HIGH IMPACT PRACTICES

Evidence-informed practices in home and community care that result in better care, better outcomes and better value.

One Client, One Team™

Transforming Integration at the Point of Care

This High Impact Practice highlights the Toronto Central Community Care Access Centre (TC CCAC) integration strategy, which has influenced the design and delivery of population-based programing. Delivering functional integration at the point of care for patients[i] with complex needs, the One Client, One Team™ strategy has been implemented with older adults, children and palliative care clients.

BACKGROUND

In Ontario, both demographics and fiscal reality are key motivators for system change. Ontario is experiencing a huge demographic shift, with the number of seniors expected to double by 2036. The number of seniors aged 75 and above is projected to increase by approximately 144 percent by 2036, and the number of individuals aged 90 and above will triple (Ontario Senior's Secretariat, 2013). While many seniors live healthy active lives, increasing numbers are living with multiple chronic conditions and disabilities. To address the growing need for health and support services, the TC CCAC designed and implemented the One Client, One Team™ strategy.

The work began by engaging and listening to patients with complex care needs and their caregivers[ii] to gain a better understanding of their experiences with the health and social care systems. Patients shared their experiences of dealing with multiple providers in a complicated and disconnected system. They expressed feelings of anxiety, confusion and a lack of confidence and trust in the system (TC CCAC Stakeholder Focus Groups, 2010). This candid feedback clearly identified an urgent need to provide better care coordination and system navigation in order to improve communication and ensure continuity of care across health and social care settings.

The One Client, One Team™ strategy evolved from this work. Using evidence-informed best practices for integrated models of care, supplemented by input from recognized experts (international, pan-Canadian and Ontario-wide), health care providers and community stakeholders, the philosophy of seamless "one team" care planning was developed. Embedded in the strategy is the concept of "care through the eyes of the patient" a concept that ensures care delivery reflects the needs and priorities of patients and their caregivers.

A number of program design elements support this philosophy by focusing on a high performing integrated care team. These program elements shape the goals and tactics for each application of the One Client, One Team™ strategy, and include the following:

- Ensure an integrated experience for the patient and caregiver.
  - Interdisciplinary, cross-organizational teams.
  - Partnerships with primary care, hospitals, specialists, community support services and Emergency Medical Services.
  - Coordinated care planning and delivery across the continuum and at the point of care.
- Simplify access to home and community-based services.
  - Single point of access
  - Integrated client assessments
  - Coordinated plan of care
  - Single patient health record
- Care planning based on what is most important to the patient and caregiver.
  - Access to care team at any time of the day or night
  - Support and education for the client and caregiver
- Support for client choice and self-management
  - Remote monitoring providing greater access to care

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Integrated models of community-based care, seamlessly connect patients, both personally and electronically in real time, to their primary care provider, to their home care provider, to pharmacy services, hospitals and other social services as needed. The home care sector plays a vital role in making these connections happen. The Canadian Home Care Association is committed to identifying and facilitating the scale and spread of promising practices of integrated community-based care.

ONE CLIENT, ONE TEAM™ FOUNDATIONAL ELEMENTS

Collaborative Partnerships

Collaborative partnerships stimulate and develop shared beliefs, ideas and principles that recognize and value the holistic needs of clients and families. These types of partnerships challenge many deeply-rooted attitudes, beliefs and behaviours currently exemplified by health care providers and the public health and social systems. The TC CCAC recognized the vital importance of collaborative partnerships to ensure that "one team" at the point of care would flourish. To achieve this catalytic shift, the TC CCAC led numerous consultations with leaders from primary care, acute care, community support services, specialized geriatric and geriatric mental health services, emergency medical services, rehabilitation, community pharmacy and complex continuing care. Through intensive and dynamic conversations, the partners recognized the value of respective team members and gained new perspectives and appreciation of each other's role and impact on the client and family. Partnerships created a new way to plan and deliver care that is responsive to patient needs, provides wrap-around care that includes community resources and ensures seamless transitions across settings and providers.

Home Care and Primary Care

Fundamental to the One Client, One Team™ strategy is the enhanced role of the home care coordinator and engagement of the primary care provider, where ultimately the two work hand-in-hand. Home care coordinators who are responsible and accountable for a specific patient group (e.g., older adults with complex care needs, palliative clients, children with complex needs) take on a "quarterback" role. Functioning as a bridge between client and family, the health care providers (e.g., primary care, acute care and specialties) and social care providers, the home care coordinator responsibilities include:

- orienting the integrated care team to what is most important for clients and their carers;
- creating and maintaining coordinated care plans based on client and family goals;
- organizing collaborative care planning and joint assessments;
- ensuring the appropriate follow up occurs;
- providing a single point of contact;
- simplifying access; and
- facilitating navigation through the health and social care systems.

Over the past year, the Toronto Central CCAC has provided services to over 77,683 people to help them live independently at home. Throughout the Toronto district, the TC CCAC works with 22 hospitals, 8 emergency departments, 34 community support agencies, 4 school boards and 16 community health centers. The TC CCAC continually strives to meet the needs of the community:

- **4 percent more people were served last year**
- **8 percent more clients, year over year, were medically complex, chronic or palliative**
- **18 percent more clients were served in the palliative care program**

The physician–patient relationship and active involvement of primary care providers is critical to ensuring comprehensive, coordinated and continuing care to individuals with complex chronic, disabling conditions (CFPC, 2011). Building partnerships between home care coordinators and primary care providers is a priority across Ontario. Since its inception in 2011, 100 percent of Family Health Teams and 95 percent of Community Health Centres in Ontario have connected care coordinators with primary care providers. In the Toronto Central LHIN, with approximately 1300 primary care physicians, 75 percent are currently connected to TC CCAC care coordinators.

This essential partnership and connection is supported in the One Client, One Team™ model by:

- aligning care coordinators with primary care practices;
- conducting joint visits and case conferences;
- adhering to primary care communication standards for all patients;
- connecting patients to primary care physicians; and
- implementing a primary care integration strategy that includes tools and engagement framework.

APPLYING THE ONE CLIENT, ONE TEAM™ INTEGRATION STRATEGY

One Client, One Team™ for Older Adults with Complex Needs

Beginning in 2010, the Integrated Client Care Program (ICCP) for older adults with complex needs provided an opportunity to apply and test the One Client, One Team™ philosophy and strategy. The initial phase of the program involved 200 clients aged 65 and older, with one or more hospitalizations within 12 months, and two or more ambulatory care sensitive conditions. Using fully integrated, inter-organizational and interdisciplinary teams, clients were able to safely remain at home through the improvement of care transitions and provision of rapid access to services in the home and community. This experience revealed several key elements that are now standards of practice for all integrated programs within the TC CCAC:

- **Care coordinators providing case management across the continuum –** Coordination and navigation across the care continuum is integrated into all aspects of a client's care planning and delivery, including in-patient hospitalization, acute care discharge planning and primary care.
- **Partnership with primary care –** Effective partnerships are supported through client case conferences, team huddles and virtual and regularly-scheduled communication. Primary care providers conduct home visits for homebound clients when necessary.
- **Emergency Medical Services (EMS) and/or Emergency Department (ED) Notification –** Team members are alerted if EMS is involved, when the client presents to an ED or if the client is admitted to the hospital. The care coordinator contacts the primary care physician and the acute care hospital contact to arrange a care conference (virtually or in person).

ONE CLIENT, ONE TEAM™

TRANSFORMING INTEGRATION AT THE POINT OF CARE

To enable seamless transitions across care settings, a single hospital site is identified for each client and EMS personnel use a transfer package containing critical health information (e.g., medications, behavioural and communication issues, mental status, assistive devices) that accompanies the patient.

- **Designated pharmacy –** Using a designated community pharmacy streamlines communications, reduces medication errors and improves medication reconciliation.
- **Caregiver support –** TC CCAC care coordinators receive training on strategies to support caregivers to recognize and address burnout, in addition to building caregivers' goals into care planning.

Outcomes

A variety of methods were used to evaluate the One Client, One Team™ strategy, including client interviews, client service record reviews, measurement of emergency department visits and hospital readmission rates, and conducting an independent client and family survey through IPSOS Reid. A longitudinal, multi-modal third party evaluation has just been completed and results are expected in 2016/17.

Findings from the evaluations reveal a statistically significant difference in the experiences and outcomes for clients and their families who received care through the One Client, One Team™ versus the traditional care delivery models. Patients felt more confident in their ability to manage their health and access community resources. Patients revealed that they felt strong relationships with their providers and thought the people taking care of them worked as a team. Health system partners also experienced a positive impact. Finally, the evaluation findings provide early understandings of the impact of One Client, One Team™ on system resource use. Fewer unplanned ED visits, decreases in Alternative Level of Care (ALC) and reduction in hospital-to-long-term care placement were realized through the application of the model.

One Client, One Team™ for Palliative Patients

In late 2010, the One Client, One Team™ strategy was implemented for patients with advanced terminal disease so that they could safely remain at home. Referred to as the Integrated Palliative Care Program, this initiative is a partnership between the TC CCAC, the Temmy Latner Centre for Palliative Care (where palliative physicians provide in-home end-of-life care through Toronto's Mount Sinai Hospital) and physicians from the Dorothy Ley Hospice. The integrated model was initially introduced in three TC CCAC districts for 270 patients. In 2016, eight fully-integrated, interdisciplinary palliative care teams were providing care to palliative patients across the local health region.

The following One Client, One Team™ design elements were adapted for this program:

- **Collaborative care coordination and coordinated care planning –** Joint visits by the palliative care coordinator and frontline providers (nurses, physicians and other providers) reinforce team integration and support coordinated assessment, care planning and delivery.
- **Palliative team "huddles" –** Daily succinct teleconferences, led by the home care coordinator and attended by the care team members (nurse practitioner, nurses, palliative care physician and personal support workers), facilitate communication, joint decision-making and pro-active responses.
- **Alignment of a single service provider –** Use of a single CCAC contracted service provider agency for nursing, personal support and rehab therapy supports consistency and continuity of care
- **Partnerships –** An EMS transfer kit is used that contains pertinent patient information (e.g., advanced care plan/Do Not Resuscitate status) and a listing of the health care team members for all patients.
- **Caregiver support –** Maintaining one single access point enables patients and caregivers to connect with the health care team 24 hours a day, 7 days a week.
- **Connections to hospice –** Engaging volunteers and other key members of the broader care team ensures an integrated palliative approach to care.

Outcomes

The Integrated Palliative Care Program has received positive feedback from patients and their caregivers, and has achieved significant benefits for the health system. An independent assessment of client and caregiver experiences with end-of-life care was conducted in 2013, using the Views of Informal Carers Experiences of Services (VOICES) survey tool. The findings indicated that:

- 100 percent of caregivers felt they were adequately supported at the time of death; and
- 98 percent of clients or caregivers reported a positive experience with the program.

In an evaluation led by Dr. Hsien Seow between April 2009 and March 2011, the Integrated Palliative Care Program was compared to a program in which clients did not receive home visits by a palliative care physician working with a home care team.
Clients receiving integrated palliative care were (n=663):

- 30 percent less likely to be hospitalized within the last 2 weeks of life;
- 30 percent less likely to have an Emergency Department visit within the last 2 weeks of life; and
- 50 percent less likely to die in hospital.

"I think that the Toronto CCAC and the leadership is more progressive than most. They have identified the big issues - complex care, mental health, children's needs, palliative care are examples of that - and I think that all of that has been the right move."

~ respondent – Senior Leader Interview

An internal review by the TC CCAC identified the following system outcomes:

- 81 percent of palliative clients who received integrated care in the community were able to die outside of hospital (in the setting of their choice); and
- 10 percent increase in the number of clients dying at home, in hospice or in palliative care unit annually, without additional resources or budgets (i.e., the setting of their choice).

LESSONS LEARNED

Implementation of the One Client, One Team™ strategy has generated a number of critical insights that have impacted the quality and effectiveness of integrated care.

Changing the conversation – New conversations among partnering organizations break down boundaries and create a sense of shared purpose. Collaborative conversations are stimulated by asking and reinforcing the following key questions:

- What is most important for clients and caregivers?
- How can team members apply the client/caregiver lens to redesigning the way we function as "one team"?
- How do patients experience the health system?
- How can the experience of clients and caregivers be improved?
- What do we really want to achieve together?

Paradigm shift – The One Client, One Team™ integration strategy embodies the unique perspectives of the client and family. Providers shift from traditional centralized decision-making models to de-centralized ones that empower collaborative decision-making at the frontline.

Simple solutions result in significant change – Simple actions were implemented and tested to inform and advance more complex solutions. For example, in the absence of an integrated electronic medical record (EMR), the teams used telephone huddles to connect multiple providers and organizations. This simple solution provided the foundation for an EMR that is currently being tested.

Self-reflect and adapt – Effective partnerships rely on trust. Continual reflection is necessary to ensure all partners are engaged and valued. Evaluating what is working, how partners are motivated and what needs to change enabled the TC CCAC to tailor their tactics to the changing needs and expectations of each partner. As partnerships mature, more difficult issues such as roles, accountability and funding were collaboratively addressed.

Allow for evolution – The TC CCAC's integration journey began in 2010 and has adapted and evolved using a plan-do-study-act approach. Feedback from staff, external providers, patients and caregivers has shaped and modified the strategy. Integration projects are intentionally framed as "multi-year strategies" instead of "pilot projects" to clearly reflect and convey TC CCAC's long-term commitment.

WHAT'S NEXT?

TC CCAC's One Client, One Team™ is a successful integration strategy that improves service coordination and delivery and results in better health outcomes for individuals with complex, chronic, disabling conditions. Positive outcomes achieved through this integration strategy are not only practical, but also sustainable. The program design elements are flexible and adaptable across different programs and customizable for unique patient populations. Through the continuous improvement process and adaptive leadership, One Client, One Team™ will be enhanced to include new care modalities such as remote monitoring and communications vehicles through a single EMR.

In 2015, Ontario introduced Patients First, a province-wide initiative to place patients at the centre of care and better support individuals with complex needs. The initiative calls for improved integration of services across sectors and providers, better access to primary care and services in the community and stronger links between services and the people providing them. The One Client, One Team™ strategy is a proven way to meet this goal and has been recognized as a leading practice to be scaled and spread across the province.

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[i] Note: The terms client and patient are used interchangeably throughout this document.
[ii] Caregivers are individuals (family members, neighbours, friends and other significant people) who take on a caring role to support someone with a diminishing physical ability, a debilitating cognitive condition or a chronic life-limiting illness (Carers Canada, 2014).

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