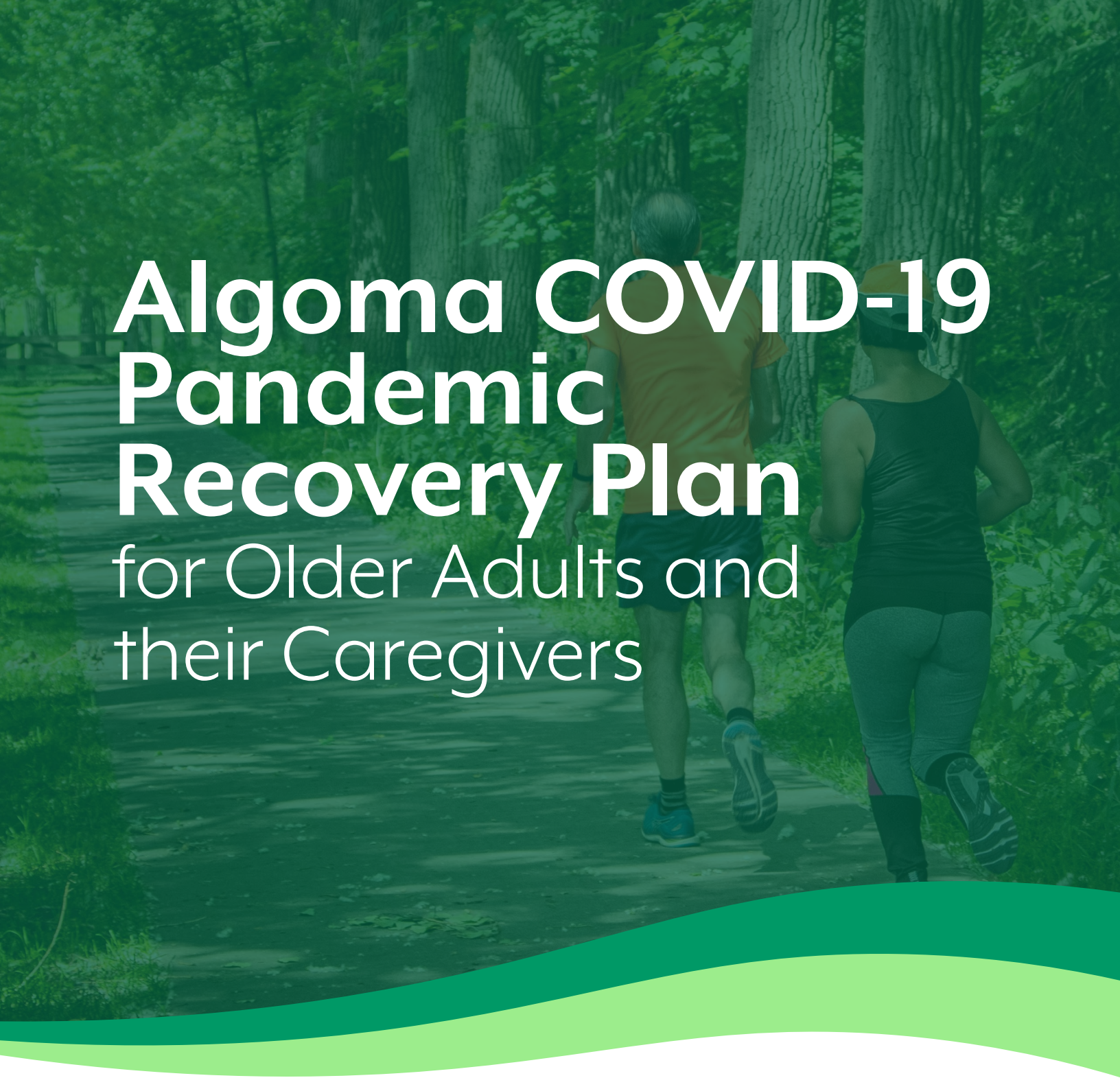

Algoma COVID-19 Pandemic Recovery Plan

for Older Adults and their Caregivers

ÉQUIPE SANTÉ
ALGOMA ONTARIO
HEALTH TEAM

ALGOMA OHT

We are a team of local health professionals, organizations, and community members working together towards a more integrated health system for Algoma residents.

The Algoma Ontario Health Team (AOHT) was officially formed in 2020 to improve coordination of care for Algoma communities. We're working to create a network where patients will have access to the right care, right team, and right care setting when they need it. We want individuals to experience seamless transitions throughout their care journey in a system that is understandable, digitally-enabled, and collaborative.

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TABLE OF CONTENTS

Introduction 4

Algoma's Older Adults 5

Health System Recovery in Ontario 5

Advancing Integrated Care for Older Adults 7

COVID-19 Recovery for Older Adults in Algoma 8

- Reversing Functional Decline 9
- Improving Mental Health and Wellbeing 10
- Supporting Primary Care 11
- Empowering Caregivers 12

Evaluation 12

Next Steps 13

Appendix A: For Consideration 15

The COVID-19 pandemic has had an immense impact on the health system and disproportionately on the most vulnerable populations, especially older adults.

Over the last 18 months, the health system has clambered to provide care for those with COVID-19 as well as implement measures to protect high risk populations.

Throughout the pandemic, health providers developed alternative methods of care provision to assist patients and caregivers during this unprecedented time. Some of these approaches include telephone wellness calls, virtual in-home geriatric consults, and virtual rehabilitation programs. Many of these alternative approaches have improved patient care and spurred novel collaborations between various providers, offering an opportunity for sustainability beyond the pandemic.

Despite these successes, the repercussions of intense, but necessary, infection prevention and control practices have reverberated throughout the older adult population — resulting in decreased access to programs and services, increased social isolation, reduced mobility, higher incidence of anxiety and mood disorders, increased caregiver burden, and delayed disease prevention and care provision[1,2].

While the long-term impacts of the pandemic on health and wellness are not yet known, there are early learnings that can be leveraged to begin the recovery process. As the province enters the recovery phase, the focus of restoring the local healthcare context will be achieved by supporting opportunities to build integrated care principles into the health system. During the pandemic, there was a pause in ameliorating the health system; its wake creates an opportunity to not only rebuild, but advance the system to where it should be.

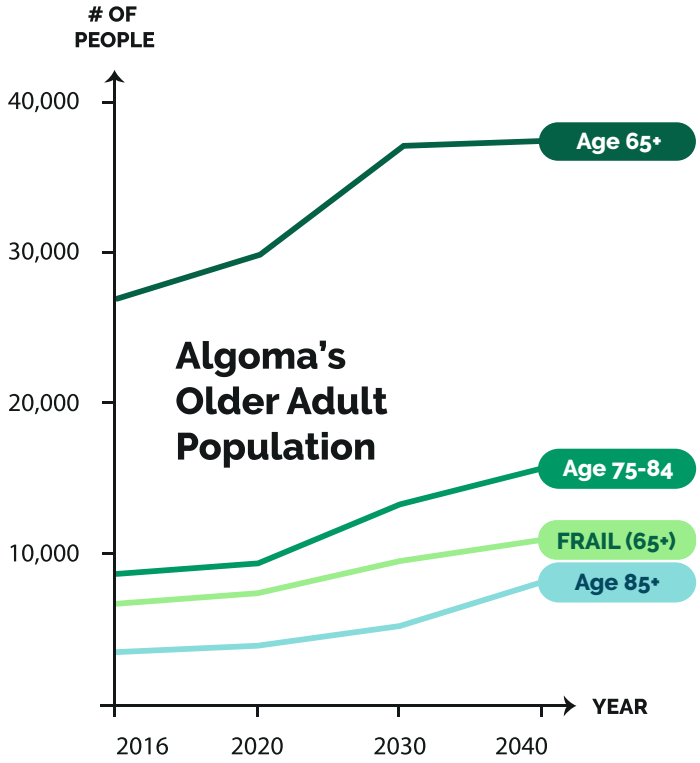
The intention of this plan is for the recommendations to be reflective of the needs of the community. Therefore, we anticipate that this plan will be reviewed and updated to reflect ongoing community needs for older adults and their caregivers.

ALGOMA'S OLDER ADULTS

Did you know that 1 in 4 adults ages 65+ are living with frailty?

Older adults are living longer lives when compared to previous generations. As our older adults live longer, there are increasing incidences of living with multiple co-morbidities, requiring specialized care.

Within this generation are over 7,000 individuals living with frailty, a geriatric syndrome characterized by reduced strength, endurance, and physical function. As our population of residents over 65 grows, so will the population of Algoma adults experiencing frailty. The Provincial Geriatrics Leadership Office (PGLO) predicts that by 2040, almost 11,000 Algoma residents will be living with frailty (see graph)[3].

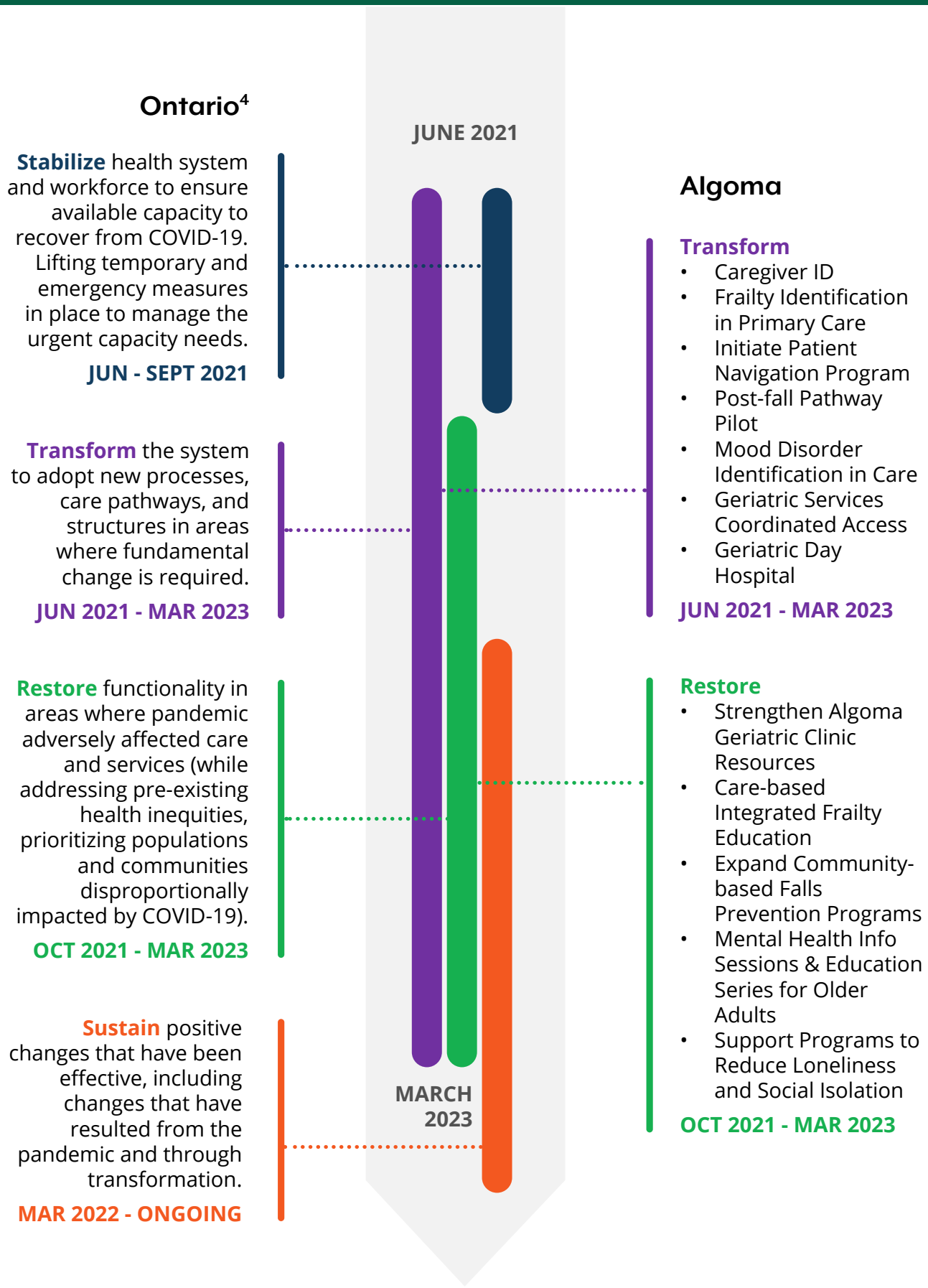


HEALTH SYSTEM RECOVERY IN ONTARIO

Ontario Health has outlined a high level approach to health system recovery[4]. The approach extends from June 2021 to March 2023 with four phases of recovery. The left side of the graphic on page 6 illustrates Ontario Health's phased approach to recovery along with descriptions of each phase.

The recovery plan for Algoma is initially focused on the two stages poststabilization: transform and restore. The right side of the graphic on page 6 maps the specific initiatives to be undertaken in Algoma as part of the recovery plan. Recovery in Algoma for older adults will focus on re-establishing services and programs and use the lessons learned from the pandemic to improve services and access to care.

Health System Recovery in Ontario vs. Algoma

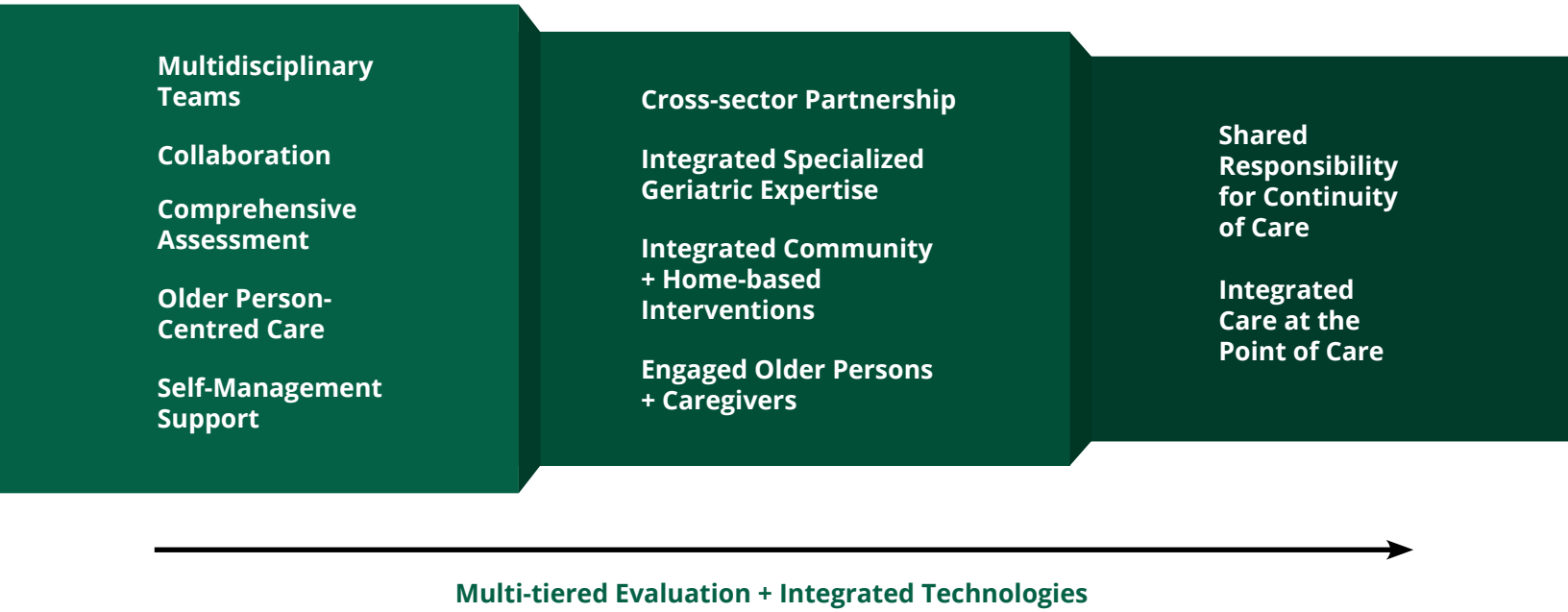


ADVANCING INTEGRATED CARE FOR OLDER ADULTS

The Provincial Geriatrics Leadership Office (PGLO) released a scoping review[5] of the key design elements required for integrated care for older adults. Through a literature review and consultation with clinical experts, the analysis identified 13 evidence-based design elements of integrated care and common principles for operationalizing these core design elements in practice. The scoping review does not prescribe importance or stages to integration based on the 13 design elements, only suggesting that there are six elements that are used most frequently. In an effort to structure the 13 design elements, we developed a staged approach to integrated care.

The graphic below organizes the design elements into a hierarchy, starting with the foundational elements at the left and then moving to the right into increasingly complex elements. The scoping review separates multi-tiered evaluation and integrated technologies as design elements; however, these pieces are critical components and should therefore be built into all integrated care projects. As such, evaluation and technology are illustrated in the graphic below as reaching across all remaining 11 design elements, which begin with the initial five foundational elements and build to the right with two additional levels of complexity.

The structured approach does not connote an importance of any design element over another, but rather illustrates the foundational pieces of integrated care needed within Algoma where the level of integrated care varies significantly. The initial five design elements, listed in the left-most column in the graphic below, are the foundational elements required to recover from the pandemic and begin developing an integrated care approach in Algoma.



COVID-19 RECOVERY FOR OLDER ADULTS IN ALGOMA

This recovery plan is about taking the learnings from COVID-19 to improve care for older adults and infuse transformative programs at the same time. Our COVID-19 recovery plan is intended to identify initial actions and empower older adults and their caregivers. The plan is a multi-dimensional approach and is organized into four focus areas:

1. **Reverse functional decline**
2. **Enhance mental health and wellness supports**
3. **Increase frailty knowledge in primary care**
4. **Empower caregivers**

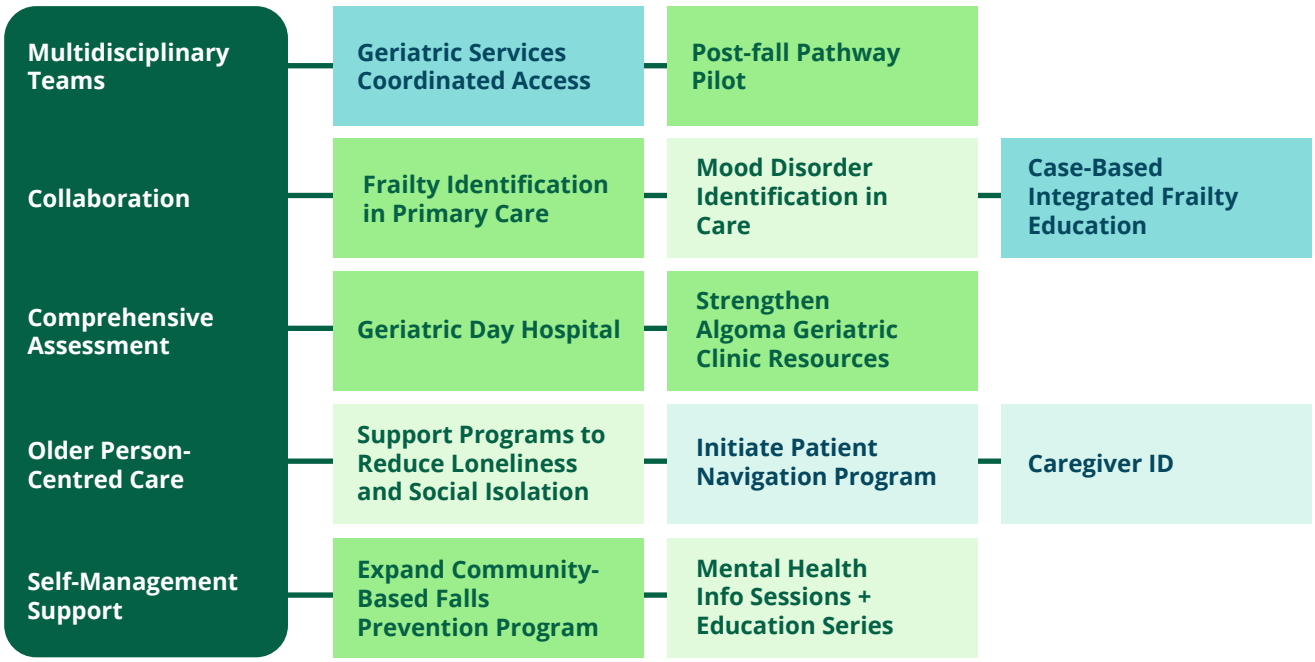
Our areas of focus and subsequent actions have been informed by evidence-based practices, current gaps in services, quality standards from Health Quality Ontario, and the Final Report of the Algoma Citizens' Reference Panel on Integrated Care[6]. The actions will build onto other existing Year 1 projects within the AOHT, such as the Post-fall Pathway, early frailty identification, and exploration of transitions in care.

In addition, our recovery plan aligns with Ontario Health's Collaborative Quality Improvement Plan[7] (cQIP) which focuses on:

- Improving overall access to care in the most appropriate setting
- Increasing overall access to community mental health and addiction services

As can be seen in the graphic below, each of the recommendations of our post-COVID recovery plan are connected to at least one of the five foundational design elements (page 7).

Year 1 + 2 Application of Integrated Care Design Elements



Reversing Functional Decline

Expanded access to community-based rehabilitative care

Given the high prevalence of functional decline, the PGLO and Rehab Care Alliance are developing recommendations and best practices for communities to begin reversing functional decline as a result of the pandemic. These reports are anticipated to be released in late fall 2021. Interimly, our recovery plan will put forth recommendations that are both evidence-based and community-minded.

In an effort to protect high risk populations and reduce the spread of COVID-19, community services were suspended, resulting in many older adults unable to access primary exercise and social activity locales. Active older adults were left with little means to exercise and maintain their health. As a result, older adults experienced higher risk of falls, declined physicality[8], and challenges managing their chronic conditions. These impacts can result in increased frailty and functional decline.

Identifying frailty early can improve quality of life for patients, increase intervention success, and delay the need for specialist care. Local clinicians and specialists as well as the Algoma Citizens' Reference Panel[6] emphasized the importance of earlier disease identification.

Recommendations

1. Strengthen Algoma Geriatric Clinic space needs
2. Launch an embedded early frailty identification tool within primary care
3. Post-fall Pathway Pilot in Emergency Department and primary care
4. Establish a Geriatric Day Hospital to complete a comprehensive assessment
5. Expand community-based falls prevention programming

Improving Mental Health and Wellbeing

Enhance mental health and wellness supports

Mental health issues have risen over the course of the pandemic with higher incidences of social isolation, functional decline, and loss of usual routines. While services were enhanced during the pandemic to decrease the prevalence of social isolation, as the community emerges from the pandemic, additional resources will be required to support individuals who have increased anxiety, are grieving the loss of time and relationships, and have new or increased mood disorders. Providing older adults with resources to understand the impact of the pandemic on mental health as well as teaching strategies to return to positive mental wellness will be critical next steps in improving mental health and wellbeing.

Recommendations

1. Provide clinicians with the tools and education needed to identify mood disorders in older adults
   a. Provide education and technical supports on the use of the Geriatric Depression Scale in primary care and community
2. Develop patient resources and educate older adults on mental wellness strategies
   a. Leverage local media platforms, both traditional and online venues, to provide information and teach self-management skills
3. Support programs to decrease loneliness and reduce social isolation

Supporting Primary Care

Increase frailty knowledge in primary care

Primary care is anticipating an influx of patient demand as capacity limits, instituted due to the pandemic, are reduced. From the pandemic experience, the value of appropriate triaging has been especially notable and improved the ability to deliver appropriate care to the right patients within resource constraints. Going forward, proactive case finding, including close partnerships with primary care, may help identify the most at-risk older adults early on and provide them with timely assessment[2].

Geerts et al. (2021)[9] suggest that the reintegration of services presents an opportunity for optimization of specialist care via improved triaging of services. This can be achieved through the development of coordinated access to Geriatric Services. Supporting primary care providers to identify frailty and ease access to geriatric services will decrease workload for primary care, improve patient-provider relationships, and increase access to the most appropriate level of service for patients.

Recommendations

1. Institute universal frailty screening and education series
   a. Develop lecture-based frailty education for primary care providers
   b. Institute universal screening in primary care focused on frailty identification and prevention
2. Establish a Geriatric Services coordinated access program
   a. Explore the technical and process requirements to support e-referrals and coordinated access

Empowering Caregivers

Early restrictions to visitation and the exclusion of caregivers had numerous unintended consequences. Due to COVID-19, this was readily seen with health providers and institutions being challenged with how they could effectively integrate caregivers into the circle of care, while maintaining a safe environment. The exclusion of caregivers during COVID-19 highlighted the important, and often unrecognized work, that they provide.

While caregivers were restricted from care facilities, fear of care providers in homes shifted the care to caregivers, in some instances leading to caregiver burnout. Educating and informing patients and caregivers on what care should look like is a key piece of self-management and advocacy. Creating awareness of Senior Friendly 7 principles is critical in empowering patients and caregivers to take charge of their health and advocate for appropriate care.

Recommendations

1. Caregiver ID
   a. Scale Caregiver ID program across Algoma
2. Patient Navigation Program Development
   a. Initiate yearly asset map of services

EVALUATION

Evaluation for our recovery plan will be planned on multiple levels to understand both the process of collaboration as well as patient outcomes. An evaluative framework will be developed that will incorporate locally directed outcomes as well as aligning indicators to the provincially defined Collaborative Quality Improvement Program (cQIP).

NEXT STEPS

The success of this recovery plan is founded in the collaboration among partner organizations. The recommendations vary in resource intensity, required collaboration, and timelines. Formalized work on these projects will start in Fall 2021 as part of the transform, restore, and sustain parts of the Ontario Health recovery phase. Some projects that are already underway are the Post-fall Pathway, Caregiver ID, and Frailty Identification in Primary Care (see below).

The program will be overseen by the Healthy Aging Working Team. Initial socialization of the recommendations will occur immediately with local partners organizations, community groups, clinicians, older adults, and caregivers.

Post-fall Pathway: In Algoma, falls are the most common reason for injury-related hospitalization and functional decline. Currently, the AOHT is working with local physicians to implement the Rehab Care Alliance Post-fall Pathway in primary care and the Emergency Department. This pathway utilizes evidence-based assessments and processes for primary care providers to reduce the risk for secondary falls and further functional decline by connecting frail older adults with rehabilitative care. The Post-fall Pathway is being implemented as an initial AOHT project to improve health outcomes for those living with frailty and reduce the burden faced by caregivers.

Caregiver ID: Caregiver ID is a program that recognizes caregivers as essential partners in care. This program, which was created by the Ontario Caregiver Organization and has been adapted for initial rollout in Algoma at Sault Area Hospital, identifies, prioritizes, and equips caregivers with the tools they need to provide high quality care for their loved ones. This program is currently rolling out at organizations throughout Algoma to help create seamless transitions between services for caregivers. Learn more: www.algomaoht.ca/caregiverid.

Frailty Identification in Primary Care: The Centre for Effective Practice (CEP) is developing a tool for primary care providers to universally screen older adults for frailty and falls risk that tailors interventions and management plans to support falls prevention. Currently, Dr. Chung is on a working group to develop this tool, which should be ready for deployment mid-fall 2021. The CEP is also working closely with the AOHT to identify relevant local resources and services to support the development of frailty and falls prevention pathway for primary care providers.

[1] Provincial Geriatrics Leadership Office (PGLO) & Rehab Care Alliance (RCA). (2021). *Pandemic Recovery Planning: Enhancing Care for Older Adults in Ontario*.

[2] van Ineveld, C. H. M., Huang, S. C., Vashney, N. K., & French Merkley, V. (2020). The Impact of COVID-19 Pandemic Restrictions on Geriatric Day Hospitals and Geriatric Ambulatory Care in Canada: Adapting for Future Waves and Beyond. *CGS Journal of CME, 10*(1). https://canadiangeriatrics.ca/wp-content/uploads/2020/09/Geriatric-Day-Hospital-Ambulatory-Care-in-Canada-FORMATTED-final.pdf

[3] Provincial Geriatrics Leadership Office (PGLO). (2020). Regional Frailty Estimates North [Data set]. Provincial Geriatrics Leadership Office.

[4] Ministry of Health (2021, June 28). *OHT Learnings through COVID-19* [Presentation]. Ontario Health Teams Virtual Engagement Series.

[5] Horgan, S., Kay, K., & Morrison, A. (2020, August). *Designing Integrated Care for Older Adults Living with Complex and Chronic Health Needs: A Scoping Review.* Provincial Geriatrics Leadership Office.

[6] Algoma Citizens' Reference Panel on Integrated Care. (2021). *Final Report of the Algoma Citizens' Reference Panel on Integrated Care.* Algoma Ontario Health Team.

[7] Ontario Health. (2021, August). *OHT Performance Measurement Framework: Collaborative Quality Improvement Plan (cQIP) Information Session* [Presentation].

[8] Statistics Canada. (2021, October 1). Canadian Health Survey on Seniors, 2020. *The Daily*. https://www150.statcan.gc.ca/n1/daily-quotidien/211001/dq211001b-eng.htm

[9] Geerts, J. M., Kinnair, D., Taheri, P., Abraham, A., Ahn, J., Atun, R., Barberia, L., Best, N. J., Dandona, R., Dhahri, A. A., Emilsson, L., Free, J. R., Gardam, M., Geerts, W. H., Ihekweazu, C., Johnson, S., Kooijman, A., Lafontaine, A. T., Leshem, E., … Bilodeau, M. (2021). Guidance for Health Care Leaders During the Recovery Stage of the COVID-19 Pandemic: A Consensus Statement. *JAMA Network Open. 4*(7): e2120295. doi:10.1001/jamanetworkopen.2021.20295

APPENDIX A: For Consideration

Clinical Considerations

The recommendations proposed in this plan were discussed at length and while some were of great importance, it was determined that the following recommendations are significant projects requiring additional resources and significant attention. Therefore, they were deemed to be beyond the scope of the recovery plan.

1. **Surgical interventions, diagnostic imaging tests and specialist care backlog**
2. **Increasing effective transitions in care**
3. **Expanding digital health tools**

Communication Considerations

Throughout our consultation with older adults and caregivers, we heard the need for traditional and continuous communication with older adults about programs, services, and engagement opportunities. In addition to new digital solutions, advisors highlighted the importance of posting notices at grocery stores, churches, community centres, and other areas where older adults commonly gather. Robust, targeted communication efforts will be critical in ensuring older adults and their caregivers can take advantage of the resources and programming outlined in this plan.

Partnership and Programming Considerations

We recognize and acknowledge that beyond the recommendations outlined in this plan, there are many organizations within Algoma that work with older adults to improve quality of life and provide upstream, preventative social programming. As part of a holistic, person-centred approach, we are committed to collaborating where possible to amplify the efforts of others and form a network of inter-connected supports for older adults and their caregivers.

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