INTEGRATE™

HOW ONE COMMUNITY IS ADVANCING INTEGRATED CARE FOR SENIORS

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“I’m lonely. My daughters don’t visit. I just stay all day in the apartment. I can’t do the things I used to. I feel so lonely.”

BETTY L.

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“It's my job to take care of my wife but it's very hard. She fights me. She thinks I’m out to get her and she won’t take the pills or let me help her get ready. It’s hard to stay in all the time and it’s hard to go out.”

STANLEY L.

A CANADIAN STORY

A GLOBAL PHENOMENON

16.9% OF CANADIANS ARE AGED 65 AND OLDER

21.9% OF CANADIANS ARE IMMIGRANTS

80% OF CANADIAN SENIORS HAVE 1+ CHRONIC CONDITION

5% OF ONTARIANS ACCOUNT FOR 65% OF PROVINCIAL HEALTH CARE COSTS

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THE DISCONNECT

AN OPPORTUNITY FOR CHANGE

ORIGINS.

Younger Populations •
Disease Specific • Episodic

NOW.

Older Populations •
Chronic • Complex Needs

A GAPPING CHALLENGE.

Planning & Delivery Disconnect •
Fragmented System • Complex Navigation • Negative Client Outcomes

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HOW DO WE BRIDGE THIS GAP AND OVERCOME THESE MONUMENTAL CHALLENGES?
HOW ONE COMMUNITY IS INSPIRING HEALTH INNOVATION
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THE INTEGRATED SOLUTION

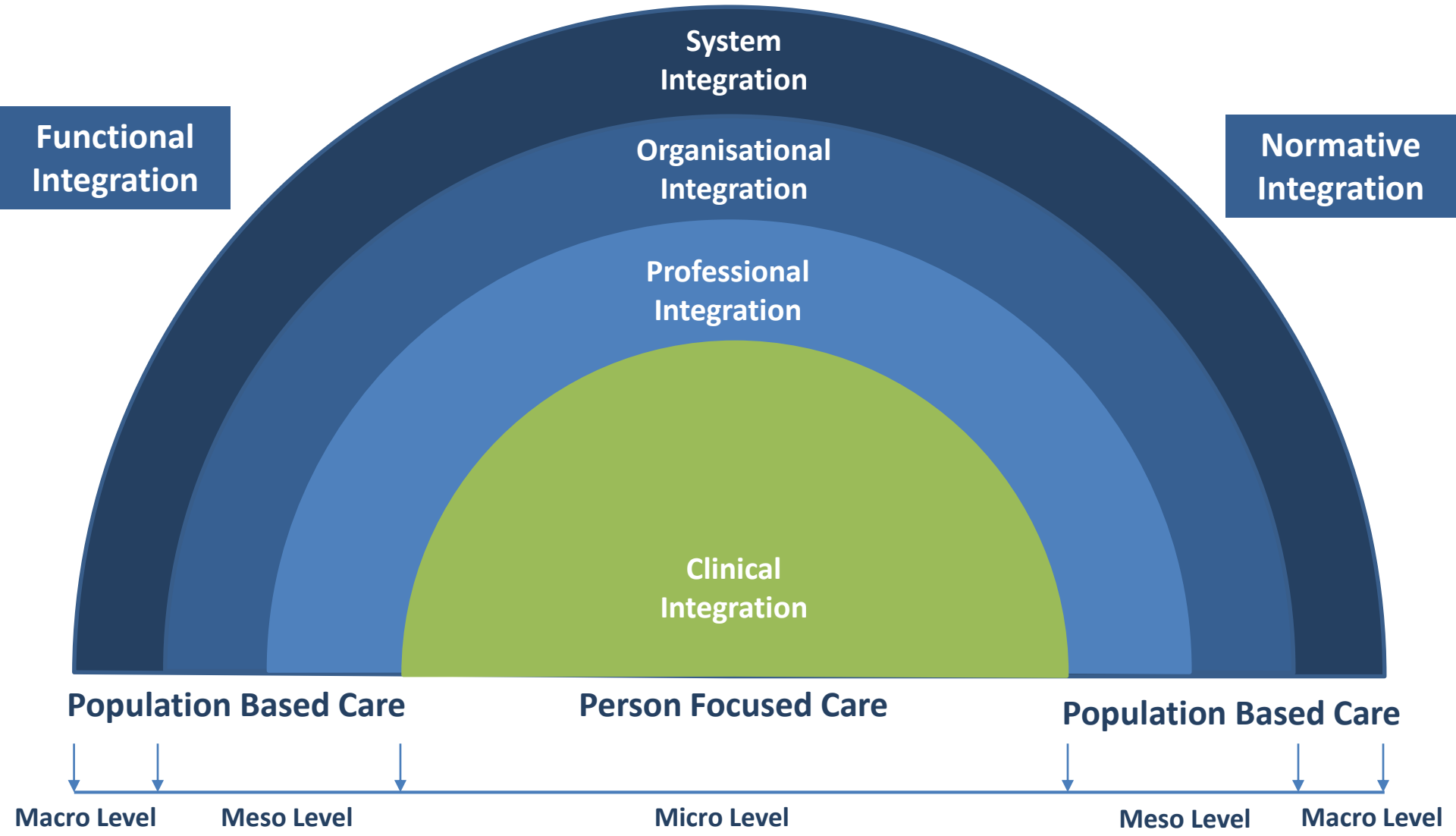
Integrated Community Based Health Primary Care (ICBPHC) supports the needs of medically-socially complex clients through strong case management, interprofessional health expertise using a chronic care model that integrates primary and specialty care as well as social services. This model allows frail seniors with complex health needs to maintain independence while staying in their home as long as possible.

DEFINING INTEGRATION

- Integration is a combination of processes, methods and tools that facilitate integrated care across the whole system, simultaneously creating new relationships, networks and ways of working, e.g. collaboration and coordination.
- Integration happens when the culmination of these processes directly benefit communities, and service users – it is by definition “patient-centred” an “population-oriented”.
- Integration is a success if it contributes to better care experiences, improved care outcomes, delivered more cost effectively

(Reference: Barron-Hamilton 2017 & Nuffield Trust 2011 & WHO 2015 & Skills for Care 2014)

Conceptual Framework for Integrated Care Based on the Integrative Functions of Primary Care



(Reference: Barron-Hamilton 2017 Australia & Valentijn, Shepman, Opheij and Bruijnzeels 2013. Netherlands)

Recognizing the need for an integrated solution, Carefirst Seniors established INTEGRATE™–an innovative, data-driven solution that provides comprehensive, centre and home-based services to coordinate primary care and support services for seniors with chronic and complex health needs.

WELLNESS PROGRAMS

COMMUNITY SUPPORT SERVICES

HOME CARE

PRIMARY CARE

ASSISTED LIVING

CHRONIC DISEASE MANAGEMENT

ADULT DAY PROGRAM

TRANSITIONAL CARE

OUR LIFE APPROACH PHILOSOPHY

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THE CAREFIRST SOLUTION

1. Clients 55+ Years
2. InterRAI CHA/HC CAPS 12-20 & MAPLe Score 4+
3. Complex Care Needs
4. Designated Geographic Area
5. Use >2+ Services
6. Lives Independently with Supports

- **I** INTERDISCIPLINARY CARE
- **N** NAVIGATION
- **T** TEAM BASED CARE
- **E** E-CONNECTIVITY
- **G** GROUNDED IN COORDINATION HUBS
- **R** RESOURCE COORDINATION
- **A** ACCESSIBILITY
- **T** TIMELINESS
- **E** ENGAGEMENT

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PRELIMINARY RESULTS

2.34%
REPORTED
FALLS

3.84%
REPORTED
HOSPITALIZATION

0.33%
REPORTED
HOSPITAL
READMISSION IN 7 DAYS

0.17%
REPORTED
HOSPITAL
READMISSION IN 8-14 DAYS

1.67%
REPORTED
ED VISITS

★★★★★ 98.3%
CLIENT SATISFACTION

N = 599 COMPLEX NEEDS PATIENTS

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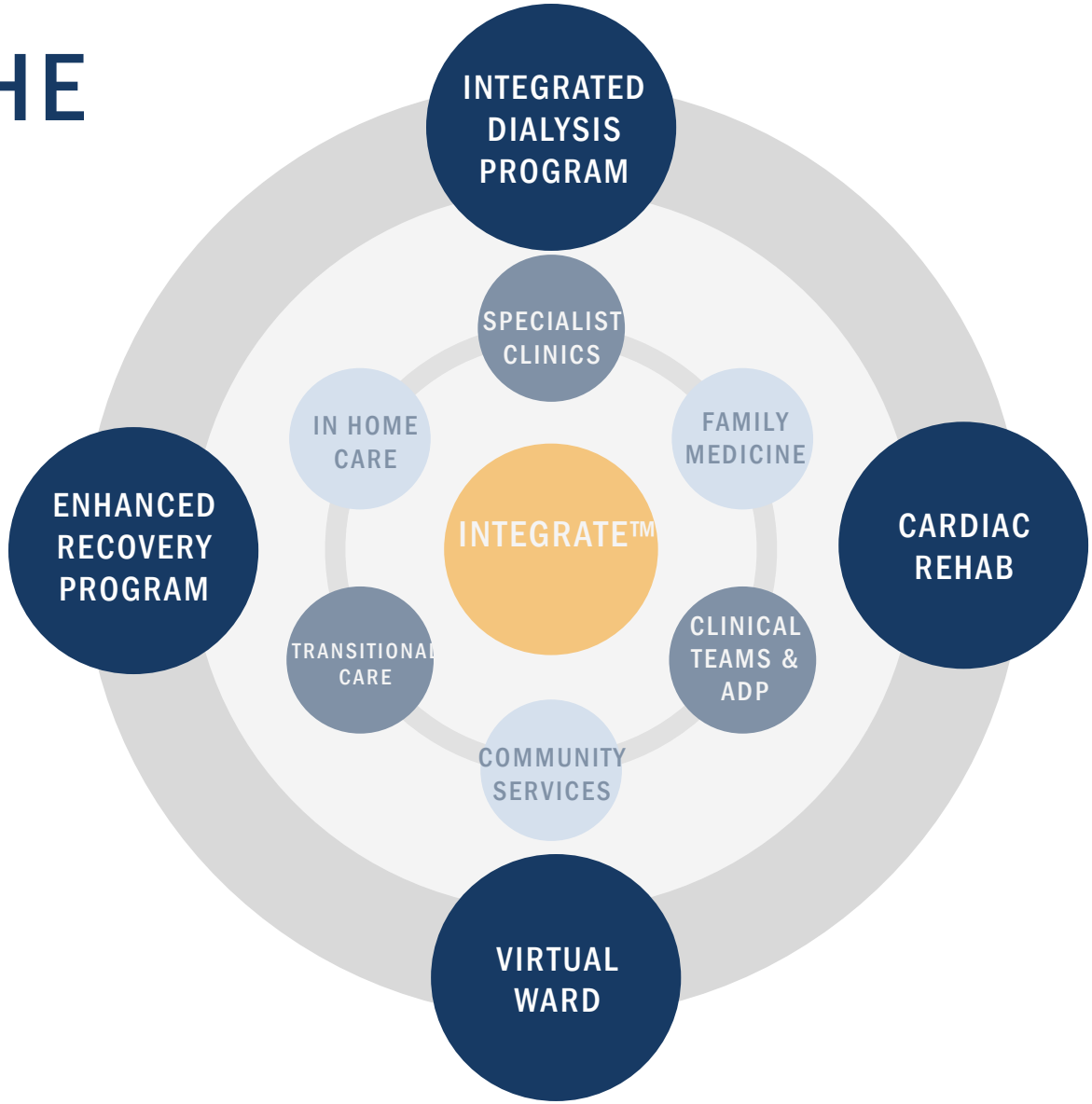
EXPANDING THE INTEGRATE™ EXPERIENCE

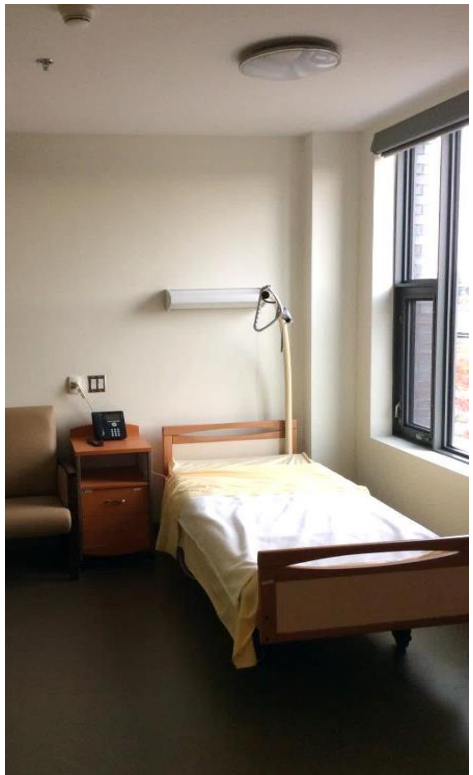
ACUTE CARE PARTNERS

Together with our acute care partners, we have developed exciting initiatives to better serve frail seniors. INTEGRATE™ is at the core of this evolution.



TRANSITIONAL CARE CENTRE

Carefirst's 30 -bed short stay respite and transitional care centre. For hospital patients that no longer require acute care but would benefit from additional care, can be discharged directly to transitional care where they are supported socially, cognitive and functionally. Transitional centre provides a gateway for patients to enter into INTEGRATE™ and fully access a range of other services that allows them to continue to live at home in the community.



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BE BOLD.

Foster innovative partnerships that push the boundaries of INTEGRATE™ and broaden a positive impact for clients.

LET THE DATA TALK.

Collect meaningful data to support the predictability of a funding model and influence future government funding structures.

LISTEN ACTIVELY.

Continue to evaluate the client and caregiver perspective for continuous user-centric experience.

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“All the people are so good to me like (Carefirst ADP staff member) who plays the guitar and sings for us. She has a beautiful voice. It’s peaceful to hear the music.”

BETTY L.

“I am so grateful to all the workers here. When she’s here (Adult Day Program), I can do jobs around the house and look after myself. She’s better with the pills...not so angry at me all the time. I can take her to the mall and we can finally meet up with friends again.”

STANLEY L.

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THANK YOU FOR LISTENING

QUESTIONS

FOR MORE INFORMATION ON CAREFIRST, PLEASE VIEW OUR FEATURE VIDEOS:

- ENGLISH (https://www.youtube.com/watch?v=XdI5MLd7CmU)
- CANTONESE (https://www.youtube.com/watch?v=tCOcLpziVGs)
- MANDARIN (https://www.youtube.com/watch?v=8mr93-i5-og&t=9s)

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LET'S CONNECT

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