Waterloo Wellington **LHIN**

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Integrated Assisted Living Program

CHCA Home Care Summit– Oct. 24 - 26 2011

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Presentation Overview

Highlight a CCAC managed model for the delivery of Assisted Living, including:

- Why this model?
- What are the guiding principles and program goals?
- What is IALP – core services, target population?
- How is program being evaluated?
- Client Stories

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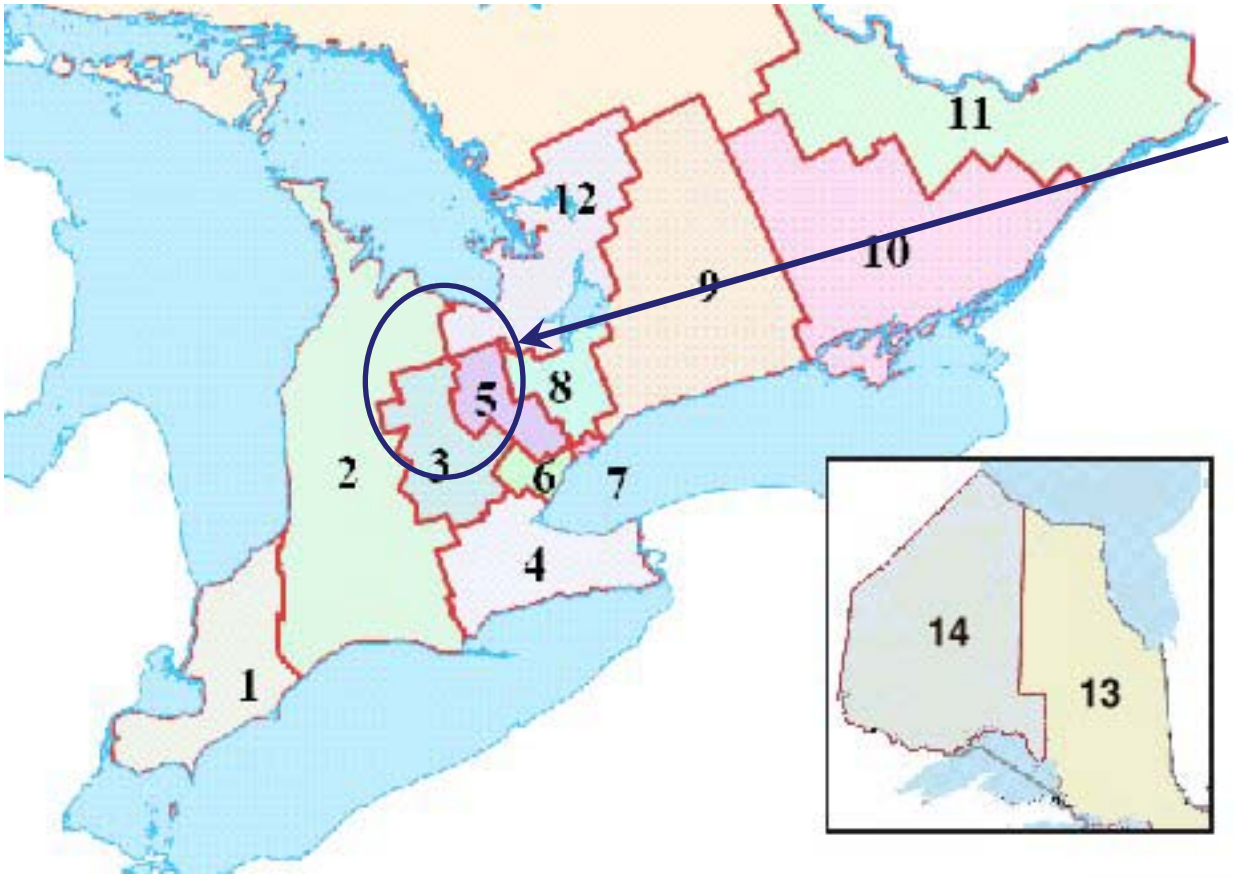

LHIN Areas:

1. Erie St. Clair
2. South West
3. ***Waterloo Wellington***
4. Hamilton Niagara Haldimand Brant
5. Central West
6. Mississauga Halton
7. Toronto Central
8. Central
9. Central East
10. South East
11. Champlain
12. North Simcoe Muskoka
13. North East
14. North West

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Healthcare in Ontario - Roles

- The Ministry provides stewardship to the system by setting provincial standards and priorities and monitoring health outcomes

- The WWLHIN provides local health system management including planning, integrating, coordinating and funding 77 health service providers

- Health Service Providers provide leadership and management of their organizations within the WWLHIN structure

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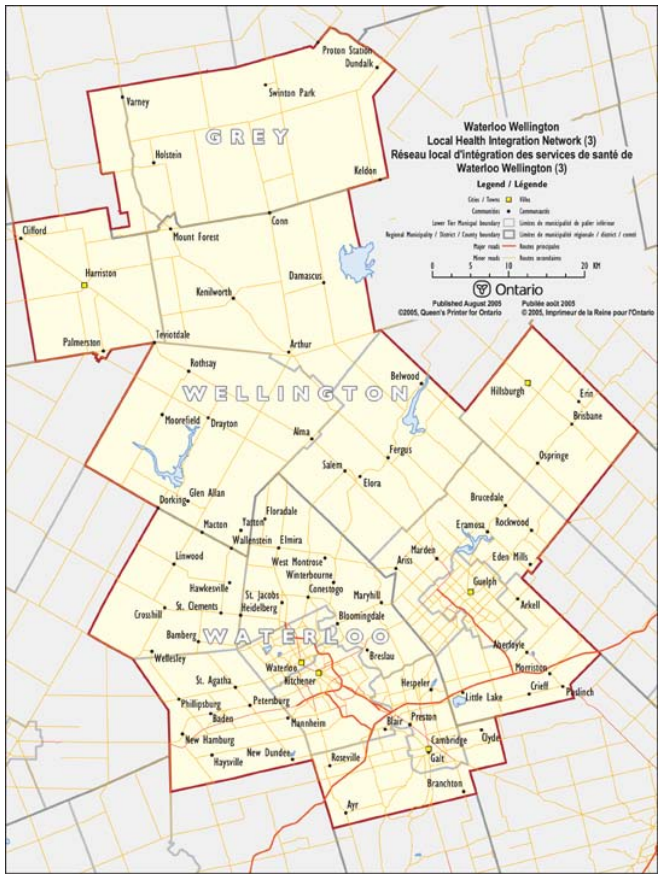

- Population: over 730,000
- 90% rural geographic base
- 12% of residents age 65+

The health service providers provide programs and services in one or more of the following sectors:

- 1 Community Care Access Centre
- 4 *Community* Health Centres (with 4 satellites)
- 21 Community Mental Health and Addictions Services
- 33 Community Support Services
- 8 Hospital Corporations (10 hospital sites)
- 34 Long Term Care Homes

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Community Care Access Centre (CCAC)

- 14 CCACs in communities across Ontario
- Local point of access to community-based health and support services
- Assess and coordinate health and support services to support people of all ages to remain at home as long as possible or return home safely from hospital
- Assist in planning and making informed choices about health care options
- Assist with Long-Term Care Home admissions
- Funded by Ministry of Health and Long Term Care through Local Health Integration Network

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Background

- Waterloo Wellington Seniors Supportive Housing Initiative researched and proposed models for supportive housing (report submitted Spring 2009)

- Aging at Home funding – innovative solutions to support seniors aging at home; reduce ALC, prevent ED visits

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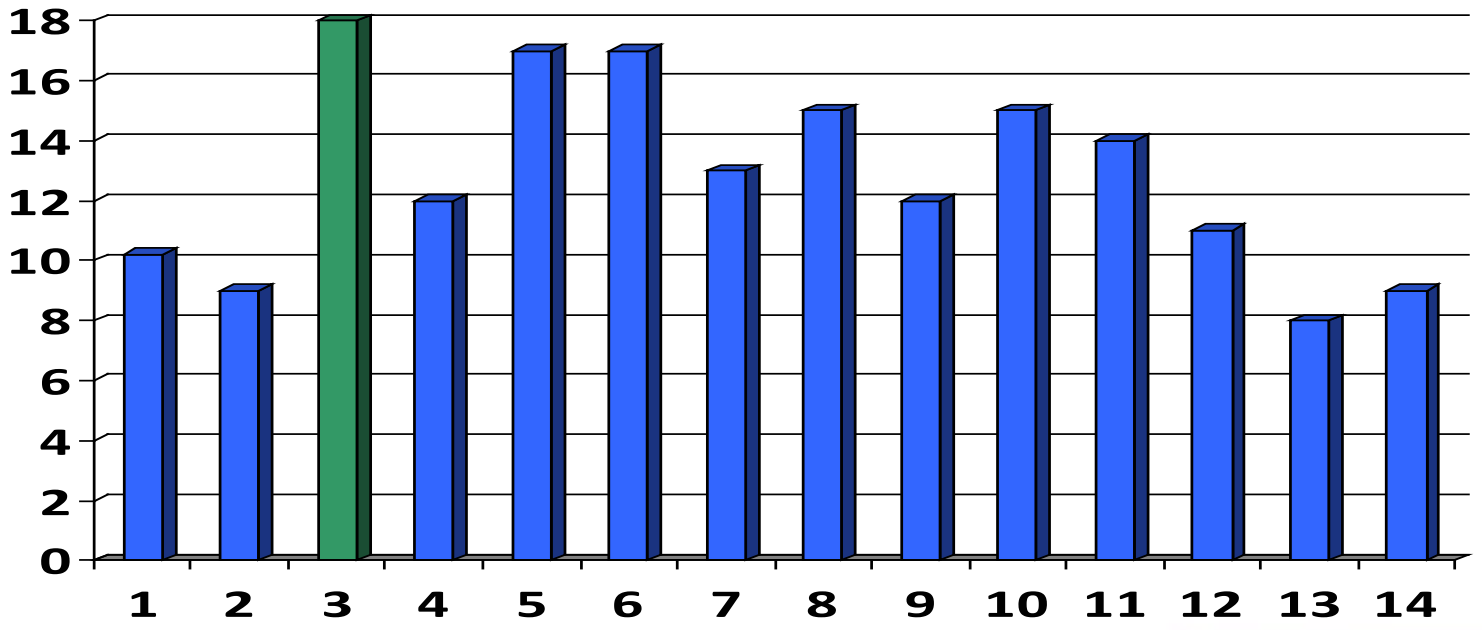
The Need for Supportive Housing

- WWLHIN LTC highly utilized:
  - One of shortest LTC LOS in province (2.6 yrs vs. provincial 3.0 yrs)
  - One of the highest occupancy rates in province (99.3%)

- Need for more options to assist seniors to remain at home
  - Highest proportion of community caseload with "Very High" (Category 4) RAI Scores in the province. Lowest proportion of "Low" (Category 1) RAI Scores.

- Very limited traditional seniors supportive housing (30 units opened February 2010)

Category 4 RAI Scores in Community (16+)



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Quick Start

"Quick Start" Supportive Housing

- Assisted living services for seniors similar to traditional "supportive housing" basket of services but in the senior's home of choice

- Able to deliver to more people without waiting for infrastructure

- CCAC uniquely positioned to provide services

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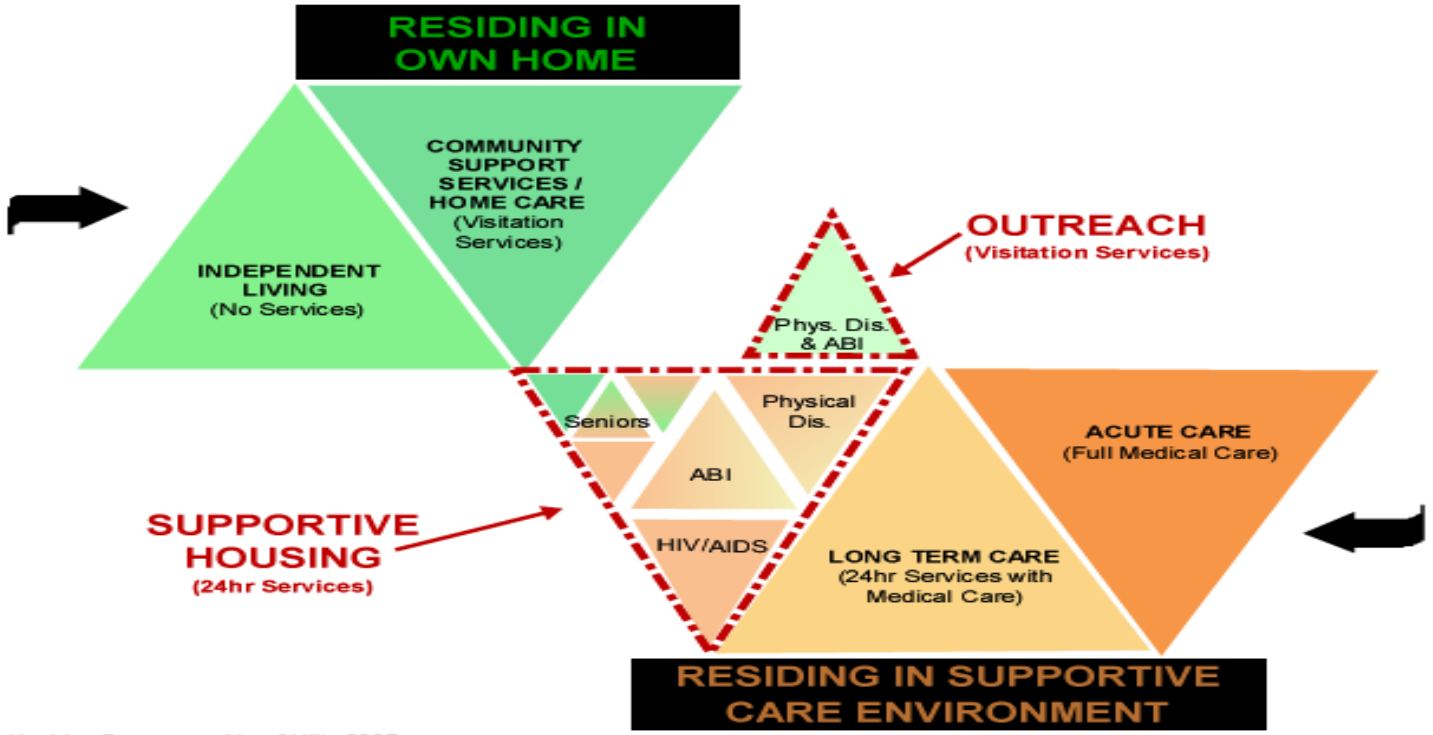
Integrated Assisted Living Program

- Aging at Home Year 2
- $5M budget
- 8 neighbourhoods, 6 urban and 2 rural
- Approx 30 clients per neighbourhood area

Continuum of Care



Developed by Lisa Gammage, Nuc-Ability 2007

IALP neighbourhoods

Chosen based on the analysis of a number of data sources linked to postal codes:

- Seniors Supportive Housing & Wellness Initiative
- Emergency Department visits and length of stay
- RAI-HC assessment data – MAPLe score and age
- Consultation with Case Managers

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Purpose

- Flexible personal support and homemaking services to support aging in place
- Basic activation, recreation needs met through access to appropriate services and programs
- Supports maintenance and/or enhancement of health outcomes

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Guiding Principles

Achievable	Innovative
Sustainable	Flexible
Evidence based	Stable
Individualized	Self-Help

Design Principles

Design processes that:

- Meet demand and need
- Deliver client value and demonstrate outcomes
- Are robust and reliable
- Use existing infrastructure (or evolve existing infrastructure)
- Maximize use of information technology
- Minimize all types of waste
  - Reduce duplication
- Achieve system goals (Alternate Level of Care, Emergency Department)
  - Design to "pull" not "push"

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Goals

- Enhanced client functioning through the provision of consistent care, services, and restoration programs and activities

- Flexible service, respecting client's autonomy and preferences

- Positive client experience as a result of enhanced level of support and activation e.g. wellbeing, quality of life

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Goals

- Prevent premature LTCH placement
- Eliminate unnecessary ED visits and medically unnecessary hospitalizations
- Cost effective service delivery that supports an integrated system and optimizes the use of Community Support Services

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Target Population

- Adults 65 years or older (or 55 years or older with an age related health condition)
- Reside in an IALP designated neighbourhood
- Have a valid Ontario Health Card
- Require the availability of assistance 24/7 to meet service needs and to support aging in place as needs change
- Have limitations in Activities of Daily Living which are most effectively met by frequent, short interventions throughout the day

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Target Population

- Have complex needs and are at risk for admission or readmission to acute care or Emergency Department
- May have cognitive impairment but are able to direct own care with minimal cueing or have a live-in caregiver who is able to direct care
- Predominately clients with a Moderate or High RAI-HC MAPLe score

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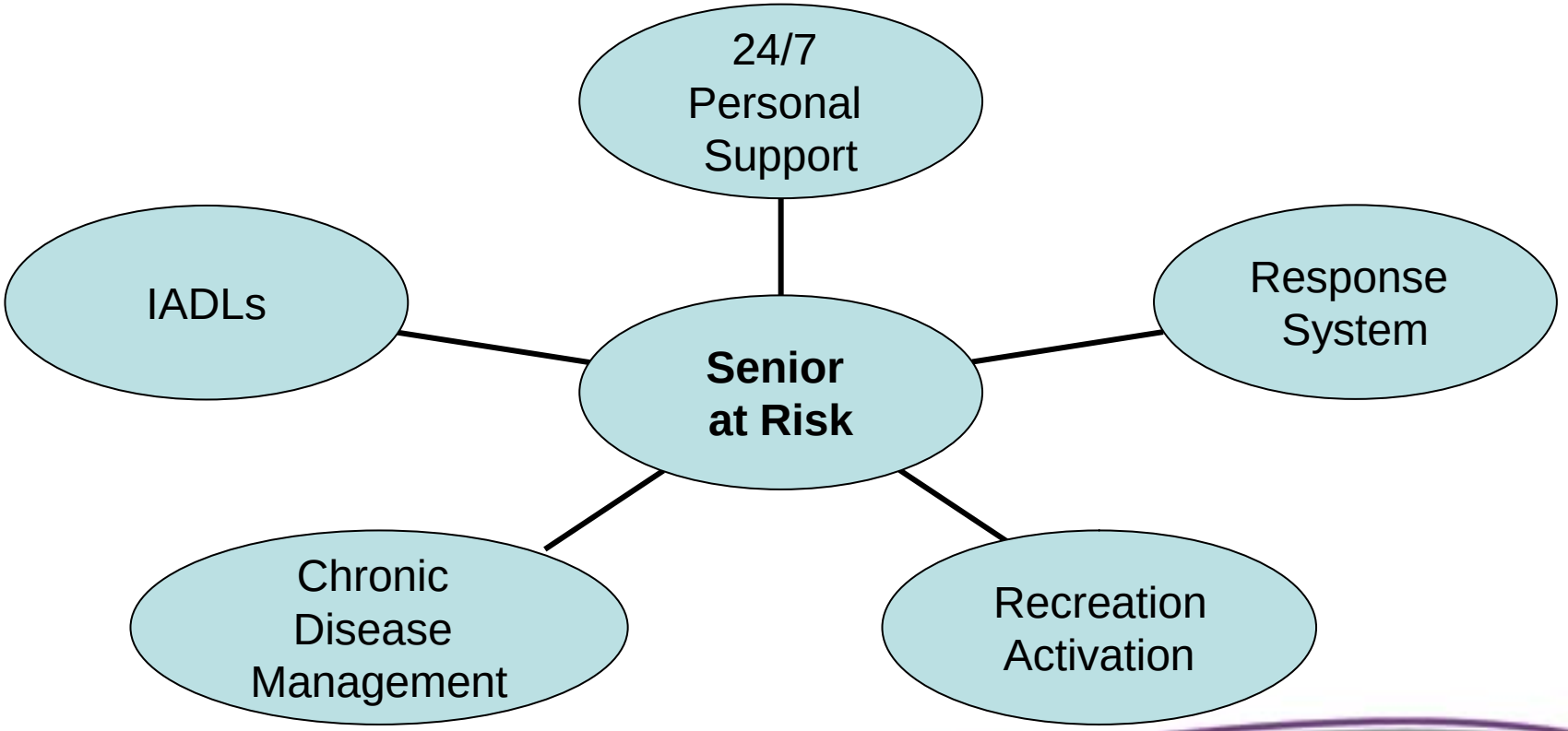
Services



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Core Services

- Availability of personal support services 24 hrs, 7 days per week
- PSW staff have the flexibility to respond to scheduled and unscheduled needs of client (cluster care model)
- Agencies paid a standard rate per client per day

Core Services

Personal Emergency Response System

- Allows for PSWs to respond in situations when client is uncommunicative
- Early intervention, improved client outcome
- Reduces caregiver stress

Core Services

Community Resource Facilitator (CRF)

- Facilitation of and linkage to health, wellness, activation, recreation and social programs and education
- Supports client in care plan implementation
- Development of social supports
- Mentor to Personal Support staff

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Core Services

- Nutritional needs planning
- Transportation arrangements for medical and social outings (e.g. day program) and accompaniment when needed
- Case Management – Individual service plan including identification of potential for improved functioning and independence

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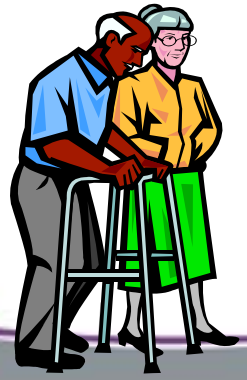
Chronic Disease Management

- Assistance and support to access appropriate community health and recreation services for seniors (e.g. primary care)

- Facilitation of general exercise programs (e.g. walking groups)
- Coaching towards self management

- Medication cueing and monitoring for compliance



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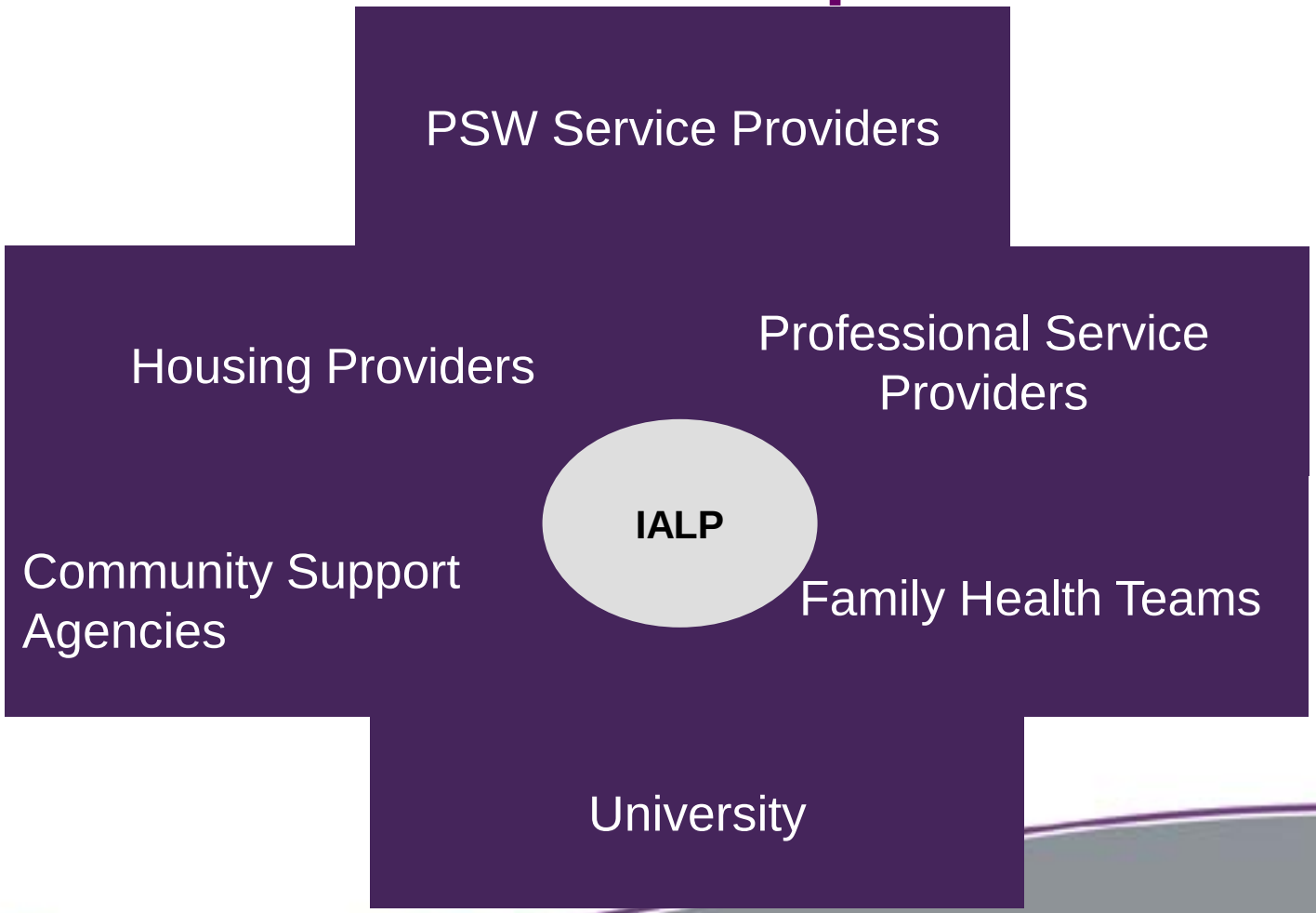
Partnerships



Evaluation

Program evaluation (University of Waterloo):

- What are the clinical outcomes as measured by RAI-HC for IALP clients compared with those with similar needs among general long stay WWCCAC?
- What is the subjective quality of life of IALP clients compared with general long stay WWCAC population?

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Evaluation

- Ipsos Reid Client Experience Satisfaction Survey – comparing IALP experience with general long stay WWCCAC client experience
- Quality of Life Client Surveys, conducted by nursing students
- Performance Measures/Objectives
- Staff Satisfaction

Year One Evaluation Results

- Female, widowed, living alone
- Less cognitively impaired than general adult long stay clients
- Less likely to be on LTCH waitlist
- Less likely to have been admitted to hospital in past 3 months

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Year One Evaluation Results

- Receive more PSW service but less nursing and therapy
- Higher percentage of PSW only service
- Higher satisfaction in comfort/environment and autonomy
- Early evidence of improved health outcomes, reduction in acute care utilization and ability to remain at home longer

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Year Two Evaluation

- Comparative report on clinical outcomes measured by RAI-HC and quality of life changes measured through the survey instrument.
- Analysis of indicators from hospital data to determine the impact of IALP model of service delivery (emerg visits, hospital admissions, ALC and length of stay in hospital)

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Year Two Evaluation

- IPSOS Reid client satisfaction survey (quarterly)
- Quality of Life survey completed by nursing students with focus on urban/rural IALP
- PSW staff satisfaction survey

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Client Success Stories

Client Success Stories

- High risk unstable diabetic senior with multiple falls. Historically non-compliant with meal plans and always called 9-1-1 after a fall.

  IALP PSW provided nutritional cueing, monitored intake and med use. When 9-1-1 appropriate, PSW stayed with client until EMS arrived, assisted client to settle at home after acute care assessment, and provided overnight monitoring.

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