

VIRTUAL LEARNING SERIES

Unleashing the Power of InterRAI ACCOUNTABLE AND SUSTAINABLE CARE

September 10 2019

VIRTUAL LEARNING SERIES

About the Canadian Home Care Association's Virtual Learning Series

The aim of the virtual learning series is to improve the capabilities of individuals and organizations across the home and community care sector.

VIRTUAL LEARNING SERIES

Today's webinar may be heard through your computer
or a dial-in audio connection.

Local: 647-260-3077

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Access Code: 5418737 #

VIRTUAL LEARNING SERIES

Features of this webinar

- To ensure you will have the best experience,
please close other programs on your computer.
- **Use the “Questions and Comments” chat pod to the left of the presentation** to ask questions or post comments throughout the webinar.
Please tell us who your questions should be directed at.
Questions will be answered at the end.
- **A link for the protected recording will be emailed to participants,**
with a copy of the slides next week.

VIRTUAL LEARNING SERIES

HARMONIZED PRINCIPLES FOR HOME CARE

Patient- and Family-Centred Care

Patients and their carers are at the centre of the planning and delivery of care.

- Foster autonomy and self-sufficiency.
- Integrate safety practices into all patient care and service delivery.
- Respect and address psychosocial, physical and cultural needs.
- Acknowledge patients and carers' unique strengths and engage them as partners in care.

Accessible Care

Patients and their carers have equitable and consistent access to appropriate care.

- Provide care that is responsive and consistent among providers and across jurisdictions
- Promote patients' and carers' understanding of care needs and options, and consequences of decisions and actions.
- Customize care to the unique needs of patients and their families to ensure appropriate care.

Accountable Care

Patients, providers and system outcomes are managed, met and reported.

- Focus on increasing capacity and improving performance.
- Ensure transparency through user-friendly reporting on service delivery information and outcomes.
- Use performance metrics and outcomes to inform planning and delivery.
- Foster adaptive leadership and governance to facilitate change and collaboration.

Evidence-Informed Care

Patients receive care that is informed by clinical expertise, patient values and best available research evidence.

- Collect and apply research evidence, provider expertise and patient experience.
- Use standardized tools and supports to strengthen the quality of services and programs delivered.
- Create a culture of innovation and ingenuity.

Integrated Care

Patients' needs are met through coordinated clinical and service-level planning and delivery involving multiple providers and organizations.

- Build strong foundational partnerships between home care and primary care.
- Optimize system resources and seamless navigation through care coordination.
- Facilitate joint planning, decision-making and open communication
- Engage health and social care sectors with a focus on continuity for the client .

Sustainable Care

Patients whose needs can reasonably be met in the home will receive the services and support to do so.

- Use current and future population needs in strategic policy and system planning.
- Modernize delivery through the exploration and testing of new funding and service models.
- Plan and manage health human resources in anticipation of changing supply and future demand.
- Develop strategic procurement approaches to evaluate and adopt innovation and new technology.

VIRTUAL LEARNING SERIES

Presenters



PROFESSOR JOHN HIRDES
School of Public Health
and Health Systems,
University of Waterloo



IAN RITCHIE
Regional Director-
East Sub-Region,
Toronto Central LHIN



LESLIE ECKEL
Knowledge Exchange
Associate at interRAI
Canada.



UNIVERSITY OF WATERLOO
FACULTY OF APPLIED HEALTH SCIENCES
School of Public Health and Health Systems



Update on Use of interRAI Systems in Canada

John P. Hirdes, PhD FCAHS

Professor

School of Public Health and Health Systems

University of Waterloo

Canadian interRAI Fellows by Network

Senior Country Fellow

- Hirdes (UWaterloo) → iNMH Chair, Board

Acute Care (Chair: Gray)

- Berg (UToronto) → PAC Chair
- Boscart (Conestoga)
- Costa (McMaster) → ED Chair
- Heckman (UWaterloo)
- Kergoat (UMontreal)
- Sinha (Mt Sinai)

Integrated Care & Aging (Chair: Declercq)

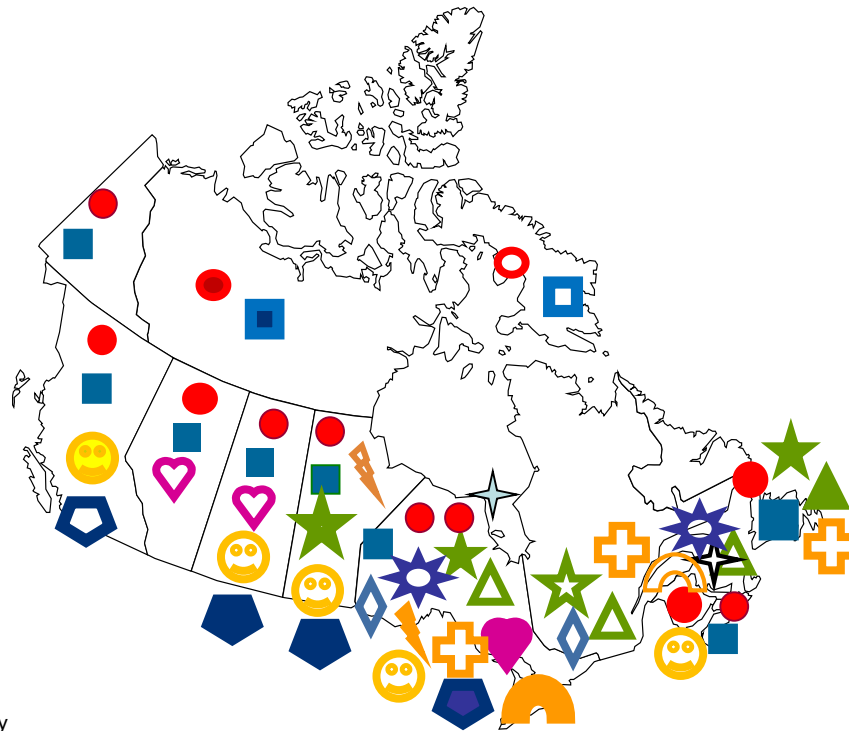
- Guthrie (WLU) → PC Chair
- Smith (Nipissing)
- McArthur (McMaster)
- Vadeboncoeur (CHEO)

Mental Health (Chair: Hirdes)

- Barbaree (Waypoint) → Forensics
- Brown (Nipissing) → Corrections
- Hoffman (Nipissing) → Police
- Kehyayan (UCalgary – Qatar)
- Martin (Lakehead) → ID Chair
- Mathias (USask)
- Perlman (UWaterloo) → Addictions
- Saari (St Eliz Research)
- Stewart (Western) → Child/Youth Chair, Board



Implementation & Testing of interRAI Instruments in Canada



Solid symbols – mandated or recommended by gov't; Hollow symbols – research/evaluation underway

- RAI 2.0/interRAI LTCF
- RAI-HC/interRAI HC
- ★ RAI-MH
- ▲ interRAI CMH
- ◆ interRAI ESP
- ♥ interRAI PC
- ✦ interRAI ID
- ✚ interRAI ED/AC
- ⚡ interRAI CA
- 🌈 interRAI CHA
- 🏠 interRAI BMHS
- 😊 interRAI SQoL
- ✦ interRAI ChYMH



Implementation status in Canada by interRAI Assessment System and number of assessments currently held at University of Waterloo's interRAI Canada data server

interRAI Instrument	Current Implementation Status													Number of Assessments Held at UWaterloo
	YK	NWT	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL	NT	
RAI 2.0 (Long-Term Care)	●	●	●	●	●	○	●			○		●		5,044,480
interRAI Long-Term Care Facility						○	◇		●	○	○		○	10,330
RAI-Home Care	●		●	●	●	○	●			●		●		4,413,724
interRAI Home Care		●		○		○	●		○		●		○	194,502
interRAI Contact Assessment				○	○	○	●							2,624,332
interRAI Community Health Assessment							●				●			61,363
interRAI Palliative Care				◇	◇		●			◇				119,274
RAI-Mental Health						○	●	◇				●		1,330,915
interRAI Community Mental Health							○	○				●		8,667
interRAI Emergency Screener for Psychiatry							○							5,249
interRAI Brief Mental Health Screener			○		●	●	●							72,734
interRAI Intellectual Disability											●			2,231
interRAI Child/Youth Mental Health							○				●			12,480
interRAI Acute Care							◇	◇				◇		997
interRAI Quality of Life			●		◇	◇	○			◇				12,235
TOTAL														13,913,513

- – Mandated across province/territory (Note: includes provinces & territories where implementation to begin in 2019 or later)
- – Mandate planned or mandated regionally only
- - Pilot or local implementations only
- ◇ - Research use only



New interRAI Instruments

Looking for Pilot Sites

- Self-report instruments
 - interRAI Check-Up → Primary care, seniors housing
 - interRAI Caregiver Needs Assessment → Any setting
- Assessor-rated instruments
 - interRAI 0-3
 - interRAI Peds-HC



New Applications of interRAI HC Data

- Personal Support Algorithm
 - Joanna Sinn, PhD thesis
 - Used to inform allocation of PS services in home care
- Referral for Specialized Geriatric Services
 - Sophie Hogan, PhD thesis
 - Used to identify home care clients who may need more specialized geriatric services or referral to geriatrician

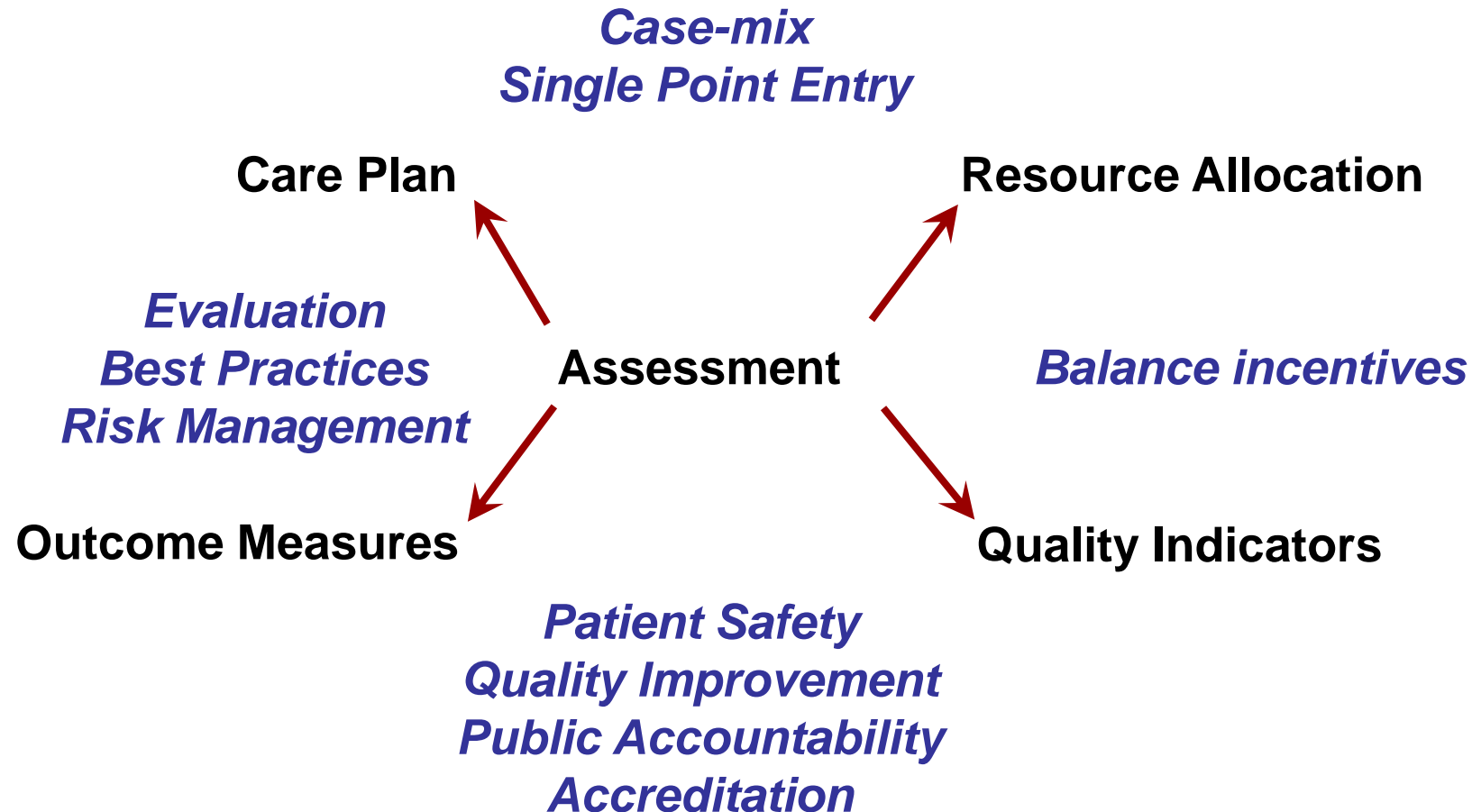


New Applications in Development

- ALC risk algorithm from interRAI HC
 - Predict risk of becoming ALC if hospitalized
 - Stella Arthur dissertation
- Update to MAPLe
 - Refinement of MAPLe
 - Expand range of of MAPLe levels, correct anomalies, resolve inconsistencies with other algorithms (e.g., MI-CHOICE)
 - Send feedback/recommendations to Hirdes



Applications of interRAI's Assessment Instruments: One assessment ... multiple applications



Vulnerable Persons at Risk (VPR) Algorithm

- Three level algorithm to identify persons at greatest risk of adverse outcomes during disaster of any type
- Refinement of original algorithm used in Christchurch NZ earthquake
 - Sandy van Solm dissertation
- Validated against mortality, hospitalization, LTC placement, clinician ratings
- Can be derived from RAI-HC and interRAI HC
- Specifications available through CIHI
- Check that your vendor has this application

JEM

Using standard clinical assessments for home care to identify vulnerable populations before, during, and after disasters

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John P. Hirdes, PhD, FCAHS
Leslie A. Eckel, PhD(c), RSW
George A. Heckman, MD, FRCPC
Philip L. Bigelow, PhD

ABSTRACT

Objectives: Several studies have shown the increased vulnerability of and disproportionate mortality rate among frail community-dwelling older adults as a result of emergencies and disasters. This article will discuss the applicability of the Vulnerable Persons at Risk (VPR) and VPR Plus decision support algorithms designed based on the Resident Assessment Instrument-Home Care (RAI-HC) to identify the most vulnerable community-dwelling (older) adults.

Design: A sample was taken from the Ontario RAI-HC database by selecting unique home care clients with assessments closest to December 31, 2014 (N = 275,797). Statistical methods used include cross tabulation, bivariate logistic regression as well as Kaplan-Meier survival plotting and Cox proportional hazards ratios calculations.

Results: The VPR and VPR Plus algorithms, were highly predictive of mortality, long-term care admission and hospitalization in ordinary circumstances. This provides a good indication of the strength of the algorithms in identifying vulnerable persons at times of emergencies.

Conclusions: Access to real-time person-level information of persons with functional care needs is a vital enabler for emergency responders in prioritizing and allocating resources during a disaster, and has great utility for emergency planning and recovery efforts. The development of valid and reliable algorithms supports the rapid identification and response to vulnerable community-dwelling persons for all phases of emergency management.

Key words: vulnerable populations, disasters, emergency management, frail elderly, interRAI

INTRODUCTION

Canada has experienced—and will continue to experience—a full range of meteorological, geological, and other natural hazards as well as unintended and intentional events.¹ In 1998, severe freezing rainstorms affected Quebec and other parts of North America. In Quebec, these storms caused major power outages and damage to roofs and trees, affecting almost five million people.² More recent examples include severe floods in Calgary, Alberta (2013), a major ice storm in Southern Ontario (2013), and the wild fire in Fort McMurray, Alberta (2016) that led to the evacuation of over 80,000 people.

Concurrently, Canada is experiencing an aging population. By 2036, seniors aged 65 years and older could represent about 25 percent of the total population (between 9.9 and 10.9 million people).³ Moreover, with technological change and the restructuring of healthcare systems, the locus of care is shifting from institutions to the home.⁴ As a result of this policy shift, a growing proportion of elderly persons with substantial care needs are residing in their own homes longer, and are dependent on formal home and community care services to manage their activities of daily living (ADL).

Old age has been repeatedly reported as having an association with morbidity and mortality resulting from a disaster.^{2,5-8} In a summary report based on a series of unpublished case studies of individual

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VPR Scale Components

- Impairment
 - CPS 2+
 - CHESS 3+
 - Vision D1=3+
 - ADL Hierarchy 3+
 - ADL Self-performance
 - Transfer
 - Locomotion
 - Toilet Use
 - IADL
 - Medication management
 - Meal preparation
 - Wheelchair
- Social Isolation
 - Lived alone
 - Alone Most/All F3a=3
 - Primary Helper
 - Withdrawal soc act
 - Reduces Social intx
- Caregiver
 - Any caregiver distress
 - Conflict fam/friends
- Technology Dependent
 - Dialysis, oxygen



Multi-pronged information strategy for emergency response

- Target vulnerable populations for immediate follow-up
- Expanded monitoring for medium term risk of increased mortality related to on-going stress of event and relocation
- Supporting continuity of care by transmission of interRAI assessments and care planning information for evacuees
- Care of evacuees using interRAI Acute Care
- Management of evacuation process
 - Decide who to move, when and how
- Post-emergency evaluation
 - E.g., Mor papers on Hurricane Katrina



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Thank you!

Questions/comments?

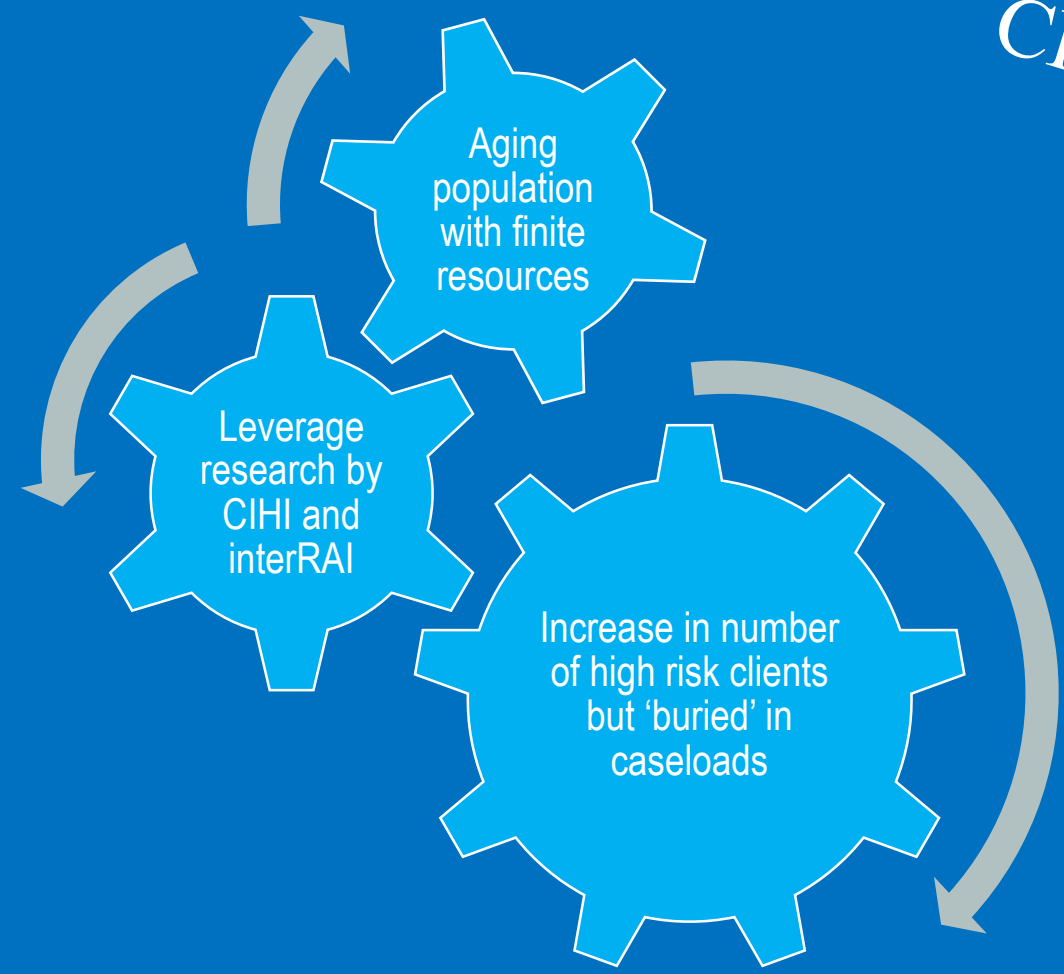
Investing in Communities

The Role of interRAI Assessments: Linking Data to Interventions/ Resource Allocation



Canadian Home Care Association Presentation
Ian Ritchie
September 10, 2019

WHY CHANGE?



Because we have to!

Alice's Experience

Ontario 

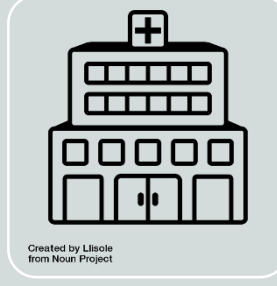
- **84 Year Old Female**
- **MAPLe 5/5 and fits HIGH RISK profile for CIHI and interRAI**
- **CRISIS risk level 4 (automatically eligible for LTC)**
- **Dementia and multiple health issues/ high CPS/MMSE**
- **Clear caregiver distress and family burnout**
- **Multiple hospitalizations that ended as ALC LTC**
- **Personal support hours/visits 10 hours/week**
- **No home visit by Care Coordinator for 6 months**
- **Alice is 1 of 40 or 80 clients on a caseload**



Needle in a Haystack Issue



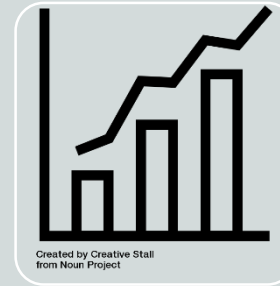
According to Cancer Care Ontario there are 4600+ clients in Ontario hospitals every day



At MGH Every week 100 clients will be admitted to home care each week



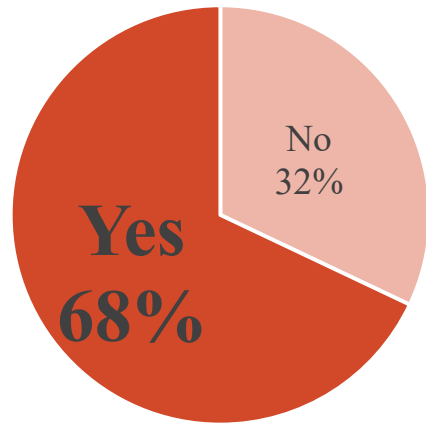
Only 1.58 clients per week will be so debilitated and frail that they will end up with an ALC-LTC designation



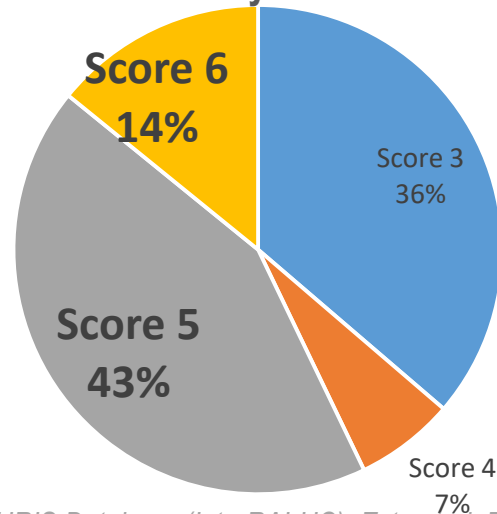
Cumulative total over 12 months will be a loss of 82 acute care beds in one medium sized hospital

Cognitive Performance

% of Clients with Dementia



% of Clients by CPS Score

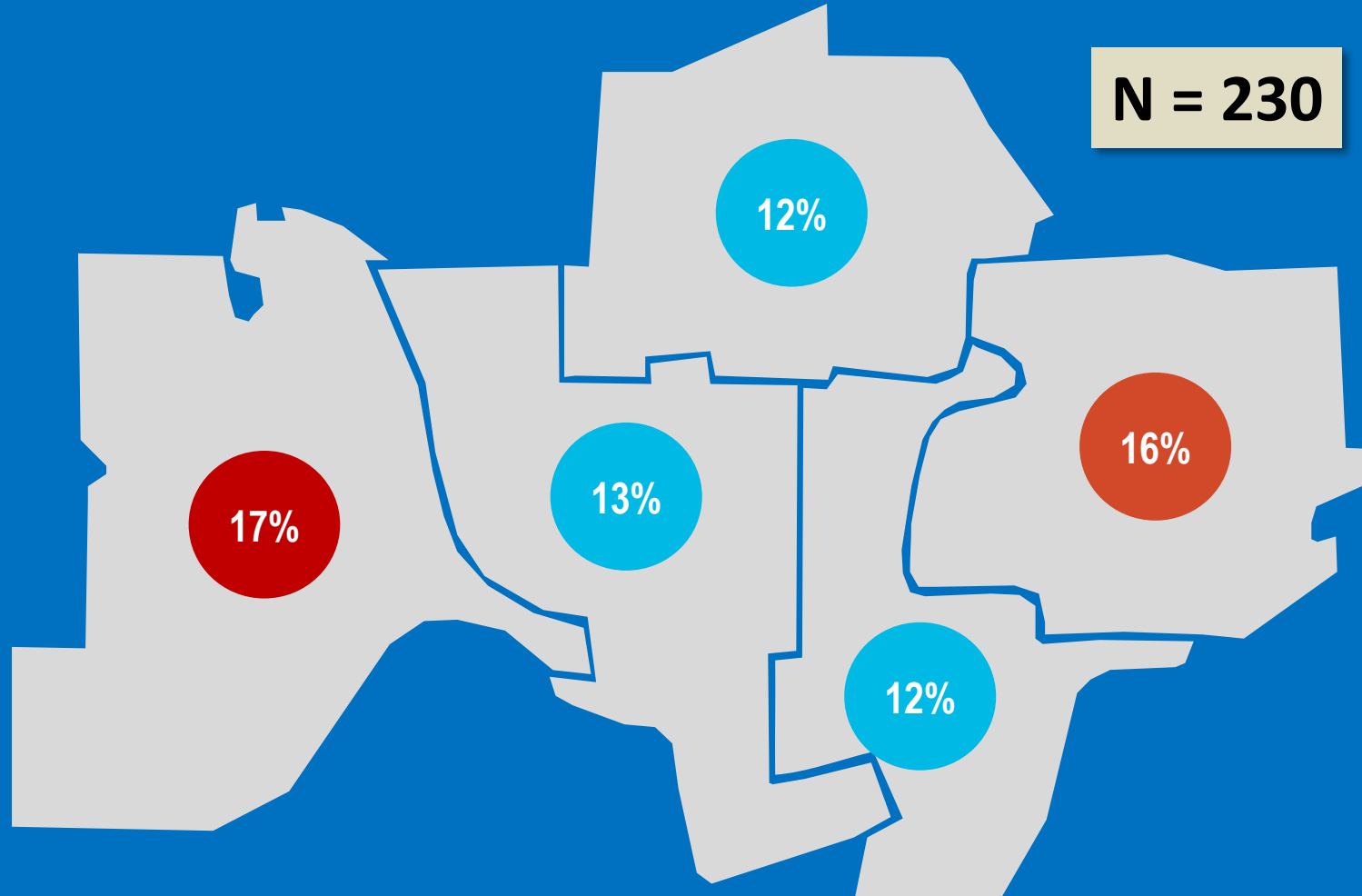


Created by dDara
from Noun Project

% of Clients with Cognitive Performance Scale Score of 6 (FY 2018/19)

Ontario 

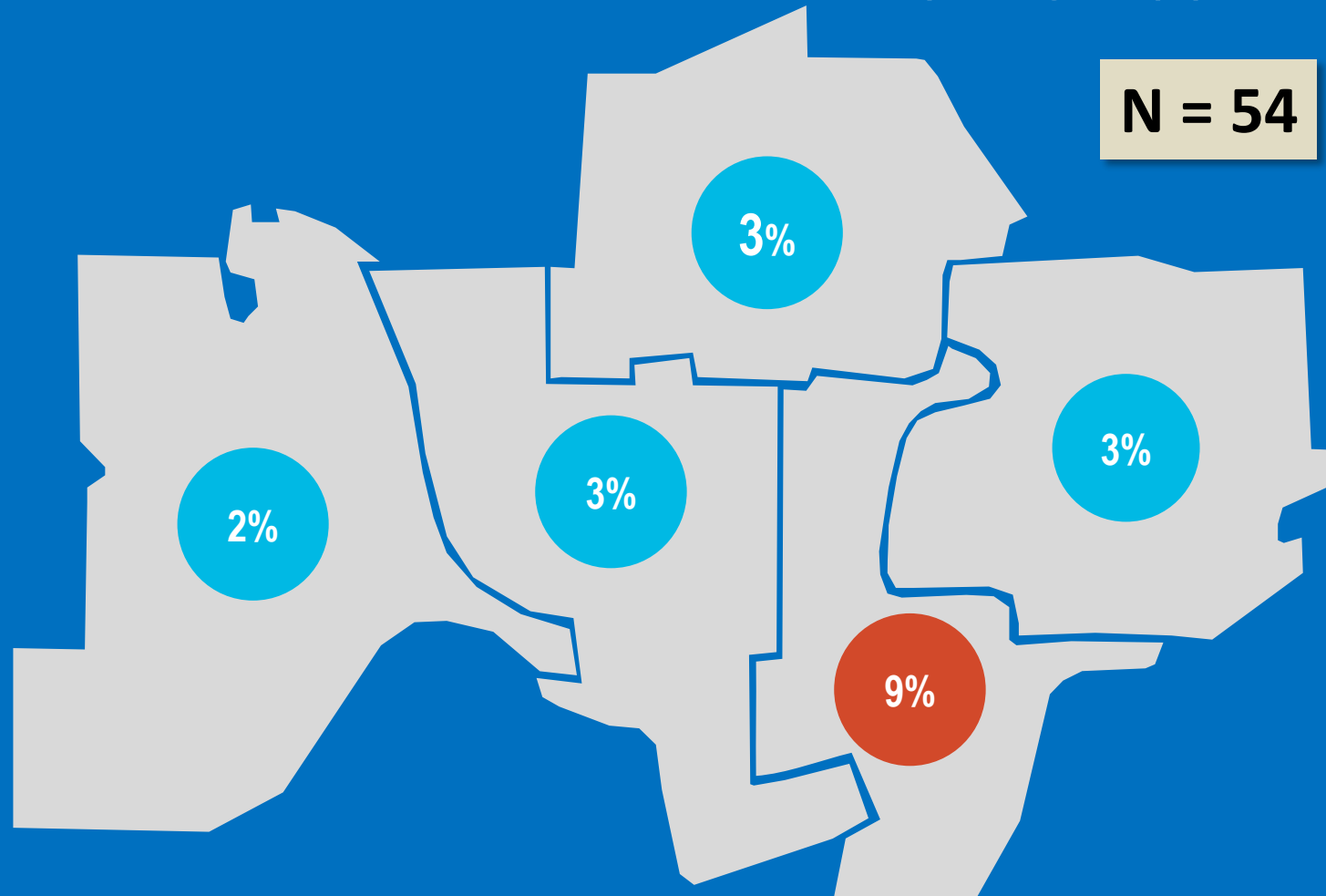
N = 230



- West and East Toronto Sub-Regions have the highest proportion of clients with a CPS score above 6

West Toronto	Mid-West Toronto	North Toronto	Mid-East Toronto	East Toronto	Grand Total
17.4%	13.0%	11.9%	11.6%	15.6%	14.1%

Percent (%) of Clients that Report No Informal Helper (Caregiver) (FY 2018/19)



- Clients in Mid-East report the highest rate of no informal help or caregivers

West Toronto	Mid-West Toronto	North Toronto	Mid-East Toronto	East Toronto	Grand Total
2.0%	3.4%	3.3%	8.5%	2.6%	3.3%

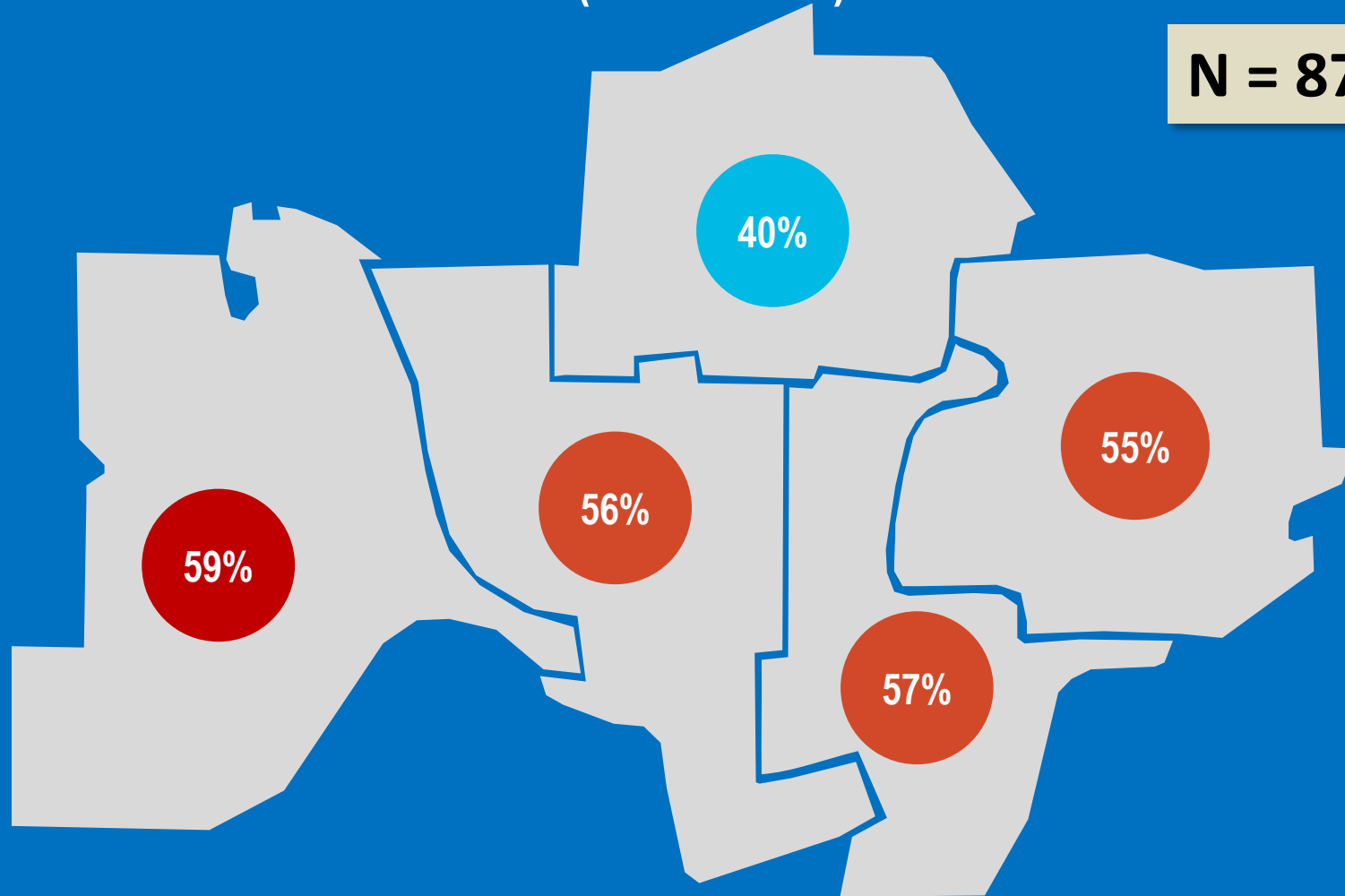
Caregiver Distress

- Informal helper reports difficulty to continue in caregiving activities
- Primary helper reports feelings of distress, anger, or depression
- Family/friends reports feeling overwhelmed



Percent (%) of Clients that Report Caregiver Distress (FY 2018/19)

N = 871

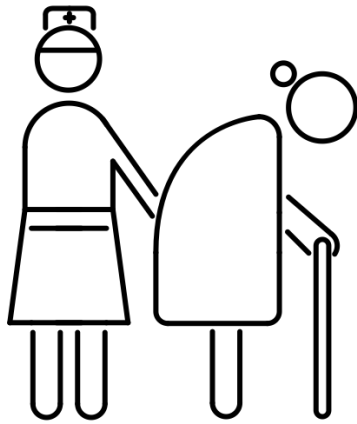


- Clients in West Toronto exhibits the highest levels of caregiver distress, and North Toronto has the lowest

West Toronto	Mid-West Toronto	North Toronto	Mid-East Toronto	East Toronto	Grand Total
59.4%	55.9%	40.1%	56.6%	54.9%	53.6%

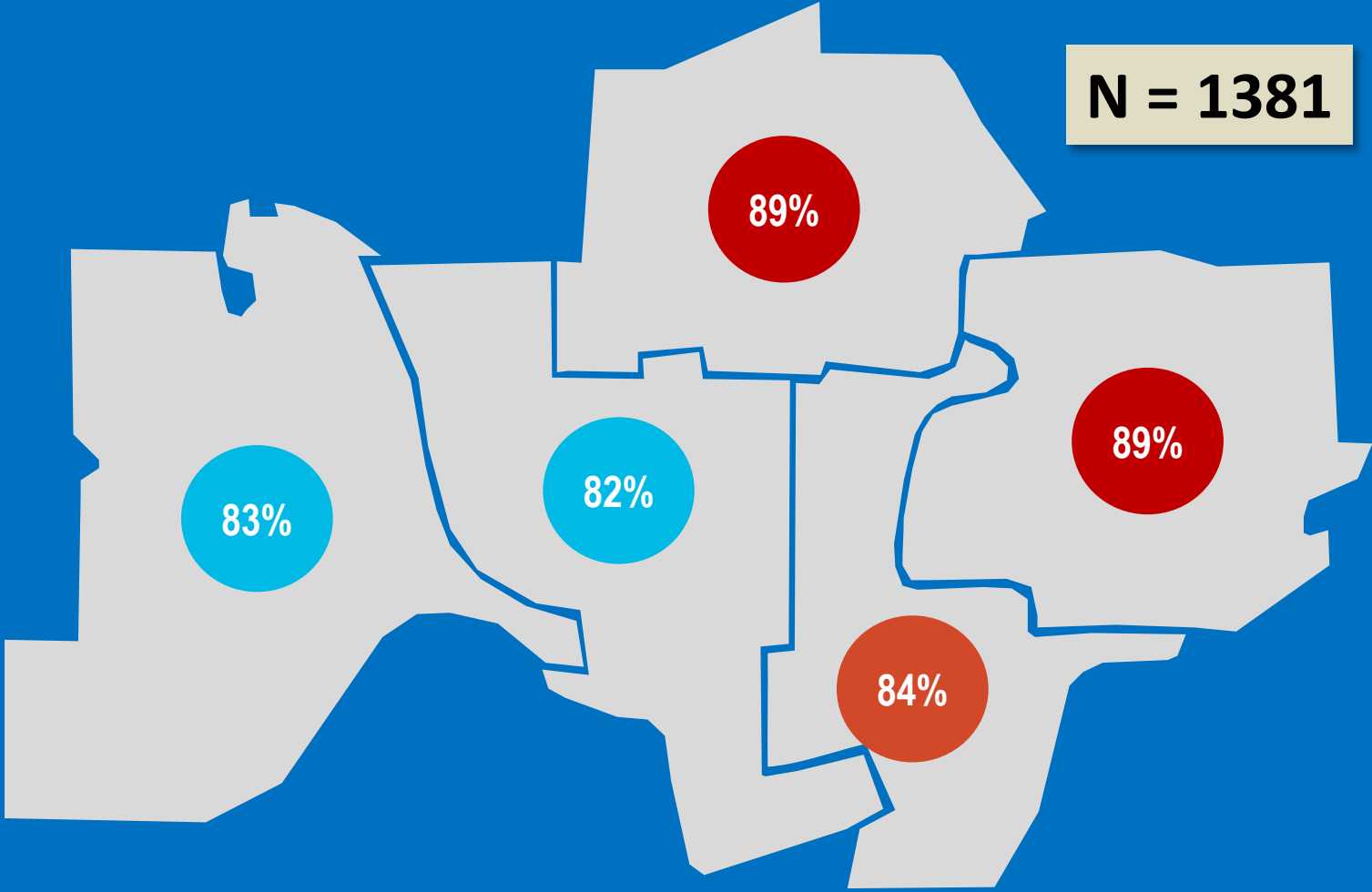
Personal Support Care Group

- The Personal Support algorithm provides a framework for allocating personal support
- Ranges from 1 to 6, where a higher group indicates greater need for personal support (1 = low high, 6 = high need)



Created by Federico Falaschi
from Noun Project

% of Clients with PS Score at 5 or Above (FY 2018/19)



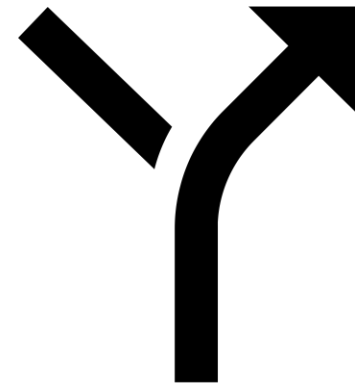
- North and East Toronto Sub-Regions have the highest proportion of clients with PS score above 5

West Toronto	Mid-West Toronto	North Toronto	Mid-East Toronto	East Toronto	Grand Total
83.4%	82.3%	89.0%	84.4%	89.2%	85.2%

DIVERT Scale

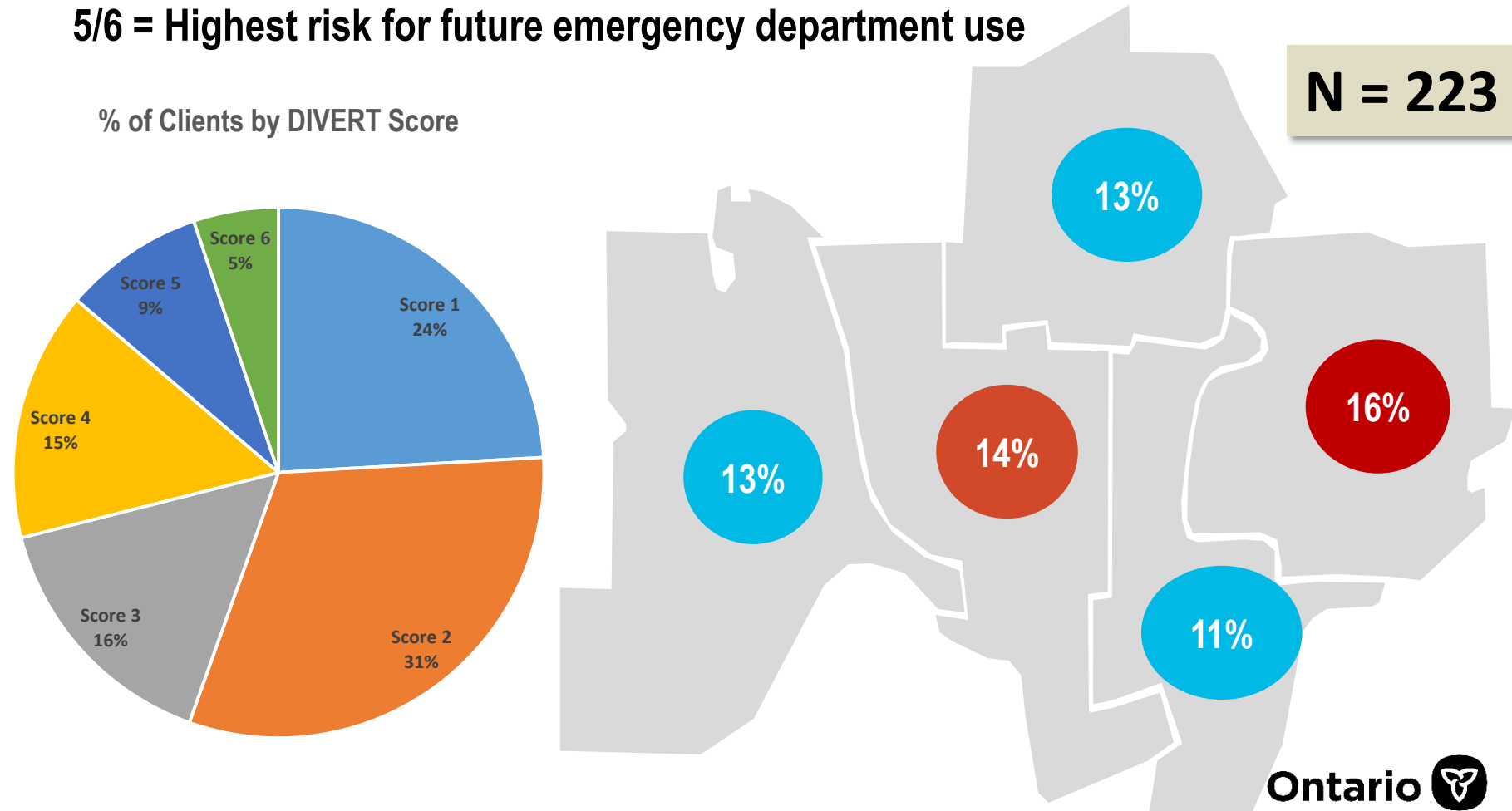
Detection of Indicators and Vulnerabilities for Emergency Room Trips

DIVERT Scale is designed to classify the risk of emergency department use in frail community-dwelling older adults.



Clients with High Scores on Detection of Indicators and Vulnerabilities for Emergency Room Trips (DIVERT) Scale

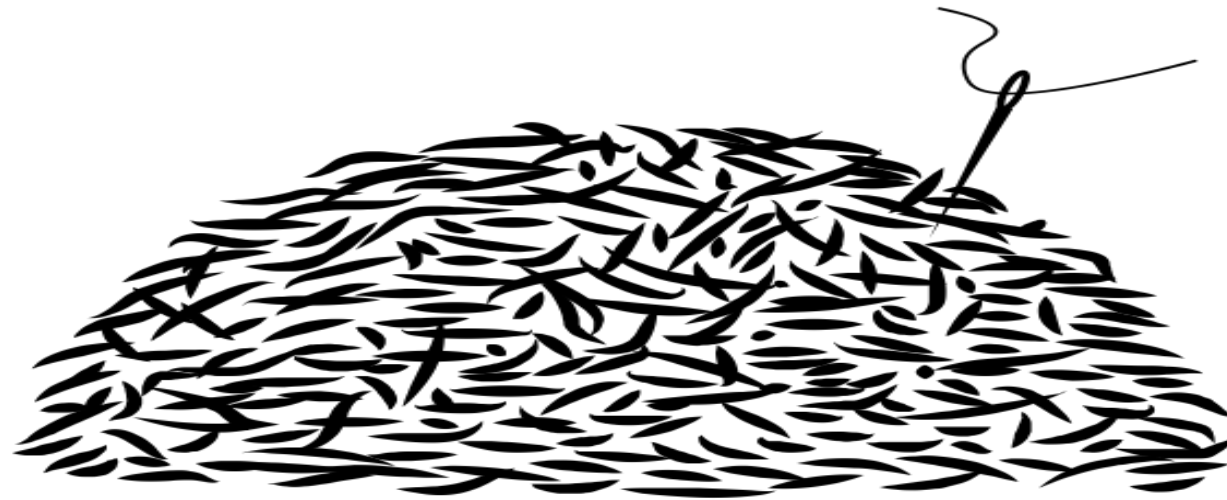
5/6 = Highest risk for future emergency department use



- Of the clients that met the CIHI criteria **14% are at the highest risk of future ED use** (score in 5-6 range)

Finding the 'Right' Clients

Using data to find and target the physically frail.



Created by R Diepenheim
from Noun Project

Latest research from InterRAI

(reference at end of presentation)

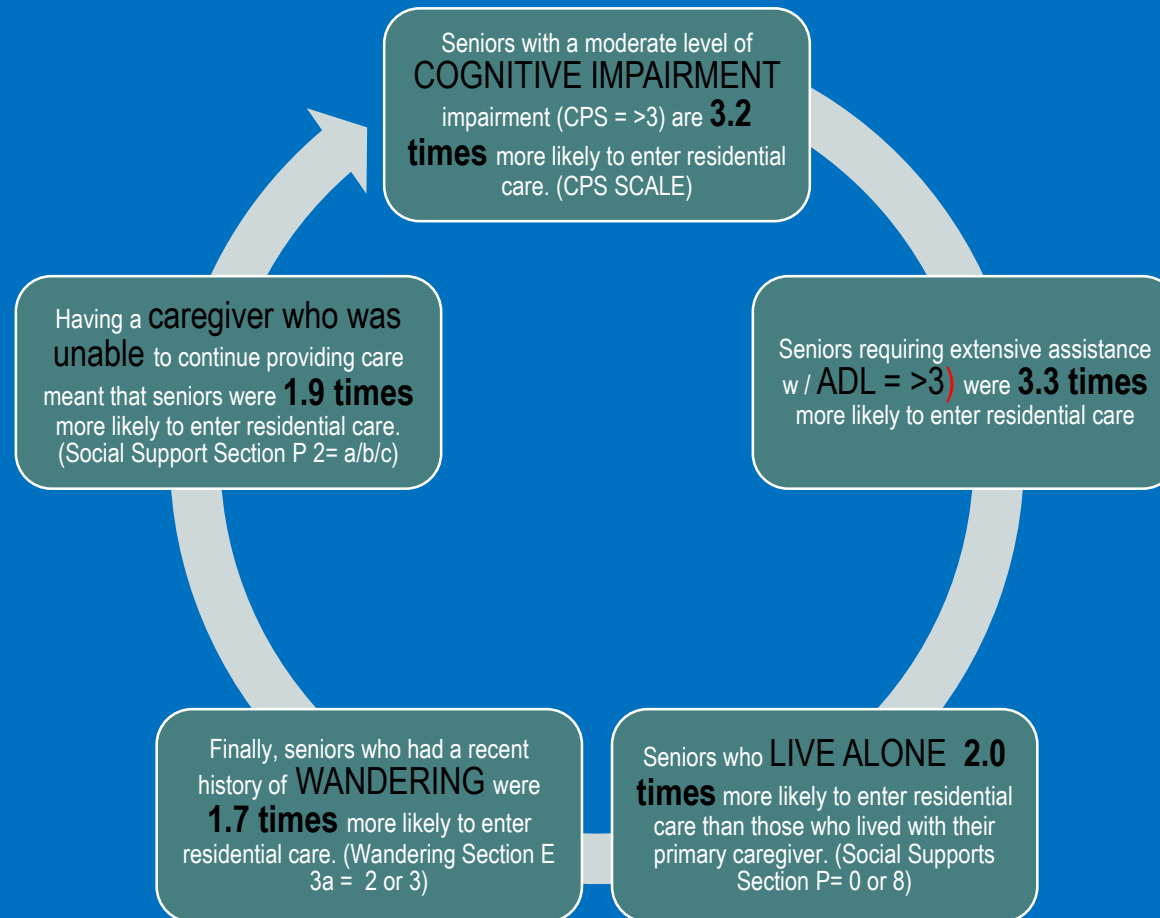
29% of MAPLe 4/5 plus
CHESS 4/5 will be in LTC
or pass away within 6
months of the
Assessment- This
Presents a large RISK

13,460 active home care clients with a interRAI-HC assessment

1,666 clients that fulfil the 'Adverse Events in Home Care' paper criteria (MAPLe \geq 4
and CHESS \geq 3)

CIHI RISK FACTORS

(n=85,000 RAI HC Assessments/Reassessments)

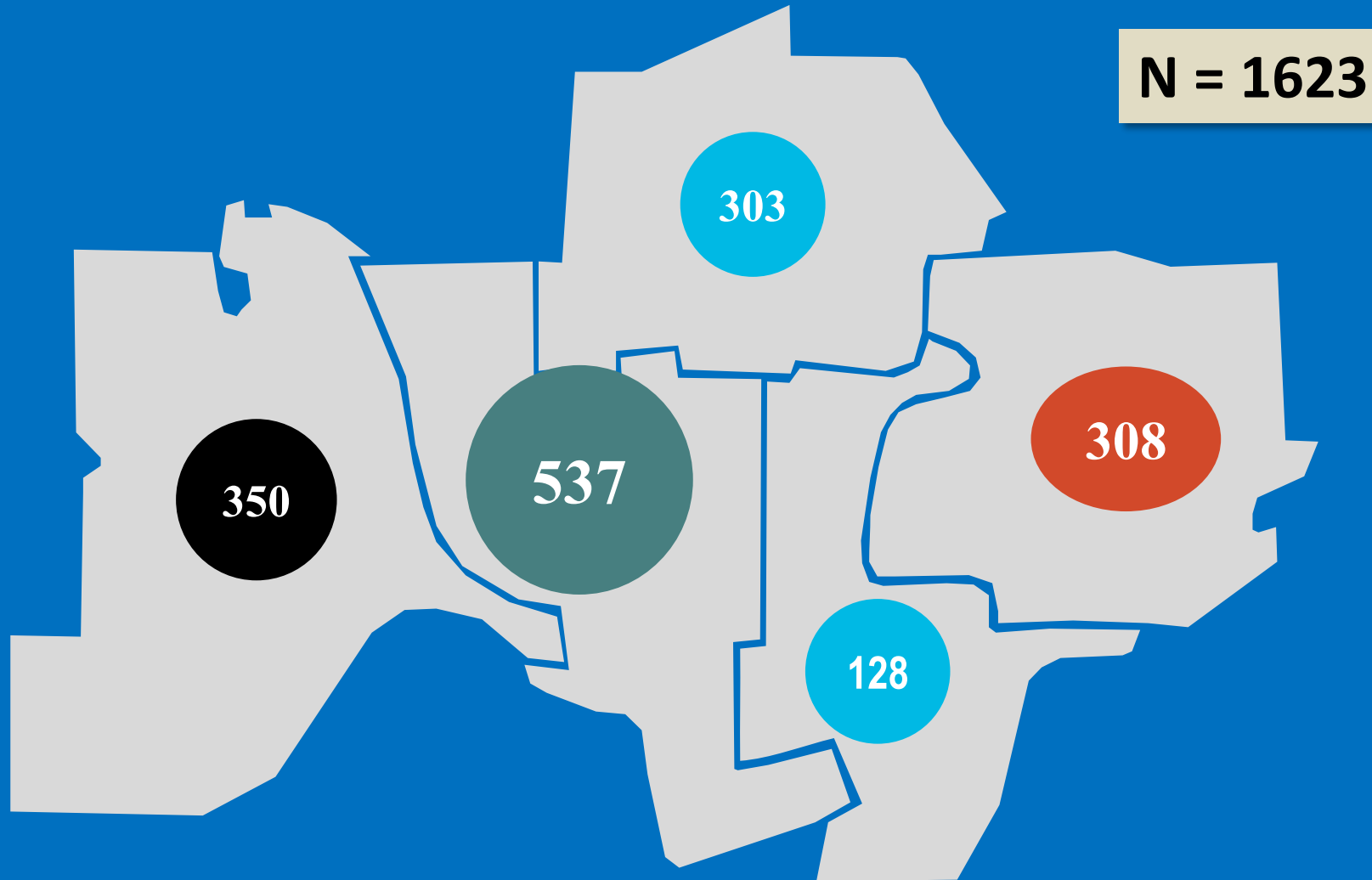


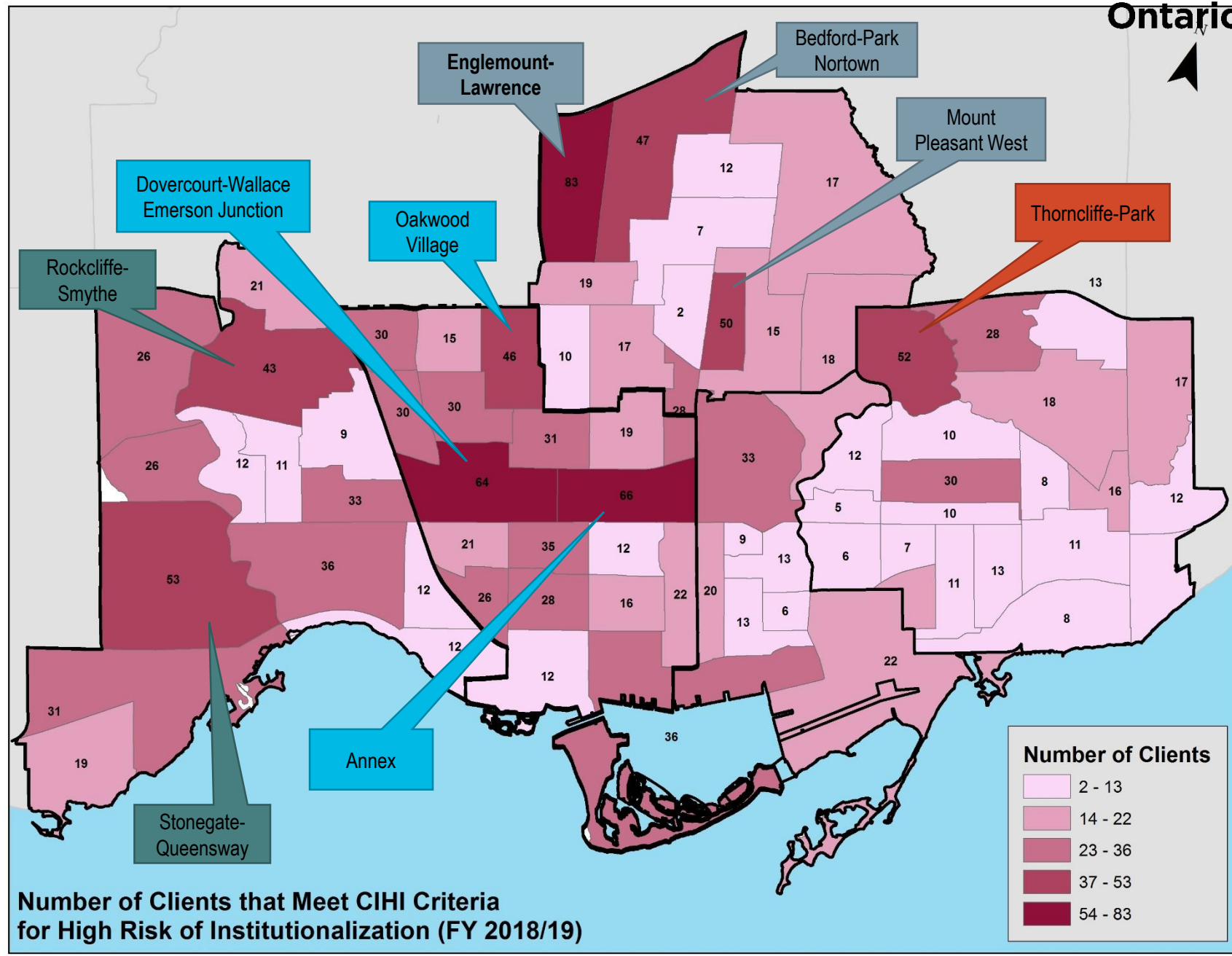
Active* Client Stratification

- 13,460 active home care clients with a interRAI-HC assessment
- 1,356 clients that fulfil CIHI Seniors in Transition Criteria (CPS \geq 3, ADLH \geq 3 and has caregiver distress or lives without caregiver)
- 1,666 clients that fulfil the Adverse Events in Home Care Paper Criteria (MAPLe \geq 4 and CHESS \geq 3)
- Only 299 clients fulfil the criteria for both papers

*Active clients as of June 20, 2019

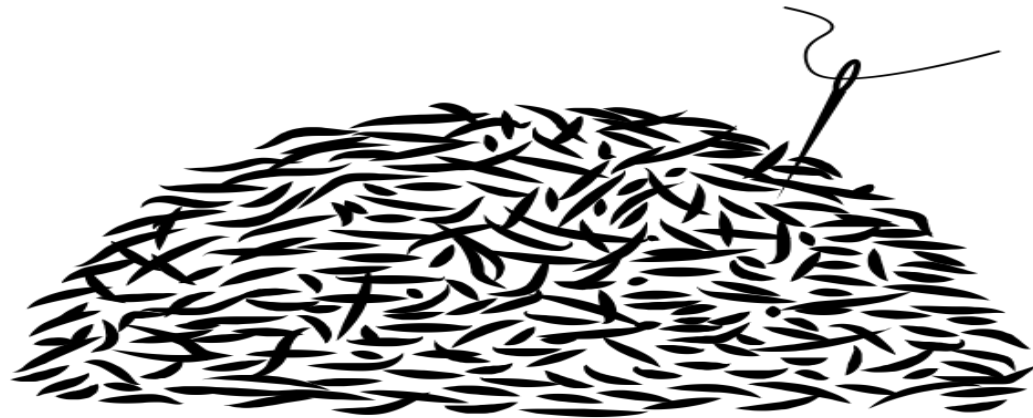
Number of Clients that Meet CIHI Criteria (FY 2018/19)





Strategy #2

Once you land on the “who”now the “what”



Potential Options/Ideas/Strategies



Original CNAV tool view

Home | Reporting Services - BI Client Ser | Reporting Services - S0013_Case | +

tcnet.partners.uhn.ca/sites/BI/_layouts/15/ReportServer/RSViewerPage.aspx?rv:RelativeReportUrl=/sites/BI/Report%20Library/S0013_CCCT/S0013_Caseload%20Navigator%2...

TCNET BI Center > Report Library > S0013_CCCT

Actions | 1 of 1 | Find Next

Client Name	HC BRN	CSSA BRN	LTC BRN	Care Plan Suggestions
[REDACTED]	5015		[REDACTED]	1
[REDACTED]	0980			1
[REDACTED]	95			1
[REDACTED]	92			4
[REDACTED]	8383			1
[REDACTED]	14		34	3
[REDACTED]	8929		90	4
[REDACTED]	01			1
[REDACTED]	6545			
[REDACTED]	5813		76	3
[REDACTED]	40			3
[REDACTED]	2431		58	3
[REDACTED]	3096			1
[REDACTED]	0802			2
[REDACTED]	5909			1
[REDACTED]	4775			3
[REDACTED]	5657		46	4
[REDACTED]	5245			2
[REDACTED]	6363			3
[REDACTED]	5510			3
[REDACTED]	4911			4
[REDACTED]	9742			4
[REDACTED]	6524			3
[REDACTED]	7391			4
[REDACTED]	1829			3
[REDACTED]	5585			5

Original view of CNAV tool with all 80 elderly clients looking the same.....basically was simply a "list"

Parameters

Complex/Chronic/Program

CareCoordinator

CNAV MOCK UP- Use strategies like this to pull out and focus on attention ...instead of Risky Clients being buried inside caseloads

Reporting Services - Develop...

TCNET BI Center > Report Library > CCCT Development Report

Unique Clients: 108

High Risk Clients: 45
 CIHI Criteria CHES/MAPLE Criteria

CCM Population

of Quality Issues

Map Cas...

Client Name	HC BRN	CSSA BRN	LTC BRN	CIHI High Risk	CHES/MAPLE High Risk	DIVERT	CRISIS Score	Age	Hospital Admissions (May 2018 - Apr 2019)	ED Visits (May 2018 - Apr 2019)	E-Notificat (Last 30 Da
[Redacted]	[Redacted]	[Redacted]	[Redacted]	High Risk	High Risk	3	3d	84	1	1	
[Redacted]	[Redacted]	[Redacted]	[Redacted]	High Risk	High Risk	4	5	89	1	3	
[Redacted]	[Redacted]	[Redacted]	[Redacted]	High Risk	High Risk	5	4a	88	1	3	
[Redacted]	[Redacted]	[Redacted]	[Redacted]	High Risk	High Risk	2	4a	95	0	0	
[Redacted]	[Redacted]	[Redacted]	[Redacted]	High Risk	High Risk	4	5	87	0	0	
[Redacted]	[Redacted]	[Redacted]	[Redacted]	High Risk		5	4a	86	0	0	
[Redacted]	[Redacted]	[Redacted]	[Redacted]	High Risk		4	3a	37	0	3	
[Redacted]	[Redacted]	[Redacted]	[Redacted]	High Risk		2	4a	89	0	1	
[Redacted]	[Redacted]	[Redacted]	[Redacted]	High Risk		2	3a	94	0	0	
[Redacted]	[Redacted]	[Redacted]	[Redacted]	High Risk		2	2	63	1	6	E-Notification
[Redacted]	[Redacted]	[Redacted]	[Redacted]	High Risk		2	4a	49	1	3	
[Redacted]	[Redacted]	[Redacted]	[Redacted]	High Risk		2	4c	91	0	0	
[Redacted]	[Redacted]	[Redacted]	[Redacted]	High Risk		2	5	94	0	0	
[Redacted]	[Redacted]	[Redacted]	[Redacted]	High Risk		4	4a	87	0	1	
[Redacted]	[Redacted]	[Redacted]	[Redacted]	High Risk		5	3a	89	0	1	
[Redacted]	[Redacted]	[Redacted]	[Redacted]	High Risk		3	1	89	0	0	E-Notification

Ontario

7/19/2019

VIEW OF UPDATED CNAV TOOL

Reporting Services - Develop... | https://tcnet.partners.uhn.ca/sites/BI/_layouts/15/f... | Snagit

File Edit View Favorites Tools Help

Home - Client Services | Google | Login pay | Suggested Sites | Toronto Central Local He... | Web Slice Gallery | Reporting Site Home Page | Reporting Services - S0017... | Macro SR report | Micro Neigh report

TCNET BI Center > Report Library > CCCT Development Report

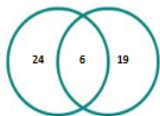
Actions | 1 of 1 | Find Next | 100%


Home Care Only
89
Total Home Care: 108

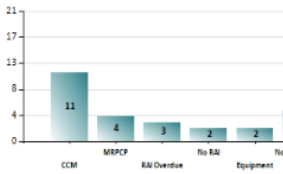
LTC Only
5
Total LTC: 23

CSS Only
0
Total CSS: 0

Clients With Multiple Referral Types
19







Parameters

Complex/Chronic/Program
Complex

CareCoordinator
EA-CO-01, EB-CO-03, EC-CO-05

Apply

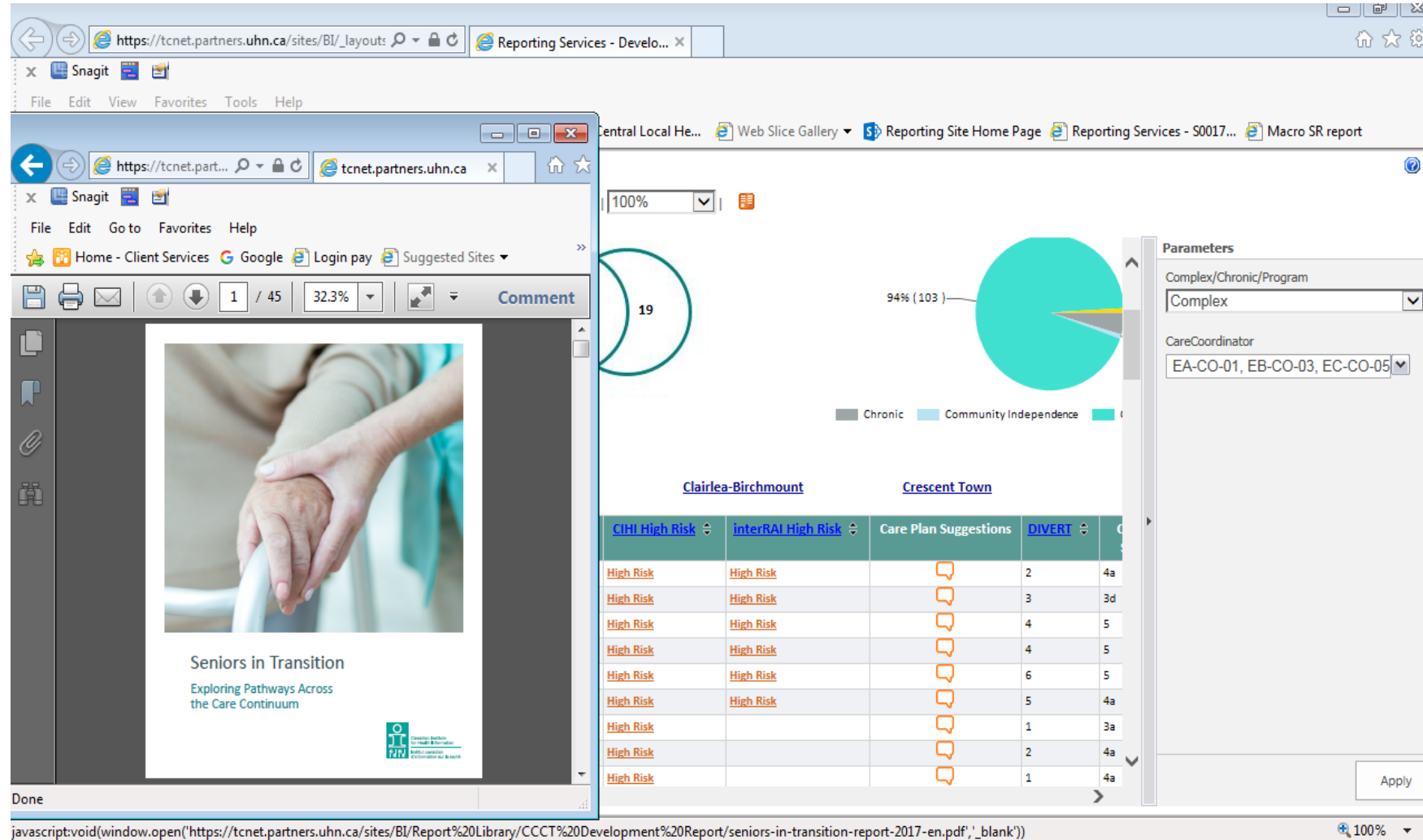
Birchcliffe-Cliffside | Blake-Jones | Broadview North | Clairlea-Birchmount | Crescent Town

Client Name	HC BRN	CSSA BRN	LTC BRN	CIHI High Risk	CHESS/MAPIe High Risk	Care Plan Suggestions	DIVERT	CRISIS Score	Age	Hospital Admissions (Jun 2018 - May 2019)	ED Visits (Jun 2018 - May 2019)	E-Notification (Last 30 Days)
[Redacted]				High Risk	High Risk		5	4+	88	1	2	
[Redacted]				High Risk	High Risk						3	
[Redacted]				High Risk	High Risk						0	
[Redacted]				High Risk	High Risk						0	
[Redacted]				High Risk	High Risk						2	
[Redacted]				High Risk	High Risk						0	
[Redacted]				High Risk	High Risk						0	
[Redacted]				High Risk	High Risk						0	
[Redacted]				High Risk	High Risk						0	
[Redacted]				High Risk	High Risk						0	
[Redacted]				High Risk	High Risk						0	
[Redacted]				High Risk	High Risk		1	3+	90	0	0	
[Redacted]				High Risk	High Risk		2	4+	78	1	1	
[Redacted]				High Risk	High Risk		1	4+	22	0	0	
[Redacted]				High Risk	High Risk		2	4+	79	0	1	E-Notification
[Redacted]				High Risk	High Risk		3	2	60	0	4	E-Notification

- Consider starting LTC application[Reason:No LTC referral]
- Consider increasing support[Reason:Current week PSW hours under 21 Hours]
- Consider scheduling home visit with client as soon as possible[Reason:Days since last home visit greater than 30 days]
- Consider making the client a 'crisis client' for LTC[Reason:Crisis Score 4+]
- Consider creating a Coordinated Care Plan [Reason: Complex Client with no CCP]

75%

CNAV tool link to research article



The screenshot shows a web browser window displaying a report interface. The main window has a URL of https://tcnet.partners.uhn.ca/sites/BI/_layout:. The interface includes a pie chart showing 94% (103) for a category, with a legend for Chronic, Community Independence, and another category. Below the chart are two sections: **Clairlea-Birchmount** and **Crescent Town**. A table below these sections lists data for various risk levels and care plan suggestions.

CIHI High Risk	InterRAI High Risk	Care Plan Suggestions	DIVERT	
High Risk	High Risk		2	4a
High Risk	High Risk		3	3d
High Risk	High Risk		4	5
High Risk	High Risk		4	5
High Risk	High Risk		6	5
High Risk	High Risk		5	4a
High Risk			1	3a
High Risk			2	4a
High Risk			1	4a

Overlaid on the left is a smaller browser window showing a PDF document titled "Seniors in Transition: Exploring Pathways Across the Care Continuum". The PDF features an image of an elderly person's hands being held by a caregiver. The document is from the Ontario Institute for Studies in Education (OISE) at the University of Toronto.

At the bottom of the browser window, a JavaScript command is visible: `javascript:void(window.open('https://tcnet.partners.uhn.ca/sites/BI/Report%20Library/CCCT%20Development%20Report/seniors-in-transition-report-2017-en.pdf','_blank'))`

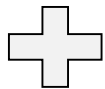
High Risk Basket Of Services (Straw dog- another example of a possible strategy)

Service	Sector
• Intensive Case Management	NCT
• Nursing/RRN/NP	NCT
• PSW	NCT
• Therapies	NCT
• Equipment	NCT
• Pharmacy	Pharmacy
• Home Based primary care including access to physician/Geriatrician	TBD/MGH/Primary Care
• Meal and grocery delivery	NCT
• Meal prep and feeding	NCT
• EMS check in's	EMS
• Adult Day Program	NCT
• Transportation services	NCT
• Tele monitoring and	NCT/Telehome care/MGH/Virtual Care
• In home Lab work	NCT
• Short Stay Respite	NCT/LTC
• Caregiver Respite/Support	NCT/AIz/TBD
• Friendly visiting and social support	NCT/TBD
• Frailty Intervention Team	Providence

Living ALONE

Over the age of **65**

Expresses
Sadness



CPS 4+
(mmse=7)



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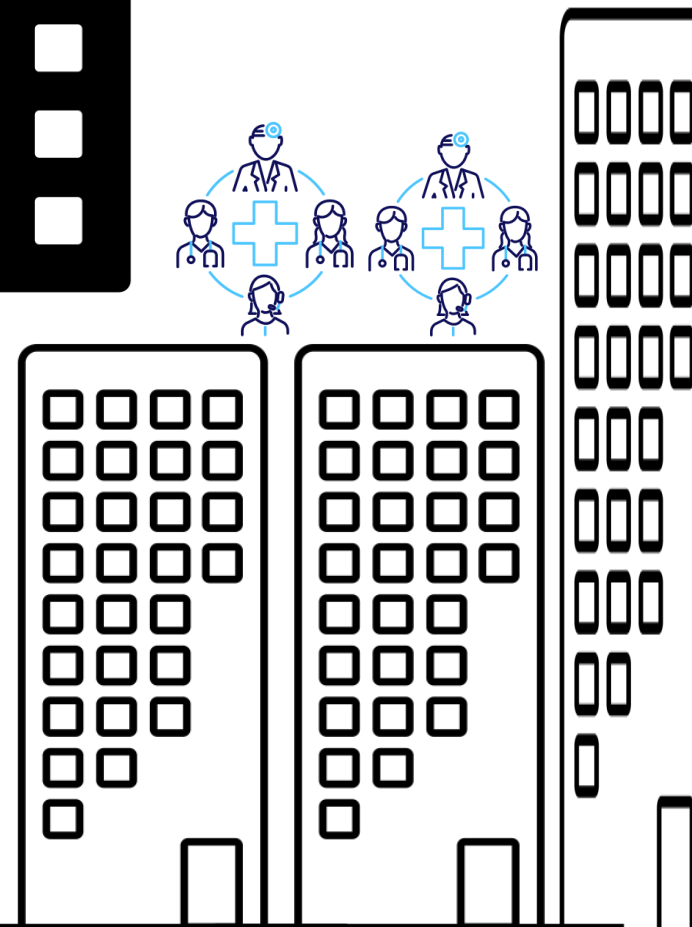


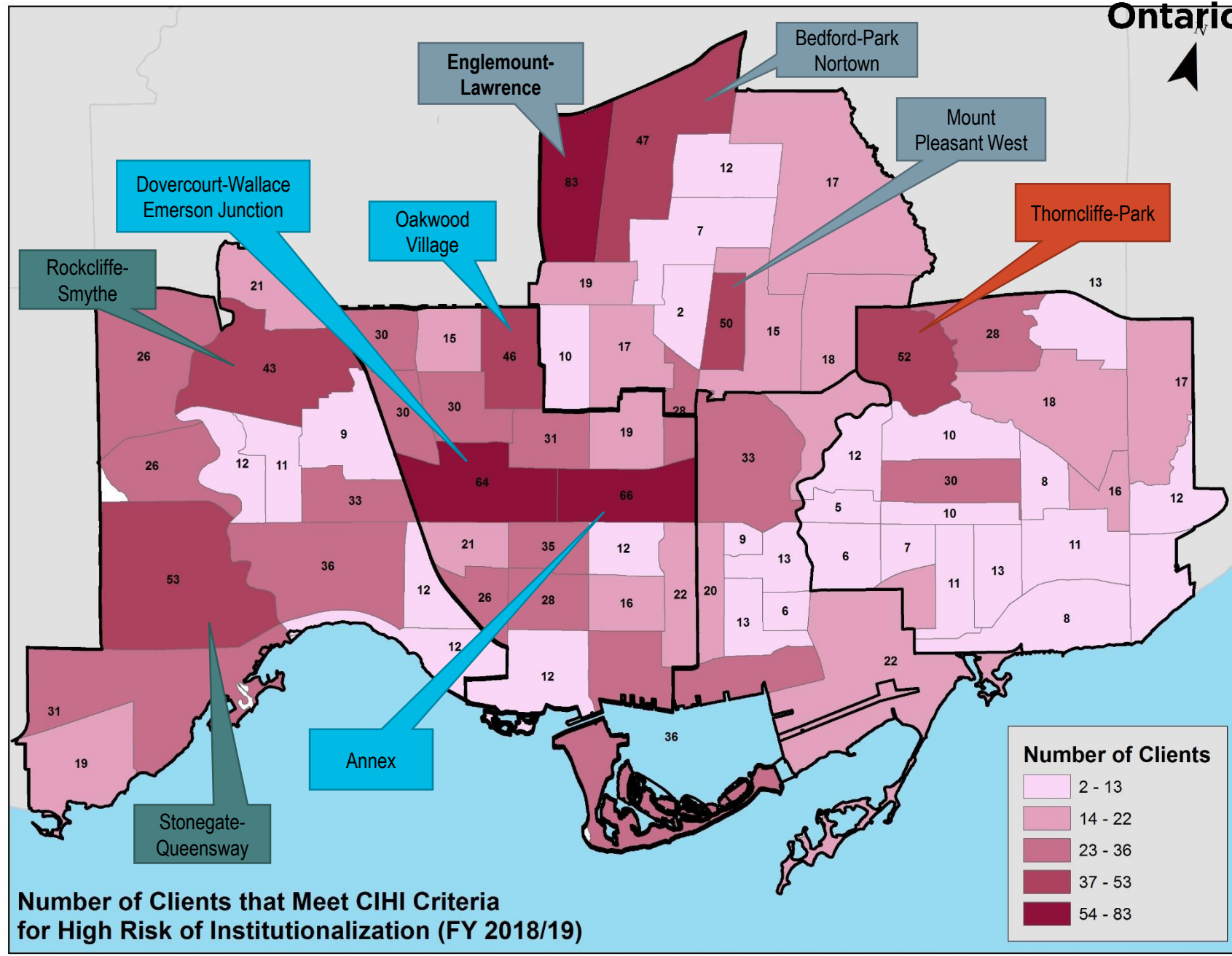
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Enablers:

BI
EDUCATION
OPERATIONS





Englemount-Lawrence

Bedford-Park Nortown

Mount Pleasant West

Thorncliffe-Park

Dovercourt-Wallace Emerson Junction

Oakwood Village

Rockcliffe-Smythe

Annex

Stonegate-Queensway

Ian Ritchie ian.ritchie@tc.lhins.on.ca C: 1 416 578 0472



Thank you!

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References

- <https://www.intellectuالتakeout.org/article/why-loneliness-epidemic-upon-us>
- <https://www.ucsf.edu/news/2012/06/12184/loneliness-linked-serious-health-problems-and-death-among-elderly>
- <https://news.uchicago.edu/story/loneliness-can-be-contagious-study-finds>
- <https://www.cihi.ca/en/seniors-in-transition/web-tools/population-growth>
- <https://www.cambridge.org/core/journals/canadian-journal-on-aging-la-revue-canadienne-du-vieillissement/article/adverse-events-in-home-care-identifying-and-responding-with-interrai-scales-and-clinical-assessment-protocols/C11F3EC59628F32596A90B9A6D58B957/core-reader>



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PROFESSOR JOHN HIRDES



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