Mississauga Halton **LHIN**

A New Vision of Assisted Living for Seniors

Awarded the 2011 National 3M Award for Quality in Healthcare

SUPPORTS
FOR DAILY LIVING

Meeting a need in Ontario's Health System

A Resource Manual for Developing an Effective
Assisted Living for High Risk Seniors Program in Your Community

The Official Seal of an Approved SDL Provider in the Mississauga Halton Local Health Integration Network (LHIN)

Our sincere thank you to the following Supports for Daily Living (SDL) Service Providers whose dedication and commitment to health system improvement and addressing the needs of high risk seniors has been pivotal to the impressive success of the Supports for Daily Living (SDL) service within the Mississauga Halton LHIN

M.I.C.B.A. Forum Italia Community Services

Nucleus Independent Living

Oakville Senior Citizens Residence

Ontario March of Dimes (Etobicoke)

Peel Senior Link

Region of Halton

Victorian Order of Nurses – Peel

Yee Hong Centre for Geriatric Care

This program and these Supports for Daily Living Providers in conjunction with the Mississauga Halton LHIN are recipients of the 2011 National 3M Award for Quality in Healthcare

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INTRODUCTION

Introduction

Throughout the province of Ontario, there exists a significant gap in services for high risk seniors with complex needs who face physical limitations in carrying out essential activities of daily living, but who have the capacity to remain living in their own homes with the appropriate personal supports. The frequency and intensity of personal support services required by these seniors over a 24-hour period, however, moves them beyond the level of personal support services offered through a visitation model of care. Some examples of frequency and intensity include:

1. **frequent contact on a daily basis,**
2. **the provision of personal care,**
3. **proper nutritional support,**
4. **help with medications, and**
5. **assessment of physical and functional status/wellbeing.**

All too often, many high risk seniors with complex needs find themselves in hospital and designated "ALC" (meaning their acute phase of care/treatment is finished and they need to go to a more appropriate setting to be cared for). Still other seniors make repeated visits to emergency departments and can end up in hospital. Many of these high risk seniors are prematurely referred to long-term care homes because another alternative does not appear to be available to them. Perhaps the need is for assistance and/or monitoring, or perhaps the need is for a new home and some assistance to be provided. Whatever the reason(s), their desire and that of their families, is that as seniors, they are able to continue living in their own homes or within a home environment, for as long as possible.

Supports for Daily Living service addresses and fills the gap in the above situations, and does so with impressive results – reducing emergency room visits, decreasing ALC pressures and diverting premature admissions to long-term care. The service also successfully repatriates seniors from long-term care homes, back into the community, and provides significant cost savings/return on investment for the local health system.

This resource manual has been prepared to provide Local Health Integration Networks and health service providers with an understanding of how the Supports for Daily Living model works, evidence of the positive impact the service can have on health system performance, and the background knowledge and guidelines to help you develop a Supports for Daily Living service in your respective communities. We believe that the manual can help to understand the thinking and background considerations to implementing a challenging new program design, transferring the new design into a project and moving forward towards project completion.

This resource manual has a companion document, "the ***Standards Manual"***, which provides the practical "how to" of complying with the MOH-LTCs Assisted Living for High Risk Seniors policy and implementing an SDL Model. A Video Resource is also available on the SDL service. The link to the video can be found at Mississauga Halton LHIN website; **http://www.mississaugahaltonlhin.on.ca/**

The Mississauga Halton Local Health Integration Network (MH LHIN)

Supports for Daily Living is
innovative thinking that is producing impressive results
. . . in dollars saved . . . in stretching resources . . . and in
providing the kind of care seniors need to keep them
within their communities for as
long as possible

To begin your information journey about the Mississauga Halton LHIN's Supports for Daily Living service, here is a brief overview to get you started:

An innovative regional service delivery model that targets high risk seniors with complex needs who are able to continue living in their own homes as long as there is access to frequent, urgent and intense personal supports throughout a 24-hour period. Applying a non-medical approach, it bridges a gap between a community visitation model of care (often a block of 1-2 hours occasionally during the week or every day) and the model of care provided in long-term care homes.

As you move down the path of considering whether an SDL model of service is appropriate for you, we hope that you will find the information contained in this resource manual, as well as the standards manual and video, helpful and educational.

We wish you the very best on your SDL journey!

Chapter One

Setting the Context for Change

"We're seeing increasingly complex patients whose care needs are quite high, who want to be at home in the community and who want to have the ability to stay in their own home as long as possible. As soon as you add services to a high risk senior in their home, you're going to prevent premature visits to the hospital."

Cathy Raiskums, Manager, Social Work
and Patient Flow Halton Healthcare Services

Setting the Context for Change

Created by the provincial government in 2006, the Local Health Integration Networks (LHINs) are charged with planning, coordinating, integrating, funding and monitoring health service providers (HSPs) including hospitals, CCACs, long-term care homes, community support services and mental health and addictions services. The balancing act comes in investing in the local health system in a way that maximizes capacity while ensuring people have access to the right care in the right place at the right time at the right cost.

Launched by the Mississauga Halton LHIN in 2008, the Supports for Daily Living service has since become a vital care option along the local health system's continuum of care for high risk seniors with complex needs. The program is *one of the cornerstone components of the MH LHIN's "Home First" philosophy and service initiatives*. The service speaks to a significant gap that existed for a frail population who were increasingly finding themselves ready to be discharged from hospital but with few options available to them other than leaving their homes and moving into long-term care. Although still mentally capable of living independently or with the support of a family caregiver/ significant other, many high risk seniors don't have the physical capacity to carry on essential activities of daily living without ongoing support. These are seniors whose frequent need for in-home support has grown beyond a once daily visit schedule, but who aren't yet ready for the transition to long-term care. While the personal care and support services coordinated through CCACs are able to address most in-home care needs, high risk seniors with complex needs often require more frequent and intense visits throughout a 24-hour day to help with dressing, bathing, toileting support, making meals and medication reminders. They also require safety checks and access to urgent response. In our experience, *flexibility*, *responsiveness* and *frequency* are the keystone requirements for the needs of high-risk seniors in the community. The success of the SDL program has been based on meeting these requirements.

The following are factors that were among the driving forces that were taken into consideration when developing the Supports for Daily Living solution to address the needs of high risk seniors with complex needs in the Mississauga Halton LHIN.

In-Home Community-Based Care

Health care is increasingly moving towards solutions that focus on in-home community-based care. Within the hospital sector, there has been a decisive shift in focus from inpatient care to ambulatory care thanks to advances in evidence-based care, technology and emerging best practices. (e.g. day surgery, births) and with the coordination of in-home supports and community-based services through CCACs, many inpatients are able to return home to recover rather than remaining in hospital.

The enhanced focus on in-home care is increasingly being seen as a viable option for reducing costs associated with more expensive health care alternatives such as hospitals.

Family members are also taking on a growing role at home as informal caregivers, providing support to aging parents with chronic diseases and other co-morbidities. Ensuring these informal caregivers have access to respite and supports within the community will be critical to ensuring they can maintain the ability to care for loved ones within the home environment.

What Seniors Want

Through a series of engagement sessions, here is a sample of what seniors told the Mississauga Halton LHIN they want:

Live with dignity & independence

- Be listened to, respected and have their opinions valued

More housing options

- Prefer to stay at home with services to assist them

More social, recreational opportunities

- Companionship, mental stimulation and interaction

Feel safe in their homes and in the community

- Telephone programs, security checks, devices to communicate emergencies

Assistance with household tasks

- Difficult to continue fulfilling household tasks as they age

Additional and more flexible homecare services

- Allotted hours don't meet their needs

Respite and support for caregivers

- Accessible and affordable respite care

This shift to a focus on in-home care represents a change in how society views its role in addressing individuals' health care and quality of life needs, and opens the doors to new investment opportunities within the community support services sector.

What Do Seniors Need?

What is it that seniors need from their local health system? What would help them to continue living independently in their own homes?

Knowing the answers to these questions is critical to shaping a Supports for Daily Living (SDL) service that is responsive to those *essential activities* of daily living that significantly impact high risk seniors' ability to function. The SDL service must always address and impact the need for 24 hour availability and intermittent care as well as on-call response. The actual delivery of services cannot be all things to all people and must primarily focus on the delivery of personal care and essential homemaking services. More social and/or recreational services are not delivered within the context of the SDL service, but are sought from community partners or are provided by an SDL provider as an *adjunct* to core services in order to address a "well rounded" approach to care. Some or even all of the additional services may require service fees of the client, but never-the-less should be offered and coordinated if the client wishes to participate. Services such as Friendly Visiting, Hospice Visiting, Adult Day Programs, Transportation for shopping, Meals on Wheels or other such activities can assist in overall benefits to a client.

Focus groups, open forums or other community engagement activities coordinated by the LHIN or in partnership with local service, church or seniors' organizations can help shape a service model that appropriately addresses the needs of seniors, who want to continue living at home, but also to feel safe and secure in doing so.

Health System Pressures

Communities across Ontario are facing unrelenting health system pressures increasingly influenced by the growing needs of a rapidly aging population. With a number of LHINs across the province projecting rapid increases in their seniors' populations within the next five to ten years, this has serious implications for local health systems that are already grappling with backlogged emergency departments, limited long-term care bed capacity and inpatient beds occupied by people no longer requiring acute medical care (deemed as Alternate Level of Care or ALC). Many of these pressures can be attributed to the absence or limited amount of appropriate community-based capacity to address the needs of high risk seniors outside of hospital and institutional type settings.

Within the MH LHIN region, long term care bed capacity is below that designated for the region. Further, the growth projections for an aging population are among the highest in the province over the next 15 years. These two pressures alone would be enough to provide reasons to look for alternate solutions to long term care, let alone the capital costs that would be required to build long term care facilities. However, we are also believers in maximizing the potential of the seniors' population. Though we know that long term care is appropriate for some seniors requiring greater care than the community can provide, it is not the answer for those seniors who can and do recover from an episodic event in hospital or those who are able to live independently with some assistance. Building more long term care beds was not the solution to address mounting pressures – the solution was to utilize the foundation of supportive housing, analyze what needed to be done, maximize creativity and take some risks.

"Too many seniors end up in hospitals and don't have enough community/ home supports post discharge. Rather than investing in more long-term care beds, the Mississauga Halton LHIN tested and invested in the Supports for Daily Living model to generate the right community capacity to support high need and at risk seniors in the community."

Narendra Shah,
Chief Operating Officer
Mississauga Halton LHIN

Systems Thinking

As community-based organizations, LHINs are accountable for advocating a systems approach to planning, coordinating and integrating health care services in their respective communities. Systems thinking works to break down the silos that have traditionally existed between sectors and providers and instead focuses on generating collaborative solutions to find efficiencies, improve patient flow and maximize limited resources. Systems thinking represents a cultural shift within the health care sector and calls for strategic planning at a provider level that embraces input, expertise and insights from other providers such as CCACs, hospitals, community support services and long-term care. It's this cross-pollination that allows the LHINs to tap into unrealized potential within the system thereby generating new opportunities and the possibility of enhanced capacity.

Systems thinking cannot be underrated as a tool for change. This type of thinking is not easy as it demands that organizations look at solutions from the perspective of what works for the whole and not the one or the few. It demands that organizations put themselves outside of what would be beneficial to their individual agencies/institutions and focus on solutions that are of benefit to patient/client flow, to easing other stakeholders' pressures though potentially increasing their own, to what makes sense rather than what works on paper and to finding the fit that functions well rather than fitting the function to current process(es) or historical patterns (eg:"well that's how we've always done it."). Systems thinking reminds organizations that patients/clients should not accommodate the agencies/institutions and their processes, but that the agencies/institutions need to "get back to" remembering the nature of providing service to their biggest stakeholder – clients/patients.

Priorities for Ontario

The Province of Ontario and the LHINs have well-defined health care priorities that are reflective of what the public has defined as being important factors in improving health system performance. Among these priorities is reducing emergency department wait times, decreasing the number of people awaiting alternative choices of care whether in the community or in facilities, and lowering length of stay and alternate level of care (ALC) days in hospital. These priorities were among the key drivers behind and critical to the success of, the development of the Supports for Daily Living service. In the case of the Mississauga Halton LHIN, the Supports for Daily Living initiative aligned in the following manner:

1. Improve access, quality and sustainability of the health system (emergency wait times and ALC)
    - Reduce ER treatment wait times by enhancing community capacity to provide non-emergent care
    - Reduce hospital stays by increasing supports in home and community settings

2. Enhance seniors' health, wellness and quality of life.
    - Transform community capacity and programs to help 'at risk' seniors live at home as long as possible

It was against these priorities that the Mississauga Halton LHIN was able to monitor and measure its success after the Supports for Daily Living service was implemented.

The LHIN's multi-year funding allocation to increase community capacity under the 'Aging at Home' strategy was intimately aligned with the MOHLTC's overall ALC reduction and ED wait time strategy. The investments in the Supports for Daily Living service were made under the Aging at Home strategy.

The Aging at Home initiative provided the MH LHIN with the ability to invest in those areas that would maximize the achievement of a vision and targeted priorities. This wasn't a simple task as the MH LHIN needed to concentrate funding in targeted areas that would address system pressures as well as take some calculated risks in choosing ideas that did not have a proven track record of meeting system pressures. Resourcing those areas and ideas was akin to jumping into the deep end of the pool (ie: Would this drive the change that was being sought? Would this be the right idea?). The

supportive housing program was one such area. Taking this program to a whole new level of change and developing a new vision (Supports for Daily Living) was untried and untested. Further, in order to expand capacity for care to accommodate hospital discharges, the MH LHIN chose to utilize the majority of the Aging at Home funding to resource the community in general and the community support services sector (of which SDL is a part), in particular, in order to target specific initiatives that addressed system pressures and drive change.

System-wide 'Home First' Philosophy

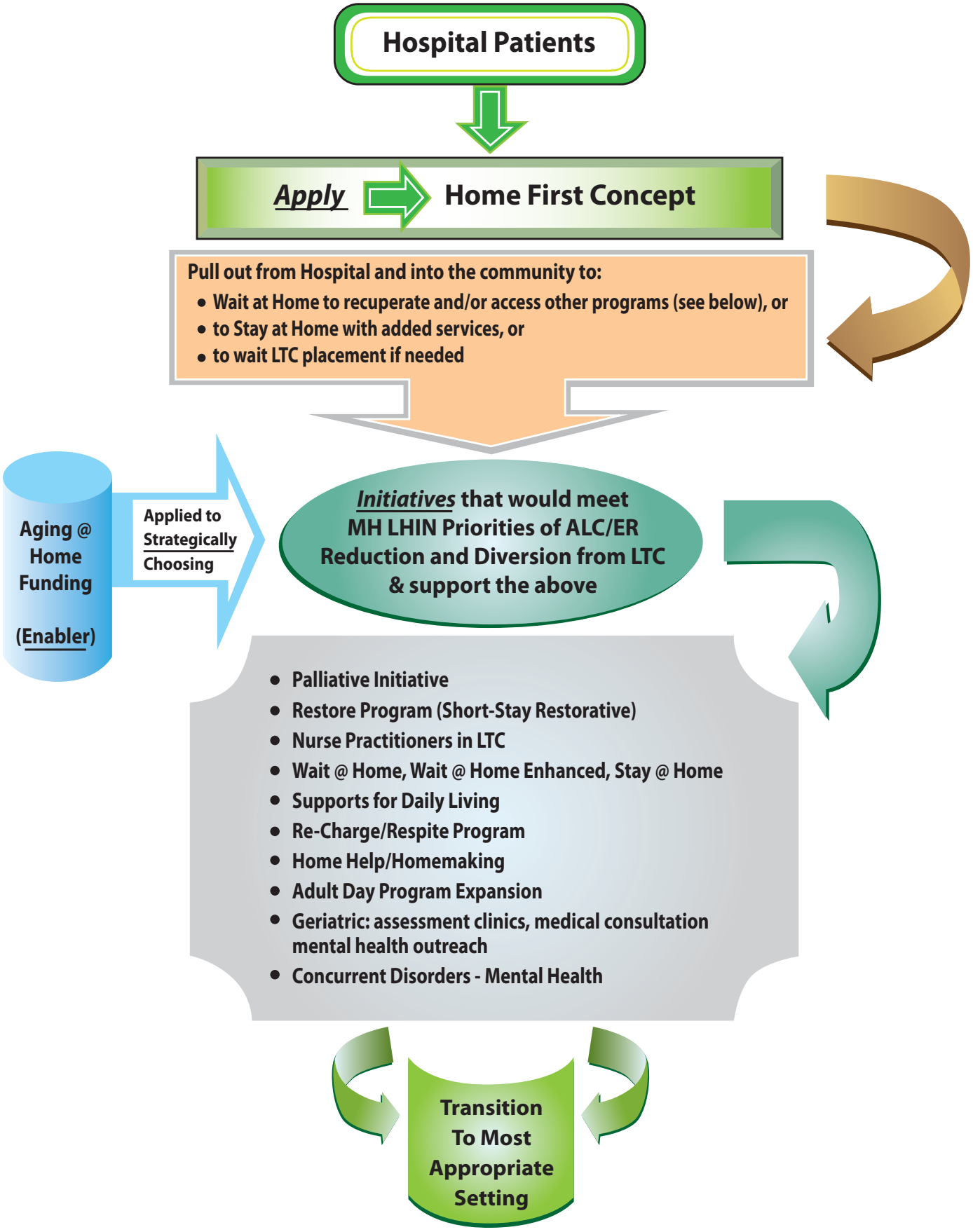
Studies have shown that well-managed patient care in the home can moderate the demand for more costly hospital/long-term care while also maintaining an individual's independence. As part of the MH LHINs' Aging at Home strategy, an initiative was developed that emphasized a new approach in thinking about high-risk seniors. This new evidence-based, person-centred approach, known as ***"Home First"***, became embedded as a distinct philosophy of managing patients in hospital to enable a transition to home wherever possible.

This philosophy is applied to all patients, but becomes specifically useful in targeting high risk seniors who require greater supports to transition home or who may be too quickly looked at for Long Term Care placement. By developing significant community programs to provide services in order to enable the transition home, high risk seniors in particular can be discharged earlier from hospitals to recover at home over a longer period of time. In some cases, these high risk seniors do transition to long term care placement. However, with the Home First philosophy in place, these seniors are able to make a life-impacting choice in their own homes and without the urgency faced in a hospital situation.

The community programs that were developed in the MH LHIN under the provisions of Aging at Home in order to support the Home First philosophy include:

- Wait at Home
- Wait at Home – Enhanced
- Stay at Home
- Supports for Daily Living
- Adult Day Program – Higher Acuity
- Short-Stay Restorative (Restore)
- Geriatric Strategy: Mental Health Outreach, Urgent Assessment Clinics, Geriatric Medical Consultation
- Home Maintenance and Repair + Home Help and Bathing
- Respite Services (Re-Charge)
- Enhanced Palliative Program

The following diagram illustrates the "strategy" behind the Home First concept:


Hospital Patients
Apply
Home First Concept
Pull out from Hospital and into the community to:
• Wait at Home to recuperate and/or access other programs (see below), or
• to Stay at Home with added services, or
• to wait LTC placement if needed
Aging @ Home Funding
(Enabler)
Applied to Strategically Choosing
Initiatives that would meet MH LHIN Priorities of ALC/ER Reduction and Diversion from LTC & support the above
• Palliative Initiative
• Restore Program (Short-Stay Restorative)
• Nurse Practitioners in LTC
• Wait @ Home, Wait @ Home Enhanced, Stay @ Home
• Supports for Daily Living
• Re-Charge/Respite Program
• Home Help/Homemaking
• Adult Day Program Expansion
• Geriatric: assessment clinics, medical consultation mental health outreach
• Concurrent Disorders - Mental Health
Transition To Most Appropriate Setting

Policy for Ontario

On January 1, 2011, the Ontario Ministry of Health and Long-Term Care introduced the *Assisted Living Services for High Risk Seniors Policy*. The policy was developed to address the needs of high risk seniors who have the ability to continue living at home with the availability of personal support and homemaking services throughout a 24-hour basis. The policy replaces the former *Assisted Living Services in Supportive Housing Policy, 1994 – updated 2001*. The MH LHIN assisted in the development of the policy through feedback to the MOHLTC. This feedback reflected the experience and development work on the new models of service delivery that had occurred in practice with the SDL service provider agencies.

The intent of the policy is to:

- enable local communities to address more fully the needs of high risk seniors so that they are able to remain safely at home
- expand cost-effective and accessible options for community care
- reduce unnecessary and/or avoidable hospital utilization and wait times of acute care services, emergency room use and admission to long-term care homes
- provide LHINs with the flexibility to adapt to client's changing care requirements
- strengthen assisted living services to achieve a more functional continuum of care for Ontario's high risk seniors within each LHIN.

Services provided under this policy are personal support, homemaking, and security checks or reassurance services. The policy points out that people receiving assisted living services in this manner may also be eligible for CCAC professional services. The policy also indicates that assisted living services are to be provided by agencies that are approved to provide these services under the *Home Care* and *Community Services Act, 1994* and that are funded by LHINs.

The Mississauga Halton LHIN's Supports for Daily Living service addresses every aspect of the new policy, providing a cost-effective solution that not only meets the needs of high risk seniors with complex needs, but also generates impressive results in reducing visits to emergency departments, diverting pre-mature admissions to long-term care and reducing length of stay and ALC days in hospital.

The success of Supports for Daily Living as a viable option for high risk seniors with complex needs rests with system-wide adoption of a Home First philosophy as it directly impacts the referral process and the ability of the LHIN to ensure people are being served in the most appropriate setting. The Home First philosophy has effectively and proactively reduced ALC length of stay (LOS) as well as reduced the demand for long term care placement in the MH LHIN. The MH LHIN continues to have one of the lowest ALC rates in the province that has been consistently evident for over 2 years running. As a result, Home First has since been launched as a provincial initiative by the Ontario Ministry of Health and Long-Term Care.

Some Areas to Remember

In the midst of trying to address what seniors need from their local health system, it is important to remember that health care funding has a limited "pot" from which to draw resources both monetary as well as human. To that end, the hours allotted in the SDL program must be focused in a targeted manner to provide the greatest impact in addressing need with a reasonable cost to the health care system. If the amount of service provided (and subsequent costs) begin to outpace that provided in another setting, it becomes imperative that SDL reassess whether the service being provided meets the criteria of ***"right care, right place, right time, right cost."***

It is also essential to remember that when the amount of service required by a client to remain with SDL services begins to outpace the SDL programs' resources, the client may be placed at serious risk for harm in that setting. As service providers, we must *remember and respect* that clients have *the right to live at risk* – they need to receive timely and factual information to make an informed choice about that risk and to understand when their needs exceed what the program can provide. These are difficult conversations, but they are essential to respecting a client's right to live at risk and the agencies' right to mitigate risk (see Standards Manual).

In many circumstances, conflicts will arise, perhaps because the family wants mom to enter a long-term care facility or dad doesn't wish to leave SDL service for long-term care even though his needs exceed what can be safely provided. In the former scenario, the SDL agency could be acting as an advocate for a client while in the latter scenario, the SDL agency is mitigating risk for the client and for itself. There are no absolutes and there isn't one way of doing things. Instead, an agency should clearly evaluate each client *individually* and *equitably* to see whether ***"right care, right place, right time, right cost"*** is or can be provided.

Policies that are *flexible within specific parameters* (an entry into and an exit from, but allow for individuality and equity in-between) are essential tools for agencies in order to avoid a "cookie-cutter" approach or keeping clients on service past the time when the risks to clients or others outpace the service that can be provided. As part of the commitment to advancing knowledge and understanding of the Supports for Daily Living program, we have developed a "package" of contents that include this SDL Resource Manual, the SDL ***Standards Manual*** that addresses the "how" of compliance in making the program work and the SDL Video. These resources are available on the Mississauga Halton LHIN website http://www.mississaugahaltonlhin.on.ca/

Chapter Two

Understanding the Landscape

"I wouldn't want to be totally alone. I'm not able to cook, and do all these things, or wash myself. How am I going to be able to do that? When I need to get dressed, or get out of bed and have a shower, they help me do that."

Delores B., age 70, stomach cancer
and breast cancer survivor

Identifying Where Seniors Live

One of the keys to developing a Supports for Daily Living service is recognizing where seniors reside within your LHIN. A Supports for Daily Living framework is based on a 'clustering' model. This means that the model is focused on those areas in the community where there are high density populations of seniors (65+). High density could exist within apartment buildings, condominium or townhouse complexes or within pockets of residential areas/neighbourhoods.

Determining where your populations of seniors reside within your LHIN can be accomplished by reviewing the postal codes of seniors (65+) who have been admitted to, and discharged from, hospital inpatient units and/or emergency departments, overlaying this information with CCAC client postal codes of seniors on service and then overlaying that information with LHIN population density mapping or Stats Canada population data. This exercise allows the LHINs to target specific areas where seniors reside in order to potentially fund an SDL program (building, hub & spoke models) to open in that area. Potential clients for an SDL program that opens in the area would be those coming from hospital as ALC inpatients or who are frequent users of the Emergency Department with MAPLe scores of 'moderate' 'high' or 'very high' needs (MAPLe 3, 4, 5) and who require *frequent care* throughout a 24 hour period that cannot be addressed through a visitation model of care.

> ***"Supports for Daily Living addresses the lack of programs available to support high need seniors in the community which is essential to address the need for the 4Rs – Right Care, Right Place, Right Time at the Right Cost."***
>
> Narendra Shah,
> Chief Operating Officer
> Mississauga Halton LHIN

Capacity and Focus

By placing Supports for Daily Living services in these more densely populated areas you have the capacity to:

- divert from and reduce, long-term care placement,
- provide support for clients who use the emergency department as a result of a decline in activities of daily living (e.g. dehydration due to poor nutrition, dizziness due to lack of eating, medication mismanagement due to lack of reminders to take the medication or taking too much),
- reduction in length of stay (LOS) in hospital that leads to a designation of ALC as a result of having no one at home to supervise or because of needing extra supports while taking longer to recover.

By focusing on clusters of seniors' populations within your community, you can:

- make the most efficient and effective use of human and financial resources in supporting the needs of high risk seniors living in these areas.
- reduce the need for extensive travel between clients,
- allow for the effective scheduling of personal support workers to respond to multiple daily service requirements of high risk seniors within a targeted area,
- accommodate and avoid displacement of seniors who may have lived in their communities for many years

Attaining Knowledge as a Place to Start/ Establishing a Baseline for Measurement

In 2008, the Mississauga Halton LHIN commissioned a retrospective review/research study with Dr. John Hirdes, Professor at the University of Waterloo, on appropriate level of care in various settings including the supportive housing program. The review/study encompassed MH LHIN agencies/facilities/providers that included 6 LTC Homes, MH CCAC, 3 hospitals and 11 Supportive Housing. The objectives of the review/study were to:

- Describe the populations in various MH LHIN service settings
- Examine appropriateness of service environments
- Pilot test the RAI Community Health Assessment (CHA) and supplementary modules in supportive housing
- Demonstrate the utility of the RAI suite of instruments to support MH LHIN decision making regarding resource allocation and service planning related to the continuum of care.

Overview of Results of Dr. J. Hirdes

- Many individuals with lower level needs based on RAI scores (less than 2 domains triggered) and based on staff ratings, were in more intensive service settings than they needed to be
- Many individuals who were waitlisted for LTC were in fact individuals with lower level needs that could have other community services provided in order to divert them from LTC (eg: CSS, CCAC, Adult Day, Supportive Housing, Homemaking, Respite, etc.)
- Few individuals with more intensive need requirements were inappropriately placed in a lesser need service setting

The following information identifies a brief overview of the number of assessments and data sources utilized in the review/study:

- ***Comparison of the care needs and appropriate service settings*** for persons in:
  - Home care with CCAC services -1,624 clients
  - Supportive housing – 367 clients
  - Long term care homes – 832 residents
  - Complex continuing care (hospitals) – 425 patients
- ***Data sources***
  - Pilot implementation of the RAI CHA in supportive housing settings
    - Among clients NOT receiving CCAC services
  - Abstracts of assessments already completed as part of normal clinical practice
    - RAI-HC
    - RAI 2.0 (CCC and LTC early adopters)
- ***Staff rating supplement on appropriateness of service setting*** (least intensive service setting that would appropriately meet a person's needs – now, @30 days, @60 days)
  - What supports/services are needed to transition to a less intensive service setting?
  - What barriers exist to transition to a less intensive service setting?
  - Is there a "fit" with the person's needs to the current service setting?

Summary Results of Dr. J. Hirdes

Long Term Care (LTC)

12% of the residents in LTC (from the assessments utilized in the review/study) within the MH LHIN LTC Homes, have lesser needs that could be more appropriately met in less intensive settings. This means that:

- In the 6 LTC homes involved in the review/study, 100 individuals did not need to be there – MH LHIN did not utilize data from the other 21 LTC Homes for the review/study, suggesting that far greater numbers exist that do not need placement in LTC

Complex Continuing Care (CCC)

- Upwards of 25% (106 patients) that were designated as ALC would be able to be cared for in settings ranging from LTC to home with CCAC services (all less intensive settings for individuals whose treatment had been completed ie; ALC).
- For those that were deemed non-ALC, upwards of 17% (64 patients) could be cared for in settings ranging from LTC to retirement homes (again, all less intensive settings)

Community Care Access Centre (CCAC)

- For those individuals on a LTC waitlist and receiving CCAC services, upwards of 37% (76 individuals) would be able to have their care needs met by either no home care or community support services (could come off of CCAC services)
- Upwards of 18% (37 individuals) receiving CCAC services could have their needs met through retirement homes or supportive housing, thus coming off of CCAC services
- For those CCAC clients in the community, upwards of 10% (142 individuals) would be able to have their care needs met by either no home care or community support services (could come off of CCAC services) while 7% (99 individuals) could have their needs met through retirement homes or supportive housing

Community Care Access Centre (CCAC) – cont'd

These results indicate that upwards of 22% (354) of the CCAC clients assessed for this review/study (N=1624) could be more appropriately served in another setting if the appropriate services were available.

Considerations by the MH LHIN on these findings included:

- The most cost-effective alternative, presuming that community support services (CSS) were less expensive than the CCAC and that the same level of care was provided:
  - Egs: 354 CCAC clients (presuming PSW service need only @ 1 hr per day X $30.00/hour X 365 days/year) = $3,876,300 or 354 clients X 2 hrs per day X $30.00/hour X 365 days/year = $7,752,600 or 354 clients X 10 hrs/week X $30.00/hour X 52 weeks/year = $5,522,400. ***Any of these examples could provide the availability of those resources to be re-focused to higher level need clients/pulling from hospital – if greater community capacity in CSS was achieved and discharge from CCAC services of lower level need clients was achieved***
  - If the CCAC has a greater caseload @ any given time than was utilized in this review/study (N=1624) and presuming the same percentage of 22% was utilized, a higher amount of resources could be re-focused

- Greater frequency of care needed throughout a 24-hour period to divert those who were LTC waitlisted

- The types of services that were needed in the community to address less intensive client needs (eg: adult day programs, bathing + homemaking services)

- "Off-loading" from CCAC caseloads those less intensive care need clients or those requiring more frequency/day care – re-focusing CCAC budget expenditures to higher acuity need individuals and pulling individuals from hospital as well as working more closely with supportive housing and CSS in order to sustain individuals in the community.

The results of the review/study created a good deal of discussion about the inappropriateness of individuals in more intensive settings for service than they needed to be as well as "right-sizing" the system. To create a sustainable system with a focus on the right care, in the right place, at the right time and at the right cost, the MH LHIN realized it needed to find alternatives for individuals by creating appropriate capacity within community and home settings as well engaging its' hospitals, LTC homes, CCAC, CSS and supportive housing sectors to examine practices and assumptions as well as contribute to ideas that would increase "flow" through the system. This approach would require an investment in the community to support individuals as well as service providers to shift their service focus from lower level to higher level need clients while transferring individuals to more appropriate care need settings.

Targeting High Risk Seniors by Leveraging Common Assessment

In 2008 the Mississauga Halton LHIN invested considerable effort in evaluating a standardized assessment tool that would be potentially beneficial to the CSS sector and effective in *determining client eligibility* for the supportive housing service. Supportive Housing providers evaluated the Common Health Assessment (CHA) instrument for appropriateness and effectiveness for their client population. During this time, 367 RAI-CHA assessments were completed, the results of which created a baseline and informed the development of the Supports for Daily Living framework. As with other inter-RAI assessment tools, the CHA includes an "algorithm" known as the MAPLe which is defined as a "Method for Applying Priority Levels". The MAPLe is scored from 1 to 5 with 1 being low risk needs and 5 being very high risk needs. The MAPLe scoring can be utilized as part of an effective strategy to prioritize clients requiring community or facility-based services.

Through the use of the CHA and the MAPLe algorithm, the Supports for Daily Living framework proposed targeting a *minimum of MAPLe level 3 clients*, with an emphasis on those at MAPLe levels 4 and 5, for eligibility to the new SDL services. This has represented a shift in the eligibility level of clients for supportive housing who have traditionally provided care to clients with lower level needs, (eg: MAPLe levels 1 and 2). However, the capacity within this sector to address high level client needs has been proven through the implementation of the Supports for Daily Living service models within the Mississauga Halton LHIN.

The following chart showcases how the SDL program adapted to its new role of meeting the needs of high risk seniors by transitioning from a supportive housing, lower client need service to a higher need SDL service within the course of 2-3 years.

	Pre SDL (2007/2008)	Post SDL (2010/2011)
% MAPLe Score 1,2	42%	8%
% MAPLe Score 3	53%	42%
% MAPLe Score 4,5	5%	50%
% 65+	74%	100%

Source: MH LHIN multi-year data indicators

The use of the CHA instrument and the MAPLe algorithm was essential for the transformation of supportive housing to SDL in order to shift the focus to higher needs seniors which in turn, delayed or permanently diverted these seniors from long term care or assisted a reduction in hospital length of stay (LOS) for those who needed a frequency model of service. With needs being met in the SDL models of service delivery, long term care beds were more readily available for those who required an even higher level of care. Similarly, those individuals who were SDL clients and needed hospitalization were returned home faster knowing that SDL service was in place to assist clients who needed a longer time for recovery. The benefit to the health care system, not to mention clients and their families, has been a resounding success. Examples of this "return on investment" or ROI is shown in Chapter 7 and highlights savings to the health care system.

Transitioning from Supportive Housing to Supports for Daily Living

An SDL Work Group, comprised of supportive housing service providers, Mississauga Halton LHIN staff and representation from the Mississauga Halton Community Care Access Centre (CCAC) conducted an assessment of the existing supportive housing service program and discovered a fragmented system of services driven by provider versus client need. The SDL Work Group began the task of developing a regionally integrated community service delivery model by establishing a common vision, a common model, common definitions and common assumptions on the road to developing a framework for this new "entity" known as Supports for Daily Living (SDL). The foundation piece to their work was utilizing the former supportive housing model as articulated in the MOHLTC's *Assisted Living Services in Supportive Housing policy, 1994* – updated 2001. From this foundation, the group identified information needs that included:

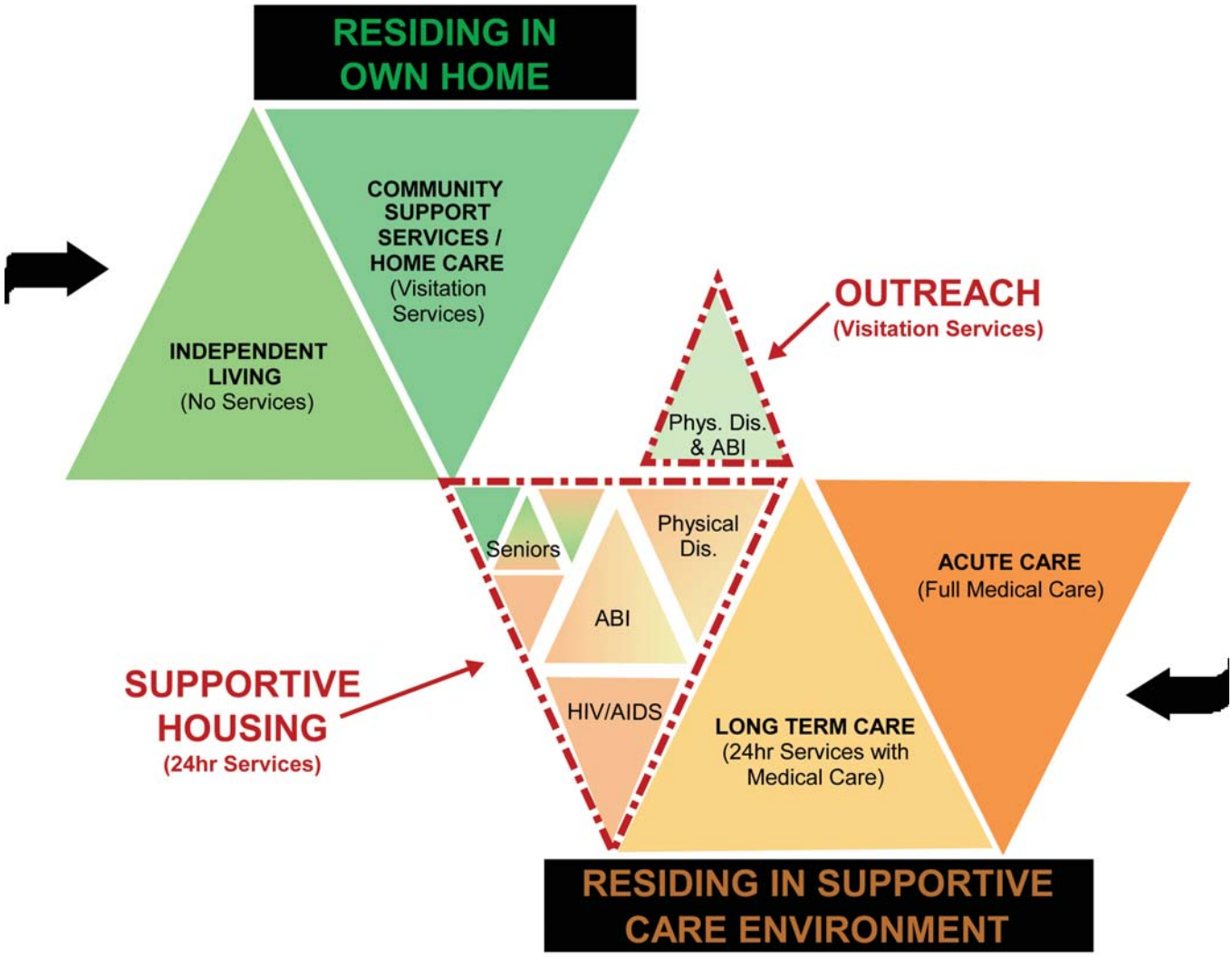
- defining the LHIN populations that would be using the service
- identifying designated neighbourhoods based on population density over the age of 65 and in all home settings (e.g. townhouses, condos, co-ops, single dwelling homes, social housing, etc.)
- developing a profile of client needs for the service (e.g. light, right, heavy)
- establishing eligibility criteria and a decision tree
- establishing a baseline amount of service time and frequency as well as service costs, and
- developing standardized core services.

The SDL Work Group reported into the Mississauga Halton LHIN's ALC Steering Committee, with the SDL Work Group Chair sitting on both groups. The ALC Steering Committee consisted of key leadership from the broader health system including the Mississauga Halton LHIN, hospitals, the Mississauga Halton CCAC, community service provider agencies and long-term care. This group provided an ideal forum for testing system-wide reaction and support for the proposed delivery model. Once the framework for the Supports for Daily Living service was approved, three lead agencies represented on the SDL Work Group, each piloted one of the three SDL models for close to a year before the model was rolled out to another five service providers within the LHIN.

The following diagrams identify the "pre-SDL" framework and the "post-SDL" framework within the continuum of care

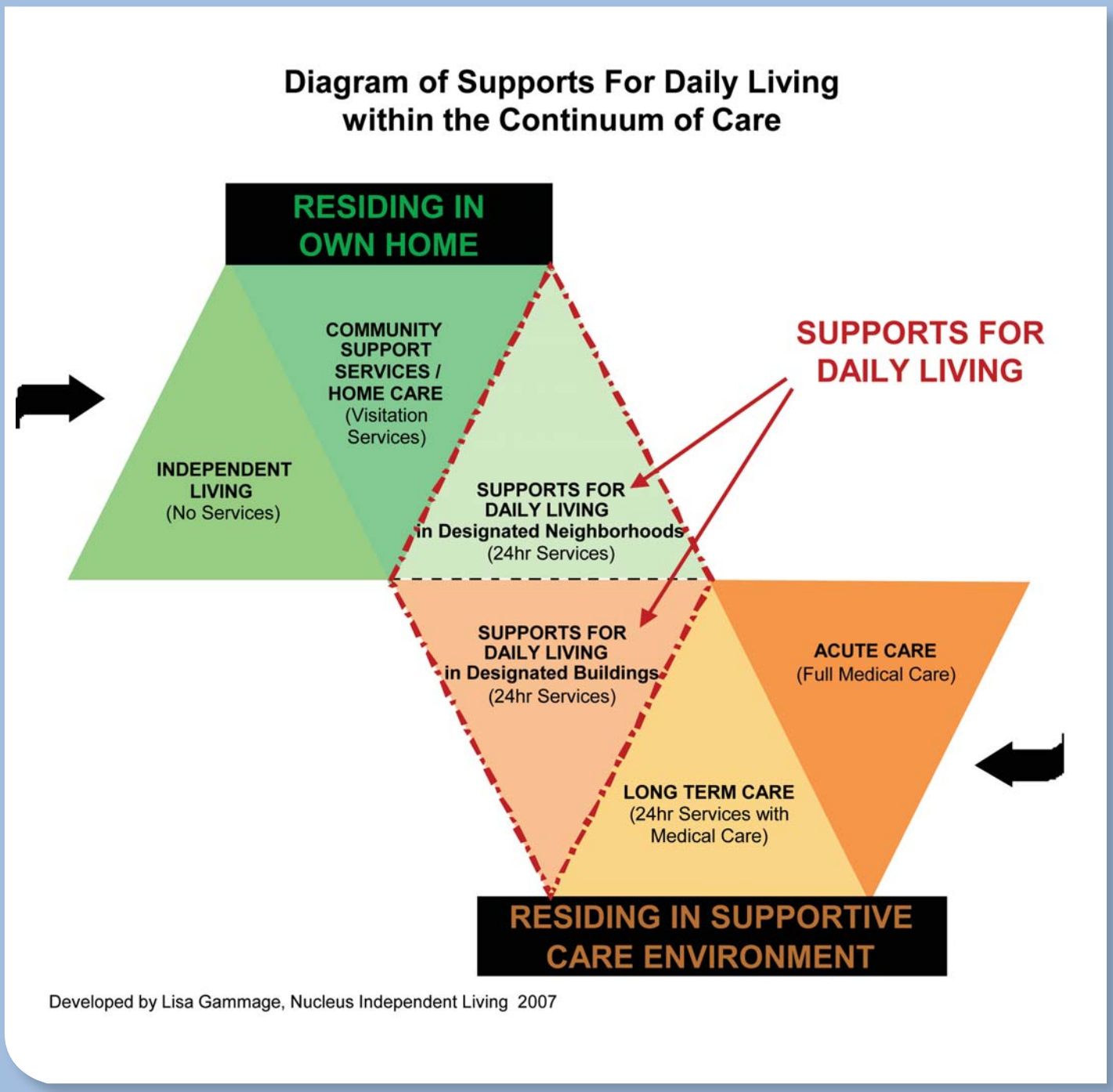
Pre-SDL Framework

Diagram of Supportive Housing within the Continuum of Care



Developed by Lisa Gammage, Nucleus Independent Living 2007

Post-SDL Framework



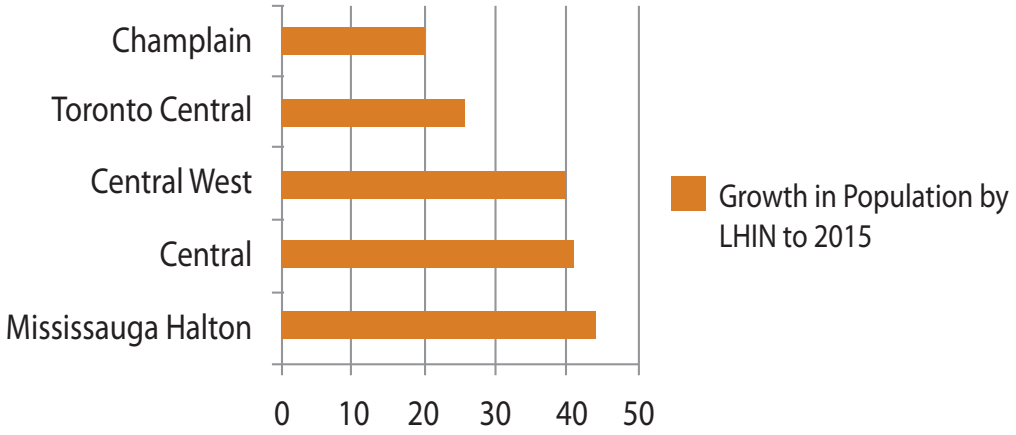
In evolving the service from the existing supportive housing model, the group ***changed the focus from providing a program in certain designated buildings to a focus on service wherever seniors lived throughout the region***. Further, the group clearly articulated that "housing" needs were separate from "service" needs. This meant that it could no longer be assumed that service would automatically be provided in a designated building just because you lived in that building as this thinking placed "service" needs at a lower priority than "housing" needs. The provision of service was to be based on eligibility criteria obtained through a standardized assessment instrument that provided objective data.

Understanding Past Practices

To change a current practice, it is often necessary to understand past practices, what was emphasized, and what had value. It is also beneficial to seek information that can provide insight to guide future direction. To this last point, the MH LHIN looked at growth projections for the LHIN of those 85+ (most likely to need assistance for daily functions) as well as the experience of other jurisdictions in the number of LTC beds for the population.

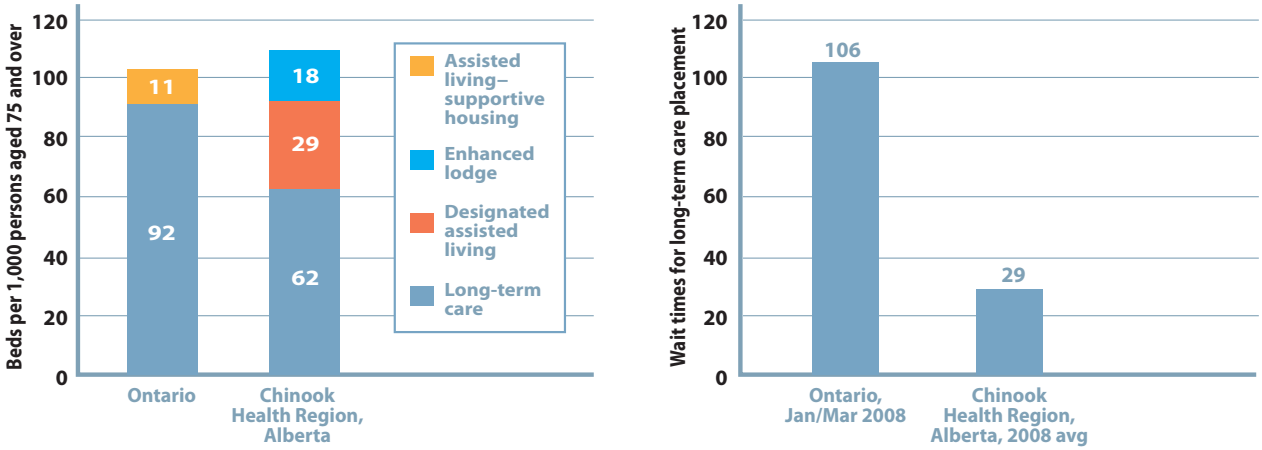
The following chart paints a clear picture of future growth in the MH LHIN of those 85+ and indicates that the LHIN will have the fastest growing population of this age group amongst those LHINs with the oldest populations.

% Growth In Population by LHIN to 2015 of Those 85+



Considering that those 85+ may have more likelihood of utilizing LTC beds and that MH LHIN already had one of the lowest ratios of LTC beds per 1,000 population, thought was given to funding more of these beds. However, in the end, the MH LHIN chose to see what the new SDL program was able to provide. The following chart as an example from Alberta in comparison to Ontario, can clearly articulate the benefit to the MH LHIN of choosing to invest in SDL. As the example identifies, Ontario as a whole has invested in LTC beds over those of assisted living/supportive housing while this Alberta region has invested in proportionately more assisted living/supportive housing. The result is that the Alberta Region has significantly shorter wait times for LTC admission than Ontario with more LTC beds.

Supply of long-term care beds and wait times for long-term care placement in Ontario and Chinook Health Region in Alberta, 2008



Source: Alberta data supplied from Chinook Health Region, Ontario data from Ontario Ministry of Health and Long-Term Care

In attempting to design a new service, such as SDL, on the foundation of the established supportive housing/assisted living service, old concepts and practices would need to be understood first in order to help them "give way" in the future. The following information comprises the "profile" of the original assisted living/supportive housing service in the MH LHIN:

Former State	Description
Target population	People who require low income housing + "some" service - no objective measurement of "most in need" for those brought on service – assumption that since an individual was in the building, service would be provided
1 model of service delivery (buildings & units)	No other innovation – this type of service delivery model often can support housing/landlord focus and mandate
Expansion	Costly capital requirements to build specific assisted living/ supportive housing buildings - permission to expand can create a NIMBY mentality Housing sites not targeted/poor rationale for where sites established
Inconsistencies	Core services not articulated and not all provided across agencies - landlord agreements superseded service agreements – some services duplicated other services available in the community - funding, amount of service per client, yearly costs, costs per hour of service

Former State	Description
Measurement	Anecdotally based - qualitative and quantitative measures lacking - no indicators – variety of agency specific assessment tools utilized (minimal validity and reliability) – no joint gathering of data for the sector – inability to show value to the system
Getting a place	Long wait lists (2 to 10 years) – lower needs clients were the norm on service
Role/function	Not understood – not positioned within continuum of care between acute, LTC or CCAC Community services – lack of clarity in moving people through the health system (ie: either keep clients requiring a higher level of care or discharge early – can't handle)
Service outside of the building (known as "outreach")	Part of assisted living/supportive housing policy mandate, but never enacted – only available for physically disabled and ABI populations and not seniors - designed and funded to only be available between 6:00am and 12:00am

Chapter Three

About Supports for Daily Living

"If I didn't have the help from Supports for Daily Living, I wouldn't be able to have a shower and get my dinner. They're friendly, they're dependable, and they have a gift for helping people."

Anne V., age 69, client with multiple sclerosis & breast cancer survivor

About Supports for Daily Living

Supports for Daily Living (SDL) is an innovative regional service delivery model that targets high risk seniors with complex needs who are able to continue living in their own homes as long as there is access to frequent, urgent and intense personal supports throughout a 24-hour period. Applying a non-medical approach, it bridges a gap between a community visitation model of care (often a block of 1-2 hours occasionally during the week or every day) and the model of care provided in long-term care homes.

Embracing out-of-the box thinking, Supports for Daily Living is a new concept in community-based assisted living that provides:

- round-the-clock availability, 365 days of the year;
- scheduled visits and on-call response - day, evening and night;
- multiple daily visits by trained personal support workers (PSWs), based on the individual needs and preferred schedule of the client;
- daily personal care and essential homemaking to assist with the activities of daily living; and
- safety checks, reminders (such as medication) and urgent response.

Clients may be eligible for up to 1.5 hours of personal support each day, seven days a week/365 days a year. Throughout a 24 hour period, services may be delivered at multiple times scheduled throughout the day or night to coincide with those times when clients most need the support. Where feasible, every effort is made to schedule service at those times most preferred by the client. Each scheduled time with the client can take as little as 5 to 15 minutes, depending on the level of support needed and the activity involved.

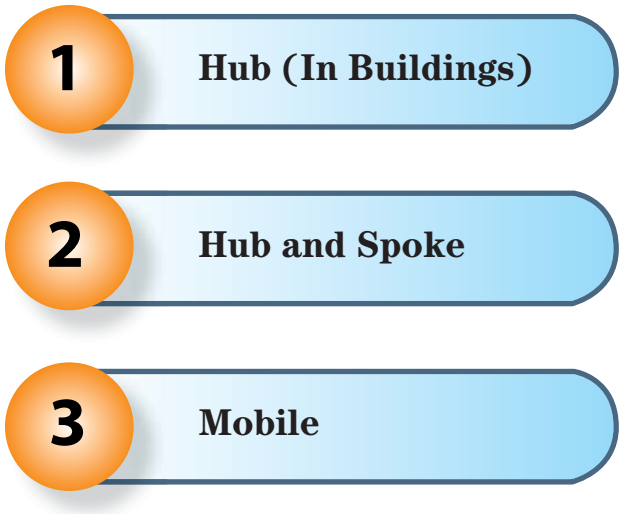
Sample Client Schedule

Time	Activity	Time Allotment
7:30 a.m.	Assistance getting up and getting dressed; make bed	30 minutes
12:00 noon	Meal preparation (make lunch)	15 minutes
3:00 p.m.	Medication reminder	10 minutes
6:00 p.m.	Meal preparation (make dinner)	30 minutes
9:00 p.m.	Security check	5 minutes

Innovative Approaches to Service Delivery

One of the reasons the Supports for Daily Living model is so effective is thanks to its agile approach to service delivery. In this model, the housing arrangements are separate and distinct from the Supports for Daily Living services offered. SDL staff are able to facilitate responses to urgent requests from SDL clients day, evening and overnight, ensuring clients are able to speak with someone live 24 hours a day, every day throughout the year.

MH LHIN utilizes three models of service delivery:



> ***"Supports for Daily Living shifts the ability to care for [high risk seniors] in a 24-hour environment outside of institutionally-based care and allows them to be at home where they want to be."***
>
> Dale Clement,
> Chief Operating Officer
> Halton Healthcare Services

Hub (In Buildings)

In the SDL "hub" model as with the traditional "bricks and mortar" supportive housing services personal support workers (PSWs) are located onsite and deliver services to eligible seniors in their individual units/apartments/condos within the building. In this model, the housing arrangements may be separate and distinct from the Supports for Daily Living services offered or housing arrangements may be a part of the overall "package" with services included in an entire building "designated" for assisted living or where a designated number of units are available. In this model, units could be rent geared to income, low income or life lease or could be apartments/condos that are rented or owned outright.

Often seniors registered with an emergency response program will identify the SDL service provider as the first responder (e.g. should the client have a fall and need immediate assistance). Because staff availability is scheduled over a 24-hour period, the SDL service provider is able to provide timely response in urgent situations. Previously, in the case of a fall, seniors often called 911 which involved an EMS response. By being listed as a first responder, personal support workers can quickly assess whether or not medical attention is required or whether the senior simply needs support to get back into bed or into a chair (see case study on page 35).

Hub and Spoke

The hub and spoke model evolves out of the 'hub (in buildings)' model. In this scenario, the Supports for Daily Living service provider has an office onsite in a building (hub)servicing clients in the building, but also provides services (the spokes) to eligible seniors who live in neighbouring apartment buildings, town homes, condos, homes or trailer parks within close geographical proximity to the building. Close proximity may be across the street, down the street or within a specific geographic distance (examples: 1 km, 2 kms). (see case study on page 37)

Mobile

The SDL Mobile model is exactly that – Mobile. Supports for Daily Living service providers travel throughout the region to deliver service regardless of where high risk seniors live. The purpose of this model is to get high risk seniors who are being discharged from the hospital, home quickly regardless of where they live. Once home and following a period of recovery, the Mobile service works to transition stabilized clients from the Mobile service to other community partners, such as another SDL provider, the CCAC or a combination of services that will address a client's needs. In this model, the housing arrangements are again, separate and distinct from the Supports for Daily Living services offered.

The SDL Mobile service also complements the other SDL service delivery models by being available to assist with pre-scheduled bookings and/or urgent and unscheduled client requests (see the chart on page 31 for examples). This model has not been tested in rural environments but is effective in high density urban communities. (see case study on page 38)

An Important Link Along the Continuum of Care for Seniors

A primary goal of most high risk seniors who have been admitted to hospital with an acute episode is to return home once their condition has stabilized. This is sometimes possible with the support of CCAC services and other community supports and/or following convalescent, rehabilitation or restorative care in another facility. However, for those high risk seniors with needs that require more frequent, urgent and/or intense personal support at home, access to readily available care is essential. Without *frequent service* throughout a 24 hour period many of these seniors would traditionally have been referred to long-term care.

Supports for Daily Living addresses the gap in Ontario's Health System for a 24-hour non-medical assisted living model that enables high risk seniors with complex needs to continue living at home or in another suitable homelike environment. It does so by providing them with access to personal supports, essential homemaking services and safety and reassurance checks at multiple daily times, seven days a week, 365 days a year. Clients who continue to require medical care can still access CCAC professional home care services including nursing, rehabilitation, etc. to address their ongoing health care needs.

SDL Core Services

	Personal Hygiene Activities	Personal Routine Activities of Daily Living
Personal Support Services	• **washing** • **bathing** • **mouth care** • **hair care** • **preventative skin care** • **changing dressings (not wound care)** • **routine hand and foot care**	• **transferring/positioning** • **turning** • **dressing/undressing** • **assistance with eating** • **assistance with toileting (diapering, emptying/change leg bag, catheterization, bowel routine)** • **assistance with exercise** • **escort to medical appointments** • **medication reminders; assistance with pre-measured medications**
Homemaking Services	Light dusting, sweeping, vacuuming, mopping floors, washing dishes/ countertops, clean and disinfecting bathrooms Laundry and planning/preparing meals	
Attendant Services	Combination of personal support and homemaking services offered at clients' preferred, pre-determined time and pre-determined task they cannot physically do for self	

How Personal Care & Support Services Differ Between the CCAC and SDL

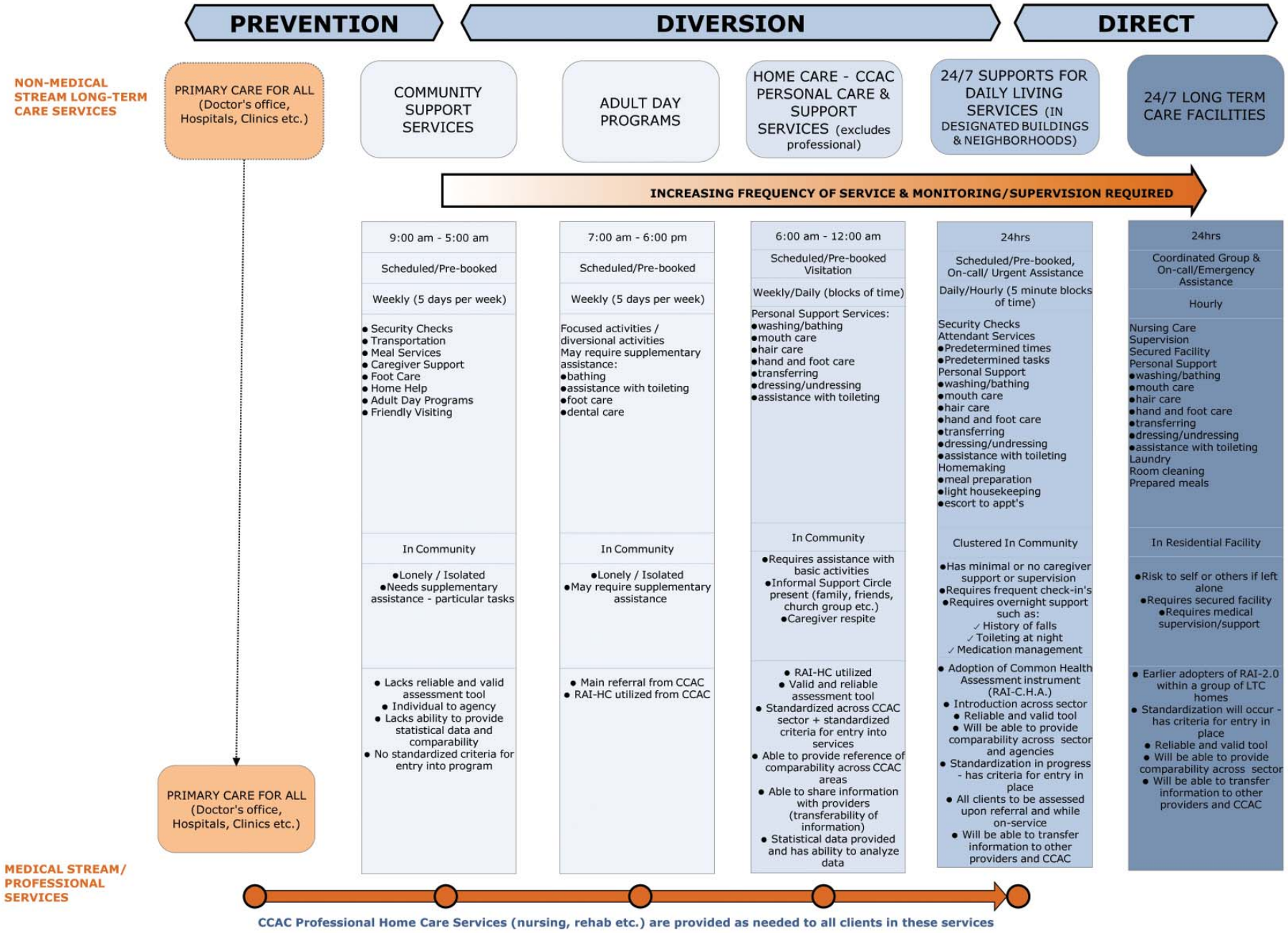
CCAC (Personal Care & Support Services)	Supports for Daily Living Services
6:00 a.m. – 12 midnight	24 hours
Scheduled/pre-booked visitation	Scheduled, plus on-call/immediate assistance
Weeky/daily (blocks of time)	Daily/hourly (5-15 minute blocks of time if needed)
Personal Support • washing/bathing • mouth care • hair care • hand and foot care • transferring • dressing/undressing • assistance with toileting • medication assistance	Security Checks Attendant Services • pre-determined times • pre-determined tasks Personal Support • washing/bathing • mouth care • hair care • hand and foot care • transferring • dressing/undressing • assistance with toileting • medication assistance Homemaking • meal preparation • light housekeeping • escort to appointments (occasional)
In Community	Clustered in Community

On Call Response

One of the unique abilities of SDL services is that they are able to respond to emergency, urgent or by request client needs.

Type of Immediate Assistance	Definition	Examples	Response
Emergency Situations	Critical situations requiring specialized immediate response (life threatening)	• fire • crime • medical emergency (difficulty breathing, uncontrolled bleeding, heart attack, etc.)	911
Urgent Situations	Unexpected situations requiring prompt attention (necessary, but not critical)	• fall • bowel/bladder incontinence • vomiting • unscheduled priority of service (e.g. forgot appointment, needs assistance to go out)	SDL
Request	Unscheduled request for assistance (desirable, but not necessary)	• dropped the remote • can't reach the aspirin in the cupboard, etc.	SDL integrated with scheduled check-in's / bookings

SPECTRUM OF CARE FOR SENIORS



Developed by Lisa Gammage and Kristina Hall, Nucleus Independent Living October 2008

1 Hub (In Buildings)

SDL and Building Ownership by Region:

Oakville Senior Citizens Residence (OSCR) Case Study

Oakville Senior Citizens Residence (OSCR) is a unique venture in the Mississauga Halton LHIN. Originally OSCR provided two services – Supportive Housing and Rent Geared to Income (RGI). With the initiation of the Aging at Home strategy, OSCR was approached to work with the LHIN and other supportive housing providers to develop a new model of service delivery (the birth of the SDL service model). OSCR became one of the founding members of the new SDL service model and today provides Supportive Housing, Supports for Daily Living (SDL) and Rent Geared to Income (RGI) as well as SDL services to clients surrounding the main site. In addition, the MH LHIN supported a pilot project at OSCR to open a five bed "intensive SDL service" (known as the recovery wing). This pilot was so successful in reducing hospital stays (LOS) and avoiding ER visits for ill residents that the LHIN has permanently funded the "infirmary". OSCR is funded by three stakeholders; the LHIN, the Client and the Region of Halton.

The Region of Halton owns the buildings occupied by OSCR. OSCR acts as the Property Manager for the Region of Halton, ensuring that the property and facility are looked after and that tenants pay rent geared to income (RGI) in both the Residential Tower and Apartment Tower (336 units). The Region of Halton funds all property expenses (maintenance, capital expenditures, taxes, utilities and other occupancy costs). OSCR and the Region of Halton have an operating agreement between them that provides OSCR with maximum autonomy while meeting the legal requirements of the Social Housing Reform Act, 2000 Regulations (this Act has been replaced by the "Housing Services Act, 2011" effective January 1, 2012). OSCR must adhere to all Region of Halton directives, follow the Service Manager's Guides to RGI, participate in annual RGI reviews and Operational reviews conducted by the Region, and submit annual budgets and financial reporting. Any changes to housing stock must be approved by the Region via a proposal submitted by OSCR and forwarded to Regional Council for approval.

Application for housing must be **submitted to HATCH** (Halton Access to Community Housing) for tenancy in both towers. The apartment tower is 100 % RGI therefore, clients must be in need of RGI to be eligible – OSCR cannot accept clients who are market rent.

In 2009, OSCR applied to the Region to have 10 units in the apartment tower designated as "Supportive Housing\SDL" units – this would enable these units to accept market rent, allowing the need for care and support to take precedence over the need for RGI. This was approved by Regional Council and OSCR now utilizes these units as SDL units funded by the LHIN. For the Residential Tower a client must need Supportive Housing to be eligible to apply for tenancy. While in the past they had "light" care clients (generally MAPLe scores of 1 – 3), eligibility to the Residential tower must now meet the minimum SDL eligibility criteria (as assessed through the Common Health Assessment (CHA) instrument) to be considered for Supportive Housing.

OSCR Example Client Profile

Mr. S, an applicant with a CHA score of 3 or higher, who needs 10.5 hours per week of frequent SDL services, would not have been eligible for OSCR's apartment tower, as he does not require a Rent Geared to Income (RGI) unit. Mr. S. would have been placed on HATCH's waitlist (3 to 5 years) for one of OSCR's apartment tower units (without SDL services). With the new SDL service model and funding and utilizing the SDL service criteria for eligibility (as per the above assessment information) Mr. S. can now become a priority candidate for any available SDL service designated apartment tower unit.

Outcome: This profile provides a clear example of the differences that have been obtained by ***changing the eligibility criteria from that of a "housing" priority to that of a "service need" priority.*** It further emphasizes the LHIN's role as a funder of "service" to articulate the priorities it is willing to fund.

Other Changes: For tenants, already living at OSCR in non-SDL apartment tower units, additional LHIN funding for SDL service provision has opened access to SDL services throughout the building. Those tenants who meet SDL service eligibility criteria (assessment with the CHA instrument required) no longer need to seek personal support and homemaking services from other community agencies. This has freed up CCAC resources to be utilized in other priority areas. Tenants remain tenants (lease agreement) but also have a Service Agreement with OSCR for SDL services – ***separating the housing need from care needs/services***.

OSCR must balance SDL and Supportive Housing clients in the residential tower as these units are not 100% funded for SDL services. The Region of Halton has accepted the OSCR admission criteria for the Residential Tower. OSCR was also required to adhere to the regulations and guidelines required by HATCH including a chronological waitlist (availability based on time of application). In 2011 OSCR adapted the waitlist criteria utilizing a "DASH" method. The Decision Algorithm for Supportive Housing (DASH) is a tool that was developed to help place prospective clients in the most appropriate care setting in order that resources at each level of care are allocated in the most cost-effective manner. Through extensive research of the supportive housing sector, and utilizing a combination of available inter-RAI data and professional opinion, it was found that alignment between client need and program capacity could be determined through the use of indicators found in inter-RAI assessment instruments (such as the CHA). Specifically, the "DASH" tool indicates a client's need for limited Home Care, or progressive levels of "Supportive Housing", or a more structured environment and Long Term Care placement. The Decision Algorithm for Supportive Housing (DASH) combines several RAI items and outcome scales to inform appropriate care placement decisions. Similar to the MAPLe, the DASH is designed to support decision making not automate it.

For SDL providers, the "DASH" tool is useful in providing a slightly different perspective on client need - one that allows for insight not only into the potential intensity of care, but also better planning as the tool indicates how far along the care continuum that client may be. When used in tandem with MAPLe scores, the DASH affords organizations the kind of robust understanding of client need necessary for determining priority. This now allows OSCR (for the Residential Tower only) to give higher priority on the waitlist (rather than chronological) to high need clients. OSCR works with HATCH and communicates daily regarding the waitlist status and to ensure compliance with HATCH regulations. OSCR strives to work in partnership with HATCH, the Region of Halton and the LHIN to ensure that the clients with the highest need receive housing and services, while ensuring they operate within agreements.

By revising OSCR's admission criteria in the residential tower a successful transformation has occurred from that of a lower need client who could manage in the community to that of a higher need client who requires support and assistance in order to remain in the community.

OSCR's 164 apartment tower residents are tenants with housing agreements. These tenants are all over the age of 65, with an average age of 85 years. Originally, OSCR's policies did not include service provision to address the care needs of these individuals and dealt with property and landlord issues only. Care needs were evident for many of these tenants. Working together with the LHIN, funding was provided for implementation of the SDL program into the apartment tower which has further freed up CCAC resources for other priorities. OSCR currently has 65 SDL clients (10 who are living in the newly designated SDL units – see above) in the apartment tower. Eligibility to the SDL program is separate from eligibility for housing. Existing tenants can now apply for SDL service, are assessed using the CHA instrument and are internally waitlisted for the service. Being a tenant in the building does not automatically have SDL service provision "attached" to it (except for the 10 SDL designated units). Subsequently, priority is given to those with the highest care needs based on objective assessment criteria utilizing the CHA instrument. This effectively separates housing needs from service needs.

SDL and Building Ownership by Region:

Peel Senior Link (PSL) – Partnership with the Region of Peel Case Study

Peel Senior Link (PSL) was initially formed in 1991, as an outcome of a housing study conducted by the MOH Long-Term Care office. The study identified the need for supportive housing services to enable seniors' to live independently in the community, and 'age in place'. PSL formed its Board of Directors and incorporated as a non-profit, charitable organization in 1993. The Board determined at the outset that they would:

- serve a low income seniors' population,
- provide support services to assist with activities of daily living,
- provide an affordable accommodation setting

PSL began a partnership with the Regional Housing Corporation in Peel region to serve eligible seniors who were renting from the corporation. These seniors who lived within the corporations' buildings were provided with access to housing that was affordable through either market units (which are typically provided at a lower rent than private sector buildings) or rent-geared-to-income (RGI).

Over time, PSL has worked collaboratively with the Regional Housing Corporation in Peel region (now called Peel Living) to champion the ability of seniors to have priority to access the affordable units particularly if they were eligible for PSL services (therefore have a need for assistance with activities for daily living). Peel Living gave its' agreement to enable seniors who were eligible for PSL supportive housing services, to move to the top of the PATH (Peel Access to Housing) central wait list for the next available unit. Only those individuals identified as "Victims of Family Violence" were given a higher priority. The Region of Peel also agreed to the aforementioned changes as they understood that if seniors sat on the wait list for social housing (8-10 years on average), they would be at risk of long term care placement. By working collaboratively together, PSL, the Region of Peel and Peel Living, have acquired a clear understanding of the critical need for the partnership arrangement and have supported its evolution over time as seniors needs, and the supportive housing program has evolved.

In 1999, the Peel Living Board formalized its' supportive housing relationship with Peel Senior Link and Peel Living. PSL became responsible to assist eligible seniors in specific Mississauga and Brampton Peel Living buildings as well as extending further support to other Peel Living buildings. As time progressed the service delivery model was also changing to address the needs of an aging population with multiple chronic conditions and complexity of care requirements. Subsequently, PSL changed its' service delivery from a 12 hour (on site) + 12 hour (emergency on-call) program, to a 16 hour (on site) + 8 hour (emergency on-call) program. Today, PSL operates a 24/7, 365 days a year program in all of its service sites.

With the new Supports for Daily Living model now well established within the MH LHIN, PSL has expanded its partnership with the Region of Peel through a Rent Supplement program. This will assist low income seniors who are not living or who have been unable to get a unit, in the affordable/social housing buildings, with supplementation of rent. Rent supplements will also be utilized in affordable/social housing buildings where the rent-geared-to-income (RGI) ratio has been exceeded.

3 **Mobile**

Nucleus Independent Living: A Case Study in Innovative Service Design

Nucleus Independent Living was founded in 1983 by a small group of individuals with spinal cord injuries who established a traditional Supportive Housing (SH) model of operations in order to enable them to leave institutional settings and live independently in the community with Attendant Care support. Attendants work from a unit within a subsidized apartment building and provide 24-hour scheduled and on-call personal support and homemaking services daily to consumers based on their individual needs. This de-linked service model continues to operate successfully in two integrated apartment buildings in Toronto's West End.

Building on the success of the Supportive Housing Program, in 1999, Nucleus established an Attendant Outreach Program in Peel region and expanded the mandate to include all persons with physical disabilities. This mobile program provides prescheduled Attendant Care to individuals residing in their own homes (apartments, townhouses, houses etc.) across a large geographical area between the hours of 6am-11pm. There is no on-call service with this program.

In 2008, Nucleus recognized an existing gap in the availability of personal support services for at-risk seniors and conceived of an idea to combine its expertise into a unique service offering, by synthesizing the knowledge gained from offering Attendant Care services to high needs consumers, the safe provision of 24hr services and the efficient scheduling of a mobile program. January 2009, as a founding member of the new SDL service model, Nucleus piloted the 24hr Mobile Supports for Daily Living (SDL) Program for high needs seniors residing in the MH LHIN area to support their desire to remain living in their homes and communities thus avoiding premature institutionalization.

The 24hr Mobile SDL Program utilizes trained PSW staff to provide both scheduled and unscheduled personal support and homemaking visits intermittently 24 hours a day, 365 days of the year. Unlike in-building or hub and spoke models of service, the Mobile service dispatches staff to clients who are grouped together geographically into clusters for efficient scheduling purposes (a virtual hub). This service model increased accessibility to SDL services for individuals in the MH LHIN who would otherwise be ineligible due to their lack of tenancy in an SDL/supportive housing building or residence within a designated hub and spoke area (surrounding an existing supportive housing building).

Priority was given to SDL eligible patients leaving hospital in an effort to avoid unnecessary long-term care placement and/or frequent hospitalization or visits to the Emergency Department. Due to the fact that the mobile program was not directly linked to any specific geographical area or specific housing mandates, the Mobile program was able to operate with a singularity of focus and concentrate only on the clients with the highest need for service. The efficiency of this model was confirmed by the 2010 Shercon Associates SDL Program Evaluation which stated that the 'Mobile component of the SDL program provides care for clients who are more impaired and more resource intensive compared to clients in the Bricks and Mortar component'.

As the concept of Supports for Daily Living services began to take hold in our communities, the demand for SDL services began to exceed the capacity for in-building and hub and spoke SDL providers to meet the need. It was quickly recognized that the flexibility inherent within the Mobile service model lent itself to changing its mandate and improving capacity. In the fall of 2010, the 24hr Mobile SDL Program evolved to become a transitional model of service.

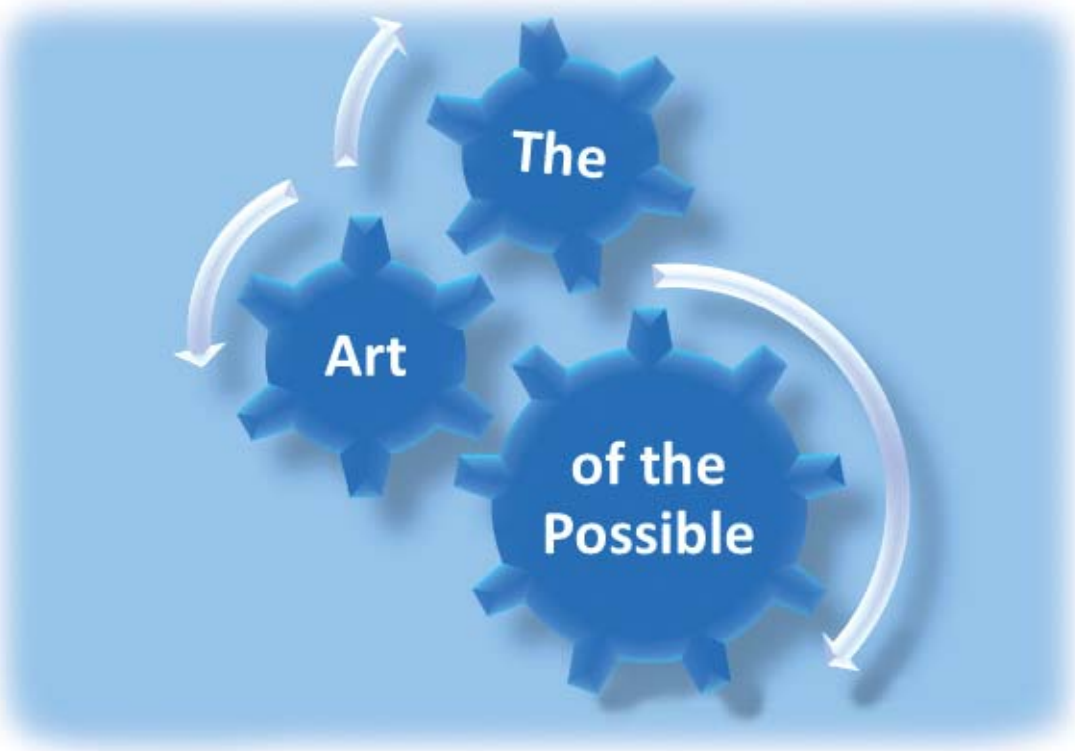
In the transitional model, the 24hr Mobile SDL Program takes on eligible clients directly from hospital living anywhere within the West Etobicoke, Mississauga and Oakville areas and supports them with intermittent visits until such time as they can be stabilized and transitioned to a more appropriate longer-term SDL provider. Clients generally fall into four different categories for their ongoing needs:

- Improved to the point of requiring less intensive services (transfer for bathing assist, CSS services, ADP, MOW, self, etc.)

- Declined to the point of requiring more intensive services (transfer to CCAC for enhanced care or LTC placement)
- Stabilized and remain SDL appropriate within SDL Providers geographical boundaries (transfer to another SDL provider)
- Stabilized and remain SDL appropriate outside SDL Providers geographical boundaries (stay on Mobile service)

As vacancies become available among SDL Hub and Spoke and In-Building providers, eligible SDL clients are transferred from the24hr Mobile SDL service to that SDL provider. Clients are informed upon intake that they are only being placed on the Mobile service temporarily until their needs stabilize and they are able to be transferred to another provider for longer term services. The standardization of the SDL framework among all SDL providers helps to minimize any difficulties experienced by the clients during a transfer process. This integrated model of services ensures the SDL capacity is used effectively and efficiently to maximize flow within the healthcare system.

Chapter Four



Setting the Stage for Success – Critical Factors

"If we want to effect change, we have to be visionary in our thinking. It's no longer acceptable to say 'that's the way we've always done it'. We have to think outside the box and put ourselves in the shoes of our clients/patients and our partners. We have to think cross-collaboratively and build on each other's strengths – only then will we see the art of the possible."

Kristina Hall, Executive Director,
Nucleus Independent Living

Identifying Opportunities

Within every health system is untapped potential waiting to be realized. Within the context of Supports for Daily Living, that potential exists within the diverse, yet often overlooked, community support services (CSS) sector.

As health care moves towards more in-home community-based care, there is a wealth of knowledge, expertise and experience within this sector that should be leveraged when looking at assisted living models that address policy and LHIN priorities. The people who live and breathe community-based care everyday recognize and understand what it means to deliver care within a home environment, and it is within this sector that the best opportunities exist for developing assisted living solutions that meet the needs of high risk seniors with complex needs.

Client-Centred/Customer Focused

One of the driving factors behind the development of a Supports for Daily Living service is a focus on client-centred care and customer focused solutions. Maintaining this focus throughout the development of the service is critical to its success. Therefore, a clear understanding of what we were all here to do was essential to keeping forward momentum and people on track. This clarity is provided in the following messages:

Frequency Messaging:

- Focus on a service that doesn't close its doors
- Focus on a service that runs 24/7 – 24/7 availability doesn't mean 24/7 bedside
- 12:00 midnight is just another number
- Needs of clients do not stop with the clock reaching a certain hour

Customer Service Messaging:

- Demand + response = service – if you can't respond to the demand, you are not providing service
- Clients are those who will have service delivered to them; customers are those that depend on the services being delivered to clients
- Know the needs of your customers, respond quickly and efficiently, suggest/find solutions – guaranteed to always place you in demand!
- Hospitals and the CCAC are customers, not just stakeholders

Client-Centred Messaging:

- Consistently address the needs of the client from the referral, assessment and intake processes to delivery of, and eventual discharge from, services.

Solutions Driven

One of the reasons why the Mississauga Halton LHIN's approach to the development of the Supports for Daily Living service has been so successful is due to its solutions-driven approach from the brainstorming and planning stages through to implementation. In aligning outcomes with local and provincial health system priorities, the focus never waivered from the LHIN's goal of helping to keep high risk seniors living in their own homes for as long as possible.

24-Hour Service Cycle and Timely Response

One of the key game-changers when it comes to developing an effective Supports for Daily Living service is recognizing and responding to the fact that the support required by high risk seniors with complex needs doesn't conveniently fit into a 9-5 timeframe. From the client perspective, seniors need help with essential activities of daily living throughout a 24-hour day from getting up in the morning to going to bed at night, to medication reminders and urgent response for unscheduled help. The need can span an entire day, every day of the week – morning, evening or night.

From a health system perspective, it's also important to respect the day-to-day reality of key health system customers/partners, particularly hospitals. Hospitals operate on a 24-hour cycle. To effectively contribute to enhanced patient flow throughout the system, the Supports for Daily Living service has to have the capacity to provide timely responses to incoming referral requests, particularly those coming from hospitals. The goal is to help seniors transition back home and/or into the community quickly and with as little disruption to their lives as possible. One of the reasons the Supports for Daily Living model works so well is because it recognizes and responds to the way its major customers work within the system. Key successes include:

- responsiveness of service design
- recognizing the pressures of major customers and adapting service response accordingly
- working with major customers to find solutions and flexible alternatives

Communications

Communication plays a key role throughout the transition process and is particularly important during the pilot and implementation phases to keep key stakeholders abreast of progress and outcomes being generated in alignment with key objectives.

Throughout the implementation phase, ongoing and consistent communication is important, particularly with health system partners including the CCAC, hospitals, community support service providers and family physicians. On an individual basis, key stakeholders include hospital social workers, discharge planners, nurses and physicians, hospital and community case managers, and SDL staff. Communications should be leveraged to help support education and training as well as to build knowledge and acceptance.

Another key stakeholder is clients/patients and families. Communication materials should be developed that are specifically targeted to this audience which can include fact sheets and/or brochures. Scripts or speaking notes for staff are also an essential component when discussing the Supports for Daily Living service. In our experience, having a "common message" and talking points to provide information and knowledge about a new service are a fundamental necessity for the development of confidence and security not only in patients/clients and their families, but also staff.

Though perhaps surprising to some, the LHIN is also another key stakeholder that should not be overlooked. It is one thing to agree to take a risk, and it is completely another to instill faith in "staying the course" with the risk that is taken. When a LHIN is navigating unknown seas, it is essential that the LHIN Lead for the initiative communicates effectively and consistently within the LHIN in order to gain and sustain support. Effective communication means that the LHIN Lead must know the details, the issues and the build of the initiative from the bottom up. Participation in the initiative from the outset and as a member of the "building" provides the perspective to understand and champion "staying the course". Though this level of involvement in an initiative is not necessarily a good fit for all LHINs, it has been our experience that it worked in the MH LHIN.

Every opportunity was taken within the MH LHIN to "spread the word" about the new SDL program, its focus, what made it different from a visitation model of service, the type of clients that were targeted for the service, why the need for the 3 different models, etc. Communication tools and mechanisms such as business meetings, department/unit meetings in hospitals, physician meetings, fact sheets, PowerPoint presentations, scripts, brochures, bulletins, e-mails, newsletter articles, etc., were utilized to provide clarity, answer questions and ease doubts. Examples of some of the communication tools and the communication plan utilized are provided in the Appendices.

The path was not an easy one and it has taken time and effort to build the SDL service to the level of trust and confidence it enjoys today. However, as in anything else, continued effort and vigilance to deliver on the promises of the service must continue if that trust and confidence is to be maintained.

Ongoing Evaluation

During the pilot phase for Supports for Daily Living, be sure to identify key metrics for evaluating the success of the service as measured against your objectives. Ongoing evaluation is important to ensure continuous quality improvement and return on investment as the service evolves and to evaluate whether or not it is achieving its' objectives.

The selected metrics should be monitored on a monthly basis to evaluate the impact the service is having on the referral of high risk seniors from hospitals, the CCAC and other health system providers and to quickly identify if an impact is not materializing. Aligning trending data to show the direct correlation between the service and system impacts on length of stay in hospitals, ED visits, long-term care admissions and ALC days is of primary importance in providing "proof" of effectiveness. Further, monthly monitoring is a useful way to spot the "uptake" of the service within the health care environment and to recognize when adjustments or further discussion/clarification should take place with health system stakeholders. When a new program/service is being "born", it is essential to stay on top of the data in order to be alert to a misalignment.

Metrics should also be used to evaluate whether those being referred to and admitted into the SDL service, meet established eligibility criteria and are, in fact, high risk seniors with needs at the MAPLe 3, 4 and 5 categories of assessment. Examples of the metrics and definitions utilized for monthly and quarterly reporting are provided in Chapter 7.

Laying the Foundation for Change

The effective implementation of a Supports for Daily Living program requires the full support of the entire health system, particularly that of hospitals, the CCAC, and the community support services sector. Every effort should be made to engage these broader health system partners as the success of the service relies on the active participation and support of others within the system. Equally important to the success of the program implementation is the leadership requirement of the LHIN. The MH LHIN was an active partner in the planning, design, evidence-based research, resourcing, policy input, implementation, communication and collaboration of the new program. It was a strategic decision to enable this partnership as the LHINs primary role is to manage health system transformation and this requires change. A change of this nature can be weighed down with many barriers, the least of which could halt progress. Given that the community support services sector hadn't traditionally addressed the needs of higher acuity clients, implementation of the new Supports for Daily Living service required a shift in thinking across the system. This type of change, in terms of recognizing the ability of Supports for Daily Living service providers to meet the needs of higher acuity patients, required the support and active participation of the LHIN.

Within the Mississauga Halton LHIN, the Supports for Daily Living (SDL) service evolved from the existing supportive housing program. With the infrastructure already in place for the 'Hub (in building)' service delivery model, changes in thinking were necessary to move supportive housing into a Supports for Daily Living/Assisted Living model that separated service from the bricks and mortar as well as providing a focus for acceptance of the higher need senior.

Supportive housing programs stand as a good starting point for any communities looking to implement an assisted living model of care like Supports for Daily Living (SDL). Having a current "stock" of supportive housing programs creates a centralized point of origin for utilizing the "hub" or "hub and spoke" model of service. If this "stock" is not available, a grouping of apartments/townhouses/homes/trailers/etc. where high risk seniors are located will provide the centralized "community" to create a "hub" or "hub and spoke" service. SDL providers have looked at a variety of changes that have either been implemented or are being considered for situating an office for staff to work from within these communities. Some examples are:

- acquiring an apartment within a building
- acquiring a rented house within the community
- acquiring a store-front office
- transporting staff into the community for their shift and then transporting them out of the community at the end of the shift

Even though the implementation of the SDL program was new to most of the supportive housing providers, some creative thinking and progressive planning enabled the transition or "shift" to a 24/7 frequency service model. This shift can be considered as the most significant change to the "old" supportive housing model and requires careful planning and scheduling of staff. The "hub and spoke" model makes such "shifting" considerably easier, as staff have a "hub" to work in and are readily available

for scheduled or unscheduled assistance or when emergencies occur. This availability has:

- played an essential role in decreasing the amount and frequency of emergency department visits
- allowed for greater efficiency as staff onsite can do other work, such as charting and reporting when not responding to client needs
- given SDL providers more flexibility in service provision in order to provide more frequent visitation to clients
- provided better continuity of client monitoring and service provision
- allowed for greater client satisfaction with service provision
- allowed clients and families a greater sense of comfort that safety and security are better assessed and monitored.

If the LHIN has groups dedicated to ED or ALC initiatives, these groups provide an ideal forum for the exchange of information regarding progress being made in the development of a Supports for Daily Living service. Referral patterns, processes, and tools need to work seamlessly throughout the system to ensure high risk seniors with complex needs that may be eligible for the service, are identified early on and the appropriate referrals are made.

Creating a sense of urgency for implementing the change based on provincial and LHIN priorities and client need and identifying leaders to champion the change are critical, as is frequent, consistent and relevant communication to gain acceptance across the health system and to support providers throughout the transition period. Quick wins and key milestones in the development of the service should be celebrated to keep people engaged and moving forward.

However, as with any change management initiative, it takes time for systems and providers to refocus their thinking around: a new paradigm of service, a requirement for higher levels of care, a greater turnover of clients as a result of increased levels of client acuity and the need for a more agile intake process to accommodate, in particular, hospital discharges. Barriers exist and need to be acknowledged in an open and frank manner – *change does need friends!*

Perhaps the greatest barrier to SDL implementation can be found in the culture of the agencies, institutions and stakeholders themselves. Breaking down the biases within organizations requires tearing down the walls and silo culture, that have taken years to build, and replacing it with mutual respect. Biases exist within healthcare – we have acknowledged and taken responsibility for the contribution these biases have made in blocking the flow of clients/patients throughout the system. Working to resolve these biases continues to be our greatest burden and our greatest success.

Cross-organizational trust, cooperation and collaboration are of paramount importance. It involves educating and re-educating across organizations, reinforcing concepts at every opportunity, correcting perceptions, following up with issues in order to resolve conflicts, ensuring a "culture" of no blame, coaching thinking and performance, utilizing fact and data to dissolve resistance, reinforcing benefits, believing in the vision and staying the course of action.

Patience is the greatest skill needed and the hardest to maintain! And just when you thought you had it right...you will need to re-educate and reinforce once again in order to sustain the gains made, to clarify roles and responsibilities and to foster trust. This is not said to dissuade you, but rather to provide the reality of true and effective change.

If you want change to "stick", you need to be prepared to continue the "journey" over the long haul. In the words of Winston Churchill, *"difficulties mastered are opportunities won."*

Strong Leadership and Champions

The development of a Supports for Daily Living (SDL) service requires not only visionary leadership, but the right individuals within the local health system to champion the initiative. Given the cross sector collaboration required for success, *strong leadership* is critical for ensuring system-wide engagement. Choosing a champion or champions is fundamental as he/she/they will ultimately lead the group implementing the change.

In the case of the SDL initiative, the MH LHIN sponsored an initial supportive housing working group to discuss and plan for a new and innovative approach to address health system pressures involving high risk seniors. This initial working group developed a vision for the Supports for Daily Living service based on what was current policy and evidence-based research. Testing the three (3) models of service delivery fell to a small group of three (3) service providers. Of this group of three, two providers were seasoned and experienced in working with seniors while the third provider was not. However, this proved to be of no consequence as the third provider became the champion for, and developer of, the SDL Mobile service model. Ultimately, this small group of three providers tested and implemented in 2008/09 the "hub (in buildings)" model, the "hub and spoke" model and the "mobile" model of SDL service. These champions laid the foundation of change for the remaining five (5) SDL provider agencies that followed in 2009/10.

With the progression of work, the initial supportive housing working group became the SDL Leadership Group sponsored by the LHIN. A chair was chosen from amongst the group to lead the initiative from a systems-level perspective while further shaping a model for Supports for Daily Living that focused on client need. In order to provide continuity and further a collaborative approach, the SDL chair was invited to sit on the LHIN Health Systems Leadership Committee that brought together hospitals, CCAC, LHIN and other system partners to discuss health system issues. This was one of the first occasions where a CSS sector provider had been invited to participate as an equal partner in health systems' issues. Under the LHINs sponsorship, this signalled a new change and the necessity of a new perspective.

The *leadership qualities* of those involved in the SDL initiative and that proved successful in the Mississauga Halton LHIN experience were those of establishing credibility, providing knowledge transfer, perseverance, the ability to challenge the status quo, the willingness to take risks and stay the course of action, the motivation to work long hours over an extended period, the capacity for innovation and new ideas, the aptitude for humour and motivating others, the talent for "selling" and communicating the initiative and the proficiency in gaining participation.

Funding and Accountability/Resourcing the New Models of Service

Embarking on a new program, like that of SDL, requires significant funding and with funding comes accountability (oversight and managing). However, before the journey began on the development of a new program, a solid foundation needed to be built and that foundation consisted of knowledge, data, targeted information and "placement" of the new program within the health care continuum as a frame of reference.

In 2007 the MH LHIN began studying supportive housing within the region. The LHIN was able to determine that:

- greater than 500 spaces were funded as supportive housing
- wait times for housing and services was 8 to 10 years
- there wasn't a standardized assessment for services
- there wasn't a differentiation between entry criteria for housing versus services
- a much younger population utilized the housing and services
- services were situated only in buildings
- a plan did not exist for where services and housing were situated (criteria not found)
- HSPs did not have standardized funding – funding was wide-ranging and did not permit higher need clients to stay on service if an HSP was funded at the low range
- standardization within supportive housing and across HSPs did not exist
- turnover was fairly high and HSPs identified that trained staff were being lost to LTC as a result of higher wages and full-time positions with a certainty of hours
- the number of supportive housing clients on service, though cumulatively large, were small in number at numerous sites

Supportive housing HSPs across the LHIN were surveyed to identify the number of service spaces funded, the number of clients served per year (turnover incorporated), the number and the status (FT/PT/Casual) of staff or whether services were contracted out to a third party, the cost per hour of service, and the amount of service provided to clients on a daily basis.

Following discussion with HSPs and the analysis of survey results, a new funding structure and performance standards were proposed. An example of the contractual letter for funding and performance expectations is provided in the Appendices section. The proposed new funding and performance standards structure:

Funding Structure	Rationale
Minimum of 30 clients in each site or new sites	• Allows for the hiring (greater retention) of staff – this number of clients would allow for FTE positions through consolidated service throughout the day/night
***Average* of 1.5 hours of service per client/per day**	• Average care by HSPs in MH LHIN was 30 mins per day (range: 20 mins to 2 hours per day/per client often offered in a one-time block)
Service funded at a rate of $34.00 per hour ($51.00 per day/per client - $18,615 per year per client) –	• LTC funded hours per person/per day = 2.4 hours • Significantly higher RUGs scores requiring greater resources to care for individuals in LTC

Funding Structure	Rationale
greater economies of scale in certain sites due to larger volumes of clients – in some sites cost has increased as smaller volumes of clients with higher acuity **MOBILE service rates are higher as a result of travel** **Ongoing evaluation of costs and effectiveness - efficiencies in delivery of services are a necessity**	• SDL program is not LTC and cannot exceed daily costs in LTC – if costs exceeded, need to question whether clients are appropriately placed in SDL – SDL program must "fit" within health care continuum and not cost the system greater than what can be produced • Hourly rate based on survey: if LHIN was wanting a higher level of acuity, then funding needed to match need and resource utilization (cost range per hour: $17.50 to $32.50 prior to standardized costing – only one provider @ the high-end range and needed to find greater efficiencies as well as move those clients who were at great risk and with a rapidly deteriorating condition (non-appropriate setting) • LHIN monitoring a requirement

Performance Standards (Accountability) Structure	Rationale
Implementation and use of the Common Health Assessment (CHA) instrument	• Reliable & valid data to show acuity levels of clients; was there a change in acuity?; highlighted profiles of clients; assisted in the formation of base measurement and ongoing evaluation
Ability to deliver on performance deliverables and targets	• New funding structure, ongoing funding predicated on outcomes of performance and meeting LHIN priorities along with return on investment
Availability of service throughout a 24 hour period	• Frequency model of care – testing the need for this type of service – core principle of the new models
Delivery of the 3 core services in the program (Personal Care, Homemaking, Attendant Care)	• Standardization – had to deliver on these services to be an SDL provider and be known in the community to be able to deliver on these services – staff levels brought up to standard where necessary
Collection and reporting of indicators and stats to the MH LHIN on a monthly and quarterly basis utilizing the document developed by the MH LHIN for the purposes	• Standardization of definitions for indicators and starting point to enable the measurement of return on investment
Contractual Letter signed by the HSP formed an amendment to the M-SAA and constituted a legal and binding document with the LHIN	• CEO/ED and Board Chair of HSP sign letter to bind organization

The Aging at Home strategy allowed the MH LHIN to strategically invest in the new SDL program, both to open new services and to change the majority of supportive housing over to the SDL models. In 2012 there are three small supportive housing providers remaining that have not been changed to the SDL models. Changes to two of the providers would not be a worthwhile investment since numbers are small and the geographic area has little demand for this level of intensity. However, one provider in a high demand geographic area with a need for increased intensity would be a worthwhile investment and will be considered as a potential site for resourcing. Further sites to consider are those with high densities of seniors that are high users of the health care system. These considerations will be a priority focus for the MH LHIN in the future in order to build on the success of the SDL program and to meet the needs of seniors in their familiar communities. Having already shifted approximately 1% of direct dollars to the community, the MH LHIN will be reviewing how future funding can be maximized to achieve specific targeted objectives. With future funding being limited, new ways of allocating existing funding to those areas that are able to deliver on priorities will be the new way moving forward. The SDL program will be required to continue to show efficiencies and effectiveness as well as new ways of delivering service in order to benefit from the new reality of healthcare funding.

Chapter Five

Roles & Responsibilities

"We have an excellent relationship with the Supports for Daily Living program. They are very responsive, very collaborative and we are always impressed by how often and how willing they are to think outside the box. The ability to customize a care plan for individuals in the community with SDL as our partners has been exceptional."

Cathy Raiskums, Manager, Social Work and Patient Flow
Halton Healthcare Services

LHIN

LHINs are mandated by the Government of Ontario to plan, coordinate, integrate and fund health care services at the local level. Given that mandate, the role of the LHIN in generating a Supports for Daily Living service should be to:

- create a vision for 'aging at home'
- facilitate and engage service providers to implement the key elements that will help realize the vision
- be a risk taker in recognizing the potential of an initiative to generate health system improvement even if there is no concrete evidence at the time
- make the necessary investments to allow the initiative to realize its potential
- set up an effective monitoring and performance management system.

In supporting the work of the team charged with developing a Supports for Daily Living service, the LHIN should be accountable for setting the pace for the fulfillment of team goals and activities as aligned with its vision for 'aging at home'. This includes setting expectations for work group activities and providing ongoing support and encouragement to the work group chair and/or project lead. It is also important that the LHIN take a leadership role in advocating on behalf of the team at the LHIN and health system level to ensure the active participation and support of other key partners within the health system.

The LHIN is also accountable for establishing SDL service provider criteria and contract deliverables and for monitoring performance.

SDL Providers

Community Services Sector (CSS) service providers that are responsible for delivering the Supports for Daily Living service accept accountability for taking a leadership role in helping to keep high risk seniors with complex needs (MAPLe 4 and 5) out of hospital and long-term care homes by delivering services that help them to continue living in their own homes as long as possible. The services they provide help divert unnecessary visits to hospital emergency departments, prevent premature admissions to long-term care, support repatriation of eligible long-term care residents back to the community, and contribute to a reduction in alternate level of care (ALC) days in hospitals.

A commitment to quality, client-centred care delivered in a timely and consistent manner is characteristic of SDL service providers and critical to client satisfaction. It is vital that SDL service providers maintain close linkages with hospitals, the CCAC and long-term care homes to promote education and understanding of SDL services and to clarify how the services can be leveraged to support more efficient and effective use of hospital, CCAC and long-term care resources.

The value that SDL service providers contribute to health system functionality can't be underestimated. The Supports for Daily Living service is a fine example of tapping into the potential of the CSS sector to build capacity within the system.

Central Registry

SDL program referrals are funnelled through a single point of access within the MH LHIN called the SDL Central Registry. Although operated on behalf of all the SDL providers, the SDL Central Registry and its employee, the SDL Systems Manager, is charged with managing the flow of referrals in the best interests of the healthcare system to optimize resources. This successful model ensures the integrity of the SDL eligibility standards while operating with a birds-eye view of the short-term and longer-term priorities within the system.

All referrals are received at the Central Registry and priority is then determined through the combined anaysis of the healthcare system pressures coupled with the client's level of need for SDL service. Priority referrals are assessed (with the Common Assessment Tool – RAI-CHA) within 48 hours and approved based on the objective eligibility criteria. Once a referral is deemed appropriate, it is redirected to the most appropriate SDL service provider based on geographical location and service availability. Additional responsibilities for the SDL Central Registry include assisting with the balancing and transfering of clients among SDL Providers to ensure optimization of client flow and the tracking and management of referral data.

The benefits of this Central Registry model include:

- Simplifying the referral process for community partners (one number to call)
- A single knowledge base of information regarding the availability and features of each of the SDL services within the MH LHIN
- A third-party view of determining eligibility ensures an objective and consistent approach to decision-making
- A solitary waitlist ensures accurate representation of the demand for SDL services

The awareness that referral sources are, in fact, the Central Registry's 'customers' and responding to meet those customer needs is the key to success for the Central Registry model. A customer-service focus and responsiveness are illustrated by the expansion of business hours to enable access on weekends and evenings and the agility to respond to hospital surges in times of system stress.

Hospital(s)

The relationship between hospitals and SDL service providers is an important one. Recognizing Supports for Daily Living as a viable discharge option for high risk seniors with complex needs can make the crucial difference between a patient being designated ALC and prematurely discharged to long-term care or returning to the comfort of their own home with supports. When hospitals are reviewing discharge plans for high risk seniors - particularly those who require frequent, urgent and intense personal supports to allow them to return home - engaging an SDL representative in the dialogue can quickly determine whether or not Supports for Daily Living is a realistic option. That liaison might take place over the phone or in a meeting where the discharge plan(s) for one or more patients are being discussed.

Once a patient has been identified as a potential candidate, an SDL representative will visit the patient at the bedside to conduct a more thorough assessment and set the wheels in motion for discharge home with appropriate SDL supports.

It's important that hospital social workers and discharge planners receive thorough and ongoing education about Supports for Daily Living so that it is among the considered options for high risk seniors with complex needs.

CCAC

Paramount to the success of SDL services is the role of the community care access centre. CCACs are often the point of access or link to in-home, community-based and long-term care services, as well as information and referral. Seen as the 'system navigator', they are increasingly being positioned as the place to go to get information about health, community and social services.

It's important that both SDL service providers and the CCAC understand and respect the distinction between the levels of personal support services they each provide. CCAC personal support services are delivered based on a visitation model. Clients receive services between the hours of 6 am and 12 am (midnight) during larger pre-scheduled blocks of time. SDL personal support services, on the other hand, are pre-scheduled over a 24-hour period in smaller increments of time to allow for increased frequency and intensity of services as well as featuring an on-call response.

By transferring existing CCAC clients who are eligible for SDL services or in referring potential clients from hospital or community settings, the CCAC is able to free up existing personal support resources to focus on the needs of other clients in the community who are eligible for CCAC services. Given SDL is a non-medical model, CCAC clients eligible for SDL services may still require CCAC professional services like nursing and rehabilitation care. SDL removes some of the existing pressures on CCACs and long-term care homes by freeing up resources and improving access to care.

CSS Services

There lies significant untapped potential among CSS service providers. The sheer breadth of services delivered by CSS agencies within their communities is staggering. This is often why, in the past, it has been difficult to gain a handle on the services available and how they can best be leveraged along the continuum of care within the local health system.

Supports for Daily Living is a fine example of how out-of-the-box thinking, open-mindedness, and a focus on client-centred care was able to transform a cluster of like-minded agencies into a dynamic and meaningful service model that maximizes their expertise in community-based care with high risk seniors. Working with their local LHIN, CSS agencies can better understand how their services align with local health system priorities and how they might contribute to helping the LHIN and other health system partners to address system pressures.

CSS service providers will be increasingly looked upon to support clients with higher level needs as health systems experience a shift to more in-home and community based care, allowing hospitals to focus on those with higher acuity needs.

Other Providers

Family physicians, family health teams, pharmacists and other providers within the health system that come into contact or work with seniors should be educated about the Supports for Daily Living service so that they are aware of its role and how to refer to the service. As health systems transition to more in-home and community-based care options, like Supports for Daily Living, the importance of providers adopting a 'Home First' philosophy and eliminating the routine practice of referring high risk seniors with complex needs to long-term care must be continuously reinforced to effect a positive change in practice.

In the development of regional health systems, it is critical that SDL providers not only have partnerships (formal and informal) with existing health service providers, but also reach out to the broader resources that exist within communities and serve a multiplicity of client needs such as income security, nutrition, social interaction, transportation, etc. By reaching out to other resources, clients will be "put in touch" with the services and supports to function in the community. SDL providers have the ability to leverage these community resources by acquiring knowledge of the resource, collaborating for smooth transitions between providers and ensuring that clients are able to access services regardless of where they enter the system. These types of partnerships require time and effort on the part of SDL providers. However, the ability to engage with local hospitals, long-term care homes, CCAC's, Public Health, primary care such as community health centres and family health teams as well as general practitioners is essential to building an integrated and coordinated service delivery system for all clients, caregivers, stakeholders and service partners.

Chapter Six

Risks & Challenges

"The challenge for any organization starting an untried initiative or program is to keep the client/patient at the centre of what you do, all the while understanding, that innovation necessitates risk taking, lots of patience and a leap of faith"

Judy Bowyer, Executive Lead, Health System
Performance Management, Mississauga Halton LHIN

The Thinking Behind the Risk

> ***"Progress always involves risk; you can't steal second base and keep your foot on first."***
>
> Fredrick Wilcox

Strategically and conceptually the Supports for Daily Living model made sense. However, proving that it did could be a whole other "ballgame" if the objectives, indicator measurement and return on investment (ROI) were not met. This is the type of risk that can keep you up at night wondering if the right choices had been made. Sometimes you just need to hold your nose and "jump" into the deep end of the pool – a leap of faith, if you will.

The MH LHIN was tested to apply this philosopy in 2008/09 when the Supports for Daily Living (SDL) initiative was launched. At the time of this writing, the results have been impressive and have affirmed the MH LHINs "leap of faith" in taking the risk with this program. With the achievement of "award-winning" status, it could be said that the program has shown its' worth, but the true measure of success is keeping the clients/patients in focus and whether those needs have been met and/or exceeded. It is one of the best testimonials and indicators to the success of the program and the risk taken, that client/family satisfaction results have been nothing short of outstanding. Feature articles in newspapers, letters from families, staff feedback concerning the progress they see with their clients on the program, family doctors observing the positive effect of the program on their patients, and hospital stakeholders who are grateful for the quick response to their needs as well as seeing the difference the program is having in the lives of their patients – these are the successes – these are the rewards for taking a risk and accepting a challenge!

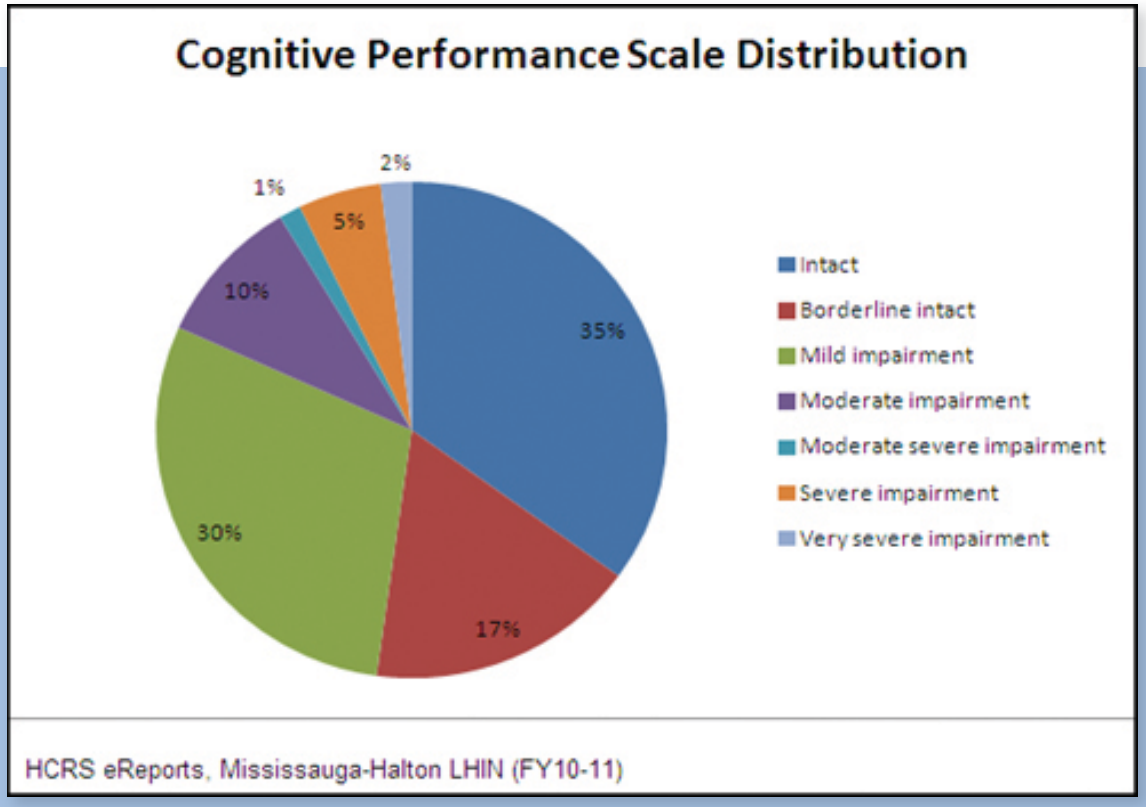
Managing Higher Acuity Level Clients – Mitigating Risk & Utilizing RAI Outputs

The SDL program is not long term care. When a person's care needs exceed the resources allotted to SDL, then the person should move to the next level of care and here is where the RAI "outputs" (such as the MAPLe algorithms, CHESS scores, Cognitive Performance Scale (CPS), etc. obtained through assessment utilizing the RAI Common Health Assessment (CHA) instrument), can play a significant role. RAI output considerations identify, along with clinical observation, that a client's needs exceed that which can be delivered in a specific setting (such as when cognition or behaviour cannot be supported in that setting). These RAI outputs, in conjunction with clinical observation, together provide the confirmation of greater risk that cannot be accommodated in the setting and should trigger discussion on an alternate care plan for the client.

Often questions arise as to whether higher level acuity clients (particularly those initially coming from a hospital stay) will have a clinical condition and/or functionality that is episodic or permanent. From our experience with the SDL program, higher acuity level clients can get "better" coming into a "frequency" model of care as offered in supports for daily living. Reasons for the improvement include better and more frequent nutrition, medication management, socialization, safety checks and risk balancing. If a person is potentially episodic even if RAI outputs indicate, at that point in time, a high impairment level,

consideration must be given to whether the individual can improve and if so, long term care should not be an option as this would be a higher level of care for someone with potential.
Conversely, staff may be "pressured" by family members to have the client enter a potentially inappropriate setting because family members are worried about the client's state. RAI outputs may indicate a high risk for the client, but an informed SDL staff person's judgment of an episodic event and improvement potential must be clearly articulated to the family and the client. The following charts provide examples of client need and cognitive impairment. In ***chart 1***, 48% of the clients in the MH LHIN SDL program showed mild to very severe cognitive impairment utilizing the RAI CPS output scale while ***chart 2*** indicates that 73% of SDL clients have moderate to very high needs. In all situations, clients were being managed within the SDL community.

Chart 1

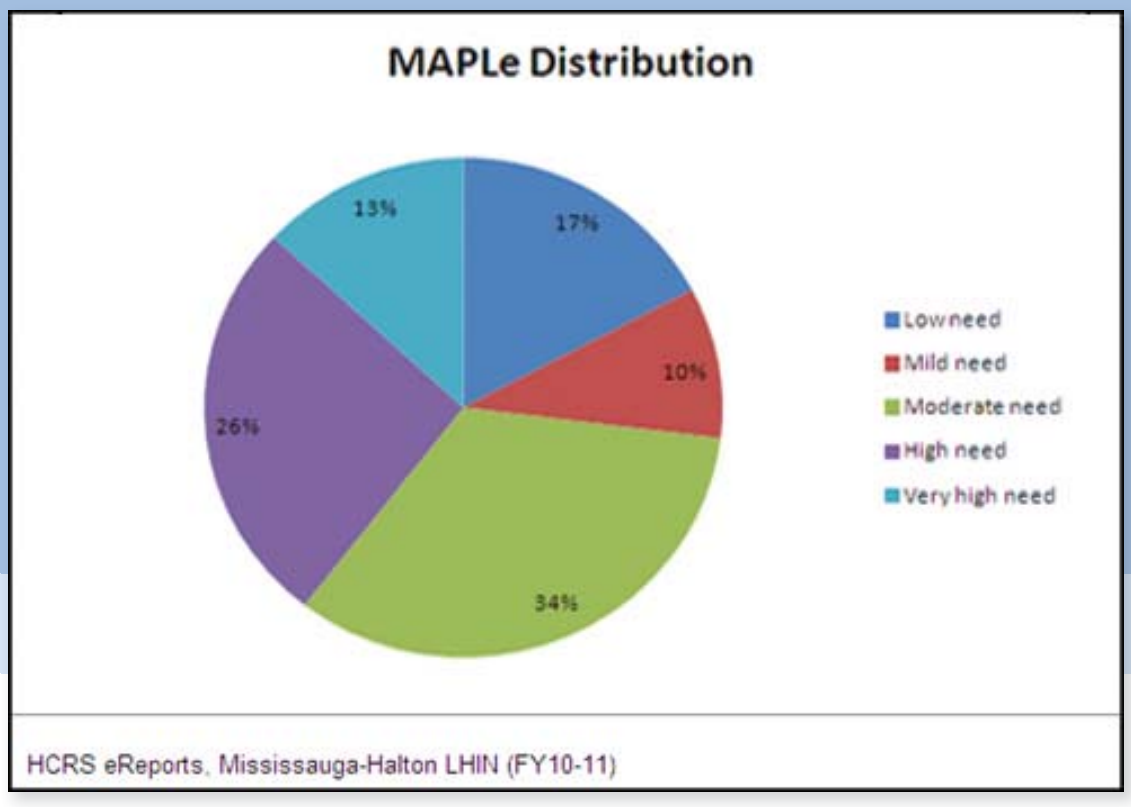


Our thanks to the Canadian Institute for Health Information (CIHI) and Dr. Norma Jutan for the HCRS eReports for Mississauga Halton. We also thank Dr. Jutan for her invaluable briefing notes utilized in the above paragraph.

Dr. Jutan's work with the information derived from the MH LHIN SDL providers (CHA data) assisted with the formation of the D.A.S.H. algorithm (see page 34) specific to supportive housing.

We thank her for her ongoing knowledge and faith in the SDL program and the satisfaction that comes from working with a "like spirit".

Chart 2



As an integrated system, the more acute a client (higher risk with combinations of high risk indicators from RAI outputs), the more resources are needed for care. Informed observation assists the system to make appropriate "resource" considerations for care. An integrated system must determine the "right care, at the right cost" for a client and for the system. Even if risks can be controlled for a client, having the client utilize high levels of resources over the long-term does not assist the system overall and detracts from equity "fairness" to other areas that need resources. These considerations are playing a more frequent role in decision-making.

The Risks in Delivering a 24-Hour Service

Among the challenges faced in proposing the implementation of a 24-hour service was considering the safety implications for staff and the practical ability of staff to offer immediate assistance in the middle of the night. Strategies were developed to address these concerns and to minimize any potential risk to staff. The following chart provides suggestions and ideas that were utilized to address potential safety issues:

	Addressing Safety Issues
Issue	**Suggestions/Ideas for Resolution**

Scheduling	• Scheduling two staff for all overnight shifts
	  o One in a supervisory capacity
	  o One male/one female
	  o Travel together in pairs

Client Location	• Conduct site/environmental risk assessments as part of client's acceptance onto service
	  o Create customized solutions based on individual circumstances (e.g. lighted walkways, designated parking, etc.)
	  o Review every 6 months

Personal Safety	• Develop check-in protocols
	• Utilize safety devices/techniques
	  o SafetyLine Home & Healthcare Worker Safety Monitoring (check-ins, motion sensor)
	  o Personal alarms/attack alarms
	  o High-powered flashlights
	  o Walkie-talkies
	  o Signage/ID tags (hologram)
	  o Training in self-defense techniques
	  o Pepper spray (dog repellant)/horn
	• Encourage scheduled bookings throughout the night

General Safety	• Identify safe locations within the community (operating 24 hours)
	  o Office
	  o Hospitals
	  o Long-term care facilities
	  o Tim Horton's
	  o McDonald's
	  o Gyms

Emergencies	• Develop emergency preparedness plan and call out protocols for services including situations dealing with:
	  o Crime
	  o Fires
	  o Medical emergency

	Providing Immediate Assistance to Clients
Emergency/Urgent Situations	• Urgent response within a 15 minute window of time (2 km radius) • Scheduling check-ins or bookings to reduce the number of 'urgent' calls • Leveraging technology to support communication of immediate needs (e.g. Lifeline/voice-monitored home security system, etc. which is part of service agreement with client) • Define the distinction between various types of immediate assistance.

Chapter Seven

Evidence & Evaluation – By the Numbers

"Evidence supports the notion that in the overall current Supports for Daily Living program, the right care is being provided in the right place at the right time and at the right cost."

Excerpt from
'Evaluation of the Supports for Daily Living Program' in the Mississauga Halton LHIN by Shercon Associates Inc., November 2010

Measuring the Investment – Two Years of Data

Evaluation is essential to knowing if you are on the right track and if you are achieving the objectives you set out to do, particularly if you have invested millions! As two years had passed since the launch of the SDL initiative, it was time that the MH LHIN evaluated what had been achieved. In 2010 a research study was commissioned by the MH LHIN and awarded to Shercon Associates Inc. Dr. David Sheridan and his team worked with the MH LHIN's Project Oversight Group to determine the final criteria for evaluation and the data sources that could be utilized. Building on the research study completed in 2008 by Dr. Hirdes, Dr. Sheridan compared RAI data from that study to 2010 RAI data from the 8 SDL programs. The framework that was utilized for the evaluation was the "ICES Evaluative Framework" design.

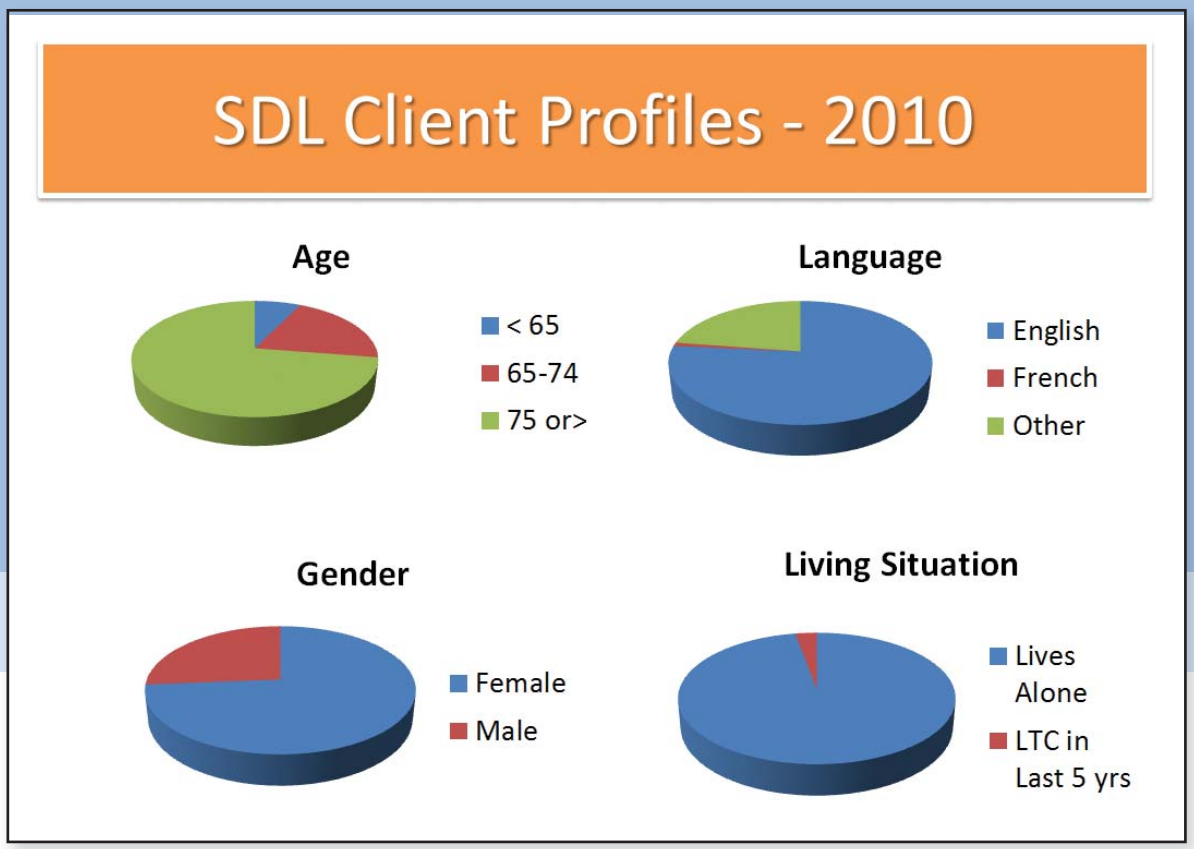
In the Evaluation Report by Shercon Associates completed in November 2010, Dr. Sheridan and his team concluded that:

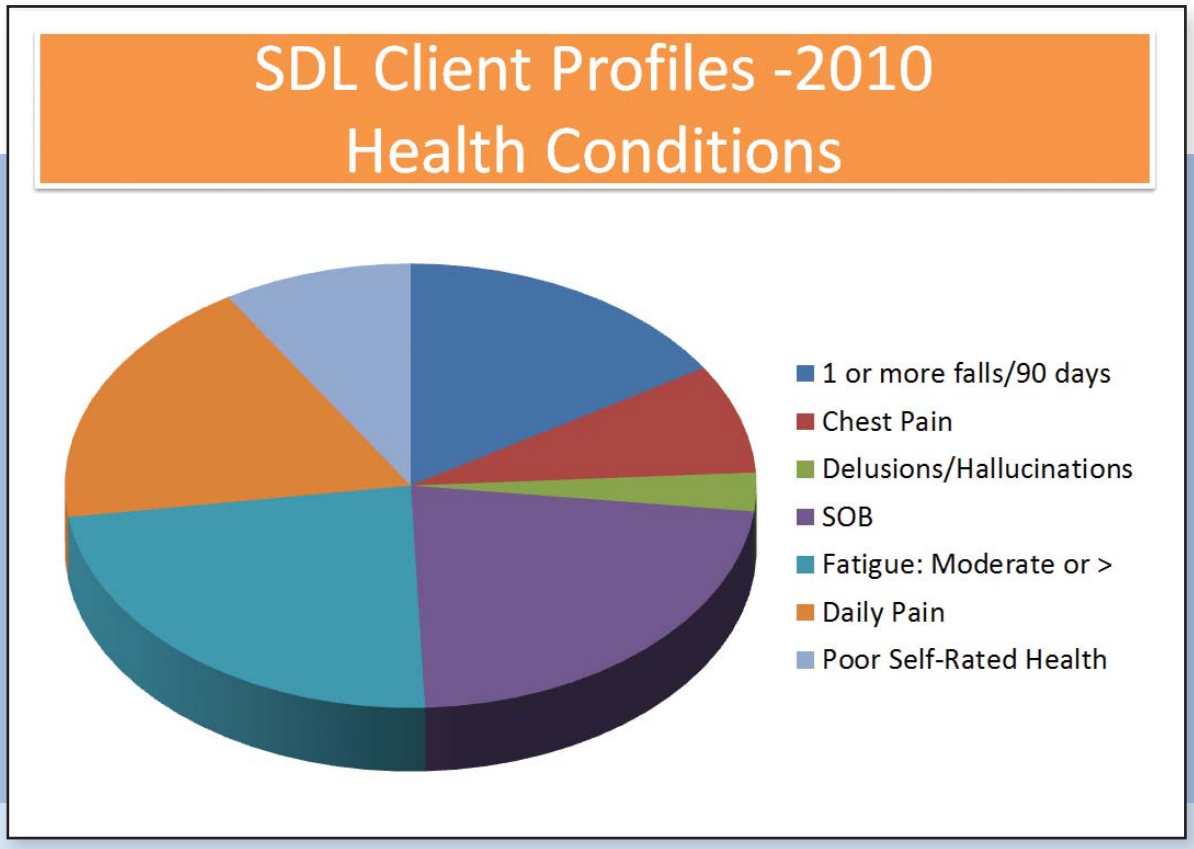
"There is strong and converging evidence that the Supports for Daily Living service is achieving its intended outcomes and supporting LHIN priorities for improving access, quality and sustainability of the health system while also enhancing seniors' health, wellness and quality of life."

Among the findings:

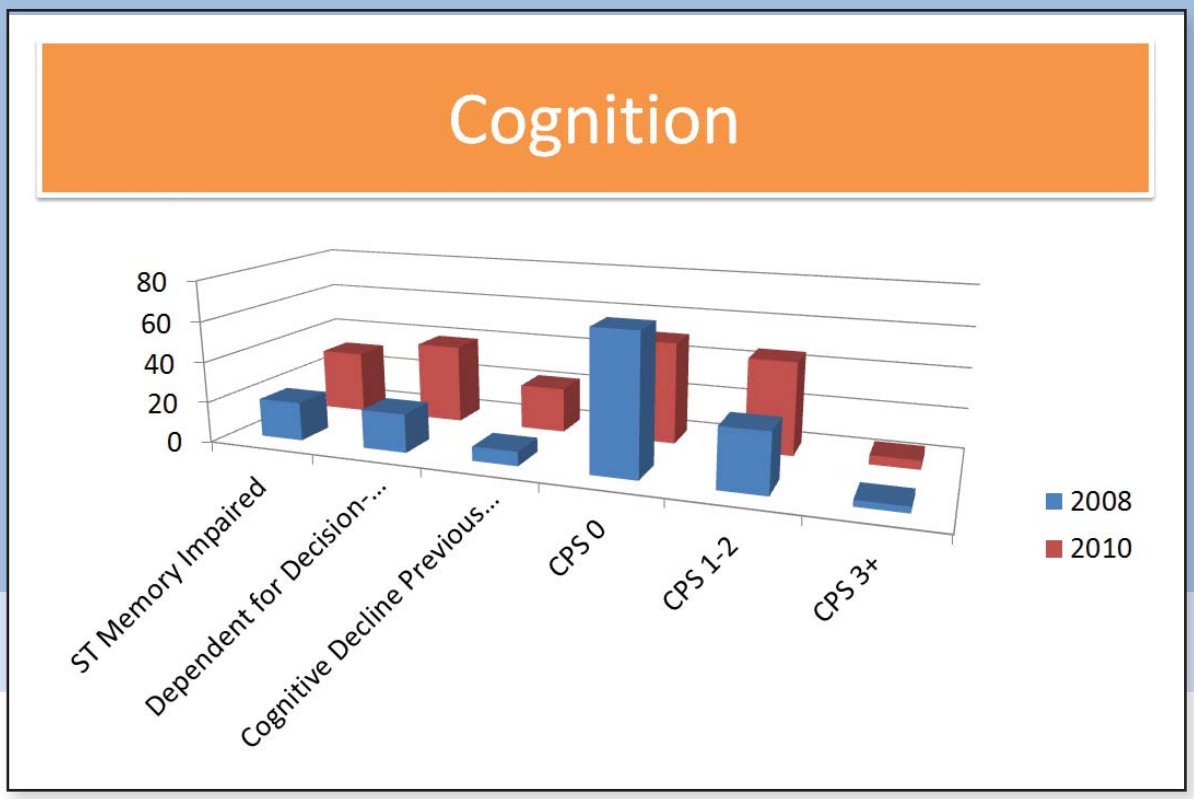
- For 9 of the 10 key RAI domains that were compared, the current SDL service is caring for a greater number and proportion of clients with higher acuity compared with the earlier supportive housing program *(see Comparisons of Evaluation Data (Pre-SDL 2008 to Post-SDL 2010) – 8 RAI Domains are given)*
- The 'mobile' component of the SDL service is providing care for clients who are more impaired and resource intensive than clients in the conventional 'bricks and mortar' aspect of the program
- Client satisfaction is high based on an analysis of client satisfaction surveys and focus groups with service users and referring sources
- The program design is effective and operating with a high level of coordination and cooperation among SDL service providers
- The program is cost-effective
- Clients are being serviced in the appropriate setting according to their RAI scores
- The model is playing a fundamental role in diverting ED visits and in the overall decrease of ALC rates as well as decreased utilization of long-term care

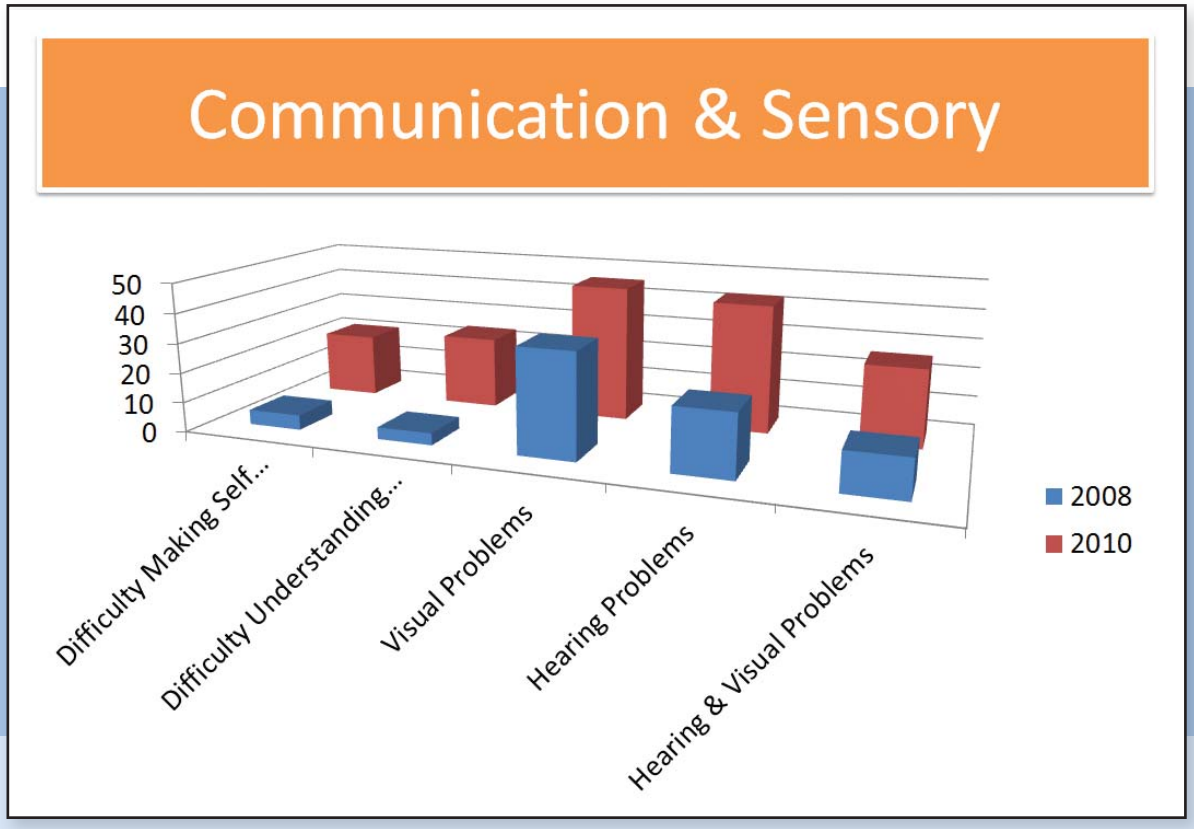
The following two charts are provided to identify the 2010 Client Profiles of those clients in the SDL programs throughout the MH LHIN (RAI Data)

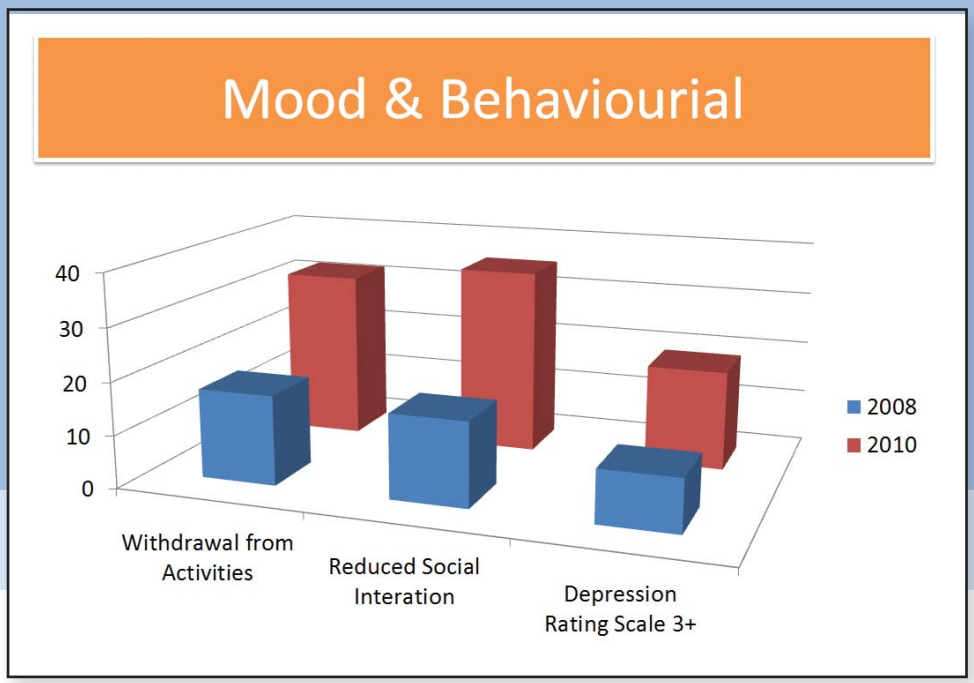

SDL Client Profiles - 2010
Age
< 65
65-74
75 or>
Language
English
French
Other
Gender
Female
Male
Living Situation
Lives Alone
LTC in Last 5 yrs


SDL Client Profiles -2010
Health Conditions
1 or more falls/90 days
Chest Pain
Delusions/Hallucinations
SOB
Fatigue: Moderate or >
Daily Pain
Poor Self-Rated Health

Comparisons of Evaluation Data
(Pre-SDL 2008 to Post-SDL 2010)





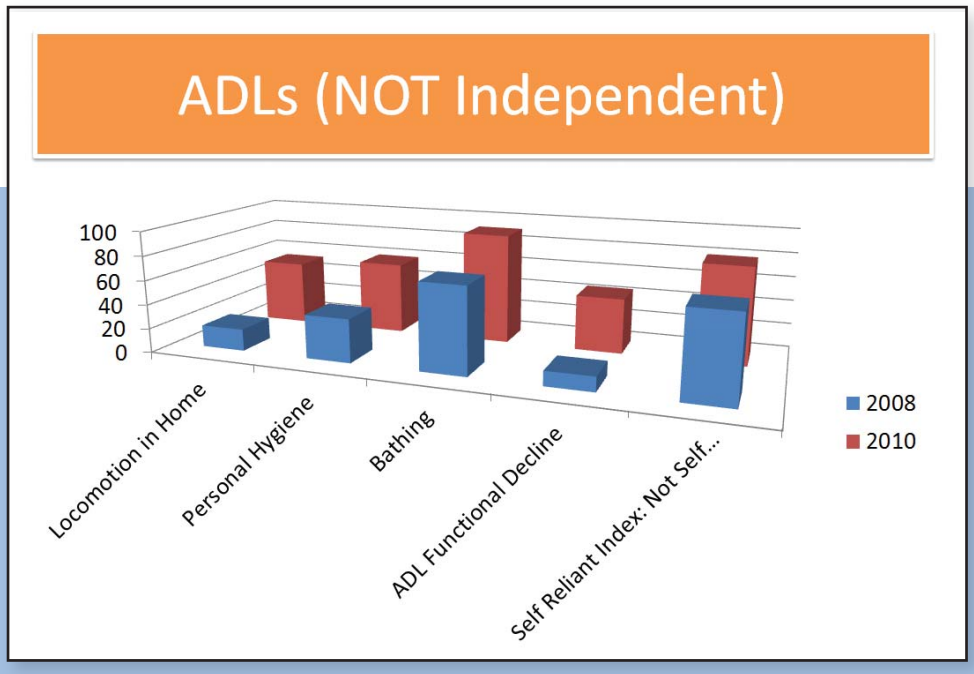


Depression Rating Scale (DRS)

Scores range from: 0 to 14

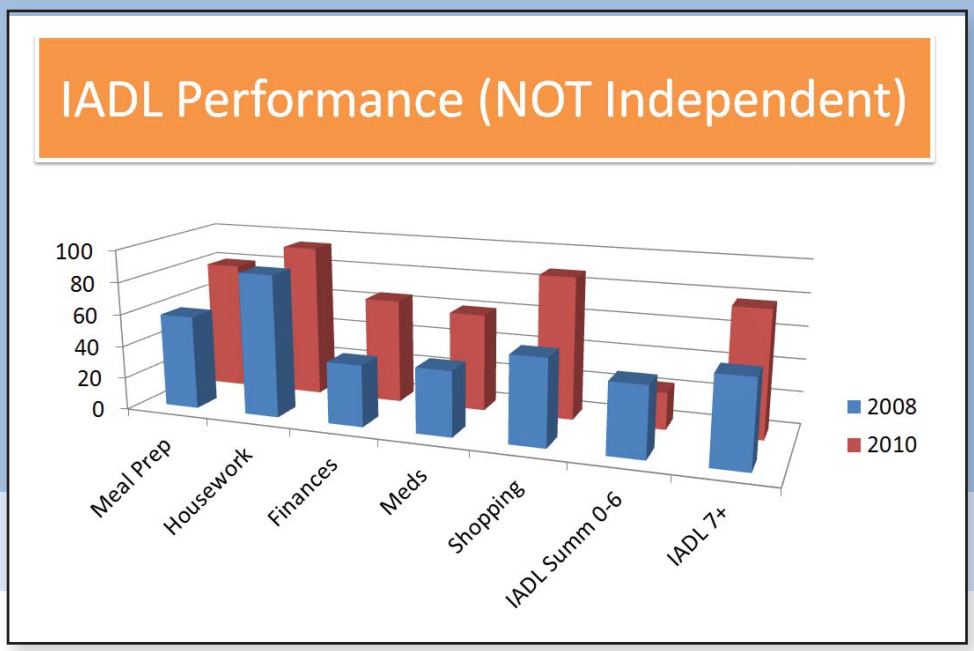
Scale scores of 3 or greater indicate major and minor depressive disorders

7 CHA items: E-1 (a to g) - Made negative statements; Persistent anger with self or others; Expressions of what appears to be unrealistic fears; Repetitive health complaints; Repetitive anxious complaints, concerns; Sad, pained, worried facial expression; Recurring crying, tearfulness.



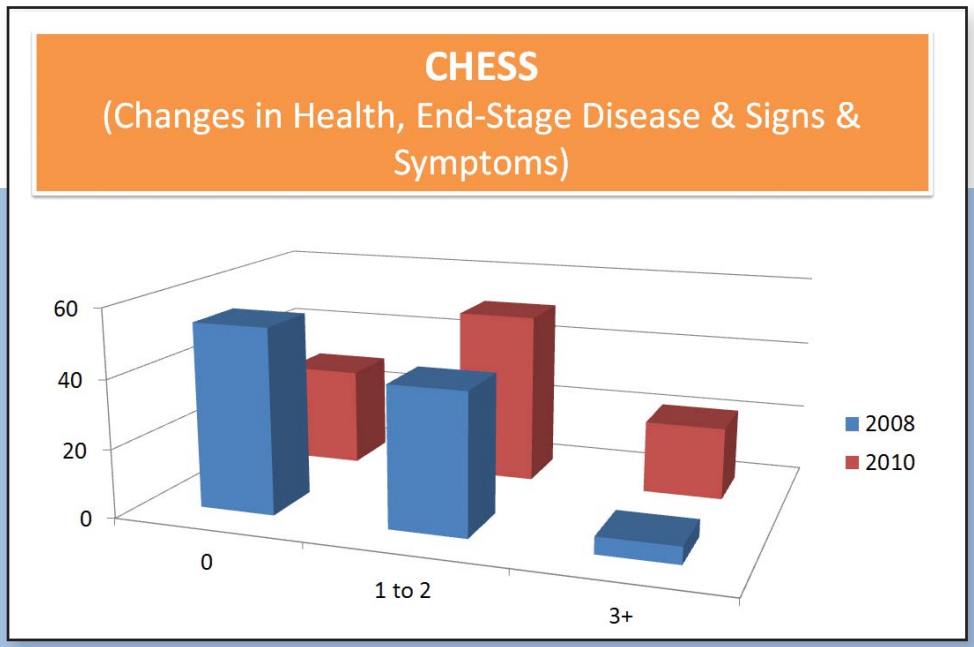
If any of the following 4 items below are NOT scored independent as shown, then the label 'Not Self Reliant' is assigned. 'Not Self Reliant' means impaired on at least one item.

4 CHA items are used: C-1; G-2 (a; b; and, e); Independent in cognitive skills for daily decision making; Independent in bathing; Independent in personal hygiene; Independent in walking



Independent Activities of Daily Living (IADL) are activities that range from preparing meals to shopping.

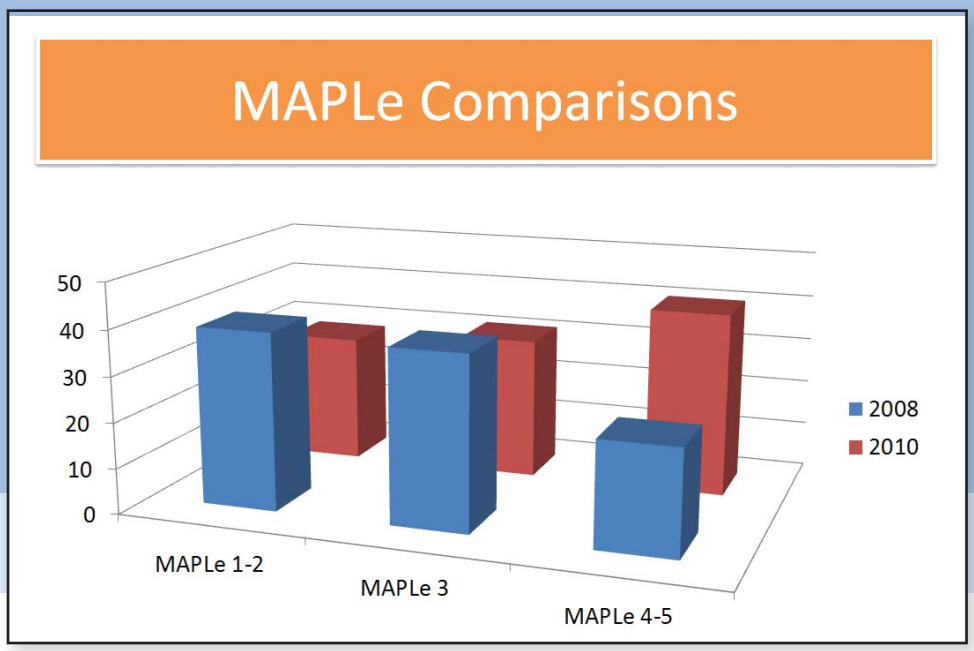
The lower the IADL Performance Summary Score, the greater the independence (or ability to perform those functions). Those individuals with an IADL Summary Score of 7+ are not independent (do not have ability or limited ability to perform those functions).



To detect frailty and instability in health, CHESS has a range of 0 to 4 in the RAI-CHA. Higher CHESS scores indicate a higher level of health frailty and instability.

(0 = not at all unstable; 3+ = highly unstable and frail)

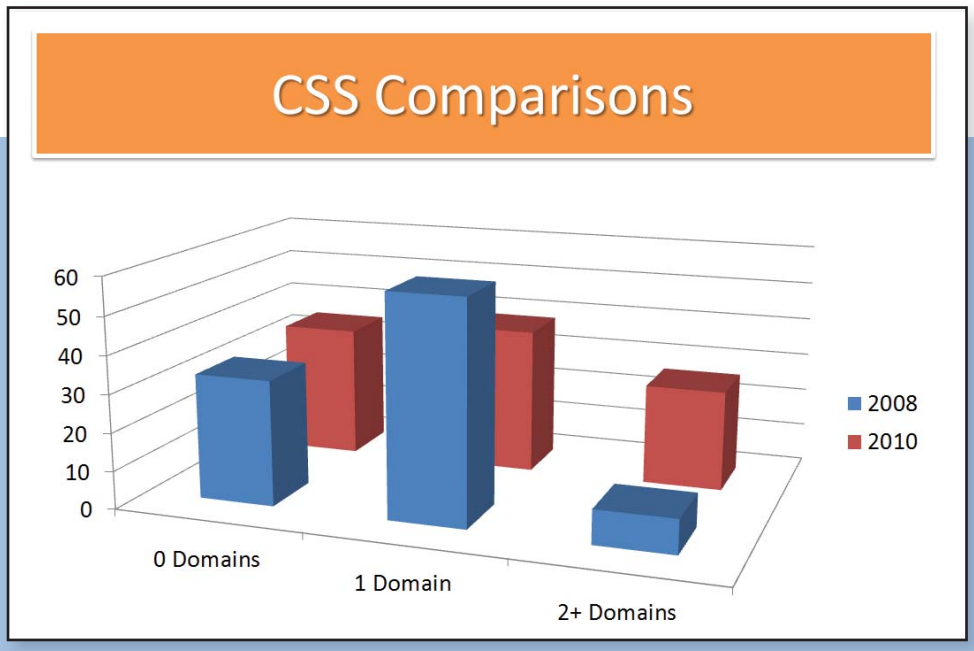
6 CHA items are used: C-3; G-5; J-3j; K-1 b or c; K-1a; J-4: Worsening of decision making; ADL decline; Vomiting; Dehydration; Weight loss; Shortness of Breath



MAPLe is an algorithm embedded in the RAI assessment instruments. The MAPLe "acronym" stands for:

- Method of Assigning Priority Levels
- The higher the MAPLe score number (ie: 5) the greater the "acuity" level of the individual

Clients in the low priority level have no major functional, cognitive, behavioural or environmental problems and can be considered to be self-reliant.
Clients in the high priority level are nearly 9 times more likely to be admitted to a long term care facility than are the low priority clients. Higher scores indicate a higher priority client.



Crude Complexity Scale (CCS) combines 3 RAI scores together to form the CCS Scale which is expressed in "domains". The 3 scores are:

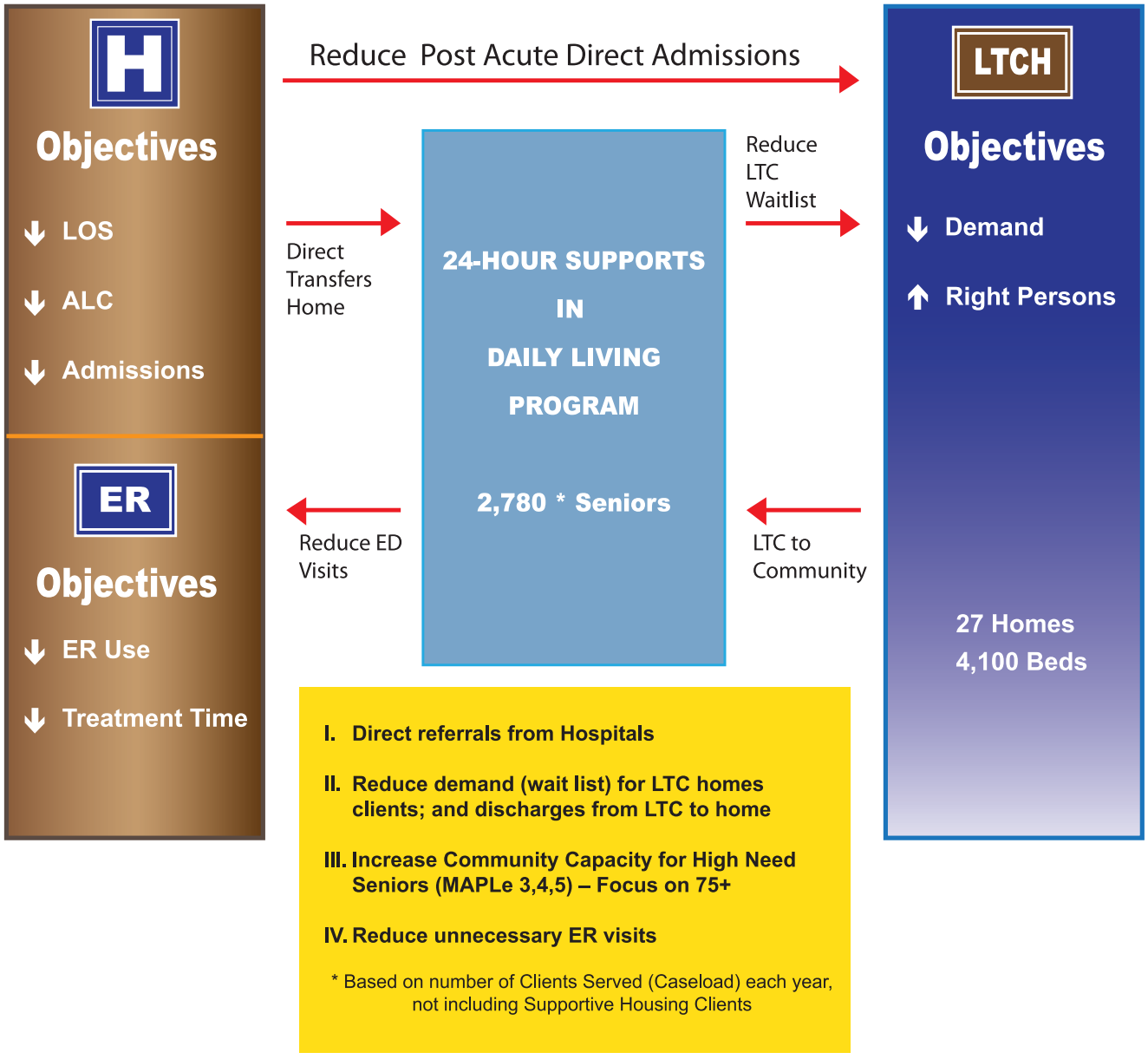
- Cognitive Performance Scale (CPS)Score
- Activities of Daily Living Scale (ADL) Score
- Changes in Health, End-Stage Disease & Signs and Symptoms Scale (CHESS) Score

The higher the number of domains that exist in the CCS, the greater the impairment of the individual.

Showing a Return on Investment (ROI)

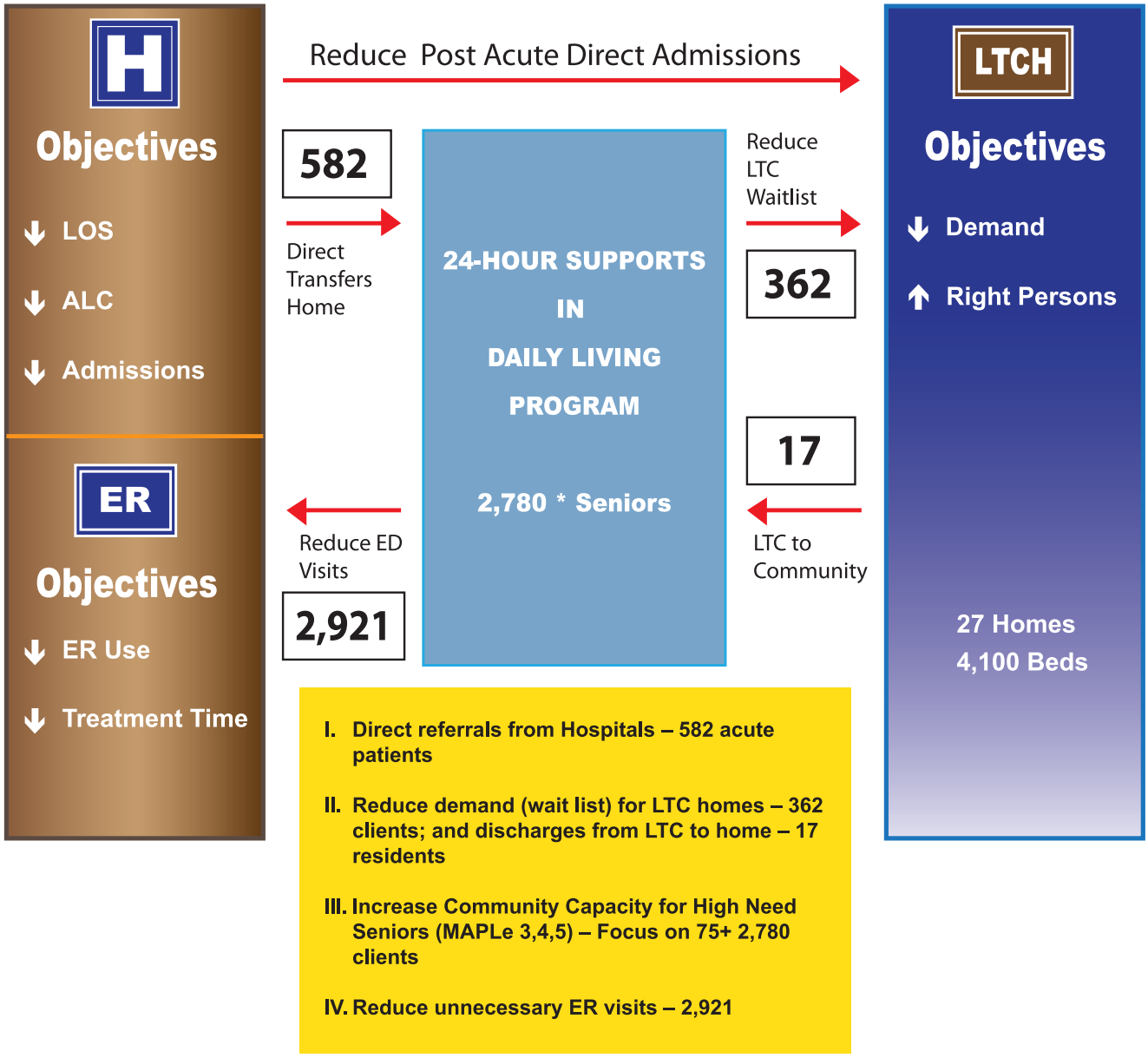
Mississauga Halton LHIN Overall Evidence-Based Strategic Approach (April 1, 2009 to December 31, 2011)

Right Care, Right Place, Right Time, Right Cost



Mississauga Halton LHIN Overall Evidence-Based Strategic Approach (April 1, 2009 to December 31, 2011)

Right Care, Right Place, Right Time, Right Cost



Two Year Analysis of Net ER Cost Savings: SDL Program Fiscal 2009/10 – 2011/12 Q3

Program	# of ER Diversions [1]	Avg. Cost of ER visit [2]	Net Savings
SDL	2,921	$166	$332,994

Based on Direct Cost of $166 - $52 = $144 net savings per visit

1 Number of ER diversions is as provided by the SDL providers from fiscal 2009/10 to the end of 2011/12 Q3

2 Average cost of ER visit as taken from the 2010/11 OCDM – Total Cost = $213.16 and Direct Cost = $165.66

Net Hospital Day "Savings": SDL Program Fiscal 2009/10 – 2011/12 Q3

Program	# of Hospital Referrals	# of Days Saved [1]	Avg. Program Cost Per Diem	Net Cost Per Diem Savings Based on Acute ALC Day [2]	Net Savings
SDL	582	16,878	$52	$398	$6,717,444

1 Number of hospital days saved is based on avg. wait time for LTCH placement from hospital within MH LHIN for fiscal 2010/11 (29 days)

2 Avg. acute ALC is $450 based on an OHA estimate found in 2010 Annual Report of the Office of the Auditor General of Ontario. (Calculation = $450 – Avg. Program Cost Per Diem)

Net LTCH "Savings":
SDL Program Fiscal 2009/10 - 2011/12 Q3

Program	# of Clients Taken From LTC Wait List or LTCH [1]	LTC Cost Per Diem [2]	Net Savings
SDL	379	$99.71	$3,023,335

[1] Calculations have been adjusted to address clients coming out of LTC at different times and coming on/off the SDL program. The average days saved are 167.2. Costs are determined by 379 * 167.2 = 63,369 days saved.
63,369 * ($99.71 - $52) = $3,023,335 in savings.

[2] LTCH costs are $152.94 (full cost) - $53.23 (patient co-pay) = $99.71 per diem (or $36,394 per year), which is representative of the cost to the healthcare system.

SDL Net Savings For 2 3/4 Years

Savings Sector	Net Range of Savings
Emergency Room	$ 332,994
Hospital Days	$ 6,717,444
Long Term Care Days	$ 3,023,335
Total Savings	***$10,073,773***

SDL Net Savings Annualized*

Savings Sector	Net Range of Savings
Emergency Room	$ 121,089
Hospital Days	$ 2,442,707
Long Term Care Days	$ 1,099,395
Total Savings	***$ 3,663,101***

* Estimated annual savings over 2 ¾ years

Savings/Benefits Not Quantified

- Reduced Ambulance Trips
- Decreased ER wait times
- Reduced medical complications as a result of delayed care (e.g. infections etc.)
- Reduce ER Visits & Hospitalization

The cost of improved patient experience and quality of care - PRICELESS

Chapter Eight

Conclusion

"From the time I get up in the morning, they get in and shave me, give me a shower, put cream on my legs for dry skin and put my pressure stockings on. It's an excellent service and everyone is cooperative and friendly."

Keith W., age 84, client with Parkinson's disease

"The Supports for Daily Living program is freeing up acute care beds, diverting visits to hospital emergency departments and reducing the demand for long-term care."

Excerpt from
'Evaluation of the Supports for Daily Living Program' in the
Mississauga Halton LHIN by Shercon Associates Inc., November 2010

The SDL initiative was formed at a time when ideas were sought to decrease the length of stay in hospitals (ALC) and of LTC beds by aging individuals. Investment in the community to support aging individuals to remain at home was an idea whose time had come, but large change would need to occur in the community sector if these individuals were to be sustained in the community with higher level needs. The community sector (CSS and the CCAC) would need to shift their service focus from that of lower level need clients to that of higher level need clients - the supportive housing group would be the first of the CSS agencies to lead the way.

On Tuesday June 7th, 2011 in Whistler B.C., the Mississauga Halton LHIN team representing all of the SDL providers was honoured to receive the prestigious National 3M Quality Award for Non-Acute Care specific to the Supports for Daily Living (SDL) Program. The award recognizes a team that has been able to clearly demonstrate and prove the impact an initiative has had on the quality of care being delivered within a health care setting. The Supports for Daily Living initiative has strived to create an innovative program that achieves the outcomes being targeted – specifically those of reducing ED visits, contributing to a decrease in hospital length of stay and diverting clients from LTC. As a result of the program's success, several millions of dollars in health care savings has been achieved, client and stakeholder satisfaction is high and maximum utilization of the program is being seen. Our post-implementation evaluation has shown clear convergence of data that the program is achieving the identified outcomes and that the MH LHIN's investment in this program is justified.

The enthusiasm for hard work, creativity and problem resolution was the "glue" that brought the vision of Supports for Daily Living to life. That vision showed the opportunity for Supportive Housing and the important new role and value it could play within health system improvement. The job was not easy and the skill sets required to "get it done" were substantial. In each of their own ways, the entire SDL group brought the skill of leadership to the forefront of the initiative, kept it there and continued to move forward when doubts were raised and issues arose. The old saying of "Lead, Follow or Get Out of the Way" was never a truer statement than when applied to a few specific members of the SDL Group. These individuals in particular, brought leadership skills to stay the course of change, work their way through doubts about the vision and ultimately champion the change to others within and outside their organizations.

The investment of time, energy and funding was ultimately targeted at clients in order to truly "age in place". This was the driver of change and all SDL group members were responsible for keeping this focus front-and-center in deliberations, planning and model development. Subsequently, the last "members" of the SDL Group were the clients and their needs – when doubts arose about the model, it was essential that group members could challenge the thinking of one another by identifying client needs that were not being met in the current system of supportive housing service delivery.

In his book, *"Managing in Turbulent Times"* (New York: Harper Collins, 1980) Peter Drucker commented *"Unless challenged, every organization tends to become slack, easy going, diffuse. It tends to allocate resources by inertia and tradition rather than results."* This comment has never been truer today as resources in healthcare have been allocated on the basis of tradition (we've always done it this way) rather than on outcomes/improvement/risk. Subsequently, a tension for change never comes about- we keep on, keeping on and the approach results in an unwillingness or resistance to acknowledge that improvement is needed. We believe that we have acknowledged improvement was needed, took the necessary risk and built a better service. Healthcare is about to shift and change, along with funding. We think Supports for Daily Living is well positioned to meet the changing shift.

"[If I didn't have Supports for Daily Living] I would have to go into a nursing home and I don't want to. Before I had my stroke, I did everything. Now I have to have somebody to help me. They give me a shower in the morning and make my bed – they're really nice."

Rhoda B., age 87,
client recovering
from stroke

Appendices

"[Supports for Daily Living] has made a big difference because I just get so tired. I couldn't handle it. I can't even get [my husband's] stockings on. They make you feel good when they come in. They're always smiling and happy. They seem to love their job. I would recommend [SDL] to anyone."

June W., wife of client with Parkinson's disease

Contractual Letter – LHIN – Administration & Sign-Back (Attachment A)

Mississauga Halton **LHIN**

700 Dorval Drive, Suite 500
Oakville, ON
L6K 3V3
Tel : 905-337-7131
Fax: 905-337-8330

[Date], Year
[Name – Individual]
[Title – Operational Head eg: Executive Director, CEO]
[Organization]
[Address]
[City & Postal Code]

Dear [Individual's Name]:

Re: **Year [X] Aging At Home Strategy Proposal – [Name of Proposal Related to SDL Services]**

The Mississauga Halton Local Health Integration Network (MH LHIN) is pleased to support your proposal for "[name the proposal related to SDL services]" as part of the Year [X] Aging at Home Strategy. The approval for this expansion is an [new/additional] allocation. The [new/additional] annualized operating approval of [$$$$] were communicated to you by [Board Chair name], Board Chair, MH LHIN in [his/her] letter dated [date, year].

Objectives

The MH LHIN Aging at Home Strategy's overall objectives are to:

Increase community support services capacity in MH LHIN to support frail and "at risk" seniors by:

1. Reducing acute care pressures through reduced Alternate Level of Care (ALC) patient days in hospitals
2. Providing an alternative to Long-Term Care (LTC) Home placement
3. Reducing unnecessary Emergency Department (ED) visits by seniors and avert admissions from ED
4. Reducing ED treatment time.

Funding

As noted in the letter to your Board Chair, funding for Aging at Home [year] will be on a one-time basis with the understanding that continued funding will be determined by the LHIN based on performance targets met in [year] and the ability of the LHIN achieving the Alternate Level of Care (ALC) 8% target set with the ministry for [year] fiscal year. Adequate notice will be provided in the event funding is not to continue or reduced in accordance with the agreement with MH LHIN.

In addition the MH LHIN reserves the right to reallocate funding to other agencies to achieve the most effective use of the funding in meeting the MH LHINs' priorities and the above objectives. It is understood that these priorities may change.

Mississauga Halton **LHIN**

700 Dorval Drive, Suite 500
Oakville, ON
L6K 3V3
Tel : 905-337-7131
Fax: 905-337-8330

The following are the administrative details regarding the funding:

[Year]	Annualized Operating Allocation (12 months)	**[$$$$$]**
[Year]	[X] months operating funding	**[$$$$]**
	Other one-time expenditures*	**[$$$]**
	TOTAL	**[$$$$$]**

*Other one-time funding is approved for specific non-recurring start-up expenditures. Examples include consultation, training, computer related items, office supplies and minor renovations. These one-time costs need to be specified in the detailed budget resubmission Attachment B.

This funding is contemplated by Article 4(section 4.4) and Article 12 of the Multi-Sector Service Accountability Agreement (M-SAA) between *[Agency]* and the Mississauga Halton LHIN. This letter and its appendices (Attachments A and B) form part of, and are subject to, that agreement as an amendment under section 4.4 and schedules 2b, 3a and E of the M-SAA.

As a dedicated program, *[Agency]* is required to maintain separate financial records for this allocation for year end audit and evaluation by the MH LHIN. Reporting requirements for this funding is included in Attachment A.

Evaluation
Evaluation of your program/service will be based on the achievement of the performance deliverables and requirements outlined in Attachment A.

Please complete the following:

1) Attachment A - Sign Back Agreement for Aging at Home Year [X] Funding
2) Attachment B - Updated Aging at Home Budget – Summary of Revenue and Expenses (for this proposal)

Return both Attachment A & B to MH LHIN, to the attention of *[Staff Member @ LHIN]* [staff member's email] no later than [date, year]. With the return of your sign-back on this date, your first payment for the initiative will be on [date, year].

If you have any questions, please do not hesitate to contact *[LHIN Lead person and telephone number]* or *[LHIN Lead Financial person and telephone number]*.

Mississauga Halton **LHIN**

700 Dorval Drive, Suite 500
Oakville, ON
L6K 3V3
Tel : 905-337-7131
Fax: 905-337-8330

I would like to take the opportunity to thank *[Agency]* for your work with the MH LHIN and commitment to improving services for seniors in our community.

Sincerely,

[CEO Name]
Chief Executive Officer

c: *[Name of Board Chair or Individual to Whom Board Letter Was Addressed + Agency Name]*
[Other Appropriate People within the LHIN]

Mississauga Halton **LHIN**

700 Dorval Drive, Suite 500
Oakville, ON
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Fax: 905-337-8330

ATTACHMENT A
Sign-Back Agreement for Aging at Home Year [X] Funding
[Agency Name]

1.1 Funding for Proposal – [Name Proposal]

Annualized Operating Funding Allocation	Cash Flow	Performance Deliverables *(Example Deliverables Provided Below)*	Start Date	Coding for Service (OHRS)
[$$$]	*[$$$ (based on start up of date & year)]*	• Maintain & support the additional [xx] clients (xx to xx from previous funding) • Continue to provide the additional [xxx] hours of service (for the xx clients) • [XX] clients (annualized) • [XXXX] (annualized) hours of service • Ability to track & trend: o Admission & annual RAI CHA – MAPLe scores (average, range)	*[Date & Year]*	Functional Centre Code [XXXX] *[Name of Program applicable to Code]*

Annualized Operating Funding Allocation	Cash Flow	Performance Deliverables *(Example Deliverables Provided Below)*	Start Date	Coding for Service (OHRS)
		○ Admissions & source (ALC, Acute Hospitals, LTC and community) ○ Discharges & destinations (LTC, Community, Death) ○ Average length of stay (LOS) – months/days ○ Falls equation (#of transfers to ER/ total falls) ○ ER diversions (ill clients diverted to more appropriate practitioners) ○ #of urgent/emergency, staff responses to clients/total client days per quarter • Completion of performance parameters as per the monthly [Program] Reporting Template • Submission of computerized CHA data • Annual client satisfaction Survey results		

1.2 Performance Requirements:

- Give priority to the frail elderly and their caregivers whose needs may require additional community programs and/or services to continue to stay at home and ensure they receive care in the most appropriate setting.
- Must communicate program/service details to other providers and the broader community through a variety of methods (e.g. newspaper, advertising, 211, 310-CCAC, etc.).
- Must commit to working with the MH LHIN, sector colleagues and/or other MH LHIN community partners such as the MH CCAC, hospitals and/or LTC Homes to reduce one or more of the following:
  - % of ALC patient days in hospital (caregiver stress may preclude discharge)
  - ED visits by seniors that could have been managed elsewhere
  - LTC Crisis Placement
  - Wait times and wait list for LTC Homes
- Must work with the MH LHIN and other sector colleagues and/or community partners to improve health system performance (e.g. common intake and assessment processes; common assessment instruments; creation of a centralized waitlist; streamlined referral processes; data collection tools and/or methodologies; common, targeted indicators and outcome measurements; etc.) for this initiative.
- Must be able to show on monthly or quarterly data reports (e.g. MAPLe scores, CPS scores, CHESS scores, RUGS scores, combination of scores, or other methodologies) that the program/service provides care and/or all available vacancies in the program/service were prioritized to those clients with the highest needs (as per performance deliverables).

1.3 Reporting Requirements: (See MSAA – Schedule C)

- The agency will maintain separate financial/statistical records and provide full accounting for this allocation since it is a dedicated program. Unspent funding and funds not used for the intended and approved purposes are subject to recovery.
- Quarterly Supplementary Reporting Template for Initiatives – [Fiscal year due dates: Q2-[*date*]; Q3-[*date*]; Q4-[*date*]]; and on-going quarterly periods until notified by MH LHIN.
- The agency will include Aging at Home revenue and expenses as well as statistical information with the quarterly WERS actual/forecast reporting. If other reports are required by the LHIN, a template with instructions will be provided.

I acknowledge that the funding for [*Agency Name and Proposal Name*] has been allocated with the understanding that [*Agency name]* will achieve:

- the performance deliverables (1.1),
- the performance requirements(1.2), and
- the reporting requirements(1.3)

I also acknowledge that continued funding for this program/service is based on:

- the program achieving the performance deliverables and requirements,
- the ability of MH LHIN achieving the ALC 8% target set with the ministry for [*Year*], and
- the MH LHIN priorities and objectives continuing to align with my agency's program in order to achieve the most effective use of the funding.

XXX _____

XXX [Board Chair] Signature Date

[Agency name]

XXX _____

XXX [ED/CEO] Signature Date

[Agency name]

Note:

Please return this form by [*Date*] to [*Staff Person's Name*] at the Mississauga Halton LHIN using one of the following methods:

- **fax: [*Number*]**
- **scan copy and send by email to: [*Staff Person's email address*]**

Sample Client Profiles & Care Plans

Scenario #1: Mr. Doe

Mr. Doe is 87 years old and has been living in the same house, on the same street for the past 40 years. He has Parkinson's and is currently very frail. His wife was his main assistance for personal care before she passed away last year. Since her passing he has lost interest in his own personal care or is too weak most days to take proper care of himself. His only son lives an hour away and works full time.

The Mississauga Halton Community Care Access Centre has one hour of service scheduled for Mr. Doe every morning during the week, however once the hour is complete Mr. Doe is on his own for the rest of the day and mainly stays sedentary on his couch or in bed until the next morning when the service provider returns.

Mr. Doe's Case Manager felt that Mr. Doe would benefit from the availability of intermittent care throughout the day or he would soon face admission to long term care to halt further deterioration. Along with admission to a Senior's Day Program and application for a Friendly Visitor, the Case Manager filled in the Supports for Daily Living referral form and attached Mr. Doe's RAI HC assessment and results. The referral was received by the Supports for Daily Living Systems Manager who handles the SDL Central Referrals. A home visit was scheduled with Mr. Doe and the SDL Systems Manager determined that he was eligible and would greatly benefit from the SDL intermittent care.

Mr. Doe now receives two visits per day for personal care, light meal prep and light homemaking, seven days a week, 365 days a year and also receives two security check phone calls in between visits to ensure he is well and to remind him to take his medication at the prescribed time. During the night he receives an additional two visits at 1:30am and 4am for toileting assistance due to his prostatitis.

Mr. Doe has become more social and confident in himself with the assistance of the Supports for Daily Living program. He now makes weekly trips to the mall and has old friends over for euchre tournaments.

Scenario #2: Ms. Jane

Ms. Jane is 92 years old and lives alone. She had a stroke and was admitted to hospital. The stroke was severe and caused her left side to be very weak and impaired which resulted in an unsteady gait and extreme imbalance while walking and performing ADLs and IADLs. She was designated ALC while waiting to move to Long Term Care. Ms. Jane had improved while in hospital and her health team decided that she may be able to return home with intermittent assistance from the Supports for Daily Living program.

After spending 53 days as an ALC patient, Ms. Jane was released home after an SDL Assessor had been to the hospital to see her and concluded that the SDL program would be appropriate for her once home.

Ms. Jane receives three visits and five security checks by phone each day. She is receiving assistance with personal hygiene, dressing, medication reminders, light meal prep and light housekeeping. Ms. Jane has also had a lifeline system installed and her SDL provider is set up to be the first responder.

Ms. Jane is safe and happy to be back in her own home. Her family has also noticed a big difference in her personality and wellbeing as a result of the support.

Scenario #3: Mrs. Smith

Mrs. Smith, 74 years old, lives in a townhouse with her husband. Her husband, Mr. Smith has had 3 heart attacks in the past which have left him quite frail. Mrs. Smith was admitted to hospital after a fall at her home which resulted in a hip fracture, she also has a diagnosis of diabetes. The health team noticed that while difficulty with diabetes was not the reason for admittance to the hospital, Mrs. Smith has not been testing her blood sugar or taking her insulin at appropriate times and may be missing some meals that would allow her blood sugar to remain steady. After treatment and recovery, Mrs. Smith was healthy enough to return home however was not able to perform all of her personal care independently due to an unsteady gait and fluctuating blood sugar. Mr. Smith is also not able to help her once home due to his own health concerns.

The hospital gave the Supports for Daily Living Central Referral Line a call to see if the SDL program would allow Mrs. Smith to safely return home with assistance. The SDL Systems Manager visited with Mrs. Smith at the hospital and determined based on her assessment score and her needs that the SDL program would be able to fulfill her needs safely in her own home and allow her to remain there avoiding a possible long term care placement or extended stay in the hospital.

Mrs. Smith was discharged with a care plan from the Supports for Daily Living program that scheduled 3 visits a day that provide assistance with transferring from bed, bathing, personal hygiene, light meal prep, medication reminders and light homemaking.

A security check by phone is performed at noon by SDL program staff to ensure Mrs. Smith remembers to test her blood sugar before having lunch.

The SDL program staff are also available for 24 hour emergency response if Mrs. Smith ever needed to call during the day or night.

As a result of the SDL program staff and the assistance provided, Mrs. Smith's hip has healed completely, she has a better understanding of her diabetes and thrives with the assistance of the SDL staff. Mr. Smith's health has also been maintained and unnecessary injury or illness due to trying to assist Mrs. Smith has been avoided.

Supports for Daily Living (SDL)

Information for Hospital Discharge Planners and CCAC Case Managers

What is Supports for Daily Living?

Supports for Daily Living (SDL) is a community-based, publicly funded health care service that effectively meets a client's frequent needs throughout the day. By providing access to 24/7 personal support and/or attendant care coverage, it allows seniors and persons with a physical disability the ability to remain living independently within their own homes, thereby preventing premature admission to long-term care. Services are funded under the umbrella of the Mississauga Halton LHIN's Aging at Home Strategy.

What services does Supports for Daily Living offer?

Supports for Daily Living provides non-medical services that include:

- personal support services (personal hygiene, activities of daily living)
- homemaking services
- attendant services (prescheduled tasks)
- safety and reassurance checks (via phone or in person)
- 24 hour urgent response

Services are available to clients at scheduled times based on client preference, anytime of the day within a 24 hour period, seven days a week, 365 days a year, and are designed for clients with overnight needs or more frequent visitation than those services offered through the CCAC. It would not be unusual for a client who has been on CCAC services to transition to SDL as their needs change and they require more frequent visitation.

SDL services can be delivered in conjunction with professional services offered through the CCAC. The goal of SDL is to support individuals to continue living independently as long as possible and to reduce premature admission of seniors and persons with a physical disability to long-term care environments.

Where are services provided?

Services are delivered to clients in their homes who live within designated geographical 'clusters' or 'hubs' in the Mississauga Halton LHIN. Clients unable to continue living in their own homes for safety or accessibility reasons, but who are still capable of living independently with support, may be eligible to apply for residence in a Supportive Housing program building serviced by SDL agencies.

As of January 2009, a 24 hour mobile SDL service is available to eligible individuals who live in their own homes, apartments, condominiums or townhouses and whose residence is not served by an onsite SDL agency. This means people can access services in their current neighbourhoods without having to move. The mobile service is also available on-call to respond to urgent client requests for support that fall outside the prescheduled client visits by SDL staff.

Who provides Supports for Daily Living services?

Supports for Daily Living are provided by designated agencies that meet approved standards for the delivery of high quality SDL services within the Mississauga Halton LHIN. Each designated agency carries the Supports for Daily Living Approved Service Provider symbol (as seen in the top right corner of page one).

Each agency applies best practice in the delivery of care, offering clients throughout the LHIN the same high quality, level and range of services, without exception. Agencies serve designated geographical service areas within the LHIN, or provide service within designated residential buildings where there are clusters of seniors or persons with a physical disability living on their own or with an informal caregiver.

In some cases, SDL agencies may be housed within designated residential buildings, while in others, services may be provided to residential buildings by SDL agencies located within the geographical area.

Who is eligible for Supports for Daily Living services?

Supports for Daily Living services are suitable for seniors or persons with a physical disability who are 65 years of age or older, and who live in their own home within the community, or in a residential setting such as an apartment complex or senior citizens' residence and who:

- demonstrate a need for daily access to personal support and/or attendant services throughout a 24 hour period (i.e. may have a history of falls, may require toileting assistance at night, assistance transferring)
- are able to direct their own care or have an SDM or a live-in caregiver to direct care
- are able to communicate their needs (with or without aides)
- are medically stable (medical/professional needs can be met by CCAC, family physician or other community providers)
- pose no risk to themselves or others
- may or may not require homemaking services

The RAI CHA evidence-based assessment tool will be used to help health professionals determine eligibility for the service.

How do I refer a patient to Supports for Daily Living?

Supports for Daily Living (SDL) Coordinators are available within hospitals in the Mississauga Halton LHIN and can facilitate patient referral to the service. Patients can also be referred to SDL through the Mississauga Halton CCAC. Efforts are currently underway to develop a central referral line to facilitate SDL referrals from both hospitals and the community.

Living independently, safely and with peace of mind.

Supports for Daily Living (SDL)

Information for Patients, Families and Informal Caregivers

When illness or disability increases your dependency on others for support, it can often lead to questions about independent living and whether or not you can still manage living in your own home. Perhaps you have been using homecare services offered through the Mississauga Halton Community Care Access Centre (CCAC), but recent changes in your health mean they're no longer adequate to support your needs. Perhaps you've had the support of a family member or friend, but they're not always available at times in the day when you most need their support. That's where Supports for Daily Living can help.

What is Supports for Daily Living?

Supports for Daily Living (SDL) is a publicly funded, community-based health care service that provides eligible seniors and persons with a physical disability with the personal support and/or attendant services you need to allow you to continue living on your own for as long as possible. There is no cost to you for the services provided.

Services are offered through approved SDL agencies within Mississauga, Halton and South Etobicoke in designated geographic areas or in designated residential buildings. Each agency is dedicated to providing the same high quality, level and range of services, regardless of where you live or what your circumstances are.

Whether you live in a private home or a residential setting (i.e. apartment building, senior citizens' residence), on your own or with an informal caregiver, Supports for Daily Living can help bring peace of mind to you and your family, delivering personal support and/or attendant services where and when you most need them – anytime – day, evening or overnight.

What services does SDL provide?

Supports for Daily Living provide non-medical services that include:

- personal support services (personal hygiene, activities of daily living)
- homemaking services
- attendant services (predetermined tasks)
- safety and reassurance checks (via phone or in person)
- 24 hour urgent response

SDL services focus on activities of daily living that you can no longer do or find challenging to do on your own such as:

√ washing/bathing
√ mouth care
√ hair care
√ menstrual care
√ preventive skin care
√ transferring/positioning/turning
√ dressing/undressing
√ assistance with eating
√ toileting
√ reminders re: pre-measured medications
√ range of motion
√ exercising
√ escorting to medical appointments
√ light dusting, sweeping, vacuuming
√ mopping floors
√ washing dishes/countertops
√ light meal support
√ bed making and laundry
√ cleaning and disinfecting bathrooms

SDL staff work together with you to determine the best mix of services to meet your needs, and then pre-schedule the services at the times of day when you most need them. They are available to come to your home at any hour within a 24 hour period of time, offering services seven days a week, 365 days a year. SDL clients receive daily security checks either in person or by phone to make sure you are okay. Electronic emergency response systems are recommended to clients, providing you with 24-hour access to SDL staff in the event of an urgent situation.

With the exception of personal support services, you can supplement these services with those offered through the CCAC and through community support services, as needed.

How do I know if I'm eligible to receive Supports for Daily Living?

Your hospital discharge planner or CCAC case manager will work with you and your family to determine whether you are eligible for Supports for Daily Living services. These services are currently available to individuals, 65 years of age or older who:

- live in their own private home, or within a residential setting such as an apartment building or senior citizens' residence
- demonstrate a need for daily access to personal support and/or attendant services throughout a 24 hour period (may or may not require homemaking services)
- are able to direct their own care or have a substitute decision-maker or a live-in caregiver to direct care
- are able to communicate their needs (with or without aides)
- are medically stable (medical/professional needs can be met by CCAC, family physician or other community providers)
- pose no risk to themselves or others

How can I find out more about Supports for Daily Living?

To find out more about Supports for Daily Living, talk to your hospital discharge planner or CCAC case manager who will be happy to talk to you about your eligibility for these services.

Living independently, safely and with peace of mind.

Supports for Daily Living Communication Plan

COMMUNICATION GOAL

To generate awareness and understanding of the role of Supports for Daily Living as a means for reducing ALC and for encouraging independent living in support of the Aging at Home Strategy.

To effectively brand Supports for Daily Living so that it is recognized as a valued service within the local health system continuum of health care services.

COMMUNICATION OBJECTIVES

1. To generate increased referrals to Supports for Daily Living and decrease premature referrals to long-term care.
2. To initiate a change in the way health care professionals, informal caregivers and seniors/frail elderly think about independent living options versus long-term care.
3. To firmly establish Supports for Daily Living as a health care service versus a community support service within the Mississauga Halton LHIN.

KEY STAKEHOLDERS

Ministry of Health and Long-Term Care

Hospitals

Community Care Access Centre

Hospital Patients

CCAC Clients

Informal Caregivers (incl. families)

Seniors, Frail Elderly and Physically Disabled

Family Physicians

Other Health System Providers (i.e. long-term care homes, community support services, complex continuing care, etc.)

Supports for Daily Living Agencies

General Public

TAGLINE

Helping you to live independently, safely and with peace of mind.

KEY MESSAGES

1. Supports for Daily Living is a publicly-funded, community-based health care service that addresses an existing health system gap between CCAC services and long-term care.
2. Supports for Daily Living supports the ability of seniors, the frail elderly and physically disabled to continue living independently in their own home settings as long as possible, preventing premature admissions to long-term care.
3. Supports for Daily Living are provided by designated agencies that meet approved standards for the delivery of high quality SDL services within the Mississauga Halton LHIN. Each agency applies best practice in the delivery of care, offering clients throughout the LHIN the same high quality, level and range of services, without exception.
4. SDL agencies serve designated geographical service areas within the LHIN, or provide service within designated residential buildings where there are clusters of seniors, frail elderly or physically disabled individuals living on their own or with an informal caregiver.
5. Supports for Daily Living include personal support services, homemaking services, attendant services, security checks, 24 hour emergency response and friendly visiting. SDL services can be supplemented by CCAC services (with the exception of personal support) and community support services. A mobile service will offer transitional support in areas beyond designated geographic boundaries, and urgent care support, as needed.
6. SDL services are available to clients at pre-scheduled times based on client preference, anytime of the day within a 24 hour period, seven days a week, 365 days a year, and are designed for clients with heavier needs than those services offered through the CCAC.
7. SDL services are suitable for seniors, the frail elderly and physically disabled individuals who live in their own home, or within a residential setting such as an apartment complex or senior citizens' residence and who:

    - demonstrate a need for daily access to personal support and/or attendant services throughout a 24 hour period
    - are able to direct their own care or have an SDM or a live-in caregiver to direct care
    - are able to communicate their needs (with or without aides)
    - are medically stable (medical/professional needs can be met by CCAC, family physician or other community providers)
    - pose no risk to themselves or others
    - may or may not require homemaking services

8. SDL Coordinators are available within each hospital in the Mississauga Halton LHIN and can facilitate patient referral to the service. Patients can also be referred to SDL through the Mississauga Halton CCAC.

    - Efforts are currently underway to develop a central referral line to facilitate SDL referrals from both hospitals and the community.

9. Supports for Daily Living supports the Mississauga Halton LHIN's Aging at Home Strategy and a local health system commitment under the ALC Strategy to refer patients to the right service by the right care provider at the right time.

DEVELOPING THE SUPPORTS FOR DAILY LIVING 'BRAND'

The development of a distinct wordmark will help visually 'brand' Supports for Daily Living among SDL agencies, health care providers, clients and informal caregivers. Through its application on signage, print and online materials, it will lend itself to identifying agencies that provide the same high quality, range and level of SDL services within the Mississauga Halton LHIN. Only those agencies that are approved by the Mississauga Halton LHIN to carry the SDL brand will be considered official providers of SDL services, sharing the same values, standards and practices for the delivery of services.

The wordmark will become a symbol for consumers of quality, community-based health care services, and will allow clients to challenge SDL providers if the quality, level and range of services expected of SDL providers is not delivered.

COMMUNICATION STRATEGY

The Mississauga Halton LHIN and SDL Steering Committee will adopt a multi-faceted approach to communication, embracing multiple communication vehicles and education initiatives over the next several months for the purposes of raising awareness, understanding and support for SDL's role within the local health system and generating increased referrals to SDL agencies.

COMMUNICATION PLAN

AUDIENCE	TACTIC	TIMING	RESPONSIBILITY
Branding	Develop a visual SDL 'wordmark' for use by approved SDL providers	Completed 2010	XXX
Approved SDL Providers	Develop an SDL Standards Kit for approved SDL providers, providing templates for communication materials they can use	Completed – revisions with new materials in 2011/12	XXX/SDL Steering Committee
Mobile SDL Launch	News Release – provide SDL providers with copy of launch news release for posting to their respective websites Incorporate quotes from one or two SDL providers involved with mobile service Consider newspaper photo op of SDL Mobile service	January 5, 2009	XXX/MH LHIN
HOSPITAL DISCHARGE PLANNERS & CCAC CASE MANAGERS			
Education/ Awareness Meetings	Develop key messages for use at awareness meetings with hospital discharge planners and CCAC case managers Service Eligibility Decision Tree	Week of Dec. 1, 2008	YYY/ZZZ
Education/ Awareness Meetings	Develop 3-5 vignettes that vividly characterize who SDL clients are and how they benefit from SDL services	By January 2009	YYY/SDL Resource Group
HOSPITAL INPATIENTS & FAMILIES/CCAC CLIENTS			
Patient/Family Meetings	Develop key messages/script for use in materials or delivered verbally by discharge planners, CCAC case managers and SDL coordinators	December 2008	YYY
Patient/Family Meetings	Develop patient fact sheet for eligible hospital inpatients preparing for discharge (this can be adapted for CCAC clients transitioning to SDL services)	Week of Dec. 1, 2008	YYY

AUDIENCE	TACTIC	TIMING	RESPONSIBILITY
FAMILY PHYSICIANS			
Family Physician Meetings	Prepare powerpoint presentation for introducing SDL at Central West/Mississauga Halton Family Physician Network or MH LHIN Family Physician meeting or hospital family practice rounds	TBD	MH LHIN
Mailings/ E-Mailings	Develop fact sheet or top 10 list to help family physicians better understand why they should refer their patients to SDL before considering a referral to LTC	TBD	MH LHIN
COMMUNITY-BASED SENIORS & INFORMAL CAREGIVERS			
	Develop key messages for use in materials or delivered verbally by SDL providers and other health care providers	December 2008	YYY
Family Physicians' Offices	General information brochure on SDL for patients to pick up in family physicians' offices	December 2008	YYY
OTHER LOCAL HEALTH SYSTEM PROVIDERS			
Announcement of SDL as a health care service within MH LHIN	E-mail announcement with accompanying SDL fact sheet from MH LHIN to all member providers	MH LHIN eLetter -	MH LHIN
HOSPITAL COMMUNITY/CCAC/GENERAL PUBLIC			
Introduction of SDL (Hospitals/CCAC)	Provide introductory article for hospitals and CCAC to use in internal newsletters and/or in announcements of service on intranets Provide introductory article for use in hospital community newsletters	2009/10 and onward	MH LHIN

AUDIENCE	TACTIC	TIMING	RESPONSIBILITY
Introduction of SDL (General Public)	Develop powerpoint presentation that can be used by MH LHIN and/ or SDL Providers in presentations at gatherings of seniors (i.e. seniors citizens' residences, seniors' recreation centres, etc.)	Ongoing	SDL Providers/ MH LHIN
Introduction of SDL (All)	Post information about SDL for health care professionals and consumers on MH LHIN website	Completed 2010	MH LHIN Website Author
	Have SDL providers ensure that their existing agency listing on both their websites and on other websites (i.e. 211.ca, etc.) list their service as SDL and not Supportive Housing	Completed 2010	SDL Providers
	Write feature article on SDL and submit to local newspapers, publications that target seniors (i.e. CARP), and local ethnic newspapers and any seniors' information sites on internet that list health care services	Ongoing	MH LHIN (eLetter); SDL Providers; Request from Newspapers

Reporting Template for SDL Stats – circa 2009/10"

Statistics for Supports for Daily Living (SDL)

HSP Agency Name: _____

	REPORTING REQUIREMENTS			____/09	
All SDL Agencies Report on These Categories	*Impact on Hospital (ER, ALC, General Beds)*				
	# of ALC clients taken out of hospital into SDL (not previously SDL clients – new)				
	# of general hospital clients taken into SDL (not inclusive of ALC – not previously SDL clients – new)				
	# of ER visits diverted (24 hour response)				
	# of clients returned back to SDL from hospital (clients on SDL services prior to hospitalization)				
	Impact on LTC Homes				
	# of clients taken out of LTC homes into SDL				
	# of clients diverted from LTC (may or may not be waitlisted – avoidance of crisis placement)				
	# of clients that came off of the LTC waitlist				
	Impact on Turnover of Clients in SDL Buildings				
	** Turnover rate of clients (defined as: leaving SDL) **Please specify destination (eg: Death, placement, etc.)**				
	SPECIALIZED REPORTING REQUIREMENTS			____/09	
OSCR	# of days reduced from hospital LOS – Recovery Unit				
Mobile	# of "Restore" patients taken into SDL				
Mobile	# of hospital patients d/c and resettled at home with Mobile Services				
	Post-Hospital Days =	*0-30*	*30-60*	*60-90*	*90-120*
Mobile	# of Home First clients taken into SDL				
Mobile	# clients transitioned to an SDL provider's unit and their LOS on Mobile Services				

Reporting Submission:

- 2nd Tuesday of each month
- Complete form above and submit via email to XXX
- Please ensure that your agency name is provided at the top of the form and that the date you are submitting is identified in the column to the right

Indicator Definition Explanation

The indicators provided on the reporting form are those that are most important to identifying impact on the ALC/ER/LTC diversion agenda. Definitions have been incorporated into the indicator as much as possible (see chart). However, in some circumstances, greater clarification is needed.

INDICATOR	DEFINITION
# of ALC clients taken out of hospital into SDL (not previously SDL clients – new)	• Straight count of clients that have come onto SDL service and who have been designated "ALC Patients" by the hospital • Clients were not previously SDL clients – new to service • Clients come either directly from hospital to SDL services (hospital referral) or come via referral from CCAC or are transferred from CCAC service to SDL within 14 days post hospital discharge
# of general hospital clients taken into SDL (not inclusive of ALC – not previously SDL clients – new)	• Straight count of clients that have come onto SDL service from within the general hospital population –have not been designated ALC • Clients were not previously SDL clients – new to service • Clients come either directly from hospital to SDL services (hospital referral) or come via referral from CCAC or are transferred from CCAC service to SDL within 14 days post hospital discharge
# of ER visits diverted (24 hour response)	• Straight count of the number of visits that were diverted from the ER by SDL clients on service • Anytime that the SDL service being provided has prevented the ambulance from having to respond to a call (would otherwise have responded if SDL was not in place) • Anytime that the SDL service being provided has allowed the ambulance to treat and release the client back to the service (would otherwise have transported the client to ER if SDL was not in place) • Anytime that staff have been able to avoid injury to a client (assuming that the injury had the potential to be treated in ER) as a result of the SDL service being in place
# of clients returned back to SDL from hospital (clients on SDL services prior to hospitalization)	• Straight count of clients that are already on SDL service at the time of hospital admission and who returned "home" to their residence and continued on SDL services • Each time a client on service enters hospital and returns to SDL services, this client is counted – multiple entries and discharges/frequent admissions and discharges

INDICATOR	DEFINITION
# of clients taken out of LTC homes into SDL	• Straight count of clients where the previous residence was a LTC facility – client now coming onto SDL services – moved out of LTC facility
# of clients diverted from LTC (may or may not be waitlisted – avoidance of crisis placement)	• Straight count of clients that, as a result of coming onto SDL services, were delayed from entering a LTC facility – as a result of caregiver stress or other factors, clients were in a situation where they would have been crisis placed into a LTC facility unless SDL services were available • Clients are counted once and once only (eg: if a client has entered hospital more than once and each time the client has been in danger of a LTC admission coming out of hospital, the client is still only counted once as a diversion from LTC as a result of being on SDL services or initially coming onto SDL services) • If clients who fit this category also came off of the LTC waitlist (following CCAC confirmation), then the same client is counted once in this category and once in the following category - # of clients that came off of the LTC waitlist).
# of clients that came off of the LTC waitlist	• Straight count of clients that, as a result of coming onto SDL services, had their name removed from the LTC waitlist – in order to count, this removal must be confirmed with the CCAC Case Manager • This count would also include clients that have died while on service
** Turnover rate of clients (defined as: leaving SDL) **Please specify destination (eg: Death, placement, etc.)**	• Straight count of clients that leave SDL service as a result of death or having been placed in a LTC facility or having gone with family – essentially anyone who leaves SDL service and where they went

SDL Monthly Report (MOBILE)

Mississauga Halton LHIN

Reporting Period	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	YTD
Impact on Hospital (ER, ALC, General Beds													
# of ALC Clients taken out of hospital into SDL (not previously SDI Clients - new)	0	0	0	0									0
# of general hospital clients taken into SDL (not inclusive of ALC clients - not previously SDL clients -	30	16	2	0									48
Total number of clients taken out of hospital in SDL (new - not previously SDL Clients	30	16	2	0	0	0	0	0	0	0	0	0	48
Number of ER visits diverted (24 hour response)	3	3	0	0									6
Number of clients on SDL service entering hospital	15	19	12	0									46
Number of clients returned back to SDL from hospital (clients on SDL services prior to hospitalization	7	10	8	1									26
Impact on LTC Homes													
Number of Clients taken out of LTC homes into SDL	0	0	0	0									0
Number of clients diverted from LTC (may or may not be waitlisted - avoidance of crisis placement	0	0	0	0									0
Number of clients that came of LTC waitlist	0	0	0	0									0
Discharge Disposition													
Discharged into other SDL Program	4	7	11	4									26
Deceased	0	4	0	0									4
Hospitalized	0	5	1	4									10
Discharged LTC	2	3	0	0									5
Improved and no longer required service	6	3	7	0									16
No longer eligible for service	0	8	0	2									10
Other	2	1	3	1									7
Total	14	31	22	11	0	0	0	0	0	0	0	0	78
Specialized Reporting Requiements													
Number of "Restore" patients taken into SDL	0	2	0	0									2
Number of hospital patients dicharged and resettled at home with Mobile services	0	0	0	0									0
Number of hospital ED patients discharged and resettled at home with Mobile services	0	0	0	0									0
Number of Home First clients taken into SDL	0	0	0	0									0
Number of clients transitioned to an SDL providers unit	4	7	11	4									26

SDL Monthly Report Definitions:

Number of ALC clients taken out of hospital into SDL (not previously SDL clients - new)
This is a straight count of clients that have come on to the SDL service and who have been designated "ALC patients" by hospital
These are clients that were not previously SDL clients - they are new to service
The client has come either directly from hospital to SDL services (hospital referral) or via referral from CCAC or have been transferred from CCAC service to SDL within 14 days of discharge from hospital

Number of general hospital clients taken out of hospital into SDL (not previously SDL clients - new- not designated ALC)
This is a straight count of clients that have come on to the SDL service from within the general hospital population - they have not been designated ALC
These are clients that were not previously SDL clients - they are new to service
The client has come either directly from hospital to SDL services (hospital referral) or via referral from CCAC or have been transferred from CCAC service to SDL within 14 days of discharge from hospital

Number of ER visits diverted (24 hour response)
This is a straight count of the number of visits that were diverted from the ER by SDL clients on service
This is counted any time that the SDL service being provided has prevented the ambulance from having to respond to a call. In other words if SDL service was not being provided an ambulance would have to be called and they would have responded
This is counted any time that the SDL service being provided has allowed the ambulance to treat and release the client back to service and prevent the client from being transported to the ER
This is counted any time that the SDL service being provided has prevented injury to a client, which otherwise would have had to be treated in the ER.

Number of SDL clients on service entering hospital
This is a straight count of clients that are already on SDL service that have been admitted to hospital

The client is counted each time they are admitted to hospital - calculating frequency of admissions

Number of SDL clients that return back to SDL service post discharge from hospital
This is a straight count of clients that are already on SDL service that have been admitted to hospital and are returning "home" to their residence and are continuing with SDL service

Number of clients that were taken out of LTC homes and put on SDL service
This is a straight count of clients who are now on SDL service whose previous residence was a LTC facility

Number of clients diverted from LTC (may or may not have been waitlisted - avoidance of crisis placement
This is a straight count of the number of clients on SDL service who were delayed from entering a LTC facility
As a result of caregiver stress or other factors the client was in a situation where they would have been crisis placed into a LTC facility if SDL services were available.
Clients are counted only once. For example if a client has entered hospital more than once and each time the client has been in danger of a LTC admission coming out of hospital, the client is still only counted once as a diversion from LTC as a result of being on SDL services.
If a client who fits into this category also came off of the LTC waitlist (as confirmed by the CCAC) then the client would be counted once for the LTC waitlist removal and and once for the LTC diverted count

Number of clients that came off of the LTC waitlist
This is a straight count of clients who have had their name removed from the LTC waitlist as a result of coming on to service with SDL.
In order for this to count this removal must be confirmed with the CCAC case manager.
This count would also include clients that have died while on service

Discharge Disposition
This is a straight count of clients that leave SDL service. This just indicates where the client went.

SDL Quarterly Report

Mississauga Halton LHIN

Reporting Period	Q1: Apr 1- Jun 30th	Q2: Jul 1- Sept 30th	Q3: Oct 1- Dec 30th	Q4: Jan 1- Mar 30th	YTD
	Admissions				
Hospital	47				47
Another Community HSP	1				1
Community					0
CCAC					0
LTC Waitlist					0
LTC Home					0
Total Admissions	48	0	0	0	48
	MAPLe Scores				
5	5				5
4	33				33
3	10				10
2					0
1					0
Average Admission MAPLe score	3.9	#DIV/0!	#DIV/0!	#DIV/0!	3.9
	CHESS scores				
5	0				0
4	0				0
3	8				8
2	19				19
1	16				
0	5				5
Average Admission CHESS score	1.4	#DIV/0!	#DIV/0!	#DIV/0!	2.1
	Age				
19-64	2				2
65-74	12				12
75 and older	34				34
% 75 years and older	71%	#DIV/0!	#DIV/0!	#DIV/0!	71%
	Gender				
Male	15				15
Female	33				33
% of Male Admissions	31%	#DIV/0!	#DIV/0!	#DIV/0!	31%
% of Female Admissions	69%	#DIV/0!	#DIV/0!	#DIV/0!	69%
	Referrals				
Hospital	45				45
Restore Program	2				2
Non - Hospital					0
CCAC					0
CSS Provider	1				1
Other					0
Total Referrals	48	0	0	0	48
	General Stats				
Client Capacity	168				168
Total Clients on Service	186				186
Total Discharges	67				67

SDL Quarterly Report Definitions:

Client Summary Tab

Admissions:
This is the number of new clients that have come on to SDL service for the quarter, when including this count please indicate where the client is coming from. For example if they were previously living in your building but were not on service they would be counted as an admission from the community.

RAI -Score
This is the MAPLe scores of only those clients that have been accepted and received SDL service. All other clients who may have been assessed but not accepted should **not** be included. The average is calculatd by a pre-populated formula.

CHESS -Score
This is the CHESS scores of only those clients that have been accepted and received SDL service. All other clients who may have been assessed but not accepted should **not** be included. The average is calculated by a pre-populated formula

Admission Age
This is the age of the clients that have been accepted and received SDL service for the quarter. This is only those clients that have been accepted on to SDL service for that quarter

Age Group	*Total # of SDL Clients*
less than 65	
65-74	
75-84	
85+	
% 75+	**#DIV/0!**

Referrals:
This is a count of referrals and where they were recived from.

Client Capacity:
This is the number of clients that you have been approved to accept on to SDL services at any given time for the

Total Number of SDL Clients Discharged:
This is the total number of clients stop recieving SDL service and are discharged from the SDL program for the fiscal year. Fiscal 2009/10 is from April 1, 2009 to March 31st, 2010 and fiscal 2010/11 is April 1, 2010 to March 31, 2010.

Total Clients on Service
This is a count of the total number of clients that received SDL service for that quarter. This includes both those that may not be reciveing service currently but did receive service at some point during the quarter as well as those that are currently receiveing service

Total Discharges
This is a count of the total number of clients that are no longer recieving SDL service currently but did receive service at some point during the quarter.

MH LHIN SDL Service Provider and LHIN Contact List

SDL Service Provider & LHIN	Contact	Contact Information
MH LHIN	Judy Bowyer	judy.bowyer@lhins.on.ca
M.I.C.B.A. Forum Italia Community Services	Nancy Caro	ncaro@forumitalia.ca
Nucleus Independent Living	Lisa Gammage	lisa@nucleusonline.ca
Oakville Senior Citizens Residence	Angela Katunas	akatunas@oakvilleseniors.com
Ontario March of Dimes (Etobicoke)	Marilyn Daley	mdaley@marchofdimes.ca
Peel Senior Link	Ray Applebaum	ray@peelseniorlink.com
Region of Halton	Karen Aikman	karen.aikman@halton.ca
Victorian Order of Nurses – Peel	Caroline Countryman	caroline.countryman@von.ca
Yee Hong Centre for Geriatric Care	Angela Lui	angela.lui@yeehong.com