Expanding the Provision of Integrated Home-Based Primary Care Across Ontario

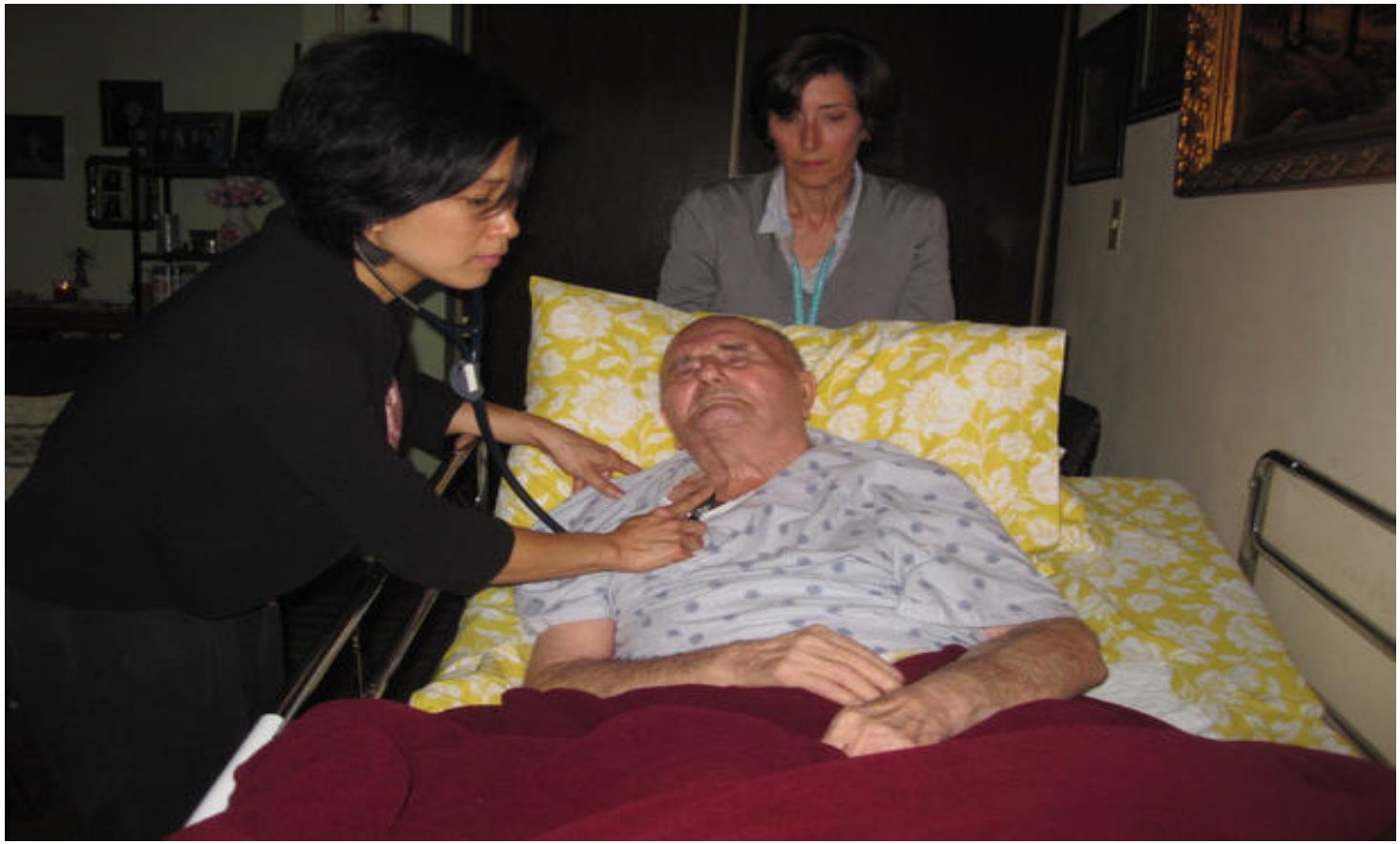
AFTHO 2012
October 16th, 2012

Dr. Sabrina Akhtar TWFHT
Dr. Mark Nowaczynski House Calls
Dr. Tracy Smith-Carrier Researcher, BRIDGES
Dr. Thuy-Nga Pham SEAFHT
Dr. Samir Sinha Dep't of Geriatrics
Dipti Purbhoo CCAC

IHBPC Project and Study Partners

6 Toronto FHTs, House Calls Partnership, and Toronto Central CCAC

Excellent Care for All – Putting the Patient at the Centre



Toronto Star August 2012

A Patient Story…one of so many

Mr D:

2 admissions in the last year for CHF and urinary tract infection.

Discharged home with instructions to follow up with his doctor after discharge…

The only caveat:

He is completely paralyzed and cannot leave his bed at all. He therefore has not seen his doctor in 2 years. His ankles have become more swollen – what is his elderly wife supposed to do now?

Excellent Care for All – Putting the Patient at the Centre

Toronto Star September 2011

A Patient Story…one of so many

Mrs. J:

Was trying to salt her front walkway and felt a "crunch" in her back

History of severe osteoporosis

Now:

Debilitating pain

Unable to leave apartment to seek care

Adverse reactions to narcotics Rx by MedVisit

How to get a handle on her pain and mobility?

Integrated Home-Based Primary Care

PRESENTATION OUTLINE

- Why? – Purpose of our IHBPC Project and Study
- Vision, Mission, Objectives
- IHBPC Program and Patient Population Description
- Understanding CCACs Role
- House Calls Model as a Complement to FHT Models
- IHBPC Primary Care Physician Funding Developments
- Developing a Network of Specialists
- Research and Development Agenda
- Challenges and Opportunities to Support Scalability

A Rising Need for Home-Based Care

- Ontario's 65+ population will **double** over the next two decades, while its 85+ population will **quadruple**
- GTA projected to be the fastest growing region of the province
- We do not know how many frail elders are not having their primary care needs met traditional office-based models
- Access to Care Issues can result in inappropriate and more costly health services utilization.

The Need For New Models of Care

- We need more innovative community-based care models that can deliver the dual goals of
  1. Enabling older adults to live safely in their own homes
  2. Alleviating the utilization of more costly and inappropriate care settings, such as acute care hospitals and long-term care

- This needs to be about delivering the **right care in the right place at the right time.**

Integrated Home-Based Primary Care (IHBPC)

Our Vision

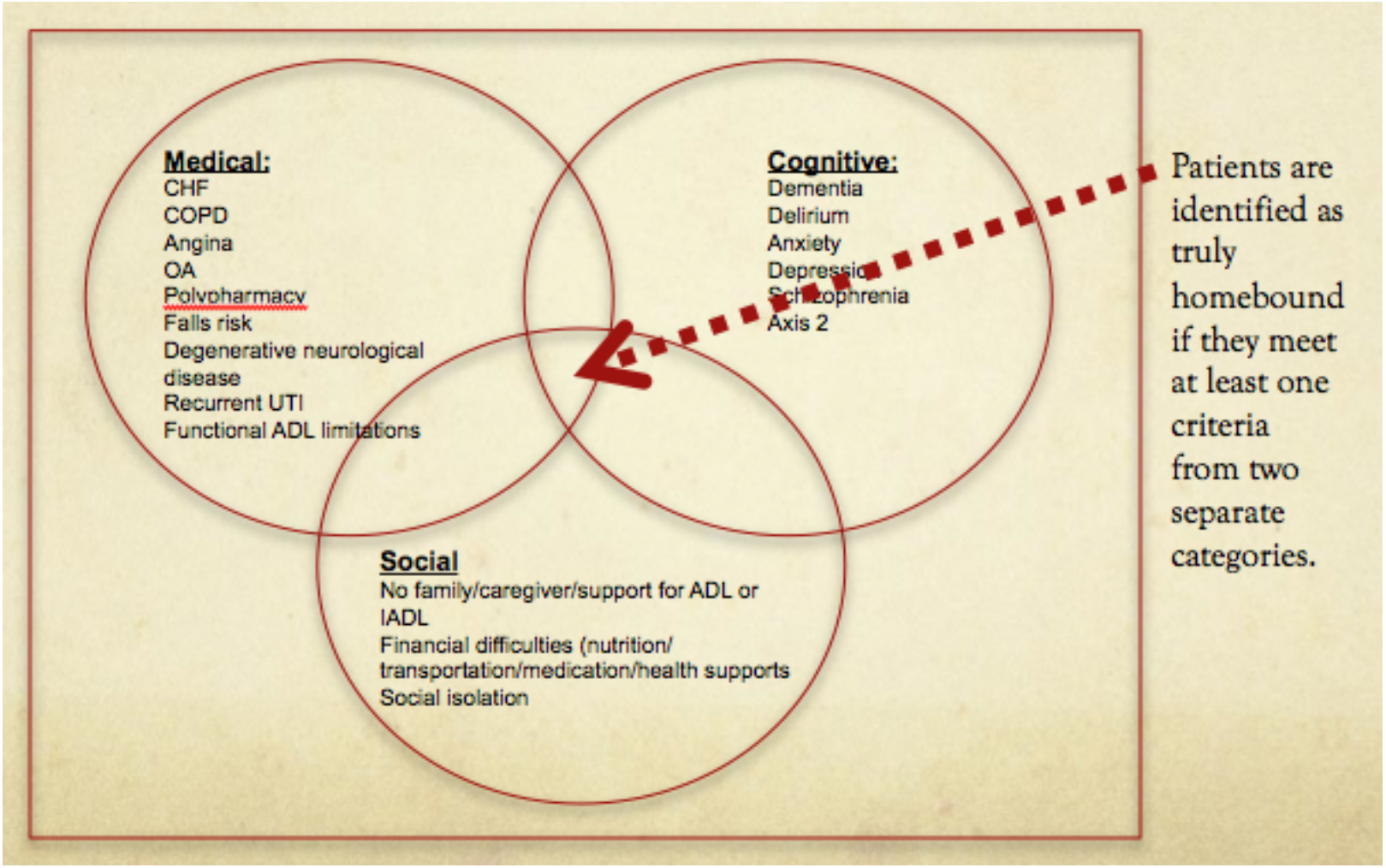
- A system of care that provides improved access to integrated home-based primary care for frail and house-bound older adults whose needs are not met by traditional office-based primary care.

Integrated Home Based Primary Care (IHBPC)

Our Mission

- To maintain patients in the community by providing comprehensive, integrated and ongoing primary and community care for older adults whose needs are not well served by office-based primary care.
- To deliver humane care that respects the choices of older adults to live at home and support their families and caregivers
- To improve quality of care while reducing health care costs and deliver high quality evaluations that demonstrate this
- To provide education and experiences to current and future medical, nursing and allied health professionals in home-based care

Who are Our Patients?



IHBPC Project Patient Enrolment Criteria

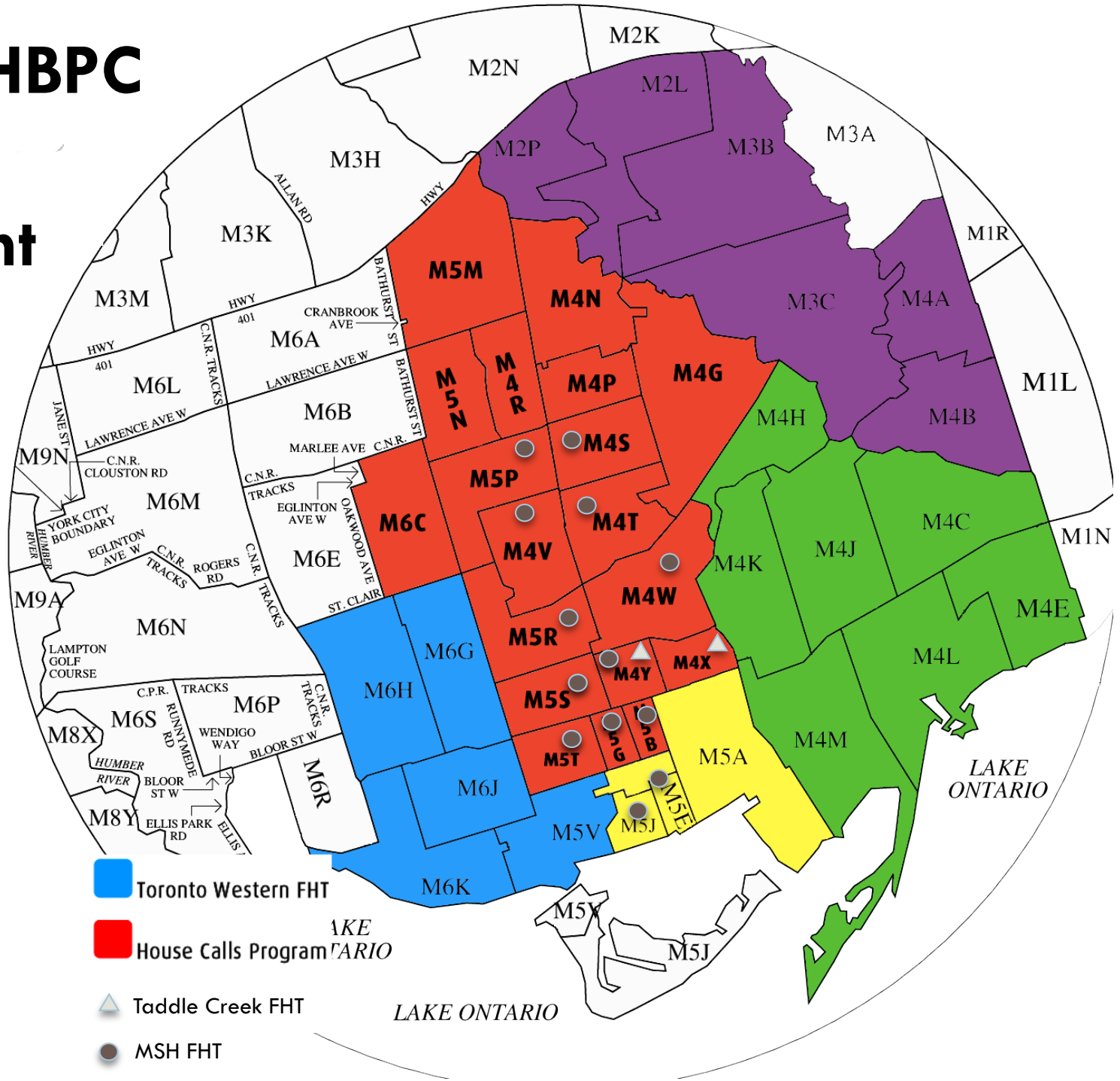
Proposed Core Criteria:

- 65 years or older (age limitation applies only to research study)
- Health care needs are not adequately served by traditional office-based primary care due to physical, cognitive or social barriers
- Patients cannot be living in a retirement or nursing home facility (where access to primary care is available).
- Needs not better met by palliative care services

High priority given to patients who are:

- Unattached to a primary care provider
- Recent discharge from an acute hospitalization within the last 30 days
- 2 or more ED visits in the last 6 months.

Current IHBPC Project Catchment Areas



Catchment Areas are porous

- South East FHT
- St. Michael's FHT
- Sunnybrook FHT
- Toronto Western FHT
- House Calls Program
- Taddle Creek FHT
- MSH FHT

IHBPC Project and Study Objectives

Patient Care Objectives

- **Provide a comprehensive** and integrated approach to home- based patient and client care
- **Improve transitions in care** between acute, primary care and community care settings
- **Establish a network** of specialists to support home-based primary care

Integrated Care Team Objectives

- **Develop shared understanding** of roles, responsibilities and accountabilities between providers
- **Improve communication** among team members and across the continuum of care and organizations
- **Enhance care management partnerships** between primary care and community care providers

MOHLTC Bridges Funded Research Study Objectives

- Investigate the patient, caregiver and system outcomes and benefits attributable to the delivery of a variety of models of integrated home-based primary care.

IHBPC Services & Supports

Work in Progress

Key Clinical Services – Ideal State

- Medication Management and Reconciliation
- Medical Management
- Chronic Disease Management
- Access to Specialty Care
- Access to In-Home Acute Medical Care
- Advanced Care Planning
- End of Life Care
- Linkage to Community and Caregiver Supports

Key Supports – Ideal State

- 24 x 7 Single Point of Access
- Use of a Portable, Unified Record
- Clinical and Community Coordination
- In Home Lab Services
- Integrated, Interprofessional Care
- Capacity Building through Training and Teaching Initiatives
- Support for Transitions in Care
- Telemedicine

IHBPC Team Members

- Primary Care Physician
- Nurse Practitioner
- Physician Assistant
- Nurse
- Pharmacist
- Specialist Physicians
- CCAC Care Coordinator
- Occupational and Physical Therapists
- Social Worker
- Trainees from the health professions
- Community Support Service Agency Staff
- Team Coordinator

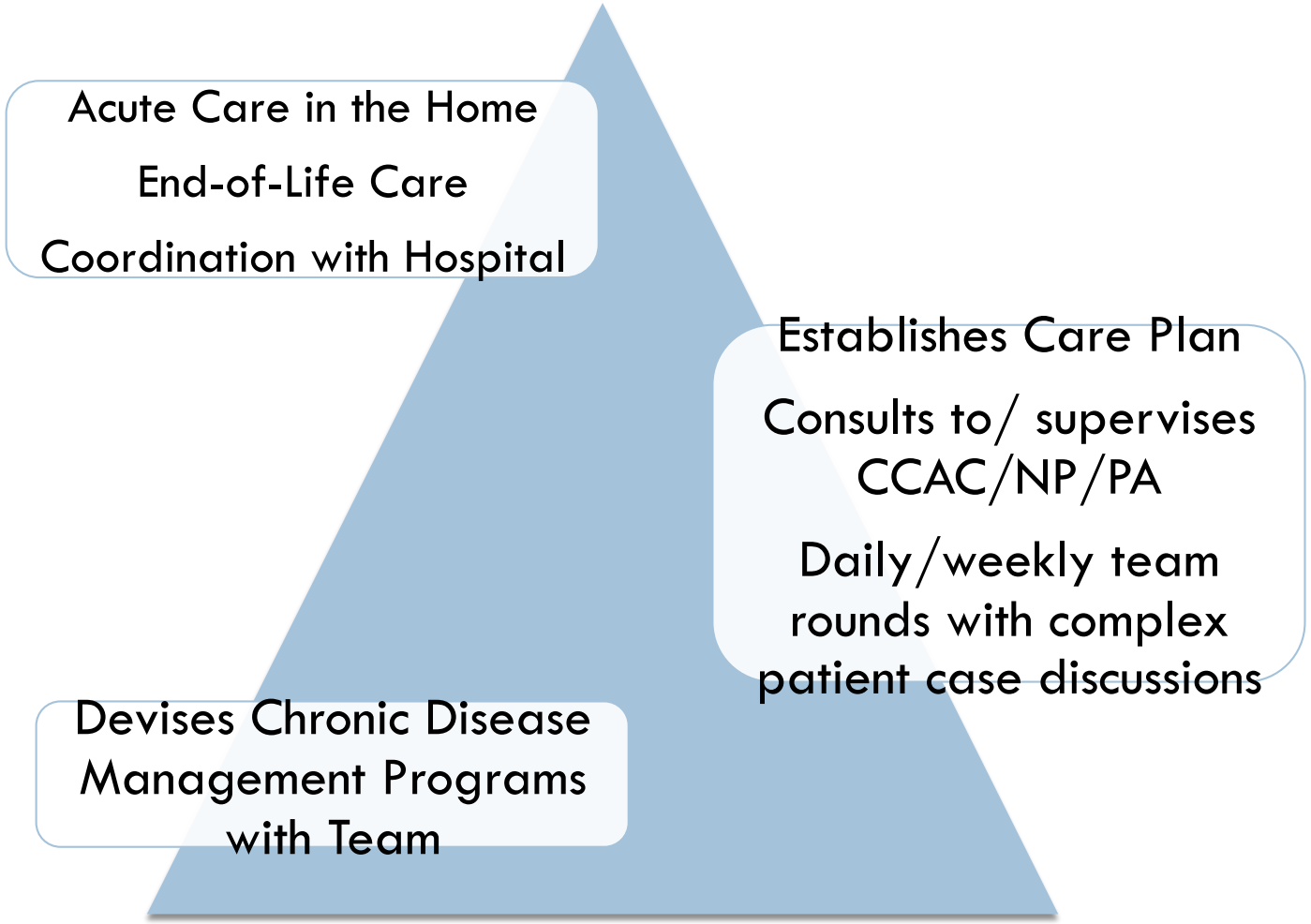
The IHBPC Team

Team Member	Roles and Responsibilities
FHT/HC Family Physician (MRP) (Working as part of an Integrated, Interprofessional Team)	Overseas overall medical and clinical care plan for patients, available for acute complicated medical care. Integrated interdisciplinary team provides ongoing comprehensive team-based care, care planning, and case management.
CCAC Care Coordinator	Intensive case management and system navigation to support patient. Communication and follow up across system. Supports IHBPC teams.
FHT Care Navigator (*Where Available*)	Assists patient in the transition across various sectors, accessing community services
FHT/HC Nurse Practitioner/Physician Assistant/ Nurse	Supports chronic disease management, illness prevention and health promotion, palliative supports, acute episodic care

The IHBPC Team (2)

	Roles and Responsibilities
FHT/CCAC Pharmacist	Provides medication reconciliation, review and patient education
Consultant Specialists to FHT/HC: Geriatricians, Internists, Psychiatrists (*Members/Roles Vary across Programs*)	Attends Case Discussions to FHT/HC at weekly team rounds. Provide Email/Telephone Consultation. Provides Home Visit Consultations.
FHT/CCAC/HC Social Worker	Liaison with community and mental health services and provides psychosocial support
FHT/CCAC/HC Therapists (where available)	Provide in-home assessment and treatment support related to functional issues.
Community Support Services Agency Staff	Provision and Management of Appropriate CSS Agency Services

FHT Family Physician: Right Provider at the Right Place at the Right Time



Using Technology for more efficient and effective Communication

FHT EMR - Instant messaging across the team about a patient

Electronic Hospital Record

Documented care plan available to ED MDs

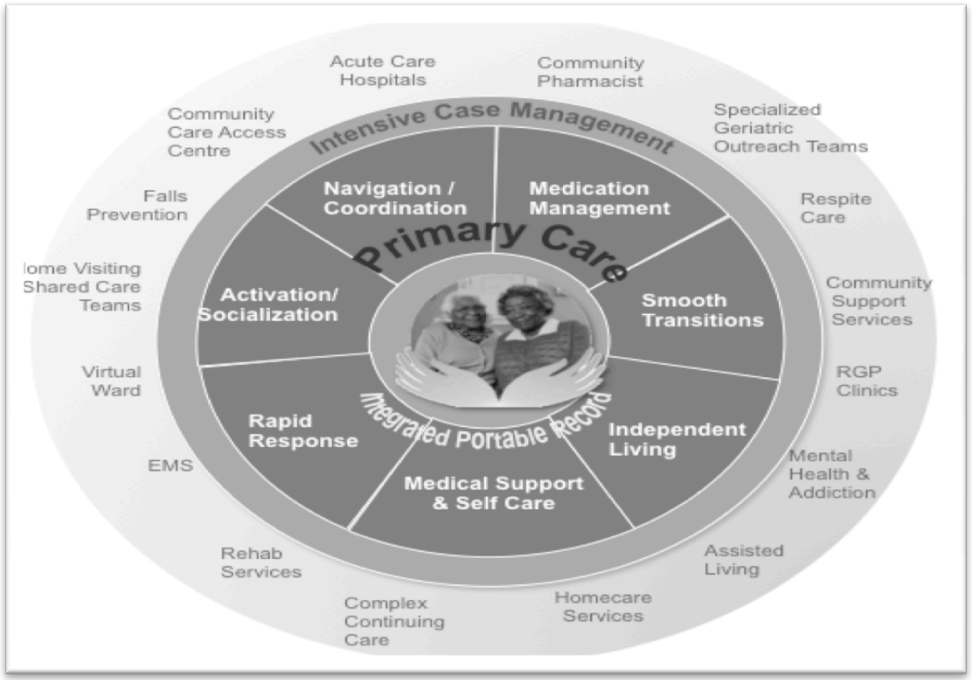
OTN vital sign monitors guide urgency of homevisits/ planned ED consults

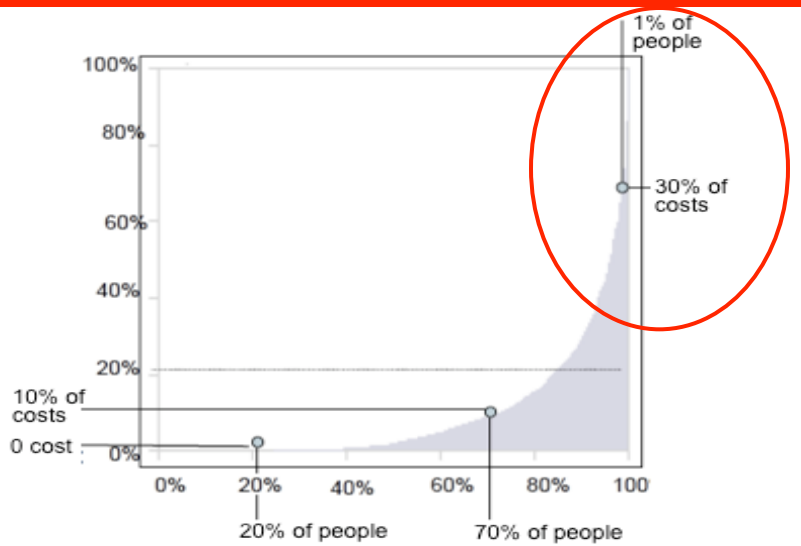
Teleconferencing involving specialists

Text/email/phone for urgent specialist consults

Evolving the Integrated Client Care Project (ICCP) Strategy to better Serve Homebound Seniors

Working as an integrated system to more effectively respond to the needs of these patients at the "top of the pyramid" ***offer one of the most significant opportunities to Improve value and drive sustainability.***





- *2007 Kaiser Permanente report estimates that **1% of the population account 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 those with multiple chronic conditions cost up to 7 times those patients with only one*

ICCP – Seniors is a TC LHIN multi-year strategy to advance integrated care for seniors with the most complex needs across health care sectors and providers

ICCP Strategy Innovation Highlights

Care Coordinators Providing Intensive Case Management	• Increased Home Visits and Case Conferencing • Increased Role in System Navigation and Transitions • Key to Developing Inter-organizational and Inter-professional Care Teams
Primary Care Engagement	• Enhanced Collaborative Working between Physicians and CCAC Care Coordinators • Increased Case Conferencing around Complex Clients
Emergency Medical Service (EMS) Engagement	• Enhanced Communication around ICCP Clients • Emergency Department Transfer Package • Hospital Repatriation System through EMS
Acute Care Engagement	• Flagging Systems • Enhanced Transitions Support • Virtual Case Conferencing via Email at Mount Sinai

Our most critical lesson learned is the need for primary care and community care to work in partnership to support seniors with complex needs

Leveraging the Toronto Central CCAC Population-Based Care Coordination & Integration with Primary Care Strategy

The CCAC Role in IHBPC

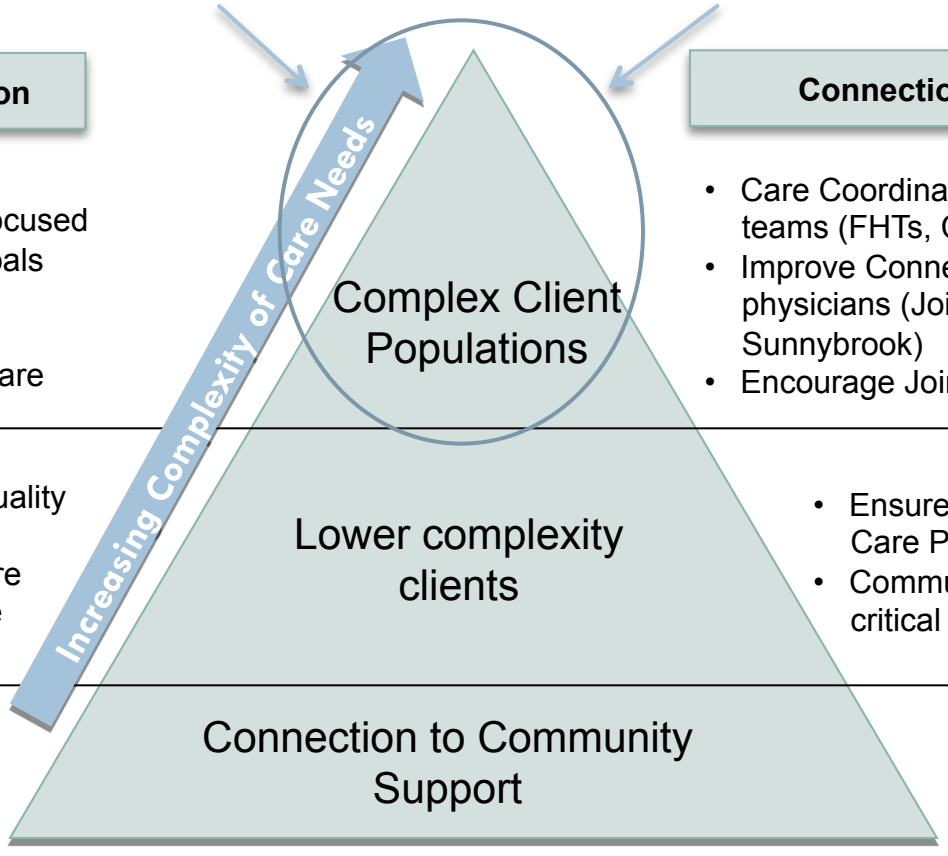
- Each IHBPC Client will be a CCAC Client
- Embed 1 CCAC Care Coordinator in each FHT & Integrate CCAC Care Coordinator with House Calls Team
- Enhance CCAC Clinical Supports for IHBPC Clients & Create a Registry of Homebound Clients

Focus of Care Coordination

- Cross system navigation
- Intensive case management focused on client and family centred goals
- Care Coordination across the continuum
- Joint care plans with primary care

Connection with Primary Care

- Care Coordinators embedded in primary care teams (FHTs, CHCs, House Calls etc.)
- Improve Connections with solo-primary care physicians (Joint work with UHN, Baycrest, Sunnybrook)
- Encourage Joint Visits and Case Conference



- Monitoring health outcomes & quality measures and system linkages
- Ensuring Linkage to Primary Care
- Transitions & Right place of care

- Ensure Clients are linked to Primary Care Physicians
- Communicate to Primary Care at critical points in the client's care

- Information and Referral
- Linkage to primary care
- Linkage to community support

Health Care Connects a key enabler

Building Capacity Across The System

- Sept 2009 – House Calls Program launched with AAHS funding through TC-LHIN
- Family Physician led interdisciplinary team providing ongoing comprehensive HBPC to frail, marginalized, & house-bound seniors who would not otherwise have access to primary care.
- Program based in a CSS Agency (SPRINT)
- MD, NP, SW, OT, Team Coordinator – all 1.0 FTE (MD FFS)
- Nov 2010 – Acute Care Partnership with MSH/UHN Geriatrics
- Aug 2011 – Second Family MD joins HC 0.5 FTE

HouseCalls
Interdisciplinary mobile team serving frail seniors
SPRINT Ontario VHA Home HealthCare Creating More Independence

House Calls – Building Capacity

- **500+** patients enrolled since Sept 2009
- Average Age = **86**
- Multiple Comorbidities with Predicted 1 Year Mortality ~ 85%
- Annual Caseload = **350**
  - High Rate of Attrition – up to 40%/Year
- Current Active Caseload **= 198**

- **Model Effectiveness**
  - 67% of Patients Die at Home
  - 14% and 29% Lower 1 and 3 Month Hospital Readmission Rate post an index Acute Care Hospitalization.

House Calls – Building Capacity

- **Scale** is a Key Driver – Active Caseload of 200

- Building capacity through training, collaboration, and by example.
  - Since 2009 - 50+ Family Medicine Residents, 200+ days
  - House Calls serves as a training hub for HBPC disciplines like nursing, therapy etc.

- Raise Awareness about HBPC
  - *House Calls with my Camera* exhibit @ ROM (2010-2011)

IHBPC Physician Funding Developments

- Care of the Elderly Alternative Funding Plan:
  - 2004 Physician Services Agreement (Palliative, HIV, COE)
  - COE AFP announced 2012

- Focused Practice Family MDs – In Home MRP Model:
  - 0.5 – 1.0 FTE
  - 120 – 150 patients annually/FTE

- Provides competitive remuneration
- COE AFP compatible with House Calls Model of Care
- COE AFP – NO Interdisciplinary Team Funding
- COE AFP – CANNOT be a party to another PEM (FHTs)

Developing a Network of Specialists

- **Specialist Involvement (Geriatricians, General Internists and Psychiatrists) will be integral to developing successful IHBPC Models**
- **Multiple Models of Specialist Involvement**
  - Telephone/Email Consultation
  - Participation in Interprofessional Team Rounds
  - Performing Solo/Joint Home Visits on IHBPC Patients
  - Local Hospitals/Clinics can Support IHBPC Models with Specialist Network Development – especially for rarer needs ie. Endocrinology.
- **Remuneration Models**
  - Sessional Payments Ideal for Rounds Participation and Email and Informal Consultation Participation Models
  - Fee for Service OHIP Billings for Direct Care Activities
- **Training & Education**
  - Opportunities for Educating Specialist Trainees Exist.

IHBPC Research and Development Agenda

- **Qualitative Analysis (IHBCP Research Team)**
  - Interviews with Patients, Caregivers, Team Members & External Stakeholders (e.g., TC-LHIN, SPRINT, CCAC, Physicians not engaged in home visits, etc.)

- **Quantitative and Economic Analysis (AHRC)**
  - Analysis of Hospitalizations, ED visits etc. using ICES data and an Economic Analysis to understand the differences between usual care and IHBPC.

IHBPC Research and Development Agenda

- **Quality Improvement Measures (IHBCP/AHRC Teams)**
  - Established Process Measures Analyses provide rapid feedback.
  - Team Interviews will highlight factors that facilitate or work as barriers to launching and sustaining IHBPC programs.

- **Training & Education**
  - Operations and Education Toolkits & Curriculum Development

Summary of IHBPC Project Measures

Process Measures	Patient & Caregiver Measures*	Team Measures	System Measures*
• Time to first home visit • # of subsequent visits • Time to medication reconciliation • Time to Advance Directives documented • Vaccination Rates • Time to completion of RAI-HC/ reassessments • Time to intervention after call for urgent concern • Date of first team meeting about patient • # team meetings • ETC. *Process Measures Database (AHRC)	• Patient Quality of Life • Caregiver Quality of Life • Caregiver Burden/ Strain • Patient and Caregiver Satisfaction with IHBPC compared to usual care *Qualitative Interviews	• Team Functioning • Facilitators and Barriers to establishing and sustaining IHBPC models • Identified Best Practices	• **Hospitalizations (Primary Outcome)** • ED Visits • Avoidable ED Visits/ Hospitalizations • LTC Admission Rates • Economic Analyses *ICES Data Analysis

Patients Enrolled in IHBPC Project

Family Health Teams & House Calls	Patients Enrolled at Go Live Date (July 1, 2012)	Patients Currently Enrolled (October 2012)
SPRINT	113	248
Mount Sinai Hospital FHT	5	14
South East Toronto FHT	22	31
Sunnybrook Hospital FHT	11	38
Taddle Creek FHT	15	20
Toronto Western Hospital FHT	34	38
St. Michaels Hospital FHT	0	9
Total	**190**	**398**

A Word On Teaching:

Principles of Family Medicine

"[Family physicians] are the doctors closest to people. They heal most of the broken-hearted, repair more of the injured and deprived, and live with the poor and dying who are without hope. ***Adaptation is the juice of family medicine - the FP adapts to the needs of people, or closes up shop****."*

- *William Victor Johnston, MD, First Executive Director of the College of Family Physicians of Canada, 1956-1965*

Future of Family Medicine

- Vision for the Future (2004) recommended that the core curriculum for all family medicine residents include care of the elderly
- A “full service” family physician; comprehensiveness highlighted
- Mandatory functions ”basket of services” for primary care agencies to include: **support for in-home care**

Sample Residency Rotation

- **Competencies:** Residents will develop an approach to integrated and interprofessional primary care of the elderly at home with community support.
  - Discuss the various roles of family physicians in the care of the elderly at home
  - Collaborate with interprofessional care providers in the care of the elderly at home
  - Demonstrate proficiency in a primary care comprehensive geriatric assessment, including appropriately thorough histories and physical examinations for elderly patients in a timely manner in the home setting
  - Describe available home care community resources and acute care supports
  - Demonstrate an effective approach to the presentation of common conditions, undifferentiated illness, and chronic disease in the elderly
  - Demonstrate an effective approach to the elderly patient presenting with confusion or cognitive impairment
  - Demonstrate medication management and reconciliation skills for elderly patients in the home
  - Discuss the role of the family physician in end of life/palliative care
  - Describe the impact of non-medical patient and family characteristics on health and well-being
  - Describe the impact of community and culture on health and well-being
  - Describe current health care system supports for home-based care and future directions for Canadian/Ontarian policy

Methods:

Mentored one-on-one home visits with program faculty (Week 1)
Scheduled and Same-Day house calls accompanies by RN and supervised by faculty over phone and in the office on return (Week 2-4)
Participation in weekly HBCP rounds (Tuesdays 12:30h)
1-2 patients accepted into resident's longitudinal practice
Case-based house calls and end-of-life seminars (TBA)
Pharmacy Home Medication Reconciliation Session

Evaluation:

Direct observation of resident at patients' bedsides in their homes – Field Notes
Professionalism & Ethics

IHBPC Project - Next Steps

- MOHLTC BRIDGES Study ongoing until Spring 2013
- CCAC Establishment of Additional Infrastructure to Support IHBPC ie. Homebound Adults Registry
- Development and Dissemination of IHBPC Operations Toolkit
- Development and Dissemination of IHBPC Training Curriculum and Educational Toolkit for family physicians of the future across the 6 Toronto Academic FHTs and House Calls Programs.
- Establishment of Support Network of Specialists and Family Physicians dedicated to IHBPC

Challenges and Opportunities for FHTs

Challenges and Proposed Solutions

- **New Alternate Funding Plan for Care of the Elderly - does not apply to FHT physicians:**

  - Adjust Capitation Fees to reflect Home-Bound Patients;
  - Extend AFP Eligibility to FHT Family Physicians;
  - Move Home Visit Codes out of basket.

- **Lack of Identification Systems for Eligible Patients that have difficulty accessing standard office-based care:**

  - Building an organized network of providers and a registry of patients in need of home visits

Challenges and Opportunities for FHTs

- **Lack of Integrated Medical Records:**

  Support the Development of shared electronic medical records across sectors for our patients

- **Limited Human Resources**

  Support the Adoption of New Technology: OTN Telemedicine, iStat, Turtles – need for pilots to improve access to care for our patients

- **Current Community Services are solely Chronic Disease Management Oriented:**

  Support the expansion of acute care community services to be delivered in patients' homes such as rapid iv fluids, iv antibiotics, imagine and intensive support (ie.Hospital at Home)

Scalability Across FHTs in Ontario

- Prioritize the establishment of home visit teams within each FHT to support IHBPC – a minimum of an MD and a NP/PA/ RN to start out with.

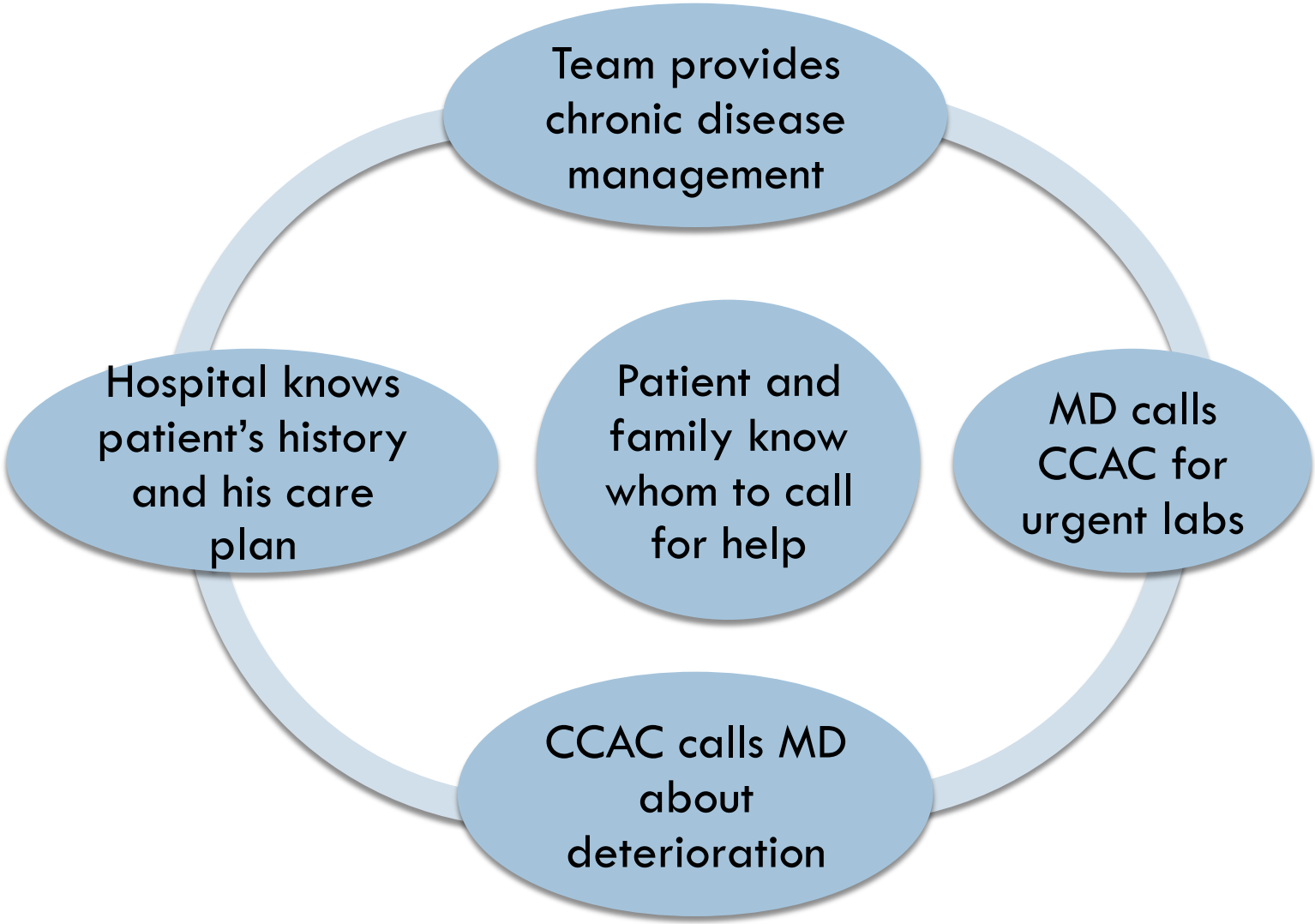
- Encourage and support close partnerships between local FHTs and CCACs in order to maximize clinical and community supports for homebound patients

Scalability Across FHTs in Ontario

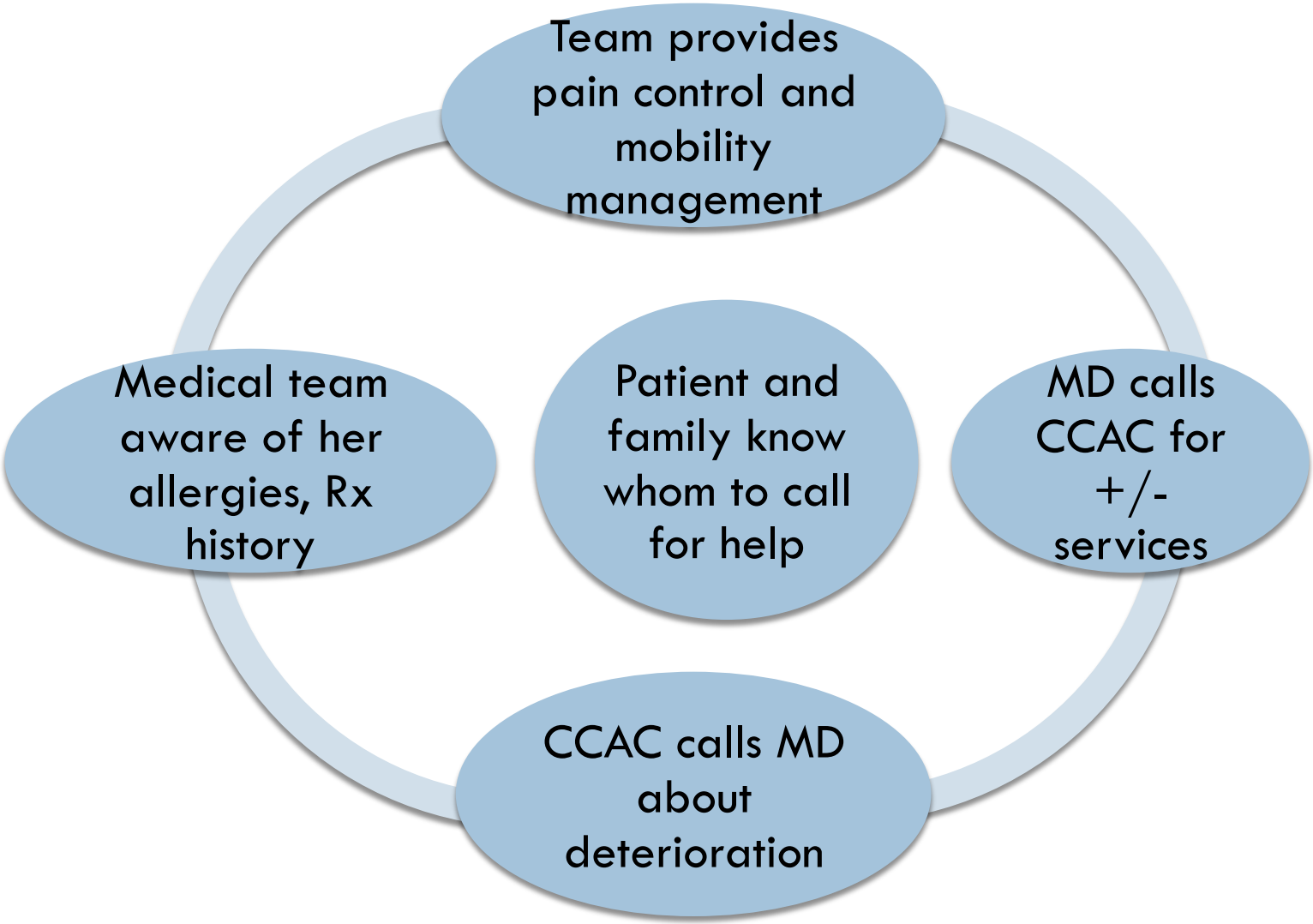
- Build capacity within CCAC to increase scope of urgent clinical services provided in the community (and thereby avoid unnecessary ED visits)

- Expand integration of OTN/telemedicine into FHTs/CCACs to better monitor homebound patients

Mr D's Care…


Team provides chronic disease management
Hospital knows patient's history and his care plan
Patient and family know whom to call for help
MD calls CCAC for urgent labs
CCAC calls MD about deterioration

Mrs. J's Care…


Team provides pain control and mobility management
Medical team aware of her allergies, Rx history
Patient and family know whom to call for help
MD calls CCAC for +/- services
CCAC calls MD about deterioration

Thank You!

Questions…?