BELLWOODS

INNOVATING INDEPENDENCE

# BOARD THINK TANK - MARCH 21, 2018

# Background

Established 60 years ago, Bellwoods Centres for Community Living Inc. is a charitable, not-for-profit organization providing community based, client direct support services, independent living education programs, and accessible, affordable housing for person with physical support needs living in the Toronto area, to enable them to live independently.

Focuses on meeting community needs through partnership development to support health and housing system priorities

Committed to enabling adults and seniors with physical support needs to live as independently as possible and to direct their own services

Provide individualized services and programs in variety of living environments in Toronto area

# Bellwoods: Core Services and Programs

| | Overview |
|---|---|
| **Supportive Housing/ Community Connect** | ○ 24/7 PSW services available on site<br>○ Permanent housing at Shaw (10), Dundas (31), and Mimico (13)<br>○ Community Connect (CC) at Shaw (21) offers up to 6 month transitional supports for ALC patients<br>○ *New in 2019* Madison (20) |
| **Housing Hubs** | ○ 24/7 access to PSW services<br>○ Housing partnerships with St. Clare's Multi-faith and Mahogany Management<br>○ Sudbury (9) and Deauville (10), *New in 2023* Birchmount (25) |
| **Attendant Outreach** | ○ PSW services offered within client home, place of work or school<br>○ Available from 6 a.m. – midnight daily<br>○ Services are available on a pre-scheduled visitation basis |
| **MILE/Case Management** | ○ Focus on optimizing safety and independence in the home through assessment, skills training, community linkages and case management<br>○ Staffed by Independent Living Educators and Program Facilitators |

# Experience Testing New Innovations:

# Piloting Short-Term Transitional Care Models in the Toronto Central LHIN

## OVERVIEW & HIGHLIGHTS

## Range of models tested

Reintegration Units (RIUs)
(14 providers)

- Clinical Care Models
- Personal Care Models

Caregiver ReCharge Services
(5 providers)

- Adult Day Program
- Respite (in-home and away from home)

## Clinical & Personal Care Units

Clinical Care Units (n=183 beds)
Personal Care Units (n=57 beds)
LOS = 42 - 180 days

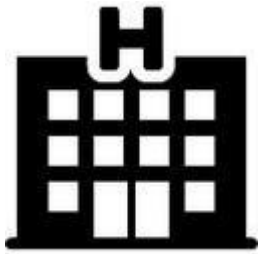
**All units support transition of patients at risk of ALC / ALC from hospital to RCUs in the community focused on the following goals:**

*Enable patients to receive clinical support and/or regain strength and independence outside of hospital.*

*Help patients and their caregivers make informed decisions about their future care needs and living arrangements.*

# Intended Outcomes of all STTCMs

- Build a regional system of RCUs
- Facilitate flow re: # patients transitioned /month
- Reduce # ALC days
- Reduce # inpatient hospital days
- Reduce ALC rate



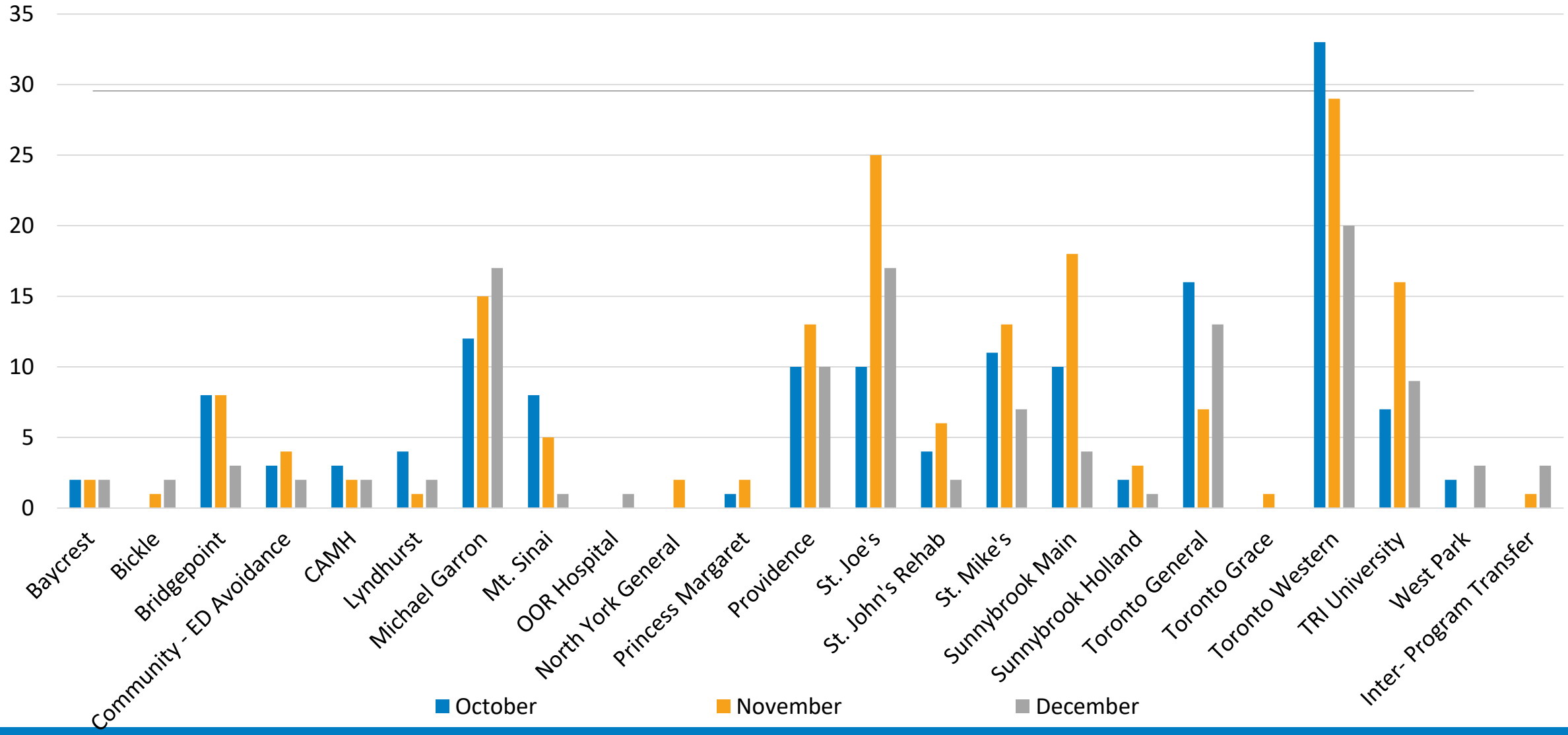
- Improve patient and caregiver experience
- Improve providers experience
- Meet occupancy rate targets in RCUs (≥89%)
- Maximize system flow
- Standardize processes and practices

# STTCM Data Trends
(TRENDS: Nov. 15, 2017- March 31, 2018 + April 1 – Dec. 2018)

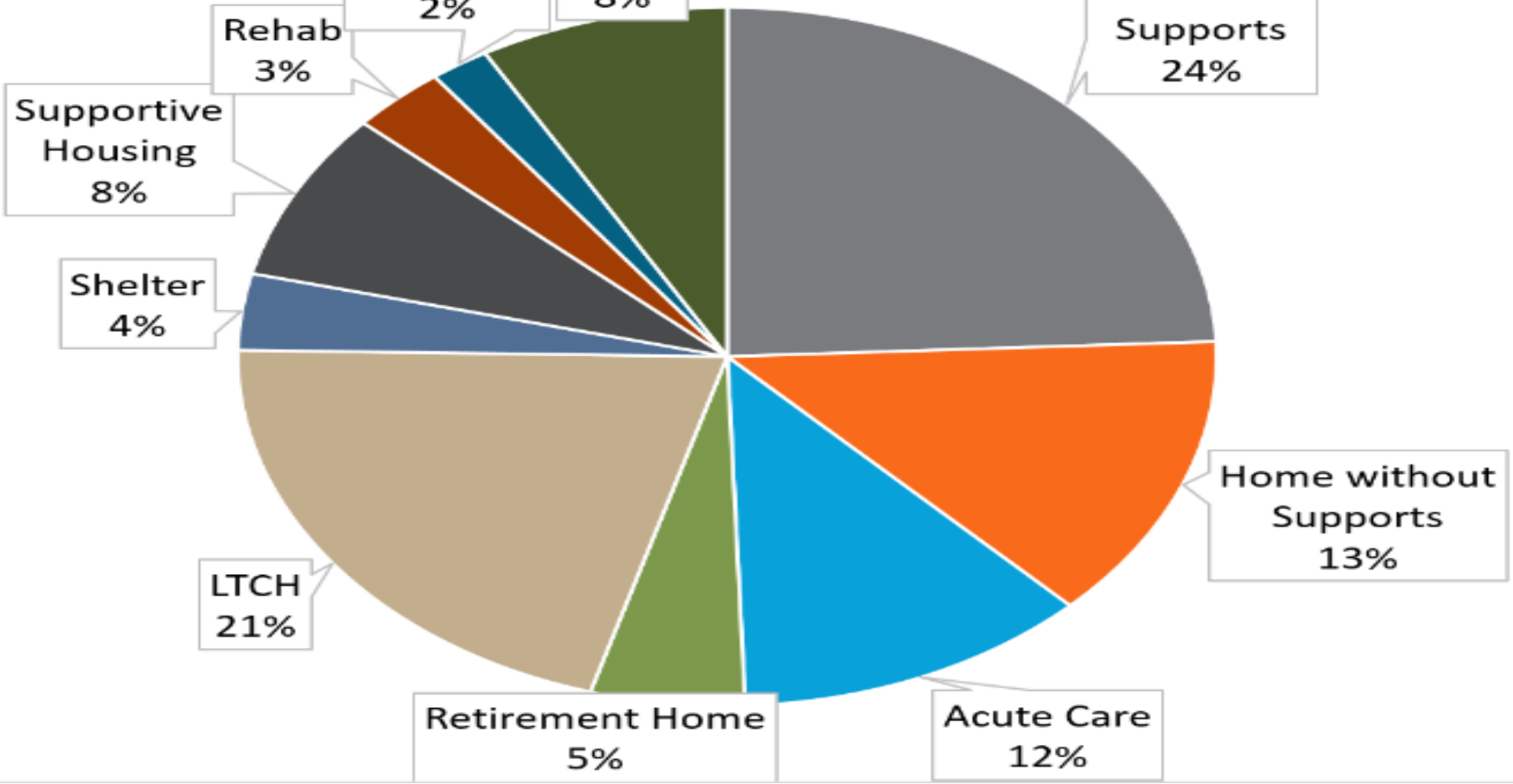
| | Reintegration units | Caregiver ReCharge |
|---|---|---|
| *Total # patients admitted* | 323 + | 63+ |
| *Total # patients discharged* | 223+ | 29+ |

*Note: Not all units were operational as of November 15, 2017- Operations of the units were phased in with the majority of beds/units/spaces operational by December 15, 2017*

# STTCM Pilot Project: Referral Source # of Referrals for 2018-19 -Q3 (Period: Oct - Dec 2018)



# In Q2 – 2018/19… the majority of patients transitioning from RCU were discharged to a community setting

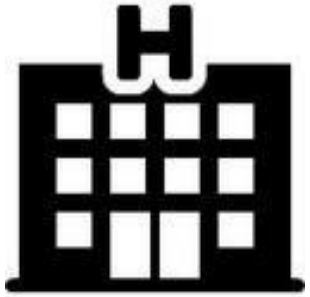


# Value of reintegration care models for hospitals

Supporting transition & flow

Improving understanding of breadth and depth of caseloads that can be successfully transitioned to the community

Building of relationships



Validating the complexity of the ALC caseload in hospitals and the lack of options/appropriate places for some patients to transition

Identifying specific cohorts of patients who are difficult to transition (and the need for program changes within hospitals )

Streamlining & coordinating access to community supports

# Value of reintegration care models for community partners

Demonstrating the ability and expertise of community partners to manage complexity and case mix

Fostering ‘integration’ among community partners in setting standards, confirming care practices, etc.

Increasing connection and coordination with hospital partners

Catalyst for other collaborations and integrated approaches

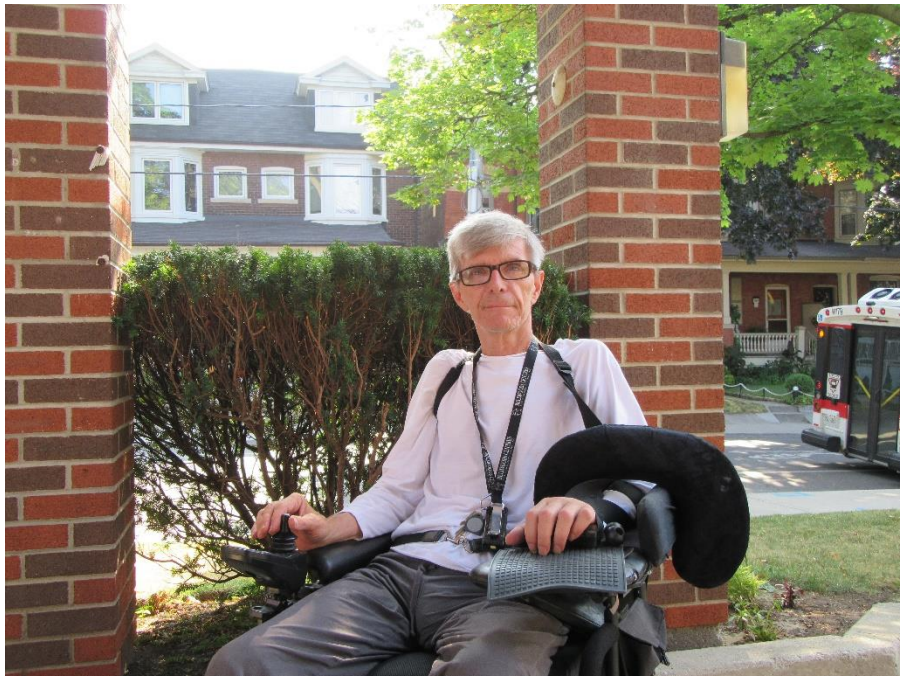
# Project Work Aligned with the New Government Mandate for Health

# Transitional Support Services

BELLWOODS INNOVATIONS & LEADERSHIP

# Reintegration Care Units

- Short term (< 6-month) transitional housing with prescheduled 24/7 PSWs and case management by MILE Facilitators for ALC or ALC at risk patients
- 15 barrier free, furnished, rent geared to income, private bachelor and one bedroom apartments
- Opportunity for clients and their families to develop new life skills and confidence by mimicking challenges of “real world”



# 10 years of results to reduce ALC

| Year | # of ALC days reduced |
|---|---|
| 2017-18 | **6,600** |
| 2016-17 | **6,319** |
| 2015-16 | **5,124** |
| 2014-15 | **4,979** |
| 2013-14 | **5,203** |
| 2012-13 | **4,772** |
| ***Total*** | ***32,997*** |

| Year | # of Transitioned ALC Clients |
|---|---|
| 2017-18 | **55** |
| 2016-17 | **37** |
| 2015-16 | **29** |
| 2014-15 | **21** |
| 2013-14 | **26** |
| 2012-13 | **27** |
| *Total* | *195* |

**Doing our part to reduce ALC rates in TCLHIN:**

- 300 Transitions since 2009
- Cost avoidance to the acute care system estimated this year at $4.5M (6600 days x $750/day)

# Caregiver ReCharge Program

Offers supplementary respite support to caregivers caring for patients who are being transitioned from TC LHIN hospitals to home.

- Temporary in-home support to caregivers who are experiencing high levels of stress or burnout as a result of their caregiving activities
- Applications are received through Centralized Referral Management (CRM)
- No charge for service

*Supports include:*

- A customized service plan to meet the individual needs of caregivers and client
- Skilled substitute in-home care given by trained staff
- Available any time of day throughout a 24-hour period
- Serving 100 clients annually

# Centralized Referral Management (CRM)

The Short Term Transitional Care Models (STTCMs) being piloted in TC LHIN are designed to support inpatients and their caregivers in the transition from hospitals to the community. These initiatives are being provided in partnership with 14 different Health Service Providers (HSP) in the community.

3 categories of STTCM programs have been initiated in TC LHIN:

## Reintegration Care Units (RCU)

- Personal Care Reintegration Units
- Clinical Care Reintegration Units

## Caregiver ReCharge

- In-Home Respite
- Overnight Respite Stays Out of the Home
- Adult Day Program

## Uninsured

- Dedicated # beds in the community for these clients
- In 2017/18 – 7 clients transitioned from hospital to the community (combined LOS of 36 years)

# Impact of CRM

2018/19 YTD (April 2018 – February 2019)

- Total client referrals to CRM @ >1700
- Total clients admitted this year: 923 (includes CRS)
- Total discharged YTD: 802
- >50% of clients discharged go home/to the community
- Total collective LOS in RCU beds (year to date): 58,304 days

Tracking of data/analytics to inform decision-making

Tracking of unmet need in the system

Streamlined solution, adding of additional programs

Shared reporting (holds everyone accountable)

CRM to lead monthly Service Resolution Tables

(case by case review of clients without a discharge destination)

**Reintegration Care Models (RCM) TCLHIN**
**February 2019**
Centralized Referral Management Statistical Summary

REFERRAL TYPE

| | In-Home Respite | ADP | Overnight | Multiple ReCharge | PCRU/ CCRU | TOTAL |
|---|---|---|---|---|---|---|
| Baycrest | | | | | 4 | 4 |
| Bickle | | | | | | 0 |
| Bridgepoint | 12 | 1 | | 1 | 2 | 16 |
| Community | | | | | 1 | 1 |
| CAMH | | | | | 1 | 1 |
| Humber River – Sunnybrook RCC | | | | | 2 | 2 |
| Lyndhurst | | | | | | 0 |
| MGH | 14 | | | 3 | 7 | 24 |
| MSH | 2 | | | | 6 | 8 |
| PMH | | | | | 1 | 1 |
| Providence | | 4 | | 1 | 4 | 9 |
| SJHC | 3 | | | 1 | 13 | 17 |
| St. John's Rehab Sunnybrook Group | | | | | 3 | 3 |
| SMH | 2 | | | 2 | 2 | 6 |
| Sunnybrook Holland Campus | | | | | 1 | 1 |
| Sunnybrook Main Campus | 1 | | | | 7 | 8 |
| TGH | 1 | | | | 10 | 11 |
| Toronto Grace | | | | | | 0 |
| TWH | 13 | | | 2 | 18 | 33 |
| TRI University | 1 | | | | 9 | 10 |
| West Park | | | | | 1 | 1 |
| Inter-Program Transfer | 1 | | | 1 | 0 | 2 |
| TOTAL | 50 | 5 | 0 | 11 | 92 | 158 |

# Housing Solutions

BELLWOODS INNOVATIONS & LEADERSHIP

# Housing with Layered Supports (new in 2018)

- 2 years of funding from the City, under the program *Housing with Layered Supports* (HLS).
- Opportunity provides ability to add a Housing Support Worker to provide case management to clients identified as homeless with focus on housing acquisition and community support.
- Program also includes funding for 20 approved rent subsidies. Rent subsidies (up to $800/month) will be used for clients requiring housing and ongoing supports to maintain their housing under this program.
- This is a significant enabler to support the transitional program and support our community to help people secure housing.

# Madison Collaborative (new 2019)

- 6 support agencies, 39 supported units, total of 82 units in the building
- Lead agency model, collaborative governance, shared accountability agreement
- Integrated service plan, integrated budget for the building, share site manager
- Collaborative approach to supporting a variety of client populations, including: adults with disabilities, seniors, clients with dual diagnosis, mental health issues, development disabilities.

Bellwoods is the lead agency for this initiative

Other partners include: COTA, Woodgreen Community Services, VITA Community Services, LOFT, Toronto Community Living

# Bellwoods' Key Partnerships

**Services**

- Toronto Central Local Health Integration Network (TC LHIN)
- Toronto Central LHIN Home and Community Care
- Centre for Independent Living Toronto
- Hospitals – acute, rehabilitation, complex continuing care
- Community Support Services - seniors, mental health and addictions, Attendant Services
- Other partners supporting shared clients and initiatives

**Housing**

- City of Toronto
- Government of Ontario
- Canada Mortgage and Housing Corporation (CMHC)
- First National Financial LP
- St. Clare's Multi-faith Housing Society
- Mahogany Management

# Looking to the future

- Find ways for the community sector to take on more leadership roles
- Continuity of services will need to grow, to address the holistic needs of our clients
- We need to operate as a system, not as individual health service providers
- Social determinant of health are critical and we have the expertise as a sector to address
- Ensure consistency of standards, not just about horizontal integrations, but vertical integration as well - government, funders, clients, caregivers want the same consistent service/expectations
- Can’t be afraid of collaborative governance models and new accountability arrangements

# Thank you!