Alberta Health Services

Seniors Health Strategic Clinical Network™

2017-2020 Transformational Roadmap

"Being a member of the SCN has enabled me to remain in the health field, which has been my interest for 50 years. It has helped me bring back, to my rural community, the advances being made by dedicated people through research. It has allowed me to be a voice to the committee and from my community. Too often we feel that concerns are not heard or validated - for me SCN provides this forum."

Margie Miller, Patient Advisor

June 26, 2017

Dear Colleagues,

We would like to acknowledge the work of the Seniors Health Strategic Clinical Network Core Committee and appreciate their active participation in the development of the Seniors Health Strategic Clinical Network (SH SCN) Transformational Road Map (TRM) 2017-2020. A listing of Core Committee members can be found at:

http://www.albertahealthservices.ca/scns/Page7702.aspx

This Roadmap outlines the strategic directions of the network by identifying several strategies that support Alberta Health Services in providing a patient focused, quality health system that is accessible and sustainable for all Albertans.

We would also like to thank members of the SH SCH Community of Practice who participated in an online survey identifying trends that impact the priorities of the network. The SCN's Patient Advisors who were interviewed provided valuable input on the future directions for the SCN. The collective work of the Core Committee, Community of Practice and the Family Advisors helps the SCN focus on key issues that will support Alberta's seniors to optimize their health, well-being and independence.

This "refresh" of the Transformational Roadmap is an opportunity for the SH SCN to celebrate the accomplishments it has achieved over the past three years. A critical look at the present has led to the identification of opportunities for innovation, and to refine the SCN's areas of focus as we work together to build a better future for Alberta's seniors.

The network continues to support healthcare system improvement by examining current practices, learning from research and responding with innovative approaches for seniors in Alberta.

Great strides have been made but there is a lot more work ahead. The SH SCN is committed to working with our partners to develop and implement strategies that address the healthcare needs of Alberta's aging population.

Sincere thanks to everyone who has contributed to this collective effort.

Jim Silvius,
Senior Medical Director,
Seniors Health Strategic Clinical Network
Alberta Health Services

Scott Fielding,
Senior Provincial Director,
Seniors Health and Emergency Strategic Clinical Networks
Alberta Health Services

Seniors Health Strategic Clinical Network™

2017 – 2020 Transformational Roadmap at a Glance

MISSION

To make improvements to healthcare services and practices that enable Alberta's seniors to optimize their health, well-being, and independence.

PLATFORMS

Aging Brain Care

Strategies on preventing, anticipating and living with cognitive changes

Frailty, Resilience, Aging-well: Late-life Transitions

Strategies on preventing, anticipating, optimizing and living with conditions that comprise health and functional abilities in later life

Anticipating an Aging Alberta

Work in collaboration to address seniors' issues through effective linkages between provider groups that are focused on improving the health of older Albertans

ACTIVITIES

Appropriate Prescribing for Seniors in Alberta

- Appropriate Use of Anti-psychotics (AUA) in LTC – sustainability
- AUA in Supportive Living
- Provincial Polypharmacy Strategy for Seniors

Elder Friendly Care in Acute Care in Alberta

- Acute Care – Rural (Pilot)
- Acute Care – Provincial
- Provincial Elder Friendly Care Strategy
- Provincial Delirium Toolkit

Advancing Dementia Diagnosis and Management in Alberta

- Integrated Community Geriatric Service Development Initiative
- Alberta Dementia Research Strategy
- Dementia resources for primary healthcare providers and the public
- Community Grants to support innovation in dementia care

Enablers

Research and Innovation | **Communication** | **Engagement** | **Quality Improvement and Measurement**

Executive Summary

The Seniors Health Strategic Clinical Network (SH SCN) Transformational Roadmap outlines the strategies to improve healthcare services and practices for the health, well-being and independence of seniors over the next three years.

Older Albertans are the fastest growing population in the province. Within 20 years, one in five Albertans will be 65 years of age or older. Seniors range from being healthy and independent to medically complex and frail. Over 75 per cent of seniors live with multiple chronic conditions that continue over many years. As health needs increase in an aging population, so does their dependence on the healthcare system, care providers and caregivers. By supporting seniors to optimize their health, quality of life, resilience and independence as they age and by continuing to support those with greater health needs, we will be able to moderate the impact on our healthcare and social support systems.

The SCN platforms represent three key strategy areas:

1. **Aging Brain Care (ABC)**
2. **Frailty, Resilience, Aging-well: Late-life Transitions Initiative (FRAILTI)**
3. **Anticipating an Aging Alberta (AAA)**

The SH SCN will address both the opportunities and challenges Alberta's changing demographics bring. This will be done through collaboration, consultation and engagement with Albertans, clinicians, researchers, educators, and other key stakeholders.

The SH SCN is playing a key role in preparing Alberta for the impact of an aging population The SCN is able to influence and inform this work; providing Albertans with information on these expected impacts, providing input on policy development, health and social planning.

Quick Facts

Within two decades, one in five Albertans will be 65 years of age or older.

The SH SCN is developing evidence-informed recommendations; partnering with educational institutions to ensure relevant educational requirements on the care of seniors is met. As well, it is collaborating with key stakeholders who are focused on improving the health of older Albertans.

The SH SCN continues to build on the four foundational enablers to succeed in achieving the outcomes identified in the Seniors Health Transformational Roadmap:

- **Research and Innovation,**
- **Engagement,**
- **Communication, and**
- **Quality Improvement and Measurement.**

Research and innovation are essential to generate, synthesize and translate knowledge. These strategies are embedded within each of the platforms of work outlined in this document. Through a collaborative membership model, the SH SCN will continue to engage with seniors, their families, communities, clinicians and partners to ensure meaningful dialogue. Effective communication will be vital for the success of the SCN and includes hearing the stories of Albertans. Quality improvement in each of the six Health Quality Council of Alberta (HQCA) Dimensions of Quality will be measured and supported by good data and measurement practices.

Contents

Introduction

Strategic Clinical Networks are provincial in scope and include small leadership teams bringing together the experiences and expertise of front line healthcare professionals, researchers, government, communities, clinical and non-clinical leaders, patients and their families to improve Alberta's healthcare system. The Seniors Health Strategic Clinical Network (SH SCN) strives to understand the evolving Alberta context for seniors care and services to inform the development of a three year strategic framework, known as the Transformational Roadmap (TRM). In 2016, the SH SCN started a process to "refresh" the 2014—2017 TRM. Lead by the Core Committee and supported by the SH SCN Leadership Team the refreshed Seniors Health Strategic Clinical Network Transformational Roadmap reflects the collaborative effort of both internal and external stakeholders.

SH SCN Mission:

To make improvements to healthcare services and practices that enable Alberta's seniors to optimize their health, well-being and independence.

Development of the Transformational Roadmap

The refresh of the 2017 – 2020 SH SCN Transformational Roadmap was undertaken to review current state, planning assumptions and trends to identify opportunities for innovation. Engagement with the Core Committee, Family Advisors and the SH SCN Community of Practice helped to identify changes in the Alberta context and validate the strategies that focus on work that aligns with the platforms of:

- Aging Brain Care (ABC),
- Frailty, Resilience, Aging-well: Late Life Transitions Initiative (FRAILTI), and
- Anticipating an Aging Alberta (AAA).

Included in this document are a glossary of terms and a list of references to aid in understanding the SH SCN Transformational Road Map.

The SCN reviews the Transformational Roadmap to ensure that the strategies remain relevant. In addition, monitoring progress on SH SCN initiatives is critical to identify required changes in direction.

The Seniors Health Community now has almost 400 members and is growing.

About the Seniors Health Strategic Clinical Network

The Seniors Health Strategic Clinical Network is now one of 15 SCNs. Collectively the SCNs demonstrate significant, positive impacts on the health status of Albertans. Like each of the other SCNs, the SH SCN is comprised of a Core Committee with representation from a wide-range of clinical and non-clinical stakeholders from across the province with an interest in seniors' health; it is supported by a small leadership team. The SCN is developing two communities for engagement and collaboration; the first has a membership of almost 400 people who represent a wide variety of frontline clinicians from across the province. The second is a Research Network with approximately 100 members who are primarily Alberta researchers. Overall, the SH SCN includes physicians, a variety of clinicians, patient or family advisors, Alberta Health Services (AHS) leaders, Zone Operations, key stakeholder organizations, researchers (including two Patient Engagement and Community Researcher), and front line staff.

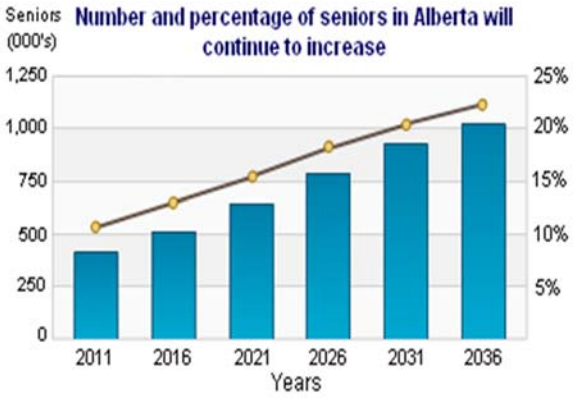
The role of the SH SCN is to promote and support healthy living and enable older Albertans to:

- Optimize their health, quality of life, resilience and independence as they age;
- Continue to contribute in their families and communities in ways that are meaningful to them;
- Have equitable access to quality services that prevent and/or treat remediable health issues;
- Receive quality care (and caring) for life limiting conditions and at end of life; and remain in their homes and communities as long as possible.

The focus of the SH SCN is on improving quality of care and quality of life based on evidence and best practices within Alberta and around the world. The SCN works collaboratively with Zone Operations and key stakeholders to improve health outcomes across the province.

Context

The proportion of Canadians age 65 and older will almost double in the next 25 years; from 14 per cent in 2011 to 25 per cent in 2036 (Canadian Institute for Health Information (CIHI), 2011). Older Albertans are one of the fastest growing populations in the province. In approximately 20 years, one in five Albertans will be 65 years of age or older (Statistics Canada, 2012). It is predicted that as early as 2015, seniors (those age 65 and older) will outnumber youth (those age 14 and younger) (CIHI, 2011).



Source: Statistics Canada population projections for Canada, Provinces and Territories 2009-2036 (medium projection)

There is significant diversity within the senior population. Seniors have varying skills, interests, abilities, levels of education, living arrangements, health status, and personal wealth. There is also a wide age range within the senior population, from 65 -105+ years. The values and needs of the "young old" and the "oldest-old" differ and must be considered in the planning and delivery of services.

Seniors have varying health needs from seniors being robust and independent, to those who are medically complex and frail. As health needs increase, so does dependence on the healthcare system and caregivers. Estimates of approximately 1/3 of deaths that general practitioners report annually are related to frailty or dementia (National Health Service, 2006). Over 75 per cent of Canadian seniors live with multiple chronic conditions including dementia for many years. Most of these seniors continue to live in community settings supported by primary care. This complexity adds to the challenge of developing seniors health strategies for the future (CIHI, 2011).

Seniors require access to a wide range of support systems, care options and living arrangements. In addition to healthcare services, many of the challenges associated with meeting the needs of an aging population are related to informal care, personal supports, housing, income and transportation. The population needs, service mix and human resources available across Alberta vary; resulting in both health and social disparities and service inequities in some areas.

Alberta's aging population, and in particular the increasing number and proportion of seniors over 85 years of age, will have a significant impact on Alberta's health and social systems. The SCN has an opportunity to provide guidance in managing the associated increase in healthcare utilization, costs and burden on informal care givers while improving the quality of care. This can be achieved by supporting the resilience and independence of seniors and through the development of new service delivery models.

Platforms

The Seniors Health Strategic Clinical Network has identified three platforms that represent key strategy areas. Outlined below is a description of each platform, including key planning assumptions, work of the SCN, anticipated outcomes and research and innovation initiatives for:

1. **Aging Brain Care,**
2. **Frailty, Resiliency, Aging-well: Late-life Transitions Initiative, and**
3. **Anticipating an Aging Alberta.**

Platform 1: Aging Brain Care

Aging Brain Care (ABC) incorporates strategies on preventing, anticipating, and living with cognitive changes that compromise the ability of older persons to maintain independent living. It includes engaging with Albertans, care providers and their communities to provide information on healthy brain aging and promoting timely intervention when cognition or function is compromised. The SCN will work collaboratively with Alberta Health, Seniors Health Provincial Program, zone operations, Primary Care Networks, other SCNs and key stakeholders to implement the Alberta Dementia Strategy and Action Plan; which addresses improved recognition, diagnosis and management of cognitive impairment, dementia and delirium across the community and care settings.

Key Assumptions

The key assumptions driving the work of the SH SCN on Aging Brain Care are:

1. While incidence of cognitive impairment and dementia rises with age, it should not be considered part of normal aging.
2. Marked increase in the prevalence of dementia is occurring as a result of population aging.
3. Cognitive disorders are not well understood and social stigma and social isolation often results.
4. Cognitive disorders often accompany multiple co-morbid conditions, thereby increasing complexity and risk.
5. Effective prevention and management of co-morbid conditions can improve function, optimize utilization of resources and improve the quality of life for older persons and their caregivers.
6. Cognitive disorders impact health, independence and quality of life and often require family and other caregivers to compensate for reduced or lost abilities and/or decision making capacity.
7. Assessment and management of cognitive disorders requires a multidisciplinary, person-centred care plan that incorporates supports for the person and their caregivers and that anticipates future care needs.
8. Family and other community caregivers provide the most care for persons living with dementia. Hospitalization and facility care often result when caregiver capacity is compromised.
9. Dementia predisposes individuals to delirium and functional decline which often occurs during an acute illness. Effective approaches that prevent, recognize, and manage delirium and functional decline improve patient experiences, outcomes and utilization of resources.
10. There are many existing evidence-based leading practices that can inform the direction of the SH SCN Aging Brain Care Platform.

Work of the SCN

As we age, our ability to learn and remember can decrease. In the next several years, the healthcare system will see older adults with memory and cognitive problems. Some questions that the SH SCN examines are: How can we best provide care to people with dementia? What supports can be offered to the families and caregivers of those with dementia? What technologies may be helpful to support self-management and caregiver support?

The SH SCN has worked closely with Alberta Health and other stakeholders to outline a preferred future on how Alberta will support people living with dementia and their caregivers.

Work in Progress

Appropriate Prescribing for Seniors in Alberta:

- *Appropriate use of Anti-psychotics in Long Term Care – sustainability,*
- *Appropriate use of Anti-psychotics in Supportive Living,*
- *Provincial Polypharmacy Strategy for Seniors.*

Over the next three years the SH SCN will continue to take an active role in leading and/or supporting new actions related to improving dementia care in Alberta. A signature project, Appropriate Use of Anti-psychotics in Long Term Care (AUA) has resulted in a significant reduction in the use of antipsychotics in Alberta's 170 long term care sites over the last three years. As a result, Alberta is recognized as a national leader in this work. That work is now expanding to include Alberta's 150 supportive living sites. The SH SCN is also implementing a pilot project to enhance "Dementia/Elder-Friendly Care in Acute Care Sites (rural)"; and it is working to fund "Community Innovations to Enhance Person-Centred Dementia Care in the Community". The SH SCN anticipates pursuing additional initiatives to enhance the lives of people living with dementia.

Families Appreciate Fewer Non-essential Medicines

Medications can cause agitation, sedation and responsive behaviors. Families notice the difference when care teams reduce pill burden.

> *"The last couple of times we met with the care team the doctor said 'our goal is to take your mom off all non-essential drugs.' Gradually they got her off of everything and we could see… she was a lot more alert, more willing to interact with the rest of us. She still has Alzheimer's, I don't think she really knows who we are, but the thing is she knows that it's a familiar face that's coming to visit her all the time. She gets a big smile on her face when she sees us, so you know for us we could see a difference and it was for the better."*

Expected Outcomes

The expected outcomes resulting from the work in Aging Brain Care are:

- Strategies on preventing, anticipating and living with cognitive conditions common in later life are available to seniors, care providers and communities.
- A user-friendly electronic care pathway is available to seniors, families and care providers.
- The time between development of symptoms and diagnosis of dementia is reduced.

Research and Innovation

Research and innovation initiatives are integrated with the work in Aging Brain Care to generate, synthesize and translate knowledge. Work in this area includes:

- Identifying practice gaps by supporting the conduct of targeted knowledge syntheses, including, but not limited to, reviews of dementia clinical practice guidelines, depression screening in those with dementia, and lifestyle interventions targeted at preventing cognitive decline.

- Collaborating with researchers in Alberta, Canada, and internationally, who are focusing their efforts in the area of cognition, dementia and delirium, for example, the SCN will develop working relationships with researchers and the Alberta based universities where most of the researchers reside. This will include participation in and support of grant applications, research projects and publications/presentations.

- Focusing on improving the quality of care, translation of knowledge, and adding value for money in the area of dementia care through partnership funding opportunities such as the Partnership for Research and Innovation in the Health System (PRIHS) competitions.

- Increasing research capacity and provision of highly qualified personnel in the field of aging and geriatrics through training and mentorship of graduate students, postgraduate students and healthcare providers.

- Supporting the creation of new knowledge and trainee capacity building through undergraduate summer studentship opportunities.

What is Dementia?

Dementia is a syndrome – usually of a chronic or progressive nature – in which there is deterioration in cognitive function (i.e. the ability to process thought) beyond what might be expected from normal aging. It affects memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement. Consciousness is not affected. The impairment in cognitive function is commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behaviour, or motivation.

World Health Organization

Platform 2: Frailty, Resilience, Aging-well: Late Life Transitions Initiative

The Frailty, Resilience, Aging well: Late Life Transitions Initiative (FRAILTI) platform incorporates strategies on preventing, anticipating, optimizing and living with conditions that compromise health and functional abilities in later life.

The work within this platform includes engaging and collaborating with seniors, their families and caregivers, the community at large, clinicians and researchers to support Albertans to age well, minimize the impacts of frailty, illness and disability, and enhance resilience - thereby maintaining and enhancing quality of life. A vital component of this platform is to support implementation and evaluation of evidence-informed leading practices in elder care across care settings in Alberta.

Key Assumptions

The key assumptions and rationale driving the work of the SH SCN for Frailty, Resilience, Aging-well; Late-Life-Transitions Initiative are:

1. Adoption of healthy living strategies undertaken at any stage of life can prevent, lessen, or delay illness, frailty and disability in later life.
2. Primary healthcare services are foundational in promoting healthy living, preventing or delaying illness, frailty and disability in advance health care planning.
3. Common co-morbid physical and mental health conditions affect an individual's resilience and increase their vulnerability to health crises.
4. Evidence informed interventions can improve health and health related quality of life, including end of life care.
5. Frailty in old age, often unrecognized and undocumented, is a major determinant of adverse health outcomes. It's recognition and management along with co-morbid conditions is essential.
6. Transitions between care and living environments increase the risk of adverse health outcomes and planning. Transitions to and from acute care can be particularly problematic.
7. Treatments generalized to frail elders may not be effective and result in harm or wasted healthcare resources. Improving health and supportive care for frail elders will benefit those who are frail, their caregivers, our healthcare system, Canadian society, and the economy.
8. Many seniors prefer to receive support services so that they can remain in the community and in their homes, even if at greater risk. With appropriate and timely supports, some risks can be mitigated.

Work of the SCN

The current SCN journey although framed in three year increments, is work that will take ten to fifteen years to complete.

Work in the area of Frailty, Resilience, Aging-well: Late-life Transitions Initiatives includes the Dementia/Elder Friendly Care– Acute Care (medical inpatient, surgical inpatient, emergency department) (D/EFC) pilot. Elder Friendly Care is the development and implementation of strategies to support healthy aging practices including falls prevention, delirium prevention and management, assessment and treatment of co-morbid depression and end of life care. Promoting elder friendly care within and across all service settings, the goal is to help prevent admissions to hospital, reduce lengths of hospital stay and decrease the number of people requiring more care at discharge.

Work in Progress

Elder Friendly Care in Acute Care in Alberta Health Services:

- *Acute Care – Rural (pilot)*
- *Acute Care – Provincial*
- *Provincial Strategy*
- *Delirium Toolkit*

In partnership with the Critical Care SCN the SH SCN will build a Critical Care Toolkit for delirium identification, diagnosis and care. As well, the SH SCN will develop a Provincial Delirium Toolkit and coordinate the overall development of the D/EFC with key partners including Covenant Health and CoAct.

Expected Outcomes

The expected outcomes resulting from the work in Frailty, Resilience, Aging-well: Late-life Transitions Initiative, are:

- Seniors are engaged with strategies that minimize the impacts of frailty, illness and disability on independence and their quality of life.
- Families, caregivers and care providers are supported to minimize the impacts of frailty, illness and disability on independence and quality of life of seniors.
- A standardized care pathway provides support for clinicians to provide evidence-informed care.
- Unintended adverse consequences of care and services are minimized.

Research and Innovation

Research and innovation generates, synthesizes and translates knowledge related to the Frailty, Resilience, Aging well: Late Life Transitions Initiative (FRAILTI) platform. Work in this area includes:

- Identifying practice gaps in healthy aging and frailty and promoting the conduct of research to address these gaps.
- Focusing on improving the quality of care, translation of knowledge, and adding value for money through targeted funding opportunities such as Partnership for Research and Innovation in Health System (PRIHS) competitions. The first three cohorts of the PRIHS grant competition have awarded funds to projects sponsored by the SH SCN.
- Collaborating with provincial, national, and international researchers focusing on healthy aging and frailty across the care continuum, including, for example, Translating Research in Elder Care (TREC) and Project SMART (Sensory Motor Adaptive Rehabilitation Technology) research groups, and the Canadian Frailty Network. This includes participation in grant applications, research projects and publications/presentations.
- With funds from a Calgary Zone Medical Affairs Quality Improvement grant, supporting the implementation and evaluation of the Elderly Friendly Initiative in the four Calgary acute care sites, paving the way for provincial Elder-Friendly Care work.
- With funding from a CIHR Knowledge to Action Grant, supporting the MOVE AB (Mobilization of Vulnerable Elders) program which was rolled out to a number of communities across Alberta (Lethbridge; Medicine Hat; Olds; Sturgeon) and the four acute care hospitals in Calgary.
- The EASE (Elder Friendly Approaches to the Surgical Environment) PRIHS Study has implemented the intervention and is completing data collection and analyses of the outcomes achieved.
- Through funds provided by Alberta Innovates, research is underway to investigate three secondary fracture prevention initiatives as part of the STOP Fractures PRIHS Study.
- In collaboration with a group of National researchers funded by the Canadian Frailty Network, we provided input into an environmental scan of care for frail seniors in Canada.

What is Frailty?

Frailty is a patient health state associated with getting older; involving multiple serious health issues that increase an individual's vulnerability for extended acute care or end-of-life care.

Frailty can occur as the result of a range of diseases and medical conditions – even fairly minor health events can trigger major changes in a person's health status. We usually associate frailty with noticeable losses in a person's physical, mental or social functioning, such as: walking speed, weight and muscle loss, fatigue, grip strength, level of physical activity and memory loss.

Recognizing frailty is a key to improving patient care and making patients and their families feel better about the care their loved ones receive.

Canadian Health Network, website February 2017

Platform 3: Anticipating an Aging Alberta

The SH SCN will proactively address the opportunities and challenges posed by Alberta's demographic change through collaboration, consultation and engagement with Albertans, clinicians, researchers, educators, and other key stakeholders. The SH SCN's role in anticipating the impact of an aging Alberta will involve influencing and informing health and social policy related to seniors health and well-being. The SH SCN will also influence issues related to future care-giving and workforce needs, community living, housing, driving motor vehicles and meeting transportation needs.

Key Assumptions

The key assumptions driving the work of the SH SCN for Anticipating an Aging Alberta are:

1. Anticipation and preparation for the impact of an aging population will benefit all Albertans.
2. An aging Alberta will result in greater opportunities for seniors to continue to contribute as citizens.
3. A proactive approach is the preferred strategy to address challenges, healthcare needs and late life care issues of older Albertans.
4. The SH SCN, its members and partners, are a valuable source of information and expertise that are willing to consult and collaborate on initiatives, related to seniors health and social needs.
5. The needs of diverse population groups must be addressed, including indigenous, immigrant, refugee and cultural groups, residents of rural developmental and other handicaps, and chronic disease.
6. Albertans and their families have a primary role in maintaining and managing their own health and must be engaged as partners in creating healthy communities. Proactive support for caregivers and organizations and community groups that support caregivers is required.
7. The rapid growth of knowledge and technology will create opportunities for enhanced communication, education, community based care and evidence informed practices.
8. Elder friendly communities will have a significant role in supporting an aging population and in helping to shift attitudes towards aging.
9. Health promotion to minimize the impacts of smoking, drugs and alcohol and maximizing safety for young athletes to minimize head injuries will have a positive impact on the health of Albertans.

Work of the SCN

An aging population is having a significant impact on Alberta, including its health system. It is important for health system leaders to recognize and include the impacts of an aging population in all of our work, through the full spectrum of services from population and public health, to community based primary healthcare, to acute care, to long term care and supportive living through to end of life care.

The SH SCN will continue to work in collaboration with other groups addressing senior's issues by promoting effective linkages between provider groups within the healthcare and social supports systems to maintain the health and independence of seniors. This includes collaboration with other SCNs and stakeholder groups that are focused on improving the health of older Albertans, including those focused on heart and stroke, mental health, and bone and joint health.

Work in Progress

Anticipating an Aging Alberta

- *Integrated Community Geriatric Service Development Initiative*
- *Alberta Dementia Research Strategy*
- *Dementia resources for primary healthcare providers and the public*
- *Community Grants to Support Innovation in Dementia Care*

Building on existing policy initiatives developed by the Governments of Alberta and Canada, the SH SCN will provide input on policy development and health and social service planning at the request of strategic and operational departments and organizations.

The SCN will continue to provide advice and develop recommendations on proposed clinical practices and strategy that are based on available evidence and that reflect best known practices.

Building and maintaining a workforce that is knowledgeable and has the skills to provide care to seniors, the SCN will partner with educational institutions to ensure the educational requirements for healthcare providers are relevant to the care of seniors. As well, the SCN will inform workforce planning models, delivery strategies and system incentives.

Expected Outcomes

The expected outcomes resulting from the work in Anticipating an Aging Alberta are:

- Increased understanding of aging by the public and major institutions.
- Positive influence on key policy and strategy decisions that impact the lives of seniors.
- Stronger collaboration amongst care providers.

Research and Innovation

Research and innovation initiatives will be integrated with the work in the Anticipating an Aging Alberta platform to generate, synthesize and translate knowledge. Work in this area includes:

- Collaborating with Alberta Health, Alberta Health Services, its partners, and municipalities to monitor demographic changes and plan health services and care delivery models that are evidence-based and reduce inappropriate practice variation and system waste.
- Workforce planning, utilization, and care delivery models based on available evidence will be considered.
- Collaborating with researchers in the fields of health promotion and injury prevention to facilitate positive health behaviors favoring health in older adulthood.
- Encouraging the development of research that considers and includes the older adult population.
- Collaborating with the research communities of the other SCNs to improve the health outcomes and quality of life for the aging Alberta population.

Foundational Enablers

Ensuring the success of the SCN strategies and actions includes a foundation that is built on:

- **Research and Innovation**;
- **Engagement** with our patients, families, communities, clinicians and partners;
- **Communication** of the stories of the SCN, the patients and the healthcare community; and
- **Quality Improvement and Measurement** that will help us identify progress and success.

The Seniors Health Research Network has over 100 members from universities and organizations across the province.

These separate, yet overlapping activities support the SCN in achieving its strategic work.

It is an honour and a pleasure to serve on the SH SCN.

Since retiring from many years of teaching, at colleges and universities, I am pleased to be working on several projects through the SCN.

All the projects are interesting and stretch the mind. I hope I am contributing to the future of the health system in Alberta.

Yvette Swendson,
Patient and Community Engagement

Research and Innovation

The Scientific Office sponsors and promotes high impact research and capacity-building opportunities that align with the SCN's platform areas. It conducts and disseminates research to address the healthcare and health service need of Alberta's older adults and their caregivers with attention to health system sustainability. The office provides the research leadership necessary for furthering these objectives, while offering guidance and support to other activities and projects undertaken by the SH SCN.

The focus is on improving the quality of care, translation of knowledge and adding value for money in the area of seniors' health and healthcare through partnership funding opportunities such as the Partnership for Research and Innovation in the Health System (PRIHS) competitions. PRIHS competitions advocate for the incorporation of patient-reported outcome measures and patient and family voices in research and evaluation to better understand the changing needs of Alberta's aging population.

Objectives of the Scientific Office include:

- Advancing knowledge, by supporting, enabling, sponsoring and conducting research that advances knowledge relevant to the three platform areas.
- Engaging and building partnerships for research and innovation –by building partnerships with researchers and interested institutes and organizations to engage in, promote and advance the use of knowledge to improve care and health outcomes for older adults.
- Research prioritization by encouraging the development of research and researchers that consider and include the older adult population.
- Research capacity building and training, by facilitating the development of graduate students and junior researchers to encourage active participation in research in the area of seniors' health.
- Research facilitation, by providing research expertise to proposals in development and offering guidance on navigating AHS research policies and processes.
- Knowledge translation - by incorporating best-evidence into health system decision-making and clinical care that improves health outcomes.

Research and Innovation is a foundational pillar necessary for the success of the SH SCN. The Scientific Office plays a crucial role in achieving the objectives that have been outlined. Through the endeavor of Research and Innovation, the Scientific Office will position the SH SCN as a key contributor to health and aging research and the translation of best-evidence into practice throughout the province.

Engagement

The SH SCN demonstrates the value of engagement by collaborating with seniors and their families, health-care providers, research and education institutions, government and the community in a meaningful way to enable input into the work of the SCN.

Patient and Family Engagement

Engagement of patients (including patients, residents and clients) and families is essential to achieving the aims of the SH SCN. The following principles will be applied:

- Diverse perspectives should be purposefully sought including those of people from a wide range of cultures and vulnerable populations and/or who live in urban/rural/remote locations.
- Albertans will be directly involved in developing strategies and plans that impact them across the continuum of care.
- Patient engagement research will be integrated into key initiatives

A range of different approaches are required to hear the voices and experiences of pre-seniors, seniors, family members, friends and other individuals who support them.

"As a member of the SH SCN Core Committee, I am able to put forward a patient voice which has evolved from Patient and Community Engagement Research and from my own experiences. I am able to keep up with the evolving healthcare system and to be exposed to current issues and research. I can participate in working groups that focus on improvements in healthcare for seniors."

Sylvia Teare, Patient Advisor, PaCER

Community Engagement

Engagement with, and learning from the general public and community groups across Alberta is essential to the success of SH SCN initiatives. The following principles will be applied:

- Communities include the geographic places where people live, non-profit and for-profit organizations and programs that impact the health and well-being of seniors (including continuing care partners), local or national policy bodies, advocacy groups and government.
- Community engagement should recognize cultural, geographic and economic diversity.
- Community engagement activities will include sharing information, seeking input and providing feedback on an ongoing basis.

Clinician Engagement

Front- line care providers, zone leaders, researchers and clinicians from non-AHS partners are helping the SH SCN achieve the vision of clinician led improvement. These activities include priority setting, identifying, implementing, and spreading evidence to practice. The following principles will be applied:

- Clinicians are represented from across the continuum of care.
- Engagement with care providers and managers from each of Alberta Health Services' five zones is essential to ensure alignment and successful implementation of programs and projects. This includes care providers and managers that work in urban, rural, and remote locations.
- Care providers from a broad range of disciplines/roles are included in the work of the SH SCN.

Engagement Activities

The following are examples of engagement activities the SH SCN has lead or participated in to inform the work of the SCN.

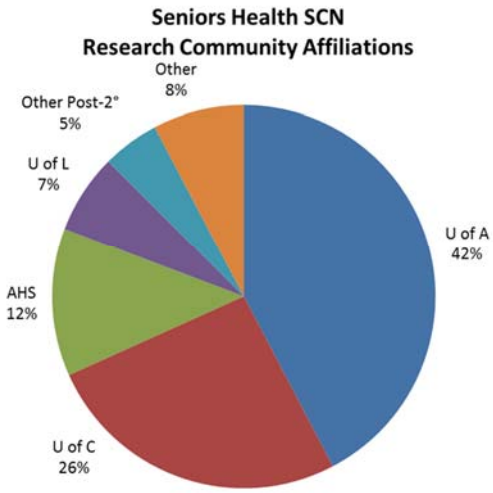
- Caregiver and care provider participation in focus groups and interviews
- SH SCN Community of Practice participation on working groups
- Public forums
- Updates of practice guidelines
- Researchers inform the development of the Dementia Research Strategy

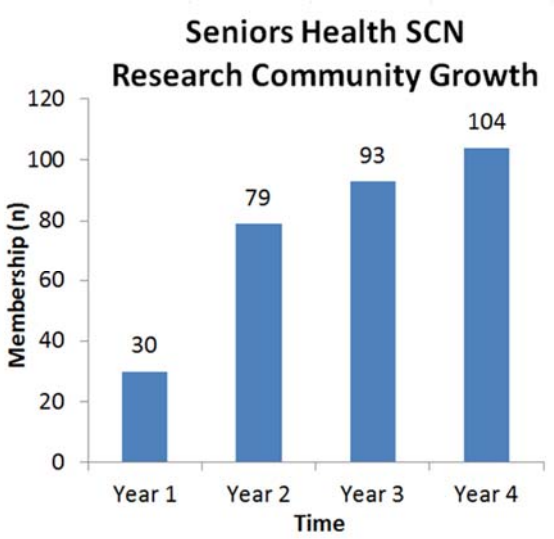
Research Engagement

SCNs have a mandate to develop a provincial research program in collaboration with Alberta's research community. They will draw on the outcomes of current studies or new research.

The Scientific Office works to build partnerships with researchers and interested institutes and organizations to engage in, promote and advance and advance the use of knowledge to improve care and health outcomes for older adults. The office brings together research community members for networking and idea exchange events, fostering collaboration among community members and identifying and encouraging collaborative opportunities to address multi – disciplinary approaches to improving seniors care in Alberta.

As a tool for communication and community engagement the Scientific Office has developed and continues to expand a searchable database of research community members conducting health and aging research aligned with SCN interests. This database is used for distribution of information to this community, that is selective, timely and of relevance to members. As well, the Scientific Office is able to connect researchers and practitioners in similar areas, identify researchers with interests complementary to collaborative opportunities, and identify those with expertise to inform SCN and AHS decision-making.





Communication

Strategic communication is vital to the success of the SH SCN. The Alberta Health Services' values of compassion, accountability, respect, excellence, and safety can be demonstrated through effective internal and external communications. To address communication gaps the SH SCN is committed to:

- Two way and timely communications between the SCN and its internal and external stakeholders and organizations.
- Listening to the stories of people, caregivers and staff and integrating them into our work, as this will add great value.
- Recognition of the diversity of across the province by using a wide range of communication methods to reach Albertans, including digital stories.
- Development of a written communications strategy.

Quality Improvement and Measurement:

Quality improvement and measurement `is a mandate of the Strategic Clinical Networks; to be successful the SH SCN will apply the following principles:

- Performance and reporting information is user friendly and widely available;
- Indicators and targets are aligned with AHS and AH performance plans;
- Expertise in data analysis and interpretation is available;
- Comparative information within and beyond Alberta is displayed;
- Evaluation is a key component of ongoing and future work;
- SCN strategies are measured and monitored to ensure the expected outcomes are being met; and
- The Health Quality Council of Alberta Quality Framework will inform this work.

Collaborative Work

Through collaboration, the SH SCN will continue working to meet the needs of older Albertans and their families. Collaborations with other SCNs, the Community, Seniors and Addiction and Mental Health Provincial Team, other Alberta Health Services programs and Alberta Health, include:

CoACT – a project that is committed to putting people first, enabling high performing teams, and using quality processes and measures to ensure collaborative care with a patient centered approach and smooth transitions between levels of care. The SH SCN has been working with CoACT to integrate elder friendly care in the care processes, in particular the 'comfort rounds' aspect of CoACT.

Palliative and End of Life Care Strategy – the development of a province-wide Palliative and End of Life Care Strategy was developed under the leadership of the Seniors Health Provincial Team and included participation by most of the SCNs. The framework and strategy provides Albertans across the province with quality care options for palliative and end of life care through: improved integration, coordination, and a focus on interdisciplinary care across the healthcare continuum.

Innovation Collaborative - is a knowledge to action approach developed as a pan-SCN approach that supports the implementation of best practices in clinical services across the care continuum and across the province of Alberta. Together the SCN family continues to improve on the methodology of Innovation Collaboratives (ICs) as a structure and process for engaging local teams in making changes designed to enhance systems of care using evidence and measurement. This approach provides SCNs a structure to introduce new practices across the province that is respectful of individual site characteristics, and leads to sustainable change that is owned by the frontline staff and site. Improvements can be linked to the use of both the collaborative methods and the application of a performance measurement tool, known as a balanced scorecard.

SCN Sustainability Framework – SCNs lead clinical initiatives across the province. As these initiatives come to an end of the ***implementation*** phase and move into the ***sustain*** phase, the intent is to successfully transition responsibility for each initiative to an operational stream, such as, zone operations. The framework was developed by the SCNs and outlines various strategies and approaches that can be used to support long-term sustainable results for the projects and initiatives each SCN is pursuing.

Appropriate Use of Antipsychotics – Canadian Connections (AUA – CC) - is an informal pan-Canadian group that shares information of benefit to provincial and national groups striving to improve appropriate prescribing in long term care, in particular the appropriate use of antipsychotics. Ensuring minimal and appropriate use of antipsychotics in LTC is an area that many jurisdictions have prioritized as needing improvement. Members learn from each other about how various jurisdictions and groups are tackling this issue. It is anticipated the interests of the group will expand to include other classes of medications where research and other

evidence has identified potential harm for older adults. The group is co-lead by Alberta Health Services (SH SCN™), the Canadian Foundation for Healthcare Improvement and the Canadian Institute of Health Information.

Looking Forward and Next Steps

Great strides have been made, but there is a lot more work ahead. The SH SCN is committed to working with its partners to develop and implement strategies that address the healthcare needs of Alberta's aging population.

The strategies identified in the Seniors Health Transformational Roadmap chart the course for the next three years to make improvements to healthcare services enabling Alberta's seniors to optimize their health, well-being and independence. In collaboration with key stakeholders, the work of the SH SCN will be prioritized in a systematic manner to ensure the greatest benefit is provided to Alberta's aging population and that the work is aligned with operational and strategic priorities. Some of the work outlined above has begun and will continue to develop in the years to come; other strategies to move this work forward will be reviewed and phase-in to ensure the SH SCN continues to support Alberta Health Services to provide a patient focused, quality health system that is accessible and sustainable for all Albertans.

Glossary

Term	Definition
Caregiver	A family member, neighbor, or friend who provides care for someone living with challenges due to disability, illness, or age
Care Provider	Includes professional providers of medical, dental, nursing and allied healthcare services as well as support service providers
Clinical Pathway (Pathway)	A Clinical Pathway is a description of evidence informed, clinician recommended interdisciplinary care to help a patient with a specific health condition or concern move progressively toward optimal health outcomes. Source: AHS Clinical Pathways Working Group, October 2013
Clinical Practice Guidelines	A systematically developed body of statements that are based on the most current and best available evidence to assist clinician and patient decision-making within specific practices of care. Implementation of clinical practice guidelines are thought to result in improved patient outcomes though the delivery of effective and appropriate healthcare. Reference: University of Calgary Institute for Public Health
Clinician	A physician or other healthcare provider who is involved in the treatment and observation of patients, as distinguished from one engaged in research
Continuing Care	Continuing care is an integrated range of services supporting the health and wellbeing of individuals living in their own home or in a supportive living or long-term care setting. Continuing care clients are not defined by age, diagnosis or the length of time they may require service, but by their need for care. Source: Coordinated Access to Publicly Funded Continuing Care Services: Directional and Operational Policy 2010
Dementia	A chronic progressive neurological disease that affects memory, orientation, comprehension, calculation, learning capacity, language, judgment and executive function. There are a variety of diseases grouped within dementia such as Alzheimer disease, vascular dementia, dementia with Lewy bodies and fronto-temporal dementia. Reference: University of Calgary Institute of Public Health
Frail/Frailty	A state of increased vulnerability to stressors due to impairments in multiple, inter-related systems that lead to decline in homeostatic reserve and resiliency. Source: Journal of Gerontology A Biological Sciences and Medical Sciences 2007 Jul;62(7):731-7
Healthy Brain Aging	Refers to maintaining optimum cognitive function in the domains of attention, perception, language, thinking, memory, executive function, praxis, judgment and our ability to live a purposeful life as we age
Knowledge translation	Knowledge translation is defined by the Canadian Institutes of Health Research as a dynamic and iterative process that includes the synthesis, dissemination, exchange and ethically sound application of knowledge to improve health, provide more effective health services and products, and strengthen the healthcare system
Long term Care Facility	Long-term Care Facility – A purpose-built congregate care option for individuals with complex, unpredictable medical needs who require 24 hour on-site Registered Nurse assessment and/or treatment. In addition, professional services may be provided by Licensed Practical Nurses and 24 hour on-site unscheduled and scheduled personal care and support are provided by Healthcare Aides. Case management, Registered Nursing, Rehabilitation Therapy and other consultative services are provided on-site. Long-term care facilities include “nursing homes”

Term	Definition
	under the Nursing Homes Act and “auxiliary hospitals” under the Hospitals Act. Source: Adapted from Alberta Health Services (AHS) Admission Guidelines for Publicly Funded Continuing Care Living Options, 2010
Palliative and End of Life Care	Palliative and End of Life Care is both a philosophy and an approach to care that enables all individuals with life-limiting illness to receive integrated and coordinated care across the continuum. This care incorporates patient and family values, preferences, and goals of care, and spans the disease process from early diagnosis to end of life including bereavement. Reference: AHS Palliative and End of Life Care Provincial Framework 2013
Patient	Includes: patients – typically someone receiving care in hospital ; client – someone receiving a support service; resident – someone living in a care facility; and older adults who have care needs
Patient and Community Engagement Researcher	Patient and Community Engagement Researchers (PaCERs) are people with various health conditions, trained to design and conduct health research, using specific adapted methods of qualitative inquiry. Source: PowerPoint Presentation to SH SCN Core Committee
Person-Centered Care / Patient-Centered Care	An approach that is centered on viewing a patient first as a person, instead of a collection of symptoms. Persons with a specific condition must be regarded individually with their own specific qualities and when providing person-centered care, their unique responses to a given condition or treatment must be taken into consideration. Reference: University of Calgary Institute for Public Health
Platforms	Represent key strategy areas that the SH SCN will be focusing on
Enablers	These are key enablers that support the SCN in achieving its strategic work
Primary Healthcare	Medical care by a physician, or other health-care professional, who is the patient's first contact with the health-care system and who may recommend a specialist if necessary
Senior	An older person; normally refers to older people that are 65 years of age or older
Supportive Living	A home-like setting where people can maintain control over their lives while also receiving the support they need. The buildings are specifically designed with common areas and features to allow individuals to “age in place.” Building features include private space and a safe, secure and barrier-free environment. Supportive living promotes residents’ independence and aging in place through the provision of services such as 24-hour monitoring, emergency response, security, meals, house-keeping and life-enrichment activities. Publicly-funded personal care and health services are provided to supportive living residents based on assessed unmet needs. Source: ASCS Supportive Living Framework, 2007

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