

Toronto Central  
Community Care Access Centre



Centre d'accès aux soins communautaires  
du Centre-Toronto

## Physicians' Forum for High Risk Seniors

A forum convened by the Toronto Central LHIN and the Toronto Central CCAC to identify opportunities and ideas for supporting family/general practitioners to care for high-risk and frail seniors

### **SUMMARY REPORT** **January 2009**

# Physicians' Forum for High Risk Frail Seniors

## SUMMARY NOTES

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#### **Available upon Request**

List of Participants attending Forum  
Material Presented at Forum  
Forum Feedback Survey Results  
Forum Interactive Session Highlights

## EXECUTIVE SUMMARY

Given increased efforts to maintain high-risk frail seniors in the community in the face of a relative shortage of family/general practitioners providing care in the home, the Toronto Central LHIN and the Toronto Central CCAC partnered to engage family/general practitioners in addressing the needs of high-risk frail seniors living in the community. They jointly hosted the ‘Physicians Forum for High Risk Seniors’ where 26 physicians and 24 service providers participated. Issues and projects, grouped by theme, important to the provision of community care for frail seniors were identified throughout the Forum.

	<b>Theme</b>
<b>Issues and Challenges</b>	<ul style="list-style-type: none"> <li>• Funding</li> <li>• Training</li> <li>• Knowledge and Lack of Resources</li> <li>• Communication and Coordination</li> <li>• Physician Support</li> <li>• Client Complexity</li> <li>• Physician Coverage</li> </ul>
<b>Strategies and Projects</b>	<ul style="list-style-type: none"> <li>• Funding</li> <li>• Models of Care and Service Delivery</li> <li>• Service Gaps and Provider Relationships</li> <li>• Capacity Building</li> <li>• Education</li> <li>• Resource Information</li> </ul>

Building on these results, key funding, planning, education, service provider and physician opportunities were identified that will improve care to high-risk seniors. As a part of a go-forward strategy, it is important for additional organizations and stakeholders to consider these opportunities and champion associated initiatives.

## 1. CONTEXT

### Background & Purpose

The timing is right for transformational change with real impact for our seniors – both action and leadership are required. The Toronto Central Local Health Integration Network (TC-LHIN) and the Toronto Central Community Care Access Centre (TC-CCAC) partnered to engage physicians, particularly family/general practitioners, in addressing the needs of high-risk frail seniors living in the community.

This document summarizes the strategic context in which the engagement took place, highlights the findings arising from a 'Physicians Forum for High Risk Frail Seniors' and outlines key activities in moving forward. Its purpose is to provide advice to influential leaders about key initiatives that will make a positive difference in the health and well-being of high-risk, frail seniors.

### TC-LHIN

The Toronto Central Local Health Integration Network (TC-LHIN) has made seniors a priority and articulated a vision for the Aging at Home Strategy -

*To enable seniors to live independently in their own homes and communities by providing safe and effective supports that are responsive to their diverse needs and those of their caregivers.*

The vision is accompanied by Aging at Home investments that totals \$48 million over a three-year period:

2008 / 09	\$ 6,194,791
2009 / 10	\$15,394,886
2010 / 2011	\$27,189,738
<b>TOTAL</b>	<b>\$48,779,415</b>

In its first year, the TC-LHIN's strategy is designed to help frail and marginalized seniors by:

- Expanding supportive housing services in under-served neighbourhoods
- Increasing transportation to medical appointments and wellness activities
- Increasing help for seniors in their homes
- Expanding the registry of resources available

The first year strategy benefits physicians, seniors and the system by:

- Reducing visits to Emergency Departments
- Safely transitioning seniors from hospital to home
- Reducing Alternate Level of Care numbers
- Supporting previously homeless seniors find housing
- Delaying long term care home admissions
- Helping seniors navigate the healthcare system

## TC-CCAC

Aligning the CCAC to LHIN boundaries gave the TC-CCAC a fresh start and the opportunity to -

- Build locally to better respond to clients' needs
- Focus its expertise to complement its partners
- Strengthen relationships within the LHIN to resolve system issues
- Increase capacity to introduce, test and replicate innovations

The TC-CCAC has made seniors a priority – targeting those most at risk and finding new ways of working that reduce need for acute and long term care. Effectively meeting their needs challenges the organization to find new ways of working with others and delivering client services.

In 2007, the TC-CCAC sponsored research to better understand the needs of seniors at risk of long term care placement. A total of 1,800 clients waiting for long term care beds were reviewed with the finding that 65% of people experienced difficulty with day-to-day tasks such as meal preparation, housekeeping and medication management. It was clear that far more individuals could be maintained in the community if more integrated care options were available with medical support from family/general practitioners.

Partnerships with the LHIN hospitals, community agencies and Emergency Medical Services (EMS) are demonstrating the potential of new innovations in how the TC-CCAC works. The power of partnership is enormous, but requires more understanding and commitment. Physician engagement helps to identify essential supports and better ways of working together and create true 'circles of care' around the most vulnerable.

## 2. FORUM

### Planning Committee

A group of individuals came together to plan the Forum. The Planning Committee was comprised of five family physicians as well as leaders from the Toronto Central LHIN and the Toronto Central CCAC:

Dr. Lisa Berger, MD Anne Johnston Health Centre  
Bobbie Carefoote, WC Healthcare Consulting  
Stacey Daub, Toronto Central CCAC  
Dr. Phil Ellison, MD UHN –TWH & Toronto Central CCAC  
Dr. Jamie Meuser, MD Family and Community Medicine, University of Toronto & Toronto Central CCAC  
Dr. Mark Nowaczynski, MD Home-Based Geriatric Primary Care  
Laura Pisko-Bezruchko, Toronto Central LHIN  
Dr. Mark Silverman, MD Anne Johnston Health Centre  
Dr. Kingsley Watts, MD St. Joseph's Family Medicine

### Objectives

The Planning Committee's aim was to bring together family/general practitioners physicians in a one-day focused session to identify and address the service challenges of high-risk and frail seniors living in the community. The goal was to go beyond issue identification and priority setting to creating a plan of action that would improve the care and services that seniors receive in the community. The Forum objectives included:

- To understand the context of seniors care including the Toronto Central LHIN's \$48M Aging at Home Strategy;
- To learn more about what is available to support family/general practice physicians providing care in the home;
- To speak directly with other physicians about the challenges of service provision;
- To apply research evidence and leading practices to identify solutions and create a 'go forward' plan.

### Overview of the Forum

The Forum was designed to achieve the stated objectives and was subdivided into four broad sections. It also met the accreditation criteria of the College of Family Physicians of Canada and was accredited for up to 4.5 Mainpro-M1 credits.

- The first part provided contextual information with presentations from Toronto Central LHIN and Toronto Central CCAC leaders. Dr. Paul Williams from the University of Toronto spoke about research evidence and leading practices.
- The second part was a panel presentation from four physicians that highlighted current practice delivery models (private practice, family health

team and community health centre).

- The third part engaged participants in an interactive discussion about the service challenges posed by caring for frail high-risk seniors in the community and the challenges to engaging physicians.
- The fourth part took the identified opportunities and narrowed the list to approximately 15 opportunities.

### **Attendees**

The Forum was held between 8:00 a.m. and 2:00 p.m. on Friday May 30 2008 at the Estates of Sunnybrook (Vaughn Estate) and was facilitated by Erik Lockhart from the School of Business, Queens University. Participants included 26 physicians and 24 service providers for a total of 50 participants.

### 3. PARTICIPANT COMMENTS

#### Feedback about the Forum

Over 80% of participants completed a feedback form and the responses indicate that the Forum was well received. It achieved its objectives in an appropriate environment and was expertly facilitated. Participants learned from each other, were respected and provided with opportunities to present their viewpoints.

#### Issues & Challenges Identified

Forum participants were asked the question “What are the service challenges in providing care to high risk, frail elderly seniors in the community?” Close to 70 issues were identified and grouped thematically:

- **Funding:** insufficient funding for compensation and incentives for family physicians/general practitioners to do house calls; for engaging with others caring for the frail seniors; and, for seeking out resources and keeping abreast of emerging trends and services for seniors
- **Training:** lack of practitioner training and knowledge in the care of seniors in their homes
- **Knowledge & Resources:** lack of knowledge and access to resources in community; confusion about service eligibility and how the system works; and, lack of timely access to short term senior and other specialist assessments
- **Communication & coordination:** lack of coordination between primary and community care and across practitioners
- **Physician Support:** lack of an interdisciplinary team to provide monitoring and allied health expertise and support
- **Client complexity:** the increasing complexity of care needs given the multicultural, mental health and cognitive status of frail seniors
- **Physician Coverage:** insufficient family physicians/general practitioners available to provide primary care to frail seniors with complex care needs, in the home and in their offices; lack of back-up coverage

#### Strategies & Projects Identified

Forum participants were also asked “What ideas can you suggest to engage the physicians in providing care to high risk, frail seniors in the community?” Over 75 projects emerged and were then narrowed to a few initiatives that addressed the following areas:

- Funding
- Models of care and service delivery
- Service gaps and provider relationships
- Capacity Building
- Education
- Resource Information

Participants suggested that the results of the Forum be consolidated and explored by the Planning Committee’s in the creation of a ‘go-forward’ plan

## 4. MOVING FORWARD

### Overview

The Planning Committee considered the opportunities generated at the Forum and is providing advice to influential decision makers who may be interested in sponsoring one (or more) of the opportunities.

Many of the opportunities relate to three primary aims and require support beyond those organizations initially involved in the Forum:

- Increasing access to health services
- Optimizing service capacity
- Providing family/general practice physicians prepared to provide medical care in the home with education & information

While the Toronto Central CCAC and the Toronto Central LHIN sponsored the Physicians' Forum, the time is right for other organizations to consider the opportunity of championing or sponsoring one or more of the proposed initiatives. For this reason, the Planning Committee has outlined the opportunities that are beneficial for funders, planners, service providers, educators and physicians to pursue.

### Funding Opportunities

- Explore physician compensation models or Alternative Payment Plans that
  - Provide incentives for physicians to care for frail, high-risk seniors in their home environments
  - Include attractive & equivalent fees for home visits & back-up coverage such as time based assessment fees and/or sessional fees for care in the home
  - Facilitate comparable physician compensation regardless of setting of care
  - Support physicians making a certain number of home visits per week appropriate to their practice
  - Support salary based funding for physicians specializing in the care for seniors
- Other funding opportunities include
  - Coverage for home-based lab testing, imaging, eye, foot and dental care
  - Assistive Device Program funding for home accessibility
  - Outcome based funding models that enable providers to be more flexible and integrated in serving frail seniors
  - Additional funding for meeting Instrumental Activities of Daily Living (IADL) needs for select seniors as indicated in research studies (i.e. Balance of Care) - homemaking, transportation, meal preparation, escort services, etc.

## **Planning Opportunities**

- Sponsor an annual Toronto Seniors Day that can include
  - Best practices in the care of seniors – clinical, service delivery, etc
  - Networking opportunities for like-minded physicians
  - Showcasing available services / service delivery models
  - Continuing Medical Education (CME) for attendance
- Other planning opportunities include
  - Advocating for group practice models that integrate primary and community care
  - Enhancing the availability of culturally competent care
  - Identifying ‘orphaned’ or ‘estranged’ seniors and assign these seniors to group practices
  - Supporting a physician ‘return of service training’ in community elder care

## **Education Opportunities**

- Create Physician Mentoring Program(s) that include joint home visits
- Incorporate into medical residency curricula programs that achieve the following:
  - Create excitement about serving seniors
  - Provide early socialization in caring for frail seniors
  - Develop expertise & comfort in the care of seniors
  - Develop connections & understanding of community based care
  - Establish the care of frail seniors as a competency/requirement & accreditation standard
- Develop Continuing Education Programs and Processes for Physicians, such as:
  - Mandatory CME on the care of frail seniors which could include mentoring, clinical experiences, and education forums.
  - Education on best practices in seniors care which could include internet blogs, website, articles, forum, and CME
  - Specialized training to become community physicians focused on the care of seniors.

## **Service Provider Opportunities**

- Test new models of scalable sustainable community-based service delivery, such as:
  - ‘Wrap-around’ Inter-professional care (IPC) teams or circles of care that support and extend the reach of primary care practitioners in the community
  - Virtual or roving IPC team(s) that can provide immediate support where needed
  - Neighbourhood models that support local family physicians/general practitioners in accessing & coordinating services for their seniors
  - Designate ‘seniors’ system navigators, care coordinators or ‘point persons’ and assign them to physicians who care for high-risk, frail

## Physician Opportunities

- seniors
  - Embed CCAC care coordinator staff within Community Health Centres, Family Health Teams and other integrated roster based group models
  - More integrated communication between primary care and community care providers (e.g. e-health, Electronic Medical Record, and single source patient record)
- Support the development and expectation for ‘Elder friendly’ hospitals where best practices for seniors care are adopted in the emergency and inpatient settings
- Implement information strategies to inform / support physicians such as
  - Centralized provincial info line for seniors care
  - Dedicated information line for physicians to ask questions / access support
  - Specific web-based folder for physicians in the Community Care Resources
  - Designated LHIN-based website for seniors care information
  - A physician’s blog for seniors care that allows for real-time problem-solving
- Improve equity of access to geriatric specialty teams across the LHIN
- Identify Seniors Assessment Units that will investigate, stabilize, and possibly coordinate care for frail seniors.
- Develop Cultural/Language based Programs
- Create a network of physicians interested in the care of seniors. Possible network activities include:
  - Identify family/general practice physicians prepared to provide house calls to home-bound or frail seniors
  - Create a list of physicians prepared to mentor other physicians
  - Outline physician information /education / support needs
  - Provide advice to Planners / Service Providers
  - Plan events for information sharing (pub night, tele-rounds, etc)
  - Advocate for seniors’ services