Integrated Client Care for Frail Older Adults in the Community: Preliminary Report on a System-Wide Approach

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Abstract

The Toronto Central Community Care Access Centre is leading a collaborative local health integration network systemic change initiative to implement and evaluate a practical model of integrated care for older adults with complex needs. The approach is embedded in the community where older adults and their families live and is designed to first and foremost improve the quality of care while ultimately bending the cost curve. The model is leveraging and aligning existing system resources by bringing together sectors from across the health system to create ways of working that build capacity in the system to be more responsive to this population. Outcomes to date will be discussed and next steps described. The secondary goal was to understand the key elements of this integration that can be scaled locally and across the province.

Older adults with complex care needs are often admitted to emergency departments, hospitals or long-term care (LTC) homes because their needs cannot, at least temporarily, be met in their home environments (Government of Ontario 2012). While more appropriate resources may be present, they may be fragmented and lacking coordination. The result consumes scarce healthcare resources while placing a significant burden on this vulnerable population. Change is needed across the healthcare system to ensure enhanced client and caregiver experience and outcomes, with a sustainable value for the system.

Research has consistently shown that a small number of clients with complex chronic conditions account for a disproportionate percentage of healthcare costs and that those with multiple chronic conditions can cost up to seven times more than those with only one chronic condition (Kaiser Permanente 2007). More specifically in Ontario, 1% of people with complex needs account for 30% of the overall health system costs and 5% account for 60% (Institute for Clinical Evaluative Studies [ICES] 2010). This is due, in large part, to a tendency on the part of key health system providers to deliver care independently from one another and as a result, inefficiencies ensue that can include unnecessary duplication of services and delays, failed transitions between care settings and upward substitution of services. All are key contributors to increased health system costs and less than satisfactory client, caregiver and provider experiences (MacAdam 2008).

The corollary is the knowledge that many pre-existing chronic conditions could be managed with primary care intervention (Bronskill et al. 2011), and people can be supported to live at home and in their communities with the appropriate resources in place. Williams et al. (2009) found that 37% of people in LTC could be supported at home with community supports. Even with a 10% gain in efficiencies, worthwhile savings can be measured (Drummond 2012). With these priorities in mind and a body of evidence that substantiates the need to develop the capacity of the community to support older adults to live and age at home actively and successfully, the notion of integration has been embraced as a mechanism to address both quality and sustainability of care, and a number of initiatives are underway across Ontario.

Background: The Ontario Experience

The Ontario Government has recognized and addressed the need for an effective, integrated and coordinated approach to caring for its older adults. In announcing Health Links, the Government put "family care providers at the centre of the healthcare system" and called for the development of "coordinated care plans for complex patients and increasing the number of complex and senior patients with regular and timely access to a primary care provider" (Government of Ontario 2012). The Drummond Report (2012) and the Minister of Health and Long-Term Care (2012) Ontario's Action Plan for the province further reinforced the needs to build capacity in the community to support older adults with complex needs. In his report, "Living Longer, Living Well, The Government's Senior Strategy," Sinha (2013) called for an alignment of resources and underlined access to primary care services based on individualized need informed by five critical principles: access, equity, choice, value and quality.

In their examination of the challenges of integrated care in Ontario, Tsasis et al. (2012) hypothesize "that part of the problem may lie in how we conceptualize the integration process and the complex systems within which integrated care is enacted." In response to these challenges, a number of integration initiatives are taking place within the Toronto Central Local Health Integration Network (TC-LHIN) and the outcomes from these are further informing provincial integration strategies for both older adults and children with complex needs, and clients who are at end of life.

Integration within the Context of the Existing Integration Network (TC-LHIN)

The focus of this paper is the integrated care for complex populations (ICCP), specifically for older adults with complex needs, which is a collaborative, multi-year strategy for integration that is generating system-level momentum. Based on preliminary results after one year of testing, it is having an improved impact on client, caregiver and provider experience as well as health system utilization (TC-CCAC 2012). The ICCP has developed its innovative integrated response to the Ontario Government's directives through an alignment of the strategies and existing services across the health system.

The strategy addresses the gaps where the system fails people and their families most by bringing together sectors from across the health system to build capacity and be more responsive to these populations. This approach is focused on functional integration at the point of care and is designed to improve quality while ultimately bending the cost curve for some of the system's most complex and costly clients.

Developing an Integrated Philosophy of Care

The ICCP is embedded in the community where older adults and their families live and its first and foremost goal is to improve the quality of care. It speaks to an intended philosophical shift in practice that touches all sectors of the health system, with the emphasis on the roles and accountabilities of providers. The belief is that better ICCP will identify and enable better system integration for all populations with high needs, with particular improvements in care transitions between providers both horizontally (e.g., between community-based providers) and vertically (e.g., between community and acute care hospital). While integrated approaches to care have long been recognized as fundamental to generating value and achieving system sustainability (MacAdam 2008), few efforts to date have been able to maintain broad system impact.

The multi-year developmental framework for the ICCP was designed based on existing programs, identified system gaps and on a review of best practices for successful integrations (e.g., PACE – The Program of All-inclusive Care for the Elderly, GRACE – Geriatric Resources for Assessment Care of Elders, CHOICE – Comprehensive Home Option for Integrated Care of the Elderly and PRISMA – Program of Research to Integrate the Services for the Maintenance of Autonomy). Not only does the strategy draw on every key component inherent in these successful integration models, it expands upon them, informed by and utilizing the local existing system resources and their capacity to generate improvement both in quality and sustainability. The ICCP intentionally did not design an alternative or new model, but considered the successes of the existing ones and then responded to the contextual challenges and strengths of Ontario's specific needs, building on the current underlying structures and processes. Through an alignment and coordination of existing resources, the ICCP focuses on growth and sustainability. An overview of these components is demonstrated in Figure 1.

The seven areas of focus listed below helped to define the specific critical components of the ICCP integrated model in the TC-LHIN context. To better understand where the system is failing older adults and their families in the TC-LHIN, sector providers, expert panels and stakeholder focus sessions were held to validate the following core concepts:

1. Medical support/self-care: Greater involvement of primary care, CCAC working hand-in-hand with primary care to ensure more active support in the community.
2. Medication management: Reducing or eliminating avoidable adverse events due to medication errors
3. Smooth transitions: Ensuring a positive client/caregiver experience during transitions between providers
4. Navigation/coordination: Active leadership for client/caregiver care planning and care coordinators bringing providers together to create wrap-around care and transition teams.

FIGURE 1.
ICCP in relation to existing models

Key Components of Successful Integration Models	PACE	GRACE	CHOICE	PRISMA	SIPA	KP	HARP	ICCP
Intensive Case Management	X	X	X	X	X	?	X	X
Primary Care Involvement	X	X	X	X	X	X	X	X
Individualised Service Plan	X	X	X	X	?	?	?	X
Interdisciplinary Specialty Team	X	X	X	X	X	X	X	X
Pharmacy Involvement/ Medication Reconciliation	X	X	X	?	?	X	X	X
Smooth Transitions	X	X	X	X	X	?	X	X
CSS Integration	X	X	X	X	?	?	?	X
Shared Electronic Health Record	–	X	–	X	–	?	X	Integrated e-record is in progress. We currently have an integrated clinical communication tool for the virtual team.
Patient Education/Self–Management	–	X	X	X	?	X	X	X
Clinical Best Practices/Care Pathways	X	X	X	X	?	?	?	In Progress
Caregiver Support	–	X	X	X	?	?	?	X
Single Point on Access	X	X	X	X	?	?	?	X
Evaluation Plan	X	X	X	X	?	?	?	X

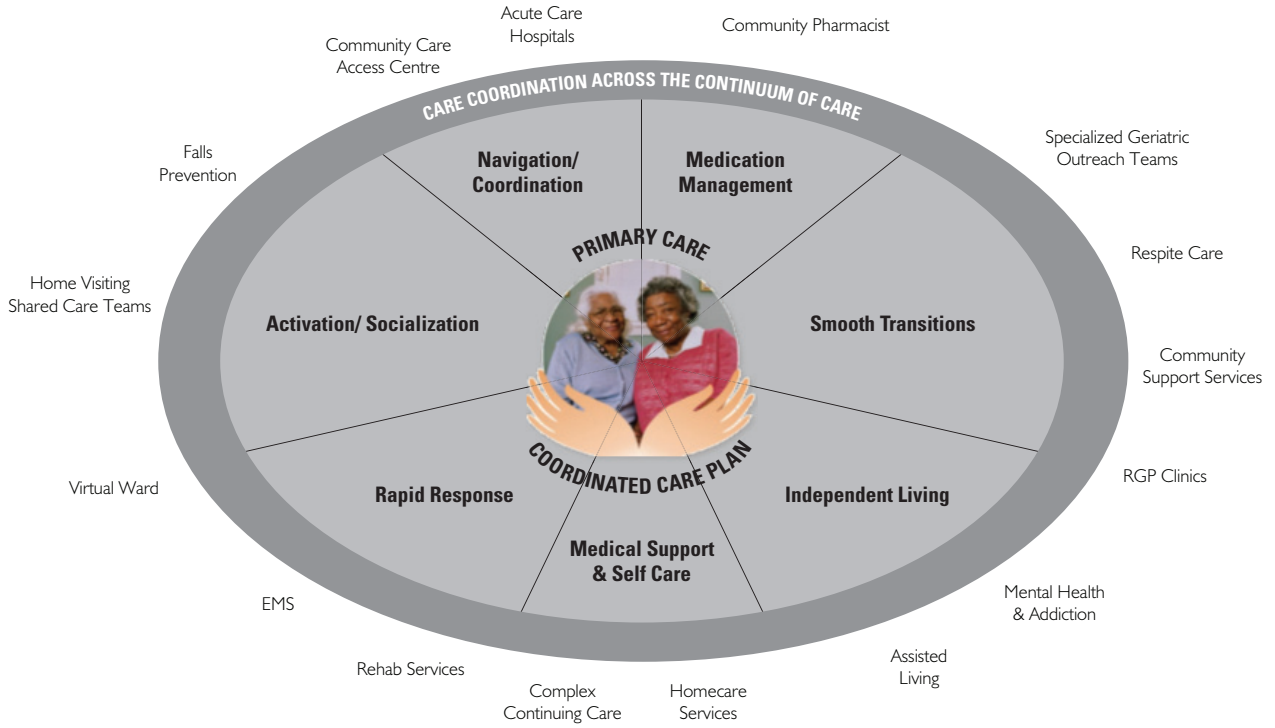
5. Rapid response: A built-in flagging system for rapid community-based response uses a range of options including the ability to pull in the entire team as needed.
6. Activation/socialization: Building client/caregiver goals for activation/socialization into all care plans regardless of destination.
7. Independent living: Supporting client and caregiver choices.Informed by the above core concepts, the Toronto Central Community Care Access Centre (TC-CCAC) initiated an extensive, iterative and consultative approach working closely with primary care, acute care, community support services, specialized geriatric and geriatric mental health services, emergency medical services, rehabilitation and complex continuing care to ensure a range of system perspectives. Emphasis was placed on clarifying accountabilities at each step of the continuum, setting shared expectations and dramatically improving communication between providers. Given the breadth of needs of this complex population, extensive initial effort was invested in engaging the relevant professional champions and systemic supporters and in securing initial agreement about roles and responsibilities within and across sectors. Particular emphasis was placed on building system-wide relationships to facilitate rapid response and wrap-around care in the community, and to create seamless client transitions. The initial investment in this time and labour-intensive approach was critical to ensure equity of representative participant interest and that all voices and challenges would be mutually addressed and respected.

Operationalizing the Approach

In March 2011, the first phase of the ICCP for older adults with complex needs was launched. Initially 200 Toronto residents with a history of being high utilizers of acute care services and requiring ongoing support to remain living in the community were tracked. Many of these relied on the support of their caregivers.

Figure 2 illustrates the ICCP organizational model. It is based on a circle of care that features a clear set of integrated care priorities and reinforces the importance of system-wide collaboration and commitment. Simple, flexible and client-focused, it leverages the use of tools and drives a functional redesign of the ways providers and sector practice ensuring integration at the point of care.

FIGURE 2.
ICCP organizational model and the seven areas of focus



In Figure 2, each integrated care team is composed of interdisciplinary interorganizational providers coming together at the point of care to create one care team and to conduct integrated assessments, joint care planning and joint home visits and/or virtual case conferences. These are each done with the clients and their caregivers' goals at the centre of all planning. Prior to the ICCP, care providers were already working with many of the clients and their families, but there was a lack of integration, coordination or shared planning. By assigning a care coordinator to provide case coordination across the continuum, each client has a system "quarterback" who ensures their healthcare providers are coming together for shared discussions, planning and follow-up. The "quarterback" also serves as the clients and caregivers' one point of contact, further simplifying clients' access to the system.

Defining the Target Population

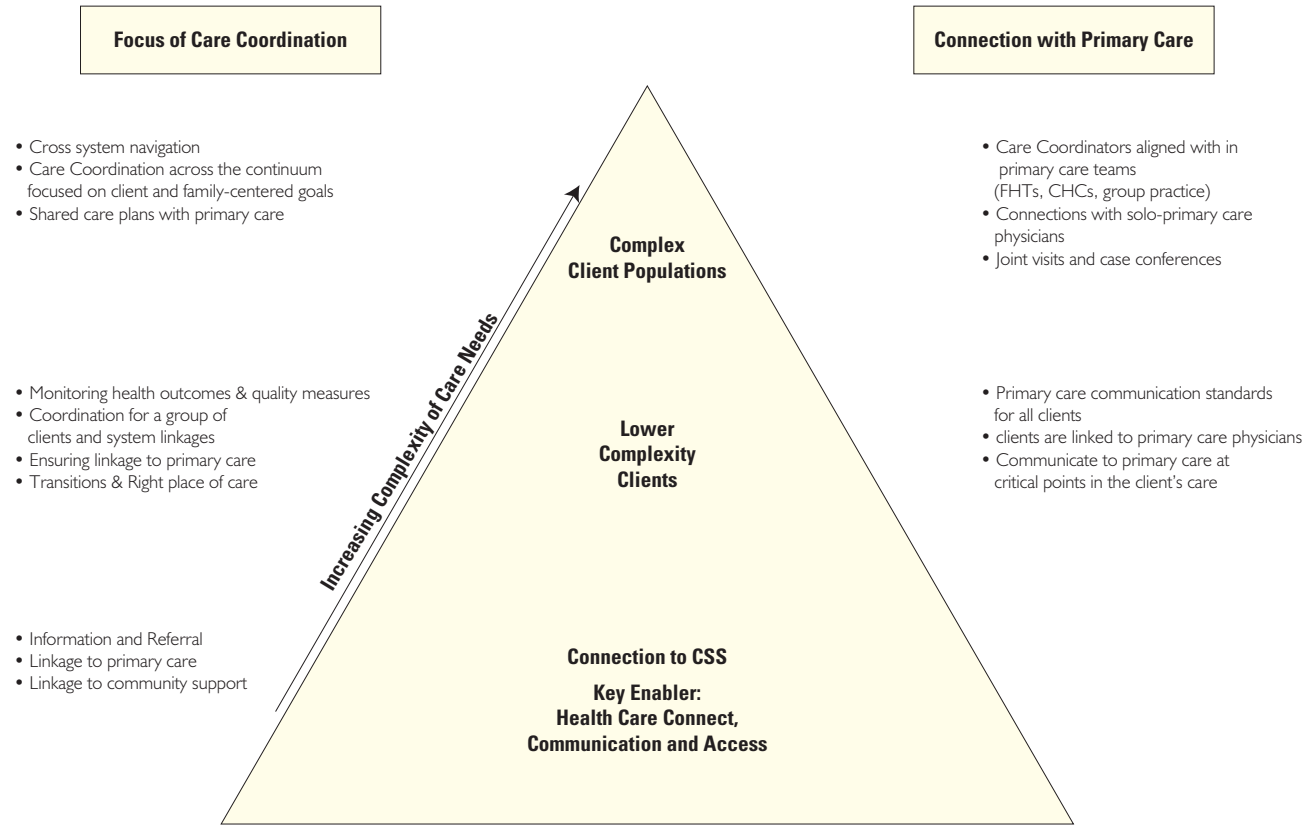
To evaluate and maximize the benefits of integration, fulfill the model's value and affordability goal and to address the local and provincial priorities related to the top 1-5% of older adults with complex needs (utilizing the system), it was initially important to clearly define baseline criteria and a definition of clinical status for this group. A practical framework that could be adapted for use in multiple care settings was applied, offering the flexibility to encompass multiple perspectives of complexity – clinical, functional, social, cognitive and environmental.

The initial target population was identified as older adults, aged 65+ with a history of one or more acute care hospitalizations in the previous year. They also had two or more ambulatory care sensitive conditions from among diabetes, asthma, chronic obstructive pulmonary disease, congestive heart failure, angina, hypertension and/or epilepsy, in addition to the social, functional and cognitive abilities determined through standardized assessment scores (Resident Assessment Instrument for Home Care/RAI-HC). Each of the 200 clients fulfilled these criteria, representing the starting point of initiating a comprehensive program that would support future elders from becoming part of the small percentage that requires exponentially greater healthcare resources.

Engaging Health System Partners

Operationalizing the model was predicated on the two pivotal drivers: the CCAC care coordinators providing care coordination across the continuum and the engagement of and proactive relationships with primary care. Unlike past models where care coordinators managed the needs of a cross-section of clients, population-based models use coordinators to target integrated care to specialized client populations, providing a more focused intensive service. Each older adult has a care coordinator who has a direct relationship with the client and that client's primary care physician, with a goal to develop a shared and coordinated care plan for support. These are the core aspects

FIGURE 3.
Population-based care coordination and integration with primary care at the TC-CCAC



and the cultural shift from which the rest of the integrated approach is built.

Care coordination acts as a connecting bridge across the continuum of care, ensuring shared care and continuity of care even with transfers between providers occur. Leveraging their expertise as system navigators, the care coordinators are able to maintain a close relationship with each of their clients as well as the primary care resources.

The role of primary care is critical. Primary care physicians are the one consistent presence throughout a client's health-care journey – the one place where people receive care for most of their medical health needs. In the absence of primary care involvement, integrated models of care are likely to fail over the long-term.

The approach also afforded an opportunity to assess the needs and potential for engagement of primary care physicians in team-based models of care (family health teams [FHTs] and community health centres [CHCs]) and those practitioners in clinical environments where fewer resources were available. In all instances, primary care physicians' willingness to partner with care coordinators to optimize client care was an essential success factor (Figure 3). Care coordinators are specifically assigned to a particular primary care practice type and are an integral member of the FHTs, CHCs or primary care physicians in solo practice. A primary care integration strategy was developed by the TC-CCAC to look at strategies and tools to engage solo family practitioners as well as those who work in team-based practices.

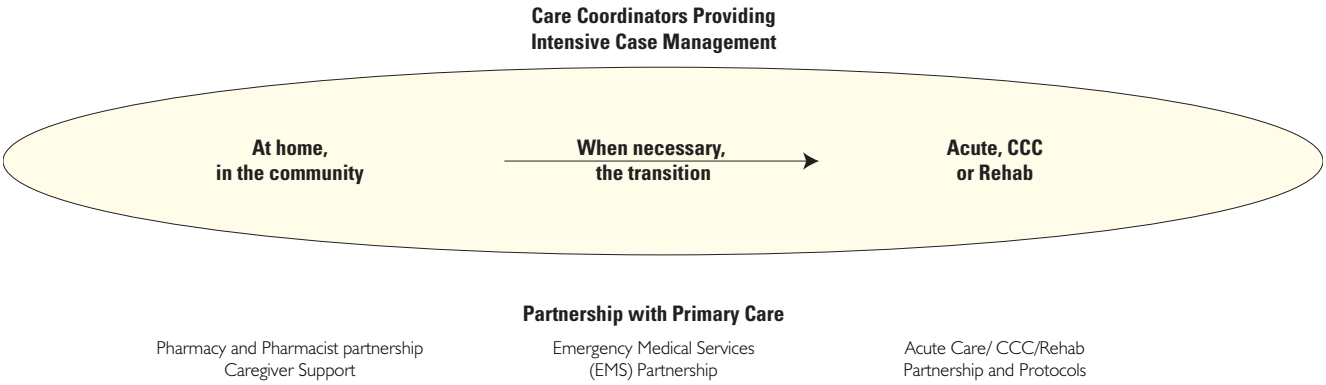
Given the innovative structural model illustrated in Figure 3, the care coordinator can apply a comprehensive case understanding to ensure interdisciplinary inter-organizational teams coming together at the point of care, regardless of where the client is being seen within the system. It is important to note that caseload sizes vary depending on the complexity of the caseload and the relationship with primary care physicians. Figure 3 represents the entire system's strategy that is used to inform how standards of practice stratify the level of integration of primary care with the level of complexity. Given that ICCP was structured to identify opportunites for scale, the innovation of Care Coordinators working hand in hand with primary care was deemed to be a significant opportunity. Based on the example of ICCP, the CCACs are in the process of aligning Care Coordinators to every primary care practice across Ontario.

Since the ICCP's implementation, six key innovations

FIGURE 4.
Key innovations demonstrating significant value and driving sustainable solutions across the TC-LHIN

Care Coordinators Providing Intensive Case Management	• System Navigation and Coordination • Client/Caregiver Quarterback • Building the interdisciplinary, inter organizational care team • Shared assessments, care plans, joint home visits, regular rounds
Partnership with Primary Care	• Weekly Case Conferencing and close communication with CCAC around Complex Patients'Care • Home Visits for homebound patients
Emergency Medical Service (EMS)	• Enhanced Communication around ICCP Clients • Emergency Department Transfer Package • Hospital Repatriation System through EMS
Acute Care	• Identification of high risk patients and flagging system • Enhanced transition communication • Virtual Ward intensive case management
Pharmacy	• Moving to a Single Pharmacy for each patient
Caregiver Support	• Focused experienced based training for Care Coordinators to support caregivers and address caregiver burden

FIGURE 5.
Key innovations demonstrating significant value and driving sustainable solutions across the continuum



(Figures 4 and 5) have demonstrated significant value and have become foundational standards of practice for the expansion of informing standards of practice for all populations with the TC-CCAC. The underlying emphasis is on creating a point-of-care partnership for clients that recognizes the centrality of self-determination and the working partnership between the care coordinator and primary care, sharing care plans, decision-making and regular communication. As the foundational standards, they are the underlying principles that remain constant and have been critical in the development of the entire ICCP. As these innovations have defined the ICCP in its approach to elderly clients with complex chronic conditions, so they also inform the integrated care of less complex populations.

These six innovations each represent paradigm shifts in service delivery and philosophy of care and are transforming the way partners are working across the system. One example of these innovative practices is the Emergency Department Transfer Package and notification system created in partnership with Toronto Emergency Medical Services (EMS). At its core is a one-page transfer summary (whose purpose is to communicate essential information to EMS and ED staff within the first two (2) hours of a 911 call) that accompanies the client to the hospital in an emergency. A sticker on the front door of the home alerts paramedics that this is an ICCP client and ensures that all the necessary documentation accompanies the client to the emergency department. The TC-CCAC care coordinator is informed, who then contacts the client's primary care physician and the acute care hospital for shared planning. The ICCP currently has five acute care hospital centres within the TC-LHIN where each maintains a list of ICCP clients, triggering specific protocols (Figures 4 and 5) when clients arrive in their emergency departments. The next phase of the ICCP will have all seven of the catchment area's acute care hospitals participating.

Initial Evaluation and Evidence

Ongoing alignment with the Ontario Government's Seniors Strategy (2013) and Health Links (2012) ensures a systemic accountability for the ICCP. The ICCP is evolutionary in nature, creating small tests of change with select clients while its partners learn, expand and evolve on a continuum, testing and demonstrating the value of its practice and innovations.

Quantitative information sources from a retrospective cohort analysis and the ICCP care coordinator time study compared process outcomes from 120 ICCP clients with 60 usual care clients over a 6-month period (June 2011 to November 2011). The analysis provided descriptive information about differences between the two groups of clients. Statistically significant increases for the ICCP population were evident in care coordinator touch points with clients/families, care coordinator home visits with clients/families, community case consults and conferences with providers related to client/family goals, hospital case consults and conferences related to client/family goals, linkages with community support services and finally the documented medication list in client's charts. The statistical significance pertains to virtual team development and interactions (CCAC and primary care working hand-in-hand) with an overall indication of improved communication and effectiveness.

Qualitative measures to date included pre and post interviews (conducted by Ipsos-Reid), focus groups, surveys and 1:1 interviews with sector providers, clients and their caregivers (conducted by TC-CCAC). Data were measured thematically against the standards outlined in the seven areas of focus in Figure 2. The analysis of each of the seven areas indicated significant changes and improvements since the inception of the ICCP. The following quotations are representative of the collected data (TC-CCAC):

A client comments: "I meet with (ICCP Coordinator) every two weeks or so. She is very thorough and she does everything she says she'll do. (She is available) anytime. I phone her about everything. She arranged for the hospital. Oh, yes, (she speaks with my doctor). This is the first time the doctor ever came to my home."

A caregiver comments: "But prior to this program if an ambulance took my father to (hospital) which is the closest to his home, and they were fully booked, he would either be left in the hall for 34 hours as he was last year, or he would be sent to (another hospital). Now with this new program there is an assigned hospital and that is where they go and it is (hospital) for that entire home and that is where my father will go. And they have everything: DNR, POA, Visa card imprint, the whole thing. So that, for frail seniors in a huge city, is a brilliant idea."

A summary of key findings from a care coordinator focus group (TC-CCC) indicated that the role is highly valued by clients, caregivers, care providers and the coordinators themselves. ICCP stakeholders' interviews placed great value on the improved emergency department transitions, medication management and the case coordination provided by the care coordinators, creating the one team approach.

Next Steps

As the model evolves and expands, more resources are aligned and leveraged to support an integrated model by further scaling care coordinators in FHTs and CHCs as well as in larger geographic areas to support solo primary care physicians. This multi-year strategy is expected to ensure that care becomes better integrated for all older adults with complex needs in the TC-LHIN. Ongoing evaluation will help inform the CCAC's broader primary care integration strategy as well as integration activities for the LHIN's palliative and complex child populations. Six of the biggest innovations generated through the model outlined in Figure 4 will be extended to the palliative and complex child populations. Throughout this process is the underlying need to plan for sustainability.

Conclusion

The Minister of Health and Long-Term Care for the Government of Ontario (2012), Deb Matthews, in referring to Health Links, stated that "By encouraging local health providers to work together to co-ordinate care for individual patients, we're ensuring our most vulnerable patients – seniors and those with complex conditions – get the care they need and don't fall between the cracks." The ICCP partners and the first-generation ICCP for older adults with complex needs have successfully transitioned the health system in the TC-LHIN into a level of readiness for transformative change. As Ontario continues to face significant challenges in achieving value and sustainability through system-wide integration, this Toronto-based model is already moving the local and provincial health system towards a scalable model for integration while also delivering a significant grassroots impact. HQ

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