

The need for an authentic focus on the goals and aspirations of older people living with frailty (or at risk of frailty) is especially important as health service providers work towards a new model of service delivery as part of an Ontario Health Team (OHT). Older adults living with frailty or at risk of frailty require a specialized, senior-friendly approach to care across the healthcare continuum in order to meet their unique needs. The Regional Geriatric Programs of Ontario are pleased to offer their support as a strategic partner in achieving this goal.

For OHTs planning to optimize the care of older adults living with or at risk of frailty, our evidence-based resources help meet the following requirements in the [OHT Full Application](#).

Section 2: About Your Team

- 2.1. Who are the members of your proposed OHT?
- 2.6. Who else will you collaborate with?
- 2.8. What services does your team intend to provide in Year 1?

OHTs will need to ensure that specialized geriatric services are available and that a core minimum of cross-sectoral services are provided. Specialized geriatric services are delivered across the continuum of care by interprofessional staff who are uniquely knowledgeable about providing care for older adults. The Regional Geriatric Programs of Ontario have developed standards for the delivery of specialized geriatric services, and other resources that can help inform the composition of your OHT team.

Planning Resources for Service Delivery

- [Guidelines for the required services for frail older adults for all OHTs](#)
- [A Competency Framework for Interprofessional Comprehensive Geriatric Assessment](#)
- [Asset mapping of specialized geriatric services in Ontario](#) which was recently completed by the Regional Geriatric Programs of Ontario on behalf of the Ministry of Health.

Section 3: How will you transform care?

- 3.1. What opportunities exist for your team to improve care for your population and health system performance in Year 1 and at maturity?

Quality Improvement Resources

- [The Senior Friendly Care \(sfCare\) Framework](#) serves as this blueprint by documenting the unique needs of older adults living with frailty and approaches to optimizing their care.
- [The sfCare Self Assessment Tool](#) provides an ideal way for health service providers to identify strengths and opportunities within each organization as a starting point for planning across their OHT to reduce variation and implement clinical standards and best evidence.
- [The sfCare Getting Started Toolkit](#) provides best evidence implementation resources including clinical standards.

Section 3: How will you transform care?

3.3. How do you propose to provide care coordination and system navigation services?

3.5. How will you support patients (and caregivers) to be active participants in managing their own health and health care?

OHTs will benefit from having an organizational focus on education for staff, older adults, and caregivers, in order to improve patient self management and/or health literacy.

Education and Patient Resources

- [The Senior Friendly 7 Toolkit](#) - includes self-management tools for older adults and their caregivers, and supports clinical best practices for healthcare providers across the sectors of care.
- [An Introduction to Senior Friendly Care – Top Tips For all Staff](#) - a five-minute video which highlights what senior friendly care is and why it's important, the needs of older adults, and ten things all staff can do to make a difference.
- [The SfCare Learning Series](#) - free education resources for Clinicians and Caregivers, with a learning series under development for PSWs (anticipated launch early 2020)
 - [sfCare Learning Series for Clinicians](#) - comprises introductory educational modules for clinicians, with supporting tools such as posters and handouts.
 - [sfCare Learning Series for Caregivers](#) - called "Caregiving Strategies", comprises a website, handbook and online course.
- [The RGP's of Ontario: Three Frequently Asked Questions on CGAs and SGS](#) - provides an overview of the evidence of effectiveness of Specialized Geriatric Services and Comprehensive Geriatric Assessment and their core components which include care coordination and system navigation.



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