Community Care
Health and Support Services
City of Kawartha Lakes

Stay the Course and Keep the Vision

A Journey of Integrating Care for Seniors

HSPRN/CRNCC Symposium
December 10, 2012

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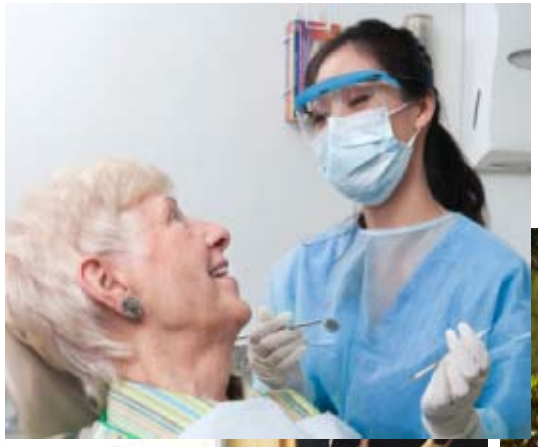
Overview

- Community Care City of Kawartha Lakes
- Beginning of Integration Journey
- Current environment and Integration Initiatives
- Barriers and enablers for success
- Lessons learned

Who Are We



Where we work

What Guides Us

Our Vision

... A healthy community through care and support

Our Mission

Community Care City of Kawartha Lakes is a leader in the collaborative design and delivery of integrated and responsive health and support services that respect individual choice, dignity and independence.

Our Values

Compassion
Accountability
Respect
Excellence

A Profile of our Seniors: Frailty & Chronicity

- Over 14% of the population are seniors aged 65 years and over
- By 2016 seniors will account for 16% of the population; by 2021 it will be 18%
- 15% of the population age 65-74 has heart disease. This prevalence increases to 26% among those age 75+
- '1% and 5% users'
- Higher prevalence of obesity, COPD, diabetes and high blood pressure than Ontario average
- Chronic conditions account for 6/10 deaths, 1/5 acute hospital separations, and 1/4 acute hospital days for LHIN residents
- Exacerbated by isolation, low income, and lack of access to care

The Beginning of the Integrated Vision

- “Early Adopter” - Began in 1983 as a concept for an independent school to develop a nursing home and adjoining apartment complex along with its elementary school
- Visited sites such as Baycrest and Mennonite Village which had accomplished this integrated approach ▸ **enabler: information sharing**
- Submitted nursing home proposal but were not successful…what next?

Seniors Apartment Complex

- If not nursing home, what about concept of seniors apartments on school property - intergenerational focus
- During planning and research, numerous contacts made, including with Ministry of Community and Social Services (COMSOC) staff Geoff Quirt and with developer and architect ▸ **relationships important enabler for future housing initiative**
- Apartments became condos – the housing door closes temporarily
- Unanticipated Outcome: personal encouragement to work with COMSOC to develop senior services in Victoria County

Let the Agency Begin

- Sought various services providers

  including Home Care Director, Municipal representation to help form a Board in

  April 1985
- Focused on collaboration with seniors groups throughout the County in the development of services in outlining areas through New Horizons grants, including Meals On Wheels
- Established one room County office in Lindsay for 3 day a week service delivery..seed funding from COMSOC

Integration and new ventures become a way of life

- Locally, focused on the expansion of Home Support Services throughout Victoria County, including meals on wheels, transportation, congregate dining ; adult day and friendly visiting
- Provincially, assisted in the integration of three provincial organizations, integration concept cross-fertilized
- Outcomes ▸ **Enablers**

  a) integration and collaboration become a way of life and entrenched value of the organization

  b) staff supportive of "disruptive leadership" style. Caution: must be sensitive to change fatigue and breaking points of staff ▸ can easily become barrier

Environment for Agency "Growth"

- In rural areas, there often is not someone else "doing it", so opportunities to add typical community services (usually with the requisite fundraising) were significant
- Board Vision and Risk-taking ▸ **enabled** atypical services such as Falls Prevention; Elder Abuse; Dr. Sandra Samuel's Senior Peer Helper program; and Non-Emergency Transportation Services
- Strong community support results in Reserve fund growth through bequests ▸ **enabler:** provides risk-taking safety-net and ultimately enables seniors' housing project to be undertaken

Seniors and Accessible Housing Becomes a Reality

- The 1983 original vision of and need for seniors housing remained
- Various initiatives attempted to develop housing – one successful in Fenelon Falls ultimately becomes independent of Community Care ▸ **enabler: basic knowledgeable of construction and supportive housing service experience**
- Failed attempts become cornerstone for subsequent opportunity ▸ **enabler: proposal writing experience!**
- Returned to architect and builder to collaborate for a shovel ready project with local Municipality: ▸ **enabler: maintenance of sustained positive working relationships** key to outcome as speed was of the essence and trust had already been established

Community Care Village Housing
Housing for Seniors

- 70 unit building – 51 rent geared to income; 19 market
- 17 modified units for accessibility
- Large common room and commercial kitchen
- Solar thermal and photovoltaic heating
- Independent board but cross representation of Community Care
- Barrier ▸ bricks and mortar and support services not in alignment


65
Community Care
ILLAGE HOUSING

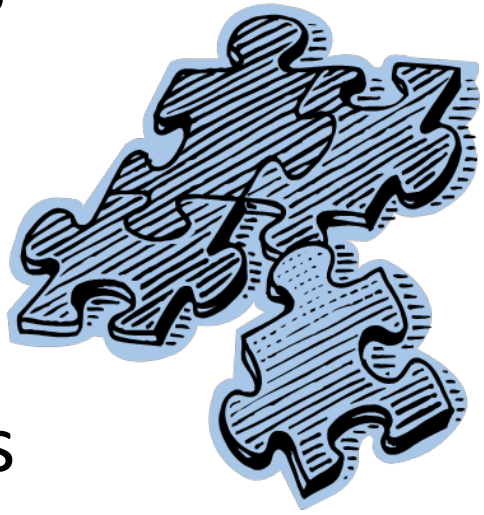
Integration Takes a Quantum Leap

- The CELHIN approves adding primary care as a division of our organization in 2009 ▸ **enabler: system alignment**
- Hospice Organization Integrated into operations in April 2011
- October 2011 sees low income dental clinic open in collaboration with our regional Health Unit
- Significant challenges but vision for and culture of integration trumps obstacles ▸ **enabler: consistent, clear vision and leadership and change management processes**

What is Integrated Care for Seniors?

- Inclusive seamless care
- Access to - prevention, primary care, medication management, interdisciplinary team, transportation, meals, dental care, home support, crisis intervention, end of life care and hospice, lab services, wellness programs
- Variety of settings
- Focus on families and caregivers
- Opportunities our infrastructure structure gives us
    - Case finding and referrals
    - Risk management
    - Chronic Disease Management approach
    - Shared assessments/shared interdisciplinary team support
    - Wellness/health promotion activity
    - Broad determinants of health lens
    - Focus on Quality
- We can`t do it all alone

Planning Principles



- Holistic approach
- Client centred - Voice of Client
- Collaborative trusting partnerships
- Coalition of the willing - Shared vision
- Focus on quality /best practice
- Be flexible
- Advocacy matters

Advancing the Integration Process

- Managing Frailty -Wrap around care
- Inter RAI CHA data for risk assessment, case finding
- Process improvement
- Initiatives - medication management
  - Training in needs of specialized populations
  - Access to primary care team
  - FHTs and Hospitals and LTC
  - Academic links
  - HUB

Today`s Integration Challenges

Barriers

- Funding silos
- Growth opportunities
  - Process changes
- Training requirements
- Readiness of partners
- Aversion to risk
- Lack of standardized outcomes/performance measures
- Technology

Enablers

- Tell a client story
- Tell 10 stories!
- Find a champion
- Build networks..invite yourself to the table
- Empower staff, volunteers, clients to create new solutions
- Transparency
- Change management

Stay the Course and Keep the Vision

- Shared vision
- No one solution …. local circumstances
- Take a risk
- Sustained positive working relationships
  - Dialogue/collaboration/teamwork
- Measure your value
- Build care continuum based on client's experience
- Adaptive Leadership
  - System thinking
  - Innovation
  - Look for opportunities


Opportunities
straight ahead


Questions