The Hospital of the Future

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Provincial Lead, Ontario’s Seniors Strategy
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Assistant Professor of Medicine
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CLPNA Meeting
10 November, 2015

Twitter: @DrSamirSinha
Rethinking Traditional Models of Acute Care for Older Adults

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Presentation Objectives

- Demonstrate how current care delivery paradigms are problematic and require an elder friendly approach.

- Introduce the Acute Care for Elders (ACE) Strategy as a care model that can deliver better patient and system outcomes.

- Discuss the opportunities a future care system can have for nurses at all levels.
Establishing our Context

- 16.1% of Canadians are 65 and older, yet account for nearly half of all health and social care spending (Census, 2011).

- Canada’s older population is set to double over the next twenty years, while its 85 and older population is set to quadruple (Sinha, Healthcare Papers 2011).

- Canada and Alberta’s ageing populations represents both a challenge and an opportunity.
How Ready Are We?
Ontario hospitals unprepared for aging population
The province’s cash-strapped health system needs to start planning now for the challenges ahead.

Over the past decade, Ontario hospitals have become the most efficient in Canada, write Samir Sinha and Anthony Dale. But enormous challenges lie ahead.
# Ontario Inpatient Hospitalizations

<table>
<thead>
<tr>
<th>Age</th>
<th>Hospitalizations</th>
<th>Total Hospital Days</th>
<th>ALOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Total</td>
<td>992,533</td>
<td>6,253,167</td>
<td>6.3</td>
</tr>
<tr>
<td>Population 65+</td>
<td>414,339 (42%)</td>
<td>3,702,664 (59%)</td>
<td>8.9</td>
</tr>
<tr>
<td>65-69</td>
<td>7.8%</td>
<td>8.6%</td>
<td>6.9</td>
</tr>
<tr>
<td>70-74</td>
<td>7.6%</td>
<td>9.3%</td>
<td>7.7</td>
</tr>
<tr>
<td>75-79</td>
<td>8.0%</td>
<td>11.1%</td>
<td>8.8</td>
</tr>
<tr>
<td>80-84</td>
<td>8.0%</td>
<td>12.5%</td>
<td>9.8</td>
</tr>
<tr>
<td>85-89</td>
<td>6.3%</td>
<td>10.8%</td>
<td>10.8</td>
</tr>
<tr>
<td>90+</td>
<td>4.0%</td>
<td>6.9%</td>
<td>11.0</td>
</tr>
</tbody>
</table>

MOHLTC / Canadian Institutes for Health Information (CIHI) 2012-13
Only a small proportion of older adults are consistently extensive users of hospital services (Wolinsky, 1995)
What Defines our Highest Users?

- Polymorbidity
- Functional Impairments
- Social Frailty
The Top 5 System Barriers to Integrating Care for Older Adults

**Issue 1:** We Do Little to Empower Patients and Caregivers with the Information They Need to Navigate the System.

**Issue 2:** We Don’t Require Any Current or Future Health or Social Care Professional to Learn About Care of the Elderly.

**Issue 3:** We Don’t Talk to Each Other Well Within and Between Sectors and Professions.

**Issue 4:** We Work in Silos and Not as a System.

**Issue 5:** We Plan for Today and Not for Tomorrow with Regards to Understanding the Mix of Services we Should Invest In to Support Sustainability.
Why Should this Matter?

According to ICES, in Ontario amongst the 65+…

- The Most Complex 10% of Older Adults Account for 60% of our Collective Health Care Spending.

- The Least Complex 50% of Older Adults Account for 6% of our Collective Health Care Spending.

(ICES, 2012)
Our Future Will Cost Us More…

(Ontario Health Care Spending Predictions, MOHLTC).

$24 billion
Our Dilemma

The way in which our cities, communities, and our health care systems are currently designed, resourced, organised and delivered, often disadvantages older adults with chronic health issues.

As Albertans and Canadians, our Care Needs, Preferences and Values are evolving as a society, with increasing numbers of us wanting to age in place.
Developing an Elder Friendly approach
Acute Care for Elders (ACE) Strategy

- Redesigns or establishes new sustainable approaches that seek to enhance and improve upon current service models.

- Requires a shift in traditional thinking that currently underpins the administration and culture of most traditional care organizations.

- Is not adverse to identifying risk factors and needs and in intervening early to maintain independence.

- Requires a relentless focus on monitoring and evaluating its outcomes to support continuous quality improvement.
The Elder Friendly Hospital™ Model

These dimensions work together to minimize functional decline, promote safety, and mitigate adverse social and medical outcomes.

(Sparke et al, 2001).
The MSH Geriatrics Continuum of Care

- Home-Based Geriatric Primary/Specialty Care Program: House Calls
- Temmy Latner Home-Based Palliative Care Program
- Integrated Client Care Program
- Reitman Centre for Alzheimer's Support and Caregiver
- Training Community and Staff Education Programs
- Community Paramedicine Program
- Independence at Home Community Outreach Team
- Outpatient Geriatric Medicine, Geriatric Psychiatry and Palliative Medicine Clinics
- Telemedicine Clinics
- CCAC – Clinic Coordinator
- ISAR Screening
- Geriatric Emergency Management Nurses
- ED Geriatric Mental Health Program
- Geri-EM.com
- Geriatric Medicine, Geriatric Psychiatry and Palliative Medicine Consultation Services
- Orthogeriatrics Program
- Intensive Care Unit Geriatrics Program
- MAUVE Volunteer Program
- ACE Unit
- CCAC – ACE Coordinator
- ACE Tracker
- Safe Patients/Safe Staff
- Hospital at Home Program

New Programs Launched Since Fiscal Year 2010-11
Programs To Be Launched in Fiscal Year 2015-16
Evidence in Action
Hospital Avoidance Care Strategies

HOSPITAL AT HOME (Leff, 2009; Shepperd et al., 2009)

- Patients with acute illnesses requiring hospital-level care are identified in the ED and offered their care at home.
- Under this model costs were lower, patients experienced fewer clinical complications, mortality at six months was lower, and patients were more satisfied.

COMMUNITY PARAMEDICINE (Sinha, 2012)

- Paramedics often see frail older adults in their own homes in pre-emergent situations and have opportunities to intervene proactively by connecting them to more appropriate care.
- Paramedics are also being utilized to provide enhanced primary care.
Hospital at Home
Hospital at Home

A FUTURE STATE PATHWAY AROUND THE CORNER

1. Patient goes to ER
2. Patient is admitted into the hospital for a short stay. If eligible, patient is then transitioned to his or her own home and receives acute level care there.
3. When ready to be discharged, patient is transitioned from acute care to home/community care

Reduced LOS, ED visits and readmissions
Enhanced patient/caregiver experience
Reduced costs

Acute Care

Home Support
ED / Alternative Care Strategies

LTC NURSE-LED OUTREACH PROGRAM (Sinha, 2011)

- ED Based Mobile RNs, NPs +/- Paramedics provide urgent care assessment and management services with partnering LTC Homes.
- Model Involves - Prevention, Avoidance, Rapid ED Engagement and Follow-up Components.
- Up to a 30% decrease in ‘Non-Urgent’, ‘Less Urgent’, and ‘Urgent’ unscheduled Ambulance Transfers.
- The cost/visit with the Mobile Team is 21% less than an ED visit.
- Enhancements in resident quality of life, nursing knowledge, and overall ED and LTC provider satisfaction noted.
Intensive Care Management

THE INTEGRATED CLIENT CARE PROGRAM

- Intensive Care Management Programs can benefit our elders with the most complex issues.

- A Home Care Coordinator/Intensive Care Manager are assigned to manage the care of these patients throughout the continuum in close collaboration with Primary Care Providers and other Specialists.

- Goal is to ensure these patients access and receive appropriate and integrated care, experience smooth transitions, and are supported to remain at home for as long as possible.
Enabling Function through Design
ED-Based Risk Screening

HIGH RISK SCREENING AND IDENTIFICATION TOOLS

- Identification of Seniors at Risk - **ISAR** (*McCusker et al.*, 1999)

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Before the illness or injury that brought you to the Emergency, did you need someone to help you on a regular basis?</td>
<td>Yes</td>
<td>01</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>00</td>
</tr>
<tr>
<td>2. In the last 24 hours, have you needed more help than usual?</td>
<td>Yes</td>
<td>01</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>00</td>
</tr>
<tr>
<td>3. Have you been hospitalized for one or more nights during the past six months?</td>
<td>Yes</td>
<td>01</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>00</td>
</tr>
<tr>
<td>4. In general, do you have serious problems with your vision, that cannot be corrected by glasses?</td>
<td>Yes</td>
<td>01</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>00</td>
</tr>
<tr>
<td>5. In general, do you have serious problems with your memory?</td>
<td>Yes</td>
<td>01</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>00</td>
</tr>
<tr>
<td>6. Do you take six or more different medications every day?</td>
<td>Yes</td>
<td>01</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>00</td>
</tr>
</tbody>
</table>

≥ 2 = Predicts Functional Decline, Recidivism, Institutionalization
Ger-i-EM
Personalized E-Learning in Geriatric Emergency Medicine

Sign Up!
Click on the button below to register now.
Registration gives you access to interactive exercises, discussion boards, and much more.
Register today.

Register

Already a member? Sign In.
Username or Email
Password
Remember Me
Login
Lost your password?

What is Geri-EM?
Who Can Use Geri-EM?
This e-learning website was designed primarily for Physicians working in Emergency Departments who want to provide optimal care to their older patients.

It will also be of interest to all health-care providers who see older patients as part of their practice – in primary care, in hospital, in long-term care, or in the community.

Members of the public with an interest in geriatric care are welcome to explore the content on this website. We encourage you to register and participate in group discussions and interactive content.

What’s Included?
Each of the six modules in this website is designed to provide in-depth knowledge about issues in geriatric emergency medicine and includes:

- recommended readings
- resources for use in the ED
- knowledge assessments (pre-tests)
- knowledge checks (post-tests)
- teaching material
- in-page question and answers with immediate feedback
- videos of simulated patient encounters
- discussion boards

Continuing Medical Education Credits
College of Family Physicians of Canada
ED-Based Geriatrics Case Management

GERIATRIC EMERGENCY MANAGEMENT (GEM)

- ED Nurses focused on improving the care of older patients.
- Frail older patients receive specialized geriatric assessments and interventions to enhance their care.
- Effective at reducing hospital admissions, recidivism, and increasing adherence and satisfaction of patients and staff…

Sinha et al, Annals of Emergency Medicine, 2011
From: root@mshcrnapp1.mtsinai.toronto.on.ca [adm@mtsinaion.ca]
To: MSH - ICCP Patient Notification
Cc: 
Subject: ICCP Patient Alert Notification

Patient was registered in Emergency on 2013/01/24 at 13:17.
This is an ICCP Pilot patient.

MRN: 805-145-401
Name: [Redacted]
Visit: 2013-395574
DoB: 1910/02/17
Location: Emerg Dept - -
## Mount Sinai’s GEM Program 2014/15

<table>
<thead>
<tr>
<th></th>
<th>GEM</th>
<th>Non-GEM</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Visits (All Ages)</td>
<td>1024 (1.7%)</td>
<td>60,121</td>
<td>61,145</td>
</tr>
<tr>
<td>ED Visits (65+)</td>
<td>939 (7.4%)</td>
<td>11,689</td>
<td>12,628 (20.7%)</td>
</tr>
<tr>
<td>ED Visits (75+)</td>
<td>783 (10.5%)</td>
<td>6,665 (89.5%)</td>
<td>7,448 (12.2%)</td>
</tr>
<tr>
<td>Ambulance Arrival Rate (75+)</td>
<td>64.5%</td>
<td>41.8%</td>
<td>44.2%</td>
</tr>
<tr>
<td>Admission Rate (75+)</td>
<td>234 (29.9%)</td>
<td>2141 (32.1%)</td>
<td>31.9% (2,376)</td>
</tr>
<tr>
<td>Avoided Admissions (75+)</td>
<td>17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoided Bed Days (75+)</td>
<td>195</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost Avoidance w/ Avoided</td>
<td></td>
<td></td>
<td>$189K* (Savings)</td>
</tr>
<tr>
<td>Admissions 75+</td>
<td></td>
<td></td>
<td>in FY 14/15</td>
</tr>
</tbody>
</table>

* Canadian Dollars
Inpatient Geriatrics Services

INPATIENT CONSULTATION TEAMS

- Proactive consultation teams with control over medical recommendations and that provide extended ambulatory follow-up and management are more likely to be effective. (Palmer, 2003; Nikolaus et al. 1999, Marcantonio et al. 2001)

ACUTE CARE FOR ELDERS (ACE) UNITS

- Can reduce the incidence of functional decline, hospital lengths of stay, and nursing home admissions. (Palmer, 1994, 2000; Landelfeld, 1995; Wong, 2006)
- ACE Principles: patient-centred care, frequent medical review, prepared environments, comprehensive discharge planning
MSH Acute Care for Elders (ACE) Unit

A NEEDS BASED RESOURCING MODEL OF CARE

- 28 Bed GIM Unit – Converted to ACE in April, 2011
- Unit-Based Nursing and Allied Health Staff with advanced training in Geriatrics w/ Daily PT Coverage.
- GIM Staff remain MRPs and select patients for admission.
- Protocolized Order Sets mean same standard of care is provided whether on or off the ACE Unit – with a focus on function.
- Geriatric Medicine and Psychiatry Services provide support through consultation.
- Our home care agency has become a key external partner.
Safer Protocolized Care

Improving Practice Standards – For ACE, GIM and Ortho patients
## Evaluating Mount Sinai’s ACE Strategy

<table>
<thead>
<tr>
<th>Metric</th>
<th>Fiscal Year:</th>
<th>2009-10</th>
<th>2013-14</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department Visits (65+)</td>
<td></td>
<td>9,406</td>
<td>11,857</td>
<td>+26%</td>
</tr>
<tr>
<td>Medicine Admissions (65+)</td>
<td></td>
<td>1,573</td>
<td>2,155</td>
<td>+37%</td>
</tr>
<tr>
<td>Total Inpatient Bed Days (65+)</td>
<td></td>
<td>18,086</td>
<td>17,941</td>
<td>-0.8%</td>
</tr>
<tr>
<td>Total Length of Stay (65+)</td>
<td></td>
<td>11.5</td>
<td>8.25</td>
<td>-28%</td>
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<tr>
<td>Average Length of Stay / Estimated Length of Stay Ratio (65+)</td>
<td></td>
<td>95.6%</td>
<td>72.8%</td>
<td>-24%</td>
</tr>
<tr>
<td>% Return Home at Discharge (65+)</td>
<td></td>
<td>71.1%</td>
<td>79.1%</td>
<td>+11%</td>
</tr>
<tr>
<td>Average Alternate Level of Care Days per Patient (65+)</td>
<td></td>
<td>2.0</td>
<td>1.6</td>
<td>-20%</td>
</tr>
<tr>
<td>Medicine Bed Counts</td>
<td></td>
<td>88</td>
<td>76</td>
<td>-14%</td>
</tr>
</tbody>
</table>
## Evaluating Mount Sinai’s ACE Strategy

<table>
<thead>
<tr>
<th>Metric</th>
<th>Fiscal Year:</th>
<th>2009-10</th>
<th>2013-14</th>
<th>Percent Change</th>
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<tbody>
<tr>
<td>Readmission Within 30 Days (65+)</td>
<td></td>
<td>14.8%</td>
<td>12.8%</td>
<td>-14%</td>
</tr>
<tr>
<td>Catheter Utilization Ratio (65+)</td>
<td></td>
<td>56%</td>
<td>14.7%</td>
<td>-74%</td>
</tr>
<tr>
<td>Pressure Ulcer Incidence (65+)</td>
<td></td>
<td></td>
<td></td>
<td>-93%</td>
</tr>
<tr>
<td>Patient Satisfaction (65+)</td>
<td></td>
<td>95.4%</td>
<td>96.9%</td>
<td>+2%</td>
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</table>

Cost Savings Through More Efficient and Quality Care for Medicine Patients 65+ $6.7M* (Net Savings) in FY 2013-14 Alone

* Canadian Dollars
Evaluating MSH’s Orthogeriatrics Service

<table>
<thead>
<tr>
<th></th>
<th>Fiscal Year:</th>
<th>2009-10</th>
<th>2013-14</th>
<th>% Change</th>
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<tbody>
<tr>
<td>Emergency Department Visits (65+)</td>
<td>9,406</td>
<td>11,857</td>
<td>+26%</td>
<td></td>
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<tr>
<td>Hip Fracture Admissions</td>
<td>145</td>
<td>196</td>
<td>+35%</td>
<td></td>
</tr>
<tr>
<td>Total Inpatient Bed Days</td>
<td>2001</td>
<td>1627</td>
<td>-18.7%</td>
<td></td>
</tr>
<tr>
<td>Average Total Length of Stay (LOS)</td>
<td>13.8</td>
<td>8.3</td>
<td>-39.8%</td>
<td></td>
</tr>
<tr>
<td>Average LOS / Estimated LOS</td>
<td>115%</td>
<td>64%</td>
<td>-44.4%</td>
<td></td>
</tr>
<tr>
<td>Average ALC Days per Patient</td>
<td>4.0</td>
<td>2.9</td>
<td>-27.5%</td>
<td></td>
</tr>
<tr>
<td>Average Total Cost Per Case</td>
<td>$21,816</td>
<td>$13,965</td>
<td>-36%</td>
<td></td>
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</table>

Cost Savings Through More Efficient and Quality Care for Hip Fracture Patients 65+ $1.2M* (Net Savings) in FY 2013-14 Alone

* Canadian Dollars
Why Develop a Provincial Strategy?
Why Develop a Provincial Strategy?

- In 2011, the province announced a new vision to make Ontario the best place to grow up and grow old in North America.
- Given our current and future challenges, the development of Ontario’s Seniors Strategy began in 2012 to establish sustainable best practices and policies at a provincial level.
- With a focus on ensuring equity, quality, access, value and choice, recommendations were developed that could support older Ontarians to stay healthy and independent for as long as possible.
Living Longer, Living Well

- Supporting the Development of Elder Friendly Communities
- Promoting Health and Wellness
- Strengthening Primary Care for Older Ontarians
- Enhancing the Provision of Home and Community Care Services
- Improving Acute Care for Elders
- Enhancing Ontario’s Long-Term Care Environments
- Addressing the Specialized Care Needs of Older Ontarians
- Medications and Older Ontarians
- Caring for Caregivers
- Addressing Ageism and Elder Abuse
- Addressing the Unique Needs of Older Aboriginal Peoples
- Necessary Enablers to Support a Seniors Strategy for Ontario
The Province Responds…

- In early 2013, the Government of Ontario responds to *Living Longer, Living Well* with its *Action Plan for Seniors* with a focus on three core areas:

  - *Elder-Friendly Communities*
  - *Healthy Older Ontarians*
  - *Promoting the Safety and Security of Older Ontarians*

- To enable this bold new agenda, the Government of Ontario soon after appointed its *first* stand-alone Minister Responsible for Seniors Affairs
Our Future Requires Choices…

(Ontario Health Care Spending, MOHLTC).
Spending on Home and Long-Term Care Across OECD Nations.
We Have Choices and Options…

- One Day in Hospital Costs ~ $1000
- One Day in Long-Term Care Costs ~ $160
- One Day of Supportive Housing or Home and Community Care Costs ~ $55

- Denmark avoided building any new LTC beds over two decades, and actually saw the closure of thousands of hospital beds, by strategically investing more in its home and community care services.

- The Ontario government while freezing its hospital and physician budgets has committed to at least an annual 4% increase in the Home and Community Care Budget from 2011 through to 2017.
How We Are Enabling *Living Longer, Living Well* in Ontario

- Investments in Health Promotion and Prevention in Older Ontarians (eg. Healthy Ageing Fairs, Exercise and Falls Prevention Classes, Vaccinations).
  - In 2013-14 – Free Exercise and Falls Prevention Classes were launched in 1,895 locations across Ontario and served **106,476** Clients.

- Ensuring all Older Ontarians have access to a primary care provider and the primary care they need (eg. More House Calls) is a Health Links Priority
  - In Ontario where half of its PCPs (5,850) and 553 Specialists performed **268,317** House Calls to 95,056 distinct patients in 2011-12.
  - In 2013-14 we saw **42,570** more house calls being performed and **12,680** more patients getting house calls in Ontario compared to 2011-12.

- Work is underway to ensure our future health and social care workforce has the knowledge and skills needed to care for Older Ontarians.
How We Are Enabling *Living Longer, Living Well* in Ontario

- Current and Future Investments are being prioritized to strengthening Home, Community and Long-Term Care. *(eg. Convalescent Care).*
  - **Ontario** has **250** additional convalescence care beds in place to allow people the opportunity to stay in or return to the community.
  - The **Supply** (-2.7%) of, **Demand** (-6.9%) for, and **Placement** Rates (-26%) into LTC Beds have all decreased in Ontarians aged 75 and better.

- Traditional Scopes of Practice are being Expanded to Improve and Bring Care Options Closer to Home *(eg. Pharmacists Giving Flu Shots, Community Paramedicine).*
  - *In 2013-14* – Over **750,000** Ontarians received their Influenza Vaccination through a Pharmacist
  - *In 2014-15* – Over **30** 12 Month Community Paramedicine Demonstration Projects have been launched across Ontario
What Excellent Care for All Older Ontarians Is Looking Like…

**Promoting Wellness across Elder Friendly Communities**
- Single points of access to information exist to empower and support self-management and the work of unpaid caregivers.
- Wellness and prevention programs reduce de-conditioning and social isolation, and improve functional capacity, independence and older adults ability to stay home longer:
  - Promoting screening and early linkages to the appropriate support services supports ageing in place and the needs of caregivers.

**Supporting Ageing in Place**
- Strengthened Primary Care models improves access and provide more home-based care options (eg. house calls).
- More investments in lower-cost community care options like home care and supportive housing lessen demands and pressures on more expensive hospitals and long-term care facilities.
- New technologies like tele-homecare are allowing people to stay and receive more care at home.

**Elder Friendly Hospital Care and Effective Transitions**
- When hospital care is required, older adults benefit from a sensitized and responsive hospital system that prioritizes the preservation of function and a return to one’s home in the community.
- Seamless and safe discharges that connect hospital, community and primary care providers are integral in managing transitions.
- Opportunities to leverage more preventative models like “Community Paramedicine” or “Hospital at Home” exist are being pursued.

**Enhanced Long-Term Care Environments**
- Quality long-term care is always there for those who require it.
- Improvements in the capacity of our long-term care sector to provide more short-stay and restorative care options is helping older persons and the caregivers stay at home longer.
What Could this All Mean for Nurses and Other Professionals?
Key Strategic Themes/Areas of Focus

- Supporting the Development of Elder Friendly Communities
- Promoting Health and Wellness
- Strengthening Primary Care for Older Ontarians
- Enhancing the Provision of Home and Community Care Services
- Improving Acute Care for Elders
- Enhancing Ontario’s Long-Term Care Environments
- Addressing the Specialized Care Needs of Older Ontarians
- Medications and Older Ontarians
- Caring for Caregivers
- Addressing Ageism and Elder Abuse
- Addressing the Unique Needs of Older Aboriginal Peoples
- Necessary Enablers to Support a Seniors Strategy for Ontario
What Unites These Professions?

- Nurses
- Physicians
- Social Workers
- Pharmacists
- Therapists
- Physician Assistants
- Personal Support Workers

**NONE** are required to receive **ANY** formalized training in the care of the elderly…When You **DON’T KNOW WHAT YOU DON’T KNOW**?…
What I have learnt…

- A lack of skills, knowledge, and training opportunities affects one’s confidence and comfort in working with certain populations.
- Education and Training doesn’t stop in school – as professionals need to be involved in lifelong learning.
- The future of care will largely rely on unpaid caregivers, PSWs and Nurses – we need to better for these groups…
- When we don’t acknowledge or celebrate the achievements of a group – it can be seen as a devaluing of the work force.
LPNs in Alberta

- LPNs represent growing part of our provincial nursing workforces with the majority working with older adults.
- LPNs are increasingly working in primary and community care settings as well as long-term care and hospital settings.
- Alberta LPNs are among the first in Canada to have mandatory training in geriatrics and dementia care. The 2015 Competency Profile takes things to a whole new level.
- LPNs will increasingly need to play a leadership role in the way we shape the delivery of elder-friendly care in Alberta.
Where LPNs Can and Should Lead…

- Ensuring Albertans and Decision Makers UNDERSTAND what LPNs are and how they uniquely contributes to helping Albertans stay health and independent.

- Establishing New Nursing-Led Models of Care
  - Inpatient, Outpatient and Community-Based etc.

- Encouraging Evidence-Based Practices and Guidelines
  - RNAO Best Practice Guidelines…

- Enhancing Education and Training Opportunities
  - Establishing Mandatory and Relevant Course Content
  - Establishing more Community and Geriatric Placements
  - Establishing Geriatric Nursing Residencies/Fellowships
Concluding Thoughts

- Whereas hospitalization offers older patients potential benefits it also exposes them serious risks.

- Pursuing an ACE Strategy requires a shift in traditional thinking to build the right hospitals for our future.

- Programs only succeed through collaboration and partnership internally and externally.

- Implementing an ACE Strategy Principles will allow us remain leaders in the delivery of complex care across the continuum.
This is Our Time to Lead
Thank You

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