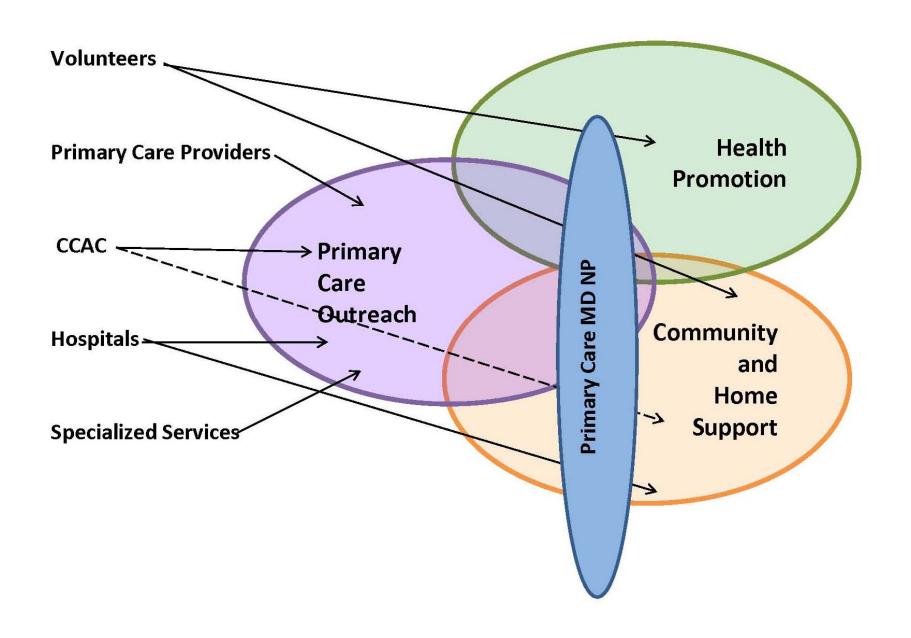
Integrating Care for Older Persons: If It's Such A Great Idea, Why Haven't We Done It Yet?

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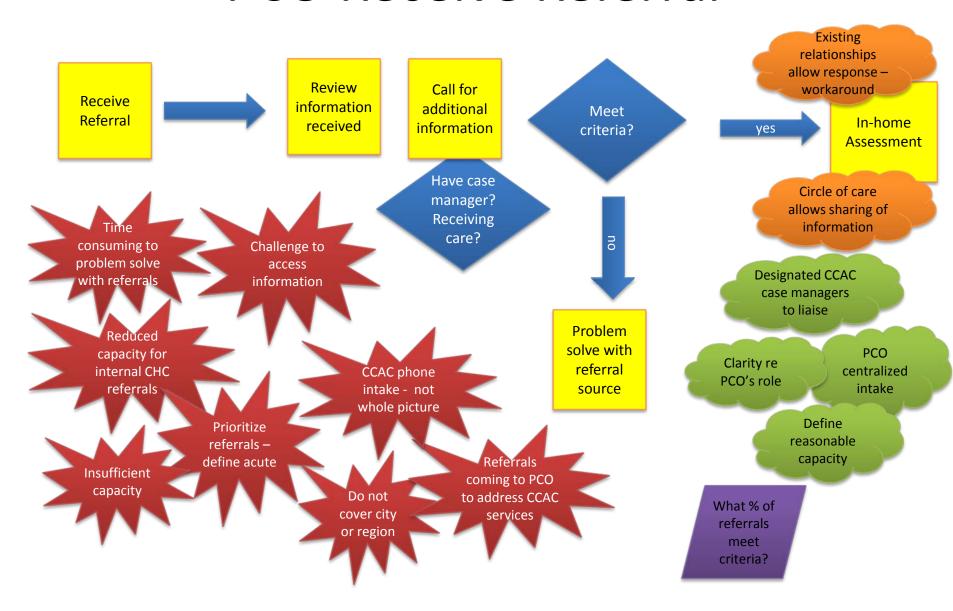
Build the Foundation

- Build, train, retain the workforce of PSW and home helpers in a best practice model
- Address cost for essential service
- Build capacity in personal support, home help, transportation, foot care
- Scope of practice
- Organizational responsibility for navigation
- Education/learning opportunities
- End of life care hospice care

What are we working on......5 key elements

- Establishing primary health care networks that address the care needs of the population being served
- Information knowing who does what and what are they willing to do differently to fill the gaps within the collaborative network
- Mapping to identify seniors failing to be identified, served appropriately, or not transitioning as optimal (falling through the cracks)
- Agreed upon referral processes
- Relationships

PCO Receive Referral



Refer to CCAC

Refer directly to CM designated for complex care

All complex clients need a plan of care and intensive case management

Less flexibility CMs stressed

Patients calling to omplain

Plans not - not

Repeat visits to emerge

accepted notified

> New stepclient reassessed in community

Liaison with Aging in Place CM mostly working Some CM present and active - report, direct referrals, immediate response

CM,, GEM, SW used to function as triangle of care - relationship & trust

Reducing referrals stats showing decreased need

Meet with CM in hospital to discuss care plan

Discuss care plan with Aging in Place Case Manager

Call CCAC to make referral

Long wait

May not meet score

Different sites -

different CM

practices

High need but do not meet score

Yes

Not providing

service for < 3

mths

Do not understand Not reading GEM assessments

105

Develop assessment framework

What is role of CCAC and CM for high-risk seniors requiring complex CM & care?

Provide information

about CCAC

policies/directives

CCAC

services

required?

Not notified of

changes to

policies

Reduced SW

to discuss

cases

CCAC scoring

ccept GEM assessment

How is nee scored?

Five Thoughts Moving Forward

- Stabilize some foundational elements including the essential workforce of PSWs and Home Helpers. Address cost where it creates hardship for seniors.
- Identify leads to build a network of care providers these networks must reflect the local context and be inclusive of primary care, health promotion and other health services, social service, community and home support services, specialty services, acute care and housing options. Increasing the continuum of service under one roof reduces transitional complexity. Where this already exists, recognize it and use the experienced knowledge.
- Remove ED visits and ALC days from the centre of our world and truly put Sarah and Dave at the centre – this means telling the story differently what do we really strive for.
- Determine common definitions and health outcomes that are based on wellness.
- Hold these networks of providers accountable for the wellness of their seniors.