Integrating Health and Social Care for Community-Dwelling Older Adults: A Description of 16 Canadian Programs

Intégration des soins de santé et des services sociaux pour les aînés vivant dans la communauté : description de 16 programmes canadiens

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TABLE 1. A brief description of the design and goals of each selected program, ordered by province, west to east

Province	Program name	Program description
British Columbia	Kamloops Seniors Health and Wellness Centre	Seniors Health and Wellness Centre patients are referred by their family doctor, nurse practitioner or specialist. The interprofessional team at the centre may include a geriatrician (family physicians with a special interest in geriatrics), mental health clinician, physiotherapist, occupational therapist, registered dietitian, rehabilitation assistant, speech and language pathologist, pharmacist, registered nurse, social worker and respiratory therapist, and provide specialized short-term care (four to eight weeks).
Alberta	Seniors' Community Hub	This involves the assessment of frailty, development of an individualized care plan and sharing of this information across all providers of a primary care network (PCN) to improve the quality, efficiency and coordination of care for frail, community-dwelling older adults, aged 65 years and older.
	Primary Health Care Integrated Geriatric Services Initiative (PHC IGSI)	PHC IGSI is designed to recognize, diagnose and provide ongoing care and support for community-dwelling older adults living with dementia (or other geriatric syndromes). There are three progressive service levels. At level one, primary health teams assess frailty and changes in brain health in older adults. Level two involves an embedded, integrated assessment team with training in dementia and frailty care. Level three involves access to specialized supports for the most complex cases.

Province	Program name	Program description
Saskatchewan	Seniors House Calls Program	Short-term, urgent, home-based care is provided to frail community-dwelling older adults who are already patients of an established care team. It involves in-home medical assessment, diagnosis and treatment, as well as integration of healthcare (physical/mental) with social care via navigation to additional community services, if needed.
	Connecting to Care (Hotspotting)	This uses data to identify patients with complex care needs who repeatedly need hospital services or visit emergency departments (high-cost, high-use patients). A multidisciplinary team provides customized patient-centred care through intensive case management.
Manitoba	My Health Teams: Financial health promoters	My Health Teams are a partnership between a regional health authority, fee-for-service practice(s) and other community organizations that work together in a PCN to plan and deliver primary care services to meet the needs of the geographically defined population they serve. The Income Security Health Promoter program is an example of a position created and shared by one My Health Team to provide support, education and direct assistance with income security within the context of chronic disease.
	Program of Integrated Managed Care of the Elderly (PRIME)	PRIME is a program for community-dwelling frail older adults (≥ 65), designed to keep participants healthy and living in their own homes (i.e., as opposed to entering institutional “nursing home” care). PRIME provides all-inclusive primary healthcare services, including medical care, personal care, socialization, physical exercise, after-hours support, day program, homecare coordination and access to an interdisciplinary team of healthcare professionals.
Ontario	Health Links	This is a network of local healthcare working as a team to support patients with multiple complex conditions (often older adults, ≥ 65). The network is designed to help primary care providers connect patients more quickly with secondary specialists, homecare services and other community supports, including mental health services. For patients being discharged from hospital, the Health Link network is designed to promote faster follow-up and referral to services, such as home care, helping reduce the likelihood of re-admission to hospital.
	Community Hubs (Langs)	Langs is an incorporated not-for-profit organization with six locations. Community Hubs provide a central access point for a range of needed health and social services, including seniors’ programming, early years, diabetes education, a resource centre, outreach services and a community health centre. The HUB@1145 Cambridge is the main site, and 20 partner organizations rent space there. Moreover, 27 additional groups deliver services on a monthly basis. This includes a community health centre with a primary care team and health promotion team.

Province	Program name	Program description
Quebec	Réseau des services intégrés pour personnes âgées en perte d'autonomie cognitive (RSI-PAPAC)	RSI-PAPAC provides at-home services designed to keep older adults with cognitive disorders living at home in their community. The goals were to facilitate early detection of the loss of cognitive autonomy for adults ≥ 70 and to improve continuity of care by encouraging a multidisciplinary approach and delivering healthcare services at home for identified clients. A training of pyscho-geriatrics was offered to all personnel working with older adults with loss of cognitive autonomy. A tool was developed for family medicine groups (FMGs) to support cognitive issues.
	Québec Alzheimer Plan in FMGs and family medicine units	The implementation of the program acts on the priority to "provide access to personalized, coordinated assessment and treatment services for people with Alzheimer's and their family/caregivers" (Bergman 2009). This included rapid detection of Alzheimer's disease in FMGs, better continuity of care and faster access to specialized care and community services. FMGs act as the patients' medical home with primary care physicians and nurses making up the majority of care. The projects have involved memory clinics and outpatient teams for the management of behavioural and psychological symptoms of dementia, as well as local health, social and community services.
New Brunswick	Rehabilitation and Reablement with the Extra-Mural Program	The Rehabilitation and Reablement program is a short-term intensive service, delivered to patients in their home, with the overall goal of rehabilitation and enabling seniors to remain in their own home or community. Patients receive up to 21 days of intensive rehabilitation therapy at either a special care home or in the senior's own home through the Extra-Mural Program. Once recovered, patients receive up to three to six weeks of reablement services from a home support worker. Emphasis is placed on living independently through relearning different abilities, such as mobility, personal care and activities of daily living, such as cooking, meal preparation and garbage removal.
Nova Scotia	Community Health Teams (CHTs)	CHTs are a community-based model of care focused on chronic disease prevention and management. Teams support individuals and families to build knowledge, confidence and skills to prevent and manage chronic diseases. Two major components of the program include: wellness programming (provides access to a range of wellness programs that complement services already available in the community) and wellness navigation (working collaboratively with family physicians, community groups, specialty programs and others to support individuals to make linkages with other programs).
Newfoundland and Labrador	Community Supports Program (CSP)	CSP is a community-based service that provides home supports and other supportive services for individuals, families and care providers. The program's aim is to promote independence, community inclusion, safety and overall well-being. This program provides financial/supportive services and case management for individuals with physical and/or intellectual disabilities and individuals requiring protection (e.g., supporting individuals 18 years and older with physical and/or intellectual disabilities). Home support services include the provision of personal and behavioural supports, household management and respite at the minimum level to maintain individual independence. Services are non-professional in nature and are delivered by an approved home support agency or by a home support worker hired by the individual or family.

Province	Program name	Program description
Prince Edward Island	Caring for Older Adults in the Community and at Home (COACH)	The COACH program provides frail seniors with in-home support for their complex health needs. The program is led by a specialized team of healthcare professionals who support frail seniors to live at home longer and return home from hospital sooner. The team works with three partner programs: home care, primary care and the provincial geriatric program.
	East Prince Seniors Initiative (EPSI)	EPSI aims to address issues related to wellness, lifelong learning and meaningful productivity to ensure that every adult receives the chance to live a healthy and productive life. EPSI operates by offering a variety of programs to seniors based on an identified need (e.g., nutrition, diabetes management, etc.). EPSI also provides navigational support to seniors when a particular need arises. This support may include helping seniors find a primary care provider, secure financial support for home or life modification due to a chronic condition and complete paperwork related to social, medical or housing assistance. There are no prior requirements or referrals needed to join any of the programs offered by this initiative.

TABLE 2. The top 10 priority services for older adults who were integrated in exemplar programs

	WHAT: Which top 10 priority services were integrated?									
Province: program name	**1. CDM**	**2. HC**	**3. RC**	**4. Pharm**	**5. MH&A**	**6. PC**	**7. Nav**	**8. AC&E**	**9. SDH-m**	**10. SDH-s**
British Columbia: Kamloops Seniors Health and Wellness Centre	X			X						X
Alberta: Seniors' Community Hub							X			
Alberta: Primary Health Care Integrated Geriatric Services Initiative					X					
Saskatchewan: Seniors House Calls Program							X	X		

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Saskatchewan: Connecting to Care (Hotspotting)								X		
Manitoba: My Health Teams: Financial health promoters	X								X	
Manitoba: Program of Integrated Managed Care of the Elderly	X	X		X						X
Ontario: Health Links		X						X		
Ontario: Community Hubs (Langs)										
Quebec: Réseau des services intégrés pour personnes âgées en perte d'autonomie cognitive					X					
Quebec: Québec Alzheimer Plan in family medicine groups and units					X					
New Brunswick: Rehabilitation and Reablement program	X									
Nova Scotia: Community Health Teams	X									
Newfoundland and Labrador: Community Supports Program		X	X						X	

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Prince Edward Island: COACH program		X								
Prince Edward Island: East Prince Seniors Initiative	X							X		

1. CDM = chronic disease management programs and/or services
2. HC = home care
3. RC = respite care
4. Pharm = community pharmacy programs
5 MH&A = mental health and addictions services
6. PC = palliative care
7. Nav = navigational services/patient navigators
8. AC&E = timely transition between urgent, acute and emergency care
9. SDH-m = services to mitigate material deprivation in the social determinants of health
10. SDH-s = services to mitigate social deprivation in the social determinants of health