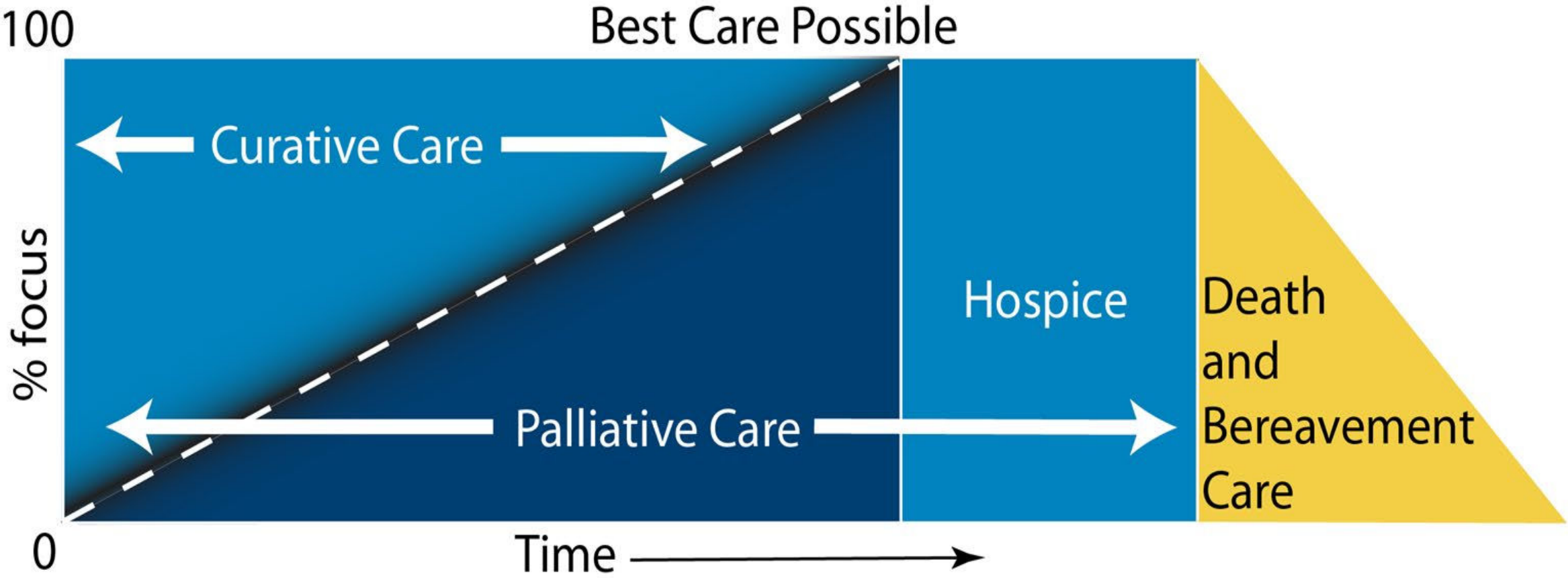
# Bottoms Up!  Ground Floor Approaches to Local Patient and Caregiver Support

*SENIOR LIFE TRANSITIONS PROGRAM*
*Saratoga Senior Center*
*Phil Di Sorbo, MS, BCPA*


100
Best Care Possible
Curative Care
% focus
Hospice
Death
and
Bereavement
Care
Palliative Care
0
Time

# Domains of Palliative Care

**National Coalition for Hospice & Palliative Care**

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*Physical*

*Emotional*

*Social*

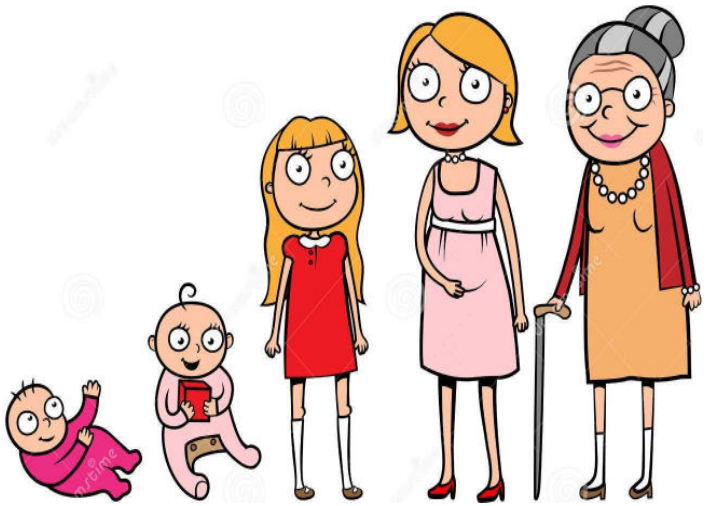
*Cultural*

*Spiritual*

*Quality of Life*

*End-of-Life*

*Ethical*



***intense person-centered focus***

## Saratoga County Data: Center for an Urban Future – January, 2023

- 50% increase in older adult population over the past decade, making it the fastest growing older adult population in the state
- 252% increase in the number of older adults in poverty over the last decade

## Albany Times Union – January, 2023

- Saratoga County has highest number of mobile home parks in NYS
- Saratoga County ranks 27$^{th}$ of 3,000 USA Counties in health disparity

## Alzheimer's Association – New York State Projections: 2020 – 2025

- Number of NYS Alzheimer's patients to increase by 12.2%

*Building Block One*

# VOLUNTEER INTENSIVE TEAMS

## Core Professional Leadership

> social assessment in the community

> collaborative service

**Building Block Two**

# EXTENDED CARE AT COMMUNITY LEVEL:

## A Medical/Social Collaborative

> extension of office-based primary care practices

> expanded community safety net

> filling service gaps:the human services equivalent "last mile".

## Building Block Three

## EMPOWERING THE SERIOUSLY ILL SENIOR AND THEIR CAREGIVER

> Address what's going on in a medically-prompted Transition
> Leverage ongoing trusted relationships

“Moving from incremental to transformational strategies to address health-related social needs,” HEALTH AFFAIRS, May 18,2023

## *Navigation/Coaching/Social Needs Require “Last Mile” Longitudinal Support*

“Meaningful navigation support must solve an analogous last mile problem to not only connect patients to appropriate services, but to ensure the patient’s social needs are met. Ideally, the navigator is someone that the patient trusts, who can both steer referrals and relieve the patient of the administrative burden. Such support should be based on a longitudinal relationship with the patient and a deep understanding of their needs, as well as knowledge of and close working relationships with community service providers”.

# Focus Area 1: Navigation & Support

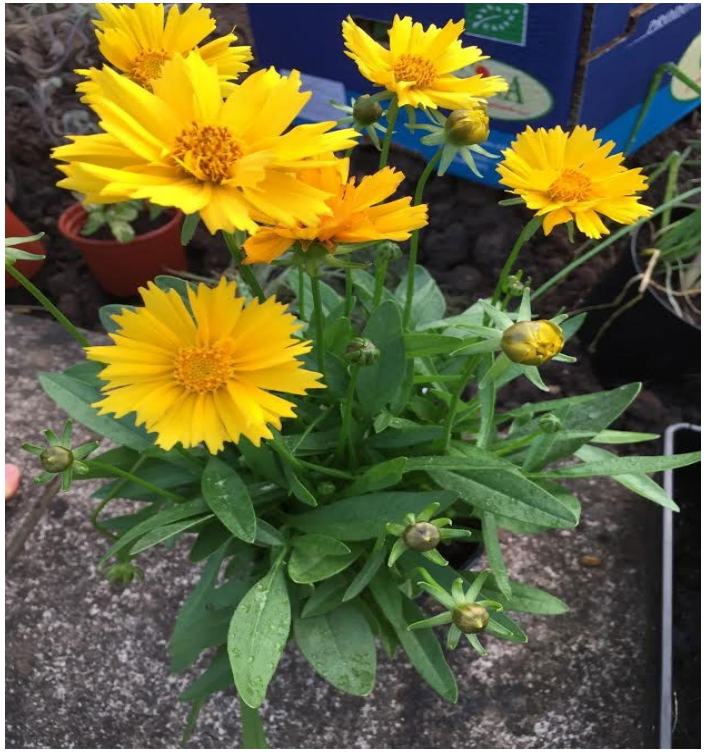
- Supporting seniors and their caregivers
- Reducing confusion and being overwhelmed
- Empowering seniors to navigate the health and social service systems

# Focus Area 2:  Aging-in-Place

- ***Housing/Home Safety***
- ***Home Care Support System***
- ***Advance Care Planning***
- ***Aging-in-Place Plan***

# Focus Area 3: Enhancing Personhood

***Providing a nurturing environment to facilitate healing, adjustment, and growth in a transition period***



# Program Flow:

| | |
|---|---|
| I. Referrals/Inquiries | Saratoga Senior Center |
| II. Screening | Phone Interview |
| III. Intake Assessment | In-Person by Team Leaders |
| IV. Work Plan Formulation and Actions | Team Members, Volunteers, Health Care Providers, and Community Partners |
| V. Closure/Evaluation | |

# ***THANK YOU!***

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*(Pick Up Client Stories!)*

QUESTIONS AND DISCUSSION