Peel Senior Link
helping seniors live independently

‘Assisted Living Services for High Risk Seniors’

Supports for Daily Living - Hub & Spoke Site Visit & Orientation

MOH&LTC Policy Team & MHLHIN Staff & Board

Raymond Applebaum, CEO

# Supportive Housing Journey - Peel/Halton Regions

Stage 1 - Early Years

Stage II – Transition Years

Stage III – ‘Supports for Daily Living’  Innovative Regional Service Delivery Model

# Early Years – Key Milestones 1991 – 1996 Peel Senior Link


- Establishment of Seniors' Day Programs
- Service Coordination in rent-geared-to-income seniors' buildings in Malton as a pilot project with Peel Regional Housing Authority
- Formation of new Not-For-Profit Corporation – Peel Senior Link (PSL) – Funding acquired by Long-Term Care (LTC) Area Office and Commissioned report by Sandi Pelly & Associates in collaboration with the Region of Peel
- Day Service Coordination Model – 14 Buildings

# Transition Years – Key Milestones 1996 – 2007 Peel Senior Link

- LTC Area Office supports the expansion of programs to include provision of on-site services, 12 hours per day, 7 days per week in 3 seniors' buildings located in Mississauga; program evaluation with the Centre for Research & Education in Human Services; agency contracts Health Care Aides and Home Helpers with Victorian Order of Nurses (VON) to provide personal support and homemaking; expansion of day service
- 12 hours on-site support to 16 hours
- 16 to 24 hour on-site support (2 pilot sites); study with Centre for Research & Education in Human Services
- Approval of a formal partnership with Peel Living

# The Journey Continues…

- Launched a private sector building location with family and seniors
- Engaged a regional pharmacy for the provision of Blister Pack medication assistance for PSL 24/7 clients; VON decides to not renew their service contract and PSL hires its own front line workforce (Personal Support Workers (PSWs) and Home Helpers); and contracted Spectrum Health Care to provide clinical advice and support for delegated act training, and in-service education

# The Journey Continues…

- Transitioned remaining sites to 24/7; and transitioned client/staff  from private building to existing service locations
- Comprehensive Policy and Procedures Manual
- Partnership with Pioneering Technology and Peel Living with Brampton Foundation support to facilitate the Safe-T-Element Program which has since been adopted by Peel Living
- Led the development of the Bramalea Community Health Centre & Diabetes Education Teams

# ‘Supports for Daily Living’ Innovative Regional Service Delivery Model – Key Milestones
# 2007 – 2014 SDL & Supportive Housing Collaboration

- Developed the Supports for Daily Living (SDL) innovative service model as one of three Health Service Providers (HSPs) in collaboration with the Mississauga/Halton Local Health Integrated Network (MHLHIN) – SDL Resource, Standards Manual, and Video
- Major Impact on the development of provincial policy – ‘Assisted Living Services for High Risk Seniors Policy 2011’
- Early adoption of the Inter-Rai Community Health Assessment (CHA) as common assessment tool
- Aging at Home allocations to expand hub & spoke model

# The Journey Continues…

- Approval by Peel Living to increase the original formal agreement from 15 to 30 clients per building location
- Enhanced service partnerships and improved transitions amongst health system providers, e.g. specialized geriatric services, mental health & addictions, primary care (Health Links), behavioral support, end of life/palliative, etc.
- 3M Health Innovation Award
- Minister's Medal Award – Honouring Excellence in Health Quality and Safety
- Partner HSP with 5 Health Links (3 in Mississauga and 2 in Brampton)

# What's new and different in SDL from Supportive Housing?

- Innovative Regional service delivery model that targets high risk seniors with complex needs in their homes
- Access to frequent, urgent and intense personal supports available throughout a 24-7 period/365
- Serves seniors in designated buildings and surrounding neighbourhoods in homes, apartments, town homes etc.

# What's new and different in SDL from Supportive Housing?

- Both scheduled visits and on-call urgent response 24-7
- Multiple daily visits by trained personal support workers, based on individual needs/client's preferred schedule
- Daily personal care and essential homemaking to assist with activities of daily living (includes safety checks)

# Coordinated Intake (Access) and (Common) Assessment

- Mississauga Halton LHIN - Established the SDL Central Registry as a single point of coordinated access to Supports for Daily Living services within the MHLHIN, referring assessed and eligible clients to 8 HSP's (includes an SDL Mobile Transitional program), and maintains a centralized waitlist
- Expanded the Central Intake this fiscal year to include respite services assessment and referral.

# Coordinated Intake (Access) and (Common) Assessment

- Central West LHIN - Collaborate with the Central West Home & Community Care (H&CC) which serves as the single point of coordinated access to Assisted Living Services for Frail Seniors (Supports for Daily Living) services within the CW LHIN, referring assessed and eligible clients to 6 HSP's and maintains a centralized waitlist

# SDL Impact on Healthcare System


- Development of strong positive working relationships among H&CC, Acute Care, Community Support Services (CSS) services and SDL providers
- Strong integrated and coordinated approach to providing SDL services
- Increased recognition of valuable role CSS services can play in meeting healthcare system needs
- Proven value of common assessment and sharing information

# MH LHIN SDL Impact


- SDL has helped nearly 3,000 high needs seniors in their homes and for this reason avoided placement in long-term care homes. This has resulted in over $17 M in savings over the past three years and continues to improve. This collaborative effort among our eight approved SDL providers provided an excellent opportunity to maximize our ability to improve support for our seniors

- Source: MH LHIN http://www.mississaugahaltonlhin.on.ca

# Gaps/Barriers/Opportunities - Examples

- Leverage the Inter-Rai CHA as the common assessment tool across sectors to establish a common health record

- Lack of medical oversight/on call consultation available to SDL providers supporting high risk seniors at home

- Need for consistency in standards amongst providers employing PSWs, e.g., medications, advanced skills, controlled acts, client behaviours, documentation

# Continued…

- Leverage mobile concept for service options e.g. lab work, dietitians, physicians/Nurse Practitioners (NPs), councillors, dental care, etc.
- Leverage Central Registry to serve as an access point and knowledge centre for all CSS services
- Falls Prevention & Exercise
- Health & Wellness program expansion
- Chronic Disease Management education and coaching
- Medication Management

# Organizational Structure

Peel Senior Link operates with a lean management structure focusing personnel resources at the site level

Currently operating 11 hub and spoke locations: 9 in Mississauga and 2 in Brampton

Each site utilizes a team of PSWs and Home Helpers lead by a Supervisor, Client Services to support approximately 35 clients per site

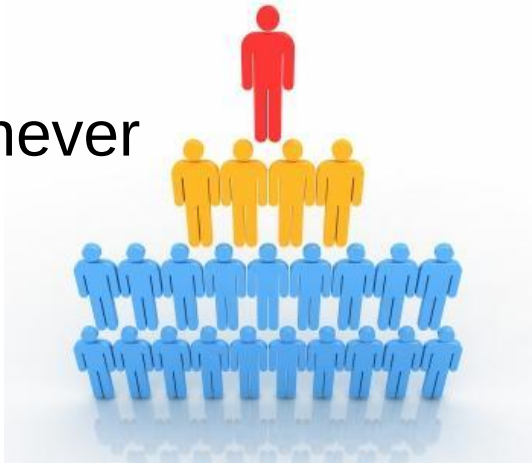
Non-medical care based on a maximum average of 90 minutes intermittent care daily

# Organizational Structure - continued

Supervisors, Client Services co-ordinate the care and services for the client

Needs are determined through the Inter-Rai CHA assessment process and conversations with the client, family (SDM), other care providers and staff along with a variety of other assessment tools

Care plans are developed and adjusted whenever the client's care needs change



# Organizational Structure - continued

The Role of the Manager, Business Units:

- Accessible support to the Supervisors
- Mentor for supervisors of client service
- Assistance/guidance with client and staff issues
- Policy interpretation ensuring consistent application of clinical/administrative policies and procedures
- PSL representation on community committees
- Assistance to the Chief Operating Officer
- Policy development/revisions and implementation regarding client and site services
- Development and implementation planning for new services/supports

# Referral process:

MH LHIN

- Via Central Registry

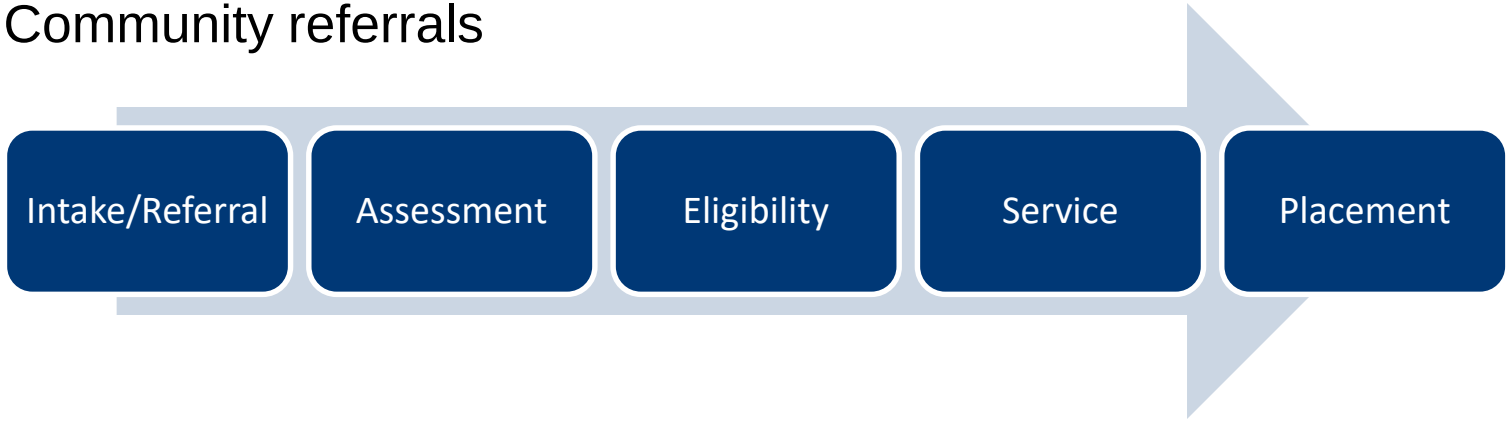
Priority given as follows:

1. to clients returning home from hospital
2. Client receiving support from Nucleus Independent Living's mobile team and also living in our catchment area
3. Community referrals

CW LHIN

- Via CW H&CC

All referrals are placed on the HPG portal



# Community Partnerships:

## Health System Partners

MH H&CC & CW H&CC
- Palliative Care support
- Wait at Home

CSS agencies

Hospitals
- Geriatric Outreach program

MH&A

MH LHIN & CW LHIN

Behavioural Support Ontario

Primary Care

Public Health e.g. Paramedics Program

## Community Partners

Peel Living

Ontario Group Homes Pharmacy
- Medication, MedsCheck
- 24 hr on-call pharmacist
- Unregulated Care Provider training

Senior Life Enhancement Centre
- Bathing Program

TENA

Emergency Response systems
- Phillips LifeLine

Meal programs
- Meals on Wheels
- Copper County

IST with SHIP and PSHS

# Advocacy – MH LHIN:

Participation on task forces, work groups, committees

Such as:

- MH SDL Leadership group
  - Policy, transitions and models of care workgroups
- H&CC collaborative
- MH LHIN Falls Prevention Collaborative
- MH LHIN Medication Management Collaborative
- MH LHIN Palliative Care Steering Committee + Knowledge Transfer Workgroup
  - PSW Competencies for Palliative Care in the Community
  - Hospice Palliative Care training via D. Ley Hospice
- Sub-region Collaboratives

# Advocacy – CW LHIN

CW LHIN Falls Prevention group

CW AL group

Sub-region Collaboratives

# Advocacy – Best practices

- Accreditation Canada
- OCSA


# Whole Person Approach to Care

Peel Senior Link works to provide care beyond the assistance with the Activities of Daily Living

What other services can we provide/arrange that will promote client wellness?

- Actively developing partnerships and proposals:
  - Community Wellness Hub
  - Nordic Walking Poles

# Whole Person Approach to Care:

Partnership with Peel Living

- PSL provides assistance with ADLs for clients but we are also available as a point of contact for all PL tenants
  - Assistance with rent reduction applications
  - Assistance with forms i.e. Canada Census
- PSL & PL work together to provide housing for clients in need i.e. living in shelters assisting them to transition to a safe home environment
- PSL co-ordinated clinics are available to clients but also tenants
  - Falls Prevention and Exercise programs
  - Income Tax clinics
  - Foot Care
  - MOW, Copper County
  - Christmas teas/annual social events

# Whole Person Approach to Care:

Social wellness via:

- Seniors Active Living Centres
- Carassauga bus trip – City of Mississauga received a Trillium grant to cover the costs of the admission and buses
- Christmas tea/annual social events
- Birthday celebrations
- Friendly visits

# Training and Development:

## Client Supervisor Meetings

- Monthly speakers
  - University of Waterloo Falls Prevention researchers
  - Health Links presentation (MH & CW)
  - Punjabi Association – cultural awareness

## Approved for funds from the PSW Training Education Fund

- Mask Fit
- Gentle Persuasive Approach
- PSW Refresher training
- All Staff training Days
  - UCP training
  - Home Helper training
  - Professionalism
  - Strategic Planning
  - Human Resources update

## Student Placement Opportunities

1. Schulich School of Business
2. Accounting Student placement
3. Partnership with Sheridan & Humber College

•Social Service Workers (5)

•Assist at site level

•Projects include:

- Cultural Resource Sheet
- Cultural client demographics
- Updating list of staff available for translation services

3. Jacobi Elliott, PhD Candidate, University of Waterloo, School of Public Health and Health Systems and Project Manager, Geriatric Health Systems Research Group – working with Peel Senior Link and Metamorphosis Network – PhD dissertation on "Productive Partnerships: Developing Patient-Provider Partnerships in Primary Care for System Navigation"

4. Partnership with Dalhousie University

•Placement for MSW student

- ❑ Cultural Competency

# Quality Improvement:

Learning Lab – OCSA – building on our culture of excellent care

- Storyboard training
- Focus on medication errors

Process Enhancement Committee

- Developing a peer review process focusing on documentation
- Forms and policy review as pertaining to care planning

Community Quality Network, Synergy West GTA Partner Agency

Accreditation process

IDEAS Project

Inter-RAI Canada Knowledge Exchange Provincial Committee

# Education & Research


1. Pelusi T, Rege S, Vitorino S. Collaborative Medication Delivery Model in Community Care. Presentation at Achieving Excellence Together 2018 – Health Shared Services Ontario Conference
2. Hendry C, Mian A, Rege S. Blockchain's role in improving outcomes in Seniors Community Care. Presentation at Blockchain in Healthcare Canada.
3. Rege, S. Getting Ready for Big Data: A Journey through Data Governance. Presentation at 3rd Annual IoT, Big Data Healthcare Summit.
4. Applebaum R. Caregiver Support. Presentation at the Probus Club of Brampton – Central Peel. April 2018
5. Pelusi T, Rege S, Vitorino S. Collaborative Approach on Medication Administration in Community Care. Poster Presentation at Health Quality Transformation 2017
6. Rege S. Seniors Care in the 21st Century: What's Changing and How Can Technology Best Serve as an Enabler? Presentation at IoT HealthCare 2017
7. Applebaum R. Client and Caregiver Quality Support – Enabling Independent Living at Home. Presentation at CARP Chapter 52, 2017
8. Toth A and Taylor A. Peel Senior Link – Program Evaluation Report. Centre for Research & Education in Human Services. August 1996
9. Applebaum R. Innovative Supports for Seniors. Ontario Non-Profit Housing Association Conference 2014.
10. Applebaum R. Senior's Health & Wellness ASSIST Model CSS. Building Community Capacity to Deliver Care Conference, June 26, 2007
11. Applebaum R. Sharing without Merging – A New Joint Venture Initiative – Ontario Community Support Association – Great Ideas Conference, October 2012
12. The Centre for Research and Education in Human Services. Peel Senior Link – Report of an Evaluation of 16 & 24 Hour Care, August 1999
13. Peel Senior Link and Sheridan College. Building Connected Communities: Reducing Loneliness and Social Isolation in Immigrants 65+ – Goal and Project Description | September 2017 Newsletter
14. Aging in Peel – Rogers TV

# Our Impact

## Our Impact 2017-2018

Total 24/7 Clients Served
**322**

New 24/7 Clients Served
**103**

Total Resident Days per Year
**117,530**

ER Visits Diverted
**103**

Savings from diverted ER
**$40,929**[1]

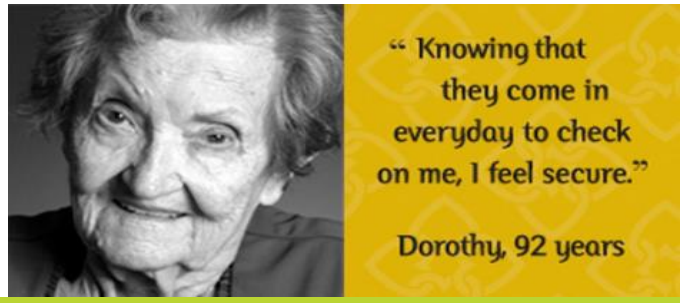
LTC Diversions
**36**

1. Seniors' Use of Emergency Departments in Ontario, 2004-2005 to 2008-2009. February 2010. Canadian Institute for Health Information

# Areas for Growth:

1. Continued evolution of the “Supports for Daily Living” program to include services for:
   - Clients with a CHA score of 1 or 2
   - Clients who require the assistance of 2 PSWs
2. Improved access to mobile dental clinics
3. Continued growth of social support programs
4. Improved transportation services
5. Continued educational opportunities for clients and staff
6. Discharge planning – preparing clients for the next step after PSL
7. Coordinated Care Plans

# Wisma Mega Indah – Sample Site – 1 of 11



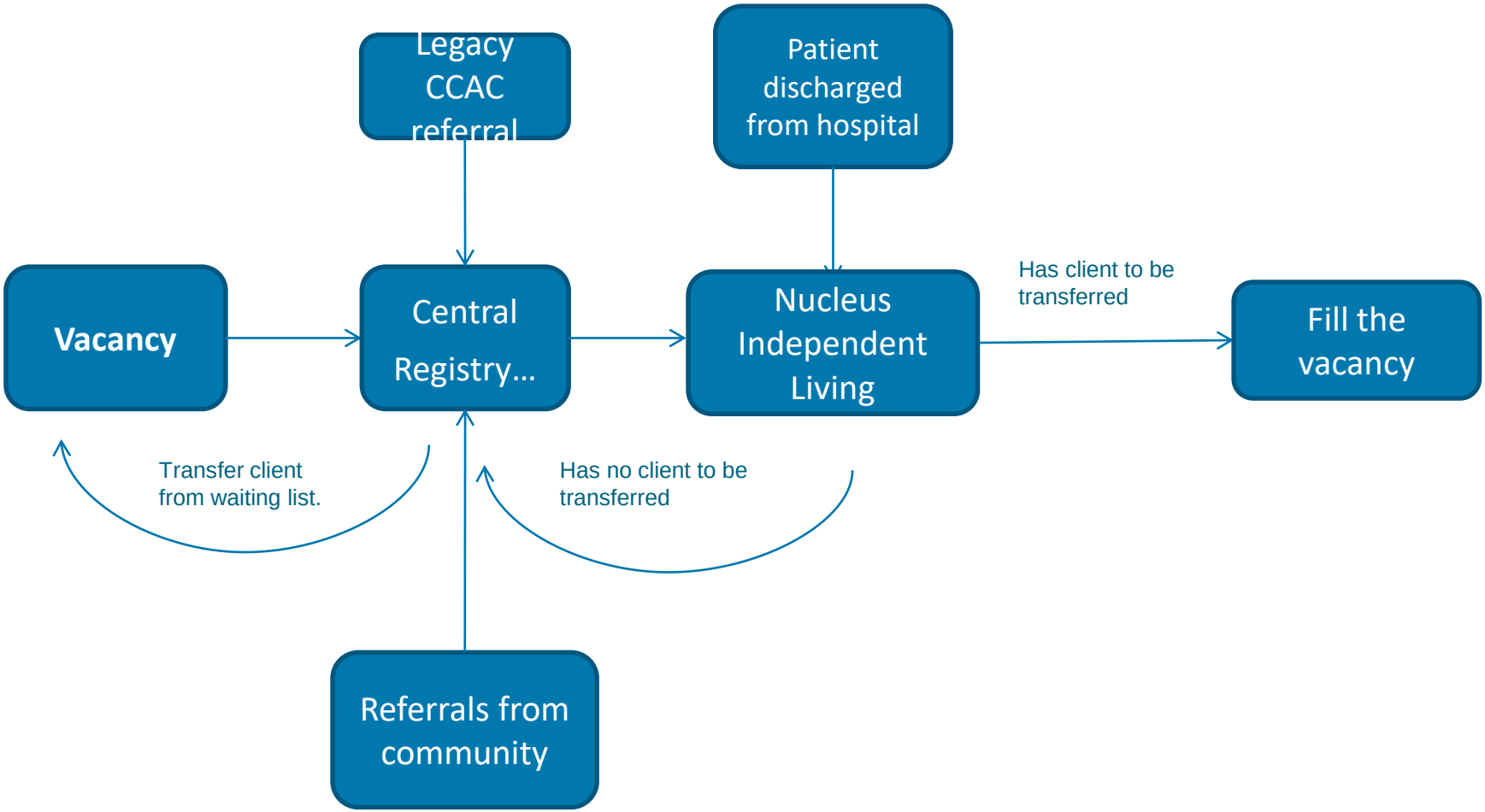
## Client demographics:

Current client number: 29 in 3 teams (Team A hub, Team B, C mobile)

•12 of the clients in the building, 17 clients are in spoke community, including 4 family buildings and one senior building and private houses in the surrounding area.

•Clients from multicultural backgrounds, more than half of the clients speak limited or no English. The primary languages are: Chinese, Indonesian, Italian, Spanish, Arabic, and Hindi.

# Intake Process:



During the intake meeting:

- Transfer sheet
- Consent form
- Care plan ( discuss with client/family, later be transferred to daily shift duties)
- Service agreement
- Falls risk assessment
- Home safety assessment


# SUPPORT FOR DAILY LIVING PROGRAM

## Non-medical daily living assistance

•Personal support/assistance; meal preparation; and safety checks.

•Personal care; shower assistance; mouth and/or hair care; preventative skin care.

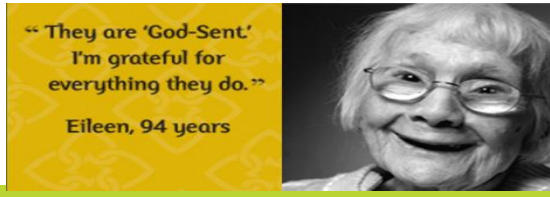
•Medication program: Assistance with pre-measured medication

•24/7 Emergency response

•Falls prevention: Group exercise class; one on one exercise assistance.

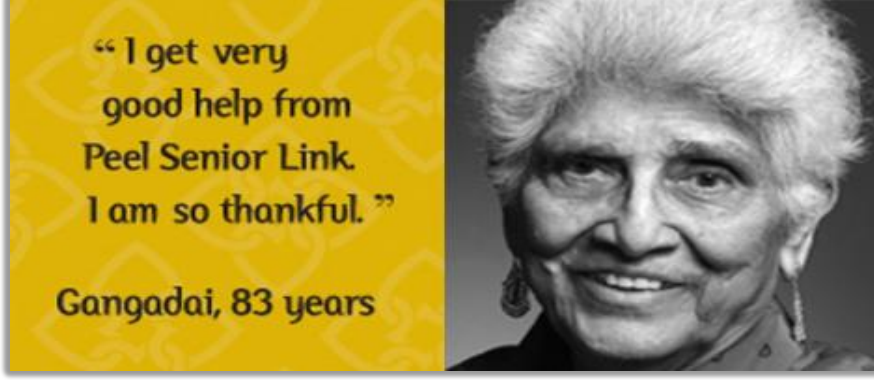
•Socialization / referral to other services in the community

•Homemaking services; light housekeeping, laundry and essential grocery shopping assistance.




SUPPORTS FOR DAILY LIVING

# Care Model:




24/7

•6 shifts rotating among the 3 teams (3 day shifts; 2 evening shifts, 1 night shift.)

Care plan

• Supervisor makes care plan based on individual client's needs. Each client is scheduled for one to a few visits with PSWs (personal support workers) per day. Each visit is no longer than 30 minutes. PSWs follows shift duties to carry out the care plan with clients. Each client is scheduled twice a week for shower assistance.

•On top of the personal care, most client also receives 1-2 hours home helping time every week, including laundry assistance, light house keeping, essential grocery shopping assistance.

## Shift change report

•The replacing staff is expected to report to work at least 10 minutes before the shift start time, a verbal client by client shift exchange report is scheduled between the in-coming and out-going staff at the end of each shift. (client debrief, pass on backpack, cell phone, key chain, medication review).

## Documentation

•At the end of the shift, staff is also expected to complete detailed documentation in the communication book in each client's file.

## Meds check during the shift change

•During the shift change report, both staff are expected to check all the medications of clients who are on PSL
•medication program, count the left over
•narcotics and fill out the counting sheets.

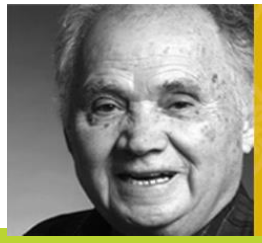
# Medication assistance:

## *Medication reminding*

•For clients who are cognitively well enough to manage their own medication, but due to their forgetfulness, they need staff to remind them at the specific time. ( telephone/in person)

## *Medication supervision*

•For clients who need cuing/encouragement to take their meds, PSWs are instructed to supervise clients to take their meds during the visits.(meds are pre-measured and labeled in a dosette container)



"The Peel Senior Link Day Service Co-ordinator is very efficient."

Enrique, 79 years

"I can't tell you how happy I am. I was lonely, but I'm not anymore."

Etta, 95 years

"With the help of Peel Senior Link, I can keep my dignity."

Frank, 90 years

# PSL Medication Program:

The Medication Program is a medication administration/management program that supports clients on multiple drug regimens or who have difficulty with medication compliance.

Resident Care Pharmacy is the approved exclusive provider of medication program.

Procedure:
1.Client signing the agreement
2.Referring client to RCP
3.Meds delivery
4.Meds check/meds pouch
5.Administration ( 7 rights)
6.Documentation

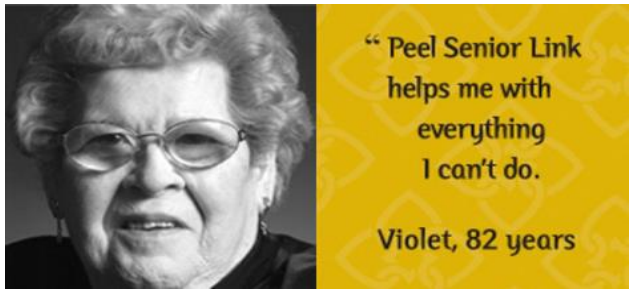
# Falls Prevention Program

•PSL works in collaboration with Lifemark Therapy and Rehab to host group exercise classes at Wisma building and Creditvale Mills senior building
•3-hour exercises classes scheduled twice a week
•Classes are instructed by PT assistants from Lifemark Therapy and Rehab.

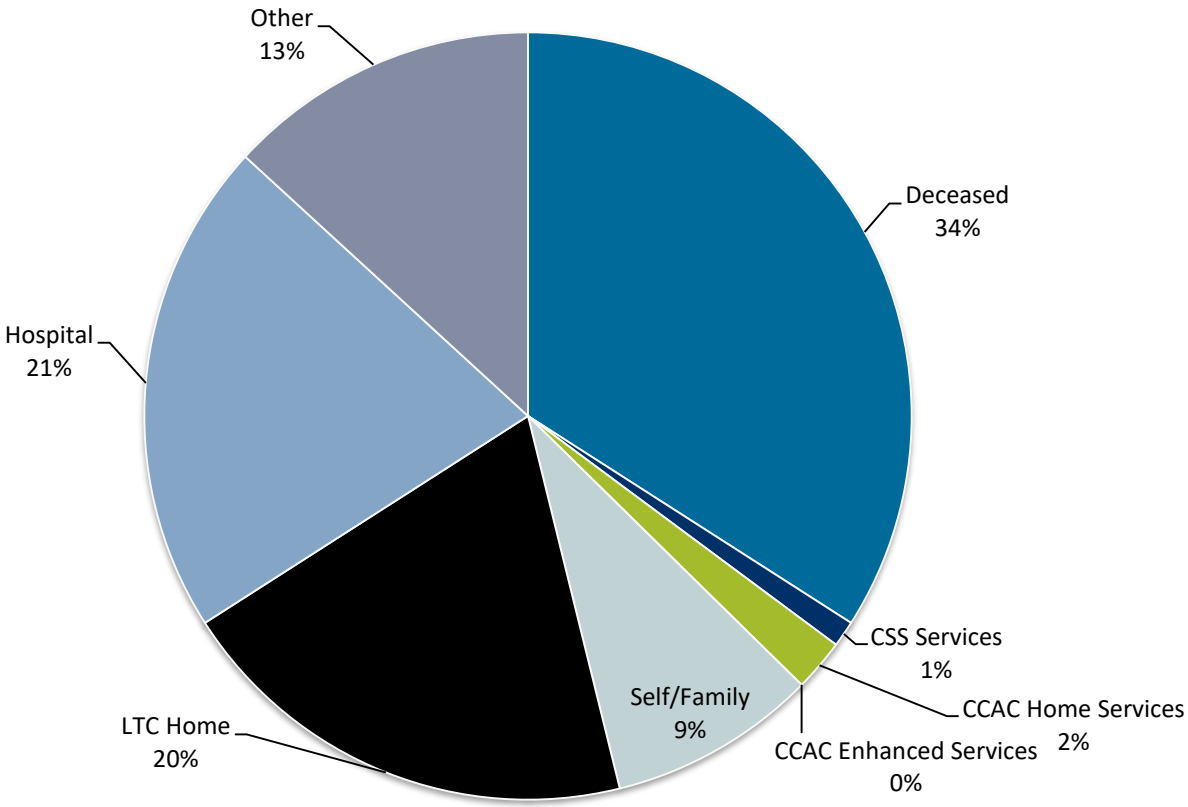
Schedule staff assisting clients walking or doing exercises as per clients' care needs.

All clients' falls are documented and reported through PSL Safety Incident reporting system. Supervisor is to investigate the cause of clients' falls. For repeating falls, supervisor is to consult with manager to draft an action plan for the client.

Supervisor submit SI report monthly to Manager for statistics.




# Discharges (2017-2018)



# Partnerships:

- Building management
- MH LHIN (SDL, Wait at home, Palliative programs)
- Central Registry
- Physicians
- Pharmacy
- Geriatrician
- Occupational Therapist (OT) and Physiotherapist  (PT)
- Home Visit Nurse

# Supports for Daily Living Model Resources

- http://www.mississaugahaltonlhin.on.ca/goalsandachievements/seniors/supportsfordailyliving.aspx
- http://www.peelseniorlink.com

- Thank You!

Peel Senior Link
helping seniors live independently

SUPPORTS FOR DAILY LIVING

ACCREDITED WITH EXEMPLARY STANDING
ACCREDITATION CANADA
AGRÉMENT CANADA
AGRÉÉ AVEC MENTION D'HONNEUR

OCSA
Ontario Community Support Association