NOVA SCOTIA HEALTH AUTHORITY
(CENTRAL ZONE)

FRAILTY STRATEGY

Optimizing experiences in frailty

Prepared by: Frailty Strategy Project Coordination Working Group
Nova Scotia Health Authority- Central Zone
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INTRODUCTION

The term “frailty” refers to the overall vulnerability that results from the accumulation of health and social issues that occur over the life course. Frailty manifests as declining function, impaired mobility, cognitive impairments and unmanageable or burdensome symptoms. Although frailty is more prevalent with advancing age, it can be thought of as a life stage that is the result of optimal medical care. Frailty is a robust predictor of poor health outcomes that matter to patients and health care systems alike including:
- increased risk of adverse effects from medical and surgical procedures
- prolonged hospital length of stay
- high risk of institutionalization
- expected functional and cognitive decline
- reduced life expectancy
- death

Application of population-based statistics suggests that of the 400,000 people living in NSHA – Central Zone (Halifax, Eastern Shore, West Hants (HESWH)), 60,000 people are seniors. Of those 60,000 seniors at least 32% are currently frail. Local data regarding healthcare utilization support this estimate. For example, from April 1, 2014 to March 31, 2015 visits to NSHA – Central Zone’s– Emergency Departments by people aged 65 years of age and over totaled 37,703 (19,807 unique patients); compared to 30,002 visits in 2010/11 (Oct–September). Of the 19,807 patients seen, 33 % were between the ages 65-70, 38% were between 71-80 years of age and 29% were over 80. While a large proportion of these patients (59%) had only one visit to the ED, a sizeable number (35%) had two to four visits and some (6%) visited the ED 5 or more times within this time frame. Many of the total number of ED visits (75%) resulted in patients returning to the community.

We are also seeing longer lengths of stay for inpatients for medical reasons that do not necessarily warrant a stay of this duration. Provincial data obtained from the Canadian Institute for Health Information (CIHI) is depicted below in Table 1.

Table 1.0 Average Lengths of Stay per Case Mix Group and Age

<table>
<thead>
<tr>
<th>Case Mix Group</th>
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<tr>
<td>Dehydration</td>
<td>60+</td>
<td>5 days</td>
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<tr>
<td>Lower urinary tract infection</td>
<td>60-79</td>
<td>6.1</td>
</tr>
<tr>
<td></td>
<td>80+</td>
<td>7.3</td>
</tr>
<tr>
<td>Dementia</td>
<td>60-79</td>
<td>13.3</td>
</tr>
<tr>
<td></td>
<td>80+</td>
<td>15.5</td>
</tr>
<tr>
<td>Heart failure without cath</td>
<td>60+</td>
<td>8.5</td>
</tr>
<tr>
<td>CABG (without MI/shock)</td>
<td>60-79</td>
<td>17.2</td>
</tr>
<tr>
<td></td>
<td>80+</td>
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As we currently do not routinely screen for frailty we cannot definitively say that this condition was the contributing factor to extended lengths of stay. However, the reasons identified for admission in the table above are more than likely the symptoms resulting from living with being frail.

The impact of frailty is demonstrated through health economic data. One half of the annual health care budget is dedicated to the Nova Scotia senior population, with the highest proportion of spending occurring in the last 6 months of life. With an estimated 55,000 frail seniors in Nova Scotia currently, providing appropriate and ‘rational’ care has become a necessity. The economic impact of frailty extends beyond seniors to those who are of younger age and frail and to family and friend caregivers. Our health care system was not designed for frailty, but we now find ourselves feeling the effects of our own successes in medical and surgical care advances developed to support and extend life.

While the single system disease model works well for those who are not frail, it falls increasingly short for those who are, and at a great expense.
Once frail, a person is more vulnerable and at risk for adverse outcomes including falls, disability, institutionalization and death. It is possible to mitigate the impact of frailty by augmenting strategies to bolster physical and social reserve including initiatives aimed at prevention and social supports\(^7\). The Frailty Strategy (FS) acknowledges the important role for preventative and rehabilitative therapies and also that success in these areas will result in an increased prevalence of frailty over the longer term. We therefore need approaches to care and supports that are designed to flex and travel with persons experiencing frailty as they transition through the stages of frailty. Mitigating impact is also a focus of other provincial strategies focused on

disease and disability associated with frailty, such as the Dementia Strategy for Nova Scotia \(^8\) and the Nova Scotia Continuing Care Strategy \(^9\).

Prior to 2014, there was no formal integration of frailty focused projects and initiatives from within the NSHA Central Zone organization. Addressing frailty had been, and continues to be, identified as a strategic priority for several departments within NSHA-Central Zone (HESWH) including the Department of Medicine, Primary Health Care (PHC) and the Department of Family Practice (DFP). Many stakeholder groups were focusing on their own initiatives within their context while possibly being unaware of the duplication of focus. A variety of frailty definitions and tools for screening and assessment exist resulting in inconsistency in how frailty is understood, how care is delivered and how outcomes are measured. This overlap and duplication of effort among departments have implications for efficacy and continuity of care of persons experiencing frailty.

The variation of frailty focused projects and initiatives, coupled with the NSHA Central Zone (HESWH) (formerly Capital Health) leadership’s awareness of the increasing prevalence of frailty putting pressures on sustainability within the health system resulted in the identification of the need to implement a structure around the work and initiatives focused on frailty. Having a strategy focused on frailty moving forward would ensure that a shared understanding and measurement of frailty is achieved and an approach to provide responsive and appropriate frailty care results. An additional intention is to ensure alignment all frailty focused initiatives across all sectors within the NSHA – Central Zone (HESWH).

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A Frailty Strategy Committee (FSC) was established in 2014 and remains active. The FSC includes NSHA-Central Zone staff representing departments/divisions including primary health care, continuing care, general medicine, geriatrics, emergency medicine and two members of the public. Associated working groups (4 in total) (see Appendix A), focused on primary health care, emergency medicine, inpatient acute care and the community, were established and tasked with identifying opportunities to synergize frailty focused initiatives. Reporting to the FSC occurred on a quarterly basis. The FSC provided advice on and approval of working group activity.

The coordination and planning of activity associated with Strategy development is co-led by two physicians (one a geriatrician and the other a family practitioner) with project management support from PHC, a part time evaluation coordinator (Department of Medicine), departmental and division directors and oversight from the Frailty Strategy Committee. Initial work focused on having the associated working groups initiate plans to implement or improve frailty focused activity within their respective contexts (for progress report see Appendix B). This work, in turn, would inform the focus and activity of the Frailty Strategy which has been under development since April 2014. While this structure was useful in moving specific aspects of care forward in specific settings, an identified limitation of this approach was inconsistency in the level and scope of focus between settings and across sectors. Consistency and alignment of initiatives across the care continuum and all sectors (organizational, community and public) will be a key outcome of the FS and will contribute to its success.

The FSC therefore elected to move forward by adopting some of the concepts integral to the collective impact approach (See Appendix C); an approach required for large scale social change. Five conditions for successful collective impact endeavors include: Common agenda, mutually reinforcing activities, shared measurement, continuous communication and a backbone organization. Application of these principles to the FS work underscores the importance of:

- Implementation of common, frailty focused initiatives across care settings/sectors
- Strategy activities mutually reinforce or support one another
- A common/shared way to measure outcomes and success across sectors
Continuous communication to ensure strong partnerships are built, that everyone is on the ‘same page’ and create motivation to mobilize the work required

- A strong leadership group that provides the supporting infrastructure to mobilize activity, resources and champions

Achieving these aspects will require system change, coordination and connection between sectors but will ensure efforts are synchronized, that we are working towards common goals and that the care experience for persons experiencing frailty is as optimal as possible.

CONSULTATION - GETTING IT RIGHT

On November 25, 2015, seventy (70) stakeholders working within various NSHA – Central Zone departments and divisions and individuals from the community and community organizations attended the NSHA – Central Zone - Frailty Strategy- Engagement Session. Participants included representatives from NSHA – Central Zone areas of Medicine, Geriatrics, Primary Health Care, Family Practice, Emergency, and from the community including long term care, Continuing Care, Caregivers Nova Scotia, and first voice caregiver representation. Stakeholders were consulted with to:

- Gather input on the areas of focus, initiatives and intended outcomes of the FS,
- Confirm that the FS vision and areas of focus were in alignment with stakeholder needs,
- Understand what is needed to mobilize the FS work.

A draft logic model (Appendix D) was presented which, has been a tool used to guide the development of strategy documents and subsequent initiatives, and outline strategy directions, activities and expected results. Session participants were asked to provide content validity for each of the strategic directions and logic model components. Insightful and valuable feedback was used to inform and influence the voice and content of a final version of the Frailty Strategy logic model. Additional actions and deliverables, revised scope (who will be impacted) and outcomes have been added. Although not included directly in the logic model, stakeholder feedback was also provided regarding more detail for targeted deliverables within the strategy. This feedback will be used to inform the FS deliverables going forward.
OUR FOCUS - WHAT WE NEED TO DO

The vision for the FS is “optimizing experiences in frailty”. We recognize that frailty touches a broad range of people - pre-frail/frail persons, family and friend caregivers, family members, providers (Physicians, NPs, pharmacists, allied health care professionals, paramedics), the NSHA-Central Zone health care system, the community sector (private facilities, services and businesses, housing authorities, legal community, community groups and organizations, church communities, Government, faith communities, academic institutions/programs, and the NSHA-Central Zone population. We want to meet those experiencing frailty where they are at in their journey in a way that both boldly embraces the difficult realities of frailty and empowers all people experiencing frailty to have their needs met, and support each other along the way.

The FS outlines six focus areas: Understanding, Engagement, Care Experience, Evaluation, Research and Knowledge Implementation, Information Technology and Management and Governance. These focus areas have been established to provide a guide to a different future for frailty through the alignment of and collective effort to move forward new and existing frailty-focused initiatives across all organizational, community and societal sectors. Each area has an outcome we intend to achieve. Ongoing or new initiatives being developed will be targeted around these focus areas that will provide direction to our work to ensure we achieve our vision.
THE FRAILTY STRATEGY WILL...

▶ Understanding
Build a culture where frailty is recognized, understood and acknowledged as a key determinant of health

▶ Engagement
Involve stakeholders* in ongoing dialogue about their experiences with frailty to strengthen partnerships and ensure a collective effort in supporting persons experiencing frailty**

▶ Care
Ensure optimal care planning and delivery for all persons experiencing frailty

▶ Evaluation, Research and Knowledge Implementation
Seek and use leading practices, evidence and experiential learning to respond and adapt to emerging information and ensure knowledge is implemented into frailty care practices

▶ Information Management and Technology
Use information technology (IT) and management (IM) structures to identify, assess, plan care and support persons experiencing frailty and inform the health care system of the contributors to frailty, its impact and outcomes of care

▶ Governance
Establish a leadership structure to guide the FS, ensure initiatives are aligned, establish shared measurement structures, build momentum, advance care practices, advocate for policy, mobilize resources and ensure sustainability of frailty initiatives across sectors

* Stakeholders include persons living with frailty, families, family and friend caregivers, providers, community organizations, businesses, government and academic institutions

* * Persons experiencing frailty includes patients, clients, family and friend caregivers.
The NSHA strategic plan will guide us along the way. In turn, it is our intention to ensure that this strategy helps the NSHA achieve their vision and mission and is in support of their strategic directions that include:

- person-centered, high-quality, safe and sustainable health and wellness for Nova Scotians
- a healthy, high-performing workforce
- engagement with Nova Scotians to create a healthier future together

We too want to ensure sustainable care for the frail population. We want to ensure persons experiencing frailty have as optimal as possible of an experience throughout their journey. This will be in part due to the availability of highly skilled professionals in this area that will support these individuals in their journey. Imperative to our success will be in how we engage all stakeholders affected by frailty to ensure we get it right.

**OUR PLAN - HOW WE WILL GET THERE**

There is much work to be done. Work has begun and continues in some areas (see Appendix B). Success will be measured by our capacity for bold innovation, our appetite for effective collaboration, and the cultivation of new partnerships. While the plan will need to adapt to the changing needs of persons experiencing frailty, we need a place to begin. The following plan outlines the reason for the call to action, the recommended actions needed to reach our vision, and what we will strive to achieve.

**UNDERSTANDING**

The word “frailty” exists in the public domain. An effective and consistent approach to frailty requires that we share a common understanding of the term and hone its connotations. We want to ensure that when frailty is spoken of that we achieve a common and accessible understanding of its meaning, contributing factors, outcomes and impact—and that understanding becomes empowerment. Advancing the current culture to one where frailty is recognized and
understood as a key determinant of health and how frailty impacts the trajectory of a person’s health care status and care path is essential. The building blocks for this begins with building a common awareness and language related to frailty as a life stage to help reduce the negative connotations associated with the term. Ultimately knowledge is power: we need to deliver knowledge about frailty to empower persons experiencing frailty and build capacity among providers and other stakeholders to provide supportive care that is responsive to changing needs. We have been working to implement a standardized, validated and feasible methodology for front-line health care workers to identify and measure frailty according to the Clinical Frailty Scale (CFS)\(^9\). The CFS will assist with building the foundation of the common vocabulary and shared understanding of frailty among all stakeholders.

▶ **BUILD** an awareness and understanding of frailty across sectors (organization, community, society) to advance a supportive culture for persons experiencing frailty

▶ **DEVELOP** and **FACILITATE** opportunities (content, materials and platforms) for provider and public education regarding frailty and leading frailty care practices

▶ Persons experiencing frailty will have a better understanding of frailty and its impact

▶ Stigma associated with frailty will be reduced through tailored messaging on optimal and effective approaches to support and empower persons experiencing frailty.

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**ENGAGEMENT**

Building on the expertise, knowledge and lived experiences of those confronting frailty is required at every step of Strategy implementation to ensure we are on the right track. Broad engagement will be needed with stakeholders within the care continuum and community and from business, academic, spiritual sectors, as well as nongovernment and not for profit organizations. The Frailty Strategy will also ensure there is ongoing communication with stakeholders about plans, initiatives, intentions and roles.

**ACTIONS**

▶ **ENGAGE** with frail persons, families, caregivers, providers on an ongoing basis to understand experiences and challenges with confronting frailty to inform frailty strategy initiatives

▶ **INVOLVE** stakeholders (persons living with frailty, families, caregivers, providers, community organizations, businesses, government, academic institutions) on an ongoing basis in frailty strategy activity development/implementation/improvements initiatives

**RESULTS**

▶ Ongoing dialogue about issues/concerns is sought so stakeholders have an increased sense of involvement in ensuring FS initiatives meet their needs.

▶ Persons experiencing frailty see their stories reflected in the system’s readiness to respond to these individuals’ experiences

▶ Partnerships among stakeholders enable a shared and efficient effort in implementing frailty initiatives

▶ Collective stakeholder understanding of the purpose and intended outcomes of FS initiatives. Collectively, everyone “owns” the work.
At a systems level, frailty is seldom discussed without “appropriateness”. While definitions of appropriateness vary by application, when we speak of appropriate care, we are speaking of care that is matched to a person’s frailty level and goals; care that is dynamic and streamlined; care that de-medicalizes the experience of death and dying. Routine identification and assessment of frailty using a shared language and tool offers opportunities for care plans that reflect leading care practices, coordinated supports and services that can be measured against the outcome of a meaningful care experience. Importantly, the care experience extends to empowering persons experiencing frailty with access to the skills and knowledge required to navigate expectations, decision making and changing health.

**SCREEN, ASSESS and MONITOR** frailty within all clinical/community/care settings
**PROVIDE** adaptable and appropriate frailty care planning based on level of frailty (inclusive of persons experiencing frailty in care decisions and plans)
**ASSESS and ADAPT** home/service/ care settings to meet the needs of persons experiencing frailty
**ENSURE** providers have access to frailty information and expertise and are equipped with the skills required to provide optimal frailty care
**ENSURE** persons experiencing frailty are provided with consistent and appropriate support via information/ knowledge/ services and are equipped with the skills required to manage care

**RESULTS**

- Persons experiencing frailty perceive their care experiences to be informed, effective and supportive as health issues emerge and frailty progresses.
The health system responds by providing leading practices in frailty care to persons experiencing frailty.

Providers have the knowledge, attitude, and skills to provide consistent assessment, care planning, care coordination, and risk mitigation.

Consistent and comprehensive and efficient care models support patients when they are most vulnerable (e.g. transitions of care, acute health crisis, very severe frailty).

Persons experiencing frailty have the right information to support their decisions.

Cost-effective and sustainable care that is in line with patient/client circumstances, trajectory and anticipated outcomes.

**INFORMATION TECHNOLOGY AND MANAGEMENT**

Use information technology (IT) and management (IM) structures to adequately identify, assess, plan care and support persons experiencing frailty and inform the health care system of the contributors to frailty, its impact and outcomes of care.

Fulfillment of the deliverables encompassed by this strategy focus will require harnessing the functionality of existing technology platforms to improve linkages and access to clinically meaningful information. Access to timely, essential, consistent and accurate information to improve care coordination, transitions and communication via a reliable and system wide accessible platform is needed.

Collecting key information on frail persons at various points of care will advance an understanding of who is frail, what is driving their frailty and how these drivers impact outcomes. Consistent data management processes and structures across all sectors will ensure consistency and efficiency of information on frail persons and its associated factors as they interact with various care providers allowing for improved continuity of care.

Using technology to deliver information on frailty and relevant resources as well as education and training materials/modules is an effective way to reach information seekers.
across stakeholder groups and will be considered as the predominant tool for education and training delivery.

**ACTION**

▶ **DETERMINE** the feasibility of collecting and entering frailty levels and associated factors within existing IT structures
▶ **ESTABLISH** a technology platform for the identification, assessment and care planning for the frail population that is accessible, shared, and integrated with existing IT structures that support/inform frailty care within and across health care settings
▶ **PROMOTE** the use of IT to deliver information, resources, education and training on frailty
▶ **IMPLEMENT** information management practices to ensure consistency in data collection, proper storage and data utility

**RESULTS**

▶ Alignment and integration of existing IT platforms and processes will result in a ‘one-stop’ access to frailty data and information.
▶ Reduced redundancy in the information collected to inform frailty status and care planning.
▶ Improved access to pertinent and ‘real time’ information required to provide care and support
▶ An informed population that has access to current, consistent frailty focused information and resources
Standardization of routine data collection is needed that will result in a clear understanding of who the frail population is, what has contributed to the existence of frailty and what is needed to improve care thereby leading to better outcomes. Ongoing feedback, monitoring and evaluation of initiatives are essential and must be inter-woven with all implementation plans.

Research underway within NSHA-Central Zone is already recognized as “world leading” in the area of frailty. While not the primary goal, successful implementation of the strategy will continue to add to this growing body of knowledge and illustrate further leading practice in frailty care. Knowledge implementation methodologies will be integral in transforming knowledge learned into practice.

**EVALUATION, RESEARCH AND KNOWLEDGE IMPLEMENTATION**

Seek and use leading practices, evidence and experiential learning to respond and adapt to emerging information and ensure knowledge is implemented into frailty care practices

**ACTIONS**

- **APPRaise/USE/RESPOND** to leading practices/evidence/experiential learning to inform FS activities
- **MONITOR** and **EVALUATE** FS activity to ensure effectiveness and understand impact
- **SEEK** and **ENGAGE** in research opportunities
- **DEVELOP** mechanisms to disseminate evaluation/research projects and findings/knowledge re: frailty
- **ENSURE** evaluation/research findings/knowledge are implemented into clinical practice

**RESULTS**

- Ongoing evaluation of frailty strategy activity
- Emerging information will be used to respond and adapt FS initiatives and planning.
Increased opportunity for research involvement, contribution and coordination
Enhanced capacity for ensuring leading and optimal practices is implemented and in place to support persons experiencing frailty

GOVERNANCE

The work encompassed by the FS includes many moving parts. Establishing a structure for oversight and coordination and alignment of all FS initiatives is needed to ensure success. Accountability to stakeholders needs to be transparent with ongoing communication being essential. Addressing the needs of persons experiencing frailty extends beyond support received at the level of each individual—collective advocacy for policy change is key. A driven, effective and action oriented leadership structure is essential to move the work forward and support the changes that are needed to be successful. Leveraging existing leadership structures and champions is essential with new leaders, advocators and champions anticipated to emerge as we move forward.

DEVELOP an evidence-based Frailty Strategy
DEVELOP structures/processes to guide and manage/coordinate FS initiatives and related work
IDENTIFY and RESOLVE resource issues
SEEK opportunities to maximize existing resources
REPORT on FS activities
PROVIDE oversight/feedback on integration and progress of FS activities
CREATE buy in for a common agenda and shared vision
EXPLORE funding opportunities to support implementation of strategy initiatives

DEVELOP structures/processes to learn, respond and adapt to emerging issues

- Improved capacity for informing the health care system of how to best support the needs of persons experiencing frailty
- New and strengthened partnerships as demonstrated through a collective approach and effort to mobilize initiatives to support and enable persons who are experiencing frailty.
- Synergy of frailty focused activities, invested partners and alignment of resources across sectors will result so as to reach the common vision.
- Accountability to stakeholders will be improved through clear and ongoing communication, transparency and action.

IMPLEMENTATION AND ENABLERS- MOVING FORWARD

The Strategy is intended to provide the building blocks to a well informed and established entity that exists to push the agenda forward to ensure effective, adaptable and sustainable care and support for those experiencing frailty. It’s a tall order that will require the involvement and collaboration of a broad range of stakeholders at various points in time. We anticipate a five year timeframe to begin or fully implement the proposed deliverables.

We will engage our stakeholders by participation in specific working groups using clear guiding principles, proven frameworks and clearly outlined deliverables and timelines. The working group activities will be overseen by the FSC that will continue to provide advice and approvals. An additional group, that includes a subset of the larger FSC, has been established to coordinate
strategy initiatives and activity and ensure they are in line with the Strategy’s vision and focus (see Appendix E).

We have an ‘organizational type’ structure to assist with mobilizing the FS work. Enabling the work to move forward will result from our success in ensuring the following conditions are achieved:

**ENABLER: NSHA – CENTRAL ZONE LEADERSHIP SPONSORSHIP**

Success requires endorsement and sponsorship from senior leadership. FS development and project management to this point has relied upon a small FTE complement. Realization of the Strategy deliverables will require bold and passionate leadership, allocation of human resources, and up-front investment in the form of commitments for collaboration, financial resources, in-house supports from existing corporate services such as engagement, communication, decision support, IT, printing services and more.

We believe we have the skills and resources within NSHA - Central Zone to establish endorsement and accomplish the deliverables, but FS deliverables will need to be prioritized. Resources necessary to achieve deliverables will need to be deployed in novel and innovative ways. Senior leadership’s support is a pre-requisite for success and their support to integrating the FS deliverables into existing planning activities within the Zone (e.g. The Dementia Strategy, Planning for Clinical Services etc) is integral for meeting our vision.

**ENABLER: READINESS FOR CHANGE**

A readiness for change will be required, and where it cannot be found, an investment in change management must be made. This work will move us away from existing attitudes and practices about how we provide care. Conflicts of interest may emerge along the way. A culture shift is what we are talking about which involves reconstructing our existing perceptions and taking risks in how we support persons experiencing frailty.
ENABLER: EVIDENCE

We will need to be aware of the emerging evidence through evaluation and research activity and that meaningful information is used to support buy in and implementation of findings and mobilize resources across sectors. We will need to demonstrate cost effectiveness and the how the work enhances the value of health care dollars.

Evaluative activity will take place concurrently, as outlined in an evaluation framework. As FS initiatives are developed and implemented along the way we will want to ensure the intended directions and outcomes of the strategy are achieved. We will appraise, use and respond to what we learn from persons experiencing frailty, providers and communities to ensure actions are evidence informed, responsive to current and emerging needs along with transparency and accountability. Performance and outcome measurement via information management structures will be also be essential to quality improvement and for establishing excellence in frailty care.

ENABLER: PARTNERSHIPS AND ENGAGEMENT

Building relationships, engaging stakeholders, especially persons experiencing frailty, and establishing collaborative partnerships with internal and community organizations will be essential. Opportunities will be sought to combine competencies and assets. Breaking down the silos and opening up the borders even within our existing internal care continuum is key.

Some of our work is already underway with pilot projects being implemented and some small changes being made to practice. We are learning and adapting the processes and understanding more clearly the needed resources as we go. We know that we will need to the same with other initiatives as we move forward. We have already taken the most difficult step. We have identified frailty as an issue of central importance to the health of Nova Scotians and to the sustainability of the system to support persons experiencing frailty at various stages. We have begun and are ready to walk along side those experiencing frailty as their journey continues.
CONCLUDING COMMENTS

Our exploration of the phenomenon of frailty has unearthed some difficult truths. Frailty is the life stage that begins when the byproduct of optimal medical care creates multi-morbidity. It is inevitable and progressive. It matters to Nova Scotians. Its prognostic significance is more consistent and pervasive than the cancer stages. Despite these universal truths, the lived experience of frailty is as unique as the individual. Recognizing and staging frailty offers the opportunity to meet persons experiencing frailty where they are at to ensure an optimal experience despite the challenges and empower and enable them to meet their challenges in their best way possible.

The effort and work required to mobilize the development, planning and implementation of these initiatives is vast. Timelines expand across many years. A shift in the status quo approach to care at the level of the provider, the public, and the system, and the perspectives we currently hold will need to evolve.

Our vision is clear - Optimizing experiences with frailty. We will achieve success through a commitment and drive to understand frailty, engage those affected at every level, provide care tailored to needs, ensure continued growth of frailty-focused evaluation and research activity. Our focus and how we plan to achieve our vision is clear and specific. The time to start is now - Let’s get to work and move forward together in supporting persons experiencing frailty.

For questions or more information on the NSHA (Central Zone) Frailty Strategy contact frailtystrategy@nshealth.ca
NOVA SCOTIA HEALTH AUTHORITY (CENTRAL ZONE)  
FRAILTY STRATEGY COMMITTEE AND WORKING GROUP MEMBERS

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<td>Mike Thibodeau</td>
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<td>Paige Moorhouse</td>
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<td>Laurie Mallery</td>
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### COMMUNITY BASED SERVICES WORKING GROUP

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<thead>
<tr>
<th>Jill Robbins</th>
<th>Judah Goldstein</th>
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<tr>
<td>Christa Mueller</td>
<td>Lynn Edwards</td>
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<td>Robert Horton</td>
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<td>Rick Gibson</td>
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<td>Anne Marie Krueger-Naug</td>
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Some of the work has begun for the NSHA- Central Zone Frailty Strategy (FS) that has been happening concurrently with our exploration and development of the Strategy. This work has helped to shape the FS and gives us insight into the resources and requirements needed for success. Below is an outline of the work in progress to date.

### UNDERSTANDING

**ACTIONS**

**BUILD** an awareness and understanding of frailty across sectors (organization, community, society) to advance a supportive culture for persons experiencing frailty

**DEVELOP** and **FACILITATE** opportunities for education re: frailty awareness and leading care practices

**WORK IN PROGRESS**

- Reviewing education materials available from other jurisdictions and processes/mechanisms for implementing education/training
- Determining existing NSHA- Central Zone education/training initiatives and exploring partnering with respective project leads
- Developing frailty training modules/materials in line with care contexts and learners’ needs (ex. Frailty Portal resources, MTU Frailty Scale; care planning guide)
- A draft awareness/communication plan has been developed with a review of resources needed to mobilize this plan

### ENGAGEMENT

**ACTIONS**

**ENGAGE** with frail persons, families, caregivers, providers on an ongoing basis to understand experiences and challenges with living/supporting frailty to inform frailty strategy initiatives

**INVOLVE** stakeholders (persons living with frailty, families, caregivers, providers, community organizations, businesses, government, academic institutions) on an ongoing basis in frailty strategy activity development/implementation/improvement initiatives

**WORK IN PROGRESS**

- Stakeholder Engagement session took place November 25, 2015. Feedback from this session was used and incorporated into the specific deliverables of the FS.
- Engagement of stakeholders remains ongoing with respective individuals/groups being consulted with as required
- Through the work of the research project titled *Implementing the ‘Frailty Portal’ in community Primary Care Practice: Evaluating feasibility, effects and expansion needs*, family members and persons living with frailty were recruited for feedback
## CARE

### ACTIONS

**ASSESS and ADAPT** home/service/care settings to meet the needs of persons experiencing frailty

**SCREEN, ASSESS** and **MONITOR** frailty within all clinical/community care settings

**PROVIDE** adaptable and appropriate frailty care planning based on level of frailty (inclusive of persons experiencing frailty in care decisions and plans)

**ENSURE** providers have access to frailty information and expertise and are equipped with the skills required to provide optimal frailty care

**ENSURE** persons experiencing frailty* are provided with consistent information/knowledge about frailty and are equipped with the skills required to manage care

### WORK IN PROGRESS

- Developing a standardized, validated and feasible methodology for front line workers to identify and measure frailty according to the Clinical Frailty Scale with pilot projects taking place in acute care and family practice settings
- The concept of a community based service focused on frailty for community dwelling frail persons unable to access primary care and/or frequent the ED/acute care is being explored

## INFORMATION TECHNOLOGY AND MANAGEMENT

### ACTIONS

**DETERMINE** the feasibility of collecting and entering frailty levels and associated factors within existing IT structures

**ESTABLISH** a technology platform for the identification, assessment and care planning for frail population and contributors that is accessible, shared and integrated with existing IT structures that inform/support frailty care within and across health care settings

**PROMOTE** the use of IT to deliver frailty information

**IMPLEMENT** information management practices to ensure consistency in data collection, proper storage and data utility

### WORK IN PROGRESS

- Collaboration with primary care to develop a Frailty Portal, a web-based application that allows clinicians to identify, stage, and respond to frailty in their patient population. The Portal includes tools and resources designed to empower clinicians and patients/caregivers to optimize decision making and care planning across the trajectory of frailty.
- Exploration of the use of the Portal to serve as a longitudinal registry of frail patients to assist clinicians during transitions of care, front line workers interested in educational resources, and planners and policy makers working at the system level to understand the current and projected needs of this population.
- Discussion with decision support is taking place to introduce frailty as a relevant data point for inclusion in the Discharge Abstract Database.
## EVALUATION, RESEARCH AND KNOWLEDGE IMPLEMENTATION

### ACTIONS

**APPRaised/USE/RESPOND** to leading practices/evidence/experiential learning to inform FS

**MONITOR** and **EVALUATE** FS activity to ensure effectiveness and understand impact

**SEEK** and **ENGAGE** in research opportunities

**DEVELOP** mechanisms to disseminate evaluation/research findings/knowledge re: frailty

**ENSURE** evaluation/research findings/knowledge are implemented into clinical practice

### WORK IN PROGRESS

- Ongoing evaluation activity and monitoring occurs with each new pilot project
- Evaluation coordinator is providing feedback, generating learning and reporting back to FS leadership to support strategic responses
- Research contributions are being made through the Frailty Portal work within Primary Care

### GOVERNANCE

The actions and deliverables for the Governance component of the Frailty Strategy are administrative in nature and will be developed, implemented and coordinated by a core group delegated to mobilize initiatives and resources, provide oversight and obtain advice and approval from the higher level Frailty Strategy Committee and NSHA Leadership

### WORK IN PROGRESS

- The Frailty Strategy Committee continues to meet on a biannual basis
- A project coordination group has been established to ensure alignment of FS initiatives and that efforts are coordinated
- Plans for establishing working group structures are underway and prioritization of work is being determined
- Bi-monthly project updates are circulated to some key stakeholders to ensure ongoing communication about FS activity and accountability
NSHA – CENTRAL ZONE FRAILTY STRATEGY

OPTIMIZING EXPERIENCES IN FRAILTY

UNDERSTANDING
Build a culture where frailty is recognized, understood and acknowledged as a key determinant of health

ENGAGEMENT
Involve stakeholders* in ongoing dialogue about their experiences with frailty to strengthen partnerships and ensure a collective effort in supporting persons experiencing frailty**

CARE
Ensure optimal care planning and delivery for all persons experiencing frailty

INFORMATION TECHNOLOGY/ MANAGEMENT
Use information technology (IT) and management (IM) structures to identify, assess, plan care and support persons experiencing frailty and inform the health care system of the contributors to frailty, its impact and outcomes of care

EVALUATION/ RESEARCH/ KNOWLEDGE IMPLEMENTATION
Seek and use leading practices, evidence and experiential learning to respond and adapt to emerging information and ensure knowledge is implemented into frailty care practices

GOVERNANCE
Establish a leadership structure to guide the F5, ensure initiatives are aligned, establish shared measurement structures, build momentum, advance care practices, advocate for policy, mobilize resources and ensure sustainability of frailty initiatives across sectors

Nova Scotia Health Authority - Central Zone Frailty Strategy Committee
(Primary Health Care/Department of Family Practice and Department of Medicine Citizens)
Project Coordination Working Group

*Persons living with frailty, families, family and friend caregivers, providers, community organizations, businesses, government, academic institutions
**Persons experiencing frailty encompasses patients, clients, families and family and friend caregivers