The Ontario Senior Friendly Hospital Strategy
An Update

Champlain LHIN SFH Symposium

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www.seniorfriendlyhospitals.ca

1

Outline

- Background and update on pan-LHIN SFH strategy
- Indicator evaluation- preliminary findings
- SFH alignments and synergies
- Next steps

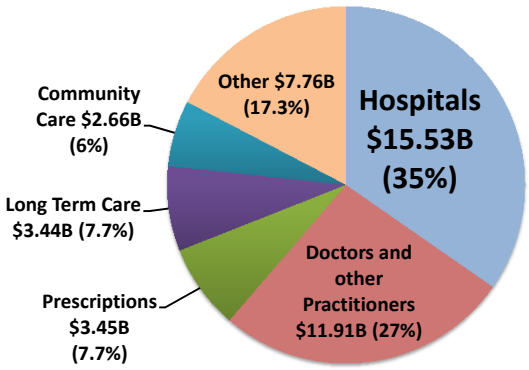
2

Context

Older Adults in Ontario
- **14.6% of pop'n** (16.4% Champlain LHIN)
- **20% of ED visits** (19% Champlain)
- **58.8% of hospital days** (67% Champlain)

(Ontario MOHLTC, 2012; RGP of Toronto, 2011)

Major Components of Ontario Health Care Spending 2010-11



Source: Ontario MOHLTC and MHP

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3

RGP Senior Friendly Hospital Framework

Processes of Care	Emotional & Behavioural Environment	Ethics in Clinical Care & Research	Organizational Support	Physical Environment
What we do	How	Who	Why	Where

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4

Ontario Pan-LHIN Senior Friendly Hospital Strategy

PHASE 1

Objective
- Identify current state

Plan
- Hospital self-assessments
- LHIN-level roll-up
- Provincial roll-up

Provincial Summary Report

PHASE 2

Objective
- Close the gap

Plan
- Implement hospital improvement plans
- Develop key enablers

SFH "Promising Practices" Toolkit

PHASE 3 - ONGOING

SFH Indicators

Objective
- Monitor and sustain hospital and system improvements

Future State
- Prevent functional decline
- Improve patient experience
- Enable hospital staff
- Improve equity

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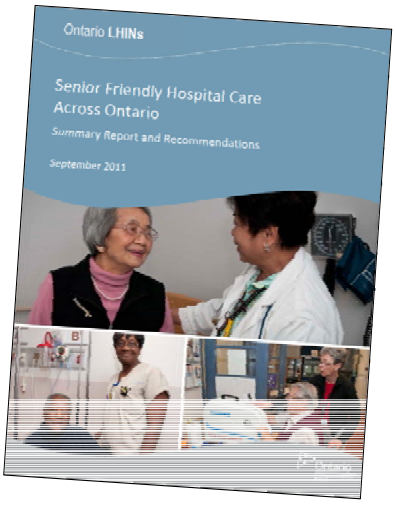
Ontario Local Health Integration Network / Réseau local d'intégration des services de santé

5

Provincial Summary of SFH Care



- a collaboration of all LHINs (14) and Regional Geriatric Programs (6) in Ontario
- a snapshot of SFH care across 155 Ontario hospitals
- identifies promising practices – these helped inform recommendations for SFH care
- identifies priority areas for action

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Three SFH Priorities for Action

- Functional Decline
- Delirium
- Transitions In Care

Focus of Toolkit and Indicator Development

Visit the site at:
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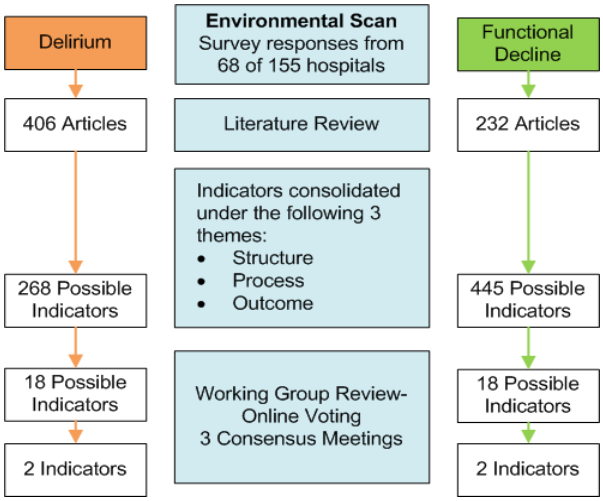
7

Indicator Development



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The SFH Indicators Report was approved by the TC LHIN in January 2013

8

Delirium Indicators (All Hospital Sectors)

Process	**Rate of baseline delirium screening**	Percentage of patients (65 and older) receiving delirium screening using a validated tool upon admission to hospital
Outcome	**Rate of hospital-acquired delirium**	Incidence of delirium in patients (65 and older) acquired over the course of hospital admission

Data Source and/or Tool	Confusion Assessment Method (CAM), CAM-ICU, or Intensive Care Delirium Screening Checklist (ICDSC)
Exclusions	Patients with decreased level of consciousness (unresponsive or requiring vigorous stimulation for a response); patients in palliative care
Considerations	Minimum frequency of screening to capture incidence – at least daily after the initial baseline screen

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Functional Decline Indicators (Acute Care Sector)

Process	Rate of ADL function assessment at admission and discharge	Percentage of patients (65 and older) receiving assessment of ADL function with a validated tool at both admission and discharge
Outcome	Rate of no decline in ADL function	Percentage of patients (65 and older) with no decline in ADL function from hospital admission to hospital discharge as measured by a validated tool

Data Source and/or Tool	Barthel Index Health Outcomes for Better Information in Care (HOBIC) – ADL Section Alpha-FIM Tool®
Exclusions	Patients in emergency department who are not admitted to hospital; patients in palliative care; patients admitted for day surgery procedures; patients with a length of stay <48 hours

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Outline

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11

Implementation

- 42 hospitals in 10 LHINs have implemented the delirium and/or functional decline indicators
- Inform future use of the indicators in quality improvement or hospital accountability structures

Evaluation		Sources of Data
Indicator definition	Technical specifications	• Action plan and progress reports • Data submissions • Staff surveys • Monthly collaboration webinars • Correspondence and coaching requests
Feasibility	Completion rates Change trends Data quality	
Clinical value	Staff perception	
Implementation strategies	Success factors Challenges	

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12

Participating Hospitals

South West
Grey Bruce Health Services
St Joseph's Health Care (London)
St Thomas Elgin General Hospital

Erie St. Clair
Hotel-Dieu Grace Healthcare

Hamilton Niagara Haldimand Brant
Brant Community Healthcare System
Hamilton Health Sciences
Joseph Brant Memorial Hospital
Niagara Health System
Norfolk General Hospital
St Joseph's Healthcare (Hamilton)

Toronto Central
Baycrest
Providence Healthcare
St Michael's
Sunnybrook Health Sciences Centre
Toronto East General Hospital
University Health Network – TWH + TRI
West Park Healthcare Centre

Central
Markham Stouffville Hospital
North York General Hospital
Southlake Regional Health Centre
Stevenson Memorial Hospital

Central East
Campbellford Memorial Hospital
Lakeridge Health
Northumberland Hills Hospital
Ontario Shores Centre for Mental Health Sciences
Peterborough Regional Health Centre
Ross Memorial Hospital
The Scarborough Hospital

South East
Brockville General Hospital

Champlain
Deep River District Hospital
The Ottawa Hospital

North East
Blind River District Health Centre
Espanola Hospital & Health Centre
Health Sciences North
Kirkland District Hospital
St Joseph's General Hospital (Elliot Lake)
Manitoulin Health Centre
North Bay Regional Health Centre
Sensenbrenner Hospital
West Nipissing General Hospital
West Parry Sound Health Centre

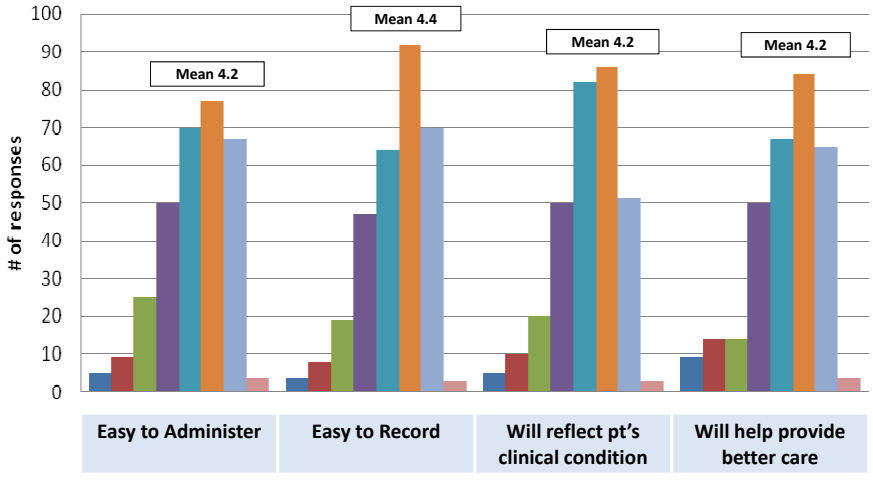
North West
St Joseph's Care Group (Thunder Bay)

Summary of Implementation:
Delirium – 42 patient care units at 31 hospital sites
Functional Decline – 24 patient care units at 22 hospital sites

13

Delirium Implementation – Staff Perceptions

n = 307 point-of-care staff from 21 (out of 35) hospital sites



14

Delirium Implementation – Staff Perceptions

Positive	CAM tool is accurate, simple, and easy to implement
Challenges	• workload and competing priorities, more paperwork • difficulties when conducting assessments (e.g. different languages, obtaining patient history from family, patients with cognitive challenges) • consistency of assessments (e.g. differences between staff, time of day) • risk of offending patients when they are repeatedly asked the same questions to assess cognition • need to link assessments with a care plan when delirium is identified
Use of the Data	• improve clinical awareness, trigger care plans and D/C planning earlier • improve staff communication, participation, and collaboration • help target education and quality improvement initiatives • help inform hospital committees and policymakers

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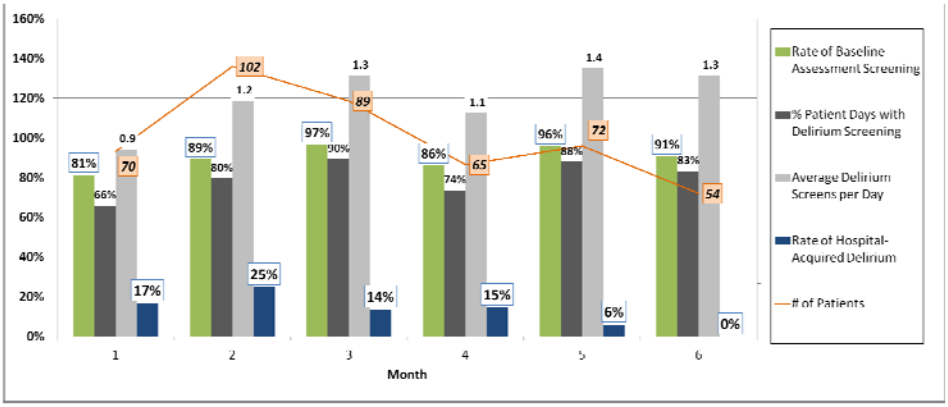
15

Delirium Implementation – Early Results

Community hospital, 2 medical unit, ALOS 5.1 days
Paper/Electronic Hybrid System, CAM currently used in other areas of hospital



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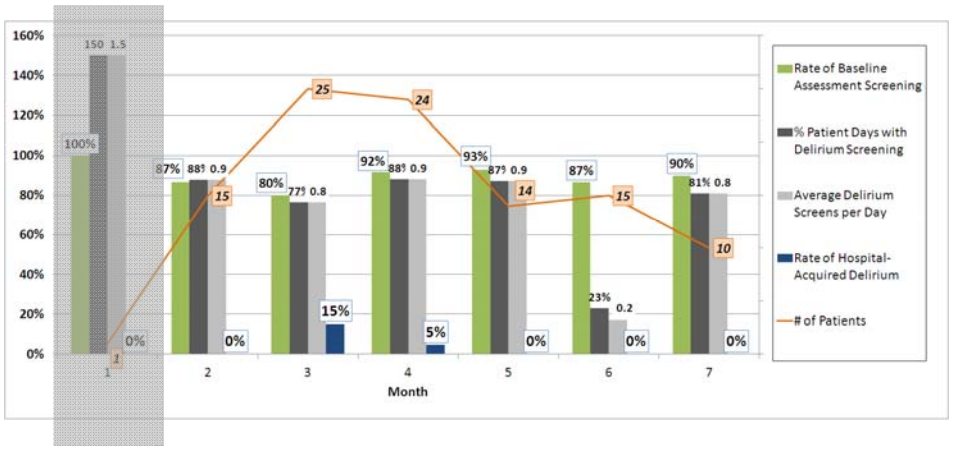
16

Delirium Implementation – Early Results

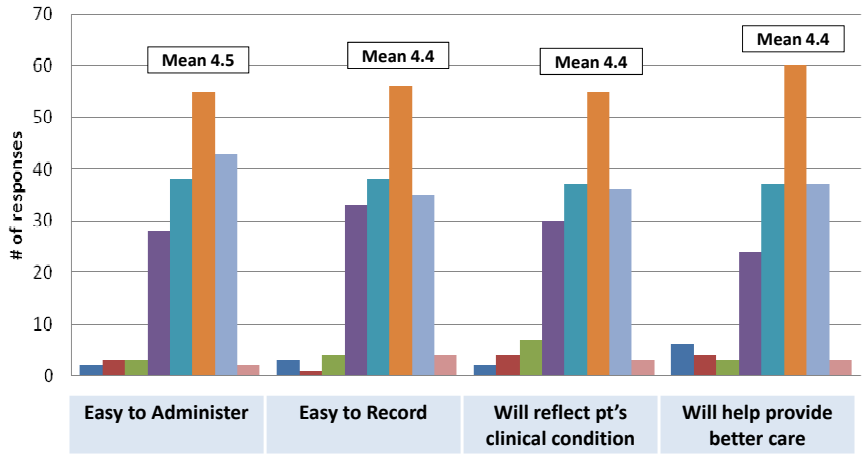
Community hospital, CCC/Rehab unit, ALOS 2-4 wks (rehab), 1-6 mths (chronic)
Paper-based System, CAM previously implemented, not currently used.



17

Functional Decline – Staff Perceptions

n = 174 point-of-care staff from 20 (out of 21) hospital sites



18

Functional Decline – Staff Perceptions

Positive	• Barthel Index can be scored quickly • HOBIC tool is efficient and straightforward
Challenges	• HOBIC tool is too long/has too many questions • workload and competing priorities • difficulties when conducting assessments (e.g. different languages, uncooperative patients, time needed to complete full functional Ax) • communication of assessments between shift changes • electronic databases need customizing for efficient input/retrieval
Use of the Data	• improve clinical awareness, trigger care plans and D/C planning • improve staff communication, participation, and collaboration • help target education and quality improvement initiatives • improve hospital/system goals (e.g. readmissions)

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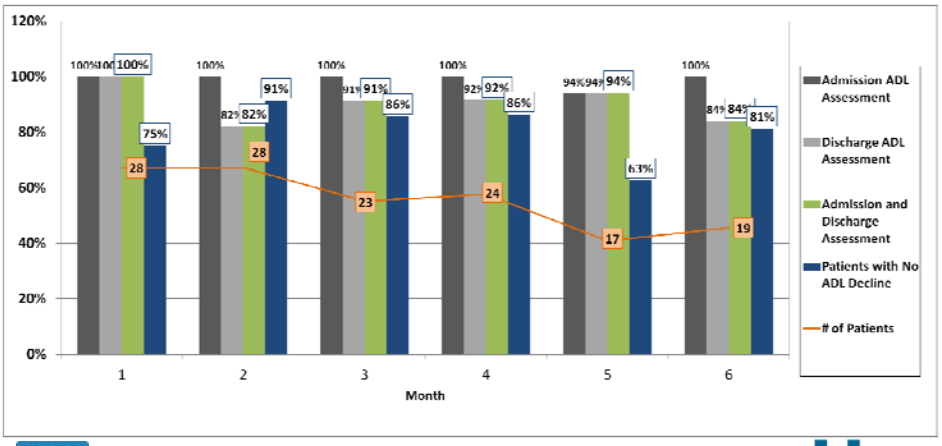
19

Functional Decline – Early Results

Community hospital, 16 beds medical unit, ALOS 7.6 days
Paper/Electronic Hybrid System, Implementing HOBIC



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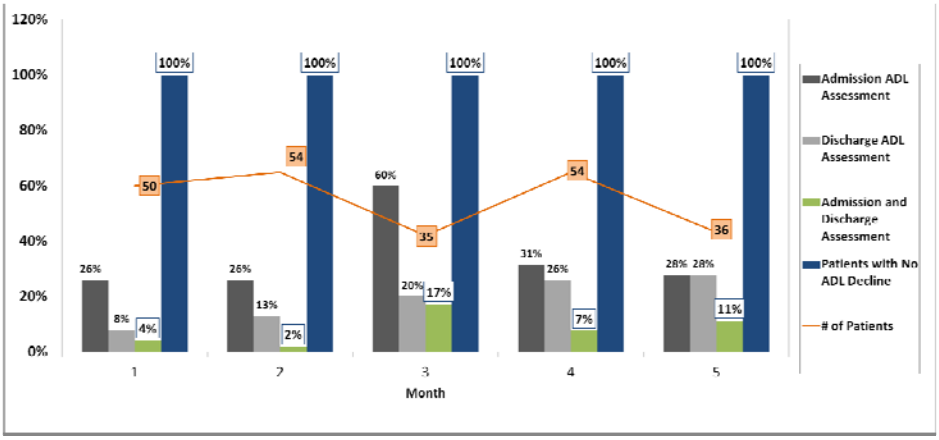
Functional Decline – Early Results

Community hospital, 16 beds medical unit, ALOS 6.42 days
Paper-based System, Implementing HOBIC



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21

Indicator Evaluation Summary

- 42 early adopter hospitals in 10 LHINS contributing to the evaluation of indicators
- Early lessons learned
  - Positive staff perceptions, +clinical value
  - Many of the challenges identified are system issues
  - Interprofessional engagement an important success factor
  - Need for education and training
  - Opportunity to improve compliance
  - Incidence rates of delirium appear consistent with literature
  - Further examination of functional decline window and technical specifications

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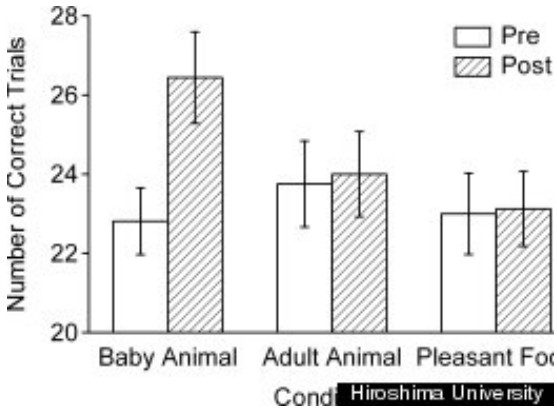
22

Kawaii

Kawaii



Nittono H. (2012) The Power of Kawaii: Viewing Cute Images Promotes a Careful Behavior and Narrows Attentional Focus.
PLoS ONE 7(9): e46362. doi:10.1371/journal.pone.0046362

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25

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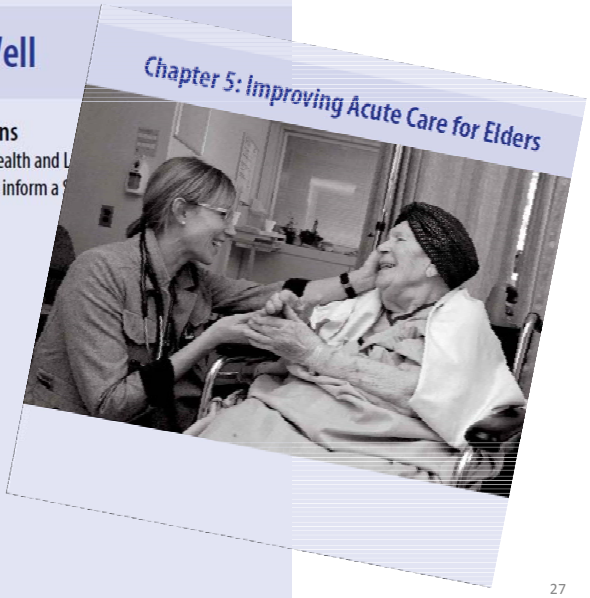
26

Living Longer, Living Well

Highlights and Key Recommendations

From the Report Submitted to the Minister of Health and L
Responsible for Seniors on recommendations to inform a

Dr. Samir K. Sinha, MD, DPhil, FRCPC
Provincial Lead, Ontario's Seniors Strategy



27

moveON

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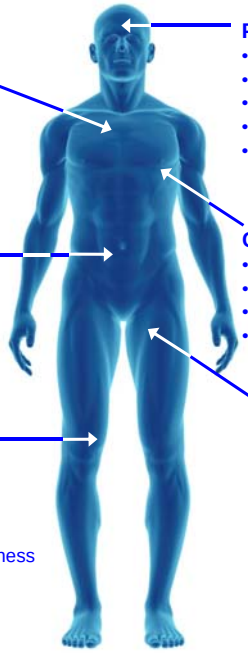
Mobilization of Vulnerable Elders in Ontario

Complications of Immobility



Respiratory System
- Decreased lung volume
- Pooling of mucous
- Cilia less effective
- Decreased oxygen saturation
- Aspiration
- Atelectasis

Gastrointestinal System
- Reflux
- Loss of appetite
- Decreased peristalsis
- Constipation

Musculoskeletal System
- Weakness
- Muscle atrophy
- Loss of muscle strength by 3-5%
- Calcium loss from bones
- Increased risk of falls due to weakness

Psychological
- Anxiety
- Depression
- Sensory deprivation
- Learned helplessness
- Delirium

Circulatory System
- Loss of plasma volume
- Loss of orthostatic compensation
- Increased heart rate
- Development of DVT

Genitourinary System
- Incomplete bladder emptying
- Formation of calculi in kidneys and infection

- Without mobilization, older patients lose 1 to 5% of muscle strength each day

  (Annals Int Med 1993;118:219-23)

- Without mobilization, elderly patients lose 1 to 5% of muscle strength each day

  (Annals Int Med 1993;118:219-23)

Early mobilization works

- Shortens duration of delirium (median of 2 days versus 4 days)
- Decreases rate of depression (odds ratio 0.14)
- Improves return to independent functional status (odds ratio 2.7 [95% CI 1.2 to 6.1])

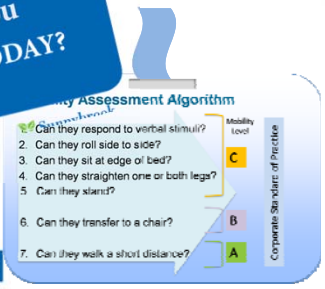
- Decreases length of stay (absolute difference of 1.1 days [95% CI 0 to 2.2 days])
- Increases rate of discharge to home (26.5% vs. 2.4%)
- Decreases hospital costs by $300/day

(Age Ageing 2007;36:219-22; J Gerontol 1998;53:307-12; Lancet 2009;373:1874-82.)

The key messages

1. Encourage mobility three times a day
2. Mobilization should be progressive and scaled
3. Mobility assessments should be implemented within 24 hours of the decision to admit

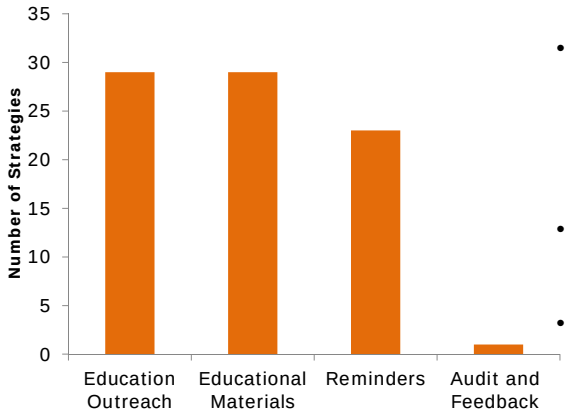
Educational Interventions



Moving Patients Together: Hands on Learning

- When? 10:45 am Wednesdays
- What? Bedside bullet teaching
- How long will it take? 10-15minutes
- Where? Listen for overhead announcement
- Who? All members of the interprofessional team

Project Results – Activities implemented



- Sites equally utilized education outreach and educational materials to deliver the MOVE ON intervention
- Most sites also added reminders to the intervention
- Only one site used audit and feedback as a strategy

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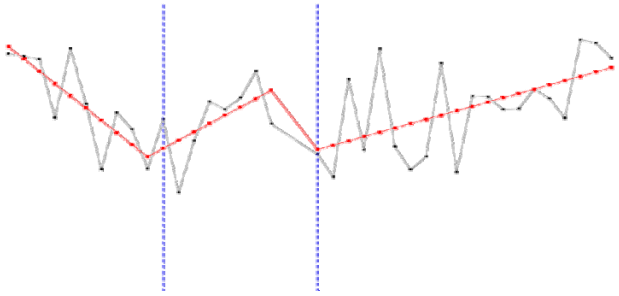
Preliminary results

- changes in rate of mobilization and LOS appear to be favourable.
- Further analysis is ongoing



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Staff Perception of MOVE ON

- ↑ sense of shared responsibility for mobilization
- ↑ communication
- ↑ interprofessional collaboration.

- + impact on unit culture - dispelling "sick culture".

"I get a lot of social workers and dieticians and pharmacists asking me to come in and just get the patient up so they can sit down and talk to them, and I have no problem doing that so it's really good to see that they're engaged in the mobility aspect of the patient as well as, you know, their role on the team as well."

"I think the… it brought to forefront the mobility thing, because usually when you think of people in hospital typically you think of people laying in the bed, but it changed that whole perception that, 'Well, do they have to by laying in a bed?' type. It's like, you know, it's the old-school thinking of what a hospital environment is."

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Reflections on success factors

Lessons learned from the implementation of MOVE ON

- Importance of stakeholder engagement
- Defining roles and planning intervention early
- Considering sustainability from project onset

Key enablers or success factors

- Effective communication between sites and coaches
- Involvement of diverse professionals and unit leaders
- Capacity building and training throughout the project
- Central Team's expertise on implementation initiatives and collaboration
- Alignment with Senior Friendly strategies

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Future Spread and Scale

Future Spread and Scale

- 14 hospitals implemented MOVE ON
- 7 MOVE ON hospitals are expanding the intervention to additional units (MOVE ON +)
- Some MOVE ON hospitals engaging in corporate rollouts of the initiative
- 11 non-CAHO hospitals expressed interest in MOVE ON in several provinces and in the U.S. and U.K.

Next Steps

- Developing support tools for selecting readiness to change and mobility assessment measures as part of a scale and spread initiative (funded through ARTIC)
- Potential to assess the impact of the MOVE ON intervention in other provinces (MOVE Alberta)

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Acknowledgements

- We would like to thank the CAHO hospitals that participated in MOVE ON.

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Ontario Coroner's Report

Recommendations on Senior Friendly Hospital implementation and delirium. OCC File No 2011-15213

The LHINs have been asked to respond to #1 by Feb 19, 2014

1. …LHINs to continue to steward the implementation of this (SFH) framework and its priorities to ensure excellent care for seniors in all Ontario Hospitals.
2. Health care providers should be …knowledgeable in the prevention and recognition of the clinical syndrome of acute delirium.
3. the investigation and management of delirium in hospitalized patients requires a coordinated, interprofessional team approach. Health care teams in acute care hospitals should have interprofessional clinical protocols for delirium…
4. Physicians …familiar with commonly cited literature regarding pharmacologic management of delirium.

- Delirium Prevention and Management
- Antipsychotic Stewardship
- Responsive Behaviours

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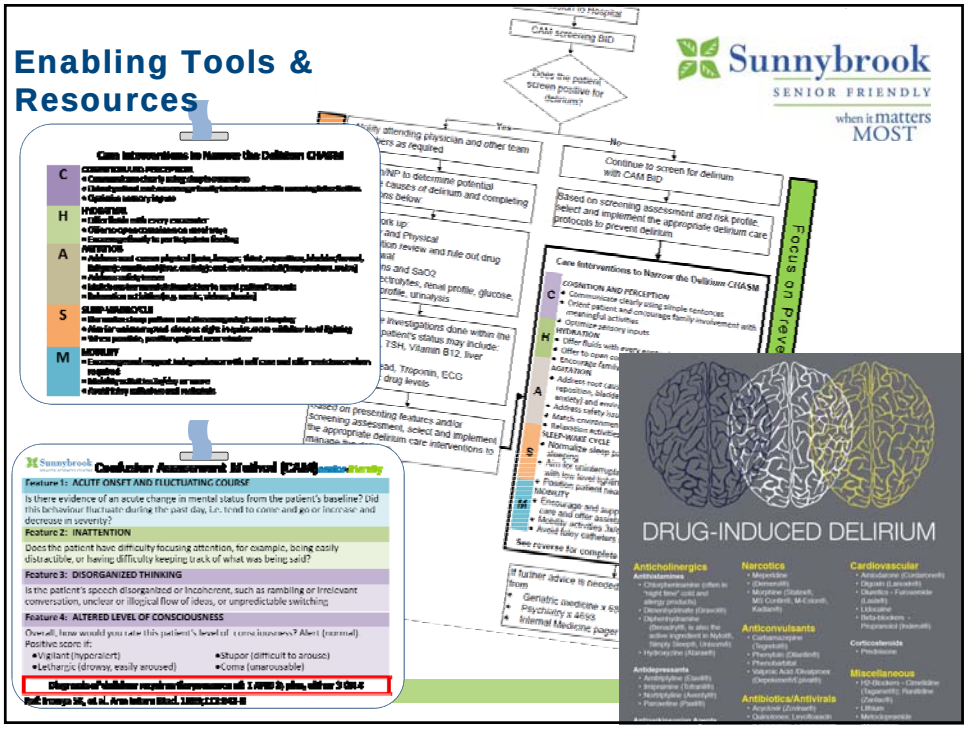
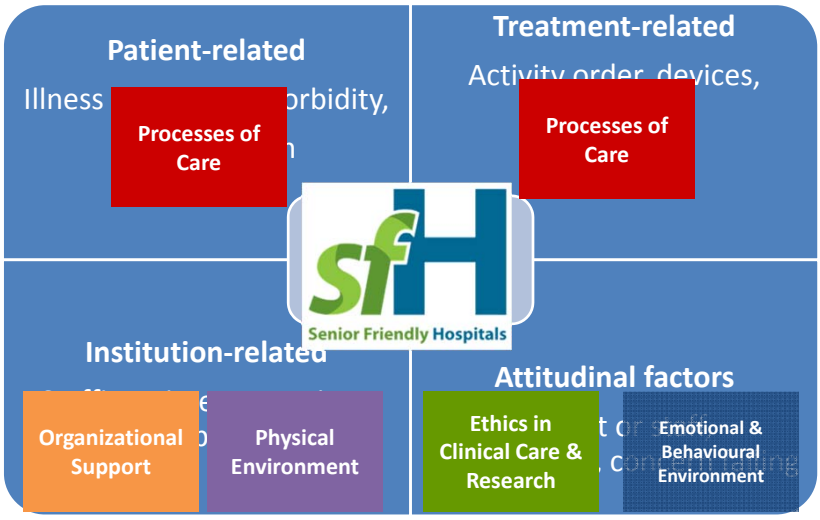
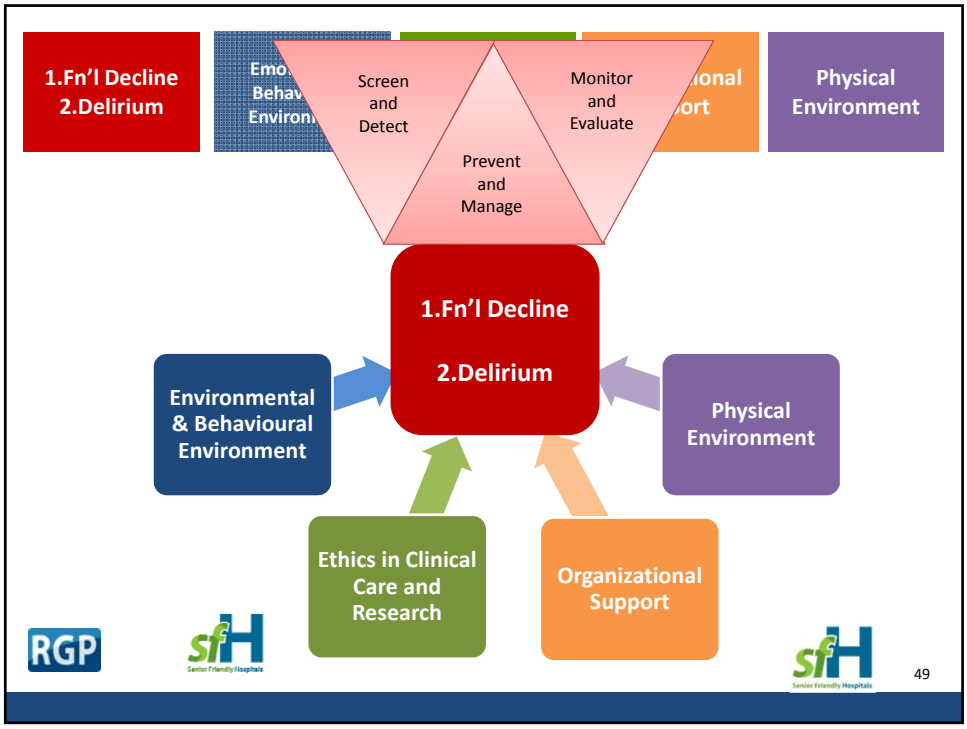
SENIOR FRIENDLY
when it matters MOST

Enabling Tools & Resources





Brown, C et al J Hosp Med 2007;2:305


1.Fn'l Decline
2.Delirium
Physical Environment
Screen and Detect
Monitor and Evaluate
Prevent and Manage
1.Fn'l Decline
2.Delirium
Environmental & Behavioural Environment
Physical Environment
Ethics in Clinical Care and Research
Organizational Support
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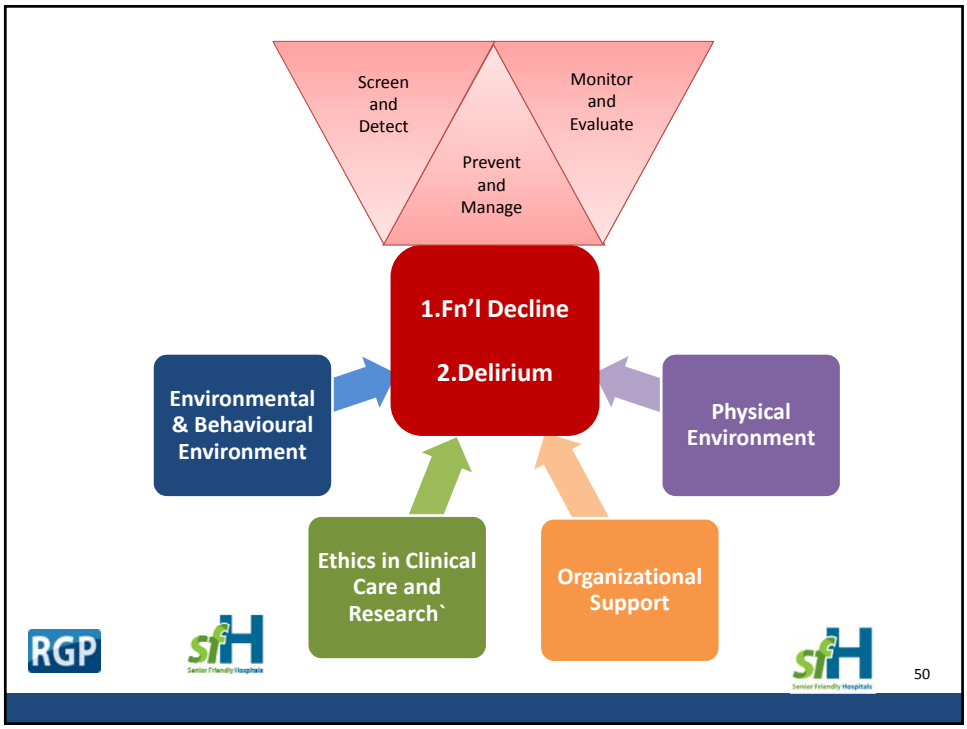
49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Organizational Support
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What's next?

- Indicator evaluation report in September
- Advocate with MOH, LHIN, HQO for SFH indicator inclusion in accountability/QIP
- Accreditation Canada –proposal to add Delirium as a new Required Organization Practice (ROP) - will be considered in 2015
- Expand collaboration webinars, coaching support to other hospitals – provincial SFH collaborative
- SFH Advanced Leadership Training Program for Ontario Hospitals
- Coordinated multisite delirium pre/intervention

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51

Acknowledgements

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Elizabeth McCarthy
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52

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Linette Perry
Maria Boyes
Susan Franchi
Karyn Popovich
Monidipa Dasgupta
Bruce Viella
Susan Bisaillon
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53

Thank you

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