CUPS
resilience for life

Connect2Care

Addressing the barriers between acute care and community, through case management, integration and advocacy.

Land Acknowledgement

In the Spirit of acknowledgement and recognition of the truth, CUPS has a desire and responsibility to promote and commit to reconciliation and healing with Indigenous peoples. CUPS values dignity, unity, healing, and accountability within our work, as we strive to build strong and resilient communities through wholistic and integrated care. CUPS respects and acknowledges the traditional territories, oral practices, and the history of the Blackfoot (Siksika, Piikani, and Kainai), the Tsuut'ina (Sarcee), the Stoney Nakota (Chiniki, Wesley, and Bearspaw) First Nations, and the Métis Nation (Region 3). We live, work, grow, play, and appreciate this beautiful territory as we are all treaty people.

Outline

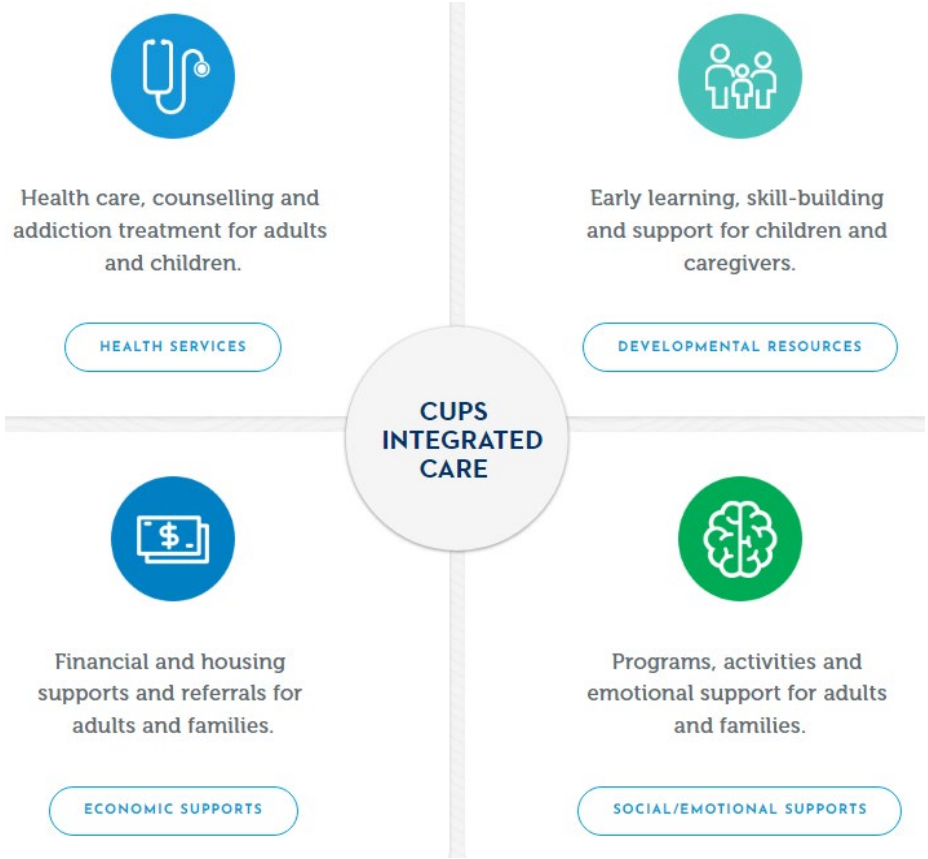
- Why We Exist
- Who We Are
- Who We Serve
- Strategies for Success
- Outcomes
- Thank You and Questions
- References

Why We Exist

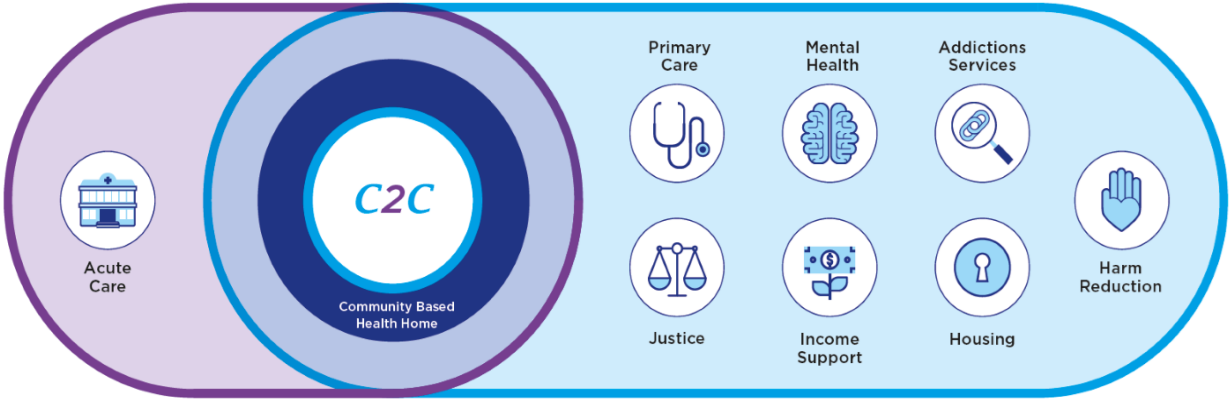
- Need identified by acute care
- Population is 2-4 times more likely to have repeat ED visits
- Creative, collaborative problem solving to meet complex needs

We don't even have a way of diagnosing their problems properly, a standardized format of agreeing that this is actually a shelter issue, this-this person is coming to our emergency department because they are cold and hungry, because they're sleeping under a bridge. There is no code in the EMR for that, so they get admitted, they get triaged as having belly pain and we CT scan them, and they get lab work done.
-Acute Care Partner

Who We Are - CUPS



Who We Are - Connect2Care



Referral Criteria:

- Experiencing homelessness or vulnerably housed AND
- ≥ 6 ED presentations or ≥ 2 hospital admissions AND
- Complex health and social needs

Who We Are

- Medical Lead
- Program Manager
- Team Lead
- Administrator
- Health Navigator x4
- Nurse Navigator
- Graduation Navigator
- Peer Navigator

Who We Serve

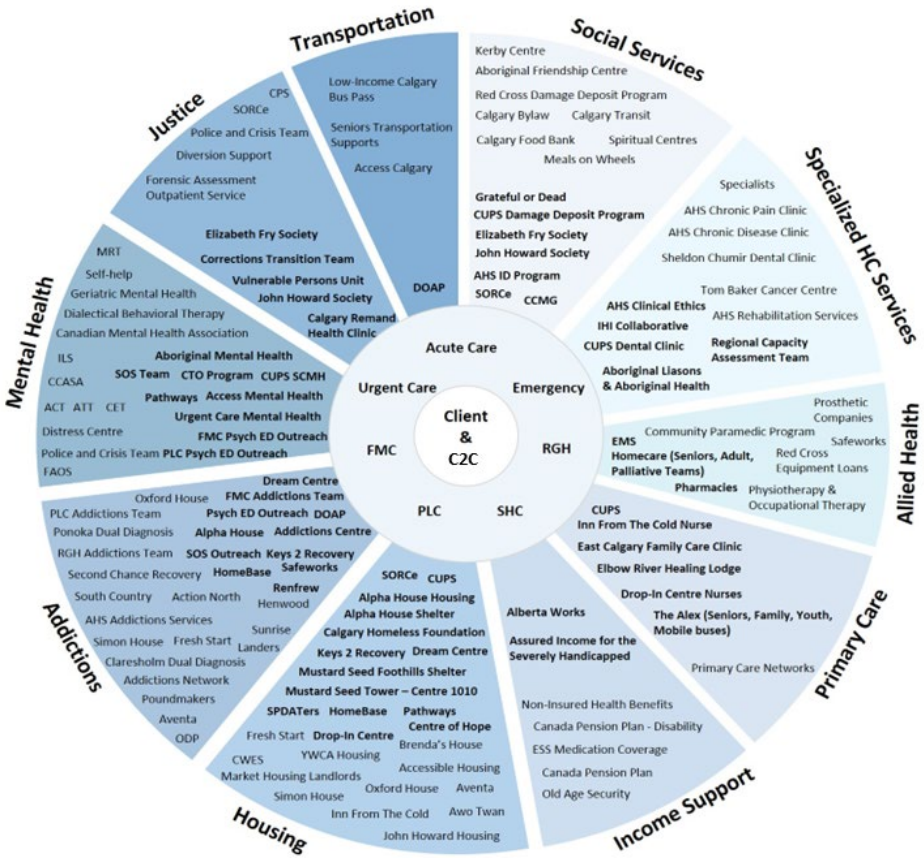
C2C/CAMPP has received a total of 395 referrals in 2021-2022

Client Conditions Reported on Referral C2C – 2019-2022

Annual Totals	2019-2020	2020-2021	2021-2022
Referrals Received for Clients with Mental Health Conditions	57 (37%)	88 (48%)	258 (65%)
Referrals Received for Clients with Active Alcohol Use	49 (32%)	75 (41%)	166 (42%)
Referrals Received for Clients with Active Substance Use	68 (42%)	90 (49%)	243 (61%)
Referrals Received for Clients Unhoused on Initial Referral	107 (71%)	148 (80%)	303 (77%)
Referrals Received for Clients not Connected to PCP on Initial Referral	80 (53%)	84 (46%)	183 (58%)

*Conditions as documented on referral

What We Do


Transportation
Low-Income Calgary Bus Pass
Seniors Transportation Supports
Access Calgary
DOAP
Social Services
Kerby Centre
Aboriginal Friendship Centre
Red Cross Damage Deposit Program
Calgary Bylaw
Calgary Transit
Calgary Food Bank
Spiritual Centres
Meals on Wheels
Grateful or Dead
CUPS Damage Deposit Program
Elizabeth Fry Society
John Howard Society
AHS ID Program
SORCe
CCMG
Specialized HC Services
Specialists
AHS Chronic Pain Clinic
AHS Chronic Disease Clinic
Sheldon Chumir Dental Clinic
Tom Baker Cancer Centre
AHS Clinical Ethics
AHS Rehabilitation Services
IHI Collaborative
CUPS Dental Clinic
Regional Capacity Assessment Team
Aboriginal Liasons & Aboriginal Health
Allied Health
Prosthetic Companies
Community Paramedic Program
Safeworks
EMS
Homecare (Seniors, Adult, Palliative Teams)
Red Cross Equipment Loans
Pharmacies
Physiotherapy & Occupational Therapy
Primary Care
CUPS
Inn From The Cold Nurse
East Calgary Family Care Clinic
Elbow River Healing Lodge
Drop-In Centre Nurses
The Alex (Seniors, Family, Youth, Mobile buses)
Primary Care Networks
Income Support
Alberta Works
Assured Income for the Severely Handicapped
Non-Insured Health Benefits
Canada Pension Plan - Disability
ESS Medication Coverage
Canada Pension Plan
Old Age Security
Housing
SORCe
CUPS
Alpha House Housing
Alpha House Shelter
Calgary Homeless Foundation
Keys 2 Recovery
Dream Centre
Mustard Seed Foothills Shelter
Mustard Seed Tower – Centre 1010
SPDATers
HomeBase
Pathways
Centre of Hope
Fresh Start
Drop-In Centre
Brenda's House
CWES
YWCA Housing
Accessible Housing
Market Housing Landlords
Oxford House
Aventa
Simon House
Inn From The Cold
Awo Twan
John Howard Housing
Addictions
Dream Centre
Oxford House
FMC Addictions Team
PLC Addictions Team
Psych ED Outreach
DOAP
Ponoka Dual Diagnosis
Alpha House
Addictions Centre
RGH Addictions Team
SOS Outreach
Keys 2 Recovery
Second Chance Recovery
HomeBase
Safeworks
South Country
Action North
Renfrew
Henwood
AHS Addictions Services
Sunrise
Simon House
Fresh Start
Landers
Claresholm Dual Diagnosis
Addictions Network
Poundmakers
Aventa
ODP
Mental Health
MRT
Self-help
Geriatric Mental Health
Dialectical Behavioral Therapy
Canadian Mental Health Association
ILS
Aboriginal Mental Health
SOS Team
CTO Program
CUPS SCMH
CCASA
Pathways
Access Mental Health
ACT
ATT
CET
Urgent Care Mental Health
Distress Centre
FMC Psych ED Outreach
Police and Crisis Team
PLC Psych ED Outreach
FAOS
Justice
CPS
SORCe
Police and Crisis Team
Diversion Support
Forensic Assessment Outpatient Service
Elizabeth Fry Society
Corrections Transition Team
Vulnerable Persons Unit
John Howard Society
Calgary Remand Health Clinic
Acute Care
Urgent Care
Emergency
Client & C2C
FMC
RGH
PLC
SHC

Strategies for Success

Develop key stakeholder relationships and partnerships

"It was really important that C2C was a community response and not a single agency response. We could not have done it alone and people needed to see how systems are divided for these clients."
- C2C Team Member

- Access to systems level decision makers
- Connections and credibility across systems
- Ability to navigate health and housing systems
- Access to trainings provided by Alberta Health Services and Calgary Homeless Foundation

Strategies for Success

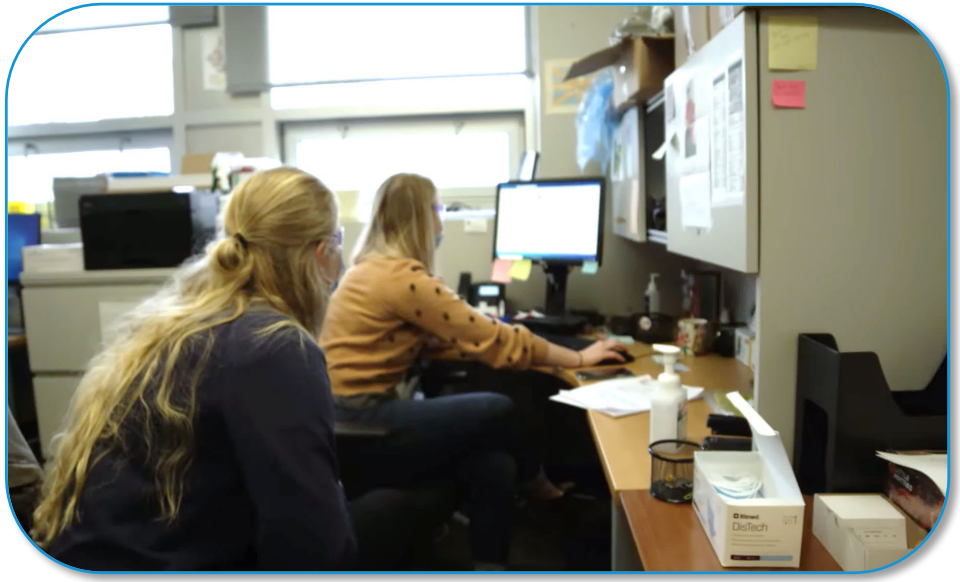
Local systems integration and bridging

"C2C referred clients to us and kinda helped us through transition in understanding the medical needs and how we can support them with their medical needs so they did a lot of that bridging from homelessness into housing and what specific need each client would have."
- Housing Partner

"…when C2C is involved in discharge planning, it kind of helps problem solve and bring to light other services"
-RN

Strategies for Success

Access to information



- Minimize duplication of services
- Strengthened coordination and collaboration

Strategies for Success

Provide holistic, wrap-around care

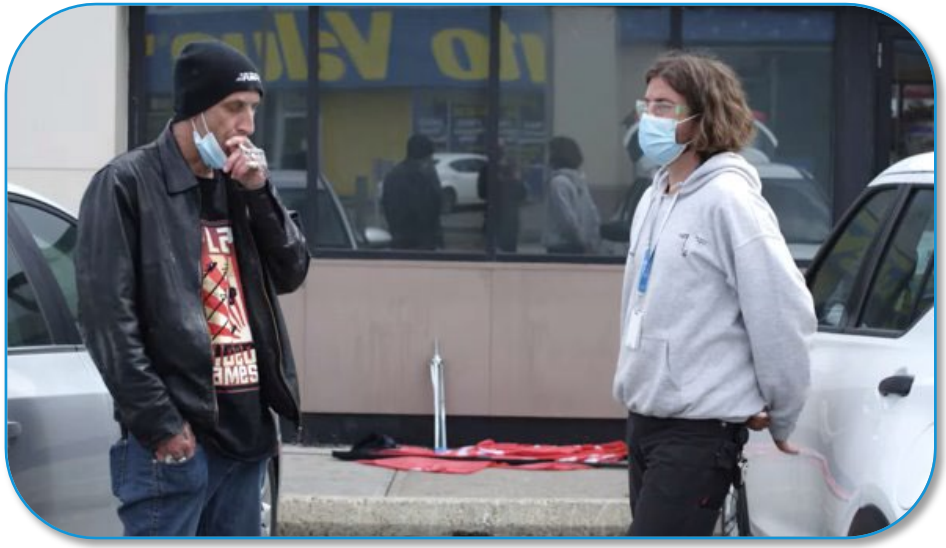
- Navigation
- Transportation and accompaniment
- Advocacy
- Health Education
- Community Referrals

"It's really hard for a client to consistently take their meds or manage their diabetes if they don't have a safe place to live. Clients don't want to talk about their health or addictions or mental health. They want to talk about where they can live."

- C2C team member

Strategies for Success

Mobile outreach, transportation, accompaniment to appointments



Strategies for Success

Engaging during times of transition

"I met [C2C worker] in the intensive care unit… on the release date that I was released from the hospital I had nowhere to go. I had [C2C worker's] help throughout the way to find [sober transition housing] to get on the sober path and find my way again and it worked out, it worked out just perfect."

- C2C client

"The fact that they are so responsive I think makes a big difference. That is what's different about C2C than any other service that I've worked with."

- Acute Care Partner

Strategies for Success

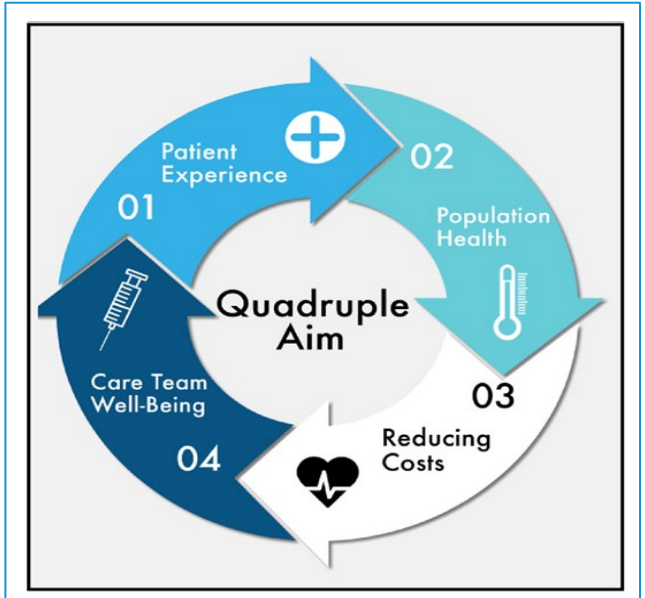
Education and advocacy

- Formal and informal education
- Presentations, mentorship, modelling
- Ongoing

I think that our practice did change because of that [interaction with the C2C team]*...we became more sensitive to peoples' needs; I think there's a greater compassion. They brought partnerships to the table that we otherwise didn't have. So absolutely my practice and our entire portfolio, our whole team, benefitted from C2C."*

- Acute Care Partner

Outcomes



Median total days admitted to acute care for C2C patients were 59% lower after enrollment

9.5 fewer days in acute care

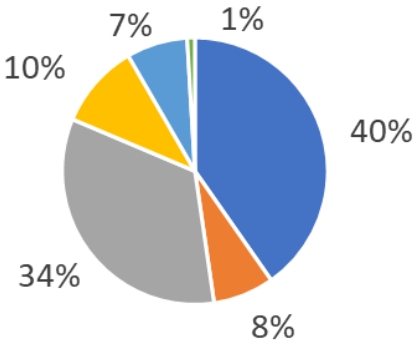
5.5 additional days on average in addiction recovery facility

2.5 mean fewer days on average in jail

*12-months before and after C2C enrollment (N=354)
Clients referred prior to November 30th, 2018.

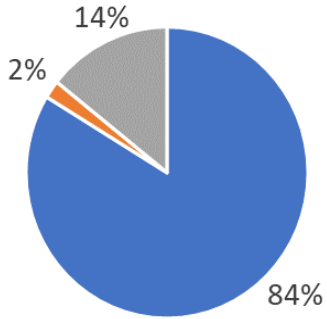
Outcomes

Final Housing Transitions



- Housed -CAA
- Housed Diversion
- Housed - Independent
- Unhoused
- Housed - Trans
- Housed - SL

Final Primary Care Transitions

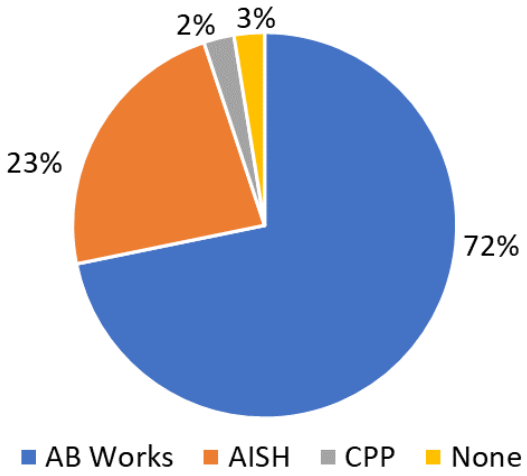


- Connected - CUPS
- Not Connected
- Connected - Other

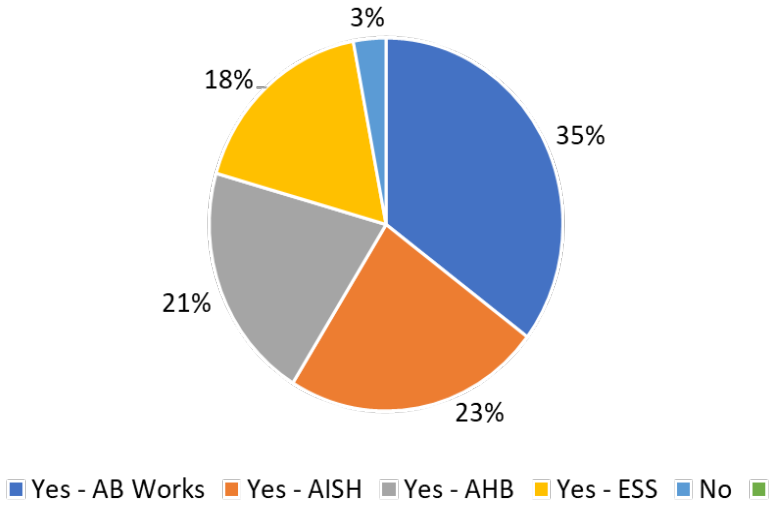
2021-2022

Outcomes

Final Income Transitions



Final Medication Transitions



2021-2022

Thank You

"Definitely a lot more clarity, like understanding my addictions and how they affected my health. Understanding you know the options and things I could do… I've learned to kind of manage my own life a little bit better…they kind of gave me the steppingstones to health and health care and I could go in and see a doctor whenever I needed to."
- C2C client

"I'm more [about] self-care now, I'm taking my meds, right. But now everything I'm doing on my own because if I let other people do that for me, I'll give up. And I need that little bit of responsibility so taking my vitamins, I'm doing-listening to my doctor, and then and I have an appointment at 2 o'clock to see my psychiatrist today."
- C2C client

"I think it's gotten better because I've gotten the health care that I need. I've gotten the different specialists and the different things that I needed."
- C2C client

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References

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