

## Overview

Many OHTs selected older adults with greater needs as one of their year 1 priority populations and have established working groups focused on ‘moving the needle’ on quadruple-aim metrics for this population. Central to such work is developing a population-health management plan, which includes four steps:

- 1) segmenting the priority population into groups with shared needs;
- 2) co-designing care pathways and in-reach and out-reach services for each group;
- 3) implementing pathways and services in a way that reaches and is appropriate to each group; and
- 4) monitoring implementation and evaluating impact.

To support this work, RISE has:

- 1) updated RISE brief 6 on population-health management;<sup>1</sup> and
- 2) developed a list of questions related to developing a population-health management plan (which is available as an appendix to RISE brief 6).

When undertaking population segmentation, OHTs will likely want to be sensitive to diversity in the population of older adults as well as to how ‘greater needs’ is defined. While many older adults report good health, some have multiple chronic conditions and intensive healthcare needs.<sup>1</sup> Older adults with complex care needs are those with multiple medical conditions, who are likely to experience unstable health status, functional limitation, and interactions with many service providers.<sup>2</sup> Older adults are described as ‘frail’ when they are more likely to experience substantial deterioration as a result of a minor illness.<sup>3</sup> Ten per cent of older Ontarians account for 60% of healthcare spending on this age group.<sup>2</sup>

When co-designing care pathways and in-reach and out-reach services, OHTs will likely want to consider the full continuum of care and how best to support more integrated and coordinated care across the continuum. Recent systematic reviews of the research literature suggest that integrated-care and coordinated-care interventions for older adults with complex needs or frailty may improve patient experiences, but do not appear to improve health outcomes or reduce costs.<sup>4,5</sup> However, additional studies have identified success factors<sup>6</sup> and promising practices<sup>7</sup> in integrated care for older adults with complex needs or frailty. Lastly, when implementing pathways and services,

### Box 1: Coverage of year 1 priority populations and OHT building blocks

This RISE brief addresses the third of four year 1 priority populations that were frequently selected by cohort 1 OHTs:

- 1) people with chronic conditions, which were sometimes more specifically defined by OHTs as including congestive heart failure, chronic obstructive pulmonary disease, dementia, diabetes, and those with complex-care needs
- 2) people with mental health and addictions issues
- 3) **older adults with greater needs, which was variably defined by OHTs as including ‘at risk,’ co-morbidities/chronic conditions, complexity, frailty, and high service users**
- 4) people at the end of life and/or needing palliative care.

This RISE brief primarily addresses **building block #4** and secondarily addresses **building blocks #3, #5 and #8**:

- 1) defined patient population
- 2) in-scope services
- 3) **patient partnership and community engagement**
- 4) **patient care and experience**
- 5) **digital health**
- 6) leadership, accountability and governance
- 7) funding and incentive structure
- 8) **performance measurement, quality improvement, and continuous learning**

OHTs will likely want to proactively identify older adults with greater needs and make careful and evidence-informed decisions to ensure that they are ‘moving the needle’ on quadruple-aim metrics for this population.

OHTs will ideally develop their population-health management plans in collaboration with:

- 1) other OHTs focused on the same year 1 priority population;
- 2) experts who are aware of the many resources available in Ontario to support their efforts; and
- 3) experts who have experience with one or more of the four steps in population-health management.

As part of the first of these three types of collaborations, OHTs may wish to discuss together:

- 1) whether to seek agreement about whether their scope includes older adults who are ‘at risk,’ living with co-morbidities, complexity or frailty, and/or are high service users; and
- 2) whether and how to differentiate their work from those focused on related year 1 priority populations, such as:
  - a. people with chronic conditions (including dementia), many of whom will be older adults with greater needs,
  - b. people with mental health and addictions issues, some of whom will be older adults with greater needs, and
  - c. people at the end of life and/or needing palliative care, again some of whom will be older adults with greater needs.

For all three of these types of collaborations, OHTs may benefit from a planned OHT Forum and the ‘learning and improvement’ collaboratives that are being considered for each year 1 priority population.

This RISE brief provides a first draft of a summary of the resources available to support the development of a population-health management plan for older adults with greater needs. Priority was given to those resources that are provincial in scope and free to access. Once proposed additions and corrections from the OHT Forum and participating experts has been acted on, an updated version will be made publicly available through the RISE website and newsletter.

We have organized these resources into five groups:

- 1) resources related to each of the four steps in population-health management;
- 2) resources related to each of the eight OHT building blocks;
- 3) provincial organizations;
- 4) government-supported initiatives; and
- 5) key legislation.

## Resources related to each of four steps in population-health management

While not always directly targeting or using language directly related to the four steps in population-health management (or the first four steps in a ‘rapid learning and improvement’ cycle to which they correspond), a number of resources can be drawn upon to inform these steps (Table 1).

**Table 1: Resources by step in population-health management**

Step	Resources
Segmenting the population into groups (or population segments) with shared needs [or more generally identifying a problem (or goal) through an internal and external review]	<ul style="list-style-type: none"> <li>• OHTs were each provided with a data package from the Ministry of Health that includes utilization and referral data on their attributed population, some of which may be relevant to understanding the needs of old adults, particularly those with greater needs</li> <li>• In 2011 ICES published a report called <a href="#">Health system use by frail Ontario seniors: An in-depth examination of four vulnerable cohorts</a>, which examines service use among specific complex older adult populations and it can be used to understand shared needs and barriers to accessing services</li> </ul>
Co-designing care pathways and in-reach and out-reach services appropriate to each group [or more generally designing a solution based on data and evidence generated locally and elsewhere]	<ul style="list-style-type: none"> <li>• Strategies and best practice guidelines can be used to inform the design of care pathways, including:               <ul style="list-style-type: none"> <li>○ <a href="#">Living longer, living well</a> (the ‘Sinha report’) was delivered to the government in 2013 to inform the development of a senior’s strategy</li> <li>○ <a href="#">Aging with confidence</a> is the most recent report on Ontario’s Action Plan for Seniors</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>○ Behavioural Supports Ontario's <a href="#">Provincial lived experience advisory network</a> includes people with dementia, neurological conditions, or mental health and/or addictions issues, and their caregivers</li> <li>○ The Registered Nurses Association of Ontario's best practice guidelines: <ul style="list-style-type: none"> <li>▪ <a href="#">Preventing falls and reducing injury from falls</a></li> <li>▪ <a href="#">Preventing and addressing abuse and neglect of older adults</a></li> <li>▪ <a href="#">Prevention of constipation in the older adult population</a></li> </ul> </li> </ul>
Implementing pathways and services in a way that reaches and is appropriate to each group [or more generally implementing the plan, possibly in pilot and control settings]	<ul style="list-style-type: none"> <li>● A number of Ontario Health's Quality Business Unit (formerly Health Quality Ontario) resources originally developed for Health Links may be relevant to OHTs' efforts to implement changed approaches to caring for older adults with greater needs, including: <ul style="list-style-type: none"> <li>○ Workbooks on organizational approaches to <a href="#">improving transitions in care</a>, <a href="#">supporting chronic disease self-management</a>, and <a href="#">facilitating aging at home</a></li> <li>○ A <a href="#">tool for adopting transitional-care practices</a></li> </ul> </li> <li>● Regional Geriatric Programs of Ontario offer <a href="#">a suite of tools for implementing senior-friendly care</a></li> </ul>
Monitoring implementation and evaluating impact [or more generally evaluating to identify what does and does not work]	<ul style="list-style-type: none"> <li>● Ontario Health's Quality Business Unit (formerly Health Quality Ontario) offers a number of <a href="#">condition-specific quality standards and indicators</a> and has published reports on its selection of indicators used in public reporting for <a href="#">home care</a> and <a href="#">long-term care</a></li> <li>● Relevant patient-reported outcome measures and person-centred evaluation tools that have been developed and piloted in Ontario, including: <ul style="list-style-type: none"> <li>○ <a href="#">Older adults experience survey</a>, which is designed for use in specialized geriatric services</li> <li>○ <a href="#">Behavioural Supports Ontario - Dementia observation system</a>, a person-centred assessment tool for designing and evaluating interventions for individuals with dementia and responsive behaviours</li> </ul> </li> </ul>

## Resources related to the OHT building blocks

A number of resources can also be drawn upon that relate to those OHT building blocks that are most connected to population-health management for older adults with greater needs (Table 2).

**Table 2: Resources by OHT building block**

Building block	Resources
<b>Building block #1: Defined patient population (who is covered, and what does 'covered' mean?):</b> Identified population and geography at maturity and target population for year 1. Process in place for building sustained care relationships with patients. High-volume service delivery target for year 1. <i>Year 1 expectations:</i> Patient access and service delivery target met. Number of patients with sustained care relationship reported. Plan in place for expanding target population. <i>At maturity:</i> Teams will be responsible for the health outcomes of the population within a geographic area that is defined based on local factors and how patients typically access care.	<ul style="list-style-type: none"> <li>● None identified</li> </ul>
<b>Building block #2: In-scope services (what is covered?):</b> Existing capacity to deliver coordinated services across at least three sectors of care (especially hospital, home care, community care, and primary care). Plan in place to phase in the full continuum of care and include or expand primary-care services. <i>Year 1 expectations:</i> Additional partners identified for inclusion. Plan in place for expanding range and volume of services provided. Primary-care coverage for a significant portion of the population. <i>At maturity:</i> Teams will provide a full and coordinated continuum of care for all but the most highly-specialized conditions to achieve better patient and population health outcomes.	<ul style="list-style-type: none"> <li>● Regional Geriatric Programs of Ontario issued <a href="#">recommendations for 'core minimum services'</a> for OHTs to support older adults</li> <li>● Regional Geriatric Programs of Ontario also completed an <a href="#">asset map of existing specialized geriatric services</a> across Ontario, as well as a <a href="#">report on the availability of geriatricians and geriatric psychiatrists</a></li> </ul>
<b>Building block #3: Patient partnership and community engagement (how are patients engaged?)</b> - Demonstrated history of meaningful patient, family and caregiver engagement, and support from First Nations communities where applicable. Plan in place to include patients, families and caregivers in governance structure(s) and put in place patient leadership. Commitment to develop an integrated patient-engagement framework and patient-relations process. Adherence to the <i>French Language Services Act</i> , as applicable.	<ul style="list-style-type: none"> <li>● Behavioural Supports Ontario's <a href="#">Provincial lived experience advisory network</a> includes people with dementia, neurological conditions, or mental health and/or addictions issues and their caregivers</li> <li>● Regional Geriatric Programs of Ontario conducted a series of focus groups to understand the <a href="#">education needs of informal caregivers</a> who support older adults living with frailty</li> <li>● An Ontario Health's Quality Business Unit (formerly Health Quality Ontario) report on <a href="#">caregiver distress</a> and an Ontario Caregiver Organization publication <a href="#">Spotlight on Ontario's caregivers</a> describe the</li> </ul>

<p><i>Year 1 expectations:</i> Patient declaration of values is in place. Patients, families and caregivers are included in governance structure(s) and patient leadership established. Patient-engagement framework, patient-relations process, and community-engagement plan are in place.</p> <p><i>At maturity:</i> Teams will uphold the principles of patient partnership, community engagement, and system co-design. They will meaningfully engage and partner with - and be driven by the needs of - patients, families, caregivers and the communities they service.</p>	<p>challenges faced by unpaid caregivers, including those caring for older adults with greater needs</p> <ul style="list-style-type: none"> <li>• <a href="#">Health TAPESTRY</a> supports trained volunteers to visit people where they live, learn about their health needs and goals, sends the information to their primary care-anchored health team to inform care planning, and often checks in again about progress</li> <li>• The <a href="#">Indigenous cognition and aging awareness research exchange</a> develops resources and tools relating to culturally safe dementia care for Indigenous people</li> <li>• Ontario Centres for Learning, Research and Innovation in Long-Term Care have resources for supporting diverse older adults in long-term care including <a href="#">LGBTQ+</a> and <a href="#">Francophone</a> older adults</li> <li>• A 2008 Ministry of Health and Long-Term Care toolkit document gives <a href="#">recommendations for culturally competent long-term care</a></li> </ul>
<p><b>Building block #4: Patient care and experience (how are patient experiences and outcomes measured and supported?):</b> Plans in place to improve access, transitions and coordination, key measures of integration, patient self-management and health literacy, and digital access to health information. Existing capacity to coordinate care. Commitment to measure and improve patient experience and to offer 24/7 coordination and navigation services and virtual care.</p> <p><i>Year 1 expectations:</i> Care has been redesigned. Access, transitions and coordination, and integration have improved. Zero cold handoffs. 24/7 coordination and navigation services, self-management plans, health literacy supports, and public information about the team's services are in place. Expanded virtual-care offerings and availability of digital access to health information.</p> <p><i>At maturity:</i> Teams will offer patients, families and caregivers the highest quality care and best experience possible. 24/7 coordination and system-navigation services will be available to patients who need them. Patients will be able to access care and their own health information when and where they need it, including digitally, and transitions will be seamless.</p>	<ul style="list-style-type: none"> <li>• The Ministry of Health and Long-Term Care's 2015 <a href="#">Assess and restore guidelines</a> are intended to help frail seniors maintain functional independence</li> <li>• A 2008 project funded by the Ministry of Health and Long-Term Care included a <a href="#">systematic review of frameworks of integrated care for older adults</a></li> <li>• Regional Geriatric Programs of Ontario offer <a href="#">a suite of tools for implementing senior-friendly care</a>, as well as tools relating to <a href="#">comprehensive geriatric assessment</a></li> <li>• A number of Ontario Health's Quality Business Unit (formerly Health Quality Ontario) resources originally developed for Health Links may be relevant to OHT's efforts to improve care for older adults with greater needs, including: <ul style="list-style-type: none"> <li>◦ Workbooks on organizational approaches to: <ul style="list-style-type: none"> <li>▪ <a href="#">Facilitating aging at home</a></li> <li>▪ <a href="#">Improving transitions in care</a></li> <li>▪ <a href="#">Supporting chronic disease self-management</a></li> </ul> </li> <li>◦ A <a href="#">tool for adopting transitional care practices</a></li> <li>◦ A summary of evidence-informed and promising practices in <a href="#">hospital-to-home transitions for people with complex health needs</a></li> <li>◦ A summary of <a href="#">innovative practices in coordinated care management for people with complex health needs</a></li> </ul> </li> <li>• Ontario Health's Quality Business Unit (formerly Health Quality Ontario) has a number of standards documents, including quality indicators, relating to care for older adults with complex needs: <ul style="list-style-type: none"> <li>◦ <a href="#">Behavioural symptoms of dementia</a></li> <li>◦ <a href="#">Chronic pain</a></li> <li>◦ <a href="#">Diabetes (type II)</a></li> <li>◦ <a href="#">Diabetic foot ulcers</a></li> <li>◦ <a href="#">Heart failure</a></li> <li>◦ <a href="#">Hip fracture</a></li> <li>◦ <a href="#">Major depression</a></li> <li>◦ <a href="#">Palliative care</a></li> <li>◦ <a href="#">Pressure injuries</a></li> <li>◦ <a href="#">Transitions between hospital and home</a></li> <li>◦ <a href="#">Venous leg ulcers</a></li> </ul> </li> <li>• The Centre for Effective Practice offers clinical tools outlining best practice in primary care for a number of conditions or medications relevant to older adults with greater needs: <ul style="list-style-type: none"> <li>◦ <a href="#">Adult depression</a> (with specific recommendations for older adults)</li> <li>◦ <a href="#">Alcohol use disorder</a> (with specific recommendations for older adults)</li> <li>◦ <a href="#">Antipsychotics and dementia</a></li> <li>◦ <a href="#">Benzodiazepine use in older adults</a></li> <li>◦ <a href="#">Chronic non-cancer pain</a></li> <li>◦ <a href="#">Falls prevention</a> (in long-term care)</li> <li>◦ <a href="#">Osteoarthritis</a></li> <li>◦ <a href="#">Proton pump inhibitor use in older adults</a></li> </ul> </li> <li>• Behavioural Supports Ontario offers documents capturing: <ul style="list-style-type: none"> <li>◦ <a href="#">Components of an approach for addressing complex care needs</a></li> <li>◦ <a href="#">Strategies for engaging primary-care providers in care for older adults with complex needs</a></li> <li>◦ <a href="#">Environmental scan of behavioural support transition units</a> including lessons learned and elements for success</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>• Behaviour Supports Ontario also coordinates the <a href="#">brainXchange Resource Centre</a>, which offers evidence summaries and resources on a number of age-related brain health concerns</li> <li>• McMaster Optimal Aging Portal provides citizen-targeted evidence-based blog posts, web resource ratings and evidence summaries on the health and social aspects of aging</li> </ul>
<p><b>Building block #5: Digital health (how are data and digital solutions harnessed?):</b> Demonstrated ability to digitally record and share information with one another and to adopt/provide digital options for decision support, operational insights, population health management, and tracking/reporting key indicators. Single point of contact for digital health activities. Digital health gaps identified and plans in place to address gaps and share information across partners.</p> <p><i>Year 1 expectations:</i> Harmonized information-management plan in place. Increased adoption of digital-health tools. Plans in place to streamline and integrate point-of-service systems and use data to support patient care and population-health management.</p> <p><i>At maturity:</i> Teams will use digital-health solutions to support effective healthcare delivery, ongoing quality and performance improvement, and better patient experience.</p>	<ul style="list-style-type: none"> <li>• The Ontario Telemedicine Network allows providers to <a href="#">consult with specialists</a> remotely or to <a href="#">refer patients for remote visits</a></li> <li>• The <a href="#">Ontario Geriatrics Learning Centre</a> offers online resources for providers seeking to build knowledge of caring for older adults</li> <li>• <a href="#">GeriMedRisk</a> is a remote consultation service for physicians, nurse practitioners, and pharmacists in Ontario to support optimal prescribing practices for older adults</li> <li>• Home Care Ontario published a position paper with <a href="#">recommendations for integrating technology into homecare</a></li> </ul>
<p><b>Building block #6: Leadership, accountability and governance (how are governance and delivery arrangements aligned, and how are providers engaged?):</b> Team members are identified and some can demonstrate history of working together to provide integrated care. Plan in place for physician and clinical engagement and inclusion in leadership and/or governance structure(s). Commitment to the Ontario Health Team vision and goals, developing a strategic plan for the team, reflecting a central brand, and where applicable, putting in place formal agreements between team members.</p> <p><i>Year 1 expectations:</i> Agreements with ministry and between team members (where applicable) in place. Existing accountabilities continue to be met. Strategic plan for the team and central brand in place. Physician and clinical-engagement plan implemented.</p> <p><i>At maturity:</i> Teams will determine their own governance structure(s). Each team will operate through a single clinical and fiscal accountability framework, which will include appropriate financial management and controls.</p>	<ul style="list-style-type: none"> <li>• None identified</li> </ul>
<p><b>Building block #7: Funding and incentive structure (how are financial arrangements aligned?):</b> Demonstrated track record of responsible financial management and understanding of population costs and cost drivers. Commitment to working towards integrated funding envelope, identifying a single fund holder, and reinvesting savings to improve patient care.</p> <p><i>Year 1 expectations:</i> Individual funding envelopes remain in place. Single fund holder identified. Improved understanding of cost data.</p> <p><i>At maturity:</i> Teams will be prospectively funded through an integrated funding envelope based on the care needs of their attributed patient populations.</p>	<ul style="list-style-type: none"> <li>• None identified</li> </ul>
<p><b>Building block #8: Performance measurement, quality improvement, and continuous learning (how is rapid learning and improvement supported?):</b> Demonstrated understanding of baseline performance on key integration measures and history of quality and performance improvement. Identified opportunities for reducing inappropriate variation and implementing clinical standards and best evidence. Commitment to collect data, pursue joint quality-improvement activities, engage in continuous learning, and champion integrated care.</p> <p><i>Year 1 expectations:</i> Integrated quality-improvement plan in place for the following fiscal year. Progress made to reduce variation and implement clinical standards and best evidence. Complete and accurate reporting on required indicators. Participation in central learning collaborative</p> <p><i>At maturity:</i> Teams will provide care according to the best available evidence and clinical standards, with an ongoing focus on quality improvement. A standard set of indicators aligned with the quadruple aim will measure performance and evaluate the extent to which Ontario Health Teams are providing integrated care, and performance will be reported.</p>	<ul style="list-style-type: none"> <li>• Ontario Health's Quality Business Unit (formerly Health Quality Ontario) has published reports on indicators used in public reporting about <a href="#">home care</a> and <a href="#">long-term care</a></li> <li>• Relevant patient-reported outcome measures and person-centred evaluation tools that have been developed and piloted in Ontario include: <ul style="list-style-type: none"> <li>○ The <a href="#">Older Adults Experience Survey</a>, which is designed for use in specialized geriatric services</li> <li>○ <a href="#">Behavioural Supports Ontario-Dementia Observation System</a>, a person-centred assessment tool for designing and evaluating interventions for individuals with dementia and responsive behaviours</li> </ul> </li> <li>• Behaviour Supports Ontario's <a href="#">Knowledge to practice resources</a> include a community of practice and planning worksheet that can support evidence-informed practice change</li> </ul>



## Provincial organizations

A number of provincial organizations support the development, implementation, delivery, and evaluation of best practices in the care of older adults with greater needs (Table 3). These organizations offer information, evidence and pre-packaged resources relevant to OHTs' efforts to improve outcomes for older adults with greater needs.

**Table 3: Organizations as resources**

Organizations	Descriptions
<a href="#">Behavioural Supports Ontario</a>	<ul style="list-style-type: none"> <li>Supports system coordination, integrated service delivery, and capacity building with respect to behavioural health needs of older adults with dementia, mental health and/or addictions issues, or neurological conditions, as well as offers centralized intake and care coordination for clients and specialized consultation and resources for organizations and providers</li> </ul>
<a href="#">Home Care Ontario</a>	<ul style="list-style-type: none"> <li>Represents home-care providers in Ontario and advocates for a strengthened home-care system</li> </ul>
<a href="#">Institute for Clinical Evaluative Sciences – Life Stage Research Program</a>	<ul style="list-style-type: none"> <li>Carries out population-based health research relating to health across the life span in Ontario, including the health of older adults, and develops provincial indicators for evaluation and system monitoring</li> </ul>
<a href="#">Ontario Caregiver Organization</a>	<ul style="list-style-type: none"> <li>Provides support and access to resources for informal caregivers, including caregivers of older adults</li> </ul>
<a href="#">Ontario Centres for Learning, Research, and Innovation in Long-Term Care</a>	<ul style="list-style-type: none"> <li>Develops, evaluates, and disseminates innovative approaches to long-term care and provides workforce education</li> </ul>
<a href="#">Ontario Health's Quality Business Unit (formerly Health Quality Ontario)</a>	<ul style="list-style-type: none"> <li>Monitors health-system performance, develops quality standards, and supports quality improvement</li> </ul>
<a href="#">Ontario Telemedicine Network</a>	<ul style="list-style-type: none"> <li>Supports virtual care and virtual communities of practice, evaluates virtual-care products</li> </ul>
<a href="#">Regional Geriatric Programs of Ontario</a>	<ul style="list-style-type: none"> <li>Disseminates and fosters best practices in geriatric services, develops models of care, and creates tools for monitoring and evaluation (and has created a <a href="#">document summarizing their resources for OHTs</a>, organized by building block)</li> </ul>

## Government-supported initiatives as resources

Many government-supported initiatives are underway that aim to increase access to, and quality of, care for older adults with greater needs (Table 4). OHTs can draw on these existing initiatives to complement and strengthen their services for this priority population.

**Table 4: Other initiatives as resources**

Initiative	Description
Health Links	<ul style="list-style-type: none"> <li>Coordinated care planning for patients who often see multiple healthcare providers, access a range of services, and may find it difficult to navigate the health system <ul style="list-style-type: none"> <li>Development of a patient-centred care plan based on the individual's needs and goals</li> <li>Coordination of the care plan across multiple health providers, services and sectors</li> </ul> </li> <li>Geographically based, inter-sectoral collaboration</li> <li>In full implementation in 82 networks of providers</li> </ul>
Ontario Drug Benefit program, Special Drugs Program, and Exceptional Access Program	<ul style="list-style-type: none"> <li>Ontario Drug Benefit (ODB) covers most of the cost of prescription drugs listed in the formulary for Ontarians over the age of 65 or in receipt of social assistance</li> <li>Special Drugs Program covers the full cost of a specific set of medications</li> <li>Exceptional Access Program may provide coverage for drugs not listed on the ODB formulary in exceptional circumstances</li> </ul>
Assistive Devices Program	<ul style="list-style-type: none"> <li>Provides coverage and grants for specific assistive devices, including home oxygen, to Ontarians with a physical disability of at least six months' duration</li> </ul>
Exercise and falls-prevention classes	<ul style="list-style-type: none"> <li>Free physiotherapist-led, community-based falls-prevention classes for older adults aged 65+ (can be accessed through self-referral via Seniors' INFOLine)</li> </ul>
Seniors' INFOLine	<ul style="list-style-type: none"> <li>Toll-free number offering multilingual information about local seniors' resources</li> </ul>

## Key legislation

While many pieces of legislation touch on the lives of older adults with greater needs, four pieces of legislation are particularly key to the development of population-health management plans. (Table 5). Additional information about relevant legislation can be found in chapter 2 of *Ontario's health system: Key insights for engaged citizens, professionals and policymakers*, which is [available for free online](#).

**Table 5: Key legislation**

Legislation	Description
<a href="#">Health Care Consent Act</a>	<ul style="list-style-type: none"> <li>• Sets out rules for obtaining informed consent and determining capacity to consent with respect to treatment decisions, admission to a care facility, and personal-assistance services</li> </ul>
<a href="#">Substitute Decisions Act</a>	<ul style="list-style-type: none"> <li>• Governs what happens when someone does not have the capacity to make certain decisions about their own property or personal care</li> </ul>
<a href="#">Long-Term Care Homes Act</a>	<ul style="list-style-type: none"> <li>• Includes regulatory requirements for long-term care homes, as well as mandatory reporting requirements for suspected abuse of long-term care home residents</li> </ul>

Additional tips about how to draw on evidence sources to improve patient care and experience can be found in [RISE brief 9 on evidence sources](#).

As noted in the introduction, an updated version of this RISE brief will be made publicly available through the RISE website and newsletter once proposed additions and corrections from the OHT Forum and participating experts have been acted on. If you would like to propose additions or corrections, please email your input to [rise@mcmaster.ca](mailto:rise@mcmaster.ca).

## References

- <sup>1</sup> Institute for Clinical Evaluative Sciences. Health system use by frail Ontarian seniors: An in-depth examination of four vulnerable cohorts. Toronto: Institute for Clinical Evaluative Sciences; 2011. <https://www.ices.on.ca/Publications/Atlases-and-Reports/2011/Health-System-Use> (accessed 10 February 2020)
- <sup>2</sup> Sinha SK. Living longer, living well: Report submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on recommendations to inform a seniors strategy for Ontario. Toronto: Queen's Printer for Ontario; 2013. [http://www.health.gov.on.ca/en/common/ministry/publications/reports/seniors\\_strategy/docs/seniors\\_strategy\\_report.pdf](http://www.health.gov.on.ca/en/common/ministry/publications/reports/seniors_strategy/docs/seniors_strategy_report.pdf) (accessed 10 February 2020)
- <sup>3</sup> Canadian Frailty Network. What is frailty? Kingston: Canadian Frailty Network; 2012-2022. <https://www.cfn-nce.ca/frailty-matters/what-is-frailty/> (accessed 10 February 2020)
- <sup>4</sup> Looman WM, Huijsman R, Fabbriotti IN. The (cost-)effectiveness of preventive, integrated care for community-dwelling frail older people: A systematic review. *Health & Social Care in the Community*. 2018; 27(1):1-30.
- <sup>5</sup> Hopman P, de Bruin SR, Forjaz MJ, Rodriguez-Blazquez C, Tonnara G, Lemmens LC, et al. Effectiveness of comprehensive care programs for patients with multiple chronic conditions or frailty: A systematic literature review. *Health Policy*. 2016; 120(7):818-32.
- <sup>6</sup> Kirst M, Im J, Burns T, Baker GR, Goldhar J, O'Campo P, et al. What works in implementation of integrated care programs for older adults with complex needs? A realist review. *International Journal of Quality Health Care*. 2017;29(5):612-624.
- <sup>7</sup> Hendry A, Vanhecke E, Carriazzo AM, López-Samaniego L, Espinosa JM, Sezgin D, et al. Integrated care models for managing and preventing frailty: A systematic review for the European Joint Action on Frailty Prevention (ADVANTAGE JA). *Translational Medicine UniSa*. 2019;19:5-10.

Waddell K, Lavis JN. RISE brief 17: Resources to support population-health management for older adults with greater needs. Hamilton, Canada: McMaster Health Forum; 2020.

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