

# HIGH IMPACT PRACTICES

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

## Developing an Integrated Primary and Home & Community Care System

This High Impact Practice describes the integration of home & community care and primary care as an important component to a new overarching philosophy – Home Is Best™ – which is being implemented across the Fraser Health Authority in British Columbia. The philosophy states that home, not hospital or residential care, is the best place to recover from an illness or injury, manage long-term conditions and live out final days. Although Home is Best™ was pioneered by Fraser Health, a similar philosophy is starting to be adopted by other B.C. Health Authorities.

Home Is Best™ is not only a philosophy but a system-wide approach to health care involving a strengthened and structured partnership between home & community care services, acute care, and primary care to improve a senior's journey within the health care system. Within the Home Is Best™ philosophy, partners agree to work together to ensure that individuals are discharged from hospital as soon as they no longer require acute services, and are supported in their homes to continue to recover or to consider other care options, or to wait for placement in residential care. At a system level, Home is Best™ is a bundle of system enablers, such as proactive discharge planning, expanded community support services, increased access to home care services, and telephone outreach, that will help seniors stay healthy in their homes for longer, return home after a hospital stay as soon as possible, and prevent or delay admission to hospital or residential care until necessary.

Ensuring that clients can access the right care at the right time in the right place with the right provider is critical to achieving best client outcomes, quality of life and effective health service delivery. Through the partnership, enabled by the Home is Best™ philosophy, clinicians are able to work in new ways to make the best and most appropriate use of

existing hospital and residential care capacity. The structural and cultural shifts are achieved by the re-organization of services provided through the Health Authority and the addition of new health professionals and community services. Through the Home is Best™ philosophy, the way community care is organized and delivered is changing and collaboration across traditional health and social care boundaries is occurring.

Through the integration of primary care and home & community care, seniors, who have been telling health care providers they want to stay in their homes as long as possible, are provided with the services and tools to realize their goals. In several prototype communities, their care is now coordinated by a health care team working alongside their family physician in a structured way. Those with less complex issues are contacted regularly by a 'surveillance nurse' who can intervene if necessary to avoid further deterioration. Building adequate home and community supports is integral to this approach. As a result, seniors and their families are less likely to experience a crisis or feel isolated knowing that adequate supports will be there when they need them. Families and clients can feel confident that home truly is a safe and viable option.

The results in the prototype communities are encouraging, as evidenced by improved health system indicators. The new philosophy and approach to care has resulted in reductions in the time it takes to admit a client to community services; a decrease in the number of patients designated as 'alternate level of care' (ALC); shorter hospital length of stay; and reduced emergency room visits. Furthermore, health care clinicians are more satisfied and effective, as this new approach encourages professionals to practice to their full scope to meet the needs of clients who are best served by their interventions.

## BACKGROUND

As in much of Canada, British Columbia (BC) is challenged to meet the increasing demand for health care within the available resources. Key pressure points include:

- An aging population
- An increase in individuals with complex and chronic conditions
- Shortages of health human resources
- System capacity limitations

To address the issues, the BC Ministry of Health committed to optimizing and redesigning key areas of service delivery. The strategies focus on promoting and improving the overall health of the population and addressing the unique needs of patients or specific patient groups, such as those with chronic diseases, frail seniors and individuals with mental illness and/or substance use disorders.

In its Service Plan,<sup>ii</sup> the Ministry announced a new focus on health care delivery in the community and committed to the Integration of Primary Care and Home & Community Care by 2015.<sup>iii</sup> The care would be patient-centred; coordinated, easily accessible and seamless. Fundamentally, the Ministry expected the system to change:

- From one that is reactive to one that treats individuals proactively in order to keep them as well as possible.
- From one that is reliant on the practitioners operating independently to one that values and encourages collaboration.
- From one that is centred on hospital care to one that has keeping people at home as the priority.

The Plan identified two key metrics:

- 1) the percentage of general practitioner physicians providing chronic disease management, and,
- 2) the percentage of people aged 75+ receiving home health care and support.

The Plan supports the call for change. Users of the health care system, while appreciative of the care they have received have said they found it to be fragmented, uncoordinated and disconnected.<sup>iv</sup> Clinicians concur. However, a number of projects in Fraser Health have demonstrated that the system can be changed and good care in the community can be realized. For example, a Physician / Case Manager Partnership Model tested in one community in Fraser Health in 2007/08 showed a 33% decrease in ER visits, a 61% decrease in hospitalizations, and increased client satisfaction.<sup>v</sup> This work needed to be leveraged as a component of the overarching philosophy – Home is Best™.

As Dr. Scott Markey said, [Prior to this redesign] “We were working in parallel universes” but once the reciprocal sharing of relevant clinical and social information started they began to wonder how they operated before.<sup>vi</sup>

## A fundamental structural change

A significant and fundamentally different approach to structural integration is required to enable the full implementation of the Home is Best™ philosophy. This complex second order change is expected to take a minimum of 36 months to complete. In the Fraser Health Authority, regional leadership, management and administrative structures to support the new delivery model were implemented over an 18-month period beginning in December 2009. A new integrated organizational model was developed. In the new structure, the management of all acute medical beds or all surgical beds is the responsibility of one executive director and medical director who manage the hospital beds regionally, in contrast to site by site, as under the previous structure. Regional health care services including all acute medical beds, community care and primary care are integrated under a single vice president to whom executive directors report. This new organizational paradigm changes the conversation about where and how resources are deployed and priorities set. The structural integration fosters new performance metrics that address the continuum of care across all settings and outcomes for the patient as opposed to sector-specific results.

## The Model of Primary and Community Care Integration in BC

A key component of the new integration paradigm is a vision of a community-based system of care and support services that is built around a person's attachment to their family physician who is part of an extended integrated team that collaborates effectively to 'wrap around' the physician and the patient.

The primary and community care team is a three-way partnership between acute, primary and community all working in collaboration. Members of the team depend on the needs and resources of the community.

In Fraser Health, the first steps to achieving this vision were the formation of partnerships between the home & community programs and in creating partnerships with primary care physicians. Fraser Health will have redesigned five of 12 communities by March 31, 2012. Having started in smaller communities in order to test the change and evaluate the results, this represents approximately one quarter of the region's population.

The strategies to effect the change include training and education. Using the expanded chronic care model as the foundation for this new shift to community-based health care, clinicians are provided with quality improvement methodologies and tools to assess, plan, implement and evaluate changes. This approach allows for the accommodation of unique local requirements enabling continued responsiveness within the broader model. Tracking data by patient populations at a practice level, by health area and by region, provide the necessary information to support continuous quality improvement.

Engagement of patients, families, caregivers and communities in the process to redesign home & community care is a vital component of enhanced integration. All stakeholders need to

understand the shift in focus and their role in self-management of their health (as opposed to waiting to treat their illness), and be aware of the intent of the health system to provide comprehensive support to enable them to remain safely at home.

### IMPLEMENTATION

The Model of Primary and Community Care Integration was implemented and tested in one BC community – Chilliwack. Chilliwack was selected as a prototype because it is a medium-sized homogeneous population with a high incidence of chronic disease. The population is slightly older and there are a number of community resources already in place that could be leveraged. The lessons learned served to guide other partnerships as they were formed.

#### Community services were redesigned

The home care case managers started to work directly with family doctors (referred to as General Practitioners, or GPs, in BC) in their practices to jointly support adult patients with chronic, complex and/or ongoing health needs; and who are already long-term care clients of the home care program. In order to streamline care and improve consistency within the team, the case managers were reorganized and assigned to a specific physician in order to streamline communications and enable better partnering. An official agreement was structured in order to emphasize the new approach and commitment to meet and actively collaborate on care strategies. Depending on the size and nature of the practice, the family doctor and case manager schedule regular case conference meetings (e.g. weekly or biweekly) or, case conference on an as-needed basis, either in person or over the telephone.

Any concerns that home care would become “too medical” or that the partnership would “waste time” quickly dissipated. The dedicated case manager and physician immediately recognized that they had information that was useful to each other and more importantly would improve care for their patients.

#### Proactive Role of the Case Manager

Client-focused, as opposed to service-focused, methods of providing care were embraced. Case managers engaged in proactive interventions and as members of the primary care partnership participated in working toward population-based outcomes. Targeted populations included adults with chronic or complex health conditions and the frail elderly.

The case manager’s new role is to understand the client and their support systems, to help identify priorities and to collaborate on a care plan with the client, family and the family physician. The work of the case manager involves facilitating referrals to community partners; coordinating care services, coaching the client/family (and sometimes the physician) to navigate the health care system; and coaching the client/family to appropriately access care when at risk of, or experiencing, declining health and/or functional status. The case manager also monitors the client’s recovery post-hospital care and supports them to regain their function.

#### Broadening and Strengthening Linkages

Access to mental health, geriatric care, and public health by the community care team was strengthened and linkages are reinforced by the participation of family physicians at the Collaborative Services Committee (CSC). The CSC comprises representatives from the Ministry of Health, the local Health Authority, and representatives from the Division of Family Practice, an organized group of local GPs. The purpose is to enable system issues to be identified and addressed collectively. For physicians it is a “shift from being isolated to being genuinely involved and having influence in the system”. For example, in Chilliwack, the CSC identified a need for integration of mental health, home health and older adult programs to better serve older adults experiencing a health crisis and being admitted to acute care. While the outcome is not yet known as the work is still in process, the appropriate persons are around the table and working together to find a more effective approach for this population.

#### New Roles, New Responsibilities

A Surveillance Nurse position was created within home care to assume the coordination responsibility for clients who have stable care plans. This allows the case manager to focus on clients who are newly referred, and those who require intense case management. The Surveillance Nurse contacts clients via the telephone and conducts a structured assessment based on the established care plan. In so doing the Nurse is able to address client questions, provide direction or clarification, or encourage the client to visit the doctor. The Nurse is able to modify the care plan based on the outcomes of the conversation (i.e. make a referral or alter home support hours) or, if warranted, request the case manager to conduct a home visit. The dialogue also serves as follow-up to reinforce health care messages and the plan of care and provide coaching on managing health-related issues, or refer to community-based programs and services. Calls typically are 20-30 minutes in duration and are fully documented as part of the client’s health care record. If required, follow-up information may be mailed to the client.

**“I like learning new things from the doctor and I know they learn some things from me... I also feel respected and a team member with something to give. Therefore, I have satisfaction with my job and myself.”**

– Case Manager

Support staff have been hired to provide administrative, non-clinical functions that had been found to consume as much as 25 percent of case manager time. Activities such as contacting the client for basic demographic, social and other collateral data prior to the case manager's visit, performing financial assessments, booking facility respite or supporting referrals for other services or to community partners are now the responsibility of the Client Services Assistant.

## OUTCOMES

The goal of the Model of Primary & Community Care Integration is to improve the outcomes of clients who have long-term health conditions that impact their function and well being. In so doing avoidable emergency room visits and hospital admissions can be decreased; hospital stays, for those requiring the expertise of the acute care team, shortened. Ultimately people will be able to live at home longer, with improved quality of life.

**“The case manager is aware of my patients’ situations, does home visits, is very clued into the situation and the problems involved... helps me tremendously to get through some of the bureaucratic issues I struggle with...is very committed to the patients and her job.”**  
— Family physician

The model anticipated achieving the “bid dot” (areas where a significant difference can be made) Triple Aim<sup>vii</sup> metrics:

- Improved population health by improving the health outcomes of each individual.
- Improved patient/provider experience through the realization of effective access and navigation of the community-based health care system.
- System sustainability as evidenced by reduced per capita costs for target populations; reduced emergency room visits and decreased hospital length of stay.

To date, the early results are very promising. Practitioners and clients are reporting more productive, meaningful relationships and interactions. They report feeling more secure in the care that

is provided. Family physicians have increased confidence in the system and the quality of care that their patients can receive at home. In the past 12 months there has been a five percent increase in the numbers of individuals discharged home who would have otherwise been headed for residential care.

Throughout the Fraser Health Authority, teams continue to refine processes for case conferencing, client/patient referrals, patient confidentiality and other issues that arise. Clients and families are enthusiastic. As one client said, “I feel more confident and in control. I’m living safely at home.”

## CONCLUSION

A fundamental philosophy shift, an innovative policy direction and a new model of operational and clinical integration will help people stay out of the hospital, maintain independence and remain living at home. Home is Best™ embraces three fundamental components:

1. Home care integration with primary care.
2. Enhanced home and community programming.
3. Strengthened acute care linkages.

The health care team can keep people safe at home and/or return them home from hospital as soon as they are ready. By partnering with family doctors and other health care professionals, more in-depth care can be provided and attention placed on the client's full range of health care needs.

Home is normal and is the best place for most individuals to age, manage or recover from an illness, or receive palliative care. Any decisions regarding a change in living circumstances can be made from the normalcy of the home setting and during a period of wellness and stable health. Individuals can be supported to prepare for a smooth transition.

Home is Best™ is the core philosophy of health system transformation currently underway in the province of British Columbia. Integration of Primary Care and Home & Community Care is the foundation of this new approach.

### SPECIAL THANKS TO THESE KEY INFORMANTS:

**Lynda Foley**, Executive Director, Home Health, End of Life, Delta Hospital & Community, Fraser Health

**Irene Sheppard**, Clinical Director, Home Health, Fraser Health

**Bonnie Irving**, Senior Consultant, Communications and Public Affairs, Fraser Health

### ENDNOTES

i Retrieved on July 21, 2011 from <http://www.fraserhealth.ca>

ii <http://www.bcbudget.gov.bc.ca/2011/sp/pdf/ministry/hlth.pdf>

iii Ministry of Health. Health Service Plan 2010/11 – 2012 /13. British Columbia

iv Foley, Linda. (2010) Developing an Integrated Primary and Community Care System. Presentation at 2010 CHCA Home Care Summit. Quebec City

v Evaluation of Physician Care Partnership. Fraser Health

vi Retrieved on July 28, 2011 from <http://www.youtube.com/watch?v=jVVEN0Rpx64>

vii Triple Aim is a framework developed by the Institute for Healthcare Improvement (IHI) to derive better health care value from the resources invested.