

CONFERENCE ABSTRACT

Core principles of integration of healthcare and social services that support continuity of care for vulnerable seniors with canadian case study: home-at-last

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Canada's healthcare and social services systems are failing vulnerable older adults. Care for high risk older Canadians (over 65) is not optimal in Canada. They comprise one of the highest healthcare user groups in Canada. In Ontario, they make up more than half of the top 5% that consume over 55% of healthcare resources. There is a priority to reduce inappropriate acute care use in Canada. Integration of health and social services (IHSS) can be leveraged to enhance better continuity of care by enabling hospitalized patients to return to home faster, or to avoid hospitalization in the first place. IHSS is an emerging trend in Canada, and is not widely understood as a means towards addressing better care transitions for vulnerable seniors. There is no common understanding of healthcare and social services integration across Canada, which can deter its application as a policy and programming instrument. The presentation will explore the common principle, concepts, core characteristics and components of integrated health and social services that support continuity of care. These concepts will be explored against the "Home-At-Last" (HAL) integrated initiative, a community-based program, situated in Ontario, Canada. HAL is a coordinated, micro-level integrated health and social services initiative that is led by CHATS-Community & Home Assistance to Seniors, a not-for-profit community and social support agency. CHATS' HAL program works with regional health and other social care partners to improve seamless services delivery, thereby reducing hospital readmissions in order to improve continuity of care for seniors. It provides home and personal support services that includes providing transitional support for patients from the point of hospital discharge. HAL has four hospital partners that provide acute care and discharge planning for patients into the community. HAL directly provides home-support within the critical first 48 hours after discharge: social care coordination (i.e. advocacy, referrals), transportation, medication and medical equipment pickup, shopping, and other activities to support daily living (i.e., meals, bathing, safety checks). HAL helped to reduce hospital readmissions, reduced hospital lengths of stay, and patients have experienced greater satisfaction and empowerment. HAL possesses many of the characteristics of integrated initiatives including a strong patient-care focus, clear and shared common goals among all integration partners, a strong focus on quality, staff and professional interaction among across all partner organizations, shared culture of accountability among the organizational partners with collaborative leadership and decision-making that is devolved to front-line staff. There is room for continued evolution and maturation of HAL, including a greater focus on shared performance

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monitoring among partners and greater vested interest in patient outcomes in the community among all integration partners.

Keywords: seniors care; integrated health and social care; community-based care; canada; continuity of care
