

## **TORONTO CENTRAL LHIN BACKGROUNDER AGING AT HOME AND ALTERNATE LEVEL OF CARE**

The Toronto Central Local Health Integration Network (LHIN) is receiving more than \$26 million in 2009/10 to support initiatives to help seniors live healthy, independent lives in their own homes and communities and to decrease the number of alternate level of care (ALC) patients in hospitals.

Having more home care and community services enables ALC patients to leave hospital sooner, making more beds available to emergency room patients. These services also provide ongoing health supports to seniors which reduces their need to go the hospital ER.

### **Aging at Home Strategy**

The Toronto Central LHIN is receiving \$15.4 million in 2009/10 to increase the range and quantity of services available to seniors, and to help relieve pressure in hospitals and long-term care homes.

This year's investment is an increase of \$ 9.2 million over 2008/09.

This \$15.4 million total investment for 2009/10 includes:

- \$5.3 million for five new initiatives this spring.
- \$10.1 million to further support and enhance projects that began in year one of the Aging at Home strategy. Funding allocations for the specific projects that are being continued or expanded in 2009/10 will be determined in the coming months. The chart below includes interim funding amounts for these projects.

The money will help increase the range and quantity of services available to seniors and help relieve pressures in hospitals and long-term care homes. The Aging at Home program expands traditional services that help seniors stay healthy and live at home. These services include home care, assistive devices, assisted living/supportive housing and end-of-life care.

The Aging at Home program also encourages innovation at a local level, by giving LHINs the flexibility to start some creative projects that are tailor-made for seniors living in communities with specific needs.

**Funding for Five new Aging at Home initiatives for 2009/10**

AAH Year Two Project Names	Service Provider	Address	Project Description	2009/10 Approved Funding
Supportive housing services for seniors with mental illness	LOFT Community Services	205 Richmond Street West Suite 301 Toronto ON M5V 1V3	<p>This project will add 37 new high support supportive housing units for marginalized and hard-to-serve seniors with dementia or mental illness South Parkdale. The project will also provide practical case management support to 20 seniors with mental illness in the Toronto Community Housing Corporation (TCHC) buildings at 245 Dunn Avenue and 85 Spencer Avenue.</p> <p>This program is projected to serve 57 seniors in 09/10.</p>	\$560,000
Specialized geriatric assessments in the community	New Heights Community Health Centres	12 Flemingdon Rd Toronto ON M6A 2N4	<p>This project will provide a comprehensive continuum of supports to vulnerable, frail, homebound, and/or marginalized seniors in the neighbourhood of Englemount-Lawrence. This will allow them to age in place and enjoy a higher quality of life.</p> <p>The model will provide comprehensive geriatric assessments, and triage clients to the most appropriate levels of care, thereby delaying the need for institutional care. The project will include a comprehensive evaluation of the senior's physical and health mental along with social, economic, functional, and environmental factors. Assessments involve the senior, the caregiver, family members, and others.</p> <p>This program is projected to serve between 400-500 seniors in 09/10.</p>	\$964,809

<p>Crisis intervention for seniors with mental illness and/or addictions</p>	<p>Woodgreen Community Services</p>	<p>835 Queen Street East Toronto ON M4M 1H9</p>	<p>This on-call seven day-a-week mobile crisis intervention and outreach service will be delivered by two multi-disciplinary outreach teams, which will provide comprehensive care in the community as well as in clients' homes, supportive housing sites, drop-in's and community centres. Outreach teams will focus on hard-to-serve and hard-to-reach clients and high priority neighbourhoods.</p> <p>The Teams will develop and implement a care plan for each client and provide services including specialized psycho-geriatric crisis support, addiction and harm reduction interventions, intensive case management, and nursing and community support services.</p> <p>This program is projected to serve 350 clients in 09/10.</p>	<p>\$666,000</p>
<p>Enhanced Care Program</p>	<p>Toronto Central CCAC</p>	<p>250 Dundas Street W. Suite 305 Toronto ON M5T 2Z5</p>	<p>The purpose of the Enhance Care Program is to provide goal-oriented, case managed, enhanced care service on a short-term basis to individuals, who, following medical treatment or surgery require more time to heal and regain the necessary level of functioning to return home. The program will target seniors in acute ALC beds and or the ER and will provide rehabilitation, support, and caregiver training.</p> <p>The Toronto Central CCAC will work closely with community providers that serve the same geographic area and/or target population.</p> <p>This program is projected to serve between 80-160 clients in 09/10.</p>	<p>\$1,833,650</p>

<p>House Calls: Continuum of care for frail and marginalized seniors</p>	<p>Senior Peoples' Resources in North Toronto, Inc.</p>	<p>140 Merton Street 2<sup>nd</sup> Floor Toronto ON M4S 1A1</p>	<p>The project includes a mobile multidisciplinary geriatric outreach and assessment team (House Calls Team) lead by a geriatric primary care physician and specialized staff that provide mental health and specialized geriatric services; intensive case management services; home assessments; and supportive housing services for people with mental illness, dementia and/or addictions.</p> <p>The project is designed to facilitate discharges from ERs, hospitals and other settings. It will link clients and caregivers to resources in the community and continually monitor the health status of clients and caregivers.</p> <p>This program is projected to serve 305 seniors in 09/10.</p>	<p>\$1,246,715</p>
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### Aging at Home Year One Projects Proposed to Continue in 2009/10

AAH Year One Project Names	Service Provider	Address	Project Description
<p>Supportive Housing Services</p>	<p>City of Toronto- 55 Bleeker Street</p>	<p>55 John Street, Metro Hall, 11<sup>th</sup> Floor Toronto, ON M5V 3C6</p>	<p>Launched in 2008/09, this program provides supportive services to seniors in this St. Jamestown building. Services include: mental health outreach counseling, wellness programming, and referral to other community services, homemaking (including laundry, cleaning, and assistance with meal preparation), personal support (bathing, dressing), security checks and medication reminders.</p> <p>To date, 16 seniors have benefited from this program. This program is projected to serve 50 seniors in 09/10.</p>
<p>Supportive Housing Services</p>	<p>Neighbourhood Link 2802 Danforth Road</p>	<p>3032 Danforth Ave Toronto ON M4C 1N2</p>	<p>Former homeless seniors in the Crescent Town community benefit from two personal support workers and a geriatric mental health case manager. Through this program which was launched in 2008/09, seniors gain assistance with activities of daily living (bathing, dressing), life skills coaching and activities to decrease isolation.</p> <p>27 seniors have benefited from this program to date. This program is projected to serve 27-28 seniors in 09/10.</p>

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Supportive Housing Services	Community Care East York 12 Thorncliffe Park	840 Coxwell Ave Suite 303 Toronto ON M4C 5T2	<p>Launched in 2008/09, this initiative provides a range of health and wellness programs to enable seniors to be supported in locations where seniors already receive services. The program responds to the needs of seniors over 80 years of age with complex health issues.</p> <p>35 seniors have benefited from this program to date. This program is projected to target 35 seniors in 09/10.</p>
Supportive Housing Services	WoodGreen Community Services First Steps to Home, 650 Queen Street West	835 Queen Street East Toronto ON M4M 1H9	<p>Launched in 2008/09, this program provides a unique form of supportive housing to high-risk seniors who are repeat shelter users. This program has helped 43 individuals leave the streets and move into permanent housing. Working with a case manager, seniors develop an action plan to improve life skills, reduce drug and alcohol use and improve their physical, emotional and mental health.</p> <p>This program is projected to target more than 28 seniors in 09/10.</p>
Supportive Housing Services	St. Christopher House  130 Vaughan Road  1775 Eglinton Avenue West,  55 Outlook Rd.	588 Queen Street West 2 <sup>nd</sup> Floor Toronto ON M6J 1E3	<p>Launched in 2008/09, this program provides services for marginalized seniors across three sites. Traditional supportive housing services such as help with activities of daily living, and intensive case management for at-risk seniors are provided. Also included are wellness, health promotion, mental health and chronic disease management services.</p> <p>88 seniors have benefited from this program to date. This program is projected to target more than 88 clients in 09/10.</p>
Supportive Housing Services	West Toronto Community Support Services 100 High Park	80 Ward Street Toronto ON M6H 4A6	<p>Launched in 2008/09, this program provides frail seniors experiencing mental health issues and social isolation, with wellness and illness prevention services.</p> <p>64 seniors have benefited from this program to date. This program is projected to target more than 50 clients in 09/10.</p>
Supportive Housing Services	Family Service Toronto  148 Pears Ave.  25. Leonard	355 Church Street Toronto ON M5B 1Z8	<p>Launched in 2008/09, this program benefits former homeless seniors who were marginalized due to their complex health problems, low income, language barriers and lack of family support. These services help seniors with behavioural issues to remain in the community and find access to consistent senior-specific</p>

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	Avenue		<p>crisis intervention and psychiatric services.</p> <p>20 seniors have benefited from this program to date. This program is projected to serve 20 seniors in 09/10.</p>
Seniors Independence Program (SIP)	Toronto Central Community Care Access Centre	250 Dundas Street W. Suite 305 Toronto ON M5T 2Z5	<p>Launched in 08/09, the Seniors Independence Program provides targeted intensive care management and support services to frail seniors at-risk of: an unexpected ER visit or hospital admission as a result of a crisis; an avoidable long-term care home placement; or, of remaining in a hospital Alternate Level of Care (ALC) bed when care could be provided in the community. An interprofessional team delivers well coordinated care and individualized service plans that allows each senior to remain in their homes or a community care setting.</p> <p>This program has served a total of 91 clients to date: 40 clients from the community and 51 clients admitted from hospital. This program is projected to serve between 200-400 seniors in 09/10.</p>
Transportation services	Toronto Ride	140 Merton Street 2 <sup>nd</sup> Floor Toronto ON M4S 1A1	<p>Launched in 2008/09, Toronto Ride is a community transportation network that provides rides to seniors through a partnership of 14 community agencies. Toronto Ride coordinates over 1000 rides per month for Toronto Central LHIN seniors monthly.</p>
Home at Last (HAL)	St. Christopher's House	588 Queen Street West 2 <sup>nd</sup> Floor Toronto ON M6J 1E3	<p>Launched in 2008/09, the Home-at-Last Program ('HAL') provides a smooth transition home for frail elderly patients discharged from hospital, and connects them with local community support services agencies. HAL is collaboration between seven Toronto hospital sites, the Toronto Central CCAC and nine Toronto area community support service agencies.</p> <p>HAL provides seniors with free assistance and transportation home upon discharge from hospital, free assistance at home from a Personal Support Worker, three free meals from Meals on Wheels, and follow-up from a community agency.</p> <p>To date, this program has benefited 320 clients admitted from acute care inpatient units and 69 clients admitted from the emergency departments. This program is projected to serve 800 seniors in 09/10.</p>
Seniors Mental Health and Addictions Services Project –	Sunnybrook Health Sciences Centre Mental Health	2075 Bayview Ave Rm C104 Toronto ON	<p>Launched in 2008/09, the Seniors Mental Health and Addictions Services (SMHAS) project has focused on: a) creating an inventory of psychogeriatric resources in hospitals and the community; b) service gap analysis</p>

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Community & Hospital Implementation	Program	M4N 3M5	<p>across the LHIN; c) development and implementation of standard processes for intake, access, assessment and referrals to improve access to these specialized services.</p> <p>This program is projected to serve 260 seniors in 09/10.</p>
Outreach to Diverse & Vulnerable Seniors (Community Development)	Woodgreen Community Services	835 Queen Street East Toronto ON M4M 1H9	<p>Launched in 2008/09, this program focused on assisting seniors and their caregivers to age in their home and communities by providing health and wellness interventions; outreach groups; needs assessments; symposiums on prevention methods and care options; workshops and seminars on culturally sensitive care options; and caregiver education and training.</p> <p>These initiatives have benefitted 1250 vulnerable seniors and their caregivers to date. This program is projected to serve 1350 seniors in 09/10.</p>
Community Navigation and Access Project (CNAP)	Woodgreen Community Services	835 Queen Street East Toronto ON M4M 1H9	<p>Launched in 2008/09 the Community Navigation and Access Project focused on improving access to and awareness of support services for seniors available in the LHIN with a goal of ensuring that “every door leads to service”. In concert with 200+ front-line staff, the 33 Community Support Service Agency Partners developed 29 community service definitions which have been adopted by other LHINs. To help improve access to services, the Toronto Central CCAC’s Community Care Resource database (CCR) was updated to include this information, including a mapping of area community support services. The project partners developed and piloted standardized intake and assessment forms.</p> <p>The pilot resulted in 240 client intakes and identified 87 frail, at-risk and marginalized seniors. This program is projected to serve more than 250 clients in 09/10.</p>
Integrated Geriatric and Psychogeriatric Outreach Services for Seniors in the Community	Regional Geriatric Program	2075 Bayview Ave Rm H478 Toronto ON M4N 3M5	<p>This program is focused on the development of a new specialized geriatric service Outreach Team to serve south west Toronto, which is currently unserved or underserved. The team will provide integrated Geriatric Medicine and Geriatric Psychiatry outreach and intensive/enhanced case management services focused on frail, marginalized, at-risk seniors with geriatric and/or psychogeriatric issues.</p> <p>A minimum of 25% of clients will be seniors referred from acute care hospitals, patients who no longer require acute care services and patients discharged from</p>

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			<p>theER, which will relieve congestion in the ER.</p> <p>Funding will also be used to expand Geriatric Emergency Medicine (GEM) nurse coverage in emergency departments.</p> <p>This program is projected to serve 1350 seniors with specialized geriatric outreach and GEM nurse services in 09/10.</p>
Stepping Stone – John Gibson	LOFT	205 Richmond Street West Suite 301 Toronto ON M5V 1V3	<p>This initiative involves the creation of 12 units at John Gibson House that provide a high level of support to psychogeriatric patients from Centre for Addiction and Mental Health (CAMH) and psychogeriatric patients in acute ALC beds, to prepare them to return to the community.</p> <p>Clients no longer requiring higher-level support will be transitioned to other units within John Gibson House or to a housing location of their choice that better meets their needs.</p> <p>To date, this initiative has benefited 8 clients. This program is projected to target 20 clients in 09/10.</p>
Diabetes Prevention & Management Program for South Asian Seniors	Flemingdon Health Centre	10 Gateway Boulevard Toronto ON M3C 3A1	<p>This initiative is focused on diabetes prevention, education and management for South Asian seniors in Toronto’s north east region (Flemingdon Park, Victoria Village and Thorncliffe Park). The project builds on and expands the Mid-Toronto Diabetes Education program at Flemingdon Health Centre allowing it to offer language specific (5 languages) and cultural relevant diabetes detection and management services. The program provides a range of services including; outreach at places of worship, information sessions, monthly voluntary screening, identification of pre-diabetic and high-risk groups, diabetes management plans based on south Asian diets and caregiver workshops.</p> <p>To date, 88 at-risk seniors have been screened for diabetes and 70 have attended educational workshops. This program is projected to serve more than 650 seniors with diabetes education and screening sessions.</p>

AAH Year One Project Names	Service Provider	Address	Project Description
Mental Health Outreach in St Jamestown	Community Resource Connections of Toronto (CRCT)	366 Adelaide Street E. Suite 230 Toronto ON M5A 3X9	<p>The St. Jamestown Outreach Program (STOP) provides outreach, assessment, referrals and intensive case management to older residents in St. Jamestown who have serious mental health problems and may also have physical health and/or substance abuse issues, and difficulties maintaining their units. These seniors have trouble accessing primary care and disease-specific support services. CRCT would work collaboratively with community partners to provide accessible, flexible, comprehensive, and coordinated services. CRCT receives referrals from the Toronto Community Housing Corporation, property management, tenant representatives and Toronto Public Health.</p> <p>43 seniors have benefited from this program to date. This program is projected to serve 80 seniors in 09/10.</p>

## Urgent Priorities Fund (UPF) - Addressing ALC Pressures

The Toronto Central LHIN is receiving \$5,645,000 to help provide community alternatives to hospital care.

Last year, this fund helped to:

- Reduce ER visits by providing additional community supports through supportive housing or by placing more nurses in long-term care homes
- Move ALC patients to a more appropriate health care setting as quickly as possible by improving the electronic flow of information from hospitals to long-term care homes.

## APPROVED UPF/Other STRATEGY PROJECTS FOR TORONTO CENTRAL LHIN

Name of Project	Service Provider	Address	Project Description	2009/2010 FUNDING
Enhanced Care Program at St Hilda's	St Joseph's Health Centre	30 The Queensway Toronto ON M6R 1B5	<p>The purpose of the Enhance Care Program is to provide goal-oriented, case managed, enhanced care service on a short-term basis to individuals, who, following medical treatment or surgery, require more time to heal and regain the necessary level of functioning to return home. The program will target seniors in acute ALC beds and or the ER and will provide rehabilitation, support, and caregiver training.</p> <p>32 seniors have benefited from this program to date.</p>	\$645,000

### **Increasing Home Care Services – CCAC Service Maximums**

The Toronto Central LHIN is receiving \$5,196,700 in 2009/10 for changes made last year to increase the availability and integration of home care services. This included increasing the limits on hours of person support/homemaking services by 50 per cent, and removing limits entirely for patients waiting for a long-term care bed or receiving end-of-life services at home.

### **Nurse-Led Outreach Team**

The Toronto Central LHIN is receiving \$250,000 for a nurse-led outreach team that is being created to provide long-term care home residents with timely and appropriate care, and stabilize residents who need more urgent attention. This team of nurse practitioners and registered nurses will travel to LTC homes to assess urgent problems, determine the need for hospital care, and provide interventions (such as intravenous therapy, antibiotic management and administering oxygen) in cases where unnecessary visits to the hospital and the ER can be avoided.