ACUTE CARE FOR ELDERS (ACE) 12-MONTH QUALITY IMPROVEMENT COLLABORATIVE

PROSPECTUS

Canadian Foundation for Healthcare Improvement / Fondation canadienne pour l'amélioration des services de santé

TVN Améliorer les soins aux aînés dont la santé se fragilise / Improving care for the frail elderly

MOUNT SINAI HOSPITAL Joseph and Wolf Lebovic Health Complex

The ACE collaborative is a partnership between the Canadian Foundation for Healthcare Improvement and the Technology Evaluation in the Elderly Network.

The Canadian Foundation for Healthcare Improvement (CFHI) identifies proven innovations and accelerates their spread across Canada by supporting healthcare organizations to adapt, implement and measure improvements in patient care, population health and value-for-money. CFHI is a not-for-profit organization funded through an agreement with the Government of Canada. The views expressed herein do not necessarily represent the views of the Government of Canada.

Technology Evaluation in the Elderly Network (TVN) is Canada's network for frail elderly and late-life care solutions. We support original research, and train the next generation of health care professionals and scientists to improve outcomes for elderly Canadians across all settings of care. Recognizing they may be nearing the end of life, TVN is dedicated to improving advance care planning and end-of-life care.

EXECUTIVE SUMMARY

Overview

The Canadian Foundation for Healthcare Improvement (CFHI), in partnership with the Technology Evaluation in the Elderly Network (TVN), is inviting applications from healthcare delivery organizations to participate in a quality improvement collaborative focused on spreading innovative elder-friendly care practices. Too often in Canadian healthcare, promising innovations remain isolated pockets of excellence. Any organization working to improve patient care, health outcomes and value-for-money should ask: "What's out there that works?" The Acute Care for Elders (or ACE) collaborative will support participating healthcare delivery organizations across Canada and internationally with the implementation, evaluation and spread of proven evidence-informed elder-friendly care practices. The ACE collaborative responds to what those working in healthcare across Canada and internationally are telling us they need in order to kick-start sustainable improvement at the service delivery level: seed funding, an evidence-based program and coaching to support the implementation of specific elder-friendly practices.

The Innovation

Over the last six years, Mount Sinai Hospital has become Canada's most widely recognized elder-friendly hospital. Located in Toronto, Ontario, Mount Sinai has implemented evidence-informed models and point-of-care interventions to demonstrate better patient, provider and system outcomes. Under the banner of the ACE Strategy, it has demonstrated significant improvements in overall quality of care outcomes, as well as reduced lengths of stay, admissions, readmissions and inappropriate resource utilization through the successful implementation of evidence-informed care processes and strategies within the hospital and across the continuum of care. The hospital's continuous quality improvement is supported through a rigorous balanced scorecard benchmarking and performance measurement tool to evaluate the effectiveness of its strategy on improving care for its elderly patients.

Each component of Mount Sinai's ACE Strategy is linked and integrated within an evidence-informed and seamless model that spans the continuum of the emergency department (ED), inpatient, outpatient and community care. This strategy was based on delivering improvements using existing resources, while demonstrating the importance of adopting an interprofessional team-based approach to care. For the care of each older patient, the strategy capitalizes on the expertise of specialist physicians – particularly geriatricians and geriatric psychiatrists – advanced practice nurses, social workers, therapists, pharmacists, dieticians and volunteers. Appendix 1 outlines the full scope of interventions and associated process and outcome measures.

Benefits of Joining the Collaborative

- Up to $40,000 in seed funding to implement the initiative
- CFHI collaborative support with the implementation, evaluation and spread of proven evidence-informed elder-friendly care practices
- Peer-to-peer networking and exchange among the entire cohort
- Monthly team educational webinars
- Support for performance measurement and evaluation
- An in-person workshop to foster cross-team learning and sharing
- Access to a network of expert faculty coaches, including Dr. Samir Sinha and his team who have led the ACE Strategy at Mount Sinai

- Individual coaching to ensure a rapid pace for testing change and troubleshoot, as needed
- Access to online learning tools and activities

Results

Comparing its baseline performance year of 2009/10 to 2013/14, four years after the launch of the ACE Strategy, Mount Sinai achieved significant results for its medical inpatients aged 65 and over, including:

- reduced total lengths of stay (12 days → 8 days)
- reduced alternate level of care days (20 percent reduction)
- reduced readmissions within 30 days (15 percent → 13 percent)
- reduced urinary catheter use (56 percent → 15 percent)
- reduced pressure ulcer incidence (93 percent reduction)
- improved rate of returning patients home as opposed to other institutional settings (71 percent → 79 percent)
- increasing rates of patient satisfaction (95 percent → 97 percent)

These overall improvements were achieved despite the hospital seeing its rates of admitted medical patients over the age of 65 climb by 37 percent, despite sustaining the region's lowest ED/admit ratio over the same period in a region with a fast growing population. Nevertheless, with improved efficiencies gained principally through length of stay reductions, the hospital was able to close eight medical beds. Overall, the cost-savings realized through these initiatives achieved an estimated $6.7 million in net acute care savings to the healthcare system in 2014 [1].

Recognition

Mount Sinai's success in achieving better patient and system outcomes in an acute care setting has been recognized by several national and international bodies:

- In 2015, Mount Sinai became the first hospital in Canada to achieve the international MAGNET© Recognition for Nursing Excellence and Patient Care with the ACE Strategy as one of the leading models of care.
- In 2015, Mount Sinai was designated a Nurses for Improving the Care of Healthsystem Elders (NICHE) Exemplar Hospital.
- In 2014, Mount Sinai's ACE Strategy was awarded the 3M Canada Healthcare Quality Team Award for Acute Care Hospitals.
- In 2014, Mount Sinai was recognized by the Commonwealth Fund as the subject of its Working Papers.
- In 2013, the ACE Strategy was recognized in the Ontario Ministry of Health and Long-Term Care's inaugural 2013 Minister's Medal Competition for Health Quality and Safety.
- Accreditation Canada has named two key components of its ACE Strategy – the ACE Unit model and the Maximizing Aging Using Volunteer Engagement (MAUVE) initiatives as Leading Practices.
- Cerner Canada awarded Mount Sinai with its Advancing Clinical Excellence award for its ACE Strategy enabling information technology innovations in 2013.
- The Ontario Hospital Association profiled Mount Sinai's ACE Medical Unit in their 2013 IDEAS Book that features initiatives thought to be highly transferrable to other hospitals and other settings across the province.
- The Canadian Institute for Health Information profiled Mount Sinai as their acute care exemplar in their 2011 Health Care in Canada Report that focused on seniors and aging.

Timeline

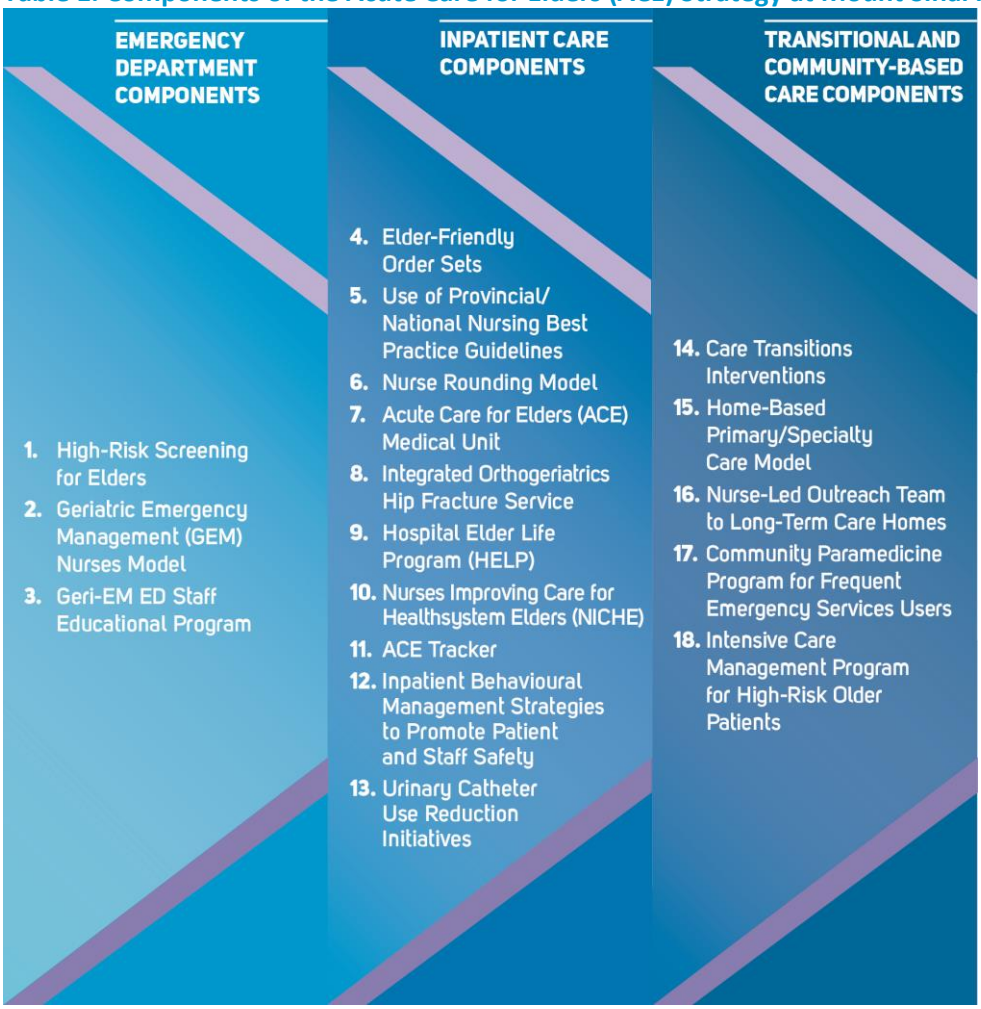
The ACE collaborative will run from March 2016 to March 2017. Pre-work begins in February. Key dates include the following:

DATE	ACTIVITY
February 1, 2016	Deadline for submitting an expression of commitment
February 19, 22 and 23, 2016	Potential dates for readiness interviews and discussing the signing of the **Memorandum of Understanding** (MOU)
March 11, 2016	Deadline for signing the MOUs
March 17, 2016	Orientation webinar requiring at least two members of each team

Participation Criteria

Teams from healthcare delivery organizations that have implemented two of the following interventions and plan to implement at least one additional ACE Strategy component during the 2016-17 collaborative:

Table 1. Components of the Acute Care for Elders (ACE) Strategy at Mount Sinai Hospital



Applications can be submitted in either English or French. Organizations must demonstrate readiness to implement innovation based on CFHI's identified criteria.

To apply, please download and complete the ***Expression of Commitment***.

Program Funding

CFHI, in partnership with TVN, will accept up to 15 teams into the ACE collaborative. Teams from Canadian healthcare organizations are eligible for seed funding of up to $40,000 each for direct costs related to adapting and implementing ACE Strategy interventions. Teams outside of Canada may also apply but are not eligible for funding. All teams accepted into the collaborative will receive support for the development and execution of their initiatives through access to CFHI coaching and educational content.

Contact

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Overview

The Canadian Foundation for Healthcare Improvement (CFHI), in partnership with the Technology Evaluation in the Elderly Network (TVN), is inviting applications from healthcare delivery organizations to participate in a quality improvement collaborative focused on spreading innovative elder-friendly care practices. Too often in Canadian healthcare, promising innovations remain isolated pockets of excellence. Any organization working to improve patient care, health outcomes and value-for-money should ask: "What's out there that works?" The Acute Care for Elders (ACE) collaborative will support participating healthcare delivery organizations across Canada and internationally with the implementation, evaluation and spread of proven evidence-informed elder-friendly care practices. This is the third collaborative in CFHI's Spreading Healthcare Innovations Initiative and it responds to what those working in healthcare across Canada and internationally are telling us they need in order to kick-start sustainable improvement at the service delivery level: seed funding, an evidence-based program and coaching to support the implementation of specific elder-friendly practices.

Why Participate?

Hospitals are Ill-equipped to Meet the Needs of an Aging Population

Healthcare in Canada faces challenges in meeting the needs of an aging population. While individuals 65 and older account for 16 percent of the population, they represent 42 percent of all acute care hospitalizations and 58 percent of all hospital days across Canada. The country's older population is also expected to double in size over the coming two decades, with those 85 and older expected to quadruple in numbers. Population aging is a global phenomenon with countries such as Japan, Italy and Spain already being particularly tested by this reality. The growing prevalence of cognitive, functional and social issues among our aging population along with a growing prevalence of multimorbidity is challenging traditional hospital models developed to treat patients with acute issues.

Despite older adults receiving the majority of care in hospital, little attention is paid to the unique needs of frail older adults within acute care settings. Many older adults present to hospital with a number of inter-related chronic and acute health and social issues. The inability to understand and address these issues in a proactive manner contributes to increased lengths of stay, cognitive and functional decline, tendency to relapse into a previous condition, and poorer patient and staff satisfaction. What is most concerning is that many of these adverse outcomes are preventable.

Research over the past two decades has improved our understanding of risk factors for adverse outcomes and effective interventions that can prevent such outcomes. Implementing evidence-informed models and point-of-care interventions in single care locations of a hospital such as the emergency department (ED), in-patient, outpatient and community care settings can improve overall outcomes and reduce lengths of stay, admissions, readmissions and inappropriate resource use.

The ACE Medical Unit model is one widely-known acute care model created in Cleveland, Ohio in the early nineties as a response to these gaps in care for acutely ill older patients. Despite the evidence supporting their ability to improve patient and system outcomes, only a few dozen of the thousands of acute care organizations across Australia, Canada, Spain, the United Kingdom and the United States have implemented ACE Units within their acute care settings to date. This remains the story for many of the other evidence-informed elder-friendly models that have been developed over the past few decades.

The ACE Collaborative: Realizing Elder-Friendly Hospitals Across Canada and Internationally

The establishment of an elder-friendly hospital requires that four interrelated dimensions of hospital culture, care and operations be re-thought and addressed: 1) social behavioural climate; 2) policies and procedures; 3) care systems, processes and services; and 4) physical design [2]. In an elder-friendly hospital, these dimensions work together to promote safety, minimize functional decline, and mitigate adverse social and medical outcomes for older adults.

The ACE collaborative will build the capacity of hospital leaders, front-line managers and providers throughout the country and internationally to better meet the complex needs of acutely ill older adults by supporting healthcare delivery organizations to effectively implement elder-friendly care components. The collaborative will support participating organizations to:

1. Adopt at least one additional ACE Strategy component to complement the at least two components already implemented (see Table 1);

2. Implement a balanced scorecard tailored to the participating site to effectively track performance on a number of commonly identified indicators at the patient, caregiver, provider and system levels; and

3. Develop their own organizational collaborative peer-to-peer coaching capacity to position each participating site as a leader in the dissemination of elder-friendly care practices within their respective region.

Please consider applying to this collaborative if your organization is looking for sustainable solutions to issues similar to those addressed by Mount Sinai, which has become a widely recognized leader in elder-friendly hospital care.

Participation Criteria

Healthcare delivery organizations that have implemented two or more of the interventions listed in Table 1 and that would be able to implement at least one additional ACE Strategy component are eligible to apply. Applications can be submitted in either English or French. Applicants must demonstrate readiness to implement innovation based on CFHI's identified criteria.

Organizational Characteristics

The ACE collaborative is designed to offer support to healthcare delivery organizations with the following characteristics:

1. A commitment to becoming an elder-friendly hospital, and interest in serving as a lead regional hospital to support the dissemination of elder-friendly care principles.
2. Have already implemented two or more of the ACE Strategy interventions (see Table 1).
3. Capability to implement at least one of the interventions identified in the ACE Strategy with the help of CFHI collaborative faculty and staff.
4. Explicit support of senior leadership and these leaders must stay actively connected to the team's work. To maximize results, participating in the collaborative should be a recognized as a priority supported by each organization.
5. A commitment to provide the necessary senior and front-line leaders, staff time and in-kind resources to implement the ACE intervention(s).

6. Where necessary, key partners and resources are identified and committed to participating.
7. Strong improvement capabilities at the team level and at the organizational, system, or population level. Suitable organizations are skilled and agile in using improvement models, running small tests of change, and implementing change.
8. Agreement to collaborate with ACE collaborative partners to implement the common balanced scorecard to support quality improvement and performance monitoring.

Team Characteristics

Overall, the team should demonstrate or identify:

- Skills in setting aims and carrying out well-designed quality improvement initiatives;
- Connections from acute- to community-care settings (e.g., given the initiative is based in hospital, the team involves community partners or demonstrates the ability to provide at-home services);
- Which team member(s) will champion the dissemination of elder-friendly practices within their organization or region. It is expected that all team members share responsibility for the adoption of the one (or more) ACE Strategy components and that the measurement lead is the steward of the balanced scorecard.

Executive endorsement and support:

- During the collaborative, the CEO (or most senior leader in the organization) will ensure the improvement team has: regularly scheduled access to the senior executive team; protected time for the work; and support for, and active engagement in, the organizational or policy change dimensions. Senior management (including a clinical or administrative lead) will support and be accountable for the overall direction, implementation, and management of the initiative.

Participating team:

- A Team Lead with the time, resources, and accountability to succeed who is designated to oversee the day-to-day activities of development and execution of the initiative.
- An Evaluation and Measurement Lead to support the tracking of results over time. Throughout the collaborative, the CFHI team will convene the Measurement Leads from each team via ongoing coaching calls to discuss common measurement challenges and approaches.
- At least one Physician Champion, who will work with the Team Lead and provide necessary clinical support to staff. Multiple Physician Champions can be included (e.g., geriatrician, primary care physician, etc. . .).
- At least one Nurse Champion, who will work with the Team Lead and Physician Champion on implementing elder-friendly practices (e.g., registered nurse, advanced practice nurse, etc. . .).
- A Patient and Family Caregiver Advisor, who has experience and expertise as a service-user within the healthcare organization and who will advise the team on patient-centred approaches to care.

Participating organizations are also encouraged to reach beyond their usual boundaries to develop cross-sectoral, multi-stakeholder or interprofessional partnerships. Partnering relationships could include healthcare organizations and groups such as regional health authorities, primary and community care organizations, public health departments, educational institutions, civic, and other non-profit or voluntary organizations focused on improving healthcare.

Participating Organizations and Team Members

Dedicated resources must be in place and teams must be committed to full participation in the collaborative, including CFHI's overall evaluation and performance measurement plan.

Timeline

The ACE collaborative will run from March 2016 to March 2017. Pre-work begins in February. Key dates include the following:

DATE	ACTIVITY
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March 17, 2016	Orientation webinar requiring at least two members of each team

CFHI Support

Relying on an adult-learning approach, this collaborative will promote networking and exchange among the entire cohort and will include, but will not be limited to:

- Monthly team educational webinars, which will focus on how to design, assess, implement and spread elder-friendly practices within healthcare delivery organizations.
- Monthly educational webinars for measurement leads, which will focus on data collection, analysis and visualization as it relates to the CFHI collaborative measurement and data collection plan.
- Regularly scheduled team progress reporting webinars.
- An in-person workshop.
- CFHI will draw on its extensive network of faculty (core and guest), coaches and staff to support teams in every step of the change management process from assessing their challenges, articulating clear improvement objectives, designing solutions, implementing models of care improvements and evaluating outcomes.
- Coaching calls with individual teams to ensure a rapid pace for testing change and to troubleshoot any barriers encountered, as needed.
- Affinity calls on topics selected by teams, as needed.
- Access to online learning tools and activities.

In addition, CFHI is striking a policy-leadership working group, the role of which is to consider the necessary management, governance, financing and policy factors to support readiness, implementation, sustainability and scale-up of elder-friendly practices.

For this collaborative, CFHI faculty and staff, with input from the collaborative team members, will design content and facilitate exchange on key topics for implementing elder-friendly practices including:

- Development of a collaborative working plan, implementation and measurement
- Elder-friendly best practices
- Stakeholder engagement (patients, families and caregivers, front-line providers and organizational leaders)
- Leadership and change management
- Sustaining and further spreading the change
- Data collection, analysis and visualization
- Communication and fundraising strategies

How to Apply

To apply, please download and complete the ***Expression of Commitment***.

By completing the Expression of Commitment, the organization and team members confirm that they have reviewed and understood CFHI's **Conflict of Interest Policy**, including the rules regarding the eligibility of foundation employees, directors and agents. Organizations from which any members of the CFHI's **Board of Directors**, or foundation agents or employees receive remuneration are eligible to apply to this competition. Applicants must fully disclose any relationship with sitting CFHI board members.

Expressions of commitment will be reviewed and screened in February and readiness interviews conducted, as needed. The deadline for submission of the expression of commitment is **February 1**. Teams and signatories are advised to hold **February 19, 22 and 23** as potential dates for readiness interviews and to discuss the signing of MOUs. It is each team's responsibility to review the MOU in full with senior executives (or their respective legal counsels) before submitting an expression of commitment to ensure there are no issues with the contents of the MOU.

CFHI will accept up to 15 teams into the collaborative, selected based on the strength of their applications as aligned with characteristics described within this document and on CFHI considerations of overall composition of the cohort of teams in terms of setting and context.

APPENDIX 1: OVERVIEW OF SELECTED MOUNT SINAI HOSPITAL'S ACUTE CARE FOR ELDERS (ACE) STRATEGY COMPONENTS

Selected ACE Portfolio Components: *Evidence-Based Elder-Friendly Hospital Interventions Implemented at Mount Sinai Hospital, Toronto*

1. Emergency Department (ED) Care Components

High-Risk Screening Tools
Evidence-based screening tools like Identification of Seniors at Risk (ISAR) and the interRAI Assessment Urgency Algorithm (AUA) have been designed for use with older adults presenting to the ED to quickly and effectively identify those who are at an increased risk of adverse outcomes including functional decline, readmission and institutionalization [3, 4]. Use of these tools must be linked to follow-up processes, including a formal clinical evaluation.

Primary Outcome Measure – Improved Detection of Geriatric Syndromes

Geriatric Emergency Management (GEM) Nurses Model
GEM nurses are ED-based advanced practice nurses who focus exclusively on assessing and addressing the needs of frail older patients while helping to connect them with specialized geriatrics services, home care and community support services, as required. GEM nurses have been found to be helpful in preventing unnecessary admissions, while also facilitating the care of older patients who may need further in-hospital assessment and support [5].

Primary Outcome Measure – Decreased Unnecessary Admissions

Geri-EM ED Staff Educational Program
This e-learning website was designed primarily for physicians and nurses working in EDs who want to provide optimal care to their older patients. This learning system presents six interactive and in-depth learning modules focusing on common geriatric issues dealt within ED settings. It can also be of interest to other healthcare providers who see older patients as part of their practice, e.g., in primary care, in hospital, in long-term care, or in the community [6].

Primary Outcome Measure – Improved Reported Confidence in Understanding and Managing Geriatric Syndomes

2. Inpatient Care Components

Elder-Friendly Order Sets
The use of elder-friendly order sets, which aim to guide the implementation of evidence-based care protocols and practices, can be an effective way to ensure ACE principles of care (refer to the Expression of Commitment) are being supported. Observed best practices include those that include activity orders as well encourage early mobilization and influence the choice of safer pain management or nausea treatment options, promote more appropriate bowel and bladder management routines, as well as encourage proactive and comprehensive discharge planning [7].

Primary Outcome Measure – Decreased Functional Decline on Discharge

Registered Nurses' Association of Ontario (RNAO) Best Practice Guidelines
Mount Sinai has established a partnership with the RNAO as a Best Practice Spotlight Organization (BPSO®). BPSO®s are organizations that commit to implement multiple RNAO clinical best practice guidelines (BPGs) using knowledge translation methods supported by RNAO and reinforced in the RNAO BPG implementation portfolio [8]. These same approaches adopted by Mount Sinai will support an evidenced-informed organizational culture and uptake of clinical practice guidelines in areas like falls, pressure ulcers and delirium that will help create elder-friendly hospitals.

Primary Outcome Measure – Decreased Falls, Pressure Ulcers and Delirium

Nurse Rounding Model
In this model, nurses and nursing assistants conduct regular patient rounds designed to improve safety and address needs that otherwise would prompt use of call bells and other alerting systems. During the rounds, they identify and address each patient's pain level, position, and comfort; offer toileting assistance; and ensure that all needed items are within reach. Several studies have since demonstrated the ability of these programs to help reduce patient falls, pressure ulcers, and call bell use, and contributed to significant improvements in patient satisfaction [9].

Primary Outcome Measure – Increased Patient Satisfaction

Acute Care for Elders (ACE) Medical Units
ACE Medical Units operate within a specially designated ward of the hospital that aims to combine geriatric assessments, quality improvement, a specially planned environment, interprofessional team rounds, frequent medical care reviews, and comprehensive discharge planning. ACE Units have been shown to reduce lengths of stay, readmissions, and long-term care placements and help hospitalized older adults maintain functional independence in basic activities of daily living [10].

Primary Outcome Measures – Decreased Length of Stay and Functional Decline on Discharge

Integrated Orthogeriatrics Hip Fracture Service
Orthogeriatrics is a co-management model that brings geriatricians and orthopedic surgeons together in the care of older patients with hip fractures. By enhancing the care of these patients with comprehensive geriatric assessments at the time of admission, and ongoing support through the length of stay, these models have shown an ability to reduce the incidence of delirium and thus shorten lengths of stay [11, 12, 13].

Primary Outcome Measure – Decreased Length of Stay

Hospital Elder Life Program (HELP)
HELP is a volunteer-based model designed to prevent delirium by keeping hospitalized older patients oriented to their surroundings; meeting their needs for nutrition, fluids, and sleep, and keeping them mobile within the limits of their physical condition [14]. HELP has been shown to be effective at reducing the incidence of delirium and functional decline in hospitals.

Primary Outcome Measure – Decreased Incidence of Hospital Acquired Delirium

Nursing Improving Care for Healthsystem Elders (NICHE)
NICHE provides clinical and organizational tools and educational resources to support a systematic change in the culture of healthcare facilities. NICHE supports organizations to achieve patient-centred care for hospitalized older adult patients. NICHE has been used by numerous hospitals across North America and other healthcare settings to foster system-wide improvements in the care of older people [15].

Primary Outcome Measures – Increased Staff Satisfaction and Confidence in Managing the Care of Older Patients

ACE Tracker
The ACE Tracker is a computer generated checklist of all older patients in a facility that takes information from multiple areas of the electronic medical record to identify the older patients' risk factors for functional decline and poor outcomes [16]. An initial study using the ACE Tracker tool has shown its ability to significantly improvement in decreased urinary catheter use and increase in physical therapy referrals.

Primary Outcome Measure – Decreased Incidence of Urinary Catheter Use

Inpatient Behavioural Management Strategies to Promote Patient and Staff Safety
These strategies provide staff with skills training and resources to help safely and effectively care for patients who are at risk of aggressive or dangerous behaviour while in hospital. These programs have two key areas of focus – supporting staff to identify risk factors for dangerous behaviour early, before an incident takes place to ensure that staff can deliver compassionate care and ease vulnerable patients through stressful situations; and access to a specialist team of mental health clinicians with behavioural expertise who can help front-line staff to determine a strategy for managing the risk and a care plan that will meet the patient's needs [17].

Primary Outcome Measures – Decreased Behavioural Incidents and Increase Staff Reported Confidence in Managing Behavioural Issues

Urinary Catheter Use Reduction Education Initiatives
Several studies have demonstrated that these nursing and physican educational interventions can significantly reduce both the incidence of urinary catheterization as well as the duration with which urinary catheters are used in a patient care episode. The decreased utilization of catheters has been shown to be particularly effective at reducing the incidence of functional decline and overall lengths of stay in hospitals.

Primary Outcome Measure – Decreased Incidence and Duration of Urinary Catheter Use

3. Transitional and Community-Based Care Components

Care Transitions Interventions
In this model, various interventions can be employed to enhance the post-discharge care of older patients. Various interventions include providing structured discharge summaries, follow-up telephone calls, whereas in more robust programs, patients are assigned with a transitions 'coach' who helps them learn self-management skills beginning at discharge [18]. In the latter intervention, a transitions coach, usually a specially trained nurse, helps patients learn to manage multiple prescriptions, follow post-hospital recommendations, and present their healthcare providers the information they need.

Primary Outcome Measure – Decreased Readmission Rates

Home-Based Primary and Specialty Care (HBPC) Model for Home Bound Patients
In this model, homebound frail older adults, for whom home-based primary care becomes a necessity and not a convenience, receive comprehensive and ongoing primary care at home with the support of a fully interprofessional team. These patients also have access to in-home geriatric medicine and psychiatry consultations as well. The HBPC Program has been shown to be effective at reducing hospitalizations and ED visits and reduce the premature need for long-term care [19].

Primary Outcome Measure – Decreased Hospitalization Rates

Community Paramedicine Program for Frequent Emergency Services Users
Specially trained paramedics in this model are deployed in non-emergency situations to do proactive home visits with older and frequent users of emergency medical services (EMS). Specifically targeting older adults with limited means, e.g., those living in public housing who call for less urgent issues, often helps to identify those who could benefit from being connected with existing home and community services as well as primary care. These programs have shown evidence of their ability to reduce uncessary future use of EMS [20].

Primary Outcome Measure – Decreased EMS Call Rates

Nurse-Led Outreach Team to Long-Term Care Homes
Specially trained nurses in this model are deployed to local long-term care homes to proactively assess and manage acute issues that may be able to be dealt with effectively at the long-term care home. These more cost-effective programs have shown evidence of their ability to reduce uncessary future use of EMS and ED Services [21].

Primary Outcome Measure – Decreased ED Visits

Intensive Care Management Program for High-Risk Older Patients
Specially trained care managers, usually with a nursing or social work background, are assigned to provide intensive care management for older adults who are seen as being frequent users of healthcare services. Through the provision of more intensive care coordination, community and primary care resources can be more quickly and effectively mobilized to reduce future hospitalizations and to manage transitions of care more effectively as well [22].

Primary Outcome Measures – Decreased Hospitalization Rates and Improved Patient Satisfaction

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