TORONTO

STAFF REPORT
INFORMATION ONLY

Community Programs Provided by the Long-Term Care Homes and Services Division

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To:	Advisory Committee on Long-Term Care Homes and Services
From:	General Manager, Long-Term Care Homes and Services
Wards:	All
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SUMMARY

While considering the report "Supportive Housing Services at Cliffwood Manor" at the October 23, 2009 meeting of the Advisory Committee on Long-Term Care Homes and Services, the committee requested information about the various community programs provided by the Long-Term Care Homes and Services Division, noting their higher level of familiarity with the long-term care homes, in comparison to their familiarity with the community programs.

There are three community programs, namely: Homemakers and Nurses Services (HMNS), Supportive Housing (SH), and Adult Day Programs (ADP). These programs, along with the ten long-term care homes, enable the division to provide individuals with both a variety of options and a continuum of care. HMNS provides homemaking services such as cleaning, laundry, help with meal preparation and limited shopping to clients living in their own homes. SH provides homemaking service plus personal care which includes help with bathing, medication reminders, and security checks for clients who live in their own apartments within designated buildings that contract with the City to host the SH program. Services are scheduled, but staff are on site 24/7 to provide ad-hoc assistance as needed. ADP provides wellness and activity programming along with nutritious meals for clients who come to the program site for a day of activities. ADPs are located at Bendale Acres, Cummer Lodge, Kipling Acres and Wesburn Manor.

This report provides an overview of the programs provided along with information about demographics, the environment in which the community programs are delivered, and a summary of the scope of operations.

Financial Impact

There are no financial implications arising from this report.

COMMENTS

According to the 2006 census, 14 percent of the City of Toronto's population (353,455) are seniors. This is an increase of 5 percent over 2001 census data. The fastest growing age groups are persons 55-59 years of age, 80-84 years of age and 85 years of age and over. These groups have increased by 26 percent, 30 percent, and 19 percent respectively between 2001 and 2006. By 2031, seniors will comprise 17 percent of the population of the City of Toronto which reflects a 42 percent increase over 2006 data in the number of citizens aged 65 and over. Care and services for older seniors is a growing concern as the population ages. By 2031, the number of people 85 years of age and over is projected to be 85 percent larger than in 2001. This large increase, including the predominance of women and the significant increase in the number of older seniors (those over 85) will require community care options to assist Toronto residents to age in place and maintain optimal levels of independence.

Not only is it the expressed wish of seniors to age in place and remain independent in their own homes for as long as possible, it is also an explicit objective of the Ministry of Health and Long-Term Care. Through the 'Aging at Home' strategy, administered by the LHINs, the Ministry has earmarked millions of dollars over a three-year period to support innovative projects to assist seniors to remain independent. The division has submitted successful proposals that rely on 'Aging at Home' funding. In year one, the division was awarded funds to initiate supportive housing services at Winchester Square (South St. Jamestown) and in year two to initiate supportive housing services at Cliffwood Manor (Don Mills and Steeles). A year three proposal has been submitted to start supportive housing services at Francis Beavis with a satellite at May Birchard (Pape and Dundas), but the results of this call for proposals are not yet known. The division's various community programs are important blocks in the foundation on which the City can build its reputation as an age-friendly community.

In Toronto, 74 percent of seniors live alone which results in isolation and increased vulnerability. Community programs fill a vital role in increasing the quality of life for these individuals. The ongoing visits, assessments, referrals and follow up made by the HMNS caseworkers and SH registered practical nurses (RPNs) provide other benefits in addition to managing the homemaking and personal care needs of clients. Potential risks can be identified at an early stage and appropriate interventions started, in order to prevent future crises. For example, if a hoarding situation is identified early, the caseworker or RPN can work with the client to deal with the clutter, thus avoiding an eviction notice. It must be noted, however, that these types of intervention can only proceed with the client's agreement. Client choice, inclusion in decision making and service plans, and advocacy are pillars of the division's community programs.

Studies demonstrate that supportive housing clients use 911 less often, visit the emergency department less often, and are admitted to the hospital through the emergency department less often than similar groups not living in supportive housing. Other studies

demonstrate that SH and ADP are viable community options that support seniors' independence in community living and delay or avoid admission to long-term care homes.

Budget

Budget for the three programs is approximately $9,000,000 with the bulk of the funding coming from the Ministry of Health and Long-Term Care (MOHLTC) either directly or through the Local Health Integration Networks (LHINs). SH and ADP are one hundred percent (100%) MOHLTC or LHIN paid, with no net cost to the City of Toronto. HMNS is a discretionary cost-shared program, operated under the *Homemakers and Nurses Services Act*. If a municipality chooses to operate a HMNS program, the program is cost-shared at a rate of 80:20.

Demographics

The majority of clients in each of the community programs are elderly women, most of whom are living with no or minimal family supports. Across all three programs, there are over 3,000 clients with service visits numbering in the tens of thousands.

Program	**Individuals Served**	**Hours of Service or Visits/year**
HMNS	2,400	87,000 visits/year
SH	420	64,000 hours of service/year
ADP	255	12,400 client days/year

Program	**Demographic**	**Percentage**
HMNS	<65	12% men, 24% women
	66-74	4% men, 14% women
	>75	9% men, 37% women
SH	<65	4% men, 4% women
	66-74	9% men, 18% women
	>75	19% men, 46% women
ADP	<65	11%
	66-74	18%
	>75	67%

The profile of health status for clients of the community programs verifies that musculoskeletal disorders (MSD) and the risk of falls are a key reason that clients are admitted to both HMNS and SH. MSDs include hip and knee replacement, osteoarthritis and osteoporosis. Cardiovascular conditions make up the second highest occurring group in HMNS and SH, including heart attacks, peripheral artery disease and strokes. Mental health issues and endocrine (e.g. diabetes) constitute the next most frequently occurring groups of diagnoses precipitating the need for the HMNS and SH. For both programs, the fourth most frequent reason for admission is cognitive impairment. In ADP, a variety of quality activities and services are provided in a safe, supportive environment for people living in the community who are physically frail, have a cognitive impairment or who are socially isolated. ADP clients often attend the program to provide respite for

their full-time caregivers. A number of ADP clients have early to mid-stage dementia and cannot be safely left alone. Individuals with developmental disabilities who are aging are another group who rely on the services available in ADP. It is also important to recognize that most clients admitted to the various community programs have more than one diagnosis, and the information included here includes only the primary diagnosis that led to clients' admissions.

Scope of Service

In HMNS, the main function is to provide homemaking services to frail elderly and disabled clients in their own homes. However, HMNS often provides the sole connection between clients and other community resources. This unique position allows HMNS caseworkers the opportunity to connect clients with other community services as needed and to advocate on their behalf with other service providers such as the Community Care Access Centre (CCAC) and landlords such as Toronto Community Housing (TCH). With direct services provided by contracted agencies, periodic re-assessment is done by the caseworker to determine ongoing need, adjust the service level accordingly and provide support to clients. A unique aspect of HMNS is the availability of a counsellor to act as a resource to caseworkers, when they encounter challenging client situations. HMNS caseworkers also have access to many resources available from the division not commonly found in community programs such as infection prevention and control resources, the Resident/Client Advocate, the Ethics Committee and the Quality Council.

HMNS has a strong focus on safety, both for clients and for community workers. The HMNS database allows caseworkers to contact all HMNS clients during community emergencies. For example, during the last power outage, HMNS caseworkers contacted all clients who were at risk and offered support, including transportation and temporary shelter at a warming center. From the staff perspective, HMNS caseworkers work with a personal safety device known as iGuard, which is capable of connecting them to 911 if situations present in which they find themselves in immediate personal risk.

The division's SH model is different from most models, in that each location has a registered practical nurse (RPN) on-site, to provide service coordination, ongoing assessment, health promotion and wellness education. Homemaking and personal care services are provided 24/7 by personal support workers (PSWs) employed by contracted service providers. There are also some innovative approaches amongst the various SH locations. For example, SH services at Winchester Square are unique in that there is a full-time mental health counsellor attached to the program to provide additional support for clients with mental health needs. SH at 111 Kendleton is another example of innovation; this location was developed through an alliance with the division, Shelter, Support and Housing Administration and Toronto Community Housing. Supportive housing services are provided for one hundred percent (100%) of the tenants at this location. In support of diversity, SH at West Don Acres has a Russian speaking RPN and contracts with a community agency to provide services in Russian because of the predominantly Russian speaking population who live in the building.

As in other community programs, client safety is a key focus, and SH has a comprehensive strategy to prevent falls and a collaborative program with Toronto Public Health to address bed bugs in buildings where these pests reside. Falls amongst seniors are the most frequent reason for admission to hospital, so by decreasing the number of falls, the number of admissions can be decreased. All clients are assessed on admission, and any factors identified that would predispose a client to falls are minimized. In partnership with Toronto Public Health, a falls prevention program called Life-Ken-Fit was introduced at Kendleton which includes strengthening and balance exercises. The re-emergence of bed bugs in Toronto has resulted in the need for SH staff to assist clients by providing information about the prevention and spread of these pests, assisting with getting their units fumigated, and helping with required laundry and vacuuming. All SH locations offer a variety of wellness programs and in order to increase spread, all wellness programs within SH are open to other tenants.

ADP programs promote clients' safety by providing a safe environment for individuals who can benefit from the social and health promotion programs, are socially isolated, need respite and/or cannot safely be left alone. As with other community programs, ongoing monitoring, assessment, and reassessment identifies risks early on, and appropriate interventions begin as soon as possible. ADP also promotes client safety by improving mobility to prevent falls and increase independence. Mobility programs, an integral part of all ADP programming, is provided in groups and has the secondary benefit of increasing socialization and preventing isolation.

All three community programs play a key role in providing specific health care information (e.g. blood pressure and diabetes) and general education about safety and aging. All information is provided personally, so one-on-one discussion is possible, and any misunderstandings or questions can be addressed immediately. Community programs, in addition to providing information from Toronto Public Health and other community sources, publishes its own educational pamphlets and a newsletter for distribution. HMNS and SH also promote the "In Case of Emergency" program in partnership with Emergency Medical Services (EMS). This program provides each client with a card to be kept in their wallet or on the fridge with important medical, medication, and contact information to be used by EMS staff in case of an emergency situation when a 911 call is placed.

Collaborative Models

Working with other agencies is ongoing and occurs at two levels. The first level is the actual provision of services, and the second is as a strategic partner in planning integrated community services. In three out of four programs (BA, CL, KA), ADP staff who provide the direct services are employees of the division; in one (WM), ADP services are provided by staff of the community agency who collaborated with the division in submitting the successful proposal for funding to the LHIN. Except for service coordination, direct HMNS services are provided by a variety of for-profit and not-for-profit contracted service providers. These agencies work with HMNS to ensure quality service is provided within the standards and parameters set by the division. Each SH

location has a similar contract with a not-for-profit community agency to provide the required direct homemaking and personal support services.

The division's community programs have a variety of important relationships with community and government agencies. Most importantly, community programs collaborate with Community Care Access Centers (CCAC), Local Health Integration Networks (LHIN) and Toronto Community Housing (TCH). A number of HMNS clients are also clients of a CCAC, with HMNS providing the requisite homemaking and the CCAC providing the required personal support. HMNS and CCAC hours can be coordinated to provide a client with a longer service span or can be delivered on different days, where more frequent contact or monitoring is beneficial for the client. HMNS staff participate fully in case conferences as required. In SH, a CCAC may provide the professional services not included in SH funding, such as nursing, physiotherapy, and/or occupational therapy.

Strategically, community programs have close ties with other community agencies, including the Community Ethics Network (CEN) Steering Committee and the Community Psychogeriatric Program. There was also strong divisional representation on the Balance of Care research project completed by the Toronto Central CCAC, reported to the Advisory Committee on Long-Term Care Homes and Services in the past, which studied the cost and value of community services. There is also close liaison with the Ministry of Health and Long-Term Care, Toronto Public Health and Toronto Emergency Medical Services.

Collaboration with the LHINs is multi-layered, with community programs staff attending the City of Toronto – 5 LHIN Dialogue meetings and more frequent interchange related to applying for 'Aging at Home' funding and monitoring performance measures, once funding has been received. There are also many other agencies such as Community Occupational Therapy Association (COTA), Ontario Disability Support Program (ODSP) and the Advocacy Centre for the Elderly (ACE) which provide complementary services to ensure that clients receive the most appropriate help to maintain their independence.

Satisfaction

Clients of community programs complete periodic Your Opinion Counts (YOC), and the division uses these results to guide quality improvement work. Past results consistently indicate a high degree of satisfaction, typically greater than 80 percent very satisfied. In addition to the high percentage result, confirmation of satisfaction is further demonstrated through a review of the written comments of the surveys returned. Comments like "[because of your service,] I am able to stay in my own home where I feel safe and comfortable," and "The most important thing to me is that I am treated with respect and my privacy is respected" are typical of the positive feedback received.

Growth

Another indicator of community programs' success is the growth in the past five years. Five new SH locations have been opened; there is a wait list at one location and two others are at capacity. There is also a wait list for HMNS service. In 2009, an additional

ADP was opened after a successful funding application submitted to the Mississauga-Haltom LHIN, in collaboration with Etobicoke Services for Seniors. This ADP, located at Wesburn Manor, is the division's only ADP provided solely for individuals with Alzheimer's or related dementias.

Challenges

Funding remains the major impediment to further expanding community programs. Population demographics provided at the beginning of this report not only demonstrate the current service needs, but highlight the fact that these needs will greatly increase in the near future. Attention needs to be focused on what resources will be available when the current cohort of baby boomers reaches old age.

Maintaining the highest safety standards is another challenge, impacting both clients and staff. Many community clients live in higher risk environments, and philosophically, the division is committed to enabling clients to make their own decisions even it means assuming a higher level of risk. This may result in a client deciding to remain in his/her present situation, even after HMNS, SH or ADP staff have provided advice. For community workers, workplace health and safety is quite complex, as staff often work alone in unfamiliar environments. While the division cannot fully eliminate this risk, it can mitigate the risk through training, technology and controls.

One final challenge that affects the community sector as a whole is the availability of qualified staff. While turnover rates among City staff have been low, a common thread of discussion among the contracted provider agencies has been the difficulty in recruiting and retaining qualified and reliable staff. This is endemic throughout the healthcare system, but is particularly relevant to the community sector where wages are lower, where there is a propensity to hire part-time staff, and where the environment contains more risks.

CONTACT

Gregory Kolesar, Manager, Community Programs
Phone: 416-392-8543; Fax: 416-392-8457; gkolesa@toronto.ca

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Sandra Pitters
General Manager, Long-Term Care Homes and Services