COMMUNITY CONNECTIONS

MAY 12, 2022

KEY PARTNERS (PROJECT TEAM)

- Champlain Dementia Network: membership from across community, acute care, specialized care, long-term care and palliative care organizations, together with key representatives from client and family groups
- Champlain Community Support Network: membership from across the spectrum of Community Support Services
- Canadian Red Cross: Chief Medical Officer providing technical and research expertise, together with linking this approach with pan-Canadian collaboration initiatives
- Compassionate Ottawa: providing input and support in community engagement and evaluation via Carleton University representation
- Financial and in-kind resources for this initiative: Regional Geriatric Program of Eastern Ontario, United Way of Eastern Ontario, Champlain Dementia Network, Champlain Community Support Network

OVERVIEW

- Partnership of community organizations to enhance urgent response / recovery response to the pandemic through a streamlined referral to support services: focused on a 3-month period with evaluation process to inform next phase and structure (consultations and data analysis ongoing through May 2022)
- Older adults can self-refer or be referred by a health care provider (with client consent)
- Key service elements:
    - Screening and assessment by a navigation team (composed of navigators from VHA Health and the Dementia Society of Ottawa and Renfrew County),
    - Full review of client service plan to ensure all appropriate support services have been optimized, and will be navigated to additional supports as needed (including health, social, housing, financial needs) – utilize an online collaboration platform to develop plan, facilitate e-referrals, and provide a feedback loop to referral sources
    - Matching of clients to volunteers for social support through existing community programs, and
    - Based on clients' and / or families' vulnerabilities and risk factors, be provided access to self-directed funding on a temporary basis to purchase services and supports.

TARGET POPULATION

- Older adults discharged from hospital (inpatient and emergency)
- Older adults on wait list for services (including for Home & Community Care, Adult Day Programs, Long Term Care and specialized geriatric assessment)
- Our particular focus is on older adults who are socially isolated, whose existing natural support network (eg. Family caregivers) requires support, and/or those who need a more fulsome review and expansion of existing support plans.
- Initially focused on City of Ottawa (late February), but have expanded regional capacity: resident home location should not limit referrals to the navigation team (navigation team can provide warm hand-off to services outside of Ottawa, even in the short term)

KEY QUESTIONS

- How does the model change how at risk older adults, and their caregivers / care partners, are supported in the community?
- What are the facilitators and barriers impacting design and implementation?
- What is the stakeholder experience of these modifications?
- How have we engaged stakeholders in the process?

Which high-performing elements of the Community Connections approach should be considered for adoption moving forward? How should they be modified, structured and funded based on the evaluation?

DESIGN PRINCIPLES

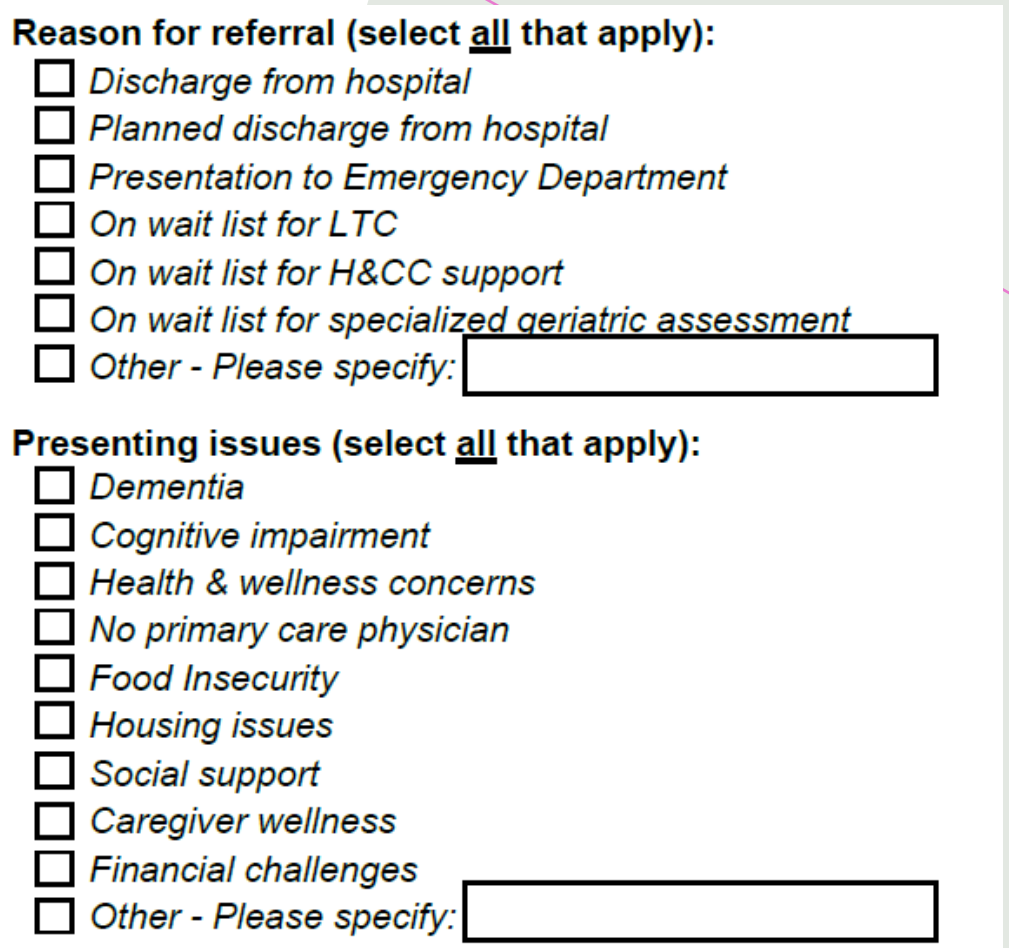
- Optimization, not creation (Aren't we already doing this?)
  - Leverage existing navigation, volunteer resources, training and support, e-health facilitators
- Brief planning process – focus on a developmental evaluation approach
- All referrals are the right referrals
- Response time matters (7 day a week approach)
- There is an essential role for volunteers in making social connections
- Effective navigation requires technology that facilitates standard of care/approach, 'living' service guide, communication across organizations and with clients, caregivers/care partners
- Navigation includes: support pathway and clinical/treatment pathway
- There are service and structural gaps in the system that will not be fixed by optimization and/or in the short term
- It's not about the numbers, it's about the impact on the experience of clients, families, and staff
- The system is stretched to / beyond capacity: the approach needs to reduce moral distress of staff
- Learnings from this process should add to ongoing initiatives and support broader health system goals
- ***Don't let the perfect be the enemy of the good: workaround / workable solutions that can be implemented today, improved on tomorrow***

TIMELINES

- January: basic design, asset mapping, lead organization engagement
- February: formation of navigation team (orientation, Careteam onboarding, design of online referral form and navigation pathway, secure self-directed funds, promotion to partners, **launch**
- March: formalize logic model, evaluation approach, daily huddles / refinement of service plan development pathway with navigation team, promotion to partners
- April: secure evaluation team resources, refine evaluation approach, establish Executive Team to coordinate communications among anchor organizations, CDN & CCSN leadership, move to weekly huddles
- May: analyse referral and action plan data, experience surveys (clients, caregivers, referral sources), interviews (clients, caregivers, referral sources, navigators, Executive Team), group discussions – learnings and opportunities (CDN, CCSN, OHTs, Project Team etc)
- June – report on “Phase One”

REFERRAL PROCESS

- The online referral form (information housed on TOH Sharepoint server) can be completed by any healthcare provider, as well as by older adults and or caregivers. The form can also be linked via QR Code
- Form includes: client/caregiver contact information, reason for referral, urgency of response needed (including within 24 hours), presenting issues, current services
- This doesn't replace existing referral pathways to medical / treatment services at discharge or in the community – it provides a mechanism to ensure supportive services and volunteers are supporting at-risk older adults to the greatest degree possible during this phase of the pandemic.
- Referrals are reviewed/actioned by a navigation team made up of VHA Health and the Dementia Society of Ottawa and Renfrew County
- "Work around" processes built in for staff already using Careteam



Reason for referral (select all that apply):

- ☐ *Discharge from hospital*
- ☐ *Planned discharge from hospital*
- ☐ *Presentation to Emergency Department*
- ☐ *On wait list for LTC*
- ☐ *On wait list for H&CC support*
- ☐ *On wait list for specialized geriatric assessment*
- ☐ *Other - Please specify:* ____

Presenting issues (select all that apply):

- ☐ *Dementia*
- ☐ *Cognitive impairment*
- ☐ *Health & wellness concerns*
- ☐ *No primary care physician*
- ☐ *Food Insecurity*
- ☐ *Housing issues*
- ☐ *Social support*
- ☐ *Caregiver wellness*
- ☐ *Financial challenges*
- ☐ *Other - Please specify:* ____

COMMUNITY CONNECTIONS

WHO WE ARE

Community Connections is a partnership of health services across our region. Our team is made up of experienced staff from VHA Health & Home Support and the Dementia Society of Ottawa & Renfrew County, and we refer to all publicly funded health and home support services.

Questions? Please contact the Dementia Society at (613) 523-4004 or npoushinsky@dsorc.org

WHO WE SERVE

Any older adult living in Ottawa, Renfrew County or Eastern Counties. You can be referred to Community Connections by your healthcare provider, or you can sign up yourself.

We work with older adults and their families to understand what services and supports will help you to stay well.

We put together a plan, and we connect you directly to services.

We make it easier to find the health and social supports you need.

We can also help you get matched with a volunteer.

Where there are extended wait lists for services, or financial challenges, we can help you to access some temporary funding to assist.

WHY ARE WE PROVIDING THIS SERVICE?

We know it can feel confusing to find the right services and supports. Accessing some services has been especially challenging during the pandemic.

Healthcare organizations have designed Community Connections to better support older adults and their families: our goal is to make sure you have access to the supports in the community that you need and want.

YOU CAN BE REFERRED BY A HEALTHCARE PROVIDER, OR SIGN UP HERE

EXPLAINING COMMUNITY CONNECTIONS TO OLDER ADULTS AND CAREGIVERS

WHAT'S INCLUDED IN A SUPPORT PLAN?

- ✓ Have Community Support Services been optimized including access to Seniors Without Walls and Friendly Voices?
- ✓ Have specific cognitive issues been considered and integrated in the plan including range of DSORC or ASCD services?
- ✓ Have readily available and person-centred supports been engaged including Ontario Caregiver Organization, PHU healthy living programs, Living Healthy Champlain, specific chronic disease associations?
- ✓ Have next steps been identified to access a primary care provider or link to their existing PC provider been made?
- ✓ Where identified, ensure appropriate medical/treatment referrals have been made to: SGS Central Intake, Falls Prevention Clinics, Centralized Intake Geriatric Psychiatry, Primary Care Outreach, Home & Community Care, iGeriMedRisk
- ✓ Have additional next steps / referrals been identified for Community Paramedicine programs, Financial assistance programs, Community Developers and Housing Support Workers / Social & Supportive Housing, Seniors' Pride Network, Mobile Mental Health Crisis Team, etc.
- ✓ Has the client / family agreed to be matched to social supports through CSS Friendly Voices program or DSORC Make a Connection program? Connected Canadians? Has this referral been made (all of these can be done via Caredove)?
- ✓ Will the client or caregiver be accessing self-directed funding? Assess for self-directed funding using decision-making tree
- ✓ Have linkages to specific OHT navigation services specialized for chronic diseases been made? (as they come online)

FEEDBACK LOOP

- The Client Support / Action Plan is housed on the Careteam platform (Careteam also interfaces with Caredove for e-referrals).
- With client consent, we invite the staffperson who referred the client to view this action plan - this enables a feedback loop to the referring source to understand what actions have been taken, together with additional information to inform current/future role with that client.
- The invitation is sent to the referral staff email address - they can accept the invitation and view the Action Plan or choose not to.
- The first time they accept a plan, they are asked to create a username and password, which would then be used any time they accept viewing rights to future invitations.
- They can remove themself from viewing rights to an Action Plan at any time.

ACTION PLAN EMBEDDED IN CARETEAM

Healthcare teams
in various settings

- Team
- Care plan

- Appointments
- Tasks
- Messaging
- Check-ins

- 3rd party integrations
- Automation & predictions

Patient, family and
support network

- Online forms
- Referrals
- Appt Sched
- Shared plans/tasks

Ocean by Cognisant MD
caredove
Petal MD
chronometriq
KlayaCare

Privacy by Patient ™

VOLUNTEER MATCHING

- The Champlain Dementia Network is working across several volunteer networks to leverage and organize existing volunteer pools to better deploy resources in Long Term Care and Retirement Home settings, and in community settings (both in-person and virtual)

Examples of volunteer services to be leveraged for social support:

- Dementia Society of Ottawa & Renfrew County – Make a Connection porch visiting and virtual
- Revivre Project (U of Ottawa Students now expanding to integrate CDN High School Intergenerational initiative, and college students)
- Community Support Services – MOW, Friendly Voices / Friendly Visiting
- Compassionate Ottawa - Advanced Care Planning, Grief and Loss Training
- Hospice Care Ottawa (In-home EOL and Bereavement Support)
- HELP Ottawa faith-based groups – facilitated through Compassionate Ottawa (coming online)
- Red Cross (potential longer term)

SELF-DIRECTED FUNDING APPROACH

- Priority identified in regional Caregiver Support Strategy (United Way, Champlain Dementia and Community Support Networks)
- Focus is on time-limited flexible funding, based on financial need, public service options, and caregiver burden (screened using InterRAI Caregiver Wellness Index)
- Up to three months ranging from $300/month for community referrals and $600/month for GEM referrals
- As per Community Support Network small pilot project, clients and families will be asked to complete data collection tools on how they used the funds
- Funds will be allocated by navigation team, and administered by VHA Health for older adults without dementia, and by Dementia Society for older adults with dementia

CLIENT OVERVIEW

- 150 referrals to date – 2:1 people with cognitive issues
- Two referrals have been 'inappropriate' – presenting issues / reasons for referral typically aligned with target population
- Tendency towards complexity
- Predominant referral sources: social workers at Bruyere, GEM nurses across sites, geriatric assessors
- Other referral sources: e.g. GPCSO, Ontario Home & Community Care, Geriatric Day Hospitals, Bruyere Memory Program, Centralized Intake (Specialized Geriatric Services)
- Predominant referral response time: within 3-5 business days
- Urgent response: typically hospital/emergency discharge
- Response time met: 95%+
- Emerging needs: ongoing care coordination / support for older adults (isolated adults)

LEARNINGS TO DATE

- Navigation:
  - Bringing ‘up’ the approach - aren’t we already doing this?
    - Leveraging Careteam template and resources to expand practice
  - There is an unmet need
  - Limits to what can be done (but volunteer and self-directed funding helps to mitigate)
  - 7 day availability essential
  - Challenges / opportunities: how to ‘stop’ navigating for older adults without ongoing care coordination, wait lists (true service gaps), client refusal / navigating those discussions, exploration of who else might ‘fit’ within the navigation team, understanding emerging client groups
- Volunteer matching:
  - Significant demand – both for companionship and ‘helpers’
  - Challenges – wait list for in-person matches (leveraging student program, reaching out to ‘lapsed’ volunteers from other sectors), ‘helper’ volunteer gap (to be explored through evaluation)

LEARNINGS TO DATE

- Positive feedback from referral sources:
  - ‘one stop’ approach,
  - they can ‘offer something’
  - few exclusion criteria
  - urgent/timely response
  - “Community Connections” easier to introduce
  - Challenges – establishing feedback/communication loop to referral source; perception of optimization already in place
- Self-directed funding is an essential facilitator – roughly half of total funding is now used
  - When other options have been exhausted
  - Low barrier
  - High importance given wait lists for public services
  - Challenges – facilitating payments, refining decision-making tree, developing ‘work arounds’ for clients challenged to administer self-directed funding, processing accountability concerns

QUESTIONS

Community Connections related:

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Careteam related:

Roxanne Dion, Champlain Community Support Network, Careteam Operational Lead

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