RESEARCH PAPER

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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Abstract

This paper describes 16 Canadian programs designed to provide integrated primary care for older adults. Publicly available data were used to identify the "what" and the "how" of integration for each program. Most programs integrated with other healthcare or medical services (vs. social services). Mechanisms of integration varied; the most common mechanism was interprofessional teams. Only 25% of the programs formally engaged with autonomous physician-led primary care practices (where most Canadians receive their primary care). Findings suggest that integrated care is a priority across Canada but also highlight how far we have to go to achieve both vertical integration within the healthcare sector (primary, secondary and tertiary services) and horizontal integration across sectors (health and social).

Résumé

Cet article décrit 16 programmes canadiens conçus pour fournir des soins primaires intégrés aux aînés. Les données publiquement accessibles ont été utilisées pour déterminer le « quoi » et le « comment » de l'intégration pour chacun des programmes. La plupart des programmes sont intégrés à d'autres services de santé ou médicaux (par opposition aux services sociaux). Les mécanismes d'intégration varient, le plus courant étant celui des équipes interprofessionnelles. Seulement 25 % des programmes se sont officiellement engagés dans des pratiques de soins primaires autonomes dirigées par des médecins (soit là où la plupart des Canadiens reçoivent leurs soins primaires). Les résultats indiquent que les soins intégrés sont une priorité partout au Canada, mais ils soulignent également le chemin que nous devons parcourir pour réaliser à la fois une intégration verticale au sein du secteur des soins de santé (services primaires, secondaires et tertiaires) et une intégration horizontale entre les secteurs (santé et services sociaux).

Introduction

Maximizing health outcomes for patients with complex care needs requires not only vertical integration of hierarchical services within the health or medical sector (i.e., primary, secondary and tertiary services) but also horizontal integration across additional sectors, including social care services and community-based supports (Conrad and Shortell 1996; Goldsmith 1994; Robinson and Casalino 1996; Shortell et al. 1996). We found multiple definitions of integration (Armitage et al. 2009) and formulated a generic working definition, as follows: the ensemble of policies and procedures that support linkages and efficient exchange among institutions that deliver complementary services. Integrated care programs formalize connectivity, alignment and collaboration between services or sectors to achieve specific objectives (Kodner and Spreeuwenberg 2002). A lack of connection to needed services leads to negative experiences for patients and their carers (health deterioration, costly social consequences and high-intensity interventions) and for the healthcare system in terms of inefficiencies and fragmentation of service (Hwang et al. 2013; Kodner 2009; Nolte and Pitchforth 2014; Paré et al. 2014; Rich et al. 2012; Wilson et al. 2016).

In Canada, primary care has the responsibility for first contact and ongoing care of populations undifferentiated by age or disease status even when patients receive services elsewhere (College of Family Physicians of Canada 2011). Valentijn et al. (2013) posit that truly comprehensive primary care requires integration of services beyond the health sector to include social sectors and community-based organizations. Significant public investments since the 2001 Health Accord (Health Canada 2006) have resulted in innovation related to primary healthcare programs designed to integrate care within the health sector and across to the social care sector. However, because healthcare in Canada is organized at the provincial or territorial level, the program innovations in one jurisdiction may not be known in another jurisdiction. Our pan-Canadian team (see p. 105) conducted a descriptive policy and program analysis across Canadian provinces to identify and compare exemplar programs that integrate primary care with health and social services for two populations: children and youth (0–25 years) with high functional health needs and community-dwelling older adults (≥ 65 years) experiencing functional decline. The hope was that this information could support the scale up and spread of innovative models of integrated primary healthcare between Canadian jurisdictions. This article presents the findings of programs designed for older adults (for children and youth see the article by Dionne et al. 2023b).

Our purpose was to collect detailed implementation data for each program with the objective of assessing the degree to which each program had achieved integration and to identify the implementation factors that predicted successful integration. However, as detailed elsewhere in this special issue (Stewart et al. 2023), this original analytic objective proved ambitious given the paucity of publicly available data for the selected programs. Based on the information that was consistently and comparatively available across programs, we instead addressed two revised analytic objectives: to identify which services each program was designed to integrate with (the "what") and to identify the primary theorized mechanisms by which integration was meant to occur (the "how"), including the extent to which programs involved autonomous physician-led practices (where the majority of older Canadians receive their primary care).

Methods

The data collection methods used in this portion of the project are described in greater detail in our companion piece (Stewart et al. 2023). Briefly, however, co-principal applicants nominated 99 publicly funded programs (i.e., programs operated by provincial/regional health authorities or community organizations) designed to connect primary care to other services, and provided relevant websites and names of one or more key informants who could provide information pertaining to program implementation. Summaries of each nominated program were reviewed and rated using the Innovative Practices Evaluation Framework (Health Quality Ontario 2016) and 16 older adult programs were selected for detailed data collection and analysis whose brief description suggested: (1) novelty and innovativeness in approach to integration and (2) the potential for scalability. We selected at least one program from every

province. Tools were developed (see Appendix 3 [available online at www.longwoods.com/content/27185] and Appendix 4 [available online at www.longwoods.com/content/27184]) to collect program implementation and integration data (Damschroder et al. 2009; Suter et al. 2009), and we used publicly available data sources (e.g., government websites, grey and published literature) and key informant interviews to populate the data collection tools for each selected program. Key informants (where involved) corrected or contextualized the information collected. Drawing from the populated data collection tool, a narrative summary of each program was produced, which was then approved by key informants.

Data analysis

The detailed narrative summary of each program was read and coded independently by one researcher and one research assistant to identify the types of services that were integrated (the "what") and the mechanisms of integration (the "how"). Coding schemes for both concepts ("what" and "how") were agreed upon before data analysis, and are described below. Two coders met to discuss, and discrepancies were resolved by independent re-reviewing of narratives by both coders until consensus was achieved. The findings were presented to the broader research team for discussion and validation.

To identify *what* each program was designed to integrate with, we used our list of 10 priority health, social and/or community services deemed most important to be linked with primary care, which was developed in an earlier project in this research program through a formal consensus process with researchers, policy makers and patient partners (Dionne et al. 2023a). For the older adult population, the top 10 services (in decreasing priority) were: (1) chronic disease management programs/services, (2) home care, (3) respite care services, (4) medication reconciliation in community pharmacy programs, (5) mental health and addictions services, (6) palliative care, (7) navigational services, (8) timely transition between urgent, acute and emergency care, (9) services to address material deprivation and (10) services to address social deprivation.

In terms of *how* the program aimed to achieve integration, we extracted the following two types of information from the narrative summaries: (1) the program's theorized mechanism(s) for achieving integration and (2) the program's relationship to autonomous physician-led practices (where the majority of older Canadians receive primary care). To measure the theorized mechanism of integration, we aimed to distill down to a few words for each program the underlying theorized means of achieving integrated care – that is, "If ___ is done, then care will be better integrated for older adults". To do this, we adapted a categorization scheme from the World Health Organization's overview of well-known approaches to integrated care (Satylganova 2016), coding our selected programs for the following operational approaches to integration: colocation of services; outreach service (assessment, recommendations and referral); case-management/navigation; interprofessional teams; and service network.

Next, we made a distinction between programs where autonomous physician practices appear to be formally engaged as care partners versus programs where autonomous physicians are not formally engaged as care partners. Programs coded as "formally engaged" with autonomous physicians were ones with explicit mention of formal contracts, pooled resources and/or a common patient record with autonomous physician practices. Programs coded as "not formally engaged" appeared to be only peripherally associated with autonomous physician-led practices (i.e., autonomous physicians might be a referral source, but there were no contracts and/or pooled resources, and sharing of patient information occurred only on an as-needed basis).

Results

Table 1 (available online at www.longwoods.com/content/27177) provides a list of the programs selected from each province and outlines a brief description of the design and goals of each program.

What was integrated?

Table 2 (available online at www.longwoods.com/content/27177) shows which of the priority services were included in the program design. Most of the integration pertained to traditional health or medical services. There was clear evidence of connection to the following priority services: chronic disease management programs or services; home care; mental health and addictions services; navigational services; timely transitions between urgent, emergency and acute care; and services to address material deprivation. There was less evidence that programs connected to respite care services, palliative care, community pharmacy programs and services to address social deprivation. Two programs had a specific focus on financial security to address material deprivation (Manitoba, Newfoundland and Labrador). We also noted that five of the 16 programs had a specifically articulated emphasis on frailty (Alberta, Saskatchewan, Manitoba, Prince Edward Island). Similarly, several programs showed a connection to geriatrics as secondary specialist care (e.g., British Columbia, Quebec) and two programs to rehabilitation services (British Columbia, Newfoundland and Labrador).

How was it integrated?

Table 3 shows the theorized mechanisms of integration, which varied across our selected programs: colocation of services (four programs), outreach (three programs), case management/navigation (six programs), interprofessional teams (eight programs) and service networks (five programs). Four of the 16 programs (25%) that we reviewed appeared to be formally engaged with autonomous physician-led practices through contracts, shared resources or shared patient records.

TABLE 3. Principal mechanism of integration and relationship to autonomous physician-led practices among selected programs for older adults

	How was it integrated?	
Province: Program name	**Mechanism for integration**	**Relationship to autonomous physician-led practices**
British Columbia: Kamloops Seniors Health and Wellness Centre	Colocation of services Interprofessional team	Not formally engaged
Alberta: Seniors' Community Hub	Outreach Service network	Unclear
Alberta: Primary Health Care Integrated Geriatric Services Initiative	Interprofessional team	Formally engaged
Saskatchewan: Seniors House Calls Program	Outreach Case management/navigation	Not formally engaged
Saskatchewan: Connecting to Care (Hotspotting)	Case management/navigation	Not formally engaged
Manitoba: My Health Teams: Financial health promoters	Interprofessional team Service network	Formally engaged
Manitoba: Program of Integrated Managed Care of the Elderly	Colocation of services Interprofessional team	Not formally engaged
Ontario: Health Links	Case management/navigation Service network	Not formally engaged
Ontario: Community Hubs (Langs)	Colocation of services Outreach	Unclear
Quebec: Réseau des services intégrés pour personnes âgées en perte d'autonomie cognitive	Interprofessional team Service network	Formally engaged
Quebec: Québec Alzheimer Plan in family medicine groups and units	Interprofessional team Service network	Formally engaged
New Brunswick: Rehabilitation and Reablement program	Interprofessional team	Not formally engaged
Nova Scotia: Community Health Teams	Case management/navigation Colocation of services	Not formally engaged
Newfoundland and Labrador: Community Supports Program	Case management/navigation	Not formally engaged
Prince Edward Island: COACH program	Interprofessional team	Not formally engaged
Prince Edward Island: East Prince Seniors Initiative	Case management/navigation	Not formally engaged

Discussion

Our scan of 16 exemplar programs designed to integrate health and social services for community-dwelling older adults was limited to a descriptive analysis due to the lack of publicly available information on the selected programs. The approaches to integrating services for older adults varied widely across the Canadian provinces in terms of what was integrated and how. Nonetheless, it is important to note that every Canadian province had an exemplar

program. Most programs limited integration to other medical or health programs, and the most likely mechanism of integration was interprofessional teams. A minority of the programs appeared to be formally engaged with autonomous physician-led practices (where the majority of older Canadians receive primary care) through contracts, pooled resources or shared patient records.

A simple finding, but nonetheless potentially worth noting, is that we were able to identify exemplar programs operating in each Canadian province. This suggests that all provinces are, to some degree, experimenting with programs designed to integrate services for community-dwelling older adults. The plethora of programs for older adults is a clear response to the policy priority given to aging well and "in place" as per the *Principles of the National Framework on Aging* (Health Canada 1998) and the more recent *Healthy Aging in Canada* (Edwards and Mawani 2006). Another project in our research program, published elsewhere (Crowell et al. 2020), selected three older adult programs that integrated services for a common complex care need and examined specific provincial contextual factors and the policy environment within which each program was initiated and implemented. They selected integrated care programs for major neurocognitive disorders, such as Alzheimer's disease, and their health reform analysis has been published elsewhere (Crowell et al. 2020). But worth noting here is that the *National Strategy for Alzheimer's Disease and Other Dementias Act* (2017) (PHAC 2019) was a key influencer in the initiation of the programs. A message that has emerged from various projects in our research program is that national policies and strategies are important for embedding innovative solutions in the health system (Crowell et al. 2020; Haggerty et al. 2023b; Scott et al. 2023).

Next, in terms of *what* was integrated, we found that very few of the exemplar programs were designed to connect with the services that our stakeholders had identified as top priorities (Dionne et al. 2023a). Indeed, the selected programs appeared to address a limited set of health- or medical-specific services that meet the needs of relatively narrow groups of patients (e.g., dementia, frailty, physical rehabilitation). Older adults with undifferentiated health concerns, or those who simply have lower-acuity medical, functional and/or social needs, do not qualify for these types of specialized programs, and thus, appear much less likely to be benefiting from programs that offer integrated care. A premise of this study is that mitigation of functional decline is the important goal and that services need to be easily coordinated from primary care where the majority of older adults are managed regardless of health condition. There is a need to move beyond disease-specific categories and funding to achieve the policy objectives of aging well in Canada.

Although specific community supports did not emerge on our list of 10 priority services (Dionne et al. 2023a), several programs designed such connections. The health reform analysis of programs for major neurocognitive disorders pointed out how critical it was for the programs to have a formal mechanism for supporting patient's caregivers and social supports, and that this was achieved through partnerships with community organizations such as local chapters of the Alzheimer's Association (Crowell et al. 2020). A similar finding was also

highlighted in the study of integrated programs for children and youth with high functional health needs (Crowell et al. 2020; Dionne et al. 2023b). This points to the wisdom of including community organizations within the integrated care solutions and to the health system providing some funding and support for their long-term stability.

In terms of *how* programs approached integration, for approximately half the programs we observed more evidence of linkage versus actual integration (Leutz 1999) with mechanisms, such as colocation of services, case management or navigation used to link patients to other (stand-alone) services. Furthermore, only a minority of the programs we reviewed (which were publicly operated by provincial/regional health authorities or community organizations) were formally engaged with autonomous physician-led practices, where the majority of older Canadians receive their primary medical care. It stands to reason that any wide-scale improvements in the integration of primary care for older adults is dependent upon successful engagement with autonomous physician-led practices, although many barriers are known to exist (Haggerty et al. 2023a; Marsden et al. 2012; Neimanis et al. 2002; Struthers et al. 2019). The findings of the health reform analysis of the programs for major neurocognitive disorders found that the extent to which programs were able to link to the network of primary care renewal models was a condition of successful scale up for the programs in Ontario and Quebec (Crowell et al. 2020). This shows how policies and programs can reinforce each other. As pointed out in a companion paper (Haggerty et al. 2023b), primary care renewal models are now the norm in five provinces and are expanding steadily in three. It will be important for integrated care programs for older adults to connect to the network of primary care renewal models to expand their reach and consolidate the larger program goals.

Finally, it is important to note several limitations. Firstly, our analysis is based on a selected sample of programs (vs. a comprehensive or systematic list); secondly, all selected programs are urban-based (vs. rural); and lastly, our data are limited to publicly available information (occasionally supplemented by key informant interviews) that was demonstrably limited in scope and detail (Stewart et al. 2023).

Conclusion

This scan of recognized exemplar programs across Canada demonstrates that integration of services for older adults is a priority of health systems across the country, but that integration of services is still restricted to traditional health or medical services. The description of the programs demonstrates how far we have to go in achieving the promises of both vertical integration within the healthcare sector (primary, secondary and tertiary services) and horizontal integration across sectors (health, social and community). In line with the national, provincial and territorial policies and goals of healthy aging, integration needs to expand to include social services. The philosophy and ideal of truly comprehensive primary healthcare (Valentijn et al. 2013) requires integrated programs to connect intentionally to the predominant mode of primary care service delivery where the health of the majority of community-dwelling older adults is managed.

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