Presenter Disclosure

Presenter: Deborah Andrews, Stephanie Dickinson

Relationships to commercial interests:

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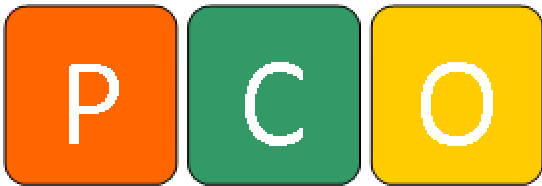
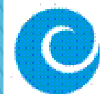


Primary Care Outreach to Frail Seniors

Primary Care Outreach:

A Shared Care Model offered from eight community health centres and two community resource centres in the Champlain LHIN

Every One Matters .  Ontario's Community Health Centres Les centres de santé communautaire en Ontario Chaque personne compte.

Primary Care Outreach

"To provide an integrated continuum of community-based services to frail seniors and their caregivers to enable them to stay healthy, live more independently in their own homes, avoid unecessary ER visits and prevent the use of ALC beds."

Vision, Mission, Values

VISION

We envision a community that works together to support seniors, their quality of life and timely access to care.

MISSION

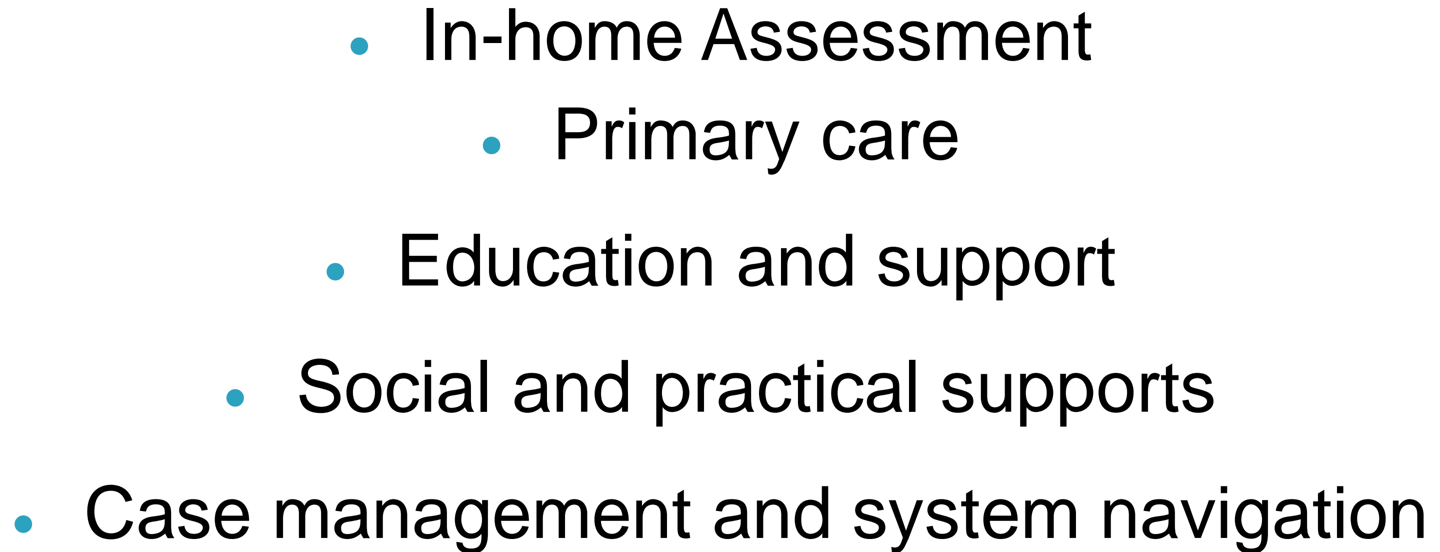
Registered Nurses and Community Health Workers work in partnership with seniors' primary care providers and other service providers in the community to help seniors achieve their goals, to provide care and appropriate supports that empower vulnerable seniors to live at home.

WE VALUE

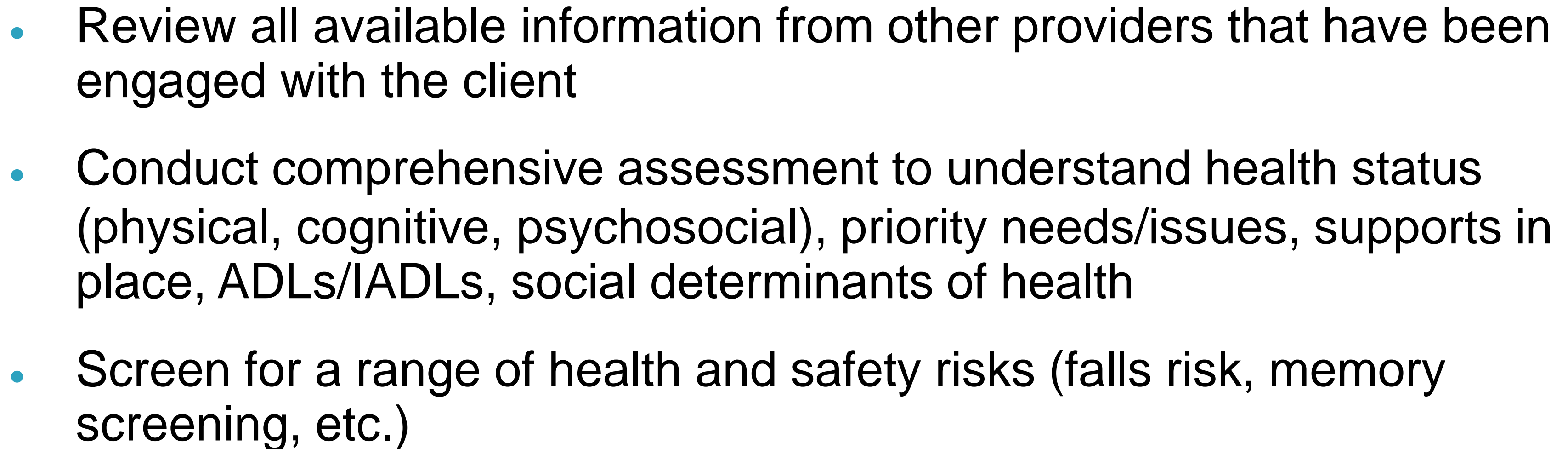
Client centered strength based care that supports client choice.

SERVICE DESCRIPTION

PCO CORE SERVICES

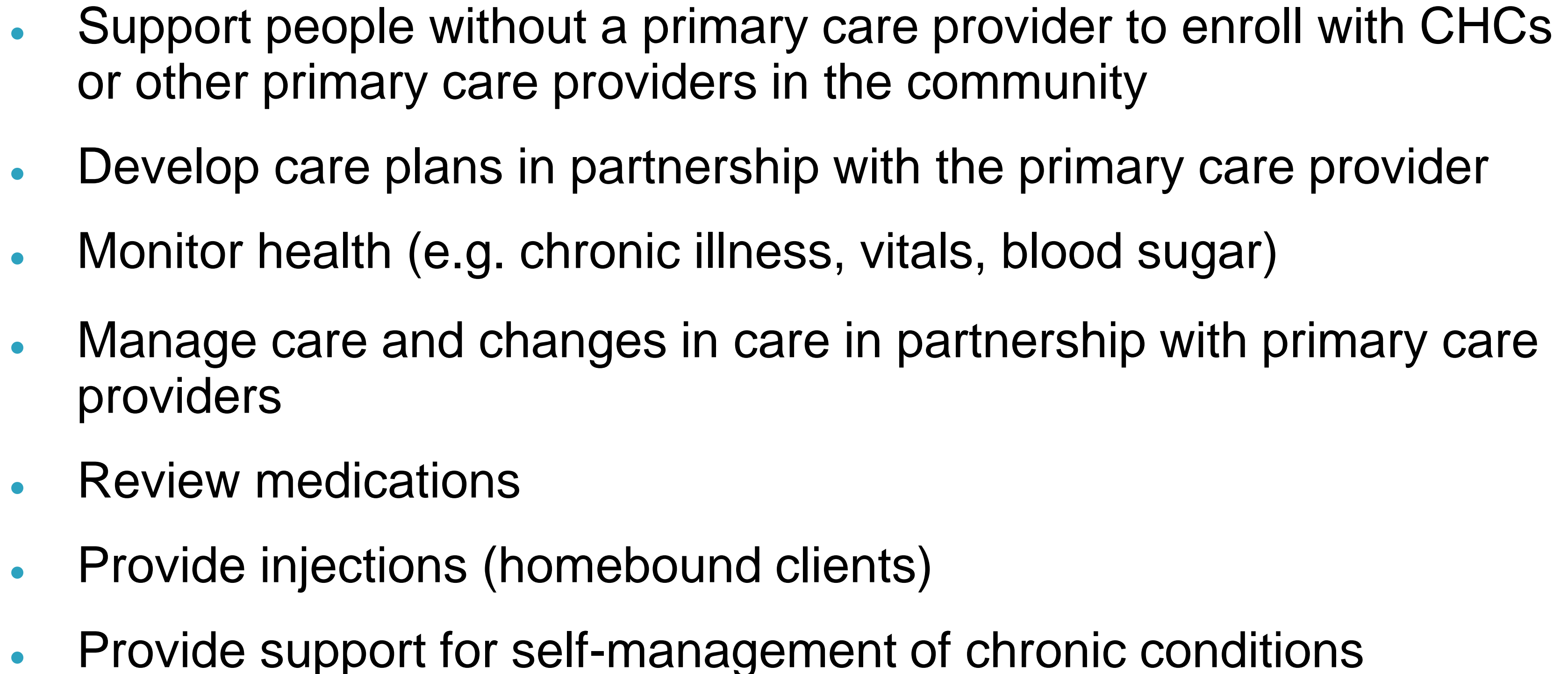


ASSESSMENT



- Review all available information from other providers that have been engaged with the client
- Conduct comprehensive assessment to understand health status (physical, cognitive, psychosocial), priority needs/issues, supports in place, ADLs/IADLs, social determinants of health
- Screen for a range of health and safety risks (falls risk, memory screening, etc.)

PRIMARY CARE

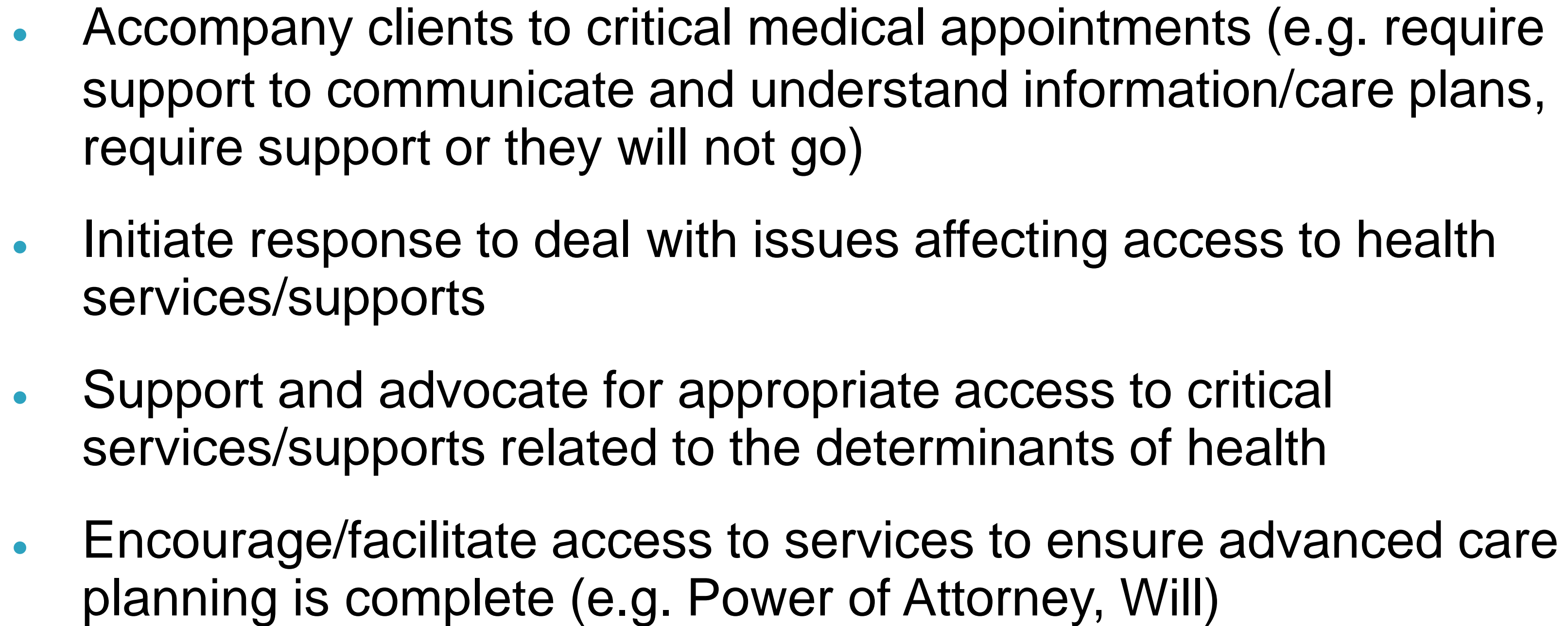


- Support people without a primary care provider to enroll with CHCs or other primary care providers in the community
- Develop care plans in partnership with the primary care provider
- Monitor health (e.g. chronic illness, vitals, blood sugar)
- Manage care and changes in care in partnership with primary care providers
- Review medications
- Provide injections (homebound clients)
- Provide support for self-management of chronic conditions

EDUCATION AND SUPPORT

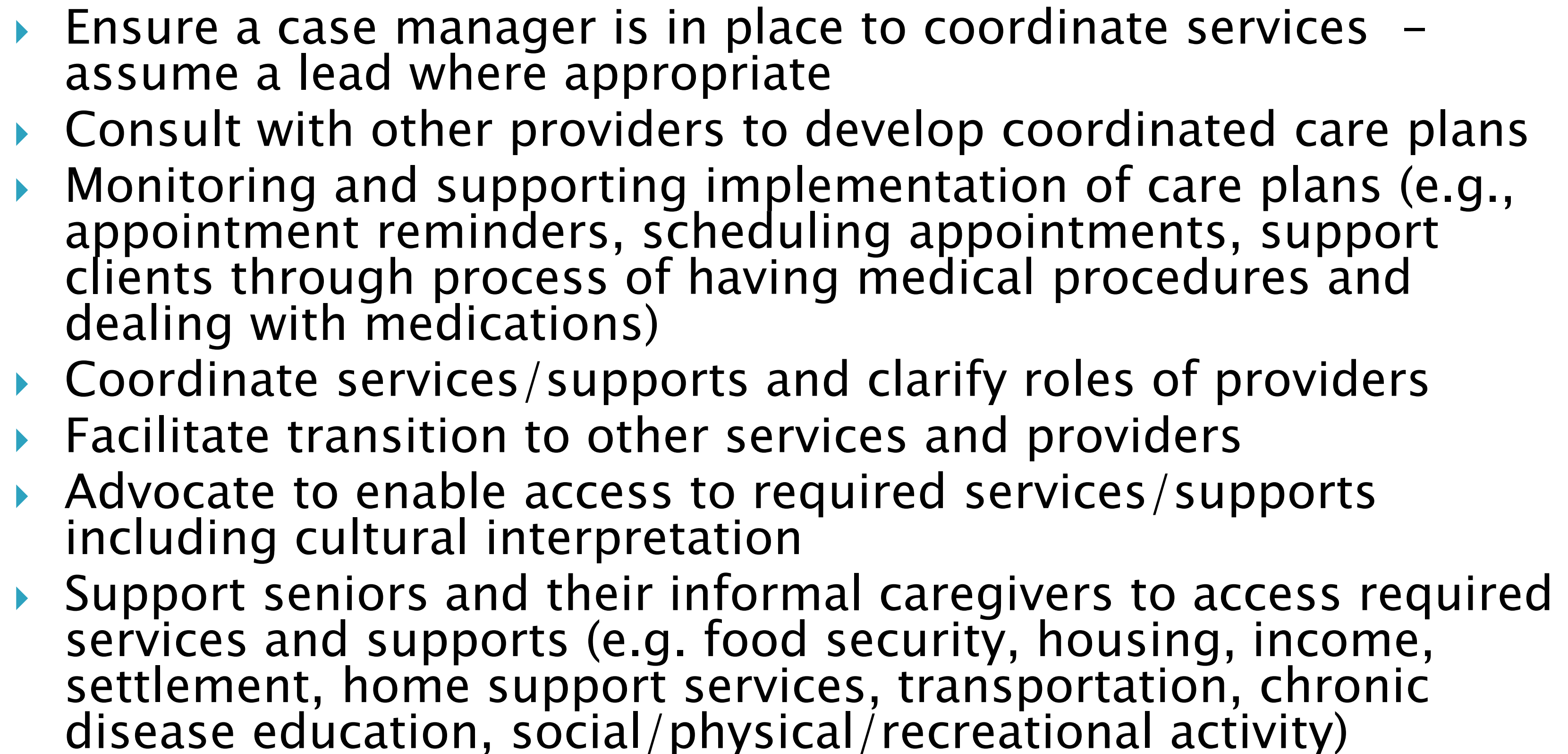
- Educate and provide advice to clients and caregivers about how to manage specific health issues (e.g. managing chronic conditions, medication use)
- Educate and provide advice to promote health and prevent issues (e.g. nutrition, safety, avoiding falls, appropriate responses in an emergency, how to navigate the health system)
- Educate and provide advice to navigate and prepare for other health services (e.g. understanding about how to prepare for a procedure)
- Provide caregiver support
- Link to other services for education and supports where appropriate
- Support Health Links by doing care coordination

SOCIAL AND PRACTICAL SUPPORTS



- Accompany clients to critical medical appointments (e.g. require support to communicate and understand information/care plans, require support or they will not go)
- Initiate response to deal with issues affecting access to health services/supports
- Support and advocate for appropriate access to critical services/supports related to the determinants of health
- Encourage/facilitate access to services to ensure advanced care planning is complete (e.g. Power of Attorney, Will)

CASE MANAGEMENT/CARE COORDINATION AND SYTEM NAVIGATION



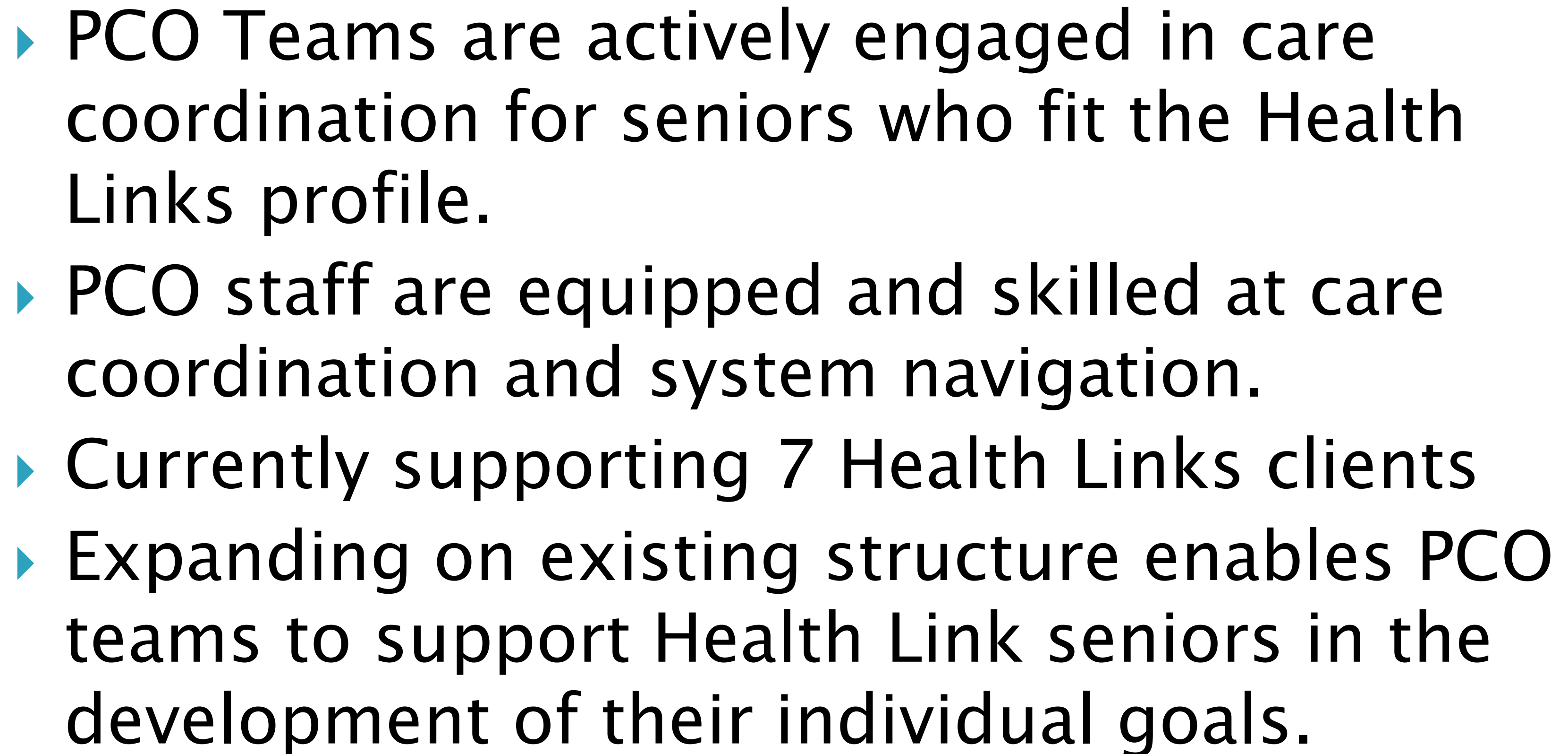
- Ensure a case manager is in place to coordinate services – assume a lead where appropriate
- Consult with other providers to develop coordinated care plans
- Monitoring and supporting implementation of care plans (e.g., appointment reminders, scheduling appointments, support clients through process of having medical procedures and dealing with medications)
- Coordinate services/supports and clarify roles of providers
- Facilitate transition to other services and providers
- Advocate to enable access to required services/supports including cultural interpretation
- Support seniors and their informal caregivers to access required services and supports (e.g. food security, housing, income, settlement, home support services, transportation, chronic disease education, social/physical/recreational activity)

MODEL OF CARE

- RN – communication with primary care provider, medication reconciliation, chronic disease management, vital checks, health education, post-discharge follow up and/or other services as needed.
- CHW – advocacy, system navigation, education, health promotion, care coordination, arranges case consults

- **PCO Teams are ideally positioned to support care coordination and the development of Coordinated Care Plans for complex seniors**

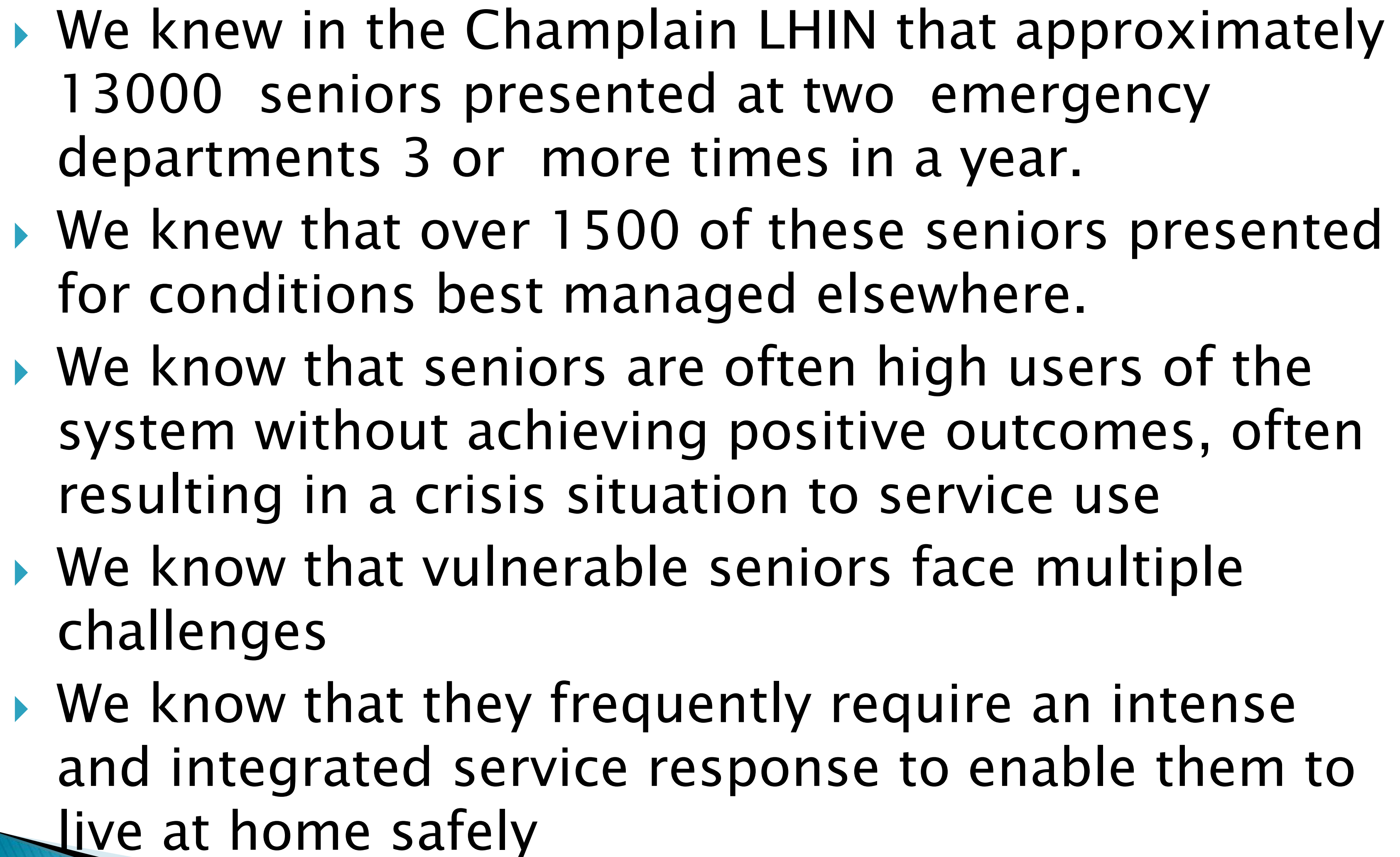
PCO AND HEALTH LINKS



PCO COMMON CLIENT PROFILE

- 65 years and older
- no informal supports or inadequate supports
- social isolation
- risk of/signs of elder abuse
- low income
- language barriers and literacy issues
- mental health concerns
- signs of cognitive decline or Dx of cognitive impairment
- signs of functional decline (ADLs/IADLs)
- polypharmacy
- difficulties following through on care plans/navigating the system
- missed appointments

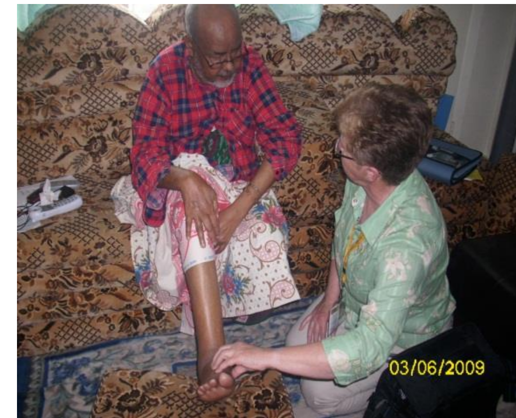
CONTEXT FOR VULNERABLE SENIORS PARTNERSHIP



- We knew in the Champlain LHIN that approximately 13000 seniors presented at two emergency departments 3 or more times in a year.
- We knew that over 1500 of these seniors presented for conditions best managed elsewhere.
- We know that seniors are often high users of the system without achieving positive outcomes, often resulting in a crisis situation to service use
- We know that vulnerable seniors face multiple challenges
- We know that they frequently require an intense and integrated service response to enable them to live at home safely

VSP EVOLUTION

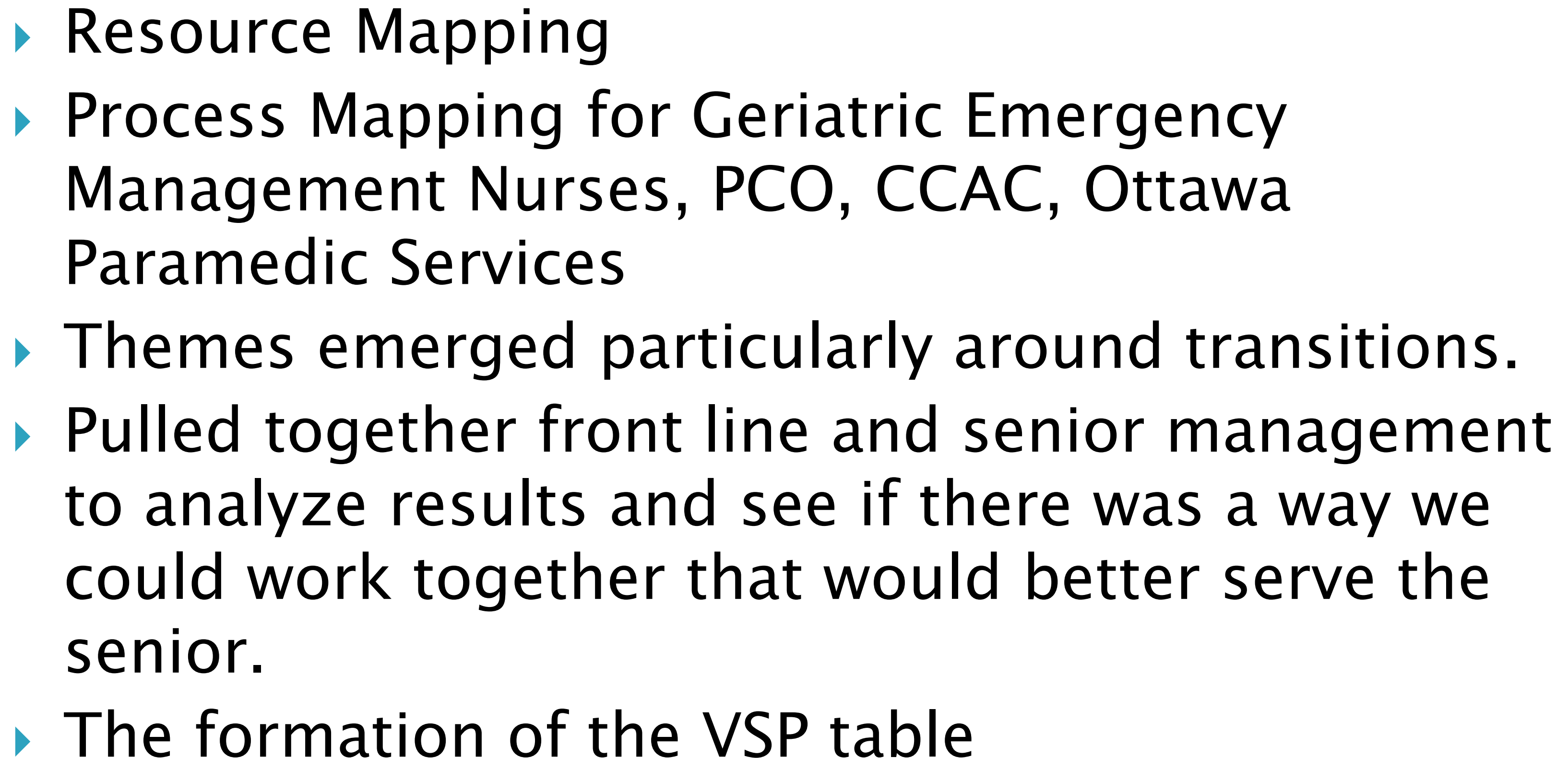
- Willingness to bring groups serving seniors together
- Work in partnership with other organizations to offer appropriate services and reduce duplication of services



Who came to the table

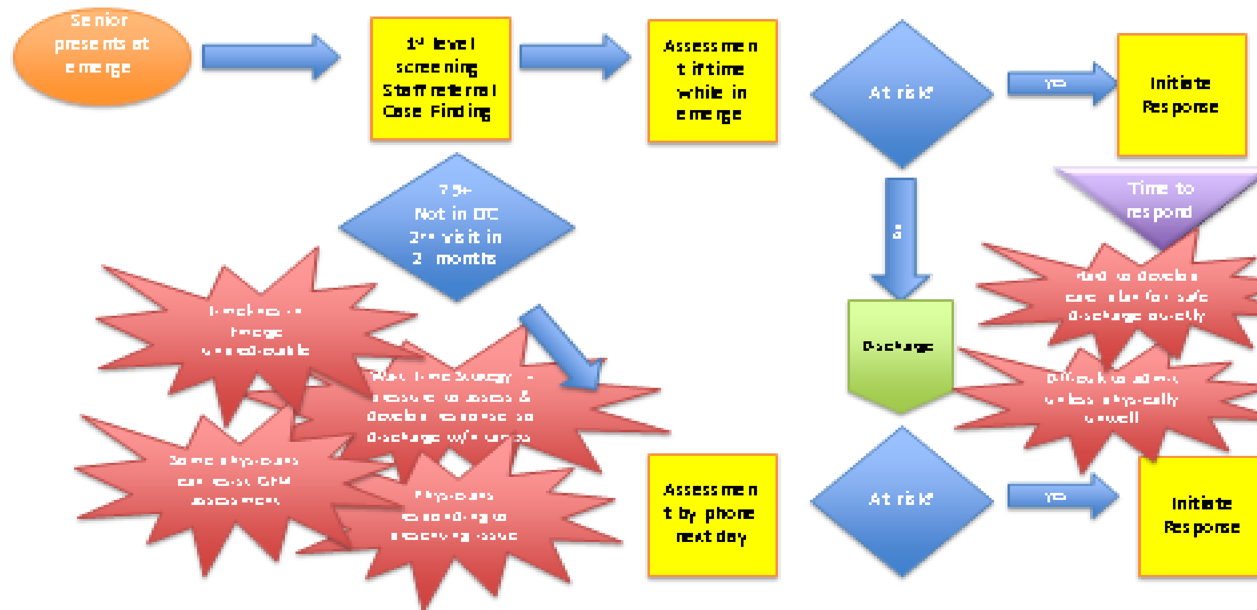
- South East Ottawa Community Health Centre (lead)
- Carlington Community Health Centre
- Centretown Community Health Centre
- Champlain Community Care Access Centre
- Geriatric Psychiatric Community Services of Ottawa
- Ottawa Community Support Coalition
- Ottawa Paramedic Service
- Ottawa Public Health
- Pinecrest Queensway Community Health Centre
- Queensway Carleton Hospital
- Regional Geriatric Program of Eastern Ontario
- Réseau des services de santé en français de l'Est de l'Ontario
- Somerset West Community Health Centre
- The Ottawa Hospital

What took place

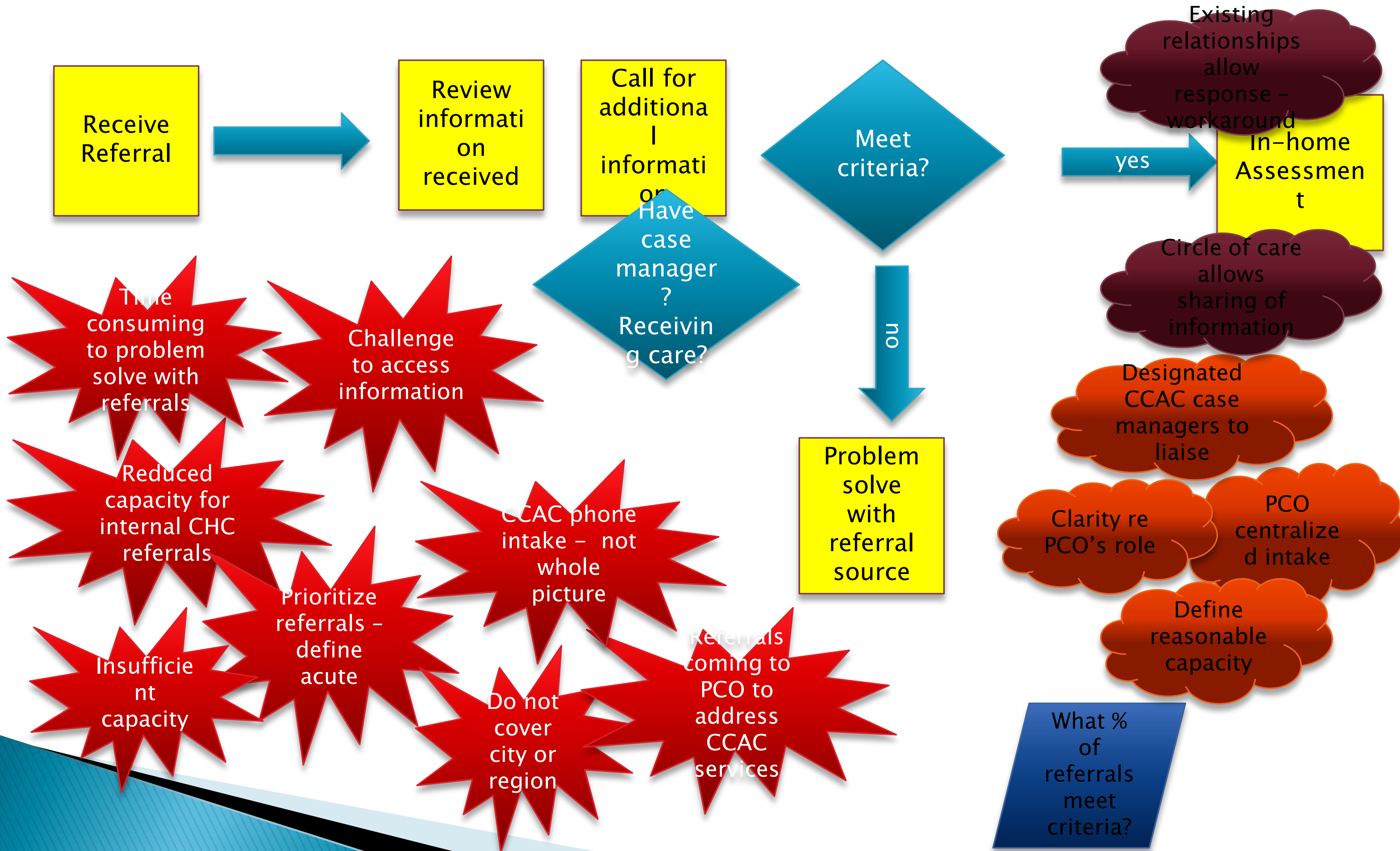


- Resource Mapping
- Process Mapping for Geriatric Emergency Management Nurses, PCO, CCAC, Ottawa Paramedic Services
- Themes emerged particularly around transitions.
- Pulled together front line and senior management to analyze results and see if there was a way we could work together that would better serve the senior.
- The formation of the VSP table

Presentation at Emerge



Receive Referral



Refer directly to CM designated for complex care

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

CCAC services required ?

Yes

Meet with CM in hospital to discuss care plan

CM arranges services

Less flexibility CMs stressed

Patients calling to complai n

Pla s not accepted – not notified

Repeat visits to emerge

Not providing service for < 3 mths

Not notified of changes to policies

Provide information about CCAC policies/directive s

Discuss care plan with Aging in Place Case Manager

Yes

Different sites – different CM practices

New step-client reassessed in community

Liaison with Aging in Place CM mostly working

Call CCAC to make referral

Long wait

May not meet score

Some CM present and active – report, direct referrals, immediate response

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

Reduced SW to discuss cases

High need but do no meet score

Do not understand CCAC scoring

Not reading GEM assessment s

ccept GEM assessment

Develop assessment framework

Reducing referrals – stats showing decreased need

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

How is need scored?

RESULTS

- Vulnerable Seniors Partnership
- This is the table that address front line issues with senior management
- Terms of Reference
- MoU
- Sub committees will be struck as needed

Terms of Reference

- Partner organizations in Ottawa, covering the continuum of services including primary care, home and community support services, community mental health, public health and acute care hospitals are committed to working together to enhance coordination of services for vulnerable seniors with complex needs. These seniors face multiple challenges, frequently requiring an intense and integrated service response to enable the senior to live at home safely. A Memorandum of Understanding (MOU) has been established to clarify how partners will work together.

Partners

Southeast Ottawa Community Health Centre
Carlington Community Health Centre
Centretown Community health Centre
Champlain CCAC
Ottawa Community Support Coalition
Geriatric Psychiatric Community Services of Ottawa
Ottawa Paramedic Service
Ottawa Public Health
Pinecrest Queensway Community health Centre
Queensway Carleton Hospital
Regional Geriatric Program of Eastern Ontario
Reseau des services de santé en francais de l’Est de l’Ontario
Somerset West Community Health Centre
The Ottawa Hospital

Thank you for your participation! Questions?

- For more information on the Primary Care Outreach program please visit:
  - www.seochc.on.ca