

POSTER ABSTRACT

Implementing and Evaluating a Model of Care Coordination in Primary Care for Older Adults using a Co-Design Approach

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Background: Older Canadians with chronic diseases are the biggest users of the health care system. Primary health care (PHC) could play a central, coordinating role in assessing and managing older adults, but at present lacks specific strategies to fulfil this role. Priorities for enhanced care coordination in PHC include: 1) consistent processes to identify and assess older persons and create individual care plans aligned with risk levels; 2) improved care coordination and system navigation; 3) improved access to appropriate services; and 4) improved patient and caregiver engagement (Heckman et al., 2013; World Health Organization, 2008; Wagner, 2000; Goodwin et al., 2013).

Aims: This study aims to understand how a model of risk-stratified care coordination for older adults can be developed and implemented in primary care. Information gathered will provide an in-depth understanding of: (1) the local context a region in Ontario, Canada (2) what referral pathways can link older patients to services appropriate for their level of risk, and (3) providers, patients and caregivers experiences to understand how the model could be modified and what factors are important for implementation in future primary care sites.

Methods: This study used mixed methods, within a developmental evaluation approach (Patton, 2011). Ongoing focus group (n=6) and key informant interviews were conducted with patients (n=15), families (n=4), and primary care and community care providers (n=15) in three locations (rural and urban) in Ontario, Canada. Data were coded using a line by line, emergent approach. Risk-screening data (n=600) and service utilization were also collected and analyzed at the study sites.

Results: A model of care coordination was developed through engagement of patients, families, and health care providers. Components of the model include: a) consistent screening (interRAI Assessment Urgency Algorithm) and referral processes; b) coordination of care through individualized care plans; and c) patient and caregiver engagement in decision-making. Implementation resulted in patient and provider awareness of resources for self-management, stronger linkages between PHC teams and community resources; improved patient and caregiver experiences and engagement in decision-making.

Conclusions: A model of care coordination was developed and implemented in primary care through an ongoing, iterative process with older adults, caregivers, and health care providers.

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This process resulted in key principles necessary for improving care coordination in primary care for older adults and their caregivers.

Limitations: This project was conducted in one Ontario region. Strategies may need to be tailored to the specific needs and resources of other communities.

Suggestions for Future Research: The next phases of our work will involve implementing and evaluating this model in primary care sites that are not team-based settings.

Keywords: carecoordination; primary care; developmental evaluation; older adults
