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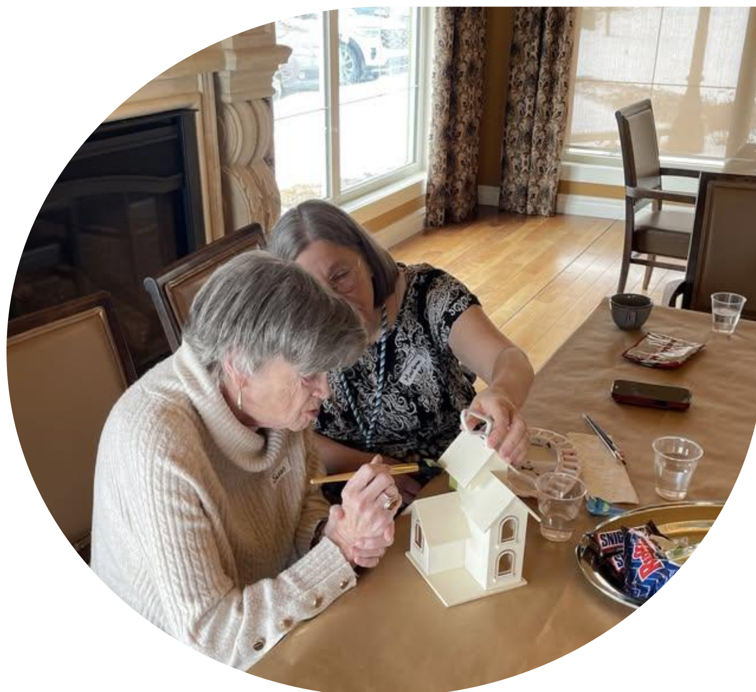
Short Term Enablement and Planning Suites (STEPS) for Abilitation: Golden Health Care in partnership with BetterLTC

Fall 2025

Golden Health Care
Community of Care



Healthcare Excellence Canada would like to formally acknowledge Golden Health Care and BetterLTC for their generosity in sharing their skills, knowledge, expertise and experiences to inform this promising practice.

About Healthcare Excellence Canada

Healthcare Excellence Canada (HEC) works with partners across the country to shape a future where everyone in Canada has safe and high-quality healthcare. We bring together people, evidence and action to move Care Forward - spreading and scaling quality and safety improvements, strengthening capacity and collective leadership and catalyzing change in policy and practice.

At HEC, healthcare excellence means improving safety, quality and value for everyone. It means care grounded in what matters most to patients, caregivers, communities and people in the workforce. It also means care that respects and responds to First Nations, Inuit and Métis priorities and is culturally safe, equitable and supported by the appropriate use of technology. Together with our partners, we embed these foundations across the health system.

Our work also focuses on expanding access to safe, connected, high-quality care closer to home and community. This includes supporting people with primary health care needs and older adults with health and social needs.

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Enabling Aging in Place collaborative

The Enabling Aging in Place collaborative brought together health and social service organizations from across the healthcare continuum to implement promising practices that can delay people's entry into long-term care. The collaborative aimed to improve safety, health and quality-of-life outcomes, while also reducing emergency department visits, lessening demands on care partners and making better use of health and social care resources.

Teams from communities across the country participated in the Enabling Aging in Place collaborative.

Short Term Enablement and Planning Suites (STEPS) for Abilitation

Golden Health Care (GHC), in partnership with the Saskatchewan Health Authority (SHA), is supporting older adults who have been designated with an alternate level of care status by providing a homelike environment as they prepare to transition back into the community or to a new destination. Diamond House is one of GHC's long-term care homes, located in Warman, Saskatchewan. GHC is using additional capacity at Diamond House to support these individuals through the Short Term Enablement and Planning Suites (STEPS) for Abilitation program.

Acute care environments are frequently operating at or beyond capacity, and they are often not the most suitable destination for older adults to continue their health and well-being journey. As a result, many older adults experience functional decline and prolonged hospital stays. The STEPS program supports older adults to transition out of acute care to a more appropriate homelike environment, increasing the likelihood for some to continue rehabilitating and return to the community, and enabling all to live with dignity and purpose while they prepare to transition to their new destination.

The STEPS program takes a relational approach to care, working with participants holistically through abilitation – an approach that aims to improve the person's experienced health state regardless of their condition. This is implemented in combination with the Friends volunteer program, which provides accompaniment from a volunteer to participants and their care partners to support them in making informed decisions related to transitions and accessing supports.

Key Features

Objectives

The objectives of the STEPS program include:

- Supporting participants to grow in abilities by engaging in their own care to find solutions that are sustainable and meaningful to them.
- Building relationships with participants embedded in trust and culturally informed care to influence improved transitions.
- Providing equitable care in partnership with participants, with a particular focus on supporting Indigenous participants.
- Supporting participants who live without a circle of care (e.g. caregivers, close ones, family, primary care provider) or participants who may experience vulnerable housing.
- Reducing the rate of admission to long-term care.
- Reducing re-hospitalization following transition to the STEPS program and future transitions.
- Supporting participants in transitioning to a place of their choosing, at an acceptable level of risk.

Population

The STEPS program supports people whom the healthcare system has labeled as needing 'more than' the care available in their former or current destination; therefore, in transition to an alternate level of care as decided by the system. Individuals may be labelled as requiring an alternate level of care (ALC) for multiple reasons, including medical, social and systemic factors.

The STEPS program is designed with intentional strategies to reach older adults who face complex health and social challenges and are affected by structural and social determinants of health. Older adults in the STEPS program often experience frailty and cognitive impairment and may have experienced a fall. They also may experience financial challenges, lack support from a circle of care and require support from the Public Trustee or Public Guardian. While many participants in the STEPS program are older adults, the program does not restrict participants by age. The STEPS program cares with individuals from a large geographic region of approximately 150km around Saskatoon, Saskatchewan.

Program team

The STEPS program has an interdisciplinary team to support participants. Team members at Diamond House include the nursing care team, physicians, social workers, occupational therapists, physical therapists, pharmacists, recreational therapists and spiritual care providers.

Friend volunteers are critical members of the team, visiting and forming trusting relationships with participants. They also accompany participants to connect with resources and supports at Diamond House and their next destination. They are especially critical for older adults who do not have a circle of care or other advocates.

The community connector at Diamond House ensures continuity of care for participants in the STEPS program as they transition by following up on care plans and facilitating interdisciplinary care team conversations. Core Diamond House staff also support the program with activities such as home and office management.

The SHA GoTeam supports the coordination of the next appropriate destination for participants to transition to from Diamond House.

A collaborative implementation team – the Wellness Team – meets regularly to support the development, implementation and ongoing sustainability of STEPS, continuously building on existing strengths and improving the program.

Philosophy

The STEPS program differs from traditional care of individuals designated as ALC, as it creates transitional care outside acute care. This enables care to be provided in a homelike environment with greater abilitative support while exploring next steps for where participants will transition to.

A relational approach is foundational to the ways of caring emphasizing wellness, inclusion and equity. The team meets individuals where

they are, helping to identify shared goals and drawing participants into the circle of care. This includes not only the person transitioning from acute care, but also their care partners, service providers and staff. The approach ensures that people who might otherwise be marginalized are actively engaged in their care.

STEPS program

The STEPS program, alongside Friend volunteers, supports individuals and their families with the transition from acute care through abilitation and on to their next destination. The program integrates streamlined digital health platforms for health improvement and monitoring, including Team CarePal and CARM&A.

Transfers to Diamond House

Participants are referred to the STEPS program at Diamond House when they are designated as ALC by the SHA Client Patient Access Services (CPAS) team following their assessment in acute care and referral to the GoTeam.

Before an individual transfers, their patient profile is shared by SHA with Diamond House, and the team must determine if they are able to support this person in the program. Once they have confirmed they are able to accept them, the transition happens quickly, with most individuals arriving two days after the transfer process is started. Upon arrival, the Diamond House team welcomes and admits the individual, then works with them and their circle of care – including family, close ones, the Public Guardian and the Public Trustee – to establish goals of care and a care plan.

Admission

On admission, the team engages the older adult and their care partners in collaboratively defining their goals. They begin the process with an opening conversation, which focuses on the person and their strengths, wishes and choices. The team does this in part through a web-based geriatric tool to help them understand who the individual is and how they see themselves. Additionally, the exercise therapist completes functional testing at intake to identify baseline abilities that support and inform individualized care goals. The care goals then drive all aspects of the individual's care, from admission until they transition to another destination.

Supports at Diamond House

The STEPS program's aim is to provide holistic care focusing on participants' goals. Supports include:

- **Abilitation care** – This is delivered in collaboration with the participant by recreational therapists, life enrichment staff, exercise therapists, physiotherapists, occupational therapists, pharmacists and other members of the interdisciplinary team, with the aim of improving the participant's health state.
- **Personal supportive care** – Activities of daily living are supported by the nursing care team.
- **Instrumental activities of daily living** – This is supported by the life enrichment team.
- **Accompaniment** – Friend volunteers accompany participants to access supports, engage in meaningful activities and build trusting relationships.
- **Care planning** – A care plan is developed in collaboration with the participant and their circle of care, and moves with the participant when they

transition, providing connections to community services such as Access Transit.

- **Celebrating culture** – The STEPS program prioritizes celebrating the cultures of persons living in the home and staff. Culture days celebrate cultural identity through food, traditions and ceremony. Cultural exchange and openness foster acceptance and equity within the home while also emphasizing trauma-informed awareness.
- **Enhancing communication** – To support the participant to be well-positioned for transitioning to their new destination, the Wellness team optimizes communication between the participant, their Circle of Care, the SHA GoTeam and SHA. This is supported by Team CarePal, an integrated care management software designed to facilitate seamless transitions from acute care to their home of choice through the STEPS program. It enhances communication among care teams and engages family members in the care process. Team CarePal is currently being piloted and is evolving as the STEPS program moves forward.

The team provides this supportive care throughout a participant's stay at Diamond House and, as the SHA GoTeam identifies a new destination, the team supports the participant to transition to their new destination.

Transitions from Diamond House

As the aim of the STEPS program is to support participants to transition from Diamond House to a new destination, the preparations for this transition are critical. Historically, system pressures have often made discharge sudden or unplanned for STEPS participants. However, Diamond House is working closely with the SHA GoTeam to improve these processes and ensure the participant is meaningfully included in finding their next destination. This may include visiting the location, exploring possibilities for integration and engagement and meeting their health and well-being needs.

They are also working to ensure participants can maintain a connection to Diamond House Friend volunteers. This has required developing a consent process for sharing information between SHA and Diamond House so that Friend volunteers can follow up after the transition to ensure the participant is safe and the transition was successful.

Additionally, prior to discharge, the exercise therapist provides ongoing assessment with engagement from care partners and participants to create a shared understanding about progress and readiness for transitions. This awareness of abilities informs place of choice for next destination and encourages an abilities model of care where the person's abilities are maximized and encouraged to continue growing upon transition.

As Diamond House continues to make improvements to the transition process, they are already seeing positive results. Participants transitioning from Diamond House are more comfortable with their new destination because of their high level of engagement in the process. They feel they had some choice in the decision, and can remain connected to the Diamond House community, if they wish, through the Friend volunteer.

Implementation context

There was additional capacity within Diamond House, and interest in moving individuals designated as ALC to a more homelike environment so they could abilitate as well as prepare for discharge.

The team faced challenges connecting existing residents of Diamond House with new participants in the STEPS program. In response, they identified resident and participant connectors within Diamond House to facilitate conversations and grow relationships between STEPS participants and permanent residents of Diamond House.

Further, this implementation is supported by BetterLTC, a University of Saskatchewan research team. They have provided research support and, alongside other partners, formed a strong implementation team. The team's success came from creating a shared vision, valuing progress over perfection and fostering psychological safety that encouraged vulnerability and risk-taking. They also had strong support from leadership to take evidence-informed risks and test creative and innovative ideas. As a result, this implementation team has undertaken a transformation in the organizational culture and approach to care.

Finally, the program's design is not static. The implementation team continually evolves the program through feedback, interdisciplinary collaboration and a commitment to equity and inclusion.

Outcomes[1]

Cost savings analysis

The STEPS program team included a Health Economist who conducted a cost savings analysis on the program outcomes to date. In total, participants spent 5,737 days in the Diamond House STEPS program. Since these individuals could not return home, they would otherwise have remained in acute care ($1,014.64 per day) or long-term care ($315 per day).

In comparison, the STEPS program at Diamond House is significantly more cost effective at $256.27 per day. Using a conservative estimate, as much as $336,951 was saved in reduced healthcare system costs.

Delayed entry to long-term care

The STEPS team has demonstrated a 5 percent reduction in admission to long-term care through the program. Most participants entered the STEPS program and had their end-destination pre-set as long-term care prior to them entering the program. However, the program has shown that this outcome can change. It also highlights the limitations when an individual is assessed for their next care destination when they are at their lowest health state (e.g. deconditioned as the result of prolonged hospitalization). The STEPS program has demonstrated that, through

[1] The outcome and impact information shared reflects information available at the time of writing this promising practice. HEC would like to acknowledge that evaluation activities are an ongoing process for many promising practices, and the type of data collected is influenced by program goals, the length of time the program has been implemented and the level of resources available to support evaluation.

supportive abilitative care and connection to appropriate resources, participants can safely transition back to the community.

This results in an additional savings of $315 per day for each participant who remains out of long-term care.

Improved participant experience with healthcare system – respect and dignity

Participants shared with program team members the significant impact that the program and its relational approach to care had on them.

> "I have seen residents breathe a sigh of relief when the work shifted from being a checklist of tasks to becoming a personalized journey. That sigh spoke volumes – it was the sound of dignity being restored, of identity being recognized, of someone finally being seen not as a patient, but as a person."
>
> – STEPS program team member

This impact was also experienced by the participants' families and care partners.

> "Families felt heard and supported. Team members realized that they had the power to create real, lasting change. And, at the heart of it, residents had their voices honored in ways that allowed them to shape their own daily experiences."
>
> – STEPS program team member

Positive impact of culture change on staff

Integrating the STEPS program and its learnings into Diamond House has fostered a culture where staff feel valued. Through the program they have prioritized ensuring caring with participants is relational. In addition to positive impacts on participants, staff experience has also improved.

> "The HEC project has profoundly shaped me. It has deepened my belief that care must always be relational, that systems must serve people – not the other way around – and that when we place humanity at the center, we not only improve outcomes, but also transform lives."
>
> – STEPS program team member

Staff have shared that they now feel more comfortable bringing forward new ideas and perspectives on the program, as well as for the larger organization. This has led to stronger internal communication and improved collaboration with partner organizations.

Funding

The STEPS program is funded by SHA. Support from the Wellness team is being sustained by Golden Health Care.

Asset-Based Community Development Approach

Asset-Based Community Development (ABCD) is a strengths-based approach to solving challenges in communities that focuses on and develops the strengths of local assets (e.g. people, physical assets) that are key to ensuring a sustainable community.

The team has engaged deeply with asset-based community development and notes that it has reframed how it views and supports older adults and their circles of care.

The STEPS program focuses on promoting participants' strengths through abilitative care to improve an individual's health state regardless of their condition. The team reinforces this strengths-based approach through weekly wellness team meetings, exercise and vitality assessments, and informal conversations that encourage participants, families and care partners to identify their needs and strengths.

The STEPS program has also positioned participants, their circles of care and community members as active co-designers of the program's assets, rather than as passive recipients. This reflects a recognition that participants and residents of Diamond House bring gifts and assets with them into their new community. This is clearly shown as younger STEPS participants often take on community building roles, befriending older residents and working to build a sense of community and reducing isolation. This intergenerational support is a natural resource that strengthens cohesion and well-being for all.

Through Friend volunteers, the program also brings the broader community into Diamond House, helping participants and residents connect with new communities. For example, they have developed a connection with the Arts Studio in Warman, and an elder now hosts monthly art classes at Diamond House. These connections strengthen participants, residents and families' access to broader community assets.

They have also connected with the community to facilitate intergenerational engagement through community partnerships. Students of the local homeschool academy are registered volunteers within Diamond House, ranging in age from two years through high school. This approach supports learning, relationship-building and aligns with best practices for supporting older adults.

Partnerships

The Diamond House team has built strong partnerships to support the STEPS program. Their partners include:

- **Saskatchewan Health Authority (GoTeam)** – provides transfers into the STEPS program and manages participants' transitions from the STEPS program to other destinations.
- **Saskatoon Tribal Council** – invites Diamond House staff, participants and residents to ceremonies and provides cultural teachings (e.g. ribbon skirts and opening prayers). As a cultural and relational partner, they support trust building with Indigenous communities.
- **Métis Nation–Saskatchewan** – supports the inclusion of Métis residents and families and helps embed cultural safety and reconciliation within the STEPS program.
- **BetterLTC** – supports planning, implementation and sustainability of the program, provides strategic capacity-building and advances opportunities for spread and scale.

Other community partners include local schools, local businesses, Riipen FuturePathways, Riipen LevelUp, the University of Saskatchewan, Crossmount Memory Café and the Red Cross Friendly Callers program. The STEPS program continues to grow its partnerships to better integrate community assets and continuously improve support for participants.

This promising practice was co-produced with Golden Health Care and BetterLTC. Information was compiled in the fall of 2025. To reflect the changing and evolving nature of care, the information may change. We encourage you to reach out to this team for any information that could help you as you work to improve care for the people you care with.

How can I learn more?

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