ALSO

Assisted Living Southwestern Ontario | Aide à la vie autonome Sud Ouest de l'Ontario

Neighbourhoods of Care

OAILSP

Ontario Association of Independent Living Service Providers

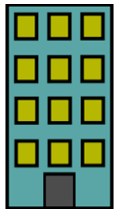
Traditional Model of ALSO Service Delivery

Personal Support (Outreach)

- 21 Hours of service per week Max.
- Provided in individual homes.
- Separate supervisor and support staff for outreach.
- If care needs increase, the consumer shifts to supportive housing or LTC or hospital.

Supportive Housing

- Separate supervisor and support staff for SH.
- Limited number of units available.
- Located in rent-to-geared income housing areas and rarely in neighbourhood of choice
- Increasing population of aging consumers with high needs.



MOBILE SUPPORTS

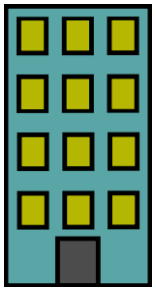
- Funding was received for Mobile Supports back in February 2011
- Since then we have transitioned over 500 people from Hospital and LTC or diverted people from LTC.
- It is virtual supportive housing
- Access to care 24 hours a day
- Lock box on door and Safeguard Alarms for 24 access to PSW and 911 if needed even from bed.
- No limit to the number of service hours for an individual (average 180 hours per month averaged over all in Functional Centre) (1994)

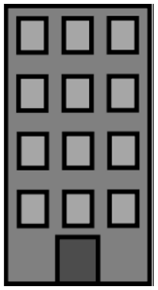
Traditional Model of Service Delivery

Outreach

Supportive Housing

LTC

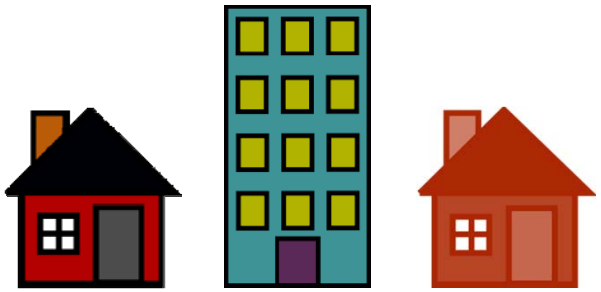




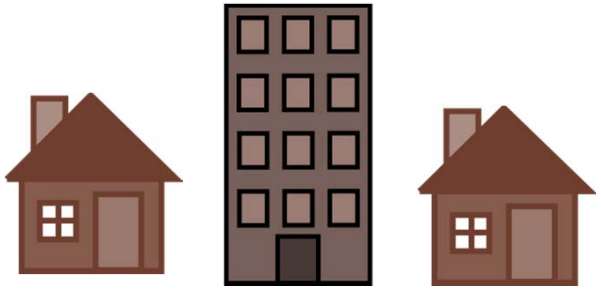
Movement of Consumers as Level of Care Increases

Internal Integration

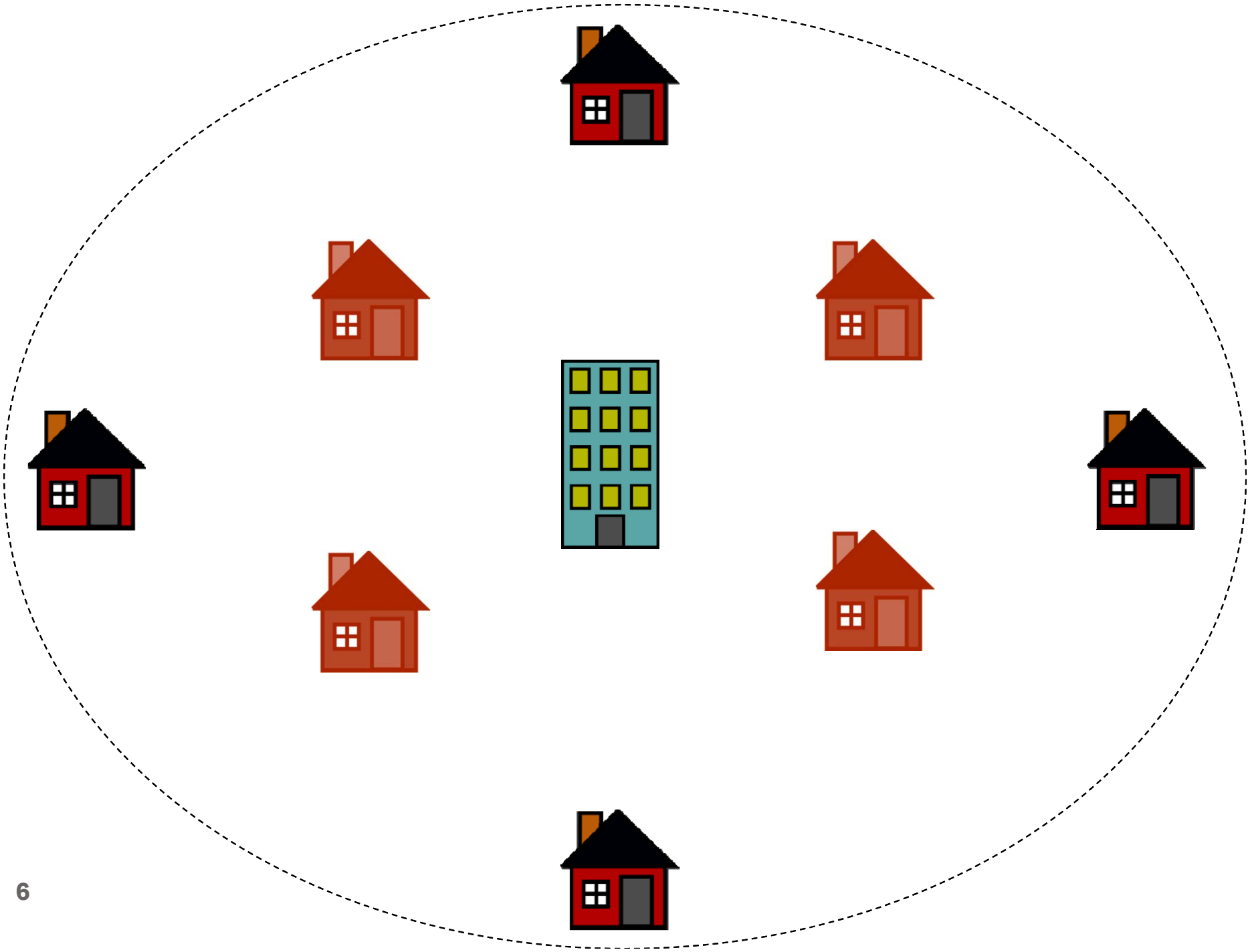
Phase 1: Attendant Services – Supportive Housing and Outreach.

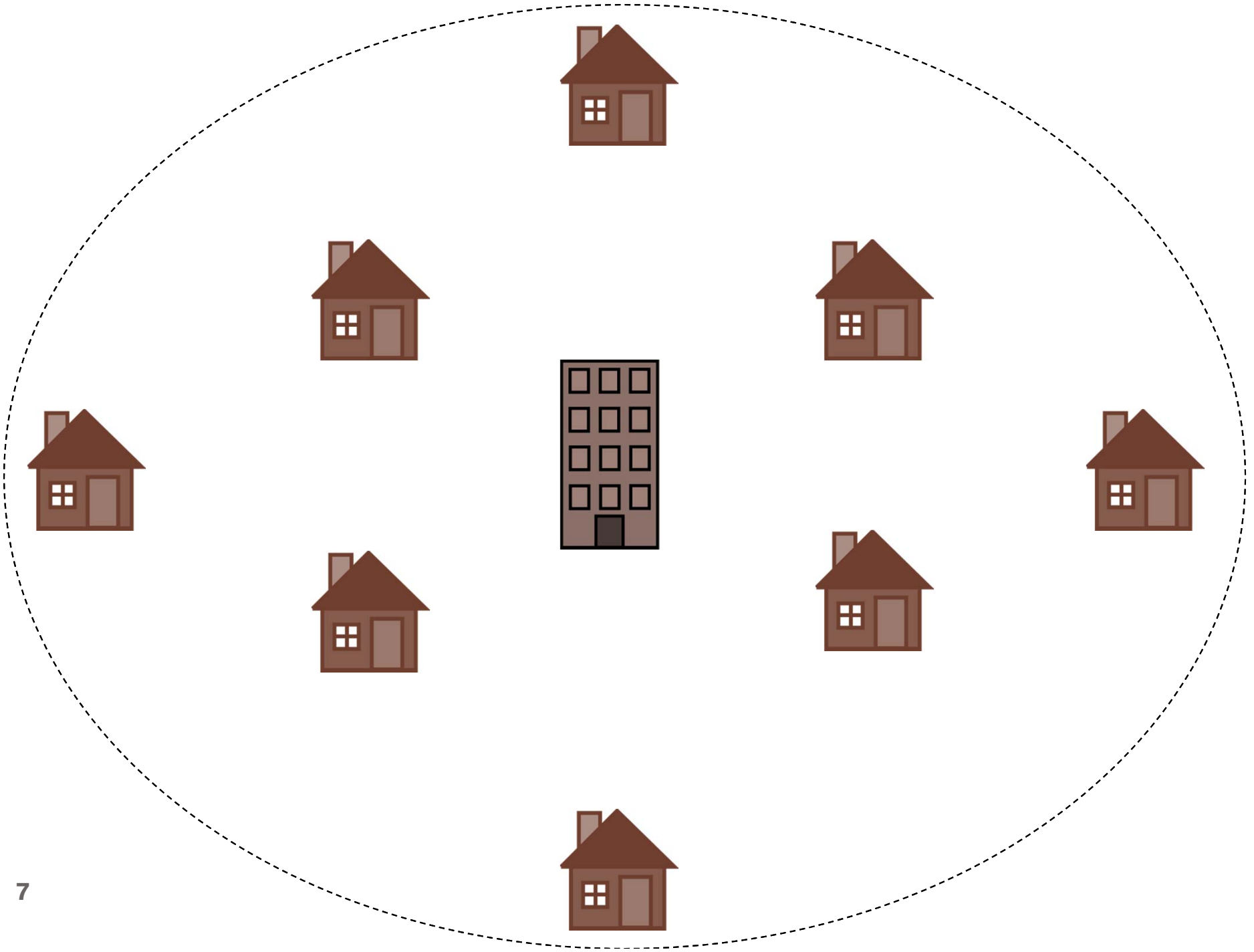


Phase 2: Addition of Mobile Services to traditional model.



Phase 3: Intra-agency integration of Services → spoke and hub model.





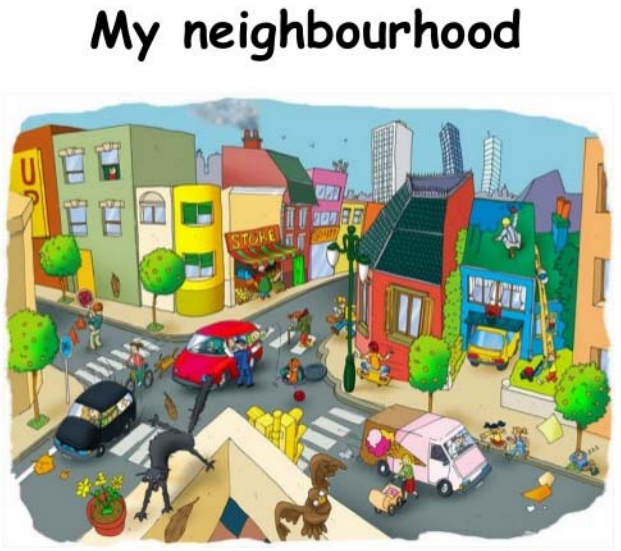
Mobile Supports

- Flexibility – several visits a day both booked and unbooked
- Care in the middle of the night
- 2 person transfers (or more)
- What are the triggers that mean someone currently cannot be supported in the community?
- Let's figure out how we can provide what is needed

Flexible/Nimble Service

- Consumers who transition after long hospital stays are often depressed and deconditioned. We have found that once home with therapy and actively engaging them in the events of their own lives like cooking (and even cleaning) – people improve!
- They may start with 5 visits a day but many ramp down to 2 – 3 visits a day or short visits
- We can transition them from AL functional centre to the Support Services/Independence Training Functional Centre – It is a book entry – nothing changes for the consumer – same staff – same great service!
- If they experience an adverse health event – we can ramp them back up in service until they are better.

Neighbourhoods of Care
Who else is working in the neighbourhood?



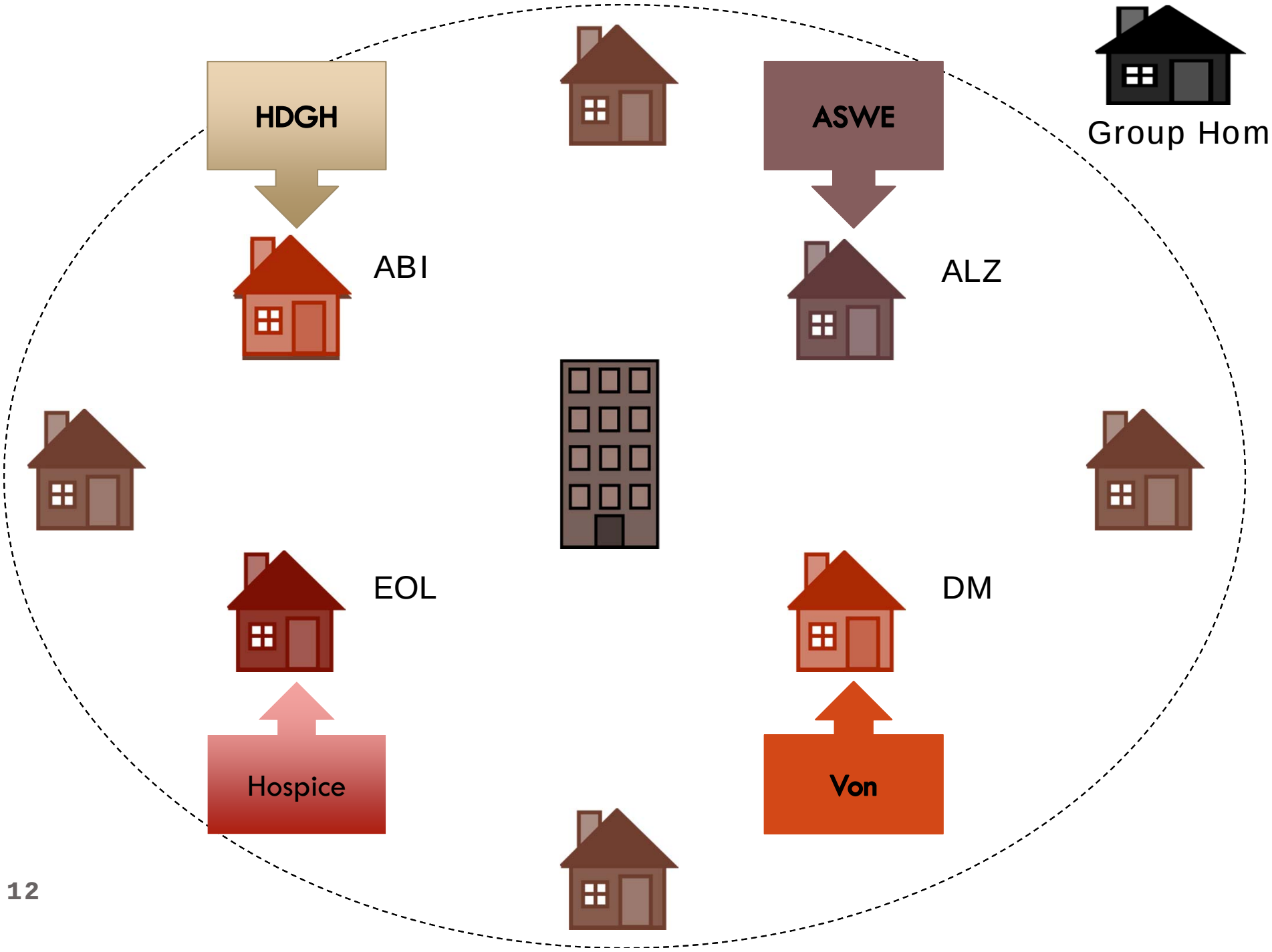
Phase 4 - Interagency Collaboration

Collaboration With:

- Alzheimer's Society
- Hospice
- VON
- Hotel Dieu Grace Healthcare
- CMHA
- U of Windsor /St. Clair College
- EMS
- Home Instead

In Order To Be Able To:

- Train staff for specialized teams (ex. dementia, palliative, ABI)
- Share staff → coverage for other agencies
- Share transportation
- Share assessments
- Make smooth transitions!


HDGH
ASWE
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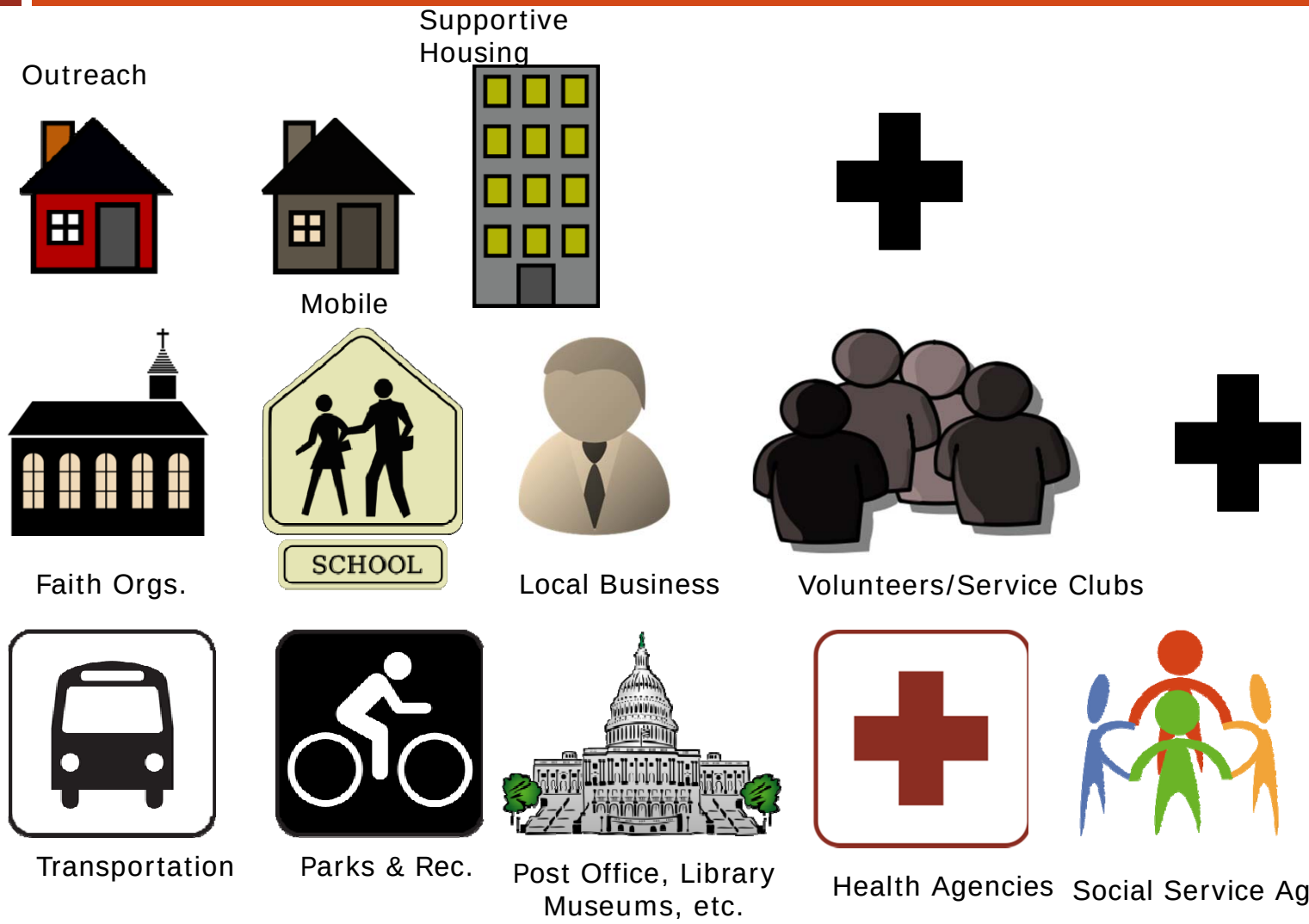
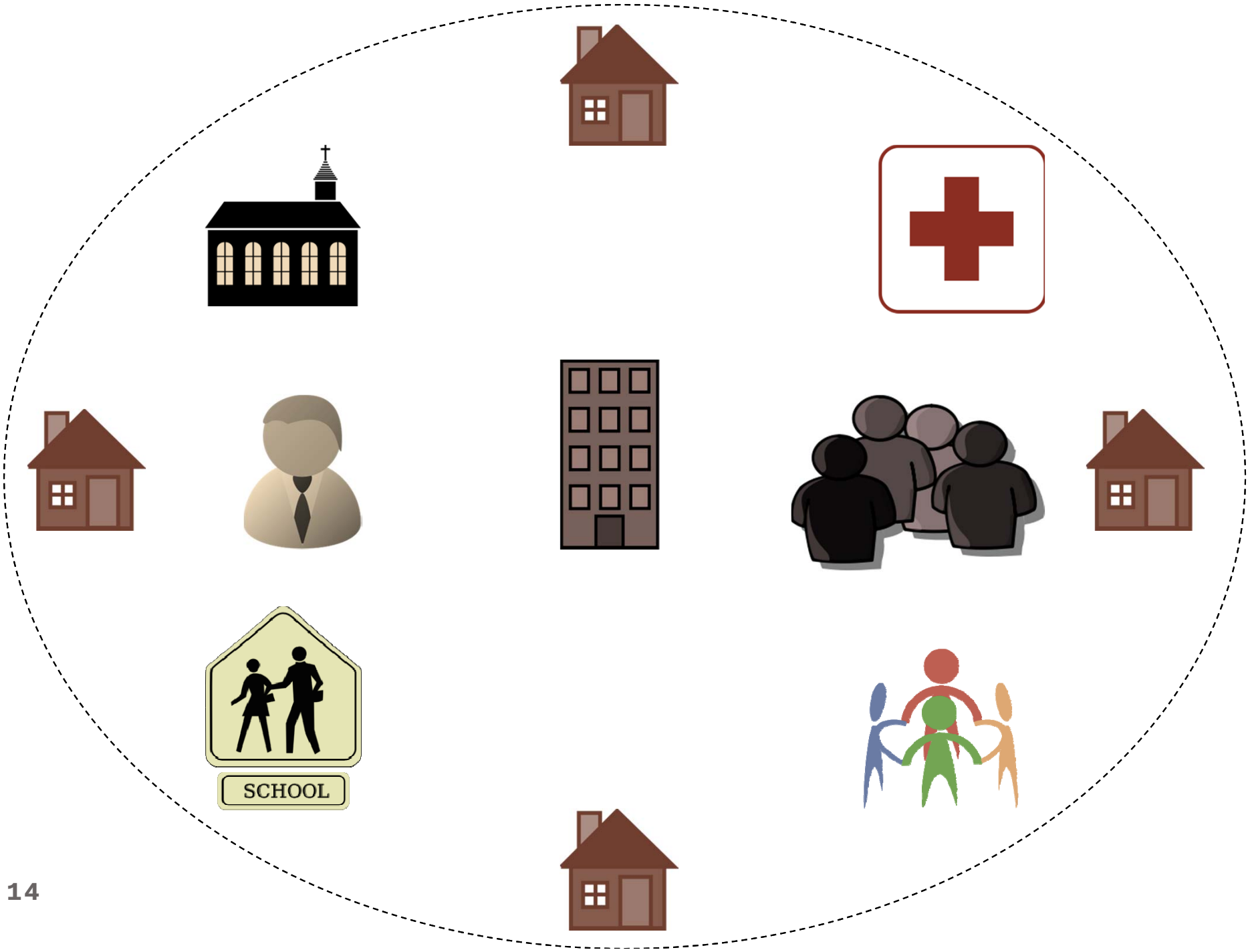
ABI
ALZ
EOL
DM
Hospice
Von

Thinking Bigger: Incorporating the Consumer's Ecosystem: Phase 5

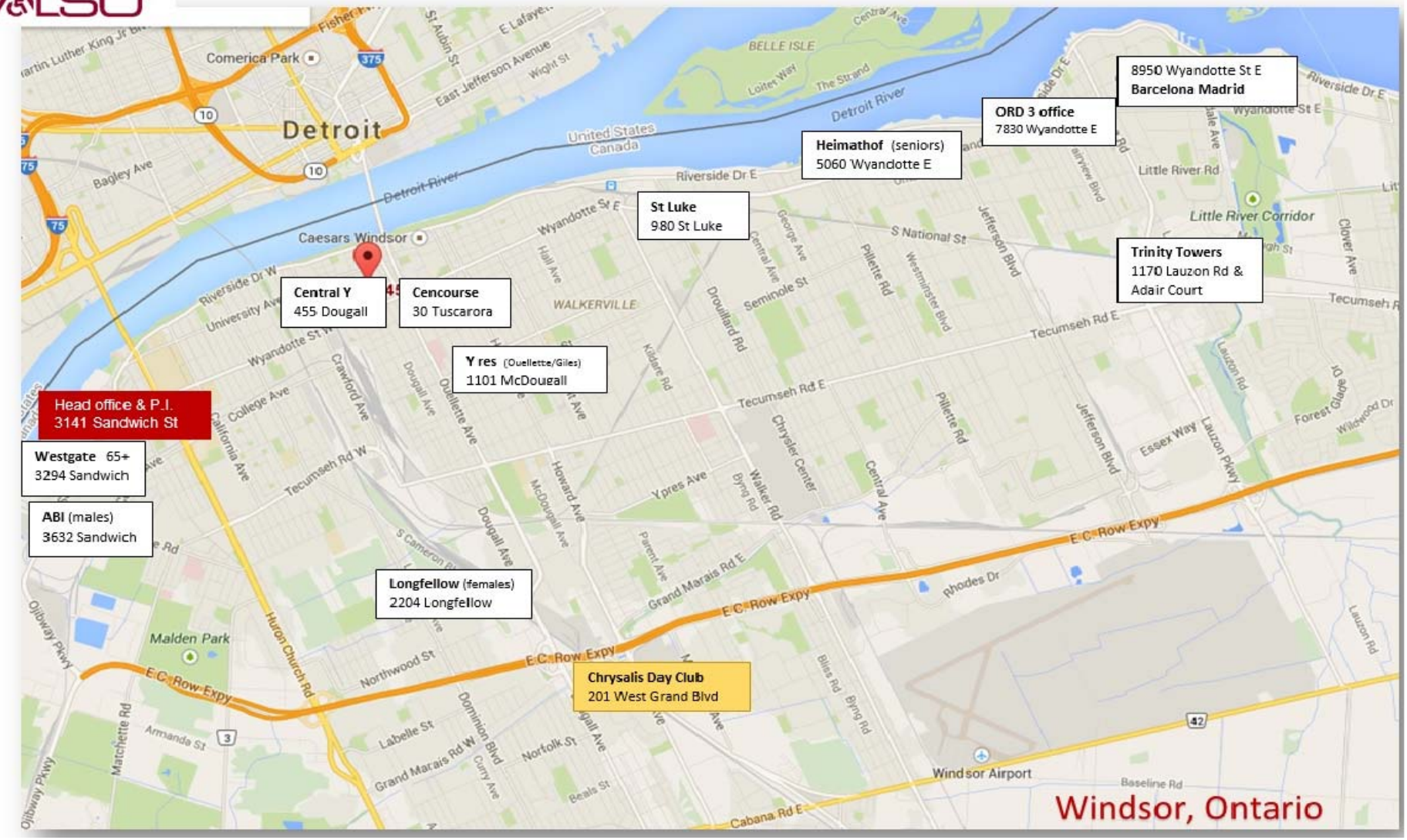



SCHOOL

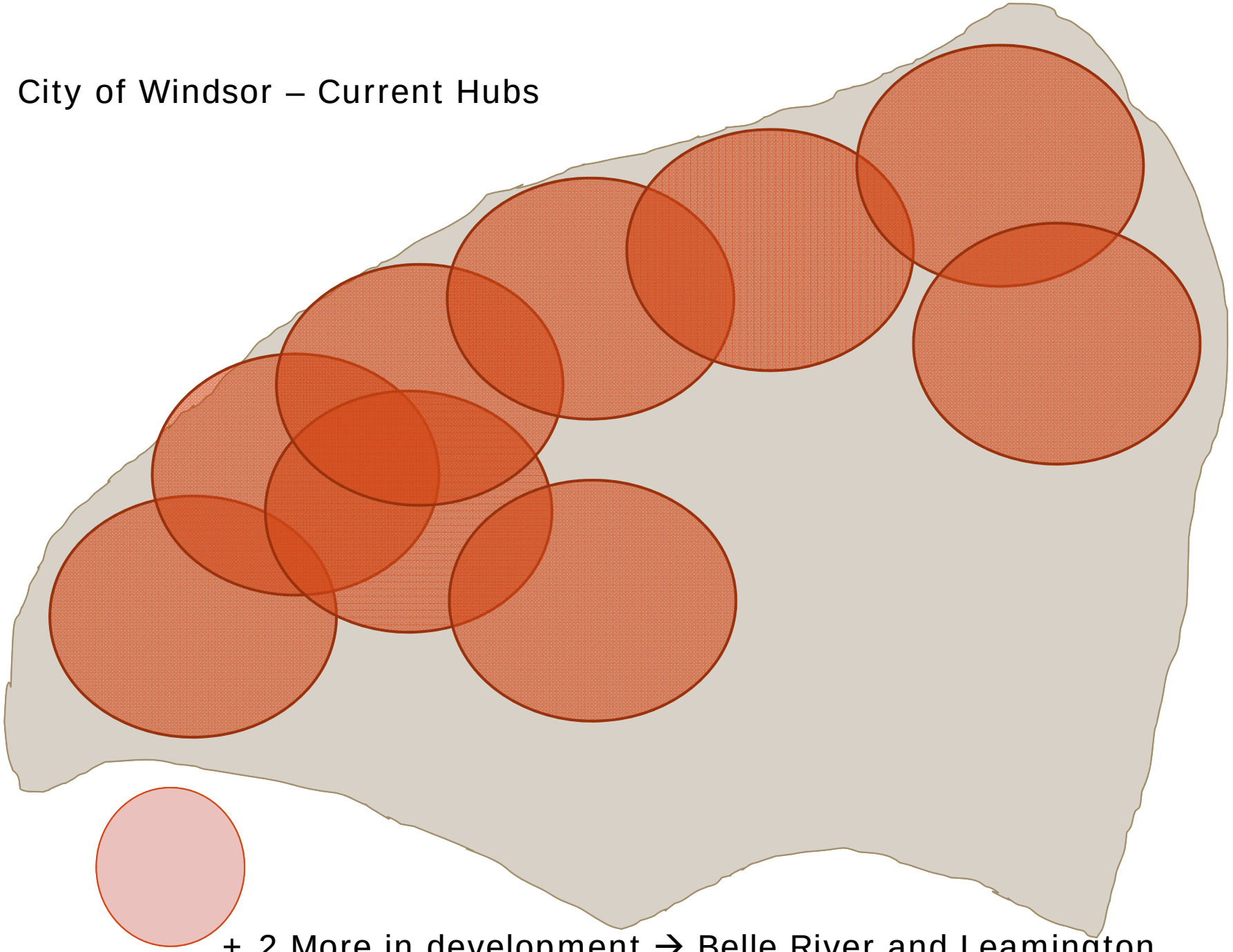
Wrap around services with non traditional partners

Example: Consumers at times can live alone and feel isolated. One consumer would regularly ask if the attendant would agree to forego her shower for that day so that the attendant could sit down and have a cup of tea and play cards for an hour. This is not the best use of our Ministry of Health funding. But is it any less important than a shower? It is something the consumer is clearly identifying they need. We set up a screened volunteer to come and do friendly visiting twice per week.

Our Locations in Windsor

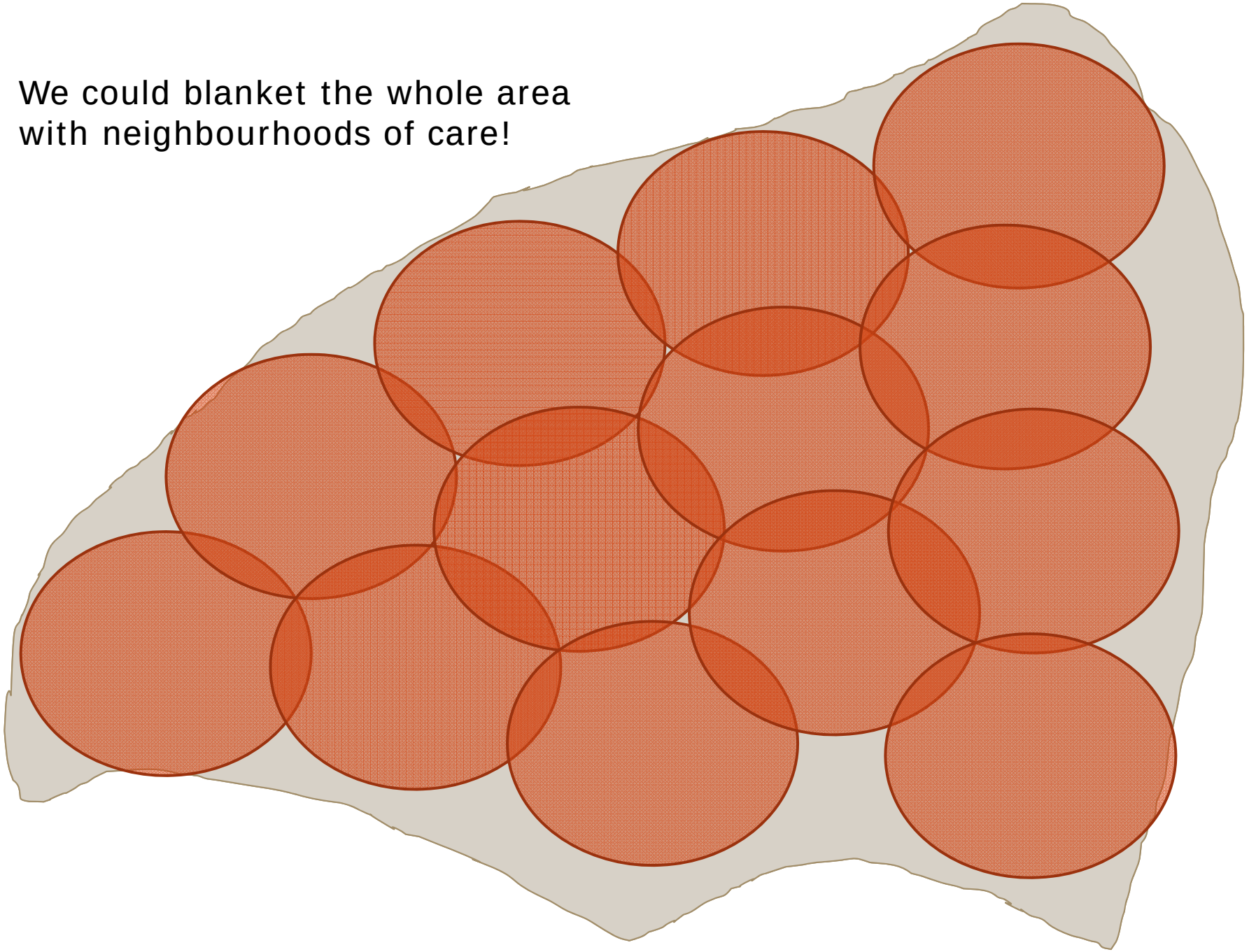


City of Windsor – Current Hubs



+ 2 More in development → Belle River and Leamington

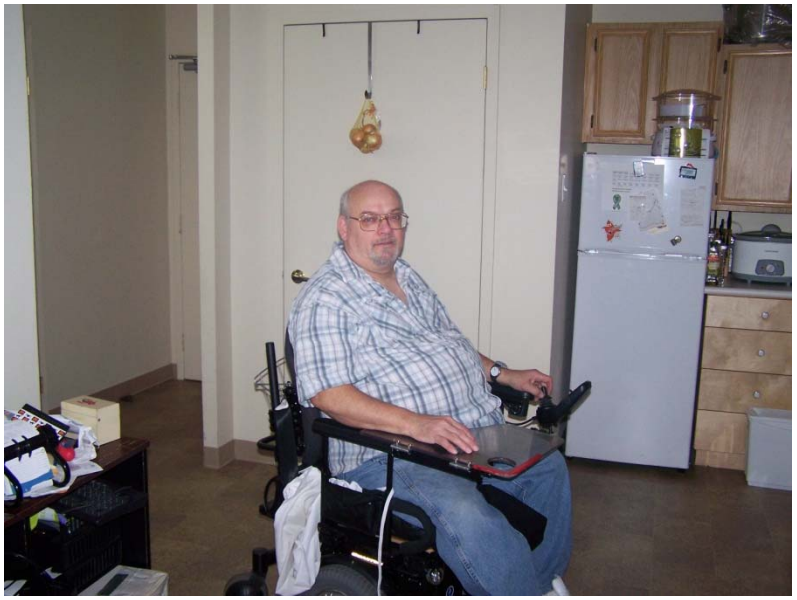
We could blanket the whole area with neighbourhoods of care!



Satisfaction

- This gentleman was our first transition
- 84 years old
- Stroke
- High Blood Pressure
- He was bed ridden when he arrived
- He speaks only Mandarin
- We have been able to hire workers who are able to speak with him in his own language.

Results



- 63 years old
- Diabetic
- Amputee
- Transitioned successfully from WRH Rehabilitation
- Bound for a homeless shelter

Statistics

- Since February 2011 we have transitioned onto service over 500 people who were ALC, in LTC or diverted from LTC
- Between June and December 2011 we transitioned 53 people and at our fastest pace were averaging 12 people per month
- Currently 41% are over the age of 65
- 51% of the 590 people on our wait list are over 55

Neighbourhoods of Care

- Are collaborative
- Are consumer centred
- Are flexible and nimble mobile services where we bring the service to the consumer and the consumer does not have to move around to get the assistance required.
- Are cost effective (averaged at about $120 per day) in AL Functional Centre

Neighbourhoods of Care

- We have had one hospital offer us space from which to operate a hub – they are 24 hours – the centre of the hub does not need to be a Supportive Housing building.
- Greater Windsor Essex School Board offering space for community hubs (Belle River)
- There are lots of people coming forward with innovative ideas!

Moving Forward

- Consumers – some flexibility required – we moved slowly – we are in our 7th year – changes gradually
- $750,000 per neighbourhood so every time we get an infusion of funding we look at the clusters we are serving already – our waiting list with geo maps – former CCAC who they might be serving in the area

ANY QUESTIONS?

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www.alsogroup.org