



Collaborative Health Intake Project Community Care Durham and CECCAC

Introduction

Community Care Durham (CCD) developed a partnership with the Central East Community Care Access Centre (CECCAC) to create a collaborative approach to providing intake services for seniors living in the community. By addressing challenges together, we enhance client care experience and have a greater potential for positive outcomes.

This project is a good example of “back office integration”, supporting the efficient use of human, technological and financial resources.

Actions

A new CCD position was created: “**Supported Referral Coordinator**” to work out of the CECCAC office in Whitby.

- ❖ The Supported Referral Coordinator performs a screening function by collaborating with CCAC Intake staff on requests for community service, sharing assessments. The Coordinator gathers preliminary information from the client, and if eligible refers to appropriate local CCD office.
- ❖ After intervention by the local CCD office, the outcome is reported to the CCAC Case manager by the Supported Referral Coordinator.
- ❖ Sharing client assessment information provides seamless linkage between services, and prevents repetition of information.
- ❖ Working together, mutual assistance and supportive problem solving is provided in serving the client, and risk management strategies are shared. Liaising with other community resources occurs as required - all geared to enhancing the client’s experience of care.

Results

- ❖ Within the first two months of operation, the Supported Referral Coordinator received **113 referrals** from the CCAC Intake team.
- ❖ Services have been provided from every local CCD office in Durham Region, and have included meals on wheels, home help, home maintenance, telephone reassurance, transportation, foot care, friendly visiting, COPE and in-home respite, with the greatest demand being for home help services.
- ❖ A “**person centred**” approach is used to engage the client in collaborative problem solving, utilizing existing resources matched to client need.
- ❖ Where services overlap between the organizations, or where there is limited service availability, we are working together to develop **innovative service responses** to meet needs as defined by the client.
- ❖ Our working experience reflects less adherence to prescriptive service ‘formulas’ related to budget, using more **integrative solutions** to meet needs.
- ❖ **Clients are empowered** to access services that make sense to them.

Challenges

Concerns have been expressed about **raising false expectations regarding service capacities**; effectively using available resources is crucial to the success of the project. To address these issues, local CCD community support programs regularly provide written notification of service capacities. This information is shared with clients as part of managing potential waiting lists. Our intent is to improve the experience of care by meeting client needs through an integrative approach, not frustrating clients by not meeting expectations.

Mental health problems exist for many seniors living in the community. The social isolation and declining independence that comes with the aging process can be stressful. COPE support programs exist in all locales, but outreach is needed to spread awareness and increase the rate of referrals for this service.

Caregiver support is a crucial component in meeting the needs of an ever increasing senior population in Durham Region. Personal Support Workers can be beneficial in maintaining seniors at home, and although both CCAC and CCD have programs to provide these services, the demand is high and waiting lists exist. As well, caregivers are typically selfless people, and do not accept help easily. This continues to be a challenging area for all service providers.



Lessons Learned

Interagency **collaboration must be supported by the senior management** of both organizations. Both need to realize a payoff for the effort expended, and there must be demonstrated positive outcomes possible through new operational practices.

Shared knowledge is the basis of success. The initial orientation provided by CCAC proved to be vital to the evolving process of working together. Openly sharing client assessments provides direction and focus to care plans developed by staff from both organizations, giving rise to innovation.

Communication at all levels is paramount to success. Staff from both organizations are interested in knowing about new projects, even if removed from the actual service. Regular newsletters are a good way to share statistical information as well as stories about clients served. Agendas for regularly scheduled staff meetings in both organizations need to include regular reports about the Collaborative Health Intake Project. Support for the project is garnered and momentum maintained for innovative practices by looking for opportunities to celebrate successes.

New Evidence/Best Practices

We know that seniors can be supported effectively at home, which is where most seniors choose to be if the right services are provided at the right time. Improving the experience of care by meeting client needs through a **more integrative approach** has a greater chance for positive outcomes. Where clients and caregivers are engaged in the process, and services are designed to address realities that are meaningful to them, compliance and cooperation result. Seniors are maintained at home at a lower cost and enjoy a higher quality of life - a “win-win” solution in keeping with the CE LHIN “**Triple Aim**” approach.

- ❖ The **positive relationship** that exists between the two organizations allows for innovative service responses.
- ❖ Our experience suggests that simple services like Meals on Wheels or Home Help can often be the answer to debilitating isolation that might otherwise lead to hospitalization.
- ❖ It is the combination of services that allows for successful maintenance at home - medical services supported by community support services that assist clients with the activities of daily living. “**Aging at home**” is possible, and it is achieved by **engaging the client** in working through solutions that arise from services that work collaboratively.
- ❖ Clients must not only receive services, but must also be engaged in the process of matching resources with the needs as they are experiencing them. The slogan “**nothing about me without me**” reflects the practice followed to ensure meaningful and effective solutions.

Next Steps

The Collaborative Health Intake Project has been operating for 3 months as a pilot project.

Based on the positive outcomes we have experienced, we plan to write a funding proposal to the CE LHIN to support it as an ongoing collaborative program.

This model of Interprofessional Collaboration could be replicated in other communities within the CE LHIN as part of the Aging At Home strategy, and we will share our experience to gain support from community agencies in other locations.

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