Senior Friendly Community of Practice for GTA Ontario Health Teams

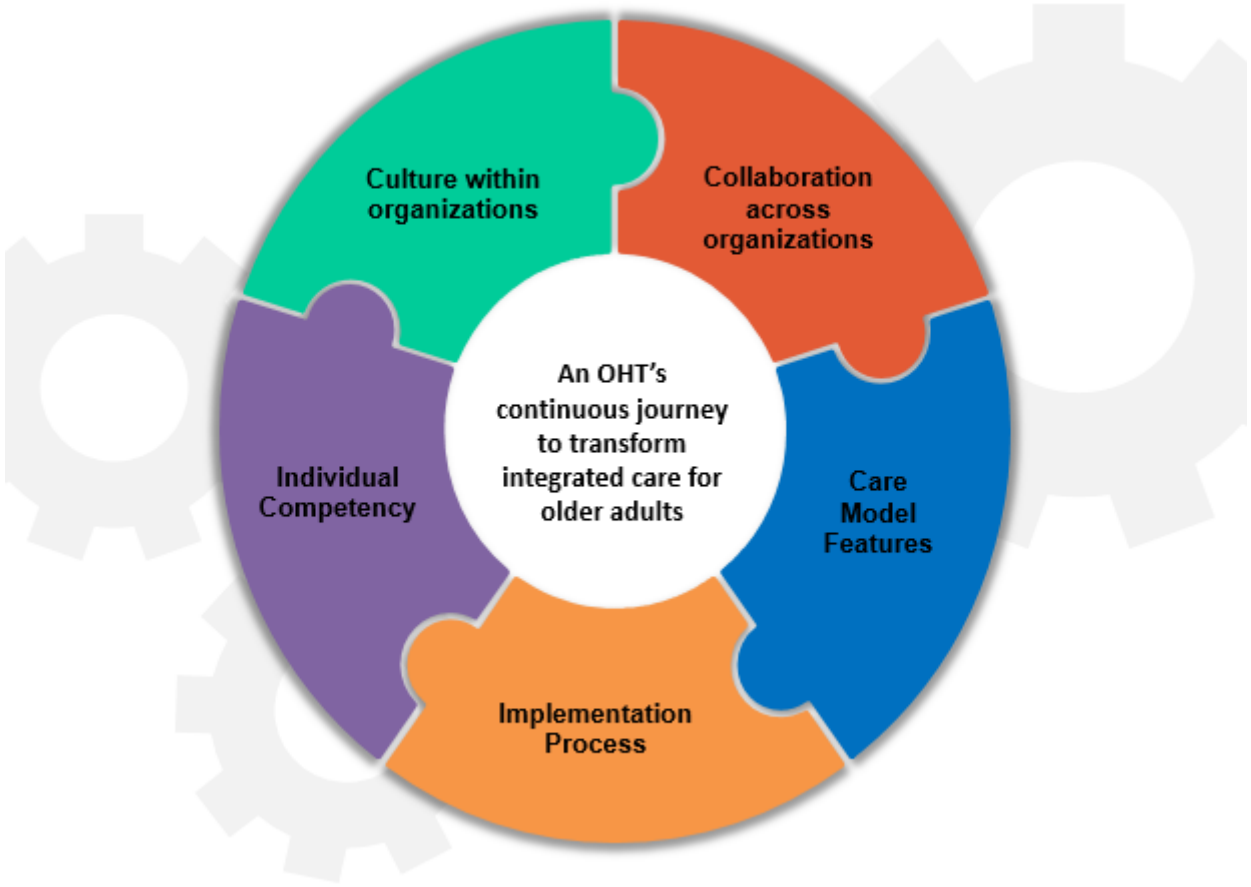
February 25, 2021 9am – 10am

Strategies for Successful Implementation

Meeting Minutes

The purpose of the framework is to give Ontario Health Teams a common language to describe models of care for older adults with frailty and to reflect on opportunities to enhance implementation of these models. This template may also be converted into a planning tool to flesh out the implementation plan for your care model.

Questions? Contact our coaches to learn more.



Modified from: *Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. Implement Sci. 2009;4:50. doi: 10.1186/1748-5908-4-50.*

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Meeting Focus: Intensive Care at Home Models

North York CARES (NYTHP): New program providing interprofessional collaborative care for high-needs patients in their homes; purpose is to provide high intensity supports to reduce ALC in hospitals and LTC due to COVID-19; secondary goal was to provide care as one team rather than a number of different organizations and to deliver this care in a sustainable manner that is an alternative to institutionalized care.

Southlake@Home (SLCOHT): Created out of necessity two years ago due to ALC challenges. It is a 16-week program for medically complex/frail older adults. Southlake directly partnered with Bayshore, SE Health, and community support agencies as well. The goal was to increase value, reduce duplication, and improve patient outcomes and experiences. Southlake is considered the leading practice model for Ontario. The quadruple aim is used to guide the work.

Individual Competency.
Organizations are made up of individuals. Successful implementation requires us to think about the characteristics of each individual involved in implementation (i.e., executives, management, and front-line staff).

Considerations from evidence:

- Does everyone (executives, management, front-line staff) have the same level of knowledge on geriatric care principles (i.e., senior friendly care)? Do they believe in these principles?
- Does everyone feel confident in delivering senior friendly care?
- Does everyone feel like they are part of the core team, partner organization, and OHT overall?

Strategies from practice:

- All agencies invited to develop care processes in the model of care **(NYTHP)**
- All partners have experience providing care to seniors at different points in their journey (hospitals, LHIN, CSS, SPO) **(NYTHP)**
- After launch we have inter-agency daily 45min huddles to address clinical issues **(NYTHP)**
- Had leadership buy-in from the CEO all the way down **(SLOHT)**
- If there were knowledge gaps from partner organizations that the hospital could support – we would invite them to participate (e.g., courses/webinars on how to detect deteriorating patients, rehab, wound care) **(SLCOHT)**
- Early on held weekly champion meetings to design the program (hospital discharge teams, rehab teams, project manager, CSS agencies) **(SLCOHT)**

Relevant resources:
Senior friendly care e-learning series

Culture within organizations.
Ontario Health Teams are made up of individual organizations. Each organization's policies, norms, values, and priorities will influence its ability to fulfill its role in implementation.

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Considerations from evidence:

- Are senior friendly values and principles evident in all policies and procedures?
- Has each organization adopted principles for assessment, management, and communication such as those outlined for the senior friendly 7?
- Does the organization have a culture of continuous improvement?
- Is each organization ready to implement integrated care?

Strategies from practice:

- All the partner organizations involved already valued and believed in the need for this high-intensity program and all of them have a culture of education and learning **(NYTHP)**
- NYGH had developed a senior care framework with some priority areas and collaborated with system partners to do this (e.g. increasing access to specialized care for seniors at home through virtual care, integrating care through a single point of contact) **(NYTHP)**
- Took a ton of work to change mindsets in hospital about how care should be provided – our core team spent a lot of time getting everyone to shift the focus from 'hours of care' to 'care needs' **(SLOHT)**
- "If you can't take feedback, you are not ready to change" – our organization really values the quality improvement process and learning as we go **(SLOHT)**

Relevant resources:
Senior friendly 7 intersectoral toolkit

Collaboration across organizations.
The quality of relationships and communication between and across partner organizations is critical for successful implementation.

Considerations from evidence:

- Quality of relationships at executive, management, and front line?
- Quality of informal and formal communication between partners?
- Shared decision-making between partners?
- Shared language on senior friendly care principles?

Strategies from practice:

- We have a history of collaboration with some of these partners; getting their input on one common senior care framework really helped bring everyone together to speak the same language **(NYTHP)**
- All the partners were very generous with their time and expertise **(NYTHP)**
- Information exchange was tough across the partners – required a heavy lift (clinical info, policies, procedures) **(NYTHP)**
- Did everything jointly, it was never the hospital dictating the outcomes **(SLOHT)**
- Aimed to have one referral process and attempting to include all voices at the table **(SLOHT)**
- We treated our partners as an extension of our organization and invited them to participate in any training opportunities that our staff were unable to attend **(SLOHT)**

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- Held two 'open house' events at the hospital for community teams to encourage the warm handover; everyone meets each other so they can understand what services are available and who is providing them **(SLOHT)**

Relevant resources:
Senior friendly care framework

Care model features.
Before implementing it is important to ensure that your care model is evidence-based, fits your context, and includes input from all stakeholders.

Considerations from evidence:

- Is there evidence that the care model is effective for older adults with frailty?
- Does the care model include an interprofessional team?
- Does it meet the needs of older adults in your setting?
- Are in-house geriatric experts playing a role in developing the care model?
- What are the advantages of this care model versus others?

Strategies for success:

- Our model builds on the successful model from the integrated community care team (ICCT) developed at Baycrest (geriatric outreach team)**(NYTHP)**
- We are working with our ICCT to provide primary care to those who are homebound **(NYTHP)**
- Working on some clearly defined processes for the transition to primary care **(NYTHP)**
- Care is flexible and aligned with the individual patient's needs – have received a lot of positive feedback from those who have gone through this program **(NYTHP)**
- Have daily and weekly rounds to talk about new patients, newly discharged from program, and patients who are not doing well and what they need **(SLCOHT)**
- Always fax and call the primary care physician to see if we can do a discharge planning meeting with them prior to patient discharge**(SLCOHT)**
- Including the perspective of providers who really wanted this change was key because they see these patients in their homes **(SLCOHT)**

Relevant resources:
Southlake@Home Model Guide

Implementation process.
The steps you take to plan for and execute implementation can impact the outcomes of your work.

Considerations from Evidence:

- Is care planned and delivered in alignment with the goals of older adults?
- Are older adults and caregivers included as partners in model, development, implementation, and evaluation?
- Are informal and formal opinion leaders engaged?

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- Is there a designated implementation leader for the care model?

Strategies from practice:

- Used a "start-up" approach - Instead of having everything in place to start the program, we started the program and figured it out as we have gone along – this really helped with collaboration and figuring out in real time what is needed **(NYTHP)**
- Had PFAC advisors on our teams as we designed our processes of care **(NYTHP)**
- The daily 45 min huddles were key – we were able to come up with innovative solutions to issues and help make connections to other services we may not have thought of **(NYTHP)**
- Created weekly rapid implementation team meetings to address emerging process issues **(NYTHP)**
- Used a co-design approach with all of our care partners and tried to have an open-mind **(SLCOHT)**
- Champion meetings were very instrumental **(SLCOHT)**
- Had a patient involved in developing the care model – her mother-in-law was the first patient to go through this program and she is also a previous GEM nurse – her feedback was instrumental **(SLCOHT)**
- Used patient and provider surveys to drive what the process would be and how we could make it better **(SLCOHT)**
- Took the time to learn what was available in our community – worked with CHATS/LOFT to get their recommendation on what services certain patients might benefit from **(SLCOHT)**
- Steering committee for the first year (including leads from geriatrics, primary care, medicine) **(SLCOHT)**
- Treated the providers as experts and let them drive the care plan design and refine as we go **(SLCOHT)**

Questions? Contact our coaches to learn more.