Community Connections

Refresh and Next Steps
March 1, 2023

Refresh: History and Functions

Community Connections is an integrated, collaborative approach to address the health and social needs of at-risk older adults. This pilot initiative was launched in January 2022 during the urgent/recovery phase of the Omicron COVID 19 waves, as a means of assisting hospitals with discharge and diversion.

- Coordinated triage / service access point through a navigation team (existing navigators + urgent funding from OHE)
- Optimize / create service plan
- Use of an online collaboration platform to develop a client service plan (Careteam), facilitate e-referrals (Caredove interface in Careteam), and provide a feedback loop to referral sources
- Matching of clients to volunteers for social support through existing community programs

From March - September 2022 (Phase One), DSORC and VHA Health & Home Support also had access to self-directed funding to provide to clients, particularly those waiting for service initiation.

Who is served?

Target is all older adults, however, partner outreach prioritized:

- Older adults being discharged from hospitals (inpatient and emergency),
- Older adults on wait lists for Home & Community Care, Specialized Geriatric Services, Adult Day Programs, Long Term Care placement.

NOTE: adults who do not fall within the target populations are not excluded from support. Initial focus was on the City of Ottawa with an expansion across Champlain in May/June.

Phase One Structures

- Project Team: Red Cross, the Champlain Community Support Network, the Champlain Dementia Network, and Compassionate Ottawa provided guidance.
- Ad-hoc Executive Team, comprised of executive and staff representation from the CDN and CCSN, and management from VHA Health & Home Support and the Dementia Society of Ottawa & Renfrew County, was formed to address operational issues, future planning, and development of the submission to Ontario Health-East Region for the urgent funding call in July,
- The Navigation Team was central to developing, implementing, and monitoring the tools and processes to support Community Connections. Initially, the team huddled briefly on a daily basis, eventually extending to weekly and now monthly huddles.

Phase One Funding

Budget of $88,500:

- VHA Health & Home Support received a total of $30,000 to provide navigation support ($16,935 to September 28, inclusive of roughly 10% in-kind contribution of time) and self-directed funding (disbursed through to end of September).
- DSORC received $55,000 for self-directed funding (disbursed through to beginning of August) – all navigation in-kind.

UPDATE: Since October 2022, VHA & DSORC have received 4FTE in urgent funding from OHE to augment navigation, AND short-term care coordination for older adults without cognitive issues

Evaluation Process

Planning

- Evaluation approach / working logic model confirmed by stakeholders
  March - June
- Development of data collection tools (interviews and surveys)
  June
- Securing resources for meeting transcription and interviews (May - June)

Collection

- Ongoing recording of project meetings February - July
- Interviews: clients, care partners, navigators, executive directors (VHA & DSORC), referring staff June - August
- Surveys: clients, care partners and referring staff July - September
- Organization financial and service reports: DSORC & VHA August - September
- Careteam platform reports, Review of referral form data: May, July, September

Analysis

- Transcription and coding of project meetings (navigation huddles, project team, executive team) - June-July
- Transcription and analysis of client, care partner and staff interviews - August-September
- Collation & Analysis: surveys, Careteam reports September

Learnings organized by:

1.1 How does the model change how at-risk older adults and their care partners/caregivers are supported in the community?

1.2 What are the facilitators and barriers impacting design and implementation?

1.3 What is the stakeholder experience of these modifications?

1.4 How have we engaged stakeholders in the process?

Phase Two: Current Activities

- January: Formalized an Executive Team to oversee Community Connections and report to CCSN and CDN on progress.
- End of February: Hired a part-time Project Manager to support the Navigation and Executive teams, and address areas of improvement identified, as well as to further develop partnerships with Ontario Health Teams. Bruyère is continuing to provide support to the initiative at a strategic and operational level through in-kind time from the Director of Strategy and Planning, but hiring a Project Manager will accelerate addressing operational issues from the first phase.
    - Funding provided via Dr. Paul Hebert's research work (aligned to role at Canadian Red Cross) for 2 days / week through to end of calendar year: Project Manager reporting to the Executive Team (in addition to within organization reporting).

Action Areas

- Expand navigation team huddles to include navigators and care coordinators from other organizations, ensure regional representation.
- Process improvements: updated mapping, updated referral form, and developing processes to encourage collaboration among organizations for clients already receiving care coordination services.
- Clients, families and staff consistently highlighted common areas of unmet need: Accompaniment (especially to medical appointments), client co-pays for medical devices and equipment, shopping/errand assistance, housework/light housecleaning, additional personal care supports
- Referrals to social programs and volunteer companionship are high, which will require streamlining of existing training programs or creative approaches to using community volunteers.
- Additional exploration of funding for coverage of client co-pays for clients needing urgent access to supports is needed. Go forward options need to be managed by organizations, on behalf of clients, including needs testing (without being administratively burdensome).
- Ongoing, stable program management is needed to support the navigation team moving forward. This includes updating tools and processes, addressing operational challenges, evaluation and follow-up with clients, families and partners in understanding their experiences, and developing funding proposals. This program management should further support the partners in operationalizing next steps.

Phase Two: Planned Activities

- Early spring: Explore the value in continuing and extending Community Connections, under what circumstances and with what resources
  - To continue and extend Community Connections, the original partners recognized that there would need to be enhancements to key services where the CCSN has identified significant unmet needs. Part of the work of the Project Manager would be to support development of any additional proposals, under the guidance of the Executive Team and the CCSN.
  - Coordination with OHTs, particularly Tier 1 (Central Ottawa and Ottawa East) will be crucial to determine what, if any, role Community Connections has in FY 2023
- By June: Completion of any additional proposals relating to the work of Community Connections, and additional proposals as directed by the CCSN.
- By June: determine next steps for the Executive Team and the structure to best carry forward the work.