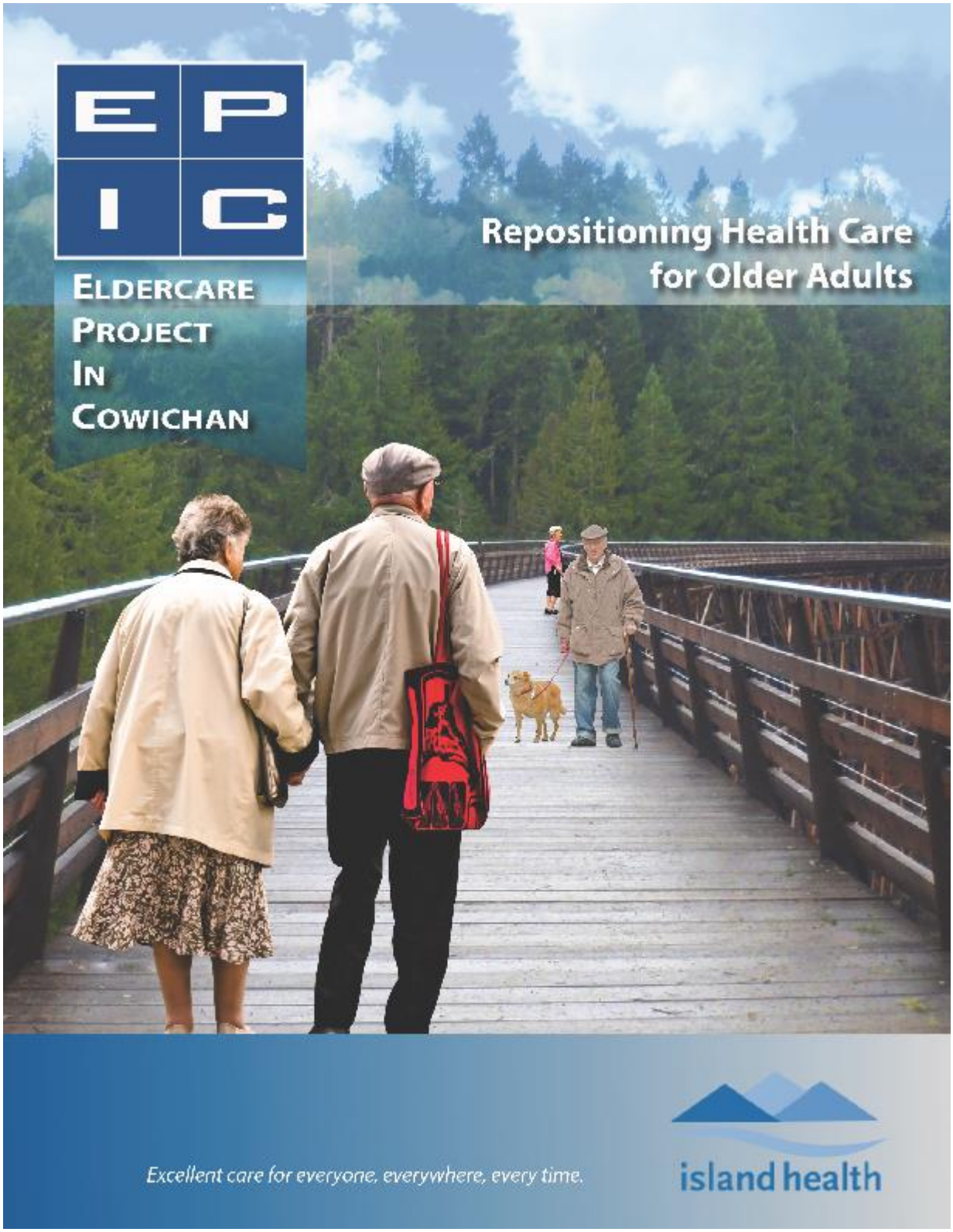
EPIC
ELDERCARE
PROJECT
IN
COWICHAN
Repositioning Health Care
for Older Adults
Excellent care for everyone, everywhere, every time.
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Taking the Next Steps: Repositioning Health Care for Older Adults

Final Report Template

1. POPULATION/PATIENT VALUE PROPOSITION

In 2013-14, in the Cowichan Communities, 10,490 people over the age of 65 were identified with low medium chronic conditions and 3,790 people were identified with frailty or high chronic conditions. The Eldercare Project In Cowichan (EPIC) has the goal to specifically focus on these 3,790 people with frailty and high chronic conditions, through a vision of creating population based integrated primary care teams. It is anticipated that whilst this will be the focus population, the system redesign will also enable a strong focus on the population with low medium chronic conditions, consequently improving the health of the senior's community overall.

Island Health, in partnership with the Cowichan Valley Division of Family Practice (CVDFP), completed extensive mapping of health services in 2013. Service gaps identified through this process along with results coming from community consultations conducted by Our Cowichan Community Health Network were compiled, prioritized and themed into three categories:

- Access to services within Island Health,
- Continuity of care from one service to another and
- Integration of services with the community.

Specific gaps for seniors included:

- Need of screening tools,
- Restricted access to specialty services and
- Gaps related to knowledge on community services access
- Need of adapted housing for seniors.

- **How it addresses the current challenges in the system.**

The goal of repositioning health care for older adults living with complex chronic diseases and frailty in Cowichan is to address these gaps listed above, and to look across the whole continuum of health and care to ensure that the right skills and services are delivered in the right place at the right time. This would be done by genuinely involving seniors and their caregivers in designing the right model of care. It would also require that all partners sign up to a shared vision and collaborate effectively to build a system that would support meaningful health outcomes for seniors.
This would result in:

- Improvement in the quality of life for seniors living with frailty and complex chronic disease
- Improvement in patient, family, care givers and provider experience
- Decreased CDH occupancy to 85%
- Decreased number of emergency visits and unplanned hospital admissions and their related cost.
- Decreased number of acute care readmissions to CDH within 30 days

- **Fiduciary Value Proposition- conceptually how does model align with goals of sustainability and scalability?**

The new model of care aligns well with goals of sustainability as one of the key foundations of the vision is to provide better care planning and case management for frail seniors. In Cowichan, we initiated a strategy around the high users of the emergency room in partnership with Island Health staff and a group of physicians. The goal of this strategy is to focus on how care planning and case management can help a small group of vulnerable people who are consuming a high proportion of ED visits and resources and how a multidisciplinary approach, case management and the engagement of primary care providers is required to produce care plans. A study conducted in 2014 by the University of British Columbia – Family Medicine Scholar Project[1] profiled 92 patients of the Cowichan District Hospital who had used 1490 visits over a period of one year and who subsequently had case management and care planning organised. The study shows that after one year, the 92 patients used only 426 visits as a direct result of care planning and case management. The gross cost savings estimated in the study was $305, 368.00 for those 92 patients. With this study in

[1] Hegan, K., Stasiuk, S., and Blackburn, G. Care plans in rural British Columbia: Bringing it back to the patient. June 2014.

mind, and the results achieved in Cowichan around care planning and case management, we believe that not only will the new model of care for frail seniors provide better quality of care but it will also decrease the cost of consumption of care for a growing proportion of patients who are using a high volume of resources.

2. THE MODEL

PROVIDE A DETAILED DISCRIPTION OF THE MODEL

The proposed model of care will have four key strategic pillars that will contribute to the overall goal of repositioning health care for frail seniors. These four strategic pillars are:

- **Community;**
- **Integrated Primary Care;**
- **Cowichan District Hospital;**
- **Residential Care/End of life.**

Each strategic pillar has key focuses with a vision of change that will drive the different partners to work together to develop an integrated plan to support a system change for frail seniors.

Community

Key focus: **Healthy living and promoting independence**

Goal:

Older people should be able to enjoy long and healthy lives, feeling safe and supported at home and connected to their community.

Vision:

This work would be led by the Community Health Network seniors group. The vision is:

- To promote a healthy lifestyle and wellness;
- Promote socialization and age-friendly communities;
- Increase awareness of the impact of economic status on the health and wellbeing of seniors assuring the right housing for older people;
- Develop a multi-modal transportation plan would include both active and passive transportation modes and connections between municipal transportation infrastructure and services;
- Coordinated care with families and the community for daily living activities and minor needs;
- Improve understanding of services available among providers who can advocate for additional services to meet senior's needs;
- Increase effective communication and facilitate access to information about available supports.

Key focus: **Caregivers Support**

Goal:

Families/caregivers of frail seniors and older adults with complex chronic conditions should have sufficient and consistent support to provide the right care to avoid exhaustion and/or isolation.

Vision:

- Early identification of care givers and their specific needs;
- Improve information sharing and training;
- Increase respite at home and training for the people who provide respite;
- Increase respite opportunities available outside of home through optimization of adult day programs / repurposing of assisted living beds;
- Increase individual support and group support;
- Improve access to community services;
- Care givers will be offered an independent assessment of their needs and will be supported into their caring role;
- Volunteer services will be available to provide a welcome home service for frail seniors who live alone and have been

discharged from hospital, available 7 days / week;
- Include discussion with older people with frailty and their care givers to define the impact of illness and symptoms on a day-to-day basis.

Integrated primary Care

Key focus: **Integration and person-centered care**

Goal:

Frail seniors and older adults with complex chronic conditions would have safe and compassionate care and services that would be easy to access throughout their life trajectory. Their experience through the system and in their community would feel positive and specific to their needs.

Vision:

- Integrated Primary Care Team

The vision is to transform the current model of service delivery for frail seniors within Cowichan into one that ensures seniors are supported to live independently and remain in their place of choice in the community for as long as possible. Our goal is that an Integrated Primary Care Team would provide safe and compassionate care and services that would be easy to access, seamless and specific to their needs.

- Multidisciplinary team approach

We are committed to transforming the traditionally siloed home and community care model to one that aligns with and, where space permits, co-locates GP Practices, the Seniors Outreach Team, the Integrated Health Network and Home and Community Care offering community based health care hubs to support seniors living at home.

- Rapid support in community

When the health and/or independence of the older person rapidly deteriorates, they should have prompt access to support close to home, including effective alternatives to hospital.

The vision is to create:

- Admission-prevention Hospital at Home services with a seniors wrap around response team;
- Pro-active identification of emerging patient issues;
- Single point of access available to facilitate accessibility to community services to manage crisis at home with specialist opinion and diagnostics;
- Provision of complex patient assessments and advanced nursing care for frail seniors to prevent hospital admissions and facilitate early discharge;
- Interfaced with community geriatrician to provide expert clinical advice, support and supervision;
- Providing urgent, coordinated medical and social care;
- Appropriate support for care givers in times of crisis;
- GP Practices to monitor hospitalization and avoidable emergency department presentations regularly and determine whether alternative care pathways may have been more appropriate.

Key Focus: **Self-Care Strategy**

Goal:

Empowering people with the confidence that they can look after themselves in many circumstances, and visit their primary care provider/physician only when they need to, gives people greater control of their own health and encourages healthy behaviors that help prevent ill health in the long-term.

The vision for the patient/family/care-givers would:

- Have personalized care plans including emergency contingency plans if an exacerbation of illness occurs;
- Have comprehensive information on their condition;
- Be assisted when they need help until they learn to support their own self-care needs;
- Have follow-up to check on progress or be referred to community services if required;
- Allow for increased ability of older people to live safely in the community for longer with proper and accessible supports;

- Improve outcomes related to falls, disability and quality of life[2].

Cowichan District Hospital

Key Focus: **Improve Acute Care for seniors when needed**

Goal:

The underlying aim of acute illness management will be to treat the person at home; acknowledging that hospital admission may sometimes be unavoidable. However, acute hospital care must meet the needs of older patients with complex co-morbidities and frailty. Services should provide adequate access to specialist input, minimize harm, provide a fluid transition from one service to another and provide compassionate and person-centered care.

The vision is to ensure that when a person typically presents in crisis with the frailty syndromes of delirium, sudden immobility or a fall that they can be assessed within a specified time frame, followed by specific treatment, supportive care and rehabilitation from an acute, front end frailty unit at the hospital.

To gain confidence that more people presenting with a frailty syndrome crisis can be safely managed at home, multidisciplinary care teams integrated within the community with the right skills will be:

- Using comprehensive geriatric assessments;
- Providing exemplary care for seniors;
- Focusing on older patients with frailty;
- Liaising services for frail older people in acute care;
- Maximizing appropriate timely discharge planning;
- Improving safety and preventing avoidable deaths;
- Minimizing harms of hospitalization;
- Improving care for inpatients with dementia and mental health problems;
- Focusing on dignified person-centered care;

The vision is also to provide adequate education and training for staff in all clinical areas focusing on eldercare and compassion for frail older people. CDH will provide safe exemplary care for seniors with a focus on prevention and treatment of falls, pressure sores, hospital acquired infection, polypharmacy and medication errors as well as malnutrition, delirium, and immobility as a result of bed rest. This will be achieved with the implementation of key strategies:

- Senior assessment available at the front door of CDH 24/7. Specialist assessment to also be available within 12 hours of admission 7 days a week;
- Rapid access to ambulatory clinics such as Wound Care and IV therapy;
- Personalized care planning including an emergency contingency plan;
- Implementation of strategic operational plans to reduce the number of ward moves, especially out of hours, with accompanying plans to improve patient experience;
- Wherever possible, seniors are not admitted to residential care directly from hospital and instead, receive adequate rehabilitation and treatment to enable them to return home directly.
- Families prepared at admission that the goal is a discharge home with appropriate support and the wait for residential care would be from home.

Key focus: **Improve discharge planning and facilitated post discharge support**

Goal:

Discharge planning needs to start at first contact with the hospital and be standardized and embedded in practice, with older people and their care givers fully and promptly involved in their own discharge plans and goals. Island Health staff, primary care providers and all the community partners should work together to ensure that patients can leave hospital once their clinical treatment is complete, with good post-discharge support in the community to reduce the likelihood of readmission or further emergency presentations.

[2] Heckman et al. (2013). Developing an integrated system of care for frail seniors. *Health Care Management Forum*.

The Vision:

- Early seniors assessment, assertive discharge, and a clear focus on patient experience and flow;
- A concerted focus on discharge planning throughout the hospital stay, and the necessary supports to discharge seven days a week;
- Employing a thorough process that assesses not only the patient's medical status but also their functional status, mobility, home environment and limitations, and social status among other conditions;
- Partnering with older people and their care givers in discharge planning;
- Ensuring integrated information systems as per the planned IHealth rollout and structured inter-professional communication
- Clear lines of communication between CDH and the community-based primary care team;
- Strengthening post-discharge assessments and support;
- Reducing delayed transfer of care.

Residential Care / End of life

Key focus: **Better choice, control and support toward the end of life**

Goal:

The goal is to ensure the older people who are nearing their end of life have access to high quality, timely and coordinated end of life care, honoring whenever possible an individual's choice and care wishes.

The vision:

By strengthening and integrating our health care system, particularly in the community sector, the vision is to provide high quality, compassionate care for all people who are dying and their families. The vision is also to create a system of shared care between specialist primary care providers and physicians, with special interest in palliative care and primary care providers. To further create a system of early identification of patients requiring palliative care. A patient with life-limiting illnesses would have a single point of entry into the system - referred by primary care providers/physicians, specialists, residential care, and home and community care. The patient's primary care provider/physicians remains the primary provider, but would have the availability of accessing palliative specialists for more complex symptom management, followed by a formal care plan developed between the primary care team, the specialist and the community support systems. An integrated care plan will provide a full continuum of support and care through to the end of life.

Specifically, the vision is to :

- Integrate advanced care planning with the older adult and their family into the community-based primary care team practice;
- Create an integrated system which delivers patients dignified and specialized care when admitted to hospital at the end of life;
- In alignment with Island Health End of Life Bed planning, support the development of hospice 'clusters' nested in residential care

Key focus: **Timely access to high quality residential care**

Whilst some people make a positive choice to enter long –term care, older people should only generally move into residential care when treatment, rehabilitation and other alternatives have been exhausted. Residents should consistently receive high-quality care that is person-centered and dignified, and have the same access to all necessary health care as older people living in other settings.

The Vision

- Reduced unnecessary or inappropriate hospital transfers
- Improvement of patient provider experience
- Reduced cost per patient as a result of a higher quality of care

Key focus: **Timely access to assisted living**

Whilst some people request or consider the option of assisted living, older people should only generally move into assisted living when all other alternatives have been exhausted. Residents should consistently receive high-quality care that is person-centered and dignified, and have the same access to all necessary health care as older people living in other settings.

The vision for this key focus will be developed through the work planned with the residential care and of life working group.

Define and quantify geography, population to be served by the model (numerator/denominator), demographic, needs of population

Located approximately 90 km northwest of Victoria on Vancouver Island, the Cowichan communities include Cowichan (LHA 65), Lake Cowichan (LHA 66) and Ladysmith (LHA 67) as well as the island communities of Penelakut and Thetis. With a population of 85,219 ,the senior population (over 65) makes up 18,621 (21%). 20% of BC's Aboriginal population live on Vancouver Island and over 8,500 individuals in the Cowichan Valley Regional District (CVRD) self-identify as an Aboriginal person.

Population identified:

- In the Cowichan Communities in 2013-14, 10,490 people over the age of 65 were identified with low medium chronic conditions and 3,790 people were identified with frailty or high chronic conditions.

Other data for consideration:

- The number of Emergency Department Visits for seniors living in Cowichan was 14, 660 in 2013/14, which accounts for 29% of all ED visits.
- At CDH, there were 8,204 visits to the ED by seniors which is lower than the ED visits by resident noted above and implies patients went outside of their area of Emergency Care.
    - 3,570 aged 65-74
    - 2,857 aged 75-84
    - 1,777 aged 85+
- The ED visits for seniors in Cowichan increases with age:
    - 2,790 (26%) 65-74 age group visited the ED
    - 1,980 (36%) 75-84 age group visited the ED
    - 1,140 (46%) 85+ age group visited the ED
- In 2014/15 the number of ED user 5 visit + per year at CDH by age groups:
    - 65-69 aged : 62 visits
    - 70 + aged : 202 visits
- In 2014/15 the number of ED user 5 visit + per year at CDH by age groups:
    - 65-69 aged : 62 visits
    - 70 + aged : 401 visits

NOTE: This number has been historically higher but with the Familiar Faces strategy in the emergency, this number has been significantly decreased

Governance and partnerships

The Eldercare Project in Cowichan (EPIC) collective governance alignment framework has been designed to put in place formal arrangements that would support our vision for community and service transformation. These include four working groups that will:

- Have an overall goal to deliver community focused health and care for seniors;
- Be supported by frontline staff, GPs, Aboriginal people and community partners;
- Improve access and continuity of care;
- Drive integration of primary, community and social care for the benefit of patients;
- Maintain current services and further develop them.

The four working groups are:

- **Community**
- **Integrated Primary Care**
- **Cowichan District Hospital**
- **Residential Care/End of life**

Location- e.g. Virtual, co-location, outreach

All work involving facility planning is anticipated to be done in partnership via the Integrated Primary Care working group and will be planned this fall.

Outline the proposed new pathway for seniors in this model, including aspects like:

With the goal of reducing this population presenting themselves at the Emergency Room , the new frailty pathway will identify frail seniors and provide integrated multidisciplinary "wrap around care" specific to their needs through care planning, case management and rapid response at home in time of crisis. Strong strategies on self-care and support to the care givers will be implemented, and assisted living and residential care will be optimized and repurposed to provide short term assessment and respite. Medication assessment and review will be a systematic component of the care.

- **24/7 care**

Described in primary care model

- **Intensity of services (adjustment of model to changing patient needs)**

Described in model of care

- **Case finding**

Described in model of care

- **Funding**

Cowichan did not have initiatives funded through the accelerated integration funding except for a few positions for the Integrated Primary Care Team in Lake Cowichan. The goal of the proposed transformation is to redesign care for frail seniors and identify gaps to fully achieve integration. Based on the new model designed with patients and physicians, we will determine the funding needs for additional resources required to achieve Community Focused health and Care.

In alignment with the Ministry of Health's recent policy papers, Island Health is undertaking system re-design work in the areas of seniors, rural/remote, and mental health and substance use. Funding for this work has been supplemented through the Integrated Primary and Community Care - Transformation Initiative budget from the Ministry of Health, which allocated $11.61M annually over three years (2015-16 to 2017-18). Within this budget approximately $3M annually will be dedicated to clinical and change management to support the seniors redesign in the three prototype communities: Comox Valley, Cowichan Valley, and the Saanich Peninsula.

3. SERVICE DELIVERY PROCESSES AND ENABLING POLICY :

Human Resources

Describe the human resource components of the proposed model

The new model of care requires realigning the current service provision within Home and Community Care, Seniors Outreach Team, Integrated Health Network, the medical specialists, Urgent care and Hospital care including diagnostic and pharmaceutical services, residential care and assisted living. To develop the specificity of the human resources component of the model will require the involvement of staff and local partners including patients/family/care givers and primary care givers/physicians.

Composition and roles

This integrated team would have functions that would provide services aligned to the specific care needs of the persons. The new model of care would:

- Provide a focus on frailty to actively find individuals at risk for deterioration, frailty and hospital admission using screening, case finding and shared predictive risk tools by creating a **Cowichan Frailty Risk Register**;
- Provide exemplary care for people with frailty/dementia/chronic complex disease;
- Support self-care for people with mild /moderate frailty
- Case management for people with moderate / severe frailty;
- Offer patients active case management including advanced seniors assessment, care planning and coordination of services to meet their needs;
- Use case management as the best vehicle to bring together all of the care treatments needed by many seniors with complex chronic disease including frailty;
- Provide seven day a week services to support frail seniors at home;
- Provide adequate step up and step down home based re-enablement services;
- Provide the workforce required for home based re-enablement which include nurses, therapists, social workers, and voluntary and community groups led by a senior clinician;
- Provide inter-professional care planning with caregivers, patients and family;
- Assure coordination and communication between caregivers, patients and families;
- Provide a comprehensive geriatric assessment initiated rapidly within four hours of referral 8am to 10pm, 7 days / week with acute episode pathways of care for seniors who require ongoing treatment but do not require admission to hospital;
- Improve the use of assistive technology including Telehealth services to assist patients in effectively managing their self-care;
- Provide simple referral systems with a single point of access for the frail older person;
- Provide group education;
- Use evidence based guidelines;
- Use common clinical tools and shared competencies;
- Provide navigator and liaison functions.

Staff and skill mix (including FTE)

The plan to define staff and skill mix (including FTE), the ratio of patients to providers and the details of the frailty pathway will be achieved in the fall 2015. This will be done with the involvement of the Integrated Primary Care working group with the support of Island Health staff, the Professional Practice team, the Process Improvement team, the CVDFP and patients/family/caregivers.

Professional Practice has successfully supported other communities with determining resource shifts particularly around role, scope and function for current and future state service delivery. It is anticipated that many community team members will require re-defined roles and functions, with the intention of optimizing the scopes of each healthcare provider.

Island Health's Professional Practice team will be involved with working groups, IPCC, Process Improvement and operations staff in assisting with a workforce review using a model that has been validated in other communities. This work will inform the development of the core, shared and unique competencies of community healthcare providers in order to optimize the scopes of practice, thus more strategically addressing the care needs in the frail elderly client population.

IM/IT

What are the proposed solutions to:

- **Access to needed information and analysis**
- **Shared charting and information sharing**

Identify enabling IM/IT tools and policy requirements

Technology will support the development of the community focused health and care model and the EPIC project will continue to implement and build on the Island Health community strategy for the single client record (SCRIPT). As part of this work we will be progressing development and implementation of a shared frailty toolkit, and developing shared electronic processes to support the hub operation including common intake processes and decision support tools. In summary :

- Develop a current state
- Develop a future state workflow with integrated community services to include internal efficiencies eg. Alignment of SORT and HCC intake processes
- Develop information sharing protocols
- Prepare for I Health single client records
- Identify assets (PC's Laptops Telephones etc.)
- Spread Home Health Monitoring for clients with heart failure and explore the opportunities for clients with COPD
- Continue to partner with CanAssist to identify opportunities to support clients in the community through technology solutions.

System Capacity and Readiness

- **Communication and engagement plans**

Patients/Families/Care givers have an important voice for the development of the model of care, to support and to be part of the establishment of the plan.

- There will be consultation forums in the Fall 2015 planned and patients/families/caregivers will also be part of the Governance of the whole strategy as well as being part of the specific working groups.
- Patients have been previously engaged in strategic work with Island Health in Cowichan. It is common in the culture of the region to include a patient voice. Some examples where patients were included are: mapping, Collective Impact, strategy, Community Forums, Child Youth Mental Health Substance Use Local Action team.
- Impact BC is supporting the strategy with patients and families to be part of the Collective Governance Alignment Framework for the Eldercare Project in Cowichan.

Aboriginal people also have an important voice in the development of the model of care, to support and be part of the establishment of the plan.

- We have discussed the vision and the proposed model and currently have an agreement in principle for participation in the *Collective Governance Alignment Framework for the Eldercare Project* with Cowichan Tribes & First Nations Health Authority (FNHA).
- An engagement plan for a broader engagement process has been developed in partnership with FNHA to include all Aboriginal People of the region including the Intertribal Health Authority, the Métis People and the Friendship Centre. Meetings are planned for the next few weeks with the leaders to discuss the vision, proposed model and to explore how the Aboriginal families can be represented and participate in the work.

Community

We have engaged with Our Cowichan (a Community Health Network) to create the vision and the proposed model and currently have an agreement in principle for participation in the *Collective Governance Alignment Framework for the Eldercare Project In* Cowichan. The Community Health Network will be taking the lead for the Community Working group via their already existing Seniors Working Group structure. A presentation to the Our Cowichan admin group is planned in the fall.

Health care providers/physicians and staff

- We have engaged with the Cowichan Leadership Team, Island Health staff and physicians who attended the

June Forum;
- A plan is being developed to engage further with staff in September;
- The CVDFP Executive Director is working in close partnership with Island Health to help develop a strategy that will include physician partnership alignment and will co-chair the EPIC Steering Group.
- Health care providers will be part of the Collective Alignment Framework Governance for the Eldercare Project In Cowichan;
- A presentation to the Collaborative Services Committee on the Frail Seniors strategy is planned in the fall.

Assisted Living and Residential Care Providers

- We worked in partnership with Island Health Residential Services program to gain an understanding of current levels of service in Cowichan;
- Further engagement is planned in the fall through the work of the Residential Care / End of Life working group.

- **Outline governance, management and leadership**

Described in section 2 governance and partnership

- **Describe readiness of community and stakeholder groups (including change management needs)**

Cowichan is in a very unique place in terms of community readiness and stakeholder groups. With the vision of improving primary health care, the CVDFP and Island Health has been working together over the last three years and extensive mapping has been achieved to provide a better understanding of the current state and the gaps in the system. A year ago, Island Health, CVDFP, Cowichan Tribes, FNHA, Our Cowichan and patients reviewed those maps, conducted an analysis and started to plan how we can improve the system. This provided the opportunity to understand the different partner's key priorities which lead to discussions of better alignment among all groups and organizations. All parties recognized the important need to focus on frail seniors and people with chronic diseases (as well as maternal health, youth, and metal health and substance use). At the same time, Our Cowichan was undergoing strategic planning and the same focus populations were identified. Frail seniors and people with chronic disease were identified as well as key priorities and a working group was put together to explore further what can be done in the community.

The Eldercare Project in Cowichan is building on this initiated work and now we have a really engaged group committed to transforming the system from a community perspective of health promotion, to prevention, to the work currently underway by physicians around improving residential care services.

Further engagement with patients, families, caregivers, physicians and staff is required to expose the details of the development of the new model. This is planned for October.

- **Outline change management and change leadership approaches and resources**

We recognize that in order to achieve these goals and tackle deeply entrenched and complex problems, it will require an innovative and structured approach to making collaboration work across not only Island Health, but with our many partners in the community including the Cowichan Valley Division of Family Practice, specialists, Aboriginal people, Our Cowichan Community Health Network and many other organizations. In Cowichan, we believe that through using the Collective Impact framework methodology, we will be able to achieve significant and lasting change by using five agreed conditions to partnership:

- All participants have a **common agenda** for change including a shared understanding of the problem and a joint approach to solving it through agreed upon actions.
- Collecting data and **measuring results consistently** across all the participants ensuring shared measurement for alignment and accountability.
- A plan of action that outlines and coordinates **mutually reinforcing activities** for each participant.
- Open and **continuous communication** is needed across the many players to build trust, assure mutual

objectives, and create common motivation.

- A **backbone organization(s)** with staff and specific set of skills to serve the entire initiative and coordinate participating organizations and agencies.

- **Skills and training needs and approaches**

The skills and training needs will be determined with the model designed with our partners in the fall with the support of Professional Practice. Here are some preliminary identified needs:

- Develop a Frailty toolkit
- Care planning
- Skill mix, care redesign
- Self-care support
- Advanced Assessment

- **How are alignment and teamwork being created and fostered in this work?**

Alignment and team work will be an essential foundation of the Integrated Primary Care Team in Cowichan.

4. TIMELINE

Provide a timeline for implementation of your model
High level overview of timeline.

Work	Timeline
Working groups underway	September 2015
Work force review complete – current state	by end of October 2015
Review role, scope and function – 'preliminary planning' i.e. IHN, SORT, HCC being focus a. Develop integration maturity plan with professional practice	Oct-Nov 2015
Review role, scope and function: staff engagement	Dec 2015 – Feb 2016
Recommendations from staff planning – prioritize integrated team maturity plan implementation	March 2016

5. BARRIERS AND OPPORTUNITIES FOR ACTION TO SUPPORT IMPLEMENTATION

The focus of the Workshop is to dialogue the proposed models of care and develop a plan to remove organizational and provincial barriers to implementation. Please describe barriers, including their importance, as well as any strategies you have started to think through that could be used to address them:

Barrier	*Level*	*Impact*	*Strategy/Action to Address*
Description ***Budget*** ▪ Workforce review and recommendations can be carried out however recommendations will be determined by budget and additional resource of which is currently unknown.	Where this barrier would be addressed: • Regional • Provincial	• Low • Medium • High	Planning for allocation of IPCC funds to support transformation work.

• Change Management Support: Additional resource is required to facilitate change management regarding role scope and function of roles solution • MOH Policy which may determine how resource is allocated Solution • Access to funds for families to maintain activities of daily (ADL) and instrumental activities of daily living (IADL) living at home		Ministry of Health Policy
Assisted living beds Repurposing assisted living beds to be utilised for short term respite and rehabilitation for acute episode	• Provincial	Revisit Ministry of Health Policy
Transportation In general, most communities in the Cowichan region are quite car-dependant, making it difficult for residents to get around if they do not have access to a vehicle. This is particularly problematic for residents with mobility issues such as seniors and people with lower incomes and can contribute to social isolation and many other issues associated with automobile-oriented communities	• Local	Develop a multi-modal transportation plan that in includes both active and passive transportation modes and connections between municipal transportation infrastructure and services.

APPENDIX: SUPPORTING DOCUMENTS

EPIC Collective Governance Alignmer

EPIC Framework Committee Diagram.d