Where Care Always Comes First

Carefirst Seniors and Community Services Association

Carefirst INTEGRATE Model

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Carefirst INTEGRATE Model

- Carefirst “INTEGRATE” Model
- Carefirst Care Coordination Hubs
- Algorithms and Workflow
- Client Engagement
- Outcomes
- Lessons Learned/Challenges

Carefirst's 8 Delegates Visiting PACE in San Francisco (July 2012)

Carefirst's 19 Delegates Visiting PACE in San Francisco (July 2015)

Carefirst INTEGRATE Model

Who is the Target Population

- *55* years or older
- RAI CHA/HC MAPLe Score 4 or above
- Complex care - multiple comorbidities
- Use at least 2 or more types of services (Adult Day Program / Assisted Living / Home Care / Geriatric Assessment Intervention Network clinic/ FHT)
- Can live safely in community at time of enrollment

Carefirst INTEGRATE Model

9 Key Dimensions - INTEGRATE

I nter-disciplinary care

- Multi-disciplinary intervention, i.e. physicians, nurses, social workers, physiotherapist, occupational therapists and frontline workers (PSWs), are involved in joint care planning and intervention

N avigation

- A care coordinator works with participants/caregivers/families throughout the process (engagement, assessment, care planning, implementation, monitoring, and evaluation) to improve access to health care and social services through case management

T eam-based practice

- A group of health care professionals with complementary skills work with participants/families toward a common purpose, with agreed upon performance goals, and approaches, e.g. coordinated care planning, for which they hold themselves mutually accountable

E lectronic health record (EHR)

- A real-time, digital version of participants' charts and **records** make available information instantly and securely to authorized users
- A virtual platform for inter/intra-net communication insures care coordination and monitoring

Carefirst INTEGRATE Care Model

G rounded in care coordination hubs

- ADP centres are “health homes” to coordinate visiting home-based and centred -based programs/services

R esources coordination

- Development of an integrated care pathway which specifies elements of care detailed in local protocols, the foreseen sequence of events, and expected patient progress over time
- Integration of home and community based services
- Arrangement of an inter-organisational network through vertical & horizontal integration

A ccessibility

- One portal entry to a circle, and continuum, of health care, social/community care and housing/transitional care services
- Care close to home and on-site service delivery, e.g. assisted living and ADPs

T imeliness

- Care services delivered and intervention occurring at the right suitable time

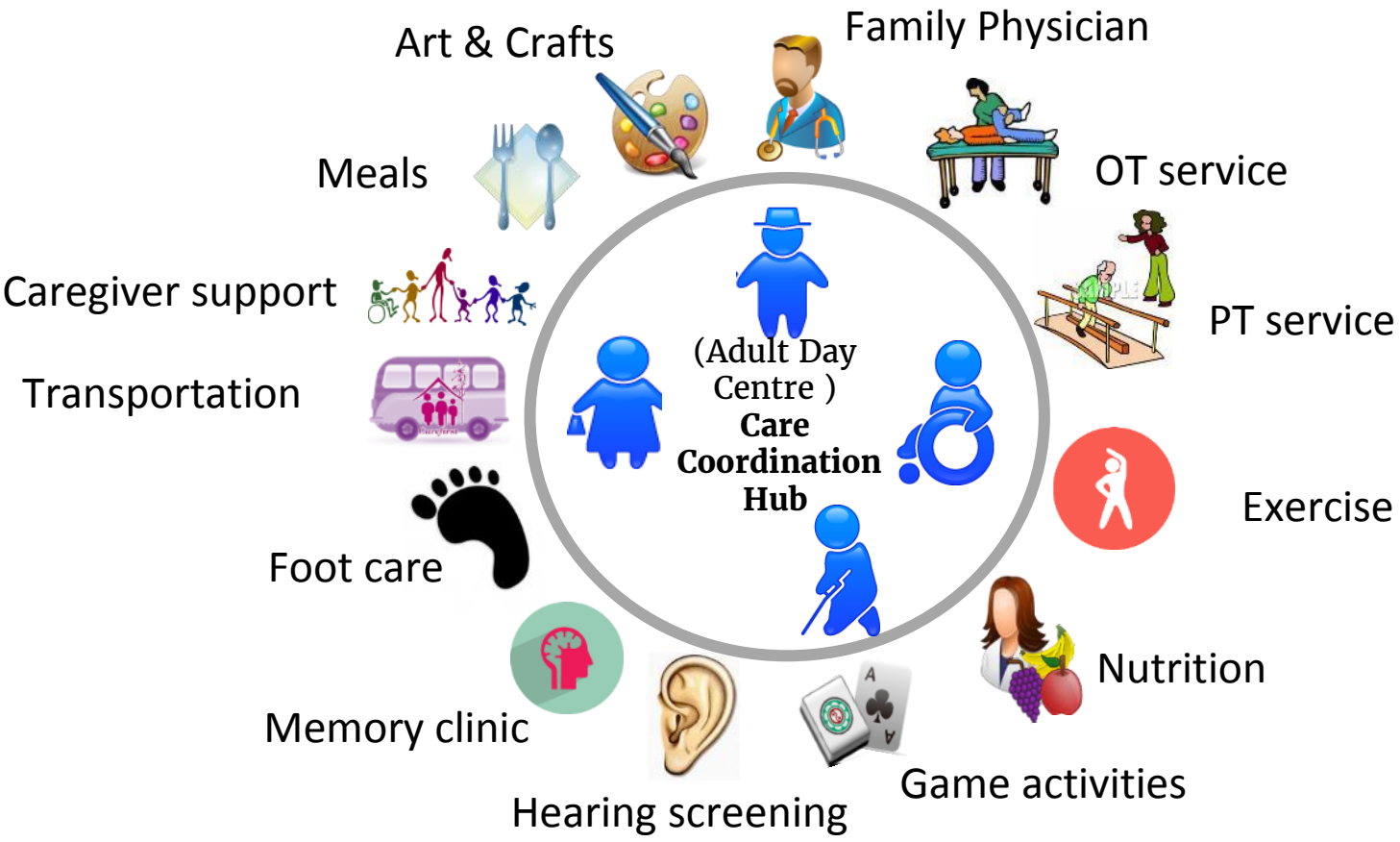
E ngagement

- Engagement and involvement of all relevant sectors - primary care, community care, acute care, rehabilitation, public health, housing, and government support to make the integration model of care a success
- Client and family centred care – program development in partnership with clients/families and incorporations of inputs from them

Carefirst Care Coordination Hubs

- Adult Day Centres and Carefirst One-Stop Multi-Services Centre as Care Coordination Hubs
- **To provide wrap around, bundled care with a combination of:**
  - Home-based programs/services
    - ✓ Assisted Living, Home Care, Meals-on-Wheels, GAIN, etc.
  - Centre-based circuit of programs/services
    - ✓ Socialization/stimulation programs (arts and craft, games, friendship, etc.)
    - ✓ Clinical intervention services (foot care, PT, OT, medical check up, memory clinic, eye/dental check up, nutrition counselling, counselling service, nursing service, GAIN)
    - ✓ Exercises and Falls Prevention Program
    - ✓ Wellness education
    - ✓ Transportation
    - ✓ Caregiver Support and Education
  - Transitional Care Centre
  - Carefirst Family Health Team (primary health care) & Specialist Clinics

Adult Day Centres as Care Coordination Hubs



Carefirst Care Coordination Hubs

- Expanded and enriched the 3 Carefirst Adult Day Care Centres become Care Coordination Hubs

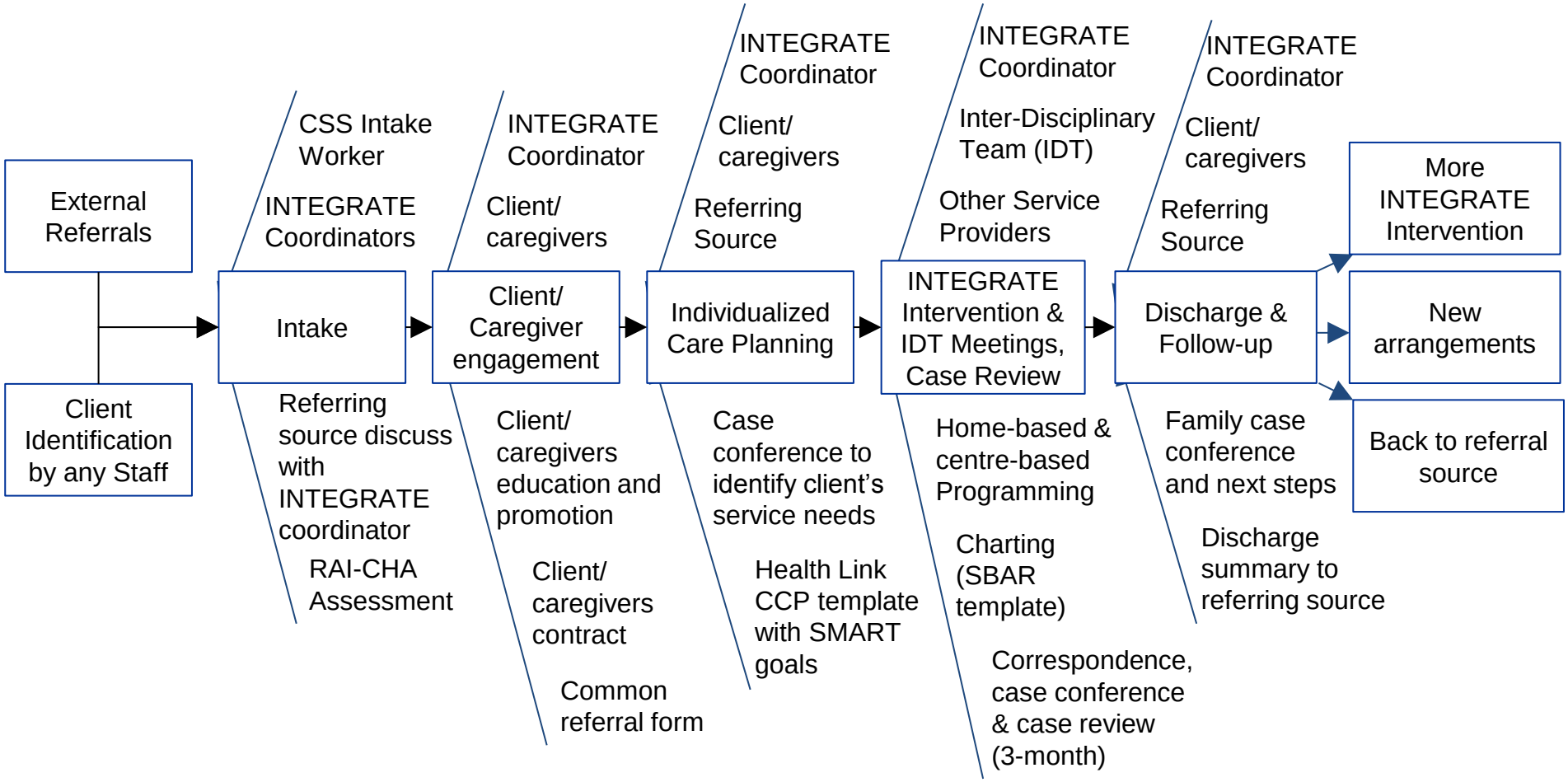
- The 3 Care Coordination Hubs are:

  1. Richmond Hill: 25/day = 75 different clients
  2. Glen Watford Drive: 50/day = 200 different clients
  3. Silver Star Blvd: 40/day = 150 different clients

  (Serve a total of 425 different clients/year with full day attendance)

- Use of intensive case management and team rounds

How Does the INTEGRATE Model Work Algorithms and Workflow



Patient Engagement

- Patient- and family-centered care - an approach to the planning, delivery and evaluation of health care
- Grounded in mutually beneficial partnerships among patients, families, and health care practitioners
- In partnership with clients and families – participate in their care planning and decisions
- With inputs from clients and families –incorporate their inputs and gaining the benefit of their help and insights to better plan and deliver care – patients can achieve better outcomes
- Organization - fosters an empathetic culture that recognizes patient, family engagement at its centre, e.g. present findings
- Organizations – provides resources for Patients, Families and Caregivers, e.g. caregivers' support groups

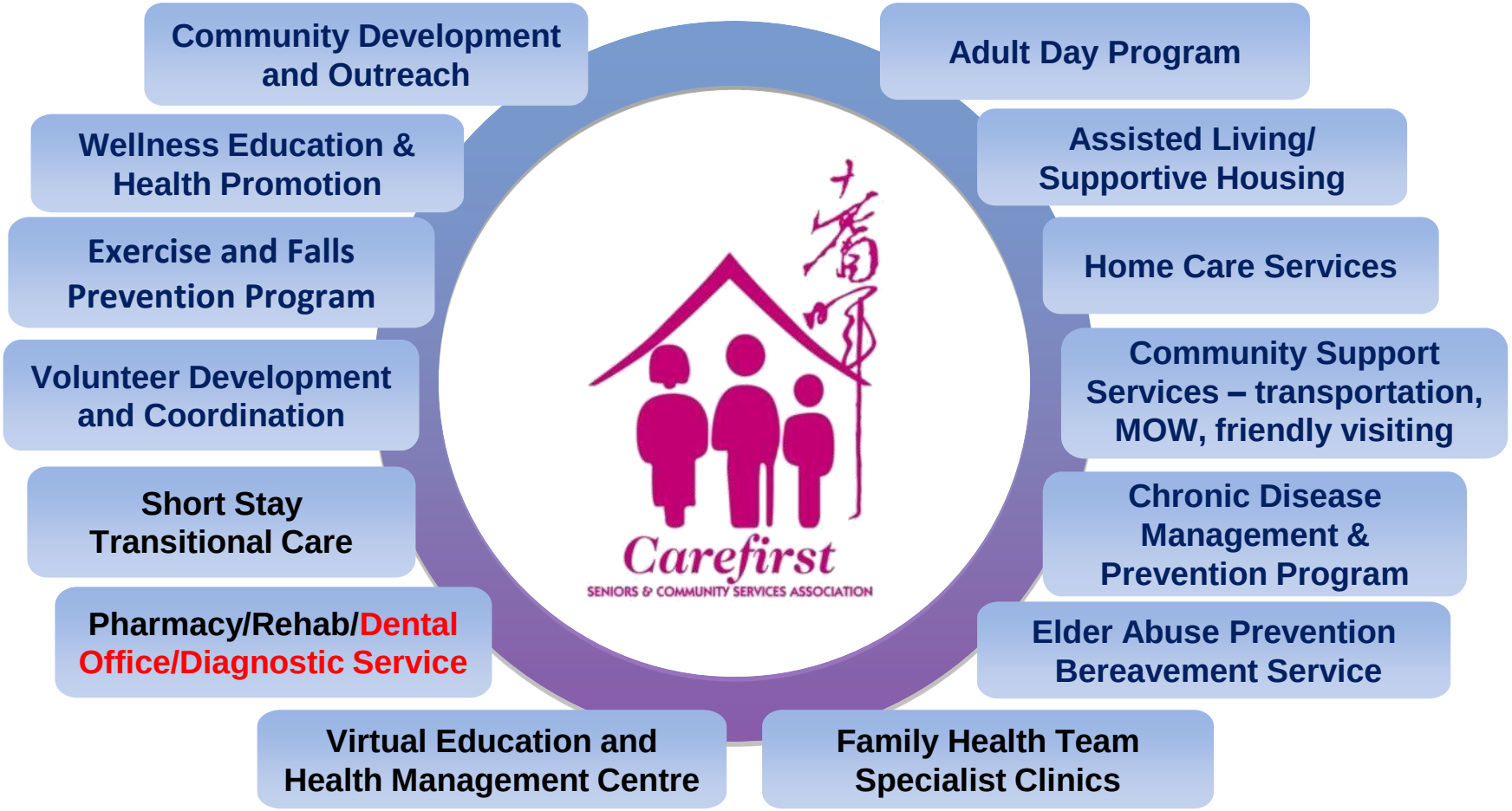
Patient Engagement

Planning for Engagement:

- Creating and Sustaining Patient and Family Advisory Council
- Recruiting for Diversity
- Measuring Engagement
- Learn frameworks and best practices to implement patient, caregiver and public engagement, and examples of effective engagement at work
- Examples:
  - ✓ 24/7 practice
  - ✓ Client first
  - ✓ Client experience – safety and service
  - ✓ Partners in care plans and service goal set

OVERVIEW OF CAREFIRST'S INTEGRATED BASKET OF SERVICES

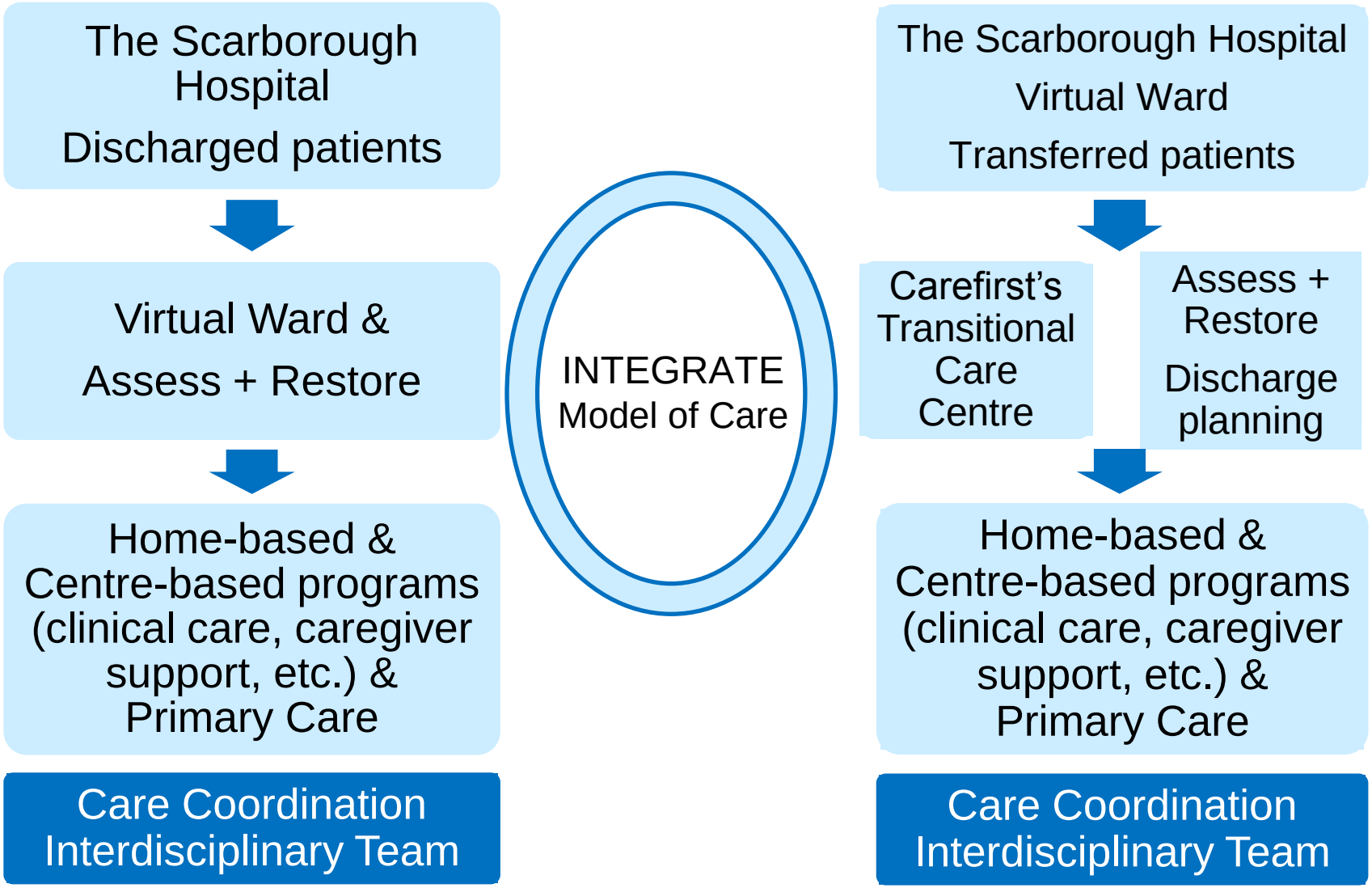
TOTAL CARE MANAGEMENT



Carefirst Seniors/FHT Interdisciplinary Team Platforms

- Use of Ontario Telemedicine Network
- Carefirst FHT – IDT platform builds on own inter-disciplinary team
- Carefirst Seniors – IDT leverages on GAIN clinic (NP, pharmacist, RN, social worker, physiotherapist, and o.t.)
- Target – more complex care patients
- IDT meetings - weekly
  - **Intake** – assessment intake and then quarterly review
  - **Care Coordination** - occurs routinely and episodically
  - **Care Plan and Treatment Planning** – routinely
  - **On-going monitoring** - The team is the collective case manager
  - **Shared decision-making**
  - **Grand Rounds** - every Thursday for education purpose for all staff
- Case management coach – available to support program staff

Integrated Care System - "Collaborative integration with the hospital and Integrated Care as the Solution"



Client Outcomes

- Increased life satisfaction of seniors: successful aging
- Increased life satisfaction of caregivers
- Reduced number of ER visits
- Reduced hospital admission/readmission
- Higher rate of community residence
- Higher consumer satisfaction

INTEGRATE Program Statistics

April 2016 – July 2016

	Number of Clients	Percentage (%)
	April/16 – July/16	**April/16 – July/16**
Total Number of Individual Served	**241**	**/**
INTEGRATE model of care participant	**241**	**/**
Hospital Re-admission (within 3 months after discharge)	**1**	**0.4%**
Emergency Room Visits (within 3 months after discharge)	**6**	**2.5%** (8% provincial rate within 3 months after discharge)
Hospitalization	**10**	**4.1%**
Long-Term Home Admissions	**3**	**1.2%**

Lessons Learned and Challenges

- Board's vision, management's leadership and staff's commitment
- Client identification – similarities, co-morbidities with high risk seniors in AL, GAIN, ADP, SHS, Home Care, CDMP and Carefirst FHT
- Comprehensive spectrum of services (medical, primary health care, social support services) that can be bundled
- Modified adaption of PACE Model practice:
  - Developed integrated care policies and protocols
  - Developed INTEGRATE care training package for staff
  - Developed INTEGRATE care work flow, algorithms, and manual
  - Involved MDs – collaboration between Carefirst Seniors and Carefirst FHT; inter-disciplinary team meetings since 2013
- Support from universities, LHIN, CCAC, and The Scarborough Hospital
- Continued support from and existing relationships with On Lok Lifeways, U.S.
- Full commitment for client-centred care delivery

Challenges

- Fragmented funding policies
- Not all LHINs and CCACs -> buy in
- Inadequate resources for on-going coaching and education
- Inadequate involvement of “outside” primary care providers

Care Always Comes First!

There's No Place Like Home!

Thank You!