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Enabling Aging in Place Promising Practices: KW4 Ontario Health Team Integrated Care Team for Older Adults

The following promising practice was prepared following interviews with the KW4 Ontario Health Team integrated care team in the fall of 2024. Healthcare Excellence Canada would like to formally acknowledge their generosity in sharing their skills, knowledge, expertise and experiences to inform this promising practice.

About Healthcare Excellence Canada

Healthcare Excellence Canada (HEC) works with partners to spread innovation, build capability and catalyze policy change so that everyone in Canada has safe and high-quality healthcare. Through collaborations with patients, essential care partners and people working in healthcare, we turn proven innovations into lasting improvements in all dimensions of healthcare excellence.

HEC focuses on improving care of older adults, bringing care closer to home and supporting pandemic recovery and resilience – with quality and safety embedded across all our efforts. We are committed to fostering inclusive, culturally safe and equitable care through engagement with different groups, including patients and essential care partners, First Nations, Métis and Inuit, healthcare workers and more.

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Model description

The KW4 Ontario Health Team (OHT) Integrated Care Team for Older Adults (KW4 ICT) is an innovative, primary care-based support model that provides older adults with complex health conditions with direct access to a specialized geriatric integrated care team embedded within a primary care setting. The integrated care team is led by a nurse practitioner and supported by a geriatrician, geriatric psychiatrist, pharmacist and other care professionals with geriatric expertise who collaborate to offer comprehensive support to older adults, their caregivers and primary care providers.

The motivation for this innovation was to provide integrated and geriatrician-supported multi-disciplinary health and social care to older adults with complex care needs, ensuring person-centred and efficient care. The co-location and interprofessional philosophy of the team ensures that care is coordinated, with the patient's goals and wishes known to all, such that care gaps, duplication and mistakes are averted.

The purpose of the KW4 OHT's integrated care team is to develop individualized care plans and interventions in collaboration with the primary care provider, the older adult and their caregivers. The goal is to identify older adults early in their frailty journey and support their health and social care needs, thereby avoiding urgent specialist intervention or institutionalization.

The KW4 OHT integrated care team was designed to:

- embed into primary care the capacity to perform an interprofessional comprehensive geriatric assessment for higher-risk older adults, and develop and implement an associated person-centred plan of care
- embed a palliative approach for older adults in a primary care setting
- optimize the self-management capacity of older adults and their informal care partners
- provide ongoing case management
- reduce the burden on older adults and caregivers of attending multiple appointments
- expedite and ensure referrals to community service programs
- reduce the primary care burden through a shared care model provided through the integrated care team
- optimize the time of geriatric specialists through shared care

The KW4 OHT integrated care team meets weekly to review referrals. If an older adult is not suitable for the KW4 OHT integrated care team, the team ensures they are directed to more appropriate resources. Once an older adult is accepted, a nurse practitioner is assigned to their case, with support from additional team members as needed. This approach emphasizes person-centred support for older adults with complex health needs by focusing on identifying personal goals, managing symptoms, and supporting advanced care planning.

The clinical workflow of the KW4 OHT integrated care team follows these steps:

1. **Referral** – The integrated care team receives a referral for an older adult with complex conditions who could benefit from a multidisciplinary team in a primary care setting. Referrals come through multiple channels: primary care providers, interRAI Assessment Urgency Algorithm case finding, emergency departments and other hospital services (including Alternate Level of Care designation, the SCOPE1 program and specialized geriatric services.

2. **Initial assessment** – At intake, patients or caregivers complete the interRAI Check-up Self-Report (CU-SR) intake assessment, with optional support from non-clinical staff. The interRAI Assessment Urgency Algorithm (AUA), a validated risk screener, then prioritizes cases for a comprehensive geriatric assessment, with higher scores indicating greater urgency for an enhanced assessment by members of the integrated care team. The AUA provides additional algorithmic assessments of cognitive function, daily living activities, mood, pain, frailty-related health instability (CHESS scale) and the risk of falls and emergency room visits.

3. **Medication review** – The team's pharmacist compiles the Best Possible Medication History, conducts a comprehensive medication review and makes deprescribing and optimization recommendations.

4. **Case review** – A nurse practitioner reviews the case and collects clinical information from all relevant sources: the older adult, their caregiver, their primary care provider, medical records (recent investigations, imaging, consult notes) and support organizations such as retirement homes.

5. **Care planning** – The integrated care team develops a preliminary care plan for each older adult during a weekly case conferencing meeting, triaging high-risk cases. These meetings are attended bi-weekly by approximately 10 community support service organizations and are hosted by the integrated care team.

6. **Patient visit** – Based on needs, the older adult is seen either at the New Vision Family Health Team (FHT), at one of the affiliated primary care offices or at home by a geriatrician, geriatric psychiatrist or other team member. During this visit, the integrated care team connects older adults and caregivers to community resources (e.g. home care, Alzheimer's

[1] Seamless Care Optimizing the Patient Experience (SCOPE) operating within KW4 hospitals.

Society). Following this visit, older adults continue to work with the integrated care team in a shared care model through clinic visits, home visits and telephone consultations.

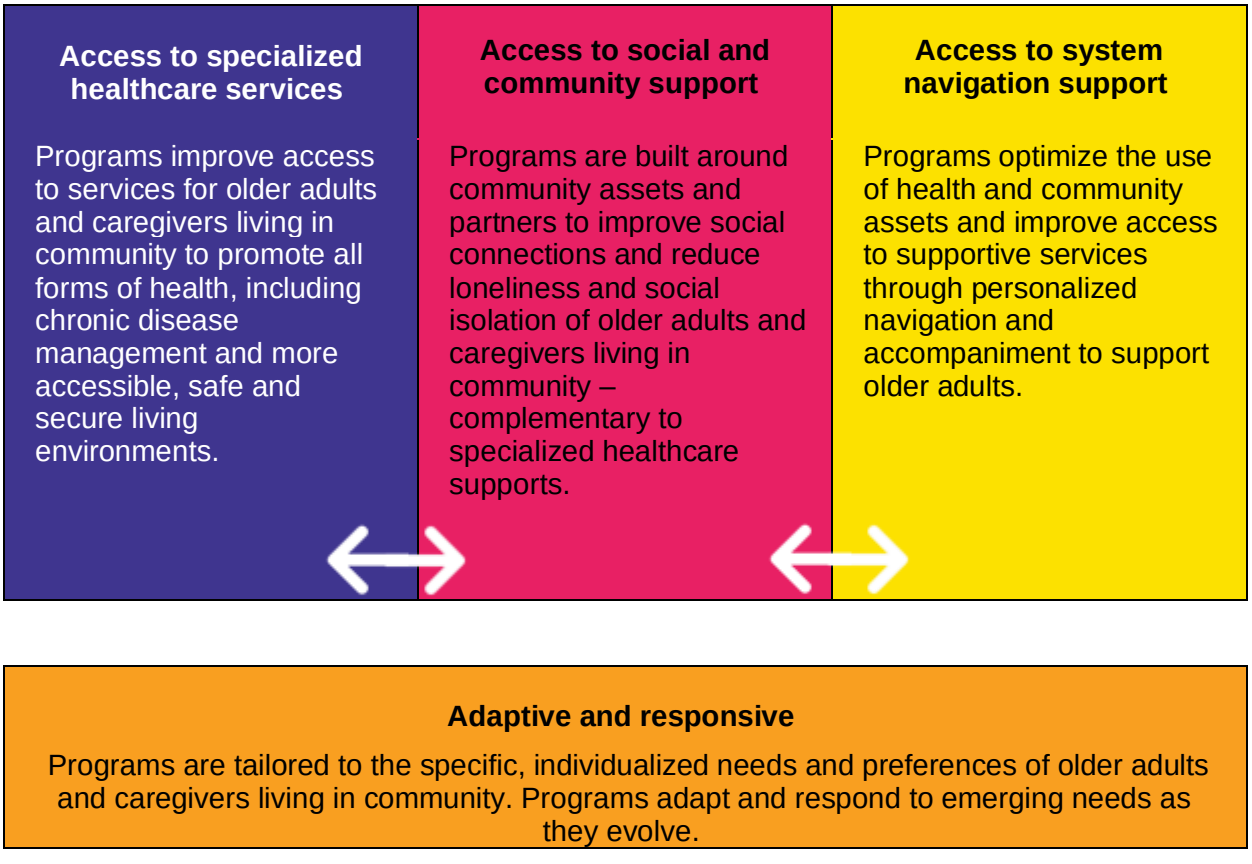
7. **Provider communication** – Finally, the care plan and assessment information are sent back to the older adult's primary care provider along with the team's contact information for any follow-up questions.

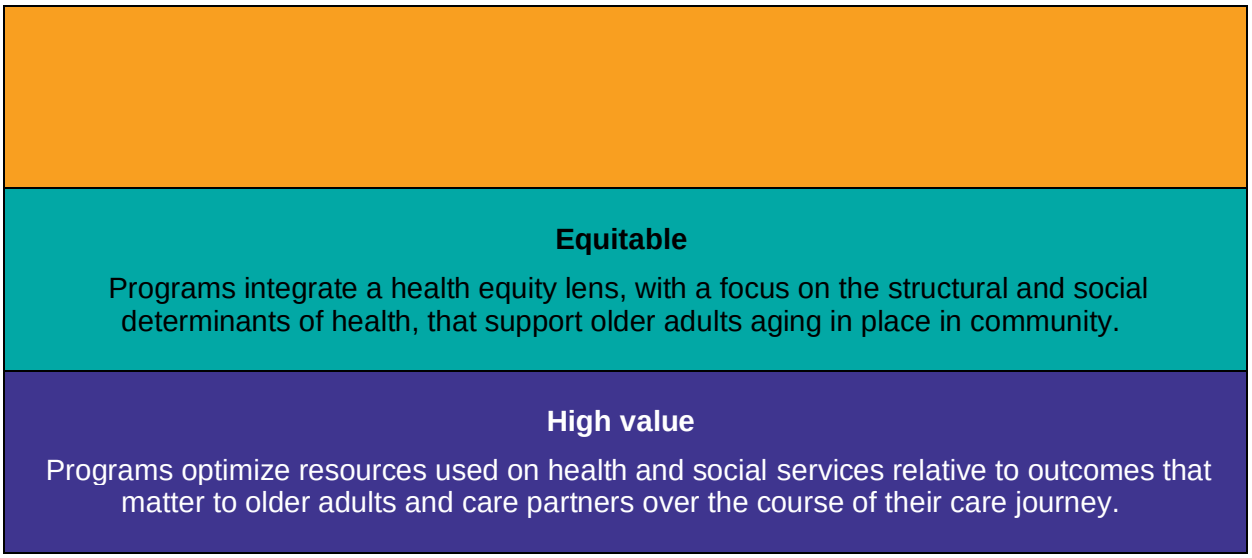
These seven steps typically occur within three to four weeks, accelerating older adults' access to a comprehensive geriatric assessment and referral to appropriate community resources.

In 2023, the KW4 OHT integrated care team expanded to three additional organizations in Kitchener-Waterloo: Westside Family Medicine Centre, Waterloo Region Family Health Organization and Frederick Street Medical Clinic. This expansion added 25 new family health organization physicians to the region and now serves 5,277 adults age 65+ (as of August 2024).

Enabling aging-in-place principles

Person-centredness is a core philosophy of HEC's Enabling Aging in Place program. All the principles must be implemented in a person-centred way and reflect a deep understanding of community assets and the needs of older adults and their care partners.





The following reflects how the KW4 OHT integrated care team fulfils HEC's Enabling Aging in Place program principles:

Access to specialized healthcare services – The KW4 OHT integrated care team provides timely access to a comprehensive geriatric assessment, which has been shown to reduce acute care utilization and improve quality of life with the potential to delay older adults from entering long-term care homes. The program facilitates direct referrals to specialized community partners, and communicates assessments, findings or referrals directly with the older adult's primary care provider.

Access to social and community support – The KW4 OHT integrated care team recognizes the importance of addressing the needs of the older adult's caregiver by assessing their requirements and connecting them to appropriate social, mental and physical supports. This comprehensive approach enables the integrated care team to directly refer the older adult to relevant community resources, ensuring both the caregiver and the older adult receive the necessary support for optimal care.

Access to system navigation support – The KW4 OHT integrated care team supports system navigation by providing information and direct referrals to community and healthcare resources. Team members are readily accessible by telephone and email, providing assistance to prevent older adults' reliance on emergency departments.

Adaptive and responsive – The KW4 OHT integrated care team prioritizes older adults' needs and adjusts to changes in an older adult's health status. Care planning and coordination are tailored to each individual's needs and preferences, with referrals to additional resources provided as new health conditions arise.

Equitable – The KW4 OHT integrated care team accepts older adults from all referral sources, including those who are unattached or unable to access a primary care physician. The program also regularly accepts referrals from the Kitchener-Waterloo shelter system.

High Value – The KW4 OHT integrated care team effectively optimizes resource utilization by significantly reducing the clinic waitlist for accessing a geriatrician. This approach facilitates prompt connections between older adults and their geriatricians, helping to prevent unnecessary emergency department visits.

Implementation

Assessing needs and assets: The KW4 OHT integrated care team for older adults was developed in 2017 by Dr. Sarah Gimbel following a qualitative evaluation of the chronic disease management programs in the New Vision FHT. The evaluation revealed that a subset of older, more complex adults was accessing multiple programs simultaneously in an uncoordinated manner. This inefficiency, caused by redundant assessments and fragmented care, highlighted system issues within the FHT.

To address these challenges, the New Vision FHT, supported by the Frail Elderly Working Group of the KW4 Ontario Health Team, piloted the integrated care team model. This shared-care approach combined geriatrician services with nursing, pharmacy, primary care and community support services. The pilot aimed to assist patients on the waiting list for specialized geriatric services and streamline access to community-based clinics and services. The successful model has since been incorporated as standard practice within the KW4 OHT integrated care team.

KW4 OHT integrated care team: The KW4 OHT integrated care team consists of nurse practitioners, a registered nurse, a lead administrator, a clinical pharmacist, a geriatrician and a geriatric psychiatrist. The lead administrator's primary responsibilities include receiving referrals, creating older adult charts and contacting older adults' primary care providers when applicable.

Target population: The program is available for anyone living in the Kitchener-Waterloo area who presents with geriatric symptoms, regardless of age. During screening and enrollment, if an older adult is not a suitable for the KW4 OHT integrated care team, the team facilitates a referral to a more appropriate service.

Partnerships: The KW4 OHT integrated care team partners directly with organizations across the Kitchener-Waterloo area, including:

- St. Mary's General Hospital
- Hospice Waterloo
- Alzheimer Society Waterloo Wellington
- Home and Community Care Support Services Waterloo Wellington
- Region of Waterloo Paramedic Services
- GeriMedRisk consultation service
- Canadian Mental Health Association Waterloo Wellington

The KW4 OHT integrated care team is seeking formal partnerships with additional acute care settings.

Adaptations over time: The premise of the program has remained stable over time. The only significant change is recent hiring of additional staff such as a nurse practitioner and a registered nurse to support the expansion.

Evaluation and impact[2]

The KW4 OHT integrated care team has proven effective in streamlining primary care, improving prescribing practices and reducing emergency department visits. An evaluation of the KW4 OHT integrated care team pilot highlighted the following outcomes.[3]

Emergency department visits: Data from an evaluation[4,5] of the KW4 OHT integrated care team showed the program reduced emergency department visits by 49.5 percent. The most common reason for emergency department visits was falls.

Impact on geriatrician waitlists: At the onset of the integrated care team pilot initiative, a target was set to address 100 older adults from the Geriatric Medicine Complex Care Clinic waitlist. Over the six-week pilot, the integrated care team contacted 138 patients, showcasing the interprofessional team's efficiency in contacting, triaging and managing waitlisted individuals. Of these, 27 patients were re-triaged as more urgent and seen by a geriatrician (while the remaining received follow-up by the integrated care team). Notably, only one of the 27 required follow-up with a geriatrician, compared to the usual practice of at least one, often more.

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[2] The evaluation and impact information shared reflects information available at the time of writing this promising practice. HEC would like to acknowledge that evaluation activities are an ongoing process for many promising practices and the type of data collected is influenced by program goals, the length of time the program has been implemented and the level of resources available to support evaluation.
[3] Cote-Boileau E, Gimbel S, Gregg S, Heckman G, Morrison A. Final Evaluation. KW4 OHT Integrated Care Team Pilot; 2022.
[4]Gimbel S, Segedi O, Leslie D. Reducing Silos and Improving Health Care Experience: Wrapping Team-based Care around Complex Geriatric Patients. AFHTO 2019 Conference, Toronto, Ontario.
[5] Heckman G, Gimbel S, Mensink C, Kroetsch B, Jones A, Nasim A, Northwood M, Elliott J, Morrison A. The Integrated Care Team: A primary care based-approach to support older adults with complex health needs; 2024.

Given that follow-ups can take 45 minutes – half the time of a full consultation – the Integrated Care Team approach significantly improved geriatricians' capacity to see new patients.

Community referrals: The weekly case conferencing meetings resulted in a diverse range of community referrals, investigations and medication change recommendations. In the first two quarters of 2024, 293 unique older adults were served, resulting in 1,369 encounters. Among these, 117 were initial visits, while 1,060 follow-up visits occurred (all visits took place in the office, via telephone or in-home). The table below shows a breakdown of older adults referred to community services from early April to the end of September 2024.

Service	Number of referrals
CSC	14
Exercise	8
Transportation	6
Meals	6
Home care	19
Physiotherapy	24
Day program	7
Chronic obstructive pulmonary disease activation program	0
Community responsive behaviour team	2
Specialized geriatric services	0
Alzheimer's Society	14
Other	13

Improved experience for older adults: Feedback from older adults and their caregivers highlights the positive impact of the KW4 OHT integrated care team. This model delivers comprehensive geriatric assessments, ensures follow-up to implement recommendations, promotes self-care and supports system navigation – all within the primary care setting. The following quotes illustrate the critical support this model provides.

"[NP] has been our nurse practitioner for the last two years so she would constantly be in touch with us and with [geriatrician] and [pharmacist] to make sure … for adjusting his medication that was great. Something that we would probably have to take my dad to hospital and they will try to facilitate this medication adjustment. She was just there constantly and so we were able to adjust my dad's medication."[5]

"[Care recipient] had a nasty wound on his leg and they [home and community care] could not send anybody for over a month. So [NP] helped me. She asked me to send her photographs, which I did and she arranged for a prescription to be delivered for antibiotic cream and explained what I should do to care for it … she called back then next weekend, "How's it going and everything there," she was just a tremendous help."[5]

"The doctor came here a couple of months ago and my husband has Parkinson's and he wanted to increase his medication. But we had talked to [NP] about this and she checked with the pharmacist and they said no. He was on the maximum and she said she would check that out elsewhere and that they did have a geriatrician that helped him out. So, Dr. actually came out here to our home and sat with [patient] for over an hour going over the problems, the timings of when he took the medication. All this stuff and yes, he fully agreed with adding an extra pill a day, so he was a tremendous help."[5]

Patient and caregiver survey: In a survey completed by 31 patients and caregivers, 85 percent rated their overall experience with the KW4 OHT integrated care team as satisfied or very satisfied and 77 percent agreed or somewhat agreed that it was helpful to be contacted by a member of the team. Additionally, 68 percent agreed or somewhat agreed that the program assisted them with their health contacts, and 77 percent agreed or somewhat agreed that the program would be helpful to access in the future if it were available.

Primary care provider survey: Of those primary care providers who responded to the survey (n=17), 82 percent agreed or somewhat agreed that the program was helpful in the overall management of their patients. In addition, 88 percent agreed that the KW4 OHT integrated care team contacted their patients and communicated a care plan promptly, and 94 percent agreed or somewhat agreed that they would find it helpful to access the team's resources such as this for complex geriatric patients in the future.

Team member survey: Of the 11 KW4 OHT integrated care team members who were contacted including geriatricians, a pharmacist, a system navigator, a care coordinator and community care support services, 100 percent were satisfied or very satisfied with their overall experience working with the team. Additionally, 73 percent agreed or strongly agreed that the integrated care team helped support their role in caring for patients and their families, and 100 percent agreed or strongly agreed that it:

- helped connect patients and their care partners to community resources
- allowed team members to collaborate with other providers and community resources
- tried to identify medical and social concerns of patients and their care partners
- helped triage patients to facilitate the highest-risk patients being seen promptly

Team members (90 percent) also indicated they would find it helpful for their role to work within a similar integrated care team in the future if it were available.

Keys to success

Shared care model: The KW4 OHT integrated care team employs a shared care model that emphasizes a patient-centred approach, establishing collaborative goals between patients and

healthcare providers. This model facilitates effective clinical handovers among providers, ensuring well-coordinated care. The approach is particularly beneficial for geriatricians, as it minimizes waitlists by enabling the team to manage numerous appointments and refer patients to appropriate services efficiently. As a result, the geriatrician's caseload can be focused on new assessments, as the team is highly proficient at implementing care recommendations and providing case management support. This is crucial for older adults, whose health status can fluctuate frequently, making a one-time consultation insufficient. Even after patients are discharged, the KW4 OHT integrated care team provides contact information for any follow-up questions or concerns, and patients have the option to re-refer themselves to the program at any time.

Clinical assessment tools: The interRAI Check-Up and Self-Reported Carer Needs (SCaN) tools allow the team to gather information on patients before their visits so that less time is spent collecting information on medical history and more time can be spent addressing their concerns and goals of care. The AUA tool allows the team to risk-stratify patients and prioritize those that are the most in need. Furthermore, these instruments are fully compatible with interRAI instruments already widely implemented in Canada, including in home care, community support services and long-term care. Ontario is currently upgrading its interRAI information management system, which includes the Check Up Self-Report, and which will make this information more widely available to all care teams. Thus, the use of the Check Up in primary care brings this important sector inline, from an information and data perspective, with other geriatric services in the community.

Focusing on the caregiver: The interRAI SCaN tool is utilized to assess the needs of caregivers. The KW4 OHT integrated care team reviews these needs and provides recommendations or adjustments as necessary. Additionally, caregivers may be referred to other community support resources for further assistance.

Key challenges

Lack of consistent base funding: KW4 OHT integrated care team is actively seeking base funding, though past efforts have been unsuccessful. Demonstrating the program's economic value through available data remains a challenge, as the metrics needed to clearly convey its impact and cost-effectiveness are complex and not always readily available. Compounding this challenge is the lack of formal recognition within existing health ministry policies and funding structures for specialized cases provided by allied health professionals in primary care settings.

Access to acute care spaces: Acute care settings often serve as a critical point for identifying and addressing urgent health issues that require immediate intervention. Without access to these patients, the KW4 OHT integrated care team may miss opportunities to engage individuals in need of follow-up care or preventive services, thereby potentially overlooking critical aspects of patient management.

Integration of electronic health records: This challenge exists at multiple levels. Even when primary care practices use similar software, differences in servers, firewalls and virtual networks often require labour-intensive, case-by-case solutions, decreasing clinical efficiency. More

significantly, substantial barriers to information sharing between primary and acute care can disrupt well-established plans of care, potentially causing harm. Finally, significant data from home care and other sectors is rarely shared with other providers within the circle of care, further hindering integration and continuity.

Funding

Currently, the KW4 OHT integrated care team does not have multi-year consistent funding and receives yearly funding from Ontario Health West.