# A FOCUS ON SENIORS

## **HOW ARE WE GOING TO GET IT RIGHT**?!!

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# WHAT IS INTEGRATION?

The Local Health Services Integrated Act, 2006:

- ***Aims to provide the methods to remove any gaps or areas of duplication in health services, improve health care encounters and health outcomes for individual clients and patients***

# Legislation re Integration

**Local Health System Integration Act, 2006 (LHSIA) – Key Points**

- *Creates an obligation on LHINs and HSPs to identify opportunities to integrate services*
- *Sets out ways for LHINs to integrate services with power to order integration (restrictions)*
- *Establishes requirements of HSPs initiating integration and roles to be played by LHINs*
- *Describes the requirements and processes related to integration decisions issued by LHINs*

# “Aging at Home” – Overview

- **Build a comprehensive mix of community based services to help seniors to stay healthy and live independently with dignity in their homes**

- **Increase services to help relieve pressures in hospitals**

  - **reducing waiting time for seniors in hospital Emergency Departments**

  - **helping seniors who are patients in acute hospital beds who need an Alternate Level of Care to get those alternate services, either at home or in another type of bed (long-term care, rehabilitation, complex continuing care)**

# Successful Aging at Home Initiatives-The provincial-wide LHIN perspective

- Home First
- Community stroke team
- 24 hour flexible in-home support program
- Palliative Care consultation teal
- Med. Mgte. Support services
- Integrated Assisted Living
- Integrated Geriatric Workers
- Geriatric outreach teams
- First Link
- Wait at Home
- Nurse Practitioner Outreach Team
- Congregate dining

# Aging at Home - Direct and Immediate

| Aging at Home Year 1 (2008/09) |
| --- |
| Caledon Community Services - Supportive Housing for Seniors (Bolton) |
| CANES - Home at Last Program |
| **Aging at Home Year 2 (2009/10 - 50% of funding )** |
| Caledon Community Services - Transitional Short-Stay Beds |
| Lord Dufferin Centre - Bridging You Home Program Bed |
| Richview Residence - Transitional Short Stay Respite Service |
| William Osler Health Centre - Regional Geriatric Service |

# Aging at Home - Diversion

| Aging at Home Year 1 (2008/09) |
| --- |
| Alzheimer's Society Dufferin - Family Support Worker |
| Supportive Housing in Peel - Physician / Nurse House Calls |
| William Osler Health Centre - LTC Nurse Practitioner Project |

| Aging at Home Year 2 (2009/10 - 35% of funding) |
| --- |
| Alzheimer Society Dufferin - Seniors Mental Health Case Mgmt |
| Caledon Community Services - Enhance Supporting Living (Bolton) |
| CANES - Community Care Respite Services |
| Cheshire Homes Peel - Behavioral Management Support |
| Supportive Housing in Peel - Integrated Service Teams for Seniors |
| William Osler Health Centre - Outreach Transition Team |

# Aging at Home - Prevention

| Aging at Home Year 1 (2008/09) |
| --- |
| Alzheimer's Society - Dufferin Caregiver Support and Seniors Telechek |
| Bramalea CHC - Seniors Community Health Programs |
| Caledon Community Services - Transportation and Volunteers |
| CANES - Home Maintenance, Homemaking and Transportation |
| Central West CCAC - Balance of Care Study and Hotline Dev't |
| Dufferin Community Services - Transportation and Congregate Dining |
| Region of Peel - Expanded Adult Day Services |
| Rexdale CHC - Ethnocultural Services for Seniors |
| Richview Residence Supportive Housing - Congregate Dining Program |
| Supportive Housing in Peel - Services for South Asian Seniors |
| |
| Aging at Home Year 2 (2009/10 - 15% of funding) |
| CANES - Somali Seniors Adult Day Program |
| Dufferin Oaks - Bathing Program and Transportation Escort |
| Region of Peel - Adult Day Program Enhancement |

# Central West LHIN: India Rainbow Community Services of Peel Adult Day Program and Supportive Services

- Services for high need - frail-elderly and cognitively impaired diverse South Asian seniors with chronic diseases
- Culturally appropriate and language specific service
- Specialized care for Alzheimer's
- Client-centered unique needs – dietary, toileting, medication
- Respite, support, education, counseling for caregivers
- Friendly Visiting; Seniors Wellness
- Clinics - Foot care, diabetes, falls prevention, etc.
- Crisis intervention and support - Transportation assistance

# Comprehensive Exercise Program


# Benefits and Outcomes

- Reducing ER visits and social isolation, promotes healthy aging
- Addressing the ALC – early detection of chronic diseases
- Comprehensive assessment – identify risks – early interventions
- Reducing falls and re-admission to ER – appropriate level of care
- Preventing early institutionalization – client-centered “timely” access to services
- Reducing service gaps – assessment at the Hospital – early discharge

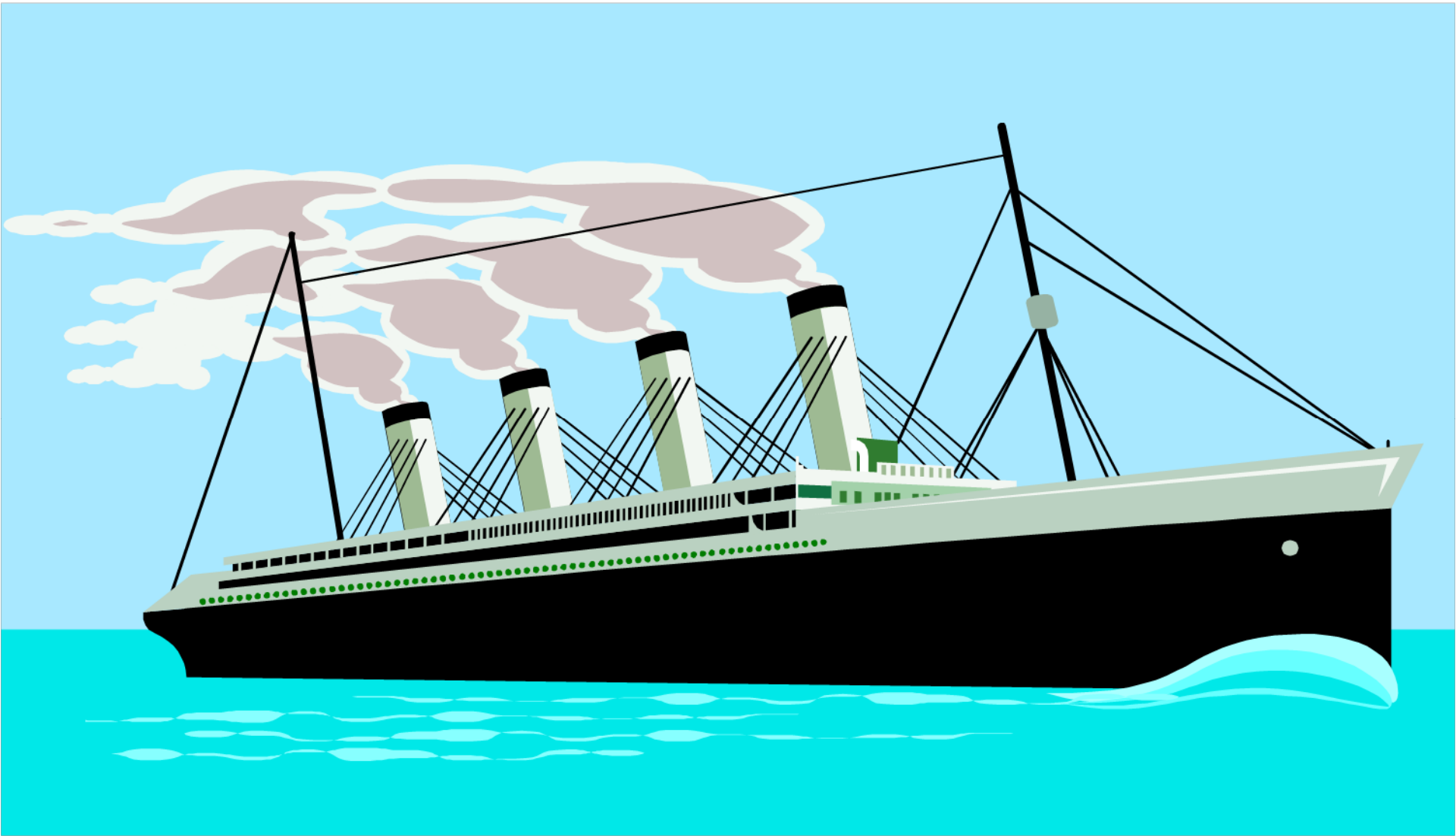
# Central West LHIN – “TeleCheck”

- TeleCheck is an innovative program where trained volunteers call seniors each day as a “check in” and as a social call
- Anyone 55 years of age and over can use this unique program free of charge and receive daily phone calls to make sure they are managing in their homes and that they do not need any assistance
- TeleCare Distress Centre runs the service and is celebrating 37 years of providing emotional and crisis line support to community members
- The TeleCheck program has services available in English, Punjabi, Hindi, Urdu, Spanish and Portuguese
- TeleCheck partners with many other providers in the community and clients are referred to the program from agencies such as the Central West CCAC, William Osler Health System, Peel Senior Link, the Salvation Army, the Fibromyalgia Group and the Alzheimer Society

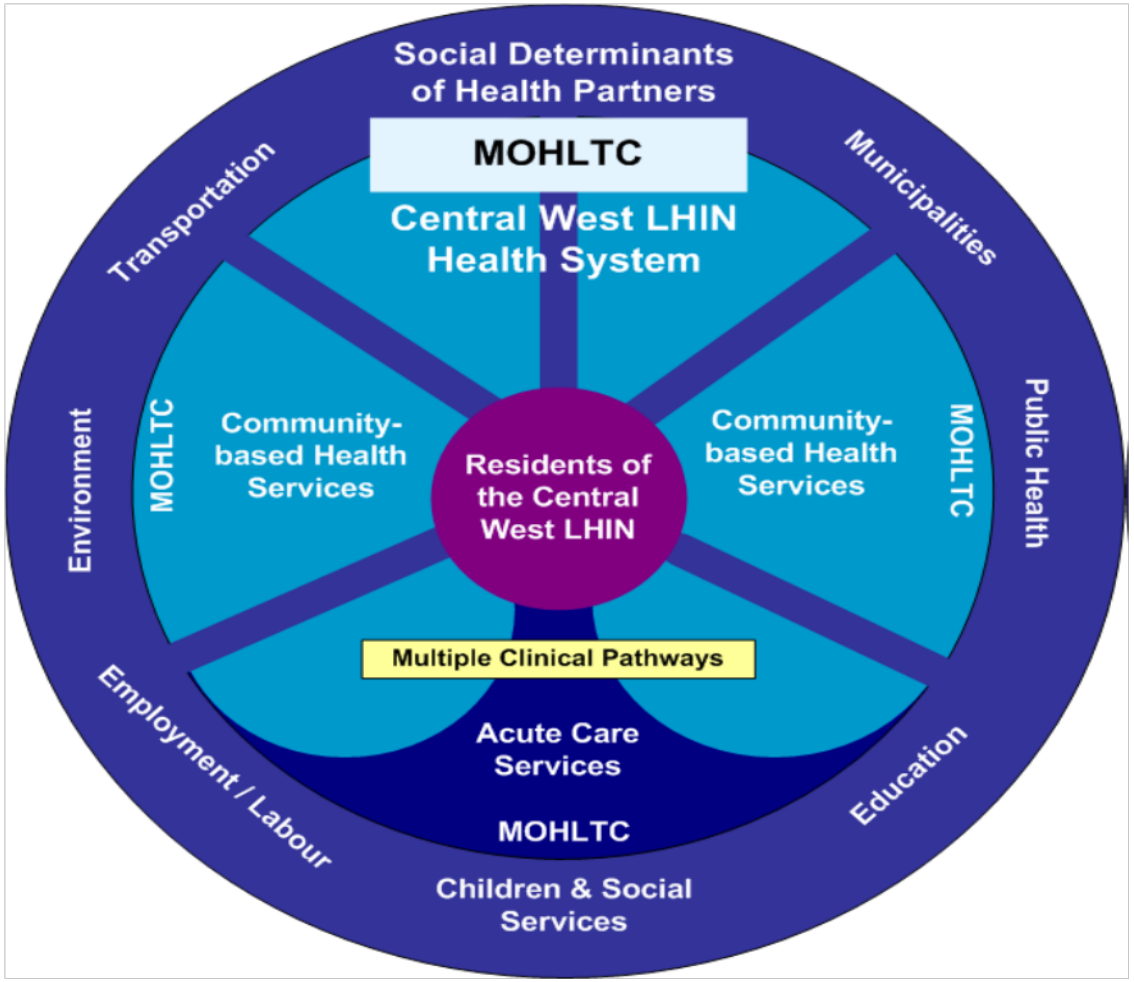
# Central West LHIN – "TeleCheck" - (cont'd)

- Currently, 33.5% of TeleCheck clients are 65-75 years of age and experiencing multiple health care issues that relate to physical health, lack of mobility, mental health and, above all, feeling isolated while living at home
- Many clients get medication reminders and thereby avoid unnecessary trips to hospital ERs due to symptoms associated with irregular medication use
- The staff at TeleCheck provide educational tips to help seniors avoid injuries due to calling and also talk about diabetes and heart care with their clients. They are constantly striving to empower their clients so they can live as fully as possible and as safely as possible in their homes

# Turning the Titanic Takes Time



# Health System Plan



# What does IHSP2 say about Primary

**Expanded team-based primary health care with different health professionals working together to ensure care is there for all residents, is built upon the needs of the LHIN's diverse communities, is connected through information technology, and is linked to community and acute care services.**

**Rationale**

- Health System Plan highlighted need to strengthen primary care and services in the community as close to home as possible
- Health System Plan presented the primary care model of the "Health and Care Centre"

**Expected Results**

- Increase in the number of primary care services
- Increase the number of residents with a primary care physician
- Develop a new primary care model in Bolton and Shelburne

# Health and Care Centres

- **Health System Plan presents a new model of community-based services – the Health and Care Centre**
- **Health and Care Centres should be developed based upon the specific needs of the local community**
- **One of primary gateways to accessing health system**

# Health and Care Centres

- **Foster and facilitate a holistic approach to health, encompassing many factors that affect people's health**
- **Focus on health promotion, disease prevention, healthcare treatment, self-management**
- **Could include geriatrics, mental health, addictions, rehabilitation, women's health, children's health**

# Health and Care Centres

- **Potential to collocate a range of healthcare professionals to integrate a broad spectrum of services at a single location to support improved access and service**
- **Linked through e-technologies to bring together health care professionals (Family Physician, Nurse Practitioner, groups practices)**
- **Could be managed by existing health service providers or could be offered by a new provider**

# CRITICAL SUCCESS FACTORS

- DRIVEN BY A PATIENT/FAMILY CENTRED AGENDA
- CITIZEN ENGAGEMENT
- GUIDED BY EVIDENCE-BASED DECISION MAKING
- EVALUATION
- GOVERNANCE ENGAGMENT
- BUILDING TRUST
- INTEGRATION FOCUS

# Building a New and Sustainable Direction

# WHAT NEEDS TO CHANGE?

- REMOVE LEGISLATIVE BARRIERS
- TURF AND SELF INTEREST
- STOP PILOTVILLE
- INCENT ADOPTION OF “BEST PRACTICE” (CONSIDER STICK AS WELL)
- “SENIORS FRIENDLY” HEALTH PROFESSIONAL INTERPROFESSIONAL EDUCATION
- REDEFINE SENIOR’S POTFOLIO IN THE GOVERNMENT STRUCTURE

**Leading health system integration for our communities…..**

***"We can't solve problems by using the same kind of thinking we used when we created them"***

***Albert Einstein***