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Establishing an integrated model of subacute care for the frail elderly

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Abstract

The current health system in Ontario is not designed to meet the needs of frail older adults. This is particularly true for older adults hospitalized due to exacerbation of chronic illness or medical crisis. This article describes the Subacute Care Unit for the Frail Elderly (SAFE) program, one which is designed to serve frail older patients who are at risk of deconditioning or disability associated with prolonged hospitalization but who may safely return home or to a retirement home following up to 4 weeks of subacute care in a restorative environment. The program centres on an intense restorative and integrated care delivery model. The patient population is medically complex, requiring medical supervision and regular adjustment to the care plan to optimize medical status. Individuals are no longer acutely ill and are considered stable or stabilizing. Care and services are designed to improve outcomes for hospitalized frail older adults by proactively addressing the conditions that contribute to alternate level of care before the deconditioning associated with prolonged hospitalization is experienced.

Introduction

The current health system in Ontario is not designed to meet the needs of frail older adults. This is particularly true for older adults hospitalized due to exacerbation of chronic illness or medical crisis. Hospital care is focused on acute needs rather than restoration. Frailty, defined as "an age-related physiological state of increased vulnerability," is not commonly considered in acute care environments despite its prevalence or association with poor health outcomes.[1,2] Approximately 24% of Canadians age 65 and older living in the community are frail, with an additional 32% identified as pre-frail.[2] Frail individuals have lower reserves and are less likely to return to baseline health following illness.[3] Frailty is a frequent reason hospitals have difficulty safely discharging patients home or to other community settings and is a key driver of alternative level of care. Fortunately, frailty in its early stages can be mitigated if addressed proactively and diligently.[4]

The partners

In 2014, an academic health sciences and long-term care home began discussing how together they might better meet the needs of frail older adults. The Ottawa Hospital (TOH) was struggling with high volumes of admitted patients in its emergency departments and an ever-increasing number of frail elderly patients designated as alternative level of care. The Perley and Rideau Veterans' Health Centre (Perley Rideau), home to 450 long-term care residents, was facing a decline in its Veteran population and exploring how it might broaden its spectrum of care and best deliver value to the local health system. Perley Rideau was additionally exploring opportunities to help residents avoid transfer to hospital by increasing on-site diagnostic and care capabilities.

The model

Over the course of the next 2 years, TOH and the Perley Rideau worked to develop a collaborative partnership and new integrated model of care—a 20-bed Subacute Care Unit for the Frail Elderly (SAFE) located within a long-term care home and supported by an acute care hospital.

The SAFE program is designed to serve frail older patients who are at risk of deconditioning and/or disability associated with prolonged hospitalization, but who may safely return home or to a retirement home following up to 4 weeks of subacute care in a restorative environment. The program centres on an intense restorative and integrated care delivery model. The patient population is medically complex, requiring medical supervision and regular adjustment to the care plan to optimize medical status. Individuals are no longer acutely ill and are considered stable or stabilizing. Care and services are designed to improve outcomes for hospitalized frail older adults by proactively addressing the conditions that contribute to alternate level of care before the deconditioning associated with prolonged hospitalization is experienced.

During planning, the partners considered whether expansion of existing subacute care models would address the identified needs of the frail elderly patients waiting in hospital. Existing programs including convalescent care, geriatric rehabilitation, and transitional care are well utilized and meet an important need in the Champlain region. However, they are

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inappropriate for medically complex older adults requiring short-term, intensive restorative care. The SAFE model is unique in the Canadian context and is distinguished by the following features:

- *Proactive:* Elderly patients admitted to TOH are assessed using standardized tools early in their length of stay to determine whether they would benefit from the SAFE program. The assessment and screening is collaborative and includes input from the hospital care team, Perley Rideau staff, Home and Community Care, the patient, and family. A SAFE flow coordinator is embedded on the General Internal Medicine units and Family Medicine units, as well as in the long-term care home facilitating interaction with the hospital team, patients, and families.
- *Restorative:* Once the patient's acute medical condition is resolving, but before medical care is concluded, the patient is transferred to the SAFE program at Perley Rideau, where the focus is rehabilitative and goals focus on preservation of function and quality of life. A distinguishing feature of this program is the holistic approach to care, with therapeutic recreation and creative arts as core components of the care delivery model. The clinical and social benefits associated with arts and recreation programs have been widely documented in the literature. Participation in recreation activities, such as leisure, music, and art, has been shown to improve physical, social, and emotional well-being in the elderly patients and increase their sense of belonging to a community.[5] Specifically, older adult participation in arts and recreation programs has shown a positive impact on doctors' visits, medication usage, fall reduction, as well as benefits across several mental health domains associated with disability and mortality.[6]
- *Collaborative and integrated:* A defining feature of the SAFE program is the collaborative care between TOH and Perley Rideau. Medical care continues at Perley Rideau where internists and geriatricians support Perley Rideau family physicians who act as the primary physician. Other members of the care team include nurses, pharmacists, physiotherapists, occupational therapists, dieticians, recreation therapists, social workers, and personal support workers. The clinical team, through partnership with TOH, is supported with on-site digital X-ray and rapid laboratory services, eliminating the need to transfer clients to hospital for simple diagnostic work. Home and community care is embedded within the program to enable effective discharge planning.
- *Client-centred:* The SAFE Program integrates care among providers and considers the needs of the whole person. It is purposefully designed to address frailty and deconditioning and prepare patients for their return home. Specific goals of care focus on: mobility/falls prevention; nutrition; dementia, delirium, and depression; family support and social networks; prevention of iatrogenesis; and readiness for return home. The program also incorporates advanced care planning to empower patients and families to effectively manage future health crises. Services are offered 7 days per week.
- *Cost-effective:* The intensive, short stay nature of the program requires an enhanced staffing and resource model compared to traditional long-term care, but less than that of acute care. Conservative financial analysis shows a cost differential of $100 per bed per day between TOH and Perley Rideau. For a 20-bed unit, annual cost savings to the health system are estimated at approximately $730,000. This analysis compares the direct cost of caring for a patient on an alternative level of care unit at TOH with the total direct and indirect cost of caring for a patient on the proposed integrated subacute care unit.

Challenges and strategies for success

Building and maintaining relationships across sectors

This initiative began with a conversation between the Chief Executive Officer (CEO) and Chief of Staff of TOH and the CEO of the Perley Rideau about the challenges and strategic issues facing their organizations. Time was spent learning about the other party months before the team began developing plans for the SAFE program. This included presentations to the boards of both organizations as well as introductions of key administrative and physician leaders. Staff toured the partner sites to learn about each other's capabilities and constraints. Simple actions such as alternating meeting locations and sharing tasks helped strengthen the relationship and develop trust between the partners. Geography was an important enabler as the hospital and long-term care home are located within 2 km and 5 minutes driving time.

The parties had a strong desire to ensure their proposal was grounded in evidence and based on a clear understanding of patients' needs. The partners, with financial support from the Local Health Integration Network 95 (LHIN), commissioned a third-party feasibility study to further analyze the opportunity and refine the team's thinking. This study was led by experts in geriatrics, health services administrative research and program evaluation and was critical in building credibility for the SAFE program with both internal and external stakeholders, including government.

Early in the development phase, TOH and Perley Rideau engaged the Champlain LHIN and the former Champlain Community Care Access Centre as full partners in the work. This included active committee participation, co-design of services, review and development of materials, and ultimately an application to the Ministry of Health and Long-Term Care (MOHLTC) signed by all four parties.

Project management

Too often strategic healthcare initiatives are run "off the side of someone's desk." This is particularly true for those under

development as it is difficult to consciously set aside scarce resources for a project that may never reach implementation. It is also true that many valuable ideas and prototypes fail to mature due to lack of sound project management.

Following completion of the feasibility study, Perley Rideau dedicated a project manager to oversee development of the SAFE program and guide the MOHLTC application process. This individual provided continuity, structure, and coordinated planning across a broad range of internal and external stakeholders. These included, but were not limited to, clinical services, rehabilitation services, home and community care, pharmacy, medical imaging, laboratory services, human resources, social work and discharge planning, education, admissions, information technology, privacy, decision support, transportation providers, contractors, physicians, various branches of the MOHLTC, and families and residents.

A steering committee, co-chaired by the Chief of Staff of TOH and the CEO of the Perley Rideau, oversaw development of the program supported by a working group. Both groups continued to meet throughout the development, approval, and implementation phases. Strong physician and administrative leadership maintained momentum through the long process.

During the implementation phase, staff created a virtual program where they tested and refined assessment, transfer, and admission processes and conducted interdisciplinary training in a simulation lab environment. The unit underwent minor renovations following relocation of 20 residents to other areas of the long-term care home.

Innovation within regulation

Long-term care in Ontario is highly regulated. *The Long-Term Care Homes Act* (2007) and its associated regulations govern many aspects of care and services within the home including eligibility and admissions, particular requirements for care and accommodation, dining, reporting and complaints, and the operation of resident and family councils. Compliance is monitored and enforced by the MOHLTC through an inspection process which occurs at minimum annually and more frequently as required. Partner organizations are also bound by separate legislation and regulation such as *the Home and Community Services Act, the Public Hospitals Act, the Healing Arts Radiation Protection Act,* and *the Personal Health Information Protection Act*.

Early planning followed a "low-rules" approach, with a desire to design the most effective model for patients, families, and partner institutions. As planning progressed, it became clear that the MOHLTC would not be able to support a program outside of the existing regulatory framework, even in a pilot phase. As the program would be housed at the Perley Rideau, a decision was made to pursue a special designation under the Long-Term Care Homes Act for the SAFE unit beds. The special designation would allow for a dedicated client wait list and provided mechanisms for modified care delivery models compared to traditional long-term care. Following extensive legal and regulatory review, the MOHLTC determined that as the SAFE program was a transitional program, it did not meet the criteria required for a special designation. Instead, the MOHLTC recommended proceeding with an enhanced convalescent care designation. This approach provided a path to MOHLTC approval but also required creative approaches to care and admissions processes.

Partnering with government

The SAFE program took 4 years from conception to implementation. This included 18 months to develop the model and submit an application to the MOHLTC, 2 years to refine the proposal and receive final approval from the MOHLTC, and 4 months to implement the program.

Throughout the process, the partners engaged regularly with both the bureaucracy and political branch to share ideas and seek feedback. Efforts were made to clearly align the proposal with MOHLTC priorities including Ontario's Patients First Strategy and demonstrate value to the broader health system. The CEO of the Champlain LHIN clearly communicated her support for the proposal with her MOHLTC colleagues.

The partners worked with four branches of the MOHLTC in addition to the LHIN on the development, approval, and implementation of the SAFE program. This required robust communications and additional effort to ensure that all parties had the information they needed to work in concert.

Flexibility and tenacity were important. Revisions were made to the budget and staffing model while respecting the original program goals. The partners had originally proposed a larger, longer term pilot, but agreed to a smaller 1-year pilot with a robust evaluation to support further approval.

Applications for the broader health sector

The SAFE program was conceived as a scalable and replicable model to address common challenges in the healthcare sector—improving care for frail older adults while also addressing hospital capacity. While there is considerable variation in local conditions, the SAFE program has broad application for the health sector, both as a comprehensive model and for its discrete program elements.

Vertical partnerships, focused on client needs, have addressed many of the traditional barriers to enhancing capacity in long-term care, including laboratory, diagnostic, and specialty clinical support. In the SAFE example, the primary partnership exists between a tertiary hospital and a long-term care home. However, the partners have consistently been impressed at the willingness of other agencies and support providers to consider new processes that better meet client needs. Long-term care homes in particular are encouraged to dialogue with third-party providers to explore how they might enhance the breadth and timeliness of service to improve existing programs. Examples include, but are not limited to pharmacy, transportation and oxygen therapy providers in addition to external clinical professionals such as nurse practitioners and physician specialists.

An effective partnership, rather than formal integration, was the prerequisite for better integration of care. Key elements of the SAFE partnership include shared client centred goals, mutual respect of capabilities and constraints, and clarity of roles and responsibilities. Hospitals, long-term care homes, and other health service providers should consider novel relationships with new or existing partners where the conditions support development of a trusting partnership.

Conclusion

The concept of short-stay subacute care units for frail older adults is not new, with transitional care and geriatric rehabilitation units located in hospital settings becoming increasingly common and relied upon as a more patient-centred alternative to acute care. However, providing subacute care within a long-term care environment is a relatively novel approach in Canada that is gaining recognition as an innovative solution to caring for the growing geriatric population. By offering integrated subacute care to frail elderly patients within a long-term care home environment, patients can benefit from programming aimed at restoring function and a "whole person" approach, leading to better outcomes at a reduced cost to the healthcare system.

This article was written two weeks before the scheduled opening of the SAFE unit. At the time of writing, the partners were completing final preparations with the understanding that the pilot phase would bring new learning and require further adaptation. Foremost, the clinical and leadership teams were looking forward to welcoming their first patients to the SAFE program and demonstrating the value of frailty informed care.

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