SOUTH WEST
Frail Senior
STRATEGY

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

STRATEGIC PRIORITIES 2019–2022

SOUTH WEST FRAIL SENIOR STRATEGY 2019-2022

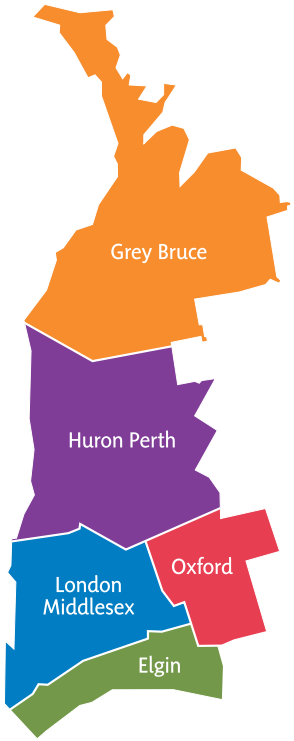
Patients and families lie at the heart of our work as health care providers. Care, then, is inherently relational – concerning the ways in which people, things, and processes are connected. When we take this patient- and family-centered view, we begin to understand how siloed activities, however effective they may be on their own, can contribute to a disjointed user experience of the health care system.

In our region of southwestern Ontario, we acknowledge that there is a great need for services supporting older adults with frailty, and that there is room for growth and alignment in our current approach. The purpose of the South West Frail Senior Strategy is to improve outcomes and experiences of the health care system for older adults with frailty and their caregivers by creating locally integrated systems of care.

There is no 'one-size-fits-all' solution. The Strategy will take a highly participatory approach, digging into sub-regional contexts and needs to best serve each area. Working together across sectors, with delivery partners and communities, we will build the capacity, infrastructure, and relationships necessary to shift the way that care is offered for this underserved population. Your voices will shape new pathways and a connected system to better serve local communities.

Roy Butler, Chair
South West Frail Senior Strategy
Steering Committee

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



SOUTH WEST
Frail Senior
STRATEGY

GUIDING PRINCIPLES

- Work grounded in best available data, evidence and best practice
- Meaningful patient, family, caregiver and community engagement
- Solutions guided by local perspectives
- Feasibility and sustainability
- Transparency

OUR AIMS

- A patient- and family-centered integrated health care system
- Quality care
- Equitable access
- Empowered patients, families, caregivers and providers

BACKGROUND

Who are we talking about?

Older adult with frailty: An individual, typically over the age of 65*, experiencing increased vulnerability resulting from a combination of physical, cognitive, social and emotional factors that influence their ability to withstand life stressors. Older adults with frailty benefit from a geriatric approach to care.

**Individuals younger than 65 may experience age-related health challenges that would also benefit from a geriatric approach.*

Geriatric approach to care: A holistic and inter-disciplinary approach focused on improving everyday functioning and quality of life. It involves comprehensive assessment to determine physical, cognitive, social, emotional and environmental needs resulting in an individualized treatment and follow-up plan.

Did you know?

- Seniors (65+) are the fastest growing age group in Ontario [1]
- By 2041, 25 per cent of the population of Ontario is predicted to be over 65 (4.6 million) [1]
- As early as 2021, 20.5 per cent of the population in the South West LHIN will be over 65 (approximately 200,000 people) [2]
- The Canadian Frailty Network estimates that approximately 25 per cent of those over age 65, and 50 per cent of those over 85 are frail [2]

[1] Aging with Confidence. *Government of Ontario* (2017).

[2] Integrated Health Service Plan 2016-2019. *South West LHIN* (2016).

SOUTH WEST Frail Senior STRATEGY

BACKGROUND

Why is frailty important?

Though the risk of frailty increases with age, not all older adults are frail. Frailty presents along a continuum, ranging from vulnerable to dependent:

Frailty is associated with risk of hospitalization, functional decline and reduced life expectancy.[1,2] Without intervention, frailty is progressive; but with appropriate and timely care, frailty can be reduced or even reversed. Currently, frailty is chronically under recognized and our existing health care system was not designed to meet the needs of this population.

In the South West region, there are a number of programs and initiatives focused on providing care for older adults with frailty, or at risk of frailty. Due to different funding streams and sectors and disease specific provincial initiatives, the capacity to coordinate these efforts has been limited. This has resulted in a disjointed experience of care for older adults with frailty, and their caregivers, as they navigate a complex system. Through a regionally coordinated approach, we can leverage the combined resources of these initiatives and programs to build an integrated system of care and improve the care experience.

[1] Frailty in older adults: evidence for a phenotype. *Fried LP, Tangen CM, Walston J, Newman AB, Hirsch C, Gottdiener J, Seeman T, Tracy R, Kop WJ, Burke G, McBurnie MA, Cardiovascular Health Study Collaborative Research Group.J Gerontol A Biol Sci Med Sci. 2001 Mar; 56(3):M146-56.*

[2] Frailty, hospitalization, and progression of disability in a cohort of disabled older women. *Boyd CM, Xue QL, Simpson CF, Guralnik JM, Fried LP. Am J Med. 2005 Nov; 118(11):1225-31.*

APPROACH

When it comes to tackling system-level change, there is no simple solution. Health care pathways for older adults with frailty cross many organizations, funders and sectors. The South West Frail Senior Strategy aims to make meaningful improvements, both within the system itself and in patient and caregiver experiences of the system. Through a collective impact framework with backbone support provided by the Strategy team at St. Joseph's Health Care London, primary care, specialized care, community support services and local communities will work through these challenges together. This level of alignment is an important factor often lacking in change initiatives.

The regional scope and focus of this work on sustainability call for high levels of community engagement. Within the collective impact framework, the Strategy has also chosen to draw on tools and practices from quality improvement and co-design. The strengths of these three approaches in collaboration, problem-solving and inclusivity are outlined below:

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-reinforcing 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

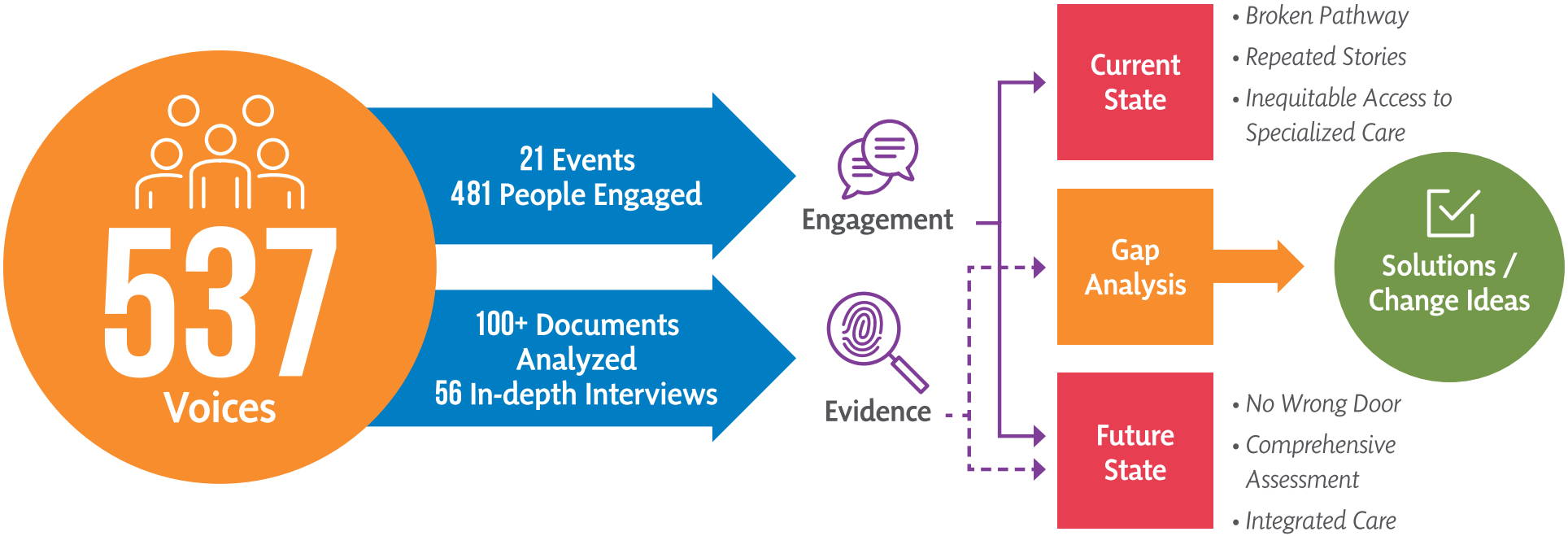
Co-Design

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

APPROACH

Discovery Phase



Solutions generated during the discovery phase were sorted and grouped to inform the development of five strategic priority areas that will drive the South West Frail Senior Strategy work for the next three years.

[1] Collective Impact Funding Stream: Backgrounder. *Ontario Trillium Foundation* (2015).

[2] Comparing Lean and Quality Improvement. *Institute for Healthcare Improvement* (2014).

[3] Experience-based Co-Design Toolkit. *The Point of Care Foundation* (2017).

STRATEGIC PRIORITIES 2019–2022

Working Together

Building Capacity

Mobilizing Information

Amplifying Voices

Looking Ahead

SOUTH WEST Frail Senior STRATEGY

WORKING TOGETHER

Goal – We will develop a system of care that breaks down silos between sectors to ensure that older adults with frailty are able to receive the care they need—close to home—when they need it. We will streamline navigation and optimize assessments and delivery of services.

What we will achieve by 2022 –

- We will formalize cross-sectoral partnerships that allow for coordinated access, easier collaboration and information sharing.
- We will develop, implement and evaluate standardized care pathways, including proactive screening and guidelines for when to consult geriatric specialists.

BUILDING CAPACITY

Goal – We will advance a wide-reaching South West Frail Senior education strategy to standardize and spread valuable resources and training regarding the care of older adults with frailty.

What we will achieve by 2022 –

- Leveraging existing education occurring across the province/region, we will build clinical capacity among health care providers from all sectors to improve access to best practice care for older adults with frailty.
- We will support caregivers with reliable educational resources and training to help them feel more confident and competent in providing everyday care for their loved ones with frailty.

MOBILIZING INFORMATION

Goal – We will develop a single source of information where older adults, caregivers and health care providers can find reliable information they need to navigate the system. We will provide 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.

What we will achieve by 2022 –

- With health care providers, older adults and caregivers, we will co-design an online resource where all of the information needed to navigate the system and find services can be accessed in one place.

- In regular communication with our growing network, we will synthesize, highlight and make sense of relevant information from multiple sources. This will include contextualizing provincial initiatives, system change, new resources and developments in best-practice. In this way, we will support an engaged and aligned workforce and help to empower communities.

AMPLIFYING VOICES

Goal – We will undertake system improvements based in patient- and family-centered care that intentionally eliminate identified access barriers for underserved populations of older adults with frailty. We will advocate for system change that is beyond our direct scope of control.

What we will achieve by 2022 –

- We will identify highly vulnerable and/or underserved population segments in each local area (e.g., Indigenous, rural, etc.) and ensure active representation in the Strategy's work through involvement in planning and improvement initiatives.
- In collaboration with regional and provincial partners including the Provincial Geriatrics Leadership Office and The Change Foundation, we will support efforts to develop and disseminate education resources for caregivers, as well as health care provider education related to engaging caregivers as full partners in care.

LOOKING AHEAD

Goal – We will plan for the future and the continual improvement of the health care system from a research and data-driven position linking related social determinants of health, resources and processes to achieve desired outcomes.

What we will achieve by 2022 –

- Through robust capacity planning, we will quantify system gaps to understand the needs of older adults with frailty and inform strategic resource allocation.
- We will employ a comprehensive evaluation framework to monitor the impact of system improvement and to inform the continual optimization of local systems of care for older adults with frailty.

NEXT STEPS

As the South West Frail Senior Strategy moves forward with this work, the following tasks have been identified as critical next steps:

- Completion of an in-depth stakeholder analysis to inform the development of working groups and support ongoing strategic communication.
- Engagement of a Regional System Coordination Facilitator who will support the formalization of local systems of care for older adults with frailty, piloting tools, agreements and processes.
- Development of working groups focused on *Education* and *Access and Navigation*.
- Work with capacity planning experts to quantify current and projected system gaps to inform strategic allocation of resources and efforts.
- Identification of key indicators and measures within the comprehensive evaluation framework of the Strategy.

STEERING COMMITTEE (as at June 2019)

Roy Butler (Committee Chair)
Vice President, Patient Care and Risk Management
St. Joseph's Health Care London

Douglas Adams
Patient/Family Partner

Dr. Michael Borrie
Geriatrician

Anne Campbell
Vice President, Partnerships and Chief Nursing Executive
Huron Perth Healthcare Alliance

Lynn Hinds
Vice President, Strategy, System Design and Integration
South West LHIN

Sandy Jansen
President and Chief Executive Officer
Tillsonburg District Memorial Hospital and Alexandra Hospital

Lynne Johnson
Director, Long Term Care
Grey County

Julie Johnston
Senior Manager, Community and Family Support Services
Victorian Order of Nurses (VON) Middlesex-Elgin

Bonnie Kotnik
Patient/Family Partner

Andy Kroeker
Executive Director
West Elgin Community Health Centre

Mary Ann Linley
Director, Geriatric Psychiatry
St. Joseph's Health Care London

Elizabeth McCarthy
Director, Specialized Geriatric Services
St. Joseph's Health Care London

Jennifer Mills Beaton
Program Lead, Health Links
South West LHIN

Dr. Brendan Mulroy
Family Physician
Grey Bruce Health Services – Owen Sound

Patricia Potter-Bereznick
Coordinator, Regional Development and
Mental Health for Seniors
St. Joseph's Health Care London

Christine Thompson
Manager, Continuing Care,
Rehabilitation and Systemic Therapy
St. Thomas Elgin General Hospital

Andrew Underwood
Executive Director
Home and Community Services of Grey-Bruce

Dr. Lisa Van Bussel
Geriatric Psychiatrist

Carol Walters
Chief Executive Officer
Alzheimer Society London and Middlesex

Jodi Younger (Ex-officio)
Vice President, Patient Care and Quality
St. Joseph's Health Care London

CONTACT US

519 646-6100 ext.45269
regionalfrailseniors@sjhc.london.on.ca
www.sjhc.london.on.ca/frail-senior-strategy

SOUTH WEST
Frail Senior
STRATEGY

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