



Theme: Cross Sector Collaboration

Synthesis of Small Group Discussions - A & B

- 1) Are you aware of any effective strategy (ies) in your community or elsewhere that has been developed for this strategy grouping? Please describe.
 - Several designated supportive housing floors within Toronto apartment complex. Medical services are provided to supportive housing tenants on a visitation basis and PSW staff are on site 24/7 for ADL and IADL services. Several community programs geared to clients' needs are provided in nearby church.
 - Regional Palliative Care Network that provides end of life care to people in their homes. The CCAC is maintaining a data base?
 - Pharmacies will organize medication for seniors when they are taking 3 or more high risk medications
 - There is a senior's program in Elliot Lake, targeting at risk seniors, that provides housing, nursing, and palliative care. These services are not funded. There is a "senior issues officer" who acts as advocate for navigable and coordinated care.
 - There is an Interim Strategies Group in North Bay that has developed and submitted a proposal for investment funding that would build capacity into the system by supporting patients in transition and identifying services for older people living with mental illness.
 - The Dementia Network in SSM and Elliot Lake meet quarterly to identify strategies that will meet needs of individuals & families living with Alzheimer Disease and related dementia.
 - The Native Friendship Centre in Sudbury provides a translation program, transportation, and a Life Long Care Program
 - There is a inter-service group of health care providers that meet on a regular basis to focus on seniors' needs

- ALC Task Forces led by LHIN coordinate monthly meetings with multi sector providers involved in ALC issues
- Mattawa General Hospital has on occasion been able to free up some of its acute care beds to help North Bay General Hospital in its ongoing bed crisis.
- Within in North Bay and Mattawa, families are able to access special transportation services to transport their individual members to adult day programs within LTCHs

2) What opportunities/challenges exist in your community for/against potential implementation?

Challenges	Opportunities
<ul style="list-style-type: none"> - Program mandates and boundaries restrict who is served and where. - IADL services are should be considered a priority to keep people in their homes - Transportation services are often uncoordinated and difficult to access - ALC patients can not be managed within home/community because of limited resources to support families in their care giving role - There is a shortage of geared to income housing - Supportive housing models need a more coordinated approach - PSW services are not provided on a 24 hour basis - Networking efforts need the participation and commitment at the executive director levels so decisions can be made and moved forward - There needs to be incentives for agencies wishing to explore collaboration and integration - Limited access to alternative accommodation such as assisted living force people unnecessarily and prematurely into high level high 	<ul style="list-style-type: none"> - Designate floors in apartment buildings that can be converted to supportive housing, ie; Ukranian Seniors Centre purchased through fund raising activities - Circle of Care model - Respite beds could be utilized more frequently if the per diem was more affordable - Break down agency mandates. Share the client “chart”. Agencies could look at opportunities to capitalize on collaborative hiring practices and shared job positions - Look at the Family Home Program that matches client with provider - Pay staff to take on added responsibilities if funding exists within current allocations - Less preoccupation with LTC beds so that resources can be diverted to supportive housing and multi disciplinary resources within home - Use a rate subsidy for families requiring financial assistance so they can have access to rest & retirement homes and LTCH short stay beds

cost settings	
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- 3) What steps, resources, and partnerships would you put in place to operationalize this strategy?
- There needs to be less emphasis on expanding the LTC sector and concentrate on investments toward supportive housing with supportive services
 - Coordination of medication between primary care physicians & pharmacies
 - Need for electronic health record that provides consistency and continuity of information on the patient
 - There needs to be a systems approach as opposed to a sector or individual HSP approach
 - Flex mandates and greater coordination can lead to resource sharing as well as shared positions between/among providers
 - Physicians and other system gatekeepers need to be educated to the importance of early identification and referral of the frail elderly
 - Use a common assessment tool for in-home assessment for elderly
 - Establish secure supportive housing for dementia clients. PSW services could be offered for clients with less medical complex issues. Access through rent geared to income. This would free up LTC facility beds presently occupied by dementia persons with less complex medical needs
 - Support aging in place through Family Home concept similar to the model used in the Association for Community Living system
 - Maximize a person's independence in the home through community supports which is more cost effective than maintaining the person in a hospital or facility setting
 - Greater information and power sharing among networks. There needs to be greater flexibility through flex mandates that will allow for shared resources
 - There needs to be greater education and public awareness about how to access and navigate the different parts of the health system, both for providers and users.

- Follow up services for patient upon discharge to ensure that at risk patients are receiving required services for prevention management