McKinnon Wilson J et al, 2021, Improving care, services and supports for older adults living with frailty in the KW4 community: Integration an enabler; co-design an imperative. *International Journal of Integrated Care* 22(S2): 167. DOI: doi.org/10.5334/ijic.ICIC21330

POSTER ABSTRACT

Improving care, services and supports for older adults living with frailty in the KW4 community: Integration an enabler; co-design an imperative

1st North American Conference on Integrated Care, Toronto, 4 - 7 October 2021

Jane McKinnon Wilson[1], Christine McLellan, Caitlin Agla, Don Wildfong

1: Waterloo Wellington Geriatric System hosted by CMHAWW, Canada

Introduction

Since 2019, the Waterloo Wellington Older Adult Strategy (WWOAS) has worked collaboratively with the KW4 OHT, representing Kitchener, Waterloo, and the Townships of Wellesley, Wilmot and Woolwich to plan, implement and evaluate activities in support of the Frail Elderly priority population. Both share an ongoing commitment to optimize the health of an aging population, strengthen the performance of our health system and achieve balance across the Quadruple Aims. Together, they have demonstrated an authentic commitment to advancing co-design approaches with patients, caregivers, healthcare and community support service organizations and providers. A number of ongoing improvement initiatives are currently under evaluation.

Aims Objectives Theory or Methods

Since 2018, the WWOAS has worked to address health system improvements that promote and support healthy aging; prevent and manage chronic disease; promote optimal aging at home for older adults with multiple chronic conditions; provide specialized care for those living with frailty; and, support caregivers.

For over two years, the WWOAS and KW4 OHT have successfully advanced strategic and operational efforts to better support older adults living with frailty by: leveraging subject matter expertise at the system/service delivery levels; harnessing momentum on shared priorities across the system; thoughtfully aligning with ongoing/future initiatives; and, adopting, adapting and building on evidence-informed recommendations.

Highlights or Results or Key Findings

Working groups, with integrated care as a key goal, have begun this work through intentional and thoughtful co-leadership, recruitment, terms of reference, and priorities to lay a foundation for true engagement.

Expanding partnerships between healthcare and community-based service organizations has also proven pivotal to ensuring service stability, supporting caregivers, decreasing hospitalization for conditions best managed in the community; reducing premature onset of frailty; and improving wait times to specialized geriatric services.

Key learnings include deepening engagement with older adults and caregivers, co-design practices at system/service levels, strengthening collaborative leadership and inter-professional practice, anchoring change management and team building on shared norms and values, and continuing quality improvement.

Conclusions

Normalizing an integration and co-design framework offered common language to address potential barriers and opportunities to deepen integration, serving as a basis for improvement and innovation at multiple levels (system, vertical and horizontal) and the appropriate targeting of interventions (i.e. normative, professional, functional, service, clinical and organizational) for system strengthening.

Implications for applicability/transferability sustainability and limitations

As a learning health system, we have shared in reflection, growth, adaptation and innovation — critical through the pandemic response/recovery — sharpening our ability to implement integrated service delivery models; support frontline providers; support older adults at risk; engage older adults and caregivers; and, participate in health system transformation at provincial/local levels.