Community Support Services Investments

Engagement with OH West CSS Providers

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JUNE 24 AND JUNE 27 , 2022

Ontario Health West

Agenda

1. Welcome and Land Acknowledgement
2. Ontario Health West connections and context
3. CSS Investment Overview
4. Let's Go Home (LEGHO) Overview
5. Discussion, Feedback & Next Steps

Housekeeping

- Please keep yourself muted
- Use the Chat function to ask questions
- Please raise your hand to ask a question during the Q&A
- Deck and materials will be shared in early July


Land Acknowledgement
Indigenous History
Month

2. Ontario Health West – Connections and Context

West – Regional Profile

4,133,908

TOTAL POPULATION

Mixture of rural and urban with the highest percentage of older adults

2.5%	2.1%	13.2%	18.1%	529	100	5
Identify as Indigenous	Identify as Francophone	Identify as visible minority	Immigrant population	Service Accountability Agreements	Home Care Service Provider Organization Contracts	Designated French-Language Service Areas

Projected population growth over next 10 years	Projected population over age of 65 in 10 years	Number of approved Ontario Health Teams
8.7%	35.1% (18% currently)	15

HEALTH SERVICE PROVIDERS

Community Mental Health & Addictions Providers	Community Support Service Providers	Community Health Centres	Public Hospitals	Aboriginal Health Access Centres	Long-Term Care Homes	Family Health Teams	Home Care Service Providers	Nurse Practitioner-Led Clinics	Designated Agencies for French Language Services
128	130	21	40	2	236	53	75	7	5

Ontario Health West

Ontario Health West – CSS Connections

Each region has teams focused on

Performance, accountability and allocation

Clinical programs

System, strategy, planning, design and implementation

Capacity, access and flow

Health equity and priority populations

Regional communication

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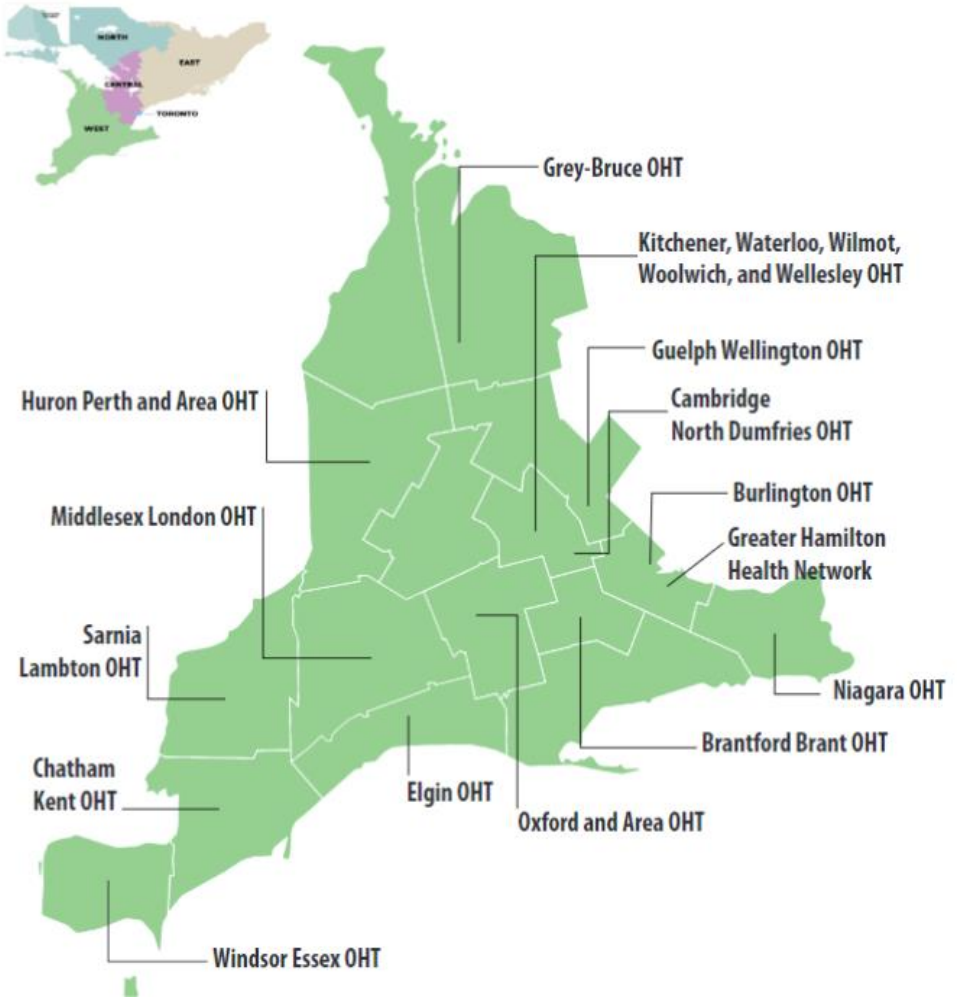
Ontario Health Teams (OHTs) – West Region

- 15 OHTs in West Region
- 130 CSS organizations providing a variety of CSS services
  - Some CSS organizations are attached/aligned to multiple OHTs
  - Varying levels of CSS engagement in OHT development



Ontario Health West

Implementation Plan

Reduce health inequities

1.1 Improve equitable outcomes and experiences, including a focus on:
- Indigenous people (Indigenous Health Plan)
- Black communities (Black Health Plan)
- Equity-deserving, high-priority, and communities with geographic disparities in access to care
- Older adults
- Children and youth
- Francophone population

1.2 Improve access to supportive care in housing, including:
- Home care
- Supportive housing
- Assisted living
- Long-term care

1.3 Advance whole person care experiences and outcomes:
- Enhance prevention and a population health approach
- Scale innovative models of service delivery
- Improve health care navigation (Health Care Navigation Service)
- Improve navigation with social services

Health System Operational Management, Coordination, Performance Measurement and Management, and Integration – Areas of Focus for 2022/23

A. Stabilize and transform health human resources (HHR)*

B. Support pandemic response, emergency risk management program, and recovery*

C. Improve access and flow (Alternate Level of Care (ALC), community paramedicine*, and clients waiting in crisis in the community)

Transform care with the person at the centre

2.1 Support improved access to high quality Mental Health and Addictions care*

2.2 Improve a person-centred continuum of long-term care (and support the fixing long-term care plan)*

2.3 Expand access to high quality integrated care through accelerated implementation of Ontario Health Teams (OHTs)*

2.4 Support people in the community (integrate home care to points of care)*

2.5 Digitally enable patient navigation and seamless patient transitions (implement Digital First for Health Strategy)*

Enhance clinical care and service excellence

3.1 Advance clinical integration and chronic disease care (Diabetes)*

3.2 Expand Provincial Diagnostic Network and genetic testing*

3.3 Improve access and quality in cancer care

3.4 Improve access and quality in renal care

3.5 Increase life-saving organ and tissue donations and transplants

3.6 Improve access and quality in cardiac, vascular, and stroke care

3.7 Transform and improve access and quality in palliative care*

Maximize system value by applying evidence

4.1 Use data to enhance equitable access to care

4.2 Advance data collection, analysis, sharing, and reporting to drive Continuous Quality Improvement (CQI)*

4.3 Support development and implementation of the MLTC's Quality Framework for long-term care*

4.4 Quantify value-add opportunities for the health system (identify efficiencies, savings, and value creation)*

4.5 Support improvement of patient safety

Strengthen Ontario Health's ability to lead

5.1 Continue building OH team*

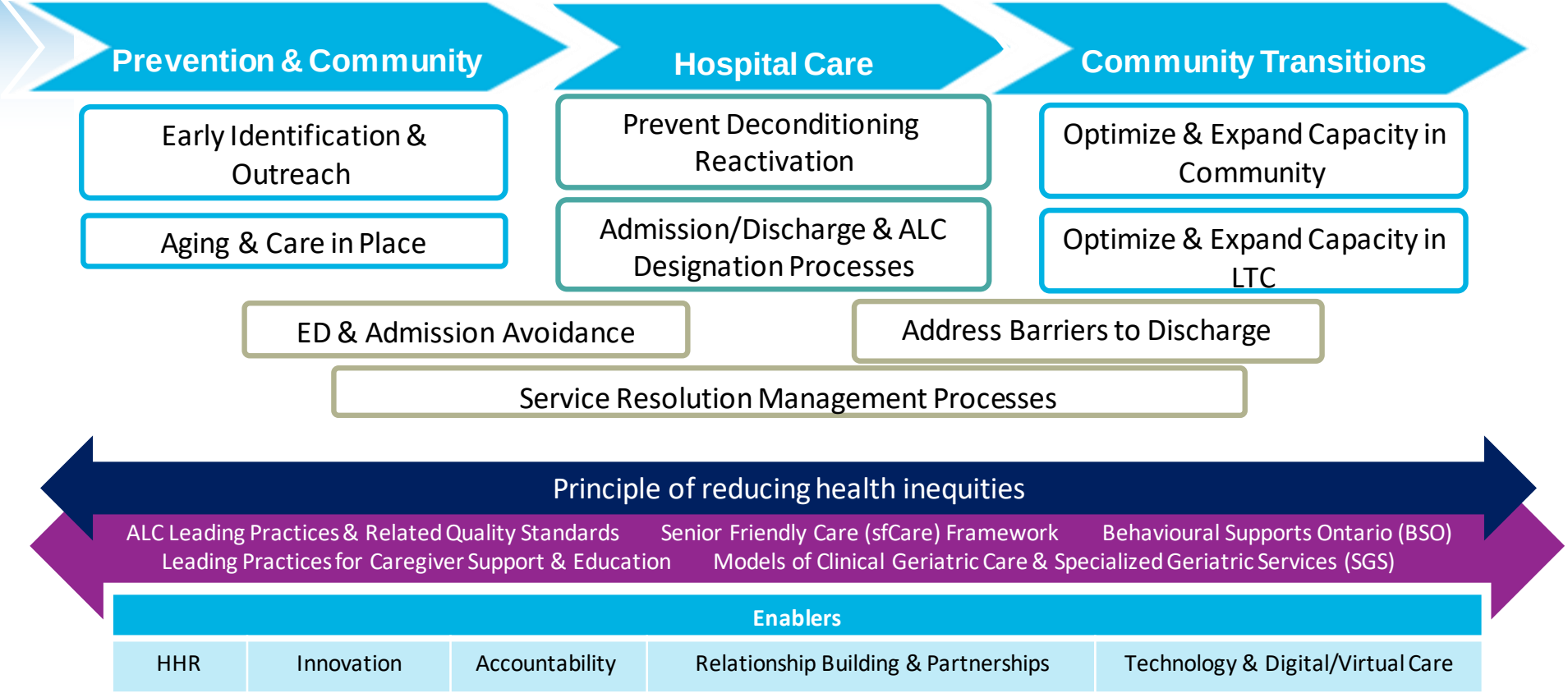
5.2 Strengthen system supports and accountabilities

5.3 Increase our role with primary care*

5.4 Support supply chain centralization*

5.5 Implement our Equity, Inclusion, Diversity, Anti-Racism strategy (year 2)

Areas of Focus Within the ALC Framework



*MOH/OH digital and virtual care funding for OHTs in the past three years has supported program development to address many of these key ALC areas. Appendix A includes detail of funding envelopes.

3. CSS Investment Overview 21/22 & 22/23

Background

The Ministry of Health provided Ontario Health West with base funding in 21/22 and 22/23 to support the continuation and expansion of Ontario Health-funded community services in the CSS sector.

- 21/22 funding is to support the continued delivery of services and to protect and prevent admissions of clients to acute settings as a result of de-stabilization in mental and/or physical health status.
  - This funding was allocated on a one-time basis in 21/22 and we are now moving forward with base allocation
- 22/23 funding is to provide a 2% increase in funding for CSS to address rising service costs
  - Use remaining funding for service expansion investments among CSS HSPs following engagements with relevant OHTs, as applicable - *allocation methodology has yet to be determined in conjunction with other Ontario Health regions.*

Other CSS Investments...

- Temporary Retention Initiative for Nurses
- Personal Support Services Wage Enhancement
  - April 1 – 27th and base allocation

4. Let’s Go Home (LEGHO): Bundled CSS Supports for Hospital Discharge and Community Stabilization

LEGHO – what is it?

LEGHO is a time-limited (4-6 week) bundle of CSS services developed by CSS providers in ESC and SW geographies to meet the needs of seniors and adults with physical disability who:

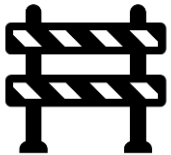
a) are discharging/have recently discharged from hospital to home

b) present at Emergency Department with needs related to social determinants of health

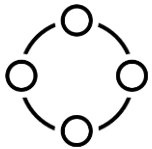
Focus on:

- ✓ ALC, ED Diversion, Admission Aversion
- ✓ Coordinating access to existing programs and services

How will LEGHO support the system?

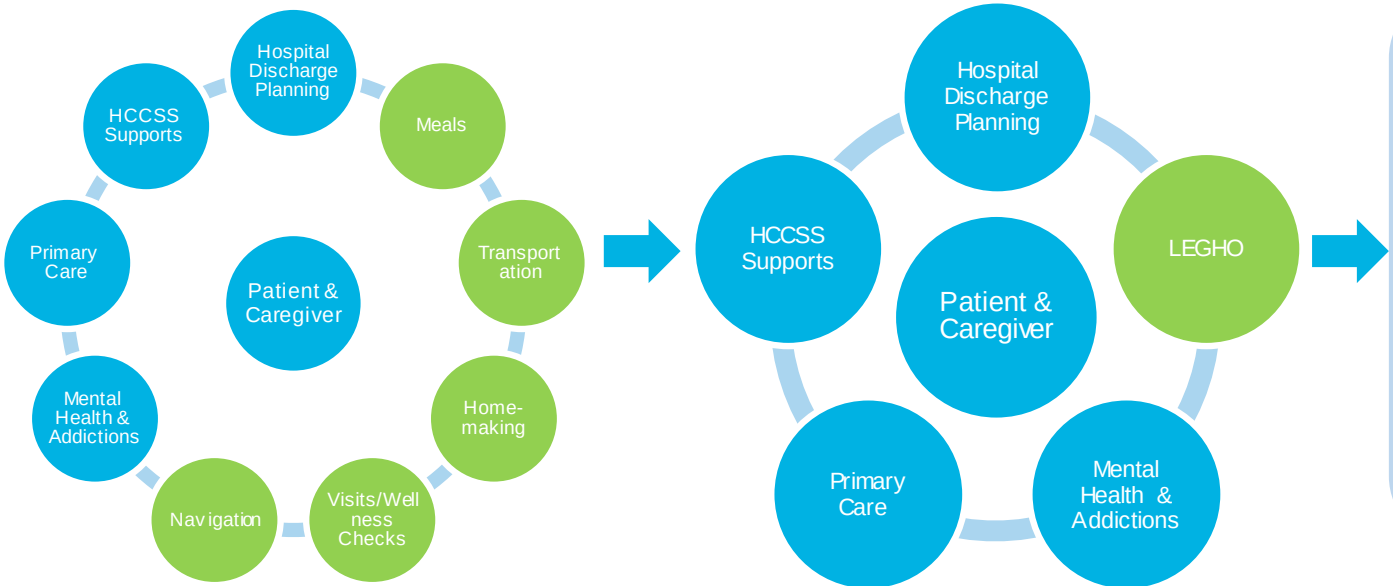


1. Remove non-clinical barriers to discharge/community stabilization:
   - Legislated co-pay for CSS services
   - Coordination between multiple CSS providers and other sectors (i.e., HCCSS, SPOs, hospitals)
   - Alignment of clinical & community supports



2. Support system goals:
   - Transform care with the person at the centre
   - Support equity-deserving populations
   - Manage Access & Flow at the system level

What will LEGHO change for patients & caregivers?



Coordinated Access to…

- Meals
- Transportation
- Homemaking
- Wellness checks
- Navigation/
- community connections

…with no financial barriers

OHT Continuum of Care

Do similar models exist?

Program	Locations Served	Included Services	Length of Service	Eligibility	Avg Cost/ Client	Base funded
Homeward Bound	ESC (Sarnia/ Chatham)	- Home at Last (discharge day) - Housekeeping - Meal Prep - Caregiver Relief/Respite - Home visits/Wellness Checks - Friendly Calls - Shopping/Meal Delivery - Assessments/Community Connections	3 weeks/ 7 service hours	• 60+ y/o • Planned/ Recent Hospital Discharge	$420	Yes
CSS Bundled Care	SW	- Home at Last (discharge day) - Housekeeping - Meals Delivery - Caregiver supports - Transportation	4-6 weeks	• Seniors/adults with physical disability • At risk for readmission to hospital, long-term care admission, and/or ED visit post discharge	$740	No

What did we learn from existing programs?

Population Supported

- Average age of clients is 75
- 40% of clients live alone
- 88% low income, fixed income, ODSP or CPP/OAS
- 70% had 3+ chronic conditions
- 47% had heart disease/ Coronary Artery Disease

Top Services Requested

- Meals on Wheels
- Visits
- Home Help
- Transportation

Partnering across organizations and sectors

- Community Paramedicine (overnight)
- Assisted Living (overnight)
- Primary Care

LEGHO Allocation Methodology

- Developed to ensure that each OHT area within the West Region receives an equitable portion of the base funding allocation
- Indicators selected to build an allocation model that focused on individuals who are older and economically disadvantaged:
  - % Population Aged 65+
  - % of People Aged 65+ Living Alone
  - % Population living below low-income measure (LIM-AT)
  - % of Patients that are Complex (4+ Conditions)
  - ON-Marg 2016 – Material Deprivation
  - ON-Marg 2016 – Dependency
  - Rate of ALC – Home (per 100,000)
  - Frailty (Provincial Geriatrics Leadership Ontario)

Metrics selected based on learning from Erie St. Clair (ESC) and South West (SW) programs

LEGHO Allocation by OHT

OHT	Base Funding*
Chatham-Kent OHT	$150,924
Sarnia-Lambton OHT	$186,319
Windsor-Essex OHT	$500,000
Elgin OHT	$125,000
Grey Bruce OHT	$210,869
Huron Perth & Area OHT	$155,980
Oxford and Area OHT	$125,000
London Middlesex OHT	$500,000
Cambridge North Dumfries OHT	$125,000
Guelph Wellington OHT	$211,689
Kitchener, Waterloo, Wellesley, Woolwich & Wilmot OHT	$294,283
Brantford Brant OHT (+Norfolk)	$272,660
Burlington OHT	$157,576
Greater Hamilton OHT (+Haldimand)	$500,000
Niagara Ontario OHT	$500,000
TOTALS	**$4,015,300**

1 CSS Organization in each OHT will receive the base funding to support LEGHO in that OHT area

**a minimum ($125,000) and maximum ($500,000) amount-per-OHT parameter was added after the methodology was applied to ensure all programs received sufficient funding to initiate programming*

LEGHO Funding – What's in scope?

- Funding is intended to:
  - Cover the cost of co-pay/client fees for 4-6 week period
  - Cover cost of coordination/alignment of services
  - Add program capacity, where needed, to include services in bundle
  - Cover one-time expenses in 2022/23 to launch the LEGHO program
  - Leverage existing programs and supports (i.e., Home at Last)
- Funding is not for the creation of new programs (i.e., no new functional centres will be funded)

Which CSS services are included?

LEGHO

Basic Bundle:

- Meals (delivery and/or prep)
- Transportation (home from hospital, to follow-up medical appoints)
- Homemaking
- Wellness checks
- Navigation/ community connections (opportunities with Assisted Living, Community Paramedicine, Primary Care)

Additional Supports Could Include:

- Friendly visits (virtual or in-person)
- Afterhours support
- Caregiver support

Service delivery period: min. 4 weeks; max. 6 weeks

LEGHO Implementation Process

Phase 1: Identify LEGHO Lead CSS Organizations

- 8 of the 15 West Region OHT geographies will need to identify a CSS LEGHO Lead (where currently no Lead CSS is identified/ Homeward Bound does not operate)
- LEGHO Lead will receive the base funding and coordinate implementation for the partners in the OHT

Due July 22, 2022

Phase 2: Implementation Plans*

- All 15 CSS LEGHO Leads will complete an implementation plan, in partnership with (at minimum) their OHT Executive Lead, HCCSS, local hospitals, and CSS partners

Due Sept.21, 2022

Phase 1: LEGHO Lead versus CSS Leads

- The “Lead” in this case is specific to delivery of the LEGHO program only
- Given the number of CSS organizations, one organization per OHT will be accountable for the LEGHO program, including:
  - Receive funding
  - Coordination and engagement among partners
  - Submit implementation plan
  - Report on metrics and evaluation criteria

Considerations for LEGHO Lead

A CSS LEGHO Lead should exhibit the following:

- Ability to influence system leaders, peers, and partners, and support creating a movement
- Demonstrated ability to represent the perspective of the sector and/or geographic perspectives
- Experience leading and working collaboratively with diverse stakeholders across health and social sectors
- Experience in addressing inequities in health that arise from the social determinates of health
- Historically provided accurate, reliable timely data to funders

Phase 2: Implementation Plans

- The identified CSS LEGHO Lead will complete an implementation plan, in partnership with (at minimum) their OHT Executive Lead, HCCSS, local hospitals, and CSS partners
- As alignment to OHTs and local system goals is key, implementation plans will need to be completed for all OHT geographies, even where programs are currently in place and/or were piloted
- The completed implementation plan will be due to OH West by **September 21, 2022**

Why an Implementation Plan?

- Funds have been allocated to all OHT geographies
- Implementation plan template and guidelines will provide minimum expectations and allow partners to build their LEGHO program together
- Goal is for partners to co-design implementation that targets local needs (i.e., OHT priority populations, OHT priority projects, local system pressures)

5. Discussion/Feedback & Next Steps

Next Steps

A. The webinar presentation, a FAQ document, a list of CSS organizations in each OHT geography, and a template for identification of CSS LEGHO Leads will be sent out to all CSS partners by July 8, 2022

B. Phase 1: Identification of a LEGHO Lead CSS Organization **by July 22, 2022**

- Funding will flow to the identified LEGHO Lead CSS organization and a deliverable of the funding will be completion of an implementation plan (including target setting)
- The identified lead CSS organization for the LEGHO program will complete an implementation plan, in partnership with (at minimum) their OHT Executive Lead, HCCSS, local hospitals, and CSS partners

C. Phase 2: Submission of Implementation Plan by **September 21, 2022**

Questions

Phase 1: CSS LEGHO Leads

What are other important considerations to CSS in identifying a CSS LEGHO Lead per OHT or per OHT Partnership?

What, if any, are the anticipated challenges in identifying a LEGHO Lead Organization?

Are there opportunities to partner across OHTs?

Phase 2: Implementation Plans

How can your OHT partners help in the completion of an implementation plan?

Can you leverage existing work and build with this investment?

How might investments and enhancements in CSS help advance achievements and/or care transformation for your OHTs priority populations?

Reflections from CSS Partners

- One Care Home & Community Support Services (June 24)
- Canadian Red Cross (June 27)
- Home & Community Care Support Services (HCCSS) Grey Bruce and Cheshire Homes of London (June 27)

onecare
Home & Community Support Services

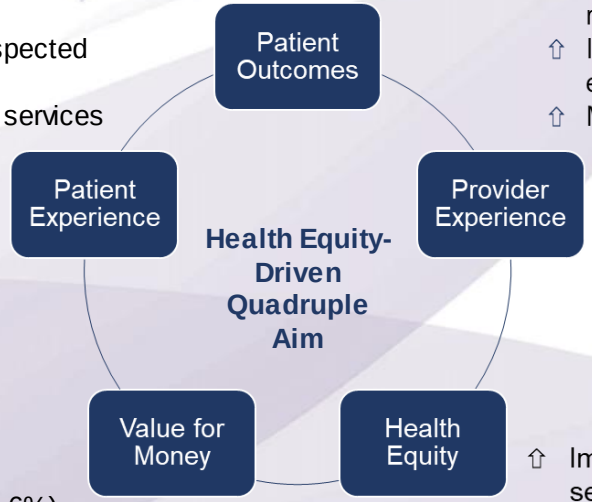
South West Community Support Services (CSS)
Bundled Care Services

Holistic Evidence-Based Program

⇧ 27% improvement in quality of life

⇧ Patients reported feeling respected and well-informed
⇧ More streamlined access to services
⇩ Reduced duplication

⇧ Better integration and strengthening of relationships with CSS
⇧ Improved understanding and expectations of system partners
⇧ More streamlined communication



⇩ 41% reduction (21.5% > 12.6%) in hospital readmissions
⇩ 10% reduction in Emergency Department (ED) visits
⇩ Reduced duplication
⇩ Low-cost solution: on average 4 weeks of bundled care support costs less than a single day in a CCC/Rehab Bed

⇧ Improved equity and access to services
⇩ Eliminates in financial barriers to accessing services by removing client co-pay

Keys to Success

- Building on CSS Central Intake
- Assessment & Coordination – calls by RPN to coordinate and transition - many clients live alone
- Coordination with HCCSS & hospital partners
- Referrals from Emergency Department
- No charge to client for services was essential –have lower incomes

Client Story

https://www.youtube.com/watch?v=lMApXerAFhI

Homeward Bound - Lessons Learned

We find motivation everyday through our work. It is not just one thing that keeps us going, but rather the knowledge that even the smallest part of our "routine" contributes to:

- Strengthening our health care system by reducing hospital stress, overcrowding and costs.
- Giving our client's families the peace of mind in knowing their loved ones are being checked on during their recovery period.
- Helping older adults maintain their independence and remain in their home
- Supporting and encouraging a wrap around of community services to serve and aid the sick and vulnerable.
- Making a real and appreciated difference in the lives of our clients.

We are proud to make a difference

Homeward Bound - Lessons Learned

There is no "typical" client

Each client is unique. Abilities, diagnosis, family supports etc., vary from client to client. It's important to be flexible with services and delivery schedules to meet case-by-case needs.

Get to know your community partners

Community connections are critically important. Don't assume whoever referred you a client also connected them with other service providers. Do your networking. Get to know fellow community agencies and educate your client facing staff regularly about their programs. Refer, refer, refer.

Discharge is not the end

A post-discharge follow up is extremely important to ensure clients are still managing well. Some clients seem to have returned to base line after 3-4 weeks of service but regress and struggle once they are not getting regular help. It is better to re-admit them to your program then waiting for them to fail and return to hospital.

Encourage Staff Versatility

Cross train staff to work in different roles and branches whenever possible. Over the long term it'll help your program bridge the gaps created by staffing shortages.

Homeward Bound was Blessed to be a Part of

Norma's Story

September 2021

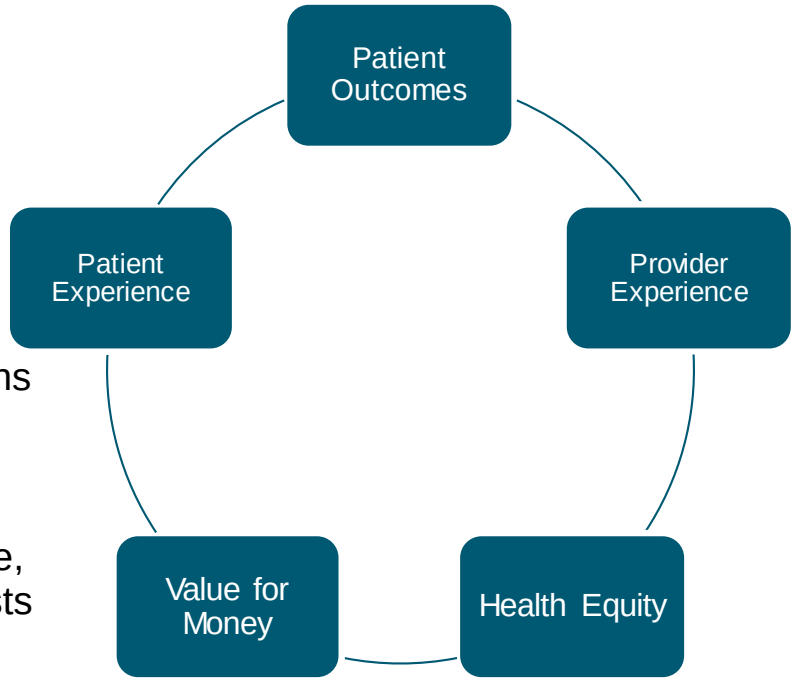
CSS Bundled Services

High Intensity Supports at Home

Alignment with OHT Priorities

- ⇧ Patients reported feeling respected and well-informed
- ⇧ More streamlined access to services
- ⇩ Reduced duplication

- ⇧ 27% improvement in quality of life



- ⇧ Better integration and strengthening of relationships with CSS
- ⇧ Improved understanding and expectations of system partners
- ⇧ More streamlined communication

- ⇩ 42% reduction (21.5% > 12.6%) in hospital readmissions
- ⇩ 10% reduction in Emergency Department (ED) visits
- ⇩ Reduced duplication
- ⇩ Low-cost solution: on average, 4 weeks of bundled support costs less than a single day in a CCC/Rehab Bed

- ⇧ Improved equity and access to services
- ⇩ Eliminates financial barriers to accessing services by removing client co-pay

Key Learnings

- The role of CSS Care Planning is an essential element of the success of Bundled Services. The CSS Care Planner provided:
  - At least weekly check-in's with problem-solving of barriers to success
  - Short term intensive support, focused on the needs of the whole person
  - System navigation as a single point of contact to set up and initiate multiple services and supports
  - Follow-up to ensure services are meeting the needs of the client
  - Support and resources to support ongoing self-management
  - Communication to all partners including Primary Care, HCCSS and Hospital
- Sharing of information between health providers is essential to ensuring seamless service delivery for the patient, but it isn't consistent nor is it simple.
  - Partners have to work very hard behind the scenes to ensure the connections are made when the systems don't make them automatically
  - Making it simpler for the client, may not always make it simpler for providers
- Collaborative Partnerships with a shared goal create stronger connections within and between health system providers, make better use of scarce resources and create improved health outcomes for patients.
  - Important for regular connections and open, honest dialogue
  - Regular review of core principles and development of rules of engagement/team values

Core Principles:

1. Relentless focus on the client/caregiver experience
   - Return to this whenever stuck on process
   - Review at every meeting as check-in
2. Relationships take time and require trust
   - The importance of communication can never be underestimated; listen with the intent of hearing
   - Engagement of partners, clients and caregivers as equals in the development of future state
   - Ownership must be shared
   - Past history and agency "hats" must be put to the side
   - Collaboratives need maintenance
3. Buy-in is required at all levels of the organization

Success Story

Mr. R is a 72 year old gentleman living in social housing who was in hospital due to a recent fall. He has multiple chronic health conditions and suffers from anxiety and depression. He has a history of addictions and has no family support.

Upon discharge his quality of life measure was 60. He signed up for Meals on Wheels, Home Help, Community Paramedicine and Care Planning. These services were provided by 4 different organizations.

During the initial intake call, Mr. R was confused about his discharge plan and had difficulty knowing which providers were involved in his care. Mr. R requested we speak with his friend and neighbour, who "knows everything" and is his primary contact.

When we contacted the friend, he became verbally aggressive and agitated and we were unable to initiate services during the call.

How did Bundled Services help?

1. The Care Planner consulted with the HCC Care Coordinator and learned that a safety plan was in place by HCC staff due to the behaviour of the friend.

2. Communication was sent to ensure all partners were made aware of the safety concern

3. A collaborative care conference was scheduled. During the care conference, Mr. R shared that he did not wish for his friend to be involved, but that he often barges in and takes over.

4. Contact information was updated and friend was removed. All partners were updated.

5. Following the Care Conference, Community Paramedicine scheduled a home visit to conduct a wellness check and home safety assessment. During the visit, the neighbour entered the home. With the consent of Mr. R, the paramedics advised the neighbour that if he continued to involve himself in Mr. R's care, the police would be called.

6. The CSS Care Planner continued to follow up with Mr. R each week, acting as the liaison to services; ensuring the Home Help services were coordinated and Meals on Wheels had arrived. Food security was identified as a concern and emergency assistance was provided to assist with groceries. Community Paramedicine continued to complete Wellness Checks every other week.

7. Mr. R became more engaged in managing his own care with his neighbour no longer being involved. He joined a social group in his building and had a new love interest.

8. At the end of the 4-week period, Mr. R's Quality of Life measure had increased from 60 to 95.