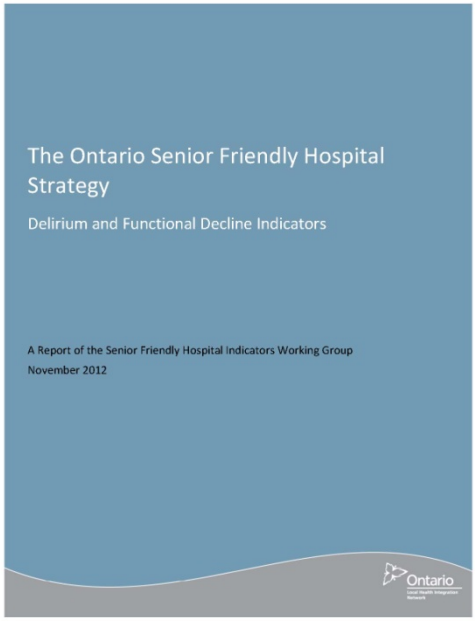
Early Identification and Management of Seniors at Risk

Rehabilitative Care Alliance – Frail Senior/Medically Complex Population

The Frail senior Medically Complex Task Group and Advisory Group of the Rehab Care Alliance are working to develop a provincial approach for frail senior/medically complex populations to support operationalization of priority elements of the "Assess and Restore Framework to Support Aging in Place". The current priority is the development of a process to facilitate direct admissions to bedded levels of rehabilitative care from the community and emergency department. . A process for screening and early identification of high risk seniors, standardized assessment for the determination of restorative potential, and a streamlined referral process are currently in development. The group's membership include representation from all LHINs, CCAC, rehabilitative care experts, geriatricians and allied health professionals with expertise in geriatric care. The committee is chaired by a geriatrician from the North East Specialized Geriatric Services, and several members of the other RGPs are active members of this group.

Senior Friendly Hospital Indicator Pilot on Delirium and Functional Decline

Beginning in 2010, the RGPs of Ontario collaborated with all LHINs in the province-wide Ontario Senior Friendly Hospital (SFH) Strategy. The strategy's outcomes included a self-assessment of all of the province's adult hospitals, the identification of hospital-acquired delirium and functional decline as priorities for quality improvement, the construction of an on-line toolkit to provide enabling resources (www.seniorfriendlyhospitals.ca), and the identification of SFH indicators for system-level monitoring of SFH quality improvement. Guided by a knowledge-to-practice model, the RGPs are coordinating feasibility testing of the SFH indicators



in 43 hospitals representing the diverse practice settings across the province. A web-based project portal, collaboration webinars, and one-on-one coaching have demonstrated their value in facilitating knowledge transfer to the point-of-care. Sites are reporting improved clinical learning and teamwork, improved recognition of older patients' vulnerability to delirium and functional decline, and integration of prevention and management interventions into front-line practice. A final report, to be generated in the fall of 2014, will provide recommendations for the ongoing use of the SFH indicators to drive continuing quality improvement in the hospital care of frail and at-risk seniors.

Building Primary Care and Community Care Capacity

Behavioral Supports Ontario

In 2012-13 Ontario announced the establishment of a Provincial Behavioral Supports Ontario Strategy to support care of older adults with responsive behaviours secondary to dementia, mental health or addictions. RGPs of Ontario have contributed to the planning and development, knowledge-to-practice (KTP) and evaluation of this important strategy.

RGPs contribute to BSO Implementation and Advisory Committees in the TC LHIN, CW LHIN, C LHIN, MH LHIN, HNHB LHIN, Champlain LHIN, CE LHIN, SE LHIN, and NE LHIN. In the CE LHIN the Senior Care Network, a new member of the RGPs of Ontario, is responsible for governance of BSO services.

RGPs provide knowledge-to-practice services supporting BSO team development. The Southeast RGP has led the development of "Behaviour Supports Online Collaborative Learning Portal (Learning Management System)". Guided by best practices in online learning, the portal features a resource library that can be used for formal training, orientation and refresher events and informal "just-in-time" learning. One of the portal's courses provides an interprofessional, interagency, blended- learning approach to three foundational skills required of behavioural health teams: communication skills, collaboration and team skills, and person- and family-centred care skills. The course also teaches person-centred, team-based processes for effective decision-making and solution finding, including P.I.E.C.E.S. three Question Template and Resident Life History.

The RGP of Toronto manages a Psychogeriatric Resource Consultation (PRC) Team of knowledge-to-practice specialists serving five LHINs. In addition to providing training to LTCH and community agency staff, the team provides training to emerging BSO teams in each LHIN. The team has planned for and delivered orientation and training on PIECES, GPA, UFirst, and Montessori approaches to the understanding and management of responsive behaviors. Two

innovations have emerged to support BSO. A Behavioral Resource Support Team curriculum has been developed and evaluated which helps agencies develop their own resource team to optimize the use of BSO and other psychogeriatric resources. The role of a PRC for Primary Care has been developed and evaluated. This role assists HealthLinks and other primary care providers in building their responsive behavior skills and optimizing their use of BSO services and the RGP is represented on a provincial Primary Care KTP process. As well, in the TC LHIN the RGP co-chairs an Educational Consortium tasked with coordinating intersectoral BSO KTP deployment. In a similar vein, the RGP in the Champlain LHIN is leading a deployment of BSO concepts in acute care, and a physician affiliate of the North East Specialized Geriatric Services is Physician BSO Lead in that region.

Finally, staff affiliated with the RGPs of Ontario in the HNHB LHIN, TC LHIN, CE LHIN, C LHIN and South West LHINs have contributed to the development of evaluation metrics for BSO.

Geriatric, Inter-professional & Inter-organizational Collaboration (GiiC)

While geriatrics, inter-professional practice and inter-organizational collaboration (GiiC) are essential elements of care for frail seniors, health professionals continue to graduate with little training in these core competencies. Informed by learning needs assessment, a team of GiiC consultants, drawn from the RGPs of Ontario, developed a toolkit containing modules on 24 core GiiC areas including: frailty, periodic geriatric health exam, continence, driving safety, falls, dementia, and delirium, adapted for use in primary care. Each module comprised overviews, quick facts, pocket practice aids, clinical tools & algorithms, patient handouts, teaching slides and case studies. Three hundred and seventy four health professionals from 181 (78%) of the province's family health teams and community health centres participated in 16 hours of train-the-trainer education. This was followed by three months of coaching in Hamilton, Ottawa, London, North Bay, Thunder Bay, Kingston and Toronto, to assist their teams in frailty focused service development. An online toolkit is available at http://www.giic.rgps.on.ca and receives approximately 2,000 usages monthly. Subjective evaluations revealed significant satisfaction and knowledge gained through the KTP process. Participating teams were offered a formal

team assessment and 74 teams received a written report with recommendations on ways to improve their teamwork. A one year follow-up 'practice change' survey revealed the development of new services, practice improvements, and enhancements to teamwork attributed to project participation.

Funded by a Health Force Ontario Interprofessional Care Grant, the project results are published in the following article:

- *Ryan, D. Barnett, R. et al. (2013) Geriatrics, Inter-professional Practice and Inter-organizational Collaboration: A Knowledge-to-Practice Process in Primary Care Teams. Journal of Continuing Education in the Health Professions, 33(3), 180-189.*

A second Health Force Ontario IPC grant continued the GiiC implementation in the Waterloo Wellington, Hamilton, Niagara, Hamilton & Brant, Mississauga Halton, Central West, Toronto Central, Central, Central East and North Simcoe and supported the development of additional modules focused on patient and family engagement resources. In the North East LHIN, a series of mini-GiiC workshops contributed to the development of a regional approach to geriatric services.

Additional KTP presentations for community services include:

- *van der Horst ML, and Wong K. The GiiC Initiative: Geriatrics, Interprofessional and Interorganizational Collaboration. Oral session presented at: Ontario Community Support Association Conference; 2010 October 20; Toronto, Canada*
- *Wong K, and van der Horst ML. Patients, Families, and Healthcare Teams – Engaging Patients in Healthcare Encounters. Oral session presented at: Geriatrics Inter-professional and Inter-organizational Collaboration Plus Workshop; 2010 August 12; Markham, Canada.*
- *Wong K. Geriatrics, Inter-professional Practice, and Inter-organizational Collaboration: The GiiC Toolkit. Oral session presented at: Toronto Public Health Falls Intervention Team Meeting; 2010 June 16; Toronto, Canada*

GiiC geriatrics interprofessional interorganizational collaboration

Evaluation

Goal Attainment Scaling Study

Goal Attainment Scaling (GAS) is an individualized goal-setting and measurement approach[1] that is potentially useful for patients with multiple, individualized health problems, such as those served by geriatric day hospitals and other specialized geriatric programs. We assessed the feasibility and utility of GAS in a multi-site study of six geriatric day hospitals affiliated with the RGPs (4 in Toronto, 1 in London, 1 in Hamilton). The study also provided an opportunity to assess the extent of patient and caregiver involvement in the goal setting process. Individualized GAS guides were developed for 15 consecutively admitted patients at each site. Staff members were surveyed on their experience with GAS.

GAS was able to detect clinically relevant change in the Day Hospital setting which can aid in demonstrating evidence for the utility and impact of Day Hospitals. Common goals included mobility, community reintegration, basic and instrumental activities of daily living, medical issues, cognition/communication, and home safety. Clients were often involved in goal-setting; family involvement was less frequent. The staff survey identified challenges and benefits related to the use of GAS. Study results are being used to inform a more consistent approach to the clinical and research use of GAS in geriatric day hospitals. The study was published.

- *Stolee, P., Awad, M., Byrne, K., Deforge, R., Clements, S., Glenny, C., & Day Hospital Goal Attainment Scaling Interest Group of the Regional Geriatric Programs of Ontario. (2012). A multi-site study of the feasibility and clinical utility of Goal Attainment Scaling in geriatric day hospitals. Disability & Rehabilitation, 34(20), 1716–1726.*

[1] Kiresuk TJ, Sherman RE (1968). Goal Attainment Scaling: a general method for evaluating community mental health programs. Community Mental Health Journal; 4, 443-453.

Geriatric Emergency Management (GEM) evaluation

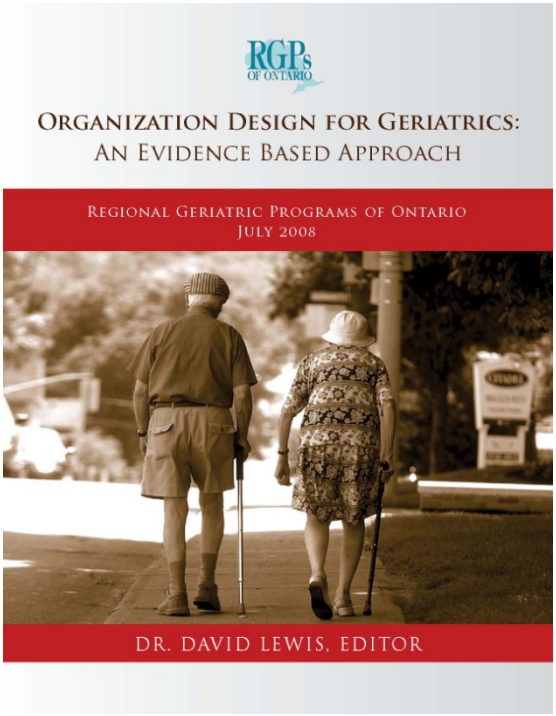
In 2004 the Ministry of Health & Long-Term Care funded 8 GEM nursing positions across the RGPs. Led by the RGP of Toronto, the GEM evaluation was focused on the effect of those eight GEM nurses on hospital and ED recidivism using an observational, retrospective cohort study design. We matched each GEM-intervened subject on selected variables to four non GEM-intervened, control subjects. We also examined stakeholder satisfaction with GEM services.

The primary outcomes of repeat ED visits and hospital admissions were not affected by the GEM intervention. Several important limitations to the analysis were considered. Inadequate matching of the comparator group was the most significant issue in this analysis. Other issues included selection bias; temporal trends in ED use and changes in health system; consultative model and follow-up; heightened awareness and adequacy of support services; a hospital admission is an appropriate disposition for some patients; and frail seniors have acute as well as chronic health needs.

Stakeholders view the GEM services very positively. Vivid patient narratives and clinical case reports affirm the value of GEM in addressing the unmet needs of frail seniors in the ED setting. Overwhelming support from opinion leaders in the ED, clinicians and other partners and positive stakeholder satisfaction data confirm the benefits of GEM services. Through our experience with GEM, we have refined our intervention models and identified systemic improvement opportunities that can enhance anticipated outcomes and build system capacity as indicated by the approximately 100 GEM nurses serving frail seniors in EDs across Ontario.

Organization Design for Geriatrics: An Evidence Based Approach Handbook

A generation ago, the province of Ontario developed a plan for a comprehensive system of health services for the elderly (A New AGEnda; Ontario Ministry of Health and Long-Term Care, 1986). Part of this plan was to use the expertise developed by the academic health science centres to help improve the quality of geriatric services provided by Ontario's acute and chronic hospitals. To support this plan, the Ministry of Health in Ontario issued its guidelines for the establishment of regional geriatric programs in teaching hospitals which led to the five RGPs.



In 2006, the Chair of the Regional Geriatric Program Central (Hamilton) led the development of a guide to best practices in the delivery of services to the elderly, which was endorsed by the RGPs. To this end, the RGPs created a handbook aimed at providing an evidence-based approach to service delivery for the elderly patient in core specialized geriatric services. The handbook includes: service descriptions; literature reviews with levels of evidence; recommendations supported by research; identified gaps in evidence; and clinical assessment tools. The handbook is available online at: http://rgps.on.ca/files/RGPHandbookFINAL.pdf.

Promoting Awareness and Disseminating Best Practices

Ontario Gerontology Association (OGA) co-sponsorship

For many years, the RGPs and the OGA have benefited from a partnership through their combined educational events. The RGPs Education Day is a full day-length workshop that occurs on the first day of the OGA 2-day Annual Conference. In collaboration with the OGA, the RGPs are able to offer its clinicians and the OGA conference attendees a broader range of educational content that is inter-sectoral and provides an opportunity for participants to network with inter-professional colleagues in the province. RGPs of Ontario staff have provided a significant contribution to the educational content of the OGA conference through keynote, workshop, paper, and poster presentations. Combining the two events has also achieved cost and process efficiencies.

RGPs of Ontario Annual Education Day

The RGPs of Ontario, in collaboration with the Ontario Gerontology Association's annual conference, host an annual provincial education day whose purpose is to highlight innovative practices in geriatrics, and to engage healthcare workers and administrators in skills building to support the care of older adults. This event was historically a networking opportunity for RGP-affiliated specialized geriatrics service providers for clinical skill development and knowledge-sharing across Ontario.

OHA SFH Annual Conference

With the breadth and scope of the Ontario Senior Friendly Hospital Strategy, the Ontario Hospital Association, in partnership with the RGPs of Ontario, created a SFH conference in 2012 to promote dissemination of SFH initiatives and networking amongst the province's clinical and administrative leaders. The RGPs of Ontario provide content expertise to shape the conference program and, through our collaborations, we identify local, national, and international speakers whose work highlights exemplary practice in SFH care.

OHA HealthAchieve geriatric workshop

Since 2000, the RGPs of Ontario have provided a key "Geriatric Session" in the Ontario Hospital Association (OHA) signature conference. The OHA HealthAchieve has been one of the largest and most respected health care events in North America – the preeminent gathering place for health care and business leaders.

The Geriatric sessions have been very well attended, receiving excellent evalatuions. The last few years have seen audience size grow to standing room only. Each year, our themes are determined, collectively by members of the RGPs of Ontario. We receive feedback from our programs and networks to identify the most relevant topics each year, and we include speakers from different RGP programs to reflect our unique and innovative programs. Some of our sessions:

- Senior Friendly Hospitals: Now that everyone is interested in seniors….what's next?
- Senior Friendly Hospitals: The Delirium Imperative: Prediction, Prevention and Measurement
- Understanding frailty among the 1-5% high users of the health system.

Seniors Health Knowledge Network (SHKN)

The RGPs of Ontario network is a member of the Seniors Health Knowledge Network (SHKN). SHKN's goal as a network of networks is to improve quality of life for Ontario's older adults and caregivers, through promoting sharing of evidence-based care practices within all older adults' health care venues; through informing policy development for service providers, care settings, and knowledge users; and through informing research from experience.

During the course of the 2013-14 funding year, the Network achieved its KE goals through delivery of 40 live webinars (attended by 1,779 sites) and their archived recordings (3,172 views to date), electronic newsletters (38,784 e-mails sent; open rate of 25%), attendance at 6 provincial conferences and a popular website.

The SHKN through its Knowledge Brokers (KB) and Information Specialists (IS), supports a number of Communities of Practice (Diabetes; Fall Prevention; Communicative Access and Aphasia; Wound Care; Medication Safety; Hospice Palliative Care; Mental Health, Addictions and Responsive Behaviours; Oral Health; Aging and Developmental Disabilities; Osteoporosis; Medically at Risk Older Drivers and Nutrition), and the Ontario Research Coalition (ORC) of Centers/Institutes on Aging and Health. Through the ORC, it supports provincial collaboration in research, links practitioners and researchers (including RGP researchers), and builds capacity for research in the sector by supporting early career researchers.

Advocacy for Frail Seniors

Elder Care Elder Health Coalition

Over 10 years ago, the government of Ontario recognized the need to develop a seniors strategy, and within that, a seniors health framework. To that end, the RGPs joined many other organizations in Ontario to form the Elder Health Elder Care Coalition. This Coalition responded to the government's request by proposing the framework: "Toward an Elder Health Framework for Ontario." The elder health framework orients policy and service delivery decisions based on the inherent values of ageing in place and choice for older persons. It provides the blueprint for services that are integrated, interdisciplinary, tailored to need, and focused on early intervention and prevention.

The Framework aimed to:

1. Heighten awareness of elder health issues and change negative attitudes towards the elderly by informing and guiding the direction and development of policies and programs related to elder health in Ontario.
2. Support the development, delivery and evaluation of a full range of accessible and integrated services in a comprehensive, systematic way for older persons in Ontario.
3. Ensure that interdisciplinary care is a cornerstone of elder health services, programs and policies.
4. Support the health of older persons through health promotion and disease prevention across the continuum of care.

This document was submitted to the Ministry of Health & Long Term Care and can be seen as a stepping stone to the present seniors' strategy.

Contribution to the Seniors Strategy

The RGPs of Ontario have actively supported the Ontario Senior's Strategy. The strategy report, "Living Longer, Living Well" is organized around 12 themes, each of which has been supported by the RGPs through various activities:

1. ***Supporting the Development of Elder Friendly Communities:*** Through advocacy the RGPs of Ontario have linked with key stakeholders in contributing to initiatives such as supportive and affordable housing options, reducing transportation barriers, minimizing social isolation, and integrating age friendly communities with the senior friendly hospital strategy.
2. ***Promoting Health and Wellness:*** The RGPs recognize the impact of social determinants of health on the older adult population. Initiatives such as GiiC have contributed greatly to providing a wealth of resources that support patients/families in their self management of healthy outcomes. GiiC also provided resources to primary care clinicians to facilitate health promotion with their patients and families.
3. ***Strengthening Primary Care for Older Ontarians:*** The GiiC Resource Toolkit has influenced other primary care models (e.g., model of integrating memory disorder clinics directly within primary care). Other activities include knowledge exchange with primary care, developing and strengthening relationships between SGS and primary care through the provincial falls prevention strategy, and enhancing communications to primary care to optimize the health outcomes for older adults.
4. **Enhancing the Provision of Home and Community Care Services to Supporting Aging in Place:** Over the years, the RGPs have established numerous partnerships and collaboratives that have further strengthened the integration of RGPs and SGS within the community. The RGPs of Ontario host an annual geriatric education day that facilitates networking with community stakeholders.
5. **Improving Acute Care for the Elders:** The SFH Strategy has been instrumental in changing care delivered to older adults within hospital. Key initiatives linked to care processes targeting functional decline and delirium have re-engineered how care is

delivered. GEM Nurses have been critical in building geriatric capacity within the emergency departments and being a leader in making EDs senior friendly.

6. **Enhancing Ontario's Long Term Care Home Environments:** Nurse Led Outreach Teams (NLOT) have provided leadership in supporting clinicians within LTC homes in diverting patients from unnecessary ED visits and hospital admissions. In addition, the NLOTs have been key knowledge brokers between SGS and LTC homes. Another initiative, Bridges to Care, was a collaborative resident-centred model whereby LTC teams were engaged in a quality improvement process that positively impacted care and practice.
7. **Addressing the Specialized Care Needs of Older Ontarians:** The RGPs have evolved the role of SGS to meet the needs of a changing system. Geriatric Medicine Outpatient Services (Geriatric Outreach Teams, Geriatric Day Hospitals, and Geriatric Clinics have been redesigned to support and enhance capacity building in the community. The RGPs have also supported a coordinated approach to accessing care.
8. **Medications and Older Ontarians:** The RGPs of Ontario have supported and advocated for an increased role of pharmacists in the management of medications in older Ontarians. The RGPs have promoted this through a variety of educational venues and continue to reach out to provincial bodies for opportunities for collaboration.
9. **Caregivers:** The RGPs have collaborated with and included caregivers in their research and program evaluation activities.
10. **Addressing Ageism and Elder Abuse in Ontario:** This important issue has been integrated in the domain of the "Emotional and Behavioural Environment" of the senior friendly hospital framework. The RGPs have played in key role in advocating for policy and procedures that strengthen the elder abuse framework.
11. **Addressing the Unique Needs of Older Aboriginal Peoples of Ontario:** The needs of older aboriginal peoples of Ontario are incorporated in the planning and development of new and ongoing programs.
12. **Necessary Enablers to Support a Seniors Strategy for Ontario:** A key foundational piece for the RGPs is their research leadership. The RGPs provide expertise in evaluation methodology, and tracking, monitoring and reporting of key performance metrics.

Ontario Interdisciplinary Council for Aging and Health (OICAH)

The mission of the Ontario Interdisciplinary Council for Aging and Health (OICAH) is to enhance the well-being of older adults in Ontario by promoting partnerships and collaboration among universities, COU affiliates and stakeholders to improve interdisciplinary and interprofessional education, research, policy, and practice related to aging.

Representatives of the RGPs of Ontario are members of OICAH and through it have an ability to access and advise relevant affiliates (Council of Ontario Faculties of Medicine, Council of Ontario University Programs in Nursing, Ontario Council of University Programs in Rehabilitation Sciences, and Council of Ontario Universities) as appropriate.

During recent consultations leading up to the Better Aging: Ontario Education Summit, the RGPs of Ontario partnered with OICAH, SHKN and AKE in developing key messages and information to support the needs of entry-level practitioners and continuous education in aging and health.

Better Health, Better Care, Better Value position paper

In 2011 the RGPs of Ontario developed a position document that identified *three Recommendations for an Action Plan;* Promoting Better Health, Better Care and Better Value.

Better Health: Convene a stakeholder steering group to create and recommend a comprehensive integrated strategy to ensure optimal wellness and outcomes for frail, Ontario Seniors.

Better Care: Facilitate, promote and ensure the use of best practices in the planning, development and delivery of care for older Ontarians with frailty.

Better Value: Create an integrated and coordinated education development strategy that will support the evolution of the required expertise and capacity for effective geriatric care across Ontario.

The RGPs of Ontario collaborate with others in the planning and delivery of evidence–based strategies and actions that are responsive to the needs of older Ontarians.

For more Information about RGPs

www.rgps.on.ca

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