Working Together to Improve Primary Care for Seniors with Complex Care Needs:

A Health Links Discussion

Summary of the Online event June 24, 2013

BACKGROUND

Health Links along with others who are supporting seniors with complex care needs such as Behavioural Supports Ontario (BSO), specialized geriatric services and senior community services face similar challenges in transforming the health care system in order to meet the needs of this shared target population.

To facilitate the sharing of effective practice and lessons learned the Alzheimer Knowledge Exchange (AKE) hosted an online discussion on June 24, 2013 for these groups to learn about how others are meeting these challenges and to share strategies.

The discussion focussed on topics identified as being common to all of these groups working with seniors with complex care needs, including:

- Understanding how seniors with complex care needs fit into Health Links target populations (the 1-5% highest users of the Health Care system) and implications related to effective care
- Enabling *true* person-centred care and engagement
- Developing best practices *with* flexibility for local adaptation

Those who registered to take part in this event were asked to indicate which of these issues was challenging to them and why and to share their ideas, strategies and resource for responding to them in a pre-session survey. A summary of their responses were shared during the session on June 24th and participants were invited to expand on and add to these ideas. The following outlines the themes and ideas shared both prior to and during the session.

1. How Seniors fit into the Common "Target Population"

What about this issue has been challenging for you?

- What exactly ***defines complex care***?
- ***Falls prevention*** - the continuum of falls prevention from healthy to frail elderly.
- Bridging care when people are approaching ***end of life***.
- Need to understand source of people accessing ED-where are they coming from (e.g. LTC, community)?
- Identifying dementia and its contribution – data reviewed is often focussed on primary diagnosis***. Secondary diagnosis*** often includes ***dementia***. Also many people with dementia not diagnosed so not captured in the data. Are the right supports in place to identify people living with dementia (not diagnosed)? [**NOTE:** Information about the contribution of dementia to the complexity of seniors' care was shared during this event as an example. See full Ontario Dementia Evidence Brief report]
- People staying at home longer with more complex needs.

What ideas, strategies or resources have you used to address this issue?

- Looking at utilization rates, ***chronic and co-morbid conditions*** in developing a care plan.
- Utilization looks at (e.g. hospital use, visits, etc.). Getting ***data from practitioner perspective*** would be of value as well as ***CCAC data***.
- How do we ***leverage LTC sector resources/expertise*** to learn about those with complex needs who are living in the community?
- The AKE ***Geriatric addictions*** community of practice is working on fact sheets to support practice: http://www.akeresourcecentre.org/Addictions.

2. Enabling True Person Centred Care & Engagement

What about this issue has been challenging for you?

- ***Ensuring "robust" person centred approach***
- Get caught discussing changes that will improve the ***provider processes***.
- ***Voice of the person and family sometimes gets lost*** among the health professionals; not "true" person-centred care
- Reconciling person-centred care with ***regulations/policies/processes/organizational culture***.

What ideas, strategies or resources have you used to address this issue?

- ***Involving patients at an early stage*** (e.g. selection committee for hiring new staff).
- Patient and caregiver share their perspective in ***developing goals & care plan***.
- Involve patient and caregivers in both steering committee & care planning (i.e. ***at both system & individual care levels***).
- Ensuring ***really listening and then acting on it***!
- Supports needed for staff to ***find a new way of doing things***.
- Working on ***comfort level of staff*** in allowing patients/clients to make choices that may not be in their best interests.

3. Consistent Best Practices with Flexibility

What about this issue has been challenging for you?

- How do we ***build in consistency, efficiency and local reality*** into the process so there is flexibility and little duplication of effort?
- How does ***BSO fit into Health Links*** for seniors? (principle of 'building on existing services' or 'service redesign'). Directly impacts a subset of the Health Links population (BSO) and could be easily built-upon for other populations.
- ***Learning needs of primary care*** related to dementia assessment, management of behaviours, delirium assessment as well as resources/services available.

What ideas, strategies or resources have you used to address this issue?

- Build in ***rigorous communication processes, standard care pathways***.
- ***Similar approach to care coordination*** - ("strict") process, but flexibility to meet patient needs.
- The opportunity to help ***make connections*** for those organizations involved with Health Links to build upon the work of BSO (principles of ***'building on existing services'*** or 'service redesign') and the learning - given our LHIN has been involved in the community with three models for BSO.
- ***Workshops*** on management of dementia and behavioural symptoms, driving and dementia, overview of BSO and opportunities for support from the additional resources, delirium assessment.
- ***RNAO best practice guidelines***.
- Knowledge about the system and how it works - easier to have ***common approach*** (everyone understands roles, how to link to the larger system).
- ***Informing practitioners of services available*** for seniors with complex needs; ***Tools and directories.***

4. Other Common Challenges

a) Inter-agency Collaboration

What about this issue has been challenging for you?

- Getting all partners around the table and ***on the same page***.
- ***Many stakeholders*** to bring together in such a way that keeps the patient at the centre of care.
- Need for ***care coordination and one access point*** but recognition that seniors with complex care don't always enter the system from the same point and vary in preference of who and what should be their central point of care.
- How do ***Community Support Services contribute to Health Links***?
- ***Sharing of patient information*** and data.
- Communication - not a straightforward approach, many partners involved - ***keeping everyone up-to-date.***

What ideas, strategies or resources have you used to address this issue?

- Developing ***integrated program to support housebound seniors*** with complex care needs - new team integrated between Baycrest, CCAC, North York General - shared care with existing primary care providers as well as primary care for those without access to primary care.
- Facilitating partnerships between primary care teams and local services.
- ***Complex Case reviews***, development of new partnerships, development/enhancements of new systems of care (i.e. BSO).
- Home First and BSO to help providers and patients address these issues and ***collaborate using all the resources available.***
- ***'Navigator' role*** (called the Integrated Community Lead) – HNHB LHIN.
- Working to develop knowledge to practice methods that involve ***EMRs as a central tool for*** structuring communication and knowledge to practice approaches.
- Health Links should develop in such a way that ***information and knowledge exchange is truly a mutual process between the medical teams and other health care providers*** serving the client.

b) System Design/Process Barriers

What about this issue has been challenging for you?

- Existing ***structures and processes not easily adaptable*** to meet the needs of this complex group and their caregivers.
- At times the ***resources simply aren't available***.
- Primary care providers and organizations have identified ***challenges with accessing specialist support*** including geriatric psychiatry, language, transportation, availability of home supports, system coordination and navigation

What ideas, strategies or resources have you used to address this issue?

- Hiring a BSO ***Project Facilitator to implement our Primary Care engagement strategy***.
- ***RGPs of Ontario, AKE and Seniors Health Knowledge Network*** have experience and expertise which can be leveraged to assist various Health Links in meeting their mandate

c) Facilitating Change

What ideas, strategies or resources have you used to address this issue?

- ***Identify areas for improvement***. Follow structured way to gain accurate and common understanding of contributing factors. Identify changes that could lead to improvements - by those closest to the process and the patient population. Test the changes using PDSAs
- Try ***small tests of change*** as close to the front line as possible, so that we can make sustainable and effective changes that lead to improvements in our system.
- ***Starting with a very small number*** of patients willing to work with the initial Care Team - give feedback throughout process & provide input to care plan itself. All patients of one family physician - gather the learnings and apply them to Care Team's work with subsequent patients. Then draw on the feedback from Care Team about what was patient-centred, and how much had to change to really understand the patients and design their care plan collaboratively. Will use this material to promote broad, general understanding of why the change is needed. Initial focus is on one diagnostic group, in the hope of ***beginning a standard (but flexible) care pathway***, and through the LHIN, will share that pathway and receive pathways from the other Health Links working with a different group.
- Start with the "vital few". Use structured interview to understand what matters to that person. Bring together the "circle of care" - health care providers and others (e.g., building superintendent) to meet. Invite patient (or his/her advocate)
- ***NHS*** experience based co-design principles , CreST program, HQO patient and family engagement approaches
- ***bestPATH*** as a support for Quality Improvement within Health Links. ***Change packages*** (e.g. transitions, supporting health independence & optimizing chronic disease management) available on HQO website www.hqontario.ca.
- New ***HQO compass*** which has best practices, quality improvement tools - launched 2 weeks ago www.hqontario.ca

NEXT STEPS

Participants of the session also indicated areas for further discussion and moving forward together as outlined below.

What more would you like to discuss with others working with Seniors with Complex Care Needs?

- How to get involved more effectively with primary care.
- How to communicate better with family physicians for health care professionals and family caregivers.
- How to integrate best practice between primary care, LTC, specialized geriatric and geriatric psychiatry.
- Best practice guidelines…how do we share them amongst all Health Links?
- Links with other non-health groups (police, first responders, etc.).
- Solutions for sharing patient information.

Suggestions for Moving Forward Together

- Sharing best practices.
- Continue the discussion around the BSO-Health Link collaboration and how they can support each other.