Health System Integration for Complex Populations

Integrated Client Care Model For Seniors With Complex Needs

Moving the Health System Towards a Scalable Model for Integration

Canadian Home Care Associations
National Home Care Summit 2011

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Presentation Outline

- Toronto Central CCAC Strategic Aims And Population Based Model Of Care
- Integrated Client Care Model For Seniors with Complex Needs – Toronto Central LHIN System Level Change Strategy
- Integrated Client Care Model Inspiring Internal Change

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Toronto Central CCAC Strategic Aims

Major Aims	**Transforming the experience for our clients and caregivers**	**Keeping people home, getting people home**	**Investing in our capacity to improve quality**
What it means for clients	*We strive to see our care through the clients' eyes and understand that every action counts to build and keep the confidence of our clients*	*We are proactive in preventing unnecessary hospital visits and supporting a positive transition experience*	*We continuously improve & evolve our programs and services, with a goal to increase value to clients, partners, and our staff*

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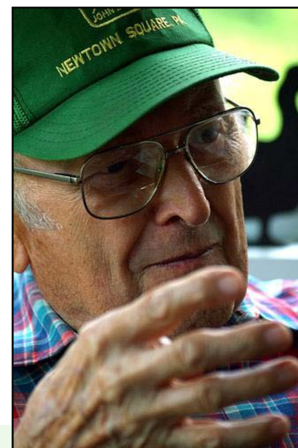
Improving Care – Through Our Clients Eyes

Integrated Care for You...
Bringing Your Care Team Together.

- *Only by looking at the system through the client's eyes will we be able to challenge old ways of working and drive innovation in how we care for our community*



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Supporting Seniors Differently

Balance of Care

- Reviewed a total of 1,800 clients waiting for long term care beds
- Far more individuals could be maintained in the community if more integrated & targeted care options were available

37% of those on LTC wait lists could remain in the community

Having their Say and Choosing their Way

- Hospital is not the best place to make life changing decisions
- Respect, caring and compassion
- Understanding client & family needs and perspectives
- "I am so confused" – need for information about options

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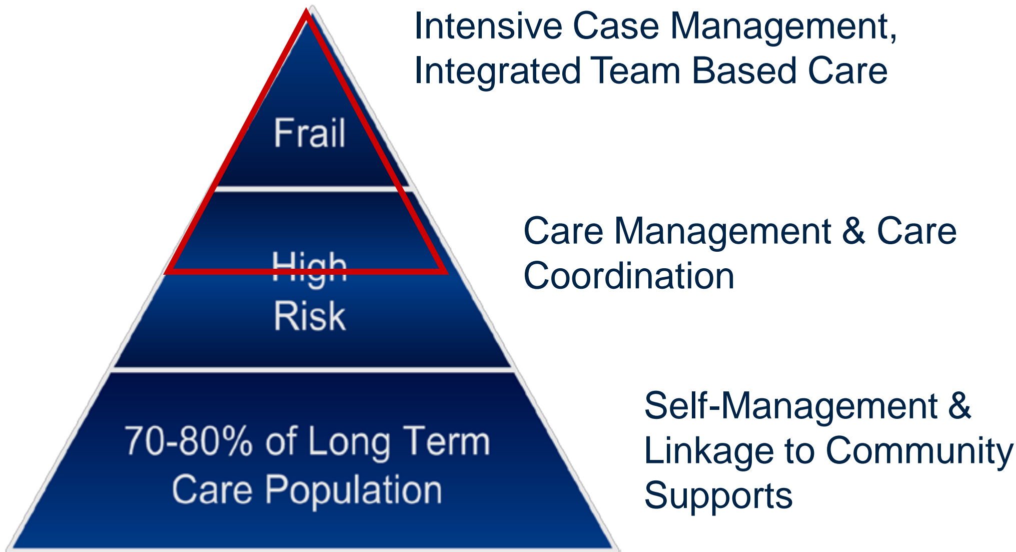
Targeting & Tailoring Services

We learned that we need to target and tailor our services and supports to the needs of seniors



* Source: Kaiser Permanente (2005)

* Margaret McAdams (2009)

Effectively meeting their needs will challenge us to find new ways of working

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Journey to Improving Care for Frail High Risk Seniors

We have been on this journey for the last 3-4 years and are continually evolving our program

Home First & Frail Seniors Pilot	Seniors Enhanced Care Program	Integrating internal staff & providers	Integrating around transitions	Integrated Care across the Care Continuum
Sept 2009	Feb 2010	Inter-professional Speciality team & Service providers June 2010	Virtual Ward April 2010	A LHIN wide initiative designed to integrate care for the top 1% of seniors with most complex needs

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Integrated Care & Intensive Case Management

- The most complex populations require integrated care and intensive case management to support their needs.

- Toronto Central CCAC is leading three integrated client care models:
  - High Risk Frail Seniors
  - Children with Medical Complexity (CMC)
  - Palliative

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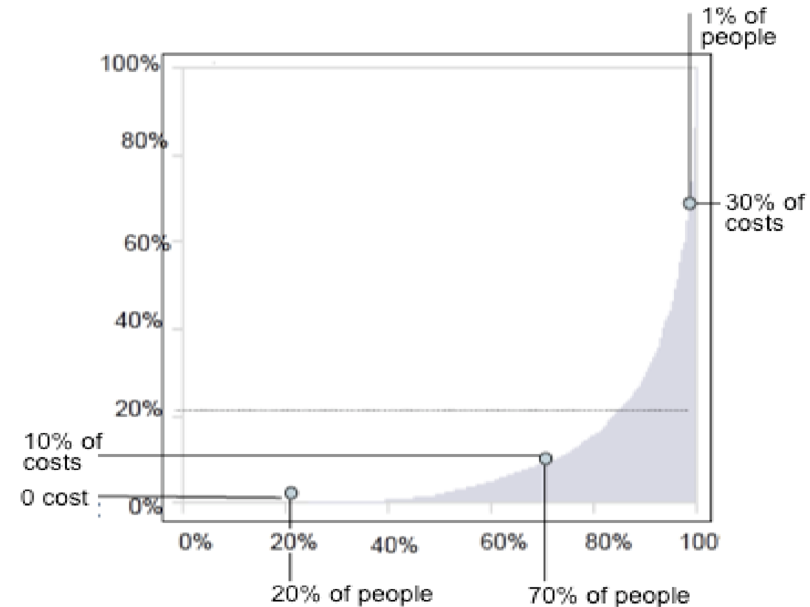
The Case For Change

Studies have consistently demonstrated that a small number of patients with complex chronic conditions account for a disproportionate percentage of healthcare costs.

Working as a system to more effectively respond to the needs of these patients at the "top of the pyramid" ***offers one of the most significant opportunities to improve value and drive sustainability.***



- *2007 Kaiser Permanente report estimates that **1% of the population accounts for 30% of total healthcare costs.***
- *Recent Ontario review estimated that 0.3% of patients account for approximately 10% of hospital discharges and 40% of bed days.*
- *Research indicates that those with multiple chronic conditions cost up to 7 times more those patients with only one.*

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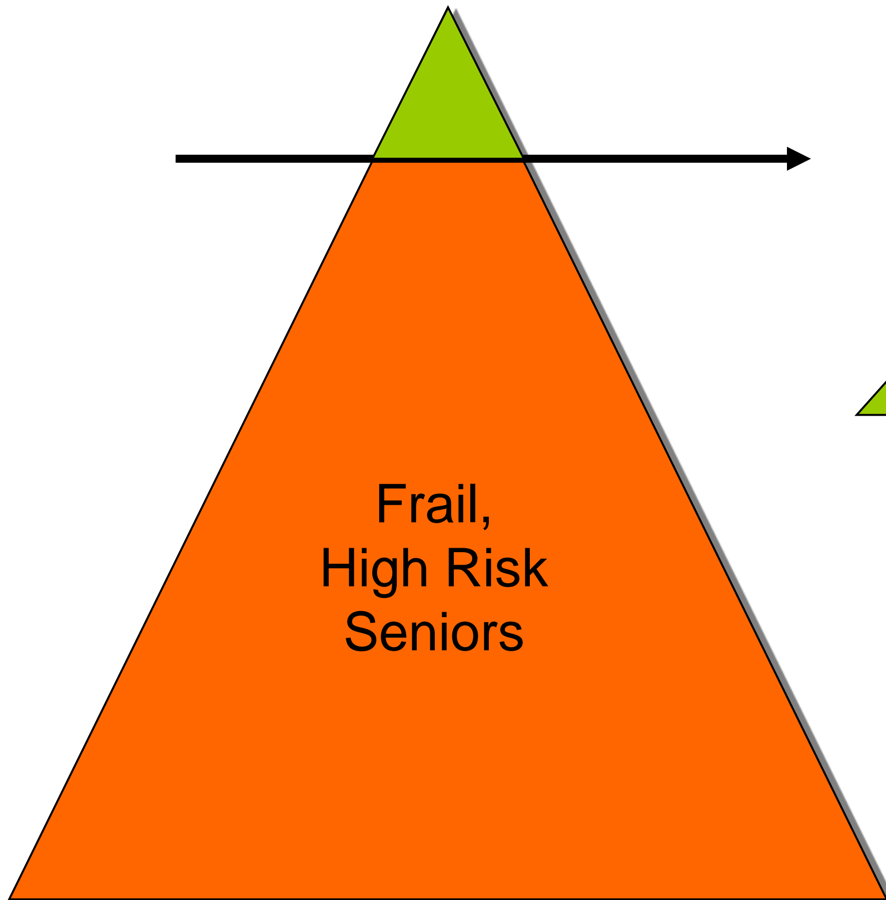
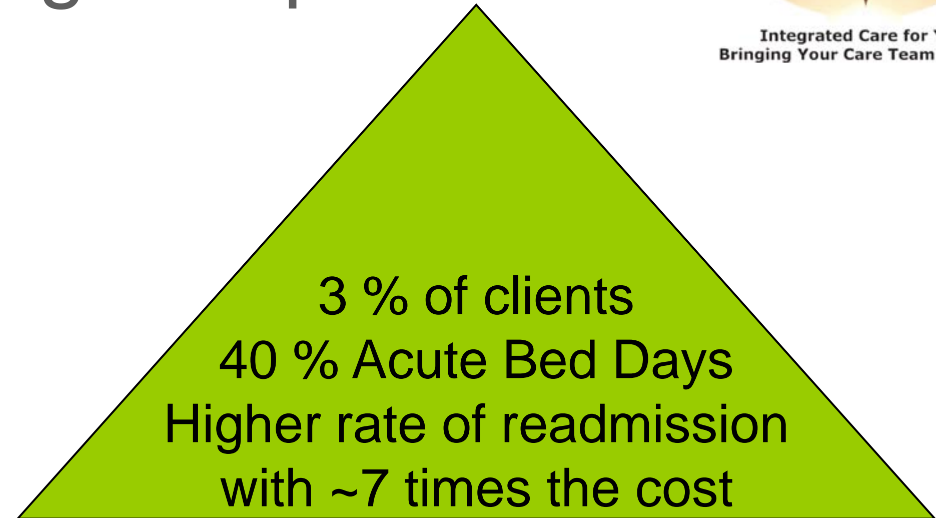
Integration Client Care for Seniors with Complex Needs: Target Population





- 2 or more ACSC (Ambulatory Care Sensitive Conditions: DM, Asthma, COPD, CHF, Angina, HTN, Epilepsy)
- RAI-HC aggregate score of ≥13
- In-patient admission to site hospitals within past year
- Age 65+
- Resides in Toronto Central LHIN

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What is Integrated Client Care for Seniors with Complex Needs?

A quality improvement effort which investigates an approach and demonstrates the value of integration and provides credible data on impact.

ICCP is a quality improvement incubator to test:

- *providing the ultimate model for supporting clients and caregivers to live and age at home successfully*
- *wrap-around care*
- *active response*

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Governance and Leadership

- Toronto Central Local Health Integration Network (LHIN) prioritized integration for complex populations.
- Value and Affordability Task Force: develop an approach for integrated care for ***Seniors with Complex Needs.***
- Project leadership: Toronto Central CCAC
- Shared Accountability: LHIN-wide Implementation Committee.

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Who Is Impacted by Integrated Client Care?

All sectors of the health care system, with an emphasis on roles and accountabilities of providers:

- within the community, where clients and caregivers live;
- at key transition points across primary care, CCAC, acute care, rehabilitation, community services, emergency medical services and complex continuing care; and
- with primary care specifically to address the needs of medically complex and home bound frail seniors.

Key Differentiators Of ICCP Model

Integrated Care for You...
Bringing Your Care Team Together.

Based on a review of best practices for successful integration, the following 7 Key Areas of focus have been identified:

1. Activation and Socialization
2. Medication Management
3. Medical Support and Self Care
4. Rapid Response in the Community
5. Independent Living
6. Coordination and Navigation
7. Smooth Transitions

The ICCP Model is built around these areas of emphasis and identifies the roles and responsibilities required of providers and sectors as they work with clients and their caregivers.

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Integrated Client Care Model at a Glance...

Acute Care Hospitals

Community Pharmacist

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Specialized Geriatric Outreach Teams

Falls Prevention

Respite Care

Home Visiting Shared Care Teams

Community Support Services

Virtual Ward

RGP Clinics

EMS

Mental Health & Addiction

Rehab Services

Assisted Living

Homecare Services

Intensive Case Management

Navigation / Coordination

Medication Management

Activation/ Socialization

Smooth Transitions

Rapid Response

Independent Living

Medical Support & Self Care

Primary Care

Integrated Portable Record

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Where Are We Today?

ICCP is underway, and all of the infrastructure is in place to support it

- Clients now rostered and being monitored as they move through the system;
- All the key players now engaged, including Primary Care (Solo, FHT, CHC), Primary Care for Home Bound, CCAC, 4 Acute Care Hospitals, all CCC/Rehab, CSS Sector, SGS Sector, Psychogeriatric Sector, EMS and more;
- Shared accountability/shared leadership, with regular communications established and working well;

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Where Are We Today?

Our model is simple, flexible, and client and caregiver focused…

ACTIVE RESPONSE IN THE COMMUNITY

- Direct partnership and follow up with primary care physicians
- Dedication to intensive case management/ care coordination
- Consolidation to single pharmacy
- Portable client record with all relevant client and provider information
- Direct collaboration in every health related sector

MITIGATE RISKS & REDIRECT

- Care Pathways
- Client and Caregiver Care Plans (Day to day, Urgent)
- Case Conferences
- Rapid response…

ACTIVE RESPONSE IN ACUTE CARE

- Flagging system for key clinicians to wrap care around client in the hospital
- Catalogue of available services/ resources in each hospital
- Standard practices for intake through discharge
- Accountability defined
- Building stronger relationship with community providers and having direct contact with primary care

WRAP AROUND CARE IN THE COMMUNITY

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Where Are We Today?

Integrated Care for You...
Bringing Your Care Team Together.

For Clients & Caregivers

the model is about wrap-around care and better planning

-Physicians are more engaged and more connected

-Portable record means key information follows the client

-Case conferencing, joint home visits and care plans with critical provider

-Continuity across care settings and providers

- Safer and more supportive transitions

For the Care Team

-Changing the culture from “rescue” to proactive

-Maintains communication and linkages across care providers/settings

-Ensures adherence to shared care plans across the continuum

-Collective responsibility to achieve client/caregivers goals

-Support from and reliance on team members

For the Health System

- Better use of system resources through alignment and linkage

- Optimizes utilization of available resources

- Sectors coming together to address and achieve a common goal

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What We Have Achieved

We are already seeing an unprecedented level of engagement among providers...

- *Collaboration* – problem solving and sharing solutions that work
- *Standards-setting* – creating care path ways that span across organizations
- *Quality improvement* – rapid cycle improvement techniques to test and implement innovations
- *Capacity building* – as individual providers build new tools, then share them across the system

Accountability, but with the autonomy to make it work in your organization

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What We Have Achieved

...and the yardstick has moved forward in every sector

FROM	TO ...
Designing around providers	Designing around clients/caregivers
Identifying problems	Envisioning possibilities
Risk aversion	Risk management
Trying one approach	Trying multiple approaches
Implementation	Innovation
Having the answer	Finding the answers
Escalating issues	Problem solving

Leading Through Ambiguity To Create Collective Solutions ...rather than waiting for the answers

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What Are We Learning?

THE SYSTEM: horizontal integration is fuelling greater vertical integration

- Catalyst for further improvement initiatives
- Creating a network of like-minded change agents, collaborating to identify new solutions
- Organizations are using ICCP as a vehicle for testing new projects
- Engagement of players that do not traditionally work together

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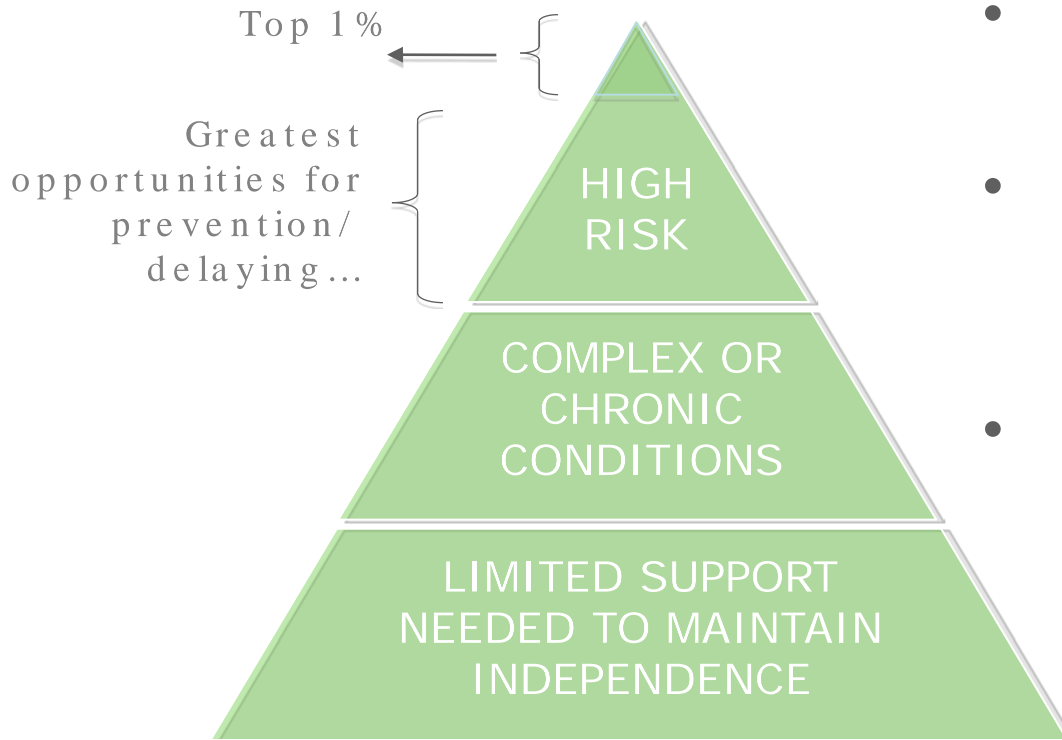
What Are We Learning?

THE CLIENTS: Targeting clients earlier may drive greater benefits



- Building relationships with clients/ caregivers
- Planning for the future/planning for emergency
- Engaging the circle of care

Impact of ICCP Strategy for Learnings

Intensity of Client Needs

HIGH RISK

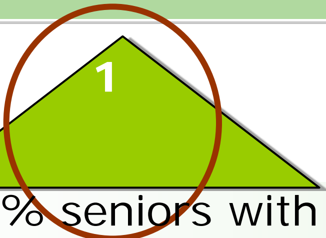
COMPLEX OR CHRONIC CONDITIONS

LIMITED SUPPORT NEEDED TO MAINTAIN INDEPENDENCE

Incubator to Test Quality Improvement

Embed in Practice

Planning Underway for Incremental Rollout



Top 1% seniors with complex needs

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What Are We Learning?

As A MODEL: Includes all of the key components of best practice models for integration AND MORE....

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	In Progress (portable with key elements electronic)
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

What's Next?

Demonstrating impact with a comprehensive evaluation framework

Three key questions:

- ***Does it work for clients/ caregivers?***
- ***Does it work for providers?***
- ***Are we making an impact?***

What's involved:

- Client/caregiver and provider surveys
- Descriptive ICES data to compare service utilization
- Active, ongoing continuous quality improvement

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Where are we Now?

2010			2011			2012	
Summer	Fall	Winter	Spring	**Summer**	Fall	Winter	Spring
Sector Focus Groups Fusion Session Roles & Responsibilities Evaluation Plan	Implementation Committee Project Management Hospital Sites Selected	Dedicated Case Managers Clients Selected Hospitals Committed FHTs Engaged Sectors Engaged Baseline Established	Further Evolution of the Model Sector Engagements Provider Specific Engagements On going Implementation and PDSA Cycles Prospective Data Collection Starts	Further Evolution of the Model Emphasis on 'nuts and bolts' Emphasis on full operations Planning	**Implementation 'Nuts and Bolts' Key Evaluation Outcomes Draft Framework for Scalability and Sustainability**	Recommendations	TC LHIN Roll Out

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Where Do We Go From Here……
Inspiration Driving Internal Change

- ICCP Inspiring Further Evolution of Population Based Care and Service
- Aligning and leverage internal resources to
  - Releasing time to care
  - Changing the conversation
  - Integration with primary care across the organization
  - Inter disciplinary and inter organizational teams

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Integrated Care for You...
Bringing Your Care Team Together.

The Integrated Client Care Model For Seniors With Complex Care Needs

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