

THE PATIENT JOURNEY



Our Health Care system is changing to better serve not only the patient of today but the patient of the future. Patients entering their senior years are often facing multiple chronic conditions and require care from several providers. The following story focuses on how those services are rendered across the care continuum.

Our Patients: With their kids out of the home and own families in tow, **John and Anne Smith** felt it was time to leave their busy and bustling life in Toronto to retire to the rural community of Bancroft, Ontario, where John had grown up. Entering their 44th year of marriage, John and Anne excitedly found a bungalow just on the outskirts of town that offered a larger yard, but was still just a short drive to the necessary amenities. As an aging couple in their late sixties, it was important to the Smiths to find a new family physician nearby. After she called a local care provider, Anne was referred to Healthcare Connect and within 60 days of their move they were connected to a family doctor.

1 Diagnosed and Community Support Service agency assistance brought in

John has noticed that Anne has become more and more forgetful over the last year. She has even become confused about directions to the grocery store – a route they have taken more than 100 times. The kids visited recently and also noticed that Anne seemed a little more distant. They encouraged John to get in touch with their family doctor to learn more. A week later, their family doctor tells them that Anne is showing signs of Dementia. John asks more questions about what he should do and whether there is help that can be provided. He is quickly reassured that services are available and is connected to the local Alzheimer Society as well as the Community Support Service agency to help provide Meals on Wheels as John transitions into the role of caregiver.

3 Community Care Access Centre (CCAC)

John's health has also worsened over the last year and his family doctor has told him that because his heart is weak, he should no longer be lifting Anne in and out of the tub for bathing. They have put him in touch with home support through the South East Community Care Access Centre (CCAC) and Anne is now receiving weekly visits, help with bathing, and has a care coordinator in place.



2 Seniors Managing Independently Living Easily (SMILE)

Nearly a year later, John is beginning to feel uncomfortable about leaving his wife at home while he attends to the things he needs to do in town. It is also hard to bring Anne with him, as she sometimes wanders off while he is not looking. As they don't have much extra money, John is not able to hire a nurse to come in and instead contacts his family doctor to see if there is anything they can offer. He is told about a program called SMILE (Seniors Managing Independent Living Easily), that will pay for Respite care and a Personal Support Worker to come into their home and look after Anne so John can continue his trips into town once a week.



4 Hip Replacement

Several years pass and Anne becomes more dependent on John. Unfortunately, their family doctor tells them that Anne will soon need a hip replacement and puts her on the waiting list.



5 Convalescent Care Bed

Following her hip replacement, Anne's Care Coordinator through the CCAC determines that she will need rehabilitation and admits her to a short-stay convalescent care bed unit to assist her with rehabilitation. She is ready to go back home after 45 days.

6 Short-Stay/ Respite

Now in their mid-eighties, John has been told by his family doctor that he is in need of heart surgery and is put on the waiting list. While he knows that the Personal Support Worker provides some help for Anne when he is home, John worries how Anne will cope while he undergoes and recovers from his surgery. The CCAC, through their Care Coordinator arranges for Anne to be moved to a short-stay respite bed in a long-term care home.

8 Residential Hospice

Through their Care Coordinator, John is admitted to a residential Hospice to fulfill his palliative journey. Following the passing of her husband and with no nearby family to continue to care for her, Anne is admitted to a nearby Long-Term Care home where she will receive full support for all of her needs.

7 Long-Term Care

Following John's recovery and Anne's return home, John has realized that he cannot continue to look after both Anne and himself. Through their CCAC Care Coordinator, John and Anne have been put on the waiting list for a long-term care bed. Six months later, John becomes very sick and is diagnosed with terminal cancer. As John's health is decreasing rapidly, Anne is put on a priority crisis list for a Long-Term Care bed.

