SOUTH WEST
Frail Senior
STRATEGY

Together, we are improving the health care system for older adults with frailty.

Improving the Health Care System for Older Adults:

A REPORT ON PROGRESS OF THE SOUTHWEST FRAIL SENIOR STRATEGY 2019-2022

A LETTER TO OUR PARTNERS AND COMMUNITY:

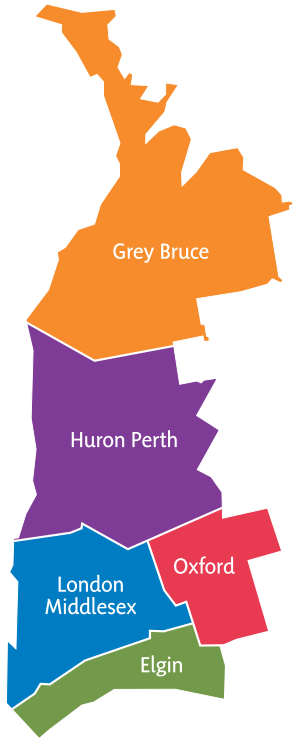
In 2019, with the support of Ontario Health West, St. Joseph's Health Care London (St. Joseph's) set a three-year plan under the Southwest Frail Senior Strategy (SWFSS) to improve outcomes and experiences for older adults with frailty and their caregivers through creation of an integrated health care system in Southwestern Ontario.

This unique strategy in the Southwest is guided by available data, evidence and best practice. Meaningful engagement with patients, families, caregivers and the community is essential to the strategy and solutions guided by local perspectives continue to drive success across our five geographical sub-regions. The strategy is gaining momentum and helping to make the vision of an integrated health care system come to life.

The successes of the past three years are owed to strong partnerships and the continued dedication of all who have contributed to the SWFSS. The COVID-19 pandemic presented many challenges over the past three years, but together, we have persevered. We have leveraged our learnings to adapt care design to better meet the needs of older adults with frailty.

We are pleased to share this report with you to highlight some of the accomplishments the SWFSS has achieved over the past three years.

Our purpose is to improve outcomes and experiences of the health care system for older adults with frailty and their caregivers.



Erin Watson
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WHY IS A FOCUS ON 'FRAILTY' IMPORTANT?

Across Canada more than 1.2 million people live with frailty, and 3.75 million caregivers, provide care to these older adults (Canadian Frailty Network, 2021). Older adults living with frailty are complex individuals who often require care from multiple sectors of the health care system. The siloed nature of Ontario's health care system continues to be a barrier for older adults to receive coordinated care. Older adults living with frailty are at risk of hospitalization, functional decline and reduced life expectancy. Appropriate and timely care that is connected through partnerships and collaboration, is crucial to reduce the severity of frailty.

Connected care through partnerships and collaboration is crucial for older adults with frailty.

Improving Our System Together

A number of programs and initiatives in Southwestern Ontario are focused on providing care for older adults with frailty, or at risk of frailty. However, different funding streams, types of care and disease specific initiatives have made coordinating these services difficult. Many older adults and their caregivers have to navigate a complex health system, often juggling between service providers. Through a regionally coordinated approach to care, we can combine and integrate services into one seamless system.

The SWFSS three-year strategic plan, set out to improve outcomes and experiences for older adults living with frailty and their caregivers. This report highlights some of the key accomplishments from 2019-2022 in achieving this work.

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Background

The 'South West' region in Ontario includes five sub-regions: Middlesex-London, Huron Perth, Grey Bruce, Elgin, and Oxford counties.

Approximately **200,000** individuals living in Southwestern Ontario are over **65** years of age.

→

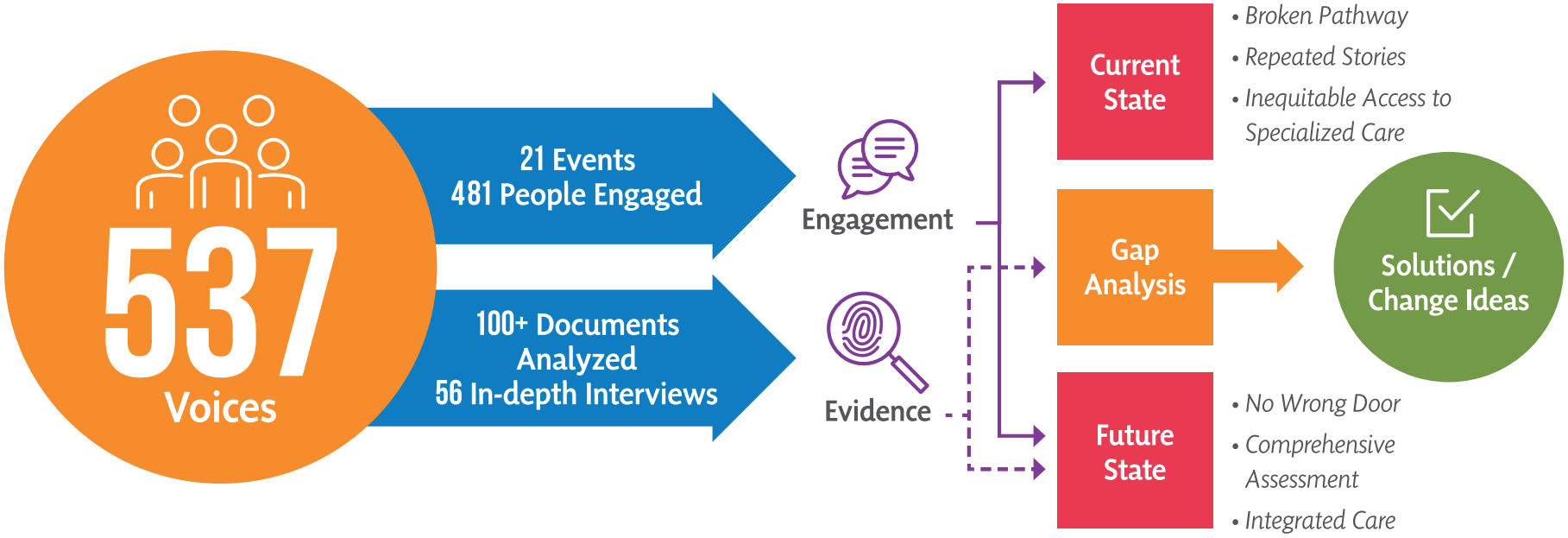
About **25%** of this population is considered 'frail.'

32% are considered 'pre-frail.'[1]

→

A high percentage of older adults with frailty live in the Grey Bruce area.

In 2019, the SWFSS team engaged more than 500 stakeholders from across the region. Together, our community identified the key areas of focus for the SWFSS strategic plan.



[1] Calculated using prevalence estimates from Hoover et al. 2013 and population estimates from 2018 (see 1 above). Reference: Hoover M, Rotermann M, Sanmartin C, Bernier J. Validation of an index to estimate the prevalence of frailty among community-dwelling seniors. Statistics Canada 2019;24(9):82-003-X. Available from https://www150.statcan.gc.ca/n1/pub/82-003-x/82-003-x2013009-eng.htm.

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THE SOUTH WEST FRAIL SENIOR STRATEGY

The SWFSS is aimed at integrating care across programs, providers, and services; and the development of a coordinated system to better meet the needs of older adults living with frailty and their caregivers.

THE FIVE PRIORITIES

Working Together

i) enable people to **work together** to develop locally integrated systems of care (i.e. break down silos between sectors);

Building Capacity

ii) advance education and **build capacity** across the region to care for older adults;

Mobilizing Information

iii) develop a process for sharing evidence-based information and **mobilizing information** into the hands of those who need it;

Amplifying Voices

iv) engage in system improvement work, focusing on underserved populations, by actively engaging patients and caregivers, and **amplifying their voices;** and lastly,

Looking Ahead

v) implement continuous quality improvement and evaluation strategies throughout the work to help identify areas for future focus **(looking ahead).**

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THE APPROACH

The SWFSS has taken a collective impact and co-design approach to all projects. Coordination support for the strategy is provided by a dedicated team at St. Joseph's along with representatives from primary care, specialized care, home and community care, community support services and local communities working together to create system improvements. The regional scope and focus on sustainability also called for high levels of meaningful engagement from older adults, caregivers, health system providers and other key stakeholders.

The Aims:

We aimed to create a patient and caregiver-centred integrated health care system; enhance quality of care; provide equitable access; and improve patient, caregiver and provider experiences.

Collective Impact

Engaging multiple players working towards a shared vision, within a coordinated structure, measured against shared indicators [1]

- Often used for complex social problems
- Cross-sector collaboration with mutually-reinforced activities
- Continuous communication and united understanding of goals
- Fosters joint ownership supporting sustainable change

Quality Improvement

Using systematic methods to identify and solve problems – common in health care settings [2]

- Targets systems and processes
- Focuses on patient and caregiver needs
- Compares current and future states to understand gaps and opportunities
- Change often starts small and grows through spread and scale

Co-Design

Enabling providers, patients and caregivers to work together in partnership to identify problems and co-create solutions [3]

- More participative than traditional quality improvement
- Brings together varied stakeholder perspectives to build mutual understanding
- Honours expertise and lived experience
- Helps to ensure solutions meet the needs of those using the system

Older Adult Engagement and Partnership

Engagement and co-design approaches are central to the success of the SWFSS. Over the past three years, many older adults have partnered in co-designing health system change across various projects such as participating in design and implementation working groups in Oxford, Elgin, Huron Perth and Grey Bruce.

Regional Patient & Family Caregiver Advisory Group

A regional patient and caregiver advisory group was also established at the onset of the strategy. This group of six older adults with experience as a patient or caregiver provided guidance to the SWFSS Team and Steering committee; acting as forum to seek feedback and advice; and, supporting communication and activities of the strategy within their communities.

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ACCOMPLISHMENTS

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WORKING TOGETHER

We continue to break down silos between sectors to ensure that older adults with frailty receive the care they need – close to home – when they need it. We are working to streamline navigation and optimize services. In 2019-2022 we:

1. **Developed a Care Pathway and Guidelines for Accessing Geriatric Physicians**
    - A literature review, clinical expert interviews and broad engagement of providers, older adults and caregivers was completed. This information gathering indicated the need to develop processes to proactively identify frailty in primary care. Tools would be most helpful if they were built into existing workflows, including integration with the electronic medical records.

2. **Fostered Partnerships in the Sub-Regions**
    - The SWFSS team built partnerships with local geriatric service providers in each sub-region. Design and Implementation Working Groups (DIWG) were formed to develop key priorities for each sub-region and to carry out the work of co-creating and implementing system improvements.
    - Two sub-region DIWG (Elgin and Grey Bruce) prioritized and created local coordinated intake access hubs for specialty geriatric services. The work was continuously evaluated and improvements were made along the way. In 15 months, more than 1,800 referrals have been triaged at the local level, improving access to care.

"People are coming together, there was a lot of willingness to recognize some pretty major aspects of the system that have not been working as good as they could, and people are having more and more buy in as we move through some of these [improvement] things together, we are starting to see some outcomes now... We have a few things in place that are working quite well now."

– Health Care Provider

DID YOU KNOW?

Before the creation of local coordinated intake and access hubs in Elgin and Grey Bruce Counties, processing of patient referrals for specialized geriatric services would take an average of seven days. After the hubs were established, referrals were processed in fewer than two days.

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WORKING TOGETHER

- The Huron Perth DIWG focused on standardizing the case review process for geriatrician consultation and streamlining weekly rounds bringing together providers from different health care organizations and sectors to jointly care for a patient. Funding has been approved by the Huron Perth Ontario Health Team to pilot a secure, approved text messaging application (HyperCare) for providers to enable fast and effective communication.
- The Oxford County DIWG focused on clarifying roles and understanding which organization best serves which type of patient. Streamlining referral pathways between local geriatric services was also priority. They also took specific interest in harmonizing privacy principles across sectors – understanding the implications of privacy to support better communication between providers, from different organizations
- Four sub-regions (Grey Bruce, Elgin, Oxford, Huron and Perth) created a local, cross-sectoral 'rounds' structure to strengthen partnerships and optimize care planning.
- Coordinated intake and access was established in Middlesex-London (Geriatric Ambulatory Access Team (GAAT)) prior to the launch of the SWFSS. However, operational leadership was aligned with the strategy to ensure smooth coordination between access points across the region. The team focused on understanding the current state and identifying areas for improvement.
    - From 2019-2022, more than 13,000 referrals for specialized geriatric services were made through the GAAT in Middlesex-London.

"The idea of integrated care had been discussed for years prior to the Frail Senior Strategy. Each team member acknowledged that changes needed to be made but without the time or abilities to make those changes. Through the FSS Working Group, we have been able to make more successful changes than ever before."

– Health Care Provider

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BUILDING CAPACITY

We continue to advance an education strategy to standardize and spread valuable resources and training regarding the care of older adults with frailty. In 2019-2022 we:

1. **Developed Educational Content for Our Partners**
    - The SWFSS team coordinated and facilitated the delivery of a learning series called "Developmental Disabilities and Aging." Many people across the region attended. **87 per cent of attendees reported learning new knowledge that would change their clinical practice.**
    - The strategy partnered with Fanshawe College to plan, implement, and evaluate an educational program about senior friendly care strategies for the Community Paramedicine Program. This work promoted best practices related to caring for older adults and helped the learners understand how to embed the strategies into their daily work.
    - 31 learners completed the *Regional Geriatric Programs of Toronto sfCare Learning Module* series and indicated an overall increase in confidence in caring for older adults with frailty.
2. **Regional Behavioural Supports Ontario Education and Capacity Building**
    - A number of educational programs were re-designed to support a virtual learning environment during the pandemic.
        - 52 health care providers attended *PIECES© Learning and Development Program*
        - Over 30 individuals have participated in *Gentle Persuasive Approaches – eLearning*
        - 97 learners were provided funding to participate in UFIRST workshop opportunities

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MOBILIZING INFORMATION

We helped older adults, caregivers and health care providers find reliable information they need to navigate the system; and, have provided a forum for centralized communication, helping system partners make sense of work happening both provincially and regionally, sharing the most current information, evidence and clinical resources. In 2019-2022 we:

1. **Created a Health Care Provider Newsletter**
    - We heard from providers that it was difficult to keep up with the most current information, research and clinical resources. To address this, we collected content from various sources and shared it with providers in one concise bi-weekly "E-Newsletter." More than 50 individuals across the region subscribed to the SWFSS E-Newsletter.
2. **Developed Online Resources and a Learning Management System**
    - To support onboarding and continued learning, the SWFSS Team is developing an online learning management system (LMS) to host and facilitate e-learning
    - The system will include Behavioural Supports Ontario (BSO) Orientation information for managerial staff, registered staff and non-registered staff. Topics include: *What is BSO, understanding the patient population, screening and assessment tools, HealthChat and additional resources*.
    - The LMS will be tested in late 2022 and early 2023 in a small number of long-term care homes in the South West before being rolled out to all organizations later in 2023.

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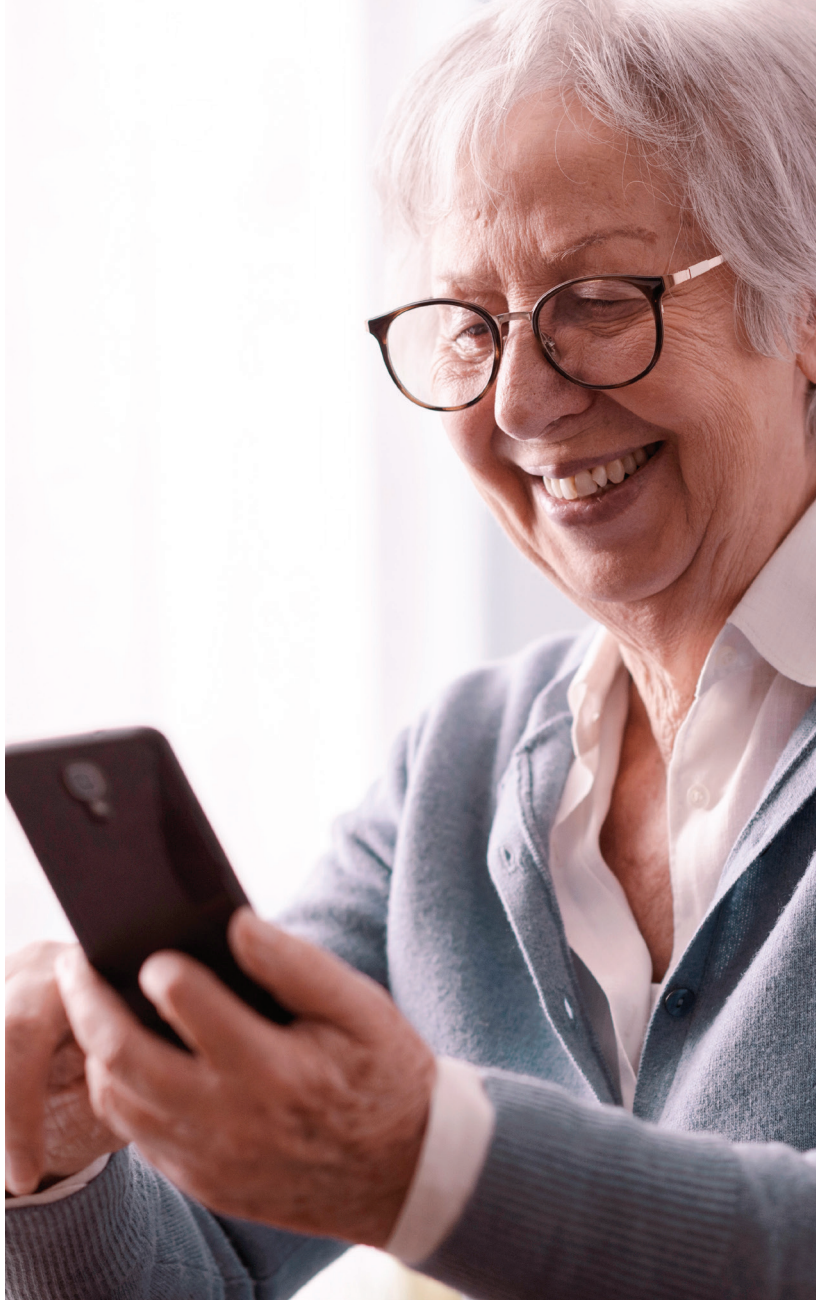
MOBILIZING INFORMATION

3. Academic Papers and Conferences (Knowledge Translation)

In 2019-2022, the SWFSS team shared the strategies work both provincially and internationally through conference presentations, manuscripts and reports. Documents and presentations have also been posted for public access:

- Elliott J., Butler L., Glover J., McIntyre Muddle K., McDonald C. Integrating geriatric medicine and mental health services to better serve older adults in Southwestern Ontario. International Journal of Integrated Care. 2022;22(S2):154. DOI: http://doi.org/10.5334/ijic.ICIC21247
- Glover J., Muddle KM.. Regional, standardized approach to the development of processes within primary care for proactive identification and intervention of frailty and guidelines for accessing specialty geriatric physicians. International Journal of Integrated Care. 2022;22(S2):153. DOI: http://doi.org/10.5334/ijic.ICIC21320
- Glover, J., Elliott J., McIntyre-Muddle, K. (2022). Co-Designing Together Through Crisis: Development of a Virtual Care Guidance Document to Support Providers and Older Adults and Caregivers. *Canadian Journal on Aging (in press)*



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AMPLIFYING VOICES

We have aimed to make system improvements that intentionally eliminate identified access barriers for underserved populations of older adults with frailty. We continue to advocate for system change that is beyond our direct scope of control. In 2019-2022 we:

1. **Engaged with Indigenous Partners**
    - Preliminary work explored to better understand the needs of older adults and caregivers from local First Nations communities.
    - Themes that emerged from this work included the need for enhanced communication and information, easier access to services, better access to transportation, and care closer to home.

2. **Increased Clinical Resources in Sub-Regions**
    - In response to gaps identified through consultation with local providers, older adults and caregivers, the SWFSS Steering Committee approved investment in additional clinical resources in the Huron Perth and Grey Bruce Counties.
    - An allocation of funds was provided to St. Thomas Elgin General to support the Elgin Geriatric Hub coordinated intake.
    - Funding for additional BSO support for Alzheimer Society SW Partners was also approved.

3. **OASIS Project**
    - Oasis Senior Supportive Living Inc. (OASIS) (www.oasis-aging-in-place.com) is an innovative model that integrates health and supportive community services for seniors within a naturally occurring retirement community (NORC). An OASIS site was developed in London, Ontario – led by Western University and a local steering committee. Funding was provided to support the ongoing implementation and evaluation of this model in Old East London and exploration of launching another site in the South West.

LOOKING AHEAD

We continue to make health system improvements from a research and data-driven position, linking related social determinants of health, resources and processes to achieve desired outcomes. In 2019-2022 we:

1. **Refreshed the BSO Indictor Definition**
    - Regionally, 77 long-term care homes, five Mobile Teams, 10 Adult Day Programs, and six Alzheimer Society sites submit BSO data to the SWFSS Team for review and coordination before it is transferred to the BSO Provincial Coordinating Office. Upon review of submitted data, the team recognized that some homes were interpreting the indicators differently and as a result the data was not accurate.
    - To ensure meaningful BSO data is collected quarterly across the region, a small working group came together to rewrite the technical definitions of more than 100 indicators. Each data point now includes the indicator posed as a question, a definition, and an example.

Indicator: How many new referrals did your BSO Team accept to the caseload during the quarter?

Definition: Count the total number of referrals you accepted to your BSO caseload. A new referral is a request for help with a resident who is not already receiving BSO support.

Example: For example, your team accepted Mr. Jones and Ms. Jackson on to the caseload; two months later, you discharged both residents. Count them as two referrals your team accepted to the caseload. If your team accepted another referral for Mr. Jones during the quarter, count this as yet another new referral.

LOOKING AHEAD

2. **Improved BSO Quarterly Reporting**
    - One-page quarterly reports were developed to support knowledge translation of the refreshed BSO activity data submitted by each organization. The reports contain a breakdown of BSO trainings and data on accepted referrals, discharges, and transitions of each BSO team.
    - A data visualization tool was created to support the analysis of BSO activity across the South West. This tool breaks down each provincial indicator by reporting sector to identify areas that may need support.

Accepted referrals to BSO caseload, standardized per 100 funded BSO hours, by quarter

Image provides an example figure displaying standardized data in BSO Quarterly Reports

DID YOU KNOW?

The SWFSS has regional accountability for Behavioural Supports Ontario (BSO) services across the region, providing coordination support to 100 BSO-funded organizations and services. From 2019 to 2022:

- More than 37,000 older adults and caregivers received behavioural supports.
- 11,463 individuals received training through 1,757 training sessions/events.

LOOKING AHEAD

3. Enhanced Capacity Planning

- Work was completed to understand how many individuals in the region live with or at risk of frailty.
- A survey was distributed to communities to better understand the needs of older adults living with frailty and their caregivers. 87 individuals responded and indicated that:
  - Older adults and caregivers want access to health care services including primary care, specialized geriatric care and mental health services.
  - They want care and support programs delivered in their community, close to home.
  - Caregivers need for more support through education and respite services.
- The table below shows the number of older adults in each geographic sub-region.

CHARACTERISTIC	SWLHIN	GREY BRUCE	HURON PERTH	LONDON MIDDLESEX	ELGIN	OXFORD
AGE (MEDIAN, IQR)						
65 to 69 years	60,440 (31.07%)	13,244 (31.55%)	9,321 (31.15%)	25,664 (30.92%)	5,569 (32.09%)	6,642 (29.83%)
70 to 74 years	49,717 (25.56%)	10,976 (26.15%)	7,391 (24.70%)	20,953 (25.25%)	4,660 (26.85%)	5,737 (25.76%)
75 to 79 years	34,449 (17.71%)	7,349 (17.61%)	5,285 (17.66%)	14,593 (17.58%)	3,225 (18.58%)	3,952 (17.75)%
80 to 84 years	23,790 (12.23%)	5,072 (12.08%)	3,785 (12.65%)	10,098 (12.17%)	1,944 (11.20%)	2,891 (12.98)
85+ YEARS	26,129, (13.43%)	5,295 (12.61%)	4,145 (13.85%)	11,688 (14.08%)	1,956 (11.27%)	3,045 (13.67%)
FEMALE[2]	105,944 (54.46%)	22,124 (52.70%)	16,128 (53.89%)	46,242 (55.72%)	9,279 (53.47%)	12,171 (54.66%)
RURAL RESIDENT[3]	58,747 (30.20%)	29,177 (69.50%)	18,645 (62.30%)	6,391 (7.70%)	2,222 (12.80%)	2,895 (13.00%)
FRANCOPHONE[4]	12,805 (1.40%)	1,605 (1.10%)	940 (0.70%)	7,990 (1.80%)	975 (1.10%)	1,295 (1.20%)
INDIGENOUS[4]	22,280 (2.40%)	5,270 (3.70%)	1,835 (1.40%)	11,145 (2.50%)	1,975 (2.30%)	2,055 (1.90%)
LICO[5]	58,358 (30.00%)	12,511 (29.80%)	7,093 (23.70%)	27,804 (33.50%)	5,033 (29.00%)	5,144 (23.10%)

[2] Population estimates by age and sex for 2018. Reference: Statistics Canada. CANSIM Table 17100139: Population estimates, July 1, by census division, 2016 boundaries, annually (Persons). Obtained June 19, 2019. (note: percentage = number of seniors in each age category / total senior population)

[3] 2011 Census of Canada – obtained from the 2016 HEAL Report for the SWLHIN

[4] From the 2019 SWLHIN Dementia report produced by workHORSE Consulting Group

[5] 2006 Census of Canada – obtained from the 2016 HEAL Report for the SWLHIN

COVID-19 PANDEMIC: INTERRUPTIONS AND INNOVATIONS

Despite the declaration of the COVID-19 pandemic in March of 2020, organizations and providers continued to collaborate. In many ways, the pandemic accelerated the need to rapidly form partnerships in new ways, tearing down largely imagined siloes that had characterized our health care system for years. From 2020-2022, additional projects were initiated to respond to the immediate needs in our community such as:

1. **A Virtual Care Guidance Document**
    - The pandemic highlighted a pressing need to collate emerging evidence and learning on how best to leverage virtual strategies to support older adults and caregivers.
    - A rapid literature review was conducted and a regional working group was established to guide the development of resources.
        - o A guidance document for health care and community support service providers was created, outlining the feasibility of virtual care with older adult patients and matching patient needs with the type of visit provided and clinical circumstance.
    - The document was distributed to partners through various methods and posted online Providing Virtual Care to Older Adults and Caregivers across the South West.

2. **COVID-19 Resources for Caregivers**
    - Early on in the pandemic, the SWFSS Team, together with a COVID-19 regional pandemic working group, identified a pressing need for one source of information to keep caregivers informed during the pandemic.
    - Existing working groups co-designed evidence and expert informed 'Tip Sheets'. These were available electronically and by hard copy.

"Sometimes there is too much information and I don't know what to believe."

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COVID-19 PANDEMIC: INTERRUPTIONS AND INNOVATIONS

- The work was also combined with 'COVID-19 Emergency Kits' that were distributed by Community Support Services partners. Over 1300 kits were distributed, containing items such as: the "Tips Sheets", hand sanitizer, a mask, and essentials like toilet paper, food items, and a dental care package.
- Additionally, an online website that housed this information was accessed over 1200 times.

3. Elder Abuse Resources

- With the increased risk for elder abuse due to the COVID-19 pandemic, the SWFSS funded a public awareness and education campaign led by the South West Elder Abuse Network. 23,000 Elder Abuse Resources were created and disseminated to more than 450 primary care, law and financial planning offices.

"I have pulled the website up many times when talking to caregivers and used it to refer them to particular resources"
– Health Care Provider

"There are some helpful information and contacts [in the kit]."
– Caregiver

ADDITIONAL LESSONS LEARNED

Key lessons learned over the last three years have been abundant.

- Local co-design approaches equal success: although meaningful co-design and engagement takes time and requires flexibility, the results are worth it.
- We cannot underestimate the importance of dedicated operational support provided by the SWFSS team at St. Joseph's to move the work forward from idea development, to implementation and evaluation.
- A 'collective impact' approach, especially in the midst of a global pandemic, is imperative to achieve results. Multi-sectoral, interdisciplinary partners came together through the shared value and goals of improving the health system for older adults. Building partnerships and collaborations has been fundamental in making changes to the health care system.

"The Strategy has provided support for our services to finally work better together. I did not think we would see this happen."

– Health Care Provider

"I am so impressed how far we have come working together; I get a little more comfortable every meeting."

– Older Adult

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NEXT STEPS

Despite some challenges with the COVID-19 pandemic, the collective action and engagement that defines the SWFSS has continued. 2022-2023 is a transition year for the team to re-group and re-focus efforts to achieving improved older adult, caregiver, and provider experiences and system outcomes. We are in the process of working with partners to develop our next three-year strategic plan, to continue building a better health system together.

To contribute to this planning or share questions and comments, email: regionalfrailseniors@sjhc.london.on.ca

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ST JOSEPH'S HEALTH CARE LONDON

Coordination support for the South West Frail Senior Strategy is provided by St. Joseph's Health Care London.