**PILOT PROPOSAL:**

**A Guide to**

**Successful Placement**

**of Individuals experiencing**

**Dementia / Behaviour**

**in Long-Term Care**

SUBMITTED: JUNE 2019

**PARKWOOD MENNONITE HOME**

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| About Parkwood Mennonite Home | | |
| Parkwood Seniors Community is a not-for-profit, charitable, faith-based campus with a history of more than 55 years of providing retirement living options. |  | Parkwood Seniors Community offers a bright, welcoming environment, caring staff and activities that contribute to an enjoyable, meaningful life. This campus of care offers a range of options for retirement living:   * 18 condominium-style Garden Homes for seniors living * independently * Parkwood Suites Retirement Residence with Independent, * Supportive and Assisted Living options in 77 suites and apartments * A 96-bed Long‑Term Care Home |

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| Introduction | | |
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| **Nearly 80% of Residents enter LTC with some degree of dementia.** |  | Transitioning from a Hospital to a LTC Home can be stressful for anyone. For individuals experiencing dementia/ behaviours, the transition to the Home can be particularly challenging and day-to-day quality of life may be difficult to achieve without the appropriate supports and programming. |
| The Need:  Patients in ALC beds experiencing dementia/behaviours are difficult to place. |  | Currently, 15% of Grand River’s Hospital acute care beds are not available for new admissions as they are occupied by patients who require an alternate level of care (ALC). The hospital is working to reduce its number of ALC beds to 9%. Some of these beds are occupied by individuals who are experiencing dementia and difficult to manage behaviours.  There are several barriers to transitioning some of these patients to LTC. There are extensive waitlists for LTC beds as the demand exceeds the supply, and the demand is growing. The Province is seeking to address this with the addition of 15,000 new beds by 2025, and more beyond that date.  For now, this means people who are determined ‘crisis’ placements have priority placement to the few beds available. This includes Parkwood Mennonite Homes. Crisis placements are typically from the community, as patients are not deemed crisis when they are receiving safe care in a hospital.  Another barrier exists in the LTC homes themselves, which may be reluctant to accept individuals experiencing dementia/behaviours based on the Home’s lack of staffing resources required to care for the specific needs of challenging behaviours.  When such an individual is transitioned into LTC, it is common for that LTC Resident to require one-on-one care funded through the Ministry of Health’s High Intensity funding program, up to 24 hr/day, every day, often up to a year.  If and when placed, there is a high risk that these individuals may be returned to the Hospital through an Emergency visit and once again become deemed ALC. |
| Proposed Pilot:  A two-part approach to successful placement of Individuals experiencing dementia / behavior |  | Parkwood Mennonite Home proposes an innovative approach to successfully place individuals who have high intensity needs due to dementia / behaviours.  A successful placement begins with a good transition from Hospital to Home. Once the Resident is settled in, enhanced and individualized programming will help to ensure the best possible quality of life and avoid future transitions. |
| Pilot Funding and Support requested from the Province |  | Parkwood Mennonite Home is requesting pilot funding for:   * 2 Program Staff and 1 BSO trained PSW (6 months) * Preferred accommodation funding   Parkwood also requests, for the purpose of the pilot, the Province lift/reduce legislative rules to allow:   * High Intensity funding Residents would receive (regardless of participation in pilot) for the duration of the pilot, as required, without requirement to reapply monthly * Preferred accommodation prioritized/designated for pilot participants * Concessions to support Adult Day Program e.g., menu selections, allowing staff to eat with Residents |
| Anticipated Outcomes |  | Through a seamless transition, individualized programming, and a more person-centric wrap-around care approach, Parkwood anticipates significant benefits:   1. Improve the safety and experience of the transition from Hospital to LTC for the patient and their family/care providers 2. Improve the individual’s quality of life in LTC 3. Increase overall satisfaction with the experience for all (Resident, family/care-providers, staff) 4. Reduce costs related to High Intensity (reduce number of hours needed per day, reduce overall amount of time needed), through reduction in behaviours as a result of participating in Adult Day Program 5. Reduce workplace violence of Resident to staff and Resident to Resident. 6. Reduce Emerg visits and hospital readmits 7. Strengthen relationships between hospital and LTC, improve communication, collaboration and information sharing, which will support the future Ontario Health Team (Parkwood is an early signatory to the KW4 OHT) 8. Help the province to realize the cost benefits realized through reducing the number of ALC beds (which are more expensive than LTC beds, with supports) and hospital readmits 9. Create a Guide that can be used by other LTC Homes in Ontario to help their local hospitals place patients experiencing dementia with behaviours who are occupying ALC beds, which will open up acute care beds for new patients and contribute to the reduction of Hallway Medicine. |
| Part 1:  Admission Transition Team  Transitioning from Hospital to LTC Home  Improving the experience of the transition from Hospital to LTC Home begins with a person-centric approach. |  | For those with dementia behaviours and their loved ones, experiencing a safe and successful transition from Hospital to LTC Home promotes peace of mind and confidence in all partners supporting the transition.  Parkwood will pilot a new approach to the transition, in partnership with WWLHIN/ Psychogeriatric Resource Consultant (PRC), and Grand River Hospital, that is safe, calm and kind. |
| Part 2:  Adult Day Program  Residents experiencing dementia / behaviours can enjoy quality of life |  | Once the Resident has successfully transitioned to the LTC Home, the Resident has the opportunity to participate in a highly individualized care plan through an Adult Day Program.  The Adult Day Program will promote quality of life through enriched activities and programs designed to support physical, mental, emotional and spiritual well-being. |
| Partners |  | The pilot will take place at Parkwood Mennonite Home and will include a Transition Coach, Parkwood’s amenities, and supports for the Adult Day Program, provided in partnership with:   * the Ministry of Health and Long-Term Care (provide pilot funding) * the LHIN/Behaviour Supports Ontario (provide Psychogeriatric Resource Consultant (PRC) support) * Grand River Hospital (provide Coach and clinical supports) * Residents and their family members who agree to participate in the pilot * Parkwood has 222 Volunteers and we would invite them to participate, with the help of some extra training |
| Transition Team:  Three Coaches |  | Parkwood proposes the creation of an Admission Transition Team to the lead the pilot.  Each partner commits to providing a Coach:   1. Coach from Hospital – pre-Transition and six weeks following Transition 2. Coach from Parkwood – ongoing 3. Coach from LHIN (Psychogeriatric Resource Consultant) – as required |
| Interdisciplinary Team - ongoing |  | * OTA / OT * PTA / PT * Restorative * Pharmacist * Medical Director * Psychogeriatric Resource Consultant * Spiritual Care / social Work * Recreation * Dietitian * R.A.I. Coordinator (do the data, case mix index) * Nurse Practitioner * Psychiatrist (Hospital) * OTN |
| Part 1:  Parkwood commitment  Pre-Transition, Transition |  | * Provide a Transition Companion (High-Intensity – 95% MoH, 5% Parkwood) for 6 weeks, 12 hours a day, to be reduced incrementally, if and as appropriate * Provide transportation (via Parkwood’s bus) to and from the Hospital in the pre-transition phase * Provide programs, amenities, trained staff |
| Part 2:  Parkwood commitment  Adult Day Program |  | * Provide the space for the program, plus the additional facilities and amenities to operate the Adult Day Program * 2 Program staff and 1 BSO trained PSW (Parkwood will hire and train)   *Note: funding for Program staff and PSW requested from Province for this pilot* |
| The overarching goal is to incorporate the Adult Day Program for all LTC Residents experiencing dementia / behaviours |  | Parkwood and Fairview seek to shift the model of care for individuals experiencing dementia / behaviours into a more Resident centric model.  Through this pilot, the organization aspires to develop an Admission Transition Team and an integrated, wrap-around care model through the Adult Day Program that can be implemented at Parkwood Mennonite Home and Fairview Mennonite Homes to transition people experiencing dementia / behaviours from both the Hospital and the Community, seamlessly, into our Homes, and provide quality of life.  Further, the team hopes to pilot these new models and hold them in a state of readiness for full implementation upon the addition of LTC beds at each Home.  Parkwood is willing to pilot the model and leverage our extensive onsite amenities and programs, as well as tap into the staff’s expertise in restorative programming. Resident’s families/caregivers will be invited to participate in the Resident’s advanced care planning and education concerning the pilot.  Parkwood believes this new model of care will have a tremendous positive impact on the successful placement of individuals experiencing dementia / behaviours, as well as their loved ones. Additionally, it will help reduce the number of patients in ALC beds in the local hospital.  Through this pilot, Parkwood will develop and publish a guide to help others roll out this model in their LTC Homes to benefit all of the people of Ontario. Parkwood hopes to identify a research student / professor for assistance. |

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| Part 1: Admission Transition Team | | |
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| Safety |  |  |
| Transitioning from Hospital to LTC Home |  | Improving the experience of the transition from Hospital to LTC Home begins with a person-centric approach.  For those experiencing dementia / behaviours and their loved ones, a successful transition goes a long way toward creating an experience that is characterized by peace of mind and confidence in the partners associated with the transition.  *Parkwood, with its partners, will pilot a new collaborative approach to the transition process that is safe, calm and kind****.*** |
| Pre-Transition: Communication with Hospital Coach |  | Three Coaches (Hospital, Psychogeriatric Resource Consultant (PRC), Parkwood) will communicate:   * Parkwood has a bed * Hospital has an ALC patient waiting for placement * Assess: Look at patient’s current and evolving care requirements * Risk Assessment (see below) * Determine if patient is appropriate for the program * Discuss estimated / targeted date of transition |
| Risk Assessment |  | * Takes place at hospital * Coach from Parkwood will visit individual prior to acceptance, with Pilot Admission criteria checklist * Patient assessed for physical and psychological readiness for care transition * Medication Reconciliation * Medical Assessment * Environment Assessment; safety for existing Residents * Family Support Assessment |
| Parkwood Staff Education |  | * Gentle Persuasive Approaches (GPA) * Mental Health first aid * Code White * Self Defence * Addictions * Montessori |
| Indicators |  | The pilot will capture indicators that are continually monitored to evaluate:   * The initial and ongoing need for one-on-one companion (High Intensity) and if so   + how much time each day / week and   + over a period of how many months * If a Resident would benefit from the Adult Day Program * Whether the Resident is benefiting from the Adult Day Program, once participating, observed through:   + Reduced need for one-on-one companion   + Risk level of behaviours is improved   + Resident is enjoyed improved quality of life   *Note: Indicators for success as well as challenges to be developed by Project team / coaches / companion* |
| Additional considerations |  | * Each Resident will require the right care companion/ attendant i.e. Male companion for male resident |

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| Transition | | |
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| Pre-Admission Checklist |  | * Admission Checklist to orient the Resident * Resident, their family, caregivers and the inter-professional team collaborate to develop/review an individualized care plan that supports the unique needs of the Resident * Admission Transition Team will review details of Adult Day Program for LTC with Resident and their family/caregivers   *Notes:*   * *Ipad used to capture data and ensure checklist is followed* * *Orientation checklist and Plan in development* * *BSO has developed a transition checklist into LTC* |
| Adult Day Programming begins as part of pre-admission |  | * Transition team has identified and assessed patient as meeting the Pilot criteria * Patient begins orientation to the LTC Home through the Adult Day Program, while still in hospital * Once a bed becomes available, and patient has been successful in Adult Day Program, patient will be admitted to Parkwood LTC Home |
| Admission |  | * Admission takes place on Monday, Tuesday or Wednesday to allow for 48 hours follow-up with the Hospital * Orientation to LTC during the first week * One-on-one support begins upon admission with Parkwood Companion (High Intensity) * Resident will be placed in a Private Room for the duration of participation in the Pilot * Room set-up will be individualized and completed prior to admission * Family / caregiver will be encouraged to participate in the admission process * Admission Conference includes three Coaches upon arrival and at six weeks; success will be evaluated at each of these conferences * The admission process is considered to be six weeks; hospital coach participates throughout this period |
| Adult Day Programming continues during orientation |  | * Resident will continue to participate in the Adult Day Program during orientation week, ensuring a familiar, continuation of programming |

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| Care | | |
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| Companion  High intensity |  | * Individualized programming 12 hours/day, 7 days/week * Companion will have a specific job description to include detailed documentation of resident care needs * Funded under High Intensity |
| Adult Day Program |  | * Following admission to LTC and throughout orientation, Resident continues to participate in Adult Day Program (see below) * Resident to attend adult day/program: 7 hours/day, 5 days/week * Companion care may be extended into Adult Day Program as determined by individual resident needs |

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| Information Flow | | | |
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| Timely, relevant information |  | Residents, family members, care providers and the Inter-professional team members will share information so they have it, when they need it, in a format they can use and understand. | |
| Consistent, continuous improvement |  | * When the patient applies to be admitted to Parkwood, ensure the application, medical history and assessment are up-to-date immediately prior to potential admission at Parkwood * Coaches, Companion and all members of the team, including Adult Day Program team, will document and share information; all will be provided with the tools; documentation will be consistent and timely * Documentation tools and communication strategies (such as checklists) are standardized to support soft, effective transitions * Prior, during and following transitions, Residents and families are provided the information and education they need to make decisions and support the care plan * Feedback is sought to continually improve communication effectiveness * Discharge summaries (if any) are transmitted to post-discharge providers within 48 hours   *Note: software platform for documentation tbd* | |
| Tools |  | * Ipads * Electronic Medical Health record shared with Parkwood; follows the patient |

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| Part 2: Adult Day Program | | |
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| Adult Day Program Details | | |
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| **Adult Day Programs** |  | Adult Day Programs proliferate in the community to support adults with a variety of needs, including those experiencing the early stages of dementia.  These programs are tailored to the needs and limitations of the individual participants. Those with similar needs participate in group programs.  Regular exercise and activities, including social activities, are important for everyone’s overall health.  For Residents experiencing dementia / behaviours, individualized programs can help to improve and reduce behaviours, improve sleeping patterns and improve quality of life. This benefits the Resident, their family, and the staff providing care and programming in the LTC Home. |
| Opportunity |  | Parkwood’s exceptional amenities on campus have long provided Residents with the opportunity to enjoy fitness activities, swimming, fitness room, entertainment, outings using the Home’s bus, and more. Parkwood has all of the amenities and programs to support special, individualized Adult Day Programming for LTC Residents experiencing dementia and behaviours.  The staff already has extensive experience in programming for Residents with special needs due to dementia, supported by our BSO trained team, and specialized therapeutic programs and services.  Parkwood’s sister home, Fairview Mennonite Homes in Cambridge, has extensive experience with Adult Day Programs, which currently offers two programs in partnership with the City of Cambridge |
| Participants |  | In addition to the identified partners, Parkwood may also reach out to partners such as the Alzheimer Society and the Schlegel Research Institute for Aging (Waterloo) to provide programming input. |
| Programming |  | * 5 days/week, Monday – Friday; weekends act as a form of Control to study behaviours on days when not attending Adult Day Programming and are also typically the time when loved ones visit * Includes two existing Parkwood Residents  (acts as a form of control) * Team – must be comprised of the right Companion (good fit) for each Resident; BSO Nurse and PSW currently employed at Parkwood * Adult Day Program will start at 1:30 p.m. (Monday – Friday), avoiding the barriers that an early morning start presents * Participants can sleep in * Program goes into the evening * Incorporates restorative approach * Personal Care * Meals/Snacks: Family style; staff eat with Residents * Choice flexibility in menu * Meds * May include trained Volunteers |
| Existing Amenities |  | The Program will be integrated with the existing Campus amenities to engage in supervised social and fitness activities, including:   * Swimming in onsite Pool * Art, music, pet and horticulture therapy * Fitness centre and exercise program * Entertainment in auditorium * Social outings, using Parkwood’s bus * Activity room, including a servery, to enjoy healthy snacks and a meal, conversation and social interaction |
| A Day in the Life: Adult Day Program | | |
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| Home Area |  | * One-on-one with Companion (High Intensity) * Individualized programming based on Resident’s needs, abilities, preferences |
| Location |  | * Parkwood Retirement Suites (outside of resident home area): main floor with access to pool, fitness centre, servery, washrooms, change rooms, games and sunroom |
| 1:30 p.m. |  | Program Start – gathering and conversation   * Welcome participants for the day in Activity room, located near a servery * Enjoy coffee and dessert together (instead of in the dining room following lunch) * Conversation and healthy interaction * Pick-up Adult Day Program patient participant from hospital with Parkwood’s bus, accompanied by Companion; join in upon arrival |
| 2 p.m. |  | Physical Activity options:   * Swimming * Bowling * Fitness classes and one on one use of treadmill, NuStep, stationary bicycle * Therapeutic Gardens walk and/or horticultural therapy * Activities of daily living stations e.g., laundry table, fidget activities, puzzles, dish washing, flower arranging, tool bench, shoeshine, silver polish, etc. * Attend Campus large group, regularly scheduled, events and presentations (music, worship, choir, special guest) * Art, music, pet and horticulture therapy * Outings, with bus |
| 3 p.m. |  | Afternoon Activity options   * Baking – to have for snack * Arts and Craft- knitting, sanding, cutting, quilting, painting * Spiritual Care * Reading * Station activities |
| 3:30 p.m. |  | * Snack Time * What’s new in the news —can be done with computer and screen to show news stories, world events, weather, sports, etc. * Rest time as needed |
| 4 p.m. |  | Activities   * Station activities * Restorative walking to dining room, ROM, etc. |
| 5 p.m. |  | Evening meal in day program dining space   * Restorative: help to prepare and clean up |
| 6 p.m. |  | Social Time   * Reminisce and Reflection * Games- sorting, cards, Montessori activities, |
| 7:30 p.m. |  | * Return patient participant to hospital |
| 7:30 p.m. |  | Restorative approach   * Brushing Teeth * Washing Face * Change into pajamas |
| 8 p.m. |  | * Return to room (other Residents in Home area are already settled for the night) * Bedtime |
| Discharge Process: | | |
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| Criteria |  | Admission Agreement, Hospital MOU to address discharge from pilot; e.g.,   * Resident condition changes and Resident must return to Hospital * Resident completes pilot Move from private to basic room * One-to-one companion   *Note: Criteria to be developed by Project partners* |
| MOU with Hospital |  | 1. Hospital resourcing commitment 2. Conditions/criteria to return Resident to Hospital 3. Process to return to hospital i.e., usual process is through emerg   *Note: Criteria to be developed by Project partners* |

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| Evaluation: | | |
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| Indicators |  | A number of indicators will be developed to:   1. Determine Resident’s status as High Intensity 2. Determine if/when High Intensity status can be removed 3. Determine if the Adult Day Program is having a positive (or negative, or no discernible) impact   The team will incorporate DOS Charting (every half hour) to evaluate:   * Behaviours * Mood * Dining interactions * 7-day check list (Montessori approach)   *Note: criteria to be developed in partnership with project team, including Psychogeriatric Resource Consultant and BSO* |
| Follow-up with Hospital |  | As required and pre-arranged:   * Psychogeriatric Therapist / Psychiatrist * Other   *Note: criteria for ongoing Hospital support to be developed in partnership between Coaches and other team members as required* |
| BSO support |  | *Note: in partnership, determine criteria to identify if and when Resident can begin weaning off High Intensity; identify supports required moving forward* |

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| Budget |

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|  | |  | **Contributed by** | | | | |  | | |
| **Item** | **Cost** | | **Existing Ministry funding** | **Net New Ministry funding** | **WWLHIN** | **Hospital** | **Parkwood** | **Notes** | |
| **Education** | $30,000 | | $0 | $0 | $10,000 | $10,000 | $10,000 | TBC: partners contribute $ and staff toward education | |
| **Tools, Equipment, Environment, Home Area** | $80,000 | | $0 | $0 | $0 | $0 | $80,000 | Parkwood has fundraised this amount for the pilot already | |
| **Lead for Pilot**  **6 months** | $52,500 | |  |  |  |  | $52,500 | Assumption: $105k annual salary, prorated | |
| **3 Transition Coaches**  **6 months each** | $157,500 | | $0 | $0 | $52,500 | $52,500 | $52,500 | Assumption: $105k annual salary x 3, prorated | |
| **Amenities and Program** | $54,900 | | $0 | $0 | $0 | $0 | $54,900 | TBC: estimated at $50/6 persons/183 days | |
| **4 Companions\*** | $60,480 | | $60,480 | $0 | $0 | $0 | $0 | \*High Intensity $: 12 hrs day x $30 hr x 42 days | |
| **2 Companions\*** | $30,240 | | $30,240 | $0 | $0 | $0 | $0 | \*High intensity funding for two Parkwood Residents who are already receiving High Intensity (not new funding) | |
| **Private Room** | $28,548 | | $0 | $19,032 | $0 | $0 | $0 | Four ALC Patients will transition to Parkwood LTC | |
| **Private Room** | $9,516 | | $0 | $0 | $0 | $0 | $9,516 | Two Existing Parkwood Residents to participate | |
| **3 Adult Day Program staff** | $81,000 | | $0 | $80,250 | $0 | $0 | $0 | Includes: 2 Program Staff, 1 BSO (PSW) for six months avg salary = $53,500/yr | |
| **TOTAL COSTS OF PILOT** | **$584,684** | | **$90,720** | **$99,282** | **$62,500** | **$62,500** | **$259,416** |  | |
| **Net new costs to Ministry** |  | |  | **$99,282** |  |  |  |  | |
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| **Assumptions:** | | | | | | | | |
| * Pilot includes: 4 Residents for 6 months from Hospital ALC, plus Parkwood will fund 2 additional existing Residents (excluding High Intensity costs), at own cost | | | | | | | | |
| * Annual salaries in budget for lead and coach: $105,000/2 (6 months) = $52,500 Note: this is not new money; project team is prepared to reorganize duties to prioritize this project | | | | | | | | |
| * All other costs calculated for 6-month pilot | | | | | | | | |
| * High Intensity funding required for individuals regardless of pilot | | | | | | | | |

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| Next Steps: | | |
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| Financials and related impact |  | 1. Costs - finalize 2. Budget - finalize 3. Financial impact / benefits –    * It costs over $750/day to care for a senior in a hospital vs $175/day in a LTC Home *Source: 2018 OLTCA Budget Submission on More Care Better Care;* this means that four patients participating in the pilot at Parkwood’s LTC Home for six weeks rather than staying in the hospital, will save $96,600. With the duration of the pilot being 6 months, the savings add up to nearly $420,000.    * Additional savings are realized due to avoidable emergency visits and hospital readmissions    * Potential savings through reduction of time needed for High Intensity   *Note: further information is required to quantify these costs, as there are various ways of calculating the cost to occupy an ALC bed/day (e.g., including costs of staff, specialists, supplies, food, etc.)* |
| Qualitative Impacts |  | The overarching goal of this pilot is to improve the quality of life for individuals experiencing dementia/behaviours. However, in doing so, we know, in conversation with our local hospitals and other partners, that this pilot will hae a positive impact on:   * Helping to reduce Hallway Medicine by reducing the number of days a person may be deemed occupying an ALC bed * Helping to reduce the #/% of ALC beds supports hospital flow from Emerg to Inpatient bed, which helps to reduce Hallway Medicine * Help to meet the Province’s Quadruple Aim by improving the experience of patients, family members and care-providers, as well as staff in hospitals and LTC. * Help our partners in our OHTs to also meet the Province’s Quadruple Aim and end Hallway Medicine   *Note: As the project gets underway, we will more clearly and definitively articulate these impacts and their corresponding indicators.* |
| Team |  | * Identify Coaches, project team / working group |
| Indicators |  | *Note: to be developed with partners* |
| Assessments |  | *Note: to be developed with partners* |
| MOUs |  | * Acquire letters of commitment * Develop and sign MOUs with partners |

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| Acknowledgements | | |
| This pilot is a collaborative effort between the Parkwood Mennonite Home, Grand River Hospital, and the Waterloo Wellington Local Health Integration Network (LHIN).  *We would like to recognize the working group for their dedication and leadership for this project.* | | |
| Sharon Stap |  | Psychogeriatric Resource Consultant Waterloo Wellington LHIN |
| Melissa Seyler |  | Psychogeriatric Resource Consultant Waterloo Wellington LHIN |
| Judy Linton |  | VP Clinical Services and Chief Nursing Executive, Grand River Hospital |
| Sherri Heimpel-Peers |  | Project Lead: ED, ALC, Patient Flow project, Grand River Hospital |
| Kate Kobbes |  | Program Director, Grand River Hospital, Freeport site |
|  |  |  |
| *Project Team Members* | | |
| Elaine Shantz |  | CEO, Parkwood and Fairview Mennonite Homes |
| Sharon Walker |  | Policy and Legislation, Parkwood and Fairview |
| Dale Shantz |  | Clinical Consultant, Parkwood and Fairview |
| Elisabeth Piccinin |  | Executive Director, Parkwood |
| Ann Jose |  | Director of Care, Parkwood |
| JoAnn Guerreiro |  | Clinical Coordinator, Parkwood |
| Jennifer King |  | Director of Programs and Environmental Services, Parkwood |
| Cynthia Lacroix |  | Consultant, Parkwood and Fairview |
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| *On behalf of all the project partners, we express our gratitude to the individuals who generously shared their insights and experiences to shape this pilot.* | | |
| Bruce Lauckner |  | CEO, Waterloo Wellington LHIN |
| Blair Philippi |  | Waterloo Wellington LHIN |
| Ron Gagnon |  | CEO, Grand River Hospital |
| Dr. Frances Morton-Chang |  | Gerontologist and Health Policy Researcher |

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| Resources | | |
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|  |  | Behavioural Support Integrated Teams (BSIT) Collaborative. *Guiding Checklist. Supporting Transitions from Acute/Community into Long-Term Care (LTC). 2019* |
|  |  | Behavioural Support Integrated Teams (BSIT) Collaborative. *Supporting Successful and Sustainable Transitions into Long-Term Care for Older Adults with Responsive Behaviours/Personal Expressions.* 2019. |
|  |  | Behavioural Supports Ontario. *Making Connections: Recommendations to enhance the use of personhood tools to improve person-centered care delivery across sectors Behavioural Supports Ontario Lived Experience Advisory.* |
|  |  | Behavioural Supports Ontario. *Recommended Core Competencies for Working with Behavioural Supports Ontario’s Target Population.* May 2018. |
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|  |  | Health Quality Council (Saskatchewan). *High-Quality Care Transitions: A Guide to Improving Continuity of Care Saskatoon.* 2018. |
|  |  | Health Quality Ontario. *Transitions from Hospital to Home. Patient and Caregiver Priorities.* 2018. |
| * 40% of patients at discharge experience unintentional discrepancies or potential errors |  | Optimizing Medication Safety at Care Transitions – Creating a National Challenge. 2011. |
|  |  | Rennke, S., MD, and Ranji, Sumant R., MD. Transitional Care Strategies from Hospital to Home: A Review for the Neurohospitalist. The Neurohospitalist 2015, Vol. 5(1) 35-42. |
|  |  | Teepa Snow: Positive Approach to Care.  <https://teepasnow.com/> Accessed: June 19, 2019 |
| * Approximately 1 in 5 patients experience adverse event such as adverse drug events following hospitalization * Nearly 20% of hospitalized older patients will be readmitted within 30 days |  | Transitional Care Strategies from Hospital to Home: A Review for the Neurohospitalist |
|  |  | *Note: additional resources have been reviewed, not yet included here* |