Staying Close to Home

**ARNNL's Recommendations to the Department
of Health and Community Services'**

Long Term Care and Community Support Services Strategy

September 2010

ARNNL is the regulatory body and professional organization representing all 6600 Registered Nurses and Nurse Practitioners in the province. In pursuit of its vision, Excellence in Nursing, ARNNL exists so there will be public protection, quality health care, and healthy public policy.

The challenges associated with providing services for our province's increasingly aging population make the organization and financing of long term care and community supportive services (LTC CSS) a priority. We are pleased that Government is taking a proactive approach to address these challenges.

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Registered Nurses (RNs) are the largest professional group who provide services to LTC CSS clients. RNs work in all regions of the province and all settings of service delivery (private homes, assisted living facilities, personal care homes, nursing homes, hospitals, and the community). As a primary provider of long term care and community services, RNs have an intimate knowledge of the needs of clients and the challenges that need to be addressed to improve the delivery of these services in the province. We appreciate the opportunity to discuss the profession's priorities for the LTC CSS system.

This response will highlight ARNNL's recommendations for enhancing the LTC CSS Strategy. For your convenience, a more detailed resource list of programs and initiatives mentioned in this submission has been compiled in Appendix A.

Our own vision of the LTC CSS system is one in which the public has access to a range of long term care and community support services with standards in place to ensure these services are accessible, affordable, provide quality health and residential services, allow for client self-determination and choice, and blend seamlessly with other health services.

OVERALL VIEWS OF THE VISION, MISSION AND GUIDING PRINCIPLES

ARNNL supports the vision, mission and guiding principles outlined in the consultation document, *Close to Home*. Our own vision of the LTC CSS system is one in which the public has access to a range of long term care and community support services with standards in place to ensure these services are accessible, affordable, provide quality health and residential services, allow for client self-determination and choice, and blend seamlessly with other health services. We believe that much of this can be achieved through Government's proposed LTC CSS Strategy.

ARNNL'S RECOMMENDATIONS FOR STAYING CLOSE TO HOME

ARNNL believes development of the following features will help ensure individuals can remain closer to home longer:

1. Strengthen the Focus on Health Promotion in the LTC CSS Strategy,

2. Implement a Chronic Disease Prevention and Management Strategy,

3. Establish a Comprehensive Caregiver Strategy,

4. Implement Rehabilitative and Restorative Care Programs for Hospitalized Seniors,

5. Enhance Community and Home Support Services, and

6. Strengthen Primary Health Care.

1. Strengthen the Focus on Health Promotion in the LTC CSS Strategy

A truly comprehensive model of care... should also strive to keep the population healthy so as to delay or prevent illnesses from occurring in the first place.

While the client-centered model outlined in the consultation document incorporates many of the features of a comprehensive model of care (e.g., supporting independence and a philosophy of aging in place), ARNNL is concerned that the focus of the Strategy appears to be on providing services without sufficient recognition of the importance of health promotion and illness prevention. Initiatives such as the creation of the Provincial Wellness Advisory Council and development of the Healthy Aging Policy Framework demonstrate Government's recognition of the importance of health promotion; however, this is not adequately conveyed in the document. For example, the vision states that individuals "requiring" LTC CSS services will achieve optimal independence and quality of life in their homes and communities. This implies that the Strategy is reactive (i.e., waiting until services are needed) rather than proactive (i.e., promoting health and preventing illness). A truly comprehensive model of care should not only provide for the ongoing needs of LTC CSS clients but should also strive to keep the population healthy so as to delay or prevent illnesses from occurring in the first place. ARNNL recommends that Government fully embrace a comprehensive model of care that reflects the full continuum of health by outwardly incorporating these concepts into the LTC CSS Strategy.

2. Implement a Chronic Disease Prevention and Management Strategy

ARNNL believes that a Chronic Disease Prevention and Management (CDPM) Strategy is a critical component of the LTC CSS system. A CDPM Strategy will ensure health promotion and disease prevention are an integral part of health care delivery and will ultimately allow people to remain close to home by preventing chronic illness

while helping those who now live with chronic conditions learn to better manage their care. Evidence from other provinces demonstrates that having a provincial CDPM Strategy reduces emergency room visits, keeps people out of hospitals and long term care institutions, and reduces lengths of stay when hospitalization is required.

ARNNL believes that to be effective, a CDPM Strategy must include the following components:

- A comprehensive **Human Resource Plan** that ensures the public has access to a range of health care providers within their community or region. There must be a sufficient number and mixture of professionals available to ensure continuity of care and to support not only primary care services, but also specialty services, such as rehabilitative care, palliative care, and mental health care. To achieve this, Government must be willing to increase its investment in the training, recruitment, and retention of LTC CSS care providers (e.g., Pharmacists, Advanced Practice Nurses, Registered Nurses, Licensed Practical Nurses, Physiotherapists, Occupational Therapists, Social Workers, Home Support Workers, etc.).

- **Primary Health Care Teams** – Interdisciplinary teams provide a full range of services, ensure a focus on wellness and prevention and increase the capacity to significantly improve positive health outcomes. Examples for consideration from other provinces include:

  - **Integrated Geriatric and Psychogeriatric Outreach Team for Seniors** (Ontario) - provides in-home geriatric and psychogeriatric consultation and assessment for seniors whose health issues prevent them from leaving their homes to seek the care they need.

  - **Integrated Health Networks** (British Columbia) - provide services to support participating family physician offices (primary care), patients and practice teams in managing chronic disease. The networks are customized for each patient, and are designed to directly address the patient's health care needs.

  - **Elderly Community Health Services** (Ontario) - provides assessment, consultation and treatment to frail elderly whose independence is at risk. A specialized team offers interventional care, health education and follow-up assessment.

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♦ *Comprehensive Home Option of Integrated Care for the Elderly* (Alberta & British Columbia) – The CHOICE program provides intensive services to selected medically complex and/or frail seniors in the community. The program offers a continuum of care and a full range of medical, social, rehabilitative and supportive services. It has demonstrated success through improved health outcomes, client and family satisfaction and a significant reduction in use of acute and emergency care.

♦ *Nurse Practitioner-Led Clinics* (Ontario) - NP-led clinics provide comprehensive, accessible, and coordinated family health care services using a collaborative practice approach that includes RNs, Registered Practical Nurses, collaborating family physicians, and other health professionals. These clinics improve the quality of care through enhanced health promotion, chronic disease management, illness prevention and case management.

Providing home care services via technology has been found to improve management of chronic diseases through improved patient self-management and immediate or preventative management between in-person office visits.

- *Technology in Home Care -* More than just the electronic health record, technology in home care means using communications and information technology to deliver health services and exchange information to and from the home and community. Currently, technology can be used to consult with health professionals via video or web conferencing and to obtain health advice through telephone help lines. The use of technology needs to be expanded to include such services as:

    ♦ providing patient reminders (e.g., telephone or electronic communication via email or social networking),

    ♦ remote monitoring of physiological signs (e.g., EKG, vital signs, weight, glucose etc.), and

    ♦ follow-up of patients and caregivers after discharge from acute care.

Providing home care services via technology has been found to improve management of chronic diseases through improved patient self-management and immediate or preventative management between in-person office visits to their health provider (e.g., electronic data capture and internet-enabled review

of results by clinicians allows medication adjustments). Patient improvements such as fewer office or emergency room visits, fewer hospitalizations, reduced length of stay, increased access to care (e.g., physically challenged, homebound or rural patients), and reduced travel time and expenses have also been reported. ARNNL recommends that government explore expanding the use of technology and that existing telehealth services, such as the provincial HealthLine program, be considered as options for expanded service delivery.

3. Create a Comprehensive Caregiver Strategy

Both formal and informal caregivers are acknowledged as critical components of the LTC CSS system at various points in the *Close to Home* document. ARNNL supports the philosophy that caregivers are essential to achieving the goal of remaining close to home.

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The creation of a caregiver strategy has been recommended by the Romanow Commission report, the Canadian Caregiver Coalition and Canadian Association of Retired Persons (CARP) as a way to ensure that caregivers continue to be able to support seniors. ARNNL believes that a comprehensive strategy will ultimately prove to be cost effective by reducing reliance on or delaying admission to costly residential long term care and enhancing positive health outcomes through the use of well-trained care providers. ARNNL believes that a ***comprehensive caregiver strategy*** is necessary to ensure support for caregivers and that this strategy must address the challenges of both informal and formal caregivers.

3.1. Informal Caregivers

When families and communities are able to support individuals in the LTC CSS system, it reduces isolation and the risk of neglect and abuse, and has the potential to reduce or delay premature admission to residential care. While there is no doubt that our province has a culture of helping each other and especially our neighbours in need, Registered Nurses and other formal caregivers report that they are increasingly called upon to coordinate and provide support that was once provided by family and friends. Caregiver burden - an all-encompassing term to describe the physical, emotional and financial toll of providing care - is undoubtedly contributing to this disturbing trend. A 2010 report from the Canadian Institute for Health Information on informal caregivers showed that nearly one-in-six caregivers of seniors receiving home care reported distress related to their role.

We believe that a comprehensive caregiver strategy must include:

- ***Support for caregiver health and well being*** – Caregiver health can be supported through a number of initiatives such as:

  ♦ *Risk Assessment* - Caregiver health and well being must be included as a component in the assessment tool adopted by the LTC CSS system. Caregivers must be assessed early and regularly to identify and plan interventions for individuals and families at risk.

  ♦ *Respite Services* – Government needs to ensure caregivers can receive a much needed break from caregiving responsibilities by increasing the availability of and access to publicly-funded community respite services provided by the public health care system, volunteer or not-for-profit sectors.

  ♦ *Networking Opportunities* – Government needs to support organizations and programs that provide information and education to caregivers, such as the Seniors Resource Centre (SRC), and telehealth initiatives such as Canada Health Infoway's Telehomecare, the SRC's Caregiver Line (1-800 number) and VON's Caregiver Connect Portal, to ensure that information, education and support are readily available and easily accessible.

  ♦ *System Navigators* - The *Close to Home* document introduces navigators for clients requiring services. We believe that this should be taken a step further to include navigators for caregivers. Navigators will increase awareness of and facilitate access to appropriate programs, services and supports.

- ***Support for employment initiatives that create supportive work environments for caregivers*** – Government can set direction and provide support for employers to develop and implement policies that promote flexibility and respect for employees' caregiving obligations (e.g., access to alternative work arrangements and flexibility with respect to time off). Formal programs that support longer employment absences (e.g., Employment Insurance programs that are on par with parental

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leave benefits and extended Compassion Care Benefit) may be benefi-
cial and should be explored.

- ***Initiatives to reduce caregiver financial burden*** – There is strong evi-
dence of the financial impact of unpaid caregiving. Government can
help alleviate caregiver financial strain by increasing access to *publicly-
funded* care services within the community (e.g., freely available or
subsidized adult day programs) and by exploring financial initiatives
implemented in other provinces such as caregiver allowances (Nova
Scotia) and refundable caregiver tax credits (Manitoba and Quebec).

It is important that all caregiver support services be accessible (e.g., through the inter-
net, telephone and/or in person), affordable, flexible (e.g., individual options as well
as group initiatives), timely (i.e., available early) and sustained. The caregiver needs
to obtain support before they are exhausted and have confidence that they can avail of
support services when needed.

3.2 Formal Caregivers

Formal caregivers are recognized in *Close to Home* as being a critical component of
the LTC CSS system. ARNNL emphasizes the importance of addressing the need for
specialized educational preparation and an adequate formal-informal and regulated-
unregulated skill mix to the delivery of safe, quality LTC CSS care.

The specialized and complex care needs of LTC CSS clients require a full range of
formal caregivers, from home support workers to regulated health professionals. Both
professional (i.e., regulated) and unregulated formal caregivers need to have special-
ized gerontological and chronic disease prevention and management knowledge and
skills to ensure quality of care and positive health outcomes.

*Healthcare Profes-
sionals...must be
supported to main-
tain and enhance
their knowledge and
skills through con-
tinuing education
and professional
development.*

Unregulated formal caregivers (e.g., home support workers, personal care attendants)
provide basic care for people within their homes and communities. Care is provided to
clients who require support to stay at home (e.g., clients requiring assistance with ac-
tivities of daily living) as well as those who have been discharged from acute care set-
tings to their homes or communities. Efforts to shift care from acute care settings to
the community have resulted in these workers providing care to increasingly complex
clients who previously would have been cared for in acute or residential long term
care. Concerns have been raised about the use of workers with little or no formal
training in these settings and limited preparation for the unique needs of LTC CSS
clients.

ARNNL recognizes that the issue of education for unregulated formal caregivers is complicated. We recommend that Government explore the pros and cons of establishing standardized, mandatory education programs and a license or certificate program for home support and other unregulated caregivers. As the regulatory body for nurses, ARNNL has experience in this area and is willing to offer our expertise to support Government's efforts to ensure the delivery of safe, competent and quality home care services.

The challenge for regulated care providers is to understand the unique needs of LTC CSS clients and to stay current with the complexity of those needs. In order to ensure that health care professionals can meet the challenge of providing care, they must be supported to maintain and enhance their knowledge and skills through continuing education and professional development. Any plan to address the training and continuing education needs of health professionals in LTC CSS should include:

Italic sidebar: While we recognize that unregulated care providers can help to increase access to care and improve the utilization of existing health human resources, it is critical that an adequate number of qualified RNs remain in place to provide the planning, support and oversight necessary to ensure safe, quality client care.

- *Gerontology Training -* Gerontology is a recognized specialty area. Since the majority of LTC CSS clients are 65 years or older, training in gerontology must be required for both care providers and those in leadership roles (e.g., case managers).

- *Professional Resources* – The LTC CSS system must include specially trained staff to support clinical training and ongoing education. Research and experience has shown that advanced practice nurses (i.e., Nurse Practitioners and Clinical Nurse Specialists), Gerontology Resource Nurses and Geriatricians are able to provide the necessary training and education. See the Resource List in Appendix A for a further description of these roles.

In addition to educational preparation, the issue of appropriate skill mix in both community and institutional settings needs to be addressed. Staffing decisions impact the quality, safety, and outcome of client care in all health care settings. Research has shown that higher levels of professional staff is linked with better patient outcomes. However, policy directions within the health care system indicate a move towards a greater utilization of unregulated care providers. While we recognize that unregulated care providers can help to increase access to care and improve the utilization of existing health human resources, it is critical that an adequate number of qualified RNs remain in place to provide the planning, support and oversight necessary to ensure safe, quality client care. For example, nurses are reporting that the RN staffing level in long term care institutions is often too low to ensure adequate professional supervision and leadership.

A comprehensive framework for staffing and skill mix decision making is essential to ensure the use of the right person, with the right skills and education at the right time. We believe Government must take a coordinated, evidence-based approach to staffing and skill mix decisions that will support all members of the care team to work to their full scope of practice, promote quality patient care, increase job satisfaction and enhance operational efficiency.

4. Implement Rehabilitative and Restorative Care Programs for Hospitalized Seniors

ARNNL believes that the client-centered model of care outlined in the consultation document must include *rehabilitative and restorative care programs*. The goal of these programs is to facilitate hospitalized seniors return home by providing comprehensive in-patient management that continues post-discharge through a continuum of rehabilitative and support services. Implementing a restorative care program will limit functional decline and decrease reliance on alternate level of care.

Without appropriate intervention, functional decline can occur as early as the second day of hospitalization.

Functional Decline

As frequent users of acute care services, seniors are at risk for a number of complications associated with hospital stays, most notably functional decline. Functional decline is associated with higher mortality rates, longer lengths of stay, greater rehabilitation consumption and costs, and increased rate of admission to long term care facilities. Without appropriate intervention, functional decline can occur as early as the second day of hospitalization.

...senior friendly acute care service delivery is a critical component of rehabilitative and restorative care.

Registered Nurses believe that senior friendly acute care service delivery is a critical component of rehabilitative and restorative care. Examples of senior friendly models of care that have demonstrated positive outcomes include:

- **Hospital Elder Life Program (HELP) -** a multidisciplinary intervention implemented hospital-wide to prevent cognitive and physical decline, promote independence, assist with transitions, and prevent readmissions. This program also focuses on recognition and management of common geriatric syndromes such as delirium and promoting sleep without drugs.

- **NICHE (Nurses Improving Care for Health System Elders) Program -** a program that helps health care institutions to assess current geriatric care and to initiate evidenced-based, age-appropriate nursing interventions. The NICHE Program provides a systematic approach to creating organizational

change across disciplines. It includes several different models of care that can be implemented individually or in conjunction with one another. Examples of the NICHE models include:

♦ *Acute Care of the Elderly (ACE) Unit* - a specific unit or a section of an existing unit (e.g., medical-surgical) is adapted to provide both medical services and geriatric interventions. The key elements of an ACE unit are an interdisciplinary team focused on preventing functional decline and geriatric syndromes, environmental adaptations, and staff with special expertise in geriatrics.

♦ *Geriatric Resource Nurse Model* – this educational and clinical intervention model prepares staff nurses as the clinical resource person for geriatric issues. Geriatric Resource Nurses are trained to act as a resource for geriatric best practices and to support to other staff on their unit.

• **Senior Friendly Hospital Strategy** - a comprehensive interdisciplinary framework to guide the development of senior friendly hospitals. The strategy, developed by the Regional Geriatric Programs of Ontario, focuses on optimizing the health of seniors, reducing inappropriate use of acute care resources and improving patient satisfaction.

Evidence has shown that delivering rehabilitation and community-based support services can reduce reliance on alternate level of care and admissions to long term care facilities.

Alternate Level of Care
Nurses report that hospitalized seniors frequently experience discharge delays because our health system lacks the community based resources necessary to ensure the provision of rehabilitative and restorative care programs. Without appropriate options for rehabilitation and reintegration back into the community, hospitalized seniors are more likely to remain in hospital as alternate level of care (ALC) patients or be admitted to long term care facilities.[1]

Evidence has shown that delivering rehabilitation and community-based support services can reduce reliance on alternate level of care. Examples of programs that address ALC through enhanced community services include:

• *Waiting at Home* (Ontario) **-** allows care providers to identify ALC patients

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[1] ALC is generally defined as patients who are occupying a hospital bed when they do not require the intensity of resources or services provided in that setting. The impact of ALC includes patients receiving care in inappropriate settings, potentially compromised management of other hospitalized patients, and increased wait times due to lack of acute care beds (e.g., patients in ER awaiting admission, cancelled surgeries, etc.).

waiting for LTC placement and provide them with enhanced levels of support in their own homes (e.g., personal support, nursing, OT, PT, etc.) for a period of 60 days.

- *Home at Last* (VON) - identifies hospitalized seniors who have limited supports upon discharge and assigns trained attendants to assist with the transition to home (e.g., home safety assessments and referral to on-going community supports) and provide support services (e.g., grocery, prescription and medical equipment pick up).

ARNNL believes that delivery of all of these services within the publicly funded health care system can be supported by partnering with other sectors, including municipal governments and the not-for-profit sector (e.g., VON, Seniors Resource Centre), and through continued support of existing programs and initiatives...

5. Enhance Community and Home Support Services

The consultation document recognizes that "aging in place" can be supported by enhancing community and home support services that enable LTC CSS clients to remain at home. ARNNL believes that aging in place can best be achieved through the creation of age friendly communities. Community and home support services that support age friendly communities include:

- *Home Support* services that extend beyond the activities of daily living and include support for meal programs, essential home making, home maintenance, etc., and *community services* such as public transportation/para-transportation, municipal recreation programs, and adult day programs that provide respite for caregivers and opportunities for social connectedness for seniors.

- *Health Promotion* initiatives that promote wellness and increase opportunities for healthy living, such as those outlined in the Healthy Aging Policy Framework and Implementation Plan (e.g., healthy eating, physical activity, tobacco reduction, fall and injury prevention etc.).

- *Supportive Living* options that enable independence while providing security. These types of living arrangements incorporate the provision of services such as 24-hour monitoring, emergency response, security, meals, housekeeping, and life enrichment activities. Government should explore whether supportive living arrangements can be implemented within the existing Canada-Newfoundland and Labrador Affordable Housing Program Agreement.

ARNNL believes that delivery of all these services within the publicly funded health care system can be supported by partnering with other sectors, including municipal

governments and the not-for-profit sector (e.g., VON, Seniors Resource Centre), and through continued support of existing programs and initiatives such as Wellness Grants, the Age Friendly Communities initiative and Sports and Recreation programs.

6. Strengthen Primary Health Care

ARNNL recognizes that change in the health care sector is challenging. We believe that Government can lead transformative change by ensuring initiatives are based upon principles shown to be effective in creating system and organizational change. Primary Health Care (PHC) embraces all of the principles required for transformative change - engaging the public, making evidence informed decisions, defining reasonable accessibility, promoting self-reliance, building capacity, and striving for equity.

We believe that PHC needs to be expanded to the entire population. ARNNL recommends that Government continue to promote and support the expansion of Primary Health Care throughout the province as the appropriate and logical approach to support delivery of LTC CSS services.

CONCLUSION

The vision, mission and principles outlined in *Close to Home* form an appropriate and meaningful foundation on which to guide the development, implementation and evaluation of long term care and community support policies and services. We believe that in order to ensure that the Strategy supports a comprehensive model of care, Government needs to strengthen the focus on health promotion, implement a chronic disease prevention and management strategy, establish a comprehensive caregiver strategy for both informal and formal caregivers, implement rehabilitative and restorative programs to facilitate hospitalized seniors return home, enhance community and home support services that support aging in place and strengthen primary health care.

ARNNL remains committed to working collaboratively with Government to advance population health, strengthen our health care system and improve access to health and community services.

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ARNNL remains committed to working collaboratively with Government to advance population health...

Appendix A: Resource List

Note: Resources are organized by the sections of the document.

Overall View of the Vision Mission and Guiding Principles

ARNNL (2006). Healthy Aging for All: A Shared Responsibility. http://www.arnnl.ca/documents/publications/Healthy_Aging_March_06.pdf

1. Strengthen the Focus on Health Promotion in the LTC CSS Strategy

Public Health Agency of Canada (2010). Creating a Healthier Canada: Making Prevention a Priority. http://www.phac-aspc.gc.ca/hp-ps/hl-mvs/declaration/index-eng.php

Public Health Agency of Canada. Centre for Health Promotion. http://www.phac-aspc.gc.ca/chhd-sdsh/index-eng.php

Public Health Agency of Canada (1997). Toward Healthy-Aging Communities: A Population Health Approach. http://www.phac-aspc.gc.ca/seniors-aines/alt-formats/pdf/publications/pro/healthy-sante/chcs-sscs/healthy_comm/healthy_comm_e.pdf

Principles for Medical Care of Older Persons. CMAJ 2000. 162(13): 1871-4.

2. Chronic Disease Prevention and Management Strategy

Primary Health Care Teams
CHSRF (2005). Interdisciplinary Teams in Primary Healthcare Can Effectively Manage Chronic Illness. http://www.chsrf.ca/mythbusters/pdf/boost3_e.pdf

Integrated Geriatric and Psychogeriatric Outreach Team for Seniors (Ontario)
http://www.stjoe.on.ca/about/publications/features_detail.php?id=169

Integrated Health Networks (British Columbia)
Health Council of Canada. Teams in Action: Primary Health Care Teams for Canadians (April 2009) – A British Columbia Perspective
http://www.healthcouncilcanada.ca/docs/rpts/2009/TeamsInAction_BC_Summary.pdf

Government of British Columbia. Primary Health Care Charter. A Collaborative Approach. http://www.primaryhealthcarebc.ca/library/publications/year/2007/phc_charter.pdf

Innovations in Community Care: From Pilot Project to System Change. Canadian Centre for Policy Alternatives. http://www.policyalternatives.ca/publications/reports/innovations-community-care

Elderly Community Health Services (Ontario)
St. Joseph's Health Centre (Toronto): http://www.stjoe.on.ca/programs/medicine/echs.php

Comprehensive Home Option of Integrated Care for the Elderly (CHOICE)
Paul, C. & Stokes, E. Alternative Models of Care for Complex Vulnerable Seniors: Lessons learned in the Community. http://www.health.gov.bc.ca/hcc/presentation/paul.pdf

Seniors have CHOICE (Alberta Health Services): http://www.albertahealthservices.ca/1362.asp

Nurse Practitioner Led Clinics (Ontario)
http://www.health.gov.on.ca/transformation/np_clinics/np_mn.html

NP Clinics InfoKit: http://www.health.gov.on.ca/transformation/np_clinics/np_infokit.html

Technology in Home Care
Home Telehealth Business Case Report (2007) - http://www2.infoway-inforoute.ca/Documents/Home_Telehealth_Business_Case_Report.pdf

Telehealth monitoring helps seniors living with heart failure - http://www.infoway-inforoute.ca/lang-en/about-infoway/news/news-releases/395-at-home-monitoring-helps-seniors-living-with-heart-failure

Stachura, M. & Khasanshina, E.. Telehomecare and Remote Monitoring: An Outcomes Overview. Prepared for The Advanced Medical Technology Association. http://www.viterion.com/web_docs/Telehomecarereport%20Diabetes%20and%20CHR%20Meta%20Analyses.pdf

3. Comprehensive Caregiver Strategy

Caregiver Strategy
Canadian Caregiver Coalition (CCC) website: http://www.ccc-ccan.ca/index.php

CCC Framework for a Caregiver Strategy: http://www.ccc-ccan.ca/content.php?doc=23

Canadian Association of Retired Persons (CARP): http://www.carp.ca/index.cfm

CARP Caregiver Strategy: http://www.carp.ca/advocacy/adv-article-display.cfm?documentid=3378

Romanow, R.   Building on Values: The Future of Health Care in Canada.
http://www.collectionscanada.gc.ca/webarchives/20071122004429/http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/hcc_final_report.pdf

3.1 Informal Caregivers

<u>**Caregiver Health & Wellbeing**</u>
CIHI (2010) Support for Informal Caregivers – The Heart of Home Care
http://secure.cihi.ca/cihiweb/products/Caregiver_Distress_AIB_2010_EN.pdf

CIHI (2010) Caring for Seniors with Alzheimer's Disease and Other Forms of Dementia. http://secure.cihi.ca/cihiweb/products/Dementia_AIB_2010_EN.pdf

Mockus-Parks, S., & Novielli, K . A Practical Guide to Caring for Caregivers .
American Family Physician 2000. http://www.aafp.org/afp/20001215/2613.html

Brown, A. (2009). Caring About Caregivers: Caregiving for the future of Ontario.
Long-Range Scenario Planning Supporting Caregiving into 2033. http://www.theconference.ca/caring-about-caregivers-final-report-pdf

<u>**Networking Opportunities**</u>
Telehealth Success Stories - http://www.infoway-inforoute.ca/about-infoway/approach/investment-programs/telehealth/458

VON Caregiver Connect - http://www.caregiver-connect.ca/en-us/Pages/Home.aspx

Seniors Resource Centre (http://www.seniorsresource.ca/)

Caregivers Out of Isolation - http://www.seniorsresource.ca/caregivers/

Financial Burden of Caregiving

Duxbury, L., Higgins, C., & Schroeder, B. (2009). Balancing Paid Work and Caregiving Responsibilities: A Closer Look at Family Caregivers in Canada. http://www.cprn.org/doc.cfm?doc=1997&l=en

VON (2010) Income Tax Measures for Caregivers: Do They Measure Up? http://www.von.ca/en/resources/govt.aspx.

3.2 Formal Caregivers

Training Unregulated Care Providers

Canadian Association on Gerontology Position Statement - Home Care in Canada http://www.cagacg.ca/publications/552_e.php

VON Personal Care Attendant Course/Home Support Worker Course http://www.von.ca/en/programs/personal_care_attendant.aspx

Training & Continuing Education for Regulated Care Providers

Gerontological Nursing Competencies and Standards of Practice - http://www.cgna.net/index.php?action=viewContents&id=5

ARNNL (2007) Advanced Practice - Nurse Practitioner Position Statement: http://www.arnnl.ca/documents/publications/Advanced_Practice_Nurse_Practitioner_Feb_2007.pdf

ARNNL (2007) Advanced Practice - Clinical Nurse Specialist Position Statement: http://www.arnnl.ca/documents/publications/Advanced_Practice_Nurse_-_Clinical_Nurse_Specialist_Feb_2007.pdf

Geriatric Resource Nurse

Definition: *At NICHE we view the GRN Model as the Foundation for Improving Geriatric Care. The underlying goal, improving the geriatric knowledge and expertise of the bedside nurse, is foundational to implementing system-wide improvement in the care of older adult patients. The Geriatric Resource Nurse (GRN) model is an educational and clinical intervention model that prepares staff nurses as the clinical resource person on geriatric issues to other nurses on their unit. GRNs are trained by geriatric advanced practice nurses to identify and address specific geriatric syndromes such as falls and confusion, and to implement care strategies that discourage the use of restrictive devices and promote patient mobility. Using pre- and post- test*

design, 4 NICHE sites employing the GRN model found a statistically significant improvement in nurses' perceptions of caring for the acutely ill older adult following implementation of the NICHE/GRN model. All of the original NICHE sites chose to implement the GRN model and over the last decade the GRN model has remained as the most frequently implemented NICHE model. Thus the GRN model is often the first step in developing and implementing other systemic geriatric initiatives, including an ACE unit, geriatric case management, transitional care, and geriatric protocol dissemination.

Source: http://www.nicheprogram.org/niche_models

Allen, J. & Close, J. The NICHE Geriatric Resource Nurse Model: Improving the Care of Older Adults with Alzheimer's Disease and Other Dementias. Geriatric Nursing, 2010; 31(2): 128-32

Fulmer T, Mezey M, Bottrell M, et al. Nurses Improving Care for Healthsystem Elders (NICHE): nursing outcomes and benchmarks for evidenced-based practice. Geriatr Nurs. 2002; 23(3): 121–127

Staffing and Skill Mix
Canadian Federation of Nurses Unions (2010). Experts & Evidence: Opportunities in Nursing. http://www.nursesunions.ca/sites/default/files/Experts%20and%20evidence_Inside_Sept%207.pdf

Canadian Nurses Association (2005). Evaluation Framework to Determine the Impact of Nursing Staff Mix Decisions. http://www.arnnl.ca/documents/publications/Evaluation_Framework_2005_e.pdf

ARNNL (2006). Staffing for Quality Care in Institutional Settings http://www.arnnl.ca/documents/publications/Enhancing_Services_for_Seniors_Position_Statement-aug-08.pdf

ARNNL (2003). Performance of Nursing Tasks by Support Workers in Community Settings. http://www.arnnl.ca/documents/publications/Performance_of_Nursing_Tasks_by_Support_Workers_2003.pdf

ARNNL & CLPNNL (2009). Professional Responsibilities When Working with Institutionally Based Unregulated Care Providers. Joint Guidelines. http://www.arnnl.ca/documents/publications/

ProfessionalResponsibilitiesWhenWorkingWithUnregulatedCareProviders-
JointGuidelines-2009.pdf

4. Rehabilitative and Restorative Care

Functional Decline
ARNNL (2008). Enhancing Services for Seniors - Facilitating Hospitalized Seniors
Return Home Advocacy Statement http://www.arnnl.ca/documents/pages/
Enhancing_Services_for_Seniors_Position_Statement_Aug_08.pdf

Hospital Elder Life Program (HELP)
Definition: *Developed by researchers at Yale University, the Hospital Elder Life Pro-
gram (HELP) is an innovative model of hospital care that uses practical interventions
to prevent delirium and functional decline in older patients. Interventions are carried
out by a skilled interdisciplinary team and trained volunteers. HELP staff—an Elder
Life Specialist and Elder Life Nurse Specialist—assess older hospital patients to iden-
tify risks and determine which interventions are appropriate, based on each patient's
needs. Patients receive personalized interventions that evolve to match their changing
needs throughout the course of hospitalization. The intervention includes standard-
ized protocols for the management of six risk factors for delirium: cognitive impair-
ment, sleep deprivation, immobility, visual impairment, hearing impairment, and de-
hydration. HELP is supported by information technology designed to prompt and
document recommended interventions, track patient progress, and report clinical and
financial performance.*

Source: http://www.commonwealthfund.org/Content/Innovations/Tools/2005/Nov/
Preventing-Delirium-in-Older-Adults--Hospital-Elder-Life-Program.aspx

HELP website: http://elderlife.med.yale.edu/public/public-main.php

Hamilton Health Services (Ontario) - http://www.hhsc.ca/body.cfm?id=1015

Inouye, SK., Bogardus, ST., Baker, DI., Leo-Summers, L. & Cooney, LM. The Hos-
pital Elder Life Program: A model of care to prevent cognitive and functional decline
in older hospitalized patients. Journal of the American Geriatric Society. 2000; 48
(12): 1728-9

Nurses Improving Care for Health System Elders (NICHE)
NICHE Models of Care - *The NICHE nursing care models can help hospitals improve*

their care to better meet the needs of their hospitalized older adult patients. These models have been implemented and tested at hospitals across the country and have been shown to be effective in improving clinical care and outcomes for elders during and following hospital admission.

NICHE Acute Care of the Elderly (ACE) Unit
The NICHE ACE model designates a specific unit or a section of a unit in order to deliver interventions known to improve the clinical outcomes of older adult patients. Key elements of an ACE unit include environmental adaptations for older patients (e.g., flooring to decrease visual glare and noise, enhanced lighting, clocks and calendars in patient rooms, communal area for activities and meals), staff with special expertise in geriatrics, and an interdisciplinary team focused on preventing geriatric syndromes.

The ACE model promotes collaborative team building and nurse-initiated clinical protocols of care. The geriatric medical director and geriatric advanced practice nurse provide clinical leadership. The ACE model also fosters hospital-wide improvement of nurses' geriatric knowledge by serving as a resource center for care of older adult patients.

NICHE Geriatric Resource Nurse

Source: http://www.nicheprogram.org/niche_models

The John A Hartford Foundation: NICHE: Nursing Care Models and Systematic Assessment Improve Care for the Hospitalized Elderly - http://www.jhartfound.org/pdf%20files/NICHE.pdf

Niche Project Faculty. Geriatric Models of Care: Which One's Right For Your Institution? American Journal of Nursing. 1994; 94(7): 21-23.

Steele, J. Current Evidence Regarding Models of Acute Care for Hospitalized Geriatric Patients. Geriatric Nursing (In Press).

Senior Friendly Hospital Strategy
Staff affiliated with the Regional Geriatric Programs of Ontario have developed a conceptual framework for senior friendly hospitals in order to optimize the health and resource outcomes for Ontario's seniors. The framework builds upon the preliminary work of the Regional Geriatric Program of Eastern Ontario (Ottawa).   It is defined

as...a systematic approach, consistent with the CMA principles on Care of the Elderly, that promotes evidence-based practices in geriatric care in acute hospital settings. It consists of 5 inter-related elements: Physical Environment, Processes of Care, Emotional and Behavioural Environment, Ethics in Clinical Care & Research, and Organisational Support.

Source: http://rgps.on.ca/senior_friendly_hospital_strategy

Regional Geriatric Programs of Ontario – *"a comprehensive, coordinated system of health services for the elderly within a region with the objective of assisting the elderly to live independently in their own communities thereby preventing unnecessary and inappropriate institutionalization."*

Source: http://rgps.on.ca/

Senior Friendly Hospital Strategy: A systematic approach to acute care for older patients. http://rgp.toronto.on.ca/PDFfiles/seniorfriendlyhospitalpresentationmarch2006.pdf

Key Elements of a Senior Friendly Hospital Framework - http://rgps.on.ca/key_elements_senior_friendly

St. Joseph's Hospital Embarks on a Journey to Become Certified as a Senior Friendly Hospital: http://www.stjoe.on.ca/about/publications/features_detail.php?id=140

Creating a Senior Friendly Physical Environment in our Hospitals (Regional Geriatric Assessment Program of Ottawa) http://www.rgpeo.com/documents/Senior-friendly-fulltext2.pdf

Alternate Level of Care
Ontario Community Support Association. Appropriate level of care: a patient flow, system integration and capacity solution Report by the expert panel on alternate level of care. December 2006. http://www.ocsa.on.ca/userfiles/alc_report_20070117.pdf

CIHI (2009) Alternate Level of Care in Canada. http://secure.cihi.ca/cihiweb/products/ALC_AIB_FINAL.pdf

Ontario Wait Times Report - http://www.health.gov.on.ca/en/pro/programs/waittimes/edrs/alc_definition.aspx

Waiting at Home - http://www.homecareontario.ca/public/docs/news/2009/may/
Ontario-investing-in-aging-at-home-program.pdf

Community Care Access Centre. Transforming Care for Seniors – Waiting at Home
and Future Plans. http://www.ryerson.ca/crncc/documents/AAHe-Syposium-
TCLHINWaitingatHomeJun2209DiptiPv3FINAL.pdf

VON's Home at Last Program - http://www.von.ca/en/about/docs/
five_year_report.pdf

5. Enhance Community and Home Support Services

Williams, A.P., Lum, J.M., Deber, R., Montgomery, R., Kuluski, K., Peckham, A.,
Watkins, J., Williams, A., Ying, A. & Zhu, L. Aging at Home: Integrating Commu-
nity-Based Care for Older Persons. HealthcarePapers 2009. 10(1); 8-21.
Public Health Agency of Canada (PHAC): Healthy Aging
http://www.phac-aspc.gc.ca/seniors-aines/publications/public/healthy-sante/index-
eng.php

Age-Friendly Rural and Remote Communities: A Guide
http://www.phac-aspc.gc.ca/seniors-aines/alt-formats/pdf/publications/public/healthy-
sante/age_friendly_rural/AFRRC_en.pdf

Canadian Association on Gerontology Policy Statement – Health Promotion for Indi-
vidual Seniors (2000) http://www.cagacg.ca/publications/554_e.php

6. Strengthen Primary Health Care

Experiences with Primary Health Care in Canada. CIHI. 2009. http://secure.cihi.ca/
cihiweb/products/cse_phc_aib_en.pdf

Primary Health Care – A Framework that Fits. Enhancing Interdisciplinary Collabo-
ration in Primary Health Care Initiative. http://www.eicp.ca/en/

World Health Organization. Fact Sheet No. 172. Integrating Prevention into health
care. http://www.who.int/mediacentre/factsheets/fs172/en/index.html

Primary Health Care and Health System Renewal - http://www.hc-sc.gc.ca/hcs-sss/
prim/renew-renouv-eng.php

CHSRF (2009) What are the Critical Benefits and Attributes of a High-Quality Primary Healthcare System? http://www.chsrf.ca/reports/11498_PHC_McMurchy_ENG_FINAL.pdf

ARNNL (2004). Role of the Registered Nurse in Primary Health Care - http://www.arnnl.ca/documents/publications/Role_of_the_Registered_Nurse_in_Primary_Health_Care.pdf

ARNNL (2004). Primary Health Care - http://www.arnnl.ca/documents/publications/Primary_Health_Care.pdf

ARNNL is the regulatory body and professional organization representing all Registered Nurses and Nurse Practitioners in the province. In pursuit of its vision, Excellence in Nursing, ARNNL exists so there will be public protection, quality health care, and healthy public policy.