A8: Building bridges between community and healthcare systems

International Forum on
QUALITY & SAFETY
in HEALTHCARE
COPENHAGEN

Adapting to a changing world: equity, sustainability and wellbeing for all

@QualityForum #Quality2023

Institute for Healthcare Improvement

BMJ

Healthcare Excellence Canada | Excellence en santé Canada

Yes, We Can!

Results from a Pan-Canadian QI Collaborative to Improve Frailty Care within Primary and Community Care

Neil Drimer

International Forum on Quality and Safety

Copenhagen, Denmark

May 16, 2023

Declaration of Interests

- None to declare

Healthcare Excellence Canada honours the traditional territories upon which our staff and partners live, work and play. We recognize that the standard of living that we enjoy today is the result of the stewardship and sacrifices of the original inhabitants of these territories

Session Objectives

Based on the Advancing Frailty Care in the Community (AFCC) collaborative:

- Describe approaches used to address frailty
- Share examples of COVID-19 adaptations
- Highlight results and lessons learned

Some Context First…

Oh Canada!

Canada is the second largest country on earth.[1]

Home to 36.9 million people, Canada is vibrant a mosaic of cultural, ethnic, and linguistic diversity.

Canada has 10 provinces and three territories, each with its own capital city.

Bordering three oceans, Canada has the longest coastline in the world and the largest group of fresh water lakes.[1]

References:

1. Statistics Canada. 2023. (table). *Census Profile*. 2021 Census of Population. Statistics Canada Catalogue no. 98-316-X2021001. Ottawa. Released March 29, 2023. https://www12.statcan.gc.ca/census-recensement/index-eng.cfm (accessed April 20, 2023)
2. Top image: The Royal Canadian Mounted Police raise the flag high carrying it into the opening ceremonies of the Vancouver 2010 Olympics. (Source: David G. McIntyre, https://olympic.ca/2020/02/12/best-fashion-memories-from-vancouver-2010/)
3. Middle image: Moraine Lake, Rocky Mountains, Canada (Source: Norada, Adobe Stock)
4. Bottom image:. Team Canada Celebrating at IIHF Women's World Championship Semifinals (Source: The Canadian Press, https://www.tsn.ca/hockey-canada/video/canada-will-need-to-be-ready-and-prepared-for-dynamic-duo-that-s~2667424)

Canadian Healthcare System(s)

- **Medically necessary care** in hospitals or by physicians are publicly funded and universally available to all citizens and permanent residents.
- **Decentralized** system(s) encompassing **13** individual provincial and territorial health care insurance plans.
- **Provinces and territories** manage, organize and deliver health
- **Federal government** is responsible for setting national health care standards and providing funding support
- Big **variation**

References:
1. Government of Canada. (2019, September 17). *Canada's Health Care System* . Canada.ca. Retrieved April 20, 2023, from https://www.canada.ca/en/health-canada/services/canada-health-care-system.html
2. Image: Map of Canada divided into 10 provinces and 3 territories. Administrative regions of Canada. Multicolored map with labels. Vector illustration. (Source: Pyty/Adobe Stock)

Primary Care in Canada

- Primary care models **vary significantly** across Canada
- Physicians typically have clinical autonomy and control over the location and organization of their medical practice.
- Many practice solo or within groups
- Largely compensated through fee-for-service billing.[1]
- Increasing interprofessional care teams, group practices and networks, patient enrollment, and blended payment schemes.[2]

References:
1. Hutchison, Brian et al. “Primary health care in Canada: systems in motion.” *The Milbank quarterly* vol. 89,2 (2011): 256-88. doi:10.1111/j.1468-0009.2011.00628.x
2. Lukey, A, et al.. “Facilitating Integration Through Team-Based Primary Healthcare: A Cross-Case Policy Analysis of Four Canadian Provinces”. *International Journal of Integrated Care*, vol. 21, no. S2, 2021, p. 12.DOI: https://doi.org/10.5334/ijic.5680
3. Stethoscope on top of Canadian Flag. (Source: Glebcallfives/ Adobe Stock)

Healthcare Excellence Canada

We work with diverse partners to shape the future of quality and safety and build a better healthcare system. **Together**. Because we believe everyone across the country deserves excellent healthcare.

2021-26 Strategy

OUR PURPOSE

To shape a future where everyone in Canada has safe and high-quality healthcare.

OUR HOW

Working with people across the country, we:

- Find and promote innovators and innovations
- Drive rapid adoption & spread of quality and safety innovations
- Build capabilities to enable excellence in healthcare
- Catalyze policy change

OUR FOCUS

- Care of older adults with health and social needs
- Care closer to home and community with safe transitions
- Pandemic recovery and resilience

QUALITY & SAFETY PERSPECTIVES

- Lived experience of patients, caregivers and communities
- People in the workforce
- Value
- Culturally safe and equitable care
- First Nations, Inuit and Metis priorities

OUR VALUES

- Partner meaningfully
- Innovate courageously
- Act with integrity
- Be inclusive

Our spread and scale collaboratives

- Bring together interprofessional teams
- Focus on innovations that tackle a common healthcare issue
- Team-based with shared learning
- Provide support for sustainable improvement, e.g.:
  - Seed funding
  - Coaching
  - Online learning platform
  - Evaluation

Advancing Frailty in the Community Collaborative (AFCC)

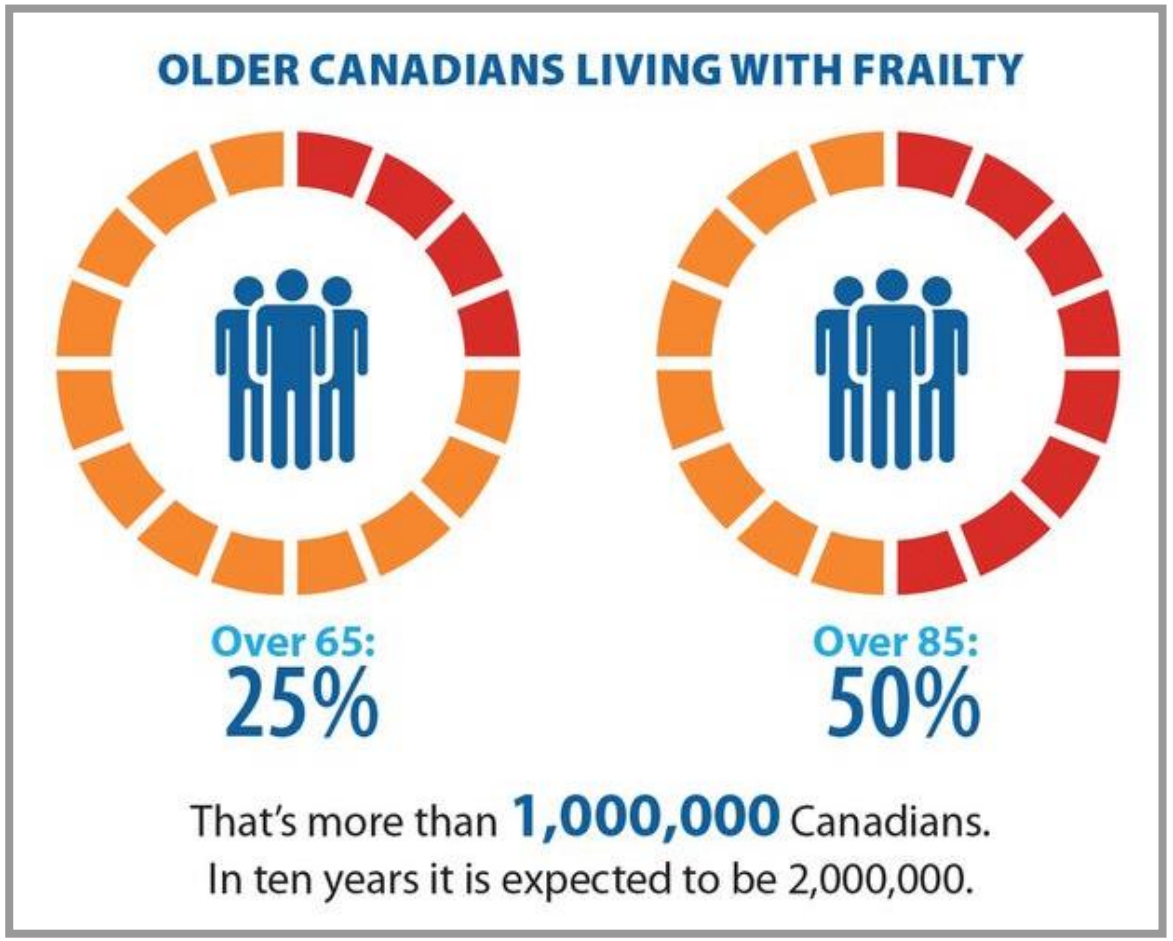
What is Frailty?

Frailty is a condition of reduced function and health in older individuals.

Older adults with frailty are more susceptible to large declines in health from minor illnesses such as the flu or falls and are more likely to be hospitalized, need long term care, or die.

Source: CFN, AVOID Frailty: https://www.cfn-nce.ca/frailty-matters/avoid-frailty/.
Image : www.nytimes.com/2016/12/28/sports/ed-whitlock-marathon-running.html

The burden of frailty is growing in Canada



Partners

Healthcare Excellence Canada

Excellence en santé Canada

Canadian Frailty Network | Réseau canadien des soins aux personnes fragilisées

Innovation Showcase

FRAILTY MATTERS: Innovation Showcase held at the 2018 Canadian Frailty Network (CFN) national conference

- From the 80 entries, the top 30 exhibited storyboards at the conference and the top 5 presented their innovations from the stage. From these five, the 2018 Frailty Innovation of the Year was named.

https://www.cfn-nce.ca/events/previous-cfn-conferences-and-events/frailty-matters-innovation-showcase/

Profiled Frailty Innovations

The Seniors' Community Hub (SCH), based in Edmonton, Alberta is an integrated, interprofessional, shared-care geriatric program within the Edmonton Oliver Primary Care Network.

The COACH Program (Caring for Older Adults in Community and at Home), based in Prince Edward Island, provides direct client care at home for older adults living with frailty, delivered by an integrated interdisciplinary team led by a Geriatric Nurse Practitioner.

CARES (Community Action and Resources Empowering Seniors) based in Fraser Health Authority in British Columbia is a collaborative, primary care model for early identification and geriatric assessment of seniors "at risk" for frailty, and provides a community-based health coaching intervention.

C5-75: Case-finding for Complex Chronic Conditions in persons 75+, is based at the Centre for Family Medicine Family Health Team in Kitchener, Waterloo, and Wellesley, Ontario, and aims to systematically identify and better manage frailty for all adults aged 75+ in primary care.

Collaborative Goals

01

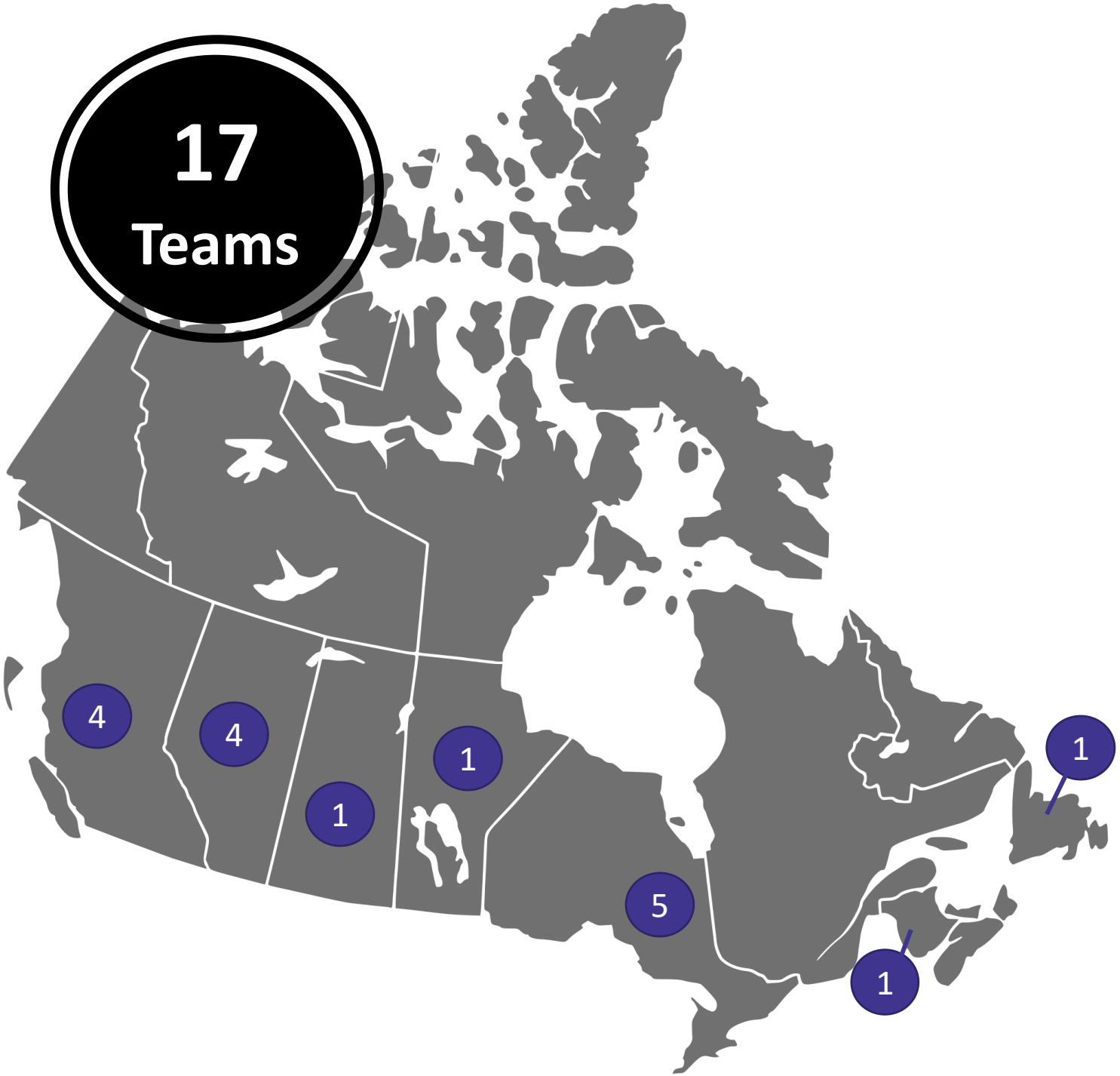
Support teams to implement the AFCC Collaborative intervention areas

02

Improve quality of care for older adults in primary care who score 4-6 on the **Clinical Frailty Scale.**

03

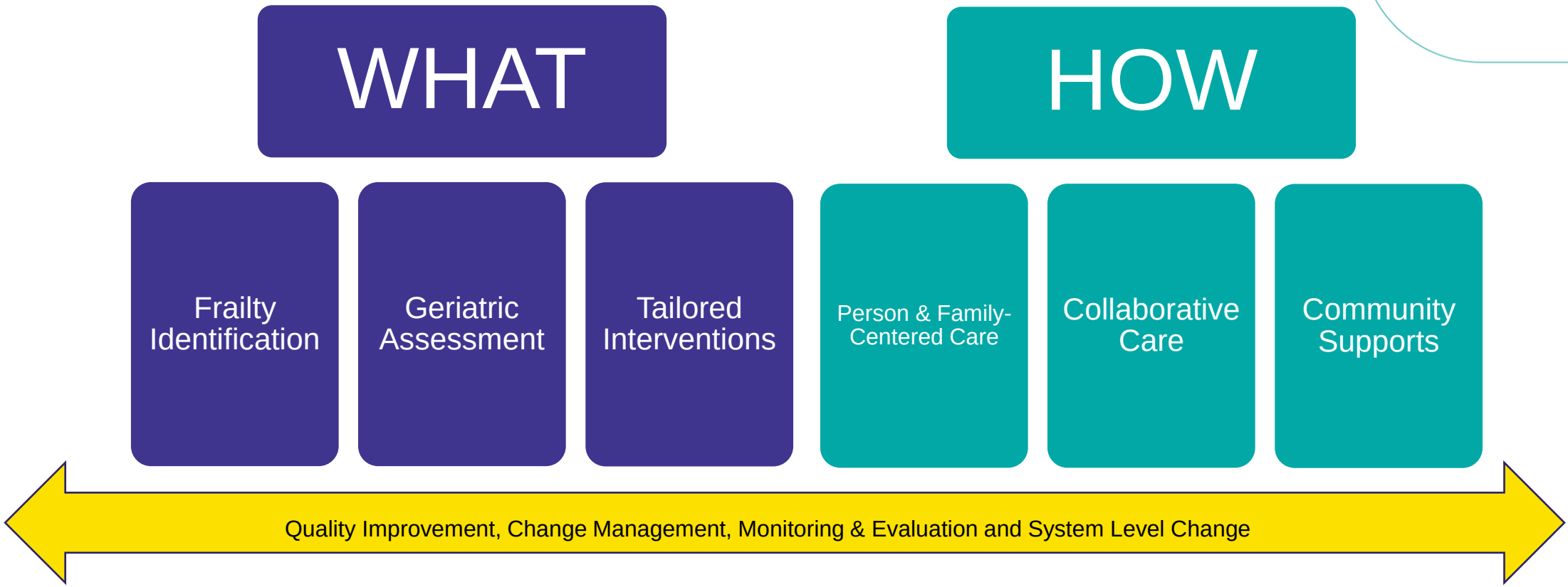
Support capacity development for QI, change management and leadership to spread and sustain frailty-related improvements.



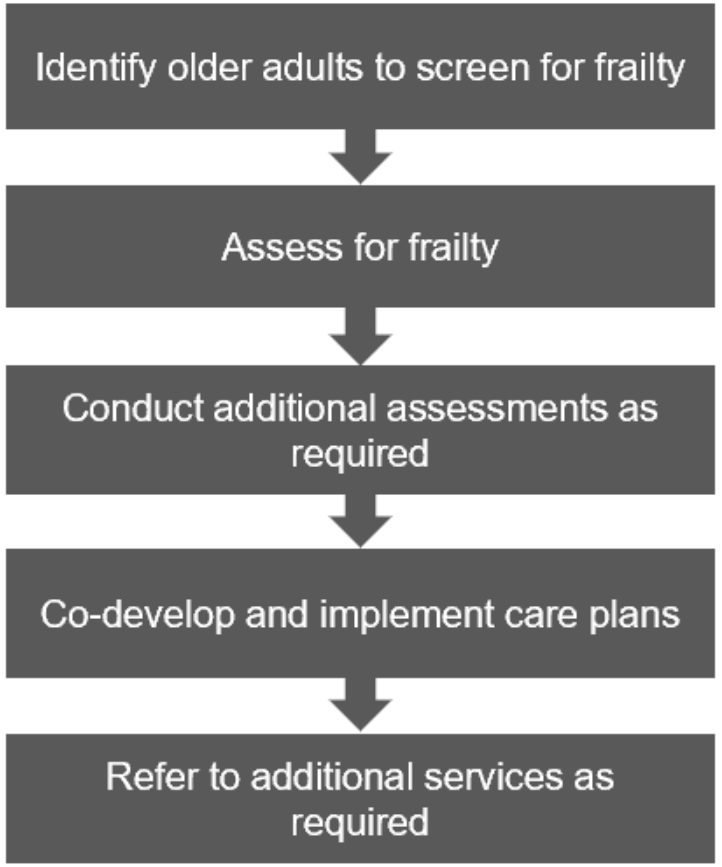
- BC – Fraser Health Authority - Aboriginal Health
- BC – Fraser Health Authority - Burnaby Divisions of Family Practice
- BC – Fraser Health Authority - Jim Pattison Outpatient Care and Surgery Centre
- BC – Island Health
- AB – Sage Seniors Association
- AB – The Alexandra Community Health Centre
- AB – Alberta Health Services, North Zone
- AB – Alberta Health Services, Calgary Zone - Southern Alberta Clinic
- SK – Saskatchewan Health Authority
- MB – Winnipeg Regional Health Authority
- ON – Centre for Family Medicine Family Health Team
- ON – Gateway Community Health Centre
- ON – New Vision Family Health Team
- ON – University of Ottawa, Champlain CARE Network Team
- ON – Wawa Family Health Team
- NB – Medavie Health Services New Brunswick - Extra Mural Program
- NL – Western Health and Eastern Health

AFCC Collaborative

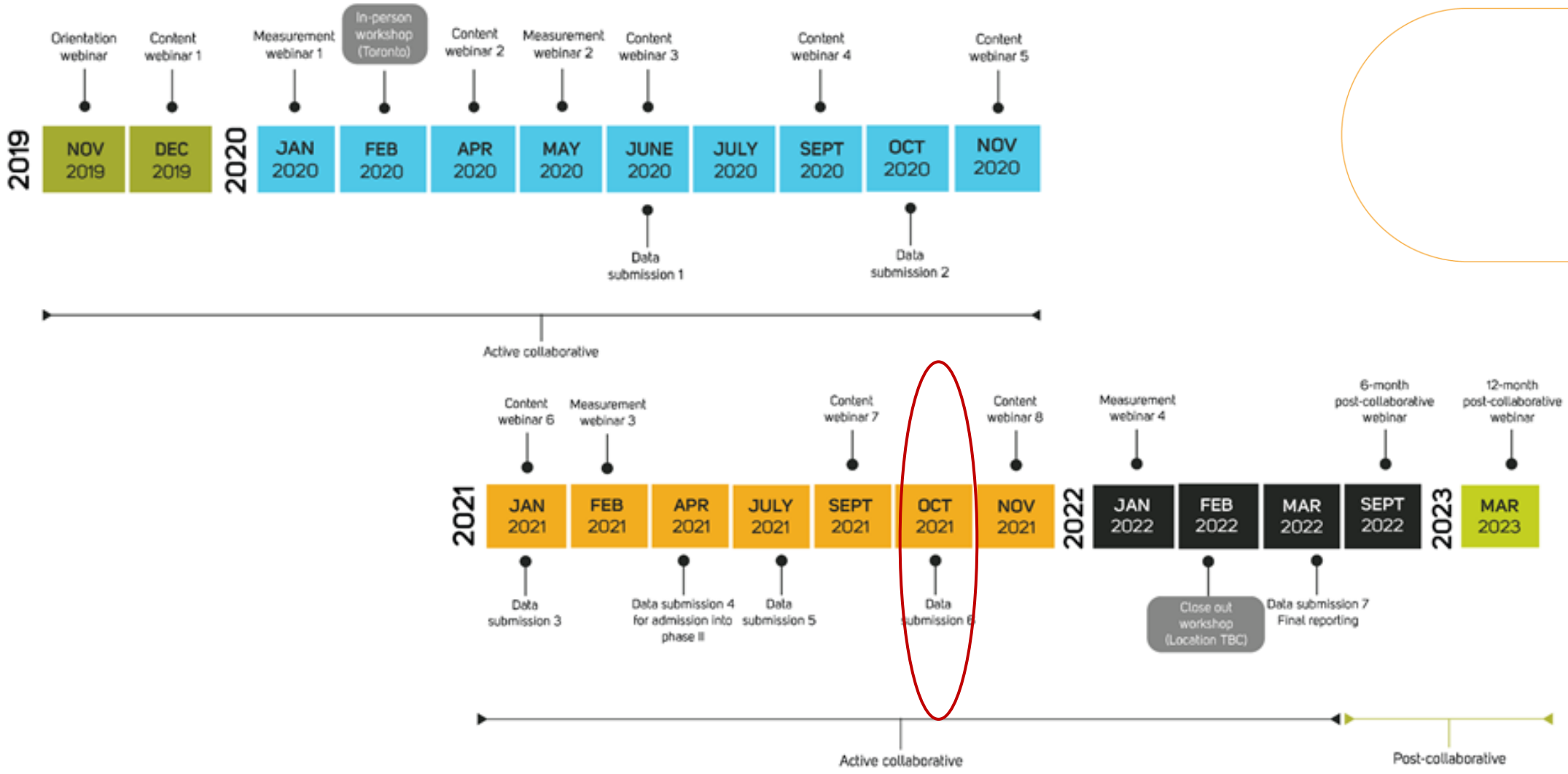
7 Common Intervention Areas



AFCC Care Pathway



Timeline


Orientation webinar
Content webinar 1
Measurement webinar 1
In-person workshop (Toronto)
Content webinar 2
Measurement webinar 2
Content webinar 3
Content webinar 4
Content webinar 5
2019
NOV 2019
DEC 2019
2020
JAN 2020
FEB 2020
APR 2020
MAY 2020
JUNE 2020
JULY 2020
SEPT 2020
OCT 2020
NOV 2020
Data submission 1
Data submission 2
Active collaborative
Content webinar 6
Measurement webinar 3
Content webinar 7
Content webinar 8
Measurement webinar 4
6-month post-collaborative webinar
12-month post-collaborative webinar
2021
JAN 2021
FEB 2021
APR 2021
JULY 2021
SEPT 2021
OCT 2021
NOV 2021
2022
JAN 2022
FEB 2022
MAR 2022
SEPT 2022
2023
MAR 2023
Data submission 3
Data submission 4 for admission into phase II
Data submission 5
Data submission 6
Close out workshop (Location TBC)
Data submission 7 Final reporting
Active collaborative
Post-collaborative

Collaborative Learning Plan

LEARNING PRINCIPLES

- All teach, all learn
- Case-based learning
- Facilitated networking
- Support from HEC faculty, coaches
- Accommodate changing team needs
- Monitoring and measuring

LEARNING ACTIVITIES

- Workshops
- Webinars
- Coaching calls
- Affinity calls
- Online learning platform

Examples of Learning Topics

Quality Improvement

QI basics (PDSA, driver diagram, etc.)	Performance measurement & evaluation
Patient engagement	Provider engagement
Change management	Technology
Sustainability	Policy considerations

Clinical / Frailty Focused

Frailty Identification	Geriatric Assessments
Case Management	Collaborative care
Person-Centered Care	Community Supports
Equity / SDoH / Cultural Safety	Interdisciplinary Teams

In March 2020…

Impacts from COVID-19

COVID-19 arrived only a few months into the collaborative – right at the start of implementation for most teams

Many teams had to halt frailty programming entirely to re-deploy staff to frontline

Other teams shut down in-person clinic visits and had to pivot to virtual screenings and assessments

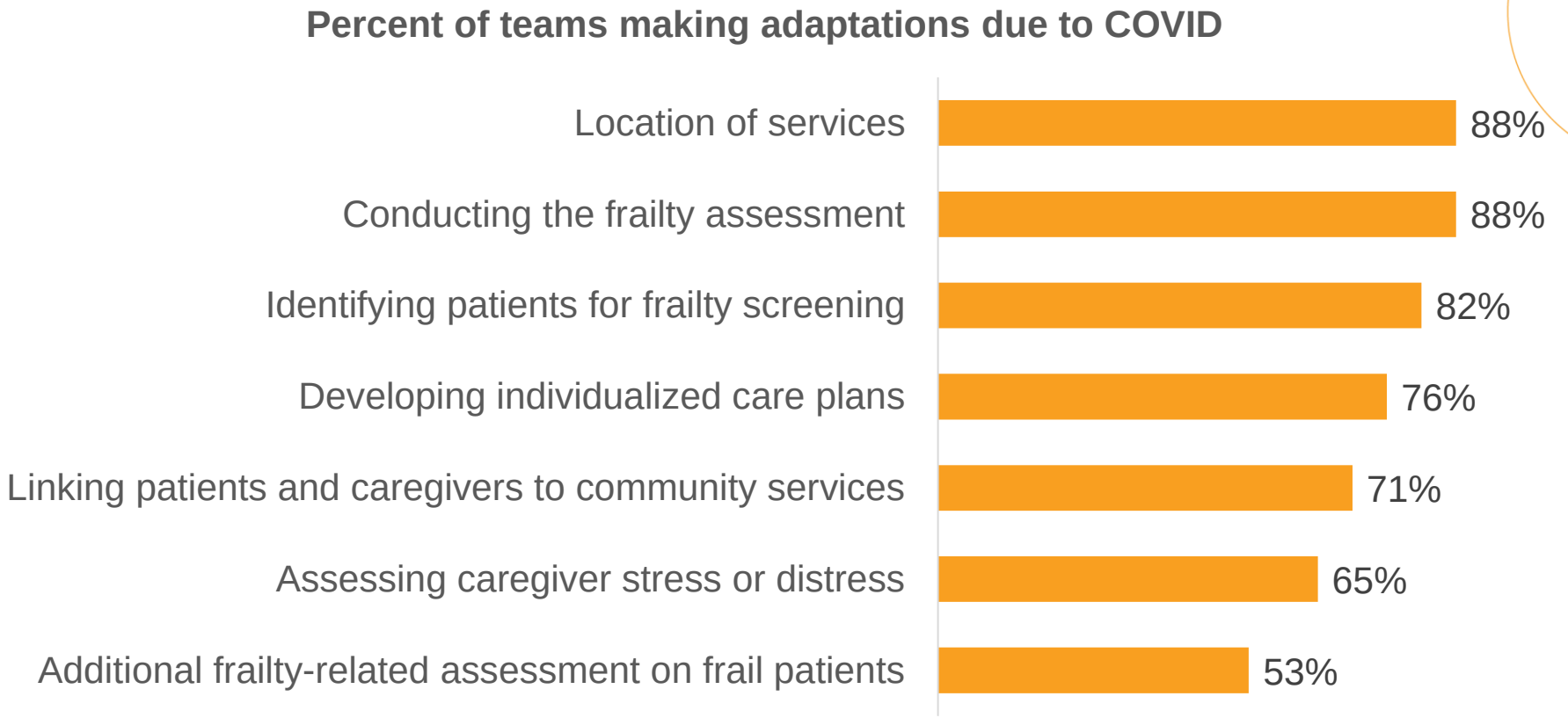
Teams eventually restarted in-person screening and other AFCC intervention areas (apart from one)

One team left early due to staffing issues

Many teams readjusted budgets and gave back seed funding

Extended AFCC for 6 months

Almost every team adapted their interventions because of COVID



Examples of Covid Adaptations

Sage Seniors Association (Alberta)	• Developed a Virtual Frailty Screen (phone)
Gateway Community Health Centre (Ontario)	• System navigator conducted frailty screening in community vs in clinic screening
Eastern/Western Health (Newfoundland)	• Frailty screening shifted from primary care to in-home screening through home care

Results & Lessons Learned

“The nurse practitioner created trust and rapport with Martha, who was very reluctant to maintain a compliant medication regimen.

“Through that trust, Martha agreed to take some crucial medications which successfully treated the new condition, and her mood and physical health improved.

We truly believe without the nurse practitioner involvement Martha may have ended up in hospital with further decline and perhaps even needing a change in living environment to a higher level of care.”

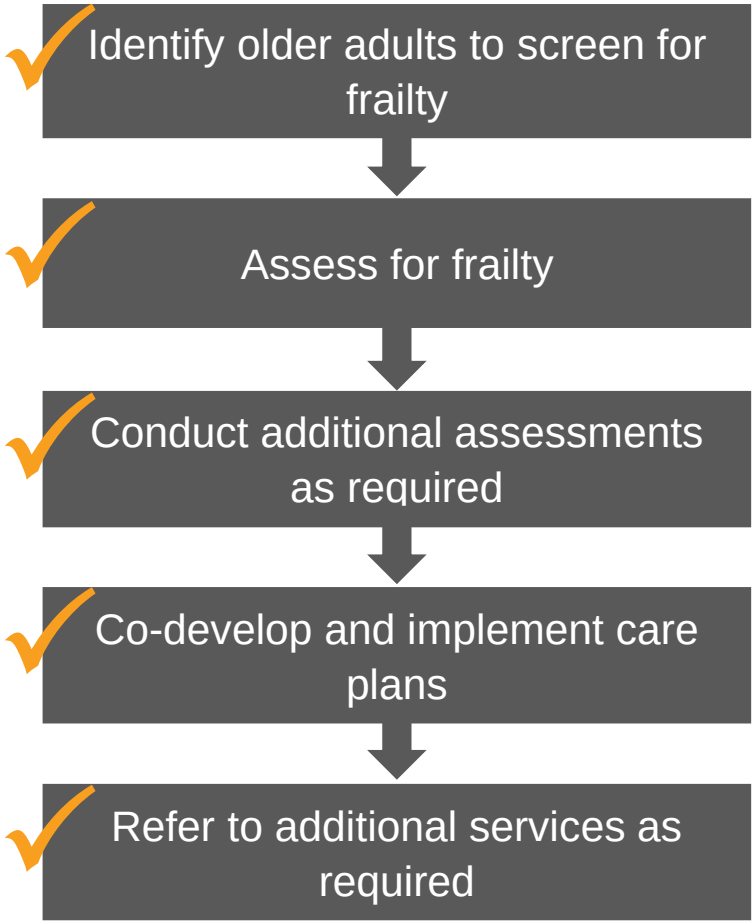
-Patient story
(from team final report)

Close to 5,000 older adults were screened for frailty

- 4,966 older adults were screened
- 35% were identified as living with frailty (1,743)
- Populations addressed included:
  - People living with HIV aged 50+
  - Indigenous seniors 55+
  - People 50+, 65+ or 75+
- Some teams screened all clients or patients, others screened according to their criteria
- Reach was affected by COVID and organizational restructuring, but teams were able to reach 74% of the older adults they had intended to engage

All teams implemented the required elements

- Lots of variation in how teams designed and implemented.
- The variations in all aspects where interventions were implemented
  - the target populations addressed
  - who screened for frailty
  - how screening was done
  - how and which further assessments were completed
  - how care plans were developed, and
  - how older adults living with frailty and their caregivers were linked to community supports and services.



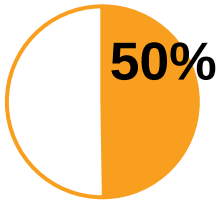
Variations in frailty interventions	
How people were identified for screening	▪ Anyone on roster or receiving service in age range (ages varied from 50+ to 75+) ▪ Practitioners identifying patients who would be suitable ▪ External referrals from community agencies, hospital discharge planners and self-referrals from clients.
Who screened for frailty	▪ Registered nurses (RNs), nurse practitioners (NPs), home care nurses, licensed practical nurses (LPNs) ▪ Primary care physicians ▪ Many allied health practitioners (occupational therapists (OTs), physical therapists (PTs), OT/PT assistant ▪ Medical office assistants ▪ Social workers, intake workers ▪ Patients/clients
How frailty screening was conducted	▪ Clinical Frailty Scale (CFS) ▪ Hand grip & gait speed ▪ Brief Frailty Assessment ▪ interRAI/AUA (Assessment Urgency Algorithm)
Who completed further assessments	▪ Many different practitioners (nurse, NPs, LPNs, elder care nurse, physiotherapist, occupational therapist, pharmacist, dietitian, social workers, health educators, research assistant)
Which further assessments were conducted	▪ Comprehensive Geriatric Assessment ▪ Resident Assessment Instrument–Home Care (RAI-HC) ▪ A standardized assessment covering areas such as quality of life, number of falls in the last year, polypharmacy, subjective memory concerns, unintentional weight loss and food insecurity, loneliness and interpersonal violence. ▪ Others: AUA, interRAI, EQ-5D, Edmonton frailty scale, Resilience/ Vulnerability Assessment Tool (RVAT)
Who was involved in care planning	▪ Physicians ▪ Case managers, RNs, LPN, social workers ▪ Patients and family members
Who frail older adults were referred to	▪ To on-site practitioners (e.g., pharmacists, social workers, geriatricians, dietitians, physiotherapists) ▪ To community partners ▪ To social prescribers

Harder to assess caregiver stress and find community supports

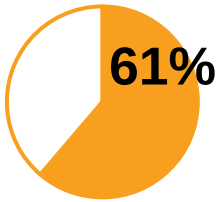
One area where less progress was made was in assessing family caregiver stress/distress. Teams found it challenging to engage with caregivers during the mostly virtual care appointments with frail older adults (compared with in-person appointments, where there are more opportunities to get to know caregivers and to speak with them one-on-one).

Many teams also mentioned that the COVID-19 pandemic adversely affected the availability of community supports.

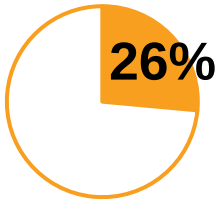
Of the 1,743 older adults who were identified as living with frailty:



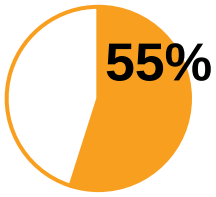
50% received a thorough geriatric assessment



61% received an individualized frailty care plan

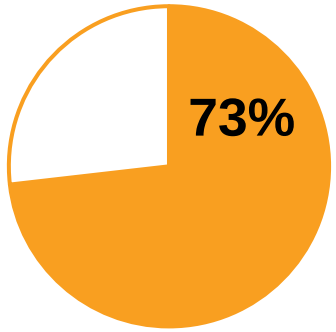


26% had family caregiver(s) assessed for stress/distress

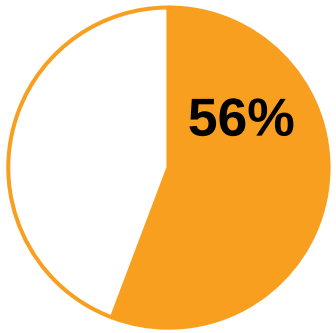


55% were referred to community programs or services

The majority of older adults living with frailty reduced or maintained their level of frailty after 6 months and maintained or improved their quality of life



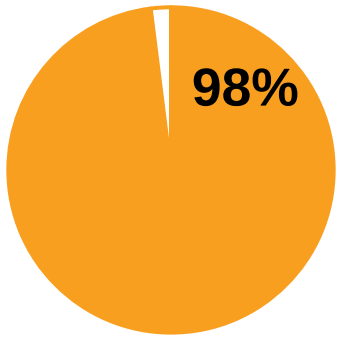
of older adults living with frailty reduced or maintained their level of frailty after 6 months (n=281)



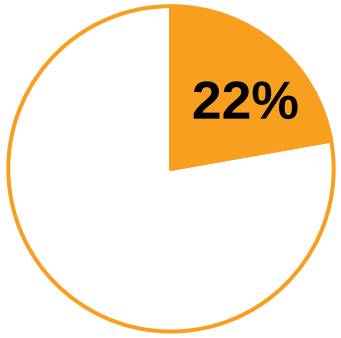
of older adults living with frailty reported that their quality of life had stayed the same or improved (n=131)

Source: Team final reports (informed by patient and caregiver surveys conducted by the teams)

The frailty care met the needs of older adults living with frailty and their caregivers



of older adults living with frailty and caregivers reported appropriate involvement in care planning (n=63)



of family/friend caregivers reported reduced stress or distress levels (n=27)

Percent reporting the program or service met their needs

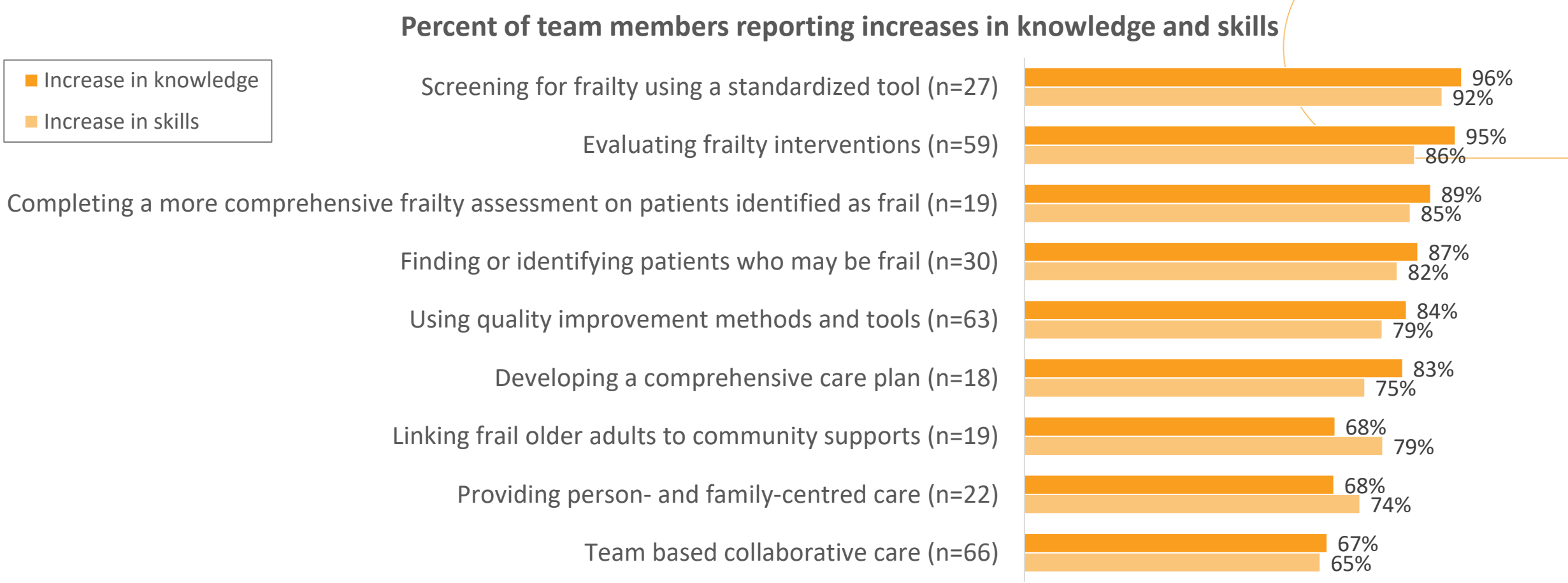
Source: Team final reports (informed by patient and caregiver surveys conducted by the teams)

“Participating in the collaborative was a huge wake-up call for me for realizing how large of a proportion of our patients are either at risk for frailty or are frail.

“Prior to this, I did not have a specialized ‘lens’ for which to screen these patients and offer different care.”

-Healthcare provider testimonial (from team final report)

Team members increased their capacity to deliver frailty care



Source: Survey of improvement team members (response rate = 61%)

Other impacts and lessons learned

- Positive impact on organizational culture → new processes, guidelines, standards and policies
- Spread and sustainability
- Stakeholder engagement and staff education
- Use standardized screening tools
- Integrate into existing workflows
- Social care and community connection
- Caregiver support

Acknowledgements and gratitude

- Canadian Frailty Network
- 17 AFCC teams
- Frailty innovators
- Collaborative coaches
- Patient and family partners
- HEC staff including Nicole Pollack and Kirby Kirvan
- Cathexis

Q&A

Thank You

For more information:

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Healthcare Excellence Canada
Excellence en santé Canada

Building communities as the best place to live- a focus on prevention and improved outcomes for young and old

Jesper Ekberg, national coordinator Strategy for health
Anette Nilsson, Development Strategist

Swedish Association of Local Authorities and Regions
And Region Jönköping County

Region Jönköpings län

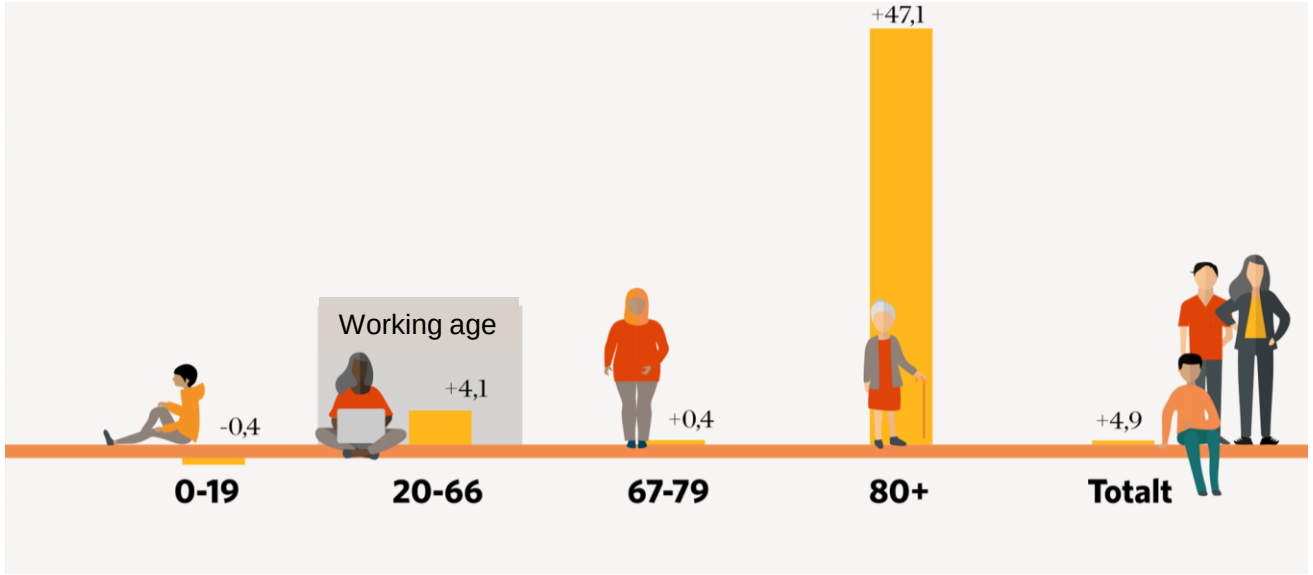
Swedish Association of Local Authorities and Regions

Collaboration for health is more needed than ever

”Obesity among 4-year olds are at least 7 times more common in Alby, Märsta and Storvreten, compared to parts of the inner City of Stockholm”

- Children's unequal conditions for health in Stockholm County, SLL 2017

Demografic changes in Sweden, age groups, 2021-2031



Swedish Association of Local Authorities and Regions

A national strategy for health

- School, social service and health care service needs to be led and coordinated to improve health and minimize risk for unhealth.
- Collaboration around aims, models and tools
- 22 aims, and indicators give the direction

22 indicators and goals

Swedish Association of Local Authorities and Regions

A good and equal health

- Young children exposed to tobacco smoke in the home
- 3-year old children with caries
- Students in year 9 eligible for upper secondary school.
- High school students graduating
- Children who have been placed with completed three years of upper secondary school as 20-year-olds.
- Newcomers in work or study 90 days after the establishment assignment
- Young people who neither study nor work.
- Physical activity in the leisure time
- Fall injuries among elderly

Quality in our services

- Students feel safe at school.
- Students feel that they get help at school when they need it.
- Students feel that school work makes them curious about learning more.
- Users of the home care service and elderly care have a positive experience around treatment, trust and security.
- More users of individual and family care will experience an improved situation after contact with the Social Services.
- Users in the field of disability experience that they can decide on things that are important to them in their daily activities.
- Patients experience better quality in terms of continuity and coordination.
- Patients experience better quality in terms of respect and treatment.
- Patients experience better quality in terms of emotional support

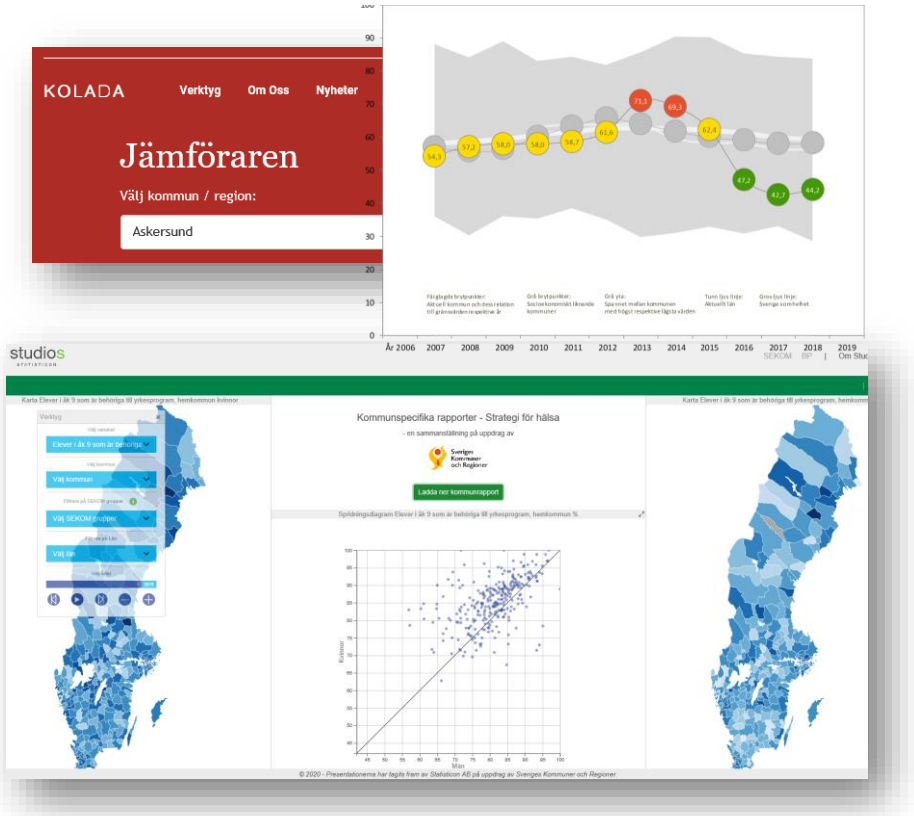
Sustainable and durable

- Life expectancy
- Differences between different groups should decrease
- Children and young people in economically disadvantaged households
- People aged 16-84 experiencing good health
- People aged 16-84 should experience that they trust other people

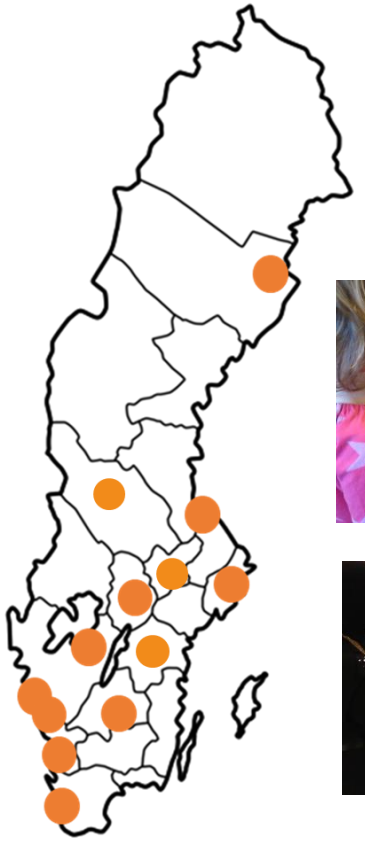
Learn from local bright spots with a common baseline

Swedish Association of Local Authorities and Regions

Baseline– 22 indicators



Connecting bright spots



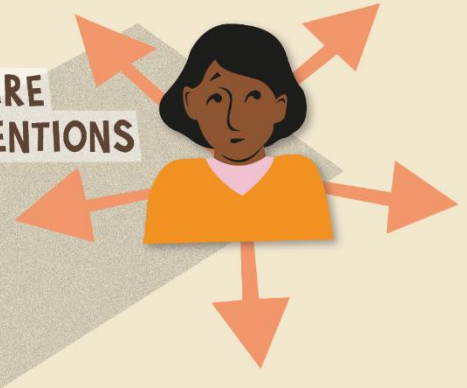
Ref. Strategy for health

INTEGRATED CARE

FROM FOCUS ON ORGANISATION

- TO FOCUS ON PERSON AND RELATIONSHIP

FROM ISOLATED CARE AND WELFARE INTERVENTIONS



- TO COORDINATION BASED ON THE FOCUS OF PERSON

FROM REACTIVE

- TO PROACTIVE AND HEALTH ENHANCEMENT

- TO ACTIVE CO-CREATORS

FROM RESIDENTS AND PATIENTS AS PASSIVE RECIPIENTS

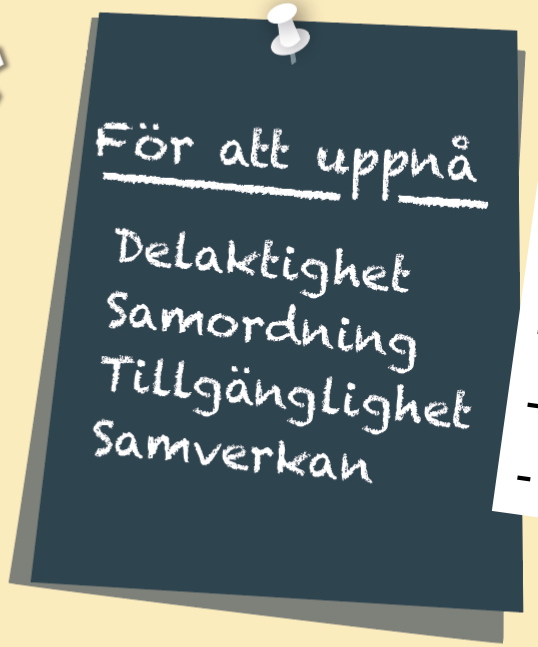
Swedish Association of Local Authorities and Regions

PATIENT CONTRACT

Dockumented agreement between patients and health care – what can I do for my self and with support from my network, and what can healtcare do?

Cohesive planning

Mål • Planerade åtgärder • Samordning
Här innefattas också författningsreglerade planer t.ex SIP



To achieve
- *Participation*
- *Coordination*
- *Access*
- *Cooperation*

Continuity

- Fasta vårdkontakter
  - samordningsansvar & kontinuitet
- Fast läkarkontakt i PV
  - medicinskt ansvar & kontinuitet

Acess

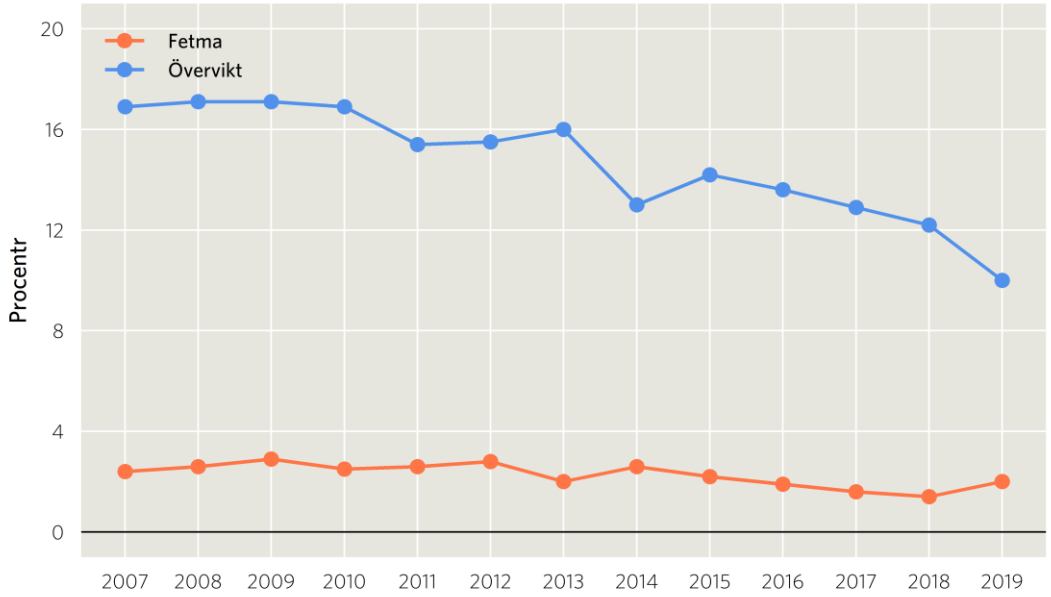
Bokade tider i samråd

Swedish Association of Local Authorities and Regions

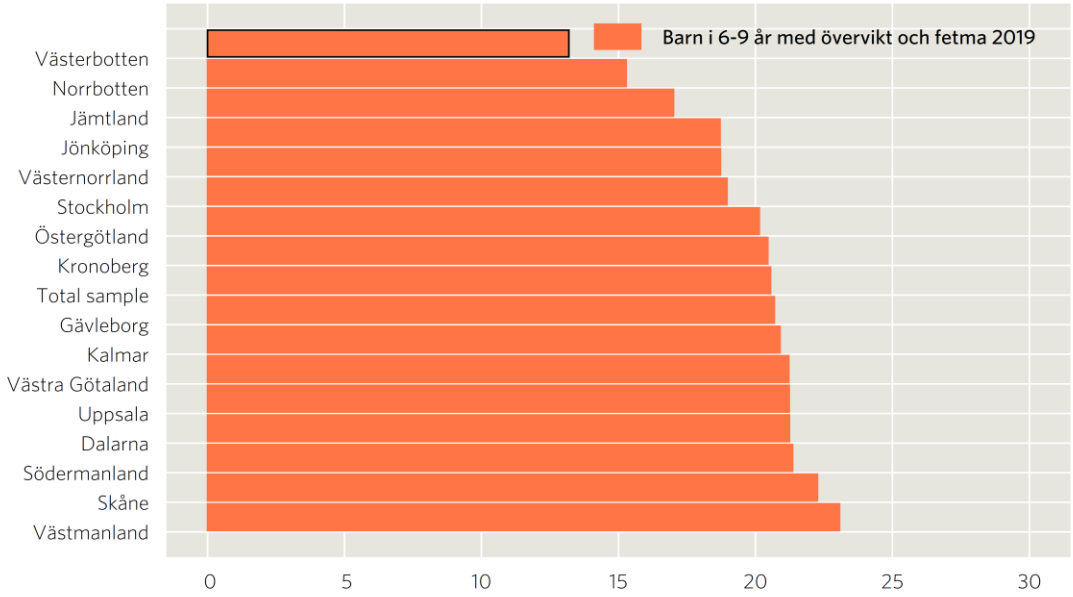
Health creates synergies

The power of health promotion - a bright spot in Västerbotten county

Swedish Association of Local Authorities and Regions



Obesity and over-weigh in four-year-olds in Västerbotten 2007–2019 (preliminary results ref. Competence center for maternal and child health care, Region Västerbotten).



Obesity and over-weigh in 6-9-year-olds nationally and by region 2018/2019. Ref Public Health Agency 2020)

region västerbotten

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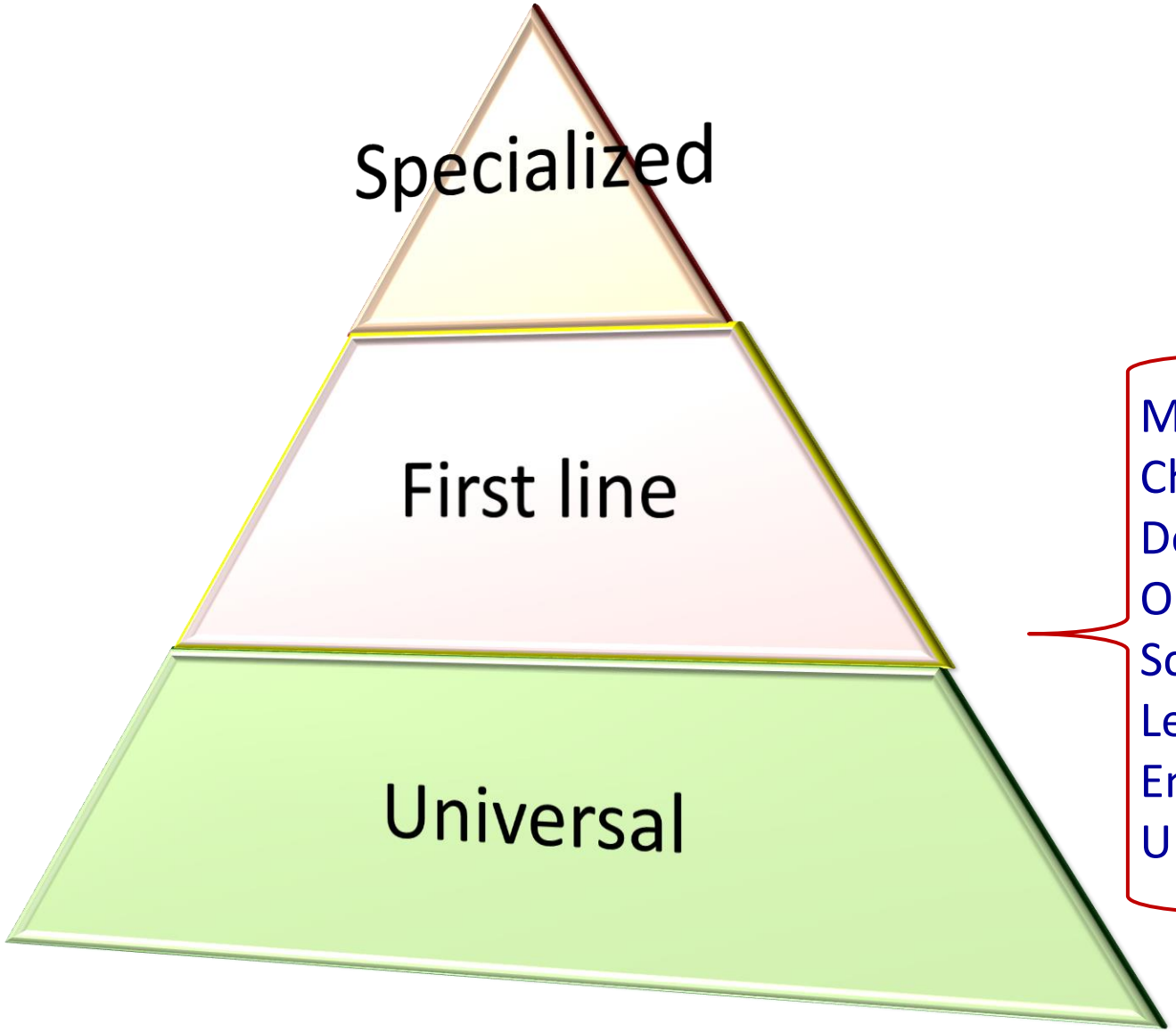

Maternal health
Child health
Dental health
Open pre-school
School
Leisure
Environment
Urban planning , etc

Included in the collaboration

region västerbotten

Activity Houses – learning from Malmö

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Challange!

- High unemployment
- Low participation in leisure and community activities
- Low socio-economic status
- Extra vulnerable area - Heavy crime at young ages
- Young and single parents

Solution!

- All activities are free
- For all ages
- Activities every day during the year
- The school is the place
- Leaders are employed or living in the neighbourhood/from the local community
- All activities are based on what matters to the the children and families

The schools with integrated Activity Houses have made the largest increase of students passing school, compared to other schools in Malmö City

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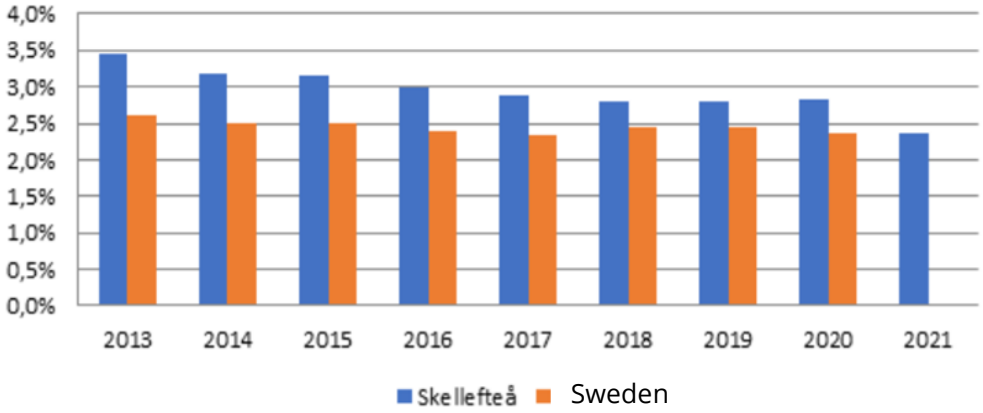
Skellefteå kommun

Life is for living

- Live your life in the best way possible
- I want to get by on my own
- Critical friends - our voice of reason
- Municipality dialogue

Fall related injuries 65+/1000 inhabitants in Skellefteå Municipality

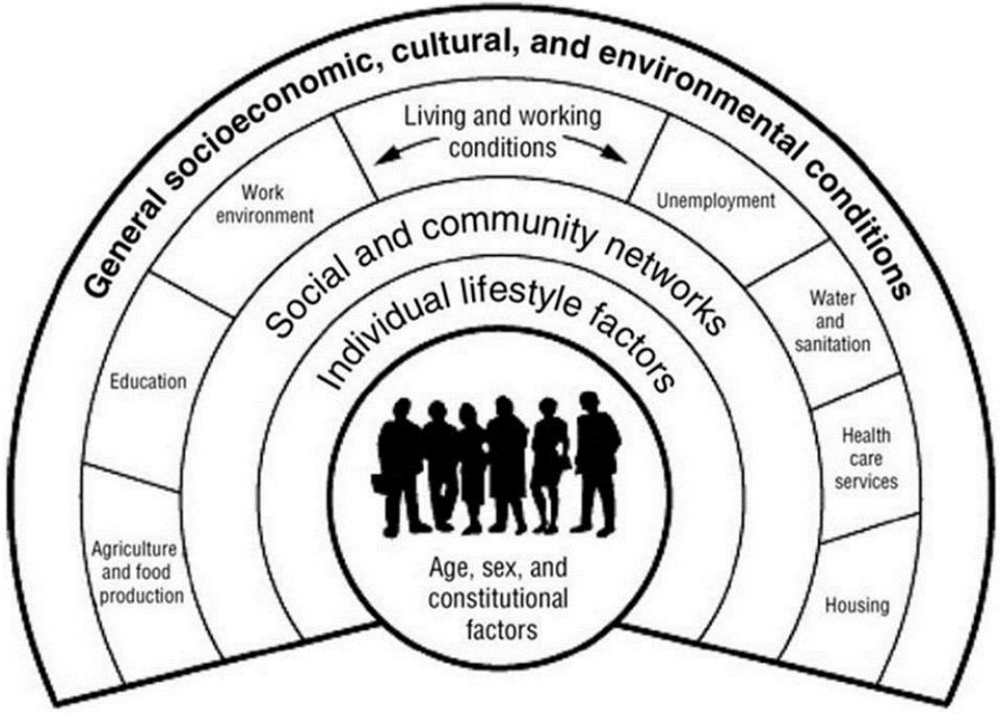


Citizen based networks

- Overall a reach and an activation of almost 10 000 seniors each year
- Passion for life in collaboration with Region Jönköping
- A helping hand
- Pioneers

Creating power to change

– Whole system approach from a society and person centered perspective
– Data driven health promotion and prevention
– Coordinated collaboration and co-production with people and patients.
– Sustainability from tests to dissamination



Source: Dahlgren and Whitehead (1991)

Whole system approach in Jönköping county

Ref. Together-programme, Jönköping County

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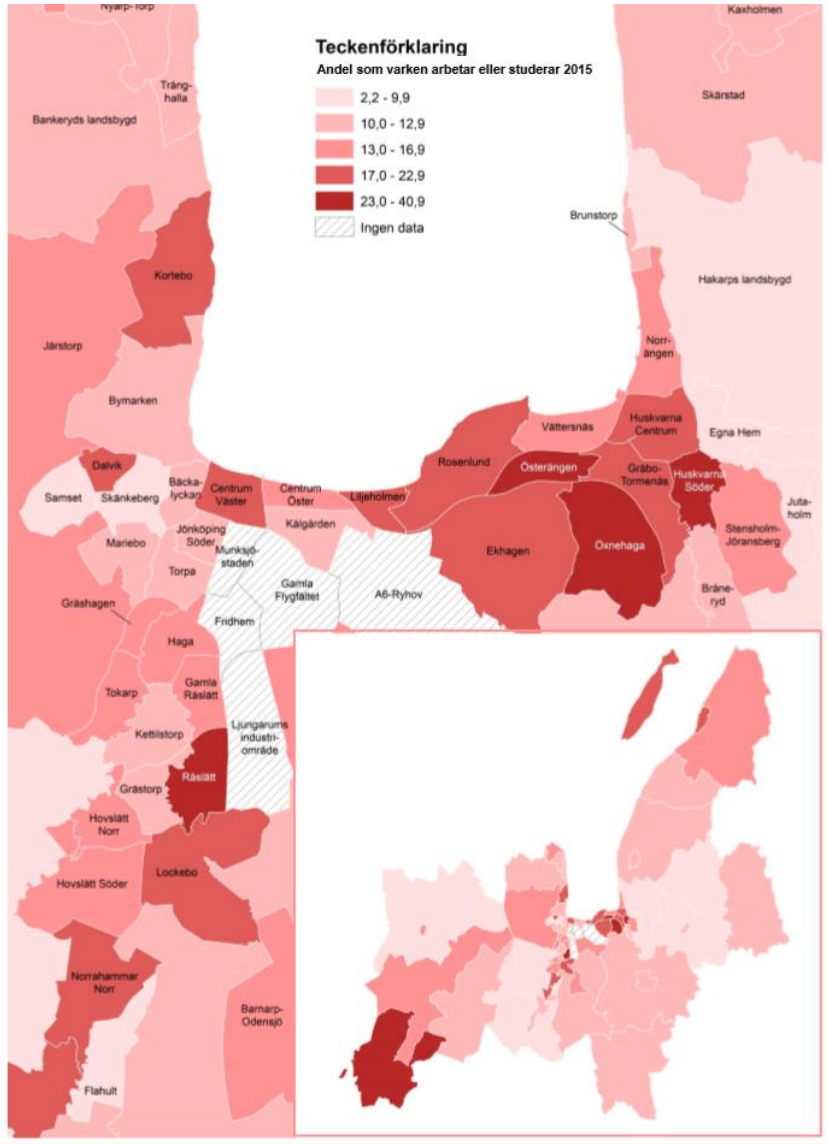
People who neither work or study



Walfare indicators , Jönköping Municipality

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Best place to live, stay and grow up

Jönköping county - on a learning journey with Scotland and Cincinnati

The aim is to improve the health of children and young people by 2% per year, until 2022

Background

Connected to the national development work *Strategy for Health*.

In the management system for collaboration between the county´s municipalities and the Region of Jönköping county.

Three areas have been prioritized for in-depth work in close collaboration:

- Completed study at school
- Mental health and wellbeing
- Physical activity and health

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Purpose

To ensure that everyone is doing their best individually.

To succeed in giving children and young people the support they need to improve their health from a holistic perspective – physical, emotional, social.

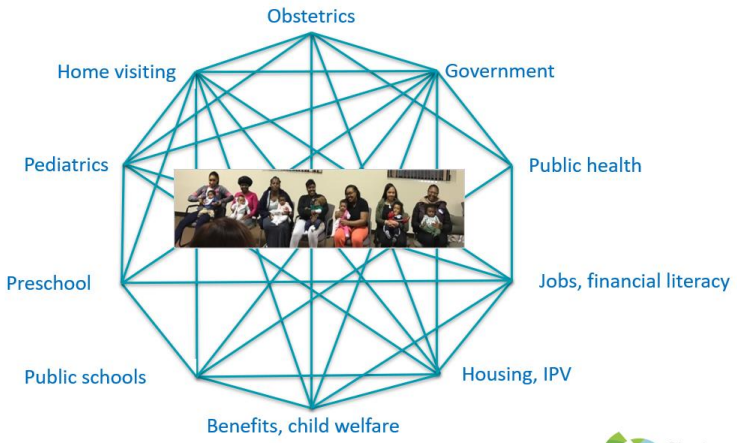
Aim

To improve the health of children and young people by 2% per year, for the next four years.

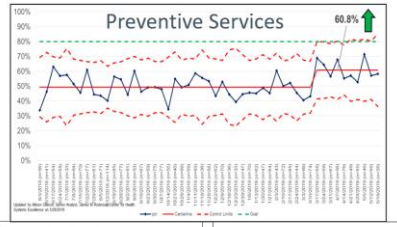
3 countries and 3 different contexts – more in common that sets us apart

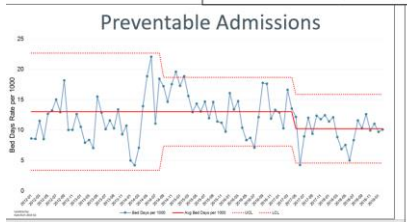
CCHMC Strategic Plan: Help Cincinnati's 66,000 children be the healthiest in the nation through strong community partnerships

Building an Early Childhood System



Cincinnati Children's
changing the outcome together





Scotland's Shared Ambition

To make Scotland the best place in the world to grow up in by improving outcomes, and reducing inequalities, for all babies, children, mothers, fathers and families across Scotland to ensure that all children have the best start in life and are ready to succeed

Multi-agency Improvement collaboration…

Creating a Shared Vision and Aims

Quality Improvement throughout the child and young person journey to achieve **excellence** and **equity** by getting it right for every child.

Pre-birth to 15 months → **15 – 30 months** → **30 months – 5 years** → **5years – 11years** → **11years – 16 years** → **16 years – 18 plus**

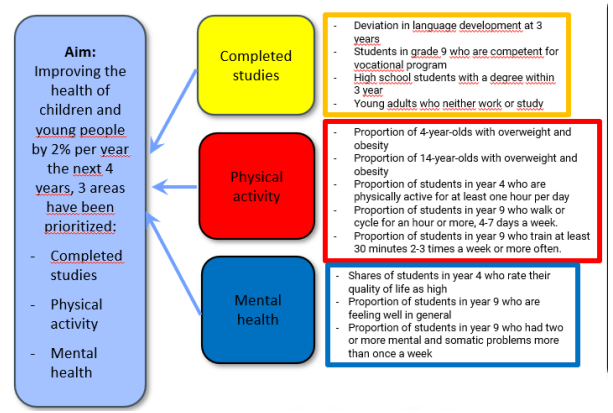
National outcome data:
Universal Pathway - Child Health Reviews
Educational Outcomes - National Improvement Framework:
Literacy, Numeracy, Health and Wellbeing

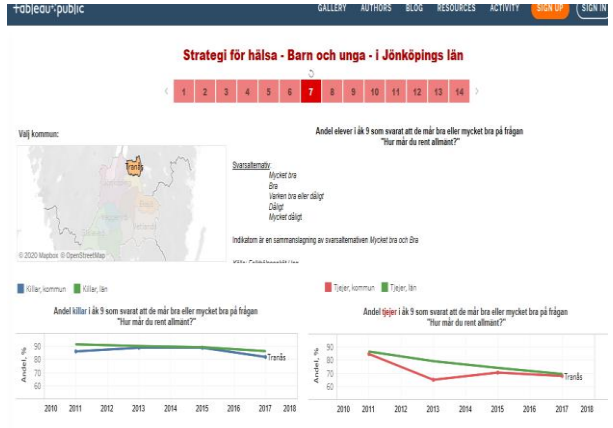
Purpose:

To ensure that everyone is doing their best individually.

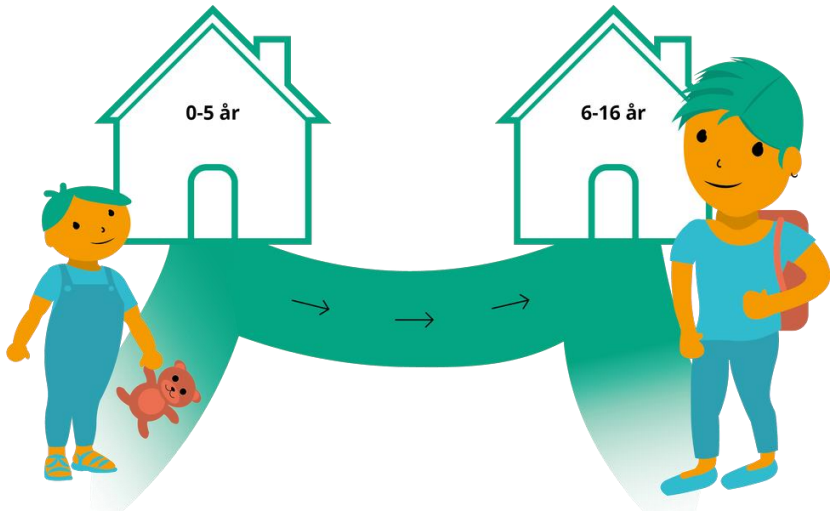
To succeed in giving children and young people the support they need to improve their health from a holistic perspective – physical, emotional, social.

Aim: To improve the health of children and young people by 2% per year, for the next four years.





Family Center ***Student Health Center***



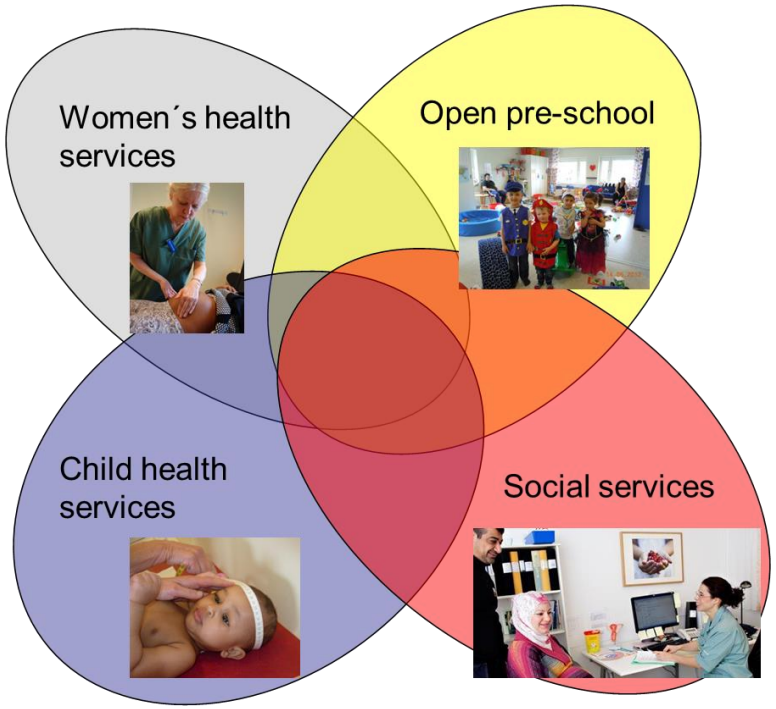
Age friendly communities – the best place to grow old

Peer support and Recovery College

BÄSTA PLATSEN

Hands on and place based in 13 municipalities

Local Family Centers



Intercultural health communication

Local Health Centers

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Take aways from a logic model

- The importance of **a common why and call for action** from a health and care-perspective.
- Increase the ability for **early detection and act jointly** in collaboration together with different societal actors, children and their families
- Work based on quality development methods in **learning networks**. Coaches to support.
- Increase the ability and speed to analyze effects on activities to **go from good examples to conceptualization**. Systematically disseminate new ways of working that contribute to the overall goal.

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